

STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Taskforce

Meeting Summary
Tuesday, September 9, 2014

Members Present: Lesley Bennett; Mary Boudreau; Claudia Coplein; Leigh Dubnicka; David Finn; Heather Gates; Shirley Girouard; Colleen Harrington (for Michael Michaud); Bernadette Kelleher; Rebecca Mizrachi; Douglas Olson; Rowena Rosenblum-Bergmans; Elsa Stone; Jesse White-Frese; Robert Zavoski

Members Absent: Peter Holowesko; Edmund Kim; Alta Lash; Randy Trowbridge; Joseph Wankerl; Tonya Wiley

Other Participants: Brody McConnell, Mark Schaefer; Marie Smith

Meeting was called to order at 6:03 p.m.

1. Introductions

The participants introduced themselves. Rebecca Mizrachi chaired the meeting.

2. Public Comment

There was no public comment.

3. Charter and Roadmap Updates

Mark Schaefer provided an update on the test grant, including questions received from CMMI on the state's application. The state had a limited timeframe to solicit input on the questions. The response will be posted on the web site and shared with the taskforce. Members were encouraged to email their questions regarding the state's response. Jesse White-Frese asked whether it was a good sign that CMMI came back with questions. Dr. Schaefer said it was encouraging; however, a lot of other states received questions as well. The only area where there appeared to be concerns was in workforce as test grant funding cannot pay for education and training. The state had to clearly spell out what they were asking to be funded.

Marie Smith revisited the charter for the group ([page 3 of the meeting presentation](#)). There was also a need to update the roadmap (page 4 of the meeting presentation). It was asked whether there would be a meeting with the Quality Council to discuss where the work of the two groups might align. Dr. Schaefer said is receptive to considering this further. Once the Taskforce completes its work on the standards, this information will be shared with the Quality Council to enable alignment.

4. AMH vs. CCIP

Brody McConnell gave an overview of the work ahead. The Taskforce will need to develop and build targeted technical assistance (TTA) as part of the Community and Clinical Integration Program (CCIP). For the day's discussion, the group was going to focus on the NCQA 2014 Standards. The group could either determine that certain elements (e.g. behavioral health) be considered "must pass" under the NCQA standards or they could decide that CCIP will be the mechanism to increase behavioral health integration. Mr. McConnell said the AMH and the CCIP are separate programs but

are not mutually exclusive. Dr. Schaefer said that the Taskforce could distinguish between tasks that could be done within an individual practice and other items that would need to be done enterprise-wide.

5. New Key Questions

Dr. Smith revisited the advanced medical home key questions (page 6 of the presentation). Those questions guided the discussion. Rowena Bergmans asked about the penetration of electronic health records (EHR). She was concerned that pediatricians were not part of the EHR initiative. Elsa Stone said that pediatricians that saw a significant number of Medicaid patients were eligible for the program. It is not possible to meet the 2014 NCQA standards without an EHR. The primary target audience for the SIM is federally qualified health centers (FQHCs) and advanced networks which likely already have EHRs, although unaffiliated practices may have the opportunity to apply within available resources.

Heather Gates asked how many practices met the standards. Dr. Schaefer said that was complicated. Between 60 and 70 percent of physicians and APRNs have EHRs. More than 1,000 practices meet either the 2008 or 2011 standards; however, there are 3,200 practicing primary care providers in the State, so a large percentage does not meet the standards. The FQHCs are working to achieve either NCQA or Joint Commission recognition. Robert Zavoiski said that depending on the practice type, Medicaid pays extra on a fee for service basis. That does not apply to FQHCs who have achieved the NCQA accreditation. Dr. Schaefer said all of the payers have different approaches and tend to tailor those approaches to the practice. In discussions with larger enterprises, they have noted that they pursue NCQA because they believe it helps to organize transformation.

Lesley Bennett asked whether free clinics could become medical homes. She said she could talk to them and see if there is a way to include them. Ms. Bergmans noted that the free clinics are 100% privately funded and that, because they help a large number of undocumented individuals, they are hesitant to take federal dollars. They are, however, interested in evolving care models.

6. "NCQA Plus" Activity

The Taskforce broke up into groups to review and discuss standards (beginning on page 7 of the presentation). The groups were asked to write down their answers so they could be synthesized. They could also create an online voting process that the group could utilize for decision making.

Standard 1: Patient-Centered Access

Group 1: The group discussed increasing scoring for categories to incentivize electronic access. The standard was very general and it was difficult to identify indicators for access to team based care.

Group 2: The group said 1A and 1C would remain as is while 1B would become must pass.

Group 3: The group went through each element and agreed with keeping 1 as a critical factor. They asked whether 2 would be at the enterprise level or practice level. For 1B, they said it should be kept critical.

Group 4: The group took a detailed approach. They said 1A should be critical and more clearly defined. Element B should be critical. They thought 1C could be difficult and potentially a burden and should be left as is.

Standard 2: Team Based Care

Group 1: The group thought 2A-4 was a critical factor and the scoring would follow accordingly. The group thought 2B-5 was critical. With 2C, they generally focused on linguistic appropriateness more than anything else and recommended exploring those areas and being sensitive to different cultural factors. They did not get to element D.

Group 2: The group thought 2A should be left as is; 2B factor 1 was critical and factor 5 very important. With Element C, they were concerned it focused only on linguistics and they had questions about that. They thought Element D should be kept as must pass.

Group 3: For Element A, factor 4 should be critical. For Element B, factors 1 and 2 should be critical as they are the basic tenets of a medical home. For Element C, 1 and 2 should be critical. They thought Element D should be kept as a must pass.

Group 4: They thought Element A should be changed to must pass as they understand the value in chronic disease management of seeing the same provider. They began discussing Element B but did not come to a conclusion.

Dr. Smith asked the group to provide feedback on the process. The next steps will be to collect the Standard 1 and 2 documents, consolidate them and send them out to the group for consensus voting. Dr. Schaefer said the Connecticut Health Foundation has expertise in the area of race and ethnicity and could provide guidance on Cultural and Linguistic Appropriateness Standards (CLAS). The Quality Council cannot establish health equity measures unless race and ethnicity data is available for a majority of patients. Dr. Stone said this was part of meaningful use and practices need to collect that data.

The Taskforce's next meeting is scheduled to take place on September 30th at the Connecticut Behavioral Health Partnership in Rocky Hill.

Meeting adjourned at 8:03 p.m.