

**STATE OF CONNECTICUT**  
**State Innovation Model**  
*Practice Transformation Taskforce*

**Meeting Summary**  
**Tuesday, October 30, 2018**  
**6:00pm – 8:00 p.m.**

**Meeting Location:** CTBHP, 500 Enterprise Drive, Suite 3D, Hartford Room, Rocky Hill

**Members Present:** Shirley Girouard; Randy Trowbridge; Elsa Stone; Douglas Olson; H. Andrew Selinger; Kate McEvoy; Anita Soutier; Lesley Bennett; Leigh Dubnicka; Rowena Rosenblum-Bergmans; Grace Damio; Anne Klee; Daniel Lawrence

**Members Absent:** M. Alex Geertsma; Heather Gates; Alta Lash; Mark Vanacore; Jesse White-Frese; Maria Dwyer; Susan Adams

**Other Participants:** Linda Green; Alyssa Harrington; Ellen Bloom; Lisa Honigfeld; Stephanie Burnham; Arlene Murphy; Mark Schaefer; Ken Lalime; Gail Sillman; Jenna Lupi; Eve Berry; Marie Smith; Mary Jo Condon; Terry Nowakowski

**1. Call to Order**

The meeting was called to order by Lesley Bennett at 6:05pm.

**2. Public Comment**

There was no public comment.

**3. Review and Approval of Meeting Summary**

*Grace Damio gave a motion to approve the October 9<sup>th</sup> meeting summary of the Practice Transformation Taskforce.*

*Elsa Stone seconded the motion.*

**Discussion:** Ms. Lesley Bennett asked the Taskforce if they remembered who seconded the motion to approve the minutes from the September 25<sup>th</sup> meeting. Members could not recall and moved to vote.

**Vote:** *All in favor.*

**4. House Rules Refresh**

**5. Purpose of Today's Meeting**

Ms. Alyssa Harrington reviewed the purpose of the Task Force meeting, which was to review the Community Integration and Diverse Care Teams capabilities based on design

group recommendations, and review Payment Reform Council provisional recommendations to date.

## **6. Review of Diverse Care Teams Capability**

Ms. Harrington reviewed the Diverse Care Team's consumer input, questions, and concerns, including that a consumer had suggested having patient experience surveys following visits. Ms. Shirley Girouard asked if NCQA and CAHPS surveys were enough to capture patient experience. Ms. McEvoy asked whether CAPHS would be a payer obligation (it is distributed for Medicaid) or whether practices would distribute the surveys. Ms. Rosenblum-Bergmans explained that hospitals and medical groups are sending out CAHPS surveys, as payers are asking this be captured in quality metrics. Ms. Harrington clarified that this was a consumer suggestion from the design groups. Dr. Mark Schaefer noted the importance of measuring care experience, a comment voiced by consumers, and the importance of avoiding duplication of existing efforts.

Ms. Harrington reviewed Diverse Care Teams capability requirements. Ms. Kate McEvoy asked whether practices could partner with federated organization to provide staffing for care team functions. She noted that Medicaid PCMH+ allows this. She suggested the capability state whether this is part of the range of options explicitly. Dr. Schaefer asked Ms. McEvoy if she had a recommendation as to whether this effort should specifically enable creation of a care team through a range of contracted or employed members. Ms. McEvoy replied that this effort should give organizations as much latitude as possible to reduce constraints around availability of workforce. Ms. Girouard added that it's important to allow people to work on the ground, closest to where the care is being delivered.

Ms. Harrington reviewed recommendations for consumer protections, which included the need to protect against underservice and the recommendation of care team members to support functions that enabled them to practice at the top of their license, but not extend beyond what they are trained or qualified to do to (to protect against patient underservice). Dr. Andrew Selinger suggested saying to avoid "adverse events" rather than "underservice". Ms. McEvoy stated that "underservice" has historically been used and that this comment encompasses more areas this effort hopes to safeguard. The group agreed both terms could be included.

Ms. Harrington noted PCM aimed to provide guidance on the essential functions of the care team and which credentialed roles have qualifications and skills to fulfill these functions, while still providing flexibility to ANs/FQHCs. Ms. Girouard noted she was happy to see the patient at the center of this map but did not see the family clearly represented. Dr. Doug Olson suggested changing "medical interpreter" to "medical interpretation" to encompass new technologies.

The Task Force moved discussed the role of the pharmacist versus the physician. Ms. Marie Smith explained collaborative practice agreements between pharmacists and physicians. In Connecticut, it has to be a formal written agreement in which the physician and pharmacist

agree on pharmacist functions collaboratively. Pharmacists must be certified and are usually PharmDs. Dr. Andrew Selinger noted the relationships and certifications differ from group to group, and that it's important to have that expertise available.

Ms. Harrington asked the Task Force whether care management and care coordination should be separate functions. Ms. Gail Sillman noted that care managers often have a higher level of experience and certification than care coordinators, such as in the Michigan PCMH model. Ms. Harrington clarified that the recommendation was that a care coordinator would be a nurse or social worker. Ms. Rosenblum-Bergmans noted if you're doing a comprehensive assessment of a patient, and if they have comprehensive needs that need a care manager, that care would fall under one bucket. She was unsure if there was a need to distinguish the two. Dr. Olson added that the definition of care coordination varies greatly and doesn't allow include comprehensive or chronic care management. Other care team members than nurses may be more qualified to make connections to the community, in which case there should be a warm hand-off between care team members. Ms. Grace Damio noted that care coordination can be done by a number of people. For example, CHWs reinforce capacity from someone of a higher clinical level. Ms. Bennett stated this effort needs to decide who the primary care coordinator is. Ms. Girouard specified the Task Force should be discussing the functions it wants to achieve, rather than titles. The group agreed that care coordination and care management should be separate functions.

Ms. Sillman highlighted that overtime, these diverse care team activities may become more distinct, and that if they're kept separate, it may allow for the evolution that is occurring simultaneously in the field. Ms. Girouard noted that the role of the family and informal caregiver is missing and, in some programs, these individuals are paid for fulfilling this function. Ms. Bennett agreed but noted that this sometimes puts too much burden on the family, and they need support from the practice care team. Dr. Randy Trowbridge noted the importance of highlighting the role of the PCP in these functions, as well as the individual responsibility of the patient and family. The group agreed to adding a statement reflecting the role of the individual and family.

Ms. Shirley Girouard requested to remove disease management as a function, emphasizing that this effort should focus on helping patients manage their lives, not their disease. Dr. Schaefer suggested changing this to health promotion and chronic illness self-management (i.e. lifestyle and behavior). The Task Force agreed to change this and to add that programs should address social determinants of health and other barriers. The group also discussed including that the care team works closely with the family and patient when available for this function. Ms. Harrington clarified that patient navigation is not a clinical function, it's aim is to identify and address barriers to patient care (i.e. navigation of insurance, etc.).

An attendee suggested adding to behavioral health integration recovery coaches and peer mentors. Dr. Schaefer asked whether a CHW could encompass those kinds of roles through. Ms. Jenna Lupi noted that the CHW Advisory Committee had considered this but the role was relatively new. She added that as proposed by the committee, CHW certification is voluntary, explaining that this effort wouldn't want to make certified individuals who are recovery coaches pursue a second certification. Ms. Damio explained that CHWs can fulfill these roles and may be specialized in certain areas based on their work and lived experience. No CHW fulfills every function. Ms. Girouard noted that a CHW is usually different from a lay person. Ms. Lupi added that the term CHW has so many different meanings. Defining the term CHW for Connecticut could encompass these different goals and the function could be reimbursed sustainably. Ms. Damio noted that as CHWs become more specialized, they need to have some experience with that specific health topic. Dr. Schaefer agreed, stating there needs to be some flexibility to innovate, but also accountability to demonstrate the requirement is being met. The group agreed to adding a statement to specify that CHWs may have more specialized roles such as a recovery coach.

Ms. Harrington shared comments from Task Force member Heather Gates, who was unable to attend the meeting. For behavioral health integration, there are other services that primary care can refer to if someone needs more than what is provided in the office setting. Primary care practices may partner/link patients to free standing behavioral health providers, which provide a wide range of community-based services such as outpatient, Assertive Community Treatment Teams, crisis intervention, Community Support Teams, evidenced based In-home teams for children, families and adults, and case management services. Ms. Harrington suggested including these services in the concept map "Health Neighborhood" section and adding this to the behavioral integration function.

The Task Force generally supported the Diverse Care Teams capability as a core capability.

## **7. Review of Community Integration Capability**

Ms. Harrington reviewed the Community Integration consumer input, questions and concerns. Ms. Rosenblum-Bergmans asked if the expectation would be for practices to conduct a gap analysis. Ms. Harrington clarified the purpose was to understand the community's needs, not just those patients attributed to the practice. Dr. Schaefer clarified the provided materials are not rules, but a list of what was heard from consumers. Dr. Andrew Selinger noted he hoped there wouldn't be too much reluctance from health systems to partner with community-based organizations to provide services they may otherwise bill for. Ms. Girouard emphasized that this capability should be focused on collaborations with the community, rather than contracts. Dr. Schaefer noted that sometimes practices must purchase the capacity to provide these services, which is being tested now with the Prevention Services Initiative. Ms. Rosenblum-Bergmans asked whether CBOs would be held to the same performance accountability standards as the practices. Dr. Schaefer confirmed, adding that this effort has recommended the contracts

include some sort of performance accountability. Ms. Rosenblum-Bergmans suggested structuring the contracts to be responsible for outcomes as well. Ms. Rosenblum-Bergmans explained that she wants to ensure this is geared towards building the capacity for those populations who are not currently being served. She suggested it made sense to have this as an elective capability for targeted interventions.

Ms. Girouard stated that solutions should arise from the community, rather than providers. Dr. Schaefer pointed to the work of the Health Enhancement Community Initiative. Ms. Damio added that part of the contracting structure was to support community-based organizations to continue social justice work. Ms. Girouard suggested that the relationship might be reversed, in which community organizations partner with the networks. The group generally supported this as an elective capability, with one member who disagreed.

### **8. Next Steps**

The next Task Force meetings will be on November 13<sup>th</sup> and November 27<sup>th</sup>. Dr. Schaefer noted that the Payment Reform Council is determining the cost to implement these capabilities.

### **9. Adjourn**

***Dr. Selinger made a motion to adjourn the meeting.***

***Motion to adjourn the meeting-seconded by Ms. Damio.***

Ms. Bennett adjourned the meeting at 8:00pm.