Connecticut State Innovation Model

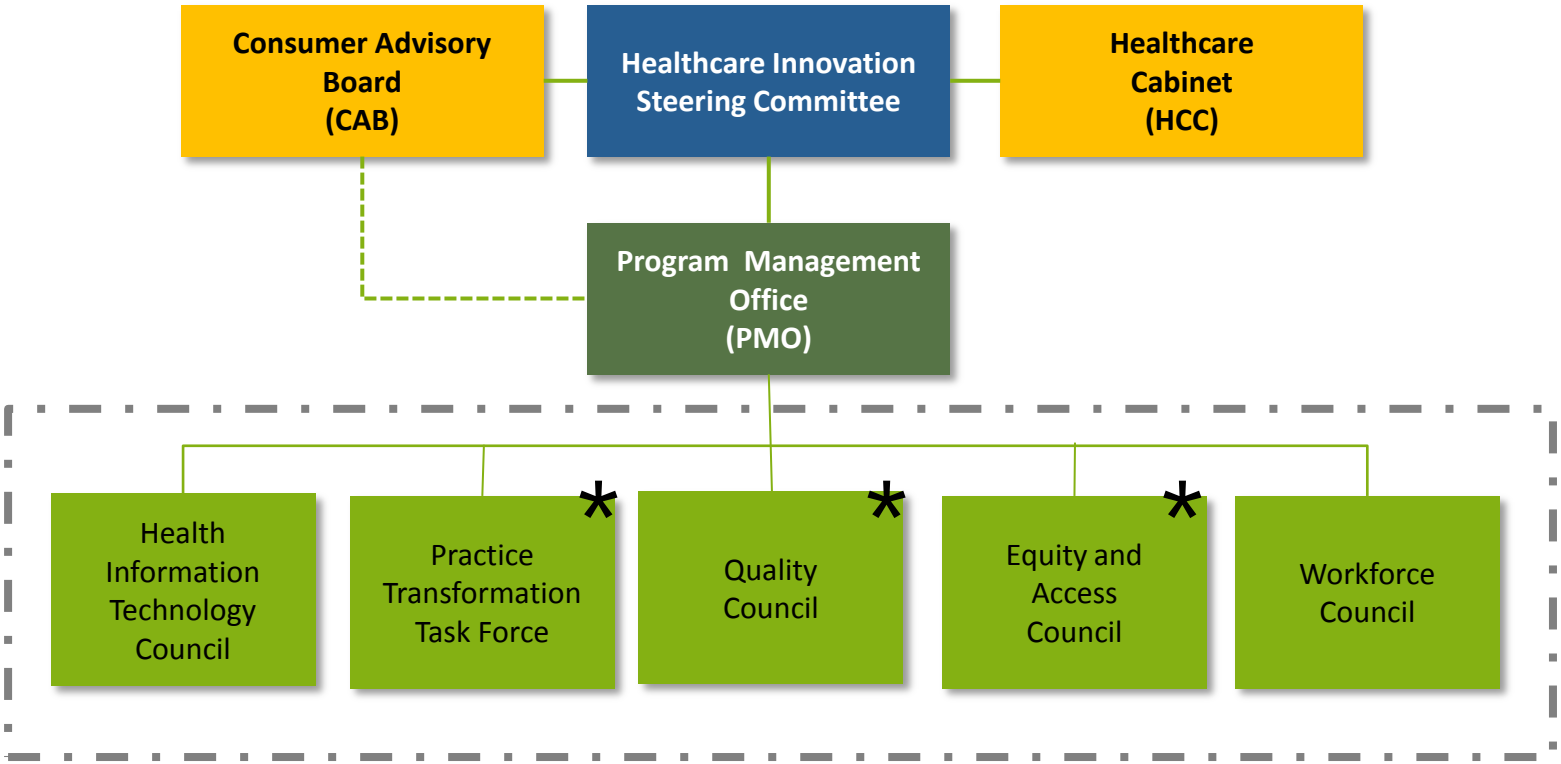
Workgroup **Charters**

Draft 2.0

SteerCo edits indicated by orange print

03/26/14

SIM WORKGROUPS



* Draft charters attached

COMPOSITION AND HIGH-LEVEL CRITERIA FOR WORKGROUP PARTICIPATION

	Composition	High-Level Criteria
Health Information Technology Council (Action Deferred)	▪ 3 consumers/advocates ▪ 2 physicians/CSMS ▪ 2 health plans ▪ 1 HIT coordinator ▪ 1 AHCT/APCD ▪ 1 hospital - 0 applications ▪ 1-2 ACO/clinically integrated network ▪ 8 DSS, DMHAS, DPH, DCF, DOC, OPM, BEST, OSC ▪ Proposal: solicit additional member via CHA ▪ Proposal: +1 ex-officio CAB liaison ▪ Proposal: Defer ACO/CIN reps	▪ Authority or ability to influence ▪ Technical expertise with provider and payer systems, health information technology and/or analytics
Practice Transformation Taskforce	▪ 4 consumers or advocates – Proposal: +2 consumers (total 6) ▪ 2 DSS, DMHAS ▪ 4 primary care/specialty providers inc APRN ▪ 1 behavioral health provider ▪ 1 FQHC ▪ 1 hospital ▪ 5 all health plans with >5% market share	▪ Authority or ability to influence ▪ Commitment to shared aspirations ▪ Direct experience with advanced primary care, clinical integration, practice transformation
Quality Council	▪ 4 consumers or advocates ▪ 3 physicians - Proposal: +3 physicians ▪ 1 hospital ▪ 1 FQHC ▪ 5 all health plans with >5% market share ▪ 4 DSS, DMHAS, DPH, OSC	▪ Authority or ability to influence ▪ Technical expertise and experience with measurement of health, quality, resource efficiency, and consumer experience
Equity and Access Council	▪ 6 consumers or advocates – Proposal: +1 ex-officio CAB liaison ▪ 2 DSS, DPH ▪ 1 Medicare – Medicare will not participate, Proposal: add OHA as co-chair ▪ 5 all health plans with >5% market share ▪ 3 physicians ▪ 1 hospital – 0 applicants, Proposal: reassign to 1 physician	▪ Commitment to appropriate care and access ▪ Experience with access & underservice issues ▪ Ability to understand claims-level data analysis ▪ Understanding of underserved populations
Workforce Council	under development	under development

PRACTICE TRANSFORMATION TASKFORCE

Role Description

Consumers & Advocates

- Provide input on aspects of practice transformation that affect consumer choice, literacy, care experience, communication, access, etc. Help **define changes required** in provider-patient interactions
- ***Qualifications:*** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred.

Physicians

- Gather broad input from diverse set of physicians, e.g., hospital-employed physicians, rural physicians
- Outline the **clinical processes, systems, and infrastructure** that need to be modified to transition majority of physicians to Connecticut's defined AMH model
- Provide insight into **potential barriers for change** and suggestions for overcoming
- **Promote** taskforce recommendations within the physician community
- ***Qualifications:*** Strong presence in CT's physician community, serving in an advanced practice or clinically integrated setting, understanding of underlying systems / infrastructure of practices, time and ability to gather data across diverse set of physicians, creative problem-solving

Behavioral Health Provider

- Provide insight into **needs of behavioral health patients** that require additional modifications in provider practices ranging from screening, assessment, brief treatment, health behavior, linkage to BH affiliate
- Help **brainstorm potential solutions**
- **Promote** taskforce recommendations within behavioral health community
- ***Qualifications:*** Strong presence in behavioral health community, expertise in primary care/behavioral health integration, familiarity with current state / transformational needs of diverse set of behavioral health providers, creative and open-minded approach to brainstorming solutions

Hospital

- Share insight on changes required to **administrative and clinical processes, systems and budgeting** for hospitals to play a role in new care delivery model
- Help taskforce define **plan for implementing** recommendations with hospitals
- **Promote** taskforce recommendations within the hospital community
- ***Qualifications:*** Strong presence in hospital executive community, detailed understanding (or ability to gather detailed information on) underlying systems / infrastructure / finances of hospitals; creative and open-minded approach to brainstorming solutions

PRACTICE TRANSFORMATION TASKFORCE (cont.)

	Role Description
Health Plans	▪ Share practice transformation expertise, standards, gap analysis or readiness assessment tools, and practice support methods currently in use ▪ Be prepared to serve as change agents to **roll-out taskforce recommendations** with network providers ▪ ***Qualifications:*** Strong relationships with network physicians, support from internal payer executives who are open to providing feedback through their medical director, creative and open-minded approach to brainstorming, familiarity with innovative care delivery and payment models at existing payer and other payers in state; represent a diversity of roles within health plan related practice transformation, e.g., medical director, medical home director, practice transformation support specialist, etc.

PRACTICE TRANSFORMATION TASK FORCE

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.

Key questions this work group needs to answer

Standards

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

Transformation Process

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

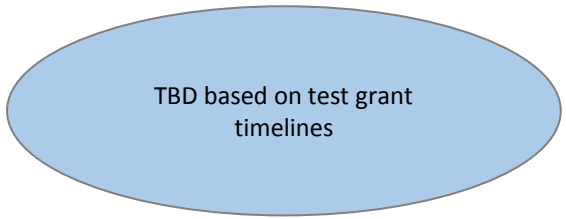
Transformation Vendor Procurement

1. Should there be a single vendor or multiple vendors? Should they be regional or statewide? Should they be funded fixed grant, flat fee per practice, or paid per successful applicant?
2. 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?

PRACTICE TRANSFORMATION TASK FORCE

Key Milestones

Date	Deliverable



Interdependencies

- Program Evaluation
- Quality Council
- HIT Task Force
- Behavioral Health Home
- Transformation Vendor Solicitation & Procurement
- Prevention Service Centers
- CHW Payment Strategy

Core Stakeholders

QUALITY COUNCIL

Role Description

Consumers & Advocates

- Provide input on aspects of quality measurement that pertain to outcomes and care experience, help prioritize **root issues** that need to be addressed by metrics
- ***Qualifications:*** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; comfortable asserting views; relationships with other consumers preferred

Primary Care Providers & Specialists

- Share what metrics are and should **be tracked** and help assess the **feasibility of tracking new metrics** within clinical setting, e.g., required changes to systems, clinical processes
- **Promote** performance measurement and provider scorecards within physician community
- ***Qualifications:*** Strong, recognized presence in physician community; ability and time to gather input from broad set of physicians regarding metrics currently being tracked; good grasp of requirements to track metrics within clinical setting (e.g., impact on clinical process / flow)

Behavioral Health Provider

- Identify and help prioritize **behavioral-health and health behavior related metrics** for inclusion on scorecards
- Share behavioral-specific metrics that are being tracked and help assess **feasibility of tracking new metrics**
- **Promote** scorecards within behavioral health community
- ***Qualifications:*** Strong, recognized presence in behavioral community; familiarity with behavioral health metrics being tracked in-state and elsewhere; understanding of technical requirements to reliably track metrics

Hospitals

- Share metrics currently tracked and help assess the **feasibility of tracking new metrics** within clinical settings, e.g., required changes to systems, clinical processes; identify and help resolve duplicative, conflicting, and unnecessary measurement mandates
- **Promote** performance measurement and provider scorecards within provider community
- ***Qualifications:*** Strong, recognized presence among hospital medical directors and quality managers, ability to solicit detailed information from other hospital medical directors and quality measurement staff as needed to understand feasibility of tracking new metrics; familiarity with state and national measurement sets and requirements

QUALITY COUNCIL (cont.)

Role Description

Health plan medical directors

- Share what metrics are being tracked and help assess the **feasibility for payers to track new metrics** with their network providers;
- Consider feasibility of transitioning to a **"common provider scorecard"** across payers
- Serve as **liaison** with internal executives to gather feedback on recommended metrics
- ***Qualifications:*** Commitment from payer executives to provide feedback through medical director, familiarity with metrics being tracked by payer in CT and in other regions, ability to comfortably problem-solve with private payer statisticians on statistical viability of metrics and methods for risk adjustment and exclusions

Health plan statisticians & measurement experts

- Facilitate selection of core set of measures; mix of process, outcome, efficiency , and patient engagement and experience metrics
- Outline data requirements, e.g., minimum patient panel size for statistical validity of prioritized metrics
- Outline risk adjustment and exclusion methods
- Help taskforce select measures that are ambitious, but feasible to implement
- ***Qualifications*:** Strong statistical analysis capabilities; creative and open-minded problem-solver; familiarity with diverse set of metrics including national measurement sets (e.g., AHRQ, NQF, NCQA, Medicare SSP), and statistics

DPH Epidemiologist

- Share what health metrics, surveillance data, and vital statistics are being tracked by DPH and other community organizations today; familiarity Healthy People 2020 measures, targets, and statistics
- Help identify and prioritize metrics to be used to track improvements in **public health**
- ***Qualifications:*** Familiarity with population-health metrics being implemented in CT and in other best practice settings to measure public health

QUALITY COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for a core set of measures for use in the assessment of primary care, specialty, and hospital provider performance. This workgroup will develop a common provider scorecard format for use by all payers and reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. SIM aims to achieve top-quintile performance among all states for key measures of quality of care, and increase the proportion of providers meeting quality scorecard targets. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work.

Key questions this work group needs to answer

Measures

1. What are the structure, process, patient engagement and experience, efficiency, disparities-sensitive, outcome, and cost measures that are in use today by national quality bodies and CT's health plans? (e.g. NQF, AHRQ, NCQA, CAPHS)
2. Which of these measures should be adopted to measure provider performance, taking into consideration the target conditions identified in the Innovation Plan?
3. Which of these measures should be adopted to measure provider performance, taking into consideration the prevention goals identified in the Innovation Plan?
4. What other measures could be used as indicators for whole-person-centered care, enhanced access, and coordinated care (e.g. behavioral health, oral health)?
5. What measures could be used as indicators of workforce productivity/timely return to work?

Metrics

1. What are the metrics for each of the measures and how will they be calculated?
2. What methods will be used for risk adjustment and exclusions?

Common Performance Scorecard

1. What are the best examples of performance scorecards currently in use?
2. What will Connecticut's common scorecard across all health plans look like?
3. What is the process for all health plans to implement the common scorecard?
4. How will cross-payer analytics be integrated for a given practice profile, including commercial and public payers?
5. Is there a recommended frequency and schedule that could be adopted across payers?
6. How will the common performance scorecard be integrated with value-based payment calculations?
7. How will the scorecards be made available to the public?

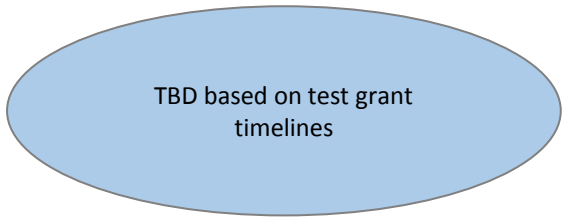
Common Care Experience Survey

1. What are the best examples of care experience surveys currently in use?
2. Is there one survey that would best align with the goals of the Innovation Plan? Are there supplemental questions that should be considered?
3. What is the process for all health plans to implement the common care experience survey?
4. One what schedule should the common care experience survey be administered?
5. How will the common care experience survey be integrated with value-based payment calculations?
6. How will the results of care experience surveys be made available to the public?

QUALITY COUNCIL

Key Milestones

Date	Deliverable



Interdependencies

- Program Evaluation
- Equity and Access Council
- HIT Task Force
- Provider Transformation
- Care Experience Survey Vendor

Core Stakeholders

EQUITY AND ACCESS COUNCIL

Role Description

Consumer Advocates	▪ Provide input on under-service safeguards from consumer perspective; gauge reasonableness and adequacy of such safeguards ▪ ***Qualifications:*** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred
Health plans – medical directors	▪ Help taskforce identify **potential issues in program design** that could negatively impact delivery of appropriate care and access ▪ Lead taskforce's efforts to **define and execute plan to identify outliers** in care delivery and payments ▪ ***Qualifications:*** Strong relationships with network physicians, support from internal payer executives who are open to providing feedback through their medical director, creative and open-minded approach to brainstorming, familiarity with innovative payment models; familiarity with safety, quality, & outlier monitoring
Health plans - program integrity	▪ Consider methods for identifying patterns of under-service, risk avoidance, or patient abandonment ▪ Lead taskforce's efforts to **define and execute plan to identify and investigate outliers** ▪ ***Qualifications:*** Prior experience in managing program integrity and surveillance; commitment to ensuring long-term, system provision of appropriate care and access; scenario modeling capabilities a plus
Academics	▪ Provide **input from academic research** on potential design facets that could compromise ability to provide appropriate care and access to care ▪ Work with PI specialists to understand **statistical requirements** to gather reliable data that will support identification of outliers ▪ ***Qualifications:*** Commitment to ensuring long-term provision of appropriate care and access; familiarity with academic research on program integrity and surveillance; statistical analysis capabilities
Physicians/ Hospitals	▪ Define and oversee plan to systematically gather input from broad range of physicians to identify potential changes to provider practices that may **compromise the system's ability to provide appropriate care and access to care** ▪ ***Qualifications:*** Commitment to ensuring long-term system provision of appropriate care and access; familiarity with under-service risks and needs of underserved populations

EQUITY AND ACCESS COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; recommend a response to demonstrated patient selection and under-service; and define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work. 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.

Key questions this work group needs to answer – Phase I – Design & Implementation

Setting Context

1. Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council.

Assessing Risk

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?
5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?
5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to patient selection?

Questions this work group may opt to consider – Phase II

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?

HEALTH INFORMATIONTECHNOLOGY COUNCIL

Role Description

Consumers & Advocates

- Provide input on aspects of health information that relate to consumer/provider communication, performance transparency, privacy, security, and shared decision making tools
- ***Qualifications:*** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred.

Health Plans

- Provide information on **existing infrastructure and HIT capabilities** across diverse set of private payers
- Liaise with internal executives to share taskforce recommendations and gather input
- Determine **feasibility of integrating systems across payers**
- ***Qualifications:*** Strong relationships with counterparts at other insurers, commitment from payer executives to provide input through representative, familiarity with or ability to gather data on HIT systems and infrastructure across diverse set of insurers, authority and ability to negotiate with counterparts at other insurers regarding potentially integrating systems / processes

State Agencies[1]

- Share detailed information on **existing infrastructure and HIT capabilities within each department**, including potential to integrate or expand on existing systems
- Define need for **new systems introductions** and outline plan for integration
- ***Qualifications:*** Familiarity with existing infrastructure and systems across departments, prior involvement in CT HIT-related initiatives, e.g., SIM, CT Data Collaborative, EHR incentive program, Direct messaging, Medicaid Information Technology Architecture (MITA)

ACO / Clinically Integrated Network

- Help taskforce understand **new systems, capabilities, and infrastructure** that will be required for providers to transition into an ACO or other clinically integrated model
- Support **prioritization and sequencing of planned changes** that will maximize impact while minimizing disruption to provider workflow
- ***Qualifications:*** Familiarity with HIT requirements associated with transitioning to an AMH-like model, personal experience implementing HIT changes in physician, hospital, and other ambulatory care settings

1 DSS, DPH, DMHAS, DCF, DOC, BEST, OPM, OSC, HIT Coordinator

HEALTH INFORMATION TECHNOLOGY COUNCIL (cont.)

Role Description

Access Health CT

- Outline **existing infrastructure / capabilities of CT's public exchange and All Payer Claims Database** that can be leveraged to support CT SIM
- Share **learnings** on implementing HIT innovation in CT based on experience with the exchange and APCD
- ***Qualifications:*** Ability to gather input / feedback from wide range of individuals at Access Health CT to provide comprehensive perspective on existing systems and capabilities; approval authority / ability to secure approval to share systems / infrastructure with CT SIM effort

Hospitals

- Provide information on **unique systems and HIT capabilities** that will be required to support needs of diverse set of hospital patients and clinically integrated care
- Share insights on **existing systems being used by CT hospitals** that can be leveraged or best practices that can be adopted
- Support prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow
- ***Qualifications:*** Relationships with other hospitals serving broad array of patients; familiarity with hospital-based information technology including electronic health records, health information exchange, analytics, and care management tools; familiarity with other HIT demands such as ICD-10

Physicians and/or CSMS

- Help taskforce understand new systems, capabilities, and infrastructure that will be required for independent practice providers to utilize new health information technology tools and infrastructure
- Support prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow
- Help identify and prioritize required **changes to existing systems / infrastructure**
- Provide insight into potential barriers for change and suggestions for overcoming
- Support identification of and vetting of **preferred vendors**
- Provide **estimation** of required financial investment
- ***Qualifications:*** Familiarity with HIT requirements associated with transitioning to an AMH-like model, personal experience implementing HIT changes at practice. Familiarity with best practice HIT changes that are in existence today and with new HIT innovations, practical experience with seeing HIT systems and infrastructure being used by physicians