

Connecticut **State Innovation Model** **Outline**

Provider Presentation
V1.1

Agenda

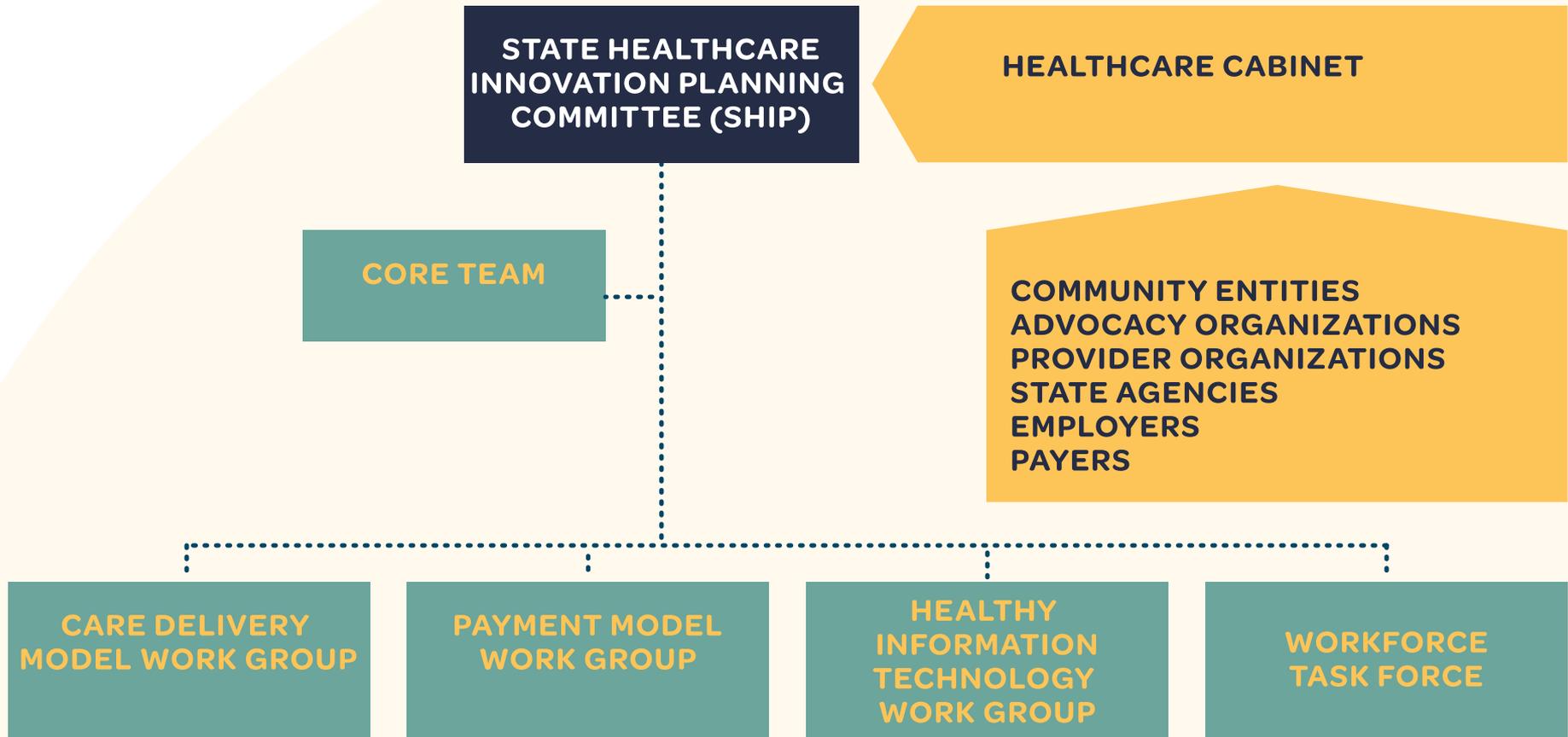
- + Purpose of Today's Meeting
- + SIM 101 Overview
- + Model Design and Stakeholder Engagement Process
- + Initiative Timeline
- + Draft Connecticut Healthcare Innovation Plan Summary
- + Discussion/ Feedback
- + Next Steps

What is a State Health Innovation Plan

- ✦ The State Innovation Model Initiative (SIM) is an initiative of the Center for Medicare and Medicaid Innovation (CMMI)
- ✦ CMMI was created under the ACA to address the need to improve quality and contain costs
- ✦ The SIM initiative awards model design and testing grants to align multiple stakeholders (including providers, consumers, employers, payers and state leaders) around health care reforms
- ✦ Connecticut's design grant requires the State to produce a state healthcare innovation plan (SHIP) and a model of healthcare delivery and payment reforms that will reach 80% of lives in CT within 3-5 years
- ✦ Connecticut will apply early next year for additional funding (up to \$45 m) to help us implement and test our model

Model Design and Stakeholder Engagement Process

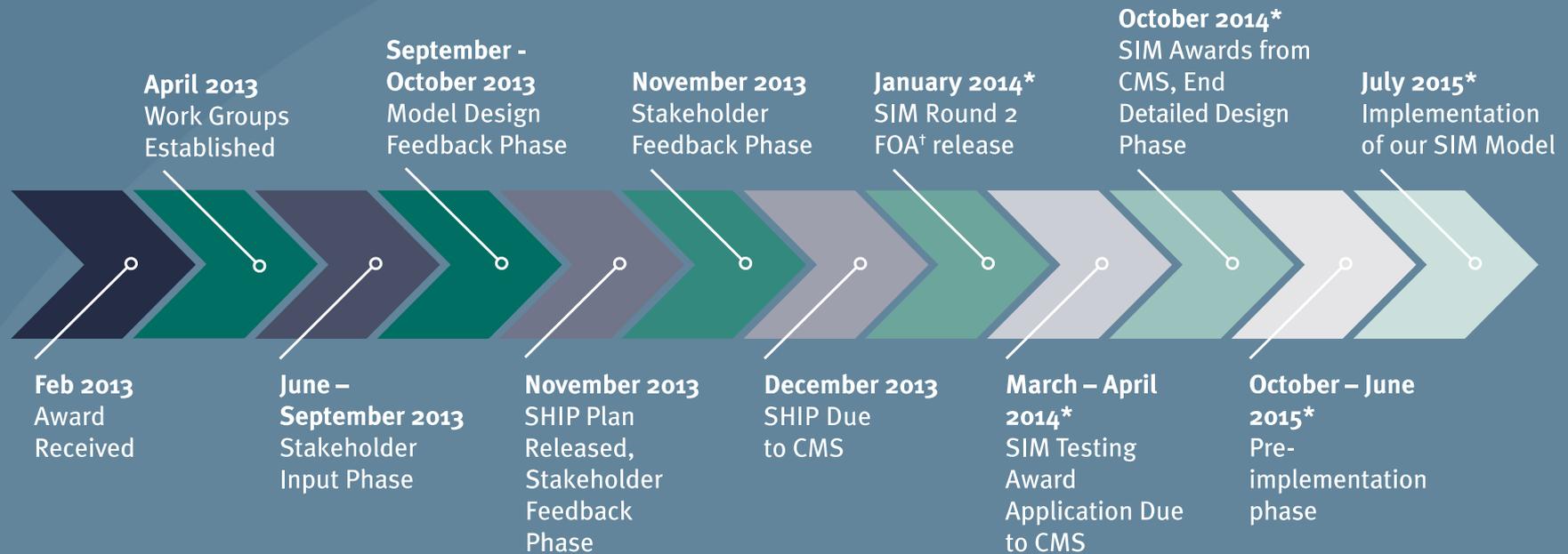
Connecticut SIM Governance Structure



Model Design and Stakeholder Engagement Process

- + Connecticut SIM Governance Structure
- + Focus on Transparency – Public Meetings, SIM Model Design Website, dedicated e-mail address
- + Stakeholder Engagement - Consumers, healthcare providers, state agencies, oversight councils and trade associations, employers and community organizations
- + Engagement Strategy Phases:
 - Input Phase** (June to mid-September 2013) – listening sessions and electronic surveys
 - Model Feedback Phase** (Mid-September to October 2013) - workgroup recommendations and emerging model was shared for feedback
 - Plan Syndication Phase** (November 2014) - focused on soliciting feedback regarding the draft plan

Initiative Timeline (anticipated)



* Estimated date

† Funding Opportunity Announcement

Connecticut's Guiding Principles for SIM

- + Understanding and consideration of what impacts health from a whole-person perspective
- + Integration of primary care, behavioral health, population health, consumer engagement, oral health, and community support
- + Accountability for health care quality and total costs in order to continuously improve quality while reducing (or controlling) costs
- + Increasing access to the right care in the right setting at the right time
- + Improving workforce development to support a diverse well trained workforce to work efficiently and effectively in our evolving care delivery environments
- + Enabling health information technologies that support continuous learning, analysis, performance, communication and data usability at the point of care
- + Supported by Medicaid, Medicare, and private health plans alike

Goal for Health System Performance Improvement

The new care delivery model and enabling initiatives empower us to achieve our goals for health system performance, including:

- + Better health and the elimination of health disparities for all of our residents
- + Better healthcare by achieving superior quality of care and consumer experience
- + A lower rate of growth in healthcare costs to improve affordability

Model Overview – Achieving the “Triple Aim”



1 PRIMARY CARE
TRANSFORMATION

2 COMMUNITY
HEALTH
IMPROVEMENT

3 CONSUMER
EMPOWERMENT

Model Overview – Achieving the “Triple Aim”

1 PRIMARY CARE TRANSFORMATION

- + Primary care transformation to Advanced Medical Homes
- + Aggregation for scale necessary to support enhanced capabilities & infrastructure
- + Value-based payment tied to quality and care experience

Model Overview – Achieving the “Triple Aim”

2 COMMUNITY HEALTH IMPROVEMENT

- + Regional communities set priorities for health improvement and health equity
- + Collaborative solutions across care delivery, public health, and community organizations
- + Financial incentives tied to health improvement

Model Overview – Achieving the “Triple Aim”

3 CONSUMER EMPOWERMENT

- + Transparent quality, consumer experience, and cost
- + Shared decision making tools and programs (e.g., choosing Wisely)
- + Value-based insurance design and other consumer incentives

Primary Drivers for Achieving Connecticut's Goals

+ CT's Innovation Plan is based on three primary drivers for health system transformation:

Primary care practice transformation to more effectively manage the total needs of a population of patients

Community health improvement through the coordinated efforts of community organizations, healthcare providers, employers, consumers and public health entities

Consumer empowerment to enable consumers to manage their own health, access care when needed, and make informed choices

Enabling Initiatives

Primary Drivers

Primary
Care Practice
Transformation

Community
Health
Improvement

Consumer
Empowerment

Enablers

PERFORMANCE
TRANSPARENCY

VALUE-BASED
PAYMENT

HEALTH
INFORMATION
TECHNOLOGY

HEALTH WORKFORCE
DEVELOPMENT

Connecticut's Advanced Medical Home Model

CORE ELEMENTS

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-based informed clinical decision making

OUR ASPIRATIONS

- + Better health for all
- + Improved quality and consumer experience
- + Promote health equity and eliminate health disparities
- + Reduced costs and improved affordability

Advanced Medical Home: Core Elements

Whole-person
centered care

PRIORITIZED INTERVENTIONS

- + Assess whole person and family with appropriate tools to identify strengths and preferences; risk factors¹; medical, behavioral health, psychosocial, and oral health and other co-occurring conditions; and ability to actively participate in care
- + Use assessment to develop and implement person-centered care planning
- + Implement shared decision-making tools
- + Collect and maintain accurate and reliable demographic data, including race, ethnicity, and primary language, to monitor health equity and outcomes and to inform service delivery

¹ Including history of trauma, housing instability, access to preventive oral health services

Advanced Medical Home: Core Elements

Enhanced access
to care (structural
and cultural)

PRIORITIZED INTERVENTIONS

- + Improve access to primary care through
 - a) extended hours (evenings/weekends)
 - b) convenient, timely appointment availability including same day (advanced) access
 - c) non-visit-based options for consumers including telephone, email, text, and video communication
- + Enhance specialty care access (e.g. through non-visit-based consultations: e.g., e-Consult)
- + Raise consumer awareness regarding most appropriate options for accessing care to meet routine and urgent health needs

Advanced Medical Home: Core Elements

Enhanced access
to care (structural
and cultural)

PRIORITIZED INTERVENTIONS ctd.

- + Taking reasonable steps to ensure meaningful access to care that is culturally and linguistically appropriate for patient populations and individuals (e.g., expanding communication and language assistance for limited English proficient (LEP) patients, addressing cultural norms regarding certain examinations)

Advanced Medical Home: Core Elements

Enhanced access
to care (structural
and cultural)

PRIORITIZED INTERVENTIONS

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

- + Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing
- + Ensure the competence of individuals providing language assistance, avoid using untrained individuals and never use minors
- + Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

Advanced Medical Home: Core Elements

Population health management

PRIORITIZED INTERVENTIONS

- + Collect and analyze health data about patient population and utilize such data to improve care delivery and health equity
- + Regularly profile health patterns and improvement opportunities for particular patient sub-populations (including those defined by health risk, condition, race, ethnicity, primary language, sexual orientation and other demographic data)

Aggregate de-identified data with State and payers to facilitate analyses, reporting and intervention

Offer data at the provider level to facilitate practice-based and/or provider-based improvement

Advanced Medical Home: Core Elements

Population health management

PRIORITIZED INTERVENTIONS ctd.

- + Apply data insights strategically in the continuous improvement of care delivery processes
- + Translate population health trends and statistics to individual patients
- + Maintain a comprehensive disease registry to track population health

Advanced Medical Home: Core Elements

Team-based,
coordinated care

PRIORITIZED INTERVENTIONS

- + Provide team-based care from a prepared, proactive, and diverse team
- + Integrate community, oral, and behavioral health with primary care with “warm hand-offs”, particularly between behavioral health and primary care practitioners (on-site if possible)
- + Develop and execute against a whole-person-centered, multi-disciplinary care plan
- + Coordinate across all elements of a consumer’s care and support needs

Advanced Medical Home: Core Elements

Team-based,
coordinated care

PRIORITIZED INTERVENTIONS ctd.

- + Promote inclusion of community health workers as team members to allow health care team to be more easily “tuned” for sub-populations served by a particular care delivery system

Advanced Medical Home: Core Elements

**Evidence-informed
clinical decision
making**

PRIORITIZED INTERVENTIONS

- + Apply clinical evidence and health economic data to target care and interventions to those for whom they will be most effective
- + Integrate disparity-specific recommendations from expert guidelines, comparative effectiveness research and community based participatory research
- + Leverage tools at the point of care to include the most up-to-date clinical evidence
- + Promote new methods for rapid adoption and application of evidence at the point of care

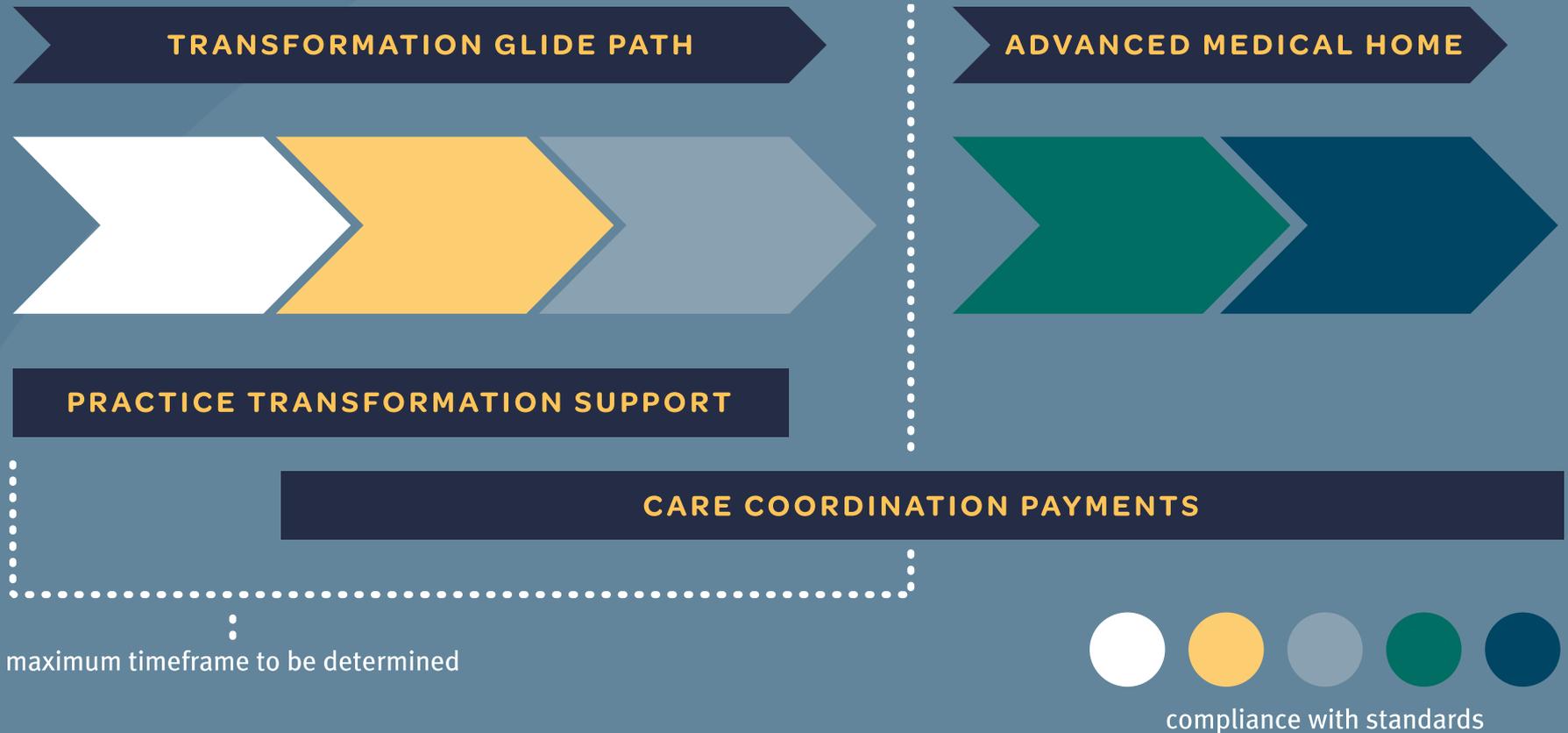
Advanced Medical Home Standards

- + We are not proposing to use existing national standards
- + Meeting national standards is both costly and administratively burdensome
- + Recognition or accreditation does not necessarily result in practice transformation
- + Time and effort spent on administrative requirements of a national accrediting body better spent on the transformation process
- + Payers have established their own standards, which has, for providers, further complicated the transformation process
- + Under SIM, Connecticut's payers will adopt a common set of accreditation standards, drawn from NCQA, AAAHC, URAC, Joint Commission, etc
- + A common set of AMH standards will simplify the transformation process

Helping Providers Achieve Accreditation

- + Practices vary greatly in ability to meet AMH standards
- + Nationally accredited practices will not have to duplicate their accreditation, but may have to meet some additional standards
- + For others, we created the Glide Path Program
 - + Facilitate the practice transformation process.
 - + Provider participants receive support as they adopt advanced practices like whole-person-centered care and care coordination.
 - + Accountable for meeting milestones and for achieving true practice transformation
- + During Glide Path, providers that demonstrate readiness will qualify for care coordination payments

Transformation Support - Helping Practices Meet Advanced Medical Home Standards



Care Team Leadership and Roles

- ✦ Connecticut's AMH model will require a care team of various healthcare service and support providers.
- ✦ Each team will have a set of "core providers" who handle primary care (e.g., PCPs, APRNs, and care coordinators).
- ✦ Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers, and community health workers.
- ✦ Flexibility in leadership: consumer's health needs and desires and the structure of the practice or organization to shape the composition of care teams and the accountable provider.

Attribution

- ✦ Expect most payer to adopt a retrospective model based on provider who has given the most primary care
- ✦ Will recommend and support attribution methods that maximize consumer choice and educate consumers on how to make those choices
- ✦ Expect that consumers will be able to select their PCPs prospectively, with possible reassignment if primary care is obtained from another provider

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

- + Integrated Delivery System
- + Medical Group Practice
- + Clinically Integrated Network
- + Strong IPA

- + *Loose IPA*
- + *Regional Cooperatives*

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Integrated Delivery System

- + Physicians and hospitals legally and financially integrated
- + Capital, infrastructure, and clinical integration among physicians, hospitals, other providers
- + Potential to distribute payment through employment agreements

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Medical Group Practice

- + Legally and financially integrated physician organization
- + Capital infrastructure, and clinical integration among physicians
- + Potential to distribute payment through employment agreements

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Clinically Integrated Network

- + Formal contractual relationship among otherwise independent physicians, hospitals, other providers
- + Capital, infrastructure, and clinical integration among physicians, hospitals, other providers

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Strong IPA

- + Physicians derive most or all of their revenue through IPA
- + Capital, infrastructure, and clinical integration among physicians

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Loose IPA

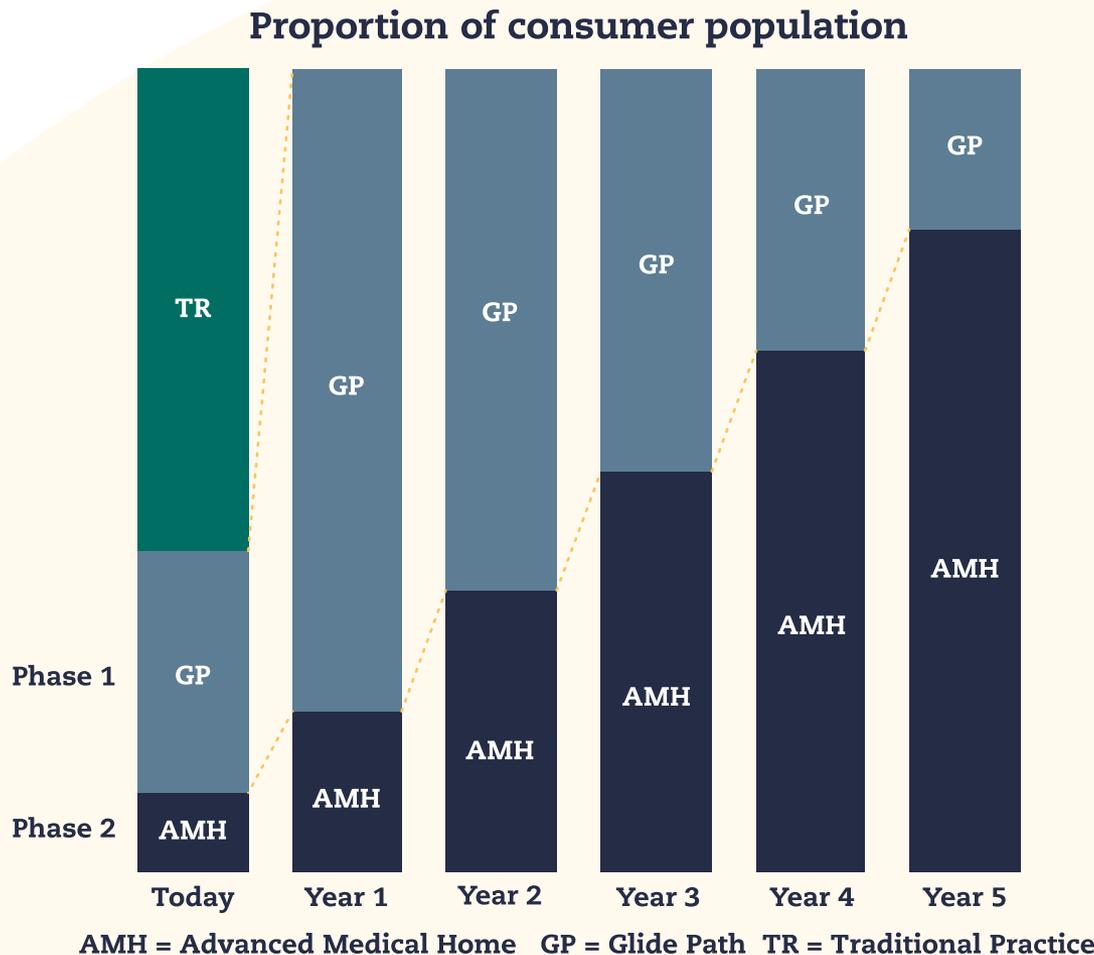
- + Physicians and/or hospitals derive only part of their revenue through IPA
- + Limited capital, infrastructure, or clinical integration among physicians

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Regional Cooperatives

- + Regional cooperative provides clinical and technical resources
- + Limited capital, infrastructure among participating physicians independently
- + Regional cooperative may or may not be channel for distribution of risk sharing

Advanced Medical Home Phase-in as Providers Complete Glide Path



Community Health Improvement

- ✦ A major part of transformation strategy is to foster collaboration among the full range of providers, employers, schools, community-based organizations, and public agencies to work to improve the health of populations within their community

- ✦ Two elements:

 - Health Enhancement Communities (HECs)**

 - Certified Community-Based Practice Support Entities (Certified Entities)**

Community Health Improvement – Health Enhancement Communities (HECs)

- + Geographic areas or regions for focused on health improvement, health equity, and prevention
- + Focus on community identified needs and priorities
- + Align metrics and financial incentives for all community participants
 - Care delivery networks/ACOs
 - Possibly other community partners
- + Financial incentives for grant based programs
- + Pooled accountability to avoid risk selection (e.g., socio-economic, race, ethnicity related risk for target conditions)

Community Health Improvement – Certified Community-Based Practice Support Entity

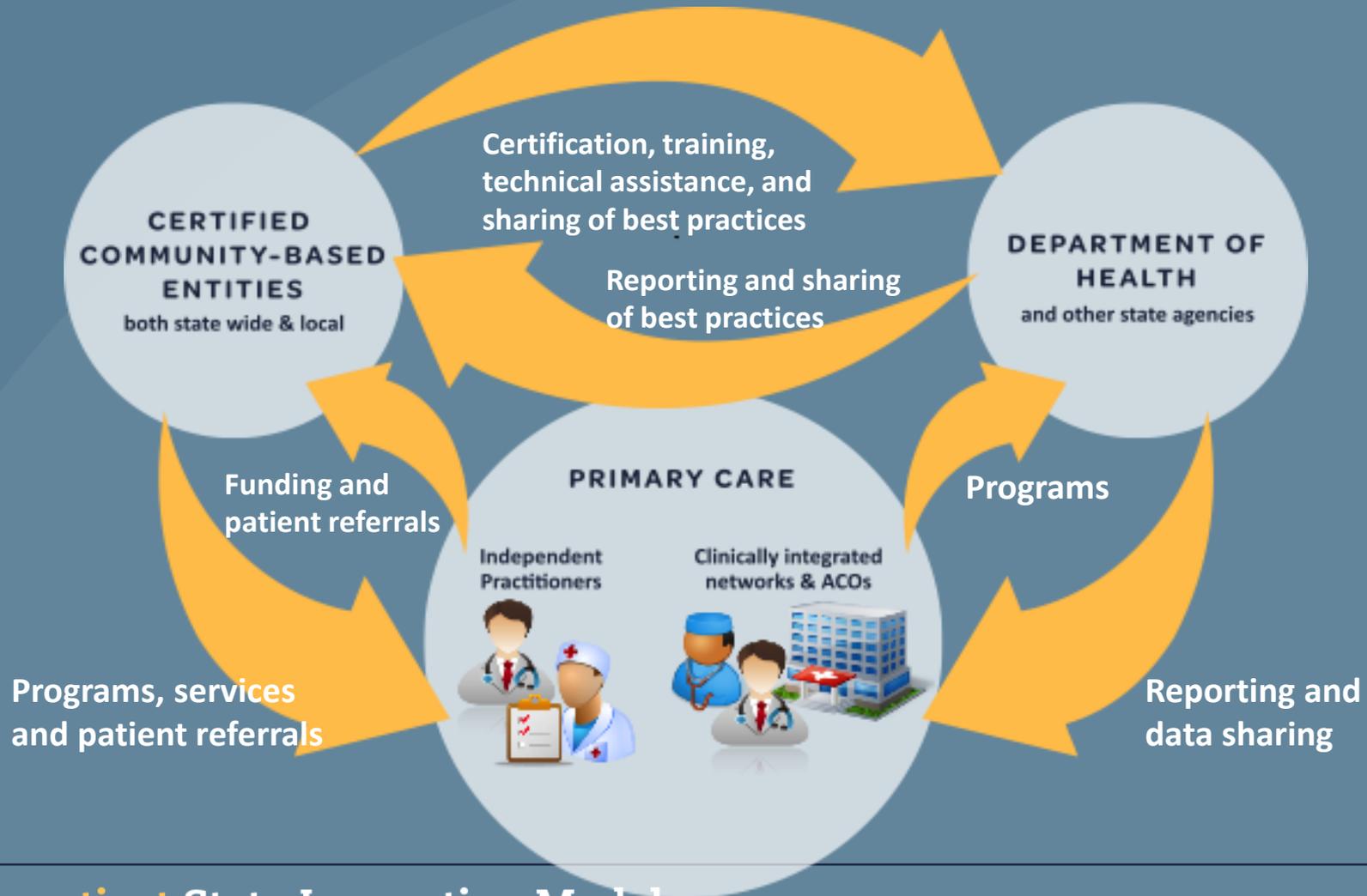
Certified Community-Based Entities (Certified Entities) are local organizations that have been designated by the state to support local primary care practices with a specified package of evidence-based, primarily preventive, community services.

- + Provide one-stop shopping for quality, evidence-based prevention services
- + Develop formal affiliations with primary care practices and share accountability for quality and outcomes
- + Demonstrate a unique understanding of community and population served and able to assist delivery of high quality, culturally and linguistically appropriate services
- + Employ and utilize community health workers
- + Support IT-enabled integrated communication protocols. Collect and report data, and evaluate performance and relevant outcomes, stratified by race/ethnicity/primary language, and other demographic data

Community Health Improvement – Illustrative Core Services of Certified Entities

- + Asthma Home Environmental Assessments (putting on AIRS)
- + Diabetes Prevention Program (DPP)
- + Falls Prevention Program

Primary care practices will be able to draw on support from Certified Entities



Consumer Empowerment

Consumers will benefit from the following:

- + Person-centered focus where review of strengths and preferences are a basis of care management
- + Self-management programs and shared decision making tools
- + Information on provider quality and cost performance to support consumer choice
- + Community engagement through the certified community-based entity
- + Rewards for positive health behavior, e.g., value-based insurance design
- + Increased access to consumer portals for health data and other information; eventually single port, combined health information (4-5 years)
- + More consumers with access to their health information through a secure portal

Consumer Drivers

SECONDARY DRIVERS

Provide information and tools to allow health, wellness and illness self-management

Improve access to health services

Introduce incentives to encourage healthy lifestyle and effective illness self-management

Implement tools for consumer input and support

CONSUMER EMPOWERMENT

The diagram features four orange chevron-shaped boxes pointing right, each containing a driver. Dotted lines from the right side of each chevron connect to a vertical dotted line. A horizontal dotted line crosses this vertical line, and a bracket-like shape extends from the intersection to the text 'CONSUMER EMPOWERMENT' on the right.

Enabling Initiatives

- + Performance Transparency
- + Health Information Technology
- + Value-Based Payment
- + Workforce Development

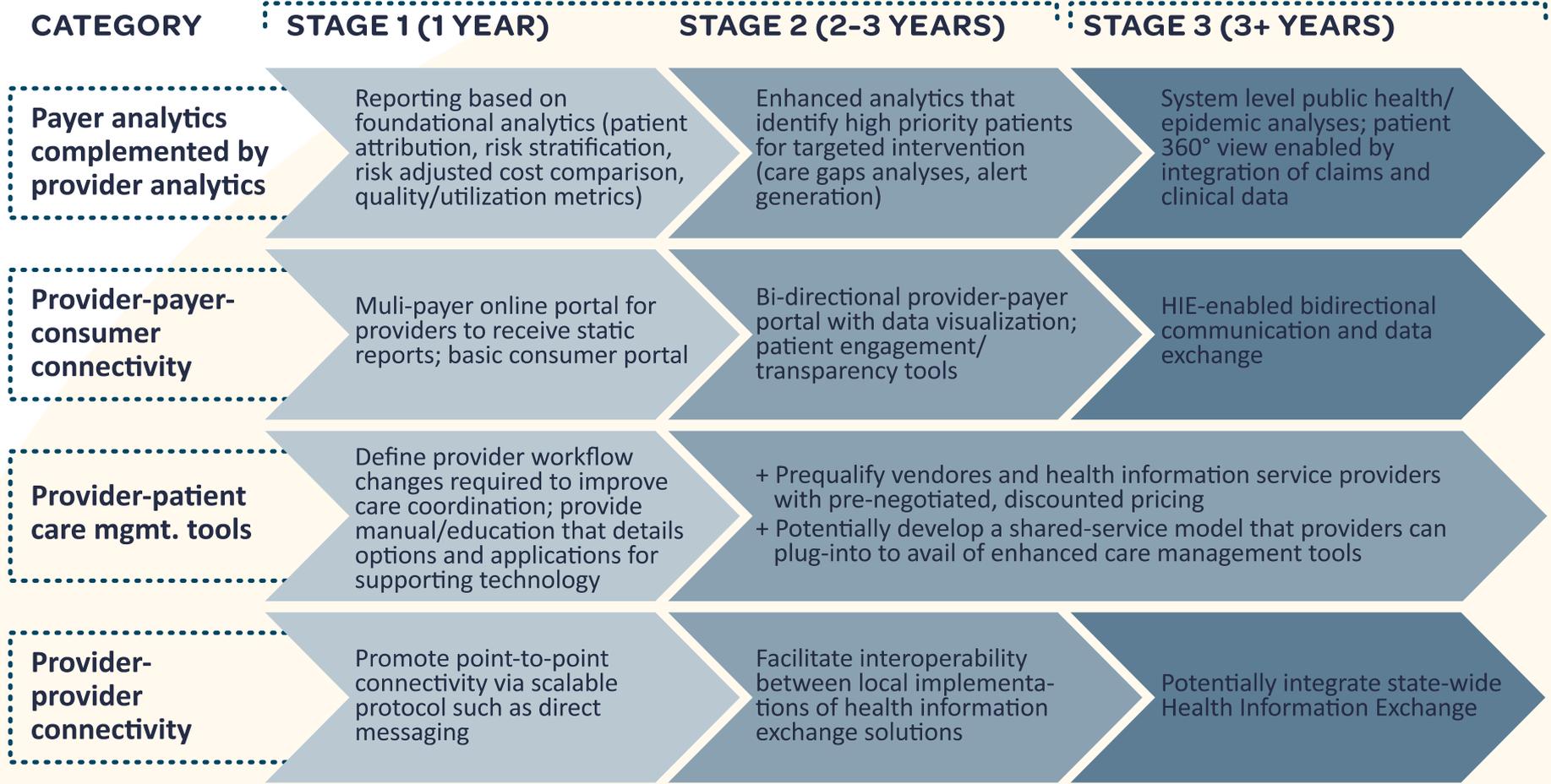
Enabling Initiative - Performance Transparency

- + Comparative information to shape program design
- + Quality of care, consumer experience and/or efficiency information to inform consumer choice of health plan
- + Transparency to inform point of care choice among treatment options, sites of care, and specific providers
- + Comparative quality and cost information, including development of common performance scorecard that includes measures of health status, health equity gaps, quality of care, consumer experience, costs of care and resource utilization

Enabling Initiative - Health Information Technology

SIM Timeframe

Beyond SIM



Enabling Initiative - Value-Based Payment

+ Pay-for-Performance:

Financial rewards for meeting quality and care experience targets

Available for Glide Path

Provides experience necessary for future success

500+ attributed consumers

+ Shared Savings Program

Share in savings if meeting quality and care experience targets

Payer and providers negotiate whether to share in losses

Practices have met initial quality metrics and progressing AMH standards

5,000+ attributed consumers

Under consideration: demonstrated underservice disqualifies practitioner from shared savings

Enabling Initiative - Workforce Development

- + Better data and analytics on CT's health workforce
- + Inter-professional education (IPE) for team based care
- + A training program and certification standards for Community Health Workers
- + Preparing our current health workforce for new models of care delivery
- + Innovation in and expansion of primary care residency programs
- + Establishing better and more flexible career tracks for health professionals and allied health professionals

Enabling Initiative - Workforce Development

+ Better data and analytics on CT's health workforce

Health workforce data will be gathered on numbers, distribution, training programs, and market demand and will be analyzed to:

- + Guide choices of people interested in health careers or in training for a different health occupation
- + Improve career advisors' ability both in secondary and post-secondary education to advise students on career choices that will increase their opportunities for employment and higher income
- + Improve the ability of schools to tailor their courses of study and the number of slots they fill to market demand
- + Enable the state and schools to target loan forgiveness programs, and the state, schools, businesses and foundations to target scholarship programs
- + Enhance the ability of the five initiatives described below to foster the primary care workforce that Connecticut's health reforms and market will require

Enabling Initiative - Workforce Development

- + Inter-professional education (IPE), CT Service Track
 - + In developing its strategies, Connecticut will look to the Inter-professional Education Collaboration (IPEC), which was founded in 2009 when allopathic and osteopathic medicine, dentistry, nursing, pharmacy and public health joined together to promote inter-professional education
 - + Connecticut's professional and allied health professional programs will expand their current collaborations to foster more and more inclusive IPE, and will work to tailor these collaborations to the specific the training needs of each profession and allied health profession
 - + Connecticut will build upon its most effective program for community-based inter-professional training, UConn's Urban Service Track (UST), to establish a [Connecticut Service Track](#) (CST) that will cover more of Connecticut's communities, and will include more health professions and more of Connecticut's training programs

Enabling Initiative - Workforce Development

- + Training and certification standards for Community Health Workers
 - + Connecticut's Area Health Education Centers (AHEC) network will work with Connecticut's Department of Public Health (DPH) to develop a training program and a certification process for Community Health Workers (CHW).
 - + This new program will cover:
 - + Nationally established core CHW competencies, and
 - + The skills necessary for CHWs to work effectively as members of multi-professional primary care teams

Enabling Initiative - Workforce Development

- + Preparing our current health workforce for new models of care delivery
 - + Our current health professionals and allied health professionals need varying degrees of retraining if they are to work effectively within the models of care delivery envisioned in this plan
 - + The state will sponsor a survey of courses in Connecticut that grant CEUs to determine how often and how well they deal with these topics, and will work with our institutions of higher education to direct more of their CEU offerings toward training in the knowledge and skills required for delivery system reform
 - + The state will work with programs and institutions within the state that are interested in providing on and off site training to individuals engaged in primary care and to primary care teams, and that have the capability to do so or are willing and able to develop this capability quickly

Enabling Initiative - Workforce Development

- + Innovation in primary care Graduate Medical Education (GME) and residency programs
 - + Connecticut's health professions schools will work with group practices Advanced Medical Home (AHC) group practices to develop new or expanded community-based residency programs
 - + Connecticut's three medical schools—the University of Connecticut Health Center, Yale and Quinnipiac's Netter School—continue to work on developing more attractive and more innovative community-based residencies for primary care physicians

Enabling Initiative - Workforce Development

- + Health professional and allied health professional training career pathways
 - + Connecticut will build upon Governor Malloy's Science, Technology, Engineering and Mathematics (STEM) initiative to ensure that all pre-health-professional baccalaureate programs prepare students for training in any of the health professions
 - + Connecticut will build upon the Connecticut Board of Regents for Higher Education's comprehensive transfer and articulation agreement to provide students with clearer and more flexible career ladders in the health professions and allied health professions
 - + Connecticut will work with its secondary schools to identify students early with an interest in the health professions and to ensure that these students are prepared for the college level courses needed to matriculate in the state's health professions' schools

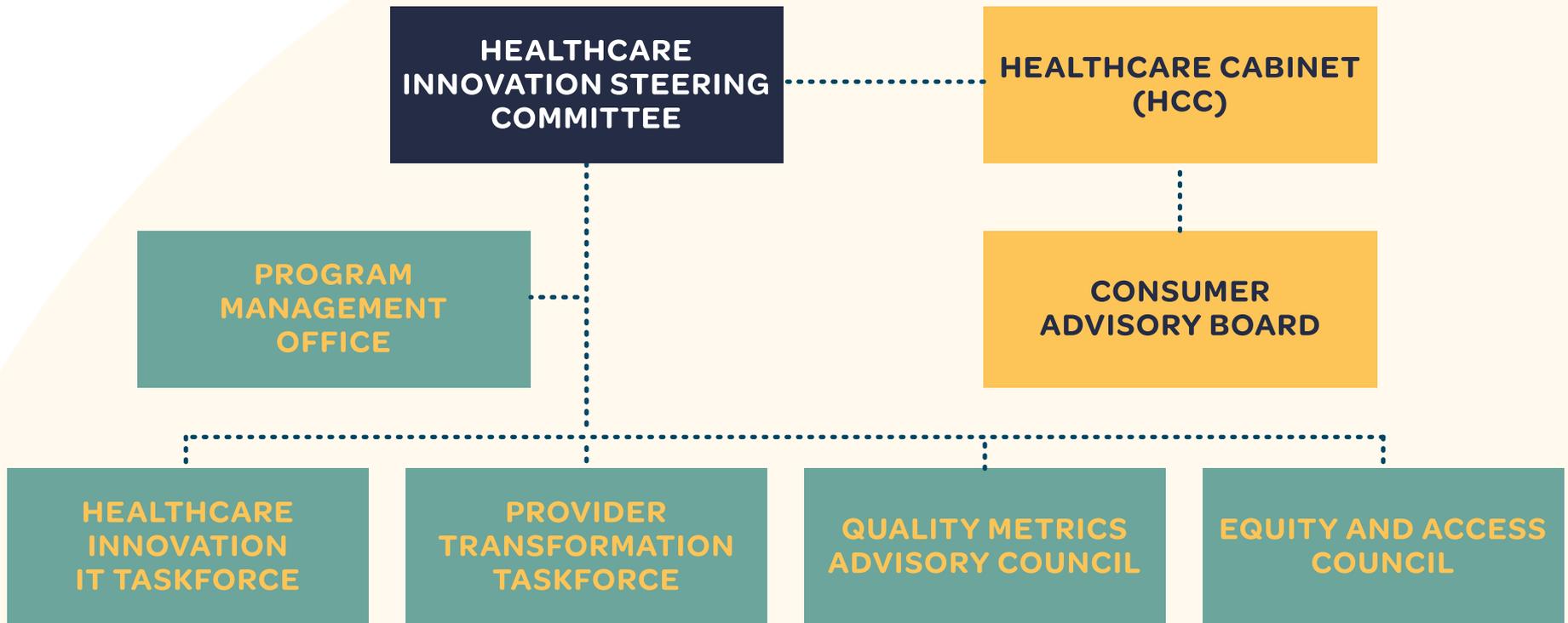
Managing the Transformation

+ GOVERNANCE MODEL

+ TRANSFORMATION ROAD MAP

Managing the Transformation - Governance Model

Opportunities for Improvement



Managing the Transformation - Transformation Road Map

CT'S INNOVATION PLAN WILL BE IMPLEMENTED OVER FIVE YEARS, DIVIDED INTO FOUR PHASES:

+ Detailed Design (January to September, 2014)

Establish new governance structures and form a program management office (PMO), with a small dedicated staff

PMO will develop the more detailed technical design necessary to support new models

+ Implementation Planning (October 2014 to June 2015)

Pending the award of grant and other funding, initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes

Example activities include procurement of technology development, practice transformation, and other external products and services necessary to support launch

Managing the Transformation - Transformation Road Map

+ Wave 1 Implementation (July 2015 to June 2016)

First year of operations of multi-payer model for AMH as well as initiation of new capabilities to support Workforce Development

Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the Connecticut Service Track

+ Wave 2+ Scale-Up (July 2016 to June 2020)

Continuous improvement of the common scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities

Primary care providers will continue to be enrolled in the Glide Path and AMH model, and providers will continue to transition from P4P to SSP as they achieve the minimum necessary scale and capabilities over time

Major expansion of Community Health Improvement and Workforce strategies, including establishment of Certified Entities

Discussion / Feedback

- + Innovation Plan Feedback/ Concerns
- + Program Funding
- + Research Findings
- + Return on Investment

Next Steps

- + Request comments / feedback by November 30th
- + Additional information about the SIM initiative can be found at:
<http://www.healthreform.ct.gov>
- + Draft 1.1 of the Connecticut Healthcare Innovation Plan (SHIP) can be found at:
<http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2742&q=334428>.

Please share your thoughts by emailing us at sim@ct.gov.