STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
July 28, 2015

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

Members Present: Susan Adams via conference line; Mary Boudreau; Grace Damio; Heather Gates; Dr. Shirley Girouard via conference line; Dr. John Harper; Bernadette Kelleher via conference line; Abigail Kelly; Anne Klee; Alta Lash; Rebecca Mizrachi via conference line; Nydia Rios-Benitez; Rowena Rosenblum-Bergmans via conference line; Eileen Smith; Dr. Elsa Stone; Dr. Randy Trowbridge via conference line

Members Absent: Lesley Bennett; Leigh Dubnicka; David Finn; Dr. M. Alex Geertsma; Beth Greig; Dr. Edmund Kim; Nanfi Lubogo; Kate McEvoy; Dr. Douglas Olson; Dr. Andrew Selinger; Joseph Wankerl; Jesse White-Frese

Other Participants: Sean Bradbury via conference line; Karen Buckley-Bates via conference line; Supriyo Chatterjee; Faina Dookh; Meredith Ferraro; Kevin Kappel; Ron Preston; Dr. Mark Schaefer; Katie Sklarsky; Sheldon Toubman; Brad Weeks

Introductions
The meeting was called to order at 6:06 p.m. Dr. Elsa Stone served as chair. Members and participants introduced themselves.

Public Comment
Sheldon Toubman, a staff attorney for New Haven Legal Assistance Association, provided public comment and urged Practice Transformation Taskforce (PTTF) members not to sign the Conflict of Interest (COI) policy. He said the COI Safeguards policy is not equal to the state's Code of Ethics (COE). He noted that the COE defines two different kinds of Conflict of Interests. One is substantial COI and the other is a potential COI. He mentioned that the COI Safeguards only deals with the substantial COI part of the COE. Mr. Toubman said hardly anybody has a substantial COI but almost everyone has only a potential COI. He mentioned that members should not sign the COI Safeguards because it is a defective and weak document that provides almost no protection. He volunteered to provide members with a copy of the revised version with cross outs indicating portions that should be taken out.

Dr. Girouard thanked Mr. Toubman for his comments and for helping to lend some clarification. Ms. Boudreau mentioned she will not be signing it until she reviews it. Dr. Schaefer said for clarification purposes, they handed the COI Safeguards out but didn't expect members to sign it today. He said members are allowed time to review and do a legal review if necessary. If any questions or concerns during the course of the review, members may contact SIM Program Management Office (PMO). Dr. Schaefer said signed copies of the COI Safeguards can be submitted to Deanna Chaparro at SIM PMO.

Ms. Smith asked why they can't just follow the state's COE. Dr. Schaefer mentioned the administration views the role of SIM governance as an advisory body. He said they acknowledge the fact that there are people at the table who have a diversity of interest but it should be balanced. There shouldn't be a particular interest that over powers a majority position. He noted it's a substantial conflict of interest policy. He mentioned that CMMI reviewed the COI statement and thought it was strong. Dr. Schaefer said Connecticut is not out of step with other SIM states. He noted the COI policy is as strong as any other SIM states they have dealt with. Mr. Toubman said there are many state agencies and boards that comply and use the COE. He said there is nothing special about SIM to prevent them from complying with this.

Minutes of June 30th Meeting
Motion: to accept the summary of the June 30, 2015 Practice Transformation Taskforce meeting – Alta Lash; seconded by Anne Klee
Discussion: There was no discussion.
Vote: all in favor

Purpose of Today's Meeting
Dr. Stone said the goal of the meeting was to provide an update on the progress to date and approach to next steps. They will obtain feedback and input on the design approach and standards for Community and Clinical Integration Program (CCIP) interventions – Complex Patients and patients with Equity Gaps. She said they will also share the summary of Vermont's experience and identify lessons for Connecticut.

Progress to Date and Next Steps
Ms. Sklarsky gave an overview of the progress to date and next steps (see presentation here). She said the objective of CT SIM is to establish a whole-person centered center healthcare system through seven strategic initiatives. The Medicaid Quality Improvement and Shared Savings Program (MQISSP) RFP process will include the opportunity for networks to demonstrate a commitment to the CCIP programs and request technical assistance to implement the programs. Ms. Lash asked whether DSS will be doing the RFP for this and what authority does DSS have over people that aren't Medicaid patients in the Advanced Networks. Dr. Schaefer explained the procurement process for the RFP. The procurement process would identify the Advanced Networks (AN) and Federally Qualified Health Centers (FQHC).

Ms. Lash asked who writes the RFP. Dr. Schaefer said typically it is done by state agency personnel. The work that PTTF produces could be a component of the RFP. He noted that there may be a select small group of advisors, with no relationship who may compete for this. He said it may be important to have DSS in the room. Ms. Lash expressed concern and mentioned there are others, in addition to Medicaid clients that are in need of CCIP capabilities. She suggested for it to benefit non Medicare as well. Dr. Schaefer mentioned the PMO administration of the CCIP agreements and overall oversight of the program will be critical. Members discussed the need to include non Medicare participants into the CCIP process.

Ms. Sklarsky reviewed the CCIP timeline and goals.

Program Design: Complex Patients & Patients with Equity Gaps
Ms. Sklarsky reviewed the program design for improving care for individuals in the target populations. Ms. Lash said she objects to having the Community Health Worker (CHW) bear the brunt of all of the activity around Equity Gaps. She suggested for the entire practice to deal with it and structure the equity part stronger. She noted the CHW does not order services in a practice.

Ms. Lash suggested trying to get out some of the prejudices because it affects care and doing a real time assessment of whether patients of color and low literacy patients receive evidenced based care. She mentioned it could be an indicator of where an intervention should be taken, before the patient has a negative outcome such as stroke or death. Ms. Lash suggested beefing up the activity around Equity Gaps.

Ms. Damio asked whether they were talking about Equity Gaps in health care or Equity Gaps in health status. It was noted that CHWs play an important role in Equity Gaps in health status because of the social determinants. CHWs can help to address the needs better. Ms. Sklarsky said they have been referring to inequities in health status. She said they can discuss whether it should be a broader definition. There may be some technological challenges and they may need to include additional people to help answer the question.

Dr. Stone noted when they defined the Health Equity population, it included people with health care problems and there is an enormous overlap with the Complex Patient population. She mentioned the CHW is on the Equity Gap side and separate from the Complex Patients part and it seems there are two things they are looking at. She suggested it should be one health care team. Dr. Stone noted that one health care team may have more than one CHW to deal with the health equities but CHWs should be part of the team. Ms. Sklarsky said they never made a decision but decided to develop the designs to see how it looks. She mentioned the need to develop a CHW capability for both populations and there may be more multidisciplinary team members imbedded. Resources would be developed and used differently depending on the needs of the patients. Ms. Damio mentioned it being important to have CHWs as part of the health care team.

Ms. Sklarsky noted there are a range of options that require varying levels of technology. She said guidelines and analytical abilities are needed to identify the gaps. Risk stratification would be used to identify the Complex Patients. She mentioned Design Group 3 will be working on the technological capabilities in a broader way. Ms. Sklarsky asked about the necessity of creating a guideline. She suggested at minimum there would be basic analytic capabilities for networks to identify. Members agreed. Ms. Sklarsky said they will survey some of the ANs to understand what the capabilities are and to have an informed opinion.

Members discussed evidenced based guidelines. Dr. Schaefer noted that some practices and ANs get health risk stratification data from the payers. It is typically claims based as opposed to Electronic Health Record (EHR) based. Dr. Schaefer asked to what extent they should require the development of the EHR based capability or whether it is sufficient to health risk stratify with data from the payer. Ms. Rosenblum-Bergmans said you would ideally want to marry the claims data with the clinical data and EHR and any social determinants available. She noted there are capabilities to overlay software and aggregate information.

It was noted that there are ANs with the capability of bringing all of the relevant information together to help make decisions. Dr. Stone mentioned they would want more than just claim based data. Ms. Kelleher said she agrees with Ms. Rosenblum-Bergmans but is not sure at what point they could expect a real result or how the data would be extracted. She mentioned it should be an ultimate goal. Ms. Lash suggested communicating this information to the Health Information Technology Council (HIT). She expressed concern regarding HIT providing the data that would be needed. She mentioned issues such as under-service and under-representation should be carefully monitored. Ms. Sklarsky said they have started a dialogue with HIT and are working to communicate on what the needs are. Dr. Schaefer said they will have to work with the HIT Council

to define what the needs and surface areas where technology may be an element to enable the care delivery of reform.

The group talked about who the members on the multidisciplinary teams should be. Ms. Sklarsky asked whether the guidelines should be around certain team members or around functions. She asked whether a manager would be needed to provide oversight. The manager could be clinical or non-clinical and would be additional to the team. Ms. Ferraro asked why the manager would be an additional person to the team. Ms. Gates said there is a lot of navigation work involved in managing and making a team like this function optimally. Dr. Stone said she agrees that someone is needed to oversee and make sure everything gets pulled together.

The group discussed the role of CHWs, doctors, registered nurses (RN), licensed practical nurses (LPN), and social workers (SW) members for the multidisciplinary teams. It was noted that the function of each position is important but mechanisms need to be in place so that things flow seamlessly. It was mentioned for social support there will need to be a decision but the role of the CHW is important. Ms. Sklarsky said it sounds like everyone agrees with requiring a CHW as a guideline, defining the minimum functions that are needed, and allowing leeway to choose who those people should be.

Ron Preston, from UConn Health, mentioned it being important in the process to inform the team that certain populations face certain challenges. It may be easier than having a complicated interdisciplinary team to reinvent the wheel. Ms. Gates suggested for there to be an individual trained in the area of Behavioral Health within the complex definition. Dr. Girouard suggested having someone available on the team that is able to make an initial assessment and referral in the area of Behavioral Health. She said they should be careful about requiring someone to be a permanent member of the team. Members discussed the need for Behavioral Health screening on the multidisciplinary team and it being important for team members to work together. Ms. Sklarsky said it sounds like everyone agrees with having a manager.

The group discussed having someone employed or imbedded into the practice or the community. It was noted that the specifics of the role is really important and that the employment relationship is not that crucial. Members also discussed not being too descriptive. Ms. Lash said they will be sharing medical information once the CHWs are imbedded in a community organization. She asked how patient confidentiality and privacy will be protected. Ms. Sklarsky noted that there is a consent registry for patients to consent sharing certain types of information. It will not be so that everyone can see all aspects of the patient's history but only for the people that would need to know. Members discussed business agreements for networks, consent agreements, and other high level solutions. Ms. Sklarsky mentioned there will be additional conversations on this topic.

Vermont Case Study
This was not discussed due to a lack of time.

Next Steps
Ms. Sklarsky suggested adding another PTTF meeting and an additional Design Group 1 meeting to discuss the behavioral health intervention and the elective capabilities. Everyone agreed. She said they will summarize where there is basic agreement, flag what would still need to be considered, and send it out to members.

The meeting adjourned at 8:01p.m.