Health Care Council—Delivery System Innovation Work Group

Minutes of meeting:
April 23, 2012 @ 11:00 AM,
Connecticut Heath Foundation, 100 Pearl Street, Hartford, CT.

Attending in person: Mark Borton, Joanne Walsh

Attending via phone: Pat Rehmer (Co-Chair), Margaret Smith, Margaret Grey, Mark Christian(??)

Mark Borton called the meeting to order at 10:05. Mark made apologies to the group on behalf of co-chairs Pat Rehmer who will be joining momentarily via phone, and for Pat Baker who will be joining in person in mid-meeting.

Minutes of the Work Group meeting on 2/29/12. Motion to approve by Margaret Smith; Second by Margaret Grey; unanimously approved.

Mark Borton then referred to the agenda and framed the question of what role does the Work Group see for itself in the future, and what does it want to focus on in the coming months? Following a brief discussion, a consensus emerged: While it was desired that the WG would receive more direction from the Cabinet, the WG would prefer to stay active and further develop actionable items relating to our Recommendations rather than pause or disband.

The WG then turned to the question of where to focus. Recognizing that our Recommendations were at the policy level, our discuss began with a consensus that we wanted to find or define an effort that the WG could undertake that would support one of the objectives, but be narrow enough that it could possibly be accomplished within a reasonable period (possibly a year?). Both Recommendation #2 (workforce/scope of practice/payment) and #3 (patient-centeredness) were discussed as the areas of greatest interest to those attending. Mark Christian (??) expressed the view that Recommendations #2 and #3 were inextricably linked and as such, could be combined. Mark Borton agreed, and offered the perspective that #2 could be thought of as a provider organizational strategy, and that #3 could be thought of as a philosophy. Margaret Grey suggested that we focus on patient-centeredness, as it is at the core of the desired system change, and affects all other areas. There was a consensus on this point. Mark Christian (??) said that it would be helpful to have or develop a definition of “patient-centeredness.” Mark Borton suggested that we adopt the definition(s) used by CT-Medicaid for their Person-Centered Medical Home and Medicare-Medicaid Dual-Eligible programs. The WG agreed. Mark will get said definitions and circulate them (see attached).
Joanne Walsh said that she thinks the “money follows the person” programs offer an excellent example of attempting to truly change from a provider-centric view to a patient- or person-centric view, and that when Dawn Lambert of DSS characterized it as a “civil rights issue” (freedom to choose)--the philosophical position became clear to her. Pat Rehmer concurred; the MFP program is an excellent program (thought still experiencing challenges), and could be used as a model--but the program itself should not be a focus of the WG because it is for too small a population. Pat will forward background info to Mark Borton.

Peggy Smith suggested that we focus on integration of dental care as a broad example of what can and needs to be done to create a truly patient-centered, integrated care model. The WG then discussed the specific bullet item in our Recommendation relating to the inclusion of dental care in the coverage plans to be offered in the Insurance Exchange--and concluded that we could formalize our Recommendation and pass it on to the leaders of the IE effort. The question became--what more could we do? Peggy suggested that we educate ourselves and other opinion leaders on the impact of dental preventive care on emergency room utilization, and that good data was available from Pat Baker/CHF. Mark Borton elaborated on this idea and offered it as a possible goal--for instance, “Seek to have dental care integrated into the CT-Medicaid Medical Home Model by 2013.” Mark then suggested if such a goal was decided upon, then a WG work effort might be to convene a group of stakeholders to develop a business case (utilization, costs, savings, measurement, etc.) that could facilitate the implementation of the goal. Such a program or effort could be an exemplar--and a narrow enough focus that we might be able to achieve it. This concept was received well received by the group. Joanne Walsh said that she was excited about the idea because it was an opportunity to break down the silos that have developed around providers.

There then ensued a discussion of dental “parity”--akin to “mental health parity” and what this meant in terms of access to services, and payment for services. While legally established, mental health parity is still quite imperfect in its implementation, especially in the commercially-insured markets. Mark Borton commented that at a recent HCC-Business Plan WG meeting, Rob Zavoski (CT-Medicaid Medical Director) referred to the Pediatric Dental Health Partnership and the Pediatric Behavioral Health Partnership as models that have been very well received and effective in Connecticut, and indeed viewed as exemplars nationally. Mark wondered if we could used said DHP and BHP models as our model for bringing dental health into CT-Medicaid PCMH program specifically, and more broadly, into the medical delivery model. This concept was well received by the WG, and Pat Rehmer said she would forward information on the BHP.

Pat Rehmer said that a good element of the BHP was that it required documentation of a working relationship between medical and mental health care providers--and that once established it allowed for enhanced reimbursement. This approach worked, but measurement, in the form of audits were necessary. Mark Borton commented that we should look for more refined measures of mental-medical provider integration, and that automating them would be much more efficient than audits, and finally, that the new single Medicaid ASO with consolidated medical and dental claims could facilitate this process.
Mark Borton then asked Margaret Grey how we might integrate Recommendation #2 (workforce/scope of practice/payment) into the aforesaid dental-focused program? Margaret replied that it was a natural fit in that APRNs in particular are very well trained in integrated care and care coordination, in both the medical and dental domains, and that they have well-documented, excellent clinical and cost outcomes therein. Were the WG to develop an effort to promote the integration of medical and dental care, the role of APRNs and similar mid-level providers, and their value, would become clear, and that doing so would be productive way to educate and engage stakeholders on the relevant workforce issues (scope of practice/payement)--which could be addressed as a follow-on effort. Pat Rehmer echoed this sentiment, saying that while CT-Medicaid is starting with PCMH, it will migrate and mature to become “health neighborhoods”—which will be much more inclusive of different types of services and providers, and the proposed WG effort would align well with CT-Medicaid’s direction.

Mark Borton then asked if there were other issues or ideas the WG would like to address—or if participants felt that the concept of medical-dental integration as the WG focus and as an exemplar of patient-centeredness was what we wanted to focus on? There was unanimous agreement to focus on medical-dental integration as the exemplar. Accordingly, Mark Borton will attempt to sketch out this idea into a 1-2 page concept paper and circulate to the WG by next week.

Given that our next regular monthly meeting is likely to be a joint HCC-WGs meeting on 5/16 (time and location TBD--info to follow) in which we will be hearing from the Capital District Physicians Health Plan (of Albany, NY), our next working meeting will be in June. At the June meeting we will plan to discuss how to operationalize the medical-dental integration concept.

There being no further business, the meeting adjourned at 12:15 PM.

Respectfully submitted;
Mark Borton
Addendum: Definitions of Patient-Centeredness

Performance Measurement for the Medicare and Medicaid Eligible (MME) Population in Connecticut

Guiding Principles:
Measurement Matrix Showing Domains, Measures, Sub-Populations, and Relevant Health Neighborhood Providers

Performance Measurement Expert Team
3/8/2012 3:15:48 PM DRAFT

“Person-Centered Care is defined as the provision of health care and social supports that:

1. Provides the MME with needed information, education and support required to make fully informed decisions about their care options and, to actively participate in self-care activities;
2. Supports the MME and their family or caregiver, if desired by the MME or is otherwise appropriate, in working together with their non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services;
3. Includes the development of an individualized plan of care, when appropriate, that is created in full partnership with the MME consumer and is consistent with his or her personal preferences and choices and is implemented in the most integrated manner and setting possible.

For the purposes of this Performance Measurement Matrix, “person-centeredness” is identified as a distinct domain but it is also anticipated that the domains and measures incorporate a person-centered approach to delivery of services and supports, measurement and quality improvement. Domain definitions are intended to be both conceptual, but practical, in nature. Each domain is associated with detailed measures.”