

Date: November 18, 2013

To: SIM Project Team

From: Brenda Shipley
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Re: Public Comment Submitted for the SIM Innovation Plan Draft 1.1

Synthesizing months of input from healthcare stakeholders on how best to utilize a federal investment to innovate care is a monumental task. Kudos for releasing the draft report and encouraging next level feedback to make our plan competitive.

I've clustered my feedback: General Comments and Health Equity.

General Comments

1. A visual representation -- SIM at-a-glance -- would be helpful.
2. Ditto for a Logic Model that connects disparate enabling initiatives to stated goals. If we do X, then our outcomes will be Y. This is especially true when an idea emanating from one of the four workgroups is cross-cutting and beneficial to all.
3. First impression: There are many elements of the plan, it reads a bit like we are trying to boil the ocean. Can we practically achieve everything outlined in the plan with an investment of \$40 million over 5 years? That's \$8 million a year. Minus the PMO costs, that leaves less than \$7 million a year for programmatic and vendor costs.
4. I believe the plan needs to be pared down to core essentials, a narrow vision, with recognition that performance measurement and oversight must be central to the plan's funding commitment. i.e. make sure a few things are achieving specific desired goals with room for analysis, feedback loops, and recalibration if metrics are off rather than having an uncontrolled experiment with too many variables to practically measure.
5. Our expected outcomes should be specifically and boldly stated in the Executive Summary, and be attached to those enabling initiative(s) that will produce the expected outcomes.
6. A Roles & Responsibilities or SIM Stakeholders at-a-glance chart would help the reader determine how payers, employers, state agencies, providers, etc. will be involved in the SIM and what they will be held accountable for. It is not always

easy to distinguish the roles, especially for broad phrasing such as “payers and providers will....”.

7. The goal of cost reduction is weakly presented. That CT's healthcare costs are the 3rd highest among states doesn't just “raise concerns”, it is a perilous economic situation. The plan attaches no sense of urgency to cost reduction and doesn't itemize specific levers to contribute to slowing cost growth. While the plan addresses micro cost drivers such as volume over value incentives at the patient-provider level, it leaves unaddressed the macro cost drivers of the healthcare industry in CT such as compensation, monopolization, and lack of volume purchasing.
8. P21. Identifies readmissions for the Medicaid population as a major drain on the state's economy -- \$92 million. This headline is buried. If this is a major cost driver, why not specifically link it to a desired outcome or enabling initiative? E.g. If the plan focused on a Big Idea “Reduce Medicaid Readmissions by 50% by 2020”, the many disparate primary care transformation initiatives to prevent hospitalizations would then have context, a clear metric on whether all these things are adding up (or not) to achieve a precise goal. The innovations need to be stated with a little more pizzazz. Even if we only had one innovation, and this was it, it would contain all the desire ingredients: access, quality, equity, cost.
9. Add a Cost Council to the Governance Structure.
10. AMH is described as a “cornerstone” of the plan, but there don't appear to be 4 corners, and the AMH isn't in the diagram on pg. 41. Also, if there are 4 corners, it is weird to say it has five core components. The visual isn't syncing with the narrative.
11. The glide path program isn't described in the Executive Summary as an enabler for transformation; yet it seems like it will have a key role. Perhaps a diagram in the Appendix that describes the glide path.
12. Regarding Value Based Payment -- It is unclear what % of CT's providers are expected to be AMHs, on the glide path, P4P, SSM, ACOs, IPAs, etc. While the diagram on P. 46 helps, it is still a bit confusing. What happens to the providers that do not participate in the new model? Is participation voluntary? And, how does a consumer know what arrangement their doctor is participating in?
13. Pg 9. 1. Suggest adding “while maintaining quality and not cherry picking patients.”
14. Pg 4. Health Information Technology – needs opening paragraph.
15. Pg 20. Quality of Care. The SIM proposal focuses on primary care transformation, not hospital transformation. While hospital metrics such as ED visits and

readmission for ambulatory sensitive care conditions will be an indicator of preventive, primary care, there needs to be a delineation in the scope for the Quality Council in terms of quality metrics, to align with all other initiatives on primary care.

16. P21. Consumer Experience of Care. Suggest moving this section to the beginning, p. 18. And shorten it up. For the SIM plan to walk the talk about patient-centeredness, then perhaps these 7 barriers to being well and staying out of the ED, as reported by the state's consumers, need to be the driving goals of the plan.
17. P30. The HITE-CT and EHR Adoption are not prominently featured in enabling initiatives, or mentioned in the Executive Summary, P10, but appear to be critical to transforming primary care model.
18. P47. Last P. Will anyone other than payers have input on the common set of accreditation standards?
19. P48. Visual makes no sense (to me). Ditto for the chart on P49. I cannot link this chart to AMH model and don't know why this chart matters.
20. P54. Unclear how certified entities will be paid for their services, and by whom.
21. P55. Suggest moving 2 bullet points on proposing legislation to the section that addresses it P 109
22. P56-58. It is unclear if the intent is to secure additional funding to keep these programs (diabetes, asthma, falls) running because they are having measurable impact on priority health areas, or if they are being included as supporting evidence of programs already underway.
23. P59. "...to help us select which interventions and programs to roll out and when". Sounds vague, as if we aren't ready/informed to commit to focusing on specific health conditions to tackle in the next 5 years with this innovation funding.
24. P60. P4. Out of the blue, this deep into the plan, nutritional purchasing is introduced for the first time. If this is an important initiative, it needs to be featured in the Executive Summary or Enabling Initiatives bullet points.
25. P65. Rewards for Nutritional Purchasing. Unclear how this ties in with this section, how the pilots would be funded or evaluated, and what populations would be considered for pilot. This sounds like a well-developed programmatic effort, but one that isn't integrated with primary care transformation and the big enabling initiatives. Its placement in the document is confusing.
26. P71. Any thought to tying upside/risk to ambulatory care sensitive conditions and not to patients with traumatic illnesses such as cancer?

27. P72. P1. "The rationale for this exclusion is to avoid negative quality outcomes for program participants". But it's okay if everyone else, outside of Medicaid, has negative quality outcomes?! I'm sure this isn't the intended translation. Suggest rewording.
28. P72. Pay for Performance. Confusing paragraph and placement. Perhaps using examples will help explain the differences between the Value Based Payment strategies: Shared Savings – Upside, Shared Savings-Risk sharing, and Pay for Performance.
29. P72. Up-front Investment in Care Coordination. This seems far too important for the success of primary care transformation to appear loosey-goosey "payers will be encouraged". Will each payer in the state come up with its own mechanism? Won't that be difficult for providers to manage?
30. At the end of the document, perhaps a Risks/Assumptions page?
31. P105. Chart is too detailed and does not include all the initiatives identified in the plan. Could this be done as a next step, if CT's proposal is accepted?
32. P109. Practice Standards Entity is introduced for the first time. Sounds critical to the transformation. Should be featured earlier. This is separate from the PMO? Not on the Governance Structure?
33. P112. Mentions CLAS based standards as a performance goal. It is not featured elsewhere as a goal/performance metric.
34. P112. Last P. The Quality, *Equity and Access, and Cost Councils* will advise on final metrics...
35. P113. The health conditions listed under Better Health (diabetes, asthma, hypertension, obesity, tobacco use) do not align with those identified as health priorities throughout the document. We need one consistent list of health conditions that the plan will impact. "Maintain" the prevalence of disease doesn't sound very ambitious.
36. P113. P3. Quality of care and consumer experience for primary care, or for all care?
37. P114. Substitution of generic prescriptions introduced for the 1st time as a performance metric. But was not featured anywhere else in the report as a goal or initiative.
38. P114. SIM Performance Dashboard introduced for the 1st time, could be better placed in Executive Summary.

39. P116.P1. Creating an entity that manages the collection and evaluation of performance data. Is this the same or different than the Practice Standards Entity? Where is it on the Governance Structure? If this is the oversight linchpin for the primary care model, it should be featured in the Executive Summary .

Health Equity

1. Pg. 5 Population Health Management. Suggest Adding: Population-based data will also be used to determine which AMHs are impacting health disparities, for which conditions, and which populations. For example, UConn's Health Disparities Institute is currently engaged in PCMH research using population-based data.
2. Pg 6 Community Health Improvement. Suggest adding: 3. Measuring impact of HECs and CBPSEs on reducing health disparities.
3. Pg 7. 2nd P. ...equip consumers with *culturally and linguistically appropriate*...information, resources...
4. Pg 7. Distinguish what payers will do and what providers will do. Add Provider education for CLAS and whole-person-centered care. Add Patient Experience surveys.
5. Pg. 8 Performance Transparency. Suggest Adding 5. Identifying disparities in healthcare and health outcomes.
6. Pg 9. APCD 1. Measurement for quality...*equity, cost*...and resource...
7. P14. 3rd P. Also add: CT will leverage its investment in organizations currently working toward promoting health equity by reducing health disparities including, the CT Multicultural Health Partnership, the CT Commission on Health Equity, and the Bioscience CT Health Disparities Institute.
8. P16. Equity and Access Council. ...methods to guard against under-service *and disparities in care and outcomes across populations*.
9. P16. Suggest adding: The Equity and Access Council will evaluate SIM transformation policy changes for impact on health equity.
10. P19. Suggest consistency on what CT's health priorities are. These population health indicators (heart disease, cancer, obesity, lead poisoning) aren't syncing with the stated health priorities/funded programs in other sections of the report (diabetes, asthma falls)

11. P19. Population Health Indicators. P1. Cite the racial and socioeconomic health disparities in CT. If the stated SIM goal is to reduce them, we need to start with a benchmark. Remove (see Health Disparities...).
12. P23. Outlines health disparities statistics, yet these also don't align with the stated health priorities in other sections of the report. Here, we have an entirely new rundown of what's broken. STD, prenatal care, low birth weight, fetal/infant mortality. Suggest the SIM consistently focus on one set of health conditions that are priorities for the state.
13. P23. P2. Since the SIM plan is not about access to health coverage (insurance), rather access to primary care, omit this.
14. P23. P3. Introduces a new problem for the first time, that isn't included elsewhere, lack of affordability for Rx, dental care, transportation, and child care. Should these issues make "the list" to be consistently identified throughout the plan as problems that will be addressed and a metric to analyze? Perhaps these can be tied together in the overall plan, through the HEC or team coordinated care concept?
15. P24. P4. Adds a couple of additional health conditions, again that don't align with other lists of conditions that will be focused on – smoking, cardiovascular and respiratory disease, cancer.
16. P29. APCD. ...report healthcare information that relates to safety, quality, *equity*,
17. P29. 4th bullet. ...understanding utilization patterns, *identifying disparities along the continuum of care, especially for ambulatory care sensitive conditions*, enhancing access.....
18. P29. Last P. ...being refined based on *stakeholder* feedback.
19. P34. No mention that SIM also had 4 Health Equity workgroup/stakeholder engagement meetings.
20. P51. HEC. How does the state plan to hold "the broader community" accountable?
21. P51. Is just one HEC planned – P51 versus P 52 – 3-5 pilots.
22. P51. What is multi-sector collaboration mean?
23. P51. The HECs must be supported with evidence in order to use evidence-based approaches. Suggest adding: HECs will be measured for impact on reduction of health disparities.

24. P52. P2. ..to support design, implementation, *ongoing outcomes measurements, and translation/dissemination to additional geographic areas.*
 25. P52. P3. Community-wide population health measures, *stratified by race, ethnicity, language, and other SES factors*, will be incorporated...
 26. P52.P4. Define "other sectors".
 27. P65. P3. Suggest adding: This task force will engage payers and large employers with diverse employee populations in discussions to innovate benefit design to reduce health disparities.
 28. P76. 2nd bullet. Payers will make claims-based analytics available to providers *and consumers...*
 29. P78. 1st bullet. ...that assess outcomes, quality, *equity*, and cost....
 30. P117. Data Types. Suggest adding a bullet point for Collection of REL and SES data for stratified analyses of health disparities.
- P118. 3rd bullet. Add *equity*.