Primary Care Subgroup Meeting
August 24, 2021

Meeting Date	Meeting Time	Location
August 24, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

Members Present:		
Dr. Mario Garcia	Lisa Honigfeld	Dashni Sathasivam
Heather Gates	Dr. Leslie Miller	Marie Smith
Dr. Alex Geertsma	Dr. Naomi Nomizu	Dr. Elsa Stone
Dr. Shirley Girouard	Lori Pennito	Dr. Randy Trowbridge
Karen Hlavac	Dr. Brad Richards	
Others Present:		
Michael Bailit, Bailit Health	Grace Flaherty, Bailit Health	Kelly Sinko, OHS
Erin Campbell, Bailit Health	Hanna Nagy, OHS	Jeannina Thompson, OHS
Members Absent:		
Lesley Bennett	April Greene	Rachel Southard
Rowena Bergmans	Ken Lalime	Lisa Trumble
Stephanie Caiazzo	Hugh Penny	Tom Woodruff
Dr. Seth Clohosey	Theresa Riordan	

Meeting Information is located at: https://portal.ct.gov/OHS/Pages/Primary-Care-Subgroup/Meeting-Agendas

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Hanna Nagy, OHS**
	Hanna Nagy called the meeting to order at 1:02PM. Jeannina Thompson administered the roll call. There was not a quorum.	
2.	**Public Comment**	**Hanna Nagy. OHS**
	Hanna Nagy invited public comment. None was voiced.	
3.	**Approval of the July 27th Meeting Minutes**	**Hanna Nagy, OHS**
	Given there was no quorum, the July 27th meeting minutes were not moved to be approved. Hanna confirmed that the meeting could proceed without a quorum.	
4.	**Follow-ups from July 27th Meeting**	**Erin Campbell, Bailit Health**
	Erin Campbell reviewed the agenda for the meeting. Erin recapped the discussion and Subgroup member feedback from the July 27th Subgroup meeting. Erin reminded the Subgroup that several members felt strongly that adoption of a primary care definition was critical and the Subgroup requested an additional review of core practice team functions. Erin shared that since July, OHS had continued to engage stakeholders to solicit feedback on draft primary care proposals. Kelly Sinko made introductory comments. Kelly expressed appreciation of Subgroup member feedback on the primary care definition and the core functions. Kelly said the August meeting would conclude the conversation on the primary care definition and core practice team functions. Kelly said more work would be done to add additional detail to core functions for implementation and evaluation after roadmap completion. Kelly asked if there were any questions on the process as she described it. There were no questions.	

Erin shared the proposed primary care definition, adopted from the National Academies of Sciences, Engineering, and Medicine, and asked the Subgroup if any members objected to adopting the definition.

- *High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.*

Discussion:

- Elsa Stone suggested that language be added to emphasize the personal relationship between clinicians and their patients and the need to have one clinician responsible for each patient. Erin Campbell suggested "interprofessional teams led by a lead clinician." Elsa suggested "clinician having a sustained relationship with patients."
- Shirley Girouard said she did not think the definition as proposed precluded a relationship between clinicians and their patients. Shirley said given there was not a quorum the Subgroup needed to wait to vote on the definition. Kelly Sinko confirmed that the group would need a quorum to vote.
- Mario Garcia said he did not object to the primary care definition but asked for clarification on the phrase "across settings." Michael Bailit said "across settings" meant across care settings – not only primary care but also when the patient is in a facility or at home. Mario mentioned the Health and Housing Community Model and the opportunity for primary care to work across the clinical and community settings. Shirley Girouard said the proposed definition does include community settings.
- Elsa Stone read an alternative Institute of Medicine (IOM) definition of primary care. Erin and Shirley Girouard clarified the proposed definition is the most recent version from the IOM (now named the National Academies of Sciences, Engineering, and Medicine).
- **Next Step**: Bailit Health and OHS will consider Subgroup member feedback on the proposed primary care definition.

Erin shared the latest draft of the core practice team functions, which were modified following OHS consideration of recent Subgroup and external stakeholder feedback.

1. *Care delivery is centered around what matters to the patient*, developing trusted relationships with patients, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.*
2. *Care delivery is team-based, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.*
3. *Practice teams formally designate a lead clinician for each patient. That person fosters a continuous, longitudinal relationship.*
4. *The practice team coordinates care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) qualified embedded clinical care management personnel to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) embedded non-clinical care coordination personnel to connect all patients with community supports to address social risk factors, and work with families and other caregivers.***
5. *Behavioral health is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.***
6. *The practice team delivers "planned care" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.*

7. *Care is easily accessible and prompt, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally competent.*
8. *Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by EHR clinical decision support.*
9. *Patients are engaged and supported for healthy living and management of chronic conditions.*
10. *The practice team utilizes patient information in conjunction with data from an EHR (when utilized by the practice), HIE, pharmacies, and payers to identify patient care needs, monitor change over time, and inform targeted quality and equity improvement activity, including design and implementation of quality improvement plans.*
11. *The practice team demonstrates an awareness of health and social issues in the community it serves and delivers community-oriented care to address health and social needs.*

**All references to word "patient" include patient and/or family caregiver.*
***Alternative approaches involving virtual care may be required for very small practices, including those in rural communities.*

Erin shared that OHS received feedback from one member that #11 should not be required, based on a voiced opinion that "delivering" community-oriented care was not feasible for practices to implement. Erin asked for the Subgroup's reaction to this feedback.

Discussion on Core Functions:

- Shirley Girouard said the core functions should be revised to be actionable because they read as characteristics more than functions.
- Alex Geertsma agreed with Shirley and said distinguishing between functions and characteristics was important for evaluating performance.

Discussion on Core Function #4:

- Marie Smith asked for clarification on the phrase "qualified embedded clinical care management personnel" because multiple members of a care team could share care management responsibilities. Michael Bailit clarified that the term "personnel" allowed for multiple people because different care management teams will have different compositions based on their resources. Marie agreed with Michael's interpretation and suggested adding a clarification to the core function.
- Alex Geertsma said it was important to balance having multiple people coordinating care and diffusing the care coordination responsibility. Alex also said care coordination curricula for clinical personnel might be necessary for accreditation and payment.
- Naomi Nomizu asked for definitions of "embedded" and "non-clinical care." Erin clarified that "embedded" implied the personnel would be physically located in the practice, although virtual care may be required for small practices. Michael Bailit clarified that care management personal would be part of the practice (at least from time to time) and it would not be a wholly telephonic function. Erin further clarified that there would be a different set of staff doing non-clinical care. Naomi said the same personnel may handle both clinical and non-clinical coordination. Michael agreed that the two functions could be integrated in a small practice.
- Alex Geertsma said, based on his experience with the PCMH for Chronic Disease in Children, it was in the interest of the patients to have embedded care managers with an allegiance to the patients and the practice.
- Shirley Girouard suggested changing the word embedded to "an established or formal relationship" or "contractual relationship." Leslie Miller said she agreed with Shirley in that she

did not like the word embedded because smaller practices may have different strategies to approaching care coordination.

Discussion on Core Function #5:

- Leslie Miller said she wished OHS would define the core functions more clearly. Michael clarified that the functions as written in the Roadmap would not be ready to operationalize but would be better defined in the future in collaboration with practices, both large and small.

Discussion on Core Function #7:

- Dashni Sathasivam suggested that the function be revised to read "and is culturally and linguistically competent."

Discussion on Core Function #9:

- Elsa Stone said providers seek to engage patients but providers cannot control whether or not patients are engaged.
- Randy Trowbridge said patient engagement is critical to health outcomes and patients should be incentivized to improve engagement.
- Leslie Miller agreed with Randy and said that doctors need adequate time to educate patients. Leslie suggested rephrasing the function to include "practices encourage engagement of patients."
- Lori Pennito suggested replacing the word "engaged" with "activated" and said clinicians can receive training to improve patient activation.
- Naomi Nomizu suggested "the practice shall engage and support patients in the self-management of chronic conditions and in healthy living." Naomi agreed with Lori Pennito that patients should be activated but said it does not mean patients will adhere to everything they are told to do.
- Shirley Girouard said patients resisting prescribed care does not imply a lack of engagement and said the patient has ultimate responsibility to do whatever they wish, even if they do not agree.
- Leslie Miller said she wished there were more practicing health care providers in the group and mentioned the Roadmap's potential administrative burden on providers.
- Alex Geertsma said he hoped resources would be allocated to mitigate the impediments facing primary care providers, such as lower-level staff to handle paperwork, so providers could focus on engagement.

Discussion on Core Function #11:

- Erin asked the Subgroup if it thought core function #11 should be required because OHS received feedback that "delivering" community-oriented care was not feasible for practices to implement.
- Lisa Honigfeld said that 10-20% of health is impacted by the medical sphere and the other 80-90% of health is influenced by other spheres. If a practice cannot accomplish core function #11 then it will not deliver value or achieve a healthy population.
- Shirley Girouard said practices both large and small should be involved with their communities, however, "demonstrates awareness" would be hard to measure.
- Leslie Miller asked how practices would prove achievement of this function. Michael Bailit said he was not yet sure how the function would be evaluated and said he planned to consult with Brad Richards about evaluation. Brad Richards acknowledged that the function was aspirational and would be difficult to implement in the current model of primary care. Leslie cautioned against overburdening providers.
- Elsa Stone said the function as written was a public health function and not a responsibility of primary care providers.

Erin shared the practice coaching proposal, modified based on OHS consideration of recent feedback.

1. *Practice teams seeking enhanced payments are required to demonstrate mastery of all 11 core functions.*
2. *Practice coaching is offered to practices to support achievement of core functions and primarily provided by an OHS-contracted third party, with shared funding provided on a pro rata basis by the state's largest commercial insurers.*
    - *Practice teams undergo an initial and then a periodic assessment to evaluate practice team functionality relative to the 11 core functions.*
3. *Some practice teams may alternatively elect to instead receive practice coaching from the following alternative sources if the source demonstrates a commitment to and plan for addressing the 11 core practice team functions in its coaching:*
    a. *commercial insurer*
    b. *internal organization or external resources*
4. *Regardless of the coaching vehicle, practice teams must demonstrate mastery of the core functions to the satisfaction of the OHS-contracted third party.*

Discussion:

- Shirley Girouard said the first statement implied that the providers would not receive money until they demonstrated competencies. Erin Campbell clarified that if practices expressed intent to achieve mastery of the 11 core functions they would be eligible for the enhanced payments. Michael Bailit added that practices would have two years to demonstrate mastery and could receive practice coaching. Shirley said this was not clear in the first statement.
- Leslie Miller said she thought the Subgroup had decided there would be one central coach. Michael clarified that OHS started by proposing that one contracted third party would provide practice coaching, but then heard (1) from insurers that some of them already engage practices in coaching and wanted to maintain these relationships, and (2) from the Subgroup that some practices had their own resources and wouldn't desire an external practice coach. Based on this feedback, OHS was proposing that practices could, if they chose, receive coaching from an insurer, from internal practice coaching resources, or receive coaching from the OHS-contracted third party.

5.	**Continuation of Roadmap Development**	**Michael Bailit, Bailit Health**

Revisiting Primary Care Payment Model Options

Michael Bailit said that the Subgroup would continue its review of a proposal for a prospective primary care payment model to the utilized as a fee-for-service alternative. Michael said the Subgroup would also newly review proposals for hybrid primary care payment models that combine varying levels of capitated and fee-for-service payments and chronic condition episode-of-care bundles.

Michael summarized the potential benefits to primary care practices of a prospective payment model, explaining it offers flexibility, allows for use of different care modalities, provides a predictable cash flow, and does not transfer significant financial risk to the practice.

Michael shared the proposed primary care payment model for Subgroup consideration.

- *Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel.*
- *Insurers can elect to enhance payments to practices however they like in order to hit the primary care spending target; the mode is not specified in OHS' recommendations.*

Discussion:

- Leslie Miller said doctors may opt out of the added payments because of the additional paperwork. Michael expressed understanding of potential physician skepticism, sharing he has seen value-

based payment models where payers offered big incentives opportunities and did not pay them out. Michael suggested OHS address at a future meeting how it will get commitment from insurers that they will spend up to the primary care spending target and how it will ensure the OHS recognition process has integrity but is not overly burdensome to practices.

- Naomi Nomizu asked whether the prospective payments were meant to offset additional infrastructure costs. Michael confirmed the extra payments would support practices in achieving the core functions. Naomi asked whether there would be ratios of care managers and clinicians to the population. Michael said he was not sure; this was a level of operational detail to work out after Roadmap completion.
- Elsa Stone asked whether the Subgroup could be more prescriptive to the payers. Michael said the primary care spend target was prescriptive but the current proposed vehicle for insurers increasing spending was flexible.
- Shirley Girouard asked where the additional money for primary care would come from. Michael said the money would come from the significant slowing of spending growth in alignment with the cost growth benchmark – a reapportionment of spending. Michael mentioned the example of the successful primary care spending target in Rhode Island.
- Alex Geertsma asked why the primary care spending target was set at 10 percent? Michael said he did not know the answer to why the Governor used 10% in his January 2020 executive order, but speculated it may have been inspired by Rhode Island's (RI) original 10 percent target. Alex asked whether RI's target led to improvements. Michael said RI insurers achieved the target, but there has not been a controlled study on the impact on practice performance. He added that RI primary care providers did feel that primary care spend target had been beneficial to primary care in RI.

Michael shared the six recommended parameters for insurer implementation of the proposed alternative primary care payment model, to be offered as a voluntary option to practices:

- *Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel*
  - *Risk-adjusted payments based on clinical complexity or by age and gender*
  - *Prospective patient attribution*
  - *Measures and monitoring practices to protect against stinting of care and undesired adverse risks*
  - *Multi-payer alignment on contractual primary care quality measures*
  - *Practice eligibility for substantial incentive payments based on quality performance*
  - *Data sharing and education*

Discussion:

- Leslie Miller said patients are keenly aware of what model is forced upon providers and would pressure doctors to make referrals. Leslie suggested incentivizing patients to stay with their primary care doctor.
- Shirley Girouard mentioned the challenges of risk adjustment and said risk adjustment based on race was missing. Shirley also mentioned patient churn because of insurance changes. Shirley wondered if insurers would agree on common quality measures.
- Lisa Honigfeld asked if there was room for considering payment incentives for outcome measures. Michael clarified that outcome measures were included under the quality measures umbrella that includes process and outcome measures.
- Alex Geertsma said that pediatric measures are primarily prevention measures and outcome measures apply more to adult medicine.

	Michael asked Subgroup members to email any additional feedback to Hanna Nagy prior to the next meeting. Michael said the Subgroup would start with discussing alternative payment models at the beginning of the next meeting.	
6.	**Next Steps and Wrap-Up**	**Hanna Nagy, OHS**
	Hanna Nagy noted the schedule change for the November and December meetings.	
7.	**Meeting Adjournment**	**Hanna Nagy, OHS**
	Lisa Honigfeld made a motion to adjourn the meeting. Naomi Nomizu seconded the motion. There were no objections. The meeting adjourned at 2:56pm.	