OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

June 14, 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Health Enhancement Community Strategy	50 min
5. Primary Care Payment Reform	50 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

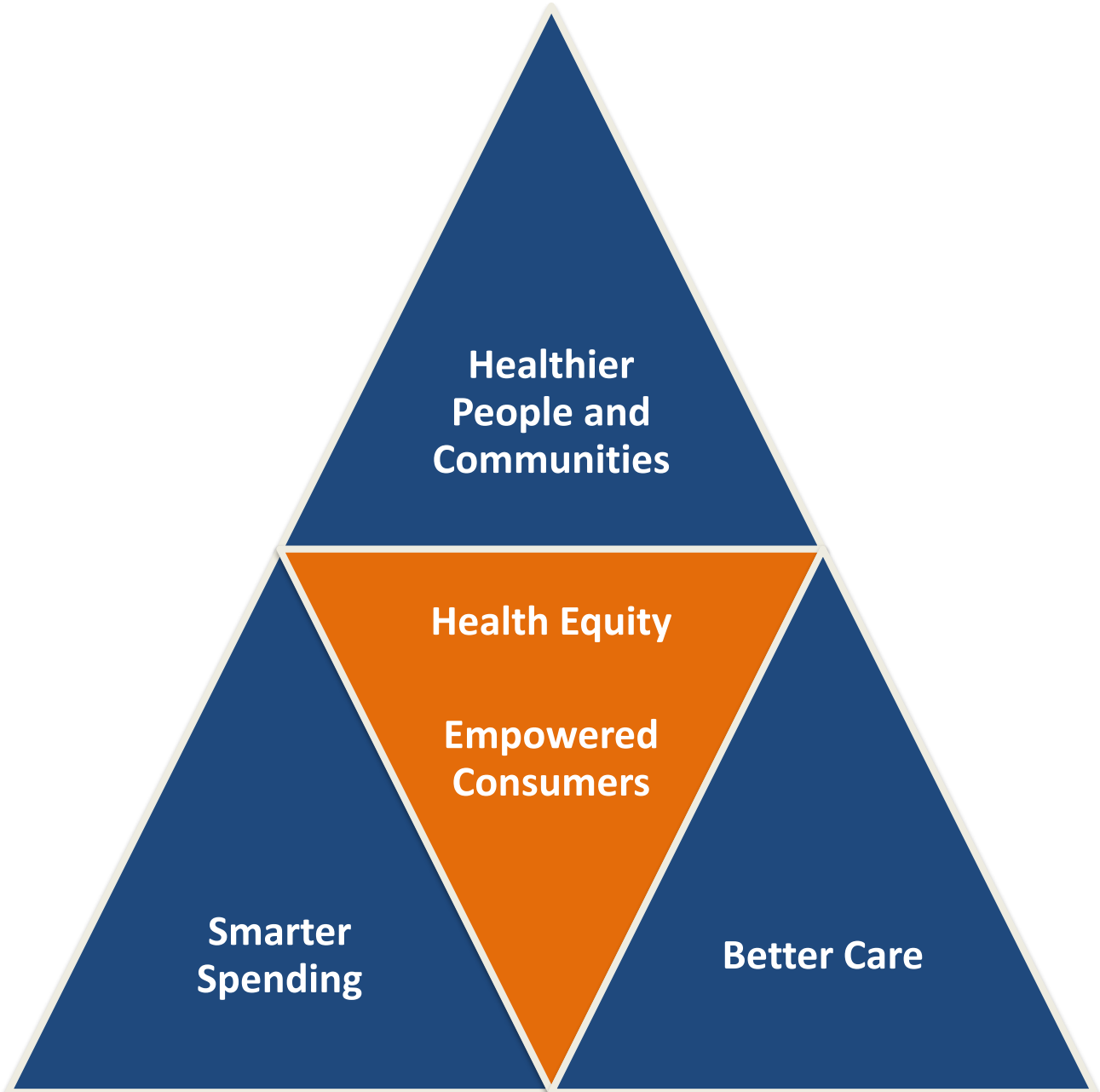
Primary Care Payment Reform: Unlocking the Promise of Primary Care

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

Connecticut State Innovation Model Aims



CT SIM: Primary Drivers to achieve Our Aims

SIM connecticut state innovation model

$5.8M

Population Health

$8.8M

Payment Reform

$13.5M

Transform Care Delivery

$650K

Empower Consumers

Health Information Technology $10M

Evaluation $3.5M

CT SIM: Primary and Secondary Drivers to achieve Aims

SIM connecticut state innovation model

Population Health Plan

- Health Enhancement Communities
- Prevention Service Centers
- Community Health Measures

Transform Care Delivery

- Community & Clinical Integration Program
- Advanced Medical Home
- Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

- Medicare SSP
- Commercial SSP
- PCMH+
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

CT SIM: Primary and Secondary Drivers to achieve Aims

SIM connecticut state innovation model

Population Health Plan

- Health Enhancement Communities
- Prevention Service Centers
- Community Health Measures

Transform Care Delivery

- Community & Clinical Integration Program
- Primary Care Modernization *(option)*
- Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

- Medicare Commercial Medicaid SSP (i.e. PCMH+)
- Primary Care Modernization *(option)*
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

Kahn's Story

The Story of Mr. Jones

Christina Polomoff,
PharmD, BCACP, BCGP

Assistant Clinical Professor

University of Connecticut School of Pharmacy

Population Health Clinical Pharmacist

Hartford Healthcare Integrated Care Partners

Medication Adherence

"Drugs don't work in people who don't take them." C. Everett Koop, MD

For every 100
Prescriptions
written

50 – 70
Go to a
pharmacy

48 – 66
Come out of
The pharmacy

25 – 30
Are taken
properly

15 – 20
Are refilled
As prescribed

Sean M. Jeffery, PharmD, BCGP, FASCP, AGSF
Clinical Professor, Department of Pharmacy Practice
University of Connecticut School of Pharmacy
Director, Clinical Pharmacy Services
Integrated Care Partners, Hartford HealthCare

Source: National Association of Chain Drug Stores, Pharmacies: Improving Health, Reducing Costs, July 2010. Based on IMS Health data

SIM connecticut state innovation model

Investing in Primary Care

Patient Engagement and Support	Care Team Diversity
Phone contact	Nurse care manager
E-mail/text support	Social Worker
Telemedicine visits	Licensed BH clinician/Behaviorists
Home visits	Pharmacists
E-consult	Nutritionist/dietician
Remote monitoring	Care coordinator (community health worker focused on community linkages)
Group visits (illness self-management, prevention, lifestyle enhancement)	Health coach (community health worker)
Tweet/chats/on-line support groups	Patient navigator (community health worker)
Patient/family advisory council	
Communication with child care/school	

Task Force Recommendations

- **<u>Recommendation 1</u>**: Connecticut's payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Care manager
Pharmacist
Behaviorist
Health coach
Patient Navigator
Care coordinator

Community Health Workers

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

Task Force Recommendations

- **<u>Recommendation 1</u>**: Connecticut's payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Email, phone, text
E-visits
Shared visits
Home visits
Longer visits (when needed)

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

Task Force Recommendations

- **Recommendation 2**: Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. Payers should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.

Flexibility without worry
Less administrative burden
Less "out of pocket"
Non-inflationary

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

Task Force Recommendations

- **<u>Recommendation 3</u>**: Primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care.

New, upfront revenue to expand care team
Flexibility
Less administrative burden
Less "out of pocket"
Non-inflationary

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

Task Force Recommendations

Leading a care team

Flexibility

More time for patients

Less time on billing documentation

Continuous learning

Self-efficacy

Opportunity to innovate

“Joy of practice”

Task Force Recommendations

- **Recommendation 4**: Primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.
- **Recommendation 5**: Primary care payment models should include the cost of new services in prospective primary care bundled payments or care management fees, which should be exempt from cost-sharing.
- **Recommendation 6**: Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.

Primary Care Capabilities for Consideration

Diverse Care Teams	 Pharmacists, Nurses	 Care Coordinators, Community Health Workers, Navigators	 Health Coaches, Nutritionists
Alternative Modes of Support & Engagement	 Phone/Text/e-mail	 Home Visits	 Telemedicine
Technology	 Patient generated data & Remote patient monitoring	 Precision & Genomic Medicine	 E-Consults
Integration and Specialization	 Behavioral Health Integration	 Practice Specialization (e.g., geriatrics, HIV)	 Community Integration

Response to Comments

Themes

- Reverse high levels of physician burnout and administrative burden
- Invest more in primary care
- Ensure flexibility in practice without the worry of losing visit based revenue
- Coordinate with healthcare education and training programs
- Make primary care an attractive training and career destination for tomorrow's healthcare workforce
- Pharmacists and community health workers are critically important
- Integrate primary care with community supports to address social determinant risks

Response to Comments

Themes

- Make sure that we advance health equity, such as by considering the needs of consumers with limited English proficiency
- Ensure behavioral health integration
- Plan for the workforce capacity and training necessary to support the model
- Ensure robust monitoring and evaluation
- Establish safeguards to ensure that patients are protected from the risk of under-service or patient selection, and that the additional funds and flexibility are well invested to the benefit of patients.

Response to Comments

Action

- Resulted in modifications to the report or recommendations
- Informed the design scope or strategy
- Informed the establishment of a robust Advisory Process

Response to Comments

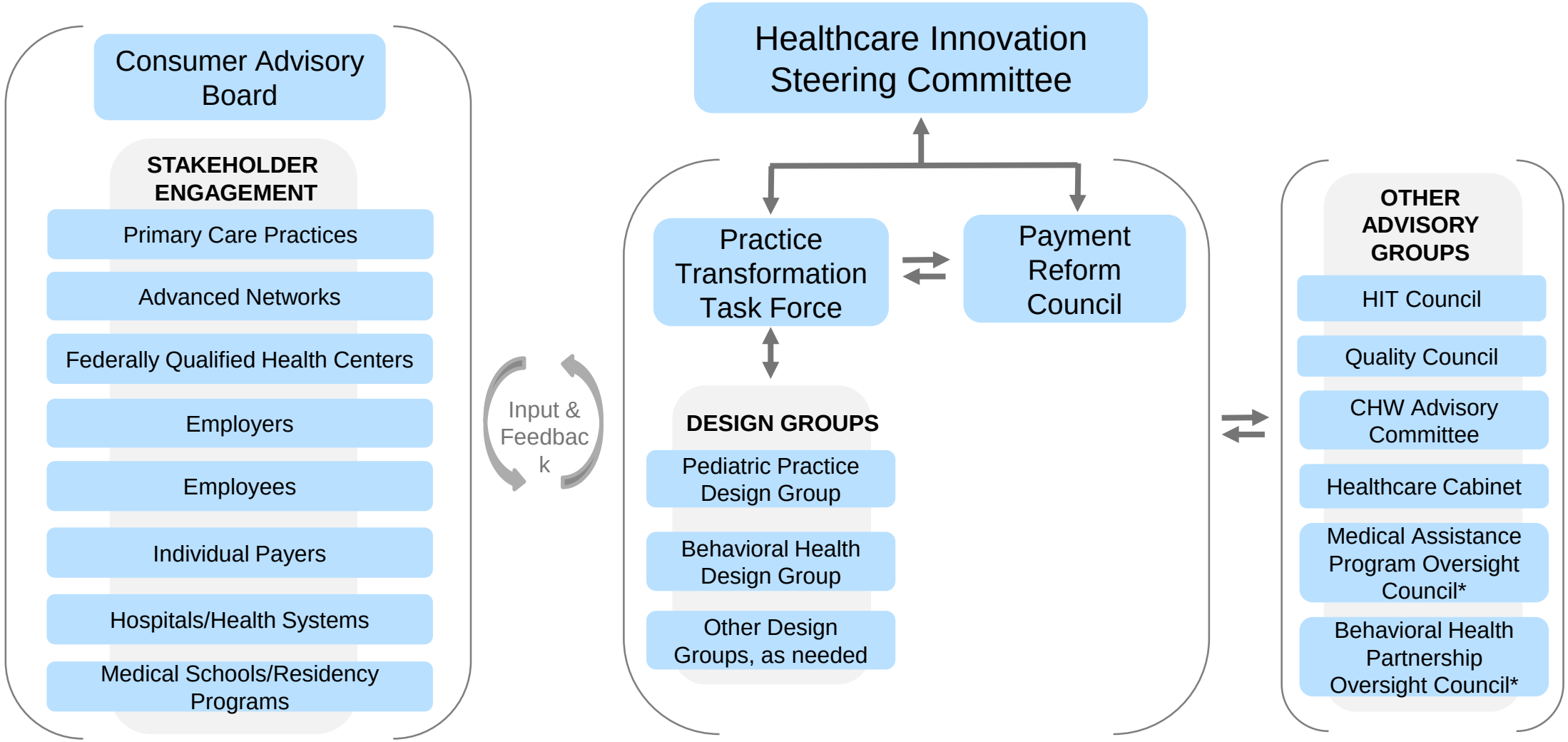
Action

Recommendation 9: Primary care payment models should maximize the flexibility that primary care teams have to expend resources on [health] the promotion of health and health equity and coordination with community services, including the use of community health workers.

Recommendation 10: Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change that results in appropriate level of service and equitable access.

Recommendation 12: Primary care training programs ~~(residencies and medical schools)~~ should be engaged early on in the development of model because of the role they play in training the next generation of clinical primary care leaders.

Advisory Process



*Pending DSS initiated collaboration agreement

Concluding Remarks

- OHS has begun referring to strategy outlined in report as ***Primary Care Modernization***
- OHS shares a vision and high hopes that the concepts and models we develop will offer a pathway to transformation in primary care delivery and payment in Connecticut that will advance our mission to promote equal access to high quality health care to improve health while controlling costs
- Our goal in 2018 is to prepare a *Primary Care Modernization* program model as an option for consideration by the governor-elect during the transition period soon after the November election

Concluding Remarks

- The design of this program model will be substantive and detailed. It will define practice capabilities that will better support patients and payment model options that will enable providers to achieve these capabilities while ensuring affordability
- The program design will specify methods for maximizing benefits to patients and safeguarding against risks

Appendix – PCM Related Materials

Potential New Language for Executive Summary - Narrative

The Task Force acknowledges the importance of monitoring the impact of primary care payment reforms, such as by monitoring the number of patient/care team interactions before and after the reforms have been implemented, to ensure that the changes results in an appropriate level of service and equitable access for all. OHS is committed to demonstrating, prior to implementation, that systems and procedures are in place to monitor the impact of reforms on consumers in a timely manner. Such monitoring should include, but not be limited to, under service, access to office visits, patient selection, and investments in innovative practices. The provision of rapid-cycle feedback to payers, providers and consumer stakeholders is intended to enable continuous learning and improvement, recognizing that the great majority of participants in healthcare are focused on improving access and quality. However, such information also provides purchasers with the ability to take intervene when problems persist.

Potential New Language for Executive Summary - Recommendation 10

Recommendation 10: Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change that results in appropriate level of service and equitable access. Such systems must for monitoring must be demonstrated and operational prior to implementation.

Potential New Language for Recommendations in Full Report - Recommendation 10

- **Recommendation 10:** Payers that utilize primary care payment models should a) ensure that quality of care is measured and rewarded, b) should employ minimally burdensome methods that are aligned across payers for comparable populations (e.g., Medicaid, Medicare, commercial) to enable practices to demonstrate that they are investing in and have implemented transformational change (e.g., care team composition, engagement in non-visit-based activities), and c) should monitor to ensure that the changes result in appropriate level of service and equitable access. The State must demonstrate, prior to implementation, that systems and procedures are in place to monitor the impact of reforms on consumers in a timely manner. Such monitoring should include, but not be limited to, under service, access to office visits, patient selection, and investments in innovative practices. The provision of rapid-cycle feedback to payers, providers and consumer stakeholders is intended to enable continuous learning and improvement, recognizing that the great majority of participants in healthcare are focused on improving access and quality. However, such information also provides purchasers with the ability to take action when problems persist.

Health Enhancement Community Strategy

Connecticut State Innovation Model Health Enhancement Community Initiative

Healthcare Innovation Steering Committee Meeting
June 14, 2018
3:00 pm – 5:00 pm

Meeting Objectives

- Provide overview of the CT Health Enhancement Community (HEC) plan design, process and work completed to date
- Preview highlights of the HEC model
  - Parameters of HEC model
  - Health Condition Priorities & Interventions
  - Medicare Impact Model
- Identify and receive feedback on key issues

Health Enhancement Community Initiative

Focuses on creating the conditions that promote and sustain cross-sector community-led strategies focused on prevention.

Provisional Definition

A Health Enhancement Community (HEC) is:

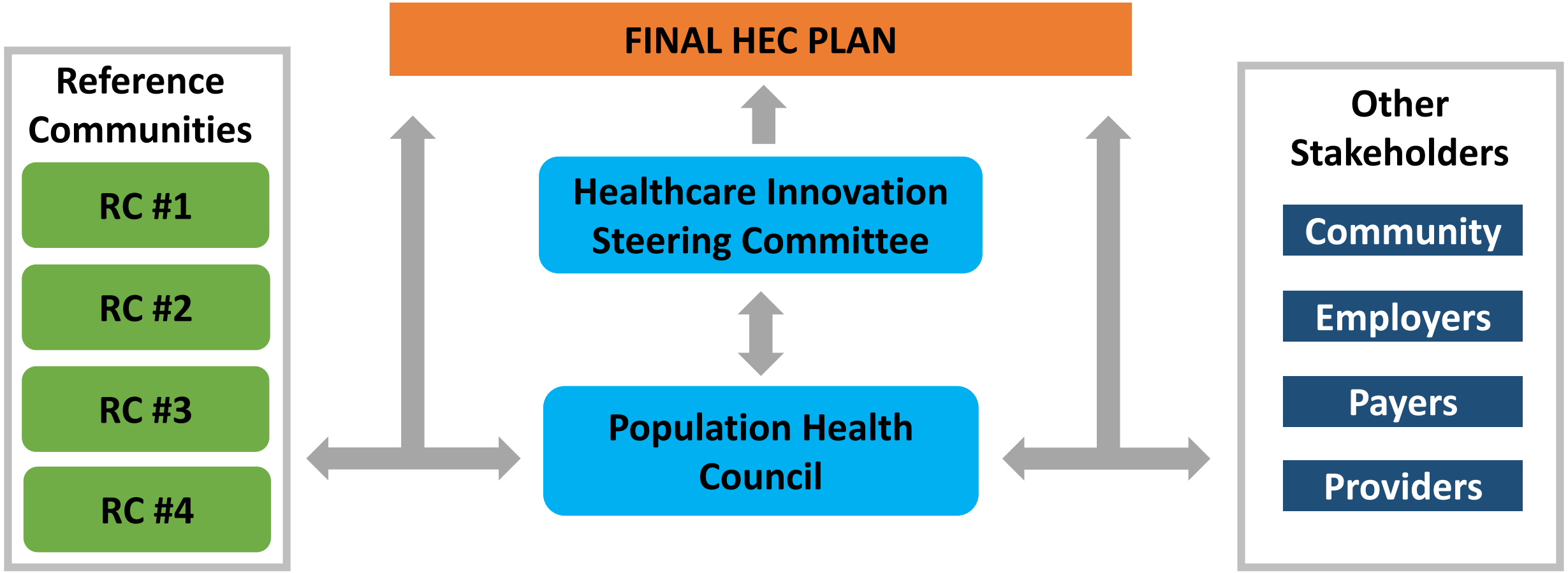
- Accountable for health, health equity, and related costs for all residents in a geographic area
- Uses data, community engagement, and cross sector activities to identify and address root causes
- Operates in an economic environment that is sustainable and rewards communities for health improvement by capturing the economic value of Improved health

Aligns with health improvement work underway in communities, previous and current SIM work, and adds sustainability and scale focus.

Many components of the HEC definition are intentionally undefined to accommodate a thoughtful, community-driven planning process.

How Will the Plan for Health Enhancement Communities Be Designed?

Approach emphasizes a multidirectional flow of information and input to support decision making



Office of Health Strategy/SIM
Department of Public Health
Jointly Administer and lead initiative

HMA
Planning support and subject matter expertise to develop strategy and draft summary plan

Design Engagement Goals

- Give the broader community a voice in the design of HECs
- Understand reality
- Validate or modify underlying assumptions
- Identify the roles of key sectors in the HECs
- Identify existing and needed resources to support the implementation and sustainability of HECs
- Obtain “OKs” on design

Key Questions

Design needs to address the following areas:

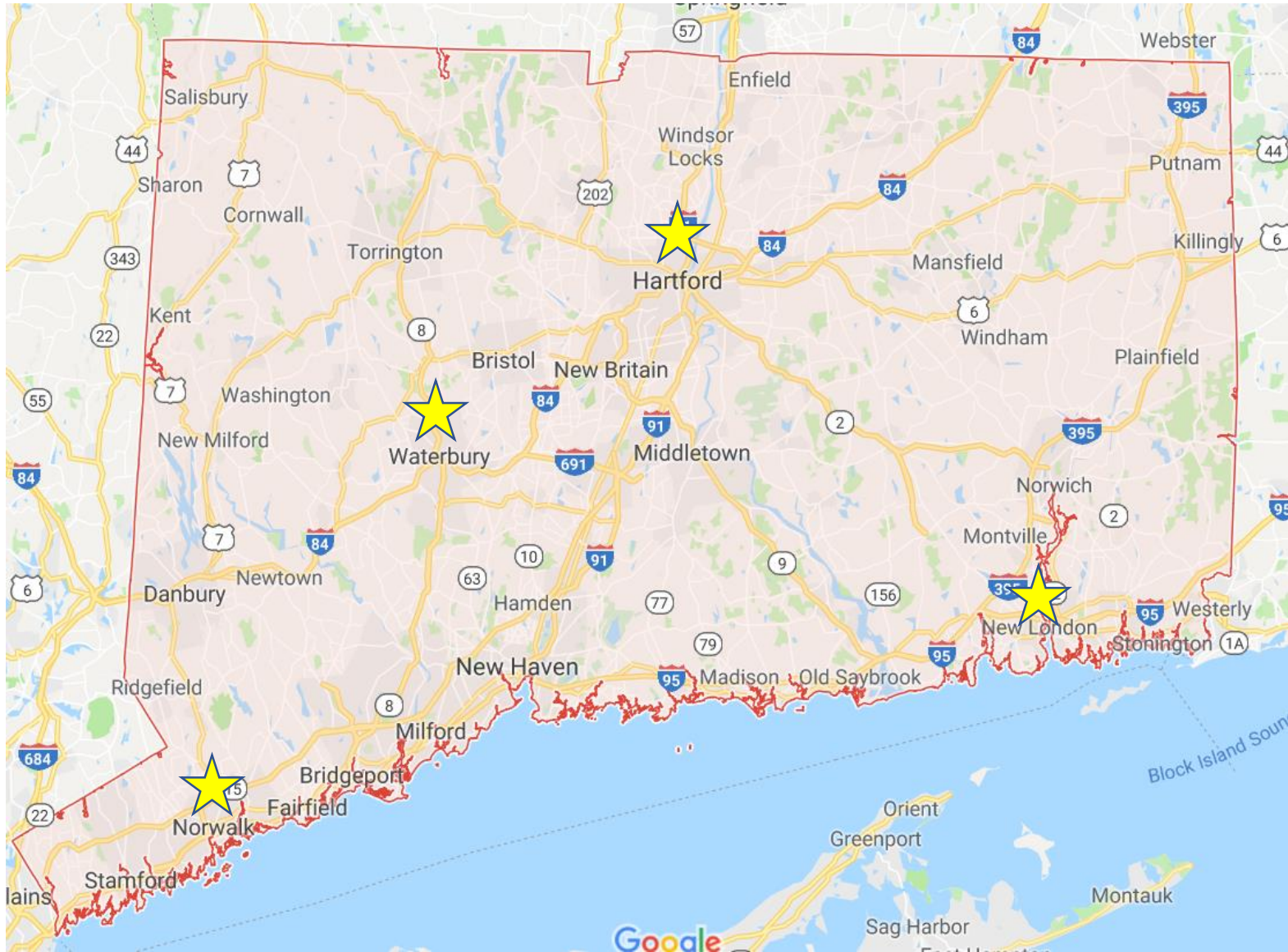
Accountability:	Define the appropriate expectation for an HEC.
Boundaries:	Define the best criteria to set geographic limits.
Indicators:	Define appropriate measures of health improvement.
State Role:	Define the level of planning flexibility.
Health Equity:	Define approaches to address disparities across communities.
Infrastructure:	Define the infrastructure needed to advance HECs (HIT, data, measurement, workforce).
Sustainability:	Define financial solution for long-term impact.
Regulations:	Define regulatory levers to advance HECs.
Engagement:	Define how to gain buy-in and participation from stakeholders.

Design Engagement Sources

- Reference Communities
  - Informational webinars on relevant topics
  - Facilitated “deep dive” meetings to formulate initial recommendations and other support
  - Stakeholder and community engagement to refine
  - Cross-pollination meeting with the Population Health Council

Reference Communities

- 4 Reference Communities selected
  - Norwalk
  - Waterbury
  - Hartford
  - New London



Design Engagement Sources

- Population Health Council
  - Monthly meetings to develop and vet design options
  - 3 Design Teams to delve deeper into design options with input from the Reference Communities and other cross-sector stakeholders
    - Interventions, Measures, Data, and Workforce
    - Financing
    - Governance and Decision-Making
  - Also welcome on informational webinars

Design Engagement Sources

- Other Stakeholder Engagement
  - Presentation and discussion at existing workgroup and committee meetings (e.g., Consumer Advisory Board)
  - Interviews and forums with broad group of stakeholders, including:
    - Community-based organizations
    - Health care providers
    - Collaboratives that are not Reference Communities
    - Employers
    - State Health Improvement Coalition Advisory Council
    - Local health directors
    - Foundations and funders
  - Economic value modeling with 2-3 employers
  - Review of existing relevant stakeholder reports and recommendations from previous planning processes

Design Engagement Sources

- HISC
  - Meetings to develop and vet design options
  - Vet Population Health Council recommendations
  - Also welcome on informational webinars

Healthcare Innovation Steering Committee Timeline

March Meeting

- Intro to HEC initiative

June Meeting

- Overview of process & work completed to date
- Preview HEC model
- Identify and obtain feedback on key issues

July Meeting

- Present financial model results to date

September Meeting

- Approve draft report for public comment release

October Meeting

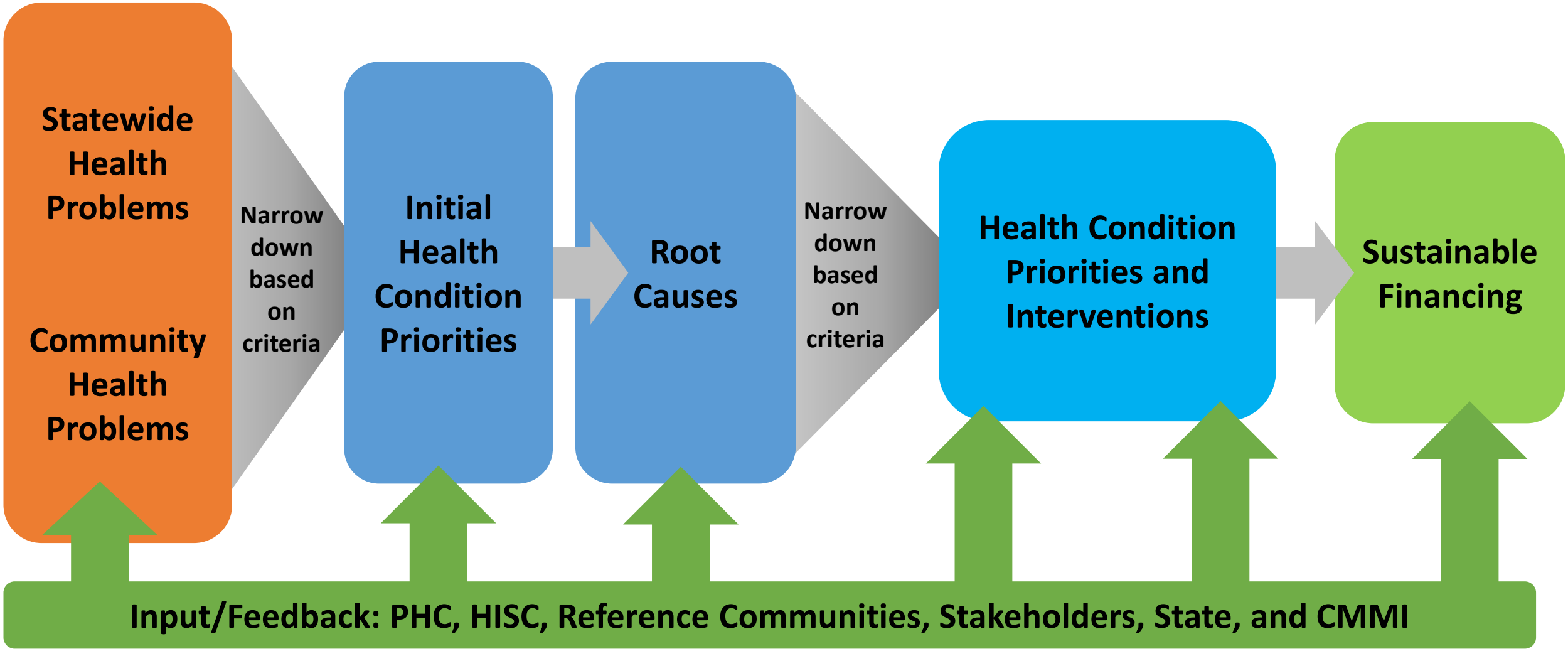
- Provide overview of feedback from public comment and proposed changes to report

November Meeting

- Review and approve final report

Parameters of the Health Enhancement Communities Model

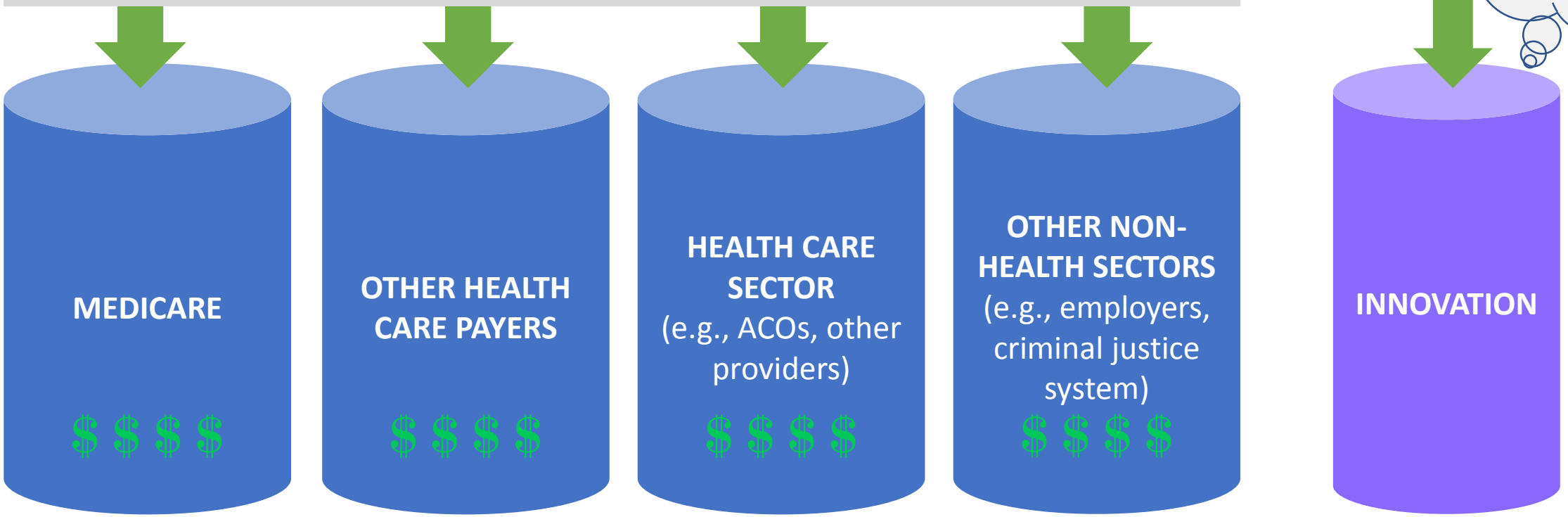
Process for Selecting Interventions



To Secure Sustainable Financing…

Most INTERVENTIONS must accrue SAVINGS to at least 1 of 4 sources of sustainable financing.

… but there's also room for innovation.



HEC Health Condition Priorities & Interventions

Summary of Initial Health Conditions Identified

- Heart disease and high blood pressure
- Diabetes
- Asthma
- Obesity (child and adult)
- Tobacco use
- Colon and breast cancer
- Maternal, infant, and child health
- Oral health for children
- Childhood lead poisoning
- Substance use including opioids
- Mental health
- Developmental conditions
- Sexually transmitted infections
- Vaccine preventable diseases
- Emerging infectious diseases
- Unintentional injuries (e.g., falls)
- Injuries from violence
- Other conditions

Although they are not **health conditions**, other **health priorities** identified included health care access, cost, insurance, and health care delivery system issues, as well as environmental factors.

Sources: SHIP health objectives, SIM health objectives, Reference Communities and Population Health Council initial priorities

Root Causes of Health Conditions

- Lack of education
- Economic instability/Socioeconomic position
- Built environment/Residential environment
- Food deserts
- Physical insecurity (crime, violence)
- Racial and ethnic disparities and inequities
- Inequities related to culture and language
- Poor access to care
- Lack of social and community supports
- Chronic stress and trauma

The menu of potential interventions usually address multiple root causes and not just one.

First Winnowing Process: To Select Initial High-Priority Conditions and Identify Root Causes

Narrow down based on criteria

- Criteria for selecting include conditions that:
  - Already have been identified in other planning processes
  - Have outcomes that can be measured and have identified data sources to support measurement
  - For which there is some evidence of a return on investment (ROI) within timeline of 3, 5, and/or 10 years
  - Are related to children and adolescents 0-18 years *and* adults
  - Emerging conditions and conditions tied to prominent health disparities

Second Winnowing Process:
To Select Health Condition Priorities and Interventions

Narrow down based on criteria

- Criteria for selecting health condition priorities:
  - Conditions for which there are statewide and community interventions that can address root causes
  - Conditions for which there are evidence-based interventions that have an ROI that accrues to the sustainable financing buckets
    - Medicare, other payers, healthcare sector, and other sectors
  - Conditions that have been successfully addressed in other similar place-based initiatives
    - And have gotten sustainable financing
  - Ability to impact through regulation and policy
  - Interventions that have scalability and transferability
  - Perceived value of interventions (to consumers and providers in addition to financial)

Medicare Impact Model

Nomenclature

#	Nomenclature	Definition
1	**Medicare Impact Model**	• A **multi-year Excel-based financial model using Medicare data to project potential future savings associated with various HEC health improvement scenarios/ interventions**. • Focus is primarily on benefits of health problems avoided (i.e., a reduction in the incidence and prevalence of acute and chronic illness and injury) as a result of primary and upstream secondary prevention.
2	**HEC Financial Sustainability Strategy**	• The **source(s) of funding and methodologies by which HECs will be paid to implement population health interventions**, including: ○ **Near-term:** funding sources to plan and implement upfront cross-sector activities and enable investments in infrastructure ○ **Medium- and long-term:** funding sources and **payment model(s)** (e.g. payer-specific methodologies, social impact bonds, tax credits) to sustain HEC activities; will rely primarily on public and private sector investments and contributions, rather than grants; will provide rewards to HECs and other contributors/investors

Overview: Medicare Impact Model

HMA, in partnership with Airam Actuarial Consulting, will create a Model that will:

- Use publicly available Medicare data
- Examine per capita costs for the Medicare population with and without HEC interventions
- Quantify the potential short term and long-term savings impact of the HECs on Medicare
- Consider how to modify the analysis for other payers
- Inform key PHC design decisions

Key Questions the Medicare Impact Model will Explore

- What are the current **baseline costs** and trajectory of health risks and health spending?
- How will the HECs improve the **trajectory of health risks and health spending** over time?
- Which **population groups are of interest**, defined by medical and social characteristics?
- Which HEC **interventions** do we think will be most effective in driving the change in the health risk and achieving savings based on the latest research?

Population Health Council Design Teams Sign-Up

- We are extending the invitation to the HISC to participate in the Population Health Council design teams
- Who would like to participate in each of the following design teams?
  1. Interventions, Measures, Data, and Workforce
  2. Financing
  3. Governance / Decision-Making

- *Time Commitment:* Two 90-minute lunch webinars in July

Discussion and Closing Comments

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Adjourn

Appendix – HEC Related Materials

Envisioned Core Elements for HECs

Multi-Sector Partnerships

- Strong buy-in from a diverse set of stakeholders.[1]
- Clarity regarding roles and responsibilities.
- Sound governance structure.[2]
- Effective communication strategy. [3]
- Lever opportunities presented by providers and payers in the health care sector. [4]

Health Improvement Activities

- Defined goals and objectives.[3]
- Planning and priority setting.
- Community Health Improvement Plan.[2]
- Targeted population.
- Coordinated root cause prevention.

Process and Outcome Measures

- Systems for reliable and valid data.[5]
- Selection and use of measures to meet accountability and performance targets.
- Community Health Needs Assessment and asset mapping process.[6]
- Social determinants of health data for vulnerable populations.[7]

Sustained Funding Mechanisms[5,6]

- Sustainable funding model that supports ongoing cross-sector activities.
- Reliable revenue streams to cover the full cost of partnership.
- Rewards investors proportionate to the economic value of health improved.

Recommendation Framework: Design Areas

Design Team #1: Interventions, Measures, Data, Workforce

- Proposed webinar topics:
  - Review proposed/narrowed down list of priority health conditions, root causes, and interventions
  - To which population and community-wide measures will HECs be accountable?
  - What IT and data infrastructure does each HEC need to support obtaining and sharing of data? What are the current capabilities?
  - What workforce and other implementation infrastructure is needed to support interventions?

Design Team #2: Financing

- Proposed webinar topics:
  - What financing sources will support the implementation costs of HECs? Where will the upfront investments come from?
  - Funds distribution: When HECs receive funding, how will it be distributed among the HEC partners?
  - Once HECs are implemented, what economic benefits will accrue and where will they accrue?
    - Review and provide input on the analytic model
    - Review and provide input on financial model results to date

Design Team #3: Governance / Decision-Making

- Proposed webinar topics:
  - Review and refine HEC mission and vision based on work to date
  - Review HEC governance structure options
  - What are the core elements of governance that each HEC will implement and for what purpose (e.g., decision-making, performance management, funds flow)?
  - How will variation in non-core aspects of governance models benefit HECs?
  - How will HECs be accountable for outcomes and how will they manage their accountability?

Timeline for Engaging Other Stakeholders (Beyond the Reference Communities)

Wave 1 Stakeholder Engagement (Before June 15)

- Hospitals and hospital community benefit coordinators *(complete)*
- CT Association for Community Action (CAFCA) Community action agencies *(complete)*
- Consumer Advisory Board *(scheduled)*
- Population Health Council – interviews with individual members *(complete)*
- State Health Improvement Coalition Advisory Council *(complete)*

Wave 2 Stakeholder Engagement (After June 15)

- Community Health Center Association of Connecticut (CHCACT) & other primary care providers
- Existing collaboratives (Bridgeport and New Haven)
- Vita Health and Wellness District
- Foundations and funders
- Local health directors
- Faith-based organizations

Methodology for Creating Initial List of Interventions

1. Used health conditions previously identified via SHIP, SIM, Reference Communities, and Population Health Council
2. Used sources in which interventions were recommended or top tier
   - The Community Guide – recommended vs. insufficient evidence or recommended against
   - Coalition for Evidence-Based Policy – Top Tier Standard vs. Near Top Tier
   - CDC HI-5 – evidence-based community-wide interventions in 5 or less years
3. Identified root causes and linked back to health condition(s)
4. Focused on community-based interventions, not clinical
5. Focused on interventions with estimated timelines for return less than 10 years

A Balanced Portfolio of Interventions

Health Affairs April 2018

1. An inventory of evidence-based intervention, including investments in the non-health care sectors
2. Diverse collection of financial sources
3. Selection process to address upstream interventions
4. Capability to capture and share portion of savings for reinvestment
5. Community infrastructure that can build and maintain a balanced portfolio (HEC)

HEC Infrastructures

Need infrastructures to support new functions	HECs will need to have capabilities to perform functions that most community collaboratives have not had to previously do or do so precisely.

HECs will need to be able to:

- Implement interventions that can achieve results, including producing an ROI
- Coordinate, manage, and monitor activities
- Use data to manage and report on defined performance measures
- Manage risks of not achieving outcomes
- Govern and distribute implementation funds and sustainable financing

Economic Benefits of the HECs

The Economic Benefit Model will quantify the myriad economic benefits of what the HECs do.	Key aspect of HEC Initiative is being able to measure specific economic benefits and where they accrue to assess success and to develop investment strategies

HMA will develop an *analytical model and a actuarial tool* with Airam Consulting to inform the sustainability approach of the HEC model including:

- Impact of the HECs on Medicare and other payers, which may be used to pursue a federal partnership
- Impact of the HECs on the economy, which will inform other implementation options and sustainability strategies

Report Sections

I. Executive Summary
II. Reference Community Illustration
III. What is a Health Enhancement Community?
IV. Learning from Reference Communities
V. Financing
VI. State Accountability
VII. Summary of Recommendations and Next Steps
VIII. Appendices