Community Health Center Association of Connecticut

Practice Transformation at CT Health Centers

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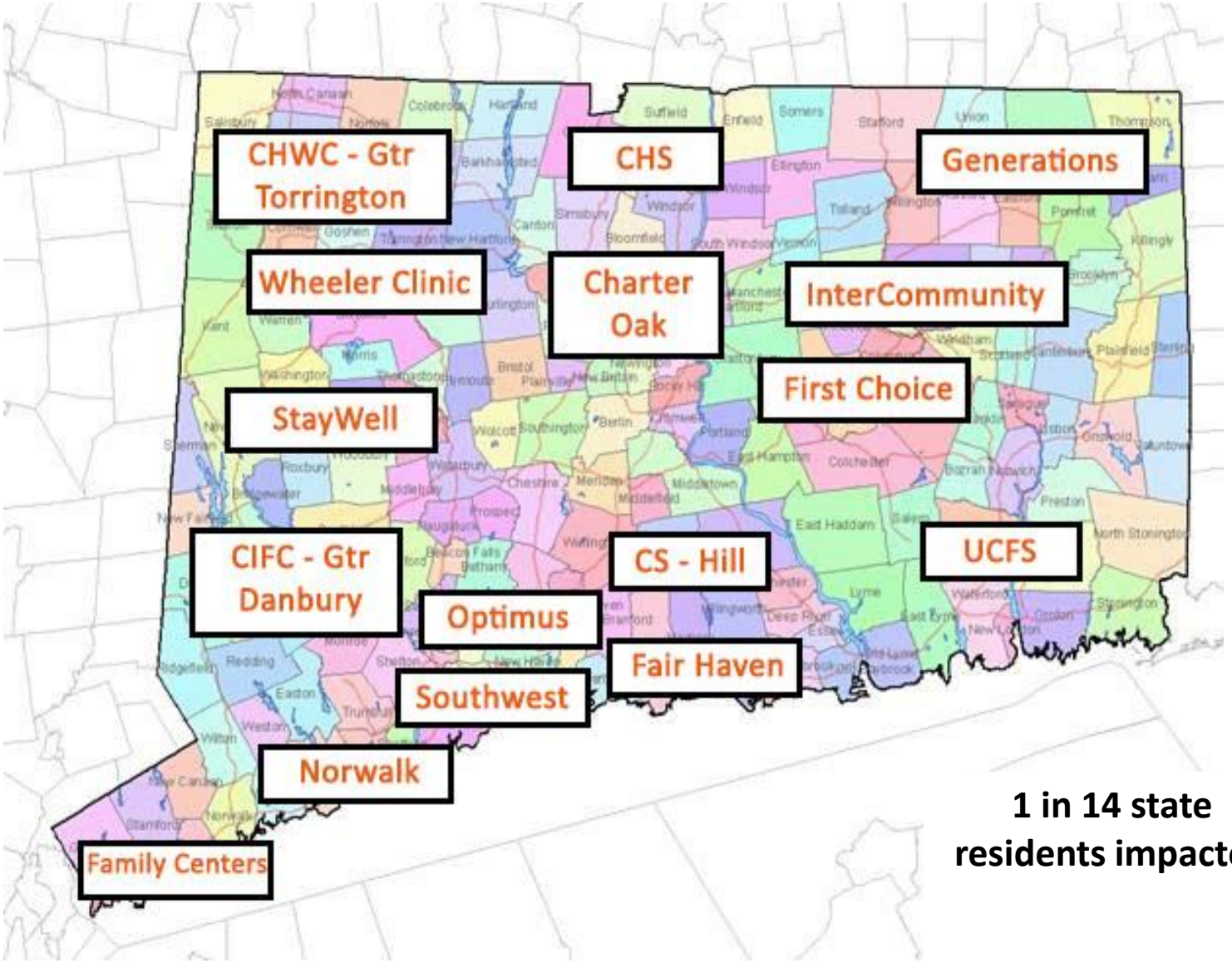
16 Member Health Centers

State-wide geographic coverage



302,465 Patients Served in 2018

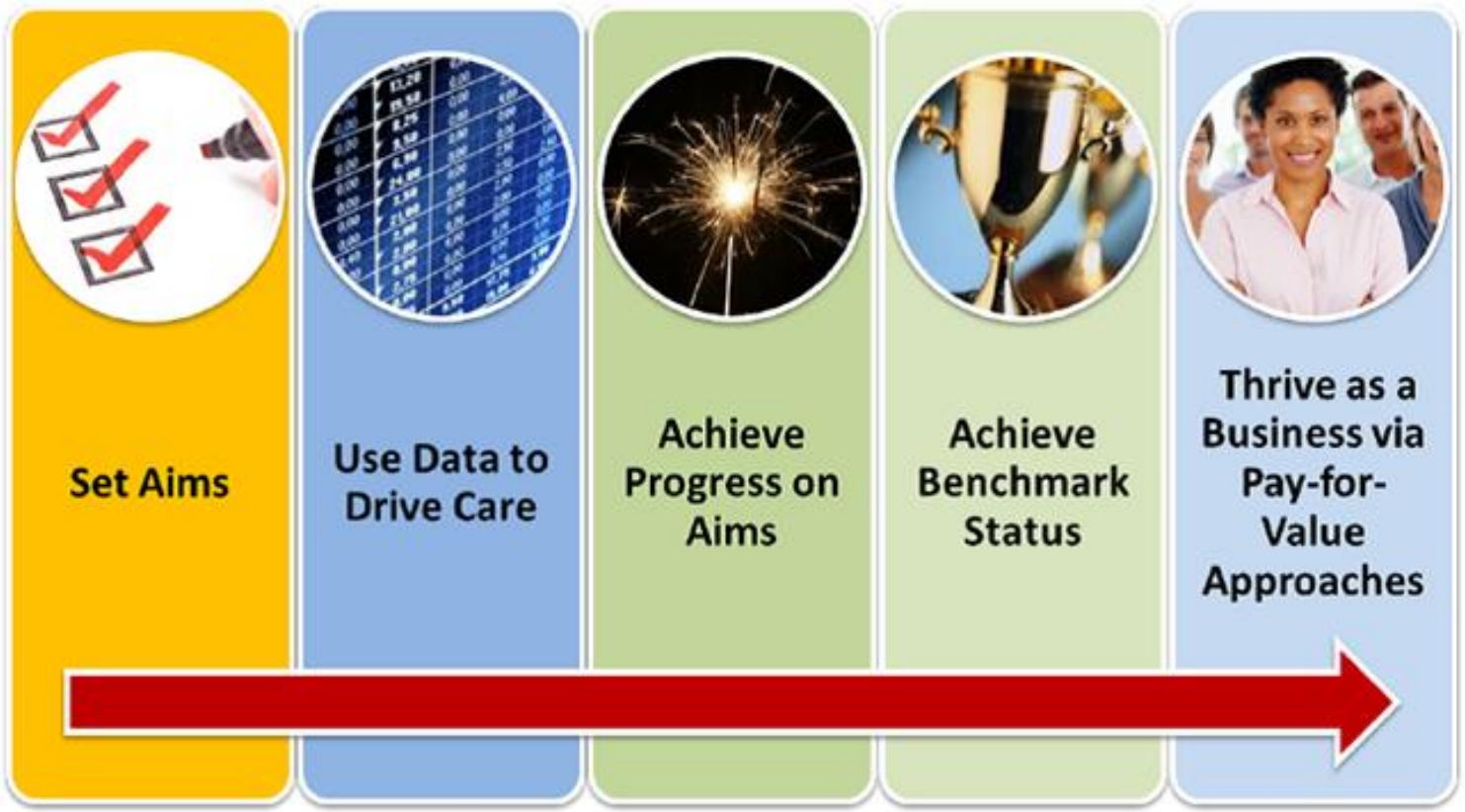
1 in 14 state residents impacted

Community Health Center Association of Connecticut

- $700 Million - Four-year initiative through the Center for Medicare & Medicaid Services (CMS)
- Prepare primary care and specialty care practices to be successful under value-based payment models
- 31 Practice Transformation Networks (PTNs) - supporting over 140,000 providers nationally
- 16 Health Centers/1,000 providers/300k patients

Primary Drivers	Secondary Drivers
Patient and Family Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidenced based care 1.7 Enhanced Access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

TCPi Transformation Roadmap



Five Phases of Transformation

CHCACT Models of Support

Coaching & Guidance	CT-PTN offers a high-touch approach with regular coaching sessions to guide transformation based on individual health center needs.
Learning Collaborative	Structured learning opportunities to drive transformation.
CMS Resources	Opportunities to learn from CMS Faculty & SANs.
Peer Network	Shared learning & experiences from other FQHCs across CT.

The Power of Health Centers

CMS AIM or PTN Measure	Target (by Sept 2019)	Cumulative Results (through June 2019)
Improved Clinical Outcomes – # of Patients meeting Diabetes Care Composite: (A1c<8, BP<140/90, LDL>100)	1,493	2,497
Improved Clinical Outcomes – # of Patients Meeting Asthma Care Measure	770	3,050
Reduction in Unnecessary Testing – Antibiotic RX's for URIs	68	388
Reduction in Unnecessary Hospitalizations (Combination of ED & Inpatient visits)	3,024	28,483
Change in Overall Medicaid Medical Cost	$38 Million	($108) Million

Segmenting Health Centers to Target Technical Assistance

Highest Performing: Exemplary Practices

- Charter Oak Health Center
- Fair Haven Community Health Care
- First Choice Health Centers
- Generations Family Health Center
- Norwalk Community Health Center
- StayWell Health Center

Other Health Centers: Targeted Technical Assistance

- Population Health Management Cohort
- Care Teams Cohort
- Diabetes Clinical Outcomes Cohort

Exemplary Practice Case Study

StayWell Health Center
Growing a healthier community one person at a time.

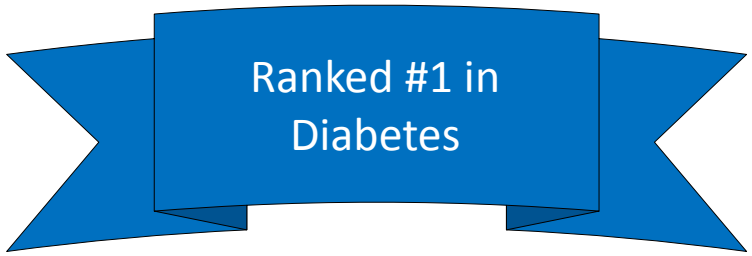
- Urban Health Center
- Location: Waterbury, CT
- Patients: 23,434
- 96% below Federal Poverty Level
- 26% served best by a language other than English
- 72 % Medicaid
- 13 % Uninsured

Systems of Care

- Care Team Model with Huddles for Individualized Person-Centered Care
- **Segmenting Patients using Risk Stratification**
- Enhanced Nursing Care for High Risk Patients
- PatientPing Alert System
- **Performance Measures Shared Monthly with Providers**

Performance Highlights

- Improved the lives of 576 patients with asthma
- Reduced Emergency Department & Hospital Inpatient visits by 2,963
- Improved the lives of 589 patients with Diabetes



Exemplary Practice Case Study

GENERATIONS FAMILY HEALTH CENTER

- Rural Health Center
- Location: Willimantic, CT
- Patients: 20,964
- 88% below Federal Poverty Level
- 17% served best by a language other than English
- 56 % Medicaid
- 9 % Uninsured

Systems of Care

- Care Team Model with Huddles for Individualized Person-Centered Care
- **Segmenting Patients using Risk Stratification**
- **Care Coordination Program**
- PatientPing Alert System
- Performance Measures Shared Monthly with Providers
- Enhanced access through Saturday hours

Performance Highlights

- Improved the lives of 278 patients with asthma
- Reduced Emergency Department visits by 874
- Improved the lives of 520 patients with Diabetes

Exemplary Practice Case Study

Charter Oak Health Center
Promoting Healthy Communities

- Urban Health Center
- Location: Hartford, CT
- Patients: 19,358
- 98% below Federal Poverty Level
- 51% served best by a language other than English
- 64% Medicaid
- 20 % Uninsured

Systems of Care

- Care Team Model with Huddles for Individualized Person-Centered Care
- Segmenting Patients using Risk Stratification
- Care Coordination Program
- **Internal Diabetes Clinic**
- Performance Measures Shared with Patients
- **Enhanced access through expanded hours 7 days a week**

Performance Highlights

- Improved the lives of 576 patients with asthma
- Reduced Emergency Department visits by 3,651
- Improved the lives of 265 patients with Diabetes

Exemplary Practice Case Study

First Choice Health Centers
For All Your Health Care Needs

- Urban Health Center
- Location: Hartford, CT
- Patients: 22,060
- 98% below Federal Poverty Level
- 17% served best by a language other than English
- 63% Medicaid
- 13% Uninsured

Systems of Care

- Care Team Model with Huddles for Individualized Person-Centered Care
- **Patient Engagement Included as Part of Risk Stratification Model**
- Various Levels of Care Coordination Based on Risk
- Performance Measures Shared Monthly with Providers
- **Transparent and Collaborative Quality Improvement**

Performance Highlights

- Improved the lives of 265 patients with Diabetes
- Reduced Emergency Department & Hospital Inpatient visits by 1,456
- Reduced Unnecessary Antibiotic Prescriptions by 167

Exemplary Practice Case Study

Fair Haven Community Health Care

- Urban Health Center
- Location: New Haven, CT
- Patients: 17,348
- 98% below 200% Federal Poverty Level
- 60% served best by a language other than English
- 58% Medicaid
- 22% Uninsured

Systems of Care

- Care Team Model with Huddles for Individualized Person-Centered Care
- **Segmenting Patients using a Clinic Model**
- Care Coordination Program for Addressing SDOH
- **Behavioral Health Fully Integrated in AICU Care Team**
- Performance Measures Shared Monthly with Care Teams

Performance Highlights

- Improved the lives of 364 patients with asthma
- Reduced Emergency Department & Hospital Inpatient visits by 1,041

Exemplary Practice Case Study

NORWALK COMMUNITY HEALTH CENTER

Care Within Reach

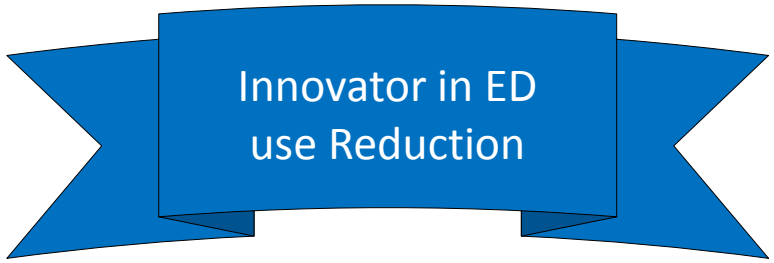
- Urban Health Center
- Location: New Haven, CT
- Patients: 12,309
- 97% below 200% Federal Poverty Level
- 33% served best by a language other than English
- 48% Medicaid
- 36% Uninsured

Systems of Care

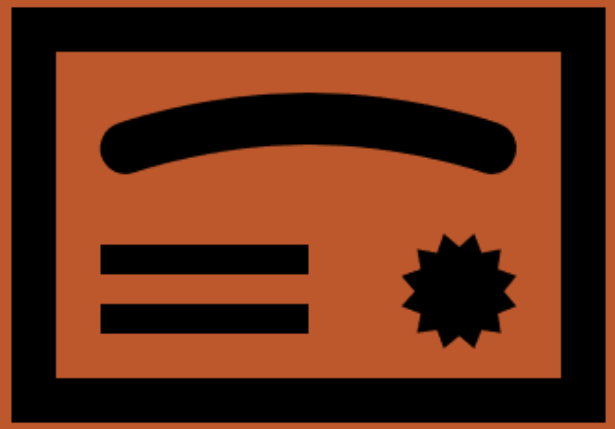
- Care Team Model with Huddles for Individualized Person-Centered Care
- Segmenting Patients using Risk Stratification
- Care Coordination Program
- **Performance Measures Shared with Patients**
- **Enhancing Care Through "No Show" model**

Performance Highlights

- Increased Diabetes control rate from 16% to 34%
- Reduced Emergency Department visits by 316
- Increased Appointment Show Rates by 52%



CT Health Centers Recognized Nationally



April 2017 CMS Grand Rounds Event

August 2018 National Expert Panel Event

- Generations
- StayWell

February 2019 CMS Quality Conference

- Charter Oak
- Fair Haven

June 2019

- Generations recognized by CMS for commitment to PFE

August 2019 National Expert Panel

- Charter Oak

August 2019 NACHC CHI

- Family Centers

September 2019 – Recognition Certificates from CMS

What Our Member Health Centers Have to Say...

Questions?