



Connecticut SIM: Health Information Technology

STATE OF CONNECTICUT

HIT work group discussion
Connecticut Valley Hospital
Page Hall, Conf. Room 365,
1000 Silver St, Middletown, CT

May 20, 2013

Objectives for today's discussion

Review



- Connecticut SIM design aspirations and roadmap
- Care delivery and payment work group considerations
- Key questions and options for designing an HIT infrastructure that supports care delivery and payment innovation

Welcome to the SIM design HIT work group

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James Wadleigh
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Josh Wojcik
Office of the State Comptroller (OSC)

Note: Representative from UnitedHealthcare/ OPTUM is being identified



Working group norms - expectations for how we will work together

Objectives

- Develop recommendation for HIT infrastructure that serves as the foundation for care delivery and payment model

Presence

- Attend bi-weekly meetings with full group
- Participate actively in discussions to jointly shape work group thinking
- As needed, meet with facilitators one-on-one or in small groups in between workgroup meetings to move the answer forward

Mindset

- Respond promptly to email and phone requests
- Leave day job at the door, think of best interest of Connecticut
- Seek consensus amongst working group

Action

- Build momentum and excitement in your respective communities
- Champion this effort broadly
- Shape the future of health care delivery in Connecticut





Connecticut has a unique opportunity to address quality, access, and cost challenges today

Although Connecticut ranks at or above the national average on many indicators of health, there exists opportunity for improvement

- Connecticut is among the top five states with the lowest rates of smoking, premature deaths, and poor mental health days and the highest rates of immunization coverage; is among the top quartile of states with the lowest obesity rates; and is among the top 50% of states with the lowest rates of preventable hospitalizations, diabetes, infant mortality, cardiovascular deaths, and cancer deaths
- Health disparities, however, continue to exist across racial and ethnic groups, illustrated by the variability in the infant mortality rate of non-hispanic black infants that is 3x that of non-hispanic white infants
- Connecticut meets national average on select indicators of quality and patient experience, but quality varies significantly across regions

At the same time, Connecticut lacks a solution for the state to address the steep growth in state health expenditures

- Connecticut faces a potential ~\$1B budget deficit in 2014 and 2015, driven in part by an increase in health care spending, which continues to grow at a rate higher than Connecticut's gross state product
- Connecticut has the third highest per individual health care spend (including the highest per enrollee spend on Medicaid patients, 8th highest per enrollee spend on Medicare patients)
- Inefficiencies in health care utilization continue to exist today, illustrated by the significant utilization of high-cost care settings (e.g., emergency department) for non-urgent visits

While Connecticut has many payment and care delivery innovations underway, no common model is shared across Medicaid, Medicare, and Commercial insured populations

The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration



CT has support from CMMI to innovate care delivery and payment model reforms and has high aspirations for what it can achieve

CMMI guidance for State Innovation Models (SIM) design states . . .

- Design care delivery and payment reform that touches **80% of state lives within 5 years**
- Roll-out across multiple payers' populations in a truly **multi-payer approach**
- Describe how "**broad-based accountability for outcomes, including total cost of care** for Medicare, Medicaid, and CHIP beneficiaries, is created"
- Test innovative payment and service delivery models that have the potential to "**lower costs,**" while "**maintaining or improving quality of care**"

. . . helped shape Connecticut's targeted aspirations

- Gain alignment around a common care delivery and payment model that is applicable across Medicare, Medicaid, and Commercial populations
- Define a solution that incorporates total cost of care accountability
- Maintain or improve leading indicators of health and patient experience under the new care delivery and payment model
- Establish timeline for rollout that will meaningfully curb health care spending growth within 3-5 years

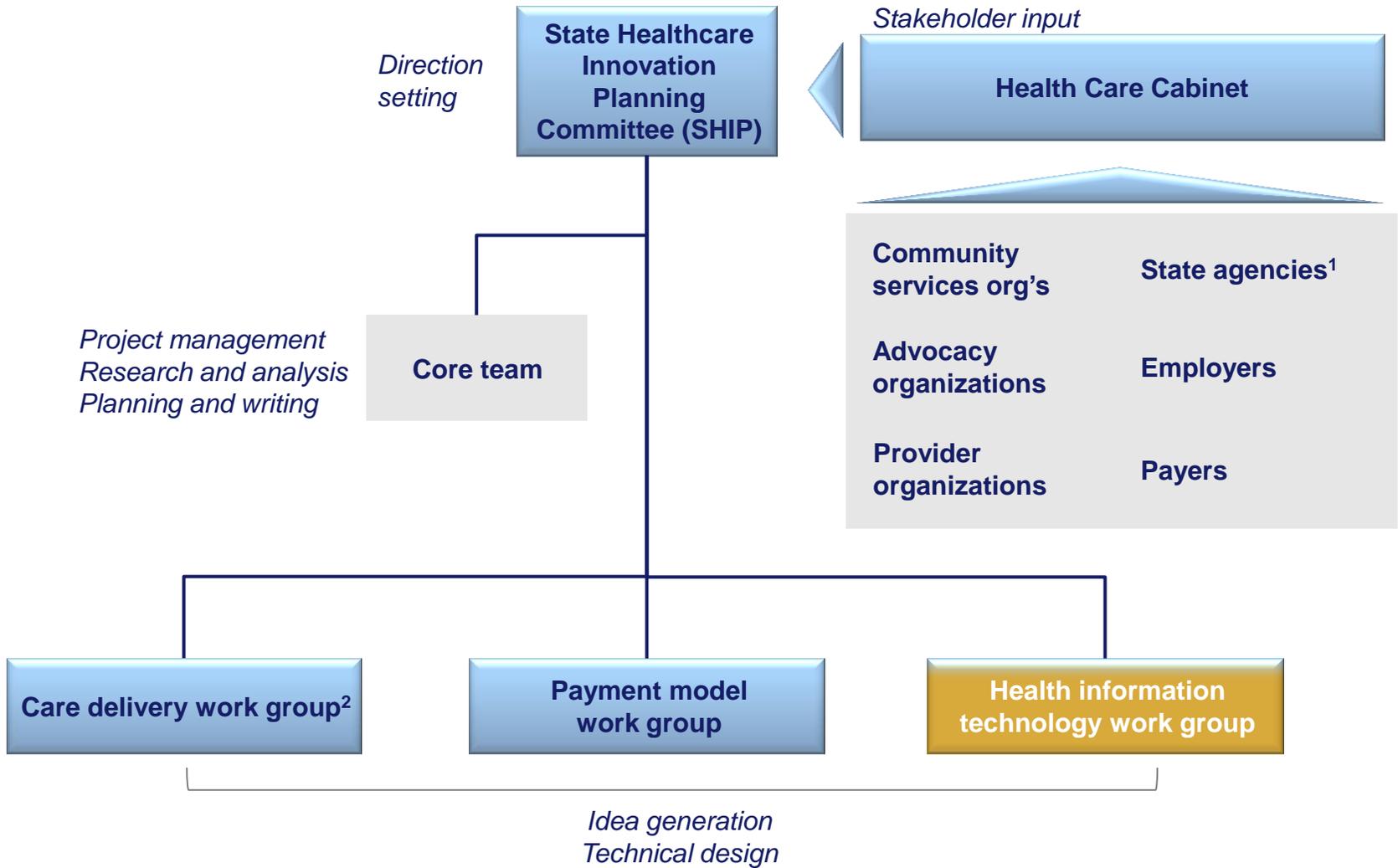
We will largely define and design the SIM care delivery and payment models by the end of July 2013



April	May	June	August
Project set-up <ul style="list-style-type: none"> Understand current state Establish vision 	Options and hypotheses <ul style="list-style-type: none"> Identify target populations and sources of value Develop health care delivery system hypothesis Pressure-test health care delivery system hypothesis Develop payment model hypothesis Align key stakeholders 	Design and planning <ul style="list-style-type: none"> Design detailed health care delivery system and payment model Develop implementation and roll-out plan Align on key quality metrics 	Syndication <ul style="list-style-type: none"> Draft testing proposal Syndicate with key stakeholders
			Finalization <ul style="list-style-type: none"> Refine and submit testing proposal



The HIT work group will provide recommendations to SHIP, the primary decision-making body

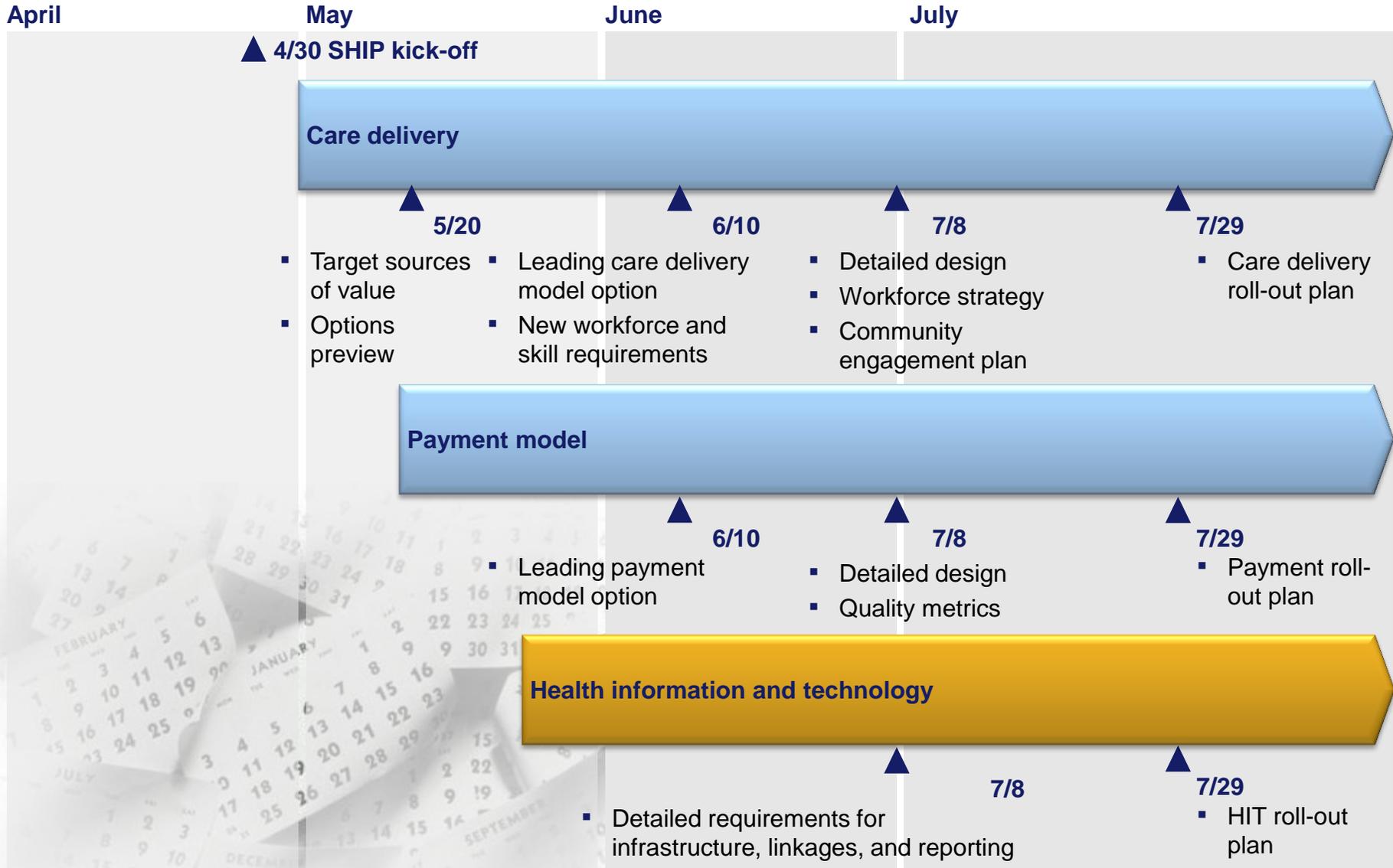


1 Planners: OSC, DMHAS, DSS, UCHC, DPH
2 Parallel process: DCF, DPH/UCHC, DMHAS



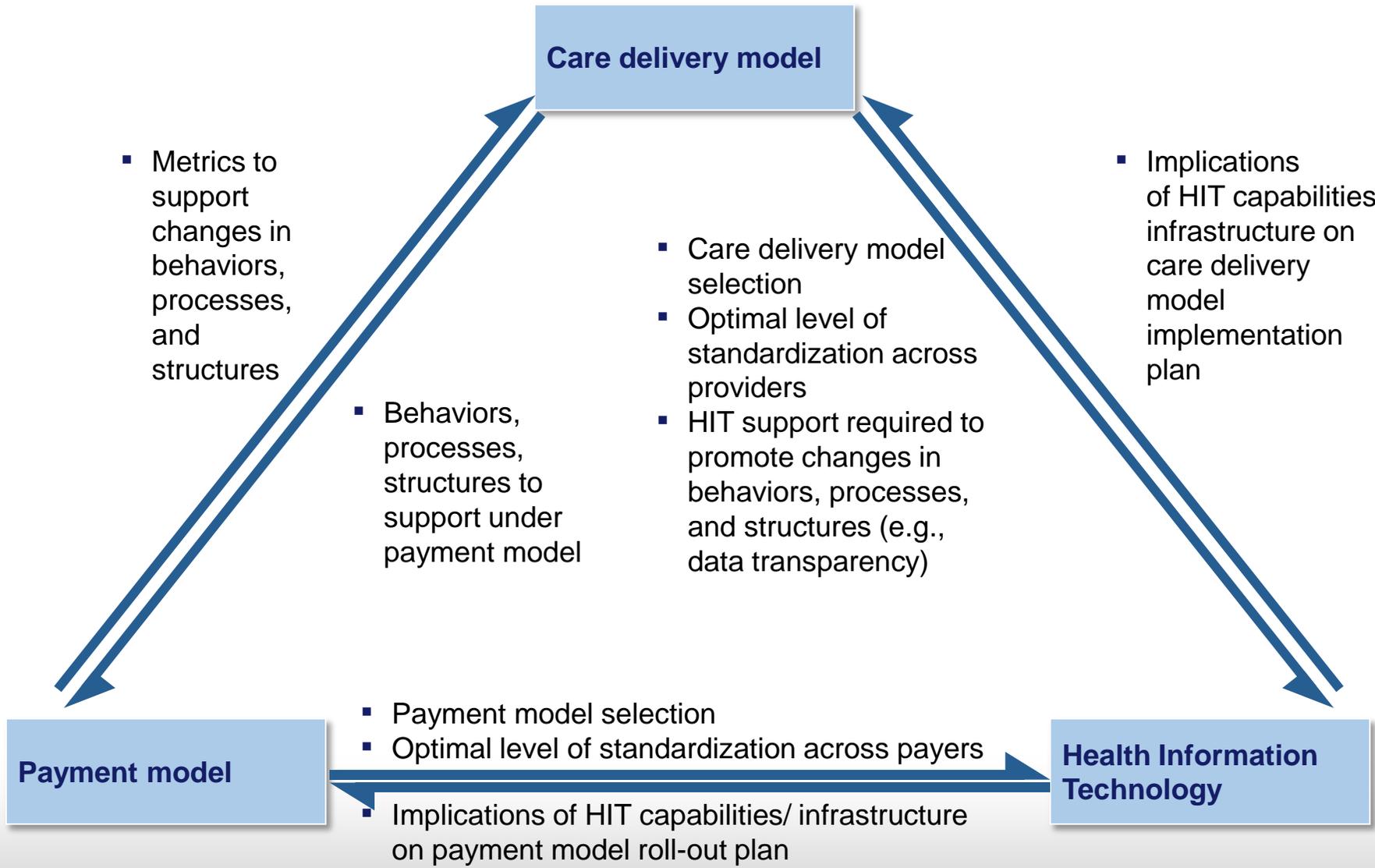
HIT will propose recommendations to the SHIP at regular intervals

▲ Recommendation to SHIP





Work groups will work closely with each other to share insights





The care delivery work group is considering focusing on a population-health model as the foundation for care delivery innovation

	Description	Examples	
Population health	Provider(s) responsible for the overall health of a population of patients over a set period of time and often targets highest cost group of patients with high touch care management		Relationships with CT physician groups to support practice of evidence-based medicine and coordinated care, particularly for patients with chronic conditions
			Patient centered primary care program which supports access to primary care and enhances care coordination
Episodes of care	Provider(s) with direct or indirect control over majority of care delivery for a defined acute procedure or condition are responsible for all care associated with the procedure or condition (e.g., CABG)		Best practices created for discrete episodes based on national or local guidelines and enforced standard clinical protocols
			
Discrete encounters	Specialty or service specific providers with direct control over discrete components of care delivery		Dedicated specialty hospital treats discrete eye procedures at lower costs and higher quality than in US

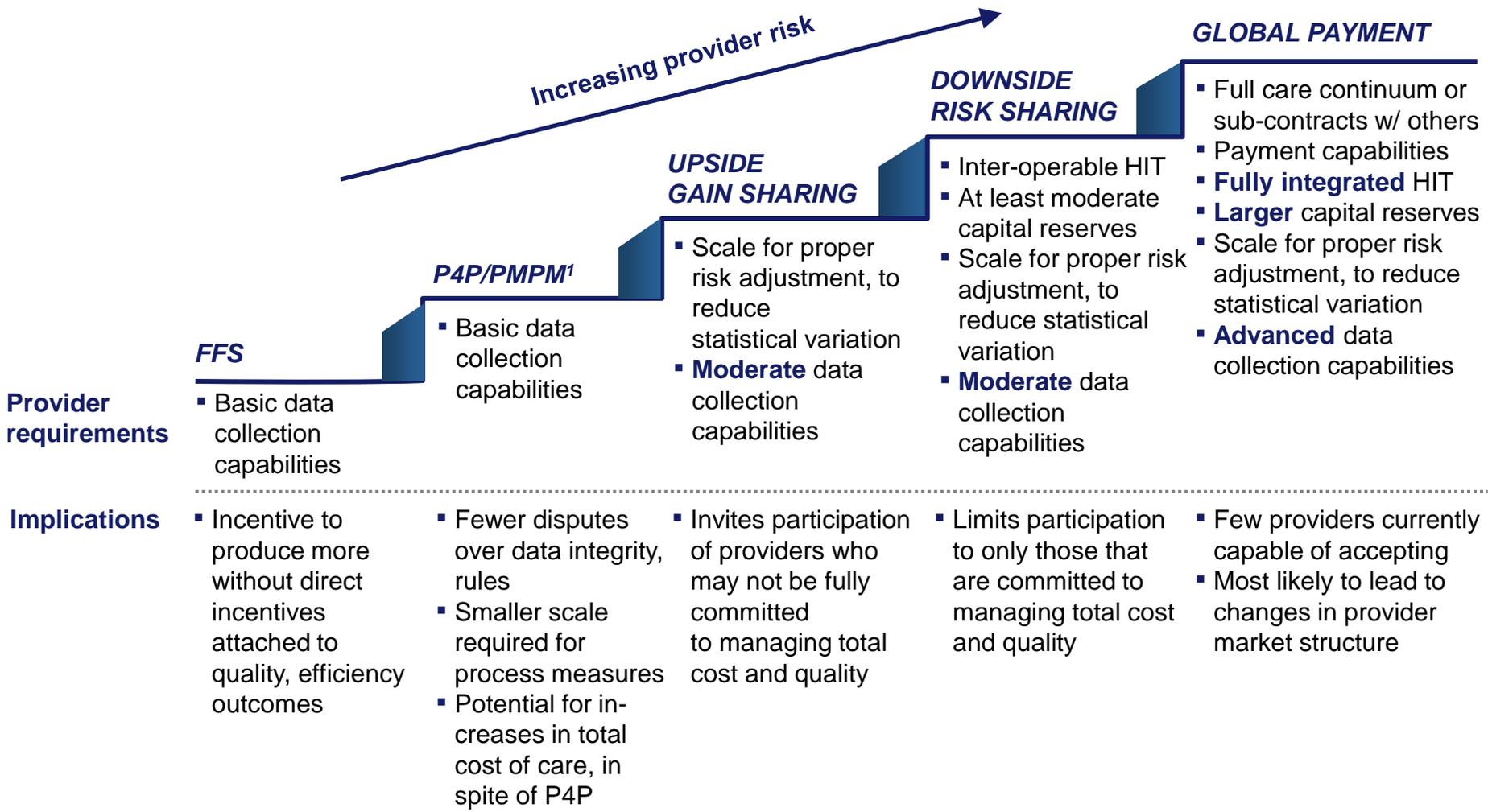


The care delivery work group is prioritizing 3-4 sources of value to target in the new care delivery model

	Description	Examples
Primary prevention	<ul style="list-style-type: none"> Prevention of disease by removing root causes 	<ul style="list-style-type: none"> Smoking cessation
Secondary prevention/ early detection	<ul style="list-style-type: none"> Early detection of disease while asymptomatic to prevent disease progression 	<ul style="list-style-type: none"> Breast cancer screening Identification and management of patients at high risk for heart disease
Selection of provider and care setting	<ul style="list-style-type: none"> Utilizing highest value care settings and downstream providers 	<ul style="list-style-type: none"> Phone consultation vs. in-person visit Optimized specialist referrals
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> Evidence-informed choice of treatment method/intensity 	<ul style="list-style-type: none"> Reduction in inappropriate utilization of c-section
Provider productivity	<ul style="list-style-type: none"> Reducing waste at provider center 	<ul style="list-style-type: none"> Improve flow in OR to increase number of surgeries performed daily
Care coordination / chronic disease management	<ul style="list-style-type: none"> Ensuring patients effectively navigate the health system and adhere to treatment protocols 	<ul style="list-style-type: none"> Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)



While providers will be held responsible for total cost of care, the payment model work group is investigating complementary payment innovations



¹ For example, PMPM for care coordination



Core care delivery and payment innovation technology beliefs

- **Technology is a critical enabler** to any care delivery and payment innovation program
- Successful programs **are iterative, focusing initially on quick-wins** then rigorously prioritize implementation roadmaps based on capabilities and value potential
- Program and underlying technology design should take a **provider-centric view** to maximize adoption
- Technology solutions should not be the rate limiter on a payment innovation program
- Payers can significantly leverage and extend **existing capabilities** (e.g., analytics) to accelerate impact
- **Robust vendor solutions** are beginning to emerge and are a critical medium-term program component; plan to **partner for the long-term** to enable the deep integration required
- Focused **change and adoption** programs should accompany any technology deployments to drive impact

Key questions for the design of a supporting HIT infrastructure for care delivery and payment innovation

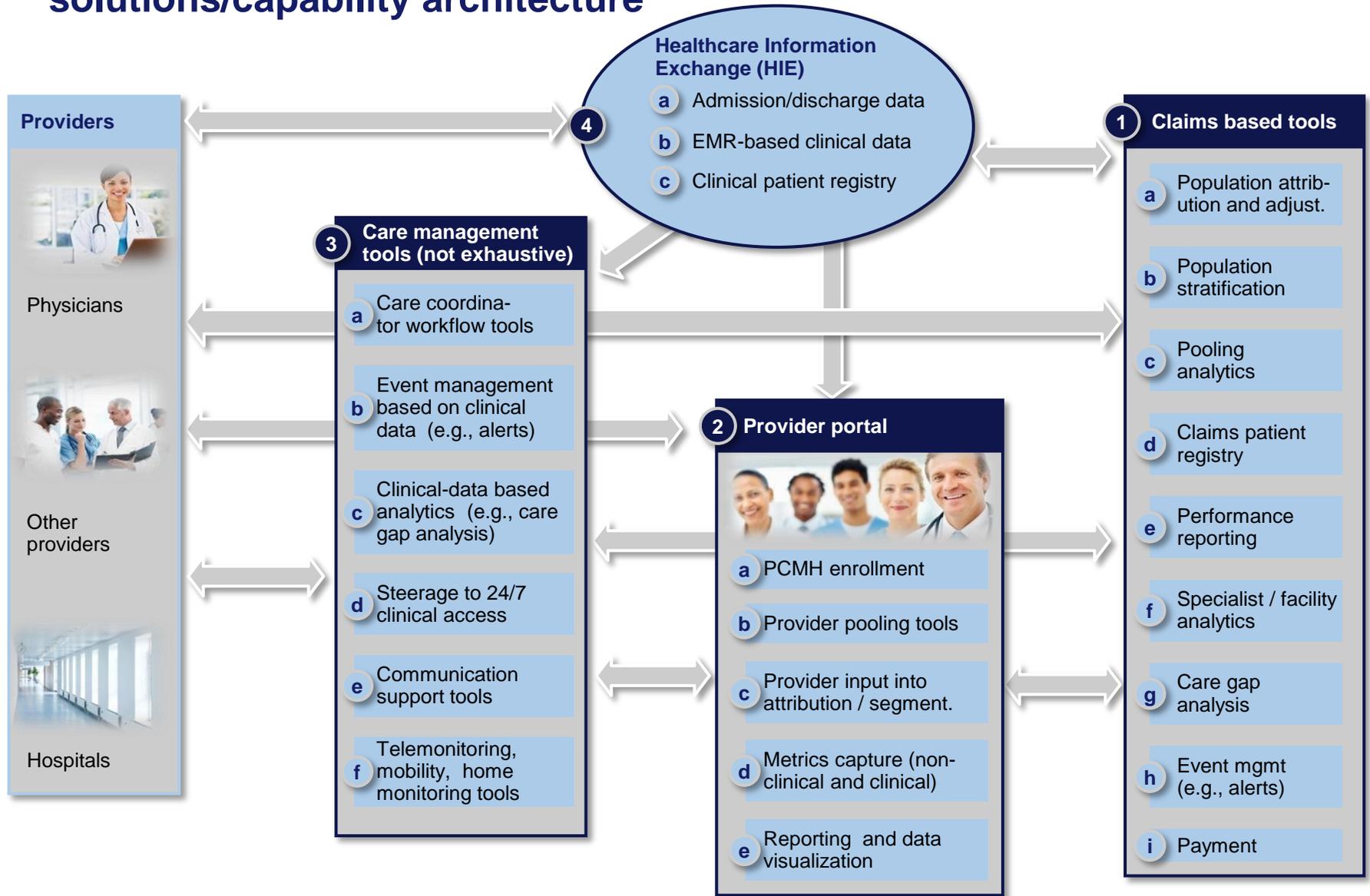
- A What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model?
.....
- B What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?
.....
- C What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, data visualization, portal)?
.....
- D What is the best strategy to develop the required HIT capabilities?
.....
- E What will be the pace of roll-out of the required capabilities throughout the state?
.....
- F What is the required budget to develop these capabilities?
.....
- G What is the best funding model to develop these capabilities?



A Across payers and providers, there are four sets of capabilities required for care delivery and payment innovation

Category	Description
1 Claims based tools	<ul style="list-style-type: none">Tools for payers to analyze claims and produce payment-related analytics, quality/outcome/performance metrics and make actual payments to providers
2 Provider portal	<ul style="list-style-type: none">Portal(s) for providers to access and submit information, data and analytics required to support care delivery and payment models
3 Care management tools	<ul style="list-style-type: none">Provider tools (e.g., workflow, event management) and analytics to e.g., physicians, care managers) coordinate the medical services for a patient (focus on highest risk)
4 Healthcare Information Exchange (HIE)	<ul style="list-style-type: none">Integrated clinical data exchange among healthcare stakeholders (e.g., payers, providers), including the longitudinal patient registry that can be enabled by HIE

A These four capabilities are often integrated into a typical solutions/capability architecture





Breakout exercise: What existing assets in Connecticut should we be aware of when designing HIT support for care delivery and payment?

- **Breakout:** Breakout into groups of 3 to discuss the following questions:
 - What **existing assets** in Connecticut can we leverage for the innovation of healthcare delivery and payment model?
 - How should these assets be leveraged in a **multi-payer** setting?
- **Group discussion:** Each group to report out synthesis for full team discussion

A Impact achievable at each stage of technology maturity

Claims-based

- Implement program based on population analytics, pooling
- Risk stratify patients based on claims-based
- Understand current performance and key utilization / quality drivers using risk-adjusted performance reports
- Make informed referral decisions based on transparent specialist/facility data (e.g., quality, cost, patient experience)
- Evaluate / understand performance using web-based tools

Clinical data-based

- Coordinate care through EMR-integrated workflow tools
- Automatically prioritize care coordinator outreach and support with automated patient engagement
- Develop more accurate predictive gaps-in-care analytics

HIE-enabled

- Provide cross-provider longitudinal patient record to all providers at point of care
- Monitor patients continuously based on mobile-enabled devices (e.g., scales, glucometers)



B Capabilities to be assessed through a set of structured interviews

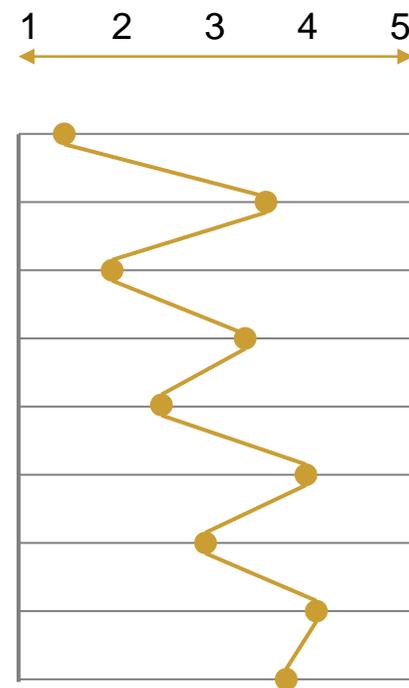
- We have developed a capability assessment tool and will need your input to complete the assessment:
 - Current levels of capabilities
 - Development approach (e.g., in-house vs. vendor)
 - Current initiatives/programs in flight
- An assessment needs to be completed for each payer

Capability	1	2	3	4	5
Population attribution and adjust					
Claims patient registry					
Performance reporting					
Specialist / facility analytics					
Care gap analysis					
Event mgmt (e.g., alerts)					
Payment					
Population stratification					
Pooling analytics					

Output will be used to inform cross-payer technology discussion and decisions

CAPABILITY

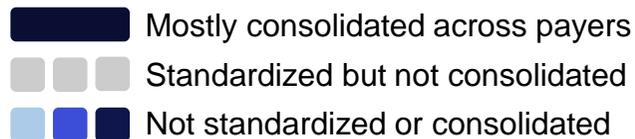
- Population attribution and adjust
- Claims patient registry
- Performance reporting
- Specialist / facility analytics
- Care gap analysis
- Event mgmt (e.g., alerts)
- Payment
- Population stratification
- Pooling analytics



**C Options for infrastructure/technology across multiple payers**

Option	Description	Rationale
 Mostly consolidated across payers	All payers using/sharing same infrastructure and technology	<ul style="list-style-type: none"> ▪ Cost synergies from scales across multiple payers ▪ Reduced operational complexity and confusion for the users (e.g., provider portal) ▪ Foundational requirements for state-wide initiatives (e.g., HIE)
 Standardized but not consolidated	Standardized output agreed-upon by all payers with independent execution and delivery	<ul style="list-style-type: none"> ▪ Output consistency (e.g., payment calculation, quality metrics, provider reports) required for state-wide roll out ▪ Stakeholder complexities associated with shared infrastructure
 Not standardized or consolidated	No standardization of output; no technology/ infrastructure sharing or consolidation	<ul style="list-style-type: none"> ▪ Cross-payer variation does not impact solution consistency ▪ Payers unable/unwilling to standardize

C Three core models to support care delivery and payment innovation technology and capabilities



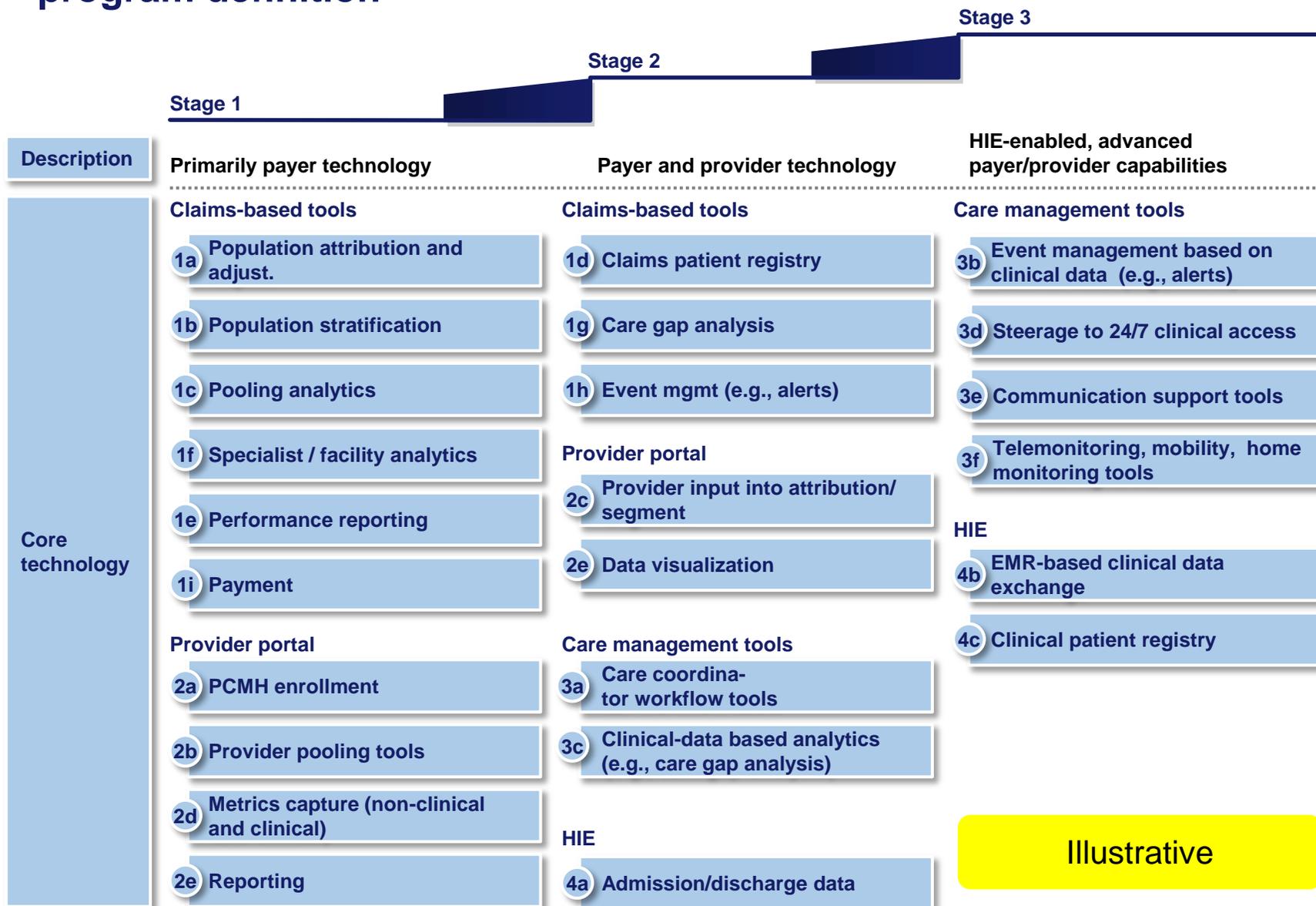
Example options for standardization (not exhaustive)

Components	A	B	C
	Coordinated	Standardized output	Shared infrastructure
Payer capabilities			
Provider portal	 		
Data visualization	 		
Reporting	 	 	
Claims-based tools	 	 	
Data	 	 	
Other capabilities			
Provider care management	 	 	
HIE			
	<ul style="list-style-type: none"> Most technology diverse by payers 	<ul style="list-style-type: none"> Unified provider-facing interfaces across payers 	<ul style="list-style-type: none"> Shared/co-owned technology and infrastructure

**D Potential approaches to develop capabilities required**

	Key options	Considerations
Care management tools	<ul style="list-style-type: none"> ▪ Pre-qualified vendor/solutions ▪ Payer-provider technology integration ▪ No payer support 	<ul style="list-style-type: none"> ▪ Availability of payer-sponsored tool ▪ Differences between payers ▪ Provider adoption ▪ Integration with Provider IT/tools
HIE	<ul style="list-style-type: none"> ▪ Leverage existing state initiative 	<ul style="list-style-type: none"> ▪ Scope and impact beyond payment innovation
Clinical patient registry	<ul style="list-style-type: none"> ▪ Buy ▪ Build ▪ Share existing 	<ul style="list-style-type: none"> ▪ Existing capabilities and payer differences ▪ HIE maturity and roadmap ▪ Payer agreement to share information
Provider portal	<ul style="list-style-type: none"> ▪ Share existing ▪ Integrate multiple portal ▪ Independent provider portal for each payer 	<ul style="list-style-type: none"> ▪ Current level of multi-payer support/integration ▪ Provider adoption ▪ Complexity and investment required to integrate or share portal
Claims based tools	<ul style="list-style-type: none"> ▪ Buy ▪ Build independently ▪ Share analytics infrastructure 	<ul style="list-style-type: none"> ▪ Efficiency gain ▪ Complexity to feed data across different payers' infrastructure ▪ Investment required

E Technology planning is part of the overall population health program definition



Illustrative



HIT work group meeting and key decision cadence

Meeting

Objectives/decisions

1st meeting
(5/20)

- Understanding of HIT capabilities that will be required across key stakeholders under new care delivery and payment models
- Criteria and approach to assess payer and health system capabilities

2nd meeting
(6/3)

- Understanding of current capabilities and linkages of key stakeholders
- Initial view on potential models for HIT standardization
- Evaluation of required health data sources required under new care delivery and payment models

3rd meeting
(6/17)

- Strawman for HIT standardization across key components
- Options to develop required capabilities (e.g., public utility vs. proprietary solutions, build vs. buy)
- Potential sequencing of required capabilities (e.g., feasibility, cost, day-one need)
- Early assessment of costs of implementing required capabilities

4th meeting
(7/1)

- Capability roadmap
- Strawman budget
- Assessment of potential funding sources

5th meeting
(7/15)

- Finalized budget
- Finalized funding sources



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- A background image showing a series of smooth, light-colored stepping stones arranged in a line across a body of water. The stones are partially submerged, and their reflections are visible in the water. The water has gentle ripples around the stones.
- Set up one-on-one meetings in the next 2 weeks to:
 - Understand current state infrastructure landscape
 - Develop first hypothesis on infrastructure roadmap for SIM
 - Assess gaps and identify options to close them
 - Discuss potential challenges to be mindful of when determining strategy
 - Synthesize findings and prepare for next discussion on June 3rd

Appendix



A Going from “good” to “great” in technology for innovative care delivery and payment models (1/2)

Category

1 Claims based tools

What “good” looks like

- Alignment across payers on analytics definition and reporting
- Separate execution and infrastructure by payers
- Fully automated algorithm-based analytics

What “great” looks like

- Pooling and analytics conducted across all participating payers for same providers
- Shared infrastructure enabling cross-payer pooling and efficient/ consistent analytics

2 Provider portal

- Single-sign-on portal connected to payer-specific interfaces
- Static periodic reporting

- Centralized multi-payer portal that allows for cross-payer reporting, information exchange
- Dynamic reporting that allows providers to create drill-down analytics and customized reports



A Going from “good” to “great” in technology for innovative care delivery and payment models (2/2)

Category

3 Care management tools

What “good” looks like

- Care coordination playbook and tool selection criteria
- Alerts sent to providers through payer-specific channels
- 24/7 access primarily through telephone
- Tele-monitoring on select high cost conditions (e.g., CHF)

What “great” looks like

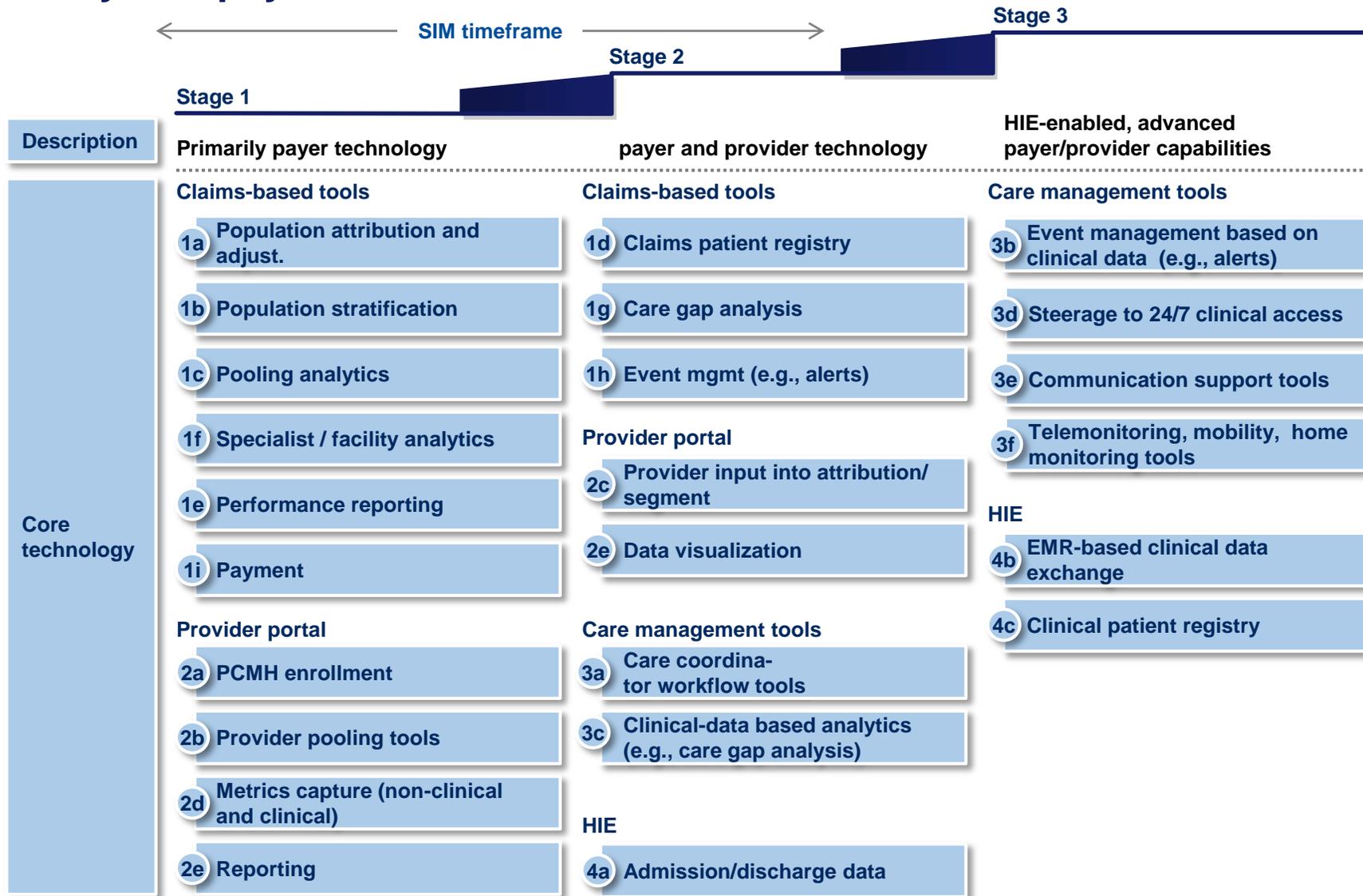
- Tools provided/developed or certified by payers
- Analytics, alerts and reminders fully integrated into workflow tools
- Single multi-payer channel for alerts/reminders for providers
- Multi-channel 24/7 access (e.g., phone, web)

4 Healthcare Information Exchange (HIE)

- Web-based tool that supports manual entry or upload of admission/discharge data and select clinical data
- Real-time access to admission/discharge information (e.g., alerts)

- API-based real-time data exchange between payer and provider EMR
- Centralized multi-payer clinical patient registry

Example staged approach to roll out technology for innovation in care delivery and payment model





Stage 1: Create separate payer reports and deliver through a common multi-payer portal

Components

Payer capabilities

Provider portal

Data visualization

Reporting

Claims-based tools

Data

Other capabilities

Provider care management

HIE

Stage 1 technology



Unified provider-facing interfaces across payers

Mostly consolidated across payers

Standardized but not consolidated

Not standardized or consolidated

Stage 1 approach

- Common portal across all participating payers
- Leveraging an existing provider portal and retrofit for multi-payer accessibility
- Standardized but separate reports for each payer
- All analytics, data and report generation technology different by payers with no consolidation

Stage 1 timeline:

- Year 1: Initial development and roll out
- Year 2-3: Addition of data visualization and more advanced functionality



Stage 2: Focus on developing care management tools for providers

■ Option chosen in case example



Options to address technology/infrastructure needs

RFQ	<ul style="list-style-type: none"> ▪ Payers set clear functional requirements and request vendors to be qualified ▪ Providers select freely among qualified vendors
Build/procure tools and provide to providers	<ul style="list-style-type: none"> ▪ Payers develop care management tools (jointly or separately) and provide to providers ▪ Tools provided with no charge or charges to the provider (e.g., lower % of gain share, one-time fee)
No payer involvement	<ul style="list-style-type: none"> ▪ Payers set guidelines and/or requirements for care management tools and are not involved in providers' selection, development or procurement of tools



Key questions to inform cross-payer technology design

Provider portal

- Are all payers willing to commit to a single provider portal for the SIM initiative?
- If yes, is there currently a portal that all providers in the state have access to?
 - If yes, are all payers willing to use this portal?
 - If no, which option should we take to have a single portal? A) Build, B) Procure, C) Revise an existing website, D) Other?

Data visualization

- Are payers willing to store all raw claims data in the same data store?
- Are payers willing to co-invest in developing shared data visualization capabilities?

Reporting

- Will there be a single report across payers or separate reports?
- If separate reports, will the reports be highly standardized?

Claims-based tools

- Do payers currently have the capabilities to perform claims analyses required by the target payment model?

Data

- Is there an existing multi-payer database?
 - If yes, are payers willing to build shared analytical capabilities for this database?
 - If no, is there a plan to develop one during the SIM timeline? (~36 months)

Provider care management

- How are payers assisting providers in care management technology today?
- Are payers willing to co-invest in a single solution for care management?

HIE

- What % of population/patients are currently covered in HIE?