

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

**July 29, 2013  
Meeting Minutes**

**Meeting Location:** 210 Capitol Avenue, Room 410, Hartford, CT

**Members Present:** Lt. Gov. Nancy Wyman (Chairwoman); Raegan Armata; Patricia Baker; Benjamin Barnes; Roderick Bremby; Bernadette Kelleher; Michael Michaud; Bill Morico (for Thomas Woodruff); Jewel Mullen; Frances Padilla; Matt Salner (for Kevin Counihan); Mark Schaefer; Thomas Raskauskas; Victoria Veltri; Cheryl Wamuo (for Fredericka Wolman)

**Members Absent:** Mary Bradley; Anne Melissa Dowling; Anne Foley; Bettye Jo Pakulis; Patricia Rehmer; Frank Torti

Meeting convened at 3:30 p.m.

**Review recommendations from care delivery, payment, and HIT work groups**

A review of the recommendations from each work group was given.

**Care Delivery:** The work group agreed to put forth a population health care model with the goal of improving care delivery for the majority of the state's population that has the ability to cover those with complex health needs. The group is recommending medical home model that is organized over how well the population is being served overall, as well as how sub-populations with particular health needs are being served. It is looking beyond the individual. It includes better efforts to undertake primary prevention activities. There has been an effort to meet with consumers and in those listening sessions, consumers have said they feel as if they are not listened to or respected, that their risk factors are not being taken into account. Consumers find they only see the provider for five minutes, yet it took six months to see the provider, and they find there is not much value in the visit. In behavioral health, consumers said the provider immediately goes into the prescription phase, rather than talking to the consumer about their concerns. The experience can vary based on the kind of coverage. Medicaid clients in particular felt the most underserved and treated as less of a person.

In an effort to address those concerns, the work group is recommending a more whole-person centered approach with enhanced access to care where consumers are engaged through a variety of means such as e-consults and patient portals. Health enhancement programs, such as the state employee health care plan, have been highlighted as means to better engage consumers. They are also recommending evidence based decision making through programs such as Choosing Wisely. They are also recommending a team based approach that includes community health workers. The group decided not to be prescriptive as to the team leadership and the structural requirements for entry. There would also be a low bar for entry through a self-assessment and commitment to transformation. A sub-group of workgroup members decided to select the best from existing standards and focus on the most important elements at each stage of transformation. The group also supports a concept put forth by the Department of Public Health that establishes certified community based support entities that can help consumers access needed services.

It was asked how the group defined foundational needs. The group looked at after hour access to care or e-consult communications. There was concern that the description was system focused, rather than consumer focused. The focus should be on what patients need in interfacing with the healthcare system. That includes addressing consumers in terms they can understand and thinking beyond tactics that may work for some people but not for others. There were also concerns that the discussion document did not address oral health or prevention beyond pre-natal care. That has been discussed in group meetings; there was acknowledgement that a better job could be done of communicating that. There remain a number of open planning strands in the development of the model.

**Payment Reform:** The work group's final meeting will take place later in the day. The group is recommending a two track system. Track 1 is pay for performance; track 2 is total cost of care. The tracks will be tied to a scorecard that looks at both quality of care and overall cost. Part of the group's charge is to develop version 1.0 of the score card. It will be important to determine adequate metrics that won't require constant updating. The group is also looking at aggregation, as there are many small practices in the state. The group is recommending providers enter into some kind of formal structure. The group is not prescribing the kind of structure. While the group has discussed cost savings, preserving and/or improving quality of care has been most important to the group. The payment model is a means to implement the care delivery model. Committee members stressed the importance of standardization in order to ease participation. There were questions regarding who would provide technical assistance and support to providers to encourage them to participate. There were also questions regarding who would pay for that support.

The committee further discussed cost savings. There is a concern that the cost savings or predicated on overutilization, however, in Medicaid there are problems of underutilization. It was mentioned that in underserved populations, when care is sought, it is at the highest price. The goal is to improve access so that underserved populations can be treated at a preventative level. The payment reform group has had formal discussions about avoiding inappropriate denials of care. That is why choosing appropriate metrics is crucial. There remains a need to identify the structure needed to design and perform program evaluation.

**Health Information Technology:** The work group completed its fifth and final session on July 15. The group achieved consensus around tools related to payer analytics, patient/provider/payer connectivity; provider/patient care management tools and provider/provider connectivity. The group is recommending more integrated clinical data exchange, looking at how to unify existing technology through tools such as portals. Standardization is a key component of the recommendation, with the use of common portals and common reporting. It was asked to what extent technology enabled movement from track 1 to track 2. In track 2, there would be more robust performance evaluation, using metrics that will help eliminate waste while also allowing the providers to enter into the model and move forward over time. There was concern that establishing too many metrics initially for track 1 providers may restrain the potential for rewards. There was also concern that the state has not yet fully embraced meaningful use technology. One of the goals is to prequalify vendors to create a technology market place. This may be an area where a policy lever is needed to ensure that technology is interoperable. Part of the recommendation is to build analytic capabilities, such as the adoption of the All Payer Claims Database (APCD). It was noted that collecting racial and ethnic data will be important to address disparities.

#### **Discuss targets to measure program success**

The committee discussed how to define success as a whole, aligning to a triple aim of health (prevention and reduced severity of disease), quality (quality targets met, improved customer

experience), and costs (reduction in total health care cost and trend). The work groups have developed an initial common score card to be used to measure quality and cost. More work is needed to get to a further level of detail. There are plans to establish a metrics work group that would include representation from each of the three work groups. The group's work would not be static. The initial scorecard will likely not be complete in time for inclusion with the plan in December, but there will be additional time for further development before the testing application is due in early 2014. The task force could eventually lead to a standing council that would refine the scorecard on an ongoing basis. The committee briefly reviewed a list of stakeholder groups for inclusion on the metrics task force. There was a recommendation to include representation from oral health and long term care. Members were encouraged to email additional suggestions to [sim@ct.gov](mailto:sim@ct.gov).

#### **Align on plan for syndication/finalization**

The work groups have largely completed their work. There will be focus groups in the next few weeks to get further feedback. There are also plans to put forth a survey to gain additional consumer input. The core team also plans to continue meeting with non-profits and area health education centers. The goal is to be as transparent as possible. The work force task force is also continuing to meet and will make their recommendations shortly. The National Governor's Association has agreed to provide additional technical assistance on population health.

The core team plans to obtain as much consumer and stakeholder input as possible by September so that they can come back to the SHIP steering committee with a draft plan. The state received a 60 day no cost grant extension. The plan is due to CMMI December 31. The plan will be a 70 to 100 page narrative document that will provide a broad picture of what health care in the state should be. The testing grant application may be due in March 2014.

The consumer engagement process will be presented at the next Health Care Cabinet meeting. SIM project leaders will be in touch with steering committee members regarding an additional SHIP meeting in September.

Meeting adjourned at 5:00 p.m.