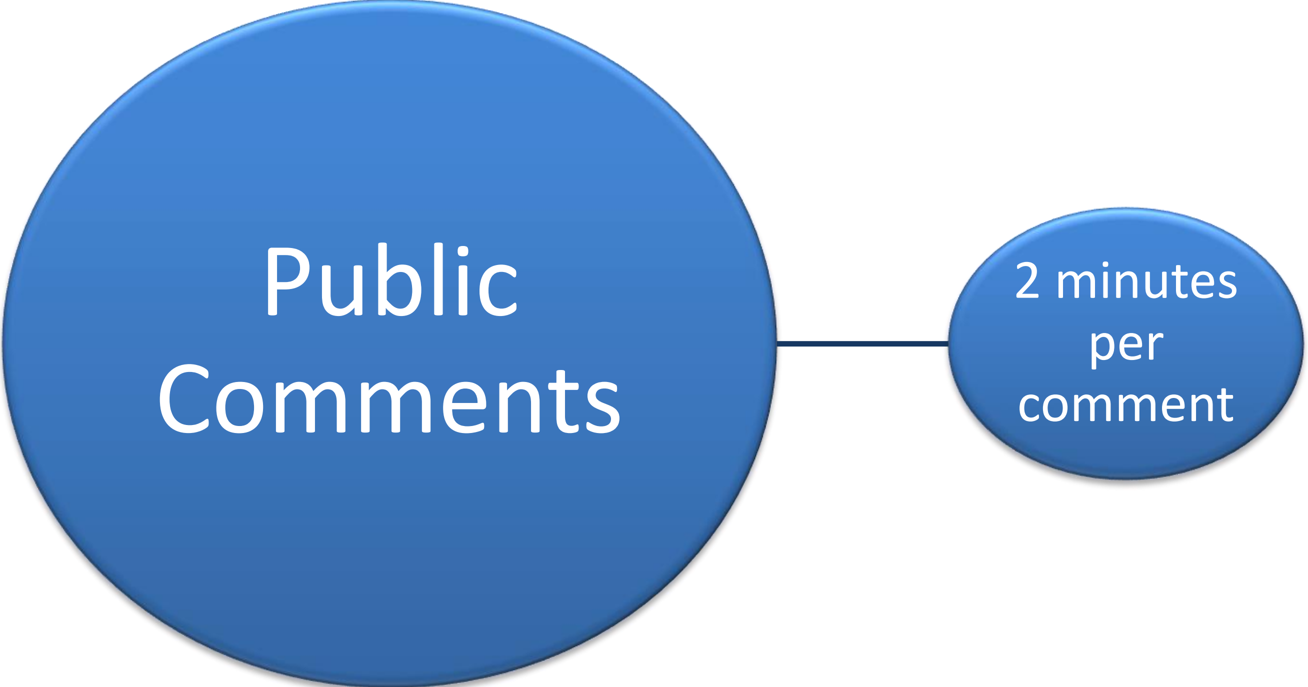
Healthcare Innovation Steering Committee

May 12, 2016

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. Population Health Council Nominations	15 min
5. HISC Nominations	5 min
6. Advanced Medical Home Program Presentation	40 min
7. Operational Plan Presentations for Year 2	40 min
8. Adjourn	


Public
Comments
2 minutes
per
comment

Approval of the Minutes

Population Health Council Nominations

Personnel Subcommittee Nominees- Population Health Council

- **Vincent Tufo**, Charter Oak Communities- Municipal Leader
- **Frederick Browne**, Griffin Hospital- Advanced Network
- **Carolyn Salsgiver**, YNHHS- Advanced Network
- **Hugh Penney**, Yale University- Large Employer
- **Martha Page**, Hartford Food System- Small Employer
- **Hayley Skinner**, ProHealth Physicians- Health Data Analytics Expert
- **Nancy Cowser**, United Community and Family Services- FQHC
- **Penny Ross**, Integrated Health Services- Urban/Rural School District
- **Susan Walkama**, Wheeler Clinic- Behavioral Health Agency
- **Steve Huleatt**, West Hartford-Bloomfield- Local Public Health Agency

HISC Nominations

Steering Committee Nominees

Consumer/Advocate:

Sharon Langer, Senior Policy Fellow, Connecticut Voices for Children

Advanced Network:

Joseph Quaranta, Community Medical Group

Advanced Medical Home Program Presentation

AMH Pilot Updates

Healthcare Innovation Steering Committee

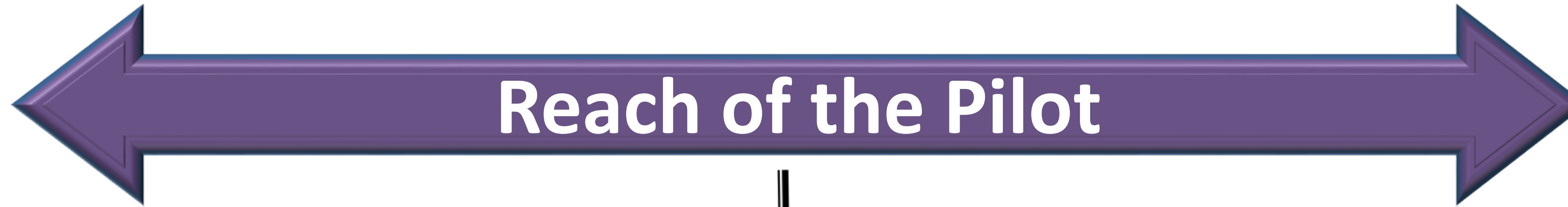
May 12th 2016

Anne Elwell, MPH, RN

Michele Kelvey-Albert, MPH, PCMH CCE

Sara Guastello, Planetree

AMH Pilot Updates



Original Cohort

- 49 Offices
  - 6 Advanced Networks
  - 1 Independent
- 141 Providers

New Cohort

- 29 Offices
  - 3 Advanced Networks
- 108 Providers

AMH Pilot Updates

- Advanced Networks & Independent Offices
  - Attrition: 1
- 15 offices submitted to NCQA as of May

Advanced Medical Home Components

Required "Areas Of Emphasis"

NCQA

SIM Critical Factors

Additional SIM Must Pass Elements

Advanced Medical Home

***Planetree® is being tested and may be considered for inclusion as a required element in AMH.*

QUALIDIGM

PLANETREE

Benefits and Challenges

Advanced Networks

Benefits

- ✓ Care coordination
- ✓ More resources
- ✓ Better access to data

Challenges

- Communication
- Bureaucracy

Independent Practices

Benefits

- ✓ Communication
- ✓ Easier to make decisions

Challenges

- Lack of infrastructure
- Lack of leadership

AMH Pilot Updates

- Interventions
  - Webinars
  - Surveys & Assessments
- Quality Improvement Measures
  - Diabetes Metrics
  - Access to Care (Press Ganey)
  - Transition of Care Calls
- Accommodations and Modifications in response to:
  - Staff Changes
  - Time Table Changes
  - Results of Needs Assessments

Evaluation Tools

Evaluation Tool	Frequency	Description
PCMH-A	Baseline, 6 months, conclusion	Used to help sites understand their current level of 'Medical homeness' and identify opportunities for improvement
Qualidigm Needs Assessment	Baseline	Used to assess leadership, culture and demographics of a practice. Used to develop an office specific plan.
AMH Pre- and Post-Assessment	Baseline, conclusion	Used to assess feelings of burn-out; EHR use; and a host of other questions based on the SIM Physician Survey.
Quality Improvement Measures	After PCMH Standard 6	List of those quality measures chosen by each practice to fulfill this NCQA requirement.

Evaluation Tools

Evaluation Tool	Frequency	Description
Planetree Baseline Observation Report	Baseline	Onsite visit conducted at the beginning of the pilot, includes observation of office workflow, and impromptu interview with patients, families and staff.
Planetree Transformation Validation Report	Conclusion	Onsite visit occurs at the end of the pilot to validate the bronze criteria have been fulfilled.
Staff Satisfaction Survey	Baseline, conclusion, 6 months post	Survey is completed by practice staff.

Evaluation Tools: Trends

Baseline Needs Assessment & PCMH-A:

- Opportunities for Improvement
  - Measuring Patient Experience
  - Care Management
  - Care Coordination
  - Engaged Leadership

Evaluation Tools: Trends

Baseline Needs Assessment & PCMH-A:

- Strengths
  - Advanced Networks
  - Patient Feedback

Evaluation Tools: Trends

- AMH Pre-Assessments
  - Feelings of burn-out: a few times a month
  - Behavioral health referrals: very challenging
  - Use of EHR: somewhat positive effect on quality and reducing cost

QUALIDIGM

Evaluation Tools: Trends

- Staff Satisfaction Surveys
  - Teamwork is an essential driver of satisfaction
  - Staff feels burdened
  - Perceived cultures of safety

QUALIDIGM

Formative Evaluation of the Q-P Process

- Webinar evaluations
- Customer satisfaction surveys
- Office-specific plans
- Planetree baseline observation report

Measure Change from Baseline

- What contributed to successful AMH transformation?
  - Themes
  - Lessons Learned

Contact

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APPENDIX

Advanced Medical Home – Areas of Emphasis

- Recommended 19 "Areas of Emphasis"
  - The Task Force established a high priority subset of ten "core" areas of emphasis that must be included in the transformation process. The areas that follow were recommended as part of the core curriculum.
  - The Task Force further established a second priority subset of nine "elective" areas of emphasis that may be included in the transformation process at the discretion of the practice.

Advanced Medical Home – Core Areas of Emphasis

- **Standard 2: Element C**
  - The practice should be knowledgeable about culturally appropriate services in the practice's catchment area and health disparities among patient populations served by the practice

Advanced Medical Home – Core Areas of Emphasis

- **Standard 3: Element C: Factor 2, 6 & 10**
  - Provide practices with training and support for evaluation and assessment of family/social/cultural characteristics, behavioral health risk factors, and health literacy. Train practices to use this information to identify patients for care management and provide more individualized care incorporating a patients cultural norms, needs, and beliefs. Identify a cohort of practices to pilot the integration of health literacy assessment and accommodation methods into clinical practice.

Advanced Medical Home - Core Areas of Emphasis

- **Standard 3: Element C**
  - Instruct practices in the provision of age appropriate oral health risk and disease screening. The practice should be advised how to implement age appropriate oral health risk and disease assessment, Including assessments for caries, periodontal disease and oral cancer.
  - Instruct practices how to better understand the health risks and information needs of patients/families and train practices to perform an accurate, patient-centered, culturally and linguistically appropriate comprehensive health assessment.

Advanced Medical Home - Core Areas of Emphasis

- **Standard 4: Element A-E**
  - Focus on empathetic care and communication between practitioners and patient/families. Provide training for techniques and best practices to support patients and improve care experience.
- **Standard 4: Element A**
  - Criteria for identifying patients for care management are developed from a profile of patient assessments and may include a combination of the following: A diagnosis of an oral health issue (e.g. oral health risk and disease assessment to include caries, periodontal disease and cancer detection); A positive diagnosis by a dentist of an oral disease condition or risk of the disease.

Advanced Medical Home - Core Areas of Emphasis

- **Standard 4: Element E**
  - Focus on shared decision making communications between patient and practitioner (taking into account patient preferences) giving the patient the support they need to make the best individualized care decisions.
- **Standard 5: Element C**
  - Proactively identifies patients with unplanned hospital admissions and emergency department visits
  - Shares clinical information with admitting hospitals and emergency departments
- **Standard 6: Element D**
  - Set goals and address at least one identified disparity in care/service for identified vulnerable population

Operational Plan Presentations- Year 2

SIM Timeline

We're here

SIM Timeline

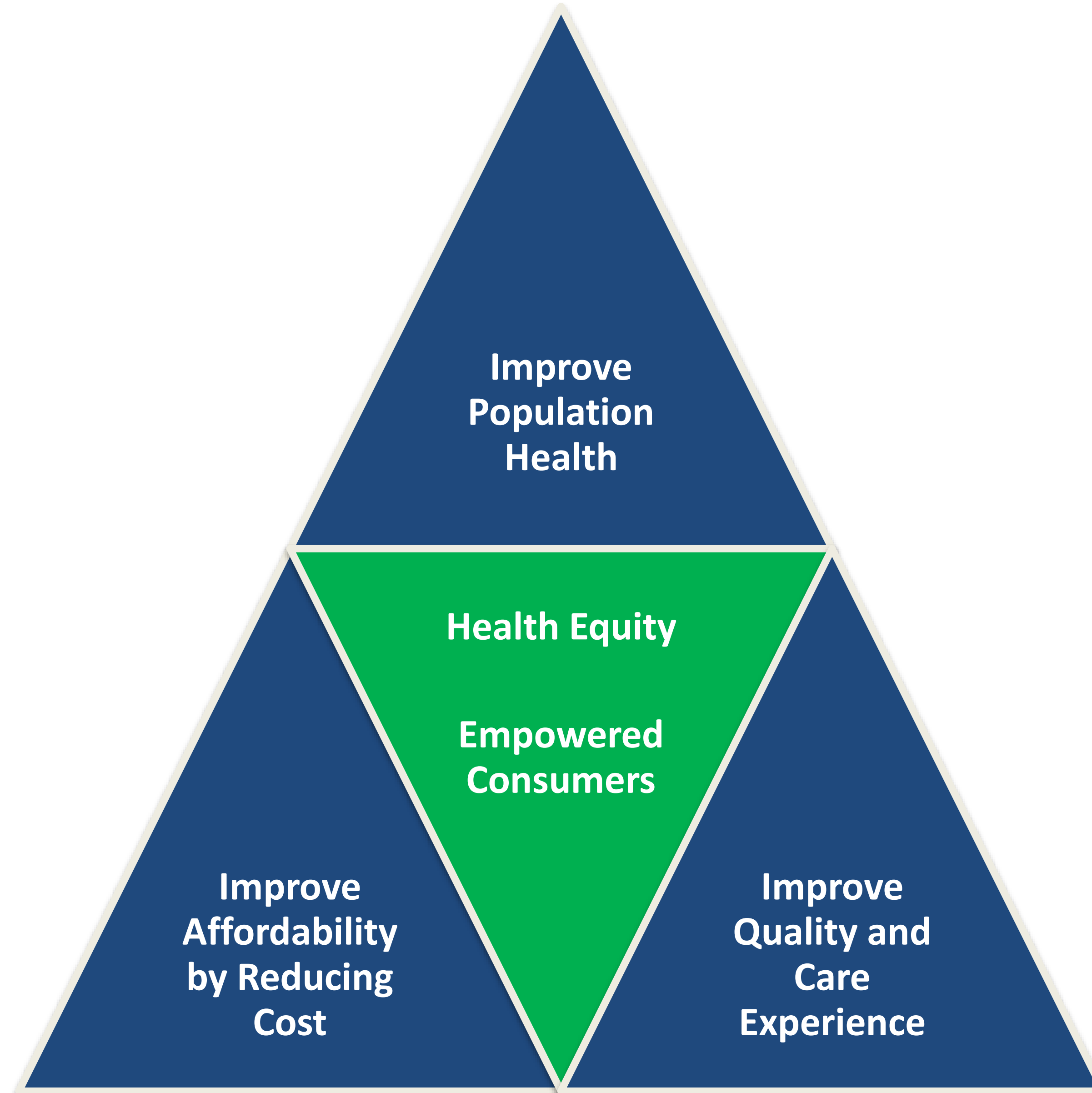
Operational Plan for Performance Year 1 (10/1/16 – 9/30/17)

Operational Plan Overview

Each year, the SIM PMO must apply to CMMI for a funding award. The Operational Plan is the document that is used to request the award. It includes each of the following, specific to the upcoming year:

1. **Operational Plan**
   a. Project Summary
   b. Detailed Operational Plan
   c. General SIM Operational Areas
2. **Budget Narrative**
3. **Performance Measures**
4. **Pace of Reform Measures**
5. **Staff Directory**
6. **Risk Mitigation Strategy**

Review: Connecticut SIM Vision



Review: Connecticut SIM Aims

Healthier People and Communities
and Improved Health Equity

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

Better Care
and Improved Health Equity

Improve performance on key quality measures, including preventative care and care experience

Smarter Spending

Achieve a 1-2% reduction in the annual rate of healthcare growth

CT SIM: Primary Drivers to achieve our Aims

$5.8M

Population Health

$8.8M

Payment Reform

$13.5M

Transform Care Delivery

$650K

Engage Consumers

Health Information Technology $10M

Evaluation $3.5M

CT SIM: Primary and Secondary Drivers to achieve Aims

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health

Population Health

- Health Enhancement Communities
- Prevention Service Centers
- Pop. Health Plan
- Comm. Health Measures

Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care

Transform Care Delivery

- AMH
- CCIP
- HIT
- CHWs

Promote payment models that reward improved quality, care experience, health equity and lower cost

Payment Reform

- MQISSP
- HIT
- Core Quality Measure Set

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions

Engage Consumers

- VBID
- Common Scorecard
- Consumer Outreach

Operational Plan Presentation Schedule

May 12

Work Stream	Presenter
Advanced Medical Home	Shiu-Yu Kettering, PMO
Community and Clinical Integration Program	Faina Dookh, PMO
Value-Based Insurance Design	Tom Woodruff, OSC
Population Health	Mario Garcia, DPH

June 9

Work Stream	Presenter
Community Health Workers	Meredith Ferraro, Southwestern AHEC
Health Information Technology	
Consumer Engagement	Pat Checko, Consumer Advisory Board
Medicaid Quality Improvement and Shared Savings Program	Kate McEvoy, DSS
Quality Measure Alignment	Faina Dookh, PMO
Evaluation	Rob Aseltine, UConn Health Center

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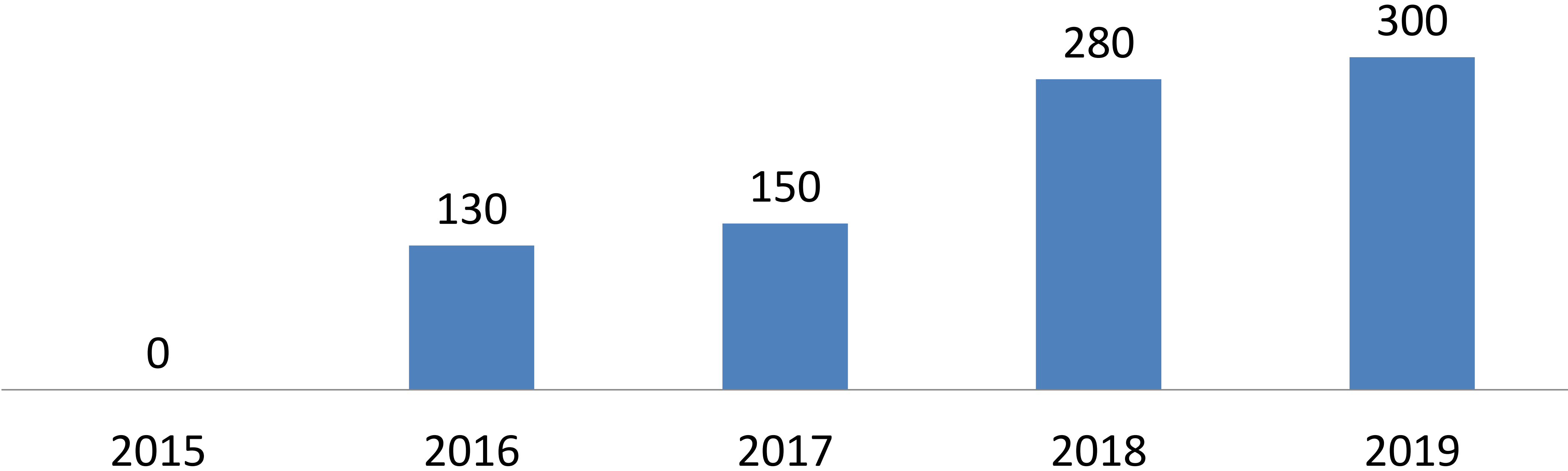
Advanced Medical Home Program

<u>Accountability Target</u>: 300 Primary Care Practices in or completed AMH Program by 2019



Advanced Medical Home Program

TRANSFORM DELIVERY SYSTEM	Pre-implementation	Perf. Year 1 (Beg. 10/1/16)			
Initiatives & Work Steps	**May- Sept. 2016**	**Q1** (Oct-Dec)	**Q2** (Jan-Mar)	**Q3** (Apr-Jun)	**Q4** (Jul-Sep)
Advanced Medical Home (PMO)					
Recruit and market to practices from Advanced Networks	Beg. 7/1 -----	-----●			
Enroll practices from Advanced Networks for Wave 1		------● 11/30			
Finalize Contracts and Launch AMH Program		--------	● 1/31		
Advanced Medical Home Program begins		12/1 ------	------	------	------→
Continuous Learning Collaborative webpage, webinar, and reporting		12/1 ------	------	------	------→

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Prevention Service Centers

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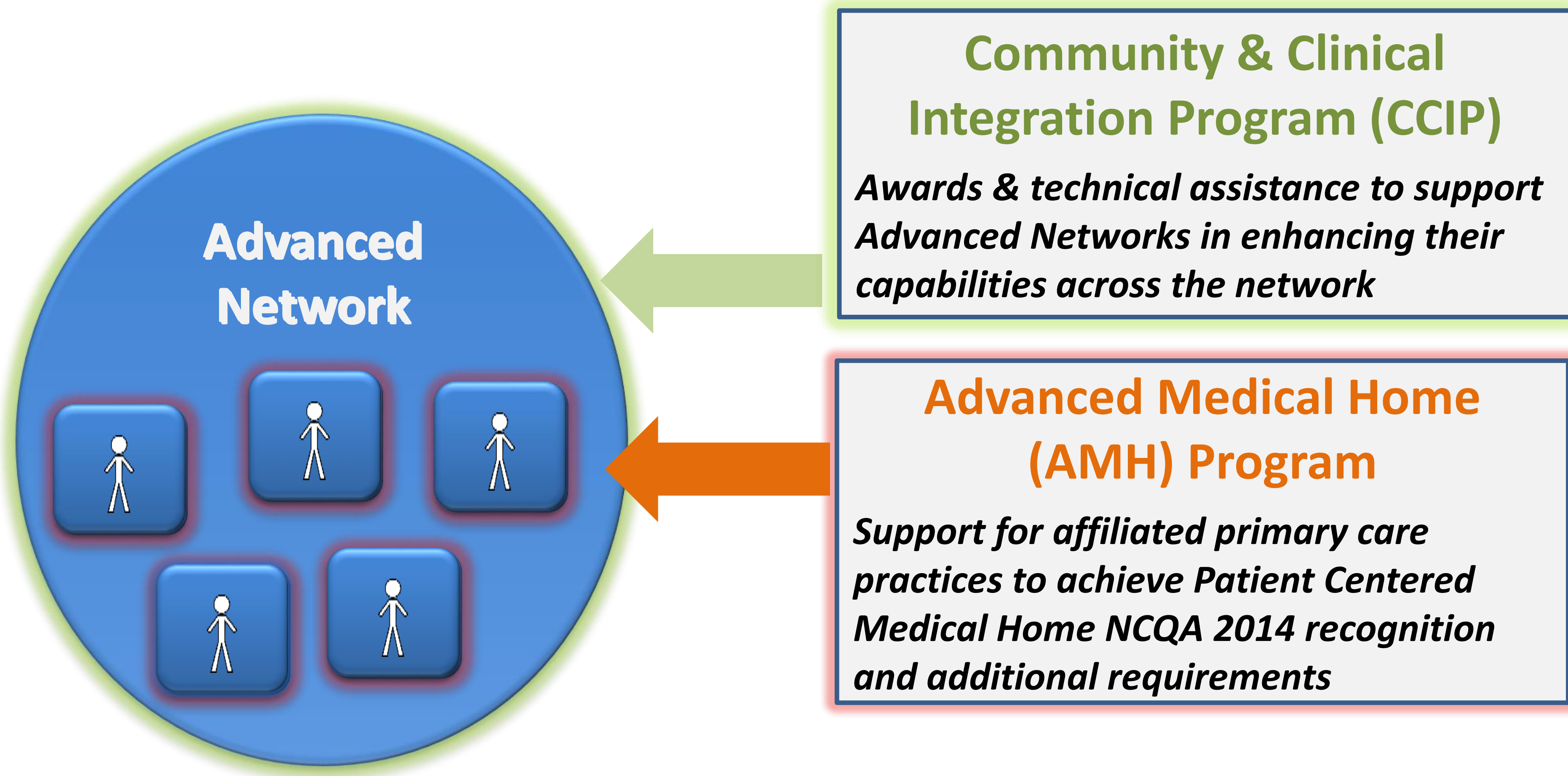
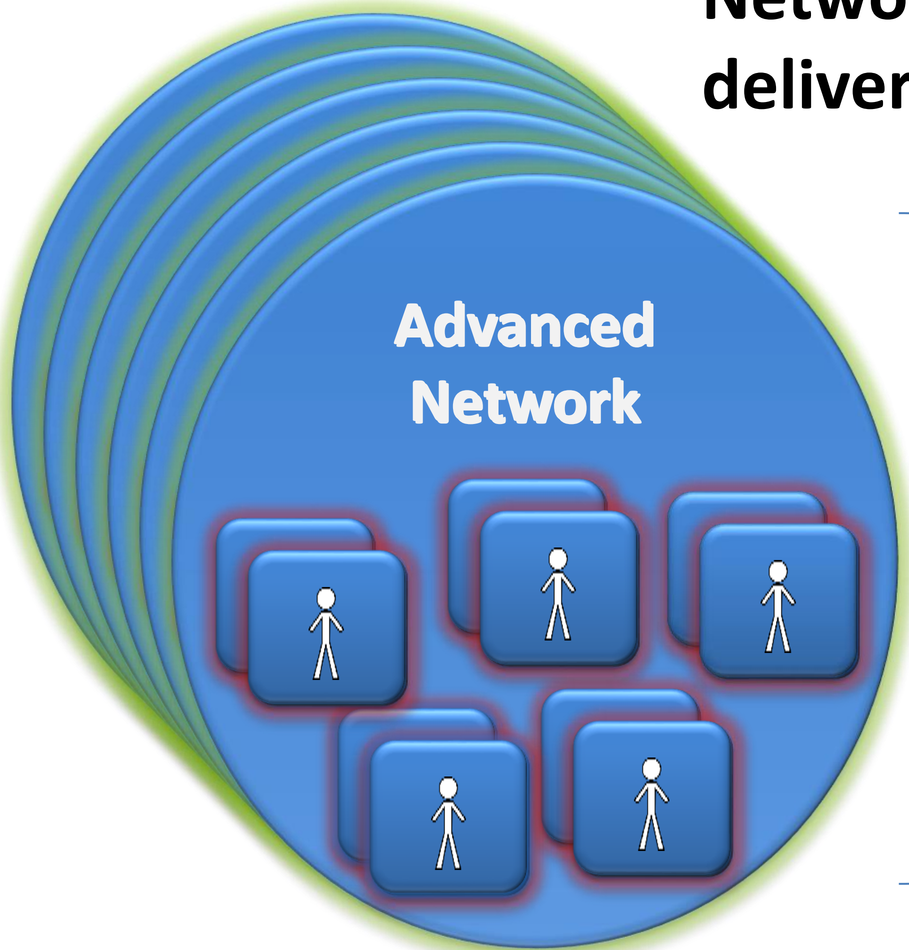
Community and Clinical Integration Program



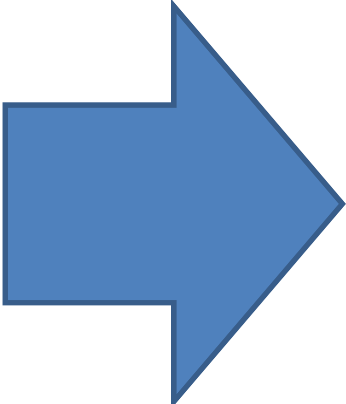
Community and Clinical Integration Program

<u>Accountability Target</u>: 1364 providers in 12 Advanced Networks and 1 FQHC participate in CCIP to improve care delivery and health outcomes



12 Advanced Networks

1364 Providers



Achieve advanced capabilities of delivering care

Community and Clinical Integration Program

TRANSFORM DELIVERY SYSTEM	Pre-implementation	Perf. Year 1 (Beg. 10/1/16)			
Initiatives & Work Steps	**May- Sept. 2016**	**Q1 (Oct-Dec)**	**Q2 (Jan-Mar)**	**Q3 (Apr-Jun)**	**Q4 (Jul-Sep)**
Clinical & Community Integration Program (PMO)					
Prepare and Issue RFP for CCIP Transformation vendor(s)	5/30				
Contract with CCIP TA vendor(s)	9/01				
Contract with Advanced Networks for Wave 1 participation	9/30				
Pre-assessment, transformation planning, learning collaborative		1/01			
Begin TA with ongoing support monthly conference calls, LC webinars, and milestone reporting (15 - 21 months)		01/1 →	→	→	→

CT SIM: Primary and Secondary Drivers to achieve Aims

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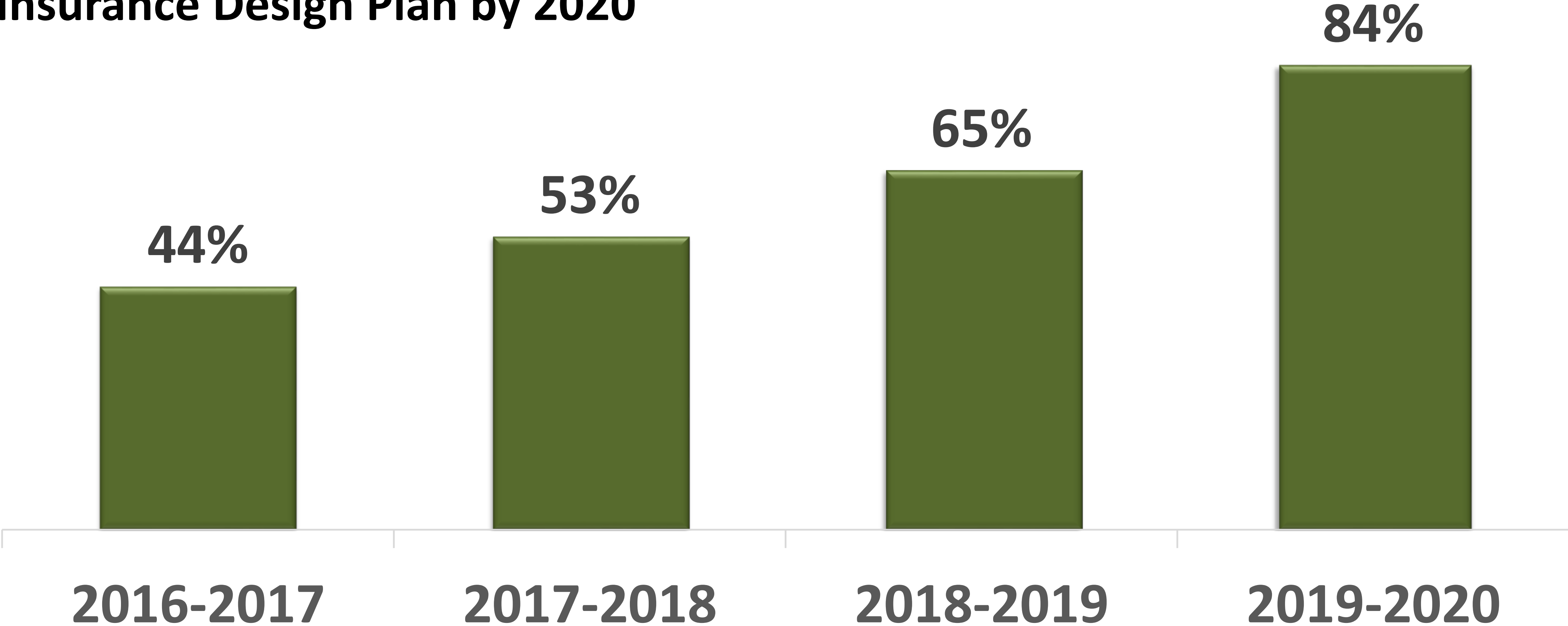
Value Based Insurance Design



NOTE: Targets subject to change based on baseline study

Value-based Insurance Design

REFORM PAYMENT & INSURANCE DESIGN	Pre-implementation	Perf. Year 1 (Beg. 10/1/16)			
Initiatives & Work Steps	**May- Sept. 2016**	**Q1** (Oct-Dec)	**Q2** (Jan-Mar)	**Q3** (Apr-Jun)	**Q4** (Jul-Sep)
Value-Based Insurance Design					
Conclude initial consortium activities and support	------• 7/31				
Finalize VBID Consortium, templates, and toolkit	------• 8/31				
Conduct Baseline Assessment	----	---• 10/31			
Circulate VBID Marketing Materials	9/01 ----	------	------	------	------→
Launch employer portal on SIM website	------• 8/31				
Plan first Learning Collaborative & recruit participants	------• 8/31				
Convene first VBID Learning Collaborative		10/01 ------	------	------	------→

CT SIM: Primary and Secondary Drivers to achieve Aims

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Population Health Planning

Accountability Targets

- Develop Population Health Assessment by Q4 2016
- Develop Population health plan by Q4 2017 (to include community health measures and PSC detailed design)
- Community health measures identified for target communities by Q4 2016
- Detailed design plan for PSCs Q4 2017
- Detailed design plan for HECs by Q4 2018
- Updated Pop Health Plan that includes HEC detailed design
- Demonstration for 2-3 PSCs launched by Q1 2018
- Launch 1-2 HECs by Q1 2019

Population Health Planning

BUILD POPULATION HEALTH CAPABILITIES

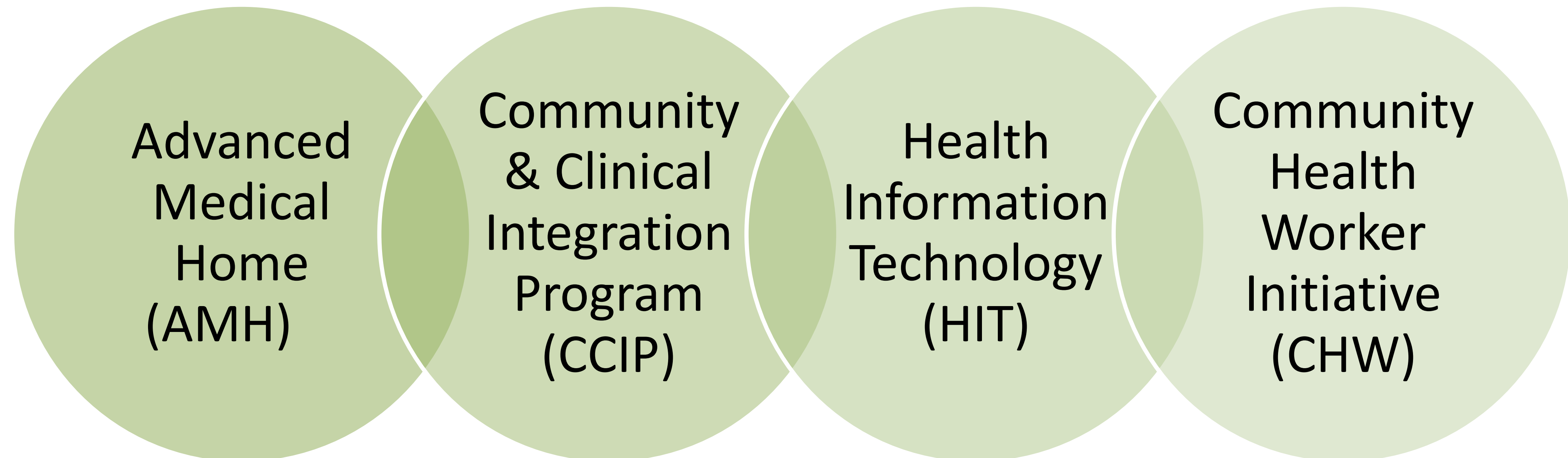
Initiatives & Work Steps	Pre-implementation May- Sept. 2016	Perf. Year 1 (Beg. 10/1/16) Q1 (Oct-Dec)	Q2 (Jan-Mar)	Q3 (Apr- Jun)	Q4 (Jul-Sep)
Plan for Improving Population Health					
Hire all DPH staff required to establish the Population Health SIM Team	- - - ● 6/30				
Establish and launch the Population Health Council	- - - ● 5/31				
Provide data and enabling methods to maintain metrics of Population Health	- - - - - -	- - - - - -	- - - - - -	- - - - - -	- - - - - - ►
While conducting a root cause and barrier analysis, define trends and improvement targets for tobacco use, obesity, and diabetes	- - - - - -	- - - - - -	- - - - - -	- - - - - -	- - - ● 8/31
Identify priority areas with highest burden of disease and community capacity to implement prevention initiatives	- - - - - -	- - - ● 12/31			
Conduct statewide scan to identify entities able to provide evidence-based community prevention services	- - - - - -	- - - - - -	● 1/31		
Design Prevention Service Centers (PSCs), research evidence-based interventions, and finalize PSC's service menu	- - - - - -	- - - - - -	- - - - - -	- - - - - -	- - - ● 8/31
Identify funding options and federal authority to support PSCs and Health Enhancement Communities (HECs)		1/1	- - - - - -	- - - - - -	- - - - - - ►
Develop a coordinated community and social service care model for multiagency health collaboratives in CT	- - - - - -	- - - - - -	- - - - - -	- - - - - -	- - - ● 9/30
Establish a planning team and guiding principles for HECs				6/1	- - - - - - ►

Adjourn

Appendix

CT SIM: Secondary Drivers to achieve Aims

1 **Transform Care Delivery** Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care

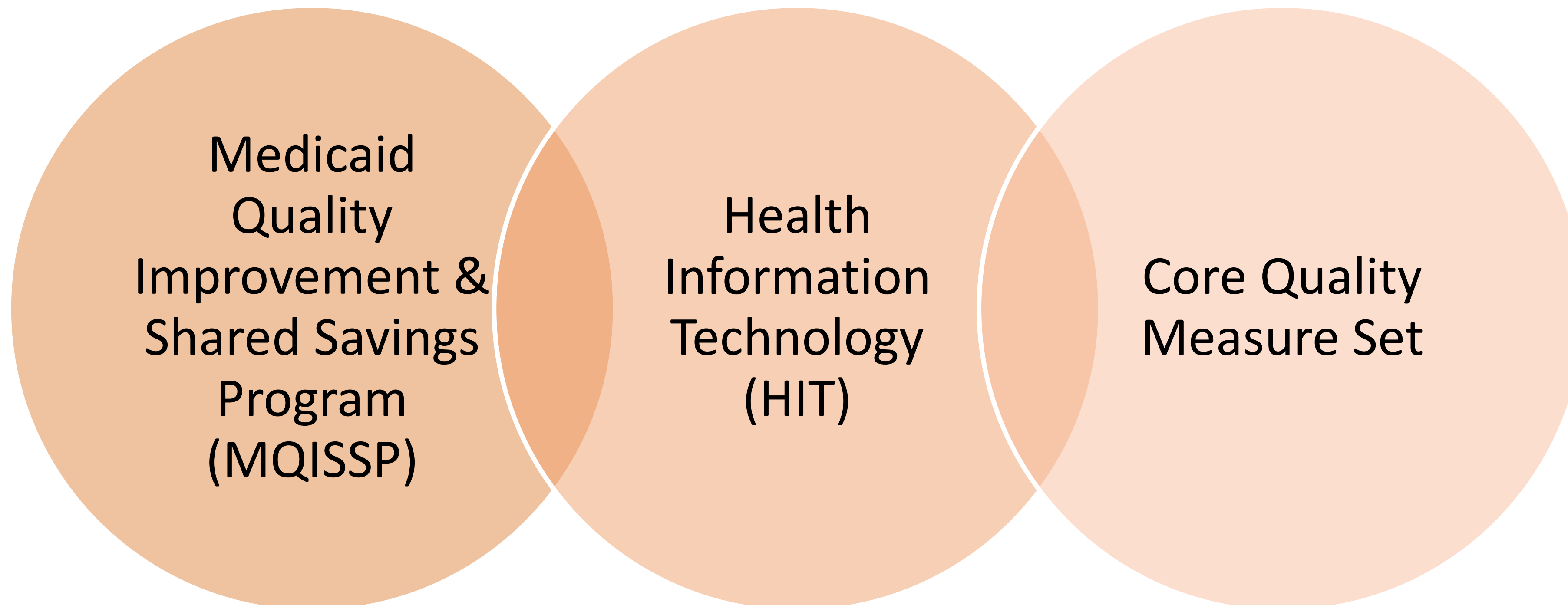


CT SIM: Secondary Drivers to achieve Aims

2

Payment Reform

Promote payment models that reward improved quality, care experience, health equity and lower cost



CT SIM: Secondary Drivers to achieve Aims

3

Engage Consumers

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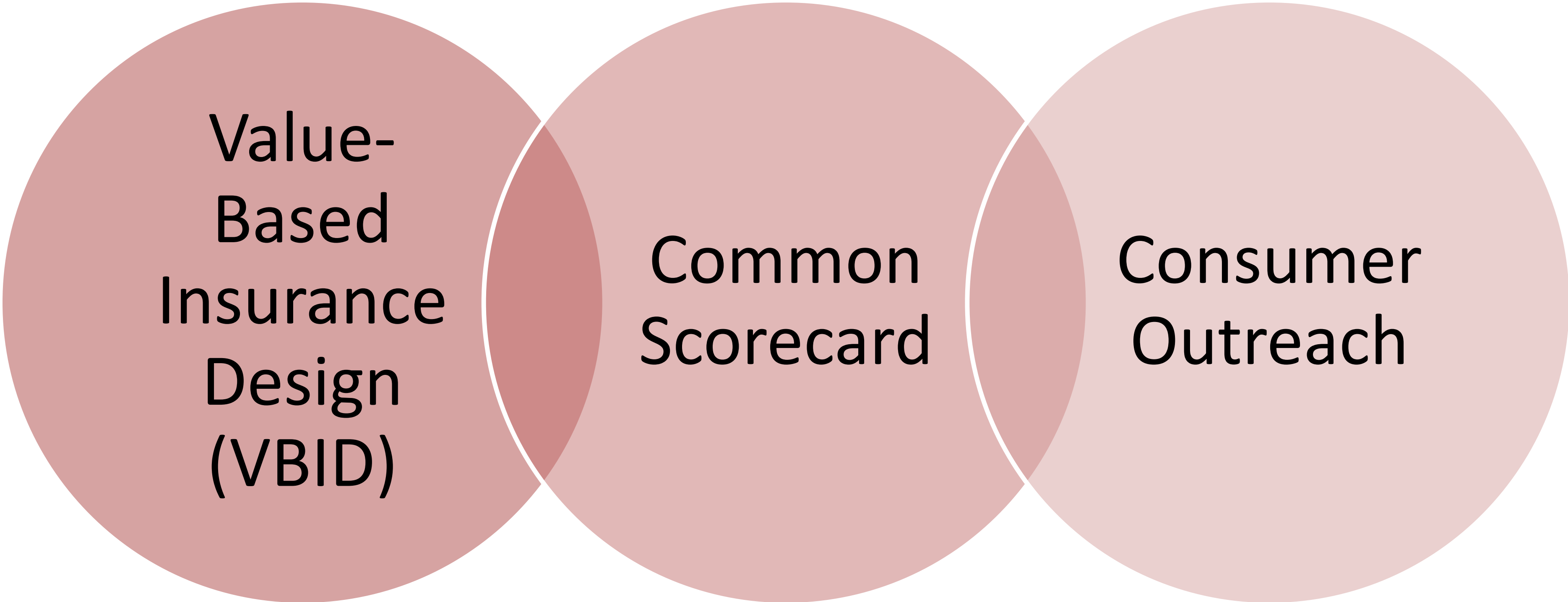

CT SIM: Secondary Drivers to achieve Aims

4

Population Health

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health