OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

October 11, 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Health Enhancement Communities	50 min
5. “Story of Medicaid” Informational Materials	10 min
6. Prevention Service Initiative	40 min
7. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Payment Reform Council Appointment

Health Enhancement Communities

Health Enhancement Community Initiative: Preview – Refined Straw Model

Healthcare Innovation Steering Committee

October 11, 2018

Meeting Objectives

Purpose of this presentation:

- Review new developments and proposed changes based on input from the PHC and other stakeholders
- Preview key concepts that will appear in the refined HEC strawperson model
- Obtain HISC input on key questions

Health Enhancement Community Initiative

Proposed Features

- HECs will be multi-sector collaboratives with formal governance structures operating in defined geographic areas that will be accountable for achieving prevention, health risk, and health equity improvements, and cost and cost trend reductions for select health priorities
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable, including rewarding communities for prevention, health improvement, and the economic value they produce.

Health Priorities

Primary Priorities Across HECs

Improve Child Well-Being

Increase Healthy Weight and Physical Fitness

Improve Health Equity

HECs may also select additional priorities but the intent is to have a statewide focus.

HEC Proposed Prevention Priorities

HEC Child Well-Being Goal: Assuring safe, stable, nurturing relationships and environments*

HECs would implement interventions to prevent Adverse Childhood Experiences (ACEs) and increase protective factors that build resilience pre-birth to 8 years old. Interventions would target:

- Physical, sexual, and emotional abuse
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Divorce or separation of a parent
- Domestic violence towards a parent
- Incarceration of a household member

HECs may also implement interventions that address other types of trauma or distress such as food insecurity, housing instability, or poor housing quality.

HEC interventions may focus on families, children, parents, and expectant parents.

** Source: CDC Essentials for Childhood*

HEC Proposed Prevention Priorities

HEC Healthy Weight and Physical Fitness Goal: Assuring individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so.

Healthy weight and physical activity are defined as:*

- *Healthy Weight:* Maintaining a healthy body weight (based on CDC BMI guidelines**)
- *Physical Activity:* At least 150 to 300 minutes of moderate-intensity activity per week to prevent weight gain.

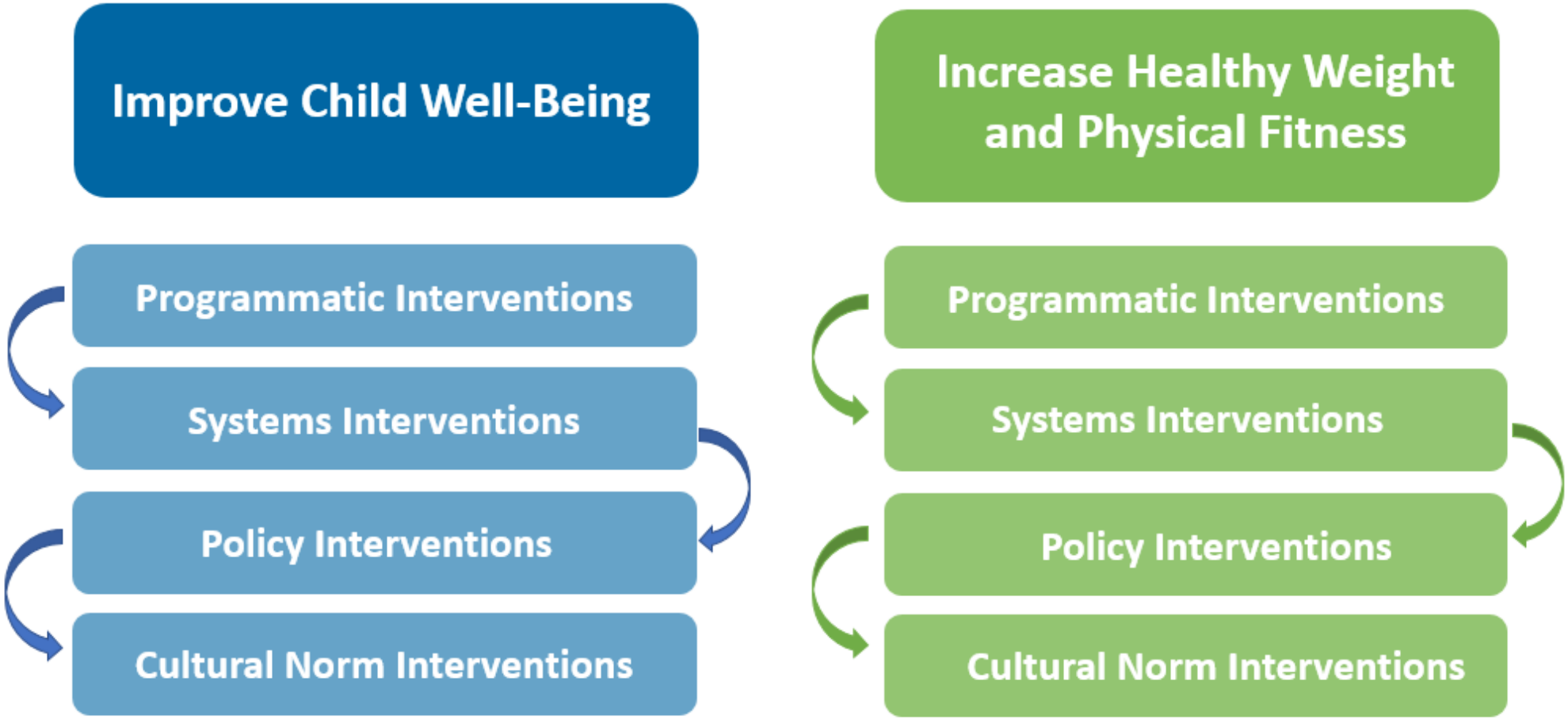
HECs would implement interventions to prevent overweight and obesity across the lifespan and the associated risks of developing serious health conditions. Interventions would target:

- Access to and consumption of healthy foods and beverages
- Access to safe physical activity space
- Reducing deterrents to healthy behaviors

** CDC*

**** https://www.cdc.gov/obesity/adult/defining.html; https://www.cdc.gov/obesity/childhood/defining.html

HEC Proposed Intervention Framework



Geography

HEC Geographies: Proposed Elements and Process

- HECs will have defined geographies for which they are accountable.
- State hopes to provisionally have 8-12 HECs and wants every geography in Connecticut included in an HEC.
- HEC geographies will be defined during an iterative State process.
  - The process will start by prospective HECs proposing geographies based on criteria defined by the State and providing rationale for their proposed geography.

Governance

HEC Governance

- HECs will need to have a formal governance structure with clearly defined decision-making roles, authorities, and processes.
  - Partner agreements, bylaws, backbone organization(s), contracts for specific services
- The governance structures will need to be effective within each HEC's unique context (e.g., geographies, populations, partners, infrastructures) and be nimble enough to adapt if circumstances change.
- There will need to be a balance between "focus and flexibility" so that HECs can quickly progress from making governance structure decisions to identifying and implementing strategies.

HEC Proposed Governance Framework

Governance Structure Element	FOCUS Required by State	FLEXIBILITY Determined by HECs
Partnership agreements	• HECs will need to have formal partnership agreements among organizations that will be part of governance structures and decision making. • HECs will need to include at minimum 2 community members in their governance structure, including on decision-making governance bodies (*See other requirements for involvement)* • HECs will need to include multiple community organizations that directly address root causes of poor health in their communities.	• HECs will determine the form of the formal agreement, who will be included in it, and how entities outside of the agreements will be involved in HECs. • HECs will not be required to form a new legal entity.
Bylaws	• HECs will need to have bylaws with clearly defined roles, governance bodies, terms of service, decision-making parameters and processes, etc.	• HECs will determine their structure and the contents of their bylaws.

HEC Proposed Governance Framework

Governance Structure Element	FOCUS Required by State	FLEXIBILITY Determined by HECs
Backbone organization	• HECs will need to have a defined backbone organization(s) that can perform or contract for the key functions required to operate an HEC.	• HECs will determine which organization(s) will be the backbone organization(s) and the structure and scope of their responsibilities.
Formal contracts for services	• HECs will have to have formal contracts with the entities providing significant administrative or other services.	• HECs will select the administrative service provider(s), determine their roles, and develop the contract(s).

Stakeholder Engagement

Community Member Engagement: Proposed Design Principles

- HEC success depends on community members shaping what HECs are and do by sharing their perspectives about their lived experience within communities, including:
  - Nuanced insights about needs and opportunities
  - Informal and formal resources and networks that can support HEC activities and lasting change in their communities
  - Real-world experience with what has worked and not worked in the past.
- Given that, the HEC model will require that community members be involved in all stages of HEC formation and operation.

Community Member Engagement: Proposed Design Principles

- Guiding principle for community engagement should be “nothing for us without us”
- Clear definition of “community member” so that involvement is not only leaders or staff of organizations and there is diversity that reflects the HEC communities
- Proposed requirements:
  - Direct involvement and decision making in designing how assets and needs are assessed; designing the HEC structure; designing the strategies for leveraging assets and addressing needs; and selecting, implementing, and evaluating interventions.
  - Dedicated seats on HEC governance structures

Community Member Engagement: Proposed Design Principles

- Proposed requirements (continued):
  - Multiple mechanisms for community members to play their role on governance bodies, including options in community settings and other than daytime meetings
  - Support for community members to meaningfully engage in HECs, including financial support, training, and leadership development
    - Don’t just bring the community to the table. Take the table to the community and be at their tables.

Community Member Engagement: Proposed Design Principles

- Proposed requirements (continued):
  - Seek out and use what community members have said in previous community engagements rather than asking the same questions repeatedly
  - Respond to and meaningfully use the input that community members provide
  - Implement regular multi-directional communication strategies
    - Show how community members' input was used to shape what the HEC is and what it does
    - Include community members as both recipients and deliverers of communications

Community Member Engagement: Sources of Input for HEC Model Design

- Information from the **SIM Listening Sessions** and **State Health Improvement Plan** engagement influenced the selection of the priorities and other aspects of the model
- **Consumer Advisory Board** had provided input on the community engagement process so that:
  - The process meaningfully captures input of community members
  - The community member input helps shape the HEC design
  - Community members hear how their input shaped the design

Design Input from Community Collaboratives

- Reference Communities were selected by the State through an RFP process to provide recommendations on HEC design: Hartford, New London, Norwalk, and Waterbury,
- Also presented and got input on the proposed model with collaboratives in New Haven and Bridgeport

The Goals of the Process are to:

- Give the existing community collaboratives and their community members a voice in the design of the HECs
- Get recommendations that are reality-based and actionable in communities

Community Member Engagement: Input for HEC Model Design Through Reference Communities

- Hartford had 5 community members participate in Deep Dive 1 and 4 community members participate in Deep Dive 2
  - Examples of how their input was used in the design:
    - A community member gave an example of a child who recently drowned to illustrate that you have to implement multiple related strategies, including addressing programs, policies, and cultural norms to prevent it from happening again
      - *This was a validation of the intervention framework.*
    - A community member said the state should define the regions or be part of it otherwise it will take too long for collaboratives to decide.
      - *This influenced the HEC and State process for defining geography.*

Community Member Engagement: Input for HEC Model Design Through Reference Communities

- Two community members said that the HEC model should the adopt the community involvement philosophy of “nothing for us without us” and gave input on multiple ways to ensure that community involvement is meaningful (e.g., funds specifically for community engagement, requirement of having community members at every table, multiple roles to collect outreach information and bring that back/represent to group, capacity building for community leaders and members, alternative engagement times for those who work)
  - *This influenced the proposed community involvement and governance elements.*

Community Member Engagement: Input for HEC Model Design Through Reference Communities

- Hosting community conversations
- Facilitating discussion sessions at existing community events
- Hosting mini-focus groups
- Doing key informant interviews
- One engaged community members through local childcare facilities; another had AmeriCorps volunteers to engage the community
- Doing brief in-person surveys (example: in community health centers waiting rooms)

Community Member Engagement: Input for HEC Model Design Through Other Communities

- **Bridgeport and New Haven Community Collaboratives** also participated in webinars about the proposed HEC model
  - Asking some participants have HMA present and facilitate a session with community members to get input on the proposed model. (Example: Clifford Beers Clinic parents meeting)
- A **Rural Forum** will be hosted by OHS, DPH, and local health departments in a rural area to get input from community members on how the proposed design should reflect the realities of rural communities.

Planned and Ongoing Stakeholder Engagement

Planned and ongoing stakeholder engagement includes:

- **State agencies** – Forum/webinar held on 9/25 and individual meetings with key agencies
- **Local health departments** – Webinar held on 9/18
- Other key groups such as the **Healthcare Cabinet, CT-AAP Executive Committee, Behavioral Health Partnership Oversight Council, Medical Assistance Program Oversight Council, PCMH+ provider entities**
- **Foundations and funders**
- **CHCACT and CHC, Inc.**
- *We estimate more than 180 individuals/entities have been reached through HEC stakeholder engagement and Reference Community efforts so far.*

Centralized Support

Centralized Support
State Partnership for Health Enhancement

- The State recognizes the need to play a critical role in assuring the support (directly or through another method) that HECs and the HEC Initiative will need to succeed, including:
  - Pursuing financing, including Medicare, Medicaid, and other payers
    - Possibly facilitate access to one or more fiduciaries to support financial management for HECs
  - Pursuing legislative and regulatory changes that will support HECs and enable the HEC Initiative
  - Providing mechanisms for easing data exchange, collection, and reporting
  - Providing a centralized resource for technical assistance, training, tools, templates, a learning community, and other types of support as HECs plan, form, implement interventions, measure and report outcomes, and receive financing

Statewide HEC Committee
HEC Advisory Committee

- Proposed design includes establishing a statewide committee that will advise the implementation and performance of the HEC Initiative, including:
  - Progress of implementation
  - Securing funding and financing
  - Strategies and improvements for healthy equity, prevention benchmarks, and reducing costs
  - Critical state and local policies
- Will comprise representatives from each HEC, community members, and other key stakeholders
  - Member categories and process for selection not yet determined
- Committee precise scope and roles have to be further considered and decided

Financing

Proposed HEC Financing Approach

- Monetizing prevention is at the core of the HEC Model
- Will require a mix of:
  - **Near-term**, upfront funding in the first five years of implementation
  - Sustainable **long-term** sources of funds beyond five years
  - Assumption that near-term financing options will serve as a bridge to longer-term financing
  - Long-term financing will rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and potentially other payers.
- Pursuing multiple strategies
  - Multi-payer demonstration
  - Social finance options

Medicare Impact Model

- The HEC Medicare Impact Model is quantifying the potential short-term and long-term savings impact of the HECs on Medicare
  - Also looking at how to modify the analysis for other payers.
- Primary analysis suggests that reducing the prevalence of obesity among the Medicare population (age 65+) by approximately 5 percentage points over a 10-year period (2021 – 2030) could yield cumulative health care cost savings of $1 billion or more.

Timeline

Current Timeline

Step	Timeframe
PHC to receive draft HEC Report	On or about Monday October 22
PHC to participate in webinar reviewing HEC Report structure and feedback process	On or about Tuesday October 23 (to be scheduled)
PHC to provide feedback on report in PHC meeting and approval to distribute to HISC with agreed upon changes	Thursday November 1
HISC review and approval of report	November – December
Public Comment period	December – January
PHC to review public comment recommendations and changes to HEC Report	January – February
HISC review and approval of HEC Report	March

Discussion

“Story of Medicaid” Informational Materials

Prevention Service Initiative

HEALTH MANAGEMENT ASSOCIATES

Prevention Service Initiative: Progress Update

October 11, 2018

SIM connecticut state innovation model

Keeping Connecticut Healthy DPH Connecticut Department of Public Health

OHS CONNECTICUT Office of Health Strategy

AGENDA

- INTRODUCTIONS
- PREVENTION SERVICE INITIATIVE OVERVIEW
- TECHNICAL ASSISTANCE OVERVIEW
- SAMPLE PROJECTS
- LESSONS LEARNED TO DATE
- Q and A

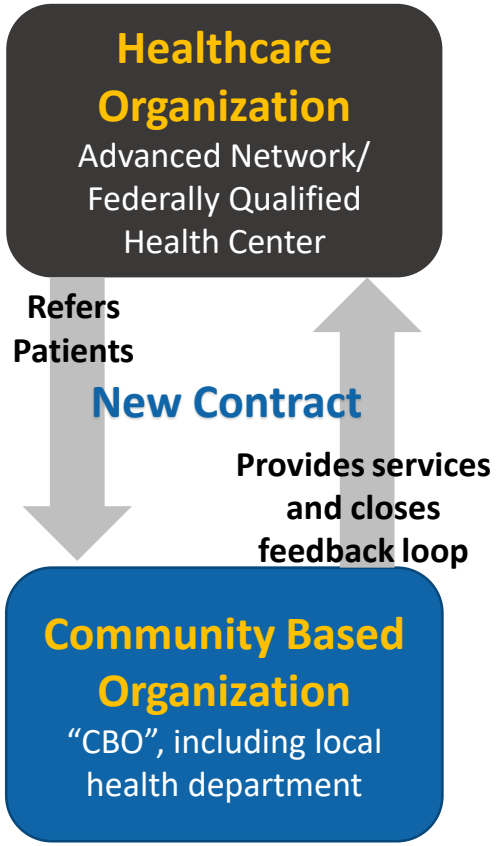
PREVENTION SERVICE INITIATIVE (PSI)

+ BUILDS ON CT DELIVERY SYSTEM REDESIGN

+ LEVERAGES "LINKAGE MODEL"

+ FOCUS – CONTRACTING WITH CBOS

+ COMMUNITY BASED PREVENTIVE SERVICES



EVIDENCE BASED PREVENTIVE CARE

DELIVERED OUTSIDE THE CLINICAL SETTING

- IMPACT CLINICAL OUTCOMES, ED/HOSPITAL USE
- ASTHMA: HOME VISITS, EDUCATION & ENVIRONMENTAL MGMT
- DIABETES: SELF-MANAGEMENT and EDUCATION PROGRAM

PREVENTION SERVICE INITIATIVE (PSI): VALUE TO COMMUNITY BASED ORGANIZATIONS

+ Focus on community's needs—new populations and services
+ Build infrastructure and capacity
+ Ability to identify additional opportunities
+ Reliable source of funding
+ Strengthen and market services

"We finally have resources to get the neediest people care"—CBO participant in PSI

PREVENTIVE SERVICES INITIATIVE (PSI): VALUE TO HEALTH CARE ORGANIZATIONS

+ Asthma and Diabetes interventions to improve quality scores
+ CHW to engage “hard to reach” patients
+ Address non- clinical SDOH
+ Provide cost effective service

VBP MEASURES

- ED USE
- HOSPITALIZATIONS
- ASTHMA MEDICATION MGMT
- DIABETES CONTROL

CBO PROJECT TEAM

Heidi Arthur, LMSW, Principal --CBO-HCO engagement and program design

+ Expertise assessing and supporting contract readiness for community based organizations addressing the social determinants of health
+ Background in behavioral health and primary care integration and VBP readiness support for behavioral health providers

Joshua Rubin, MPP, Principal – CBO-HCO finance and operations

+ Expertise supporting behavioral health and health care provider readiness for VBP
+ Expertise with Integrated Network design and development

HCO PROJECT TEAM

Jodi Bitterman Pekkala, MPH, Senior Consultant –HCO-CBO workflows and quality metrics

+ Expert in health policy and analysis and quality improvement
+ Patient-Centered Medical Home Certified Content Expert™ (PCMH CCE™)
+ Certified Healthcare Effectiveness Data and Information Set (HEDIS®) compliance auditor with knowledge of HEDIS data collection, measurement, and reporting processes

Kathy Ciccone, DrPH, RN, MBA, Subcontractor –HCO-CBO engagement and systems design

+ Expertise with large-scale quality assurance and improvement collaboratives
+ Former Executive Director of the Quality Institute at the Healthcare Association of New York State (HANYS)
+ Expertise creating partnerships and negotiating program development in response to delivery system reforms
+ Provided guidance on measure development and standardization, metric formulation, and quality improvement programs

SIM connecticut state innovation model

DPH Connecticut Department of Public Health

OHS CONNECTICUT Office of Health Strategy

HEALTH MANAGEMENT ASSOCIATES

TECHNICAL ASSISTANCE

+Organizational assessments

+Site Visits

+TA plans

+Webinars and tools

+Group Learning Sessions

+Regional calls

+1:1 TA coaching and support

+Peer to peer relationship building

+SharePoint

MOST COMMON HCO TA NEEDS

+ Refining patient selection process and internal support needs
+ Referral processes and feedback loop--internal and with CBOs
+ Quality Metrics and ROI
+ Provider and patient engagement
+ Developing and Negotiating Contracts with CBOs

"When is a patient engaged , and therefore in the program? Where should this data live—our system? The CBOs? Both?"—HCO participant in the PSI

MOST COMMON CBO TA NEEDS

+ Understanding VBP environment
+ Marketing CBO value with HCOs
+ Defining Metrics to evaluate impact and ROI
+ Data collection
+ Rate structures
+ Developing and Negotiating Contracts

"It's not just a referral….we need to communicate what we're doing in the community"—*CBO participant in PSI*

WEBINARS

CBO TOPICS
Initiating Service Planning
Business Planning for Successful Service Delivery to New Healthcare Customers
Metrics: Moving from Outputs to Healthcare Outcomes
IT Infrastructure: Building the Interface with the Healthcare System
Community Health Workers: Best Practices
Business Plan Discussion

HCO TOPICS
Prevention Service Initiative Learning Session Follow Up
Quality Measures Patient Privacy/Information Sharing
Evaluation & Return on Investment: Part 1
ROI Calculator for Partnerships to Address the Social Determinants of the Health- *Guest presenter, Professor Victor Tabbush*

TECHNICAL ASSISTANCE: TOOLS

- Assessment
  - AN/FQHC Self-Assessment for Contracting with CBOs for Asthma and Diabetes Prevention Services
  - CBO Readiness Assessment for Healthcare Contracting with HCOs for Asthma and Diabetes Prevention Services
- HCO project development
  - CBO fact sheets
  - Project planning
  - Project budgeting
- CBO business development
  - Value Proposition Planning Guide
  - CBO Logic Model Tool
  - CBO IT Planning Tool
  - Budget Planning Spreadsheet
  - CBO Business Plan Template
- Linkage tools
  - CBO/HCO requirements and responsibilities
  - Framework for partnership discussion
  - Contract template

SUCCESSES

- Six partnerships under development
  - Northeast Medical Group – Yale New Haven Health and Stratford Health Department
  - Naugatuck Health District – Pomperaug Health District and Prospect Waterbury
  - Fair Haven Community Health Center and Milford Health Department
  - St. Vincent's Health Partners – Value Care Alliance and Hispanic Health Council
  - Community Health Center and Connecticut Community Cares and Hispanic Health Council
  - Optimus Health Care and Southwestern CT Agency on Aging and Hispanic Health Council

Connecticut Community Care

Target Population:

- Individuals with an A1C 8+
- Provider selection
- Adults

Project:

- Project: Live Well with Diabetes Plus and Community Health Worker/Navigation
- Service(s): Screening, RD, Group and Individual Diabetes Education, Community Health Worker/Navigation support for SDOH
- Goals: Reduction A1C, Improvements in self-efficacy/activation, positive behavior change (healthy eating, exercise)

Unresolved Issues:

- Evaluation tool – Self-Efficacy for Diabetes?
- Interpretation Services for RD (certify CHW or service)? How are other CBOs addressing this?

Next Steps:

- Respond to RFP
- Solidify Proposed Pricing Model
- Define ROI
- Develop Referral Process and Reporting Structure
- Build out our electronic CMS to include this program/service
- Build CQI with partner – check-ins, measurement, adjustments

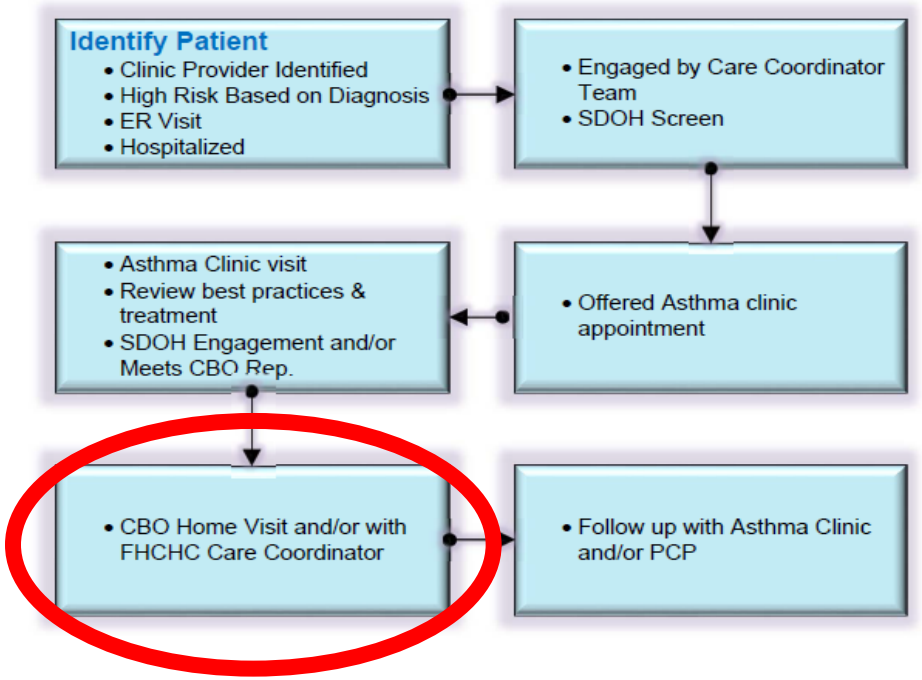
Fair Haven Community Health Care

CASE EXAMPLE: FAIRHAVEN COMMUNITY HEALTH CARE AND MILFORD HD

+ Target Population:

- + All children and adults with a dx of persistent asthma
- + Risk, utilization

+ Project:



- **Challenges:**
  - ROI Calculations for sustainability, scale
- **Lessons Learned:**
  - Cannot wait for RFP award to prepare for partnership or else behind the curve. Requires several months of dedicated preparation
- **Accomplishments:**
  - Created specialty RAAC Clinic (Respiratory, Airway and Allergy Conditions Clinic) to prepare for partnership

- **Unresolved Issues:**
  - Information sharing between CBO and HCO – EMR access vs. media scan, reporting

- **Next Steps:**
  - Create workflow to support deliverables

PSI Lessons Learned

CHALLENGES

- Perceived vs. Actual Complexity-- paradigm shift
- Sites required/requested more 1:1 TA than expected – each came into PSI with very different “starting points”
- Hard to initiate planning before partner is known
- Some “mismatch” between Providers and CBOs
- Working with an evolving model
- Patient engagement; provider buy-in TB
- Logistics

LESSONS LEARNED

- Model and vision requires repetition
- Most HCOs were not familiar with the services provided by the CBOs
- CBOs need more support than expected with:
  - Budget design
  - Advocating for the value of their services
  - Understanding how to adapt EBPs to new circumstances
    - new population, timeframes, relationship, cost structure, etc.
- SDOH opportunity is attractive for all partners
- Units of service in CBO-HCO relationships are complex
- Selecting measures and ensuring ROI is highly individualized

- Pricing Models—> ROI
- IT integration for screening, shared plan, and data collection—
  - *"We're moving from Microsoft office suite to EHR"—CBO participant in the PSI*
- Evaluation tools and CQI needs to get to the heart of what we're looking at
  - short and long term assessments for health and SDOH improvement
  - how well are providers "selling" the program
- Program issues, such as interpreter services, provider buy-in

TAKE AWAYS

- PSI represents a highly unique approach to very common problem faced in many states
- Contracting and adapting in order to leverage the capacity of outside partners and ensure ROI → PSI is a preparation model for VBP environment
- Critical to share the context in which this project is operating
  - reinforce the novelty, no one has the answers,
  - Collaboration essential--have to problem-solve together
- Trust and relationship building is fundamental

QUESTIONS

Adjourn