



# Connecticut State Innovation Model

STATE OF CONNECTICUT

Model Overview

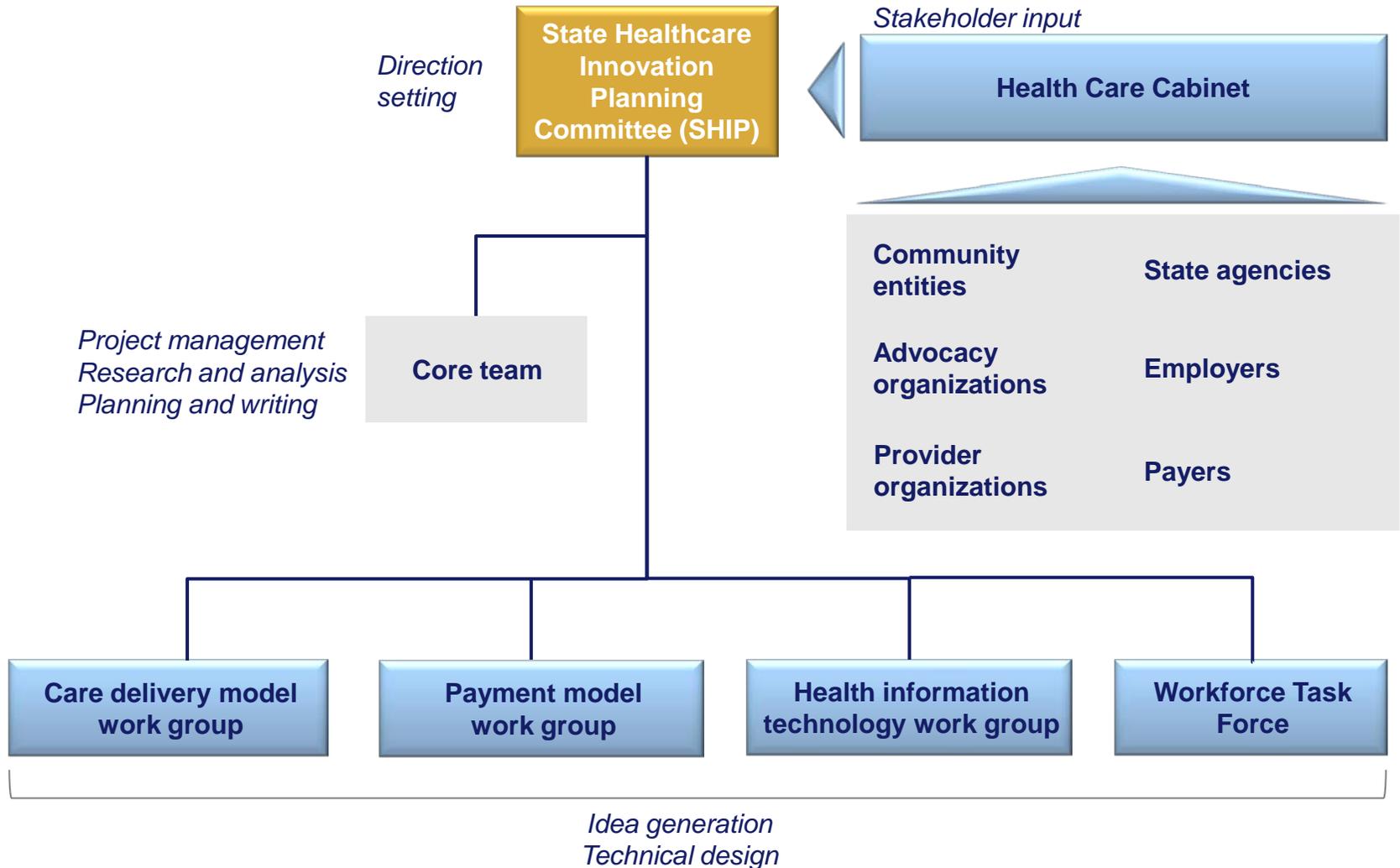
# State Innovation Model Initiative

- Center for Medicare and Medicaid Innovation (CMMI) funding opportunity
- State Healthcare Innovation Plan
- Connecticut one of 16 “model design grant” states
- Application for \$30 to \$45 million over 3 - 4 years

# CMMI Guidance for Applicants

- Healthcare reform and innovation
- Include 80% of state lives within 5 years
- Involve Medicare, Medicaid and commercial insurers
- Providers responsible for quality and outcomes
- Align with DPH State Health Improvement Plan and Healthy People 2020
- Payment reform – from volume based payment to value-based payment
- Reduce costs - 3-5 year return on investment

# Planning Process and Structure



# Connecticut's Vision for SIM

**Establish a whole-person-centered health care system that promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability**

- 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
- Increased access to the right care in the right setting at the right time
- Continuously improving workforce development to support a diverse well trained workforce that can work efficiently and effectively in our evolving care delivery environments
- 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

# **Key Stakeholder Input Activities**

## Our process recognizes different stakeholder perspectives



**Patients/  
consumers/  
consumer  
advocates**

Medicaid, uninsured,  
employer insured,  
seniors, young  
adults, pregnant  
mothers



**State  
Departments**



**Families**



**Trade  
Associations,  
Oversight  
Councils**



**Clinicians and  
healthcare  
givers**

Medical doctors,  
FQHC's, nurses,  
home care agencies



**Payers**

Medicaid, Medicare,  
commercial



**Hospitals/  
facilities/  
nonprofits**



**Employers**

Small and large  
employers, HR  
representatives



**Community/  
state/ nonprofit  
entities**

Focusing on: health,  
education,  
employment

# 1 A set of key questions were posed to stakeholder groups to better understand their health care experiences



## Patients/ consumers

- What are the biggest problems you've had with the way healthcare is given today?
- How would you like your doctors to work with you?
- Who do you talk to for help on health-related issues?
- What role do you think you or your family can play in taking care of your health?
- *[Follow-up to prior question]* What help do you or your family need for you to be able to take better care of your health?
- What are the things you like about the health care you get today?



## Clinicians/ health care providers/ hospitals/ nonprofit service providers

- What best practices have you practiced or observed that you think should be practiced more broadly by clinicians in Connecticut?
- What do you believe are the biggest obstacles to delivering high-quality, high-value care today?
- What support or tools do clinicians need to be able to address those obstacles?
- How do you think consumers, families, and the broader community can be best involved to deliver high-quality, high-value care?
- What are your biggest fears about a new care delivery and payment model being implemented in Connecticut?
- What types of support do you think will be most helpful to clinicians who want to transition into a population-health based, total cost of care model?
- What kinds of training/educational opportunities should be available to help you in the transition to a new model of care?



## Community/ state agencies/ nonprofit entities

- What are the biggest health-related challenges your clients face today?
- What role do you play in delivering health care services and/or providing other support to your clients to address those challenges?
- What have you found to be the most effective ways to help your clients address those challenges?
- What are the greatest difficulties you encounter when trying to help your clients manage their health?
- What have you found to be the most effective strategies when you've run into those difficulties when trying to help your clients?
- What support or tools would you need in order to address your client's health care needs and/or help your clients manage their health more effectively?
- What is the best way for you to communicate and work with clinicians and other nonprofit service providers to achieve the best health outcomes for your clients?



## Consumer Advocates

- What do you believe are the biggest obstacles to delivering high-quality, high-value care today?
- How do you think consumers, families, and the broader community can be best involved to deliver high-quality, high-value care?
- What are the biggest health-related challenges your clients face today?
- What role do you play in delivering health care services and/or providing other support to your clients to address those challenges?

**As of September 3, 2013: During the input stage of the SIM proposal, the input from approximately 1069 consumers was coded, categorized, and incorporated into the planning process.**

Stakeholder	Event	Description	Participants
<b>Consumers</b>	<b>HUSKY/Charter Oak consumer advisory board meeting (CHNCT) (7/9)</b>	<ul style="list-style-type: none"> <li>▪ CHNCT is a not-for-profit health plan and a Managed Care Organization which serves the HUSKY, SAGA and Charter OAK Health Plan populations.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 8 COAK members; 4HUSKY members</li> <li>▪ 9 other participants (SIM representatives, state officials);</li> </ul>
	<b>AARP Focus Group (7/17)</b>	<ul style="list-style-type: none"> <li>▪ An ad hoc member meeting at the Shelton Senior Center. American Association of Retired Persons is a nonprofit organization which advocates for people over 50, focusing on hunger, income, housing, and isolation.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 10 AARP members</li> </ul>
	<b>Meeting of Kitchen Cabinet and Mothers for Justice (7/17)</b>	<ul style="list-style-type: none"> <li>▪ Mothers for Justice (MFJ) is an advocacy group seeking to empower women to affect policy.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 20-25 Kitchen Cabinet and Mothers for Justice, many of whom have HUSKY coverage.</li> </ul>
	<b>STRIVE Focus Group (8/8)</b>	<ul style="list-style-type: none"> <li>▪ STRIVE is a “second chance” program for people who have experienced barriers to employment). It provides employment orientation and basic skills development.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 18 students of the STRIVE program, [19-57 years old (average 37). Predominately women of color and not currently in the workforce. (11 had public funded, 5 uninsured).]</li> </ul>
	<b>CT Health Foundation Road Show (June-August)</b>	<ul style="list-style-type: none"> <li>▪ CT Health Foundation focuses on improving healthcare quality for populations of color and underserved communities. Held 5 meetings focused on health equity, barriers to health care, best practices by clinicians, and recommendations for changes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Five meetings with just over 200 participants were used to solicit input about healthcare in the cities of Waterbury, Norwalk, New Haven, Norwich and Hartford.</li> </ul>
	<b>Family Advisory Board for DCF Region 3 (7/11)</b>	<ul style="list-style-type: none"> <li>▪ DCF Regional Advisory Council: Family advisory board advises and maintains a comprehensive system of services for children, youth, and families within the region.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 6 participants</li> </ul>

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Stakeholder	Event	Description	Participants
Consumers	Employees of Employer Sponsored Insurance focus group (8/14)	<ul style="list-style-type: none"> <li>Meeting for employees of the City of New Haven which had insurance through the city. Hosted by the City of New Haven, Livable City Initiative (LCI) which aims to enhance the experience of residents of New Haven.</li> </ul>	<ul style="list-style-type: none"> <li>14 employees of the City of New Haven. [Men and women from 4 departments (Livable Cities, Finance, Corporate Counsel, Human Resources).(Hispanic, African American, Caribbean, Caucasian ages 24-55)]</li> </ul>
	E-Consumer Survey (August)	<ul style="list-style-type: none"> <li>SIM Planners directed Sellers Dorsey to develop and disseminate an online survey. The survey tool was sent out to Universal Health Care Foundation of Connecticut's list-serve of 19,000 people on Thursday, August 15, 2013 and included questions on where and how often people sought treatment, their thoughts on the quality and cost of their care, and barriers to access.</li> </ul>	<ul style="list-style-type: none"> <li>784 people responded to the survey before the August 20, 2013 deadline. There were also 530 responses to the open-ended question "How would you improve the way healthcare is delivered?" and 286 responses to "Please provide any additional comments or information that you would like to share" for a total of 816 open ended responses, which were categorized and incorporated into the Exhibit.</li> </ul>
	DPH Led Health People 2020/State Health Improvement regional forums	<ul style="list-style-type: none"> <li>While not focused on SIM, these focus groups examined health and barriers to good health for the State Health Improvement Plan. Results are being reviewed and will inform the community health related elements of the SIM SHIP.</li> </ul>	

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**As of September 3, 2013: During the input stage of the SIM proposal, SIM representatives also solicited input from providers, community organizations, advocacy groups, employer organizations, trade associations, state departments and oversight councils in at least 18 different focus groups and meetings.**

Stakeholder	Event	Description	Participants
<b>Service/ Providers</b>	<b>Meeting with Home Care Agency Representatives (8/9)</b>	<ul style="list-style-type: none"> <li>In person follow up meeting from Governor's HHS Non-Profit Group</li> </ul>	<ul style="list-style-type: none"> <li>6 representatives from varying agencies and organizations (DPH, CT Association for Healthcare at Home, CT Community Care, Leading Age CT)</li> </ul>
	<b>Community Health Center Association of Connecticut (CHCACT) (8/5)</b>	<ul style="list-style-type: none"> <li>CHCACT provides advocacy, program administration and technical assistance to its 13 member community health centers, with 80 different sites throughout CT.</li> </ul>	<ul style="list-style-type: none"> <li>4 members</li> </ul>
	<b>Connecticut Hospital Association Meeting (7/23)</b>	<ul style="list-style-type: none"> <li>CHA represents hospitals and health related organizations. CHA does advocacy on behalf of the interests of hospitals, leadership services for community-based care, research and education in delivery and financing, and other assistance.</li> </ul>	<ul style="list-style-type: none"> <li>Mostly financial and government relations, (e.g., CFOs). Minimal clinical staff.</li> </ul>
	<b>United Community and Family Services (UCFS) Consumer FQHC board (7/25)</b>	<ul style="list-style-type: none"> <li>UCFS provides various community services such as outpatient Primary Medical Care, outpatient Behavioral Health Services, eldercare services and community health services.</li> </ul>	
	<b>CHNCT Lunch &amp; Learn event for organizations working with mothers (7/11)</b>	<ul style="list-style-type: none"> <li>Community Health Network (CHNCT) is a not-for-profit health plan and Managed Care Organization which serves the HUSKY, SAGA and Charter OAK Health Plan populations.</li> </ul>	<ul style="list-style-type: none"> <li>12 direct service providers who are Medicaid enrollees, and 1 agency staff who served as coordinator</li> </ul>

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Stakeholder	Event	Description	Participants
Leadership Organizations (State Departments, Trade Associations, Oversight Councils)	<a href="#"><u>CT Behavioral Health Partnership Oversight (CT BPH) (7/12)</u></a>	<ul style="list-style-type: none"> <li>CT BHP is a Partnership of DCF, DSS, ValueOptions® and an Oversight Council to provide access to community based behavioral health services and support. DMHAS has been recently added to create an integrated behavioral health service system for CT's Medicaid populations.</li> </ul>	
	<a href="#"><u>Medical Assistance Program Oversight Council Meeting (MAPOC) (6/14)</u></a>	<ul style="list-style-type: none"> <li>MAPOC is a collaborative body of legislators, Medicaid consumers, advocates, providers, insurers and state agencies to advise DSS on the development of Connecticut's Medicaid Managed Care program. SIM representatives attended a full Council meeting, which occurs once a month.</li> </ul>	
	<a href="#"><u>CT Multicultural Health Partnership Event (6/20)</u></a>	<ul style="list-style-type: none"> <li>CTMHP is a Partnership to draw together expertise, resources, and programming to eliminate health disparities in Connecticut.               <ul style="list-style-type: none"> <li>Mission is to evaluate and recommend strategies to support the evolving needs of Connecticut consumers and small businesses. Further, to utilize the Exchange as a catalyst for change in Connecticut's delivery system using its unique role to identify and promote new ways to provide efficient, high quality, and affordable care.</li> </ul> </li> </ul>	
	<a href="#"><u>Access Health CT Board Strategy Committee</u></a>		
	<a href="#"><u>Behavioral Health CEO Meeting (CT Association of Nonprofits) (6/26)</u></a>	<ul style="list-style-type: none"> <li>CT Nonprofits is a membership organization for nonprofits. It connects organizations with information, education, advocacy and collaboration.</li> </ul>	

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Stakeholder	Event	Description	Participants
Consumer Advocates/ Community Organizations	Central Area Health Education Center (AHEC) (8/16)	<ul style="list-style-type: none"> <li>Central AHEC is a non-profit organization focusing on health disparities and diversifying the healthcare workforce by providing and coordinating programs that improve the health status of those in central Connecticut.</li> </ul>	<ul style="list-style-type: none"> <li>8 members</li> </ul>
	CHNCT Lunch & Learn event for organizations working with mothers (7/11)	<ul style="list-style-type: none"> <li>Community Health Network (CHNCT) is a not-for-profit health plan and Managed Care Organization which serves the HUSKY, SAGA and Charter OAK Health Plan populations.</li> </ul>	<ul style="list-style-type: none"> <li>12 direct service providers who are Medicaid enrollees, and 1 agency staff who served as coordinator</li> </ul>
	<u>CT Association of Non-Profits forum with Central AHEC, and CHCACT (7/30)</u>	<ul style="list-style-type: none"> <li>CHCACT provides advocacy, program administration and technical assistance to it's 13 member community health centers, with 80 different sites throughout CT.</li> <li>CT Nonprofits is a membership organization for nonprofits. It connects organizations with information, education, advocacy and collaboration.</li> <li>Central AHEC is a non-profit organization focusing on health disparities and diversifying the healthcare workforce by providing and coordinating programs that improve the health status of those in central Connecticut.</li> </ul>	

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**Stakeholder**   **Event**

**Description**

**Participants**

**Employer  
Input**

**CT Business Group on Health: Wellness Committee (7/16)**

▪ Connecticut Business Group on Health is an employer advocacy group focusing on the quality and cost of delivery of healthcare.

▪ 10-15 broad range of employers, from small to large; Anthem, YNHH, Pro Health, Black and Decker, AISF, Sacred Heart, Ability Beyond Disability

**Northwestern Connecticut Chamber of Commerce-Representatives of businesses NE CT (8/15)**

▪ NWCTEDC is a business organization advocating for the business community in Northwest CT.

▪ 10 participants [many are Human Relations or benefits managers of local accounting firms, banks, and other]

**Hartford small employer focus group (8/15)**

▪ A number of small businesses were identified by the Universal Health Foundation and invited to a forum to discuss their experiences providing healthcare to their employers.

▪ 2 small business owners attended: The managing partner of a law firm that employs 9 people, The co-owner/book-keeper of a family owned auto-body shop that employs 15 people

**CT Business Group on Health Council Meeting (6/7, 6/28)**

▪ Connecticut Business Group on Health is an employer advocacy group focusing on the quality and cost of delivery of healthcare.

**CT Health Care Cost Containment Committee meetings (ongoing)**

▪ The Health Care Cost Containment Committee is the labor-management committee that oversees the state employee health plan. Meetings are held on the 1<sup>st</sup> Monday of every month, except for Holidays. A SIM representative reports on the progress of the SIM and its possible effect on the state employee plan.

## Stakeholder group perspectives represented in synthesis of stakeholder engagements

	Stakeholder group	Date	Methodology
<b>A</b> UConn MME Focus Groups	<ul style="list-style-type: none"> <li>MMEs, families, caregivers</li> </ul>	2012	<ul style="list-style-type: none"> <li>Focus groups</li> </ul>
<b>B</b> DMHAS Multicultural Focus Group	<ul style="list-style-type: none"> <li>Consumers from a variety of racial, ethnic, socioeconomic, and LGBTQ backgrounds</li> </ul>	2009	<ul style="list-style-type: none"> <li>Focus groups</li> </ul>
<b>C</b> HealthFirst Connecticut Authority	<ul style="list-style-type: none"> <li>Consumers, payers, providers, agencies, community organizations</li> </ul>	2009	<ul style="list-style-type: none"> <li>Multi-stakeholder work groups; 9 public forums</li> </ul>
<b>D</b> Access Health CT Research	<ul style="list-style-type: none"> <li>Uninsured consumers, employers</li> </ul>	2012	<ul style="list-style-type: none"> <li>Focus groups</li> </ul>
<b>E</b> Duals Demonstration Public Comments	<ul style="list-style-type: none"> <li>Community organizations, state agencies, consumer advocates</li> </ul>	2012	<ul style="list-style-type: none"> <li>Letters of support, public commentary</li> </ul>
<b>F</b> Evaluation of HIE initiative consumer surveys	<ul style="list-style-type: none"> <li>General consumer population</li> </ul>	2013	<ul style="list-style-type: none"> <li>Survey</li> </ul>
<b>G</b> OHA behavioral health hearings	<ul style="list-style-type: none"> <li>Mental health consumers, providers, facilities, and social service organizations</li> </ul>	2012	<ul style="list-style-type: none"> <li>Testimonies</li> </ul>
<b>H</b> PRI Testimonies	<ul style="list-style-type: none"> <li>Consumers, providers, researchers</li> </ul>	2013 (Phase 2)	<ul style="list-style-type: none"> <li>Interviews</li> </ul>
<b>I</b> The Community Foundation of Greater New Haven	<ul style="list-style-type: none"> <li>Consumers from a variety of racial, ethnic, socioeconomic backgrounds</li> </ul>	2012	<ul style="list-style-type: none"> <li>Qualitative Interviews</li> </ul>

# Care Delivery Workgroup

## Learning from the Health Care Journey

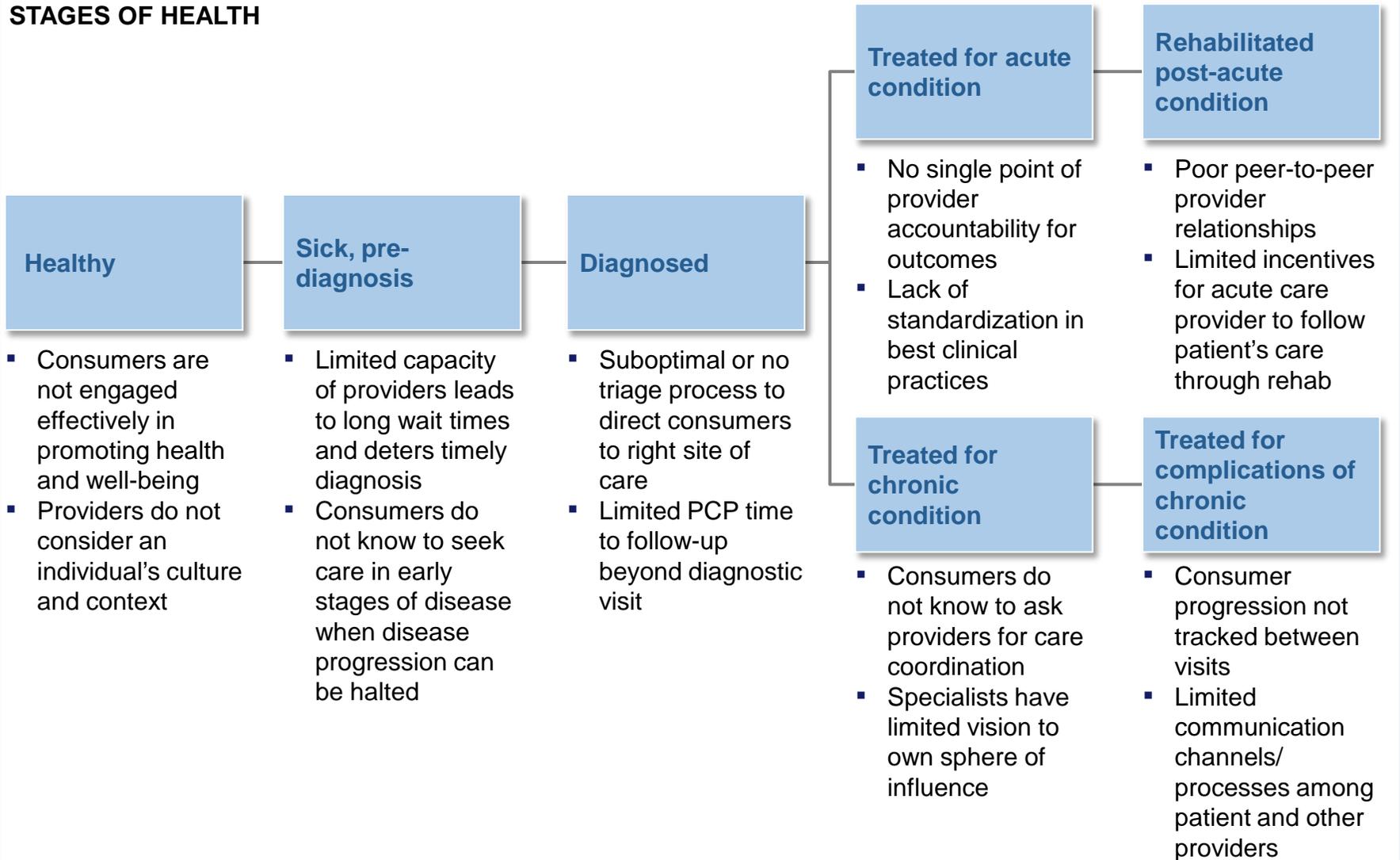
### *A child with asthma*

Kathy is a six year old girl who came into the office for asthma. The exam doesn't consider important things about Kathy, such as her history of anxiety, violence in the home, and a parent with addiction problems. Her mother doesn't entirely understand the care plan, which contains many unfamiliar terms, and does not explain why and how conditions in the home might affect asthma. The PCP is also unaware of a longstanding infestation of mice. Kathy has a series of visits to the ED, ultimately leading to a hospitalization. The PCP learns of this several weeks after her discharge.

# Care Delivery Work Group

## Consumer Journey – Barriers to Care

### STAGES OF HEALTH



# **Primary Care Transformation**

## **Core Elements**

# Connecticut's Advanced Medical Home Model

## *Core Elements*

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-informed clinical decision making

## *OUR ASPIRATIONS*

- Better health for all
- Improved quality and consumer experience
- Reduced costs and improved affordability

Performance transparency

Consumer empowerment

Health information technology

Value-based payment

Workforce development

## *ENABLING INITIATIVES*

# Advanced Medical Home – Core Elements

## Prioritized interventions

### 1 Whole-person-centered care

- Whole person and family assessments that identify strengths and capacities, risk factors<sup>1</sup>, behavioral health, oral health and other co-occurring conditions, and ability to self-manage care
- Person centered care plan and shared decision making tools
- Address cultural, linguistic, health literacy barriers to care

### 2 Population health management

- Gather and analyze information about patient population
- Gain insight into health patterns and improvement opportunities for particular patient sub-populations (e.g., by health risk, condition, or race/ethnicity)
- Apply these insights strategically in the continuous improvement of care delivery processes.
- Translate population health trends and statistics to individual patients
- Maintain a disease registry

<sup>1</sup> Including history of trauma, housing instability, access to preventive oral health services

# Advanced Medical Home – Core Elements

3

Enhanced access to care (structural and cultural)

## Prioritized interventions

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- 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 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
  - Outreach, engagement and navigation support tuned to race/ethnicity/culture
-

# Advanced Medical Home – Core Elements

4

Team-based,  
coordinated care

## Prioritized interventions

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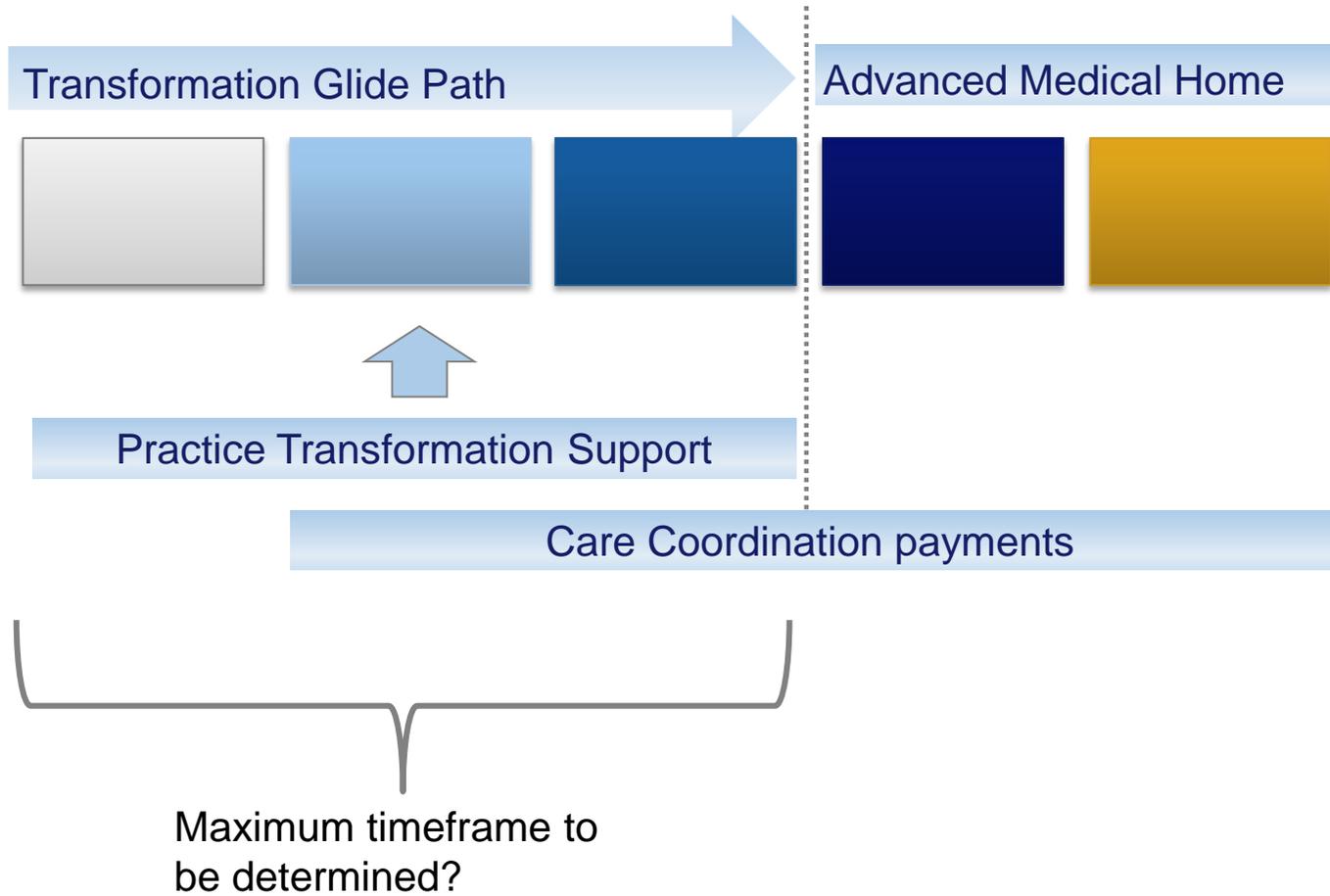
- Provide team-based care from a prepared, proactive, and diverse team
  - Integrate behavioral health and primary care with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)
  - Develop and execute against a whole-person-centered care plan
  - Coordinate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

5

Evidence-informed  
clinical decision  
making

- Apply clinical evidence and health economic data to target care and interventions to those for whom they will be most effective
  - 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
-

# Transformation Support – Helping Practices Meet Advanced Medical Home Standards



# Enabling Initiatives

# Consumer Empowerment

- Securely share health data on consumer portal
- Self-management programs
- Shared decision making tools – e.g. Choosing Wisely
- Provider quality and cost performance to inform consumer choices
- Promote community outreach programs
- Value-based Insurance Design
- Incentives for positive health behavior

# Performance Transparency

- Collection, integration, analysis and dissemination of data for performance reporting on health, health care quality and cost
- Statewide performance metrics to demonstrate improvement over time
- Track AMH performance on quality, care experience, and equity measures on common scorecard
  - For use by payers to determine whether providers qualify for value-based incentive payments
- Track broader array of providers on quality, outcome and cost measure for use by consumers and providers in deciding where and from whom to obtain services
- Establish rapid cycle analysis of quality and consumer experience data to support continuous improvement

# HIT - Four Categories of HIT Capabilities to Support Reforms

Category	Description
<b>Payer Analytics</b>	<ul style="list-style-type: none"><li>▪ To understand and improve care, billed services (claims) can be analyzed to know the types of illnesses, how they are getting treated and their relative costs, e.g., the number of asthma patients being treated at EDs.</li></ul>
<b>Portals for Patients &amp; Providers</b>	<ul style="list-style-type: none"><li>▪ Web Portals for providers &amp; patients to access medical information (e.g., medications and lab results), look up educational material, schedule appointments and understand how providers compare to each other on quality measures.</li></ul>
<b>Care Management</b>	<ul style="list-style-type: none"><li>▪ A portal for care managers to document patients' needs and follow-up for people with specific high need conditions.</li></ul>
<b>Provider to Provider Info Sharing</b>	<ul style="list-style-type: none"><li>▪ Sometimes referred to as an HIE (Health Information Exchange), it refers to: (1) a confidential way to share information between providers, or, (2) a 'clearinghouse' of medical information that can be viewed, with consent, or in an emergency.</li></ul>

# HIT - Strategy to Develop Required HIT Capabilities

## Category

## Strategy



Payer Analytics  
(Viewing Billed Services  
& Medical Info)

- Build on payers' current systems and use common areas of quality measures.
- Longer term: use a collection of service information from all payers to understand public health needs and give consumers information on costs and quality by different providers.



Portals for Patients &  
Providers

- Select an existing provider portal for use across multiple providers
- Leverage AccessHealth CT's (the CT Health Insurance Exchange) *All Payers' Claims Database (APCD)* and service information for improving patients' understanding.
- Minimize the number of portals consumers have to go.



Care Management

- Near term: develop understanding of provider care management process and technology needs
- Medium term: pre-qualify vendors for simplified selection
- Long term: host shared service to access care management capabilities



Provider to Provider Info  
Sharing

- Coordinate State-wide efforts for Provider to provider sharing of patient information
- Develop infrastructure for sharing information between providers

# Value-Based Payment

- Pay-for-performance (P4P)
  - Financial rewards for providers that meet quality standards
  - Available to providers on the Glide Path<sup>1</sup>
  - Provides experience necessary for success with shared savings program
  - Must have 500+ attributed consumers

<sup>1</sup>Provider groups with sufficient attributed consumers may elect to negotiate a shared savings program arrangement with individual payers in advance of achieving AMH status.

# Value-Based Payment

- Shared Savings Program
  - Share in savings if provider meets minimum quality standards
  - Payer and providers negotiate whether to share in losses
  - Practices have met initial quality metrics and progressing on AMH standards
  - 5,000+ attributed consumers

# Value-Based Payment

- Advantages of Shared Savings Programs
  - Rewards providers for improved quality over time
  - Rewards providers for finding innovative ways to reduce waste, inefficiency and other unnecessary costs
  - Reducing costs makes coverage more affordable for consumers
  - Allows providers to be more flexible...by getting out of the *volume treadmill*, they can find other ways to improve consumer access, satisfaction, and outcomes (e.g., hiring pharmacists to help with medication or using phone and e-mail for timely communication with consumers)

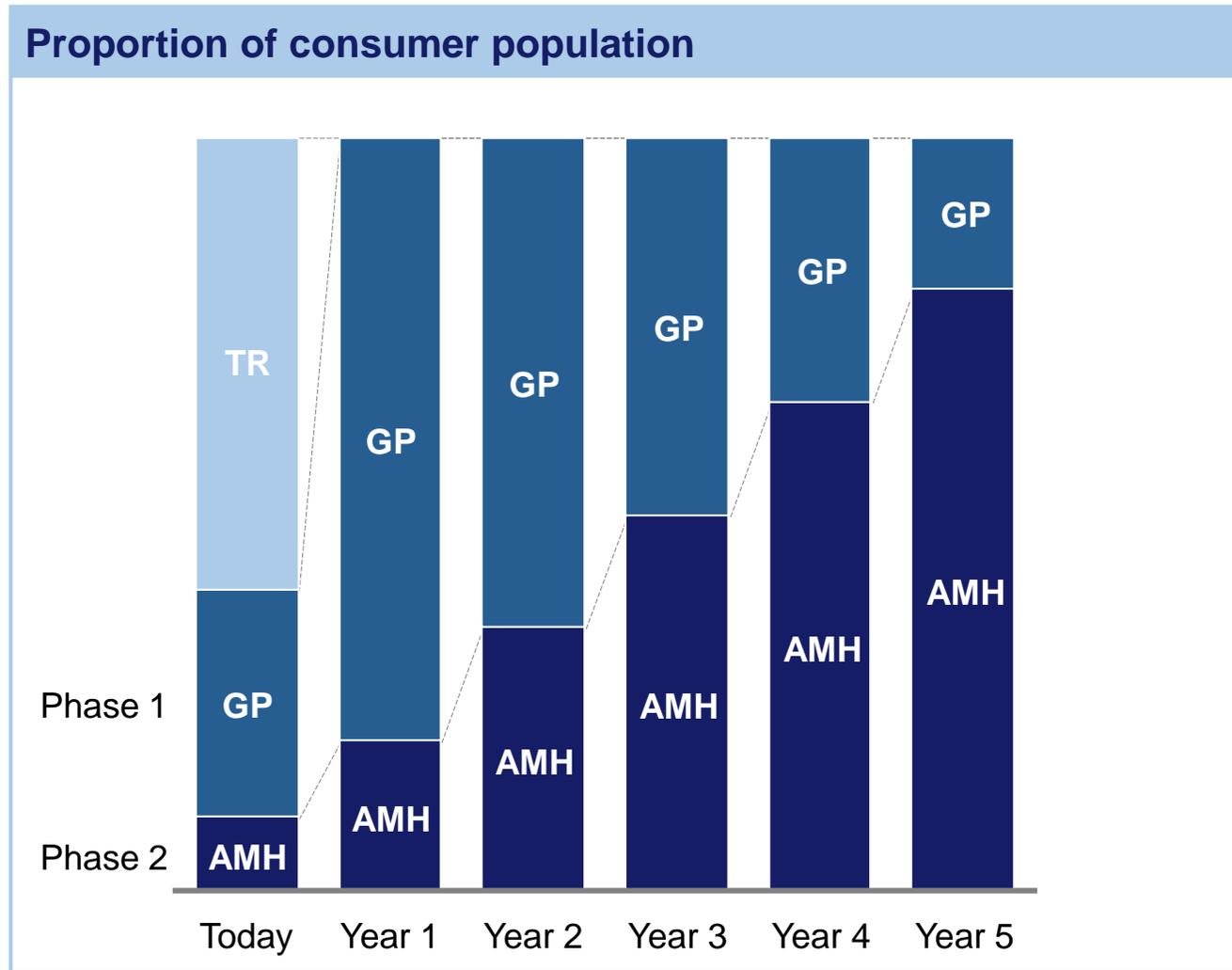
# Workforce Development

- Improved health workforce data collection and analyses
- Connecticut Service Track: inter-professional training for team & population health approaches to health services
- Training program and certification standards for Community Health Workers,
- Development of core STEM curricula for baccalaureate degrees in the health field, and career ladders and career flexibility through comprehensive articulation agreements among schools that train health care professionals and allied health professionals

# Workforce Development

- Assistance for practicing primary care clinicians in adapting to care delivery models that emphasize teamwork, best practices, population health, patient engagement, learning collaboration, continuous improvement and the meaningful use of Health Information Technology (HIT)
- Assistance in developing primary care clinical skills for primary care clinicians who have been away from direct patient care and for specialists interested in primary care
- More innovative and compelling primary care GME programs

# Advanced Medical Home Phase-in as Providers Complete Glide Path



**AMH = Advanced Medical Home**  
**GP = Glide Path**

**TR = Traditional practice**

# Community Health Improvement

# Community Health Improvement

- Geographic areas or regions focused on health improvement, health equity, and prevention
- Prioritize community needs
- Align metrics and financial incentives for all community participants
  - Care delivery IPAs/networks/ACOs
  - Other community partners
- Pooled accountability to avoid risk selection
- Financial incentives for grant based programs

# Certified Community-Based Entity

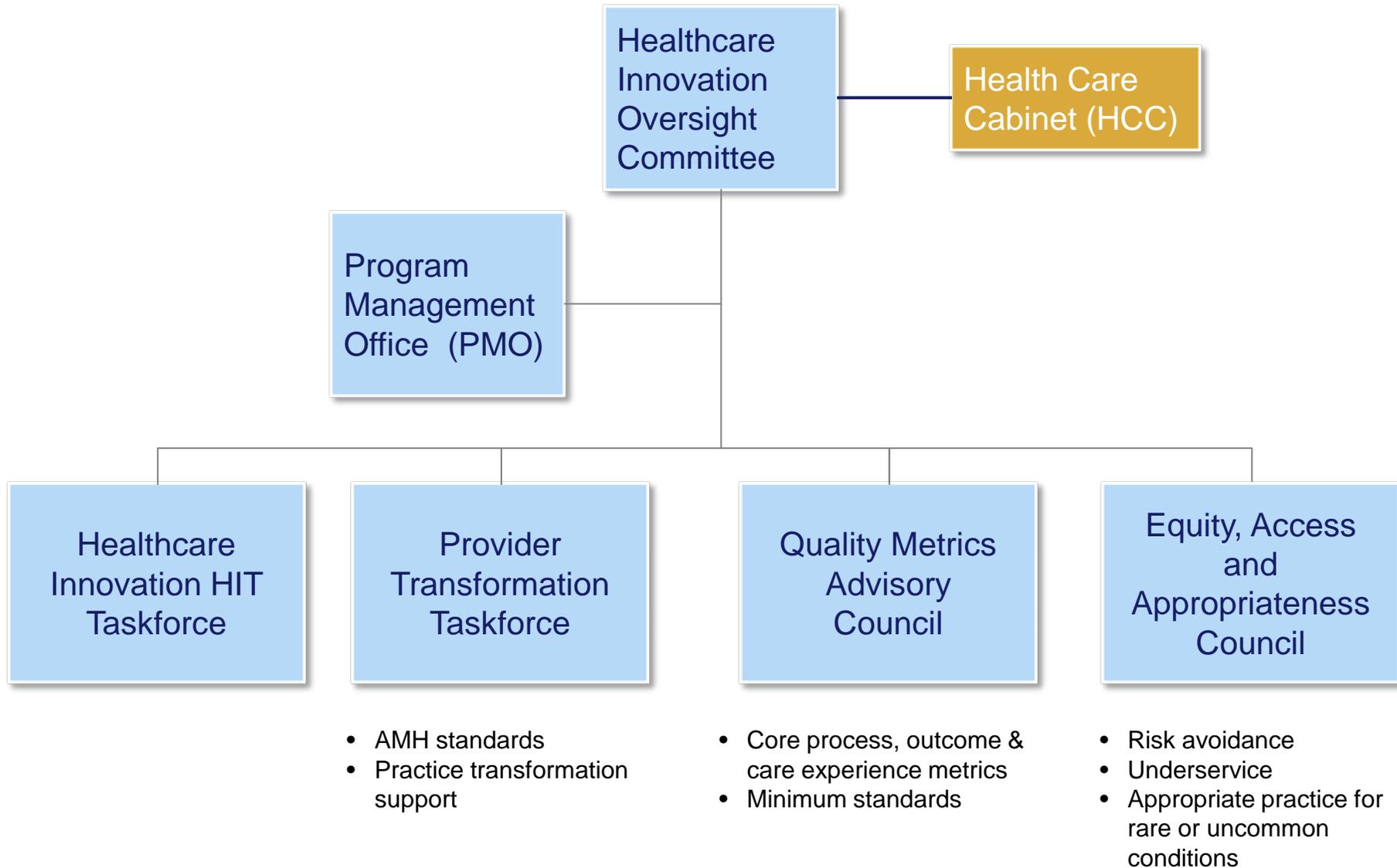
- Support local primary care practices with a specified package of evidence-based community services.
- Deliver core set of evidence-based community interventions.
- Formal affiliations with primary care practices and share accountability for quality and outcomes.
- Unique understanding of community and population served and able to deliver high quality, culturally and linguistically appropriate services.
- Meet specified standards pertaining to the type, quality, scope and reach of services.
- Employ and utilize community health workers
- IT-enabled integrated communication protocols. Collect and report data and evaluate performance and relevant outcomes.

# Certified Community-Based Entity

## Illustrative Core Services

- Asthma Home Environmental Assessments (putting on AIRS)
- Diabetes Prevention Program (DPP)
- Chronic Disease Self-Management Programs
- Falls Prevention Program
- Core Services foundational framework includes: DPH's State Health Assessment, CDC's four-domain framework on chronic disease prevention and health promotion, proven effectiveness, reduction of health disparities and return on investment potential.

# **Proposed New Governance and Operating Model**



# Quality Metrics Advisory Council

- Provider Quality and Care Experience Metrics
  - Process (e.g., HBA1C)
  - Outcome (e.g, fewer hospitals stays for ambulatory care sensitive conditions)
  - Care experience
  - Health equity

# Equity Access & Appropriateness Council

- Medicare/Medicaid/private payers – dedicated divisions focused on risks inherent to volume based payment
- Special SIM council – focus on methods for identifying and addressing concerns related to payment reforms that reward economy and efficiency, e.g.,
  - Avoiding/discharging higher risk clients
  - Systematic under-service (e.g., tests, procedures)
  - Appropriate care for rare or uncommon conditions

# Composition and high-level criteria for participation

	Composition	Criteria for participation
Oversight Committee	<ul style="list-style-type: none"> <li>▪ Similar to existing SHIP, plus additional provider, consumer, and/or consumer advocate</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commitment to shared aspirations</li> <li>▪ Formal authority or ability to influence</li> <li>▪ Awareness of related initiatives</li> </ul>
PMO	<ul style="list-style-type: none"> <li>▪ Program Director</li> <li>▪ 3-5 dedicated staff initially</li> <li>▪ Increase as necessary over time (10-15)</li> <li>▪ External consulting support as needed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aspirational mindset and bias for action</li> <li>▪ Analytic problem solving skills</li> <li>▪ Ability to influence without authority</li> <li>▪ Experience with transformational change</li> </ul>
HIT Taskforce	<ul style="list-style-type: none"> <li>▪ Similar to composition of SIM HIT Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>▪ Formal authority or ability to influence</li> <li>▪ Technical expertise with HIT</li> </ul>
Provider Transformation	<ul style="list-style-type: none"> <li>▪ 2-3 consumers or advocates</li> <li>▪ 2-3 physicians</li> <li>▪ 1-2 behavioral health providers</li> <li>▪ 1-2 hospital executives</li> <li>▪ 2-3 payer medical directors</li> <li>▪ 1 self-insured employer representative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Direct experience with provider transformation</li> </ul>
Quality Advisory Council	<ul style="list-style-type: none"> <li>▪ 2-3 consumers or advocates</li> <li>▪ 3-5 physicians</li> <li>▪ 2-3 behavioral health providers</li> <li>▪ 2-3 hospital medical directors</li> <li>▪ 2-3 payor medical directors</li> <li>▪ 1-2 statisticians from private payers</li> <li>▪ 1 epidemiologist from DPH</li> </ul>	<ul style="list-style-type: none"> <li>▪ Technical expertise and experience with measurement of health, quality, and consumer experience</li> </ul>
Equity Access and Appropriateness Council	<ul style="list-style-type: none"> <li>▪ 1-2 statisticians</li> <li>▪ 2-3 representatives from academic schools</li> <li>▪ 3-4 consumer advocates</li> <li>▪ 4-5 payer representatives from program integrity, fraud &amp; abuse, and/or audit division</li> <li>▪ 4-5 providers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Relevant experience and technical experience with audit methodologies</li> <li>▪ Expertise in standards of practice and evidence based practice</li> </ul>

# Care Delivery Workgroup

## Learning from the Health Care Journey

### *A child with asthma*

Kathy is a six year old girl who came into the office for asthma. The exam doesn't consider important things about Kathy, such as her history of anxiety, violence in the home, and a parent with addiction problems. Her mother doesn't entirely understand the care plan, which contains many unfamiliar terms, and does not explain why and how conditions in the home might affect asthma. The PCP is also unaware of a longstanding infestation of mice. Kathy has a series of visits to the ED, ultimately leading to a hospitalization. The PCP learns of this several weeks after her discharge.



**When Kathy comes into the primary care office for symptoms of asthma, her nurse practitioner partners with her and her family to manage and coordinate her care. A concern for the well-being of Kathy and her family is expressed in verbal and nonverbal interactions. Kathy and her mom feel listened to. She is given a whole-person assessment to identify her mental health issues, changes in her living situation, other health conditions, and other social-determinants of her health and underlying causes of her asthma.**

**A Care Coordinator provides information to Kathy and her family about asthma triggers, and makes referrals to a mental health provider for the parent's addiction problems, as well works with them to address housing concerns.**

**Team-  
Based,  
Whole-  
Person  
Centered  
Care**



**Together with the family, a comprehensive care plan is developed, with understandable language, to meet their goals; including setting a schedule for follow-up assessment phone calls and appointments. The Care Coordinator ensures that Kathy’s family understands the care plan, as well as how conditions in the home might affect Kathy’s asthma.**

**Immediately after the visit, the Care Coordinator arranges an introduction to the practice’s licensed clinical social worker. Kathy returns to the practice for several behavioral health treatment visits. Her anxiety is related to bullying at school, which the social worker helps address with Kathy’s educational team.**

**Team-  
Based,  
Whole-  
Person  
Centered  
Care**



**The Care Coordinator connects Kathy and her family with a Certified Entity in their community which conducts a home assessment to identify asthma triggers that may be present. The home assessment reveals a mice infestation and actions are taken to address this important asthma trigger. Through electronic health information exchange, there is timely information flow about Kathy's progress from the Certified Entity to her primary care provider.**

**Coordinated,  
Community-  
based**



**A Community Health Worker follows up with Kathy's mother about her substance use problem and violence in the home. She meets several times with her to make sure that she is successfully connected to care and support.**

**Calls, texts, or/and emails are used as reminders for routine appointments. Kathy's mother uses the practice's consumer portal to ask questions about Kathy's medication. ED visits and hospital admissions are successfully avoided.**

**Coordinated,  
Community-  
based**



**Kathy's primary care provider is part of an Advanced Medical Home. The practice knows that it will be accountable for the care it provides, including the care experience for Kathy's mom and the effective control of Kathy's asthma.**

**The practice receives regular reports on quality, efficiency, and patient satisfaction. The practice uses this information to continuously improve the quality of service that they provide children like Kathy.**

**Improved  
Access and  
Enhanced  
Health  
Information**