STATE OF CONNECTICUT
State Innovation Model
Consumer Advisory Board

Meeting Summary
April 5, 2018

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

Members Present: Alan Coker; Kevin Galvin; Robert Krzys; Velandy Manohar; Arlene Murphy; Terry Nowakowski; Ann Smith

Members Absent: Jeffrey Beadle; Alice Ferguson; Rev. Bonita Grubbs; Linda Guzzo; Stephen Karp; Theanvy Kuoch; Nanfi Lubogo; Denise Smith

Other Participants: Lesley Bennett; Sharon Langer; Alta Lash; Jenna Lupi; Bradley Richards; Mark Schaefer; Shiu-Yu Schiller; Robin Lamott Sparks; Elsa Stone; Jan VanTassel; Jesse White-Frese

1. Meeting Objectives and Process
The meeting was called to order at 6:15 p.m. Arlene Murphy and Kevin Galvin co-chaired the meeting.

2. Introductions
Members and other participants introduced themselves.

3. Public Comment
There was no public comment.

4. Practice Transformation Task Force (PTTF) Recommendations and Review Questions

- Primary Care Payment Reform Overview
  - Dr. Schaefer presented the PCPR overview.
    - Ms. Smith asked when on the slide talking about the Primary Care Modernization, was it an oversight, intentional, or not an important element of the model to include Behavioral Health Integration. Dr. Schaefer said he overlooked it. He said for a practice to co-locate it, he sees it as an essential component.
    - Ms. VanTassel said PTTF recommendation mentioned that providers need to be sure that they are able to measure quality and measure under-service. She said it needs to be part of the package. Dr. Schaefer said everyone involves needs to know that you are getting what you think you are paying for. He said the reporting of out the demonstration is critically important.
    - Ms. VanTassel asked are we going to have an effective way to measure quality outcomes and under-service. Dr. Schaefer said if primary care is the only entity that where the payment is being bundled, then the question is whether primary care is doing less with the bundle than before the bundle. Are they no longer doing visits because they no longer have to get paid? He said a referral to a consult does not come out of the bundle. Everything else would still be fee for service.
    - Ms. Lamott Sparks said there was a meeting about Integrated Mobile Health because 60% of their calls are not emergencies. She said if we have a culture where people are calling 911 because it is the easiest thing to remember, care coordinators are not

going to see them because they will get EMS. She noted the need to address what is going on in the cities. Dr. Schaefer said he recently joined the Mobile Integrated Health workgroup and they said there are folks that call 911 because the remote control fell under the bed. It is a lot of this going on. Dr. Schaefer said that changing primary care is going to change every problem that we have in healthcare. He said if there are home visits for non-emergent purposes, patients may overtime not use the only tool to get someone to the house. Dr. Richards said there is so much of a need to get people in the homes often times and one of the biggest barriers is they don't have someone. He said they have visiting nurses if available. He said having someone available for easy access such as CHWs or telemedicine, it makes a huge difference. He said he would like to do more home visits but it is not financially viable for the practice to do it.

- Ms. Lamott Sparks said we have not talked about integrating this into the system. She asked how do you integrate the existing system and transition somebody. Dr. Schaefer said they could do it. He said they could create elective areas where we encourage practices to innovate and provide some technical assistance. He said they can create thru the payment the flexibility, especially in the urban areas where it makes more sense for practices to be able to do it. Dr. Schaefer said he thinks they should add mobile integrating as one of the things to look at as an elective option.
- Ms. Langer said with some of the other models, how they measure quality after putting some of these pieces into place. Dr. Schaefer said there going to have a quality score card that the payers will expect them to report out on. He said care experience is also important. Dr. Richards said Iora Health uses a net promoter score (NPS). It is a measuring if you would recommend this to someone else. They really look at whether people are satisfied with the service and would they recommend it to someone else. Dr. Richards said other healthcare systems are starting to use this as well.
- Dr. Manohar said on all of the OHS documents there are consumers but on these documents, he does not see consumers at all. He said the first slide, at the bottom there are comments. He said there are many reports but he did not see anyplace how we answer the needs mentioned such as the transportation issue. Dr. Schaefer said in the planning process we need to touch back on the things that were raised in the listening forums and ask whether these things will further our ability to address these things or not.
- Dr. Manohar said the document is beautiful and he does not have a problem with the panels listed on the left column but he would like to have consumers involved "from the get go". He mentioned stakeholders are mentioned a lot but he would never start panel groups without consumers. Dr. Schaefer said they met with the CAB and other consumers for input. He said the program management office has been informed from the listening forums. Dr. Manohar said they want them in the beginning. Dr. Schaefer said if there are specific recommendations that should be taken on advising the process they should do it and take it back to PTTF.
- Ms. Murphy said she would like clarification on what exactly is being proposed. The recommendations of the PTTF are complete and comprehensive. She said they talk about the improvements that are needed in primary care and most of them nobody would disagree about. She asked what is it we are working on or being proposed here. Dr. Schaefer said last year's report was phase one and got us to the goal post. He said the next phase is to figure out how we are going to move the ball down the field. He said we need an advisory process for this second phase where we actually consider all of the capabilities that we would build in as a requirement. He said they

have to ask all stakeholders whether the product fulfill the ambitions. He said we are going into this phase and then start the conversation with Medicare with a concept paper.
    - Ms. Murphy asked what they would start the conversation with Medicare for. Whether for grant. Dr. Schaefer said for demonstration. He said the most challenging patients are in Medicare. Medicare does not change their payment rules very often. He said we are saying to Medicare that we want to design a Connecticut reform that builds on what is already happening and addresses some of the problems that is not happening. He said Medicare would need to do a waiver. The Medicare waiver should not be confused with a Medicaid waiver.
    - Ms. Smith noted the importance of consumer/community input at the beginning of the design process. She said we have been hearing from consumers how the Connecticut system does not serve them. She said she is not understanding how the Primary Care Modernization model will do this. She said if she does not see a focus on CHWs in the workforce development to make sure there are folks to go into the communities to develop repo ire and trust with the residents. If we do not have this, than anything we do with bundling primary care payment or value based payment is not going to get us to where we want to be in terms of improvement and healthcare outcomes for those who have substandard healthcare.
    - Ms. Nowakowski said she sits on the Community Health Worker (CHW) Advisory Committee. She said regarding the proposed changes, until you have trusted members of every community sitting alongside the clinician, sitting alongside a trusted member and you know them, you are never going to get to what is going on in that person's life. She said in primary care they are paid so little but are tasked with trying to manage people's lives and their care and it's impossible. She said it is all about someone being able to go into the home in the community to see what is going on and we do not have that today.

- PTTF Consumer Representative Remarks
    - Alta Lash of PTTF and HISC provided remarks. She said if a practice accepts bundle payments there are commitments that go with it. First, there is the commitment to be innovative. Second, is to accept certain standards of accountability. Third, we do want to see some simplification of paperwork so the providers and the team have more time to spend with the patient. Ms. Lash said patient centered has always been the primary concern and is where PTTF started. PTTF developed the standards that they felt were important and incorporated them into the community and clinical integration program (CCIP). Ms. Lash said she want to reassure everyone that the consumers on PTTF are very vocal.
    - Lesley Bennett of PTTF provided remarks. Ms. Bennett said her sole focus is to advocate throughout the state for patients and patient centered care. She is the parent and caregiver of someone with a rare disorder. She said when PTTF developed the recommendations they were focused totally on patients and actual users. The key things that they need is transportation and communication. She said they focused on the CHWs but it can't be incorporated right now unless we start funding the primary care practice with more money. They have to be able to get the CHWs and care coordinators.
- Physician Remarks
    - Elsa Stone, MD of PTTF provided physician remarks. She said she wanted to provide an overview from a physician's point of view. She said she is co-chair of PTTF and got involved because she was frustrated with the healthcare system as we know it and by the lack of necessary supports to help patients achieve their goals for improved health.

Dr. Stone said physicians are committed to face to face visits and it is the only activity that generates the revenue to keep the practice running. She said the pressure is on physicians to see more and more patients. She said patients are losing out and doctors are burning out. It is time to modernize and it can only happen with changes in how we pay for primary healthcare. Dr. Stone said the recommendations of PTTF and the payment reform are vitally important. She said change is hard but change we must.

- Ms. White-Frese said there is "a disconnect" that is going on in all the different parts and it is why we are doing this. She there are so many pieces that yet need to be in place. There is a need to have a deeper understanding of the multiple needs that so many families have and how difficult things are for them to manage in the primary care setting. She said this is a good place to start but unless they put other things in place they may not see much progress.
- Mr. Krzys said he thinks we are all in agreement that we can measure some underservice right now. He said we are all in agreement that there is an underservice problem. He said whatever is in the services to be bundled whether CHWs, Behavioral Health, transportation, and telemedicine, there may be some parts that is so profound that it would have to be essential benefits of it. He said one thing that should be addressed by the state and by the community is who is going to do it. Mr. Krzys said he thinks it is the workforce thing. He said we have to have a plan as a state to develop these workforces. These are jobs for young people in the community. He said it is necessary to emphasize certain things in this model.
- Mr. Galvin said one thing he finds exciting about this is the care coordination. He said one of the challenges with it is the fact that as we all went through the ACA people might argue that we didn't do a very good job of bringing the people into the primary care arena. He asked whether there will be a methodology to bring people into the primary care arena from the different segments of our communities to make it as robust a population as possible.

- Bradley Richards, MD, of Yale School of Medicine provided physician remarks. He said the patient population where he works in is mostly Medicaid and there are dual eligible patients in Medicaid/ Medicare. He said there is fragmentation of payment under FFS. He said as a provider he would like to work where the payment would allow to take care of patients as a person and currently it is hampered. Dr. Richards spoke about a patient that they had to have police do a safety check on. He said outside of the clinic walls they do not have a relationship with him. He said there is no one to follow up on him. This is one example. He said the capitated payments are not going to fix everything but they will allow for underserved populations to provide more services that are really needed. He said there is a lot of opportunity to do things differently.
  - Mr. Galvin asked whether workforce development should be more at the front end of the discussion in the development of this. He said they should consider developing the workforce population. Dr. Schaefer said we have to figure out a grow curb on some of this and is one of the reasons we might want to start with the integration of a CHW on the team in practices throughout the state and to give the team time to accommodate the team approach. He said if we did this on scale and if primary care practices came forward in large numbers to do this, without question we have to look at the areas where there are gaps and where the workforce needs to be. Dr. Schaefer said we are looking at ways to provide input on where the workforce is and where it needs to be. He said some of the letters received were about collaborating and ensuring the training programs were aligned. He said CHWs and physicians are an important part of the workforce.

5. Additional Discussion and Questions

- Ms. White Frese asked whether capitated payments are made by the insurance companies to the providers. She asked whether the rates paid to the providers different for every payer for the same requirements. Dr. Schaefer said they are not going to pay the same amount because a commercial population has fewer demands on the healthcare system. The amount that Medicare pay will be high and the revenue will be different. The cost of care is different.
- Mr. Coker asked whether anyone was familiar with the WISE program. He said it is run through the Department of Mental Health and Addiction Services (DMHAS). It provides a case manager and recovery assistant to check on patients several times a week. He said the program is good and he thinks we could borrow what they do and what is being recommended for primary care. He said the program is active and is state run. He suggested looking at what they do and "piggy back off" of this program. He said he knows physicians are underpaid but maybe there could be more input from consumers.
- Ms. Smith said she appreciates the comments from the physicians and how they put it in perspective. She said we can do this but if we don't have the infrastructure to support it we won't be able to realize all of the potential that it proposes for us. She said in thinking about highly regulated things are, how we are going to develop a robust pool of CHWs that will be inclusive to allow it to be representative of the patient population that we have. She asked how it would allow for cultural sensitivities that we have. She said it is not a one size fits all for a solution to it. Ms. Smith said a lot of the initiatives are not often presented in a way that John Doe can understand. It is not heard about until it is set in stone or approved and then it is too late for them to change it. She said the timeline is aggressive. Dr. Schaefer said he is glad to hear it. He said it is going to be tough in doing it right, planning, and building. He said it will be tough in another way and that is getting people to do it. He said payers would much rather align with what they are doing nationally and this will be tough to sell.
- Ms. Lamott Sparks said she thinks what is missing is another layer to figure out a linkage to fit with the community and what is happening in the ground level. She said there should be a solution that works for the community and not be just sitting there and nobody uses it.
- Dr. Manohar said there should be someone looking at all of the information coming in. He said it will take a tremendous effort otherwise there will be silos.
- Ms. Murphy said she thinks they all agree that change is needed. She said they are hearing there is a need for robust patient, family, and community input so that we solve the real problems at the community level. She said they will generate a list of questions. She asked whether there is a way to have patient/ family participation at the beginning of this process. She said not just practices talking here and consumers talking there but people around the same table to communicate with each other. She asked whether this is a good next step. Dr. Schaefer said yes. He said he would like to talk to the chairs first and the CAB about solving for this.

6. Additional Public Comment

There was no additional public comment.

The meeting adjourned at 8:00 p.m.