

SIM WORKGROUP COMPOSITION – Draft for discussion

The Healthcare Innovation Steering Committee will determine the size, composition and membership of the Consumer Advisory Board and workgroups for the State Innovation Model initiative. The following guidelines are proposed as a reference for establishing the Consumer Advisory Board and workgroups, other than the workforce council, which will be considered separately. Categories of membership are also proposed for discussion.

Consumer Advisory Board

The Consumer Advisory Board is comprised of a diverse group of individuals many of whom are involved in community development, community services and advocacy. Some represent community development, community health, prevention, and housing. Others bring their own experience such as HIV/AIDS, trauma, cancer, and childhood health/emotional conditions. We have representatives of low-income children and families and an expert in building community partnerships and communications. There is race/ethnic diversity as well.

In its meeting on February 11, the Consumer Advisory Board expressed an interest in adding 4 to 6 consumers whose primary credential is that they are a user of health services. In pursuing the involvement of consumers, the Consumer Advisory Board proposes to solicit the perspective of individuals who have experienced health conditions such as cardio vascular disease, diabetes, asthma, arthritis, psychiatric illness, and/or substance use. Among these should be an older adult who is covered by Medicare fee-for-service and an individual covered by Medicaid. They noted that a single condition should not be the only consideration, as individuals have experience with a variety of challenges in living (i.e., social determinants) that influence their ability to use and benefit from the healthcare system.

A focus on recruiting consumers would bring the issues of quality of care, accessibility, care experience, person centered planning, shared decision making and transparency to the center of our deliberations. These individuals would be among those consumers who would be asked to participate in the workgroups while receiving ongoing education and support from the Consumer Advisory Board. Consideration should also be given to individuals with physical disabilities, intellectual disabilities, or serious and persistent mental illness, especially in the future when special populations become more of a focus under SIM.

The Consumer Advisory Board proposes to make recommendations with an eye toward establishing a diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions.

Workgroups (Councils/Taskforce)

Size and composition

The workgroups proposed in the Innovation Plan will be focused on the production of technical work products. The size of the workgroups is an important consideration. Experts that we have worked with generally recommend workgroups of no more than 9-12 in the interest of efficiency and the development of relationships to support an effective team process. The workgroups will undertake considerable technical material review (e.g., medical home

standards, quality metric sets); they will need to exercise judgment about scope, pacing, and feasibility; and they will need to solve problems. Balancing the need for an efficient group process with the considerable number of stakeholders that must be represented, we would propose to aim for 14-16 members, but set an absolute maximum of 18 members on any workgroup.

There are essentially four broad categories of representation: consumer, private payer, provider, and state agency. We should aim for significant and balanced representation from among these four categories, although there are other considerations that should be taken into account. Consumer/advocate participation must be significant and meaningful on all workgroups. The workgroups will not have the authority to require that any purchaser or provider follow their recommendations. As such it will be important that we have the buy-in of both.

Many physicians in Connecticut have not invested in practice transformation and some remain skeptical as to the value of the proposed reforms. It is important that physician providers see themselves represented in significant numbers on these workgroups if we want the broader physician community to support these recommendations. This can be achieved by including practicing physicians, and also, where possible, physician representatives from the health plans and state agencies.

The buy-in of private payers will be necessary to ensure that recommended changes are adopted by each payer and that implementation is prioritized and adequately resourced. For this reason it is important that all payers with more than 5% market share be invited to participate in the Practice Transformation Task Force, Quality Council, and Equity and Access Council. It is less important that all payers participate in the HIT Council given that much of the work will be undertaken by state agencies and their partners.

Qualifications

Ideal candidates should be broadly supportive of the proposed reforms and well suited to collaborative problem solving and a constructive group process.

For state agencies, private payers, and providers, we should in general express a preference for individuals with subject matter expertise. For example, state agency personnel assigned to the Health Information Technology Council should play a role in the development of enabling technologies in their agencies. Health plan representatives on the Quality Council should have responsibility for oversight of quality measurement or have expertise in the technical aspects of quality measurement, such as a statistician who is familiar with reliability, validity, and statistical power. Primary care physicians that are selected should be working in or towards an advanced practice environment. Specialists should be working in or collaborating with a clinically integrated network or accountable care organization so that they bring direct experience working to achieve team-based, integrated care and performance accountability.

In recommending candidates for participation, we should emphasize diversity, e.g., health plan representatives who play a variety of roles in quality measurement rather than having five statisticians. The Project Management Office may need to actively engage in soliciting the right

mix from the provider, health plan and state agency communities. The Consumer Advisory Board should consider the same in recommending consumers and advocates.

There are a variety of considerations in selecting providers for participation. The preferred size of the workgroups is such that we cannot expect to include the vast array of provider types whose input might be useful to the workgroup's work. We recommend including primary and specialty care physicians on all workgroups and considering behavioral health, and home health providers depending on the focus of the group. Across the various workgroups, we should consider a mix of primary care providers including family medicine, internal medicine, pediatric, and nurse practitioners, as well as large and small group practitioners. Soliciting input from other healthcare providers will be an important part of the workgroup process. This is discussed further under stakeholder engagement.

With respect to consumers and advocates, it is recommended that we express a preference for individuals with expertise related to the care of health conditions. For example, an advocate representative from a condition specific association such as the American Heart Association will have condition specific knowledge of how primary care transformation could better prevent cardio vascular conditions or better serve individuals with such conditions. They may know how practice transformation applies to such conditions, how to consider condition specific quality measures, how access might be compromised, and how health information technology can improve patient care. The same is true of consumers as well as consumer caregivers. It would be preferable to enlist consumers who need or have needed an effective, accessible, and caring health system, whether for the treatment of a serious acute condition or a chronic condition.

Stakeholder engagement

Each workgroup should be asked to consider which stakeholders need to be consulted in order to support the development of their work products. Accordingly, as part of each workgroup charter, workgroups will be asked to develop a plan for stakeholder engagement. Consulting with a larger stakeholder community will help ensure that a variety of perspectives and needs are considered with respect to design and implementation. It will allow for fuller consideration of intended and unintended consequences as well feasibility issues.

We will also recommend that workgroups consider the “design team” concept used by Access Health Connecticut when problems emerge that require a mix of experts from within and outside of the workgroup, or across workgroups. For example, a practice transformation standard involving coordination of care and requiring a particular health information technology solution might require a HIT/Practice Transformation design team with outside participants. Such teams would be convened as needed. They would undertake one or more problem-solving sessions, always task focused and time limited.

With respect to consumers, the project management office will be developing a broader consumer engagement strategy in consultation with the Consumer Advisory Board and the Steering Committee. Workgroups will be expected to utilize this broader strategy or propose an alternative strategy appropriate to their scope and objectives.

There are a sizable number of providers who have expressed interest in the reforms, but who cannot be accommodated at the workgroup table. These include various physician specialties,

long term service and support providers, home health, pharmacists, podiatrists, chiropractors, dentists, nurses, physician assistants, non-medical professionals and a wide variety of behavioral health providers. The same is true of state agencies such as the Departments of Housing, Aging and Development Services and the Offices of the Child Advocate and Early Childhood. These parties will need to be considered in developing the engagement plan.

Time commitment and solicitation of members

The final approved workgroup composition will be posted to the state's website at www.healthreform.ct.gov along with a solicitation for workgroup members. The solicitation will be posted for at least 10 business days. The time commitment will be an important consideration for prospective members. Most workgroups should be asked to complete their detailed design work by October 31, 2014. We should propose a charter for each workgroup before it begins operation, but allow that charter to be amended by the group. While we can leave the actual meeting schedule to the workgroup, we should set an expectation in the solicitation so respondents have some sense of what they are committing to. The expectation is monthly meetings beginning March or April, 2014 and extending through October 2014, followed by bi-monthly or quarterly meetings thereafter as the work of the group requires. Meetings will be approximately two hours duration. We should make every effort to schedule meetings in the early evening (6-8pm) at a central location (or alternating locations) and begin evening meetings with a light meal. Resources permitting, it is recommended that we make arrangements to provide a modest stipend to consumers to offset incidental costs such as mileage and day care expenses.

The proposed draft composition for each workgroup is attached, except for the workforce council.