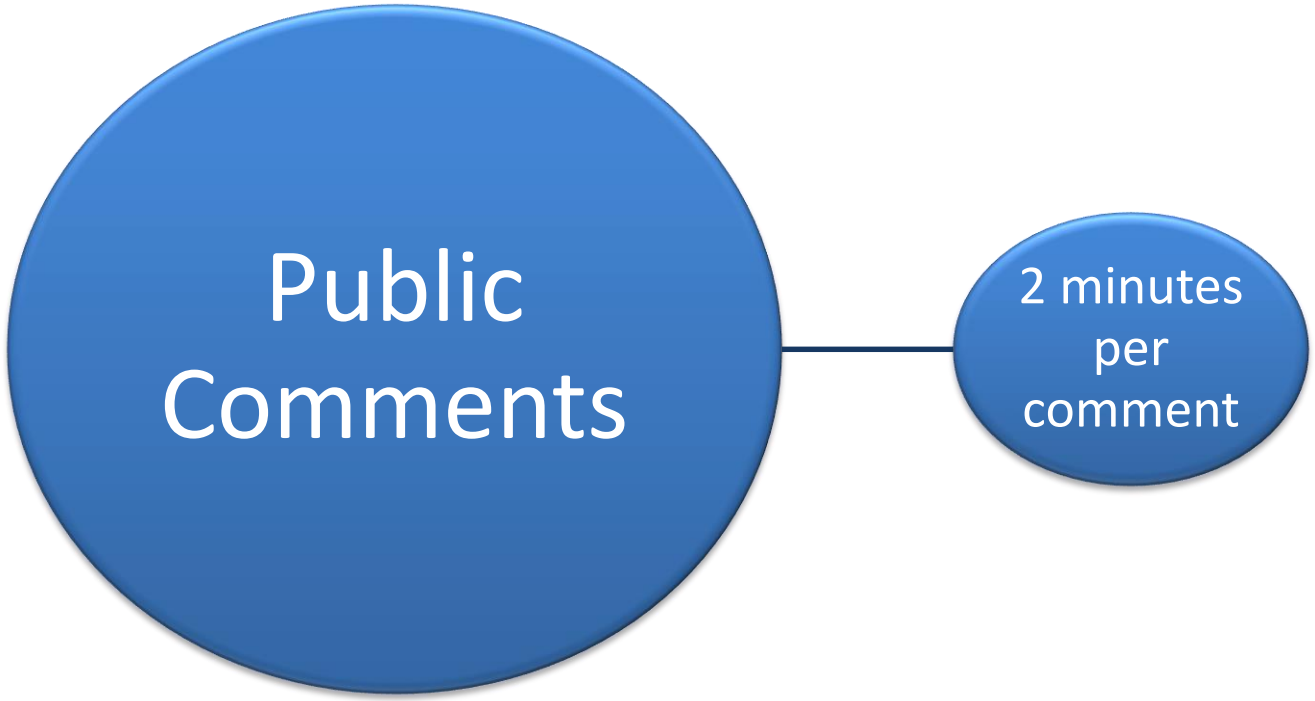
Healthcare Innovation Steering Committee

November 10, 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. VBID Self-Insured Employer Manual, Approval	10 min
5. Quality Council Report	30 min
6. HIT Update	30 min
7. Care Delivery Reform Updates	30 min
8. Adjourn	


Public Comments
2 minutes per comment

Approval of the Minutes

VBID Self-Insured Employer Manual

VBID Self-Insured Employer Manual

Note added: ***The above is an example for marketing purposes only. This is not intended to serve as a recommendation on screenings by age. Such decisions should be evidence-based and in line with the needs of the employee population.**

HEALTH ENHANCEMENT PROGRAM (HEP) Requirements

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

Quality Council Report- Review of Public Comment

Public Comments Received as of August 5, 2016

Advocacy Unlimited
CT Association of School Based Health Centers
CT Children's Medical Center
CT Dental Health Partnership
CT Hospital Association
CT Oral Health Initiative
Doug Larson
Health Equity Solutions
Kathy Langlais
Khmer Health Advocates
Lawrence Rifkin
Lisa Honigfeld
Planned Parenthood of Southern New England
ProHealth Physicians
Sharon Efron
Supriyo Chatterjee

Highlights

- Comment #6: All metrics should be recommended for use at the level for which they have been validate
- Comment #7: To be used for a payment model, measures should have absolute targets of success available
  - For example, metrics for vaccination rates typically do have absolute targets whereas a metric like avoiding the emergency department for patients with asthma lacks an absolute target

Health Equity Measures

- Comment #15: Commenter concurs that measures of health equity should be included as part of the program and suggests they be included in the Development or Reporting Measure Set.
- Until validity can be determined, however, they should not be included in the Core Measure Set.
- Recommends PMO develop a sampling methodology in advance of reporting and data collection and test it for reliability and validity in advance of scorecard development or inclusion in the payment program

Preventive Services

- Chlamydia screenings
- Adolescent female immunizations HPV (NQF 1959)
- Prenatal Care and Post-Partum Care (NQF 1517)
  - NQF Perinatal and Reproductive Health Project 2015-2016
- Oral health: Primary Caries Prevention (1419)

Chronic Care

- Avoidance of antibiotic tx in adults w/acute bronchitis (NQF 0058)
- Appr. treatment for children with upper respiratory infection (NQF 0069)
- Depression Remission measures (0710, 1885)

Alignment Reporting

The PMO will monitor progress toward alignment on an annual or semi-annual basis. The baseline assessment of alignment will occur after the measure set is finalized with annual or semi-annual reassessments thereafter.

The PMO has considered methodologies to calculate statewide alignment. One option under consideration is to calculate alignment as a percentage using the following formula:

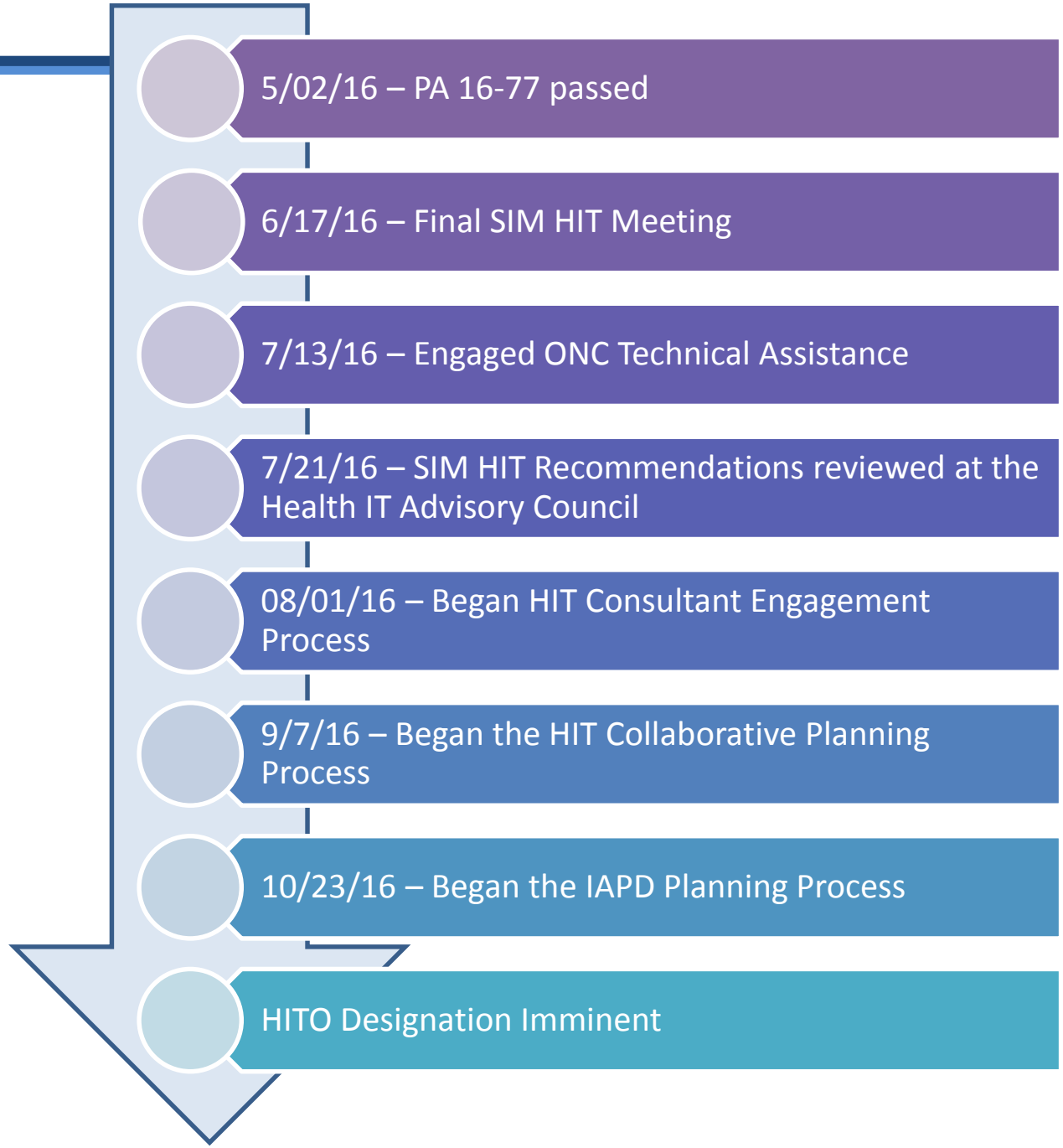
$$\% \text{ Alignment} = \frac{\text{SUM (\# of measures Payer 1: \# of measures Payer X)}}{\text{\# of payers * number of measures}}$$

Alignment Score = 53.33% (commercial) 50% (commercial and Medicaid)
(Claims measures only)

Disposition and Committee Action

- Response to Comments Revised to Reflect
- Quality Council Report edited to align with response to comments
- Request HISC to approval the final report and recommendations

HIT Updates


5/02/16 – PA 16-77 passed
6/17/16 – Final SIM HIT Meeting
7/13/16 – Engaged ONC Technical Assistance
7/21/16 – SIM HIT Recommendations reviewed at the Health IT Advisory Council
08/01/16 – Began HIT Consultant Engagement Process
9/7/16 – Began the HIT Collaborative Planning Process
10/23/16 – Began the IAPD Planning Process
HITO Designation Imminent

Technical Assistance

Federal Partners

Patricia MacTaggart, Senior Advisor at ONC

Terry Bequette, ONC Consultant

Tom Novak, Medicaid Interoperability Lead

HIT Consultant

Carol Robinson, Principal at CedarBridge

Teresa Younkin, Director of Operations & Program Management

Public Act 16-77

Legislative Refresher

HITO, with consultation with the statewide Health IT Advisory Council:

1. Oversee the development and implementation of the statewide health information exchange
2. Coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation
3. Serve as the state liaison to the statewide health information exchange

Health IT Advisory Council shall:

- Advise the HITO in developing priorities and policy recommendations for advancing the state's HIT and exchange efforts and goals
- Advice in the development and implementation of the statewide HIT plan and standards
- Development of appropriate governance, oversight and accountability measures to ensure success in achieving the state’s health information technology and exchange goals

Goals of the statewide health information exchange

1. Allow real-time, secure access to patient health information and complete medical records across all health care provider settings;
2. Provide patients with secure electronic access to their health information;
3. Allow voluntary participation by patients to access their health information at no cost;
4. Support care coordination through real-time alerts and timely access to clinical info;
5. Reduce costs associated with preventable readmissions, duplicative testing and medical errors;
6. Promote the highest level of interoperability;
7. Meet all state and federal privacy and security requirements;
8. Support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics;
9. Support population health analytics;
10. Be standards-based; and
11. Provide for broad local governance that (A) includes stakeholders, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange.

SIM HIT Council

Activities and Recommendations

Summary of SIM HIT Council's Work

- The last meeting was held on June 17, 2016
- SIM HIT Council recommended themes and topics that should be shared with the Health IT Advisory Council. They include:
  - Production of eCQMs
  - Need for stakeholder engagement
  - Other
    - Operational Plan
    - SIM work stream and HIT needs
    - HIT investments by other SIM States
    - OSC value based insurance design data pilot

Please see 9/15 Meeting Materials for Recommendations
http://portal.ct.gov/ltgovernor/Health_IT_Advisory_Council/

eCQM Decision Point for the Health IT Advisory Council:

A. Move forward with a Pilot

B. Move forward with an RFI/RFP process

Estimated Timeline:
eCQM Measurement and Reporting System

Request for Information (RFI) & Request for Proposals (RFP)

Steps to Evaluate Technical Options for eCQM Measurement and Reporting System	Approximate Dates
RFI Planning	December 2016
Post RFI for Public Comments / Responses	January 2017
Presentation of RFI Feedback to Advisory Council	February 2017
Develop RFP business, technical, and functional requirements, informed by RFI responses and with stakeholder feedback	February - March 2017
RFP for eCQM Measurement and Reporting System posted	April 2017
RFP Evaluation Phase	May 2017
RFP Awarded	June 2017

Admission, Discharge and Transfer (ADT)

Alert Notification

What is an ADT message?

These messages communicate that

- a patient's "state" (admitted, discharged, or transferred) has changed, or
- his or her personal or demographic information (such as the patient's name, insurance, next of kin, attending doctor, etc.) has been updated.

These seemingly simple and ever-present messages contain a wealth of information, and are valuable tools to help health care providers better coordinate a patient's care.

Process to Select Use Case Strategy for Alert Notification Services

As part of the state's strategy, HITO will support engagement of hospitals and providers to align and leverage strategies:			
Identify and evaluate health IT needs related to alert notifications	Understand current alert notification solutions that have been invested in by hospitals and provider groups	Determine if current hospital/provider alert notification solutions can easily interoperate with Medicaid alert notification strategy	Determine if enhancements of current hospital and/or provider solutions are needed to meet alert notification needs of providers

Estimated Timeline:
Expanding the Alert Notification Infrastructure
To support multi-payer participation

Steps to Expand Alert Notifications	Approximate Dates
IAPD Submission	December 2016
Stakeholder engagement and environmental scan	December – Feb 2017
Determine Fair Share Contribution for multi-payer participation	January - March 2017
Develop priority use cases	March – May 2017
Support expansion of alert notification infrastructure	May 2017 - beyond

Next Steps

November

- Health IT Advisory Council Meeting

December

- IAPD Submission

2017

- Conduct Stakeholder Engagement
- Collaborative Process with Key Stakeholders
- RFI/RFP Development for eCQM
- RFI/RFP for HIE Management Entity/ Services
- Use Case Factory

For more information:

Contact: Sarju.Shah@ct.gov

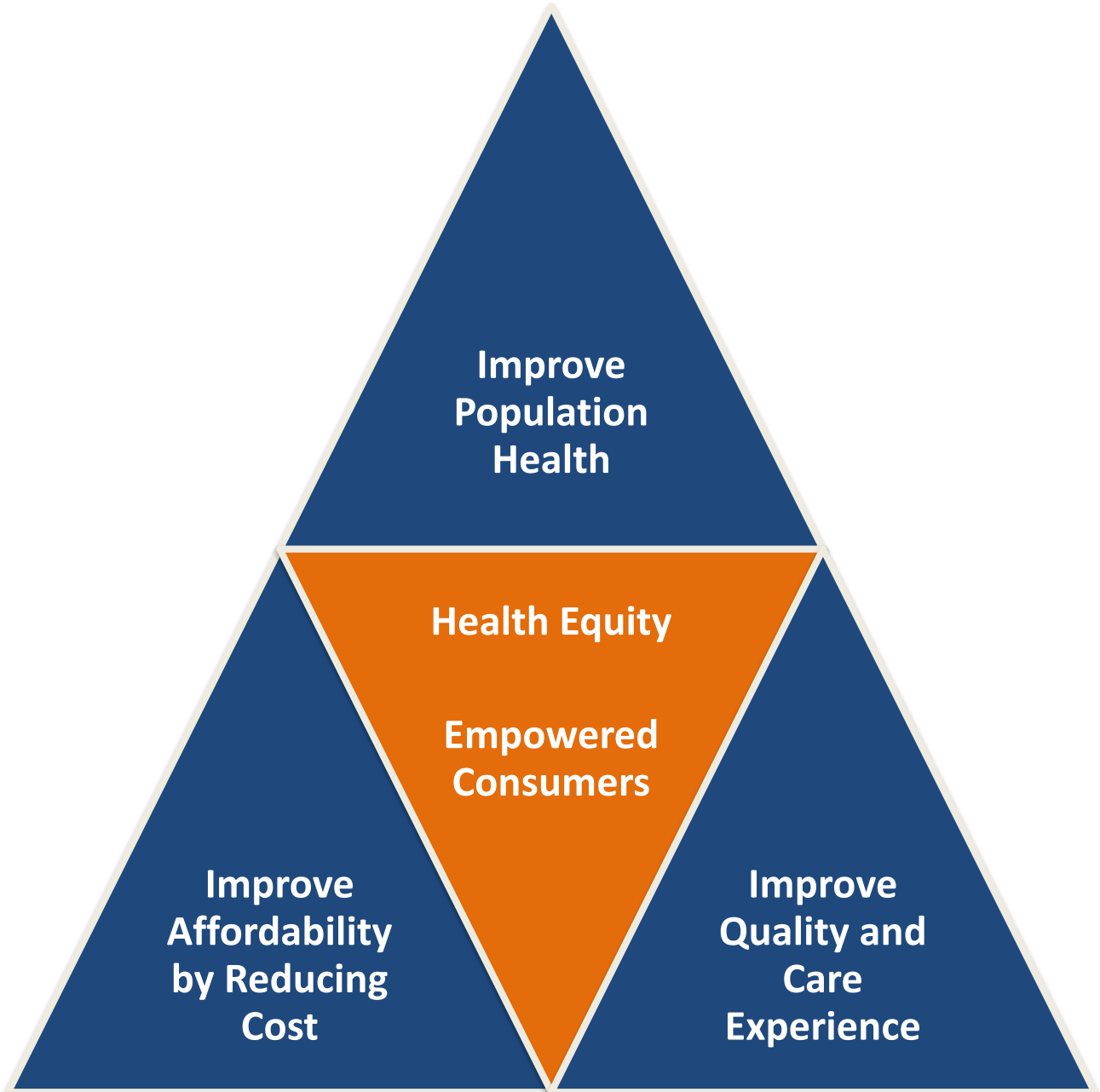
Learn more about the Health IT Advisory Council
http://portal.ct.gov/ltgovernor/Health_IT_Advisory_Council/

Upcoming meetings: LOB – 1:00 PM - 3:00 PM

- 11/17/16
- 12/15/16

Care Delivery Reform Updates

Review: Connecticut SIM Vision



CT SIM: Primary Drivers to achieve Aims

Population Health

Payment Reform

Transform Care Delivery

Empower Consumers

Health Information Technology

Evaluation

Advanced Medical Home Program

What is it?

A SIM initiative to improve care delivery in primary care practices

What will it do?

Provide technical assistance to help practices achieve NCQA PCMH Recognition plus additional elements

Who can participate?

Primary Care Practices that have not yet achieved NCQA PCMH Recognition and have an ONC recognized EHR

What will it focus on?

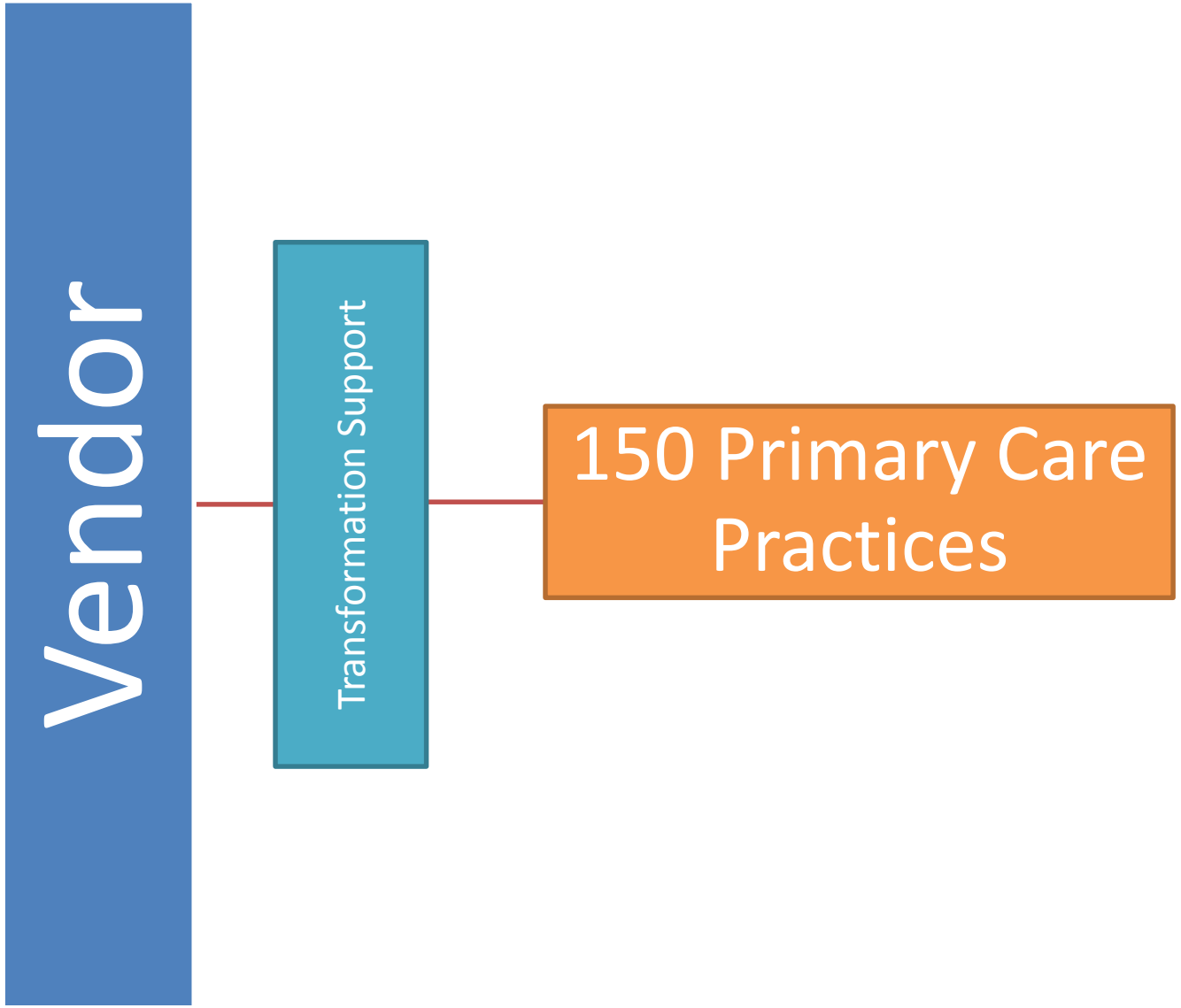
The NCQA Standards with an additional focus on person-centered care and health equity

The AMH Standards

- Patient-Centered Access
- Team-based Care
- Population Health Management
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

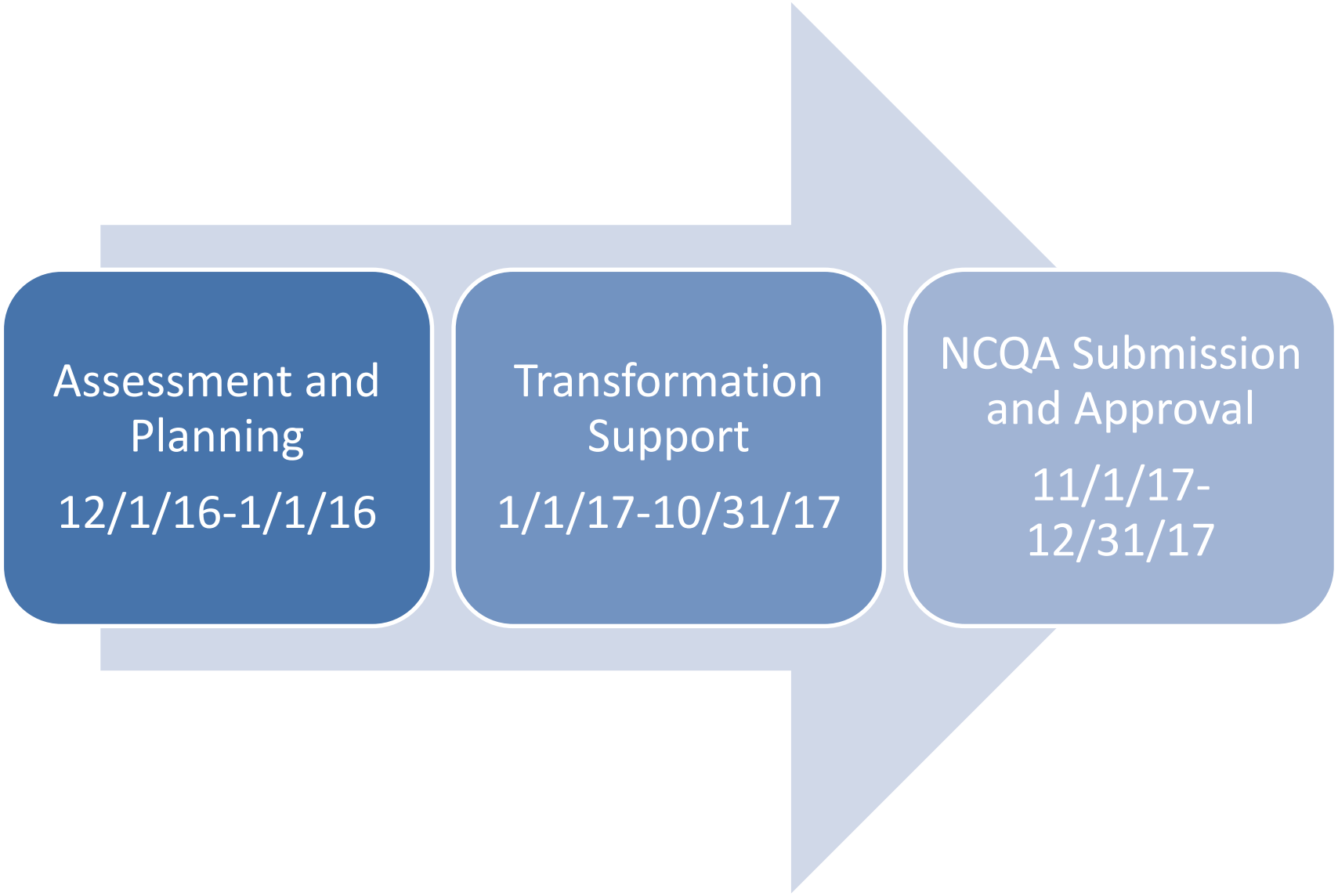
Within these standards, PTTF has identified must-pass elements and critical factors

AMH- How will it work?



- SIM PMO will contract with a Vendor that has expertise in primary care practice transformation
- Primary care practices will apply in response to a request for applications to participate in the program. The recruitment goal is 150 practices for Wave 1.
- The Vendor will provide transformation support to each practice and assist them in applying for NCQA recognition

AMH- What is the anticipated timeline?



AMH- Transformation Support

To support the practices in transformation, the vendor will:

- Develop promotional materials in collaboration with the PMO
- Support provider outreach and recruitment efforts
- Assess current practice capabilities and gaps
- Provide change facilitation and management
- Monitor and track the progress of each practice against accountability milestones, and
- Conduct an on-site validation survey.

AMH- Learning Collaborative & Evaluation

Learning Collaborative:

The Vendor will develop and support a Learning Collaborative to encourage peer-to-peer learning between participating practices. The Collaborative may consist of in-person and virtual activities and should maximize the sharing of tools and resources.

Evaluation:

The Vendor will develop a method to assess the impact of transformation support on practices and providers, as well as on patients.

Practices Interested in PCMH Recognition?…Save the date!

Advanced Medical Home: Realizing the Vision

Keynote: Marci Nielsen, MD
- Patient Centered Primary Care Collaborative

December 8th, 5:15 to 9pm
Sheraton Hartford South, Rocky Hill

Find out more about medical home and why NCQA recognition makes more sense than ever

Details:

www.healthreform.ct.gov

Conference event jointly hosted by SIM PMO, DSS, and CSMS

Community & Clinical Integration Program

What is it?
A SIM initiative to improve care delivery

What will it do?
Provide technical assistance, peer learning, and transformation awards* to provider networks

Who can participate?
Provider networks in the Patient Centered Medical Home+ initiative (formerly called MQISSP)

What will it focus on?
Three key standards:
-Complex Care Management
-Health Equity Improvement
-Behavioral Health Integration

*PCMH+ Track 2 Participants Only

The CCIP Standards

Comprehensive Care Management

Comprehensive care team, Community Health Worker , Community linkages

Health Equity Improvement

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

Behavioral Health Integration

Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

What are the Standards really about?

- Understanding the whole person
- Focusing on outcomes
- Connecting with the care team
- Expanding the care team
- Linking to community supports
- Using data to guide improvement

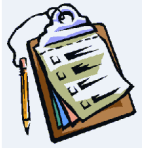
Key Elements of Comprehensive Care Management in CCIP

Identify and Assess

Identify Individual with complex health care needs

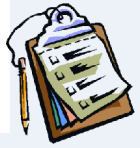
Conduct Person-Centered **Assessment**

Plan and Execute



Develop Individualized **Care Plan**

Establish Comprehensive **Care Team**



Execute and monitor individualized care plan

Monitor and Evaluate

Identify patient readiness to **transition** to self-directed care maintenance and primary care team support

Monitor individuals to reconnect to comprehensive care team when needed

Evaluate and improve intervention

Key Elements of Behavioral Health Integration in CCIP

Identify

Identify individuals with behavioral health needs

Serve

Integrated (on-site) brief assessment and treatment

or

Behavioral health referral and treatment

Behavioral health coordination with primary care source of referral

Evaluate

Track behavioral health outcomes/improvement for identified individuals

Health Equity Improvement in CCIP: P1 – Continuous Quality Improvement

Analyze

Expand collection reporting and analysis of standardized data stratified by sub-population

Identify and prioritize opportunities to reduce a healthcare disparity

Implement

Implement interventions to address identified disparities

Evaluate

Evaluate whether the intervention was effective

Health Equity Improvement in CCIP: P2 – Conduct a pilot

Assess and Plan

Create a more culturally and linguistically sensitive environment

Establish a CHW capability

Identify individuals who will benefit from **CHW** support

Implement

Conduct a person-centered **needs assessment**

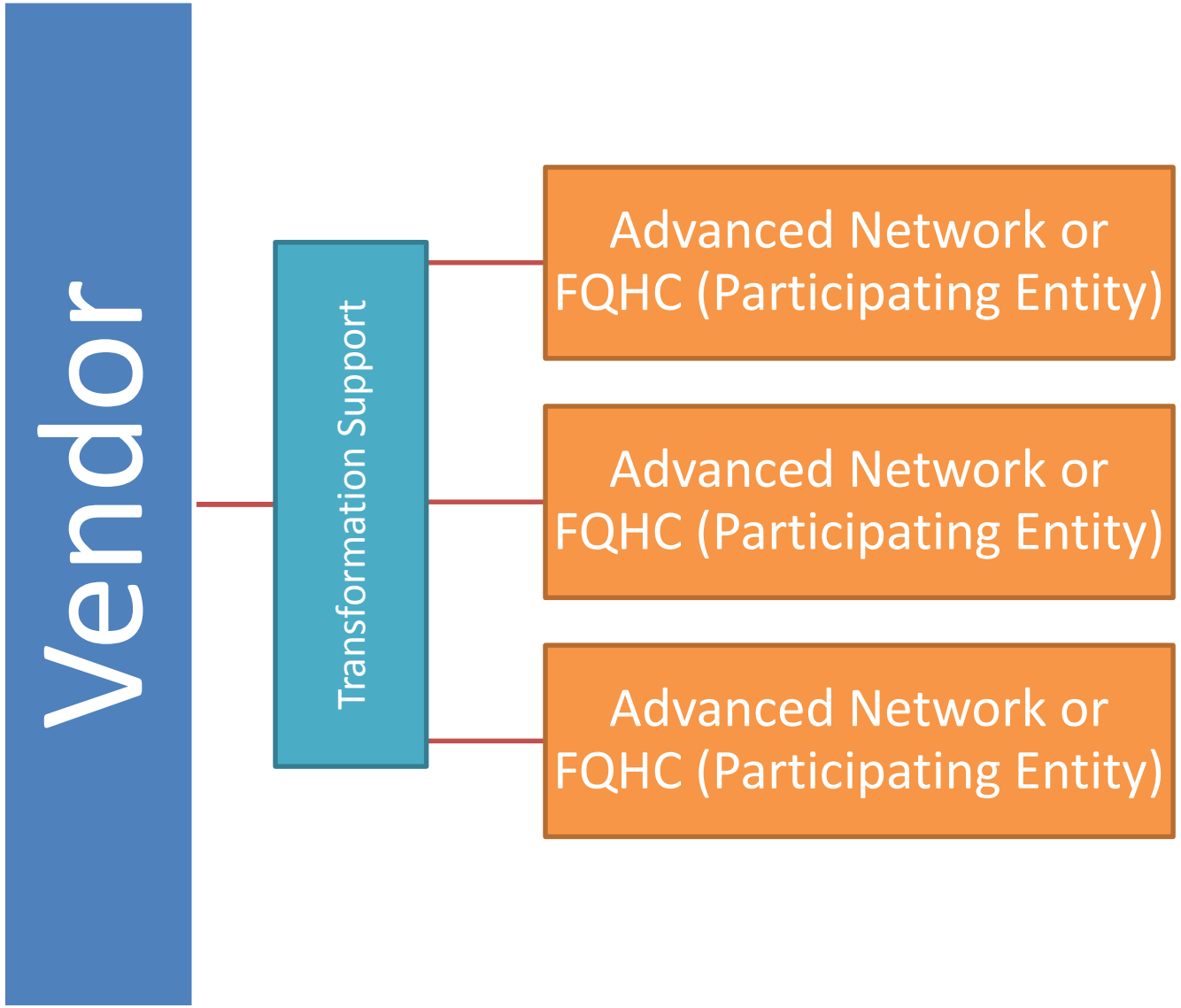
Create a person-centered self-care **management plan**

Execute and monitor the person-centered self-care management plan

Monitor

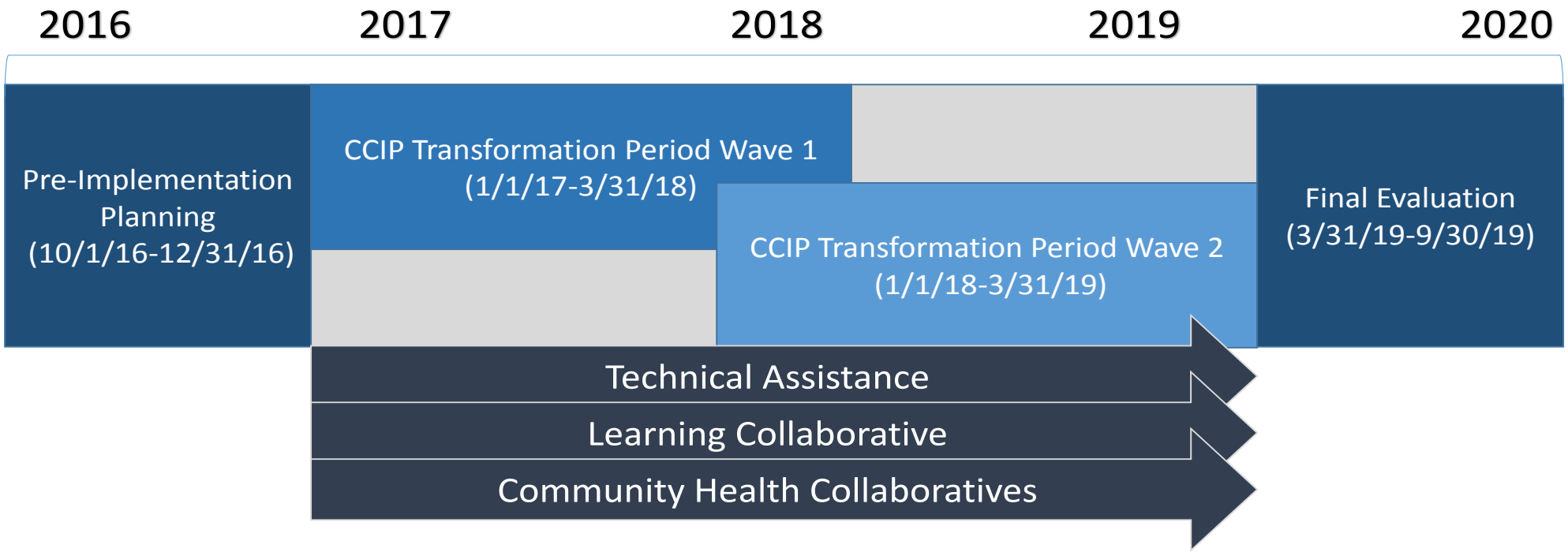
Identify a process to determine when an individual is ready to transition to self-directed care maintenance

CCIP- How will it work?



- SIM PMO will contract with a Vendor that has expertise in practice and system transformation
- Advanced Networks/FQHCs (For CCIP: Participating Entities or **PEs**) that have been selected to participate in **PCMH+ Track 2** will apply and be selected for awards to help them meet the Standards
- The Vendor will provide transformation support to each PE over a period of 15 months
- Each PE will develop a unique transformation plan based on their needs

CCIP- What is the process and anticipated timeline?



Stage 1: Pre-Implementation Planning

- The Vendor will develop a plan detailing its approach to support the PEs in achieving the CCIP standards.
- The Major components of the Plan:
  - Technical Assistance Activities
  - Learning Collaborative Strategy
  - Community Health Collaborative Strategy
  - Evaluation Plan

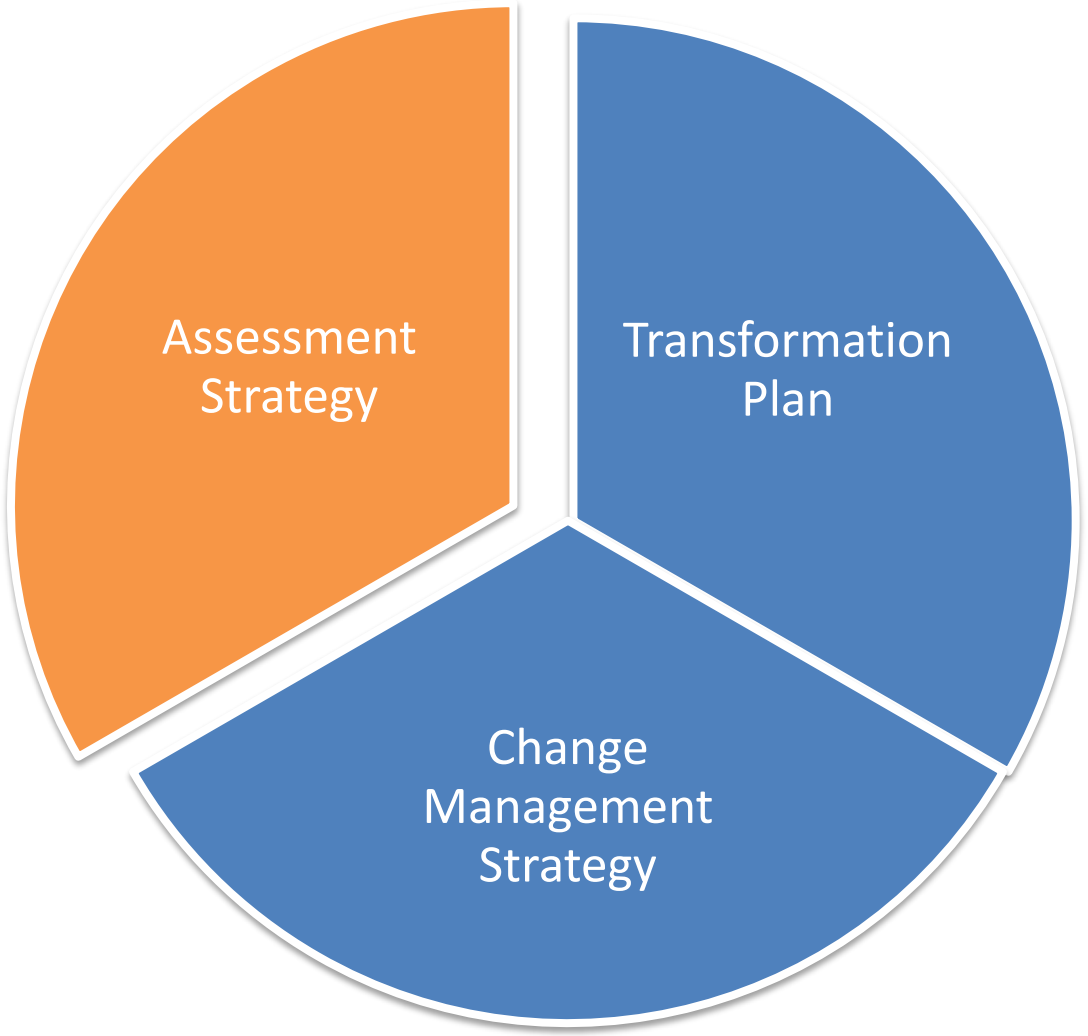
Stage 2: Transformation Period

- During this period, the Vendor will provide technical assistance, initiate the learning collaborative, and begin the community health collaboratives.
- The PE will utilize its transformation award funding to help facilitate transformation. For example, the PE may use some of these funds to hire a CHW or invest in expanded electronic health record capabilities.

CCIP- Technical Assistance

1. Assessment Strategy:

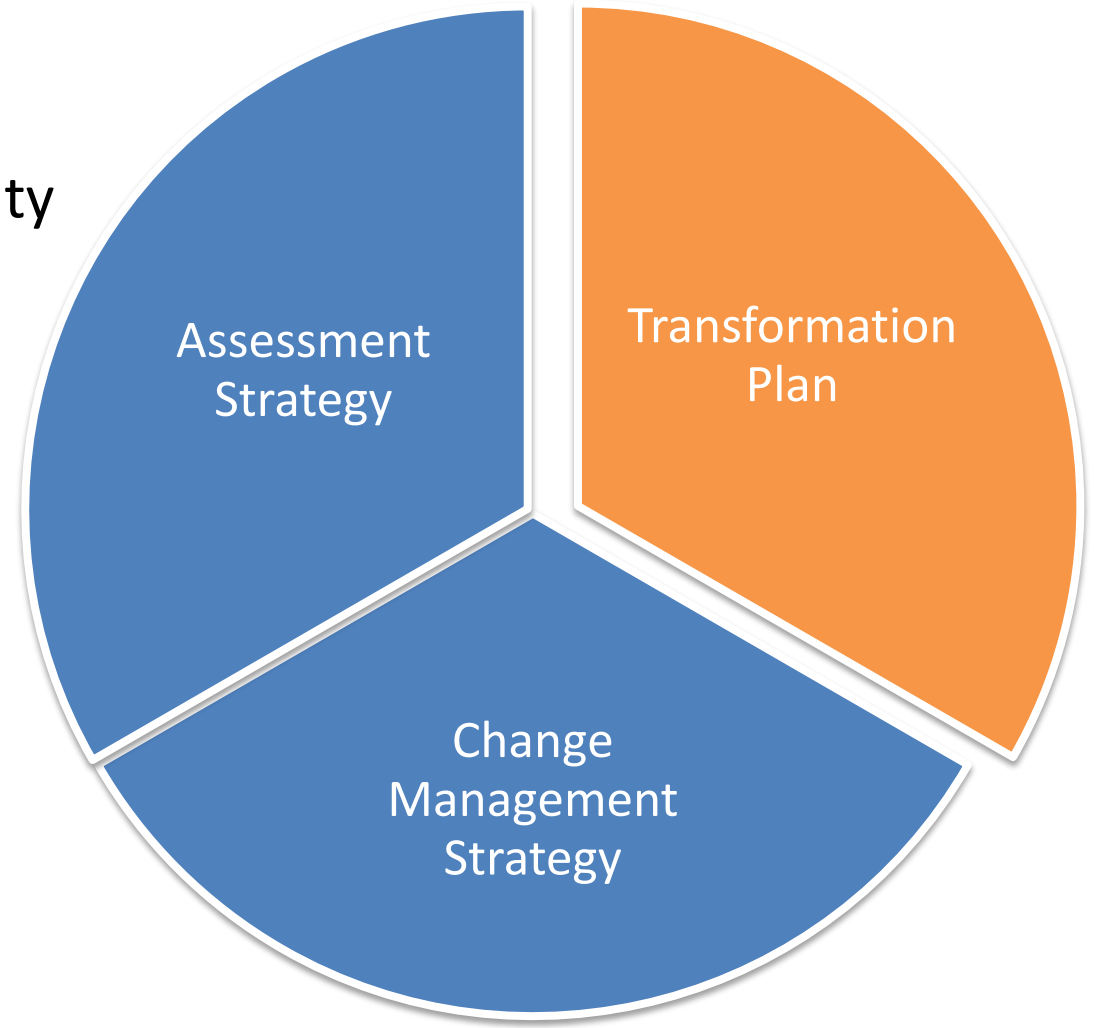
- The Vendor will use a readiness assessment to identify gaps, determine baselines, and assess resources needed to achieve the standards.
- The Vendor will engage in periodic assessments and a post-assessment to monitor progress toward the standards and achievement at the end.
- The Vendor will also evaluate its own services.



CCIP- Technical Assistance

2. Transformation Plan:

- Vision and Commitment to Change
- Tasks and Activities the Participating Entity will undertake to support its staff in transformation, for example:
  - Providing quality improvement expertise
  - Providing clinical guidance, expertise, and support
- Tasks and activities the Vendor will undertake
- Target populations
- Progress Monitoring



CCIP- Technical Assistance

3. Change Management Strategy:

The Vendor will develop a comprehensive strategy for each PE that includes evidence-based approaches to change management.

CCIP- Learning Collaborative

The **Learning Collaborative** will serve as a peer-to-peer learning opportunity for PEs to focus on specific topics that will support achievement of the CCIP standards. Activities may include:

- In-person meetings
- Interactive web-based webinars, discussion boards, videos
- Focus groups to address barriers

CCIP- Community Health Collaborative

- The **Community Health Collaborative** will serve to further the goals of CCIP by bringing together cross-sector partners to:
  - Develop standard protocols for linking individuals to services and improving care transition coordination
  - Develop a sustainable plan for collaboration on protocol evaluation and improvement
- The Vendor will be responsible for establishing the Collaborative, and may choose to build on existing Collaboratives
- The PMO will work with the Vendor to identify target areas for these Collaboratives based on concentration of PCMH+ beneficiaries

CCIP- Final Evaluation

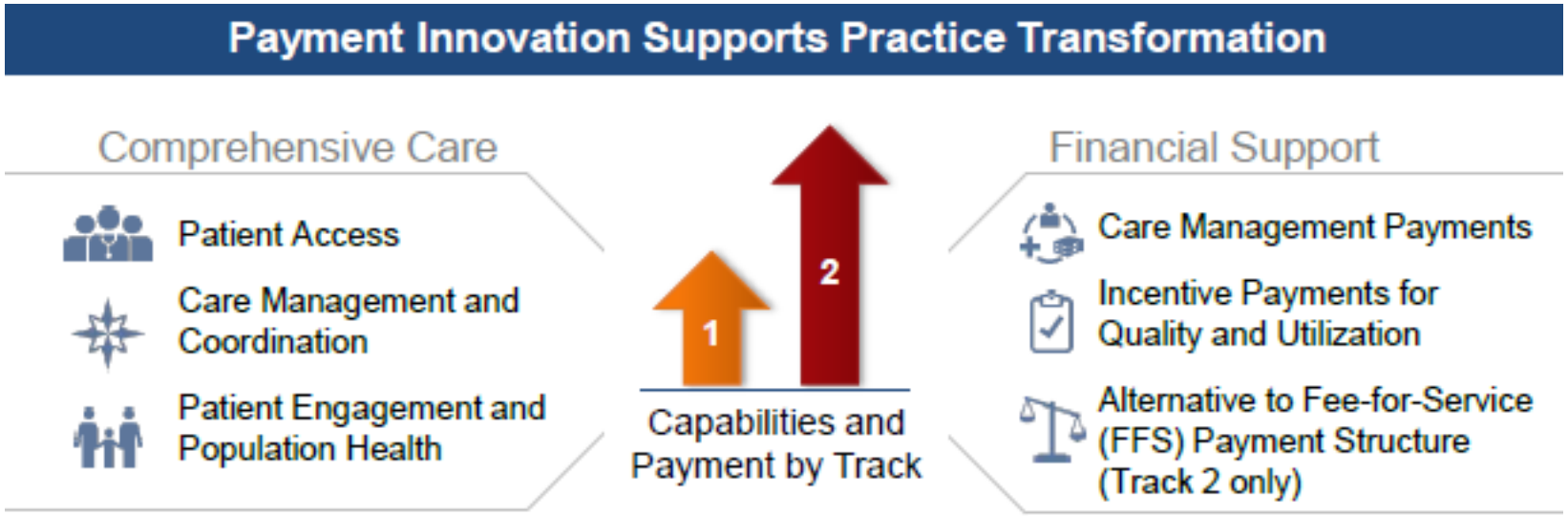
Stage 3: Final Evaluation

The Vendor will develop an evaluation report, including:

- Details on all of the assessment results from the PEs
- Success, Barriers, and Challenges that PEs encountered in achieving the CCIP standards
- Lessons learned and recommendations for future care delivery transformation efforts
- Recommendations for state or municipal policy changes that could support advancements in care

After CCIP: Making Primary Care Transformation Sustainable

- Investments into transforming primary care, such as the addition of CHWs to the care team, may be difficult to sustain based on only shared savings
- Alternative Payment Models can support practice transformation



After CCIP: Making Primary Care Transformation Sustainable

For example, Comprehensive Primary Care Plus (CPC+), uses the following payment model to support primary care innovation:



	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard FFS
	Paid prospectively on a quarterly basis	Paid prospectively on an annual basis; must meet quality and utilization metrics to keep incentive payment	Regular Medicare FFS claims payment
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)
	Paid prospectively on a quarterly basis	Paid prospectively on an annual basis; must meet quality and utilization metrics to keep incentive payment	CPCP paid prospectively on a quarterly basis; Medicare FFS claim is submitted normally but paid at reduced rate

Adjourn