

# Connecticut Health Care Cabinet (HCC)— Delivery System Innovation Work Group:

Summary of HIT and ACO presentations  
at HCC meeting of 2/14/2012

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# Summary of Presentations to HCC:

- Business Plan (coverage for un-insured) Work Group
  - Healthcare Information Technology (HIT) Work Group
  - Atrium Health's experience as an Accountable Care Organization (ACO).
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- Presentations available on HCC website  
<http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2742&Q=333890>

# Business Plan Work Group

Summary of presentation to HCC on 1/10/12

- **Co-Chairs:**
  - Ben Barnes, Secretary: Office of Policy and Management
  - Frances Padilla, EVP, Universal Healthcare Foundation of CT
  - Nancy Yedlin, VP, The Donaghue Foundation
- **Background**
  - Long history of health care reform
  - 2010 Sustinet Partnership board recommendations
  - Public Health Plan to drive delivery system innovation, improve health, and lower costs
  - Economic and political obstacles
  - PA11-53 creates Cabinet & charges it with developing a business plan for alternatives to private insurance to achieve same goals

# Connecticut Health Insurance Exchange

- Marketplace of health insurance products
  - Affordability and quality to uninsured, under-insured and small businesses
  - Data presented so far requires analysis, raises more questions
  - Who is still left out?
    - Small businesses with low wage workers?
    - Basic Health Program for those up to 200% FPL?
    - Are subsidies enough for high-cost state like CT?
    - Immigration status?

# Timeline

- ***Assessment Phase (through March)***: gather and analyze data
  - Mercer, Milliman, Census ACS, Medical Assistance Program Oversight Council, other sources
- ***Analysis & Recommendations Phase (through May)***: analyze, discuss findings from assessment, develop recommendations, refine, present draft recommendations to Cabinet
- ***Writing Phase (through Sept.)***: provide drafts for review & feedback, seek public comment, obtain Cabinet vote and transmit final report

# Health Information Technology Work Group

Summary of Interim Report to HCC, 2/14/12.

- Co-Chairs
  - Roderick Bremby Commissioner, DSS
  - Victor G. Villagra, MD, President H&T Vector
- Recommendations
  - Used the inventory [of State agencies, HIT assets, projects] as “case studies” to generate broad recommendations because most issues cut across all agencies
  - Focused on
    - Integrated architecture
    - Process and operational efficiencies
  - Service excellence to internal and external customers

# Recommendation regarding DSS:

- Upgrade or replace the EMS system to conform to CMS Exchange requirements
- Expand the scope of the EMS upgrade to meet the business needs of all the agencies (single eligibility system)
- Take advantage of the 90/10 federal dollars. (DSS is working with Gartner to plan for this opportunity)

# Recommendations regarding DPH:

- Upgrade, as necessary the interoperability capability of the three MU Provider-DPH interfaces required to meet MU criteria and HITE-CT standards:
  - Laboratory Information Management System (LIMS)
  - CT Immunization Registry and Tracking System (CIRTS)
  - Public Health Information Network Messaging (PHINMS)

# Recommendations regarding DHMAS:

- Seek funding to support a continuously operating forum where all users of HIT can:
  - Meet regularly
  - Maintain current their knowledge about new and emerging HI technologies.
  - Share best practices
  - Integrate existing technologies across agencies (e.g. Avatar)
  - Have operational capabilities: e.g.: create committees and sub-committees to develop shared plans, acquire and test new ideas/technologies

# Recommendations regarding HITE-CT:

- Support the leadership role of HITE-CTs in developing standard policies for:
  - Interoperability
  - Privacy
  - Security
  - Vocabulary
  - Transactions
  - Information content
  - Standard operating procedures
- Prioritize which of the agencies' IT systems are most critical to support health reform initiatives
- Develop a Master Patient Index
  - Maintain identity throughout the system
  - Build comprehensive longitudinal health records

## Recommendations for HITE-CT: (cont.)

- Accelerate the adoption of eHRs by all providers:
  - Seek and disseminate information about affordable electronic health record alternatives to proprietary systems, specifically open source electronic health records.
  - Develop a surveillance system for early identification of unintended widening the “digital divide” among providers based on lack of access to capital or other barriers.
- Develop standards/definitions pertinent to:
  - Data quality (coded, text, etc.)
  - Rules for data access and use (including derivative products and services)
  - Data ownership

# Recommendations for HITE-CT: (cont.)

- Develop tools and systems to support care coordination activities across providers, settings and “layers” of the health system
- Develop a system to support consumer/patient self-management knowledge and skills
- Develop technology systems that facilitate peer-peer support activities
- Develop technology systems that facilitate shared medical decision making

# Recommendations for HITE-CT: (cont.)

- Data elements, database configuration and consumer portal software should facilitate health plan comparisons based price, benefits design and features that enhance access, promote better health and meets patient personal needs such as access to:
  - High-quality (evidence based) health information
  - Decision support tools and services
  - Health Risk Assessment and predictive tools (health and cost)
  - Effective behavior change programs
  - Self-management tools (e.g. self-monitoring)
  - Peer and professional health support systems
  - Incentives/reward programs for adherence to preventive health recommendations, early detection programs, chronic and acute care management, compliance and other value-based benefits.

# Recommendations from Sustinet Committees and Task Forces carried forward by the HTWF:

- Preventive Services
  - Enable community-based preventive services (immunizations, lab tests, screenings). This will require electronic connectivity with Medical Homes
- Health Disparities Committee
  - Intake systems must capture race and ethnicity data
  - Data should support disparities reporting needs and management of incentives and penalties
  - Establish a disparities baseline using existing data

# Atrius Health, an Accountable Care Organizations (ACOs): Applied Lessons

- Marci Sindell, Chief External Affairs Officer
  - Beth Honan, Vice President, Contracting Atrius Health
- Non-profit alliance of six leading independent medical groups
  - Dedham Medical Associates
  - Granite Medical Group
  - Harvard Vanguard Medical Associates
  - Reliant Medical Group (Southboro, South Shore)
- Provide care for ~ 1,000,000 adult and pediatric patients
  - almost 50 ambulatory sites and 3,000,000 encounters
- 1000 physicians, 1450 other healthcare professionals across more than 35 specialties

# Atrius Health as an “ACO”

- Alliance established in 2004 with governance structure that matches Medicare ACO requirements
- Long history with global payments, with >75% of revenue currently from global payments across commercial, Medicare and Medicaid populations, managing risk across continuum
- One of first on BCBSMA Alternative Quality Contract
- One of 32 Medicare Pioneer ACOs

# Strong infrastructure to manage risk

- 100% on Electronic Health Record
  - Data warehouse has eligibility, claims and clinical information used for managing quality and cost.
  - Nearly all administrative transactions conducted electronically
  - Patient portal to communicate and expand access to 250,000 patients
  - *MyHealth* [portal]
  - Creating linkages to hospital partner EHR's
- 33 practices are Level 3 NCQA Patient-Centered Medical Homes
- Weekend and evening urgent care
- After hours telephone support using NPs and Pas
- Clinical pharmacy program
- Chronic disease management programs
- Many years experience with Pay-for-Performance (P4P)
  - Top performer on Massachusetts Health Quality Partners quality ratings
  - Over \$20m at risk annually based on Blue Cross AQC performance

# Payment Systems – Global Payment

- A “*per member per month*” (pmpm) payment made by the health plan made on a monthly basis for members that have selected an Atrius Health PCP.
  - happens whether or not we have provided services
  - typical Commercial “gross” capitation is @ \$400 pmpm, Medicare \$900 pmpm and Medicaid \$350pmpm
  - typical Commercial “net” capitation payment is 40% of the gross capitation payment, Medicare is closer to 30%
  - remaining 60% - 70% is kept by the health plan and paid out on our behalf to outside providers as services are delivered.
- Atrius Health global payments are adjusted for the specific patient population that has selected our PCP’s

# BCBSMA reports that AQC is significantly improving quality across network

- Year-1 improvements in the quality were greater than any one- year change seen previously in our provider network
  - Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures
  - AQC groups exhibited exceptionally high performance for all clinical outcome measures with *more than half approaching or meeting the maximum performance target* on measures of diabetes and cardiovascular care
  - There were no significant changes in AQC groups' performance on patient care experience measures overall
- Year-2 showed continued significant quality improvements among AQC groups relative to others
  - Some groups are nearing performance levels believed to be best achievable for a population

# Atrius Health ACO Strategies

- Foster culture of service to patient
- Strengthen our distributed physician leadership at all levels in the organization
- Create compact with staff at every level to clarify roles at top of license
- Continue our LEAN journey to improve quality, patient safety, patient experience, and reduce costs
- Implement & spread “new and improved” Patient Centered Medical Home, including management of high risk populations and next level of chronic disease programs
- Strengthen collaboration across specialists, hospitals, and post-acute care to be successful Accountable Care Organization without hospital ownership