CT InCK
Embrace New Haven

"Where healthcare meets community"

Information Session:
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Clifford Beers Community Care Center

This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of an award now totaling $8,124,562 since 2020 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS, HHS or the U.S. Government.

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Agenda 09-12-2022

- Program overview
- Service Integration Level Explanation / ASOs & Data Driven Approach
- Equity and Decision Making
- Partnership Council - explanation slide
- Learning Collaborative
- Timeline June-now or future
- Next Steps and Contact Information

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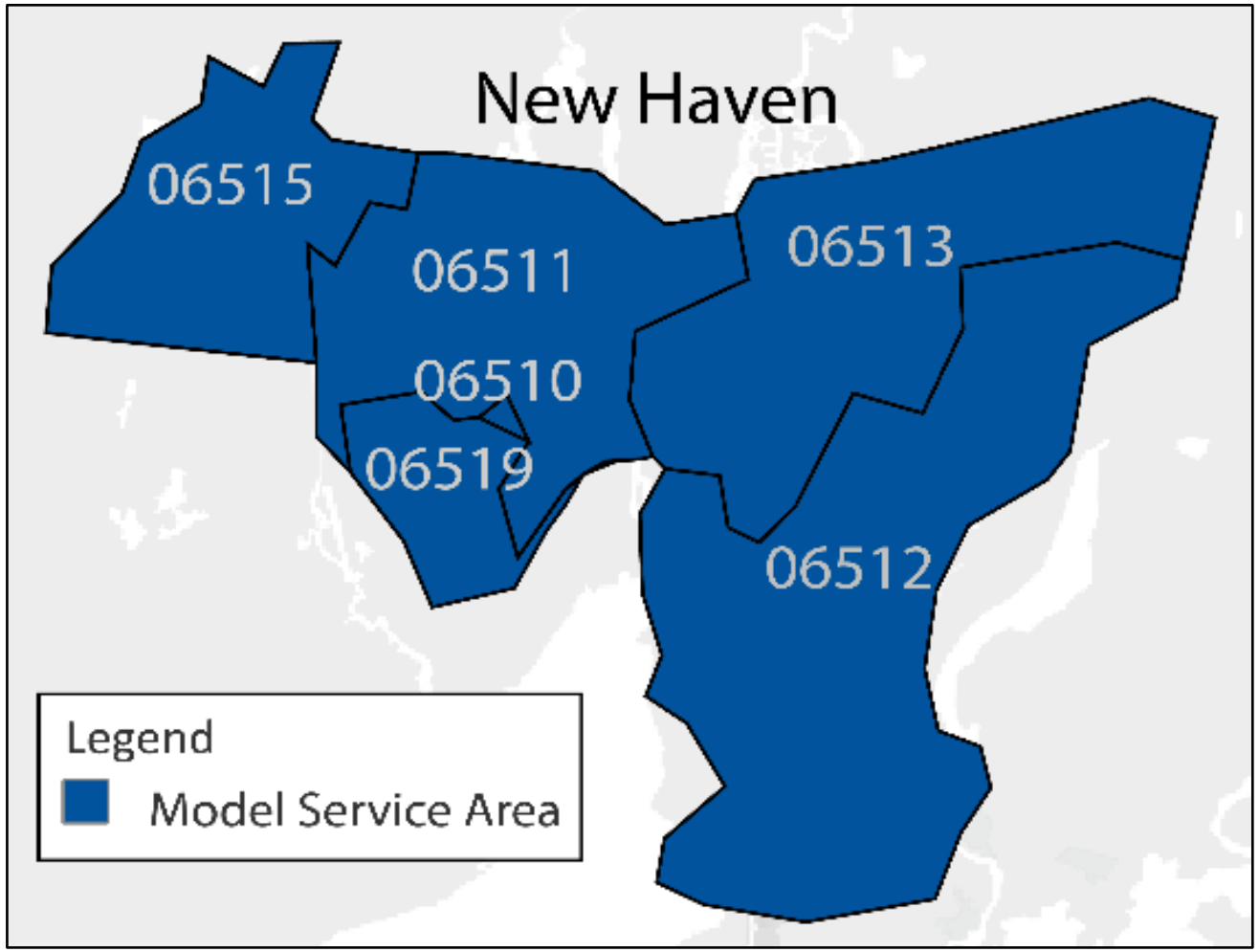
Clifford Beers & Connecticut Department of Social Services



CT-InCK Model

Population:

- Receiving/Eligible Medicaid/CHIP
- Birth up to age 21
- Pregnant and Postpartum (up to 1 year) Individuals

Service Area: New Haven residents in targeted zip codes (06510;06511)

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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

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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

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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****.*

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Stratifying Risk - *Core Child Services*

SIL 2

Focuses on comprehensive needs assessments and intensive care coordination

- ***more than one service type***

SERVICE TYPES

a. Physical health
b. Behavioral health
c. Home and community based/social services
d. Special education or Early Intervention
e. Child welfare
f. Locally-selected optional service types (e.g., Juvenile Justice)

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Stratifying Risk - *functionality*

SIL 2

Focuses on comprehensive needs assessments and intensive care coordination

- who exhibit a ***functional symptom or impairment***

FUNCTIONAL SYMPTOMS/IMPAIRMENTS

i. Substance use
(including in-utero exposure, substance use by a child or primary caregiver)
ii. Serious emotional disturbance
iii. Chronic medical condition
iv. Medically complex condition

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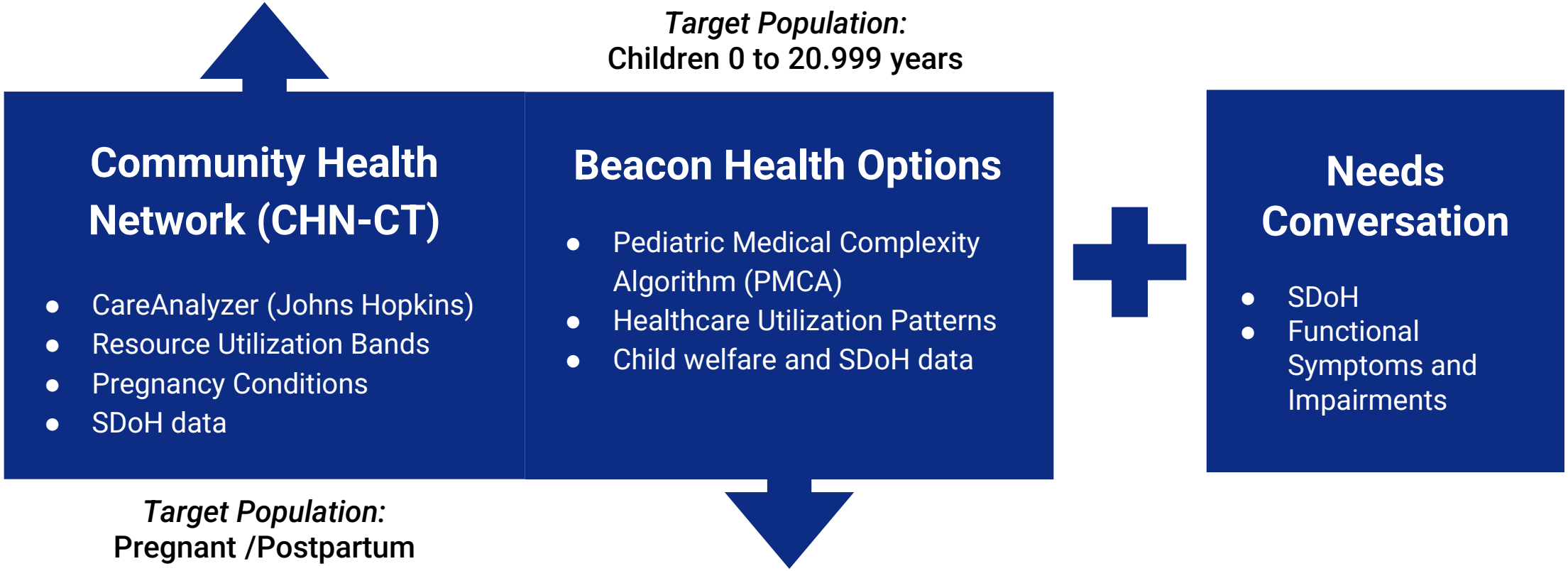
Stratifying Risk in Population



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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

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Linking Relationships

Member

Individuals in the InCK Target Population

InCK Provider

InCK organizations that are currently managing members of the Target Population

InCK Relationship

InCK target population is compared against the InCK organization client list to find member/provider relationships

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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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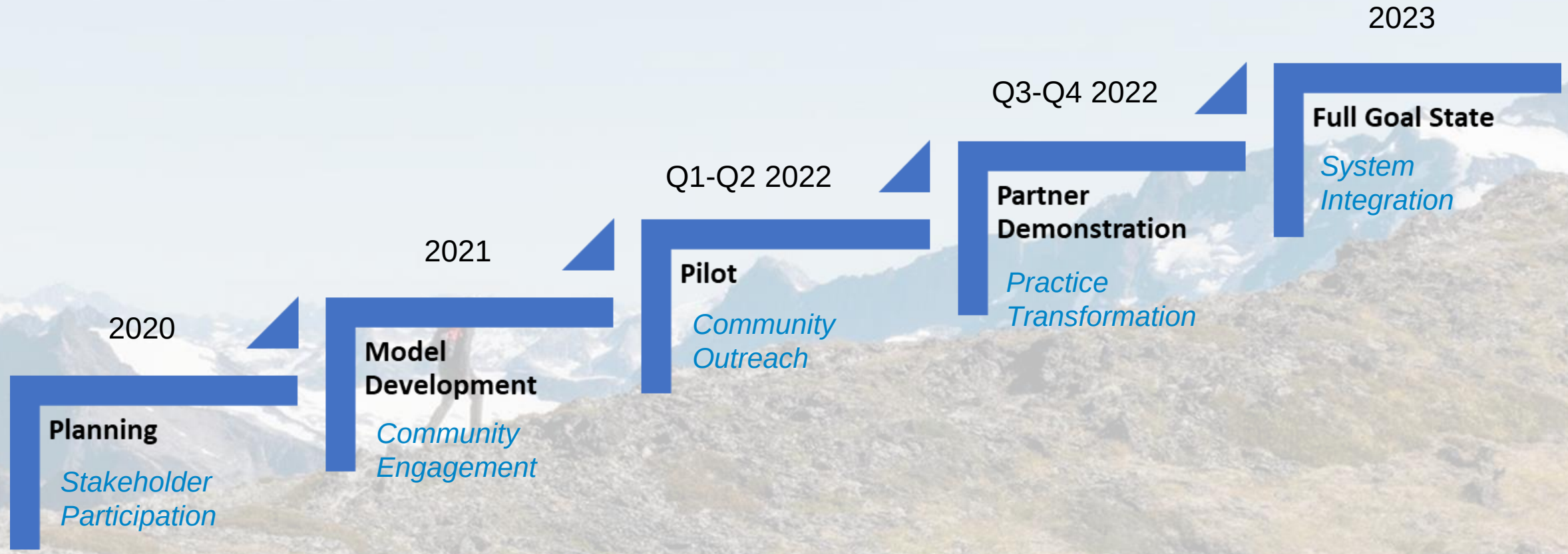
InCK Model Milestones



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Learning Collaborative

- Launched Learning Collaborative June 2022
- 5-6 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

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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[MJ1] .

1. 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. 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. 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).

Anticipated presentation date of HEDIS baseline measures

CHN
Well-Child Visits in First 15 Months of Life*
Well-Child Visits in 3rd, 4th, 5th, 6th Years of Life*
Adolescent Well-Care Visits (ages 12-21)*
Ambulatory Care: Emergency Department Visits*
Beacon Health Options
Follow-Up After Hospitalization for Mental Illness*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
Screening for Clinical Depression and Follow-Up Plan*
Kindergarten Readiness
Chronic Absence from School (K-12)
Food Insecurity Assessment
Housing Stability Assessment

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Technology Update

- **Unite Us**
    - **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)

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Contact Information

Whitney Jordan, InCK Project Manager
wjordan@cliffordbeers.org

Seth Poole, Director Systems of Care
spoole@cliffordbeers.org

Kitty Tyrol, Director Training & Resources
ktyrol@cliffordbeers.org

Manuel Rivera, Program Manager
mrivera@cliffordbeers.org

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

CT-InCK Website

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

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