STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Taskforce

Meeting Summary
March 17, 2015

Meeting Location: CT State Medical Society, 127 Washington Avenue, North Haven

Members Present: Lesley Bennett; Mary Boudreau; Heather Gates; Shirley Girouard; John Harper; Bernadette Kelleher; Edmund Kim; Alta Lash; Michael Michaud; Rebecca Mizrachi; Douglas Olson; Rowena Rosenblum-Bergmans; H. Andrew Selinger; Elsa Stone; Randy Trowbridge; Joseph Wankerl

Members Absent: Leigh Dubnicka; David Finn; M. Alex Geertsma; Nanfi Lubogo; Jesse White-Frese; Tonya Wiley

Other Participants: Anne Elwell; Tim Elwell; Michele Kelvey Albert; Alan Manning; Michelle Moratti; Stephanie Rich

The meeting was called to order at 6:14 p.m.

Introductions
Rebecca Mizrachi served as meeting chair. The meeting participants introduced themselves.

Public Comment
Mark Schaefer told the Task Force that Jennifer Jackson of the Connecticut Hospital Association submitted written content requesting hospital representation be considered for inclusion in the Task Force's membership (see public comment here). Dr. Schaefer said that this request is a result of discussion at the March 12th Healthcare Innovation Steering Committee meeting as to whether a review of participants was needed for discussions regarding the Community and Clinical Integration Program. Dr. Schaefer recommended this request be reviewed during the CCIP discussion.

Qualidigm/Planetree transformation process
Tim Elwell provided an overview of Qualidigm's approach to practice transformation (see presentation here). He congratulated the Task Force on their work and noted that though their recommendations are ambitious, they are achievable and enables the state to be a nationwide leader. Qualidigm decided to partner with Planetree to help address the patient centered focus expressed in the Advanced Medical Home Pilot Request for Proposals. Michele Kelvey-Albert discussed Qualidigm's approach to working with practices to transform, looking at areas such as the electronic health records and developing policies and procedures.

Shirley Girouard asked whether the presentation was informational only. Dr. Schaefer said the purpose is for the Task Force to understand Qualidigm's approach. The Task Force will continue to advise on the implementation and could recommend adjustments as needed. He said that the Steering Committee endorsed the Task Force's recommendations at its last meeting, clearing the way for the contract with Qualidigm to be executed and the Request for Applications for the AMH pilot to be released.

Dr. Girouard asked what Qualidigm's role in the pilot recruitment and selection process was. Dr. Schaefer said that two members of the team advised on the development of the RFA and could provide guidance if needed during the screening process. The Program Management Office will be selecting the practices for participation.

Alan Manning, Chief Operating Officer, provided background on Planetree and what they will contribute to the transformation process. Planetree's focus is on making sure practices have proper techniques and methods to work in a patient centered way. He discussed their work with the VA in New Jersey to transform their processes, ensuring that veterans and their families were involved in all of their discussions and decision making. Alta Lash noted that much of Planetree's experience was in a hospital setting and asked how they would adapt that to primary care. Mr. Manning said that nearly all of the hospitals they have worked with have outpatient clinics but that they hadn't traditionally worked with independent clinics. He also said that Planetree was an international organization and that their work in the Netherlands has been with primary care clinics.

They also discussed provider burn out. Mr. Manning said that practices must be staff centered as well as patient centered. He said staff members want more active engagement, to do the work they signed on for, and for autonomy in the process. When staff feel like they have achieved those things, burn out decreases. He said patient satisfaction cannot be improved until staff satisfaction is improved. Ann Elwell said they look at ways to have members of the entire care team work at the top of their licenses and to create means for doctors to spend more time engaging with patients.

Qualidigm and Planetree will be spending 15 months helping practices to transform. The original proposal called for 12 months but they pushed out the timeline in order to accommodate all of the areas of emphasis.

Community and Clinical Integration Program

Dr. Schaefer and Michelle Moratti provided an overview of the strategy for the Community and Clinical Integration Program (CCIP) (see presentation here). The Chartis Group, with Ms. Moratti as lead, will support the next planning phase. This initiative is aimed at the enterprise level to look at creating broader service networks.

The Task Force discussed how the program could potentially work at length. Dr. Schaefer said a hybrid model or matching grants could be used but that a strategy for whom would do the work has not been discussed. He noted that those providers who successfully engage in the first wave of the Medicaid Quality Improvement Shared Savings Program (MQISSP) would commit to the CCIP. The Task Force will need to look at how to incentivize community organization participation. Ms. Lash expressed concerns about taking on problems outside providers capabilities, such as housing. Ms. Moratti said the level of collaboration aimed for is unprecedented and it is normal to feel uncomfortable. They may not be able to solve the larger problems but they can connect to a broader set of issues that will create momentum towards a solution. Dr. Schaefer said the question is whether there is something practices can do to better connect their patients to needed services within the community. For some capabilities there are existing programs that the Task Force can examine and learn from. Ms. Moratti said the notion is to move from organizations being accountable on an individual basis to creating collective accountability.

Ms. Bennett asked whether the program would concentrate on larger cities, noting that there are concerns about a lack of behavioral health providers in Bridgeport and Stamford. Dr. Schaefer said that the CCIP is proposed as an attachment to the MQISSP and is not directed towards particular

cities; however it does offer opportunities for the challenged cities in Connecticut. The program could be used to address the behavioral health needs of a particular community.

Ms. Lash said that the Consumer Advisory Board members have asked about the role of community health workers and that this seemed to be an appropriate time for that discussion. Dr. Schaefer that community health workers are an explicit part of the solution and that there are plans for the Board to meet with the work force development leads in April to discuss the initiative. He said that the state's community health worker strategy went beyond the CCIP.

The Task Force discussed potential additional membership and who should be at the table. Dr. Schaefer said there are plans to meet with the Steering Committee's Personnel Subcommittee to deliberate on the issue and wanted to share the Task Force's ideas with them. He said they could take the CT Hospital Association's request into account and they could bring the issue to the Consumer Advisory Board. The groups suggested for representation included housing, employment, food security, faith based organizations, the Hispanic Health Council (and other such racial and ethnic based groups), rural health, home health, an accountable care organization from a different part of the state; hospitals, educational institutions, and disease specific groups (such as the American Heart Association or the American Cancer Society).

Ms. Lash said that at the last Steering Committee meeting, Dr. Thomas Raskauskas said that a social worker could be helpful. She said she was not sure it was that simple but that she was concerned they are making the program much more complicated than it needs to be. She cautioned that the program should be very clear and very targeted in their approach. She said there are lessons that could be taken from Federally Qualified Health Centers, many of whom have social workers on staff.

Heather Gates asked for clarification on what types of connections they were trying to make and whether they were looking to connect primary care to other providers or whether they were trying to connect primary care to the social service system. Dr. Schaefer said there is a need to improve both types of connections and that communication was the biggest problem.

The Task Force could convene design groups to better look at the issues. The PMO will circle back to the Task Force with options for potential design groups.

Douglas Olsen said there are no perfect solutions as there are many problems with chronic conditions and population health management. The Task Force will need to define the problems, identify potential interventions and potential means for operationalizing them. He said the Task Force will have to be comfortable with the potential for failure but also succeeding. Elsa Stone said that in the SIM design phase the Care Delivery Work Group looked at gaps and that a concept has been laid out and has to be integrated. She said she feels overwhelmed all the time at the idea of making connections. It is essential that it happens but she is not sure how to do it. Dr. Schaefer said they will have to solve something that can actually be implemented – what can be focused on that will make a difference. He said the next meeting they will begin a systematic development process.

Adjourn
The meeting adjourned at 8:08 p.m.