SIM Prevention Service Initiative

Healthcare providers are increasingly being held accountable for healthcare quality and cost through value-based payment. This has created demand for effective prevention services offered by community organizations (CBOs). CBOs that can provide these services efficiently to accountable care organizations (ACOs) have an opportunity to take advantage of this potential demand and establish mutually-beneficial formal arrangements.

Gaps that the model aims to address:

1. Individuals have unmet prevention needs related to asthma, hypertension, and diabetes that can be met by Bucket-2[1] prevention services
2. Despite the strong evidence of their effectiveness, Bucket-2 prevention services offered by community-based organizations or public health entities are currently under-utilized by ACOs
3. CBOs and public health entities provide evidence based prevention services, but have limited service delivery capacity and need support in marketing and delivering these services to ACOs

Prevention services that the model promotes:

The model promotes health related services delivered in community settings (CDC "Bucket 2" services):

- Asthma Self-Management and in-Home Environmental Assessment
- Diabetes Self-Management Program
- Diabetes Prevention Program
- Evidence-based assistance with use of Self-Monitored Blood Pressure devices
- Chronic Disease Self-Management Program
- Medication Therapy Management by community pharmacists
- Evidence-based hypertension interventions led by Community Health Workers
- Early Childhood Behavioral Programs*

*Additional discussion and vetting against criteria needed

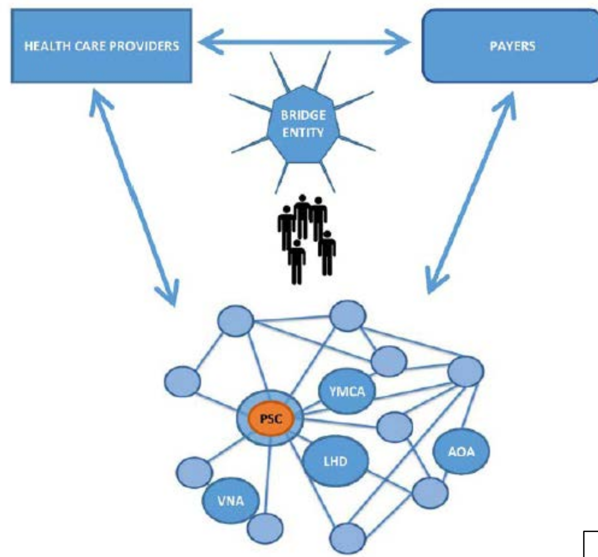
Program goals:

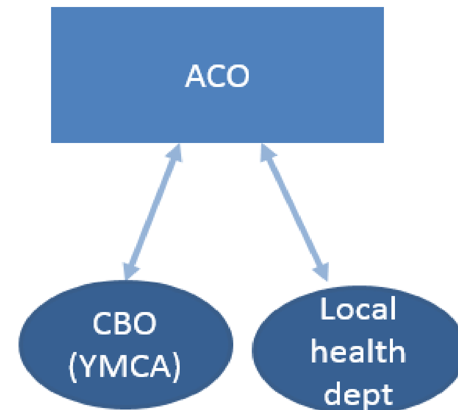
1. Increase the number and quality of formal referral linkages and contractual relationships between the healthcare sector (ACOs) and the community sector (CBOs, public health entities).
2. Increase the number of individuals with unmet prevention needs who complete evidence-based "Bucket 2" prevention services.
3. Improve ACO performance on quality measures related to asthma, diabetes, hypertension, ED utilization, and readmissions for a defined ACO-attributed population.
4. Enable ACOs to succeed in shared savings programs and other alternative payment models.
5. Open avenues for community integration to address clinical and social determinants of health.

Two models are detailed on the next three pages:

[1] https://nam.edu/wp-content/uploads/2016/05/CDCs-618-Initiative-Accelerating-Evidence-into-Action.pdf

	"Network Lead Entity Model"	"CBO/ACO Linkage Model"
High-level Overview	This model focuses on building the **competencies of one community-based organization (CBO), designated as the "lead entity"** in a region. The lead entity receives this designation by meeting requirements of: infrastructure, prevention experience, mission flexibility, CHNA and CHIP engagement. The lead entity will be required to have formal agreements with other community organizations in the region, who also deliver evidence-based prevention services. Technical assistance will focus on building the lead entity's capabilities related to the following standards: core services, fiduciary capacity, sustainability standards, administrative, accountability, leadership and governance, and connectivity. After the lead entity has improved its performance on these standards, the technical assistance will help the lead entity market its services to the healthcare sector and other payers.	This model focuses on **preparing CBOs that can provide effective prevention services to enter into and succeed in formal arrangements with accountable care organizations**. Multiple CBOs in three regions will receive SIM-funded technical assistance focusing on developing business strategies and formal contractual arrangements with ACOs. This approach is modeled after similar work done in California, where technical assistance that improved CBOs' competencies related to market success increased the number of formal partnerships and referral pathways between the healthcare and community sectors. This work has been expanded to multiple states.





*Arrows represent contractual linkages

Strategy	"Network Lead Entity Model"	"CBO/ACO Linkage Model"
1. Improve capabilities of community organizations and public health entities to deliver a specific set of prevention services to the healthcare sector	**Network Lead Entity is one community based organization that meets standard requirements, in each of three regions, to establish accountable arrangements with ACOs. TA focuses on improving administrative capabilities and data management for performance indicators and financial analytics.**	**Multiple community organizations that provide evidenced-based prevention services are selected in each of three regions to participate in TA. The TA focuses on business processes and operational capabilities necessary to support service delivery agreements with ACOs.**
	15 month technical assistance (TA) provided to one lead community entity and its partners, by a vendor contracted by the State through SIM. Entity selected for TA through RFP based on requirements: infrastructure, prevention experience, mission flexible, CHNA and CHIP engagement. The lead entity would represent one or more of the services. For example, one lead for Diabetes Prevention Programs in the region. The lead entity must have pre-established formal MOUs or contracts with partner community organizations to apply. TA focus on standards related to core services, fiduciary capacity, sustainability standards, administrative, accountability, leadership and governance, and connectivity. TA will also focus on establishing a linkage with ACOs. One-time SIM-funded infrastructure grants may be awarded to the lead entity.	15 month TA provided to community based organizations (CBOs) in region by a vendor contracted by the State through SIM. CBOs selected for TA through RFA based on entry level requirements: currently offer one or more of the identified services, and commitment to improve their capabilities to enter into and sustain business agreements with ACOs. TA focus on helping the CBO plan and promote services, establish a sustainable business model to meet demand, a business process for communication and coordination with ACO partners, and data collection and reporting. TA will also focus on establishing business agreements with ACOs. Potential CBO support grants to offset costs of TA participation.
2. Promote collaboration between the community organizations and public health entities that deliver these services	**A Lead Entity model requires the lead entity to establish partnerships as a prerequisite before receiving TA.**	**This model promotes regional peer-learning and collaboration through joint-learning activities led by the TA vendor.**
	One entity designated as the lead/backbone organization must have established formal contractual or other partnerships with other community organizations to apply for TA. The lead entity will be responsible for maintaining collaboration between these CBOs. CCIP Community Health Collaboratives will include these entities and support the development of consensus protocols related to the use of prevention services.	Participants receiving TA will have opportunities to participate in a regional peer-to-peer learning network or consortium, potentially in cohorts organized by service focus (e.g., diabetes management). TA will help CBOs share challenges and solutions related to developing business capabilities and determine whether and what type of formal partnerships (e.g., subcontracts) may be needed to meet demand. CCIP Community Health Collaboratives will include these entities and support the development of consensus protocols related to the use of prevention services

3. Promote the establishment of formal referral (and potential financial) arrangements/linkages between these community organizations and ACOs	**This model facilitates a formal linkage between ACOs and a lead entity per region.** TA will be designed to formalize referrals under contractual arrangements, and to coordinate between the regional ACOs and the lead entity. Impact will be measured by whether a contract is executed between the ACO and the lead entity which should include having ACOs systematically refer patients with prevention needs and tracking quality measures. In regions where a Bridge Entity (CMS AHC initiative) exists, we will see whether referrals to the lead entities can be facilitated by them.	**This model facilitates formal linkages between ACOs and CBOs that offer services aligned with healthcare sector quality performance priorities.** TA will facilitate formal referral and contractual arrangements by coordinating between the ACOs and participating CBOs in the region. Impact will be measured by number of formal arrangements /contracts executed. Such arrangements will establish ACO referral processes and procedures for tracking quality measures that correspond to the offered services. In regions where a Bridge Entity (CMS AHC initiative) exists, we will determine whether referrals to these CBOs can be facilitated by them.
4. Formally recognize organizations that deliver these services	**This model calls for a Prevention Service Center (PSC) Standard designation and renewal process for PSC lead entities.** The lead community organization will receive a provisional designation as a "Prevention Service Center" if they are selected to participate in the demonstration. The designation will be upgrade to permanent if demonstration goals are met. A designation will be provided by a body with cross representation of payers, healthcare providers and prevention experts. SIM/DPH will lead the standardization.	**TA participants are recognized as Prevention Service Providers if they are selected to participate in the TA.** Participants receiving TA will be referred to as "Prevention Service Providers" for the duration of the 15 month period. Renewable recognition will be considered in the future as ACO acknowledge value and ROI from prevention interventions.
5. Promote ACOs to adopt services and measure their impact on their attributed populations	**Activities for both models are comparable.** TA will include support for ACOs to select and track a set of quality measures (e.g., ED utilization, readmissions, A1C control) that reflect performance in serving attributed populations linked to the referral arrangements with the lead entity. CBOs and ACOs engaged in regional solutions to expand prevention will include total population health measures, as designed by DPH/SIM, as part of their impact assessment. PCMH+ Contract may require PCMH+ Participating Entities to implement or demonstrate a contractual relationship with the lead Prevention Service Center entity in each community where such entities exist. CCIP Standards will require linkages with lead entities in addition to existing requirements for linkages with providers of social determinant supports.	**Activities for both models are comparable.** TA will include support for ACOs to select and track a set of quality measures (e.g., ED utilization, readmissions, A1C control) that reflect performance in serving attributed populations linked to the referral arrangements with the lead entity. Regional population health quality measures will help assess progress. PCMH+ Contract may require PCMH+ Participating Entities to implement or demonstrate contractual relationships with at least one community organization participating in the "SIM Prevention Service Initiative" in each community where such entities exist. CCIP Standards will require linkages with participating CBOs in addition to existing requirements for linkages with providers of social determinant supports.