STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
June 30, 2015

Meeting Location: Connecticut Behavioral Health Partnership, Suite 3D, 500 Enterprise Drive, Rocky Hill

Members Present: Susan Adams; Lesley Bennett via conference line; Heather Gates; Shirley Girouard via conference line; Beth Greig; Abigail Kelly; Anne Klee; Alta Lash; Kate McEvoy via conference line; Rebecca Mizrachi via conference line; Douglas Olson; Nydia Rios-Benitez; Eileen Smith; Elsa Stone; Randy Trowbridge via conference line; Jesse White-Frese via conference line

Members Absent: Mary Boudreau; Grace Damio; Leigh Dubnicka; David Finn; M. Alex Geertsma; John Harper; Bernadette Kelleher; Edmund Kim; Nanfi Lubogo; Rowena Rosenblum-Bergmans; H. Andrew Selinger; Joseph Wankerl

Other Participants: Sean Bradbury via conference line; Supriyo Chatterjee; Faina Dookh; Kathy Henchey; Ron Preston; Mark Schaefer; Katie Sklarsky

Introductions
The meeting was called to order at 6:10 p.m. Elsa Stone served as chair.
Members and participants introduced themselves.

Public Comment
Supriyo Chatterjee provided public comment (see public comment here). He referenced his public comment to the CT Healthcare Innovation Steering Committee (HISC) on June 11th that included the operative word "Trust". He suggested examining how the US Health & Human Services Public Service Funding regulations may be applied to the CT State Innovation Model (SIM) project. He noted in the draft CT SIM Conflict of Interest Safeguards, there is much about protocols and beneficiaries but little about its effect on the outcomes.

Ms. Girouard asked how it compares to the states Code of Ethics and what trumps federal law or state law. Mr. Chatterjee said a set of regulations have been around for a long time to basically establish objectivity and research. It gains the trust of the public and ensures transparency so there's no conflict of interest. Mr. Chatterjee suggested consulting with an attorney regarding federal and state law.

Minutes of June 9th Meeting
Motion: to accept the summary of the June 9, 2015 Practice Transformation Taskforce meeting – Heather Gates; seconded by Alta Lash
Discussion: There was no discussion.
Vote: all in favor
Abstain: Shirley Girouard

Purpose of Today's Meeting

Elsa Stone reviewed the purpose of today's meeting. She said they will work to gain an understanding of target population definitions and CCIP interventions for each target population. They will come to a consensus on CCIP overall program structure and gain understanding of remaining CCIP design needs that will be addressed by design groups and offline with subject matter experts.

Ms. Lash expressed thanks to SIM PMO and the Chartis Group for rearranging the PTTF schedules and sending out the meeting materials early. She said it really makes a huge difference.

Conflict of Interest

Mark Schaefer reviewed the Conflict of Interest Safeguards (see document here). He said the Health Information Technology Council (HIT) reviewed the Conflict of Interest document and raised an issue that the disclosure provisions were important. Dr. Schaefer said they entered the disclosure provisions from the state's Code of Ethics, statutory provision 1-85, into the Conflict of Interest protocol. He noted it is not in a final draft because HISC wanted some additional work on the protocol. Dr. Schaefer said HISC wanted members to proceed on the drafted Conflict of Interest document to raise awareness and sign that they will disclose potential conflict of interest. Members discussed the Conflict of Interest Safeguards. Ms. Stone asked whether they should vote on this. Dr. Schaefer said members can sign the draft Conflict of Interest Safeguards in the next few days and submit to the PMO electronically, by mail, or other methods. Ms. Gates noted the expiration date on it. Dr. Schaefer noted HISC felt that an expiration date was needed so that it would be readdressed to have a final policy.

Target Populations Defined

Ms. Sklarsky introduced new member, Beth Greig. Ms. Greig is from St. Francis Medical Center and director of case management. Members welcomed her to the Practice Transformation Taskforce (PTTF).

Ms. Sklarsky gave an overview of the target populations defined (see presentation here). Members reviewed and discussed the three target population and their definition. The first target population defined was Complex Patients, clinically and socially. Ms. Lash expressed concern by the way the examples, Camden Coalition and Hennepin, described their project. She noted one was patient centered and the other was money oriented. She suggested being very clear about who is being selected and why, because when they go to evaluate success, it makes a difference in the approach.

Ms. Girouard asked whether the targeted groups such as Medicaid sub-populations and mild to moderately mentally ill advocacy groups or provider groups that care for those specific populations, have been engaged in any of the discussions. Ms. Sklarsky said yes they have been engaged, in particular, the Mental Health arena. She noted the Department of Social Services (DSS) will be giving a webinar presentation on some of the work they have been doing regarding the Medicaid population. Ms. Greig noted Ad Hoc groups that are part of hospital based programs, mostly around behavioral health and substance abuse populations, help bring together community resources on complex patients. She said they meet to talk about people that are struggling in the community and how they can use available resources.

Ms. Gates mentioned that the groups are not mutually exclusive or discreet. She said individuals could cut across all three areas and there's a lot of overlap. Ms. Sklarsky said as they get into more detail of designing the interventions around the populations they will see the overlap a lot more. She said if an Advance Network or Federally Qualified Health Center (FQHC) is implementing one of these programs, they may need to address how the overlap plays out.

Mr. Olson mentioned it is important to note there is a difference between high cost and high utilization. He said a program could be very successful in reducing cost but have no impact on utilization and vice versa. He said it is something for people to think about when they design programs regardless of whether for multiple populations or one discreet population. Ms. Girouard suggested adding quality into the equation as well.

The second target population defined was Equity Gaps. Ms. Sklarsky asked whether the definition on equity gaps was defined too narrowly. Ms. Lash suggested being very clear in what is wanted in interventions such as diabetes or asthma. Dr. Schaefer noted the Health Equity Design Group (HEDG) has not finalized all of the recommendations. He said the information is preliminary and they are waiting to hear back from HEDG as to what they think should be part of the score card.

Ms. Smith expressed concern with the three diagnoses being focused on along with the screenings. She said the screenings are related to age and sex. She noted the LDL screening is something used to manage a hypertension and diabetes while colorectal screening is age related. She suggested looking at and following the specific guidelines by Hedis Measurements. Dr. Schaefer asked whether she was talking about the measurement or the clinical protocol that would be followed. Ms. Smith said yes but there are a series of measurements that go with each diagnosis. She suggested moving focus items into the proper category and decide by male, female, age, or other.

Ms. Stone noted the three diagnoses and two screenings are common place in the disadvantaged population. She said it's not so much that they are connected to each other but rather the population is lacking in getting these services done. They are listed so the group can decide on which they will next focus on. Ms. Sklarsky said part of the reason the clinical areas of focus were chosen is because they align with the score card and they are known gaps within the populations being looked at.

It was noted that there are number of non English speaking patients and that the language problem is a big barrier to health care. Members talked about why they should narrow the equity gaps and expressed concern with how to address the various equity gaps that exist. Ms. Sklarsky said they can continue to discuss this as they have the design group meetings.

The third target population defined was Behavioral Health. Ms. Gates noted that Medicaid Behavioral Health Homes exist and are in progress. Ms. Lash said that in some parts of Connecticut there are not enough behavioral health service providers and it can be a big challenge to meet the requirement of being connected.

CCIP Overall Approach

Ms. Sklarsky noted two key decisions on the CCIP approach that are required. Members discussed defining the approach for core community linkages for each target population. Ms. Lash expressed concern that putting the responsibility on the Community Health Worker (CHW) to address the Health Equity gap is not good enough. She suggested including the clinical health team to be part of the responsibility. Ms. Sklarsky mentioned the aim to have the CHW integrated and to be working with the primary care team directly. She said they can clarify this.

CCIP Target Population Interventions

Ms. Sklarsky gave an overview of the three target population interventions. Ms. Rios-Benitez mentioned seeing the person as involved in the decision making process and the center of the Multidisciplinary Team (MDT). Mr. Olson noted it was important to measure the health literacy of the patient.

Ms. Stone noted food security and nutrition was important for community linkages for complex patient target populations. Mr. Olson said housing, food security, and vocational/employment are very important. Members agreed. Ms. Adams suggested for home health to be included as a linkage especially for patients with chronic diseases. Ms. Sklarsky noted home health will be included with the Health Care Transitions standards and will not be lost.

Ms. Greig mentioned economic assistance should be considered a community linkage for equity gap target populations. She said the cost of medications for conditions such as hypertension, asthma, or diabetes can be prohibitive. Ms. Stone noted that economic assistance, housing, and nutrition were important. Members agreed. Ms. Girouard said they may not want to prescribe this if they want to be patient centered. She said it would be up to the providers to determine what the needs of their patients are. Ms. Sklarsky mentioned providers can go outside of the list if they feel there is something more important.

Members discussed the CCIP behavioral health integration intervention. Ms. Gates noted that the entire health care system in CT is in its infancy in developing integrated care between behavioral health and primary care. Ms. Sklarsky asked whether they want to focus the screening efforts on one area for the behavioral health need, such as depression, substance abuse, and trauma as opposed to being comprehensive. Ms. Girouard said diagnosis is extremely helpful in generating coverage. She noted it was a tough call to make and suggested being careful with how they prescribe diagnosis. Members agreed on not being so prescriptive on it.

Mr. Olson mentioned that there are lots of primary care practices that already screen for these things but it may be done by non providers. He said there can be harm done by asking but sometimes the harm has to be done in order to achieve a therapeutic outcome. Ms. Stone mentioned that patients can answer by screen or paper and where they do not have to answer to another person. Mr. Olson noted there are a lot of different standardized validated instruments and tools that exist that can be used for multiple delivery ways, in multiple populations and languages. Ms. Sklarsky said it sounds like there are solutions to screening more broadly, that's not going to be over burdensome to expect of a practice.

CCIP Design Needs
Ms. Sklarsky said there will be more design group sessions and they are going to be more spread out. She noted the standards are going to be designed around the interventions and the elective capabilities will be separate. Everything will be pulled together into one document that will include the clinical component, community component, and the analytic capabilities. The design groups will be developing different parts of the document. Ms. Sklarsky explained what each of the design groups will be focusing on.

Next Steps
Ms. Sklarsky reviewed the PTTF revised timeline of meetings. The next PTTF meeting will be July 28th and the focus will be community linkages and discussing the clinical capability standards from Design Group 1.

Motion: to adjourn the meeting – Alta Lash
Discussion: There was no discussion.
Vote: All in favor

The meeting adjourned at 8:00 p.m.