Practice Transformation Standards and Quality Measure Comparison

Presentation to the Consumer Advisory Board

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SIM connecticut state innovation model

SIM Aims

Healthier People and Communities and Improved Health Equity

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

Better Care and Improved Health Equity

Improve performance on key quality measures, including preventative care and care experience

Smarter Spending

Achieve a 1-2% reduction in the annual rate of healthcare growth

CT SIM: Primary Drivers to achieve Our Aims

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$5.8M

Population Health

$8.8M

Payment Reform

$13.5M

Transform Care Delivery

$650K

Empower Consumers

Health Information Technology $10M

Evaluation $3.5M

CT SIM: Primary and Secondary Drivers to achieve Aims

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Population Health Plan

- Health Enhancement Communities
- Prevention Service Centers
- Community Health Measures

Transform Care Delivery

- Community & Clinical Integration Program
- Advanced Medical Home
- Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

- Medicare SSP
- Commercial SSP
- Medicaid PCMH+
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

CT SIM: Primary and Secondary Drivers to achieve Aims

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- **Quality Measure Alignment**

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Aligning Quality Measures & Promoting Meaningful Measures

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Problem:

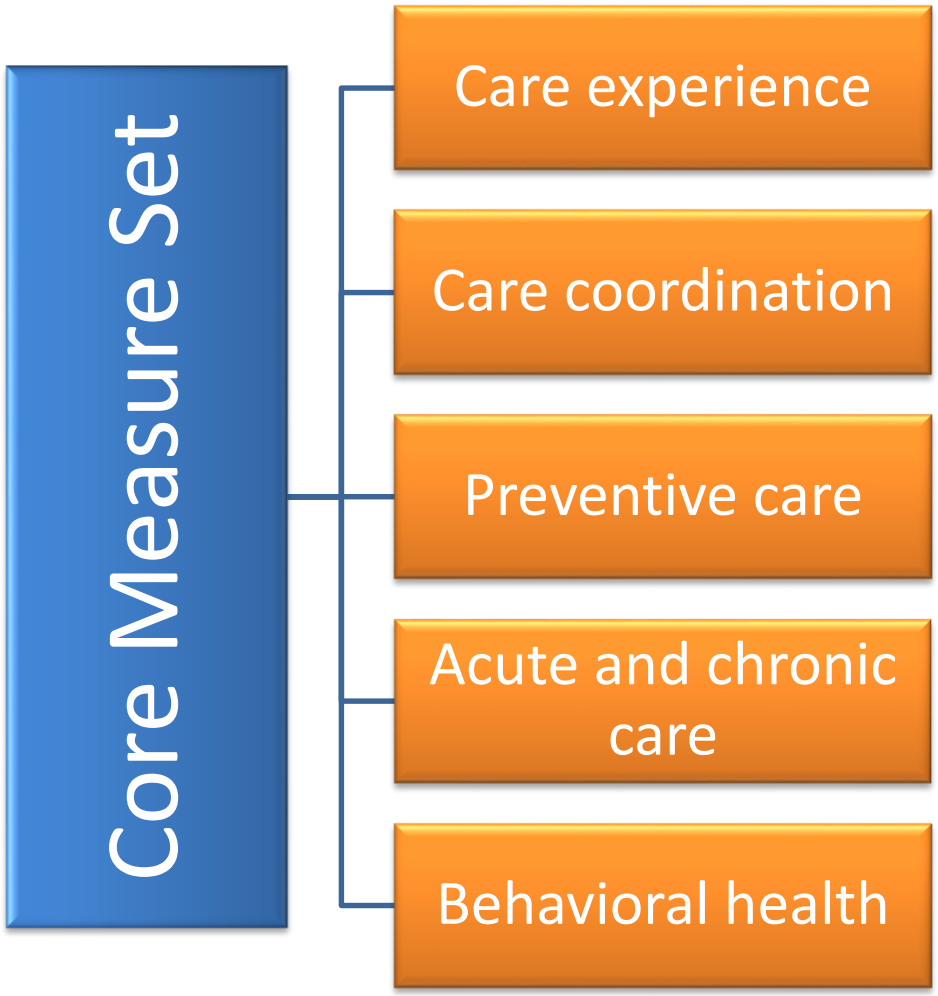
1. Too many measures
2. Little alignment on measures
3. Focus is on process rather than outcomes

Burdensome and ineffective for quality improvement efforts of doctors and performance transparency for consumers

SIM Quality Measure Alignment Initiative:

Work with payers to promote alignment across measures used in Alternative Payment Models in Connecticut

Quality Measure Alignment



QC Provisional Core Measure Set

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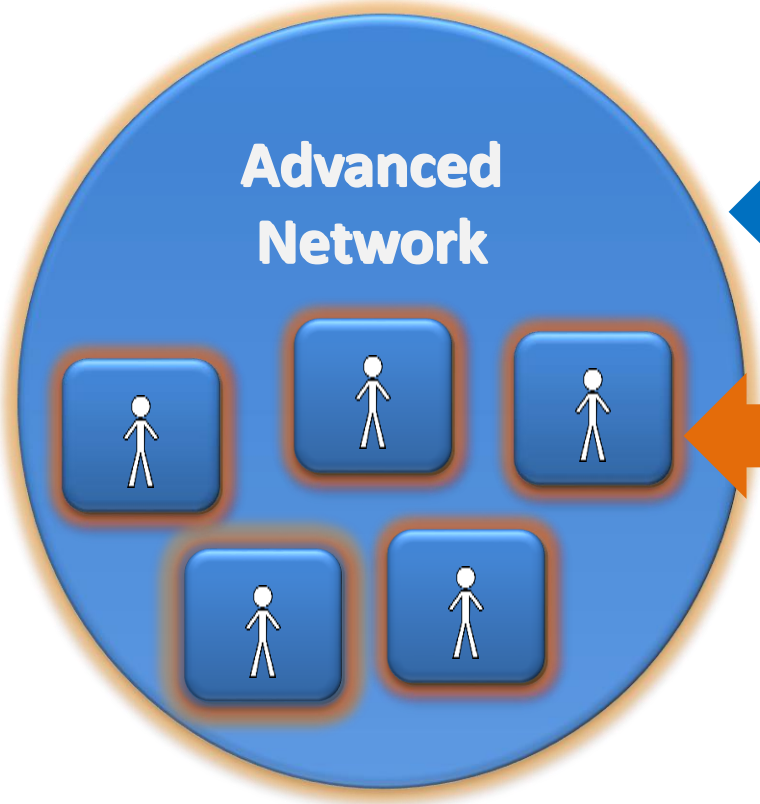
Consumer Engagement
PCMH - CAHPS care experience measure
Care Coordination
Plan all-cause readmission
Annual monitoring for persistent medications
Prevention
Breast cancer screening
Cervical cancer screening
Chlamydia screening in women
Colorectal cancer screening
Adolescent female immunizations HPV
Weight assessment and counseling for nutrition and physical activity for children/adolescents
BMI screening and follow up
Developmental screening in first 3 years of life
Well-child visits in the first 15 months of life
Adolescent well-care visits
Tobacco use screening and cessation intervention
Prenatal Care & Postpartum care
Screening for clinical depression and follow-up plan
Behavioral health screening (Medicaid only)

Acute & Chronic Care
Medication management for people w/ asthma
DM: Hemoglobin A1c Poor Control (>9%)
DM: HbA1c Testing
DM: Diabetes eye exam
DM: Diabetes: medical attention for nephropathy
HTN: Controlling high blood pressure
Use of imaging studies for low back pain
Avoidance of antibiotic treatment in adults with acute bronchitis
Appropriate treatment for children with upper respiratory infection
Behavioral Health
Follow-up for children prescribed ADHD medication
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only)
Depression Remission at 12 Twelve Months
Progress towards depression remission
Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment
Unhealthy Alcohol Use – Screening

Transforming Healthcare Delivery



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

Support for affiliated primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations

Community & Clinical Integration Program

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

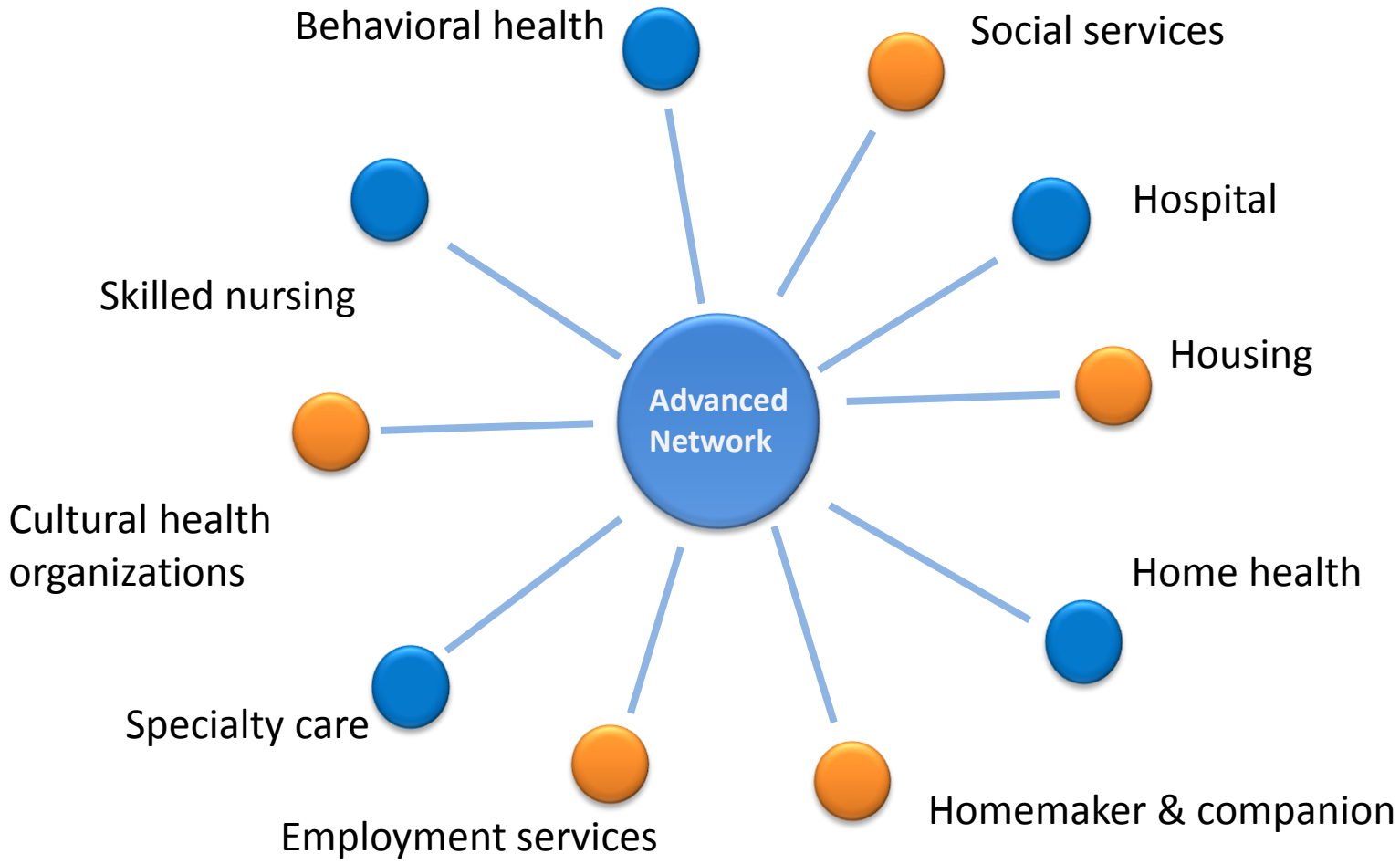
Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

CCIP emphasizes….



…coordination and communication with key clinical and community partners

Addressing the Needs of Individuals that Care Teams Serve

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Attitudes, values, beliefs
Challenging life events
Behavioral health and physical health needs
Personal goals for care

Understanding the whole person

Exchanging health information

Patient as part of the medical home team

Expanding the care team

Linking to community supports

Using data to guide improvement

Using innovative care delivery models and tools

Health Coach
Patient Navigator
Behavioral Health Counselor
Nutritionist
and more…

Practice Transformation Standards and Quality Measures

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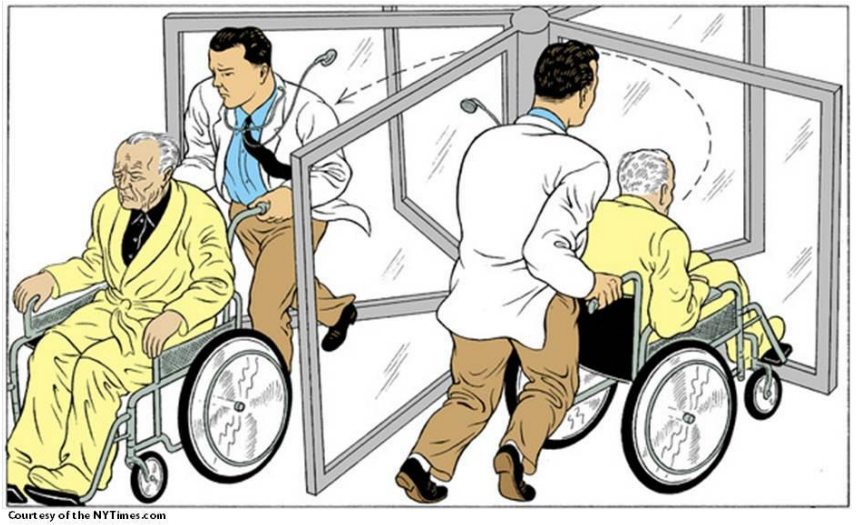
Core Measure Set

- Care experience
- Care coordination
- Preventive care
- Acute and chronic care
- Behavioral health

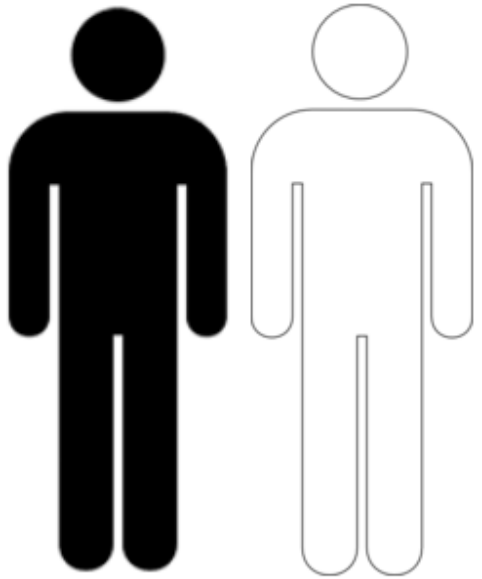
1 out of every 2 hospitalizations in the homeless population resulted in a 30-day hospital inpatient readmission

54% of readmissions occurred **within 1 week**

And **75% within 2 weeks**



Courtesy of the NYTimes.com



Practice Transformation Standards and Quality Measures

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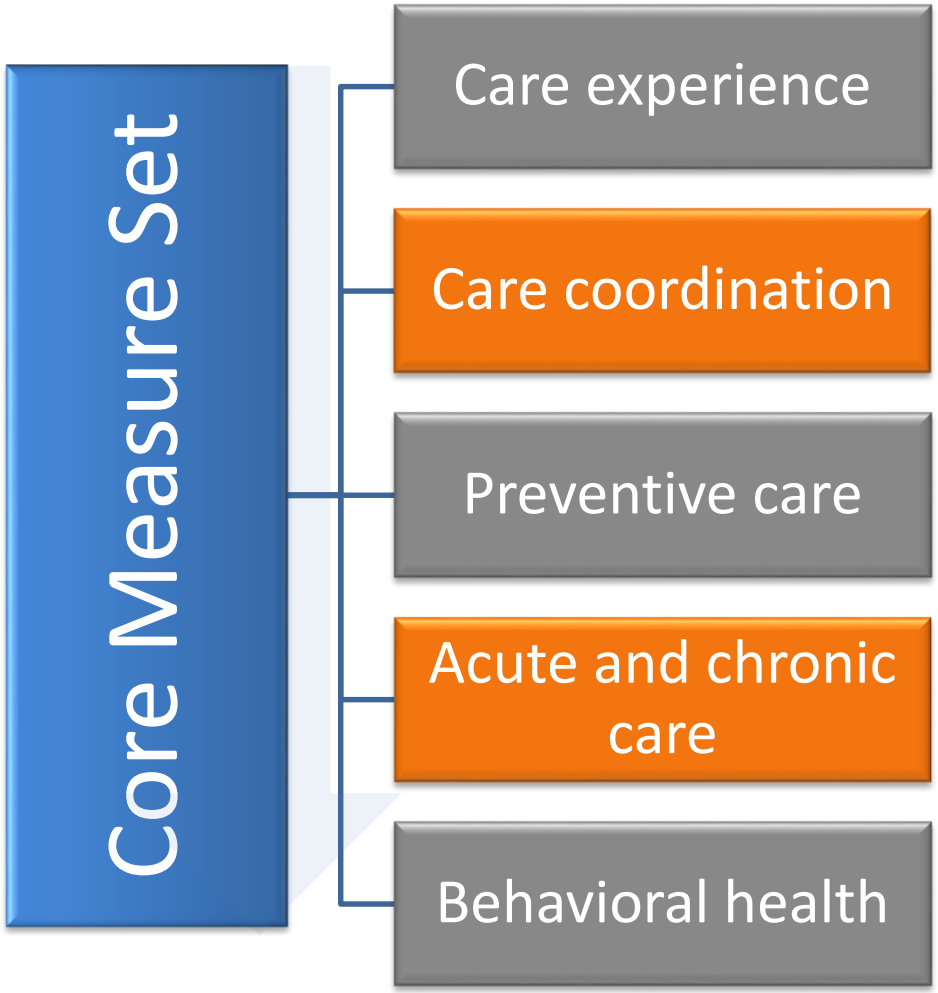

Practice Transformation Standards include comprehensive care management:

Identify
Individual with complex health care needs

Assessment, Care Team, Care Plan

Evaluate and improve intervention

"Tracking utilization (claims data), measures relevant to focus population's needs (i.e., complex individuals)…"

Practice Transformation Standards and Quality Measures

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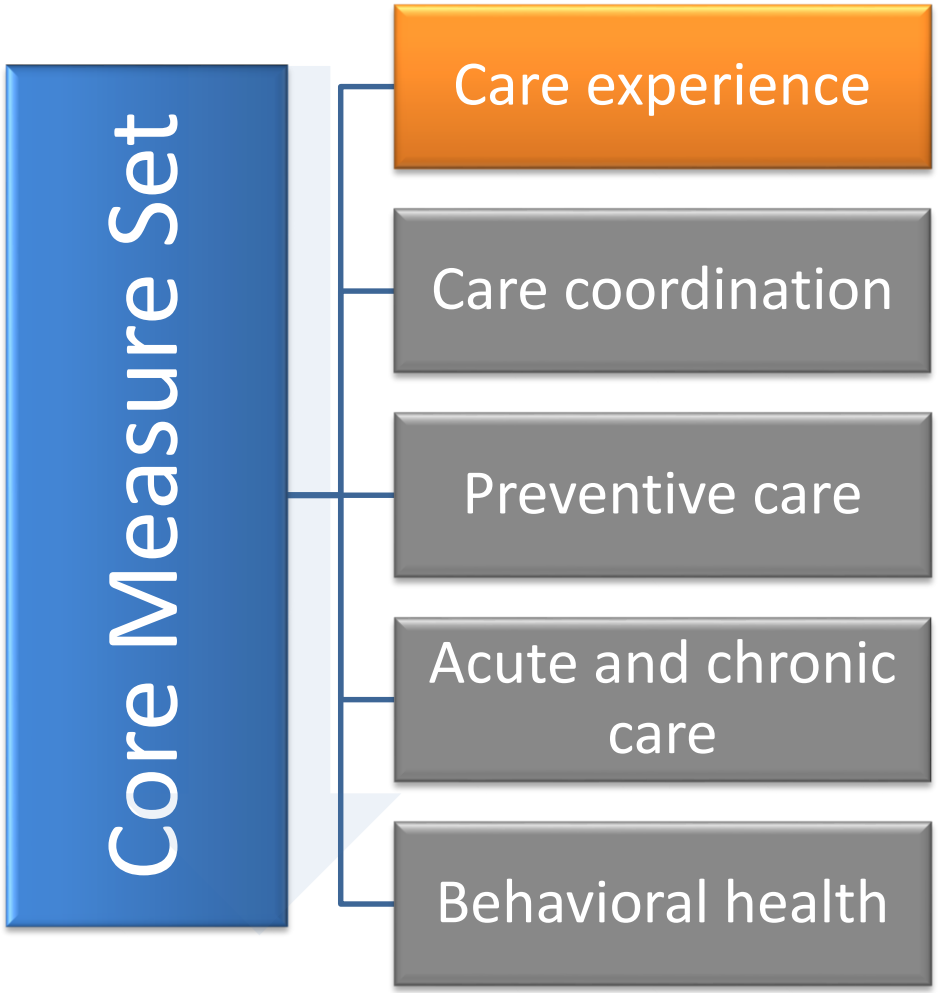
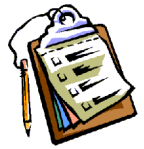


Practice Transformation Standards include:

Conduct Person-Centered **Assessment**

Establish Comprehensive **Care Team**

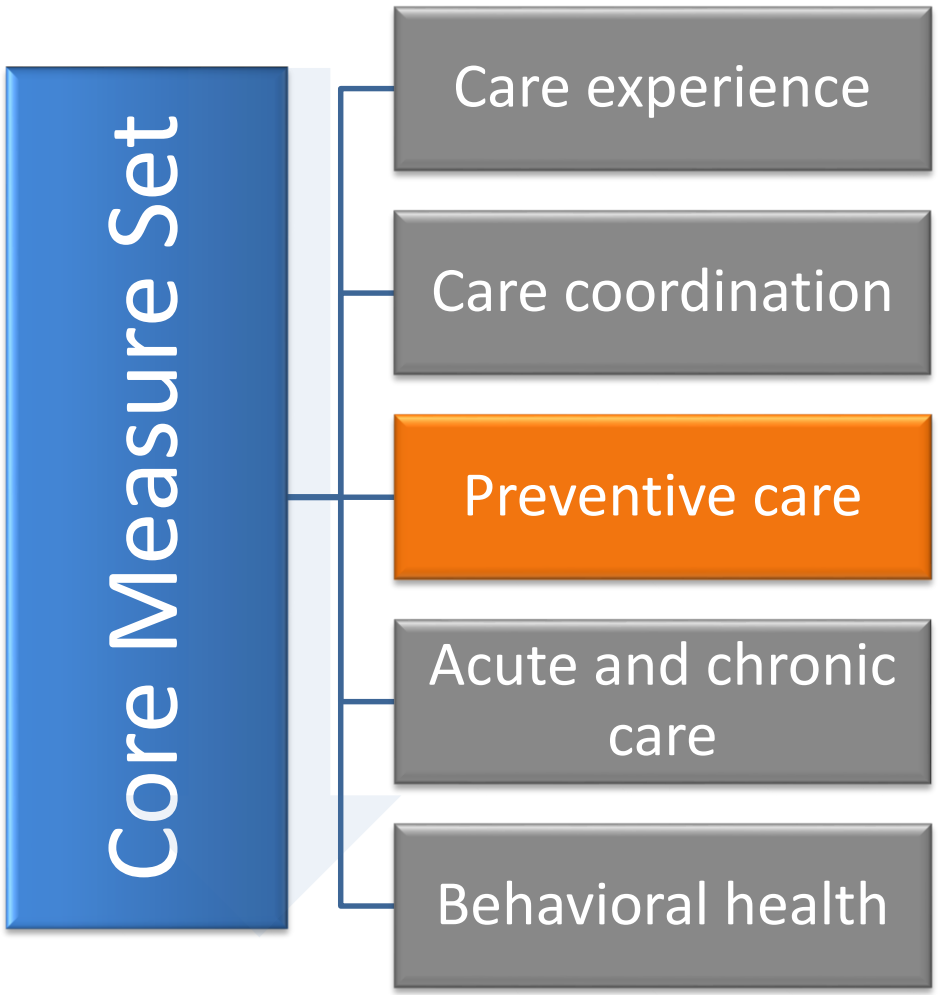


Develop Individualized **Care Plan**

Evaluate and improve intervention

"Care plan reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals…"

Practice Transformation Standards and Quality Measures



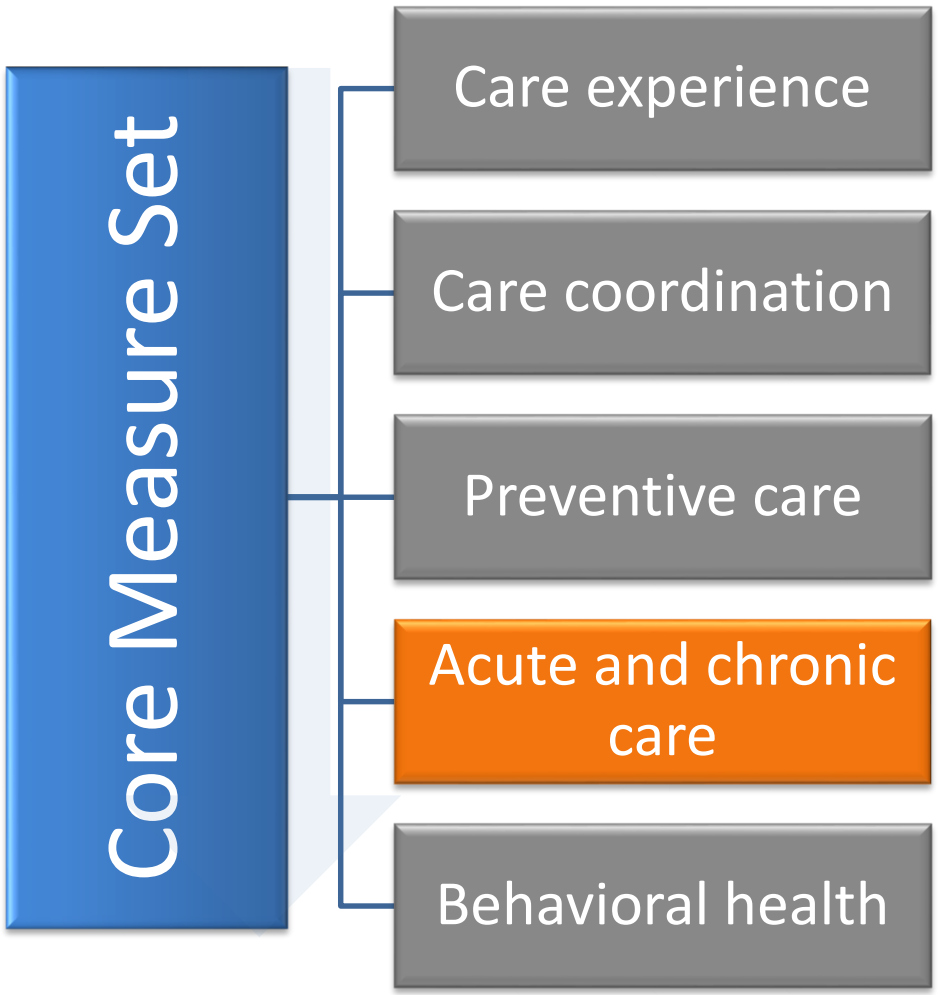
Practice Transformation Standards include health equity improvement:

Expand collection reporting and analysis of standardized data stratified by sub-population

Identify and prioritize opportunities to reduce a healthcare disparity

Evaluate whether the intervention was effective

Practice Transformation Standards and Quality Measures



Practice Transformation Standards include health equity improvement:

Implement a pilot intervention to address the identified disparity

Pilot must focus on one of three conditions: Diabetes, Hypertension, or Asthma

Establish a CHW capability

Identify individuals who will benefit from **CHW** support

Conduct a person-centered **needs assessment**

Create a person-centered self-care **management plan**

Practice Transformation Standards and Quality Measures

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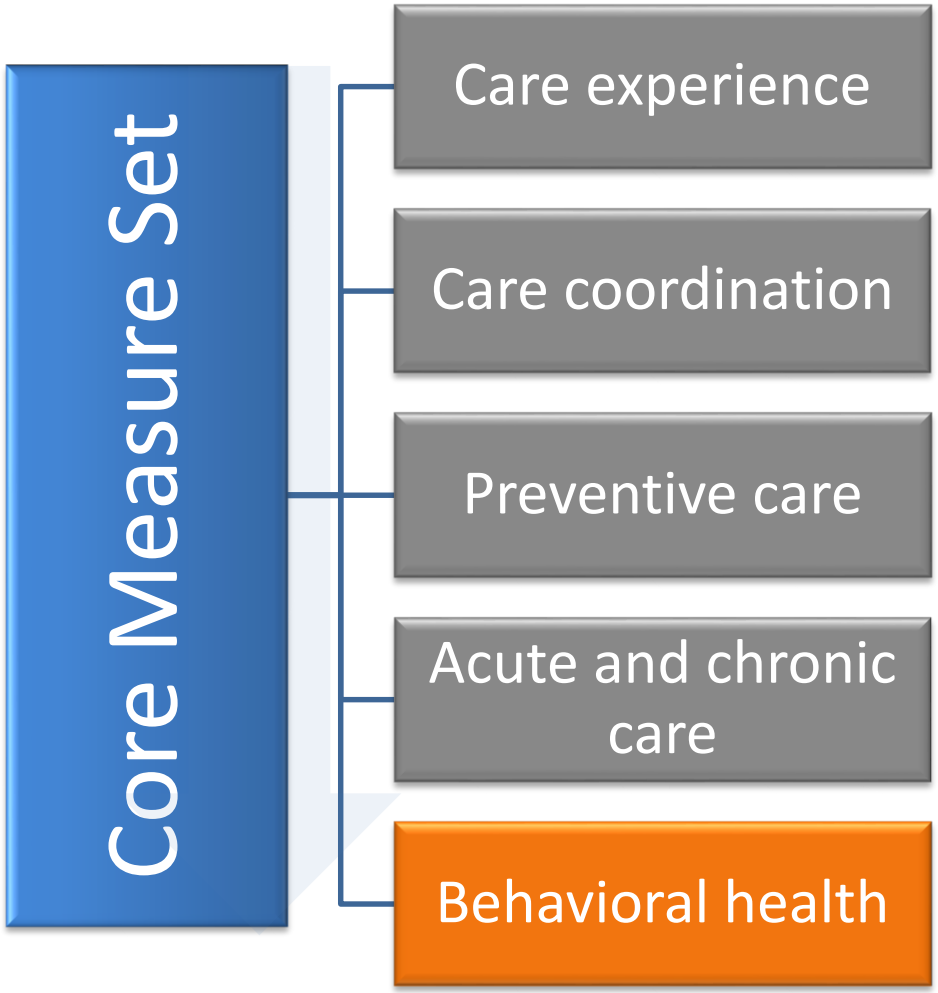

Practice Transformation Standards include behavioral health integration:

Identify individuals with behavioral health needs

Integrated (on-site) brief **assessment** and **treatment**

or

Behavioral health **referral** and treatment

Behavioral health coordination with primary care source of referral

Track behavioral health outcomes/improvement for identified individuals