

Practice Transformation Taskforce Meeting

June 24th, 2014



Agenda

Introductions (20 min)

Public Comments (10 min)

SIM Background (20 min)

Practice Transformation Task Force Charter (20 min)

Key Questions Focus (50 min)

TF Meeting Schedule

Introductions & Executive Team

- **State Representatives**

- Michael Michaud, Department of Mental Health & Addiction Services
- Robert Zavoski, MD – Department of Social Services

- **Provider Representatives**

- Rebecca Mizrachi, APRN – Norwalk Community Health Center
- Heather Gates – Community Health Resources
- Rowena Rosenblum Bergmans – Western CT Health Network
- Douglas Olson, MD – Norwalk Community Health Center
- Edmund Kim, MD – Family Medicine
- Elsa Stone, MD – Pediatrics
- Randy Trowbridge, MD – Psychiatrist

- **Payer Representatives**

- Claudia Coplein – ConnectiCare
- David Finn – Aetna
- Bernadette Kelleher – Anthem
- Joseph Wankerl – Cigna
- Leigh C. Dubnicka, Sr. – United
- Peter Holowesko - UTC

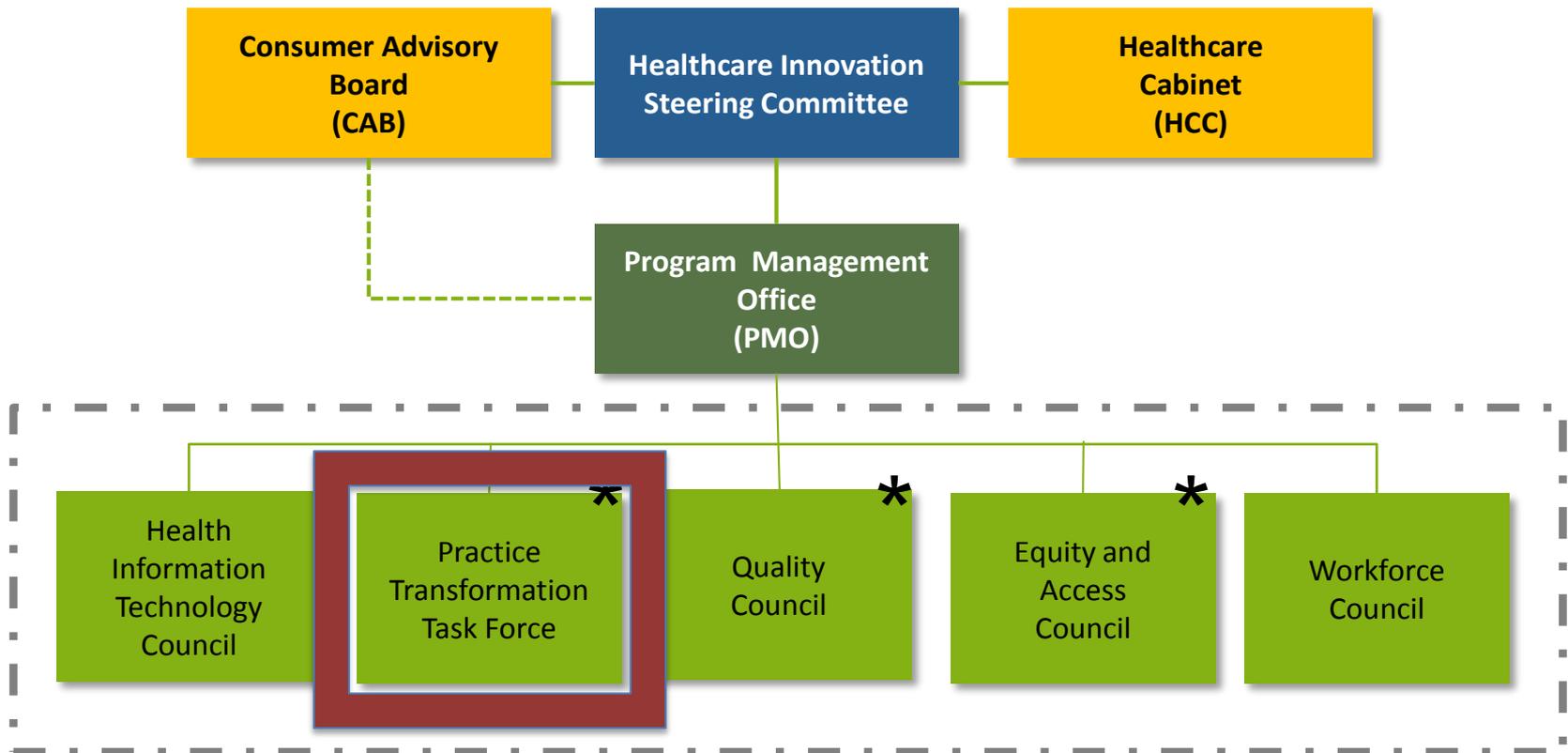
- **Consumer and Advocate Representatives**

- Lesley Bennett
- Mary Boudreau
- Shirley Girouard
- Alta Lash
- Jesse White-Frese
- Tonya Wiley

Task Force Ground Rules

- Expectations of taskforce members:
 - Presence
 - Attend meetings
 - Prepare and participate between meetings as needed to move issues along
 - Outlook
 - Leave jobs and titles at the door; focus on best interest of CT citizens
 - Look for consensus to make recommendations to PMO
 - Action
 - Find solutions for proposed questions
 - Build ideas and be proponent of change and transformation
 - Be vocal and share the importance of our mission

Governance Structure



Agenda

Introductions (20 min)



Public Comments (10 min)



SIM Background (20 min)



Practice Transformation Task Force Charter (20 min)



Key Questions Focus (50 min)



TF Meeting Schedule

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

2 minutes
per
comment

Agenda

Introductions



SIM Background



Practice Transformation Task Force Charter



Key Questions Focus



TF Meeting Schedule

What is the State Innovation Model?

- + 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
- + *SIM Design* grants enable states to develop a State Healthcare Innovation Plan to improve health and healthcare
- + Align providers, consumers, employers, payers, and state leaders around health and health care reforms
- + Reach all of Connecticut's citizens in 3-5 years
- + Connecticut's Healthcare Innovation Plan was submitted December 30, 2013

Connecticut's vision for reform...

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

Achieving the Vision

Primary Drivers

**Primary
Care Practice
Transformation**

**Community
Health
Improvement**

**Consumer
Empowerment**

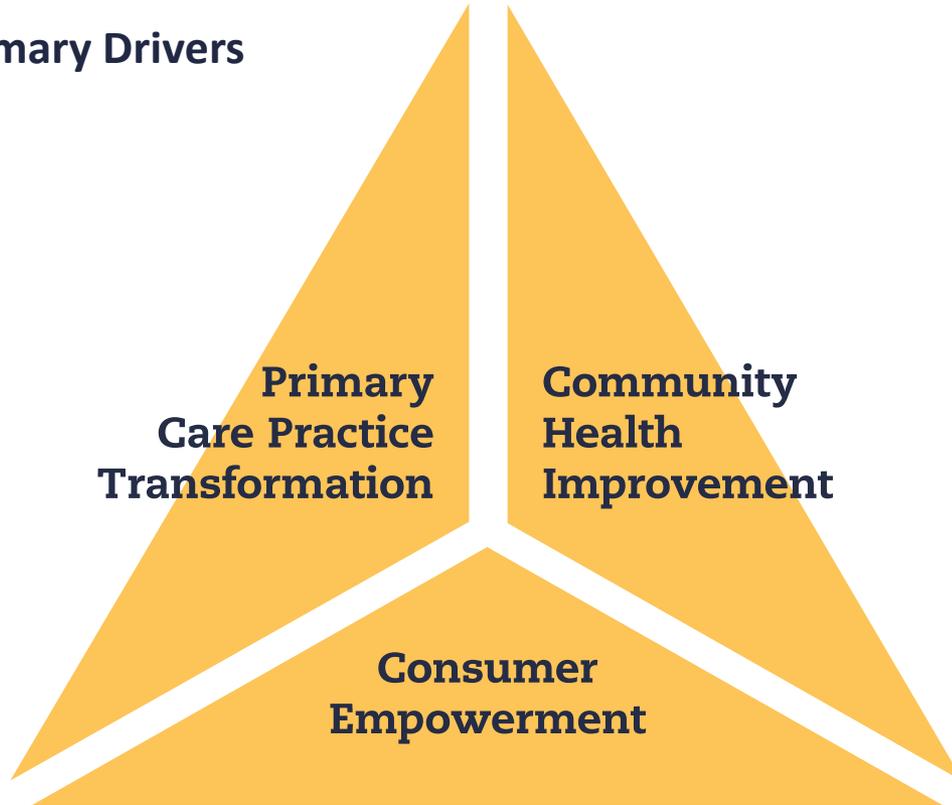
Enablers

**PERFORMANCE
TRANSPARENCY**

**VALUE-BASED
PAYMENT**

**HEALTH
INFORMATION
TECHNOLOGY**

**HEALTH WORKFORCE
DEVELOPMENT**



Primary Care Transformation

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

What Consumers Tell Us

- + Coverage and care are unaffordable
- + Long wait times (especially for specialists)
- + Limited office hours
- + Not enough time with PCP or specialist
- + Not listened to or feel unwelcome
- + PCP is too focused on Electronic Health Record
- + No information or information is hard to understand
- + Poor communication between PCPs, specialists and hospitals
- + Discrimination against those with disabilities

What Doctors Tell Us

- + Primary care is often administratively burdensome and unrewarding
 - + Huge paperwork demands
 - + Other administrative burdens like prior authorization
 - + Not enough time with patients
 - + EHRs get in the way of relationship with patient
- + Poor or inefficient communication with other doctors and hospitals
- + No one to help teach patients in self-care
- + Needed services are often unavailable (e.g., behavioral health)
- + No resources to connect

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 such as 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

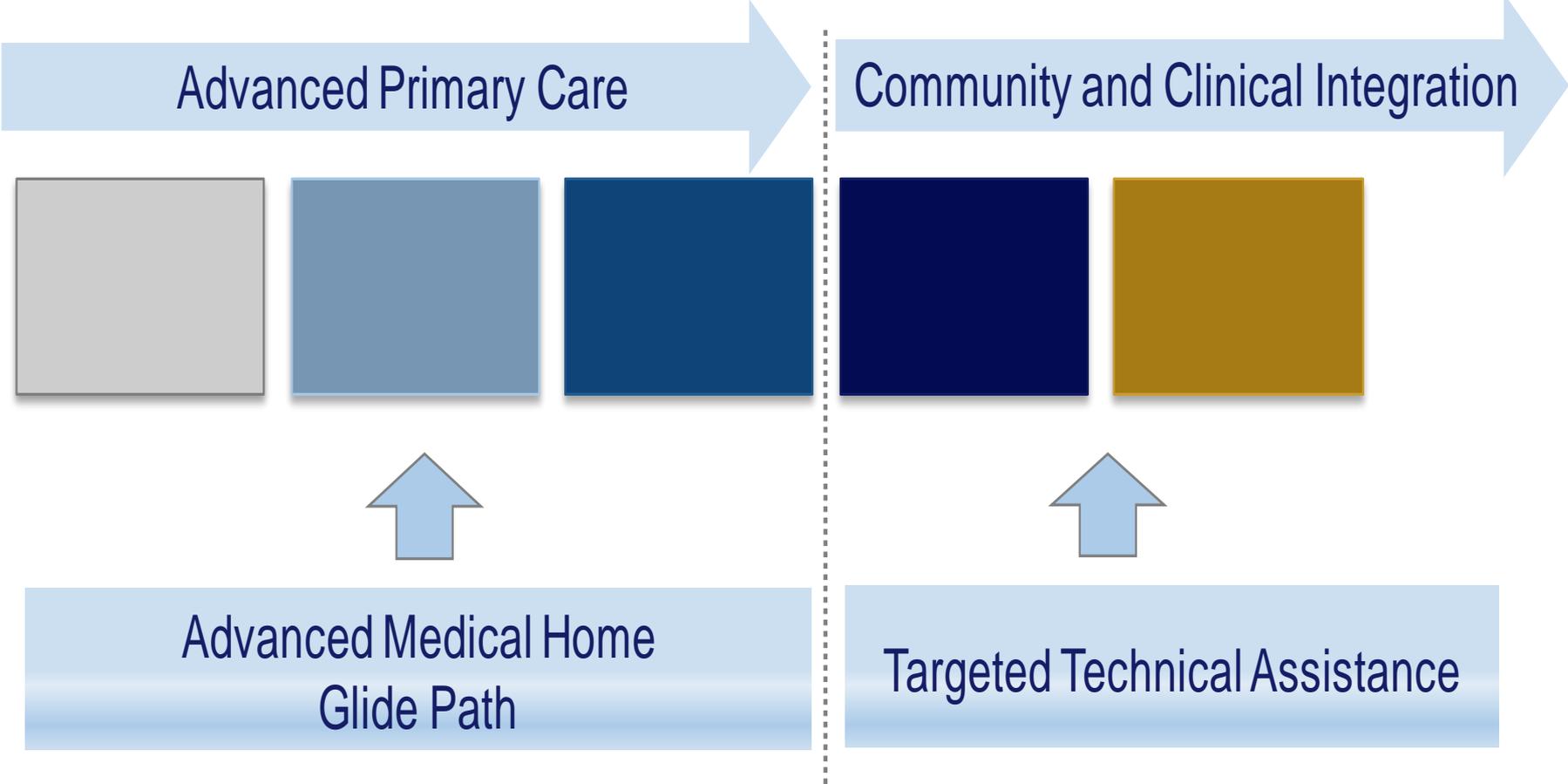
Advanced Medical Home: Core Elements

**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: Glide Path



Advanced Medical Home Standards

- + The state will adopt a common set of AMH standards drawn from the best available national standards and health plan tools
- + Supplemental CT designed standards will also be considered
- + A common set of AMH standards recognized by all payers will simplify the transformation process
- + We have not proposed to require accreditation or recognition by a single national accrediting body
- + Providers and payers expressed concern that:
 - + Accreditation process 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
- + **NOTE: This approach to establishing standards will be a focus of today's meeting**

Helping Providers Achieve Recognition...

The Glide Path Program

- ✦ Practices vary greatly in their need for support to meet AMH standards
- ✦ For practices that are not advanced 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

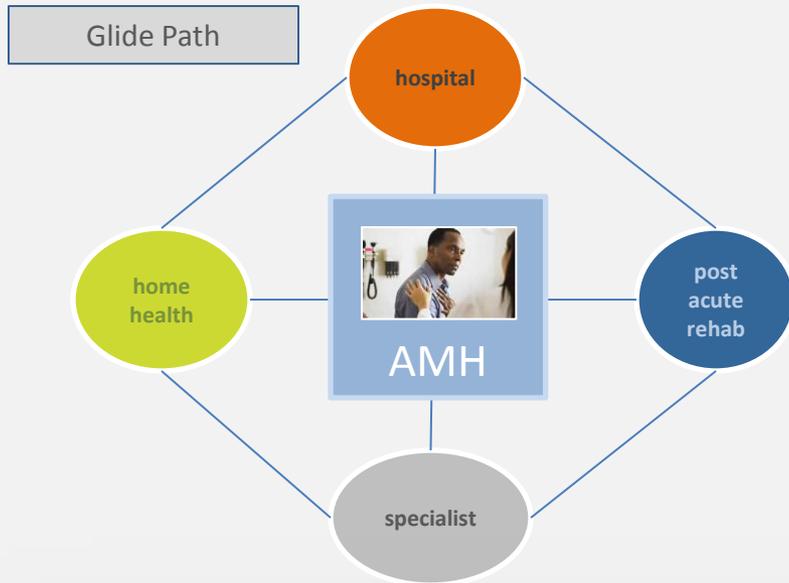
Model Test Grant

- + Funding Opportunity Announcement released May 22, 2014
- + Twelve states will be awarded \$20-\$100 million each over a 4-year period.
- + Funding will support the implementation of states' proposed healthcare delivery and payment reforms
- + Funding will be proportionate to the state's population & scope of reform
- + Grant application due July 16th
- + 4-year timeframe which includes up to one year for pre-implementation planning

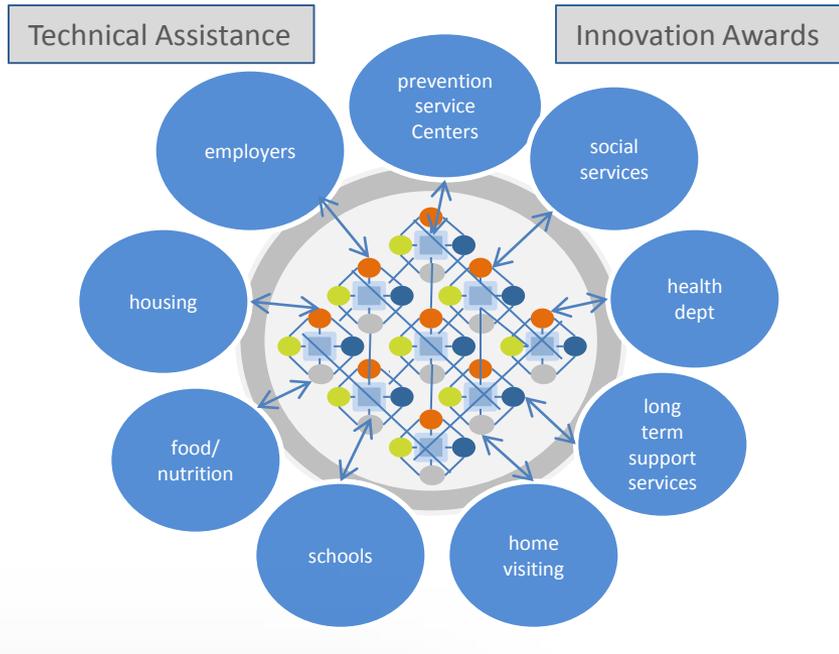
Model Test Grant

- + Model Test scope expands practice transformation activities envisioned in Innovation Plan in recognition of pace of market consolidation
- + AMH glide path
- + **New:** Targeted Technical Assistance to optimize practices that may be affiliated with large groups but not yet advanced
- + **New:** Innovation Awards to practices for novel approaches to community and clinical integration – multiple waves, demonstration projects, must be completed within Model Test period

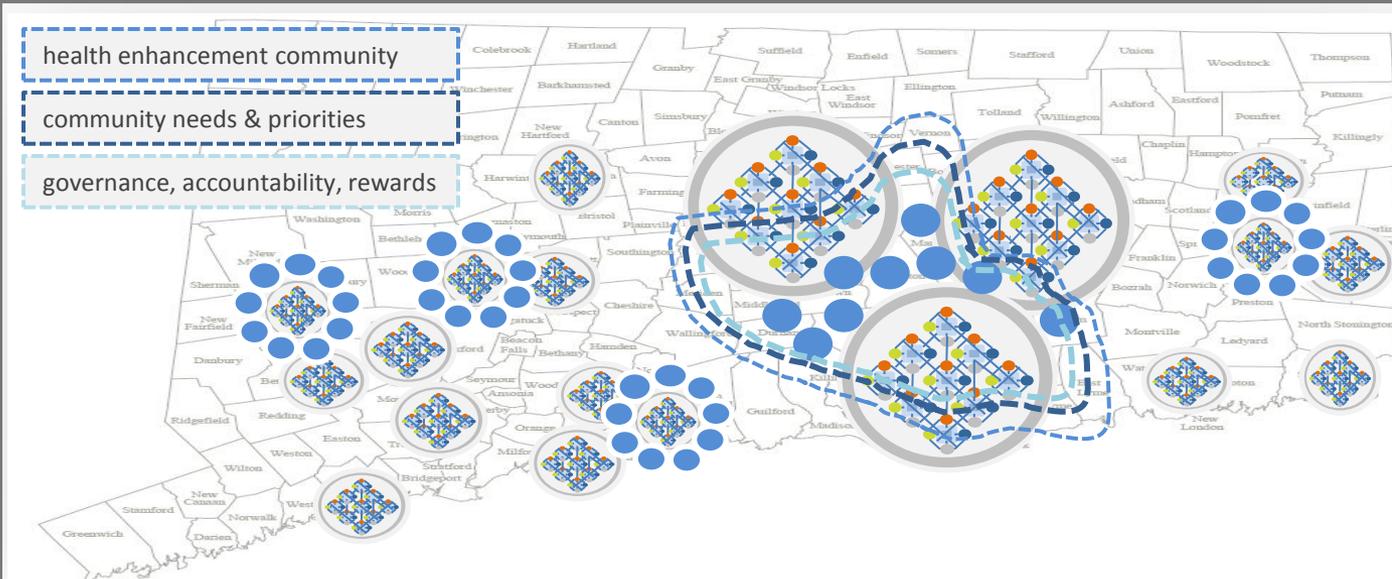
Advanced Primary Care



Community and Clinical Integration



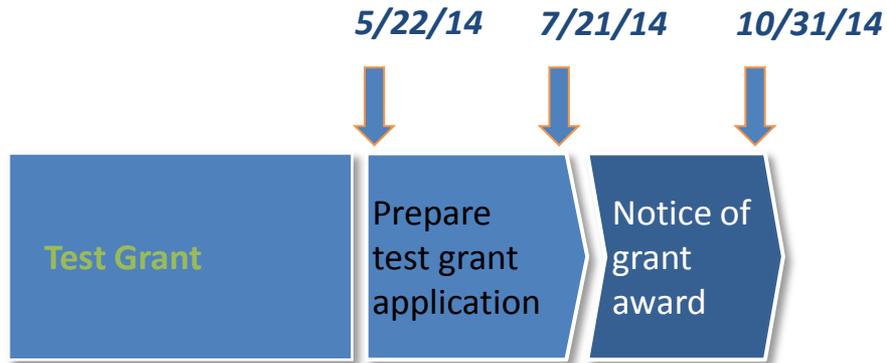
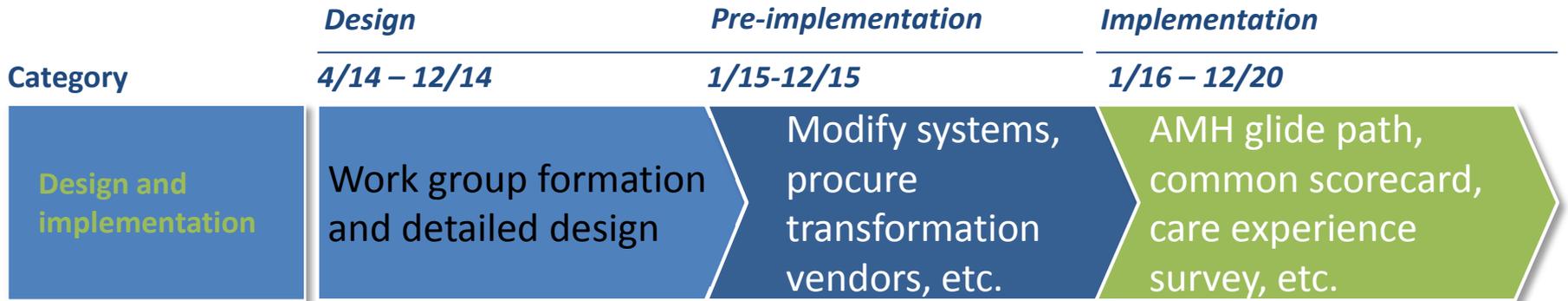
Population Health Plan



PRIMARY CARE DELIVERY ECOSYSTEM

DRAFT
PRE-DECISIONAL

Timeframe



Managing the Transformation – Transformation Road Map

**INNOVATION PLAN WILL BE IMPLEMENTED OVER FIVE YEARS,
DIVIDED INTO FOUR PHASES:**

+ Detailed Design (April to December, 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

+ Pre-implementation planning and activities (January 2015 to December 2015)

Pending the award of grant and other funding, initiate implementation planning targeted at a January 1, 2016 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 (January 2016 to December 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 (January 2017 to December 2020)

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

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

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

Agenda

Introductions



SIM Background



Practice Transformation Task Force Charter



Key Questions Focus



TF Meeting Schedule

Practice Transformation Charter

- This Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Connecticut Healthcare Innovation Plan (SHIP).
- The AMH Model has five core components:
 - **(1) Whole-person-centered care**
 - **(2) Enhanced access**
 - **(3) Population health management**
 - **(4) Team-based coordinated care**
 - **(5) Evidence-informed clinical decision making.**
- This work group will develop the **advanced medical home standards**, detail the design of a **“glide path” program** in which providers are offered practice transformation support services for a limited period of time, advise on the process for **vendor selection** for practice transformation support and practice certification, and coordinate with interdependent workgroups and initiatives.
- The Task Force will identify **key stakeholder groups** whose input is essential to various aspects of the Task Force’s work and formulate a plan for engaging these groups to provide for necessary input.
- The Task Force will convene **ad hoc design teams** to resolve technical issues that arise in its work.

Practice Transformation Key Questions

Standards

- What are the medical standards in use today by national accrediting bodies and CT health plans?
- Which of these standards align with and would best achieve AMH core components?
- What additional standards should be considered that are not in use today? (e.g., oral health; NCLAS)?
- Of the above standards, which standards represent core capabilities that are achievable for small practices and essential for improving value?
- Which standards should be established for coordinating with behavioral health homes and prevention service centers?
- Should the standards be applied uniformly, or should there be adjustments based on practice characteristics?
- Should such standards be applied by site or by group?

Practice Transformation Key Questions

Transformation Process

- What are the criteria that a practice must meet to qualify for the AMH glide path?
- What readiness assessment tools exist today and which among them should be adapted for use in the Advanced Medical Home program?
- What are the milestones that correspond to major achievements in the glide path?
- Which milestones are recommended as a qualification for advance payments?
- What are the requirements for certification as an AMH?
- What process should be used to support practice transformation? On-site, IT, learning collaborative, targeted technical assistance?
- How will this taskforce support the transformation pace and process?
- What technical assistance should be provided to assist practices with selection, implementation, adoption of EHR?

Practice Transformation Key Questions

Transformation Vendor Procurement

- Should there be a single vendor or multiple vendors?
- Should they be regional or statewide?
- Should the level of support and pricing depend upon the practice readiness assessment? For example, should there be tiered levels of support based on level of readiness/gaps or the presence or absence of an EHR?
- Should they be funded fixed grant, flat fee per practice, or paid per successful applicant?
- Flat fee (based on # of practices, scope of services)?
- Fee per transformation based on # of practices and starting status

Practice Transformation Key Questions

Transformation Vendor Contract

- Withhold paid out based on:
 - Practices' satisfaction with vendor services?
 - Practices' experience once transformed; i.e., practice is more rewarding?
 - # practices achieving AMH recognition?

Practice Transformation Key Questions

Targeted Technical Assistance & Innovation Awards

NEW QUESTIONS BASED ON MODEL TEST SCOPE CHANGE

- What should the TTA and IA priorities be, or how should the priorities be established?
- What is the criteria for a practice to receive targeted technical assistance?
- What is the criteria for a practice to receive an Innovation Award?

Practice Transformation Roadmap

6/24

7/28-9/9

9/30

11/4

11/18-12/16

Kick-off

- SIM Background
- Introductions
- Practice Transformation Task Force Charter
 - Goals
 - Ground Rules
- Key Questions Focus
- TF Meeting Schedule
- Recommendation for Steering Committee
 - Standards for AMH recognition

Practice Transformation Models & AMH Recognition

- AMH Standards
- CPCi model
 - Provider perspective
 - Payer perspective
- SIM AMH Alignment
- Readiness Assessment
- Milestones
- Specific stratification details/Levels
- Recognition for completion

Provider Recruitment Processes

- # practices
- # providers
- Regions??
- Level of advancement
- Application process

Glide Path/LC/ TTA

- Glide path
 - Services provided
 - Requirements
 - Time frame
- Learning Collaborative
 - Services provided
 - Requirements
- TTA
 - Services provided
 - Requirements

Next Steps

- Summary
- Final Decisions

Care Management Ad Hoc Groups: (suggested)

- Behavioral Health
 - Med Management
 - Oral Health
-
- Self-Management
 - Care experience
 - Care Coordination

Agenda

Introductions



SIM Background



Practice Transformation Task Force Charter



Key Questions Focus



TF Meeting Schedule

Key Question – Single Standard & National Recognition

Steering Co Request

- Should Connecticut adopt a single existing national standard (e.g., NCQA) for the AMH Glide Path and require national accreditation or recognition?

What is the current AMH strategy?

Strategy

- Recruit and enroll practices in Glide Path
- Facilitate transformation through on-site and telephonic Practice Transformation Support
- Supplemented by Learning Collaborative
- Track practice transformation – accountability for meeting milestones
- Help practices meet milestones & achieve transformation (teach and demonstrate)
- Commitment to ongoing learning and collaboration
- Multiple waves of enrollment

What are the Potential Medical Home Core Functions and Accountability Milestones?

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

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

Practice Transformation

Based on work of Bodenheimer, Wagner, CPC Initiative

Practice Transformation Elements	National Medical Home	CPCI
Whole-Person Centered Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence-Based Clinical Decisions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Care Coordination (post-visit and referral follow-up)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Expand Access to Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Team-Based Care Delivery	<input checked="" type="checkbox"/> Teamlets	<input checked="" type="checkbox"/> Dynamic/expanded teams; "Share the care"/demand capacity
Clinical Quality and Performance Metrics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Optimal Use of HIT: EMR, E-Rx, Patient Portal, E-consults	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Leadership Commitment (culture change, continuous QI)		<input checked="" type="checkbox"/>
Consumer Engagement		<input checked="" type="checkbox"/>
Care Experience (patient/family advisory councils, survey)	NCQA 2014	<input checked="" type="checkbox"/>
Continuity of Care (across settings and providers: care transitions, non-visit based encounters)		<input checked="" type="checkbox"/>
Shared Decision-Making	NCQA 2014	<input checked="" type="checkbox"/>
Risk-Stratification/Targeted Care Management Strategies Integrated Behavioral Health, Med Management, Self-Management for Chronic Diseases	NCQA 2014 Partial	<input checked="" type="checkbox"/>
Population Health Management	NCQA 2014	<input checked="" type="checkbox"/>
Payment Blend (FFS, Risk-adjusted PMPM, Shared Savings)	<input checked="" type="checkbox"/> Partial	<input checked="" type="checkbox"/> Full
Multi-payer Commitment		<input checked="" type="checkbox"/>
Transformation Accountability Milestones		<input checked="" type="checkbox"/>
Learning Collaborative		<input checked="" type="checkbox"/>
Provider experience	NCQA 2014	<input checked="" type="checkbox"/>

Recognition Programs

	NCQA PCMH	Massachusetts PCMH	Oregon PCPCH
Core Measures	6 (Patient-Centered Access; Team-Based Care; Population Health Management; Care management and Support; Care Coordination and Transitions; Performance Measurement and QI)	6 (Care Coordination; Enhanced Access & Communication; Integrated Clinical Care Management; Population Health Management; Performance Management; Resource Stewardship)	6 (Access to Care; Accountability; Comprehensive Whole Person Care; Continuity; Coordination and Integration; Person and Family Centered Care)
Criteria	27 (100 points)	45 (45 points)	67 (550 points)
Must Pass Measures	6	15	10
Tiers	3	3	3
Site Visit	No	Yes	Yes
Payment Reform/Multipayer	No	Yes	Yes
Practice Cost	\$	Free	Free

Rationale for AMH over NCQA

- Evolving process
- State driven
- Best of breed approach
- Flexibility
- Focus on specific elements and goals
- Common standards for payers
- Clear accountability measures

Alternate NCQA Approach

- Require that practices obtain NCQA PCMH recognition
- Nationally standardized process with technical support from NCQA
- Possibility for add-on criteria
- 80% medical home market share
- Recently updated and improved standards

Information

Provided:

- PCPCC - Medical Home Report
- MGMA - Recognition Comparison
- NEJM – Accelerating Primary Care

What additional information do you need to make an informed decision?

Discussion for SIM Steering Committee Recommendation

	Advantages	Disadvantages
Requiring (NCQA)		
CT AMH: CT specific selected standards from best available national standards		

Agenda

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SIM Background



Practice Transformation Task Force Charter



Key Questions Focus



TF Meeting Schedule

Meeting Schedule

