



# CONNECTICUT HEALTHCARE INNOVATION PLAN



SUBMITTED  
DECEMBER 30, 2013



**Nancy Wyman**

LIEUTENANT GOVERNOR  
STATE OF CONNECTICUT

December 30, 2013

Dear Connecticut Stakeholder,

I am pleased to share with you our State Health Innovation Plan. This Plan, created under the State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation (CMMI) represents the culmination of your participation and input into each stage of the development process. As a part of the wide range of individuals and organizations that contributed to this effort, you have truly helped bring the State of Connecticut closer to its goal of improved access to higher quality healthcare that produces better health outcomes at a reduced cost.

Together with your collaboration, we have produced an ambitious framework for making Connecticut a healthier state through a more efficient healthcare system that is whole-person centered, and targets the elimination of longstanding and persistent health disparities.

We are depending on your active participation as we move forward with planning and implementation, and hope you will continue to lend your efforts.

You can stay up-to-date and involved by visiting [www.healthreform.ct.gov](http://www.healthreform.ct.gov) and expressing your comments and suggestions via email to [sim@ct.gov](mailto:sim@ct.gov).

With kindest regards,

A handwritten signature in blue ink that reads "Nancy Wyman".

Nancy Wyman  
Lieutenant Governor

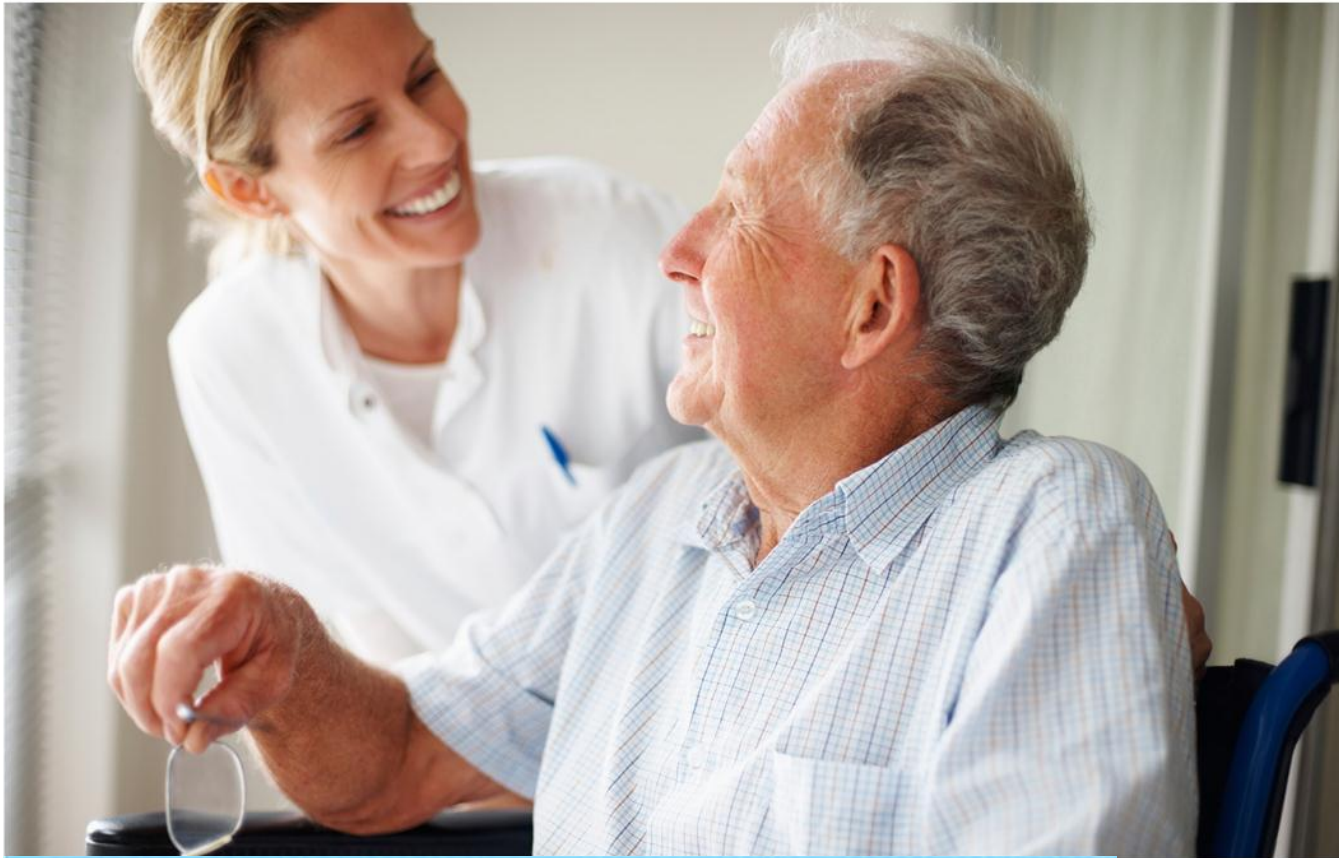
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# I. EXECUTIVE SUMMARY

# Executive Summary

## INTRODUCTION

Connecticut's Healthcare Innovation Plan ("Innovation Plan") is the product of a shared vision of a broad range of stakeholders to establish primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume. We envision a healthcare system rooted in primary care and prevention, integrated with community resources, and truly accessible to our residents. We recognize that providers in the care delivery system are one among many community participants that must work together to achieve the broader goal of improved community health. Most importantly, achieving our goals of better health and better healthcare require the involvement of empowered and informed consumers who take an active role in the continuous pursuit of a healthier lifestyle and effective management of chronic conditions.

Our Innovation Plan is possible because, as we learned through many months of broad stakeholder engagement, many are already striving to improve health and our healthcare system. There is utility in combining our disparate efforts in support of the collective good. Connecticut's Innovation Plan leverages current public and private sector investments in healthcare reform initiatives, such as our state's health insurance marketplace, prevention efforts and value based payment reforms. Our plan is distinctive; it strongly promotes health equity throughout all its initiatives, ties provider payment to consumer experience, builds Health Enhancement Communities, leverages healthcare workforce development programs serving disparity populations in urban areas, and powers all through the effective use of health information technology.

We are forming a collaborative community of stakeholders across Connecticut for fulfilling this plan. We are ready to launch.

## BACKGROUND

In March 2013, Connecticut received a \$2.8 million planning grant from the Center for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan. CMMI's charge was to design a model for healthcare delivery supported by value-based payment methodologies tied to the totality of care delivered to at least 80% of our population within five years. Moreover, the Innovation Plan must promote the Triple Aim for everyone in Connecticut: better health while eliminating health disparities, improved healthcare quality and experience, and reduction of growth in healthcare costs.

Our Innovation Plan is the product of a model design process embracing broad stakeholder input and alignment. We conducted more than 25 consumer focus groups, an extensive survey comprising almost 800 individuals, and more than 45 multi-stakeholder meetings including

public and commercial payers, healthcare providers, employer purchasers, consumer and health equity advocates, and public agencies. These forums included wide-ranging discussions of our current healthcare system and barriers to community health improvement.

Core workgroups were also established to engage in focused deliberation, evaluation, development, and prioritization of options for innovation in care delivery, payment reform, health information technology, workforce development, and health equity. Along the way, we considered economic incentives driving care delivery decisions and the limitations of our healthcare workforce. Empowering Connecticut's healthcare consumers and recognizing the role community plays in health is vital to our plan. We learned that improving care delivery and the consumer experience of that delivery require the smart use of health information technology.

## **CONNECTICUT'S CURRENT HEALTH SYSTEM – “AS-IS”**

Connecticut has a rich array of healthcare, public health, and support services. Despite this, healthcare in Connecticut falls short. For example, the state has high emergency department utilization rates, especially for non-urgent conditions, and 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.<sup>1</sup> In 2012, healthcare spending in Connecticut was \$29 billion. That year, we ranked third highest among all states for healthcare spending per capita, at \$10,470. These figures raise concerns about continued affordability of healthcare coverage and access. High healthcare spending adversely impacts the competitiveness of our state's business community. 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.

Significant barriers prevent achievement of the Triple Aim, despite the resources that Connecticut devotes to healthcare. These barriers include barriers in access to care, a fragmented delivery system that often fails to educate and inform consumers, a lack of transparency about cost and performance, and payment methods that reward volume of service rather than quality, access and overall health improvement.

<sup>1</sup> NORC, Benchmark State Profile Report for Connecticut (2013)

## OUR VISION FOR THE FUTURE – “TO-BE”

Our vision is to establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

In the future providers, networks, and payers will work together on effective population health management. Our health workforce will be capable in whole-person-centered-care and population health, prepared to work as teams, and supported by the latest evidence-informed clinical decision making tools.

We will judge our efforts a success if primary care transformation, community health improvement, and consumer empowerment innovations have demonstrable positive impact on health outcomes, care quality, health equity, consumer experience, and costs.

### EXHIBIT 1: State Innovation Model Goals

Better Health	<ul style="list-style-type: none"><li>• Decrease the statewide rates of diabetes, obesity, tobacco use, asthma and falls</li></ul>
Alleviating and eventually eliminating health disparities	<ul style="list-style-type: none"><li>• Close the gap between the highest and lowest achieving populations for each target measure impacted by health inequities</li></ul>
Better quality of care and consumer experience	<ul style="list-style-type: none"><li>• Achieve top-quintile performance among all states for key measures of quality of care, increase preventative care and consumer experience and increase the proportion of providers meeting quality scorecard targets</li></ul>
Lower costs	<ul style="list-style-type: none"><li>• Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, which corresponds to a 1-2% reduction in the annual rate of healthcare growth</li></ul>

## GUIDING PRINCIPLES

To achieve our vision, innovation efforts will be logically integrated and our program decisions will be consistently aligned with a core set of guiding principles:

- Whole-person-centered care is more than the integration of medical, oral, and behavioral health. It is also the consideration of social, cultural, emotional, and economic contexts for



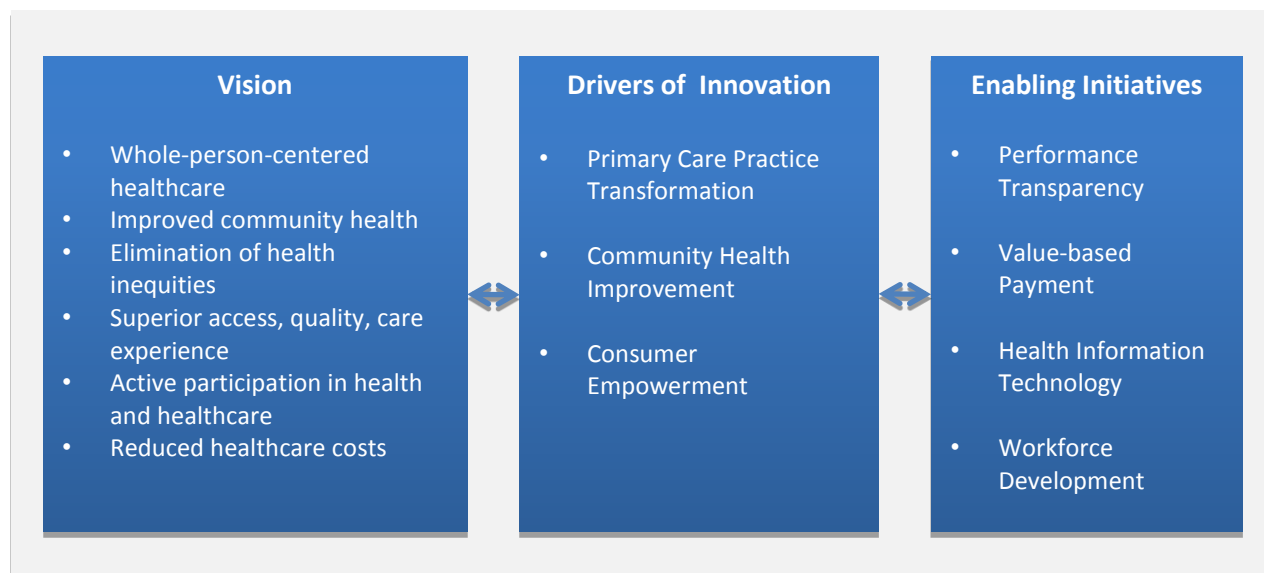
wellbeing. It is team based, coordinated care for individuals with complex needs, and provided in the right setting at the right time.

- A healthy community is a strong community. Community health improvement requires attention to a community's particular healthcare needs and social determinants of health, requires the collaboration of a wide range of community partners, and the expansion of a diverse and well-trained workforce that includes "non-traditional" providers such as community health workers.
- Every person has the right to be treated with respect, to receive culturally and linguistically appropriate whole-person-centered care, and to be fully informed and share in decisions that affect them and their families, regardless of socioeconomic status, race, ethnicity, language, gender/transgender, sexual orientation, geography, religion, ability/disability, or age.
- Health information technology powers primary care transformation, enabling point of care information and communications, continuous learning, and performance improvement. The use of technology for data collection and analytics provides for evidence-based approaches to care delivery, population health management, consumer access to cost and quality information, and tools to measure achievement of access, quality, equity, and cost goals.
- Healthcare economics must change so that providers are financially rewarded for whole-person-centered and evidence-based care, the continuous improvement of quality and care experience, and the reduction of unnecessary and avoidable costs, to improve affordability.
- Access to information that is culturally and linguistically appropriate is vital for improved health literacy to empower all patients to navigate the healthcare system, to choose their providers, to actively participate in their health and healthcare decisions, and to play an active role in their community and statewide health policy.
- Quality primary care is the bedrock of an effective healthcare delivery system. Access to primary care that is whole-person-centered, safe, effective, equitable, and based on the strongest clinical evidence is both fundamental and essential for improving health and healthcare outcomes.
- A highly-trained, well-equipped, and diverse primary care workforce with the capacity to meet the evolving needs of our population's health and the demands of healthcare system reforms is crucial to the attainment of our vision.
- Affordability of healthcare will not be achieved at the expense of quality healthcare. We will not reward the achievement of cost savings through inappropriate means, including under-service of patients.
- For our healthcare delivery system transformation to be meaningful and sustainable, we must continuously engage our stakeholders, including consumers, advocates, employers, community organizations, providers, local and state officials, Medicaid, Medicare, and private health plans.

- The advancement of our vision requires a commitment to measuring the impact of transformation initiatives on health, access, quality, equity, and costs, and further, by establishing a mechanism for oversight and mid-course corrections.

## OUR STATE INNOVATION MODEL AT-A-GLANCE

### Exhibit 2



## PRIMARY DRIVERS OF INNOVATION

In order to achieve the goals we have set forth and our vision for improved health and healthcare, three drivers of transformation are necessary:

- **Primary care practice transformation:** An Advanced Medical Home model will allow practices to manage effectively the total needs of a population of patients.
- **Community health improvement:** Designated Prevention Service Centers (“Prevention Service Centers”) and Health Enhancement Communities (HECs) will coordinate the efforts of community organizations, healthcare providers, employers, consumers and local public health entities.
- **Consumer empowerment:** Mechanisms for consumer input and feedback, incentives for positive care experience, and enhanced information will enable consumers to manage their own health 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:

- **Whole-person-centered care:** Care that addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health.
- **Enhanced access:**<sup>2</sup> 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 care that is convenient, timely, and linguistically and culturally appropriate.
- **Population Health Management:** use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations.
- **Team-based coordinated care:**<sup>3</sup> 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.
- **Evidence-informed clinical decision making:** Applying clinical evidence to healthcare decisions using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care to enable consumer directed care decisions.

Practices are in very different stages in terms of their ability to meet the advanced standards for becoming an Advanced Medical Home, so we designed the Glide Path program, which provides technical assistance and other support to facilitate the practice transformation process. When practices demonstrate readiness to coordinate care, payers (insurance companies, self-funded employers, Medicaid, Medicare) will begin to finance care coordination services and other advanced primary care activities. 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, we recognize that effective prevention cannot be achieved by the care delivery system or by public health agencies acting alone. A major part of our transformation strategy is to foster collaboration among the full range of healthcare 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:

<sup>2</sup> Paulus RA, et al. Health Affairs 2008; Reforming the healthcare delivery system, Geisinger report , 2009

<sup>3</sup> ACA Sec. 3502: Establishing Community Health teams to support the Patient Centered Medical Homes.

- **Designated Prevention Service Centers (DPSCs)** to strengthen community-based health services and linkages to primary healthcare.
- **Health Enhancement Communities (HECs)** to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities in areas with the highest disease burden, poorest indicators of socioeconomic status, and pervasive and persistent health disparities.

## Consumer Empowerment

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. A person's values and preferences and the freedom to make informed decisions must be placed at the center of any efforts to achieve our vision.

Primary care practices will equip consumers with culturally and linguistically appropriate information, resources, and opportunities for them to play an active role in managing their health. As part of our plan for consumer empowerment, we include a three-pronged strategy detailed in the Innovation Plan:

- **Enhanced consumer information and tools** to enable health, wellness, and illness self-management, including shared decision making with providers.
- **Consumer input and advocacy** via decision-making roles in the SIM governance structure and through consumer care experience surveys that will directly affect provider payment.
- **Consumer incentives** to encourage healthy lifestyles and effective illness self-management through the promotion of value-based insurance designs (VBID) and employer incentive programs.

## ENABLING INITIATIVES

Connecticut will enable our broad transformation through performance, cost and price 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 role in achieving our vision.

### Performance Transparency

Diverse groups of stakeholders have emphasized that increased transparency of quality, cost and price is a fundamental prerequisite to improving our health system. Transparency is essential for shaping our new care delivery and payment models, for informing consumer choice of health plans and providers, for guiding providers' own performance improvement efforts, and for identifying disparities in health and health outcomes. We will achieve this level of transparency with the following levers and focus areas:

- **Create a common scorecard** that reflects the AMH provider’s ability to meet measures of health status, quality of care and consumer experience.
- **Track primary care performance** for quality, care experience, equity and cost measures, with the goal of future expansion to other parts of the healthcare system.
- **Combine data across payers** in order to be able to track a provider’s true performance for their entire patient panel and to make reporting more efficient.
- **Ensure multiple levels of reporting** so that consumers, payers, providers and policy makers can access quality, cost, price, and equity information.

## 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, 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 across all payers strengthens the business case for providers to invest in advanced practice and performance improvement, while eliminating conflicting payer incentives. Based on the guidance from our workgroups and input from stakeholders, and our steering committee, we defined a strategy for value-based payment that comprises four components:

- **Two tracks for value-based payment:** In our Glide Path model, most providers who are new to value-based payment will begin in **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)**. A SSP introduces accountability for the overall cost of care for a panel of patients. A practice can share in savings when it provides more effective and efficient care or losses if care becomes less effective and efficient.
- **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, care experience, health equity, and cost. This will reduce complexity for providers, increase the business case for investment in new capabilities, and sharpen providers’ focus on specific measures of success supported by all payers.

Payers and providers will independently negotiate the level of outcomes-based bonus payments made under P4P. Similarly, payers and providers will be free to determine whether they want to share in gains and whether they want to share in losses under a SSP arrangement. Arrangements in which providers share in gains but not losses (“upside” arrangements) meet the minimum requirements of our Innovation Plan. Medicaid will establish an upside only shared savings program, although the timing has not been determined.



## Health Information Technology

Health information technology plays a central and supporting role in every element of our proposed reforms. It is the means by which we develop our strategy, target our resources, measure our progress, manage continuous improvement, inform our care decisions, and communicate across individuals, providers, and systems. Our Innovation Plan defines a health information technology strategy that is based on four principles:

- **Advanced payer and provider analytic capabilities** to support improvements in care delivery and health, with the eventual introduction of cross-payer (“aggregate”) analytics made possible by Connecticut’s All Payer Claims Database (APCD) and advancements in health information exchange.
- **Creation of multi-payer portal for providers and consumers** to allow easier access to information and better decision making by providers and consumers.
- **Guidelines for care management tools.** Since Connecticut has a large number of small provider practices, we will establish shared guidelines rather than mandatory procedures for adopting care management tools.
- **Standardized approach to clinical information exchange** to accelerate providers’ use of direct messaging for secure communication and coordinated care delivery across different sites of care. Our plan begins with point to point communication and evolves to a comprehensive, statewide, health information exchange.

## Health Workforce Development

For the Innovation Plan to succeed, it is essential that Connecticut has a healthcare workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. With input from stakeholders and a workforce task force, we lay out six broad, multipurpose initiatives:

- **Health workforce data and analytics** will be collected in order to make informed decisions regarding training initiatives and regional needs.
- **Inter-professional education (IPE)**, a **Connecticut Service Track** will be created to promote team and population-health approaches to health professional training.
- **Training and certification standards for Community Health Workers** will ensure that community health workers with common core competencies become an integral part of the healthcare workforce.
- **Preparation of today’s workforce for care delivery reform** so providers are able to adapt to our advanced and accountable care delivery models.
- **Innovation in primary care Graduate Medical Education (GME) and residency programs** so that these efforts better align with our health and healthcare reforms.

- **Health professional and allied health professional training career pathways** to improve career flexibility, expand the pipeline of healthcare professionals, and promote workforce diversity.

## **WHAT MAKES OUR PLAN DISTINCTIVE?**

All State Innovation Model designs are required to include new healthcare delivery and value-based payment models. Our plan meets these requirements, but is distinct in the following areas:

- Readiness to Launch with Extensive Stakeholder Support
- Promotion of Health Equity
- Equity and Access Council
- Designated Prevention Service Centers and Health Enhancement Communities
- Connecticut Service Track for Healthcare Workforce Development

### **Readiness to Launch with Extensive Stakeholder Support**

Connecticut's Innovation Plan will launch quickly and successfully, with broad stakeholder support. Connecticut has a strong foundation of health reforms upon which to build. 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 accountable care organization and medical home models.<sup>4</sup> Stakeholders are eager to identify sustainable models that will support innovation on a greater scale.

Connecticut is tilled ground for maximizing federal investment to improve the health and healthcare of our residents. Our state health insurance marketplace, Access Health CT, has enrolled over 65,000 individuals into qualified health plans and Medicaid as of December 29, 2013 for coverage beginning January 1, 2014.

### **Promotion of Health Equity**

Connecticut is one of the most racially, ethnically, and culturally diverse states in the country; in some counties Connecticut residents speak over 60 languages. Yet the state performs unacceptably on many population health and quality of care measures when one compares results by race, ethnicity, geography and income.

<sup>4</sup> Patient-Centered Medical Home Program: Program description and guidelines, CareFirst, 2011.

To achieve the Triple Aim for everyone, the state has committed to eliminating persistent barriers to health equity and will leverage current investments in this area as more fully described in the “Foundational Strengths and Initiatives” section.

During the design process we solicited advice through the formation of a health equity group to ensure inclusion of health equity’s crosscutting influences on primary care practice transformation, community health improvement, consumer empowerment, performance transparency, value-based payment, workforce development, health information technology, and governance. Furthermore, our evaluation plan will examine our success in reducing health equity gaps in health and health care quality.

Our Innovation Plan is committed to promoting health equity through the elimination of health disparities in every aspect of the model. Although the promotion of health equity is a distinguishing feature of our plan, it is viewed not as a separate and distinct initiative, but rather inherent to all elements of the plan.

### **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 underservice. 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 and to prevent providers from benefiting from unwarranted denials of care.

### **Consumer Empowerment**

Consumer empowerment is one of the primary means of achieving our goals. It encompasses distinct initiatives and is also embedded throughout the plan as a means to achieving our goals. Consumer experience must matter to a much greater degree than it does today. For this reason, Connecticut intends to be among the first states to measure care experience statewide at the practice level and to factor care experience performance into our payment methods across all public and private payers. We will promote the widespread adoption of value-based insurance designs as a powerful means for rewarding healthy behavior. In addition, consumers will be represented in all of the key committees, councils and task forces that shape our SIM reforms over the next five years.

### **Designated Prevention Service Centers and Health Enhancement Communities**

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 proposed Health Enhancement Communities (HECs) and Designated Prevention Service Centers (DPSCs) are innovative opportunities to foster an alignment among our Advance Medical Home providers

and a diverse array of community participants. The proposed innovation will establish a structure that allows a bi-directional flow of information from providers to community based organizations and local health departments allowing for the planning and deployment of strategic investments in community health.

## **Connecticut Service Track for Healthcare Workforce Development**

Connecticut will build upon its current program for community-based interprofessional education, UConn's Urban Service Track (UST), established to serve disadvantaged populations in urban settings through team-based care, cultural and linguistic appropriateness, and population health. The envisioned Connecticut Service Track (CST) extends beyond urban communities to include Connecticut's more rural counties—effectively covering all of Connecticut.

The CST program, as more fully described in the “Foundational Strengths and Initiatives” section, reaches across health professions schools, including nursing and allied health professions schools and additional community providers, increasing the number of participating schools, occupations, and community service locations.

## **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, a successor to the existing Steering Committee, with additional consumer, consumer and health equity advocate and provider representation. A Project Management Office will also be established to lead detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress to the public, state government, and CMMI. The Project Management Office will sit within Connecticut's Office of the Healthcare Advocate. The Steering Committee and Project Management Office will seek ongoing input and guidance from Connecticut's Healthcare Cabinet and Consumer Advisory Board.

Five 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, care experience, and health equity metrics and performance targets; methods for safeguarding equity, access, and appropriate levels of service; and workforce initiatives. Consumer membership in the task forces and councils will be facilitated through the statutorily created Consumer Advisory Board throughout the detailed design, pre-implementation and implementation phases of this initiative.

This structure is expected to be in place by February 2014.

### EXHIBIT 3: Future Governance Structure



### 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 pre-implementation planning beginning in October 2014; Wave 1 implementation beginning in July 2015; and subsequent scale-up through successive waves of implementation in State Fiscal Years (SFY) 2017-2020.

- Detailed Design (January 2014 to September 2014)
- Pre-implementation Planning (October 2014 to June 2015)
- Wave 1 Implementation (July 2015 to June 2016)
- Wave 2+ Scale-Up (July 2016 to June 2020)

### Evaluating our Innovation Plan

We will establish parallel evaluation tracks to measure the progress of our Innovation Plan; one track to monitor the *pace* of implementation and the other to monitor the *performance* of our initiatives and their associated impact on community health, quality of care, health equity, and costs.

Pace and performance dashboards, as discussed in detail in the Managing Transformation section of this plan, will be established by the Project Management Office and used to guide SIM efforts, report to stakeholders, and inform CMMI.



Baselines for population health, quality of care, health equity, and cost performance measures were developed in part using the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), Connecticut's State Health Assessment and our financial analysis. Performance targets for population health, quality of care, and health equity are aligned with Connecticut Department of Public Health's Healthy Connecticut 2020 plan.

The SIM evaluation team will be established as a formal collaboration among Connecticut's institutions of higher learning through which the breadth and depth of expertise required for rigorous evaluation of SIM will be gained. The evaluation team will employ a multi-method approach, including quantitative research methods and sophisticated statistical modeling in combination with qualitative data.

## **Financial Analysis**

Our Innovation Plan is projected to create more than \$3 billion in value over 5 years from State Fiscal Year (SFY) 2016 through SFY 2020. Research by the Institute of Medicine has suggested that approximately 30% of healthcare spending is unnecessary. The projected savings assumes that we will begin to eliminate some of this unnecessary spending through the initiatives proposed in our plan.

There are ample opportunities to generate value in Connecticut. We anticipate savings in healthcare spending attributed to poor healthcare outcomes, savings from improvements in prevention efforts, and reductions in excess costs such as duplicative or unnecessary tests and procedures. In Connecticut, an estimated 40% of our Medicaid enrollees with chronic conditions account for nearly 70% of our Medicaid spending, including spending on acute events that could have been prevented through more effective primary care. Connecticut has a 26% higher per capita use of hospital emergency departments than neighboring states and nearly 50% of those visits are for non-urgent care. We are among the highest cost states in spending per year per person in Medicaid, Medicare and private insurance.

Our financial projections for the potential impact of our Innovation Plan are based on achieving our aspiration that by SFY 2020 at least 90% of Connecticut's primary care providers will achieve AMH recognition and participate in shared savings plans. Additionally, we project about 50% of self-funded employers and 25% of fully-insured employers will adopt the AMH model for their employee benefit plans.

Achieving value will require meaningful investments in the care delivery systems. Projections assume that an average of 30-50% of savings achieved through implementation of the care delivery model will be paid to primary care providers in the form of bonus payments, net of increased spending on care coordination.

## **SUMMARY**

Our Innovation Plan is the synthesis of our work groups' findings and recommendations, robust public commentary, deliberations by our steering committee and the Healthcare Cabinet, and

the broadly representative focus groups that vetted our emerging design. Moreover, this plan builds upon a foundation of innovations and reforms already underway in Connecticut. Our Innovation Plan will guide the development of the initiatives that will constitute our proposal for a CMMI model testing grant that we anticipate submitting in the Spring of 2014. In selecting initiatives and crafting our testing grant proposal we will continue to work with stakeholders to continuously improve the Innovation Plan as an effective roadmap for achieving a healthier Connecticut.



## II.CONTEXT FOR HEALTH SYSTEM TRANSFORMATION

# 1. Connecticut's Healthcare Environment

Connecticut has a rich array of healthcare, public health, and support services that provide a strong foundation for advancement. Despite this, the state must improve on measures of healthcare quality and equity. 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, third highest among all states for healthcare spending per capita, at \$10,470. 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.

## 1.1 POPULATION DEMOGRAPHICS AND COVERAGE—HIGHLIGHTS

Connecticut has 3.5 million residents. According to the U.S. Census Bureau, 71.2% of the state's population is White, 9.3% African American, 13.4% Hispanic, 4.1% Asian and 2.1% other.<sup>5</sup> The population continues to become more diverse with a growth in Asian (+65%), Hispanic (+50%), and Multiracial (+31%) groups within the last 10 years.<sup>6</sup>

### Healthcare Coverage

In 2011, 64% percent of the state's residents had employer-sponsored or individual health coverage. Of the remaining 36%, Medicare covered 13%, Medicaid covered 13% and 10% were uninsured.<sup>7</sup> Since then, the uninsured rate has dropped to 9.1%,<sup>8</sup> commercial enrollment has

<sup>5</sup> U.S. Census Bureau, American Community Survey 1 Year Estimates (2012), available [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_12\\_1YR\\_CP05&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_CP05&prodType=table)

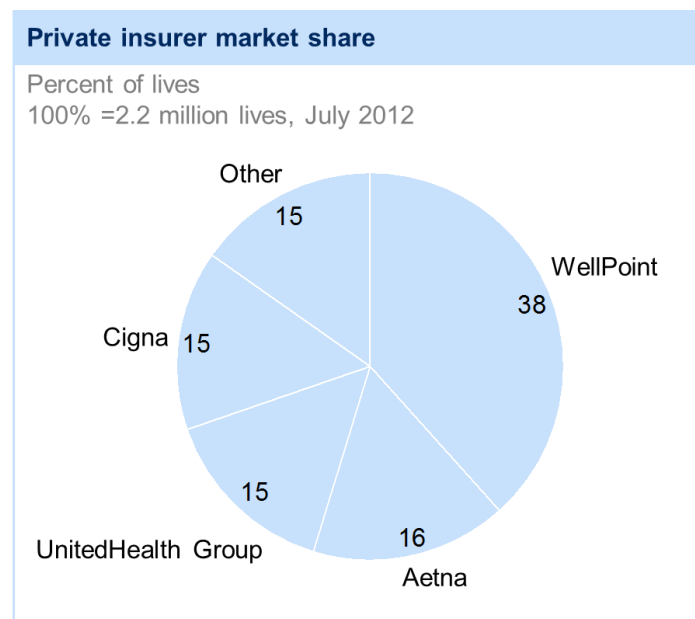
<sup>6</sup> Connecticut Department of Public Health, State Health Assessment Preliminary Findings (2013)

<sup>7</sup> Kaiser Family Foundation, State Health Facts (2011)

increased and Medicaid enrollment current stands at over 17% of the state population.<sup>9</sup> Both numbers are expected to increase through Qualified Health plan and Medicaid coverage under the Affordable Care Act.

At present, four commercial payers cover 85% of the nearly 2.5 million lives in the private insurer market: Anthem, Aetna, UnitedHealth Group and Cigna.<sup>10</sup> Connecticut also has a high proportion of self-insured employers.<sup>11</sup> Fifty-two percent of the lives covered by Medicaid are children; however, children only account for 17% of total Medicaid payments.<sup>12</sup>

#### EXHIBIT 4:



While only 10.1% 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.<sup>13</sup> In urban areas, where 88% of Connecticut residents live, many (25%) are below the federal poverty line.<sup>14</sup> And in Connecticut, where the family self-sufficiency standard exceeds that in other states, the percentage of residents living in real poverty exceeds 25%.

<sup>8</sup> US Census Bureau, American Community Survey 1 Year Estimates (2012).

<sup>9</sup> Department of Social Services enrollment reports.

<sup>10</sup> HealthLeaders InterStudy, Market Overview: Southern Connecticut (2012)

<sup>11</sup> Kaiser Family Foundation, State Health Facts (2011)

<sup>12</sup> Kaiser Family Foundation, State Health Facts (2011)

<sup>13</sup> Connecticut Association for Community Action, Meeting the Challenge of Poverty (2013)

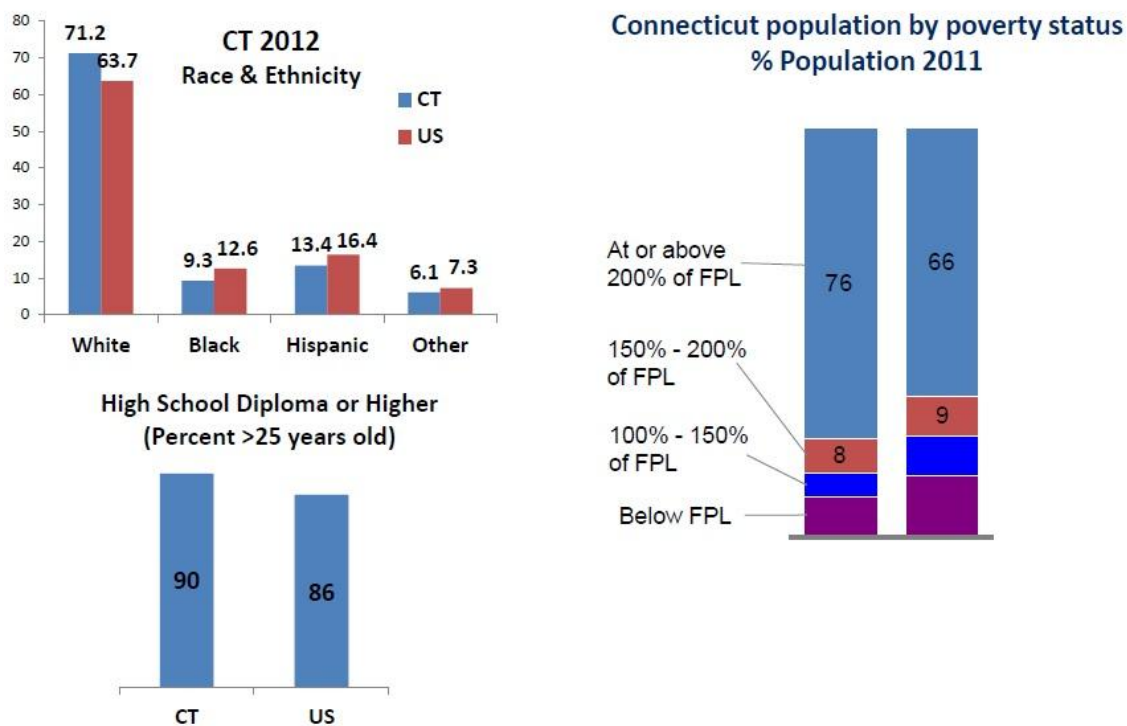
<sup>14</sup> U.S. Census Bureau, 2010 Census



The state's income disparity between high and low income wage earners, the second largest in the United States,<sup>15</sup> also produces health issues. Although Connecticut has the third highest median household income in the nation in 2011, approximately \$66,000, three major urban cities (Hartford, New Haven and Bridgeport) have median incomes that are approximately 50% lower.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup>

## EXHIBIT 5:

### Connecticut Population Demographics



<sup>15</sup>US Census Bureau, 2010 Census

<sup>16</sup>CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

<sup>17</sup>CBSNews.com, America's Richest Cities (2013)

<sup>18</sup>Connecticut Health Foundation, Community Health Data Scan Update, 2013: Focus on Race and Ethnicity Disparities, July 2013

## Income

Certainly, health disparities are not limited to racial and ethnic minority populations. We know that socioeconomic status (SES), meaning levels of educational and economic achievement, are correlated with health disparities as well. Indeed, residents with less than a twelfth grade education report that their health is poor to fair at twice the rate of those with at least a twelfth grade education.<sup>19</sup> Further, lower levels of SES may contribute to or worsen racial and ethnic health disparities, given minorities are more likely to have lower SES. Hispanics in Connecticut report poor to fair health at a rate of two and one half that of white, non-Hispanics, while Black, non-Hispanic residents report that their health is poor to fair at nearly twice the rate of whites.<sup>20</sup>

As elsewhere in the US, 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.<sup>21</sup> These individuals face more than increased risk for disease but also challenges to 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.”<sup>22</sup>

We must be aware of and address health disparities aggressively as we aim to improve the overall health and the consumer experience of care in Connecticut. Our Innovation Plan 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.

## 1.2 POPULATION HEALTH INDICATORS – HIGHLIGHTS

Healthy Connecticut 2020 is our state’s version of National Healthy People initiative. It provides a solid framework or roadmap for health promotion and disease prevention by setting goals and objectives to identify, reduce or eliminate most of the preventable diseases and avoidable health disparities during the current decade.

The state Department of Public Health (DPH) started the framework process by launching and putting together a comprehensive State Health Assessment. The Assessment describes the health status of Connecticut residents and identifies resources in Connecticut that can be mobilized to address health issues. Throughout the inception of the SIM and to date, our care

<sup>19</sup> Centers for Disease Control and Prevention, Connecticut BRFSS 2011.

<sup>20</sup> Ibid.

<sup>21</sup> CT Department of Public Health, 2009

<sup>22</sup> National Healthcare Disparities Report, Agency for Healthcare Research and Quality, Publication No. 13-0002, 2013.

delivery workgroup has worked closely with DPH to align SIM's values and objectives with that of the State Health Improvement Plan ("Healthy Connecticut 2020").

The state DPH aligns most of its health measures and indicators with that of the National Healthy People Initiative to promote consistency and comparability. The table below highlights some of those measures. (See Appendix C)

#### EXHIBIT 6: Population Health Measures and Indicators

POPULATION HEALTH MEASURES AND INDICATORS	National Rate	CT Rate	White Non- Hispanic	Black, Non- Hispanic	Hispanic	Other
<i>Chronic Disease and Prevention Measure</i>						
% of adults > 18 yrs with diagnosed diabetes		8.5% <sup>23</sup>				
% of adult smokers who attempted to quit smoking <sup>24</sup>	64.7%	68%	65.3%	74.6%	79.0%	69.2%
% of current smokers among adults <sup>19</sup>	21.2%	17.1%	16.8%	20.8%	17.1%	16.4%
% of obesity among adults <sup>19</sup>	27.8%	24.5%	23.0%	32.8%	32.6%	16.4%
Median intake of fruits and vegetables (5 times per day) by adults <sup>19</sup>	2.9	3.1	3.3	2.7	2.7	2.9
% of adults who participated in enough aerobic and muscle strengthening exercise to meet recommended guidelines <sup>19</sup>	20.9%	21.8%	22.4%	21.9%	17.0%	21.7%
% of adults with current asthma - 2010 <sup>20</sup>	8.6%	9.2%	8.5%	15.4%	11.5%	--
% of children with current asthma - 2009	11.3% <sup>20</sup>	13.1% <sup>25</sup>	10.6% <sup>22</sup>	14.8% <sup>22</sup>	16.9% <sup>22</sup>	12.2%
% adults reporting 14 or more unhealthy days physically or mentally in the last month <sup>19</sup>	8.2%	6.9%	6.1%	8.5%	11.7%	5.9%
% of children with dental decay <sup>26</sup>	--	--	33%	50%	50%	--
% children with untreated dental decay <sup>22</sup>	--	--	9%	18%	15%	--

<sup>23</sup> CDC BRFSS 2011.

<sup>24</sup> Data from CDC - BRFSS 2011 – supplied to SIM states.

<sup>25</sup> Connecticut School-based Asthma Surveillance Report 2010

<sup>26</sup> Connecticut DPH State Health Assessment: Preliminary Findings(2013) – internal citations omitted

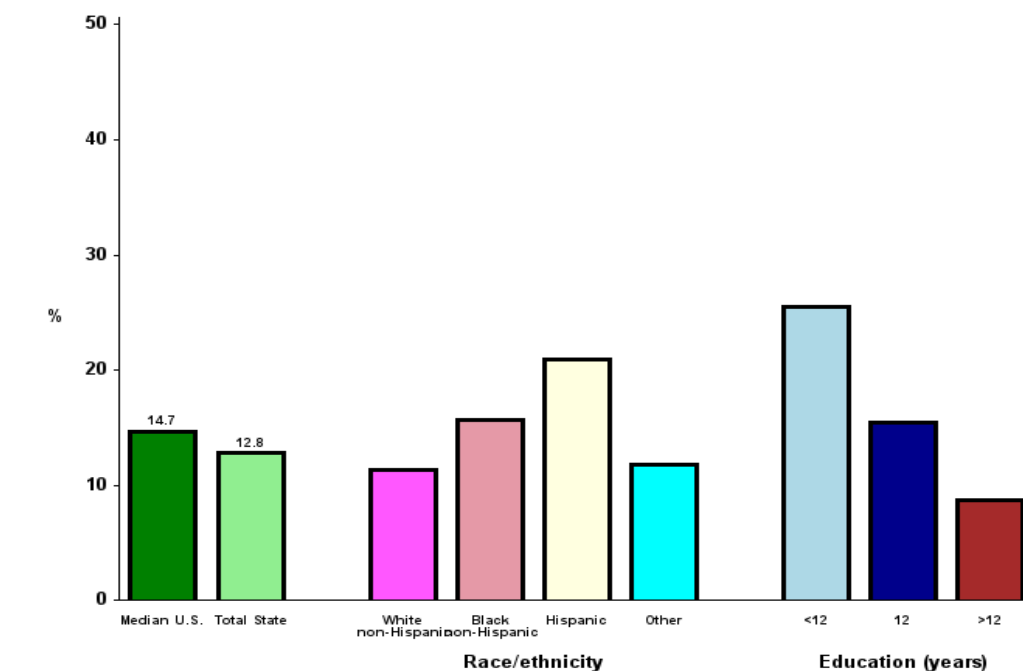
POPULATION HEALTH MEASURES AND INDICATORS	National Rate	CT Rate	White Non- Hispanic	Black, Non- Hispanic	Hispanic	Other
<b><i>Quality of Care Measures</i></b>						
% of adults with diabetes who reported receiving a foot exam in the previous year <sup>19</sup>	77.8%	80.8%	79.6%	90.2%	86.0%	--
% of adults with diabetes who reported receiving a dilated eye exam in the previous year <sup>19</sup>	72.3%	79.6%	81.4%	81.2%	--	90.4%
% of adults with diabetes who reported receiving 2 or more A1c tests in the previous year <sup>19</sup>	70.7%	72.9%	72.9%	82.0%	65.2%	--
Rate of hospitalizations due to falls per 100,000 population <sup>21</sup>	--		249.6	--	--	--
% of adults who are taking medicine for their HBP <sup>19</sup>	77.7%	79.3%	81.0%	84.7%	61.6%	66.9%
% adults between 50-75 who had appropriate screening for colorectal cancer	67.8% - median	74.8%	76.7%	65.3%	65.8%	66.1%
% adults reporting 14 or more unhealthy days physically or mentally in the last month <sup>19</sup>	8.2%	6.9%	6.1%	8.5%	11.7%	5.9%

Connecticut's performances on some of these key measures vary by race/ethnic group with Non-Hispanic African American and Hispanic residents faring worse than non-Hispanic White residents. Across these key measures, significant disparities exist between rural and urban centers.

Behavioral health measures also follow similar trends as the other key measures with respect to race and ethnicity. For example, while Connecticut as a whole fares better than other states on poor mental health days, one study from CDC reports that Hispanic residents and non-Hispanic African American residents experience poor mental and physical health days at rates twice and one and two-thirds the rate of white residents, respectively. Educational disparities result in an even greater variation in reports of unhealthy days.

## EXHIBIT 7: Population Health Indicator—Unhealthy Days

Figure. Percent of adults aged  $\geq 18$  years who reported having 14 or more unhealthy days physically and mentally in the past month, by selected characteristics, Connecticut BRFSS 2011



Source: Centers for Disease Control and Prevention

Perhaps the greatest contributor to health disparities is the lower level of healthcare 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 (ESI). Although public programs provide a safety net for Hispanics (30%) and African Americans (16%), a significant number of minorities remain self-insured or uninsured.<sup>27</sup>

### 1.3 QUALITY OF CARE AND RESOURCE EFFICIENCY

Connecticut can enhance its performance on at least three *system-wide* healthcare quality of care and resource efficiency measures: disease-specific quality process and outcome metrics, hospital admissions and readmissions, and health systems and payer performance.

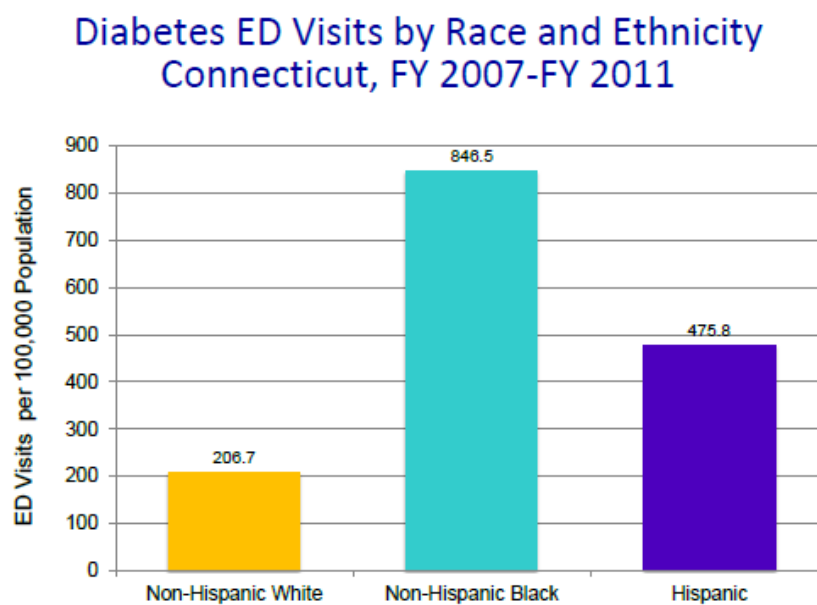
<sup>27</sup> We are grateful to the Connecticut Health Funders Collaborative for providing data that assisted us with this and other portions of our Innovation plan. The collaborative includes: the Aetna Foundation; the Connecticut Health Foundation; the Patrice and Catherine Weldon Donaghue Medical Research Foundation; the Foundation for Community Health; the Universal Health Care Foundation of Connecticut, Inc.; and the Children's Fund of Connecticut.



## Disease-specific quality process and outcome metrics

Over a four year period, non-Hispanic African American individuals with diabetes visited hospital emergency departments at over four times the rate that non-Hispanic whites did and nearly two times the rate that Hispanic residents did.

### EXHIBIT 8:



Source: Connecticut Department of Public Health, OCHA  
from Connecticut Hospital Association CHIME, Inc.  
Emergency Department Database.

Connecticut Department of Public Health  
[www.ct.gov/dph/SHIPcoalition](http://www.ct.gov/dph/SHIPcoalition)



Connecticut experiences significant variations in rates of ED use for adults and children across race/ethnic groups for diabetes and asthma related ED visits. For example, the most recent public health data shows that there were 107.1 ED visits per 10,000 population (children) and 61.2 (adults).<sup>28</sup> Asthma-related ED visits soared from 80.2 to 107.1 per 10,000 population.<sup>29</sup>

Hispanics visited the ED for asthma at a higher rate than either non-Hispanic Black residents or Whites. Connecticut also underperforms among race/ethnic groups for diabetes and hypertension quality of measures, signaling the need for vast improvements.

Racial and ethnic disparities in quality of care such as those highlighted here 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

<sup>28</sup> Ibid.

<sup>29</sup> CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

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).<sup>30</sup>

## **Hospital readmissions**

Connecticut's overall readmission rate was less than the national average in 2010 (13.4% vs. 19.2% respectively).<sup>31</sup> Medicaid readmission rates, however, were significantly higher as compared to other states' Medicaid readmission rates. The total 30-day readmission rate for 2010 was 12.8% (on a total of 89,246 acute hospitalizations). The rate of readmissions for medical issues only 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%.

Readmissions are a major and unnecessary drain on the state's funds. Across Medicaid, hospital readmissions under 30 days cost the state \$92 million.<sup>32</sup> 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. Medicaid and Medicare readmission rates suggest significant opportunities for improvement.

Connecticut's success will be measured by the public health measures detailed above, metrics included in the common scorecard for primary care practices including care experience and health equity metrics, and readmission rates. These concrete measures will provide us with evidence of success and opportunities to continuously improve our performance.

## **Health Systems Performance**

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 metrics<sup>33</sup> – 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.

<sup>30</sup> Connecticut Health Funders Collaborative

<sup>31</sup> Connecticut DPH, Chart Book: Availability and Utilization of Health Care Services at Acute Care Hospitals and Federally Qualified Health Centers (2011)

<sup>32</sup> Office of the Governor, Connecticut Medicaid Hospital Readmissions (2013)

<sup>33</sup> CMS: Hospital Compare (2012)

## Payer Performance

Payers submit annually to the Connecticut Insurance Department (CID) reports on several measures of quality based on HEDIS® and CAHPS® measures. The current (CID) reporting requirements do not include reporting on measures of obesity, tobacco use or asthma, and only one measure related to diabetes is reported.<sup>34</sup> NCQA ranks Connecticut health plans using performance measures that include HEDIS® and CAHPS®. Performance varies by health plan and product indicating opportunities for growth.

### EXHIBIT 9: Population Health Indicator - By Payer

#### Eye Exams for People with Diabetes

The percentage of all members with diabetes (type II and I) who: (a) were enrolled on December 31, 2012; and (b) turned 18 through 75 years of age during 2012; and (c) were continuously enrolled during 2012; and (d) had either a retinal or dilated eye examination in 2012, or had a negative retinal or dilated eye examination in 2011.



### EXHIBIT 10: NCQA Health Plan Rankings 2013-2014

Health Plan	NCQA Ranking <sup>35</sup>
Aetna	59 (PPO,) 80 (HMO)
Anthem Blue Cross Blue Shield of Connecticut	29 (HMO) <sup>36</sup>
Cigna	72 (PPO), 137 (HMO)
ConnectiCare	46 (HMO) <sup>37</sup>

<sup>34</sup> 2013 Consumer Report Card on Health Insurance Carriers in Connecticut, Connecticut Insurance Department, available at [www.ct.gov/cid](http://www.ct.gov/cid).

<sup>35</sup> NCQA Health Insurance Plan Rankings 2013-2014, Summary Report, available at [www.ncqa.org](http://www.ncqa.org)

<sup>36</sup> No PPO ranking available.

Health Plan	NCQA Ranking <sup>35</sup>
Harvard Pilgrim <sup>38</sup>	1, 9 (HMOs), 4 (PPOs)
UnitedHealthcare	65 (HMO-Oxford), 116 (PPO), 131 (PPO, Oxford)

## 1.4 STANDARDS OF PRACTICE RELATED TO TRAUMA

An extensive and powerful body of research findings link childhood trauma or adverse childhood experiences (ACES) to long-term health and social consequences. The ACES Study<sup>39</sup> triggered a series of examinations by medical investigators of the importance and clear association between health behaviors and lifestyle factors and the leading causes of morbidity and mortality. In addition to linkages between ACES and poor physical and mental health, and chronic disease, they are also linked to lower educational achievement, lower economic status and impaired social success in adulthood.

As Connecticut deploys an evolving model of innovative health system improvements in pursuit of the triple aim, consideration of the effects of ACES on Connecticut health outcomes should be central to community health initiatives.

During the summer of 2013, the Department of Public Health, with funding from the Department of Social Services, completed the initial ACES CDC survey module of Connecticut residents. Among adults in Connecticut, 7.6% are estimated to have experienced at least 5 of 8 ACES during childhood, affecting 200,000 adult residents. Compared to no ACES, adults with 3-8 ACES in Connecticut are 2.8 times more likely to smoke; 2.3 times more likely to report poor mental health; and 2.0 times more likely to report poor general health.

While there is much to learn about the prevalence of ACES in Connecticut and their relationship to adult chronic illness and disease, the trauma-informed practice networks developed throughout Connecticut can serve to help reduce further trauma and increase resilience.

## 1.5 CONSUMER 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 to improve consumer care

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<sup>37</sup> Ibid.

<sup>38</sup> Harvard Pilgrim is in the process of entering the Connecticut market.

<sup>39</sup> Felitti, Anda, et.al. 1998

experience. (See Appendix F.) 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. The most common issues and barriers identified through this process include:

### **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. Comparative analyses of cost and affordability concerns affect all populations, but minority populations even more so.

### **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 preventive care.

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.

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.<sup>40</sup> 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.<sup>41</sup>

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

<sup>40</sup> Ibid

<sup>41</sup> Ibid

barrier preventing access to clinic-based care. Lack of child care was reported as a major impediment to access for multiracial individuals as well.<sup>42</sup>

The Innovation Plan 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.

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 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.

### **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 and the ability to potentially prevent illness.

### **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.

### **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.

During the input, model feedback and plan syndication phases of our Innovation Plan, the Community Health Center Association of Connecticut, with funding from the Connecticut Health Foundation, conducted a campaign called, Txt2Be Heard, collecting input directly from

<sup>42</sup> Ibid

consumers on problems with the current Connecticut healthcare delivery system.<sup>43</sup> See the video here:

#### **EXHIBIT 11 – Txt 2b Heard Video Link - CHCACT**



### **Consumer Engagement**

A wide range of consumer organizations and groups work daily to advocate for and promote consumer healthcare interests at the community, local and state levels. A cadre of community health workers, patient navigators, health coaches, interpreters and translators work to educate consumers and ensure the delivery of community-based health services. Strong and vibrant community organizations also serve communities that the state traditionally struggles to reach. Networks of community and faith-based organizations fill current gaps in our health system. With the rollout of Connecticut's health insurance exchange, Access Health CT, a centralized network of hundreds of navigator and assister community organizations works to facilitate enrollment in healthcare coverage. That network will continue to work on engaging communities in their healthcare and overall health.

Connecticut plans to capitalize on the community work of these organizations to develop the best possible team based approaches to healthcare in our primary care transformation model, to empower consumers, to deliver designated prevention support entities and to create health enhancement communities.

## **1.6 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.

<sup>43</sup> <http://www.youtube.com/watch?v=dEI16u4h6vk>.



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 spending on older adults and persons with disabilities; they were 49% vs. a 32% national average.<sup>44</sup>

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%).<sup>45</sup>

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%<sup>46</sup> and the expected enrollment growth rate is 0.9%, based on historical rates.<sup>47</sup>

Connecticut ranks fourth among states for the cost of employer-sponsored health insurance and eighth for the cost of individual coverage.<sup>48</sup> 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.<sup>49</sup> Commercial PMPM costs have been increasing at 9% annually.<sup>50</sup>

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 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.

<sup>44</sup> Kaiser Family Foundation, State Health Facts (2009)

<sup>45</sup> CT SIM Design Grant Application, Financial Analysis (2013)

<sup>46</sup> CT SIM Design Grant Application, Financial Analysis (2013)

<sup>47</sup> Kaiser Family Foundation, State Health Facts (2009)

<sup>48</sup> Kaiser Family Foundation, State Health Facts (2012 and 2010, respectively)

<sup>49</sup> 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)

<sup>50</sup> CT SIM Design Grant Application, Financial Analysis

## 1.7 CURRENT HEALTH INFORMATION TECHNOLOGY (HIT) LANDSCAPE

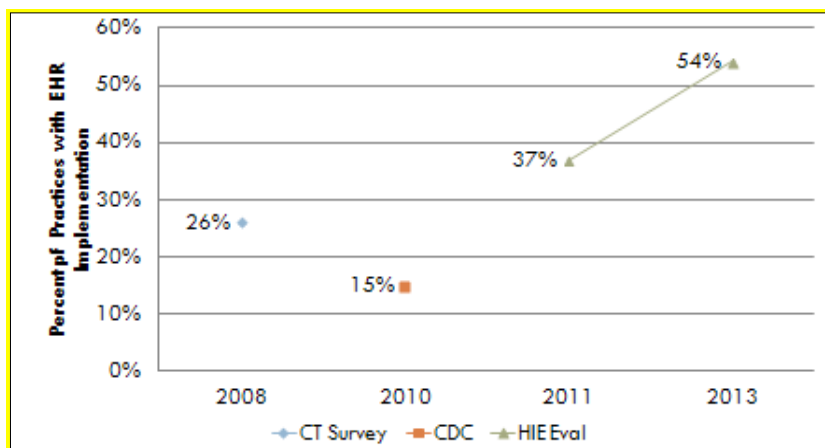
### Electronic Health Records and Health Information Exchange

The Health Information Technology for Economic and Clinical Health (HITECH) act, enacted as a part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides funds to small, privately-owned primary care practices, federally-qualified health centers (FQHCs), critical area access hospitals, and other community health centers to stimulate the adoption of health information technologies. These technologies include electronic health records (EHRs), e-prescribing systems, and laboratory information systems. Funding was made available to all states through multiple initiatives, such as the health information technology extension program, state health information exchange cooperative agreement program, and community college consortia to educate health information technology professionals program. C.1 future hit landscape

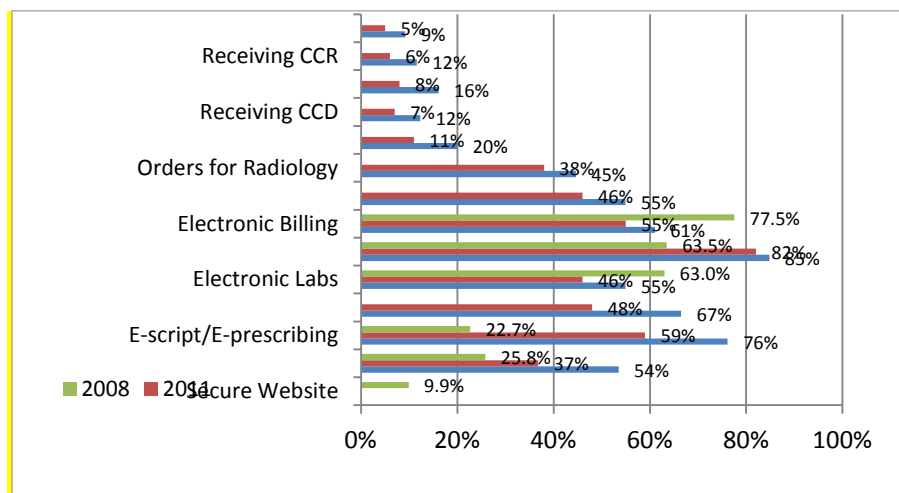
The Office of the National Coordinator (ONC) has invested approximately \$30 billion to implement the HITECH Act. The Health Information Technology Extension Program provides each state the funds to increase the EHR adoption rate among its physicians. Similarly, under the HIE program, states are expected to build infrastructure and mechanisms that support the exchange of health information among physicians' offices, hospitals, laboratories, pharmacies, registries, etc. Additionally, the state of Connecticut has established a functional health insurance marketplace and is a Medicaid expansion state. As of November 2013, the State of Connecticut received over \$278 million through the various HIT initiatives funded through the Department of Health and Human Services (HHS).

Currently, some 54% of the practicing physicians have adopted certified EHRs, a significant increase from 37% in 2011. Also, over 5,000 eligible professionals and all hospitals have received payments for adoption of EHRs and many have attested to achieving Meaningful Use Stage 1. Additionally, 96% of the pharmacies are enabled for receiving e-prescribing. However, lab interoperability is low, with only 40% of the physicians having the ability to order and view laboratory results electronically.

#### EXHIBIT 12: Change in EHR Adoption among Physicians between 2008 and 2013



### EXHIBIT 13: Current Use of IT Components



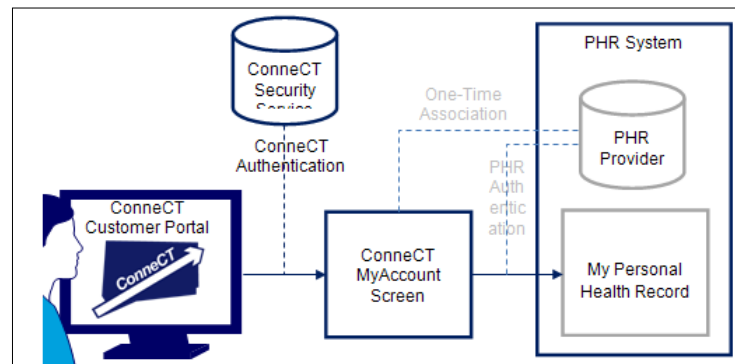
Many HIT initiatives have been evolving simultaneously and hence have not had the benefit of sequencing. Progress on HIE has been slow, particularly in systems interoperability that permit timely sharing of health information. This slow progress can be traced to misaligned funding streams that contributed to the lack of coordination among many HIT initiatives. Our state will see a substantial change in the exchange of health information over the next two years once providers have EHRs that are certified. The rate of EHR adoption is projected to be at 75% by the year 2015 based on current national trends.

Also, the Health Information Exchange of CT (HITE-CT), the Connecticut's designated HIE, is purchasing the Provider Directory and Enterprise Master Patient Index (EMPI) that are the building blocks for the operation of a statewide exchange. The Department of Public Health is working toward being able to accept electronic messages into its immunization registry and is exploring purchasing a syndromic surveillance system in the next year.

Additionally, the Department of Social Services (DSS) is working on many key HIT initiatives. First, the agency is enabling the use of Direct Messaging protocol to send messages between providers and/or systems to enhance care-coordination for an array of program services, e.g., dual-eligibles (Medicare/Medicaid), Patient Centered Medical Home (PCMH) model, long term post-acute care provider network) by ensuring exchange of documents, e.g. discharge summaries, assessments, and continuity of care. Second, DSS is developing an integrated Eligibility System which will provide a consumer interface with the health insurance marketplace by December 2015. Third, DSS is exploring the possibility of allowing Medicaid beneficiaries the option to connect to a Personal Health Record (PHR) using the same user name and password they establish to sign into the integrated eligibility portal. Fourth, DSS will use Quality Reporting Document Architecture (QRDA) Category III standards for receiving eClinical Quality Measures as one option in their EHR Incentive program. Lastly, DSS has applied for a planning and demonstration grant for Testing Experience and Functional Tools

(TEFT) in Community-Based Long Term Services and Supports that demonstrate the use of standards (content and transport) to improve the care coordination and service delivery in community-based long term care. Together these initiatives will operationalize the *no wrong door* concept as people access health care. These initiatives will also move us from single use to enterprise use technologies based on standards for both content and transport.

#### EXHIBIT 14: Use of HIT Components: TEFT Grant proposal



#### All Payer Claims Database (APCD)

APCDs are an essential tool for revealing differences in price and performance for state healthcare systems. Access Health CT is developing an APCD to collect, assess and report healthcare information that relates to safety, quality, equity, 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, identifying disparities along the continuum of care especially for ambulatory care sensitive conditions, enhancing access and reducing barriers to care
- Enable the aggregated analytics that can inform public policy and reform

The APCD was authorized under Public Act 12-166, to receive PHI (“protected health information”) data from various carriers via a state mandate, including public payer data like Medicaid and Medicare. This mandate further instructs use of the APCD “(1) to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions, (2) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services, researcher

or the Connecticut Health Insurance Exchange for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. Such disclosure shall be made in a manner to protect the confidentiality of health information, as defined in 45 CFR 160.103, and other information, as required by state and federal law.”

The APCD will be a large database from multiple payers, which can act as an anchor to create a centralized repository of other data sources – HIE, Master Provider Index, payer analytics/reports, provider analytics, care management and other intervention program metrics and analytics, and create other value added information like episode grouping, risk profile of patients, quality metrics derived from evidence based medicine, pharmacy utilization, etc.

APCD has three defining characteristics – historical claims data, connectivity keys based on members’ identification which links disparate data from variety of sources, and analytic capabilities. These three characteristics will be important for the success of the SIM project.

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 stakeholder 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 a plan to be operational by late summer 2014.

The main initial focus will be to create information for consumers using Connecticut’s health insurance marketplace, and other consumers as well. Anticipated functions include the following: (i) transparency tools that illustrate the cost of various services offered by physicians, hospitals, outpatient departments or independent labs/radiologic services, (ii) tools for selecting the best places to go for services within a geographic area, (iii) tools for finding the highest value providers, i.e., those that offer the lowest cost but highest quality medical services, (iv) tools for choosing the right insurance product for the family, (v) tools for reporting and visualizing how healthcare is disseminated within the state, highlighting geographic, race/ethnic (if available), payer (e.g., Medicaid versus commercial) variations, and lastly (vi) tools that enable researchers to investigate other topics to add to our growing body of healthcare knowledge.

Connecticut is in the process of formulating additional policies and procedures regarding data use, privacy and security issues. It is contemplated that APCD will be able to share data with various entities both private and public, as allowable under the strict guidelines of HIPAA regulations. Under the allowable guidelines we can use both de-identified and limited data sets for various research activities and cost transparency reporting, provided the member identification is never compromised. We also recognize that various types of research involving ‘treatments and coordination of care’ by non-public health state projects/agencies may require patient consents as a prerequisite for data use. We intend to formulate data use and privacy rules that will accommodate sharing PHI information on a case by case basis as may be necessary in the SIM project, subject to consumer consent consistent with the HIE data sharing principles.

All these assets are available to the SIM initiative for re-use. The technologies and systems are designed with the capability of scaling to enterprise requirements. Should the Healthcare Innovation Steering Committee decide to use any or all parts of HIT components being deployed, they will have a foundation upon which to build rather than being forced to procure, assemble and deploy these assets anew.

For the SIM initiative to be successful in harnessing the power of HIT there is work to be done on the developing Data-Use and Reciprocal Support Agreements (DURSA) across agencies and public-private enterprises. Some initial work was completed in 2009 by DSS (supported by a CMS transformation grant), that produced a 30-page DURSA that was signed by three FQHCs and one hospital. This agreement should be used as a starting point for any future work, as this approach presents the possibility of operationalizing data driven decision making sooner.

We will need to identify the best possible way to maintain informed consent with the goal being to design and implement a system that makes it easy for consumers to grant and revoke consent for sharing their health information across systems. One possible solution is a consent repository that can be queried by all participating providers to assess consumer consent status, potentially linked with the EMPI. There may be other solutions that will be evaluated, but having a clear and actionable informed consent process is critical to the success of any HIT solution aimed at improving the care experience.

The ongoing consumer survey that was initiated in 2011 to gauge Connecticut residents' perception and intent to use HIT provides us with some insight into the level of engagement of our residents. A sample of randomly selected household telephone numbers generated over 600 responses. Respondents were predominantly white (80%) and female (65%) with a mean age of 58. Most (80%) reported being in excellent or good health and 89% were satisfied with their primary care provider (PCP). One in four respondents reported familiarity with HIE, 50% reported familiarity with the EHRs, 21% reported familiarity with a personal health record (PHR), and 23% reported being interested in getting a PHR. It was interesting to note that 24% of respondents reported being interested in sharing their health information via an EHR and 33% reported being somewhat interested in sharing their health information. Almost 70% expressed support for a National HIE. Nearly two-third (63%) of respondents expressed support for an opt-in model which is different from the opt-out model that was adopted by HITE-CT. In response to questions about reasons that people were disinterested in use of HIT, the most commonly cited reasons for disinterest were related to privacy and security concerns.<sup>51</sup>

## 1.8 CURRENT PRIMARY CARE WORKFORCE

Connecticut does not have centralized, updated data on its primary care workforce. However, there are three recent estimates of primary care physicians (MDs) in Connecticut that include

<sup>51</sup> Tikoo, 2013, [http://cicats.uchc.edu/wp-content/uploads/2013/04/Frequency\\_ConsumerSurvey\\_201307011.pdf](http://cicats.uchc.edu/wp-content/uploads/2013/04/Frequency_ConsumerSurvey_201307011.pdf)

practitioners of family medicine, internal medicine or pediatrics. The University of Connecticut Health Center's Center for Public Health and Health Policy's (CPHHP) estimates that there are 2,585 primary care physicians currently practicing in Connecticut based on an analysis of DPH licensing data. The Office of the State Comptroller (OSC), working with Anthem, identified approximately 2,600 primary care physicians in active practice in Connecticut. The Robert Graham Center's estimate is 2,580 as of 2010. The Connecticut State Medical Society estimates capacity in excess of 3,000. It is not clear that Connecticut has enough primary care physicians and other primary care practitioners now or to meet the greater demand for team-based primary care in the future. Overall, findings drawn from recent data are mixed:

- Connecticut has more primary care practitioners per 100,000 people than the national average. There are more physicians and substantially more physician assistants (PAs), nurse practitioners (NPs) and other advanced practice registered nurses (APRNs), registered nurses (RNs) and medical assistants per person in Connecticut than most everywhere else in the nation; however, there is an uneven distribution of primary care physicians with five of the state's eight counties, the non-urban counties, have 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 dentists, nurse practitioners, nurses, pharmacists, physicians, physician assistants and social workers actively practicing;
- The license data indicates that, except for physician assistants, more than one out of five licensed primary care professional is at least 60 years old. The professional health workforce poorly represents the racial and ethnic composition of the state with minorities concentrated in lower skilled occupations, while more than 75 percent of practitioners in every health profession are white. Licensed nurses at all levels are 23.3 percent African American, and social workers are 18.6 percent African American. Persons in allied health professions demonstrate greater diversity but have great difficulty climbing the career ladder to the higher rungs of the allied health professions (e.g. occupational & physical therapy) and to the clinical health professions (e.g. dentistry, medicine, nursing, pharmacy, social work).

As elsewhere in the country, the number of allied health professionals has been growing, making these occupations among the more robust employment prospects in Connecticut. There has been a corresponding expansion of allied health professions' programs and training slots. 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. Advanced medical homes and integrated systems of care may impact the market demand for professionals in terms of both numbers and skills. For example, in Connecticut, according to national Pharmacy Workforce Project data, there has been an oversupply of pharmacists for the past 3-5 years. New pharmacists find it difficult to find full-time employment and many working in multiple part-time positions. But this apparent oversupply of pharmacists and their current difficulties in finding employment are tied to the



prevalence of pharmacists in traditional dispensing roles. The demand for pharmacists will likely increase and their training will likely be impacted once team-based Advanced Medical Homes (AMHs) and integrated systems of health care become common since the medication management services that they require call for pharmacists in direct patient care roles.

Two additional factors make it tricky to estimate the numbers of primary care physicians Connecticut will need. The first is that specialists, nurse practitioners and physician assistants are practicing as primary care clinicians and pharmacists are poised to play a greater role. The second is that primary care physicians are also gaining additional skills and may assume some responsibilities that are now borne by medical specialists, freeing the specialists to concentrate on carrying into practice advances in their fields

## 2. Foundational Strengths and Initiatives

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 integrate them into the new care delivery, consumer empowerment and community health improvement models.

For instance, efforts are already underway to:

- Transform primary care
- Establish community partnerships
- Activate and engage consumers
- Fight health disparities
- Promote transparency in utilization, cost, and quality, and
- Create an advanced workforce ready to meet today's healthcare challenges.

The following section will outline these foundational efforts. These and other initiatives are described further in Appendix D.

### 2.1 BUDDING EFFORTS TO TRANSFORM PRIMARY CARE

#### **Improving Access to Primary Care**

Connecticut was the first state in the nation to expand Medicaid coverage under the Affordable Care Act, signaling our readiness to be the lead on coverage reform. This expanded access to coverage created opportunities for promoting population health through access to primary care and extensive care coordination services under Medicaid. It also enabled the state to begin the expansion of primary care service capacity, well in advance of the full coverage expansions planned for January 1, 2014.

In October of 2013, Connecticut made further advances in healthcare coverage across population groups through the launch of our Health Insurance Exchange, Access Health CT. Since its creation in 2011, Access Health CT has been building awareness of the exchange and the benefits available to those who need help to obtain healthcare. Connecticut is one of a number of states that chose to implement its own health insurance exchange. Access Health CT has successfully created an online enrollment process, signing up 3,847 people for healthcare coverage in its first 15 days and over 65,000 individuals as of December 29, 2013.

Our success is due in part to a partnership of the Office of the Healthcare Advocate (OHA) and Access Health CT that created an extensive Navigator and In-Person Assistor (NIPA), and certified application counselor network of over 800 community organizations, community health centers and hospitals, which reaches diverse and underserved communities in thirty-

three languages in every corner of our state. While this cohesive network of community organizations is now focused on enrolling our 309,000 uninsured residents into Medicaid or private healthcare coverage, we will harness this network and shift its focus on building ongoing consumer engagement.

## **Movement toward Advanced Primary Care and Value Based Payment**

Connecticut is home to several medical home programs that focus on advanced primary care including person-centered care, population health, team-based care, and coordinated care. These efforts have gained considerable momentum since 2009 when the Office of the State Comptroller (OSC) required implementation of a Patient-Centered Medical Home program for the self-insured state employee health plan with Anthem and UnitedHealthcare. By 2010, over 45,000 employees were enrolled in the pilot, which was based on NCQA's medical home model.

In 2011, DSS established the Medicaid Person-Centered Medical Home program, which is based on the Joint Commission and NCQA medical home models. The Medicaid PCMH program includes metrics to evaluate performance on healthcare quality and consumer experience. This is the first medical home initiative in Connecticut that considers care experience as a determining factor in the payment of performance rewards. DSS also introduced a Glide Path program, in which providers were offered practice transformation support and enhanced fees to enable the achievement of medical home milestones.

Nearly all of the state's Federally Qualified Health Centers (FQHCs) participated in the Medicaid Glide Path program and over 75% are already recognized by either NCQA or the Joint Commission as medical homes. The remaining 25% are on track to achieve recognition in 2014. All FQHCs align with the whole-person-centered care and health equity tenets of the AMH model. They are also pressing forward with advanced population health capabilities. The Community Health Center Association of Connecticut was funded by the Health Resources and Services Administration (HRSA) in 2012 to establish a Health Center Controlled Network (HCCN) for the purpose of improving population health, reducing health disparities, and improving operational and clinical quality. The FQHCs have already completed full adoption of EHR at all sites. Currently, they are pursuing network-wide meaningful uses practices and population-based quality improvement strategies using popHealth. These are exceptional achievements that equip FQHCs to continue their leadership in the continued improvement of services provided to Connecticut's most vulnerable and health challenged populations.

Connecticut's commercial payers have also been increasingly active in promoting advanced primary care nationally and in Connecticut, typically using their own methods for determining providers' readiness to achieve quality targets and participate in pay for performance programs. Similarly, the Connecticut State Medical Society's IPA administered grant funding to provide a number of primary care practices with transformation support.

Medicaid and commercial payers in the state are actively implementing value-based payment initiatives that emphasize population-health based ACO and PCMH models. There are several commercial insurance carrier Pay for Performance (P4P) and ACO initiatives. For example,

Anthem Blue Cross Blue Shield of CT and CIGNA are negotiating and implementing provider contracts with P4P and Accountable Care initiatives. Six Connecticut organizations are currently participating in the Medicare Shared Savings Program (MSSP) ACOs which promote accountability and coordinated care among participating providers/ health systems and uses infrastructure investment to support the effort.

Connecticut also has two groups<sup>52</sup> actively participating in the CMMI Advance Payment ACO Model which is designed for physician-based and rural providers who voluntarily come together 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. Two more groups are also participating in the Bundled Payment Care Initiative (BPCI) in which they 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.

These efforts to encourage providers to take on more accountability for total cost of care have accelerated a trend toward provider integration into organizations that have the scale and capabilities to accept this responsibility.

## **Provider Integration**

Historically, Connecticut's physician market has been highly fragmented, with primary care in particular being comprised by a large proportion of small independent practices of one to three physicians. Over the past several years, Connecticut like the rest of the country has seen an increasing number of physicians employed by hospitals. (See "Use of Executive, Administrative and Legislative Policy Levers" for more on this issue.)

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), large medical groups and/or independent practice associations (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 the 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 50 to 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 important 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

<sup>52</sup> HealthLeaders InterStudy, Market Overview: Southern Connecticut (2012)

future, as well as for combining or aggregating performance across PCPs at sufficient level or scale to support outcomes-based measures of quality and shared savings payment arrangements. Notably, all of the payers are continuing to use open access rather than gate-keeper models in their payment reforms.

### **Integrated Care Demonstration for Medicare/Medicaid Eligibles**

One of the most significant care delivery and payment reform initiatives in the public sector is the Integrated Care Demonstration for Medicare/Medicaid Eligibles (MMEs) led by DSS. The development of this program was supported by a grant from CMMI. This program integrates long-term care, medical services, and behavioral health services and supports. It also promotes the system's transformation toward a person-centered model. The program has two primary features. The medical and behavioral health ASOs will expand and tailor their intensive care management (ICM) and care coordination capabilities so they can better meet the needs/preferences of Medicare/Medicaid Eligibles. 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, DSS will create new, multi-disciplinary provider arrangements called "Health Neighborhoods," which will be responsible for achieving quality targets while better managing total cost of care. Health Neighborhoods that succeed in reducing Medicare and Medicaid costs below projections will be rewarded with shared savings. Participating providers will be linked to their Health Neighborhoods through care coordination contracts and health information technology. This arrangement 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. DSS will use its experience with this program to inform its implementation of shared savings in the general Medicaid program.

### **Behavioral Health and Primary Care Integration and Coordination Initiatives**

Connecticut is committed to better integrating behavioral and physical health care in its efforts to transform care delivery. There has been considerable work done to set the stage for integration in the public sector with the elimination of capitated managed care and the implementation of Medicaid program wide efforts to better manage and coordinate care in the medical, behavioral health, and oral health arenas.

The Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) contract with a single administrative services organization to coordinate the management of services and supports for all Medicaid and State Children's Health Insurance Program (SCHIP) covered children and adults, regardless of the nature of the program (e.g., housing) or source of funds (e.g., child welfare). The Partnership offers intensive case management for complex cases, peer support, ASO payment withholds tied to the achievement of targets (e.g., reduction in hospital ED overcrowding); and performance rewards.

Similar administrative services organization structures have been established for medical and dental services. These direct administrative services organization arrangements make it easy for the agencies to require and oversee coordination across these major benefit areas. The administrative services organization structure also simplifies the design and implementation of care delivery and payment reforms, such as the PCMH program, all of which are achieved through the Medicaid state plan. Care coordination provided through these arrangements can be reduced and funds redirected to support care coordination within primary care and behavioral health service settings.

Connecticut's behavioral health agencies are offering various forms of integrated behavioral health and primary care services through no fewer than fourteen separate operations. FQHCs are delivering onsite primary care at DMHAS programs in at least seven distinct areas of the state. In most cases the primary care services are offered to all clients, and others only target populations, e.g., young adults or persons with specific medical diagnoses. In at least one area of the state, DMHAS is providing behavioral health services to clients of a medical care clinic, at the site of that clinic and to their clients. In at least two areas of the state DMHAS-funded programs are the providers of both behavioral health care and medical or dental care, but at this stage, the services are limited to specific sites or target populations. In at least two areas of the state, DMHAS providers have grants from the Substance Abuse and Mental Health Services Agency (SAMHSA) to conduct on-site medical screening to their behavioral health clients who are then triaged to medical providers who have formed a collaborative. Lastly, in at least two circumstances, hospital primary care providers provide advanced practice nurses who work out of the behavioral health sites. At these sites, all behavioral health clients can access on-site primary care, and are offered the opportunity to continue with primary care there even if they are eventually discharged from behavioral health services. At the executive level of the department, DMHAS is considering how to expand these models and in some cases is funding the primary and behavioral health care coordination role through "care facilitators" or "engagement specialists."

Collectively these efforts and other private provider led efforts to integrate primary care and behavioral health care will inform our practice transformation efforts in the area of primary care and behavioral health integration. Already these efforts have surfaced significant barriers to integrated care, such as regulations that make it challenging for behavioral health clinics to co-locate clinicians in primary care practice settings. These are among the policy barriers that we will be examining during the detailed design phase.

Finally, the Department of Mental Health and Addiction Services (DMHAS) is working to provide integrated behavioral and medical healthcare to individuals with severe and persistent mentally illness (SPMI) through the Medicaid health home initiative. This integrated model would provide a cost-effective, longitudinal "Behavioral Health Home" that will facilitate patients' access to an inter-disciplinary array of behavioral health, medical care, and community-based social services and supports.

## 2.2 STRIDES TO PARTNER WITH COMMUNITIES

Connecticut has a strong foundation of private and public entities working in communities to improve health.<sup>53</sup> The Community-Based Care Transition Programs (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. With a \$2,500,000 federal Community Transformation Grant, the state is creating community-level initiatives in rural areas to reduce the incidence of obesity, smoking and poor mental health days.

Several organizations in Connecticut are convening and engaging those working in local communities to strengthen their effectiveness. The Southwestern Area Health Education Center (AHEC) currently facilitates a statewide Community Health Worker (CHW) Task Force, working within the health care system and in community health centers performing outreach related to substance misuse, HIV/AIDS, maternal and child health, housing, and other socioeconomic issue affecting health. The Connecticut Association of Directors of Health (CADH) is comprised of 74 local health departments and districts which it mobilizes and supports to strengthen their delivery of public health services and preventative care.

Our Innovation Plan aims to leverage the expertise and experience of these entities and initiatives, and build on the existing strengths of local public health infrastructure.

## 2.3 EMERGING EFFORTS TO ENGAGE CONSUMERS

Connecticut has made progress in activating consumers through educational efforts and incentives, electronic means, and value-based insurance design.

In 2011, Connecticut received up to \$10 million to implement the CMMI funded “Incentives for the Prevention of Chronic Disease in Medicaid Demonstration.” This smoking cessation program entitled Rewards to Quit focuses on education, monitoring smoking rates, and financial incentives for quitting. In collaboration with Yale University, the state is examining the role of incentives and varying levels of incentives in changing health behavior among Medicaid recipients. This work will inform the incentive strategy outlined in our Innovation Plan.

The Department of Public Health, in conjunction with the Community Health Network of Connecticut, also provides “Choices,” a set of culturally-sensitive nutrition education courses. In addition, 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 care.

<sup>53</sup> ACA Sec. 3502: Establishing Community Health teams to support the Patient Centered Medical Homes.



These initiatives are elevating cost and quality transparency as a priority, that figures centrally in our consumer empowerment strategy. With the APCD in place, Access Health CT will launch a consumer portal to help inform consumers with respect to their choice of healthcare provider or setting, and cross-provider cost comparisons on the health insurance exchange. Access Health CT will also establish relationships with third-party consumer engagement vendors, e.g., Castlight, Truven Health Analytics to help it better engage consumers.

## **Value Based Insurance Design and the Connecticut Health Enhancement Program**

The State of Connecticut Employee Health Plan implemented value-based insurance design (VBID) as an integral part of its 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. It has had a significant positive impact on cost trends and the use of screening and preventive services.

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. Medical decisions continue to be made by the consumer 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:
  - a. Diabetes, both Type 1 and 2
  - b. Asthma and COPD
  - c. Heart failure/heart disease
  - d. Hyperlipidemia
  - e. Hypertension
  - f. 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.

## **2.5 THE WILL TO ELIMINATE HEALTH DISPARITIES**

The health equity stakeholder community in the state is coalescing, and consolidating efforts to create public and political will to eliminate health disparities. 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.

The state's investments in this area includes the Commission on Health Equity, which was established by legislative mandate to affect legislation to improve the health outcomes of residents based on race, ethnicity, gender and linguistic ability, and the Bioscience Connecticut Health Disparities Institute, which was established by legislative mandate to enhance research and the delivery of care to minority and underserved populations.

Connecticut-based organizations have been making strides in this area. The Connecticut State Medical Society (CSMS) has done nationally recognized work to promote health equity in

physician services. They have developed continuing medical education initiatives and materials particularly regarding health literacy and other efforts designed to develop best practices to reduce avoidable readmission associated with racial and ethics disparities. The increasing complexity and scope of patient problems routinely necessitates combined efforts of physicians from different disciplines, skilled nursing professionals, and other health care professionals. This has generated the need for primary care physicians to work in collaboration with other physicians and health care providers to reduce readmissions and eliminate diagnostic testing redundancies. CSMS continues to support research and test potential strategies and skill-sets to drive down healthcare inequities.

The Connecticut Multicultural Health Partnership, an independent membership organization was established to identify and address health disparities, with a focus on implementation of National Standards on Culturally and Linguistically Appropriate Services (CLAS).

The Saint Francis Center for Health Equity also addresses health disparities through community engagement, education, and research. One example of their engagement efforts include its partnership with the Curtis D. Robinson Men's Health Institute to hold the annual Town Hall Meeting on Health Disparities; the 2013 Town Hall focused on health equity and attracted more than 600 patient, provider and community advocates.<sup>54</sup>

Additionally, CT Health Foundation, Connecticut's largest independent health foundation, has made significant investments promoting cultural and linguistic competence, community-driven health promotion, and systemically improving the quality of the patient-provider encounter for patients of color. Now focused on health equity, the foundation is committed to embedding equity into the implementation of health reform by increasing the number of people of color who are enrolled in affordable insurance, able to navigate the system, and receive care that is affordable, comprehensive, and accountable.

The Connecticut Health Funders Collaborative is a coalition that 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, and the Children's Fund of Connecticut. The collaborative provided data that assisted the SIM team in the development of portions of our Innovation Plan specifically related to health disparities in Connecticut.

## **2.6 TRANSPARENT QUALITY AND COST DATA**

In addition to the APCD described in the previous section, major investments have been made in the service of making healthcare quality and cost data transparent and publicly available. For

<sup>54</sup> <http://www.healthjusticetownhall.org/watch-live/>

example, 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.

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. The Department of Mental health and Addiction Services (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. In the private sector, Connecticut's payers and hospitals use portals to offer consumers access to health information and other engagement tools.

## **2.7 HEALTHCARE WORKFORCE FOUNDATION**

With significant grant funding from the Health Resources and Services Administration (HRSA) and the Department of Veterans Affairs Connecticut has a number of innovative primary care medical residency programs which we can expand and upon which we can build. Included are training programs at Griffin Hospital, UConn, and Western Connecticut Health Network. These and other residency programs are discussed in the Workforce Development Section and summarized in Appendix E.



### III. OUR VISION FOR OUR FUTURE HEALTH SYSTEM

# Our Vision for the Future

*Establish a whole-person-centered health care system that improves community health and eliminates health inequities for all of Connecticut; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.*

## 1. State Goals and Transformation Diagram

The goals of our Innovation Plan align with our overall aims and with the soon to be released Connecticut's Healthy Connecticut 2020. A preliminary set of proposed performance measures are presented below. Final measures will be recommended by the Quality Council by mid-2014, so that the measurement and evaluation strategy can be fully implemented by March 2015.

Connecticut's goals for all the state's citizens include:

- **Better health:** Decrease the prevalence of disease targeting diabetes, asthma, hypertension, obesity, tobacco use, and falls.
- **Alleviating and eventually eliminating health disparities:** Close the gap between the highest and lowest achieving populations for each health and healthcare quality measure impacted by health inequities.
- **Improving health care quality and care experience** including the following:
  - Increase the proportion of providers meeting the comprehensive quality scorecard targets at the aggregate level
  - Improve preventative care (e.g. mammograms, colorectal cancer screenings); reduce gap between current and ideal performance by 10%.
  - Top-quintile performance among all states for key quality measures related to chronic illness management (e.g., asthma, diabetes, hypertension, COPD)
  - Improve statewide consumer experience scores (clinician/group CAHPS® and Medicare CAHPS® surveys) by 10% over baseline.
- **Reduction in the rate of growth of healthcare spending** per capita through the reduction of waste and inefficiencies, which will average more than a billion dollars per year in savings over the coming 10 years
  - Achieve savings through better, more appropriate and cost effective care: 10% reduction in avoidable readmissions; 10% reduction in hospitalizations for ambulatory care sensitive conditions; 10% reduction in ED admissions without hospitalization; and a 20% reduction in duplicative testing for selected conditions (e.g., those identified by Choosing Wisely®). Also, encourage the optimization of generic prescribing and use of lower-cost providers and/or settings of care of equal or greater quality.

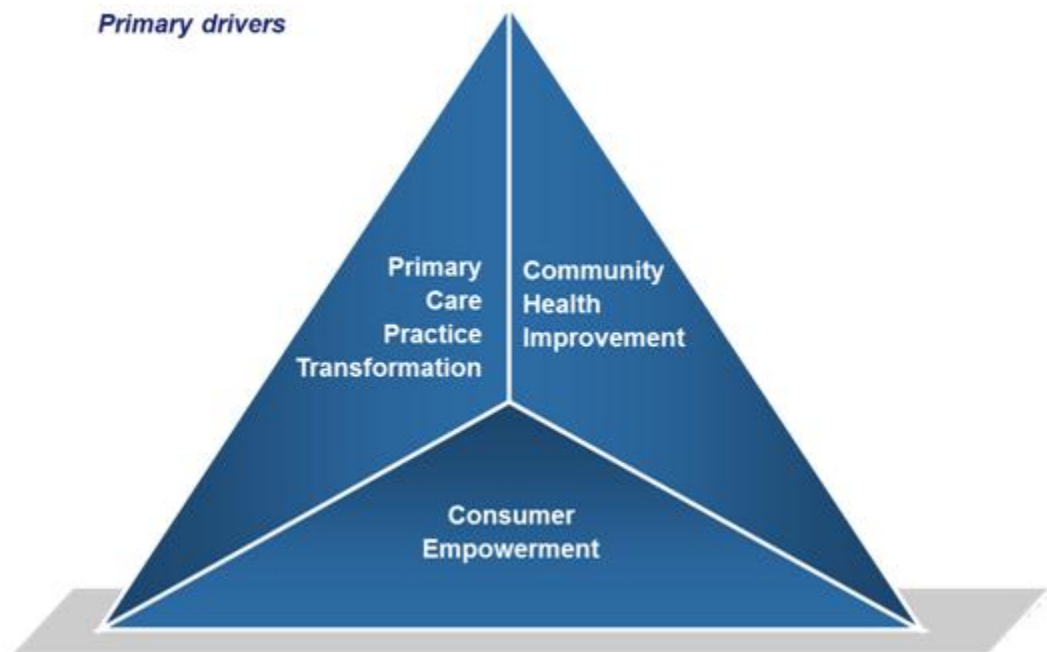
- Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, which corresponds to a 1-2% reduction in the rate of healthcare growth.

## Primary Drivers

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

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

**EXHIBIT 15: Primary Drivers Pyramid**



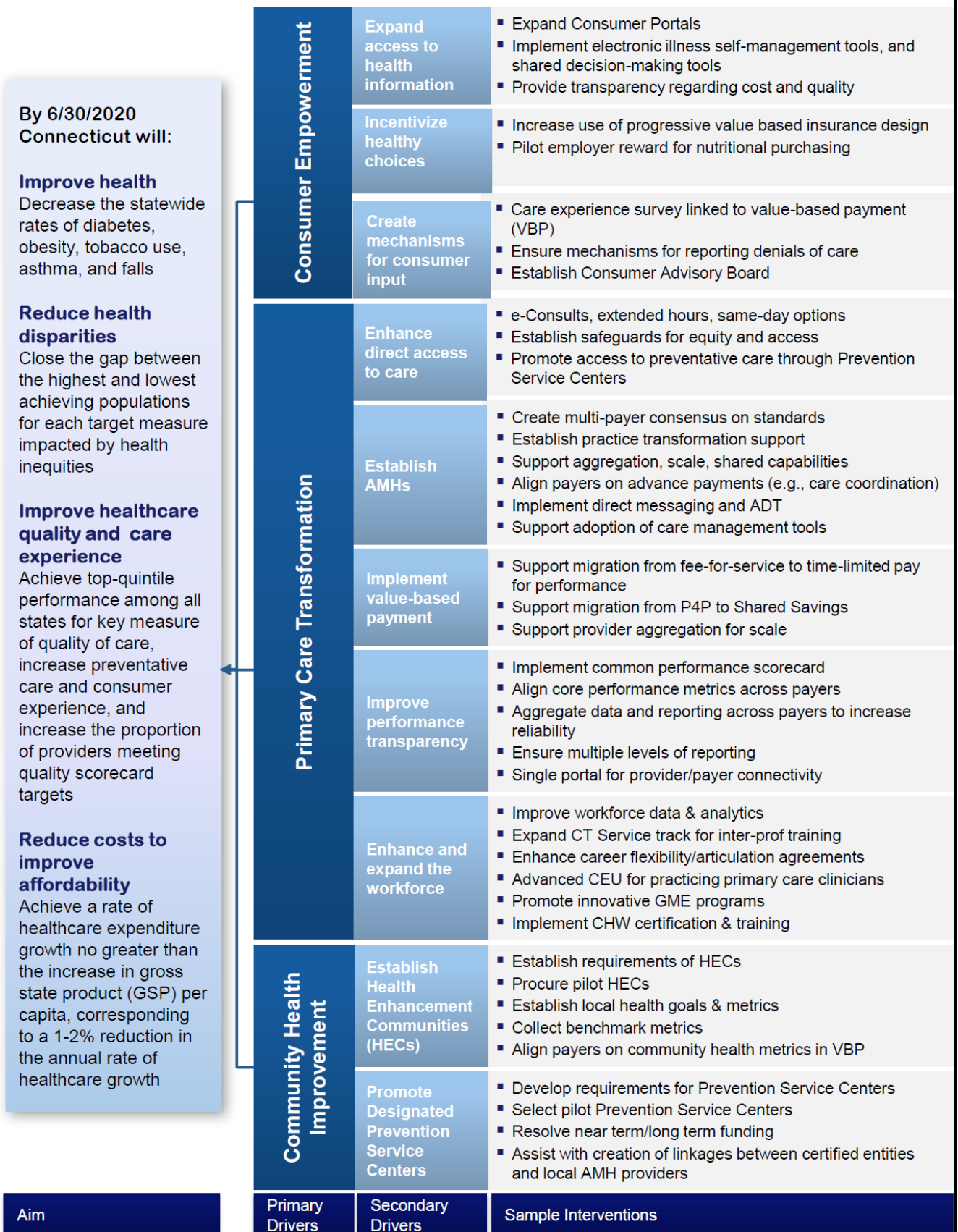


## **Driver Diagram**

We have produced a driver diagram that shows the relationship between our vision and aims and our three primary drivers—primary care transformation, community health improvement, and consumer empowerment. It also illustrates the role of secondary drivers and the specific interventions that will be undertaken by the State in the course of implementing our plan. The discussion that follows of our major reforms and enabling initiatives will provide a more complete understanding of the proposed activities and their inter-relationships. In addition, the driver diagram provides an important touchstone for our evaluation. The evaluation will provide us with information regarding our success in implementing the elements of our plan and the impact on the state’s overall performance, as well as insights into the relationship between proposed interventions and target outcomes.



## Connecticut State Innovation model: Project Driver Diagram



## 2. Primary Care Practice Transformation

### 2.1 CORE COMPONENTS

The Advanced Medical Home (AMH) is the cornerstone of Connecticut's care delivery reform model, complementing the medical home reforms that are already underway in practices and health systems throughout Connecticut. Under this model a primary care team-based practices coordinates the entirety of a person's care. This model has five core components, described below.

#### **Whole-Person Centered Care**

To be considered an AMH, a practice must meet standards that encompass the full set of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health. High-priorities include:

- Conducting whole-person assessments that identify consumer/family strengths and capacities, risk factors (e.g., history of trauma, housing instability, unemployment, oral health conditions), behavioral health and other co-occurring conditions (e.g., early childhood caries), and the ability of the patient to self-manage care. This will require the introduction of simple assessment tools that can be easily integrated into practice.
- Supporting consumers with person-centered care planning, care coordination, and clinical interventions based on the whole-person assessment.
- Identifying and assisting consumers who need to find community-based entities and services that can help provide whole-person-centered care

#### **Enhanced Access**

Lack of access is a barrier that prevents some consumers from participating in their healthcare. Consumers report difficulty making appointments with their providers after regular business hours, transportation issues, long wait times to get an appointment, and reliance on the Emergency Department for urgent care needs.

AMH standards will focus on reducing barriers to healthcare access to services, including preventive care through team-based care. The AMH will expand provider hours and offer remote consultations. In order to reach previously disparity 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 (One example is the expectation that, primary care practices have care coordinators who speak the languages prevalent among the patient population). High-priorities include:

- Creating non-visit based options such as text messaging, emails, phone calls, and video communication;

- Extending hours on evenings and weekends and same-day appointment options to their panel of patients, to ensure convenient, timely appointment availability.
- Enhancing access through telemedicine, with an initial focus on specialty care access, e.g., by establishing e-consultation methods through primary care providers can obtain non-visit based specialty consultation.
- Providing clear, easily accessible information on where consumers can go to meet their care needs (e.g., clearly communicated physician locations and hours).
- Taking 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), including use of qualified and trained interpreters and never minors.<sup>55</sup>
- Partnering with Recognized Prevention Service Centers 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.
- Engaging in stakeholder efforts to 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.

## **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., recommend that diabetics engage 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-priorities are:

<sup>55</sup> 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.

- Collecting and maintaining accurate and reliable demographic data, including race, ethnicity, sexual orientation, language preference and other demographic data, to monitor health quality and outcomes and to inform service delivery<sup>56</sup>
- 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 care coordination and other support services, such as Prevention Services Centers
- Maintaining a disease registry
- Combining de-identified data to facilitate analyses, reporting and intervention

### **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-priorities are:

- Developing and implementing a whole-person centered treatment plan in partnership with the patient (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)
- Including community health workers as team members to better serve populations.

### **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-priorities are:

- Applying clinical evidence to target preventive care and interventions toward those patients for whom the interventions will be most effective.

<sup>56</sup> Providers may not be the only source of race/ethnicity information. The APCD advisory committee is currently examining the methods that will most effectively provide for the acquisition of race/ethnicity data to support population health management and the development of health equity metrics.

- Leveraging EHR decision support, shared decision making tools, and provider quality and cost data to incorporate the most up-to-date evidence into clinical practice, to enable patient-directed care decisions.
- Incorporating clinical recommendations for different community sub-groups.

## 2.2 AMH STANDARDS

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 standards for AMH. 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 for the many providers who are not yet participating in an advanced care delivery model.

Medicaid will align its current PCMH standards with those established under the AMH program. Medicaid proposes both to retain its current recognition of PCMH practices that have achieved NCQA recognition and Joint Commission accreditation and additionally to recognize providers that have achieved AMH status. At a minimum, Medicaid will be seeking to include the following in the AMH standards:

- expand the scope of support for patients within medical homes to more fully include measures to identify and address social determinants of health, behavioral health, oral health;
- enable fuller adherence to the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (See Appendix B for CLAS Standards list);
- more fully incorporate data collection and analytics in support of a population health-based approach; and
- expand the disciplinary range of the care team, both within and affiliated with the medical home.

To the extent that the above are not included in the core AMH standard set, DSS may establish these as additional standards applicable to providers that serve Medicaid.

## **2.3 PROVIDERS ELIGIBLE TO QUALIFY AS AMH PROVIDERS**

The Primary Care Transformation Task Force will define the practice and provider types that will be permitted to receive AMH recognition. We anticipate that eligible practices and providers will include those led by internists, family physicians and pediatricians and APRN administered practices with necessary collaboration agreements in place. The same is true of School Based Health Centers, an essential means of access to primary care services for children in Connecticut.

The Primary Care Transformation Task Force will also consider the role of OBGYNs with respect to primary care. In Connecticut, the legislatively mandated Statewide Primary Care Access Authority (SPCAA), in its 2010 report to the General Assembly, defined primary care practitioners to include physicians with specialties in family practice, internal medicine, pediatrics, obstetrics and gynecology, homeopathic medicine and naturopathy, advance practice registered nurses, licensed nurse midwives, and physician assistants. The state recognizes that OBGYNs are not among the providers who qualify for primary care payment incentives under Medicaid or Medicare. Consideration of this issue will include Connecticut's commercial payers and Medicaid.

## **2.4 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., physicians, APRNs, physician assistants, and nurse or social work care coordinators). Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, 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 provider. It also acknowledges that the leadership of the team may change. The State also encourages members of the care team to collaborate across all types of providers – whether primary, acute, specialist, community, or social care – and leverage community health workers.

## **2.5 ATTRIBUTION OF CONSUMERS TO PROVIDERS**

Attribution is the process of linking consumers to the providers who will be accountable 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.

We expect that all payers will adopt a retrospective approach to attribution, attributing consumers to the provider who gave them most of their primary care during a defined reporting period. *Consumers are free to change (PCPs) at any time*, which means they can always choose the PCP they intend to use. However, if most of a consumer's care during the reporting period was delivered by a provider other than their chosen PCP, payers may attribute the member to the PCP who provided most of their primary care for the purpose of quality and cost accountability. As the consumer continues visits with her chosen PCP, the attribution (and accountability) will shift to the chosen PCP.

The State will support ongoing multi-payer alignment and refinement of the attribution strategy. Efforts will focus on which providers are eligible for attribution (e.g., all providers billing for primary care activities vs. only primary care providers) and accountability for behavioral health consumers who see both a behavioral health (BH) specialist and PCP (e.g., potentially through dual attribution). The State will seek to standardize necessary technical details such as when and how often payers report attributed 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.

## **2.6 HELPING PROVIDERS ACHIEVE AMH RECOGNITION**

Our primary focus for primary care transformation support is on those unaffiliated solo or small group primary care practices that are not already recognized by one of the national medical home accrediting or recognizing bodies. We recognize that meeting AMH standards can be daunting for practices, particularly for those that are unsure of how it will affect their practice, those that are reluctant to invest in an EHR, and those comprised of physicians who are nearing retirement. For these providers we have created the Glide Path Program to facilitate the process of becoming an AMH. This program builds upon a successful practice transformation process administered by Medicaid over the past several years.

The Glide Path Program will encourage 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 will be 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. The Glide Path Program duration and intensity will be flexible, recognizing that Connecticut's primary care practices are in very different stages in terms of the structures and processes that they have in place to AMH standards.

The Glide Path Program will hold practices accountable for achieving milestones for practice transformation as a condition for continuing to receive transformation support. More advanced practices and provider systems may take responsibility for a broader array of quality and performance metrics, including responsibility for total cost care via participation in a shared

savings program (see Value-Based Payment). AMH standards will increase in number and rigor as providers approach recognition (see Exhibit 18).

Providers who are already part of a group or network that participates in an advanced care delivery model may be provided the tools to assess their existing practice gaps and allowed to take advantage of practice transformation support through learning collaboratives. The State may also make Glide Path Program support available on a limited basis dependent on the availability of practice transformation resources. Providers who are already recognized by a national medical home accrediting body will be granted AMH status through a reciprocity arrangement; however, such providers may be required to meet additional Connecticut specific standards. This includes Connecticut's FQHCs providers, which have been on the leading edge of primary care advancement.

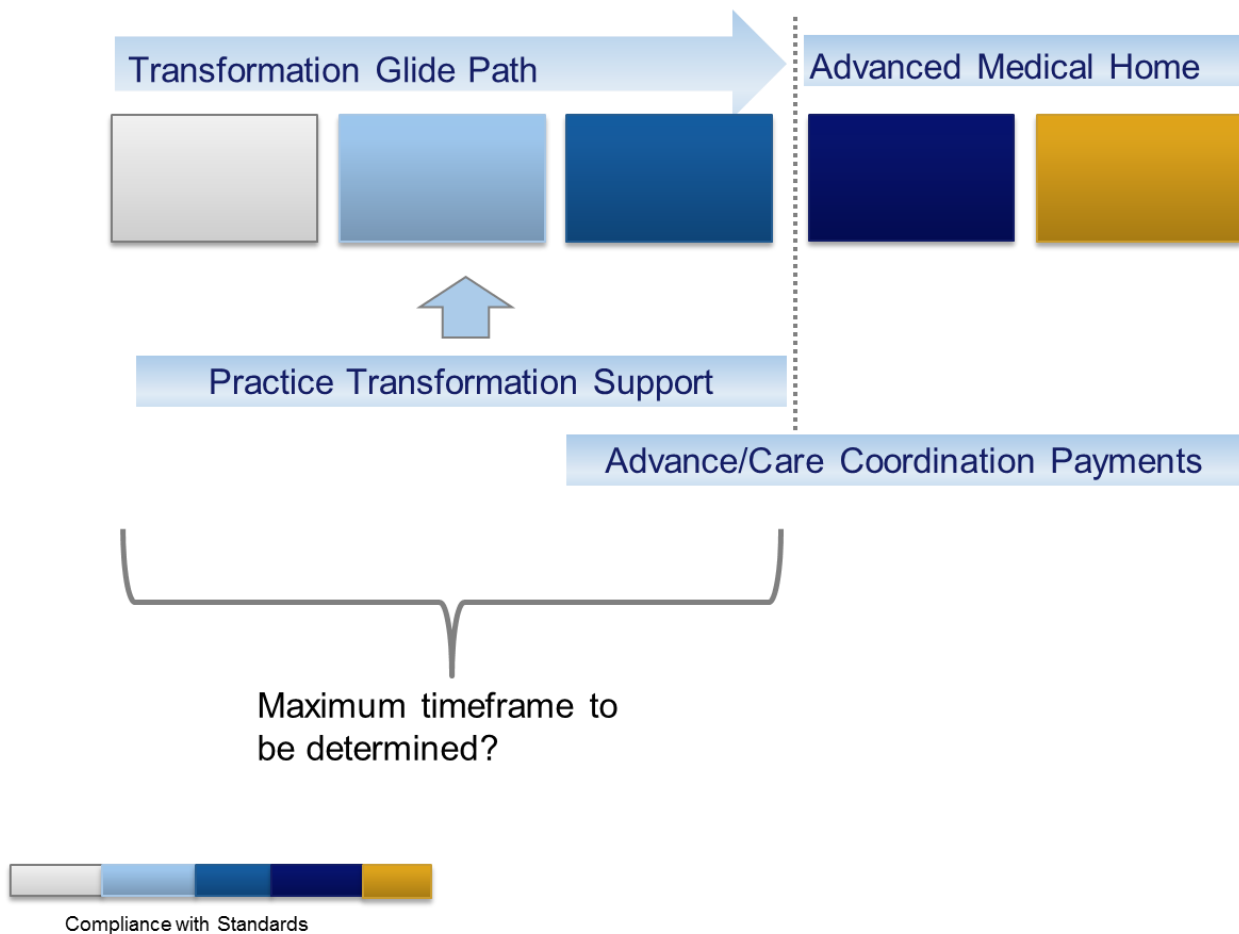
## **2.7 PAYMENTS TO SUPPORT ADVANCEMENTS IN PRACTICE AND CARE COORDINATION**

Many independent practices and also larger groups and systems lack the capital necessary to fund new capabilities and processes, or to weather the transition costs on 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 capabilities such as care coordination, which is essential to achieving improvements in care for individuals with complex care needs. Funding is typically implemented through up-front fees, paid either on a monthly (PMPM) or quarterly (PMPQ) basis or through enhancements to the fee or reimbursement schedule. Payments will be based on providers meeting mandatory pre-requisites (e.g. meaningful use of EHR) as well as milestones for practice transformation. The majority of commercial payers and Medicaid will provide advanced payments, beginning either during the Glide Path (once readiness is demonstrated) or once AMH recognition is achieved. Payers' willingness to provide advance payments or care coordination fees may be contingent on satisfactory progress against transformation milestones and demonstrated savings over time. In some cases, providers may elect to waive care coordination fees and practice transformation support in favor of higher levels of shared savings rewards.

We anticipate that FQHCs will qualify for advance payments from commercial payers, assuming they meet the same requirements as other AMH providers. FQHCs that have achieved PCMH recognition are not currently eligible to receive care coordination or advance payments from Medicaid. The State will review whether to continue this policy under SIM.



## EXHIBIT 17: Connecticut's Transformation Glide Path to AMH Status



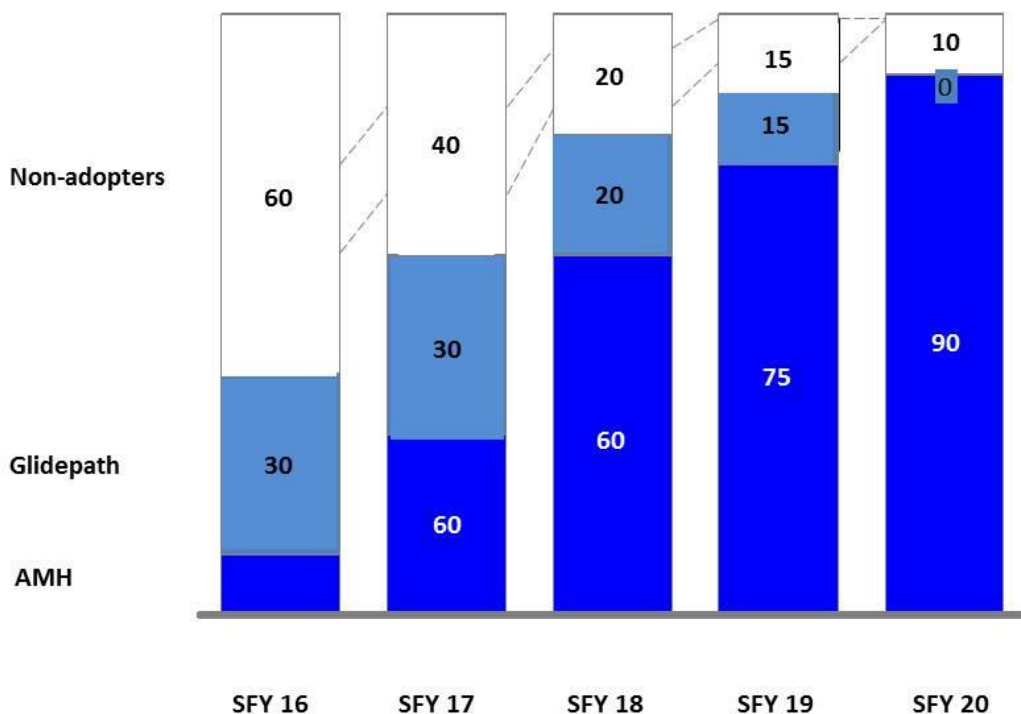
### 2.8 TRANSFORMATION PATH FOR PROVIDERS

As stated earlier, 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 18).

## EXHIBIT 18:

### Targeted Pace of Primary Care Practice Transformation

% of PCPs working toward Advanced Medical Home certification



## 2.9 PROVIDER AGGREGATION TO ACHIEVE SCALE AND CAPABILITIES

We anticipate that many independent PCPs will wish to affiliate with one another in order to gain the scale necessary to adopt efficiently 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 19). Their choice of a model will not affect their ability to participate in an SSP – only their performance against the standards and panel size will do that. In order to protect consumer choice and affordability, the State will monitor for signs of excessive market consolidation and consider legal and regulatory actions as appropriate.

## EXHIBIT 19: Clinical Integration Models to Attain Scale and Capabilities

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

### 2.10 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 Demonstration to Integrate Care for Medicare/Medicaid Enrollees will begin a year in advance of the implementation of AMH. 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.<sup>57</sup>

<sup>57</sup> Kaiser Family Foundation, State Health Facts (2009)

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' 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.

The Innovation Plan provides additional opportunities to collaborate with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) as we roll out the AMH model. The Connecticut Legislature passed Public Act 13-178, directing the DCF to create a comprehensive and integrated behavioral health plan for all Connecticut's children by October 2014. Once implemented, this plan will address critical systemic issues facing behavioral health services for children. These include access to quality and effective care; performance results and outcomes ensured through enhanced accountability measures; employment of prevention focused techniques with an emphasis on early identification and intervention; elimination of racial and ethnic outcome disparities by creating culturally competent networks of care; and the integration of school and community-based mental health services.

The timeframe for the implementation of the children's behavioral health plan is October 2014, nine-months in advance of AMH implementation. This will allow for effective collaboration between the DCF children's behavioral health plan and the AMH model to assure integration between primary and behavioral health care.

## CASE EXAMPLE

Accompanied by her mother, Olga, a six year old girl, is discharged from an emergency department after an asthma attack. Her mother's employer does not offer health insurance and Olga has no regular source of primary care. In Connecticut's current medical system, Olga is medically stabilized and provided her medications and follow-up instructions for outpatient care. Her mother's primary language is not English and she does not understand the care plan, which contains many unfamiliar terms and does not explain why and how conditions in the home might affect asthma. Olga is visibly anxious at the point of discharge, and her mother does not make a follow up appointment with a primary care physician (PCP).

Connecticut SIM envisions a different scenario for Olga. Olga's mother, with the help of a bilingual in-person assistor, enrolls in health coverage through Access Health CT. Olga's primary care provider is a recognized **Advanced Medical Home (AMH)**. The AMH ensures that a PCP is accountable for and coordinates the entirety of Olga's care. At the point of contact with her PCP, a comprehensive, **whole-person assessment** is completed to determine her barriers to health, including other health issues, her living situation, and other social-determinants of her health and underlying causes of her asthma. A care coordinator provides information to Olga and her family about asthma triggers, and because her care is **team-based**, makes an appointment for a mental health provider to address Olga's history of anxiety.

In collaboration with Olga and her family, the **care coordinator** will develop an action plan to meet their goals; including preparing a schedule for follow-up assessment phone calls and appointments. Also, with their permission they connect Olga and her family with a **Designated Prevention Service Center** within their community to conduct a comprehensive home assessment to identify possible asthma triggers. The home assessment reveals a mice infestation and the "designated entity" takes actions to eliminate it and all other identified triggers.

This proposed model promotes collaboration between primary care providers, community organizations and state/ local health agencies using fully functional **Health Information Technology**. The use of HIT provides access, and a constant feedback loop to ensure that each consumer receives an appropriate, holistic level of care that promotes prevention and wellness. HIT ensures that there is a timely and updated information flow about Olga's progress between the contracted Designated Entity and her primary care providers.

### 3. Community Health Improvement

Health is impacted by the communities in which people live. Connecticut's geography reflects a need for targeted innovations. For instance, 40% of black and 30% of Hispanic residents reside in just three large cities or Manufacturing Centers.<sup>58</sup> Health outcomes, such as rates of ED Non-urgent visits and percent of ED non-admits, correlate with the "Five Connecticuts:" wealthy, suburban, rural, urban periphery, and urban core.<sup>59</sup> Community resources can be better leveraged, engaged, and coalesced to work towards a common vision of improved health that addresses the unique needs of their community.

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 – preventing illness or injury, managing chronic illness and improving the health of consumers. Unfortunately, these programs 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 are evidence-based community health programs 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 vulnerable to funding cycles and thus 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 health and healthcare quality of Connecticut's residents, eliminating health disparities, and improving care experience. The State is proposing two community health improvement strategies. These strategies will support our efforts to advance primary care and empower consumers, while incorporating these reforms into an overarching strategy to improve the health of vulnerable communities.

- **Designated Prevention Service Centers:** Local centers of evidence based primary and secondary prevention services intended to serve as cost-effective resource to AMH providers, helping them to achieve their illness prevention and management goals.
- **Health Enhancement Communities (HECs):** Enterprising communities organized to facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities.

<sup>58</sup> Community Health Data Scan: Preliminary Results (2013)

<sup>59</sup> Ibid.

### 3.1 DESIGNATED PREVENTION SERVICE CENTERS

Connecticut proposes the creation of Prevention Service Centers that have been designated by the Program Management Office as meeting criteria for the provision of evidence-informed, culturally and linguistically appropriate prevention services. Prevention Service Centers may be new or existing local organizations, providers (e.g., FQHCs), non-profits or local health departments. Prevention Service Centers will initially focus on environmental quality issues in homes and promoting positive health behavior. Their primary purpose is to provide a single source of evidence-based, preventive services to local primary care practices that might otherwise lack the resources and infrastructure to provide these services.

Prevention Service Centers will foster alignment and collaboration between primary care providers, community-based services and State health agencies. They will supplement AMH and community interventions as the literature has shown that a single intervention often does not reduce an overall medical or behavioral burden or sustain preventive health behavior.<sup>60</sup> Their workforce will include the emerging community of certified community health workers envision as part of our healthcare workforce development strategy.

Prevention Service Centers also provide a special opportunity to implement the Institute of Medicine's (IOM) best practices in integrating primary care and public health.<sup>61</sup> The IOM recognizes that the degree of integration may vary and consequently offers several best practices to help primary care and public health providers decide on which community-based programs/activities to integrate.

#### **Selection of Initial Evidence-Based Services**

The identification of an initial service package was based in part on our Innovation Plan goals and also the target conditions for which AMH providers and HECs will be held accountable. We also considered the importance of linking clinical practices with population health strategies that are already established in Connecticut. With this in mind, the Department of Public Health, Department of Aging, Department of Social Service, stakeholders from the SIM Care Delivery workgroup and the SIM Steering Committee prioritized three community prevention programs that Prevention Service Centers will focus on during the SIM implementation phase. These evidence-based community-based programs are already being implemented in some regions in Connecticut and include:

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

<sup>60</sup> 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.

<sup>61</sup> IOM Report 2012: <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

- Falls Prevention Program

These programs were selected in part because of the recent comprehensive State Health Assessment<sup>62</sup> conducted by DPH. This assessment identified and ranked the leading causes of hospitalization in the state (e.g., diabetes, asthma, injuries). These conditions also correlate with the leading causes of healthcare costs in Connecticut and are target conditions of the Innovation Plan. All three programs are basic elements of the Center for Disease Control's (CDC's) framework.<sup>63</sup> The state also selected these programs because there is strong evidence of their effectiveness and return on investment (ROI) with respect to disease prevention and health promotion. The State also assessed the programs' ability to serve individuals or groups and to address or reduce health disparities. Finally, this framework aligns with the State's emerging CDC-supported Coordinated Chronic Disease Plan, which identifies priorities and measures for diabetes, asthma and injury prevention. The rationale for selecting each target condition and service is discussed in greater detail later in this section.

### **Proposed Prevention Service Center Criteria**

The proposed criteria for Prevention Service Centers will help assure that high quality, coordinated services are available to clients. Satisfying these criteria will earn an entity the "designated" status and listing in a portal accessible by primary care providers and consumers. The criteria will require at minimum that Prevention Service Centers be responsible for the delivery of a core set of evidence-based community interventions. They will be expected to meet the following requirements:

- Enter into formal understanding or agreement 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 collaborating primary care and other relevant providers and health agencies
- Include community health workers in the provision of services

<sup>62</sup> 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](http://www.ct.gov/dph/lib/dph/state_health_planning/ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf) Accessed August 19, 2013

<sup>63</sup> Chronic Disease Prevention and Health Promotion Domain:  
[http://www.astphnd.org/resource\\_files/477/477\\_resource\\_file3.pdf](http://www.astphnd.org/resource_files/477/477_resource_file3.pdf)

## **Relationship of Designated Prevention Service Centers and State Health Agencies**

The state is working to break down silos in its workforce by encouraging state and local health agencies to collaborate in their data collection, programs and community investments. State and local health agencies played a major role in the SIM planning phase and will do so again in the Prevention Service Center's establishment and specific evidenced-based population health program selections.

## **Quality Assurance and Reporting requirements**

Prevention Service Centers will deliver a "minimum package" of services of evidence-based interventions that have high potential to improve health outcomes, reduce health disparity and medical costs. During the implementation phase, the Program Management Office will lead a transparent planning process by engaging key state agency, community and provider groups to develop detailed standards and the process for designation. DPH and other involved state agencies will also provide technical assistance and best practices to organizations that are voluntarily seeking designation or have achieved designation.

## **Subcontracting by Prevention Service Centers**

As primary care practices become AMHs, the state expects the demand for Prevention Service Center services to grow. The state will meet this demand by allowing Prevention Service Centers to enter into subcontract arrangement with local partners in order to ensure an adequate supply of preventive services.

## **Strategy to engage community resources**

The Project Management Office will begin the process of educating and engaging providers, community based organizations (CBO), consumers and other stakeholders on the benefits of integrating AMHs and community resources during the detailed design phase. During the first 18 months of SIM implementation, the Project Management Office will:

- Initiate a state wide campaign to educate providers and AMHs, who are critical partners to a successful integration on the benefits of collaboration
- Begin a state wide scan using the Community Transformation Grant to identify existing infrastructure and community based entities that may be appropriate for the initial pilot implementation
- Propose legislation to speed up the CHW certification process to ensure that identified entities from the scan have a sufficient number of CHWs to meet the designation criteria
- Propose a platform that brings prospective Prevention Service Centers and primary care practices to the table to determine and agree to partnership terms that are fair to all parties



- Sets up and maintain a list of Prevention Service Centers that is accessible to AMHs, Prevention Service Centers, State health agencies and consumers.

## **Prevention Service Centers and Health Equity**

Prevention Service Centers will help address health equity through a targeted approach. The Project Management Office will give priority to placement of Prevention Service Centers in areas where health equity gaps are substantial and that may also be recognized as a Health Professional Shortage Areas (HPSA).

## **Financing Designated Prevention Service Centers**

The State is currently evaluating several financial options to ensure that our Prevention Service Center model is financially sustainable. During the initial pilot phase, the state will explore the possibility of secure start-up funding from Connecticut's health foundations or allocating a portion of the test grant funds. Beyond an initial one or two year start-up phase, the State anticipated that primary care providers will purchase such services as needed to achieve their quality objectives (e.g., reducing hospitalization rates for asthma). We do not intend to establish an exclusive market for Prevention Service Centers within any geographic area. Accordingly, the viability of a Prevention Service Center in the long run will depend on the value of the services that they provide to their primary care practice clients.

## **Rationale for the Proposed Prevention Service Center Programs**

### **Diabetes Prevention Program (DPP)**

Connecticut acknowledges that its population is getting older and becoming increasingly overweight and sedentary. An estimated 8.3% or 25.8 million people have diabetes in the United States compared to 163,000 people or 8.5% percent in Connecticut.<sup>64</sup> If this situation is ignored in Connecticut, diabetes may lead to disability, blindness, increased healthcare costs and increased mortality. To address this public health issue, Connecticut will use the SIM to leverage the State's 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. Type 2 diabetes accounts for about 90 to 95% of all adult cases. Its treatment protocol focuses on weight control, exercise, diet and medication.

<sup>64</sup> 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](http://www.ct.gov/dph/lib/dph/aids_and_chronic/chronic_disease/pdf/dpcp_plan_8_10_07.pdf) Accessed August 19, 2013

The DPP may help delay patients' becoming type 2 diabetics by 58%<sup>65</sup> and can reduce costs.<sup>66</sup> 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 Office of the State Comptroller 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, through the Prevention Service Center, SIM is potentially looking at policy changes that allow DPP to impact a larger population.

Literature shows that the burden of diabetes disproportionately affects the less educated, racial minorities and those regions with fewer resources. (See Current Connecticut Environment – Section 2) 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. Prevention Service Centers can improve the DPP's outcomes by using Health Information Technology (HIT) to connect closely to the AMHs and incorporate additional evidence-based services into the DPP. Recruitment and retention of multi-lingual leaders and community health workers will be a priority in order to better serve the Hispanic population and other vulnerable populations. Connecticut intends to address this diabetes related disparity by reducing the percent of low-income (<25k) adults with diabetes from 14.3% to 12.0% by 2020.<sup>67</sup>

### **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 residents who lack health insurance and hence depend on emergency departments for their medical care. Just as importantly, individuals may not receive 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. As described in Section 2, Hispanics and Non-Hispanic blacks had a high rate of asthma emergency department visit in Connecticut. According to a recently published study, 9.2% of adults and

<sup>65</sup> 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

<sup>66</sup> Robert E. Ratner, MD, FACE- AN UPDATE ON THE DIABETES PREVENTION PROGRAM: Endocr Pract. 2006 ; 12(Suppl 1): 20–24.

<sup>67</sup> Live healthy Connecticut : Connecticut's Coordinated Chronic Disease Prevention Plan. DPH, Hartford CT (DRAFT)

11.3% of children living in Connecticut have asthma.<sup>68</sup> In 2009, Connecticut spent over \$112 million for acute care management of asthma as a primary diagnosis. It also spent \$80.3 million on hospitalization charges and \$32.6 million on asthma-related emergency department (ED) visit charges in 2009.

The U.S Environmental Protection Agency encourages individuals and communities to participate in decisions about proposed activities 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.<sup>69</sup>

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 will encourage qualified entities operating in vulnerable communities to join in the SIM efforts of expanding the AIRS program’s accessibility. Successful implementation and collaboration between providers and Prevention Service Centers in this effort will be monitored and evaluated in an ongoing basis. The state proposes that a reduction of emergency department visit among Hispanic Connecticut residents for which asthma is the primary diagnosis from 170.5 per 10,000 to 162 per 10,000 by 2020.<sup>70</sup>

### **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.<sup>71</sup> The fact that the chances of falling and being seriously injured increases with age is well documented. Available data in the state shows that

<sup>68</sup> The Burden of Asthma in Connecticut – 2012 Surveillance Report:

[http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/3\\_fast\\_facts\\_about\\_asthma\\_in\\_ct\\_2012.pdf](http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/3_fast_facts_about_asthma_in_ct_2012.pdf)

<sup>69</sup> 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](http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/kims_final_published_airs_in_ct.pdf) Accessed August 20, 2013

<sup>70</sup> Live healthy Connecticut : Connecticut’s Coordinated Chronic Disease Prevention Plan. DPH, Hartford CT (DRAFT)

<sup>71</sup> 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](http://www.ct.gov/dph/lib/dph/state_health_planning/ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf) Accessed August 26, 2013

Non-Hispanic whites have the highest fall death rate (6.1/100,000), followed by non-Hispanic blacks (2.3/100,000) and Hispanics (1.2/100,000).<sup>72</sup> Data from 2009 show that Falls ranks highest in the number of unintentional injury death in Connecticut. One estimate shows that Connecticut spends \$119 million more every year on home or nursing home long-term care for older adults who sustain a fall-related injury.<sup>73</sup> 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 urgently addressed, the direct and indirect treatment costs in the United States will be an estimated \$54.9 billion annually in 2020.<sup>74</sup>

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.

Some additional action steps that may help in the reduction of hospitalizations and deaths due to falls include;

- Facilitating connections between clinical providers and community providers on ways to implement fall risk assessment as a routine part of healthcare visits and other services for older adults
- Identifying barriers to implementation of effective fall prevention interventions and strategies to address those barriers

While some factors that increase the risk of falls such as age and previous falls cannot be changed, Connecticut's evidence-based falls prevention program is determined to address and reduce the changeable risk factors. The state proposes that by 2020, it will reduce hospitalizations due to falls to no more than 245.0 per 100, 000 population.<sup>75</sup>

<sup>72</sup> Connecticut Injury Prevention and Control Plan, 2008-2012.

<sup>73</sup> 2006 analysis prepared for the Long Term Care Planning Committee regarding the costs of falls among older adults in Connecticut

<sup>74</sup> 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. *Connecticut Injury Prevention and Control Plan-2008-2012: State of Connecticut Department of Public Health*

<sup>75</sup> Connecticut Injury Prevention and Control Plan-2008-2012: State of Connecticut Department of Public Health

## **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 Prevention Service Centers. Projected cost savings and the innovative quality health experience will be due in part to the solid foundation provided by the SIM, but also from the effect of more AMHs participating in the achievement of our shared health goals. The areas that will be considered for enhancement of the basic package are obesity (promoting nutrition and exercise), tobacco cessation, and hypertension.

## **3.2 HEALTH ENHANCEMENT COMMUNITIES**

It is well understood that all pathways to better health do not travel through the health care system. Differences in healthcare explain only a portion of the disparities in health outcomes that are observed in Connecticut. Neighborhoods with more limited financial resources tend to have less access to resources that promote good health, such as safe neighborhoods, high quality foods, and well-paying jobs. To prevent avoidable illness and improve care for the sick, Connecticut must address the community health factors that impact residents in their homes, schools, worksites and neighborhoods. Our Innovation Plan acknowledges this critical truth, and has included the goal of improving community health in its overarching vision statement. To this end, our Innovation Plan makes a prioritized investment and commitment to expanding access to community prevention services that can improve health at the individual and population level.

## **Prevention and Public Health Leadership in Connecticut**

### **Department of Public Health**

In Connecticut, community health efforts are championed by the Department of Public Health (DPH) in collaboration with its sister agencies and numerous community based organizations. DPH efforts have included participation in numerous CDC initiatives, with highlights including:

- **Community Transformation Grants (CTGs):** DPH received a planning award to build capacity to support healthy lifestyles, targeting tobacco-free living, active living and healthy eating, quality clinical and other preventive services, healthy and safe physical environments, and social and emotional wellness.
- **Racial and Ethnic Approaches to Community Health (REACH):** Connecticut's REACH site supports community-based programs and culturally tailored interventions to eliminate health disparities in the areas of diabetes, cardiovascular disease, and mental health.
- **Action Communities for Health, Innovation, and Environmental change (ACHIEVE):** The ACHIEVE initiative is directed toward reducing tobacco use and exposure, promoting physical activity and healthy eating, improving access to quality preventive healthcare services, and eliminating health disparities. Three communities in Connecticut are participating in this initiative.

Through these efforts and numerous others, Connecticut has demonstrated success in the realm of prevention, including a nationally recognized community garden, an award winning walking/biking trail, creation of bicycle lanes, establishment of a Food Policy Council, start the school day with a walk initiative, comprehensive employee wellness initiatives, Clean Indoor Air Act laws, and smoking bans throughout the state in restaurants, bars, cafes, and workplaces. Of note, DPH is finalizing the Connecticut State Health Improvement Plan, entitled Healthy Connecticut 2020, which will provide a roadmap for improving health and health equity in Connecticut through the end of the decade.

### **Connecticut Hospitals**

Increasingly, Connecticut hospitals are playing a role in improving community health. The hospitals are providing services ranging from outreach and support services for cancer, diabetes, asthma and other chronic conditions, to healthy lifestyle education programs, to direct financial assistance and medical care for homeless individuals and migrant farm workers.

To inform this community engagement, hospitals are conducting Community Health Needs Assessments (CHNAs) in collaboration with local health departments, health centers, and other public health expert and community groups. The Connecticut Hospital Association (CHA) has supported individual hospital efforts by partnering with the Connecticut Association of Directors of Health, along with Connecticut health departments, districts and health centers, to develop a common process for conducting CHNAs, summarized in the 'Guidelines for Conducting a Community Health Needs Assessment.' Additionally, the CHA has developed hospital-specific community profile reports that provide health, demographic and hospital utilization data consolidated from a number of sources.

One example is the development of the 'Greater New Haven Community Index 2013' by the Yale-New Haven Hospital. This initiative has helped to increase understanding of the current status of the community in order to identify (1) priorities for future planning and funding; (2) existing strengths and assets on which to build upon; and (3) areas for further collaboration across organizations, institutions, and community groups.

### **HEC Initiative**

Building upon ongoing efforts by the public health and local communities, the SIM proposes a new initiative to create Health Enhancement Communities (HECs). The purpose of these newly created HECs will be to intensify and coordinate community resources to improve health in areas with the highest disease burden, worst indicators of socioeconomic status and pervasive and persistent health disparities.

The HECs will be collaborative partnerships—alliances among people and organizations from multiple sectors working together to improve conditions and outcomes related to health and well-being of entire communities. This model is well-established and variations of the model are being implemented with respect to community health interventions in numerous states, including Connecticut.

One example of an effective collaborative partnership is a health and wellness district jointly sponsored by Charter Oak Communities, City of Stamford and Stamford Hospital. The vision is not only to revitalize the economic health and well-being of Stamford's West Side residents but also to ensure a health and wellness destination that can improve the quality of life for the entire city. Areas of focus include expanding access to healthier food, fitness opportunities, and preventive health and medical care as well as job training and workforce development. Informed by a local CHNA and a collaborative strategic planning process, the initiative is well underway and has achieved a number of accomplishments, including:

- *Fairgate Community Health Center* providing acute, non-urgent primary health care services for low income, uninsured and underinsured members of the community.
- *Fairgate Farm* providing opportunities for community residents of all ages to work as urban farmers, cultivating fresh produce for local nutritional, obesity-reduction and healthy medicine programs.
- *Stamford Hospital's Obesity-Prevention Program, in partnership with Kids' Fitness and Nutrition Services (KIDS' FANS)* promoting smart eating, physical activity and healthy weight for children.
- *Fairgate, Westwood and Palmer Square* providing affordable, "green" residential communities designed to facilitate walking, biking and the use of public transportation.

A second example of a collaborative partnership in Connecticut is the ongoing implementation of the 2013 Greater Bridgeport Region Community Health Improvement Plan. This comprehensive regional health planning effort is being led by the Primary Care Action Group (PCAG)—local health departments, federally qualified health centers, state agencies, hospitals and numerous community and non-profit organizations serving the Greater Bridgeport area. This effort has resulted in two outcomes:

- A Community Health Assessment (CHA) that identified the health related needs and strengths of the Greater Bridgeport Region
- A Community Health Improvement Plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across the Greater Bridgeport Region

Informed by CHA's qualitative data from focus groups, key informant interviews and community forums as well as quantitative data from local, state and national indicators, the PCAG members and the community-at-large, selected four key health priorities the CHIP:

- Reducing the incidence, progression and burden of cardiovascular disease and diabetes.
- Reducing and preventing obesity by creating environments that promote healthy eating and active living.
- Increasing the understanding of mental health and substance abuse as public health issues in order to achieve equal access to prevention and treatment.
- Improving access to quality health care for all individuals.

Action plans are being developed for each of these areas by the community for implementation.

### **How is the HEC unique?**

The HEC initiative will build upon all of the community health initiatives previously described and others, particularly with respect to mobilizing existing partnerships and resources. However, the HEC initiative will be unique in a number of critical ways, including the—

- Leadership and implementation at the state-level, in collaboration with local health government and stakeholders.
- Coordination and alignment with all relevant state and local health initiatives and resources within HEC targeted communities.
- Intensity and multi-pronged nature of the interventions, which shall include policy, system-level and environmental interventions.
- Prioritized focus on vulnerable communities, including those with the greatest health disparities based on race, ethnicity and socioeconomic status.
- Integration with SIM's clinical initiatives, including use of common measures, financial incentives and shared accountability with providers.
- Collaboration with other state (Departments of Social Services, Mental Health and Addiction Services, Education, etc.) and non-State (foundations, health systems, faith community, etc.) partners.

The HEC initiative will be transformative, providing a sustainable, replicable platform to strengthen community health leadership, partnerships, capacity and skills to effectively promote health, reduce disease and address disparities.

### **HEC Leadership**

The Program Management Office will oversee the coordination for this initiative in collaboration with multiple health and human service agencies that will lend their expertise, resources and authorities to support this effort. The Department of Public Health will have a major leadership role, assisting design, implementation and evaluation of community interventions. Importantly, high quality and reliable local data are critical in this design, and each HEC will require dedicated epidemiologic and data support. DPH will support these data functions, including coordination with health and human services agencies regarding available data sources, ongoing review and analysis of existing data, and identification of opportunities to enhance data collection through new sources.

Notably, in order to enhance and better link community and clinical preventive services, AMHs will play a meaningful role in the HEC initiative as well. It is expected that any AMH in selected HECs will serve as a partner in addition to other stakeholder entities. To facilitate integration and coordination of effort, the common scorecard and value based payment system



incorporates community-wide population health measures common to the HEC and AMH initiatives. The measures are based on the entire community population, including those who may be attributed to healthcare providers participating in a Shared Savings Program.

## **HEC Areas of Focus**

Committed to prioritizing community needs and improving health, the state has used the findings from the State Health Assessment, and preliminary recommendations from the Healthy Connecticut 2020 and CDC supported Coordinated Chronic Disease Prevention and Health Promotion Plan to inform this effort.

Generally, the priorities of the HEC will reflect local health concerns and assets in the selected communities. However, as a new pilot initiative, the SIM proposes an initial set of focus areas, for which evidence-based interventions already exist as well as measures that will not only allow tracking and reporting of population health outcomes but also inform future expansion and direction of the program.

The CDC has collaborated with the CMMI to suggest three core topic areas, including associated measures, relating to tobacco use, obesity and diabetes care. “Second tier” focus areas and measures relate to community characteristics, health care factors and overall health system performance. Additionally, CDC has provided baseline data and state- and county-level estimates, using 2011 and 2012 BRFSS survey data.

Given these suggested topic areas and population-level measures, we propose that at a minimum, each HEC commits to evidence-based programs addressing tobacco use, nutrition, physical activity and diabetes care. Evidence based interventions for each of the priority areas that have been recommended by peer-reviewed or expert sources, such as the Guide to Community Preventive Services and Morbidity and Mortality Weekly Report (MMWR) will be encouraged as HEC strategies. The interventions must relate to policy, system-level and environmental actions that can improve community health. For example, HEC interventions might include:

- Policy interventions, such as new legislation to institute a smoking ban in public areas or create new financial incentives to reduce food desserts
- Systems-level interventions, such as automatic referrals to tobacco cessation services for identified smokers in HEC partner programs or facilitating partnerships between hospitals (and other worksites) and local farmers to expand farmer markets and Consumer Supported Agriculture programs
- Environmental interventions, such as monitoring compliance with new FDA restrictions of tobacco marketing to children or modernizing existing playgrounds to encourage greater use

## **Selection of HECs**

Although the HEC proposals can be expected to vary, at a minimum each HEC must:

- Include sponsorship by a local public-private partnership, including at least one local health department, within the target community;
- Comprise a contiguous geographic area defined either by zip codes or census tracts;
- Demonstrate poor health outcomes and economic disadvantage;
- Contain a resident population of not less than 10,000 but not greater than 80,000;
- A resident population, at least 75% of which is attributed to an AMH participating in a SSP, and
- Benefit from in-kind or financial support from an entity or entities separate from the state.

It is understood that high-risk communities may not have the resources to advocate effectively on their own behalf. The Project Management Office will proactively solicit participation and provide technical assistance for communities who need it.

Applications for the HEC initiative will be reviewed based on information submitted within the following proposed categories:

- Purpose: proposed areas of focus to improve health outcomes and reduce disparities, which, at a minimum, must address tobacco, obesity and diabetes.
- Community needs and assets: HEC health concerns, including health outcomes and disparities; community resources that would support HEC activity, including existing community health infrastructure, initiatives, coalitions, and funding sources.
- Core disease targets: measurable [1, 3 and 5-year] targets for improvement using supplied BRFSS data.
- Strategy: proposed evidence-based community interventions to improve health outcomes and reduce health disparities; how such interventions complement local clinically- and community-based interventions and avoid duplication of effort; how the partnership will ensure coordination and integration of social services, mental and behavioral health services, etc; and how the proposal will address socioeconomic determinants of health.
- Leadership: public-private partners, including specific roles, governance structure, and accountability.

Submitted applications, along with work plans outlining timelines, evaluation plans and budgetary information, will go through exhaustive reviews led by the Project Management Office using stringent criteria for grading and selection. The state recommends designation of 3 to 5 applications as pilot HECs, which will be operational by 2018. The final number of HECs will depend on the availability of funding at the time of the announcement.

## **Sustainability**

As a major policy undertaking, the state will support and approve a legislative framework that establishes the HEC. It will hold public forums within a specified timeline to increase awareness and solicit input from the public throughout this process. Of interest, this legislation is

anticipated to include at least two financial provisions to support the HEC, through establishment of the following:

- A permanent HEC reserve fund that will be invested and managed by the Project Management Office in cooperation with DPH, DSS and other state agencies. The state intends to monitor savings resulting from the HEC initiative and allocate a portion thereof to this reserve fund.
- Tax credits and other benefits to encourage providers and community coalitions to invest in their community.

Finally, small providers in pilot HECs struggling to meet benchmarks toward shared savings will receive priority in the practice transformation assistance.

### **Future considerations**

Over time, and informed by the evaluation of the pilot HECs, this initiative may evolve to target more community health needs beyond our Innovation Plan's present focus, to encompass more geographic areas, or to address other challenges. Overall, Connecticut's support for the HEC initiative is consistent with the federal aim of creating a Community Integrated Health System 3.0, by encouraging the integration of Connecticut's healthcare providers with community resources, value-based payments, and support for learning organizations that can rapidly deploy best practices.

## 4. 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. And in order to achieve community health improvement, consumers should be empowered to be engaged in broader efforts to improve the health of their communities.

In order for individuals to make the best healthcare decisions for themselves and their families, a true working partnership must be developed between the individual and 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 an 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, and limited methods for inter-visit communication. 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. (As noted earlier, in some counties of Connecticut, over 60 languages are spoken.)

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. However, many consumers are actively engaged at the community level in their healthcare through direct services from patient navigators, health coaches and community health workers, and community organizations that provide education and direct services. (See Current Healthcare Environment.) Leveraging the expertise of these individuals and organizations is a key to both primary care transformation and community health improvement.

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.

Consumers, employers, payers, participating providers, and the state will each play a role in executing a three-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**

#### **4.1 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 Innovation Plan.

##### **Promoting Consumer Engagement in the Planning and Implementation of SIM**

The SIM Project Management Office will formally engage the Consumer Advisory Board<sup>76</sup> to provide ongoing input into the design, implementation and future changes to the SIM program model. The recently reconstituted Consumer Advisory Board will provide direct input to the Steering Committee. At least two of its members will sit on the Steering Committee. Its members will either sit on or facilitate member participation on the various councils and task forces to ensure their voice is represented in multiple processes of the SIM. The Board will also help to identify potential issues and concerns and craft resolutions.

The Consumer Advisory Board will be the primary facilitator for further solicitation from and engagement with consumers on our model. Its members are deeply involved in a diverse group of community organizations. We anticipate that the Consumer Advisory Board will work with organizations and networks including those discussed in Section 2 of this document.

Finally, SIM will create additional mechanisms for consumers to raise concerns about the model, and about their healthcare delivery system. 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. Through our efforts to promote health equity, practices that are adhering to CLAS standards will have to ensure that they create conflict and grievance resolution processes that are culturally and linguistically appropriate to prevent and resolve conflicts.<sup>77</sup> Each Council or Task Force will provide for public comment at each meeting.

<sup>76</sup> Members of the Consumer Advisory Board are listed at [www.healthreform.ct.gov](http://www.healthreform.ct.gov).

<sup>77</sup> CLAS standard 14

## Measuring and Incentivizing Positive Care Experience

One method of capturing consumers' experience of the way their healthcare provider meets their needs is through care experience surveys. Providers note that they currently collect the Consumer Assessment of Health Plans Survey (CAHPS®) as a condition for NCQA accreditation. However, this information is not adequate to reliably assess consumer performance at the practice level, nor is the tool designed to make this assessment. Some payers note that NCQA recognition requires that practices undertake such surveys and some payers require that providers do care experience surveys as a condition for more advanced value based contracts (P4P, SSP). However, even though they may require the collection and use of such data, they do not factor the results into payment. The payers supported the concept of tying care experience to value based payment and noted this is a key element of the Triple Aim. However, they note that there are costs involved in doing so. They acknowledge that co-sourcing a statewide provider care experience survey, statistically valid at the level of the panel rather than the practice, could be the most cost-efficient approach and they are willing to explore it. They also note that there are technical challenges as it assumes one can reliably identify each practice's and physician's panel, which they note is more difficult to do in attribution-based payment environments. Finally, there would be costs associated with integrating such data into value-based payment contracts, although this was not identified as a significant barrier

The most important means to improving consumer experience is to measure experience and to tie measured experience to value-based payment. Connecticut intends to distinguish its application by becoming the first state to implement statewide consumer experience surveys into value based payment rewards. The result will be the widespread adoption of continuous quality improvement activities at the practice level that focus on the continuous improvement of patient experience

Connecticut payers have committed to examining cost effective ways that this can be accomplished. 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. One method that is under consideration is the co-sourcing of the survey vendor who would provide statistically valid care experience survey data at the level of the practice. The funding and costs that would be necessary to support a co-source vendor would be determined during the planning process.

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.

## 4.2 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. Our plan will increase transparency and access to information through the establishment of consumer portals, the promotion of decision-support tools, the leveraging of HIT to disseminate quality and cost data, and the development of consumer information curricula.

### **Consumer Portal**

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.

### **Decision Support Tools**

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. A collaborative of organizations, including providers, consumers and advocacy organizations in Connecticut is exploring opportunities to strategically deploy *Choosing Wisely*®.

### **Quality and Cost Transparency**

Selection of treatment settings and providers will be increasingly important as consumers become more sensitive to variations in quality, cost 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 hospital services and expanding to include services provided by specialists. Consumers will have access, for example, to consistent quality data measures for diabetes, obesity, tobacco use and asthma at the payer level so that they can compare and consider plan performance when making healthcare decisions.

## Consumer Curricula

Finally, we will develop curricula with consumers designed to educate consumers about their role in a more person-centered, information rich, and transparent healthcare system. Consumers, community organizations, providers, payers, and employers have specifically requested that SIM play a role in the development of educational materials, for wide use.

The consumer curricula will focus on:

- How to use decision-support tools, and portals to access information about healthcare needs, quality and cost (e.g., how to choose an effective doctor). The materials will also focus on how to make decisions using this information.
- How to participate in healthcare decision-making, e.g., how to report denials of care, how to advocate for conflict-resolution processes.
- How to prepare for a doctor's visit (e.g., asking appropriate questions about risk and benefits to treatment options, how to foster shared decision making).

These materials will be available in multiple languages and will prepare consumers to engage in a productive clinician-patient relationship which meets the consumer's personal goals, leverages their understanding of their own health and provides insight into how the healthcare system transformation affects them. In addition, our HIT initiatives lay important infrastructure for promoting quality and cost transparency, but educational efforts are essential in making sure consumers are aware of these tools, and are able to use them in meaningful ways. Strategies for disseminating the information will be developed, including considering ways to educate consumers at the point of care, e.g., taking advantage of the "waiting room opportunity."

## 4.3 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)**
- **Rewards for nutritional purchasing**

### 4.3.1 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.

### **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 the State of Connecticut, 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 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.

### **4.3.2 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 aim to support several pilots during the two years of our SIM initiative using systems for indexing overall nutritional quality.

As part of our vision for activating consumers in the area of nutritional purchasing, we aim to pilot the integration of a nutritional scoring system based on the overall nutritional value of the food 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. Pilots affecting SNAP populations will focus on areas where there are adequate high quality food options available.



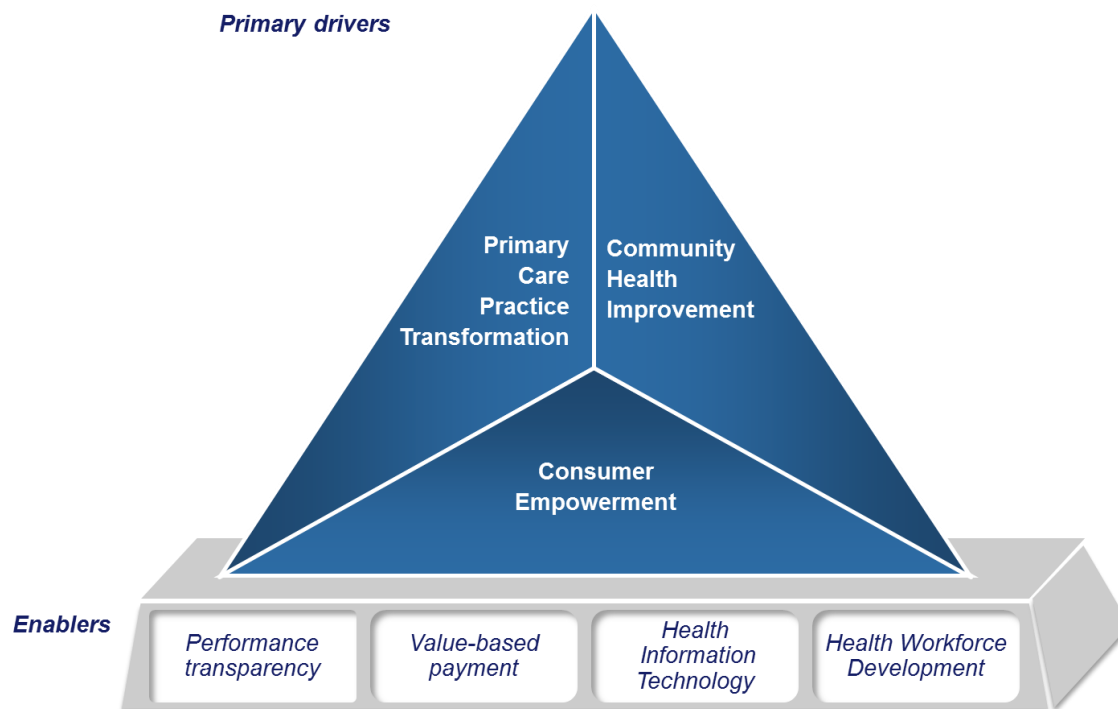
## IV. ENABLING INITIATIVES

# 1. Overview of 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.
- **Healthcare Workforce Development** will seek to ensure that we have the right number of people with the right skills and capabilities for the future.

**EXHIBIT 20: Primary Drivers Pyramid with Enabling Initiatives**



## 2. 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 empowering consumers and improving our health system.

**Consumers** need information about provider quality and cost to inform them when they are choosing their provider and health plan. Currently, when consumers choose between health plans they have only limited information regarding the extent of a provider network; 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 price, cost and quality of care, consumer experience, and/or efficiency. 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.

**Payers** need this information to establish pricing for new rewards. **Policy makers** and those accountable for the SIM need it to shape models, increase the specificity of our multi-payer design of new care delivery and payment models, and, in the long term, inform self-evaluation and continuous improvement.

Lastly, **providers and practices** require this level of transparency in order to inform referral decisions, identify disparities in health and health outcomes, and to focus their efforts for improving 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 and commitment to excel in patient care has been as much or more of a motivating factor in driving provider performance improvement efforts tied to pay-for-performance than were the economic incentives themselves.

The levers and priorities which will drive towards the effective production of comparative quality and cost information are described below.

### 2.1 CREATION OF A COMMON PERFORMANCE SCORECARD

Our strategy for achieving performance transparency involves a common provider performance scorecard, beginning with primary care. In Years One and Two, the payers will each produce a common scorecard organized around an agreed upon core metric set, based on the recommendations of the Quality Council. The common scorecard will include 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 complexity and costs for providers and also simplify the process of use these data for patient care and quality improvement. The feasibility of including oral health outcome measures will be considered,

looking to measures developed by the Dental Quality Alliance, especially those aimed at increasing services for high risk patients.

Employers are especially interested in the impact of care delivery and payment reforms on workforce health and productivity. There appears to be interest among large employers and suppliers in building upon the standard productivity measures that are in use today (see for example the national business group on health's website, [www.businessgrouphealth.org](http://www.businessgrouphealth.org), link to EMPAQ). We plan to work with the same small group of employers, consultants and suppliers that developed these initial standard metrics and the co-chair of the NCQA employer advisory board to undertake further work in this area.

## **2.2 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.

## **2.3 COMBINING DATA ACROSS PAYERS TO INCREASE RELIABILITY OF MEASURES**

Beginning in Year Three when the APCD is fully operational, we will combine data 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 intend to work toward consolidated reporting which will be more efficient for payers, and more practical for providers than accessing multiple payer reports. We will offer multiple reporting levels and analytic tools to inform a wide range of providers and healthcare decision makers. The scorecards will include methods for appropriate risk adjustment and exclusions, developed with input from providers, payers, and other stakeholders.

## **2.4 MULTIPLE LEVELS OF REPORTING TO INFORM DECISION MAKING**

As we gain greater insight into provider performance on these dimensions, information about the cost and quality of care will be reported at multiple levels to inform decision-making by consumers, providers, and payers at the point of care, as part of program development efforts, and at the point of choosing between health plans, whether on the Marketplace or in other venues, including state agency websites, community organization sites and on the All-Payer Claims Database site. This will include: comparative analysis of population segments; provider-to-provider comparisons; plan-to-plan comparisons; and state and regional summaries.

### 3. Value-Based Payment Strategy

All of the payers in Connecticut are implementing value-based payment strategies. In a value based payment program, 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. Providers must achieve pre-determined thresholds for quality of care in order to earn financial rewards. The state is proposing two value-based payment program options: 1) pay for performance and 2) shared savings.

Under a pay for performance program (P4P), providers receive financial rewards if they meet quality, utilization and care experience targets. Providers need about 500 patients with a particular payer to participate in pay for performance. Although pay for performance is an excellent way to help providers learn how to measure and improve their performance, it is less effective than a shared savings program (SSP) in rewarding continuous quality improvement across all areas of practice, promoting practice efficiency and the elimination of waste, and the control of total cost of care.

Under a SSP providers are also accountable for quality and care experience targets; however, they are also accountable for the total cost of care of their patients. Total cost of care includes the full set of healthcare costs associated with an of all the covered health services an individual receives within a stated period's healthcare delivery, including: professional fees, inpatient facility fees, outpatient facility fees, pharmacy costs and ancillary costs (e.g., lab tests, diagnostics). If providers manage total cost of care while achieving quality targets, they earn a share of the savings. Providers need a minimum of 5,000 patients with a particular payer to implement shared savings.

Our Innovation plan focuses on aligning all payers in the design and rollout of these pay for performance and shared savings programs so that providers can develop a plan for primary care practice transformation in a more uniform and predictable business environment. P4P and SSPs aim to increase the proportion of a practice's revenue that is tied to performance (e.g., quality, care experience, efficiency) and to reduce the proportion that is tied to fee for service volume. The Innovation Plan does not propose to eliminate fee-for-service, which will remain the foundation for our proposed payment reforms.

#### 3.1 PAY FOR PERFORMANCE PROGRAM

We propose pay for performance as a transitional program. Providers will receive assistance in developing new practice protocols, skills and tools to help them meet these targets and improve their performance over time. All commercial payers, including those that operate as administrators for self-funded plans, and Medicaid have agreed to support enhanced pay for performance for providers participating in the Glide Path Program, as well as AMH providers who do not have enough patients (< 5000) to participate in a SSP. Smaller providers may not meet these panel sizes, unless and until participating payers resolve how to combine or "aggregate" their enrollees for the purpose of performance 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 discrete measures in addition to the same measures of quality and consumer experience to which the shared savings programs will be tied.

### 3.2 SHARED SAVINGS FOR ADVANCED MEDICAL HOMES

The Shared Savings Program (SSP) is our primary payment reform under SIM. Under a SSP, providers are responsible for the overall cost of care for their patients. They are rewarded with a share of any savings if they meet quality targets. Payers project how much it should cost for a provider to serve their patients for one year. This is similar to establishing an annual budget. However, it is actually a virtual budget, because the provider will continue to be paid fee-for-service. The projected budget will be higher for patients with chronic illnesses, because these patients typically require more services. This process is called risk adjustment--the use of healthcare utilization data to group patients into different levels of risk that correspond to different projected budgets.

Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget. The budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care. The provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer, but only if the provider meets quality standards.<sup>78</sup>

Advanced Medical Homes will qualify for shared savings program participation if they have:

- Recognition under a set of standards for medical home
- Clinical integration (e.g., an integrated IT platform, a physician portal, physician alignment, nursing collaboration, and governance structure)
- Population health management capabilities, including for various sub-populations (e.g., predictive analytics, risk stratification, prevention, outcomes tracking, disease management, coordination with community programs, and concurrent review)
- Financial risk management capabilities(e.g., cost and utilization analytics/ benchmarking)
- Minimum patient panel of more than 5,000 covered individuals with each payer, until we implement methods for pooling covered individuals across providers (short term) and across payers (longer term)

<sup>78</sup> Some providers also choose an arrangement where they return funds to the payer if their costs exceed the projected budget. This is called a risk arrangement. Usually a provider in this kind of arrangement also has an opportunity to earn more shared savings. However, undertaking this kind of arrangement is a decision between payers and providers and is not a condition of participation in our model.



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

Shared savings offers 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, partnering with consumers to improve their health and achieving quality targets. This model also increases providers' accountability for high quality care that prevents the worsening of disease, readmissions, and redundant care (e.g., duplicate tests). Making providers responsible for the downstream impact of withholding needed care discourages them from doing it. In addition, we will apply advanced methods to identify under-service. In addition, as was discussed in the performance management section, providers will be rewarded based on both their quality and efficiency.

The shared savings program will include exclusions and adjustments to ensure that utilization by consumers with exceptional or unpredictable service needs does not unfairly affect providers' performance measures or discourage providers from seeing patients with more complex needs. These methods will help ensure that providers are held responsible only for those outcomes that they can manage effectively in their partnership with the patient. For example, shared savings programs typically exclude individuals who require organ transplants or who have experienced a significant traumatic injury. This will help lessen the chances that providers will try to improve their performance by avoiding or discharging more complex patients. Providers will need to fully understand the methods that are employed by the payers in order to improve the confidence that providers have in their measured performance.

Medicaid will align with other payers to the extent of implementing an upside only shared savings program for the general population. The Department will, based on the early experience of other payers with this approach, assess the need for protections for Medicaid beneficiaries and on this basis will determine when during the test grant period to implement an upside only shared savings program.

Prior to implementation of the Innovation Plan, DSS is proposing to limit its use of a shared savings approach in Medicaid to the activities proposed under the Demonstration to Integrate Care for Medicare-Medicaid Enrollees ("duals demonstration"). DSS is proposing to implement the duals demonstration at a point in time in 2014 to be determined by the pace of settling a Memorandum of Understanding with the Centers for Medicare and Medicaid Innovation (CMMI).

FQHCs that have achieved PCMH recognition are not currently eligible to receive performance payments of any kind under the Medicaid program. The State is reviewing whether FQHCs may be permitted to receive pay for performance or shared savings incentives under SIM during the detailed design phase of this initiative.

### **3.3 LINKING CARE EXPERIENCE TO VALUE BASED PAYMENT**

None of Connecticut's commercial payers measures consumers' care experience at the practice level, nationally or in Connecticut. In addition, none of these payers links performance on care experience measures to value-based payment. All of Connecticut's commercial payers recognize the importance of care experience as part of the value equation and they are committed to finding cost-efficient ways to measure practice level performance and to integrate care experience performance into their pay for performance and shares savings programs. Both Medicare and Medicaid are currently committing resources to the measurement of care experience for their respective populations. One of Connecticut's key planning objectives in the first six months of 2014 is to investigate methods for implementing this linkage, including the possibility of co-funding a vendor to assess care experience on behalf of all the payers, including Medicare and Medicaid. Under this arrangement, the vendor would select a statistically valid sample for the practice, without regard to payer. Payers may then factor practice wide performance into their determination of value based payment rewards. This is one example of "pooled" or "aggregated" performance measurement.

### **3.4 DATA COMBINATION TO MEASURE PROVIDER PERFORMANCE**

Currently, only the largest providers have patient panel sizes large enough (i.e., providers who see more than 5,000 consumers) to reliably project total cost of care for one or more payers. In addition, many small providers do not have enough patients to participate in a pay for performance program with more than one payer. In order for value based payment programs to gain adoption among smaller market share payers, it will be necessary to aggregate payers' data for performance measurement and reporting. Such aggregation will enable those small practices that wish to remain independent to do so, while providing a path for participation in advanced payment models. 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. Payers are currently preparing for the submission of data to the APCD, which will be the source of commercial data for aggregation.

### **3.5 ENSURING EQUITY AND ACCESS**

Medicare, Medicaid and to a lesser extent commercial payers have made substantial investments to counter the excessive utilization that is characteristic of fee-for-service payment systems. The focus of these activities, commonly referred to as program integrity audits, 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, we anticipate that focusing payment on value with quality performance requirements will lessen the likelihood of both under-service and over-service. Still, there is the possibility that some providers might seek savings through

under-service, just as the fee for service system encourages over-service. Under-service might include reducing necessary access, inappropriate patient selection, cost shifting, withholding appropriate care or inappropriate referral practices. Quality metrics will help guard against this for conditions that have metrics such as diabetes and asthma; however, a focus on quality metrics may not prevent systematic efforts to under-serve, particularly for uncommon conditions, or conditions outside the scope of such metrics.

Payers have offered a range of perspectives on this issue. Several payers acknowledged that as cost accountable payment reforms such as shared savings programs become the default payment mechanism, methods for monitoring under-service may be of increasing importance. Others note that NCQA health plan accreditation requires monitoring for under-service and over-service so additional monitoring maybe unnecessary. Yet it remains unclear whether this monitoring reaches more subtle levels of under-service. Finally, one payer reported that these NCQA requirements have been phased out in favor of a portfolio of requirements that proactively address quality, safety, continuity, coordination, and gaps in care.

We believe that it is essential to develop program integrity functions that focus on these issues. Such functions are beyond the scope of Quality Metrics Council, whose focus is on quality measurement and improvement. To this end, Connecticut proposes to establish an Equity and Access Council, comprised of consumer advocates, payer-based experts in audits and advanced analytics, providers, clinical experts and researchers from the state's academic health centers. The task of this Council will be to examine to what extent under-service is likely to occur under value based payment methods, recommend methods that will help guard against these risks, and urge payers to adopt such methods on or before implementation. Practitioners who participate in our new model and are determined to have achieved savings through systematic under-service, will not receive shared savings. Determination of under-service would be subject to appeal rights established in the practitioner's contracts and/or the savings distribution policies of the organization to which the practitioner belongs. DSS will participate in the Equity and Access Council and will not implement shared savings arrangements under the general Medicaid program until reasonable and necessary methods for monitoring under-service are in place.

Connecticut will continue to engage CMMI in this issue to provide for Medicare's participation. Connecticut will also pursue the participation of the National Quality Foundation (NQF) and NCQA. 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.

### **3.6 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.
- Practitioners who achieve savings through inappropriate methods, such as under-service, will not be eligible to receive shared savings.

### 3.7 EMPLOYER ENGAGEMENT

A number of Connecticut's self-funded employers are contracting with their carriers in a manner consistent with our proposed care delivery and payment reforms. Given that self-funded employers comprise 60 to 85% of the commercial carriers' business, engagement of these employers is of primary importance. The SIM Project Management Office will include staff dedicated to employer engagement. These staff will develop materials to make the business case to employers and provide employers with a health insurance procurement template that contains elements consistent with SIM goals. The staff will do this work in collaboration with the Office of the State Comptroller, the Connecticut Business Group on Health, the Northeast Business Group on Health, and the Connecticut Business and Industry Association.

## 4. Health Information Technology

Health Information Technology (HIT) has the potential to enable primary care transformation, community health improvement, and consumer empowerment, if positioned and leveraged in a meaningful way. Much has been written about the advantages of using HIT and Health Information Exchanges (HIEs) and their resulting benefits to improving quality of care, patient safety, and efficient care delivery. For instance, capabilities such as direct messaging between providers will promote provider communication across settings; payer and provider access to integrated clinical, payment claims, and population health data enables performance improvement and; consumers' ability to message their providers and care team members and more readily access information relevant to them results in a connected delivery of care that is consumer driven.

We hypothesize that better decisions about health and well-being are possible when consumers, payers and providers have easy access to integrated clinical, payment claims, and population health data, and focus on transforming data into actionable information and knowledge. Consequently, the uptake of these standards-based technologies will lead to improvements in Connecticut's health outcomes, consumer care experience, and reduced cost of care.

To achieve the full potential of the AMH transformation, Connecticut 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. Despite Connecticut payers and large providers already establishing significant capabilities, such as, advanced payer analytics and experience with medical home pilots, obstacles remain. Smaller providers face technical challenges and the state's Health Information Exchange (HIE) and APCD are in the early stages of development. Our Innovation Plan proposes the following strategies to advance CT's HIT infrastructure:

- **Enhance payer analytics**
- **Strengthen consumer-provider-payer connectivity**
- **Promote provider-consumer care management tools**
- **Expand provider-provider connectivity**

### 4.1 PAYER ANALYTICS

We will leverage, expand, and advance analytics to enable health risk stratification, the conduct of basic population analyses, and gaps and alerts. 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, such as, 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.

Although payer specific tools enable promising capabilities, these methods are limited in as much they offer a payer specific view. In parallel with these payer led efforts, the state will implement the APCD and begin the development of an integrated data warehouse or registries that can generate information, alerts, and reminders as needed by providers to improve their compliance with guideline-based care protocols, especially for chronic conditions like, asthma, diabetes, obesity, tobacco use, and sickle-cell, which are the focus of the Advanced Medical Home. Everyone engaged in the health care system, including payers, are expected to make relevant data available for population-based analytics, either directly or through the APCD. These analytics will help in the identification of consumer groups that can benefit from increased care coordination.

Currently, there are large differences in the ability of small versus large provider groups to produce and/or consume data in a way that impacts practice. Our proposed solution does not take away anyone's capability but provides enhanced ability to access data and information for both large and small providers. For example, providers can use the results/alerts generated from the integrated data warehouse or registries to identify occasions for care interventions, e.g., vaccination reminders and follow-up activities. Additionally, if resources permit, they can analyze their effectiveness with various sub-populations and use this information to support continuous quality improvement. While payer specific analytic capabilities will remain, the State's investment in integrated, cross-payer data analytic functionality will provide an additional resource to providers, researchers, and policy makers.

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; the State will complete the implementation of the APCD; and planning will be completed for the integrated data warehouse. In Stage Two (Years Two to Three), we will implement enhanced analytics, e.g., care gaps analyses, alert generation that identify high-priority consumers who need targeted intervention, implement analytics that identify health disparities, and begin development of the integrated data warehouse. 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 and implement aggregate analytics and cross-payer provider scorecards by means of the integrated data warehouse.

## 4.2 CONSUMER-PROVIDER-PAYER CONNECTIVITY

Our HIT strategy will work toward the development of a single provider portal to simplify connectivity to payer data and analytics, and to provide access to statewide data and analytics. 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 to support access to the payer-provider analytics described above.

Our plan also seeks to enhance consumer access to a consolidated personal health record and decision support information through a single portal. As of January 2014, most certified EHRs have to be able to provide direct messaging capabilities to maintain their certification. The increased uptake of personal health records coupled with the enhanced ability for patients to message their providers and care team members will increase access to healthcare information, services, and communication, resulting in a connected delivery of care that is consumer-driven. 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

In Stage One (Year One) payers and the state will collaborate to develop a multi-payer online portal for providers that will receive static reports or provide access to individual payer portals through a federated log-in. As referenced earlier, Connecticut is also developing an Enterprise Master Patient Index (EMPI) and an Eligibility Management System (EMS), both of which will help link and coordinate the different state health and human services agencies. A consent management process and system will be linked to the EMPI which providers will be able to query. In Stage Two (Years Two to Three), the State will examine the feasibility of a provider portal that allows bi-directional communication between payers and providers as well as data visualization tools. In Stage Three (Three+ years) a fully functional HIE and APCD will enable the development of solutions that provide consumer-provider-payer connectivity.

## 4.3 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 help the teams implement the most appropriate interventions and better manage follow-up care. Lastly, they will facilitate 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, NLM tools, and specialized technology.

Over the longer term (Years Two to Three +), we will provide a minimum set of reports that can be used by providers for effective and efficient care-coordination and patient management.

The minimum set of tools will be available so that no provider feels that they are at a disadvantage in this new services delivery model. At this stage we will also assess the viability of developing the shared-service care management toolkit mentioned earlier.

#### **4.4 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 management. Direct messaging will promote provider communication across care settings. In the long-term, EHR-based clinical data exchange will ensure that providers can access consumers' past care information, even when consumers visit different sites of care, provided the consumers have consented to sharing their health information with members of the care team.

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. For example, DSS is exploring the possibility of processing Admission, Discharge and Transfer (ADT) information from hospitals in real time to ensure that PCPs and care team members are alerted when patients are admitted to and discharged from the hospital setting, so that they can coordinate care delivery and transitions across different settings, 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. 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.

#### **4.5 TARGETED PRACTICE HIT SUPPORTS**

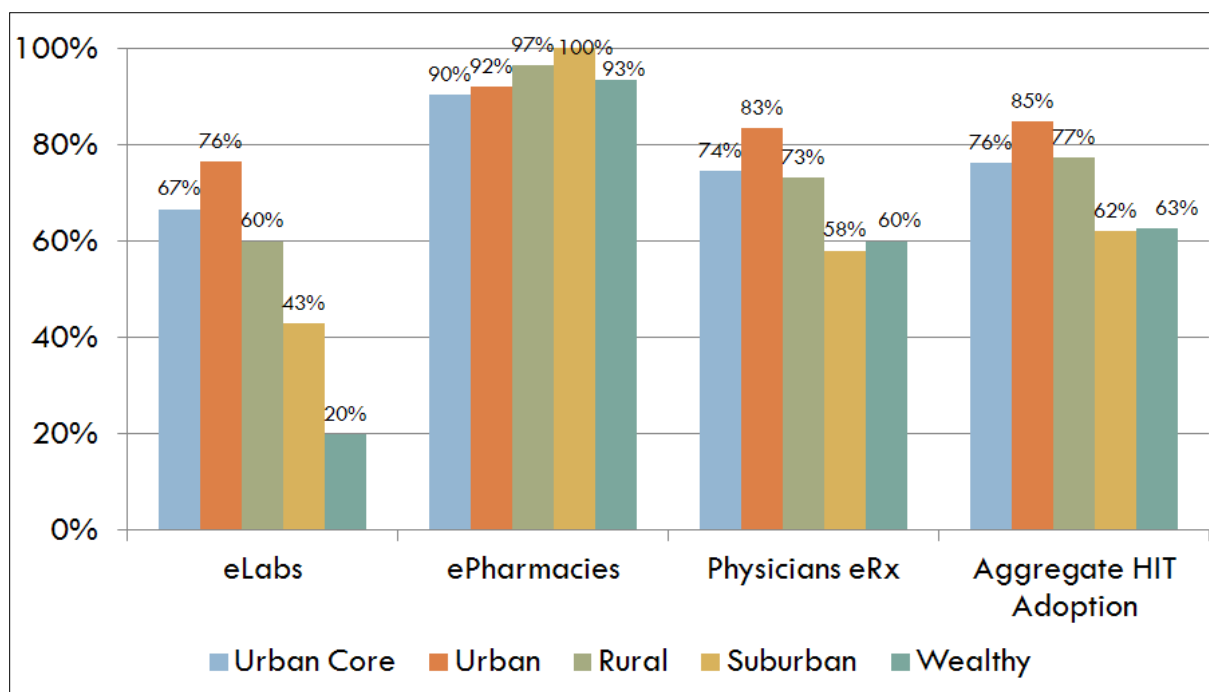
Our goal will be to identify gaps in connectivity and work with all providers that are experiencing challenges in adopting technologies and address them as they arise.

For instance, 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.

Furthermore, a recent analysis of HIT adoption data across the state reveals a complicated picture of HIT adoption by town type which may be counter intuitive. We found that physicians in wealthier counties do not meet the EHR incentive thresholds and hence may be on a different timeline for EHR/HIT adoption.



**EXHIBIT 21: HIT Adoption by Town Type**



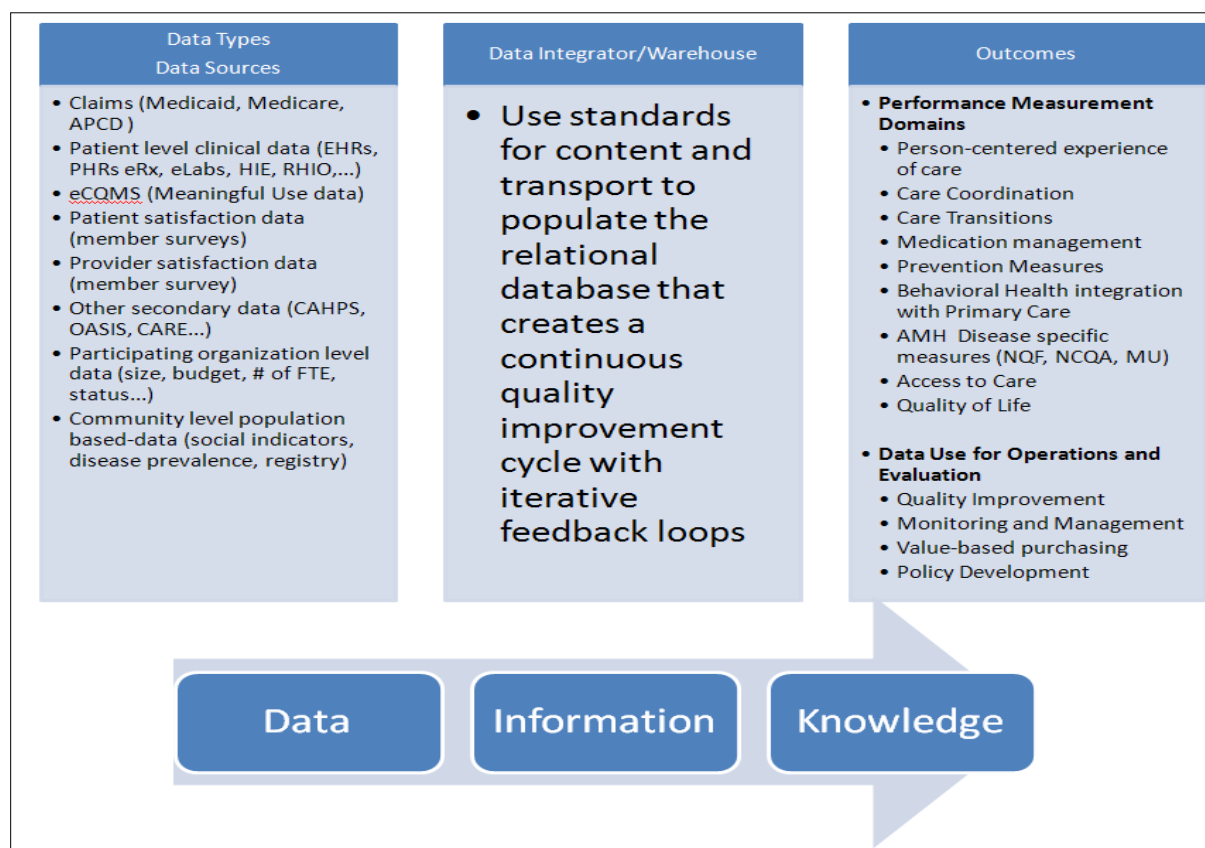
We plan to direct SIM funds to cover some of the gaps in HIT funding

- Connecting HIT infrastructure
- Incentivizing labs and independent pharmacies for adopting standards based HIT
- Incentivize professionals that are unable to access the EHR incentives provided through the HITECH act to adopt HIT tools to be able to interoperate with others

#### 4.6 OVERVIEW AND TIMELINE

Connecticut's overall HIT strategy aims to move the state from integrating and identifying all data that are available to actionable knowledge (Exhibit 22). In the first year, Connecticut will leverage existing stakeholder capabilities as it launches a broad array of fundamental payer-based components. These components will include consumer attribution, risk stratification, performance reporting and specialist and facility analytics. Most importantly during the first year, mechanisms will be identified for bringing disparate data types and sources together including the APCD. If this integration is successful, it will provide the data needed to carry out operations and evaluation over the course of the grant. The State will work toward realizing the goal of one provider portal that provides access to static reports or one step access to individual payer portal, to reduce unnecessary burden for patients and providers. In the second and third years of the project, Connecticut will further develop provider care management tools and dramatically augment the portal and payer analytics, including the introduction of statewide data capabilities.

## EXHIBIT 22: Data Integration: data types, data sources, and Outcome



The timeline for Connecticut's HIT strategy sequences the implementation of capabilities according to 1) their value to the AMH model, 2) their current state of development, 3) the time needed to implement them, and 4) their interdependencies with other capabilities (see Exhibit 23). It is not until Stage 3 that we contemplate the integration of public health/epidemic analyses to support our community health improvement goals, including the implementation of Health Enhancement Communities.

## EXHIBIT 23: 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)
<b>Payer analytics complemented by provider analytics</b>	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
<b>Provider-payer-consumer connectivity</b>	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
<b>Provider-patient care mgmt. tools</b>	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"> <li>Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing</li> <li>Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools</li> </ul>	
<b>Provider-provider connectivity</b>	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

## 5. Healthcare Workforce Development

As described in the “current Healthcare Environment Section,” Connecticut will have to undertake an aggressive strategy to recruit and retain primary care providers to meet the needs of our residents. Realizing healthcare delivery as envisioned in this plan demands a Connecticut health workforce of sufficient size, composition and education. This workforce must:

- Meet an increased demand for health services stemming from more of our residents having health insurance as a consequence of the Affordable Care Act;
- Meet the health service needs of a population that is growing older and more racially diverse by dealing effectively with the multiple co-morbidities of people who are frail and with the poorer overall health of people of color;
- 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;
- Meet the need for professionals with public health training who can work with Advanced Medical Homes (AMHs) on both broad and targeted measures to enhance the health of our communities;
- Work in care teams, grounded in primary care but including specialty care, which can employ more effectively and efficiently diagnostics, therapies, surgeries, drugs, devices and assistive technology;;
- Engage patients in maintaining their own health, in participating in their own healthcare and in making decisions, together with their families;; and
- 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 the healthcare 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.

Our Workforce Development plan includes six multi-purpose initiatives to achieve these objectives:

### **1. Health workforce data and analytics**

- 2. Training and certification standards for Community Health Workers**
- 3. Interprofessional education (IPE) and Connecticut Service Track**
- 4. Developing innovative residency programs in primary care and preventive medicine**
- 5. Preparing today's workforce for reform**
- 6. Health professions and allied health professions career pathways**

Loan forgiveness warrants special mention. It is an obvious means for Connecticut to entice students to choose primary care in the first place and to stay in it once they have chosen it. One additional consideration for enticing students to practice primary care in Connecticut is loan forgiveness. Over the next year, the state will review approaches to loan forgiveness, and consider how it might be funded and how it should be targeted. The Affordable Care Act calls for federal funding for loan forgiveness, and if this occurs, Connecticut will participate.

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.

## **5.1 HEALTH WORKFORCE DATA AND ANALYTICS**

Current data is not sufficient for a detailed or reliable account of the state's health workforce in terms of how many practitioners are working in Connecticut, where they are practicing, and what they are practicing. The data is virtually silent about how the various occupations are trained and the state of their knowledge and skills. It's of minimal use for predicting workforce needs of the future care delivery system outlined in our Innovation Plan. These shortcomings are why improving Connecticut's health workforce data and the analyses of this data is the first of our six initiatives.

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 immediate and future health workforce needs. Meanwhile, the state will improve and make better use of health workforce data that is gathered by the Office of Higher Education, the Board of Regents for Higher Education and the Departments of Education, Labor and Public Health.

Starting this fall (October 2013), DPH implemented mandatory online license renewals for physicians, dentists, registered nurses and advanced practice registered nurses. DPH is currently integrating standard, national survey questions into the online renewal process only 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 analyze it. The Council for State Boards of Nursing (NCSBN) will store and analyze data on

Connecticut's nurses, enabling DPH to compare Connecticut's nursing data to nursing data of other states.

Following the example of nursing, DPH will engage other health professional associations at both the state and federal levels to develop survey questions. DPH will work to hasten the approval of online renewal as an option to other health professions that it licenses. Since it is the Connecticut Department of Consumer Protection (DCP) that licenses pharmacists, DPH will work with DCP on survey questions for pharmacists. DPH will collaborate broadly with pertinent boards and commissions and the state's institutions of higher education to:

- Develop the infrastructure for an internet-based healthcare workforce data portal that provides key information: employment and wage data, real time job postings, licensure and certification data, educational institutional capacity and limitations, as well as socio-economic trends and demographics; and
- Use data to help ensure that educational programs have the capacity to train a health workforce that matches health employer needs.

Finally, the U.S. Department of Health and Human Services has identified three health disparities measures on the health workforce. Workforce diversity is central to culturally competent and whole-person centered care. Recruitment for clinical training programs should consider students and practitioners from minority and underserved populations. To this end, on-going collection and reporting of the following measures is vital:

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

UConn will coordinate necessary data analytic capacity and connectivity, working closely with the Board of Regents for Higher Education, Yale and Quinnipiac but also with the Department of Public Health, the Department of Labor, the Department of Education, the Office of Higher Education, payers and providers. UConn's interest in coordinating the analysis of workforce data flows from the University's own efforts to tie together from across its schools and campuses analysts who work with data pertinent to health policy—creating, in effect, a virtual health policy institute. For example, UConn's new Health Disparities Institute (HDI) can analyze data to identify health disparities across the continuum of care (inpatient, outpatient, medical, mental health, dental, pharmacy) for specific health conditions and specific populations. HDI can work with the health disparities measures listed above, and assess policy implications. Once its security and confidentiality are assured, workforce data will be made available for analyses by third parties, and thus will impact a broad range of workforce planning.

UConn is already collecting data on student education and projected workforce participation. Its Center for Public Health and Health Policy (CPHHP) has recently worked with several state

agencies to create a mechanism for linking students' elementary, secondary and post-secondary educational experiences to later workforce participation. P20 WIN (Preschool through 20 and Workforce Information Network) ties together information on individual students maintained by Connecticut's Department of Education, Department of Labor and Board of Regents for Higher Education. In phase two, the Connecticut Conference of Independent Colleges and UConn will contribute data, resulting in a dataset that will track educational experience and achievement over time. CPHHP will link this data to employment outcomes. The National Center for Educational Statistics is funding the technical infrastructure for P20 WIN. This network currently has access to over 70 million education 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 analytic support for monitoring the development of Connecticut's health 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 therefore 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.

Robust data on Connecticut's health workforce serves multiple purposes. Whether the numbers and training of a profession are more or less than 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. Health workforce data will help schools determine the offerings they develop and also the number of slots they plan to fill both near term and long term. When the data shows a misalignment of skills, programs that educate practitioners will know to adjust their curricula. Should Connecticut decide to establish a loan forgiveness strategy, credible, current and detailed workforce data will not only enable the state and schools to target loan forgiveness, 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.

The following steps are planned for 2014:

- Yale School of Public Health working with UConn and the Connecticut State Medical Society will conduct a survey of the state's smaller medical practices to determine:
  - How do they stand in terms of the resources required for care coordination, and ultimately for meeting the metrics required to become Advanced Medical Homes;
  - What, in view of the practices, might the best approaches be for getting them the resources they need;

- What the opportunities are for affiliating with other practices to form IPAs, joining existing IPAs and joining hospital based systems or ACOs for the purposes of the data aggregation and connectivity required for the analytics required for shared savings payment methodologies and continuous practice improvement.
- DPH and UConn will organize a meeting of the parties in the state that are interested in collecting and analyzing health workforce data: (1) to determine what we can do now with existing resources to improve data collection and analysis, and (2) what additional resources and orchestration we will need to fulfill this initiative.

## 5.2 TRAINING AND CERTIFICATION STANDARDS FOR COMMUNITY HEALTH WORKERS

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

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

CHWs' value to these teams is their capacity to address the pervasive, persistent and expensive problem of health disparities. CHWs generally come from the communities they serve, and therefore, are more likely to understand the cultures of these communities and the challenges their residents face. This experience enables the CHW to be a bridge, an interpreter and advocate 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 patients.

CHWs will work primarily with Connecticut's economically disadvantaged residents, particularly in disparity communities that are generally in poorer health and have poorer health outcomes. 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.

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, AHEC and DPH will work with all interested parties, including community-based organizations, and will consult Connecticut's advanced primary care practices and the Connecticut Association for Homecare at Home (CAHCH) to gain their perspectives on how best to train CHWs to work effectively with 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 interprofessional educational (IPE) curricula developed for Connecticut's health professions schools. AHEC and DPH will work with UConn's schools of social work and nursing, Connecticut State Colleges and Universities' nursing programs coordinated by ConnSCU's central offices, and the Connecticut League for Nursing and the Connecticut Chapter of the National Association of Social Workers 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 get the services they need. Finally, AHEC and DPH will consult the public health programs at Yale, UConn and Southern Connecticut State University.

Connecticut AHEC will provide CHW training at its four regional centers and CAHCH, and will also work closely with ConnSCU's community colleges. AHEC will provide basic training in the fundamentals, and the community colleges will provide AHEC's CHW graduates with more advanced and specialized training. Not only will the community college programs lead to certifications in CHW specialties, these programs' course credits will count toward other allied health certifications and toward professions degrees. All training in the health field should constitute rungs on career ladders.

Finally, AHEC and DPH will address the following concerns. A number of parties have commented that in developing CHW training and certification Connecticut should carefully consider whether related occupations should be included as CHWs, and if they are not included as such, what the relationship between CHWs and these occupations should be. Among examples given are local health department employees, patient navigators and integrative health coaches. A related concern is that CHW certification requirements not become an unintended impediment to existing CHWs and to their employers.

### **Description of basic CHW Training**

National Culturally and Linguistically Appropriate Services (CLAS) Standards together with insights drawn from Massachusetts' AHEC's experience and the parties listed above will be incorporated into a curriculum that is culturally relevant, evidence-based and covers the National Community Health Worker Advisory Study's (1998) 11 core competencies plus one.<sup>79</sup>

<sup>79</sup> Understanding the healthcare system; knowledge of resources and constraints; health promotion and disease prevention; effective communication, documentation and outreach skills; advocacy and cultural sensitivity; understanding community health education; capacity building; informal counseling/social support; legal and ethical responsibilities; special topics – e.g. oral health, violence, infectious disease; providing services to individuals with HIV/AIDS and other chronic conditions; plus providing services to individuals with multiple co-existing conditions and disabilities.

## 5.3 INTERPROFESSIONAL EDUCATION (IPE) AND A CONNECTICUT SERVICE TRACK

Interprofessional teams are integral to AMHs. In our view, a key to successful interprofessional primary care is educating future practitioners together particularly in population health and patient centered care, and having a significant portion of this training in clinical settings outside of institutions. Connecticut will pursue two avenues to IPE. The first is collaboration among our clinical professions schools and programs. The second is a Connecticut Service Track

### **Working together on interprofessional education**

Starting in the first year and continuing throughout implementation, our clinical schools will construct a learning collaborative dedicated to interprofessional education. To an unprecedented degree, these schools are disposed toward joint efforts and mutual support. They will be building on what is already substantial experience. The University of Connecticut, Connecticut State Colleges and Universities, Yale University and Quinnipiac University all have and are contemplating further IPE programs.

Interprofessional education requires careful consideration of pedagogy and curriculum. Prudence dictates that notable changes be piloted and monitored. Moreover, maintaining a disciplined focus on the specific needs of individuals and individual communities, especially when combined with efforts to bridge gaps among disciplines in culture, language and knowledge, helps overcome interdisciplinary barriers.

Nursing has been at the forefront of IPE in Connecticut, as it has been in improving workforce data (initiative #1) and career ladders (initiative #6). Our state's eight nurse practitioner programs are all engaged in interprofessional education having long considered it fundamental to nursing excellence. These programs continue to seek opportunities to augment their IPE strategies.

UConn's School of Medicine and School of Dental Medicine share classes in the core biomedical sciences during the first two years of education. These schools are now working toward adding interprofessional clinical education 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, UConn is looking to the Interprofessional Education Collaboration (IPEC), which was founded by six national professional associations: allopathic and osteopathic medicine, dentistry, nursing, pharmacy and public health. Since 2009, IPEC has sponsored symposia and training workshops to enhance interprofessional education, particularly the

integration of students' clinical experiences. IPEC has also developed curricula and guidelines that can inform the development of IPE in Connecticut.

For the past several years, Yale's three clinical professions programs—the School of Medicine, the Graduate School of Nursing and the Physician Associate program—have been working toward incorporating longitudinal clinical experience (LCE) into their curricula, LCE being following patients through a course of care rather than encountering them episodically. Since 2005, students from these programs have volunteered to staff and run the Haven Free Clinic, which provides free care on Saturdays to uninsured patients in one of New Haven's poorest neighborhoods.

Yale's School of Medicine, Graduate School of Nursing and Physician Associate program will pilot their interprofessional LCE curriculum in stages. Pilot 1 begins this January (2014) with 12 students, 4 from each program, and will be an inpatient experience. Pilot 2 begins this fall (2014) with more students, and will include both inpatient and outpatient experiences. Students will be teamed with residents and faculty from the three healthcare professions, and will work together as teams to care for patients.

Another example of interprofessional collaboration among Yale's three clinical professions programs is Yale's Healthcare Improvement Group (HIG), which is led by medical, nursing and physician associate students who are committed to finding solutions to healthcare's challenges. As the Yale Open School chapter of the Institute for Healthcare Improvement (IHI), HIG seeks to address the IHI Triple Aim of improving health, improving health services (including the experience of these services), and reducing the increase in the overall cost of health services.

The VA Connecticut Healthcare System (VAHCS), which is Yale affiliated, is one of only five VA facilities to have received a \$5 million grant from the Department of Veterans Affairs to establish a Center of Excellence in Primary Care Education. The center provides training in interprofessional collaboration to internal medicine residents and nurse practitioners, as well as to undergraduate students in medicine, nursing, pharmacy and psychology. Participants learn conflict management, how to work effectively as members of a team, and how to appreciate the input of others and their contributions to caring for patients. Residents and students come from Yale School of Medicine, Yale School of Nursing, University of Connecticut School of Medicine and Fairfield University School of Nursing. The center is establishing a one-year postgraduate fellowship in primary care for nurse practitioners. Medical residents and nurse practitioners will train in teams, taking care of patients together for a year, with the nurse practitioners providing continuity of care while the medical residents are training at other locations.

Interprofessional collaboration shows up repeatedly in Quinnipiac University's statements of principles and purpose, as does primary care. Interprofessional education and primary care are key means and ends for all three of Quinnipiac's health professions' schools: The Frank H. Netter MD School of Medicine, the School of Nursing and the School of Health Sciences, which includes the physician assistant, occupational therapy and physical therapy programs. These schools are housed together in a single building. The university's focus on interprofessional care carries over to its collaboration with the university's principal clinical partner, St. Vincent's

Medical Center. Medical, nurse practitioner and physician assistant students participate in clinical rotations together. Discussions are underway with the University of Saint Joseph School of Pharmacy to include their students in these rotations.

Since the medical school has just matriculated its first class, the development of common courses is a work in progress. Two are already in place: Health Systems, and Healthcare Challenges and Team-Based Solutions. Other offerings are being considered in subjects such as multidisciplinary patient assessment, Schwartz Rounds, discharge planning, rehabilitation and home care. Students from the three programs also regularly participate together in symposia.

## **A Connecticut Service Track**

Connecticut will build upon its most effective program for community-based interprofessional education, UConn's Urban Service Track (UST), to establish a Connecticut Service Track (CST). Six professions' schools are currently participating in UST: Quinnipiac's school for Physician Assistants, and UConn's Schools of Dental Medicine, Medicine, Pharmacy, Nursing and Social Work. UST serves underserved populations in urban settings, and stresses team-based care, cultural and linguistic appropriateness, and population health.

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In establishing a Connecticut Service Track (CST):

- 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 nursing and 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.

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 interprofessional 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.

## 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 competencies.<sup>80</sup> Faculty includes university and community health center clinicians, patients and other community partners. UST explores the 11 competencies in terms of the needs of a number of vulnerable populations: children/youth, the elderly, individuals with HIV/AIDS, incarcerated and ex-offender populations, immigrants/refugees, disparity populations, veterans and people who abuse substances. Students participate in problem-based learning activities that include clinical skills and case studies.

In addition, attention is paid to the skills needed for interprofessional teamwork. There are formal quarterly learning retreats, community outreach activities, community based research, advocacy and leadership education. Critical to the success of UST is the opportunity for students 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 education, 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

All of our professions schools for clinicians have expressed interest in IPE, and we anticipate that by the third year of this plan's implementation, all of our clinicians in training will be participating in some level of IPE.

The Connecticut Service Track will get underway during the first year of implementation. By that time CST will be expanded to training sites in our rural communities. We expect there also to be some additional schools participating. By the end of the third year of implementation, we expect that all of our clinical professions schools will be participating.

<sup>80</sup> The 11 competencies include: Resource constraints, cultural and linguistic appreciation, population health and public health, health policy, advocacy, healthcare financing and management, interprofessional teamwork and leadership, community resources, professional and ethical conduct, quality improvement and patient safety

## 5.4 DEVELOPING INNOVATIVE RESIDENCY PROGRAMS IN PRIMARY CARE AND PREVENTIVE MEDICINE

Nurse practitioners and physician assistants are practicing as primary care clinicians and pharmacists are poised to play a greater role. Primary care physicians are gaining additional skills and may assume some responsibilities that are now borne by medical specialists, freeing the specialists to concentrate on carrying into practice advances in their fields. Connecticut likely does not have enough primary care physicians now, and will not have enough in the future unless action is taken. Since it is residencies that determine the discipline and capabilities of a clinician and also often determine where clinicians settle to practice, Connecticut must work to enhance its primary care residency programs for all primary care clinicians and also for clinicians whose focus is preventive medicine and public health.

All of Connecticut's schools that educate primary care clinicians—UConn, Yale and Quinnipiac, Fairfield University, Sacred Heart University, Southern Connecticut State University, Saint Joseph's University and Western Connecticut State University—are attuned to the shifting conditions of practice that future primary care clinicians will face and to the emergent importance of primary care and population health. As will be evident in the descriptions below, our schools and also our teaching hospitals are working on reconstituting primary care residencies in ways commensurate with this plan. Connecticut's primary care medical residency programs are all pursuing sites for training in community based practices, and are all intent upon the medical home model, population health and interprofessional teamwork—as is Connecticut's sole nurse practitioner residency program.

As with interprofessional education, the case for expanded and innovative primary care residencies has already been accepted. A learning collaborative will foster cooperative action for the expansion and improvement of primary care residencies, with the Connecticut Institute for Primary Care Innovation (CIPCI) serving as a convener. This collaborative will assist our medical residency programs in making better use of existing resources, including pooling resources for primary care faculty and curriculum development. Connecticut has a number of innovative primary care medical residency programs that have received significant federal grant funding from the Health Resources and Services Administration (HRSA). These include training programs at UConn, Griffin Hospital and Western Connecticut Health Network. The collaborative will leverage their experience and this federal investment.

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

For medicine, residency accreditation is changing dramatically with the Accreditation Council for Graduate Medical Education's (ACGME) increased emphasis on sponsoring institutions' responsibility for overseeing graduate medical education in keeping with Clinical Learning Environment Review (CLER) goals, which include patient safety, quality improvement, community health, reducing health disparities and improving care transitions. Residencies must

also reflect the healthcare delivery system that residents will enter, the watchwords here being patient centered medical homes and interprofessional teams.

All of Connecticut's institutions for training health professionals are actively following ACGME's lead and, in many cases, they are doing so in practices that are progressing on a path to advanced primary care, and in some cases, serving some of Connecticut's communities with the greatest health needs. These programs are summarized in Appendix E.

## **5.5 PREPARING TODAY'S HEALTH WORKFORCE FOR REFORM**

It will be many years before clinicians being trained today predominate in Connecticut healthcare. Meanwhile, the success of healthcare reform depends on an existing health workforce that was trained for a care delivery system that we hope to transcend. Consequently, our current health and allied health professionals need additional education. Meeting this need is key to primary care practice transformation, a core objective of this plan. To this end, University of Connecticut, Yale University, Quinnipiac University and Connecticut State Colleges and Universities will combine, with the Connecticut Center Institute for Primary Care Innovation (CIPCI) as convener, to consider what their most effective contributions would be and to propose cooperative approaches to making them.

Part of this exercise will be determining just what education is required and for whom. Obvious topics are whole-person centered care, care coordination, HIT, consumer empowerment, team-based care, population health, working with public health agencies, working with community-based providers of support services, as well as in clinical areas of import to primary care, such as geriatrics and behavioral health.

Although every one of these topics is important, HIT is worthy of special note. The effective use of HIT is the sine qua non of the reforms envisioned in this plan and the reason that many of these reforms would have been unfeasible even a short time ago. Connecticut's healthcare workforce is lacking in capability for effectively and efficiently using HIT to forward the goals laid out in this plan. For some in the workforce, there is also the question of choosing the right EHR. Some progress has been made in achieving stage 1 meaningful use with approximately 85% of Connecticut's eligible hospitals and 45–50% of eligible Medicare providers having achieved it, while eligible Medicaid providers are getting there at a slower but accelerating pace. Achieving stage 2 meaningful use is substantially more complicated, requiring the exchange of healthcare data between organizations on different EHRs and electronically with patients through patient portals and personal health records. The need of both AMHs and emerging ACOs for population based yet personalized care adds further complexity to the effective use of HIT.

Over the next year, UConn will coordinate with healthcare employers, and with ConnSCU, Quinnipiac and Yale to assess the need for HIT training and to map coordinated approaches to fulfilling it. As with primary care residencies, we have a train-the-trainer problem with HIT. Most of our hospital systems are upgrading or replacing their EHRs and thus are competing for

the same small pool of capable HIT workers, which, in itself, is reason for our community colleges' to expand their capacity for training HIT workers.

Whether the topic is HIT or any of the others from the list above, one lever is the requirement to earn Continuing Education Units (CEUs) as a condition for maintaining licenses to practice. The courses that confer CEUs should include offerings that emphasize the skills required by AMHs. The state will sponsor a survey of CEU courses, and will work with our institutions of higher education to improve these offerings. Consideration will be given to modifying CEU requirements to stress practice transformation.

Other forms of in-service training will require additional resources. IPAs and ACOs typically can support some training. We will survey their offerings and work with these providers to improve them. We will assist smaller group primary care practices either through enlisting the assistance of providers with established programs or through independent programs. One important training venue will be the CIPCI whose mission includes enhancing the skills of our existing primary care clinicians. Another venue is the Connecticut Center for Primary Care (CCPC), which is affiliated with Connecticut's largest physician group and the Primary Care Coalition of Connecticut.

Finally, it is important to note that patients who have a predominant and difficult malady may prefer to have specialty practices, such as cardiology or oncology, serve as their medical homes. Therefore, in some measure, lessons in practice transformation for primary care practices will also be pertinent to specialty care practices.

Education for practice transformation must be addressed within the coming year, and should get underway during the first year of implementation. As with the other initiatives, remedies will not be born full-blown but will ramp up over time. However, we must have a reliable sense soon of what is needed, where it is needed and how it might be provided.

## **5.6 HEALTH PROFESSIONS AND ALLIED HEALTH PROFESSIONS CAREER PATHWAYS**

Connecticut will build upon two ongoing efforts to increase students' ability to accrue the capabilities and the credits 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. Connecticut State Colleges and Universities will be the lead, working with Connecticut's other colleges and universities. Both efforts 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 careers and technological advances that will strengthen Connecticut's economy.

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 surveys to succeed in any of the state's health professions schools and programs; and
- Increase the representation of minorities in training for both the health professions and the allied health professions, but particularly for the health professions.

For the long-term excellence of this workforce, we must do a better job near-term of interesting students in STEM, especially minority students, 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 question is which of these initiatives have been the most productive, and why. During the first year of this plan's implementation, the state will work with our universities and public schools to establish a process for answering this question and then will work with these schools to apply the lessons learned.

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 agreement applies to all subjects and all majors, and emphasizes seamlessness between associate degree programs and baccalaureate programs by calling 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.

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

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

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 return to school for a career change when market demands change.

2. In working through articulation agreements, schools will become more aware of what each other is doing, and if that 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. Such alignment will also help students to climb these ladders. Among other things, this will help provide an avenue by which students from underserved communities can progress from lower skilled jobs to higher skilled ones, including professional careers, which will help 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.

Developing STEM criteria and workable articulation agreements is not done easily or quickly. But since Connecticut State Colleges and Universities have already laid a foundation for this development, it can get underway reasonably soon and certainly within the first year of this plan's implementation.

## 5.7 CONCLUSION

The University of Connecticut, which supported the development of these initiatives, will help support their execution. The Connecticut Institute of Primary Care Innovation (CIPCI) will serve as convener for the several initiatives that require leadership from all four of Connecticut's university systems. Chartered by the Connecticut General Assembly as part of Bioscience Connecticut, CIPCI opened in 2012. It is a collaboration between the University of Connecticut School of Medicine and St. Francis Hospital and Medical Center that was designed in part to engage a broad community of institutions intent on improving primary care for Connecticut's residents. This mission, together with its ample facility, make CIPCI a natural meeting place for the several initiatives that require leadership from all four of Connecticut's university systems.

The leads and their assists for the six initiatives are:

- Health workforce data and analytics
  - The Department of Public Health (DPH) assisted by the University of Connecticut
- Training and certification standards for Community Health Workers
  - Connecticut's Area Health Education Centers (AHEC) assisted by DPH
- Interprofessional education (IPE)
  - University of Connecticut, Yale University, Quinnipiac University and Connecticut State Colleges and Universities with CIPCI as convener, and AHEC for the Connecticut Service Track
- Expansion of innovative primary care and preventive medicine residency programs

- University of Connecticut, Yale University, Quinnipiac University and Connecticut State Colleges and Universities with CIPCI as convener
- Practice transformation: preparing today’s workforce for care delivery reform
  - University of Connecticut, Yale University, Quinnipiac University and Connecticut State Colleges and Universities with CIPCI as convener
- Health professions and allied health professions career pathways
  - Connecticut State Colleges and Universities

Connecticut has long had many islands of excellence in the education of clinicians and allied health professionals. Our intent is to tie these islands together and flesh them out to form a community of excellence that will give our state the health workforce to realize this plan.



## V. FINANCIAL ANALYSIS

# 1. Financial Analysis

Although the growth in U.S. healthcare spending has abated somewhat since 2008, most health economists and actuaries believe that spending levels going forward will continue to outpace general inflation and growth of the economy without significant changes in healthcare financing and care delivery, like those contemplated in our Healthcare Innovation Plan.

By fully and successfully implementing the changes outlined in this plan, we project that we will create more than \$3 billion in value over 5 years from State Fiscal Year (SFY) 2016 through SFY 2020.<sup>81</sup> After accounting for reinvestments to improve quality, access, and equity and consumer experience, as well as program investments to support model implementation, provider practice transformation, and health information technology, we project a net \$1 billion per year in savings by SFY 2020, contributing to improved affordability.

This level of near-term savings, realized through reductions in waste and inefficiency in the system, would reduce the rate of increase in healthcare spending by 1-2 percentage points within 5 years for participating payers, bringing the rate of growth in healthcare spending more closely in line with the growth of our economy after adjusting for general inflation and significantly reducing the extent to which healthcare spending crowds out real wage growth or investments in education, housing, and other critical needs.

## 1.1 BASELINE HEALTHCARE SPENDING

Healthcare economists and actuaries differ in their forecasts for healthcare spending growth. While the rate of increase in healthcare spending may be influenced by macro-economic and other factors outside the scope of our Plan, for purposes of our financial analysis we have assumed a baseline of approximately 5% average increase in healthcare spending without the changes described in this plan. After adjusting for 1-3% inflation, this translates to 2-4% real growth in healthcare spending. If we were to achieve 1-2% increase in gross state product per capita, this would translate to healthcare spending growth of 1-3 percentage points in excess of real productivity gains for our economy.

This includes 5.5% annual increase in spending for commercially insured and self-insured populations, based on 0.5% annual growth in the number of covered persons and 5% annual growth in the cost per person per year.

Medicare costs in Connecticut are estimated at \$8.5 billion in 2014, based on approximately \$14,300 per each of 600,000 Medicare beneficiaries. We have assumed that without the changes outlined in our Plan, total costs would increase to more than \$10 billion by SFY 2020,

<sup>81</sup> State Fiscal Year 2016 runs from July 1, 2015 through June 30, 2016

based on about 1% annual growth in beneficiaries (to 625,000) and 3% annual increase in spending per beneficiary (to about \$16,600).

Medicaid claims costs in Connecticut were \$5.9 billion in 2012. These costs are shared between state general revenues and federal matching payments. We estimate that more than 50% of these costs are for long-term services and supports and other costs that are not directly addressed by our Advanced Medical Home model and are addressed by Connecticut's Integrated Care Demonstration and other initiatives that pre-date our State Innovation Models initiative. Accordingly, our financial analysis of impact for Medicaid is restricted to \$2.7 billion in spending (in 2012) for 592,000 enrollees directly addressed by the AMH model as described in our plan at an average of \$4,500 per enrollee. Without implementation of our Plan, we estimate these costs would increase to \$3.25 billion by SFY 2020 based on 3% annual growth in enrollment (to 694,000 in SFY 2020) and 2% growth in per cost per enrollee (to \$5,170 by SFY 2020).

The growth in Medicaid spending outlined above excludes the costs associated with Medicaid expansion based on the Affordable Care Act. We project that by SFY 2020, we will cover approximately 189,000 enrollees based on expansion of Medicaid under the Affordable Care Act, at a total cost of approximately \$975 million in SFY 2020, to be largely covered by federal spending.

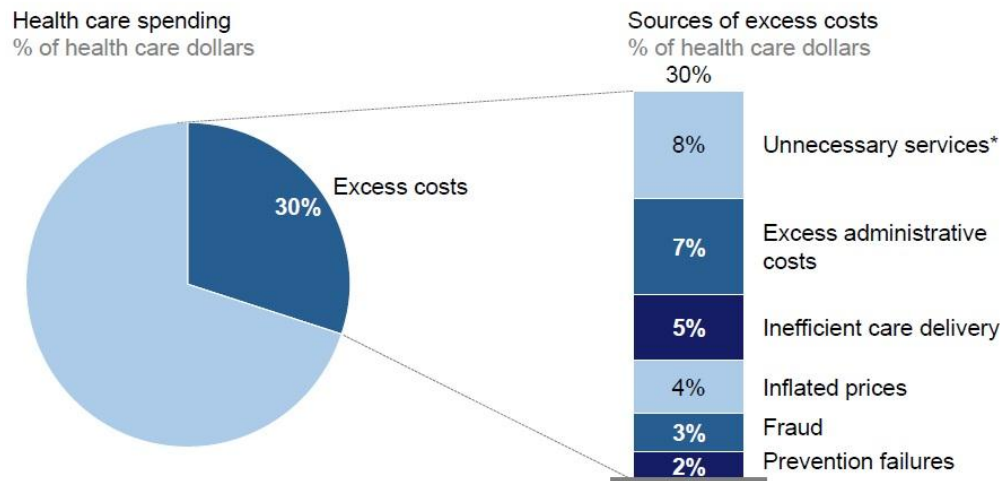
## **1.2 POTENTIAL IMPACT BEFORE INVESTMENTS**

Research by the Institute of Medicine has suggested that approximately 30% of healthcare spending is unnecessary.<sup>82</sup> This is consistent with the findings of many dozens of research studies by a range of academic and other research institutes.

<sup>82</sup> Institute of Medicine Report, September 2012.

## EXHIBIT 24:

### Institute of Medicine Findings



\*Includes: overuse—beyond evidence-established standards; discretionary use beyond benchmarks; and unnecessary choice of higher-cost services  
SOURCE: Institute of Medicine September 2012 report on 2009 health care spend

Analysis of Medicaid, Medicare, and Commercial costs in Connecticut uncovers many of the same circumstances that contribute to preventable healthcare costs found in the Institute of Medicine report, and as addressed by examples of successful population-based models used in our benchmarking. For example:

- About 40% of our Medicaid enrollees have chronic conditions, and account for nearly 70% of our Medicaid spending, excluding dual eligible;<sup>83</sup> this includes spending on acute events that could be prevented through more effective management of chronic conditions.
- Risk-adjusted cost of care is 20% higher for relatively healthy Medicaid patients who access the system directly through specialists without care by a primary care physician.<sup>84</sup>
- Medicare announced recently that 24 of Connecticut's 31 hospitals in Connecticut will face Medicare readmission penalties in the next fiscal year.
- Our medical readmission rate for Medicaid was 11.8% in 2011, the highest rate among peer states – tied only with New York Medicaid –and much higher than the peer-state benchmark of 9.4%.<sup>85</sup>

<sup>83</sup> McKinsey analysis of Connecticut 2012 Medicaid claims data

<sup>84</sup> McKinsey analysis of Connecticut 2012 Medicaid claims data

<sup>85</sup> Connecticut DPH, Chart Book: Availability and Utilization of Health Care Services at Acute Care Hospitals and Federally Qualified Health Centers (2011)

- Connecticut has a 26% higher per-capita use of the Emergency Department than neighboring Massachusetts, despite similar demographics and health risk; and nearly 50% of our ED visits are for non-urgent needs, reflecting potential primary care access challenges.<sup>86</sup>

During the course of our work, our Care Delivery workgroup reviewed research examining more than 20 examples of population-based models for improving care delivery in conjunction with value-based payment. These included examples ranging from independent primary care practices participating in PCMH models, to ACOs formed by hospital systems, medical groups, and/or IPAs; as well as health systems including financially integrated physicians and hospitals. The impact of these models has been wide ranging, most averaging 1-2 percentage points reduction in trend, or 6-12% total reduction in costs over a 5-year period.<sup>87</sup>

Many other examples of population-based models have been implemented without strong evidence of impact. Contributing factors have included: lack of focus on high-risk populations; reliance on structural measures of capabilities without direct incentives for new processes and better outcomes; insufficient support for primary care practice transformation; and a weak business case for change based on insufficient reward levels and/or participation by only one payer representing a small fraction of a provider's patient panel.

We believe that our model design, if fully supported on a multi-payer basis, will address the pitfalls associated with less successful pilots. Our goal is that participating providers, over the course of 5 years, will eliminate unnecessary healthcare spending representing 6-12% of the total cost of care for populations who are in-scope for shared savings programs. We have

<sup>86</sup> CT Office of Health Care Access (includes Medicaid, Medicare, commercial and uninsured), 2009; MA: Massachusetts Health Care Cost Trend Efficiency of Emergency Department Utilization in Massachusetts, 2010

<sup>87</sup> Patient-Centered Primary Care Collaborative report on PCMH outcomes and savings  
Health Affairs 28(5), 2009. Transforming the role of a Medicaid health plan from payer to partner, Commonwealth Fund, 1423(5), 2010.  
Commonwealth Fund, "HealthPartners: Consumer-focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda," Group Practice Journal, "HealthPartners Medical Group: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program: Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010  
Paulus RA, et al. Health Affairs 2008; Steele G. Lecture ACC Health System Reform Summit 2009  
Health Affairs, "American Medical Home Runs," September/October 2009  
Eastern Maine Healthcare Systems' Annual Report, 2012, Office of the National Coordinator for Health Information Technology: Bangor Beacon Community.  
Massachusetts Payment Reform Model: Results and Lessons, BCBSMA.  
NYCCP website (<http://www.carecoordination.org>)  
Care Model Process," November/December 2006.  
CMS: Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration: Massachusetts General Hospital and Massachusetts General Physicians Organization (MGH), September 2010.  
Massachusetts General Hospital's Program to Coordinate Care for High Risk Medicare Patients: A Success Story; MedPAC: Care coordination in fee-for-service Medicare, June 2012.

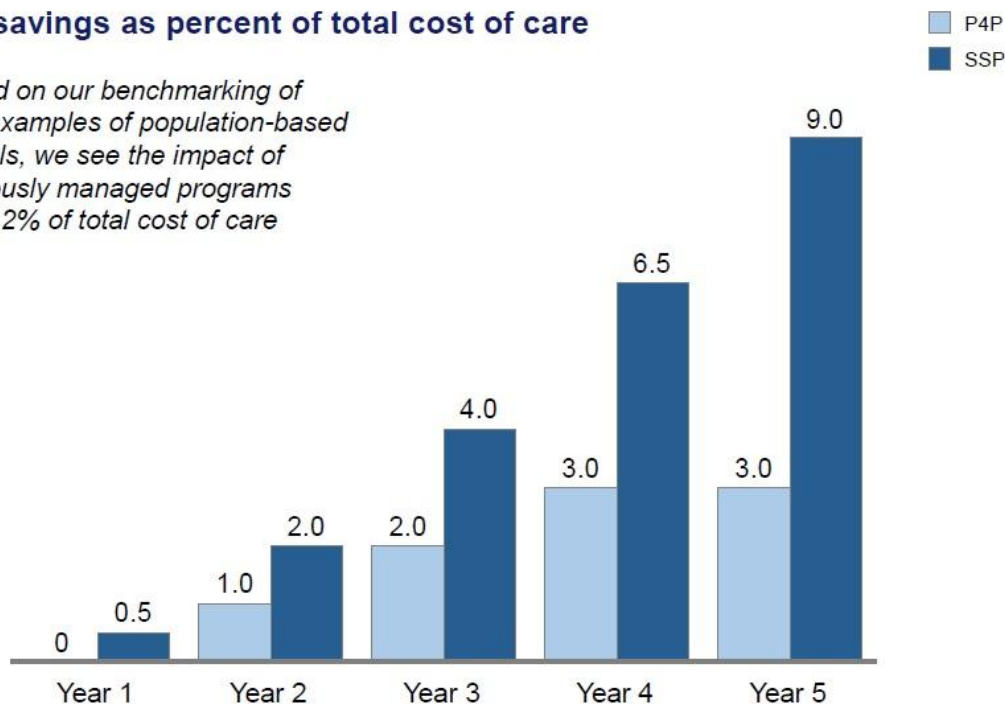


assumed a more moderate level of impact from pay-for-performance programs that introduce lower levels of upside gain and do not include any downside risk.

#### EXHIBIT 25:

##### Gross savings as percent of total cost of care

*Based on our benchmarking of ~20 examples of population-based models, we see the impact of rigorously managed programs at 6-12% of total cost of care*



SOURCE: Assumptions used for impact projections, based on review of case examples in literature

We find this projected level of impact to be consistent with the range of impact observed in successful ACO, PCMH, and other programs similar to our AMH model. We believe that the principal challenge in achieving this level of impact will be to bring the same level of practice transformation support and rigorous performance management to a state-wide implementation that has been brought to past efforts implemented at a smaller scale, frequently by self-selecting groups of providers with highly motivated leadership teams.

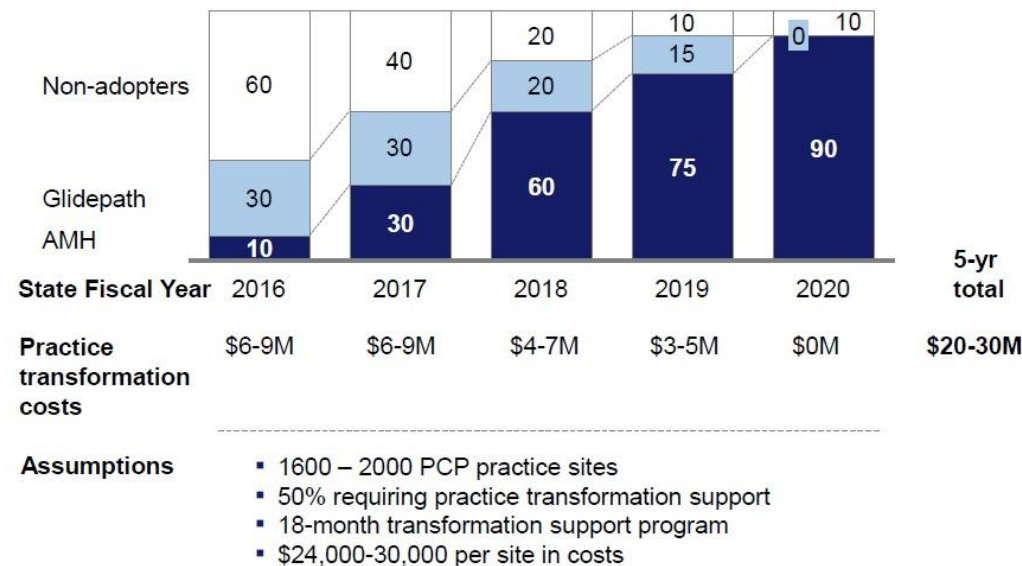
### 1.3 TARGETED PACE OF IMPLEMENTATION

Our projections for the potential impact of our model is based on achieving our bold aspiration that by SFY 2020 at least 90% of Connecticut primary care providers (weighted by patient panel size) would achieve AMH recognition, increasing steadily from a baseline of 10% estimated for SFY 2016. This pace of implementation assumes that by SFY 2016, 10% of PCPs are prepared to meet AMH criteria, and an additional 30% are on a Glide Path to transform their practices, with additional practices transitioning into the Glide Path and then achieving AMH recognition over time.

## EXHIBIT 26:

### Statewide investment in practice transformation

% of PCPs working toward Advanced Medical Home certification



1 Of the 62% of PCPs moving toward SSP today, assumes SSP arrangements are in place today only with 20% of their patient panel;  
SOURCE: CT Office of the State Comptroller, CSMS interview, Department of Social Services, benchmarking with practice transformation vendors

We believe that this level of provider adoption is achievable only with significant support for the AMH model across Medicare, Medicaid, and Commercial payers, including self-funded employers. We estimate that the State can directly influence healthcare payments for 23% of the population covered by Medicaid and the State employees' health plan. Medicare participation would bring an additional 17% of the population. Commercial fully-insured plans would bring approximately 24% of the population, with the overwhelming majority of that volume represented by the payers who have participated closely in the development of our State Healthcare Innovation Plan.

We also assume meaningful adoption of new models by self-funded employers, based on the strong leadership we have found among some self-funded Connecticut employers on this issue. Our Commercial payers also may indirectly influence the adoption of our proposed model by self-funded employers, the majority of whom have benefits administered by Commercial insurers based on networks that have been historically contracted under the same terms spanning fully insured and self-insured businesses. Our projections assume that about half of self-funded employers adopt the model in SFY 2016 and that as we gain momentum and evidence of success, nearly all self-funded payers adopt the model over time, in addition to fully insured payers, Medicaid, and Medicare.

While our Plan does not prescribe a direct link between AMH status and shared savings, our goals for impact assume that the early adopters of the model (40% of PCPs in SFY 2016) participate in shared savings. We also assume that a majority of those who elect to not

participate in AMH practice transformation in SFY 2016 nonetheless participate in pay-for-performance models, and that they transition to shared savings models over time.

Our belief that 40% of PCPs may participate in shared savings by SFY 2016, and more than 80% by SFY 2020 is based on research conducted by our Office of State Comptroller in September 2013, involving surveys of the leading carriers in the state identifying 11 emerging provider systems, medical groups, Independent Practice Associations, and clinically integrated networks that have either already negotiated a shared savings arrangement for total cost of care with at least one carrier, or are taking steps to do so. Our financial projections are based on an assumption that two thirds of these PCPs would participate in shared savings in SFY 2016, and that the remainder would migrate from P4P to shared savings by SFY 2020 in addition to the majority of other PCPs are not currently affiliated with one of these groups, depending on the success they see among early adopters, reinvestment of savings in the delivery system

Achieving the level of impact described previously will require meaningful investments in the delivery system, both to offset the cost of new capabilities and processes (e.g. care coordination for high-risk populations) and reductions in provider productivity during the course of practice transformation, as well as to provide a meaningful incentive to undertake the changes. Most providers participating in our workgroups believe that some level of upfront investment is necessary, whether in the form of care coordination fees, enhanced fee-for-service payments, or otherwise. Most payers are supportive of making upfront investments only for practices that demonstrate the capacity and motivation to transform, and only as a true “advance” on shared savings payments, meaning that they would not continue beyond the first year without demonstration of improvements in resource utilization that offset the cost of the upfront investments.

Our current assumption is that payers will independently determine whether to offer care coordination fees or other upfront investments, and that the level of funding for such payments would be determined independently by each payer. Similarly, we anticipate that payers will independently determine the level of bonus payments and/or shared savings payments; in the case of Commercial insurers, we anticipate that such terms may vary from one provider to the next based on contract negotiations between payers and providers.

As an input into our projections, we have examined the level of care coordination fees and shared savings distributions paid to providers under the Comprehensive Primary Care initiative, the Medicare Shared Savings Program and other models supported by CMMI, as well as under Commercial and Medicaid PCMH and ACO programs in Connecticut and other parts of the U.S. based on published literature as well as interviews with experts familiar with these arrangements. We have also considered the level of distributions necessary to provide for meaningful incentives to independent physicians, as well as physicians employed by or affiliated with hospital systems for which reductions in avoidable admissions may mean lost contribution margin.

Again, we anticipate that the mix of upfront investment and shared savings payments as well as the level of such payments may vary by payer, and may be different for providers who have the scale and capabilities to accept downside risk. We also anticipate that hospital-based provider

organizations may require a higher potential payout to offset lost contribution margin attached to reductions in hospitalizations. Payers may be willing to offer higher payout levels to these organizations depending on their willingness to in turn accept downside risk.

Based on these considerations, we have assumed in our projections that an average of 30-50% of savings achieved through implementation of the model will be paid to providers in the form of bonus payments and shared savings, net of increased spending on care coordination. We have assumed that providers will demand the higher end of this range from Commercial payers in order to offset lost income for hospital-based providers associated with reductions in avoidable hospital admissions; whereas we project a lower share of savings for Medicare and the bottom end of this range for Medicaid in light of lower contribution margins for hospitals for Medicare and Medicaid, in comparison with Commercial volume. The actual level of shared savings will depend on policy and contractual decisions yet to be determined by payers and providers.

Based on the assumptions outlined above, total reinvestments in the delivery system would reach \$800 million per year by SFY 2020 if our plan were fully and successfully implemented.

## **1.4 PROGRAM INVESTMENTS**

We estimate that fully implementing the plan as outlined will require an average of \$15-25 million per year investment through SFY 2020 for primary care practice transformation, health information technology development, and program management (i.e., detailed design, implementation, stakeholder engagement, and self-evaluation, as well as support for workforce development and community health improvement including regional grants in SFYs 2018-2020. We anticipate that we will be able to fully realize this investment with the support of SIM test grant funding. In the absence of test grant funding we intend to proceed with implementation; however, we will re-evaluate our priorities and narrow the scope accordingly.

These costs are based on benchmarking the level of investment made by other States as well as private payers making at-scale investments in similar initiatives. Relative to benchmarks, we have scaled these investments based on the size and fragmentation of our primary care workforce, as well as the scope and complexity of our model in comparison with models implemented in other markets.

## EXHIBIT 27:

### Program investments<sup>1</sup>

	Benchmark range	Connecticut estimate	Total budget (\$M by SFY)
<b>Practice transformation</b>	<ul style="list-style-type: none"> <li>\$10,000-50,000 per PCP site</li> </ul>	<ul style="list-style-type: none"> <li>1600 – 2000 PCP sites</li> <li>50% requiring practice transformation support</li> <li>18-month transformation support program</li> <li>\$24,000-30,000 per site</li> </ul>	<ul style="list-style-type: none"> <li>2015: 1</li> <li>2016: 6-9</li> <li>2017: 6-9</li> <li>2018: 4-7</li> <li>2019: 3-5</li> <li>2020: 0</li> </ul>
<b>Health information technology<sup>2</sup></b>	<ul style="list-style-type: none"> <li>\$20-30M over 3 years</li> <li>\$3-5M per year thereafter</li> </ul>	<ul style="list-style-type: none"> <li>\$30M over 4 years based on relatively modest HIT capability in the state</li> <li>\$4M per year based on high number of payers, moderate PCP fragmentation</li> </ul>	<ul style="list-style-type: none"> <li>2015: 5M</li> <li>2016: 10M</li> <li>2017: 10M</li> <li>2018: 5M</li> <li>2019: 4M</li> <li>2020: 4M</li> </ul>
<b>Program management</b>	<ul style="list-style-type: none"> <li>\$10-30M per year for initial 3-4 years</li> <li>\$3-5M per year thereafter</li> </ul>	<ul style="list-style-type: none"> <li>\$7.3-15M per year for 4 years beginning SFY2015, focused on AMH, excluding support for special needs pop'ns</li> <li>Tapering to \$4M per year</li> <li>Additional \$4M per 2018-2020 for Community Health Improvement</li> </ul>	<ul style="list-style-type: none"> <li>2015: 7.3</li> <li>2016: 10</li> <li>2017: 15</li> <li>2018: 14</li> <li>2019: 8</li> <li>2020: 8</li> </ul>

<sup>1</sup> Does not include program-specific investments (e.g. Choosing Wisely), SNAP/ NuVal, workforce (e.g., CT Service Track, CHW training)

<sup>2</sup> Excludes HIE costs

SOURCE: Literature review, testing grant application review

## 1.5 NET SAVINGS TO THE SYSTEM

If fully and successfully implemented, our plan could achieve \$1.5-2.0 billion in gross savings in SFY 2020, or \$1 billion net of program investments and value-based payments to providers.

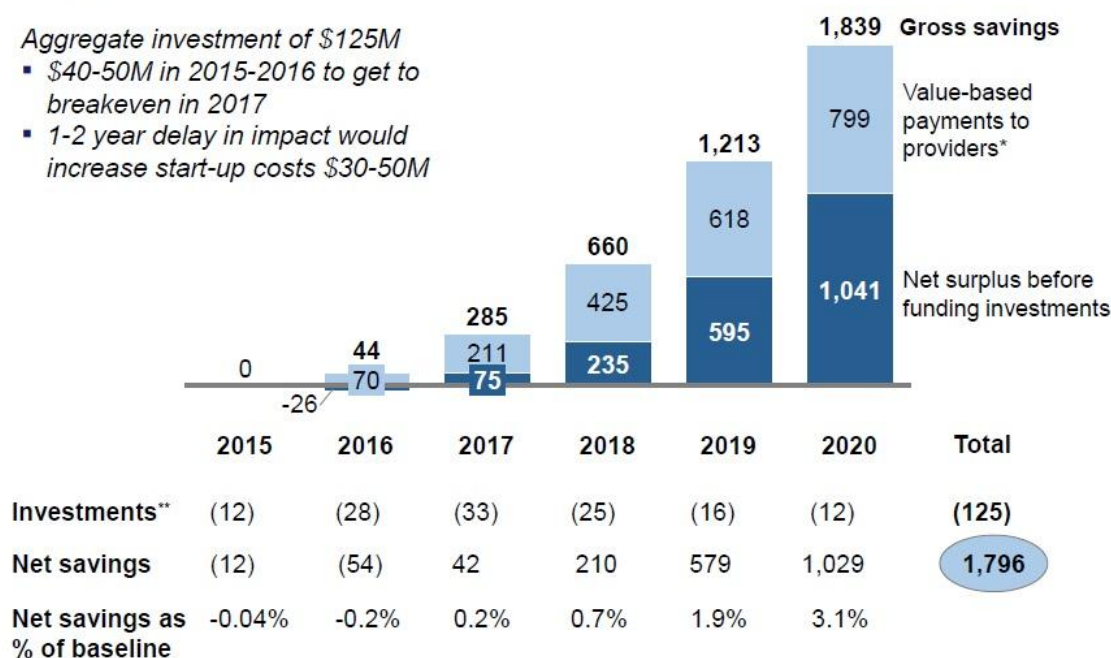
### EXHIBIT 28:

#### Potential financial impact – All Connecticut

\$ millions

Aggregate investment of \$125M

- \$40-50M in 2015-2016 to get to breakeven in 2017
- 1-2 year delay in impact would increase start-up costs \$30-50M



\*Includes care coordination fees, shared savings, and bonus payments tied to quality, experience, and efficiency

\*\*Reflects practice transformation support, HIT, and Program Management

Based on the pace of implementation reflected in our plan, we would achieve breakeven on our investments by SFY 2017, and by SFY 2020 we would reduce the annual rate of increase in healthcare spending by 1-2 percentage points, bringing it more closely in line with the long-term growth rate of our economy.

Net savings to our Medicaid program would exceed \$130 million per year by SFY 2020 for the non-expansion population for which the State General Funds cover 50 percent of spending, translating to more than \$65 million per year in savings to State. This does not include additional savings for the Medicaid expansion population, which would largely accrue to reductions in federal spending.

Net savings to the Medicare program would exceed \$300 million in SFY 2020, whereas net savings to Commercial insured and self-insured payers would exceed \$500 million per year.

## 1.6 SUSTAINABILITY

Assuming successful implementation of our plan at the pace outlined above, the level of savings outlined above would continue to grow over time in proportion to baseline healthcare spending growth and as providers continue to eliminate unnecessary spending from the system, with those providers joining the model in 2017 starting their climb toward greater quality and efficiency over a 5-year period stretching to 2022. As the AMH model continues to mature, our goal for 1-2 percentage point reduction in healthcare spending growth may be sustained through 2022.

Sustained mitigation of trend beyond this timeframe will be dependent on improvements in prevention driven by our Health Enhancement Communities, as well as reductions in year-over-year wage increases for our healthcare workforce based on an expansion in capacity and shift in skill mix. The direct impact of these changes is not included in our near-term financial analysis, as further definition is required around the policy changes supporting our goals for community health improvement and workforce development, and the return on these investments is likely to fall outside the 5-year time horizon used for our analysis.

## 1.7 FINANCIAL RISK

As illustrated above, successful implementation of our plan could enable us to reach breakeven on our investments by SFY 2017, after an initial investment of approximately \$70-100 million, reflecting negative net savings through SFY 2016, plus about \$30 million in program investments in SFY 2017 that will run ahead of medical cost savings accruing to participating payers. A one- to two-year delay in impact would increase our start-up costs by \$30-50 million and delay achievement of breakeven as well as abatement of healthcare spending growth.

Factors that could lead to such a delay include: delays in funding or resourcing for program investments; low participation of payers and/or under-funding of practice transformation and/or provider incentives; low uptake of providers; or care coordination fees and/or shared savings payments made without rigorous alignment with activities and outcomes that drive near-term return on investment.



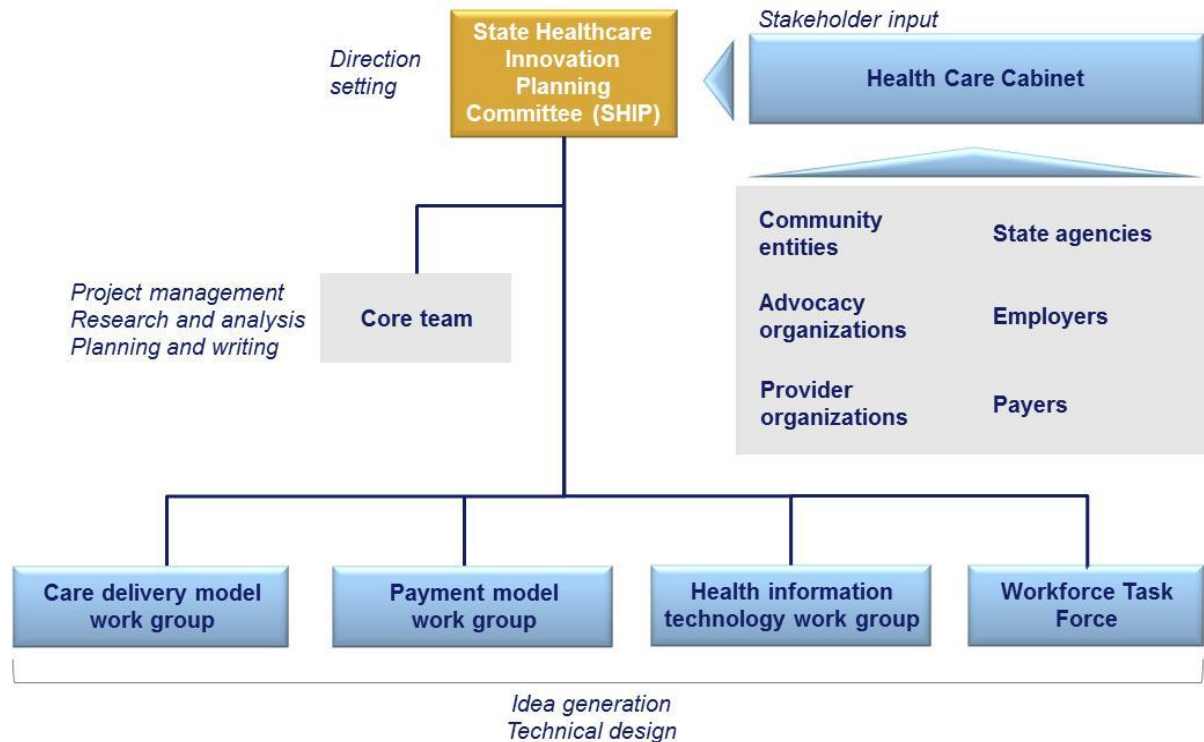


## VI. MANAGING THE TRANSFORMATION



# 1. State Innovation Model Design Process

**EXHIBIT 29: Model Design Process Governance Chart**



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.

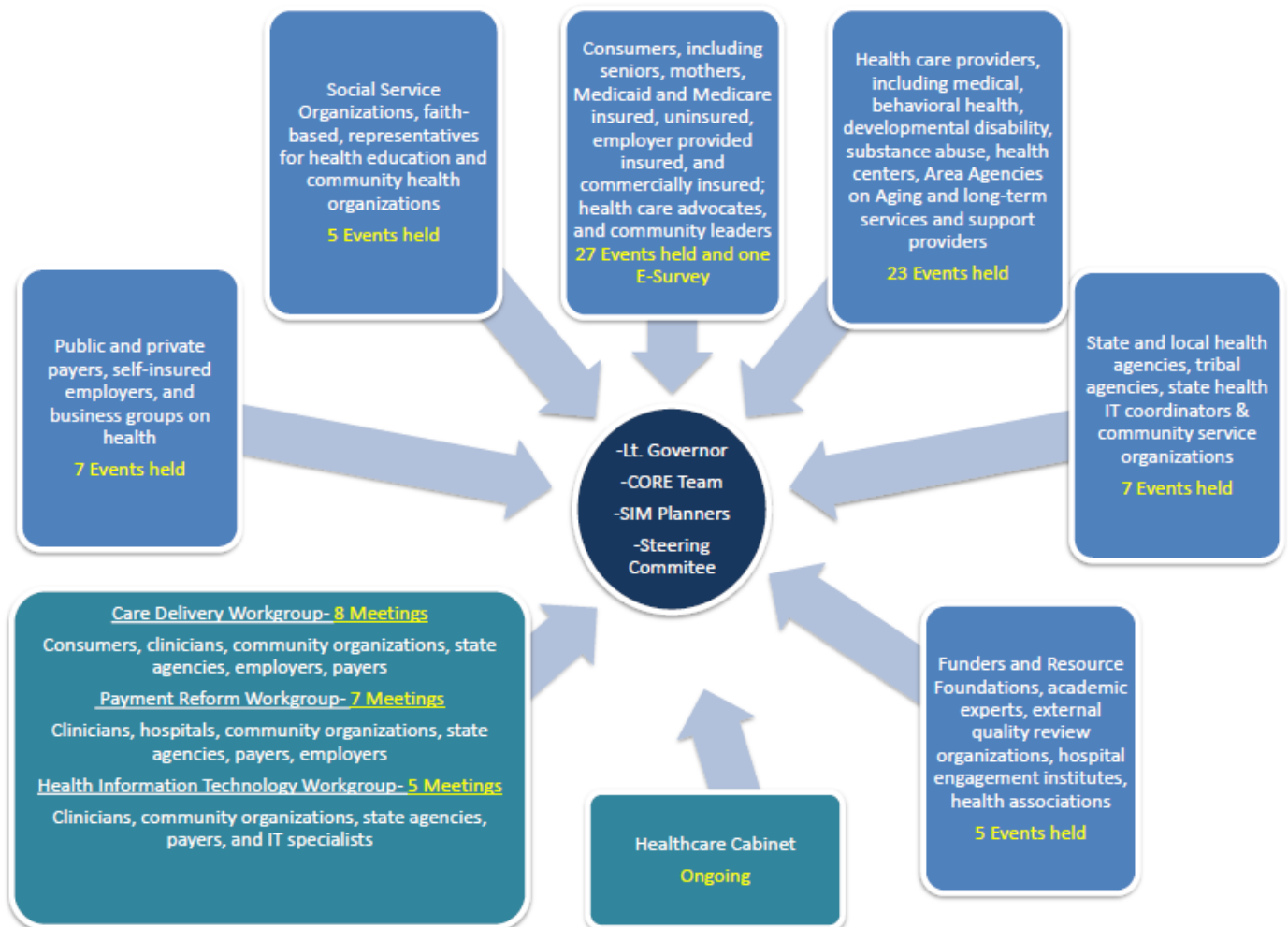
A State Healthcare Innovation Plan Steering Committee (Steering Committee) was formed in order to guide the core team on issues of key strategic, policy and programmatic concerns. This committee is chaired by the Lieutenant Governor and includes Commissioners from seven state departments including the DSS, the Department of Public Health (DPH), the Office of Policy and Management (OPM), the Office of the State Comptroller Office (OSC), DMHAS, the Department of Children and Families (DCF) and the Connecticut Insurance Department (CID) and the Dean of the School of Medicine from the University of Connecticut Health Center (UCHC). 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 Access Health CT. The core team reported on at least a monthly basis to the Steering Committee. Two consumer advocates were added to the steering committee in November 2013.

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.

### **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. For a complete list of stakeholder events and participants, see Appendices F and G.

## EXHIBIT 30: Stakeholder Participation Diagram



## 1.1 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.

### EXHIBIT 31

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

The workgroups also deliberated on a set of options related to specific focus areas particularly pertinent for Connecticut, including options for aligning regulatory authorities, for mechanisms to develop community awareness, and for leveraging HIT and EHR to improve health. A full description of these considerations can be viewed in the Appendix H.

## 1.2 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 begin 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.

### **1.3 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 input into and feedback on the stakeholder strategy described in detail below.

### **1.4 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](http://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](mailto:sim@ct.gov)) and staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

### **1.5 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 December, the SIM Planning team had met with more than 50 stakeholder groups. (See Appendix G for full list of stakeholder events).

### **Input Phase (June-September 2013)**

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. The Healthcare Cabinet was instrumental in assisting the planning team with meeting participation. A set of key questions was developed for each stakeholder category, 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 with the help of the Universal Health Care Foundation of Connecticut and its extensive community of 18,000 listserv subscribers. 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 (September - October 2013)**

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*.

Also during this phase, the SIM team convened three meetings with health equity stakeholders for the purpose of feedback on the emerging model. These discussions catalyzed the prominence of health equity in our innovation plan.

### **Plan Syndication Phase (November – December 2013)**

A complete draft of the Innovation Plan was posted the SIM website on November 1<sup>st</sup>, 2013 and in the Connecticut Law Journal on November 5th. Written comments were requested with a posted deadline of November 30<sup>th</sup>. Comments received after that date were considered. All comments received were posted at [www.healthreform.ct.gov](http://www.healthreform.ct.gov). The SIM planning team returned to many of the above forums and convened or reconvened focus groups to gather feedback on the plan.

The SIM planning team reviewed all of the written comments and learnings from the various meetings and focus groups. Much of the commentary resulted in adjustments to the plan and clarifications where the original plan was unclear. Other comments raised issues that required review by the Steering Committee. Finally, there were a number of comments that additional detail that will only be available when the State completes the detailed design phase in 2014. These comments will be summarized and made available to the SIM planning team and the various councils and task forces that will be doing the detailed design work. The SIM planning team is in the process of preparing a formal response to comments, which we expect to post alongside the comments by the end of January 2014.

## 1.6 DESIGN PROCESS DELIBERATIONS

Throughout the various phases of the project the SIM planning team brought issues to the Steering Committee for consideration. The issues were framed in slide presentations that were shared with the Committee in advance of the meetings. After presenting the model overview in early September, Steering Committee members were asked to comment and a detailed response to comments was provided to facilitate decision making in the October meeting.<sup>88</sup> A similar process was followed in December, this time focusing on the most important and challenging issues raised during the syndication phase. The SIM planning team prepared a summary of each issue with an analysis and recommendation for discussion.<sup>89</sup> The major issues were resolved, paving the way for preparation of the final plan. The Steering Committee operated on a consensus model. Although it was not practicable to bring all of the design decisions to the Steering Committee, it is fair to say that the Steering Committee supports the overall approach outlined in the Innovation Plan and that issues that were the subject of the most concern were resolved.

<sup>88</sup> [http://www.healthreform.ct.gov/ohri/lib/ohri/SIM\\_Steer\\_Cmt\\_Issues\\_09172013.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/SIM_Steer_Cmt_Issues_09172013.pdf)

<sup>89</sup> [http://www.healthreform.ct.gov/ohri/lib/ohri/SHIP\\_1-1\\_Syndication\\_Key\\_Issues\\_12102013.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/SHIP_1-1_Syndication_Key_Issues_12102013.pdf)



## 2. Future 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:

**EXHIBIT 32: Future Governance Structure**



- **Healthcare Innovation Steering Committee:** a group similar to the existing Steering Committee with additional consumer advocates, consumers, health equity 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.
- **Consumer Advisory Board:** The Consumer Advisory Board will be directly linked to the Steering Committee and the Program Management Office for the purpose of providing advice and guidance. The Consumer Advisory Board will also be invited to arrange for consumer representation on each of the SIM taskforces and councils, as well as the steering committee. The Consumer Advisory Board will facilitate consumer participation at these meetings, provide the necessary guidance and support, and discuss issues brought back from the meetings with the larger group. This will reinforce consumers in every part of the planning process. The Board will solicit further input from the broader consumer community on an ongoing basis. The Consumer Advisory Board will also coordinated participation of consumer organizations and networks, including the navigator and assister network created through Access Health CT.

- **Healthcare Cabinet (HCC):** 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 Healthcare Cabinet will provide input and guidance to the Steering Committee and Project Management Office.
- **Program Management Office (PMO): a state office sitting within the Office of the Healthcare Advocate and 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. Accountability for health equity will reside within the PMO. Health equity objectives and solutions will be integrated into the work of the various councils and task forces.
- **Provider Transformation Taskforce:** a group that will be comprised of consumer and health equity 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 Metrics Council** will develop a core measurement set for use in the assessment of primary care, specialty and hospital provider performance and the overall evaluation of the Connecticut health and healthcare systems. The council will develop a common provider scorecard format for use by all of the payers. The measurement set will be reassessed on a regular basis to identify gaps, to incorporate new national measures as they become available, and to keep pace with changes in technology and clinical practice. The Council will be comprised of consumers, consumer advocates, a health equity advocate, 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, equity, and consumer experience. Physicians representing all types of physician practices will be consulted in the metrics development process.
- **Health Information Technology 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 and health equity advocates, public health expert including NCQA, NQF, and Medicare, 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.

- **Workforce Taskforce:** will provide counsel and support in the execution of the six initiatives described in Enabling Initiatives, D. Healthcare Workforce Development. The council will monitor shifts in workforce needs as the implementation of this plan progresses, and will advise on how these needs can be best addressed. The council will consider whether scopes of practice of health professions and/or allied health professions need to be addressed, and if so, the process by which they should be addressed. The council will be comprised of senior educators and administrators broadly representative of the colleges and universities that educate Connecticut's clinical professionals and allied health professionals and of the clinical professions: dental medicine, medicine, nursing, pharmacy, physician assistant and social work, experts in field of health workforce development, and representatives of both non-profit and for-profit healthcare providers.

Lieutenant Governor Nancy Wyman will provide the overall authority for the Connecticut Healthcare Innovation Plan ("Innovation Plan"). The Project Management Office (PMO) will be accountable for the conduct of specific initiatives, especially those that involve interagency collaboration or which do not fall within the purview of a single line agency. Accountability for other elements and initiatives of the Plan will reside within line agencies. These agencies will work closely with the PMO to implement aspects of the Plan and the designated line agency leads will participate on the SIM implementation team. During the next several weeks, we will determine which departments and individuals will have ownership and accountability over specific initiatives.

To the extent possible, decisions regarding the plan will be made in a collaborative process with the Program Management Office, the taskforces and councils, the Healthcare Cabinet and the Consumer Advisory Board, with the Lt. Governor being the ultimate decision maker.

During stakeholder feedback, a variety of healthcare professionals requested involvement in the SIM governance structure. We believe it is important to garner as many diverse perspectives as possible to create meaningful reform. We will consider whether and to what extent representatives of the many healthcare professionals will be appointed to councils directly versus advising through a separate mechanism.

## 3. Transformation Roadmap

The State 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. It aims to transform Connecticut's healthcare system by establishing Advanced Medical Homes, strengthening community-based linkages, and empowering consumers. Within five years (input specific goals here).

### 3.1 HIGH-LEVEL TIMELINE

Four phases will mark the implementation of the transformation over the next five years: producing a detailed design, intensive planning, and two waves of implementation.

#### **Detailed Design (*January to September, 2014*)**

Pending stakeholder feedback and refinement of the Innovation Plan, the first nine months will include the following main activities:

- **Establishment of governance structure** including Project Management Office, task forces and councils, as described in the governance section.
- **Developing the more detailed technical design** necessary to support new models, including; measures of quality, consumer experience, and resource utilization; technical requirements for shared HIT capabilities; evaluation design, pace and performance dashboards and metrics; finalization of care coordination fees; detailed rules for patient attribution, costs included in "total cost of care," risk-adjustment, clinical exclusions, and cost outlier provisions; CLAS considerations finalized and; P4P bonus schedules and risk corridors for shared savings for Medicaid.
- **Engaging stakeholders** to align on design details. Taskforces and councils outlined in the governance section, meetings, and other events will gather consumers, advocates, payers, and providers to collaborate on issues such as setting medical home standards and determining methods for identifying and responding to evidence of inappropriate patient selection and under-service.
- **Creating initial long-term, scalable infrastructure** including: designing a suggested menu of VBID options that can be offered on an insured or self-insured basis; identifying Health Enhancement Communities pilots and; strategies for piloting and funding Designated Prevention Service Centers.

#### **Implementation Planning (*October 2014 to June 2015*)**

Pending award of CMMI State Innovation Models Testing Grant and securing other funding, 9 months of implementation planning will begin to prepare for 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.
- **Continue engaging stakeholders**, through: structures developed in the governance structure; education and enrollment of providers interested in Glide Path and AMH model; engagement of public and private payers and funders around Certified Entities; and education and marketing to consumers.
- **Develop or implement elements finalized during detailed design phase**, such as: version 1.0 of consumer/provider portals and version 1.0 AMH performance reports for Medicaid and other payers electing to leverage common reporting; nutritional assistance pilot program; Community Health Worker basic training and; community wide population health measures for EHCs.

#### **Implementation Wave 1 *(July 2015 to June 2016)***

State Fiscal Year 2016 will mark the first year of operations of the multi-payer model for the Advanced Medical Home as well as initiation of new capabilities to support Workforce Development. Key activities will include:

- **Official launch of AMH model**, including rolling out practice transformation support to Glide Path providers; arrange for quarterly payments of care coordination fees;
- **Collection and reporting of data** such as capturing clinical data and transformation milestones through the multi-payer provider portal; implement collection of pace and performance data by July 1, 2014; aggregating data across payers and; quarterly performance reporting to providers based on the AMH Common Scorecard and; deploy new surveys and database to support workforce data collection and analysis.
- **Launching and supporting Health Enhancement Community pilots, Community Health worker training, and Connecticut Service Track.**
- **Educate, inform, and incentivize stakeholders** such as: by marketing to consumers on how to use Patient Portals, and where to go for care needs; by educating and enrolling Wave 2 participating providers for Glide Path and AMH models and; by implementing the nutritional assistance pilot program.
- **Further development of AMH supporting infrastructure**, including developing version 2.0 portal and performance reports, and designing the Connecticut Service Track, the Community Health Worker training program, and flexible career ladder.

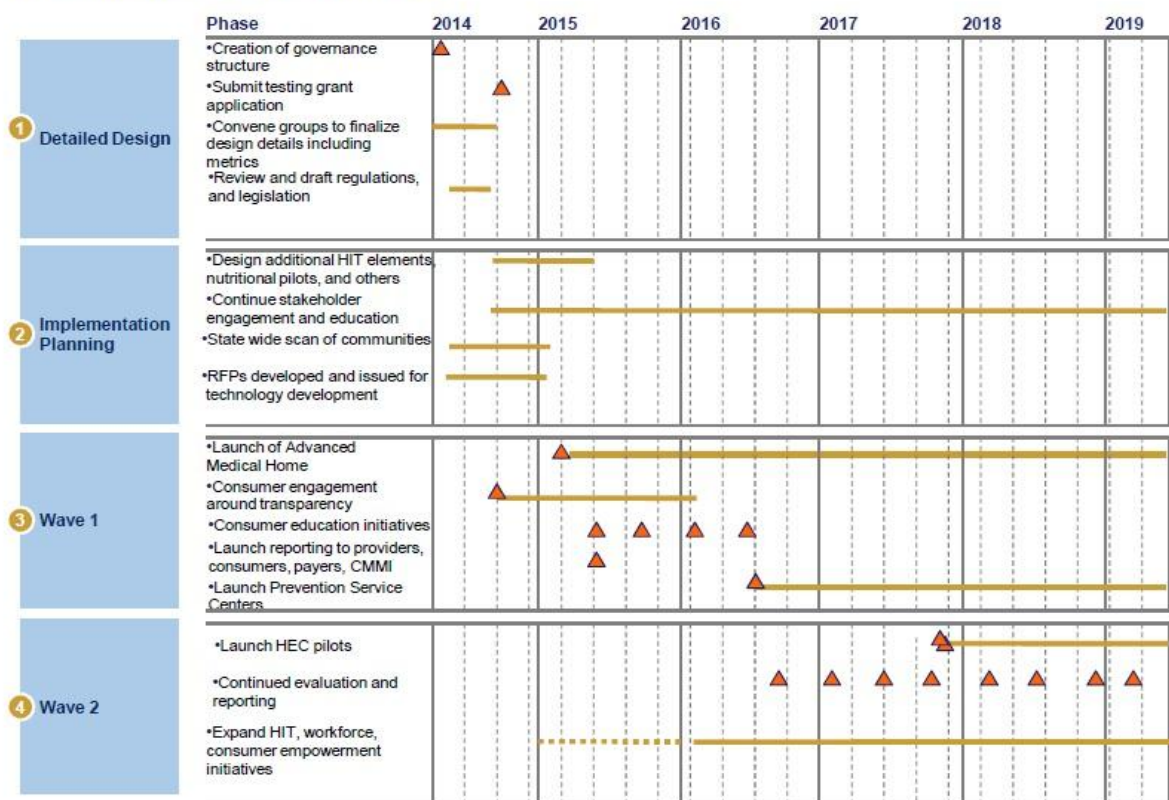
#### **Implementation Wave 2+ *(July 2016 to June 2020)***

In SFY 2017 and beyond, continuous improvements, and scaling up of initiatives will be achieved. 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 includes these major activities:

- **Continuous improvement** on areas such as to the Common Scorecard; consumer/provider portal; data aggregation; analytic and reporting capabilities and; Community Health Worker training.
- **Expansion of initiatives**, including the nutritional assistance program.
- **Launch of final elements**, such as: launch of Certified Entities; implementation of Connecticut Service Track; implementation of Community Health Worker training program; implementation of support for flexible career ladders; Primary care residency programs that stress AMHs are expanded and; full implementation of plan for health workforce data and analysis.
- **Continuing monitoring and reporting** in order to evaluate our progress and effectiveness of initiatives.

#### EXHIBIT 33:

#### Timeline for transformation



## 3.2 MAJOR MILESTONES

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.

### EXHIBIT 34: Major Milestones (1/2)

#### Primary Care Transformation and Enabling Initiatives

	Detailed Design Jan – Sept 2014	Implementation Planning Oct 2014 – June 2015	Wave 1 July 2015 – June 2016	Wave 2+ July 2016 – June 2020
Advanced Medical Home	<ul style="list-style-type: none"> <li>Achieve multi-payer consensus on standards</li> <li>Payers align on advance payments (e.g., care coordination)</li> </ul>	<ul style="list-style-type: none"> <li>Conduct baseline capability assessment/performance reporting for providers interested in Glide Path and AMH model</li> <li>Procure practice transformation products/services</li> </ul>	<ul style="list-style-type: none"> <li>Implement direct messaging and ADT</li> <li>Conduct baseline capability assessment for Wave 2 providers</li> <li>Initialize practice transformation supports</li> <li>Launch AMH</li> <li>Remove policy barriers to PC/BH integration</li> </ul>	<ul style="list-style-type: none"> <li>Practices adopt care management tools</li> </ul>
Performance Transparency	<ul style="list-style-type: none"> <li>Develop core set of quality metrics</li> <li>Finalize evaluation scorecard</li> <li>Collection of pace and performance data implemented by July 1, 2014</li> </ul>	<ul style="list-style-type: none"> <li>Develop V1.0 AMH performance reports for Medicaid and other payers</li> <li>Develop standards reporting requirements for payers and providers</li> </ul>	<ul style="list-style-type: none"> <li>Institute quarterly performance reports</li> <li>Capture clinical data and transformation milestones</li> <li>Implement common performance scorecard</li> <li>Implement core performance metrics</li> </ul>	<ul style="list-style-type: none"> <li>Manage program evaluation and outcomes effectively</li> <li>Aggregate cross-payer data</li> </ul>
Value-Based Payment	<ul style="list-style-type: none"> <li>Finalize rules for patient attribution, risk adjustment</li> <li>Finalize Medicaid payment structure rules (e.g., bonus schedule, CC fees)</li> <li>Identify Equity and Access monitoring methods</li> </ul>	<ul style="list-style-type: none"> <li>Establish AMH analytics for risk stratification, attribution and TCOC calculation</li> </ul>	<ul style="list-style-type: none"> <li>Introduce shared savings, moving away from FFS</li> <li>Pay Care coordination fees quarterly</li> <li>Implement Equity and Access monitoring methods</li> </ul>	<ul style="list-style-type: none"> <li>Execute tailored modifications</li> </ul>
Health Information Technology	<ul style="list-style-type: none"> <li>Develop technical requirements for shared HIT capabilities, RFPs for technology development</li> </ul>	<ul style="list-style-type: none"> <li>Develop V1.0 consumer/provider portals</li> <li>Procure technology development products/ services</li> <li>Implement APCD</li> </ul>	<ul style="list-style-type: none"> <li>Implement system level public health/ epidemic analyses</li> <li>Launch bi-directional provider-payer-patient communication/ data exchange</li> <li>Potentially integrate statewide HIE</li> </ul>	<ul style="list-style-type: none"> <li>Expand HIT adoption</li> </ul>
Workforce Development	<ul style="list-style-type: none"> <li>Conduct provider transformation survey</li> <li>Constitute Health Workforce Council</li> </ul>	<ul style="list-style-type: none"> <li>Draft legislation for CHW certification</li> </ul>	<ul style="list-style-type: none"> <li>Design CT Service Track, CHW training program and flexible career ladder</li> <li>Implement mandatory e-licensing renewals for all health professionals</li> <li>Implement Pace &amp; Performance Dashboards</li> </ul>	<ul style="list-style-type: none"> <li>Launch CT Service Track, CHW training program and flexible career ladder</li> <li>Implement health workforce data and analysis</li> <li>IPE becomes standard practice</li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>Finalize evaluation measures and targets</li> </ul>	<ul style="list-style-type: none"> <li>Collect baseline data</li> </ul>	<ul style="list-style-type: none"> <li>Establish performance team to review rapid cycle analyses and adjust course as necessary</li> </ul>	



## EXHIBIT 35: Major Milestones (2/2)

### Community Health Improvement & Consumer Empowerment

	Detailed Design Jan – Sept 2014	Implementation Planning Oct 2014 – June 2015	Wave 1 July 2015 – June 2016	Wave 2+ July 2016 – June 2020
Designated Prevention Service Center	<ul style="list-style-type: none"> <li>Conduct statewide scan and evidence review</li> <li>Complete regional definition and identification</li> <li>Explore funding strategies and convene stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Engage funders</li> <li>Initiate feasibility study</li> <li>Engage public and private payers</li> </ul>	<ul style="list-style-type: none"> <li>Engage and educate AMHs</li> <li>Update intervention protocols</li> <li>Complete Prevention Service Center procurement</li> </ul>	<ul style="list-style-type: none"> <li>Launch of Prevention Service Center pilot</li> <li>Evaluation begins</li> </ul>
Health Enhancement Communities (HECs)		<ul style="list-style-type: none"> <li>Develop HEC requirements</li> </ul>	<ul style="list-style-type: none"> <li>Create community-wide population health measures</li> <li>Set up reserve fund</li> <li>Release RFP</li> <li>Establish HECs and regional incentive pools in statute</li> </ul>	<ul style="list-style-type: none"> <li>HEC Application review</li> <li>Launch 3-5 HEC pilots</li> <li>Implement regional incentive pools</li> <li>Design evaluation</li> </ul>
Consumer Information	<ul style="list-style-type: none"> <li>Convene consumer experts</li> <li>Prepare consumer curricular with stakeholder inputs</li> </ul>	<ul style="list-style-type: none"> <li>Identify third party funding for health education</li> <li>Create standards for decision support tools</li> <li>Choose decision support tools</li> </ul>	<ul style="list-style-type: none"> <li>Marketing begins to consumers about Consumer Portal</li> <li>Distribute information about where to go to meet care needs</li> <li>Implement decision support tools</li> </ul>	<ul style="list-style-type: none"> <li>Launch Consumer Portal</li> <li>Marketing begins to consumers about Consumer Portal</li> </ul>
Consumer Incentives		<ul style="list-style-type: none"> <li>Design nutritional assistance pilot program</li> <li>Design menu of VBID options</li> </ul>	<ul style="list-style-type: none"> <li>Launch of nutritional assistance pilot program</li> <li>Promotion of VBID</li> </ul>	<ul style="list-style-type: none"> <li>Expand nutritional assistance program</li> </ul>
Mechanisms for consumer input	<ul style="list-style-type: none"> <li>Formation of the Consumer Advisory Board</li> </ul>	<ul style="list-style-type: none"> <li>Identify funding for Care Experience vendors</li> <li>Procure survey vendors</li> <li>Conduct baseline survey</li> </ul>	<ul style="list-style-type: none"> <li>Incorporate consumer experience surveys into value based payment</li> </ul>	



## 4. Use of Executive, Regulatory and Legislative Levers

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

**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
- Accredit 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

**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, in conjunction with the APCD Advisory Council, will consider changing this policy so that the APCD can provide detailed analytics at the individual level.

**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).

**Modernize regulatory approaches to adopt meaningful safeguards to foster patient care and access:** Innovations to the state's healthcare delivery system are designed to improve access to quality affordable care. Connecticut's Office of the Attorney General (OAG) plays an active role in ensuring open and competitive health care markets through the enforcement of the Connecticut Antitrust Act and by providing counsel and advice to state agencies on competition policy. Lack of pricing transparency and highly concentrated markets often lead to higher health care costs for employers and consumers. Thus, for markets to be truly competitive, all consumers must have sufficient and viable alternatives among an array of providers as well as meaningful and reliable pricing information so that the consumer can make informed decisions and obtain the highest quality of care. Accordingly, the OAG intends to propose legislation that will (1) support transparency in

health care price information for consumers, and (2) require notice of acquisition of physician provider practices. The Connecticut Healthcare Innovation Plan believes that competition and transparency are necessary adjuncts to a transformed health care delivery system that incorporates promotion of integrated care models and fully supports the Attorney General's proposed legislative efforts to provide increased access to cost, price and quality data for healthcare services to enable patient choice. Connecticut will also explore possible legislative or administrative actions related to the APCD to allow for unimpeded access to such data by consumers. Connecticut will also pursue legislative or regulatory changes to ensure payer reporting to the Connecticut Insurance Department on public health and quality metrics utilized in the SIM model.

**Remove barriers to primary care and behavioral health integration:** Adult behavioral health clinics are currently not permitted to co-locate licensed clinicians in primary care practice settings. DPH and DMHAS will review licensing and reporting to eliminate duplication and administrative complexity, to allow providers the flexibility to integrate primary and behavioral health, and to allow use of other clinical staff in a practice under the supervision of a physician. Review barriers to primary care-behavioral health service integration caused by insurance regulation and/or carrier policies. Ensure patient access to team-based care may require regulatory action to allow co-location of behavioral health clinic providers in the primary care practice's location.

**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 eHealthConnecticut, 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. To support meaningful use, the state will consider requirements that clinical labs electronically report data to the ordering physician and to the APCD using consistent codes and values among all labs doing business in Connecticut.

**Enable multi-payer and provider participation in our care-delivery model:** By enabling updated online information on primary care practitioners' participation in a medical home and readiness for our AMH model through an online licensure application and renewal process, providers can demonstrate to multiple payers their willingness to participate in the AMH. Payers can identify practices that are willing to engage in Connecticut's shared savings programs.

**Ensure removal of barriers to provider participation in our model:** Connecticut will undertake a review of regulations that are inconsistent with federal law and/or directly conflict with participation in the AMH and shared savings programs, but we will do so in a manner that ensures the consumer access to superior quality care is not compromised. The Connecticut Insurance Department will also ensure that amendments to standardized claims forms are required.

The state will consider regulatory provisions that might enable solo and small practices to accurately and efficiently share clinician and cost information real time with their peers across the system (and across practices). The State will evaluate how this could be achieved with consideration of anti-trust restrictions, potentially, by allowing the collaborative sharing of such information as monitored by a state actor such as the health care advocate's office.

**Ensure Population Health:** Connecticut will continue to propose legislative and/or regulatory action to ensure that while all efforts are statewide, but address how special populations may be disproportionately impacted. The state will continue to address the following areas: exposure to secondhand smoke in indoor environments, reduction of the availability of tobacco products, reduction of the consumption of excess sodium, increase access to affordable and nutritious foods and beverages, increase access and opportunities for physical activity, increase access to programs that prevent dental caries/cavities, increase the utilization of credentialing and certification of Chronic Disease Self-Management (CDSM) programs and providers.

**Ensure VBID programs are appropriately packaged:** The Connecticut Insurance Department will monitor insurance plans to ensure that the details of wellness programs and any payments or reimbursements to consumers are contained in policy documents (policies for individual insurance and group certificates for group health policies).

**Prepare for a new workforce and community health improvement:** The state will determine what legislative and regulatory actions are needed to designate prevention support entities and health enhancement communities, to expedite a certification of "community health worker," to bring community based organizations and AMHs to the table to determine and agree to partnership terms that are fair to all parties, to allow practitioners to practice at the top of their licenses, to adopt loan forgiveness programs, to include cultural competency standards for licensed providers and to develop training opportunities and career ladders, to determine designation and resourcing of Health Enhancement Communities.

**Review and identify options for restructuring Medicaid supplemental payment programs to align the incentives with the goals of the state's payment and delivery system reform Model:**

The Connecticut Department of Social Services (Connecticut's state Medicaid agency) will expand the current Medicaid supplemental payment structure, which currently includes, among other programs, the Person-Centered Medical Home (PCMH) program. Through a variety of mechanisms, including Medicaid State Plan amendments, Medicaid waivers, and revision of state Medicaid regulations, the scope of the PCMH program could be broadened and/or new programs could be created to align incentives with the payment and delivery system reforms. For example, performance incentive payments could be expanded, care coordination payments could be made on a per-member-per-month or other basis, and payment methods could include shared savings. The Department will engage with CMS to determine the most appropriate approach to potential State Plan Amendments and/or waivers that would accomplish these goals.

## 5. Evaluation plans

To evaluate the state's performance in achieving our vision, we will closely monitor our *performance* relative to the overall goals of the SIM and the *pace* of healthcare system transformation necessary to achieve these goals. To assess Connecticut's implementation of its enabling initiatives and their impact on the primary drivers of health system transformation, we will draw from multiple data sources on a regular schedule to monitor changes in the state's health system (e.g., uptake of the AMH practice model, prevalence of value based payments), we will develop measures and use methodologically rigorous data collection strategies, and measure progress towards the SIM goals.

We will collect measures frequently enough to allow for rapid cycle evaluation and facilitate mid-course corrections if the state fails to meet its performance and pace targets. To provide a comprehensive assessment of the state's progress in achieving these goals, we will use a multi-method approach that uses quantitative research methods and sophisticated statistical modeling in combination with qualitative data and interviews from key stakeholders. In this section, we discuss our methods for measuring our achievements along these dimensions.

### 5.1 TRACKING PROGRESS: PACE AND PERFORMANCE DASHBOARDS

The results from the analyses described above will be tracked and summarized on Pace and Performance “dashboards” that will allow the state to monitor progress and make adjustments as necessary. The dashboards 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 Program Management Office and members of the Steering Committee, to ensure that the program is on track and that modifications can be made on an ongoing basis.

### 5.2 PERFORMANCE DASHBOARD

A preliminary set of proposed performance measures are presented below. Final measures will be recommended by the Quality Council by mid-2014, so that the measurement and evaluation strategy can be fully implemented by March 2015.

## EXHIBIT 36: Performance Dashboard Targets

### PERFORMANCE DASHBOARD

#### Performance Dashboard: Targets (1/3)

● Improving ● Maintaining  
● Deteriorating

	Metrics	Statewide				Equity specific	
		Current Perf. <sup>1</sup>	Benchmark	5-year target	Trend	Current Gap/Perf.	Target
Health	▪ Diabetes (adults)	▪ 8.5%	▪ 75th	▪ 8%	●	▪ 14.3%	▪ 12%
	▪ Asthma (adults)	▪ 8.6%	▪ --	▪ TBD	●	▪ --	▪ 0%
	▪ Asthma (children)	▪ 11.3%	▪ --	▪ TBD	●	▪ --	▪ TBD
	▪ Falls resulting in death (per 100,000)	▪ 6.3	▪ --	▪ 5.3*	●	▪ --	▪ TBD
	▪ Obesity (adults)	▪ 24.5%	▪ Top 5	▪ 23.3%	●	▪ 21.4%	▪ 0%
	▪ Median fruit/veg intake (times per day)	▪ 3.1	▪ --	▪ TBD	●	▪ 0.6	▪ TBD
	▪ Participation in aerobic exercise (adults)	▪ 21.8%	▪ --	▪ TBD	●	▪ 5.4%	▪ TBD
	▪ 14 or more unhealthy days in past month	▪ 6.9%	▪ --	▪ TBD	●	▪ 5.6%	▪ TBD
	▪ Tobacco use (current smokers)	▪ 17.1%	▪ Top 5	▪ 15%	●	▪ 25%	▪ 23%
	▪ Tobacco use (attempted to quit)	▪ 68%	▪ --	▪ TBD	●	▪ --	▪ TBD
Quality	<i>Improved quality</i>						
	▪ P4P providers meeting comprehensive quality scorecard targets/index	To be defined over remainder of design phase by metrics taskforce					
	▪ SSP providers meeting comprehensive quality scorecard targets/index						

<sup>1</sup> 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

\*Subject to change



## Performance Dashboard: Targets (2/3)

Improving
 Maintaining

Deteriorating

	Metrics	Statewide				Equity specific	
		Current Perf. <sup>1</sup>	Benchmark	5-year target	Trend	Current Gap/Perf	Target
Quality (cont'd) & Care Exp.	▪ Children well-child visits	▪ 90.3%	▪ Top 5	▪ TBD		▪ --	▪ TBD
	▪ Mammogram for women over 50 in last 2 years	▪ 83.9%	▪ --	▪ TBD		▪ 74%	▪ 77.7%
	▪ Adults aged 50+ who had colorectal cancer screening	▪ 74.8%	▪ --	▪ TBD		▪ 11.4%	▪ TBD
	▪ Optimal diabetes care (annual foot exam)	▪ 72.7%	▪ --	▪ 75.3		▪ %	▪ TBD
	▪ Optimal diabetes care (annual dilated eye exam)	▪ 79.6%	▪ --	▪ TBD		▪ --	▪ TBD
	▪ Optimal diabetes care (annual-2 or more A1c tests)	▪ 72.9%	▪ --	▪ TBD		▪ 7.7%	▪ TBD
	▪ Taking HBP medication (adults)	▪ 78.7%	▪ 50th	▪ 79.2		▪ 19.4%	▪ TBD
	▪ Providers serving racial/ethnic minorities	▪ --	▪ --	▪ TBD		▪ --	▪ 0%
	<i>Improved consumer experience*</i>						
	▪ CAHPS Clinician/group Surveys	To be further developed by evaluation team					
▪ CT Medicare ACO Survey scores							
▪ CT Medicare ambulatory CAHPS Scores							
<i>Attribute savings to better, more appropriate, and cost effective care</i>							
Cost	▪ Hospitalizations (ambulatory care sensitive conditions)	▪ --	▪ --	▪ TBD		▪ --	▪ TBD
	▪ Readmissions for avoidable complications	▪ --	▪ --	▪ TBD		▪ --	▪ TBD
	▪ ED utilization (ambulatory care sensitive cond.)	▪ --	▪ --	▪ TBD		▪ --	▪ TBD

<sup>1</sup> 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

\*Preliminary and partial

## Performance Dashboard: Targets (3/3)

Improving
 Maintaining

Deteriorating

	Metrics	Statewide				Equity specific	
		Current Perf. <sup>1</sup>	Benchmark	5-year target	Trend	Current Gap/Perf. <sup>3</sup>	Target
Cost	ED use without hospitalization	1244					
	Duplicative testing	—	—	—		—	—
	Generic prescriptions	—	—	—		—	—
	Use of lower-cost providers	—	—	—		—	—
	Asthma ED visits (per 10,000 pop)	168.3	—	—		8.5%	—
	Hospitalizations due to falls (per 100,000)	249.6	—	245*			—
	<i>Expenditures relative to GSP</i>						
	PMPY cost trend	—	—	—		—	—
	GSP per capita trend	—	—	—		—	—
	Difference between PMPY and GSP	—	—	—		—	—

<sup>1</sup> 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

\* Subject to change

### 5.3 PACE DASHBOARD

The State will also track 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. The State will examine increases in payer, employer and provider participation in advanced primary care and shared savings arrangements over the next several years, with the goal of achieving desired impact within 5 years. We will look for evidence that we are improving healthcare outcomes while reducing the waste and inefficiencies that collectively account for approximately 6 to 12 percent of healthcare spending. We expect to see a portion of savings shared with providers who contribute to the savings while also meeting goals for quality of care and consumer experience. After 5 years, we expect to maintain or decrease rate of cost increases through efficiencies arising from workforce development and improved prevention arising from community health improvement.

Metrics that reflect the pace of reform will include, for example:

#### **Primary drivers**

- Primary care practice transformation: Number and percent of providers able to meet each practice transformation standard and national CLAS standards; number and percent of providers who are participating in the Glide Path, number and percent of providers who are AMH recognized
- Community Health Improvement: Number and percent of population residing in a Health Enhancement Community; number and percent served by Prevention Service Centers; number and percent of practices assisted by a Prevention Service Center; 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 a VBID or employer incentive program; 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 care experience; number of consumers and percent of population who access quality and cost information, participate in shared decision making, and have access to a consumer portal (limited scope/full scope).

#### **Enabling initiatives**

- Performance transparency: Number of payers who have adopted the 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 participating in a shared savings arrangement; number of payers including care experience in their value-based payment models

- Health information technology: Number of payers offering advanced analytics; implementation of provider portal, initial and advanced with analytics; number and percent of providers participating in direct messaging; number and percent of providers using 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; # of certified CHWs per year; articulation agreements, etc.

## 5.4 EVALUATION TEAM

Connecticut's colleges and universities collectively possess a wealth of expertise in the evaluation methodologies and approaches required to assess changes in healthcare delivery, spending, and health outcomes associated with Connecticut's State Innovation Model. Accordingly, the SIM Evaluation Team will consist of a formal collaboration among these institutions through which the breadth and depth of expertise required for rigorous evaluation of SIM programs and activities will be assembled. The Evaluation Team will be led by researchers at the University of Connecticut Health Center and Yale University.

Other faculty and staff in Connecticut's universities will provide both the subject matter expertise and the methodological and statistical expertise (e.g., experimental design; survey and questionnaire design; program evaluation; and advanced statistical modeling) for the proposed projects.

## 5.5 THE ROLE OF THE SIM PROJECT MANAGEMENT OFFICE

Connecticut's SIM Project Management Office will manage the overall evaluation and improvement efforts, with responsibilities including, but 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 and,
- Publishing results to increase transparency on performance relative to targets

The Project Management Office will work with the Quality Council, which will review and make final recommendations regarding measures and performance targets, and measures that will be presented on the statewide Performance Dashboard. Final decisions will be made in consultation with the Steering Committee by mid 2014, so that the measurement and evaluation strategy can be fully implemented by March 2015.



The Project Management Office will work with the Evaluation Team to evaluate the AMH model's performance and identify opportunities for continuous performance improvement. The Project Management Office and the Evaluation Team will also work with various state agencies to develop monitoring and evaluation expertise in those agencies. This arrangement will ensure continuity and develop in-state expertise for continued evaluation of its health system transformations.

## 5.6 DATA TYPES AND DATA SOURCES

To monitor system changes and progress towards the Innovation Plan goals, Connecticut will use existing data whenever possible and will coordinate closely with CMMI and other relevant parties when developing new measures and data collection strategies. Satisfying this condition will help ensure that the new measure can be used to support and assess continuous improvement efforts. The state will also share successes and challenges with CMMI and other states so they can collectively develop best practices. Finally, Connecticut will provide 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.

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

### Survey Data

Existing survey data as well as newly collected surveys of patients/consumers, providers, and large employers will be used to assess changes in healthcare delivery and health outcomes associated with the SIM. Examples of data that could be collected through surveys include:

- Consumer experiences with healthcare (e.g., reports of the quality of providers' interactions with consumers ; consumer engagement, education, and decision-making; the quality of care transitions; access to care outside of normal business hours; and whether culturally and linguistically sensitive care is provided. Health status in selected groups of patients.
- Provider activities, changes in practice arrangements, and perceptions of and/or reactions to policy and system changes (e.g., physician's implementation of AMH components such as flexible scheduling and EHRs/clinical decision support), percent of revenue received through value based payments.
- Employer programs and/or contracts that provide incentives for more efficient and effective care and what proportion of employees are covered by different insurance plans/products.
- Payer covered populations, proportion of individuals who are covered under value based insurance designs (VBID), are in plans/systems that are eligible for advance or care coordination payments, and/or other performance incentives.

The Evaluation Team has access to a great deal of existing survey data, including the CDC's Behavioral Risk Factors Surveillance System (BRFSS) which includes interviews with over 6000 CT residents in 2009, and three recent surveys of CT physicians that examined issues related to

the CT physician workforce and their impact on patient access to care, implementation of the medical home, and physicians' and their staffs' levels of cultural competence. In addition, existing data on CT consumer experiences with their health plans and medical services is available through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) projects funded by the Agency for Healthcare Research and Quality (AHRQ). Dr. Paul Cleary from the Evaluation Team is Principal Investigator of one of the CAHPS® projects and also works on several CAHPS® implementation projects for the Centers of Medicare & Medicaid Services (CMS). Thus, he has access, contingent on CMS approval for its use, to data from samples drawn from every Medicare Advantage plan in CT, as well as a probability sample of Medicare beneficiaries in traditional fee-for-service Medicare, hospital CAHPS® data collected for CMS, and CAHPS® data from accredited health plans in CT. These data can be used to develop state-specific and subgroup estimates (e.g. by gender, race, ethnicity). For example, preliminary analyses indicate that the average rank among states of Connecticut on Hospital CAHPS® composite scores in 2009 and 2010 was about 30 and the average rank on Medicare ambulatory CAHPS® scores was about 22, which reflects below average consumer assessments of hospital care and close to average assessments of ambulatory care in a State with the third highest per capita healthcare expenditures in the country.

Regarding the development of new surveys to assess SIM participation and performance, the evaluation team has extensive experience developing and administering patient, provider, and population surveys. A population-based survey of CT residents could augment data available from existing sources (e.g., the BRFSS) to assess health status, changes in health and healthcare access, and health disparities. Our experience with statewide surveys in both Massachusetts and Connecticut leads us to believe that we could achieve the best response rates at lowest cost by conducting a systematic probability survey of adults in CT using a mixed-mode strategy consisting of mail surveys, CATI (Computer Assisted Telephone Interviews), and personal interviews. We could use the United States Postal Service (USPS) database of residential addresses as the sampling frame. RDD surveys have become increasingly challenging due to widespread use of cell phones, high rates of nonresponse attributable to caller ID, and other types of call screening. As a result, coverage rates for RDD samples are roughly 65-70%, but coverage with address based sampling is typically 98% or greater. The sample could be purchased from commercial vendors such as the Genesys system from Marketing Systems Group. Their data include names of adult occupants for over 90% of households, and telephone numbers for 65% of households. We could improve the efficiency of the sample by stratifying by county, with the 3 largest counties oversampled to capture a higher proportion of urban residents, where disparities in access to and outcomes of care may be most pronounced.

In addition to the BRFSS, several existing instruments could be used as sources for questions to be used in a new CT survey:

- The California Health Interview Survey (CHIS), a survey of CA residents conducted every two years. CHIS is a comprehensive survey that assesses health status, access to care, health insurance, health behaviors, food security, and exposure to violence.

- The Commonwealth Fund 2006 Health Care Quality Survey, which surveyed a nationally representative sample of adults in the US on issues such as health insurance coverage, access to a medical home, and racial and ethnic disparities in health outcomes.
- The Commonwealth Fund Biennial Health Insurance Survey, which surveys a nationally representative sample of adults (n = 4,432 in 2012) ages 19 and older living in the continental United States. That survey asks about health insurance coverage, as well as the costs of, and access to, health care.
- The Commonwealth Fund Affordable Care Act Tracking Survey, which is a set of question about awareness and use of Health insurance exchanges that were included in a Social Science Research Solutions omnibus telephone survey of 682 adults (19-64) in the U.S. who were potentially eligible for coverage under the Affordable Care Act
- CAHPS® Patient-Centered Medical Home (PCMH) Survey, which assesses access to timely and appropriate care, doctor-patient communication, coordination and comprehensiveness of care, and support for self-management and shared decision-making. There also are CAHPS® surveys that assess experiences with health insurance exchanges, health information technology, and cultural comparability of care.
- The Public and the Health Care Delivery System, a 2009 NPR/Kaiser Family Foundation/HSPH survey about the public's perceptions on issues including electronic medical records, coordination of care, physician decision-making, and the cost effectiveness of care.

A rigorous development process will be used for all surveys to produce instruments that yield reliable data. The methods used will vary depending on whether the questions are being adapted from validated surveys or are newly developed. However the types of methods that the team has expertise in, and have used in the development of other surveys include:

- **Psychometric analyses:** The two most frequently used ways of assessing reliability are to estimate internal consistency and plan level reliability. In addition, Item Response Theory can be used to assess degree of measurement error variance, test information, standard error of measurement, and precision measures taking on different values at different points along the scale. We typically assess content validity using focus groups and cognitive interviews. We evaluate construct validity by examining associations among scales. We assess criterion validity by examining the association between scales and the general ratings and behavioral variables, such as utilization rates. We also assess responsiveness, which is the degree to which instrument can detect change or differences.
- **Focus Groups:** We frequently conduct focus groups to learn about the salience of different issues to certain groups of consumers and/or to learn more about any problems they may have understanding and responding to standardized questionnaires.
- **Cognitive Testing:** Cognitive interviews are used to find out how respondents understand questions and what their answers mean. Although cognitive interviews take many forms, the basic goal is to ask people to explain their understanding of questions and elaborate on their answers so that the way they are performing the question and answer process

can be evaluated. Interviews typically are conducted at a place convenient to the respondent. Participants are interviewed and then asked a series of follow-up questions to probe for a deeper level of information from the respondent. Interviewers ask respondents to summarize their understanding of the meaning of questions in their own words and to provide a narrative explanation of how they arrived at an answer to a fixed-response question. Interviewers are free to probe further and a minimum set of follow-up questions ensures that our objectives are met. The main goals of this effort are to evaluate question comprehension, how answers were formed, and what the answers mean.

- **Field Pretests:** Once focus groups and cognitive testing have been completed, we frequently field test the resulting instrument under realistic conditions. Although often this will simply entail a mail or telephone survey, we sometimes do more intensive data collection to help refine questions. Examples of additional techniques are:
  - Interviews are tape recorded, after obtaining permission of the respondent. The behavior of interviewers and respondents during the interview is systematically coded. The rates at which interviewers read questions other than as worded, are asked for clarification of questions, and have to probe to get adequate answers have proven reliable indicators of difficulties with survey questions.
  - Interviewers fill out standardized rating forms for each question, focusing on how difficult it is to read as worded and how difficult the respondents find it to answer.
  - Interviewers report their observations on problems with the flow of the instrument.
  - Once the telephone interview pretest is completed, often a comparable self-administered questionnaire is pre-tested. Finally, we often carry out a larger pretest of a mail and/or telephone survey protocol.

## **Clinical/Claims Data**

Changes in the frequency, types, and costs of medical services received by CT residents groups will be assessed primarily using claims information from CT's All Payer Claims Database (APCD). The Connecticut All-Payer Claims Database (APCD) will provide a comprehensive repository of eligibility data, medical claims, pharmacy claims, dental claims, and provider information beginning in July 2014. The APCD will provide a critical source of longitudinal information on patients' access to, cost of, and outcomes of healthcare provided in Connecticut. Although race and ethnic information is typically poorly represented in APCDs, disparities in access to, outcomes of, and quality of care among different race and ethnic groups in State can be examined by incorporating race and ethnicity information from ancillary data sources in CT, such as birth records and CT's Hospital Inpatient Discharge Database.

- **Healthcare Effectiveness Data and Information Set (HEDIS):** HEDIS a tool developed by the National Committee for Quality Assurance (NCQA), another important source of clinical data for evaluating SIM. HEDIS consists of 75 measures across 8 domains of care. HEDIS is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data,

and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans and monitor performance on a year-to-year basis. HEDIS data published by NCQA in **Quality Compass** can be used to assess quality improvement and benchmarking plan performance. It includes up to three years of trend data and includes Commercial plans, as well as Medicare and Medicaid data.

- **Quality Compass:** Quality Compass is a product of NCQA, but the evaluation team will work with plans in CT to see if they will voluntarily submit data to the evaluation team in exchange for comparative analyses that they can use to facilitate quality improvement efforts.

## Other Administrative Data

- **The Preschool through 20 and Workforce Information Network (P20 WIN):** This information system provides a vehicle for tracking and monitoring changes to Connecticut's healthcare workforce. The development of P20 WIN was funded by a grant from the National Center for Educational Statistics (NCES) of the U.S. Department of Education and is currently being deployed by the University of Connecticut's Center for Public Health and Health Policy. It provides integrated, record-level data from the Connecticut State Department of Education (SDE), the Board of Regents for Higher Education (BOR), the Department of Labor (DOL), and the CT Conference of Independent Colleges. This system integrates students' academic performance and achievement data from grades K-12 and postsecondary academic performance in 2- and 4-year colleges with wages records reflecting labor force participation. The system includes over 70 million records from 3.5 million individuals and contains historical data from 2004 to the present.
- **Licensure data:** In 2015 the CT State Department of Public Health will mandate that physicians, dentists, advanced practice registered nurses, nurse midwives, registered nurses and practical nurses renew their licenses online. The online license renewal application will be expanded to include a series of questions that provide contextual information about providers' practice settings/conditions and whether they are in certified AMHs or are adopting elements of the AMH. Questions will include the location (zip code) of primary practice location; total number of hours of direct patient care delivered in CT in typical week; number of hours delivering primary care in a typical week; board certification; number of physicians in primary practice group; whether the their primary practice group has AMH certification; whether primary practice has an EHR; whether practice offers flexible scheduling; whether practice employs designated care coordinator(s).
- **Hospital Discharge Data (HDD):** The Hospital Discharge Data incorporates provider information and patient-level demographic, clinical and billing data, submitted voluntarily by all non-federal, acute-care hospitals in the state. It is also known as the Acute Care Hospital Inpatient Discharge Database (HIDD) or Connecticut Hospital Information Management Exchange Data (ChimeData). The Connecticut Hospital Association's (CHA) Data Services offers this data collection and reporting service through its ChimeData program, which collects and edits administrative discharge (UB-04 claims-based) data

from inpatient admissions, hospital-based outpatient surgery, and emergency department non-admissions. ChimeData's database is the most comprehensive hospital database in the state, recording over 31 million patient encounters dating back to 1980; the electronic database contains data from 1991 to the present. Geocoded data are not available; however, patient zip code, town and county of residence are collected. This dataset may be used in the early phases of the evaluation to establish baseline and target measures before the APCD is fully implemented, and as a means of cross-validating APCD generated reports. It also provides one of the most complete sources of information on race/ethnicity. For more information on hospital discharge data visit: [www.ct.gov/ohca](http://www.ct.gov/ohca) or [www.ct.gov/dph/HospitalDischargeData](http://www.ct.gov/dph/HospitalDischargeData).

- **Connecticut Vital Records Death Registry (Death Registry):** contains records pertaining to deaths that occur within the state as well as deaths of Connecticut residents occurring in other states, or in Canada. Mortality statistics are compiled in accordance with World Health Organization (WHO) regulations, which specify that deaths be classified by the current version of the Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death. Deaths from 1999 to the present are classified by the Tenth Revision of the International Classification of Diseases (ICD-10). The electronic database contains data from 1949 to the present. [www.ct.gov/dph/Mortality](http://www.ct.gov/dph/Mortality)
- **School-Based Asthma Surveillance System (SBASS):** In accordance with Connecticut General Statutes Section 19a-62a(b), since 2003 the Connecticut Department of Public Health (DPH) Asthma Program has conducted school-based asthma surveillance using data from the Health Assessment Record (HAR). The HAR is distributed to school health care providers by the Connecticut State Department of Education (SDE). Pursuant to CGS §10-206, the HAR records physical exam findings, screenings, immunizations, and chronic diseases (asthma, anaphylaxis, allergies, diabetes, seizures, and other). Information on medications that need to be taken in school, insurance status, asthma severity, diagnostic source, and school location are also recorded on the HAR. Demographic information captured on the HAR includes: age, gender, race, and ethnicity. Based on the options provided by the legislation, school districts choose the grades for which health assessments will be conducted. The districts may choose to require a HAR for each student in grades pre-kindergarten (PK) or kindergarten (K), 6 or 7, and 9 or 10. The School-Based Asthma Surveillance System (SBASS) entails school districts submitting HAR data on students with asthma to the DPH Asthma Program annually. A student is considered to have asthma if s/he meets any of the following conditions: 1) diagnosis of asthma indicated on the HAR; 2) an order for asthma medication by a health care provider is on file in the school health record; 3) an Asthma Action Plan (AAP) is on file; 4) the child exhibits asthma symptoms at the time of the examination; or 5) a parental note is on file that indicates that the child has asthma. Abstraction of specific demographic and asthma symptom data from the HARs into a designated reporting form is done by public school nurses. The completed reports from each school are sent to the DPH by school district nurse supervisors. Asthma Program staff review the forms for completeness and enter them into a database.

## **Qualitative Data**

Semi-structured interviews with key stakeholders will provide critical information on the pace of delivery system transformation, barriers to change, and satisfaction. Stakeholders and critical informants will include professional societies and advocacy organizations, the Consumer Advisory Board, payers and large employers. We will use a purposeful approach to identify stakeholders in organizations with higher and lower levels of success in uptake of innovations. We will apply the criterion of theoretical saturation to determine the number needed in each strata. Based on our prior work we estimate this will be approximately 10-12 organizations. We plan 2-4 key informant interviews per site and will conduct additional interviews until we reach theoretical saturation.

Interviews will be approximately 1 hour in length, conducted by videoconference. Interviews will be audiotaped and transcribed by professional transcriptionists. Interviews will follow a standard interview guide beginning with a standard “grand tour” question, e.g.: “Please describe your organization’s experience with implementing the [change being investigated] over the past 3 months.” Follow-up questions may explore sources of resistance to implementing strategies, how resistance was managed, and approaches to tailoring the change packet and related tools.

## **Other sources of health equity data**

Many of Connecticut’s performance goals focus on alleviating (and eventually eliminating) Connecticut’s substantial 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). The Evaluation Team reviewed several potential state and federal data sources to identify baseline information on health and health disparities in Connecticut. Our review of Connecticut specific health data (Appendix I) was facilitated by a 2013 study commissioned by the CT Health Foundation, which identified twelve relevant reports.

Collectively these reports provide a baseline for gauging the State’s success in reducing and eliminating disparities in health outcomes, access to care, and the quality of care received, and identify existing data sources available to track progress during the implementation of SIM initiatives.

DPH’s State Health Assessment conducted as part of Health People 2020 and scheduled for release in January 2014 will also provide baseline data on public health measures by race, ethnicity, and other demographic factors.

## **5.7 MATRIX OF MEASURES AND DATA SOURCES**

Connecticut’s pace and performance measures and the data sources from which they are derived are presented below:

**EXHIBIT 37: Performance and Pace Data Sources**

PERFORMANCE GOALS	METRICS	DATA SOURCES				
		Consumer Surveys	Qualitative Data	Clinical / Claims Data	Plan/Employer/ Provider Surveys	Administrative Data
Better health (general):						
% of population with current diabetes	Prevalence/ treatment rates	X		X		
% of children with current asthma	Prevalence/ treatment rates	X		X		
% of adults with current asthma	Prevalence/ treatment rates	X		X		
% of population with current hypertension	Prevalence/ treatment rates	X		X		
% of obesity among adults	Prevalence/ treatment rates	X		X		
Median intake of fruits and vegetables (times per day) by adults	Health behavior	X				
% of adults who participated in enough aerobic and muscle strengthening exercise to meet recommended guidelines	Health behavior	X				
% adults reporting 14 or more unhealthy days physically or mentally in the last month	Health behavior	X				
% of adults who currently smoke cigarettes		X				
% of adult smokers who attempted to quit smoking	Health behavior	X		X		
Falls with injury	Prevalence/treatment rates	X		X		
Better health (health disparities):						
Close gap between highest and lowest achieving populations for each target metric impacted by health inequities	Reduced disease prevalence	X		X	X	
Quality of care and consumer experience (general):						
Increase proportion of providers meeting the comprehensive quality scorecard targets	N/% of providers able to meet each scorecard target			X	X	
Quality	Child well-visits			X		



	Mammogram for women >40 past 2 yrs			X		
	Adults >50 who had colorectal cancer screening			X		
	% of adults with diabetes who reported receiving a foot exam in the previous year			X		
	% of adults with diabetes who reported receiving a dilated eye exam in the previous year			X		
	% of adults with diabetes who reported receiving 2 or more A1c tests in the previous year			X		
	% of adults taking HBP medication			X		
Improve care to underserved populations	N/% increase number of providers serving racial/ethnic minorities, Medicaid patients (esp. preventative care)			X	X	X
Improve statewide consumer experience scores	CAHPS® Clinician/Group Surveys (Medicaid/Commercial)	X				
	CT Medicare ACO Survey (SSP) scores relative to US	X				
	CT Medicare ambulatory CAHPS® scores relative to US	X				
<b>Quality of care and consumer experience (health disparities):</b>						
Close gap between highest and lowest achieving populations for each target metric impacted by health inequities	Improved performance on measures of healthcare process and outcomes			X		
<b>Cost and Resource Use</b>						
<b>1-2% reduction in rate of growth of healthcare spending per capita:</b>						
Attribute savings to better, more appropriate, and cost effective care	Hospitalizations for ambulatory care sensitive conditions			X		
	Hospital readmissions for potentially avoidable complications			X		
	ED utilization for ambulatory sensitive conditions			X		
	ED use without hospitalization			X		
	N/% duplicative tests, by condition			X		
	Volume of generic prescriptions (where appropriate)			X		

	<i>Use of lower-cost providers and/or settings of care of equal or greater quality</i>			X	X	X
<i>Expenditures relative to GSP</i>	<i>PMPY cost trend (1 year and 3 year average)</i>			X		
	<i>GSP per capita trend (1 year and 3 year average)</i>			X		
	<i>Difference between PMPY and GSP trends</i>			X		

PACE GOALS	METRICS	DATA SOURCES				
		Patient/ Consumer Surveys	Qualitative Data	Clinical and Claims Data	Physician/Medi- cal Provider Surveys	Administrative Data
Primary Drivers of System Transformation:						
Primary Care Practice Transformation	N/% of providers able to meet each practice transformation standard				X	X
	N/% of providers that meet NCLAS standards				X	X
	N/% of providers who are participating in the Glide Path				X	X
	N/% of providers who are AMH recognized				X	X
Community Health Improvement	N/% of population residing in a Health Enhancement community	X				X
	N/% served by Prevention Service Center	X		X	X	
	N/% of practices assisted by a Prevention Service Center	X		X	X	
	% of population in need/assisted by Diabetes Prevention Program, Asthma Indoor Risk Strategies, Falls Prevention Program	X		X		
Consumer Empowerment	N of consumers and % of population participating in recommended VBID	X	X		X	
	N of consumers and % of population participating in recommended employer incentive program	X		X	X	
	N of consumers and % of population attributed to an AMH provider (general and by race/ethnicity)			X	X	
	N of consumers and % of population attributed to a provider accountable for the consumer's care experience					
	N of consumers and % of populations who accessed provider quality/cost information	X				
	N of consumers and % of populations who report shared decision making	X				
	N of consumers and % of populations with access to consumer portal (limited scope/full scope)	X				
Enabling Initiatives:						
Performance	N of payers using common metrics scorecard				X	X

PACE GOALS	METRICS	DATA SOURCES				
Transparency						
	Implementation of APCD			X		
	Implementation of hospital quality and cost scorecard			X	X	
	Implementation of specialist quality and cost scorecard			X	X	
Value-Based Payment	N/% of providers participating in qualified P4P payment arrangements				X	X
	N/% of providers participating in a shared savings payment arrangement					
	N of payers including care experience in their value-based payment models		X			X
Health Information Technology	Number of payers offering advanced analytics at each stage					
	Implementation of provider portal, initial and advanced					
	N/% of providers participating in direct messaging			X	X	
	N/% providers offering care management tools				X	
	N/% of patients with access to transparency-related tools	X	X			X
	N/% of consumers with access to qualified consumer portal	X	X			X
Workforce Development	% of providers participating in e-licensing (by profession)				X	X
	Implementation of workforce data storage and analytics solution					X
	N/% of primary care providers, including APRNs			X		X
	Number of trainees that complete the Connecticut Service Track					X
	3-year retention of CST trainees					X
	Number of certified CHWs					
	Articulation agreements					X

## 5.8 ANALYSES

In addition to routinely presenting descriptive summary of measures in a “dashboard” we will conduct analyses to assess trends in structure, process, and outcomes. As indicated in the introduction to this section, the evaluation team will use a multi-method approach that uses quantitative research methods and sophisticated statistical modeling in combination with qualitative data and interviews from key stakeholders.

### Quantitative Analyses

The rich and diverse data sources identified above will permit us to use a range of sophisticated analytic approaches to track intra- and inter-individual changes over time in key performance metrics. For example, assessments of mean changes from baseline to follow-up across the state and within subsets of sites or in different parts of the state will be examined using hierarchical regression models that control for both patient clinical and socio-demographic characteristics and clinic characteristics. Logistic regression models will be used to analyze binary measures and linear regression models will be used to analyze continuous measures.

These models will account for the fact that patients are clustered within sites and sites may be clustered within larger organizations. They can, for example, include a random intercept and period term to account for correlation among patients within a clinic and allow for differential changes in outcomes across sites. Tests for differences in changes in outcomes across groups of sites can be estimated using an interaction term between period of measurement (pre versus post innovation) and group (e.g. adopters vs. non-adopters of an innovation).

### **Qualitative Analyses**

Analyses of qualitative data will be done by a 3-member team using widely accepted coding techniques for qualitative data and the constant comparative method. Coding will be done in iterative steps, in which codes are refined during analysis of transcripts from successive interviews. Team members will independently code all transcripts and then meet to code in several joint sessions, assigning codes to observations by a negotiated, group process. We will use a grounded theory approach, which is inductive. Data will be entered into ATLAS to facilitate analysis. As recommended when doing qualitative analysis, we will search for disconfirming evidence, interview multiple respondents at each organization for triangulation, and maintain a detailed audit trail to document analytic decisions.

### **Health Equity Analyses**

The promotion of health equity through the elimination of health disparities is a distinctive feature of our plan. While the above system level analyses may identify improvement in overall rates of tobacco use, diabetes, obesity, asthma, or ambulatory care sensitive conditions, they may not reveal reductions in disparities experienced by certain sub-populations. Demographic identifiers are not always or uniformly available in claims or EHR data, requiring a strategic data collection strategy, which may include data collection at the point of care. To observe the sustained effect of system change at the level of the individual, such as improved control in asthma or diabetes, we plan to track individuals over time with repeated observations for individuals served by AMH's and those participating with AMHs while residing in an HEC pilot. A well-planned evaluation will focus on targeted data acquisition and analysis that goes beyond claims and the EHR; is collected over time, both within and between subjects; focuses on sub-group analyses; and is obtained from tracking cohorts with some patient level interviews or observations. Ideally, we will form tracking cohorts that will allow evaluation of outcomes at the practice, provider and individual level overtime and that will allow evaluation of sub-groups known to benefit disproportionately by system change such as those with co-morbidities. Finally, because the reduction of health disparities relies on change at multiple levels, including that of the individual, we will conduct process interviews that will allow us to understand unintended consequences, pockets of resistance to change, and opportunities for mid-course corrections to address the specific needs of sub-groups.

The State will monitor health equity gaps, to the extent that data are available, for each of the core measures that comprise the performance evaluation. We recognize that measures of health equity in the extent to which they can be influenced by the Innovation Plan. Accordingly, we intend to select a small group of conditions and corresponding health equity

gaps that will be targeted for improvement in order to assess our progress toward achieving health equity goals using the following criteria:

- The prevalence of target conditions among population subgroups
- The impact of the condition or process in terms of morbidity and/or mortality
- Racial or ethnic disparity in morbidity and mortality
- The cost of untreated or inappropriately treated cases
- Urgency of the condition and ability to avoid larger problems later
- The extent to which factors affecting disparities can be changed (e.g. easier to change access to care than environmental factors)
- Opportunities for intervention (e.g. existing coalitions, community support, available funding, political interest/will).

## VII. APPENDICES

## Appendix A: 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

**Local Health Department:** A local health department is a government agency that reports to a mayor, city council, county board of health or county commission and that has responsibility for ensuring the safety of the water we drink, the food we eat, and the air we breathe; creating and maintaining conditions in communities that support healthier choices in areas such as diet, exercise, and tobacco; and leading efforts that prevent and reduce the effects of chronic diseases, such as diabetes and cancers.



**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)

**Payer:** Payer refers to public or private insurers such as Medicaid, Medicare or one of Connecticut’s commercial health plans that pay for healthcare services. The term includes fully insured health plans as well as those that pay for health care services on behalf of a self-insured employer.

**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

# Appendix B: National Culturally and Linguistically Appropriate Services (NCLAS Standards)

## The National CLAS Standards<sup>90</sup>

The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

### Principal Standard

**1)** Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### Governance, Leadership and Workforce

**2)** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

**3)** Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

**4)** Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

### Communication and Language Assistance

**5)** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

**6)** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

**7)** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

<sup>90</sup> U.S. Department of Health and Human Services Office of Minority Health

8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

### **Engagement, Continuous Improvement and Accountability**

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

## Appendix C: Population Health Measures

MEASURES	National Rate	CT Rate	White Non-Hispanic	Black, Non-Hispanic	Hispanic	Other
<b><i>Population Health Measure – Tobacco Use</i></b>						
% of adult smokers who attempted to quit smoking <sup>91</sup>	64.7%	68%	65.3%	74.6%	79.0	69.2
% of current smokers among adults <sup>1</sup>	21.2%	17.1%	16.8%	20.8%	17.1%	16.4%
<b><i>Population Health Measure – Diabetes</i></b>						
Age-adjusted leading cause of death per 100,000 <sup>92</sup>			15.1	35.9	24.5	9.0
Adults with diabetes <sup>93</sup>	10.2%	9.2%				
<b><i>Population Health Measure – Obesity</i></b>						
% of obesity among adults <sup>1</sup>	27.8%	24.5%	23.0%	32.8%	32.6%	16.4%
Median intake of fruits and vegetables (times per day) by adults <sup>1</sup>	2.9	3.1	3.3	2.7	2.7	2.9
% of adults who participated in enough aerobic and muscle strengthening exercise to meet recommended guidelines <sup>1</sup>	20.9%	21.8%	22.4%	21.9%	17.0%	21.7%
<b><i>Population Health Measure – Asthma</i></b>						

<sup>91</sup> Data from CDC - BRFSS 2011 – supplied to SIM states.

<sup>92</sup> Data from DPH Statewide Health Assessment Preliminary Findings 2013

<sup>93</sup> Kaiser Family Foundation

% of adults with current asthma - 2010 <sup>2</sup>	9.2%		N/A	N/A	N/A	N/A
% of children with current asthma - 2010 <sup>2</sup>	11.3%		N/A	N/A	N/A	N/A
<b>Population Health Measure – Hypertension</b>						
% of Adults ever told by provider they had HBP <sup>2</sup>			30.5%	38.8%	22.9%	
<b>Population Health Measure – Child Oral Health</b>						
% of children with dental decay <sup>2</sup>			33%	50%	50%	--
% children with untreated dental decay <sup>2</sup>			9%	18%	15%	--
<b>Quality of Care Measure – Preventable Hospital Visits</b>						
# of preventable hospital visits - <b>Children</b> – 2008 <sup>2</sup>						
-Asthma			65	391	238	
-Gastroenteritis			61	89	129	
-Urinary Tract infection			30	27	71	
-Perforated Appendix			24	35	21	
-Diabetes short-term complications			13	30	31	
# of preventable hospital visits - <b>Adults</b> – 2008 <sup>2</sup>						
-Congestive Heart Failure		363	375	461	256	
-Bacterial Pneumonia		333	346	319	287	
-Urinary Tract Infection		192	201	168	160	
-Chronic Obstructive Pulmonary Disease		179	198	131	124	
-Asthma		127	81	319	337	
<b>Preventable Hospital Visits – Geographic Differences</b>						
	Urban Core	Urban Periphery	Suburban	Rural	Wealthy	
% of non-urgent ED visits in “The Five	52.9%	46.9%	39.8%	42.9%	37.5%	

Connecticut's" Town Groupings <sup>2</sup>						
<b>Quality of Care Measure – Diabetes</b>						
% of adults with diabetes who reported receiving a foot exam in the previous year <sup>1</sup>	77.8%	80.8%	79.6%	90.2%	86.0%	N/A
% of adults with diabetes who reported receiving a dilated eye exam in the previous year <sup>1</sup>	72.3%	79.6%	81.4%	81.2%	N/A	90.4%
% of adults with diabetes who reported receiving 2 or more A1c tests in the previous year <sup>1</sup>	70.7%	72.9%	72.9%	82.0%	65.2%	N/A
Diabetes ED visits FY 2007-2011 <sup>2</sup>			206.7	846.5	475.8	N/A
Diabetes ED visits by Age FY 2011 < 18 <sup>2</sup>		56.5	N/A	N/A	N/A	N/A
Diabetes ED visits by Age FY 2011 18-44 <sup>2</sup>		283.1	N/A	N/A	N/A	N/A
Diabetes ED visits by Age FY 2011 45-64 <sup>2</sup>		432.9	N/A	N/A	N/A	N/A
Diabetes ED visits by Age FY 2011 65+ <sup>2</sup>		636.7	N/A	N/A	N/A	N/A
<b>Quality of Care Measure – Asthma</b>						
Adjusted ED rates for asthma (adults) per 10,000 population- 2009 <sup>2</sup>		61.2	N/A	N/A	N/A	N/A
Adjusted ED rates for asthma (children) per 10,000 population - 2009 <sup>2</sup>		107.1	N/A	N/A	N/A	N/A
Age Adjusted ED rates for asthma per 10,000 population (total population) - 2009 <sup>2</sup>		168.3	34.2	127.3	170.5	41.7
<b>Quality of Care Measure – Cancer Screening</b>						
Percentage of women receiving mammograms for breast cancer screenings - 2010 <sup>2</sup>		83.8%				
% adults between 50-75 who had appropriate screening for colorectal cancer	67.8% - median	74.8%	76.7%	65.3%	65.8%	66.1%
<b>Quality of Care Measure – Hypertension</b>						
% of adults taking HBP medication <sup>1</sup>	77.7%	79.3%	81.0%	84.7%	61.6%	66.9%



<b>Quality Measure – Falls</b>						
Rate of ED Visits per 10,000 population – Falls <sup>2</sup>		110				
# Deaths Due to Unintentional Deaths – Falls - 2009 <sup>2</sup>	24,792	356				
Hospitalizations Due to Falls <sup>94</sup>		249.6				--
<b>Quality of Care Measure – Access to Care</b>						
Adults with ongoing source of care (2008) <sup>2</sup>		~87%	89.4%	82.3%	73.9%	
<b>Quality of Care Measure – Unhealthy Days</b>						
% adults reporting 14 or more unhealthy days physically or mentally in the last month <sup>1</sup>	8.2%	6.9%	6.1%	8.5%	11.7%	5.9%

<sup>94</sup> Connecticut Injury Prevention and Control Plan, 2000-2012, DPH. (Data subject to change pursuant to State Health Improvement Plan, projected release January 2014.)

## Appendix D: Foundational initiatives

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

### B.1 POPULATION HEALTH INITIATIVES

- **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.
- **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.
- **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.
- **Food and nutrition policy:** As of July 1, 2006, Connecticut banned the sales of regular and diet soda as well as electrolyte replacement drinks, e.g., sports drinks like Gatorade. The 2006 legislation allows for school vending machines and stores to stock low and non-fat milk, soy or rice milk and pure fruit and vegetable drinks. In addition, Connecticut became the first state in the country, this year, to require that (Genetically Modified Organism) GMO foods be labeled. However, for our state's law to be implemented four other states (at least one of which shares a border with Connecticut) must pass similar measures, as the legislation requires that a total population of at least 20 million (combined states) for the legislation to take effect. The legislation will require sellers and producers of GMO foods to label their products as such.
- **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).

## B.2 COMMUNITY BASED 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 poor mental health days.
- **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.

- **Federally Qualified Health Centers (FQHC):** Over 75% of Connecticut's FQHCs are already recognized by either NCQA or the Joint Commission as patient-centered medical homes; with the remaining 25% on track to achieve accreditation in 2014. All FQHCs align with the whole-person-centered care tenets of the AMH model.
- **Connecticut Association of Directors of Health (CADH):** CADH is a non-profit organization comprised of 74 local health departments and districts. Local health directors are the statutory agents of the Commissioner of Public Health and are critical providers of essential public health services and population data at the local level in communities throughout the state.
- **Community Health Workers (CHWs):** Southwestern Area Health Education Center (AHEC) currently facilitates a statewide Community Health Worker (CHW) Task Force, working within the health care system and in community health centers performing outreach related to substance misuse, HIV/AIDS, maternal and child health, housing, and other socioeconomic issue affecting health. Other AHECs.....
- **Community Based Organizations (CBOs):** Connecticut is home to many non-profit civic and faith-based organizations working to improve health in underserved communities through programmatic and policy efforts. These organizations play vital roles as trusted partners in their communities, and will be instrumental in achieving community health improvement. A partial listing includes:

## B.2 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.

### B.3 HEALTH INFORMATION TECHNOLOGY INITIATIVES

- **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. CT's health exchange, Access Health CT, has begun to

develop an APCD to collect, assess and report healthcare information that relates to safety, quality, equity, 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, identifying disparities along the continuum of care especially for ambulatory care sensitive conditions, enhancing access and reducing barriers to care
  - Enable the aggregated analytics that can inform public policy and reform
  - Enable the analysis of disease within and the development of prevention strategies for the state's population.
- **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. The organization 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.
  - **Health Information Technology Exchange:** HITE-CT will help providers share information across sites of care via a secure network. 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.
  - **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.

## B.4 PRIMARY CARE TRANSFORMATION 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.

## B.6 HEALTH EQUITY INITIATIVES

- **The Connecticut Health Foundation (CT Health):** Connecticut's largest independent health foundation, has worked on three major issues since inception: oral health for low income families, children's mental health, and the elimination of racial and ethnic health disparities. In 2012, CT Health made a strategic shift that makes expanding health equity its central

focus. To CT Health, health equity means helping more people of color access better care. CT Health's evolved vision for health equity requires the integration of oral, mental and physical health.

The foundation has invested more than \$21,000,000 in a wide range of initiatives such as: supporting Access Health CT Navigators in the state's three urban metropolitan areas, integrating health literacy in six adult education programs, improving the quality of diabetes care in small primary care practices serving high numbers of patients of color and federally qualified health centers, promoting early identification of children at risk of mental health issues in order to reduce the number of children of color in the juvenile justice system, funding a report on African American health by the CT NAACP, which catalyzed the formation of the state Commission on Health Equity, developing the Department of Public Health's socio-demographic data collection policy and 2009 health disparities surveillance report, implementing a Health Leadership Fellows Program dedicated to increasing the number of people of color as leaders and change agents in the promotion of health equity and community data scans in XXXX and 2013 to help target areas of focus.

- **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).
- **Connecticut Multicultural Health Partnership (CMHP):** CMHP has been awarded a 2-year grant from the federal Office of Minority Health to implement a plan to address the adoption of 2013 National CLAS standards to targeted healthcare organizations.
- **Bioscience Connecticut Health Disparities Institute (HDI):** The University of Connecticut Health Center established the HDI to focus on health disparities research, community outreach and engagement, capacity building, and policy. Its Health Disparities Data Collaborative program is currently working to translate research on the impact of PCMH models on the reduction of health disparities. Health equity is one of six population health objectives identified in the UConn Health 2020 Strategic Plan
- **Connecticut Commission on Health Equity.** The purpose of CHE is to affect legislation to improve the health outcomes of residents based on race, ethnicity, gender and linguistic ability. In establishing CHE, the Connecticut General Assembly acknowledges that: (1) equal enjoyment of the highest attainable standard of health is a human right and a priority of the state, (2) Connecticut residents experience barriers to the equal enjoyment of good health based on race, ethnicity, national origin and linguistic ability, and (3) that addressing such barriers requires data collection and analysis and the development and implementation of policy solution

## 6.5 CONSUMER EMPOWERMENT INITIATIVES

- **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.
- **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.
- **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 and the Center for Medicare Advocacy that helps seniors navigate the health system.
- **Access Health CT:** With the APCD in place, Access Health 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. Access Health CT will also establish relationships with third-party consumer engagement vendors, e.g., Castlight, Truven Health Analytics to help it better engage consumers on data available in the APCD
- **Office of the Healthcare Advocate (OHA):** OHA is the state’s consumer assistance program under the Affordable Care Act. Since 2001, OHA has advocated for consumers, educated them about their healthcare rights and options for coverage, filed appeals for denials of coverage and advocated systemically for statutory revisions to protect consumers. OHA manages the Navigator and In-Person Assister Program in partnership with Access Health CT.

## B.5 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/ Marketplace (Access Health CT):** In October of 2013, Access Health CT began operating the state’s health insurance exchange. Since its creation in 2011, Access Health CT has been building awareness of the exchange and the benefits available to those who need help to obtain healthcare. Connecticut is one of a number of states that chose to implement its own health insurance exchange. Access Health CT has successfully created an online enrollment process, signing up 3,847 people for healthcare coverage in its

first 15 days. Expanded access to coverage extends opportunities for promoting population health and ensuring individuals experience timely appointments and coordinated care.

- **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.
- **Navigator and In-person Assister Program (NIPA):** The successful roll out of CT's health exchange is due in part to an extensive Navigator and In-Person Assister (NIPA) and certified application counselor network of over 800 community organizations, community health centers and hospitals that reaches diverse and underserved communities in thirty-three languages in every corner of our state.

## B.6 REBALANCING INITIATIVES AND WAIVERS

- **Medicaid HCBS waiver for Acquired Brain Injury:** serves individuals age 18-64; must have acquired brain injury (developmental and degenerative disorders do not qualify) and meet the "level of care" requirement of otherwise needing care in a nursing facility, chronic disease hospital or an intermediate care facility; uses 300% of SSI as income standard as well as Medicaid asset limits; those eligible for Medicaid for the Employed Disabled may also qualify; service array includes case management, personal care assistance, homemaker, chore services, companion, home-delivered meals, respite care, vocational supports, housing supports, home and/or vehicle modification, personal emergency response systems, transportation, supported employment, specialized medical equipment and supplies; approximately 369 participants
- **Medicaid HCBS waiver for Elders:** serves individuals age 65 and older; must be in need of nursing facility care and evidence at least three "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration); uses 300% of SSI as income standard as well as Medicaid asset limits; those eligible for Medicaid for the Employed Disabled may also qualify; service array includes adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation, personal care assistants, and adult family living; approximately 10,400 participants
- **Medicaid Personal Care Assistance waiver:** serves individuals age 18-64; recent legislation requires participants to transition to elder waiver at age 65; uses 300% of SSI as income standard as well as Medicaid asset limits; those eligible for Medicaid for the Employed Disabled may also qualify; service array includes personal care assistant (PCA), personal emergency response system (PERS) and assistive technology (AT); approximately 850 participants

- **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 HCBS waiver Katie Beckett:** serves children; effective 1/1/12 caps participation at age 22; qualifies children based on their income/assets, and not the financial profile of the family; service array includes only case management; 203 participants; waitlisted; five-year wait for service
- **Medicaid Comprehensive Support Waiver with DDS:** currently approved for four waivers; must have been assessed to have 1) an intellectual disability as defined in C.G.S. Section 1-1g; or 2) Prader-Willi Syndrome; must have need for ICF/MR level of care and show need for at least one of the waiver services; uses 300% of SSI as income standard as well as Medicaid asset limits; those eligible for Medicaid for the Employed Disabled may also qualify; service array includes licensed residential services (community living arrangements, community training homes, assisted living), residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities, individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support)
  - a. **Comprehensive Supports:** provides services to individuals who reside in licensed Community Living Arrangements (CLA), Community Companion Homes (CCH) or assisted living facilities; also can support individuals who reside in their own or family homes and require a comprehensive level of support
  - b. **Individual and Family Supports:** provides services to individuals who reside in their own or family homes and who require less extensive support (typical service plans are \$59,000 or less per year)
  - c. **Employment and Day Supports:** provides services (employment, respite, specialized medical services) to young adults transitioning from school to work; cost cap of \$28,000 per year
  - d. **Autism:** provides services to individuals with Autism Spectrum Disorders (ASD) whose IQs are greater than 70 and who reside in their own or family homes; cost cap of \$60,000 per year
- **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. The state chose to exercise the option to expand Medicaid coverage to 138% of the federal poverty line, which will guarantee access to health coverage to tens of thousands individuals.

- **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.
- **HCBS Medicaid waiver Mental Health (WISE):** serves individuals age 22 and older; must have a diagnosis of serious mental illness; must meet one of the following residence profiles: currently reside in a nursing facility, live in the community, have an active psychiatric disorder and be under consideration for placement in a nursing facility, or already discharged from a nursing facility under Money Follows the Person; must have two or more serious life problems due to mental illness; must not be in need of emergency psychiatric hospitalization; must need rehabilitation and professional assistance in developing and implementing a plan for recovery; uses 300% of SSI as income standard as well as Medicaid asset limits; those eligible for Medicaid for the Employed Disabled may also qualify; service array includes assertive community treatment (ACT), community support program (CSP), peer support, recovery assistant, short-term crisis stabilization, supported employment, transitional case management, non-medical transportation, specialized medical equipment, and home accessibility adaptations; approximately 200 participants
- **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. The Money Follows the Person (MFP) initiative that has led efforts toward systems change in long-term services and supports. In addition to its work in having transitioned over 1,700 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and substance abuse intervention, peer support, informal care giver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions. An additional key

aspect of the demonstration is the development of improved LTSS quality management systems. In 2012, the Governor has publicly committed to a significant expansion in the target for individuals transitioned, to a total of 5,000 individuals.

- **My Place.** Finally, the plan emphasizes the need 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. In support of this, the state launched the “My Place” web site (<http://www.myplacect.org/>) in late June, 2012. 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. This effort is being promoted by an extensive campaign of billboards and radio ads. My Place CT envisions kiosks at various community entry points include medical offices, libraries, pharmacies, etc. providing access to people at community locations that they already visit frequently. My Place CT will be supported by community access points where people will not only have access to web based pre-screens and information but also one to one assistance. It is anticipated that RFPs for this service will be announced by the Department within the next 6 months. In the final phase of My Place CT, the web based system will support electronic referrals to both formal LTSS and to local community services and supports. It is anticipated that this support will be especially helpful to hospital discharge planners and others seeking streamlined, automated coordination assistance.
- **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.
- **State Balancing Incentive Payments Program.** Further, MFP also led efforts to submit an application to CMS under the State Balancing Incentive Payments Program (BIPP). Connecticut received confirmation in Fall, 2012 of a \$72.8 m. award. Key aspects of the award include:
  - a. The development of a pre-screen and a common comprehensive assessment for all persons entering the LTSS system, regardless of entry point. It is anticipated that medical offices, various State agencies administering waivers, and the ASOs will all utilize the same tool so that the people served by the State’s systems won’t be continually asked the same question unless there is a status change. The anticipated result is a more efficient system where information is shared and unnecessary duplication is eliminated.
  - b. The development of conflict free case management across the system.
  - c. The development of a ‘no-wrong door’ system for access to LTSS. Phase one of the State’s ‘no wrong door’ launched on June 27, 2013. The web based platform was branded “My Place CT” and aims to coordinate seamlessly with both ConneCT and

the health insurance exchange over the next two years. Additional information about My Place CT is detailed below.

- d. The development of new LTSS aimed to:
  - i. address gaps that prevent people from moving to or remaining in the community;
  - ii. streamline the existing LTSS delivery system; and
  - iii. build sufficient supply of services to address the projected demand.



## Appendix E: Current Workforce Residency Programs

Connecticut has a number of innovative primary care medical residency programs that have received significant federal grant funding from the Health Resources and Services Administration (HRSA), including training programs at Griffin Hospital, UConn, and Western Connecticut Health Network.

The SIM will leverage a number of interprofessional collaborations currently underway to prepare the state's future healthcare workforce, including:

Yale has relocated to New Haven the community-hospital training site for its internal medicine residency program. Yale New Haven Hospital (YNHH) is reassessing its women's health, pediatrics and adult primary care practices as a basis for placing greater emphasis on longitudinal ambulatory training for its OB-GYN, pediatrics and internal medicine residency programs. The aims of a longitudinal clinical experience (LCE) curriculum dovetail with CLER goals. Both the School of Medicine and YNHH are committed to ensuring that Yale's primary care practices are patient centered medical homes that embrace interprofessional education and care.

In 2010, UConn's School of Medicine's internal medicine residency program developed an innovative track for residents interested in primary care. The track, office-based medicine, was designed to give residents a realistic experience of primary care, to educate them in public health and community resources, and to be a counterpart to the school's hospital-based curriculum. Based on the success of this track, the residency program received a HRSA grant under the Primary Care Residency Expansion Act to add two additional residency positions per academic year. The success of the office-based medicine track and the expansion of the primary care residency program are reflected in the growth of residents in the two combined by over 400%. This has translated to growth of graduating residents entering primary care. 65% of the residents in these programs have thus far chosen career paths in primary care. UCHC 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.

UConn 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. UConn's goal is to increase this number by at least 30%. This initiative is also meant to encourage students to continue training in Connecticut's residency programs. UCHC 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.

UConn 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, primary care informatics and correctional health—in less time than it would take to pursue primary care and the related specialty sequentially. Shaving a year off this combined training is an inducement, and will also get these residents into active practice sooner. To do this, UConn must persuade the pertinent national board specialty organizations and national board certification processes of the value of its approach.

The UConn/St. Francis family medicine residency program has been a strong contributor to Connecticut’s supply of primary care physicians for over 35 years. Its ambulatory practice site, Asylum Hill Family Medicine Center, is a level 3 PCMH. The center cares primarily for central Connecticut’s underserved residents. The residency works closely with the Connecticut Institute for Primary Care Innovation (CIPCI). Both are adjacent to St. Francis Hospital. Consideration is being given to adding several residents per year, and partnering with local AMHs to provide community practice sites. The residency also has a geriatrics fellowship that runs in concert with UConn’s School Of Medicine.

Connecticut Children’s Medical Center (CT Children’s) is home to UConn’s pediatric residency program,, which educates 20 residents a year. Historically, half of the residency graduates have entered primary care, and most have stayed in Connecticut. In July of 2013, CT Children’s implemented a revised curriculum. It includes 4 concentrations, two of which are designed to enhance the primary care education of residents. The Primary Care concentration includes pathways in Community Practice and General Academic Pediatric Practice. The Population Health concentration includes pathways for Resident Education in Advocacy and Child Health (REACH) and Global Health. These pathways prepare residents to partner with communities locally and abroad, through instruction and hands-on experiences.

CT Children’s residency program also benefits from the center’s newly established Office of Community Child Health, which provides opportunities for residents to practice service coordination and interprofessional teamwork. Most notable is the “Help Me grow” program, which links appropriate services to children’s needs.

St. Vincent’s Medical Center’s internal medicine residency program is moving toward greater emphasis on ambulatory care. Residents are being exposed to both small group practice and clinic settings. As a consequence, more of St. Vincent’s residents are choosing primary care. The center is also the principal clinical affiliate of the new Frank H Netter School of Medicine at Quinnipiac University, which enrolled its first students in August 2013. In 2011, St. Vincent’s Health Partners was established primarily as an association of St. Vincent’s Medical Center’s physicians to provide them with an array of supports: practice management resources, patient navigators, electronic health records, group purchasing discounts, contracting and shared data analytics on quality measures. SVHP affords a spectrum of primary care settings for training sites. Even its smallest practices have expressed interest in working with residents.

Developed in conjunction with Yale faculty, Danbury Hospital's primary care residency program is focused on training residents in the Patient Centered Medical Home model. Setting it apart from Danbury's other residency programs, the primary care residency's rotations are principally in community health centers and PCMHs.

Danbury Hospital has also been instrumental in developing a second primary care residency program with Danbury's new (2009) Federally Qualified Health Center (FQHC). Connecticut sees greater participation of FQHCs as training sites not only for medical residencies but also for nurse practitioner and pharmacy residencies. Nationally, Connecticut has led the way in building this role for FQHCs in both medicine and nursing.

This past July, Connecticut's and the nation's first FQHC based primary care medical residency program enrolled its first three residents. HRSA funded its development under its Teaching Health Center Program. Danbury Hospital received this grant in 2010 and has partnered with the Greater Danbury Community Health Center (GDCHC), which is now independently accredited by ACGME. GDCHC's parent company, Connecticut Institute For Communities, Inc. (CIFIC), will engage other FQHCs in considering further expansions of FQHC based residency programs.

Connecticut was also the first state to establish an FQHC based residency program for new nurse practitioners. In 2007, Connecticut's largest Federally Qualified Health Center (FQHC), Community Health Center, Inc (CHC), launched *Nurse Practitioner Residency Training in Community Health and Primary Care*, whose model has been replicated in fifteen FQHCs around the country. CHC's program is intensive, 12 month, full-time, and designed expressly to support new nurse practitioners in becoming primary care clinicians in challenging safety-net settings such as FQHCs.

Connecticut sees a greater number of primary care NPs exercising greater responsibilities as critical to meeting the growing need for primary care in our state. All eight of the state's academic nurse practitioner programs will expand their enrollments and their offerings in primary care. In addition, Connecticut will build upon its experience as the national leader in developing post-graduate residencies in primary care for new nurse practitioners, particularly in FQHCs and other safety net providers.

Connecticut has a number of small pharmacy residency programs based in hospitals and ambulatory clinics that with additional funding can be expanded and extended to community practice settings. For the past seven years, the UConn School of Pharmacy has offered one ambulatory care pharmacy residency at the Burgdorff Clinic in Hartford. As part of an interprofessional care team, the resident manages a panel of patients with multiple chronic diseases, and conducts a longitudinal research project that incorporates quality improvement initiatives. There are small pharmacy residency programs with staff pharmacist preceptors at YNHH, UCHC and West Haven VA Hospital. All could include community-based group practices or FQHCs in their programs.

In addition to primary care residencies, we see our residencies in preventive medicine and public health as critical to the fulfillment of this plan. If population health is to be a core

concern of primary care, Connecticut must have clinicians who are expert in population health to work with primary care clinicians. Connecticut will leverage federal investment. Two of Connecticut's teaching hospitals have received grants from HRSA's Preventive Medicine and Public Health Training Grant Program: Griffin Hospital in 2010 and Danbury Hospital just this past November.

In tandem with the Yale School of Medicine, Griffin built a program that has become a national model. Their preventive medicine residents work at least a day a week in an FQHC. Griffin's 2010 HRSA grant has provided continued support for this program.

Danbury Hospital's 2013 grant will enable a second joint project with Greater Danbury Community Health Center (GDCHC), its partner for its new primary care medical residency program. The two institutions will now also be developing a preventive medicine residency program. That the two residency programs will be centered at GDCHC. For primary care residencies, the issues are principally resources and logistics. Connecticut's residency programs see that much is to be gained by a concerted approach to working with our transforming primary care practices. They also see that much is to be gained in working together to develop programs for training the trainers, that is, for preparing our community-based clinicians to be educators and mentors to residents. The leaders of the residency programs and the leaders of the institutions that sponsor them will work together in devising creative approaches to supporting and expanding primary care residencies. The Connecticut Institute for Primary Care Innovation (CIPCI) will host a conference during the first year of this plan's implementation.

# Appendix F: Plan Development Participation

## C.1 STATE HEALTH CARE INNOVATION PLANNING STEERING COMMITTEE MEMBERS

Nancy Wyman  
Committee Chair  
Lieutenant Governor

Anne Melissa Dowling  
Deputy Commissioner  
Connecticut Insurance Department

Victoria Veltri  
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State Healthcare Advocate  
Office of the Healthcare Advocate

Anne Foley  
Under-Secretary, Policy Development & Planning  
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Mark Schaefer  
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Patricia Baker  
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Jan Van Tassel\*  
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Connecticut Legal Rights Project

Thomas Woodruff  
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Office of the State Comptroller

- **Added November 2013**

## **C.2 CORE PLANNING TEAM**

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State Healthcare Advocate

Michael Michaud, Associate Project Director  
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Mark Schaefer, Associate Project Director  
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## **C.3 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

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## Appendix G: Stakeholder Engagement Events

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

Meeting with Burton Edelstein, dental provider and expert on oral health, Children's Dental Health Project	10/9/ 2013 and 10/15/2013
New Haven County Medical Association and Hartford County Medical Association's joint annual meeting: exhibit hall	10/21/2013
Center for Integrative Medicine at Saint Francis Hospital	10/26/13
Connecticut State Medical Society – General Practitioners, PCPs	11/13/2013
American College of Physicians-Annual Scientific Meeting	11/15/2013
Center for Health Equity at Saint Francis/ CDRMHI, Integrative Health Coach and Patient Navigation program	11/18/2013
Connecticut State Medical Society - Specialists	11/20/2013
Community Health Center Association of Connecticut (CHCACT)	11/26/2013
Connecticut Center for Primary Care	11/25/2013
Connecticut Community Providers Association	12/05/2013
Connecticut Hospital Association meeting	12/10/2013
Community Health Network (CHNCT): Direct service providers of mothers on Medicaid	12/11/2013
<b>C. Consumers, healthcare advocates, employers &amp; community leaders</b>	<b>27</b>
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
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
STRIVE Focus Group	8/ 8/2013
Hartford small employer focus group	8/15/2013
AARP Advocacy Leadership Council	9/9/2013
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
Consumer Advocate Forum	10/7/2013
Covering Connecticut's Kids & Families	10/30/2013
Southeastern Asian American Community Leaders	11/12/2013
Focus group of Shelton AARP members Follow Up	11/15/2013
Universal Healthcare Foundation of CT Consumer meetings (3 sessions)	11/19, 21, 25/2013
Connecticut Council for Family Service Agencies	11/19/2013
Wheeler Clinic	11/19/2013
STRIVE Focus Group Follow Up	11/20/2013
Western Health Network	11/22/2013
Kitchen Cabinet and Mothers for Justice Follow Up	12/4/2013
Northwestern Regional Mental Health Board	12/5/2013
HUSKY Advisory Committee to CHNCT Follow Up	12/11/2013
CT Health Foundation Fellows	12/11/2013
<b>D. Public and private Payers, self-insured employers and public and private health plans</b>	<b>7</b>
CT Business Group on Health Council Meeting	6/7/2013 6/28/2013
CT Business Group on Health: Wellness Committee	7/16/2013
Employees of Employer Sponsored Insurance Focus Group	8/14/2013
Northwestern Connecticut Chamber of Commerce-Representatives of businesses NE CT	8/15/2013
CT Business Group on Health – Annual Meeting (CT-BGH)	9/27/2013
Employees of Employer Sponsored Insurance Focus Group Follow Up	11/14/2013
Accountable Care Task Force – Yale New Haven Hospital	12/19/2013
<b>E. Social Service Organizations, faith-based, representatives for health education and community health organizations</b>	<b>5</b>
Central Area Health Education Center (AHEC)-Community Organizations	8/16/2013

Connecticut Partners for Health meeting regarding Consumer Empowerment	10/9/ 2013
Health Quest Northeast District	11/15/2013
Universal Healthcare Foundation of CT Consumer meetings (3 sessions)	11/19, 21, 25/2013
Qualidigm	11/18/2013
F. Funders and Resource Foundations, academic experts, external quality review organizations, hospital engagement networks, policy institutes and health associations	5
CT Multicultural Health Partnership Event	6/20/2013
CT Association of Directors of Health	9/18/2013
CT Partners for Health	10/3/2013
The Donoghue Foundation	10/9/2013
CT Association of Directors of Health	11/20/2013

## Appendix H: Focus Areas for Connecticut – options considered

### Focus areas for Connecticut – options considered (1/4)

Focus area/ question	Options considered
<b>A</b> Options for creating multi-payer strategies to move away from payment based on value and toward payment based on outcomes	<ul style="list-style-type: none"> <li>▪ Episode-based payment</li> <li>▪ Pay-for-performance</li> <li>▪ Total cost of care accountability</li> </ul>
<b>B</b> Strategies to improve effectiveness, efficiency, and appropriate mix of the health care workforce	<ul style="list-style-type: none"> <li>▪ Roles: Scope of practice acts/regulations</li> <li>▪ Capacity: Recruitment, retention, increase in provider training/education (e.g., medical school class size), regulatory/ licensing, productivity</li> <li>▪ Skills/ behaviors: Addition to training curriculum, clinical decision support, peer provider programs; role modeling, increased performance transparency, greater data sharing across providers</li> <li>▪ Structure: Integrated provider structures (e.g., coordinated care teams)</li> </ul>
<b>C</b> Options for aligning regulatory authorities such as certificate of need programs to reinforce accountable care and delivery system transformation	<ul style="list-style-type: none"> <li>▪ No change</li> <li>▪ Re-assess CON requirements for:               <ul style="list-style-type: none"> <li>– Hospitals</li> <li>– Physicians/ practitioners</li> <li>– OP surgical facilities</li> <li>– Central Service facilities</li> </ul> </li> </ul>
<b>D</b> Options for restructuring Medicaid supplemental payment programs to align with the goals of the state's payment and delivery system reform model, including	<ul style="list-style-type: none"> <li>▪ No change</li> <li>▪ Restructure to increase access</li> <li>▪ Increase Medicaid supplemental payments to all providers to increase Medicaid consumers' access to care</li> <li>▪ Increase supplemental payments to subsets of providers in underserved areas</li> <li>▪ Restructure to support provider enrollment in new model and adoption of practice standards</li> <li>▪ Make existing supplemental payments contingent on enrollment</li> <li>▪ Increase Medicaid supplemental payments to reward providers who are enrolled and are meeting practice standards</li> </ul>



## Focus areas for Connecticut – options considered (2/4)

Focus area/ question	Options considered
<b>E</b> Options for regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform, including	<ul style="list-style-type: none"> <li>Regulations that enable a practice standards/ metrics coalition to select metrics, set the minimum requirements for accreditation and publish results</li> <li>Regulations that mandate that qualified health plans as well as fully insured employer health plans<sup>1</sup> are contributing data and supporting medical home adoption</li> <li>Regulations to encourage adoption of a common scorecard</li> <li>Reporting requests/ denials to APCD</li> <li>Eliminate regulations that prohibit premium rebates or premium incentives in the commercial market</li> </ul>
<b>F</b> Options for creating mechanisms to develop community awareness of and engagement in state efforts to achieve better health and health care, including	<ul style="list-style-type: none"> <li>Align provider metrics with state's goals for better health and health care (e.g., triple aim)</li> <li>Align certification criteria of community-based entities with state's goals for better health and health care through the certifying entity</li> <li>Create a broader consumer engagement plan</li> </ul>
<b>G</b> Review and identify options for coordinating state-based health insurance exchange activities, including	<ul style="list-style-type: none"> <li>Coordinate stakeholder outreach across SIM and health insurance exchange</li> <li>Complement consumer education strategies (e.g., Choosing Wisely)</li> <li>Leverage data collected through APCD</li> <li>Align programmatic targets</li> <li>Integrate CT SIM metrics for measurement of provider quality/ performance on health insurance exchange</li> </ul>
<b>H</b> Options for integrating the financing and delivery of public health services and community prevention strategies with health system redesign models, including	<ul style="list-style-type: none"> <li>Increase awareness of public health services and prevention strategies (e.g., 211, certified entity)</li> <li>Encourage providers to apply preventive strategies/population-health management strategies (e.g., maintain disease registry, risk stratify to target interventions)</li> <li>Encourage providers to coordinate with public health services and prevention strategies (e.g., hold provider accountable for reach-out, align certification criteria for community entities with provider scorecard)</li> </ul>

## Focus areas for Connecticut – options considered (3/4)

Focus area/ question	Options considered
<b>I</b> Options for leveraging community stabilization development initiatives in low income comm. and encouraging community investment to improve community health, including	<ul style="list-style-type: none"> <li>▪ Hold providers accountable for whole-person centered care to create provider pull for community stabilization development initiatives; and encourage provider investment into community-based entities by generating awareness of entities through the certifying entity.</li> </ul>
<b>J</b> Options for integrating early childhood and adolescent health prevention strategies with the educational system, including: Primary prevention and secondary prevention	<ul style="list-style-type: none"> <li>▪ Primary prevention and secondary prevention</li> </ul>
<b>K</b> Options for creating models that integrate behavioral health, substance abuse, children's, dental health, and long term services and support, including:	<ul style="list-style-type: none"> <li>▪ Across BH, dental, substance abuse:</li> <li>▪ Whole-person-centered assessment and treatment plan</li> <li>▪ Provider accountability for outreach to behavioral health providers when required</li> <li>▪ LTSS</li> </ul>
<b>L</b> Options for creating or expanding models such as the Administration on Community Living's Aging and Disability Resource Centers and Money Follows the Person Program and Balancing Incentive Program (BIP) to support long term services and support, including	<ul style="list-style-type: none"> <li>▪ Align objectives around a person-centered, community-based environment, promotion of independence and dignity for individuals, consumer engagement, and resources and services that support the needs of family caregivers.</li> <li>▪ Money Follows the Person (MFP): Hold providers accountable for total cost of care and for cost/ resource utilization metrics that encourage utilization of lower-cost community-based care settings</li> <li>▪ Balancing Incentives Program (BIP): Ensure complementarity of CT SIM care delivery model and BIP's conflict-free case management services and core standardized assessment instruments</li> </ul>

## Focus areas for Connecticut – options considered (4/4)

Focus area/ question	Options considered
<b>M</b> Options for using other policy levers that can support delivery system transformation, including	<ul style="list-style-type: none"> <li>▪ Establish and monitor practice standards</li> <li>▪ Enable providers to operate at the top of their license</li> <li>▪ Improve workforce capability through training</li> <li>▪ Improve provider retention</li> <li>▪ Integrate primary care and population health</li> <li>▪ Address privacy concerns to expand utility of APCD</li> <li>▪ Enable Medicaid participation in new model</li> <li>▪ Promote a multi-payer strategy and provider collaboration that does not violate anti-trust regulations</li> <li>▪ Ensure interoperability of EMR</li> <li>▪ Setting up a state metrics taskforce to consider requiring patient engagement metrics and reporting on patient safety</li> </ul>
<b>N</b> Options for leveraging HIT, HER, HIE to improve health and coordination of care across service providers, including	<ul style="list-style-type: none"> <li>▪ Payer/ provider analytics</li> <li>▪ Provider-payer-consumer connectivity</li> <li>▪ Provider-consumer care management tools</li> <li>▪ Provider-provider connectivity</li> </ul>

# Appendix I: Health Disparities Report Data Summary

**Table 1. Health Disparities Reports Data Summary**

	CT Health Data Scan	2009 CT Hth Disparities Report	Common-wealth	Kaiser	Kaiser Wmn's Health CT	NAACP 2007	ACSC CT	Hispanic Health Council	NCI State Cancer Profile	CDC US Cancer Stats (USCS)	CT Hlth Fndtn Racial and Ethnic Panel Report
<b><u>CT State Specific Detail</u></b>	Yes	yes	no	yes	yes	yes	yes	yes	yes	yes	
<b><u>Disparity</u></b>							Prevent-able hosp. data from CT Office of Health Care Access 2008				
<b><u>Health Status</u></b>											
fair/poor health	x, 1		x, 9		X, 21	X, 3					
limited activity	x, 1				X, 21	X, 3					
chronic condition or disability			x, 10								
chronic condition or disability by FPL			x, 10								x
life expectancy			x, 11								
Obesity	x, 1	x, 5	x, 10		X, 21			x			
Smoking	x, 1	x, 5	x, 9		X, 21						x
Diabetes	x, 1	x, 5	x, 12		x, 21	x, 3, 15		x			
cardiovascular disease			x, 11			x, 15					
cancer incidence			x, 9, 13			x, 13				x, 13	x

HIV/AIDS incidence		x, 5	x, 14	x	x, 14						
HIV/AIDS prevalence								x			
asthma (all ages)			x, 9								
asthma (adult/adolescent)	x, 1		x, 9			x, 15					
asthma (pediatric)						X, 3		x			
asthma (adult - ever told)	x, 1										
frequent mental distress	x, 1		x, 15		x, 21						
serious psychological distress					x, 22	X, 3					
low birthweight (live babies)	x, 5	x, 5			x, 9	X, 2					
prematurity						X, 2					
seat belt use	x, 1										
binge drinking	x, 1										
<b>Mortality</b>											
infant mortality	x, 6	x, 5	x	x							
cardiovascular/heart disease mortality	x, 8	x, 5	x, 9								
cancer incidence and mortality	x, 8	x, 5	x		x, 13				x, 13		
asthma mortality			x, 9								x
diabetes mortality	x, 8	x, 5		x				x			
HIV mortality	x, 8	x, 5									x
<b>Access to and Utilization of Health Care</b>											

no doctor			x, 10		x, 21	x, 15					
regular source of care	x, 1		x, 10			x, 15					
no routine checkup in past 2yrs	x, 1				x, 21						
go without needed care			x, 10			x, 15					
forgo dental care	x, 1	x, 28	x, 10		x, 21			x			
pediatric dental care		x, 5									
forgo prescription meds			x, 10								
angioplasty rate			x, 11								
no mammogram in past 2yrs	x, 1	x, 5			x, 21						
no Pap smear in last 3yrs	x, 1	x, 5			x, 21						
late/no prenatal care	x, 3	x, 5			x, 24	X, 3		x			
cancer screenings (Pap, Mammo, PSA, Colonoscopy)	x, 1	x, 5				x					
HIV (ever tested)	x, 1										
flu vaccine	x, 1										
ED visits	x, 7										
asthma hospitalizations		x, 5, 8, 11									
diabetes hospitalizations		x, 5									
<b>Health Insurance Coverage</b>											
lack insurance	x, 1	x, 5	x, 16	x	x, 23	x		x			
no insurance by education level			x, 10								



continuous insurance			x, 10								
insurance by citizenship			x, 11								
<b>Quality of Care</b>											
physician perspective of QOC			x, 11								
heart attack mortality rates			x, 11								
Medicare quality ranking by state			x, 11								
mortality rate due to hospital complications			x, 17								
post-op complications			x, 17								
youth restraints in psychiatric hospitals			x, 11								
physical restraints in nursing homes			x, 17								
length of time to appointment date			x, 10								
leave ER/ED without treatment			x, 17								
timeliness of emergent procedures			x, 17								
rates of preventive screenings/procedures	x, 1		x, 18, 11, 17								
pneumococcal vaccination	x, 1		x, 17								
pediatric dental care			x, 18								
prenatal care			x, 17								
treatment for depression			x, 17								
recommended hospital care for pneumonia			x, 17								
recommended hospital care for heart failure			x, 17								
ER/ED use for regular care			x, 19			x, 15					

ACSC/100,000	x, 4		x, 20			x, 26	x				
<b><u>Social Determinants</u></b>											
living in poverty	x, 8	x, 8	x, 9	x	x, 25	x, 27					
median household income			x, 8		x, 25						
education level		x, 8	x, 8								
no high school diploma		x, 8			x, 25						
college graduate	x, 8	x, 8									
woman in female head of household home w/ children	x, 8				x, 25						
birth data by education level	x, 5, 8										

**Source Key**

1 - BRFSS '99-'03; 2 - CDC NSCH 2004; 3 - DPH Vital Statistics; 4 - CT Office of Healthcare Access and US Census; 5 - DPH; 6 - DPH CT Resident Deaths '03; 7 - CHIME Database, CHA; 8 - US Census; 9 - CDC National Center for Health Statistics 2006; 10 - The Commonwealth Fund 2006; 11 - publication; 12 - NIH 2005; 13 - SEER database; 14 - CDC HIV/AIDS Surveillance Report 2006; 15 - BRFSS 2005; 16 - National Center for Health Statistics 2004; 17 - AHRQ National Healthcare Disparities Report 2006; 18 - AHRQ National Healthcare Disparities Report 2005; 19 - The Commonwealth Fund Biennial Health Insurance Survey 2005; 20 - The Commonwealth Fund National Scorecard 2006; 21 - BRFSS 2004-2006; 22 - SAMHSA 2004-2007; 23 - Current Population Survey 2004-2006; 24 - CDC National Center for Health Statistics 2007; 25 - CPS 2004-2006; 26 - CT Office of Health Care Access 2005; 27 - UConn Center for Population Research; 28 - BRFSS 2008