STATE OF CONNECTICUT
State Innovation Model
Healthcare Innovation Steering Committee

Meeting Summary
October 12, 2017

Meeting Location: Legislative Office Building Room 1D, 300 Capitol Avenue, Hartford

Members Present: LG Nancy Wyman; Patricia Baker; Jeffrey G. Beadle; Mary Bradley; Patrick Charmel; Anne Foley; Suzanne Lagarde; Sharon D. Langer; Alta Lash; Kate McEvoy (for Roderick L. Bremby); Robert McLean; Michael Michaud (for Miriam Delphin-Rittmon); Frances Padilla; Raul Pino; Joseph L. Quaranta via conference line; Jan VanTassel

Members Absent: Catherine F. Abercrombie; Robert Blundo; Terry Gerratana; Bruce Liang; Robin Lamott Sparks; Kristina Stevens; Katharine Wade; Deremius Williams; Thomas Woodruff

Call to Order and Introductions
LG Nancy Wyman called the meeting to order at 2:59 p.m.

Public Comment
There was no public comment.

Minutes
Approval of the minutes was deferred to later in the meeting.

Value Based Insurance Design Templates
Jenna Lupi presented on the Value Based Insurance Design (VBID) templates (see meeting presentation here). She said the VBID templates were shared with the Healthcare Innovation Steering Committee (HISC) a few months ago and then put out for public comment. There were not any changes made to the VBID templates after public comment.
Approval of the VBID templates was postponed until later in the meeting.

Health Enhancement Community Planning Update
Faina Dookh provided an update on Health Enhancement Community Planning. She said they are in the beginning stages of planning for the Health Enhancement Community (HEC) planning process. Department of Public Health (DPH) and the program management office (PMO) are working to procure a dedicated consultant to assist with this process. There are two members from HISC and two members from the Population Health Council serving as advisors and providing input on the development of the procurement. They are looking to release the request for proposal (RFP) within the next two weeks. Ms. Dookh said there will be an upcoming Ad Hoc HISC meeting to discuss the HEC planning process work and the Population Health Council's charter.

PCMH+ Participating Entity Presentations
Kate McEvoy presented on the Person Centered Medical Home Plus (PCMH+) program and introduced representatives from the participating entities.

Optimus Health Care
Ludwig Spinelli, Optimus CEO, and Dr. Alix Pose expressed thanks to the Department of Social Services (DSS) for their efforts and for the PCMH+ program. Mr. Spinelli acknowledged Community Health Network for getting the data back to them. The representatives spoke regarding the details of the data, the collaboration, and the importance of the program. Dr. Pose said they are starting to achieve their goals. They have hired 6 community health workers (CHWs) and 2 RN care

coordinators, fully implemented the Care Coordination Initiative, and engaged over 500 high risk PCMH+ members. It was mentioned that with the intervention of CHWs, patient satisfaction is increased and wellness is improved with a goal to decrease cost. Patient focus groups help to improve care delivery by providing direct information on what they are doing and how well they are doing. The Optimus Health Care representatives said they would be glad to answer any questions.

Fair Haven Community Health Center
Dr. Douglas Olson, Vice President of Clinical Affairs, and Vivian Acevedo-Rivas, Associate Director of Patient Support Services at Fair Haven Community Health Center (FHCHC), expressed thanks for having them there. The representatives spoke about some of their challenges and opportunities and how the PCMH+ program has improved FHCHC. Ms. Padilla said it seems like telehealth is a trend. She asked how telehealth has worked with the patients at FHCHC and how has it made a difference for the quality of life for clinicians.

Dr. Olson said like PCMH+, it is investing time and resources. He said a great number of patients need consults and specialty care. He said they ask patients for their permission and whether it is okay to send as an e-consult. Dr. Olson said it improves access because it is really fast. He said it's proved very successful on specialties such as dermatology where the average wait time for a dermatology referral is up to 8 months. He said the show rate for e-consults is 100%. He mentioned it is not easy to set up but well worth the time invested. Ms. Padilla said it seems like a trend for the future.

Dr. McLean said there is some start-up money to make it happen. He asked how many have occurred and the volume per month. Dr. Olson said it is probably somewhere in the teens per month. He said at this point it is not covered by all payers. He said currently they only have the e-consults available for a small number of specialties. He said the e-consult has to be ordered within five days of the visit. Ms. Padilla asked whether there is any possibility for e-consult to become part of PCMH+. Ms. McEvoy said there is a distinct effort around reimbursement for the e-consults. She said CMS reversed its approval of the methodology. However, they are negotiating another approach that is acceptable to CMS.

Value Care Alliance
Dr. Kirsten Anderson, Chief Medical Officer, and Georgia Pelletier, Director of Population Health for Value Care Alliance (VCA), expressed thanks to the committee and DSS for inviting them. The representatives spoke about key focus areas and how they are achieving in the PCMH+ program with multidisciplinary teams, comprehensive care plans, community action, individual/population interventions, and patient stratification. Dr. McClean asked how high risk patients are identified. Dr. Anderson said there are multiple ways of doing it. She said one way is they go through the data, there is a risk score in the data, they take the top high risk patients and outreach to those patients. Patients can also be referred from one of the practices, from Community Health Network (CHN), and through their interdisciplinary teams.

Dr. McLean asked what kind of risk score is being used. Dr. Anderson said the risk score that they use is a 40% chance of being high cost in the next year. The risk score comes from CHN. Dr. McLean asked are they the only people that would get the interventions. Dr. Anderson said no, they get the intervention plus all of the other patients that were referred through CHN, the practices, and interdisciplinary team members. She said any referral they receive they bundle through the process of having an intervention. Dr. McLean asked whether other people have access to the CHWs. Dr. Anderson said no. She said they receive referrals for patients with no insurance and they work on those patients with the same process.

Yale New Haven Health – Northeast Medical Group
Kate Dangremond, Director of Clinical Integration and Population Health Management, and Liza Estevez, Patient Navigator, thanked committee members for having them. The representatives provided some of the framework about the PCMH+ population that they are working with. They also spoke about improvements in delivery of care, outreach, enhanced care coordination, and the success of linking patients to multiple community resources. Dr. McLean said the EMMI call is a great system but information has to be coordinated with managers and office staff.

Ms. Baker asked what distinguishes EMMI call from an appointment confirmation call. Ms. Dangremond said EMMI is a great tool because it is standardized where possible and personalized where it is important so it does not feel like a "robocall". She said the caller ID will show their provider's office and provider's name, initial parts of the calls are recorded so it does not feel like a "robovoice", and it offers the patient the opportunity to make a warm transfer to their provider's office to speak with someone.

Ms. Baker said communities resources are stretched thin and their ability to cover cost and participate fully are going to be pressed even more. She asked how they are able to engage a community to make it successful verses just calling community action agencies. Ms. Dangremond said they have partnerships where they work with community resources and have coalitions that have existed for several years. She said they also work closely with community members to talk about how the community collectively can develop ways to work together to enhance capacity to make sure they navigate people to the right resources at the right time.

Ms. McEvoy said the DSS is trying to be as enabling as possible. She said there are provider collaborative discussions. She said there are some extraordinary things going on including embedding 211 within the electronic health records. Ms. McEvoy said DSS helps to fund United Way and 211 system. She mentioned that they don't need to create a community registry of resources because 211 is that entity. She said they are charged with keeping the information relevant and current.

Dr. Schaefer said he has a question for all of the presenters. He said you are making a lot of investments such as advanced analytics to drive improvement and hiring staff such as CHWs for coordination or navigation. He said as we think about the long view, we want to think about how to support these kinds of investments two and three years out. He asked regarding sustainability of the investments. Ms. Dangremond said they think about it as the start up on things and the opportunity to test a model. She said their intention in terms of sustainability is to be deliberate in how they use the resources, how they assess the impact, and how it enables them to make the business case to provide the rationale as to why it is the right model for them moving forward.

Dr. Anderson said from the VCA perspective, they have set up the case to be able to measure return of investment (ROI) from the very beginning in their ability to track the impact of staff on ER, inpatient commissions, and unnecessary cost of care. Dr. Anderson said in the anecdote they said if you are able to deploy resources that make that kind of impact on one patient, what about the impact on an entire population. She mentioned they have CHWs at their interdisciplinary team meetings and other members have gotten use to the fact that they can say they need help for a patient's problem. She mentioned it's going to be hard to unwind this.

Dr. Olson said the interoperability between health information technologies (HIT) is huge. He said if someone goes to another place to receive care that is not within their electronic medical record (EMR) and has low health literacy, it is like that visit never happened. It is easier to just reorder the same test because the patient is there and they aren't able to talk to the other specialist or provider. He said there is a lot of opportunities for HIT improvements and any investments made in this area will pay dividends long term.

Dr. McClean said having a HIT system would provide lots of good data in real time in terms of utilization. He asked whether there is any other data that is needed but not being received to manage the populations. Ms. Dangremond said it is necessary to think about what types of data you need, how you are integrating, validating, and how to turn them into actionable information that is needed to improve care. She said they are grateful to DSS for the strides in trying to make more data available to them. Ms. Dangremond said being able to have the claims data integrated into their EMR would be the first step and pulling external population data sources would be the second.

Mr. Charmel said in terms of sustainability, VCA is seeing the difference the investments are beginning to make in the health of the populations. He said it is important to move the needle enough to generate shared savings. He said the key is what they are doing in the community. Mr. Charmel said they have developed new linkages with community action agencies but the agencies do not have enough capacity. He suggested their job is to talk to all pieces of the delivery system on how they look at resource allocation. He said he thinks it will be a tough thing to make happen and how they begin the discussion and articulate will be important.

Commissioner Pino said they have seen improvement in some health indicators across the state. He said CT is at the point that they should not rely on the success they are having with certain health conditions. He said resources may be within the system. He said sometimes we have the tendency to add more but maybe we have to reallocate for a better perspective. Commissioner Pino also suggested embracing the CHW. He said DPH has committed to developing this program and there are resources out there. He mentioned October is breast cancer awareness month. Ms. Padilla said during this legislation, there was a bill passed quantifying the role or the definition of the CHW. She mentioned the need to maximize on the opportunity for making the case for these services to be reimbursed by all payers.
The Committee thanked the presenters.

Minutes
Motion: to approve the August 10, 2017 Healthcare Innovation Steering Committee meeting summary – Jeffrey Beadle; seconded by Jan VanTassel.
Discussion: There was no discussion.
Vote: All in favor.

VBID Updated Templates
Jenna Lupi presented briefly on the VBID updated templates. There were no questions.

Motion: to approve the VBID updated templates – Jan VanTassel; seconded by Patricia Baker.
Discussion: There was no discussion.
Vote: All in favor.

Adjournment
Motion: to adjourn the meeting – Frances Padilla; seconded by Jeffrey Beadle.
Discussion: There was no discussion.
Vote: All in favor.

The meeting adjourned at 4:57 p.m.