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Care delivery model work group meeting #2

Discussion document
May 28, 2013

Today's points for review and decision-making

Review



- **SHIP's vision** for care delivery, payment and HIT innovation
- Care delivery work group **roadmap/ calendar** through August
- **Synthesis of first work group** discussion
 - Early hypothesis on population health model +/- episodes
 - Sources of value: Cost impact, timing, and feasibility of capture based on literature review
 - Brainstorm exercise on major barriers to care for select sources of value

Align and finalize



- **Prioritized, Connecticut-specific barriers to health** that we want to address
- Prioritized **sources of value** that our model will address, triangulated across literature review and CT-specific barriers

SHIP provided guidance on a vision for care delivery, payment, and HIT innovation



Strawman vision

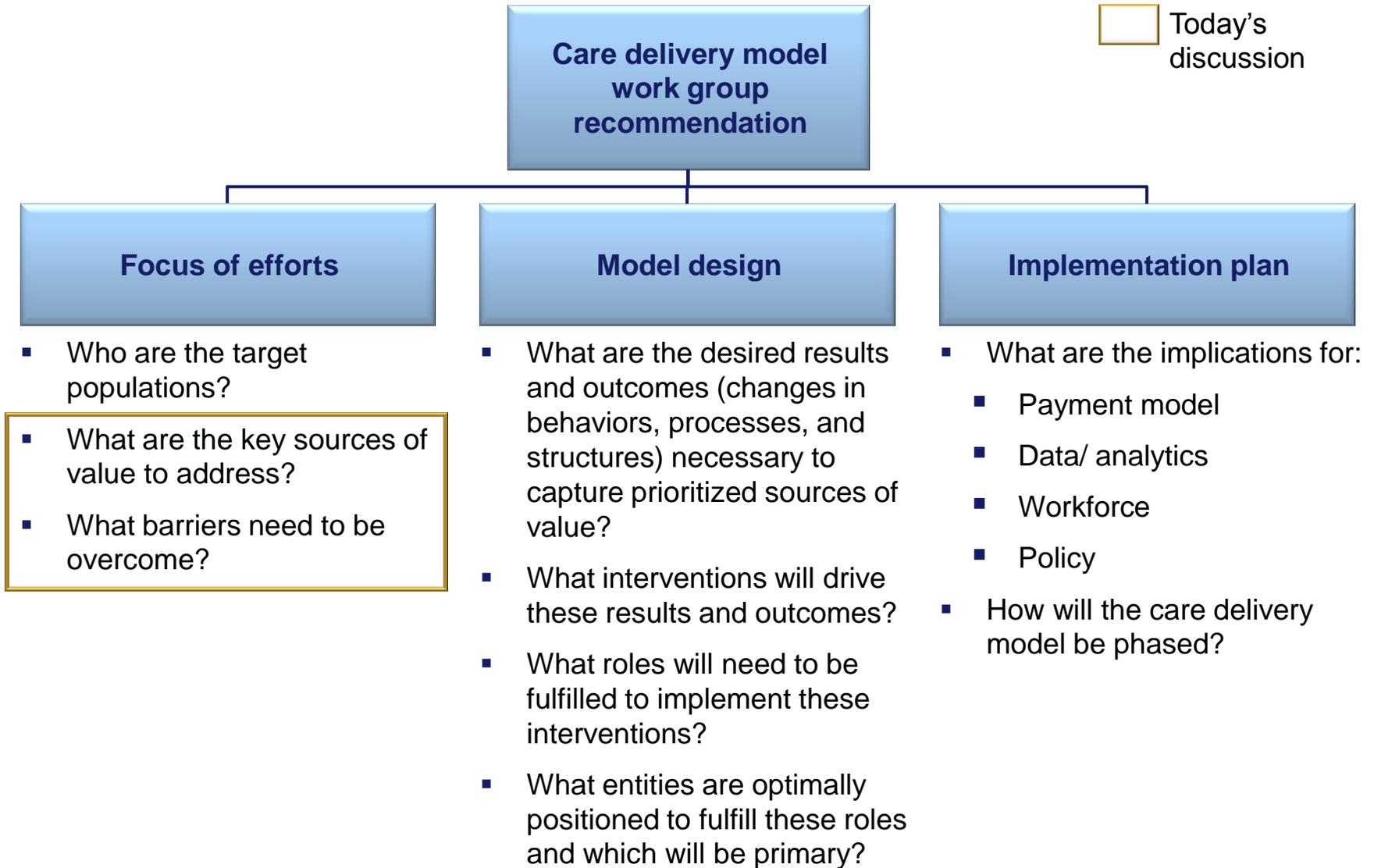
Establish a person-centered healthcare system that improves affordability, promotes value over volume, and reduces health inequities for all of Connecticut

- Integration of primary care, behavioral health, population health, consumer engagement, and community support
- Shared accountability for the total cost and quality of healthcare
- Increased access to the right care in the right setting at the right time
- Migration to 21st-century healthcare workforce and health information technology that promotes usability at the point of care
- Supported by Medicaid, Medicare, and private health plans alike



The care delivery work group will address the following questions

 Today's discussion





The set of interventions we define will inform care delivery, payment, and HIT innovation design



Enablers

Care delivery

Workforce strategy

- Define roles and responsibilities
- Conduct capabilities assessment
- Define strategies to fulfill capability/ capacity gaps

Community outreach, education, engagement

- Define how patients and communities will be incorporated into new care delivery model

Roll-out

- Define 3-5 year roll-out plan and pace

Payment

Metrics

- Define metrics and scope of accountability

Payment

- Define incentives/ reward structure

Attribution

- Define rule for attribution

Roll-out

- Define 3-5 year roll-out plan and pace

HIT

Identify relevant current HIT capabilities

- Leverage existing assets

Standardize across stakeholders

- Apply integrated approach as possible

Roll-out

- Define 3-5 year roll-out plan and pace



The care delivery work group process will span the next eight weeks with analysis and prep work in between

Workshop title

Description

May 28: Barriers to care and sources of value

- Review SHIP's vision for care delivery, payment and HIT innovation
- Discuss barriers to achieving good health in the context of the patient journey
- Discuss and prioritize barriers as well as sources of value in care delivery

June 10: Interventions to eliminate barriers and required roles

- Define interventions to address barriers
- Define roles and responsibilities required to conduct interventions in the new care delivery model
- Identify who could play these roles across payers, providers and community

June 24: Defining workforce needs

- Discuss how entities involved in health delivery can work together
- Review workforce capacity and capabilities against needs of new care delivery and payment model
- Discuss tools and other enablers required to support individuals in new delivery model

July 8: Defining tools and enablers

- Define how tools and enablers will be developed and/or promoted for future development
- Discuss strategy for meeting workforce capacity and capability needs

July 22: Implementing the care delivery model

- Align on care delivery implementation plan with phasing, including plan to support provider transition
- Align on communication plan

We discussed the idea of pursuing a population health model as the foundation for care delivery innovation



Leading hypothesis and rationale

- **Lay foundational care delivery model that is population-health based**
 - Builds on ongoing efforts in state (e.g., Medicare ACOs, Anthem PCMH, Cigna ACO, Medicaid PCMH)
 - Is in-line with CMMI guidelines of reaching 80% of the population within 5 years
 - Addresses health access inequities by encouraging comprehensive care
- **Consider whether to layer on episodes to target high opportunity procedures/ conditions**
 - Episodes represent targeted, near-term cost saving opportunity but require significant investment of time and effort to scale
 - Each individual episode requires significant episode-specific effort to design
 - Requires significant coordination and buy-in of specialists
 - Potential exists to consider select high opportunity episodes as supplementary to a population-health model, but ability to meet high resource and investment requirements of episode-design will need to be weighed

For discussion

- How aligned are we on population health models serving as the foundation?
- Any reservations about the model?
- What is our ingoing hypothesis on ability to phase-in episodes?

Today we will continue our discussion on prioritizing sources of value by focusing on your patient stories and barriers specific to CT

LAST WEEK

THIS WEEK

1 Leverage examples and experience of others

Prioritize sources of value based on literature review that informs cost impact, timing, and feasibility of capture

Source of Value	Time to Impact	Difficulty of Implementation	Health Equity Impact	Cost Impact
Primary prevention for others	7+ years	High	Improves health equity and quality of care	High
Care coordination/chronic disease mgmt	3-7 years	Medium-High	Improves health equity and quality of care	Medium
Effective diagnosis and treatment	3-7 years	Medium	Improves health equity and quality of care	Medium
Primary prevention for mothers/newborns	<3 years	Medium-Low	Improves health equity and quality of care	Low
Provider productivity	<3 years	Low-Medium	Improves health equity and quality of care	Low
Selection of provider type and care setting	<3 years	Low	Improves health equity and quality of care	Low
Secondary prevention/early detection	7+ years	Low-Medium	Improves health equity and quality of care	Low

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

2 Define barriers CT needs to address and how those map to sources of value

Prioritize sources of value based on barriers specific to Connecticut

STAGES OF HEALTH

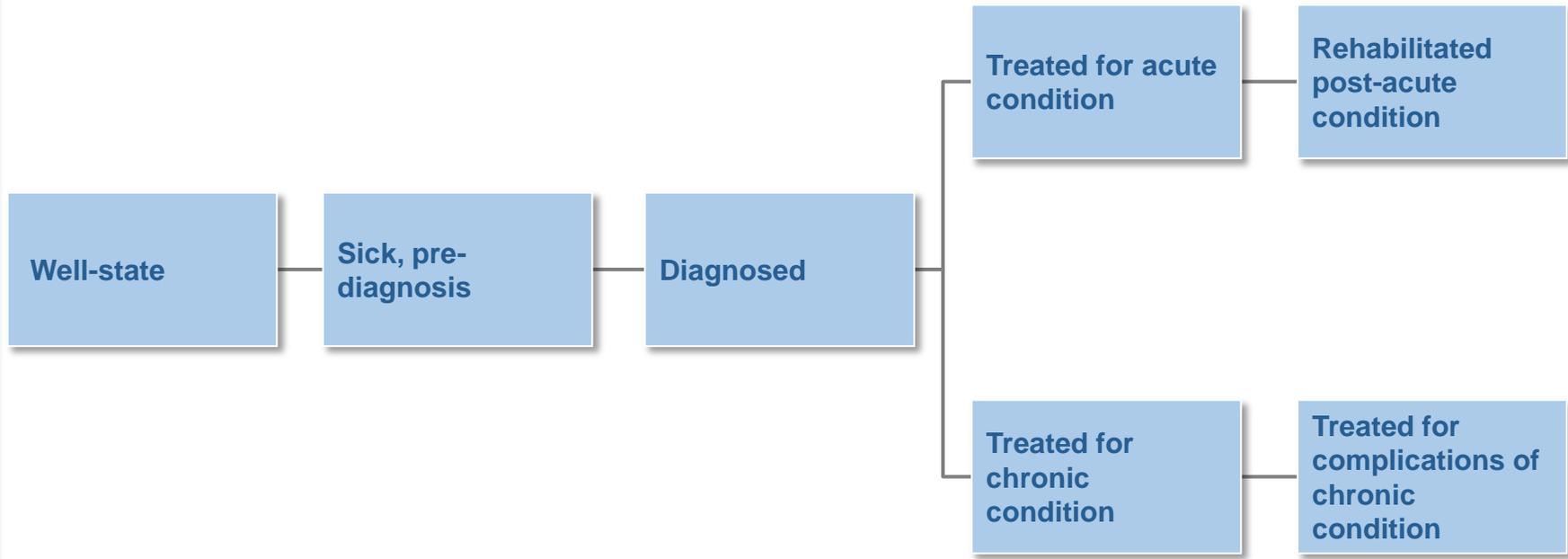
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    Well-state --> Sick and asymptomatic --> Diagnosed
    Diagnosed --> Treated for acute condition --> Rehabilitated post-acute condition
    Diagnosed --> Treated for chronic condition --> Treated for complications of chronic condition
    
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PRIORITIZED SOURCES OF VALUE FOR CONNECTICUT

2 We will discuss the broader set of barriers in Connecticut across the stages of health to help prioritize sources of value (1 of 3)

STAGES OF HEALTH



2 We will discuss the broader set of barriers in Connecticut across the stages of health to help prioritize sources of value (2 of 3)

Categories of barriers

	Description	Examples
Sub-optimal behaviors	<ul style="list-style-type: none"> What are the provider (i.e., clinicians) and patient behaviors that are not contributing to optimal health today? 	<ul style="list-style-type: none"> Limited use of evidence-based practices among physicians/ practitioners Consumers do not follow-through on chronic care management plans
Ineffective processes	<ul style="list-style-type: none"> What are the procedural limitations (e.g., patient flow, information/data flow, clinical interactions) that are contributing to sub-optimal patient and provider behaviors? 	<ul style="list-style-type: none"> Absence of care team meetings to review risk stratified patient registries Lack of post-acute event conversations between acute and primary care providers
Misaligned structures	<ul style="list-style-type: none"> What are the barriers that exist in the workforce, organization of providers, HIT, and other infrastructure today that prevent optimal patient and provider behaviors? <ul style="list-style-type: none"> Workforce competencies, capacity, and management Delivery setting Physical space Governance and organization changes Incentives 	<ul style="list-style-type: none"> Lack of networks to support care coordinators across multiple practices Limited IT system capabilities to share data across care settings

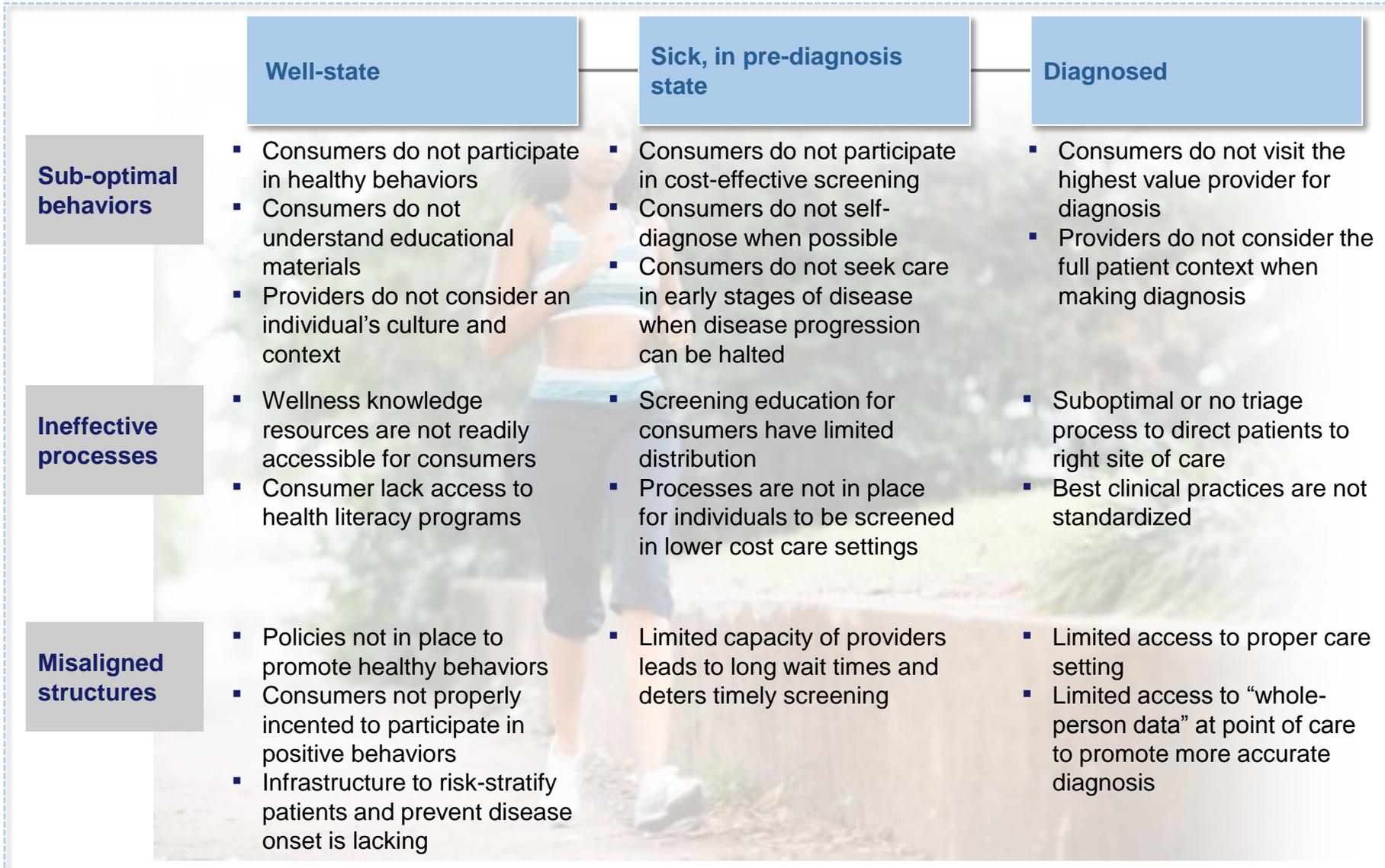
2 We will discuss the broader set of barriers in Connecticut across the stages of health to help prioritize sources of value (3 of 3)

BREAKOUT EXERCISE INSTRUCTIONS

- **Group discussion:** Discuss barriers along stages of health through the story of an individual (*15 min*)
- **Breakout:** Breakout into 3 groups to share personal stories and map barriers along patient journey (*20 min*)
 - Review starter list of barriers along stages of health that have been provided as a conversation starter
 - Add to and refine the list as necessary through patient story examples
 - Prioritize five of the barriers in your refined list
 - Note: refer to handouts for starter list of barriers identified in the last work group meeting
- **Group debrief:** Each group to report out synthesis for full team discussion (*25 min*)
 - Can you share a patient story that illustrates barriers?
 - What barriers along the stages of the patient journey did you discuss?
 - Which five did you prioritize and why?
 - How do these barriers map to the sources of value along the stages of health?
 - How does this mapping impact your prioritization of the sources of value?

BREAKOUT GROUP 1: What are some of the barriers we see across the stages of health prior to treatment?

POSTER



BREAKOUT GROUP 2: What are some of the barriers we see across the stages of health during treatment of acute conditions?

POSTER

Treated for acute condition

Rehabilitated post-acute condition

Sub-optimal behaviors

- Consumers do not ask the provider for highest value treatment
- Providers do not consider value of selected treatment

- Consumers do not adhere to rehab plans
- Providers do not follow-up with consumers
- Providers do not engage the community in a patient's rehab plan

Ineffective processes

- Limited access to “whole-person data” at point of care to promote more accurate treatment
- Lack of standardization in best clinical practices

- Poor peer to peer provider relationships lead to redundancies and inefficient patient hand-offs

Misaligned structures

- Limited quality and cost transparency data
- Limited health IT infrastructure to support clinical decision making
- FFS reimbursement rewards overtreatment with consequences for patient (e.g., iatrogenic effects of surgery, CT scan, etc.)
- No single point of accountability for outcomes
- Limited access to “whole-person data” at point of care to promote more accurate treatment

- Limited incentives for acute care provider to follow patient's care through rehab

BREAKOUT GROUP 3: What are some of the barriers we see across the stages of health during treatment of chronic conditions?

POSTER

Treated for chronic condition

Treated for complications of chronic condition

Sub-optimal behaviors

- System does not consider the patient as a 'whole person'
- Consumers do not ask providers for care coordination
- Providers do not interact with the consumer's community in chronic condition treatment plan

- Consumers and providers do not use telephonic or other remote care providers
- Providers do not coordinate with each other in management of comorbidities
- Providers do not engage the community in the chronic care plan
- Consumers are not engaged in self-care

Ineffective processes

- Lack of touch points between provider and members of the community who could support care plan
- Limited communication channels/ processes among patient and other providers involved in care

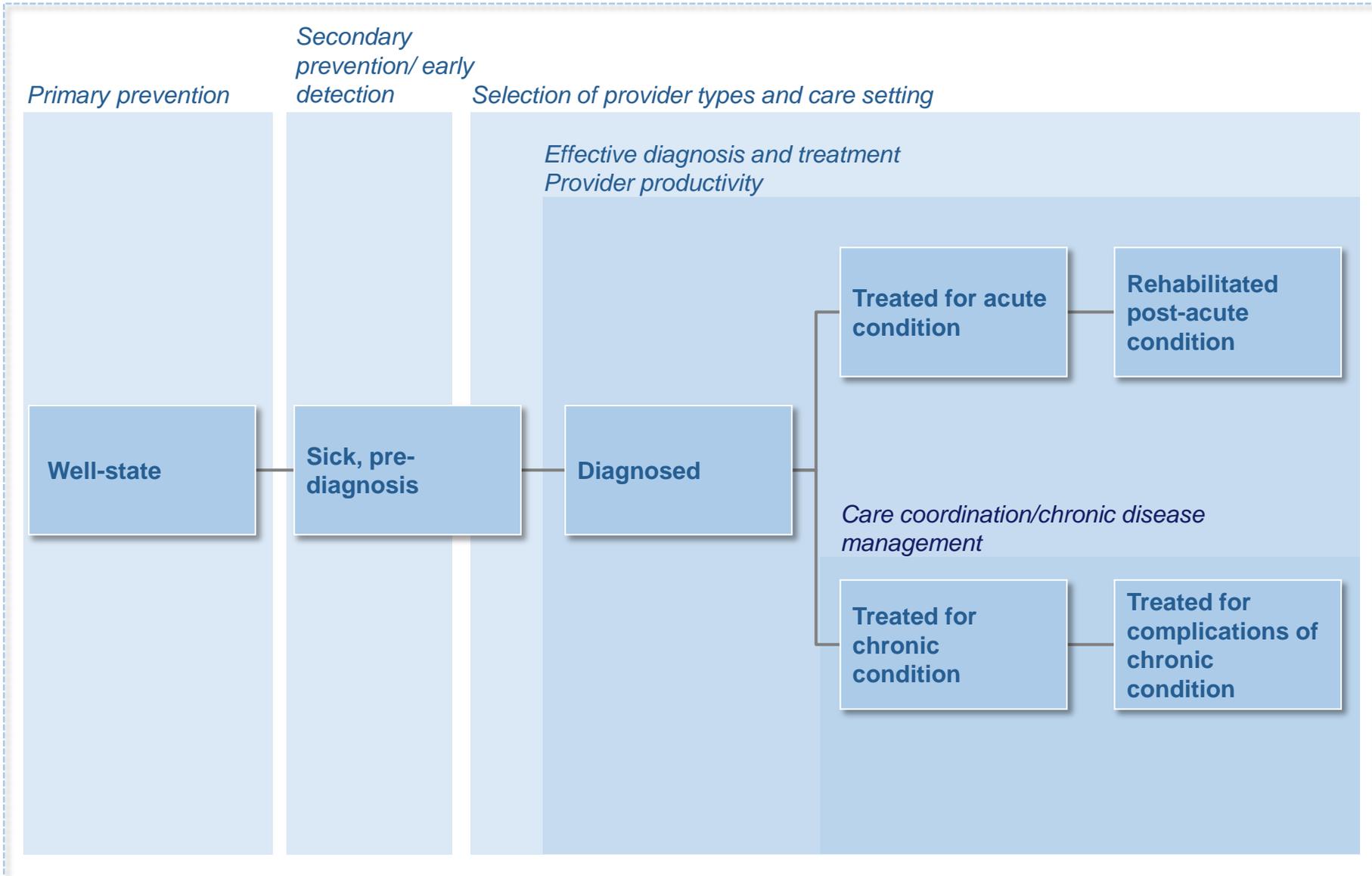
- Lack of touchpoints between provider and members of the community who could support care plan
- Limited communication channels/ processes among patient and other providers involved in care (e.g., BH and primary care not integrated)

Misaligned structures

- Limited access to proper care setting
- FFS system discourages use of lower cost providers who may be non-billable
- Limited incentive to coordinate care
- Lack of HIT to share data across care settings

- FFS system discourages delivery of care outside of office visits (e.g., phone calls)
- Lack of HIT to share data across care settings

GROUP DISCUSSION: Sources of value along the stages of health



Break out group debrief session

- **Can you share a patient story that illustrates barriers?**
- **What five barriers along the stages of the patient journey did you prioritize and why?**
- **How do these barriers map to the sources of value along the stages of health?**
- **How does this mapping impact prioritizing the sources of value?**

Next week we will discuss how a base population-health model can address barriers by incorporating changes to roles, structures, processes, and behaviors

Core components of population health models (e.g. ACO and PCMH)

Enhance Access/Continuity

- Provide patients access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- Provide access to community and home-based services

Identify/manage populations

- Collect demographic and clinical data for population management
- Assess and document patient risk factors to identify patients for proactive and point-of-care reminders

Care management

- Provide resources for patients and practitioners to support care management activities
- Emphasize pre-visit planning, assessing patient progress toward treatment goals , and addressing patient barriers to treatment goals

Care coordination

- Ensure referral tracking, follow-up, and information exchange across providers and sites of care
- Support self-care process

Measure/improve performance

- Collect, integrate, and disseminate data for care management and performance reporting
- Use performance and patient experience data to continuously improve

... and discuss customizing the base population health model Connecticut wants to implement to meet its unique needs

ILLUSTRATIVE

Case examples of customizations

	Overview	Changes in behaviors, processes, & structures
CareMore	<ul style="list-style-type: none">26 care centers across CA, AZ and NV, acquired by WellPoint in 2011Provides nurse-led tiered and coordinated care at centralized sites supported by 'extensivist' physicians in hospitals	<ul style="list-style-type: none">NPs provide personalized, prescriptive disease management programs tailored to acuity levelsCare is delivered at centralized clinics by multi-disciplinary teams, supported by a robust technology platformExtensivists based in hospitals focus on avoiding admissions, readmissions and managing transitions
CareOregon	<ul style="list-style-type: none">Non-profit health plan serving Medicaid and Medicare recipients in OregonDeveloped PCMH model covering >45,000 Medicaid enrolleesDeveloped high-intensity care coordination targeted at 3% of members responsible for 29% of spend	<ul style="list-style-type: none">Care delivered by multi-disciplinary teamsStaff supported to operate at top of licenseFocus on population health and preventionIntegrated behavioral healthBarrier-free access for patientsPatient involvement in care decisions, program design and evaluation
Colorado Children's Healthcare Access Program	<ul style="list-style-type: none">CCHAP is a nonprofit org that began as a 18-month pilot, led by the state government, that has expanded across CO to assist pediatric practices with gaining higher Medicaid reimbursement rates for 1.2m Medicaid children, of which 150,000 enrolled so far	<ul style="list-style-type: none">Eligible families are provided with care coordination and other support servicesClinical practice staff receive training and are linked to community-based resources including behavioral health, housing, social, and nutrition services



- Meet one-on-one to refine proposed changes to behaviors/processes
- Synthesize findings and prepare for next discussion on June 10th

Appendix

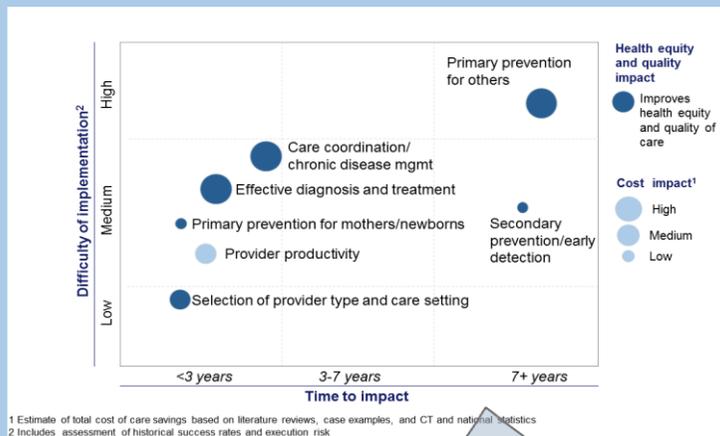
Today we will continue our discussion on prioritization of sources of value based on a review of examples specific to Connecticut

LAST WEEK

THIS WEEK

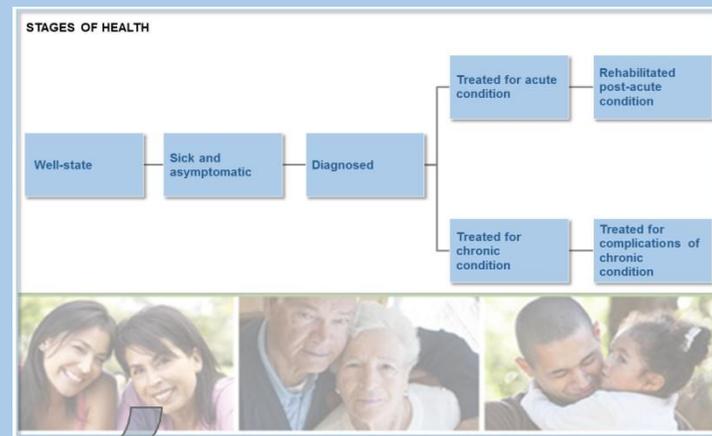
1 Leverage examples and experience of others

Prioritize sources of value based on literature review that informs cost impact, timing, and feasibility of capture



2 Define barriers CT needs to address and how those map to sources of value

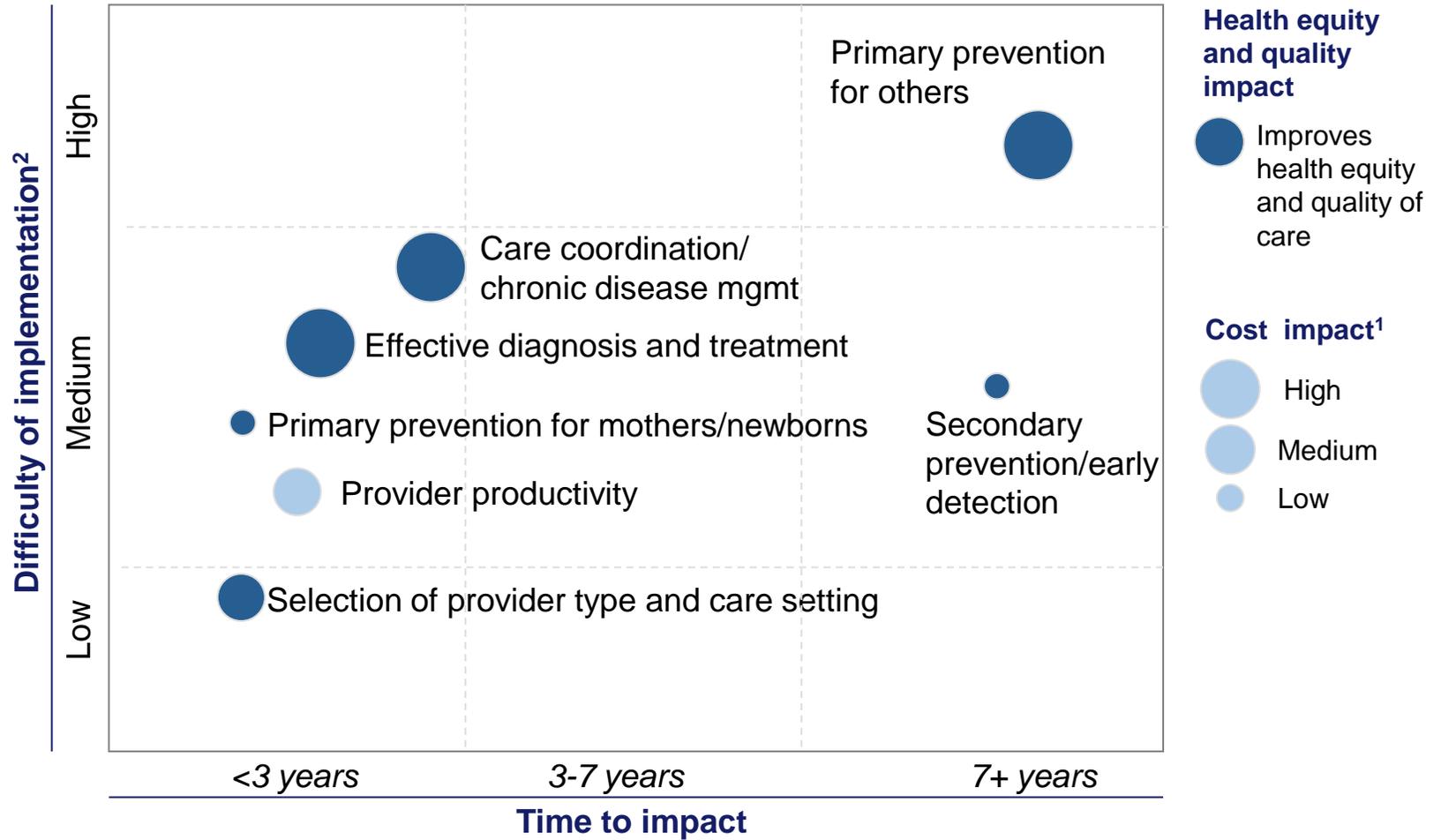
Inform prioritization of sources of value based on an understanding of barriers Connecticut seeks to address



PRIORITIZED SOURCES OF VALUE FOR CONNECTICUT



1 Last meeting we reviewed a potential prioritization of sources of value in care delivery informed by literature review..



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

SOURCE: See appendix for supporting evidence

1

Literature and case example insights provide a high-level view of cost savings, timing, and feasibility of addressing sources of value



These supporting facts and literature are:

- Order of magnitude estimation of cost savings potential for each source of value
- Sense of time to impact and feasibility of each source of value based on medical literature and case examples
- Base of tangible examples to foster a rich discussion



These supporting facts and literature are not:

- Intended to model out detailed projection of future savings for Connecticut
- Comprehensive list of actions to target within each source of value
- Mutually exclusive sets of savings
- Exclusively double blinded controlled studies
- Studies or case examples representative of entire population (results in one segment may not be representative of the broader population)

1

Literature and case example insights informing sources of value assessment – cost impact (1 of 5)

PRELIMINARY

Primary prevention

Risk factor intervention-obesity

Risk factor intervention-obesity

Relevant facts	Sources
<ul style="list-style-type: none"> Obesity related illnesses account for 4 – 10% of national health expenditures Published success rates of interventions show the capture rates ranging from 25-50% 	<ul style="list-style-type: none"> <i>Journal of Health Economics</i> 31 (2012) 219– 230 <i>Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy</i>, 2010 (3):285-295
<ul style="list-style-type: none"> Smoking related illnesses account for 4 -5% of national health expenditures Success rates of interventions range from 20-40% 	<ul style="list-style-type: none"> CDC

SOURCE: Case examples and medical literature review

Literature and case example insights informing sources of value assessment – cost impact (2 of 5)

PRELIMINARY

Relevant facts

Sources

Primary prevention mothers/newborns

Health promotion

- Preterm births are ~10.1% of all births in CT each year (37.7K)
- ~75% of pre-term births are preventable
- A preterm infant costs \$42K more than a full term infant
- Connecticut health spending per year is ~\$30B per year

- March of Dimes CT statistics, 2012
- Preventable preterm births. *The Guardian* 2012.
- State Health Facts. KFF. 2009.
- Thomson Reuters. Cost of prematurity. 2008.

Secondary prevention /early detection

Screening

- Per life savings ranges from 0.14% for cervical cancer screening to 0.69% for colorectal cancer screening
- % of population not in compliance with screening ranges from 32% (breast cancer) to 65% (colorectal)
- Employer experiences demonstrate ability to fully capture

- Costs and benefits of cancer screening. Milliman 2005
- *Arch Intern Med.* 2012; 172(7):575-582.
- Caterpillar case example

Literature and case example insights informing sources of value assessment – cost impact (3 of 5)

PRELIMINARY

Relevant facts

Sources

Selection of provider types and care settings

Shift to lower acuity providers or care settings

- Savings from shifting:
 - ED volume to urgent care: ~67%
 - From physician to physician extender: ~21%
 - From hospital-based ambulatory surgery to ambulatory surgical center (ASC): ~40%
- As a % of total U.S. healthcare spend:
 - ~0.3% are low acuity ED visits
 - ~8% are labor costs of primary care visits
 - ~3% are hospital based ambulatory surgery
- Potential 50% capture rate given applicable volume ranges from 20% of ED patients to 90-100% of PCP and hospital outpatient surgery volume

- Health Affairs, 29, no.9 (2010):1630-1636
- *Health Services Research* 2004 June; 39(3): 607-626
- HCUP 2010

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Literature and case example insights informing sources of value assessment – cost impact (4 of 5)

PRELIMINARY

Relevant facts

Sources

Effective diagnosis and treatment

Reduce unnecessary services

- 31% of health care expenditures are wasted dollars spent on inefficient and/or ineffective care delivery
- 27.5% of wasted dollars spent are accounted for by unnecessary services, driven largely by ineffective diagnosis and treatment

- Institute of Medicine, September 2012

Provider productivity

Improve provider productivity

- Demonstrated savings from improving provider productivity and patient throughput range from 10-15%
- Inpatient costs represent ~21% of total health care spending

- Industry experts
- Health Care Cost and Utilization Report: 2011

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Literature and case example insights informing sources of value assessment – cost impact (5 of 5)

PRELIMINARY

Relevant facts

Sources

Care coordination and disease management

Care coordination and disease management

Administrative simplification

- After adjusting for ~2% savings on 40% fewer readmissions, Geisinger achieved 5% total savings through a PCMH model combining care coordination and disease management

- Geisinger

- Savings from reducing administrative inefficiencies range from 5% from standardizing forms to 30% from co-locating payor/provider billing
- Administrative tasks comprise 15% of total health spend
- Capture rate of ~70-80% seen in a large state initiative

- Health Affairs 2005. 24(6)
- Industry expertise

1

Literature and case example insights informing sources of value assessment– level of difficulty (1 of 3)

	Level of difficulty	Relevant facts	Sources
Primary prevention	<ul style="list-style-type: none"> ▪ High 	<ul style="list-style-type: none"> ▪ Wide range of interventions of variable efficacy and feasibility ▪ Treatment effects for many interventions are relatively small (though population-level impact may still be high) 	<ul style="list-style-type: none"> ▪ AJMC, 2013 ▪ BMJ, 2007 ▪ CJC, 2007 ▪ Cochrane Review, 2009 ▪ Cochrane Review, 2010 ▪ Cochrane Review, 2012 ▪ Cochrane Review, 2013 ▪ JECH, 2012 ▪ JSH, 2008 ▪ NEJM 2009 ▪ NEJM, 2010
Primary prevention for mothers/ newborns	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Community efforts targeted at pregnant women have demonstrated success though there is challenge associated with changing behaviors 	<ul style="list-style-type: none"> ▪ Cochrane Review, 2008 ▪ Cochrane Review, 2010 ▪ Cochrane Review, 2012
Secondary prevention / early detection	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Risks of over-diagnosis/treatment ▪ Uptake may be lowest in highest needs sub-groups ▪ Targeted programs for specific risk groups can be delivered through disease management 	<ul style="list-style-type: none"> ▪ BMJ, 2008 ▪ Cochrane Review, 2013 ▪ Cochrane Review, 2011 ▪ Cochrane Review, 2011 ▪ EHJ, 2008 ▪ NEJM, 2012 and 2009

1 Literature and case example insights informing sources of value assessment– level of difficulty (2 of 3)

	Level of difficulty	Relevant facts	Sources
Selection of provider types and care setting	<ul style="list-style-type: none"> ▪ Low 	<ul style="list-style-type: none"> ▪ Has been successfully demonstrated ▪ Role substitution can meet initial resistance ▪ Requires appropriate coaching, management and oversight ▪ Requires extensive collaboration between care providers ▪ Effective for stroke patients 	<ul style="list-style-type: none"> ▪ BMJ, 2013 ▪ Cochrane Review, 2009 ▪ Cochrane Review, 2011 ▪ Cochrane Review, 2012 ▪ IJIC, 2012 ▪ The Health Foundation, 2010
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Behavior change at level of individual clinical pathways may be onerous ▪ May meet provider resistance given autonomy of clinical practice ▪ Addressing unwarranted variation may be controversial 	<ul style="list-style-type: none"> ▪ Birth, 2012 ▪ Dartmouth ▪ Cochrane Review, 2011 ▪ NEJM, 1988 ▪ JAMA, 2002 ▪ PDS, 2012 ▪ Robert Wood Johnson Foundation, 2013
Provider productivity	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Size of efficiency opportunity likely to vary significantly between providers ▪ Potential impact is extrapolated from specific patient groups/ pathways and may not be applicable to all patient types 	<ul style="list-style-type: none"> ▪ Cochrane, 2011 ▪ Cochrane Library, 2013 ▪ Health Affairs, 2012 ▪ MHI case study ▪ NEJM, 2011 ▪ McKinsey blinded client data- hospital lean operations

1 Literature and case example insights informing sources of value assessment– level of difficulty (3 of 3)

	<u>Level of difficulty</u>	<u>Relevant facts</u>	<u>Sources</u>
Care coordination and chronic disease management	<ul style="list-style-type: none">▪ Medium	<ul style="list-style-type: none">▪ Several case examples exist of successful care coordination▪ Lack of clear evidence on what type of program to introduce for any specific population	<ul style="list-style-type: none">▪ Camden Coalition of Healthcare Providers case▪ Care Oregon case▪ Care More case▪ Colorado Childrens' Health Program case▪ New York Care Coordination Program case

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Literature and case example insights informing sources of value assessment– time to impact (1 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Primary prevention	<ul style="list-style-type: none"> 7 + years 	<ul style="list-style-type: none"> Due to need to address root cause of disease and time course of disease progression, primary prevention requires 10+ years to achieve meaningful cost impact though medical benefits may accrue sooner 	<ul style="list-style-type: none"> AJMC, 2013 BMJ, 2007 CJC, 2007 Cochrane Review, 2009 Cochrane Review, 2010 Cochrane Review, 2012 Cochrane Review, 2013 JECH, 2012 JSH, 2008 NEJM 2009 NEJM, 2010
Primary prevention for mothers/ newborns	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Specific, identified opportunity to improve outcomes through pregnant women's behaviors (e.g., vitamins, alcohol avoidance) Shorter-term cost impact via healthier newborns 	<ul style="list-style-type: none"> Cochrane Review, 2008 Cochrane Review, 2010 Cochrane Review, 2012
Secondary prevention / early detection	<ul style="list-style-type: none"> 7 + years 	<ul style="list-style-type: none"> Similar to primary prevention, screening for early signs of disease requires 10+ years to achieve cost impact given time course of disease progression 	<ul style="list-style-type: none"> BMJ, 2008 Cochrane Review, 2013 Cochrane Review, 2011 Cochrane Review, 2011 EHJ, 2008 NEJM, 2012 and 2009

1 Literature and case example insights informing sources of value assessment– time to impact (2 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Selection of provider types and care setting	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Cost impact can be achieved immediately by changing referral patterns to high value providers 	<ul style="list-style-type: none"> BMJ, 2013 Cochrane Review, 2009 Cochrane Review, 2011 Cochrane Review, 2012 IJIC, 2012 The Health Foundation, 2010
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Time to achieve cost impact primarily restricted by provider behavior changes required (e.g., prescribing behaviors and clinical pathways) Engaging patients in decision making and dropping rate of unnecessary elective procedures has faster impact 	<ul style="list-style-type: none"> Birth, 2012 Dartmouth Cochrane Review, 2011 NEJM, 1988 JAMA, 2002 PDS, 2012 Robert Wood Johnson Foundation, 2013
Provider productivity	<ul style="list-style-type: none"> <3 years 	<ul style="list-style-type: none"> 3-6 months for provider-initiated reforms 2-3 years for system initiated payment reform 	<ul style="list-style-type: none"> Cochrane, 2011 Cochrane Library, 2013 Health Affairs, 2012 MHI case study NEJM, 2011 McKinsey blinded client data- hospital lean operations

SOURCE: Case examples and medical literature review

1 Literature and case example insights informing sources of value assessment– time to impact (3 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Care coordination and chronic disease management	<ul style="list-style-type: none">▪ < 3 years	<ul style="list-style-type: none">▪ Case examples achieved meaningful cost savings impact in 1-3 years	<ul style="list-style-type: none">▪ Camden Coalition of Healthcare Providers case▪ Care Oregon case▪ Care More case▪ Colorado Childrens Health Program case▪ New York Care Coordination Program case

SOURCE: Case examples and medical literature review



2 ... and discussed potential barriers to care coordination and disease management in Connecticut (1 of 3)

- Individuals have limited access to primary care
 - Portions of community do not have access to primary care doctors
 - Limited capacity of providers leads to long wait times
 - Individuals who are better positioned to promote positive behaviors and support behavioral modification/ lifestyle changes have not been effectively involved in chronic disease management to date
 - Pharmacists and community health workers are just two of many potential individuals in the community who may be better positioned to support chronic disease management, given the more regular interactions they have with individuals outside of the doctor's office
- Effective selection of provider type and care setting are also limited
 - Patients have limited access to most appropriate care setting (e.g. , ERs are open 24/7 whereas PCP offices have limited access)
 - Patients are not aware of variability in quality and price differences between provider types and care settings and have limited access to data demonstrating variability in quality and price
 - Providers have limited information on comparative performance



2 ... and discussed potential barriers to care coordination and disease management in Connecticut (2 of 3)

- Payment models do not support care coordination
 - Each provider is paid separately for the discrete set of services they provide
 - The payment an individual receives is not tied to the performance of other providers involved in the care of an individual
 - Limited incentives (e.g., care coordination per member per month) exist to promote care coordination
- The current reimbursement model also does not promote value
 - FFS reimbursement precludes non-visit based activities (email/telephonic follow-up, coordination with other members of treatment team) and non-billable workers (e.g., community health workers)
 - FFS reimbursement rewards overtreatment, and also rewards medical errors (payments for corrective procedures are reimbursed)
 - Rush of the FFS system (more procedures = more revenue), interferes with the development of a relationship between patient and care providers
- Consumers are not properly incented to participate in positive behaviors (e.g., smoking cessation, regular screenings) in insurance and policy design



2 ... and discussed potential barriers to care coordination and disease management in Connecticut (3 of 3)

- Behavioral health and primary care are not integrated (e.g., PCP does not always know who to refer patient to for behavioral health issues)
- Providers lack proper channels and processes for communication with each other, thereby leading to redundancies and inefficient patient hand-offs
 - Poor peer to peer relationships (e.g., poor doctor-doctor, nurse-doctor comms)
 - Limited shared Health IT infrastructure to support clinical decision making (e.g., a given provider can't access imaging result performed elsewhere)
 - Information/data unavailable at the point of patient/provider decision making
- Consumers and providers lack information that limit the potential for care coordination
 - Lack of consumer information/education around benefits of care coordination
 - Lack of trust in providers of telephonic care coordination (does this person really represent Medicare)
 - Lack of full understanding of patient needs through telephonic vs. face-to-face interactions
 - Lack of individuals and resources able to bridge cultural/race/ethnicity barriers
- Consumers lack access to knowledge and other methods of promoting health or health care literacy and therefore do not fully understand how to follow-through on their care plans
- Health care data is not complete
 - Providers: Lack of complete information on the patient to inform diagnosis and treatment
 - Payers: Need comprehensive claims data to have a complete picture for risk assessment
- The system does not consider the patient as a “whole person,” i.e., it does not consider the broader set of influencers (e.g., culture, socioeconomic conditions, other medical conditions) that impact a person's health