CT State Innovation Model (SIM)

Health Care Cabinet Update

August 13, 2013

SIM Model Design Concerns for Cabinet

- How are the results obtained to date being incorporated—how are they being used to inform design?
- What should planning regarding the long term process focus on?
- What does the Cabinet see as critical criteria to make the long term process vital and an integral part of a continuous Quality improvement effort?

SIM Model Design Update: Multiple groups involved in the examination of key sets of questions:

- State Health Innovation Plan (SHIP) Steering Committee
- Care Delivery Workgroup
- Payment Model Workgroup
- Health Information Technology (HIT) Workgroup
- State Program Planners
- Workforce Taskforce
- Metrics Taskforce
- Population and Public Health Taskforce
- Policy Taskforce
- Health Equity Taskforce

A Population Health Model for Connecticut

Connecticut's population health medical home model enables it to target multiple **opportunities to remove waste and improve sub-par care in the current system.**

We will prioritize patient engagement and experience with appropriate provider types and care settings, effective diagnosis and treatment selection, and care coordination/chronic disease management to achieve cost, quality and health equity impact.

Connecticut's model will **overcome barriers** which arise at multiple stages of a consumer's health

- Lack of **whole person-centered care** and population health management
- **Restricted access** to appropriate care
- **No team-based** coordinated comprehensive **approach** to care
- **Limited consumer engagement & lack of consumer satisfaction**
- **Insufficient use** of **evidence-informed** clinical decision making
- **Inadequate performance management**

What interventions and changes in behaviors/ processes, and structures are required?

Connecticut's **state-wide population-health model** directly addresses barriers to high quality, high value care. The **medical home approach,** in which a primary care provider helps coordinate the entirety of a person's care, sits at the **cornerstone of the model**. This model will overcome barriers to access and **achieve high quality, low cost care.** The population-health model has six key components:

- Whole person centered care and population health management
- Enhanced access to care (structural and cultural)
- Team-based, coordinated, comprehensive care
- Consumer engagement
- Evidence-informed clinical decision making
- Performance management

Overview: There are 5 predominant opportunities to engage consumers and the community in the SIM process

		Description
Syndication/ pre-testing	**1 Gather feedback and input into first draft of SHIP**	▪ Share first draft of SHIP and solicit input
	2 Generate awareness and excitement	▪ Share vision for change and describe model at a high-level ▪ Create awareness across stakeholder groups of how the model will impact them
	3 Prepare for implementation	▪ Small working groups to further refine and provide feedback on model for implementation
Testing	**4 Provide in-depth education on how to participate in new model**	▪ Share details of model design for providers/ payers to determine if and how they can enroll ▪ Inform community entities on the roles they can play in the new model
	5 Involve the community in care delivery and continuous improvement	▪ Empower consumers to join their own care team and manage their own health ▪ Solicit input from consumers and the broader community on effectiveness of the model and how to continuously improve

Connecticut can leverage relationships from stakeholder engagement during the design phase and add as needed to fill gaps

XXX New group for syndication

Groups for syndication

Patients/ consumers/ families

HUSKY
- HUSKY Consumer Advisory Board
- Christian Community Action Meeting

SENIORS
- Shelton AARP Focus Group
- AARP Advocacy Leadership Council Meeting

FAITH-BASED
- Congregations Organizing for a New CT
- Interfaith Fellowship

MENTAL HEALTH
- Mental Health Advisory Boards
- CT Association of Addiction and Recovery
- Advocacy Unlimited

OTHER
- Family Advisory Board Meeting for DCF Region 3
- United Community & Family Services (UCFS) Board Meeting
- Consumer advocates
- Consumer focus groups (2 uninsured, 2 insured)
- St. Francis Patient Architects
- The Witness Project
- UCHF outreach via SurveyMonkey

Clinicians

MEDICAL SOCIETIES
- AAFP
- CSMS
- CAFP

OTHER
- Additional engagement via hospital organizations

Hospitals/ facilities/ AMC

BEHAVIORAL HEALTH
- Behavioral Health CEOs (via CT Association of Nonprofits)

HOSPITALS
- CT Hospital Association

AMCs
- UCHC
- Yale

OTHER PROVIDERS
- Generations board
- CHCACT
- Central AHEC
- St. Francis Center for Health Equity
- Long-term support and services/ centers for aging

Community/ state/ local entities

MOTHERS' SERVICES
- Mothers lunch and learn (CHNCT)

OTHER
- CT Association of Nonprofits
- UHCF
- CT Health Foundation
- CT Health Foundations Health Equity Leadership Fellows
- Health Equity Data Collaborative
- Access Health CT board
- Legislative leaders
- Tribal organizations
- Local agencies
- Local/ municipal/ community leaders

Employers

Business Groups on Health
- BGH Council Meeting
- BGH Wellness Committee
- BGH Regional Seminar
- Eastern Connecticut Business Group on Health

LARGE EMPLOYERS
- Pitney Bowes

OTHER
- Employer focus group

Payers

Medicaid
Anthem
United
Aetna
Cigna

Multiple

MULTIPLE
- Medical Assistance Program Oversight Council
- CT Multicultural Health Partnership
- Public meetings

Community engagements generated insights on patient needs and potential solutions (1 of 2)

1 **Consumers report a range of issues regarding access to care, driven by payer coverage and limited provider availability**

- Consumers can lose coverage without fully understanding why[1]
- Even for those with coverage, benefits can change without notice to consumers[1]
- Plans often have limited coverage for vision, hearing, oral health, and behavioral health[2]
- State coverage decreases the network of physicians available to patients and makes it harder to get timely appointments[1]
- There is often limited access to specialists due to network constraints[1,4]
- Beyond insurance coverage, providers are often unwilling to take up complex cases, making it harder for those in the most need to access care[1]
- Providers lack weekend and nighttime hours which makes it difficult to coordinate around work, which makes ED usage more likely[3,4]
- There are often long wait times to see doctors and multiple patients scheduled at once[4]

2 **Even when consumers are able to access care, they share concerns that providers do not respect them nor have the time and ability needed to understand them as a whole-person**

- For some, the experience of seeing the provider feels rushed. Consumers fear that doctors don’t truly listen, especially when they are too focused on entering data into a computer[4]
- Consumers often feel blamed for side effects or other complex issues[1]
- Medicaid consumers feel stigmatized by providers and seen as just a “state client”[1,4]
- Consumers fear that providers are too quick to prescribe instead of thinking through the full background of a patient[4]
- Some consumers have had health problems persist due to the lack of a whole-person assessment[4]
- Patients feel as though the whole experience could be made more inviting, including the office environment[3]

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2 AARP Focus Group
3 CT Business Group on Health
4 Health Kitchen Cabinet

Community engagements generated insights on patient needs and potential solutions (2 of 2)

3 **Consumers want to be engaged in promoting their health, but lack the education and communication tools to participate today**

- Consumers lack transparency in costs[4]
- Without being told how to manage care, patients with chronic illness can often get worse because they do not know environmental triggers[4]
- Patients often feel limited in their ability to manage care when providers use big words and do not attempt to help them understand their conditions[1,3]
- Family members want to help but materials are often not in accessible language[1]
- Consumers are often unsure of how costs work[2]
- Employers want to help with engagement but often lack the materials to do so.[3]
- Lifestyle management services dealing with obesity and stress may be very helpful[3]
- Education in patients' rights, treatment decisions, and self-advocacy would also enable engaged consumers[1,4]
- Waiting room could be an effective site of patient care education[4]
- Community forums to attain health information, especially ones in which providers know about and can recommend, would prevent ED visits and enable self-management[1]
- Access to various forms of clinician-consumer communication channels would help consumers prevent problems before they occur[1]

4 **Consumers can feel the impact of today's fragmented care system on their health care experience and on the quality of care they receive**

- Many have experienced duplicative testing when there is a lack of communication between specialists and primary care providers[2,3]
- The lack of central records makes it difficult when individuals are sick yet away from their hometown[3]
- Consumers benefit from having a single point of contact to help them navigate the system[1]
- For those with very particular health needs (e.g., diabetes), it's important that the care coordinator understands the unique challenges they face[1]

5 **While consumers are interested in greater sharing of data across providers and with consumers, there exist concerns around data security**

- Some patients feel as though data sharing is a violation of their privacy[1,4]
- While digital communication may be helpful, there are also concerns over email security[2]

6 **Any care delivery/payment reform must not increase likelihood of denials of necessary care**

- Implementing total cost of care accountability must have provisions to address the implication that providers may have an incentive to deny care to consumers and may no longer act as champions for consumers[5]
- Special attention must be given to Medicaid consumers who are already at risk underutilization of care and are less able to advocate for themselves given language barriers[5]

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5 Consumer advocate input

Taskforces will focus on questions to further prepare for implementation

Taskforce	Mandate
Metrics taskforce[1]	▪ For what metrics will providers be accountable in years 1-5? ▪ What will be the practice standards for providers to be recognized under Connecticut's accreditation model and how will they be phased?
Workforce taskforce	▪ How can CT prepare its workforce for a new care delivery model?
Population and public health taskforce	▪ How do ongoing population and public health initiatives support the CT SIM effort? ▪ How will the certifying entity be implemented?
Policy taskforce	▪ What regulatory and policy changes ought to be made in order to achieve comprehensive transformation in Connecticut?
Health equity taskforce	▪ How can the care delivery model be implemented to improve health equity, e.g., changes to workforce training, practice protocols?

[1] Includes definition of practice standards

Connecticut’s metric scorecard will be further developed before testing grant submission and during the testing phase

Payment work group

- **Mandate**: Form recommendation for how metrics will be used to measure performance and develop frameworks to support the proposed care delivery model
- **Recommendations** include:
  - Types of metrics to include, mapped to the Triple Aim: health risk factors, consumer experience, quality, and utilization measures (among others)
  - Metric selection methodology: CMMI core measures plus Connecticut specific additions mapped to prioritized care delivery model interventions
  - How providers will be held accountable to metrics: payment in the P4P track is contingent on quality alone in year 1, and contingent on both quality and efficiency in subsequent years
  - How metrics can be used to track performance: as conditions for participation (practice standards), basis for qualifying for payouts, basis for estimating savings, basis for risk-adjustment, and for informational or reporting purposes

Metrics task force

- **Mandate**: Build on payment model work group recommendations to define v1.0 metric scorecard
- Taskforce will be responsible for:
  - Assessing availability of metrics from CMMI core measures and payment work group additions that are currently being tracked in Connecticut
  - Designing Connecticut-specific additions to the metric scorecard, including what will be measured and how it will be measured
  - Feasibility of tracking these metrics, and the required structures to do so
  - Determination of the specific metrics that will be included in the scorecard, including the implied balance of metrics in year 1 and over time

**The metrics task force may continue into the testing phase to continue to update and refine metrics*

Appendix

CT SIM: Deliverable 1.2 Stakeholder engagement plan

Key activities and sources of insight

Structure and framing outlined	▪ Outlined how stakeholder engagement could be phased over project time period ▪ Defined two methodologies to engage stakeholders: – Broad consumer, clinician, and community engagement efforts – Involvement of key stakeholders in workgroup meetings, the state agency program planner process, and the workforce taskforce
Work groups & stakeholder outreach events completed	▪ **Care Delivery, Payment,** and **HIT:** Developed materials for and supported the facilitation of three multi-stakeholder work groups over the course of several months of grant design ▪ **Health Care Cabinet**: Developed materials for presentation to the Governor's Health Care Cabinet on the SIM effort ▪ **Other stakeholder outreach events:** Coordinated and developed materials for community-based focus groups and presentations
In-state one-on-ones completed	▪ Conducted interviews on outreach strategies with Universal Healthcare Foundation CT, CHNCT, Health Justice CT, CIPC, CT Health Foundation, CAN, CHCACT; interviews covered strategies for engagement that have worked in the past and potential engagement opportunities in the future
Primary and secondary data analyzed	▪ Synthesized takeaways relevant to SIM from prior stakeholder engagement efforts ▪ Reviewed 6 peer state testing grants and examples of large-scale stakeholder engagement efforts to identify best practices in stakeholder engagement

Overview: Objectives for engaging stakeholders, by phase

🟦 Detailed in following pages

Sept ▼ Nov ▼

Initial design

- **Identify barriers to optimal health and health outcomes in Connecticut** today
- Gather **patient stories**
- Brainstorm **potential care delivery interventions** to address those issues
- **Develop a draft state healthcare innovation plan,** with input from focus groups, work groups, community outreach forums and e-forums
- Gather stakeholder input on metric scorecard through **metric taskforce**

Syndication/ finalization

- Share state health care innovation plan with diverse group of stakeholders **to understand how it can be refined** (e.g., public meetings)

Continuous improvement in stake-holder engagement

- Gather input into **a testing grant application to CMMI,** putting forth a model that takes into account feedback from stakeholder outreaches
- Continue to maintain **excitement and momentum** for the CT SIM effort
- Prepare for **long-term stakeholder engagement**

Overview: Components of stakeholder engagement plan

These pages focus on stakeholder engagement during the design phase. Continued stakeholder engagement during the testing phase is discussed in deliverable 6.1: Community outreach, education, and engagement

- There are three different ways to solicit stakeholder input in the CT SIM design phase
  1. Broad consumer, clinician, and community engagement efforts
  2. Involvement of key stakeholders in workgroup meetings, the state agency program planner process, and the UCHC/ DPH workforce taskforce
  3. Synthesis of prior stakeholder engagements relevant to the SIM effort
- The following pages outline for each of these types of engagements
  - **Who**: The groups of stakeholders to engage
  - **How**: The forums through which stakeholder input is being solicited
  - **What**: The type of input to solicit from each stakeholder group

Overview: Description of stakeholder engagement activities

Strategies	Description	Timing
1 **Broad consumer, clinician, and community engagement efforts**	**Pre-existing forums.** Regularly convening groups of consumers, providers, and employers who can provide insight on barriers and propose solutions	Attended in June, continuing into July and onward
	Focus groups. Organized sessions with consumer to explain and get feedback on issues/ barriers to address	Hold in July
	E-forums. Email and e-survey for individuals to submit feedback and input into SIM vision and model design	July/ August
2 **Involvement in steering committee and work groups/ task forces**	**Work groups.** Committees of diverse stakeholders focusing on care delivery, payment, and HIT	Ongoing meetings
	SHIP. Steering committee guiding the SIM process and sharing insight into content	Ongoing with possible extension into Oct.
	Program planners. Planners integrating CT SIM and state agency efforts	Weekly meetings
	Workforce taskforce. DPH/ UCHC led initiative to examine workforce requirements and strategies	Ongoing
3 **Synthesis of past stake-holder outreach**	Examination of pre-existing consumer and provider feedback on the healthcare system	Ongoing review

Overview: Stakeholder engagement is a transparent and ongoing process with a unique focus on consumers

From the beginning this has been a fully transparent and open process

- Meetings have been announced publicly on website and all minutes and documents are publicly posted
- Anyone in the state is invited to attend and participate actively – this has been announced on CT-N and on the website

We have multiple forums for input and design advice, including several targeted specifically at consumers

- HCC, CAB, 1:1 outreach to consumer groups, e.g., HUSKY consumer advisory board, AARP Shelton focus group, Mothers Lunch and Learn, Christian Community Action Meeting, consumer boards of several health centers, regional mental health boards
- Working groups and SHIP with select formal consumer appointees, and open meetings to allow active participation from any individuals/ groups who were interested (we have had participation from several folks who are not direct appointees to work groups but have chosen to attend)
- Email address and transparent contact information for those who were unable to physically attend meetings

We are only halfway through the process – there remain several months of continued work group discussions as well as solicitation of feedback and input to a hypothesis on the model

- Work groups will continue to convene over the next few months on an as-needed basis
- There are multiple active opportunities to continue to give input for range of folks who have chosen not to attend forums to date: AARP Advocacy Leadership Meeting on September 9, Business Group on Health Regional Seminar on September 27, broader outreach with the Connecticut Association of Nonprofits, in addition to focus groups, meetings with specific organizations, public meetings, e-forums and the metrics task force

Components of stakeholder engagement plan

1. **Broad consumer, clinician, and community engagement efforts**
2. Involvement in steering committee, work groups, and task forces
3. Synthesis of prior stakeholder engagements

WHO

1 Our process recognizes different stakeholder perspectives

		Example perspectives about health transformation
	**Patients/ consumers/ consumer advocates**	▪ How will this change consumers' experience? ▪ How will consumers really know if my care is better?
	**Families**	▪ How will this affect the delivery of care for my family member? ▪ How can I participate in this model to support my family member?
	**Clinicians and healthcare givers**	▪ How can I manage administrative burden? ▪ Will I be able to maintain my income level?
	**Hospitals/ facilities/ nonprofits**	▪ How will any changes affect my revenue and cost position relative to alternatives?
	**Community/ state/ nonprofit entities**	▪ How will this effort affect my clients? ▪ How will this effort impact my agency's goals? ▪ How can I participate in this model?
	**Employers**	▪ How will this affect my employees and my ability to afford health insurance for them? ▪ How can I support employee wellness?
	**Payers**	▪ How can we manage medical expenditures and focus more on value? ▪ Will I want to shift to this new payment model?

① Stakeholder engagement seeks to include consumers from diverse backgrounds

Age	Status of illness	Location	Disability	Payer	Cultures
Elderly	Complex chronic	Urban	Disabled	Medicare	Linguistic
Adults	Early-stage chronic	Rural	Nondisabled	Medicaid	Ethnic
Children (parents as advocates)/ teenagers	At risk	Suburban		Commercial	
Pregnant mothers	Healthy				
	Family member of patient				

1 Stakeholder engagement seeks to include clinicians from diverse backgrounds

Provider type	Affiliation	Location	Specialty
▪ MD	▪ Hospital	▪ Urban	▪ Primary care
▪ RN	▪ Multi-provider	▪ Rural	▪ Specialists
▪ PA	▪ Individual	▪ Suburban	▪ Behavioral Health
▪ PhD			
▪ Licensed Medical/ Clinical Social Worker (LMSW/LCSW)			
▪ DDS/DMD			
▪ Other healthcare givers (e.g., CHW)			

HOW

① Our broad consumer, clinician, and community engagement efforts take the form of 3 main strategies during the design phase

	Description	Timing
Pre-existing forums	Regularly convening groups of consumers, providers, and employers who can provide insight on barriers to optimal health and health care and propose solutions	Attended in June, continuing into July and onward
Focus groups	Organized sessions with consumers, employers, and providers to understand what challenges in today's health care delivery model exist today and how they can be addressed	July/ August
E-forums	Opportunities for individuals to submit input on key barriers/ issues and to share patient stories over email and in an e-survey	August

HOW

1 We are meeting with diverse stakeholder groups in focus groups and other forums (1/2)

Stakeholder groups	Event	Date
Multiple	CT Behavioral Heath Partnership Oversight Council	6/12 (Completed)
	Medical Assistance Program Oversight Council meeting	6/14 (Completed)
	CT Multicultural Health Partnership event	6/20 (Completed)
	Health Equity Data Collaborative	*TBD*
	CT Association of Non-Profits	July 30
	Access Health CT Board	Ongoing
Nonprofits/community entities	BH CEO Meeting (CT Association of Nonprofits)	6/26 (Completed)
	Eastern CT FQHC Board meeting	In progress
	Mothers lunch and learn (CHNCT)	7/11 (Completed)
	Connecticut Hospital Association meeting	7/23 (Completed)
	United Community & Family Services Board Meeting	7/25 (Completed)
	Generations	TBD
	CHCACT	*TBD*
	Central AHEC	8/6
	St. Francis Center for Health Equity	*TBD*
	CT Health Foundation	*TBD*
	UHCF	7/25 (Completed)
	CT Health Foundation Health Equity Leadership Fellows	*TBD*

1 We are meeting with diverse stakeholder groups in focus groups and other forums (2/2)

Stakeholder groups		Event	Date
Patients/ consu-mers/ families	**HUSKY consumers**	▪ HUSKY consumer advisory board meeting (CHNCT) ▪ CCA Health Kitchen Cabinet	▪ 7/09 (Completed) ▪ 7/17 (Completed)
	Families	▪ Family Advisory Board Meeting for DCF Region 3	▪ 7/13 (Completed)
	Faith-based groups	▪ Congregations Organizing for a New CT ▪ Interfaith Fellowship	▪ *TBD* ▪ *TBD*
	Seniors	▪ Shelton AARP Focus Group ▪ AARP Advocacy Leadership Council meeting	▪ 7/17 (Completed) ▪ 9/09
	Mental Health Consumers	▪ Advocacy Unlimited ▪ Connecticut Community for Addiction and Recovery ▪ DMHAS Mental Health Boards	▪ *TBD* ▪ *TBD* ▪ *TBD*
Employers		▪ CT Business Group on Health Council Meeting ▪ CT Business Group on Health Wellness Committee ▪ CT Business Group on Health Regional Seminar ▪ OSC Health Care Cost Containment Committee meetings	▪ 6/07, 6/28 (Completed) ▪ 7/16 (Completed) ▪ 9/27 ▪ Ongoing

WHAT

1 A set of key questions is being posed to stakeholder groups to better understand their health care experiences

Patients/ consumers

- What are the biggest problems you've had with the way healthcare is given today?
- How would you like your doctors to work with you?
- Who do you talk to for help on health-related issues?
- What role do you think you or your family can play in taking care of your health?
- *[Follow-up to prior question]* What help do you or your family need for you to be able to take better care of your health?
- What are the things you like about the health care you get today?

Clinicians/ health care providers/ hospitals/ nonprofit service providers

- What best practices have you practiced or observed that you think should be practiced more broadly by clinicians in Connecticut?
- What do you believe are the biggest obstacles to delivering high-quality, high-value care today?
- What support or tools do clinicians need to be able to address those obstacles?
- How do you think consumers, families, and the broader community can be best involved to deliver high-quality, high-value care?
- What are your biggest fears about a new care delivery and payment model being implemented in Connecticut?
- What types of support do you think will be most helpful to clinicians who want to transition into a population-health based, total cost of care model?
- What kinds of training/educational opportunities should be available to help you in the transition to a new model of care?

Community/ state agencies/ nonprofit entities

- What are the biggest health-related challenges your clients face today?
- What role do you play in delivering health care services and/or providing other support to your clients to address those challenges?
- What have you found to be the most effective ways to help your clients address those challenges?
- What are the greatest difficulties you encounter when trying to help your clients manage their health?
- What have you found to be the most effective strategies when you've run into those difficulties when trying to help your clients?
- What support or tools would you need in order to address your client's health care needs and/or help your clients manage their health more effectively?
- What is the best way for you to communicate and work with clinicians and other nonprofit service providers to achieve the best health outcomes for your clients?

Consumer Advocates

- What do you believe are the biggest obstacles to delivering high-quality, high-value care today?
- How do you think consumers, families, and the broader community can be best involved to deliver high-quality, high-value care?
- What are the biggest health-related challenges your clients face today?
- What role do you play in delivering health care services and/or providing other support to your clients to address those challenges?

WHAT

1 Community engagements generated insights on patient needs and potential solutions (1 of 2)

1 **Consumers report a range of issues regarding access to care, driven by payer coverage and limited provider availability**

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- For some, the experience of seeing the provider feels rushed. Consumers fear that doctors don’t truly listen, especially when they are too focused on entering data into a computer[4]
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- Consumers lack transparency in costs[4]
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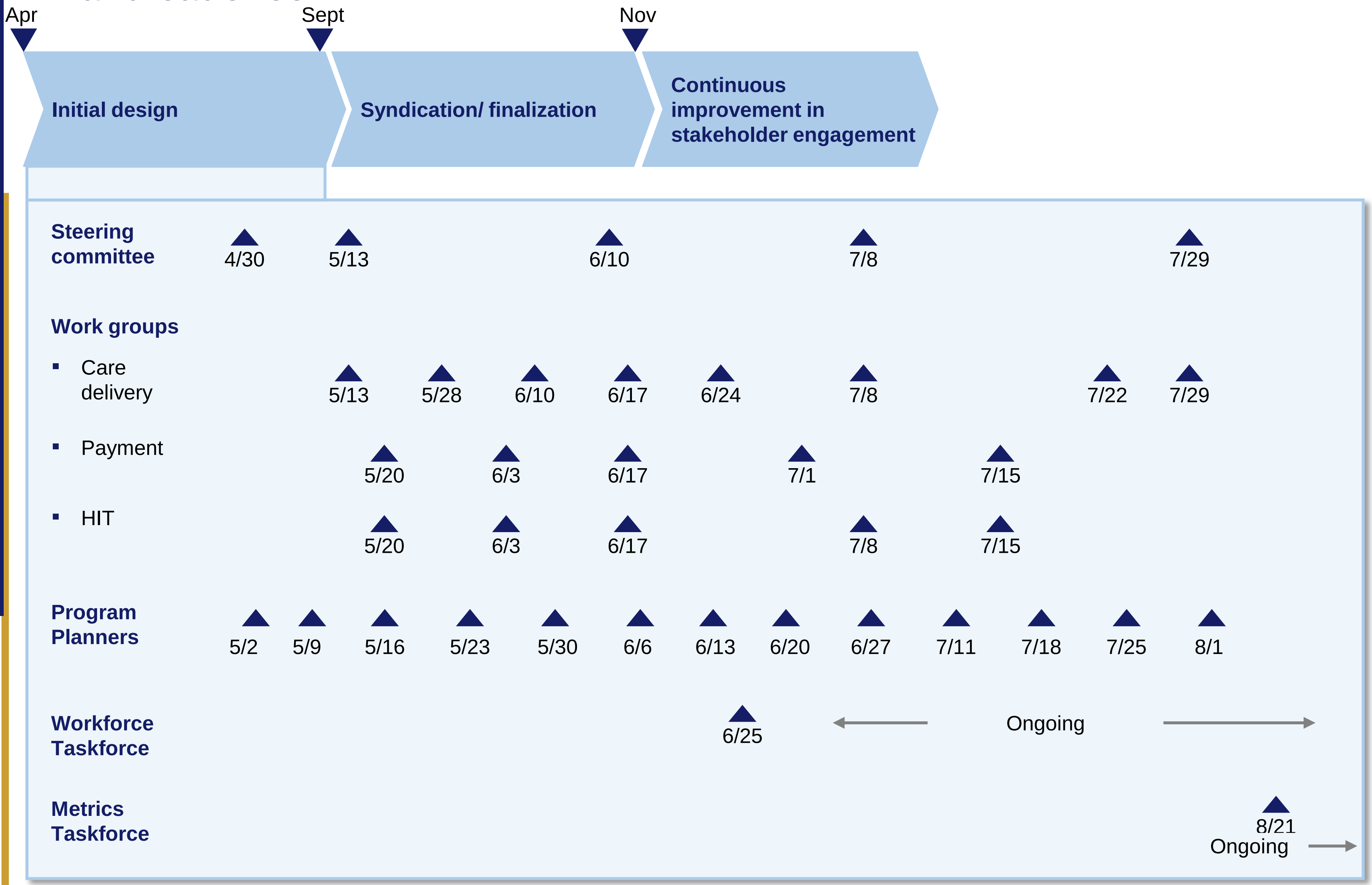
3. Synthesis of prior stakeholder engagements

WHO

2 Stakeholders involved in workgroup and SHIP steering committee

	SHIP	CDWG	PWG	HITWG
Consumers/ patient advocates	▪ Vicki Veltri ▪ Pat Baker ▪ Frances Padilla	▪ Gaye Hyre ▪ Dawn Johnson ▪ Sal Luciano	▪ Vicki Veltri ▪ Jill Zorn	
Providers	▪ Frank Torti	▪ Jeffrey Howe ▪ Edmund Kim ▪ Adam Mayerson ▪ Robert McLean ▪ Lynn Rapsilber ▪ Elsa Stone	▪ Courtland Lewis ▪ Todd Staub ▪ Mike Taylor ▪ Susan Walkama	▪ Alan Kaye ▪ Barry Simon ▪ Jonathan Velez
Hospitals	▪ Tom Raskauskas		▪ William Gedge ▪ Tom Raskauskas ▪ Robert Smanik	
Community organizations/ agencies	▪ Roderick Bremby ▪ Kevin Counihan ▪ Anne Dowling ▪ Anne Foley ▪ Jewel Mullen ▪ Patricia Rehmer ▪ Fredricka Wolman	▪ Daren Anderson ▪ Mehul Dalal ▪ Meredith Ferraro ▪ Alice Forrester ▪ Thomas Woodruff ▪ William Young ▪ Robert Zavoski	▪ Paul DiLeo ▪ Kate McEvoy ▪ Lori Pasqualini ▪ Thomas Woodruff ▪ David Guttchen	▪ John DeStefano ▪ Daniel Maloney ▪ Dan Olshansky ▪ Mark Raymond ▪ Mark Root ▪ Minakshi Tikoo ▪ James Wadleigh ▪ Joshua Wojcik
Employers	▪ Mary Bradley	▪ Laurel Pickering	▪ Mary Bradley	
Payors	▪ Raegan Armata ▪ Bernadette Kelleher ▪ Donna O'Shea	▪ Peter Bowers ▪ Donna O'Shea ▪ Rosemary Sullivan	▪ Bernadette Kelleher ▪ Kathy Madden ▪ Melissa Pappas ▪ Joseph Wankerl	▪ Daniel Carmody ▪ Bernadette Kelleher ▪ Mike Miller
Others	▪ Michael Michaud ▪ Bettye Jo Pakulis ▪ Mark Schaefer ▪ Nancy Wyman	▪ Mark Schaefer		▪ Michael Michaud ▪ Victor Villagra

2 Work group, SHIP, program planner, and workforce taskforce meeting and cadence



Apr
Sept
Nov

Initial design
Syndication/ finalization
Continuous improvement in stakeholder engagement

Steering committee: 4/30, 5/13, 6/10, 7/8, 7/29

Work groups

- Care delivery: 5/13, 5/28, 6/10, 6/17, 6/24, 7/8, 7/22, 7/29
- Payment: 5/20, 6/3, 6/17, 7/1, 7/15
- HIT: 5/20, 6/3, 6/17, 7/8, 7/15

Program Planners: 5/2, 5/9, 5/16, 5/23, 5/30, 6/6, 6/13, 6/20, 6/27, 7/11, 7/18, 7/25, 8/1

Workforce Taskforce: 6/25 ← Ongoing →

Metrics Taskforce: 8/21 Ongoing →

2 Groups examined a set of key questions over the course of several meetings (1/2)

	Questions
Care delivery	▪ Who should be the target populations? ▪ What does the group believe are the prioritized opportunities to improve quality and reduce waste? ▪ What barriers need to be overcome? ▪ What interventions and changes in behaviors/ processes and structures will likely be required to capture the prioritized opportunities to improve quality (e.g., incorporate patient perspectives and engage patients in their healthcare)? ▪ What roles should be fulfilled to implement these interventions? ▪ What entities are optimally positioned to fulfill these roles and which will be primary? ▪ What are the likely implications for: – Payment model – Data/ analytics – Workforce – Policy ▪ How should the care delivery model be phased?
Payment	▪ What opportunities does the group think will there be to reduce waste while improving quality? ▪ What metrics (e.g., structure, process, outcome, care experience, cost and resource use) does the group think will be considered preliminarily as a criteria for eligibility for participation and for eligibility for payment (to be refined throughout SIM process)? ▪ What should be the reward structure? ▪ How should we define the level of performance we wish to reward? ▪ What should be the targets for benchmarking performance, bonus payment amounts, and levels of gain/risk sharing? ▪ What should be the rule for attribution? ▪ At what level should performance be aggregated for sound performance measurement and the distribution of rewards? ▪ What exclusions and adjustments should be applied for fairness and consistency and to safeguard against inappropriate denials of care? ▪ What should be the pace of roll-out of the new payment model throughout the state? ▪ How should payers and providers be enabled to adopt the new payment model?

Note: work groups were responsible for developing a set of recommendations on these questions for further evaluation

2 Groups examined a set of key questions over the course of several meetings (2/2)

	Questions
HIT	▪ What HIT capabilities are likely required across key stakeholders? ▪ What current CT HIT capabilities are relevant to this effort? ▪ What does the work group think is the optimal level of infrastructure standardization/consolidation across each component? ▪ What does the work group think is the best strategy to develop the required HIT capabilities? ▪ What should be the pace of roll-out of the required capabilities throughout the state? ▪ What will likely be the required budget and best funding model to develop these capabilities? ▪ How could Connecticut be distinctive?
Program planners	▪ How can current programs be integrated into the SIM design? ▪ What roles can state agencies play in the SIM testing phase?
Workforce	▪ What is the current state of Connecticut's workforce (number and types of relevant roles, skills/behaviors, capacity, structure)? ▪ What changes to the workforce (number and types of relevant roles, skills/behaviors, capacity, structure) are required to support Connecticut's new care delivery model? ▪ What should be the strategy to fill the gap between current and desired future state workforce? ▪ What should be the high-level implementation plan?

Note: work groups were responsible for developing a set of recommendations on these questions for further evaluation

Overview: Components of stakeholder engagement plan

1. Broad consumer, clinician, and community engagement efforts
2. Involvement in steering committee, work groups, and task forces
3. **Synthesis of prior stakeholder engagements**

3 Stakeholder group perspectives represented in synthesis of stakeholder engagements

	Stakeholder group	Date	Methodology
A UConn MME Focus Groups	MMEs, families, caregivers	2012	Focus groups
B DMHAS Multicultural Focus Group	Consumers from a variety of racial, ethnic, linguistic, socioeconomic, and LGBTQ backgrounds	2009	Focus groups
C HealthFirst Connecticut Authority	Consumers, payers, providers, agencies, community organizations	2009	Multi-stakeholder work groups; 9 public forums
D Access Health CT Research	Uninsured consumers, employers	2012	Focus groups
E Duals Demonstration Public Comments	Community organizations, state agencies, consumer advocates	2012	Letters of support, public commentary
F Evaluation of HIE initiative consumer surveys	General consumer population	2013	Survey
G OHA behavioral health hearings	Mental health consumers, providers, facilities, and social service organizations	2012	Testimonies
H PRI Testimonies	Consumers, providers, researchers	2013 (Phase 2)	Interviews

3 Overview of insights from prior stakeholder engagements

	Insights
A UConn MME Focus Groups	▪ Care coordination is limited today by an absence of centralized records ▪ Consumers are concerned about the potential disruption to existing relationships with trusted physicians if they were to transition into a medical home model ▪ Consumers and families express need for education (e.g., training on medication so they can improve adherence, explanation of health care coverage)
B DMHAS Multicultural Focus Group	▪ Providers lack understanding of and concern for consumers' backgrounds ▪ Consumers feel that there is discrimination and a lack of respect from their providers ▪ If consumers were to receive education and support, they would prefer it to be delivered by someone from a similar background; peer-based support and services could be one solution
C HealthFirst Connecticut Authority	▪ Consumers are challenged by the difficulty of accessing primary care providers and specialists ▪ The insured can still face high healthcare costs due to gaps in coverage and high premiums ▪ Consumers face a lack of care coordination which leads to more complications and worse outcomes
D Access Health CT Research	▪ Uninsured consumers health care coverage should be expanded to them, but fear that attempts at expanding access to them will only provide low-quality care ▪ Employers want to see their employees insured but fear the additional costs of providing employees coverage
E Duals Demonstration Public Comments	▪ Various advocacy groups see enhancing care coordination as key to improving patient experience and outcomes ▪ At the same time, these groups fear payment reforms that may reduce care for most vulnerable, employ an opt-out option instead of an opt-in, and focus on costs instead of patient quality and outcomes
F Evaluation of HIE initiative consumer surveys	▪ The level of awareness of HIT technologies greatly differs across the population ▪ Consumers believe that more information on how the technologies work and greater privacy precautions could help increase acceptance of the technology
G OHA behavioral health hearings	▪ Consumers face difficulties getting coverage for mental health services and retaining coverage over time ▪ Insurers and third party administrators, including Medicaid, sometimes deny medically necessary procedures due to arbitrary treatment classifications
H PRI Testimonies	▪ Lack of consistent focus on improving access to substance abuse treatment for people outside the state service system ▪ Lack of understanding, training and effective community resources for substance abuse in youth leads to limited screenings, sub-optimal locators, long-wait times and services that are not age-appropriate

A UConn MME Focus Groups: Barriers to be addressed

	Barriers shared by individuals in group	Solutions proposed by group
Enhanced access to care (structural and cultural)	▪ Duals find it difficult to find providers since many do not accept Medicare/Medicaid ▪ Even when PCPs accept Medicare/Medicaid, there is often limited appointment availability ▪ Consumers feel they have limited oral health care coverage ▪ Consumers feel providers often do not understand the needs of those with development disabilities or severe and persistent mental illness ▪ Consumers feel discrimination from pharmacists and health care providers due to their conditions ▪ DDs fear that a health home model will assign them doctors, causing them to lose doctors they currently use and trust	▪ Consumers would benefit from more frequent trips to PCPs to address medical concerns as they arise instead of relying on ED visits ▪ Emphasize continuity of care with same provider ▪ More providers should accept Medicaid and Medicare patients ▪ There should be a shorter wait for available for appointments
Team-based, coordinated, comprehensive care	▪ Many consumers see multiple providers at once, and providers rarely communicate with one another ▪ The lack of centralized medical history makes seeing multiple providers even more difficult ▪ For DDs, there was difficulty transitioning from pediatric to adult care since they need to switch providers ▪ After hospitalization, consumers experience a lack of discharge planning ▪ Consumers often do not understand how to take their medications ▪ Sometimes consumers find themselves rarely seeing their PCP, focusing on care from specialists ▪ Throughout the process, consumers are frustrated by needing to continuously fill out paperwork	▪ Consumers would benefit from additional channels for coordination and communication both between providers themselves and between providers and consumers ▪ Health neighborhoods based around team-oriented care could provide enhanced coordination ▪ Less paperwork for patients and providers
Consumer engagement	▪ Consumers lack information on their medication and side effects ▪ Consumers do not understand or know when there are changes in healthcare coverage ▪ Providers do not take the time to listen to consumers and understand them as a whole person	▪ More available information in order to avoid coverage gaps (e.g., provider information, explanation of benefits)

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B DMHAS Multicultural Focus Group: Barriers to be addressed (1/2)

	Barriers shared by individuals in group	Solutions proposed by group
Whole-person-centered care and population health management	▪ Consumers find it difficult to find sensitive providers with whom they can discuss race, neighborhood, employments, income, sexual relations, drug use, language barriers, LGBTQ issues, and other factors not always considered by providers ▪ Consumers feel that there are times when they are stereotyped, disrespected, or even dismissed by providers	▪ Consumers would benefit from services tailored to their cultural/ social needs ▪ Providers should be encouraged to ask more about a person's life experience ▪ Providers should have the capacity to provide information on jobs, housing, and other services and help coordinate such services for their patients ▪ Use cultural assessments to reduce potential stereotyping
Enhanced access to care (structural and cultural)	▪ Consumers often lack trust in their providers, especially when providers cannot be flexible with the consumer’s needs or fail to show compassion ▪ Limited hours and strict clinic rules can make it difficult for clients to both take their medication and make it to work ▪ Consumers reported instances of racism within provider interactions ▪ For those who prefer speaking in a language other than English, there are often language barriers in communicating with providers ▪ Consumers find it difficult to schedule regular appointments with providers ▪ Administrative burden of paperwork weakens provider effectiveness	▪ Encouraging providers to connect with the community ▪ Building more partnerships with community organizations ▪ Services in community centers ▪ Language assistance ▪ More flexible hours ▪ Inclusion of culturally-diverse artwork in offices ▪ Increase provider training (e.g., cultural competence)

B DMHAS Multicultural Focus Group: Barriers to be addressed (2/2)

	Barriers shared by individuals in group	Solutions proposed by group
Team-based, coordinated, comprehensive care	▪ Consumers discussed disappointments with not being linked to more follow-up services and supports following detox	▪ Increased service user education and training post-visit (e.g., job training, recovery education, services to rebuild one's life after jail or treatment)
Consumer engagement	▪ Some consumers do not know that information about their home life should be discussed to ensure that the provider can understand the consumer as a whole person ▪ Consumers often feel as though providers do not listen when concerns are brought up, and that they must be very persistent and emotional to have their concerns heard	▪ Consumers would benefit from peer support services, in which peers mentor the consumer through the care process ▪ Education events in the community could help consumers have more information about healthcare services ▪ Provider training to better understand how groups express their concerns and to listen effectively and professionally

C CT Health First Authority: Barriers to be addressed

	Barriers shared by individuals in group	Solutions proposed by group
Enhanced access to care (structural and cultural)	▪ The uninsured have difficulty paying for care ▪ Insured individuals still face high out-of-pocket expenses ▪ Underinsurance, in which insurance does not cover significant expenses, affects a significant group of young adults and adults near retirement. ▪ The lack of providers who accept Medicaid consumers makes it harder to find PCPs and specialists ▪ Charter Oak clients face difficulty paying for care due to high cost sharing, annual caps and difficulty accessing care due to a limited network of providers.	▪ Medicaid expansion would provide coverage for the uninsured ▪ The state should expand FQHCs to provide new centers of care ▪ Automatically enroll providers, with an opt-out option, to be participants in public programs ▪ Practices should offer more culturally and linguistically appropriate services
Team-based, coordinated, comprehensive care	▪ Fragmented care leads to worse outcomes, especially for the elderly ▪ Infrastructure to promote provider information sharing (e.g., mailing lists to alert providers of patients not receiving medication) is inaccurate ▪ Poor information sharing during care transitions leads to medical errors	▪ The medical home model could help improve health outcomes ▪ Enhanced HIT can avoid provider errors
Consumer engagement	▪ Consumers are rarely engaged by providers in preventative efforts ▪ To the extent that they are engaged, it is often through remote care protocols and not in person interactions ▪ Lack of consumer education on clinical and population health weakens their ability to take an active role in their care	▪ Public education efforts can encourage consumers to undertake preventative efforts
Evidence-informed clinical decision making	▪ Lack of provider adoption of HIT has led to patient information not being collected electronically, which makes it difficult for providers to take advantage of automated alerts, reminders, and diagnosis/support tools to increase the effectiveness and timeliness of care	▪ Enhanced HIT and HIE adoption would improve clinical effectiveness ▪ Providers should pursue evidence-based prescribing by providing them with enhanced education on medication
Effective Diagnosis and Treatment	▪ Share information during care transitions (all must be transmitted by paper or called in), leading to poor utilization, missed diagnoses, and medical errors	▪ Providers should use branded drugs over generics

D Access Health CT: Barriers to be addressed

	Barriers shared by individuals in group	Solutions proposed by group
Enhanced access to care (structural and cultural)	▪ Uninsured consumers see the healthcare system as unfair, as employment circumstances can dictate coverage ▪ Uninsured consumers fear that new options provided to them will not be affordable ▪ Those without insurance fear that new options will have minimal coverage and poor access since they are given through a state program ▪ Employers want to see their employees covered under plans yet fear taking on additional costs ▪ Minority consumers report experiencing poor healthcare quality when covered under insurance	▪ New healthcare options need to be presented as both affordable and high-quality
Consumer engagement	▪ Uninsured consumers often misunderstand the meanings of key healthcare terms such as “copay” and “network”. ▪ Consumers do not fully understand how the Affordable Care Act works or how it will affect their lives	▪ Consumers need to be educated in how the ACA can help them

E Duals Demonstration Public Comments: Barriers to be addressed (1/2)

	Barriers shared by individuals in group	Solutions proposed by group
Whole-person-centered care and population health management	- Understands that initiative is intending to address current lack of whole-person-centered approach	- Advocacy groups strongly believe in the whole-person approach - Advocacy groups are excited about comprehensive care plans
Enhanced access to care (structural and cultural)	- Duals have difficulty finding providers who accept coverage - CT's innovative programs such as Money Follows the Person can have high barriers that prevent those who would benefit from the programs from accessing them - Cost sharing has prevented MMEs from accessing needed medication due to prohibitively high costs	- Advocacy groups fear that capitation as a solution would harm vulnerable populations, especially due to the limited ability of the vulnerable to advocate against undue cuts - Cutting Medicaid co-pays would enhance access for those who need
Team-based, coordinated, comprehensive care	- For those not in nursing facilities, consumers find it difficult to access integrated care - The comorbidity of duals means that a single provider is often insufficient	- Some advocates preferred the PCMH concept to Health Neighborhoods - A behavioral health co-lead who could oversee care would be helpful for the SPMI population

E Duals Demonstration Public Comments: Barriers to be addressed (2/2)

	Barriers shared by individuals in group	Solutions proposed by group
Consumer engagement	▪ MMEs form a vulnerable population and may not fully understand how reforms will affect them, potentially leading to loss of desired services	▪ Consumers should opt-in instead of opt-out to ensure understanding ▪ An independent ombudsman could help vulnerable individuals ▪ Pharmacists can serve as educators to help MMEs understand medications
Performance management	▪ Advocates remain concerned that total cost of care accountability will lead to denials of care	▪ Share savings only for ER; prevents harms of other shared savings models ▪ Need to reward quality, not only savings

F HIE consumer survey: Barriers to be addressed

	Barriers shared by individuals in group	Solutions proposed by group
Consumer engagement	▪ Consumers are divided in their level of familiarity with HIE, EMR, and personal health records ▪ Consumers are divided in their level of interest in personal health records; those who are uninterested do not understand personal health records or have privacy concerns ▪ Some consumers cannot understand the printed information shared by their providers	▪ Consumers should opt-in to HIT systems to quell privacy concerns ▪ About two thirds of consumers believe that HIT can improve doctor/patient interactions
Evidence-informed clinical decision making	▪ A majority of consumers are very or somewhat interested in sharing information between providers	▪ Almost half of consumers believe that HIT can improve quality of care ▪ Almost half of consumers believe that HIT can decrease unnecessary care

G Behavioral health hearings: Barriers to be addressed (1/2)

Enhanced access to care (structural and cultural)

Barriers shared by individuals in group

- Children and their families often lack access to children’s psychiatrists due to low availability of providers and high costs of services
- Consumers cannot get insurers to pay for hospitalization even when a consumer is in a high risk situation (e.g., suicide)
- Children can lose coverage as they age out of specialized children’s programs, creating discontinuities in care
- Consumers are denied coverage under Medicaid for scientifically proven treatment due to “arbitrary” treatment classifications
- Providers struggle to give medically necessary care when insurance cannot cover treatment
- Appeals are costly and timely, preventing adequate recourse for those denied coverage
- Consumers sit on waitlists to access mental health facilities
- Even if insurance covers care, the waits for approval leave the consumer still struggling without treatment
- There is a lack of system capacity for mental health services, specifically for consumers needing specialized services; Connecticut also experiences a lack of beds, though this may be a general concern or one particularly relevant to mental health diagnoses
- There is a lack of integration of mental health and substance use into overall care
- Poor coordination between public programs

Solutions proposed by group

- CT needs to develop a network of available and qualified children and adolescent psychologists
- Insurance companies and health plans ought to be required to cover medically necessary mental health care (e.g., residents covered by self-funded and fully insured plans should have access to community based services) and should not have different rules for coverage
- Improve CID oversight by instituting a new check of plan compliance with the federal parity law and require plan data to be used to actively measure utilization review results
- Require substance use treatment decisions to be made more quickly and appropriately
- Make the appeals process more user-friendly so that consumers can more easily appeal coverage denials

Note: Recommendations from PRI Phase 1 Report on Access to Substance Use Treatment for Insured Youth included

G Behavioral health hearings: Barriers to be addressed (2/2)

	Barriers shared by individuals in group	Solutions proposed by group
Consumer engagement	▪ Consumers feel that health plans do not listen to them or their providers ▪ Consumers feel that they need to turn to public programs because private plans deny coverage ▪ Consumers feel they are pushed out of services if they cannot get payment ▪ When trusting relationships between patients and providers are formed, these relationships are often disrupted ▪ When consumers decide to get help, help is often restricted or delayed ▪ Stigma and discrimination can keep people from seeking care for mental health and substance use issues ▪ Lack of communication between primary care provider and behavioral health ▪ Those with substance abuse disorders often do not accept that they have a condition that requires medical treatment	▪ Hold a public awareness and education campaign to promote awareness of substance abuse disorders and treatment options ▪ Prevention, awareness and screening programs must be enhanced ▪ Provide better communication about diagnoses ▪ Stress importance of engaging in continued treatment and communication with PCP ▪ Enhance community programs and peer support networks
Team-based, coordinated, comprehensive care	▪ There is a disconnect between hospital substance abuse treatment and mental health programs, causing people to leave the hospital without proper transitions for mental health treatment ▪ Lack of community based services, including peer supports, for those covered by private plans ▪ Lack of coordination of care across payers ▪ Lack of cost-effectiveness research	▪ An integrated program in which consumers move from hospital treatment directly into mental health treatment could prevent this discontinuity ▪ Adopt peer support and recovery model that takes into account whole person ▪ Increase coverage for community based services for privately covered individuals ▪ Coordinate care across all agencies and plans, potentially through the use of a coordinating entity ▪ Promote use of intensive case managers

Note: Recommendations from PRI Phase 1 Report on Access to Substance Use Treatment for Insured Youth included

H PRI: Access to Substance Use Treatment for Insured Youth (Phase 2)

	Barriers shared by individuals in group	Solutions proposed by group
Enhanced access to care (structural and cultural)	▪ Substance abuse treatment locators exist in Connecticut, but exhibit two deficiencies which increase access issues for consumers: – Locators are inconsistent, and often yield different results – Locators do not display information on whether treatment providers are accepting new clients ▪ Inadequate behavioral health capacity leads to substantial wait times for several levels of treatment, including IP, detoxification, residential treatment, in-home treatment models, OP individual counseling ▪ Adolescent psychiatrists are particularly difficult to access, largely because of cost or no available appointment times	▪ The State should perform a review of current locators and promote the use of only one locator based on performance (the decision should be publicized) ▪ The locator should contain information on whether the treatment provider is accepting new clients ▪ DMHAS and DCF should propose the launch of an urgent care center for behavioral health
Effective Diagnosis and Treatment	▪ There is a lack of routine screening of adolescents for substance use, for a range of reasons including but not limited to: – Lack of provider training leaves providers feeling uncomfortable on how to screen – Providers are unaware of available resources – Providers are under time and financial pressures ▪ There is a lack of treatment facilities that have adolescent-focused programs	▪ Create a consultation line to aid providers in screening, training, consultation and referral activities for both mental health and substance abuse ▪ DMHAS and DCF should offer training and/or other resources to providers to ensure age-appropriate care
Team-based, coordinated, comprehensive care	▪ Current insurance plans do not cover or only partially cover case management services to coordinate care after intensive substance use treatment ▪ Few recovery supports are available in Connecticut to youths and adolescents	▪ state agencies should develop more robust and accessible recovery programs in less-intensive clinical settings after intensive substance use treatment, as well as supports (e.g., separate schooling) for recovering substance users