DRAFT Meeting Notes

State-Wide Health Care Facilities and Services Plan Advisory Body

April 24, 2013

9:00 a.m.

Agenda Item	Discussion	Action/Results
Item I Opening Remarks	Karen Roberts and Kaila Riggott facilitated the meeting on behalf of Kimberly Martone. They noted that any handouts would be posted onto the website. This is the first time the group has met since The Plan was released last fall and discussions have already started with subcommittee chairs regarding the recommendations.	
Item II Facilitator presentations: Primary Care Subcommittee-Evelyn Barnum Behavioral Health Subcommittee – Al Bidorini/Lauren Siembab Acute Care Subcommittee-Carl Schiessel	**Al Bidorini** – Discussed Behavioral Health and passed out table prioritizing the subcommittee's recommendations, and reminded the group the prioritization is only reflective of adult behavioral health. The recommendations were also given to CT Assoc. of Non-Profits and CCPA (CT Community Providers Assoc.), but only CCPA responded. There was input from three subcommittee members. Robert Plant was lead on the children's side but had left state service and therefore nothing was received on the prioritization of recommendations from the children's side. There is a replacement from DCF but there has not been any formal discussion on the children's side. Priorities to consider were listed on handout, they are: 1) Further consider how health care reform and possible blended behavioral health license might change the landscape for both behavioral health finance and delivery of care in the future. At this point, Wendy Furniss gave a brief update on the blended rate regulations. A draft is finished and is proceeding through review . Five categories of behavioral health and substance abuse licenses will be combined into one. One license will list the various services provided by each entity. Goal is to streamline process and relieve the burden on the provider community not to have to respond to multiple sets of regulations and multiple, differently timed licensure visits. Will be in place by the end of 2013. Al continued with the prioritization of recommendations. The subcommittee was also asked to look into what entities or individuals may play a key role with Priority #1. The Office of Health Care Advocate and Health Care Cabinet will play key roles and the SIM grant may be leveraged. Priority #1 will consume the rest of this year and possibly next year. Important to do in harmony and use resources wisely. Priority #2 ,provide more focus on the provision and interrelation or co-location of mental health, primary care and/or oral health services,so that no matter your access to care, the care is looked at holistically and seamlessly. Once the Health Care Exchange is in place this will be better coordinated and attended to. Players include Community Health Centers, DPH, DMHAS, DCF, FQHCs, Primary Care Administrators, Professionals from the	.

	Behavioral Health side, DSS, along with others. DMHAS has some models in place that are putting forth models of integration. We may need to look into reimbursement policies and integration as this might be an impediment. Rollout could be 18 months or so, starting now and continuing thru 2014. Priority #3is to have a better inventory of services. Need to include additional types of service providers (private practitioners, VA services). We will need to look into a way to inventory private practitioners (licensing division, CT Psychological Association); there currently is no easy way to do this at this point. Priority #4 Once we have a full understanding of the system's capacity, is there a way to determine unmet need based upon this new demand? Currently there is no up and running model. There are some preliminary models but we would have to evaluate them before this rolls out (SAMHSA). The Federal changes could create new demand. **Carl Schiessel** – Acute Care and Ambulatory Surgery subcommittee gave their rankings to the recommendations which are on pages 133 and 134 of the Plan. The recommendations are pretty specific. Of the 16 recommendations, six arose from an exercise that the subcommittee engaged in with the Behavioral Health Subcommittee as an ED focus group examining increased volume of patients with behavioral health issues as a primary or secondary diagnosis. They felt that it is their job to assess the impacts of these recommendations and their impacts on the care providers in particular. Where the gaps are in service; how the existing facilities are addressing them; and coordinating with other subcommittees to implement the recommendations. **Karen Roberts** spoke about two of the Primary Care subcommittee recommendations prior to Evelyn's arrival. The first is to consider mandating responses on all license renewal applications to certain survey questions, i.e., actively practicing in the state, primary location of practice and whether actively treating patients. The second ties into what Al and Lauren were speaking to -. providing additional plan focus on the provision of mental health and oral health services in primary care settings and assessing the interrelation of the services with primary care. **Evelyn Barnum** then clarified that the primary care subcommittee did not bring the integration of behavioral health into primary care to the highest level of priority. The subcommittee focused on having the inventory, using licensure mechanism to get at who is actually practicing in CT, for example. Electronifying the licensure process and then having a database so we know who is providing services where and to whom was one of the top priorities. The second was focusing on understanding the hospital-affiliated, hospital-associated, hospital-run primary care practices. The third was to improve the hospital reporting system. The subcommittee left it up to the behavioral health subcommittee to work on the integration of behavioral into the primary care settings. If the primary care physicians identify need for behavioral health services, then what do they do with these patients? The availability of a work force is not there. The Primary Care	

	Coalition had a meeting in March and their presentation was on the integration of behavioral health care into primary care and the lack of services was brought up.	
Item III Presentation on SIM Grant – Michael Michaud and Sue Nimitz	Some coordination pieces were discussed first. SIM stands for State Innovation Model. Michael Michaud is the Associate Project Director for SIM and is also the regional manager for DMHAS. He talked about referencing the Affordable Care Act and the need for coordination. Below is a bulleted list of some of the primary points made during this presentation: • DPH is going to have a full time planner on board dedicated to this project through its conclusion, which is September 30th (started in April 1). That person will serve as a colleague along with Sue, who will be the DMHAS program planner. • DPH and DMHAS Comrs. Mullen and Rehmer are on the steering committee to provide more integration and then there will be work groups set up. Those work groups will have representatives from various companies and state agencies, allowing for more integration. • The SIM Grant will cumulate in a written plan on how to transform the health care system both in terms of service delivery and payment, with the goal of improving health care and outcomes and decreasing costs. The whole goal includes moving from a volume services-based system to a value-based system. That plan is to be completed no later than September 30th. The testing implementation grant is far more significant ($40 million plus over 3 or 4 years). In order to qualify for that grant, the plan has to be included in the application to CMS, which is due by October 1st. This will impact all insured persons or payer - public or private (Medicare, Medicaid, state employees and CHIP just to name a few). • Regarding the organizational structure, the project is nested at the Lieutenant Governor's office, there is a steering committee (SHIP-State Health Innovation Plan) which includes the Lieutenant Governor, Health Care Advocate along with the Comrs. Of DMHAS, DPH, DSS, Ct. Ins. Dept., OPM, Anthem, CIGNA, DCF, Comptroller, The Exchange, Dean of UCONN Health Center, Specialist provider who is knowledgeable in payment reform, Ct. Health Foundation and a large employer. DMHAS and DPH will have program planners and a fulltime person for DSS, State Comptroller's Office and UCONN Health Center. Mark Schaefer, Michael Michaud and Vicky Veltri are the core team. It will bring in the consultant and the planners from various state agencies. • There are 8 work streams that are handled by the teams listed on the chart. In addition there will be three work groups that will kick off in mid-May. They are: Health Delivery, Payment Methodology Reform and Health Information Technology (HIT). Six states are ready to implement their plan, those states are: ME, VT, MA, MN, AR, OR and their plans are being researched. NY, WA and NE have received grants for pre-testing assistance (are in between writing and implementing the plan). CT is one of 16 states that received a grant to write the	Michael Michaud would see if he could release the expanded document of the one he distributed at the meeting that explains each of the boxes. If it could be released they will get it to DPH for dissemination. The Office of Health Reform and Innovation's webpage for the State Innovation Model Initiative is http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2742&q=334428 .

	plan. • Mark Schaefer and Michael Michaud went out and interviewed 12 of the 15 companies or agencies who are represented on the SHIP. There are 3 left to do. Some of the common themes from the interviews are; Everyone views this as the single largest opportunity to act, time is right, let's do something bold, there is an agreement that we move from a volume-based system to a value-based system, which has to include some sort of total cost of care accountability, thinking about ACO's, or PCMH's. Things that were heard from everybody interviewed is to focus on three or four centerpiece items- to move forward (do not bite off more than you can chew.) Health equality and health disparities concerns were; SHIP group was very strong in this area: A greater need for state and national understanding of public health; -differentiating public health from medical care and population health; not just managing a panel of patients or panel of providers; we have to ensure that public health is a prominent component of this transformation initiative. How do we do that? The application should showcase public health advance system performance, capacity, agility and resilience; access to medical care, primary and specialist is a superordinate goal for the severe and persistent mental illness population. This means integrating primary care into mental health settings. • Primary care should be a competent and include primary care standard of practice that is comparable to what is provided in other primary care settings. We need to recognize the importance of non-health services, basic needs, housing in achieving health and recovery. The Comrs. stressed the importance of family education and involvement, prevention and control of chronic illness, a reduction in morbidity and mortality, we need to emphasis public health quality measurement in our health system with a focus on transparency and consumer engagement, providing patients with access to this information to make the decisions about where they go for care. • The community health worker in services to persons with medical needs, needs to be addressed in the SIM, how do we create fertile soil for the community health worker in the SIM? • Last comment, integrated primary care, public health and behavioral health is referred to by SAMHSA as public mental health and it needs to be considered heavily when developing the SIM model. • A question was asked how would the statewide facility plan be incorporated in the SIM plan? The person who will be assigned by DPH should be able to bring this information to the SIM group. The assigned planner would need to be in contact with the provider community groups as well. Information gathering for the SIMS grant will end in August and then in mid-August the writing will need to start. The state is putting together a plan and at the same time completing the	

	grant for a possible implementation grant. The state will be moving forward even if they do not receive the implementation grant. A suggestion was made that it might be a valuable resource to hear what physicians are saying as they develop their groups. The grant requirements are: improved overall health, lower costs and improved health care delivery.	
Item IV Presentation by Health Insurance Exchange Kevin Counihan, Chief Executive Officer of Access Health CT	Kevin Counihan was unable to attend this meeting. He will give his presentation at a later date.	Mr. Counihan presented information briefly in a conference call with OHCA and subcommittee facilitators on May 15, 2013.
Item V Group Discussion	A question was brought up as to what now happens to the group, are we going to continue to meet or do we become part of SIMS?	
Item VI Next Steps	OHCA will let the SIM Grant contacts know more about what was in our plan and some of that process and see if it helps with the SIM grant process. Information from this meeting will be given to Kimberly Martone, who was unable to attend, and next steps would be discussed at that time. Karen Roberts informed participants that if they had any suggestions for next steps they could email Kim.	Kim will let the group know if they need to meet again. SIM Grant contacts were provided a copy of the Statewide Facilities Plan

Attending in person: Karen Roberts, Kaila Riggott, Olga Armah, Steven Lazarus, All Veyberman, Brian Carney, Michael Michaud, Susan Niemitz, Lauren Siembab, Al Bidorini, Carl Schiessel, Barbara Bunk, Sandra Bauer, Wendy Furniss and Evelyn Barnum

Conference call-in: Nancy Rosenthal, Matthew Katz, Karen Weeks, Ken Ferrucci, Pat Charmel, Bob Smanik, Stuart Markowitz, Kara Koss, Alan Kaye, Lynn Salsgiver