

**State of Connecticut
State Innovation Design Model
State Healthcare Innovation Planning Steering Committee**

**July 8, 2013
Meeting Minutes**

Members Present: Lt. Gov. Nancy Wyman (Chair); Victoria Veltri; Michael Michaud; Mark Schaefer; Patricia Baker; Matthew Salner (for Kevin Counihan); Anne Melissa Dowling; Anne Foley; Bernadette Kelleher; Katharine Lewis (For Jewel Mullen); Frances Padilla; Bettye Jo Pakulis; Thomas Raskauskas; Patricia Rehmer; Frank Torti; Fredericka Wolman; Thomas Woodruff

Members Absent: Raegan Armata; Mary Bradley; Roderick L. Bremby

Meeting convened at 1 p.m.

Discuss goals for today's meeting, share progress from other work groups, review synthesis from third work group meeting

Committee members reviewed the detailed requirements of its innovation plan in preparation for the first draft of the application. There will be two parts to the state's grant application. One will be an outline of the broader plan and the other will be more technical. The application will address state goals, describe the state health care environment, report on design process deliberations, detail health system design and performance objectives, propose payment and delivery systems models, propose health information technology solutions, address workforce development issues, provide financial analysis, include evaluation plans and a roadmap for health system transformation. The first part will be between 50 and 100 pages of narrative and exhibits and the second part will be much more prescriptive and focused on the testing grant period in detail. The application is due to CMMI at the end of September. Committee members will be asked to perform an initial review for substance to ensure all key points are addressed. A second review will look at language and grammar.

Overview of relevant work group recommendations to date

Care Delivery: the group has spent time setting a foundation to elevate the quality of care for all populations with the understanding that it will need to be tuned to include certain special needs populations. The focus of the group's work has been on the coordination of care of individuals through a whole-person centered approach. There is interest in improving selection of provider types and care setting, effective diagnosis and treatment selection, and care coordination/chronic disease management; for pregnant women/newborns, there is a special emphasis on primary prevention.

Providers will be asked to think more broadly about their patients, including looking at where they live, who is in their household, whether there are behavioral health conditions that may influence overall health. Consistent with a population health approach, providers will need to look beyond one patient with diabetes but at all of their patients with diabetes and their effectiveness in treating subpopulations (e.g., different outcomes for different race/ethnic groups).

The work group has identified additional roles that will be needed to support the model, such as community health workers trained to facilitate interventions. There has been some debate

regarding who will be in charge of the care team. It was decided that it will be at the discretion of the provider, which should allow for innovation over time.

Consumer engagement is a major emphasis, empowering patients to make sound health decisions. The work group has been excited about giving patients a role in their care through programs such as Choosing Wisely that provides pros and cons on procedures such as mammograms and colonoscopies. It was suggested that the group look at further simplifying the language in such a campaign as the reading level for Choosing Wisely was high.

At the group's most recent meeting, the group discussed setting a credential for providers participating in the model such as NCQA. It has been suggested that the state would set a low bar for entry into the care delivery model, with a progressively rigorous set of standards that providers could work towards. Committee members asked who would hold providers accountable and who would lead in training and evaluating. This will be a future topic of discussion.

Payment Reform: the group agreed to adopt a two track model that would allow for greater provider participation. In the first track, providers will begin in pay for performance and transition to total cost of care. In the second track, providers will begin in total cost of care. The goal is that nearly all providers would move to total cost of care within five years.

The model will continue with fee for service as a baseline with pay for performance and total cost of care serving as bonus payments based on quality and utilization metrics. The idea is that as time goes on, fee for service will become less important as time goes on.

The group is developing a scorecard of key metrics and looking to reward on both relative and absolute performance. The group has determined that patient volume will need to be aggregated for the purposes of performance management.

Committee members discussed how the model would be funded. There has been evidence of a correlation between improving care delivery and reducing costs (e.g. expanded office hours leading to lower emergency room utilization). Committee members were asked to be mindful of the fact that there is a two year state budget in place with a spending cap. An additional meeting has been scheduled for July 29th. The payment reform group will have two more meetings to work out the remaining details of the payment model.

Health Information Technology: the HIT work group had its fourth meeting that morning and will wrap up its work the following Monday. The group has outlined integrated clinical data exchange between providers. They have spent a great deal of time talking about standardization and consolidation. They are also looking at near term education efforts. At the morning's meeting, the group ranked categories that would make CT distinctive in health IT. The group overwhelmingly supported a reinvestment strategy. The group is looking to repurpose what already exists and stage implementation.

Workforce Task Force: the task force reviewed a study on provider-patient ratios. Connecticut's ratios do not look different from the rest of the country. In Fairfield, Hartford, and New Haven counties, the ratio of providers to patients is good. However, there are different ratios in the northwestern and eastern parts of the state where the ratio of providers to patients may be insufficient.

That study did not include specialists or allied health professionals and it does not adjust for the impact of care delivery reforms. There are plans to survey providers about their challenges. Other research shows that 65% of all practices have three or fewer physicians, which has implications for the design of care delivery and payment reforms. There are plans to further study that statistic, as well as the shortage of geriatricians in the state. Other areas of interest include provider racial and ethnic diversity, public health providers, and community health workers. UConn Health Center is hosting a National Governors Association technical assistance program on work force on July 24.

Program Planner Update

The Department of Public Health has taken the lead in population health and is hosting a technical assistance program from the National Governors Association on July 10. The agenda for the population health TA includes a comprehensive definition of public health, an open discussion on using a health impacts pyramid to assess how the state is aligned within the population health model, and a look at how to pay for population health delivery. The technical assistance team is comprised of officials from the NGA, the CDC, and CMS.

The Office of the State Comptroller is looking at state employee data and physician integration and doing research on affiliations, looking at the provider practices state employees tend to use. Additionally, by early next year, a significant portion of the state employee population will be participating in an ACO. They are looking at new accounting mechanisms to deal with the change in billing.

The Department of Mental Health and Addiction Services has submitted a letter of intent to apply for a round two health care innovations grant to address gaps in the special health population area. Additionally, the agency commissioners are reviewing 10 innovation grant proposals to determine whether to offer letters of support. Committee members will receive information on those proposals.

Discussion on stakeholder engagement

A large number of consumer input forums are scheduled for July. Due to a lack of time, committee members were encouraged to attend the Health Care Cabinet meeting on July 9 at 9 a.m. for more detail and discussion on stakeholder engagement.

Meeting adjourned at 2:30 p.m.