Connecticut SIM: Creating a Culture of Value

CT Behavioral Health Partnership Oversight Council
October 15, 2015
What is a State Innovation Model Grant?

SIM grants are awarded by the federal government through the Center for Medicaid and Medicare Services (CMS) Innovation center. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

1. Improve health system performance
2. Increase quality of care
3. Decrease Costs

There are two types of grants awarded; a grant to design an innovation model and a grant to test an innovation model. Connecticut and New York were awarded design grants in April 2014 and test grants in December 2014 which will be implemented over the next five years.

Design Grant and Test Grant Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Design Grant Awarded</td>
</tr>
<tr>
<td>2014</td>
<td>Test Grant Awarded</td>
</tr>
<tr>
<td>2015</td>
<td>SHIP Published</td>
</tr>
<tr>
<td>2016</td>
<td>Design/Pre-Implementation Complete</td>
</tr>
<tr>
<td>2017</td>
<td>Implementation Phase 1/1/16-12/31/19</td>
</tr>
<tr>
<td>2018</td>
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<tr>
<td>2019</td>
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<tr>
<td>2020</td>
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</tbody>
</table>
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
**Our Journey from Current to Future: Components**

**CT SIM Component Areas of Activity**

- **Transform Healthcare Delivery System**
  - $13m
  - *Transform the healthcare delivery system* to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

- **Build Population Health Capabilities**
  - $6m
  - *Build population health capabilities* that reorient the healthcare toward a focus on the wellness of the whole person and of the community.

- **Reform Payment & Insurance Design**
  - $9m
  - *Reform payment & insurance design* to incent value over volume, engage consumers, and drive investment in community wellness.

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- **Engage Connecticut’s consumers throughout** $376k
- **Invest in enabling health IT infrastructure** $10.7m
- **Evaluate the results, learn, and adjust** $2.7m
Healthcare today – 1.0

Connecticut’s Current Health System: “As Is”

- Limited accountability
- Poorly coordinated
- Pays for quantity without regard to quality
- Uneven quality and health inequities
- Limited data infrastructure
- Unsustainable growth in costs
Healthcare Spending has Outpaced Economic Growth

Source: CMS, National Health Expenditure Data
Escalating costs mean...

**Patients** will experience:
- Insurance premiums resulting in less take-home pay
- Deductibles and co-pays for needed medical care
- Access to social services and Medicaid

**Communities** will experience:
- Money for programs that support housing, education, the environment, and community development
Escalating costs mean...

....the **business community** will experience

- Competitiveness
- Economic development
US = Lowest Ranking for Safety, Coordination, Efficiency, Health

How about Connecticut?
**Connecticut** - healthcare spending = More than $30 billion, *fourth highest of all states* for healthcare spending per capita

Connecticut: Uneven Quality of Care

Rising rate of Emergency Department utilization

<table>
<thead>
<tr>
<th>Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries</th>
<th>2011</th>
<th>195</th>
<th>183</th>
<th>129</th>
</tr>
</thead>
</table>

CT ranking out of 50 states

High Hospital Readmissions

<table>
<thead>
<tr>
<th>Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries</th>
<th>2012</th>
<th>52.0</th>
<th>45</th>
<th>26</th>
</tr>
</thead>
</table>

CT ranks 36th out of 50 states

Health disparities persist in Connecticut

Diabetes Death Rates - Race/Ethnicity

Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut Residents, by Race or Ethnicity, 2000–2004

- Total: 17.9
- Black or African American: 40.2
- Hispanic: 24.3
- White: 15.8

Source: DPH 2008b, 2008v
Health disparities persist in Connecticut

Health disparities devastate individuals, families and communities, and are costly:

- From 2003-2006 there were $229.4 billion in direct medical costs from minority disparities
  - $57.35 billion/year

- 30.6% of direct costs for African Americans, Asians & Hispanics were due to disparities

- The cost of the disparity for the Black population in Connecticut is between $550 million - $650 million a year

Source: LaVeist, Gaskin & Richard (2009). The Economic Burden of Health Inequalities in the US. The Joint Center for Political & Economic Studies. As reported by DPH
Stages of Transformation
Stages of Transformation

Connecticut’s Current Health System: “As Is”

**Fee for Service 1.0**
- Limited accountability
- Pays for quantity without regard to quality
- Lack of transparency
- Unnecessary or avoidable care
- Limited data infrastructure
- Health inequities
- Unsustainable growth in costs

**Accountable Care 2.0**
- Accountable for patient population
- Rewards
  - better healthcare outcomes
  - preventive care processes
  - lower cost of healthcare
- Competition on healthcare outcomes, experience & cost
- Coordination of care across the medical neighborhood
- Community integration to address social & environmental factors that affect outcomes

Our Vision for the Future: “To Be”

**Health Enhancement Communities 3.0**
- Accountable for all community members
- Rewards
  - prevention outcomes
  - lower cost of healthcare & the cost of poor health
- Cooperation to reduce risk and improve health
- Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities
- Community initiatives to address social-demographic factors that affect health
Getting to...

Accountable Care 2.0
Targeted Initiatives

Statewide Initiatives
Model Test Hypothesis for SIM Targeted Initiatives

High percentage of patients in value-based payment arrangements

+ Resources to develop advanced primary care and organization-wide capabilities

= Accelerate improvement on population health goals of better quality and affordability

MQISSP
Medicare SSP
Commercial SSP

+ MQISSP is the Medicaid Quality Improvement and Shared Savings Program

- [MQISSP](#)
- [Medicare SSP](#)
- [Commercial SSP](#)
- [Advanced Medical Home Program](#)
- [Community & Clinical Integration Program (CCIP)](#)
Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer
Accountability for quality and total cost
Connecticut has many Advanced Networks

= Advanced Network chosen in Wave 1 to participate in Medicaid Quality Improvement & Shared Savings Program (MQISSP)
Resources aligned to support transformation

Community & Clinical Integration Program (CCIP)
Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for all populations
Using population health strategies
Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:

- Supporting Individuals with Complex Needs
  Comprehensive care team, Community Health Worker, Community linkages

- Reducing Health Equity Gaps
  Analyze gaps & implement custom intervention
  CHW & culturally tuned materials

- Integrating Behavioral Health
  Network wide screening, assessment, treatment/referral, coordination, & follow-up

Comprehensive Medication Management
E-Consults
Oral health
New capabilities will support clinical integration and communication across the medical neighborhood.
New capabilities will also support coordination and integration with key community partners.

- Social services
- Housing
- Homemaker & companion
- Employment services
- Cultural health organizations
Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

*Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more*
Using HIT to enable new Advanced Network capabilities

- Consent registry
- Provider Directory
- Master Patient Index
- Admission, Discharge Transfer Information
- AMH
- SIM HIT Enabling Technologies
- CCIP
- Analytic tools
- Direct messaging
Value Based Payment

Value = Quality & Care Experience

Total Cost of Care
Expanding the reach of Value Based Payment

- FFS
- P4P
- Upside
- Gain share
- Downside
- Risk share
- Prepayment/Bundle
- SIM
Expanding the reach of Value-Based Payment

Medicare SSP

MQISSP

Advanced Network

Commercial SSP
Reaching the tipping point

MQISSP

Medicare SSP

Commercial SSP

% of consumers in an Advanced Network in value-based payment arrangement
Reaching the tipping point

Culture of Value

% of consumers in an Advanced Network in value-based payment arrangement

MQISSP

Commercial SSP

Medicare SSP
Putting it all together

Medicare SSP

Commercial SSP

Advanced Network

Community & Clinical Integration Program (CCIP)

Advanced Medical Home (AMH) Program
SIM Targeted Initiatives and FQHCs

- SIM targeted initiatives focus on Federally Qualified Health Centers (FQHCs), as well as ANs. Much of this narrative applies to FQHCs, except that FQHCs:
  - Will not require AMH support, because they are already recognized as PCMH (NCQA or Joint Commission) (there may be one or two exceptions)
  - May have limitations on their ability to participate in CCIP as a result of their receipt of Transforming Clinical Practices Initiative Awards
  - Do not currently have Medicare or commercial SSP arrangements; consequently, MQI SSP will get them to greater than 50% of their population in VBP, based on that experience, commercial or Medicare VBP contracts would follow
Targeted Initiatives

Statewide Initiatives
Statewide Initiatives

Quality Measure Alignment
Value-Based Insurance Design
Value-based Payment
## Shared Savings Program - Participation Projections

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<thead>
<tr>
<th>Year</th>
<th>Beneficiaries</th>
<th>%</th>
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<tbody>
<tr>
<td>2016</td>
<td>1,305,000</td>
<td>38%</td>
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<tr>
<td>2017</td>
<td>1,745,000</td>
<td>50%</td>
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<tr>
<td>2018</td>
<td>2,270,000</td>
<td>64%</td>
</tr>
<tr>
<td>2019</td>
<td>2,596,000</td>
<td>73%</td>
</tr>
<tr>
<td>2020</td>
<td>3,117,000</td>
<td>88%</td>
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Estimated 2014 State Population: 3,596,677
Quality Measure Alignment
Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals

2. Common cross-payer measure of care experience tied to value based payment

3. Common provider scorecard
Outcomes Measures

Today:

Health Plan → **Claims Data** → Quality Performance Scorecard

- PCMH CAHPS
- Care Coordination
- All-cause Readmissions
- Prevention
- Breast Cancer Screening
- Colorectal Cancer Screening
- Health Equity Gap
- Chronic & Acute Care
- Diabetes A1C Poor Control
- Health Equity Gap
- Hypertension Control
- Health Equity Gap

- **Process Measures**
  (E.g., Diabetes foot exam, well-care visits, medication adherence)

- **National consensus to move towards outcomes:**

Health Plan → **Claims Data** → Process & Outcome Measures

- **EHR Data**
- Diabetes A1C control, blood pressure control, depression remission
Opportunities and barriers

• Producing new measures is expensive

• Currently, all costs are borne by health plans and their clients

• SIM funds can support the conduct of care experience surveys and production of measures that will otherwise have to be produced separately by each payer
Core Measure Set

Payers currently produce claims based measure
State proposes to produce
- EHR based measures
- Care experience survey measures

SIM Funded HIT

New Technology on behalf of all payers

EHR measure production

Provisional Core Quality Measure Set 10-6-15

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF</th>
<th>ACO</th>
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<tr>
<td>Consumer Experience Measure</td>
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<td></td>
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<tr>
<td>PCMH – CAHPS measure</td>
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<tr>
<td>0005</td>
<td></td>
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<tr>
<td>Care coordination/patient safety</td>
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<tr>
<td>Plan all-cause readmission</td>
<td>1768</td>
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<tr>
<td>All-cause unplanned admissions for patients with DM</td>
<td>0283</td>
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<tr>
<td>Asthma in younger adults admission rate</td>
<td></td>
<td>36</td>
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<tr>
<td>Asthma admission rate(child)</td>
<td>0728</td>
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<tr>
<td>Emergency Department Usage per 1000</td>
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<td>Documentation of current medications in the medical record</td>
<td>0419</td>
<td>39</td>
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<tr>
<td>Annual monitoring for persistent medications (roll-up)</td>
<td>2371</td>
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<tr>
<td>Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions</td>
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<tr>
<td>Prevention Measure</td>
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<tr>
<td>Breast cancer screening</td>
<td>2372</td>
<td>20</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>0032</td>
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<tr>
<td>Chlamydia screening in women</td>
<td>0033</td>
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<td>Colorectal cancer screening</td>
<td>0034</td>
<td>19</td>
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<tr>
<td>Adolescent female immunizations HPV</td>
<td>1959</td>
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<td>Weight assessment and counseling for nutrition and physical activity for children/adolescents</td>
<td>0024</td>
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<tr>
<td>Preventive care and screening: BMI screening and follow up</td>
<td>0421</td>
<td>16</td>
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<tr>
<td>Developmental screening in the first three years of life</td>
<td>1448</td>
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<td>Well-child visits in the first 15 months of life</td>
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<tr>
<td>Well-child visits in the third, fourth, fifth and sixth years of life</td>
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<tr>
<td>Adolescent well-care visits</td>
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<tr>
<td>Tobacco use screening and cessation intervention</td>
<td>0028</td>
<td>17</td>
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<td>Prenatal Care &amp; Postpartum care</td>
<td>1517</td>
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<td>Frequency of Ongoing Prenatal Care (FPC)</td>
<td>1391</td>
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<tr>
<td>Oral health: Primary Caries Prevention</td>
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<tr>
<td>Screening for clinical depression and follow-up plan</td>
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<td>Oral Evaluation, Dental Services (Medicaid only)</td>
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<td>Behavioral health screening (pediatric, Medicaid only, custom measure)</td>
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<tr>
<td>Acute &amp; Chronic Care Measure</td>
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<tr>
<td>Medication management for people with asthma</td>
<td>1799</td>
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<tr>
<td>Asthma Medication Ratio</td>
<td>1800</td>
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<tr>
<td>DM: Hemoglobin A1c Poor Control (&gt;9%)</td>
<td>0059</td>
<td>27</td>
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<tr>
<td>DM: HbA1c Screening (interim measure until NQF 0059 is stood up)</td>
<td>0057</td>
<td></td>
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<tr>
<td>DM: Diabetes eye exam</td>
<td>0055</td>
<td>41</td>
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<tr>
<td>DM: Diabetes foot exam</td>
<td>0056</td>
<td></td>
</tr>
<tr>
<td>DM: Diabetes: medical attention for nephropathy</td>
<td>0062</td>
<td></td>
</tr>
<tr>
<td>HTN: Controlling high blood pressure</td>
<td>0018</td>
<td>28</td>
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<tr>
<td>Use of imaging studies for low back pain</td>
<td>0052</td>
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<tr>
<td>Avoidance of antibiotic treatment in adults with acute bronchitis</td>
<td>0058</td>
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</tr>
<tr>
<td>Appr. treatment for children with upper respiratory infection</td>
<td>0069</td>
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<tr>
<td>Cardiac stress imaging: Testing in asymptomatic low risk patients</td>
<td>0072</td>
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<tr>
<td>Behavioral Health Measure</td>
<td></td>
<td></td>
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<tr>
<td>Follow-up care for children prescribed ADHD medication</td>
<td>0108</td>
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</tr>
<tr>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
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<tr>
<td>(pediatric, Medicaid only, custom measure)</td>
<td></td>
<td></td>
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<tr>
<td>Depression Remission at 12 Twelve Months</td>
<td>0710</td>
<td>40</td>
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<tr>
<td>Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
<td>1365</td>
<td></td>
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<tr>
<td>Unhealthy Alcohol Use – Screening</td>
<td></td>
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</tbody>
</table>
Payer Agnostic Measures

Payer specific measure:

Payer 1 calculates measure

Payer 2 calculates measure

Payer 3 calculates measure

Payer 4 calculates measure

Agnostic measure:

All patients in a shared savings arrangement

Agnostic Measure
(calculated without regard to payer)

A health plan or employer would need to accept aggregate performance as a reasonable proxy for payer or employer specific sub-populations.

In other words, an employer would assume that providers will be as effective managing diabetes for their own employees, as anyone else’s employees.
Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals

2. Common cross-payer measure of care experience tied to value based payment

3. Common provider scorecard?

Future focus of Quality Council
Common Scorecard?

Payer agnostic scorecard for public reporting

SIM Funded HIT?

Claims and EHR Data?

New Technology on behalf of all payers

APCD?
Value-based Insurance Design
Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

Use high value services
(e.g., preventative services, certain prescription drugs)

Use high performance providers
Who adhere to evidence-based treatment

Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

Health promotion & disease management

Health coaching & treatment support
Aligning strategies to engage consumers and providers

Value-based Insurance Design

Advanced Network

Value-based Payment
Program Goals

1. Develop prototype VBID plan designs that align the interests of consumers and providers

2. Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans
Key Partners

CBIA CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

NORTHEAST BUSINESS GROUP ON HEALTH

Connecticut Business Group on Health
Promoting a better healthcare delivery system

Office of the State Comptroller
(state employee health plan)
SIM VBID Components

• **Employer-led Consortium**: peer-to-peer sharing of best practices

• **Prototype VBID Designs**: using latest evidence, to make it easy for employers to implement

• **Annual Learning Collaborative**: including panel discussions with nationally recognized experts and technical assistance

CT’s Health Insurance Market Exchange) will implement VBID in Year 2 of the Model Test (subject to Board approval)
<table>
<thead>
<tr>
<th>Year</th>
<th>Percent adoption</th>
</tr>
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<tbody>
<tr>
<td>2016</td>
<td>44%*</td>
</tr>
<tr>
<td>2017</td>
<td>53%</td>
</tr>
<tr>
<td>2018</td>
<td>65%</td>
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<tr>
<td>2019</td>
<td>74%</td>
</tr>
<tr>
<td>2020</td>
<td>85%</td>
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</tbody>
</table>

*Estimate – will establish empirical baseline 2015
Health Enhancement Communities 3.0
Community and clinically integrated throughout Connecticut
ACO accountability rewards better healthcare...

but it does not reward better health

Health determinants that affect mortality

10% is healthcare

60% is social, environmental and behavioral health determinants

- Genetics
- Social Circumstances
- Environmental Conditions
- Behavioral Choices
- Medical Care
Taking aim at the determinants of health requires...  

a regional focus
Expand linkages among community stakeholders...

building upon those that already exist

- Relationships among ACOs and all community stakeholders
- Accountability for the health and well-being of all community residents
A pathway to community accountability

- Community Development
- Employers
- Health Departments
- City Planners
- Schools

Example only: actual regions may be smaller and/or have different boundaries.
Accountability for...

- All residents of the community
- Performance
  - improving community health (i.e., prevention outcomes)
  - improving health equity
  - lowering the cost of healthcare and the cost of poor health
Rewards for ACOs that play a role in producing measurable improvement in community health

<table>
<thead>
<tr>
<th>Health Improvement &amp; Quality Performance Scorecard</th>
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<tbody>
<tr>
<td>Care Experience</td>
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<tr>
<td>PCMH CAHPS</td>
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<tr>
<td>Care Coordination</td>
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<tr>
<td>All-cause Readmissions</td>
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<td>Prevention</td>
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<td>Breast Cancer Screening</td>
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<td>Colorectal Cancer Screening</td>
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<tr>
<td>Health Equity Gap</td>
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<tr>
<td>Chronic &amp; Acute Care</td>
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<tr>
<td>Diabetes A1C Poor Control</td>
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<tr>
<td>Health Equity Gap</td>
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<tr>
<td>Hypertension Control</td>
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<tr>
<td>Health Equity Gap</td>
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<tr>
<td>Community Health Improvement</td>
</tr>
<tr>
<td>Obesity prevalence</td>
</tr>
<tr>
<td>Health Equity Gap</td>
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<tr>
<td>Diabetes Prevalence</td>
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</table>
Rewards for ACOs that play a role in producing measurable improvement in community health

<table>
<thead>
<tr>
<th>Health Improvement &amp; Quality Performance Scorecard</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
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<tr>
<td><strong>Care Experience</strong></td>
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<td><strong>Prevention</strong></td>
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<td><strong>Chronic &amp; Acute Care</strong></td>
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<td>Hypertension Control</td>
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<td><strong>Community Health Improvement</strong></td>
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<td>Obesity prevalence</td>
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<td>Diabetes Prevalence</td>
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<td>Health Equity Gap</td>
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</tbody>
</table>

Attributed consumers

All community members
Rewards for community participants... through new vehicles for reinvestment

- Wellness trust?
- Community stakeholder distributions?
- Consumer incentives?
- Targeted investments...for example
  - Access to healthy food
  - Enhanced walkability
  - Opportunities for an active lifestyle
  - Improvements in housing stock
Evaluation
By 6/30/2020 Connecticut will:

**Improve Population Health**
Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

**Improve Health Care Outcomes**
Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

**Reduce Health Disparities**
Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

**Reduce Healthcare Costs**
Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.
Aims:
By 6/30/2020 Connecticut will:

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<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults who are obese</td>
<td>24.50%</td>
<td>22.95%</td>
</tr>
<tr>
<td>Percent of children who are obese</td>
<td>18.80%</td>
<td>17.65%</td>
</tr>
<tr>
<td>Percent of children in low-income households who are obese</td>
<td>38.00%</td>
<td>35.55%</td>
</tr>
<tr>
<td>Percent of adults who currently smoke</td>
<td>17.10%</td>
<td>14.40%</td>
</tr>
<tr>
<td>Percent low income adults who smoke</td>
<td>25.00%</td>
<td>22.43%</td>
</tr>
<tr>
<td>Percent of youth (high school) who currently smoke</td>
<td>14.00%</td>
<td>12.72%</td>
</tr>
<tr>
<td>Percent of adults with diabetes</td>
<td>8.50%</td>
<td>7.86%</td>
</tr>
<tr>
<td>Percent of adults with diabetes – low income</td>
<td>14.30%</td>
<td>11.32%</td>
</tr>
</tbody>
</table>

* Baselines & goals may change due to new data
CT SIM Test Grant: Aims

Aims:
By 6/30/2020 Connecticut will:

**Improve Population Health**
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<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>% adults regular source of care</td>
<td>83.9%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Risk- std. all condition readmissions</td>
<td>15.9</td>
<td>13.1</td>
</tr>
<tr>
<td>Ambulatory Care Sensitive Condition Admissions</td>
<td>1448.7</td>
<td>1195.1</td>
</tr>
<tr>
<td>Children well-child visits for at-risk pop</td>
<td>62.8</td>
<td>69.1</td>
</tr>
<tr>
<td>Mammogram for women &gt;50 last 2 years</td>
<td>83.9</td>
<td>87.7</td>
</tr>
<tr>
<td>Colorectal screening- adults aged 50+</td>
<td>75.7</td>
<td>83.6</td>
</tr>
<tr>
<td>Colorectal screening- Low income</td>
<td>64.9</td>
<td>68.2</td>
</tr>
<tr>
<td>Optimal diabetes care- 2+ annual A1c tests</td>
<td>72.9</td>
<td>80.1</td>
</tr>
<tr>
<td>ED use- asthma as primary dx (per 10k)</td>
<td>73.0</td>
<td>64.0</td>
</tr>
<tr>
<td>Percent of adults with HTN taking HTN meds</td>
<td>60.1%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Premature death- CVD adults (per 100k)</td>
<td>889.0</td>
<td>540.0</td>
</tr>
</tbody>
</table>

* Baselines & goals may change due to new data
Aims: By 6/30/2020 Connecticut will:

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A major goal of the Model Test is to improve equity in access and quality. We will monitor equity gaps for the core dashboard measures and target selected areas for improvement.
Aims:

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<tr>
<th>Measure</th>
<th>Baseline</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASO/Fully insured</td>
<td>$457</td>
<td>$603</td>
</tr>
<tr>
<td>State employees w/o Medicare</td>
<td>$547</td>
<td>$722</td>
</tr>
<tr>
<td>Medicare</td>
<td>$850</td>
<td>$1,096</td>
</tr>
<tr>
<td>Medicaid/CHIP, incl. expansion*</td>
<td>$390</td>
<td>$509</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>$515</strong></td>
<td><strong>$679</strong></td>
</tr>
</tbody>
</table>

* Baselines & goals may change due to new data
Health System Transformation Critical Path

- **Fee for Service 1.0**
  - Volume-based
  - Poorly coordinated
  - No quality & cost transparency
  - Unsustainable healthcare costs
  - Limited data infrastructure
  - Persistent health disparities
  - Uninformed consumers

- **State Innovation Model Test Grant**
  - “As is”

- **Accountable Care 2.0**
  - Accountable for patient population
  - Rewards
    - Better health outcomes
    - Preventive care processes
    - Lower cost of healthcare
  - Competition on healthcare outcomes, experience & cost
  - Coordination of care across medical neighborhood
  - Community integration to address social-demographic factors that affect outcomes

- **Health Enhancement Communities 3.0**
  - Accountable for entire community population
  - Rewards
    - Prevention outcomes
    - Lower cost of healthcare & health
  - Cooperation to reduce risk and improve health
  - Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities
  - Community initiatives to address social-demographic factors that affect health

- **2015-2019**
  - Test Grant

- **“To Be” 2019+**
  - Health Enhancement Communities
  - 3.0
Questions
7. Core Standards

The three core interventions focus on populations who have demonstrated health needs that align with SIM goals, align with CT population health goals, and that provide both evidence-based standards for improvement with flexibility in implementation. Their objectives are as follows:

<table>
<thead>
<tr>
<th>INDIVIDUALS WITH COMPLEX HEALTH NEEDS</th>
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<tbody>
<tr>
<td>• Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual’s overall health status</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>INDIVIDUALS EXPERIENCING HEALTH EQUITY GAPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this program is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>INDIVIDUALS WITH UNMET BEHAVIORAL HEALTH NEEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intended to improve the ability of primary care practices to identify and treat behavioral health needs within the primary care setting, to ensure referral and linkage for those who require behavioral health specialty care, and follow-up</td>
</tr>
</tbody>
</table>
Design Programs: Complex Individuals

Complex Patient Intervention Objective
Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual’s overall health status.

Intervention Highlights

- Complex individuals will be identified through risk stratification that considers clinical, behavioral, and social risk factors.

- Individuals with complex needs will be connected to a Comprehensive Care Team (CCT) to receive more intensive care management support.

- The CCT will include a Community Health Worker to provide community focused care coordination with social services and to provide culturally and linguistically aligned self-care management education. Additionally, there will be a case manager, a clinically focused care coordinator, and a CCT manager.

- The CCT will also have access to a licensed behavioral health specialist to address behavioral health needs of complex individuals.
Intervention Highlights

- The network will conduct a **root cause analysis** among their complex patient population to identify and implement additional interventions to the CCT and/or additional CCT team members that may be beneficial.

- The CCT will perform a **person-centered needs assessment** that will inform a **person-centered care coordination plan** to support the individual to reach his/her clinical, social, and behavioral treatment goals. This plan will be incorporated into the primary care plan and coordinated through the primary care providers and expanded community care team.

- The individual will be **transitioned to self-directed care management** when the CCT and individual feels ready.

- There will be processes in place to **monitor transitioned patients** for the need to reconnect post-transition.
**Equity Gap Intervention Objective**
Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this program is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care.

**Intervention Highlights**

- The CCIP equity gap program will include two elements – 1) standards on how to do **health equity continuous quality improvement**; and 2) standards for an **intervention to address identified equity gaps**

- The **continuous quality improvement** standards provide guidance on how to routinely capture and analyze data to **identify health care disparities at a population level**

- The intervention standards provide guidance on how to **standardize certain care processes to make them more culturally and linguistically appropriate** and offering the **support of a Community Health Worker to those who will benefit** from more culturally supportive care
Intervention Highlights

• The CHW will be trained to offer culturally and linguistically appropriate education specific to the patient’s clinical area of need (e.g.; diabetes) and on better self-care management skills.

• The CHW will collaborate with the patient to develop a person-centered self-care management plan that reflects the patients cultural needs, personal preferences, values, strengths and readiness to change.

• The networks will monitor the equity gap intervention for effectiveness through monitoring quality and patient experience metric.
Behavioral Health Integration Intervention Objective
The Behavioral Health Integration standards are intended to improve the ability of primary care practices to identify and treat behavioral health needs either within the primary care setting or to make, confirm, and close the communication loop on a referral when necessary.

Intervention Highlights

- The networks will incorporate the use of a screening tool to screen all patients for mental health, substance abuse, and trauma needs.

- When a behavioral health need is identified, the primary care providers will determine in collaboration with the patient if they want/can be treated in the primary care setting or would prefer/need a referral.

- Networks will develop an MOU with at least one behavioral health provider to support the facilitation and accountability for the referral process.

- Processes and protocols will be developed in partnership with behavioral health providers to facilitate referral tracking, follow up, and ensuring that the behavioral health care plan is shared with primary care when a referral is made.

- Provision of appropriate behavioral health training on promotion, detection, diagnosis, and referral for treatment for primary care practice.
Appendix: Elective Intervention Standards
The elective standards represent best practices in areas that complement the core standards, but that are not limited to patients within the focus populations of CCIP. The objectives of each intervention are as follows:

<table>
<thead>
<tr>
<th><strong>Comprehensive Medication Management</strong></th>
<th><strong>Electronic Consults</strong></th>
<th><strong>Oral Health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intended to assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.</td>
<td>• Intended to improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.</td>
<td>• Improve dental and overall health for all populations by providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual’s oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.</td>
</tr>
</tbody>
</table>
Oral Health Integration Intervention Objective

Improve dental and overall health for all populations through providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual’s oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Intervention Highlights

- The networks standardize care processes to **routinely do an oral health screening and exam**
- The appropriate primary care providers are trained to **provide preventive care** within the primary care setting
- The practice will develop resources and processes/protocols **to make, manage, and close out dental referrals** with a **preferred dental network** for individuals who do not have a regular source of dental care
- The network and the preferred dental network establish **technology to support communication** of the relevant care information between primary care and dental providers
E-consults Intervention Objectives:
Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Intervention Highlights

- The networks will **elect one specialty area to do e-consults** – common areas already in practice in Connecticut include cardiology and dermatology

- **A specialist practice/providers will be identified** either within or outside the network, depending on the Advanced Network/FQHCs physician make up, with which to **establish e-consult protocols**

- The designated specialists reviewing e-consults will determine 1) if **a face to face is needed**; 2) if **more information on the patient is needed** before a determination about a face to face consult can be made; or, 3) A **face to face consult is not needed** and a **consult note is provided** from the specialist to the primary care provider on how to care for the patient in the primary care setting

- The networks will have to establish a **reimbursement mechanism** for e-consults
Design Programs: Comprehensive Medication Management

**Medication Therapy Management Objective**
CMM is a system-level, person-centered process of care provided by pharmacists to optimize the complete drug therapy regimen for a patient’s given medical and socio-economic condition. This intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. This intervention is designed assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.

**Intervention Highlights**

- The networks develop processes to **assess the risk of a patient’s pharmacy regimen**.
- The networks **design a pharmacist integration model** that aligns with their needs and capacity
- The pharmacist **integrates with the care team** and provides CMM services
- The **medication action plan is person-centered** and addresses medical issues such as appropriateness, efficacy, and safety as well as socio-economic issues such as affordability, cultural traditions and lifestyle
- CMM is a fluid process that **includes follow-up and subsequent touch points** with the patient
- The medication **action plans becomes part of the primary care plan** and becomes part of the care conferences regarding patient progress
Establish consensus protocols to better standardize the linkage to and provision of socio-economic services related to the health needs of patients and care transition coordination among community participants. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next stage of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionally in need of better coordination with community resources.
Shared Governance Objective

Development of Advanced Network and FQHC linkages to community resources is a key component of the CCIP. Because many of the needed community resource providers are resource, capacity, and geographically constrained the PTTF is recommending convening community stakeholders to establish local Community Health Collaboratives to better integrate social services. The structure will be developed by the technical assistance vendor in the service areas where there are Advanced Networks and/or FQHCs participating in CCIP with the involvement of the CCIP participants and other key healthcare stakeholders to be transitioned to local oversight. Efforts are already underway to coordinate these activities with DPH and other public health efforts.

Intervention Highlights

• The **Community Health Collaboratives** will be the primary vehicle of community consensus.

• To establish the Community Health Collaboratives the technical assistance vendor will convene healthcare stakeholders from **across the healthcare continuum** and **relevant community stakeholders**.

• The stakeholders convened will be representative of the community being served and has to include **consumer representation**.

• The community collaborative will be responsible for establishing protocols and processes for **network linkages to shared resources in the community** and can serve as a resource for determining additional community needs (e.g.; transitions from hospitals to home).

• **Prioritization of the linkages** established will be informed by an **assessment of the communities needs and resources conducted by the community collaborative**.