

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Connecticut SIM

A Vision for Better Health

Draft

May 14, 2015

Vision

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

Components of our State Innovation Model Initiative

**Transform
Healthcare
Delivery System**

Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

**Build Population
Health Capabilities**

Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

**Reform Payment &
Insurance Design**

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout

Invest in enabling health IT infrastructure

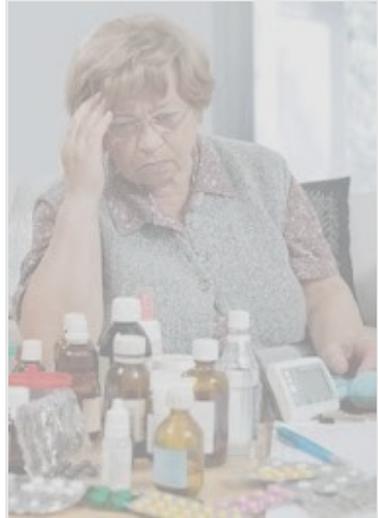
Evaluate the results, learn, and adjust

Healthcare today – 1.0

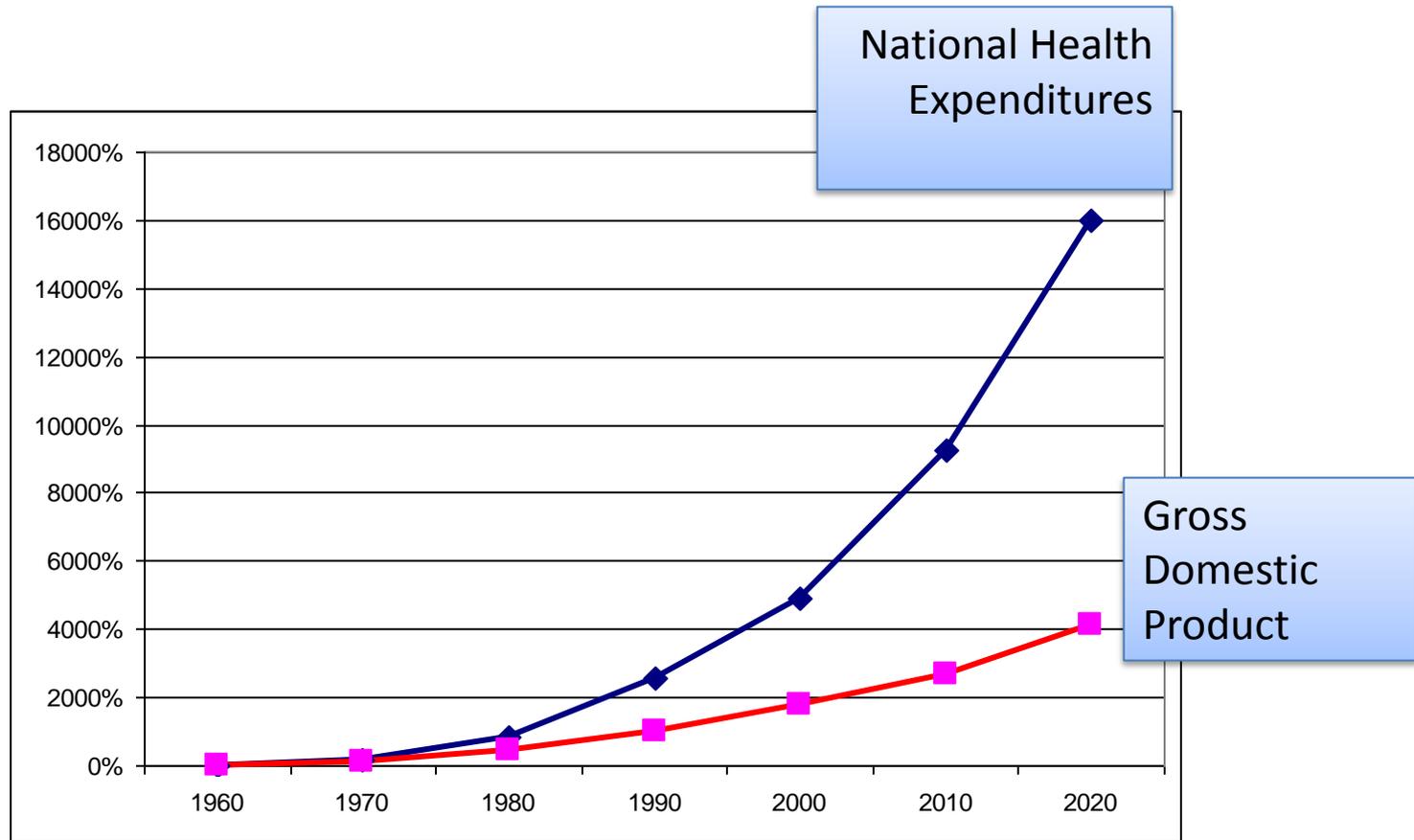
Connecticut's Current Health System: "As Is"

*Fee For Service
Healthcare* **1.0**

- **Limited accountability**
- **Poorly coordinated**
- **Pays for quantity without regard to quality**
- **Uneven quality and health inequities**
- **Limited data infrastructure**
- **Unsustainable growth in costs**



Healthcare Spending has Outpaced Economic Growth



Source: CMS, National Health Expenditure Data

Connecticut - healthcare spending = More than \$30 billion, **fourth highest of all states** for healthcare spending per capita

CMS (2011) Health Spending by State of Residence, 1991-2009.

http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Escalating costs mean...

....**patients** will experience



Insurance premiums resulting in less take-home pay



Deductibles and co-pays for needed medical care



Access to social services and Medicaid

....**communities** will experience



Money for programs that support housing, education, the environment, and community development



Escalating costs mean...

...the **business community**
will experience



US = Lowest Ranking for Safety, Coordination, Efficiency, Health

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

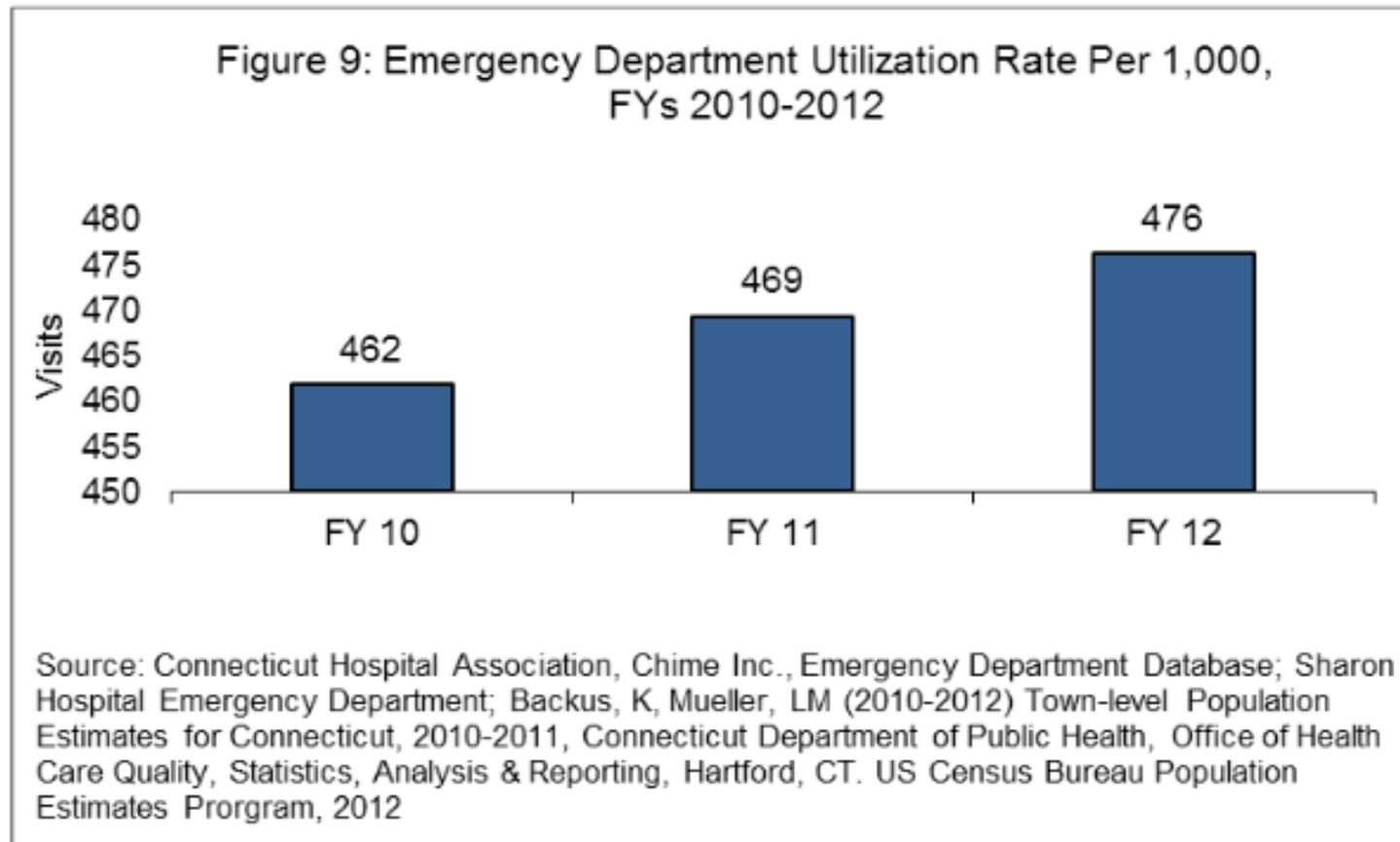
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Commonwealth Fund: <http://www.commonwealthfund.org/publications/press-releases/2010/jun/us-ranks-last-among-seven-countries>

**How about
Connecticut?**

Connecticut: Uneven Quality of Care

Connecticut has a rising rate of Emergency Department utilization

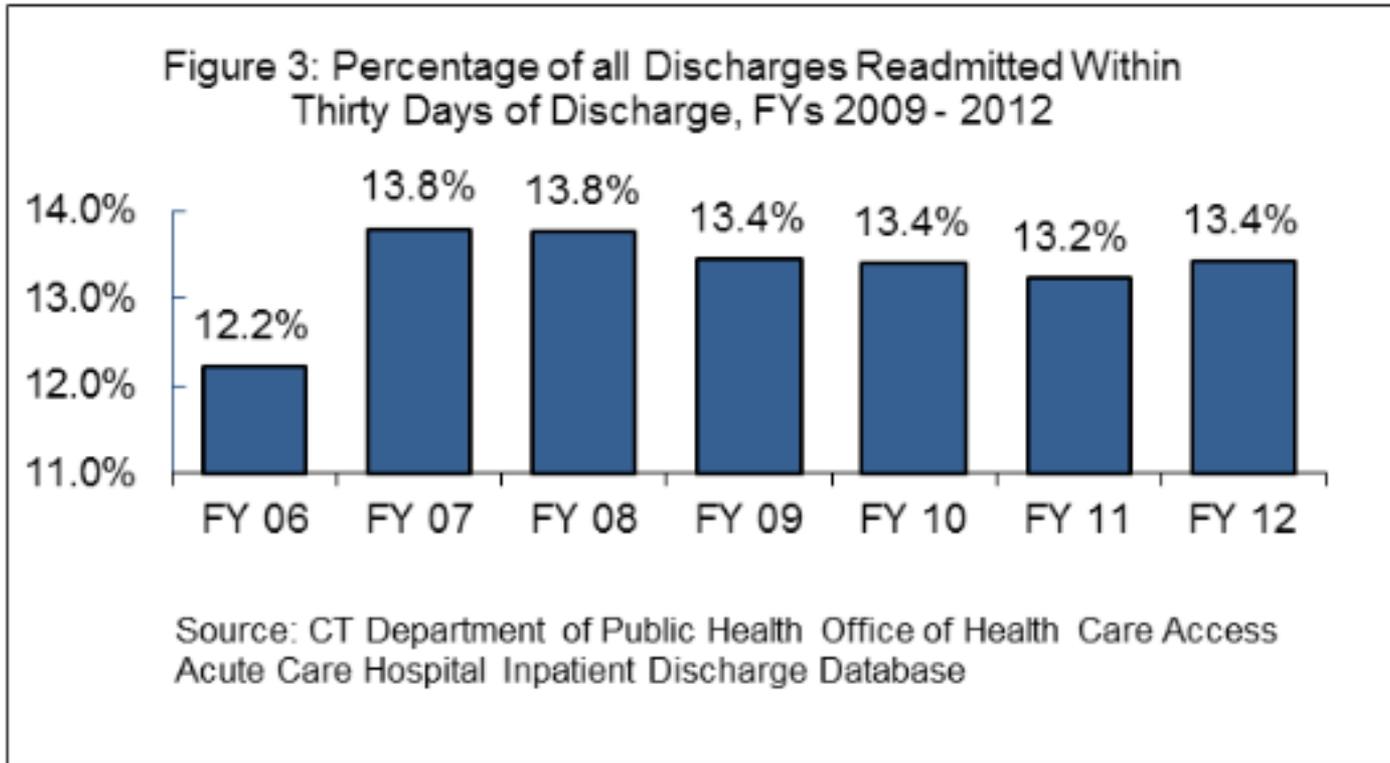


Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40
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CT ranking out of 50 states

Connecticut: Uneven Quality of Care

Connecticut has a high rate of hospital readmissions



CT ranks
36th out
of 50
states

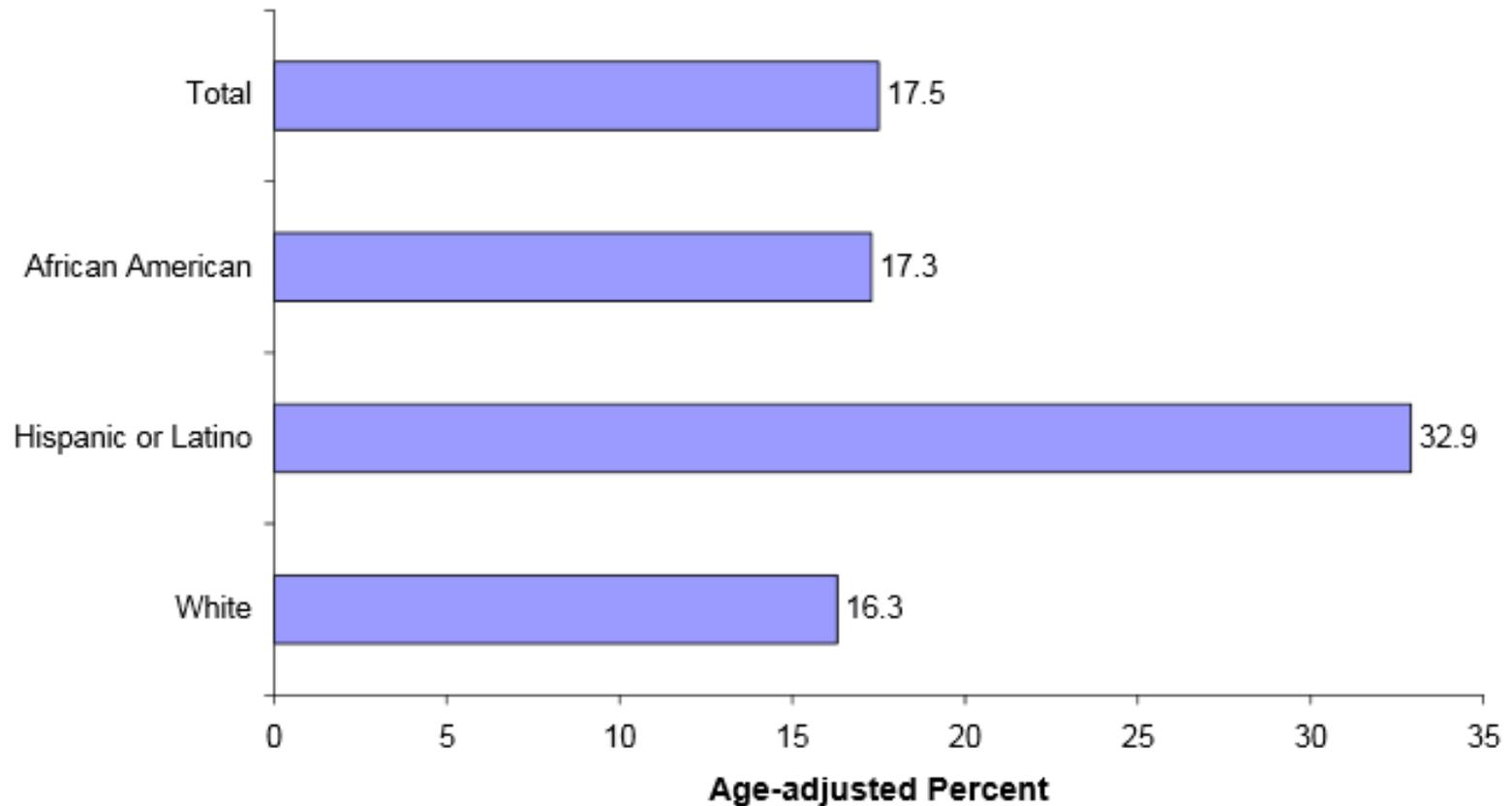


Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36
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Health disparities persist in Connecticut

Never Had Blood Cholesterol Checked – Race/Ethnicity

Figure 18. Never Had Blood Cholesterol Checked, Connecticut Adults, Rates by Race or Ethnicity, 2005

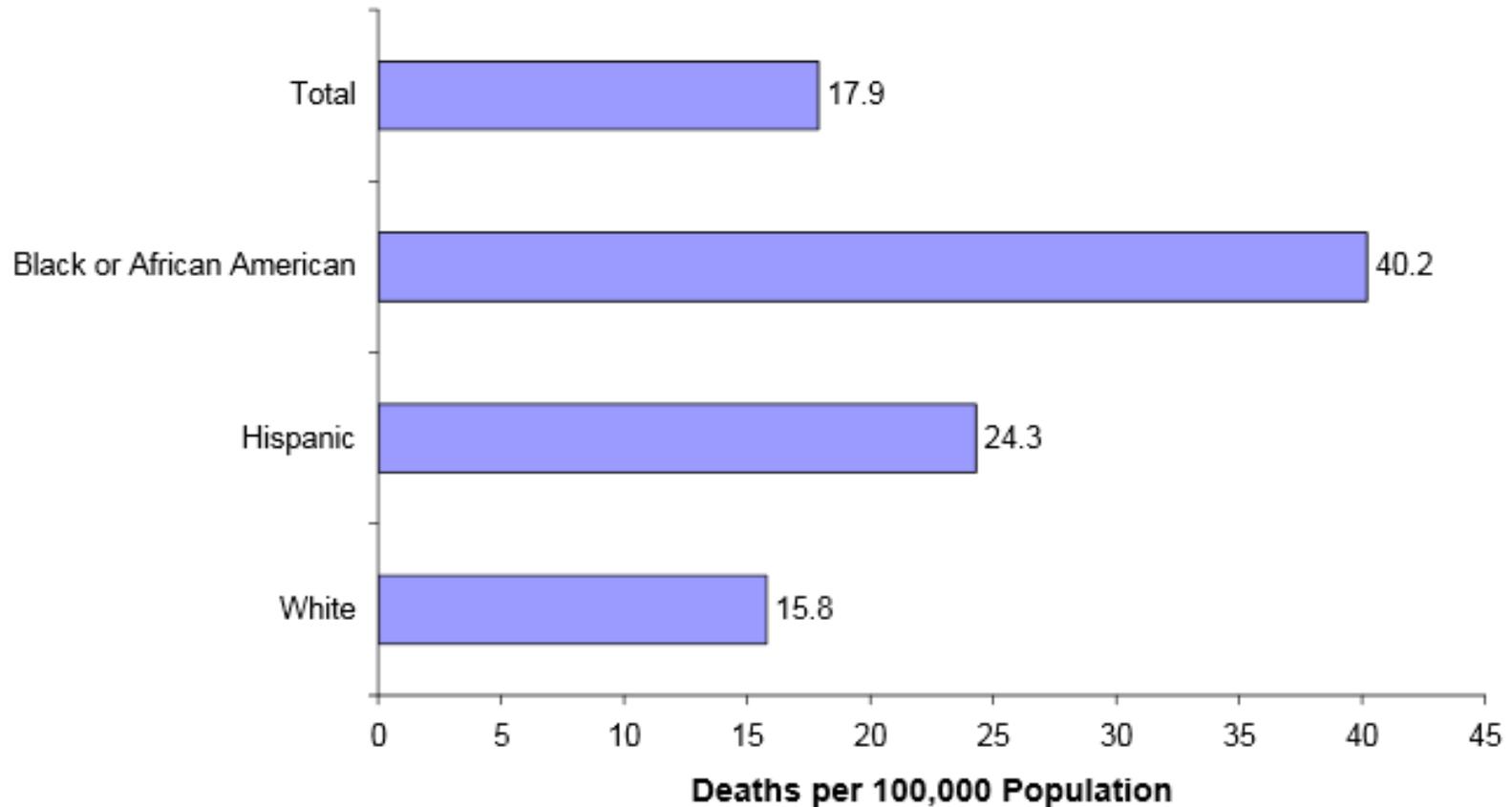


Source: DPH 2008a.

Health disparities persist in Connecticut

Diabetes Death Rates - Race/Ethnicity

Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut Residents, by Race or Ethnicity, 2000–2004



Source: DPH 2008b. 2008v.

Health disparities persist in Connecticut

Health disparities devastate individuals, families and communities, and are *costly*:

- From 2003-2006 there were \$229.4 billion in direct medical costs from minority disparities
 - \$57.35 billion/year
- 30.6% of direct costs for African Americans, Asians & Hispanics were due to disparities
- The cost of the disparity for the Black population in Connecticut is between \$550 million - \$650 million a year

Stages of Transformation

Stages of Transformation

Connecticut's Current Health System: "As Is"

Fee for Service 1.0

Limited accountability
Pays for quantity without regard to quality
Lack of transparency
Unnecessary or avoidable care
Limited data infrastructure
Health inequities
Unsustainable growth in costs



Accountable Care 2.0

Accountable for patient population
Rewards

- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost
Coordination of care across the medical neighborhood
Community integration to address social & environmental factors that affect outcomes

Our Vision for the Future: "To Be"

Health Enhancement Communities 3.0

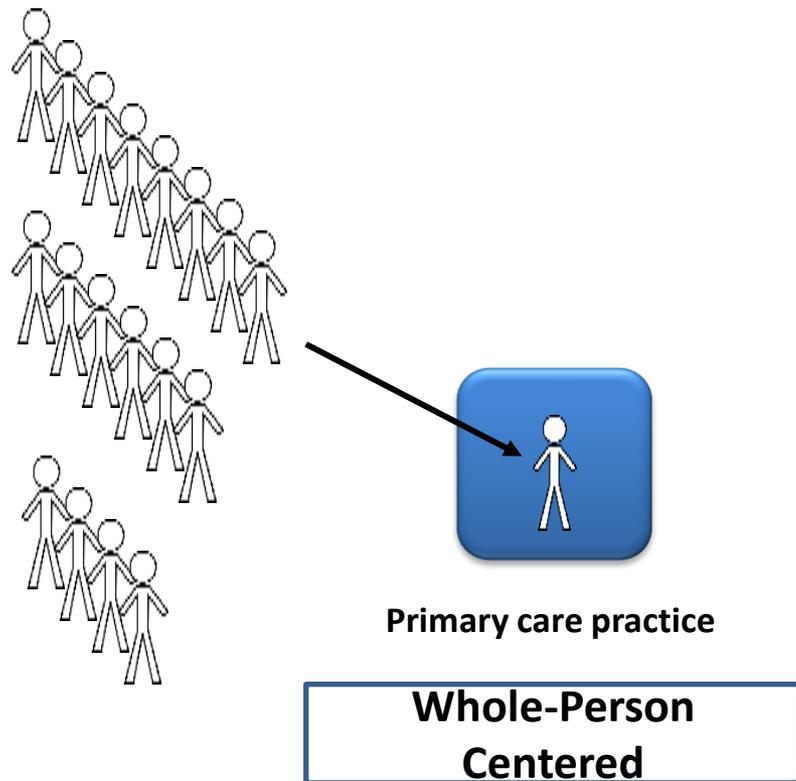
Accountable for all community members
Rewards

- prevention outcomes
- lower cost of healthcare & the cost of poor health

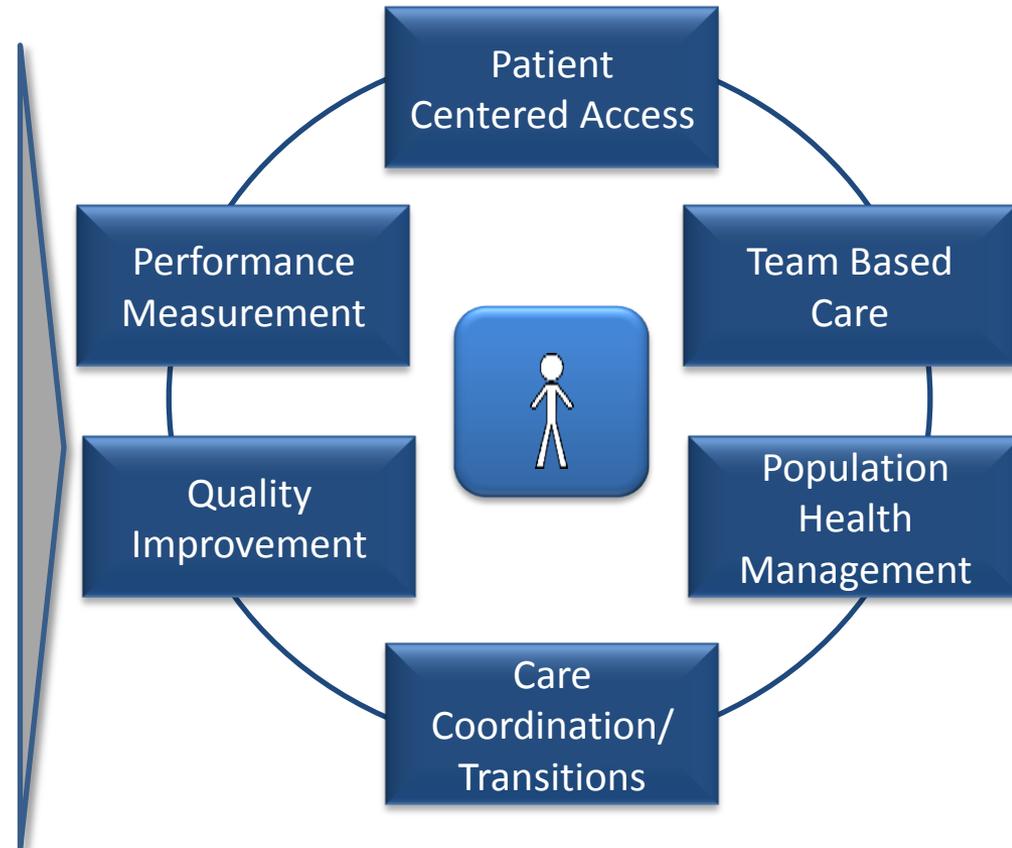
Cooperation to reduce risk and improve health
Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities
Community initiatives to address social-demographic factors that affect health

Accountable Care 2.0

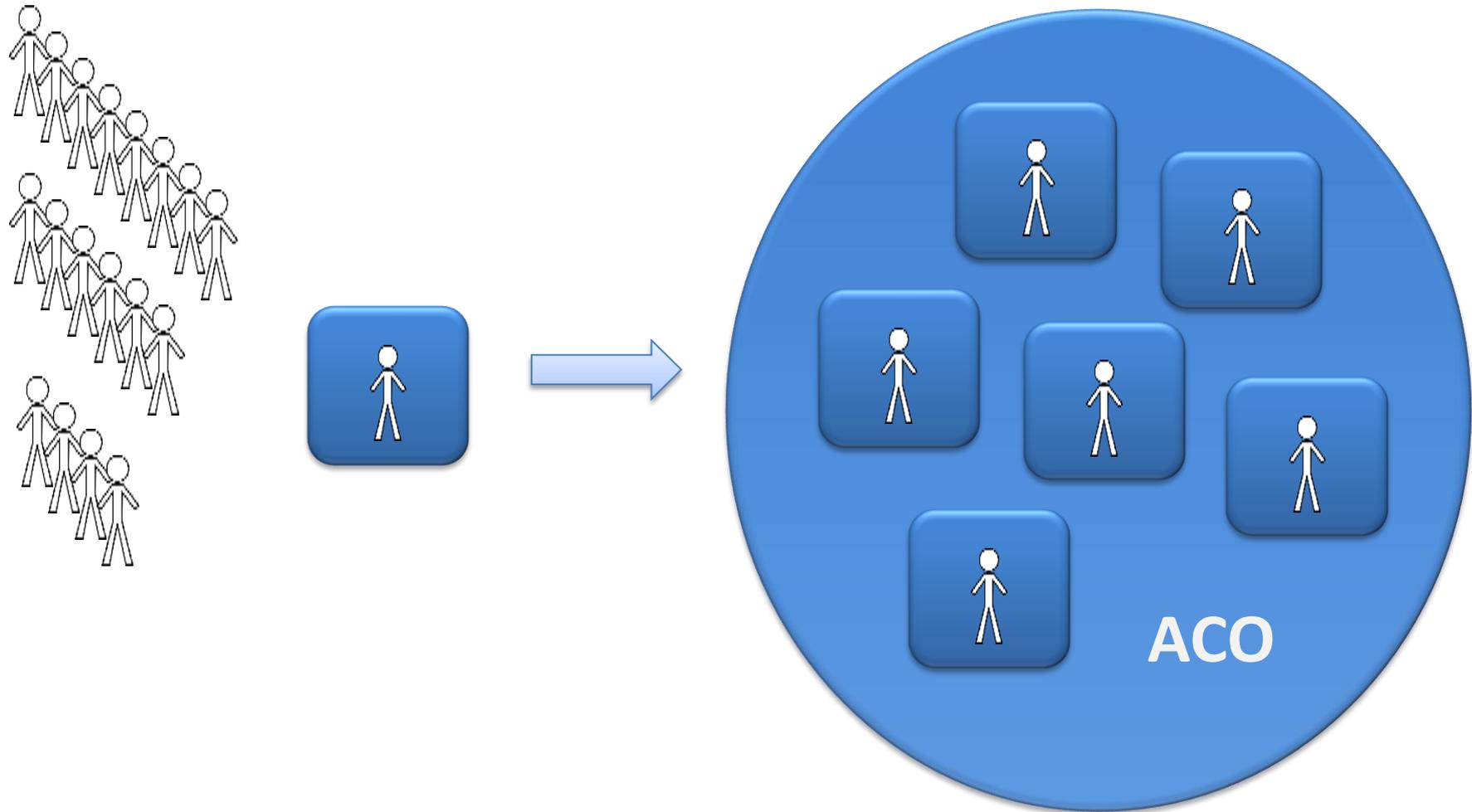
Improving Primary Care



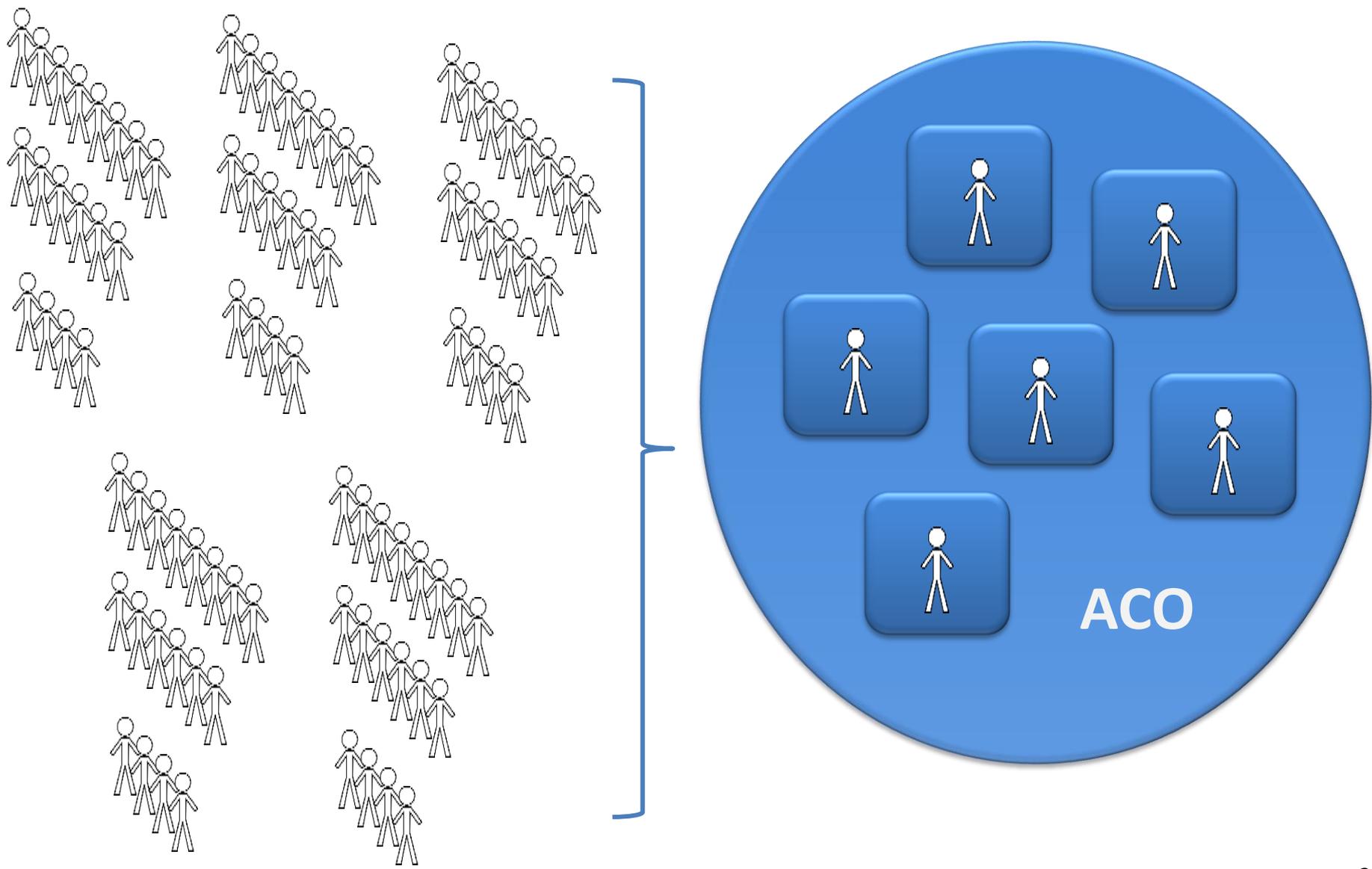
Advanced Medical Home Glide Path



Primary care partnerships for accountability



Accountability for thousands of consumers



Enabling new capabilities for tomorrow's ACOs



Community and Clinical Integration Program

Improve Communication Between Providers:

- Integrated behavioral and oral health
- Medication Therapy Management
- E-Consults

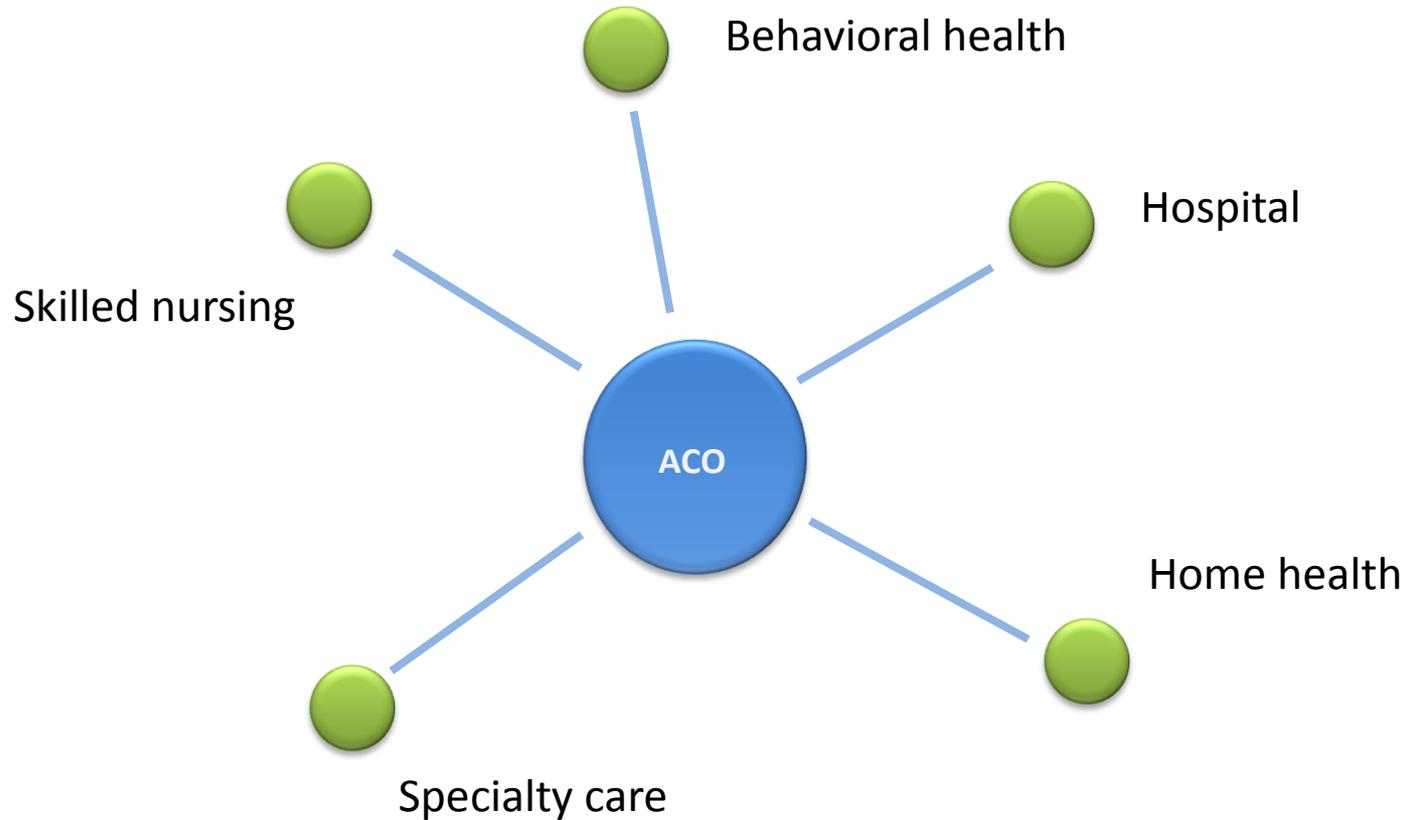
Support Care Transitions and Linkages to Community Services:

- Integration with community and long term services and social supports
- Community health workers as coaches & navigators
- Dynamic Clinical Care Teams

Target Patients With Greatest Need:

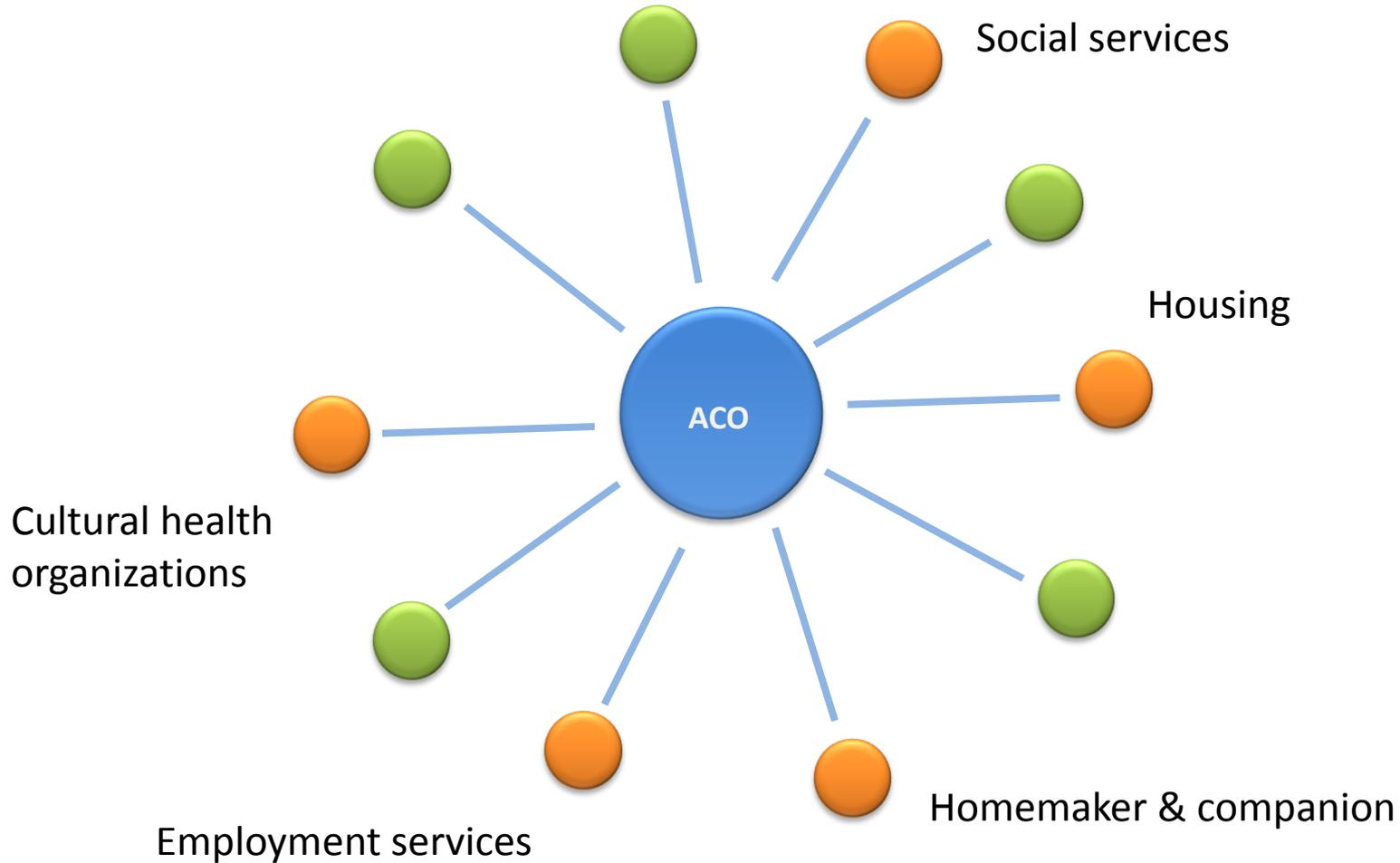
- Identifying “super utilizers” for targeted intervention
- Identifying and addressing health inequities
- Focused patient experience improvement for most vulnerable populations

New capabilities will support....



**...clinical integration and communication
across the medical neighborhood**

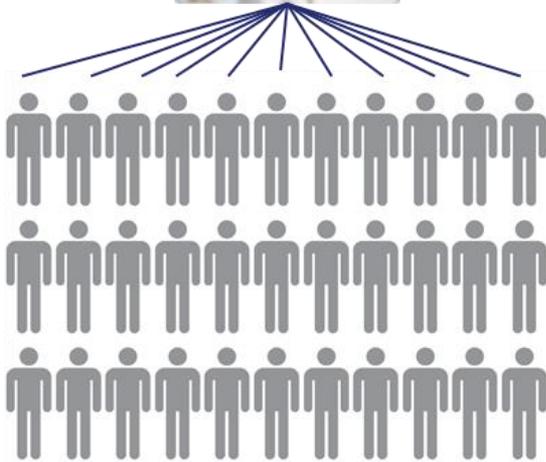
New capabilities will also support...



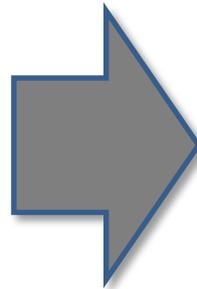
...coordination and integration with key community partners

Providers within ACOs will be accountable for...

And, ensuring these consumers receive high quality care at a lower cost



Consumers Who see Them the Most (Attributed Population)



Better healthcare outcomes



Preventive care processes

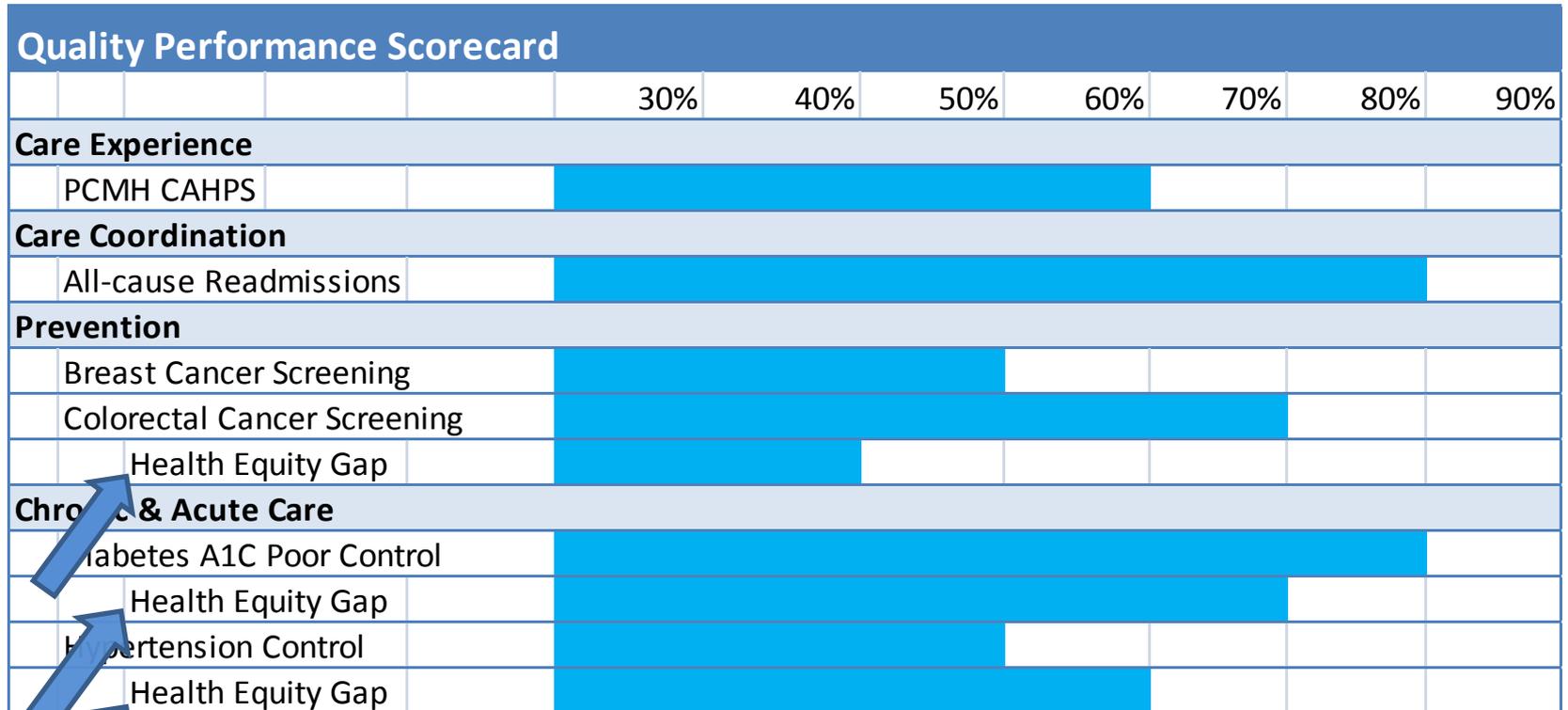


Improved health equity

Value-based Payment Reform

A share in the savings if...

they provide better quality for lower cost

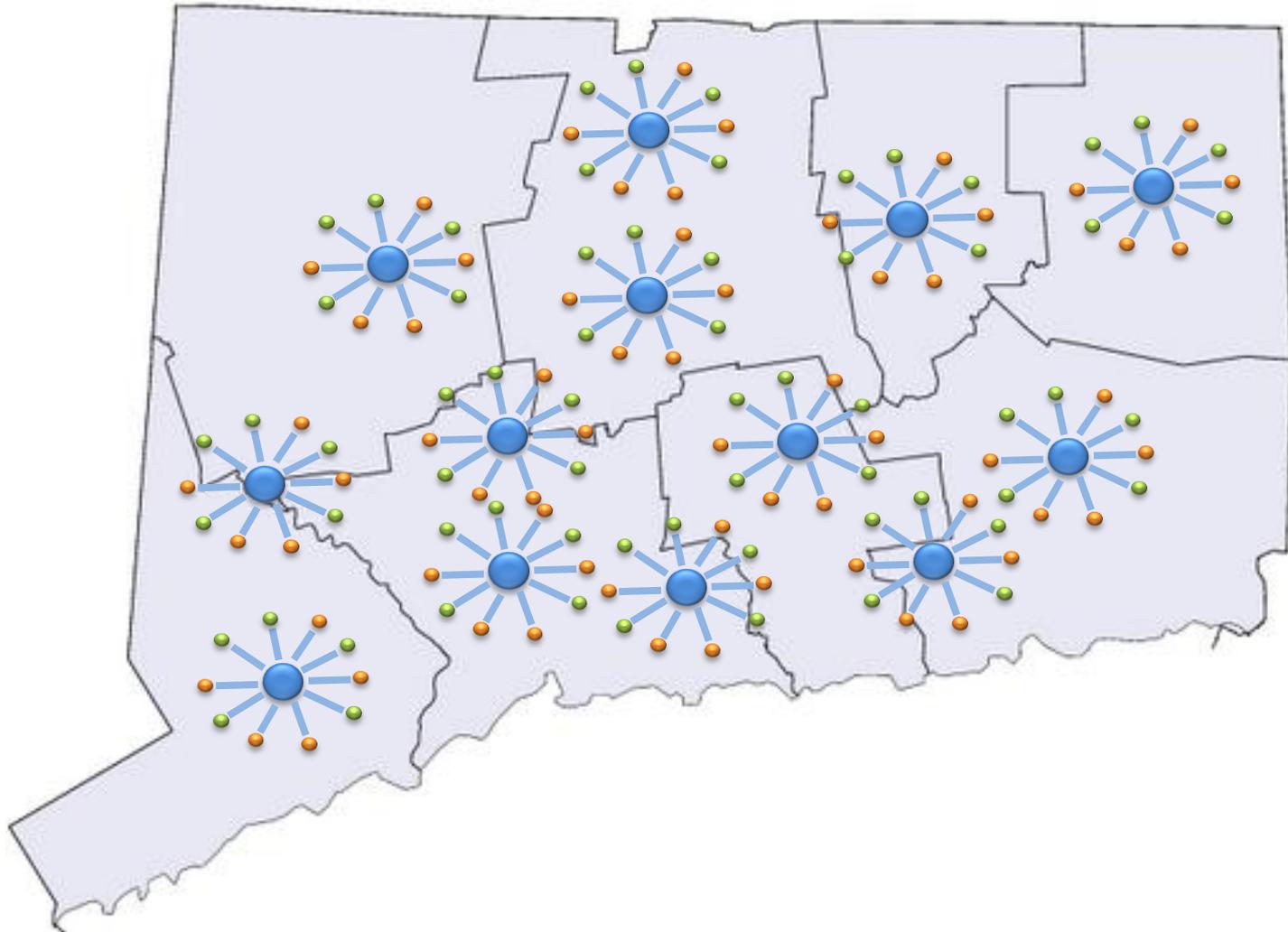


Shared savings support investments in....

- Care planning and communication tools
- Care management and transition coordination
- After hours support
- Access improving technologies like e-consult and e-visits
- Community health workers to support patient engagement, self-management and navigation
- Data analytics to support continuous quality improvement
- Innovation...creative solutions that we have never before considered

Promote community and clinical integration...

throughout Connecticut



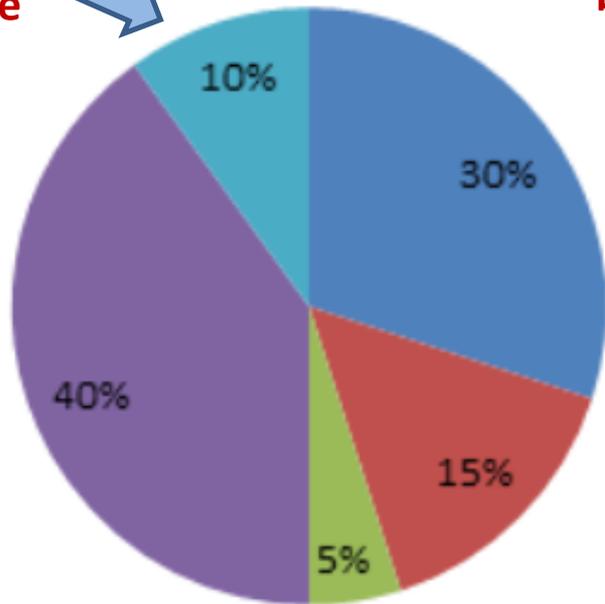
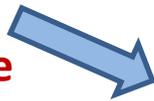
***Health Enhancement
Communities 3.0***

ACO accountability rewards better healthcare...

but it does not reward better health

Health determinants that affect mortality

10% is
healthcare



60% is social, environmental and
behavioral health determinants

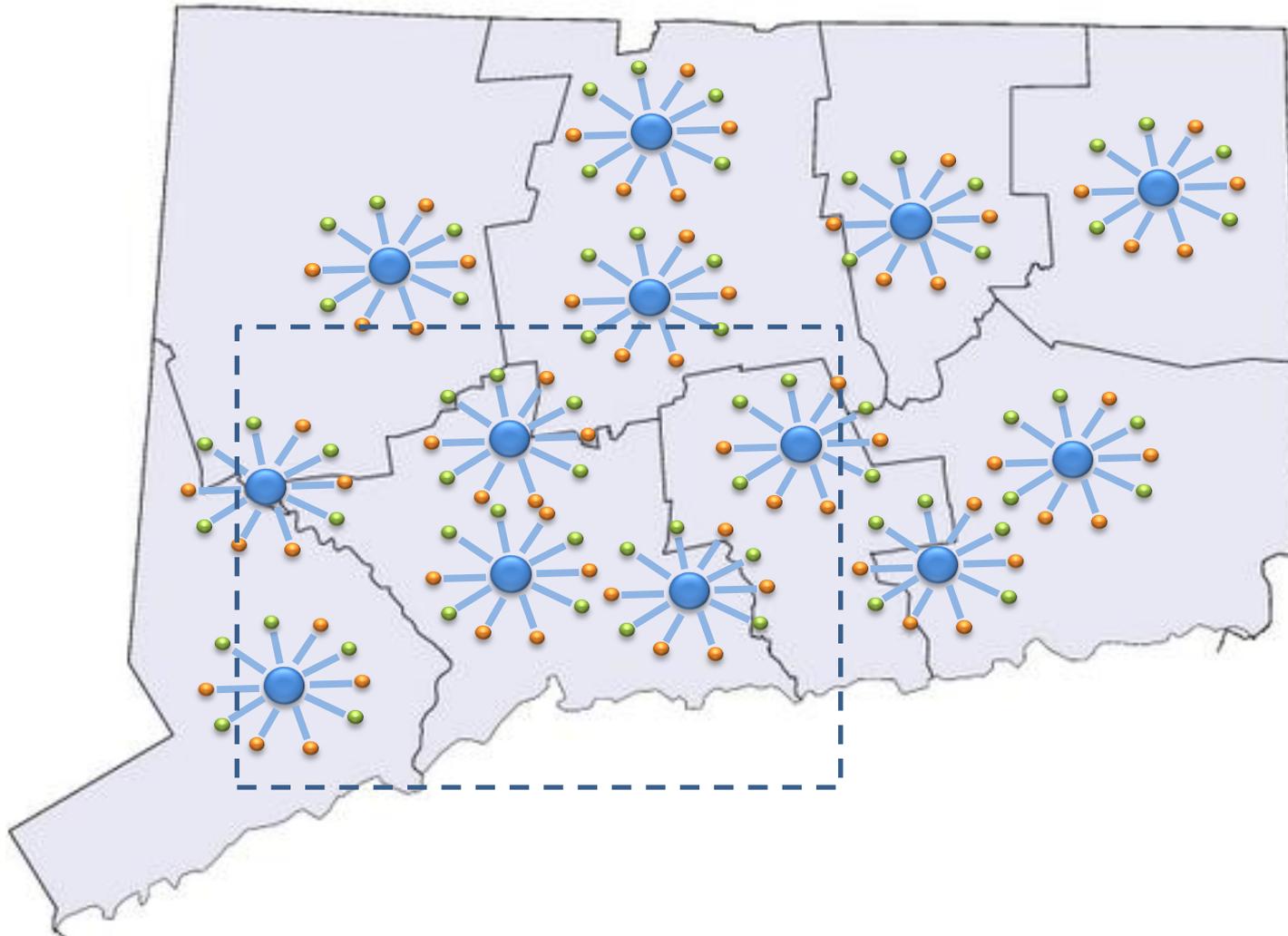
- Genetics
- Social Circumstances
- Environmental Conditions
- Behavioral Choices
- Medical Care

Well recognized by federal policy makers...

“Most determinants of health status are social and are influenced by actions and encounters that occur outside traditional institutional health care delivery settings, such as in employment, retail, education and other settings”

Taking aim at the determinants of health requires...

a regional focus

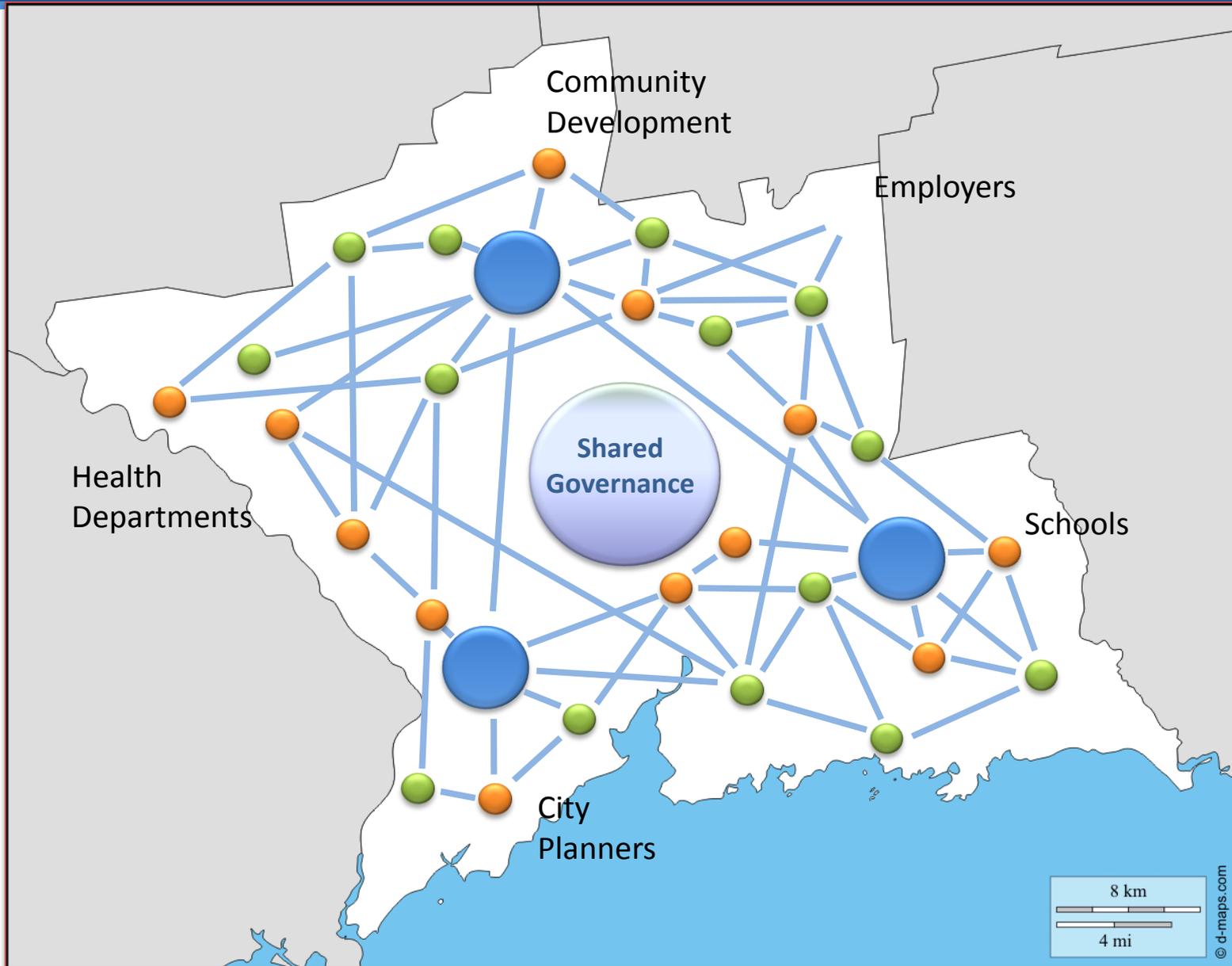


Expand linkages among community stakeholders...

building upon those that already exist

- Relationships among ACOs and all community stakeholders
- Accountability for the health and well-being of all community residents

A pathway to community accountability



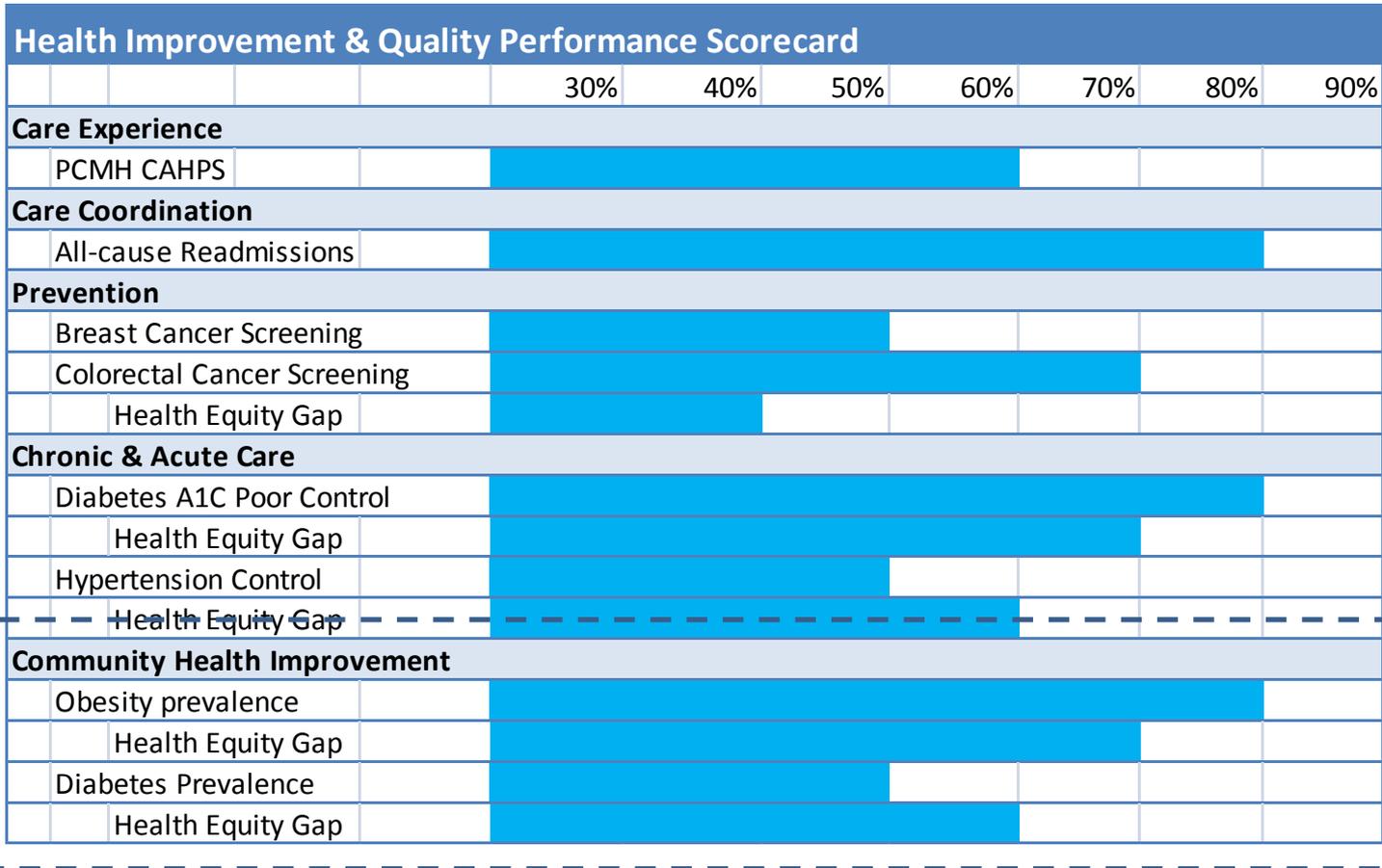
Example only: actual regions may be smaller and/or have different boundaries

Accountability for...

- All residents of the community
- Performance
 - improving community health (i.e., prevention outcomes)
 - improving health equity
 - lowering the cost of healthcare and the cost of poor health

Rewards for ACOs that play a role in producing...

measurable improvement in community health



Attributed consumers

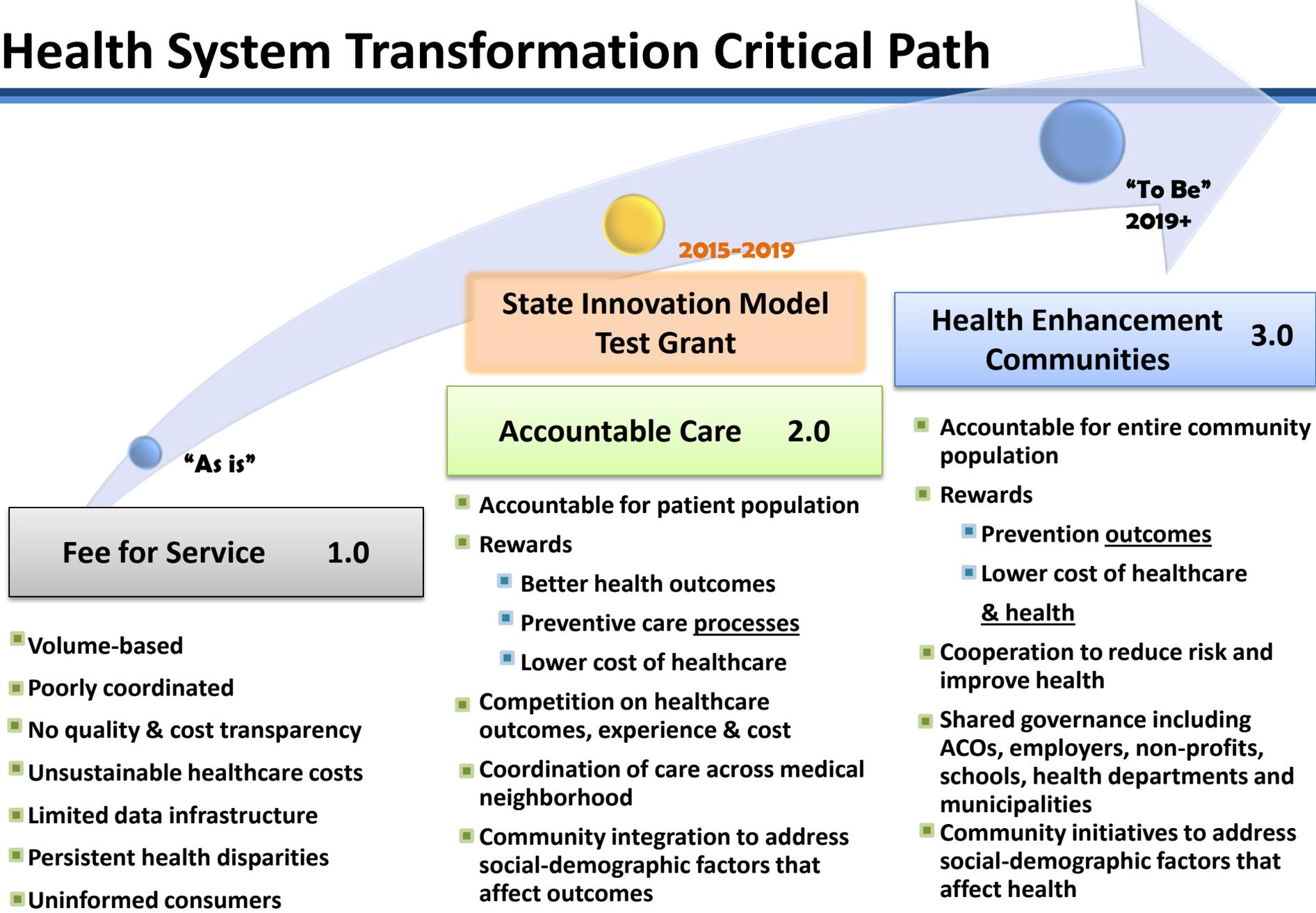
All community members

Rewards for community participants...

through new vehicles for reinvestment

- Wellness trust?
- Community stakeholder distributions?
- Consumer incentives?
- Targeted investments...for example
 - Access to healthy food
 - Enhanced walkability
 - Opportunities for an active lifestyle
 - Improvements in housing stock

Health System Transformation Critical Path



Our Journey from Current to Future: Components

CT SIM Component Areas of Activity

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Evaluate the results, learn, and adjust

Model Test Grant Award

SIM Test Grant Request	Revised Total
Plan for Improving Population Health	\$ 6,244,006
Care Delivery/Payment Reform	
Medicaid QISSP	\$ 7,877,886
AMH Glide Path	\$ 8,056,445
Clinical Community Integration	\$ 4,592,928
Innovation Awards	\$ -
Quality Alignment	\$ 617,400
Health Information Technology	\$ 10,769,595
Workforce Development	\$ 992,998
Value-based Insurance Design	\$ 325,576
Consumer Engagement	\$ 376,568
Program Evaluation	\$ 2,700,000
PMO Administration	\$ 2,446,598
Total	\$ 45,000,000

Questions