

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN

# Healthcare Innovation Steering Committee



March 10, 2016

# Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
	
2. Public comment	10 min
	
3. Approval of the Minutes	5 min
	
4. Population Health Council- Charter and Composition	20 min
	
5. CHW Advisory Committee Nominations	15 min
	
6. Logic Model Discussion	30 min
	
7. Work Stream Updates	20 min
	
8. Adjourn	

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graph LR; A((Public Comments)) --- B((2 minutes per comment))
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Public  
Comments

2 minutes  
per  
comment

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# Approval of the Minutes

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# Population Health Council Charter and Composition

## Proposed Composition and Criteria for Participation in the Population Health Council

DRAFT

### Population Health Council

#### Composition

- Access Health CT Representative (1)
- Municipal leadership member (1)
- Advance Network (ACO) Representatives (2)
- Health Plan Representatives (1)
- Large and Small Employer (2)
- Consumers/advocates (5)
- Connecticut Hospital Association (1)
- Health Data Analytics expert (1)
- Health Economist (1)
- Federally Qualified Health Centers (1)
- Urban/Rural school district (1)
- Behavioral Health agency (1)
- Local Public Health agency (1)

#### Criteria For Membership

- Direct work experience in the CT public health and healthcare environment
- Knowledge of health related data collection and interpretation
- Experience with outpatient patient care
- Direct experience in regional planning and development organizations.
- Demonstrable experience in community engagement activities related to prevention and health promotion
- Organizational experience in population health management
- Large self-insured organizations/small employers
- Organizational interest in policy advocacy
- Consumers representing philanthropic sector; environmental health interest, homeless advocates, non-profit food systems, disabilities, housing or economic support; advocate against violence, chambers of commerce, racial/ethnic/geographically diverse communities

### Support & Technical Assistance Team

- State Agencies: DPH, DCF, DMHAS, DSS (Ex officio)
- PMO staff (1)
- DPH-SIM Staff (2)
- Contractor Facilitator (HRiA)

- Expertise in public health and healthcare research, policy and evaluation
- Knowledge of CT SIM
- Experienced supporting communications
- Experience facilitating collaborative activities

**DRAFT**

## Population Health Council

### Charter:

The Population Health Council is a workgroup charged by the Healthcare Innovation Steering Committee with developing a **sustained vision** for improving Population Health in the context of payment, insurance and practice reforms, and community integration and innovation.

The Council **leverages existing state resources** available through the State Innovation Model and builds on the framework established in the State Health Improvement Coalition. The Council uses the State and Community-based Health Assessments, as well as any other Connecticut specific health indicators, as the basis to both advance population health planning and establish a **long term strategy** for public health. This strategy will have a special focus on areas of high burden of disease and on demographic groups impacted by health disparities. The council will focus on addressing root causes of disease and defining priorities based on burden of cost, reducing inequities and improving overall health.

The council will recommend to the SIM Healthcare Innovation Steering Committee **a strategy to maintain a system of population health data, overall health improvement monitoring, and community accountability metrics.**

In addition, the council will assess **community health capabilities** in order to recommend the extension of prevention services outside of clinical settings. The council will, as a result, formulate **a strategy for the establishment of Community Prevention Service Centers.**

Lastly and more importantly, the council will recommend **guiding principles** and a **sustainability strategy** for the designation of **Health Enhancement Communities**, which are structured community-wide collaborations with a multi-sector agenda for health improvement.

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# CHW Advisory Committee Nominations

# PROPOSED COMPOSITION AND CRITERIA FOR COMMUNITY HEALTH WORKER ADVISORY COMMITTEE PARTICIPATION

## CHW Advisory Council

- 5 CHWs
- 1 Advanced Network/ACO
- 1 FQHC
- 1 Physician
- 1 Nurse
- 1 Social Worker
- 4 Consumers/Consumer Advocates\*
- 1 Community College Representative
- 1 DSS Representative
- 1 DPH Representative\*\*
- 2 Health plans
- 1 Self-funded Employer
- 2 Employers of CHWs †
- Other

## Preferred Qualifications For Membership

- Ability to work collaboratively on ground-breaking initiative
- Knowledge of the CT healthcare environment and healthcare reform
- Ability to contribute to CHW preliminary draft model
- Ability to contribute to Workforce Development criteria
- Experience working with/employing CHWs
- Physician, Nurse and Social Worker should have role representing state professional organization
- Experience with community-based non-profit services, behavioral-health/recovery experience, or peer-support experience
- Represent the geographic diversity of the State
- Represent diverse communities, especially communities that may be harder to engage

## CHW Project Team Support

- 1 PMO member
- CT AHEC
- CHW Consultants

- Expertise in public health and healthcare
- Knowledge of CT SIM
- Experience navigating legislative process
- Ability to facilitate collaborative activities

\*Nominated by the Consumer Advisory Board

\*\* DCF, DMHAS, and DOL representatives will be invited as needed

† An organization with a demonstrated commitment to CHWs and who currently employs CHWs

# Personnel Subcommittee Nominees- CHWS

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- **Juan Carmona**, Project Access
- **Loretta Ebron**, Optimus Healthcare
- **Liza Estevez**, Northeast Medical Group
- **Milagrosa Seguinot**, SW AHEC
- **Mayce Torres**, Planned Parenthood

# Personnel Subcommittee Nominees- Providers

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- **Peter Ellis**, Project Access (Physician)
- **Michael Corjulo**, Community Asthma Integrated Resources & Children's Medical Group (Nurse)
- **Terry Nowakowski**, The Connection Inc. (Social Worker)
- **Thomas Buckley**, UConn School of Pharmacy (Other)

# Personnel Subcommittee Nominees- General

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- **Nicholas Peralta**, ProHealth Physicians (ACO)
- **Yolanda Bowes**, United Community and Family Services (FQHC)
- **Linda Guzzo**, Capitol Community College (Comm. College Rep.)
- **Lauren Rosato**, Planned Parenthood (Self-funded Employer)
- **Migdalia Belliveau**, Generations Family Health Center (CHW Employer)
- **Darcey Cobbs-Lomax**, Project Access (CHW Employer)

# Consumer Advisory Board Nominees

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- **Ashika Brinkley**, Connecticut Association of Directors of Health
- **Grace Damio**, Hispanic Health Council
- **Tiffany Donelson**, Connecticut Health Foundation
- **Jacqueline Ortiz Miller**, Curtis D Miller Center for Health Equity

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# Logic Model

# What Will be Covered

1. **Logic Model in the Context of SIM**
2. **What is a Logic Model?**
3. **Review of Logic Model draft**

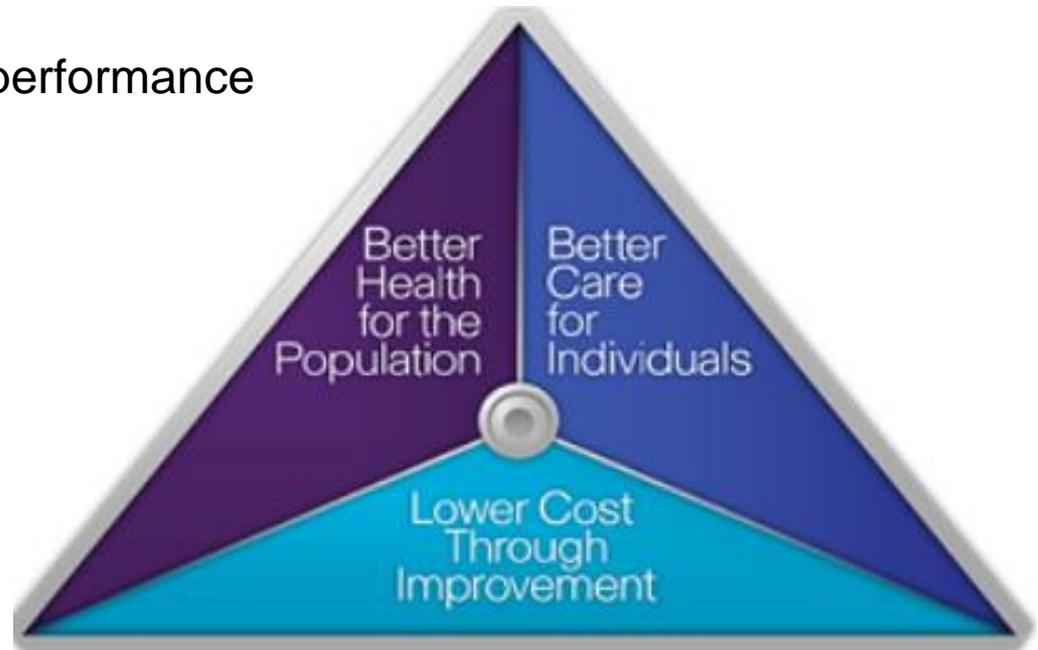


- 
- 1. Context of SIM**
  - 2. What is a Logic Model?**
  - 3. Review of Logic Model draft**

# What is a State Innovation Model Grant?

SIM grants are awarded by the federal government through the ***Center for Medicaid and Medicare Services (CMS) Innovation center***. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

- 1 Improve health system performance
- 2 Increase quality of care
- 3 Decrease Costs



Connecticut awarded a \$45 million test grant, four-year grant: 2015 – 2019

# CT SIM Test Grant Aims



**By 2020 Connecticut will:**

## **Improve Population Health**

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

## **Improve Health Care Outcomes**

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

## **Reduce Health Disparities**

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

## **Reduce Healthcare Costs**

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

# CT SIM Test Grant: Core Metrics

CMMI requires SIM States to collect and monitor progress on the following metrics:

## Model Participation Metrics

- Beneficiaries, Providers & Provider Organizations in any value-based payment or alternative payment model in the state supported by SIM

## Payer Participation

- Payer participation in value-based purchasing and/or alternative payment models supported by SIM

## Model Performance Metrics

- ED Visits; Readmissions; Cost of care; Tobacco Screening; Controlling high blood pressure; BMI Screening & Follow-up

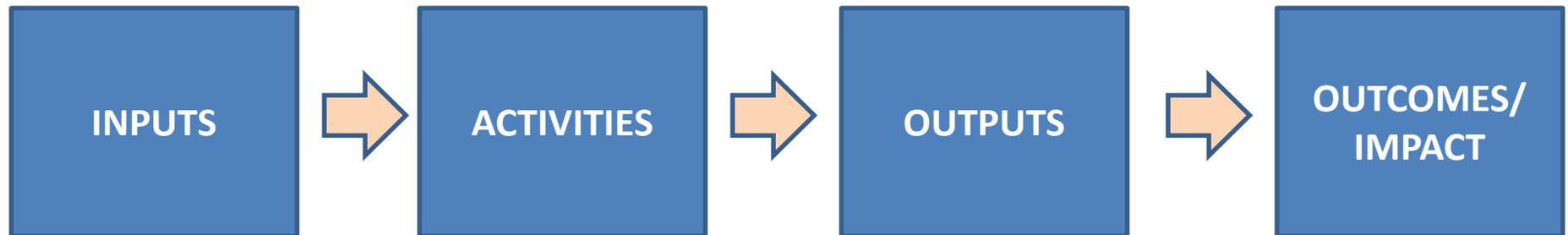
## State Healthcare Landscape

- Total number of beneficiaries in the state receiving care through any value-based payment and alternative payment models
- Total number of providers in the state in any value-based payment and alternative payment models

- 
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  - 2. What is a Logic Model?**
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# Logic Model

- A graphical depiction of the logical relationships between the inputs and activities, and the project outputs and outcomes
- The purpose of this is to assess the “if-then” causal relationships between the elements of the program. And if activities of a program are implemented, then certain outputs and outcomes can be expected



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- 1. Context of SIM**
  - 2. What is a Logic Model?**
  - 3. Review of Logic Model draft**

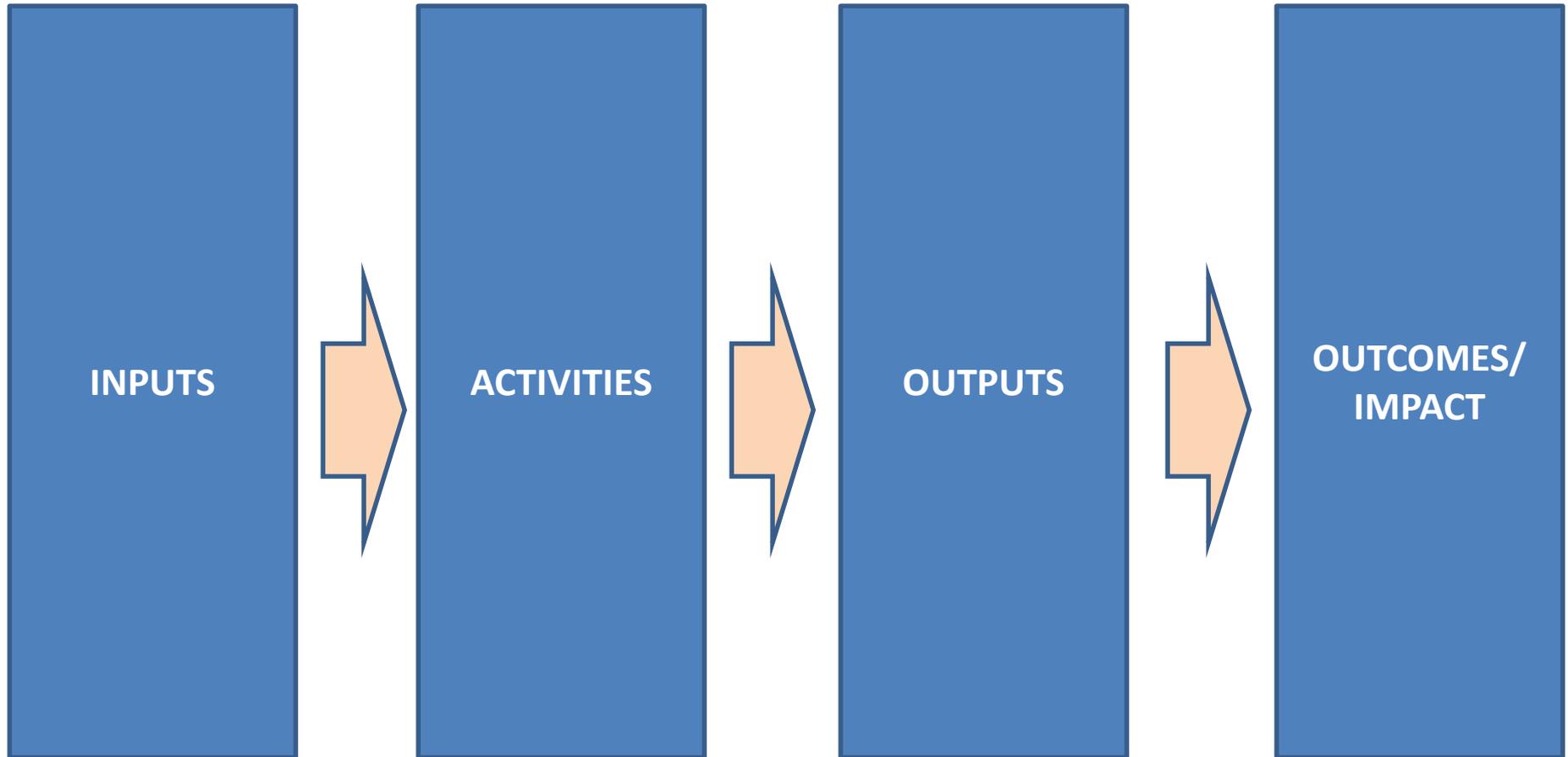
# Logic Model Design Process

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- Building off work done for the 2014 State Healthcare Innovation Plan, and 2014 SIM grant submission
- Version 2 released in November 2015
- Reviewed with:
  - Practice Transformation Task Force
  - Quality Council
  - Dr. Garcia (DPH)
  - Evaluation team
  - Core Team
  - HIT Council

# Logic Model

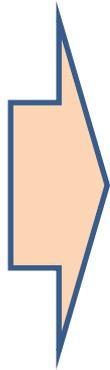
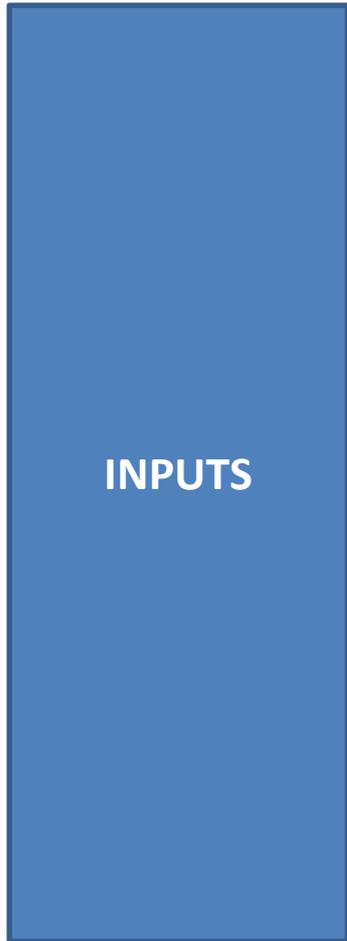
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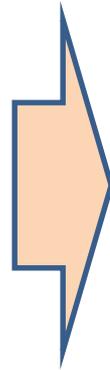
# Logic Model



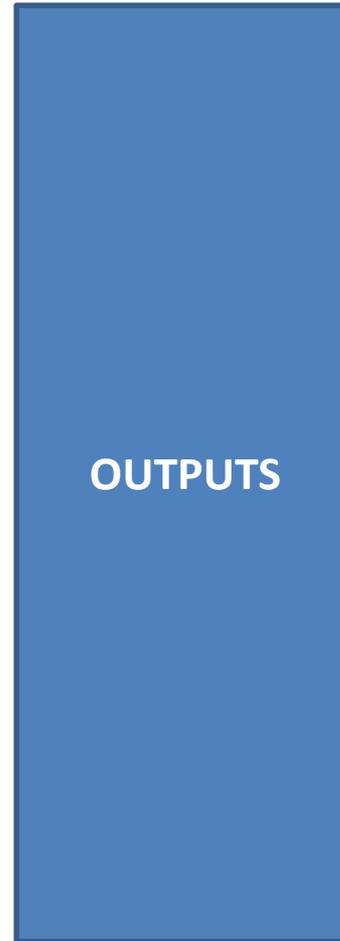
## Inputs



## Activities



## Outputs



## Impact



# CT SIM Test Grant Triple Aim: Better Care

By 6/30/2020 Connecticut will:

## Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

## Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

## Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

## Reduce Healthcare Costs

1-2% percentage point reduction in annual healthcare spending growth, by 2020

Measure	Baseline	2020 Goal
% adults regular source of care	83.9%	93.0%
Risk- std. all condition readmissions	15.9	13.1
Ambulatory Care Sensitive Condition Admissions	1448.7	1195.1
Children well-child visits for at-risk pop	62.8	69.1
Mammogram for women >50 last 2 years	83.9	87.7
Colorectal screening- adults aged 50+	75.7	83.6
Colorectal screening- Low income	64.9	68.2
Mental Health Days	TBD	TBD
Optimal diabetes care- 2+ annual A1c tests	72.9	80.1
ED use- asthma as primary dx (per 10k)	73.0	64.0
Percent of adults with HTN taking HTN meds	60.1%	69.5%
Premature death- CVD adults (per 100k)	889.0	540.0

# CT SIM Test Grant Triple Aim: Better Care

By 6/30/2020 Connecticut will:

## Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

## Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

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# CT SIM Test Grant Outcomes: Healthier People

By 6/30/2020 Connecticut will:

**Improve Population Health**  
 Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

**Improve Health Care Outcomes**  
 Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

**Reduce Health Disparities**  
 Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

**Reduce Healthcare Costs**  
 1-2% percentage point reduction in annual healthcare spending growth, by 2020



Measure	Baseline	2020 Goal
Percent of adults who are obese	24.50%	22.95%
Percent of children who are obese	18.80%	17.65%
Percent of children in low-income households who are obese	38.00%	35.55%
Percent of adults who currently smoke	17.10%	14.40%
Percent low income adults who smoke	25.00%	22.43%
Percent of youth (high school) who currently smoke	14.00%	12.72%
Percent of adults with diabetes	8.50%	7.86%
Percent of adults with diabetes – low income	14.30%	11.32%

# CT SIM Test Grant Outcomes: Healthier People

By 6/30/2020 Connecticut will:

**Improve Population Health**

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

**Improve Health Care Outcomes**

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

**Reduce Health Disparities**

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

**Reduce Healthcare Costs**

1-2% percentage point reduction in annual healthcare spending growth, by 2020



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Percent of adults with diabetes	8.50%	7.86%
Percent of adults with diabetes – low income	14.30%	11.32%

# CT SIM Test Grant Triple Aim: Smarter Spending

By 6/30/2020 Connecticut will:

## Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

## Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

## Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

## Reduce Healthcare Costs

1-2% percentage point reduction in annual healthcare spending growth, by 2020



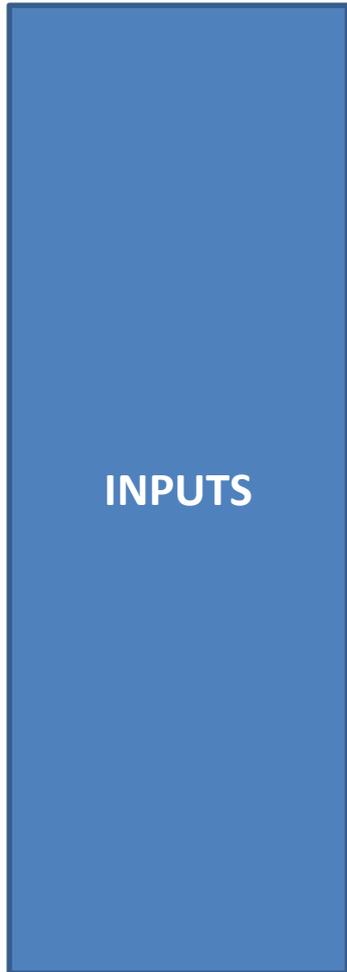
Measure	Baseline	2020 Goal
ASO/Fully insured	\$457	\$603
State employees w/o Medicare	\$547	\$722
Medicare	\$850	\$1,096
Medicaid/CHIP, incl. expansion	\$390	\$509
Average	\$515	\$679

# Logic Model

Triple aim



*Inputs*



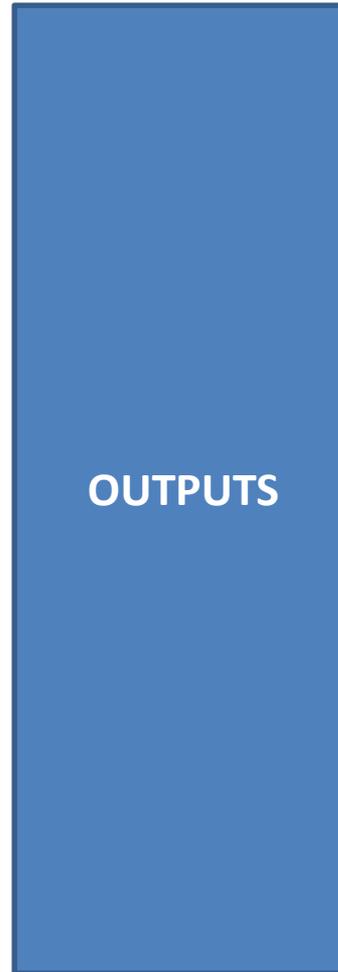
INPUTS

*Activities*



ACTIVITIES

*Outputs*



OUTPUTS

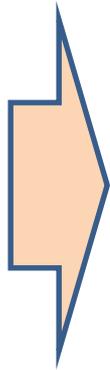
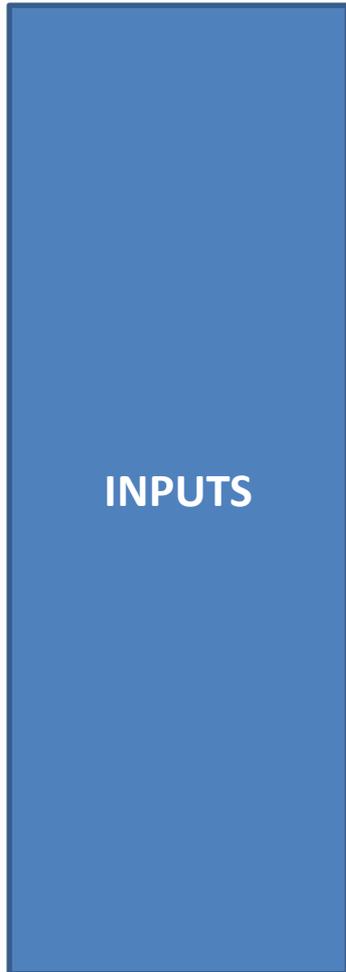
*Impact*



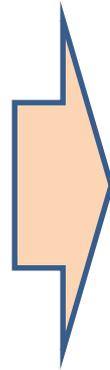
# Logic Model



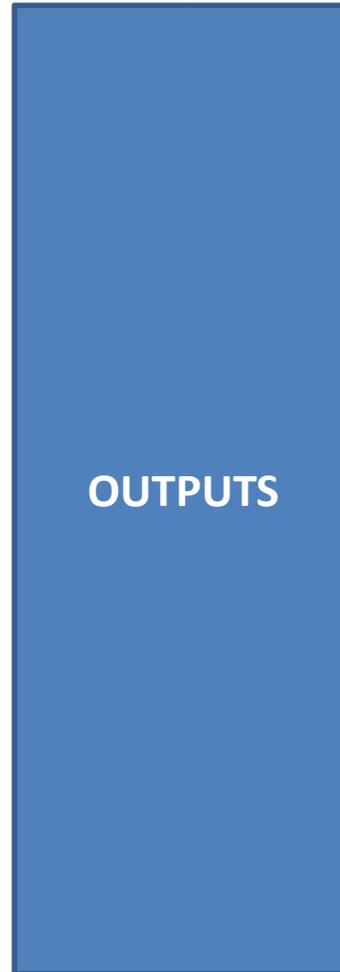
## Inputs



## Activities



## Outputs



## Impact



# Logic Model

## Primary Drivers

## Triple aim



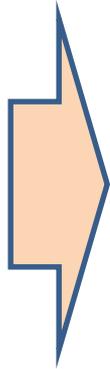
### Inputs

### Activities

### Outputs

### Impact

INPUTS

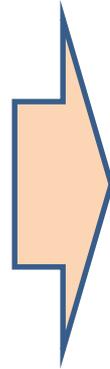


Strengthen care delivery capabilities

Promote payment models that reward value

Engage Consumers

Population Health Plan activities



OUTPUTS



❖ Better Care, **with reduced disparities**

❖ Reduced Cost

❖ Healthier People, **with reduced disparities**

❖ Reduced Cost

# Primary Drivers

## System components or factors that contribute directly to achieving the aim

1. **Strengthen capabilities** of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care
2. **Promote payment models** that reward improved quality, care experience, health equity and lower cost
3. **Engage consumers** in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
4. Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**

# Primary Drivers

1. **Strengthen capabilities** of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care
  - a) Community & Clinical Integration Program
  - b) Advanced Medical Home Program
  - c) Promote use of Community Health Workers through policy framework and outreach
  - d) Health information technology
2. **Promote payment models** that reward improved quality, care experience, health equity and lower cost
3. **Engage consumers** in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
4. Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**

# Primary Drivers

1. **Strengthen capabilities** of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care
2. **Promote payment models** that reward improved quality, care experience, health equity and lower cost
  - a) Medicaid Quality Improvement & Shared Savings Program
  - b) Statewide recommended core quality measure set for value-based payment
  - c) Health information technology
3. **Engage consumers** in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
4. Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**

# Primary Drivers

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1. **Strengthen capabilities** of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care
2. **Promote payment models** that reward improved quality, care experience, health equity and lower cost
3. **Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions**
  - a) Value Based Insurance Design
  - b) Public common scorecard
  - c) Public meetings, focus groups, listening tours
4. Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**

# Primary Drivers

1. **Strengthen capabilities** of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care
2. **Promote payment models** that reward improved quality, care experience, health equity and lower cost
3. **Engage consumers** in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
4. **Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health**
  - a) Develop and designate Health Enhancement Communities
  - b) Develop financial incentive model to reward HEC's for health improvement
  - c) Designate Prevention Service Centers
  - d) Conduct root cause and barrier analysis
  - e) Engage health, government, and community stakeholders

# Logic Model: Cover Page



## Primary Drivers

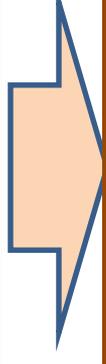
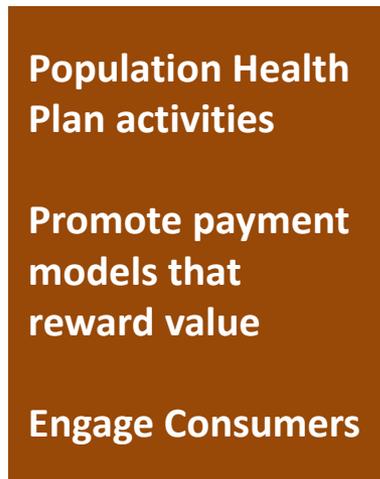
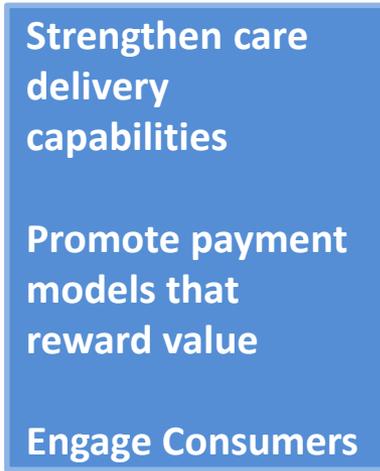
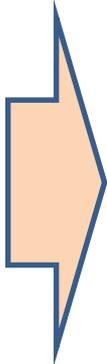
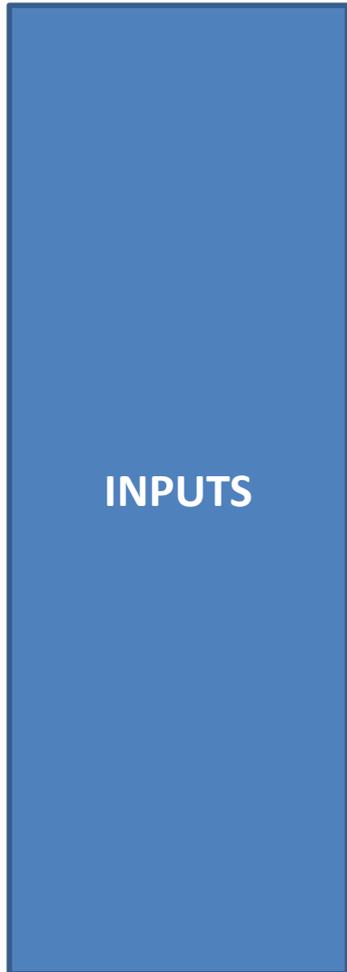
## Triple aim

### Inputs

### Activities

### Outputs

### Impact



# Pages layout

Page 0  
Legend

Page 1  
Cover Page

Page 2  
Improve care, while reducing  
disparities and reduce cost

Page 3  
Improve population health, while  
reducing disparities and reduce cost

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# Discussion

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# Work Stream Updates

# Work Stream Updates

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## Population Health

- Revised Population Health Council Charter and Composition based on recommendations and feedback from HISC
- UConn State Data Center continued work on developing innovative methods for small-area populations to inform planning efforts
- **Next Steps:**
  - Approval of Charter and Composition
  - Issue a member solicitation
  - Issue a draft concept paper on Population Health Assessment Status report
  - Screen and hire Primary Prevention Services Coordinator

# Work Stream Updates

## Advanced Medical Home (AMH)

- Qualidigm contract to enroll up to 50 additional practices into the AMH Vanguard Program
- On February 23<sup>rd</sup> the PMO released a Request for Applications (RFA) for the AMH Vanguard Program to enroll an additional two cohorts with 25 practices each.
- The PMO is preparing an addendum that would allow FQHCs and Advance Networks who participate in the CMMI Practice Transformation Network Program to apply for the RFA

## Next Steps:

- Prepare presentation that describes AMH Vanguard progress and evaluation activities to date to the April 14<sup>th</sup> HISC meeting.

# Work Stream Updates

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## Medicaid Quality Improvement Shared Savings Program (MQISSP)

- Produced an updated version of the PCMH issue paper to reflect stakeholder input from the January MAPOC meeting
- **Next Steps:**
  - Hold a Shared Savings calculation webinar with DSS and the MAPOC Care Management Committee
  - Continue developing member communication materials

# Work Stream Updates

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## Value-Based Insurance Design (VBID)

- Collected feedback from first VBID Consortium meeting through discussion guides
- Freedman Healthcare began interviews with health plans and business groups
- Discussed design session for Learning Collaborative goals and structure
- **Next Steps:**
  - Executive team meeting on March 17, followed by second Consortium meeting on March 22
  - Hold additional health plan discussions
  - Schedule design session to plan Learning Collaborative Kickoff
  - Determine development assessment criteria for VBID plans

# Work Stream Updates

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## UConn Evaluation

- Published Dashboard in February with new population health data
- Met with health plans regarding a proposed process for implementation of the PCMH CAHPS survey
- Meet with DSS regarding the adoption of PCMH CAHPS 3.0 for Medicaid
- Finalized Behavioral Health access items to be added to PCMH CAHPS survey
- **Next Steps:**
  - Finalize PCMH CAHPS content and sampling frame
  - Continue discussion with health plans regarding the PCMH CAHPS survey and several dashboard measures

# Work Stream Updates

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## Community Health Worker Initiative

- Finalizing CHW Advisory Committee nominations
- Hired new Program Manager, Stanley Zazula
- Met with DSS to discuss sustainable payment mechanisms
- **Next Steps:**
  - Hold first CHW Advisory Committee meeting on March 29
  - Hire 2 CHWs to implement CHW initiative
  - Refine metrics and targets and continue to work with evaluators to develop evaluation plan

# Work Stream Updates

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## Consumer Engagement

- Continued planning for Behavioral Health Forum to take place in April
- Deadline extended for Consumer Engagement Coordinator RFP
- Began planning 2<sup>nd</sup> rural health forum in Northwestern CT
- **Next Steps:**
  - Finalize plans for Behavior Health Forum
  - Continue establishing Workforce Design Group
  - Continue solicitation for Consumer Engagement Coordinator (deadline April 1)

# Work Stream Updates

## Health Information Technology (HIT)

- HIT Team continued to work on the HIT section of the SIM Operational Plan
- Conducted a series of conference calls with work stream leads and PMO regarding programmatic requirements for: AMH, CCIP, MQISSP, VBP and VBID
- **Next Steps:**
  - Ascertain the edge-server indexing capabilities the HIT Council members are interested in having demonstrated and develop criteria for evaluation
  - Secure updated status from PMO on payer/provider commitments to use eCQMs and participate in pilot test of edge server indexing.
  - Continue work on HIT section of the SIM Operational Plan

# Work Stream Updates

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## Program Management Office

- Incorporated edits from the Core Team for the Operational Plan
- Submitted budget amendment to CMMI
- Submitted a request for an additional 5-month no-cost extension, which better aligns first performance year with major initiatives (e.g., AMH, CCIP, HIT, MQISSP)

### Next Steps:

- Submit budget amendment to align with no-cost extension, if approved
- Prepare Operational Plan for new deadline (August 1)
- Amend MOAs to incorporate scope and budget for second extension

# Work Stream Updates

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## Quality Measure Alignment

- PMO meeting with health plans to discuss PCMH CAHPS survey
- PMO review of recommended core measure set of the Core Quality Measure Collaborative
- **Next Step:**
  - Finalize alignment process and second draft of report for HISC review
  - Meet with Quality Council to review Core Quality Measure Collaborative recommendations and implications for the Quality Council's Provisional Core measurement set
  - Prepare second draft of Quality Council report
  - Prepare for discussion of public scorecard with APCD, evaluation team and Quality Council

# Core Quality Measures Collaborative

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- The Core Quality Measure Collaborative is led by the America's Health Insurance Plans (AHIP) and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations, employers and consumers
- **Problem they are addressing:** The difficulty of having actionable and useful information because physicians and other clinicians must currently report multiple quality measures to different entities. Measure requirements are often not aligned among payers, which has resulted in confusion and complexity for reporting.

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- The Collaborative has reached consensus on **seven core measure sets** at the national level, as a step forward for alignment of quality measures between public and private payers.
- This effort intends to promote the use of accurate, useful information on health care quality that can inform the decisions of consumers, employers, physicians and other clinicians, and policymakers. Especially in the context of value-based reimbursement models.

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- The **seven measure sets** provide a framework upon which future efforts can be based:
  - Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics

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- Designed to be meaningful to patients, consumers, and physicians, the alignment of these core measure sets will aid in:
  - promotion of measurement that is evidence-based and generates valuable information for quality improvement,
  - consumer decision-making,
  - value-based payment and purchasing,
  - reduction in the variability in measure selection, and
  - decreased provider's collection burden and cost.
- CMS believes that by reducing burden on providers and focusing quality improvement on key areas across payers, quality of care can be improved for patients more effectively and efficiently.

# Implications for Connecticut

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- Connecticut has developed a collaborative, and multi-stakeholder state-level process and infrastructure to review and recommend quality measures
- What is the role of the Quality Council going forward? Should the Quality Council continue state level review to ensure that the quality measure alignment process takes into account Connecticut's goals, opportunities for improvement, and public health priorities?
- Will this national measure set make quality measure alignment occur at a faster rate in Connecticut, especially among the large health plans?

# Next Steps

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- The Quality Council reviewed the quality measures recommended by the Collaborative. There is much alignment between the two measure sets. The Council will...
  - Review the quality measures recommended by the Collaborative **that are not** on the SIM Quality Council's list. Consider whether any of these should be added to the SIM QC list.
  - Review the quality measures recommended by the SIM QC list **that are not** on the Collaborative's list. Consider whether any of these should be removed from the SIM QC list.
  - Consider the relevance of the principles identified by the Collaborative.
  - Consider their recommended target of no more than 15 measures for clinicians

For more information about the Core Quality Measure Collaborative:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>

<http://www.ahipcoverage.com/2016/02/16/ahip-collaborative-partners-announce-core-set-of-quality-measures/>

# Work Stream Updates

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## Community and Clinical Integration Program (CCIP)

- PMO incorporated feedback from joint meeting of Practice Transformation Task Force (PTTF) and Care Management Committee (CMC) into **fourth draft** of CCIP Report
- PMO concluded public comment on **fourth draft** of the report
- **Next Steps:**
  - Release response to comments by members of the CMC
  - CMC discussion of CCIP in meeting on 3/16/16
  - Prepare RFP to procure CCIP vendor(s)

# CCIP Draft 4 Public Comments Summary

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## General Comments in Support of the Report and Process:

- CCIP builds on proven innovations and is based on extensive research
- The process for developing the report and standards has been inclusive, an ongoing iterative process with multiple periods of public comment, meetings, and webinars
- Providers requested consistency with standards and requirements from the beginning of the SIM process, which led to the development of standards that will benefit all patients
- The CCIP Program will provide the necessary TA and potential transformation awards to aid with the standards, helping to reduce provider burden

# CCIP Draft 4 Public Comments Summary

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- Training, support, and development of feedback mechanisms is crucial for providers, leaders, and cross-organizational teams. New roles must be well defined, as well as workflows and measures for team-based care.
- Care plans are a great approach for patients with complex needs, as long as they are available when needed and editable by the Care Team.
- Medicaid has been effective in the shift to PCMH and reaching disparate populations, but equity in utilization does not equate to improved health outcomes. CCIP addresses this by including specific standards and accountability to address health equity.

# CCIP Draft 4 Public Comments Summary

## Suggestions

- Include data on homelessness/housing stability when identifying high need, high cost users
- Build collaborations between health, behavioral health, and housing systems in order to ensure an integrated system of care
- Use the CHW model to expand and sustain the Patient Navigator workforce in supportive housing
- Expand and sustain existing supportive housing initiatives targeting high utilizers
- Address the integration of primary care into behavioral health settings and address the needs of patients with identified chronic behavioral needs or explain why they are not addressed at this time

# CCIP Draft 4 Public Comments Summary

## Suggestions

- Provide technical assistance to identify currently complex patients and those at **rising risk** of complexity
- Encourage the inclusion of providers on the outpatient care team with palliative care skills focused on living with chronic disease, rather than end-of-life care
- Expand access strategies, beyond e-consultations
- Care plans must be available and editable across multiple members of the care team, within and across organizations
- Creating the right training, support, development and feedback mechanisms for providers and other leaders will be crucial
- Cross organizational/team workflow design for their roles and how to work together with outcome and process measures is key

# CCIP Draft 4 Public Comments Summary

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## Concerns about the standards

- Prescriptive, which may undermine flexibility and innovation
- Burdensome for providers
- Could undermine drivers of current Medicaid success like the DSS PCMH and Intensive Care Management programs
- Could cause duplication in efforts around care management, population risk identification, and community collaboration
- Only required of Medicaid participating providers
- Lack of evidence

## Suggestions to address concerns:

- Delay CCIP or delay MQISSP
- Make the CCIP standards optional

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Adjourn