CT InCK
Embrace New Haven

"Where healthcare meets community"

A Partnership between CT Department of Social Services and Clifford Beers

Clifford Beers Community Care Center
Clifford Beers Community Health Partners

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Agenda

- Program Overview
- Expected Outcomes
- APM Updates
- Statewide Agency & Partnership Council
- Parent Advisory
- Learning Collaborative
- Practice Transformation Investments
- Technology Platforms
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CT InCK Goals

1. Early identification and intervention of service needs
2. Integrated Care Coordination and case management
3. Develop state Medicaid Reimbursement model

The Opportunity

Value Added Benefits

- Improved prevention, identification, and treatment of physical and behavioral health challenges and substance use in pediatric populations requires using population-level surveillance and screening for children with multiple physical, behavioral, or other health-related needs and risk factors
- Leverage data-driven, community-level quality improvement across sectors toward shared goals
- Reduce avoidable inpatient hospitalizations and out-of-home placements
- Early detection and intervention is critical for the prevention and treatment of behavioral health and substance use disorders

Initial Expected Outcomes

- Improved prevention, identification, and treatment of physical and behavioral health challenges and substance use in pediatric populations requires using population-level surveillance and screening for children with multiple physical, behavioral, or other health-related needs and risk factors
- Leverage data-driven, community-level quality improvement across sectors toward shared goals
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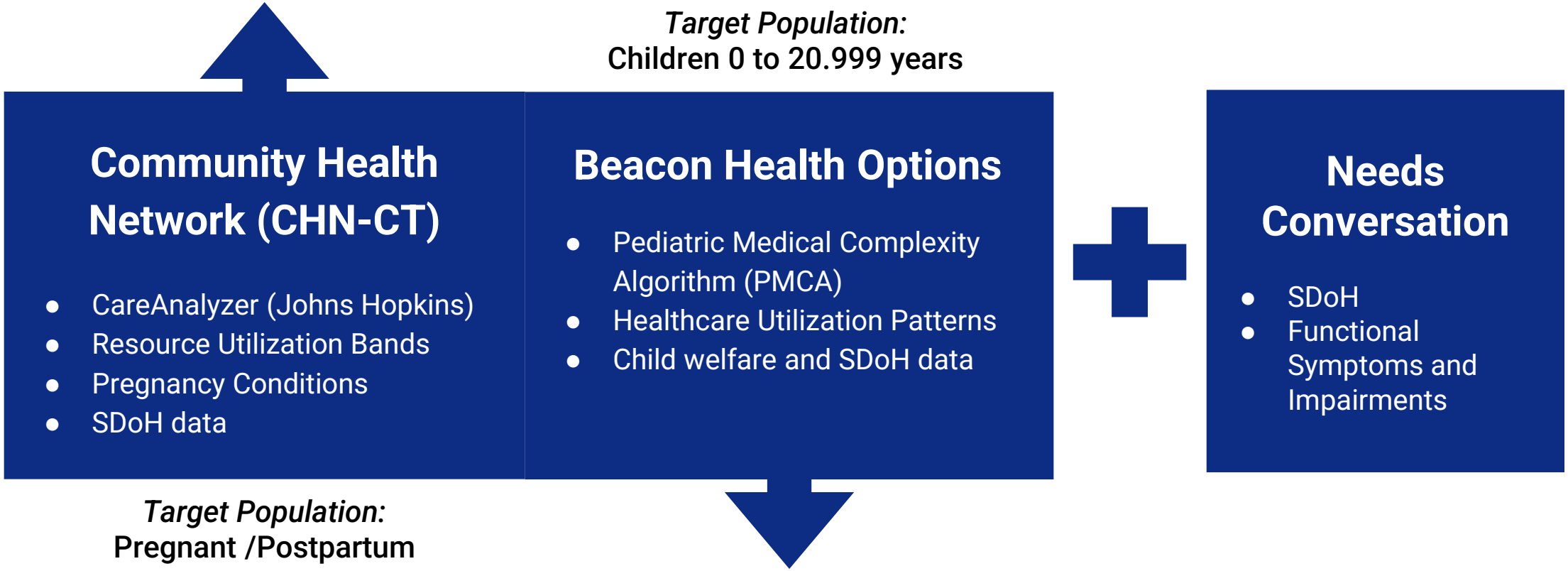
Stratifying Risk in Target Population

SIL 1 Focuses on basic, preventive care and active surveillance for developing needs and functional impairments	**SIL 2** Focuses on comprehensive needs assessments and intensive care coordination	**SIL 3** Focuses on child-centered care planning, intensive care coordination, and home and community-based services
• CHO/InCK Provider Assigned	• **Intensive** Care Coordination	• **Intensive** Care Coordination
• Annual Needs Conversation	• Annual Needs Conversation	• Twice Annual Needs Conversation (6 months)
• Includes entire target population until otherwise stratified higher	• Includes members with needs involving ***more than one service type*** and who exhibit a ***functional symptom or impairment***	• Includes children who meet **Level 2** criteria who are ***currently***, or are at ***imminent risk*** *of being, placed* ***outside the home****.*

Stratifying Risk in Population



APM Guiding Principles

Overarching Goal

Incentivize the transformation of the current system to whole-family, person-centered care, with social and health needs adequately met

Overarching Design Principles

- **Provider Diversity:** Develop a performance measurement approach that is appropriate for both clinical and non-clinical provider organizations
- **Glidepath:** Develop glidepath from pay for reporting / pay for process to pay for performance over time
- **Equity:** Include equity-focused measures through all years of the demonstration

APM Updates

APM budget of $7.2 million and support the following reimbursement rates:

- SIL 2: **$201** PMPM;
- SIL 3: **$443** PMPM (subject to CMCS discussion and approval)

Initial Quality Measures

Quality Performance Measures

Each measure listed below is weighted equally. Each provider that meets the target for each measure will receive the entire performance-based payment for each quality measure

1. ***Successful Completion of Needs Conversations*:** This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider.

2. ***Comprehensive Collection of Race, Ethnicity, and Language Data*:** This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider.

3. ***Referral Efficacy*:** This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across all attributed patients).

Statewide Agency & Partnership Council

- Advise on processes and procedures to promote care coordination across core child services
- Advise on activities to coordinate eligibility and enrollment across child-serving programs
- Contribute to system integration development
- Identify and develop ongoing process improvement efforts

Parent Advisory Group

Update:

- Began on November 15, 2021 (virtually)
- 7 Meetings to date
- $50 Parent Stipend/meeting

Feedback:

- Building Trust
- Families Being/Feeling Listened to
- Harm by Systems: NHPS, Police, DCF, etc.
- Embrace New Haven (CT InCK) is on the right track!

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Learning Collaborative

- Launched in June 2022
- 7 total providers (physical, behavioral and community based organizations)
- Overall Goal: work collaboratively to learn, evaluate and seek improvement on the CT InCK model.
- General Requirements - 6 monthly sessions, kick-off July through December 2022
- Information Sharing
- Training
- Evaluate & Test
- Go-Live - Q1 2023

Practice Transformation Investments

- CT Health Foundation Stipend
- DCF Flex Funds
- CMS Practice Transformation dollars
- Additional Philanthropic Support

Technology Update

- **Unite Us**
  - **Closed Loop Referral Platform** component only
- **ZaneNet**
  - Safe, secure and private hosted environment including an **Admin Portal** for managing InCK program technologies and data uploads
  - **Needs Assessment** is a data collection tool available in a mobile phone application, email or in-person (flexible and electronic)
  - **Care Management** system to manage beneficiary care coordination activities (document, monitor and care planning)

Contact Information

Jennifer Richmond, VP of Population Health &
Inck Project Leader
jrichmond@cliffordbeers.org

CT-InCK Website

https://www.cliffordbeers.org
/embrace-new-haven-ct-inck

Alice Forrester, PhD, CEO
Clifford Beers Community Health Partners
aforreester@cliffordbeers.org