



TO: Office of the Health Care Advocate and State Health Care Innovation Plan Leaders
FROM: Patricia Baker, President & CEO, Connecticut Health Foundation (CT Health)
RE: Public Comment on State Healthcare Innovation Plan Draft 1.1
DATE: November 26, 2013

Thank you for the opportunity to comment on Draft 1.1 of Connecticut's State Innovation Model (SIM) Health Care Innovation Plan. CT Health appreciates the level of effort that SIM leaders and stakeholders have invested in this initiative. I am pleased to have participated on the SIM Steering Committee. Elizabeth Krause, CT Health Vice President of Policy and Communications, and I are also pleased to have participated in the Health Equity sub-committee.

The Foundation shares the desire to shape this initiative in a manner that truly transforms the health care system for the people of Connecticut – especially with regard to advancing health equity. In 2012, the Commonwealth Fund found that health insurance coupled with a medical home is associated with reduced health inequities¹, which makes the prospect of SIM's wide scale Advanced Medical Home (AMH) in connection with Connecticut's coverage expansion particularly exciting.

CT Health and SIM Leadership agree that a solid plan to improve health equity will distinguish Connecticut from other states applying for federal SIM funding. At this time, CT Health offers comments on the approach to health equity, oral health, and the overall document content and structure with the goal of further strengthening the plan to obtain funding.

Health Equity

CT Health encourages SIM Leadership to describe the need and opportunity for health equity in Connecticut in a more compelling way if it is to indeed differentiate Connecticut from other states and serve as Connecticut's "quadruple aim."

Health equity is woven throughout the plan, which CT Health supports in concept. The plan's approach to health equity, however, is diffuse and needs a clear overarching strategy and accountability.

CT Health encourages SIM Leadership to leverage the ideas that the Health Equity sub-committee expert group developed in order to strengthen the approach in the draft. Consistent with many of the comments of the Health Equity sub-committee, a robust description of the approach to health equity should be added including plans to:

¹ J. Berenson, M. M. Doty, M. K. Abrams, and A. Shih, Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities, The Commonwealth Fund, May 2012.

- Collect, stratify and distribute patient data by race, ethnicity and primary preferred language for each provider to track opportunities to decrease health disparities and improve delivery of equitable care. Information and support should be delivered to providers in two areas:
 - Support for using the stratified data mentioned above, including explicit measurement of progress toward achieving improvement plans. For example, stratification could (hypothetically) first demonstrate higher HA1c levels among African Americans in a particular practice. Ideally, that practice would develop an intervention to identify why African Americans had different clinical findings than other patients and develop a data-driven intervention to improve outcomes. Following a sufficient opportunity to implement the intervention, re-measurement could indicate improvement for this measure.
 - Information that helps providers better understand the person-centered social, economic and behavioral aspects of inequities, consistent with SIM goals and objectives. For example, providers may benefit from literature and best practice examples that explain and address the relationship between social, economic and behavioral well-being.
- Create an infrastructure to address disparities and guide development, implementation, evaluation and improvement efforts. It is unclear who will be accountable for health equity and how monitoring and evaluation will work. CT Health believes that the general governance design, as well as the Equity and Access Council and the Quality Metrics Advisory Council will need clear roles and responsibilities. Further, CT Health strongly supports the proposal to build health equity metrics into the Common Performance Scorecard.
- Continuously monitor payment reforms to ensure that they are incentivizing equitable care while guarding against exacerbating inequities and potentially promoting under-utilization. This is especially important given the limitations and lack of conclusions within national literature on aligning payment models with health equity objectives.
- Leverage the exciting and important community-based SIM components, which are critical to the ability to provide culturally and linguistically effective care that recognizes that health starts in the communities where people live. The proposed Health Advancement Communities, Certified Community-Based Practice Support Entities, and Community Health Workers have high potential and would benefit from further explanation. In particular, CT Health recommends explaining how these concepts fit together with the other SIM components, including financing, as well as other state initiatives such as Health Neighborhoods. Finally, CT Health advises that SIM leadership must be mindful to preserve a true role for community-based organizations, which are central to implementing a successful person-centered approach.

Oral Health

While oral health is alluded to, the “what” and “how” of a fully integrated and detailed approach to improving oral health is unclear. CT Health maintains that SIM should strive to ensure that medical health includes oral health. CT Health suggests the following content be incorporated into the draft:

- The use of a simple oral health risk-assessment tool by primary care and dental providers.
- Integration of oral health into the “warm hand-offs” between providers.

- Integration of oral health into inter-professional, team care, and/or provider training initiatives.
- A plan to develop and implement oral health outcome measures. We suggest looking to measures developed by the Dental Quality Alliance, especially those aimed at increasing services for high risk patients.

Other Innovation Plan Content

The draft Innovation Plan would benefit greatly from:

- **Clearer background descriptions** of key information that provides the foundation for Connecticut's SIM, including:
 - Data that paints the health care and health equity landscape in Connecticut, including around asthma, diabetes, falls, and hospital readmissions as conditions for which the plan later proposes intervention
 - The population that would be served under SIM
 - Current initiatives and key opportunities in development to improve Connecticut's delivery system (e.g., APCD, ACOs, PCMH, HIE) that support the proposed overall model with racial, ethnic, and preferred language data being an essential common thread
- **A clear description of the AMH model**, including an explanation of how Connecticut's SIM design addresses data-driven opportunities to improve, while building on the current landscape of initiatives referenced above. CT Health recommends the description include how:
 - The AMH works, including its relationship to existing delivery system vehicles such as PCMH and ACOs. We suggest a transparent description of plans to develop unique standards (apart from NCOA and JCAHO) and a description of how the SIM initiative will guide and support providers under system transformation efforts.
 - Consumers, payers, provider practices (in hospital-based, group and individual), employers (including large, medium and small), and advocates will interact under this new transformed delivery system.
 - Insurers will interact with the new system. The current draft does not offer a detailed description of the role of insurers, which theoretically should be central to a multi-payer demonstration where the system is accountable at the payer and provider levels.
 - Community-based grassroots strategies will function to reach and engage individuals outside of large employer groups in the community.
 - The proposed reimbursement design will work with the care delivery model. We believe it is important to describe how care delivery and financing will be aligned.
 - SIM promotes system transformation to a medically, behaviorally and socially-oriented whole-person, chronic disease management mindset that is evidence-based. Specific efforts highlighted by CMS to achieve system re-design include: treatment planning with regular monitoring; coordination of care between multiple providers and settings; medication management and evidence-based care delivery; measurement of quality and outcomes; and support for patient self-management with support from family.

- In support of **consumer empowerment**, a stronger demonstration of the new system's commitment to being responsive to and respectful of the needs and preferences of consumers, as well as a description of how consumer input will be incorporated into the continuous quality improvement loop are needed. Consumer empowerment, which is vitally important, is a two way street that includes both providing effective resources to consumers, as well as designing an adaptive system that is driven by their input on an ongoing basis.
- An expanded description of **elements of SIM governance that would ensure a robust SIM model**, including:
 - Adequate resourcing
 - An infrastructure that promotes accountability for progress and outcomes at the population-based level and at the provider level. We believe that SIM should be managed within a government agency that resembles the former Office of Healthcare Reform and Innovation under the leadership of the Lt. Governor and Advisory Councils.
 - Essential expertise with robust knowledge of: stakeholder collaboration, payer collaboration and management, value-based purchasing and design, network support, education and accountability, care management and delivery system design, quality management and improvement, data infrastructure and reporting, and technology among other substantive areas. Reliance on consultants in combination with a Project Management Office would likely fail to support the state's ability to build capacity and key competencies, while being prohibitively expensive over time.

Organization of the Document

As a grant making foundation that has reviewed and funded hundreds of proposals, CT Health believes that the way in which the document is organized, given the complexity of the issues contained within, will be important to the Center for Medicare and Medicaid Innovation (CMMI's) funding decision.

While we understand the lift associated with editing such a lengthy document at this point in time, we recommend that the document follow a simplified and linear structure. For example, New York issued a draft SIM document to stakeholders on November 19, 2013 that incorporates a structure that closely resembles the outline of key issues provided above including (in an optimal order): background (data and current initiatives), goals and objectives, innovations, governance to manage the plan, and, measurement of success.

Please let CT Health know how we can be helpful as this process moves forward. We look forward to our continued participation and to expanding health equity across the state through delivery system innovation.