

Connecticut **State Innovation Model** **Outline**

Overview Presentation
Consumer Advisory Board
January 27, 2014

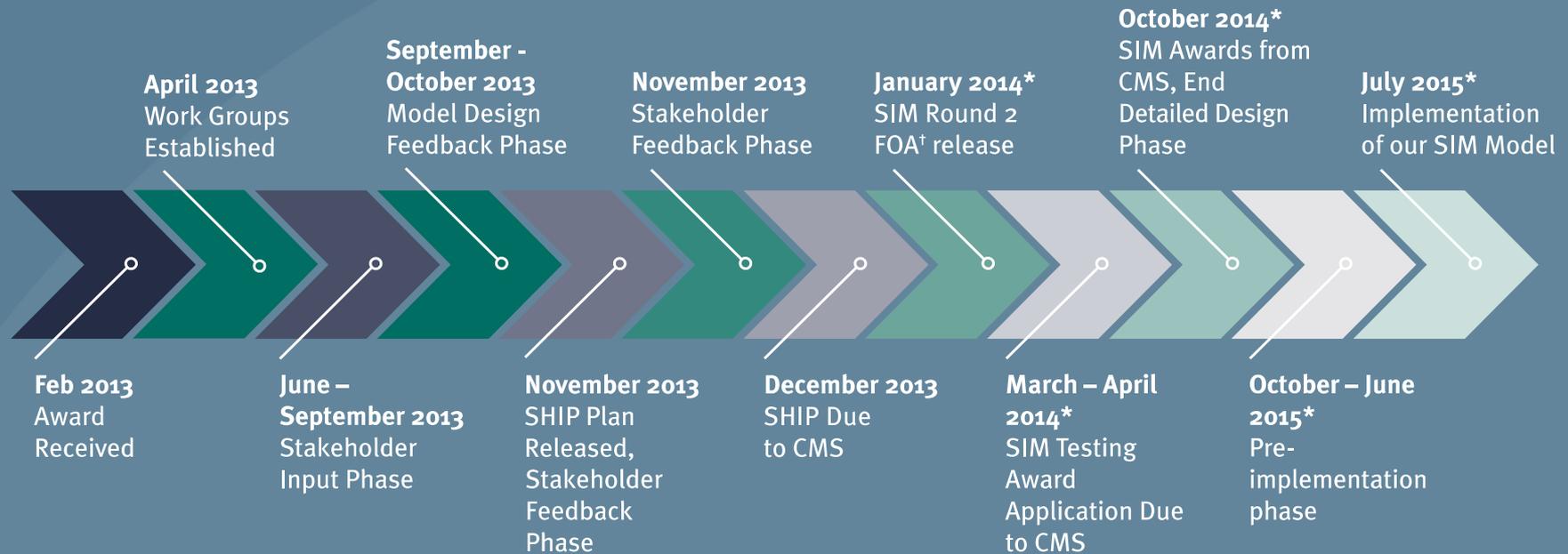
Agenda

- + Purpose of Today's Meeting
- + SIM 101 Overview
- + Model Design and Stakeholder Engagement Process
- + Initiative Timeline
- + Draft Connecticut Healthcare Innovation Plan Summary
- + Discussion/ Feedback
- + Next Steps

What is a State Healthcare Innovation Plan?

- ✦ The State Innovation Model Initiative (SIM) is an initiative of the Center for Medicare and Medicaid Innovation (CMMI)
- ✦ CMMI was created under the ACA to improve quality and contain costs
- ✦ Design grants allows states to develop an “Innovation Plan” to improve health and healthcare
- ✦ Plan should align providers, consumers, employers, payers and state leaders around health care reforms
- ✦ Plan should reach 80% of Connecticut’s citizens in 3-5 years
- ✦ Plan was completed in December 2013
- ✦ Now Connecticut will apply for \$40 to \$50 million dollars to help us implement and test our model

Initiative Timeline (anticipated)



* Estimated date

† Funding Opportunity Announcement

Goal for Health System Performance Improvement

The new care delivery model and enabling initiatives empower us to achieve our goals for health system performance, including:

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

Model Overview – Achieving the “Triple Aim”



**1 PRIMARY CARE
TRANSFORMATION**

**2 COMMUNITY
HEALTH
IMPROVEMENT**

**3 CONSUMER
EMPOWERMENT**

Model Overview – Achieving the “Triple Aim”

1 PRIMARY CARE TRANSFORMATION

- + Primary care transformation to Advanced Medical Homes
- + Practices joining together to support enhanced capabilities & infrastructure
- + Value-based payment tied to quality and care experience

Model Overview – Achieving the “Triple Aim”

2 COMMUNITY HEALTH IMPROVEMENT

- + Regional communities set priorities for health improvement and health equity
- + Collaborative solutions across care delivery, public health, and community organizations
- + Financial incentives tied to health improvement

Model Overview – Achieving the “Triple Aim”

3 CONSUMER EMPOWERMENT

- + Transparent quality, consumer experience, and cost
- + Shared decision making tools
- + Insurance and employer incentives to reward good health behavior

Enabling Initiatives

Primary Drivers

Primary
Care Practice
Transformation

Community
Health
Improvement

Consumer
Empowerment

Enablers

PERFORMANCE
TRANSPARENCY

VALUE-BASED
PAYMENT

HEALTH
INFORMATION
TECHNOLOGY

HEALTH WORKFORCE
DEVELOPMENT

Connecticut's Advanced Medical Home Model

CORE ELEMENTS

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-based informed clinical decision making

OUR ASPIRATIONS

- + Better health for all
- + Improved quality and consumer experience
- + Promote health equity and eliminate health disparities
- + Reduced costs and improved affordability

Advanced Medical Home: Core Elements

Whole-person
centered care

PRIORITIZED INTERVENTIONS

- + Assess whole person and family and living conditions
- + Use person-centered care planning
- + Use shared decision-making tools
- + Use race, ethnicity, and primary language to inform service delivery

1 Including history of trauma, housing instability, access to preventive oral health services

Advanced Medical Home: Core Elements

Enhanced access
to care (structural
and cultural)

PRIORITIZED INTERVENTIONS

- + Improve access to primary care through
 - a) extended hours (evenings/weekends)
 - b) convenient, timely appointments including same day (advanced) access
 - c) non-visit-based options for consumers including telephone, email, text, and video communication
- + Enhance specialty care access (e.g. through non-visit-based consultations: e.g., e-Consult)
- + Inform consumers about options for accessing routine and urgent care needs
- + Culturally and linguistically appropriate services

Advanced Medical Home: Core Elements

Population health management

PRIORITIZED INTERVENTIONS

- + Collect and use data to improve care delivery and health equity
- + Profile outcomes and improvement opportunities for subgroups of consumers
- + Apply data insights to continuously improve care delivery
- + Apply population health trends and statistics to individual patients
- + Maintain a comprehensive disease registry to track population health

Advanced Medical Home: Core Elements

Team-based,
coordinated care

PRIORITIZED INTERVENTIONS

- + Provide team-based care, flexible and diverse team
- + Integrate community, oral, and behavioral health with primary care with “warm hand-offs”,
- + Follow a whole-person-centered, multi-disciplinary care plan
- + Coordinate across all elements of a consumer’s care and support needs
- + Care management for those with complex care needs
- + Include community health workers

Advanced Medical Home: Core Elements

**Evidence-informed
clinical decision
making**

PRIORITIZED INTERVENTIONS

- + Apply clinical evidence to improve care
- + Integrate disparity-specific recommendations
- + Use tools and methods at the point of care to include the most up-to-date clinical evidence

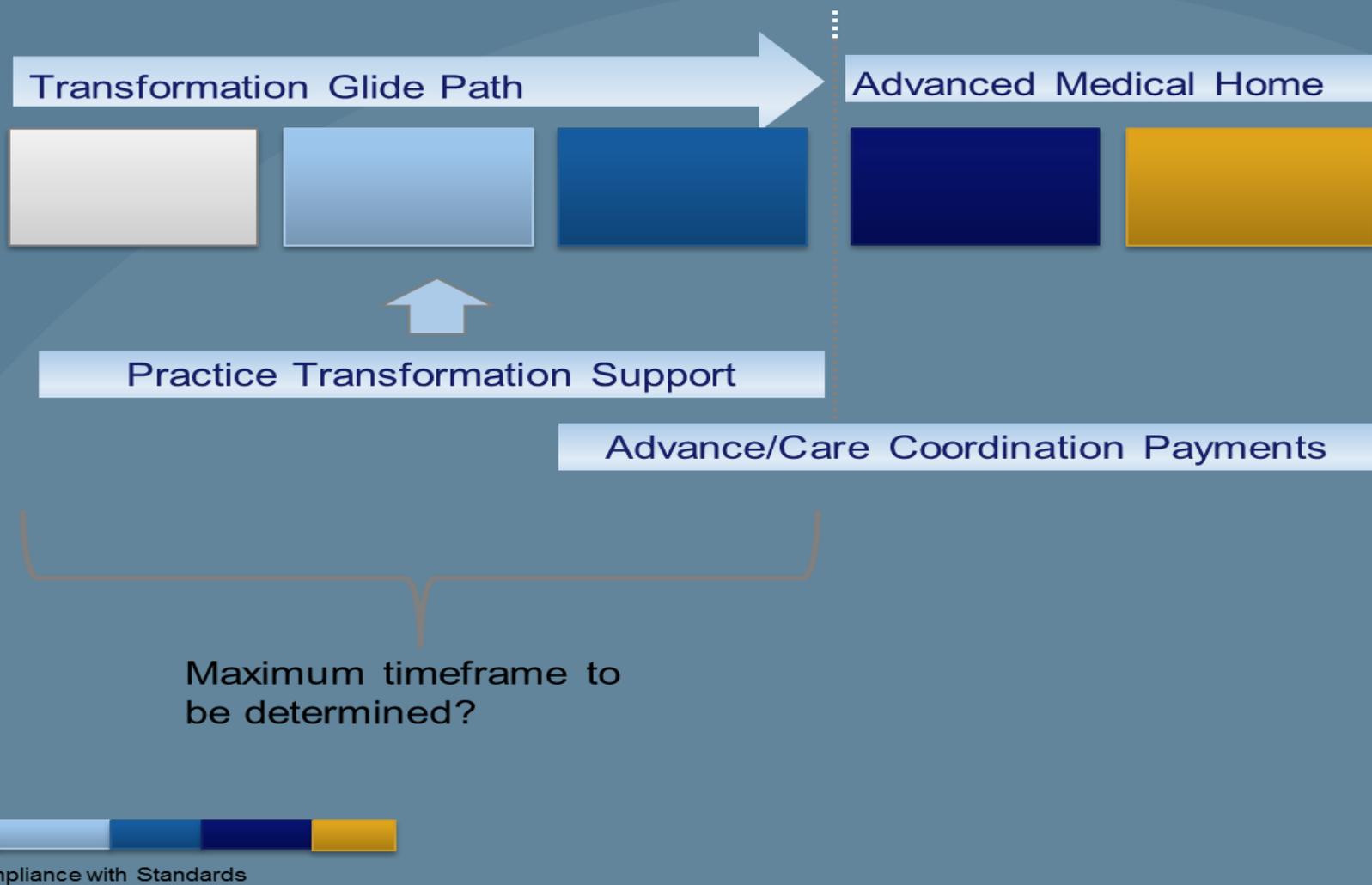
Advanced Medical Home Standards

- + We are not proposing to use existing national standards
- + Meeting national standards is both costly and administratively burdensome
- + Recognition or accreditation does not necessarily result in practice transformation
- + Time and effort spent on administrative requirements of a national accrediting body better spent on the transformation process
- + Payers have established their own standards, which has, for providers, further complicated the transformation process
- + Under SIM, Connecticut's payers will adopt a common set of accreditation standards, drawn from NCQA, AAAHC, URAC, Joint Commission, etc
- + A common set of AMH standards will simplify the transformation process

Helping Providers Achieve Recognition

- + Practices vary greatly in their need for support to meet AMH standards
- + For providers without a large group affiliation, we created the Glide Path Program
 - + Facilitate the practice transformation process.
 - + Provider participants receive support as they adopt advanced practices like whole-person-centered care and care coordination.
 - + Accountable for meeting milestones and for achieving true practice transformation
- + During Glide Path, providers that demonstrate readiness will qualify for advance payments to support care coordination and other functions

Helping Providers Achieve Recognition



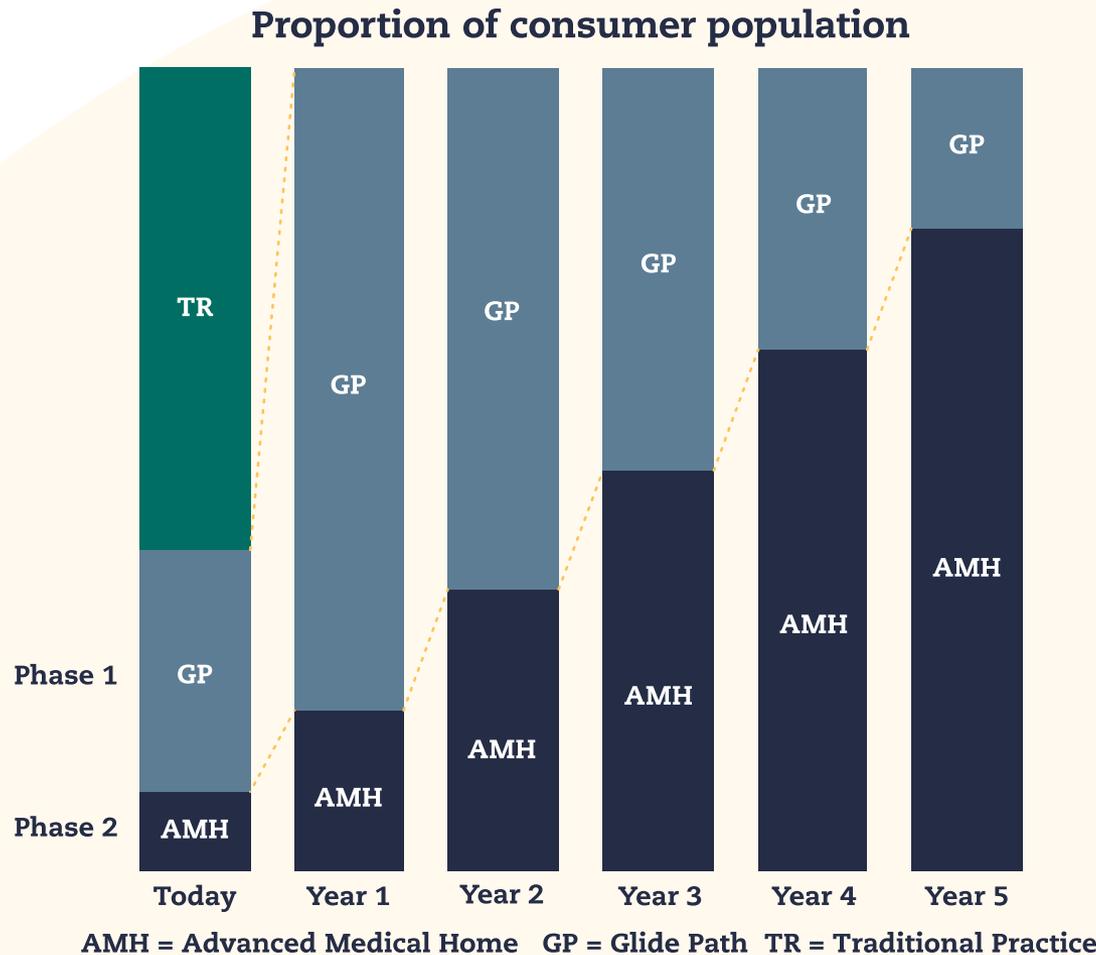
Care Team Leadership and Roles

- + Care team of various healthcare service and support providers
- + “Core providers” of primary care (e.g., PCPs, APRNs, and care coordinators)
- + Eventually fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers, and community health workers
- + Flexibility in team lead – depends on consumer needs and the practice’s preferred approach

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

- + Integrated Delivery System
- + Medical Group Practice
- + Clinically Integrated Network
- + Strong IPA
- + Loose IPA
- + Regional Cooperatives

Advanced Medical Home Phase-in as Providers Complete Glide Path



Community Health Improvement

- ✦ A major part of transformation strategy is to foster collaboration among the full range of providers, employers, schools, community-based organizations, and public agencies to work to improve the health of populations within their community

- ✦ Two elements:

 - Designated Prevention Service Centers (PSCs)**

 - Health Enhancement Communities (HECs)**

Prevention Service Centers

Designated Prevention Service Centers are local organizations that have been designated by the state to support local primary care practices with a package of evidence-based, primarily preventive, community services.

- + Provide one-stop shopping for quality, evidence-based prevention services
- + Develop formal affiliations with primary care practices and share accountability for quality and outcomes
- + Demonstrate a unique understanding of community and population served and able to assist delivery of high quality, culturally and linguistically appropriate services
- + Employ and utilize community health workers
- + Support IT-enabled integrated communication protocols. Collect and report data, and evaluate performance and relevant outcomes, stratified by race/ethnicity/primary language, and other demographic data

Prevention Service Centers – Core Services

- + Asthma Home Environmental Assessments (putting on AIRS)
- + Diabetes Prevention Program (DPP)
- + Falls Prevention Program

Community Health Improvement – Health Enhancement Communities (HECs)

- + Regional communities accountable for health improvement and health equity
- + Focus on local needs and priorities
- + Align metrics and financial incentives for all community participants
 - Care delivery networks/ACOs
 - Possibly other community partners
- + Financial incentives for grant based programs
- + Pooled accountability so providers are rewarded for finding new consumers and serving high risk consumers

Consumer Empowerment

Consumers will benefit from the following:

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

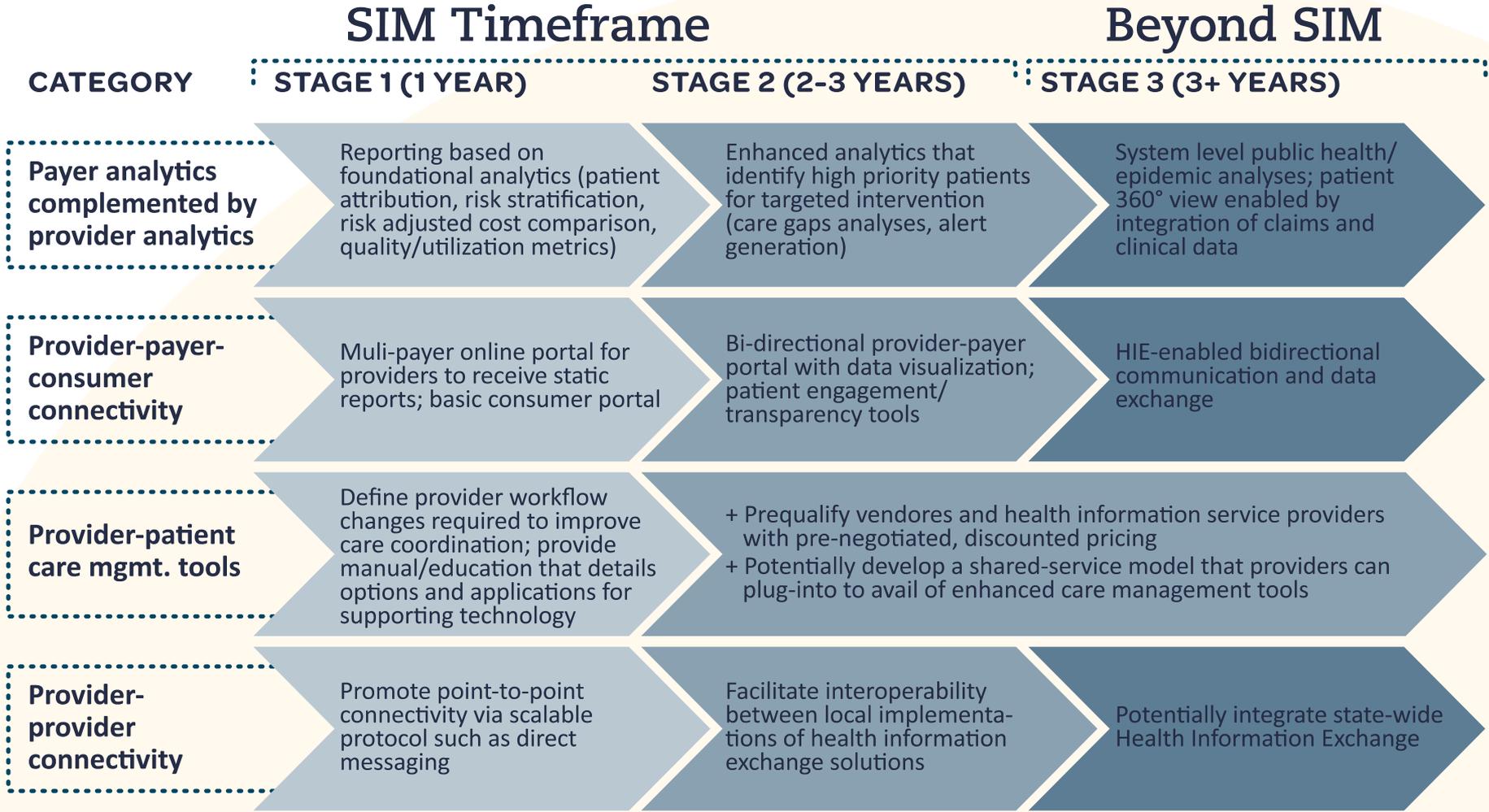
Enabling Initiatives

- + Performance Transparency
- + Health Information Technology
- + Value-Based Payment
- + Workforce Development

Enabling Initiative - Performance Transparency

- + **Create a common scorecard** that reflects the 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

Enabling Initiative - Health Information Technology



Enabling Initiative - Value-Based Payment

+ Pay-for-Performance

Financial rewards for meeting quality and care experience targets

Available for Glide Path participants

Teaching improvement - provides experience necessary for future success

500+ attributed consumers

Enabling Initiative - Value-Based Payment

+ Shared Savings Program

Share in savings if meeting quality and care experience targets

Payer and providers negotiate whether to share in losses

Practices have met initial quality metrics and progressing AMH standards

5,000+ attributed consumers

Guiding principle - underservice disqualifies a practitioner from shared savings

How do providers know who their accountable for?

- + Most payers use a “look back” model to determine for which consumers a provider is accountable
- + Usually this is done by looking at which provider a consumer has gone to the most for primary care
- + Our plan supports this approach to holding providers accountable
- + However, we also support consumer choice...consumers can always choose to go to a new provider of their choice
- + As the consumer starts going to this new provider, that provider will eventually be responsible for their health outcomes

Enabling Initiative - Workforce Development

- ✦ Better data and analytics on CT's health workforce
- ✦ Inter-professional education (IPE) for team based care
- ✦ A training program and certification standards for Community Health Workers
- ✦ Preparing our current health workforce for new models of care delivery
- ✦ Innovation in and expansion of primary care residency programs
- ✦ Establishing better and more flexible career tracks for health professionals and allied health professionals

Managing the Transformation

+ GOVERNANCE MODEL

+ TRANSFORMATION ROAD MAP

Managing the Transformation - Governance Model



Who Will Participate in Governance?

- + Proposed composition of Councils and Task Force under development
- + Considerations
 - + Meaningful consumer and consumer advocate participation
 - + Key participants – Payers and providers
 - + Range of expertise
 - + Not too big, not to small

Managing the Transformation - Transformation Road Map

CT'S INNOVATION PLAN WILL BE IMPLEMENTED OVER FIVE YEARS, DIVIDED INTO FOUR PHASES:

+ Detailed Design (January to September, 2014)

Establish new governance structures and form a program management office (PMO), with a small dedicated staff

PMO will develop the more detailed technical design necessary to support new models

+ Implementation Planning (October 2014 to June 2015)

Pending the award of grant and other funding, initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes

Example activities include procurement of technology development, practice transformation, and other external products and services necessary to support launch

Managing the Transformation - Transformation Road Map

+ Wave 1 Implementation (July 2015 to June 2016)

First year of operations of multi-payer model for AMH as well as initiation of new capabilities to support Workforce Development

Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the Connecticut Service Track

+ Wave 2+ Scale-Up (July 2016 to June 2020)

Continuous improvement of the common scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities

Primary care providers will continue to be enrolled in the Glide Path and AMH model, and providers will continue to transition from P4P to SSP as they achieve the minimum necessary scale and capabilities over time

Major expansion of Community Health Improvement and Workforce strategies, including establishment of Prevention Service Centers

For more information...

- + Additional information about the SIM initiative including the final Connecticut Healthcare Innovation Plan can be found at:
<http://www.healthreform.ct.gov>
- + Click on “SIM Initiative”

Please share your thoughts by emailing us at sim@ct.gov.

Appendix

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Integrated Delivery System

- + Physicians and hospitals legally and financially integrated
- + Capital, infrastructure, and clinical integration among physicians, hospitals, other providers
- + Potential to distribute payment through employment agreements

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Medical Group Practice

- + Legally and financially integrated physician organization
- + Capital infrastructure, and clinical integration among physicians
- + Potential to distribute payment through employment agreements

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Clinically Integrated Network

- + Formal contractual relationship among otherwise independent physicians, hospitals, other providers
- + Capital, infrastructure, and clinical integration among physicians, hospitals, other providers

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Strong IPA

- + Physicians derive most or all of their revenue through IPA
- + Capital, infrastructure, and clinical integration among physicians

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Loose IPA

- + Physicians and/or hospitals derive only part of their revenue through IPA
- + Limited capital, infrastructure, or clinical integration among physicians

Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

Regional Cooperatives

- + Regional cooperative provides clinical and technical resources
- + Limited capital, infrastructure among participating physicians independently
- + Regional cooperative may or may not be channel for distribution of risk sharing