

CAB “Monday Check In” Comments Received* – June 16, 2014

Bob Krzys page 1; Alice Ferguson page 3; Steve Karp page 5;

Theanvy Kuoch page 6, Pat Check page 8

**Additional materials may have been sent by these individuals*

Please check their emails for more information

To: Consumer Advisory Board Members

From: Bob Krzys, CAB Member

Re.: My input for the June 16, 2014 check-in

As we discussed during the June 11, 2014 conference call, we have a very short timeline to discuss and come to an agreement about the content of the “Consumer Engagement” narrative. The narrative will have to be finalized before the Workgroups gain traction and in the case of the Workforce workgroup, even before the group is formed!

However, Jeff Beadle’s two page summary and his oral presentation of that summary at the June 12, 2014 Steering Committee meeting did a great job of detailing the broad outlines of how an effective Consumer Engagement piece can dovetail with the rest of the SIM initiative. Additionally, the first draft of the “narrative” distributed Saturday, June 14th, captures all of the Jeff’s presentation.

I think that the CAB needs to supplement the narrative with the “why” of Consumer Engagement. By that I mean while it is crucial that the “how” be described to demonstrate the pervasive commitment Connecticut is making to Consumer Engagement, we need a clear few sentences as to why Consumer Engagement will drive the success of the rest of the SIM initiative. Consumers are the customers and their interests will drive more effective delivery of health care services and better outcomes and more equal access and better care coordination and a more affordable system as the plan is implemented over the four year period.

I offered to comment on Issue Brief #8 during the call as did others. I will try to contact Mr. Ron Preston early next week to discuss his presentation which is intertwined with the concept of Community Health worker.

In the meantime, I would comment on Issue #8 as follows:

This is an excellent roadmap for establishing and bringing to fruition an effective program for community health workers. I assume we all fully support the concept since it is one of the six initiatives in the SIM grant.

As you will note, Ron Preston, who I referred to earlier, appears to be the author.

My comment is that the Issue Brief or the narrative should refer to the NIPA program. It should acknowledge that Access Health spent some limited funds on the IPA's (\$6,000 per assister contract; total of 300 contracts?) and the Connecticut Foundations funded the six larger Navigator grants. This experience yielded the creation of a dedicated core of competent community based people who met with people and enrolled thousands of them in Medicaid, the Medicaid expansion and in various Qualified Health Plans on the Exchange. Many of these assisters are eager to stay involved. Many are incredible advocates for a population that is underserved. I believe the SIM grant should provide a funding provision for the immediate uptake of those assisters who are able to participate in training to be a Community Health Worker. Many are already trained and competent in community interaction. The timeline for the "boot camp" provisions in Issue Brief #8 should be added to by a procedure to solicit and incorporate these assisters early in the process and find ways to get them into the Community College programs as soon as possible. Additionally, it is my hope that the NIPA Program will be funded in some manner now to prepare for the November 15, 2014 open enrollment.

In summary, I believe Brief #8 is a great outline and should be dovetailed with the good things that came out of the NIPA experience. This observation correlates with at least one of Jeff Beadle's point to the Steering Committee last week.

I also want to mention Issue Brief #1. The Care Experience Survey is the linchpin of feedback from the consumers and will help to determine progress on health equity in that it will assess how the consumer was serviced at the front of the delivery system and during the clinical portion of the system. It may also serve as a metric to judge providers. While this type of data gathering is not something I am familiar with, I would observe that Jeff Beadle's reference to the establishment of a "feed back" loop is part and parcel of an effective way for consumers to impact desirable changes in the delivery system. Perhaps others can comment on ways to stress the importance and the "how" of implementing the best practice for soliciting, receiving and acting upon consumer engagement as well as the associated IT issues.

Lastly, can we send distribute after Monday's submissions, all the submissions and can the co-chairs advise on how we want the Monday June 23rd check in to proceed, i.e., by conference call, by Skype; by further comments or a combination.

I look forward to communicating with all to put out the best narrative that will be supported by all advocacy groups to insure the best chance of a successful application.

Email from Alice Ferguson

Good morning, I think I understood your request to read the above mentioned Issue Briefs to mean you are looking for interest, expertise and or questions about the set we are given and read them by 10am each Monday morning to insure the CAB can add to or alert us to needs or areas requiring our focus. With that said, I am glad to report I have read them all, but admittedly have more questions than expertise to offer. In each I have highlighted what I think are key terms and definitions and believe I have a very, very basic understanding. I assume any group discussion may or may not happen as we hone our process... Is that correct? Below is what I got from each of them...

Issue Brief 5:

Is there an elementary definition of VBID? I think I understand it as a model the SIM is supporting? After reading it, my question was "Where does the voice of the consumer" figure into this discussion even though the topic is "Employer Engagement?"

It speaks of Access Health considering its implementation, which led me to another question, "Could you explain where the SIM process and development stand in the overall role of Healthcare in CT. Moreover, what is the role of SIM versus Access Health CT in the overall State of CT Healthcare landscape. Am I correct that the Test Grant is seeking to fill gaps and needs in Healthcare services that are currently in place? (Kinda feel awkward asking that but I really want to understand).....

Issue Brief 6:

I read alot of reference to "urban areas" throughout this brief. I have no exposure to AHEC other than CAHEC from some years ago. From my recollection they weren't staffed to do this level of community involvement, so what urban areas is this brief referencing, i.e. where is UST practiced? It may not matter, I was just wondering in what part of the state this exists or was done in. Further, my personal exposure to CHS and Charter Oak leave me thankful that I had private healthcare in all my years. I have had exposure with friends and family in these facilities and in my experience most often it is substandard. Also, recent exposure to Hartford Hospital demonstrated an absolutely decline from my own experience in terms of responsiveness and inclusion of the patients in their own healthcare (This may not be applicable to this brief).

Issue Brief 7:

The six primary care disciplines the Coalition is considering make sense; however, there are so many disease specific concerns that would seem to need particular focus outside of primary care, HIV/AIDS and communicable diseases being among others, like I Asthma, Diabetes, and others I think require specific focus. Are the Teaching Centers placing any focus on healthcare issues beyond primary care? Shouldn't they be?

Issue Brief 8

Is there a more specific definition of a Community Healthcare Worker, and what responsibilities does that role entail as it relates to this Issue Brief and overall Healthcare? It speaks about "needing SIM dollars to develop and operate its program." How is that decided and does our CAB need to have input on that issue?

I gave it my best shot.... I am not sure if you need to spend any time on answering these questions unless they are ones our CAB needs to address. I raised each point based on what I know about each of them.

Have a great week.

Alice

Email from Steve Karp

I reviewed the briefs 5-8 this weekend. Here are some initial thoughts.

#5. I hope we do not leave out the individual insurance plan market from discussions on VBID. Not as easy to get to in terms of impact but the value of such design will offer value to individuals too. Insurers should be engaged in this aspect too. Also, no mention of role of organized labor. Seems they belong at the table in some of the councils being proposed. I do see VBID as having strong potential to being a positive step.

#7. I wonder what the politics are in having 8 FQHCs participate but not the others? Some significant urban centers are not covered, most notably Stamford. Also, am interested in why Quinnipiac Medical School not mentioned as it is my understanding that they are looking at a interdisciplinary, primary care focus.

#8. How does the CHWs intersect with the case managers in AMH? Also surprised the CHW is being seen as attached to medical practices as I saw it as more community organization based.

Steve

Issue Brief #8 Community Health Worker Initiative

Response from Theanvy Kuoch representing traumatized special needs communities

Theanvy Kuoch presented the issue brief to members of the SEA community on June 11th and 12th. The following is the communities' response.

The Southeast Asian American Community strongly supports the inclusion of Community Health Workers in the SIM's plan because they know that our communities cannot access health care without them. (Ct. SEA Needs Assessment 6/30/2014 and Berthold et al, 2014) Trauma and lack of appropriate care is responsible for our high prevalence of diabetes, cardiovascular disease and stroke which results in early disabilities and death.

The vast majority of SEA communities arrived as refugees and in our early years, we were part of a Federal plan for developing resources through the Office of Refugee Resettlement (ORR). For many years, the Mutual Assistance Association (MAA's) acted as the safety net organizations for their communities. They were staffed by ethnic workers who understood the cultural and language of the people and many had been trained to do direct service and public health in the refugee camps. Funding for these programs faded over the years and was never replaced with State funding. Right now we have no statewide plan for providing support and interpreting despite the fact that over 50% of people who need an interpreter to access care do not get one.

These "special needs" communities have not been in the state's data collection system as well as in the support system generally provided recipient of Medicaid and Medicare. This means that their inclusion in the newly innovated system will require attention to far more than the training and certification of the workers themselves. Great consideration need to be given to the infrastructure for assuring that these services are available to all who need them on a statewide basis.

There are about 22,000 Southeast Asian refugees living in Connecticut who were resettled across the state. Few areas have concentrations of one ethnic group that is large enough to develop ethnic specific services. With this small a number of people who are spread across the state, it is not reasonable to believe that they will be able to participate in "person-centered" medical homes that include a community health worker from their community on the treatment team.

Yet the urgency of need in our communities requires us to envision solutions that are truly innovative and are built on existing resources. The SEA community based organizations need to be a part of the training of community health workers and their deployment in our communities. When we envision training to promote the use of community health workers we always think on multiple levels.

First and foremost we have to build partnerships for the use of multidisciplinary, cross-cultural teams that can first deliver the most vital services. That means we need to train Community Health Workers and the professionals who will be part of those teams. CHW's must have a standardized set of core competencies, but they must learn their specialty training as part of a team. This specialty training need to include "cultural humility for those CHW's working with these communities"

The SEA community based organization are ideal places for their members to access care, but we need to have training to complete the administrative duties necessary for managing CHW's. We also should consider resource sharing so that we do not have to duplicate the infrastructure for management of contracts, billing, Health Information Technology and evaluation. In this regard, each CBO need to be trained to work as part of a team.

Over the years we have built truly innovative partnerships to address the specific problems of our communities. We work with the UCONN School of Pharmacy and the Ct Pharmacists' Association to pilot a project to test the use of cross- cultural teams for Medication Therapy Management. This project delivered services face to face and by videoconferencing and garnered tremendous support from the community while at the same time reaping a cost benefit of \$3000 per person.

The UCONN Schools of Social Work and Behavioral health have been active in helping the communities publish important data about trauma and chronic disease as well as the role of community health workers delivery wellness and prevention services. They will be helping to test a risk assessment tool that measures trauma, chronic disease and the social determinants of health in terms of both risk and resiliency. These tools are essential measuring the effectiveness of programs.

We are proud that our state is committed to eliminating disparities in health and we understand that as communities we must be engaged in that process in order to succeed. Not succeeding comes at a tremendous price. Our communities estimate that as many as 15% of our members have complex chronic disease that will cost our state as much as \$100,000,000 but most of all we know that we are losing our loved ones from chronic disease too early in their lives.

To : Consumer Advisory Board

From: Pat Checko

Subject: Checking –in 6/15/14; Issue Briefs 6-8

These three initiatives were all developed by or with AHEC (primarily Dr. Bruce Gould at Central AHEC at UCHC). Together they represent an investment of \$1M per annum for 5 years.

#6 Connecticut Service Track (Dr. Bruce Gould, Central AHEC)

This is a proposed extension to an existing program at AHEC at the UCONN Medical School. There is no discussion of the existing Urban Service Track program achievements and contribution to IP team based community care in urban areas where it currently exists, so it is difficult to imagine how its extension to all health professions schools in Connecticut. While all AHECS will be involved in coordination, it is not clear what their roles would be or their capacity to carry out the initiative. It seems to be the least relevant to the promulgation of practice transformation among the three proposals.

Questions

1. How does the consumer directly benefit from this initiative?
2. No budget is presented, but is most likely for staff and coordination.
3. How would this curriculum be integrated into the training for nursing, pharmacy, medicine and other health care professions? Will there be an opportunity for internships in settings to practice IP team care? Such as at UCHC?

#7 Teaching Health Center Initiative (Drs.Ahmati, Preston, Gould)

This proposal would support the development of 6-8 Teaching Health Centers in CT offering residency programs offering one or more primary care disciplines (Internal Medicine, Family Medicine, Pediatrics, Psych, OB/GYN and Dentistry). These residencies will be in collaboration with Connecticut's Teaching Hospitals to provide rotations. Medicare is interested in supporting community based residency programs. The initiative is requesting funding for 5 years @~\$500,000 per annum for core team and faculty salaries and associated costs. Once up and running the program will be sustained by DGME payments.

Comments

1. This appears to be a good way to train future PCPs to meet the shortage that we anticipate with the rollout of ACA. Their point is well taken that clinicians doing their residencies at THC's will be better prepared and more inclined to serve disadvantaged communities.
2. The currently proposed CHCs do not include any in Hartford or CHC Inc., a CHC with centers in 13 communities that is not a member of the Community Health Center of

Connecticut. CHCCT will have 2 full-time employees working on this project. The opportunity to participate should be available to all FHQCs in CT.

#8 Community Health Workers (Preston/Gould)

Community Health Workers are critical to the concept of integration of public health, prevention and health care and will play a transformative role in person- centered wellness and care models. This is a good and ambitious initiative that unfortunately focuses primarily on the clinical aspects of the CHWs role in Advanced Medical Homes and Prevention Centers. There are many models for the role of CHW including: Lay Health Worker, Care Delivery Team. Health Education, Navigation, Care Coordination, and Outreach and Enrollment models.

The Southwest AHEC has been very engaged with the CHW workforce . Recently ,working with the Yale School of Public Health, they conducted a survey regarding the CT HW workforce that was presented to the Healthcare Innovation Team.

It is critical that a plan to train CHWs not concentrate exclusively on clinical issues and ignore the other important and critical roles CHWs plan in the “continuum of wellness and health” for the future.

I agree with Bob’s comments about the potential to utilize assisters in these roles, as well as other community and faith based individuals who understand the culture, needs and burdens , as well as the language of, the people we serve, especially those most profoundly affected by the social determinants of health. I’d like to see CHWs in the bodegas, and barber shops educating, navigating, connecting to services like smoking cessation and providing the link between them and the “health care community”.

Other issues

1. As with other professionals and paraprofessionals there will need to be a certification process. Will it end up being a strictly academic training standard, or will it need to be a professional certification process.
2. Will there need to be different trainings for different “specialty areas” or will they be generalists who will be able to work in a variety of settings and functions.
3. What will be the role of the Department of Insurance, Insurance Committee, DPH and payors in determining scope of practice and payment systems for CHWs?

Am attaching some papers on CHWs should you like to read more. Massachusetts is definitely the model in New England and the proposal addresses working with them on this initiative.