SIM Health IT Council Meeting

APRIL 15, 2016

Agenda

Introductions

Public Comments

Minutes Approval

HIT Relevant Updates

VBID Pilot

Zato Demonstration

Q&A

Next Steps

HIT Relevant Updates

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HIT Relevant Updates

- Quality Measure Alignment
- CCIP Standards

Quality Measure Alignment

Core Quality Measure Collaborative Recap

- Last meeting: Core Quality Measure Collaborative released core set of quality measures to promote alignment among private and public payers
- **Problem**: Lack of actionable data because:
  1. Too many measures
  2. Little alignment on measures
  3. Measures are process or structural instead of outcome focused
- **In Connecticut - path forward**:
  - Promote alignment among payers
  - Support use of outcome based measures, including eCQMs
- **Value add** exists for consumers, policy-makers, providers, employers, and health plans who all need actionable, timely, comprehensive information on the quality of care

Quality Measure Alignment Next Steps

April
- Conversations held with CMS and AHIP
- Quality Council reviews information and makes recommendation

May
- Finalize alignment strategy
- Continued discussions with Connecticut health plans

June-July
- Steering Committee review Quality Council report and measures
- Solicit public comment – including gaps in eCQM reporting

July-Sept
- Finalize measures and begin implementing alignment strategy

Community and Clinical Integration Program Standards

Community and Clinical Integration Program (CCIP) STANDARDS

- Finalized and approved last month
- Currently being incorporated into MQISSP RFP – to be released in June
- Next step – procure CCIP vendor
- Transformation technical assistance begins with chosen networks in October/November 2017

Statewide Goal: Provide transformation support for health care providers so that they can achieve advanced capabilities that will improve healthcare quality, health equity and affordability

- SIM supports a range of care delivery reform investments to support provider networks that are organizing to take financial responsibility for clinical quality, total cost of care, and patient health outcomes. We refer to these organizations as "Advanced Networks."
- SIM provides direct support to individual practices affiliated with Advanced Networks through our Advanced Medical Home initiative. This support is only available to practices that are not already NCQA recognized as PCMH.
- SIM also provides support to Advanced Networks through the CCIP. This program focuses on individuals with complex health care needs, health equity improvement, and behavioral health integration. CCIP emphasizes the development of new capabilities to effectively integrate non-clinical community services with traditional clinical care.

CCIP Core and Elective Standards

Core Standards

Comprehensive Care Management

Comprehensive care team, Community Health Worker, Community linkages

Health Equity Improvement

Analyze gaps & implement custom intervention + **CHW & culturally tuned materials**

Behavioral Health Integration

Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Elective Standards

Oral health Integration

E-Consult

Comprehensive Medication Management

CORE STANDARD 1: COMPREHENSIVE CARE MANAGEMENT

1. **Identify individuals with complex health care needs**
2. **Conduct person-centered assessment**
3. **Develop an individualized care plan**
4. **Establish a comprehensive care team**
5. **Execute and monitor the individualized care plan**
6. **Identify whether individuals are ready to transition to self-directed care maintenance and primary care team support**
7. **Monitor individuals to reconnect to comprehensive care team when needed**
8. **Evaluate and improve the effectiveness of the intervention**

CORE STANDARD 2A:
HEALTH EQUITY IMPROVEMENT

1. **Expand the collection, reporting, and analysis of standardized data stratified by sub-populations**
2. **Identify and prioritize opportunities to reduce a healthcare disparity**
3. **Implement a pilot intervention to address the identified disparity**
4. **Evaluate whether the intervention was effective**
5. **Other organizational requirements**

CORE STANDARD 2B:
HEALTH EQUITY PILOT INTERVENTION

1. **Create a more culturally and linguistically sensitive environment**
2. **Establish a Community Health Worker (CHW) capability**
3. **Identify individuals who will benefit from CHW support**
4. **Conduct a person-centered needs assessment**
5. **Create a person-centered self-care management plan**
6. **Execute and monitor the person-centered self-care management plan**
7. **Identify process to determine when an individual is ready to transition to self-directed maintenance**

CORE STANDARD 3:
BEHAVIORAL HEALTH INTEGRATION

1. **Identify individuals with behavioral health needs**
2. **Address behavioral health needs**
3. **Behavioral health communication with primary care source of referral**
4. **Track behavioral health outcomes/improvement for identified individuals**

COMMUNITY HEALTH COLLABORATIVES

1. **Planning Strategy**
2. **Identify and convene stakeholders impacted by the Community Health Collaborative model in defined area(s)**
3. **Develop standardized protocols and processes for network linkages to shared services**
4. **Implement long-term assessment and improvement process**

ELECTIVE STANDARDS

1. **Oral Health Integration**
2. **E-Consults**
3. **Comprehensive Medication Management**

POTENTIAL HIT IMPLICATIONS

- **Advanced Networks participating in CCIP and all entities participating in MQISSP will be working to advance their care delivery capabilities, as well as improve on quality measures to do well in alternative payment models**
- **They likely already have made or will make HIT investments to enable them to perform well**
- **Some investments may be more efficient as a state initiated shared utility (SIM HIT investment)**

POTENTIAL HIT IMPLICATIONS

- The planning process for CCIP capabilities has revealed potential gaps across health systems including the need to:
  - **share health information efficiently across clinical and community partners**
  - **use e-referral, tracking and follow-up to effect clinical and non-clinical linkages to services and supports**
  - **receive timely information re: ADTs**
  - **effectively coordinate and communicate with inter-disciplinary team including patient, patient supports, clinical and non-clinical community partners**
  - **care teams have access to a comprehensive view of the patient and care plan**
  - **analytic tools enable use of clinical systems to identify high risk populations and sub-population analyses (e.g., race, neighborhood, social factors) to support targeted continuous quality improvement**
- How can the State Innovation Model HIT investments promote care delivery transformation and address the gaps that exist in the above areas?

Value-Based Insurance Design Pilot

THOMAS WOODRUFF

Data Structure

TRADITIONAL DATA

NON-TRADITIONAL DATA

Medical claims

Pharmacy claims

Dental claims

Lab Value Data
- **A1C reading**
- **Cholesterol results**

Electronic Medical Record (EMR) Data
- **Blood Pressure**
- **BMI**

care management solutions
a ConnectiCare affiliate

Zato Demonstration

MINAKSHI TIKOO

Zato Logistics

- Council members have been invited to a Zato Demonstration on either Tuesday, May 17th or Monday, May 23rd.
- The demonstration will be held at Baystate Health in Springfield, MA and will promptly begin at 10 am.
- The Confidentiality and Non-Disclosure Agreement (NDA) must be signed and sent to Paul McOwen prior to the demonstration date. Signed NDA permits participating in the viewing of the demonstration.

Next Steps

HIT Council Meeting Schedule: May 20; June 17; July 15; August 19

HIT Section of the SIM OPs Plan:

- Council Members will have an opportunity to review the HIT portion of the SIM OPs plan between May 23 – May 27. Input submitted by May 27 will be reviewed and discussed at the June 17th Council meeting
- The HIT Contractor will present the HIT OPs Plan at the June 17 Council meeting.
- Final draft of HIT OPs plan due to PMO by July 1.