



DRAFT 1.0

CONNECTICUT HEALTHCARE INNOVATION PLAN



DRAFT AS OF OCTOBER 24, 2013

WORK IN PROGRESS

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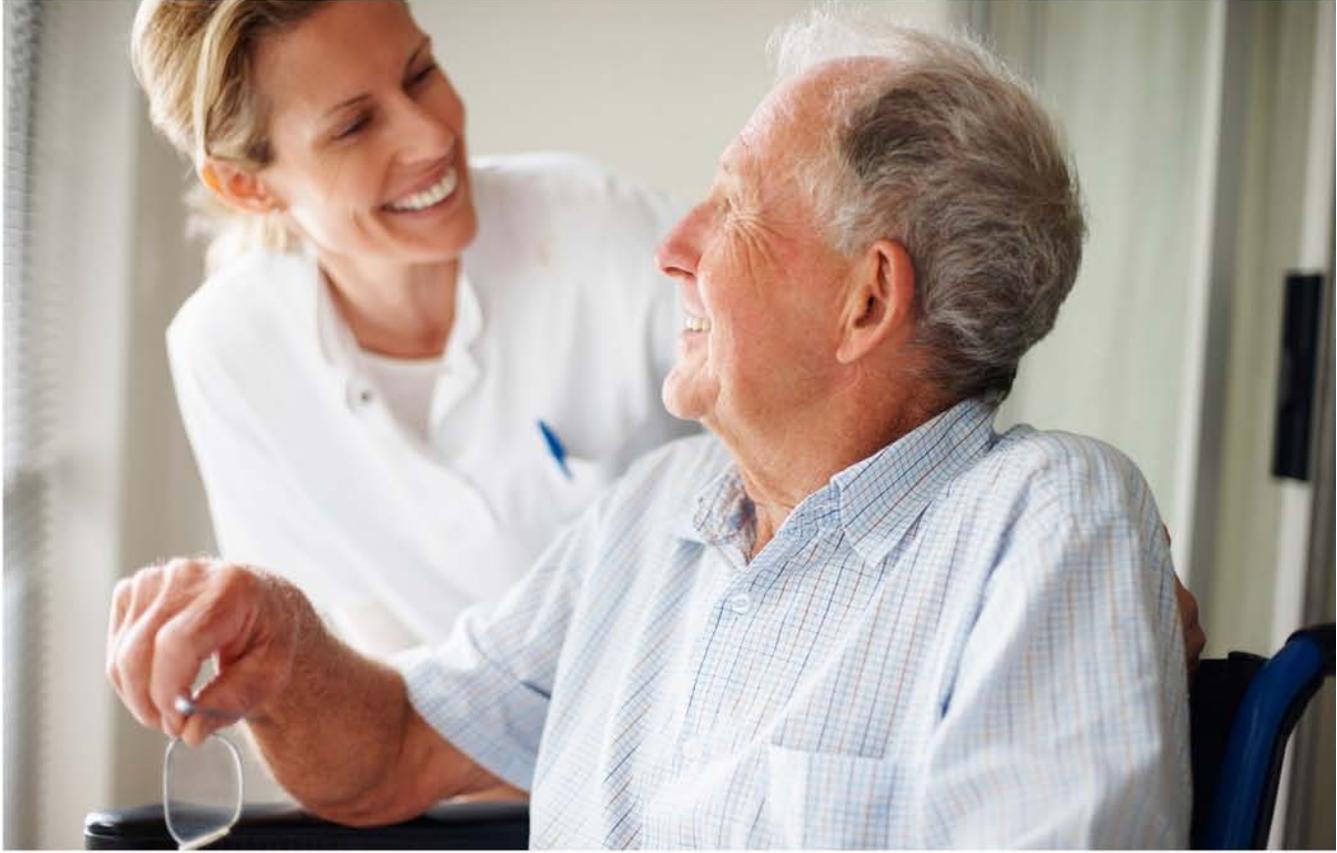
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EXECUTIVE SUMMARY

Vision for the future

By 2020, Connecticut will establish a whole-person-centered health system that ensures superior health care quality and access, promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability.

CONNECTICUT'S CURRENT HEALTH SYSTEM

Connecticut's residents are among the healthiest in the nation, and the state has an exceptionally rich array of healthcare, public health, and support services that provide a strong foundation for advancement. Despite this, the State must improve on indicators of healthcare quality. Significant health inequities and socioeconomic disparities persist, keeping the State from achieving higher quality outcomes and a more effective and accountable care delivery system. The State also faces the significant challenge of high health care costs in both the private and public sectors.

In 2012, health care spending in Connecticut was \$29 billion. We rank third highest among all states for health care spending per capita, at \$10,470 in 2012. These figures raise concerns about continued affordability of health care coverage and the impact of health care spending on business competitiveness with other states. Just as importantly, over the past several years, growth in health care spending has outpaced our economy's growth, meaning that each year fewer resources have been available to support education, housing, paying down consumer debt, or saving for the future.

Consumers, consumer advocates, providers, private payers, employers and state agency officials report barriers in access to care, frustration with a delivery system that currently focuses primarily on payment for treatment versus payment and rewards for quality, improved access and overall community health improvement.

OUR STATE INNOVATION MODELS INITIATIVE

In March 2013, the Governor's Office received a \$2.8 million planning grant from the Centers for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan (SHIP). Our SHIP is Connecticut's vision for achieving the Triple Aim for everyone in Connecticut: better health, while eliminating health disparities, improved health care quality and experience, and lower health care costs. CMMI charged us with designing new health care delivery and payment models that would include value-based payment tied to the totality of care delivered to at least 80% of our population within five years.

Connecticut's SHIP reflects the alignment of our payers (Medicaid, our state employees' plan, commercial plans, self-funded plans and hopefully Medicare), healthcare providers, employers, consumers, advocates and public agencies. The SHIP

also reflects our vision for building on ongoing innovations within our state that will bring best practices to scale on a statewide with the support of all payers. Connecticut is already home to many innovative health care organizations, public entities and community-based organizations that have made significant investments in improving health and health care. To date, however, these efforts have been mostly pilot programs, focused on single populations and/or select geographic regions within the state. Participants in our State Innovation Models initiative are eager to identify sustainable models that will support innovation on a greater scale.

This SHIP is the product of broad stakeholder input, including more than 20 consumer focus groups and various forms of surveys comprising almost 1,600 individuals, and more than 25 multi-stakeholder meetings including payers, providers, employer purchasers, and consumer advocates. In these forums, we surfaced issues with our current health care system and barriers to community health improvement. We then evaluated and prioritized potential options for innovation. We also established principles for value-based payment and health information technology that will be implemented on a multi-payer basis for the benefit all our covered populations. In parallel, we developed our understanding of the current health care workforce and defined initiatives that will expand and align our workforce to address the needs identified through workgroups and consumer feedback. Throughout these efforts, we recognized that empowering Connecticut's residents, all of whom are health care consumers, is a central goal and key to achieving our overall aims.

Over the next several weeks, this plan will be refined based on further stakeholder feedback and public comment. It will be submitted to CMMI by the end of December. In the following months, the SHIP will guide the development of the initiatives that will constitute our proposal for a CMMI model testing grant that we anticipate submitting this spring. In selecting initiatives and crafting our proposal we will continue to work with stakeholders to continuously improve the SHIP itself to make it a more effective roadmap for achieving a healthier Connecticut.

GOALS FOR HEALTH SYSTEM PERFORMANCE IMPROVEMENT

We will judge our efforts a success if the new care delivery model and enabling initiatives empower us to achieve our goals for health system performance, including:

- Better health and the elimination of health disparities for all of our residents
- Better healthcare by achieving distinctive quality of care and consumer experience
- A lower rate of growth in health care costs to improve affordability

Primary drivers of transformation

Our SHIP is based on three primary drivers for health system transformation:

- **Primary care practice transformation** to manage the total needs of a practice's population of patients
- **Community health improvement** through the coordinated efforts of community organizations, health care providers, employers and public health entities
- **Consumer empowerment** to help consumers manage their own health, access care when needed, and make informed choices regarding their care

PRIMARY CARE PRACTICE TRANSFORMATION

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

1. **Whole-person centered care**
2. **Enhanced access**
3. **Population health management**
4. **Team-based coordinated care**
5. **Evidence-informed clinical decision making**

COMMUNITY HEALTH IMPROVEMENT

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

1. **Establishing Health Enhancement Communities (HECs) in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities**
2. **Strengthening community-based health services and linkages to primary health care by establishing a Certified Community-Based Practice Support Entity**

CONSUMER EMPOWERMENT

At the most fundamental level, human autonomy, a person's control over their mind and body, must be respected and placed at the center of any efforts to achieve our vision. The delivery of whole-person-centered care requires a transformation in how payers and providers respect and enable consumers to be active participants in the management of their health. Transformation also requires recognition of the many factors outside of a provider's office that affect health and the deep network of community organizations in the State with which the State can partner to improve community health and empower consumers.

The State will encourage providers to equip consumers with information, resources, and opportunities for them to play an active role in managing their health. The state will support participating payers' adoption of benefit plan designs that reward consumers who use these resources to understand and make informed health care decisions.

As part of our plan for consumer empowerment, we will encourage payers and providers to participate in a four-pronged strategy detailed in the SHIP:

- 1. Consumer input and advocacy**
- 2. Enhanced consumer information and tools to enable health, wellness, and illness self-management**
- 3. Consumer incentives to encourage healthy lifestyles and effective illness self-management**
- 4. Improved access to health services**

Enabling Initiatives

Connecticut will enable transformation through performance transparency, value-based payment, health information technology, and workforce development. These initiatives, described in detail in the SHIP, are highlighted here because of their critical role in achieving our vision.

PERFORMANCE TRANSPARENCY

Diverse groups of stakeholders told us repeatedly that increased transparency of costs and quality is a fundamental prerequisite to improving our health system. Connecticut's strategy to increase performance transparency includes a common provider performance scorecard to increase consistency, including measures of health status, quality of care, consumer experience, and cost of care and resource utilization. To assure the accuracy of the scorecard, the State will:

- 1. Combine or aggregate data across payers to increase reliability of measures to allow for sample sizes that reliably reflect a provider's true performance**
- 2. Use tools such as risk adjustment and clinical and outlier exclusions to lessen the risk that any single provider would be disadvantaged because of the composition of their patient population.**
- 3. Require multiple levels of reporting to inform decision making by consumers, providers and payers.**

VALUE-BASED PAYMENT

A key enabler of our transformation will be the shift from purely fee-for-service payment, which reward providers for delivering a greater volume of products and services, to value-based payment, which reward providers for delivering high-quality care and a positive consumer experience, while reducing waste and inefficiency. Value-based payment also reduces health care costs or at least controls the growth in health care spending over time. Implementing these payment changes on a multi-payer basis strengthens the business case for providers to invest in new capabilities and processes, while eliminating the potential that they will be operating under conflicting incentives. Based on the guidance from our SIM Payment Model Workgroup, we have defined a strategy for value-based payment that comprises five principles:

- 1. Two tracks for value-based payment--Pay for Performance (P4P) and Shared Savings Programs (SSP)--to adjust for the variety of scale and capabilities of providers in the state.**

2. Alignment of payers to adopt similar reward structures tied to a common scorecard. Payers will be encouraged to tie SSP and P4P programs to the same common scorecard for quality, experience, and resources utilization to reduce complexity for providers, increase the business case for investment in new capabilities, and sharpen provider focus on specific measures of success supported by all providers.

3. Provider and Payer independence in setting risk parameters and levels of outcomes-based payments. Payers and providers will make independent decisions on the level of risk or gain sharing made under SSP, and/or the level of outcomes-based bonus payments made under P4P. (Upside-only arrangements meet the requirements of our model. Risk sharing is not applicable to Medicaid.)

4. Support for providers to aggregate for scale and capabilities to assist providers in achieving the scale and capabilities necessary to effectively manage a population of patients.

HEALTH INFORMATION TECHNOLOGY

Based on the input from our SIM Health Information Technology Workgroup, we have defined a health information technology strategy that is based on four principles, as outlined below.

1. Implementation of the All Payer Claims Database (APCD) to allow for aggregated performance measurement for quality and resource utilization.

2. Creation of a multi-payer portal for consumers and providers to allow easier access to information and better decision making by providers and consumers

3. Guidelines for care management tools. Because Connecticut has a large number of small provider practices, we will establish shared guidelines rather than mandatory procedures for adopting care management tools.

4. Standardized approach to clinical data exchange to accelerate providers' use of direct messaging for secure communication with other providers and to ensure coordinated care delivery across different sites of care

HEALTH WORKFORCE DEVELOPMENT

For this plan to succeed, it is essential that Connecticut have a health workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. We lay out seven broad, multipurpose initiatives based upon input from our health workforce taskforce:

1. Health workforce data and analytics

- 2. Inter-professional education (IPE)**
- 3. Training and certification standards for Community Health Workers**
- 4. Preparation of today's workforce for care delivery reform;**
- 5. Innovation in primary care Graduate Medical Education (GME) and residency programs**
- 6. Health professional and allied health professional training career pathways**

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Managing the transformation

TRANSFORMATION ROADMAP

Our Plan will be implemented over five years, divided into four phases: 9-month detailed design beginning in January 2014; 9-month implementation planning beginning in October 2014; Wave 1 Implementation beginning in July 2015; and subsequent scale-up through successful waves of implementation in State Fiscal Years (SFY) 2017-2020.

1. Detailed Design (January to September, 2014). Pending stakeholder feedback and refinement of the Plan, the State will establish new governance structures and form the program management office (PMO) that will have a small dedicated staff that will rely on contracted support as necessary. The PMO will develop the more detailed technical design we need to support our new models, including such activities as defining primary care practice transformation standards/ milestones and establishing common measures of quality, consumer experience, and resource utilization for a balanced provider scorecard.

2. Implementation Planning (October 2014 to June 2015). Pending the award of the CMMI State Innovation Models Testing Grant and our securing other funding, we will initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes. Example activities during this period include procurement of technology development, practice transformation, and other external products and services necessary to support launch; as well as development of the first versions of consumer/provider portals and the first versions of AMH performance reports for Medicaid and other payers electing to use common reporting.

3. Wave 1 Implementation (July 2015 to June 2016). State Fiscal Year 2016 will mark the first year of operations of our multi-payer model for AMH as well as initiation of our new capabilities to support Workforce Development. Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the CT Service Track under our Workforce enabling initiative.

4. Wave 2+ Scale-Up (July 2016 to June 2020). In State Fiscal Year 2017 and beyond, we will continuously improve the Common Scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities. In addition, primary care providers will continue to be enrolled in the Glide Path and AMH model, and providers will continue to transition from P4P to Shared Savings as they achieve the minimum necessary scale and capabilities over time. This period will also mark the major expansion of our Community Health Improvement and Workforce strategies, including

establishment of Certified Entities and implementation of the Connecticut Service Track.

GOVERNANCE STRUCTURE

We will also establish the following structures to provide oversight and staff support during detailed design and implementation:

- **Healthcare Innovation Steering Committee:** a successor to the existing steering committee, this group will have additional consumer, consumer advocate and provider representation. It will guide Connecticut's SIM and be responsible for overall strategic guidance, reviews of SIM's impact, and coordination with other public and private initiatives.
- **Program Management Office:** this small state staff will provide core staff support to SIM, as described above, and will oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate SIM progress to the public, state government and CMMI.
- **Provider Transformation Taskforce:** this group's members all have direct experience in provider transformation. The taskforce will set AMH standards, advise on vendor selection for transformation support and practice certification, and coordinate practice transformation standards and support to ensure that the SIM aligns with other care delivery models in the state.
- **Quality Advisory Council:** this group will ensure that the AMH model provides the appropriate levels of quality health care and consumer experience. All council members will have technical expertise and experience with measuring health, quality and consumer experience. More specifically, the council will develop a Common Provider Scorecard with metrics and targets; it will also update the scorecard annually based on provider, payer, and consumer input.
- **Healthcare Innovation HIT Taskforce:** this taskforce will be similar to the one currently advising the SIM HIT process. Participation criteria include technical HIT expertise and either the formal authority or the ability to influence public or private HIT systems. The taskforce will set HIT priorities and develop payer and provider education materials, define standards for system interoperability and consistent formats for reports and portals, and coordinate with HIE, HIX, other HIT-intensive initiatives.
- **Equity and Access Council:** this council will be made up of consumer advocates, experts in program integrity and surveillance, academics, and physicians who are committed to ensuring long-term, systemic provision of appropriate care and access, especially to typically underserved communities. They will assess potential strategies to ensure equitable access to appropriate service and shape

Connecticut's plan to ensure the AMH model systematically includes at risk populations and limits the risk of under-provision of requisite care.

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What makes our plan distinctive?

Connecticut's SIM will launch quickly and successfully. Existing innovations that complement our SHIP are already improving access, integrating behavioral and mental health care, and addressing equity issues in communities, workplaces and schools. Medicaid and Commercial payers are implementing payment initiatives that support ACO and PCMH models.

We specifically carry the principle of the promotion of health equity and the elimination of health disparities through each component of our SHIP. Connecticut is one of the most racially, ethnically and culturally diverse states in the country—in some counties of Connecticut, over 60 languages are spoken--yet the State performs unacceptably on many quality measures that capture race, ethnicity and other cultural data. To achieve the triple aim, the State must commit to eliminating persistent barriers to health equity.

Connecticut now has multiple examples of population-health oriented Person-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACO) that create a strong foundation for the AMH model. We will leverage their knowledge and momentum as we enhance our AMH standards.

Our value based payment reforms emphasize achievement of quality and care experience targets, while also recognizing the need for methods to guard against under-service. Through the establishment of an Equity and Access Council, Connecticut intends to be a national leader in the identification and deployment of advanced analytic methods that offer special protections for consumers as we migrate to value-based payment environments.

Our state is advancing and succeeding in health information technology. Connecticut is only one of 14 states to successfully launch and operate a state-based health insurance exchange, Access Health CT, offering access to health coverage to our 344,000 residents. Access Health CT is also responsible for launching Connecticut's All-Payer Claims Database (APCD), which will play a significant role in supporting consumer empowerment in decision-making, performance transparency, and analytical capabilities. A diverse set of stakeholders from consumer advocates to payers to providers and state agencies has offered expertise and insight into potential uses for data collected by the APCD.

We will partner with commercial payers and employers to integrate consumer engagement innovations, including value-based insurance design (VBID), into the AMH model. VBID is achieving outstanding results with Connecticut's state employees and retirees. Consumers receive financial incentives to attend yearly physicals and undergo recommended preventive testing. They can also access health education via classes on chronic conditions and a health portal. Approximately 98% of eligible Connecticut state

employees and retirees are enrolled in the program, and physicians are reporting a remarkable impact on patient interest in well care visits and attention to chronic disease management.

Connecticut is committed to its public providers integrating behavioral and physical health care. Governor Malloy and the Connecticut's General Assembly strongly support the state's innovative and recovery-oriented services in behavioral health, especially those serving children. Closer coordination with primary care providers will help extend this expertise. In one example, the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) are working together as the Connecticut Behavioral Health Partnership (CTBHP). The CTBHP delivers person-centered, family-focused, community-based care for children, adults and families under the Medicaid and State Children's Health Insurance Program (SCHIP). The partnership also offers intensive case management for complex cases, peer support, payment withholds to the ASO that depend on targets (e.g., reduction in hospital ED overcrowding); and bonuses/pay for performance.

Finally, our consumer advocates and the consumers we reached in focus groups and other forums are guiding us on consumer empowerment. They will help the State implement an ambitious and ongoing stakeholder engagement plan that calls for broad input; finally, they will help the AMH model deliver a better care experience and higher quality of care through their attention to access to care and the prevention of unwarranted denials of care.



CONTEXT FOR HEALTH SYSTEM TRANSFORMATION

Connecticut health care environment

Connecticut ranks among the top states in the nation on healthcare, based on many of its health indicators – e.g., high immunization rates, low smoking rates, premature death rates and numbers of poor mental health days that are all better than the national average. However, many other indicators need significant improvement. For example, Connecticut has high emergency department utilization rates, especially for non-urgent conditions, and it has a relatively high rate of hospital readmissions. Substantial health inequities and socioeconomic disparities also exist. The state faces significant challenges healthcare expenditures with per capita spending ranked among the highest in the nation. The State will leverage its strengths to improve care across all populations and will further address more complex issues among specific groups.

POPULATION DEMOGRAPHICS AND COVERAGE--HIGHLIGHTS

Connecticut has 3.5 million residents. According to Moody's Analytics, 72% of the population the state's population is white, 11% black, 10% Hispanic and 7% other.¹

Income: While only 11% of residents are below the federal poverty line (FPL) in Connecticut, lower than the U.S. average of 15%, 720,000 (21%) of residents were living at or near poverty in 2010.² In urban areas, where 88% of Connecticut residents live, many (25%) are below the federal poverty line.³ And in Connecticut, where the family self-sufficiency standard exceeds that in other states, the percentage of residents living in real poverty exceeds 25%.

Healthcare Coverage: Sixty-four percent of the state's residents have employer-sponsored or individual health coverage. Of the remaining 36%, Medicare covers 13%, Medicaid covers 13% and 10% are uninsured.⁴ Four commercial payers cover 85% of the 2.2 million lives in the private insurer market: Anthem, Aetna, UnitedHealth Group and Cigna.⁵ Fifty-two percent of the lives covered by Medicaid are children; however, children only account for 17% of total Medicaid payments.⁶

Connecticut has a high proportion of self-insured employers⁷. This is a challenge as many of these employers have yet to make up-front investments in care coordination

¹ Moody's Analytics (2011)

² Connecticut Association for Community Action, Meeting the Challenge of Poverty (2013)

³ U.S. Census Bureau, 2010 Census

⁴ Kaiser Family Foundation, State Health Facts (2011)

⁵ HealthLeaders InterStudy, Market Overview: Southern Connecticut (2012)

⁶ Kaiser Family Foundation, State Health Facts (2011)

⁷ Kaiser state health facts

fees to support the delivery of higher-value care. The State partnered with the Connecticut Business Group on Health and the Northeast Business Group on Health to engage these employers to become active participants in the transition to higher value care.

POPULATION HEALTH INDICATORS -- HIGHLIGHTS

Connecticut's excellent immunization rates and its low rates of smoking, premature deaths and poor mental health days currently place it in the top 10% of states.⁸ It also ranks in the top half of states for the lowest rates of diabetes, infant mortality, cardiovascular deaths and cancer deaths.⁹ However, racial and socioeconomic health disparities persist and provide significant opportunities for improvement in these and other areas (see *Health Inequities and Socioeconomic Disparities*, page 19).

- For adults, the leading causes of death in Connecticut are heart disease and cancer, with almost equal rates for men and women.
- Adult obesity is significantly below the national average – 25.4% of males and 23.6% of females are obese, compared to national averages of 44% and 48%, respectively.¹⁰
- Childhood obesity is a problem among males. In 2011, 33% of male 9-12 grade students were overweight or obese compared to 20.1% of their female peers. While this trend increased by 3% for the males from 2005 to 2011, it decreased for females by (-.6) %.
- 619 children below the age of six had lead poisoning in 2011.¹¹

QUALITY OF CARE

While Connecticut performs well on certain population health status indicators, it could enhance its performance on at least three system-wide healthcare quality indicators: disease-specific quality process/outcome metrics, patient service levels, and hospital readmissions.

Disease-specific quality process and outcome metrics: Connecticut surpasses national averages on multiple quality measures. For example, its mammogram rate for breast

⁸ The Connecticut State Health Assessment, conducted by the Connecticut Department of Public Health (DPH), helped create these pages. It examined mortality and hospitalization, maternal and child health, environmental and occupational health, and chronic disease prevention and control

⁹ America's Health Rankings (2012)

¹⁰ CDC, Fast Stats: Obesity and Overweight (2009)

¹¹ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

cancer screenings among women 40+ is 85.6% vs. the 67.1% national benchmark.¹² However, the state underperforms on other measures; for example, only 69.4% of the State's diabetic patients received a dilated eye exam, significantly lower than the 82.1% national benchmark.¹³

Patient service levels: Of the four large health systems in the state (Yale New Haven, St. Francis Healthcare, Hartford Healthcare, and Western Connecticut), only one consistently exceeds the national averages on quality metrics¹⁴ – Western Connecticut. Their ratings on these metrics present each of these systems with opportunities to develop and advance their services. According to the Centers for Medicare and Medicaid Services (CMS), patients' experiences in the State's hospitals met the national average. However, the timeliness of treatment did not, with patients spending 341 minutes in the Emergency Department (ED) before inpatient admission vs. a national average of 274 minutes.

Hospital readmissions: Although Connecticut's overall readmission rate was less than the national average in 2010 (13.4% vs. 19.2% respectively¹⁵), its Medicaid readmissions were significantly higher. The combined Medicaid medical/behavioral health 30-day readmission rate for 2010 was 12.8% (on a total of 89,246 acute hospitalizations), which indicates significant opportunities for improvement. The medical-only rate of 11.8% was the highest rate among peer states – tied only with New York Medicaid –and much higher than the peer-state benchmark of 9.4%. The Medicaid behavioral-health 30-day readmission rate in Connecticut was almost twice that at 18.4% in 2010.

Readmissions are a major drain on the State's funds. Across Medicaid, hospital readmissions under 30 days cost the state \$92 million.¹⁶ The largest number of these occurred within the 45-64 year-old age group and cost the State \$32 million. Medicare also announced recently that 24 of Connecticut's 31 hospitals in Connecticut will face Medicare readmission penalties in the next fiscal year. The average Medicare penalty for our hospitals is higher than the national average, at 0.43% of Medicare funds.

CONSUMER EXPERIENCE OF CARE

Consumer engagement was the primary vehicle we used to understand the current experience of care. We conducted numerous focus groups and attended many

¹² CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

¹³ CDC, Diabetes Report Card

¹⁴ CMS: Hospital Compare (2012)

¹⁵ Connecticut DPH, Chart Book: Availability and Utilization of Health Care Services at Acute Care Hospitals and Federally Qualified Health Centers (2011)

¹⁶ Office of the Governor, Connecticut Medicaid Hospital Readmissions (2013)

community-based meetings to gather consumers' perceptions of issues, barriers to care and ideas for solutions. We also reviewed information gathered from focus groups related to other Connecticut reforms, especially those that focused on services for individuals with disabilities. Consumers' personal stories were powerful and sometimes difficult to hear, but they spurred us to a higher level of awareness and aspiration. Issues and barriers identified through this process include:

1. Unaffordable and insufficient coverage – A significant number of consumers expressed concern about the affordability of health care options, remarking that to enroll or maintain healthcare coverage, consumers need lower premiums, co-pays, deductibles and lower prescription costs. Consumers also expressed the need for more coverage for vision, dental, mental health and behavioral health services. For many, affordability and lack of coverage for some services are the main barriers to getting appropriate care.

2. Barriers to access - Nearly all consumers reported the following barriers: long wait times to get appointments (especially with specialists), limited hours of provider offices, inability to find an available provider (including specialists), prior authorization and referral requirements, distant locations to access providers, and a sense, especially among Medicaid recipients, that they are not welcome. Consumers want same day appointments and convenient, direct access, especially for non-urgent care. A large number of consumers want more preventative care.

3. Low quality in care delivery experience –Some consumers reported that providers sometimes do not listen, respect them and their symptoms, follow-up, spend enough time with them, or understand them as a whole-person. Medicaid recipients widely reported being treated with a lack of respect and dignity. They desire a more holistic approach to care, where the whole person is considered, including their social, emotional and economic contexts.

4. Barriers to engagement – Many consumers explained that their lack of health literacy, their lack of access to information--including knowing which providers offer higher value services--communication tools, support and navigation, prevent active participation in one's own treatment,.

5. Fragmented care system – Consumers want better communication and coordination between doctors, between doctors and specialists, and between doctors and payers. Consumers want direct access to their records, and they want them to be electronic, share-able, frequently updated, consistent, and secure. Some worry about privacy, security and the ability to control access to their health information. They want to understand who will use their data and how.

7. Disability sensitivity - Individuals with disabilities had concerns about disruptions to existing relationships with providers (e.g., when transitioning from pediatric to adult care), paternalism, a lack of understanding of their strengths and needs, and

discrimination by health care providers who may not want to see them because of their disability.

HEALTH EQUITY AND SOCIOECONOMIC DISPARITIES

The considerable consumer outreach we conducted and input we solicited made it clear that consumer experience and access is especially poor for various subsets of the population, particularly those on Medicaid. The input from these subsets reflects the racial and socioeconomic disparities that permeate Connecticut.

While the SIM process cannot directly impact the unequal living conditions, life opportunities and distribution of material resources, it can start to resolve the differences in health care access, utilization and outcomes. In time, SIM can also provide community incentives to address some of the social determinants of health, risk and illness. Moreover SIM aims to enhance the integration between our efforts to transform primary care and improve community health.

Data Highlights

Connecticut's significant racial and ethnic disparities affect multiple health areas, including sexually transmitted diseases, diabetes, prenatal care, low birth weight and fetal and infant mortality. Diabetes and sexually transmitted diseases are significantly more prevalent in the Black than in the Hispanic and White populations. The rates of inadequate prenatal care, low birth weight, and fetal and infant mortality are higher among Black and Hispanic populations than in the White population. For instance, infant mortality rates among Black (13%) and Hispanic (7.1%) populations are two to three times higher than in the White population (3.8%).¹⁷ In terms of oral health, the incidence of childhood untreated decay in Blacks (18%) and Hispanics (15%) is 50% to 100% higher than in Whites (9%).¹⁸

The State's income disparity between high and low income wage earners, the second largest in the United States¹⁹, also produces health issues. Although Connecticut has the third highest median household income in the nation, approximately \$65,000, three major urban cities (Hartford, New Haven and Bridgeport) have median incomes that are approximately 50% lower.²⁰ By way of contrast, the Stamford metro area is now one of the wealthiest areas in the nation with 17.9% of households reporting high income.²¹

¹⁷ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

¹⁸ Gini coefficient is commonly used as a measure of income/wealth inequality

¹⁹ 2010 US Census Bureau

²⁰ CT DPH, Connecticut State Health Assessment : Preliminary Findings (2013)

²¹ CBSNews.com, America's Richest Cities (2013)

Health disparities emerge from these discrepancies: “. . . poor people often face more barriers to care and receive poorer quality of care when they can get it”²². Lower-income adults are more likely to be obese and obesity has been linked to numerous chronic health conditions, including diabetes and heart disease. The same study shows that adult smokers in Connecticut are more likely to have lower incomes and less education, and smoking cigarettes has also been linked to many chronic diseases including cardiovascular and respiratory ones²³.

Other equity issues may also drive lower consumers’ health. A large education achievement gap exists among the different groups. For all residents age 25 or older, 35.7% are college graduates; however, among Black and Hispanic populations, the rates are half that at best –18.2% and 14.6%, respectively.²⁴ In addition, one’s childhood living situation plays a significant role in all of these outcomes, from educational attainment to overall health, including behavioral health and oral health. We are examining if this is the impact of whether or not children came from a two-parent household. Within the state, 20.4% of all family households are led by a female with no adult male present. Within Black and Hispanic populations, 44.2% and 35.1% of households are headed by females only.²⁵

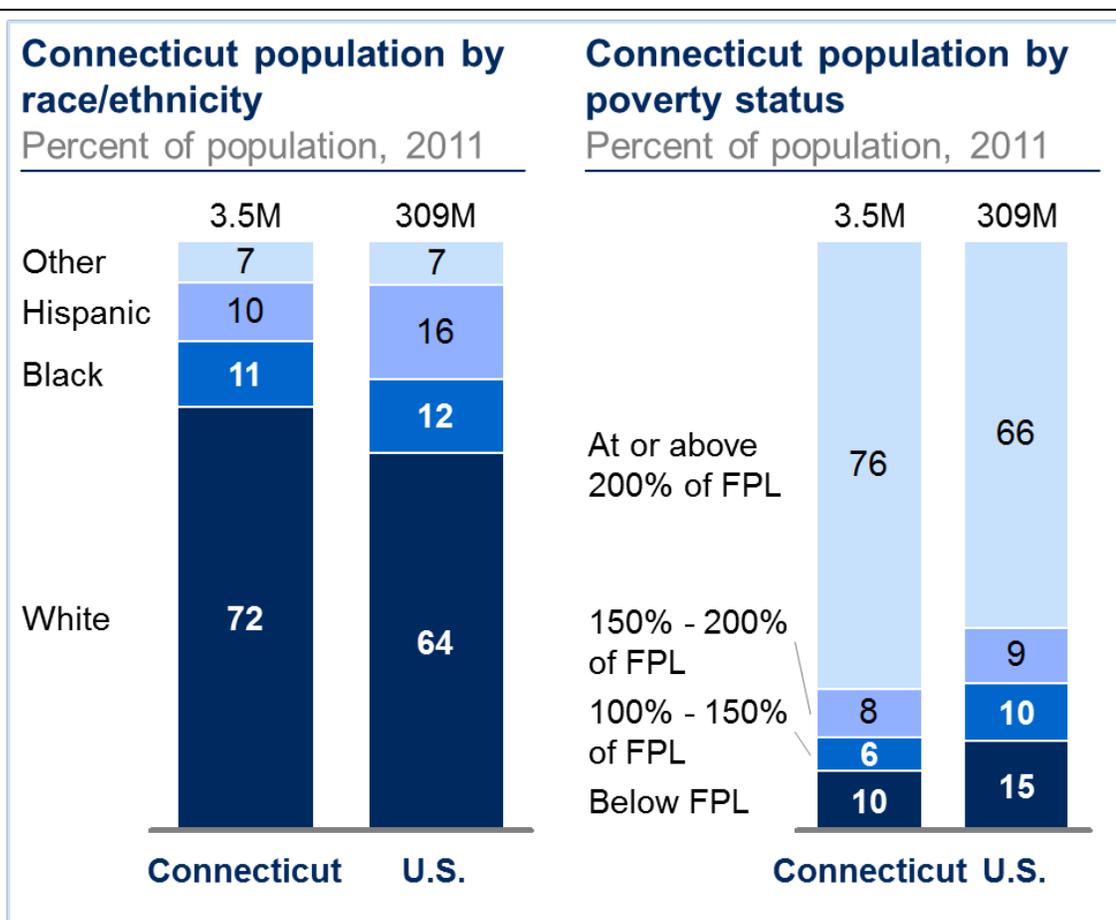
We must be aware of and address these health disparities as we aim to improve the health and the consumer experience of care.

²² National Healthcare Disparities Report, 2013

²³ CT Department of Public Health, 2009

²⁴ Connecticut Health Foundation, Community Health Data Scan Update, 2013: Focus on Race and Ethnicity Disparities, July 2013

²⁵ Ibid



Source: Moody's Analytics

HEALTH CARE COSTS

Although Connecticut ranks among the top states on several indicators of population health, these accomplishments come with extremely high price tag. Unchecked, these expenditures threaten to create a budget deficit for the State in the next two years that would crowd out other important areas of public expenditure.

In 2009, health care spending in Connecticut was \$8,654 per person vs. the U.S. average of \$6,815 across all services and payers. This places the State above the U.S. 90th percentile in health care spending for total cost of care.

Medicaid spending per enrollee in the state (\$9,600 Per Member Per Year or PMPY) was the highest of any state and significantly higher than the national average (\$5,500 PMPY) in 2009. Per enrollee spend on aged and disabled persons, \$24,800 and \$33,000 respectively were both the highest in the country, and partially drove these figures.

Long-term costs accounted for most of the spend on the disabled and aged; they were 49% vs. a 32% national average.²⁶

We expect the number of Medicaid enrollees to increase significantly by 2020, as Connecticut implements Medicaid expansion under the Affordable Care Act (ACA). This will increase total Medicaid spend even more than the expected growth in per member per month (PMPM) costs. Currently (2013), the State has ~620,000 Medicaid enrollees. We estimated Medicaid PMPMs and recent annual PMPM growth trends by 2020 of: adults (~\$330, 12%), children (\$290, 20%), and disabled (\$2,400, 6.2%).²⁷

There are approximately 470,000 Medicare enrollees (excluding dual eligibles—people on both Medicare and Medicaid) in Connecticut with a PMPM cost of ~\$1,100 (for Medicare fee for service (FFS) and Medicare Part D). The recent annual PMPM growth rate was 4%²⁸ and the expected enrollment growth rate is 0.9%, based on historical rates.²⁹

In Connecticut costs for private insurance are below the national average, with the average private insurance cost per person at \$2,945 vs. \$3,268 (the national average) in 2009.³⁰ However, the number of individuals covered by private insurance will also increase as a result of the Affordable Care Act (ACA), with enrollment expected to reach two million individuals in 2018.³¹ Commercial PMPM costs have been increasing at 9% annually³².

Given the expected enrollment growth in every category, and the upward trends in costs on a PMPM basis, we predict significant increases in total health care costs over the next decade – unless we successfully execute the State Innovation Model. By doing so, we can transform and address some of the most important drivers of these cost trends.

²⁶ Kaiser Family Foundation, State Health Facts (2009)

²⁷ CT SIM Design Grant Application, Financial Analysis (2013)

²⁸ CT SIM Design Grant Application, Financial Analysis (2013)

²⁹ Kaiser Family Foundation, State Health Facts (2009)

³⁰ NORC, Benchmark State Profile Report for Connecticut (2013)

³¹ Rand Health, The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut (2011)

³² CT SIM Design Grant Application, Financial Analysis

Our foundation for innovation

The SHIP will benefit greatly from the wide-ranging healthcare initiatives already underway in Connecticut. Many of them are pursuing similar goals to the SIM; as a result, we can build from and easily integrate them into the new care delivery and payment models. For instance, efforts are already increasing consumers' access to care and providers' participation in integrated networks and their use of HIT – all major elements of SHIP.

INNOVATION AND REFORM INITIATIVES ALREADY UNDERWAY

Connecticut has established a range of **population health initiatives** focused on activating and educating consumers (e.g., Rewards to Quit, NuVal, CHOICES), and is addressing socioeconomic and other wellness issues in communities, workplaces, and schools. We are making advances in increasing **access** to healthcare coverage across population groups through our health insurance exchange, Access Health CT. Behavioral health initiatives have been established or are being developed to improve early detection and treatment of mental health and substance use conditions, strengthen integration of behavioral health and primary care, and to fortify practices around early intervention and coordination between schools and public agencies. In addition, Medicaid and commercial payers in the state are actively implementing **primary care improvement** and **payment initiatives** that emphasize population-health based ACO and PCMH models. **HIT initiatives** are increasing the capture and transfer of clinical and claims data that support all these efforts, though in limited ways. These initiatives are described in more detail in the Appendix.

PROVIDER INTEGRATION

Historically, Connecticut's physician market has been highly fragmented, with primary care in particular comprising primarily small independent practices of one to three physicians each. Over the past several years, Connecticut like the rest of the country has seen an increasing number of physicians employed by hospitals.

More striking, however, is the significant activity in Connecticut over the past 12-18 months among physicians and hospitals organizing into clinically integrated networks, accountable care organizations (ACOs), and/or independent practice associates (IPAs) for purposes of accepting value-based payment arrangements from Medicare and private payers. Based on an informal survey conducted by Connecticut's Office of State Comptroller, we identified 11 emerging networks, ACOs, or IPAs that have either accepted value-based payment arrangements or are working toward such arrangements with at least one major payer for January 2014. These 11 networks comprise approximately 60% of the estimated 2,600 PCPs in the state.

While these 11 organizations currently have only limited capability to support team-based care and other core elements of Connecticut's Advanced Medical Home model, we believe that they provide a strong organizational framework for the adoption of such capabilities in the future, as well as for combining or aggregating performance across PCPs at sufficient level or scale to support a shared savings program (SSP) and outcomes-based measures of quality.

HEALTH INFORMATION TECHNOLOGY ADOPTION

Although Connecticut has found it difficult to implement Electronic Health Records (EHRs) and create successful health information exchanges in the past, it made more progress in 2013. In December 2012, Connecticut's rate of EHR adoption was one of the lowest in the nation – 26.9% vs. the national benchmark of 44%.³³ However, since then, private payers and providers have been developing and implementing EHRs more actively across the state.

eHealthConnecticut received a \$5.7 million grant (from the Office of the National Coordinator and the U.S. Department of Health and Human Services) to accelerate the adoption of EHR. eHealthConnecticut helps Connecticut's providers select, implement, and use systems in ways that enhance health care quality, safety and efficiency. It plans to transition **80% of physicians to EHRs by 2014**. In one sign of progress, 5,238 Connecticut providers have registered for the EHR incentive program as of July 2013.

The Health Information Technology Exchange of Connecticut (HITE-CT) is also starting to create a health information exchange that will connect providers. This statewide exchange, managed by HITE-CT, will provide a secure electronic network that doctors, hospitals, and other health care providers can use to safely share information and improve patient care.

³³ NCHS Data Brief, Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001-2012)

State Innovation Model design process

In any change process of this scale, there are multiple stakeholders, who raise important and diverse concerns while bringing valuable knowledge to the overall process. CT's process incorporated stakeholders at every phase of model design and began with top state leadership. Lt. Governor Nancy Wyman, a former X-Ray Technician and tireless advocate for improving health care access and affordability led the process, ensuring participation from a broad range of public and private entities.

The Lt. Governor appointed a CORE leadership team, consisting of one person from each of three major state departments: The Office of the Healthcare Advocate (OHA), the Department of Social Services (DSS), the state's Medicaid authority, and the Department of Mental Health and Addiction Services (DMHAS). Overall project direction was provided by the Healthcare Advocate. The CORE team led the process of model design and made the day-to-day procedural decisions under the oversight of the Lt. Governor. The team developed a comprehensive model design and stakeholder engagement process that identified the categories of stakeholders necessary to design the process, laying out a phased approach for stakeholder input and feedback that allowed the team to incorporate input and feedback into the SHIP.

A State Healthcare Innovation Plan Steering Committee (Steering Committee) was formed in order to guide the CORE team on issues of key strategic, policy and programmatic concerns. This committee is chaired by the Lt Governor and includes Commissioners from seven state departments including the DSS, the Department of Public Health (DPH), the Office of Policy and Management (OPM), the Office of the State Comptroller Office (OSC), DMHAS, DCF and the CT Insurance Department (CID) and the Dean of the School of Medicine from the University of Connecticut. High-level representatives from the following organizations also sit on the steering committee: Anthem, UnitedHealthcare and Cigna (payers), St Vincent's Health Partners (providers), Pitney-Bowes (employer), the CT Health Foundation and Universal Healthcare Foundation (advocacy and community organizations) and Access Health CT. The CORE team reported on at least a monthly basis to the Steering Committee.

Five state agencies that have a major role in overseeing or delivering healthcare each assigned a dedicated program planner to support the core team throughout the SIM process. These agencies included DSS, DPH, DMHAS, OSC, and UConn. The Planners worked to ensure alignment among the state agencies and the SIM effort. At the same time, they kept their own leadership, contracted providers and constituency abreast of the process and used feedback from their stakeholders to inform the design process. This was a key strategic endeavor that enabled each state department to align their mission to SIM going forward and created opportunities for each state department to lend their expertise to the planning process. Collectively, we refer to the CORE team and Planners as the SIM planning team.

CARE DELIVERY, PAYMENT AND HIT WORK GROUPS

Three workgroups were established to consider the related design issues of care delivery, payment reform and health information technology. Membership of the work groups consisted of a broad array of stakeholders that included physicians, providers, payers, employers, high-level state participants and consumers. Importantly, each work group member was appointed by the Lieutenant Governor’s office, again demonstrating the enormous investment made by the state. Below, we describe each group and the questions they considered.

Care Delivery, Payment, and HIT work groups and questions considered			
	Care Delivery	Payment	HIT
Members & timing	<ul style="list-style-type: none"> Consumers, clinicians, community organizations, state agencies, employers, and payers Biweekly meetings 	<ul style="list-style-type: none"> Clinicians, hospitals, community organizations, state agencies, payers, and employers 	<ul style="list-style-type: none"> Clinicians, community organizations, state agencies, payers, and IT specialists
Questions	<ul style="list-style-type: none"> Who are the target populations? What are the areas of improvement to address that can lead to higher quality and lower cost? What barriers need to be overcome? What interventions and changes in provider and consumer behaviors/ processes, and structures are required to be successful? What roles will need to be fulfilled to implement these interventions? What entities are optimally positioned to fulfill these roles and which will be primary? What are the implications for payment model, data/ analytics, workforce, and policy? How will the care delivery model be phased? 	<ul style="list-style-type: none"> What types of metrics will be used for eligibility for participation and eligibility for payment, focusing on metrics that would ensure providing clinically appropriate care while minimizing waste? What is the reward structure? How do we define the level of performance we wish to reward? What will be the rule for attribution? At what level will performance be aggregated for measurement and rewards? What will be the pace of roll-out of the new payment model throughout the state? At what pace will accountability and payment type for participating providers be phased in? 	<ul style="list-style-type: none"> What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model? What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model? What is the best strategy to develop the required HIT capabilities? How can the proposed future state model be designed in order to be financially viable and self-sustaining?

WORKFORCE TASK FORCE

In addition to the work groups described above, the CORE team identified the need for more exploration of the existing healthcare workforce in Connecticut and workforce development needs that would emerge as a result of SIM. Thus, under the auspices of SIM, UConn and the DPH launched a joint taskforce to assess Connecticut’s current provider landscape and to propose workforce changes required to support the new care delivery and payment model. In particular, the taskforce examined: the current state of Connecticut’s health workforce, including numbers and types of relevant roles, skills, capacity and structure; and the health workforce changes required to support

Connecticut's new care delivery model of team-based care. The taskforce outlined a number of initiatives for implementing these changes.

HEALTH CARE CABINET

Connecticut's Healthcare Cabinet was established in 2011 to advise Governor Dannel P. Malloy and Lt. Governor Nancy Wyman on issues related to implementation of federal health reform and the development of an integrated health care system for the state. The Cabinet consists of both voting and non-voting members, is chaired by the Lt. Governor and includes nine state departments: OHA, DPH, OSC, DSS, OPM, DMHAS, DCF, CID and the Department of Developmental Disabilities (DDS) as well as the Non-Profit Liaison to the Governor. Other representatives are appointed by legislative leadership and represent home health care, small businesses, hospitals, faith communities, HIT industry, primary care physicians, advanced practice registered nurses, consumer advocates, labor, oral health services, community health centers, the health care industry and insurance producers. Two members-at-large also participate. The Healthcare Cabinet is charged with improving the physical, mental and oral health of all state residents while reducing health disparities by maximizing the state's leveraging capacity and making the best use of public and private opportunities. The CORE team presents to the Healthcare Cabinet on a monthly basis to obtain input on various aspects of model development. The Healthcare Cabinet also provided early, instrumental feedback on the stakeholder strategy described in detail below.

TRANSPARENCY

Transparency and "two-way communication" were integral aspects of the model design and stakeholder engagement process. All work group and Steering Committee meetings were publicly announced and posted and were accessible in person or by telephone. Meeting materials, minutes, and agendas were made available on the website in an effort to ensure broad public visibility. An email address was staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

BROADER STAKEHOLDER ENGAGEMENT

Stakeholder engagement has been an essential component of the CT SIM design process. The strategy to engage stakeholders was comprehensive and phased in over time in order to accommodate the multiple goals and the need for broad engagement. Early in the process, the CORE team met with individual members of the Steering Committee and the work groups in a series of small, informal discussions. The team gathered diverse perspectives on potential solutions to the current challenges of

Connecticut's health care system and used this information to support the SHIP and work group planning process.

In consultation with the Healthcare Cabinet and Steering Committee, the CORE team developed a strategy for engaging a wide array of stakeholders falling into five main groups: (1) consumers, (2) health care providers, (3) state agencies, oversight councils and trade associations, (4) employers and (5) community organizations. The strategy involved three phases, the input phase focused on listening sessions to identify health care problems and solutions supplemented by electronic surveys, the model feedback phase in which the workgroup recommendations and emerging model was shared for feedback, and the SHIP syndication phase focused on soliciting feedback regarding the detailed plan. In general, the strategy favored joining existing stakeholder groups and forums, rather than holding town hall meetings and public hearings, since the former was more conducive to sharing personal experience and meaningful dialogue.

Input Phase

During the input phase, the SIM planning team focused on attending a combination of existing forums, such as council meetings and conferences, and also special meetings convened specifically for the purpose of providing input for SIM. A set of key questions was developed for each stakeholder category that was designed to capture barriers/obstacles, supports/successes and personal accounts and experiences with the health care system. In addition, the sessions focused on consumer stories and the barriers that consumers encounter at different stages of the health care journey, from well care, to sickness and diagnosis, acute care and chronic care.

Community listening forums and focus groups were held from June through mid-September, 2013. The forums and focus groups consisted chiefly of consumers, providers, employers, state departments, oversight councils, trade associations and community organizations. All forums were held in the community, at settings that were convenient and accessible to the members. Importantly, all members of the SIM planning team participated in these events.

Across the categories, stakeholders willingly shared their concerns, their hopes and their own stories resulting in a wealth of information. The individual narratives were frequently poignant and difficult to hear, but they inspired us to a greater level of awareness and aspiration. Based on information gathered during this phase, work groups more carefully considered issues relating to safety net populations, access, and the need to integrate behavioral health and oral health into primary care.

During July and August, we distributed an electronic survey specific to the SIM Process via an electronic list serve from a large healthcare advocacy organization participating on the Steering Committee. Open-ended questions about recommendations for improving healthcare were attached to an existing electronic survey already in process

by a second healthcare advocacy organization. Responses to the open-ended questions were catalogued. About 1600 electronic responses were received, in one form or another, and were incorporated into the model design.

Model Feedback Phase

From mid-September through October, 2013, the SIM team continued to meet with stakeholders for the purpose of feedback on the emerging model. Again, these forums included provider, employer and trade associations; consumer and advocacy forums; and community organizations. During this phase, the Lt Governor convened a special forum to obtain input from and hear the concerns of consumer advocates. Consumer advocates raised concerns in the areas of governance, consumer protections related to inappropriate denials of care and the importance of a quality monitoring system, and the need for consumer empowerment and education. Several important solutions were incorporated into the model in order to address these concerns. Of note, an Equity and Access Council was proposed to develop methods to protect against adverse selection, access issues, and under-service. And consumer advocates will sit on the Quality Metrics Council to help build the Common Scorecard.

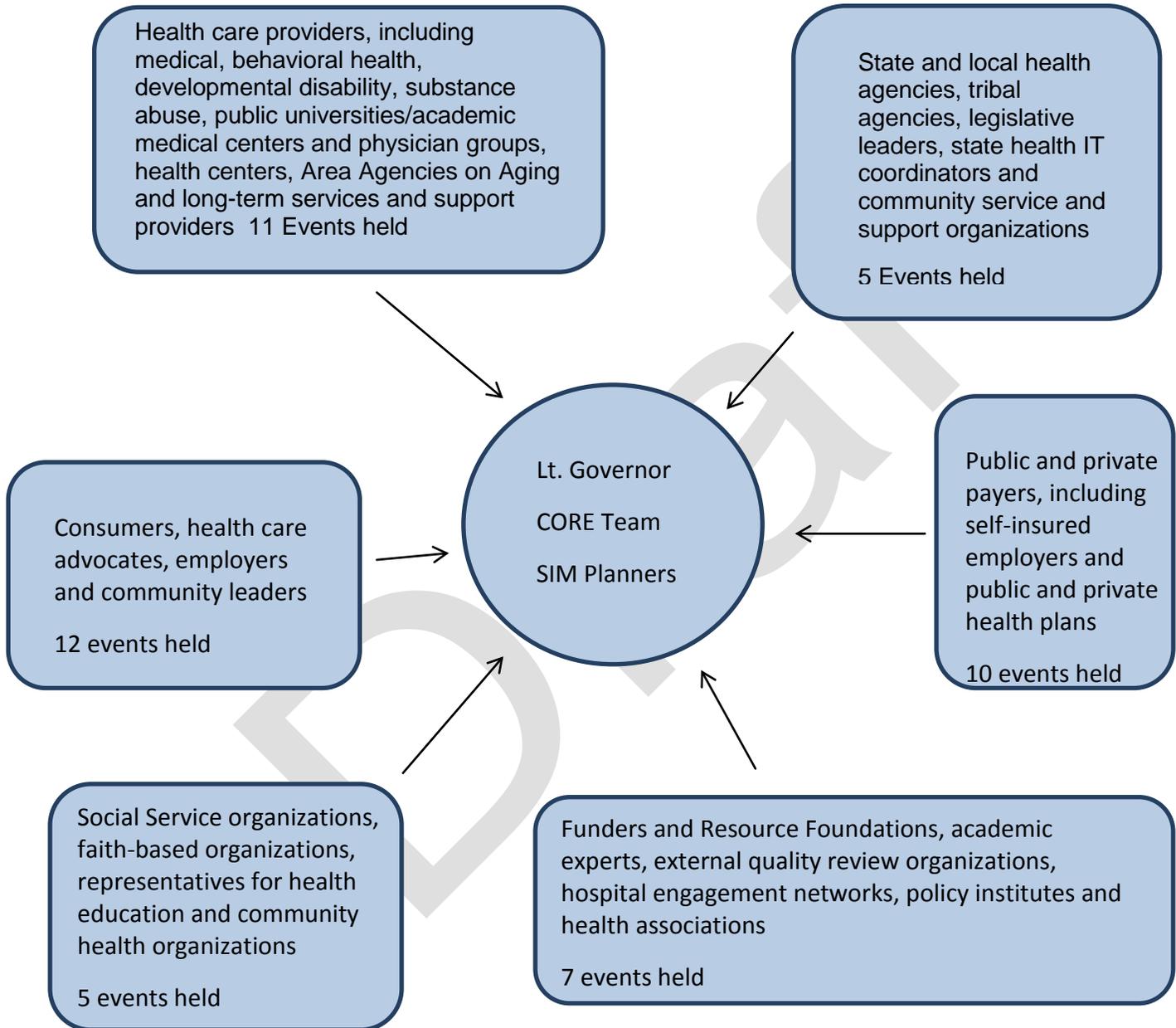
Syndication Phase

A complete draft of the SHIP was posted on November 1st, 2013. After posting, the SIM team returned to many of the above forums and reconvened focus groups to gather feedback on the detailed plan. The SIM planning team held a public forum and accepted written comments on the plan after posting it in the Connecticut Law Journal and on the SIM website.

We recognize that outcomes are better and costs are reduced when care planning is centered on the whole person and consumers have access to information and decision-making tools that assist them in selecting the best treatment choices possible. We know the care experience is central to any positive transformation in our health care system. The process of eliciting and incorporating stakeholder and consumer feedback must be robust. Stakeholder engagement can never be finalized; it must be an on-going and transparent process that continues to critically inform the evolution of health care services in CT. The Consumer Advisory Board of the Healthcare Cabinet was recently reconstituted and will serve as the major coordinating entity to solicit consumer feedback on future stakeholder engagement. However, we will rollout more detailed plan to formalize and strengthen broad stakeholder input to successfully drive quality improvement and enhance the experience of care for all Connecticut residents.

Stakeholders who actively participated in the Design Process

The SIM design process ensured input from a diverse group of stakeholders through various mechanisms in a phased approach that enabled us to successfully include all categories of stakeholders represented below.



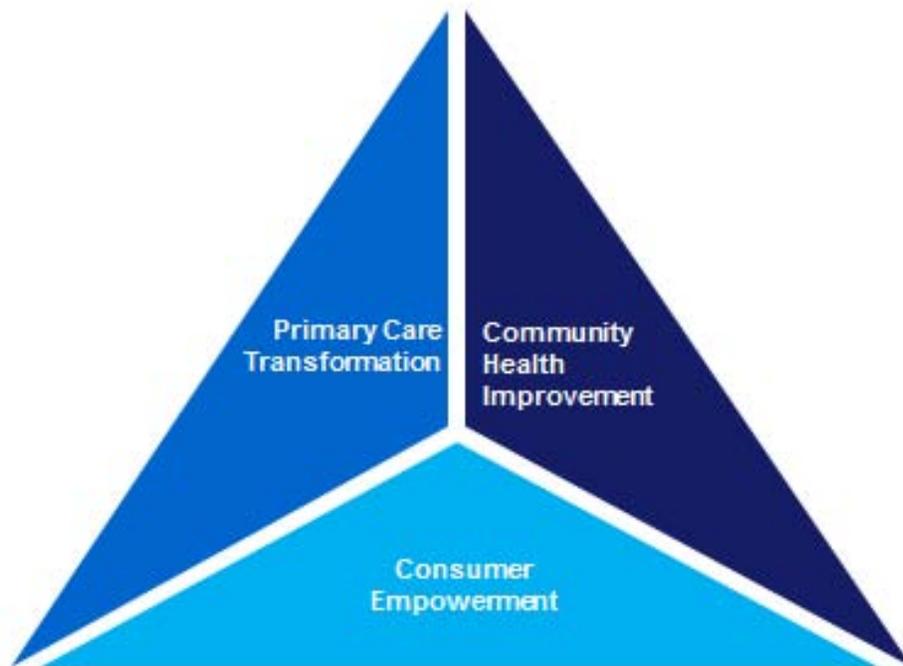


OUR VISION FOR
OUR FUTURE
HEALTH SYSTEM

Primary drivers for transformation

Our State Healthcare Innovation Plan is based on three primary and equal drivers for health system transformation:

- **Primary care practice transformation** to manage the total needs of a population of patients
- **Community health improvement**, through the aligned efforts of community organizations, health care providers, and public health entities
- **Consumer empowerment** to manage their own health, access care when needed, and make informed choices regarding their care



PRIMARY CARE PRACTICE TRANSFORMATION

The Advanced Medical Home (AMH) is the cornerstone of Connecticut's care delivery reform model. Under this model a primary care team coordinates the entirety of a person's care. This model has five core components, described below.

1. **Whole-person centered care:** The AMH model will consider the full set of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health. High-priority changes will include:

- Conducting whole-person assessments that identify consumer/family strengths and capacities, risk factors (e.g., history of trauma, housing instability, access to preventive oral health services), behavioral health and other co-occurring conditions (e.g., early childhood caries), and ability to self-manage care
 - Supporting consumers with person-centered care planning, care coordination, and clinical interventions based on the whole-person assessment
 - Identifying and assisting providers who need to find community-based entities and services that can help provide whole-person centered care
- 2. Enhanced access:** These changes will provide groups that were excluded or had difficulty accessing the healthcare system with care that meets their needs. The model will also expand provider hours and even offer remote consultations. In order to reach previously underserved populations, it is essential to ensure that consumers have convenient, timely, and linguistically/ culturally appropriate care (e.g., primary care practices have care coordinators who speak the languages prevalent among the patient population) consistent with NCLAS standards. High-priority changes include:
- Improving access to primary care through: extended hours on evenings and weekends; convenient, timely appointment availability, including same-day access; and non-visit-based options including telephone, email, text, and video communication
 - Enhancing specialty care access, e.g., by establishing eConsults between specialists and primary care providers
 - Providing clear, easily accessible information on where consumers can go to meet their care needs (e.g., clearly communicated physician locations and hours)
 - Delivering care that is more culturally, socially, and linguistically appropriate for patient populations and individuals (e.g., prevalent language, cultural norms regarding certain examinations)
- 3. Population health management:** Providers can determine which of their specific patient populations are at the greatest risk by analyzing and interpreting the data on the populations in their panel or geography (e.g., by placing consumers in a disease registry). They can then conduct early interventions to halt disease progression (e.g., place diabetics in diet and weight loss programs). Providers will collaborate with community-based organizations to deliver these interventions and adapt them so they provide reduce health equity gaps for various racial/ethnic/cultural populations. High-priority changes include:
- Using population-based data to understand specific risks for one’s own panel, key sub-populations (e.g., race/ethnicity) and individual patients

- Using risk stratification analyses to identify consumers who are at higher risk and then targeting support efforts
 - Maintaining a disease registry
 - Partnering with certified community-based entities and other social service and support entities to address clinical and support needs when necessary
- 4. Team-based coordinated care:** Multi-disciplinary teams offer integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral health care with medical care, whether through co-location or as part of a virtual team. High-priority changes include:
- Developing and implementing a whole-person centered treatment plan (see #1)
 - Providing team-based care from a prepared, proactive team
 - Integrating behavioral health, oral health, and primary care with “warm”, coordinated hand-offs between practitioners (on-site, if possible)
 - Coordinating all elements of a consumer’s care (e.g., coordinate, track, and follow-up on laboratory tests, diagnostic imaging, and specialty referrals; reconcile or actively manage consumer medications at visits and post-hospitalization).
- 5. Evidence-informed clinical decision making:** Connecticut will encourage providers and patients to make clinical care decisions that reflect an in-depth, up-to-date understanding of the evidence regarding the clinical outcomes and cost-effectiveness of various treatments. High-priority changes include:
- Applying clinical evidence to target preventive care and interventions toward those patients for whom the intervention will be most effective
 - Leveraging EHR decision support, shared decision making tools, and provider quality and cost data at the point-of-care to incorporate the most up-to-date evidence into clinical practice, so as to enable patient directed care decisions

Attribution of consumers to providers

Attribution is the process of linking consumers to the providers who will be responsible for their care. We will recommend and support attribution strategies that maximize consumer choice and educate consumers on how to make those choices. The State will also champion attribution methods that accurately reflect the consumer-provider relationship, provide access and accountability for those parts of the population that do not have PCPs, and reward high-quality and timely care.

Based on payer input, we expect most to adopt a retrospective approach to attribution, attributing members to the provider who has given them most of their primary care during a defined reporting period. Members can also select their PCPs prospectively. However, if most of their care during the reporting period was delivered by a provider other than their selected PCP, payers may choose to reassign the member to the provider who provided most of their primary care.

The State will continue refining its attribution strategy so it can determine which providers are eligible for attribution (e.g., all providers billing for primary care activities vs. only primary care providers) and define accountability for behavioral health consumers who see both a Behavioral Health (BH) specialist and PCP (e.g., potentially through dual attribution). It will also maximize access for all consumers regardless of their payer or population type (e.g., behavioral health) and standardize necessary technical details (e.g., frequency of payer reporting of consumer panels' to providers). We will also educate consumers on why they should choose a PCP, how to select a PCP (e.g., various PCPs available, their profiles, strengths, etc.), how care may differ if they select an AMH, and how to make the best use of this new approach to primary care.

Roles needed to implement the new capabilities and processes

Connecticut's AMH model will require a care team of various health care service and support providers. Primary care and behavioral health providers must collaborate closely for this to work. Each team will have a set of "core providers" who handle primary care (e.g., PCPs, APRNs, and care coordinators). Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers, and community health workers. Any other class of caregiver can also be included when deemed necessary.

The model's flexibility allows the consumer's health needs and desires and the structure of the practice or organization to shape the composition of care teams and the accountable provider. It also acknowledges that the leadership of the team may change. The State also encourages caregivers and support staff to collaborate across all types of providers – whether primary, acute, specialist, community, or social care – and leverages community health workers.

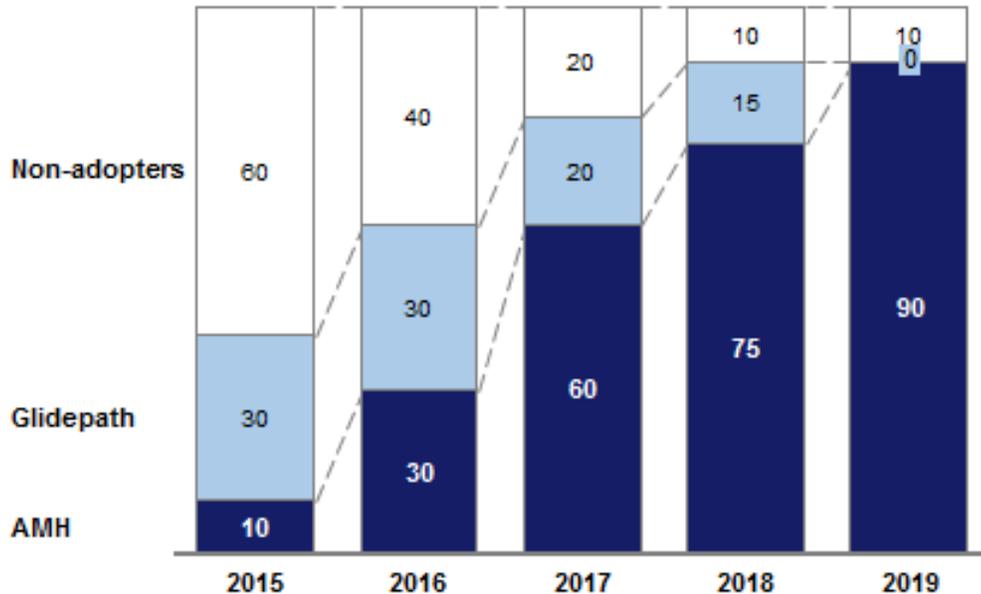
Accreditation and performance paths for providers

The two ways providers will participate in the value-based payment system – as Advanced Medical Homes or as participants in the Glide Path who are working toward accreditation as an AMH – will evolve over time. The majority of providers will start either simply as PCPs or in the Glide Path, with only a small minority as AMHs; however, by Year 5 we aspire that the vast majority will be accredited AMHs (Exhibit 9).

Exhibit 9: Growth in AMH as the Glide Path Providers Gain Accreditation

Targeted Pace of Primary Care Practice Transformation

% of PCPs working toward Advanced Medical Home certification



7

Helping providers achieve the AMH accreditation

Because practices are in very different stages in terms of their ability to meet the standards for becoming an AMH, Connecticut has designed a variety of programs to not only help providers but to make it easy for them to start the transformation. We recognize that this can be daunting for practices, particularly for those who are unsure of what it means for them, and those that are reluctant to invest in an EHR or affiliate with a larger system, including some physicians that are nearing retirement.

We divide providers into two basic groups: those that are already nationally accredited as medical homes and those that are not. Accredited practices will not have to duplicate their accreditation, but may have to meet some additional standards. For all other providers, we created the Glide Path Program to facilitate the practice transformation process. It encourages practices to participate early in the process by setting low conditions for entry (e.g., self-assessment and a statement of commitment). Participants receive support as they adopt advanced practices like whole-person-centered care and care coordination. As they move forward, they are held accountable for meeting milestones and for achieving true practice

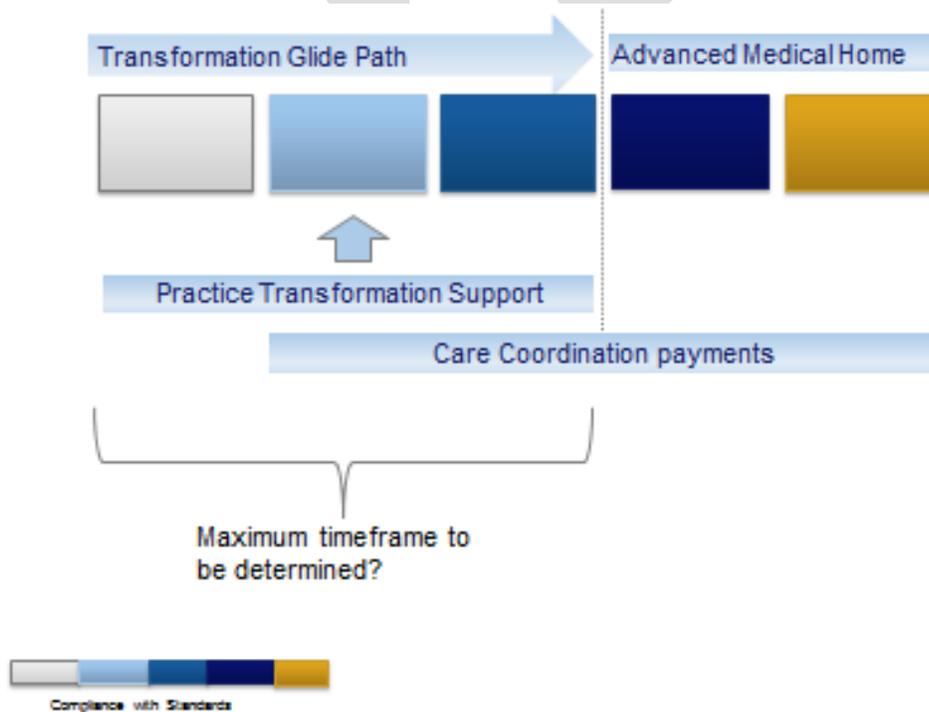
transformation, thus ensuring that cost savings are driven through quality improvements and more effective clinical decisions – not lower quality care.

Providers who are already part of a network or group and participating in an advanced payment reform such as SSP may be given the option to assess existing practice gaps and to take advantage of practice transformation support through the Glide Path Program to achieve full AMH status. This option will in part be dependent on the availability of sufficient practice transformation resources.

The Glide Path holds practices accountable for achieving milestones for practice transformation as a condition for continuing to receive transformation support. Payers' willingness to fund care coordination fees may also be contingent on satisfactory progress against transformation milestones. More advanced practices and provider systems will need to take responsibility for a broader array of quality and performance metrics, responsibility for total cost care via participation in a shared savings program. These standards will increase in number and rigor as providers approach their accreditation (Exhibit 6).

The accreditation standards, which will be defined by the AMH Practice Transformation Taskforce, may be drawn from NCQA, AAAHC, URAC, Joint Commission, Center for Medicare and Medicaid Innovation (CMMI) or other national/local standards which link to practice transformation support.

Exhibit 6: Connecticut's Transformation Glide Path to AMH Status



Provider Aggregation to Achieve Scale and Capabilities

We anticipate that many independent PCPs will need to affiliate with one another in order to gain the scale necessary to efficiently adopt the new capabilities needed to achieve AMH status. They can use a variety of formal and informal clinical integration models to attain the scale they need (Exhibit 10). Their choice of a model will not affect their ability to participate in Shared Savings – only their performance against the standards does that. Throughout this process the State will watch for potential market consolidation and, if necessary, take legislative or regulatory action.

Exhibit 10: Clinical Integration Models to Attain Scale and Capabilities

A Integrated Delivery System	<ul style="list-style-type: none"> ▪ Physicians and hospitals legally and financially integrated ▪ Capital, infrastructure, and clinical integration among physicians, hospitals, other providers ▪ Potential to distribute payment through employment agreements
B Medical Group Practice	<ul style="list-style-type: none"> ▪ Legally and financially integrated physician organization ▪ Capital, infrastructure, and clinical integration among physicians ▪ Potential to distribute payment through employment agreements
C Clinically integrated network	<ul style="list-style-type: none"> ▪ Formal contractual relationship among otherwise independent physicians, hospitals, other providers ▪ Capital, infrastructure, and clinical integration among physicians, hospitals, other providers
D Strong IPA	<ul style="list-style-type: none"> ▪ Physicians derive most or all of their revenue through IPA ▪ Capital, infrastructure, and clinical integration among physicians
E Loose IPA	<ul style="list-style-type: none"> ▪ Physicians and/or hospitals derive only part of their revenue through IPA ▪ Limited capital, infrastructure, or clinical integration among physicians
F Regional cooperatives	<ul style="list-style-type: none"> ▪ Regional cooperative provides clinical and technical resources ▪ Limited capital, infrastructure among participating physicians independently ▪ Regional cooperative <u>may or may not</u> be channel for distribution of risk sharing

Implications for populations with special needs

Connecticut's AMH model will address the primary care needs of most individuals in the state. However, additional interventions are required to meet the needs of various populations who have unique health care needs (e.g., people with complex health conditions). In these cases, our AMH model's flexibility allows us to create tailored options for these populations and add these on at an appropriate time.

The Medicaid population offers significant opportunities. The AMH model and the Integrated Care Demonstration for Medicare/Medicaid eligibles will begin in parallel. Aspects of the Medicare/Medicaid model, e.g., the medical home standards for

participation, may be adjusted to maximize alignment with AMH. In addition, specialized initiatives for older adults and disabled populations who use Medicaid would have a material impact on health care costs given the service intensity and high costs associated with these groups, particularly in long-term care. Among Medicaid enrollees, the spending per enrollee for elderly adults (\$24,800) and persons with disabilities (\$33,000) were the highest in the country. Long-term care costs (49% vs. 32% national average) were the primary driver.³⁴

We will also collaborate with the Department of Mental Health and Addiction Services (DMHAS) as we roll out the AMH model. AMH is complementary to DMHAS's behavioral health home model, which DMHAS plans to implement in 2014. By combining a DMHAS behavioral health provider with an AMH-accountable PCP, the patient would receive excellent, seamless behavioral health and medical care.

An estimated 15% of DMHAS's population will be dually attributed to an accountable behavioral health provider in DMHAS's behavioral health home model and to an accountable PCP in the AMH model. The behavioral health provider will be responsible for the delivery and cost of behavioral health care and the PCP will be responsible for the delivery and cost of medical care. Both accountable providers will collaborate closely. The majority (~85%) of DMHAS's population served by DMHAS providers today will be dually attributed to a PCP under Connecticut's AMH model and to the DMHAS system.

COMMUNITY HEALTH IMPROVEMENT

Connecticut has a rich array of community-based organizations with a deep and unique understanding of the communities they serve. Many community-based programs share a common objective with clinical practices –improving the health of clients whom they serve. Unfortunately, they face multiple obstacles in achieving this goal. Few systems, structures and incentives exist that would help foster collaboration and coordination between clinical practice and community services. Furthermore, it is unclear how prevalent evidence-based community health programs are in regions with vulnerable and high-risk populations. Current data suggests that the need for such programs far outstrips their availability. Finally, many community-based services rely on grant funding, leaving even the highest quality services highly vulnerable to funding cycles and potentially unsustainable.

The State Innovation Model (SIM) in coordination with other ACA initiatives offer unique opportunity to design a focused and coordinated approach to improving community health and reducing avoidable health disparities not easily addressed by the healthcare sector alone. A community health improvement approach is critical to

³⁴ Kaiser Family Foundation, State Health Facts (2009)

the successful achievement of the state's aim of improving the health and healthcare quality of Connecticut's residents, eliminating health disparities, and improving care experience.

Specific strategies proposed to implement the community health improvement approach include:

1. Establishing **Health Enhancement Communities (HECs)** in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities
2. Strengthening community-based health services and linkages to primary health care by establishing a **Certified Community-Based Practice Support Entity**

Health Enhancement Communities

In formulating a strategy for community health improvement, the state recognized three essential considerations. First, the true measure of success in community health improvement lies in outcomes—a reduction in disease prevalence and complications and a reduction in health disparities. Second, holding healthcare providers accountable for such outcomes might result in their avoiding risky consumers, rather than taking on the challenge of prevention. Third, health outcomes are influenced by a multitude of factors, most of which lie beyond the influence of healthcare providers acting alone. The solution lies in elevating the goal of public health improvement, from healthcare provider specific accountability to that of the broader community, and its many participants.

The state proposes the adoption and designation of a geographically bound region characterized as having a high level of health improvement opportunities and avoidable health disparities as Health Enhancement Communities (HECs). An HEC would have sufficient population to allow for reliable tracking of population health measures, contain a significant number of Advance Medical Homes and demonstrate capacity for multi-sector collaboration to address issues of health. The HECs would allow for coordinated and focused efforts from the public health, social service, education and private and non-profit sector to address key drivers of health impairment and avoidable health disparities through evidence-based approaches.

Design and Process

Committed to a community-driven approach to prioritizing community needs and improving health and health equity; SIM will utilize the findings from the State Health Assessment and the recommendations from the State Health Improvement Plan (Connecticut 2020) and CDC supported Coordinated Chronic Disease Plan as foundation to this structure. We will also identify and work with keen local health departments

(LHD) and non-profit hospitals that conduct community health needs assessment in their regions to find shared priorities and alignments with SIM and Healthy People Connecticut 2020 objectives.

The state recommends the creation of three to five pilots, HECs that will be fully operational by the end of 2019. The pilot communities will be identified and selected by using rigorous criteria and valid measures that are in alignment with CMMI and CDC. The proposed SIM Program Management Office will be the coordinating body for this initiative and will work with a multiple health and human service agencies to support design and implementation.

Community-wide population health measures will be incorporated into the common scorecard and value based payment system. The measures will be based on the entire community population, including those who may be attributed to healthcare providers participating in a Shared Savings Program.

Risk selection by providers to enhance scorecard performance is a well-known concern in programs that provide incentives on basis of quality scores. The inclusion of community-population metrics as part of provider scoring and ultimately financial incentives will counter the effect of risk-selection and importantly serve to drive healthcare providers to collaborate and coordinate with other sectors.

High quality, reliable local data will be imperative to inform HEC design and administration. The HEC will require dedicated epidemiologic and data support. Critical data functions would include coordination with health and human service agencies regarding available data sources, ongoing review and analysis of existing data, review of opportunities to enhance data collection and consideration of including emerging data sources.

Connecticut's approach is consistent with the federal aim of creating a Community Integrated Health System 3.0, by encouraging the integration of our healthcare providers with community resources, value-based payments, and support for learning organizations that can rapidly deploy best practices.

Certified Community-Based Practice Support Entity

The State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, herein referred to as Certified Entities. As the title suggests, Certified Entities would support a set of local Advanced Medical Homes with a specified package of evidence-based community services. This structure fosters alignment and collaboration between primary care providers, community-based services and State health agencies. It will also increase the impact of both AMH and community interventions as the literature has shown that a single intervention will not

usually reduce an overall medical or behavioral burden or sustain preventative behavior.³⁵

Certified entities also provide a special opportunity to implement the Institute of Medicine's (IOM) best practices in integrating primary care and public health.³⁶ The IOM recognizes that the degree of integration in communities/states may vary and offers several best practices to help primary care and public health providers decide on which community-based programs/activities to integrate.

Proposed Certification Criteria

The proposed criteria for entity certification will help assure that high quality, coordinated services are available to clients.

Each Certified Entity would:

- ✓ Be responsible for the delivery of a core set of evidence-based community interventions identified by the State Innovation Model (SIM) – see the following section for selected interventions and rationale
- ✓ Enter into formal understanding or affiliations with primary care practices and share accountability for quality and outcomes
- ✓ Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services
- ✓ Meet specified standards pertaining to the type, quality, scope and reach of services
- ✓ Have IT-enabled integrated communication protocols, including bi-directional referrals with affiliated primary care and other relevant providers and health agencies
- ✓ Employ community health workers for their services (Refer to Workforce Development section)

³⁵ A Report on Recommendations of the Task Force on Community Preventive Services: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5410a1.htm> Accessed October 2, 2013.

³⁶ IOM Report 2012: <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

Relationship of Certified Entities with State Health Agencies

We are working hard to break down silos in our workforce by encouraging health agencies to collaborate in their data collection, programs and community investments. State health agencies played a major role in the SIM planning phase and will do so again in the Certified Entity's establishment and community program selections

Quality Assurance and Reporting requirements

The *certified entity* as envisioned would deliver a "minimum package" of services that emphasizes evidence-based interventions that have high potential to improve outcomes and reduce costs. At the initial SIM implementation phase DPH will lead a transparent assessment planning process through engaging key state agency, community and provider groups to develop standards and process for certification. Contingent on stakeholder input, the certifications may be issued directly by DPH or a designated third party. DPH and other involved state agencies will also provide technical assistance and best practices to organizations that are seeking certification or have achieved certification

The AMH will be responsible for outcomes derived from their certified entity as this will affect their overall standard and metrics benchmarks. This is necessary to ensure that partners hold each other responsible for outcomes and to allow certified entities to compete in the market.

Subcontracting by certified entity

As primary care providers improve their outcomes and become AMHs, we expect the demand for certified entity services to grow significantly. We will meet this demand by allowing selected entities to subcontract certain services on a case by case basis.

The choice for a partner to sub-contract with will be left to the sole discretion of the certified entity. However, the sub-contracting entity will also be held accountable for the outcomes.

Strategy to engage/recruit community resources

Efforts are in place to begin the process of educating and/or engaging providers, community based organizations (CBO), consumers and other pertinent stakeholders on the benefits of integrating AMH's and community resources. The first 18 months of the SIM implementation will be crucial as we:

- Initiate a state wide campaign to educate providers and AMH's, who are critical partners to a successful integration on the benefits of such collaboration
- Begin a state wide scan using the Community Transformation Grant to identify existing infrastructure and capable entities that may be appropriate for the initial SIM implementation

- Propose legislation to speed up the CHW certification process (See the Workforce Development section) to ensure that identified entities from the scan have enough CHW to qualify for certification
- Propose legislation that brings CBOs and AMHs to the table to determine and agree to partnership terms that are fair to all parties
- Set up and maintain a state database of certified entities that is accessible to AMH's, certified entities and State health agencies. (See HIT section)

Certified Entity and Health Equity

Certified entities will help address health disparities through a targeted approach. They can deal with environmental quality issues in homes, health behavior modifications, and access to and quality of care. DPH will give priority to placement of certified entities and special attention to areas designated as a Health Professional Shortage Areas (HPSA) and regions/populations identified as high medical utilizers.

Financing Certified Entities

The State is currently evaluating several financial options to ensure that our Certified Entity model is financially sustainable. During the initial phase, we will explore the potential use of existing programmatic state funds and grants as a starting point.

Scaling of Best Practices in Health Improvement

Our State health agencies recognize the importance of linking clinical-community services with population health strategies. To bring this to life, DPH, the Department of Aging, DSS and stakeholders from the Care Delivery workgroup prioritized three community programs that Certified Entities could focus on during the initial stages of SIM implementation. These community-based programs, which already exist, are:

- Diabetes Prevention Program (DPP)
- Asthma Home Environmental Assessment Programs
- Falls Prevention Program

These three programs were selected partly because of the recent, Department of Public Health (DPH) comprehensive, State Health Assessment³⁷. This assessment identified and ranked the leading causes of hospitalization in the state (e.g., diabetes, asthma, injuries). These also correlated to the leading causes of healthcare costs in Connecticut and are core areas of the emerging SHIP. These programs are also basic

³⁷ Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 19, 2013

elements of the CDC's framework³⁸ for preventing chronic diseases and promoting health. This framework also aligns with the State's emerging CDC-supported Coordinated Chronic Disease Plan, which identifies priorities and indicators for these diseases.

Other important criteria included the programs' ability to prevent disease and promote health as well as evidence of their effectiveness and their return on investment (ROI). The State also looked at how much access they provided to quality health services, what their targeted approaches were to individuals or groups, and how much they were able to address or reduce health disparities.

Diabetes Prevention Program (DPP)

An estimated 8.3% or 25.8 million people have diabetes in the United States compared to 163,000 people or 6.2% percent in Connecticut.³⁹ If this situation is ignored in Connecticut, diabetes may lead to disability, blindness, increased healthcare cost and increased mortality.

Connecticut acknowledges that its population is getting older and becoming increasingly overweight and sedentary. To address this public health issue, Connecticut will use the SIM to leverage the existing, evidence-based Diabetes Prevention Program (DPP). DPP increases referrals to, use of, and/or reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes. The DPP may help delay patients' becoming type 2 diabetics by 58%⁴⁰ and can reduce costs⁴¹. Type 2 diabetes accounts for about 90 to 95% of all adult cases. Its treatment protocol focuses on weight control, exercise, diet and medication.

DPH and its partners are committed to supporting and broadening the impact of DPP. DPH will continue to promote the CDC-recognized DPPs statewide, encouraging health care systems to refer eligible participants to them. It will also convene established Connecticut DPP sites two to four times a year to share best practices and lessons learned in implementation, recruitment and retention. DPH and its partners such as the Department of Social Services (DSS), the SIM team and the State Comptroller's

³⁸ Chronic Disease Prevention and Health Promotion Domain:
http://www.astphnd.org/resource_files/477/477_resource_file3.pdf

³⁹ The Connecticut Diabetes Prevention and Control Plan 2007-2012:
http://www.ct.gov/dph/lib/dph/aids_and_chronic/chronic_disease/pdf/dpcp_plan_8_10_07.pdf Accessed August 19, 2013

⁴⁰ Linda M Delahanty, MS, RD, David M Nathan, MD- Implications of the Diabetes Prevention Program (DPP) and Look AHEAD Clinical Trials for Lifestyle Interventions: J Am Diet Assoc. 2008 April; 108(4 Suppl 1): S66–S72.
doi:10.1016/j.jada.2008.01.026

⁴¹ Robert E. Ratner, MD, FACE- AN UPDATE ON THE DIABETES PREVENTION PROGRAM: Endocr Pract. 2006 ; 12(Suppl 1): 20–24

Office will continue discussions to ensure that DPP will be a covered benefit for publicly employed or publicly insured beneficiaries. The current targeted populations are the employed or those receiving services from the 14 DPP-trained institutions (i.e., hospitals, local health). However, we are potentially looking at policy changes that allow DPP to impact a larger population. Literature has shown that the burden of diabetes disproportionately affects the less educated, racial minorities and those regions with fewer resources.

Connecticut is determined to eliminate diabetes-related health disparities. It can start to accomplish this by collaborating with Community Health Centers and other community-based organizations that deal with disparate populations. Certified entities can improve the DPP's outcomes by using Health Information Technology (HIT) to connect closely to the AMHs and incorporate even more evidence-based care into the DPP. We also plan to try and recruit Spanish-speaking leaders and community health workers to help make up the workforce in the new certified community-based organizations to help serve the Hispanic population and other vulnerable populations.

Asthma Home Environmental Assessment Programs

Patients diagnosed with asthma may be exposed to several environmental allergens that may trigger or exacerbate their conditions, especially in their homes. Some of these individuals may be poor, urban dwellers who lack health insurance and hence depend on emergency departments for their medical care. Just as importantly, they may not have received adequate education on how to detect and avoid some of their asthma triggers.

Asthma is an important issue for Connecticut's residents and a significant health care cost. According to a recently published study, 9.2% of adults and 11.3% of children living in Connecticut have asthma. In 2009, Connecticut spent over \$112 million for acute care management of asthma as a primary diagnosis. It also spent \$80.3 million on hospitalization charges and \$32.6 million on emergency department (ED) visit charges in 2009.

The U.S Environmental Protection Agency encourages individuals and communities to participate in decisions about a proposed activity that will affect their environment and health. To make this possible, the DPH administers and local health departments carry out asthma home visit and environmental assessment known as "Putting on AIRS". The program has already produced results, decreasing the number of asthma-related emergency department visits, visits to health care providers and missed days of school/work due to asthma.⁴²

⁴² KIMBERLY H. NGUYEN, M.S., M.P.H. et al- Quality-of-Life and Cost-Benefit Analysis of a Home Environmental

Asthma Indoor Risk Strategies (AIRS) is a free, in-home asthma education and environmental home assessment program provided by a certified asthma educator and an environmental specialist. It improves patient/family asthma recognition and self-management skills through education and interactive interventions that identify and decrease exposure to asthma triggers in the home. It also teaches patients how to properly use their medication devices to administer prescribed asthma medications.

AIRS is a statewide regional program currently conducted through local health departments. Current AIRS partners are Northeast District Department of Health, Naugatuck Valley Health District, Milford Health Department, Ledge Light Health District, Central Connecticut Health District and Stratford Health Department. The State is currently encouraging qualified entities operating in vulnerable communities to apply for certification and thus expand the program's accessibility.

Falls Prevention Program

Injuries to the musculoskeletal system are one of the leading causes of hospitalization among the over 64 year age group in Connecticut.⁴³ The fact that the chances of falling and being seriously injured increases with age is well documented. In one estimate, Connecticut spends \$119 million more every year on home or nursing home long-term care for older adults who sustain a fall-related injury.⁴⁴ This is also a national trend, with the United States spending \$28 billion annually on fall victim treatment. If the rate of falls is not dealt with urgently, the direct and indirect treatment costs in the United States will be an estimated \$54.9 billion annually in 2020.⁴⁵

The Connecticut State Legislature tried to address this issue as it examined the State's shifting demographics. As part of this effort, the Department of Aging helped fund the Yale University's Connecticut Collaboration for Fall Prevention (CCFP). This program works with community-based sites, faith based organizations, home care agencies, outpatient rehabilitation centers, senior centers, assisted living facilities, hospitals and providers. The program uses a standard curriculum and protocol with a "train the trainer" approach; this makes it easy for the partner organization to maintain the program and keep working with consumers. The primary risk factors that providers

Assessment Program in Connecticut: Journal of Asthma, Early Online, 1–9, 2010:

http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/kims_final_published_airs_in_ct.pdf Accessed August 20, 2013

⁴³ Lisa Wolff ScD-Connecticut State health Assessment: http://www.ct.gov/dph/lib/dph/state_health_planning/ship/coalition_kickoff/ct_sha_prelim_rev020413.pdf Accessed August 26, 2013

⁴⁴ 2006 analysis prepared for the Long Term Care Planning Committee regarding the costs of falls among older adults in Connecticut

⁴⁵ Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. Journal of Forensic Science 1996; 41(5):733–46. The Gerontologist 1994; 34(1):16–23.

look for are such things as vision problems, balance impairments, postural hypotension, use of four or more medications and home hazards.

Interventions that may be considered in the future

As community-based services become more integrated with primary care, we envision stronger, more innovative and more cost-effective certified entities. The projected cost savings and the innovative quality health experience expected will be due in part to the solid foundation of the SIM, but mostly from the effect as more AMHs participate more actively in integration.

As this occurs, we will use our selection framework, the annual health equity scores from the State regions and the State health assessment to help us select which interventions and programs to roll out and when.

CONSUMER EMPOWERMENT

The delivery of truly whole-person-centered care requires transformation in how providers and payers respect and enable a person's right to be active participants in the promotion and management of their own health.

In order for individuals to make the best health decisions for themselves and their families, a true working partnership must be developed between the individual and their provider. Every consumer has unique insights into the daily issues, both medical and non-medical, that can compromise their health. They also have control over the daily decisions they make that contribute to their health and well-being. Providers possess the medical background to recognize and diagnose illness and suggest treatment options. Together, these two perspectives form the most effective partnership for making health-related decisions.

SIM provides a unique opportunity to transform the partnership model between consumers and providers today. Consumers have reported barriers to engaging with their providers due to inconvenient appointment times, time constraints, during visits, limited methods for inter-visit communication, and transportation issues. Consumers also tell us that providers sometimes fail to understand their needs as a whole-person. At the same time, consumers have difficulty understanding medical information provided to them due to language and literacy barriers, limited tools to support decision-making, and a lack of quality and cost information.

Opportunities to engage consumers also exist outside of the care delivery system. For example, the conventional benefit designs used by many payers and self-funded employers do little to encourage consumers to invest time and effort in health-promoting behaviors, such as actively seeking preventive care, effective management of chronic illness, reducing smoking and other high risk behavior, and choosing among treatment options and providers that offer the highest value.

Looking beyond health care and benefits, we believe it is important to begin to promote methods for improving diet and exercise, health behaviors that have a great deal to do with the emergence and control of chronic illness, but which are notoriously difficult to influence through the care delivery system. Our initial steps in this direction focus on pilot initiatives to promote nutritional purchasing and healthier eating.

Through our extensive stakeholder engagement process, we have assembled a robust understanding of the identified needs and created mechanisms to address the issues. The state will ask participating providers and payers to jointly execute a four-pronged strategy:

- Implement formal mechanisms for on-going consumer input and advocacy
- Provide consumer information and tools to enable health, wellness, and illness self-management
- Introduce consumer incentives to encourage healthy lifestyles, high value healthcare choices and effective self-care
- Improve access to health services

Mechanisms for consumer input and advocacy

The impact of care delivery and payment transformation on both the experience of care and on outcomes will be a central concern in the implementation and continuous quality improvement of our state's AMH model.

Currently, care experience is not a factor used by commercial payers in their value based payment models. Participating payers will track the impact of the AMH model on the experience of care by implementing and collecting care experience surveys and linking pay for performance and shared savings program payment to scores on these surveys.

In addition, the SIM project management office will formally engage the Health Care Cabinet's Consumer Advisory Board to provide ongoing input into the design, implementation and future changes to the SIM program model. The board will also help to identify potential issues and concerns and craft resolutions.

AMH practice standards will also promote effective methods for engaging consumers in providing feedback to the practice in order to support the continuous improvement of care processes and care experience, including a focus on welcoming, engagement, communication, person centered care planning and shared decision making.

Finally, our Equity and Access Council will examine current opportunities for consumers to report concerns about denial of service or under-service and will make recommendations as to whether and how mechanisms additional or more user-friendly methods can be established.

Enhanced consumer information and tools to enable health, wellness, and illness self-management

In order to partner effectively with their providers, consumers will need more health information shared in a timely manner. At the same time, they will need the appropriate tools that enable them to act on this information.

Some practices in CT have already established consumer portals and the feedback has been positive. These portals enable consumers to access their clinical data such as lab results as well as educational materials on illness self-management and health management. The SIM project will facilitate the expanded use of consumer portals with the integration of information from various provider settings. Expansion in access to such portals will emphasize interactive communication with the primary care practice team including the ability to clarify the care plan, ask about a change in condition or solicit additional explanation of test results.

The market is rapidly producing a range of decision support tools to better enable consumers to understand screening, diagnosis and treatment options and make decisions based on this better information and consideration of their own preferences and goals. Our practice transformation standards and technical assistance process will include elements that focus on person-centered care planning and the incorporation of decision support tools into the practice workflow. We will focus on the use of robust tools that meet minimum quality standards, e.g., that are evidence based, have high utility in practice settings, are adaptable for varying levels of health literacy, and can be tailored for culture, race, ethnicity, or disability status. The Choosing Wisely initiative offers provider and consumer-friendly educational materials on how to engage in conversations on whether a treatment option is the right treatment for an individual consumer. Materials produced by Choosing Wisely are among those that we intend to support, including partnering with private foundations and Consumer Reports to improve the utility of these tools with varying populations.

Selection of treatment settings and providers will be increasingly important as consumers become more sensitive to variations in quality and price for healthcare services. Accordingly, our health information technology reforms will focus on improving the measurement and dissemination of quality and cost information, initially focused on hospitals services and expanding from there to include services provided by specialists.

Finally, we will develop curricula designed to educate consumers about their role in a more person-centered, information rich, and transparent healthcare system. Payers and employers have specifically requested that SIM play a role in the development of these materials, which we believe will also be of interest in community colleges and other adult education settings.

Consumer incentives to encourage healthy lifestyles and effective illness self-management

There are few incentives today for consumers to invest the time and effort to make healthier lifestyle decisions and to partner with providers in proactively managing their health and illness. Connecticut intends to pursue two strategies that promise to improve consumer engagement in their healthcare and in nutritional awareness and purchasing.

Value-Based Insurance Design (VBID)

For many years employers have attempted to limit their health insurance costs, in many cases by shifting an increasing share of the costs to employees. While this strategy has limited employer cost, it has done little to slow the growth in spending. In many cases, because employees were required to pay higher deductibles and copayments, they put off needed care, which can lead to an increase in future cost for both employees and employers. VBID is one method to encourage consumer participation in health and wellness by providing incentives (positive and negative, dependent on program design) to choose high-value health care.

Overview of the State of Connecticut Employee Health Plan

The State of Connecticut Employee Health Plan implemented value-based insurance design (VBID) as an integral part of the Health Enhancement Program (HEP) in September of 2011. This program was established under a collective bargaining agreement covering health and pension benefits, and extended to non-bargaining unit employees and elected officials.

HEP is designed to enhance the ability of patients, with their doctors, to make the most informed decisions about staying healthy and, if ill, to treat their illness. Any medical decisions continue to be made by the patient and his or her physician.

Participation in the HEP is voluntary for all employees and retirees, including dependents enrolled in the Plan. The HEP requires those who enroll to:

- Comply with a minimum schedule of wellness exams and screenings.
- Participate in disease counseling and education programs specific to their condition:
 - ✓ Diabetes, both Type 1 and 2
 - ✓ Asthma and COPD
 - ✓ Heart failure/heart disease
 - ✓ Hyperlipidemia

- ✓ Hypertension
- ✓ Annual dental cleaning

Participants enrolled and compliant with the program are eligible for reduced or waived copayments for prescription drugs for their specific condition, and waived office visit copayments for the evaluation and treatment of their condition. An employee whose enrolled family members have any of the specified conditions, and are compliant with HEP, receives an annual payment of \$100.

Employees, and retirees whose retirement date is after the effective date of the program, who do not enroll in the HEP, or who are removed for noncompliance, are required to pay \$100 per month in additional premium, and subject to an annual deductible of \$350 per person/\$1400 maximum per family for services not otherwise covered by copayments.

The State Employee Health Plan and the HEP are overseen by the joint labor-management Health Care Cost Containment Committee. The Plan is administered by the Office of the State Comptroller (OSC), and HEP compliance is monitored by a vendor. Enrolled employees can access a secure patient portal provided by the vendor, where they can review their program compliance and view and download educational materials relevant to their specific conditions. Neither OSC nor the employee's agency staff has access to a participant's personal health information.

Employee participation is now 98% for active employees and eligible retirees; and of those enrolled, there is a 98% compliance rate. Anecdotal feedback from primary care providers indicates that participants are more engaged in their care and more inquisitive about their health status.

OSC is currently reviewing utilization and cost data from the past two years to measure the effect of the HEP and other structural changes to the Plan, in comparison to the periods prior to the program. Preliminary data indicates positive results:

- 35% increase in preventive service visits for established patients, and a 6% increase in E&M visits for non-preventive services over a three year period
- 4% decrease in emergency department services for Employees, but continued increases for Retirees not subject to HEP.
- 6% decrease in the hospital admission rate and a 4% decrease in the inpatient days rate
- reduction in the total medical cost trend from 7.6% prior to the HEP, to 2.2% for the current year

The HEP program was introduced as part of a larger transformation of the state employee health plan that included maximizing use of PCMH's and changes in

emergency department copayments. These other changes may also affect the measurement of the HEP changes effect on utilization and cost.

Integrating Value-Based Insurance Design (VBID) into Connecticut Health Care

Many leading national employers implemented elements of value-based insurance design over the past few years, but few with a large employee presence in Connecticut. Larger employers based in Connecticut with VBID programs include General Electric, Pitney Bowes, United Technologies, The Hartford, and Stanley-Black & Decker. United Healthcare and CVS Caremark both of which have a large retail presence in Connecticut have also implemented VBID programs for their employees.

In Connecticut, VBID programs have been limited mostly to self-insured employers, partly because state insurance regulations prohibited certain practices common to VBID programs. However, the wellness provisions of the ACA preempt some of those regulations. The State will identify other regulations that may hinder the progress of further VBID implementation.

Building on the experience in the design and management of the HEP Program, the Office of the State Comptroller will organize a taskforce including employers with medium to large size workforces in Connecticut and the four major insurance carriers to review VBID programs in place in Connecticut and other states. We will design a suggested menu of VBID options that insurance carriers can offer to employer groups on either an insured or self-insured basis, and explore the needed infrastructure and support to these companies may require. The goal is to demonstrate that a well-designed and implemented VBID program can improve the effectiveness of the State's SIM model for employees who are incentivized to actively participate in their health care.

Rewards for Nutritional Purchasing

Food purchasing and diet are among the most difficult behaviors to influence and yet diet is widely recognized in the public health literature as one of the main contributors to chronic illness prevention and effective management. We believe that incentive based programs hold promise in changing food purchasing and eating habits and we intend to support several pilots during the two years of our SIM initiative using systems for indexing overall nutritional quality.

The NuVal Nutritional Scoring system scores food items with a number between 1-100 based on the overall nutritional value of the food. Yale University led the development of this pioneering system, which has been adopted by two food retailers in Connecticut. As part of our vision for activating consumers in the area of nutritional purchasing, we will pilot the integration of NuVal nutritional scores with nutrition coaching and employer incentives to promote the purchase of foods with higher nutritional scores are rewarded. We will coordinate a partnership with payers to support the evaluation of these pilots with respect to health outcomes and cost-

effectiveness. Depending on the results of the evaluation, rewards for nutritional purchasing may be adopted as part of the recommended VBID or as an independent employer administered health incentive initiative.

In parallel with the above effort, the Office of the State Comptroller will be examining other options for incorporating diet and nutrition programs into the HEP. This will include consideration of other systems for indexing overall nutritional quality.

Rewards for nutritional purchasing through employers could reach a substantial portion of Connecticut residents, but this approach alone would not provide the broad reach that we are seeking to achieve through CT's SIM initiative. The Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) is the nation's most important anti-hunger program. In 2012, it helped almost 47 million low-income Americans to afford a nutritionally adequate diet in a typical month. After unemployment insurance, SNAP is the most responsive federal program providing additional assistance during economic downturns. It also is an important nutritional support for low-wage working families, low-income seniors, and people with disabilities with fixed incomes. The Department of Social Services will explore with the US Department of Agriculture the option of implementing a nutrition rewards pilot program within SNAP using an evidence-based overall nutritional quality index.

Improved access to health services

A material barrier that prohibits a subset of consumers from participating in their care today is the lack of access: consumers have difficulty making appointments with their providers during regular business hours, and/or have difficulty securing transportation to the physician's office.

Glide Path and AMH providers will be encouraged to decrease structural barriers to health care access. Glide Path accreditation standards and AMH provider performance scorecards will measure providers' abilities to provide non-visit based options such as test messaging, emails, and phone calls. In addition, providers will be required to open for extended hours and offer same-day appointment options to their panel of patients. In addition, payers and providers will encourage the adoption of non-visit based specialty consultation options such as e-consultation.

In addition, as detailed elsewhere, the State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, which would partner with AMH's to provide improved access to evidence-based community services, such as diabetes prevention, in-home environmental assessments for asthma, and help in preventing falls among older adults or other individuals at-risk of falling as a result of health conditions.

Finally, an Equity and Access Council will be established to help ensure that the care delivery and payment reforms do not result in unintended reductions in access for

particular populations or inappropriate reductions in service for particular populations, procedures or conditions.

Draft

Enabling initiatives

Connecticut's three primary drivers for innovation are supported by four enabling initiatives, which provide the infrastructure, systems and resources to bring primary care practice transformation, community health improvement, and consumer empowerment into action. Each enabling initiative plays a distinct role. Performance transparency ensures that all participants (including consumers) understand how they and the system are doing and fosters individual accountability. Value-based payment builds off this accountability and rewards providers who deliver high quality, whole-person centered care that also controls costs. Health information technology is vital in connecting all the different groups in Connecticut – consumers, providers, payers, state and regulatory entities, and communities. Finally, our workforce development initiative will seek to ensure that we have the right number of people with the right skills and capabilities for the future.

PERFORMANCE TRANSPARENCY

Throughout the design process, diverse groups of stakeholders have told us repeatedly that increased transparency into costs and quality is a fundamental pre-requisite to improving our health system. Our strategy for achieving this goal involves a common performance scorecard, beginning with primary care. It will use data that is aggregated across payers, with risk adjustment and exclusions as appropriate, and offering multiple reporting levels to inform a wide range of health care decision makers.

1. Common performance scorecard to increase consistency. In the months ahead, a common performance scorecard will be established, including measures of health status, health equity gaps, quality of care, consumer experience, costs of care and resource utilization. Consistency of measures across payers will reduce business complexity and administrative costs for providers associated with reporting.

2. Beginning with primary care and moving outward. The scorecard will initially focus on key process and outcomes measures related to quality, equity, care experience, cost, and resource efficiency within the primary care setting. Over time, additional data elements will be added to support our goals for community health improvement and consumer empowerment, in particular informed choice of specialists and hospitals.

3. Aggregation of data across payers to increase reliability of measures. Data underlying the common scorecard will be aggregated across Medicaid, Medicare, and participating Commercial payers. Doing so will allow for larger “sample sizes” that will more reliably reflect a provider's true performance. Over time, we may also work toward consolidated reporting which will be more efficient for payers, and more practical for providers than accessing multiple payer reports.

4. Multiple levels of reporting to inform decision making. Performance will be reported at multiple levels to inform decision making by consumers, providers, and payers at the point of care, point of purchase of health insurance, and as part of program development efforts. This will include: isolation of patient-level data; comparative analysis of population segments; provider-to-provider comparisons; plan-to-plan comparisons; and state and regional summaries.

VALUE-BASED PAYMENT STRATEGY

Providers who meet specific thresholds on quality, cost, and equity metrics, or who improve their historical performance will be compensated for providing high-value care. Under all models, providers must achieve pre-determined thresholds for quality of care in order to earn shared savings or bonus payments.

Shared Savings for Advanced Medical Homes

The State will allow Advanced Medical Homes to qualify immediately for shared savings program participation. They will possess:

- Accreditation under a set of standards for a medical home
- Clinical integration (e.g., an integrated IT platform, a physician portal, physician alignment, nursing collaboration, and governance structure)
- The ability to manage population health (e.g., predictive analytics, risk stratification, prevention, outcomes tracking, disease management, coordination with community programs, and concurrent review)
- Financial risk management (e.g., cost and utilization analytics/ benchmarking)

In some cases, provider organizations may already be adopting shared savings arrangements with Medicare and/or private payers though they have not yet achieved the level of capabilities associated with an Advanced Medical Home. The State does not wish to disrupt such arrangements; however, we will nonetheless encourage these providers to work toward AMH status and capabilities as a strategy for improving quality and care experience while succeeding under shared savings.

Shared savings payment models offer a range of benefits that will help increase the quality of care in Connecticut and reduce waste in the system. Value-based payment tightly aligns provider and consumer interests by rewarding primary care providers for considering the needs of the whole person and partnering with consumers to improve their health. This model also increases providers' accountability for high quality care that prevents disease exacerbation, readmissions, and redundant care (e.g., duplicate tests). Denial of necessary care is discouraged because providers are responsible for the downstream impact of withholding necessary care. In addition, we will adopt advanced analytics to identify outliers for underuse. In addition, as discussed in the

performance management section, providers will be rewarded based on both their quality and efficiency performance.

Under the shared savings model, providers will take on accountability for total cost of care. Total cost of care is defined as the full set of health care costs associated with an individual's health care delivery, including: professional fees, inpatient facility fees, outpatient facility fees, pharmacy costs and ancillary costs (e.g., lab tests, diagnostics).

- Payers and providers may select from various risk levels when adopting the Shared Savings model:
 - Upside-only: where providers are eligible for smaller bonuses but do not share in risk), which physician-led ACOs with limited capital may favor. (Upside-only arrangements meet the requirements of our model.)
 - Risk-sharing: where providers are eligible for a greater share of savings and a share of risk (not applicable to Medicaid), which hospital-based ACOs may use to help offset lost margins associated with reductions in hospital volume

The Connecticut AMH model will include exclusions and adjustments to ensure that consumers with exceptional or unpredictable service needs do not unfairly affect providers' performance measures. Both payers and providers will have approved these adjustments. For example, shared savings models typically exclude individuals who require organ transplants or who have experienced a significant traumatic injury. This makes sure that providers are held responsible only for those outcomes that they can manage effectively in their partnership with the patient.

Pay for Performance Program

Participation in shared savings tied to total cost of care typically requires a minimum patient panel size of 5,000 or more patients. Smaller providers may not meet these panel sizes, unless and until participating payers resolve how to aggregate performance for purposes of measurement and rewards. In the interim, many providers—especially those earlier in the development of AMH capabilities, may favor a pay-for-performance program structured around bonus payments tied to discreet measures of resource utilization in addition to the same measures of quality and consumer experience to which the Shared Savings Programs will be tied.

Up-Front Investment in Care Coordination

Some providers lack the investment capital necessary to fund new capabilities and processes, or to weather the transition costs on practice productivity that can arise during a change in business models. In addition to the technical assistance that the State will provide through practice transformation support, payers will be encouraged to fund new responsibilities for care coordination through up-front fees, paid either on

a per-member-per-month (PMPM) basis or through enhancements to the fee schedule. Such payments should be based on providers meeting mandatory pre-requisites (e.g. meaningful use of EMR) as well as progress milestones for practice transformation. In some cases, providers may elect to waive care coordination fees and practice transformation support in favor of higher levels of shared savings rewards.

Guidelines for Payer Reward Structures

Each payer will determine their reward structure's specific targets, pricing, and risk levels. However, Connecticut provides a set of guiding principles for the structures' design:

- Both P4P and Shared Savings should deliver meaningful rewards that will support the capability building needed to transform the delivery system
- Both P4P and Shared Savings should reward both absolute performance and performance improvement
 - For select measures of quality and efficiency, providers will need to achieve a minimum level of performance in order to receive rewards
 - The level of the reward will be tied to the degree of performance or improvement beyond the minimum acceptable level
 - Providers that achieve distinctive performance may continue to earn rewards on a sustainable basis, without further improvements
- Glide Path providers should have an opportunity to earn rewards in the first year based on quality performance alone; rewards in subsequent years should require performance on both quality and cost savings

Data Aggregation to Measure Provider Performance

Given the market competition among Connecticut's payers, only the largest providers currently have patient panel sizes that are large enough to reliably measure total cost of care. Even resource utilization measures to be used in pay for performance programs may require patient panels that small practices can only meet for their largest payer. In order for pay-for-performance programs to gain adoption among smaller market share payers, it will be necessary for payers to aggregate data for performance measurement and reporting. Defining the technical details of payer data aggregation will be among our key objectives in the months ahead to prepare for launch of the new payment models.

Ensuring Equity and Access

Medicare, Medicaid and to a lesser extent commercial payers have made substantial and ever increasing investments to counter the excessive utilization that is endemic to our fee-for-service payment system. The focus of these activities, commonly referred to as audit or program integrity, is on a broad range of excess service issues. Payers rely on administrative data and advanced analytics to identify billing outliers (providers whose patterns of service activity differ from their peers) or unusual trends in utilization that might signify inappropriate services by major provider systems or segments (e.g., home health care, personal care) of the market.

As Connecticut pursues a shared savings program, there is the possibility that a few providers might seek savings through inappropriate methods. These include reducing necessary access, adverse risk selection, lowering quality of care, cost shifting, withholding appropriate care or inappropriate referral practices. Quality metrics will help guard against this for target conditions (e.g., diabetes, asthma). However, they may not prevent more systematic efforts to under-serve, particularly for uncommon conditions, or any conditions that are outside the scope of quality improvement metrics.

We believe that it is important to establish an integrity-like function that focuses on these issues of risk avoidance and under-service, including establishing guidelines for consequences of under-service (e.g., may lead to discontinuation of shared savings participation or network disenrollment).

Moreover, we believe that these functions should be separate and apart from quality measurement and continuous quality improvement activities, which should focus on targeting opportunities for improvement and expanding the core measurement set. To this end, Connecticut proposes to establish an Equity, Access and Appropriateness Council, comprised of consumer advocates, payer-based experts in audits and advanced analytics, and clinical experts and researchers from the state's academic health centers. The task of this Council will be to recommend an audit strategy and methods that will help guard against these risks and to encourage payers to adopt such methods on or before implementation. The state anticipates that payers will expand or repurpose existing audit resources to support the recommendations of this council.

The Equity and Access Council may also recommend circumstances under which the findings of audit processes might result in disqualification from value-based payment rewards such as shared savings or other penalties or sanctions.

Connecticut is excited by this opportunity to develop innovative methods to prevent under-service and believes that the work done here can serve as a national model.

HEALTH INFORMATION TECHNOLOGY

Health Information Technology (HIT) is a critical enabler of care delivery and payment innovation. When consumers, payers and providers have easy access to integrated clinical, claims, and population health data, they can make better health care decisions. This will lead to improvements in Connecticut's health care quality, cost, and patient experiences.

Although a variety of HIT assets currently **exist** (e.g. databases, interfaces, tools), they are akin to **separate systems** rather than the integrated, accurate system that Connecticut needs. They focus on subsets of the Connecticut population or collect incomplete/ lower-quality data that is difficult to act on. In addition, few of the payer, provider and health agency systems are linked, which makes it difficult to share information between them.

HIT **supports** every element of our **vision**. It facilitates whole-person centered care by helping providers stratify consumers and develop tailored care plans and uses telehealth and other technologies to enhance access for all populations. Its ability to share useful data at the point-of-care and enhance communication expedites team-based coordinated care and evidence-informed clinical decision making. It is also a crucial element of ongoing performance management and consumer activation. In the former, it provides the mechanism for measuring and communicating provider performance to payers, providers and consumers; in the latter, it provides many of the channels where consumers can obtain their information and connect with their providers.

Connecticut's pragmatic approach to developing its HIT will help it provide immediate support to the proposed care delivery and payment model. The State will first ask payers and providers to leverage their existing analytics and other technology-related capabilities; this prevents unnecessary investments in a common infrastructure, which would be duplicative, expensive and time-consuming.

However, Connecticut will invest in a shared consumer and provider portal that makes it convenient and easy to access standardized provider performance scorecards and other important information. The State will encourage smaller practices to take advantage of a 21st century HIT infrastructure by simplifying technology procurement through vendor prequalification and standardization and educating them about their options. This program is designed to accelerate technology adoption among this group and encourage them to transition to the AMH model.

How HIT Supports the AMH Delivery Model, Consumer Empowerment and Enablers

As one of the four enablers of Connecticut's care delivery model, HIT's support of some of the components is particularly important:

- **Whole-person-centered care:** Payers will collaborate in the development of common assessment tools for defining patient needs, encompassing primary care, behavioral health and oral health care, and social supports, among others. Under the new system, consumers' values and preferences will play a prominent role when they and their providers make health care decisions. This requires that they be fully informed about the risks and benefits around their treatment choices. We will use connectivity and care management / member engagement tools to provide the majority of Connecticut's residents with the information they need to accomplish these goals.
- **Enhanced access.** Payers will provide consumers with access to channels (e.g., web portals, apps) that offer customized guidance and shared decision aids to help them make their care choices (e.g., which providers may best match their needs, what diagnoses mean, which types of treatment are appropriate). Providers will employ secure e-communications (e.g., email) and use e-consults to increase consumer's access to specialty care. Consumers will also be able to use these tools to interact with members of their care team as they review their medical information, care plans and any other recommendations based on their unique needs.
- **Population health management.** Payers will make claims-based analytics available to providers so they can segment consumer populations based on the consumers' expected utilization of health resources. Providers can then identify those consumer groups that will most likely benefit from increased care coordination. They can also use technology to conduct a joint analysis of clinical and claims data. Providers can use the results to identify times for care interventions (e.g., vaccination reminders) and follow-up activities. They can analyze their effectiveness with various sub-populations and use this information to support continuous quality improvement.
- **Team-based, coordinated care.** Direct messaging will promote provider communication across care settings. In the long-term, EHR-based clinical data exchange will ensure that providers always have access to patients' past care information, even when the patients visit different sites of care. Information on in-network/area specialists' and acute care facilities' performance (e.g., on quality, cost and utilization) will help providers support consumer's health decisions more effectively.
- **Evidence-informed clinical decision-making.** Providers will receive analytic reporting to identify gaps in care (e.g., missing cholesterol screenings for consumers with cardiac disease). This data is much more concrete and actionable than evidence-based care guidelines, which do not provide data on individuals.
- HIT also supports several of the enabling initiatives, including: **Performance management.** HIT will expedite and communicate the analytics and reports that assess and monitor provider performance. As mentioned before, these reflect

quality (e.g. number of well child visits, preventive screenings), cost, and utilization; together, they facilitate providers' adoption of accountability and transition to the shared savings model.

What Will Help Connecticut Succeed with HIT

Connecticut's care delivery and payment redesign will be distinctive as it transforms our healthcare system to a whole-person centered, cost-effective one that starts to resolve the long-standing health and health care inequities in our state. To achieve this, we will ensure that all providers, regardless of size, have access to the technology they need to successfully transition to the new model. Our HIT strategy also leverages many of Connecticut's unique strengths.

- 1. Concentration and capabilities of health care leaders.** We can leverage best practices and capabilities (e.g. advanced research, tools, and infrastructure) from our prestigious academic medical centers and the large, national health insurers who are based here.
- 2. Cross-payer commitment.** The State will seek public and private payer commitments to gain the momentum it needs to successfully roll out the cross-payer HIT infrastructure. The high level of collaboration that already exists between Medicaid and the largest commercial payers (who account for 85% of commercial lives) is already making this possible. Specific mechanisms will include a standardized approach to analytics that reduces providers' administrative burden and a single interface/portal to exchange information with providers.
- 3. Engaged consumer base.** Connecticut will take advantage of its broad, diverse and engaged consumer stakeholder community as it tries to accelerate the public's adoption of consumer-facing care technology. HIT technology could provide consumers with knowledge about health and health care, offer cost and quality performance information on their providers, and help them make joint decisions with their providers and care coordinators.
- 4. Strengths of the public behavioral health system.** DMHAS has already implemented a web-based data information system – the DMHAS Data Performance (DDaP) system. DDaP is a centralized repository of demographic, clinical and service information for over 100,000 clients each year. Approximately 150 Private Non-Profit (PNP) providers enter the information, which DMHAS analyzes to assess quality and resource use. DMHAS will operationalize an EHR for its State-operated facilities in the first quarter of 2014.
- 5. Robust HIT governance in the state.** The State is in the process of developing a mechanism for coordinating HIT across state agencies, filling in any gaps, and focusing the use HIT on improving health outcomes long-term.

HIT Capability Assessment and Roadmap for Building Them

To achieve the full potential of the AMH transformation, Connecticut’s payers and providers will need to deploy a wide range of HIT capabilities. These include payer analytics, consumer and provider portals, clinical healthcare information exchanges and provider-consumer care management tools.

While Connecticut payers and large providers have significant capabilities today (e.g., advanced payer analytics and experience with PCMH pilots), considerable obstacles remain. Smaller providers face technical challenges, a Health Information Exchange (HIE) is still limited and the rollout of an APCD via Access Health CT (Connecticut’s Health Insurance Exchange) is still in its preliminary stages. The State will leverage its existing capabilities as it accelerates HIT adoption.

The timeline for Connecticut’s HIT strategy sequences the implementation of capabilities according to: their value to the AMH model, their current state of development, the time needed to implement them and their interdependencies with other capabilities (Exhibit 8). Fundamental and high-impact capabilities – both high priorities - will fall into the early development category, as did critical enablers for other categories. Existing capabilities will also be leveraged in the earlier stages. However, highly complex technology solutions will be rolled out later stages so the State will have sufficient lead time to develop them.

Exhibit 8: Sequencing for Rolling Out the HIT Strategy

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 yrs)	Stage 3 (3+ yrs)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
Provider-payer-patient connectivity	Multi-payer online portal for providers to receive static reports; basic patient portal to allow consumers to enter quality metric data	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange ¹ solutions	Potentially integrate state-wide Health Information Exchange ¹

1 HITE-CT will drive adoption of provider-provider connectivity tools and eventual creation of a state-wide health information exchange

In Year One, Connecticut will leverage existing stakeholder capabilities as it launches a broad array of fundamental payer-based components; these will include consumer attribution, risk stratification, performance reporting and specialist/facility analytics. The State will also create a provider and consumer portal. In years two and three, it will further develop provider care management tools and dramatically augment the portal and payer analytics.

- **Payer analytics.** Payer analytics include tools that payers use to analyze claims data; these analyses then produce metrics that assess outcomes, quality and cost and can affect providers' reimbursement. Examples of payer analytics include risk stratification, quality metric and total cost of care calculations and consumer attribution. Provider tools that use clinical data to assess population risk and identify care opportunities (e.g., prostate screenings) can complement these analytics.

Payer analytics are already being deployed in Connecticut. The PCMH/Accountable Care Organization (ACO) pilots are already using payer risk adjustments and performance analytics tools. Select providers (e.g., ACOs) are also analyzing clinical data.

At the state level, AccessHealth CT is developing the APCD. It will collect, assess and report health care information that relates to safety, quality, cost-effectiveness, access and efficiency. When complete, the APCD will:

- Create comparable, transparent information
- Provide consumer tools that enable consumers to make informed decisions
- Promote data element standardization so that data can be compared nationally
- Facilitate the broader policy goals of improving quality, understanding utilization patterns, enhancing access and reducing barriers to care
- Enable the aggregated analytics that can inform public policy and reform

Connecticut has already drafted the data submission guide that describes the data elements and formats for required data files; it is being refined based on payer feedback. The policy and procedures that are based on the guide will probably take effect in September 2013, with implementation immediately thereafter. The goal is to have the first data submission in early winter 2014.

The timeline for payer analytics echoes the overall HIT timeline; it starts by leveraging existing tools and then implements the new ones as they become available. In the short term, payers will capitalize on existing population health analytics while they establish the full set of tools required to support shared savings accountability among providers. In the longer term, APCD will provide consumers with analytics that allow them to make cost/quality comparison across providers.

During Stage One (Year 1), payers will standardize provider reporting based on core analytics (e.g., consumer attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics). Enhanced analytics (e.g., care gaps analyses, alert generation) that identify high-priority consumers who need targeted intervention will be implemented in Stage Two (Years 2 - 3). During Stage Three (3+ Years), we will integrate public health and clinical data analytics so providers have more meaningful performance information and consumers possess a more comprehensive view of their care.

- **Consumer-provider-payer connectivity.** Connecticut and payers will need to establish channels (e.g. portals) where providers and consumers can access relevant information and submit data that is required to support the proposed care delivery and payment model.

Significant progress has already been made. Many providers have access to payer-based portals that connect the providers with health plans and practice management systems (e.g. Availity for Anthem). In addition, the State will deploy a single provider portal for use across multiple payers in the near-term.

Consumers have access to multiple portals that allow them to track claims and account activity, find doctors and services, access health advice and get answers to coverage questions (e.g., myCigna for Cigna). Yale New Haven Health System patients can access the MyChart patient portal, which they can schedule appointments, send messages to their provider, review and get refills on their medications and review their health conditions (with links to MedLine Plus Connect for clinical information in English and Spanish).

Access Health CT is also developing a consumer portal to help inform consumers of their choices (e.g. cross-provider cost comparisons) on the Health Insurance Exchange. It will become operational once the APCD is completed. Connecticut will also establish relationships with third-party consumer engagement vendors (e.g., Castlight, Truven Health Analytics) to help it better engage consumers.

In Stage One (Year 1) payers and the State will collaborate and set up a multi-payer online portal for providers, who will receive static reports. They will also establish a consolidated consumer portal where consumers can access their claims information and enter clinical data to support quality measurement. Connecticut is also developing a Master Client Index (MCI) and an Integrated Eligibility Management System (EMS), both of which will help link and coordinate the different State Health and Human Services agencies. These two elements will reinforce consumers' ownership of their health data and how it is used (i.e., consent management). In Stage Two (Years 2-3), the State will upgrade the provider portal so it allows bi-directional communication between payers and providers as well as data visualization and consumer engagement/transparency

tools. In Stage Three (3+ years) a fully functional health information exchange (HIE) will enable consumer-provider-payer connectivity.

- **Provider-consumer care management tools.** Care management tools will help care teams (physicians, care coordinators) identify care opportunities and prepare for consumer encounters. They will also assist the teams implement the most appropriate interventions and better manage follow-up care. Lastly, they will facilitate their consumer outreach.

Today, DMHAS manages a system of care for behavioral health populations (i.e., safety net populations that include Serious and Persistent Mental Illness (SPMI)); this system uses several care management tools. While select providers also employ these tools, their level of technological maturity varies significantly.

The State will deploy a range of solutions to help all providers build their care management capabilities. In the near-term, it will set requirements for adopting the care management tools and educate providers on the basic process changes and available technologies (e.g. risk stratifying the population with Excel). In the medium term, we will create a marketplace of pre-qualified vendors of customized care management technologies; this venue will simplify providers' procurement process. If it decides not to create the marketplace, the State will consider offering a shared service – a basic care management toolkit – providers (e.g. smaller practices) can plug into.

In Stage One (Year 1) the State will identify the provider workflow changes required to improve care coordination and detail the options and applications for supporting technology. We will also educate consumers on healthy behaviors and how to make high-quality, cost-efficient decisions about their care. To do this, the State will leverage existing infrastructure, payers' proprietary tools, and specialized technology.

Over the longer term (Years 2-3+), we will pre-qualify vendors and health information service providers and obtain pre-negotiated, discounted pricing. At this stage we will also assess the viability of developing the shared-service care management toolkit mentioned earlier.

- **Provider-provider connectivity.** Provider-provider connectivity is the integrated exchange of clinical data between doctors, hospitals, and other health care providers through a secure, electronic network.

This secure data exchange is a key enabler of population health. In 2012, the State established the Health Information Technology Exchange of Connecticut (HITE-CT), a quasi-public agency, to develop and implement secure systems and processes for sharing health care information. It collaborates closely with communities statewide. HITE-CT also promotes the direct exchange of information between providers (e.g., through system internal messaging). Some of the state's large

provider systems (e.g. Hartford Healthcare, Yale) are already applying their own health information exchange solutions.

Connecticut's SHIP/SIM strategy will coordinate closely with HITE-CT as the latter expedites provider-provider connectivity, initially through direct messaging and ultimately through the establishment of a Health Information Exchange (HIE) that crosses provider groups.

In Stage One (Year 1), the State, via HITE-CT, will promote the direct exchange of information between providers with technologies that are easily scalable (e.g., direct messaging), as well as financial and technical assistance when appropriate. It will also support existing efforts to enable clinical connectivity, accelerate EHR adoption, and promote its frequent use. In the medium term (Years 2-3), provider groups will try to align local health information exchanges so the exchanges can work together. Eventually (Years 3+), the State will transition to a clearing house (HIE) model for clinical data exchange.

Approach to Standardization and Consolidation

One of the HIT's critical success factors is its reliance on multiple payers. Standardizing technology and, in some cases, consolidating it into a single service shared by multiple payers drives provider and consumer impact. This can also drive efficiencies and second-order benefits (e.g., APCD can support research).

All Connecticut payers will adopt a standard performance report (e.g., quality metrics, report format), but will continue to use their existing analytic approach. The Healthcare Innovation HIT taskforce will develop a provider/consumer portal, which is combined in order to minimize complexity. Providers will be able to choose the care management toolkit that best meets their needs.

- **Payer analytics.** Payer analytic tools will be standardized across payers but not consolidated. Payers will generate highly standardized metrics/analytics/reports although their infrastructure will remain independent.
- **Provider-payer-consumer connectivity.** A single portal for consumers and providers will access information from and submit metrics to multiple payers. One portal vs. two will avoid operational complexity and user confusion. The state will examine the existing consumer and provider portals, scale up the ones it selects and apply these across multiple payers. Once it has consolidated these into one consumer/provider portal, consumers will be able to access their payer's proprietary engagement and education tools.
- **Provider-consumer care management tools.** Because Connecticut has a great many small providers, it will establish shared guidelines rather than mandatory procedures for adopting care management tools. Although providers will have to

commit to adopting enabling technologies, they can select the vendors and particular solutions independently.

- **Provider-provider connectivity.** The State will promote clinical data exchange with a standardized – not consolidated – approach. This aligns with the HITE-CT initiative, which is focused on accelerating providers’ use of direct messaging for secure communication with other providers during Stage One. The exchange of Admission, Discharge and Transfer (ADT) information between providers will also ensure coordinated care delivery across different sites of care (e.g. acute vs. primary care settings). During Stage Two, the Meaningful Use guidelines for EHR adoption (spearheaded by eHealthConnecticut) will help providers find ways to make their separate EHR solutions work together. The State may require that providers’ EHR solutions possess integrated HL7-based ADT messaging functionality so that the EHR can communicate with other providers, hospitals and ancillary systems.

Other Considerations

- **Coordinating with state-wide HIT initiatives.** The State will establish a Healthcare Innovation HIT Taskforce for the Connecticut SIM transformation. It will liaise with the Department of Social Services (DSS) HIE and the Health Insurance Exchange (HIX) initiatives, both of which CMS funds. The taskforce will coordinate efforts across all three programs as they integrate clinical and claims data and use it to provide a more complete picture of provider performance. It will also use a provider/patient portal to deliver actionable data to these groups. The taskforce will also help set HIT priorities and identify dedicated funding mechanisms.
- **Assisting rural providers and small practices.** HIT capabilities vary significantly between big and small hospitals and providers. The State defined a Glide Path for small practices or rural providers who may need transformation support before they can develop the capabilities needed to meet the State’s practice accreditation standards and enter into value-based payment.
- **Affecting and leveraging MMIS.** Connecticut’s Medicaid Management Information System (MMIS), the record-keeping system for all Medicaid claims and payments, will continue doing this into the future. However, our SIM initiative will leverage the Medicaid DSS, using some of its measures of state outcomes and performance to complement our state analytics under the new model. We will also use MMIS as the starting point for different data integration approaches. In one case, the State will create a single database that contains MMIS Medicaid and state employee claims; this will be the first step toward a multi-payer claims database that we would use to analyze outcomes, quality, and cost. In a second instance, Connecticut will create a comprehensive view of Medicaid consumers by integrating MMIS Medicaid claims data with HIE clinical data.

HEALTH WORKFORCE DEVELOPMENT

Realizing healthcare delivery as envisioned demands a Connecticut health workforce of sufficient size, composition and training. This workforce must:

- Meet an increased demand for health services stemming from more of our residents having health insurance as a consequence of the Affordable Care Act;
- Meet the health service needs of a population that is growing older and more racially diverse by dealing effectively with the multiple comorbidities of people who are frail and with the poorer overall health of people of color;
- Focus on health rather than disease by bringing to bear the insights and methods of population health both to reduce the need for expensive health services and to achieve a healthier Connecticut;
- Work in care teams, grounded in primary care but encompassing specialty care, which can employ more effectively and efficiently a medical toolkit whose diagnostics, therapies, surgeries, drugs, medical devices and assistive technology are many, powerful and hard to calibrate, and becoming increasingly more so;
- Engage patients in maintaining their own health, in participating in their own health care and in making decisions, together with their families, regarding that care both because it is more effective and because it is patients themselves who should judge the tradeoffs of available treatments; and
- Partake wholeheartedly but with respect for privacy in the informatics/HIT revolution that affords unprecedented capabilities in
 - record keeping and retrieval,
 - answering clinical questions and identifying best practices,
 - quality control and error reduction,
 - data generation and analytics on outcomes and processes,
 - simulation, distance learning and e-consultation,
 - monitoring of patients in their homes, and
 - communication by clinicians and other care givers among themselves, with patients and their families and with researchers and educators.

Connecticut's health workforce must do all of these with the triple aim of improving health while eliminating health disparities, improving health services, and reducing the increase in the overall cost of health services.

Since our understanding of Connecticut's health workforce needs is still evolving and the initiatives we identify are in various stages of design, this health workforce plan of action is a work in progress. We will continue to refine our vision for our health workforce and our approaches for achieving this vision.

This section includes an assessment of Connecticut's current primary care workforce and a description of six multi-purpose initiatives:

1. Health workforce data and analytics
2. Inter-professional education (IPE)
3. Training and certification standards for Community Health Workers
4. Preparing today's workforce for care delivery reform;
5. Innovation in primary care Graduate Medical Education (GME) and residency programs;
6. Health professional and allied health professional training career pathways

Connecticut's current primary care workforce

Available data is not sufficient for a detailed or reliable account of Connecticut's health workforce in terms of how many practitioners are working in Connecticut, how much they are practicing, where they are practicing or even what they are practicing. The data says virtually nothing about how the various occupations are trained and what their knowledge and skills are. It is of little use for predicting workforce needs of the future care delivery system outlined in this plan. These shortcomings are why improving Connecticut's health workforce data and the analyses of this data is the first of our six initiatives.

Nonetheless, there are a number of recent surveys that bear upon Connecticut's health workforce. In May and June 2013, the Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) used these studies to evaluate Connecticut's primary care workforce. CPHHP found all these surveys to be problematic, yet together they paint a basic picture.

CPHHP's scan is supplemented by the 2011 Connecticut Health Care Workforce Assessment, which was prepared for Connecticut's Allied Health Workforce Policy Board, the Connecticut Office of Workforce Competitiveness and the Connecticut Employment and Training Commission. This report places a greater emphasis than CPHHP's scan on allied health professionals and on market demand for both primary care professionals and allied health professionals.

Findings drawn from recent data covering recent supply and demand are mixed:

- Connecticut has a better ratio of professionals and allied health professionals engaged in providing primary care to population than the national average,
- There is a maldistribution, since all but Connecticut's urban counties have a worse ratio, and
- Providers report difficulty hiring primary care physicians.

The demand for primary care services will increase with Connecticut's aging population and a projected additional several hundred thousand covered lives resulting from the full implementation of the Affordable Care Act. This challenge is compounded by the fact that the average professional clinician is middle aged with significant numbers of them over 60 years old.

What is apparent to all but ill-defined is the disconnection between the requirements of newer models of care delivery, the content of current training programs, and the skill sets of the existing health workforce. For example, there is a serious lack of primary care workers who are trained to identify and address behavioral health needs. This applies to all disciplines and all levels of health workers and especially to those who come from culturally and/or economically disadvantaged populations. Related to this problem is that market demand under our current delivery system may not reflect the market demand for new skills and new roles under the delivery system we hope to achieve.

Pharmacists present a good example of both quandaries. In Connecticut, according to national Pharmacy Workforce Project data, there has been an oversupply of pharmacists for the past 3-5 years. New pharmacists are finding it difficult to find full-time employment and many are working in multiple part-time positions. But this apparent over supply of pharmacists and their current difficulties in finding employment in our state are tied to how pharmacists are currently used in Connecticut's health care delivery system, which is in pharmacies, and may not reflect future demand under a system that is rebased on inter-professional primary care teams that include pharmacists.

Composition is also a problem. The professional health workforce poorly represents the racial and ethnic composition of the state with minorities concentrated in lower skilled occupations, while professional clinicians are overwhelmingly white. Persons at the lower rungs of the allied health professions who demonstrate greater diversity have great difficulty climbing the career ladder to the higher rungs of the allied health professions (e.g. occupational & physical therapists) and to the clinical health professions (e.g. nursing, pharmacy, social work, dentistry, medicine).

Principal Findings

For most of the Connecticut health care practices, Connecticut has more practitioners per 100,000 people than the national average. However, five of the state's eight counties, all the non-urban ones, had PCP ratios lower than the national average. While Connecticut has a higher number of almost all identified health care providers per person than nationally, there are substantially more physician extenders and related occupations per person in Connecticut than elsewhere. There are high numbers of physician assistants, registered nurses, and medical assistants compared to national averages.

Age: The number of active licenses overestimates the number of practitioners actively practicing, as practitioners often maintain their licenses when they move out state, retire, or assume non-direct care positions. The license data indicates that for many health professions, more than one out of five licensees is at least 60 years old. Psychologists have the highest proportion of licensees 60 or older, at 35 percent. The only exceptions are dental hygienists and physician assistants, with only eleven and seven percent of their number over the age of 60. Roughly 27 percent of holders of the physician and surgeon license are 60 or older. In public sector behavioral health, 55 percent of the professionals (including psychiatrists, physicians, psychologists, psychiatric social workers and nurses) are age 50 or older, with 34 percent age 55 or older. A virtually inevitable exodus of highly trained and specialized staff during the coming decade will challenge our capacity to deliver services and to integrate behavioral health and primary care.

Gender: Several professions disproportionately employ one gender. For example, women comprise 94.7 percent of registered nurses and 98.6 percent of dental hygienists. On the other hand, more than 80 percent of dentists are men. 36 percent of MDs and DOs are women. However, significant differences are observed across specialty, with women comprising more than half (52 percent) of pediatric physicians. Both pediatric physicians and pharmacists are more evenly split between men and women.

Race: More than 75 percent of practitioners in every health profession identify themselves as White. Licensed Nurses are 23.3 percent Black; Counselors are 18.6 percent Black; and Pharmacists are 16.7 percent Asian. Minorities constitute less than 10 percent of every other health profession.

The 2011 Connecticut Health Care Workforce Assessment's⁴⁶ report includes an overview of the allied health workforce, and just as significantly, delves into recent provider demand and the drivers of future workforce need—which begins to light the way for our workforce development plan.

As elsewhere in the country, allied health professionals have grown significantly in number relative to health professionals, and currently represent one of the more robust employment prospects in Connecticut. There has been a corresponding expansion of allied health professional training slots and programs. Consequently, supply appears to be keeping pace with demand. But it is unclear what the future demand will be both in terms of numbers and skill sets.

The drivers of increased demand for allied health professionals are:

1. The need for people proficient in technologies:

- The increasing importance of health information technology (HIT), and
 - The increasing complexity of diagnostic and therapeutic technology;
2. An aging population, which has more acuity, perception, mobility, deconditioning and dexterity problems—creating the need for people specifically trained to deal with these problems, and
 3. The rebalancing of long-term care toward home care, which requires people to be far more independent, increasing further the need for the aforementioned competencies.

These three drivers will continue to intensify for the foreseeable future, impacting not only the need for allied health professions, but also the training of most, if not all, health professionals.

Six multi-purpose initiatives

What follows are summaries of six multi-purpose initiatives that Connecticut will pursue. Each is designed to make significant contributions to developing a health workforce that will fulfill our state's plan for delivery system reform, and meet current and future needs for health services. Each initiative addresses numerous concerns, but taken together they still do not encompass everything that must be addressed. Our intent is to get underway with a manageable number of concrete actions that reflect the priorities laid out in this plan.

1. Health Workforce data and analytics

Over the next five years, Connecticut will collect and report real-time health workforce data, and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs. Meanwhile, the state will improve and make better use of health workforce data that is gathered by a number of state agencies, including the Office of Higher Education, the Board of Regents and the Departments of Education, Labor and Public Health. The Department of Public Health will lead as described below, which will require additional resources. DPH will seek these resources with the understanding that their availability will determine the pace of implementation.

Starting this fall (2013), DPH began mandatory online license applications and renewals for physicians, dentists and nurses. While e-licensing can incorporate workforce survey questions, questions have been developed only for nursing. Also, DPH has no "data warehouse" to store expanded e-licensing data, and little capacity to mine it or analyze it.

E-licensing applications and renewals for nurses now include standard, national survey questions that will be analyzed and stored at the National Council for State Boards of

Nursing (NCSBN) database. NCSBN will provide DPH with access to data that will allow Connecticut to benchmark and compare its data to that of other states.

Working with their professional associations, DPH will develop comparable questions for physicians, dentists and other health professionals and allied health professionals that DPH licenses or certifies. DPH will also extend e-licensing to all of these professions and allied health professions. Understanding that a balance must be struck between the quality and quantity of the information requested and the burden of providing this data, DPH will work with the Connecticut General Assembly to develop mandatory survey questions for all DPH's e-licensing applications and renewals.

Since data is also needed on provider demand, consumer demand, consumer satisfaction and educational programs, DPH will collaborate broadly with, among others, our Department of Labor (DOL), pertinent boards and commissions, and the state's institutions of higher education. In addition, payers and providers will be asked to help in collecting and analyzing data.

DPH will work together with all of these parties to:

- Develop the infrastructure necessary to sustain an internet-based healthcare workforce data portal to provide efficient and effective access to key information (employment and wage data, labor market information including real time job postings, licensure and certification data, educational institutional capacity and limitations, as well as socio-economic trends, demographics, performance-related information, and research studies) to inform strategy, planning, policy development and implementation and evaluation; and
- Use the data collected through the portal to continuously inform the strategic plan to ensure that the health workforce matches employer needs and that the appropriate number and variety of programs exist to train the needed professionals.

DPH will seek a solution to its need for a "data warehouse" as part of the state's overall Health Information Exchange (HIE) strategy.

UConn will take the lead in developing the necessary data analytic capacity and connectivity, working closely with the Department of Public Health, the Department of Labor, the Department of Education and the Office of Higher Education, the Board of Regents as well as with payers and providers. UConn's interest in leading the analysis of workforce data follows from the University's efforts to tie together shared project analysts from across its schools and campuses who work with data pertinent to health policy—creating, in effect, a virtual health policy institute. Each school brings its particular subject and clinical expertise to the task. With the security and confidentiality of this data assured, it will be made available for analyses by third parties, and thus will impact a broad range of workforce planning activities.

UConn has already begun collecting data on student education and training and eventual workforce participation. The University of Connecticut Health Center's Center for Public Health and Health Policy (CPHHP) has recently collaborated with several state agencies to create a mechanism for linking students' elementary, secondary and post-secondary educational experiences to later workforce participation. The product of this initiative, P20 WIN (Preschool through 20 and Workforce Information Network), links individual-level information maintained by Connecticut's Board of Regents for Higher Education, Department of Education and Department of Labor. In a second phase of the project, the Connecticut Conference of Independent Colleges and the University of Connecticut will contribute data to the network, resulting in a robust data set that will track student educational experiences and achievement over time and that will link this data to employment outcomes. Funding for the development of the technical infrastructure for the P20 WIN network has been provided to Connecticut by the National Center for Educational Statistics. This network currently has access to over 70 million educational and wage records from Connecticut residents from 2004 to the present. In addition to CPHHP, there are a number of other schools and divisions of UConn—e.g. the Schools of Nursing, Pharmacy, Dental Medicine, Social Work, Business and the College of Agriculture and Natural Resources—that can provide the analytic support for the State's efforts to use these data as well as other data sources (e.g. DPH licensing information) to monitor workforce development in the health and allied health professions.

UConn will make its analyses broadly accessible and useful to policy makers and stakeholders. CPHHP already has experience doing this. Its faculty and staff have worked extensively with the state's Hospital Inpatient Discharge Database, which contains medical claims data on all hospital admissions from all 30 acute care hospitals in the state. In addition, faculty from UConn's Department of Statistics have extensive experience and expertise in the sophisticated longitudinal modeling and data mining that are needed to track individuals' progress through secondary and postsecondary education, and into the workforce.

Finally, for anything approaching useful real-time health workforce data, the gathering and storage of this data and access to it require protocols, training and infrastructure comparable to what are required for data on other topics pertinent to health resources, services, processes and outcomes. Our strategy for workforce data must thus be developed as part of the Connecticut's broader designs for health informatics and HIT, and must draw in large measure on the broader resources available for these efforts.

How better data and analyses will drive health workforce development

Health workforce data will be analyzed, packaged and disseminated to impact the career choices of students and the programs that train health professionals and allied

health professionals, and will thus help drive remedies to problems in supply and in training.

- Whether the numbers of a profession are more or less than what the market requires will be known as will a far better estimation of future demand. Career advisors both in secondary and post-secondary education will be better able to advise students on career choices that will increase their opportunities for employment and higher income.
- These numbers will also influence schools in the offerings they develop and also in the number slots they plan to fill both near term and long term. When the data shows a misalignment of skills, programs that train these practitioners will know to adjust their curricula and pedagogies accordingly.
- Connecticut has long considered implementing loan forgiveness programs to encourage students to choose occupations for which there is a critical need. Credible, current and detailed workforce data will not only enable the state and schools to target loan forgiveness programs, it will also enable the state, schools, businesses and foundations to target scholarship programs.
- Finally, better data will enhance the ability of the five initiatives described below to foster the primary care workforce that Connecticut's health reforms and market will require.

2. Inter-professional education (IPE)

Advanced Medical Homes are the foundation of care delivery under SIM. Inter-professional teams are integral to their success, as is expertise in population health. Historically, students of different clinical disciplines have rarely trained together beyond attending basic science courses together, and population health has not been central to clinical curricula. In our view, the key to preparation for inter-professional team primary care is to train future caregivers together particularly in subjects that pertain to population health and patient centered care, and to have a significant portion of this training tied to the direct care of consumers in clinical settings outside of institutions.

Joint Clinical Training

All three of Connecticut's medical schools—Yale, Quinnipiac University's Netter School and the University of Connecticut Health Center (UCHC)—have or are contemplating IPE programs. At both Yale and Netter, medical, nursing and physician assistant students do a portion of their clinical training together.

UConn's School of Medicine (SOM) and School of Dental Medicine (SODM) have long shared classes in the core biomedical sciences during the first two years of training. The schools are now working toward adding inter-professional clinical training for UConn's

medical and dental students during the final two years with the ultimate goal of including students from UConn's Schools of Nursing, Social Work and Pharmacy.

In developing its strategies, Connecticut will look to the Interprofessional Education Collaboration (IPEC), which was founded in 2009 when six national professional associations joined together to promote inter-professional education. These associations included allopathic and osteopathic medicine, dentistry, nursing, pharmacy and public health. Since 2009, IPEC has sponsored symposia and training workshops to enhance inter-professional education, particularly the integration of clinical experiences for students to develop skills needed for multidisciplinary health care teams. The organization also has developed curricula and guidelines for IPE that could guide the development of IPE in Connecticut. IPE Centers have developed nationally and can be found at University of California San Francisco, Jefferson University, Creighton University and the University of Kansas.

A Connecticut Service Track

Connecticut will build upon its most effective program for community-based inter-professional training, UConn's Urban Service Track (UST), to establish a Connecticut Service Track (CST) that will cover more of Connecticut's communities, and will include more health professions and more of Connecticut's training programs.

Six professions' schools are currently participating in the UST: Quinnipiac's school for Physicians' Assistants, and UConn's Schools of Dental Medicine, Medicine, Social Work, Pharmacy and Nursing. UST is focused on team-based care, cultural and linguistic appropriateness, and population health in its approach to serving disadvantaged populations in urban settings.

In establishing a Connecticut Service Track (CST), the state will increase UST's scope, participating institutions and number of students such that:

- The focus of the program will be extended beyond urban communities to include Connecticut's more rural counties—effectively, covering all of Connecticut;
- Other Connecticut health professions schools, including allied health professions schools, and additional community providers will participate, increasing the number of occupations and community service locations;
- Residency training, having already been piloted within UST, will be included;
- Some offerings will be tailored for and offered to both health professions students and the current clinical workforce; and
- Enrollment, which in 2013 was 191, will be increased at least threefold.

Connecticut's Area Health Education Center Program (AHEC), which administers the UST with the six participating schools, will also administer the CST with more participating schools. The goal of UST has been to build a pipeline of well-qualified health care professionals equipped to work in inter-professional teams and committed to caring for Connecticut's urban underserved populations. However, skills and issues relevant to caring for urban poor overlap with those necessary for optimal care of rural populations. Many skill sets and curricula can be used in either setting. UST faculty is reviewing UST's curriculum to identify content and skill sets for students interested in rural practice. Connecticut's more rural counties combined with our more urban ones essentially constitute our whole state. AHEC with its statewide reach through its program office at the UConn Health Center and its regional centers in Hartford, Waterbury, Willimantic and Trumbull is well equipped both to implement this expanded program.

Description of the Urban Service Track

All Urban Health Scholars participate in a two-year curriculum that complements the existing curricula in the six schools and focuses on 11 competency areas. Faculty presenters include university and community health center clinicians, patients and other community partners. UST's Learning Retreats explore the 11 competencies in terms of the perspectives and needs of a number of vulnerable populations: children/youth, the elderly, individuals with HIV/AIDS, incarcerated and ex-offender populations, immigrants/refugees, veterans and people who abuse substances. Students participate in problem-based learning activities that include clinical skills and case studies.

The 11 competencies:

1. Resource constraints;
2. Cultural and linguistic appreciation;
3. Population health and public health;
4. Healthy policy;
5. Advocacy;
6. Health care financing and management;
7. Inter-professional teamwork and leadership;
8. Community resources;
9. Professional and ethical conduct;
10. Quality improvement; and
11. Patient safety.

In addition, attention is paid to the skills needed for inter-professional teamwork. There are formal quarterly Learning Retreats, community outreach activities, community based research, advocacy and leadership training, as well as other professional development opportunities. Critical to the success of UST is the opportunity for trainees to apply knowledge and skills gained in real world settings. This is done through a variety of community outreach activities that focus on health promotion, education, health risk screenings and health careers awareness for individuals from underrepresented backgrounds. Each year, UST sponsors 48-52 community activities that together reach thousands of residents.

Mentors drawn from both the participating schools and the community instruct students in leadership, effective management of a team, working with team members with different skills and training, effective utilization of community partners and preceptors, and grant writing.

Mentoring is peer-to-peer, faculty-to-student and faculty-to-faculty, and is both informal and formal. Urban Health Scholars are encouraged to participate in informal lunch and dinner discussions on navigating health professions training, career decisions and professional development. Formal activities include monthly meetings with faculty to discuss discipline specific issues, and quarterly dinners focused on career development. The participants of the program evaluate every team.

Interprofessional Training for Team and Population Health Approach to Care:

Purpose	Priorities	Required Components	Collaborative Partners
Community-based, Inter-professional training for health professions students	<ul style="list-style-type: none"> • Vulnerable and underserved populations • Primary care • Public service • Team-based care 	<ul style="list-style-type: none"> • Inter-professional health school partners • Dedicated faculty • 11 core competency areas • Mentorship • Leadership Training • Public Service 	<ul style="list-style-type: none"> • Health Professions training institutions (graduate & undergraduate) [UConn, Quinnipiac, Yale, State College System] • Community Partners • Health Professional Organizations (CCPC, CTAFP, CIPC etc.) • HealthCare Training Partners (Residency Programs, Hartford Hospital, CHCs etc.)

UST has been effective at persuading students to go into primary care. In 2013, students who have graduated from UST were surveyed to determine whether the program positively impacted their desire to work in primary care and with medically underserved communities. 59.6 percent reported that it had contributed to their choice of primary care, and 56.9 percent reported that it contributed to their desire to work in medically underserved communities.

With the exception of HIT, a Connecticut Service Track will cover the principal skills required for the enhanced primary care envisioned in this plan, in that it will:

- Instill skills for working in multi-professional primary care teams;
- Improve culturally and linguistically appropriate skills necessary for serving Connecticut's economically and culturally disadvantaged populations in both urban and rural communities;
- Provide training in community settings that will be participating in SIM care delivery and payment reforms; and
- Provide training in the principles and methods of population health.

But CST will also help address both shortages of primary care practitioners and the maldistribution of these practitioners in that it will:

- Better serve the needs of Connecticut's more rural communities, which currently have less access to primary care,
- Enhance access to specialty and dental services for urban disadvantaged populations, and
- Encourage more students to go into primary care.

3. Training and certification standards for Community Health Workers

Connecticut's Area Health Education Centers (AHEC) network will work together with Connecticut's Department of Public Health (DPH) to develop training for Community Health Workers (CHW). Over the past decade, CT AHEC developed substantial expertise in developing and operating several small-scale programs and collaborating with other states in the development of their programs. This new program will cover:

1. Nationally established core CHW competencies, and
2. The skills necessary for CHWs to work effectively as members of multi-professional primary care teams.

Together with DPH, Connecticut AHEC will also develop a certification process that reflects these competencies and skills.

Our aim is not just to train community health workers in the essentials but also to train them to work as members of multi-professional primary care teams,

which are the foundation of health care delivery as set forth in this plan. CHWs' value to these teams is their capacity to address the pervasive, persistent and expensive problem of health disparities in our state.

CHWs generally come from the communities they serve, and therefore, are more likely to understand the cultures, languages and idioms of these communities and the challenges their members face. This experience enables a CHW to be a bridge and an interpreter for a patient and her care team. CHWs can inspire familiarity and trust, and can be as instructive and supportive to caregivers as they are to consumers.

CHWs will primarily work with Connecticut's economically disadvantaged residents, particularly in communities of color, who are in poorer health and have poorer health outcomes. In large measure, these disparities are driven by the greater difficulties economically or culturally disadvantaged people have in navigating health care delivery and making optimal use of available services. But these disparities are also driven by disproportionate challenges in daily living, more frequent breakdowns in communication with their clinicians, and unaddressed risks for developing ill health that are more prevalent in some populations.

In addition, consumers who do not understand the health care system and in turn are not understood by it are more likely to use health services inefficiently, making providing services to them more expensive. A reliance on emergency departments for primary care exemplifies this problem, but it runs deeper. There are substantial savings to be had in assisting people who need a friendly and knowledgeable hand to help them use health care properly and to follow through with their courses of treatment.

Connecticut has community health workers now, although not nearly enough of them. Our intent is to train enough CHWs to meet the needs of consumers and the requirements of the models of care that are developing in Connecticut now and will be developed further under this plan. Improved data and data analyses on market demand will help in establishing this number.

We understand the CHWs frequently specialize. Examples are assisting diabetics to access treatment and follow therapeutic regimens, helping smokers to quit smoking, and serving as Community Dental Health Coordinators who work within dental practices to coordinate dental care, reduce dental anxiety, arrange transportation, and even help patients to enroll in Medicaid. The surveys described above also showed that, most often, Connecticut's current CHWs assumed specific tasks and missions with little structured instruction in fundamental skills and insights for how to be most effective as CHWs. AHEC will provide this instruction.

**Integration of Primary Care Extender Approaches to Care:
Developing a Community Health Worker Training Program**

Purpose	Priorities	Key Components	Collaborative Partners
Develop and implement a training program for Community Health Workers	<ul style="list-style-type: none"> • Nationally established core CHW competencies • The skills necessary for CHWs to work effectively with and within Patient Centered Medical Homes (PCMH) 	<ul style="list-style-type: none"> • Community Health Worker (CHW) 11 Competency Curriculum • Basic and Advanced Training Modules • CT Department of Public Health CHW Certification • Career pathways 	<ul style="list-style-type: none"> • CT AHEC Network • MASS AHEC • UConn Schools of Nursing and Social Work • CT Department of Public Health • CT-RI Public Health Training Center • Healthcare providers & other similar agencies

AHEC’s approach will be inclusive. In developing a training program, AHEC will work with all interested parties, including community-based organizations and primary care providers, but also with nursing and social work since both engage in care coordination, and with Massachusetts AHEC, which has developed a model program for training CHWs and is currently working with Massachusetts DPH on developing certification standards.

Connecticut AHEC will consult Connecticut’s advanced primary care practices to gain their perspectives on how best to train CHWs to work effectively with their care teams. In turn, Connecticut AHEC will offer sessions to the clinicians and other members of primary care teams on the role of CHWs as primary care extenders. AHEC will also include CHWs in the inter-professional educational (IPE) curricula developed for Connecticut’s health professions schools.

AHEC will work together with UConn’s School of Nursing and UConn’s School of Social Work to identify how CHWs can best assist nurse care coordinators and social workers in assuring that patients make optimal use of resources for staying healthy and getting the services they need.

Connecticut AHEC will provide CHW training at its four regional centers, and will also work closely with the state’s Community Colleges and the State University System to develop certificate and degree programs for more advanced and specialized training. Discussions with the Community Colleges are already underway. AHEC is also working with the CT-RI Public Health

Training Center at the Yale School of Epidemiology and Public Health, as well as with public health programs at the University of Connecticut Health Center and Southern Connecticut State University. All have shown interest in contributing to the building of a capable CHW workforce.

Description of CHW Training

Insights drawn from Mass AHEC's experience, and discussions with primary care practices, nursing, social work and other parties with purchase on the role of CHWs will be incorporated into a curriculum that is culturally relevant, evidence-based and interactive. This curriculum will provide two levels of training: basic and advanced. The basic course will incorporate 50+ core competencies, roles and responsibilities endorsed by the World Health organization, the Community Health Worker National Education Collaborative, the National Community Health Advisor Study, American Public Health Association, the Community Health Worker Collaborative and the Massachusetts Association of Community Health Workers. The training will entail 48 hours of classes, an additional 8 hours of practicum and field placement.

The National Community Health Worker Advisory Study (1998) defines the core competencies for CHWs as:

1. Understanding the health care system;
2. Knowledge of resources and constraints;
3. Health promotion and disease prevention;
4. Effective communication, documentation and outreach skills;
5. Advocacy and cultural sensitivity;
6. Understanding community health education;
7. Capacity building;
8. Informal counseling/social support;
9. Legal and ethical responsibilities;
10. Special topics – e.g. oral health, violence, infectious disease;
11. Providing services to individuals with HIV/AIDs and other chronic conditions

The advanced training modules focus on population health approaches to diabetes, cardiovascular disease and stroke, asthma, women's health concerns, cancer, oral health, homelessness, domestic violence and many other concerns.

In addition, there will be instruction in the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care, which were

developed to advance health equity, improve quality and help eliminate health care disparities.

Purposes served

By working with primary care teams, well trained CHWs will facilitate better health and better health outcomes for the people and communities they serve, and in so doing, CHWs will help end health disparities in Connecticut.

Connecticut's Community Health Workers will thus advance at least four objectives of this plan:

1. Better health,
2. Better health care,
3. An end to health disparities, and
4. Reduced costs.

4. Preparing today's workforce for care delivery reform

It will be many years before clinicians being trained today predominate in Connecticut's health workforce. Meanwhile, the success of healthcare reform depends on our existing health workforce, which was trained under different circumstances and for a care delivery system that we hope to transcend. Our current health professionals and allied health professionals need varying degrees of retraining if they are to work effectively within new models of care and if these models are to succeed.

One lever is the requirement of health professionals and allied health professions to earn Continuing Education Units (CEUs) as a condition for maintaining their licenses to practice. The courses that confer CEUs should emphasize the knowledge and skills required to meet AMH care delivery standards.

We will survey courses in Connecticut that grant CEUs to determine how often and how well they deal with these topics, and we will work with our institutions of higher education to improve these offerings.

IPAs, clinically integrated networks, and accountable care organizations (ACOs) have resources for in-service training. We will survey the content and quality of their offerings and work with these providers to improve them.

We will assist smaller group and independent primary care practices that do not have their own resources to provide this training either through enlisting the assistance of providers with established programs or through independent programs. One resource for the latter will be the Connecticut Center for Primary Care Innovation (CIPCI), which opened in 2012 and is legislatively chartered and affiliated with the UCHC and St. Francis Hospital. CIPCI's mission is closely aligned with SIM and the enhancement of

the skills of our existing primary care clinicians. Another resource is the Connecticut Center for Primary Care (CCPC), which is affiliated with ProHealth Physicians and also with the Primary Care Coalition of Connecticut.

5. Developing innovative Graduate Medical Education (GME) and residency programs in primary care

If the healthcare reforms envisioned in this plan are to succeed, we must increase soon the number of primary care clinicians in Connecticut: physician assistants, nurse practitioners, but particularly physicians. Rebasement health care on primary care requires it as do an increasing numbers of insured lives and an aging population. Connecticut will work to enhancing and expanding its residency programs in primary care since it is residencies that determine the discipline of a clinician and also often determine where clinicians settle to practice.

Although nurse practitioners (NPs) and physician assistants (PAs) are important in the mix, training primary care physicians must be our priority for three reasons. First, far and away, the greatest unmet demand in our state for health professionals and allied health professionals is for primary care physicians. Second, although NPs and PAs also specialize, in recent times, the draw of specialty care has been stronger for physicians. Third, expanded use of NPs and PAs as physician extenders is no substitute for having an adequate number of primary care physicians. The astounding breadth of today's medical toolkit requires it. If ever more finely specialized physicians must know more and more about less and less. Primary care physicians must know more and more about more and more. It is they who must be the ultimate care coordinators when the problems are many and not routine and the possible approaches are hard to sort through or even to recognize. Also, much of what is developed for physicians in residency programs can and should be extended to nurse practitioners and physician assistants in training.

What might innovative primary care medical residencies entail?

- There must be far greater involvement of the state's key provider organizations that are participating in care delivery and payment reforms to serve as sites for primary care training. More and more of health care is moving out of hospitals and other institutions to community settings. Primary care physicians must be trained in the venue in which they will work. The immediate issue is not a want of willingness by primary care group practices to participate in our state's primary care residency programs. We have a train-the-trainer problem. Many of our best prospects for faculty mentors in primary care practices, although first-rate clinicians, were trained in another time and have been engaged in a paradigm of care delivery that we are in the process of transcending. We must construct a faculty development program that enables our community-based faculty to become effective teachers and role models for the system of care

described in this SHIP. These mentors must be trained in a manner consistent with the AMH model.

- **UCHC's Office Based Medicine Curriculum:** For its Internal Medicine training program, our state medical school offers an office-based medicine curriculum as a counterpart to the school's hospital-based curriculum. UCHC plans to offer an office-based curriculum track for its Pediatrics, Family Medicine and OB-GYN programs. This expansion will increase residency training in our communities, which should help persuade more of our graduating residents to practice there. The office-based track:
 - Enhances skills in ambulatory training by providing residents more structured opportunities in sub-specialty clinics that complement the primary care provided by medical homes;
 - Provides instruction in the business of medicine. Residents are taught coding, billing and office management; and
 - Exposes residents to various practice styles and environments for community-based primary care, particularly in community health centers that have coordinated inter-professional care teams with proficiencies in psychiatry, dental medicine, primary care medicine, nutrition and pharmacy.
- UCHC is recruiting students within its undergraduate medical program to work with its Graduate Medical Education program in family medicine, pediatrics and internal medicine. The intent is to bring together interested students with residents and attending physicians who can serve as mentors and role models. It is important to identify students early in medical school who have some interest in primary care as a means of increasing the number of graduates choosing primary care. UCHC's goal is to increase this number by at least 30%. This initiative is also meant to encourage our students to continue training in Connecticut's residency training programs, the idea again being that physicians are more prone to practice where they have done their residencies. UCHC will also expose its medical students interested in primary care to innovative models of healthcare delivery and public health advocacy, and work with these students on leadership skills. They will be encouraged to get their Masters of Public Health. Students who enter our residency programs and commit to primary care in Connecticut may be offered loan deferments.
- UCHC is working toward developing streamlined and combined residencies that train physicians in primary care together with one of the specialties associated with primary care i.e.; geriatrics, adolescent medicine, women's health, behavioral health and correctional health in less time than it would take to pursue primary care and the related specialty sequentially. Combining

residencies has the dual purpose of drawing medical graduates into primary care and also training physicians in related specialties whose practitioners are also in short supply. Shaving a year off this combined training is an inducement, and will also get these residents into active practice sooner. To do this, we must persuade the pertinent national board specialty organizations and national board certification processes of our approach.

Connecticut's three medical schools—the University of Connecticut Health Center, Yale and Quinnipiac's Netter School—are all attuned to the shifting conditions of practice that future physicians will face and to the emergent importance of primary care. All three are working on reconstituting primary care education in ways commensurate with this plan. Connecticut's primary care practices are becoming medical homes and affiliating with each other and also with integrated systems of care. The potential is great for developing innovative primary care medical residencies within networks of primary care practices and thereby increasing the number of primary care medical residents; and in keeping with our aforementioned interests in inter-professional training (IPE), not only our schools of nursing physician assistant programs, but also our schools of pharmacy and social work will be encouraged to coordinate their graduate education with these medical residencies.

6. Health professional and allied health professional training career pathways

Connecticut will build upon two ongoing initiatives to increase students' ability to accrue the credits and the capabilities needed to advance in the health and allied health professions, and also to increase the flexibility to change programs midstream or otherwise move from one health career to another.

Both initiatives were launched in 2012. The first is Governor Malloy's and is focused on Science, Technology, Engineering and Mathematics (STEM) education. Connecticut's baccalaureate programs in both public and private colleges and universities are being encouraged to ensure that their STEM courses of study provide a sound foundation for both careers and technological advances that will strengthen Connecticut's economy.

The second initiative is the implementation of the Connecticut Board of Regents for Higher Education's comprehensive transfer and articulation agreement that enables students to transfer more easily across the 17 Connecticut State Colleges & Universities. This articulation policy applies to all subjects and all majors, and emphasizes seamlessness between associate degree programs and baccalaureate programs.

This agreement calls for:

- A common general education core
- Common lower division pre-major pathways

- A focus on credit applicability to degree
- Junior status upon transfer
- Guaranteed or priority university admission
- Associate and bachelor degree credit limits

In line with Governor Malloy's STEM initiative, the State of Connecticut will work with its public and private colleges and universities to

- Ensure that their STEM courses of study related to health and health services provide the knowledge and skills needed for every graduate of these studies to succeed in any of the state's health professions schools and programs; and
- Increase the representation in Connecticut of minorities in training for both the health professions and the allied health professions, but particularly for the health professions.

Connecticut will further develop articulation agreements among its schools that train health professionals and allied health professionals to

- Establish, in so far as it is feasible, comparable requirements for credit courses so that the schools can accept each other's credits;
- Articulate pathways from entry-level training through to advanced degrees and certifications, ensuring that at each step of the career ladder that articulation agreements exist between institutions to ensure a seamless transition for students; and
- Provide opportunities for students to participate in prior learning assessments in order to provide credit for past experience and accelerate their training.

Our Department of Public Health will work together with our schools and providers to ensure that current licensing requirements align with new industry demands and accreditation requirements. DPH will also work with Connecticut's General Assembly and the Allied Health Workforce Policy Board on improving the classifications and certification of allied health workers.

Developing solid STEM core curricula and well-designed articulation agreements for the health and allied health professions serves at least three purposes:

1. Having programs constructed of courses with common content and requirements will make it easier to change programs or go to back school for a career change when market demands change. This will help the workforce to keep pace with the delivery system's changing requirements.
2. In working through articulation agreements, schools will become more aware of what each other is doing and if this knowledge is tied to approximate real-time

data on workforce demand and analyses of the trends in this demand—the schools will be better able to calibrate their programs to Connecticut’s needs.

3. In that standards among the programs line up so that credits achieved in one can be applied to requirements of higher level programs, this will help students plan career ladders by enabling them to see where they might go from the more entry level job they now, and helping them to get there. Among other things, this will help provide an avenue by which students from disadvantaged communities can progress from lower skilled jobs to higher skilled ones, including professional careers, helping to redress the under representation of these communities in the health professions. Having people with ground level experience in health care in professional programs should also be a boon to these programs.

It is also critical to develop a health workforce whose professionals and allied health professionals are more representative of Connecticut’s population. We must do a better job of interesting minority students in STEM while they are still in grade school, identify and encourage those who are interested, and prepare them for college level STEM courses. All of Connecticut’s universities currently have initiatives with our public schools, which are dedicated to these purposes. The state will work with our universities to expand these initiatives and to develop others. The following are examples of UConn’s current collaborations with our public schools that are targeted at increasing minority participation in STEM and the health professions:

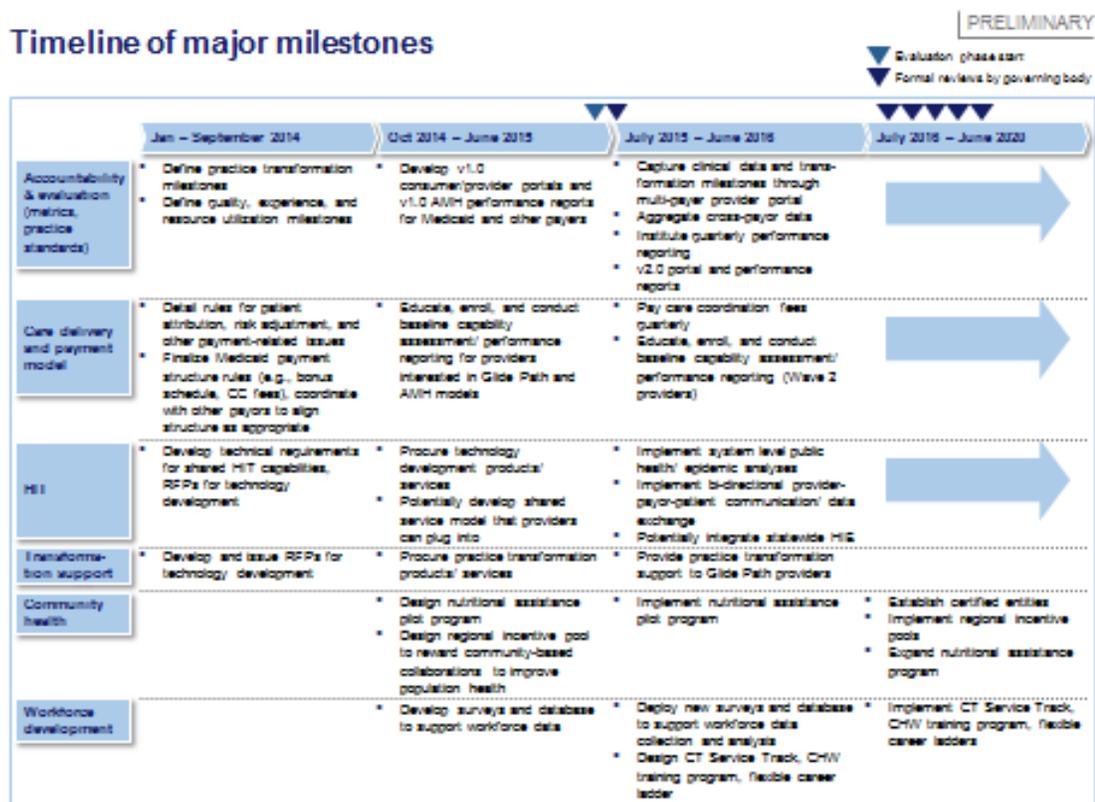
- The *Louis Stokes Alliance for Minority Participation*,
- The Aetna Health Professions Partnership Initiative at UCHC,
- *Great Explorations Middle School*,
- *Jumpstart Saturday Academy and Summer Programs*,
- *Juniors Doctors Academy*,
- *Health Professions Academy* at Bulkeley High School and the *Health Careers Academy* at Weaver High School,
- School of Pharmacy faculty’s work with the New Haven Public Schools, and
- UConn Chapter members of *Student National Pharmaceutical Association (SNPhA)*β



MANAGING THE TRANSFORMATION

Transformation roadmap

Our Plan will be implemented over a five-year period, contingent on financing, changes in public policy, and contractual changes between private payers and providers. Key milestones are outlined below, divided into four phases as illustrated in the Exhibit below and described in detail following.



1. Detailed Design (January to September, 2014). Pending stakeholder feedback and refinement of the Plan, new governance structures will be established and our program management office will be formed including a combination of internal and contracted support as necessary to develop the more detailed technical design necessary to support our new models. Major activities include:

- Definition of primary care practice transformation milestones; measures of quality, consumer experience, and resource utilization; methods for identifying and responding to evidence of inappropriate patient selection and under-service
- Detailed rules for patient attribution, costs included in “total cost of care”, risk-adjustment, clinical exclusions, and cost outlier provisions

- Finalization of care coordination fees, P4P bonus schedules, and risk corridors for shared savings for Medicaid; coordination with other payers to align payment structures, as appropriate, while preserving independence in pricing decisions
- Development of technical requirements for shared HIT capabilities, and development of requests for proposal (RFPs) to support procurement of technology development, practice transformation support, and evaluation support
- Design a suggested menu of VBID options that can be offered on an insured or self-insured basis, identify needed infrastructure and support
- Finalize evaluation design, pace and performance dashboard and metrics, and data sources. Implement collection of pace and performance data by July 1, 2014

2. Implementation Planning (October 2014 to June 2015). Pending award of CMMI State Innovation Models Testing Grant and securing other funding, we will initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes. Key activities during this implementation planning period include:

- Procurement of technology development, practice transformation, evaluation support and other externally sourced products and services necessary to support launch
- Development of v1.0 consumer/provider portals and v1.0 AMH performance reports for Medicaid and other payers electing to leverage common reporting
- Education, enrollment, baseline capability assessment, and baseline performance reporting for providers interested in participating in Glide Path and AMH models
- Design of nutritional assistance pilot program as part of Community Health Improvement strategy
- Design of regional incentive pool to reward community-based collaborations to improve population health

3. Implementation Wave 1 (July 2015 to June 2016). State Fiscal Year 2016 will mark the first year of operations of our multi-payer model for AMH as well as initiation of our new capabilities to support Workforce Development. Key activities will include:

- Practice transformation support to Glide Path providers
- Capture of clinical data and transformation milestones through the multi-payer provider portal
- Data aggregation across payers
- Quarterly performance reporting to providers based on the AMH Common Scorecard

- Quarterly payments of care coordination fees
- Development of v2.0 portal and performance reports
- Education, enrollment, baseline capability assessment, and baseline performance reporting for Wave 2 participating providers for Glide Path and AMH models
- Implementation of nutritional assistance pilot program
- Deployment of new surveys and database to support workforce data collection and analysis
- Design of Connecticut Service Track
- Design of Community Health Worker training program
- Design of flexible career ladder

4. Implementation Wave 2+ (July 2016 to June 2020). In State Fiscal Year 2017 and beyond, continuous improvements will be made to the Common Scorecard, consumer/provider portal, data aggregation, analytic, and reporting capabilities. In addition, primary care providers will continue to be enrolled in the Glide Path and AMH model, including transition of providers from P4P to Shared Savings over time as they achieve minimum necessary scale and capabilities. This period will also mark the major expansion of our Community Health Improvement strategy as well as expansion of our Workforce strategy, including:

- Establishment of Certified Entities
- Implementation of regional incentive pools to reward community-based collaborations to improve population health
- Expansion of nutritional assistance program
- Implementation of Connecticut Service Track
- Implementation of Community Health Worker training program
- Implementation of support for flexible career ladders

Use of executive, regulatory, legislative authorities

Connecticut will use its executive, regulatory and legislative authorities to enact lasting structural transformation in several arenas.

- 1. Establish and monitor practice standards:** Connecticut will define practice standards for provider entry and participation in its SIM model. It will create an entity that will:
 - Select practice standards and metrics and refine these over time
 - Set targets for practice standards and metrics
 - Accredite providers based on practice standards
 - Aggregate data at the statewide level and perform audits as needed
 - Publish results to increase transparency on performance relative to targets
- 2. Integrate primary care and population health:** Connecticut is considering certifying Community-based Practice Support Entities (Certified Entities). This will standardize services offered by community organizations and make quality services more transparent and accessible to primary care practices. Because this is a new function, the State may need to expand the mandate of current state organizations (e.g., DPH) or establish a new entity.
- 3. Address privacy concerns to expand APCD's usefulness:** An All Payer Claims Database (APCD) is being developed at the state level. Cross-payer claims data could generate detailed, actionable analytics on individual consumers, which could then meet payer data collection requirements for the HIE. In an example, the state of Arkansas' State Innovation Plan has proposed an APCD that will profile provider patient panels, create patient registries, measure quality, and better position the state to meet any payer data collection requirements for their HIE. However, Connecticut's current policy governing APCD prohibits its use for these purposes due to privacy concerns. The State will consider changing this policy so that the APCD can provide detailed analytics at the individual level.
- 4. Enable Medicaid and state employee participation in the new model:** Medicaid will adopt the proposed reforms, which leverage current initiatives in Connecticut. Connecticut will also consider what other changes may be required to assist Medicaid and state employees as they participate in the new model (e.g., payment changes for Medicaid or union discussions for state employees).
- 5. Promote provider collaboration and a multi-payer strategy that do not violate anti-trust regulations:** Several states taking part in the SIM effort have adopted

policies that afford varying degrees of protection for public and private payers. They have usually employed either legislation or executive orders. Connecticut may consider similar measures.

- 6. Ensure that EMR systems work together:** The fluid exchange of clinical data across care settings will be a critical component of the new care delivery and payment model. Many of Connecticut's providers are already transitioning to electronic medical records, encouraged by the efforts of eHealth Connecticut, HITE-CT, and the HIT Coordinator. By requiring EMRs to meet certain technical standards that will help ensure their ability to work together, the State can improve cross-EMR performance while preserving providers' flexibility in selecting their systems. This approach will continue to promote EMR adoption while limiting the proliferation of incompatible systems.

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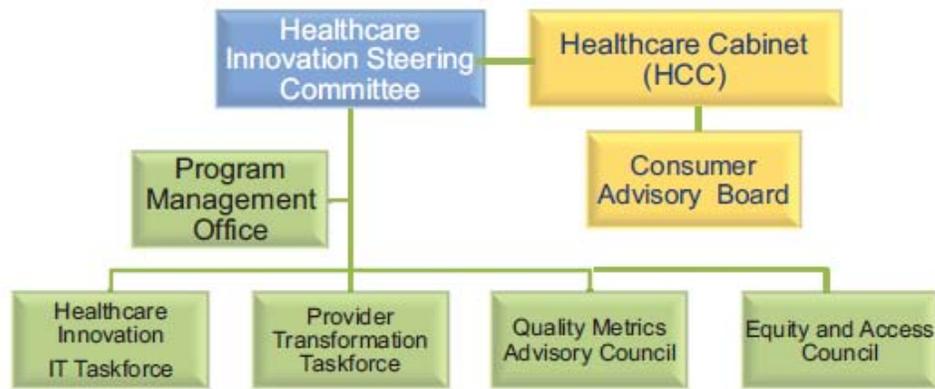
Multi-stakeholder governance structure

In order to sustain the momentum generated during the SIM Design Phase, provide oversight and staff support detailed design and implementation, we will establish the following structures:

- **Healthcare Innovation Steering Committee:** a group similar to the existing steering committee with additional consumer advocate and provider representation, will guide Connecticut's SIM initiative. It will be responsible for: overall strategic guidance; reviews of SIM's impact; and coordination with other public and private initiatives.
- **Program Management Office:** a state office composed of approximately five full time state employees, who will manage vendors, oversee evaluation efforts, communicate SIM progress to the public and state government, engage with stakeholders, and provide staff support to SIM.
- **Provider Transformation Taskforce:** a group that will be comprised of consumer advocates, physicians, behavioral health providers, hospital executives, payer medical director, and a self-insured employer representative, all with direct experience with provider transformation. The taskforce will: set medical home standards; advise on vendor selection for transformation support and practice certification; and coordinate with practice transformation standards and support to align with other care delivery models in the state (e.g., DMHAS behavioral health homes).
- **Quality Advisory Council** will ensure the AMH model provides appropriate levels of quality health care and consumer experience. It will be comprised of consumers/consumer advocates, physicians, behavioral health providers, hospital medical directors, payer medical directors, statisticians from private payers, and an epidemiologist from DPH, all of whom have technical expertise and experience with measurement of health, quality, and consumer experience. Specially, the council will: develop a common provider scorecard with metrics and targets; and update the scorecard annually based on provider, payer, and consumer input.
- **Healthcare Innovation HIT Taskforce** will be comprised of a group similar to the one currently advising the SIM HIT process. Participation criteria include formal authority or the ability to influence public or private HIT systems and technical HIT expertise. The taskforce will: set HIT priorities and develop payer and provider education materials; define standards for system interoperability and consistent formats for reports and portals; and coordinate with HIE, HIX, other HIT-intensive initiatives.
- **Equity and Access Council** will be comprised of consumer advocates, public health experts, academics, and clinicians with a commitment to ensuring long-term, systemic provision of appropriate care and access, especially to typically

underserved communities. They will recommend retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care; recommend a response to demonstrated patient selection and under-service; and define Connecticut's plan to ensure the AMH model systematically includes at risk populations.

In addition to the above executive branch governance structure, the Healthcare Innovation Steering Committee will consult with the Health Care Cabinet throughout the pre-implementation and implementation phases of the SHIP. In addition, the SIM Project Management Office will establish an ongoing relationship with the Consumer Advisory Board of the Health Care Cabinet to ensure that meaningful consumer input and advice is solicited ongoing through the life of the project.



Evaluation plans

Connecticut will closely monitor and evaluate its SIM along two dimensions: pace/participation and performance/outcomes. In this section, we discuss our goals and methods for measuring these dimensions. We also cover the methods we will use to ensure equity, access, and appropriateness of care during the transition in order to implement safeguards against unanticipated harm.

PACE/PARTICIPATION GOALS FOR SIM

We will create a “Pace Dashboard” that tracks milestones and metrics for each component of our delivery system reform. Over the next six months, the Program Management Office will define specific milestones and metrics (including timelines and targets) to ensure we are on track for launch by Q1 2015. Metrics will include, for example:

- Primary drivers:
 - Primary care practice transformation: Number and percent of providers able to meet each practice transformation standard; number and percent of providers who are participating in the glide path, number and percent of providers who are AMH certified
 - Community Health Improvement: Number of and percent of population served by Certified Community-Based Practice Support Entities; number and percent of practices assisted by a certified community entity; percent of population in need assisted by Diabetes Prevention Program, Asthma Indoor Risk Strategies, or Falls Prevention Program
 - Consumer empowerment: Number of consumers and percent of population participating in VBID; number of consumers and percent of population with access to consumer portal (limited scope/full scope); number of consumers and percent of population attributed to an AMH provider; Number of consumers and percent of population attributed to a provider who is accountable for the consumer’s service quality, care experience, and cost
- Enabling initiatives
 - Performance transparency: Number and percent of AMH providers participating on common metrics scorecard; implementation of APCD; implementation of hospital quality and cost score card; implementation of specialist quality and cost score card
 - Value-based payment: Number and percent of providers participating in qualified P4P payment arrangements; Number and percent of providers

eligible for shared savings or total cost of care payments; number and percent of providers participating in shared savings or total cost of care payments;

- Health information technology: Number and percent of providers participating in direct messaging; number and percent of providers offering care management tools; percent of patients with access to transparency-related tools; number and percent of consumers with access to a qualified patient portal
- Workforce development: Percent of providers participating in e-licensing; implementation of workforce data storage and analytics solution; number of trainees that complete the Connecticut Service Track; 3-year retention rate of CST trainees; articulation agreements, etc.

PERFORMANCE GOALS FOR SIM

The AMH care delivery model and enabling initiatives have a set of goals, described below, that closely align with Healthy People 2020 and uses CMMI's core measures as a foundation. By focusing on these goals, we will create better health for all of Connecticut's citizens, help the State achieve top-quartile performance on key quality of care and consumer experience measures and control health care spending.

Many of these goals focus on alleviating (and eventually eliminating) Connecticut's health care inequities. The AMH model's whole-person, team-based approach and incorporation of national CLAS based standards will address some of the social underpinnings of unequal care (for example, enhancing access will assist underserved populations to gain care through locations/ methods/ times that are more aligned with their needs). As we move forward, the State will also develop targeted interventions to address issues specific to certain ethnic/ racial/ socioeconomic segments (e.g., decreasing racial inequities in infant mortality).

The Quality Advisory Committee will advise on the final metrics and targets on the provider scorecard as well as the statewide Performance Dashboard, for final decision by the Steering Committee by mid-year 2014, to ensure we are on track for implementation in Q1 2015.

Connecticut's specific goals will include:

- **Better health** for all the State's citizens: Maintain or decrease the prevalence of disease, targeting diabetes, asthma, hypertension, obesity and tobacco use
- **Alleviating and eventually eliminating health disparities** for all the State's citizens: Close the gap between the highest and lowest achieving populations for each metric impacted by health inequities
- Top-quintile performance among all states for key measures of **quality of care and consumer experience** within the health care system

- Increase the proportion of providers meeting the comprehensive quality scorecard targets at the aggregate level
- For underserved populations: increase the number of providers that meet NCLAS standards; increase preventative care (e.g. child-well visits, mammograms, colorectal cancer screenings); decrease hospital visits for acute exacerbations of asthma and other chronic conditions
- Improve statewide consumer experience scores (clinician/group, hospital, and other entity surveys) for each entity over time
- 1-2 percentage point reduction in the rate of growth **health care spending** per capita, which will save more than a billion dollars over 10 years
 - Ensure that savings correlate with reductions in: potentially avoidable complications; hospitalizations for preventable, acute exacerbations of chronic disease; unnecessary emergency room utilization; and duplicative testing. Also ensure that savings correlate with the substitution of generic prescriptions where appropriate and use of lower-cost providers and/or settings of care of equal or greater quality

These measures will be tracked on a program-wide “Performance Dashboard” that allows the State to check on progress and make adjustments as necessary (an example dashboard is provided below in Exhibit X). The dashboard will also be provided to CMMI at regular intervals. Provider-specific performance will be tracked and rewarded as part of the provider scorecard – several of those measures roll up into the overall program Performance Dashboard.

Exhibit X: Example Model Performance Dashboard

● Improving ● Maintaining
● Deteriorating

Metrics	Statewide				Equity specific	
	Current Perf. ¹	Benchmark	Absolute target	Trend	Current Perf. ²	Target
Health	• Diabetes prevalence	• 7.3%	• 75 th	• 7.5%	●	• TBD • 0%
	• Asthma prevalence (adults)	• 9.2%	• 75 th	• 7.8%	●	• TBD • 0%
	• Hypertension prevalence	• 29.8%	• 50 th	• <30.8%	●	• TBD • 0%
	• Obesity prevalence	• 23%	• Top 5	• Maintain	●	• TBD • 0%
	• Tobacco use (current smokers)	• 13.2%	• Top 5	• Maintain	●	• TBD • 0%
Quality	<i>Improved quality</i>					
	• Track 1 providers meeting comprehensive quality scorecard targets/index	To be defined over remainder of design phase by metrics taskforce				
	• Track 2 providers meeting comprehensive quality scorecard targets/index					
	<i>Illustrative quality scorecard targets/index measures</i>					
	• Providers meeting NCLAS standards	• TBD	• TBD	• TBD		• TBD • 0%
	• Children well-child visits	• 90.3%	• Top 5	• Maintain	●	• TBD • 0%
• Mammogram for women over 40 in last 2 years	• 81.4%	• Top 5	• Maintain	●	• TBD • 0%	
• Adults aged 50+ who had colorectal cancer screening	• 75.7%	• Top 2	• Maintain	●	• TBD • 0%	
Quality (cont'd)	• Optimal diabetes care (annual foot exam)	• 72.7%	• 75 th	• 75.3%	●	• TBD • 0%
	• Hospital visits for asthma (per 100,000)	• 135.5	• TBD	• TBD	●	• TBD • 0%
	• HTN: controlling high blood pressure (taking medicine)	• 78.7%	• 50 th	• 79.2%		
	• Adult weight screening and follow-up	• TBD	• TBD	• TBD		
	• Measure: Pair: A) Tobacco Use Assessment B) Tobacco Cessation Intervention	• TBD	• National average	• A) 62.7% • B) 20.9%		
Cost	<i>Improved consumer experience</i>					
	• Statewide patient experience survey scores	• TBD	• TBD	• TBD		
	• State medical cost trend growth rate (3 year avg.)	• 5.1	• GBP+1	• 4.8	●	
• Statewide ambulatory care sensitive hospitalizations (per 100,000)	• 1,244	• TBD	• TBD			

¹ Benchmark years may vary
 Note on approach: Current performance compared to three year trend and relative performance to peer states. Benchmark set as Connecticut's target movement relative to peer states over the course of the testing phase, with an absolute target indicated as the current absolute performance of the state at that benchmark level
² 3 % difference between lowest and highest performing sub-group, goal is 0% difference

METHODS FOR EVALUATING ELEMENTS OF THE AMH MODEL

Connecticut needs to be able to collect, track, and evaluate performance data at all levels if it is going to execute and continuously improve the AMH model in order to achieve our aims. By creating an entity that manages this effort, the State not only gives accountability and transparency the priority they deserve but builds on the method it already uses with CMMI evaluation contractors.

Data Types

Several data types will be collected to evaluate the areas of transformation. They include, but are not limited to:

- Consumer experience surveys: These surveys collect data on the quality of providers' interactions with consumers (e.g., respectful, welcoming), consumer engagement education, and decision-making, and the quality of care transitions. They also examine access to care outside of normal business hours and whether culturally and linguistically sensitive care is provided.

Connecticut is examining the possibility of a site-based vs. statewide co-sourced vendor survey.

- Continued input from Consumer Advisory Board
- Clinical and claims data: This information indicates whether specified clinical processes and desired outcomes have been followed or achieved
- Self-reported data on provider activities and structures, through systematic surveys: This data provides a picture of how available certain structures, capabilities, and processes (e.g., e-consult capability, translation services) are among providers.
- Self-reported data on primary care provider satisfaction through systematic surveys; Continued input from medical & other healthcare societies on the provider experience with the model (e.g., Association for Family Practice, Pediatrics, Nursing), across transformed practices and those that have not yet started the journey
- Payer interviews

Data Sources

Connecticut will leverage existing data sources whenever possible and will coordinate closely with CMMI and other relevant parties when designing approaches to collect data for new metrics. In dealing with new measures, one of the metrics task force's important selection criteria is whether a metric can be tracked easily. Satisfying this condition will help ensure that the new metric offers meaningful feedback and supports continuous improvement. The State will also share successes and challenges with CMMI and other states so they can all develop best practices. Finally, Connecticut will commit to providing access to all state-based stakeholders and data, as well as private entity stakeholders/data as possible, to CMS for broader evaluation purposes, within the constraints of HIPAA and other regulations.

Data Collection and Evaluation Methodology

Connecticut's SIM Project Management Office will manage evaluation and improvement, utilizing in-state entities for portions of this charge as is deemed necessary. The PMO's evaluation responsibilities include, but are not limited to:

- Selecting practice standards and quality metrics and refining these over time
- Accrediting providers by means of a validation survey based on practice standards
- Setting targets for practice standards and quality metrics
- Aggregating data at the statewide level and performing audits as needed
- Publishing results to increase transparency on performance relative to targets

This entity will also evaluate the AMH model's performance and identify areas where continuous performance improvement is necessary. These analyses may be done in-house, through a state research group and/or with external vendors. If possible, the State will rely on an internal organization or agency for evaluations to build in-state capacity. This arrangement will last throughout the SIM Testing Phase to provide continuity and develop in-state expertise, and beyond for the state's continued evaluation of its health system transformation.

APPENDIX

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Glossary

Attribution – Prospective consumer selection: Allows consumers to select the provider responsible for their care in advance of a defined evaluation period (e.g., 12 months)

Attribution –Attribution: Assigns a provider who will be held accountable for a consumer. The attributed provider is deemed responsible for the consumer's cost and quality of care, regardless of which providers actually deliver the services

Attribution –Prospective auto-assignment: Uses historical claims data to assign a consumer to a providers' consumer roster prior to the start of a defined evaluation period (typically used when a consumer does not select a provider within a specified period of time). If no historical claims data exists, alternative rationales (e.g., provider quality) can be used

Attribution –Retrospective claims-based: Assigns consumers to providers based on historical claims data at the end of a defined evaluation period after the consumer has received care from their accountable provider

Care plan: Documented approach to managing a consumer's condition or disease over time

Choosing Wisely Campaign: Campaign to encourage physicians, consumers and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary and, in some instances, harmful

CID: Connecticut Insurance Department

Connecticut Service Track: Inter-professional training program for team and population-health approaches to health services

Consumer panel: The consumers designated (via an attribution methodology) to be under the care of a particular provider

Diagnosis-Related Group (DRG): A system to classify health care services by "groups" using a grouping methodology based on ICD codes

DMHAS: Department of Mental Health and Addiction Services that serves adults who are medically indigent or poor and who have serious and persistent behavioral health concerns (i.e., safety-net populations).

DPH: Department of Public Health

DSS: Department of Social Services

Exclusions: The exclusion of consumers from attribution (e.g., due to their intensity of service use, population type) to ensure that care is not denied to them

Fee for Service (FFS): A discrete payment is assigned to a specified service; currently the predominant reimbursement methodology in the United States

Gini coefficient: A measure of the income inequality within a location that examines how equally wealth is distributed across a population

Health Information Exchange (HIE): A secure, interoperable, standards-based health information infrastructure offered through eHealthConnecticut to enable timely exchange of medical data between providers at the point-of-care

Health insurance exchange: A marketplace through which consumers can conduct research on and purchase health insurance coverage

Integrated delivery systems: Provider networks integrating primary care, specialty care, and acute care along clinical and HIT infrastructure dimensions

Learning collaboratives: A series of learning sessions in which providers can discuss experiences and share best practices

Medical home: A team based primary care model that provides comprehensive and continuous care to consumers over time; its goal is to improve health, health care and costs

Metrics –Care experience: Consumer and their caregivers' experience of care, often measured via surveys

Metrics –Cost and Resource Use: The frequency with which units of defined health system services or resources are used; one can also apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit (i.e., monetize the health service or resource use units)

Metrics –Outcomes: The health state of a consumer (or change in health status) resulting from healthcare –desirable or adverse

Metrics –Processes: A healthcare service provided to, or on behalf of, a consumer. This may include, but is not limited to, measures that address adherence to recommendations for clinical practice based on evidence or consensus

Metrics –Structures: Features of a healthcare organization or clinician that affect their ability to provide healthcare. These may include, but are not limited to, measures that address HIT, provider capacity, systems and other healthcare infrastructure supports

OPM: Office of Policy & Management

OSC: Office of the State Comptroller

Patient portal: Channels/interfaces (e.g., web, apps) that allow consumers/patients to perform activities such as tracking claims and account activity, finding doctors and services, accessing health advice and getting answers to coverage questions

Pay for Performance (P4P): Process that compensates physicians based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)

Per member per month (PMPM): A payment administered or calculated per member per month, typically given as a performance bonus or form of support

Population health management: Population health is the delivery of care from one to many individuals within society. It addresses the health care issues of a broad set of patients/consumers. Population health strategies can include a variety of models, including governmental public health approaches, community-based entities, multi-sector organizations. They integrate population strategies into clinical care (population-based medicine) and can define populations geographically (e.g., health of a community), clinically (e.g., health of those with specific diseases), or socioeconomically.

Prospective payment: Payment to a provider at a predetermined rate of treatment regardless of the cost of care for a specific consumer or event

Risk adjustment: Method for determining whether consumer characteristics will necessitate higher utilization of medical services

Risk corridors: A financial arrangement that determines how risk/savings will be spread between a payer and a provider

Risk sharing: An agreement to share responsibility for the value of care by agreeing to share both savings below a predetermined threshold and additional costs over a predetermined threshold

Shared savings: An agreement to share responsibility for the value of care by agreeing to share both savings below a predetermined threshold and additional costs over a predetermined threshold

Social determinants of health: The economic and social conditions (e.g., risk factors associated with living and working conditions) that influence a consumer's health status

Triple aim: Originally developed by the Institute for Healthcare Improvement (IHI), the Triple Aim is a framework that describes an approach to optimizing health system performance. The goals of the Triple Aim are defined as: improving the health of populations, improving the consumer experience of care (including quality and satisfaction), reducing the cost of health care

UHC: The University of Connecticut Health Center

Whole person centered: An approach to care that places the person at the center of their care, encourages self-management and takes into account the full set of medical, social, behavioral health, cultural, and socioeconomic factors that contribute to a consumer's health

Draft

Foundational initiatives

POPULATION HEALTH INITIATIVES

- **Community Transformation Grant:** As the recipient of \$2,500,000 in federal grant money, the State is creating community-level initiatives in rural areas to reduce the incidence of obesity, smoking, and bad mental health days.
- **Choices:** The Department of Public Health, in conjunction with the Community Health Network of Connecticut, provides Choices, a set of culturally-sensitive nutrition education courses.
- **Community-Based Care Transition Programs:** The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and for reducing readmissions for high-risk Medicare beneficiaries. Two groups in Connecticut are participating in this program: Connecticut Community Care and the Greater New Haven Coalition for Safe Transitions.
- **Education programs:** Several awareness campaigns in the State are encouraging value-based decision-making. The Choosing Wisely campaign helps consumers pick high-quality, high-value care at the point of diagnosis. CHOICES is a state program through DSS that helps seniors navigate the health insurance system.
- **Healthcare Associated Infections Program:** Connecticut has a committee dedicated to preventing healthcare-related infections. The organization recently introduced "It's Good for You, Connecticut," an initiative encouraging patient responsibility in completing their antibiotics, working to prevent the spread of germs, and getting a flu vaccine.
- **Health Care Innovation Awards (HCIA):** The Health Care Innovation Awards are funding up to \$1 billion in awards to organizations that implement the most compelling new ideas to deliver better health, improve care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the greatest health care needs. Four HCIA recipients are currently applying their efforts in Connecticut: the partnership of San Francisco Community College and Yale University, Health Resource in Action, the partnership of University of North Texas Science Center and Brookdale Senior Living, and TransforMED.
- **Healthy Connecticut 2020:** Under the national initiative of Healthy People 2020, the State developed a framework for health promotion and disease prevention. We expect to release the State Health Improvement Plan by the end of January 2014.

- **Healthy Homes:** This DPH initiative improves housing safety by promoting awareness of home dangers.
- **HEARTSafe:** This DPH program encourages workplaces and the population at-large to learn how to identify cardiac arrest and to attain the training and technology to respond effectively.
- **Medicaid Medical and Dental ASOs:** In 2012, Connecticut started to use an ASO model to manage Medicaid patient services. The Community Health Network of Connecticut (CHNCT) is now the central coordinator of medical health services; it also provides customer services and intensive care management.
- **Nursing Home Diversion Modernization Grant:** This program supports those who are not eligible for Medicaid but are at high risk for being placed in a nursing facility. The program uses an innovative assessment tool to identify high-risk patients and uses a website to offer caregivers support.
- **NuVal:** A joint venture between Griffin Hospital and TopCo Associates LLC, NuVal is a private company that licenses a proprietary food scoring system to food retailers in Connecticut and across the country. The scoring system allows consumers to make informed choices about the nutritional value of products when they buy them.
- **Planetree:** Based in Derby, Planetree is a leading national organization in patient-centered care approaches. It works with hospitals in the State and nationally to improve the patient experience. It is also a co-chair of the National Priorities Partnership that NQF convened to develop the National Quality Strategy.
- **Rewards to Quit:** In 2011, Connecticut received an “Incentives for the Prevention of Chronic Disease in Medicare Demonstration” under CMMI. This tobacco cessation program focuses on education, monitoring smoking rates, and incentivizing quitting.
- **School Health Survey:** The DPH uses two surveys to track the health of Connecticut’s youth on key population-level indicators of health. The Youth Tobacco Component is a school-based survey of students in grades 6 – 12. It assesses randomly chosen classrooms within selected schools and is anonymous and confidential. The Youth Behavioral Component is also a school-based survey of students, but only of high-school grades 9 – 12; it is also anonymous and confidential.
- **State Partnership Grant Program to Improve Minority Health:** The State Partnership Grant Program to Improve Minority Health is a grant funded by the US Department of Health and Human Services. As part of the grant, Connecticut will promote and implement national Culturally and Linguistically Appropriate Services (CLAS) Standards for health and social service providers. It will also investigate the social factors that contribute to the leading causes of death in

Connecticut (e.g., cancer, cardiovascular disease, infant mortality, associated low birth weight).

BEHAVIORAL HEALTH INITIATIVES

- **Behavioral Health Homes:** DMHAS is working to provide integrated behavioral and medical health care to the severely and persistently mentally ill (SPMI) population. This integration would provide a cost-effective, longitudinal Home which would facilitate patients' access to an inter-disciplinary array of behavioral health, medical care, and community-based social services and supports.
- **Campus Suicide Initiative:** This three-year (August 2011-July 2014), \$1.4 million grant was awarded under the federal Garrett Lee Smith Memorial Act. It helps states, tribes, and colleges/universities develop and implement youth, adolescent and college-age early intervention and prevention strategies to reduce suicide. The goal of the CCSPI is to bring sustainable evidence-based, suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher learning statewide for students up to age 24.
- **Behavioral Health Partnership (DSS, DMHAS, and DCF):** This program provides integrated care under Medicaid and CHIP for those who are eligible for coverage in both medical and behavioral health. Specific initiatives include intensive care management, support programs for family members, and provider training sessions.
- **Mental Health Legislation:** Following recent and on-going tragedies due to guns and violence, legislators passed two laws providing groundbreaking reforms. The legislation starts with training in mental health risk reduction and school violence prevention for teachers, childcare providers, and children's clinicians. Mental health services are being integrated into early childhood programs and DCF is creating a care coordination program that integrates mental health and pediatrics. In addition, the Office of Early Childhood is crafting a public awareness campaign about children's behavioral health. A task force is also studying the provision of behavioral health services to 16-25 year-olds. The legislature also passed a regulation that requires reviews of how effectively insurance plans' cover mental health. Accompanying this, they established three additional Assertive Community Treatment Teams.
- **Prescription Drug Monitoring Program:** This legislation tries to prevent prescription drug abuse by requiring providers who give out controlled substances to register for the electronic prescription drug monitoring program.
- **SAMHSA Grant Proposals:** Connecticut received a \$9 million grant to integrate behavioral health with primary care and provide key preventative services.

- **Screening, Brief Intervention and Referral to Treatment (SBIRT):** DMHAS was awarded a five-year SAMHSA grant through August 2016. By partnering with Federally Qualified Health Center (FQHC) sites statewide, SBIRT dramatically increases the identification and treatment of adults who are at-risk for substance misuse or diagnosed with a substance use disorder. It accomplishes this by using routine screenings that are based on evidence and use well-tested instruments, by relying on short manual-based interventions and brief treatment protocols, and by basing assessments and treatment referrals on ASAM (2001) criteria. Partners include DMHAS, the Community Health Center Association of Connecticut (CHCACT), nine Federally Qualified Health Centers (FQHCs) and the University of Connecticut Health Center.
- **CMS Round 2 grant submission:** DMHAS recently submitted a proposal seeking to transform the state Local Mental Health Authority (LMHA) recovery-oriented system of care by implementing CSTAARR, a care delivery and payment reform model. This model will implement rapid access to outpatient behavioral health clinics, add primary care nursing, expand prescriber positions and formalize collaborative meetings with local hospitals in order to address avoidable use of those hospital systems. These proposals will provide a 1.77% return on investment to CMS and a 1.9% reduction in total cost of care over a three year period.

HEALTH INFORMATION TECHNOLOGY INITIATIVES

- **eHealthConnecticut:** Established in 2006, eHealthConnecticut is a non-profit that is trying to expand providers' use of electronic health records. The organization is using federal funding to support small providers who are working with underserved populations via its regional extension center.
- **All-Payer Claims Database:** Connecticut's centralized database will collect data that will ultimately enable the analysis of disease within and the development of prevention strategies for the State's population.
- **Health Information Technology Exchange:** HITE-CT will help providers share information across sites of care via a secure network.
- **Connecticut Data Collaborative:** The Connecticut Data Collaborative is a public partnership working to make federal, state, local, and private healthcare data publicly available in a central portal. This data can then be used for data-based planning and policymaking. The collaborative is a project of the New Connecticut Foundation, a 501(c)3 nonprofit organization affiliated with the Connecticut Economic Resource Center.

- **Medicaid EHR Incentive Program:** DSS is collaborating with the UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September, 2011 to January, 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals.
- **Health portals:** Both the private and public sectors are enhancing consumers' ability to gather health information on the Internet. DSS has launched "My Place," a website to provide shared decision-making tools, information on how to access community health services, and a clearinghouse for caregivers. DSS hopes to make this portal available via kiosks throughout the community. In the private sector, Connecticut's payers and hospitals use portals to offer consumers access to health information and other engagement tools.
- **Availity:** Multiple providers and their office staff can access information for members through Availity, one of the largest electronic health information networks that connect providers, health plans and practice management systems with essential real-time business and clinical information. Availity offers a wide variety of online tools that allow providers to access real-time information from multiple payers via one secure sign-on; the data includes eligibility, benefits, claims, test results, and many other services.
- **Payer analytics programs:** Payers in the State have developed analytic engines to profile provider patient panels and measure provider quality and performance. They have also created sophisticated analytics tools for reporting and data visualization as part of their PCMH/ACO pilots in Connecticut (e.g. Anthem BCBS pulls together 'drill-down analytics' and reports for PCPs in its networks).

PAYMENT INNOVATION INITIATIVES

- **Patient-Centered Medical Home (PCMH):** Connecticut is home to several PCMH programs. In 2011, DSS established the Medicaid PCMH initiative. The Office of the State Comptroller (OSC), with Anthem and UnitedHealthcare, then introduced the PCMH to state employees, enrolling over 45,000 employees in the pilot. These PCMHs include metrics to evaluate performance on health and consumer satisfaction. Several private payer PCMH efforts are in process as well, including Anthem and Cigna.
- **Medicare Shared Savings Program (MSSP) ACOs:** This flagship Medicare program promotes accountability and coordinated care among participating providers/health systems and uses infrastructure investment to support the effort. Six CT organizations currently participate as MSSP ACOs: Hartford HealthCare, St. Francis HealthCare, ProHealth, Pioneer Valley Accountable Care, Accountable Care Clinical Services, and Accountable Care Organization of New England.

- **Commercial Insurance Carrier P4P and ACO initiatives:** Anthem Blue Cross Blue Shield of Connecticut and CIGNA are negotiating and implementing provider contracts with Pay for Performance (P4P) and taking steps toward implementing Accountable Care initiatives. As of 1/1/2014, the State expects 11 provider groups with over 1,500 PCP's to be participating in some form of P4P/ACO contract .
- **CMMI Advance Payment ACO Model:** The Advance Payment ACO Model is designed for physician-based and rural providers who have come together voluntarily to provide coordinated, high quality care to their Medicare patients. Through this model, selected participants will receive upfront monthly payments, which they can use to make important investments in their care coordination infrastructure. Connecticut has two groups actively participating in this model: PriMed (Fairfield and New Haven counties) and MPS ACO Physicians (based in Middletown).
- **FQHC Advanced Primary Care Practice Demonstration:** This demonstration project, operated by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals who work in teams to coordinate and improve care for up to 195,000 Medicare patients. One practice in Connecticut, Community Health & Wellness Center of Greater Torrington, Inc., is already participating in this program.
- **Integrated Care Demonstration for Medicare/Medicaid Eligibles (MMEs):** Connecticut has received funding to design an integrated program for dual eligible individuals. The program integrates long-term care, medical services, and behavioral health services/supports. It also promotes the system's transformation toward a patient-centered model. The program has two primary features. An Administrative Services Organization (ASO) will improve Connecticut's medical and behavioral health ASOs by expanding/ tailoring their intensive care management (ICM) and care coordination capabilities so they can better meet the needs/ preferences of MMEs. The State will also integrate Medicare data into existing Medicaid-focused predictive modeling and data analytics and help providers use it more effectively.

In the programs' second feature, the MME initiative will create new, multi-disciplinary provider arrangements called "Health Neighborhoods." Providers will be linked to these through care coordination contracts and electronic means. They will promote local accountability among groups of providers who work together to deliver more integrated care that better meets the needs of MMEs, using care coordination agreements and electronic communication tools.
- **Bundled Payment Care Initiative (BPCI):** Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care that also costs less to

Medicare. Connecticut has two groups that are already participating in the BPCI: Greenwich Hospital and Bayada Home Health Care.

- **Incentives for the Prevention of Chronic Disease:** Section 4108 of the Affordable Care Act authorizes grants to States to provide incentives to all Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors (e.g., Connecticut's Rewards to Quit program). This program applies to all ages.
- **Medicaid Emergency Psychiatric Demonstration:** This Demonstration will test whether Medicaid can support a higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable.
- **State Employees' Health Enhancement Program (HEP):** OSC introduced HEP, a program providing monetary incentives for preventative care for state employees. This program includes self-management recommendations via an online portal that also enhances patient engagement. HEP also embedded value-based insurance design into the State Employee Health Plan, rewarding employees who participated in the program by lowering certain co-pays and requiring higher premium shares for those who did not. Preliminary results indicate increased use of PCP's and preventive services. The State will partner with other employer groups and payers to encourage the adoption of similar programs.

HEALTH CARE ACCESS INITIATIVES

- **Access to Recovery (ATR):** Following the success of ATR I and II, ATR III is a four-year grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). ATR III is a presidential initiative which provides vouchers to adults with substance use disorders; these vouchers help pay for a range of community-based clinical treatment and recovery support services. All services are designed to keep recipients engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.
- **Care 4 Kids:** DSS sponsors this program, which provides monetary support to low-income families so they can purchase childcare.
- **Health Insurance Exchange:** In October of 2013, Connecticut will open the state's health insurance exchange, Access Health CT. Since its creation in 2011, Access Health CT has been building awareness of the exchange and the benefits available to those who need help to obtain healthcare.
- **Medicaid Expansion for Low-Income Adults:** Connecticut was the first state to create a new eligibility group after the passage of the ACA. This group provides coverage for those who are between 18 and 65, are ineligible for Medicaid

Managed Care (MMC), without insurance, and with income below 56% of the federal poverty line. This will now extend to below 138% of the federal poverty line.

REBALANCING INITIATIVES

- **Medicaid HCBS waiver for Acquired Brain Injury:** This program provides case management, a homemaker, personal care, prevocational assistance, supported employment, respite, community-living support, home delivered meals, independent living skill training, cognitive behavioral health programs, a substance abuse program, transitional living, vehicle mods, chore, environmental accessibility adaptations, transportation, Personal Emergency Response System (PERS), a companion, specialized medical equipment and supplies for the PD and brain injured from age 18 to any maximum age.
- **Medicaid HCBS waiver for Elders:** This program provides adult day health, care management, a homemaker, a personal care assistant, respite, assisted living, assistive technology, chore, a companion, environmental accessibility adaptations, home delivered meals, mental health counseling, PERS, and transportation for aged individuals from age 65 and up.
- **Medicaid Personal Care Assistance waiver:** Provides personal care, assistive technology, and PERS for physically disabled individuals ages 18-64.
- **Medicaid HCBS Waiver for People with Serious Mental Illness in Nursing Homes with DMHAS:** Provides community support, supported employment, assertive community treatment, home accessibility adaptations, non-medical transportation, peer supports, a recovery assistant, short-term crisis stabilization, specialized medical equipment, and transitional case management for individuals with mental illness from age 22 on.
- **Medicaid Home and Community Supports Waiver for Persons with Autism with DDS:** Provides community companion homes, a live-in companion, respite, assistive technology, clinical behavioral health support, a community mentor, individual goods and services, an interpreter, job coaching, a life skills coach, non-medical transportation, PERS, a social skills group, and a specialized driving assessment for individuals with autism from age 3 to any maximum age.
- **Medicaid Comprehensive Support Waiver with DDS:** Provides adult day health, community training homes/community living arrangements, group day supports, a live-in caregiver, respite, supported employment, an independent support broker, an adult companion, assisted living, behavioral health support, continuous residential supports, environmental modifications, health care coordination, individual goods and services, individualized day supports, individualized home supports, an interpreter, nutrition, parenting support, PERS, personal support, senior supports, specialized medical equipment and supplies, transportation, and

vehicle modifications for persons with Development Disorders (DD) from age 18 to any maximum age and for Individuals with Intellectual Disabilities (IID) from age 3 to any maximum age.

- **Medicaid Expansion for Low-Income Adults:** Connecticut was the first state to create a new eligibility group after the passage of the ACA that provides coverage for those between 18 and 65, ineligible for Medicaid Managed Care, without insurance, and with income below 56% of federal poverty line. This will now expand to 138% of the federal poverty line.
- **Medicaid Employment and Day Supports Waiver with DDS:** Provides adult day health, community-based day support options, respite, supported employment, an independent support broker, behavioral health support, individual goods and services, individualized day support, an interpreter, specialized medical equipment and supplies, and transportation for individuals with DD from age 18 to any maximum age and with ID from age 3 to any maximum age.
- **Medicaid Individual & Family Support Waiver with DDS:** Provides adult day health, community companion homes, group day supports, individual supported employment, a live-in companion, prevocational services, respite, an independent support broker, behavioral health support, companion supports, continuous residential supports, environmental modifications, group-supported employment (formerly supported employment), health care coordination, individualized day supports, individualized home supports, individually directed goods and services, an interpreter, nutrition, parenting support, PERS, personal support, senior supports, specialized medical equipment and supplies, transportation, vehicle modifications for DDs from age 18 to any maximum age, and IIDs from age 3 to any maximum age.
- **Money Follows the Person:** Under a federal program, Connecticut has given those in long-term care the option to shift from nursing facilities to other living environments while maintaining their access to healthcare funding. Connecticut will invest the savings from this effort in programs that add flexibility to long-term care.