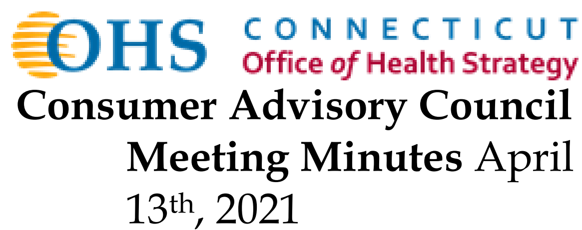

Consumer Advisory Council Meeting Minutes April 13th, 2021

Meeting Date	Meeting Time	Location
April 13th, 2021	3:00 – 5:00 p.m.	Zoom Meeting

Participant Name and Attendance

Jeffrey G. Beadle		Robert Krzys	X	Christiane Pimentel	X
Adrienne Benjamin	X	Terry Nowakowski	X	Peggy Lampkin	X
Alan Coker		Velandy Manohar	X	Andre L. McGuire	
SB Chatterjee	X	Soneprasith Phrommavanh	X	Daniel C. Ogbonna	X
Taylor Edelmann	X	Ann R. Smith	X		
Others Present					
Terry Gerratana (OHS)		Dashni Sathasivam (HES)		Margaret Trinity (Bailit Health)	
Ormand Clarke (OHS)		Michele Scott (Consumer)			
Leslie Greer (OHS)		Sarah Leathers (Healing Meals)			
Krista Moore (OHS)					

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Consumer-Advisory-Board

	Agenda	Responsible Person(s)
1.	**Welcome**	Terry Nowakowski
	Call to Order The scheduled meeting of the Consumer Advisory Council (CAC) was held on Tuesday, January 12th via zoom. The meeting convened at 3:03 p.m. Terry Nowakowski chaired the meeting.	
2.	**Public Comment**	Terry Nowakowski
	No public comment was raised	
3.	**Approval of the February 9th & March 9th Meeting Summary**	Terry Nowakowski
	The motion was made by Terry Nowakowski and seconded SB Chatterjee by to approve of the minutes of the Consumer Advisory Council meetings of February 9th, 2021 & March 9th, 2021. Motion carried.	
4.	**CT OHS Growth Benchmark Unintended Adverse Consequences Measurement Plan**	Krista Moore & Margaret Trinity
	• Krista Moore led a discussion of the OHS Healthcare Benchmark Initiative including a status update, the Monitoring Plan, select findings on costs and cost growth drivers. Under an Executive Order by the Governor, OHS is mandated to monitoring healthcare spending. The benchmark provides a target towards which payers and providers can aim with the goal of making Connecticut's annual healthcare cost growth more sustainable. • Benchmark values for 2021 is 3.4%, 2022 is 3.2% and 2023 – 2025. There are no penalties for exceeding the benchmark. • The primary care spend target is an expectation for what percentage of healthcare spending should be devoted to primary care. Connecticut has been found to spend more on specialty	

care than primary care. OHS calculated a statewide weighted average of current primary care spending. The best estimate was found to be 4.8% primary care spend. This was used to set the target spend of 5% in 2021. Executive Order #5 requires that this target reach 10% by 2025. In late 2021, the OHS Primary Care and Community Health Reforms Work Group will recommend to OHS primary care spending targets for 2022 – 2024.

- Quality benchmarks are targets which all public and private payers, providers and the State must work to achieve to maintain and improve healthcare quality in the state. These quality benchmark may include clinical quality measures, under- and over-utilization measures, and patient safety measures, but are not limited to these types of measures. CT will be the second state to have statewide quality benchmarks, Delaware being the first. OHS's Quality Council will develop recommendations during the summer for adoption on January 1st, 2022.
- The Monitoring plan was developed in response to concerns raised by the Technical Team and Stakeholder Advisory Board raised concerns that the cost growth benchmark might cause providers to reduce healthcare services inappropriately. This is known as stinting, in which providers provide less or lower care to meet targets. Other states with cost growth benchmarks have not documented stinting. OHS drafted a monitoring plan for adverse consequences in late 2020 with measures to track preventative care, access to care and to detect under-service. The monitoring plan was recently adopted and released.
- To understand costs and cost growth drivers, OHS had a contractor to perform an initial data analysis that included the Connecticut All-Payer Claims Database combined with other data resources. More analytic work will be conducted in 2021. Some findings included commercial medical spending per member per month increased 15% from 2015 – 2018. Spending grew 4.9% per year, excluding retail pharmacy, where spending growth in other states has been high. The average annual wage growth in CT during this period was 1.47%
- Out-of-pocket spending grew and reflects changes in employer decisions on plan design, and employee plan selection as employers and employees try to cope with high costs.
- Commercial hospital spending grew 6.9% per year on average from 2015 – 2018. Inpatient acute, Outpatient ER and Outpatient non-ER were main service categories experiencing the greatest change.
- Chronic illnesses were common associated with far-above average spending
- Overall, the goal is for this data to inform concrete corrective action.
- Velandy Manohar asked 2015 – 2018 spending went up by 15%?? Do we have such data from previous years (2012-2014) to see longer trends? He asked about the social determinants of health and how that would be considered in analysis. He was interested in knowing the top 5 causes of death and if there have been changes in these rates of mortality. Given that some of these causes of death (heart disease, COPD, stroke, accidents etc.) are preventable to reduce risk. He would like to see another set of data. Having data on costs alone with disease types. He would like to also have data on social determinants. outcomes.
- Krista Moore responded that this is the first brush of analysis tackling low-hanging fruit.
- Velandy Manohar was interested in seeing data from 2011 – 2014 to compare with the data from 2015 – 2018 and he suggested having a crude measure of all-cost mortality rate and considering the longevity rate. He also noted that the pandemic will impact this analysis.
- SB Chatterjee referenced his public comment related to the data use strategy, mentioning the importance of race, ethnicity and language data as well as algorithms, which is suspect to bias.

The heavy dependence on APCD, however it has a low completion rates of demographic race and ethnicity data. How are these items going to be addressed in the context of the cost growth benchmark? He also noted that the health disparities are costly. To put dollar amounts to disparities, the data needs to be clean to tackle these issues.

- Margaret Trinity thanked SB Chatterjee for his public comment. All the comments were carefully considered. She clarified that the benchmark is a percentage was set based on guidance from the advisory body. OHS is collecting data from the state's carriers to evaluate performance against the benchmark. The findings shared in Krista Moore's presentation were based on the APCD, however the benchmark itself is not reliant on APCD data. There is a lag in the data, which is why the findings presented were from 2015 - 2018 interest in adding the 2019 and 2020 data to the data use strategy moving forward.
- Daniel Ogbonna asked for clarification PMPY (per member per year) and how that relates to increased spending on chronic illness spending.
- Margaret Trinity thanked Daniel Ogbonna for his question clarified that the cost growth benchmark relates to capturing data from the insurance carriers and understanding the performance of providers and systems against that benchmark (is rate for healthcare spending in the state at or above or below the benchmark). Separate from that, OHS has also taken up the Data Use Strategy, a deep dive into the data in the APCD to understand some of the reasons of the healthcare cost growth and drivers of the growth in CT. The analytics contractor looked at chronic illnesses with the main point that chronic illnesses are costly to consumers and the system. Understanding the cost drivers in the state and why they are growing is important.
- Krista Moore added that the more spent on primary care, the less will be spent on treatment down the road, curbing cost growth.
- Terry Nowakowski stated that since this does not include HUSKY or Medicare, the cost of health care and its rapid increase is jeopardizing people's other social determinants of health.
- Margaret Trinity highlighted the monitoring plan which she shared in the chat. This ensures sure that the benchmark doesn't impact the quality and access of care. Measures of underutilization of medical services, measures of out-of-pocket spending etc. looking pre-benchmark implementation and post.
- Daniel Ogbonna asked if there was a dollar amount assigned to the benchmark.
- The Benchmark is expressed as a percentage (3.4%) and not a dollar amount. The carriers of healthcare submit data, so health care spending in the state is measured against the 3.4%. She reinforced that there are not penalties for not achieving the benchmark.
- Adrienne Benjamin asked how much have hospitals raised their rates and how does that relate to the drivers of cost? Also, if we want people to go more to their primary care provider, there needs to be more than 15 minutes in a visit. This needs to be changed within the system and not structured to enable the quality relationships with their primary care provider is crucial. The quality of health care is rooted in the primary care experience and the insurance companies has hampered this. Opioids addiction has grown, and there is no mention of that in chronic disease, but it would be interesting to see if that could be pulled out and analyzed separately.

- Krista Moore and Margaret Trinity express agreed that there is going to be more data analysis in the future with OHS committed doing more analytics along those lines of behavioral health and substance use.
- Adrienne Benjamin asked if the analytics will look at how many patients a provider must see in a day to be viable.
- Margaret Trinity brought up the primary care spend target and the Primary Care Workgroup would be responsible for discussing the approaches for achieving greater spending in primary care and what is needed to get there.
- Ann Smith agreed that the amount of time allotted for a primary care visit should be viewed within the context of recently published reports of the decline in the number of independently practicing physicians whose practices who have not been bought up by hospital systems. As in any other industry, it is important to look at the anti-trust laws and anti-competitive laws so that these smaller competitors are not continued to be squeezed out
- Margaret Trinity asked if that the availability of primary care providers and what does that supply look like was part of Ann Smith's concern.
- Ann Smith agreed while also noted that this is a pre-pandemic concern. Without regulatory constraints and the impact on rising costs, viewing primary care services in the same way looking at internet and utility services as they are being impacted by the same types of positive and negative pressures.
- Margaret Trinity mentioned that one of the impacts of the primary care spend target will be increased payments to primary care physicians.
- Ann Smith hopes there are enough independent primary care providers to benefit from this.
- Margaret Trinity shared the Monitoring plan: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Reports-and-Updates/Unintended-Adverse-Consequences-Measurement-Plan.pdf
- Terry Gerratana shared that in Massachusetts has published the percentage of growth in the costs of various health care systems and providers. There is no penalty rather transparency in that people can see if a carrier or system is growing at greater rates and above and beyond the benchmark.
- Margaret Trinity agreed that there will be reports published by OHS.
- Krista Moore also said there may be a public hearing and there will be public reporting.
- SB Chatterjee shared a comment about people who had recovered from COVID-19 and other related outcomes. He asked if there have been thoughts about these types of outcomes regarding people who had COVID and recovered in the analytics?
- Margaret Trinity remarked that the state is looking at pre-benchmark spending, collecting data from carriers prior to the pandemic since they know that the impact of COVID-19 on healthcare spending is an anomaly.
- Velandy Manohar brought up the need to look at the role of primary care providers settings and providers as contexts through which to administer vaccines and address vaccine hesitancy. Pharmacies have been deployed, but there should be more strategy to include primary care.
- Terry Nowakowski asked if it is still the intent to have telehealth, CHWs and pay-for-performance to incentive more primary care in the state given that they are not compensated adequately. Is the intent of OHS to follow through on some of the objectives/approaches developed under SIM?

	• Krista Moore responded that OHS is continuing to work on health care delivery transformation and payment reform. As for aspects of SIM, she shared that they are still trying to figure out how they will be continuing certain aspects of that. • Terry Gerratana thanked Krista Moore and Margaret Trinity for presenting.	
5.	Committee Reports - Consumer Engagement and Outreach Standing Committee	Velandy Manohar, Robert Krzys, Terry Gerratana
	• Velandy Manohar did not have a committee update as the CE&O would be reconvening in May. • Dashni Sathasivam shared that at that meeting the committee would review and discuss the report. The report would then be reviewed by the full council for approval for posting • Bob Krzys provided an update on the Membership Committee. He asked members to fill out the asset mapping survey in a timely fashion because those results would be considered by the committee when reviewing the CAC applications. The next membership meeting would review each application submitted. He shared that there was a report that were a part of this meeting's materials. Attendance and term limits were one point of discussion. According to the bylaws, if a member misses 3 meetings in the calendar year you are subject to removal. There were various people who missed more than 3 meetings. The membership committee is recommending to the CAC that 2020 was a unique year given the pandemic and it would be in the best interest of the council to take the position that there would not be a strict application of the attendance policy for 2020. • Move to approve the attendance provision of the bylaws for 2020 be waived • Regarding term limits, when the bylaws were adopted in 2019, there were a number of members from the CAB previously. The bylaws did not address that the two 3- year terms, what is to be done for people with previous years of service under the CAB. Because it was difficult to sort out participation levels, going forward the Membership committee recommends that all members regardless of significant prior service would start fresh in regards to term limits that were adopted in the 2019. • Bob Krzys mentioned that if Michele Scott is approved, as she is slated to be, there would be 14 members of the CAC without counting himself, as he would be leaving the Council at the end of May and not counting Jason Prignoli on a leave of absence. And we have 5 new applications to consider at the next membership meeting and there can be up to 17 members so unless anyone else resigns, there are only 3 seats open. • Peggy Lampkin provided comments that she had difficulty being recognized for her attendance since she has only had the capability to join via phone. She is glad to see the updated attendance procedures to address these issues. • Bob Krzys responded that Peggy Lampkin comments were a part of the reason prompting new attendance procedure of having roll call. Her situation was noted in the Membership report though she wasn't noted by name. • Terry Nowakowski also noted that this has been a different time because prior to this, the CAC always met in person and prior to the pandemic there were many new members. There is just a desire to have a fresh start. • Bob Krzys moved to waive the attendance provisions of the bylaws for calendar year 2020. Velandy Manohar seconded. Motion carried.	

	• Bob Krzys moved that the term limit provisions of the bylaws will not count towards service of a CAC if a member had served previously served as a member under the SIM CAB. Velandy Manohar seconded. Ann Smith Abstained. Motion carried. • SB Chatterjee moved to formally accept Michele Scott as a member of the CAC. Velandy Manohar seconded. Motion carried. • Bob Krzys shared that the next Membership Committee meeting review go over applications which would close on April 14th and put together a 3-person nominating committee to nominate a vice-chair. • Members of the CAC thanked Leslie Greer for her work in disseminating the application. • Terry Gerratana agreed that Leslie Greer has done a great job. • Peggy Lampkin asked what is the criteria for the membership and nominating committee? She asked because she is a new member. • Terry Nowakowski responded that she and any of the existing CAC members qualify to be on the committee or role of vice-chair if they have interest.	
5.	**Connie Opt-Out Consent Form Feedback**	Dashni Sathasivam
	• Dashni Sathasivam presented the draft Connie Opt-out patient form to the CAC and asked for their feedback on the form and the opt-out workflow. There are 5 different ways for people to opt-out. Connie has 44 participating organizations including Yale New Haven Health and Hartford Healthcare being the two organizations furthest in the process of having their connection to the HIE. • Adrienne Benjamin asked if the opt-out workflow something that would be shown to patients? • Dashni Sathasivam replied no, this is the technical graphic as it is admittedly not user friendly. • Adrienne Benjamin was glad to hear that. • SB Chatterjee voiced a question. As this is the fourth attempt of the Health Information Exchange. According to him, he noted that in attempt number three there were robust documentation in the opt-in/opt-out process from around 6 or. 7 years ago. Were those considered? He said that he'll • What are the provisions for multilingual including Spanish-speaking consumers and others. What is the outreach plan? • Dashni Sathasivam thanked him for his question and shared that many consumers have been asking that same question. • Velandy Manohar asked if there was a deadline to send in the form? Will people in the state when the HIE will be operational to have this be a truly informed consent? • Dashni Sathasivam responded that once a form to opt-out is submitted within 5 days the system will have processed the request. • Adrienne Benjamin noted that this is way too complicated. Newspapers are written at a 5th grade level. First of all, what is Connie? We throw around Connie like people know what that is. There is a lot of paranoia and suspicion around electronic communication and people being hacked. With the opt-out model, you are assuming people want to be opt in and making them opt-out and that has to be explained. The purpose is we want to learn more about health and how people doing. We want to improve things of people in Connecticut between their doctors and for their healthcare. There needs to be a basic human paragraph.	

- SB Chatterjee agreed that simplicity is key particularly for communication and concerns about the multilingual aspects. Since the HIE is a network of networks. Logistically how does one reach the patients in other systems that are tied to Connie. if you opt-out once does that reach all systems?
- Ann Smith noted that when she sees this, her eyes cross and what is the context in which this is presented and when would someone to read through this, asked their questions, get their questions answered and consent? Especially given the time constraints in the current primary care setting. There are also a lot of words. How can this be communicated in a way: here's what happens if you opt-in and if you opt-out so people can see the ramifications of their decisions. We should be trying to find a different way to communicate rather than just through these words. She also had a suggestion around the order of these questions: sharing health information more, she wants to know more about what it means and know to know that up front. Right now, it is buried down there and overall everything is too much and too dense. This is geared towards getting people to opt-out because who is going to get to the place of opting-out.
- Velandy Manohar noted that the opt-out model is a tricky way of doing things.
- SB Chatterjee shared that opt-in/opt-out is a deeply ethical issue and a clinical issue. Studies show that if you make opt-in model, then many people will not participate. With opt-out, more people are likely to stay in and there is a collective good when we have accurate deidentified data. Though there needs to be a lot of time spent on how to message that.
- Velandy Manohar is concerned about what people have access to. It is vital to know what we want released to whom in recovery care. Who needs to know the information, for what reasons and for which period of time?
- Daniel Ogbonna agreed that editing the questions and the order listed is important. He agreed with many of the points expressed by other CAC members. As for opt-in vs opt-out and People who feel forced to opt-out and reservations and misconceptions. He suggested building off the question of what would be the reasons the ideal reasons for me opting in or staying in who wants to have my health information, which is an asset, in the system.
- Terry Nowakowski agreed with the statements that had been made and the language needs to more simplistic and examples are important to include. In thinking about the vulnerable population. Particularly transient population with multiple complex conditions. Having examples as to why this is important and what they should be alerted to would help them make informed decisions. It would also be valuable to have this outreach include the Health Enhancement Communities and CHWs to have this consent happen in a relational environment.
- SB Chatterjee the outreach is critical.
- Ann Smith asked to what extent can there be done a graphical representation of when opted in, here's what has happen in a given situation, but same situation but you opted-out of Connie, what would be some of the outcomes of that situation. This would enable another way to show people benefits of Connie and here's the outcomes of opt-out. This could consider people who may not read this and a way to show this.
- Dashni Sathasivam agreed and mentioned that a multimedia approach would also be helpful.
- Adrienne Benjamin added that an example of why collecting medical data is helpful to moving health care forward and helps researchers. Something is brief and clear.

	• Sone Phrommavanh asked who will be informing patients about consent? Will it be a PCP or will some entity be contracted? Will this be one time or every six months is there a timeframe. • Dashni Sathasivam clarified that once someone opts out, their decision remains enforced indefinitely. There will be an e-consent type of tool that is being developed to help providers do informed consent. • Dashni Sathasivam will follow up with a survey link for additional feedback.	
7.	New Business/Announcements	Terry Nowakowski
	• Terry Nowakowski reminded everyone to please ask	
8.	Adjournment	
	Terry Nowakowski moved to adjourn the meeting. Velandy Manohar seconded. Motion carried. The meeting adjourned at 4:57 PM.	