STATE OF CONNECTICUT
State Innovation Model
Healthcare Innovation Steering Committee

Meeting Summary
March 12, 2015

Members Present: LG Nancy Wyman; Patricia Baker; Jeffrey G. Beadle; Mary Bradley; Patrick Charmel; Anne Foley; Bernadette Kelleher; Suzanne Lagarde; Alta Lash; Kate McEvoy (for Roderick L. Bremby); Robert McLean; Jane McNichol; Michael Michaud; Jewel Mullen; Frances Padilla; Ron Preston (for Bruce Liang); Thomas Raskauskas; Robin Lamott Sparks; Jan VanTassel; Victoria Veltri; Thomas Woodruff

Members Absent: Catherine F. Abercrombie; Tamim Ahmed; Raegan M. Armata; Anne Melissa Dowling; Terry Gerratana; Courtland G. Lewis; Michael Williams

Other Participants: Mehul Dalal; Deb Dauser Forrest; Elizabeth Krause; Michelle Moratti; Mark Schaefer; H. Andrew Selinger

Call to order and introductions
The meeting was called to order at 3:03 p.m. LG Nancy Wyman called the roll and it was determined a quorum was present.

Public comment
There was no public comment.

Minutes
Motion to approve the February 5, 2015 meeting summary – Anne Foley; seconded by Jane McNichol.
There was no discussion.
Vote: all in favor.

HIT Council replacement appointment
Mark Schaefer provided an update on the need for a replacement member to the Health Information Technology Council. Steve O'Mahony of the Western Connecticut Health Network has taken a position out of state and can no longer serve on the Council. The Personnel Subcommittee recommended appointing the sixth ranked member on the applicant list – Ludwig Johnson of Middlesex Hospital.

Motion to appoint Ludwig Johnson to the Health Information Technology Council – Robert McLean; seconded by Thomas Raskauskas.
There was no discussion.
Vote: all in favor.

Standards for AMH Pilot – final recommendations
Dr. Schaefer provided an overview of the process used to develop the final recommendations for the Advanced Medical Home Pilot (see presentation here). Steering Committee members were invited to participate in the February 17th Practice Transformation Taskforce meeting with Qualidigm to finalize the recommendation.

Robert McLean noted that there were concerns that MUST PASS elements could be onerous but that a MUST PASS element requires only 50% of factors be met. He said it may sound worse than it truly is. He suggested emphasizing the definition of MUST PASS as the Pilot is marketed so that the concept seems less overwhelming.

There was discussion as to the purpose of the learning collaboratives. Dr. Schaefer said the idea is to create a community amongst those participating in the transformation process so that they can share their experiences and learn from one another. The program is similar to what CMMI uses for its practice transformation programs. Thomas Raskauskas said that St. Vincent's has participated in a collaborative with Qualidigm and that they are held at an early hour so as to avoid interfering with clinical time. He noted that providers do understand the value of sessions.

Frances Padilla asked what level of staffing would participate in the learning collaboratives. Dr. Schaefer said he would need to check with Qualidigm. Ms Padilla noted that whoever participates in the collaboratives should use the experiences to build within the entire organization. Bernadette Kelleher noted that Anthem holds learning collaboratives that are targeted to different levels (clinician-specific, office staff-specific). She noted that they can be tuned to various members of the practice team.

Patricia Baker complimented the Practice Transformation Task Force on their efforts. She said that the providers, payers, and consumers around the table worked in a deliberative, open minded way. She noted that while she left the February Steering Committee meeting concerned, the February 17th Task Force meeting was an example of what collaboration can do and that these final recommendations were a product of that collaboration.

Motion to accept the final recommendations from the Practice Transformation Task Force for the AMH Pilot – Patricia Baker; seconded by Jane McNichol.
There was no discussion.
Vote: all in favor.

CCIP Design Strategy
Michelle Moratti of Chartis provided an overview of the strategy for the Community and Clinical Integration Program (see presentation here). With regard to the target population for the initiative, Ms. Baker suggested not segregating populations by payer type as there will be health inequities found in those covered by commercial plans. Mary Bradley noted that part of the goal of the program should be to remove duplicative efforts and waste. Jan VanTassel suggested they take a different approach to integration so that it is not solely top down and clinically focused. She said that there should be a mechanism for greater involvement by community organizations. Ms. Moratti said that the Practice Transformation Task Force will define the approach but that integration should occur in multiple directions in order to attain the desired result. Jewel Mullen suggested that heath equity gaps should be addressed as well, noting that the entire health and human service enterprise is needed to ensure success. Housing and food are both issues that impact health outcomes. Suzanne Lagarde asked for a definition of technical assistance. Dr. Schaefer said it would be similar to what CMS has done with their Comprehensive Primary Care Initiative, where experts in various areas work with the leadership or transformation team within the enterprise to reengineer their care systems.

There was discussion on providing grants to practices participating in the initiative to help pay for investments needed to transform. Jane McNichol suggested that funding not go to just advanced

networks and federally qualified health centers because the community partners may not be able to participate if there is no funding available for them. Ms. VanTassel agreed and noted that the mental health system has done an excellent job of building community groups that help people in a cost effective way. Commissioner Mullen said that opportunities should be directed to clinicians as much as possible as they will be the adopters and innovators. Alta Lash noted that while community health centers have developed linkages with other groups, other practices have not.

Ms. VanTassel suggested grants be made available to non-clinical community organizations. Ms. Moratti said that was consistent with the intent of the program and could be included. Dr. Lagarde asked how much funding was available. Dr. Schaefer said there is $4.5 million, divided between two waves. He said there is a need to maximize the funding available and the proposals should include community organization participants. Ms. Baker said that a small grant could go a long way towards investment in a transformed system. Patrick Charmel noted that in a fee for service environment, eliminating waste could equal an elimination of revenue. He said there was a need for a careful approach. Kate McEvoy said there may be authorities available under Medicaid that would support these investments through both the Medicaid State Plan and possible waiver programs. Ms. VanTassel cautioned that Medicaid was not a population that would show immediate savings. Ms. McEvoy said that they would examine access barriers and protections and be deliberative in their process. Dr. Raskauskas said that for an ACO, one social worker could eventually become self funding as that person could build an integrative program within the network; however, funds to support the initial investment are needed.

Ms. Padilla asked about the timeline for implementation. The timeline has not yet been defined but could be discussed at the next Steering Committee meeting. Dr. Schaefer said that while the timeline is not set, the plan is to complete the design process by the end of June. Ms. Padilla requested that future discussion include milestones.

Commissioner Mullen asked whether there were best practices from both within Connecticut and from other states that could be leveraged. Dr. Schaefer said that could be researched as part of the planning strategy. Ms. Kelleher said that there may be resources at Anthem that could assist in finding initiatives in other states.

Mr. Charmel asked whether the Committee needed to look at the composition of the Task Force as they are taking on a broader charge. Dr. McLean noted that there are entities being discussed that are not currently at the table. LG Wyman asked members to email their suggested Task Force additions to the PMO. It was suggested that the Personnel Subcommittee consider the matter and the PMO also confer with the Consumer Advisory Board. Ms. Baker cautioned against adding too many people. Dr. Schaefer said that a design group structure could be used to bring in expertise that is not represented on the Task Force itself.

Quality Council

Process Overview

Mehul Dalal, Deb Dauser Forrest, Elizabeth Krause, and Andrew Selinger presented on behalf of the Quality Council (see presentation here). The Council initially worked in subgroups to review the measures before coming together for a full review. Ms. Krause spoke on behalf of the consumers on the Council. She said that the consumer group worked with Ignatius Bau, a health equity consultant, for help in understanding the quality measures. She noted that the consumers had the leanest recommended measure set but that they were open to the recommendations of others. Dr. Selinger spoke on behalf of the physicians and said that each shared their knowledge. Ms. Dauser Forrest said that all of the major payers were recommended. She said that if all of the payers were

collecting data for the measure, they recommended it be included; if they thought the measure was valuable but would require additional work, they provisionally recommended it. If a measure had too low a base rate or other issue, they would not recommend it. She noted that the payers would need to bring the recommendations back to their national leadership for further action.

Provisional Measure Set

Dr. Selinger presented the provisional measure set. There were questions regarding measures dealing with controversial topics, such as the cervical cancer screening measure. Dr. Selinger noted that there will be moving targets. Dr. Schaefer said that the Council utilized the principle not to recommend changing a measure so that the state can engage in "apple to apple" comparisons with other states. There were concerns about the flu shot measure. Ms. Bradley noted that they are often provided by employers. Dr. Raskauskas noted that in hospitals there is no claim generated. Dr. Selinger said that the measure was derived from electronic health records and that the hope is that the doctor would ask the patient if he or she had received a flu shot and record it in the EHR. Dr. Schaefer said the Council would confirm that the measure is, in fact, EHR derived.

There were also concerns about recommending the poor control measure for diabetes. Dr. Dalal said that they spoke with the Yale Team and that there were concerns that tight control could drive over treatment. It was mentioned that a lower percentage measure of good control could be used that would avoid the over treatment issue. Dr. Schaefer said that additional research could be conducted.

Outstanding Issues

The Committee discussed including a falls prevention measure in the provisional set. Dr. Schaefer said that the Council opted to focus on populations that fell primarily under commercial and Medical coverage. Falls prevention is typically specific to those over age 65 and Medicare already has a measure in place. Dr. Selinger said that at the end of the day there will be a falls prevention measure on the scorecard but that the Council opted to defer discussion on the Medicare-specific measures. Due to a lack of time, it was decided that that the Committee would continue discussion of the Provisional Measure Set and the inclusion of a falls prevention measure at its April meeting. The Committee thanked the Council for the work conducted to date.

Adjourn

The meeting adjourned at 5:00 p.m.