STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
March 22, 2016

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

Members Present: Susan Adams; Lesley Bennett; Grace Damio; Garrett Fecteau; Shirley Girouard via conference line; Beth Greig; Edmund Kim; Anne Klee; Ken Lalime via conference line; Alta Lash via conference line; Kate McEvoy via conference line; Douglas Olson via conference line; Nydia Rios-Benitez; Rowena Rosenblum-Bergmans via conference line; Elsa Stone; Randy Trowbridge via conference line; Jesse White-Frese via conference line

Members Absent: Mary Boudreau; Leigh Dubnicka; David Finn; Heather Gates; M. Alex Geertsma; John Harper; Abigail Kelly; Rebecca Mizrachi; H. Andrew Selinger; Eileen Smith; Anita Soutier

Other Participants: Supriyo Chatterjee; Faina Dookh; Mark Schaefer; Vicki Veltri via conference line

The meeting was called to order at 6:10 p.m.

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

Public Comment
There was no public comment.

Minutes
Motion: to accept the minutes of the February 2, 2016 Practice Transformation Taskforce (PTTF) meeting–Anne Klee; seconded by Susan Adams.
Discussion: There was no discussion.
Vote: All in favor.

Purpose of Today's Meeting
Ms. Bennett reviewed the purpose of today's meeting. She said they will discuss public comments to the CCIP Draft 4 and the implementation strategy and edits for final standards and report.

CCIP Comments and Proposed Edits
Dr. Schaefer provided an overview of the proposed Community and Clinical Integration Program (CCIP) implementation strategy and accommodations for participants (see presentation here). He said that some members of the Care Management Committee (CMC) noted a concern that the launch of CCIP could compromise the successful Person Centered Medical Home (PCMH) program that is being administered by the Department of Social Services (DSS), the foundation on which Medicaid Quality Improvement & Shared Savings Program (MQISSP) is based, and CHNCT Intensive Care

Management program (ICM). Dr. Schaefer said they are proposing to add several accommodations to the report such as an exemption request, coordination protocols, a timetable, and alignment.

Ms. Bennett asked about the number of care plans with regard to the coordination protocol. She mentioned that the master care plan is in the medical home and they will figure out the care coordination. She said it sounds like there are three or four different levels now. Dr. Schaefer said along with the taskforce recommendations, there is an emphasis to build out one care plan in terms of what the Advance Network is administering with its care coordination support. Members discussed the need for information sharing of care plans. Dr. Stone noted that it is important to have one care plan that everyone is aware of even if others are responsible for implementing it.

Ms. Dookh reviewed the public comments and responses. The public comments are highlighted in blue and places with specific edits to the report are red lettered within the green. The taskforce discussed edits to the language for Comprehensive Care Management (CCM), core standard one. Ms. Rosenblum-Bergmans expressed concern regarding the automated referral process. She mentioned the possibility of bringing in local data sources to identify the high risk or those that have psychosocial issues that need to be addressed. Ms. Rosenblum-Bergmans asked for the meaning of automated in requiring a referral process to be an automated system. There was a discussion regarding meaning of the word "automate".

Dr. Stone asked whether the referrals were going to a network's comprehensive care team or a PCMH team. Dr. Schaefer said the comprehensive care team should be the PCMH care team with additional people. Dr. Stone said sometimes when referring to patients with complex needs, a lot of other people will be called in to create the comprehensive care team. She said the doctor in the office may not be on the ground doing everything, it may be funneled off to this other team because it is more specialized. Dr. Schaefer asked should it be called a medical home care team, when there is a new patient and there is no comprehensive care team. Members discussed and agreed to use the term "medical home care team" and "electronically alert" instead of the word "automate".

Ms. Dookh said there was a suggestion to integrate a resource directory to promote referrals to community supports. She said the proposed edit includes integrating it into CCM, standard five. Dr. Stone asked who will be creating this up to date directory. Dr. Schaefer said the most up to date directory that exist today is 211. It was mentioned that a lot of Advanced Networks and federally qualified health centers (FQHC) do not have the ability to tap into an up to date resource directory. There may be a need to figure out a technology solution for up to date resources to be effective with community linkages. The taskforce discussed whether to establish a directory resource guide as part of the element within the standard.

Ms. McEvoy suggested that info line 211 has an extensive searchable database to various types of resources. She said almost all of the types of services and supports that are numerated by PTTF are already included in the info line 211 directory and there are no barriers to using it. Members agreed to establish language including protocols for accessing an up to date resource directory such as 211, for referring individuals to needed community resources and verifying that the individual was effectively linked to services. There was a suggestion to include tracking referrals language.

The taskforce discussed edits to the language in core standard two, health equity improvement (HEI) part one. Dr. Girouard asked whether the language could be simplified. She expressed concern that most people won't understand what the word "granular" means in this context. Dr. Kim suggested taking out the word "granular". Members agreed. Dr. Schaefer verified that everyone was okay with the other proposed edits in this standard. There was a discussion

regarding the importance of collecting race and ethnic data. Supriyo Chatterjee suggested looking at ACO provision 4302 which mandates the collection of real data. He said they have processes and procedures to capture analytics.

Mr. Chatterjee said on the receiving end, you cannot force a patient to give his or her status out because it is an option. He mentioned health literacy is also problem. Mr. Chatterjee said community health workers (CHWs) may be able to encourage patients to provide the information. Dr. Schaefer said it is important not to neglect educating consumers as to why the information is needed for healthcare improvement. Ms. Damio noted that along with other training for this initiative, training will be needed for providers or whomever will be collecting the information. She said people should know the reason that the information is being collected, the social background of why people are affected by the categorizations, and how to explain it to patients.

The taskforce discussed talked about the edits to language in core standard two, HEI part two. There was a question about whether the five practices referenced would mean five locations. It was clarified that it is intended to mostly mean sites and some practices have more than one site. It was noted that when looking at a network with multiple practices within the network, there could be one tax identification number with several locations. There was a suggestion to be clear and say five practice locations instead of five practices. Dr. Schaefer said this edit will be made.

The taskforce discussed proposed edits to HEI part two, standard three. Members agreed to change "automated referral to CHW" to "electronic alert to medical home care team". Ms. Dookh said a link was sent out in advance regarding the comprehensive response to comments. She said it is an attempt to address many of the concerns, clarify some of the process that the taskforce has underwent, and propose some of the edits in the CCIP report. Dr. Schaefer said they will import some of the material in the appropriate sections of the report unless there are objections to what was read in the response to comments. Ms. Damio suggested including the richness of input into the introduction of the report. Dr. Schaefer said this can be looked at in the executive summary and main report. He said there are some things that occurred after the fourth draft that might be referenced.

CCIP Timeline

Ms. Dookh reviewed the CCIP timeline. The Healthcare Innovation Steering Committee (HISC) will have a special meeting on March 30, 2016. Ms. Dookh said the final edits will be turned into a draft five report and finalized. She said it will mirror the edits discussed and the content in the draft four report. Ms. Dookh verified that everyone was in support with the report going to HISC. Members agreed. Dr. Schaefer expressed thanks to everyone for all of the efforts.

Next Steps and Adjourn

Motion: to adjourn the meeting-Susan Adams; seconded by Elsa Stone.
Discussion: There was no discussion.
Vote: All in favor.

The meeting adjourned at 7:56 p.m.