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CT State Innovation Model: Opportunities to advance health equity

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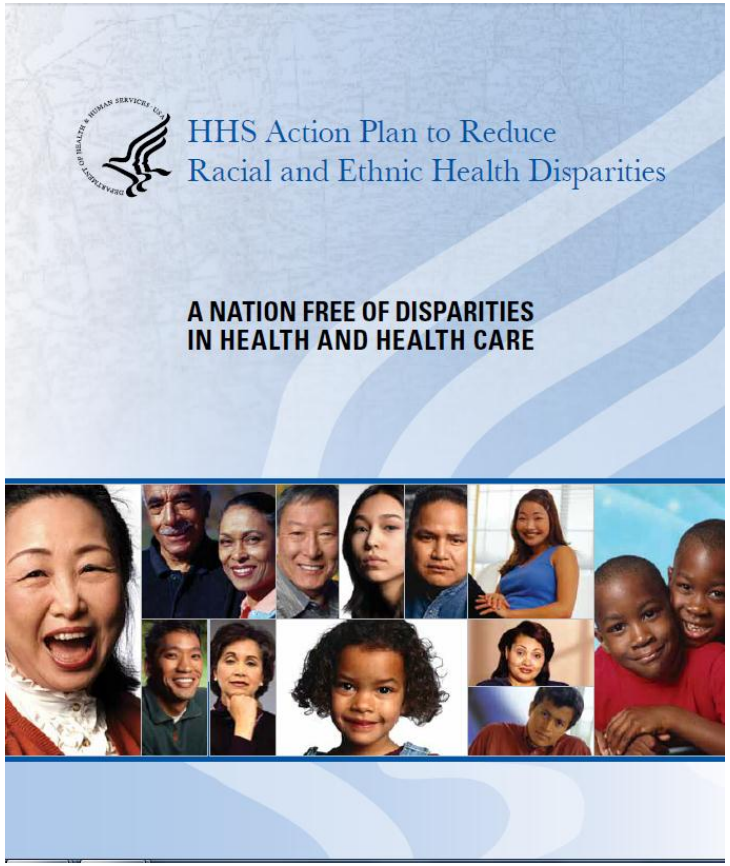
TASKS

- Review and analysis of Federal and national expert group recommendations to advance health equity
- Assess SIM's impact on reducing disparities
- Develop recommendations for health equity inclusions
- Help to review/edit/draft sections of the proposal

FEDERAL HEALTH INITIATIVES

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

- Increase the availability, quality and use of data to improve the health of minority populations
- Measure and provide incentives for better healthcare quality for minority populations
- Incorporate “Key Disparity Measures”



Federal HHS Initiatives

- Let's Move: goal of solving the challenge of childhood obesity within a generation
- HHS Strategic Plan to End the Tobacco Epidemic: includes the goal of supporting evidence-based tobacco control policies at the state and local levels
- The National HIV/AIDS Strategy: goal of ensuring access to high-quality, life extending care, free from stigma and discrimination
- HHS Seasonal Influenza Task Force: goal of maximizing vaccinations in targeted racial and ethnic minority groups
- Million Hearts Initiative: goal of preventing 1 million heart attacks and strokes by 2017 by tackling ABCS (aspirin, blood pressure, cholesterol, smoking)
- National Alzheimer's Plan: goal of increasing awareness/education, care and research

The Innovation Center (CMMI) Initiatives

Graduate Nurse Education Demonstration

The Graduate Nurse Education Demonstration is supporting hospitals for the reasonable cost of providing clinical training to advanced practice registered nursing (APRN) training.

Independence at Home Demonstration

The Independence at Home Demonstration is supporting home-based primary care for Medicare beneficiaries with multiple chronic conditions.

Medicare Coordinated Care Demonstration

The Medicare Coordinated Care Demonstration is testing whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield patient outcomes without increasing program costs.

Multi-Payer Advanced Primary Care Practice

In the Multi-Payer Advanced Primary Care Practice Demonstration, CMS joining in multi-payer primary care initiatives that are currently being conducted within states.

Initiatives Focused on the Medicaid and CHIP Population

Medicaid Emergency Psychiatric Demonstration

The Medicaid Emergency Psychiatric Demonstration is supporting treatment for psychiatric emergencies at private psychiatric hospitals in 11 states and the District of Columbia.

Initiatives Focused on the Medicaid and CHIP Population

Medicaid Incentives for the Prevention of Chronic Diseases Model

The Medicaid Incentives for the Prevention of Chronic Diseases Model is supporting 10 states providing incentives for Medicaid beneficiaries to participate in prevention programs and

Initiatives Focused on the Medicaid and CHIP Population

Strong Start for Mothers and Newborns Initiative: Effort to Reduce Early Elective Deliveries

The Strong Start effort to reduce early elective deliveries supports providers and mothers-to-be in their efforts to decrease the number of early elective deliveries and improve outcomes for mothers and infants.

Initiatives Focused on the Medicaid and CHIP Population

Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models

This initiative will test three evidenc based maternity care service approaches that aim to improve the health outcomes of pregnant wome and newborns.

Initiatives Focused on the Medicaid and CHIP Population

Strong Start for Mothers and Newborns Initiative: General Information

Strong Start supports reducing elective deliveries prior to 39 weeks and offers enhanced prenatal care to decrease preterm births through awards to 27 organizations.

Initiatives Focused on the Medicare-Medicaid Enrollees

Financial Alignment Initiative for Medicare-Medicaid Enrollees

Enables states to integrate care and payment systems for Medicare-Medicaid enrollees and better coordinate their care.

Initiatives Focused on the Medicare-Medicaid Enrollees

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Offers enhanced clinical services to beneficiaries in extended-care nursing facilities.

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Health Care Innovation Awards

The Health Care Innovation Awards are funding competitive grants to compelling new ideas that deliver health care at lower costs to people enrolled in Medicare, Medicaid, and CHIP.

CMMI Initiatives

Health Care Innovation Award Round II

- Focused on Medicaid and CHIP populations
- Models specifically encouraged include those targeting persons living with HIV/AIDS; addressing geographic, clinical or socioeconomic disparities; and bridging clinical and community prevention
- Additional focus on prevention and control of cardiovascular disease, COPD/asthma, diabetes and hypertension

HHS Promotores de Salud Initiative

The goals of the HHS Promotores de Salud/Community Health Workers Initiative:

- Recognize the important contributions of promotoras in reaching vulnerable, low income, and underserved members of Latino/Hispanic populations, and
- Promote the increased engagement of promotores to support health education and prevention efforts and access to health insurance programs.
- Currently supported by a few Innovation Center grants

National CLAS Standards

Culturally and Linguistically Appropriate Services

- Principal Standard: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Remaining standards categorized as follows:
  - Governance, Leadership and Workforce
  - Communication and Language Assistance
  - Engagement, Continuous Improvement and Accountability

NATIONAL HEALTH INITIATIVES

Community Catalyst

General Recommendations:

- States should collect racial/ethnic data collection using new OMB standards and guidance released by HHS
- States should require plans or provider groups to collect data from all the dual eligible beneficiaries they serve and then analyze, understand and address disparities

Recommendations for Exchanges

- Diverse consumer input
- Language access
- Robust outreach programs
- Simplified enrollment
- Robust networks of safety-net providers
- Develop quality strategies to reduce disparities, including focus on plan participants

NCQA
Measuring quality.
Improving health care.

NEW EVALUATION PROGRAM HELPS HEALTH CARE ORGANIZATIONS IMPROVE MULTICULTURAL CARE AND REDUCE DISPARITIES

WASHINGTON, DC — The National Committee for Quality Assurance (NCQA) releases today Multicultural Health Care (MHC), an evaluation program designed to help health care organizations monitor and reduce health care disparities among racial and ethnic minorities.

MHC uses evidence-based standards to evaluate how health care plans and other health and wellness organizations measure, analyze and adjust their services to meet the health care needs of diverse populations.

Health care organizations can earn MHC Distinction by meeting rigorous standards in these areas:

- Race/Ethnicity and Language Data Collection
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Programs
- Reducing Health Care Disparities

"Cultural competency is crucial to providing high quality health care," said NCQA president Margaret E. O'Kane. "I commend and thank The California Endowment for their leadership in California and in the national policy arena, and for helping equip health care professionals with tools to help them care for diverse populations."

MHC distinction standards are modeled after Federal Office of Minority Health (OMH) Standards.

The California Endowment, a private health foundation that provides grants to community-based organizations throughout California, funded development of the NCQA MHC standards.

NQF Endorsed Disparity Measures

L1A: Screening for preferred spoken language for health care	Department of Health Policy, The George Washington University	Aug 09, 2012	Endorsed
L2: Patients receiving language services supported by qualified language servcies providers	Department of Health Policy, The George Washington University	Aug 09, 2012	Endorsed
Language services measure derived from language services domain of the C-CAT	American Medical Association	Aug 09, 2012	Endorsed
Leadership commitment measure derived from the leadership commitment domain of the C-CAT	American Medical Association	Aug 09, 2012	Endorsed
Workforce development measure derived from workforce development domain of the C-CAT	American Medical Association	Aug 09, 2012	

FEDERAL FUNDING TO CONNECTICUT

Community Transformation Grant

Capacity-Building States and Communities Award

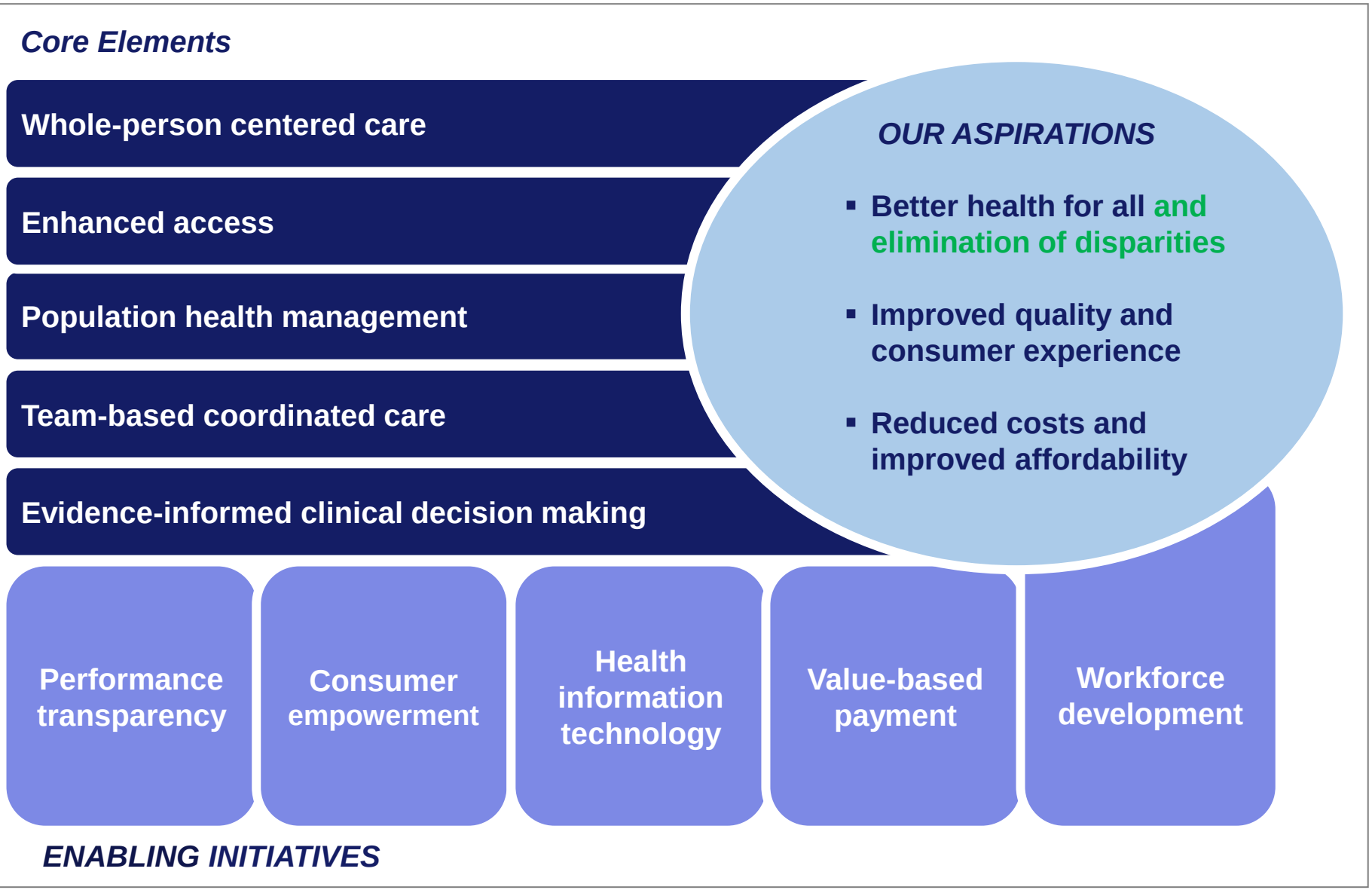
- FY 2011 and FY 2012 funding
- Grant supports
  - tobacco free living;
  - active living and healthy eating;
  - clinical and community preventive services to prevent and control high blood pressure and high cholesterol;
  - social and emotional wellness; and
  - healthy and safe physical environments.

RECOMMENDATIONS

SIM SUGGESTIONS

- Collect racial and ethnic health/health care data.
- Conduct quality measurement and reporting stratified by race, ethnicity and primary language.
- Expand language access, including in health exchange.
  - Encourage CLAS implementation.
- Target at least one population based on health priority that is more prevalent in minority populations and bridges clinical- and community-based prevention.
  - Cardiovascular, obesity, HIV/AIDS, asthma, diabetes, tobacco
- Support workforce diversity, including CHW initiatives

MODIFIED WORDING
Connecticut's Advanced Medical Home Model



Advanced Medical Home – Core Elements

1 Whole-person-centered care

Prioritized interventions

- Assess whole person and family to identify strengths and capacities, risk factors[1], behavioral health, oral health and other co-occurring conditions, and ability to self-manage care
- Use assessment to develop and implement person-centered care plan and shared decision making tools
- Collect and maintain accurate and reliable demographic data, including race, ethnicity, and primary language, to monitor health equity and outcomes and to inform service delivery

1 Including history of trauma, housing instability, access to preventive oral health services

Advanced Medical Home – Core Elements

2 Enhanced access to care (structural and cultural)

Prioritized interventions

- Improve access to primary care through
  - a) extended hours (evenings/weekends)
  - b) convenient, timely appointment availability including same day (advanced) access
  - c) non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance specialty care access through non-visit-based consultations: e.g., e-Consult
- Raise consumer awareness regarding most appropriate options for accessing care to meet routine and urgent health needs
- Ensure practitioner cultural responsiveness, including collecting and disclosing provider demographic information, such as race/ethnicity and languages spoken fluently

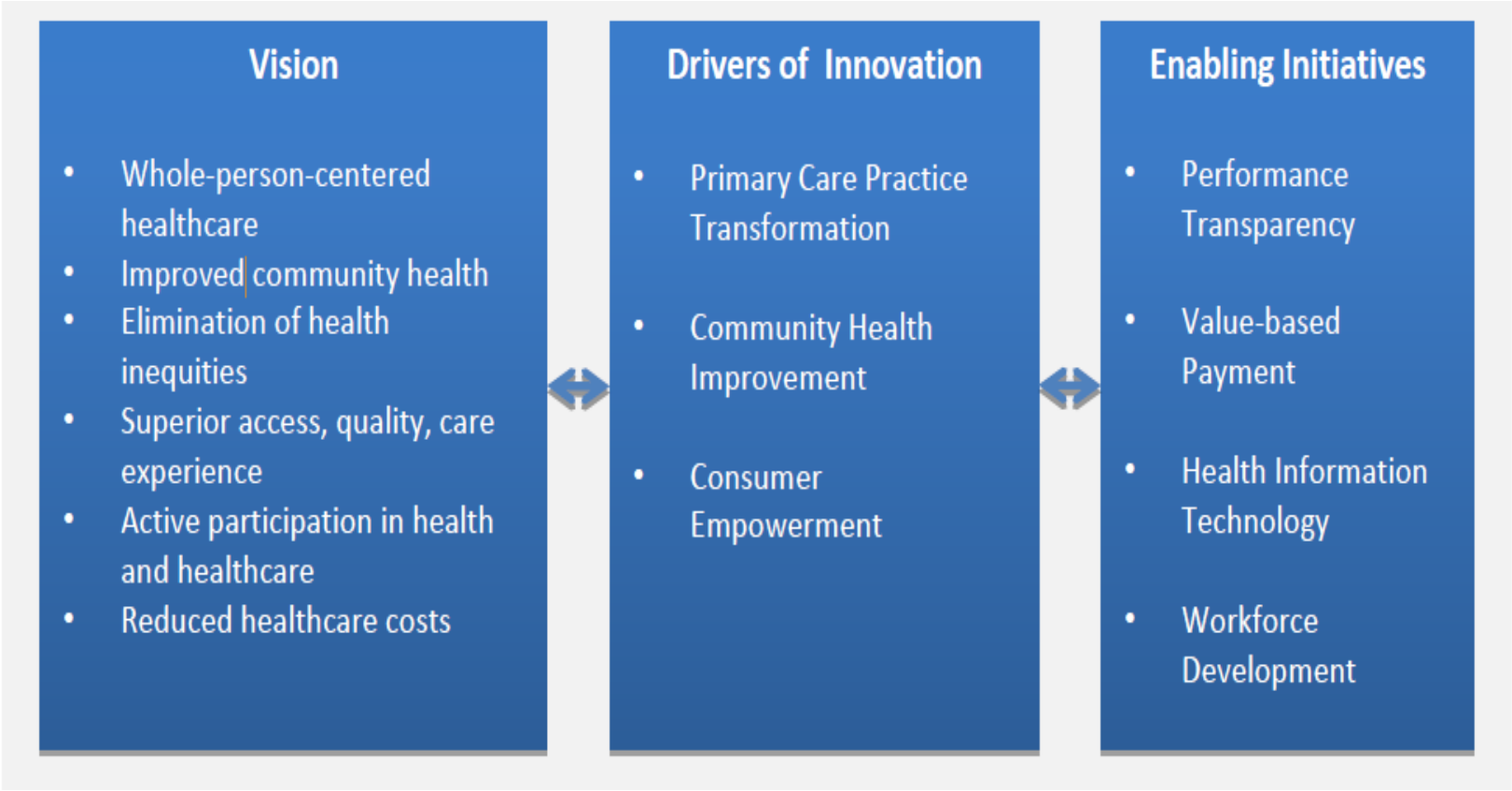
SIM AREAS OF HEALTH EQUITY FOCUS

We will judge our efforts a success if primary care transformation, community health improvement, and consumer empowerment innovations have demonstrable positive impact on health outcomes, care quality, health equity, consumer experience, and costs.

EXHIBIT 1: State Innovation Model Goals

Better Health	• Decrease the statewide rates of diabetes, obesity, tobacco use, asthma and falls
Alleviating and eventually eliminating health disparities	• Close the gap between the highest and lowest achieving populations for each target measure impacted by health inequities
Better quality of care and consumer experience	• Achieve top-quintile performance among all states for key measures of quality of care, increase preventative care and consumer experience and increase the proportion of providers meeting quality scorecard targets
Lower costs	• Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, which corresponds to a 1-2% reduction in the annual rate of healthcare growth

CT SIM


Vision
Whole-person-centered healthcare
Improved community health
Elimination of health inequities
Superior access, quality, care experience
Active participation in health and healthcare
Reduced healthcare costs
Drivers of Innovation
Primary Care Practice Transformation
Community Health Improvement
Consumer Empowerment
Enabling Initiatives
Performance Transparency
Value-based Payment
Health Information Technology
Workforce Development

PRIMARY CARE PRACTICE TRANSFORMATION

A cornerstone of our Innovation Plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements:

- **Whole-person-centered care:** Care that addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health.
- **Enhanced access:**[2] an array of improvements in access including expanded provider hours the primary care team; clear, easily accessible information; and care that is convenient, timely, and linguistically and culturally appropriate.
- **Population Health Management**: use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations.
- **Team-based coordinated care:**[3] multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team.

COMMUNITY HEALTH IMPROVEMENT

While primary care transformation is essential, we recognize that effective prevention cannot be achieved by the care delivery system or by public health agencies acting alone. A major part of our transformation strategy is to foster collaboration among the full range of healthcare providers, employers, schools, community-based organizations, and public agencies to collectively work to improve the health of populations within their community. Our approach to community health improvement comprises two elements:

- **Designated Prevention Service Centers (DPSCs)** to strengthen community-based health services and linkages to primary healthcare.
- **Health Enhancement Communities (HECs)** to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities in areas with the highest disease burden, poorest indicators of socioeconomic status, and pervasive and persistent health disparities.

CONSUMER EMPOWERMENT

The delivery of whole-person-centered care requires a transformation in how payers and providers respect and enable consumers to be active participants in the management of their health. A person's values and preferences and the freedom to make informed decisions must be placed at the center of any efforts to achieve our vision.

Primary care practices will equip consumers with culturally and linguistically appropriate information, resources, and opportunities for them to play an active role in managing their health. As part of our plan for consumer empowerment, we include a three-pronged strategy detailed in the Innovation Plan:

- **Enhanced consumer information and tools** to enable health, wellness, and illness self-management, including shared decision making with providers.
- **Consumer input and advocacy** via decision-making roles in the SIM governance structure and through consumer care experience surveys that will directly affect provider payment.
- **Consumer incentives** to encourage healthy lifestyles and effective illness self-management through the promotion of value-based insurance designs (VBID) and employer incentive programs.

HEALTH WORKFORCE DEVELOPMENT

For the Innovation Plan to succeed, it is essential that Connecticut has a healthcare workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. With input from stakeholders and a workforce task force, we lay out six broad, multipurpose initiatives:

- **Health workforce data and analytics** will be collected in order to make informed decisions regarding training initiatives and regional needs.
- **Inter-professional education (IPE)**, a Connecticut Service Track will be created to promote team and population-health approaches to health professional training.
- **Training and certification standards for Community Health Workers** will ensure that community health workers with common core competencies become an integral part of the healthcare workforce.
- **Preparation of today's workforce for care delivery reform** so providers are able to adapt to our advanced and accountable care delivery models.
- **Innovation in primary care Graduate Medical Education (GME) and residency programs** so that these efforts better align with our health and healthcare reforms.
- **Health professional and allied health professional training career pathways** to improve career flexibility, expand the pipeline of healthcare professionals, and promote workforce diversity.

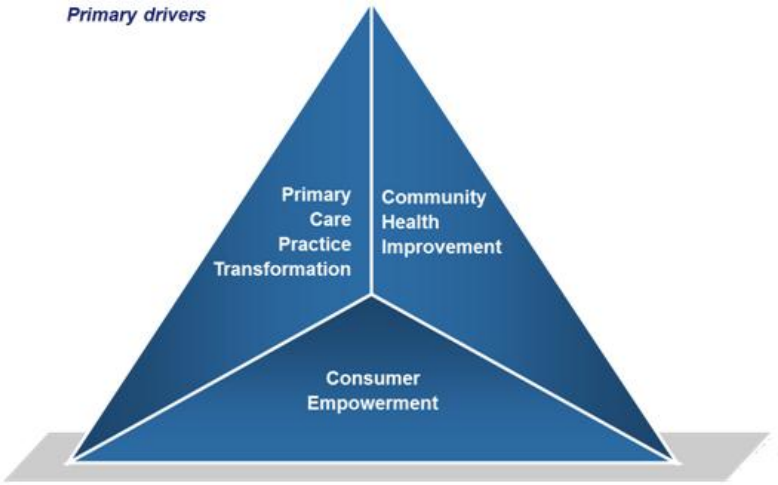
PERFORMANCE TRANSPARENCY

Diverse groups of stakeholders have emphasized that increased transparency of quality, cost and price is a fundamental prerequisite to improving our health system. Transparency is essential for shaping our new care delivery and payment models, for informing consumer choice of health plans and providers, for guiding providers' own performance improvement efforts, and for identifying disparities in health and health outcomes. We will achieve this level of transparency with the following levers and focus areas:

- **Create a common scorecard** that reflects the AMH provider's ability to meet measures of health status, quality of care and consumer experience.
- **Track primary care performance** for quality, care experience, equity and cost measures, with the goal of future expansion to other parts of the healthcare system.
- **Combine data across payers** in order to be able to track a provider's true performance for their entire patient panel and to make reporting more efficient.

SUMMARY

- Enhanced access to care
- Culturally and linguistically appropriate services
- Racial/ethnic data collection and analysis
- Community Health Workers
- Health Enhancement Communities
- Diseases with high prevalence in disparity communities



LOOKING AHEAD

TOP FIVE

- Enrollment– phase 1
- Enrollment—phase 2
- From Coverage to Care
- Workforce, especially for Medicaid
- Quality measures

**Prevention