STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
January 8, 2019
6:00 – 8:00 p.m.

Meeting Location: This was a Webinar/Conference Call

Members Present: Supriyo Chatterjee; Maria Dwyer; H. Andrew Selinger; Elsa Stone; Grace Damio; Juan David Ospina; Lesley Bennett; Douglas Olson; Jesse White-Frese; Randy Trowbridge; Mark Vanacore; Rowena Rosenblum-Bergmans; Anita Soutier; Anne Klee; Leigh Dubnicka; Shirley Girouard;

Members Absent: M. Alex Geertsma; Alta Lash; Heather Gates; Daniel Lawrence; Kate McEvoy; Susan Adams

Other Participants: Mark Schaefer; Ellen Bloom; Stephanie Burnham; Jeff Lasker; Nadine Repinecz; Karen Siegel, John Freedman

1. Call to Order
The meeting was called to order by Dr. Elsa Stone at 6:10 p.m.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Dr. Elsa Stone asked for a motion to approve the December 18th meeting summary of the Practice Transformation Task Force meeting.
Ms. Maria Dwyer made a motion to approve the minutes.
Dr. Douglas Olson seconded the motion.
***Discussion*:** Dr. Olson requested Ms. Rowena Rosenblum-Bergmans be removed from "Members Present" list since she was not at the meeting.
Vote: All in favor. None opposed.

4. House Rules Refresh

5. Purpose of Today's Meeting
Dr. Elsa Stone reviewed the purpose of the discussion, which was to review the pediatric behavioral health integration capability, follow up on pediatric universal home visits for newborns, and review and approve selected adult capabilities.

6. Pediatric Behavioral Health Integration

Dr. John Freedman reviewed the definition and goal of the pediatric behavioral health integration capability with the Task Force. Dr. Freedman then reviewed the pediatric behavioral health concept map, the corresponding care team and network requirements, and how to build said team-based care. Dr. Freedman outlined meaningful and actionable information needed for the measurement of

outcomes. Dr. Andrew Selinger stated that he completely supports this capability, and hopes this effort approaches it with the same rigor seen with the adult population. Dr. Stone added that one cannot do pediatric medicine without dealing with the behavioral health component. Dr. Douglas Olson agreed, but expressed reservations regarding the implementation plan. Ms. Shirley Girouard expressed the same concerns over operationalizing and financing. Mr. Juan David Ospina asked if the plan was to introduce this capability to Federally Qualified Health Centers (FQHCs), and if not, then which types of medical networks in Connecticut? Dr. Freedman explained that this capability would apply to all participating organizations and that both FQHCs and Advanced Networks could participate. Another Task Force member explained that there is a Health Enhancement Community initiative that covers pediatrics and that if this capability would create any overlap? Dr. Mark Schaefer explained that the pediatric behavioral health capability would help practices intervene earlier, ideally hoping to address emotional and behavioral health issues before they become problematic. Dr. Schaefer stated that he believes this intervention could prevent the emergence of more serious conditions and that it is consistent with the Health Enhancement Community strategy.

Dr. Schaefer then addressed the Task Force's concerns over operationalization and agreed that this warrants a dedicated conversation with the Task Force. Dr. Schaefer proposed the group complete the development of the portfolio of capabilities so that they can inform the payment reform work, and then look at a practical and feasible plan for operationalizing the capabilities. Dr. Schaefer does have some ideas for how to proceed with implementation, it's simply not yet on paper, and proposed February for this conversation. Dr. Freedman agreed this timeline was reasonable. Ms. Girouard expressed her concern over feasibility once more, and Dr. Schaefer offered that this is an iterative process, where the discussions over practicality and feasibility might lead the group to dial back on certain aspects of the proposed scope, as might the payment reform and public comment process. Dr. Olson expressed his support of this idea and concept once more and appreciated the recommendation to discuss the implementation process as a group. Dr. Jeff Lasker stated that after many conversations with pediatricians throughout the design group process, he knows that these additional capabilities would be very welcomed by them. These pediatricians feel constrained with their ability to deal with a lot of these issues, and from the practice point-of-view, these would be welcomed additions, Dr. Lasker explained. Dr. Stone summarized the sense of the group and offered that the Task Force supports the behavioral health integration capability. Ms. Girouard agreed that the concept resonates with other work the Task Force has done but reiterated her concern over the payment model. Dr. Stone reminded Ms. Girouard that this aspect of the process has yet to come.

7. Universal Home Visits for New Parents

Dr. Freedman reviewed a follow-up on universal home visits with the Task Force. Ms. Jesse White-Frese mentioned the minutes from the previous Task Force meeting and asked the group to comment on the other types of programs in the community that already do home visits for newborns and how this effort plans to coordinate with these programs to avoid duplication. Dr. Stone explained that this capability is more universal and is connected to the medical home. Ms. Jesse White-Frese referenced the Nurturing Families Program and agreed a program like this is less universal but enquired over the proposed coordination for this capability so that the resources can be used effectively across the system. Dr. Stone explained that this effort hopes the Centers for Medicare and Medicaid Services (CMS) will participate in this process so there would not be any redundancy. How we pay for this is always an issue, Dr. Stone continued, and the group will have to defer to the Payment Reform Council to see what they come up with. Dr. Schaefer agreed this effort will have to look at the process of all current Connecticut home visiting programs to see the means

by which families are identified, the timeframe within which families get a visit, and by whom. Every child and family need to be connected to a primary care team, Dr. Schaefer continued, and every family would get one visit. This could be a means to assess whether there is a need for a sustained home visiting intervention through Nurse Family Partnership or Nurturing Families Network, added Dr. Schaefer. That might allow those programs to focus on families who would benefit after an initial engagement meeting, risk assessment, and early guidance session. Dr. Schaefer reminded the group that this is still a hypothetical, and that if conceptually this is the right thing to be doing, the Task Force needs to circle back with those existing programs to avoid duplication and make best use of available resources. Dr. Schaefer added that if this capability does successfully reduce risk for children, quantifying and monetizing the economic value it produces could be a part of the Health Enhancement Community initiative. Ms. Lesley Bennett agreed that universal home visits is a great idea, but is concerned about paying for it and asked if the Task Force should be thinking about another grant for it? Dr. Olson stated that he would like to look at the 2016-2017 data on these programs in terms of the number of people funded by them and the number of families touched. This is an opportunity for the group to look at what has been done historically and what this effort is looking to scale, Dr. Olson explained. Ms. Grace Damio added that in specific communities throughout the state, there are clusters of maternal and child health programs that involve home visiting and believes that what already exists in certain communities should be used and built on. Dr. Schaefer agreed that this effort needs to better understand the landscape and what the group is purchasing and avoid duplication while working off what already exists throughout Connecticut today.

Dr. Stone summarized that the concept is supported by the Task Force and emphasized the importance of linking newborns back to the medical home. Dr. Selinger agreed and stated that anything that integrates the silos of the office with the community is a good thing. Ms. Girouard agreed, and said it will be interesting to see what is already being done and how the group plans to pay for it. Ms. Damio gave her support for the universal home visits capability as well. Dr. Olson agreed, and emphasized the importance of implementing it well. Mr. Juan David Ospina added that this effort needs to work off base-line data to ensure proper measurement and program success, to which Dr. Stone agreed.

8. Selected Adult Capabilities Summary Documents

Dr. Freedman then reviewed the two-page, high-level summary documents of the capabilities with the Task Force. With the completion of the Task Force's review of the capabilities, Dr. Freedman continued, this effort is now ready to begin the process of review with stakeholders and approval of the recommendations in these two pagers. Dr. Freedman then went over the proposed adult behavioral health integration capability two-pager. Ms. Girouard added that to be able to present a clear definition to the public, this effort must explain the term "modernization" (ie. the financing mechanisms) and give people a sense of what is current practice and how what is being proposed differs from that. How will the financing of this differ from the financing we already have, and what is the risk associated with making these changes?

Ms. Jesse White-Frese asked if the first page is intended for the general public, and if the second page is more so for providers? Dr. Schaefer explained that the first page is meant to speak to both providers and consumers, with the left side of the first page being in consumer-friendly language, and the right side being in provider-friendly language. The other pieces of the two-pager contain patient examples, the summary of requirements, the health information technology requirements,

and the measuring impact and health equity aspects, continued Dr. Schaefer. The purpose is to communicate the utility of the capabilities, he explained. Ms. Jesse White-Frese stated that she could see a clear difference in the language between the consumer and provider-oriented parts but asked the group if they thought the provided terminology was truly consumer-friendly. Ms. Girouard asked if the Task Force considered using the Getting Better, Staying Healthy framework that CAHPS used to look at healthcare through the eyes of the consumer? Dr. Schaefer replied that this effort can take a look at this. Dr. Selinger asked if these documents are intended to be presented in a group setting while holding the viewer's attention over a period of time, or are these to be independently reviewed when someone has the time and inclination to do so? Dr. Schaefer explained that he was thinking more the latter; that this group wanted simple, readily, accessible summaries for anyone who wants to sit down and examine what this is about. This content will also likely be borrowed for future presentations of the capabilities. Dr. Selinger explained he will have to sit down and more closely examine these proposed documents since they're daunting and do require effort on the part of the reader. Dr. Schaefer explained that this effort is looking for documents that serve as a bridge and provide more information on each capability, without having to do a deep-dive on non-graphical information previously compiled. Ms. Damio enquired over the intended audience of the two-pagers, to which a fellow Task Force member explained they're oriented towards consumers and the primary care team. Ms. Damio then stated she thought it was odd to include the consumer and the primary care team language on the same page. Dr. Schaefer acknowledged that this was a great question and explained that developing a document that didn't speak to consumers felt wrong. With that said, Dr. Schaefer continued, the document needs to be technical enough to speak to employer, provider, and payer audiences as well. Dr. Schaefer stated that the patient perspective belonged here because it's a combination of how a care team will change what they can do for patients, but also incorporates the consumer perspective (i.e. "What will this do for me?"). Ms. Damio added that its important for the provider to see what the consumer perspective is, but it's not really targeting consumers on the street. Ms. Girouard added that a document that both groups can understand is essential so that everyone understands the system together. Ms. Damio explained that many consumers look for documents that are not dense in text and are more graphical. She is not sure this format will be effective for large sectors of the community. Ms. Lesley Bennett agreed. Dr. Schaefer stated that it felt wrong to put forth a document that's consumable for those who are doing the technical part of primary care modernization, without having something that speaks to why it matters to the people represented. Ms. Damio agreed this made a lot of sense.

Dr. Schaefer then reviewed the patient experience, care team network requirements, health information technology requirements, measuring impact, and improving health equity sections with the group. Ms. Girouard added that it should be made clear to people what these capabilities are attempting to fix. Another Task Force member stated that they believed this was too much to incorporate. Dr. Selinger asked if the health plans and/or professional groups were going to be looking for any evidence-based support for these impactful outcomes in the literature? Dr. Schaefer agreed that he believes they will, however, they are not in the two-pagers. There will be links to a full-paged view of the capability concept map and a more complete summary of the guidelines, including the evidence supporting it, Dr. Schaefer reassured. Dr. Olson added that he thought the two-pager was too text heavy, that no one is going to take the time to read it, and that the way it is presented must be changed.

Dr. Schaefer admitted that he has labored over what to leave out in these two-pagers but is concerned over cutting out key points. Dr. Olson highlighted the natural questions asked when looking at these two pagers and focused on the "how care will improve" aspect. He suggested removing bullets and cutting down on text. Ms. Damio stated that this format is a hybrid between a policy piece and an infographic. It's not graphic enough to be an infographic, and this effort does not want this to be a policy brief. Ms. Damio suggested making these summaries a few more pages to make it friendlier on the eyes and easier to read. Dr. Schaefer reminded the group that the audience is intended to be employers, health plans, state agency policy folks, the consumers and consumer advocates who are more involved in health policy, and providers (i.e. physicians, Affordable Care Organizations, Advanced Networks, Federally Qualified Health Centers, the practice). One Task Force member agreed it is a challenge to communicate such a wealth of information in such a concise manner, but did not see any context for why? A simple statement that explains why this effort is doing primary care modernization would be helpful to the reader as well. Mr. Juan David Ospina agreed. Ms. Rowena Rosenblum-Bergmans asked if these will be presented in the context of a framework document? Dr. Schaefer agreed. Ms. Rosenblum-Bergmans then asked if an introductory summary or statement in the beginning was possible, and then asked if one document must speak to all audiences? Should this be tailored more so towards certain audiences over others? Dr. Schaefer asked Ms. Rosenblum-Bergmans what she thought should be incorporated into the document to show what the obligations and opportunities are? Ms. Rosenblum-Bergmans explained that the audience she is thinking about are the payers and employers. Ms. Rosenblum-Bergmans explained that she did not think she would use this for internal stakeholders, and that she would not have to "sell it" internally. Dr. Schaefer agreed this may be true with all the capabilities. As caregivers, Ms. Rosenblum-Bergmans continued, we know we need to do all these capabilities, it is a matter of changing the way we pay for it and understanding the connections to the community. It's clear we will not be successful in managing populations unless we can do these things, Ms. Rosenblum-Bergmans explained. Ms. Rosenblum-Bergmans explained she was unsure if she would use these as a mechanism for convincing leadership to invest in these programs. Ms. Rosenblum-Bergmans stated that she believed this information is great for external audiences. Dr. Selinger added that the external audiences would need the education and motivation to read through and absorb it all. Ms. Rosenblum-Bergmans agreed. Dr. Schaefer pointed to the CPC+ documents and explained how he felt these were useful in communicating with potential partners.

Dr. Schaefer reassured that the group will reevaluate these two pagers and will try and come up with documents that are substantially more accessible. Dr. Stone added that she believed the presented terminology is a bit over the head of the average person the street. Dr. Selinger acknowledged the different tiers of an audience, and requested time to review the documents and submit feedback. Dr. Schaefer agreed and asked the Task Force to take a closer look over the next couple of days.

At the end of the meeting, Dr. Schaefer reviewed the DRAFT Concept Map of the Pediatric Behavioral Health Integration capability with the Task Force, and asked the Task Force where they thought the place for this image was? Dr. Selinger explained that he thought this was the kind of visual that would resonate with a broader audience if the terminology was simplified. Ms. Damio suggested that combining the two-pagers with this concept map might produce a higher utility. Another Task Force member suggested starting with the original primary care model, and then adding the modernization initiative over time. Dr. Stone expressed her approval of the layout of the concept map.

9. Adjournment

Dr. Selinger made a motion to adjourn. Ms. Jesse White-Frese seconded the motion.

The meeting adjourned at 8:08pm.