Connecticut State Innovation Model

Population Health Council

Tuesday, January 26th, 2017

3:00 – 5:00 PM

500 Enterprise Drive, Rocky Hill, CT

Rocky Hill, CT

Dial in #: 1-800-593-9940/passcode: 9502934

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Meeting Objectives

- Summarize results from December meeting
- Provide context for today's and February's meetings regarding next phase of stakeholder engagement and feedback
- Present and comment on criteria for community selection
- Select epicenters from maps and next steps for demarcation of boundaries
- Identify potential interviewees and key questions for stakeholder engagement

Context for Today's and February's Meetings

- Menu of services selection outcomes
- SIM Context: PSC, PCMH+ & CCIP
- Selection of PSCs Markets: Regions and Criteria
- Stakeholders Engagement

Menu of Services Selection Outcomes

PSCs Menu of Services Ranking

Diabetes Self-Management Education & Support Program

Asthma Home Assessment Program

Diabetes Self-Management Program

Medication Therapy Management

Diabetes Prevention Program

Self-Monitored BP

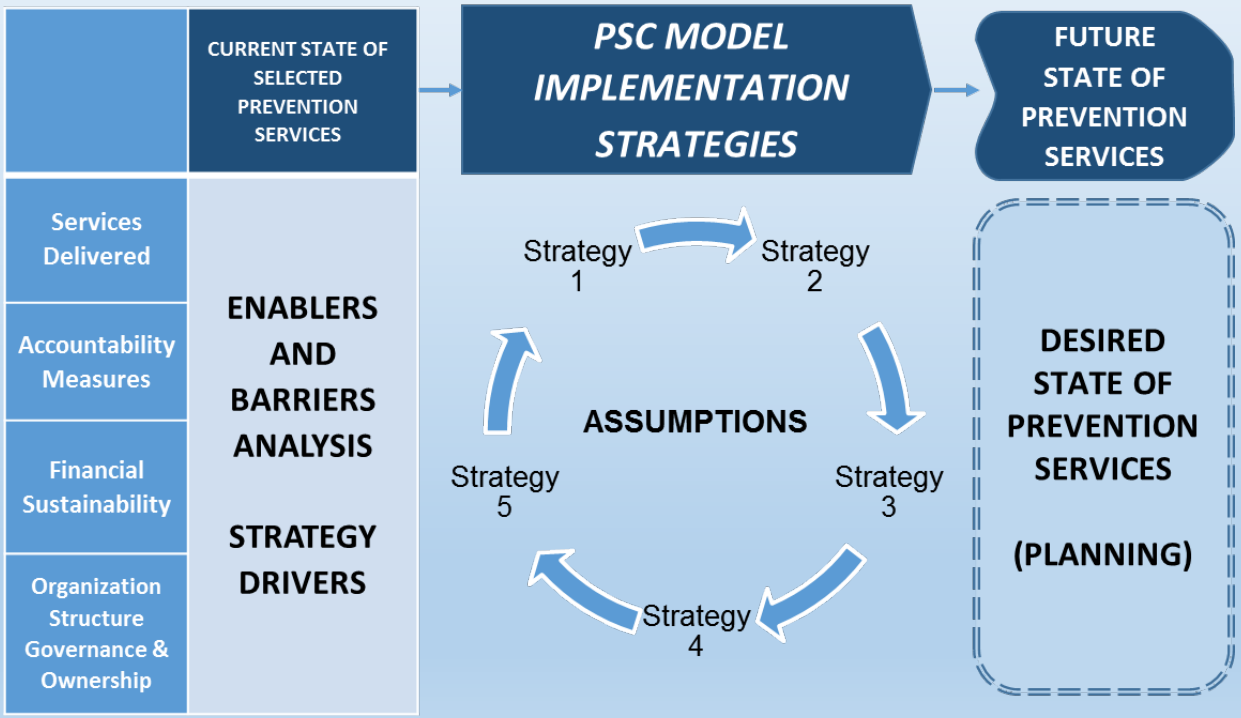
Check. Change. Control

Million Hearts Collaborative

WISEWOMAN

Chronic Diabetes Self-Management Program

Next Steps


CURRENT STATE OF SELECTED PREVENTION SERVICES
Services Delivered
Accountability Measures
Financial Sustainability
Organization Structure Governance & Ownership
ENABLERS AND BARRIERS ANALYSIS
STRATEGY DRIVERS
PSC MODEL IMPLEMENTATION STRATEGIES
FUTURE STATE OF PREVENTION SERVICES
Strategy 1
Strategy 2
Strategy 3
Strategy 4
Strategy 5
ASSUMPTIONS
DESIRED STATE OF PREVENTION SERVICES
(PLANNING)

SIM Context: PSCs, PCMH+ & CCIP

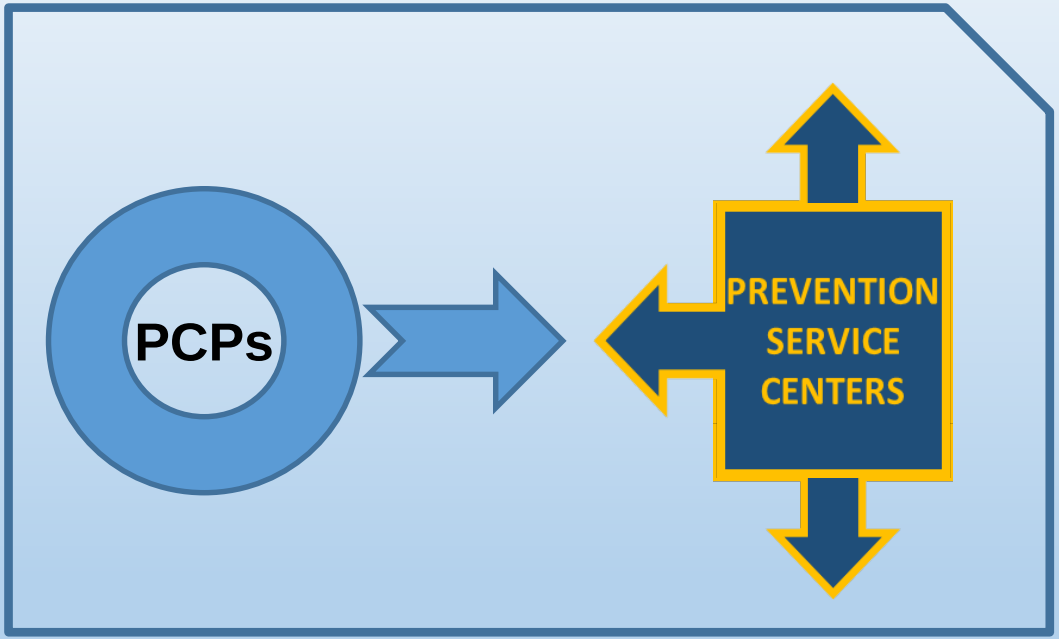
Testing the Population Health Impact of the Connecticut State Innovation Model

Improved Standards of Clinical Care

Community Health Collaboratives

Attributed Population

SSP/PCPM / PCP+



Improved Community Health Capacity

Community Based Prevention

Total Population

Self Sustaining Financing Model

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Emerging Financing Vehicles for Community Integration Structures

Payment Models for Care Delivery

Global Budgets/ Capitation
Shared savings
Care Coordination Fees
Pay For Performance

Multisector Funds

Blended: co-mingled
Braided: Coordinated Targeting
Medicaid Waiver

Innovative Financial Vehicles

Hospital Community Benefits
Social Impact Bonds
Community Development Financial Institutions
Program Investments
Wellness Funds

What is PCMH+?

- PCMH+ is the **Medicaid Shared Savings opportunity** (formerly MQISSP) offered to Primary Care Practices who are designated as Patient Centered Medical Homes by DSS
- PCMH+ builds on the Medicaid PCMH program:

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What is CCIP?

CCIP provides:
Technical Assistance & Peer Learning

AND

Transformation Awards to Advanced Networks and FQHCs to help them achieve the **CCIP Standards**

Comprehensive Care Management
Comprehensive care team, Community Health Worker , Community linkages

Health Equity Improvement
Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Behavioral Health Integration
Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Oral health Integration
E-Consult
Comprehensive Medication Management

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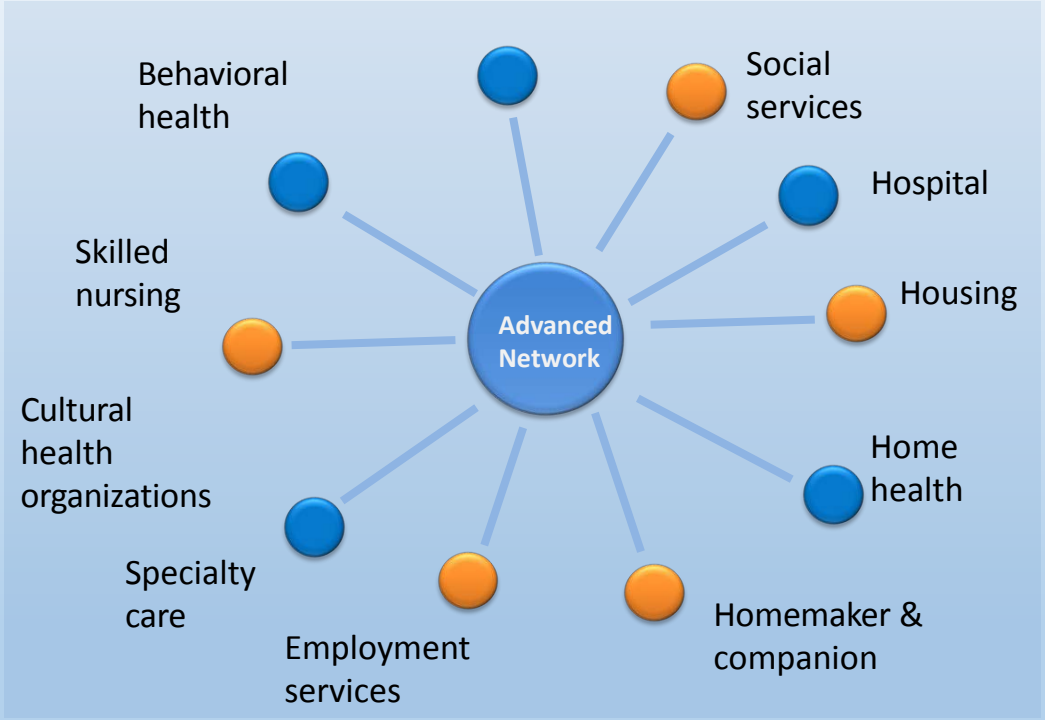
Selection of PSCs Markets: Regions and Criteria for PSCs Epicenters

Community Health Collaboratives

1. CCIP PEs are required to participate in a **Community Health Collaborative** to promote coordination between clinical and community organizations

2. The PMO will work with DSS and DPH to weigh criteria for selecting the regions for Collaboratives. Criteria may include:

- Percent of region covered by a value-based payment arrangement
- Existing Infrastructure for Collaboratives
- High-risk regions based on population health data



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Prevention Service Centers Regions Selection Criteria

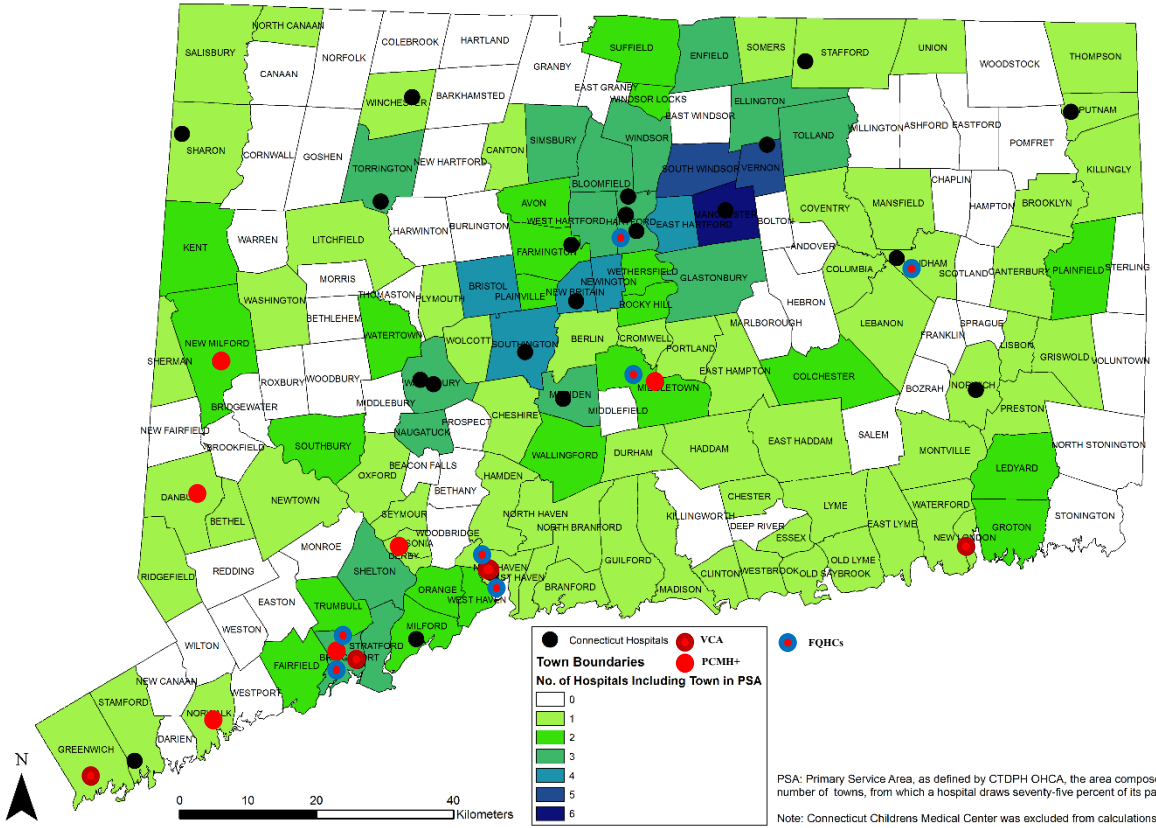
PRE-SELECTION OF DEMONSTRATION AREAS (Epicenters - CHCs)

1. Meaningful presence of accountable providers (including PCMH+, FQHCs and hospitals)
2. High proportion of resident population attributed to participating PCMH+ providers

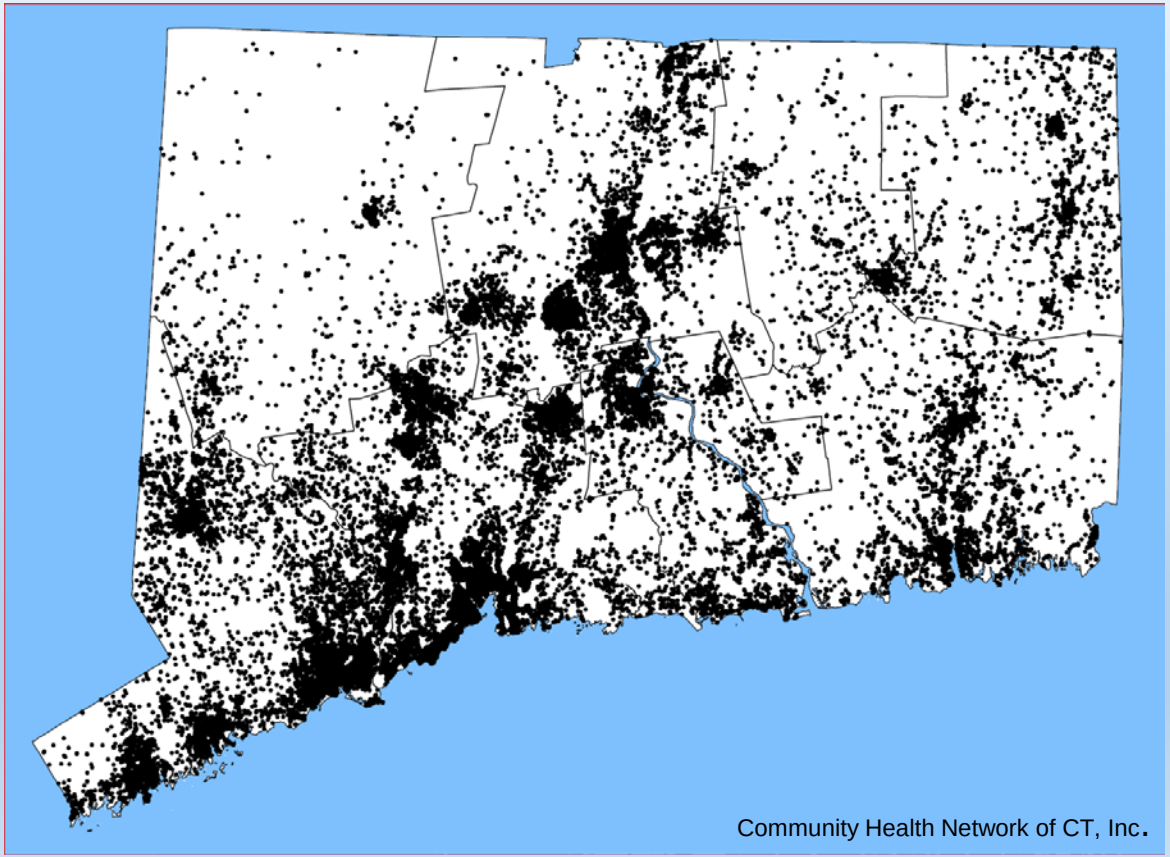
FINAL SELECTION OF DEMONSTRATION AREAS (Jurisdictions - PSCs)

3. Measurable burden of health outcomes for prioritized conditions (suitable BRFSS sample)
4. Areas with recognized health disparities, health risks and other determinants of poor health
5. Ongoing implementation of prevention initiatives related to the PSCs menu of services
6. Presence of potential implementer Community Based Organizations (CBOs)

Overlap of Hospital Primary Service Areas in Connecticut 2014-2015

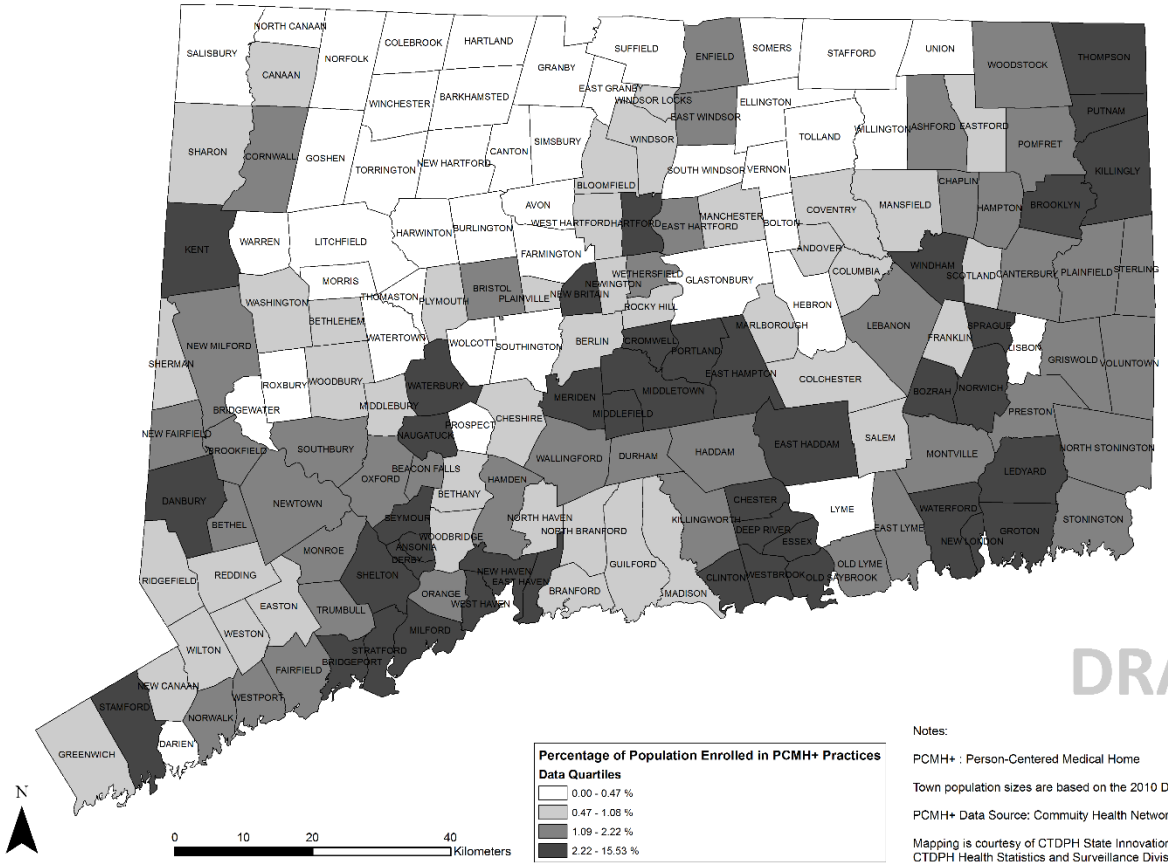


CT Medicaid Patient Center Medical Home+ (??)
Geographical Distribution of Enrolled Members, 2017



Community Health Network of CT, Inc.

Percentage of Town Populations Enrolled in PCMH+ Practices



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Notes:

PCMH+ : Person-Centered Medical Home

Town population sizes are based on the 2010 Decennial Census.

PCMH+ Data Source: Community Health Network of CT, Inc., 2016

Mapping is courtesy of CTDPH State Innovation Model and CTDPH Health Statistics and Surveillance Division.

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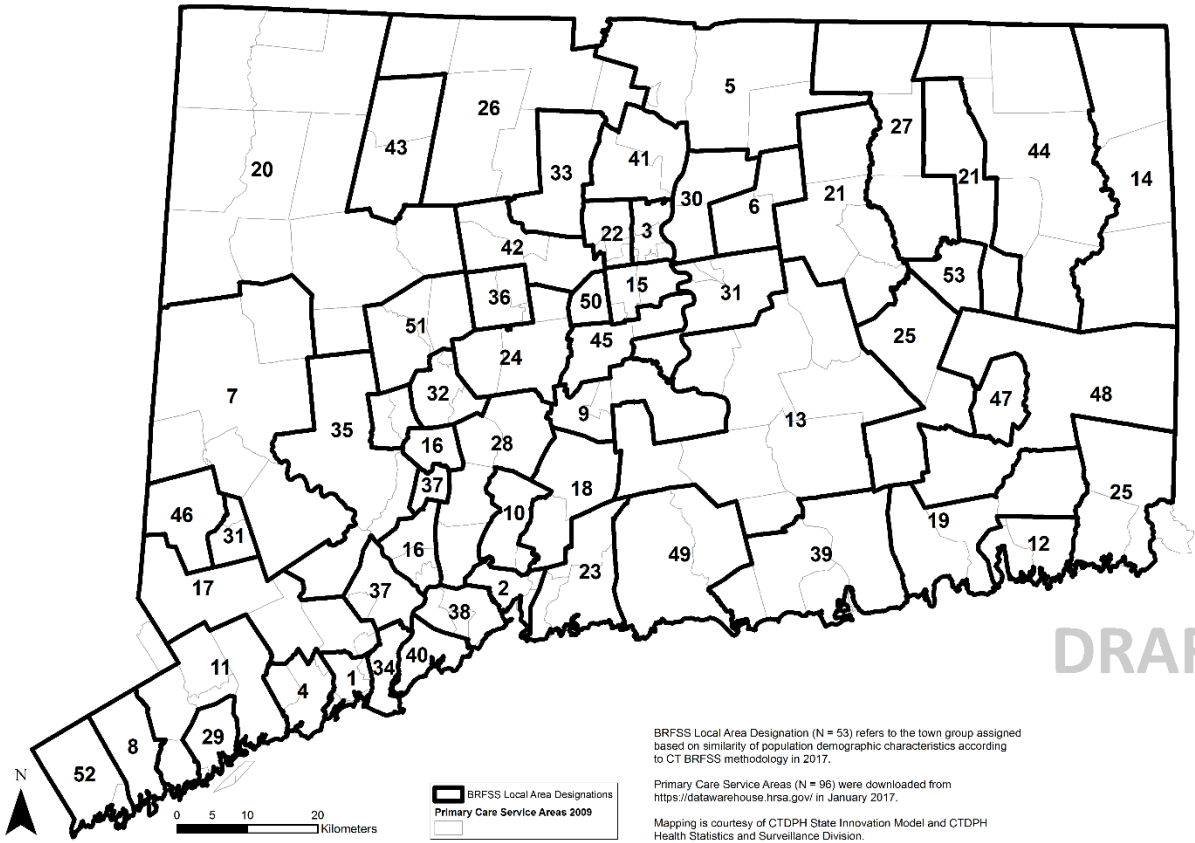
BRFSS Local Area Designations and Primary Care Service Areas in CT



BRFSS Local Area Designation (N = 53) refers to the town group assigned based on similarity of population demographic characteristics according to CT BRFSS methodology in 2017.

Primary Care Service Areas (N = 96) were downloaded from https://datawarehouse.hrsa.gov/ in January 2017.

Mapping is courtesy of CTDPH State Innovation Model and CTDPH Health Statistics and Surveillance Division.

Stakeholder Engagement

SIM/DPH Population Health Planning
HRiA CONSULTING

1. Operational capacity analysis of CBOs in the state:

* Conduct a fact finding analysis of CBOs affiliated to networks implementing selected prevention service initiatives.
* Profile all participating agencies in the selected networks regarding their type of operation, fiduciary capacity, span of service, IT infrastructure or dependencies, sustainability strategy and adaptation to healthcare reform payment system.
* Recommend minimum operational standards to launch a demonstration.

2. Listening sessions and CBOs engagement:

* Validate SIM planning assumptions through inquiries with CBOs affiliated to regional systems potentially implementing the DSS Person Centered Medical Homes (+) and the SIM Community and Clinical Integration Program (CCIP).
* Summarize and discuss with stakeholders from the population health council the challenges and opportunities of CBOs to intersect with the healthcare system market

Stakeholder Groups and Key Questions

1. Which stakeholders/groups should we consider in our outreach to test our model and assumptions?
    - Health Departments
    - CBO's involved in the provision of services related to Menu
    - Local/Regional collaboratives or consortia whose work might be related to primary objectives of the PSC
    - Other?

2. What key questions should we consider with these stakeholders/groups to learn more about current capacity and to test current assumptions?

Next Meeting

Proposed Date

February 23, 2017, 3:00-5:00 p.m.

Agenda Topics

- Ongoing discussion of stakeholder engagement and/or
- Key findings and implications for the PSC Model