STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
September 29, 2015

Meeting Location: Connecticut Behavioral Health Partnership, Suite 3D, 500 Enterprise Drive, Rocky Hill

Members Present: Susan Adams; Lesley Bennett; Mary Boudreau; Grace Damio; David Finn via conference line; Heather Gates; Dr. Shirley Girouard; Beth Greig; Dr. John Harper; Abigail Kelly; Anne Klee; Alta Lash via conference line; Kate McEvoy via conference line; Nydia Rios-Benitez; Rowena Rosenblum-Bergmans via conference line; Eileen Smith via conference line; Dr. Elsa Stone; Dr. Randy Trowbridge via conference line; Jesse White-Frese

Members Absent: Leigh Dubnicka; Dr. M. Alex Geertsma; Bernadette Kelleher; Dr. Edmund Kim; Rebecca Mizrachi; Dr. Douglas Olson; Dr. H. Andrew Selinger; Joseph Wankerl

Other Participants: Karen Buckley via conference line; Supriyo Chatterjee; Faina Dookh; Meredith Ferraro; Kevin Kappel; Paul Morandi; Mark Schaefer; Marie Smith

The meeting was called to order at 6:07 p.m.

Introductions
Lesley Bennett and Elsa Stone served as meeting co-chairs. Members and participants introduced themselves.

Public Comment
There was no public comment.

Minutes of September 1st Meeting
Motion: to accept the minutes of the September 1st Practice Transformation Taskforce (PTTF) meeting- Shirley Girouard; seconded by Susan Adams.
Discussion: There was no discussion.
Vote: All in favor

Purpose of Today's Meeting
Ms. Bennett reviewed the purpose of the meeting (see presentation here).

Review of Public Comments to CCIP Report
Kevin Kappel reviewed the public comments to the Community and Clinical Integration Program (CCIP) report. The executive team met and decided on the best focus for tonight's PTTF meeting. Kevin Kappel noted that all of the public comments are posted online. Members reviewed and discussed the various public comments.

A. Financial Incentives and long-term TA
The group talked about financial incentives and long-term technical assistance (TA). Ms. Lash said

she can't see how they can start this without having additional resources other than technical assistance with a provider. She said it may not be feasible. Dr. Schaefer said they are proposing to reallocate a portion of the grant to support the transformation awards, to providers, health systems and their partners. He noted it won't be a huge amount of money and he is hoping to bring this topic up at the next HISC meeting.

Dr. Girouard expressed concern about the pressure to have things done by a certain time if important issues need to be addressed more completely. She asked for clarification of the relationship between CCIP work and Medicaid. Ms. McEvoy explained the relationship of CCIP, Medicaid, the goals of Medicaid Quality Improvement and Shared Savings Program (MQISSP), and the reason for the ambitious timeframe. She noted they are looking to align efforts and time in terms of development of the standards for the two initiatives. Ms. McEvoy also mentioned a document outlining the Department of Social Services (DSS) initiatives that was shared with HISC and is intended to be a go-to source of what they have been doing.

B. Community Health Board structure
Members discussed changing the language and there was a suggestion to change the term "board" to collaborative since board has a specific connotation that is not in line with the intent. The group also talked about who would be accountable for the creation of the community health collaborative and ensuring the collaboratives meet the standards in the document. Dr. Schaefer said it was recommended by the taskforce that the transformation vendor would be charged with facilitating or convening in areas where there are advanced networks and federally qualified health centers (FQHC) participating in MQISSP. He noted the transformation vendor will also be providing technical assistance to some of the participants in areas and they would be in a good position to develop protocols that align. It was reinforced that this concept would not be the responsibility of the participating providers to stand up, and therefore there was additional time to clarify the logistics. The program management office (PMO) is working with DPH and other stakeholders to ensure that these community structures are coordinated with and build off of existing population health convening activities already in place in Connecticut. This concept will evolve over time.

C. Care plan references and content
The group talked about the care plan being one central plan of care instead of multiple plans. There was a suggestion for the plan to be called the patient's care plan and the patient should be the one that signs off on it. It was noted that there should be one plan of care that everyone shares and details of elements within the plan would be done by individuals pertaining to expertise or specialty. Members discussed the possibility of the electronic health record with a care plan component as well as a care coordinator to pull information together and support the team. There was the clarification that the various care plans referenced in the standards were intended to be extensions or additional components of the patient's central plan, and the group agreed that the best way to reference it was as components.

Dr. Schaefer mentioned some practices or systems are purchasing care management software and addendum to guide care management and pull elements together. It was noted that software data solutions take time, are expensive, and funding may not be available. Dr. Trowbridge said primary care physicians can accomplish a lot of things if given the time. He mentioned that patients need to understand their role, be empowered through educational elements, and be involved in their own health. Mr. Trowbridge said that patients shouldn't be coddled for everything that they need done. Ms. Adams suggested for it to be what the patient's goals are for healthcare so they will be engaged and accountable for some of their care.

D. Integration / coordination of CCIP and PCMH
Ms. Lash asked about the position of the Care Management Committee (CMC) of Medical Assistance Program Oversight Council (MAPOC) regarding CCIP. Ms. McEvoy noted the Care Management Committee did not take a formal position on CCIP. The first opportunity to review CCIP formally was at the last committee meeting. Ms. Lash expressed concern about the committee not having ample time to talk about CCIP and timeline issues. Ms. Lash said she thinks there is a problem figuring out how this applies to more than just Medicaid. She mentioned it is suppose to apply to everyone in the FQHCs and advanced networks. Dr. Schaefer explained why CCIP is linked to MQISSP procurement and why DSS positions around eligibility directly effects who ultimately can access the CCIP.

E. Integration / coordination of CCIP and behavioral health
Ms. White-Frese asked, if FQHC is getting support as part of the medical home program, how support from the transformation vendor and support from community health network would not be conflicting. Dr. Schaefer said the CCIP support is intended to be at the level of the organization. Support might be for setting up e-consults for use by the primary care network. He said they are looking for capabilities where it helps for organization support via infrastructure, resources or policy changes.

F. Standards flexibility
The group discussed whether all standards should be optional. It was noted that the detail and activities to achieve the standards could be cumbersome. There was a suggestion for flexibility on how to meet the standards but that all standards shouldn't be optional. Ms. Bennett mentioned there should be an allowance for teams to innovate and figure out how to get there because things are always changing in healthcare. Ms. Gates said practices should meet the highest standard whatever it may be. She noted the process has involved a lot of expertise to develop the standards and things aren't prescribed to such a degree that it creates an undue burden.

Dr. Schaefer suggested for an ongoing engagement between the PMO and PTTF regarding where adjustments may be needed and to ensure the standard being imposed is relevant and not a barrier to achieving goals to person centered care and better health. There was the sense that the standards should be maintained as core and required since they do reflect evidence-based best practices in care management. But the PMO and transformation vendor should work with the participating providers to address any issues of burdens.

G. Reframing Medication Therapy Management
Ms. Bennett invited Marie Smith to comment regarding medication therapy management. Ms. Smith said the term "medication therapy management" (MTM) is used to describe a pharmacy drug benefit. She noted that comprehensive medication management (CMM) is about the principles and implementation approaches that PTTF subscribes to regarding patient centeredness. She said with CMM the pharmacist is part of the health care team not the dispensing role. Ms. Smith said the model of CMM services is not brand new but hasn't been defused widely because of sustainable reimbursement. Dr. Schaefer mentioned the PMO is inclined to incorporate much of what Ms. Smith is recommending.

H. CCIP health IT capabilities
Dr. Schaefer said the Health Information Technology (HIT) Council is establishing a couple of design groups to help figure out the best way to spend the SIM funds to enable some of the health information technology capabilities. He noted that funds are limited. Ms. Lash expressed concern that the HIT component of this is problematic. She said questions about racial ethnic disparity and

prevention of under service hinge on a reliable timely HIT component. Ms. Lash suggested that PTTF communicate to the HIT Council the concern about having something that will be effective and timely. Members discussed eConsults. Dr. Schaefer said SIM does not have any funding attached to the eConsults elective.

I. Complex patient definition

Mr. Kappel said a commenter specified that the plan will need to define what condition the patient would need to have to be deemed complex. He said the request was to adopt the Institute of Medicine (IOM) definition going forward. Members discussed three different definitions of complex patients. Mr. Kappel said it sounds like there is strong opposition to the IOM definition. Members agreed that the top definition, on slide 15, reflected the best complex patient definition. There were a few recommendations to change some of the wording. The group agreed to "patients who have or are at risk for multiple complex health conditions" instead of "patients who have multiple complex medical conditions".

Standards for Community Health Workers

The group discussed standards for Community Health Workers (CHW) and whether there was a need for more regulations or a standard definition. Ms. Rosenblum-Bergmans said that CHWs come in all shapes and sizes and respond to the community that they are in. She noted there are certain baseline trainings in certification programs around culture competency, readiness for change, and being able to assess various dangerous situations in a home. Ms. Rosenblum-Bergmans suggested that it may be beneficial to learn what some other states have in their certification programs.

Ms. White-Frese asked about the current capacity of CHWs in CT. Meredith Ferraro, of Southwestern AHEC, said they don't have a total handle on the number of CHWs in CT because they are called 40 different titles. She said the title of CHW was created because there needed to be an umbrella of everyone doing community outreach for grant funding purposes. Ms. Ferraro noted they are tasked with creating a community health worker advisory board. She said they will include Carl Rush and Joanne Colista from Massachusetts, who serves as vice chair of the certification board and will provide consulting services. Dr. Schaefer said there are a few states that have imbedded some standardization and expectations for care delivery reform. He said they will report back on this subject.

Review of CCIP Timeline

The next PTTF meeting is scheduled for October 13, 2015. Dr. Schaefer said they are planning to present the CCIP report and standards to HISC on October 8th and deliver the CCIP standards to DSS by October 12th. Dr. Schaefer expressed thanks to everyone for the work so far. He said they are looking to disseminate the next draft report to HISC and PTTF on Friday, October 2nd. Dr. Girouard asked about future PTTF meetings. Dr. Schaefer said there will be a discussion regarding the focus and cadence of PTTF meetings going forward.

Other Business

J. Coordination with the HIT Workgroup

This was not discussed due to a lack of time.

The meeting adjourned at 8:06 p.m.