STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
August 26, 2015

Meeting Location: Connecticut Behavioral Health Partnership, Hartford Room (Suite 3D), 500 Enterprise Drive, Rocky Hill

Members Present: Susan Adams; Lesley Bennett; Mary Boudreau; Grace Damio; Leigh Dubnicka via conference line; Dr. Shirley Girouard via conference line; Beth Greig; Abigail Kelly; Anne Klee; Kate McEvoy; Nydia Rios-Benitez; Dr. Randy Trowbridge via conference line; Joseph Wankerl via conference line; Jesse White-Frese via conference line

Members Absent: David Finn; Heather Gates; Dr. M. Alex Geertsma; Dr. John Harper; Bernadette Kelleher; Dr. Edmund Kim; Alta Lash; Nanfi Lubogo; Rebecca Mizrachi; Dr. Douglas Olson; Rowena Rosenblum-Bergmans; Dr. H. Andrew Selinger; Eileen Smith; Dr. Elsa Stone

Other Participants: Supriyo Chatterjee; Faina Dookh; Dr. Mark Schaefer; Katie Sklarsky

Introductions
The meeting was called to order at 6:09 p.m. Lesley Bennett served as chair. Members and participants introduced themselves.

Public Comment
Supriyo Chatterjee delivered public comment (available here). Ms. Bennett said it could possibly be for a different organization or another state agency. She mentioned it is something that members should be aware of but she is not sure whether it's PTTF's responsibility to deal with directly. Mr. Chatterjee said it pertains because the Cultural Competency CLAS and Medical Homes are part of the SIM project. Dr. Schaefer said they have made their recommendations with regards to the Medical Home and screening them to focus on health equity related issues such as adopting the CLAS element. Dr. Schaefer invited Mr. Chatterjee to discuss the issue offline to see if there is relevance to PTTF's work and circle back to the taskforce. Dr. Girouard mentioned when someone provides public comment to the committee they have an obligation to examine the issues and find out whether or not it is something that should be paid attention to.

Minutes of July 28th Meeting
Motion: to accept the summary of the July 28, 2015 Practice Transformation Taskforce meeting – Abigail Kelly; seconded by Susan Adams.
Discussion: There was no discussion.
Vote: all in favor

Purpose of Today's Meeting
Ms. Bennett said the goal of the meeting was to provide the taskforce the feedback that was provided by Healthcare Innovation Steering Committee (HISC) on Community and Clinical Integration Program (CCIP) design work to date. It is also to will solicit feedback and input on the design approach and guidelines for CCIP interventions – complete conversations on Complex

DRAFT

Patients and patients with Equity Gaps. She said they will obtain feedback and input on the design approach and guidelines for establishing community linkages for all target populations.

Ms. Sklarsky noted that the discussions from the design groups will be brought back to PTTF for review before it is taken to the Healthcare Innovation Steering Committee (HISC).

Ms. Sklarsky expressed thanks to everyone for coming in for an additional PTTF meeting.

Feedback from Health Innovation Steering Committee

Ms. Sklarsky gave an overview of the feedback from HISC (see presentation here). She said the summary of the CCIP work was presented to the HISC on August 13th and HISC provided some suggestions for PTTF to consider. She noted the feedback was overall positive from HISC. Members discussed the summary of suggestions and comments from HISC. Dr. Girouard mentioned not seeing the active role of the patient in the model or anything highlighted regarding patient centeredness and self care but rather a list of what is happening to the patient.

Ms. Sklarsky said they will be talking in more detail about where the patient will be involved with the needs assessment and care plan. She mentioned the patient should be in the center of any plan that is being done, it is helpful to note as they go through the guidelines. Ms. Adams asked what happens to the patient who no longer needs the extra support. Ms. Sklarsky said it would probably be a team decision. She said there is a survey that assesses the patient's readiness to coordinate their own care. The survey is used in the Camden model to show changes in the patient's point of view of how they are transitioning and managing their care.

Ms. Sklarsky mentioned that if the patient is not reaching the specific treatment goals of the care plan there should be a reassessment. Dr. Schaefer suggested modifying the model to show there is a process for the patient that no longer needs active CCIP support, assessing the need for continued support and if there is a need for continued support it loops back. Members discussed the transition of care to traditional outpatient services. Ms. McEvoy suggested a person centered term of self-management or self-directed because it is directed by oneself or one's circle of support.

The group discussed the definition of Complex Patients. Ms. Bennett gave an alternate definition of Complex Patients from Harvard: people or individuals who need extra care due to complicated medical issues often compounded by social, economic, environmental, and behavioral factors. She noted that Harvard's definition encompasses everything that is going to affect the patient. It was noted that there are different views and definitions of complex patients. Dr. Trowbridge said there should be a clinician or someone on the team who has this prospective. He mentioned they shouldn't quantify complex situations. Dr. Trowbridge suggested for it to be a general prospective and letting the team figure out who falls into true complex situations.

Mr. Chatterjee suggested modifying and repositioning the arrow in the picture on slide seven to the center of the diagram. Ms. Sklarsky said it sounds like people want to change the definition of complex. She asked whether members wanted to adopt the definition discussed. Dr. Schaefer suggested, as a matter of protocol, using the established definition of complex and to refine it if needed. Ms. Greig said she agrees with keeping the complex definition and making a comparison. It was noted that the whole team should understand what the definition means.

Ms. White-Frese asked whether participating FQHCs would identify the areas of elective capabilities initially or potentially identify as they go along in the work that they are doing. Ms. Sklarsky said it could be either because if they applied and receive technical assistance to do the core pieces they

DRAFT

may recognize the need for additional support in one of the areas. She said the technical support vendor should help support them in doing it. Ms. White-Frese asked how will there be accountability if the team chooses not to address the need because of the work involved. Ms. Sklarsky said narrowing the target populations and core capabilities was done in a way to note what is needed and what should be done. There is no policing mechanism or any PMO monitoring to confirm there is an issue. Dr. Schaefer said they may be able to propose some options on doing this before it is presented to HISC in October. He mentioned an assessment process on the front end and a periodic or closing gap assessment will need to be factored in.

Ms. Bennett asked whether Care Transitions should be elective. She mentioned it being critical. Dr. Schaefer said it is something that a lot of healthcare systems are already focusing on as core business. The group talked about Care Transitions and whether or not it should be part of the core CCIP guidelines. It was noted that Care Transitions is important. Ms. McEvoy said there is an effort in Connecticut sponsored by Qualidigm to examine this issue and to look at where there is a break down or lack of clear ownership. There is work done by Qualidigm to see how to improve on this.

Dr. Schaefer suggested taking a step back to do an assessment of Qualidigm and discuss what is deemed as core verses optional elective. He said all of the comments will be taken under advisement and they will circle back with some thoughts about where to go with this issue. Ms. Boudreau expressed concern with the group of four being called CCIP Elective Capabilities. She suggested giving it a different name such as "developmental" but is not sure it's the right term. Dr. Girouard suggested calling it "additional considerations" or "additional issues of importance".

Ms. McEvoy expressed concern regarding deferring the conversation and not resolving the issue regarding Care Transitions. Dr. Schaefer said he didn't mean to defer much later and not have it resolved by October for the recommendations. He mentioned wanting to review Qualidigm's information and current work. It was noted that some of the standards are on a payer agnostic basis.

Program Design: Complex Patients & Patients with Equity Gaps

Ms. Sklarsky said they will be focusing on completing the conversation on guidelines for the last several CCIP process steps. She reviewed suggested guidelines for discussion on Complex Patients and Equity Gaps. Ms. Sklarsky asked whether everyone agrees with the big buckets and whether it gives enough guidance. Ms. Greig suggested for the needs assessment to include how the patient is integrated into each one for patient centeredness. Ms. Sklarsky noted that everyone would have to develop a needs assessment to be used as a tool. The needs assessment would require the patients input and identify what the patient feels most challenged by as part of the process.

Dr. Girouard said it should require the patient's full participation not the patient's input. The goals that evolve from the care plan should be the patient's goals not the providers because the goals maybe different. Ms. Sklarsky mentioned it was discussed to not make it overly burdensome for the patient. Ms. Rios-Benitez said it is not for them to determine whether it is a burden for the patient. She mentioned it should start patient centeredness and the patient driving unless it's a situation where the patient does not want to be involved.

Ms. Sklarsky asked whether it was a matter of adopting the language to make more prominent a question to ask up front. Dr. Schaefer said focus should be on the standard which is the direction of the patient instead of the exception. The group discussed the suggested guidelines and the patient being involved in all parts of the assessment. Ms. Sklarsky said it sounds like the group agrees that

the guidelines are more about information that needs to be gathered versus how it's being gathered.

Members discussed the care plan. Ms. Kelly suggested including a section on the care plan that would identify the patient's strengths and natural supports not just everything that is wrong. Ms. Klee mentioned a term called SNAP (strength, needs, abilities, and preferences) to identify care values. It was mentioned that the community health workers (CHW) version would be an important part of the health care record. There may also be components from different people done in a parallel way.
The group discussed whether to consolidate everything under one master care plan and the goals of the care plan. It was noted that the care plan and the interventions are different.

Program Design: Community Linkages
This was not discussed due to a lack of time.

Program Design: Monitoring & Reporting Needs
This was not discussed due to a lack of time.

Next Steps
Ms. Bennett noted the time as being after 8:00 pm. Ms. White-Frese noted that they are only halfway through the meeting presentation slides. She asked whether to anticipate being able to pick up where they left off at the next meeting. Ms. Sklarsky asked for time to figure out the best way to do it and let them know about the plan because they have a lot of information to still go through. Dr. Schaefer agreed. Ms. Bennett asked whether members wanted to continue the meeting for another five minutes or more. Members decided to end the meeting. Ms. Bennett thanked everyone for their participation.

Motion: to adjourn the meeting – Susan Adams; seconded by Shirley Girouard.
Discussion: There was no discussion.
Vote: all in favor

The meeting adjourned at 8:06 p.m.

DRAFT