# STATE OF CONNECTICUT
# State Innovation Model
# *Practice Transformation Task Force*

## Meeting Summary
## December 12, 2017

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

**Members Present:** Susan Adams via conference line; Lesley Bennett; Grace Damio; Leigh Dubnicka via conference line; Heather Gates via conference line; Shirley Girouard via conference line; Anne Klee; Douglas Olson; Elsa Stone; Randy Trowbridge via conference line

**Members Absent:** Mary Boudreau; Garrett Fecteau; M. Alex Geertsma; Edmund Kim; Alta Lash; Kate McEvoy; Michael Michaud; Rebecca Mizrachi; Rowena Rosenblum-Bergmans; H. Andrew Selinger; Eileen Smith; Anita Soutier; Jesse White-Frese

**Other Participants:** Supriyo Chatterjee; Lisa Honigfeld via conference line; Michele Kelvey-Albert; Ken Lalime; Jenna Lupi; Mark Schaefer

### 1. Call to Order
The meeting was called to order at 6:08 p.m. Elsa Stone chaired the meeting. Members and other participants introduced themselves.

### 2. Public Comment
There was no public comment.

### 3. Review and Approval of Meeting Summary
The approval of the meeting summary was deferred.

### 4. Purpose of Today's Meeting
Dr. Stone reviewed the purpose of today's meeting (see presentation here).

### 5. Review and Discussion of PCPM White Paper
Dr. Schaefer introduced the lead and subject matter expert on the Primary Care Payment Model (PCPM) white paper, Ken Lalime. He was an independent contractor to Qualidigm but is now the executive director of CT Community Health Center Association. He also introduced Michele Kelvey-Albert who is the project lead at Qualidigm for the PCPM white paper, CCIP, and AMH initiatives.

Dr. Schaefer provided an overview of the payment reforms and the PCPM white paper. He said the conclusion of the recommendations was pretty much completed in June but there were still some items left unresolved. Dr. Schaefer said there is consideration of timing of when to target the release of the report for public comment as a platform for other opportunities. He said they are hoping to formalize the PTTF recommendations in December or early January. The co-chairs are receptive to revisions to the recommendations if members feel they need to be further amended. Dr. Schaefer said the PMO is also interest in comments on the draft report. The PMO is aiming to

send the final document to HISC for approval before it proceeds to public comment. The process would be concluded in March. Dr. Schaefer said they would like to have a presentation team at the HISC meeting in January to give perspective on the importance of the recommendations that are being put forward. Other guest from the field may also be invited to join.

Dr. Girouard expressed concern that they are not considering the current context of things that are going on in the healthcare market, on both the state and federal level, as they move forward. She suggested acknowledging this because currently the demands on providers are tremendous. Dr. Stone said all of our efforts are to create a system that would be more cost effective and produce better care, there will be struggles but it doesn't mean they shouldn't keep trying. Dr. Schaefer said the report calls attention to the issue of provider burden. He suggested perhaps this is something that should be part of the platform regardless of the economic challenges that we face.

Ms. Lupi presented on the review of the PCPM white paper. Dr. Girouard said medical homes have been around for a while and long before this work. Ms. Lupi said they could make it explicit. Dr. Schaefer said they could add that pediatrics introduced the concept in the 60's. He said if there are references that describe the work that was done and that should be referenced in the report to send them. Dr. Olson said there was an article that was published in July of this year in the New England Journal of Medicine. It speaks of FQHCs and the implementation of patient centered medical homes being funded by CMS from 2011 to 2014. It showed increased care utilization, patient admissions, and Medicare Part B expenditures. He asked whether it could be referenced to say that patient centered medical homes have a lot of good but will not solve of all the problems, for balance. It may help to make the important point to potential payers that they may see upfront cost and it is not necessarily a failure but may be an early indicator of success.

Ms. Lupi spoke about the white paper components. She said following the discussion of each of the options there is a short summary of the PCPM options. She said there is also a section with special considerations for pediatrics. Ms. Honigfeld noted the importance of the number of preventative visits in the very early years of life. She said the early visits are important and probably more could be done at them to make a bigger contribution to long term health during this time. She mentioned structuring payment in a way that practices can use the 12 visits in the first two years of life for a bigger contribution. Ms. Honigfeld sent in other comments and they were distributed before tonight's meeting. Her comments will also be posted on the PTTF webpage.

Ms. Lupi said they will review the recommendations in case there are edits that need to be made. *Recommendation 1* - Ms. Gates said she submitted comments for the group to consider regarding Behavioral Health as it relates to the primary care setting. She mentioned the question of whether possible to support the integration of primary care in the behavioral health setting and to treat it the same way as they are thinking about expanded services within primary care. She suggested for them to also look at behavioral healthcare reform because it is inadequate. Ms. Gates said she wanted to expand upon pediatric practices in terms of early diagnosis and identification of behavioral health problems and substance use from the ages of 10-12 on, because it is under identified and leads to problems later in teenage years.

Dr. Schaefer said the Health Affairs Journal just released an article over the weekend on behavioral health payment reform. He suggested for the group to take a look at this. It would be interesting to see what it says about behavioral health payment models. He said as a follow up on this they could look at the HCP-LAN report regarding PCP designation and circle back to the group.
The Taskforce discussed using the term "consumer" as opposed to "patient" or "client". It was mentioned that a consumer support system could be family or a surrounding community but

patient seems narrower and infers a direct relationship with practitioner. It was noted that there is variability in using the terms client and patient in mental health. Ms. Gates said in the context of this work, she thinks "patient" is the more appropriate term. Dr. Schaefer mentioned that in the balance of the report they use the term patient several times. He suggested consistency in using the term "patient" for recommendation 1 and also adding "expanded and diverse care teams".

*Recommendation 2* - Dr. Schaefer expressed concern about the recommendations being able to stand alone. He suggested introducing language that says what the three primary care payment models are. He asked whether everyone was okay with it being drafted to bring the language in. Members agreed. Dr. Stone suggested adding three bullet points for the three different models.

*Recommendation 3* – Dr. Girouard suggested simplifying the recommendations by putting the rationale for the recommendation separately. The Taskforce discussed the possibility of simplifying the recommendations. There was a suggestion to put in the executive summary a reduced version and have the expanded version in the body of the report. It was mentioned that separating the rationale from the recommendation would be more fragmented. Another suggestion was to separate them in a table with the recommendation in the first column and the rationale in the second column. Ms. Gates said she likes the way it is because the whole paragraph makes sense and can stand alone without further explanation. Dr. Schaefer said they will take this under advisement.

*Recommendation 4* – Dr. Schaefer said members of HISC reviewed the response that was sent to the feds and one person offered an edit to recommendation 4. The suggestion is to change the term from "increase the amount of money" to "at least double the amount of money". Dr. Schaefer asked whether the Taskforce wanted to put something in there that is this bold. Ms. Bennett said she thinks they have to drive it that hard and it is not unreasonable for primary care for what they are asking them to do. Members agreed. Dr. Schaefer said he is not hearing any dissent.

*Recommendation 5* – There was a discussion about some of the things that are currently non-billable and billable services. Pharmacists and nutritionists are generally non-billable. It was noted that the total cost of services should be reduced. Ms. Klee mentioned that in some states peer supports is billable. Dr. Schaefer said if you are offering health coaching, it could be offered in the bundle. Mr. Lalime suggested it could be called coaching.

*Recommendation 6* – There was a discussion that risk-adjusted methods should also take into consideration clinical and social determinant risks in addition to stand approaches. Ms. Bennett suggested that they may need to define this a little more. There was a question of whether risk adjustments apply to things that are age or gender adjustments. It was noted that age and gender categories are also risk. Dr. Schaefer said they are saying that they should use risk adjustment and it should include social determinant risk which is not typical.

*Recommendation 7 & 8* – There were no concerns or edits to these recommendations.

*Recommendation 9* – Ms. Honigfeld had a recommended addition to recommendation 9. She said there is a hope that primary care would not only coordinate with community services, not duplicate and rebuild, but make maximum use of care management and care coordination. She said the flexible payment should allow combining of resources. Dr. Girouard suggested talking explicitly about non-health issues such housing, food, and air conditioning. She said it should be made clear that it is what they are talking about. Members discussed adding some examples. It was noted that listing items may interfere with the central message. The recommendation has language that is intended to encompass what all of the community based providers see as necessary to support

vulnerable populations. There was substantial support for leaving the recommendation with broad language as originally worded.

*Recommendation 10* – There were no edits to this recommendation.

*Recommendation 11* – Members discussed that fact that the recommendation started with the word "to". There was a suggestion to change the word "to" to "should". Members agreed change the order of the wording and put "should effectively incent and enable practice transformation" at the end of the recommendation.

**6. Next Steps and Adjournment**

Dr. Schaefer said there may be invited guests in March or April to speak at the HISC or to have a panel discussion to bring a variety of perspectives that say this is the vision that we are trying to unlock with transformation. He mentioned that bringing in someone who has lived through some of the issues would be important. Ms. Klee said that she knows a doctor that may be able to provide some perspectives on integrated care. He works with behavioral health providers and is a primary care provider.

The Taskforce agreed to have a conference call in the next week or so if a quorum can be gotten. The call will be to vote on the revisions to the report and recommendations and to submit to HISC.

The meeting adjourned at 8:04 p.m.