OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

November 15, 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Community Health Center Inc. & Value Care Alliance presentations on CCIP Progress	50 min
5. Health Enhancement Communities Report	50 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Community Health Center Inc.: CCIP Progress

Community Health Center, Inc.

Updates for Community & Clinical Integration Program Steering Committee

November 15, 2018

Dr. Daren Anderson, VP/CQO, CHCI; Director, Weitzman Institute
Adriana Rojas, Project Manager

Community Health Center, Inc.

CHC Profile

- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $100m
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)

CHC Locations in Connecticut

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation


Si algo le parece mal, confíe en sus instintos.
Diga algo.
888.270.6633 ext. 3335

Community & Clinical Integration Program

Improve Health Equity
Improve Complex Care Management
Improve Integration of Behavioral Health and Primary Care

Enhance Data Collection and Application

- Acquisition
  - SOGI
  - SDOH
  - Race/ethnicity
  - Patient Ping
  - Population health data sets
- Application
  - Dashboards
  - Provider/team reports

Enhance Primary Care Team

- Enhance skills and capacity of core team
  - Nurse CCM training
  - CCM ECHO
  - MAT
- Expand care team
  - CHW
  - PharmD
  - Chiropractor

Enhance Engagement with Medical Neighborhood

- Community Based Organizations (PSI)
  - Hispanic Health Council
  - CT Community Care
- eConsults

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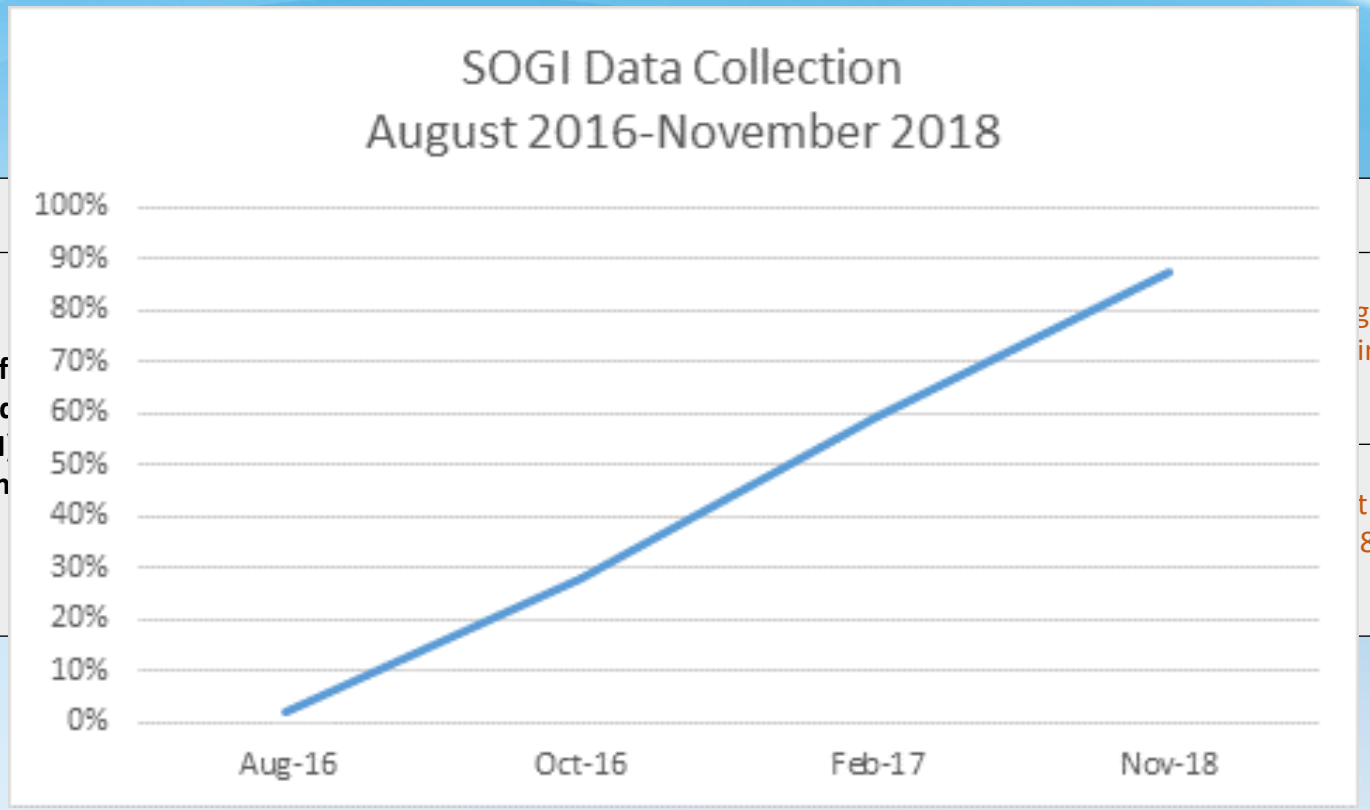
Complex Care	Health Equity	Behavioral Health (depression)	Behavioral Health (substance abuse)
Increase use of Person Centered Assessments (PCAs) with complex patients	Increase collection of CDC compliant race and ethnicity data documented in the EHRs	Improve rate of depression screening	Improve rate of substance use screening
Increase identification of social determinants of health (SDOH) needs among high risk patients	Establish a baseline for collection of sexual orientation and gender identity (SOGI) data documented in the EHRs	Improve rate of primary care follow-up for depression	Improve rate of primary care follow-up for substance use
Increase use of CHW for navigation/linkage	Increase collection of sexual orientation and gender identity (SOGI) data documented in the EHRs	Improve rate of BH specialist follow-up for depression	Improve rate of SU specialist follow-up for substance use
Increase use of comprehensive care team	Increase collection of preferred language data documented in the EHRs	Improve the rate of appropriate follow up for depression in an integrated care system	Improve the rate of appropriate follow up for follow-up for substance use in an integrated care setting
Decrease hospital admissions		Depression remission	



Goal		Value	%
Increase collection of sexual orientation and gender identity (SOGI) data documented in the EHRs			

Goal	Measurement	Type	*Guidelines*		Description	Value	%
Increase collection of sexual orientation and gender identity (SOGI) data documented in the EHRs	**% of patients with SOGI data documented in the EHRs**	Process	***All patients age 13+ will be asked about sexual orientation and gender identity***	**Numerator**	Patients greater than 13 years of age with SOGI data EVER documented in the EHRs	28113	89%
				Denominator	Patients age 13 and older as of visit date who had a medical visit 4/1/18-6/30/18	31265	

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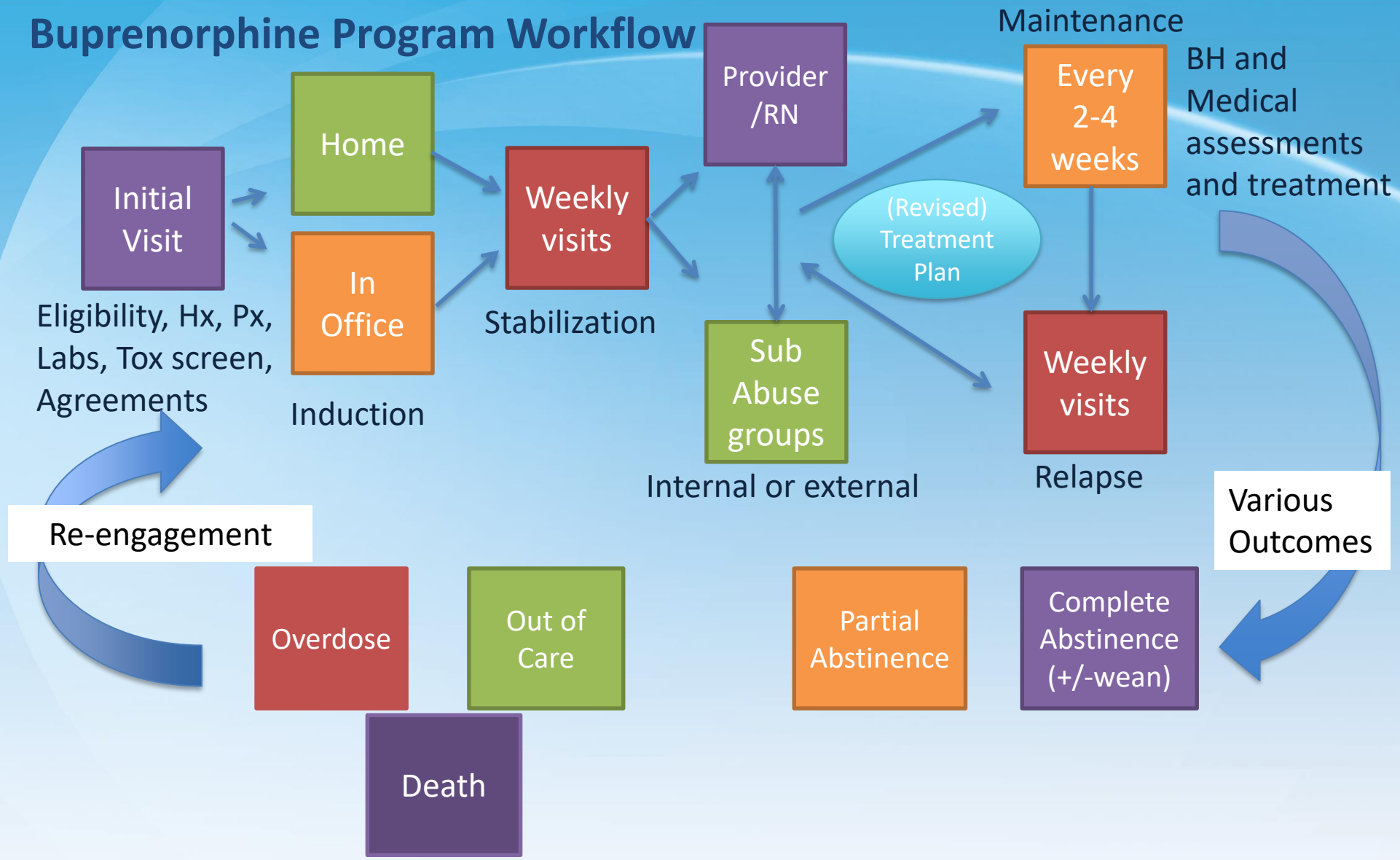
Buprenorphine Program Workflow



Weitzman ECHO® Complex Care Management

Community Health Workers at CHC

- Much of healthcare is determined by factors that cannot be addressed in the clinic
- New opportunity given growth of value based care and shared savings with PCMH+
- CHWs represent an evidence based tool to improve care of complex cases and improve health equity

CHCI phase 2 funding plan:

- Close collaboration with the Penn Center for CHWs
- Recruitment and training of CHWs
- Project ECHO for CHWs
- Robust evaluation/ROI analysis

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Prevention Services Initiative

- Collaboration with community-based care organizations
- Focus on Diabetes
- CHWs
- Diabetes education and support
- Integration with clinical teams

Hispanic Health Council
Health. Hope. Community.

CONNECTICUT COMMUNITY CARE™
Caring From Every Perspective

Moving Knowledge, Not Patients

Re-thinking the way pediatric primary care
and specialists work together

CeCN
Community eConsult Network, Inc.

Connecticut Children's
MEDICAL CENTER

CeCN Highlights

CeCN is a national, non-profit provider of eConsults that was **designed, tested, and developed** by a large primary care practice in Connecticut.

Where health care is a right, *not a privilege*, since 1972.

Community Health Center, Inc.

CeCN

Community eConsult Network, Inc.

An eConsult is
a complete consult sent electronically to a specialist including appropriate PHI from the patient's chart with a **formal consult note in response**

PCP

Consult question + Relevant chart content

Specialist

CeCN
Community eConsult Network, Inc.

The consult note from the Specialist to the PCP includes:

- Recommendation about whether a face-to-face is needed
- Management advice and education about the particular case

CeCN
Community eConsult Network, Inc.

CeCN

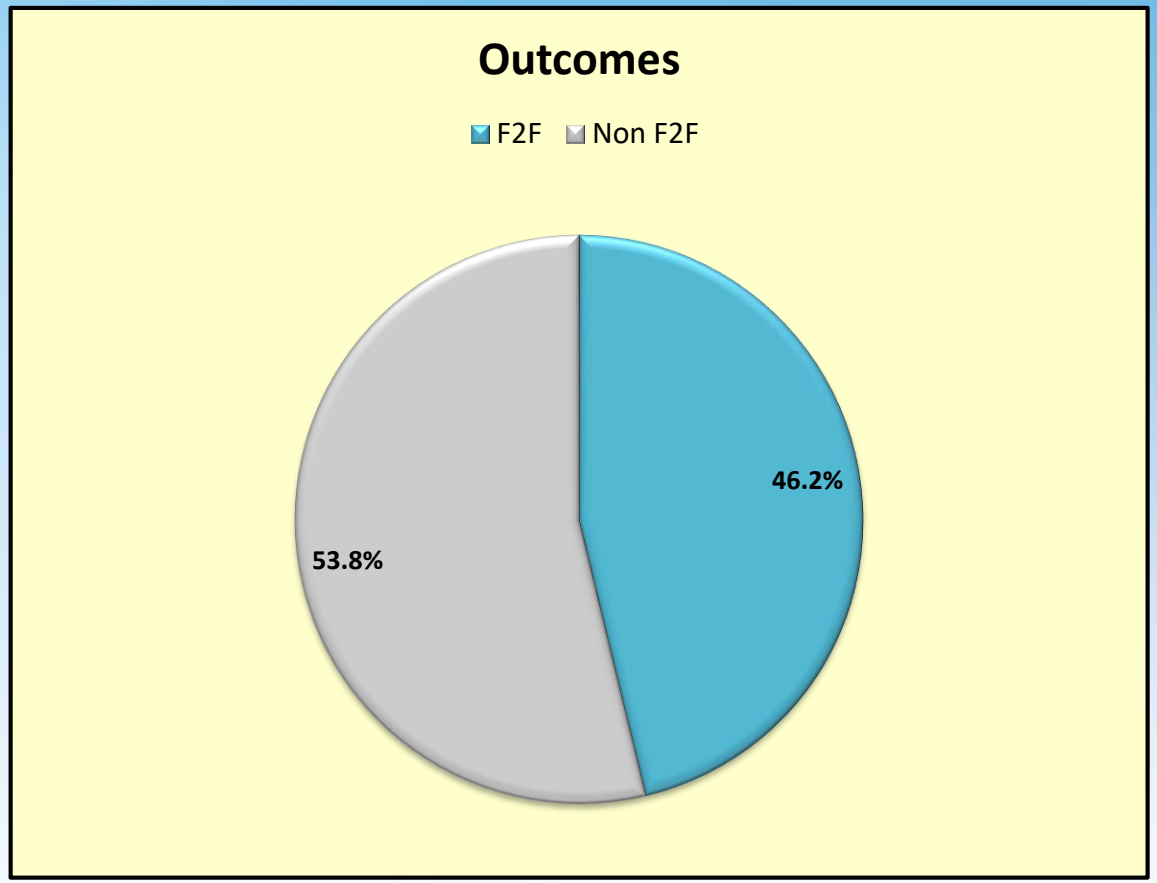
Community eConsult Network, Inc.

- Addiction Medicine
- Allergy
- Diabetic Education
- Cardiology
- Complex Primary Care
- Dermatology
- Endocrinology
- ENT
- Gastroenterology
- Hematology
- Infectious Disease
- Neurology
- Nephrology

- OB/GYN
- Orthopedics
- Ophthalmology
- Pain Management
- Pharmacy
- Psychiatry
- Rheumatology
- Sleep Medicine
- Transgender Care
- Travel Medicine
- Urology
- Complex Pediatrics
- Genomic Medicine

- Pediatric Cardiology
- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Infectious Disease
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Neuropsychiatry
- Pediatric Psychiatry
- Pediatric Pulmonary

Total pediatric eConsults: 305
May 2017 through November 12, 2018



CeCN Connecticut Payer Contracts

ConnectiCare®
You know us by ♥.

Anthem®

Harvard Pilgrim Health Care

Connecticut Department of Social Services
Making a Difference

CeCN
Community eConsult Network, Inc.

weitzman institute inspiring primary care innovation

TO BE ADDED

By Daren Anderson, Victor G. Villagra, Emil Coman, Tamim Ahmed, Anthony Porto, Nicole Jepeal, Giuseppe Maci, and Bridget Teevan

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The People-to-People Health
Foundation, Inc.

Reduced Cost Of Specialty Care Using Electronic Consultations For Medicaid Patients

ABSTRACT Specialty care accounts for a significant and growing portion of year-over-year Medicaid cost increases. Some referrals to specialists may be avoided and managed more efficiently by using electronic consultations (eConsults). In this study a large, multisite safety-net health center linked its primary care providers with specialists in dermatology, endocrinology, gastroenterology, and orthopedics via an eConsult platform. Many eConsults were managed without need for a face-to-face visit. Patients who had an eConsult had average specialty-related episode-of-care costs of $82 per patient per month less than those sent directly for a face-to-face visit. Expanding the use of eConsults for Medicaid patients and reimbursing the service could result in substantial savings while improving access to and timeliness of specialty care and strengthening primary care.

Confidential

Barbara Starfield described primary care as "the provision of first contact, person-focused, ongoing care over time that meets the health-related needs of people, referring only those too uncommon to maintain proficiency."[1] The number of patients with conditions deemed "too uncommon to maintain proficiency" has shifted over the past two decades, as suggested by a substantial increase in the number of patients referred to specialists from primary care providers. Between 1999 and 2009 the number of visits to specialists in the US increased from 41 million to 105 million.[2] One study found that approximately 25 percent of all visits to a community health center resulted in a referral to a specialist.[3] For such patients who are cared for in the health care safety net, the challenge posed by increased demand for specialty consultations is compounded by limited access, particularly for the uninsured, patients with Medicaid, and those residing in rural locations. Nationally, approximately one-third of specialist providers limited or were unwilling to see patients with Medicaid in 2011.[4]

The increase in specialty referrals for patients with Medicaid makes a substantial contribution to year-over-year health care cost increases and has significant economic consequences for state budgets.[2,5] Specialty care is significantly more expensive than primary care.[6] Limited access compounds the problem by delaying needed treatment and increasing the use of urgent care and emergency departments.[7]

Advanced payment models are rapidly expanding across the country and are providing increased incentives for primary care providers to find ways to increase value and reduce the cost of care. Many cost-saving interventions in primary care have focused on enhancing access in order to reduce unnecessary emergency department visits or on improving care coordination and hospital discharge follow-up to reduce costly hospitalization and rehospitalization. Less attention has been paid to finding strategies to reduce the need for specialty consultation despite the fact that a decision to refer to a specialist is one of the most common, and likely most expensive, decisions made by primary care providers each day.

Daren Anderson (Daren@chc1.com) is director of the Weitzman Institute at Community Health Center Inc., in Middletown, Connecticut.

Victor G. Villagra is an assistant professor at the UCONN Health Disparities Institute, University of Connecticut Health Center, in Farmington.

Emil Coman is a research associate in the Ethel Donaghue Center for Translating Research into Practice and Policy, University of Connecticut Health Center, in Farmington.

Tamim Ahmed is president of Health Analytics LLC, in Glastonbury, Connecticut.

Anthony Porto is a research assistant at the Weitzman Institute, Community Health Center

Nicole Jepeal is a quality improvement analytics director at CareOregon Inc., in Portland, OR; was a research associate at the Weitzman Institute, Community Health Center Inc., at the time this work was conducted.

Giuseppe Maci is a research associate at the Weitzman Institute, Community Health Center Inc.

Bridget Teevan is a public health epidemiologist in the Rhode Island Department of Health, in Providence. She was a research associate at the Weitzman Institute, Community Health Center Inc., at the time this work was conducted.

The intervention costs[a] for face to face and eConsult patients and differences between them

Estimated Post Costs[A]	Face to face		eConsults		Differences (Δ)	
	Average	95%CI	Average	95%CI	Average	95%CI
Total Costs	$157	($148; $166)	$74	($59; $88)	-$84****	(-$101; -$67)
Dermatology	$43	($36; $51)	$29	($18; $41)	-$14*	(-$27; $0)
Endocrinology	$126	($104; 148)	$63	($31; $94)	-$63**	(-$102; -$25)
Gastroenterology	$71	($61; $80)	$12	($-1; $26)	-$59***	(-$75; -$42)
Orthopedics	$117	($107; $127)	$32	($14; $49)	-$85****	(-$105; -$65)

THANK YOU

www.weitzmaninstute.org

Value Care Alliance: CCIP Progress

Health Enhancement Communities Report

Health Enhancement Community Initiative: Draft HEC Proposed Framework

Healthcare Innovation Steering Committee Meeting

November 15, 2018

Meeting Objectives

Purpose of today's meeting:

- Provide an update of the design of the Health Enhancement Community (HEC) framework
- Obtain HISC input on key topics
  - HISC recommendations and takeaways from today's meeting will be reported back to the Population Health Council for discussion

Current Timeline

Step	Timeframe
Milestone: *PHC receives draft HEC Proposed Framework (complete)*	*Monday October 22*
PHC provides feedback on draft HEC Proposed Framework (complete)	*Tuesday October 23 – Thursday November 1*
PHC Meeting – Discuss HEC Proposed Framework (complete)	*Thursday November 1*
HISC Meeting – Discuss HEC Proposed Framework	Thursday November 15
Make Framework revisions and send to PHC	Mid to Late November
PHC Meeting to review revised Framework	November 29
HISC review and acceptance of Framework for public comment release	December – January
Public Comment period	January – February
PHC review public comment recommendations and changes to HEC Framework	February – March
HISC review and approval of HEC Framework	March

Integration of SIM Health Enhancement Communities (HECs) and Primary Care Modernization (PCM)


CLINIC
OFFICE
COMMUNITY CENTER
MARKET
SCHOOL

HEC Design: Proposed Framework

What the Proposed Framework Is and Isn't

- It articulates the state-level vision and goals for the Health Enhancement Community Initiative and sets some key priorities and parameters.
- The framework isn't the end of HEC design work or a "fully baked" model.
  - Aspects of the model will evolve and be further defined in 2019
  - Communities will make many decisions about what HECs are and do in their communities

What Decisions Have and Haven't Been Made

- Some decisions about what is in the framework have been made.
- Many other decisions have not been
  - Either because input from stakeholders is still coming in or because decisions will be made by communities.
- The HEC Initiative must have enough **focus** to ensure that there can be state-level improvements and enough **flexibility** to ensure that communities have the freedom to make choices based on the strengths, needs and circumstances in their communities.

What Decisions Have and Haven't Been Made

- Main parts of the framework that have been determined are the overall focus of HECs, the two health priorities, and the categories of interventions (but *not* the interventions themselves).
- Overall Focus: Improving community health and wellbeing and preventing poor health by addressing social determinants of health.
  - It is not about improving health care *after* people are already ill. It is about creating healthier communities and preventing people from becoming ill in the first place

What Decisions Have and Haven't Been Made

- Health Priorities:
  - **Improving Child Well-Being in Connecticut Pre-Birth to Age 8 Years**
    - This priority is focused on preventing or lessening the impact of Adverse Childhood Experiences, which are stressful or traumatic events, including abuse, neglect, and serious problems in the household or community.
  - **Improving Healthy Weight and Physical Fitness for All Connecticut Residents**
    - This priority is focused on preventing overweight and obesity and the related serious health conditions.
- But what if community members want to do something else?
  - They can! Community member ownership and trust is critical.
  - State-level measures and financing models will be tied to the two health priorities

What Decisions Have and Haven't Been Made

- Interventions:
  - Categories are been determined
    - Systems, policies, programs, and cultural norm interventions
      - Based on stakeholder feedback not just to create more programs
  - Interventions that HECs will do have *not* been selected
    - HECs will select them
    - Community members will be involved in selecting interventions that matter most to them
    - HECs can choose to connect, improve or expand existing interventions or implement new interventions to fill gaps.
    - HECs also will select measures they will used to assess the outcomes of the interventions they select

What Decisions Have and Haven't Been Made

- Other examples
  - Governance:
    - Some but not all parameters have are been determined
      - HECs required to establish formal agreements, bylaws, backbone organization, and contracts for services
    - The precise structure, memberships, roles, decision making processes, etc. will be determined by HECs
  - Geography
    - Parameters and the general process have been determined
    - Geographies have not been determined
      - Prospective HECs will propose geographies, which will be finalized in iterative process with the State

Community Involvement

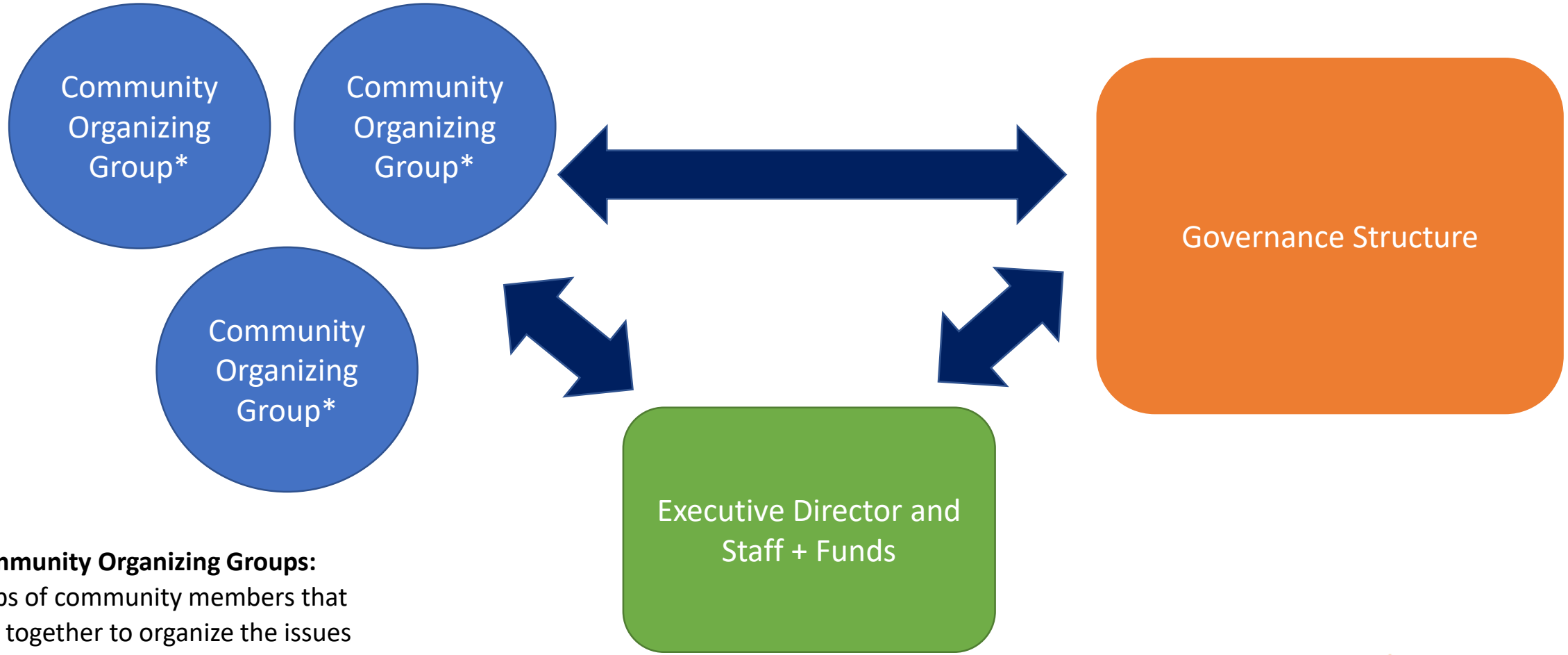
Community Involvement

- We developed and revised report language based on:
  - Findings from the SIM Listening Sessions
  - Input from the community members to date
    - Community member engagement done by Reference Communities
    - A parent group affiliated with Clifford Beers Clinic in New Haven
  - Input from the Consumer Advisory Committee co-chairs
  - Input from the PHC
  - Input from the HISC meeting
  - Input from meetings with community advocates on the HISC

Community Involvement: Key Discussion Point

- Given their unique and essential perspectives and insights about their communities, HECs' success depends on the ongoing involvement of community members who make decisions about things that matter most to them.
- In addition to community members being involved in HEC formation and operation, **the HEC structure will include locally owned and directed community organizing groups** that identify and implement strategies for improving community health and prevention.
- The community organizing groups will have ownership and decision-making authority on issues in their communities that are most important to them.

Community Involvement: Potential Structure for Discussion



*** Community Organizing Groups:**
Groups of community members that come together to organize the issues and interventions that matter most to them.

Community Involvement: Proposed Report Revisions

- Implications for community organizing groups driving what happens at community level also means they will drive other decisions, including community- and intervention-specific measures.

State Partnership for Health Enhancement

New: State Partnership for Health Enhancement

- Using Behavioral Health Partnership as a model, the draft framework describes establishing a multi-agency partnership, **the State Partnership for Health Enhancement**, to oversee and administer the HEC Initiative.
- The State Partnership would comprise multiple State agencies that have purviews that include child well-being and healthy weight and physical fitness.
- Agencies would support HECs in multiple ways. This includes:
  - Pursuing legislative and regulatory changes that will support HECs and enable the HEC Initiative
  - Enabling the provision of a centralized resource for technical assistance and other types of support as HECs form and implement interventions
  - Establishing an HEC Advisory Committee that would advise on the implementation and performance of the HEC Initiative

Discussion and Q&A: HISC Guidance/Recommendations for the PHC

Adjourn