

**State of Connecticut
State Innovation Design Model
Care Delivery Work Group**

**July 8, 2013
Meeting Minutes**

Members Present: Dr. Robert McLean (Co-Chair); Dr. Mark Schaefer (Co-Chair); Dr. Daren Anderson; Dr. Peter Bowers; Dr. Mehul Dalal; Ms. Meredith Ferraro; Dr. Alice Forrester; Ms. Gaye Hyre; Dr. Leah Jacobson; Ms. Dawn Johnson; Dr. Edmund Kim; Mr. Sal Luciano; Mr. Bill Morico; Ms. Susan Niemitz; Dr. Chinedu Okeke; Dr. Donna O'Shea; Ms. Laurel Pickering; Mr. Ron Preston; Ms. Lynn Rapsilber; Dr. Elsa Stone; Ms. Rosemary Sullivan; Ms. Cheryl Wamuo; Dr. Thomas Woodruff; Mr. William Young; Dr. Robert Zavoski

Members Absent: Dr. Jeffrey Howe; Dr. Adam Mayerson; Ms. April Wang

Meeting convened at 6 p.m.

Finalize recommendation on practice standards based on sub-team's input

A care delivery work group sub-team developed a recommendation on Connecticut's approach to practice standards since the last work group meeting. Given the work group's previous decision not to be overly prescriptive on the care team, care team leader, or structure of eligible entity, the sub-team aligned on the idea that it was important to set standards and they should help practices along the path to managing the total cost of patients' care. They recommend that the initial barrier to entry be low for a specified amount of time and that CT will define a set of practice standards (likely pulling from national standards) which will be tied to practice transformation support.

To arrive at their recommendation, the sub-group evaluated several options including using NCQA certification and developing unique, Connecticut-specific criteria. There was concern that certain national certification standards were too high a bar to set, due to the administrative burden and cost, and may prevent providers from participating in the new model.

The group looked at Oregon's experience developing their patient centered primary care home (PCPCH) as an example to assess the benefits and limitations of developing state-specific criteria versus adopting existing accreditation standards.

There were discussions as to who would perform evaluations/audits in Connecticut. It was mentioned that if the practice standards were clearly identifiable through outcomes or claims data, the certification may not matter and could just be self-reported.

Currently, Medicaid uses national accreditation and state specific criteria set in regulation as a standard. A private payer uses its own standards, which they review collaboratively with providers. The need to shift provider thinking towards greater collaboration with payers was discussed. One private payer described their use of a pay for performance structure before moving providers into an ACO. The group discussed the potential need to provide professional guidance given that not all providers will be on the exact same path.

The group discussed engaging patients in this process, determining if they are receiving information in a timely fashion, or if they understood their discharge paperwork.

Review how HIT and payment work groups propose to enable care delivery model

The group looked at the context of care within the state. Connecticut has a large number of unaffiliated practitioners. To that end, the payment reform group has developed a two track system that supports movement of all practices towards managing the total cost of patients' care. There would be a low bar for entry in the first year to allow for adoption of pay for performance structure and to begin to work on transformation. The model would evolve so that an increasing proportion of providers would take on total cost of care accountability.

The payment work group continues to work on defining metrics for each of the tracks. It was noted that the payment work group is including metrics which ensure providers maintain or improve the quality of care in addition to reducing costs.

The group discussed the high number of single practitioner primary care sites in the state today. A number of the ACOs in the state include these independent practices. The group discussed the possibility that small practices may need to contract with one of the emerging ACOs to participate in the model. The group discussed better incorporating behavioral health into ACOs. There may be multiple ways to integrate behavioral health but whichever way it happens; it was acknowledged that it will be a key component of the new model.

The Health Information Technology (HIT) work group is discussing the levels of standardization required and has aligned on standardizing reports for providers to review. They are looking at capitalizing on existing infrastructure, prequalifying vendors and creating a market place to support smaller practices in finding practice transformation support. They are also evaluating an interoperability connectivity policy between providers.

Review the Department of Public Health's proposal for a community-based support entity

The group reviewed a proposal from the Department of Public Health to develop certified community-based practice support entities. There has long been a distinction between public health and clinical care. The proposal represents an opportunity to blend the two approaches. Area health education centers and YMCAs could potentially become community based support entities. The entities would need to meet specified requirements, have integrated access to data, and be responsible for providing particular services. DPH has overseen more concentrated efforts that would fit within the concept such as asthma home environmental assessments and diabetes prevention programs.

The work group considered pros and cons associated with the concept. The concept could present an opportunity for improved quality of care and expanded savings. There was a concern about the wages of workers employed at these entities which was acknowledged. The proposal could represent an opportunity to target and address health disparities.

DPH could serve in a quality assurance and certification role. It was discussed that the entities need to be both large and small and include faith based groups, the more "local" and embedded in the community, the better. It was noted that mental health and social services should be incorporated or coordinated with these entities.

Define other provider needs in the new care delivery model; Assess outcomes from today's meeting and outline open questions

The group did not do the break out activity due to a lack of time. Members were asked to review the breakout exercise in the discussions slides and come up with ideas on what is needed for

providers to participate and thrive in the new model. Members were asked to submit their ideas by noon on Wednesday, July 10. A synthesis of the ideas will be shared back with the group.

The group discussion touched on making the proposed system appealing to specialists as they will need to participate in these reforms. Members were asked to think about how specialists will fit within Connecticut's vision for a medical home. For example, specialists may need to think about how they interact with their referral groups, and whether there are services such as screenings that could be done at a lower level. Members were asked to also continue to share their thoughts on this subject.

Meeting adjourned at 8 p.m.