STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
September 25, 2018

Meeting Location: This was a Webinar/Conference Call

Members Present: Maria Dwyer; Shirley Girouard; Susan Adams; Randy Trowbridge; Elsa Stone; Douglas Olson; Leigh Dubnicka; Grace Damio

Members Absent: M. Alex Geertsma; Garrett Fecteau; Anita Soutier; Anne Klee; Lesley Bennett; Heather Gates; Alta Lash; Mark Vanacore; Eileen Smith; Jesse White-Frese; Kate McEvoy; Rowena Rosenblum-Bergmans; H. Andrew Selinger

Other Participants: Mary Jo Condon; Linda Green; Alyssa Harrington; Pano Yeracaris; Judy Levy; Mark Schaefer; Ellen Bloom; Velandy Manohar; Susan Kelley; Lisa Honigfeld; Stephanie Burnham

1. Call to Order
The meeting was called to order at 6:01 p.m. by Ms. Elsa Stone.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Motion: to approve the September 4th meeting summary of the Practice Transformation Taskforce – seconded
***Discussion*:** There was no discussion.
Vote: All in favor.

4. House Rules Refresh
Ms. Stone reviewed the house rules with members.

5. Purpose of Today's Meeting

Ms. Alyssa Harrington of Freedman HealthCare reviewed the purpose of the meeting, which was to provide updates on consumer and stakeholder engagement, design groups, the Payment Reform Council, and review the adult behavioral health integration design group recommendations. Ms. Harrington noted that the Payment Reform Council has begun meeting and discussed the Council's role and purpose. Ms. Shirley Girouard asked who the members of the Council were. The selection process and members were reviewed and Ms. Harrington noted they would follow up with the member listing. The Payment Reform Council began meeting on September 20th. During their next meeting, they will discuss the options that the Task Force recommended in the June report.

6. Consumer Engagement Strategies

Ms. Harrington highlighted activities over the last few months and those that are upcoming as well, including engaging consumer advocates through small and individual meetings, participating in

design groups, three public forums, discussions with specific consumer groups such as parents, persons with disabilities, and older adults, and planning for upcoming meetings with housing authority residents and employees. Ms. Harrington acknowledged that the Consumer Advisory Board (CAB) worked hard to get consumer representation in all design groups, and that some consumers had expressed they felt meaningfully engaged in the groups. The team continues to use feedback from the CAB listening sessions over the past couple of years in the skeletons and design group discussions and will add input from PCM consumer engagement efforts. Ms. Harrington explained they were also planning SIM News series on consumer engagement. Ms. Harrington provided some highlights from the consumer discussions that already took place over consumer discussions to date (available in the meeting materials).

7. Design Group Updates and Process

Ms. Harrington discussed efforts to improve the design group process to provide more time for material development, sending materials to participants in advance, and design group input and review. The new process also establishes a feedback loop from the Task Force back to design groups after the Task Force makes recommendations.

8. Primary Care Modernization Capabilities

Ms. Harrington gave an update on progress of the design groups and capabilities left for the Task Force to review, explaining that several design groups are still meeting (or will meet in the next few weeks). These include diverse care teams, pain management and MAT, older adults, persons with disabilities, pediatrics, and community integration. Pediatric behavioral health integration will be reviewed by the pediatrics group prior to the Task Force.

Dr. Randy Trowbridge noted that the Task Force had discussed functional medicine in a previous meeting but that it needed to be given due diligence and further investigation. Two members of the Task Force had thought it should be a core elective, two had thought it should be elective, and two thought it should not be included, which does not seem to be inclusive. Ms. Harrington noted that the Task Force had asked Freedman HealthCare to speak to experts in the State about integrative medicine examples and confirmed the team would discuss this topic again with the Task Force. Ms. Girouard believed it would be helpful to have a dialogue about this and asked to call it integrative healthcare rather than integrative medicine. Dr. Trowbridge acknowledged that this was an excellent point, pointing out that the difference in the functional medicine movement is that its already structured and mirrors the model of what we are trying to do in Connecticut. Ms. Stone stated that there will be another discussion regarding this after Freedman HealthCare speaks to some experts on integrative healthcare.

9. Adult Behavioral Health Design Group Recommendations

Ms. Harrington discussed consumer input, needs, and concerns of the adult behavioral health integration capability (as provided on the meeting materials). Ms. Girouard asked if the term was behavioral health and not behavioral medicine, which was confirmed. Ms. Harrington shared that a design group had met to discuss this capability. Ms. Harrington noted that the overall recommendation from the design group was to support full integration of dedicated behavioral health clinicians and care coordinators with behavioral health expertise into primary care.

Ms. Harrington then showed a draft diagram of the concept map for behavioral health integration and highlighted a few key points summarizing key elements of the capability and explained that the

model does not intend for primary care to treat serious behavioral health concerns that need to be handled by specialists. Ms. Harrington then went over specific elements of the capability that should be provided by the practice versus the network, as well as what infrastructure would be needed for the practice versus the network. Ms. Harrington reviewed the considerations for the Payment Reform Council, which included a supplemental bundle accounting for illness burden, severity, and social determinants of health needs to encourage practices to work with those with more serious behavioral health concerns.

Ms. Maria Dwyer asked to clarify if these recommendations were in reference to all behavioral health clinicians or if it was only Medicaid. She asked if there was still a concern with access to behavioral health given the new CT Insurance Department (CID) regulations around behavioral health network adequacy. Ms. Stone added that access is inadequate in the commercial field. Dr. Mark Schaefer explained that in a statewide survey conducted by Yale and UConn, 47% of ACOs indicated that behavioral health referrals were challenging or very challenging. Dr. Schaefer added that the department of insurance conducted another survey, and that he can find out those results.

Ms. Harrington noted that one of the Task Force members who could not join had expressed concern that behavioral health specialists were not reimbursed adequately, and this needed to be addressed to ensure the behavioral health system could adequately coordinate with primary care and handle referrals. Ms. Stone asked if there was sufficient workforce to accomplish this, to which Dr. Schaefer replied that Connecticut has one of the highest per capita availability of behavioral health professionals (although many practice independently or are out-of-network). Dr. Schaefer added that if the Task Force believed behavioral health should be integrated into primary care, then there would need to be workforce development and trainings in primary care for graduating clinicians. A design group member added that many of his colleagues are now independent, so perhaps there can be efforts can help bring some of these people back to practices.

It was discussed that several Task Force members had expressed concern with requiring a behavioral health clinician to be on-site prior to the meeting, as this was unrealistic. The team clarified that an on-site behavioral health clinician at every practice was not being proposed. The behavioral health clinician was intended to be a dedicated resource that could support a panel of patients in multiple practices and be available through telemedicine visits instead. He suggested that for the larger ACOs, there be some thought to the ratio of behavioral health support to the number of patients attributed to a practice (or by disease burden) for not doing so could promote a degree of underservice. Mr. Douglas Olsen shared some of the same concerns and noted having a resource available through telemedicine seemed to make sense. He suggested that for the larger ACOs, there be some thought to the ratio of behavioral health support to the number of patients attributed to a practice (or by disease burden), otherwise there may be a risk of underservice. Providers would also have access to telephone or eConsults with a behavioral health specialist. Ms. Girouard confirmed that the Task Force was not voting on the concept map, to which Ms. Harrington replied that the concept map is just to show the approach to behavioral health integration and helps define the capability. Dr. Schaefer replied that the Task Force will be asked to vote on this illustration of the capability when the time comes. Ms. Stone added that all practices should strive to have an on-site behavioral health clinician, to which a member of the design group agreed.

A member of the design group stated that it was her understanding there would be a payment incentive provided to ensure that there would be an on-site behavioral health specialist integrated

into practices overtime, however, she did not see an incentive or a timeline. Currently, it is very difficult for consumers to pay for providers, and incentives would help alleviate this problem. Additionally, the design group member noted that there are many out-of-network psychiatrists which restricts access. Dr. Schaefer replied that it will take time to build the capacity, do the hiring and reengineer workflows. There will be phases, Dr. Schaefer continued, to the design and the first phase will focus on what we want to achieve, while the second phase will focus on the timeline.

Ms. Girouard stated that the other capabilities the Task Force has reviewed have been more specific, to which Dr. Schaefer replied that may be true and referenced what Mr. Doug Olsen spoke of earlier regarding provider to patient ratios. He noted that Advanced Networks have expressed the need for flexibility in determining staffing ratios. Dr. Schaefer expressed uncertainty of where the Task Force should land regarding this issue of specificity. The team will look at the specificity of other capabilities and where additional definition was needed.

The Task Force was then asked if they support the provided recommendations, to which Ms. Stone replied that she believed they were well thought-out, but that this effort must be bidirectional and must implement a change on the behavioral health side as well. Dr. Doug Olson echoed Ms. Stone's comment, and believes the recommendations provided a nice framework to move the ideas in the right direction. Mr. Olsen then confirmed he supported the recommendations put forth. Ms. Girouard, however, stated that she could not support the recommendations for she believed they were not consistent in terms of specificity (in comparison to previous set-forth capability recommendations). It was asked what level of specificity Ms. Girouard would like to see, to which Ms. Girouard replied that these recommendations should be consistent with the others that have been put forth, especially around what would be included in the bundle.

Ms. Grace Damio stated that she believed the recommendations were well thought-out and looks forward to the fine tuning of them. Ms. Stone then asked the group if it would be fair to say the Task Force supports the concepts put forth, to which Dr. Trowbridge stated that he believed this was an excellent model of the direction we need to be heading in. However, he added that it is lacking in detail, but does believe it is a critical part of primary care; we simply need to define and specify as we move along. Ms. Dwyer agreed, but expressed concern over the new CID requirements. Dr. Schaefer noted that full behavioral health integration has benefits beyond increasing access, and that the team would try to highlight these. A design group member supported this.

Dr. Schaefer stated the group will consider all of this and believed there was enough support to have this move forwards as a capability. Ms. Girouard reiterated while she agreed with the concept, she did not believe the group was ready to move forward with the capability. Ms. Harrington noted the team would circle back to Ms. Girouard to discuss what was needed in terms of specificity.

11. Next steps

There is a Practice Transformation Taskforce meeting scheduled for October 9th and 30th. There are ongoing design group meetings in October, and the Payment Reform Council will continue to meet.

12. Adjourn

Motion: to adjourn the meeting-seconded

The meeting adjourned at 7:15pm.