



CONNECTICUT
Office of Health Strategy

Community Integration Design Group Meeting 2

September 2018

What we Heard in Session 1: Consumer Feedback

- **Additional Consumer Input, Needs and Concerns**
 - Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
 - There will be gaps in what community services are available depending on geography and need for capacity building in those areas
 - Need to address needs of patients who are not seeking primary care - Payment Reform Council is considering auto-assignment of high ED utilizers to primary care practices
 - If primary care practices are doing needs assessments largely based on those accessing care, we might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this
 - Look into the UPenn IMPaCT model - under consideration by diverse care teams design group
 - SDOH screening needs to be culturally appropriate and provided by the appropriate care team member

Are we missing anything?

What we Heard in Session 1: Approach

Approach:

- Requires process for how networks and practices will identify gaps in care and services
- Requires process for how CBO network will be identified
- Practice should identify needs beyond just population seeking care
- Need way to monitor that primary care CBO linkages are happening and impacting outcomes
- Networks would not contract with CBOs providing non-healthcare related services, but could contract with CBOs that connect people to those services
- All practices should screen all patients for SDOH needs

Are we missing anything?






Draft Concept Map for Community Integration

Primary care

Network uses person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services

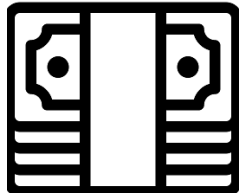


Community

		Contracts With Community Placed Services			
Type of Service	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness self-management services	Complex care coordination for high risk patients, often with SDOH needs	Support for patients with acute or chronic medical risk at home
Examples of Models	Health Leads or Project Access? 	Barbershop Approach 	Prevention Services Initiative 	Community Care Teams, Leeway Community Living 	Mobile Integrated Health/ Community Paramedicine 

Payment Model Options for Supporting Community Integration

Basic Bundle



Supplemental Bundle



Fee for Service Payments



Key Points

- Supplemental bundle provides upfront payment for networks to invest in new capabilities
- Purchasing community placed services may be an optional use of supplemental bundle payments
- Purchasers wouldn't be required to implement any particular service (networks want flexibility)
- These are not the only options that might be developed with community based partners
- How needs are identified is determined by the network (analytics, care teams, health risk stratification)
- State would offer TA similar to PSI to help networks develop these capabilities

Community Placed Navigation or Linkage Services



Health Leads Example

Primary care practices contract with organization that provides on-site aids to connect patients to social services

- Volunteer advocates screen patients for social determinants of health needs
- Links patients depending on SDOH needs to basic resources like food, clothing, housing, etc.
- Provides updates to healthcare provider
- Measurable outcomes: Improved health outcomes

Project Access New Haven Example

Partners with local providers to identify underserved patients with urgent medical needs and connect them with donated medical care and services

- Coordinates timely care for low-income, uninsured adults through partnership with Yale New Haven Hospital
- Patient Navigators help patients navigate the system, identify and address barriers to care, and ensure timely access to needed care
- Measurable outcomes: Reduced wait-times, increased show rates for medical appointments, improved health and quality-of-life, increased ease of getting care, high program satisfaction

Early Intervention and Secondary Prevention Services

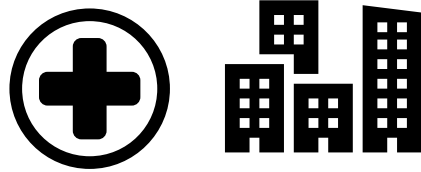


Barbershop Example:

Community members are trained to screen and educate other community members on health and condition management and connect them to primary care services

- May include screening for certain health conditions
- May include on-site access to medical services or practitioners
- Measurable outcomes: Improved health outcomes

Chronic Illness Self-management Services

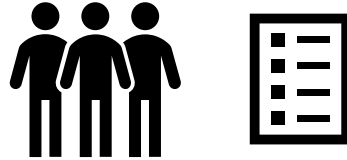


CT SIM Prevention Services Initiative Example:

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
- Measurable outcomes:
 - Increase number of individuals with unmet prevention needs who complete community-placed, evidence-based prevention services and maintain or improve wellness;
 - Improve network/FQHC performance on quality measures for asthma or diabetes and associated ED visits or admissions/readmissions through use of community-placed, evidence-based prevention services
- CT SIM provides technical assistance to CBOs and ACOs to build skills for entering into agreements

Complex Care Coordination for High Risk Patients (often with SDOH needs)



Community Care Teams (CCTs) Example:

Locally based care coordination teams employed to manage patient's complex illnesses across providers, settings, and systems of care

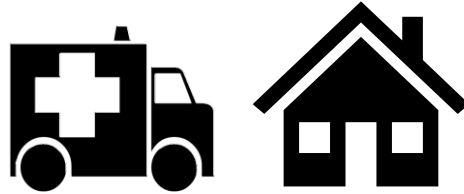
- Clinical and non-traditional health providers such as community health workers, peers, and navigators
- Focus on high risk patients, transitions of care, reducing avoidable ED visits
- CCTs currently operating across the state; initiatives to create collaboration and address challenges with data collection and implementation

Leeway Community Living Model Example:

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

- Supports informed choice for individuals at risk for long-term skilled nurse home placement
- Expanded care teams conduct home visits and developed individualized care plan
- Feedback to primary care provider
- Measurable outcomes: Reduced ED visits, hospital admissions, admissions to skilled nursing homes

Support for Patients with Acute or Chronic Medical Risk at Home



Community Paramedicine/Mobile Integrated Health Example:

Expands the role of paramedics to improve access to care through stabilization services provided at patient's home or in the community

- Supervised by trained clinicians through teleconsultation for education and training to provide care in the home
- CT Mobile Integrated Health workgroup is making recommendations for MHI in the State
- Case Study: Commonwealth Care Alliance has urgent call-line that deploys paramedics to visit patients in their homes to provide in-home assessment and treatment
- Measurable outcomes: Reduced ED visits and admissions, cost savings






Draft Concept Map for Community Integration

Primary care

Network uses person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services



Community

		Contracts With Community Placed Services			
Type of Service	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness self-management services	Complex care coordination for high risk patients, often with SDOH needs	Support for patients with acute or chronic medical risk at home
Examples of Models	Health Leads or Project Access? 	Barbershop Approach 	Prevention Services Initiative 	Community Care Teams, Leeway Community Living 	Mobile Integrated Health/ Community Paramedicine 

Questions for Discussion

- Should networks have the option of requesting they use a portion of the supplemental bundle for these services?
- Are these the right kinds of services to provide as examples of how to use supplemental payments?
- Do networks need to demonstrate the community placed service is evidence-based service or should they be allowed to pilot programs (with requirement that they collect quality and cost data)?
- Should SDOH screening be universal (especially if it is used for adjusting the supplemental bundle for illness severity and SDOH needs)?
- What are ways to monitor adequate access to community placed services and services are meeting needs of patients?

Next Steps

- Summarize feedback and recommendations and circulate to group for final review
- Task Force reviews and makes recommendation to Payment Reform Council (PRC)
- Final PRC report at end of year