

# **Healthcare Innovation Steering Committee**

June 12, 2014

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Overview of Physician Survey

June 12, 2014

# Proposed Survey Design

- **Data collection:** Mail survey with telephone follow-up to non-responders
- **Sample:** Physicians that have submitted claims to two or more of the State's major insurers in the past year
  - Sample will be provided by insurers and augmented with contact information from CSMS
  - Expected N = 600 completed surveys from PCPs, 600 surveys from physicians in 6 specialty areas
- **Survey development process:**
  - Developed with input from Technical Advisory Panel
  - Will include pilot testing to insure questions are clear and consistently understood
- **Deliverable:** Final report that characterizes CT physician workforce

# Survey Topic Areas

- a. Amount of primary care currently provided and any anticipated
- b. Access to, and use of, different aspects of health information technology (EHRs, disease registries);
- c. Physicians' or their practices' ability to provide comprehensive medical care for patients;
- d. Adoption of PCMH principals:
  - Providing care coordination care for patients with chronic diseases;
  - Use of primary care teams;
  - "Open access" scheduling;
  - Visits in which multiple patients with chronic illness meet together with a trained clinician;
- e. Availability and use of shared decision making tools;
- f. Ownership and organization of practices and affiliations with larger care systems/organizations such as networks
- g. Physicians' attitude/concerns regarding care coordination and medical home or advanced primary care principles;
- h. Physicians' attitudes/concerns regarding larger coordinating entities, such as clinically integrated health systems or ACOs.
  - Support and resources needed to provide primary care services to complex patients
- i. Status of adoption of cultural and linguistic appropriateness standards
- j. Percentage of patient panel attributed to Medicaid, Medicare, CHIP, and private insurance.

# Healthcare Innovation Steering Committee: Practice Transformation

Marie Smith, PharmD, FNAP  
Brody McConnell, P3 Student  
UCONN School of Pharmacy

June 12, 2014

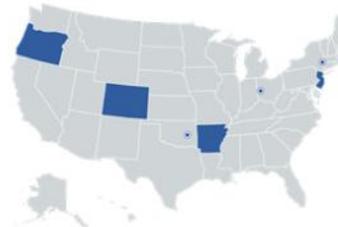
# CT expertise with CMMI

- Marie Smith (UCONN): Faculty leave July - Dec 2013
- **Team Member - Comprehensive Primary Care (CPC) Initiative**  
<http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>
- CMS/CMMI's Medical Home Initiative with shared saving regional approach

## *Moving towards Comprehensive and High-Value Primary Care*

...strengthen freestanding primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers

- **Selection criteria:** HIT use, recognized advanced primary care practice, patient panel covered by participating payers, participating in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.
- **7 regions – 497 practices - 2,347 providers** serving an estimated **315,000 Medicare beneficiaries**
  - ✓ New York: Capital District-Hudson Valley Region
  - ✓ New Jersey: Statewide
  - ✓ Ohio & Kentucky: Cincinnati-Dayton Region
  - ✓ Arkansas: Statewide
  - ✓ Oklahoma: Greater Tulsa Region
  - ✓ Colorado: Statewide
  - ✓ Oregon: Statewide
- **Multi-payer initiative:** 31 commercial payers/state Medicaid programs + Medicare
  - Payers implement strategies that align with the CPC approach to achieve comprehensive primary care
- Began in Fall 2012....**4-year initiative....\$ 322 Million funding** (comparison: ACOs =\$252Million, PFP=\$500Million)
- Year 1 reporting being conducted now



# What is the current SIM AMH approach?

## Advanced Medical Home:

- **Tracks practice transformation – accountability for meeting milestones**
- Focuses on risk-stratification and targeted care management
- Aspires to expanded and dynamic clinical care teams
- Payment blend of
  - FFS, monthly risk-adjusted PMPM
  - P4P => shared savings
- Multi-payer model
- Commitment to ongoing learning and collaboration

## Strategy

- Recruit and enroll practices in Glide Path
- Facilitate transformation through Practice Transformation Technical Assistance
- Help practices meet milestones and transform to AMH standards
- Multiple waves of enrollment

# Issues to Resolve

EXHIBIT 19: Clinical Integration Models to Attain Scale and Capabilities

A Integrated Delivery System	<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 Medical Group Practice	<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>
C Clinically integrated network	<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>
D Strong IPA	<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>
E Loose IPA	<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>
F Regional cooperatives	<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>

## FOA prefers state borrow from Medicare methods:

- Medicare Shared Savings Program, aka ACO
- PCMH...the most popular example being the CPCI

## • Consumer advocate concerns

- Must have payment for transformation
- Need alternative to consolidation

## • Payer concerns

- Payer-specific panel size too small
- Advance payment insufficient and will not result in change
- Small panel means you cannot hold practice accountable for quality and cost
- Too small and lacking infrastructure to hire new team members and develop advanced capabilities
- Need Medicare to lead

# Proposed Resolution

- Adopt CPCI-like methodology
- Pathway for practice to *remain independent*, share accountability for quality and cost, and become part of a learning community
- Model revisions
  - Geographic pooling of small to mid-size practices
  - Additional standards, beyond medical home
  - Emphasis on local leadership
  - On-site practice transformation support & learning collaboratives
  - Shared utility solutions – population health analytics, shared hiring of team members (care coordinators, pharmacists), etc.
  - Invite Medicare and other payers to provide risk-adjusted advance payment

# What are potential AMH Core Functions and Accountability Milestones?

1	<b>Care Management for High Risk Patients</b>	<ul style="list-style-type: none"> <li>• Empanelment</li> <li>• Risk-stratification</li> <li>• Establish and support expanded clinical teams with professionals/staff practicing at the top of license or training</li> <li>• Targeted Care management Strategies (integrated behavioral health, medication management, self-management for targeted chronic conditions)</li> <li>• Identify and plan care for social and environmental risk factors</li> <li>• Point of care reminders</li> <li>• Optimal use of HIT</li> </ul>
2	<b>Access</b>	<ul style="list-style-type: none"> <li>• 24/7 access to PCP (e.g. Telephone, electronic, same day visits, Rx refills)</li> <li>• Scheduling options that are patient/family centered</li> <li>• Help patients receive health insurance coverage</li> </ul>
3	<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>• Consumer Engagement</li> <li>• National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care</li> <li>• Care Experience (Consumer/family advisory councils; surveys)</li> <li>• Monitor metrics</li> <li>• Involve team and consumer</li> </ul>
4	<b>Quality Improvement</b>	<ul style="list-style-type: none"> <li>• Consumer Engagement</li> <li>• Care Experience (Consumer/family advisory councils; surveys)</li> <li>• Provider Experience</li> <li>• Quality Improvement Plan</li> <li>• Monitor metrics</li> <li>• Involve team and consumer</li> <li>• Learning Collaboratives</li> </ul>
5	<b>Care Coordination</b>	<ul style="list-style-type: none"> <li>• Preventative Care, Medical Services, Behavioral Health (Comprehensive Health Assessment)</li> <li>• Care Continuity</li> </ul>
6	<b>Shared Decision Making</b>	<ul style="list-style-type: none"> <li>• Evidence-based decision aids for procedures, tests, treatments</li> <li>• Patient/family engagement in care plans</li> </ul>
7	<b>Participate in Learning Collaborative</b>	<ul style="list-style-type: none"> <li>• Shared best practices across providers, practice staff, and PMO</li> <li>• Webinar education, telephone support, live sessions</li> <li>• Collaboration web site hub</li> </ul>
8	<b>Health Information Technology</b>	<ul style="list-style-type: none"> <li>• Optimal use of HIT for risk stratification, population health, patient data exchange, care coordination, quality improvement measurement and reporting, learning collaboration</li> </ul>

## Major Functions and Milestones:

- Risk stratification of panel
- Care management for high risk patients with targeted strategies
- Culturally/linguistically appropriate services
- Improve non-visit access
- Improve patient experience and track with direct feedback
- QI reports based on SIM mandated measures
- Shared decision making with patient
- Learning Collaborative participation
- Meaningful EHR Use

# Proposed AMH Timeline

## July-October 2015

- Recruit practices and select regions through RFP
- Begin targeted technical assistance and learning collaboratives

## 2016

- P4P\* – quality improvement, care experience, reduced avoidable hospitalizations and ED visits; P4P contingent on hospital and ED savings
- Total cost Shared Saving simulation – TCOC training

## 2017

- Shared Savings Plan begins

\*Is P4P sufficient in 2016 to meet federal requirements?

# How might SIM regions be established?

	CPCI	SIM CT
Regional Markets	7	Up to 3
Practices	500	75-120
Primary Care Providers	2400	300-600
Lives Covered	315,000 Medicare lives + commercial and Medicaid	600K – 1.2 Million lives

## Options for regional approach:

- Align with CPCI regional approach
- Up to 3 Regions – TBD
  - 25-40 practices/region
  - 100-200 PCPs/region
- 600K - 1.2Million lives covered

## Payment model :

### FFS with Advance Payments

- Year 1/2 - full negotiated PMPM
- Year 3/4 – reduced negotiated PMPM

### P4P – payment in Year 1+

**Shared savings** –practices must reach quality and care experience threshold for eligibility; net out Advance Payments

- Shared savings – what year to begin?
- Practice % of regional savings = 
$$\frac{\text{(practice's total annual care management fees)}}{\text{(region's sum of total annual care management fees)}}$$

# How might the AMH Glide Path be stratified?

Elements	Tier 1	Tier 2	AMH
<b>EHR Status</b>	No EHR	Have EHR	Meaningful use with EHR
<b>Readiness Assessment (Level of AMH Achievement)</b>	Required; Meets <50% of AMH criteria	Required; meets 50%-80% of AMH Criteria	Passed; 80%+ AMH criteria
<b>Time frame for intensive SIM Support</b>	18 months to achieve AMH	9 months to achieve AMH	n/a
<b>Glide Path Support</b>	Practice transformation examples – EHR implementation, Work flow redesign, Quality reporting, risk stratification methods	Practice transformation examples – EHR Functionality, care team expansion, risk-based population health	Targeted technical assistance
<b>Shared Resource Network (Ex. Care coordinator, pharmacist, etc)</b>	No	Yes	Yes

# How might the Learning Collaborative be established?

Level	Leader	Activities	Frequency	Method
State	SIM Staff	Office Hours for SIM practices	2 x month	Conf call/phone
	SIM/Vendor	National Subject Matter Experts	Monthly	Webinar
	SIM/Vendor	Regional Faculty Sessions – highlight SIM “bright spots”	Monthly	Webinar
	SIM/Vendor	SIM practice surveys	As needed	Online
	SIM Staff	SIM Meeting – Regional Faculty, Payers, Vendors, SIM Leaders	Annual	Live session
Regional	Vendor	Coaching/technical assistance for SIM practices	As Needed	On-site/phone
	Vendor	Regional SIM Meetings	Quarterly	Workshops
	Vendor	Regional SIM Session	Monthly	Webinars
Practices	Vendor	Learning Collaborative - ask questions; share best practices and patient feedback; post and archive resources - useful forms, workflow templates, presentations	Daily	Online
	Vendor	Milestone Reporting	Quarterly	Online

# What is the SIM support and payment model target?

- **Last Steering Committee – Issue Brief #4**
  - Establish additional expectations for advanced networks and FQHCs
  - Allocate SIM test grant dollars to provide support to these advanced networks/FQHCs
- **ACOs, Advanced Networks, and FQHCs (Community and Clinical Networks)**
  - Targeted technical assistance to improve care experience
    - ex. Integrated Behavioral Health, Medication Management, Self-Management for Chronic Conditions, E-Consults
  - Potential innovation grants
  - Learning Collaborative
  - Payment model - FFS, advance payment (optional), shared savings

# What might Targeted Technical Assistance (TTA) look like?



## Practice-level assistance with:

- Workflow redesign/efficiencies
- Risk stratification
- Expanded team-based care
- Patient/family engagement
- Population health reports
- Quality measures reports

## Transformation continuum:

- Readiness assessment
- Practice-directed priorities
- Milestone-driven

# Vendor Procurement Strategy

- **Types of vendors**
  - Practice transformation process
  - Technical assistance experts
  - Learning collaborative
- **Procurement process**
  - Regional scope of coverage
  - RFP process
- **Vendor payment options**
  - Flat fee (based on # of practices, scope of services)
  - Fee per transformation based on # of practices and starting status
  - Withhold paid out based on:
    - Practices' satisfaction with vendor services
    - Practices' experience once transformed; i.e., practice is more rewarding
    - # practices achieving AMH recognition

# Connecticut State Innovation Model

# Presentation to SIM Steering Committee Consumer Engagement

06/12/14

Jeffrey G. Beadle, Executive Director Windham Regional Community Council

# Consumer Advisory Board

- Consumer representation
  - Advice, guidance, and representation on Steer Co
  - Workgroups – SIM detail design & implementation
- Cross-workgroup convening
- Consumer representative communication & education plan
- CAB sub-committees and ad-hoc workgroups, e.g.
  - Population Health
  - Health Equity
  - Behavioral Health

# Highlights of Proposed Activities

- Consumer-led learning collaborative
  - On-going Consumer Education
  - On-going Listening Tours
  - On-going Feedback Loops
- Outreach: leverage NIPA network & other community assets
- Issue-driven Focus Groups
- Consumer Communications Plan
  - Materials
  - Website portal
  - Social media

Connecticut State Innovation Model

# Presentation to SIM Steering Committee Employer Engagement

06/12/14

Mary Bradley, Director of Healthcare Planning, Pitney Bowes  
Brenda Shipley, SIM Project Management Office

# Background

- Employers are a critical stakeholder in influencing how consumers seek and pay for care.
  - Employers are the ultimate payers
  - Employers make decisions on plan designs
  
- Maximizing the value of the health care dollars leads to:
  - Provider reimbursement
  - VBID
  
- VBID aligns the interests of consumers and providers.
  - Increasing adherence of high value prescriptions
  - Encouraging healthy lifestyles
  - Incentivizing the use of high value services
  - Promoting the medical home model

# Strategy to Engage Employers

- Convene a multi-stakeholder group to reaffirm what should be incented by employers, recognizing limited resources
- Develop prototype plan designs aligned to the delivery of accountable care
  - Recognize possible barriers with account based plans
- Leverage the unified employer voice to enable our health plans to administration these designs
- Educate employers
- Support employer adoption of VBID
- Measure outcomes

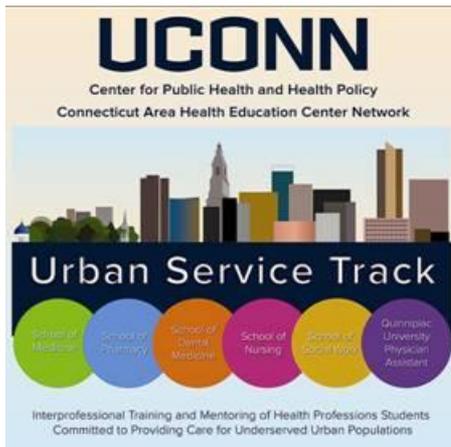
# Proposed Activities

- Employer representation
- Baseline of information
- Employer-led consortium
  - Guidance for value based payment arrangements
  - Template for minimum VBID benefit plan
  - VBID implementation toolkit
- Employer-led learning collaborative
- VBID implementations (demonstration, Access Health CT, pilots)
- Employer-led innovation pilot – workforce healthcare quality measures
- Evaluation

# VBID Timeline

## Employer Engagement - VBID - Milestones

	01/01/15 - 03/31/15	04/01/15 - 06/30/15	07/01/15 - 09/30/15	10/01/15 - 12/31/15
Year 1	Release Vendor RFP	Kick-Off Employer Consortium	VBID Template Design	VBID Tool Kit
	Demonstration Employers ready-to-go VBIDs			
	01/01/16 - 03/31/16	04/01/16 - 06/30/16	07/01/16 - 09/30/16	10/01/16 - 12/31/16
Year 2	Learning Collaborative #1	Pilot #1 Decisions	Pilot #1 – EE Communications	Pilot # 1 Open Enrollment
	01/01/17 - 03/31/17	04/01/17 - 06/30/17	07/01/17 - 09/30/17	10/01/17 - 12/31/18
Year 3	Learning Collaborative #2	Pilot #2 Decisions	Pilot #2 – EE Communications	Pilot # 2 Open Enrollment
	01/01/18 - 03/31/18	04/01/18 - 06/30/18	07/01/18 - 09/30/18	10/01/18 - 12/31/18
Year4	Learning Collaborative #3	Pilot #3 Decisions	Pilot #3 – EE Communications	Pilot # 3 Open Enrollment



# SIM WORKFORCE DEVELOPMENT

## The Connecticut Service Track

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# Connecticut Service Track

## What is it?

- Initiative to engage health professions student trainees in public service and inter-professional education.

## Why?

- To develop adequate numbers of I/P practice ready providers

# Interprofessional Health Care Education

- Evidence accruing that Patient Centered Medical Home (PCMH) models based on team based practice improve health outcomes with some decrease in utilization in high cost areas (e.g. ER use). (*Hoff, T. et. al. Medical Care Research and Review 69(6) 619-644. 2012*)
- Health Care Environment:

The Perfect Storm

vs.

The Alignment of the Planets

- **Value based health care** with imperative to improve outcome and experience, decrease cost, improve population health status.
- Ascendency of the **PCMH** model and **population health payment** reform.
- Implementation of the **Affordable Care Act** (ObamaCare) January 2014.
- **Accreditation requirements** for Health Professions Schools across all major disciplines.

# Connecticut Service Track

## How will CST be built?

- Inventory existing programs and resources
- Conduct survey to identify interested academic, community and healthcare partners.
- Develop geographic hubs for CST participants.
- Provide IPE/Service materials and opportunities in a central web repository.
- Provide meeting venue/forum to showcase best practices.
- Use clear benchmarks and a strong evaluation component.

# Teaching Health Center Graduate Medical Education (THCGME)

## Primary Care Medical/Dental Residencies & Community Health Centers

Health Innovation Steering Committee

June 12, 2014

# Leads

- Dr. Ramin Ahmadi — Western CT Health Network
- Board of Community Health Center Association of CT (CHCACT) — Jim Maloney
- 8 Community Health Centers
- Dr. Kiki Nissen — UCHC (technical assistance)

- Optimus Health Care Bridgeport
- CIFC Greater Danbury Community Health Center Danbury
- Cornell Scott-Hill Health Center New Haven
- Fair Haven Community Health Center New Haven
- First Choice Health Centers Hartford
- Generations Family Health Center Willimantic
- United Community and Family Services Norwich
- StayWell Health Center Waterbury

- Internal Medicine
- Family Medicine
- Pediatrics
- Psychiatry
- OB GYN
- Dentistry
- (Geriatrics)

## SEC. 5508. INCREASING TEACHING CAPACITY.

`(a) Program Authorized- The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

`(b) Amount and Duration- Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than **\$500,000**.

`(c) Use of Funds- Amounts provided under a grant under this section shall be used to cover the costs of--

`(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with--

`(A) curriculum development;

`(B) recruitment, training and retention of residents and faculty;

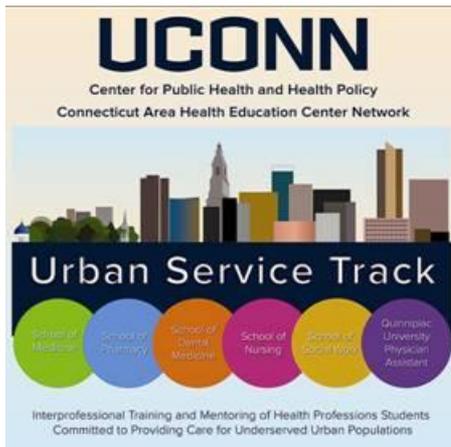
`(C) accreditation by the **Accreditation Council for Graduate Medical Education** (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

`(D) faculty salaries during the development phase; and

`(2) technical assistance provided by an eligible entity.

# Advantages

- Primary care clinicians who train in community health centers more likely to stay in the communities and in primary care
- Means of increasing GME slots in CT
- Building collaboration with HRSA
- Truly innovative
- CT's community health centers working with each other and with CT's hospitals
- Approaching the feds with an innovative idea as a state and as a community



# SIM WORKFORCE DEVELOPMENT Community Health Worker Initiative

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# Community Health Workers (CHWs)

- **Who are they?**
  - Trusted community liaisons who serve as coordinators and health coaches in homes and communities where they provide assistance in finding and accessing healthcare, preventive and other social service programs.
- **Why are they important?**
  - Help people navigate the healthcare system and find needed resources to improve health status and health outcomes.
  - Work closely with other healthcare professionals in promoting strategies for healthier living in the community.
  - Carry out policies and programs created by healthcare organizations and other social service groups.
- **Focus for CHW's**
  - Improve the effectiveness and reach of Advanced Medical Homes (AMHs) and prevention centers.

# Community Health Worker Initiative

- Development of courses of study and career ladders.
  - Collaboration between AHEC and its state regional centers with the current four CSCU campuses working on CHW training and education: Gateway, Housatonic, Capital and Charter Oak.
- Development of Sustainable Funding:
  - Building relationships with other key players such as employers, state agencies, and insurance companies to define the role of CHWs in health care delivery and sustainable payment mechanisms.
- Standardization of training:
  - Encourage all CHWs to receive training in basic core competencies offered through CT AHEC Network or Community Colleges.
- Specialized Training:
  - Partner with community based agencies and healthcare entities to develop and promote specialized trainings at community colleges
- Advocacy:
  - Support the Community Health Worker Association of Connecticut in advocating for CHWs as an essential discipline within the health care delivery system and as an entry point into the health and social services professions.

# CHW Initiative Work Plan

## – Pre-Award

- Establish partnerships with various stakeholders
- Collaborate with states that have existing CHW programs
- Build models for CHW programs & training in Connecticut

## – Year 1

- AHEC and CT State Colleges & Universities (ConnCSU) implement a 2 pronged CHW programs
  - Community based
  - College based
- Integrate primary care systems content into CHW training and programs
- Train PC practices regarding integration of CHWs into their practice models
- Promote CHWs to employers
- Provide support for the Community Health Worker Association of CT

## – Year 2

- Conduct skills assessments, implement evaluation components, identify potential funding for CHWs, and promoting of CHWs and CHW programs

## – Year 3

- Support ongoing trainings, sustainable funding, and promote CHW workforce development and hiring by health system and other employers
- On-going evaluation of CHW Initiative.