STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Taskforce

Meeting Summary
Tuesday, April 7, 2015

Location: CT Behavioral Health Partnership, Hartford Room (Suite3D), 500 Enterprise Drive, Rocky Hill

Members Present: Lesley Bennett; Mary Boudreau; Leigh Dubnicka via conference line; David Finn via conference line; Shirley Girouard via conference line; John Harper; Bernadette Kelleher via conference line; Alta Lash; Rowena Rosenblum-Bergmans via conference line; H. Andrew Selinger via conference line; Elsa Stone; Randy Trowbridge; Jesse White-Frese

Members Absent: Heather Gates; M. Alex Geertsma; Edmund Kim; Nanfi Lubogo; Michael Michaud; Rebecca Mizrachi; Douglas Olson; Joseph Wankerl; Tonya Wiley

Other Participants: Faina Dookh; Kathleen McCarthy; Michelle Moratti; Kevin Morris; Mark Schaefer; Katie Sklarsky

Meeting was called to order at 6:10 p.m.

1. Introductions
Lesley Bennett chaired the meeting. Members and participants introduced themselves.

2. Public Comment
There was no public comment.

3. Minutes of March 17 Meeting
Motion to accept the minutes of the March 17th Practice Transformation Taskforce Meeting – Alta Lash; seconded by Jesse White-Frese.
There was no discussion.
Vote: all in favor.

4. Purpose of Today's Meeting
Ms. Bennett said the purpose of the meeting was to review and understand the work group charter and how the Community and Clinical Integration Program (CCIP) work will be incorporated. She said they will work towards consensus on the proposed approach, process, and time line of CCIP.

5. Practice Transformation Task Force (PTTF) – CCIP Charter and Revised Charge
Review PTTF "Revised" Charter:
Ms. Moratti presented an overview of the CCIP development (see presentation here); the revised Task Force charter and the CCIP charge. In follow up to the previous meeting, the Task Force will incorporate the development of the CCIP into the group's charter. Ms. Moratti said that for the program to be successful, they need to be clear about the charge and the process used to develop the program. Ms. Moratti also gave an overview of the intent of the program: it is a collection of programs that integrate healthcare delivery and community organizations and include both traditional and non-traditional care providers. Dr. Schaefer added that it is focused on the integration between the health systems and community groups.

Community and Clinical Integration Charge
Ms. Moratti reviewed the modified charter as defined in the Model Test Grant. She reviewed the list of CCIP components as grouped by three categories: driving vertical integration with providers and community organizations; enabling coordination and collaboration within an integrated healthcare delivery system; and ensuring transparency in the delivery to drive improvement, close health equity gaps, and be a force for

change. Alta Lash said the only component that stood out to her was identifying super utilizers. Ms. Moratti noted that the first category would identify them but that the other two categories would identify how to serve their needs. Dr. Girouard expressed concern with the term "super utilizers" as it may have implications that they are receiving inappropriate care. Dr. Schaefer said the term is used nationally to characterize a certain set of programs aimed at a certain set of clients and consequently has familiarity and meaning for our target audience. The Task Force discussed the possibility of using this term as a parenthetical reference to clarify the intent of any other term that we might use.

6. Key Questions to Design Our Approach

CCIP Approach, Process, and Timeline

The members reviewed and discussed the key design questions. Dr. Girouard asked where the consumers were in the process. Ms. Moratti noted that they considered consumer representatives as proxies but there is a need to test the process with the lead organizations and the community. There is the opportunity to test more directly with community members. Ms. Moratti said they will use more precise language. Ms. Bennett asked who would conduct the interviews. Ms Moratti said this work could be done through the PMO and could include PTTF members as appropriate.

Ms. Lash asked whether it was anticipated that the PMO would award grants to entities that are engaging in clinical and community integration activities. Dr. Schaefer noted when the Department of Social Services (DSS) procures for the Medicaid shared savings program participants they will embed the CCIP standards and expectations into the RFP process. Any system competing to be a part of the Medicaid Quality Improvement and Shared Savings Program (MQISSP) would need to demonstrate a commitment to developing the CCIP capabilities and engage with the technical assistance vendor if they don't already have the capabilities. Dr. Schaefer said as an additional enabler, there is potential to supplement technical assistance with matching grants. CMMI has not yet approved the use of matching grants.

Ms. Bennett asked about the time frame for implementation. Ms. Moratti said Phase 1 would run through the end of April and Phase 2 would run through the end of June. She noted they are organizing around categories in order to move to a rapid design process for defining the standards. The aim is to work through three design groups. She provided an overview of how the process would be executed. Suggestions can be submitted directly to Dr. Schaefer or through the PMO.

Dr. Girouard asked how consumer participation fits in. Ms. Moratti said that consumer interactions could be included in the research process to ensure it is effective. When looking at integration and linkages with community organizations, they can focus the discussion on the consumers most impacted by those linkages.

The design groups would include both PTTF members and others who are interested in contributing. Ms. Moratti highlighted a stakeholder engagement process that would include testing across all three design groups and across all stakeholder categories. The design groups will be open for anyone to participate. Dr. Schaefer provided an overview of how other design groups have worked to date. He suggested the groups begin with PTTF members and expand to others interested in testing the preliminary ideas. PTTF members discussed using webinars to ensure a smooth process.

Revised Membership

The Task Force discussed adding additional members to meet the charge. The Personnel Sub-Committee of the Healthcare Innovation Steering Committee met on April 2 to discuss the issue, not looking at the topic of design groups. They have proposed five categories. Dr. Schaefer noted that if the PTTF recommendations differ from the Personnel Subcommittee's, both could be presented to the Steering Committee for deliberation at their April 9th meeting. Once the categories are finalized, the PMO would engage in a solicitation for potential nominees. Dr. Schaefer asked whether the Consumer Advisory Board should recruit any of the five categories, as they are charged with nominating consumer/advocate representatives. He noted that the PMO is not seeking to add another state agency representative but would like to find a DSS replacement for Robert Zavoski. There will not be any additional commercial payer representatives added.

The Personnel Sub-committee wanted to add three additional categories but could not narrow down the choice beyond the five categories: practice manager, hospital, housing, cultural health organization, and home

health. Ms. Lash suggested they be very specific in what they are looking for in these categories. For example, she noted that the housing representative should be someone who works in housing at the ground level, rather than a policy person. Dr. Schaefer said the person sitting and working with consumers is closer to the barriers but the person who is running the organization may understand what is needed to orchestrate change and coordination with other community entities. Ms. Bennett said she would prefer those who are encountering the challenges that consumers experience. The Task Force discussed whether long term care should be included. It was noted that home health and long term care can be consuming to navigate.

The Task Force discussed which elements were potentially missing. Dr. Schaefer suggested that DSS could serve as a conduit to long term services and supports, such as through their existing waiver or demonstration programs (e.g. Money Follows the Person). Dr. Stone noted that the categories represent where the linkages need to occur and would move that they keep five categories, rather than three. Dr. Schaefer asked whether they should request that someone from DSS participate. The group agreed. Dr. Girouard asked how consumer participation fits in. Dr. Schaefer suggested the Consumer Advisory Board nominate the housing and cultural health organization representatives. The members agreed to this.

Motion to accept the 5 positions including consumer participation appointed by the CAB, Housing and Cultural Health organization, other appointees, on the ground hands on people, and ask for DSS representation- Elsa Stone; seconded by Randy Trowbridge.
Vote: all in favor; 1 abstention (Shirley Girouard)

7. Next Steps
Ms. Bennett said the Task Force should consider whether the CAB will have time for the two appointments. Dr. Schaefer noted he has already discussed the appointment process with them and they have agreed to make recommendations in time for a special meeting of the Steering Committee. He added that the CAB will seek to make recommendations by April 22nd. Ms. Bennett noted the CAB will also try to replace the member who has not attended in addition to the slots for housing and cultural health.

Motion to adjourn – Leslie Bennett; seconded by Jesse White-Frese.
There was no discussion
Vote: all in favor

Meeting adjourned at 8:05 p.m.