Issue Brief #4 – Strategy for Advancing Care Delivery in Primary Care Practices and Advanced Groups and Networks

As previously described in Issue Brief #3, the Innovation Plan proposes to establish a SIM glide path program in which small to mid-size physician practices are provided with practice transformation support services to become an Advanced Medical Home (AMH). Our glide path program specifically targets practices that are not affiliated with medical groups, clinically integrated networks, health systems, or Federally Qualified Health Centers (FQHC) that have already achieved or are working toward advanced primary care.

Currently, there are approximately twelve advanced medical groups, networks, or systems (hereafter "advanced networks") and they are in or pursuing shared savings program arrangements with one or more payers, including Medicare.[1] These systems appear to include more than half of Connecticut's primary care physicians and that number is growing. In addition, there are 14 FQHCs, all of which will be medical home recognized or accredited before the implementation of SIM.

Our Plan did not propose to extend practice level transformation support beyond the glide path program aimed at small to mid-size practices, as most providers employed by or affiliated with advanced networks are already positioned with internal resources and payment incentives to support raising the standard of care for their practices. However, in light of market shifts and the increasing proportion of both providers and patients affiliated with advanced networks in Connecticut, as well as what we've learned from other SIM test grant states, an approach to supporting advanced networks warrants further consideration.

This issue brief explores how our Plan could be modified to include one or both of the following:

1. Establish additional expectations for advanced networks and FQHCs over and above our core AMH standards,

2. Allocate SIM test grant dollars to provide support to these advanced networks and FQHCs.

<u>Current Plan and Statement of the Issue</u>

Our AMH model is focused on developing core capabilities in small to mid-sized practices. In the first couple of years of transformation, these practices are unlikely to adopt elements of our AMH model that require a mature advanced practice environment or greater scale and

[1]Note that the shared savings arrangements large systems enter into, such as with Medicare, do not necessarily include all practices or clinics affiliated with the system, such as safety net clinics.

infrastructure. For example, the integration of a diverse, multi-function care team including practice- and community-based partners is unlikely to be a near term capability for most of the providers on our glide path.

Clinical integration among primary care, specialty care, hospital, ambulatory surgery, post-acute rehab and home health services is likely only to be achieved by better resourced advanced networks. This may also be true for advanced analytics and sophisticated continuous quality improvement processes. Recognizing this, both NCQA and URAC[2] have developed an accreditation process that specifically targets higher order clinical integration and care delivery capabilities in advanced networks. This accreditation process establishes expectations that apply to the overall enterprise, and also assesses whether most of the participating primary care practices are engaged in advanced primary care.

These new accreditation models are targeted to Accountable Care Organizations and other advanced systems. While they appear to effectively cover clinical integration activities, they do not emphasize *community integration*. By community integration, we are referring to linkages with key long term support service partners (e.g., case management agencies and homemaker and companion providers), social services, health departments, schools and essential community supports such as housing and food service providers.

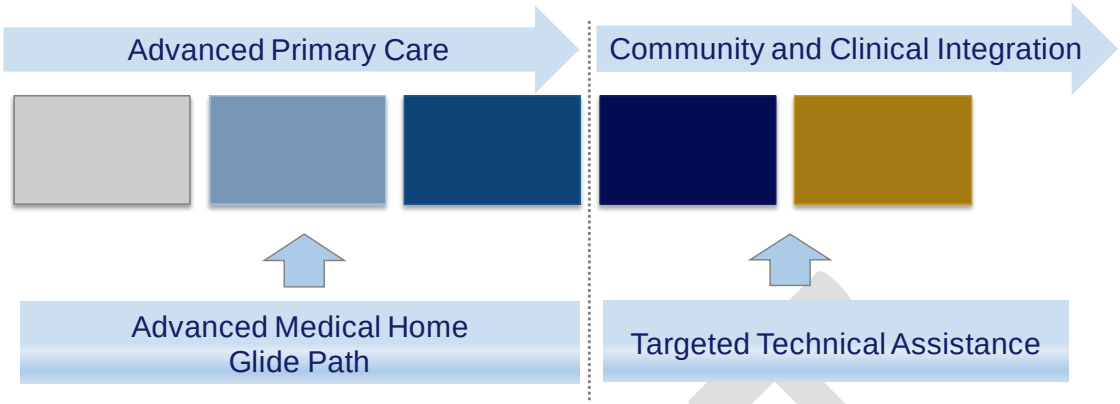
By omitting from our Plan a strategy specifically targeted to advanced networks and FQHCs, we fail to capitalize on our vision to more effectively serve those individuals with the most significant care needs; individuals who are also challenged with limited income, unstable housing, food insecurity, personal safety, and isolation—what we commonly refer to as the social determinants of health. This gap may also substantially reduce the competitiveness of our test grant application. In our review of SIM test grant and design grant plans, we found that community integration is a strategy that figures centrally in the plans of most states.

Proposed Adaptation of the Practice Transformation Model

We propose to extend our primary care transformation model from advanced primary care (i.e., AMH glide path) to community and clinical integration. With this broader focus we would expand our practice transformation support strategy to encompass targeted technical assistance focused on the development of capabilities that support community and clinical integration in advanced networks and FQHCs (see figure 1).

[2] An independent, nonprofit organization and leader in promoting health care quality through its accreditation, education, and measurement programs (http://www.urac.org)

Figure 1



Targeted technical assistance could cover a range of capabilities based on a survey of advanced networks and FQHCs or otherwise identified gaps in community and clinical integration. Options could include:

- Direct messaging: integrating Direct into practice and extending Direct to community partners
- Integrated care with long term support and service providers
- Fostering community linkages with social service and preventive health providers
- Community care team and related "hot spotting" models of integrated care
- Integrating e-consultation
- Integrated care processes for managing special conditions (e.g., chronic pain, sickle cell)
- Understanding and closing health equity gaps

Although the targeted technical assistance could be conducted as a Learning Collaborative involving multiple networks, the model could also work as a competitive process in which only a few would be selected and provided with more individualized support. This could be coupled with Innovation Grants for advanced networks and FQHCs that are seeking support in implementing more innovative community integration solutions (e.g., integrating smart phone technology in the care of chronic conditions or high risk patients).

All Connecticut residents could potentially benefit from community and clinical integration capabilities; however, Medicare and Medicaid beneficiaries are among those who would benefit the most from this extension beyond primary care transformation. Supporting advanced networks and FQHCs with technical assistance for community and clinical integration creates a natural conceptual bridge in our innovation model, advancing coordinated care delivery to community and clinical integration and ultimately to health enhancement communities. Moreover, this support leverages a greater number of early adopters of advanced care with demonstrated readiness for change to impact our model's stated aims.