Connecticut State Innovation Model

Population Health Council

Thursday July 28, 2016

3:00 – 5:00 PM

Northend Senior Center

80 Coventry Street, Hartford

Dial in #: 877-916-8051/passcode: 5399866

Welcome: Co-Chairs (Susan Walkama, Steve Huleatt)

- Minutes Approval
- Public Comment
- Welcome New Members To Table

Meeting Purpose and Outcomes

- Understand key aspects of innovative community based prevention and SIM
- Learn success factors of models in community
- Reflect on key questions:
  - What are the current supports/incentives for Community Prevention models to be successful and sustainable?
  - What are the current barriers/issues to overcome to implement Community Prevention models more broadly?

Overview: Innovations in Community Prevention and SIM: Mario Garcia

- Clinical and Community Prevention (10 mins)
  Video (20 mins)

STATE HEALTHCARE INNOVATION MODEL

POPULATION HEALTH PLANNING

COMMUNITY PREVENTION

A PATHWAY FOR BUILDING A PREVENTION SERVICES CENTERS MODEL

MARIO GARCIA, MD, MSc, MPH

ISSUES, CHALLENGES AND SOLUTIONS

CURRENT PARADIGM:

Disease Care vs. Health Protection
Impact on Population Health

SOCIAL DETERMINANTS OF HEALTH:

Community Activation –
Community Integration —

MULTIDIMENSIONAL APPROACH TO PREVENTION:

Clinical Prevention Strategies
Community Health Strategies

HEALTH ENHANCEMENT COMMUNITIES:

Structured Networks, Agenda for Health, Designation Criteria
Transformation Triggers

ISSUES, CHALLENGES AND SOLUTIONS

CURRENT PARA

Diseas

Impact

SOCIAL DETERM

Comm

Comm

MULTIDIMENSIONAL APPROACH TO PREVENTION:

Clinical Prevention Strategies

Community Health Strategies

HEALTH ENHANCEMENT COMMUNITIES:

Structured Networks, Agenda for Health, Designation Criteria

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MULTIDIMENSIONAL APPROACH TO PREVENTION:

Clinical Prevention Strategies

Community Health Strategies

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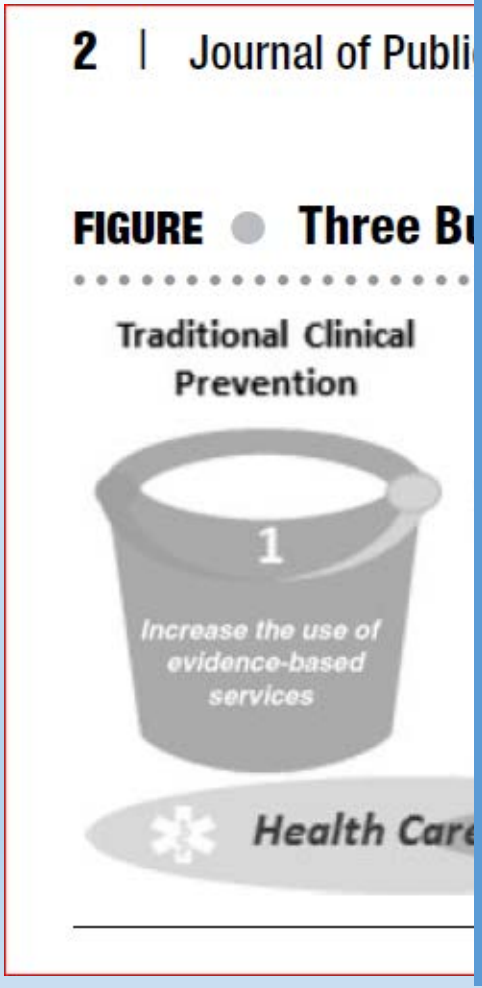
Community Prevention Services **DHHS-CDC The Guide to Community Preventive Services**

Systematic Review Development Teams and a CDC led coordination team of 6-12 reviewers. This includes topic area experts, a task force member, a liaison, an economist, and one or more research fellows. This group develops the logic model for the review, conducts data collection and analysis, and presents findings. Consultants are also involved to offer advice to the coordination team throughout the review process. A dissemination team urges constituents and partners to translate all science-based recommendations and findings into practical actions and include them in public health strategies and programs.

Clinical Primary Prevention **U.S. Preventive Services Task Force**

Clinical preventive services such as screenings, counseling services, and preventive medications. Recommendations issued from the fields of preventive medicine and primary care, including internal medicine, family medicine, pediatrics, behavioral health, obstetrics and gynecology, and nursing. The recommendations apply only to people who have no signs or symptoms of the specific disease or condition under evaluation, and the recommendations address only services offered in the primary care setting or services referred by a primary care clinician.



FLU VACCINES – COLONOSCOPIES OBESITY AND TOBACCO USE SCREENING

- Clinical Setting
- Evidence Based of Efficacy, Health Improvement and Cost-Effectiveness
- Reimbursed
- ACA mandated
- No Cost-sharing

Insurers: Financial incentives, quality measures

Providers: Monitoring compliance

Public Health: Social marketing, provide stronger evidence for best practices

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FIGURE ● **Three Buckets of Preventi**

HOME BASED APPROACHES – EDUCATIONAL COUNSELING – COMMUNITY HEALTH WORKERS – COMMUNITY BASED BEHAVIORAL CHANGE INTERVENTIONS

- Outside Clinical Setting
- Patient-focused
- Clinical in nature
- (Asthma, Diabetes)
- Historically no reimbursed
- Work in relatively short time

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SMOKING REGULATIONS – TAX DISCENTIVES – SOCIAL MARKETING – HEALTHY EATING AND PHYSICAL ACTIVITY INTERVENTIONS – HOUSING POLICIES

- Target an entire population group
- Geographic / Jurisdiction boundaries
- Evidence by association
- Long term returns
- Community Guide
- No reimbursement models
- Attractive to providers in large markets

Insurers: VBID opportunities

Providers: Unfamiliar with solutions

Public Health: Experience promoting pilots through grant funded initiatives

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FIGURE ● Three Buckets of Prevention

HEALTH ENHANCEMENT COMMUNITIES DESIGNATION

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PREVENTION SERVICE CENTERS MODEL FOR COMMUNITY HEALTH

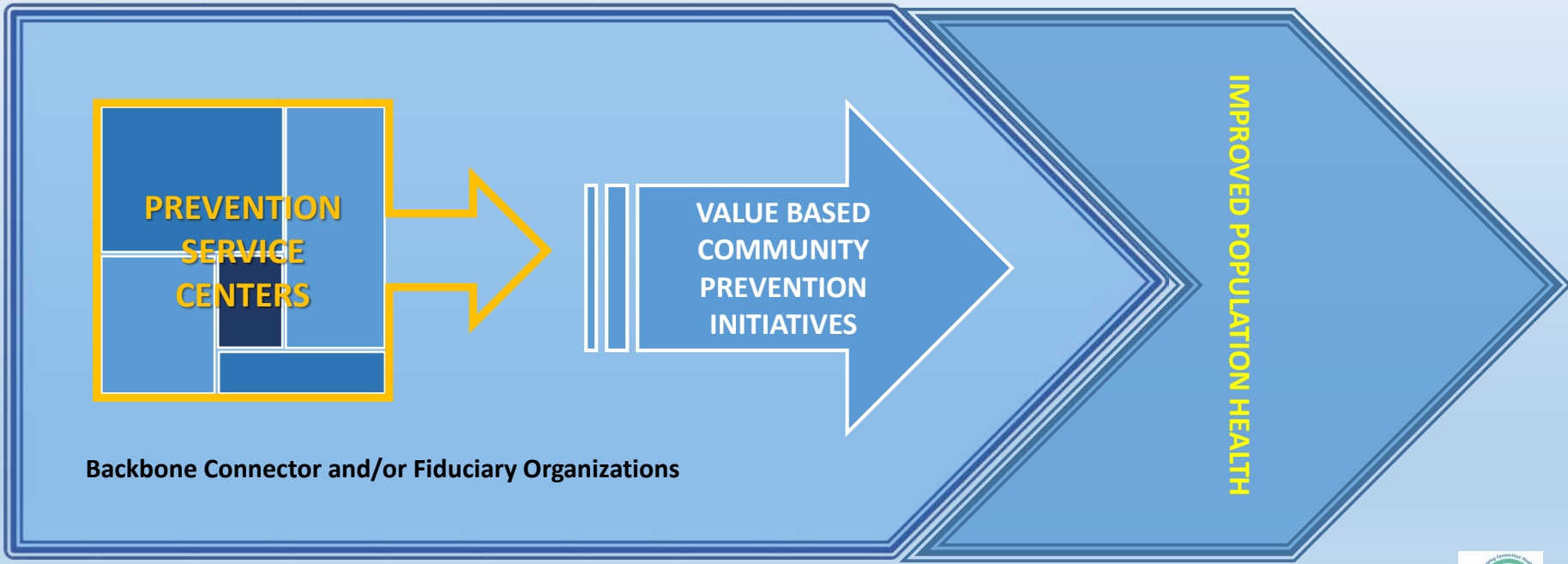

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FIGURE 1. California ACH Five Key Domains

Clinical Services

- Services delivered by the healthcare system
- Includes primary and secondary prevention, disease management programs, and coordinated care that is provided by a physician, health team, or other health practitioner associated with a clinical setting

Community and Social Services Programs

- Programs that provide support to patients and community members
- Delivered by governmental agencies, schools, worksites, or community-based organizations
- Frequently target lifestyle and behavioral factors, such as exercise and nutrition habits; also include peer support groups and social networks

Clinical-Community Linkages

- Mechanisms to connect community and social services and programs with the clinical care setting to better facilitate access to and coordination between healthcare, preventive, and supportive services
- Can help form strong bonds between community and healthcare practitioners and, ideally, involves bi-directional feedback systems between the two

Environment

- Social and physical environments that facilitate people being able to make healthy choices
- May include community improvements such as building parks or bike lanes, making farmers markets more available, or transforming corner stores to carry more fruits and vegetables

Public Policy and Systems Change

- Policy, regulatory, and systems changes that affect how the healthcare and other systems operate and influence the overall ability of people to be healthy
- Address environmental issues, school policies, health and social systems coordination, and financing to support prevention-related activities

Introduction of Case Studies: Co-Chairs

- YMCA Diabetes Prevention Program
- Child Health and Developmental Institute: Promoting Early Detection of Children At Risk for Developmental Delay and Connection to Services

YMCA Diabetes Prevention Program

- Partners
  - Centers for Disease Control and Prevention
  - American Medical Association
  - American Diabetes Association
  - Diabetes Advocacy Alliance
  - Centers for Medicare and Medicaid Innovation (CMMI)
  - National Council on Aging
  - National Council of La Raza
  - Local Ys partner with Health Departments, Hospital Systems, Employers
- Focus – Chronic Disease Prevention
  - Based on the results of the DEPLOY study, a collaboration of the the Indiana School of Medicine and the YMCA of Greater Indianapolis, it was determined the Y could deliver a cost effective, group based lifestyle intervention program.

Key Component 1: Use of Data/Metrics

- *Every DPP participant is weighed at every session, food activity journals are collected, attendance recorded*
- *Disparities in health equity are addressed through accessibility.*
  - *The Y's DPP is for everyone in the community, Y membership is not required*
  - *All those who qualify can participate, regardless of ability to pay*
  - *Percentage of low-income served tracked in database*
  - *Urban low-income recruitment in several New Haven neighborhoods resulted in participants subsidized with Sam's Club grant, facilitated by CHW*
  - *Grant opportunities pursued to continue to fund scholarships*
- *Impact is measured based on reduction in number of prediabetics converting to type 2 diabetes, fewer related complications and chronic disease, reduction in medical costs*
- *CDC measures performance based on weight loss at 16th week and year end, attendance, data collection requirements*

Key Component 2: Community and Partner Engagement for Coordinated Service Delivery

- *The Y is a national network uniquely positioned to deliver lifestyle intervention, embedded in rural, suburban, and urban communities*
- *Evidence based curriculum, proven 58% risk reduction when meeting program goals*
- *Infrastructure and curriculum developed and established in collaboration with NIH, CDC, Diabetes Prevention and Control Alliance results in consistent program delivery*
- *National oversight and support with local delivery*
  - *Program provided in CT in over 65 cities (including New Haven and Bridgeport) and towns*
  - *Over half the state's population now has access to the Y's DPP*
  - *Several more Y associations plan to become providers*

Key Component 3: Financial Rewards and Incentives

- *Collaboration*
  - *CT Ys are part of the DPH-led CT Diabetes Partnership*
  - *Three Y representatives will sit on the Diabetes Advisory Council, being formed in response to recent legislation*
  - *Partner with hospital systems as a resource for their diabetes education efforts*
  - *Build Medical Referral Networks*
- *DPP dissemination was initially funded by Robert Wood Johnson Foundation and Y-USA, local Ys working toward sustainability through enhanced reimbursement opportunities*
- *Continues to be grant funded, in addition to program revenue. Goal is to become sustainable with program revenue, with grant funding to ensure continued scholarship assistance.*
- *CDC Program Recognition increases financial opportunity as it ensures consistent delivery, establishing value, resulting in greater confidence among government and private insurers, employers, and grant funders*

Key Results

- *Medicare reimbursement for DPP becomes effective January 2018*
- *A CPT code specifically for diabetes prevention has been assigned and will be used for private insurance reimbursement by the Y beginning January 2017*
- *For a typical population of 100 high-risk adults aged 50 and over who meet the program goals, the following results might be expected over three years:*
  - Prevent 15 new cases of type 2 diabetes.
  - Prevent 162 missed work days.
  - Avoid the need for blood pressure or cholesterol drugs in 11 people.
  - Add the equivalent of 20 years of good health.
  - Avoid $91,400 in health care costs.

Next Steps in Evolution

- To sustain DPPs and enhance success
  - Greater awareness of the prevalence of prediabetes (hopefully through media campaigns, and increased screening and education from medical providers)
  - Communicate the value of prevention – healthier, more productive work force resulting in better bottom line, lower health care costs, improved quality of life
  - Expanded insurance coverage and reimbursement
  - More medical provider referrals
  - Expanded growth of food justice and access movements
- Some barriers to providing the DPP more broadly
  - Lack of coverage and reimbursement by Medicaid and private insurers, most participants are self pay
  - Lack of awareness of the risk factors for type 2 diabetes, e.g. being overweight and physically inactive

Child Health and Developmental Institute: Promoting Early Detection of Children At Risk for Developmental Delay and Connection to Services

- State support
  - Department of Public Health Children and Youth with Special Health Care Needs program and Learn the Signs, Act Early Campaign
  - Department of Social Services Medicaid and PCMH programs
  - SIM Pediatric Quality Measures Work Group
  - United Way 211 Child Development Infoline
  - Office of Early Childhood (Birth to Three, Help Me Grow, Home Visiting)
- Goal:
  - Early detection of children at risk for developmental delay through universal surveillance and screening
  - Connection of children at risk for delay to intervention services

Key Component 1: Use of Data/Metrics

- *Pediatric practice billing data**
- *Medicaid billing data**
- *Head Start performance data**
- *Early childhood comprehensive systems grant needs assessment**
- *Connecticut Children's Medical Center Office for Community Child Health, Practice Quality Improvement program*
- *United Way 211 Child Development Infoline: single point of entry for connection to services*

** address social determinants of health in some way*

- *What measures of performance would you recommend based on your experience? Because data needs cross systems (health, early care and education) inclusion of screening in a state tracking system would be helpful*

Key Component 2: Community and Partner Engagement for Coordinated Service Delivery

- *Pediatric practice training program: CHDI's Educating Practices in the Community Program*
- *Office of Early Childhood, Head Start program, which trains staff to perform screens and tracks data*
- *Office of Early Childhood Home Visiting programs*
- *United Way 211 Child Development Infoline/Help Me Grow: connects children and families to follow up services, report back to PCMH*
- *Family engagement through all screening tools, which are all parent completed*
- *Pending funding: opportunity to extend screening to family resource centers in Hartford*

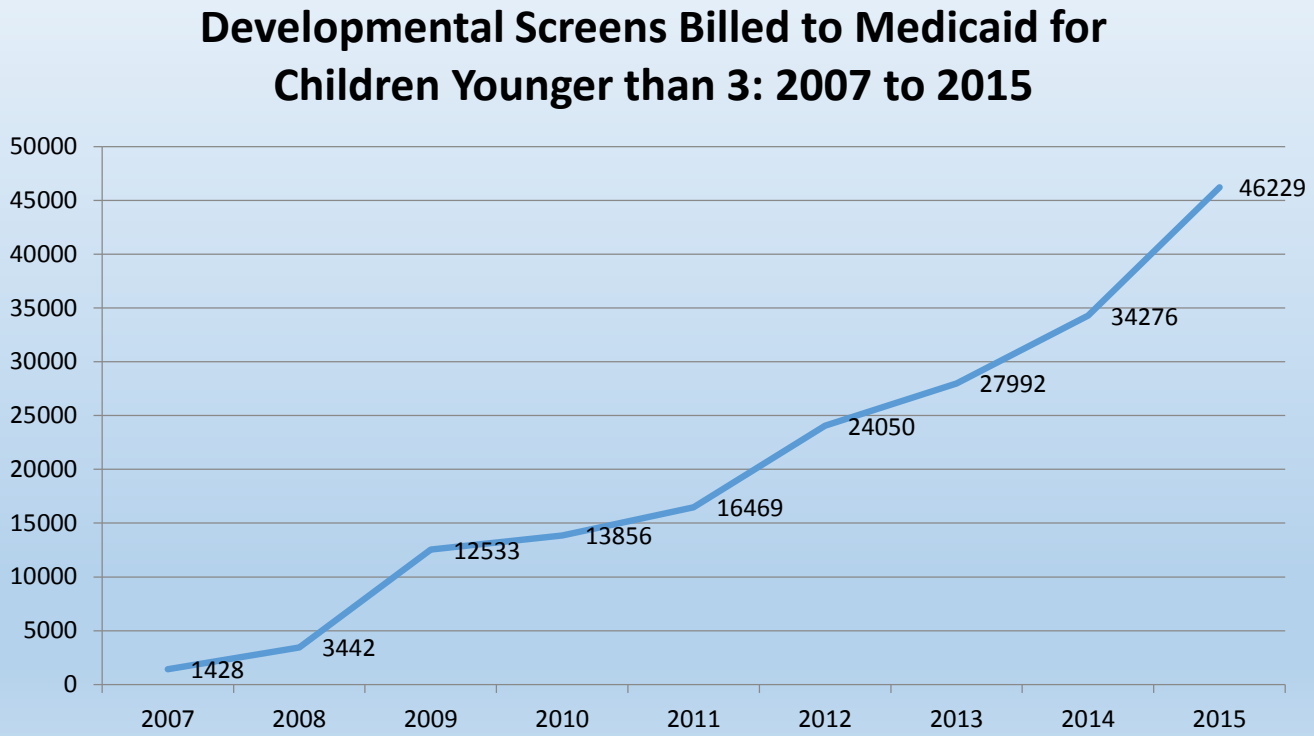
Key Component 3: Financial Rewards and Incentives

- *What strategies were used for promoting accountability, reducing competition, and encouraging cooperation/collaboration?*
  - *Medicaid and commercial insurance payment for screening (CPT code 96110) in primary care child health settings*
  - *PCMH performance measurement and pm/pm rewards program*
  - *OEC funding of Child Development Infoline for follow: funding from US Department of Education under Part C of IDEA*
  - *OEC funding of Early Intervention Services from US Department of Education*
  - *OEC Help Me Grow funding in state budget*

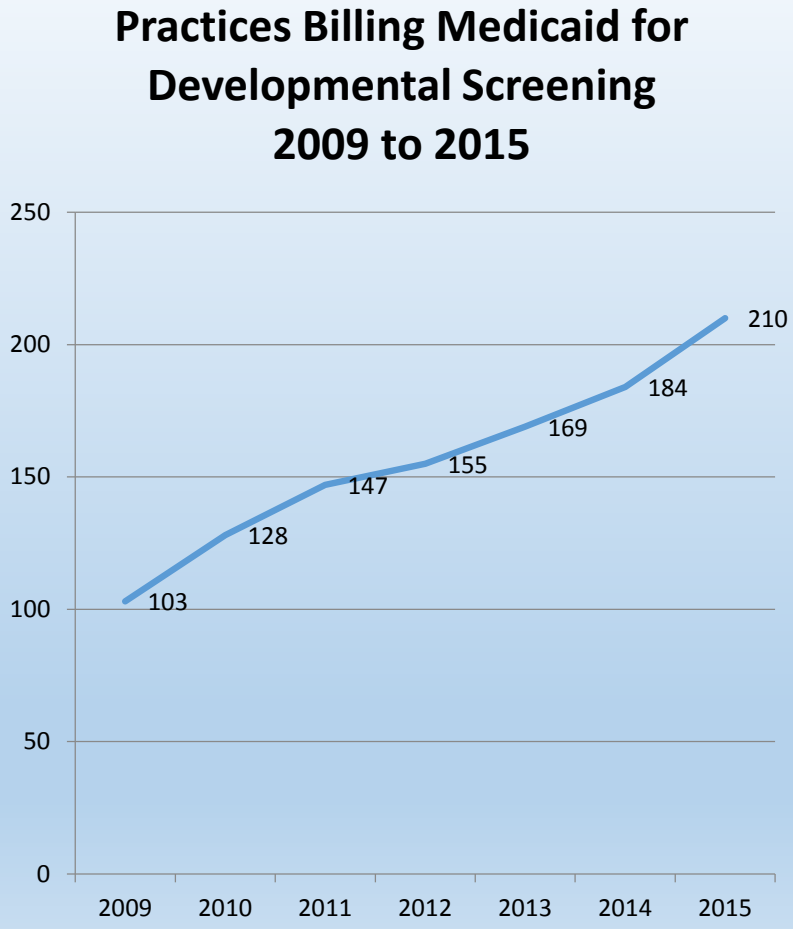
Key Results

- *Policy improvements*
  - *Payment for screening in primary care by Medicaid and commercial insurers*
  - *Inclusion of screening as PCMH quality measure*
  - *Inclusion of screening as SIM quality measure for MQISSP*
- *Systems improvements*
  - *Child Development Infoline single point of entry for all follow up*
  - *Help Me Grow for services when children do not quality for Birth to Three*
  - *Development of a new mid-level assessment for children with mild and moderate delays*
- *Improvements on key indicators*
  - *Medicaid requirement that providers use U codes to document outcome of screening*

Key Results


Developmental Screens Billed to Medicaid for Children Younger than 3: 2007 to 2015
50000
45000
40000
35000
30000
25000
20000
15000
10000
5000
0
1428
3442
12533
13856
16469
24050
27992
34276
46229
2007
2008
2009
2010
2011
2012
2013
2014
2015

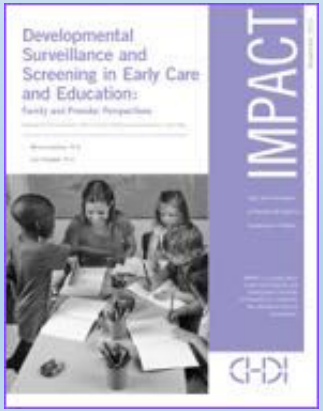
Key Results


Practices Billing Medicaid for Developmental Screening 2009 to 2015
250
200
150
100
50
0
103
128
147
155
169
184
210
2009
2010
2011
2012
2013
2014
2015

Resources for Connecticut

- http://www.chdi.org/publications/reports/impact-reports/earlier-better-developmental-screening-connecticuts-young-children/

- http://www.chdi.org/index.php/publications/reports/impact-reports/developmental-surveillance-and-screening-early-care-and-education-family-and-provider-perspectives



Next Steps in Evolution

- What is needed for Community Prevention models to be successful and sustainable?

  - Improved tracking of service utilization across systems
  - Improved information sharing across systems
  - Evaluation of dollars saved in other systems (lower special education costs)
  - Consideration of **long term** savings and outcomes across systems
  - Support for services across systems

Questions for Discussion (Rose Swensen)

- Ideas for fostering synergies, compatibility among sectors
- Strategies for bridging differences
- Implications for our plan

Next Steps

Next meeting date: September 22, 2016 3-5 p.m.

Agenda

- Conceptual: Current Data on Key Indicators (Update from State Health Assessment)
- Operational: Proposed Structure for Planning Process (Working Groups)

- **Key Questions for Reflection**
  - **How should we frame the data to be most useful for planning?**
  - **What is “progress”?**
  - **How should we measure progress, interim and long-term?**
  - **What Essential Questions do we need to address in our plan? (round 1)**