

STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
December 18, 2018

Meeting Location: This was a Webinar/Conference Call

Members Present: Susan Adams, Supriyo Chatterjee, Maria Dwyer, Heather Gates, Shirley Girouard, Daniel Lawrence, Kate McEvoy, Douglas Olson, Rowena Rosenblum-Bergmans, H. Andrew Selinger, Elsa Stone, Mark Vanacore

Members Absent: Lesley Bennett, Grace Damio, Leigh Dubnicka, M. Alex Geertsma, Anne Klee, Alta Lash, Juan David Ospina, Anita Soutier, Randy Trowbridge, Jesse White-Frese

Other Participants: Mary Jo Condon, Linda Green, Judy Levy, Mark Schaefer, Ellen Bloom, Lisa Honigfeld, Stephanie Burnham, Hillary Deignan, Jeff Lasker, Beth Garrigan, Nadine Repinecz

1. Call to Order

The meeting was called to order at 6:00 p.m. by Ms. Linda Green.

2. Public Comment

Ms. Shirley Girouard sent in two letters for the public comment period. Dr. Elsa Stone proposed these be moved to the executive committee to be studied and then brought back to the Task Force at a later meeting. Dr. Mark Schaefer explained the hope was to discuss primary care capabilities better able to support people with disabilities. Since there is no consensus on the capabilities, the executive team will have to examine this and reassess the timeline of the project and then circle back to the Task Force with updates. Ms. Kate McEvoy asked about the format of broadcasting the Task Force recorded webinars for those unable to attend. Dr. Schaefer explained these are available via the Office of Health Strategies' website, and that he will look into displaying these more prominently. Ms. McEvoy then explained how some are struggling with dissociating the transformation of primary care practice from the financial model, and Dr. Schaefer agreed with her observation.

3. Review and Approval of Meeting Summary

Motion: Dr. Elsa Stone asked for a motion to approve the November 27th meeting summary of the Practice Transformation Task Force meeting.

Ms. Susan Adams made a motion to approve the minutes.

Dr. Doug Olson- seconded.

Discussion: Ms. Shirley Girouard sent in a comment on the meeting minutes in relation to the genomic screening discussion.

Vote: All in favor. None opposed.

4. House Rules Refresh

5. Purpose of Today's Meeting

Ms. Linda Green reviewed the purpose of the meeting which was to review the pediatric capabilities, review recommendations on adult capabilities and alignment with the payment model, and the continued review of the Payment Reform Council work to date.

6. Pediatric Capabilities: Medical Home Care Teams

Ms. Green reviewed the health neighborhood with the Task Force, and the core functions in and around the medical home (while not dictating who is on the care team). The overarching goal is to support child health promotion and wellbeing. Ms. Green then highlighted the expanded medical home care team functions with the Task Force. Ms. Girouard suggested the word “pediatrician” be changed to “primary care provider”, Dr. Andy Selinger added “board certified, residency-trained family physicians”, and Dr. Stone added this should be changed to “primary care clinician”. Dr. Schaefer asked who Dr. Stone envisioned be encompassed in the “primary care clinician” function? Dr. Stone explained she envisioned pediatricians, ACRNS, and PAs (people who are the head of the care team).

Ms. Green then reviewed the medical home care team recommendations and the care coordination recommendations with the Task Force. Ms. Girouard added that care coordination extends beyond the school nurses and to the other providers in the community that have contact with students (i.e. coaches and teachers) as well. Ms. Judy Levy explained that this list was not meant to be limited to just school nurses. Ms. Heather Gates added that stronger linkages to behavioral health are needed and that integrative care in a pediatric practice will not be able to address all the needs of all the kids all the time. Ms. Green explained that there is a separate design group oriented around this that will be discussed during the next Task Force meeting. Ms. Kate McEvoy asked for more detail on integrated care management in Medicaid and if this was in reference to the Administrative Services Organization intensive care management strategies or if it was applying to PCMH+ care coordination activities conducted by the Federally Qualified Health Centers (FQHCs) and Advanced Networks? Ms. Green explained that the provided materials were not intended to be exclusive, and that this effort will make sure to include more good examples. Dr. Schaefer mentioned running the terminology by Ms. McEvoy to ensure its accuracy. Ms. McEvoy added that she was struggling with describing United Way 211 (referring to the provided materials) as a care coordination resource. She recognized its incredible value in terms of the inventory, but asked the Task Force if others felt that it was appropriate to refer to United Way 211 as a care coordination resource? Dr. Schaefer asked the chair if Dr. Lisa Honigfeld could weigh in. Dr. Stone agreed. Dr. Honigfeld then explained that the community feels there is a lot of care coordination out there for children. The general feeling, she continued, is that at some level, we need some coordination of the coordinators. For many practices and issues, United Way 211 is the care coordination and place of triage for children who are at risk for developmental delays.

7. Pediatric Capabilities: Oral Health

Ms. Green reviewed the oral health integration recommendations with the Task Force. Ms. Green explained that the design group was very clear that oral health functions should be integrated into care team functions. Ms. Girouard asked about oral health interventions before age 1, to which a Task Force member replied that varnish begins at age 6 months. Ms. Girouard mentioned a project she worked on that oriented around cleaning mouths before feeding, and a Task Force member explained that there isn’t a point in cleaning if the teeth have not come in yet. Once the teeth emerge, then the fluoride varnish treatment can begin.

8. Community Integration

Ms. Green reviewed the community integration flow-chart with the Task Force and explained how the Advanced Networks or Federally Qualified Health Centers (FQHCs) will facilitate arrangements with community-placed services on behalf of practices that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services. Ms. Girouard added that she would like to think of it as community integration *and* collaboration and that the box in the middle of the flow-chart should be shown going in both directions. The Advanced Network or health center needs to collaborate with the community to determine what is best for that community. More fluidity is needed here, Ms. Girouard stated. Ms. Green then pointed to the arrow depicting the ongoing relationship between the medical home and the health neighborhood. Ms. Green stated the group will work to make this relationship clearer. Ms. Green continued to explain that the recommendation from the design group was to make community integration a core, practice-based service that is facilitated by the network, which makes arrangements with certain community-placed services on behalf of practices to help them meet patient and family needs.

9. Alternative Ways to Access Care

Dr. Schaefer explained that when he reads about universal home visits for new parents, telemedicine visits between patients and providers, phone, text, and email encounters, and eConsults between PCPs and subspecialists, he does so with an eye towards whether he would know these capabilities were happening or not in primary care. In reference to universal home visits, he then asked the Task Force if community-based health workers provide peer parenting support or if they solve for social determinants of health needs? Dr. Stone explained that it depends on the family. For a family that is doing very well, only one in-home visit might be needed and using the community health workers (CHWs) in the practice could help bridge this. All contact with the family also needs to be documented, Dr. Stone continued, for everyone touching that patient needs to know what is going on. Dr. Schaefer asked if there was a way to better assess what it would take for the network to meet this requirement? Ms. Girouard explained that there is an abundance of evidence around home visiting and identifying families at risk and that language would be helpful here. Dr. Stone responded by saying the group will go back and specify. Dr. Schaefer added that he very much supports and appreciates the bold step to propose universal home visits for new parents. It was agreed that a more precise description would be helpful. Ms. Heather Gates asked how this capability differed from the Nurturing Families program that exists in Connecticut, connected to the hospital, and goes out to visit new moms? A Task Force member explained that these programs have strict eligibility requirements, are not connected to the medical home, and the design group favored a more universal capability. Ms. McEvoy explained payers will want to know how these things relate and emphasized the importance of eliminating redundancy and tightening up the language.

Ms. Green reviewed the optional capabilities, partnerships with home visiting services in the community and group well child visits, with the Task Force. Ms. Green then went over expanding PCP expertise through telementoring programs like Project ECHO. A consumer sent in a comment explaining that these trainings should be conducted in collaboration with selected community-based organizations. Ms. Green then reviewed the pediatric capabilities summary table provided to the Task Force and asked the group if they were in support of the discussed capabilities. Ms. Gates noted that she thought the capabilities were very ambitious, but that she would want to see the

payment structure behind them. Her primary concern is that these capabilities will not be implemented appropriately. Ms. Girouard agreed and highlighted her ongoing concern over the payment structure and what happens to access. Dr. Andy Selinger supported the principles provided and compared the pediatric population efforts to the geriatric population. It's about how this is all implanted and paid for, he concluded. Dr. Stone replied that in terms of working out the financials, if this effort does not know what it is aiming for, it can't possibly get there. Ms. Girouard stated that she was not yet ready to make a commitment. Ms. McEvoy asked Dr. Selinger to elaborate on his comparison. Dr. Selinger explained that in geriatrics, the operational capabilities seem to synchronize with the same things we think about in the pediatric population. There is validity to it, he added, and how you deploy and deliver operations that apply to both ages in this spectrum are similar. Ms. McEvoy and Ms. Girouard agreed that these two specializations do not seem comparable. Dr. Stone confirmed that this effort needs to have people who have the sense of a child and the sense of a senior. Ms. Green then summarized that this group has heard concerns about whether these capabilities will roll out once the payment model is completed but did not hear too many objections to the vision presented for pediatric care. Dr. Stone added that she would very much like to see children grow up with this kind of community around them. Ms. Gates agreed that this is an ideal design, but its linkage to a payment model that can successfully implement it is not clear. How do we go from vision to implementation?

Dr. Schafer stated that with a lot of the adult capabilities, we look at supporting chronic illness self-management, more efficient and effective ways to engage patients beyond office visits, and care team members that can solve for problems that sometimes go unsolved. With all these programs, our employer purchasers are expecting a return on investment, in addition to much better, person-centered and effective care outcomes. Some of the capabilities being solved for here pay dividends in the long term, and there are some near-term benefits in the potential reduction in adverse childhood events. The challenge for any payer is to make a longer-term bet. From a process perspective, we are not predicting to be done with this phase of the model design process until May (and it could even run longer). We are going to have to look at what the Payment Reform Council advises and circle back to the Task Force to make adjustments (if needed). Ms. Green thanked the pediatric design subgroup for all their work and time.

Ms. Green moved on to congratulating the Task Force for getting so much done in the past six months. Ms. Green explained that the review of the capabilities will be complete by early January, the design groups have wrapped up, and the Payment Reform Council will wrap up in January as well. Ms. Green then gave an overview of the work ahead, predicting that the final report will be issued in May of 2019. Dr. Schaefer stated that the group will review some of the concerns that were raised with the executive team and will discuss the level of precision necessary to get to where we can complete payment model options. We may revisit in that process with the executive team a realistic time table for completing the capabilities with a level of specificity that allows the Payment Reform Council to complete their work. We will probably have to revisit the timing of the Payment Reform Council but will circle back once the executive team members can meet.

10. Recommendations on Adult Capabilities

Ms. Green reviewed where the Task Force has landed on the recommended capabilities for adults (i.e. team-based care, expert care, and supporting and engaging patients in alternative ways). Ms. Green then asked the Task Force: 1. Do we have the capabilities right (core v. elective, all practices

v. some)? 2. Is there anything to add or take out? 3. Which of these capabilities will need a longer lead time to ramp up?

Ms. Gates asked if the definition of people with disabilities was included. Dr. Schaefer explained that the group that was meeting to discuss individuals with disabilities was primarily focused on physical, intellectual, and neurological people with disabilities (and not so focused on behavioral health disabilities). Ms. Gates replied that there either needs to be a new category for people with these disabilities or they should be included in this. Dr. Schaefer asked if the Advanced Networks and FQHCs are the best place for individuals with psychiatric or addiction-related disabilities, and, if so, it does sound like this has not been given due consideration. When we talk about integrative care, Ms. Gates responded, how do we ensure this population has improved outcomes for their health and how do we meet their primary care needs? Ms. McEvoy emphasized the importance of avoiding the duplication of services when it comes to this issue, and Dr. Doug Olson agreed and asked if primary care services could be or should be optimally provided within an expanded behavioral health home model of care? Ms. McEvoy has had this question over time, and there are multiple ways to solve for this. The more serious the condition, the more she leans towards providing the primary care within the behavioral health setting. Ms. McEvoy emphasized the importance of the definition, in addition to knowing who we are talking about and the severity of the condition. Dr. Schaefer explained that much of the work done around behavioral health integration will go a long way towards enabling the care team to be more sensitive, effective, and engaging towards individuals with a spectrum of behavioral health needs. Dr. Schaefer went on to explain that he believed a bolder and more direct effort to solve for the considerable health inequities and primary care gaps is beyond the scope of this group, and that the group should rely on the behavioral health integration strategy as a substantial step forward in bettering the behavioral health capability in Connecticut. As a clinical psychologist himself, Dr. Schaefer has a deep understanding and respect for this issue and believes that this effort has done something responsive.

Ms. Girouard emphasized the importance of ensuring that everyone has access to primary care (even if they have serious complex conditions), and that the definitions are essential to moving forward. Dr. Doug Olson agreed, but went on to highlight that the higher the risk population, the more resources they require, and the model laid out addresses the need of additional resources (where there is additional risk). Ms. Girouard responded by saying it will be a terrible thing to delete the most vulnerable population from this effort, to which Dr. Olson completely agreed. Another Task Force member explained how she fully supports integrative care, but that this effort needs to be explicit about how each of these components can be implemented depending on the needs of the individual. Dr. Stone concluded that this is a good start and that she supports it.

11. Review of Payment Reform Council Work to Date

Ms. Mary Jo Condon reviewed the hypothetical cost estimated for the core capabilities with the Task Force. Ms. Condon explained how the provided cost estimates are mainly for the adult core capabilities, that the estimates are based on literature and are not actuarial assessments, and that the thinking here was that the hypothetical cost estimates would roll up. The provided materials, explained Ms. Condon, begin to show how these capabilities will be paid for over time.

When discussing the accountability process, Ms. McEvoy stated that this tracks consistently with the tools and strategies they use for PCMH+ and that the feedback heard from stakeholders has

been: If the services are bundled, and there's no longer the detailed coding, what will be the basis for claims analysis? Ms. McEvoy continued by describing the risk associated with bundling payments for Medicaid members and how this could incentivize underservice. Ms. Condon acknowledged Ms. McEvoy's concerns and explained that this effort has examined the strategy behind CPC+ and saw that they have some very specific approaches to looking at the generated data for any possible decreases in patient contact. Ms. Condon added that looking at office visits through the shadow claims will also be important, as well as looking at the connections to the care team members. It is important to have that data recorded and have there be financial or correction plans for those who do not play by the rules. Dr. Schaefer stated that he believes there is universal agreement around the need for transparency and accountability with regard to patient visits and contacts. The Payment Reform Council had a discussion where the payers felt that shadow claiming should be continued for as long as needed. If there is a basic bundle, Dr. Schaefer continued, the question is: Do we defeat the aim of reducing administrative burden by encumbering with shadow claims and are there trusted EHR-based alternatives to reporting care team contacts (including PCP contacts)? Ms. Condon added that advocates have raised some concerns that downside risk options might not be the best approach for Medicaid and for certain providers. If Medicaid participates, Ms. Condon continued, this effort recommends that Medicaid considers some other model options that might begin to address some of the concerns around under service and patient selection.

12. Adjourn

Dr. Olson made a motion to adjourn the meeting.

The meeting adjourned at 8:00pm.