

A decorative graphic in the top-left corner consisting of a grid of overlapping squares. Some squares are solid blue, while others are semi-transparent with a fine grid pattern, creating a layered effect.

Connecticut SIM: SHIP steering committee

July 8, 2013

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

Contents

- **Outline of State Healthcare Innovation Plan requirements**
- Overview of relevant work group recommendations to date
- Program planner update
- Discussion on stakeholder engagement

State Healthcare Innovation Plan: Detailed requirements

■ Detailed in following pages

Requirement	Description
A State goals	<ul style="list-style-type: none">▪ Vision statement▪ Current status and future plan for care delivery/ payment model, and performance
B Description of state health care environment	<ul style="list-style-type: none">▪ Population demographics and health status▪ Existing in-state health care initiatives▪ Current health care cost and quality levels and trends▪ HIT environment
C Report on design process deliberations	<ul style="list-style-type: none">▪ How stakeholders were engaged and their input solicited
D Health system design and performance objectives	<ul style="list-style-type: none">▪ Description of performance targets for cost, quality, and population health▪ Goals for improving care and population health, reducing costs
E Proposed payment and delivery system models	<ul style="list-style-type: none">▪ Proposed payment and service delivery models▪ How payers, providers, and other key participants will be encouraged to participate in new model

SOURCE: Notice of Award, Attachment B, Section 9

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State Healthcare Innovation Plan: Detailed requirements

■ Detailed in following pages

Requirement	Description
F Health information technology	<ul style="list-style-type: none"> ▪ HIT model to support care delivery and payment model¹ ▪ How providers, especially rural providers, small practices, and BH providers, will develop HIT through CT SIM and other state initiatives ▪ Cost allocation plan or methodology ▪ Impact on MMIS (Medicaid Management Information Systems), including implementation timelines
G Workforce development	<ul style="list-style-type: none"> ▪ Gap in workforce supply and demand¹ ▪ Strategies to improve effectiveness, efficiency, and appropriate mix of health care workforce
H Financial analysis	<ul style="list-style-type: none"> ▪ Addressable costs and projected cost savings by population ▪ Required level of investments and projected ROI ▪ Plan for sustaining model over time
I Evaluation plans	<ul style="list-style-type: none"> ▪ Plans to enable CMS evaluation of SHIP, including identification of data sources and of a research group to assist in program evaluation
J Roadmap for health system transformation	<ul style="list-style-type: none"> ▪ Timeline for transformation ▪ Policy, regulatory, and/or legislative changes needed to implement SIP ▪ Federal waiver or State plan amendments needed to implement SIP, and associated timing

¹ Not specifically specified in SHIP requirements, but is an implicit requirement

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Emerging care delivery work group recommendations

Target populations

- Establish a foundational model that meets the general needs of all patient populations; anticipate additional set of interventions to be developed in future years to meet specialized needs of sub-populations with complex care needs

Sources of value

- Address all sources of value, with emphasis on selection of provider types and care setting, effective diagnosis and treatment selection, and care coordination/chronic disease management; for pregnant women/newborns, special emphasis on primary prevention

Core components of new care delivery model

- Roll-out a whole-person-centered medical home model that promotes:
 - 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

Provider eligibility for participation

- Encourage broad participation by setting the bar for entry low (e.g., self-assessment) but phase in CT-selected practice guidelines as requirements for continued support for any entity choosing to participate in the model

Emerging payment work group recommendations

Reward structure and pace of roll-out

- Adopt a “two-track” model to enable providers to participate in payment reform:
 - Track 1: Providers unable to adopt TCC enter “on-ramp” pay-for-performance (P4P) model to build TCC capacity by years 3-5 of testing grant
 - Track 2: Providers capable of doing so will adopt total cost of care (TCC) based payment model immediately

Metrics

- Develop initial scorecard comprised of CMMI core measures and work group additions to track performance against prioritized interventions; hold providers accountable for quality in year 1, and both quality and savings in future years

Level of performance

- Reward providers for both absolute performance and performance improvement (example: all providers eligible to receive payment based on performance improvement, with increasing potential payout based on absolute performance)

Performance aggregation

- Aggregate performance across payers/purchasers, and across providers to the extent necessary to achieve minimum patient volumes to support P4P and TCC performance measurement (methods of aggregation to be determined)

Emerging HIT work group recommendations

Capabilities required in new model

- Payer tools to analyze claims data to manage performance and payment
- Channels for patients and providers to access/submit health information
- Provider tools and analytics to coordinate medical services for patients
- Integrated clinical data exchange among providers via a secure, electronic network

Existing capabilities and initiatives that can be leveraged

- Existing payer/provider analytics and experiences as part of PCMH/ACO pilots
- Patient and provider portals currently hosted by payers
- DMHAS care mgmt. experience/tools used to manage behavioral health populations
- HITE-CT promoting point-to-point connectivity; localized HIE solutions, eHealthConnecticut
- State data assets and initiatives, e.g., DPH and DSS databases, CT Data Collaborative, APCD¹

Level of standardization

- Standardized metrics/analytics/reports created by payers' independent infrastructure
- Consolidated portal for consumers/patients and/or providers to access and share information²
- Standardized care mgmt guidelines with flexibility for providers to select own technology/tools
- Standardized but not consolidated provider connectivity tools (e.g. direct messaging)

Roll out

- Continue to build on existing payer and provider population health analytics to establish full set of tools required in end-state (near term and ongoing effort)
- Develop or select/scale a single provider portal for use across multiple payers (near term)
- Potentially develop state relationships with 3rd party patient engagement tool vendors
- Deploy a range of solutions to enable providers at different levels of technology maturity to create care management capabilities:
 - Educate providers on process changes and technology adoption (near term)
 - Simplify procurement through creating a marketplace or pre-qualifying vendors (medium term)
 - Host shared service for providers to access basic care management capabilities (long term)
- Ensure alignment with eHealthConnecticut and HITE-CT strategies to accelerate EHR adoption and enable connectivity between providers (ongoing effort)

¹ Potential when established - led by Access Health CT

² Patient portal, while consolidated, could give consumers access to their payer's proprietary engagement/education tools

Emerging workforce taskforce recommendations

Workforce supply and demand

- At the aggregate level, the ratio of health care professionals per person in Connecticut exceeds that of the United States, but is low within sub-regions
 - In particular, the ratio of office-based primary care physicians per person in Connecticut exceeds that of the United States (72.3 PCPs per 100,000 vs. 59.9 per 100,000)
 - However, five of the state’s eight counties fall below the national PCP-population level: Litchfield, Middlesex, New London, Tolland, and Windham

New capabilities required

- The workforce data environment is highly limited today
 - Disparate data sources offering wide range in estimation of supply and demand
 - Lack of real-time capabilities to track supply and demand
- In coming weeks, the workforce taskforce will discuss several workforce strategies (e.g., learning collaboratives) to improve the capability level and mix of Connecticut’s workforce to achieve the aspiration of the care delivery model

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Program planner update



Next steps on the state health care innovation plan (SHIP)

- Continue to work with workgroups to define recommendations on remaining open questions
- Integrate work group recommendations into the State Healthcare Innovation Plan
- Share the draft State Healthcare Innovation Plan with the SHIP steering committee on July 29
- Prepare to syndicate with broader group of stakeholders in August and September



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Overview: stakeholder engagement

- We discussed in the last SHIP steering committee meeting the need to:
 - Gather input from a **wide range of stakeholders**: patients/ consumers, clinicians, hospitals/ facilities, community/ state agencies, employers
 - Engage with stakeholders in an **authentic and meaningful** way
 - Hear **directly from individuals** within the community as well as from organized entities
 - Meet individuals in forums that are **convenient and accessible** to them
 - Use materials that are **clear and easy-to-understand**
- We have made progress on the stakeholder engagement plan
 - Expanded the types of individuals involved in the workgroup, steering committee, and parallel process
 - Started to engage with individuals and providers in the broader community
 - Simplified materials to gather targeted input
- Stakeholder engagement, however, is a **dynamic process**. We ask for your feedback and for your support today to continue to shape and add to the existing efforts

We have updated the stakeholder engagement plan

Strategies	Description	Timing
a Involvement in work group, steering committee, and parallel process	<ul style="list-style-type: none"> ▪ Work groups. Committees of diverse stakeholders focusing on care delivery, payment, and HIT ▪ SHIP. Board guiding the SIM process and sharing insight into content 	<ul style="list-style-type: none"> ▪ Ongoing Monday meetings ▪ Meets next on 7/29
b Synthesis of past stakeholder outreach	<ul style="list-style-type: none"> ▪ Examination of pre-existing consumer and provider feedback on the healthcare system 	<ul style="list-style-type: none"> ▪ Ongoing review
c Broader consumer, clinician, and community engagement efforts	<ul style="list-style-type: none"> ▪ Pre-existing forums. Regularly convening groups of consumers, providers, and employers who can provide insight on their perspectives ▪ Focus groups. Organized sessions with consumer to explain and get feedback on specific components of the healthcare system and SIM ▪ E-campaign. Email, text, and online forums for individuals to submit feedback and input into CT SIM vision and model design 	<ul style="list-style-type: none"> ▪ Attended in June, continuing into July and onward ▪ Hold in July ▪ July/ August

We have expanded the group of stakeholders involved in work groups ...

	SHIP	CDWG	PWG	HITWG
Consumers		<ul style="list-style-type: none"> Gaye Hyre Dawn Johnson Sal Luciano 		
Providers	<ul style="list-style-type: none"> Frank Torti 	<ul style="list-style-type: none"> Jeffrey Howe Edmund Kim Adam Mayerson Robert McLean Lynn Rapsilber Elsa Stone 	<ul style="list-style-type: none"> Courtland Lewis Todd Staub Mike Taylor Susan Walkama 	<ul style="list-style-type: none"> Alan Kaye Barry Simon Jonathan Velez
Hospitals	<ul style="list-style-type: none"> Tom Raskauskas 		<ul style="list-style-type: none"> William Gedge Tom Raskauskas Robert Smanik 	
Community organizations/agencies	<ul style="list-style-type: none"> Pat Baker Roderick Bremby Kevin Counihan Anne Dowling Anne Foley Jewel Mullen Frances Padilla Patricia Rehmer Fredricka Wolman 	<ul style="list-style-type: none"> Daren Anderson Mehul Dalal Meredith Ferraro Alice Forrester Thomas Woodruff William Young Robert Zavoski 	<ul style="list-style-type: none"> Paul DiLeo Kate McEvoy Lori Pasqualini Thomas Woodruff Jill Zorn 	<ul style="list-style-type: none"> John DeStefano Daniel Maloney Dan Olshansky Mark Raymond Mark Root Minakshi Tikoo James Wadleigh Joshua Wojcik
Employers	<ul style="list-style-type: none"> Mary Bradley 	<ul style="list-style-type: none"> Laurel Pickering 	<ul style="list-style-type: none"> Mary Bradley 	
Payors	<ul style="list-style-type: none"> Raegan Armata Bernadette Kelleher Donna O'Shea 	<ul style="list-style-type: none"> Peter Bowers Donna O'Shea Rosemary Sullivan 	<ul style="list-style-type: none"> Bernadette Kelleher Kathy Madden Melissa Pappas Joseph Wankerl 	<ul style="list-style-type: none"> Daniel Carmody Bernadette Kelleher Mike Miller
Others	<ul style="list-style-type: none"> Michael Michaud Bettye Jo Pakulis Mark Schaefer Vicki Veltri Nancy Wyman 	<ul style="list-style-type: none"> Mark Schaefer 	<ul style="list-style-type: none"> Vicki Veltri 	<ul style="list-style-type: none"> Michael Michaud Victor Villagra

... and started to engage with the broader community

Stakeholder groups	Event	Date	
Multiple	<ul style="list-style-type: none"> Medical Assistance Program Oversight Council meeting CT Multicultural Health Partnership event 	<ul style="list-style-type: none"> 6/14 (Attended) 6/20 (Attended) 	
	<ul style="list-style-type: none"> Behavioral Health CEO Meeting (CT Association of Nonprofits, CAN) United Community & Family Services (UCFS) Board Meeting Broader CAN outreach Eastern CT FQHC Board meeting OSC Health Care Cost Containment Committee 	<ul style="list-style-type: none"> 6/26 (Attended) 7/25 In progress In progress Monthly 	
Patients/ consumers/ families	HUSKY consumers	<ul style="list-style-type: none"> HUSKY consumer advisory board meeting (CHNCT) 	<ul style="list-style-type: none"> 7/09
	Mothers	<ul style="list-style-type: none"> Mothers lunch and learn (CHNCT) 	<ul style="list-style-type: none"> 7/11
	Seniors	<ul style="list-style-type: none"> Shelton AARP Focus Group AARP Advocacy Leadership Council Meeting 	<ul style="list-style-type: none"> Week of 7/08 9/09
	Teens	<ul style="list-style-type: none"> Teens' Forum (CHNCT) 	<ul style="list-style-type: none"> 7/17
	Faith-based groups	<ul style="list-style-type: none"> Christian Community Action Meeting 	<ul style="list-style-type: none"> 7/17
	Families	<ul style="list-style-type: none"> Family Advisory Board Meeting for DCF Region 3 	<ul style="list-style-type: none"> 7/13
Employers	<ul style="list-style-type: none"> BGH Council Meeting BGH Wellness Committee BGH Regional Seminar 	<ul style="list-style-type: none"> 6/07, 6/28 (Attended) Month of July 9/27 	

We have simplified questions for individuals to provide targeted input

Patients/consumers	Clinicians/hospitals	Community/ state agencies
<ul style="list-style-type: none">▪ 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?▪ <i>[Follow-up to prior question]</i> 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?	<ul style="list-style-type: none">▪ 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?	<ul style="list-style-type: none">▪ 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?▪ 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?

We have found it helpful to provide example patient stories to facilitate discussions (see Appendix)

Next steps on stakeholder engagement

- **Identify a dedicated facilitator to continue to engage with the broader community**
- **Define plan for continued community outreach, education, and engagement during testing phase**
- **Continuously improve stakeholder engagement – this is just the beginning**





APPENDIX

Care Delivery Workgroup

Learning from the Health Care Journey

A child with asthma

Kathy is a six year old girl whom comes 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 months after her discharge.

Care Delivery Workgroup

Learning from the Health Care Journey

A older man with a heart condition

Mr. Rodriguez is a 71 year old man who lives alone. He speaks English as a second language. He has Type 1 diabetes, high cholesterol and hypertension. He suffers a heart attack and is discharged home after a brief hospitalization. He has some difficulty hear and following conversations, and this was worse than usual on the day he left the hospital. He met with the discharge nurse, but recalls little of the details of his aftercare plan. He decides to resume all his pre-hospitalization medications and waits to hear from his cardiologist. He is readmitted to the hospital within one week.