

**Connecticut**

As per page 6 of the SIM Round 2 Funding Opportunity Announcement (FOA), “CMS encourages applicants to propose payment models that directly align with one or more existing Medicare programs, demonstrations, and/or models, such as accountable care organizations (ACOs), primary care medical homes, and bundled payment programs. Medicare’s participation is not guaranteed and will be assessed on a case-by-case basis after thorough review of the proposed model.” Below are common elements in current CMS advanced primary care models. If the state proposed an advanced primary care model, indicate potential SIM model requirements.

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<b>I. Practice Budget</b>	Physician practices are required to complete an annual budget or forecast with projected new practice revenue flow and plan for anticipated practice expenses associated with practice change (practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center). This is due to the Innovation Center within 3 months of enrollment.	<ul style="list-style-type: none"> <li>a. Record actual expenditures and revenue from program year 1.</li> <li>b. Complete an annotated annual budget forecast with projected new Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change in program year 2. This information will be due Q1 of program year 2.</li> </ul>	<p>State has requirement for practices to submit a budget? Yes/No</p> <p>N/A</p>
<b>II. Care Management for High Risk Patients</b>	<p>Provide information about care management of high risk patients:</p> <ul style="list-style-type: none"> <li>a. Indicate the methodology used to assign a risk status to every empanelled patient. (“Empanelled” means that all attributed patients have a designated provider/ care team within the practice and that systems are in place to produce reports based on provider/care team). <i>The methodology can use a global risk score or a set of risk</i></li> </ul>	<ul style="list-style-type: none"> <li>a. Maintain at least 95% empanelment to provider and care teams.</li> <li>b. Continue to risk stratify all patients, achieving risk stratification of at least 75% of empanelled patients.</li> <li>c. Provide care management to at least 80% of highest risk patients (those that are clinically unstable, in transition, and/or otherwise need active, ongoing, intensive care management).</li> <li>d. Implement one or more of the following three specific care management strategies for patients in higher risk cohorts</li> </ul>	<p>State has requirement for care management for high risk patients?: <u>YES</u></p> <p>Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA Standards. PCMH Standard 4A focuses on Care Management that includes a systematic approach to the identification of patients with behavioral health conditions, high utilization, poorly controlled or complex conditions, care transitions; <b>PCMH Standard 4B focuses on care planning/self-care support that includes self-management</b></p>

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	<p><i>indicators (e.g. number of medications, problems, ER/hospitalization use, or a systematic assessment of psychosocial complexity).</i></p> <p>b. Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category.</p> <p>c. Provide practice-based care management capabilities and indicate the following:</p> <ul style="list-style-type: none"> <li>• Who provides care management services</li> <li>• Process for determining who receives care management services</li> <li>• Examples of care management plans on request.</li> </ul> <p>Be able to generate lists of patients by risk category</p>	<p>(beginning with those at highest risk):</p> <ol style="list-style-type: none"> <li>1. Integration of behavioral health;</li> <li>2. Self-management support for at least 3 high risk conditions;</li> <li>3. Medication management and review.</li> </ol>	<p>plans – this is a <b>MUST PASS</b> element. PCMH Standard 4C focuses on Medication Management.</p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 4A and 4C as "must pass" elements at its meetings on 9/9, 9/30 and 10/14/2014.</b></p> <p>The CT SIM proposal has also identified 3 high priority care management strategies for high risk patients in its Targeted Technical Assistance (TTA) under the Community and Clinical Integration Program (CCIP):</p> <ol style="list-style-type: none"> <li>1. integration of behavioral and oral health</li> <li>2. medication management</li> <li>3. self-management support for chronic diseases facilitated by Community Health Workers to close health equity gaps</li> </ol>
<p><b>III. Access and Continuity</b></p>	<p>Provide and attest to 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice’s medical record for patient advice and to inform care by other professionals.</p>	<ol style="list-style-type: none"> <li>a. Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record.</li> <li>b. Enhance access by implementing at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment for a timely response.</li> </ol>	<p>State has requirement for Access and Continuity?: <u>YES</u></p> <p>Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA standards. PCMH Standards 1A/B focus on 24/7 access and alternative types of clinical encounters. <b>Standard 1A is a MUST PASS element.</b></p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will</b></p>

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			consider whether to add Standard 1B as a "must pass" element at its meetings on 9/9, 9/30 and 10/14/2014.
<b>IV. Patient Experience</b>	<p>Assess and improve patient experience of care by selecting at least one of the following:</p> <ol style="list-style-type: none"> <li>a. Provide at least 2 quarters of focused survey data based on at least one CG-CAHPS domain chosen by the practice after review of results from the initial CG-CAHPS survey (<a href="https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx">https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx</a>) results done under this Initiative;</li> <li>b. Provide evidence of guidance from a patient and family advisory council that meets at least quarterly, along with specific discussion of how this feedback was used to change practice workflow or policy. A description of a patient and family advisory council can be found at <a href="https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Custom-Service/Listening-Posts/Advisory-Councils.aspx">https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Custom-Service/Listening-Posts/Advisory-Councils.aspx</a></li> </ol>	<ol style="list-style-type: none"> <li>a. Continue year 1 efforts by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC). <ul style="list-style-type: none"> <li>• <b>Option A:</b> Conduct practice-based survey monthly.</li> <li>• <b>Option B:</b> PFAC that meets quarterly.</li> <li>• <b>Option C:</b> Office based surveys administered quarterly and PFAC convened semi-annually.</li> </ul> </li> </ol> <p>Care experience surveys</p> <ol style="list-style-type: none"> <li>b. Develop communication(s) to patients about the specific changes your practice is implementing (e.g. a pamphlet or posters).</li> </ol>	<p>State has requirement related to patient experience?: YES</p> <p>As part of our Model Test, all health plans and Medicaid will require a care experience survey as a condition for participating in a SSP arrangement as of the 2016 contract year, using a tool recommended by the Quality Council.</p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 6C – Measures of Patient/Family Experience as a "must pass" element at its meetings on 9/9, 9/30 and 10/14/2014. The PTTF will consider the requirement of a Patient Family Advisory Council as a supplement to the 2014 NCQA standards that are required as part of our AMH Program.</b></p>
<b>V. Quality Improvement</b>	At least quarterly, generate and review practice- or provider-based reports with a	a. Report the EHR clinical quality measures	State has requirement quality improvement?: <u>YES</u>

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	<p>minimum of one quality measure and one utilization measure. These two measures may be derived from the list of measures that practices will be reporting to the Innovation Center for purposes of calculating a quality score for shared savings distribution, or the practice may choose any NQF endorsed measures based on clinical importance and/or improvement potential.</p>	<p>required by CMS for your program.</p> <p>b. Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care.</p>	<p>Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA standards. PCMH Standards 6A-F focus on “Performance Measurement and Quality Improvement”. <b>Standard 6D – Implement Continuous Quality Improvement is a MUST PASS element.</b></p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 6A, B C, E, F as "must pass" elements at its meetings on 9/9, 9/30 and 10/14/2014.</b></p> <p>Quality and care experience measures will be developed by the Quality Council, which is comprised of the five major health plans, one large employer, six consumer advocates, three state agencies, six practicing physicians, one FQHC and one hospital. Health plan representatives include medical directors, statisticians and measurement experts.</p> <p>The Quality Council will propose a core set of measures for use in the assessment of primary care, specialty care, including behavioral and oral health, and hospital provider performance and will reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. The Council will complete its recommendations regarding primary care by December 2014.</p> <p>Health plans will modify systems and</p>

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			<p>contracts in 2015 and implement the new measurement set and scorecard in 2016.</p> <p>The SIM Quality Council has already committed, as a super-ordinate guiding principle, to maximize alignment with the Medicare ACO measure set, including the ACO measure of care experience.</p>
<p><b>VI. Care Coordination Across the Medical Neighborhood</b></p>	<p>Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement – with numerator and denominator data – to assess impact and guide improvement in one of the following areas.</p> <ol style="list-style-type: none"> <li>Notification of ED visit in timely fashion.</li> <li>Practice medication reconciliation process completed within 72 hours of hospital discharge.</li> <li>Notification of admission and clinical information exchange at the time of admission.</li> <li>Notification of discharge, clinical information exchange, and care transition management at hospital discharge.</li> <li>Information exchange between primary care and specialty care related to referrals to specialty care.</li> </ol> <p>The milestone for Year 1 is to select and report on the measurement (this reporting is not related to the reporting required for shared savings in Year 2). In</p>	<p>Select two of the three options below, building on your Year 1 activities:</p> <ol style="list-style-type: none"> <li>Track % of patients with ED visits who received a follow up phone call within one week.</li> <li>Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours.</li> <li>Enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.</li> </ol>	<p>State has requirement related to Care coordination across the medical neighborhood?: <u>YES</u></p> <p>Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA standard. PCMH Standards 5B/C is “Care Coordination and Care Transitions “. <b>Standard 5B – Referral Tracking and Follow-Up is a MUST PASS element.</b></p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 5C as a "must pass" element at its meetings on 9/9, 9/30 and 10/14/2014.</b></p> <p>In addition, the CT SIM proposal has identified the following areas to track as indicators of care coordination across the medical neighborhood:</p> <ul style="list-style-type: none"> <li>hospitalizations for ambulatory care sensitive conditions</li> <li>readmissions for avoidable complications</li> <li>medication reconciliation</li> <li>asthma ED visits</li> </ul>

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	Year 2, the practice will need to describe activities they undertook to improve the results.		<ul style="list-style-type: none"> <li>hospitalization due to falls</li> </ul>
<b>VII. Shared Decision Making</b>	Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid. Make a decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid for this priority area. Information about shared decision making is available at <a href="https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making.aspx">https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making.aspx</a>	<ol style="list-style-type: none"> <li>Implement shared decision making tools or aids in two health conditions, decisions or tests as component of shared decision-making.</li> <li>Generate a metric for the proportion of patients who received the decision aid, OR</li> <li>Provide quarterly counts on run charts of patients receiving the decision aids and show growth in use of the aids.</li> </ol>	State has requirement related to shared decision making?: <u>YES</u>  Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA standards. PCMH Standard 4E is "Support Self-Care and Shared Decision-Making."  <b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 4E as a "must pass" element at its meetings on 9/9, 9/30 and 10/14/2014.</b>
<b>VIII. Participate in Learning Collaborative</b>	Participate in the market-based learning collaborative and share knowledge, tools, and expertise with other practices in the market as indicated by: <ol style="list-style-type: none"> <li>Attendance at three face-to-face meetings annually and in web-based meetings at least monthly.</li> <li>Sharing of materials or resources on the collaboration site.</li> <li>Reporting on the Innovation Center's on-line Collaboration Site of at least 6 key measures that are of importance to the practice and which will be used to guide active testing of changes in the practice. These may include measures required for patient experience, risk status assignment, care</li> </ol>	<ol style="list-style-type: none"> <li>Participate in SIM learning sessions in your region.</li> <li>Participate in one learning webinar per month.</li> <li>Contribute a minimum of one document or experiential story to the SIM Collaboration Website.</li> <li>Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty are bound by confidentiality agreements.</li> </ol>	State has requirement related to Participating in Learning Collaboratives?: <u>YES</u>  The SIM PMO will establish 3 statewide Learning Collaboratives (LCs). One LC will be for practitioners and staff participating in the AMH Glide Path. Two other LCs will be offered to participants in MQISSP and the CCIP program, one each for FQHCs and Advanced Networks.  LCs will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Practices will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.

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	coordination, etc., as described above.		
<b>IX. Health Information Technology</b>	Attest to the requirements for Stage 1 of Meaningful Use for the EHR Incentive Programs (for practitioners participating in the Medicaid EHR Incentive Program, adopting, implementing, or upgrading certified EHR technology is not sufficient, the practitioner must attest to Stage 1).	<ul style="list-style-type: none"> <li>a. All eligible professionals in the practice successfully attest to Meaningful Use in accordance with the requirements of the Meaningful Use program.</li> <li>b. Upgrade EHR technology to the 2014 edition ONC Certification.</li> <li>c. Identify the care settings/providers for which the practice has the ability to exchange health information electronically.</li> </ul>	<p>State has requirement related to Health Information Technology?: <u>YES</u></p> <p>Practices in the Advanced Medical Home (AMH) Glide Path must meet 2014 NCQA standards. PCMH Standard 6G is “Use Certified EHR Technology” and focuses on the use of a certified EHR for Meaningful Use reporting and bidirectional exchange of electronic health information.</p> <p><b>PLEASE NOTE: The CT Practice Transformation Taskforce (PTTF) will consider whether to add Standard 6G as a "must pass" element at its meetings on 9/9, 9/30 and 10/14/2014.</b></p> <p>Over 5,300 providers and all hospitals have received payments for adoption of EHRs, of whom 60% have attested to achieving Meaningful Use Stage 1.</p> <p>CT’s overall HIT/HIE strategies aim to move the state from simply identifying and integrating available data to using such data and analytical tools to drive transformational change. Investments in these areas support increased communication between providers, care coordination and integration across settings, population health assessments, improved care delivery and quality measurement and reporting.</p>