Services address population health priorities and tangible problems in the community based on available data

Population Health Significance

Emerging Issues from CT Hospital CHNAs

Older Adult Health Issues
- Transportation
- Availability/affordability of senior assisted housing
- Social support systems
- Engagement in medical decision-making
- Repair/maintenance required of them to remain independent in their own homes
- Burden of chronic diseases

Access to Care
- Health Literacy
- Cost of copays/medications
- Absence of program/services tailored for special populations (homeless, mentally-ill, teens, ethnic and racial minorities)
- Challenges navigating the insurance marketplace

Community Infrastructure
- Inadequate structures that fail to support physical activity
- Accessibility to green spaces
- Food desert

Asthma
- Asthma management and prevention education
- Environmental and housing conditions

Mental Health & Substance Abuse Services
- Ineffective existing programs
- Limited treatment options (youth psychiatric and behavioral care)

Obesity
- Exercise and nutrition education
- Heart Disease and Diabetes

Population Health Significance

Priorities from SIM State Health Profile

Diabetes
- An estimated 8.9% of Connecticut adults have diagnosed diabetes (types 1 and 2), or approximately 250,000 adults. An additional 83,000 adults are estimated to have undiagnosed diabetes
- Older residents, racial and ethnic minorities and persons with lower socioeconomic status have higher rates of diabetes
- As income and education increased, diabetes prevalence decreased
- Hispanic adults are less likely to have had 2 A1C tests in the past year compared to non-Hispanic Whites
- Non-Hispanic Black adults have the highest prevalence of diabetes
- Younger adults are more likely to participate in adequate weekly physical activity compared with older adults. Also, adults with annual household incomes of less than $25,000 were less likely to participate in participate in adequate physical activity compared with adults with annual household incomes of $75,000 and more
- Obesity rates are highest among African Americans, Hispanics, and people with the least education and lowest incomes. 60 % of adults are obese or overweight.
- About one out of every three Connecticut adults consumed fruits less than once on a daily basis, and out of every five consumed vegetables less than once daily
- 7.9% of the Connecticut population lives in census tracts that are food deserts (over 283,000 people).

Asthma
- About 1 in 10 Connecticut residents has asthma
- Non-Hispanic African-Americans and Latinos are 4 times more likely than non-Hispanic Whites to go to the Emergency Rooms and be hospitalized for asthma
- Non-Hispanic African Americans are 2-3 times more likely to die from asthma than any other racial or ethnic group
- Among children, non-Hispanic Black and Hispanic youth populations are more likely to be told that they have asthma than non-Hispanic White populations
- Asthma is more common in lower socioeconomic groups

Hypertension
- Non-Hispanic African American adults are more likely to have high blood pressure compared with non-Hispanic White and Hispanic residents
- Premature mortality due to stroke is significantly higher among non-Hispanic Black and Latino residents when compared to non-Hispanic White residents
- Premature mortality due to heart disease is significantly higher among non-Hispanic Black residents compared to any other racial and ethnic groups

Depression
- 1 in 6 CT adults (18.3 %) have been told they have a depressive disorder.
- Compared to their counterparts in the state, the risk was significantly greater for Women (23.1%), Adults with a disability (42.3%) and Adults with no more than a HS education (20.7%).

Extent to which there is an evidence based protocol for the service to effectively address community health needs

COMMUNITY BASED DISEASE PREVENTION (PRIMARY PREVENTION)			
	DIABETES	ASTHMA	HYPERTENSION
Available Effectiveness Evidence	• Strong endorsements by the Centers for Disease Control and prevention(CDC) • National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and, • U.S. Dpt. of Health and Human Services (HHS)	Triggers identification Abatement Immunizations Physical Activity	TBD
VBP Cost Benefit (Savings & Effectiveness)	• CMS Actuary Certification: DPP reduce Medicare spending. • $2,650 estimated savings per Medicare enrollee over a 15-month period • Direct medical cost per participant/3 years estimated at $2,780 individual coaching • CT costs: $450 per person/year group coaching • Strong analysis by the Institute for Clinical and Economic Review at (CTAF). • Systematic review by the CDC Community Preventive Services Task Force (CDC-CPSTF) • Medication use reduction • Unscheduled visits costs • Reduction of complications	TBD	TBD

COMMUNITY BASED DISEASE CONTROL (SECONDARY PREVENTION)			
	DIABETES	ASTHMA	HYPERTENSION
Available Effectiveness Evidence	• CDC Community Guide (CPSTF) (Norris, SL, 2002) • American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics (Brunisholz, 2014)	• Strong endorsement by the National Heart, Lung and Blood Institute (NHLBI) and the National Asthma Education and Prevention Program (NAEPP-EPR-3)	• Endorsed by the CDC Community Preventive Services Task Force in Comparative Effectiveness (CDC-CPSTF) • Uhlig, K. 2013
VBP Cost Benefit (Savings & Effectiveness)	• Systematic review by ADA shows clear cost-effectiveness and cost-savings.	• Reduction on operational expenses due to ED overutilization and unscheduled PCP visits • Return on Investment (ROI) (mixed results)	• Value comparisons referenced by the CPSTF

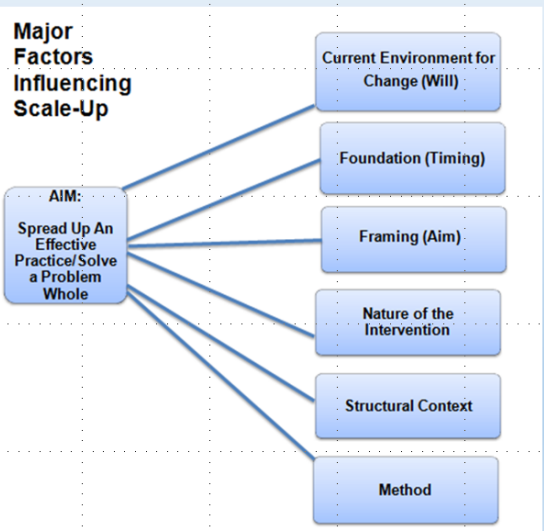
service provides healthcare market value in the context of payment reforms by either adding to a public quality score card (Medicaid/Medicare) or by yielding return on investment for payers and providers

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Consumer Engagement						
1	PCMH – CAHPS measure**	0005		NCQA		☐	☐
	Care Coordination						
2	Plan all-cause readmission	1768		NCQA	Claims	☐	
3	Annual monitoring for persistent medications (roll-up)	2371		NCQA	Claims		
	Prevention						
4	Breast cancer screening	2372	20	NCQA	Claims		
5	Cervical cancer screening	0032		NCQA	Claims		
6	Chlamydia screening in women	0033		NCQA	Claims		
7	Colorectal cancer screening	0034	19	NCQA	EHR	☐	
8	Adolescent female immunizations HPV	1959		NCQA	Claims		
9	Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024		NCQA	EHR		
10	Preventative care and screening: BMI screening and follow up	0421	16	CMMC	EHR		
11	Developmental screening in the first three years of life	1448		OHSU	EHR		☐
12	Well-child visits in the first 15 months of life	1392		NCQA	Claims		☐
13	Adolescent well-care visits			NCQA	Claims		☐
14	Tobacco use screening and cessation intervention	0028	17	AMA/ PCPI	EHR		
15	Prenatal Care & Postpartum care***	1517		NCQA	EHR		☐
16	Screening for clinical depression and follow-up plan	418	18	CMS	EHR	☐	
17	Behavioral health screening (pediatric, Medicaid only, custom measure)			Custom	Claims		☐

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Acute & Chronic Care						
18	Medication management for people w/ asthma	1799		NCQA	Claims	☐	☐
19	DM: Hemoglobin A1c Poor Control (>9%)	0059	27	NCQA	EHR	☐	
20	DM: HbA1c Screening****	0057		NCQA	Claims		☐
21	DM: Diabetes eye exam	0055	41	NCQA	EHR		
22	DM: Diabetes: medical attention for nephropathy	0062		NCQA	Claims		
23	HTN: Controlling high blood pressure	0018	28	NCQA	EHR	☐	
24	Use of imaging studies for low back pain	0052		NCQA	Claims		
25	Avoidance of antibiotic treatment in adults with acute bronchitis	0058		NCQA	Claims		☐
26	Appr. treatment for children with upper respiratory infection	0069		NCQA	Claims		
	Behavioral Health						
27	Follow-up care for children prescribed ADHD medication	0108		NCQA	Claims		
28	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only)	2800		NCQA	Claims		☐
29	Depression Remission at 12 Twelve Months	0710	40	MNCM	EHR		
30	Depression Remission at 12 months – Progress Towards Remission	1885		MNCM	EHR		
31	Child & Adlscnt MDD: Suicide Risk Assessment	1365		AMA/ PCPI	EHR		
32	Unhealthy Alcohol Use – Screening			AMA/ PCPI	EHR		

Service lends itself to a community based dissemination model in terms of replicability and scalability

Why Do We Fail to Take Effective Practice to Scale?



- Because we lack incentives to do so.
- Because we don't expect to do so.
- Because we don't appreciate how large-scale change unfolds.
- Because we don't know how to do so (or at least we don't approach the challenge systematically enough).

McCannon, J. *The Spread Problem*. CMS. AHRQ meeting, Feb, 2011

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Service aligns with the SIM priorities

	VALUE BASED PAYMENT		CARE DELIVERY REFORM		CONSUMER EMPOWERMENT		POPULATION HEALTH		HEALTH IT		
PRIORITIES	Commercial SSP & Medicaid PCMH+ Scorecard	Community & Clinical Integration Program	Advanced Medical Home Program	PCMH+ elements	Community Health Worker Initiative	Value Based Insurance Design	Community Measures (2018)	Prevention Service Centers (2018)	Health Enhancement Communities (2019)	HIE/ADT/ eCQMs	HIT: Other (mobile apps, EHR SaaS, Care Analyzer)
Individuals with Complex Health Needs	Readmission payment measure	Standard 1: comprehensive care management	Foundational PCMH skills	Employ a care coordinator/ assign care coordination activities	Enable CHW workforce that can integrate into care teams	Recommended: Complex case management program			TBD	Providers have access to comprehensive info about patients (eg ADTs); enable referral f/u	Care Analyzer allows identification of individuals with complex health needs
Diabetes: prevention and control	A1C control (NQF 0059) measure as core reporting (short term) and payment (long term) measure *	Standard 2: Health Equity Intervention focused on diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can do diabetes prevention and control	Recommended: Obesity screenings, chronic disease management	Obesity incidence/ prevalence & up-stream indicators	Include diabetes prevention, pre-diabetic identification	TBD	Enable use of clinical data to track A1C control & act on data	Mobile apps focus on diabetes management & sharing info with provider
Hypertension (HTN): prevention and control	HTN control (NQF 0018) measure as reporting (short term) and payment (long term) measure *	Standard 2: Health Equity Intervention: diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can identify undiagnosed HTN and do HTN control activities	Recommended: Blood pressure screenings, chronic disease management, anti-hypertensives, ACE inhibitors	Obesity incidence/ prevalence & up-stream indicators	Include HTN prevention, undiagnosed HTN identification	TBD	Enable use of clinical data to track HTN control & act on data	Mobile apps focus on HTN management & sharing HTN info with provider
Asthma	Asthma Hospital/ED admission measure as payment measure *	Standard 2: Health Equity Intervention: diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can do home asthma assessments	Recommended: chronic disease management	(?)	Include asthma triggers assessments	TBD		Mobile apps focus on asthma management & sharing info with provider
Depression	Depression remission & progress (NQF 0710, 1885) as reporting (short term) and payment (long term) measure	Standard 3: Behavioral health integration into primary care, focus on PHQ-9	Depression screening is a new critical element	Promote universal screenings	Enable CHW workforce that can integrate into care teams	Recommended: mental health screenings, anti-depressants	(?)		TBD	Enable use of clinical data to track depression remission control & act on data; enable referral f/u	EHR SaaS enables behavioral health providers to connect to primary care

Service meets the description of the 2nd bucket of prevention model

(Bucket 2)

Innovative preventive interventions that extend care outside the clinical setting

John Auerbach, MBA – *The 3 Buckets of Prevention.* Public Health Management Practice, 2016

"The approaches in bucket 2 are […] clinical in nature and patient-focused. But they include interventions that have not been historically paid for by fee-for-service insurance and occur outside of a doctor's office setting—interventions that have nonetheless been proven to work in a relatively short time. Several have been piloted within the public health sector with grants from governmental agencies and foundations.

An example of a bucket 2 approach grew out of epidemiologic analysis by the Camden Coalition of Health Providers in New Jersey. By geocoding Camden health data, Camden Coalition staff identified a disproportionate number of symptomatic asthmatic patients living in 2 buildings. In response, they designed homebased approaches to identify and reduce environmental triggers and provide customized, home-based preventive educational counseling."

- Home Based Approaches
- Educational Counseling
- Community Health Workers
- Behavioral Change Interventions
- Outside Clinical Setting
- Patient-focused
- Clinical in nature
- Historically no reimbursed
- Work in relatively short time

Service is conducive for a lead agency to provide oversight, contracting and fiduciary support

Michigan Community Hub Model

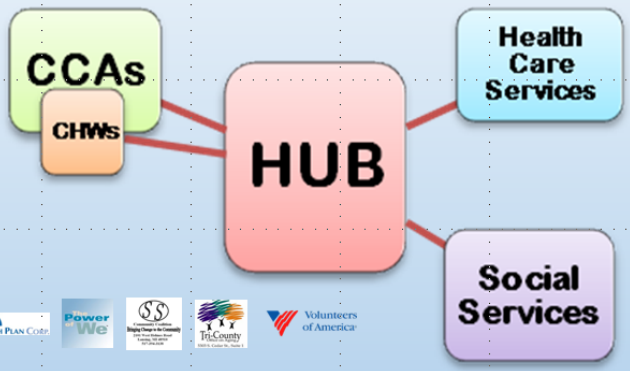
pathways to better health

Lead Agency/Fiduciary – Ingham County Health Dept.

Community HUB – Ingham Health Plan Corp,

Convener – Power of We

Care Coordination Agencies – 10



- Allen Neighborhood Center
- Barry-Eaton District Health Dept.
- Capital Area Community Services
- Ingham County Health Dept.
- Mid-Michigan District Health Dept.
- National Council on Alcoholism
- NorthWest Initiative
- Southside Community Coalition
- Tri County Office on Aging
- Volunteers of America