State Innovation Model Initiative

STATE OF CONNECTICUT

Presentation to the Health Care Cabinet

May 11, 2014

Updates

- The budget proposed by the Governor to establish the Program Management Office has been authorized by the legislature
- Grant announcement (FOA) has not been released
- Governance structure is emerging – membership has been finalized for the following work groups
  - Practice Transformation Task Force
  - Quality Council
  - Equity and Access Council
- Additional appointments to the Consumer Advisory Board
- Draft charters have been developed for several work groups

Current Activities

- Program Management Office is focused on developing additional programmatic detail and surfacing questions on various elements of the program
- This work is typically summarized in Issue Briefs, which enable the Steering Committee, Consumer Advisory Board, Health Care Cabinet and others to comment
- Based on the comments we receive, we intend to further detail the program elements or “building blocks” of the test grant application
- This enables us to develop draft position descriptions, justification and budget
- This also enables us to begin to develop our evaluation plan

Current Activities

- As the entire application comes together, these building blocks may be further modified (or in some cases removed) based on the recommendations that we receive from the Steering Committee and input from other advisors committees and individuals

- We are *considering* additional Issue Briefs in the following areas:
  - Prevention Service Centers
  - Employer engagement
  - Workforce data storage, collection and analytics
  - Support for community health workers
  - Connecticut service track
  - Elements of our HIT strategy

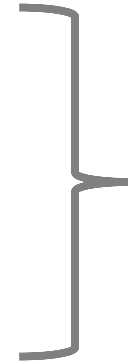
Work Groups

- Start date for work groups has not been set
- We are hoping to launch one or two work groups in June
- Now that budget is authorized, we will be procuring for work group support including facilitation and subject matter expertise

Issue Brief #4: Strategy for Advancing Care Delivery in Primary Care Practices and Advanced Networks and FQHCs

Terminology

- Integrated delivery systems
- Large medical groups
- Clinically Integrated Network



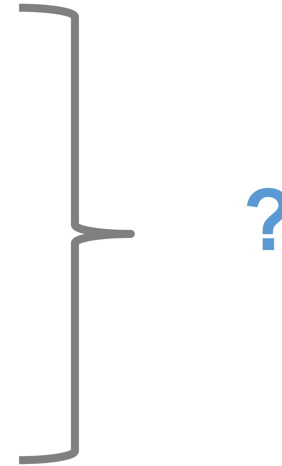
Advanced Network*

- Federally Qualified Health Center (FQHC)
- Independent Practice Associations
- Small to mid-size practices (unaffiliated)

*Applies if most practices are moving toward medical home recognition

Current Approach

- Integrated delivery systems
- Large medical groups
- Clinically Integrated Network
- Federally Qualified Health Center (FQHC)



?

- Independent Practice Associations

AMH?

- Small to mid-size practices (unaffiliated)

AMH

Core Dimensions of Practice Transformation

CORE ELEMENTS

- Whole-person centered care
- Enhanced access
- Population health management
- Team-based coordinated care
- Evidence-based informed clinical decision making

OUR ASPIRATIONS

- Better health for all
- Improved quality and consumer experience
- Promote health equity and eliminate health disparities
- Reduced costs and improved affordability

Advanced Medical Home

- Small to mid-size practices (primarily late adopters) will be
  - limited in their ability to fully achieve the capabilities that correspond with our Core Dimensions
  - gradual in their achievement of advanced primary care milestones during the three year test grant period
- In turn, we will be limited in our ability to achieve our vision
- Unless our strategy enables and incentivizes a higher standard of performance and continuous improvement in Connecticut's advanced networks and FQHCs

Advanced Networks and FQHCs

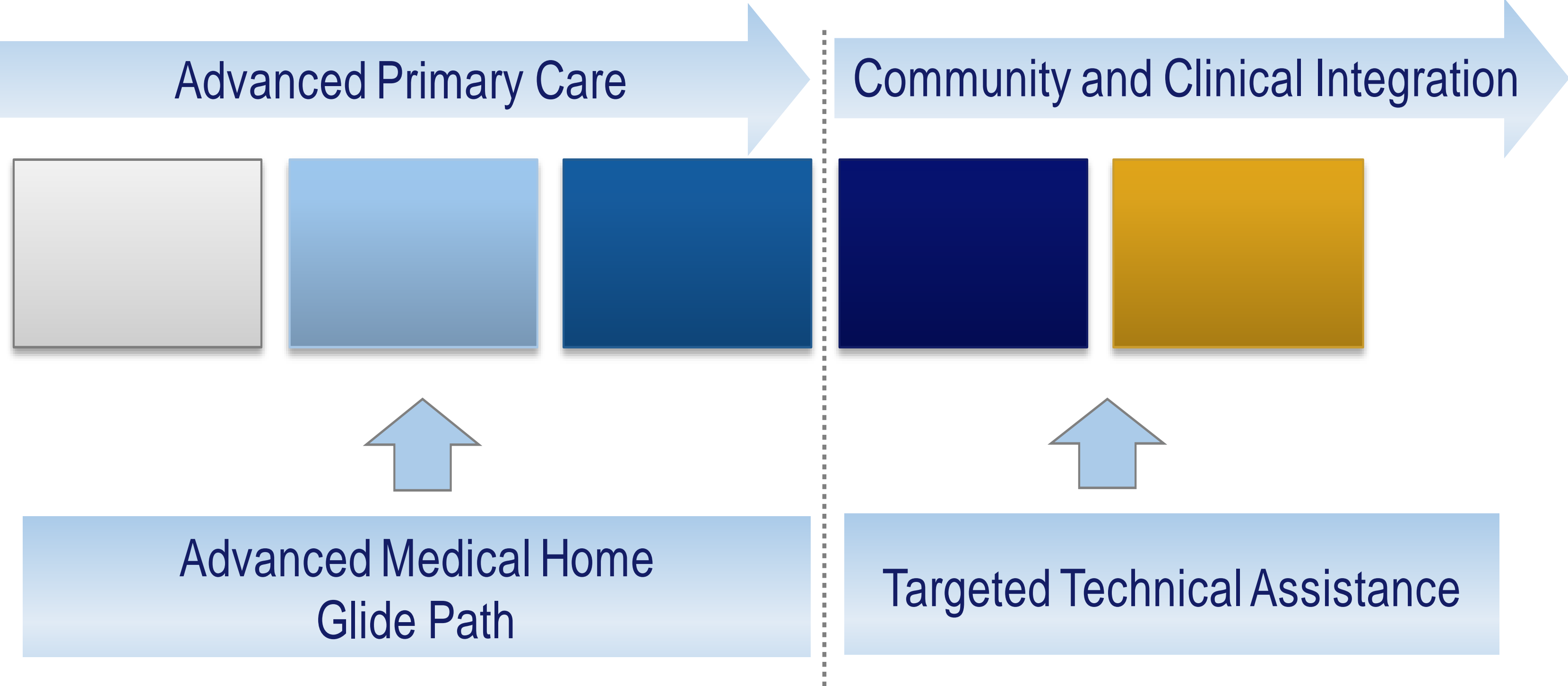
- As it stands today, many advanced networks are working on:
  - Using EHR and claims data to identify high risk consumers
  - Integrating care coordinators into care teams
  - Actively facilitating care transitions
  - Resolving access issues by making better use of existing clinical capacity
  - Undertaking advanced analytics to identify variations in practice within the network
  - Educating and aligning clinicians around evidence based guidelines
  - Exchanging information with clinical partners (specialists, hospitals, nursing facilities, home health, etc.)
  - Other analytics to support continuous quality improvement

Should our plan....

1. Establish additional expectations for advanced networks and FQHCs over and above our core AMH standards?

2. Allocate SIM test grant dollars to provide support to these advanced networks and FQHCs?

Proposed Extension of our Care Delivery Reforms



Issue Brief #4: Strategy for advancing care delivery in primary care practices and advanced networks

Community and Clinical Integration

- Private health plans, self-funded employers and Medicare are driving improvements in clinical integration through shared savings program arrangements
- In addition, NCQA and URAC have developed a higher level of recognition targeted to advanced networks that focus on clinical integration and use of data across the enterprise
- These standards
  - encompass, but move beyond, existing medical home standards
  - could drive improvement if voluntarily pursued by Connecticut's advanced networks or are required by Connecticut's payers

Community and Clinical Integration

- Private health plans and self-funded employers are less likely to drive:
  - care team diversity (e.g., to include community health workers), and
  - community integration (e.g., coordination with housing supports)
  - Cultural and linguistic appropriateness standards (NCLAS)
- Most of the benefits would accrue primarily to Medicaid and Medicare beneficiaries
- Medicaid (and perhaps Medicare) would likely need to drive developments in these areas

Targeted Technical Assistance

- Focus on a range of capabilities based on a survey of advanced networks and FQHCs,
- Other identified gaps in community and clinical integration

Targeted Technical Assistance

- For example:
  - Direct messaging: integration & extension to community partners
  - Integrating community health workers into care team
  - Community linkages w/ social service and preventive health providers
  - Community care teams & “hot spotting”
  - Integrated care processes for managing special conditions (e.g., chronic pain, sickle cell)
  - Cultural and linguistic appropriateness (NCLAS)
  - Understanding and closing health equity gaps
  - Integration with long term support and service providers

DRAFT
PRE-DECISIONAL

PRIMARY CARE DELIVERY AND PAYMENT INNOVATION MODEL

Delivery Model

Advanced Primary Care

small-med independent practices

physicians: 1,120 # patients: 1.4m

Community & Clinical Integration

Advanced networks, FQHCs and practice groups

physicians: 1,680 #patients: 2.1m

Transformation Support

Advanced Medical Home Glide Path

HIT Adoption
- •ONC-certified eHR
- •eRx
- •Secure Email

Care Coordination & Management Tools
- •Shared Decision Making
- •Referral Tracking and follow-up
- •Chronic illness gaps, alerts
- •Chronic illness self-management
- •Disease Registries
- •Health Risk Stratification
- •Care coordination

Structural Standards
- •EHR
- •Extended business hours
- •CLAS
- •Use of data

Analytics
- •CQI Reporting

Targeted Technical Assistance

Innovation Grants? + Learning Collaboratives

Community Care Integration Approach
- •Expanded care team w/Health Coaches & Patient Navigators
- •Home Visiting / Outreach
- •Linkage to Prevention Service Centers & Health Depts
- •Community Care Teams / Hotspotter
- •Linkage to Long Term Supports & Services
- •Linkage to Housing and other Social Supports

Clinical integration and Advanced Care Management
- •Provider access to electronic data
- •Timely information exchange
- •Monitoring practice patterns
- •Clinician/provider detailing
- •Behavioral Health
- •Oral Health
- •Medication therapy management
- •Expanded care registries
- •Home visits and monitoring
- • Process for care transitions
- •e-consults
- •Telemedicine

Structural Standards
- •E.g., URAC, NCQA
- •CLAS
- •Consumer portal
- •Personal health record
- •Consumer decision aids

Analytics and Quality Improvement
- •Integration and use of data
- •Rapid Cycle CQI (quality, experience, cost)
- •Population health analysis
- •Data to assess & improve disparities

Payment Model

Pay for Performance (P4P)	Pay for Performance (P4P) + Advanced Payments for Care Coordination	Shared Savings Plan (SSP) + Advanced Payments for Care Coordination, New Services & Non-Visit Based Activities and/or Shared Service Solution (e.g., insurer, ASO)

Cross-payer common quality performance scorecard, care experience inclusion in value based payment calculation

whole-person-centered, enhanced access, team-based coordination, evidence-based, population health