



Connecticut SIM: SHIP steering committee meeting

Supporting materials || Exhibits
June 10, 2013

- **Care delivery work group**
 - Payment work group
 - HIT work group
 - Stakeholder engagement

The care delivery work group has identified barriers to health in CT and tonight will discuss interventions to overcome them

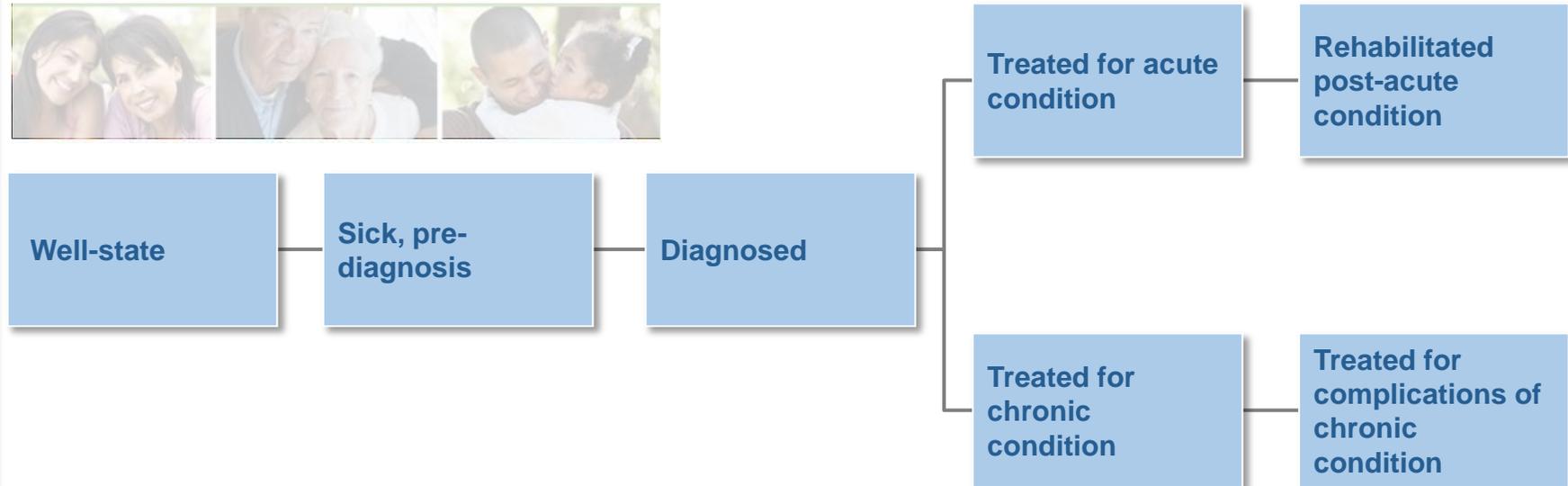


- **The care delivery work group aligned on a population-health based care delivery model as the foundational care delivery model for Connecticut**
- **On May 28th, the care delivery work group discussed how individuals in Connecticut experience care along the stages of health (*Exhibit 1*)**
 - They mapped the individuals' experience from well-state through diagnosis, then treatment for either an acute or chronic condition
- **Through these patient stories, they identified the barriers they saw to optimal health outcomes in Connecticut today (*Exhibit 2*)**
- **Tonight they will discuss how elements of a population health model, and specific interventions, can overcome these barriers (*Exhibit 3*)**
 - Whole-person centered care and population health management
 - Enhanced access to care (structural and cultural)
 - Team-based, coordinated, comprehensive care
 - Consumer engagement
 - Evidence-informed clinical decision making
 - Performance management

EXHIBIT 1: On May 28th, the care delivery work group discussed how individuals in Connecticut experience care along the stages of health



STAGES OF HEALTH



Consumer stories

- A 67 year old man suffers a myocardial infarction, takes the wrong medications when he returns home, and ends up back in the hospital within a week
- A 36 year old man with an opiate addiction loses his Medicaid provider and falls through the system
- A 7 year old girl who presents with Asthma has an unsafe home environment and is temporarily removed from her mother's custody
- A 28 year old woman relies on multiple specialists for care and thinks of the ED as her primary care provider
- Two senior women fall and fracture their hips, one has a care coordinator who helps her make changes to prevent a future fall
- Two senior women with congestive heart failures incur significantly different costs of care based on care setting selected
- A 54 year old woman with a low level of education, does not comply with referrals to a GI specialist because she is afraid of doctors she does not know and hospitals

EXHIBIT 2: Through these patient stories, they identified the barriers they saw to optimal health outcomes in Connecticut today (1 of 2)



1 Lack of whole person centered care and population health management

Barriers

- Lack of understanding of whole person context (social, cultural, mental health)
- Limited access to “whole-person data” at point of care to promote more accurate diagnosis
- Lack of infrastructure to risk-stratify consumers and prevent disease onset

2 Restricted access to appropriate care (structural and cultural)

- Suboptimal or no triage process to direct consumers to right site of care
- Limited capacity (e.g., limited time, inefficient use of time) of providers
- Lack of consumer access to appropriate care (e.g., primary, specialty, behavioral)
- Cost of treatment prevents adoption

3 No team-based, coordinated, comprehensive approach to care

- No single point of accountability at point of care
- Limited incentives for provider to coordinate or follow up with consumer’s care
- Providers do not interact with the consumer’s community
- Providers (e.g., specialists) have limited vision to own sphere of influence
- Limited use and multiple formats of HIT systems across providers and care settings
- No comprehensive treatment plan developed for consumers
- Poor relationships and communication between providers
- FFS reimbursement rewards overtreatment

EXHIBIT 2: Through these patient stories, they identified the barriers they saw to optimal health outcomes in Connecticut today (2 of 2)



4 Limited consumer engagement

Barriers

- Consumers lack incentives to be involved in self-diagnosis, self-care, and healthy behaviors
- Consumers are not aware of available health care resources
- Consumers do not understand educational materials
- Consumers do not use quality and cost data to inform decisions (e.g., visit highest value provider)
- Consumers are not compliant with treatment/rehab plans
- Wellness resources are not readily accessible by consumers
- Lack, or limited distribution, of health literacy (including screening education) programs
- Policies and funding not in place to promote healthy behaviors
- Limited communication channels/processes among consumer and other providers involved in care

5 Insufficient use of evidence-informed clinical decision making

- Best clinical practices not standardized
- Limited health IT infrastructure to support clinical decision making

6 Inadequate performance management

- Limited quality and cost transparency data
- Multiple formats of information systems

EXHIBIT 3: Tonight they will discuss how elements of a population health model can overcome these barriers (1 of 2)



Description

1 Whole person centered care and population health management

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to stratify patient population and **identify high-risk consumers**

2 Enhanced access to care (structural and cultural)

- Provide consumers **access to culturally and linguistically appropriate routine/urgent care** and clinical and mental health advice **during and after office hours**
- Provide care to consumers that is **accessible in-person or remotely** (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

3 Team-based, coordinated, comprehensive care

- Leverage **multi-disciplinary teams** and enhanced **data sharing** to improve care planning, diagnosis, treatment, and consumer coaching
- This will ensure adherence to care plan and **successful care transitions** across care settings and care disciplines (e.g., medical, social, behavioral)

Note: Overcoming financial barriers to access will be considered outside of the scope of the care delivery model

SOURCE: National Committee for Quality Assurance (NCQA) standards for PCMH accreditation, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

EXHIBIT 3: Tonight they will discuss how elements of a population health model can overcome these barriers (2 of 2)



4 Consumer engagement

Description

- Appropriately **educate and encourage consumers** to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to **follow-through on care plans**, and administer self-care as needed

5 Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of **evidenced-based care** reflecting clinical outcomes and cost-effectiveness

6 Performance management

- Collect, integrate, and **disseminate data for care management and performance reporting** on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to **improve and compare performance** with other providers

SOURCE: National Committee for Quality Assurance (NCQA) standards for PCMH accreditation, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

Patient stories informing core components of Connecticut's population-health based model (1 of 3)



1 Whole patient centered care and population health management

Description

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a patient's health
- Assess and document patient risk factors to **identify high risk patients**

Patient story from CT

- A 7 year old girl comes into the office for asthma
- Provider finds out she has been held back in school and has a history of anxiety, sadness, and anger
- She comes from a large family with prior incidents of disorderly conduct and domestic violence
- Her mother is unemployed, divorced and has no child support
- They are getting evicted from a mice and mold infested home

2 Enhanced access to care (structural and cultural)

- Provide patients **access to culturally and linguistically appropriate routine/urgent care** and clinical and mental health advice **during and after office hours**,
- Care should be **accessible in-person or remotely** (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

- A 27 year old 1st generation polish immigrant who is a self-employed house cleaner and for whom English is a second language, is in her second pregnancy
- She had a prior miscarriage and this places her in a high risk maternity situation
- She is not accustomed to or familiar with medical services and treatments that can help prevent a subsequent miscarriage or pre-term birth
- She is not likely to seek medical care unless something 'is wrong'

SOURCE: National Committee for Quality Assurance (NCQA) standards for ACO accreditation and PCMH recognition, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

Patient stories informing core components of Connecticut's population-health based model (2 of 3)



3

Team-based, coordinated, comprehensive care

Description

- Leverage **multi-disciplinary teams** and enhanced **data sharing** to improve care planning, diagnosis, treatment, and patient coaching
- This will ensure adherence to care plan and **successful care transitions** across care settings and care disciplines (e.g., medical, social, behavioral)

Patient story from CT

- A 67 years old male suffered a myocardial infarction, and is being discharged from the hospital to home
- Patient and his wife thought they understood the discharge orders, but the discharge process was overwhelming
- At home, they are confused about medications and follow-up
- Patient decides to resume all pre-hospitalization medications and most physical activities.
- He is waiting for his cardiologist to reach out with an appointment for rehab
- Patient is readmitted within the week

4

Patient engagement

- Appropriately **educate and encourage patients** to engage in healthy behaviors and reduce risky behaviors
- Encourage patients to partner with the provider to **follow-through on care plans**, and administer self-care as needed

- A 57 year old divorced executive, has a very stressful job and works on average 60 hours a week
- He is overweight, a smoker, lives alone, has family history of cancer, suffers from frequent headaches and has minimal physical activity
- Patient is at risk for Type 2 Diabetes, hypertension, stroke, colorectal cancer and depression
- Patient needs an annual physical, colorectal screening, physical activity, and down time

SOURCE: National Committee for Quality Assurance (NCQA) standards for ACO accreditation and PCMH recognition, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

Patient stories informing core components of Connecticut's population-health based model (3 of 3)



5 Evidence-informed clinical decision making

Description

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of **evidenced-based care** reflecting clinical outcomes and cost-effectiveness

Patient story from CT

- A 52 year female is a new patient to the local PCP's practice
- Her past history is significant for type 2 diabetes and hyperlipidemia for which she is on Metformin and Lipitor
- She is also on 40mg of Omeprazole which she has been taking for years despite no current symptoms of acid reflux
- Her new provider continues the current medications including the Omeprazole since Carmen is convinced the medication is critical for her wellbeing despite no evidence of renewed symptoms

6 Performance management

- Collect, integrate, and **disseminate data for care management and performance reporting** on cost and quality effectiveness of care
- Use performance and patient experience data to identify opportunities to **improve and compare performance** with other providers

- A 65 year old male with history of high blood pressure and high cholesterol
- He is prescribed a new anti-hypertensive for his uncontrolled hypertension which he does not fill-out because the copay for the medication was beyond his means
- Equivalent care could have been provided via medications that were tailored to Vega's current insurance plan
- Lack of provider performance metrics on cost of care meant this did not occur

SOURCE: National Committee for Quality Assurance (NCQA) standards for ACO accreditation and PCMH recognition, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

- Care delivery work group
- **Payment work group**
- HIT work group
- Stakeholder engagement

On June 3rd, the payment work group aligned on a set of guiding principles and developed a working hypothesis



Progress to date

The payment model work group aligned on a set of guiding principles to guide strategic decisions on payment design (*Exhibit 1*)...

- Variation in the payment model should be based on the needs of whole-person centered care, and not solely on the needs of the health system
- The payment model must be financially sustainable
- The payment model should be aligned across payers

...and aligned on the set of strategic design questions to consider (*Exhibit 2*)

- Payment model will consider questions pertaining to payment, metrics, attribution and rollout

The payment work group also had an early discussion on the reward structure to implement as part of the payment model (*Exhibit 3*)

- *Working hypothesis*: develop a two track payment model, with “Track 1” enabling providers to transition into an upside/downside risk-sharing model in year 1 and “Track 2” enabling providers to participate in the new payment model with P4P bonuses/PMPM fees in years 1/2 with an eventual ramp-up to upside/ downside risk-sharing in year 3

In its next meeting, the payment work group will focus primarily on developing the set of quality measurements to be measured under the new population-health based model (*Exhibit 4*)

Exhibit 1: The payment work group aligned on a set of principles to guide the work group's strategic decisions on payment design



Guiding principles for payment reform

- Variation in payment model should be based on the needs of the whole-person, and not solely on the needs of the health system
- Payment model should complement and enable the care delivery model
- Providers should be rewarded for effective behaviors (quality and cost)
- If successful, providers will be held accountable for elements within the scope of provider control
- Payment model must be financially sustainable
- Payment model should help improve – not detract from – consumer access and health equity
- The payment model should leverage and be complementary to ongoing initiatives in Connecticut
- Payment model should be aligned across payers

Exhibit 2: The payment work group aligned on a set of strategic questions on payment design (1 of 2)



Strategic design considerations

1 Metrics

- What will be the scope of accountability for cost and quality?
- What are the sources of value we hope to promote with the payment model?
- What metrics will be used for eligibility for participation and eligibility for payment?

Illustrative examples of options

- Population health, episodes of care, discrete encounters
- Effective diagnosis and treatment, selection of provider and care setting, chronic disease management
- Structure (e.g., EMR adoption), processes (e.g., create a care plan), outcomes (e.g., lower costs, complications)

2 Payment

- What is the reward structure?
- How do we define the level of performance we wish to reward?
- How will consumers be incented?
- What are the targets, pricing, and risk corridors?

- Global payment, gain/risk sharing, P4P, conditional care coordination fees, conditional FFS enhancements
- Absolute, relative, improvement
- Top down (e.g., state programs) or bottoms-up (e.g., at employer level)
- Quality targets, care coordination fees and/or bonus payment amount, benchmark trend, minimum savings, risk sharing splits, stop loss, gain sharing limits

Across each of these design decisions, how important is it for state and commercial payers to be aligned?

Exhibit 2: The payment work group aligned on a set of strategic questions on payment design (2 of 2)



Strategic design considerations

Illustrative examples of options

3 Attribution

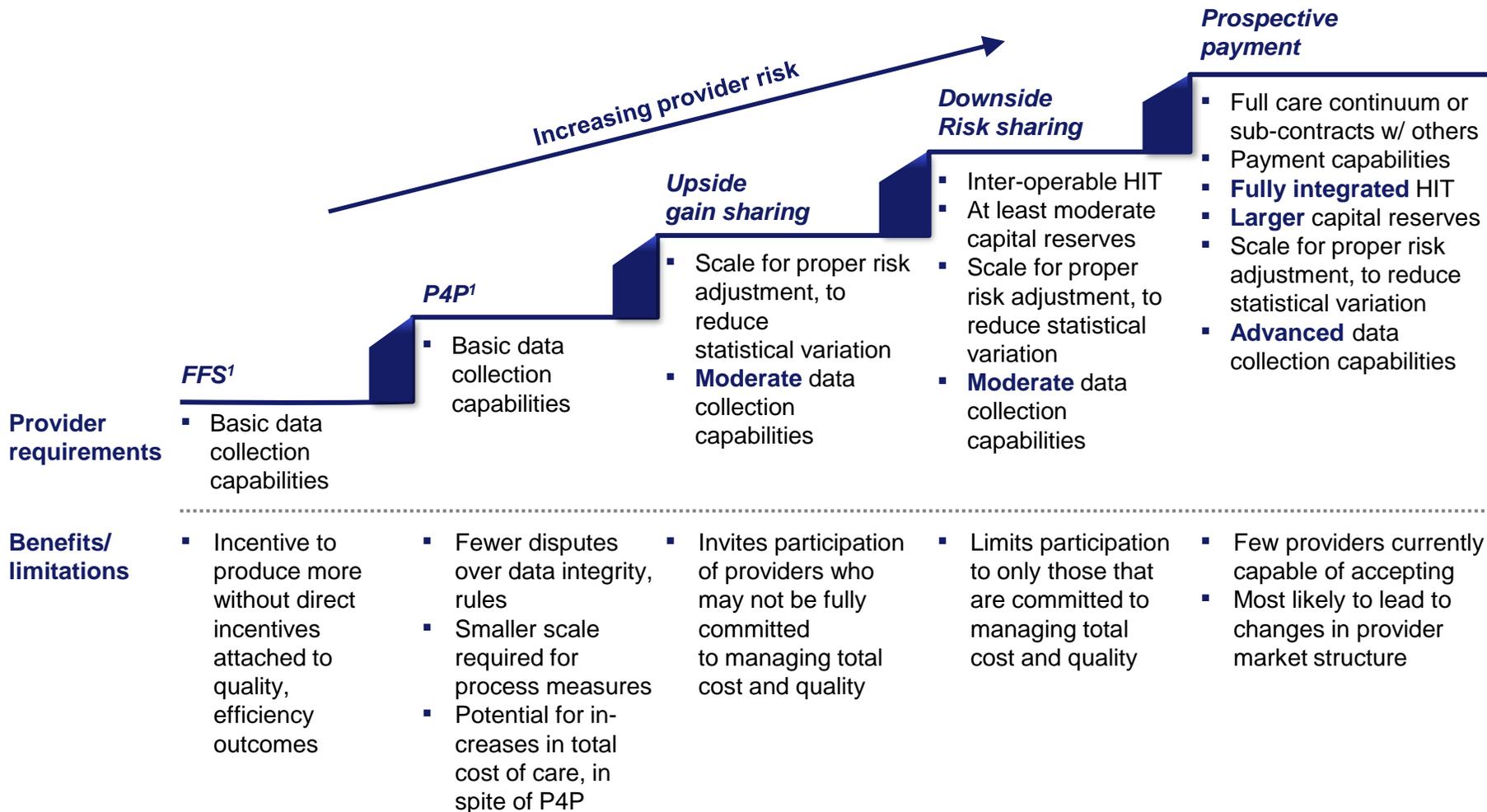
- What will be the rule for attribution?
 - At what level will performance be aggregated for measurement and rewards?
 - What exclusions and adjustments will be applied for fairness and consistency?
- Prospective member selection, plan auto-assignment, retrospective attribution
 - By physician, practice, virtual pod, or ACO/joint venture
 - Risk adjustment and/or exclusions by: beneficiary, clinical, outlier, provider-option, and/or actuarial minimums

4 Rollout

- What will be the pace of roll-out of the new payment model throughout the state?
 - At what pace should accountability and payment type for participating providers be phased in?
 - How will payers and providers be enabled to adopt the new payment model?
- Mandatory and universal, staged by geography or other criteria, voluntary
 - Baseline reporting period, transitional payment model (e.g., P4P), direct to end state (e.g., risk sharing)
 - Up-front investment, in-kind support, PMPM fees

Across each of these design decisions, how important is it for state and commercial payers to be aligned?

Exhibit 3a: The payment work group had an early discussion around a working hypothesis around reward structure (1 of 2)



Some models also incorporate per-member-per-month fees for care coordination and/or practice transformation. These may be structured as a form of P4P, FFS, or transitional subsidies, depending on the criteria used to qualify for the fees

Exhibit 3a: The payment work group had an early discussion around a working hypothesis around reward structure (2 of 2)



Working hypothesis and rationale

Ultimately seek to hold providers accountable for total cost of care within the population-health based model

- Promotes provision of high-value interventions (e.g., care coordination, upstream preventive care, admission/ discharge planning)
- Meets CMMI stipulations that providers be held accountable for total cost of care

Provide a “two-track” option for providers to transition into the end-state payment model

Enable “Track 1” for providers to transition into an upside/ downside risk-sharing model starting in year 1

- Provides opportunity for subset of providers who are at scale and have an existing set of population-health model capabilities to immediately begin upside/ downside risk-sharing beginning in year 1 (*Exhibit 3a*)

Enable “Track 2” for providers to participate in the new payment model with P4P bonuses/ PMPM for care coordination in years 1 and 2, with eventual ramp-up to upside/ downside gain-sharing by year 3

- Allows Connecticut’s long tail of small practices to participate in payment model beginning in year 1 while providing them time to develop the required capabilities (e.g., patient pooling, population-health management capabilities) to shift to upside/ downside risk-sharing (*Exhibit 3b*)

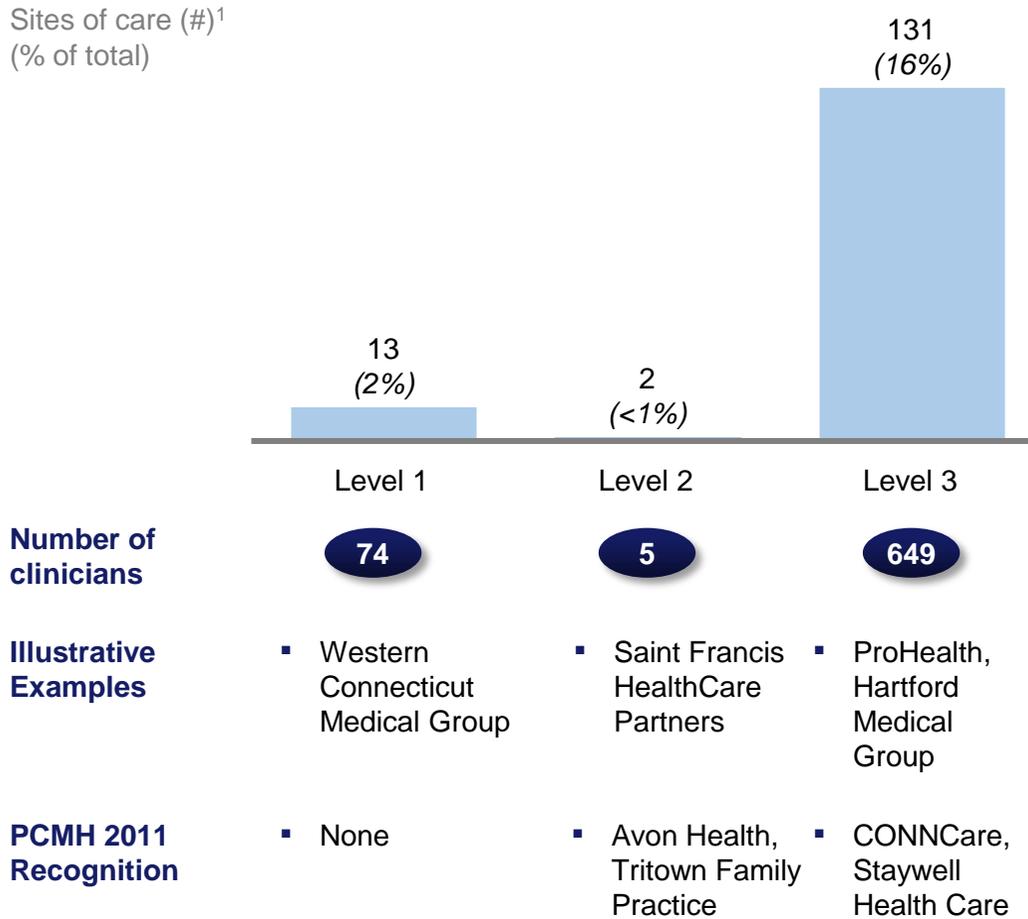
Exhibit 3b: Some providers are already participating in population-health based payment innovations



NON-EXHAUSTIVE

NCQA Physician Practice Connections – PCMH 2008 Recognition

Sites of care (#)¹
(% of total)



Additional capabilities

- **CMS** has recognized several ACOs in Connecticut under Medicare Shared Savings (e.g., Hartford HealthCare, ProHealth Physicians, Saint Francis HealthCare Partners, Primed LLC) and its Advanced Payment ACO program (e.g., MPS ACO Physicians, Primed LLC)
- **Commercial payers** are also participating in innovation: Anthem (e.g., episodes pilot, PCMH pilot), CIGNA (e.g., accountable care initiatives with Day Kimball, New Haven Community Group, ProHealth), and Aetna (e.g., coordinated care collaboration with ProHealth)
- The **State of Connecticut** has also launched a number of innovative initiatives including the State employee/Medicaid PCMH pilot, the ICI Duals initiative, HEP, and SPMI health homes
- Roughly 40% of Connecticut physicians have transitioned to **electronic medical records**

¹ ~800 sites of care in Connecticut that have at least one PCP

Note: NCQA PPC-PCMH 2008 standards revised in PCMH2011 standards. New applications will be subjected to PCMH2011 standards

SOURCE: NCQA, 2012 Health Leaders InterStudy Report, CMS, SK&A data (methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians)

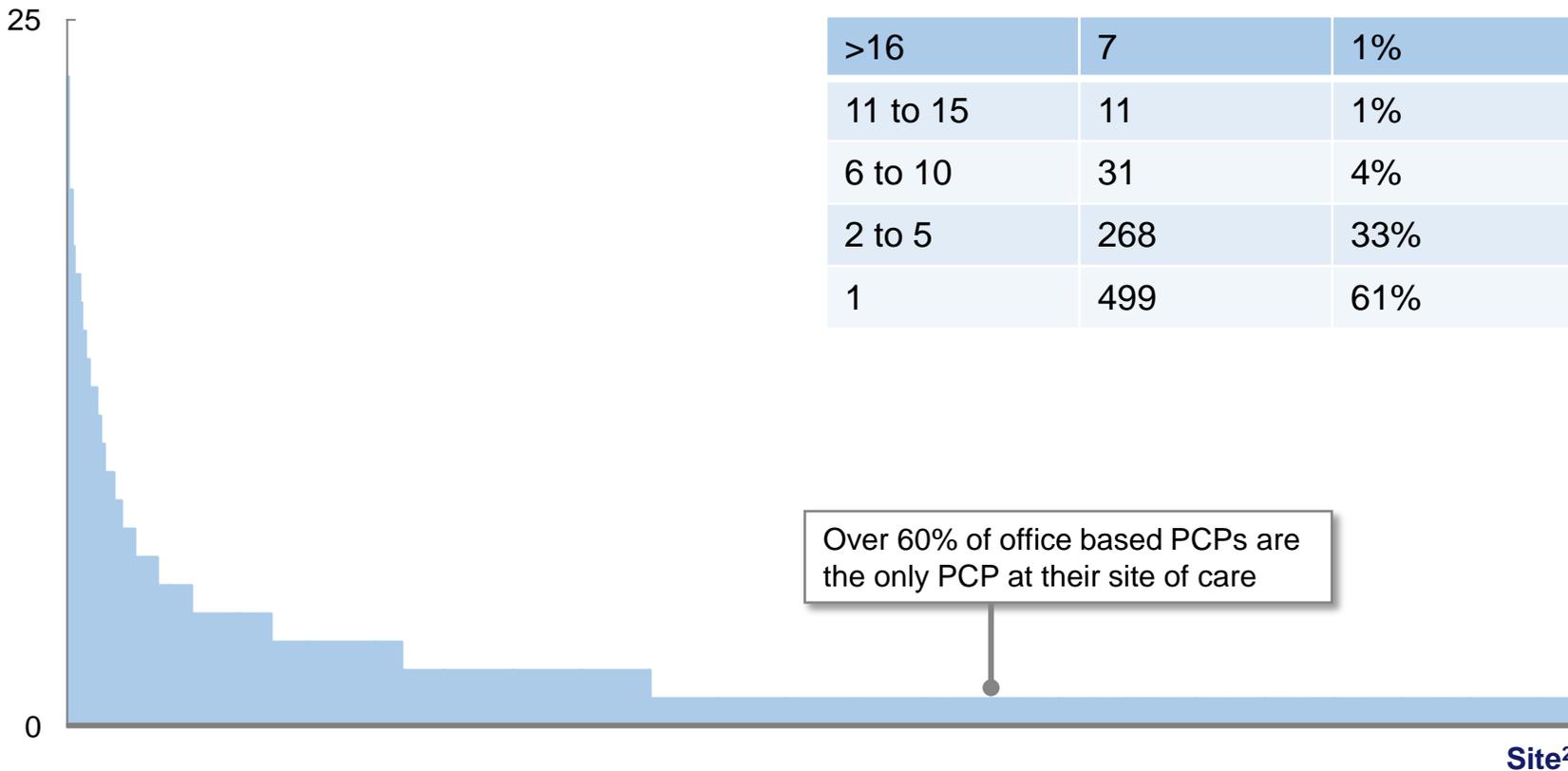
Exhibit 3c: Connecticut has a long tail of small PCPs who will require pooling and support to participate in a shared savings model



PCP fragmentation¹

PCPs per site in Connecticut (n=~800 sites, ~1740 PCPs)

PCPs on site



Over 60% of office based PCPs are the only PCP at their site of care

¹ PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists

² Total number of sites = ~800sites in Connecticut with at least one PCP

SOURCE: SK&A data (~800 sites captured). Methodology: information collected from medical trade associations , phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

Exhibit 4: Next meeting, the payment work group will develop a set of quality measurements that will be used to hold providers accountable



	Definition	Benefits	Illustrative examples
Structures	<ul style="list-style-type: none"> The establishment of resources and infrastructure that are required to achieve the desired results and outcomes of the care delivery and payment model 	<ul style="list-style-type: none"> Creates the incentive for providers to invest time and resources into infrastructure development Is relatively clearer to measure Provides tangible set of metrics that can be tracked for sources of value with longer time to impact 	<ul style="list-style-type: none"> Adults' Access to Preventive/Ambulatory Health Services Availability of care during evenings, weekends, or holidays
Processes	<ul style="list-style-type: none"> Execution of a set of actions or a series of actions required to achieve specific outcomes 	<ul style="list-style-type: none"> Provides actionable steps to guide providers towards desired outcomes of care delivery model Creates clear association between desired behaviors and payment Is relatively clearer to measure 	<ul style="list-style-type: none"> Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Well-Child Visits in the First 15 months of Life
Outcomes	<ul style="list-style-type: none"> Demonstrated impact on quality, patient experience, utilization, costs, and clinical outcomes under the new care delivery and payment model 	<ul style="list-style-type: none"> Ties provider performance/rewards directly to our system goals Enables providers to apply judgment on optimal structures/processes 	<ul style="list-style-type: none"> Quality/ patient experience: Patient satisfaction with health system experience Utilization: Re-admits/1000, ER/1000 Costs: Overall cost index to peers, PMPM Clinical outcomes: Controlling chronic disease (e.g., hypertension, diabetes)

- Care delivery work group
- Payment work group
- **HIT work group**
- Stakeholder engagement

The HIT work group has developed a perspective on existing assets that could support care delivery and payment models



Data is critical to improving care delivery and outcomes

Existing assets could be leveraged in this effort

Need to be mindful of gaps in existing capabilities

Non-technological barriers also limit information flow

Takeaways

- Clinical, claims, and systemic data, when integrated and allowed to flow freely between patients, payers, and providers improves care delivery and outcomes
- Applying a 'whole-person' perspective to HIT infrastructure design will ensure collaboration between consumers, providers, and payers
- State agency databases (e.g., APCD) could help inform system level decisions
- Private (payer/provider) databases, end-user interfaces, and data analytics tools could help operationalize the new care delivery and payment model
- Existing assets tend to focus on subsets of the population and the data collected is not always at the level of quality/completeness that makes it actionable
- Lack of linkages between the different systems limits the flow of information
- Consumer privacy concerns are material considerations that need to be addressed
- Legal & policy sensitivities constrain the level of sharing
- Business imperatives at times promote non-sharing
- Lack of overall ownership of the HIT infrastructure leads to poor coordination

The HIT work group is developing a capability road map that could successfully enable a population health model



Resource and time constraints call for a pragmatic approach to designing an HIT infrastructure that focuses on must-have capabilities (Exhibits 1 and 4)

- The needs of a population health model continue to evolve and no two implementations are identical
- HIT infrastructure design should be based on a set of 'must-have' elements that build in flexibility to support a variety of flavors of the population health model
- The system should incorporate different paths for provider groups at different stages in their adoption of technology

The group proposed a framework to prioritize HIT capabilities to develop in the short-term (Exhibit 3)

- How **foundational** is a capability to the long-term HIT goals?
- Where does the capability need to reside (**centralized/distributed**)?
- How **feasible** is it that the capability can be developed in the short-term?

Analysis of provider (clinical) data in conjunction with payer (claims) data, while complex, is critical to long-term success of care delivery and payment innovation

- Metrics that enable a population health care delivery model rely on clinical more than claims data
- An APCD-equivalent information system for clinical data would more robustly support payment reform

Leveraging existing HIT capabilities is particularly relevant for the state of Connecticut (Exhibit 2)

- The Department of Mental Health and Addiction services (DMHAS) is already managing a system of care for behavioral health populations that includes some advanced HIT infrastructure components
- In addition to infrastructure, process insights from these behavioral health initiatives (e.g. Managing care coordination efforts across the state, governance structures) could be relevant to a broader HIT effort

In its next meeting, the HIT work group will review the updated capability roadmap that incorporates feedback from the breakouts and 1:1 conversations with the team (Exhibit 5)

Exhibit 1: Categories of HIT capabilities across stakeholders that are required for care delivery and payment innovation



Category	Description	Typical tech pathway
A Payer analytics	<ul style="list-style-type: none"> Tools for payers to analyze claims and produce payment-related analytics, quality/outcome/ performance metrics and make actual payment for episodes and population health 	<ul style="list-style-type: none"> Heavy upfront development/ sourcing followed by incremental enhancement
B Provider - payer - patient connectivity	<ul style="list-style-type: none"> Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models 	<ul style="list-style-type: none"> Start with basic or low tech solutions to allow time for development or sourcing of tech-enabled enhancement
C Provider – patient care mgmt.	<ul style="list-style-type: none"> Provider tools (e.g., workflow, event management) and analytics to e.g., physicians, care managers) coordinate the medical services for a patient (focus on highest risk) 	<ul style="list-style-type: none"> Highly dependent on state-specific starting point
D Provider-provider connectivity	<ul style="list-style-type: none"> Integrated clinical data exchange among healthcare stakeholders, including the longitudinal patient registry that can be enabled by HIE 	



Exhibit 2: Existing assets in CT that could be leveraged in HIT infrastructure design

NOT EXHAUSTIVE

Data



- **State sources**
 - OSC data warehouse (across Anthem & United)
 - Licensure data
 - Public health registries: Birth, death, immunization records
 - DMHAS databases (160K users)
 - United Way 211 (referral search)
 - DSS claims database
- **Private sources**
 - CHIME (CT Hospital Association)
 - All payer claims database (APCD)

Payer Analytics



- **Claims data analytics**
 - Payer risk adjustment and coding analytics
- **Clinical data analytics**
 - CT Tumor registry

Connectivity



- **Patient access**
 - ConneCT
 - OSC State employee portal
 - Access Health CT

Exhibit 3: Considerations for developing a HIT capability roadmap



HIT capabilities need to be placed onto a staged roadmap based on:

- **Value:** foundational requirements and high impact capabilities need to be prioritized and developed early
- **Current maturity:** existing capabilities need to be leveraged at earlier stages
- **Time to develop/implement:** high complexity technology solutions should roll out at later stages to allow for sufficient lead time for development
- **Interdependency:** critical enablers for other capabilities needs to be prioritized for earlier development



Exhibit 4: Example HIT capability road map that the work group used as a starting point in their discussion

ILLUSTRATIVE



Initial launch

Meet minimum requirements rapidly through lower tech/cost solutions without interrupting day-to-day operations

Scaling up

Build tech-enabled solutions to further enhance information transparency and capture most value

Optimized value and efficiency

Complete system-wide connectivity to maximize efficiency of care

A Payer Analytics

- Automated **claims-based algorithms** for foundational analytics:
 - Episodes
 - Patient attribution, stratification and pooling
 - Performance and payment

- Enhanced analytics that identifies high priority patients for **targeted intervention**:
 - Care gaps analyses
 - Alert generation

- **System level** public health/epidemic analyses
- **Patient 360** view enabled by integration of claims and clinical data

B Provider - payer – patient connectivity

- **Multi-payer online** portal for providers to download static electronic performance reports

- **Bi-directional** portal that allows data exchange between payers and providers
- Patient portal providing cost transparency and

- **HIE-enabled** bidirectional communication and data exchange

C Provider-patient care management

- **Low-tech** care management support, e.g., :
 - Excel list of disease specific high risk/cost patients
 - Care management training modules/playbooks

- **Certified** care management vendors and/or workflow tools
- **Local EMR** data integrated into care management tool

- Enhanced **care management** tools:
 - Automated patient comm
 - Direct linkage to payer alert
 - 24/7 clinical acces
- **Remote monitoring and tele-medicine**

D Provider-provider connectivity

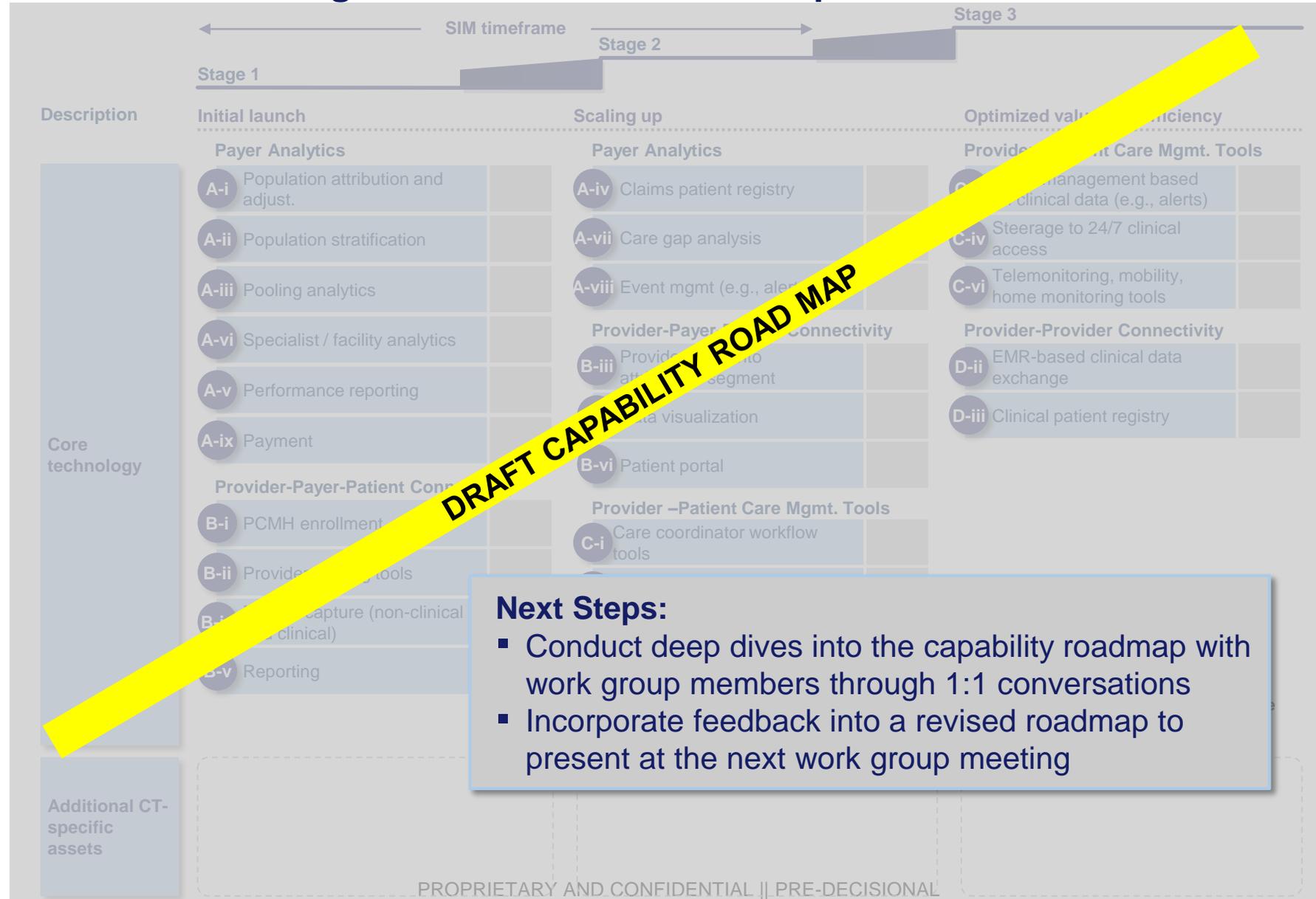
- **Low-tech** solutions (e.g., telephone) to allow information exchange between providers to deliver care to same patient

- **Admission/discharge** data sharing between hospitals and PCPs

- **Clinical patient registry**
- **HIE-enabled** bidirectional communication and data exchange



Exhibit 5: The road map was discussed via a breakout exercise and feedback was sought to refine based on CT-specific considerations



Exhibits

- Care delivery work group
- Payment work group
- HIT work group
- **Stakeholder engagement**

The next 8 weeks are just the beginning of a longer journey of stakeholder engagement

Opportunities for stakeholder engagement

	April	July - Sept	Oct – early '14	Mid-'14
	Model selection and framework design	Share and jointly refine framework	Build out framework	Implement model
Description	<ul style="list-style-type: none"> ▪ Generate awareness ▪ Understand needs ▪ Gather input on model design 	<ul style="list-style-type: none"> ▪ Review draft framework ▪ Invite feedback so framework can be further refined 	<ul style="list-style-type: none"> ▪ Define framework in more detail ▪ Identify supporting community initiatives to leverage in new model 	<ul style="list-style-type: none"> ▪ Generate awareness of model design ▪ Enable consumers, providers, and other stakeholders to actively participate

PRELIMINARY: We have drafted an initial stakeholder engagement plan



SHIP	▲ 4/30	▲ 5/13	▲ 6/10	▲ 7/8	▲ 7/29			
Work groups								
▪ Care delivery		▲ 5/13	▲ 5/28	▲ 6/10	▲ 6/17	▲ 6/24	▲ 7/8	▲ 7/22
▪ Payment		▲ 5/20	▲ 6/3	▲ 6/17	▲ 7/1		▲ 7/15	
▪ HIT		▲ 5/20	▲ 6/3	▲ 6/17		▲ 7/8	▲ 7/15	
HCC		▲ 5/7		▲ 6/11		▲ 7/9		
CAB		TBD						
Regional town halls						▲ 7/15	▲ 8/19	
E-forum	←	Ongoing						→
Letters from the LG	←	Ongoing						→
Employer engagement	<i>Participate in existing employer/ business group meetings to share and gather input</i>							
Consumer-targeted engagement	<i>For discussion: potential open session on 6/24 (consumers/ employers) or 7/1 (providers), existing forums, e-communications, or focus groups to understand consumer and provider perspectives</i>							
Clinician-targeted engagement								

Engagements will seek to reach consumers with diverse perspectives/ backgrounds ...

Age	Status of illness	Location	Disability	Payer	Cultures
▪ Elderly	▪ Complex chronic	▪ Urban	▪ Disabled	▪ Medicare	▪ Linguistic
▪ Adults	▪ Early-stage chronic	▪ Rural	▪ Nondisabled	▪ Medicaid	▪ Ethnic
▪ Children (parents as advocates)/ teenagers	▪ At risk	▪ Suburban		▪ Commercial	
▪ Pregnant mothers	▪ Healthy				

...as well as clinicians with diverse perspectives/ backgrounds

Provider type	Affiliation	Location	Specialty
▪ MD	▪ Hospital	▪ Urban	▪ Primary care
▪ RN	▪ Multi-provider	▪ Rural	▪ Specialists
▪ PA	▪ Individual	▪ Suburban	▪ Behavioral Health
▪ PhD			
▪ Licensed Medical/ Clinical Social Worker (LMSW/LCSW)			

We are considering a range of forums for broader engagement to use the right approach at the right time (1 of 2)

In-person sessions

1-on-1

Forum best suited to ...

- Understand unique perspective of individual/ entity
 - Gather targeted feedback/ input on specific elements of model design
-

Focus group

- Gather deep level of insight into a specific group of individuals by engaging with a representative sub-set
-

Pre-existing forums (e.g., FQHC/ community/ union events)

- Generate awareness of Connecticut SIM design effort by sharing brief updates on Connecticut SIM design effort and work groups' current thinking
 - Provide opportunity for individuals/ entities to begin to ask questions and provide input as part of shorter Q&A
-

Open sessions/ town halls

- Share information with a broader group of individuals/ entities
- Bring together diverse group of stakeholders and help them understand each other's perspectives
- Provide opportunity for longer Q&A with larger group

We are considering a range of forums for broader engagement to use the right approach at the right time (2 of 2)

Forum best suited to ...

E-forum & other media

Online/email surveys

- Gather information/ perspectives across large number of people
 - Engage younger
 - Reach individuals who may not be able to participate in in-person sessions given limited time or ability to join
-

Newsletters, emails, and mailings

- Generate awareness of the effort so individuals/ entities who want to participate are empowered to do so
 - Provide more frequent updates on the effort
 - Reach individuals/ entities who may not be able to participate in in-person sessions given limited time or ability to join
-

Other media (e.g., radio/ TV broadcast)

- Generate awareness of the effort so individuals/ entities who want to participate are empowered to do so

Starter list of pre-existing forums that have been shared with us

NOT EXHAUSTIVE

Associated groups

Existing forums

Consumer-targeted forums

CHNCT

- Lunch & Learns
- Health fair

School events

- School board meetings

Cultural Events

- Escape Fire movie screenings

Community organizations

- Faith-based groups
- Cross-community partnerships

Advocates

- Universal Healthcare Foundation of CT

Clinician-targeted forums

Clinician associations¹

- County/ state meetings
- Website/ newsletters/ social media/ peer review journals
- Resident outreach

FQHCs

- Board of Director meetings

Others

- Practice staff meetings
- Medical journals

¹ Connecticut State Medical Society; American College of Physicians (ACP); Connecticut Academy of Family Physicians (CAFP); Other