

**STATE OF CONNECTICUT
STATE INNOVATION MODEL DESIGN
CARE DELIVERY WORK GROUP**

**June 24, 2013
Meeting Minutes**

Members Present: Dr. Robert McLean (Chairman); Dr. Mark Schaefer (Co-Chair); Dr. Peter Bowers; Dr. Mehul Dalal; Ms. Meredith Ferraro; Dr. Alice Forrester; Dr. Jeffrey Howe; Ms. Gaye Hyre; Dr. Edmund Kim; Mr. Sal Luciano; Dr. Adam Mayerson; Mr. Michael Michaud; Mr. Bill Morico; Dr. Chinedu Okeke; Dr. Donna O'Shea; Mr. Ronald Preston; Ms. Lynn Rapsilber; Dr. Elsa Stone; Ms. April Wang; Dr. Thomas Woodruff; Mr. William Young; Dr. Robert Zavoski

Members Absent: Dr. Daren Anderson; Dr. Leah Jacobson; Ms. Dawn Johnson; Ms. Laurel Pickering; Ms. Rosemary Sullivan

Meeting convened at 6 p.m.

Review prioritized interventions and roles identified in last week's breakout groups

The group briefly reviewed past discussions regarding prioritized interventions within a "medical home plus" model. The focus of the review was the prior meeting's discussions on the most critical interventions along each element of the model (whole-person-centered care and population health management; enhanced access to care; team-based, coordinated, comprehensive care; consumer engagement; evidence-formed clinical decision making; performance management). It was announced that the workforce task group's work will be its own section of the grant application, led by UCHC, with its first meeting taking place on June 25th. The workforce group will assess current capabilities, determine what gaps exist, and develop a strategy on how to address those gaps moving forward. Both the workforce and health information technology groups will tailor their work in support of the models developed by the care delivery and payment reform groups

Review landscape of select roles in Connecticut

The group reviewed a list of roles involved in the new care delivery model, identified in the previous' meetings break-out groups. Members indicated that long term support providers were missing from the listing (e.g. nurses' aides, personal care assistants, homecare workers, etc.). Specialty physicians were also not listed. The point was made that the list was not exhaustive and only captured those roles specifically mentioned in the previous meeting's break-out groups.

The group viewed two presentations: one on data related to the health worker supply in Connecticut and the other on community health workers.

The first presentation was a brief prepared by the University of Connecticut Center for Public Health and Public Policy that looked at various available statistics regarding the state's current health care work force. Data sources included the American Medical Association, the American Academy of Physician Assistants, the Centers for Medicare and Medicaid National Provider Identification File, the US Census Bureau, the National Center for the Analysis of Healthcare Data, the US Bureau of Labor Statistics, and the Connecticut Department of Labor. The existing data is imperfect – data collection is done sporadically and there is minimal ability to perform analytics. The group discussed the possibility of developing a more sophisticated data and analytics system on work force capabilities as part of the new care delivery model.

The second presentation was based on materials presented at the Community Health Worker Symposium sponsored by Southern Connecticut State University on June 21st. It included an overview of who community workers are – there are multiple titles within the scope of the community health worker field and they have been siloed. There was discussion of where and how community health workers could be used, particularly in terms of patient navigation and mental health.

Define criteria, if any, for entities to participate in new care model

The group discussed the care team structure based on the prior week's discussion. The structure and composition of the team should be flexible and take into account existing structures. Connecticut is predominantly a small practice state. There is concern among small practices of being "eaten up" by larger providers. The model should provide a path that would give smaller practices support without forcing consolidation. There is the potential to build on existing relationships as one or two physician practices already share call with six or seven other practices.

In the next meeting, the group will discuss whether it is possible to create hubs or entities that could support providers. It was mentioned that the group had not discussed how prescriptive to be regarding the mix of patients from different payers on a provider's panel. This may be discussed in this work group in the future or a different forum.

The group discussed the idea of prequalifying entities to participate in the new care delivery model. There was concern about imposing additional burdens that would scare away providers. For Medicaid providers instituting a medical home system, they had to eventually meet the NCQA criteria for medical homes. Providers were given assistance to get to that standard. It was suggested that there be an "on ramp" structure that would allow providers to build towards the standard. There could be incentives and rewards given to those providers who move towards and successfully implement a medical home structure without penalizing those who don't. There was general agreement that some criteria needed to be put into place.

The group then discussed and voted on the type of criteria to include. The options included:

1. 24% – PCMH certification by established accreditation body
2. 48% – PCMH certification by established accreditation body plus select CT specific interventions/guidelines
3. 14% – CT specific criteria (e.g., self-reported and validated with audits or claims based process metrics)
4. 14% – Other

It was suggested that providers could start with the NCQA assessment and then decide what they wanted to change. There may be ways for small practices to enter a franchise type relationship that would allow them to remain independent while receiving similar benefits as a larger medical home structure.

Those who selected options 3 and 4 said they had concerns as to whether the NCQA structure worked for Connecticut and whether it provided a low enough entry point. It was suggested they

look at implementing lower standards that provide incentives and don't exclude providers from participating.

Assess outcomes from today's meeting and outline open questions

Several members agreed to participate in a conference call to further discuss the criteria for participation in the model. Members were asked to review pages 16-18 of the discussion document.

Meeting adjourned at 8:30 p.m.