State of Connecticut
Healthcare Innovation Steering Committee

March 24, 2014
Meeting Summary

Members Present: Lt. Gov. Nancy Wyman (Chair); Tamim Ahmed; Patricia Baker; Jeffrey G. Beadle; Mary Bradley; Patrick Charmel; Anne Foley; Bernadette Kelleher; Suzanne Lagarde; Courtland G. Lewis; Robert McLean; Jane McNichol; Michael Michaud (for Patricia Rehmer); Jewel Mullen; Thomas Raskauskas; Mark Schaefer; Jan VanTassel; Michael Williams; Thomas Woodruff

Members Absent: Raegan Armata; Roderick L. Bremby; Anne Melissa Dowling; Frances Padilla; Frank Torti; Victoria Veltri

Meeting was called to order at 3:00 p.m.

Approval of February meeting summary
Motion to accept the meeting summary – Anne Foley; seconded by Patricia Baker.
No discussion.
All voted in favor of the motion.

Review of governance structure and draft workgroup charters
Brenda Shipley presented information on proposed workgroup charters (see presentation here). The charters include information on workgroup composition, key questions, and key milestones. It is anticipated the Program Management Office will also offer to have a similar conversation on the charters with the Consumer Advisory Board. Final adjustments will be made with the workgroups once they convene.

With respect to the Practice Transformation Taskforce, the committee discussed the percentage of electronic medical record adoption in the state. A recent article pegged the state's adoption rate at 32%. According to the Innovation Plan, the state's own survey had shown adoption at 50-60%. There may be a need to perform a new survey or to develop an implementation strategy that assumes some practices will be starting from scratch. The state could also seek information on which practices received EHR adoption incentives. There is a plan to provide an update on health information technology at the next meeting.

The committee discussed the composition of the Quality Council. The proposed charter offers more detail on the type of representatives sought for membership, particularly with respect to the health plans. It was suggested that workforce productivity or time to return to work be measured. Cross-generational representation should also be taken into account.

The committee discussed the language used in the Equity and Access Council charter. The proposed language makes reference to "intentional failure of a provider to offer necessary services." There was concern that the use of the word "intentional" set up a legal standard that would be too difficult to reach. Substitutions included "a pattern of failure," "systematic," or "repeated." It was also suggested that the language reference "evidence-based medically necessary services." It was decided that further discussion of the appropriate terminology should take place outside of the meeting.

It was asked how the group would measure equity in terms of disparities. It was noted that the Equity and Access Council is primarily focused on under-service and patient selection issues. The reduction of health equity gaps will be part of the scope of the Quality Council. Other concerns that were raised included access to specialty care, particularly in Medicaid, and how regional variations could translate to access issues. The workgroups will have the opportunity to consider expanding their charters to address issues such as these.

In addition to drafting workgroup charters, the Program Management Office is also developing a guide with information on deliverables, vision, and tips on public meetings so that the workgroups operate in a consistent way. Steering committee members asked how they could be supportive of the office's efforts to stand up the workgroups. The office has limited staff available and is hoping to identify additional resources necessary to facilitate the workgroup process until additional staff is hired. There was a suggestion that perhaps a public-private partnership could be developed to help put resources in place.

Nominations for workgroups and proposed adjustments to composition
A review of the application process was provided. The Program Management Office undertook an online solicitation of consumers, advocates, and providers that began on February 26th and end on March 19th. The length of the solicitation period resulted in a compressed timeframe to organize and review the many applications received. Recommendations have been made by the Consumer Advisory Board, Personnel Sub-committee, and independent physicians regarding a slate of workgroup nominees and changes to workgroup composition.

Jeffrey Beadle explained the process the Consumer Advisory Board used to make recommendations. The board reviewed 74 consumer and advocate applications. They used a numerical scoring system of 1 to 5 to begin to rank the applicants. In addition to the score, the board took gender, racial, and ethnic diversity into account, among other factors. They convened three meetings to review and discuss the applicants before voting on the list of nominees. Only one person is serving on more than one group. The board plans to come back to the Steering Committee with an additional Health Information Technology Council recommendation. They are also requesting an increase in the number of Practice Transformation Taskforce consumer/advocate slots from 4 to 6.

Michael Michaud gave an overview of the Personnel Sub-Committee's process. They received 62 provider applications and used a similar rating scale of 1 to 5. They conducted their review over a 5 hour session before voting on their slate of nominees. In light of the lack of a hospital candidate for the Equity and Access Council, the sub-committee recommended that an additional physician be added. For the Health Information Technology Council, the sub-committee recommends consulting with the Connecticut Hospital Association to solicit additional hospital and Accountable Care Organization candidates. They are not requesting the composition of that workgroup be changed.

Courtland Lewis presented the physician recommendation, which calls for a significant increase in the number of physicians on the Quality Council, among other changes detailed in their written recommendation. Following the February 18th Steering Committee meeting, physicians were concerned with the direction the Quality Council might take. They believe that there must be physician engagement in SIM and that this is necessary for the Council's efforts to be effective. There are federal mandates that physicians need to take into account and they want to make sure the Council moves in a compatible direction. They also want to make sure that the variety of physician specialties is taken into account.

Concerns were expressed that the physician recommendation is contrary to the committee's principle of balanced and proportional representation among the major categories of participant. It was also stated that the work should not be provider-centric but rather a partnership between patients and providers. The metrics the council develops should be diverse. There was further comment that balance should not come at the expense of expertise. It was noted that many non-physician health professionals have expertise in quality measurement, including, for example, nurses. The physicians understand that everyone cannot be represented; however, they want to ensure that various perspectives are recognized. There was a concern that the physician recommendation includes making all agency representatives on the Quality Council ex-officio.

It was decided that consideration of nominations and recommendations be tabled to an interim meeting. The Program Management Office will share the nominee applications with the steering committee for review prior to that interim meeting. The committee will need to resolve the composition recommendations before voting on the slate of nominees.

Letter from consumer advocates (March 10, 2014)
A group of advocates sent the steering committee a letter addressing their concerns on March 10, 2014. Committee members reviewed a draft of key points that could comprise a response to the letter (see key points here).

One of the concerns raised by the advocates was that the steering committee did not understand that a group of advocates recommended that the workgroups be comprised of 51% consumers and advocates. Committee members noted that the recommendation was considered in the previous meeting, but that they had decided that balance was the principle to strive for. There was a concern that the 51% recommendation would make the workgroup size unworkable. The committee supported and was comfortable with the numbers it proposed, recent recommendations for revision notwithstanding.

Motion: To utilize the key points in a response to the independent advocates with suggested modifications – Patricia Baker; Nancy Wyman seconded.
In addition to the key points listed, it was suggested that there be reference to a "balanced and proportional approach." Committee members did take the advocate recommendation into account and opted for a balanced approach. There was also discussion of the point of providing stipends to support participation. The aim is to find a means to provide modest stipends for consumer workgroup members only if the funds to support the measure could be established and that such stipend be limited to consumers and specifically those whose participation is not otherwise supported by their employer. It was suggested that be clearly stated.
All voted in favor of the motion.

Care experience surveys – process and financing
The Program Management Office is hopeful the test grant funding announcement will be released by the end of March. The committee reviewed a first issue brief regarding the use of care experience surveys (see Preliminary Issue Brief #1 here). Consistent with the Innovation Plan, it is proposed that payers would incorporate the information from the surveys into value based payment. The proposal is that there would be a standardized survey that is statistically valid for the size of a practice. Questions were raised as to who would be accountable and the proposed timing of administration. There is a question as to how it will be funded. NCQA practices are already required to bear the expense of completing a survey as a condition of recognition. The state is proposing to use its combined purchasing power to procure a vendor for practices, and that practices could choose to pay a fee for their patients to participate in a state administered survey.

The practices would benefit from the state's purchasing power and be relieved of the burden of administering a survey themselves. The state administered survey could either be handled by the Program Management Office or through a memorandum of understanding with the Department of Social Services. Committee members were asked to provide feedback to the Program Management Office within the next week.

It was recommended that the diversity of providers in the state be taken into account. There needs to be a variety of physician input. Consideration of the extent to which patient experience can be measured is key. Standardization should also be taken into account…payers and providers should align around a single standardized survey.

Medicare also requires that Accountable Care Organizations complete a care experience survey. The Medicare and NCQA vendor lists are similar. It will be important to take who will be responsible for the cost into account. There may be potential to "piggyback" on Medicare's survey requirement. There is not a desire to impose more than one survey. There may be a need for two standards, one for Accountable Care Organizations and one for everyone else.

Financing options for new services and activities

The committee reviewed the second issue brief regarding financing of services and activities. (see Preliminary Issue Brief #2 here). The brief examines ways to pay for unfunded services related to the expansion of care teams (pharmacists, nutritionists, patient navigators, etc.) and the adoption of non-visit based means of supporting patient care. These activities will not occur without a means of financial support in the short term. It is important to start preliminary conversations early. A fee for service structure may be unlikely. Committee members were asked to provide feedback to the Program Management Office within the next week to prepare a more fully realized proposal to the next committee meeting. In addition, there was interest in convening a one-time meeting of interested participants to discuss this issue of financing. The Program Management Office will send a solicitation for the participation of interested members.

Letters of support

Other states attached as many as 100 letters of support to their test grant applications. The Program Management Office will begin reaching out to various stakeholders to begin the process with the hope that some will be willing to sign on early.

Meeting adjourned at 5:00 p.m.

Next meeting: Thursday, April 24, 2014 at 10 a.m. in State Capitol Room 310 (Old Appropriations)