The Role of Accountable Care Organizations in Community Health Improvement

Opportunities and Challenges
Overview of Value Care Alliance (VCA)

- 5 Health Systems in Connecticut
  - Griffin Hospital
  - Lawrence + Memorial Hospital
  - Middlesex Hospital
  - St. Vincent’s Hospital
  - Western Connecticut Healthcare

- Founded in December, 2013
- Core component of VCA philosophy is that CARE BELONGS IN THE COMMUNITY

Vision Statement –
An essential Partner for Employers, Payers and Providers seeking a competitive integrated system of care that operates at high efficiency and produces outstanding outcomes.

Mission Statement –
Enhancing the health and wellness of patients by delivering exceptional care through a clinically integrated network of care providers who work together to coordinate patient-centered, high-quality and efficient care.
Shift to Value Based Care

Value Based Care

- Payment rewards value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- IT capability essential for population health management
- Realigned incentives, encourage care coordination
- Community partnerships critical to realizing full potential of Population Health Management
To be effective in an Accountable Care Environment, hospitals must take on new roles.
Aetna Shared Savings Contract
- Upside only for 3 years
- Quality targets must be met to receive shared savings
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Cancer Screening
- Approximately 23,000 lives under management
- PCP attribution is a 2-year look back

Aetna Whole Health Product
- Upside 2 years, then downside in year 3
- Quality targets must be met to receive shared savings
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Diabetes Retinal Eye Exam
- Expect ~8,000 lives by 2018
- Co-branded, tiered network product with Hartford Healthcare
- PCP selection model
## Aetna Quality Baselines & Targets Established for the 6 Selected Measures

<table>
<thead>
<tr>
<th>Measure Grouping</th>
<th>Measure Number</th>
<th>Measure Short Description</th>
<th>Eligible Population in Denominator</th>
<th>Numerator</th>
<th>VCA Baseline Rate</th>
<th>Aetna National Adjusted Average</th>
<th>25% Target</th>
<th>50% Target</th>
<th>75% Target</th>
<th>100% Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Screening</td>
<td>100084</td>
<td>Colorectal cancer screening</td>
<td>8,039</td>
<td>5,991</td>
<td>74.52%</td>
<td>71.13%</td>
<td>71%</td>
<td>72%</td>
<td>73%</td>
<td>74%</td>
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<tr>
<td>Cancer Screening</td>
<td>100360</td>
<td>Breast cancer screening (UPDATED)</td>
<td>4,768</td>
<td>4,262</td>
<td>89.39%</td>
<td>88.31%</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Cancer Screening</td>
<td>100364</td>
<td>Cervical cancer screening (UPDATED)</td>
<td>10,422</td>
<td>9,749</td>
<td>93.54%</td>
<td>93.25%</td>
<td>91%</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
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<tr>
<td>Diabetes</td>
<td>100016</td>
<td>Diabetes: Retinal eye exam</td>
<td>1,693</td>
<td>817</td>
<td>48.26%</td>
<td>53.10%</td>
<td>51%</td>
<td>52%</td>
<td>53%</td>
<td>54%</td>
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<tr>
<td>Diabetes</td>
<td>100024</td>
<td>Diabetes: Hemoglobin A1c testing</td>
<td>1,734</td>
<td>1,580</td>
<td>91.12%</td>
<td>92.33%</td>
<td>91%</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>100160</td>
<td>Diabetes: Medical attention for nephropathy</td>
<td>1,403</td>
<td>1,178</td>
<td>83.96%</td>
<td>92.79%</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
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</tbody>
</table>
Participation in the Medicare Shared Savings Program by VCA Members

- **Western Connecticut Health Network**: 25,000 Attributed Lives
- **Middlesex Hospital**: 7,500 Attributed Lives
- **Griffin Hospital**: 4,500 Attributed Lives
- **St. Vincent’s Medical Center**: 6,500 Attributed Lives
Bigger is Better
Savings thresholds for Shared Savings Distribution

MSRs by Number of Assigned Beneficiaries

<table>
<thead>
<tr>
<th>Assigned Beneficiaries</th>
<th>Minimum Savings Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>5000</td>
<td>3.9%</td>
</tr>
<tr>
<td>6000</td>
<td>3.6%</td>
</tr>
<tr>
<td>7000</td>
<td>3.4%</td>
</tr>
<tr>
<td>8000</td>
<td>3.2%</td>
</tr>
<tr>
<td>9000</td>
<td>3.1%</td>
</tr>
<tr>
<td>10,000</td>
<td>3.0%</td>
</tr>
<tr>
<td>15,000</td>
<td>2.7%</td>
</tr>
<tr>
<td>20,000</td>
<td>2.5%</td>
</tr>
<tr>
<td>50,000</td>
<td>2.2%</td>
</tr>
<tr>
<td>60,000+</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Representative Shared Savings Payment

- No downside if savings are negative
- Shared savings accrue from first dollar, but no payment earned unless savings exceed MSR
- Shared savings payment not to exceed 10% of benchmark
## 2013 Connecticut MSSP Performance

<table>
<thead>
<tr>
<th>ACO</th>
<th>States where beneficiaries reside</th>
<th>Type</th>
<th>Start date</th>
<th>2013 Shared Savings</th>
<th>2013 ACO shared savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Clinical Services</td>
<td>IA, PA, CT, MA, PA</td>
<td>Multi State</td>
<td>1/1/2013</td>
<td>$10.53 M</td>
<td>$5.16 M</td>
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<tr>
<td>Accountable Care Coalition of Mount Kisco</td>
<td>NY, CT</td>
<td>Multi State</td>
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<td>0</td>
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<tr>
<td>Accountable Care Organization of New England</td>
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<tr>
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<td>0</td>
<td>0</td>
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<tr>
<td>Lahey Clinical Performance Accountable Care Org</td>
<td>MA, NH, CT</td>
<td>Multi State</td>
<td>1/1/2013</td>
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<td>0</td>
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<tr>
<td>MPS ACO Physicians</td>
<td>CT</td>
<td>Single State</td>
<td>7/1/2012</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pioneer Valley Accountable Care</td>
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<tr>
<td>PriMed</td>
<td>CT</td>
<td>Single State</td>
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<tr>
<td>ProHealth Physicians ACO</td>
<td>CT</td>
<td>Single State</td>
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<td>0</td>
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<tr>
<td>Saint Francis HealthCare Partners ACO</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>WESTMED Medical Group</td>
<td>NY, CT</td>
<td>Multi State</td>
<td>7/1/2012</td>
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<td>0</td>
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<tr>
<td>Family Health ACO, LLC</td>
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<tr>
<td>CMG ACO, LLC</td>
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<td>Multi State</td>
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<tr>
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<td>Multi State</td>
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<tr>
<td>Physicians Accountable Care Solutions, LLC</td>
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<tr>
<td>WCHN ACO</td>
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<td>Multi State</td>
<td>1/1/2015</td>
<td>0</td>
<td>0</td>
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<tr>
<td>ACO</td>
<td>States where beneficiaries reside</td>
<td>Type</td>
<td>Start date</td>
<td>2014 Shared Savings Rate</td>
<td>2014 Shared Savings</td>
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<tr>
<td>------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>--------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Accountable Care Clinical Services</td>
<td>IA, PA, CT, MA, PA</td>
<td>Multi State</td>
<td>1/1/2013</td>
<td>+ 1.1%</td>
<td>0</td>
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<tr>
<td>Accountable Care Coalition of Mount Kisco</td>
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<td>Multi State</td>
<td>4/1/2012</td>
<td>- 7.3%</td>
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</tr>
<tr>
<td>Hartford Healthcare Accountable Care Organization</td>
<td>CT</td>
<td>Single State</td>
<td>1/1/2013</td>
<td>+ 2.4%</td>
<td>0</td>
</tr>
<tr>
<td>MPS ACO Physicians</td>
<td>CT</td>
<td>Single State</td>
<td>7/1/2012</td>
<td>- 5.3%</td>
<td>0</td>
</tr>
<tr>
<td>Pioneer Valley Accountable Care</td>
<td>MA, CT</td>
<td>Multi State</td>
<td>1/1/2013</td>
<td>+ 0.03%</td>
<td>0</td>
</tr>
<tr>
<td>ProHealth Physicians ACO</td>
<td>CT</td>
<td>Single State</td>
<td>1/1/2013</td>
<td>- 5.7%</td>
<td>0</td>
</tr>
<tr>
<td>Saint Francis HealthCare Partners ACO</td>
<td>CT</td>
<td>Single State</td>
<td>1/1/2013</td>
<td>+ 0.9%</td>
<td>0</td>
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<tr>
<td>WESTMED Medical Group</td>
<td>NY, CT</td>
<td>Multi State</td>
<td>7/1/2012</td>
<td>+ 6.7%</td>
<td>$3.27M</td>
</tr>
<tr>
<td>Family Health ACO, LLC</td>
<td>CT, NY</td>
<td>Multi State</td>
<td>1/1/2014</td>
<td>+ 1.1%</td>
<td>0</td>
</tr>
<tr>
<td>CMG ACO, LLC</td>
<td>CT, NY</td>
<td>Multi State</td>
<td>1/1/2015</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Northeast Medical Group ACO, LLC</td>
<td>CT, NY</td>
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<td>1/1/2015</td>
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<tr>
<td>Physicians Accountable Care Solutions, LLC</td>
<td>CA, MA, PA, TX, UT, WV, CT, IO</td>
<td>Multi State</td>
<td>1/1/2015</td>
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<td>N/A</td>
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<tr>
<td>WCHN ACO</td>
<td>CT, NY</td>
<td>Multi State</td>
<td>1/1/2015</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>
Value Care Alliance

Total Attributed Lives

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>31,000</td>
</tr>
<tr>
<td>MSSP</td>
<td>43,500</td>
</tr>
<tr>
<td>eACO</td>
<td>17,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>91,500</td>
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</table>

New MSSP Quality Measures Creating a Greater Need for Physicians to Have Hospital ACO Partners

<table>
<thead>
<tr>
<th>New 2015 MSSP Quality Measures...</th>
<th>... In addition to existing MSSP Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility 30-day all-cause readmissions (ACO-35)</td>
<td>Risk standardized, all-cause readmissions (ACO-8)</td>
</tr>
<tr>
<td>All-cause unplanned hospital admissions for patients with diabetes (ACO-36)</td>
<td>Ambulatory Sensitive Conditions Admissions: COPD or Asthma in older adults (ACO-9)</td>
</tr>
<tr>
<td>All-cause unplanned hospital admissions for patients with heart failure (ACO-37)</td>
<td>Ambulatory Sensitive Conditions Admissions: CHF (ACO-10)</td>
</tr>
<tr>
<td>All-cause unplanned hospital admissions for patients with multiple chronic conditions (ACO-38)</td>
<td></td>
</tr>
</tbody>
</table>
Intersection of Quality Performance
MSSP and Aetna ACO Programs
### ACO Quality Measures – MSSP and Aetna
#### Many Require Community Collaboration

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>MSSP</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: How Well Your Providers Communicate</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Patients’ Rating of Doctor</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Access to Specialists</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Health Promotion and Education</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Shared Decision Making</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Health Status/Functional Status</td>
<td>Y</td>
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</tr>
<tr>
<td>CAHPS: Stewardship of patient resources</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Risk-Standardized, All Condition Readmission</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in older adults</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (CHF)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility 30-day all-cause readmission measures</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>All-cause unplanned admissions for patients with diabetes</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>All-cause unplanned admissions for patients with heart failure</td>
<td>Y</td>
<td></td>
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</table>
## ACO Quality Measures – MSSP and Aetna

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>MSSP</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause unplanned admissions for patients with multiple chronic conditions</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Percent of primary care physicians who successfully meet Meaningful Use</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of current medications in the medical record</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Falls: screening for future fall risk</td>
<td>Y</td>
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<tr>
<td>Preventive care and screening: influenza immunization</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Pneumonia vaccination status for older adults</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Preventive care and screening: body mass index screening and follow-up</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Preventive care and screening: tobacco use screening and cessation intervention</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Preventive care and screening: screening for clinical depression and follow-up</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>plan</td>
<td></td>
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</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Preventive care and screening: screening for high blood pressure and follow-up</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>documented</td>
<td></td>
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</tr>
<tr>
<td>Diabetes hemoglobin A1c poor control (&lt;9%)</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
# ACO Quality Measures – MSSP and Aetna

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>MSSP</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes eye exam</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Diabetes Medical Attention for Nephropathy</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Controlling high blood pressure</td>
<td>Y</td>
<td></td>
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<tr>
<td>Ischemic vascular disease: use of aspirin or another antithrombotic</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Heart failure: beta-blocker therapy for left ventricular systolic dysfunction (LVSD)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Coronary artery disease (CAD): angiotensin-converting enzyme (ACE) inhibitor or angiotension receptor blocker (ARB) therapy-diabetes of left ventricular systolic dysfunction (LVEF &lt;40%)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td>Y</td>
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Health System Perspective

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>Risk Share</th>
<th>Capitation</th>
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</thead>
<tbody>
<tr>
<td>Manage Acuity</td>
<td>Manage Chronic Diseases</td>
<td>Manage Populations</td>
<td></td>
</tr>
<tr>
<td>Reactive</td>
<td>Engaged</td>
<td>Pro Active with increased focus on communities with health disparities</td>
<td></td>
</tr>
<tr>
<td>Inpatient Focused</td>
<td>Outpatient Focused</td>
<td>Across Continuum Concentration</td>
<td></td>
</tr>
<tr>
<td>Inpatient Care Coordination</td>
<td>Outpatient Care Coordination Focused</td>
<td>Coordinated Care Across the Continuum and collaboration with community stakeholders</td>
<td></td>
</tr>
<tr>
<td>No Patient Outreach</td>
<td>Limited Patient Outreach</td>
<td>Robust Patient Portal</td>
<td></td>
</tr>
<tr>
<td>Limited Monitoring of Post Acute Provider Activity</td>
<td>Identification of Post Acute Care Network</td>
<td>Post Acute Care Network Strategy with Quality and Utilization Measures and Metrics</td>
<td></td>
</tr>
</tbody>
</table>
Success in ACO 3.0

- Success in the era of advanced accountable care will require

1) Comprehensive Community Wide Health Needs Assessment
2) Adoption of a Broader Definition of Community Health
3) A Health Profile of Disease Prevalence and Relative Mortality as well as Quality of Life Indicators with Focus on Social Determinants of Health
4) Use Geo-Mapping of Disease Prevalence, High Service Utilizers, and community resources to Improve the Effectiveness of Interventions
Coming to Terms with Health Inequities

- Unhealthy housing
- Exposure to array of environmental hazards
- Limited access to healthy food sources & other basic services
- Unsafe neighborhoods
- Lack of public space, sites for exercise
- Limited public transportation options
- Inflexible and/or poor working conditions
- Health impacts (e.g., allostatic load) of chronic stress
Capabilities exist today across the VCA that will enhance ACO performance

- Repository of Claims and Clinical Data

- Advanced Analytics, Disease Registries, Risk Stratification, Predictive Modeling

- Best Practices across VCA members
  - Community Care Teams (Middlesex and WCHN)
  - Asthma Initiative (CHA effort across VCA members)
  - Pre-Diabetes Initiative
  - Accountable Health Communities Grant (WCHN, St. V’s, Griffin and Middlesex)
Highest diabetes prevalence occurs in communities like Derby, Shelton, Ansonia, Seymour and Bridgeport. Low areas include Ridgefield, Westport and Wilton.

The lowest income areas are closely aligned with diabetes prevalence, including Ansonia and Bridgeport, but also Danbury.

It appears that the communities with the highest prevalence and lowest income have increased rates of diabetes management, bringing A1c values into much better control than other, more wealthy communities.
Income has a strong correlation with Diabetes prevalence. Lower-income communities manage far more diabetics per-capita than their more affluent counterparts.

When looking at the ability of healthcare providers to control diabetes, however, income has no meaningful correlation. Even poorer communities with higher prevalence diabetics are equally effective at managing the disease.
Patients with a higher utilization of preventive office visits control their Diabetes better, by measure of A1c scores less than 8.
With some exceptions, utilizers of preventive visits are typically less prone to utilize the Hospital or Emergency Department.
There are hundreds of patients with currently low costs PMPY but A1Cs > 9. These represent the rising risk population, that require immediate engagement for oral treatment and behavioral counseling to avoid costs in Year 2-5.
ARCADIA ANALYTICS
MAPPING CAPABILITIES

TOTAL POPULATION
Map illustrating the distribution of all members attributed to the VCA by membership density

DIABETIC POPULATION
Map illustrating the distribution of the diabetic patients that are a subset of the total VCA population

CRITICAL DIABETICS
Map illustrating the distribution of those diabetic patients where the last A1c lab value was greater than 9
**DIABETIC LOCAL VIEW**

Zoomed view of local distribution of critical diabetic patients with A1c lab values greater than 9.

**STREET VIEW**

Street level view of patient home environment for selected critical diabetic patient.
A Comprehensive Approach to Diabetes Prevention and Management

Healthy Behaviors
- 5+ Fruits/Vegetables Per Day
- Physical Activity

Physical Environment
- Park Access
- Availability of Affordable Nutritious Food

Clinical Care
- Adults Taking HgA1c Test in Past Year

Morbidity/Mortality
- Diabetes Prevalence
# Evidenced Based Diabetes Management

<table>
<thead>
<tr>
<th><strong>Who?</strong></th>
<th><strong>What?</strong></th>
<th><strong>When?</strong></th>
</tr>
</thead>
</table>
| Adults ages 18-75 years with diabetes mellitus | ✓ Check at least once annually:  
  - LDL-C level (target measure is <100 mg/dL)  
  - Urine micro albumin or macro albumin or treatment of nephropathy  
  - Neuropathy screen or evidence of medical attention to existing neuropathy  
  - Blood pressure (Target measure is <140/90)  
  - Tobacco use status (Target measure is # non-users)  
  - Comprehensive foot examination  
  - Dilated eye exam by ophthalmologist/optometrist  
  - Serum creatinine & calculated GFR  
  - BMI | During measurement year |
|          | ✓ Check HbA1c at least 2 times annually; target measure is <8% for most patients (2-4 times based on goal) | During measurement year |
|          | ✓ Prescribe at least 2 generic diabetic medications with at least 80% days covered since first Rx | In previous 2 years |
|          | ✓ Two or more face-to-face visits for diabetes | In the previous 12 months |
|          | ✓ CCD printed; includes action plan | Every visit |
PREDIABETES

86 million American adults—more than 1 out of 3—have prediabetes

1 out of 3 people with prediabetes do not know they have it

Prediabetes increases your risk of:
- Type 2 diabetes
- Heart disease
- Stroke

If you have prediabetes, losing weight by:

- Eating healthy
- Being more active

can cut your risk of getting type 2 diabetes in half.
Intervención de estilo de vida

El currículo de la intervención de estilo de vida del Programa Nacional de Prevención de la Diabetes se basa en el currículo del estudio de investigación del Programa de Prevención de la Diabetes (DPP, por su sigla en inglés), respaldado por los Institutos Nacionales de Salud, el Instituto Nacional de la Diabetes y Enfermedades Digestivas y Renales, y el Acuerdo de Cooperación U01-DK48489. La intervención del estilo de vida del DPP ha sido adaptada por Plan Forward (Universidad de Indiana) y Group Life Balance (Universidad de Pittsburgh). Ciertos conceptos del currículo de intervención del estilo de vida del Programa Nacional de Prevención de la Diabetes se han adaptado a partir de estas fuentes. Ambas adaptaciones derivan del estudio de investigaciones del DPP respaldado por el Departamento de Salud y Servicios Humanos, que posee ciertos derechos sobre el material.
National Diabetes Prevention Program Curriculum

Session 1: Welcome to the National Diabetes Prevention Program
Session 2: Be a Fat and Calorie Detective
Session 3: Three Ways to Eat Less Fat and Fewer Calories
Session 4: Healthy Eating
Session 5: Move Those Muscles
Session 6: Being Active - A way of Life
Session 7: Tip the Calorie Balance
Session 8: Take Charge of What's Around You
Session 9: Problem Solving
Session 10: Four Keys to Healthy Eating Out
Session 11: Talk Back to Negative Thoughts
Session 12: The Slippery Slope of Lifestyle Change
Session 13: Jump Start Your Activity Plan
Session 14: Make Social Cues Work for You
Session 15: You Can Manage Stress
Session 16: Ways to Stay Motivated

Session 1: Welcome to Sessions 7-12
Session 2: Fats - Saturated, Unsaturated, and Trans Fat
Session 3: Food Preparation and Recipe Modification
Session 4: Healthy Eating - Taking it One Meal at a Time
Session 5: Healthy Eating with Variety and Balance
Session 6: More Volume, Fewer Calories
Session 7: Staying on Top of Physical Activity
Session 8: Stepping up to Physical Activity
Session 9: Balance Your Thoughts for Long-Term Maintenance
Session 10: Handling Holidays, Vacations, and Special Events
Session 11: Preventing Relapse
Session 12: Stress and Time Management
Session 13: Heart Health
Session 14: A Closer Look at Type 2 Diabetes
Session 15: Final Session: Looking Back and Looking Forward
Community Collaboration in Diabetes Prevention

In the YMCA's Diabetes Prevention Program, a trained lifestyle coach facilitates a small group of adults to discuss behavior changes that can improve the health of participants. The program consists of 25 one-hour sessions delivered over the course of a year.

**Program Goals**
- Lose 5–7% of your body weight
- Gradually increase your physical activity to 150 minutes per week.

**Participants do this through:**
- **Healthy Eating** – Eating smaller portions, reducing fat in your diet and discovering healthier foods can help prevent the onset of type 2 diabetes.
- **Increasing Physical Activity** – Moderate physical activity (walking, swimming, mowing the lawn) for as little as 30 minutes, five days a week, can help improve your blood pressure, raise your good cholesterol and prevent blood flow problems.
- **Losing Weight** – Reducing your body weight by as little as 5–7% can offer tremendous benefits for people at risk for diabetes.
The Connecticut Asthma Initiative was developed in 2015 by the Connecticut Hospital Association, in collaboration with hospitals and community partners, to improve the lives of people living with asthma. The initiative is led by Anne Diamond, JD, CNMT, CEO, UConn Health John Dempsey Hospital, and Stuart Marcus, MD, CEO, St. Vincent’s Medical Center. Members comprise nearly 100 people from 60 organizations including hospitals, community organizations, state government, and more.

The Vision of the initiative is to:
- Eliminate mortality due to asthma.
- Ensure that no one in Connecticut unnecessarily limits his or her life because of asthma.

The Goals are to:
- Improve access and appropriate care by partnering with the community.
- Reduce asthma hospitalizations and ED visits.
- Significantly advance progress toward health equity for asthma care and outcomes by 2017.
The program utilizes national asthma guidelines by National Heart Lung and Blood Institute, nursing resources from National Association of School Nurses.

Asthma action plans (also called a management plan) are written plans that are developed with doctors to help patients control their asthma.
Asthma Fast Facts in FY 2014

Total Utilization

Principal and Secondary Diagnosis: 109,085
- 73,295 ED Non-Admissions
- 35,790 Inpatient Discharges
Principal Diagnosis Only: 26,277
- 21,933 ED Non-Admissions
- 4,344 Inpatient Discharges

Frequent Visitors

66 Inpatient Discharges

472 Patients who returned to the hospital for asthma 4 or more times in the year

Data and Analysis Sources: FY 2014 ChimeData
Asthma by Payer: Medicaid Utilization Rate Decreasing but Comparatively High

**FY 2014 Utilization Rates by Payer**

- Medicaid utilization rate nearly 5 *times higher* than other payers

**Trends in Medicaid Utilization**

- Utilization Rate per 10,000 Beneficiaries

**Key Insights**

- While there has been a recent decrease in the Medicaid utilization rate, it remains nearly *5 times higher* than all other payers

Data and Analysis Sources: FY 2014 ChimeData, 2010 – 2014 CT DSS
Asthma by Age and Race: Pediatric and Non-White Utilization is High

Key Insights

- The Pediatric population, and Blacks/African Americans, and Hispanics had the highest asthma utilization rates by age and race/ethnicity respectively.

Data and Analysis Sources: FY 2014 ChimeData, 2008 – 2012 ACS
County Variations Highlight Geographic Differences in Asthma Inpatient Utilization Rates

Data and Analysis Sources: FY 2014 ChimeData, 2008 – 2012 ACS
County Variations Highlight Geographic Differences in Emergency Department Asthma Utilization Rates

Data and Analysis Sources: FY 2014 ChimeData, 2008 – 2012 ACS
Asthma Prevalence – Griffin Hospital

Key Insights
• Asthma prevalence among patients seen at Griffin Hospital is primarily focused in Derby, Shelton, and Ansonia, with secondary clusters focused in Oxford and Naugatuck.
Town Variations Highlight Geographic Differences in Asthma Utilization Rates

Data and Analysis Sources: FY 2014 ChimeData, 2008 – 2012 ACS
Selecting Hospital and Related Resources

Currently Available Resources:

- CHA Member Hospitals
- FQHCs
- Putting on AIRS Sites
- School Based Health Centers
- Statewide Asthma Programs
- Smoking Cessation Programs
- Local Health Departments
Resource Contact Information Built into Map Tool

Site Name: Naugatuck Valley Health District
Contact: Jennifer Hettrick
Phone: (203) 881-3255
Website: www.nvhd.org
Address: 98 Park St., Seymour, CT 06683
Resource Contact Information - Griffin Hospital
Outreach Through Community Partners Griffin Hospital Parish Nurse Program
About the Valley Council for Health & Human Services

The Valley Council is a vibrant partnership network of nonprofit health and human service organizations serving the residents of Connecticut’s lower Naugatuck River Valley. The Council is recognized as a statewide model for effective collaboration to benefit the community.

Mission

To work together to improve the health and quality of life of the Valley community and its residents by identifying community needs and developing culturally responsive services delivered by our membership and partners.
Membership

- Agency on Aging of South Central CT
- American Red Cross, CT and RI Chapter
- Ansonia Housing Authority
- Area Congregations Together (ACT)/Spooner House
- Bhcare, Inc.
- Big Brothers Big Sisters of Southwestern CT
- Boy Scouts of America, Housatonic Council
- Boys & Girls Club of the Lower Naugatuck Valley
- Callahan House Association
- Catholic Charities
- Coordinated Transportation Solutions, Inc.
- Christ Episcopal Church, Fiscal Sponsor for the Kathleen C.B. Samuel Memorial Food Bank
- Derby Bureau of Youth Services
- Derby Day Care Center, Inc.
- Derby Neck Library Association
- Derby Public Library
- Family & Children’s Aid, Inc.
- Girl Scouts of Connecticut, Inc.
- Greater Valley Chamber of Commerce
- Griffin Hospital
- Julia Day Nursery & Kindergarten
- Literacy Volunteers of Greater New Haven, Valley Program
- Lower Naugatuck Valley Parent Child Resource Center
- Master’s Table Community Meals, Inc.

- Naugatuck Valley Health District
- New Haven Legal Assistance, Inc.
- Rape Crisis Center of Milford, Inc.
- Shelton Youth Service Bureau
- SONCCA (Seymour-Oxford Nursery & Child Care Assoc, Inc)
- St. Vincent DePaul/Helping Hands of the Valley Thrift Shop & Food Bank
- TEAM, Inc.
- The Christian Counseling & Family Life Center
- The International Institute of Connecticut, Inc.
- The Salvation Army – Greater Valley Corps
- The WorkPlace, Inc.
- Valley Community Foundation, Inc.
- Valley Parish Nurse Program
- Valley Regional Adult Education
- Valley United Way
- Valley YMCA
- Visiting Nurse Association of South Central CT
- Wellmore Behavioral Health
- Women’s Business Development Council
Accountable Care Communities

Building Capabilities to Identify and Address Social Services Needs
Spotlight: Accountable Health Communities Grant

- Collective effort of Griffin, WCHN, St. V’s, and Middlesex

- CMS Innovation Center is funding $157M in grants under this program
  - They will award up to 44 grants
  - The grant application must follow one of 3 tracks
  - The potential award under Track 3 is the greatest (up to $4.51M over 5 years); Track 2 awards can be up to $2.57M; Track 1 awards can be up to $1M

- CMS is testing inventions on total health care costs and inpatient and outpatient utilization

- The funds are intended to screen beneficiaries, connect them to community services (specifically food, housing, violence intervention programs, and transportation), study the impact of those interventions

- The grant funds cannot be used for community services or directed to the providers of those services

- The funds would be used for activities like case management of at-risk individuals, which would in turn connect people to the right community services to help meet their social services needs