# State Innovation Model Initiative


October 16, 2014

Presentation to the Healthcare Innovation Steering Committee

# HIT Council Composition

# COMPOSITION AND HIGH-LEVEL CRITERIA FOR WORKGROUP PARTICIPATION

## Health Information Technology Council

### Composition

- 3 consumers/advocates
- 2 physicians
- 2 health plans
- 1 AHCT/APCD
- 1 CHA
- 1 CSMS
- 4-5 ACO/clinically integrated network/hospital
- 2 FQHC & CHCHACT
- 4 DSS, DPH, BEST, OSC, DMHAS
- 1 ex-officio CAB liaison
- Up to two MAPOC designees

### High-Level Criteria

- Authority or ability to influence
- Technical expertise with provider and payer systems, health information technology and/or analytics

*Staff support provided by statewide HIT Coordinator

## Practice Transformation Taskforce

- 6 consumers or advocates
- 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
- Up to two MAPOC designees
- 1 ex-officio CAB liaison

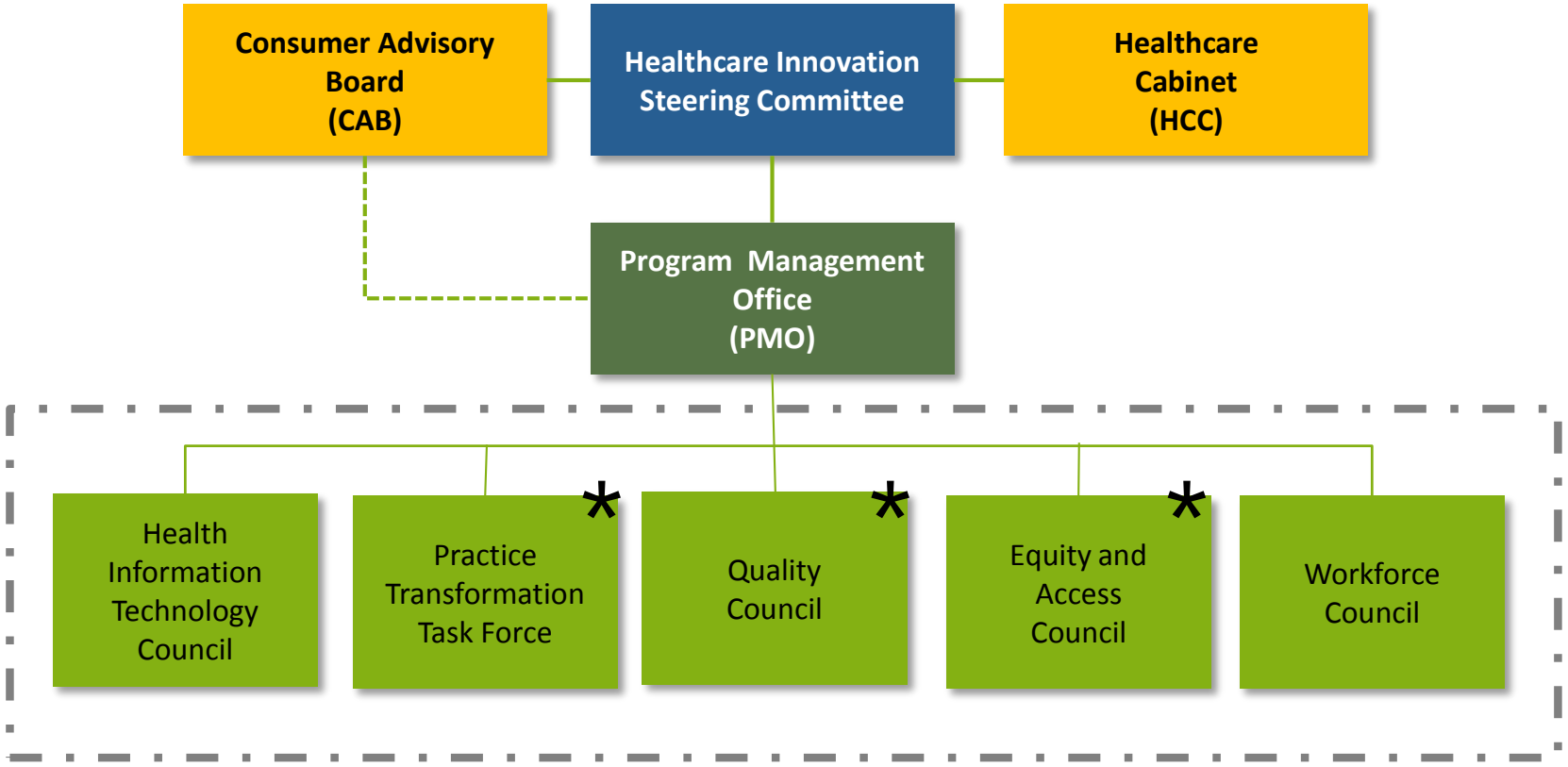
- Authority or ability to influence
- Commitment to shared aspirations
- Direct experience with advanced primary care, clinical integration, practice transformation

# COMPOSITION AND HIGH-LEVEL CRITERIA FOR WORKGROUP PARTICIPATION

| | Composition | High-Level Criteria |
|---|---|---|
| Quality Council | ▪ 4 consumers or advocates<br>▪ 6 physicians<br>▪ 1 hospital<br>▪ 1 FQHC<br>▪ 5 all health plans with >5% market share<br>▪ 4 DSS, DMHAS, DPH, OSC<br>▪ Up to two MAPOC designees | ▪ Authority or ability to influence<br>▪ Technical expertise and experience with measurement of health, quality, resource efficiency, and consumer experience |
| Equity and Access Council | ▪ 6 consumers or advocates + 1 ex-officio CAB liaison<br>▪ 2 DSS, DPH<br>▪ 1 OHA<br>▪ 5 all health plans with >5% market share<br>▪ 4 physicians<br>▪ Up to two MAPOC designees | ▪ Commitment to appropriate care and access<br>▪ Experience with access & underservice issues<br>▪ Ability to understand claims-level data analysis<br>▪ Understanding of underserved populations |

# Update

# SIM Governance Structure



# SIM & Medicaid

## Integrated planning & Oversight

- SIM related Medicaid planning integrated with longstanding Medicaid advisory structure
- Medical Assistance Program Oversight Council (MAPOC)
- Care Management Committee (CMC) will advise on Medicaid Quality Improvement and Shared Savings Program
- SIM representatives on CMC include:
  - HISC: Jane McNichol, Robin Lamott Sparks
  - CAB: Sharon Langer

# SIM & Medicaid

## MAPOC representation within SIM

- Steering Committee
  - Representative Cathy Abercrombie
  - Senator Terry Gerratana
- Consumer Advisory Board
  - Alicia Woodsby
  - Rev. Bonita Grubbs

# SIM & Medicaid

## MAPOC representation within SIM

- Equity and Access:
  - Kristen Hatcher, JD
  - Katherine Yacavone
- Health Information Tech:
  - Matt Katz (CSMS)
- Practice Transformation:
  - Dr. Alex Geertsma
  - Dr. Andrew Selinger

# Building SIM PMO Capacity

- RFP for PMO consultation services
  - Proposals due 9/4/14
  - Currently under review
  - Priority:
    - work group support
    - PMO administrative support
- Seeking approval for state funded positions

# Test Grant Application

# CMMI Interview – 10/1/14

- Convened with CMMI – video-conference
  - 30 minute presentation
  - Questions for stakeholders
- Second tier response to questions – 10/9/14

# Connecticut Participants

| | |
|---|---|
| Nancy Wyman<br>*Lieutenant Governor* | Patrick Charmel<br>*Griffin Hospital* |
| Roderick L. Bremby<br>*Department of Social Services* | Patricia Checko<br>*SIM Consumer Advisory Board* |
| Jewel Mullen<br>*Department of Public Health* | Paul Cleary<br>*Yale School of Public Health* |
| Mark Schaefer<br>*Director of Healthcare Innovation* | Jill Hummel<br>*Anthem Blue Cross and Blue Shield* |
| Victoria Veltri<br>*State Healthcare Advocate* | Suzanne Lagarde<br>*Fair Haven Community Health Center* |
| Tamim Ahmed<br>*Access Health Analytics* | Katharine K. Lewis<br>*Department of Public Health* |
| Robert Aseltine<br>*UConn Health Center* | Kate McEvoy<br>*Department of Social Services* |
| Mary Bradley<br>*Pitney Bowes* | Robert McLean<br>*Connecticut Medical Group* |

# Connecticut Participants

| | |
|---|---|
| Michael Michaud<br>*Dept. of Mental Health & Addiction Services* | Kristin Sullivan<br>*Department of Public Health* |
| Ron Preston<br>*UConn Health Center* | Minakshi Tikoo<br>*State Health IT Coordinator* |
| Marie Smith<br>*UConn School of Pharmacy* | Thomas Woodruff<br>*Office of the State Comptroller* |
| Robin Lamott Sparks<br>*Bridgeport Child Advocacy Coalition* | |

# Second Tier Program Questions

- Insurance assessment
- Medicaid capabilities
- Physician survey
- Community Transformation Grants
- Access to claims data

# Why Connecticut?

- Unprecedented collaboration across diverse partners
- Strong record of success & commitment to sustain
- Intent to lead the nation:
  - Empowering consumers
  - Making care experience matter
  - Putting health equity into the value equation
  - Integrating behavioral health
  - Consumer safeguards
- Demonstrated commitment among all of Connecticut's commercial payers
- Ensure success of Medicare ACO model

# Physician Survey

# Motivation

- Need baseline information on:
  - How physicians are currently practicing, in what settings
  - How “advanced” their practices are
  - What challenges they face in managing their practices
  - Attitudes toward medical home, technological advances, their career in medicine

# Proposed Survey Design

- **Approach:** Mail survey (self administered) with telephone follow-up to non-responders
- **Survey development process:**
  - Developed with input from Technical Advisory Panel
  - Will include pilot testing to insure questions are clear and consistently understood

- Tom Woodruff
- Kim Martone
- Daren Anderson
- Matt Katz
- Claudia Gruss
- Peter Bowers
- Rob Zavoski
- Greg Makoul
- Tom Meehan
- Gary Price

# Survey Topic Areas

*** Red highlights indicate areas enhanced following TAP review**

1. Practice characteristics
   - Practice type, size, ownership
2. Technology
   - EHR implementation and capabilities
   - Attitudes/toward assessment of EHR impact
     - E.g., Impact on cost of care, quality of care

# Survey Topic Areas

*** Red highlights indicate areas enhanced following TAP review**

3. Medical Home characteristics
   - PCMH designation
   - PCMH features in their practices (e.g., primary care teams, open access)
   - Attitudes toward PCMH
     - E.g., Improve quality of patient care, fit with business strategy

# Survey Topic Areas

*** Red highlights indicate areas enhanced following TAP review**

4. Cultural competency
   - Training, approach to encounters
5. Physician attitudes about medical practice
   - Anticipated changes to practice, challenges to managing a practice, satisfaction with career

# Survey Topic Areas

*** Red highlights indicate areas enhanced following TAP review**

6. Narrow networks
   - ◆ Denial of membership in a network
7. Demographics

# Sample

- **Sample:** Physicians that have submitted claims to two or more of the State's major insurers in the past year
  - Sample will be provided by OSC and augmented with contact information from CSMS
  - Expected N = 600 completed surveys from PCPs, 600 surveys from physicians in 5 specialty areas

# Sampling Strategy

| | Affiliated | | Unaffiliated | |
|---|---|---|---|---|
| **Primary Care Physicians** | **Target N** | **Sample** | **Target N** | **Sample** |
| Internal Medicine/Family Practice | 200 | 667 | 200 | 667 |
| Pediatrics | 100 | 333 | 100 | 333 |
| **Total** | 300 | 1000 | 300 | 1000 |

# Sampling Strategy

| | | |
|---|---|---|
| **Specialists** | **Target N** | **Sample** |
| Cardiology | 125 | 417 |
| Gastroenterology | 125 | 417 |
| Obstetrics-Gynecology | 125 | 417 |
| Endocrinology | 125 | 417 |
| Pulmonology | 125 | 417 |
| **Total** | 625 | 2083 |

# Timeline

- Oct 2 – Create cognitive instrument
- Oct 17-20 – Schedule cognitive interviews
- Oct 21 – Obtain sample
- Oct 27-29 – Conduct 6 cognitive interviews
- Oct 31 – Finalize survey
- Nov 7 – Mailing
- Nov 15 – Postcard mailing
- Dec 7 – Start telephone calls
- Jan 7 – Stop telephone calls
- Jan 16 – Deliver data

# What we will learn

- Characteristics of the physician workforce
- Factors that distinguish affiliated/non-affiliated physicians
- Status of CT physicians in adopting key components of patient-centered care whether or not they are medical home recognized
- Attitudes toward practice advancement and challenges for Connecticut in achieving its transformation goals

# Proposal
# Advanced Medical Home Pilot

# AMH Pilot Project

- Conduct a pilot of our AMH practice transformation standards and methods, including:
  - Recruitment
  - Practice transformation support
  - Learning Collaborative
- Practices serve as a learning lab
- Precursor to large scale SIM grant funded Glide Path that will be brought to scale later in the year (250 practices by June 2016)

# AMH Pilot Project

- Increasing attention to the level of satisfaction of members of the primary care team
- This is important for several reasons

# Primary Care Team Satisfaction

1. the future of the primary care workforce depends on primary care being a rewarding setting within which to work,
2. a satisfied and high functioning clinical team is likely to lead to higher quality performance, improved care coordination and better patient care experience, and
3. we will only be successful at accelerating primary care advancement if primary care practitioners are willing to invest the time, effort, and resources.

# Objectives

- Test program administration such as methods of practice recruitment, criteria for participation, and progress monitoring and make adjustments before we scale up with a larger number of practices and additional vendors in the last quarter of 2015,
- Test different methods of transformation (e.g., a clinical micro-systems approach to practice assessment, use of tech enablers, etc.) before finalizing our statewide strategy,

# Objectives

- Determine whether our method provides enough assistance and tools to make participation in the NCQA recognition process less challenging and resource intensive,
- Assess and optimize impact on practice experience…if satisfaction with practice does not improve, expansion will be challenging, and

# Objectives

- Recruit practices to champion the value of AMH Glide Path transformation support, which will support practice recruitment later in the year.

# Standards

- Standards and methods shall be those recommended by the Practice Transformation Task Force and approved by the Healthcare Innovation Steering Committee
- Standards for the Glide Path and pilot will be the NCQA standards with some additional *required* elements or factors, and possibly a limited number of new requirements.

# Methods

- Methods refers to the “how” of providing practice transformation support, as distinct from the standards, which will be those recommended by the Practice Transformation Task Force.
- For example, how to integrate EHR intro patient care process

# Methods

- Some advantage to being less prescriptive about methods for the purpose of our pilot.
- Invite respondents to propose methods and these methods will be a consideration in the selection of a qualified vendor.

# Methods

- Emphasize methods that hold promise in reducing physician “burn out” and enhancing satisfaction of the primary care team as well as:
  - Patient care experience, engagement and shared decision making,
  - Health equity, and
  - Integrated behavioral health
- Methods for the conduct of the Learning Collaborative will also be based on those proposed by vendors as part of the procurement

# Eligibility

- In addition to the commitment and support of the Advanced Network(s), we will base individual practice eligibility for the pilot on criteria similar to those that will be required under the AMH Glide Path. Such criteria may include:
  - Engaged leadership, as evidenced in part by an identified lead physician or APRN,
  - ONC certified EHR,

# Eligibility

- Not currently recognized under an existing national medical home standard including NCQA 2011 or 2014,
- Commitment to apply for NCQA 2014 medical home recognition and obtaining NCQA recognition as a condition for participating in and completing the pilot, and
- Commitment to participate in the Learning Collaborative.
- Practices recognized under the NCQA 2008 standards would be eligible to participate.

# Recruitment

- Notify all of Connecticut's Advanced Networks of the opportunity for their practices to participate in the AMH pilot through an RFA (Request for Applications process).
- Target those organizations that have been identified as participating in the Medicare SSP or have an SSP arrangement with one or more of Connecticut's commercial health plans.

# Funding

- Practices will receive SIM PMO funded practice transformation support for up to 18 months.
- SIM PMO will arrange for discounted license and application fees with NCQA.
- A partial subsidy of these fees may be considered.
- Practices will not otherwise receive direct funding for their participation.

# Program Management

- A withhold will be established, release contingent on:
  - the number of practices that successfully achieve NCQA recognition and
  - practice ratings of satisfaction with the vendor's services.
- Assess practice satisfaction on entry into the pilot, at the point of NCQA recognition as a medical home, and 6-months post-recognition

# Implementation and Oversight

- Practice Transformation Task Force will be a key partner in supporting the implementation, oversight, and evaluation of the pilot,
- A small group of advisors from the PTTF will be enlisted to support the procurement process including the evaluation of potential vendors to provide practice transformation support under the pilot.

# Questions