STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
January 29, 2019
6:00 – 8:00 p.m.

Meeting Location: CTBHP, Litchfield Room, Suite 3D, Rocky Hill

Members Present: Supriyo Chatterjee; Maria Dwyer; H. Andrew Selinger; Elsa Stone; Grace Damio; Douglas Olson; Mark Vanacore; Anita Soutier; Susan Adams; Daniel Lawrence; Juan David Ospina; Lesley Bennett; Randy Trowbridge

Members Absent: M. Alex Geertsma; Alta Lash; Heather Gates; Kate McEvoy; Jesse White-Frese; Rowena Rosenblum-Bergmans; Anne Klee; Leigh Dubnicka; Shirley Girouard

Other Participants: Mark Schaefer; Stephanie Burnham; Nadine Repinecz; Karen Siegel; Linda Green; Vinayak Sinha; Mary Jo Condon; Beth Cheney; Elizabeth Garrigan; Belinda Sam; Erika Vuernick; Lisa Honigfeld; Arlene Murphy

1. Call to Order
The meeting was called to order by Dr. Elsa Stone at 6:00 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 January 8th meeting summary of the Practice Transformation Task Force meeting.
Ms. Lesley Bennet made a motion to approve the minutes.
Dr. Andy Selinger seconded the motion.
Vote: All in favor. None opposed.

4. House Rules Refresh

5. Purpose of Today's Meeting
The purpose of the Task Force meeting was to review the Draft Capability Summaries in order to pass them to the Payment Reform Council to inform supplemental bundle design. Dr. Mark Schaefer explained that the summaries will allow scenario modeling of the capabilities for inclusion in the supplemental bundle and will be reviewed by the Healthcare Innovation Steering Committee (HISC) in February. HISC will then review payment reform in March. The stakeholder feedback period, Dr. Schaefer continued, will occur in March and early April.

6. Review Draft Capability Summaries

Ms. Linda Green explained how the provided summary documents have previously been deliberated by the Task Force and that they simply comprise the input and feedback from the design groups, consumer discussions, and the Task Force's comments from prior meetings. Ms. Green explained that the intended audience for these summary documents is the stakeholder community engaged in the design of the PCM initiative, which includes but is not limited to payers, providers, consumers, and employers. As the stakeholder input process continues, these capabilities will continue to evolve and improve, and a draft of the PCM report will include additional sections and descriptive materials.

Ms. Green described how each of the three groups of capabilities will be reviewed over the course of the meeting, and that any adjustments that have been made were done so in response to feedback received. Additionally, the Task Force will discuss all general comments and substantive questions raised by members prior to the meeting.

Adult and Pediatric Core Capabilities

a. Health Equity Improvement (Core)

Ms. Green emphasized how this core capability identifies key components of an effective Health Equity Improvement strategy by mirroring the Community & Clinical Integration Program's (CCIP) health equity standards and requirements. In order to achieve the capability, a network must achieve the goals and demonstrate improvement in the process measure, Ms. Green explained. A network must have a clear, documented policy and procedure for collecting granular race and ethnic data, analyzing the data to identify disparities in care, and conducting root cause analyses to identify and implement interventions that address those disparities. Dr. Schaefer added that this is a recently added capability, aimed at breaking down the requirements needed to address effective community integration and health equity.

Dr. Elsa Stone inquired over the percentage of EMRs capable of collecting the needed data. Dr. Schaefer explained how the 2015 EHRs need to be able to collect race, ethnicity, and sexual orientation and gender identity data. Dr. Schaefer noted that, in terms of workflow, there is a barrier to integrating collected information. The data collected, he explained, allows for another data point to segment the population to understand disparities. The intent is to not prescribe disparities to tackle, but instead to make sure these variables are among those considered when identifying who to serve, and how to better serve them. A Task Force member inquired over why this effort was addressing only three, to which Dr. Schaefer explained that this is simply a minimum benchmark and that if a practice can do this, then this effort could be scaled further.

A Task Force member expressed concern over mirroring the CCIP standard, and Dr. Schaefer acknowledged the challenges in data collection in CCIP. He proposed a concept where scaling can potentially start within a few practices, and then extend out to the network. He expressed how he would support a network's decision to develop new processes, procedures, and integrations of new care team members on a limited scale at first, have them determine their workflow, and then scale up. Mr. Juan David asked who will oversee the compliance process for this, to which Dr. Schaefer replied that this will be discussed in upcoming stakeholder discussions to identify who may have oversight. Mr. Juan David expressed that this effort should consider a third party, and Ms. Burnham added that the Patient Centered Medical Home

(PCMH+) program has learned what information to collect, and it's now the "how" and "who" that must be determined during these stakeholder conversations.

b. Community Integration to Address Social Determinants (Core)

Ms. Green explained that this capability is designed to identify social determinants of health and other barriers that may affect a patient's healthcare outcomes and address those barriers by connecting patients to community resources. Ms. Green then identified a few of the practice and network requirements for the Task Force. There were no follow-up questions.

c. Adult Behavioral Health Integration (Core)

Ms. Green explained how this capability includes brief interventions encompassing a diverse range of approaches, intervention targets, and delivery methods. These brief interventions may address issues such as substance abuse, pain control, prevention and intervention with health risk behaviors, suicide, and others. Dr. Andrew Selinger added that in a primary care setting, there are three main questions that orient around depression, counseling, and medication. Dr. Schaefer explained that behavioral health co-morbidities may be identified and resolved over a few visits, potentially involving a referral. This idea is to have more immediate access to behavioral health care in practices, Dr. Schaefer explained, which could mitigate the need for a follow-up appointment.

d. Diverse Care Teams (Core)

Ms. Green addressed the question of whether an expanded care team improves preventive care for those with complex illnesses and disabilities. Dr. Schaefer noted that expanded care teams will allow primary care to assist generally disengaged populations, and that the Department of Developmental Disabilities says those with complex illnesses and disabilities are less likely to get requisite preventive care. Dr. Elsa Stone added that when someone has a complex illness or disability, their focus may not always be on preventative measures, therefore a diverse care team or community health worker/coordinator can help keep track of a person's holistic health. Ms. Burnham then offered up an example of a patient who received preventive care only when they were accompanied to the doctor and noted that when patients are checked on by other members of the care team, it results in more preventative healthcare services.

e. eConsults (Core)

Ms. Green explained that eConsults occur when a primary care provider electronically consults with specialists for non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit. The Task Force had no follow-up questions or comments.

f. Community Purchasing Partnerships (Elective)

Ms. Green described how this was a new capability that came out of community integration and referred to primary care practices contracting for home and community-placed services that extend the reach of primary care to better meet the needs of diverse communities, address social determinants of health or help fill in gaps in services. Ms. Green then touched on the changes made to this capability since the last Task Force review.

A Task Force member asked if there were any lessons learned from the Preventive Services Initiative (PSI) out of the SIM office. Dr. Schaefer explained how Advanced Networks and Federally Qualified Health Centers are contracting with agencies to provide some preventive

services under PSI. Dr. Doug Olson added that its still very early for results, but that the initiative has allowed for providers to contract with Community Based Organizations (CBOs) and that the work of CBOs has been promising.

There are calculations to measure return of investment, Dr. Olson continued, and SIM has allowed this to extend to other organizations. However, some organizations are simply not experienced enough, and this kind of relationship-building takes investment and time. Ms. Grace Damio noted that there is a systemic approach to creating community purchasing partnerships that health care organizations are simply not used to. It is helpful to have SIM technical assistance and initiation to help build what is needed in terms of comfort level and fluidity of exchange. Dr. Schaefer explained that the idea is to give practices the flexibility to use supplemental funding for this purpose. When you have Medicare, Medicaid, or commercial funding in a practice, it is economical for the provider to use this supplemental funding, even if it is only a marginal benefit. Today, Dr. Schaefer continued, there needs to be a 2:1 return on investment for this to be economical. If, for example, Fair Haven Community Health Center invests $1 and gets $1.80 back, then 90 cents are shared with the payer, leaving only 90 cents for the practice, resulting in a 10 cent loss.

g. Oral Health Integration (Elective)

Ms. Green brought up a previous question asked by a Task Force member regarding a consideration to survey practices that can integrate dental information into electronic health records. Dr. Andy Selinger added that in a primary care practice, there would need to be open text fields rather than a data field. This is because the open text fields would reduce the barrier in collecting information in the electronic health records, Dr. Selinger explained. Dr. Schaefer noted that this is core for pediatric practices, and elective for adults; the adult practice could use the supplemental funding for OHI. For example, the Wheeler Clinic is currently doing this under their own volition. Mr. Supriyo Chaterjee added that there is a gap being closed here, and that the progress occurring in the industry enables stronger analytics. Dr. Schaefer acknowledged that this was worth looking into in the lead up to implementation.

h. Telemedicine/Phone/Text/Email (Core)

Dr. Selinger noted that telemedicine may be a poor substitute for an in-person visit because it does not allow for the care team to build a relationship with the patient as well. Dr. Schaefer acknowledged concerns over national tele-doctor issues, as it is counterintuitive to relationship-building. By putting this into the bundled primary care reimbursement, Dr. Schaefer continued, this could give practices the flexibility to use it when appropriate. It was noted that it is vital for patients to be able to have the choice of an in-person visit.

i. Remote Patient Monitoring (Core)

Ms. Green explained that remote patient monitoring uses connected digital devices and technology to move patient health information from one location, such as at a person's home, to a healthcare provider in another location for assessment and recommendations, usually at a different time. It is most helpful for patients with certain conditions, including congestive heart failure (CHF). In terms of electronic health records being able to ingest information and support platforms, Mr. Juan David mentioned that EHRs do not typically support RMP and asked if there was a way to incentivize practices to use platforms that do? Dr. Schaefer acknowledged that it would be valuable to investigate this further before the 2021 go-live date.

Mr. Chaterjee added that there needs to be a certified and standardized devise. Dr. Schaefer replied that there are platforms that might not provide data into an electronic health record but could potentially get information to nurses to review certain parameters of CHF patients. Electronic health record interoperability would be ideal, Dr. Schaefer continued, but the RMP would still reduce hospitalizations. Dr. Schaefer admitted that the cost is high and that this effort will be investigating this further.

j. Shared Medical Appointments (Elective)

Mr. Chaterjee asked if this capability involves community health workers? Dr. Schaefer replied that it might, but that it was not prescriptive. Mr. Chaterjee stressed that this capability should be a core, but other Task Force members disagreed. Ms. Grace Damio explained that in her experience, it is difficult to get patients with complex medical and social complexities together at the same time.

k. Pain Management and Medication Assisted Treatment (Core)

Ms. Green reviewed the concept map for the capability and mentioned that Task Force members had not electronically submitted comments on this capability. There were no additional comments during the discussion.

l. Older Adults with Complex Needs

A Task Force member mentioned the model resembled that of CareMore. Dr. Schaefer explained that CareMore is an Anthem subsidiary model that began in California and is a highly specialized practice geared towards complex adults with chronic conditions who are often dual eligible. Flexibility and money for primary care is critical here, Dr. Schaefer continued, and relying on codes for billing is not ideal. Dr. Schaefer went on to explain that the care teams are flexible, and CareMore uses a for-profit, capitated approach. Dr. Doug Olson added the approach was disruptive and has seen some promising outcomes due to home visits, warm handoff from the hospital to the home and a strong team-based approach.

Dr. Schaefer stated that in addition to CareMore, Commonwealth Care Alliance is one of the highest rated and utilizes capitated payments for dual eligible beneficiaries Dr. Elsa Stone expressed that she would be happy to be able to refer patients to these practices. Dr. Schaefer went on to acknowledge that the ease of access to face-to-face visits is critically important, and that a practice should be able to provide this in CT. Dr. Schaefer concluded that this effort must prioritize practice locations that are accessible to the communities they serve. Dr. Elsa Stone added that there are simply not enough geriatricians, but Dr. Schaefer reassured that Project ECHO can help attract other team members.

m. Pediatric Diverse Care Teams

Ms. Green reviewed the concept map for the capability and mentioned that Task Force members had not electronically submitted comments on this capability. There were no additional comments during the discussion.

n. Pediatric Behavioral Health Integration

Ms. Green reviewed the concept map for the capability and mentioned that Task Force members had not electronically submitted comments on this capability. There were no additional comments during the discussion.

o. Pediatric eConsults and Co-management

Ms. Green reviewed the concept map for the capability and mentioned that Task Force members had not electronically submitted comments on this capability. There were no additional comments during the discussion.

p. Pediatric Community Purchasing Partnerships

Ms. Green explained to the Task Force that this is an elective capability, yet other parts of community integration will remain core. Ms. Burnham noted that when looking at school-based health centers and seeing how this resource could be leveraged in Health Enhancement Communities, these health centers are a little too under the radar. Ms. Green replied that the diverse care team and behavioral health integration capabilities require coordination with services across schools and all settings where children receive care. Dr. Schaefer concluded that this effort can examine whether this capability can bring these service delivery solutions together.

q. Alternative Ways to Engage Patients and Their Families

Ms. Green expressed how universal home visits for newborns was strongly supported by the Task Force. Dr. Schaefer asked if this effort should try to harmonize the language of adults and pediatrics, to which member of the Task Force agreed. Dr. Elsa Stone added that shared visits could be multiple caregivers and group visits could be multiple patients. It was agreed that uniformity in the language would indeed be best.

Dr. Schaefer asked the Task Force if universal home visits should be just for newborns, to which Dr. Elsa Stone agreed that it should (according to the design group). Dr. Schaefer acknowledged that there has been a lot of work done on home visits, and that this is significant to ask of pediatric practices. Dr. Schaefer explained that this effort wants to expand the two-pager to show that universal home visits are only to be offered to newborns and not all children. Ms. Mary Jo Condon expressed consumer concern over requiring home visits due to reporting to the Department of Child and Families. Ms. Condon added that studies from Duke show that home visits result in reductions in emergency department and hospital visits within the first six months of life and stated that those identified for home visits should be able to pursue one if needed. Dr. Lesley Bennett added that Oregon has moved to mandate surveillance of newborns but has received significant push-back. Dr. Schaefer offered up a RAND study showing near-term and long-term benefits of home visits, and that it is important to consider offering this to everyone. Dr. Schaefer concluded that this effort will develop a two-pager on universal home visits with a bit more detail and stating that the visits would be optional to families, with a status-pending similar to the disabilities two-pager. Ms. Grace Damio stated that she supports universal offerings, in addition to utilizing community health workers for home visits (with a clear definition of roles and knowledge of how to connect to other care team members).

7. Discussion

Ms. Green reminded the Task Force that all these capabilities are to be phased in. Dr. Schaefer added that this effort has conversed with the Department of Labor and its Office of Workforce

Competitiveness on how to phase-in implementation of the additional workforce. Dr. Schaefer noted that this effort has not yet resolved integrative medicine but reassured that this will be revisited at a later date. Dr. Elsa Stone asked for a motion to accept these capabilities and have them passed on to the Payment Reform Council for inclusion in the supplemental bundle. Dr. Andy Selinger made a motion to accept the capabilities, and Dr. Lesley Bennett seconded his motion. Mr. Juan David asked if these capabilities are to replace or complement current initiatives behind the PCMH+ model? Dr. Schaefer explained that the goal here is to support practices participating in an ACO/Shared Savings arrangement, and that includes PCMH+. The intent, continued Dr. Schaefer, is to direct opportunity towards practices that are involved in any and all arrangements with payers (shared savings or accountable care organizations). Dr. Shaefer acknowledged that this effort has not yet discussed the need for proportion of patients in a shared savings arrangement. The Task Force then approved the changes to the capabilities and movement to the PRC for inclusion in the supplemental bundle.

8. Next Steps

Ms. Green concluded that the capabilities with the Task Force's comments will be sent to the Payment Reform Council and reminded the group that the next Task Force meeting will be held in late February. Ms. Green added that the Health Innovation Steering Committee briefing on the capabilities will be held on February 14th, and that feedback from this briefing will be collected and recorded for PTTF review.

9. Adjournment

A member gave the motion to adjourn the meeting. Dr. Andy Selinger seconded the motion. The meeting adjourned at 8pm.