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Care delivery model work group meeting #7

Discussion document
July 22, 2013

Agenda

Discuss aspects of Connecticut and its new model that are distinctive *40 min*

.....
Provide and discuss feedback on care delivery recommendations and level of personal and organizational support *60 min*

.....
Discuss next steps for the work group *20 min*

Connecticut's strengths and opportunities . . .

Inequalities in health

- Connecticut's population experiences **health access** and **outcome inequalities by race** (e.g., preterm births and low birthweight births have **higher occurrence in non-Hispanic Black and Hispanic populations**, non-Hispanic Black Medicaid population has the highest 30-day readmission rate and the highest diabetes-related ED visits (~2X Hispanic population and ~4X white population)

High medical spend

- Connecticut has **higher spending per capita than the national average**² (e.g., highest Medicaid spending in country, second highest dual spending)
 - Represents opportunity to **achieve significant savings** for **re-investment**

Concentration of health care leaders

- Home to several of the **largest health insurers** in the country and prestigious **academic medical centers** with thought leaders who can help spread Connecticut innovations to other states

Strength in behavioral health

- Existing strengths in behavioral health management** and recent **mental health legislation**
 - Connecticut was one of 6 states awarded the top grade in the National Alliance on Mental Illness's assessment of public mental health services

Engaged consumer base

- Grass roots** population and community health initiatives throughout the state
- Broad and diverse consumer stakeholder community** provided input into care delivery problems and solutions

Cross-payer commitment

- Medicaid and largest commercial payers, which account for 85% of commercial lives, are in **full collaboration and actively involved in co-design**

Providers of all types

- Connecticut is home to **large integrated health systems** as well as a **multitude of solo practitioners** (~60% primary care physicians are the only PCP at their site of care)

1 Gini coefficient is a measure of inequality of income in a population

2 \$8,654 in Connecticut vs. \$6,815 nationally for all health services in 2012 – Connecticut state profile – SHADAC for SIM

What are Connecticut's challenges which need to be overcome?

...can be built on or overcome with our care delivery model

Inequalities in health

- Model lays foundation for **increased physical and cultural access**, including the use of **electronic and telehealth enablers (e.g., e-consults)** to improve access to care in rural and underserved areas
- Metrics tracked will hold providers accountable for **care experience** and **understanding the whole person** including his/her behavioral, social and cultural context

High medical spend

- **Model** will support practices towards managing the **total cost of care** of a population and **achieving savings** which can be reinvested

Concentration of health care leaders

- **Learning collaboratives** will disseminate best practices developed at leading provider institutions

Strength in behavioral health

- Model aims to **better integrate behavioral health and primary care** with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)

Engaged consumer base

- Plan to support existing efforts and integrate with primary care by **certifying community based organizations** to provide population health services
- Plan to engage **consumer on own care team** with improved information and education
- Support consumer wellness management, illness **self-management**, engagement with general health and personal health information as well as **communication with providers** through **patient portal**

Cross-payer commitment

- Payers will provided standardized reports with **data, actionable at the point of care**, to providers

Providers of all types

- The model's initial **barrier to entry will be low (e.g., self-assessment)** and practice standards will be **phased in over time** to aid practices' transformation towards managing the health of a population and its total cost of care

Other supporting elements or recommendations?

Roundtable discussion

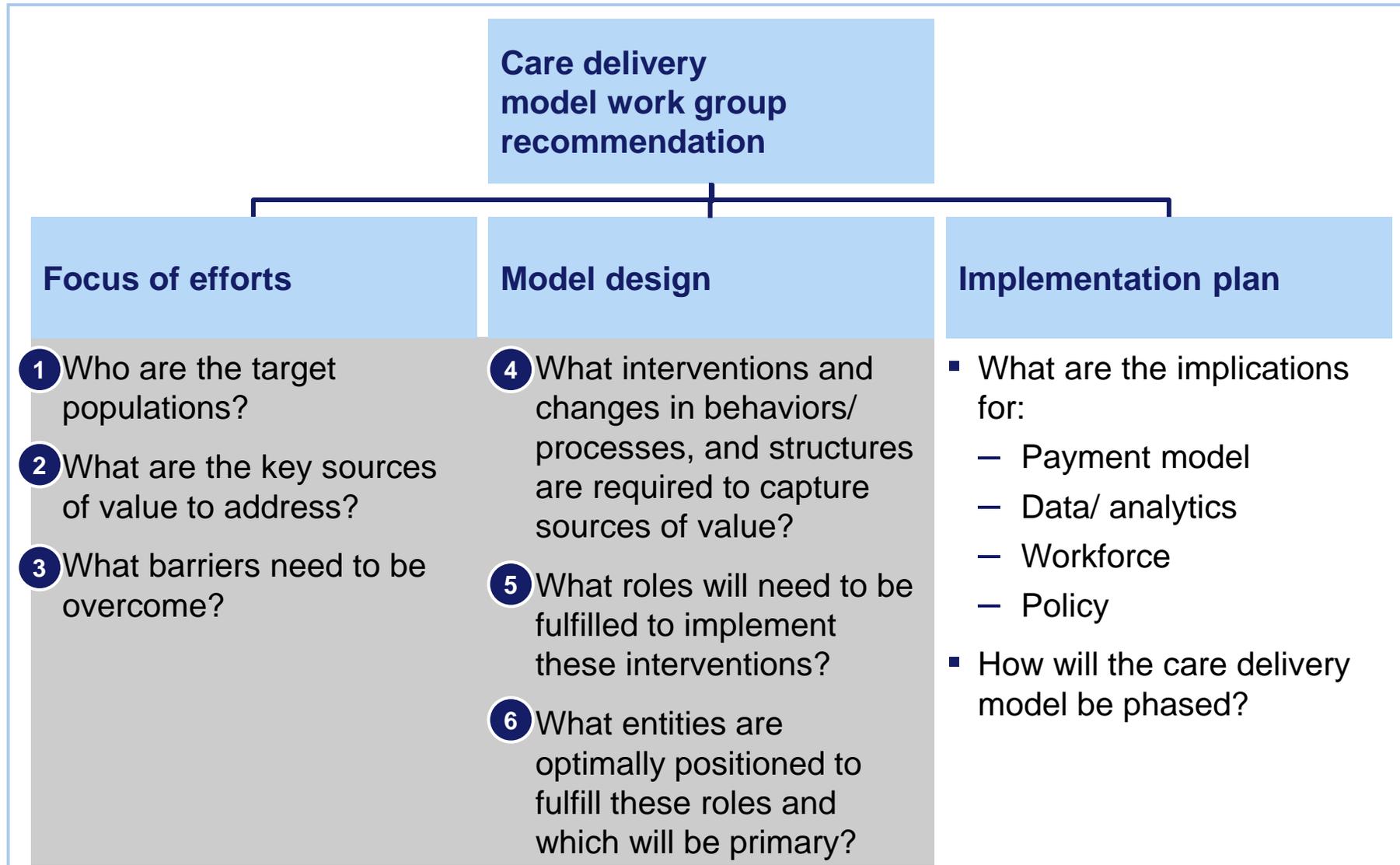
Instructions

- Provide feedback on the strawman care delivery answer for the SHIP
- Indicate level of your and your organization's support



Our answers to key questions led us to recommendations to the SHIP

■ For review today



1 Who are the target populations?

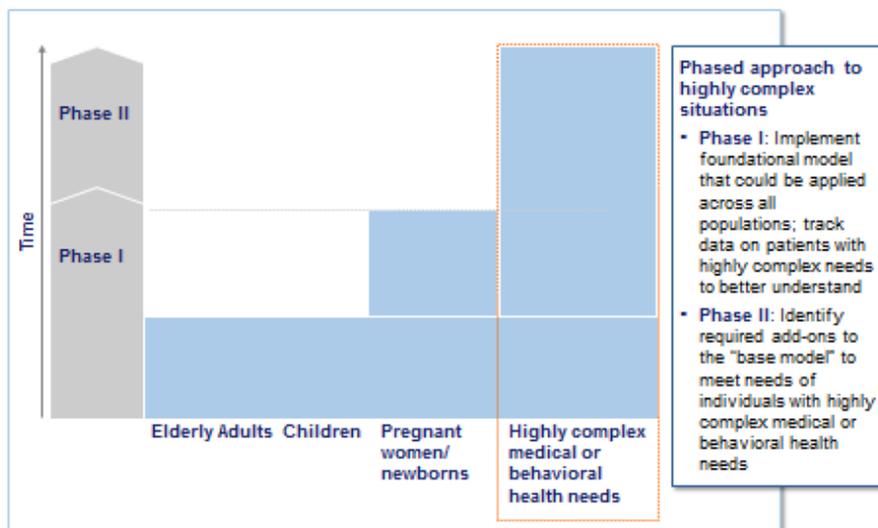
Connecticut will target the **foundational needs** of Connecticut's population with its new care delivery and payment model

Individuals with highly complex medical or behavioral health needs may require **additional layers of care-delivery innovation** to address their unique needs

Connecticut's foundational **medical home model** will make it possible for these "add-ons" to be layered on in later stages

This implies that patients currently receiving the majority of their care in **behavioral health homes** will remain there

We discussed designing a model that could be foundational across populations, with phasing in of add-ons to account for complexity



2 What are the key sources of value to address?

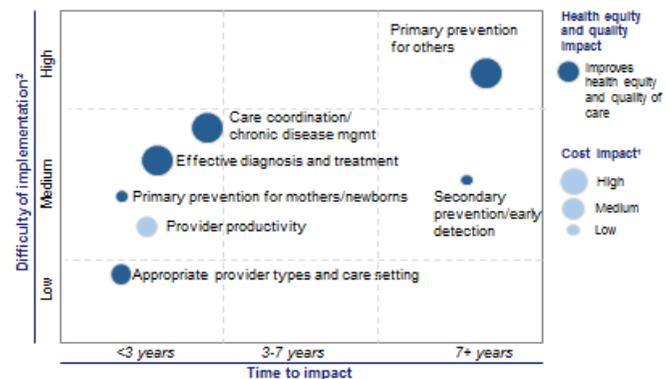
Connecticut’s population health, medical home model enables it to target multiple sources of value which represent **opportunities to remove waste and improve sub-par care in the current system**

Appropriate provider types and care setting, effective diagnosis and treatment selection, and care coordination/chronic disease management, will be prioritized due to their ability to **achieve cost, quality and health equity impact** within a short period of time (e.g., the time frame of the SIM testing grant) and be targeted with interventions broadly across the state; **for mothers and newborns, primary prevention will be prioritized**

Sources of value

	Description	Examples
Primary prevention	• Prevention of disease by removing root causes	• Smoking cessation • Diet and exercise
Secondary prevention/ early detection	• Early detection of disease while asymptomatic to prevent disease progression	• Cervical cancer screening • Identification and management of patients at high risk for heart disease
Appropriate provider types and care setting	• Utilizing highest value provider types and care settings	• Choice of care setting for immunization administration • Optimized utilization of physician extenders
Effective diagnosis and treatment selection	• Evidence-informed choice of treatment method/intensity	• Enforcement of evidence-based inpatient clinical pathways
Provider productivity	• Reducing waste at provider center	• Improve flow in OR to increase number of surgeries performed daily • Streamline emergency room triaging
Care coordination / chronic disease management	• Ensuring patients effectively navigate the health system and adhere to treatment protocols	• Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)

Prioritization matrix of sources of value



1 Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics
2 Includes assessment of historical success rates and execution risk

③ What barriers need to be overcome?

Connecticut's model will **overcome barriers** which arise at multiple stages of a consumer's health - well-state, diagnosis, treatment for either a chronic condition or acute condition, post treatment care

- Lack of **whole person-centered care** and population health management
- **Restricted access** to appropriate care
- **No team-based** coordinated comprehensive **approach** to care
- **Limited consumer engagement**
- **Insufficient use of evidence-informed** clinical decision making
- **Inadequate performance management**

Barriers identified fall into 6 categories (1 of 2)

	Barriers
① Lack of whole-person-centered care and population health management	<ul style="list-style-type: none"> • Lack of understanding of whole-person context (social, cultural, behavioral) • Limited access to whole-person data at point of care to promote more accurate diagnosis and treatment planning • Lack of infrastructure to risk-stratify consumers and prevent disease onset in high-risk consumers
② Restricted access to appropriate care	<ul style="list-style-type: none"> • 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 • Limited availability of culturally/ linguistically accessible care
③ No team-based, coordinated, comprehensive approach to care	<ul style="list-style-type: none"> • No single point of accountability for consumer's total care • Limited incentives for provider for admission, transfer, and discharge planning • Suboptimal or no triage process to direct consumers to right site of 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 lead to medical errors/ redundancies • No comprehensive treatment plan developed for consumers • Poor relationships and communication among providers

Barriers identified fall into 6 categories (2 of 2)

	Barriers
④ Limited consumer engagement	<ul style="list-style-type: none"> • Consumers lack incentives and are not enabled 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 have quality and cost data to inform decisions (e.g., visit highest value provider) • Consumers have difficulty being 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	<ul style="list-style-type: none"> • Best clinical practices not standardized • Limited health IT infrastructure to support clinical decision making • FFS reimbursement rewards overtreatment
⑥ Inadequate performance management	<ul style="list-style-type: none"> • Limited quality and cost transparency data • Multiple formats of information systems

4 What interventions and changes in behaviors/ processes, and structures are required to capture sources of value?

Connecticut's **state-wide population-health model** directly addresses barriers to high quality, high value care. The **medical home approach**, in which a primary care provider helps coordinate the entirety of a person's care, sits at the **cornerstone of the model**. This model will overcome barriers to access sources of value and **achieve high quality, low cost care**. The population-health model has six key components:

- 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

Prioritized list of interventions (1 of 2)

Prioritized interventions

- | | |
|--|--|
| 1 Whole-person-centered care and population health management | <ul style="list-style-type: none"> • Identify consumers with high-risk or complex care needs • Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors¹, behavioral health and other co-occurring conditions, and ability to self-manage care |
| 2 Enhanced access to care (structural and cultural) | <ul style="list-style-type: none"> • Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication • Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers • Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours) |
| 3 Team-based, coordinated, comprehensive care | <ul style="list-style-type: none"> • Provide team-based care from a prepared, proactive team • Integrate behavioral 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 treatment plan • Coordinate across all elements of a consumer's care |

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

Prioritized list of interventions (2 of 2)

Prioritized interventions

- | | |
|---|--|
| 4 Consumer engagement | <ul style="list-style-type: none"> • Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice • Use person centered care planning methods to develop and support implementation of self-management care plan • Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal |
| 5 Evidence-informed clinical decision making | <ul style="list-style-type: none"> • Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice—ensure data is actionable and timely • Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression) • Maintain disease registry • Implement evidence-based guidelines |
| 6 Performance management | <ul style="list-style-type: none"> • Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks • Use performance and consumer experience data to continuously improve whole person centeredness • Establish learning collaboratives to disseminate best practices |

5 What roles will need to be fulfilled to implement these interventions?

Connecticut's model will require a care team of **traditional and non-traditional health workers** providing a **whole person centered approach**. It will encourage various individuals to collaborate across primary, acute, specialist, community, and social care. It will particularly require **collaboration between primary care and behavioral health providers**

While it necessitates a team approach and collaboration across multiple provider types, Connecticut's **model is flexible** in that it does not define the leader, or composition, of care teams. Care teams should have a set of "**core providers**" **who provide primary care (e.g., PCPs, APRNs)** but the model does not impose any other limitations on the structure or exact composition of the care team, e.g.

- **Specialists, behavioral health providers, and physician extenders** can be included on the care team as the entity deems necessary
- The “leader” of the care team can be selected by each entity; **leadership may be fluid** and vary with consumer's health needs

⑥ What entities are optimally positioned to fulfill these roles and which will be primary?

Connecticut's model is **not prescriptive on the structure of participating provider entities** as it is designed to meet providers where they are and **support them in their transformation** towards managing the care of a population and achieving the triple aim. Providers will need to have a **sufficient volume of patients** in aggregate to achieve statistical significance when measuring performance.

Connecticut will define practice standards, phased over time, which encourage practices to **transform towards managing total cost of care**. These standards will be largely drawn from NCQA, AAAHC, URAC, Joint Commission, CMMI and other national standards which will be tied to practice transformation support. The models' initial **barrier to entry will be low** (e.g., self-assessment and statement of commitment) for initial period of program. Standards will **become increasingly rigorous and outcome based** over time to guide practices on their path towards managing the total cost of care. Practices which are already nationally accredited will **not have to duplicate accreditation**, but rather may have to meet a few additional standards.

As long as entities have lead provider and meet pre-qualification criteria we outlined, we are not prescriptive about required levels of integration

	Advanced primary care model			Integrated delivery network		
	Single PCP	PCP practices	Geo-centric risk pool of PCPs/ practices	Integrated groups of PCPs/ practices	+ Specialists/ behavioral health	+ Hospitals + Community orgs
Clinical integration						
Shared infrastructure (e.g., HIT)						
Financial integration (ability to bear risk, scope of accountability)						

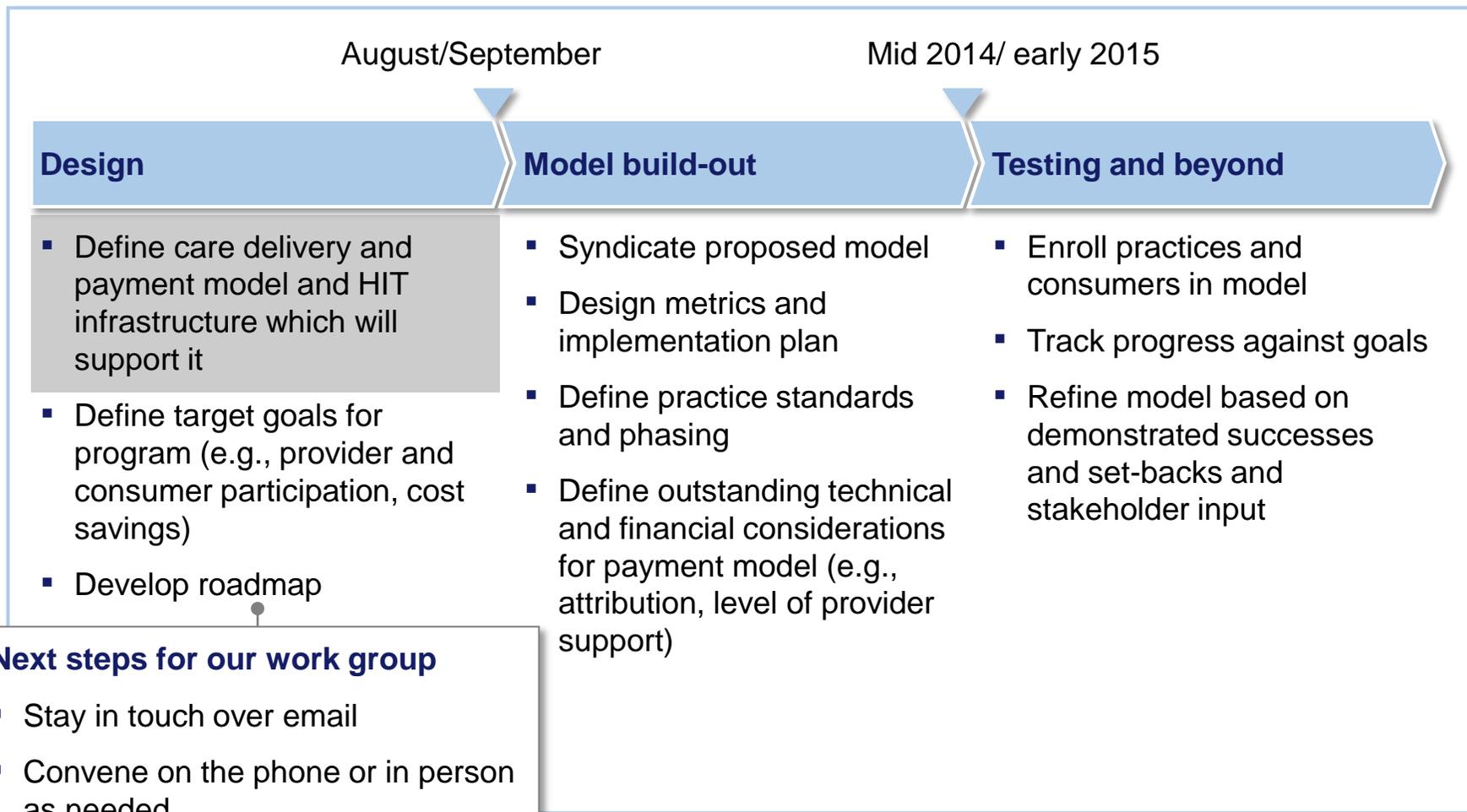
Differences in level of clinical/financial integration and data sharing have implications on how care is delivered and total cost of care is optimized

	Advanced primary care model			Integrated delivery network		
	Single PCP	PCP practices	Geo-centric risk pool of PCPs/ practices	Integrated groups of PCPs/ practices	+ Specialists/ behavioral health	+ Hospitals + Community orgs
Optimized referrals						
Negotiation of provider fees						
Improved coordination/standardization						
Optimized HIT and provider support tools						

Optimal for market with high level of provider variability
Optimal for market with less provider variability

During the remainder of the design and build-out phases, the SHIP and cross-work group team will refine and add detail behind recommendations

■ Completed



Next steps for our work group

- Stay in touch over email
- Convene on the phone or in person as needed
- Serve as ambassadors in our respective communities

The roadmap for the program will be refined by the SHIP, core team and work group co-chairs

ILLUSTRATIVE EXAMPLE

- ▼ Evaluation phase start
- ▼ Formal reviews by governing body

	2014	2015	2016	2017	2018	2019
Targets (cost impact, enrollment, impact on quality/patient experience, health inequalities)		30% patients treated by practices managing TCC		50% patients treated by practices managing TCC		80% patients treated by practices managing TCC
	Quality and patient experience targeted (structure & process)	Additional assessment of programmatic success against efficiency and outcomes based targets				
	Patient experience survey selected	Patient experience survey launched				
Accountability (metrics, practice standards)	Practice/ standards committee established	Continuous measurement and quality improvement				
	Full end-state metrics/ standards finalized					
HIT	Analytics engines (standardized across payers) set up to monitor provider performance	Providers educated on care management tools and have access to qualified vendor marketplace			HITE-CT established	
	Patient and provider portal established					
Workforce development	To be determined by UCHC workforce task force					
Transformation support	Regional provider collaboratives and transformation support launched			State wide provider collaboratives and support publishing of best practices achieved		
	Services provided by community-based support entities defined	Community-based support entities certified by DPH	DPH certified community-based support entities launched and continuously improved			
	Regulatory/policy changes implemented	Ongoing policy review and improvement				

Appendix

Ideas to improve inequalities in access to care

Improve inequalities

- Need to consider poverty, lack of living wages, housing, environmental issues, public safety (i.e. violence, have safe parks and walking trails)
 - Incorporate public/population health considerations into medical/health care

Leverage technology

- The Connecticut Hospital Association (CHA) technology allows geographic information system (GIS) mapping for hospital admissions, diagnoses, ER visits, etc. This data can be integrated with local city/town and state GIS systems (and Google) to link environmental, public health, crime and safety, economic development, poverty, health professional shortage areas, medically underserved areas and other systems to focus on Population Health with PCMH and individual patient health and outcomes

Understand CT's workforce

- Need to get a better handle on who the community health workers (CHWs) (umbrella term) are in CT across all of the state agencies and community based organizations (survey)
- Consider multiple roles of CHWs and certification/credentialing/registry requirements

Ensure model is culturally sensitive

- Ensure model is culturally sensitive (e.g. medical interpreters available, patients educated on how to advocate for themselves)
 - Ensure all workers who interact with patients (e.g., physicians, front desk staff etc.) are culturally sensitive

Eliminate silos

- Encourage elimination of siloes of effort across multiple stakeholders in the state (e.g., tobacco cessation programs at DPH, DSS, DHMAS, insurers, community based organizations, hospitals) by better integrating and improving communication channels
 - Includes eliminating silos between DPH, DSS, DHMAS, DDS, DCF, even Public Safety, Economic Department etc.

Recommendations to refine specific elements of model

Adapt solution for multiple care settings

- Work group discussed how care model is changing in the ambulatory setting but need to consider how model will work in other care settings (e.g., nursing homes)

Consider consumers receiving insurance for first time

- Need to consider dynamics of populations not traditionally covered by insurance entering insured population in 2014
 - Consider how this shift will impact the cost equation of population health model
 - Support with data analytics
 - Consider soliciting feedback on model from consumers currently uninsured to understand their risk profile and how they will fit into the new care model

Ensure infrastructure supports care delivery and payment models

- Ensure Connecticut's infrastructure can meet the needs of the proposed care delivery and payment models
 - Account for IT system support provided by Connecticut's Health IT Regional Extension Center (HITREC)

Ideas to improve model and support providers

Innovate patient education

- Begin education in the waiting room by streaming content via a “clearinghouse”
 - Television with brief, engaging videos about common health and medical problems and current issues in the media
 - Tablets or kiosks that allow patients to choose topics specific to their health
-

Partner primary care with population health

- Take advantage of opportunity to advance the role of the Department of Health (DPH) to actively engage with primary care practices with needs assessments and education regarding programs available to the practices (state or community specific)
 - Support concept of DPH community based support entities
-

Support CT specific practice standards

- Support idea of CT developing own standards which establish a low initial threshold for participation and provide practices support to achieve transformation within 5 years
-

Support providers in transformation

- Make a successfully completed application available online for reference
- Offer on-site training to aid completing the application and making required clinical changes
- Establish learning collaboratives

Provider needs and overall recommendations

Ensure care team works at the top of their license

- Ensure workers operate at the top of their license which will likely will require practices to employ or have access to care managers
 - Consider leveraging creative models to enable sharing of care managers across practices

Offer provider education and share best practices

- The Connecticut team which assesses compliance with practice standards can facilitate sharing of best practices(e.g. ,care manager learnings) and provider networking

Share data on specialists to optimize referral patterns

- Provide PCPs data on specialists in their area to optimize referrals
 - Ideally data would include cost of care provided (by condition if possible), utilization (e.g., high cost imaging), quality (e.g., HEDIS measures) and patient satisfaction (survey based)
 - Can also share data with specialists to enable them to improve

Ensure integration of BH and primary care

- Consider defining practice standards which define relationship between the PCP and behavioral health (BH) provider
- Ensure behavioral health costs are included in total cost of care
 - Share data on BH provider cost, utilization, quality and patient satisfaction

Ideas to improve inequalities in access to care

Co-locate primary care practices at hospitals

- Target emergency department (ED) overuse by co-locating culturally competent (e.g., similar ethnic and cultural backgrounds to local population) primary care practices with hospitals
- Offer “one stop shop” for medical, behavioral health services and ancillary services (e.g., labs, imaging)
- Provide social service support (e.g., help completing application for Medicaid, and forms for other social services)

Establish community healthcare centers

- To improve geographic access to care, establish community healthcare centers in rural and urban areas currently underserved
 - Use city/state partnerships
 - Consider repurposing old buildings to reduce cost

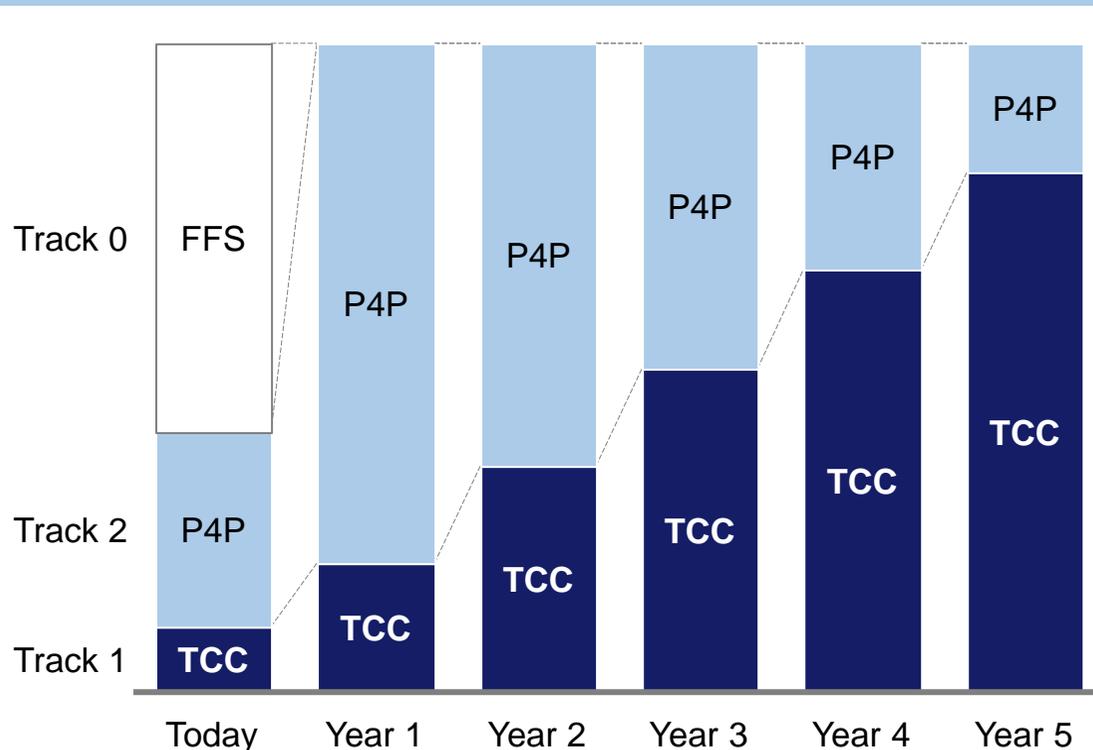
Co-locate grocery stores with primary care

- Increase consumers’ access to healthy foods by co-locating a small grocery store near primary care practice in the hospital and in community health centers in rural / urban areas
 - Stock grocery store with fresh fruits/vegetables and other healthy food choices
 - Consider offering incentives to purchase healthy foods
 - Consider expanding program by establishing farmers markets in low income urban areas to encourage healthy eating (e.g., fresh produce, etc.)

The payment work group aligned on a two-track approach to enable these smaller practices to eventually manage total cost of care

ILLUSTRATIVE

Proportion of consumer population



Work group to define necessary milestones (e.g., provider adoption, legislative action to facilitate transformation) over 3-5 years of testing grant in upcoming sessions

Definitions

- **Fee for service (FFS):** a discrete payment is assigned to a specified service
- **Pay for performance (P4P):** physicians are compensated based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)
- **Total cost of care (TCC):** agreement to share responsibility for the value of patient care by tying a portion of payment to achievement of total cost and quality metrics

Specific characteristics of CT model to be defined by work groups in upcoming sessions

Note: Total Cost of Care model (TCC) may include upside gain sharing, full risk sharing, and/or capitation and does not assume a level of provider integration

The HIT work group is proposing staged technical provider support and considering how some may be offered as shared services

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 yrs)	Stage 3 (3+ yrs)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify 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
Provider-payer-patient connectivity	Multi-payer online communication tool for providers to receive static reports; basic patient portal to allow consumers to enter quality metric data	Bi-directional provider-payer communication tool with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange ¹ solutions	Potentially integrate state-wide Health Information Exchange ¹

¹ HITE-CT will drive adoption of provider-provider connectivity tools and eventual creation of a state-wide health information exchange

SOURCE: HIT workgroup discussions