

---- **Concept Outline** ----

The Integration of Public Health and Primary Health Care in the State Innovation Model

Background and Context:

The State Innovation Model (SIM) aims to establish a care delivery and financing model that improves population health, enhances health care quality and reduces costs. Connecticut's working vision with SIM is to establish a person-centered healthcare system that improves affordability, promotes value over volume and reduces health inequities.

Community resources can play a vital role in improving individual and population health outcomes and reducing costs. Connecticut has a rich array of community-based organizations with a long tradition of providing services with a deep and unique understanding of the communities they serve.

However, there are lack of structures and incentives to drive clinical-community collaboration and coordination. Providers generally lack awareness, incentives or mechanisms to take advantage of available community resources that could help their patients. Further, availability of many community-based services is contingent on grant funding, leaving even the highest quality services vulnerable to funding cycles. Standards, required certifications and the evidentiary basis for community-based services also vary, creating additional barriers to integrating the use of these resources into routine clinical practice (1).

The following concept serves as one possible model to address the aforementioned issues and to operationalize the integration of public health and primary health care in the context of financing and delivery redesign. The concept aligns with "innovative" model designs sought by CMS for the testing phase and the CMS Innovation Center's "Community Integrated Health Care System 3.0" vision.

Certified Community-Based Practice Support Entity

The concept proposes the creation of a *Certified Community-Based Practice Support Entity*, herein referred to as the *Certified Entity*. As the title suggests, the *certified entity* would support a set of local primary care practices with a specified package of evidence-based community services.

Each *Certified Entity* would:

- Be responsible for the delivery of a core set of evidence-based community interventions.
- Enter into formal affiliations with primary care practices and share accountability for quality and outcomes.
- Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services.
- Meet specified standards pertaining to the type, quality, scope and reach of services.
- Have IT-enabled integrated communication protocols, including bi-directional referrals with affiliated primary care and other relevant providers.
- Collect and report data and evaluate performance and relevant outcomes.

Illustrative Core Services:

The following are illustrative examples of the type of evidence-based community services that could support high-quality clinical care, improve population health and in many cases reduce costs.

- Asthma Home Environmental Assessments
 - Home environmental assessments to identify and remove asthma triggers improves medication adherence, reduces asthma symptoms and decreases healthcare utilization (2).
 - Assessments and follow up can be conducted by public health workers, including community health workers.
 - A state-wide program administered by CT DPH has been in place and has shown return on investment in a 6 month timeframe (2).

- Diabetes Prevention Program
 - Persons at risk for developing diabetes can substantially delay progression to diabetes through enrollment in a group lifestyle intervention program (3).
 - Trained lay health workers can deliver the intervention.
 - Public health could provide training, technical assistance and monitor protocol adherence and reporting.
 - Select “Y’s” and employers are already providing or planning to provide this program in CT.
 - The program can be cost-saving from the perspective of a payer.

- Chronic Disease Self-Management Programs
 - Persons with various chronic diseases (hypertension, diabetes, arthritis) can learn self-management skills in a group setting based on a model developed at Stanford University (4,5).
 - Demonstrated outcomes include improved quality of life and decreased utilization of hospital services (4-6).
 - The intervention can be delivered by trained non-health professionals.
 - Public health can train, provide technical assistance and monitor quality of these programs.
 - CT DPH has worked with the Area Agencies on Aging to offer this program at various locations in the State.

- Population-based services to increase cancer screenings
 - Client reminders, outreach and navigation can improve the utilization of recommended cancer screenings for colorectal, cervical and breast cancer (7).
 - Underutilization of screenings is expected to persist even in the context of expanded health insurance coverage (8, 9).
 - The *certified entity* could perform education, outreach and navigation to improve cancer screening.
 - Public health could assure protocol adherence, and monitor quality and outcomes of population-based services.

- Community Health Worker-based interventions
 - Community Health workers (CHWs) are trusted members of the community which make them uniquely positioned to engage traditionally vulnerable populations and improve health equity.

- A recent review of the literature demonstrates the value and potential return on investment in deploying CHWs (10).
- CT has an emerging movement to professionalize the CHW workforce.

Financing

During the startup phase, an existing entity (e.g. non-profit) with relevant service-delivery and administrative expertise could serve as a pilot. Startup costs could be provided by the SIM testing award.

Several models could be explored for long-term financial stability. Possibilities include:

- Organizations that benefit financially from the reduced costs (e.g. those sharing some degree of financial risk) could pool resources to fund the *certified entity*.
- Groups of affiliated providers could pay a membership fee to participate in the shared service.
- Models where the *certified entity* shares risk/reward as part of an accountable care model could also be explored

Eligible Entities

A range of entities could be eligible for the certification; illustrative examples include:

- local health departments
- community-based organizations including AHECs and “Y’s”
- Accountable Care Organization or Independent Practice Associations, or their subdivisions
- Subdivisions of large medical groups or health systems
- Service-oriented academic institutions

Quality Assurance and Certifications

A mechanism for third party certification would need to be defined, a role that could be played by DPH. The *certified entity* would need to deliver a “minimum package” of services with emphasis on evidence-based interventions with high potential to improve outcomes and reduce costs.

Additional certification requirements could include demonstrated ability to deliver culturally and linguistically appropriate care and existence of standardized communication protocols with providers. Similar to Person-centered Medical Home certifications, levels of designation could be established, with higher levels signifying more comprehensive services, potentially including extended services such as transportation or caregiver supports.

Data, Surveillance and Health IT

- Population level data could inform locations and the composition of services based on need that should be offered in a given area.
- Health IT and HIE with EMR integration would facilitate referrals and information exchanges between the *certified entities* and clinical practices.
- *Certified entities* would report program specific data and health outcomes to maintain certification.

Roles of Public Health

On the highest level, public health brings to the table:

- Expertise in data and surveillance
- A dedicated focus on improving health equity
- An understanding of the role of community resources in improving individual and population health outcomes
- An understanding of the primary care workforce and areas of need

With respect to the *certified entity*, public health can:

- Lead in definition of “minimum package” and initial certifications
- Offer technical assistance to certified entities and other relevant parties
- Lead in defining standards for culturally and linguistically appropriate services
- Quality assurance of entities to maintain certification
- Provide initial workforce and define future workforce requirements to staff the *certified entity*
- Assure geographic coverage and availability of services, especially to at-risk and vulnerable populations informed by DPH data on Health Professional Shortage Areas.
- Work with local Community Transformation Grant coalitions, already focusing on improving quality preventive services to identify potential *certified entities*.
- Local health departments could serve as the certified entity or handle some of the roles listed above

References

1. IOM (Institute of Medicine). Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington, DC: The National Academies Press; 2012.
2. Nguyen KH, Boulay E, Peng J. Quality-of-Life and Cost-Benefit Analysis of a Home Environmental Assessment Program in Connecticut. *J Asthma*. 2011 Mar;48(2):147-55.
3. Diabetes Prevention Research Group. Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. *N Engl J Med*. 2002 Feb;346(6):393-403.
4. Lorig KR, Sobel DS, Stewart AL, Brown BW, Bandura A, Ritter P, et al. Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial. *Med Care*. 1999 Jan;37(1):5-14.
5. Lorig KR, Sobel DS, Ritter PL, Laurent D, Hobbs M. Effect of a Self-management Program on Patients with Chronic Disease. *Eff Clin Pract*. 2001 Nov-Dec;4(6):256-62.
6. Lorig KR, Ritter P, Stewart AL, Sobel DS, Brown BW Jr, Bandura A, et al. Chronic Disease Self-management Program: 2-year Health Status and Health Care Utilization Outcomes. *Med Care*. 2001 Nov;39(11):1217-23.
7. The Guide to Community Preventive Services [Internet]. Rockville (MD): The Community Preventive Services Task Force [updated 2012 Mar 29; cited 2013 Jul 1]. Cancer Prevention & Control: Client-Oriented Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. Available from: <http://www.thecommunityguide.org/cancer/screening/client-oriented/index.html>.
8. NCQA (National Committee for Quality Assurance). Focus on Obesity and on Medicare Plan Improvement: The State of Health Care Quality 2012. Washington, DC: NCQA; 2012.

9. CDC (Centers for Disease Control and Prevention). Cancer Screening – United States, 2012. MMWR. 2012 Jan 27;61(3):41-5.
10. The Institute for Clinical and Economic Review. Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England (Draft Report). Boston (MA): The New England Comparative Effectiveness Public Advisory Council (CEPAC); 2013.