Connecticut State Innovation Model

STATE OF CONNECTICUT

Proposed Health Equity Features of SIM Design

Primary Care Transformation

MODIFIED WORDING
Connecticut's Advanced Medical Home Model

Core Elements

- Whole-person centered care
- Enhanced access
- Population health management
- Team-based coordinated care
- Evidence-informed clinical decision making

OUR ASPIRATIONS

- Better health for all
- Improved quality and consumer experience
- Eliminate health disparities
- Reduced costs and improved affordability

ENABLING INITIATIVES

- Performance transparency
- Consumer empowerment
- Health information technology
- Value-based payment
- Workforce development

Advanced Medical Home – Core Elements

	Prioritized interventions
1 Whole-person-centered care	▪ Assess whole person and family to identify strengths and capacities, risk factors[1], behavioral health, oral health and other co-occurring conditions, and ability to self-manage care ▪ Use assessment to develop and implement person-centered care plan and shared decision making tools ▪ Collect and maintain accurate and reliable demographic data, including race, ethnicity, and primary language, to monitor health equity and outcomes and to inform service delivery

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

Advanced Medical Home – Core Elements

2 Enhanced access to care (structural and cultural)

Prioritized interventions

- Improve access to primary care through
  - a) extended hours (evenings/weekends)
  - b) convenient, timely appointment availability including same day (advanced) access
  - c) non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance specialty care access through non-visit-based consultations: e.g., e-Consult
- Raise consumer awareness regarding most appropriate options for accessing care to meet routine and urgent health needs
- Ensure practitioner cultural responsiveness, including collecting and disclosing provider demographic information, such as race/ethnicity and languages spoken fluently

Advanced Medical Home – Core Elements

2 Enhanced access to care (structural and cultural)

Prioritized interventions

Expand communication and language assistance

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Advanced Medical Home – Core Elements

2 Population health management

Prioritized interventions

- Collect and analyze health data about patient population
- Gain insight into health patterns and improvement opportunities for particular patient sub-populations (including those defined by health risk, condition, race, ethnicity, primary language and other demographic data)
  - Aggregate de-identified data with State and payers to facilitate analyses, reporting and intervention
- Apply these insights strategically in the continuous improvement of care delivery processes.
- Translate population health trends and statistics to individual patients
- Maintain a disease registry

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

Advanced Medical Home – Core Elements

4 Team-based, coordinated care

Prioritized interventions

- Provide team-based care from a prepared, proactive, and diverse team
- Integrate community, oral, and behavioral health with primary care with “warm hand-offs”, particularly between behavioral health and primary care practitioners (on-site if possible)
- Develop and execute against a whole-person-centered care plan
- Coordinate across all elements of a consumer’s care and support needs
- Promote inclusion of community health workers as team members to allow health care team to be more easily “tuned” for sub-populations served by a particular care delivery system

Advanced Medical Home – Core Elements

5 Evidence-informed clinical decision making

Prioritized interventions

- Apply clinical evidence and health economic data to target care and interventions to those for whom they will be most effective
- Integrate disparity-specific recommendations from expert guidelines, comparative effectiveness research and community based participatory research
- Leverage tools at the point of care to include the most up-to-date clinical evidence
- Promote new methods for rapid adoption and application of evidence at the point of care

Community Health Improvement

Certified Community-Based Entities

Certified Community-Based Entities are local organizations that have been designated by the state to support local primary care practices with a specified package of evidence-based, primarily preventive, community services.

- Provide one-stop shopping for high 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.

Certified Community-Based Entity
Illustrative Core Services

- Asthma Home Environmental Assessments (putting on AIRS)
- Diabetes Prevention Program (DPP)
- Chronic Disease Self-Management Programs
- Falls Prevention Program
- Core Services foundational framework includes: DPH's State Health Assessment, CDC's four-domain framework on chronic disease prevention and health promotion, proven effectiveness, reduction of health disparities and return on investment potential.

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Enabling Initiatives

Performance Transparency

- Collection, integration, analysis and dissemination of data for performance reporting on health, health care quality and cost
- Analyze and report Statewide performance metrics to demonstrate improvement over time
- Track AMH performance on quality, care experience, and equity measures on common scorecard. For use by payers to determine whether providers qualify for value-based incentive payments
- Track broader array of providers on quality, outcome and cost measure for use by consumers and providers in deciding where and from whom to obtain services
- Establish rapid cycle analysis of quality and consumer experience data to support continuous improvement

Performance Transparency

- Statewide and provider specific health, healthcare quality and care experience metrics will be analyzed by race, ethnicity, primary language and other demographic data in order to—
  - Identify and address gaps,
  - Monitor and report the effectiveness of efforts to close gaps, and
  - reward providers for doing so.

Performance Transparency

- Performance metrics across the various domains for disparity populations would align with measures used in national/federal initiatives, including the following—
  - HHS' Action Plan to Reduce Racial and Ethnic Disparities in Care
  - AHRQ's National Healthcare Disparities Report
  - Healthy People 2020 Leading Health Indicators
  - NQF's 2012 endorsed measures for language services and the Communication Assessment Tool

Consumer Empowerment

Consumers will benefit from the following:

- Secure sharing of health data on consumer portal
- Self-management programs
- Shared decision making tools
- Provider quality and cost performance to inform consumer choices
- Community engagement through the certified community-based entity
- Value-based Insurance Design
- Incentives for positive health behavior

Health Information Technology

Addressing the special needs of safety net providers will require IT systems that are able to do the following:

- Accommodate complex caseloads, particularly with respect to advanced clinical decision support and integration of tools for patient outreach.
- Accurately capture demographic information, including race, ethnicity and language, to facilitate reporting and analyses [in accordance with Meaningful Use requirements]
- Target underserved communities with consumer applications customized for diverse populations, including cultural appropriateness and health/technological literacy.
- Ensure the security and privacy of personal health information

Value-Based Payment

- Pay-for-performance (P4P)
  - Financial rewards for providers that meet quality and care experience targets, including those for disparity populations
  - Available to providers on the Glide Path[1]
  - Provides experience necessary for success with shared savings program
  - Must have 500+ attributed consumers

[1]Provider groups with sufficient attributed consumers may elect to negotiate a shared savings program arrangement with individual payers in advance of achieving AMH status.

Value-Based Payment

- Shared Savings Program
  - Share in savings if provider meets quality and care experience targets, including those for disparity populations
  - Payer and providers negotiate whether to share in losses
  - Practices have met initial quality metrics and progressing on AMH standards
  - 5,000+ attributed consumers

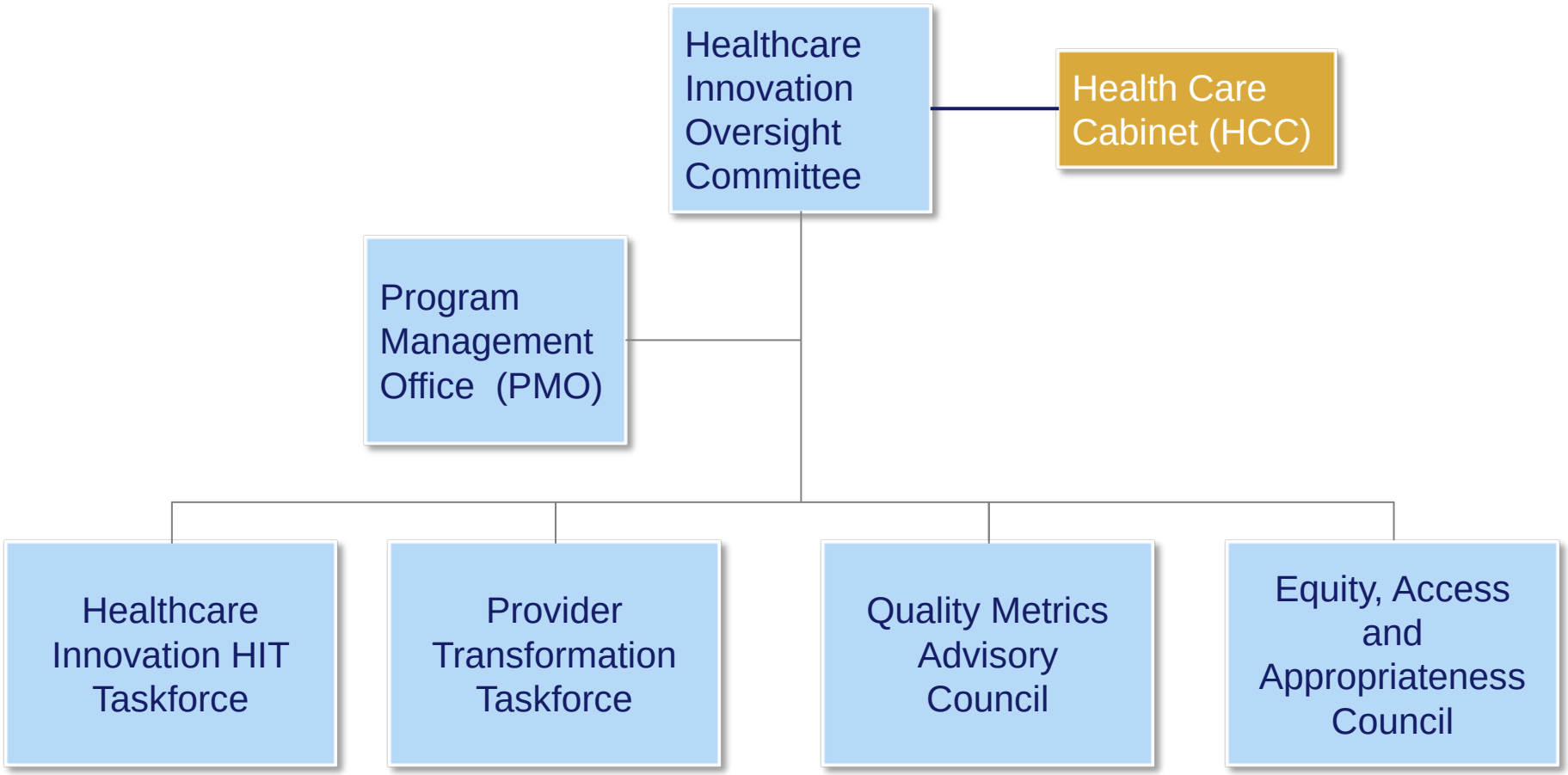
Workforce Development

- Improved health workforce data collection and analyses, stratified by race, ethnicity and other demographic data
- Connecticut Service Track: inter-professional training for team & population health approaches to health services
- Investment in workforce diversity initiatives across the educational pipeline
- Training program and certification standards for Community Health Workers and interpreters
- Development of core STEM curricula for baccalaureate degrees in the health field, and career ladders and career flexibility through comprehensive articulation agreements among schools that train health care professionals and allied health professionals

Governance and Operating Model

Advanced Medical Home – Governance model

PRELIMINARY



- AMH standards
- Practice transformation support

- Core process, outcome & care experience metrics
- Minimum standards

- Risk avoidance
- Underservice
- Appropriate practice for rare or uncommon conditions

Quality Metrics Advisory Council

- Provider Quality and Care Experience Metrics
  - Process (e.g., HBA1C)
  - Outcome (e.g, fewer hospitals stays for ambulatory care sensitive conditions)
  - Care experience
  - Health equity (previously described)

Equity Access & Appropriateness Council

- Medicare/Medicaid/private payers – dedicated divisions focused on risks inherent to volume based payment
- Special SIM council – focus on methods for identifying and addressing concerns related to payment reforms that reward economy and efficiency, such as
  - Avoiding or inappropriately discharging higher risk clients
  - Systematic underuse/misuse/overuse (e.g., tests, procedures)
  - Appropriate care for rare or uncommon conditions