PREVENTION SERVICE INITIATIVE:
RESPONSE TO HISC COMMENTS

OVERVIEW

DPH and the PMO have prepared the following summary and FAQ in response to the comments and questions about the Prevention Service Initiative offered by Steering Committee members at the July 13 meeting. The subsequent summary describes the initiative within our overall strategy for health care delivery system reform.

Healthcare providers in new payment models are making unprecedented investments in care delivery improvements. Payment reform (i.e., Shared Savings Programs) is the central tactic in our State Innovation Model (SIM) to spur accountable providers to invest in care improvements. These investments in infrastructure and staff are largely not fee-for-service reimbursable and are being made to improve quality and efficiency.

For example, accountable providers are investing in health IT, analytics, care management, and the elimination of gaps in care. They are also investing in care coordination staff, usually nurses and social workers, to reduce avoidable ED and hospital visits for high-risk patients. In some cases, they are using certified staff such as registered dieticians or nurses to provide diabetes or asthma self-management guidance. However, they generally have not been investing in community health workers or community partnerships that could help them to deliver better care at a lower cost. The Community & Clinical Integration Program (CCIP) and Prevention Service Initiative (PSI) are our primary means of helping them to do this.

The Community & Clinical Integration Program (CCIP) encourages accountable providers to make investments in community linkages to address social determinants of health. This includes collecting and using race, ethnicity, and social determinant data to improve care and building relationships with CBOs to address housing, nutrition, economic, legal, and transportation needs. CCIP also requires that providers hire community health workers to provide more culturally competent care, help patients navigate the health system, and link patients to community supports. CCIP includes transformation grants to offset the near-term costs of making these additional investments and evaluating whether they improve outcomes and generate a return.

The Prevention Service Initiative (PSI) extends the CCIP focus on CBO providers of social services to CBO providers of evidence-based prevention services including diabetes and asthma self-management.¹ We believe that these services have the ability to improve outcomes and generate a return on investment for eligible patients. The CBOs that provide these services appear to be under-utilized—none of them have written referral agreements with accountable providers—and they lack the resources to expand capacity to meet the need. Accountable providers in new payment models now have a financial interest in extending their investments to services and supports in the community that will enable them to deliver better care at lower cost.

The PSI approach is relatively simple. Accountable providers will be required to execute at least one financial agreement with a CBO provider of evidence-based diabetes or asthma self-management services. SIM will fund technical assistance to the CBOs to help them offer high quality services and to be successful in these new

agreements. We anticipate that these CBOs will be required to include community health workers as part of their service model in order to qualify.

The financial agreement will be expected to have payment terms linked to successful patient engagement and program completion, and perhaps incentives for outcomes. As with the CCIP requirements, the SIM office is proposing to prime the pump by offering grants and technical assistance to accountable providers to enable them to identify appropriate patients, establish referral workflows, negotiate agreements, and to pay for services for the first 12-to-18 months. All parties will carefully evaluate the interventions to validate that they produce a return on investment. Our plan for sustainability would be continued funding by the accountable provider using their own resources.

The Prevention Services Initiative aligns with the central premise of our payment reforms—that the promise of a return on investment will encourage providers to invest in new capabilities and community partnerships to achieve higher value healthcare.

FREQUENTLY ASKED QUESTIONS

1. **How does SIM/PSI relate to the CMMI/AHC grant?**
   Organizations participating in the CMMI/AHC grant are expected to make investments in screening for social determinants of health (SDOH) needs and referring to community based organizations (CBOs) that can address those needs. They are building systems that support efficient screening, referral and linkage. In contrast, the PSI focuses on identifying patients with asthma or diabetes that they are unable to serve effectively and referring them to CBOs that are better able to engage them in chronic illness self-management. We expect that organizations participating in the CMMI/AHC grant may decide to extend the systems that they develop to support PSI service referral and linkage.

2. **How are the CCIP and the PSI similar or different?**
   The CCIP initiative requires that Advanced Networks/FQHCs develop referral and linkage arrangements with CBOs to address SDOH needs. In contrast, the PSI initiative focuses on developing referral and linkage arrangements with CBO providers of chronic illness self-management services to address the needs of patients with asthma and diabetes. The PSI initiative will also provide Advanced Networks/FQHCs with grant funding and require that they enter into financial agreements with at least one CBO provider of chronic illness self-management services.

3. **Where is the PSI going to be implemented?**
   The PSI targets Advanced Networks and FQHCs that are participating in accountable care arrangements with Medicare, Medicare and/or commercial payers. The first wave of PSI will be implemented in three areas with high accountable care penetration, using PCMH+ penetration as a proxy. The PMO coordinated with DPH in designating these target communities, so the same communities will be the focus of the CCIP Community Health Collaboratives. The target communities include Bridgeport, New Haven, and Middletown and surrounding areas.

4. **How is the PSI linkage model going to be sustained?**
   Recent payment reforms have created a new market for community-based services. Similar models in other states have shown that accountable healthcare organizations are willing to provide financial reimbursement to CBOs for these services.² Even so, SIM is proposing initial financial support for Advanced Networks and FQHCs

to enable them to pay for CBO services. This will reduce the need to use their own resources for upfront investment and will allow them time to validate the quality and financial returns of such an arrangement. The expectation is that accountable healthcare organizations will continue to fund these services because it helps them to succeed in value-based payment models.

5. **How does the CHW initiative relate to PSI?**
The CCIP initiative incentivizes the healthcare sector to hire CHWs as part of the healthcare team. In contrast, the PSI relies on CBOs that utilize CHWs to extend the capacity of their primary care teams to support patients with chronic illnesses. CBOs will receive technical assistance to align their workforce in ways that are compatible with the utilization of CHWs.

6. **Will there be sufficient demand from the healthcare sector for community based services?**
Although the healthcare sector may not currently have strong demand for community based services, one of the aims of the PSI is to strengthen this demand. One way is to build the capabilities of CBOs so that they are strong partners in impacting healthcare outcomes. Another is to require that Advanced Networks/FQHCs invest in these services and then help them evaluate the return on investment.

7. **Would scarce resources for prevention be better invested within the healthcare sector?**
The goal of the PSI is to catalyze the healthcare sector to invest their own resources in prevention services. Recent payment reforms have made this financially feasible if the services generate sufficient savings. Advanced Networks and FQHCs can do this either by building the services themselves or by purchasing the services from a community organization that currently delivers them. In many cases, it may be more cost-effective and practical to purchase the service. For example, it may not make business sense to build a service tuned to the cultural needs of every sub population. The PSI focuses on the latter approach and provides technical assistance to CBOs to ensure they are ready to take advantage of this opportunity.

8. **Why is the PSI focused on community organizations?**
A basic assumption of the PSI initiative is that healthcare providers can fundamentally improve their performance by incorporating underutilized community services in their strategic approach to quality improvement and cost reduction. The initiative further assumes that a) there are some segments of the population for whom healthcare providers cannot build efficient and effective practice based solutions and b) that community service providers can more flexibly provide services in accessible, non-traditional settings. Community based organizations have proven ability to deliver prevention services, but need additional technical assistance to build their business capabilities and align their service models with the needs of healthcare organizations that are accountable for quality and cost.

9. **Were human and social services agencies included in the PSI planning?**
Close to fifty community based organizations across five regions of the state participated in focus groups sessions. In addition, six Advanced Networks/FQHCs were consulted in a series of in-person interviews. These stakeholder engagements were conducted in a listening session format where the basic PSI assumptions were validated.

10. **How is the SIM process going to implement and launch the PSI demonstration?**
The DPH/PMO teams are working to procure a vendor that will provide technical assistance to both CBOs and Advanced Networks/FQHCs. This procurement will be followed by the identification through an RFA of CBOs that can demonstrate experience with evidence based prevention services and that can articulate how the improvement of organization capabilities would allow them enter and succeed in financial arrangements with the healthcare sector. The CBOs will be selected from the above noted service areas. DSS will be requiring that
PCMH+ participating entities enter into at least one contractual agreement with a CBO provider of prevention services. Finally, the DPH and the PMO intend to offer grant support for both CBOs and Advanced Networks/FQHCs to enable their participation in this initiative. The demonstration is scheduled to launch in January 2018 and is expected to last 18 months.

11. Are hospital Community Benefits considered in the PSI solution?
Community Benefits funds are independent filings from hospitals and health systems related to their individual contributions, mostly to unreimbursed care and workforce education. Smaller proportions of these funds are dedicated to prevention and other limited solutions to social determinants of health. We anticipate that hospital anchored Advanced Networks may consider the use of Community Benefit funds as a means to sustain their financial commitments to community-based providers of prevention services.