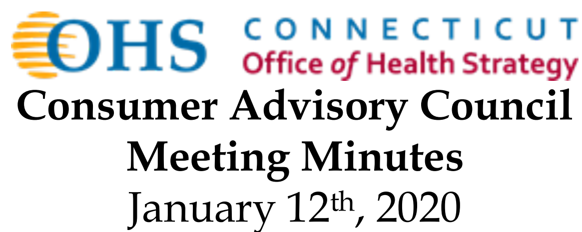

Consumer Advisory Council
Meeting Minutes
January 12th, 2020

Meeting Date	Meeting Time	Location
January 12th, 2020	3:00 – 5:00 p.m.	Zoom Meeting

Participant Name and Attendance

Jeffrey G. Beadle	X	Christiane Pimentel		Adrienne Benjamin	
Alan Coker	X	SB Chatterjee	X	Peggy Lampkin	X
Robert Krzys	X	Soneprasith Phrommavanh	X	Andre L. McGuire	X
Velandy Manohar	X	Taylor Edelmann	X	Daniel C. Ogbonna	X
Terry Nowakowski	X	Ann R. Smith	X		
Others Present					
Dashni Sathasivam (HES)		Dawn Fuller-Ball (HES)		Laura Morris (OHS)	
Terry Gerratana (OHS)		Olga Armah (OHS)		Leslie Greer (OHS)	
Ormand Clarke (OHS)		Margaret Trinity (Bailit)			

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Consumer-Advisory-Board

	Agenda	Responsible Person(s)
1.	**Welcome**	**Terry Nowakowski**
	Call to Order The scheduled meeting of the Consumer Advisory Council (CAC) was held on Tuesday, January 12th via zoom. The meeting convened at 3:03 p.m. Terry Nowakowski chaired the meeting.	
2.	**Public Comment**	**Terry Nowakowski**
	There was no public comment.	
3.	**Approval October 13th, 2020 & November 10th Meeting Summaries**	**Terry Nowakowski**
	The motion was made by Velandy Manohar and seconded Alan Coker by to approve the minutes of the Consumer Advisory Council meeting of October 13th, 2020. Ann Smith abstained. **The motion carried.** The motion was made by Velandy Manohar and seconded by SB Chatterjee to approve the minutes of the November 10th, 2020. The **motion carried.**	
4.	**Program: Review of Quality Benchmark (Executive Order #5)**	**Olga Armah, OHS, Margaret Trinity, Bailit**
	• Terry Gerratana introduced the team working on the Quality Benchmark initiative at OHS. She • She described the Cost Growth Benchmark, Primary Care Spend Target, Data Use Strategy, and Quality Benchmark streams. • Olga Armah provided a refresher on the OHS policy development process for developing the quality benchmark. She referenced the report released in November 2020 which established the parameters for the Healthcare Benchmark Initiative, for which 24 public comments were submitted. This report established the Cost Growth Benchmark for 2021 – 2025 which aim to make the annual health care cost more sustainable:	

- 2021: 3.4%; 2022: 3.2%; 2023-2025: 2.9%.
- There are no penalties for surpassing the benchmark.

- The report also established he Primary Care Spend Target for 2021: 5%, with Executive Order 5. Mandating this target reach 10% by 2025. The Primary Care and Community Health Reforms Work Group began convening in 2020 and charged with recommending the primary care spend targets for 2022- 2025 to OHS. OHS will be monitoring for unintended consequences related to these initiatives to track preventative services, access to care and detect under-utilized services and member services. The monitoring approach will be released by the end of January 2021.
- In 2021 the Quality Council will be developing recommendations on Quality Benchmarks across public and private payers with input from the Technical Team and Stakeholder Advisory Body.
- OHS Stakeholder Engagement initiatives included 9 meetings with stakeholder organizations in 2020 and in 2021 OHS seeks to focus on engagement with Black, Indigenous, and People of Color (BIPOC). Stakeholder engagement will continue in 2021 with an emphasis on engaging Black, Indigenous, and People of Color (BIPOC) communities. Briefings will also be provided to additional relevant stakeholders. OHS will also be engaging stakeholders in in examining factors that are driving healthcare costs growth. Educational briefings with community and civic organizations about the healthcare benchmark initiative and also providing briefings to legislators, MAPOC, providers, payers, hospitals, employers and more
- Olga Armah posed the question to the CAC: What is driving up healthcare costs and making healthcare unaffordable for Connecticut residents? Members can email additional thoughts and comments to OHS@ct.gov.
- Velandy Manohar asked: Does the Quality Benchmarks measure and monitor the efficacy in identifying and addressing the unique social determinants of health factors that impact the outcomes, satisfaction and per capita costs across the age groups and zip codes.
- Margaret Trinity responded that this was a topic of great interest to the Technical team and OHS. There are intentions to look at the benchmark's impact on low-income and BIPOC communities and OHS is interested in pursuing that line of analysis.
- Velandy Manohar asked that with the pandemic impacting healthcare costs, is the 2021 benchmark realistic and expenses and if the rate outline would be able to be sustained?
- Margaret Trinity shared that this was a point of conversation among the Technical Team and they anticipated that 2021 and 2020 would be impacted by the pandemic. The baseline analysis would be used by 2018 and 2019 to calculate trends pre-pandemic.
- Velandy Manohar asked if constraints being placed due to the benchmarks given the additional costs and burdens related to COVID-19, impact providers?
- Olga Armah reminded that the benchmark is assessed on a population of providers in an entire system versus individual or even a hospital. The average is being assessed.
- Terry Nowakowski understands the drive to increase primary care. She asked: how is network adequacy going to be maintained? Given the trends towards specialization, will primary care network adequacy be studied, particularly among vulnerable communities?
- Olga Armah described that retrospective analysis will be done among those not meeting the benchmark to demonstrate gaps which would include issues such as network adequacy.
- Bob Krzys posed an example: if there is a provider running a primary care practice in Hartford county and they are spending a set amount on his patients. The provider wants to address SDOH

DRAFT

and intends to hire 30 CHWs. Where will the provider get the money to implement this to meeting the 10% primary care spend.

- Olga Armah mentioned that this spend is looking at an advanced network level, not a 1-person practice. There is a threshold for the population being assessed. OHS is looking at the bigger networks. Secondly, OHS is looking at the payer level, and looking at the population that the payers are serving and if they are hitting that target. Payment increases or coordinated care or additional funds for coordinated care may be recommendations as these are often where barriers exist. If a small provider has a population below the threshold that is being considered.
- Margaret Trinity noted that primary care practices will likely benefit from the implementation of primary care spend target to create a rebalancing effect towards the investment in primary care. Payers have discretion as to how they will reach their primary care spending. It is unlikely to all translate to higher fees for a primary care practice.
- Margaret Trinity posed the question again to the CAC: What is driving up healthcare costs and making healthcare unaffordable for Connecticut residents?
- Ann Smith responded to the question of what is driving healthcare costs noting that this is endemic to the system given fractured processes and inefficiencies making it hard to be responsive to patient needs. Additional competitive factors also inflate prices far beyond what is needed.
- Terry Nowakowski added that there are many providers, hospitals and specialist. Sometimes more is not better, which is why she was asking about primary care and access as this can increase quality and reduce care. Some people are not getting the right care at the right time.
- Velandy Manohar mentioned several factors driving costs: integrated care that addresses co-morbid psychiatric and behavioral health care or substance use at primary care visit. Not enough school-based clinics given that 10% of school system have school-based health clinics, having more widespread comprehensive school-based medicine would help to address youth and family health. The wide disparities in co-pays for prescriptions are a significant barrier to having patients take and stay on their medicine leading to greater and preventable expenses down the line. Lastly, more use of CHWs and minimizing patients need of going into an office visit or long-term care.
- Ormand Clarke added that the lack of initial access to treatments like counselling which if provided in an earlier stage could leads to decreased costs later.
- Ann Smith mentioned that the hyper specialization of our healthcare system is one reason for increased cost. Greater integration of health system can increase outcomes and reduce costs.
- Taylor Edelmann mentioned that the aging population and the increase in chronic diseases is one reason. Also, unnecessary ED visits when an office visit would be better suited is contributing to costs. An often not discussed driver is health care administration and the administrative costs embedded within the systems. Increase and overuse of technology (e.g. MRIs) is also driving costs. Lastly, high prescription drug costs. It is not one single factor.
- SB Chatterjee added that digital medicine and technological equipment and the health equity implications related to access. There is not good governance. He referenced an example of algorithmic bias based on race, which was found and published in Health Affairs.

DRAFT

	• Alan Coker stated that COVID-19 has compounded the healthcare costs because people are avoiding health services, or may have greater barriers to accessing to appropriate care and he finds it hard to see beyond the current situation to improvement. • Velandy Manohar mentioned hidden billing and there is a real fear about getting health care due to the possibility of medical debt. 66.5% of bankruptcy were connected to high-cost of medical cares and loss of work. • Terry Gerratana asked what is the timeline for this work and what can the Council do to support this. • Margaret Trinity and Olga Armah thanked the CAC for having them and mentioned that the benchmark team would like to come back on a quarterly basis to the CAC meeting to provide updates and solicit feedback. The primary care workgroup is ongoing.	
5.	Committee Reports - Consumer Engagement and Outreach Standing Committee	Velandy Manohar, Taylor Edelmann, Dashni Sathasivam
	• Velandy Manohar mentioned that the LGBTQ youth health equity panel is the current focus and there will be planning for another focus after the LGBTQ event. • Taylor Edelmann provided an updated on the event. One panelist has dropped out and he is in the process of trying to find another provider. The panelists will receive a stipend for participating. • Terry Gerratana noted that the draft flyer being shared has not been finalized and thanked Taylor Edelmann for his work on putting that together. • Dashni Sathasivam provided a summary of the phone call that she and Terry Gerratana had with Steven Hernandez the Executive Director of the Commission on Women, Children, Seniors, Equity & Opportunity • The LGBTQ+ Network is under the Commission. They will share it among their listservs and social media • Terry Gerratana clarified that this will be a Facebook Live event and is effectively a zoom webinar that will be broadcasted on the Commission's Facebook page. The team is working on figuring out a way to capture data on participants. Steven will also alert CTN and they can choose to broadcast. Also the recording can be embedded onto the OHS website. The flyer should be confirmed in the next 5 – 7 days and asked the CAC to share these materials once they are finalized. • Taylor Edelmann asked if there would be a Facebook Event created for this event. • Dashni Sathasivam said that she would follow up with The Commission to discuss this • Terry Nowakowski agreed that she will this out to her networks at the partnership. This is also a good dove-tail given that this is human-trafficking month. • Terry Nowakowski asked how will people interested in continuing the conversation be able to continue the dialogue. Taylor Edelmann mentioned that sustainability and continuing the conversation was a concern and priority of his and he asked Steven Hernández if there could be a sub-committee focused on LGBTQ youth and he was in favor of this idea. That will likely be a recommendation in the report. Also, Taylor asked him if they would be surveying LGBTQ youth in addition to the current survey on LGBTQ adults because it is challenging to serve a community if you do not know where they are.	

DRAFT

	• Terry Nowakowski also hopes that this will bring more attention to minors and hopes to get people at the table voicing these issues and concerns. • Dashni Sathasivam urged CAC members to not only attend but to participate by placing questions in the chat during the event. • Terry Nowakowski asked if there was anyone else who wanted to make a comment. • Daniel Ogbonna agreed in Alan Coke's comment about the benchmark initiative and about how the system needs reform but is not doing enough to address the rising costs. On the other hand, Taylor Edelmann's point that there are instances where the system is doing too much related to technology and ordering diagnostic tests unnecessarily and there is room for improvement and highlighted this interesting duality. • SB Chatterjee added that while apps and technologies are decreasing in cost in other areas, they are not in the health care field. • Velandy Manohar stated that he and others on the group are willing and available to have conversations about. • Terry Nowakowski seconded this statement.	
6.	OHS Listening Sessions;	Terry Gerratana and Dashni Sathasivam
	• Terry Gerratana provided a brief introduction and the HIE Consent project and asked the CAC if members would consider volunteering to be community co-hosts or helping to connect OHS to communities and organizations and talk to and recruit participants. HES will handle all of the logistics and scheduling. • Dashni Sathasivam reminded the CAC that they were the first group receiving the introductory HIE Consent presentation and feedback. She shared the various objectives of the HIE Consent consumer feedback initiative. This is an ongoing engagement that will consist of 3 – 4 sessions across 2021 that will last 1.5 – 2 hours long engaging 10-12 people in a group with a continuity of feedback with ideally the same group of people. She reiterated asking the CAC to consider being a community co-host. Community participants will receive $25 per session in appreciation for their time. Dashni mentioned that either a community co-host could either identify individuals to participate and send her the names or they could send out a message and ask interested members to email Dashni and she can coordinate with them. • Terry Gerratana asked if there were materials that could be provided to community co-hosts. • Dashni Sathasivam mentioned that there is email text and a flyer that is ready and can be tailored or edited to a specific group. • Velandy Manohar asked for materials that he could share. • Ormand Clarke asked if participants were restricted to Connecticut residents. • Terry Gerratana clarified that ideal participants would be people that work here and get their health care in Connecticut or basically connected to Connecticut health care. • Laura Morris agreed that participants would be limited to those who have a policy or receive care in Connecticut. • Ormand Clarke asked if there were other eligibility criteria for participants? • Dashni responded that beyond what Laura Morris has mentioned, the criteria are open. Community members will only be able to participate in one series of sessions.	

DRAFT

	• Ormande Clarke asked if mentally disabled communities would be engaged. • Dashni Sathasivam shared the list of groups that are looking to reach. • Ann Smith volunteered and asked the Dashni and Terry follow up to have more conversations. • Alan Coker also asked for information and will try to engage with the American School for the Deaf. • Terry Gerratana emphasized that this engagement focused on community members with lived experienced as opposed to a group of advocates. • Sone Phrommavanh also volunteered to identify key people in the South East Asian community, CHWs and substance use. • Taylor Edelmann said he could help with LGBTQ and HIV communities. • Dashni Sathasivam stated that not all groups are captured in the list as it is not exhaustive and asked CAC members to please let them know if there is a community they would like to be engaged or affiliated with or belong to that goes beyond this list. • Ann Smith asked that there is a mapping of where there is representation and where there isn't to actively pursue where there may be gaps and help bridge areas that are not covered. • Terry Nowakowski asked about the platform because she would like this to get to the shelter population. • Ann Smith agreed because there is a need to safeguard populations and how to get feedback from groups where virtual participation is not possible either for safety or bandwidth concerns. • Terry Gerratana mentioned that she and Dashni would follow up in the next week and provide more information to answer some of the questions posed. • Jeff Beadle also stated that he is in various organizations that would blend well with the listening sessions.	
7.	New Business/Announcements	Terry Nowakowski
	• There were no new business or announcements discussed.	
8.	Adjournment	
	Terry Nowakowski moved to adjourn the meeting. Velandy Manohar seconded. Motion carried. The meeting adjourned at 5:00 PM.	

DRAFT