Connecticut SIM: Program Overview

October 8, 2015

Vision

Establish a whole-person-centered healthcare system that:

- improves population health;
- eliminates health inequities;
- ensures superior access, quality, and care experience;
- empowers individuals to actively participate in their healthcare; and
- improves affordability by reducing healthcare costs

SIM Initiatives

Statewide Interventions	Targeted Interventions
Plan for Improving Population Health	Medicaid QISSP
Quality Measure Alignment	Advanced Medical Home Program
HIT/Analytics/Performance Transparency	Community & Clinical Integration Program
Value Based Insurance Design	
Community Health Workers	
Consumer Engagement	
Evaluation	

Targeted Initiatives

Statewide Initiatives

Model Test Hypothesis for SIM Targeted Initiatives

High percentage of patients in value-based payment arrangements

MQISSP
Medicare SSP
Commercial SSP

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Resources to develop advanced primary care and organization-wide capabilities

- Advanced Medical Home Program
&
- Community & Clinical Integration Program (CCIP)

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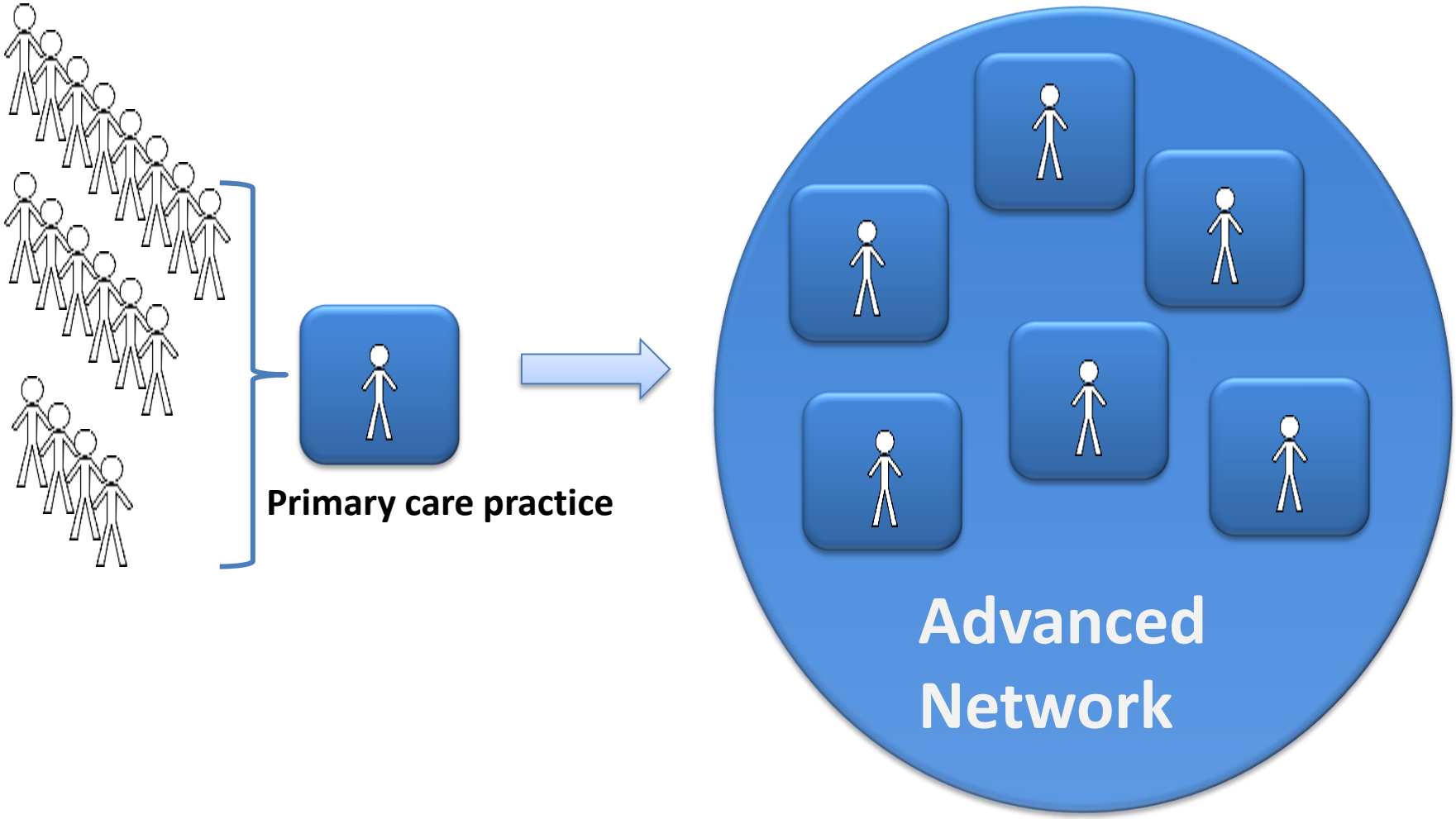
Accelerate improvement on population health goals of better quality and affordability

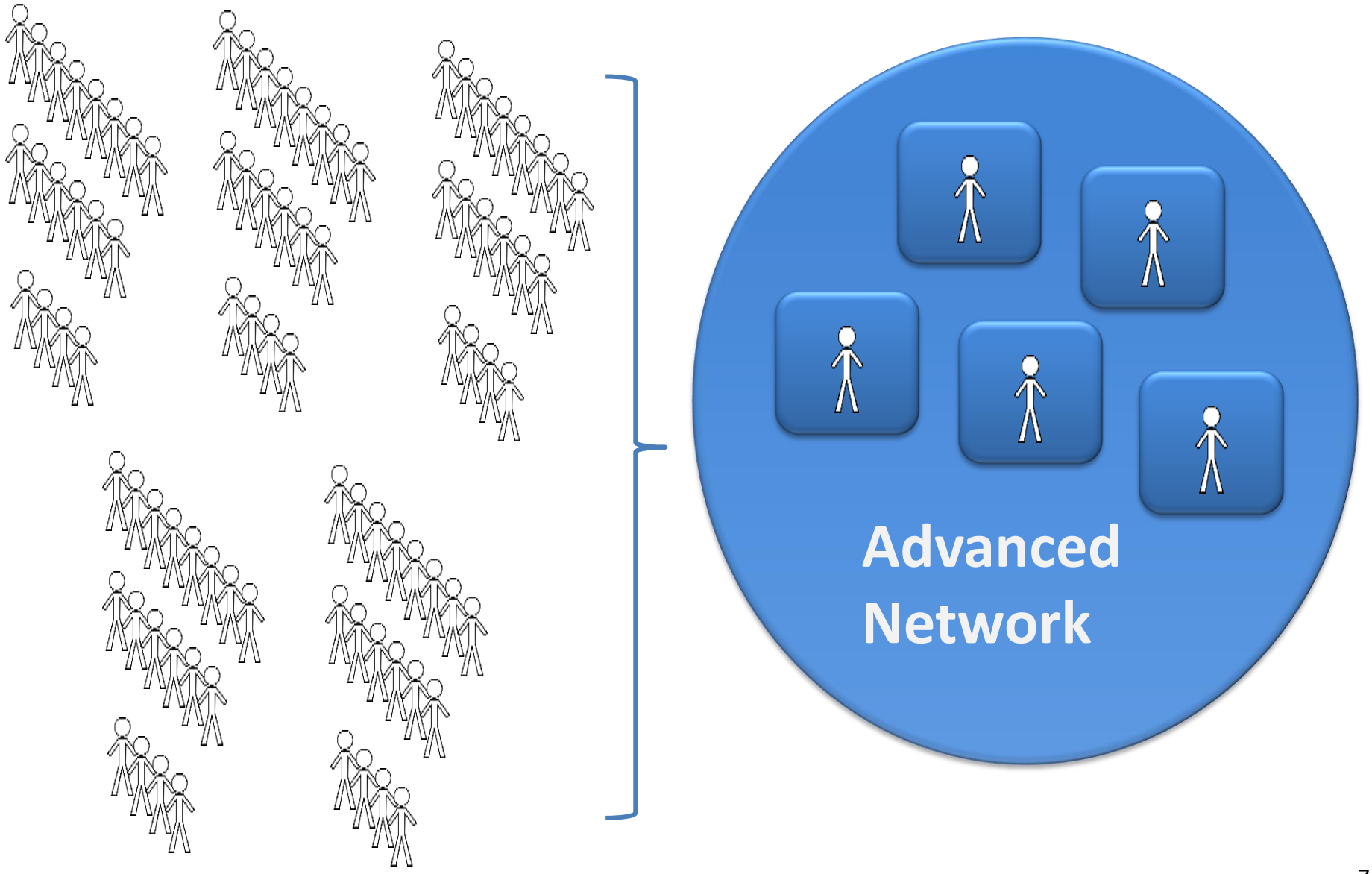
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability

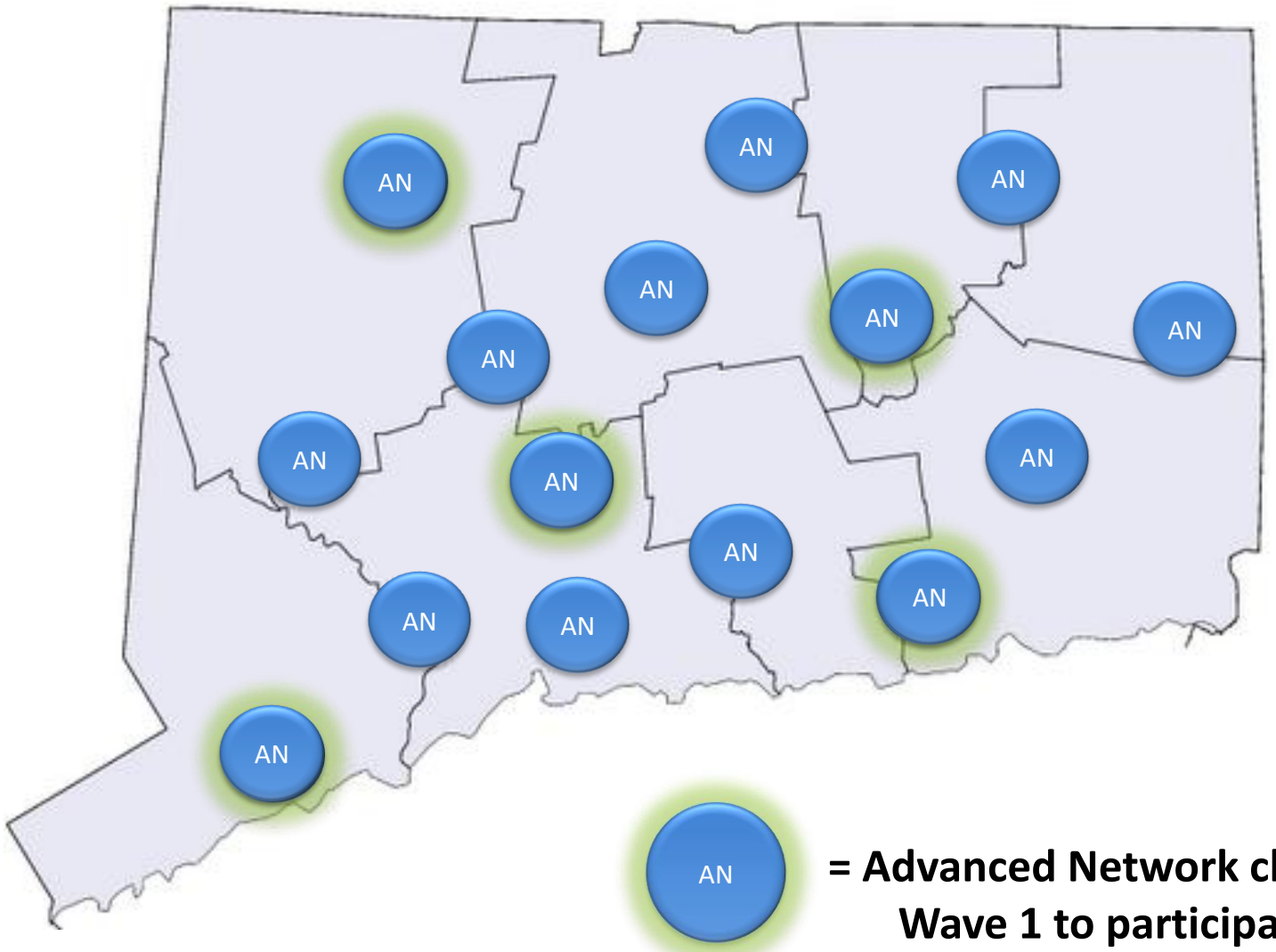


Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

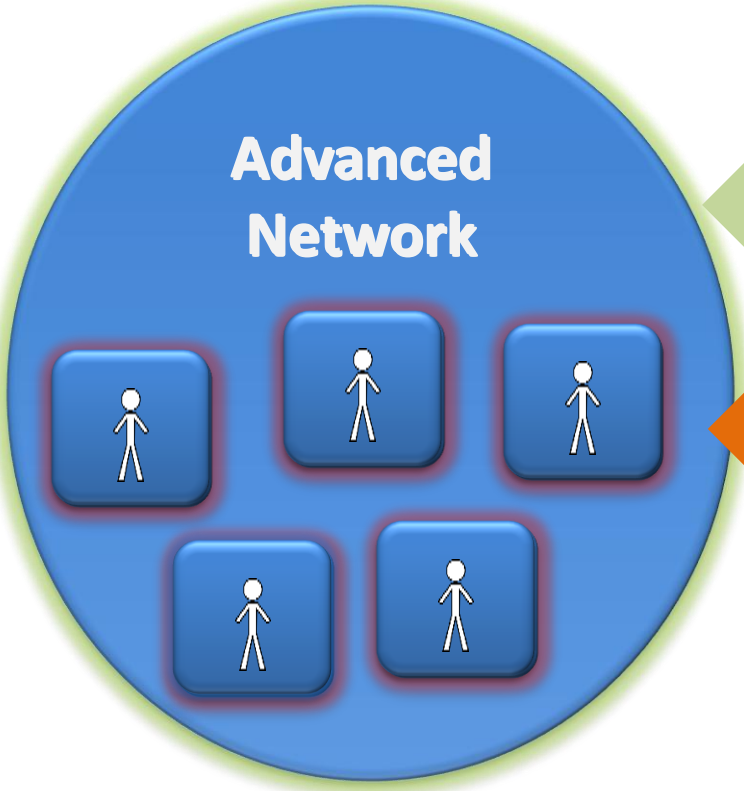
Accountability for quality and total cost



Connecticut has many Advanced Networks



Resources aligned to support transformation



Community & Clinical Integration Program (CCIP)

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

Advanced Medical Home (AMH) Program

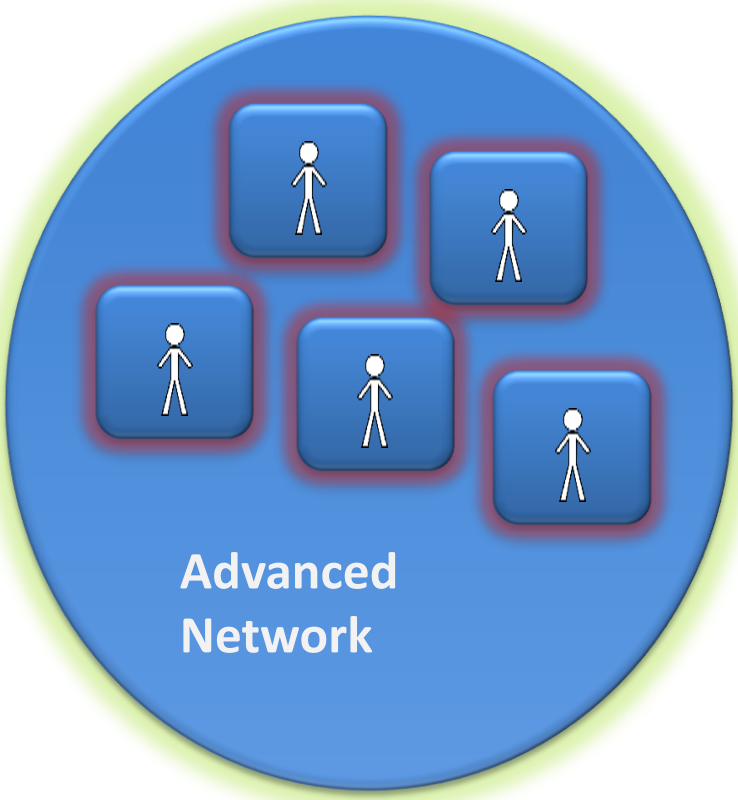
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations
Using population health strategies

Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ **CHW & culturally tuned materials**

Integrating Behavioral Health

Network wide screening, assessment, treatment/referral, coordination, & follow-up

Community Health Collaboratives

Comprehensive Medication Management

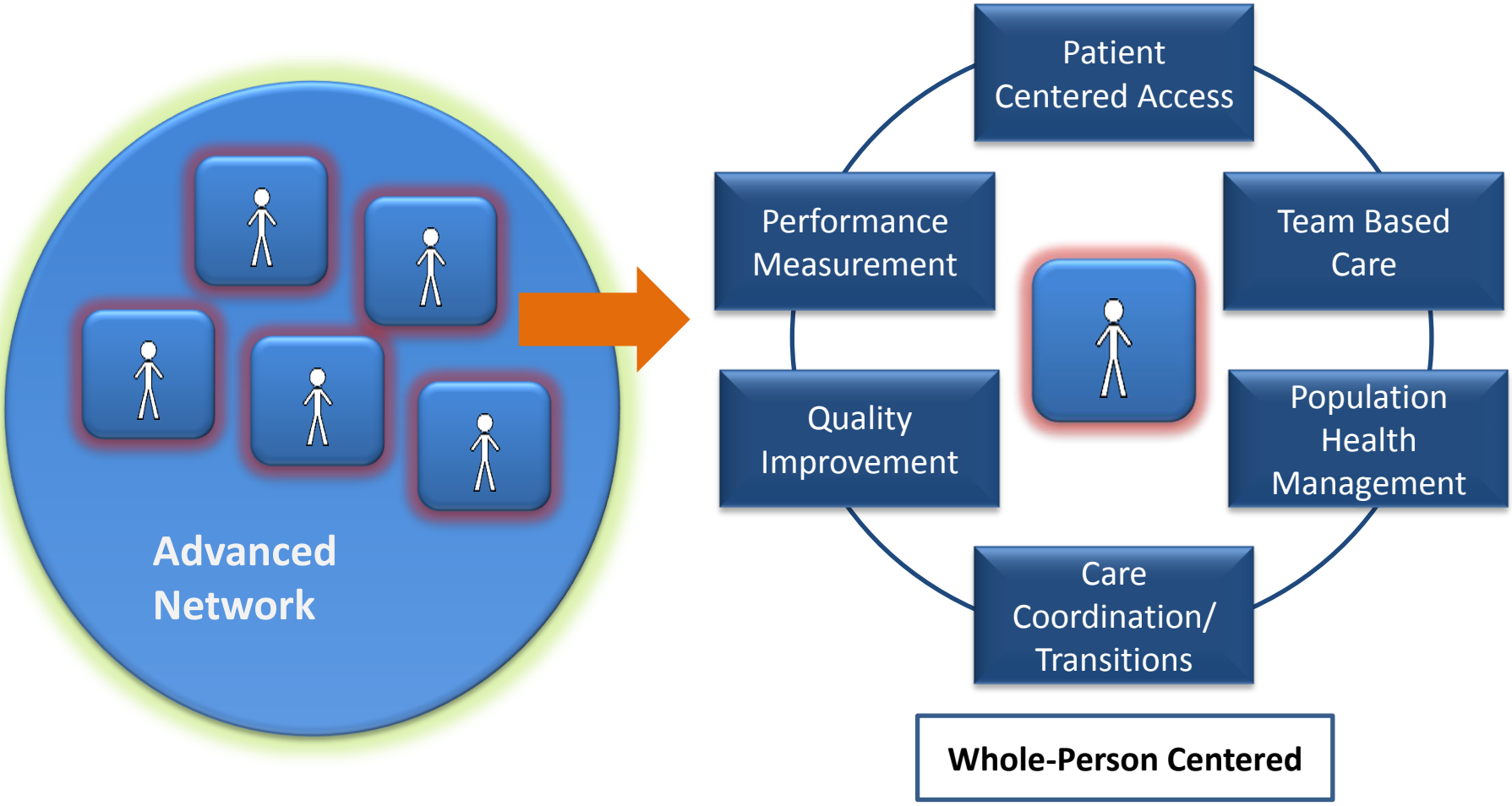
E-Consults

Oral health

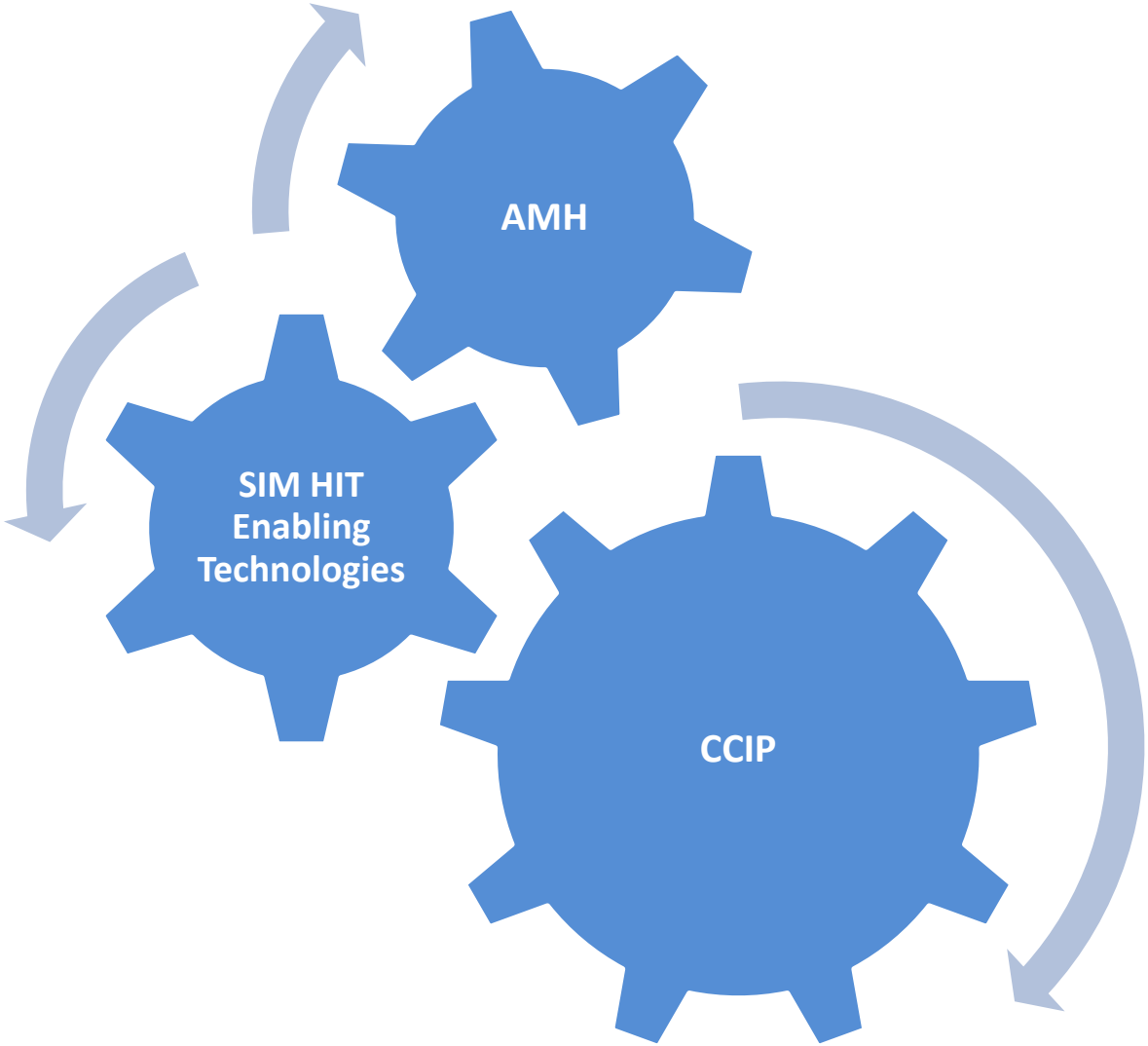
Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

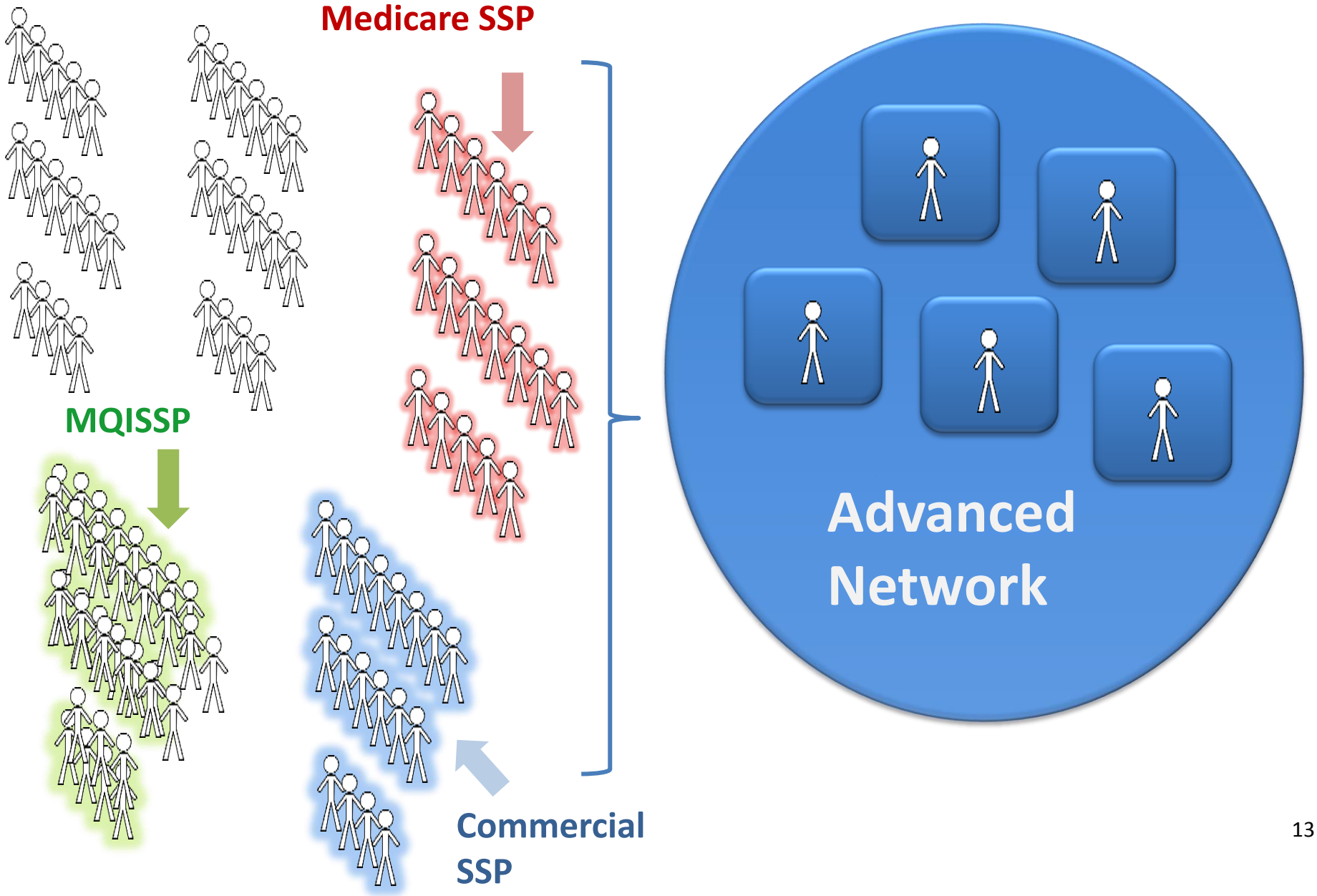
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



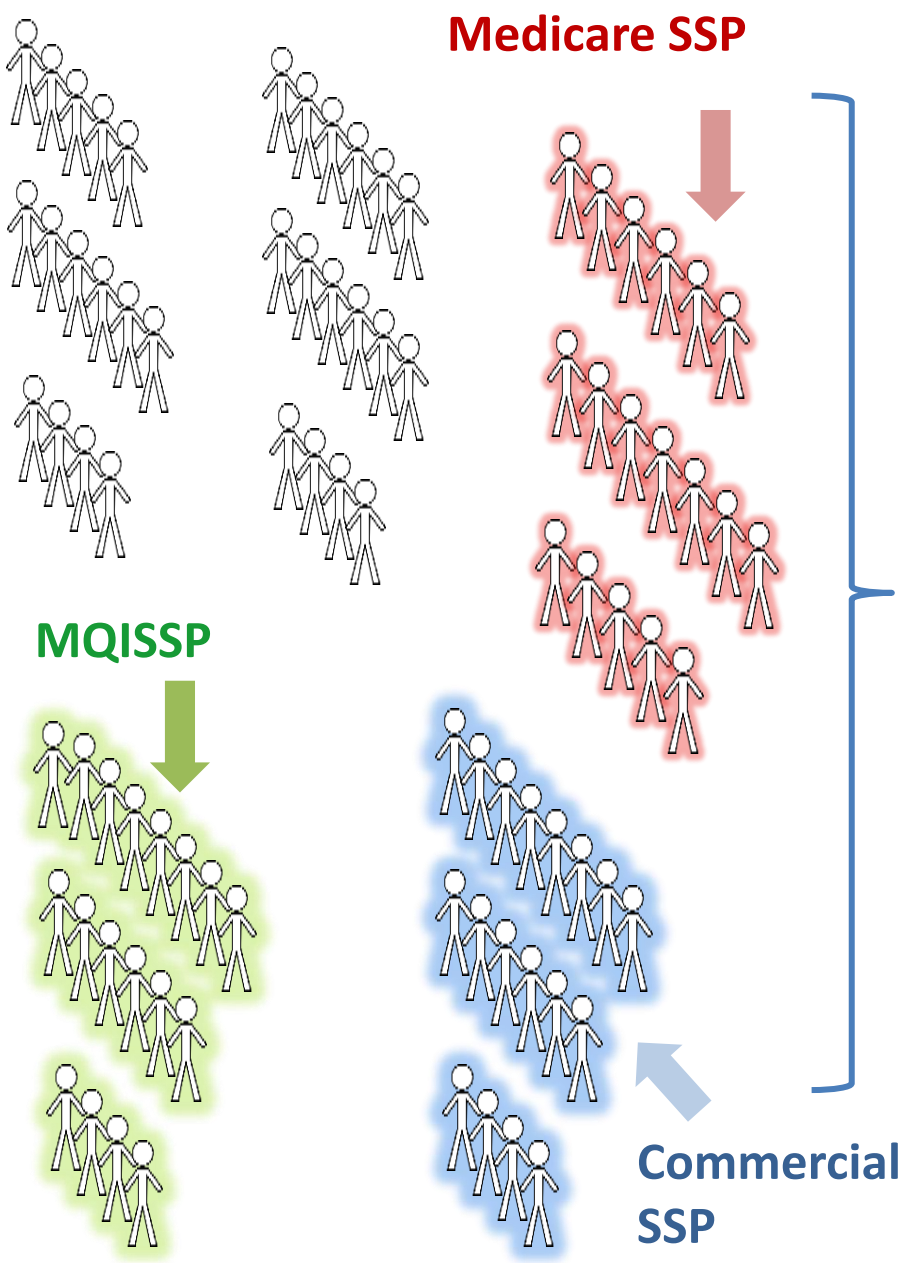
Using HIT to enable new Advanced Network capabilities

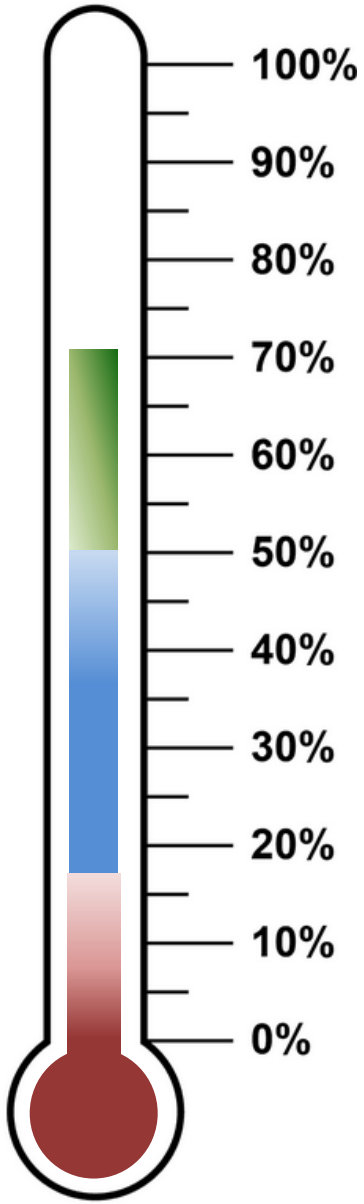


Expanding the reach of Value-Based Payment



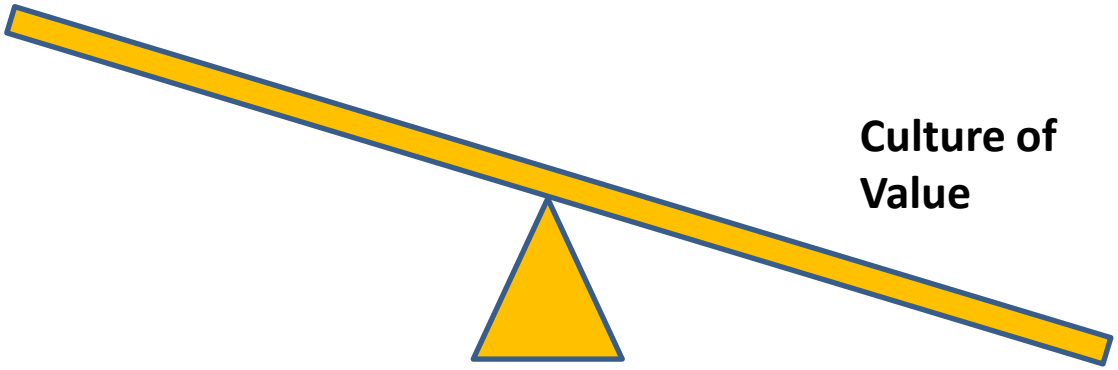
Reaching the tipping point

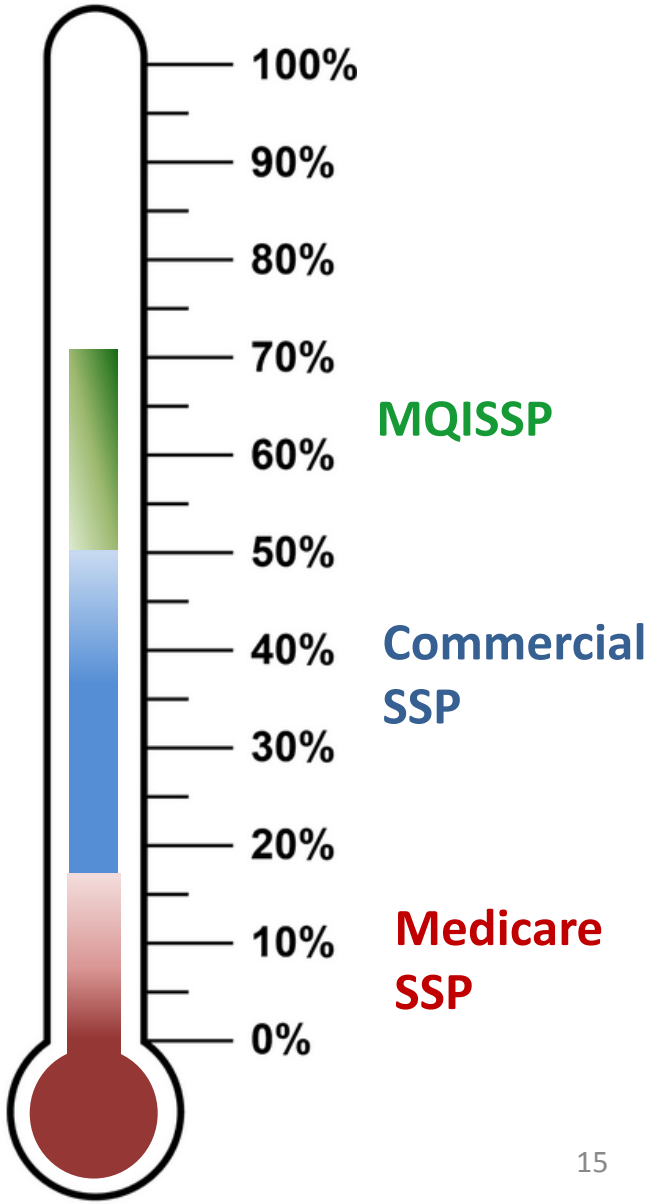




% of consumers in an Advanced Network in value-based payment arrangement

Reaching the tipping point





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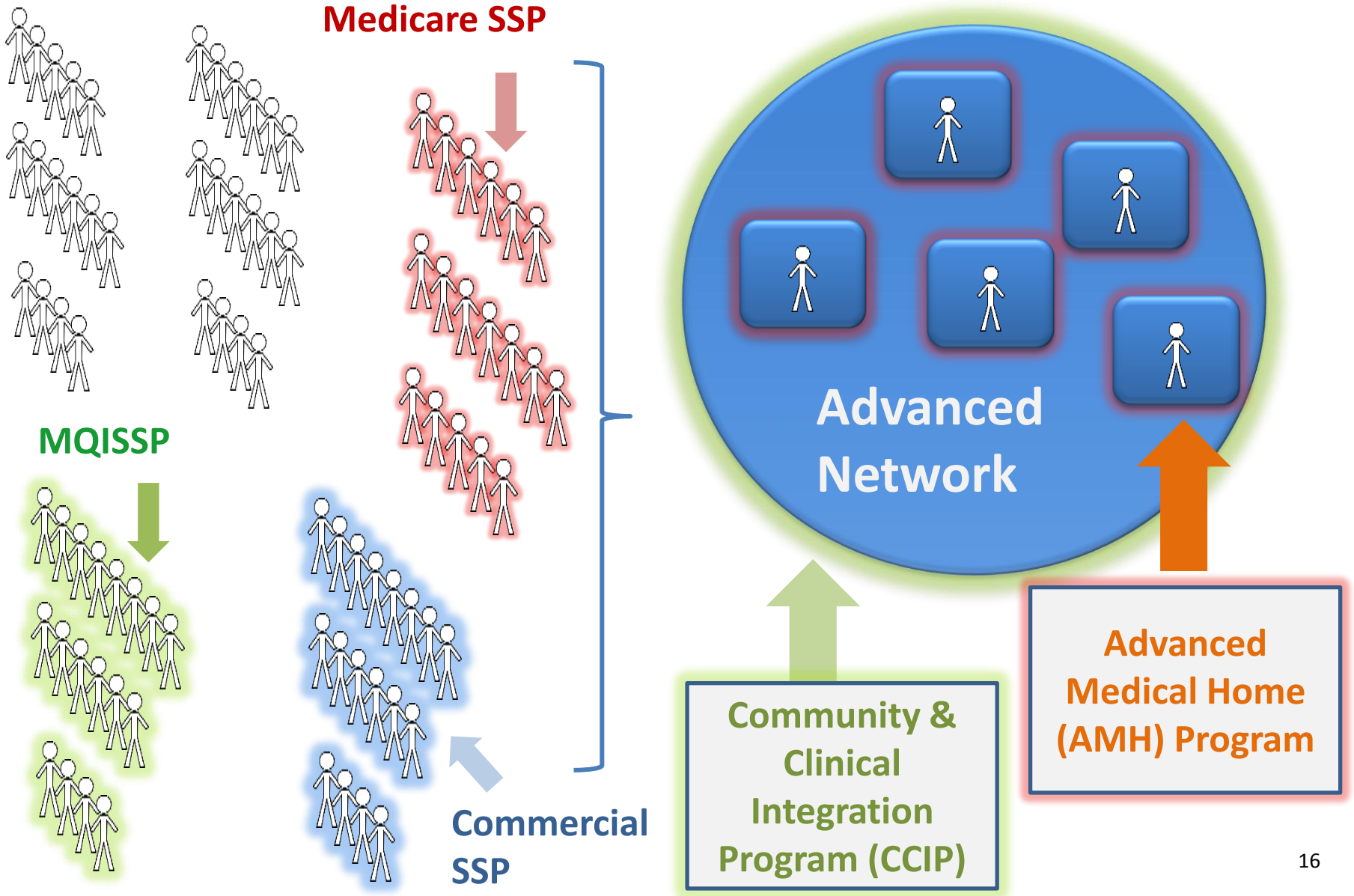
Putting it all together



Targeted Initiatives

Statewide Initiatives

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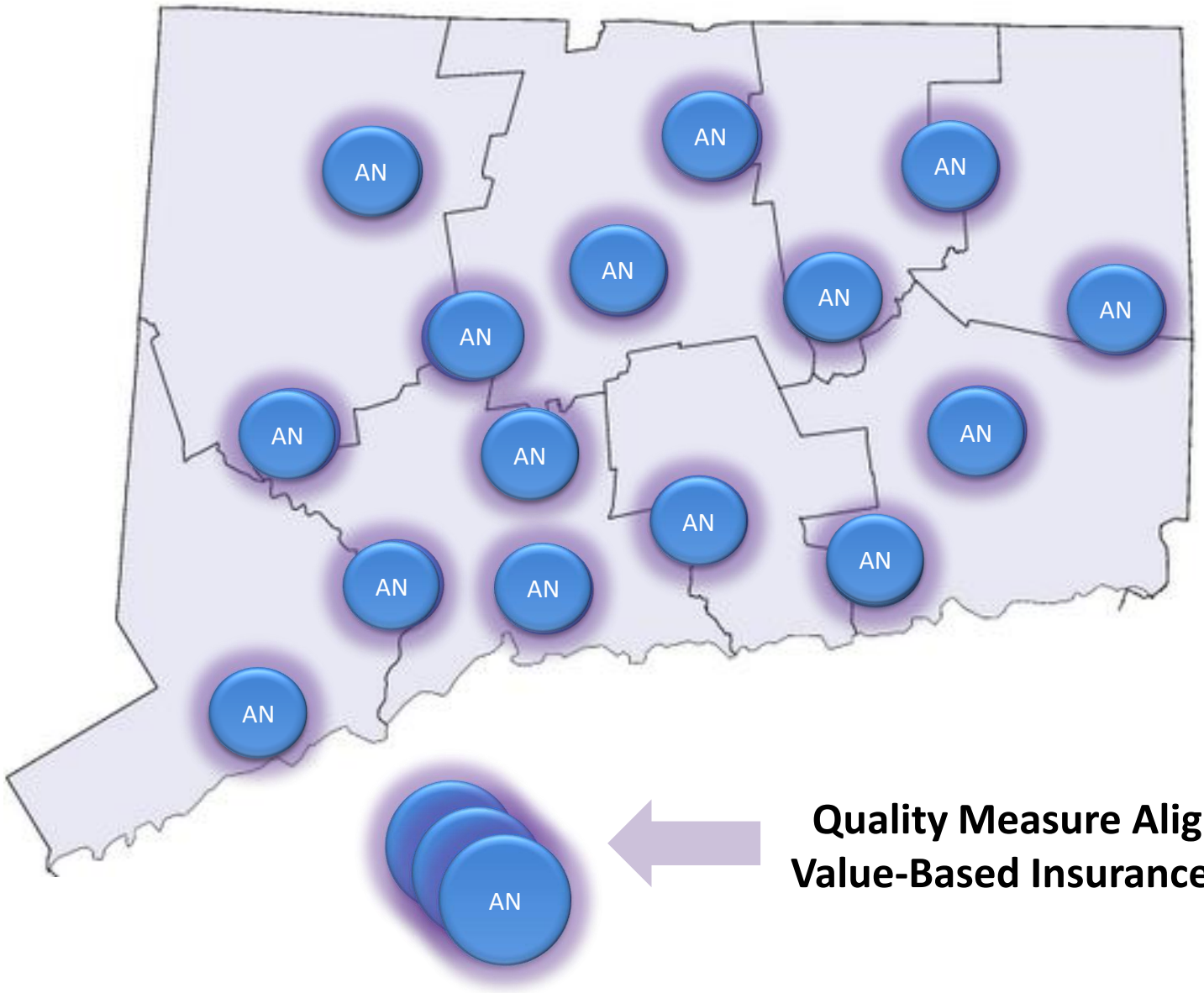


Quality Measure Alignment
Value-Based Insurance Design

Quality Measure Alignment

Quality Measure Alignment

Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard

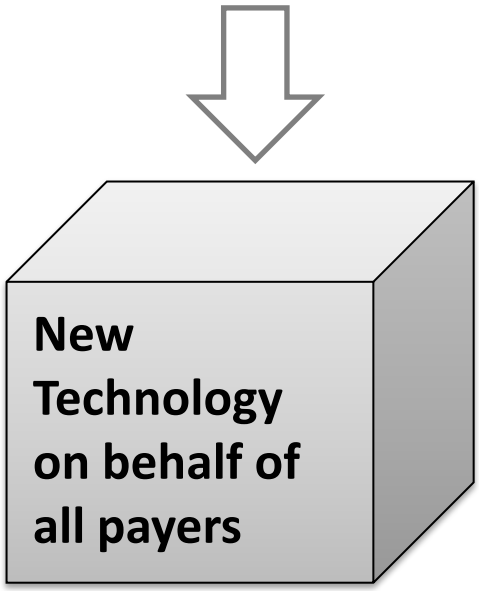
Core Measure Set

Payers currently produce claims based measure

State proposes to produce

- **EHR based measures**
- **Care experience survey measures**

SIM Funded HIT



EHR measure production

Provisional Core Quality Measure Set 10-6-15

Consumer Experience Measure	NQF	ACO
PCMH – CAHPS measure	0005	

Care coordination/patient safety	NQF	ACO
Plan all-cause readmission	1768	
All-cause unplanned admissions for patients with DM		36
Asthma in younger adults admission rate	0283	
Asthma admission rate(child)	0728	
Emergency Department Usage per 1000		
Documentation of current medications in the medical record	0419	39
Annual monitoring for persistent medications (roll-up)	2371	
Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		

Prevention Measure	NQF	ACO
Breast cancer screening	2372	20
Cervical cancer screening	0032	
Chlamydia screening in women	0033	
Colorectal cancer screening	0034	19
Adolescent female immunizations HPV	1959	
Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024	
Preventative care and screening: BMI screening and follow up	0421	16
Developmental screening in the first three years of life	1448	
Well-child visits in the first 15 months of life	1392	
Well-child visits in the third, fourth, fifth and sixth years of life	1516	
Adolescent well-care visits		
Tobacco use screening and cessation intervention *Prenatal Care & Postpartum care*	0028 1517	17
Frequency of Ongoing Prenatal Care (FPC)	1391	
Oral health: Primary Caries Prevention	~~1419~~	
Screening for clinical depression and follow-up plan	0418	18
Oral Evaluation, Dental Services (Medicaid only)	2517	
Behavioral health screening (pediatric, Medicaid only, custom measure)		

Acute & Chronic Care Measure	NQF	ACO
Medication management for people with asthma	1799	
Asthma Medication Ratio	1800	
DM: Hemoglobin A1c Poor Control (>9%)	0059	27
DM: HbA1c Screening (interim measure until NQF 0059 is stood up)	0057	
DM: Diabetes eye exam	0055	41
DM: Diabetes foot exam	0056	
DM: Diabetes: medical attention for nephropathy	0062	
HTN: Controlling high blood pressure Use of imaging studies for low back pain	0018 0052	28
Avoidance of antibiotic treatment in adults with acute bronchitis	0058	
Appr. treatment for children with upper respiratory infection *Cardiac strss img: Testing in asymptomatic low risk patients*	0069 0672	

Behavioral Health Measure	NQF	ACO
Follow-up care for children prescribed ADHD medication	0108	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)		
Depression Remission at 12 Twelve Months	0710	40
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	
Unhealthy Alcohol Use – Screening		

Quality Measure Alignment

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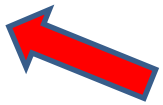
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard?

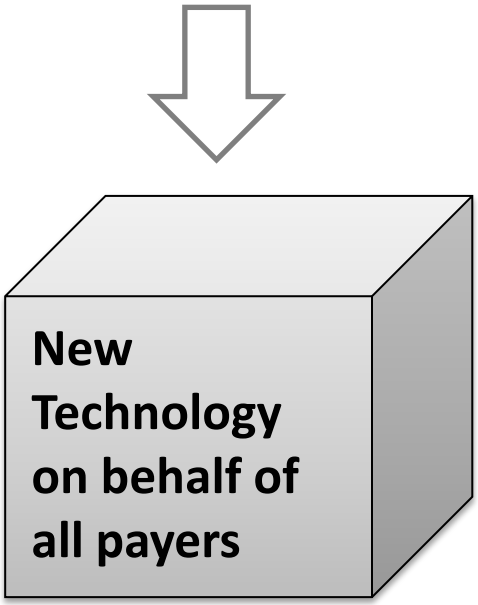


Future focus of Quality Council

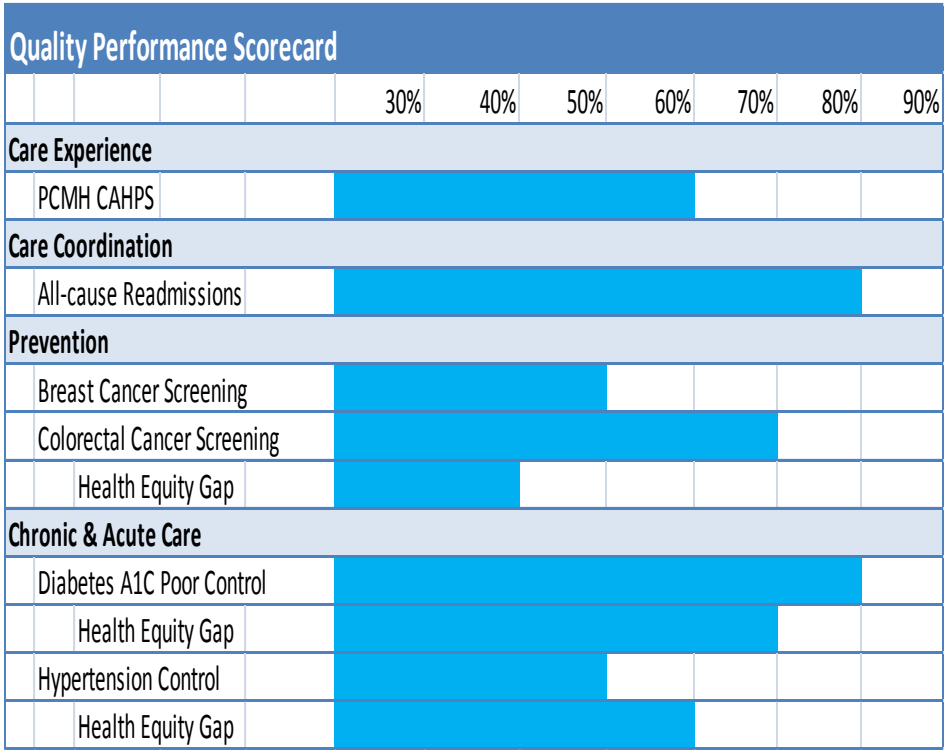
Common Scorecard?

Payer agnostic scorecard for public reporting

SIM Funded HIT?



Claims and EHR Data?



APCD?

Value-based Insurance Design

Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

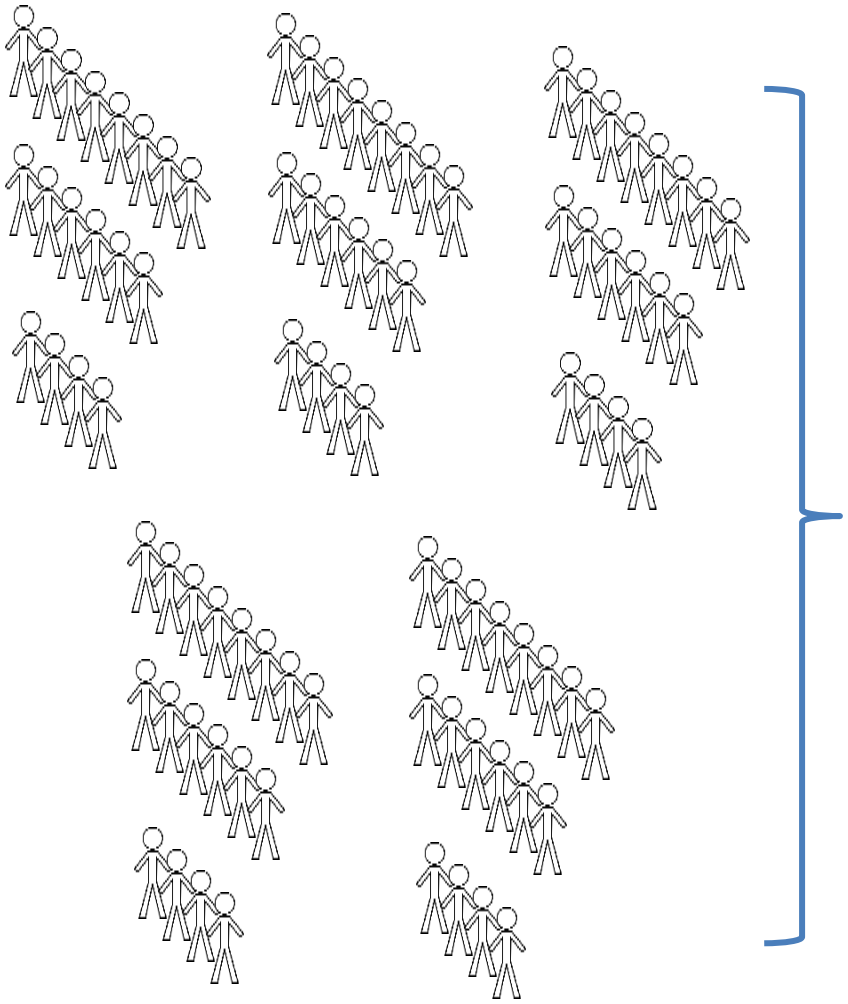
Use high value services
(e.g., preventative services, certain prescription drugs)

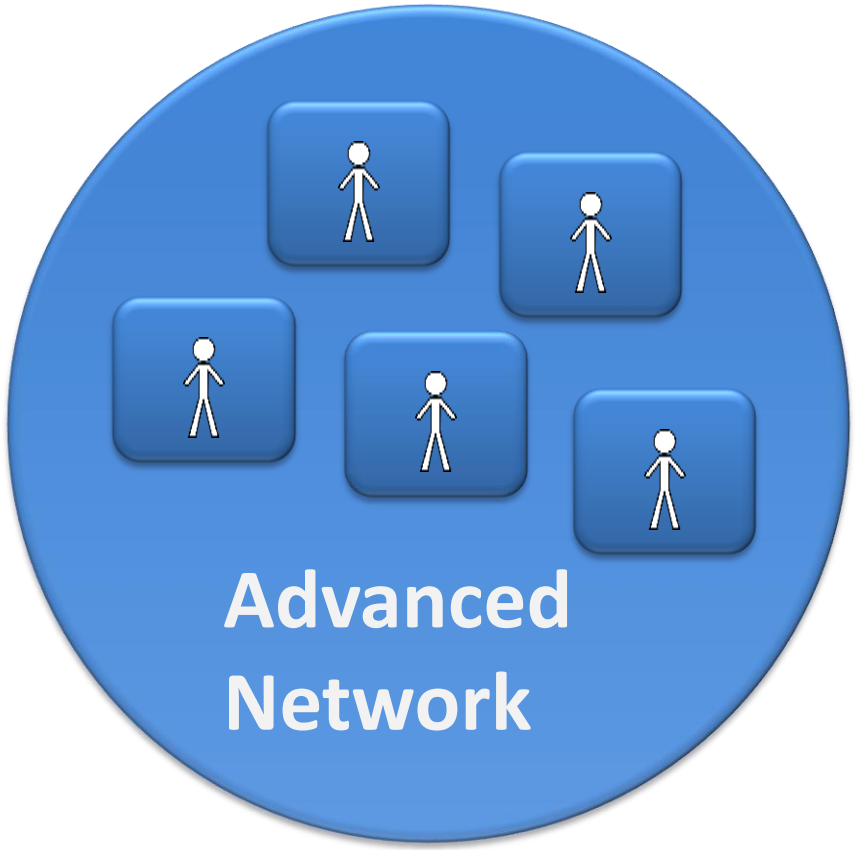
Use high performance providers
Who adhere to evidence-based treatment

Health promotion & disease management

Health coaching & treatment support

Aligning strategies to engage consumers and providers





Value-based Insurance Design

Value-based Payment

Consumer Engagement

Overall Goal

- The overall goal of the CAB's **Consumer Engagement and Communication Framework** is to support meaningful integration of consumer perspective into the SIM process, while providing outreach and education to consumers about how the planned innovations identified in the CT SIM will change their experience with the healthcare system.

Consumers

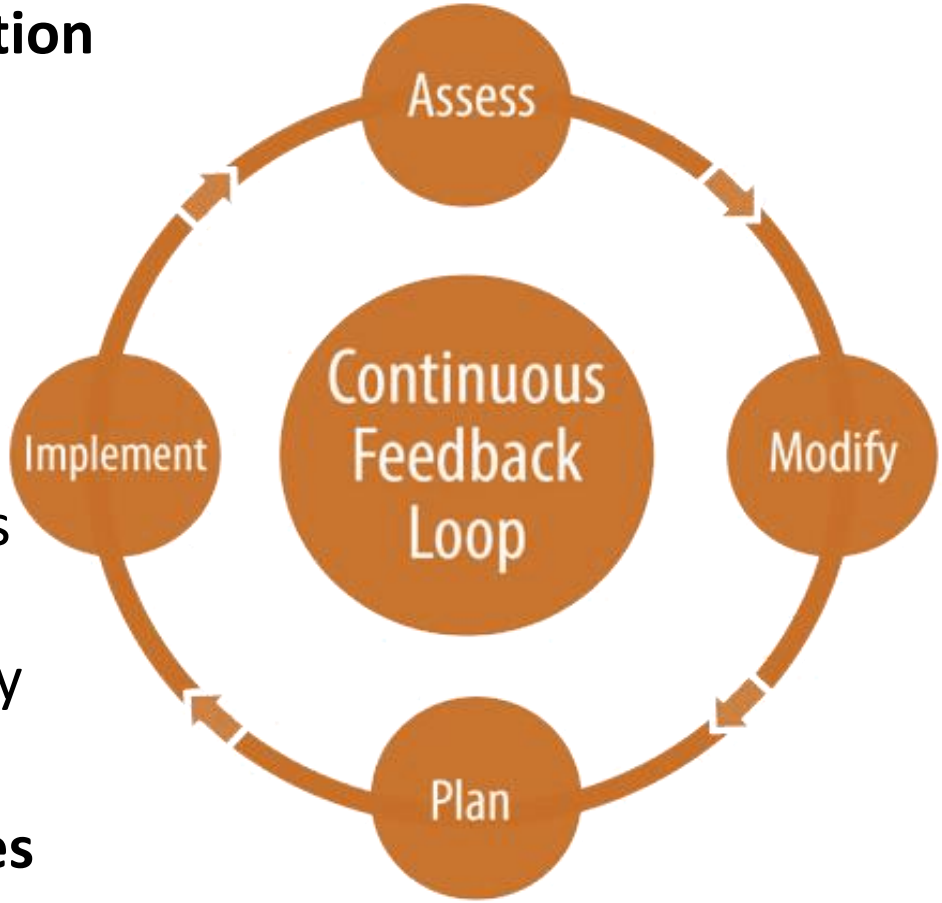
Involved in the SIM process

Consumers

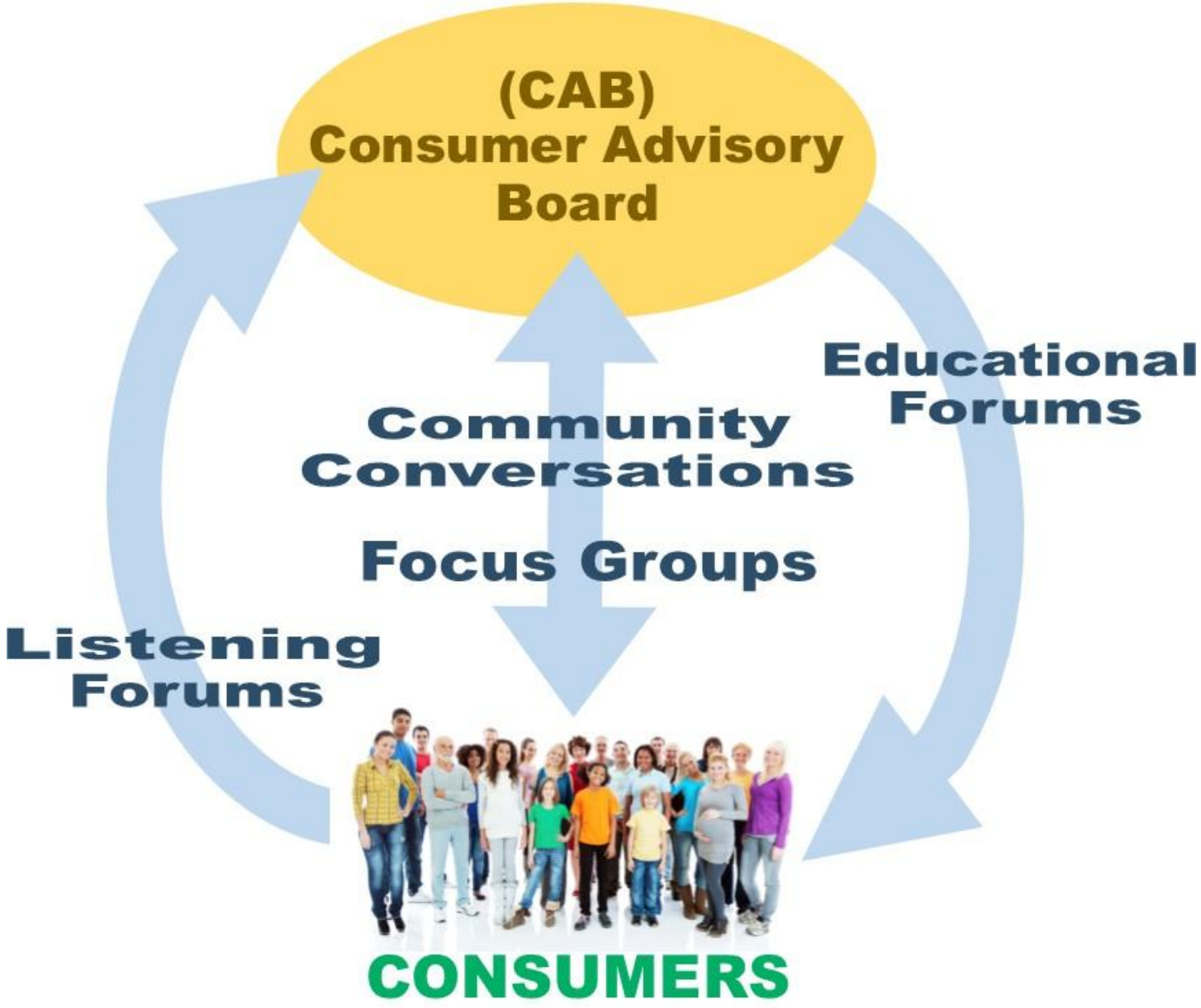
Outreach & Education

Primary Work Streams

1. **Comprehensive multichannel engagement and communication plan**
2. Consumer engagement and **communication strategies** for sharing, collecting, and disseminating information
3. Establishment of a Continuous **Feedback Loop** to plan, implement, assess, and modify current strategies
4. Creation of **outreach strategies** that include everyone and every community in this process



Objectives (1 of 2)

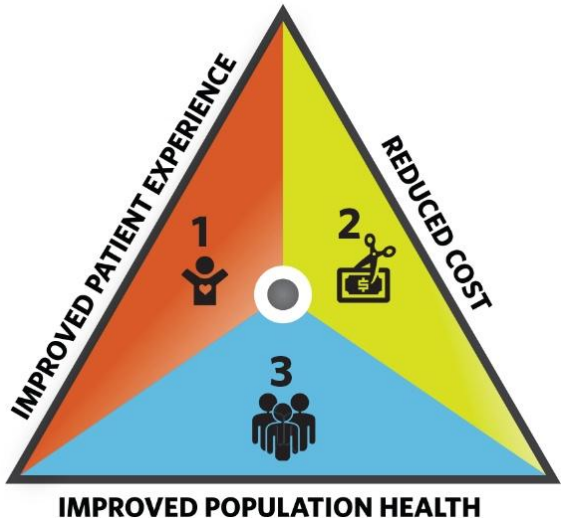


Objectives (2 of 2)

- Coordinate communication and activities between consumer representatives across the CT SIM Governance Workgroups
- Develop and implement a process for the review of selected informational materials developed by CT SIM Program Management Office (PMO)
- Identify, secure, and maintain partnerships with community-based organizations and cross-sector stakeholder groups

Evaluation

Accountability Aims by 2020



By 6/30/2020 Connecticut will:

Improve Population Health

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

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

CT SIM Test Grant: Aims

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Measure	Baseline	2020 Goal
Percent of adults who are obese	24.50%	22.95%
Percent of children who are obese	18.80%	17.65%
Percent of children in low-income households who are obese	38.00%	35.55%
Percent of adults who currently smoke	17.10%	14.40%
Percent low income adults who smoke	25.00%	22.43%
Percent of youth (high school) who currently smoke	14.00%	12.72%
Percent of adults with diabetes	8.50%	7.86%
Percent of adults with diabetes – low income	14.30%	11.32%

* Baselines & goals may change due to new data

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Measure	Baseline	2020 Goal
% adults regular source of care	83.9%	93.0%
Risk- std. all condition readmissions	15.9	13.1
Ambulatory Care Sensitive Condition Admissions	1448.7	1195.1
Children well-child visits for at-risk pop	62.8	69.1
Mammogram for women >50 last 2 years	83.9	87.7
Colorectal screening- adults aged 50+	75.7	83.6
Colorectal screening- Low income	64.9	68.2
Optimal diabetes care- 2+ annual A1c tests	72.9	80.1
ED use- asthma as primary dx (per 10k)	73.0	64.0
Percent of adults with HTN taking HTN meds	60.1%	69.5%
Premature death- CVD adults (per 100k)	889.0	540.0

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CT SIM Test Grant: Aims

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A major goal of the Model Test is to improve equity in access and quality. We will monitor equity gaps for the core dashboard measures and target selected areas for improvement.

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Measure	Baseline	2020 Goal
ASO/Fully insured	$457	$603
State employees w/o Medicare	$547	$722
Medicare	$850	$1,096
Medicaid/CHIP, incl. expansion*	$390	$509
Average	$515	$679

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Questions