STATE OF CONNECTICUT State Innovation Model
Practice Transformation Taskforce
Meeting Summary
Tuesday, November 13, 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, H. Andrew Selinger, Susan Adams, Lesley Bennett, Maria Dwyer, Leigh Dubnicka, Heather Gates, Mark Vanacore, Anne Klee, Daniel Lawrence

Members Absent: Douglas Olson, M. Alex Geertsma, Alta Lash, Rowena Rosenblum-Bergmans, Anita Soutier, Edmund Kim, Kate McEvoy, Grace Damio

Other Participants: Ken Lalime, Alyssa Harrington, Mark Schaefer, Linda Green, Stephanie Burnham, Tom Agresta, Ellen Bloom, Eve Berry

1. Call to Order
The meeting was called to order by Ms. Lesley Bennett at 6:00pm.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Ms. Susan Adams gave a motion to approve the October 30th meeting summary of the Practice Transformation Taskforce.
Dr. Andrew Selinger seconded the motion.
Discussion: There was no discussion.
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 Older Adults with Complex Needs capability s, revisit Oral Health integration, and provide an update on the genomic screening capability.

6. Review of Older Adults with Complex Needs

Ms. Harrington reviewed feedback from older adult consumers from the design group, AARP, and the CT Alliance for Retired Americans. Ms. Harrington then reviewed the Older Adults with Complex Needs capability definition, goals, concept map and capability requirements. A member asked if primary care practices specialized in geriatrics already exist, to which it was confirmed that there are not many and their capacity is often limited.

Ms. Shirley Girouard noted she is an advocate for the capabilities but expressed concern with how all of these capabilities would be supported financially. Dr. Schaefer noted that there today there aren't many practices fully supported by a bundled payment with flexibility to serve older adult patients with complex needs.

Ms. Harrington reviewed the key capability requirements for a subset of practices specializing in geriatrics for older adults with complex needs. Susan Adams explained that many of the listed services are provided for patients through visiting nurses and home-care companies. Therefore, palliative care must fall under home-health and not hospice care. It was encouraged that this effort not reinvent the wheel but allow for services to be provided by both home care agencies and primary care practices. There needs to be coordination between primary care teams, and social workers and home health aides.

Dr. Schaefer asked if this effort should expand use of hospice services and advanced care planning. Task Force members discussed that education of practitioners and patients around palliative care and end of life decisions is key. Dr. Schaefer asked if this effort should establish a core expectation around readiness since it's not clear what should be expected of practices in advanced care planning. Ms. Lesley Bennett replied that there is currently little palliative care in Connecticut.

Dr. Selinger pointed out that currently advanced care planning is paid for with billing codes. Dr. Schaefer added that this could potentially be supported in the basic bundle and could be a condition of participation. A member stated that having an adoptable initiative is the first step, to which Ms. Harrington pointed out that Rhode Island is doing an advanced directive training program. Dr. Elsa Stone explained that it would help if EMRs had a prominent place to document this. Dr. Selinger confirmed an APRN could code for advanced care planning. Dr. Schaefer explained there was the HIT Advisory Council had recommended building an advanced directive registry by 2021. Networks could link to this registry for monitoring advanced directives. Ms. Harrington enquired if this would be all practices or just the subset specializing in geriatrics, to which Dr. Schaefer confirmed it would be all practices. Ms. Adams replied practices could report on what percentage of their population has an advanced directive now and establish improvement on this as a condition of participation. Tom Agresta from the HIT Advisory Council added that it might be possible to include this as a quality metrics in the eCQM and would investigate the feasibility of this.

Ms. Harrington reviewed the implementation recommendations from the design group, including considering providing a financial incentive for providers who avoid nursing home placement for Medicare beneficiaries. Dr. Stone asked if this could ever create a perverse incentive of not admitting patients to nursing homes when it was not the best for the patient to stay in the home. Dr. Schaefer noted that one could make the argument that the incentive to manage total cost of care has the potential to result in an underservice, however, in most cases patients prefer to age in place. The idea is that there is an incentive for the care team to maximize their abilities to care for these patients. He noted that a

financial incentive may be hard to implement especially for a multi-payer demonstration that requires a cross federal program arrangement. Dr. Schaefer asked the group if they want to lead with these recommendations. The group discussed modifying the language to "Consider providing a financial incentive for providers who support avoidable nursing home placement, as they do today for hospital and Emergency Department services for Medicare beneficiaries and for whom there are associated cost savings".

The Task Force generally supported care for older adults with complex needs as a core capability. Ms. Girouard noted she continues to struggle with how this will be paid for.

7. Review of Oral Health Integration

Ms. Harrington reminded the group that the Task Force had previously reviewed oral health integration and supported the concept but had questions about the feasibility of implementation. The Task Force discussed the challenges with implementing this in a commercial population in which dental services are not covered under medical insurance. Many FQHCs have integrated oral health but they serve a predominately Medicaid population in which dental services are covered. Ms. Harrington reviewed the feedback from CCIP entities who had chosen not to pursue the oral health integration standard, citing challenges with insurance and measuring oral health services.

Ms. Girouard stated that this is complicated due to the separation of the insurance and difficult for practices to be able to implement. Ms. Maria Dwyer agreed, stating that she too believed this was necessary but difficult to implemented. It was suggested that the Oral Health capability be an elective, at least initially. Dr. Selinger noted he believed it should be a basic screening. The group discussed focusing oral health integration on exams and screenings only and not treatment but that this may add too many screening requirements for practices.

The Task Force generally supported oral health integration as an elective capability for adults. The pediatrics design group will discuss oral health integration for children.

8. Update on Genomic Screening

Dr. Schaefer updated the Task Force on the Genomic Screening capability, stating that Dr. Murray had met with the Department of Public Health. They believe it is a problem that roughly 80% of people with one of the three conditions are currently unaware of it and were impressed with the value this screening may provide. Dr. Murray is discussing financing this with the NIH and CDC.

Dr. Schaefer also noted that Dr. Murray is now proposing a less expensive screening panel for about $170 a person. It was recommended to add in the pharmacogenomic screening strategy for two drugs: breast cancer risk reduction and post stent operation. Dr. Schaefer explained that Dr. Murray and others were skeptical of the clinical utility for psychiatric conditions. Lesley Bennett asked how many genes were covered in the panel. Dr. Schaefer responded that he wasn't sure. Task Force members discussed whether genomic screening

should be prioritized over other capabilities that may be more effective. Ms. Girouard responded that she remained opposed to including genomic screening in the payment mechanism because there is still a significant amount of research that needs to be done. Dr. Schaefer added that in terms of health equity, this could provide a lot of useful information since Connecticut has a demography that mirrors the nation from a coverage perspective. Ms. Girouard noted that a more effective use of funding to improve health equity would be training to improve women's health and perinatal outcomes and mortality for black women and addressing sociological barriers to health care. She noted there is little evidence available on the efficiency of these genomic screenings and not enough for evidence-based practice. Dr. Trowbridge agreed with Ms. Girouard and explained how he thought genomic screening was a great idea but may not be the best use of funding right now. Genomic screening should be studied further, but there are other nonpharmacological tests that are more cost-effective. Dr. Schaefer noted this would aim to identify treatable conditions sooner for populations at higher risk. Dr. Selinger asked if there was more evidence on the cost effectiveness the of the screenings. The Task Force expressed there needed to be more research in this area before re-considering this capability.

9. Next Steps

Ms. Harrington noted that the next Task Force meeting would be November 27th and gave an update on forming an integrative medicine design group. Ms. Girouard asked to discuss SIM funding ending. Dr. Schaefer noted that SIM funding would continue to support this design phase. Ms. Girouard also suggested discussing the transition in administration. The group can discuss these items after the new year.

10. Adjourn

Susan Adams made a motion to adjourn the meeting. Anne Klee seconding the motion.

The meeting adjourned at 7:30pm.