OHS CONNECTICUT Office of Health Strategy

Community Integration Design Group Meeting 1

September 2018

Agenda

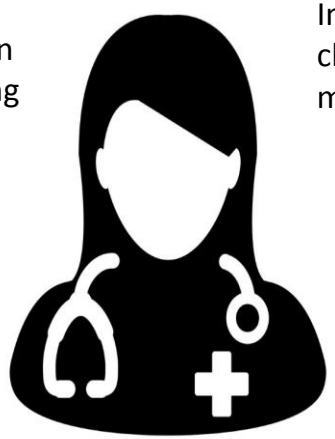
Introductions	10 minutes
Overview of PCM and Purpose of the Design Group	15 minutes
Discussion of Community Integration Models	50 minutes
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

Building the Primary Care System We Need

Primary care's challenges…

Insufficient coordination and coaching

Ineffective chronic care management



Too little revenue dedicated to primary care, inflexible FFS payment

Limited consumer support between visits

Inconvenient; limited access via phone, email, text = more time away from work, family

Poor integration of mental health and substance use services

How we've tried to fix them….

Shared "savings" with no downside financial risk

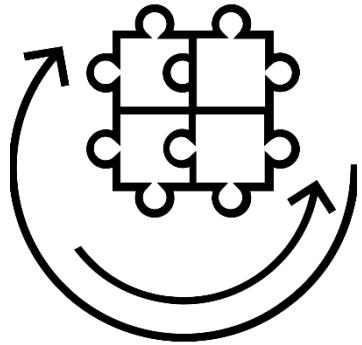
Llifestyle coaching, decision support and help navigating the system

Investments in onsite clinics, biometric screening, EAPs, nutritionists, fitness centers, national telemedicine

Carrier and third-party administered programs to manage chronic conditions, complex cases, care transitions and care gaps

What we really need…..

Integrated, expanded care teams that engage patients in their health, identify risks and manage conditions



Technology to keep providers connected with each other and their patients

Convenient, accessible care with options for email, phone, text and virtual visits

Increased investment in primary care; bundled payment; downside risk to drive reductions in total cost of care

Why Focus on Primary Care?

1. Research, experience of others shows us it works

2. CT providers and patients tell us it's needed

3. Aligns with national focus on primary care as critical path to achieve overall savings while improving health and outcomes

Primary Care Modernization Model Design

Primary Care Modernization Initiative: Design a multi-payer primary care payment reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Project Goals

- Define practice capabilities and payment model options that support them
- Collaborate with leadership and support from providers, payers and consumers as partners in the payment reform design
- Include participation from Medicaid, Medicare, Medicare Advantage and commercial health plans
- Model design for consideration by the Governor-elect following the Nov. 2018 election
- If model moves forward, implementation would begin in 2020/2021

Primary Care Modernization: The Work To Date

Stakeholders have identified many goals for a new model of primary care in Connecticut, including:

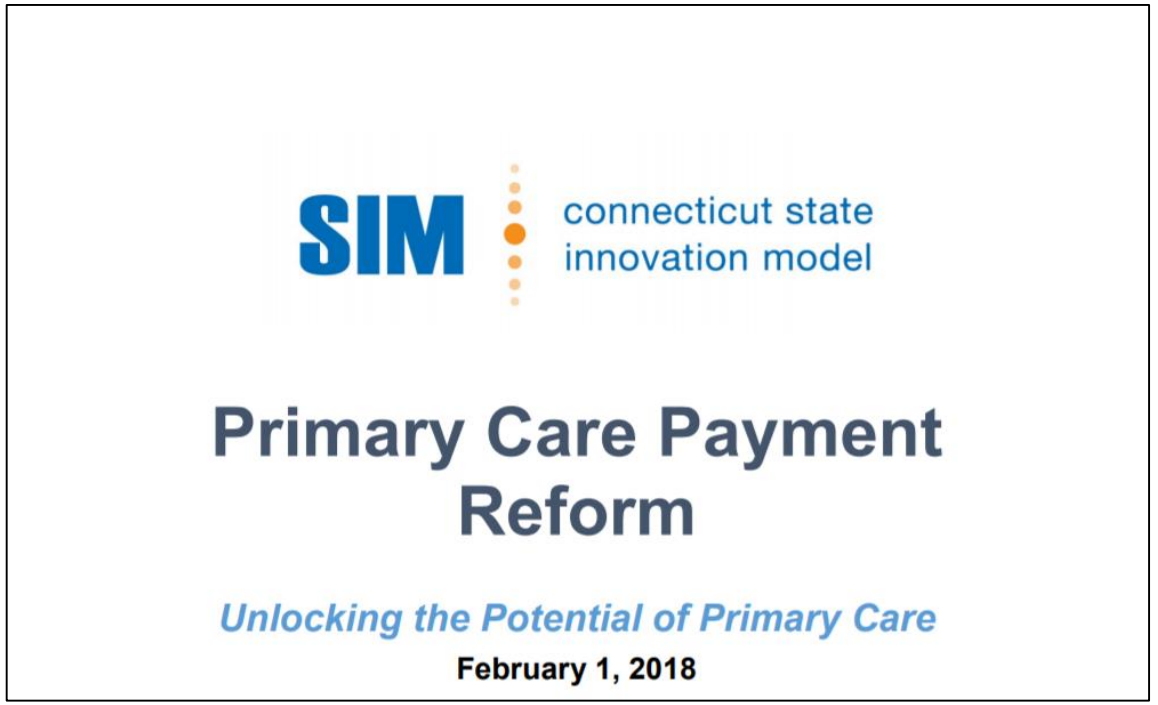
1. Support patient-centered, coordinated care and a better patient experience.

2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed.

3. Expand care teams and improve access outside the traditional office visit.

4. Double investment in primary care over five years through more flexible payments.

5. Reduce total cost of care while protecting against underservice and improving quality and patient experience.



Today's Session

- Define community integration

- Make recommendations on approaches to community integration
  - Should this capability be required for all networks and practices?
  - Which models should be considered?

- Next session:
  - Review feedback on approach
  - Recommendation to Practice Transformation Task Force

Consumer Needs

- Patients and families need a variety of support services beyond traditional medical care.
- Support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions
- Support services beyond traditional medical care that connect patients with affordable solutions and community resources
- Improvement of health outcomes particularly in low-income communities
- Care and care teams that address religion/language barriers and other cultural differences
- Support securing transportation and child care for in-office visits and/or alternative ways to access care

Question: What are we missing?

Community Integration

Extends primary care services into the community and connects patients to community-based services for patients with high risk, social determinants of health needs, and/or chronic conditions

Approach:

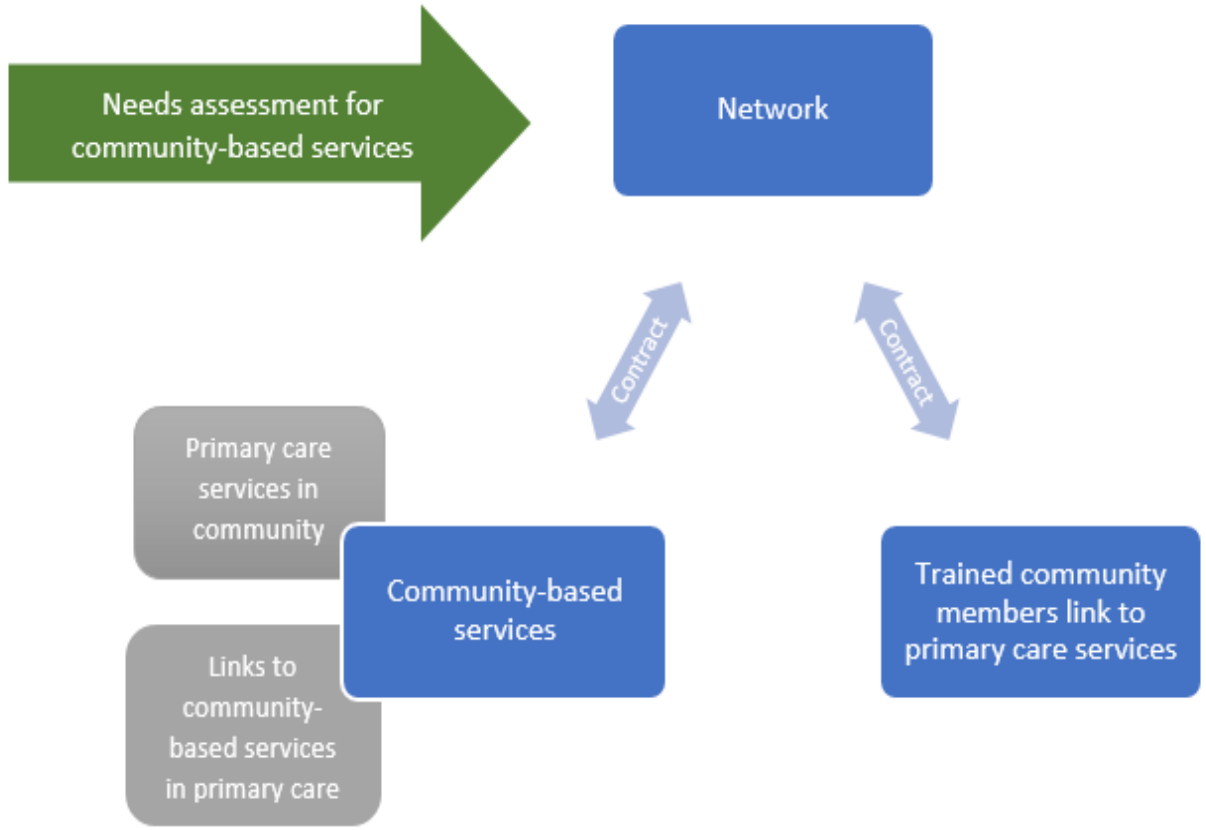
1. Practices identify needs for community-based services

2. Practices provide access to appropriate community-based services by:

   a. Purchasing community-based services to extend primary care services into the community setting or providing community-based services within primary care

   b. Training community members to link patients to primary care

3. Tracking referrals to community-based services and outcomes



Business Case for Community Integration

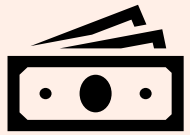
It may be more efficient for networks to purchase services from the community to address care gaps

- Shared savings payment arrangements: must get a 2:1 Return on Investment (ROI) to not lose money
- With upfront per member per month payment: only need better than a 1:1 ROI

Typical Medicare Shared Savings Arrangement

Network invests in CHW

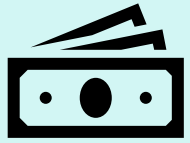
For every $1 invested, total cost of care goes down by $1.80



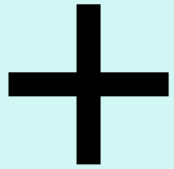
Medicare shares 50% of savings with network ($0.90)

Network loses $0.10 for every $1 invested

New model with upfront PMPM



Network receives upfront payment to invest in CHW



Network nets $0.90 for every $1 invested

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SIM connecticut state innovation model

Questions for Discussion

- Is this approach missing any components? What would be required for implementation?
- Should all networks be required to integrate community-based services or should this be optional?

Social Determinants of Health Screening

1. Care team members conducts social determinants of health screening
2. A standard set of social determinants codes are captured in the patient's EHR.
3. A care team member connects patients to community services that address their individual needs.
4. Patients are screened annually. High-risk patients are screened every 6-months

Questions for Discussion:

- Should all practices be required to screen for social determinants of health?
- What network resources are needed to enable this capability? Other considerations for implementation?

Community Integration Models

Extending Primary Care Services into the Community

Prevention Services Initiative: Advanced Networks contract for services of a community-based organization to improve chronic care outcomes

- CBOs provide culturally appropriate chronic disease management services
- Health departments provide asthma in-home assessment and remediation services

Community Paramedicine/Mobile Integrated Health: Expands the role of paramedics to improve access to care through stabilization services provided at patient's home or in the community

- Reduces ED visits and admissions
- CT Mobile Integrated Health workgroup making recommendations for pilot program

Leeway Community Living Model: Coordination care team is anchored to the primary care physician group to identify patients at high risk for hospitalization and/or nursing home placement

- Expanded care team conducts in-home assessments and develops individualized care plan
- Reduces ED visits, cost-effective, longer person is in program more cost savings

Community Integration Models:

Linking to Community Services in Medical Settings

Health Leads: Primary care practices contract with organizations that provide on-site aids to connect patients to social services.

- Connects patients to services to address social determinants of health needs on-site

Community Care Teams (CCTs): Locally based care coordination teams employed to manage patient's complex illnesses across providers, settings, and systems of care

- Focus on high risk patients, transitions of care, reducing avoidable ED visits
- CCTs currently operating across the state; initiatives to create collaboration and address challenges with data collection and implementation

Community Referrals to Primary Care

Barbershop approach: Leaders in the community are trained to screen and educate other community members on health and condition management and connect them to primary care services

Questions for Discussion

- Should all of these models be included in the payment model? Should any be required?
- Which services are more efficient to be provided as community-based services than provided by the network or practice?
- What resources would the network need to provide to support this capability?
- How would we monitor contracts between networks and community-based services and ensure they are meeting needs of patients?

Next Steps

- Summarize feedback and recommendations
- Task Force reviews on October 9 and makes recommendation to Payment Reform Council (PRC)
- Final PRC report at end of year