



Connecticut Healthcare Innovation Plan

State Innovation Model Initiative

STATE OF CONNECTICUT

*Presentation to the Healthcare Innovation Steering
Committee*

April 24, 2014

Revised Work Group Charters

- + Edits were made to the Charters and they were redistributed to the Steering Committee
- + Primary remaining issue is with the Equity and Access Council Charter
- + Draft for discussion
 - + Eliminated “intentional”
 - + Placeholder substitution “systematic or planned”
 - + Considered but do not recommend “evidence-based”
 - + Add statement that it is not necessary to prove intent

Equity and Access Charter (partial)

Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. Under-service refers to **systematic or repeated** failure of a provider to offer **[evidence-based]** medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. **A finding of failure shall not require proof of intentionality or a plan.**

Issue Brief #4: Strategy for Advancing Care Delivery in Primary Care Practices and Advanced Networks and FQHCs

Terminology

- + Integrated delivery systems
- + Large medical groups
- + Clinically Integrated Network
- + Federally Qualified Health Center (FQHC)
- + Independent Practice Associations
- + Small to mid-size practices (unaffiliated)

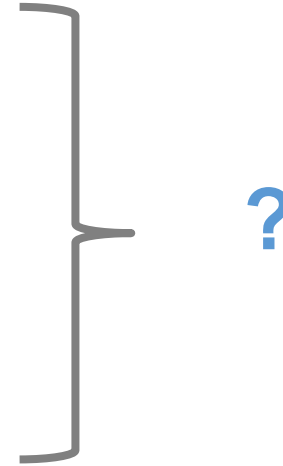


**Advanced
Network***

*Applies if most practices are moving toward medical home recognition

Current Approach

- + Integrated delivery systems
- + Large medical groups
- + Clinically Integrated Network
- + Federally Qualified Health Center (FQHC)



+ Independent Practice Associations



AMH?

+ Small to mid-size practices (unaffiliated)



AMH

Core Dimensions of Practice Transformation

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

- + Small to mid-size practices (primarily late adopters) will be
 - + limited in their ability to fully achieve the capabilities that correspond with our Core Dimensions
 - + gradual in their achievement of advanced primary care milestones during the three year test grant period
- + In turn, we will be limited in our ability to achieve our vision
- + Unless our strategy enables and incentivizes a higher standard of performance and continuous improvement in Connecticut's advanced networks and FQHCs

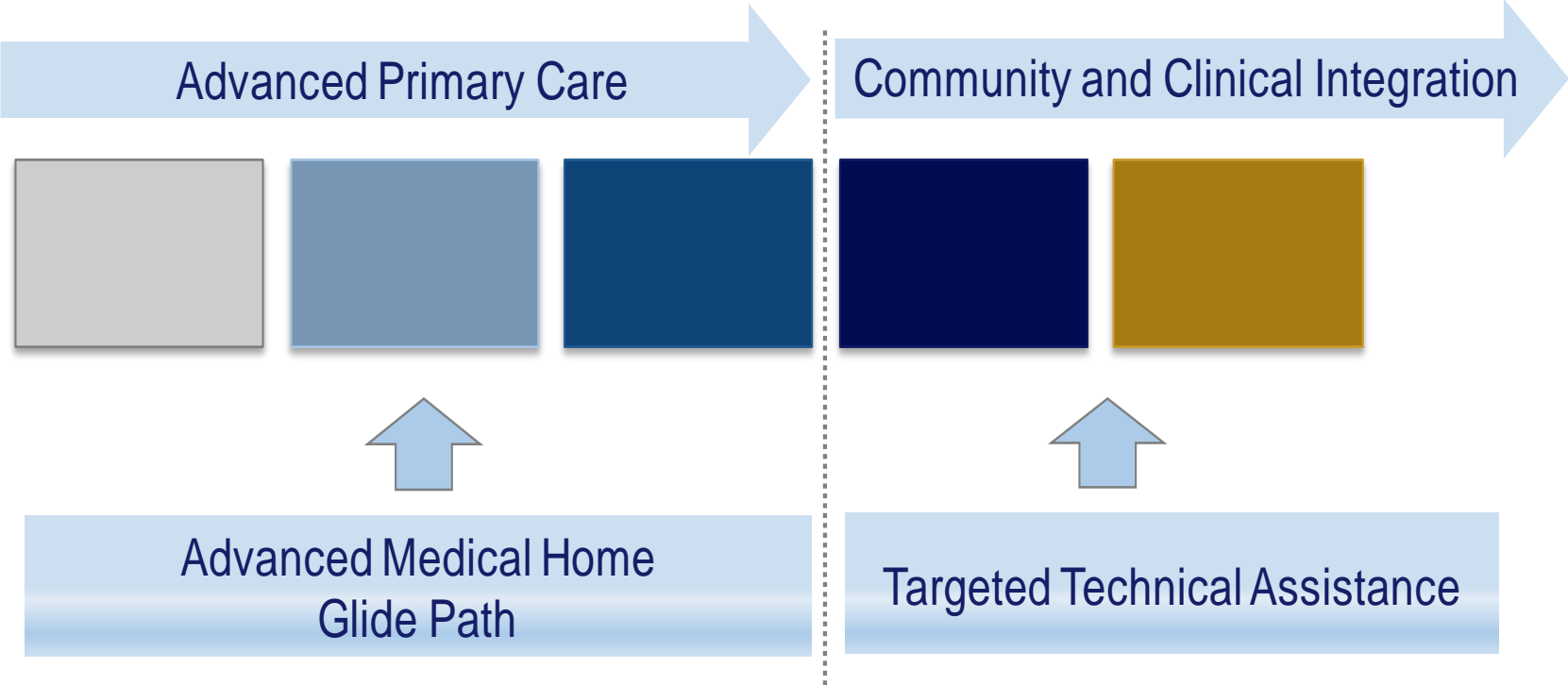
Advanced Networks and FQHCs

- + As it stands today, many advanced networks are working on:
 - + Using EHR and claims data to identify high risk consumers
 - + Integrating care coordinators into care teams
 - + Actively facilitating care transitions
 - + Resolving access issues by making better use of existing clinical capacity
 - + Undertaking advanced analytics to identify variations in practice within the network
 - + Educating and aligning clinicians around evidence based guidelines
 - + Exchanging information with clinical partners (specialists, hospitals, nursing facilities, home health, etc.)
 - + Other analytics to support continuous quality improvement

Should our plan....

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?

Proposed Extension of our Care Delivery Reforms



Community and Clinical Integration

- + Private health plans, self-funded employers and Medicare are driving improvements in clinical integration through shared savings program arrangements
- + In addition, NCQA and URAC have developed a higher level of recognition targeted to advanced networks that focus on clinical integration and use of data across the enterprise
- + These standards
 - + encompass, but move beyond, existing medical home standards
 - + could drive improvement if voluntarily pursued by Connecticut's advanced networks or are required by Connecticut's payers

Community and Clinical Integration

- + Private health plans and self-funded employers are less likely to drive:
 - + care team diversity (e.g., to include community health workers), and
 - + community integration (e.g., coordination with housing supports)
 - + Cultural and linguistic appropriateness standards (NCLAS)
- + Most of the benefits would accrue primarily to Medicaid and Medicare beneficiaries
- + Medicaid (and perhaps Medicare) would likely need to drive developments in these areas

Targeted Technical Assistance

- + Focus on a range of capabilities based on a survey of advanced networks and FQHCs,
- + Other identified gaps in community and clinical integration

Targeted Technical Assistance

- + For example:
 - + Direct messaging: integration & extension to community partners
 - + Integrating community health workers into care team
 - + Community linkages w/ social service and preventive health providers
 - + Community care teams & “hot spotting”
 - + Integrated care processes for managing special conditions (e.g., chronic pain, sickle cell)
 - + Cultural and linguistic appropriateness (NCLAS)
 - + Understanding and closing health equity gaps
 - + Integration with long term support and service providers

Delivery Model

Advanced Primary Care



small-med independent practices
physicians: 1,120 # patients: 1.4m

Community & Clinical Integration



Advanced networks, FQHCs and practice groups
physicians: 1,680 #patients: 2.1m

Advanced Medical Home Glide Path



HIT Adoption

- ONC-certified eHR
- eRx
- Secure Email

Care Coordination & Management Tools

- Shared Decision Making
- Referral Tracking and follow-up
- Chronic illness gaps, alerts
- Chronic illness self-management
 - Disease Registries
- Health Risk Stratification
- Care coordination

Structural Standards

- EHR
- Extended business hours
 - CLAS
 - Use of data

Analytics

- CQI Reporting

Targeted Technical Assistance

Innovation Grants?

+

Learning Collaboratives

Community Care Integration Approach

- Expanded care team w/Health Coaches & Patient Navigators
 - Home Visiting / Outreach
- Linkage to Prevention Service Centers & Health Depts
 - Community Care Teams / Hotspotter
- Linkage to Long Term Supports & Services
- Linkage to Housing and other Social Supports

Clinical integration and Advanced Care Management

- Provider access to electronic data
- Timely information exchange
- Monitoring practice patterns
- Clinician/provider detailing
 - Behavioral Health
 - Oral Health
- Medication therapy management
 - Expanded care registries
 - Home visits and monitoring
 - Process for care transitions
 - e-consults
 - Telemedicine

Structural Standards

- E.g., URAC, NCQA
- CLAS
- Consumer portal
- Personal health record
- Consumer decision aids

Analytics and Quality Improvement

- Integration and use of data
- Rapid Cycle CQI (quality, experience, cost)
 - Population health analysis
- Data to assess & improve disparities

Pay for Performance (P4P)

Pay for Performance (P4P) +
Advanced Payments for Care Coordination

Shared Savings Plan (SSP) +
Advanced Payments for Care Coordination, New Services & Non-Visit Based Activities and/or Shared Service Solution (e.g., insurer, ASO)

Payment Model

Cross-payer common quality performance scorecard, care experience inclusion in value based payment calculation

whole-person-centered, enhanced access, team-based coordination, evidence-based, population health

Issue Brief #3: Glide path administration

- + Innovation Plan proposed “glide path” program
- + Practices receive intensive support to develop new skills and capabilities
- + Achieve milestones along a 1 to 2 year process
- + Proposed program is modeled after the DSS Glide Path program

Issue Brief #3: Glide path administration

- + Option 1: Each payer could administer the glide path program independently. PMO would present the program and facilitate to linkage to each payers program.
 - + Pros – Lower cost to SIM Program Management Office
 - + Cons – Fragmentation; provider burden
- + Option 2: DSS modifies their current glide path program to serve as multi-payer single point of glide path enrollment
 - + Pros - Single front door would facilitate the engagement and enrollment; less burdensome providers; use of DSS infrastructure minimizes cost
 - + Cons – Supplants some existing payer infrastructure and potential reduction in control

Glide Path Flow Diagram

