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CONNECTICUT HEALTHCARE INNOVATION PLAN



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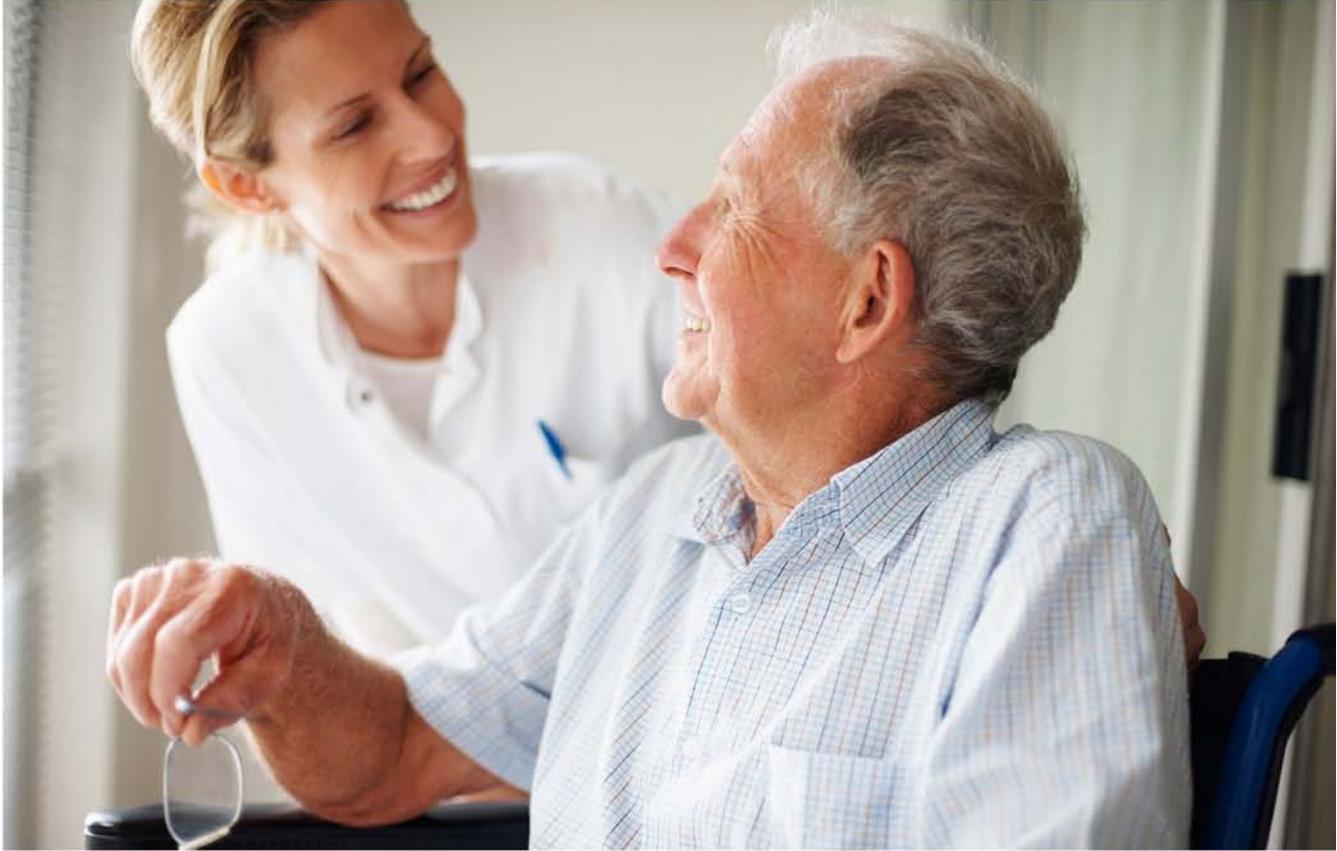
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EXECUTIVE SUMMARY

Vision for the future

By 2020, Connecticut will establish a whole-person-centered health system that ensures superior healthcare quality and access, promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability.

CONNECTICUT'S CURRENT HEALTH SYSTEM

Connecticut's residents are among the healthiest in the nation, and the state has an exceptionally rich array of healthcare, public health, and support services that provide a strong foundation for advancement. Despite this, the state must improve on indicators of healthcare quality. For example, Connecticut has high emergency department utilization rates, especially for non-urgent conditions, and it has a relatively high rate of hospital readmissions. Significant health inequities and socioeconomic disparities persist, keeping the state from achieving higher quality outcomes and a more effective and accountable care delivery system. The state also faces the significant challenge of high healthcare costs in both the private and public sectors.

In 2012, healthcare spending in Connecticut was \$29 billion. We rank third highest among all states for healthcare spending per capita, at \$10,470 in 2012. These figures raise concerns about continued affordability of healthcare coverage and the impact of healthcare spending on business competitiveness with other states. Just as importantly, over the past several years, growth in healthcare spending has outpaced our economy's growth, meaning that each year fewer resources have been available to support education, housing, paying down consumer debt, or saving for the future.

Consumers, consumer advocates, providers, private payers, employers and state agency officials report barriers in access to care, a delivery system that fails to educate and inform consumers, and misguided payment methods that reward volume of service rather than quality, access and overall health improvement.

OUR STATE INNOVATION MODELS INITIATIVE

In March 2013, the Governor's Office received a \$2.8 million planning grant from the Centers for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan ("Innovation Plan"). Our Innovation Plan is Connecticut's vision for achieving the Triple Aim for everyone in Connecticut: better health, while eliminating health disparities, improved healthcare quality and experience, and lower healthcare

costs. CMMI charged us with designing new healthcare delivery and payment models that would include value-based payment tied to the totality of care delivered to at least 80% of our population within five years.

Connecticut's Innovation Plan reflects the alignment of our payers (Medicaid, our state employees' plan, commercial plans, self-funded plans and hopefully Medicare), healthcare providers, employers, consumers, advocates and public agencies. The Innovation Plan also reflects our vision for building on ongoing innovations within our state that will bring best practices to scale on a statewide basis with the support of all payers. Connecticut is already home to many innovative healthcare organizations, public entities and community-based organizations that have made significant investments in improving health and healthcare. To date, however, these efforts have been mostly pilot programs, focused on single populations and/or select geographic regions within the state. Participants in our State Innovation Models initiative are eager to identify sustainable models that will support innovation on a greater scale.

This Innovation Plan is the product of broad stakeholder input, including more than 20 consumer focus groups and various forms of surveys comprising almost 800 individuals, and more than 25 multi-stakeholder meetings including payers, providers, employer purchasers, and consumer advocates. In these forums, we surfaced issues within our current healthcare system and barriers to community health improvement. We then evaluated and prioritized options for innovation. We also established principles for value-based payment and health information technology that will be implemented on a multi-payer basis for the benefit all covered populations. In parallel, we developed an understanding of the current healthcare workforce and defined initiatives that will expand and align our workforce to address the needs identified through workgroups and consumer feedback. Throughout these efforts we recognized that empowering Connecticut's residents, all of whom are healthcare consumers, is a central goal and key to achieving our overall aims.

Over the next several weeks, this plan will be refined based on further stakeholder feedback and public comment. It will be submitted to CMMI by the end of December. In the following months, the Innovation Plan will guide the development of the initiatives that will constitute our proposal for a CMMI model testing grant that we anticipate submitting this spring. In selecting initiatives and crafting our proposal we will continue to work with stakeholders to continuously improve the Innovation Plan to make it a more effective roadmap for achieving a healthier Connecticut.

GOALS FOR HEALTH SYSTEM PERFORMANCE IMPROVEMENT

We will judge our efforts a success if the new care delivery model and enabling initiatives empower us to achieve our goals for health system performance, including:

- Better health and the elimination of health disparities for all of our residents
- Better healthcare by achieving superior quality of care and consumer experience
- A lower rate of growth in healthcare costs to improve affordability

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Primary drivers of transformation

Our Innovation Plan is based on three primary drivers for health system transformation:

- **Primary care practice transformation** to more effectively manage the total needs of a population of patients
- **Community health improvement** through the coordinated efforts of community organizations, healthcare providers, employers, consumers and public health entities
- **Consumer empowerment** to enable consumers to manage their own health, access care when needed, and make informed choices regarding their care

PRIMARY CARE PRACTICE TRANSFORMATION

A cornerstone of our Innovation Plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements:

1. **Whole-person centered care:** care that address the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health.
2. **Enhanced access:** an array of improvements in access including expanded provider hours and same-day appointments; e-consult access to specialists; non-visit methods for access the primary care team; clear, easily accessible information; and convenient, timely, and linguistically and culturally appropriate.
3. **Population health management:** Using population-based data to understand the risks for one's own panel, key sub-populations (e.g., race/ethnicity) and individual patients and using that information to guide care coordination and continuous quality improvement.
4. **Team-based coordinated care:** Multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team.

- 5. Evidence-informed clinical decision making:** Applying clinical evidence to target preventive care and interventions toward those patients for whom the intervention will be most effective and using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care to incorporate the most up-to-date evidence into clinical practice, so as to enable consumer directed care decisions.

Connecticut has designed a variety of programs not only to help providers but to make it easy for them to start the transformation. Because practices are in very different stages in terms of their ability to meet the standards for becoming an AMH, we created the glide path program, which provides technical assistance and other support to facilitate the practice transformation process. Participating practices continue to receive support as they adopt advanced practices like whole-person-centered care and care coordination. When practices have demonstrated readiness to coordinate care, payers will begin to reimburse them for providing care coordination services. In time, providers will take responsibility for a broader array of quality and performance metrics, including offering a better care experience for their patients.

COMMUNITY HEALTH IMPROVEMENT

While primary care transformation is essential to effectively manage chronically ill populations, we recognize that effective prevention cannot be achieved by the care delivery system or by public health agencies alone. A major part of our transformation strategy is to foster collaboration among the full range of providers, employers, schools, community-based organizations, and public agencies to collectively work to improve the health of populations within their community. Our approach to community health improvement comprises two elements:

- 1. Establishing Health Enhancement Communities (HECs) in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities**
- 2. Strengthening community-based health services and linkages to primary healthcare by establishing a Certified Community-Based Practice Support Entity**

CONSUMER EMPOWERMENT

At the most fundamental level, human autonomy, a person's control over their mind and body, must be respected and placed at the center of any efforts to achieve our

vision. The delivery of whole-person-centered care requires a transformation in how payers and providers respect and enable consumers to be active participants in the management of their health. Transformation also requires recognition of the many factors outside of a provider's office that affect health and the network of organizations with which the state can partner to improve community health and empower consumers.

The state will encourage providers to equip consumers with information, resources, and opportunities for them to play an active role in managing their health. The state will support participating payers' adoption of benefit plan designs that reward consumers who use these resources to understand and make informed healthcare decisions.

As part of our plan for consumer empowerment, we will encourage payers and providers to participate in a four-pronged strategy detailed in the Innovation Plan:

- 1. Consumer input and advocacy via decision-making roles in the governance structure of our model**
- 2. Enhanced consumer information and tools to enable health, wellness, and illness self-management, including shared decision making with providers**
- 3. Consumer incentives to encourage healthy lifestyles and effective illness self-management**
- 4. Improved access to health services**

Enabling Initiatives

Connecticut will enable transformation through performance transparency, value-based payment, health information technology, and workforce development. These initiatives, described in detail in the Innovation Plan, are highlighted here because of their critical role in achieving our vision.

PERFORMANCE TRANSPARENCY

Diverse groups of stakeholders have emphasized that increased transparency of quality and cost is a fundamental prerequisite to improving our health system. Transparency will support our aims in multiple ways at different points in time:

- 1. Shaping the design of new networks, payment models, and clinical interventions**
- 2. Informing consumer choice of health plan and network at the point of purchase of healthcare coverage**
- 3. Influencing consumer choice of provider at the point of care, as well as referral from one healthcare professional to another provider**
- 4. Inspiring and guiding providers' own performance improvement efforts**

Connecticut's strategy to increase performance transparency, payers have agreed to adopt a common performance scorecard that reflects the AMH provider's ability to meet measures of health status, quality of care, consumer experience, cost of care and resource utilization. Eventually, this scorecard will be expanded to include other providers, such as hospitals and specialists, which will inform consumer's decisions about where to go for care.

VALUE-BASED PAYMENT

A key enabler of our transformation will be the shift from purely fee-for-service payment, which rewards providers for delivering a greater volume of services and procedures, to value-based payment, which rewards providers for delivering high-quality care and a positive consumer experience, while reducing waste and inefficiency. Value-based payment also reduces healthcare costs or better controls the growth in healthcare spending over time. Implementing these payment changes on a multi-payer basis strengthens the business case for providers to invest in new capabilities and processes to improve performance, while eliminating the potential that they will be

operating under conflicting payer incentives. Based on the guidance from our Payment Model Workgroup, we have defined a strategy for value-based payment that comprises four principles:

- 1. Two tracks for value-based payment:** Most glide path providers who are new to value-based payment will begin in the Pay for Performance (P4P), which introduces rewards for performing well on quality and care experience targets. Eventually, all providers, as they achieve the scale and capabilities, will migrate to a Shared Savings Program (SSP). An SSP introduces accountability for the overall cost of care for a panel of patients and the ability to share in savings when a practice provides more effective and efficient care.
- 2. Alignment of payers to adopt similar reward structures tied to a common scorecard.** Payers will be encouraged to tie SSP and P4P programs to the same common scorecard for quality, experience, and resources utilization to reduce complexity for providers, increase the business case for investment in new capabilities, and sharpen provider focus on specific measures of success supported by all providers.
- 3. Provider and Payer independence in setting risk parameters and levels of outcomes-based payments.** Payers and providers will make independent decisions on the level of risk or gain sharing made under SSP, and/or the level of outcomes-based bonus payments made under P4P. Arrangements in which providers share in gains but not losses (“upside” arrangements) meet the minimum requirements of our Innovation Plan. Payers and providers may also decide to share in losses (“downside” or “risk” arrangements). Medicaid providers will not participate in risk arrangements.
- 4. Support for providers to affiliate or organize,** for example, as independent practice associations (IPAs), accountable care organizations (ACOs), or clinically integrated networks to enable them to achieve the scale and capabilities necessary to effectively manage a population of patients.

HEALTH INFORMATION TECHNOLOGY

Based on the recommendations of our Health Information Technology Workgroup, we have defined a health information technology strategy that is based on four principles:

- 1. Implementation of the All Payer Claims Database (APCD)** to allow for aggregated performance measurement for quality and resource utilization.

2. **Creation of a multi-payer portal for consumers and providers** to allow easier access to information and better decision making by providers and consumers
3. **Guidelines for care management tools.** Because Connecticut has a large number of small provider practices, we will establish shared guidelines rather than mandatory procedures for adopting care management tools.
4. **Standardized approach to clinical data exchange** to accelerate providers' use of direct messaging for secure communication with other providers and to ensure coordinated care delivery across different sites of care

HEALTH WORKFORCE DEVELOPMENT

For the Innovation Plan to succeed, it is essential that Connecticut have a healthcare workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. We lay out six broad, multipurpose initiatives based upon input from our health workforce taskforce:

1. **Health workforce data and analytics**
2. **Inter-professional education (IPE), the Connecticut Service Track**
3. **Training and certification standards for Community Health Workers**
4. **Preparation of today's workforce for care delivery reform**
5. **Innovation in primary care Graduate Medical Education (GME) and residency programs**
6. **Health professional and allied health professional training career pathways**

Managing the transformation

GOVERNANCE STRUCTURE

The Lieutenant Governor will provide overall leadership for the Innovation Plan implementation. She will establish a Healthcare Innovation Steering Committee by, a successor to the existing Steering Committee, with additional consumer, consumer advocate and provider representation. A Project Management Office will also be established to lead the detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress to the public, state government and CMMI.

Four specialized task forces and councils are envisioned focusing on provider transformation standards, support, and technical assistance; coordination of the various health information technology projects; quality and care experience metrics and performance targets; and methods for safeguarding equity, access, and appropriate levels of service. This structure is expected to be in place by January 2014.



The Steering Committee and Project Management Office will seek ongoing advice and guidance from Connecticut's Healthcare Cabinet, which was established in 2011 to advise Governor Dannel P. Malloy and Lieutenant Governor Nancy Wyman on issues related to implementation of federal health reform and the development of an integrated healthcare system for the state. Consumer input will be provided through the Consumer Advisory Board throughout the detailed design, pre-implementation and implementation phases of this initiative.

TRANSFORMATION ROADMAP

Our Innovation Plan will be implemented over five years, divided into four phases: 9-month detailed design beginning in January 2014; 9-month implementation planning beginning in October 2014; Wave 1 Implementation beginning in July 2015; and subsequent scale-up through successful waves of implementation in State Fiscal Years (SFY) 2017-2020.

1. Detailed Design (January to September, 2014). Pending stakeholder feedback and refinement of the Innovation Plan, the state will establish new governance structures and form a program management office (PMO). The PMO will have a small, dedicated staff that will rely on contracted support as necessary. The PMO will develop the more detailed technical design necessary to support our new models, including such activities as defining primary care practice transformation standards/ milestones and establishing common measures of quality, consumer experience, and resource utilization for the common scorecard.

2. Implementation Planning (October 2014 to June 2015). Pending the award of the CMMI State Innovation Models Testing Grant and our securing other funding, we will initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes. Example activities during this period include procurement of technology development, practice transformation, and other external products and services necessary to support launch; as well as development of the first versions of consumer/provider portals and the first versions of AMH performance reports for Medicaid and other payers electing to use common scorecards.

3. Wave 1 Implementation (July 2015 to June 2016). State Fiscal Year 2016 will mark the first year of operations of our multi-payer model for AMH as well as initiation of our new capabilities to support Workforce Development. Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the Connecticut Service Track.

4. Wave 2+ Scale-Up (July 2016 to June 2020). In State Fiscal Year 2017 and beyond, we will continuously improve the common scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities. In addition, primary care providers will continue to be enrolled in the Glide Path and AMH model, and providers will continue to transition from P4P to SSP as they achieve the minimum necessary scale

and capabilities over time. This period will also mark the major expansion of our Community Health Improvement and Workforce strategies, including establishment of Certified Entities and implementation of the Connecticut Service Track.

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What makes our plan distinctive?

Connecticut's Innovation Plan will launch quickly and successfully. Existing innovations that complement our Innovation Plan are already improving access, integrating behavioral and mental healthcare, and addressing equity issues in communities, workplaces and schools. Medicaid and Commercial payers are implementing payment initiatives that support ACO and PCMH models. Our plan offers the following areas of distinction:

- Promotion of Health Equity and Elimination of Disparities for All CT Residents
- Equity and Access Council
- Consumer Empowerment
- Community Health Improvement through Certified Community Based Entities and Health Enhancement Communities

Connecticut is one of the most racially, ethnically and culturally diverse states in the country—in some counties of Connecticut, residents speak over 60 languages --yet the state performs unacceptably on many quality measures that capture race, ethnicity and other cultural data. We focus our model on the promotion of health equity and the elimination of health disparities by taking specific action steps through each component of our Innovation Plan.

To achieve the triple aim, the State has committed to eliminating persistent barriers to health equity. The State's strong partnership with the stakeholder community has allowed ongoing opportunities for sharing ideas, soliciting feedback and fostering collaboration, which will help to ensure successful efforts to achieve health equity. One example of stakeholder engagement is the annual Curtis D. Robinson Men's Health Institute Town Hall; the 2013 Town Hall focused on health equity and attracted more than 600 patient, provider and community advocates.

<http://www.healthjusticetownhall.org/watch-live/>.

Consumer Empowerment

Consumer empowerment through engagement is vital to our innovation plan. We will build on our current successes. We will partner with commercial payers and employers to integrate consumer engagement innovations, including value-based insurance design (VBID), into the AMH model. VBID is achieving outstanding results with Connecticut's state employees and retirees. Consumers receive financial incentives to attend yearly physicals and undergo recommended preventive testing. They can also access health

education via classes on chronic conditions and a health portal. Approximately 98% of eligible Connecticut state employees and retirees are enrolled in the program, and physicians are reporting a remarkable impact on patient interest in well care visits and attention to chronic disease management.

Connecticut is committed to its public providers integrating behavioral and physical health care. Governor Malloy and the Connecticut's General Assembly strongly support the state's innovative and recovery-oriented services in behavioral health, especially those serving children. Closer coordination with primary care providers will help extend this expertise. In one example, the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) are working together as the Connecticut Behavioral Health Partnership (CTBHP). The CTBHP delivers person-centered, family-focused, community-based care for children, adults and families under the Medicaid and State Children's Health Insurance Program (SCHIP). The partnership also offers intensive case management for complex cases, peer support, payment withholds to the ASO that depend on targets (e.g., reduction in hospital ED overcrowding); and bonuses/pay for performance.

Connecticut now has multiple examples of Person-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACO) that create a strong foundation for the AMH model. We will strengthen our current care delivery models through the development of key consumer experience quality metrics in our AMH. Those consumer experience metrics will be created through the work of consumers on our Quality Council.

Connecticut developed a strong and deep community network through a partnership between the Office of the Healthcare Advocate and Access Health CT in creation of the Navigator and In-Person Assister Program. The network reaches individuals in all areas of the state, at all income levels and represents over thirty languages. While this cohesive network of community organizations is now focused on enrolling our 344,000 uninsured residents into Medicaid or private healthcare coverage, we will harness this network and shift its focus on building ongoing consumer engagement.

Connecticut's consumer advocates and the consumers we reached in focus groups and other will help the state implement an ambitious and ongoing stakeholder engagement plan that calls for broad input; finally, they will help the AMH model deliver a better care experience and higher quality of care through their attention to access to care and the prevention of unwarranted denials of care.

Equity and Access Council

Our value based payment reforms emphasize achievement of quality and care experience targets, while also recognizing the need for methods to guard against under-service. Through the establishment of an Equity and Access Council, Connecticut intends to be a national leader in the identification and deployment of advanced analytic methods that offer special protections for consumers as we migrate to value-based payment environment and to prevent providers from benefiting from unwarranted denials of care.

Community Health Improvement

Community health improvement is a key component of our model—realizing that the goal of community health is in the value of our diverse communities. The states proposal Health Enhancement Communities (HECs) and Community Based Certified Entities are innovative opportunities to increase the impact of our AMH and community interventions to implement the Institute of Medicine’s (IOM) best practices in integrating primary care and public health.

Connecticut’s Areas of Distinction are the keys to achieving our vision.



CONTEXT FOR HEALTH SYSTEM TRANSFORMATION

Connecticut healthcare environment

Connecticut ranks among the top states in the nation on healthcare, based on many of its health indicators – e.g., high immunization rates, low smoking rates, premature death rates and numbers of poor mental health days that are all better than the national average. However, many other indicators need significant improvement. For example, Connecticut has high emergency department utilization rates, especially for non-urgent conditions, and it has a relatively high rate of hospital readmissions. Substantial health inequities and socioeconomic disparities also exist. The state faces significant challenges in healthcare expenditures with per capita spending ranked among the highest in the nation. The state will leverage its strengths to improve care across all populations and will further address more complex issues among specific groups.

POPULATION DEMOGRAPHICS AND COVERAGE--HIGHLIGHTS

Connecticut has 3.5 million residents. According to Moody's Analytics, 72% of the state's population is white, 11% African American, 10% Hispanic and 7% other.¹

Income: While only 11% of residents are below the federal poverty line (FPL) in Connecticut, lower than the U.S. average of 15%, 720,000 (21%) of residents were living at or near poverty in 2010.² In urban areas, where 88% of Connecticut residents live, many (25%) are below the federal poverty line.³ And in Connecticut, where the family self-sufficiency standard exceeds that in other states, the percentage of residents living in real poverty exceeds 25%.

Healthcare Coverage: Sixty-four percent of the state's residents have employer-sponsored or individual health coverage. Of the remaining 36%, Medicare covers 13%, Medicaid covers 13% and 10% are uninsured.⁴ Four commercial payers cover 85% of the 2.2 million lives in the private insurer market: Anthem, Aetna, UnitedHealth Group

¹ Moody's Analytics (2011)

² Connecticut Association for Community Action, Meeting the Challenge of Poverty (2013)

³ U.S. Census Bureau, 2010 Census

⁴ Kaiser Family Foundation, State Health Facts (2011)

and Cigna.⁵ Fifty-two percent of the lives covered by Medicaid are children; however, children only account for 17% of total Medicaid payments.⁶

Connecticut has a high proportion of self-insured employers⁷. This is a challenge as many of these employers have yet to make up-front investments in care coordination fees to support the delivery of higher-value care. The state partnered with the Connecticut Business Group on Health and the Northeast Business Group on Health to engage these employers to become active participants in the transition to higher value care.

POPULATION HEALTH INDICATORS -- HIGHLIGHTS

Connecticut's excellent immunization rates and its low rates of smoking, premature deaths and poor mental health days currently place it in the top 10% of states.⁸ It also ranks in the top half of states for the lowest rates of diabetes, infant mortality, cardiovascular deaths and cancer deaths.⁹ However, racial and socioeconomic health disparities persist and provide significant opportunities for improvement in these and other areas (see *Health Inequities and Socioeconomic Disparities*, page 19).

- For adults, the leading causes of death in Connecticut are heart disease and cancer, with almost equal rates for men and women.
- Adult obesity is significantly below the national average – 25.4% of males and 23.6% of females are obese, compared to national averages of 44% and 48%, respectively.¹⁰
- Childhood obesity is a problem among males. In 2011, 33% of male 9-12 grade students were overweight or obese compared to 20.1% of their female peers. While this trend increased by 3% for the males from 2005 to 2011, it decreased for females by (-.6) %.
- 619 children below the age of six had lead poisoning in 2011.¹¹

⁵ HealthLeaders InterStudy, Market Overview: Southern Connecticut (2012)

⁶ Kaiser Family Foundation, State Health Facts (2011)

⁷ Kaiser state health facts

⁸ The Connecticut State Health Assessment, conducted by the Connecticut Department of Public Health (DPH), helped create these pages. It examined mortality and hospitalization, maternal and child health, environmental and occupational health, and chronic disease prevention and control

⁹ America's Health Rankings (2012)

¹⁰ CDC, Fast Stats: Obesity and Overweight (2009)

QUALITY OF CARE

While Connecticut performs well on certain population health status indicators, it can enhance its performance on at least three system-wide healthcare quality indicators: disease-specific quality process/outcome metrics, patient service levels, and hospital readmissions.

Disease-specific quality process and outcome metrics: Connecticut surpasses national averages on multiple quality measures. For example, its mammogram rate for breast cancer screenings among women 40+ is 85.6% vs. the 67.1% national benchmark.¹² However, the state underperforms on other measures; for example, only 69.4% of the state's diabetic patients received a dilated eye exam, significantly lower than the 82.1% national benchmark.¹³

Patient service levels: Of the four large health systems in the state (Yale New Haven, St. Francis Healthcare, Hartford Healthcare, and Western Connecticut), only one consistently exceeds the national averages on quality metrics¹⁴ – Western Connecticut. Their ratings on these metrics present each of these systems with opportunities to develop and advance their services. According to the Centers for Medicare and Medicaid Services (CMS), patients' experiences in the state's hospitals met the national average. However, the timeliness of treatment did not, with patients spending 341 minutes in the Emergency Department (ED) before inpatient admission vs. a national average of 274 minutes.

Hospital readmissions: Although Connecticut's overall readmission rate was less than the national average in 2010 (13.4% vs. 19.2% respectively¹⁵), its Medicaid readmissions were significantly higher. The combined Medicaid medical/behavioral health 30-day readmission rate for 2010 was 12.8% (on a total of 89,246 acute hospitalizations), which indicates significant opportunities for improvement. The medical-only rate of 11.8% was the highest rate among peer states – tied only with New York Medicaid –and much higher than the peer-state benchmark of 9.4%. The Medicaid behavioral-health 30-day readmission rate in Connecticut was almost twice that at 18.4% in 2010.

¹¹ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

¹² CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

¹³ CDC, Diabetes Report Card

¹⁴ CMS: Hospital Compare (2012)

¹⁵ Connecticut DPH, Chart Book: Availability and Utilization of Health Care Services at Acute Care Hospitals and Federally Qualified Health Centers (2011)

Readmissions are a major drain on the state's funds. Across Medicaid, hospital readmissions under 30 days cost the state \$92 million.¹⁶ The largest number of these occurred within the 45-64 year-old age group and cost the state \$32 million. Medicare also announced recently that 24 of Connecticut's 31 hospitals in Connecticut will face Medicare readmission penalties in the next fiscal year. The average Medicare penalty for our hospitals is higher than the national average, at 0.43% of Medicare funds.

CONSUMER EXPERIENCE OF CARE

Consumer engagement was the primary vehicle we used to understand the current experience of care. We conducted numerous focus groups and attended many community-based meetings to gather consumers' perceptions of issues, barriers to care and ideas for solutions. We also reviewed information gathered from focus groups related to other Connecticut reforms, especially those that focused on services for individuals with disabilities. Consumers' personal stories were powerful and sometimes difficult to hear, but they spurred us to a higher level of awareness and aspiration. Issues and barriers identified through this process include:

1. Unaffordable and insufficient coverage – A significant number of consumers expressed concern about the affordability of healthcare options, remarking that to enroll or maintain healthcare coverage, consumers need lower premiums, co-pays, deductibles and lower prescription costs. Consumers also expressed the need for more coverage for vision, dental, mental health and behavioral health services. For many, affordability and lack of coverage for some services are the main barriers to getting appropriate care.

2. Barriers to access – Nearly all consumers reported the following barriers: long wait times to get appointments (especially with specialists), limited hours of provider offices, inability to find an available provider (including specialists), prior authorization and referral requirements, distant locations to access providers, and a sense, especially among Medicaid recipients, that they are not welcome. Consumers want same day appointments and convenient, direct access, especially for non-urgent care. A large number of consumers want more preventative care.

3. Low quality in care delivery experience – Some consumers reported that providers sometimes do not listen, respect them and their symptoms, follow-up, spend enough time with them, or understand them as a whole-person. Medicaid recipients widely

¹⁶ Office of the Governor, Connecticut Medicaid Hospital Readmissions (2013)

reported being treated with a lack of respect and dignity. They desire a more holistic approach to care, where the whole person is considered, including their social, emotional and economic contexts.

4. Barriers to engagement – Many consumers explained that their limited health literacy and a lack of access to information—including knowing which providers offer higher value services—communication tools, support and navigation, prevent active participation in their own treatment.

5. Fragmented care system – Consumers want better communication and coordination among providers, between doctors, other providers and specialists, and between doctors, other providers and payers. Consumers want direct access to their records, and they want them to be electronic, share-able, frequently updated, consistent, and secure. Some worry about privacy, security and the ability to control access to their health information. They want to understand who will use their data and how.

7. Disability sensitivity – Individuals with disabilities had concerns about disruptions to existing relationships with providers (e.g., when transitioning from pediatric to adult care), paternalism, a lack of understanding of their strengths and needs, and discrimination by healthcare providers who may not want to see them because of their disability.

HEALTH EQUITY AND SOCIOECONOMIC DISPARITIES

The considerable consumer input that we solicited made it clear that consumer experience and access is especially poor for various subsets of the population, particularly those on Medicaid. Their input reflects the racial and socioeconomic disparities that permeate Connecticut.

While the Innovation Plan cannot directly impact the unequal living conditions, life opportunities and distribution of material resources, it can start to resolve the differences in healthcare access, utilization and outcomes. In time, the Innovation Plan can also point to community incentives to address some of the social determinants of health, risk and illness. Moreover, the state aims to enhance the integration between our efforts to transform primary care and improve community health.

Data Highlights

Connecticut's significant racial and ethnic disparities affect multiple health areas, including sexually transmitted diseases, diabetes, prenatal care, low birth weight and fetal and infant mortality. Diabetes and sexually transmitted diseases are significantly

more prevalent in the African American than in the Hispanic and white populations. The rates of inadequate prenatal care, low birth weight, and fetal and infant mortality are higher among African American and Hispanic populations than in the white population. For instance, infant mortality rates among African American (13%) and Hispanic (7.1%) populations are two to three times higher than in the white population (3.8%).¹⁷ In terms of oral health, the incidence of childhood untreated decay in African Americans (18%) and Hispanics (15%) is significantly higher than in whites (9%).¹⁸

In Connecticut, as is true for every other state, the disparities in health reflect significant disparities in care access and quality across a number of domains. The first and perhaps the greatest contributor to health disparities is the lower level of coverage among minority populations. In contrast to approximately two-thirds of whites (65%) and Asians (63%), only half of African Americans (50%) and one-third of Hispanics (33%) are covered by employer sponsored insurance. Although public programs provide a safety net for Hispanics (30%) and African Americans (16%), a significant number of minorities remain self-insured or uninsured.¹⁹

Comparative analyses of cost and affordability concerns paint a similar picture, affecting all populations certainly, but minority populations even more so. One quarter of Hispanics and African Americans reported that they were unable to get needed prescription medications because of affordability. Asians had the highest rate of not getting or delaying medical care (40% vs. 33% for whites) because they worried about the cost (83%), doctors would not accept their health insurance (15%), and other factors.²⁰ About one-third of Hispanics (33%) and one quarter of Asians (27%) and African Americans (27%), as compared to 18% of whites, did not receive needed dental care because of a worry about cost.²¹

Not surprisingly, access issues for minority populations are not limited to coverage and cost concerns. As one example, Hispanics reported lack of adequate transportation to be a major barrier preventing access to clinic-based care. Lack of child care was reported as a major impediment to access for multiracial individuals as well.²²

¹⁷ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

¹⁸ Gini coefficient is commonly used as a measure of income/wealth inequality

¹⁹ We are grateful to the Connecticut Health Funders Collaborative for their assistance with this portion of our Innovation plan. The collaborative includes: the Aetna Foundation; the Connecticut Health Foundation; the Patrice and Catherine Weldon Donaghue Medical Research Foundation; the Foundation for Community Health; the Universal Health Care Foundation of Connecticut, Inc.; and the Children's Fund of Connecticut.

²⁰ Ibid

²¹ Ibid

²² Ibid

Finally, racial and ethnic disparities in quality of care have been documented in Connecticut, which can have a meaningful impact on health outcomes. Patient-provider communication is one example, with findings that Asians were significantly less likely to have spoken to their providers about overall goals for health (32% vs. 57% across all populations in CT). Additionally, Asian Americans were less likely to be screened for depression (24% vs. 39% across all CT populations).²³

Certainly, health disparities are not experienced by only racial and ethnic minority populations. We know that socioeconomic status (SES), meaning levels of educational and economic achievement, can independently lead to health disparities as well. Further, lower levels of SES may contribute to or worsen racial and ethnic health disparities, given minorities are more likely to have lower SES.

The state's income disparity between high and low income wage earners, the second largest in the United States²⁴, also produces health issues. Although Connecticut has the third highest median household income in the nation, approximately \$65,000, three major urban cities (Hartford, New Haven and Bridgeport) have median incomes that are approximately 50% lower.²⁵ By way of contrast, the Stamford metro area is now one of the wealthiest areas in the nation with 18% of households reporting high income.²⁶ In Connecticut, for all residents age 25 or older, only 36% are college graduates; the rates are half that at best among African American (18%) and Hispanic (15%) populations.²⁷

Not surprisingly, low SES populations in Connecticut are at higher risk for numerous chronic health conditions. As one example, lower-income adults are more likely to be obese, which is associated with diabetes and heart disease. Similarly, residents with low SES are more likely to smoke, which increases their risk for cardiovascular and respiratory disease and cancer.²⁸ These individuals face more than increased risk for disease but also challenges obtaining care. As stated by the 2013 National Healthcare Disparities Report, ". . . poor people often face more barriers to care and receive poorer quality of care when they can get it."²⁹

²³ Connecticut Health Funders Collaborative

²⁴ 2010 US Census Bureau

²⁵ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

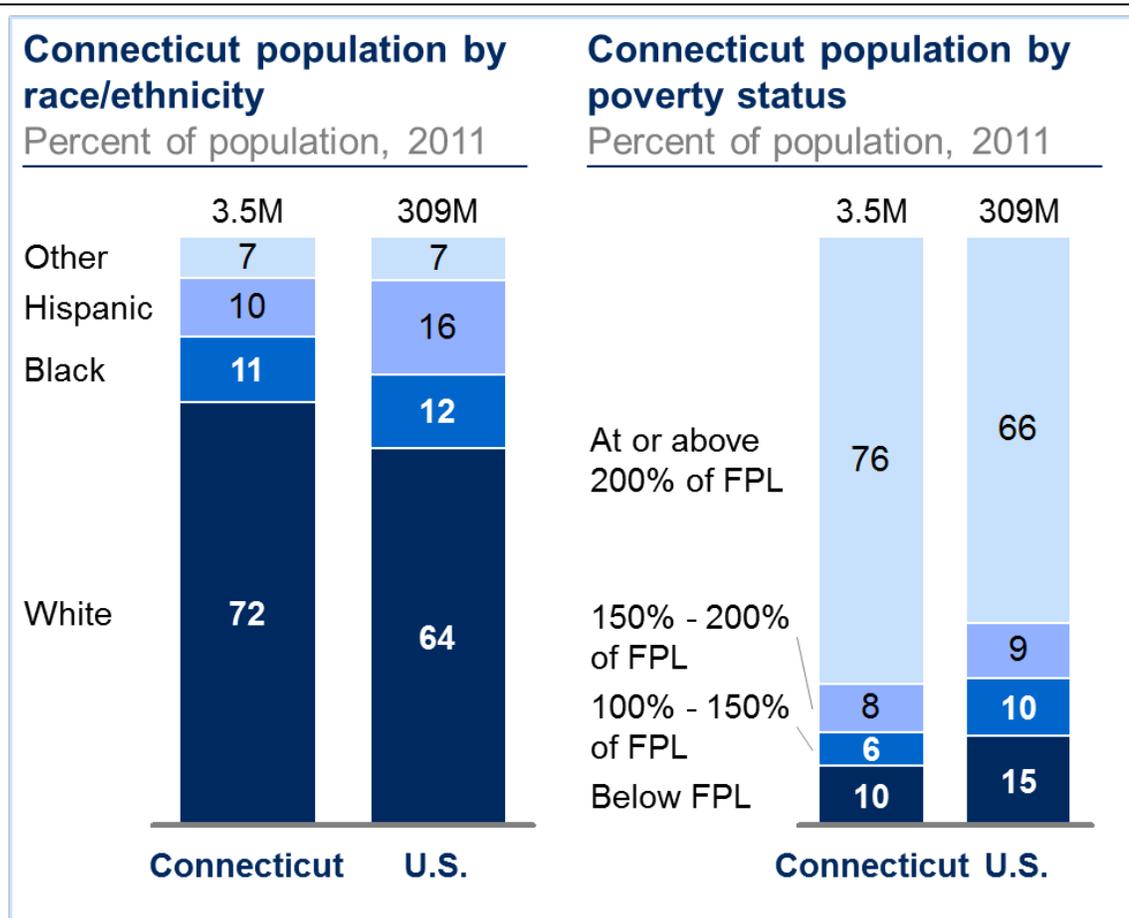
²⁶ CBSNews.com, America's Richest Cities (2013)

²⁷ Connecticut Health Foundation, Community Health Data Scan Update, 2013: Focus on Race and Ethnicity Disparities, July 2013

²⁸ CT Department of Public Health, 2009

²⁹ National Healthcare Disparities Report, 2013

We must be aware of and address health disparities as we aim to improve the overall health and the consumer experience of care in Connecticut. The SIM meaningfully incorporates and addresses the unique concerns of disparity populations, and by doing so will close gaps in care and improve the health for all populations.



Source: Moody's Analytics

HEALTH CARE COSTS

Although Connecticut ranks among the top states on several indicators of population health, these accomplishments come with an extremely high price tag. Unchecked, these expenditures threaten to create a budget deficit for the state in the next two years that would crowd out other important areas of public expenditure.

In 2009, healthcare spending in Connecticut was \$8,654 per person per year vs. the U.S. average of \$6,815 across all services and payers. This places the state above the U.S. 90th percentile in healthcare spending for total cost of care.

Medicaid spending per enrollee in the state (\$9,600 Per Member Per Year or PMPY) was the highest of any state and significantly higher than the national average (\$5,500 PMPY) in 2009. Per enrollee spend on older adults and persons with disabilities, \$24,800 and \$33,000 respectively were both the highest in the country, and partially drove these figures. Long-term costs accounted for most of the spend on older adults and persons with disabilities; they were 49% vs. a 32% national average.³⁰

We expect the number of Medicaid enrollees to increase significantly by 2020, as Connecticut implements Medicaid expansion under the Affordable Care Act (ACA). This will increase total Medicaid spend even more than the expected growth in per member per month (PMPM) costs. Currently (2013), the state has over 630,000 Medicaid enrollees. We estimated Medicaid PMPMs and recent annual PMPM growth trends by 2020 of: adults (~\$330, 12%), children (\$290, 20%), and disabled (\$2,400, 6.2%).³¹

There are approximately 470,000 Medicare enrollees (excluding people on both Medicare and Medicaid) in Connecticut with a PMPM cost of ~\$1,100 (for Medicare fee for service (FFS) and Medicare Part D). The recent annual PMPM growth rate was 4%³² and the expected enrollment growth rate is 0.9%, based on historical rates.³³

In Connecticut, costs for private insurance are below the national average, with the average private insurance cost per person per year at \$2,945 vs. \$3,268 (the national average) in 2009.³⁴ However, the number of individuals covered by private insurance will also increase as a result of the Affordable Care Act (ACA), with enrollment expected to reach two million individuals in 2018.³⁵ Commercial PMPM costs have been increasing at 9% annually³⁶.

Given the expected enrollment growth in every category, and the upward trends in costs on a PMPM basis, we predict significant increases in total healthcare costs over

³⁰ Kaiser Family Foundation, State Health Facts (2009)

³¹ CT SIM Design Grant Application, Financial Analysis (2013)

³² CT SIM Design Grant Application, Financial Analysis (2013)

³³ Kaiser Family Foundation, State Health Facts (2009)

³⁴ NORC, Benchmark State Profile Report for Connecticut (2013)

³⁵ Rand Health, The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut (2011)

³⁶ CT SIM Design Grant Application, Financial Analysis

the next decade – unless we successfully execute the State Innovation Model. By doing so, we can transform and address some of the most important drivers of these cost trends.

Draft

Our foundation for innovation

The Innovation Plan will benefit from the wide-ranging healthcare initiatives already underway in Connecticut. Many of them are pursuing similar goals to those outlined in this plan; as a result, we can build from and easily integrate them into the new care delivery and payment models. For instance, efforts are already increasing consumers' access to care and providers' participation in integrated networks and their use of HIT – all major elements of this plan.

INNOVATION AND REFORM INITIATIVES ALREADY UNDERWAY

Connecticut has established a range of **population health initiatives** focused on activating and educating consumers (e.g., Rewards to Quit, NuVal, CHOICES), and is addressing socioeconomic and other wellness issues in communities, workplaces, and schools. We are making advances in increasing **access** to healthcare coverage across population groups through our AccessHealth CT. Behavioral health initiatives have been established or are being developed to improve early detection and treatment of mental health and substance use conditions, strengthen integration of behavioral health and primary care, and to fortify practices around early intervention and coordination between schools and public agencies. In addition, Medicaid and commercial payers in the state are actively implementing **primary care improvement** and **payment initiatives** that emphasize population-health based ACO and PCMH models. **HIT initiatives** are increasing the capture and transfer of clinical and claims data that support all these efforts, though in limited ways. These initiatives are described in more detail in the Appendix.

PROVIDER INTEGRATION

Historically, Connecticut's physician market has been highly fragmented, with primary care in particular being comprised primarily of small independent practices of one to three physicians each. Over the past several years, Connecticut like the rest of the country has seen an increasing number of physicians employed by hospitals.

More striking, however, is the significant activity in Connecticut over the past 12-18 months among physicians and hospitals organizing into clinically integrated networks, accountable care organizations (ACOs), and/or independent practice associates (IPAs) for purposes of accepting value-based payment arrangements from Medicare and private payers. Based on an informal survey conducted by Connecticut's Office of State

Comptroller, we identified 11 emerging networks, ACOs, or IPAs that have either accepted value-based payment arrangements or are working toward such arrangements with at least one major payer for January 2014. These 11 networks comprise approximately 60% of the estimated 2,600 PCPs in the state.

While these 11 organizations currently have only limited capability to support team-based care and other core elements of Connecticut's Advanced Medical Home model, we believe that they provide a strong organizational framework for the adoption of such capabilities in the future, as well as for combining or aggregating performance across PCPs at sufficient level or scale to support an SSP and outcomes-based measures of quality. Notably, all of the payers are continuing to use open access rather than gate-keeper models in their payment reforms.

HEALTH INFORMATION TECHNOLOGY

All Payer Claims Database (APCD)

Connecticut is one of a number of states that chose to implement its own health insurance exchange. Access Health CT, Connecticut's exchange has successfully created an online enrollment process, signing up 3,847 people for healthcare coverage in its first 15 days. AccessHealth CT has also begun to develop an APCD to collect, assess and report healthcare information that relates to safety, quality, cost-effectiveness, access and efficiency. When complete, the APCD will:

- Create comparable, transparent information
- Provide consumer tools that enable consumers to make informed decisions with regard to quality and cost of services
- Promote data element standardization so that data can be compared across the state and nationally
- Facilitate the broader policy goals of improving quality, understanding utilization patterns, enhancing access and reducing barriers to care
- Enable the aggregated analytics that can inform public policy and reform

In order to implement the APCD, CT has drafted a Data Submission Guide (DSG) that describes the data elements and formats for required data files and is being refined based on payer feedback. The policy and procedures based on the DSG have also been drafted and will undergo legislative review. First data submission will begin in the spring of 2014.

With the APCD in place, AccessHealth CT will launch a consumer portal to help inform consumers with respect to their choice of healthcare provider or setting, e.g., cross-provider cost comparisons on the health insurance exchange. AccessHealth CT will also establish relationships with third-party consumer engagement vendors, e.g., Castlight, Truven Health Analytics to help it better engage consumers.

Health information exchange

HITE-CT was established through a \$7.29 million award from the Office of the National Coordinator (ONC) for Health Information Technology in March, 2010. HITE-CT's purpose is to establish health information exchange capability across Connecticut's healthcare systems. Specifically, HITE-CT will provide a secure electronic network that doctors, hospitals, and other healthcare providers can use to safely share information and improve patient care CT HITE is responsible for developing and implementing a strategic and operational plan to ensure measurable progress within the state towards universal adoption of HIE. Additionally, HITE-CT works with DPH to promote the development of health information technology, increased adoption and meaningful use of electronic health records, assure the privacy and security of electronic health information, and collaborate with DSS, the State's Medicaid agency.

EHR Adoption

eHealthConnecticut received a \$5.7 million grant (from the Office of the National Coordinator and the U.S. Department of Health and Human Services) to accelerate the adoption of EHR. eHealthConnecticut helps Connecticut's providers select, implement, and use systems in ways that enhance healthcare quality, safety and efficiency. It plans to transition 80% of physicians to EHRs by 2014.

Connecticut has encountered challenges in promoting the adoption of Electronic Health Records (EHRs). In December 2012, Connecticut's rate of EHR adoption was one of the lowest in the nation – 26.9% vs. the national benchmark of 39.6%.³⁷ However, in part through the efforts of eHealthConnecticut, substantial progress has been made, with many providers developing and implementing EHRs more actively across the state in 2013. As one indicator of progress, 1,033 Connecticut providers (20% of all CMS incentive eligible providers) have registered for the REC program and with CMS as of July 2013. While program targets have not been identified or quantified past the end of the present cooperative agreement, one component of eHealthConnecticut's

³⁷ NCHS Data Brief, Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001-2012)

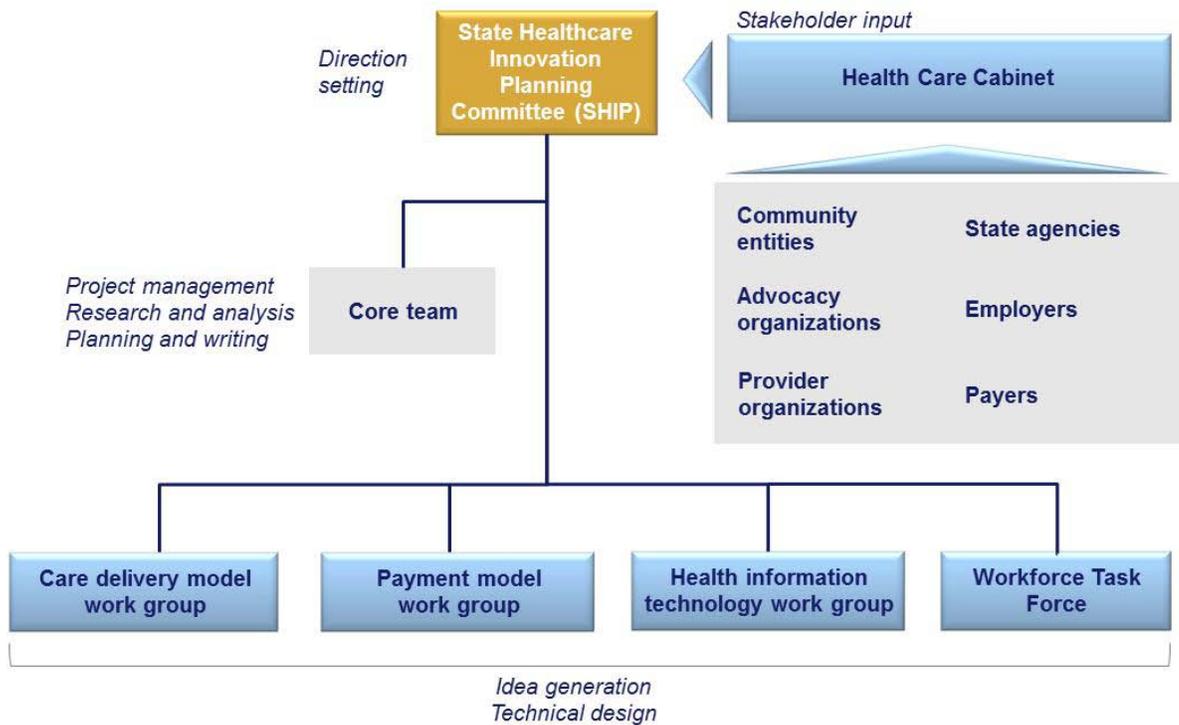
sustainability plan is to continue to offer services to CT's providers that support their use of HIT, improve their meaningful use experience and enable them to participate in the electronic exchange of clinical care data. DMHAS will operationalize an EHR for its State-operated facilities beginning in the second quarter of 2014 and intends for its facilities to participate in the HIE.

Draft

State Innovation Model design process

In any change process of this scale, there are multiple stakeholders who raise important and diverse concerns while bringing valuable knowledge to the overall process. Connecticut's process incorporated stakeholders at every phase of model design and began with top state leadership. Lieutenant Governor Nancy Wyman, a former healthcare provider, a healthcare purchaser in her former role as State Comptroller, and tireless advocate for improving healthcare access and affordability led the process, ensuring participation from a broad range of public and private entities.

The Lieutenant Governor appointed a core leadership team, consisting of one person from each of three major state departments: The Office of the Healthcare Advocate (OHA), the Department of Social Services (DSS), the state's Medicaid authority, and the Department of Mental Health and Addiction Services (DMHAS). Overall project direction was provided by the Healthcare Advocate. The core team led the process of model design and made the day-to-day procedural decisions under the oversight of the Lieutenant Governor. The team developed a comprehensive model design and stakeholder engagement process that identified the categories of stakeholders necessary to design the process, laying out a phased approach for stakeholder input and feedback that allowed the team to incorporate input and feedback into the Innovation Plan.



A State Healthcare Innovation Plan Steering Committee (Steering Committee) was formed in order to guide the core team on issues of key strategic, policy and programmatic concerns. This committee is chaired by the Lieutenant Governor and includes Commissioners from seven state departments including the DSS, the Department of Public Health (DPH), the Office of Policy and Management (OPM), the Office of the State Comptroller Office (OSC), DMHAS, DCF and the Connecticut Insurance Department (CID) and the Dean of the School of Medicine from the University of Connecticut (UConn). High-level representatives from the following organizations also sit on the Steering Committee: Anthem, United Healthcare and Cigna (payers), St Vincent’s Health Partners (providers), Pitney-Bowes (employer), the Connecticut Health Foundation and Universal Healthcare Foundation (advocacy and community organizations) and AccessHealth CT. The core team reported on at least a monthly basis to the Steering Committee.

Five state agencies that have a major role in overseeing or delivering healthcare each assigned a dedicated program planner to support the core team throughout the SIM planning process. These agencies included DSS, DPH, DMHAS, OSC, and UConn. The Planners worked to ensure alignment among the state agencies and the SIM planning effort. At the same time, they kept their own leadership, contracted providers and constituency abreast of the process and used feedback from their stakeholders to

inform the design process. This was a key strategic endeavor that enabled each state department to align its activities with those proposed under the Innovation Plan and created opportunities for each state department to lend their expertise to the planning process. Collectively, we refer to the core team and Planners as the SIM planning team.

CARE DELIVERY, PAYMENT AND HIT WORK GROUPS

Three workgroups were established to consider the related design issues of care delivery, payment reform and health information technology. Membership of the work groups consisted of a broad array of stakeholders that included physicians, providers, payers, employers, high-level state participants and consumers. Importantly, each work group member was appointed by the Lieutenant Governor’s office, again demonstrating the committed leadership of the state. Below, we describe each group and the questions they considered.

Care Delivery, Payment, and HIT work groups and questions considered			
	Care Delivery	Payment	HIT
Members & timing	<ul style="list-style-type: none"> Consumers, clinicians, community organizations, state agencies, employers, and payers Biweekly meetings 	<ul style="list-style-type: none"> Clinicians, hospitals, community organizations, state agencies, payers, and employers 	<ul style="list-style-type: none"> Clinicians, community organizations, state agencies, payers, and IT specialists
Questions	<ul style="list-style-type: none"> Who are the target populations? What are the areas of improvement to address that can lead to higher quality and lower cost? What barriers need to be overcome? What interventions and changes in provider and consumer behaviors/ processes, and structures are required to be successful? What roles will need to be fulfilled to implement these interventions? What entities are optimally positioned to fulfill these roles and which will be primary? What are the implications for payment model, data/ analytics, workforce, and policy? How will the care delivery model be phased? 	<ul style="list-style-type: none"> What types of metrics will be used for eligibility for participation and eligibility for payment, focusing on metrics that would ensure providing clinically appropriate care while minimizing waste? What is the reward structure? How do we define the level of performance we wish to reward? What will be the rule for attribution? At what level will performance be aggregated for measurement and rewards? What will be the pace of roll-out of the new payment model throughout the state? At what pace will accountability and payment type for participating providers be phased in? 	<ul style="list-style-type: none"> What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model? What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model? What is the best strategy to develop the required HIT capabilities? How can the proposed future state model be designed in order to be financially viable and self-sustaining?

WORKFORCE TASK FORCE

In addition to the work groups described above, the core team identified the need for more exploration of the existing healthcare workforce in Connecticut and workforce development needs that would emerge as a result of SIM. Thus, under the auspices of SIM, UConn and the DPH launched a joint taskforce to assess Connecticut's current provider landscape and to propose workforce changes required to support the new care delivery and payment model. In particular, the taskforce examined: the current state of Connecticut's health workforce, including numbers and types of relevant roles, skills, capacity and structure; and the health workforce changes required to support Connecticut's new care delivery model of team-based care. The taskforce outlined a number of initiatives for implementing these changes.

HEALTH CARE CABINET

Connecticut's Healthcare Cabinet was established in 2011 to advise Governor Dannel P. Malloy and Lieutenant Governor Nancy Wyman on issues related to implementation of federal health reform and the development of an integrated healthcare system for the state. The Cabinet consists of both voting and non-voting members, is chaired by the Lieutenant Governor and includes nine state departments: OHA, DPH, OSC, DSS, OPM, DMHAS, DCF, CID and the Department of Developmental Disabilities (DDS) as well as the Non-Profit Liaison to the Governor. Other representatives are appointed by legislative leadership and represent home health care, small businesses, hospitals, faith communities, HIT industry, primary care physicians, advanced practice registered nurses, consumer advocates, labor, oral health services, community health centers, the healthcare industry and insurance producers. Two members-at-large also participate. The Healthcare Cabinet is charged with improving the physical, mental and oral health of all state residents while reducing health disparities by maximizing the state's leveraging capacity and making the best use of public and private opportunities. The core team presents to the Healthcare Cabinet on a monthly basis to obtain input on various aspects of model development. The Healthcare Cabinet also provided early, instrumental feedback on the stakeholder strategy described in detail below.

TRANSPARENCY

Transparency and "two-way communication" were integral aspects of the model design and stakeholder engagement process. The project was governed by and compliant with state policies and procedures regarding public meetings. Throughout the project the state maintained a website dedicated to the SIM model design process

at www.healthreform.ct.gov. All Steering Committee meetings and those of the four workgroups were publicly announced on Connecticut's television network (CT-N), posted on the website, and accessible in person or by telephone.

Meeting agendas, materials, and summaries were made available on the website in an effort to ensure broad public visibility. A dedicated email address was established (sim@ct.gov) and staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

BROADER STAKEHOLDER ENGAGEMENT

Stakeholder engagement has been an essential component of our SIM design process. The strategy to engage stakeholders was comprehensive and phased in over time in order to accommodate the multiple goals and the need for broad engagement. Early in the process, the core team met with individual members of the Steering Committee and the work groups in a series of small, informal discussions. The team gathered diverse perspectives on potential solutions to the current challenges of Connecticut's healthcare system and used this information to support the Innovation Plan and work group planning process.

In consultation with the Healthcare Cabinet and Steering Committee, the core team developed a strategy for engaging a wide array of stakeholders falling into five main groups: (1) consumers, (2) healthcare providers, (3) state agencies, oversight councils and trade associations, (4) employers and (5) community organizations. The strategy involved three phases, the *input phase* focused on listening sessions to identify healthcare problems and solutions supplemented by electronic surveys, the *model feedback phase* in which the workgroup recommendations and emerging model was shared for feedback, and the *Plan syndication phase* focused on soliciting feedback regarding the detailed plan. In general, the strategy favored joining existing stakeholder groups and forums, rather than holding town hall meetings and public hearings, since the former was more conducive to sharing personal experience and meaningful dialogue. By the end of October, the SIM Planning team had met with more than 50 stakeholder groups. See Appendix – Stakeholder Engagement as of October 31, 2013 for a detailed list.

Input Phase

During the input phase, the SIM planning team focused on attending a combination of existing forums, such as council meetings and conferences, and also special meetings convened specifically for the purpose of providing input into the Innovation Plan. A set

of key questions was developed for each stakeholder category that was designed to capture barriers/obstacles, supports/successes and personal accounts and experiences with the healthcare system. In addition, the sessions focused on consumer stories and the barriers that consumers encounter at different stages of the healthcare journey, from well care, to sickness and diagnosis, acute care and chronic care.

The core team held Community listening forums and focus groups from June through mid-September, 2013. The forums and focus groups consisted chiefly of consumers, providers, employers, state departments, oversight councils, trade associations and community organizations. All forums were held in the community, at settings that were convenient and accessible to the members. Importantly, all members of the SIM planning team participated in these events.

Across the categories, stakeholders willingly shared their concerns, their hopes and their own stories resulting in a wealth of information. The individual narratives were frequently poignant and difficult to hear, but they inspired us to a greater level of awareness and aspiration. Based on information gathered during this phase, work groups more carefully considered issues relating to safety net populations, access, and the need to integrate behavioral health and oral health into primary care.

During July and August, we distributed an electronic survey specific to the SIM process via an electronic list serve from a large healthcare advocacy organization participating on the Steering Committee. Open-ended questions about recommendations for improving healthcare were attached to an existing electronic survey already in process by a second healthcare advocacy organization. Responses to the open-ended questions were catalogued. Almost 800 electronic responses were received and were incorporated into the model design.

Model Feedback Phase

From mid-September through October, 2013, the SIM team continued to meet with stakeholders for the purpose of feedback on the emerging model. Again, these forums included provider, employer and trade associations; consumer and advocacy forums; and community organizations. During this phase, the Lieutenant Governor convened a special forum to obtain input from and hear the concerns of consumer advocates. Consumer advocates raised concerns in the areas of governance, consumer protections related to inappropriate denials of care and the importance of a quality monitoring system, and the need for consumer empowerment and education. Several important solutions were incorporated into the model in order to address these concerns. Of note, an Equity and Access Council was proposed to develop methods to protect

against adverse selection, access issues, and under-service. And consumer advocates will sit on the Quality Metrics Council to help build the Common Scorecard.

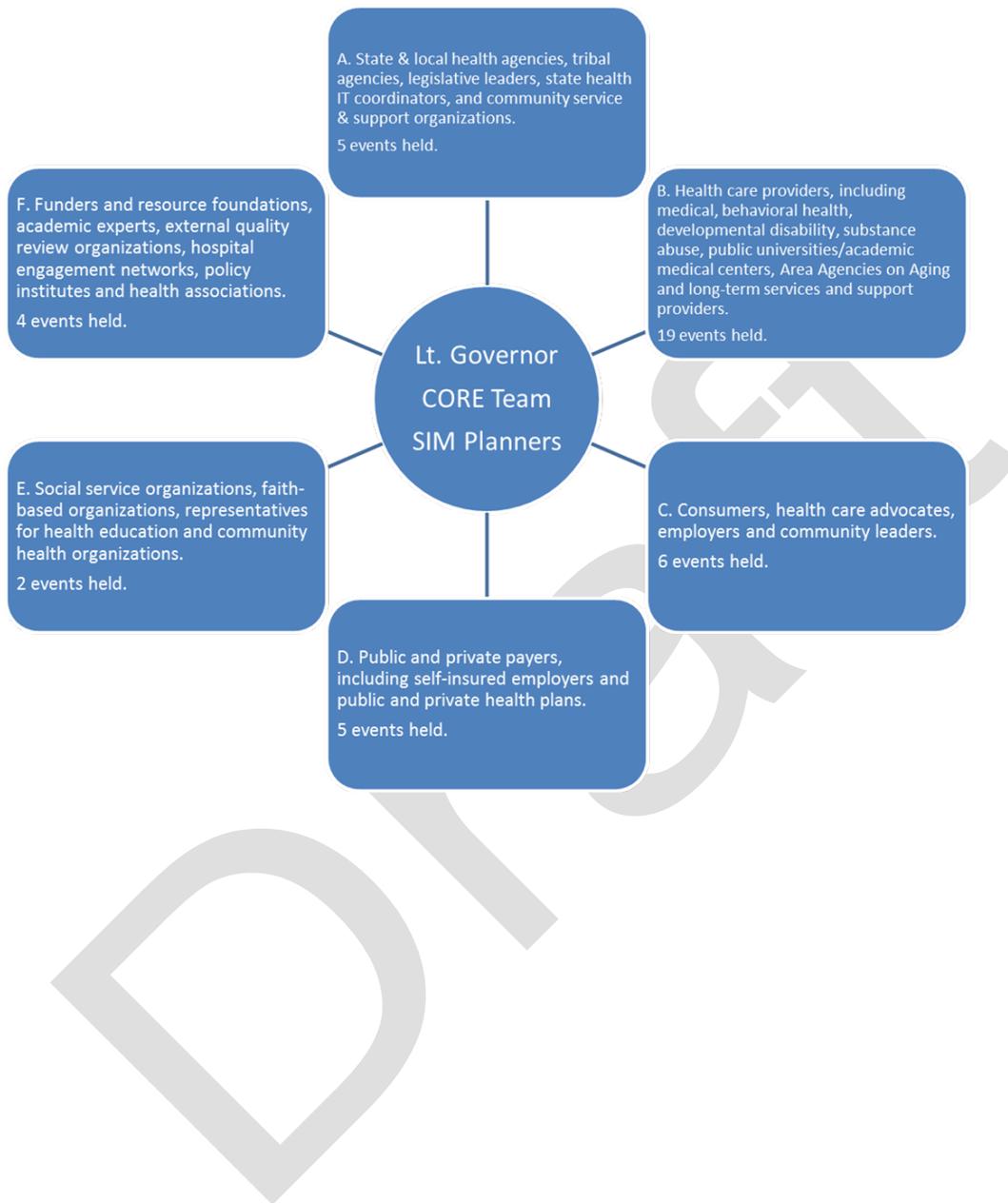
Plan Syndication Phase

A complete draft of the Innovation Plan was posted on November 1st, 2013. After posting, the SIM planning team returned to many of the above forums and reconvened focus groups to gather feedback on the detailed plan. The SIM planning team held a public forum and accepted written comments on the plan after posting it in the Connecticut Law Journal and on the SIM website.

We recognize that outcomes are better and costs are reduced when care planning is centered on the whole person and consumers have access to information and decision-making tools that assist them in selecting the best treatment choices possible. We know the care experience is central to any positive transformation in our healthcare system. The process of eliciting and incorporating stakeholder and consumer feedback must be robust. Stakeholder engagement can never be finalized; it must be an on-going and transparent process that continues to critically inform the evolution of healthcare services in CT. The Consumer Advisory Board of the Healthcare Cabinet was recently reconstituted and will serve as the major coordinating entity to solicit consumer feedback on future stakeholder engagement. However, we will roll out more detailed plan to formalize and strengthen broad stakeholder input to successfully drive quality improvement and enhance the experience of care for all Connecticut residents.

Stakeholders who actively participated in the Design Process

The SIM design process ensured input from a diverse group of stakeholders through various mechanisms in a phased approach that enabled us to successfully include all categories of stakeholders represented below (as of October 31, 2013). See Appendix – Summary of Stakeholder Input to the Design and Model.



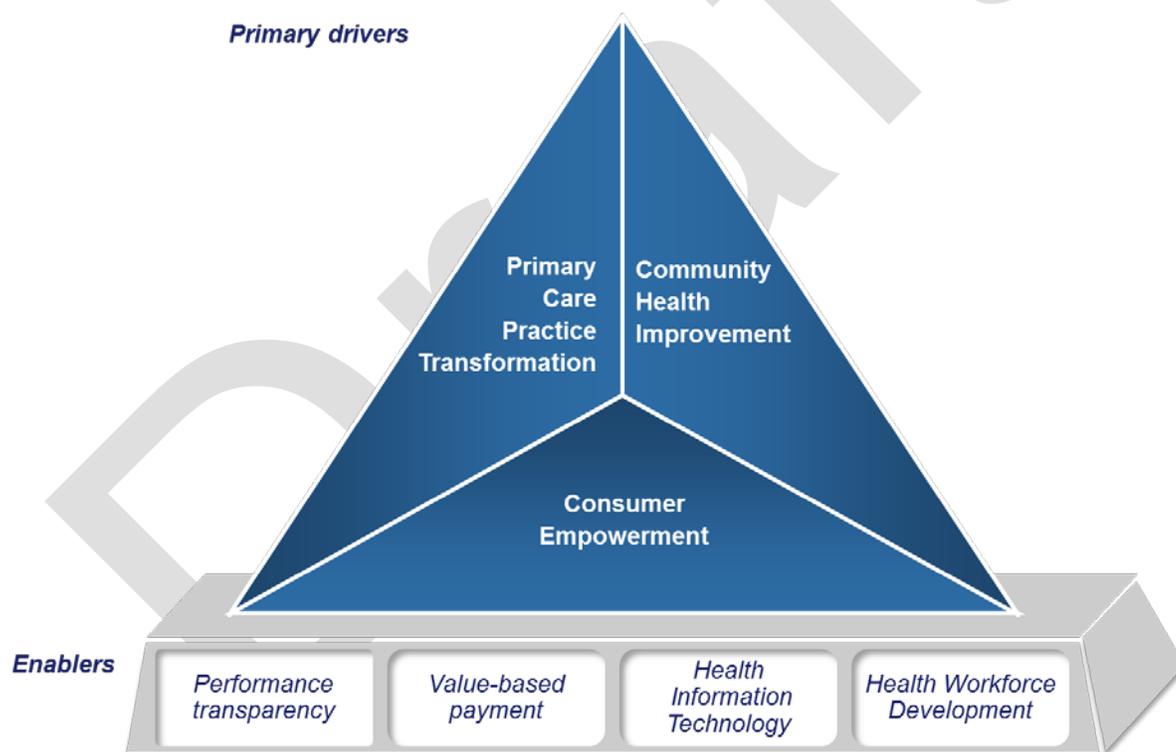


OUR VISION FOR OUR FUTURE HEALTH SYSTEM

Primary drivers for transformation

Our State Healthcare Innovation Plan is based on three primary and equal drivers for health system transformation:

- **Primary care practice transformation** to manage the total needs of a population of patients
- **Community health improvement**, through the aligned efforts of community organizations, healthcare providers, and public health entities
- **Consumer empowerment** to manage their own health, access care when needed, and make informed choices regarding their care



PRIMARY CARE PRACTICE TRANSFORMATION

The Advanced Medical Home (AMH) is the cornerstone of Connecticut's care delivery reform model. Under this model a primary care team coordinates the entirety of a person's care. This model has five core components, described below.

- 1. Whole-person centered care:** The AMH model will consider the full set of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health. High-priority changes will include:
 - Conducting whole-person assessments that identify consumer/family strengths and capacities, risk factors (e.g., history of trauma, housing instability, access to preventive oral health services), behavioral health and other co-occurring conditions (e.g., early childhood caries), and ability to self-manage care
 - Supporting consumers with person-centered care planning, care coordination, and clinical interventions based on the whole-person assessment
 - Identifying and assisting providers who need to find community-based entities and services that can help provide whole-person centered care

- 2. Enhanced access:** These changes will enable consumers that were excluded or had difficulty accessing the healthcare system with care that meets their needs. The model will also expand provider hours and even offer remote consultations. In order to reach previously underserved populations, it is essential to ensure that consumers have care that is convenient, timely, and consistent with the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (e.g., primary care practices have care coordinators who speak the languages prevalent among the patient population). High-priority changes include:
 - Improving access to primary care through: extended hours on evenings and weekends; convenient, timely appointment availability, including same-day access; and non-visit-based options including telephone, email, text, and video communication
 - Enhancing specialty care access, e.g., by establishing eConsults between specialists and primary care providers
 - Providing clear, easily accessible information on where consumers can go to meet their care needs (e.g., clearly communicated physician locations and hours)
 - Taking reasonable steps to ensure meaningful access to care that is culturally and linguistically appropriate for patient populations and individuals (e.g., expanding communication and language assistance for limited English)

proficient (LEP) patients, addressing cultural norms regarding certain examinations)³⁸

- 3. Population health management:** Providers can determine which of their specific patient populations are at the greatest risk by analyzing and interpreting the data on the populations in their panel or geography (e.g., by placing consumers in a disease registry). They can then conduct early interventions to delay disease progression (e.g., place diabetics in diet and weight loss programs). Providers will collaborate with community-based organizations to deliver these interventions and adapt them so they provide reduce health equity gaps for various racial/ethnic/cultural populations. High-priority changes include:
 - Collecting and maintaining accurate and reliable demographic data, including race, ethnicity and other demographic data, to monitor health quality and outcomes and to inform service delivery
 - Using population-based data to understand specific risks for one’s own panel, key sub-populations (e.g., race/ethnicity) and individual patients
 - Using risk stratification analyses to identify consumers who are at higher risk to inform and target support efforts
 - Maintaining a disease registry
 - Partnering with certified community-based entities and other social service and support entities to address clinical and support needs when necessary
 - Aggregating de-identified data with State and payers to facilitate analyses, reporting and intervention
- 4. Team-based coordinated care:** Multi-disciplinary teams offer integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral health care with medical care, whether through co-location or as part of a virtual team. High-priority changes include:

³⁸ There is no “one size fits all” solution and what constitutes “reasonable steps” for large providers may not be reasonable where small providers are concerned. To determine the appropriate level of LEP services, each AMH shall consider four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program; (2) the frequency by which LEP individuals come into contact with the program; (3) the nature and importance of the service provided; and (4) the resources available to the provider and the costs of interpretation/translation services.

- Developing and implementing a whole-person centered treatment plan (see #1)
 - Providing team-based care from a prepared, proactive and diverse team
 - Integrating behavioral health, oral health, and primary care with “warm”, coordinated hand-offs between practitioners (on-site, if possible)
 - Coordinating all elements of a consumer’s care (e.g., coordinate, track, and follow-up on laboratory tests, diagnostic imaging, and specialty referrals; reconcile or actively manage consumer medications at visits and post-hospitalization)
 - Include community health workers as team members to better serve diverse populations when appropriate.
- 5. Evidence-informed clinical decision making:** Connecticut will encourage providers and patients to make clinical care decisions that reflect an in-depth, up-to-date understanding of the evidence regarding the clinical outcomes and cost-effectiveness of various treatments. High-priority changes include:
- Applying clinical evidence to target preventive care and interventions toward those patients for whom the intervention will be most effective
 - Leveraging EHR decision support, shared decision making tools, and provider quality and cost data at the point-of-care to incorporate the most up-to-date evidence into clinical practice, so as to enable patient directed care decisions
 - Incorporating clinical recommendations for disparity populations as available

Attribution of consumers to providers

Attribution is the process of linking consumers to the providers who will be responsible for their care. We will recommend and support attribution strategies that maximize consumer choice and educate consumers on how to make those choices. The State will also champion attribution methods that accurately reflect the consumer-provider relationship, provide access and accountability for those parts of the population that do not have PCPs, and reward high-quality and timely care.

Based on payer input, we expect most to adopt a retrospective approach to attribution, attributing members to the provider who has given them most of their primary care during a defined reporting period. Members can also select their PCPs prospectively. However, if most of their care during the reporting period was delivered by a provider

other than their selected PCP, payers may choose to reassign the member to the provider who provided most of their primary care.

The State will continue refining its attribution strategy so it can determine which providers are eligible for attribution (e.g., all providers billing for primary care activities vs. only primary care providers) and define accountability for behavioral health consumers who see both a Behavioral Health (BH) specialist and PCP (e.g., potentially through dual attribution). It will also maximize access for all consumers regardless of their payer or population type (e.g., behavioral health) and standardize necessary technical details (e.g., frequency of payer reporting of consumer panels' to providers). We will also educate consumers on why they should choose a PCP, how to select a PCP (e.g., various PCPs available, their profiles, strengths, etc.), how care may differ if they select an AMH, and how to make the best use of this new approach to primary care.

Roles needed to implement the new capabilities and processes

Connecticut's AMH model will require a care team of various healthcare service and support providers. Primary care and behavioral health providers must collaborate closely for this to work. Each team will have a set of "core providers" who handle primary care (e.g., PCPs, APRNs, and care coordinators). Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers, and community health workers. Any other class of caregiver can also be included when deemed necessary.

The model's flexibility allows the consumer's health needs and desires and the structure of the practice or organization to shape the composition of care teams and the accountable provider. It also acknowledges that the leadership of the team may change. The State also encourages caregivers and support staff to collaborate across all types of providers – whether primary, acute, specialist, community, or social care – and leverages community health workers.

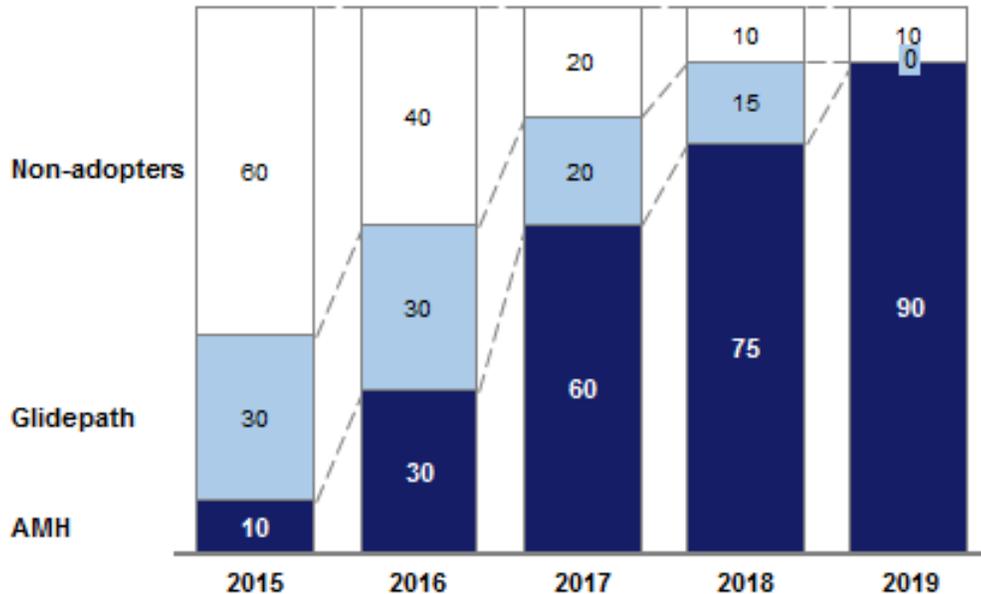
Accreditation and performance paths for providers

The two ways providers will participate in the value-based payment system – as Advanced Medical Homes or as participants in the Glide Path who are working toward accreditation as an AMH – will evolve over time. The majority of providers will start either simply as PCPs or in the Glide Path, with only a small minority as AMHs; however, by Year 5 we aspire that the vast majority will be accredited AMHs (Exhibit 1).

Exhibit 1: Growth in AMH as the Glide Path Providers Gain Accreditation

Targeted Pace of Primary Care Practice Transformation

% of PCPs working toward Advanced Medical Home certification



7

Helping providers achieve the AMH accreditation

Because practices will be in very different stages in terms of their ability to meet the standards for becoming an AMH, Connecticut has designed a variety of programs to not only help providers but to make it easy for them to start the transformation. We recognize that this can be daunting for practices, particularly for those who are unsure of what it means for them, and those that are reluctant to invest in an EHR or affiliate with a larger system, including some physicians that are nearing retirement.

We divide providers into two basic groups: those that are already nationally accredited as medical homes and those that are not. Accredited practices will not have to duplicate their accreditation, but may have to meet some additional standards. For all other providers, we created the Glide Path Program to facilitate the practice transformation process. It encourages practices to participate early in the process by setting easily achievable requirements for entry (e.g., self-assessment and a statement

of commitment). Participants receive support as they adopt advanced practices like whole-person-centered care and care coordination. As they move forward, they are held accountable for meeting milestones and for achieving true practice transformation, thus ensuring that cost savings are driven through quality improvements and more effective clinical decisions – not lower quality care.

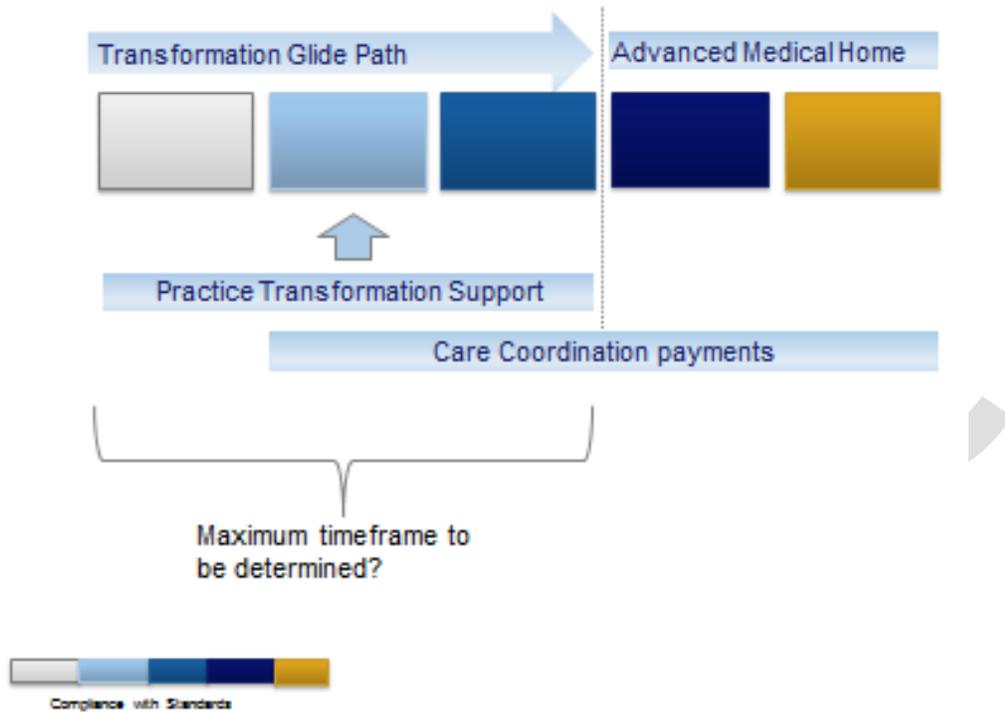
Providers who are already part of a network or group and participating in an advanced payment reform such as SSP may be given the option to assess existing practice gaps and to take advantage of practice transformation support through the Glide Path Program to achieve full AMH status. This option will in part be dependent on the availability of sufficient practice transformation resources.

The Glide Path holds practices accountable for achieving milestones for practice transformation as a condition for continuing to receive transformation support. Payers' willingness to fund care coordination fees may also be contingent on satisfactory progress against transformation milestones. More advanced practices and provider systems will need to take responsibility for a broader array of quality and performance metrics, responsibility for total cost care via participation in an SSP. These standards will increase in number and rigor as providers approach their accreditation (Exhibit 2).

Providers and payers in Connecticut now have several years of experience with national medical home standards. Many providers report that meeting national standards is both costly and administratively burdensome and that recognition or accreditation does not necessarily result in practice transformation. They have also indicated that the time and effort spent on the administrative requirements of a national accrediting body would be better spent on the transformation process. Payers in turn have established their own standards and this has, for providers, further complicated the transformation process.

Accordingly, Connecticut's payers will adopt a common set of accreditation standards for AMH, which will be defined by the Practice Transformation Taskforce. The standards may be drawn from NCQA, AAAHC, URAC, Joint Commission, Center for Medicare and Medicaid Innovation (CMMI) or other national/local standards, recognizing that each of the national standards today has strengths and weaknesses. A common set of AMH standards will simplify the transformation process.

Exhibit 2: Connecticut's Transformation Glide Path to AMH Status



Provider Aggregation to Achieve Scale and Capabilities

We anticipate that many independent PCPs will need to affiliate with one another in order to gain the scale necessary to efficiently adopt the new capabilities needed to achieve AMH status. They can use a variety of formal and informal clinical integration models to attain the scale they need (Exhibit 3). Their choice of a model will not affect their ability to participate in an SSP – only their performance against the standards does that. In order to protect consumer choice and affordability, the State will monitor for signs of market consolidation and consider legal and regulatory actions as appropriate.

Exhibit 3: Clinical Integration Models to Attain Scale and Capabilities

A Integrated Delivery System	<ul style="list-style-type: none"> ▪ Physicians and hospitals legally and financially integrated ▪ Capital, infrastructure, and clinical integration among physicians, hospitals, other providers ▪ Potential to distribute payment through employment agreements
B Medical Group Practice	<ul style="list-style-type: none"> ▪ Legally and financially integrated physician organization ▪ Capital, infrastructure, and clinical integration among physicians ▪ Potential to distribute payment through employment agreements
C Clinically integrated network	<ul style="list-style-type: none"> ▪ Formal contractual relationship among otherwise independent physicians, hospitals, other providers ▪ Capital, infrastructure, and clinical integration among physicians, hospitals, other providers
D Strong IPA	<ul style="list-style-type: none"> ▪ Physicians derive most or all of their revenue through IPA ▪ Capital, infrastructure, and clinical integration among physicians
E Loose IPA	<ul style="list-style-type: none"> ▪ Physicians and/or hospitals derive only part of their revenue through IPA ▪ Limited capital, infrastructure, or clinical integration among physicians
F Regional cooperatives	<ul style="list-style-type: none"> ▪ Regional cooperative provides clinical and technical resources ▪ Limited capital, infrastructure among participating physicians independently ▪ Regional cooperative <u>may or may not</u> be channel for distribution of risk sharing

Implications for populations with special needs

Connecticut’s AMH model will address the primary care needs of most individuals in the state. However, additional interventions will be required to meet the needs of various populations who have unique healthcare needs (e.g., people with complex health conditions). In these cases, our AMH model’s flexibility allows us to create tailored options for these populations and add these on at an appropriate time.

The Medicaid population offers significant opportunities. The AMH model and the Demonstration to Integrate Care for Medicare/Medicaid Enrollees will begin in parallel. Aspects of the Medicare/Medicaid model, e.g., the medical home standards for participation, may be adjusted to maximize alignment with AMH. In addition, specialized initiatives such as Money Follows the Person for older adults and individuals with disabilities who use Medicaid will continue to have a material impact on healthcare costs given the service intensity and high costs associated with these groups, particularly in long-term care. Among Medicaid enrollees, the spending per enrollee for elderly adults (\$24,800) and persons with disabilities (\$33,000) were the

highest in the country. Long-term care costs (49% vs. 32% national average) were the primary driver.³⁹

We will also collaborate with the Department of Mental Health and Addiction Services (DMHAS) as we roll out the AMH model. AMH is complementary to DMHAS's behavioral health home model, which DMHAS plans to implement in 2014. By combining a DMHAS behavioral health provider with an AMH-accountable PCP, the patient would receive excellent, seamless behavioral health and medical care.

An estimated 15% of DMHAS's population will be dually attributed to an accountable behavioral health provider in DMHAS's behavioral health home model and to an accountable PCP in the AMH model. The behavioral health provider will be responsible for the delivery and cost of behavioral health care and the PCP will be responsible for the delivery and cost of medical care. Both of these accountable providers will collaborate closely. The majority (~85%) of DMHAS's population served by DMHAS providers today will be dually attributed to a PCP under Connecticut's AMH model and to the DMHAS system.

COMMUNITY HEALTH IMPROVEMENT

Connecticut has a rich array of community-based organizations and local governmental and non-governmental health and human service agencies with a deep and unique understanding of the communities they serve. These entities administer community-based programs that share a common objective with clinical practices –improving the health of clients whom they serve. Unfortunately, they face multiple obstacles in achieving this goal. Few systems, structures and incentives exist that would help foster collaboration and coordination between clinical practice and community services. Furthermore, it is unclear how prevalent evidence-based community health programs are in regions with vulnerable and high-risk populations. Current data suggests that the need for such programs far outstrips their availability. Finally, many community-based services rely on grant funding, leaving even the highest quality services highly vulnerable to funding cycles and potentially unsustainable.

The SIM initiative offers a unique opportunity to design a focused and coordinated approach to improving community health and reducing avoidable health disparities not easily addressed by the healthcare sector alone. A community health improvement approach is critical to the successful achievement of the state's aim of improving the

³⁹ Kaiser Family Foundation, State Health Facts (2009)

health and healthcare quality of Connecticut's residents, eliminating health disparities, and improving care experience.

Specific strategies proposed to implement the community health improvement approach include:

1. Establishing **Health Enhancement Communities (HECs)** in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities
2. Strengthening community-based health services and linkages to primary health care by establishing a **Certified Community-Based Practice Support Entity**

Health Enhancement Communities

In formulating a strategy for community health improvement, the state recognized three essential considerations. First, the true measure of success in community health improvement lies in outcomes—a reduction in disease prevalence and complications and a reduction in health disparities. Second, holding healthcare providers accountable for such outcomes might result in their avoiding risky consumers, rather than taking on the challenge of prevention. Third, health outcomes are influenced by a multitude of factors, most of which lie beyond the influence of healthcare providers acting alone. The solution lies in elevating the goal of public health improvement, from healthcare provider specific accountability to that of the broader community, and its many participants.

The state proposes the adoption and designation of a geographically bounded region characterized as having a high level of health improvement opportunities and avoidable health disparities as Health Enhancement Communities (HECs). An HEC would have sufficient population to allow for reliable tracking of population health measures, contain a significant number of Advance Medical Homes and demonstrate capacity for multi-sector collaboration to address issues of health. The HECs would allow for coordinated and focused efforts from the public health, social service, education and private and non-profit sector to address key drivers of health impairment and avoidable health disparities through evidence-based approaches.

Design and Process

Committed to a community-driven approach to prioritizing community needs and improving health and health equity; the state will utilize the findings from the State Health Assessment and the recommendations from the State Health Improvement Plan

(Healthy Connecticut 2020) and CDC supported Coordinated Chronic Disease Plan as foundation to this structure. We will also identify and work with local health departments (LHD) and non-profit hospitals that conduct community health needs assessment in their regions to find shared priorities and alignments with the Innovation Plan and Healthy People Connecticut 2020 objectives.

The state recommends the creation of three to five pilots, HECs that will be fully operational by the end of 2019. The pilot communities will be identified and selected by using rigorous criteria and valid measures that are in alignment with CMMI and CDC. The proposed Program Management Office will be the coordinating body for this initiative and will work with a multiple health and human service agencies to support design and implementation.

Community-wide population health measures will be incorporated into the common scorecard and value based payment system. The measures will be based on the entire community population, including those who may be attributed to healthcare providers participating in a Shared Savings Program.

Risk selection by providers to enhance scorecard performance is a well-known concern in programs that provide incentives on basis of quality scores. The inclusion of community-population metrics as part of provider scoring and ultimately financial incentives will counter the effect of risk-selection and importantly serve to drive healthcare providers to collaborate and coordinate with other sectors.

High quality, reliable local data will be imperative to inform HEC design and administration. The HEC will require dedicated epidemiologic and data support. Critical data functions would include coordination with health and human service agencies regarding available data sources, ongoing review and analysis of existing data, review of opportunities to enhance data collection and consideration of including emerging data sources.

Connecticut's approach is consistent with the federal aim of creating a Community Integrated Health System 3.0, by encouraging the integration of our healthcare providers with community resources, value-based payments, and support for learning organizations that can rapidly deploy best practices.

Certified Community-Based Practice Support Entity

The State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, herein referred to as Certified Entities. As the title suggests, Certified Entities would support a set of local Advanced Medical

Homes with a specified package of evidence-based community services. This structure fosters alignment and collaboration between primary care providers, community-based services and State health agencies. It will also increase the impact of both AMH and community interventions as the literature has shown that a single intervention will not usually reduce an overall medical or behavioral burden or sustain preventative behavior.⁴⁰

Certified entities also provide a special opportunity to implement the Institute of Medicine's (IOM) best practices in integrating primary care and public health.⁴¹ The IOM recognizes that the degree of integration in communities/states may vary and offers several best practices to help primary care and public health providers decide on which community-based programs/activities to integrate.

Proposed Certification Criteria

The proposed criteria for entity certification will help assure that high quality, coordinated services are available to clients.

Each Certified Entity would:

- Be responsible for the delivery of a core set of evidence-based community interventions – see the following section for selected interventions and rationale
- Enter into formal understanding or affiliations with primary care practices and share accountability for quality and outcomes
- Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services
- Meet specified standards pertaining to the type, quality, scope and reach of services
- Have IT-enabled integrated communication protocols, including bi-directional referrals with affiliated primary care and other relevant providers and health agencies
- Employ community health workers for their services (Refer to Workforce Development section)

⁴⁰ A Report on Recommendations of the Task Force on Community Preventive Services: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5410a1.htm> Accessed October 2, 2013.

⁴¹ IOM Report 2012: <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

Relationship of Certified Entities with State Health Agencies

We are working hard to break down silos in our workforce by encouraging health agencies to collaborate in their data collection, programs and community investments. State health agencies played a major role in the SIM planning phase and will do so again in the Certified Entity's establishment and community program selections

Quality Assurance and Reporting requirements

The *certified entity* as envisioned would deliver a "minimum package" of services that emphasizes evidence-based interventions that have high potential to improve outcomes and reduce costs. During the implementation phase DPH will lead a transparent assessment planning process by engaging key state agency, community and provider groups to develop standards and process for certification. Contingent on stakeholder input, the certifications may be issued directly by DPH or a designated third party. DPH and other involved state agencies will also provide technical assistance and best practices to organizations that are seeking certification or have achieved certification

The AMH will be responsible for outcomes derived from their certified entity as this will affect their overall standard and metrics benchmarks. This is necessary to ensure that partners hold each other responsible for outcomes and to allow certified entities to compete in the market.

Subcontracting by certified entity

As primary care providers improve their outcomes and become AMHs, we expect the demand for certified entity services to grow significantly. We will meet this demand by allowing selected entities to subcontract certain services on a case by case basis.

The choice for a partner to sub-contract with will be left to the sole discretion of the certified entity. However, the sub-contracting entity will also be held accountable for the outcomes.

Strategy to engage/recruit community resources

Efforts are in place to begin the process of educating and/or engaging providers, community based organizations (CBO), consumers and other pertinent stakeholders on the benefits of integrating AMH's and community resources. The first 18 months of implementation will be crucial as we:

- Initiate a state wide campaign to educate providers and AMH's, who are critical partners to a successful integration on the benefits of such collaboration

- Begin a state wide scan using the Community Transformation Grant to identify existing infrastructure and capable entities that may be appropriate for the initial implementation
- Propose legislation to speed up the CHW certification process (See the Workforce Development section) to ensure that identified entities from the scan have enough CHW to qualify for certification
- Propose legislation that brings CBOs and AMHs to the table to determine and agree to partnership terms that are fair to all parties
- Set up and maintain a state database of certified entities that is accessible to AMH's, certified entities and State health agencies. (See HIT section)

Certified Entity and Health Equity

Certified entities will help address health disparities through a targeted approach. They can deal with environmental quality issues in homes, health behavior modifications, and access to and quality of care. DPH will give priority to placement of certified entities and special attention to areas designated as a Health Professional Shortage Areas (HPSA) and regions/populations identified as high medical utilizers.

Financing Certified Entities

The State is currently evaluating several financial options to ensure that our Certified Entity model is financially sustainable. During the initial phase, we will explore the potential use of existing programmatic state funds and grants as a starting point.

Scaling of Best Practices in Health Improvement

Our State health agencies recognize the importance of linking clinical-community services with population health strategies. To bring this to life, DPH, the Department of Aging, DSS and stakeholders from the Care Delivery workgroup prioritized three community programs that Certified Entities will focus on during the initial implementation phase. These community-based programs, which already exist, are:

- Diabetes Prevention Program (DPP)
- Asthma Home Environmental Assessment Programs
- Falls Prevention Program

These three programs were selected partly because of the recent, Department of Public Health (DPH) comprehensive, State Health Assessment⁴². This assessment identified and ranked the leading causes of hospitalization in the state (e.g., diabetes, asthma, injuries). These also correlated to the leading causes of healthcare costs in Connecticut and are core areas of the emerging Innovation Plan. All three programs are basic elements of the CDC's framework⁴³ for preventing chronic diseases and promoting health. Finally, this framework aligns with the State's emerging CDC-supported Coordinated Chronic Disease Plan, which identifies priorities and indicators for these diseases.

Other important criteria included the programs' ability to prevent disease and promote health as well as evidence of their effectiveness and their return on investment (ROI). The State also looked at how much access they provided to quality health services, what their targeted approaches were to individuals or groups, and how much they were able to address or reduce health disparities.

Diabetes Prevention Program (DPP)

An estimated 8.3% or 25.8 million people have diabetes in the United States compared to 163,000 people or 6.2% percent in Connecticut.⁴⁴ If this situation is ignored in Connecticut, diabetes may lead to disability, blindness, increased healthcare costs and increased mortality.

Connecticut acknowledges that its population is getting older and becoming increasingly overweight and sedentary. To address this public health issue, Connecticut will use the SIM to leverage the existing, evidence-based Diabetes Prevention Program (DPP). DPP increases referrals to, use of, and/or reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes. The DPP may help delay patients' becoming type 2 diabetics by 58%⁴⁵ and can reduce costs⁴⁶. Type 2

⁴² Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 19, 2013

⁴³ Chronic Disease Prevention and Health Promotion Domain:
http://www.astphnd.org/resource_files/477/477_resource_file3.pdf

⁴⁴ The Connecticut Diabetes Prevention and Control Plan 2007-2012:
http://www.ct.gov/dph/lib/dph/aids_and_chronic/chronic_disease/pdf/dpcp_plan_8_10_07.pdf Accessed August 19, 2013

⁴⁵ Linda M Delahanty, MS, RD, David M Nathan, MD- Implications of the Diabetes Prevention Program (DPP) and Look AHEAD Clinical Trials for Lifestyle Interventions: J Am Diet Assoc. 2008 April; 108(4 Suppl 1): S66–S72.
doi:10.1016/j.jada.2008.01.026

diabetes accounts for about 90 to 95% of all adult cases. Its treatment protocol focuses on weight control, exercise, diet and medication.

DPH and its partners are committed to supporting and broadening the impact of DPP. DPH will continue to promote the CDC-recognized DPPs statewide, encouraging healthcare systems to refer eligible participants to them. It will also convene established Connecticut DPP sites two to four times a year to share best practices and lessons learned in implementation, recruitment and retention. DPH and its partners such as the Department of Social Services (DSS), the SIM planning team and the State Comptroller's Office will continue discussions to ensure that DPP will be a covered benefit for publicly employed or publicly insured beneficiaries. The current targeted populations are the employed or those receiving services from the 14 DPP-trained institutions (i.e., hospitals, local health). However, we are potentially looking at policy changes that allow DPP to impact a larger population. Literature has shown that the burden of diabetes disproportionately affects the less educated, racial minorities and those regions with fewer resources.

Connecticut is determined to eliminate diabetes-related health disparities. It can start to accomplish this by collaborating with Community Health Centers and other community-based organizations that deal with disparate populations. Certified entities can improve the DPP's outcomes by using Health Information Technology (HIT) to connect closely to the AMHs and incorporate even more evidence-based care into the DPP. Recruitment and retention of Spanish-speaking leaders and community health workers will be a priority in order to better serve the Hispanic population and other vulnerable populations.

Asthma Home Environmental Assessment Programs

Patients diagnosed with asthma may be exposed to several environmental allergens that may trigger or exacerbate their conditions, especially in their homes. Some of these individuals may be poor, urban dwellers who lack health insurance and hence depend on emergency departments for their medical care. Just as importantly, they may not have received adequate education on how to detect and avoid some of their asthma triggers.

Asthma is an important issue for Connecticut's residents and a significant healthcare cost. According to a recently published study, 9.2% of adults and 11.3% of children living in Connecticut have asthma. In 2009, Connecticut spent over \$112 million for

⁴⁶ Robert E. Ratner, MD, FACE- AN UPDATE ON THE DIABETES PREVENTION PROGRAM: Endocr Pract. 2006 ; 12(Suppl 1): 20-24

acute care management of asthma as a primary diagnosis. It also spent \$80.3 million on hospitalization charges and \$32.6 million on emergency department (ED) visit charges in 2009.

The U.S Environmental Protection Agency encourages individuals and communities to participate in decisions about a proposed activity that will affect their environment and health. To make this possible, the DPH administers and local health departments carry out asthma home visit and environmental assessment known as “Putting on AIRS”. The program has already produced results, decreasing the number of asthma-related emergency department visits, visits to healthcare providers and missed days of school/work due to asthma.⁴⁷

Asthma Indoor Risk Strategies (AIRS) is a free, in-home asthma education and environmental home assessment program provided by a certified asthma educator and an environmental specialist. It improves patient/family asthma recognition and self-management skills through education and interactive interventions that identify and decrease exposure to asthma triggers in the home. It also teaches patients how to properly use their medication devices to administer prescribed asthma medications.

AIRS is a statewide regional program currently conducted through local health departments. Current AIRS partners are Northeast District Department of Health, Naugatuck Valley Health District, Milford Health Department, Ledge Light Health District, Central Connecticut Health District and Stratford Health Department. The State is currently encouraging qualified entities operating in vulnerable communities to apply for certification and thus expand the program’s accessibility.

Falls Prevention Program

Injuries to the musculoskeletal system are one of the leading causes of hospitalization among the over 64 year age group in Connecticut.⁴⁸ The fact that the chances of falling and being seriously injured increases with age is well documented. In one estimate, Connecticut spends \$119 million more every year on home or nursing home long-term

⁴⁷ KIMBERLY H. NGUYEN, M.S., M.P.H. et al- Quality-of-Life and Cost–Benefit Analysis of a Home Environmental Assessment Program in Connecticut: Journal of Asthma, Early Online, 1–9, 2010: http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/kims_final_published_airs_in_ct.pdf Accessed August 20, 2013

⁴⁸ Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 26, 2013

care for older adults who sustain a fall-related injury. ⁴⁹ This is also a national trend, with the United States spending \$28 billion annually on fall victim treatment. If the rate of falls is not dealt with urgently, the direct and indirect treatment costs in the United States will be an estimated \$54.9 billion annually in 2020.⁵⁰

The Connecticut State Legislature tried to address this issue as it examined the State's shifting demographics. As part of this effort, the Department of Aging helped fund the Yale University's Connecticut Collaboration for Fall Prevention (CCFP). This program works with community-based sites, faith based organizations, home care agencies, outpatient rehabilitation centers, senior centers, assisted living facilities, hospitals and providers. The program uses a standard curriculum and protocol with a "train the trainer" approach; this makes it easy for the partner organization to maintain the program and keep working with consumers. The primary risk factors that providers look for are such things as vision problems, balance impairments, postural hypotension, use of four or more medications and home hazards.

Interventions that may be considered in the future

As community-based services become more integrated with primary care, we envision stronger, more innovative and more cost-effective certified entities. The projected cost savings and the innovative quality health experience expected will be due in part to the solid foundation of the SIM, but mostly from the effect as more AMHs participate more actively in integration.

As this occurs, we will use our selection framework, the annual health equity scores from the State regions and the State health assessment to help us select which interventions and programs to roll out and when.

CONSUMER EMPOWERMENT

The delivery of truly whole-person-centered care requires transformation in how providers and payers respect and enable a person's right to be an active participant in the promotion and management of their own health.

In order for individuals to make the best health decisions for themselves and their families, a true working partnership must be developed between the individual and

⁴⁹ 2006 analysis prepared for the Long Term Care Planning Committee regarding the costs of falls among older adults in Connecticut

⁵⁰ Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. *Journal of Forensic Science* 1996; 41(5):733-46. *trial. The Gerontologist* 1994; 34(1):16-23.

their provider. Every consumer has unique insights into the daily issues, both medical and non-medical, that can compromise their health. They also make daily decisions that contribute to their health and well-being. Providers possess the medical background to recognize and diagnose illness and suggest treatment options. Together, these two perspectives form the most effective partnership for making health-related decisions.

SIM provides a unique opportunity to transform the partnership model between consumers and providers today. Consumers have reported barriers to engaging with their providers due to inconvenient appointment times, time constraints, during visits, limited methods for inter-visit communication, and transportation issues. Consumers also tell us that providers sometimes fail to understand their needs as a whole-person. At the same time, consumers have difficulty understanding medical information provided to them due to language and literacy barriers, limited tools to support decision-making, and a lack of quality and cost information.

Opportunities to engage consumers also exist outside of the care delivery system. For example, the conventional benefit designs used by many payers and self-funded employers do little to encourage consumers to invest time and effort in health-promoting behaviors, such as actively seeking preventive care, effective management of chronic illness, reducing smoking and other high risk behavior, and choosing among treatment options and providers that offer the highest value.

Looking beyond healthcare and benefits, we believe it is important to begin to promote methods for improving diet and exercise, health behaviors that have a great deal to do with the emergence and control of chronic illness, but which are notoriously difficult to influence through the care delivery system. Our initial steps in this direction focus on pilot initiatives to promote nutritional purchasing and healthier eating.

Through our extensive stakeholder engagement process, we have assembled a robust understanding of the identified needs and created mechanisms to address the issues. Employers, payers, participating providers, and the state will each play a role in executing a four-pronged strategy:

- Implement formal mechanisms for on-going consumer input and advocacy
- Provide consumer information and tools to enable health, wellness, and illness self-management
- Introduce consumer incentives to encourage healthy lifestyles, high value healthcare choices and effective self-care
- Improve access to health services

Mechanisms for consumer input and advocacy

The impact of care delivery and payment transformation on both the experience of care and on outcomes will be a central concern in the implementation and continuous quality improvement of our AMH model.

Currently, care experience is not a factor used by commercial payers in their value based payment models. Participating payers will track the impact of the AMH model on the experience of care by implementing and collecting care experience surveys and linking pay for performance and shared savings program payment to scores on these surveys.

In addition, the SIM project management office will formally engage the Health Care Cabinet's Consumer Advisory Board to provide ongoing input into the design, implementation and future changes to the SIM program model. The board will also help to identify potential issues and concerns and craft resolutions.

AMH practice standards will also promote effective methods for engaging consumers in providing feedback to the practice in order to support the continuous improvement of care processes and care experience, including a focus on welcoming, engagement, communication, person centered care planning and shared decision making.

Finally, our Equity and Access Council will examine current opportunities for consumers to report concerns about denial of service or under-service and will make recommendations as to whether and how mechanisms additional or more user-friendly methods can be established.

Enhanced consumer information and tools to enable health, wellness, and illness self-management

In order to partner effectively with their providers, consumers will need more and better health information in a timely manner. At the same time, they will need the appropriate tools to enable them to act on this information.

Some practices in Connecticut have already established consumer portals and the feedback has been positive. These portals enable consumers to access their clinical data such as lab results as well as educational materials on illness self-management and health management. The SIM project will facilitate the expanded use of consumer portals with the integration of information from various provider settings. Expansion in access to such portals will emphasize interactive communication with the primary care practice team including the ability to clarify the care plan, ask about a change in condition or solicit additional explanation of test results.

The market is rapidly producing a range of decision support tools to better enable consumers to understand screening, diagnosis and treatment options and make decisions based on this better information and consideration of their own preferences and goals. Our practice transformation standards and technical assistance process will include elements that focus on person-centered care planning and the incorporation of decision support tools into the practice workflow. We will focus on the use of robust tools that meet minimum quality standards, e.g., that are evidence based, have high utility in practice settings, are adaptable for varying levels of health literacy, and can be tailored for culture, race, ethnicity, or disability status. The Choosing Wisely initiative offers provider and consumer-friendly educational materials on how to engage in conversations on whether a treatment option is the right treatment for an individual consumer. Materials produced by Choosing Wisely® are among those that we intend to support, including partnering with private foundations and Consumer Reports to improve the utility of these tools with varying populations.

Selection of treatment settings and providers will be increasingly important as consumers become more sensitive to variations in quality and price for healthcare services. Accordingly, our health information technology reforms will focus on improving the measurement and dissemination of quality and cost information, initially focused on hospitals services and expanding from there to include services provided by specialists.

Finally, we will develop curricula designed to educate consumers about their role in a more person-centered, information rich, and transparent healthcare system. Payers and employers have specifically requested that SIM play a role in the development of these materials, which we believe will also be of interest in community colleges and other adult education settings.

Consumer incentives to encourage healthy lifestyles and effective illness self-management

There are few incentives today for consumers to invest the time and effort to make healthier lifestyle decisions and to partner with providers in proactively managing their health and illness. Connecticut intends to pursue two strategies that promise to improve consumer engagement in their healthcare and in nutritional awareness and purchasing.

Value-Based Insurance Design (VBID)

For many years employers have attempted to limit their health insurance costs, in many cases by shifting an increasing share of the costs to employees. While this

strategy has limited employer cost, it has done little to slow the growth in spending. In many cases, because employees were required to pay higher deductibles and copayments, they put off needed care, which can lead to an increase in future cost for both employees and employers. VBID is one method to encourage consumer participation in health and wellness by providing incentives (positive and negative, dependent on program design) to choose high-value healthcare.

Overview of the State of Connecticut Employee Health Plan

The State of Connecticut Employee Health Plan implemented value-based insurance design (VBID) as an integral part of the Health Enhancement Program (HEP) in September of 2011. This program was established under a collective bargaining agreement covering health and pension benefits, and extended to non-bargaining unit employees and elected officials.

HEP is designed to enhance the ability of patients, with their doctors, to make the most informed decisions about staying healthy and, if ill, to treat their illness. Any medical decisions continue to be made by the patient and his or her physician.

Participation in the HEP is voluntary for all employees and retirees, including dependents enrolled in the Plan. The HEP requires those who enroll to:

- Comply with a minimum schedule of wellness exams and screenings.
- Participate in disease counseling and education programs specific to their condition:
 - Diabetes, both Type 1 and 2
 - Asthma and COPD
 - Heart failure/heart disease
 - Hyperlipidemia
 - Hypertension
 - Annual dental cleaning

Participants enrolled and compliant with the program are eligible for reduced or waived copayments for prescription drugs for their specific condition, and waived office visit copayments for the evaluation and treatment of their condition. An employee whose enrolled family members have any of the specified conditions, and are compliant with HEP, receives an annual payment of \$100.

Employees, and retirees whose retirement date is after the effective date of the program, who do not enroll in the HEP, or who are removed for noncompliance, are required to pay \$100 per month in additional premium, and subject to an annual deductible of \$350 per person/\$1400 maximum per family for services not otherwise covered by copayments.

The State Employee Health Plan and the HEP are overseen by the joint labor-management Health Care Cost Containment Committee. The Plan is administered by the Office of the State Comptroller (OSC). Enrolled employees can access a secure consumer portal provided by the vendor, where they can review their program compliance and view and download educational materials relevant to their specific conditions. Neither OSC nor the employee's agency staff has access to a participant's personal health information.

Employee participation is now 98% for active employees and eligible retirees; and of those enrolled, there is a 98% compliance rate. Feedback from primary care providers indicates that participants are more engaged in their care and more inquisitive about their health status.

OSC is currently reviewing utilization and cost data from the past two years to measure the effect of the HEP and other structural changes to the Plan, in comparison to the periods prior to the program. Preliminary data indicates positive results:

- 35% increase in preventive service visits for established patients, and a 6% increase in E&M visits for non-preventive services over a three year period
- 4% decrease in emergency department services for Employees, but continued increases for Retirees not subject to HEP.
- 6% decrease in the hospital admission rate and a 4% decrease in the inpatient days rate
- reduction in the total medical cost trend from 7.6% prior to the HEP, to 2.2% for the current year

The HEP program was introduced as part of a larger transformation of the state employee health plan that included maximizing use of PCMH's and changes in emergency department copayments. These other changes may also affect the measurement of the HEP changes effect on utilization and cost.

Integrating Value-Based Insurance Design (VBID) into Connecticut Health Care

Many leading national employers implemented elements of value-based insurance design over the past few years, but few with a large employee presence in Connecticut.

Larger employers based in Connecticut with VBID programs include General Electric, Pitney Bowes, United Technologies, The Hartford, and Stanley-Black & Decker. United Healthcare and CVS Caremark both of which have a large retail presence in Connecticut have also implemented VBID programs for their employees.

In Connecticut, VBID programs have been limited mostly to self-insured employers, partly because state insurance regulations prohibited certain practices common to VBID programs. However, the wellness provisions of the ACA preempt some of those regulations. The State will identify other regulations that may hinder the progress of further VBID implementation.

Building on the experience in the design and management of the HEP Program, the Office of the State Comptroller will organize a taskforce including employers with medium to large size workforces in Connecticut and the four major insurance carriers to review VBID programs in place in Connecticut and other states. We will design a suggested menu of VBID options that insurance carriers can offer to employer groups on either an insured or self-insured basis, and explore the needed infrastructure and support to these companies may require. The goal is to demonstrate that a well-designed and implemented VBID program can improve the effectiveness of the State's SIM model for employees who are incentivized to actively participate in their healthcare.

The Connecticut Medicaid program does not include cost-sharing for any of its covered populations, so VBID methods are not directly applicable. However, DSS has implemented the Rewards to Quit program to provide financial rewards for smoking cessation and it will consider similar opportunities to reward positive health behavior in other areas to the extent that such incentives would be coverable under Medicaid and cost-effective.

Rewards for Nutritional Purchasing

Food purchasing and diet are among the most difficult behaviors to influence and yet diet is widely recognized in the public health literature as one of the main contributors to chronic illness prevention and effective management. We believe that incentive based programs hold promise in changing food purchasing and eating habits and we intend to support several pilots during the two years of our SIM initiative using systems for indexing overall nutritional quality.

The NuVal® Nutritional Scoring system scores food items with a number between 1-100 based on the overall nutritional value of the food. Yale University led the development of this pioneering system, which has been adopted by two food retailers in Connecticut. As part of our vision for activating consumers in the area of nutritional

purchasing, we will pilot the integration of NuVal® nutritional scores with nutrition coaching and employer incentives to promote the purchase of foods with higher nutritional scores. The program will track both increases in the purchasing of the targeted foods and changes in overall purchases to monitor any substitution effects that may occur whereby savings in highly nutritious foods are spent on additional low nutrition foods.

Additionally, incentives for purchasing more nutritious foods (subsidies) and disincentives for purchasing less nutritious foods (taxes) will be incorporated as research has shown that subsidies and taxes may have different impact on different population groups.

We will coordinate a partnership with payers to support the evaluation of these pilots with respect to health outcomes and cost-effectiveness. Depending on the results of the evaluation, rewards for nutritional purchasing may be adopted as part of the recommended VBID or as an independent employer administered health incentive initiative.

In parallel with the above effort, the Office of the State Comptroller will be examining other options for incorporating diet and nutrition programs into the HEP. This will include consideration of other systems for indexing overall nutritional quality.

Rewards for nutritional purchasing through employers could reach a substantial portion of Connecticut residents, but this approach alone would not provide the broad reach that we are seeking to achieve through Connecticut's SIM initiative. The Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) is the nation's most important anti-hunger program. In 2012, it helped almost 47 million low-income Americans to afford a nutritionally adequate diet in a typical month. After unemployment insurance, SNAP is the most responsive federal program providing additional assistance during economic downturns. It also is an important nutritional support for low-wage working families, low-income seniors, and people with disabilities with fixed incomes. The Department of Social Services will explore with the US Department of Agriculture the option of implementing a nutrition rewards pilot program within SNAP using an evidence-based overall nutritional quality index.

Improved access to health services

A material barrier that prohibits a subset of consumers from participating in their care today is the lack of access: consumers have difficulty making appointments with their

providers during regular business hours, and/or have difficulty securing transportation to the physician's office.

Glide Path and AMH providers will be encouraged to decrease structural barriers to healthcare access. Glide Path accreditation standards and AMH provider performance scorecards will measure providers' abilities to provide non-visit based options such as text messaging, emails, and phone calls. In addition, providers will be required to open for extended hours and offer same-day appointment options to their panel of patients. In addition, payers and providers will encourage the adoption of non-visit based specialty consultation options such as e-consultation.

In addition, as detailed elsewhere, the State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, which would partner with AMH's to provide improved access to evidence-based community services, such as diabetes prevention, in-home environmental assessments for asthma, and help in preventing falls among older adults or other individuals at-risk of falling as a result of health conditions.

Finally, an Equity and Access Council will be established to help ensure that the care delivery and payment reforms do not result in unintended reductions in access for particular populations or inappropriate reductions in service for particular populations, procedures or conditions.

Enabling initiatives

Connecticut's three primary drivers for innovation are supported by four enabling initiatives, which provide the infrastructure, systems and resources to support primary care practice transformation, community health improvement, and consumer empowerment. Each enabling initiative plays a distinct role. Performance transparency ensures that all participants (including consumers) understand how they and the system are doing and fosters individual accountability. Value-based payment builds off this accountability and rewards providers who deliver high quality, whole-person centered care that also controls costs. Health information technology is vital in connecting all the different groups in Connecticut – consumers, providers, payers, state and regulatory entities, and communities. Finally, our workforce development initiative will seek to ensure that we have the right number of people with the right skills and capabilities for the future.

PERFORMANCE TRANSPARENCY

Throughout the design process, diverse groups of stakeholders have told us repeatedly that increased transparency in quality and cost is a fundamental prerequisite to improving our health system. Transparency will support our aims in multiple ways at different points in time: in shaping the design of new networks, payment models, and clinical interventions; as an input into consumer choice of health plan and network at the point of purchase of healthcare coverage; influencing consumer choice of provider at the point of care, as well as referral from one healthcare professional to another provider; and importantly to inspire and inform providers' own performance improvement efforts.

1. Shaping program design. In the near-term, comparative information regarding regional variation and provider performance variation on key health, quality and resource utilization measures will be informative to increasing the specificity of our multi-payer design of new care delivery and payment models. Similar information will also be instructive to payers in establishing pricing for new rewards. Longer term, the same comparative analyses will inform self-evaluation and continuous improvement to model designs.

2. Input into consumer choice of health plan. Currently, when consumers choose between health plans they have only limited information regarding network breadth; some may choose a network based on whether their current physician or their neighborhood hospital is in the network, but without information regarding how these

providers compare to others in quality of care, consumer experience, and/or efficiency. As we gain greater insight into provider performance on these dimensions, this information will be made available to consumers (and other purchasers) at the point of choosing between health plans, whether on the Marketplace or in other venues.

3. Point of care transparency. Many have experienced the challenges and frustration of trying to identify accessible, high-quality providers at the point in time when symptoms develop and we need to access care. Even those who are under the care of a physician may be referred to another provider based on limited anecdotal experience of their referring physician, but without alternatives to choose from or objective data that consumers could use to participate in the referral decision. The progression of some providers toward AMH status and increased copays and deductibles among commercially insured consumers will likely fuel increased demand for transparency to inform point of care choice among treatment options, sites of care, and specific providers. At the same time, as primary care providers increasingly shoulder responsibility for the quality of care and resource utilization of other providers who care for their patients, PCPs also will increasingly demand information that they can use to inform those referral decisions.

4. Provider performance improvement. Providing comparative quality and cost information to providers will be critical to informing where they focus their efforts to improve care. Past experience with consumer transparency initiatives has suggested that even performance data that is only seldom accessed by consumers can have a significant impact on providers' own efforts to improve performance. Some industry experts have suggested that providers' own competitiveness as well as simply their commitment to excel in patient care have been as strong or more strong a motivating factor in driving provider performance improvement efforts tied to pay-for-performance than were the economic incentives themselves.

Our strategy for achieving this goal involves a common performance scorecard, beginning with primary care. It will use data that is aggregated across payers, with risk adjustment and exclusions as appropriate, and offering multiple reporting levels to inform a wide range of healthcare decision makers.

- **Common performance scorecard to increase consistency.** In the months ahead, a common performance scorecard will be established, including measures of health status, health equity gaps, quality of care, consumer experience, costs of care and resource utilization. Consistency of measures across payers will reduce business complexity and administrative costs for providers associated with reporting.
- **Beginning with primary care and moving outward.** The scorecard will initially focus on key process and outcomes measures related to quality, equity, care

experience, cost, and resource efficiency within the primary care setting. Over time, additional data elements will be added to support our goals for community health improvement and consumer empowerment, in particular informed choice of specialists and hospitals.

- **Aggregation of data across payers to increase reliability of measures.** Data underlying the common scorecard will be aggregated across Medicaid, Medicare, and participating Commercial payers. Doing so will allow for larger “sample sizes” that will more reliably reflect a provider’s true performance. Over time, we may also work toward consolidated reporting which will be more efficient for payers, and more practical for providers than accessing multiple payer reports.
- **Multiple levels of reporting to inform decision making.** Performance will be reported at multiple levels to inform decision making by consumers, providers, and payers at the point of care and point of purchase of health insurance, and as part of program development efforts. This will include: isolation of patient-level data; comparative analysis of population segments; provider-to-provider comparisons; plan-to-plan comparisons; and state and regional summaries.

VALUE-BASED PAYMENT STRATEGY

Providers who meet specific thresholds on quality, cost, and equity metrics, or who improve their historical performance will be compensated for providing high-value care. Under all models, providers must achieve pre-determined thresholds for quality of care in order to earn shared savings or bonus payments.

Shared Savings for Advanced Medical Homes

The State will allow Advanced Medical Homes to qualify immediately for shared savings program participation. They will possess:

- Accreditation under a set of standards for a medical home
- Clinical integration (e.g., an integrated IT platform, a physician portal, physician alignment, nursing collaboration, and governance structure)
- The ability to manage population health (e.g., predictive analytics, risk stratification, prevention, outcomes tracking, disease management, coordination with community programs, and concurrent review)
- Financial risk management (e.g., cost and utilization analytics/ benchmarking)

In some cases, provider organizations may already be adopting shared savings arrangements with Medicare and/or private payers though they have not yet achieved the level of capabilities associated with an Advanced Medical Home. The State does not wish to disrupt such arrangements; however, we will nonetheless encourage these providers to work toward AMH status and capabilities as a strategy for improving quality and care experience while succeeding under shared savings.

Shared savings payment models offer a range of benefits that will help increase the quality of care in Connecticut and reduce waste in the system. Value-based payment tightly aligns provider and consumer interests by rewarding primary care providers for considering the needs of the whole person and partnering with consumers to improve their health. This model also increases providers' accountability for high quality care that prevents disease exacerbation, readmissions, and redundant care (e.g., duplicate tests). Denial of necessary care is discouraged because providers are responsible for the downstream impact of withholding necessary care. In addition, we will adopt advanced analytics to identify outliers for underuse. In addition, as discussed in the performance management section, providers will be rewarded based on both their quality and efficiency performance.

Under the shared savings model, providers will take on accountability for total cost of care. Total cost of care is defined as the full set of healthcare costs associated with an individual's healthcare delivery, including: professional fees, inpatient facility fees, outpatient facility fees, pharmacy costs and ancillary costs (e.g., lab tests, diagnostics).

- Payers and providers may select from various risk levels when adopting the Shared Savings model:
 - Upside-only: where providers are eligible for smaller bonuses but do not share in risk), which physician-led ACOs with limited capital may favor. (Upside-only arrangements meet the requirements of our model.)
 - Risk-sharing: where providers are eligible for a greater share of savings and a share of risk, which hospital-based ACOs may use to help offset lost margins associated with reductions in hospital volume

The Connecticut AMH model will include exclusions and adjustments to ensure that consumers with exceptional or unpredictable service needs do not unfairly affect providers' performance measures. Both payers and providers will have approved these adjustments. For example, shared savings models typically exclude individuals who require organ transplants or who have experienced a significant traumatic injury. This makes sure that providers are held responsible only for those outcomes that they can manage effectively in their partnership with the patient.

Risk sharing will not be considered for the Medicaid program in the early phases of deploying value based payment reforms under SIM. Efforts subjecting Medicaid providers to downside risk will be informed by experiences of other SIM value based payment reforms on quality outcomes for patient participants. The rationale for this exclusion is to avoid negative quality outcomes for program participants and unintended contraction of the Medicaid provider network.

Pay for Performance Program

Participation in shared savings tied to total cost of care typically requires a minimum patient panel size of 5,000 or more patients. Smaller providers may not meet these panel sizes, unless and until participating payers resolve how to aggregate performance for purposes of measurement and rewards. In the interim, many providers—especially those earlier in the development of AMH capabilities, may favor a pay-for-performance program structured around bonus payments tied to discreet measures of resource utilization in addition to the same measures of quality and consumer experience to which the Shared Savings Programs will be tied.

Up-Front Investment in Care Coordination

Some providers lack the investment capital necessary to fund new capabilities and processes, or to weather the transition costs on practice productivity that can arise during a change in business models. In addition to the technical assistance that the State will provide through practice transformation support, payers will be encouraged to fund new responsibilities for care coordination through up-front fees, paid either on a per-member-per-month (PMPM) basis or through enhancements to the fee schedule. Such payments should be based on providers meeting mandatory pre-requisites (e.g. meaningful use of EMR) as well as progress milestones for practice transformation. In some cases, providers may elect to waive care coordination fees and practice transformation support in favor of higher levels of shared savings rewards.

Guidelines for Payer Reward Structures

Each payer will determine their reward structure's specific targets, pricing, and risk levels. However, Connecticut provides a set of guiding principles for the structures' design:

- Both P4P and Shared Savings should deliver meaningful rewards that will support the capability building needed to transform the delivery system

- Both P4P and Shared Savings should reward both absolute performance and performance improvement
 - For select measures of quality and efficiency, providers will need to achieve a minimum level of performance in order to receive rewards
 - The level of the reward will be tied to the degree of performance or improvement beyond the minimum acceptable level
 - Providers that achieve distinctive performance may continue to earn rewards on a sustainable basis, without further improvements
- Glide Path providers should have an opportunity to earn rewards in the first year based on quality performance alone; rewards in subsequent years should require performance on both quality and cost savings

Data Aggregation to Measure Provider Performance

Given the market competition among Connecticut's payers, only the largest providers currently have patient panel sizes that are large enough to reliably measure total cost of care. Even resource utilization measures to be used in pay for performance programs may require patient panels that small practices can only meet for their largest payer. In order for pay-for-performance programs to gain adoption among smaller market share payers, it will be necessary for payers to aggregate data for performance measurement and reporting. Defining the technical details of payer data aggregation will be among our key objectives in the months ahead to prepare for launch of the new payment models.

Ensuring Equity and Access

Medicare, Medicaid and commercial payers have made substantial and ever increasing investments to counter the excessive utilization that is endemic to our fee-for-service payment system. The focus of these activities, commonly referred to as audit or program integrity, is on a broad range of excess service issues. Payers rely on administrative data and advanced analytics to identify billing outliers (providers whose patterns of service activity differ from their peers) or unusual trends in utilization that might signify inappropriate services by major provider systems or segments (e.g., home health care, personal care) of the market.

As Connecticut pursues a shared savings program, there is the possibility that a few providers might seek savings through inappropriate methods. These include reducing necessary access, adverse risk selection, lowering quality of care, cost shifting,

withholding appropriate care or inappropriate referral practices. Quality metrics will help guard against this for target conditions (e.g., diabetes, asthma). However, they may not prevent more systematic efforts to under-serve, particularly for uncommon conditions, or any conditions that are outside the scope of quality improvement metrics.

We believe that it is important to establish an integrity-like function that focuses on these issues of risk avoidance and under-service, including establishing guidelines for consequences of under-service (e.g., may lead to discontinuation of shared savings participation or network disenrollment).

Moreover, we believe that these functions should be separate and apart from quality measurement and continuous quality improvement activities, which should focus on targeting opportunities for improvement and expanding the core measurement set. To this end, Connecticut proposes to establish an Equity, Access and Appropriateness Council, comprised of consumer advocates, payer-based experts in audits and advanced analytics, and clinical experts and researchers from the state's academic health centers. The task of this Council will be to recommend an audit strategy and methods that will help guard against these risks and to encourage payers to adopt such methods on or before implementation. The state anticipates that payers will expand or repurpose existing audit resources to support the recommendations of this council.

The Equity and Access Council may also recommend circumstances under which the findings of audit processes might result in disqualification from value-based payment rewards such as shared savings or other penalties or sanctions.

Connecticut is excited by this opportunity to develop innovative methods to prevent under-service and believes that the work done here can serve as a national model.

HEALTH INFORMATION TECHNOLOGY

Health Information Technology (HIT) is a critical enabler of primary care transformation, community health improvement, and consumer empowerment. When consumers, payers and providers have easy access to integrated clinical, claims, and population health data, they can make better healthcare decisions. This will lead to improvements in Connecticut's healthcare quality, consumer experience, and cost.

Although a variety of HIT assets currently exist, e.g. databases, interfaces, tools, they are akin to separate systems rather than the integrated, accurate system that Connecticut needs. They focus on subsets of the Connecticut population or collect incomplete, lower-quality data that is difficult to act on. In addition, few of the payer,

provider and health agency systems are linked, which makes it difficult to share information between them.

Connecticut's approach to developing its HIT will provide immediate support to the proposed reforms. The state will initially ask payers and providers to leverage their existing analytics and other technology-related capabilities; this prevents unnecessary investments in a common infrastructure, which would be duplicative, expensive and time-consuming.

Our HIT strategy also leverages many of Connecticut's unique strengths.

- 1. Concentration and capabilities of healthcare leaders.** We can leverage best practices and capabilities, e.g., advanced research, tools, and infrastructure from our prestigious academic medical centers and the large, national health insurers who are based here.
- 2. Cross-payer commitment.** The State will seek public and private payer commitments to gain the momentum it needs to successfully roll out the cross-payer HIT infrastructure. The high level of collaboration that already exists between Medicaid and the largest commercial payers (who account for 85% of commercial lives) is already making this possible. Specific mechanisms will include a standardized approach to analytics that reduces providers' administrative burden and a single interface (portal) to exchange information with providers.
- 3. Engaged consumer base.** Connecticut will take advantage of its broad, diverse and engaged consumer stakeholder community as it tries to accelerate the public's adoption of consumer-facing care technology. HIT technology could provide consumers with knowledge about health and healthcare, offer cost and quality performance information on their providers, and help them make joint decisions with providers and care coordinators.

How HIT Supports Primary Care Transformation and Consumer Empowerment

The proposed HIT strategy supports the proposed reforms in the following ways:

- **Whole-person-centered care:** Payers will collaborate in the development of common assessment tools for defining patient needs, encompassing primary care, behavioral health and oral health care, and social supports, among others. **Under the new system,** consumers' values and preferences will play a prominent role when they and their providers make healthcare decisions. This requires that they be fully informed about the risks and benefits around their treatment choices.

We will use connectivity and care management and member engagement tools to provide the majority of Connecticut’s residents with the information they need to accomplish these goals.

- **Enhanced access.** Payers will provide consumers with access to portals that offer customized guidance and shared decision aids to help them make their care choices, e.g., which providers may best match their needs, what diagnoses mean, which types of treatment are appropriate. Providers will employ secure e-communications, e.g., email, and use e-consults to increase consumers’ access to specialty care. Consumers will also be able to use these tools to interact with members of their care team as they review their medical information, care plans and any other recommendations based on their unique needs.
- **Population health management.** Payers will make claims-based analytics available to providers so they can segment consumer populations based on the consumers’ expected utilization of health resources. Providers can then identify those consumer groups that will most likely benefit from increased care coordination. They can also use technology to conduct a joint analysis of clinical and claims data. Providers can use the results to identify times for care interventions, e.g., vaccination reminders and follow-up activities. They can analyze their effectiveness with various sub-populations and use this information to support continuous quality improvement.
- **Team-based, coordinated care.** Direct messaging will promote provider communication across care settings. In the long-term, EHR-based clinical data exchange will ensure that providers always have access to consumers’ past care information, even when consumers visit different sites of care. Information on in-network and area specialists and acute care facilities’ performance, e.g., on quality, cost and utilization, will help providers support consumers’ health decisions more effectively.
- **Evidence-informed clinical decision-making.** Providers will receive analytic reporting to identify gaps in care, e.g., missing cholesterol screenings for consumers with cardiac disease. This approach implements evidence-based care guidelines at the level of the individual consumer.

HIT Capability Assessment and Roadmap for Building Them

To achieve the full potential of the AMH transformation, Connecticut’s payers and providers will need to deploy a wide range of HIT capabilities. These include payer analytics, consumer and provider portals, clinical healthcare information exchanges and provider-consumer care management tools. Although Connecticut payers and

large providers have significant capabilities today, e.g., advanced payer analytics and experience with PCMH pilots, obstacles remain. Smaller providers face technical challenges, the state’s Health Information Exchange (HIE) is limited and the rollout of the APCD is in its preliminary stages. The State will leverage its existing capabilities as it accelerates HIT adoption.

The timeline for Connecticut’s HIT strategy sequences the implementation of capabilities according to: their value to the AMH model, their current state of development, and the time needed to implement them and their interdependencies with other capabilities (Exhibit 4). Fundamental and high-impact capabilities – both high priorities - will fall into the early development category, as did critical enablers for other categories. Existing capabilities will also be leveraged in the earlier stages. However, highly complex technology solutions will be rolled out in later stages so the State will have sufficient lead time to develop them.

Exhibit 4: Sequencing for Rolling Out the HIT Strategy

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 years)	Stage 3 (3+ years)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
Provider-payer-consumer connectivity	Multi-payer online portal for providers to receive static reports; basic consumer portal	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange solutions	Potentially integrate state-wide Health Information Exchange

In Year One, Connecticut will leverage existing stakeholder capabilities as it launches a broad array of fundamental payer-based components; these will include consumer attribution, risk stratification, performance reporting and specialist and facility analytics. The State will also create a provider and consumer portal. In years two and

three, it will further develop provider care management tools and dramatically augment the portal and payer analytics.

- **Payer analytics.** Payer analytics include tools that payers use to analyze claims data; these analyses then produce metrics that assess outcomes, quality and cost and can affect providers' reimbursement. Examples of payer analytics include risk stratification, quality metric and total cost of care calculations and consumer attribution. Provider tools that use clinical data to assess population risk and identify care opportunities, e.g., prostate screenings, can complement these analytics.

The timeline for payer analytics follows the overall HIT timeline; it starts by leveraging existing tools and then implements new ones as they become available. Initially, payer analytic tools will be standardized across payers but not consolidated. Payers will generate highly standardized metrics, analytics and reports, although their infrastructure will remain independent. Payers will capitalize on existing population health analytics while they establish the full set of tools required to support shared savings accountability among providers. In the longer term, the APCD will provide an additional resource for advanced analytics.

During Stage One (Year One), payers will standardize provider reporting based on core analytics, e.g., consumer attribution, risk stratification, risk adjusted cost comparison, quality and utilization metrics. Enhanced analytics, e.g., care gaps analyses, alert generation that identify high-priority consumers who need targeted intervention will be implemented in Stage Two (Years Two to Three). During Stage Three (Three+ Years), we will integrate public health and clinical data analytics so providers have more meaningful performance information and consumers possess a more comprehensive view of their care.

- **Consumer-provider-payer connectivity.** Payers will establish portals where providers and consumers can access relevant information and submit data that is required to support the proposed reforms. Many providers have access now to payer-based portals that connect the providers with health plans and practice management systems; however, there is a need for a single provider portal for use across multiple payers.

Many commercially insured consumers have access to multiple portals that allow them to track claims and account activity, find doctors and services, access health advice and get answers to coverage questions. Some patients also have access to a consumer portal through which they can schedule appointments, send messages to their provider, review and get refills on their medications and review

their health conditions, e.g., with links to MedLine Plus Connect for clinical information in English and Spanish.

In Stage One (Year One) payers and the state will collaborate and set up a multi-payer online portal for providers, who will receive static reports. Connecticut is also developing a Master Client Index (MCI) and an Integrated Eligibility Management System (EMS), both of which will help link and coordinate the different State Health and Human Services agencies. These two elements will reinforce consumers' ownership of their health data and how it is used, i.e., consent management. In Stage Two (Years Two to Three), the State will upgrade the provider portal so it allows bi-directional communication between payers and providers as well as data visualization tools. In Stage Three (Three+ years) a fully functional health information exchange (HIE) will enable consumer-provider-payer connectivity.

- **Provider-consumer care management tools.** Care management tools will help care teams (physicians, care coordinators) identify care opportunities and prepare for consumer encounters. They will also assist the teams implement the most appropriate interventions and better manage follow-up care. Lastly, they will facilitate their consumer outreach.

The State will deploy a range of solutions to help all providers build their care management capabilities. In Stage One (Year One) the State will identify the provider workflow changes required to improve care coordination and detail the options and applications for supporting technology. We will also educate consumers on healthy behaviors and how to make high-quality, cost-efficient decisions about their care. To do this, the State will leverage existing infrastructure, payers' proprietary tools, and specialized technology.

Over the longer term (Years Two to Three +), we will pre-qualify vendors and health information service providers and obtain pre-negotiated, discounted pricing. At this stage we will also assess the viability of developing the shared-service care management toolkit mentioned earlier.

- **Provider-provider connectivity.** Provider-provider connectivity is the integrated exchange of clinical data between doctors, hospitals, and other healthcare providers through a secure, electronic network. Secure data exchange is a key enabler of population health.

The state will promote clinical data exchange with a standardized – not consolidated – approach. In Stage One (Year One), the state, via HITE-CT, will promote the direct exchange of information between providers with technologies that are easily scalable, e.g., direct messaging, as well as financial and technical

assistance when appropriate. The exchange of Admission, Discharge and Transfer (ADT) information between providers will help ensure coordinated care delivery across different sites of care, e.g. acute vs. primary care settings. The state will also support existing efforts to enable clinical connectivity, accelerate EHR adoption, and promote its frequent use. The Meaningful Use guidelines for EHR adoption (spearheaded by eHealthConnecticut) will help providers find ways to make their separate EHR solutions work together. The State may require that providers' EHR solutions possess integrated HL7-based ADT messaging functionality so that the EHR can communicate with other providers, hospitals and ancillary systems

In the medium term (Years Two to Three), provider groups will align local health information exchanges so the exchanges can work together. Eventually (Years 3+), the State will transition to a clearing house (HIE) model for clinical data exchange.

Other Considerations

- **Coordinating with state-wide HIT initiatives.** The state will establish a Healthcare Innovation HIT Taskforce for the Connecticut SIM transformation. The taskforce will coordinate efforts across programs as they integrate clinical and claims data and to produce a more complete picture of provider performance. The taskforce will also help set HIT priorities and identify dedicated funding mechanisms.
- **Assisting rural providers and small practices.** HIT capabilities vary significantly between large and small providers. The State defined a Glide Path for small practices or rural providers who may need transformation support before they can develop the capabilities needed to meet the state's practice accreditation standards and enter into value-based payment.
- **Affecting and leveraging MMIS.** Connecticut's Medicaid Management Information System (MMIS), the record-keeping system for all Medicaid claims and payments, will continue doing this into the future. However, our SIM initiative will leverage the Medicaid DSS, using some of its measures of state outcomes and performance to complement our state analytics under the new model. We will also use MMIS as the starting point for different data integration approaches. In one case, Connecticut will create a comprehensive view of Medicaid consumers by integrating MMIS Medicaid claims data with HIE clinical data.

HEALTHCARE WORKFORCE DEVELOPMENT

Realizing healthcare delivery as envisioned demands a Connecticut health workforce of sufficient size, composition and training. This workforce must:

1. Meet an increased demand for health services stemming from more of our residents having health insurance as a consequence of the Affordable Care Act;
2. Meet the health service needs of a population that is growing older and more racially diverse by dealing effectively with the multiple comorbidities of people who are frail and with the poorer overall health of people of color;
3. Focus on health rather than disease by bringing to bear the insights and methods of population health both to reduce the need for expensive health services and to achieve a healthier Connecticut;
4. Meet the need for professionals with public health training who can work with communities on both broad and targeted measures to enhance the health of these communities;
5. Work in care teams, grounded in primary care but encompassing specialty care, which can employ more effectively and efficiently a medical toolkit whose diagnostics, therapies, surgeries, drugs, medical devices and assistive technology are many, powerful and hard to calibrate, and becoming increasingly more so;
6. Engage patients in maintaining their own health, in participating in their own healthcare and in making decisions, together with their families, regarding that care both because it is more effective and because it is patients themselves who should judge the tradeoffs of available treatments; and
7. Partake wholeheartedly but with respect for privacy in the informatics/HIT revolution that affords unprecedented capabilities in:
 - record keeping and retrieval,
 - answering clinical questions and identifying best practices,
 - quality control and error reduction,
 - data generation and analytics on outcomes and processes,
 - simulation, distance learning and e-consultation,
 - monitoring of patients in their homes, and
 - communication by clinicians and other care givers among themselves, with patients and their families and with researchers and educators.

Connecticut's health workforce must do all of these with the triple aim of improving health while eliminating health disparities, improving health services and reducing the increase in the overall cost of health services.

Since our understanding of Connecticut's health workforce needs is still evolving and the initiatives we identify are in various stages of design, this health workforce plan of action is a work in progress. We will continue to refine our vision for our health workforce and our approaches for achieving this vision.

This section includes:

- An assessment of Connecticut's current primary care workforce; and
- Six multi-purpose initiatives:
 1. Health workforce data and analytics;
 2. Inter-professional education (IPE);
 3. Training and certification standards for Community Health Workers;
 4. Preparing today's workforce for care delivery reform;
 5. Innovation in primary care post graduate education and residency programs;
and
 6. Health professional and allied health professional training career pathways.

Connecticut's current primary care workforce

Available data is not sufficient for a detailed or reliable account of Connecticut's health workforce in terms of how many practitioners are working in Connecticut, how much they are practicing, where they are practicing or even what they are practicing. The data says virtually nothing about how the various occupations are trained and what their knowledge and skills are. It is of little use for predicting workforce needs of the future care delivery system outlined in this plan. These shortcomings are why improving Connecticut's health workforce data and the analyses of this data is the first of our six initiatives.

Nonetheless, there are a number of recent surveys that bear upon Connecticut's health workforce. In May and June 2013, the Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) used these studies to evaluate Connecticut's primary care workforce. CPHHP found all these surveys to be problematic, yet together they paint a basic picture.

CPHHP's scan is supplemented by the 2011 Connecticut Health Care Workforce Assessment, which was prepared for Connecticut's Allied Health Workforce Policy Board, the Connecticut Office of Workforce Competitiveness and the Connecticut Employment and Training Commission. This report places a greater emphasis than CPHHP's scan on allied health professionals and on market demand for both primary care professionals and allied health professionals.

Finally, there have been three separate efforts recently to estimate the number of primary care physicians practicing in Connecticut. After considerable sifting and adjusting, CPHHP's best estimate is 2,585 primary care physicians (PCPs) currently practicing in Connecticut. Research by the Office of the State Comptroller, working with Anthem, has identified approximately 2,600 primary care physicians in active practice in Connecticut. The Robert Graham Center estimate is 2580 as of 2010. So, we have a reasonably credible ball-park figure, but no firm sense from these assessments of whether Connecticut has enough primary care physicians now, or, more significantly, whether the state will have enough in the future when we expect the model of care delivery to be far more team-based and reliant on the meaningful use of HIT. What makes estimating particularly tricky is that whereas other clinical professionals may assume some duties currently performed by PCPs, PCPs may assume some responsibilities that are now mostly performed by medical specialists. In the balance, considering current market demand, Connecticut almost certainly does not currently have sufficient PCPs, and almost certainly will not have sufficient PCPs in the future unless action is taken, even though other professionals assume some duties that PCPs perform today and even though primary care becomes more team-based.

Overall, findings drawn from recent data covering recent supply and demand are mixed:

- Connecticut has a better ratio of professionals and allied health professionals engaged in providing primary care to population than the national average. For most of the Connecticut healthcare practices, Connecticut has more practitioners per 100,000 people than the national average. There are substantially more physician extenders—physician assistants, registered nurses and medical assistant—per person in Connecticut than elsewhere;
- There is a maldistribution of primary care physicians, since five of the state's eight counties, all the non-urban ones, had PCP ratios lower than the national average;
- Across the state, providers report difficulty hiring primary care physicians;

- The number of active licenses overestimates the number of practitioners actively practicing, as practitioners often maintain their licenses when they move out of state, retire, or assume non-direct care positions;
- The license data indicates that for many health professions, more than one out of five licensees are at least 60 years old. Psychologists have the highest proportion of licensees 60 or older, at 35 percent. The only exceptions are dental hygienists and physician assistants, with only eleven and seven percent of their number over the age of 60. Roughly 27 percent of holders of the physician and surgeon license are 60 or older. In public sector behavioral health, 55 percent of the professionals (including psychiatrists, physicians, psychologists, psychiatric social workers and nurses) are age 50 or older, with 34 percent age 55 or older.
- The professional health workforce poorly represents the racial and ethnic composition of the state with minorities concentrated in lower skilled occupations, while professional clinicians are overwhelmingly white. More than 75 percent of practitioners in every health profession identify themselves as white. Licensed Nurses are 23.3 percent African American; Counselors are 18.6 percent African American. Pharmacists are 16.7 percent Asian. Minorities constitute less than 10 percent of every other health profession. Also, persons at the lower rungs of the allied health professions who demonstrate greater diversity have great difficulty climbing the career ladder to the higher rungs of the allied health professions (e.g. occupational & physical therapists) and to the clinical health professions (e.g. nursing, pharmacy, social work, dentistry, medicine.)
- As elsewhere in the country, allied health professionals have grown significantly in number relative to health professionals, and currently represent one of the more robust employment prospects in Connecticut. There has been a corresponding expansion of allied health professional training slots and programs. Consequently, supply appears to be keeping pace with demand. But it is unclear what the future demand will be both in terms of numbers and skill sets.

The demand for primary care services will increase with Connecticut's aging population and a projected additional several hundred thousand covered lives resulting from the full implementation of the Affordable Care Act. This challenge is compounded by the fact, noted above, that the average professional clinician is middle aged with significant numbers of them over 60 years old. A virtually inevitable exodus of highly trained professionals during the coming decade will challenge our capacity to deliver services and to integrate behavioral health and primary care.

What is apparent to all but ill-defined is the disconnection between the requirements of newer models of care delivery, the content of current training programs, and the skill sets of the existing health workforce. For example, there is a serious lack of primary care workers who are trained to identify and address behavioral health needs. This applies to all disciplines and all levels of health workers and especially to those who come from culturally disadvantaged populations. Related to this problem is that market demand under our current delivery system may not reflect the market demand for new skills and new roles under the delivery system we hope to achieve.

Pharmacists present a good example of both quandaries. In Connecticut, according to national Pharmacy Workforce Project data, there has been an oversupply of pharmacists for the past 3-5 years. New pharmacists are finding it difficult to find full-time employment and many are working in multiple part-time positions. But this apparent oversupply of pharmacists and their current difficulties in finding employment in our state reflect the fact that pharmacist workforce projections have been based on traditional dispensing roles of pharmacists and the projected per capita consumption of pharmaceuticals. With the implementation of new healthcare delivery models and medication management services, pharmacist workforce projections must incorporate scenarios in which pharmacists will increasingly be involved in non-dispensing and direct patient care roles. Pharmacist workforce demand is expected to increase with team-based care delivery models in Advanced Medical Homes (AMHs), Accountable Care Organizations (ACOs) and other integrated health systems of care.

Six multi-purpose initiatives

What follows are summaries of six multi-purpose initiatives that Connecticut will pursue. Each is designed to make significant contributions to developing a health workforce that will fulfill our state's plan for delivery system reform, and meet current and future needs for health services. Each initiative addresses numerous concerns, but taken together they still do not encompass everything that must be addressed. Our intent is to get underway with a manageable number of concrete actions that reflect the priorities laid out in this plan.

Health Workforce data and analytics

Over the next five years, Connecticut will work toward collecting and reporting real-time health workforce data, and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs. Meanwhile, the state will improve and make better use of health workforce data that is gathered by a

number of state agencies, including the Office of Higher Education, the Board of Regents and the Departments of Education, Labor and Public Health.

The Department of Public Health (DPH) will lead as described below; however, additional resources must be identified both for DPH and for other participating state agencies. The availability and extent of these resources will determine the pace of implementation. Also, the effort must be cooperative and coordinated, meaning that sister state agencies and other stakeholders must do their part.

Starting this fall (October 2013), DPH implemented mandatory online license renewals for physicians, dentists and nurses. DPH is currently in the process of integrating standard, national survey questions into the online renewal process for nurses. While DPH can incorporate workforce survey questions into the online renewal process, DPH has no “data warehouse” to store expanded e-licensing data, and no capacity to mine it or analyze it. Thus, the data will be analyzed and stored by the National Council for State Boards of Nursing (NCSBN). NCSBN will provide DPH with access to data that will allow Connecticut to benchmark and compare its data to that of other states.

DPH intends to engage the other professional associations approved for e-licensing, at both state and federal levels, to develop and integrate national survey questions similar to the nurses. The administration will work to hasten the approval of online renewal as an option to other professions licensed by DPH to aid in an easy and streamlined healthcare workforce data collection. Understanding that a balance must be struck between the quality and quantity of the information requested and the burden of providing this data, the administration and its agencies will collaborate broadly with pertinent boards and commissions and the state’s institutions of higher education to:

- Develop the infrastructure necessary to sustain an internet-based healthcare workforce data portal to provide efficient and effective access to key information—employment and wage data, labor market information including real time job postings, licensure and certification data, educational institutional capacity and limitations, as well as socio-economic trends, demographics, performance-related information and research studies—to inform strategy, planning, policy development, implementation and evaluation; and
- Use the data collected through the portal to continuously inform a strategic plan to ensure that the health workforce matches employer needs and that the appropriate number and variety of programs exist to train the needed professionals.

DPH's Primary Care Office (PCO) recently developed a Statewide Retention Plan that provides an overview of the National Health Service Corps (NHSC) importance in Connecticut's Health Professional Shortage Areas (HPSA's). The developed retention plan contains summaries of data results and series of proposed actions that fall under these three categories:

- Increase the retention of NHSC providers who remain in a Connecticut HPSA upon completion of their site commitment;
- Improve workplace morale for NHSC providers; and
- Enhance the perception that NHSC sites are professionally rewarding and are employers of choice.

Finally, the U.S. Department of Health and Human Services has identified a number of key health disparities measures of which three are related to workforce. Workforce diversity is a key element of culturally competent and patient centered care. Recruitment and training for clinical programs should include a focus on students and practitioners from minority and underserved populations. A mechanism for on-going measurement and reporting of these measures as they relate to Connecticut's workforce is vital to workforce recruiting and training:

1. Percentage of clinicians receiving National Health Service Corps scholarships and loan repayment services (by race, ethnicity);
2. Percentage of degrees awarded in the health professionals, allied and associated health professionals fields (by race, ethnicity); and
3. Percentage of practicing physicians, nurses, and dentists (by race, ethnicity).

UConn will take the lead in developing the necessary data analytic capacity and connectivity, working closely with the Department of Public Health, the Department of Labor, the Department of Education, the Office of Higher Education and the Board of Regents as well as with payers and providers. UConn's interest in leading the analysis of workforce data follows from the University's efforts to tie together shared project analysts from across its schools and campuses who work with data pertinent to health policy—creating, in effect, a virtual health policy institute. Each school brings its particular subject and clinical expertise to the task. For example, UConn's new Health Disparities Institute (HDI) is set up to provide data analytics to identify health disparities across the continuum of care (inpatient, outpatient, medical, mental health, dental, pharmaceutical) for specific health conditions and specific populations. HDI can analyze the data that is derived from the three health disparities measures listed above, and assess the policy implications. With the security and confidentiality of

workforce data assured, it will be made available for analyses by third parties, and thus will impact a broad range of workforce planning activities.

UConn has already begun collecting data on student education and training and eventual workforce participation. The University of Connecticut Health Center's Center for Public Health and Health Policy (CPHHP) has recently collaborated with several state agencies to create a mechanism for linking students' elementary, secondary and post-secondary educational experiences to later workforce participation. The product of this initiative, P20 WIN (Preschool through 20 and Workforce Information Network), links individual-level information maintained by Connecticut's Board of Regents for Higher Education, Department of Education and Department of Labor. In a second phase of the project, the Connecticut Conference of Independent Colleges and the University of Connecticut will contribute data to the network, resulting in a robust data set that will track student educational experiences and achievement over time and that will link this data to employment outcomes. Funding for the development of the technical infrastructure for the P20 WIN network has been provided to Connecticut by the National Center for Educational Statistics. This network currently has access to over 70 million educational and wage records from Connecticut residents from 2004 to the present. In addition to CPHHP, there are a number of other schools and divisions of UConn—e.g. the Schools of Nursing, Pharmacy, Dental Medicine, Social Work, Business and the College of Agriculture and Natural Resources—that can provide the analytic support for the State's efforts to use these data as well as other data sources (e.g. DPH licensing information) to monitor workforce development in the health and allied health professions.

UConn will make its analyses straightforward and accessible to policy makers and stakeholders. CPHHP already has experience doing this. Its faculty and staff have worked extensively with the state's Hospital Inpatient Discharge Database, which contains medical claims data on all hospital admissions from all 30 acute care hospitals in the state. In addition, faculty from UConn's Department of Statistics have extensive experience and expertise in the sophisticated longitudinal modeling and data mining that are needed to track individuals' progress through secondary and postsecondary education, and into the workforce.

Finally, for anything approaching useful real-time health workforce data, the gathering and storage of this data and access to it require protocols, training and infrastructure comparable to what are required for data on other topics pertinent to health resources, services, processes and outcomes. Our strategy for workforce data must thus be developed as part of Connecticut's broader designs for health informatics and

HIT, and must draw in large measure on the broader resources available for these efforts.

How better data and analyses will drive health workforce development

- Health workforce data will be analyzed, packaged and disseminated to impact the career choices of students and the programs that train health professionals and allied health professionals, and will thus help drive remedies to problems in supply and in training.
- Whether the numbers of a profession are more or less than what the market requires will be known as will a far better estimation of future demand. Career advisors both in secondary and post-secondary education will be better able to advise students on career choices that will increase their opportunities for employment and higher income.
- These numbers will also influence schools in the offerings they develop and also in the number of slots they plan to fill both near term and long term. When the data shows a misalignment of skills, programs that train these practitioners will know to adjust their curricula and pedagogies accordingly.
- Connecticut has long considered implementing loan forgiveness programs to encourage students to choose occupations for which there is a critical need. Credible, current and detailed workforce data will not only enable the state and schools to target loan forgiveness programs, it will also enable the state, schools, businesses and foundations to target scholarship programs.
- Finally, better data will enhance the ability of the five initiatives described below to foster the primary care workforce that Connecticut's health reforms and market will require.

Inter-professional education (IPE)

Advanced Medical Homes are the foundation of care delivery under SIM. Inter-professional teams are integral to their success, as is expertise in population health. Historically, students of different clinical disciplines have rarely trained together beyond attending basic science courses together, and population health has not been central to clinical curricula. In our view, the key to preparation for inter-professional team primary care is to train future caregivers together particularly in subjects that pertain to population health and patient centered care, and to have a significant portion of this training tied to the direct care of consumers in clinical settings outside of institutions.

Joint Clinical Training

All three of Connecticut's medical schools—Yale, Quinnipiac University's Netter School and the University of Connecticut Health Center (UCHC)—have or are contemplating IPE programs. At both Yale and Netter, medical, nursing and physician assistant students do a portion of their clinical training together.

UConn's School of Medicine (SOM) and School of Dental Medicine (SODM) have long shared classes in the core biomedical sciences during the first two years of training. The schools are now working toward adding inter-professional clinical training for UConn's medical and dental students during the final two years with the ultimate goal of including students from UConn's Schools of Nursing, Social Work and Pharmacy.

In developing its strategies, Connecticut will look to the Inter-professional Education Collaboration (IPEC), which was founded in 2009 when six national professional associations joined together to promote inter-professional education. These associations included allopathic and osteopathic medicine, dentistry, nursing, pharmacy and public health. Since 2009, IPEC has sponsored symposia and training workshops to enhance inter-professional education, particularly the integration of clinical experiences for students to develop skills needed for multidisciplinary healthcare teams. The organization also has developed curricula and guidelines for IPE that can guide the development of IPE in Connecticut. IPE Centers have developed nationally and can be found at University of California San Francisco, Jefferson University, Creighton University and the University of Kansas.

A Connecticut Service Track

Connecticut will build upon its most effective program for community-based inter-professional training, UConn's Urban Service Track (UST), to establish a Connecticut Service Track (CST) that will cover more of Connecticut's communities, and will include more health professions and more of Connecticut's training programs.

Six professions' schools are currently participating in UST: Quinnipiac's school for Physicians' Assistants, and UConn's Schools of Dental Medicine, Medicine, Social Work, Pharmacy and Nursing. In its approach to serving disadvantaged populations in urban settings, UST stresses team-based care, cultural and linguistic appropriateness, and population health.

In establishing a Connecticut Service Track (CST), the state will increase UST's scope, the number of participating schools and the number of students such that:

- The focus of the program will be extended beyond urban communities to include Connecticut's more rural counties—effectively covering all of Connecticut;

- Other Connecticut health professions schools, including allied health professions schools and additional community providers will participate, increasing the number of occupations and community service locations;
- Residency training, having already been piloted within UST, will be included; and
- Some offerings will be tailored for and offered to both health professions students and the current clinical workforce.

Connecticut’s Area Health Education Center Program (AHEC), which administers UST with the six participating schools, will also administer the CST together with more participating schools. The goal of UST has been to build a pipeline of well-qualified healthcare professionals equipped to work in inter-professional teams and committed to caring for Connecticut’s urban underserved populations. However, skills and issues relevant to caring for urban poor overlap with those necessary for optimal care of rural populations. Many skill sets and curricula can be used in either setting. UST faculty is reviewing UST’s curriculum to identify content and skill sets for students interested in rural practice. Connecticut’s more rural counties combined with our more urban ones essentially constitute our whole state. AHEC with its statewide reach through its program office at the University of Connecticut Health Center and its regional centers in Hartford, Waterbury, Willimantic and Trumbull is well equipped both to implement this expanded program.

Description of the Urban Service Track

All Urban Health Scholars participate in a two-year curriculum that complements the existing curricula in the six schools and focuses on 11 competency areas. Faculty presenters include university and community health center clinicians, patients and other community partners. UST explores the 11 competencies in terms of the perspectives and needs of a number of vulnerable populations: children/youth, the elderly, individuals with HIV/AIDS, incarcerated and ex-offender populations, immigrants/refugees, veterans and people who abuse substances. Students participate in problem-based learning activities that include clinical skills and case studies.

The 11 competencies are:

1. Resource constraints;
2. Cultural and linguistic appreciation;
3. Population health and public health;
4. Healthy policy;

5. Advocacy;
6. Healthcare financing and management;
7. Inter-professional teamwork and leadership;
8. Community resources;
9. Professional and ethical conduct;
10. Quality improvement; and
11. Patient safety.

In addition, attention is paid to the skills needed for inter-professional teamwork. There are formal quarterly learning retreats, community outreach activities, community based research, advocacy and leadership training, as well as other professional development opportunities. Critical to the success of UST is the opportunity for trainees to apply knowledge and skills gained in real world settings. This is done through a variety of community outreach activities that focus on health promotion, education, health risk screenings and health careers awareness for individuals from underrepresented backgrounds.

Mentors drawn from both the participating schools and the community instruct students in leadership, effective management of a team, working with team members with different skills and training, effective utilization of community partners and preceptors, and grant writing.

UST has been effective at persuading students to go into primary care. In 2013, students who have graduated from UST were surveyed to determine whether the program positively impacted their desire to work in primary care and with medically underserved communities. 59.6 percent reported that it had contributed to their choice of primary care, and 56.9 percent reported that it contributed to their desire to work in medically underserved communities.

Training and certification standards for Community Health Workers

Connecticut's Area Health Education Centers (AHEC) network will work together with Connecticut's Department of Public Health (DPH) to develop training and a certification process for Community Health Workers (CHW). Over the past decade, CT AHEC developed substantial expertise in developing and operating several small-scale programs and collaborating with other states in the development of their programs. This new program will cover:

1. Nationally established core CHW competencies, and
2. The skills necessary for CHWs to work effectively as members of multi-professional primary care teams.

Our aim is not just to train community health workers in the essentials but also to train them to work as members of multi-professional primary care teams, which are the foundation of healthcare delivery as set forth in this plan. CHWs' value to these teams is their capacity to address the pervasive, persistent and expensive problem of health disparities in our state.

CHWs generally come from the communities they serve, and therefore, are more likely to understand the cultures, languages and idioms of these communities and the challenges their members face. This experience enables a CHW to be a bridge and an interpreter for a patient and her care team. CHWs can inspire familiarity and trust, and can be as instructive and supportive to caregivers as they are to consumers.

CHWs will primarily work with Connecticut's economically disadvantaged residents, particularly in communities of color, who are in poorer health and have poorer health outcomes. In large measure, these disparities are driven by the greater difficulties economically or culturally disadvantaged people have in navigating healthcare delivery and making optimal use of available services. But these disparities are also driven by disproportionate challenges in daily living, more frequent breakdowns in communication with their clinicians, and unaddressed risks for developing ill health that are more prevalent in some populations.

In addition, consumers who do not understand the healthcare system and in turn are not understood by it are more likely to use health services inefficiently, making providing services to them more expensive. A reliance on emergency departments for primary care exemplifies this problem, but it runs deeper. There are substantial savings to be had in assisting people who need a friendly and knowledgeable hand to help them use healthcare properly and to follow through with their courses of treatment.

Connecticut has community health workers now, although not nearly enough of them. Our intent is to provide our current CHWs with additional skills and to train enough new CHWs to meet the needs of consumers and the requirements of the models of care that are being developed in Connecticut now and that will be further developed under this plan. Improved data and data analyses on market demand will help in establishing this number.

We understand that CHWs frequently specialize. Examples are assisting diabetics to access treatment and follow therapeutic regimens, helping smokers to quit smoking,

and serving as Community Dental Health Coordinators who work within dental practices to coordinate dental care, reduce dental anxiety, arrange transportation, and even help patients to enroll in Medicaid. More often than not, Connecticut's current CHWs assumed specific tasks and missions with little structured instruction in fundamental skills and insights for how to be most effective as CHWs. AHEC will provide this instruction.

AHEC's and DPH's approach will be inclusive. In developing a training program, they will work with all interested parties, including community-based organizations.

Connecticut AHEC and DPH will consult Connecticut's advanced primary care practices to gain their perspectives on how best to train CHWs to work effectively with their care teams. In turn, Connecticut AHEC will offer sessions to the clinicians and other members of primary care teams on the role of CHWs as primary care extenders. AHEC will also include CHWs in the inter-professional educational (IPE) curricula developed for Connecticut's health professions schools.

AHEC and DPH will work together with UConn's School of Nursing and UConn's School of Social Work to identify how CHWs can best assist nurse care coordinators and social workers in assuring that patients make optimal use of resources for staying healthy and getting the services they need.

Connecticut AHEC will provide CHW training at its four regional centers, and will also work closely with the state's Community Colleges and the State University System to develop certificate and degree programs for more advanced and specialized training. Discussions with the Community Colleges are already underway. AHEC is also working with the CT-RI Public Health Training Center at the Yale School of Epidemiology and Public Health, as well as with public health programs at the University of Connecticut Health Center and Southern Connecticut State University. All have shown interest in contributing to the building of a capable CHW workforce. The inclusion of our institutions of higher education is important for ensuring that there is a career ladder for CHWs by ensuring that they can earn credits not only for more specialized CHW responsibilities, but also credits that can be applied to certifications in the allied health professions and ultimately to degrees in the health professions.

Description of CHW Training

Insights drawn from Mass AHEC's experience, and discussions with primary care practices, nursing, social work and other parties with purchase on the role of CHWs will be incorporated into a curriculum that is culturally relevant, evidence-based and interactive.

The National Community Health Worker Advisory Study (1998) defines the core competencies for CHWs as:

1. Understanding the healthcare system;
2. Knowledge of resources and constraints;
3. Health promotion and disease prevention;
4. Effective communication, documentation and outreach skills;
5. Advocacy and cultural sensitivity;
6. Understanding community health education;
7. Capacity building;
8. Informal counseling/social support;
9. Legal and ethical responsibilities;
10. Special topics – e.g. oral health, violence, infectious disease;
11. Providing services to individuals with HIV/AIDs and other chronic conditions

In addition, there will be instruction in the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Healthcare, which were developed to advance health equity and to improve quality. By working with primary care teams, well trained CHWs will facilitate better health and better health outcomes for the people and communities they serve, and in so doing, CHWs will help end health disparities in Connecticut.

Preparing today's workforce for care delivery reform

It will be many years before clinicians being trained today predominate in Connecticut's health workforce. Meanwhile, the success of healthcare reform depends on our existing health workforce, which was trained under different circumstances and for a care delivery system that we hope to transcend. Our current health professionals and allied health professionals need varying degrees of retraining if they are to work effectively within new models of care and if these models are to succeed.

One lever is the requirement of health professionals and allied health professions to earn Continuing Education Units (CEUs) as a condition for maintaining their licenses to practice. The courses that confer CEUs should emphasize the knowledge and skills required to meet AMH care delivery standards.

The state will sponsor a survey of courses in Connecticut that grant CEUs to determine how often and how well they deal with these topics, and will work with our institutions of higher education to improve these offerings. This will be voluntary cooperation. There is no immediate need to change the requirements for CEUs, and there is considerable willingness on the part of our institutions of higher education to support the reform of care delivery.

Independent practice associations (IPAs), clinically integrated networks and accountable care organizations (ACOs) generally have resources for in-service training. We will survey the content and quality of their offerings and work with these providers to improve them.

We will assist smaller group and independent primary care practices that do not have their own resources to provide this training either through enlisting the assistance of providers with established programs or through independent programs. One important resource will be the Connecticut Center for Primary Care Innovation (CIPCI), which opened in 2012 and is legislatively chartered and affiliated with the UHC and St. Francis Hospital. CIPCI's mission is closely aligned with SIM and the enhancement of the skills of our existing primary care clinicians. Another resource is the Connecticut Center for Primary Care (CCPC), which is affiliated with ProHealth Physicians and also with the Primary Care Coalition of Connecticut.

Developing innovative post graduate clinical education and residency programs in primary care

If the healthcare reforms envisioned in this plan are to succeed, there must soon be an increase in the number of primary care clinicians in Connecticut: physicians, physician assistants, nurse practitioners and clinical pharmacists. Establishing primary care as the foundation of healthcare requires it, as do an increasing numbers of insured lives and an aging population. Since it is residencies that determine the discipline and the certification of a clinician and also often determine where clinicians settle to practice, Connecticut must work to enhance its primary care residency programs for all the healthcare professions.

This being said, training primary care physicians must be a priority for three reasons. First, far and away, the greatest unmet demand in our state for health professionals is for primary care physicians. Second, although NPs and PAs also specialize, in recent times, the draw of specialty care has been stronger for physicians. Third, even taking into account a far greater use of physician extenders and team approaches to care, ultimately there is no substitute for having a critical number of primary care physicians. The astounding breadth of today's medical toolkit requires it. It is primary care

physicians who must be the ultimate care coordinators when the problems are many and not routine and the possible approaches are hard to sort through or even to recognize.

Nationally, there is a substantial shortage of medical residencies. Last year, 1,761 graduating MDs could not secure a position. Increasing the number of primary care medical residency positions, particularly if they are in innovative and well-designed residency programs, is a direct means of increasing the number of PCPs in Connecticut.

Much of what is developed for physician residency programs can and should be extended to programs for nurse practitioners, physician assistants, pharmacists and allied health professionals in training. Indeed, what is developed in these programs should inform physician residencies. Also, as described above, the health professions and allied health professions should have more joint training.

What might innovative post-graduate healthcare residencies entail? There must be far greater involvement of the state's key provider organizations that are participating in care delivery and payment reforms to serve as sites for primary care training. More of healthcare is moving out of hospitals and other institutions to community settings. Primary care clinicians must be trained in the venue in which they will work.

This being said, the immediate issue is not a want of willingness by primary care group practices to participate in our state's primary care residency programs. We have a train-the-trainer problem. Many of our best prospects for faculty mentors in all the health professions, although first-rate clinicians were trained in another time and have been engaged in a paradigm of care delivery that we are in the process of transcending. We must construct a multidisciplinary faculty development program that enables our community-based faculty to become effective teachers and role models for the system of care described in our Innovation Plan. These mentors must be trained in a manner consistent with the AMH model.

UHC's Office Based Medicine Curriculum: For its Internal Medicine training program, our state medical school offers an office-based medicine curriculum as a counterpart to the school's hospital-based curriculum. UHC plans to offer an office-based curriculum track for its Pediatrics, Family Medicine and OB-GYN programs. This expansion will increase residency training in our communities, which should help persuade more of our graduating residents to practice there. The office-based track:

- Enhances skills in ambulatory training by providing residents more structured opportunities in sub-specialty clinics that complement the primary care provided by AMHs;

- Provides instruction in the business of medicine. Residents are taught coding, billing and office management; and
- Exposes residents to various practice styles and environments for community-based primary care, particularly in community health centers that have coordinated inter-professional care teams with proficiencies in psychiatry, dental medicine, primary care medicine, nutrition and pharmacy.

UHC is recruiting students within its undergraduate medical program to work with its Graduate Medical Education programs in family medicine, pediatrics and internal medicine. The intent is to bring together interested students with residents and attending physicians who can serve as mentors and role models. It is important to identify students during the admissions process and early in medical school who have some interest in primary care as a means of increasing the number of graduates choosing primary care. UHC's goal is to increase this number by at least 30%. This initiative is also meant to encourage our students to continue training in Connecticut's residency training programs, the idea again being that physicians are more prone to practice where they have done their residencies. UHC will also expose its medical students interested in primary care to innovative models of healthcare delivery and public health advocacy, and work with these students on leadership skills. They will be encouraged to get their Masters of Public Health. Students who enter our residency programs and commit to primary care in Connecticut may be offered loan forgiveness of deferments.

UHC is working toward developing streamlined and combined residencies that train physicians in primary care together with one of the specialties associated with primary care—geriatrics, adolescent medicine, women's health, behavioral health and correctional health—in less time than it would take to pursue primary care and the related specialty sequentially. Combining residencies has the dual purpose of drawing medical graduates into primary care and also training physicians in related specialties whose practitioners are also in short supply. Shaving a year off this combined training is an inducement, and will also get these residents into active practice sooner. To do this, we must persuade the pertinent national board specialty organizations and national board certification processes of the value of our approach.

Connecticut's three medical schools—the University of Connecticut Health Center, Yale and Quinnipiac's Netter School—are all attuned to the shifting conditions of practice that future physicians will face and to the emergent importance of primary care. All three are working on reconstituting primary care education in ways commensurate with this plan. Connecticut's primary care practices are becoming certified Patient Centered Medical Homes and affiliating with each other and also with integrated

systems of care. The potential is great for developing innovative primary care medical residencies within networks of primary care practices and thereby increasing the number of primary care medical residents; and in keeping with our aforementioned interests in inter-professional training (IPE), not only our schools of nursing physician assistant programs but also our schools of pharmacy and social work will be encouraged to coordinate their residencies with these medical residencies.

Health professional and allied health professional training career pathways

Connecticut will build upon two ongoing initiatives to increase students' ability to accrue the credits and the capabilities needed to advance in the health and allied health professions, and also to increase the flexibility to change programs midstream or otherwise move from one health career to another. Both initiatives were launched in 2012.

The first is Governor Malloy's Science, Technology, Engineering and Mathematics (STEM) initiative. Connecticut's baccalaureate programs in both public and private colleges and universities are being encouraged to ensure that their STEM courses of study provide a sound foundation for both careers and technological advances that will strengthen Connecticut's economy.

The second initiative is the implementation of the Connecticut Board of Regents for Higher Education's comprehensive transfer and articulation agreement that enables students to transfer more easily across the 17 Connecticut State Colleges & Universities. This articulation policy applies to all subjects and all majors, and emphasizes seamlessness between associate degree programs and baccalaureate programs.

This agreement calls for:

- A common general education core;
- Common lower division pre-major pathways;
- A focus on credit applicability to degree;
- Junior status upon transfer;
- Guaranteed or priority university admission; and
- Associate and bachelor degree credit limits.

In line with Governor Malloy's STEM initiative, the State of Connecticut will work with its public and private colleges and universities to:

- Ensure that their STEM courses of study related to public health and health services provide the knowledge and skills needed for every graduate of these studies to succeed in any of the state’s health professions schools and programs; and
- Increase the representation in Connecticut of minorities in training for both the health professions and the allied health professions, but particularly for the health professions.

Connecticut will further develop articulation agreements among its schools that train health professionals and allied health professionals to:

- Establish, in so far as it is feasible, comparable requirements for credit courses so that the schools can accept each other’s credits;
- Articulate pathways from entry-level training through to advanced degrees and certifications, ensuring that at each step of the career ladder that articulation agreements exist between institutions to ensure a seamless transition for students; and
- Provide opportunities for students to get credit for past experience.

Our Department of Public Health will work together with our schools and providers toward a better alignment of licensing requirements with new industry demands and accreditation requirements. This is a tremendous undertaking that must come in stages because the resources and effort required can be committed only over time. But it is important to make a start.

Developing solid STEM core curricula and well-designed articulation agreements for the health and allied health professions serves at least three purposes:

1. Having programs constructed of courses with common content and requirements will make it easier to change programs or go to back to school for a career change when market demands change. This will help the workforce to keep pace with the delivery system’s changing requirements.
2. In working through articulation agreements, schools will become more aware of what each other is doing, and if that this knowledge is tied to approximate real-time data on workforce demand and analyses of the trends in this demand, the schools will be better able to calibrate their programs to Connecticut’s needs.
3. Lining up the standards among the programs so that credits achieved in entry level programs can be applied to meeting the requirements of higher level programs will help students plan career ladders by enabling them to see where

they might go from the more entry level jobs. Such alignment will also help students to climb these ladders. Among other things, this will help provide an avenue by which students from disadvantaged communities can progress from lower skilled jobs to higher skilled ones, including professional careers. This will help to redress the under representation of these communities in the health professions. Having students with practical work experience matriculating into professional programs should also further advantage these programs.

It is also critical to develop a health workforce whose professionals and allied health professionals are more representative of Connecticut's population. We must do a better job of interesting minority students in STEM while they are still in grade school, identifying and encouraging those who are interested, and preparing them for college level STEM courses. All of Connecticut's universities currently have initiatives with our public schools that are dedicated to these purposes. The state will work with our universities to expand these initiatives and to develop others.



MANAGING THE TRANSFORMATION

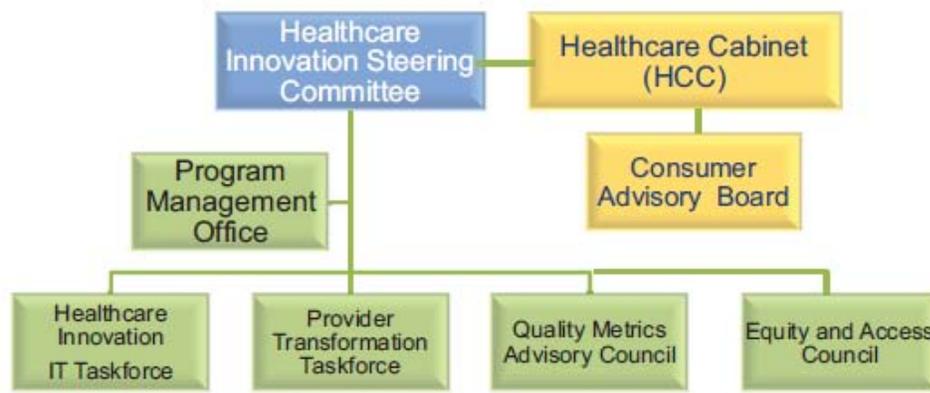
Governance structure

In order to sustain the momentum generated during the SIM Design Phase, provide oversight and staff support detailed design and implementation, we will establish the following structures:

- **Healthcare Innovation Steering Committee:** a group similar to the existing Steering Committee with additional consumer advocate and provider representation, will guide Connecticut's SIM initiative. It will be responsible for: overall strategic guidance; reviews of SIM's impact; and coordination with other public and private initiatives.
- **Program Management Office:** a state office composed of approximately five full time state employees, who will manage vendors, oversee evaluation efforts, communicate SIM progress to the public and state government, engage with stakeholders, and provide staff support to SIM.
- **Provider Transformation Taskforce:** a group that will be comprised of consumer advocates, physicians, behavioral health providers, hospital executives, payer medical director, and a self-insured employer representative, all with direct experience with provider transformation. The taskforce will: set medical home standards; advise on vendor selection for transformation support and practice certification; and coordinate with practice transformation standards and support to align with other care delivery models in the state (e.g., DMHAS behavioral health homes).
- **Quality Advisory Council** will ensure the AMH model provides appropriate levels of quality healthcare and consumer experience. It will be comprised of consumers/consumer advocates, physicians, behavioral health providers, hospital medical directors, payer medical directors, statisticians from private payers, and an epidemiologist from DPH, all of whom have technical expertise and experience with measurement of health, quality, and consumer experience. Specially, the council will: develop a common provider scorecard with metrics and targets; and update the scorecard annually based on provider, payer, and consumer input.
- **Healthcare Innovation HIT Taskforce** will be comprised of a group similar to the one currently advising the SIM HIT process. Participation criteria include formal authority or the ability to influence public or private HIT systems and technical HIT expertise. The taskforce will: set HIT priorities and develop payer and provider education materials; define standards for system interoperability and consistent formats for reports and portals; and coordinate with HIE, HIX, other HIT-intensive initiatives.

- **Equity and Access Council** will be comprised of consumer advocates, public health experts, academics, and clinicians with a commitment to ensuring long-term, systemic provision of appropriate care and access, especially to typically underserved communities. They will recommend retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care; recommend a response to demonstrated patient selection and under-service; and define Connecticut’s plan to ensure the AMH model systematically includes at risk populations.

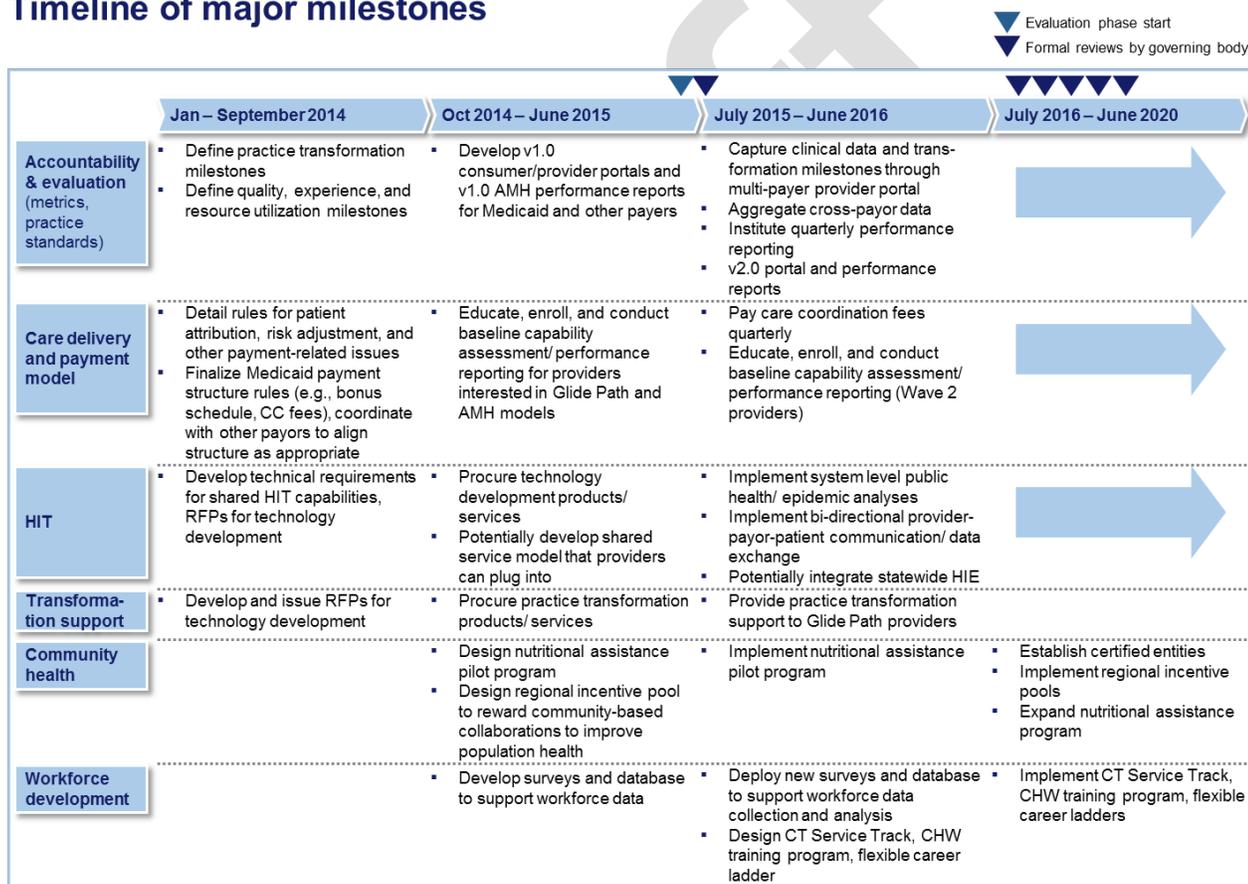
In addition to the above executive branch governance structure, the Healthcare Innovation Steering Committee will consult with the Health Care Cabinet throughout the pre-implementation and implementation phases of the Innovation Plan. In addition, the SIM Project Management Office will establish an ongoing relationship with the Consumer Advisory Board of the Health Care Cabinet to ensure that meaningful consumer input and advice is solicited ongoing through the life of the project.



Transformation roadmap

Our Innovation Plan will be implemented over a five-year period, contingent on financing, changes in public policy, and contractual changes between private payers and providers. Key milestones are outlined below, divided into four phases as illustrated in the Exhibit 5 below and described in detail following. The state will track whether implementation is or is not on schedule for each milestone.

Timeline of major milestones



1. Detailed Design (January to September, 2014). Pending stakeholder feedback and refinement of the Innovation Plan, new governance structures will be established and our program management office will be formed including a combination of internal and contracted support as necessary to develop the more detailed technical design necessary to support our new models. Major activities include:

- Establishment of governance structure including project management office, task forces and councils
- Definition of primary care practice transformation milestones; measures of quality, consumer experience, and resource utilization; methods for identifying and responding to evidence of inappropriate patient selection and under-service
- Detailed rules for patient attribution, costs included in “total cost of care”, risk-adjustment, clinical exclusions, and cost outlier provisions
- Finalization of care coordination fees, P4P bonus schedules, and risk corridors for shared savings for Medicaid; coordination with other payers to align payment structures, as appropriate, while preserving independence in pricing decisions
- Development of technical requirements for shared HIT capabilities, and development of requests for proposal (RFPs) to support procurement of technology development, practice transformation support, and evaluation support
- Design a suggested menu of VBID options that can be offered on an insured or self-insured basis, identify needed infrastructure and support
- Finalize evaluation design, pace and performance dashboards and metrics, and data sources. Implement collection of pace and performance data by July 1, 2014

2. Implementation Planning (October 2014 to June 2015). Pending award of CMMI State Innovation Models Testing Grant and securing other funding, we will initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes. Key activities during this implementation planning period include:

- Procurement of technology development, practice transformation, evaluation support and other externally sourced products and services necessary to support launch
- Development of v1.0 consumer/provider portals and v1.0 AMH performance reports for Medicaid and other payers electing to leverage common reporting
- Education, enrollment, baseline capability assessment, and baseline performance reporting for providers interested in participating in Glide Path and AMH models
- Design of nutritional assistance pilot program as part of Community Health Improvement strategy
- Design of regional incentive pool to reward community-based collaborations to improve population health

3. Implementation Wave 1 (July 2015 to June 2016). State Fiscal Year 2016 will mark the first year of operations of our multi-payer model for AMH as well as initiation of our new capabilities to support Workforce Development. Key activities will include:

- Practice transformation support to Glide Path providers
- Capture of clinical data and transformation milestones through the multi-payer provider portal
- Data aggregation across payers
- Quarterly performance reporting to providers based on the AMH Common Scorecard
- Quarterly payments of care coordination fees
- Development of v2.0 portal and performance reports
- Education, enrollment, baseline capability assessment, and baseline performance reporting for Wave 2 participating providers for Glide Path and AMH models
- Implementation of nutritional assistance pilot program
- Deployment of new surveys and database to support workforce data collection and analysis
- Design of Connecticut Service Track
- Design of Community Health Worker training program
- Design of flexible career ladder

4. Implementation Wave 2+ (July 2016 to June 2020). In State Fiscal Year 2017 and beyond, continuous improvements will be made to the Common Scorecard, consumer/provider portal, data aggregation, analytic, and reporting capabilities. In addition, primary care providers will continue to be enrolled in the Glide Path and AMH model, including transition of providers from P4P to SSP over time as they achieve minimum necessary scale and capabilities. This period will also mark the major expansion of our Community Health Improvement strategy as well as expansion of our Workforce strategy, including:

- Establishment of Certified Entities
- Implementation of regional incentive pools to reward community-based collaborations to improve population health
- Expansion of nutritional assistance program
- Implementation of Connecticut Service Track

- Implementation of Community Health Worker training program
- Implementation of support for flexible career ladders

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Use of executive, regulatory, legislative authorities

Connecticut will use its executive, regulatory and legislative authorities to enact lasting structural transformation in several arenas.

- 1. Establish and monitor practice standards:** Connecticut will define practice standards for provider entry to and participation in its SIM model. It will create an entity that will:
 - Select practice standards and metrics and refine these over time
 - Set targets for practice standards and metrics
 - Accredite providers based on practice standards
 - Aggregate data at the statewide level and perform audits as needed
 - Publish results to increase transparency on performance relative to targets
- 2. Integrate primary care and population health:** Connecticut is considering certifying Community-based Practice Support Entities (Certified Entities). This will standardize services offered by community organizations and make quality services more transparent and accessible to primary care practices. Because this is a new function, the state may need to expand the mandate of current state organizations (e.g., DPH) or establish a new entity.
- 3. Address privacy concerns to expand APCD's usefulness:** An All Payer Claims Database (APCD) is being developed at the state level. Cross-payer claims data could generate detailed, actionable analytics on individual consumers, which could then meet payer data collection requirements for the HIE. In an example, the state of Arkansas' State Innovation Plan has proposed an APCD that will profile provider patient panels, create patient registries, measure quality, and better position the state to meet any payer data collection requirements for their HIE. However, Connecticut's current policy governing APCD prohibits its use for these purposes due to privacy concerns. The state will consider changing this policy so that the APCD can provide detailed analytics at the individual level.
- 4. Enable Medicaid and state employee participation in the new model:** Medicaid will adopt the proposed reforms, which leverage current initiatives in Connecticut. Connecticut will also consider what other changes may be required to assist

Medicaid and state employees as they participate in the new model (e.g., payment changes for Medicaid or union discussions for state employees).

- 5. Promote provider collaboration and a multi-payer strategy that do not violate anti-trust regulations:** Several states taking part in the SIM effort have adopted policies that afford varying degrees of protection for public and private payers. They have usually employed either legislation or executive orders. Connecticut may consider similar measures.
- 6. Ensure that EMR systems work together:** The fluid exchange of clinical data across care settings will be a critical component of the new care delivery and payment model. Many of Connecticut's providers are already transitioning to electronic medical records, encouraged by the efforts of eHealth Connecticut, HITE-CT, and the HIT Coordinator. By requiring EMRs to meet certain technical standards that will help ensure their ability to work together, the state can improve cross-EMR performance while preserving providers' flexibility in selecting their systems. This approach will continue to promote EMR adoption while limiting the proliferation of incompatible systems.

Evaluation plans

Connecticut will closely monitor and evaluate its SIM along two dimensions: pace/participation and performance/outcomes. In this section, we discuss our goals and methods for measuring these dimensions.

PACE/PARTICIPATION GOALS FOR SIM

We will create a “Pace Dashboard” that tracks milestones and metrics for each component of our delivery system reform. Over the next six months, the Program Management Office will define specific milestones and metrics (including timelines and targets) to ensure we are on track for to launch our evaluation by July 1, 2014. Metrics will include, for example:

- Primary drivers:
 - Primary care practice transformation: Number and percent of providers able to meet each practice transformation standard; number and percent of providers who are participating in the glide path, number and percent of providers who are AMH certified
 - Community Health Improvement: Number and percent of population residing in a Health Enhancement Community; number and percent served by Certified Community-Based Practice Support Entities; number and percent of practices assisted by a certified community entity; percent of population in need assisted by Diabetes Prevention Program, Asthma Indoor Risk Strategies, or Falls Prevention Program
 - Consumer empowerment: Number of consumers and percent of population participating in VBID; number of consumers and percent of population with access to consumer portal (limited scope/full scope); number of consumers and percent of population attributed to an AMH provider; Number of consumers and percent of population attributed to a provider who is accountable for the consumer’s service quality, care experience, and cost
- Enabling initiatives
 - Performance transparency: Number and percent of AMH providers participating on common metrics scorecard; implementation of APCD; implementation of hospital quality and cost score card; implementation of specialist quality and cost score card

- Value-based payment: Number and percent of providers participating in qualified P4P payment arrangements; Number and percent of providers eligible for shared savings or total cost of care payments; number and percent of providers participating in shared savings or total cost of care payments; number of payers including care experience in their value-based payment models
- Health information technology: Number and percent of providers participating in direct messaging; number and percent of providers offering care management tools; percent of patients with access to transparency-related tools; number and percent of consumers with access to a qualified consumer portal
- Workforce development: Percent of providers participating in e-licensing; implementation of workforce data storage and analytics solution; number of trainees that complete the Connecticut Service Track; 3-year retention rate of CST trainees; articulation agreements, etc.

PERFORMANCE GOALS FOR SIM

The AMH care delivery model and enabling initiatives have a set of goals, described below, that closely align with Healthy People 2020 and uses CMMI's core measures as a foundation. By focusing on these goals, we will create better health for all of Connecticut's citizens, help the state achieve top-quartile performance on key quality of care and consumer experience measures and control healthcare spending.

Many of these goals focus on alleviating (and eventually eliminating) Connecticut's health inequities. The AMH model's whole-person, team-based approach and incorporation of national CLAS based standards will address some of the social underpinnings of unequal care (for example, enhancing access will assist underserved populations to gain care through locations/ methods/ times that are more aligned with their needs). As we move forward, the state will also develop targeted interventions to address issues specific to certain ethnic/ racial/ socioeconomic segments (e.g., decreasing racial inequities in infant mortality).

The Quality Advisory Council will advise on the final metrics and targets on the provider scorecard as well as the statewide Performance Dashboard, for final decision by the Steering Committee by mid-year 2014, to ensure we are on track for implementation in Q1 2015.

Connecticut's specific goals will include:

- **Better health** for all the state’s citizens: Maintain or decrease the prevalence of disease, targeting diabetes, asthma, hypertension, obesity and tobacco use
- **Alleviating and eventually eliminating health disparities** for all the state’s citizens: Close the gap between the highest and lowest achieving populations for each target metric impacted by health inequities
- **Top-quintile performance among all states for key measures of quality of care and consumer experience** within the healthcare system
 - Increase the proportion of providers meeting the comprehensive quality scorecard targets at the aggregate level
 - For underserved populations: increase the number of providers that meet NCLAS standards; increase preventative care (e.g. child-well visits, mammograms, colorectal cancer screenings); decrease hospital visits for acute exacerbations of asthma and other chronic conditions
 - Improve statewide consumer experience scores (clinician/group, hospital, and other entity surveys) for each entity over time
 - Potentially creating a “consumer experience index” roll-up metric or including other metrics on experience, pending further input from the Quality Advisory Council
- 1-2 percentage point reduction in the **rate of growth of healthcare spending** per capita, which will average more than a billion dollars per year in savings over the coming 10 years
 - Targeting elimination of waste and inefficiencies representing 6-12 percent of healthcare spending for populations care for under total cost of care shared savings programs
 - Expectation of increasing payer and provider participation in such arrangements over the coming several years, with 5 years required for participating providers to approach targeted impact
 - Beyond 5 years, sustained mitigation of healthcare trend based on increased efficiencies arising from workforce development and improved prevention arising from community health improvement
 - A portion of savings to be shared with providers who contribute to the savings while also meeting goals for quality of care and consumer experience
 - Ensure that savings correlate with reductions in: potentially avoidable complications; hospitalizations for preventable, acute exacerbations of chronic

disease; unnecessary emergency room utilization; and duplicative testing. Also ensure that savings correlate with the substitution of generic prescriptions where appropriate and use of lower-cost providers and/or settings of care of equal or greater quality

These measures will be tracked on a program-wide “Performance Dashboard” that allows the state to check on progress and make adjustments as necessary (an example dashboard is provided below in Exhibit 6). The dashboard will also be provided to CMMI at regular intervals. Provider-specific performance will be tracked and rewarded as part of the provider scorecard – several of those measures roll up into the overall program Performance Dashboard. Outcomes will also be calculated and reported for particular beneficiary group characteristics where possible (e.g., demographic groups, gender, geographic cuts) to ensure progress is occurring across various facets of Connecticut’s population.

Both the Performance and Pace dashboards will be the basis of regularly scheduled “data-driven performance review meetings” attended by the PMO and members of the Steering Committee, to ensure that the program is on track and that modifications can be made on an ongoing basis.

Exhibit 6: Example Model Performance Dashboard

● Deteriorating ● Maintaining ● Improving

Metrics	Statewide				Equity specific		
	Current Perf. ¹	Benchmark	Absolute target	Trend	Current Perf. ³	Target, %	
Health	▪ Diabetes prevalence	7.3%	75 th	7.3%	●	TBD	0
	▪ Asthma prevalence (adults)	9.2 %	75 th	7.8%	●	TBD	0
	▪ Hypertension prevalence	29.8 %	50 th	<29.8%	●	TBD	0
	▪ Obesity prevalence	23 %	Top 5	Maintain	●	TBD	0
	▪ Tobacco use (current smokers)	13.2 %	Top 5	Maintain	●	TBD	0
Quality	Improved quality						
	▪ Track 1 providers meeting comprehensive quality scorecard targets/index	To be defined over remainder of design phase by metrics taskforce					
	▪ Track 2 providers meeting comprehensive quality scorecard targets/index						
	<i>Illustrative quality scorecard targets/index measures</i>						
	▪ Providers meeting NCLAS standards	TBD	TBD	TBD		TBD	0
	▪ Children well-child visits	90.3 %	Top 5	Maintain	●	TBD	0
▪ Mammogram for women over 40 in last 2 years	81.4 %	Top 5	Maintain	●	TBD	0	
▪ Adults aged 50+ who had colorectal cancer screening	75.7 %	Top 2	Maintain	●	TBD	0	

● Deteriorating ● Maintaining ● Improving

Metrics	Statewide				Equity specific		
	Current Perf. ¹	Benchmark	Absolute target	Trend	Current Perf. ³	Target, %	
Quality (cont'd)	Optimal diabetes care (annual foot exam)	72.7%	75 th	75.3%	●	TBD	0%
	Hospital visits for asthma (per 100,000)	135.5	TBD	TBD	●	TBD	0%
	HTN: controlling high blood pressure (taking medicine)	78.7%	50 th	79.2%			
	Adult weight screening and follow-up	TBD	TBD	TBD			
	Measure Pair: A) Tobacco Use Assessment B) Tobacco Cessation Intervention	TBD	National average	A) 62.7% B) 20.9%			
Improved consumer experience							
Cost	Statewide patient experience survey scores	TBD	TBD	TBD			
	State medical cost trend growth rate (3 year avg.)	5.1	GSP+1	4.8	●		
	Statewide ambulatory care sensitive hospitalizations (per 100,000)	1,244	TBD	TBD			

1 Benchmark years may vary

Note on approach: Current performance compared to three year trend and relative performance to peer states. Benchmark set as Connecticut's target movement relative to peer states over the course of the testing phase, with an absolute target indicated as the current absolute performance of the state at that benchmark level

3 % difference between lowest and highest performing sub-group, goal is 0% difference

METHODS FOR EVALUATING ELEMENTS OF THE AMH MODEL

Connecticut needs to be able to collect, track, and evaluate performance data at all levels if it is going to execute and continuously improve the AMH model in order to achieve our aims. By creating an entity that manages this effort, the state not only gives accountability and transparency the priority they deserve but builds on the method it already uses with CMMI evaluation contractors.

Data Types

Several data types will be collected to evaluate the areas of transformation. They include, but are not limited to:

- Consumer experience surveys: These surveys collect data on the quality of providers' interactions with consumers (e.g., respectful, welcoming), consumer engagement education, and decision-making, and the quality of care transitions.

They also examine access to care outside of normal business hours and whether culturally and linguistically sensitive care is provided.

Currently, commercial payers are not collecting or applying care experience measures in their value-based payment models. Connecticut is examining the possibility of a statewide co-sourced vendor survey as an alternative to practice-administered surveys.

- Ongoing input from the Consumer Advisory Board
- Clinical and claims data: This information indicates whether specified clinical processes and desired outcomes have been followed or achieved
- Self-reported data on provider activities and structures, through systematic surveys: This data provides a picture of how available certain structures, capabilities, and processes (e.g., e-consult capability, translation services) are among providers.
- Self-reported data on primary care provider satisfaction through systematic surveys; Continued input from medical & other healthcare societies on the provider experience with the model (e.g., Association for Family Practice, Pediatrics, Nursing), across transformed practices and those that have not yet started the journey
- Payer interviews

Data Sources

Connecticut will leverage existing data sources whenever possible and will coordinate closely with CMMI and other relevant parties when designing approaches to collect data for new metrics. In dealing with new measures, one of the metrics task force's important selection criteria is whether a metric can be tracked easily. Satisfying this condition will help ensure that the new metric offers meaningful feedback and supports continuous improvement. The state will also share successes and challenges with CMMI and other states so they can all develop best practices. Finally, Connecticut will commit to providing access to all state-based stakeholders and data, as well as private entity stakeholders/data as possible, to CMS for broader evaluation purposes, within the constraints of HIPAA and other regulations.

Data Collection and Evaluation Methodology

Connecticut's SIM Project Management Office will manage evaluation and improvement, utilizing in-state entities for portions of this charge as is deemed necessary. The PMO's evaluation responsibilities include, but are not limited to:

- Selecting practice standards and quality metrics and refining these over time
- Accrediting providers by means of a validation survey based on practice standards
- Setting targets for practice standards and quality metrics
- Aggregating data at the statewide level and performing audits as needed
- Publishing results to increase transparency on performance relative to targets

This entity will also evaluate the AMH model's performance and identify opportunities for continuous performance improvement. These analyses may be done in-house, through a state research group and/or with external vendors. If possible, the state will rely on an internal organization or state agency for evaluations to build in-state capacity. This arrangement will last throughout the SIM Testing Phase to provide continuity and develop in-state expertise, and beyond for the state's continued evaluation of its health system transformation.

APPENDIX

Draft

Glossary

ACO – Accountable Care Organization: An accountable care organization is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Attribution – Prospective consumer selection: Allows consumers to select the provider responsible for their care in advance of a defined evaluation period (e.g., 12 months)

Attribution –Attribution: Assigns a provider who will be held accountable for a consumer. The attributed provider is deemed responsible for the consumer's cost and quality of care, regardless of which providers actually deliver the services

Attribution –Prospective auto-assignment: Uses historical claims data to assign a consumer to a providers' consumer roster prior to the start of a defined evaluation period (typically used when a consumer does not select a provider within a specified period of time). If no historical claims data exists, alternative rationales (e.g., provider quality) can be used

Attribution –Retrospective claims-based: Assigns consumers to providers based on historical claims data at the end of a defined evaluation period after the consumer has received care from their accountable provider

Care plan: Documented approach to managing a consumer's condition or disease over time

Choosing Wisely Campaign: Campaign to encourage physicians, consumers and other healthcare stakeholders to think and talk about medical tests and procedures that may be unnecessary and, in some instances, harmful

CID: Connecticut Insurance Department

Clinically integrated network: A clinically integrated network brings together hospital(s), physicians and other dedicated healthcare providers who deliver services focused on quality, performance, efficiency and value to the patient. Network providers develop and sustain clinical initiatives that enhance access to care, clinical quality, cost control and the patient experience by: coordinating the continuum of care across affiliated caregivers, including employed, contracted and partnered community physicians, implementing evidence-based clinical protocols to enhance patient outcomes, establishing a meaningful set of quality measures to review clinical care and improve clinical performance, achieving efficiencies in the delivery of care, and

partnering with payers to develop contracts that drive definable clinical improvement and add value to patients.

Common Scorecard: A series of metrics that all participating payers will support with uniform definitions to reduce complexity for providers and increase the feasibility of pooling statistics across payers for increasing reliability of measures for which one payer may not represent sufficient volume on its own

Connecticut Service Track: Inter-professional training program for team and population-health approaches to health services

Consumer panel: The consumers designated (via an attribution methodology) to be under the care of a particular provider

Diagnosis-Related Group (DRG): A system to classify healthcare services by "groups" using a grouping methodology based on ICD codes

DMHAS: Department of Mental Health and Addiction Services that serves adults who are medically indigent or poor and who have serious and persistent behavioral health concerns (i.e., safety-net populations).

DPH: Department of Public Health

DSS: Department of Social Services

Exclusions: The exclusion of consumers from attribution (e.g., due to their intensity of service use, population type) to ensure that care is not denied to them

Fee for Service (FFS): A discrete payment is assigned to a specified service; currently the predominant reimbursement methodology in the United States

Gini coefficient: A measure of the income inequality within a location that examines how equally wealth is distributed across a population

Health Information Exchange (HIE): A secure, interoperable, standards-based health information infrastructure offered through eHealthConnecticut to enable timely exchange of medical data between providers at the point-of-care

Health insurance exchange: A marketplace through which consumers can conduct research on and purchase health insurance coverage

Integrated delivery systems: Provider networks integrating primary care, specialty care, and acute care along clinical and HIT infrastructure dimensions.

IPA – Independent Practice Association: An independent group of physicians and other health-care providers that are under contract to provide services to members of different HMOs, as well as other insurance plans, usually at a fixed fee per patient.

Learning collaboratives: A series of learning sessions in which providers can discuss experiences and share best practices

Medical home: A team based primary care model that provides comprehensive and continuous care to consumers over time; its goal is to improve health, healthcare and costs

Metrics –Care experience: Consumer and their caregivers’ experience of care, often measured via surveys

Metrics –Cost and Resource Use: The frequency with which units of defined health system services or resources are used; one can also apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit (i.e., monetize the health service or resource use units)

Metrics –Outcomes: The health state of a consumer (or change in health status) resulting from healthcare –desirable or adverse

Metrics –Processes: A healthcare service provided to, or on behalf of, a consumer. This may include, but is not limited to, measures that address adherence to recommendations for clinical practice based on evidence or consensus

Metrics –Structures: Features of a healthcare organization or clinician that affect their ability to provide healthcare. These may include, but are not limited to, measures that address HIT, provider capacity, systems and other healthcare infrastructure supports

OHA: Office of the Healthcare Advocate

OPM: Office of Policy & Management

OSC: Office of the State Comptroller

Pace dashboard: A report that presents statistics summarizing progress toward the achievement of Innovation Plan implementation objectives and milestones.

Patient portal: Channels/interfaces (e.g., web, apps) that allow consumers/patients to perform activities such as tracking claims and account activity, finding doctors and services, accessing health advice and getting answers to coverage questions

Pay for Performance (P4P): Process that compensates physicians based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)

Performance dashboard: A report that presents statistics summarizing the state's overall progress toward the achievement of health, healthcare outcomes, resource efficiency, and cost objectives.

Per member per month or per member per year (PMPM or PMPY): 1. A measure of the cost of healthcare services incurred per member during the specified period, calculated by dividing the cost of a service for the whole group by the number of members in the group. 2. A payment administered or calculated per member per month, typically given as a performance bonus or form of support.

Population health management: Population health is the delivery of care from one to many individuals within society. It addresses the healthcare issues of a broad set of patients/consumers. Population health strategies can include a variety of models, including governmental public health approaches, community-based entities, multi-sector organizations. They integrate population strategies into clinical care (population-based medicine) and can define populations geographically (e.g., health of a community), clinically (e.g., health of those with specific diseases), or socioeconomically.

Prospective payment: Payment to a provider at a predetermined rate of treatment regardless of the cost of care for a specific consumer or event

Risk adjustment: Method for determining whether consumer characteristics will necessitate higher utilization of medical services

Risk corridors: A financial arrangement that determines how risk/savings will be spread between a payer and a provider

Risk sharing: An agreement to share responsibility for the value of care by agreeing to share both savings below a predetermined threshold and additional costs over a predetermined threshold

Shared savings: An agreement to share responsibility for the value of care by agreeing to share both savings below a predetermined threshold and additional costs over a predetermined threshold

Social determinants of health: The economic and social conditions (e.g., risk factors associated with living and working conditions) that influence a consumer's health status

Triple aim: Originally developed by the Institute for Healthcare Improvement (IHI), the Triple Aim is a framework that describes an approach to optimizing health system performance. The goals of the Triple Aim are defined as: improving the health of populations, improving the consumer experience of care (including quality and satisfaction), reducing the cost of healthcare

UCHC: The University of Connecticut Health Center

Whole person centered: An approach to care that places the person at the center of their care, encourages self-management and takes into account the full set of medical, social, behavioral health, cultural, and socioeconomic factors that contribute to a consumer's health

Draft

Foundational initiatives

This section summarizes Connecticut's federally funded initiatives, state funded initiatives, demonstrations and waivers.

POPULATION HEALTH INITIATIVES

- **Community Transformation Grant:** As the recipient of \$2,500,000 in federal grant money, the state is creating community-level initiatives in rural areas to reduce the incidence of obesity, smoking, and bad mental health days.
- **Choices:** The Department of Public Health, in conjunction with the Community Health Network of Connecticut, provides Choices, a set of culturally-sensitive nutrition education courses.
- **Community-Based Care Transition Programs:** The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and for reducing readmissions for high-risk Medicare beneficiaries. Two groups in Connecticut are participating in this program: Connecticut Community Care and the Greater New Haven Coalition for Safe Transitions.
- **Education programs:** Several awareness campaigns in the state are encouraging value-based decision-making. The Choosing Wisely campaign helps consumers pick high-quality, high-value care at the point of diagnosis. CHOICES is a state program through DSS that helps seniors navigate the health insurance system.
- **Healthcare Associated Infections Program:** Connecticut has a committee dedicated to preventing healthcare-related infections. The organization recently introduced "It's Good for You, Connecticut," an initiative encouraging patient responsibility in completing their antibiotics, working to prevent the spread of germs, and getting a flu vaccine.
- **Health Care Innovation Awards (HCIA):** The Health Care Innovation Awards are funding up to \$1 billion in awards to organizations that implement the most compelling new ideas to deliver better health, improve care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the greatest healthcare needs. Four HCIA recipients are currently applying their efforts in Connecticut: the partnership of San Francisco Community College and Yale University, Health Resource in Action, the

partnership of University of North Texas Science Center and Brookdale Senior Living, and TransforMED.

- **Healthy Connecticut 2020:** Under the national initiative of Healthy People 2020, the state developed a framework for health promotion and disease prevention. We expect to release the State Health Improvement Plan by the end of January 2014.
- **Healthy Homes:** This DPH initiative improves housing safety by promoting awareness of home dangers.
- **HEARTSafe:** This DPH program encourages workplaces and the population at-large to learn how to identify cardiac arrest and to attain the training and technology to respond effectively.
- **Medicaid Medical, Behavioral Health and Dental ASOs:** Recognizing opportunities to achieve better health outcomes and streamline administrative costs, Connecticut has historically contracted with ASOs to manage its Medicaid behavioral health and dental services. On January 1, 2012, Connecticut expanded this effort by transitioning Medicaid medical services from a managed care infrastructure that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot to a medical ASO. This extended state-of-the-art managed care services to the entire Medicaid and CHIP population. The medical and behavioral health (BH) ASOs (respectively, CHN-CT and Value Options) provide a broad range of services, including: member support, Intensive Care Management (ICM), predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. CHN-CT and Value Options coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a behavioral health unit staffed by credentialed individuals that is co-located with the medical ASO.
- **Nursing Home Diversion Modernization Grant:** This program supports those who are not eligible for Medicaid but are at high risk for being placed in a nursing facility. The program uses an innovative assessment tool to identify high-risk patients and uses a website to offer caregivers support.
- **NuVal®:** A joint venture between Griffin Hospital and TopCo Associates LLC, NuVal is a private company that licenses a proprietary food scoring system to food retailers in Connecticut and across the country. The scoring system allows consumers to make informed choices about the nutritional value of products when they buy them.

- **Planetree:** Based in Derby, Planetree is a leading national organization in patient-centered care approaches. It works with hospitals in the state and nationally to improve the patient experience. It is also a co-chair of the National Priorities Partnership that NQF convened to develop the National Quality Strategy.
- **Rewards to Quit:** In 2011, Connecticut received an “Incentives for the Prevention of Chronic Disease in Medicare Demonstration” under CMMI. This tobacco cessation program focuses on education, monitoring smoking rates, and incentivizing quitting.
- **School Health Survey:** The DPH uses two surveys to track the health of Connecticut’s youth on key population-level indicators of health. The Youth Tobacco Component is a school-based survey of students in grades 6 – 12. It assesses randomly chosen classrooms within selected schools and is anonymous and confidential. The Youth Behavioral Component is also a school-based survey of students, but only of high-school grades 9 – 12; it is also anonymous and confidential.
- **State Partnership Grant Program to Improve Minority Health:** The State Partnership Grant Program to Improve Minority Health is a grant funded by the US Department of Health and Human Services. As part of the grant, Connecticut will promote and implement national Culturally and Linguistically Appropriate Services (CLAS) Standards for health and social service providers. It will also investigate the social factors that contribute to the leading causes of death in Connecticut (e.g., cancer, cardiovascular disease, infant mortality, associated low birth weight).

BEHAVIORAL HEALTH INITIATIVES

- **Behavioral Health Homes:** DMHAS is working to provide integrated behavioral and medical healthcare to the severely and persistently mentally ill (SPMI) population. This integration would provide a cost-effective, longitudinal Home which would facilitate patients’ access to an inter-disciplinary array of behavioral health, medical care, and community-based social services and supports.
- **Campus Suicide Initiative:** This three-year (August 2011-July 2014), \$1.4 million grant was awarded under the federal Garrett Lee Smith Memorial Act. It helps states, tribes, and colleges/universities develop and implement youth, adolescent and college-age early intervention and prevention strategies to reduce suicide. The goal of the CCSPI is to bring sustainable evidence-based, suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher learning statewide for students up to age 24.

- **Behavioral Health Partnership (DSS, DMHAS, and DCF):** This program provides integrated care under Medicaid and CHIP for those who are eligible for coverage in both medical and behavioral health. Specific initiatives include intensive care management, support programs for family members, and provider training sessions.
- **Mental Health Legislation:** Following recent and on-going tragedies due to guns and violence, legislators passed two laws providing groundbreaking reforms. The legislation starts with training in mental health risk reduction and school violence prevention for teachers, childcare providers, and children’s clinicians. Mental health services are being integrated into early childhood programs and DCF is creating a care coordination program that integrates mental health and pediatrics. In addition, the Office of Early Childhood is crafting a public awareness campaign about children’s behavioral health. A task force is also studying the provision of behavioral health services to 16-25 year-olds. The legislature also passed a regulation that requires reviews of how effectively insurance plans’ cover mental health. Accompanying this, they established three additional Assertive Community Treatment Teams.
- **Prescription Drug Monitoring Program:** This legislation tries to prevent prescription drug abuse by requiring providers who give out controlled substances to register for the electronic prescription drug monitoring program.
- **SAMHSA Grant Proposals:** Connecticut received a \$9 million grant to integrate behavioral health with primary care and provide key preventative services.
- **Screening, Brief Intervention and Referral to Treatment (SBIRT):** DMHAS was awarded a five-year SAMHSA grant through August 2016. By partnering with Federally Qualified Health Center (FQHC) sites statewide, SBIRT dramatically increases the identification and treatment of adults who are at-risk for substance misuse or diagnosed with a substance use disorder. It accomplishes this by using routine screenings that are based on evidence and use well-tested instruments, by relying on short manual-based interventions and brief treatment protocols, and by basing assessments and treatment referrals on ASAM (2001) criteria. Partners include DMHAS, the Community Health Center Association of Connecticut (CHCACT), nine Federally Qualified Health Centers (FQHCs) and the UConn Health Center.
- **CMS Round 2 grant submission:** DMHAS recently submitted a proposal seeking to transform the state Local Mental Health Authority (LMHA) recovery-oriented system of care by implementing CSTAARR, a care delivery and payment reform model. This model will implement rapid access to outpatient behavioral health

clinics, add primary care nursing, expand prescriber positions and formalize collaborative meetings with local hospitals in order to address avoidable use of those hospital systems. These proposals will provide a 1.77% return on investment to CMS and a 1.9% reduction in total cost of care over a three year period.

HEALTH INFORMATION TECHNOLOGY INITIATIVES

- **eHealthConnecticut:** Established in 2006, eHealthConnecticut is a non-profit that is trying to expand providers' use of electronic health records. The organization is using federal funding to support small providers who are working with underserved populations via its regional extension center.
- **All-Payer Claims Database:** Connecticut's centralized database will collect data that will ultimately enable the analysis of disease within and the development of prevention strategies for the state's population.
- **Health Information Technology Exchange:** HITE-CT will help providers share information across sites of care via a secure network.
- **Connecticut Data Collaborative:** The Connecticut Data Collaborative is a public partnership working to make federal, state, local, and private healthcare data publicly available in a central portal. This data can then be used for data-based planning and policymaking. The collaborative is a project of the New Connecticut Foundation, a 501(c)3 nonprofit organization affiliated with the Connecticut Economic Resource Center.
- **DMHAS Data Performance (DDaP) system:** DMHAS has already implemented a web-based data information system – the DMHAS Data Performance (DDaP) system. DDaP is a centralized repository of demographic, clinical and service information for over 100,000 clients each year. Approximately 150 Private Non-Profit (PNP) providers enter the information, which DMHAS analyzes to assess quality and resource use
- **DMHAS electronic care management tools:** manages a system of care for behavioral health populations (i.e., safety net populations that include Serious and Persistent Mental Illness (SPMI)); this system uses several care management tools. While select providers also employ these tools, their level of technological maturity varies significantly.
- **Medicaid EHR Incentive Program:** DSS is collaborating with the UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September, 2011

to January, 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals.

- **Health portals:** Both the private and public sectors are enhancing consumers' ability to gather health information on the Internet. DSS has launched "My Place," a website to provide shared decision-making tools, information on how to access community health services, and a clearinghouse for caregivers. DSS hopes to make this portal available via kiosks throughout the community. In the private sector, Connecticut's payers and hospitals use portals to offer consumers access to health information and other engagement tools.
- **Availity®:** Multiple providers and their office staff can access information for members through Availity®, one of the largest electronic health information networks that connect providers, health plans and practice management systems with essential real-time business and clinical information. Availity offers a wide variety of online tools that allow providers to access real-time information from multiple payers via one secure sign-on; the data includes eligibility, benefits, claims, test results, and many other services.
- **Payer analytics programs:** Payers in the state have developed analytic engines to profile provider patient panels and measure provider quality and performance. They have also created sophisticated analytics tools for reporting and data visualization as part of their PCMH/ACO pilots in Connecticut (e.g. Anthem BCBS pulls together 'drill-down analytics' and reports for PCPs in its networks and CHNCT predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling).
- **Care management tools:** CHN-CT has fully implemented for Medicaid a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs (e.g. food and housing security), culturally attuned conversation scripts as well as chronic disease management scripts. Additionally, CHN-CT now has in place geographically grouped teams of nurse care managers.
- **My Place:** The state launched the "My Place" web site (<http://www.myplacect.org/>) in late June, 2013 to enable consumers, caregivers and providers to access timely and accurate information with which to make decisions, means of connecting with services (both health-related and social services), and a clearinghouse through which formal and informal caregivers can find opportunities to provide assistance. Initially the site will start by focusing on workforce development - helping people who are entering or re-entering the workforce to understand what types of caregiving jobs are available, to list

positions and to provide contacts. At later stages it will grow and evolve, and will encompass a partnership with Infoline 2-1-1.

PAYMENT INNOVATION INITIATIVES

- **Patient-Centered Medical Home (PCMH):** Patient-Centered Medical Home (PCMH): Connecticut is home to several PCMH programs. In 2009, the Office of the State Comptroller (OSC) required implementation of PCMH for the self-insured state employee health plan with Anthem and UnitedHealthcare. By 2010, over 45,000 employees were enrolled in the pilot. In 2011, DSS established the Medicaid PCMH initiative. This PCMH program includes metrics to evaluate performance on health and consumer satisfaction. Several private payer PCMH efforts are in process as well, including Anthem and Cigna.
- **Medicare Shared Savings Program (MSSP) ACOs:** This flagship Medicare program promotes accountability and coordinated care among participating providers/health systems and uses infrastructure investment to support the effort. Six Connecticut organizations currently participate as MSSP ACOs: Hartford HealthCare, St. Francis HealthCare, ProHealth, Pioneer Valley Accountable Care, Accountable Care Clinical Services, and Accountable Care Organization of New England.
- **Commercial Insurance Carrier P4P and ACO initiatives:** Anthem Blue Cross Blue Shield of Connecticut and CIGNA are negotiating and implementing provider contracts with Pay for Performance (P4P) and taking steps toward implementing Accountable Care initiatives. As of 1/1/2014, the state expects 11 provider groups with over 1,500 PCP's to be participating in some form of P4P/ACO contract .
- **CMMI Advance Payment ACO Model:** The Advance Payment ACO Model is designed for physician-based and rural providers who have come together voluntarily to provide coordinated, high quality care to their Medicare patients. Through this model, selected participants will receive upfront monthly payments, which they can use to make important investments in their care coordination infrastructure. Connecticut has two groups actively participating in this model: PriMed (Fairfield and New Haven counties) and MPS ACO Physicians (based in Middletown).
- **FQHC Advanced Primary Care Practice Demonstration:** This demonstration project, operated by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals who work in teams to

coordinate and improve care for up to 195,000 Medicare patients. One practice in Connecticut, Community Health & Wellness Center of Greater Torrington, Inc., is already participating in this program.

- **Integrated Care Demonstration for Medicare/Medicaid Eligibles (MMEs):** Connecticut has received funding to design an integrated program for dual eligible individuals. The program integrates long-term care, medical services, and behavioral health services/supports. It also promotes the system's transformation toward a patient-centered model. The program has two primary features. An Administrative Services Organization (ASO) will improve Connecticut's medical and behavioral health ASOs by expanding/ tailoring their intensive care management (ICM) and care coordination capabilities so they can better meet the needs/ preferences of MMEs. The state will also integrate Medicare data into existing Medicaid-focused predictive modeling and data analytics and help providers use it more effectively.

In the programs' second feature, the MME initiative will create new, multi-disciplinary provider arrangements called "Health Neighborhoods." Providers will be linked to these through care coordination contracts and electronic means. They will promote local accountability among groups of providers who work together to deliver more integrated care that better meets the needs of MMEs, using care coordination agreements and electronic communication tools.

- **Bundled Payment Care Initiative (BPCI):** Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care that also costs less to Medicare. Connecticut has two groups that are already participating in the BPCI: Greenwich Hospital and Bayada Home Health Care.
- **Incentives for the Prevention of Chronic Disease:** Section 4108 of the Affordable Care Act authorizes grants to states to provide incentives to all Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors (e.g., Connecticut's Rewards to Quit program). This program applies to all ages.
- **Medicaid Emergency Psychiatric Demonstration:** This Demonstration will test whether Medicaid can support a higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable.
- **State Employees' Health Enhancement Program (HEP):** OSC introduced HEP, a program providing monetary incentives for preventative care for state employees.

This program includes self-management recommendations via an online portal that also enhances patient engagement. HEP also embedded value-based insurance design into the State Employee Health Plan, rewarding employees who participated in the program by lowering certain co-pays and requiring higher premium shares for those who did not. Preliminary results indicate increased use of PCP's and preventive services. The state will partner with other employer groups and payers to encourage the adoption of similar programs.

HEALTH CARE ACCESS INITIATIVES

- **Access to Recovery (ATR):** Following the success of ATR I and II, ATR III is a four-year grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). ATR III is a presidential initiative which provides vouchers to adults with substance use disorders; these vouchers help pay for a range of community-based clinical treatment and recovery support services. All services are designed to keep recipients engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.
- **Care 4 Kids:** DSS sponsors this program, which provides monetary support to low-income families so they can purchase childcare.
- **Health Insurance Exchange:** In October of 2013, AccessHealth CT began operating the state's health insurance exchange. Since its creation in 2011, AccessHealth CT has been building awareness of the exchange and the benefits available to those who need help to obtain healthcare.
- **Medicaid Expansion for Low-Income Adults:** Connecticut was the first state to create a new eligibility group after the passage of the ACA. This group provides coverage for those who are between 18 and 65, are ineligible for Medicaid Managed Care (MMC), without insurance, and with income below 56% of the federal poverty line. This will now extend to below 138% of the federal poverty line.

REBALANCING INITIATIVES

- **Medicaid HCBS waiver for Acquired Brain Injury:** This program provides case management, a homemaker, personal care, prevocational assistance, supported employment, respite, community-living support, home delivered meals, independent living skill training, cognitive behavioral health programs, a substance abuse program, transitional living, vehicle mods, chore, environmental

accessibility adaptations, transportation, Personal Emergency Response System (PERS), a companion, specialized medical equipment and supplies for the PD and brain injured from age 18 to any maximum age.

- **Medicaid HCBS waiver for Elders:** This program provides adult day health, care management, a homemaker, a personal care assistant, respite, assisted living, assistive technology, chore, a companion, environmental accessibility adaptations, home delivered meals, mental health counseling, PERS, and transportation for aged individuals from age 65 and up.
- **Medicaid Personal Care Assistance waiver:** Provides personal care, assistive technology, and PERS for individuals with physical disabilities ages 18-64.
- **Medicaid HCBS Waiver for People with Serious Mental Illness in Nursing Homes with DMHAS:** Provides community support, supported employment, assertive community treatment, home accessibility adaptations, non-medical transportation, peer supports, a recovery assistant, short-term crisis stabilization, specialized medical equipment, and transitional case management for individuals with mental illness from age 22 on.
- **Medicaid Home and Community Supports Waiver for Persons with Autism with DDS:** Provides community companion homes, a live-in companion, respite, assistive technology, clinical behavioral health support, a community mentor, individual goods and services, an interpreter, job coaching, a life skills coach, non-medical transportation, PERS, a social skills group, and a specialized driving assessment for individuals with autism from age 3 to any maximum age.
- **Medicaid Comprehensive Support Waiver with DDS:** Provides adult day health, community training homes/community living arrangements, group day supports, a live-in caregiver, respite, supported employment, an independent support broker, an adult companion, assisted living, behavioral health support, continuous residential supports, environmental modifications, healthcare coordination, individual goods and services, individualized day supports, individualized home supports, an interpreter, nutrition, parenting support, PERS, personal support, senior supports, specialized medical equipment and supplies, transportation, and vehicle modifications for persons with Development Disorders (DD) from age 18 to any maximum age and for Individuals with Intellectual Disabilities (IID) from age 3 to any maximum age.
- **Medicaid Expansion for Low-Income Adults:** Connecticut was the first state to create a new eligibility group after the passage of the ACA that provides coverage for those between 18 and 65, ineligible for Medicaid Managed Care, without

insurance, and with income below 56% of federal poverty line. This will now expand to 138% of the federal poverty line.

- **Medicaid Employment and Day Supports Waiver with DDS:** Provides adult day health, community-based day support options, respite, supported employment, an independent support broker, behavioral health support, individual goods and services, individualized day support, an interpreter, specialized medical equipment and supplies, and transportation for individuals with DD from age 18 to any maximum age and with ID from age 3 to any maximum age.
- **Medicaid Individual & Family Support Waiver with DDS:** Provides adult day health, community companion homes, group day supports, individual supported employment, a live-in companion, prevocational services, respite, an independent support broker, behavioral health support, companion supports, continuous residential supports, environmental modifications, group-supported employment (formerly supported employment), healthcare coordination, individualized day supports, individualized home supports, individually directed goods and services, an interpreter, nutrition, parenting support, PERS, personal support, senior supports, specialized medical equipment and supplies, transportation, vehicle modifications for DDs from age 18 to any maximum age, and IIDs from age 3 to any maximum age.
- **Money Follows the Person:** Under a federal program, Connecticut has given those in long-term care the option to shift from nursing facilities to other living environments while maintaining their access to healthcare funding. Connecticut will invest the savings from this effort in programs that add flexibility to long-term care.
- **Nursing Home Diversification.** Another important feature of rebalancing is use of a Request for Proposals process and an associated \$40 million in grant and bond funds through SFY 2015 to seek proposals from nursing facilities that are interested in diversifying their scope to include home and community-based services. Undergirding this effort is town-level projections of need for LTSS and associated workforce, and a requirement that applicant nursing facilities work collaboratively with the town in which they are located to tailor services to local need.

Plan Development Participation

State Health Care Innovation Planning Steering Committee Members

Nancy Wyman
Committee Chair
Lieutenant Governor

Anne Melissa Dowling
Deputy Commissioner
Connecticut Insurance Department

Victoria Veltri
Project Director
State Healthcare Advocate

Anne Foley
Under-Secretary, Policy Development &
Planning
Office of Policy and Management

Michael Michaud
Associate Project Director
DMHAS

Bernadette Kelleher
Vice President
Anthem Blue Cross and Blue Shield

Mark Schaefer
Associate Project Director
Department of Social Services

Jewel Mullen
Commissioner
Department of Public Health

Tamim Ahmed
Executive Director
Access Health Analytics

Frances Padilla
President
Universal Healthcare Foundation of CT

Raegan M. Armata
Marketing Product Manager
Cigna

Betty Jo Pakulis
Chief of Staff
Office of the Lieutenant Governor

Patricia Baker
President & Chief Executive Officer
Connecticut Health Foundation

Thomas Raskauskas
President & Chief Executive Officer
St. Vincent's Health Partners

Mary Bradley
Director of Healthcare Planning
Pitney Bowes

Patricia Rehmer
Commissioner
DMHAS

Roderick L. Bremby
Commissioner
Department of Social Services

Frank Torti
Executive Vice President
UConn Health Center

Fredericka Wolman
Chief of Pediatrics
Department of Children & Families

Thomas Woodruff
Director, Healthcare Policy & Benefit Services
Office of the State Comptroller

CORE PLANNING TEAM

Victoria Veltri, Project Director
State Healthcare Advocate

Michael Michaud, Associate Project Director
Department of Mental Health & Addiction Services

Mark Schaefer, Associate Project Director
Department of Social Services

State Agency Program Planners

Faina Dookh, Department of Social Services

Bill Morico, Office of the State Comptroller

Susan Niemitz, Department of Mental Health & Addiction Services

Chinedu Okeke, Department of Public Health

Ronald Preston, UConn Health Center

Cheryl Wamuo, Department of Children & Families

Care Delivery Work Group Member Listing

Robert McLean (Co-Chairman)
Doctor of Internal Medicine & Rheumatology
Connecticut Medical Group, LLC

Edmund A. Kim
President-Elect
CT Academy of Family Physicians

Mark Schaefer (Co-Chairman)
SIM Associate Project Director
Department of Social Services

Sal Luciano
Executive Director
Council 4 AFSCME

Daren Anderson
Vice President/Chief Quality Officer
Community Health Center, Inc.

Adam B. Mayerson
Endocrinologist
Endocrine Associates of Connecticut

Peter Bowers
Medical Director
Anthem Blue Cross and Blue Shield

Donna LaLiberte O'Shea
Market Medical Director, CT
United Healthcare

Mehul Dalal
Chronic Disease Director

Laurel Pickering
President and Chief Executive Officer

Department of Public Health

Meredith Ferraro
Executive Director
Southwestern Area Health Education Center

Alice M. Forrester
Executive Director
Clifford Beers Child Guidance Clinic

Jeffrey B. Howe
Family Practitioner
Putnam Medical Associates

Gaye Hyre
Community Member/President
ArtBra New Haven Cancer Survivors Group

Leah B. Jacobson
Senior Medical Director – New England
Aetna

Dawn H. Johnson
Senior Consultant
Sellers Dorsey

Payment Work Group Member Listing

Thomas A. Raskauskas (Co-Chairman)
President and CEO
St. Vincent's Health Partners

Victoria Veltri (Co-Chairwoman)
SIM Project Director
Office of the Healthcare Advocate

Mary Bradley
Director of Health Care Planning
Pitney Bowes, Inc.

Paul J. DiLeo
Deputy Commissioner
Dept. of Mental Health & Addiction Services

William S. Gedge
Senior VP, Payer Relations
Yale-New Haven Health Systems

Northeast Business Group on Health

Lynn Rapsilber
Programs Chairperson
CT Advanced Practice Registered Nurse Society

Elsa Stone
Pediatrician
Pediatrics Plus

Rosemary Sullivan
Product Director for Customer Health Solutions
Cigna Healthcare

Thomas C. Woodruff
Director, Healthcare Policy & Benefit Services
Office of the State Comptroller

William Young
Chief Operating Officer
Alcohol & Drug Recovery Centers, Inc.

Robert W. Zavoski
Medical Director
Connecticut Department of Social Services

Kate McEvoy
Interim Director of Health Services
Department of Social Services

Melissa Pappas
Senior VP, Southern New England Network
Aetna

Lori I. Pasqualini
President
Connecticut Business Group on Health

Robert E. Smanik
President and CEO
Day Kimball Hospital

Todd Staub
Doctor of Internal Medicine
Litchfield Internal Medicine

David Guttchen
Director, CT Partnership for Long Term Care
Office of Policy and Management

Michael Taylor
Chief Executive Officer
Cornell Scott Hill Health Center

Bernadette Kelleher
Vice President
Anthem Blue Cross and Blue Shield

Susan Walkama
President and CEO
Wheeler Clinic

Courtland G. Lewis
Orthopedist
Orthopedic Associates of Hartford

Joseph Wankerl
Provider Contracting
Cigna Healthcare

Kathy Madden
Vice President of Network Operations
ConnectiCare

Thomas C. Woodruff
Director, Healthcare Policy & Benefit Services
Office of the State Comptroller

Health Information Technology Work Group Member Listing

Mark Raymond (Co-Chairman)
Chief Information Officer
Bureau of Enterprise Systems & Technology

Dan Olshansky
Health Information Technology Director
Dept. of Mental Health & Addiction Services

Michael Michaud (Co-Chairman)
SIM Associate Project Director
Dept. of Mental Health & Addiction Services

Mark Root
Director of Nursing
Department of Children & Families

Daniel P. Carmody
Informatics Delivery
Cigna Healthcare

Barry Simon
Chief Executive Officer
Gilead Community Services

John DeStefano
Chief Technology Officer
Health Information Technology Exchange of CT

Minakshi Tikoo
Health Information Technology Lead
Department of Social Services

Alan Kaye
Vice President
Radiological Society of Connecticut

Jonathan Velez
VP and Chief Medical Information Officer
Hartford Healthcare

Bernadette Kelleher
Vice President
Anthem Blue Cross and Blue Shield

Victor Villagra
Health Policy Scholar
Ethel Donaghue TRIPP Center

Daniel G. Maloney
Project Management and Business Analysis
Department of Public Health

James Wadleigh
Chief Information Officer
Access Health Connecticut

Mike Miller
Client Relationship Executive
Optum Government Solutions

Joshua Wojcik
Policy Director
Office of the State Comptroller

Workforce Task Force Member Listing

Jewel Mullen (Co-Chair)
Commissioner
Department of Public Health

Chinedu Okeke
SIM Planner
Department of Public Health

Frank Torti (Co-Chair)
Dean and Executive Vice President
UConn Health Center/UConn School of
Medicine

Ron Preston
SIM Planner
UConn Health Center

Thomas Agresta
Faculty Director
UConn Health Center

Alice Pritchard
Executive Director
CT Women's Education and Legal Fund

Marc Camardo
Epidemiologist, Infectious and Chronic Diseases
Department of Public Health

Salome Raheim
Dean
UConn School of Social Work

Lisa Davis
Deputy Commissioner
Department of Public Health

Susan T. Reisine
Chair, Oral Health and Diagnostic Sciences
UConn Health Center

Terry Edelstein
Nonprofit Liaison
Office of the Governor

Suzanne Rose
Senior Associate Dean for Education
UConn Health Center

Ann Ferris
Professor of Medicine and Public Health
UConn Health Center

Lawrence Silbart
Professor and Department Head
UConn School of Agriculture

Jennifer Filippone
Practitioner Licensing and Investigations
Department of Public Health

Marie Smith
Assistant Dean
UConn School of Pharmacy

Kristi Gafford
Chief of Staff
UConn Health Center

Linda Spivack
Statewide Director
CT League of Nursing

David Gregorio
Faculty Director, Community Medicine
UConn Health Center

Kristin Sullivan
Section Chief, Planning & Workforce
Development
Department of Public Health

George Kuchel
Chair, Center on Aging
UConn Health Center

Paula McCauley
Dean
UConn School of Nursing

Susan Niemitz
SIM Planner
Dept. of Mental Health & Addiction Services

Victor Villagra
Health Policy Scholar
UCHC Ethel Donaghue TRIPP Center

Robert Zavoski
Medical Director
Department of Social Services

Meredith C. Ferraro, Executive Director
Southwestern AHEC, Inc

Health Care Cabinet

Nancy Wyman
Cabinet Chair
Lieutenant Governor

Ellen Andrews
Executive Director
Connecticut Health Policy Project

Patricia Baker
President & Chief Executive Officer
Connecticut Health Foundation

Ben Barnes
Secretary
Office of Policy and Management

Philip Boyle
Vice President
First Niagara Risk Management

Roderick Bremby
Commissioner
Department of Social Services

Terry Edelstein
Nonprofit Liaison
Office of the Governor

Joette Katz
Commissioner
Department of Children and Families

Kevin Lembo
State Comptroller

Thomas Leonardi
Commissioner
Connecticut Insurance Department

Jeffrey Lucht
Senior Vice President
United Healthcare

Terrence W. Macy
Commissioner
Department of Developmental Services

Donna Moore
Blueprint Health

Jewel Mullen
Commissioner
Department of Public Health

Bonita Grubbs
Executive Director
Christian Community Action

Steven Hanks
VP and Chief Medical Officer
Hospital of Central Connecticut

William Handelman
Nephrology Associates of Northwestern CT, LLC

Linda St. Peter
IBIS Consortium

Robert Tessier
Executive Director
Coalition of Taft-Hartley Health Funds, Inc.

Frances Padilla
President
Universal Healthcare Foundation of CT

Patricia Rehmer
Commissioner
Department of Mental Health & Addiction
Services

Margaret A. Smith
Chief Dental Officer
Generations Family Center, Inc.

Victoria Veltri
Health Care Advocate

Joanne Walsh
President and CEO
Constellation Health Services

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Stakeholder Engagement as of October 31, 2013 (PRELIMINARY LIST)

Group	Date of Meeting or Event
A. State and local health agencies, tribal agencies, legislative leaders, state health IT coordinators & community service organizations, etc.	5
CT Health Care Cost Containment Committee meetings	ongoing
Access Health CT Strategy Committee	On-going
Monthly Conference Call for Directors of Local Health Departments/Districts	9/16/ 2013
Healthcare Cabinet	On-going
CT Behavioral Health Partnership Oversight (CTBPH) Council Meeting	7/12/2013
Medical Assistance Program Oversight Council Meeting (MAPOC)	6/14/2013
B. Healthcare Providers, including medical, behavioral health, etc.	19
Meeting with Home Care Agency Representatives	8/9/2013
Community Health Center Association of Connecticut (CHCACT)	8/5/2013
Connecticut Hospital Association meeting	7/23/2013
Behavioral Health CEO Meeting (CT Association of Nonprofits)	6/26/2013
United Community & Family Services (UCFS) Consumer Board Meeting	7/25/2013
Community Health Network (CHNCT): Direct service providers of mothers on Medicaid	7/11/2013
American College of Physicians-Governor's Council,	9/10/2013
Connecticut Institute for Primary Care Innovation (CIPCI) and the Center for Health Equity at Saint Francis	9/26/2013
Meeting with Burton Edelstein, a pediatrician, dental provider,	10/9/ 2013 and 10/15/2013
New Haven Community Medical Group (NHCMG)	9/12/2013
New Haven County Medical Association and Hartford County Medical Association's joint annual meeting: exhibit hall,	10/21/2013
CT Association of Non-Profits forum for CT SIM with the CT Association of Nonprofits, Central AHEC, CHCACT	7/30/2013
CT Association of Non-Profits BH Forum for DMHAS Providers	7/25/13
Center for Integrative Medicine at Saint Francis Hospital	10/26/13
C. Consumers, healthcare advocates, employers & community leaders	16
HUSKY Advisory Committee to CHNCT	7/ 9/ 2013

Focus group of Shelton AARP members	7/17/ 2013
Kitchen Cabinet and Mothers for Justice	7/17/ 2013
STRIVE Focus Group	8/ 8/2013
CT Health Foundation Road Show (5 meetings)	June-August 2013
Family Advisory Board for DCF Region 3	7/13/2013
United Community & Family Services (UCFS) Consumer Board Meeting	7/25/2013
AARP Advocacy Leadership Council	9/9/2013
Consumer Advocate Forum	10/7/2013
Southeastern Regional Mental Health Board	9/11/2013
South Central Regional Mental Health Board	9/17/2013
Southwestern Regional Mental Health Board	9/19/2013
North Central Regional Mental Health Board	9/25/2013
Northwestern Regional Mental Health Board	9/30/2013
Hartford small employer focus group	8/15/2013
Covering Connecticut's Kids & Families	10/30/2013
D. Public and private Payers, self-insured employers and public and private health plans	5
CT Business Group on Health: Wellness Committee	7/16/2013
Northwestern Connecticut Chamber of Commerce-Representatives of businesses NE CT	8/15/2013
CT Business Group on Health Council Meeting	6/7/2013 6/28/2013
CT Business Group on Health – Annual Meeting (CT-BGH)	9/27/2013
Employees of Employer Sponsored Insurance Focus Group	8/14/2013
E. Social Service Organizations, faith-based, representatives for health education and community health organizations	2
Connecticut Partners for Health meeting regarding Consumer Empowerment	10/9/ 2013
Central Area Health Education Center (AHEC)-Community Organizations	8/16/2013
F. Funders and Resource Foundations, academic experts, external quality review organizations, hospital engagement networks, policy institutes and health associations	4
The Donoghue Foundation	10/9/2013
CT Multicultural Health Partnership Event	6/20/2013
CT Association of Directors of Health	9/18/2013
CT Partners for Health	10/3/2013

Summary of Stakeholder Input to the Design and Model*

Consumers

Theme	Principal Comments	SIM Efforts
<ul style="list-style-type: none"> ➤ Healthcare is unaffordable ➤ Challenges with insurance coverage 	<ul style="list-style-type: none"> • Want lower, transparent costs • Limited coverage for vision, dental and behavioral health • Navigating the system is difficult 	<p>By implementing the AMH, SIM will improve healthcare and the experience of care while reducing costs. By utilizing a whole-person centered approach, the needs of the whole person will be considered and addressed</p>
<ul style="list-style-type: none"> ➤ Access 	<ul style="list-style-type: none"> • Long wait times • Limited office hours • Limited access to specialists • Referral process is confusing 	<p>AMH standards will require same day access for acute concerns, expanded office hours, formalized referral streams to specialists and warm hand offs</p>
<ul style="list-style-type: none"> ➤ Not respected or understood as a whole person 	<ul style="list-style-type: none"> • Want a personalized and holistic approach to care that respectfully considers the context of their lives • People using public entitlements feel stigmatized 	<p>Under AMH, team-based care will coordinate with community-based services using a whole-person centered approach that incorporates social determinants and the whole context of a person's life</p>
<ul style="list-style-type: none"> ➤ Care experience feels fragmented 	<ul style="list-style-type: none"> • Improve communication between multiple providers • Want one provider to be accountable for their care • System and discharge planning lack continuity 	<p>Through the AMH, people will be attributed to one provider who will be accountable as a partner in their care and to facilitate communication with other providers, thus improving continuity</p>
<ul style="list-style-type: none"> ➤ Lack 	<ul style="list-style-type: none"> • Want information about 	<p>Common provider scorecards will</p>

information and tools to engage in health and wellness	provider quality <ul style="list-style-type: none"> Want understandable education and resources to enable informed treatment choices 	create quality transparency Consumer Empowerment education and decision-making tools will improve ability to make informed choices
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Healthcare Providers

Theme	Principal Comments	SIM Efforts
➤ Want to change how they practice	<ul style="list-style-type: none"> Wish to spend more time with their patients, consider social determinants and provide more holistic care Want to include non-traditional providers 	Under AMH, team-based care will coordinate with community-based services and non-traditional providers using a whole-person centered approach that incorporates social determinants and the whole context of a person’s life
➤ Need supports to transform	<ul style="list-style-type: none"> Need patient data made available and improved tools to manage this data Desire support for meaningful transformation 	The HIT Taskforce will improve provider-to-provider connectivity and assist with mechanisms to better manage data and the Provider Transformation Taskforce will provide practice change supports

Community Service Organizations

Theme	Principal Comments	SIM Efforts
➤ Need to integrate care	<ul style="list-style-type: none"> Integrate care with social determinants of health Integrate behavioral health and primary care Improve access and coordination 	AMH standards will require improved access and coordination and a whole-person centered approach will integrate with behavioral health and address social determinants of health
➤ Need to address public	<ul style="list-style-type: none"> Focus on Preventative health 	SIM stresses the need for community health improvement

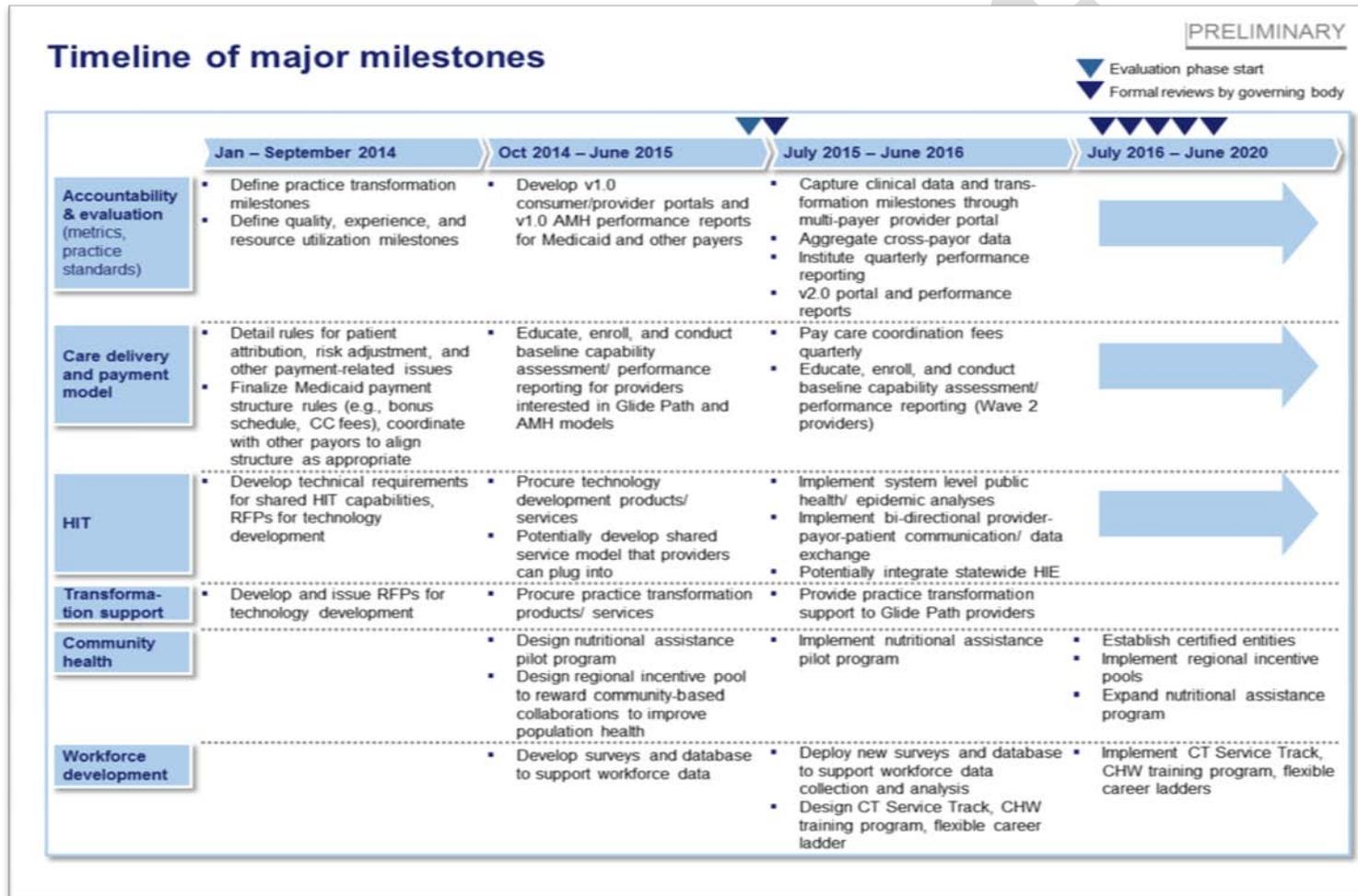
health concerns	<ul style="list-style-type: none"> • Create concrete measures to address health disparities • Focus on non-traditional providers and create sustainability for those services 	and will promote public health initiatives, strengthen community services and outcomes and reduce health disparities
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Employers

Theme	Principal Comments	SIM Efforts
<ul style="list-style-type: none"> ➤ Concerned with affordability 	<ul style="list-style-type: none"> • Dissatisfied with unnecessary tests and procedures • Worried about affordability of healthcare overall ➤ 	Under AMH, healthcare becomes value-based, eliminating unnecessary care and therefore reducing overall costs
<ul style="list-style-type: none"> ➤ Desire help with consumer engagement 	<ul style="list-style-type: none"> • Want to incentivize employees for health and wellness • Lacks materials to engage consumers 	Value-based insurance designs are already being piloted in CT and can lend expertise and Consumer Empowerment education and decision-making tools will improve ability to make informed choices

*** This appendix is not meant to be an exhaustive list of all concerns raised in more than 50 stakeholder events, rather it is meant to be a broad overview of the major themes that emerged during the stakeholder engagement process.**

Full Page Charts and Exhibits



DRAFT AND PRE-DECISIONAL

● Deteriorating ● Maintaining ● Improving

Metrics	Statewide				Equity specific		
	Current Perf. ¹	Benchmark	Absolute target	Trend	Current Perf. ³	Target, %	
Health	▪ Diabetes prevalence	7.3%	75 th	7.3%	●	TBD	0
	▪ Asthma prevalence (adults)	9.2 %	75 th	7.8%	●	TBD	0
	▪ Hypertension prevalence	29.8 %	50 th	<29.8%	●	TBD	0
	▪ Obesity prevalence	23 %	Top 5	Maintain	●	TBD	0
	▪ Tobacco use (current smokers)	13.2 %	Top 5	Maintain	●	TBD	0
Quality	Improved quality						
	▪ Track 1 providers meeting comprehensive quality scorecard targets/index						
	▪ Track 2 providers meeting comprehensive quality scorecard targets/index	To be defined over remainder of design phase by metrics taskforce					
	<i>Illustrative quality scorecard targets/index measures</i>						
	▪ Providers meeting NCLAS standards	TBD	TBD	TBD		TBD	0
	▪ Children well-child visits	90.3 %	Top 5	Maintain	●	TBD	0
▪ Mammogram for women over 40 in last 2 years	81.4 %	Top 5	Maintain	●	TBD	0	
▪ Adults aged 50+ who had colorectal cancer screening	75.7 %	Top 2	Maintain	●	TBD	0	

● Deteriorating ● Maintaining ● Improving

Metrics	Statewide				Equity specific		
	Current Perf. ¹	Benchmark	Absolute target	Trend	Current Perf. ³	Target, %	
Quality (cont'd)	▪ Optimal diabetes care (annual foot exam)	72.7%	75 th	75.3%	●	TBD	0%
	▪ Hospital visits for asthma (per 100,000)	135.5	TBD	TBD	●	TBD	0%
	▪ HTN: controlling high blood pressure (taking medicine)	78.7%	50 th	79.2%			
	▪ Adult weight screening and follow-up	TBD	TBD	TBD			
	▪ Measure Pair: A) Tobacco Use Assessment B) Tobacco Cessation Intervention	TBD	National average	A) 62.7% B) 20.9%			
Cost	<i>Improved consumer experience</i>						
	▪ Statewide patient experience survey scores	TBD	TBD	TBD			
	▪ State medical cost trend growth rate (3 year avg.)	5.1	GSP+1	4.8	●		
▪ Statewide ambulatory care sensitive hospitalizations (per 100,000)	1,244	TBD	TBD				

1 Benchmark years may vary

Note on approach: Current performance compared to three year trend and relative performance to peer states. Benchmark set as Connecticut's target movement relative to peer states over the course of the testing phase, with an absolute target indicated as the current absolute performance of the state at that benchmark level

3 % difference between lowest and highest performing sub-group, goal is 0% difference

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 years)	Stage 3 (3+ years)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
Provider-payer-consumer connectivity	Multi-payer online portal for providers to receive static reports; basic consumer portal	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange solutions	Potentially integrate state-wide Health Information Exchange