Connecticut Primary Care Modernization Initiative **DRAFT**

OHS CONNECTICUT Office of Health Strategy

Draft Response to Consumer Advisory Board Questions dated 10/3/18, 2/14/19 and 2/20/19

Introduction

The Office of Health Strategy (OHS) received a memo from Arlene Murphy and Kevin Galvin, Co-chairs, Consumer Advisory Board dated February 20, 2019 compiled consumer comments and questions regarding the Primary Care Modernization design initiative. The February 20, 2019 memo is attached below:

PCM-Consumer-Questions-and-Concern

Background: A report and recommendations of the Practice Transformation Task Force (Task Force) entitled *Primary Care Payment Reform: Unlocking the Potential of Primary Care* was published on June 14, 2018. In this report, the Task Force recommended that Connecticut's payers and providers implement reforms to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement because such diverse methods of care have been shown to improve health outcomes for consumers and, over time, reduce costs. The Task Force urged the state to engage Medicare and the State's public and private payers to examine how to make such reforms a reality in Connecticut.

Since the report was published, OHS has begun referring to the strategy outlined in the report as Primary Care Modernization. Primary Care Modernization is a high priority for OHS because we believe it offers a pathway to a systemic transformation in person-centered primary care delivery in Connecticut that will advance our mission to promote equal access to high quality health care, improve health, and control costs.

The PCM design process, like all projects undertaken by SIM and OHS generally, is built on substantial engagement with stakeholders representing providers, payers, consumers, employers and government leaders. The goals of engagement are to listen, to receive and integrate the best ideas and thinking from a broad spectrum of people who are experts and participants in this system, and to achieve broad consensus across these sectors on a framework for the future. Our work this year should be characterized as a research, engagement and design process.

Our goal is to prepare a PCM program model as an option for consideration by this administration. The design of this program model will be substantive and detailed so that we can all consider how the model will benefit patients and whether it will improve affordability. It will define proposed practice capabilities that will better support patients and model payment options that will enable providers to achieve these capabilities while ensuring affordability. The program design will specify methods for maximizing benefits to patients and safeguarding against risks.

We are grateful to all of the many stakeholders that provided input into and reviewed and commented on the original draft report. In reviewing the comments, a variety of themes were evident. Providers identified the

need to reverse the high levels of physician burnout and administrative burden that is a dominant feature of primary care practice today. They endorsed the importance of investing more in primary care and ensuring that flexibility in practice can be maintained without losing visit-based revenue. Some consumers expressed concerns about whether the specific types of practice capabilities would improve care for particular consumers such as people living with disabilities, and also raised concerns about whether the payment models could adversely affect access to care for all patients. Our academic commenters noted the importance of coordinating with medical education and residency training programs and ensuring that we make primary care an attractive training and career destination for tomorrow's physicians. Others noted the critical importance of new team members, such as pharmacists and community health workers; the need to better integrate primary care with community supports to address social determinant risks; and addressing urgent concerns such as health equity, behavioral health integration, workforce adequacy, and the needs of consumers with limited English proficiency.

A number of commenters emphasized the importance of robust monitoring and evaluation and the need for safeguards to ensure that patients are protected from the risk of under-service or patient selection, and that the additional funds and flexibility are well invested to the benefit of patients. In many cases, the comments resulted in specific modifications to the report or recommendations. In all cases, the comments inform the design work that lies ahead and the attached advisory process that is our guide.

Finally, in commenting on the proposed bundled payment model options, we would like to take a moment to clarify terminology. We have followed the more recent convention of using the term "bundled payment" to refer to payment methods that bundle the costs associated with specific services, procedures or conditions. This convention is reflected in the following articles from the Harvard Business Review:

https://hbr.org/2016/07/how-to-pay-for-health-care
https://hbr.org/2016/07/the-case-for-capitation

In these articles, the term capitation is used to refer to models in which a provider organization or managed care organization is paid a monthly premium for all or nearly all of the costs of care (e.g., hospital, physicians, home health, ambulatory surgery, rehabilitation, etc.). To avoid confusion we use the term bundled payment rather than capitation to refer to the bundling of primary care services, whether rendered by a PCP (Basic Bundle) or by members of the primary care team (Supplemental Bundle). Given the above, it is important to note that the Payment Reform Council has not recommended capitation in the form of a monthly payment for all of the costs of care. We recognize that this convention is not reflected in CMMI's primary care payment reform, Direct Contracting.

Regardless of terminology, we recognize the concerns of some advocates that bundled payment may result in less care for a population, such as people with disabilities.

All of the public comments received in response to the original report and other PCM related planning materials are posted on our website. Comments are provided in full as submitted to OHS, except that formatting has not been preserved and citations have been removed.

This document includes current information and responses but we wish to note that we are writing it in a continuously changing environment as things evolve at the state and federal levels.

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19, page 1:

1. Consumers have expressed concerns that the proposed bundled payment would be at downside risk for all or most of care. This means that providers could lose reimbursement if they do not generate enough savings in all medical expenses.

Response: This question about payment models, together with questions 2, 3 and 4 below, have been the most significant and urgently raised concerns about the PCM draft proposals. As we understand it, CAB members are here raising the very important question about how we design a payment system with new financial incentives and risks to providers that, at the same time, ensures that providers do not increase their revenue by denying care or turning away patients who require the most care. This is an essential question, as any proposed model is intended to make it *more viable* to provide flexible and preventive care, in the office and in the community, by paying primary care providers adequately and in advance, so they can hire diverse care team members and routinely provide better services to patients. The goal is to balance the incentives for increased, flexible, preventive and integrated care with safeguards against misuse of the payment model to the detriment of patients. Here are some of the strategies:

- Providing higher risk-adjusted payments for patients with complex medical and social needs;
- Monitoring the volume of patient encounters and “touches” to flag under-service;
- Consumer surveys to determine whether primary care services are more accessible and convenient;
- Deploying quality measures to hold providers accountable for good health outcomes.

This payment model offers an alternative to fee-for-service payment models that reward providers for the volume of medical visits, tests and treatments, but under-reimburse providers that are eager to offer care that is more convenient for consumers, whole-person centered care and focused on prevention and patient well-being.

The Payment Reform Council (PRC) is not specifically recommending or requiring downside risk. The PRC has recommended that the PCM primary care payments be coupled with the Medicare Shared Savings Program (MSSP) or another shared savings program model that provides accountability for total cost of care. The PRC has not taken a final vote on a recommendation as to whether the shared savings program model should include downside risk. Recently, Medicare introduced new rules for the Medicare Shared Savings Program that require providers to accept some downside risk within two or three years of participating. MSSP participating providers in CT will be required to take downside risk, whether or not they participate in PCM. It is likely that the Council will leave the question of downside risk to the discretion of payers other than Medicare, whether commercial or Medicaid, should they decide to participate in PCM.

2. It is unclear how the payment model would improve care for patients and families. For example, some of the most important elements of primary care reform (care coordination, community integration) would be funded through the Supplemental Bundle. The Basic Bundle appears to only include payment for physicians, physician assistants, advanced practice nurses and telehealth.

Response: The PCM payment model is currently a straw model...which is to say that it has not been finalized pending additional stakeholder input and further PRC deliberations. As referenced in the question, the straw model has two components, a Basic Bundle and a Supplemental Bundle, which support the kinds of activities referenced in the question. Together, the Basic and Supplemental Bundles are intended to allow a step-by-step adoption and growth opportunity for providers: The Basic Bundle would be a monthly advance payment to cover the time of primary care clinicians, including physicians, advanced practice nurse

practitioners and physician assistants. This would enable primary care clinicians to treat patients based on their needs and preferences, without worrying whether the support they provide is billable. It would allow PCPs to work more with patients through video visits, phone, text, and e-mail, and to offer home visits. The Supplemental Bundle would be an upfront, monthly payment to hire community health workers, navigators, care coordinators, health coaches and pharmacists to provide team-based care. It would also allow them to introduce patient financial incentives and also to cover occasional one-time non-health care expenses to improve outcomes such as carpet cleaning for someone with asthma.

The PTTF prepared a compendium of two page summaries of the capabilities that the bundled payments are intended to enable. These two-page summaries outline the benefits to patients, families and providers and also to the goal of improving health equity. https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCM-Capabilities-Compendium-updated.pdf?la=en

3. It has not been demonstrated how the proposed payment model would address Connecticut's significant health disparities. For example, providers may be required to evaluate social determinants of health. However, funding maybe insufficient to address identified needs. How will the payment model support the services needed to respond to these assessments?

   Response: The above referenced two-page summaries describes how each capability will help to reduce health disparities. In general, the PCM capabilities that would be supported by the proposed model would work together to address barriers to care such as language differences, cultural differences, lack of transportation, lack of childcare, lack of flexibility to take time from work, and low literacy. The PCM model would also invest in patient support and care coordination that would increase early testing and prevention, and assist all patients with securing and maintaining needed medications.

   Some communities will require more substantial investments to address root-cause social determinant risks such as unsafe or unaffordable housing. The health care providers that participate in PCM would also be expected to participate in cross-sector collaboratives as part of the Health Enhancement Community initiative. Health Enhancement Communities will foster investments in these types of larger scale, place-based solutions.

4. It has not been demonstrated how the payment model supports the infrastructure needed to measure, evaluate and address access, quality or care and patient experience.

   Response: The PRC recommends that providers be permitted to use the Supplemental Bundle funds to pay for infrastructure costs needed to measure and address access, quality of care and patient experienceas they relate to the proposed PCM capabilities

B. Comments and questions originally received from Members of the Consumer Advisory Board in 2018, with original responses and updates (questions resubmitted in memo dated 2/13/19, pages 2 and 3)

As part of our planning and public comment process, SIM produced a comprehensive "Response to Public Comments," dated June 14, 2018. The questions below were submitted last year, and our original responses are reproduced below, for your convenience. Where appropriate, we have added an update to our response from last June. The entire document from 2018 can be found here: https://portal.ct.gov/-

/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCM_Response_to_Comments_Final_20180614.pdf?la=en

1. Ann Smith asked when Dr. Schaefer was commenting on the slide about Primary Care Modernization capabilities, was it an oversight, intentional, or not an important element of the model to include Behavioral Health Integration.

   Original Response: The omission was an oversight. The slide correctly reflects the importance of Behavioral Health Integration, which will need to be included in the Primary Care Modernization design, consistent with Recommendation 8 of the report. **The Task Force is committed to including behavioral health integration as an essential feature of the PCM model design.** (p. 34)

   Updated Response: The Task Force included Behavioral Health Integration as a required capability in the PCM straw model. Please see the adult and pediatric concept maps and the two-page summary in the design group reports: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCM-Capabilities-Compendium-updated.pdf?la=en

2. Jan Van Tassel said PTTF Recommendations mentioned that providers need to be sure that they are able to measure quality and under-service. She said that this needs to be part of the package. She asked are we going to have an effective way to measure quality and measure under-service?

   Original Response: Recommendation 10 acknowledges the importance of measuring quality. It is not known at this time whether additional quality measures will be recommended above and beyond those primary care quality measures that are already part of each payer's shared savings program arrangement. We continue to encourage all payers to adopt the Core Measures recommended by the SIM Quality Council.

   Recommendation 10 also speaks to ensuring that providers demonstration transformational change. This recommendation has been further modified to reference the importance of monitoring level of service and equitable access. We envision that the EHRs of participating practices may be required to report the number of patient "touches" in addition to direct patient encounters. (p. 34)

   > **Recommendation 10:** Payers that utilize primary care payment models should a) ensure that quality of care is measured and rewarded, b) should employ minimally burdensome methods that are aligned across payers for comparable populations (e.g., Medicaid, Medicare, commercial) to enable practices to demonstrate that they are investing in and have implemented transformational change (e.g., care team composition, engagement in non-visit-based activities), and c) should monitor to ensure that the changes result in appropriate care team composition, utilization and equitable access for all. The State must demonstrate, prior to implementation, that systems and procedures are in place to monitor the impact of reforms on consumers in a timely manner. Such monitoring should include, but not be limited to, under service, access to office visits, patient selection, care experience and investments in innovative practices. The provision of rapid-cycle feedback to payers, providers and consumer stakeholders is intended to enable continuous learning and improvement, recognizing that the great majority of participants in healthcare are focused on improving access and quality. However, such information also provides purchasers with the ability to take action when problems persist.

The Task Force will ensure that the provisional payment design options including the methods for ensuring that flexible funds are wisely invested and that patients are protected from the risk of under-service (e.g., loss of access to office-visits) and patient selection. Additional information on this point is provided in the response to Question #22.

Updated Response: One of the concerns about the Basic Bundle is that a team might provide less care because the practice is not paid for each visit. The proposed models include public contact/encounter reporting that would be required of PCM participating providers. This transparency will help ensure that providers use the flexibility of the Basic Bundle to provide more rather than fewer services to patients. A reduction in the level of service would trigger a review and possible corrective action. We have developed examples of the reporting and a graphical illustration of change in level of service over time.

3. Robin Lamott Sparks described a meeting about Integrated Mobile Health held because 60% of 911 calls in their community are not emergencies. If people call 911 for healthcare, care coordinators do not get to see them. Robin Lamott Sparks said we have not talked about integrating the existing system and transition. She noted the need to address what is going on in the cities.

Original Response: The Task Force recognizes that misuse of 911 is a problem that undermines our efforts to ensure that patients get the right care, in the right setting at the right time. The Task Force will examine areas where work with related systems, agencies and policies may be needed to better support primary care patient engagement and the use of enhanced primary care teams and capabilities.

In addition, bundled or capitated payments can provide the opportunity for practices to create new creative partnerships that support a better, more person-centered care experience, while also reducing avoidable costs. For example, Commonwealth Care Alliance used the flexibility afforded by capitated payment to payment for community paramedicine as an extension or enabler of advanced primary care. OHS is currently participating in a Mobile Integrated Health Workgroup convened by the Department of Public Health. Depending on the outcome of this work group process, the proposed PCM program model may afford an opportunity for Advanced Networks and FQHCs to design and test local community paramedicine partnerships.

Updated Response: The Task Force recognizes the value of coordination with providers of Emergency Medical Service (EMS) providers. Specifically, the Task Force is recommending that PCM enable non-emergency service partnerships with EMS providers that would support care for patient with more complex needs at home. These partnerships would enable the provision of community paramedicine (also known as mobile integrated health) and the use of funds in the Supplemental Bundle to purchase access to such services. Community paramedicine was specifically supported by the Task Force as part of the Community Purchasing Partnerships capability, which is summarized in a two-pager. We anticipate that such partnerships may reduce 911 calls that are not emergencies.

In order for PCM providers to contract for community paramedicine services, such services need to be recognized within the scope of EMS. Public Act 17-146 Section 45 requires the Department of Public Health, within available appropriations and in consultation with the Departments of Insurance and Social Services, to convene a 24 member working group to review specific tasks related to the implementation of a mobile integrated health program that would allow a paramedic to provide community based healthcare within their scope of practice. Additionally, the legislation required the Department of Public Health to make recommendations regarding transportation of a patient to a destination other than an emergency department. The program must allow a paramedic to provide community-based health care (i.e., using patient-centered, mobile resources outside the hospital) within his or her scope of practice

and make recommendations regarding non-emergency transportation by EMS providers. Under the bill, the Department of Public Health's Commissioner must report the working group's findings and recommendations to the Human Services, Insurance, and Public Health committees.

The Legislative Report to the General Assembly was submitted to the Legislative on 3/1/2019. Below is the full report.

MIH-Report-to-CT-General-Assembly_2

Below is Section 45 of Public Act 17-146 as well as a link to the full Public Act 17-146: https://www.cga.ct.gov/2017/ACT/pa/2017PA-00146-R00HB-07222-PA.htm

Public Act 17-146 Sec. 45.pdf

4. Arlene Murphy asked for clarification of exactly what is being proposed and the time frame. The PTTF recommendations talk about needed improvements in primary care. What exactly is being proposed and how will risks be addressed? What would be the proposed concept paper Medicare request?

Original Response: In October 2017, the Center for Medicare and Medicaid Innovation (CMMI) invited State Innovation Model (SIM) states to propose state specific multi-payer demonstrations as a means to sustain and build upon the payment reforms that they have undertaken through SIM. A multi-payer demonstration enables Medicare participation in State-directed reforms. It also provides the opportunity to tap Medicare resources to help finance reforms. SIM states have a time-limited opportunity to use their SIM grants to fund the considerable cost of planning for a demonstration. In order to be considered for a demonstration, CMS requires the participation of Medicaid and the state's largest private payers, and the support of stakeholders. In order for Medicare to participate in a SIM model under this pathway, the model must meet the set of principles outlined below, and be an Innovation Center test of a novel model under section 1115A authority. In other words, the demonstration would require a **Medicare** waiver. A waiver would not necessarily be required for Medicaid, if the Department of Social Services elects to participate.

OHS has begun examining how a multi-payer demonstration could provide a means to implement Primary Care Modernization. A multi-payer demonstration could also include a second initiative focused on rewarding provider and community partners for enhancing community health. This second initiative is called the Health Enhancement Community (HEC) initiative. The slide presentation from the April meeting of the Population Health Council is the best way to become familiar with what the proposed HEC initiative is about.

CMMI has set forth principles that it would consider in reviewing a State's proposal for Medicare participation in a multi-payer model that could require specific new waiver authority to align Medicare with the model. These include the following:

1) patient-centered,
2) accountable for total cost of care,

3) transformative,
4) broad-based,
5) feasible to implement and
6) feasible to evaluate.

The process of seeking a demonstration begins with a State's expression of interest to its SIM project officer. After this expression of interest, there are three steps to negotiating a demonstration as follows:

- **State submits proposal to CMS on state-specific model**: To initiate the co-development process, states should be prepared to describe in a proposal the overarching payment structure they are proposing, rationale for selecting that structure, and rationale for why this cannot be accomplished through an existing CMS model or program. States should also articulate their vision for payment delivery reform, how Medicare participation advances that goal, and what else it will take to achieve that vision. A proposal can be submitted to CMS at any time and can 4 be submitted at the same time as when a state and the Innovation Center begin to engage in a series of discussions on a potential state-specific multi-payer model.
- **CMS and state co-develop high-level parameters of state-specific model**: Through a series of discussions, the Innovation Center and the state would work to come to agreement on a viable model design that meets the criteria outlined below including the high-level parameters of the model (e.g. overview of payment structure, framework for financial targets achieved under the model, population health and quality goals under the model and goals for healthcare provider and multi-payer participation and lives covered by the model).
- **CMS and state enter into in-depth negotiations to co-develop model**: Negotiations would include identifying the financial, quality and scale targets that the state will commit to, and identifying the Medicare program/policy waivers and operational considerations that CMS would need to provide to give the state the flexibility to operate the multi-payer model and that is necessary to test the model. The goal of the negotiations is to develop an agreement between CMS and the state on the terms of the state-specific model with Medicare participation. Such an agreement would be signed by the Innovation Center and the Governor of the state. (p. 35)

More information about the multi-payer demonstration option can be obtained from https://innovation.cms.gov/Files/x/sim-medicare-mpmodelsguidance.pdf.

Updated Response: OHS continues planning activities related to Primary Care Modernization and Health Enhancement Communities for consideration by the Lamont Administration. Next steps include:

- May 2019 - Conclude Primary Care Modernization straw model feedback engagements, including four meetings with consumer groups who previously provided feedback, and up to ten additional community meetings;
- June/July 2019 - Publish draft report for public comment; further engage consumer stakeholders
- September 2019 – Finalize PCM report

September 2019 – Complete HEC Medicaid and Commercial impact models

Regarding the question about risk to consumers, OHS has begun to formulate a multi-component strategy for transparency and accountability based on stakeholder feedback to ensure that ease of access improves under PCM. As noted above in question A.1, these strategies include:

- Primary Care Contact Reporting

This innovation represents a leap forward from prior methods of monitoring patient care. We anticipate that providers will be required to track all clinical patient encounters and contacts including face-to-face and virtual contacts (e.g. phone, text, email and video visits) with all clinical and non-clinical staff. Patient encounters will be entered into the electronic health record.

Until the Health Information Exchange has the functionality to capture these notes, providers would create a periodic report of encounters and contacts, and upload this in standard format to the Health Information Exchange. Report content and format would be determined through a stakeholder process involving OHS, consumers, participating providers, and other stakeholders. OHS, payer partners and stakeholder advisors might utilize the Access Tracking Report to inform decisions about whether each AN/FQHC could continue participation or be subject to a corrective action plan.

In addition to the Access Tracking Reports, the PRC recommended that OHS and individual payers use claims data to identify significant changes in care patterns that might reflect underservice, referrals aimed at maximizing revenue, or unexpected needs for care.

- Consumer Experience Surveys

PCM will include care experience surveys that include questions about ease of access. This will allow us to use consumer experience to directly inform whether we are achieving our access goals.

- Mystery Shopper Surveys

As an additional measure of protection, we are recommending the conduct of periodic mystery shopper surveys to measure whether access to new patients in primary care is improving. Such surveys would also enable us to measure whether the intended goals for improved access are occurring for patients with significant clinical and/or social risk or other special needs.

5. Ann Smith noted the importance of consumer input at the beginning of the process. She said that we have been hearing from consumers on how the Connecticut system does not serve them. She said that there is not an understanding how the proposed Primary Care Modernization model will do this.

Original Response: The Task Force has proposed to modify the *draft* Advisory Process to include the Consumer Advisory Board as a key advisor early in the planning process and throughout the process. In fact, we would propose to have the Consumer Advisory Board be the first advisory panel that the Task Force engages in early June as we begin the planning process with the new PCM consultant. The Task Force would then circle back to the Consumer Advisory Board on one or more occasions to get feedback on the provisional model design. A full revised Advisory Process diagram and detailed summary is attached. (p. 35)

Updated Response: OHS, in consultation with the Task Force, followed the above reference Advisory Process in the conduct of planning activities over the past eight months. In July 2018, OHS arranged for the PCM consultant, Freedman Healthcare, to work with the CAB co-chairs and the CAB to plan and undertake consumer engagement activities through the Fall of 2018. Some of these engagements included only consumers. Others were “Design Groups” in which the CAB co-chairs arranged for consumer participation in discussions about, e.g., diverse care teams, pain management, older adults, individuals with disabilities, child behavioral health integration, and community integration, among others. Freedman Healthcare highlighted consumer comments in the summary of design group deliberations and used these comments as a point of reference in preparing capability summaries for the

Task Force's deliberations. In addition, the two page capability summaries include a summary of consumer benefits, outcomes and health equity implications that are informed by and in many cases responsive to concerns of consumers and other individuals that participated in the various forums.

6. Ann Smith stated that there must be a focus on CHW's in workforce development as they are in communities and can develop rapport with residents. If we do not have this, then bundling primary care payment is not going to get us to where we want to be in terms of improvement and healthcare outcomes for those with substandard healthcare.

Original Response: The Task Force is committed to ensuring that CHWs feature significantly in the program design likely serving various roles such as health coach, navigator, care coordinator, linkage to community services and language support. The question regarding planning for an adequate workforce will be referred to the CHW Advisory Committee for consideration, once they have completed their certification study. (p.35)

Updated Response:

In light of the above noted concerns, OHS met with the Department of Labor's Office of Workforce Competitiveness (OWC) to examine how best to support an expansion in the available workforce to support diverse care teams, including CHWs. OWC is willing to help develop a workforce strategy once the PCM design is finalized and it is certain what members of the workforce will be needed and in what capacity. They are also interested in considering how best to retrain current capacity.

Recognizing that the full complement of care team members, including CHWs, will not be available at the start of PCM, the Task Force proposed a staged implementation strategy. We anticipate that Advanced Networks and Federally Qualified Health Centers will deploy diverse care teams on a limited basis, within available workforce constraints, in the first year and expand over a period of five years. This will give the workforce market more time to adjust to the demand for workforce members that is brought about by PCM initiative.

In addition, the Community Health Worker Advisory Committee has developed recommendations with respect to the training, promotion, utilization and certification of Community Health Workers as well as establishing a framework for sustainable payment models for compensation. The Committee examined critical issues for employers with regard to CHWs relating to hiring, supervising, and technical support. Specific recommendations and deliverables may include a definition and scope of work for CHWs, a process for certification, and recommendations for sustainable payment. The committee has three design groups.

Design Group 1, Certification Requirements: Was established to determine requirements for certification and renewal of certification of community health workers, including any training experience or continuing education requirements.

Design Group 2, Methods & Administration of Certification Program: Was established to determine methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills and an electronic registry.

Design Group 3, Training Curricula: Was established to determine requirements for recognizing training program curricula that are sufficient to satisfy the requirements of certification.

A bill was introduced this legislative session, An Act Concerning Community Health Workers, Senate Bill 859. This bill was voted out of committee, and on April 2, 2019 was sent to the Legislative Commissioners Office for statutory review and formal drafting of the raised bill's language. The raised bill's language is very general, simply requiring that Department of Public Health establish a certification program for Community Health Workers, but including no additional specificity with the exception that the Department of Public Health is required to establish a Community Health Worker certification program by 1/1/20. Because Department of Public Health professional criteria are typically established in statute, in order to facilitate the development and implementation of this program, the Office of Health Strategy working with the Department of Public Health and Health Equity Solutions, drafted substitute language that provides specific criteria for the Department of Public Health to use for certification. These criteria mirror the recommendations of the State Innovation Model Community Health Worker Advisory Committee. It is anticipated that the bill will be raised on the floor and amended to replace the existing, general, language with the substitute language. There hasn't been any real opposition to this bill or the concept, and the Public Health Committee is very committed to getting this bill passed this session. The bill is now on the Senate calendar for a vote.

On April 17, the legislative Office of Fiscal Analysis projected a cost of little over $60,000 over the next two years to certify an estimated 415 CHWs and produce an indeterminate revenue gain. Here is the Connecticut General Assembly page for CB 859:
https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB00859&which_year=2019

Community Health Worker Bill SB-859.p

Link to the Community Health Worker Advisory Committee: https://portal.ct.gov/OHS/SIM-Work-Groups/CHW-Advisory-Committee

7. Terri Nowakowski stated that until you have trusted members of every community who can sit alongside the clinician, you are never going to get what is going on in that person's life. She noted that Community Health Workers are often paid very little in primary care settings but are tasked with trying to manage so much that it is impossible. It is all about someone being able to go into homes and the community to what is going on and we don't have that today.

Original Response: See response to question #6 above.

Updated Response: The Task Force and many stakeholders recognize that CHWs are an essential member of the primary care team. Diverse care teams are a required capability within the PCM straw model and CHWs are a recommended member of diverse care teams. The proposed Supplemental Bundle will offer providers the necessary resources to hire CHWs and to pay them in accordance with their responsibilities.

8. Jesse White-Frese stated there is a need to have a deeper understanding of the multiple needs that so many families have and how difficult things are for them to manage in primary care.

Original Response: Quite a bit of information is available from listening forums of the Consumer Advisory Board and other sources, both Connecticut specific, and more broadly, about the barriers that

interfere with the effective use of primary care. The Task Force is open to considering additional listening forums or focus groups with the Consumer Advisory Board if more information or a deeper understanding is needed. However, we also suggest that patient and family advisory councils might be the best long term strategy for ensuring that providers are self-evaluating their services and making changes over time in response to consumer input. This is especially important if the new payment models provide them with the flexibility to make changes in real time, without having to deal with the limitations of fee-for-service. (p. 37)

Updated Response: For the PCM design phase that began in July 2018, OHS contracted with Freedman Healthcare to partner with the CAB to engage additional consumer groups including, e.g., parents of children with behavioral health problems, older adults, individuals with disabilities and a mixed community of individuals brought together by a housing authority. These engagements informed the straw model that was completed in February. Laura Morris, OHS Director of Consumer Engagement and Tekisha Everette, Executive Director of Health Equity Solutions, are in the process of preparing material for a second round of engagements with these same groups. A third round is planned when the PCM recommendations are released for public comment. We continue to believe that the best means to achieve a long term focus on person-centered improvement is for each provider to include consumers and families on patient and family advisory councils and to convene patients and families to better understand problems and solutions. These approaches have been promoted through PCMH+ and CCIP.

9. Bob Krzys said that whatever services are in the bundle whether they include CHWs, behavioral health, transportation, telemedicine, there may be some parts that are so profound that they would have to be essential health benefits. One thing that must be addressed is workforce.

Original Response: The Task Force supports this recommendation. We envision that the bundled payment options would be accompanied by certain "essential benefits" or capabilities, while also leaving room for flexibility and innovation. Part of the design work over the coming months will be distinguishing *essential* from *elective*. For example, it might be the case that every practice would be required to have a collaborative agreement with a consulting pharmacist and to offer patients the option of video appointments (when clinically appropriate), while only a few might elect to contract with a community paramedicine partner or a community based provider of diabetes self-management services.

Once the model is defined, the Task Force will need to project the workforce needs that are likely to emerge as a result of the initiative. Part of the rationale of proposing a staged approach with respect to capabilities and funding, is to provide time for workforce supply to meet demand. (p. 37)

Updated Response: In the current straw model, the Task Force has recommended that certain capabilities be deemed "essential" and should be required of all PCM participating providers. Telemedicine services and diverse care teams are both required capabilities as illustrated in the adult and pediatric PCM concept maps. Please see response to question B.6 for a response to the comment about workforce.

10. Kevin Galvin said one thing he finds exciting about this is the care coordination. He said one of the challenges with it is the fact that as we all went through the ACA people might argue that we didn't do a very good job of bringing the people into the primary care arena. He asked whether there will be a methodology to bring people into the primary care arena from the different segments of our communities to make it as robust a population as possible.

Original Response: By offering practices a bundle or capitation, there is more of an incentive to do outreach to get patients assigned to their practice and to keep them engaged in care. In addition, by risk

adjusting the payment (clinically and based on social risks), practices will be more receptive to higher risk patients. Of course, practices would need to have capacity on their panels in order to outreach and engage new patients. The Task Force anticipates that the expansion of the care team and the use of more efficient methods of patient care and support would enable practices to increase their panel size beyond what they have today under fee-for-service. (p. 37)

Updated Response: As noted above, the Task Force recognized that CHWs are essential members of the primary care team. Diverse care teams are a required capability within the PCM straw model and CHWs are a recommended member of diverse care teams. CHWs can be recruited from the diverse communities and populations that are served by primary care and they can be highly effective in engaging members of these communities in the use of primary care for their preventive care, urgent care and chronic care needs. The proposed PCM payment models will reward practices that are able to engage new patients and keep them engaged for all of their primary health care needs.

11. Kevin Galvin asked whether workforce development should be more at the front end of the discussion in the development of this. He said they should consider developing the workforce population.

Original Response: Once the model is defined, the Task Force will need to project the workforce needs that are likely to emerge as a result of the initiative. One of the reasons for waiting until the model is further defined is because we are not certain which members of the workforce will be required under the model and at what volume. Part of the rationale for proposing a staged approach with respect to capabilities and funding, is to provide time for workforce supply to meet demand. OHS has engaged the Department of Labor, Office of Workforce Competitiveness and they have agreed to collaborate on the development of a strategy that helps ensure that healthcare employers have access to qualified workers to fulfill new care team roles. (p.37)

Updated Response: See updated response to question B.6. above.

12. Jesse White-Frese asked whether capitated payments are made by the insurance companies to the providers. She asked whether the rates paid to the providers different for every payer for the same requirements.

Original Response: Under the proposed model, commercial and public payers would pay for services through upfront bundles or capitation, of which there are currently three recommended options, while some primary care services would remain fee-for-service. Currently, there do not appear to be many primary care capitation arrangements in Connecticut. (p. 38).

Updated Response: The current straw model recommends a Basic Bundle for the services of the PCP and a Supplemental Bundle. The Basic Bundle would be based on each practice's historical revenue. The Supplemental Bundle would be a uniform bundled payment amount that begins at a lower rate in the first year and gradually increases over time. The Medicare rates would be the same across all providers. The commercial rates for the Supplemental Bundle might vary slightly across payers. However, the Council recommends that, within any payer, the bundled payment amounts are uniform across practices. In this way, the commenters concern would be addressed in as much as there would be a high degree of consistency with respect to the payment amounts and the requirements.

13. Alan Coker asked whether anyone was familiar with the WISE program. He said it is run through the Department of Mental Health and Addiction Services (DMHAS). It provides a case manager and recovery assistant to check on patients several times a week. He said the program is good and he thinks we could

borrow from what they do and what is being recommended for primary care. He said the program is active and is state run. He suggested looking at what they do and "piggy back off" of this program

Original Response: During the design process, the Task Force will examine the WISE program and other programs that might inform the design of our PCM model. (p. 38)

Updated Response: The WISE program is designed for individuals who qualify for nursing facility level of care due to serious and debilitating behavioral health and medical needs. The concepts of person-care represented in the WISE program are very much a part of the PCM person-centered care capabilities. PCM also incorporates the concept of Community Health Workers, which can include peer based recovery support. Under the proposed PCM model, those providers that have patients with serious psychiatric needs would also be able to use their Supplemental Bundle funds to contract for supports through community organizations.

14. Ann Smith noted if we don't have the needed infrastructure to support this initiative, we won't be able to realize the potential it proposes for us. She asked how we are going to develop a robust pool of CHWs that will be inclusive and representative of the communities being served. This should not be a one size fit all strategy. How are cultural sensitivities going to be addressed? Ms. Smith raised the concern that initiatives are often not presented in understandable language. By the time consumers become involved, the initiative is set in stone and it is too late to make changes. The timeline for this initiative is too aggressive.

Original Response: The Task Force acknowledges the importance of infrastructure for planning and for implementation, if the Governor elects to support the PCM program model. The timeline for this initiative is based in part on access to funding through SIM. These dollars could potentially be used to cover planning and pre-implementation costs; however, they are only available until early 2020. A proposed 2020 target for a demonstration offers the possibility that the demonstration could provide a new source of funds to support care delivery reform and associated infrastructure needs after the SIM grant ends. Finally, some of Connecticut's accountable provider stakeholders have indicated that helping their networks is critical and time sensitive due in part to high levels of frustration and burnout.

The Task Force will take into consideration the importance of ensuring that we do not propose a one-size fits all solution. It is likely that we will recommend certain core capabilities for all practices, while recommending other capabilities depending on the characteristics of the practice, the goals of the practice, their patient population and the communities they serve. Urban practices serving vulnerable populations are likely to need a different care team composition than a suburban practice in an affluent community. Similarly, practices that focus on older adults with multiple chronic conditions will need different capabilities than practices that serve a younger employed population.

As noted previously, the Task Force is planning to include Consumer Advisory Board input at the start of the process. However, our longer term goal should perhaps be to connect provider organizations with patient and family advisory councils that can help ensure that there is a consumer informed continuous improvement process over time. (p. 38)

Updated Response: Promoting the use of CHWs will help bridge cultural and health literacy gaps. Technical assistance can help providers understand the importance of recruiting CHWs from the communities they are working to serve and ensuring that the new recruits are trained to engage patients in a culturally sensitive manner and are well supervised in their work.

The Adult and Pediatric Diverse Care Team capability summaries identify medical interpretation - using translators - as a key function. The Supplemental Bundle will provide resources to support qualified medical interpretation. There are many opportunities to improve care for different race/ethnic, disability and income groups that can be enhanced through CHWs and qualified medical interpretation. Doing so will require that ANs/FQHCs collect and analyze data that reveal health disparities. Root cause analyses will help reveal when these or other issues are the source of disparity. The Task Force has recommended that all ANs/FQHCs that participate in PCM be required to achieve the Health Equity Improvement capability.

15. Robin Lamott-Sparks said that what is missing is another layer to figure out a linkage to fit with the community and what is happening at the ground level. She said there should be a solution that works for the community and not be just sitting there and nobody uses it.

Original Response: This comment underscores the importance of ensuring ongoing engagement by the accountable provider organizations with the communities they serve to ensure that the solutions are relevant and responsive. Moreover, this would seem to be a caution against the pursuit of overly-prescriptive and inflexible standards developed by state-level groups. (p. 38)

Updated Response: The Task Force recognizes that practices are embedded within a broader health neighborhood and it has specifically recommended that all participating providers develop the skills and tools to effectively engage with community partners in support of patient care. These recommendations are summarized in the Community Integration capability.

The Task Force also recommended that ANs/FQHCs engage in partnerships with community providers who can provide the key to achieving person-centered care outcomes that are otherwise out of reach. Partnerships of this sort are underway today in the SIM Prevention Service Initiative and in the Commonwealth Care Alliance's community paramedicine partnership.

16. Velandy Manohar said there should be someone looking at all the information coming in. He noted it will take a tremendous effort otherwise there will be silos.

Original Response: OHS will contract with a PCM consultant that will be responsible for gathering and synthesizing all of the information that informs the planning process and using this information to solicit design input from the work groups, the advisory panels, and the Consumer Advisory Board. (p. 38)

Updated Response: The Task Force acknowledges that there will be an important role for oversight and monitoring. OHS will continue to play a significant role in program administration, management, data collection and analysis as innovations are implemented across sectors. This is in addition to direct oversight responsibilities that each payer is likely to undertake to ensure that the program is generating value for their respective members and employer clients.

17. Arlene Murphy asked whether there is a way to have more consumer participation at the beginning of this process. She said not just practices talking here and consumers talking there but people around the same table to communicate with each other. She asked whether this is a good next step.

Original Response: The Task Force has proposed to modify the *draft* Advisory Process to include the Consumer Advisory Board as a key advisor early in the design process and periodically throughout. In fact, the Task Force would propose to have the Consumer Advisory Board be the first advisory group that we engage in early June as we begin the planning process with the new PCM consultant. The Advisory Process diagram has been substantially revised based on input received by stakeholders. The revised diagram and a new detailed advisory process summary are attached.

The Task Force agrees with the importance of having people around the same table communicating with each other. The draft Advisory Process currently has three groups for multi-partner discussion including the Steering Committee, the Practice Transformation Task Force and the Pediatric Study Group. We are asking the Child Health and Development Institute to add additional consumers to the Pediatric Study Group. These groups include a mix of consumers, practices, healthcare organizations, health plans, and state agencies. (p. 38)

Updated Response: Perhaps the best example of PCM planning in which consumers and providers were at the table is that of "Design Groups." The Task Force established Design Groups to undertake more in-depth examination of particular areas of primary care development. Design groups generally included consumers, providers and other members of the stakeholder community. Design groups were convened in a variety of areas such as pediatrics, diverse care teams, pain management, older adults, individuals with disabilities, child behavioral health integration, and community integration, among others. There was often a high degree of consumer/provider interaction and problem solving in these meetings.

C. Attachment Consumer Advisory Board Public Comment to Practice Transformation Task Force Meeting, October 9, 2018 from Arlene Murphy, Consumer Advisory Board

Link to public comment: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-09/Public-Comment-to-PTTF-by-Arlene-Murphy-10-3-18.pdf

Original Response: This public comment was shared and added to the Minutes of the Meeting. Alyssa Harrington from Freedman Healthcare publicly apologized for misrepresenting the CAB's perspective and emailed Arlene Murphy stating that she would work with the PTTF Co-Chairs on the process for providing a response. Ms. Murphy replied that no response was necessary.

FW Practice Transformation Task

D. Attachment: Public Comment to Payment Reform Council from Patricia Baker, Connecticut Health Foundation and Lisa Honigfeld, Child Health and Developmental Institute Children's Fund of CT dated November 6, 2018

Link to Public Comment: https://portal.ct.gov/-/media/OHS/SIM/Payment-Reform-Council/Meeting-11-15-18/Payment-Reform-Council-Memo.pdf

Original Response: These comments were presented to the Payment Reform Council on November 6, 2018. The Council considered the recommendation regarding the inclusion of preventive services in the Basic Bundle and decided to include preventive services in the Basic Bundle for pediatric primary care services. The PCM bundled payment approach, including a Basic Bundle for PCP services and a Supplemental Bundle for other services, is otherwise aligned with the commenters request for flexibility, a greater focus on health promotion and population health. It will also support pediatric care team collaboration with community supports, more time with families, and evidence based innovations such as group well child visits and literature promotion. In addition, subsequent to the submission of these

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comments, the Supplemental Bundle was expanded to include the costs of an offer of universal home visits for parents of newborns. This latter development will provide a new opportunity to engage parents in pediatric care, to reinforce the development of protective factors and to identify early opportunities for risk reduction. These and other opportunities for health promotion are illustrated in the discussion of Primary Care Modernization as a means to support community health improvement on pages 57-60 of the Health Enhancement Community Technical Report.

The second part of the recommendation refers to the inclusion of non-health outcomes such as school readiness in the PCM payment model. We agree with the importance of rewarding outcomes including rewards for non-health outcomes such as school readiness as discussed on pages 63-65 of the Health Enhancement Community Technical Report. By establishing these measures within the HEC Framework, we create the opportunity for rewards to flow to PCM participating Advanced Networks and FQHCs, as well as other cross-sector partners whose efforts will be instrumental to improving outcomes that require community-wide investments and advancements.

E. Attachment: Capitation Letter from People with Disabilities and Advocates for People with Disabilities Public Comment to Practice Transformation Task Force dated November 16, 2018

Link to Public Comment: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-12-18/CapitationLetterfrom-DisabilityAdvocatestoSIMFinal111618.pdf

Original Response: On December 20, 2018, Victoria Veltri, Executive Director of the Office of Health Strategy, issued a response to this letter from people with disabilities and advocates for people with disabilities.

Letter_Veltri_Marshall_response_to_PCN

Updated Response: A great deal of attention has been paid to improving access and quality for people with disabilities. Through a variety of stakeholder meetings, and meetings with the Practice Transformation Task Force, we have proposed the following model, as part of PCM, in order to improve care for people with disabilities. This summary highlights the many different ways that primary care could better serve people with disabilities, whether by ensuring access, multiple means of communicating or visiting with the primary care team, adaptive technologies or equipment, or specially trained and experienced care team members who are attentive to the nuances of improved patient experience, who ensure preventive care performance equal to patient peers without disabilities, and the experience to assess and emphasize patients' strengths, while effectively dealing with challenges common to neurological, developmental or physical disabilities. Importantly we recognize that the challenges faced by individuals with disabilities are not all the same. For example, people with physical disabilities may face different access or care challenges then those with development disabilities. Our care delivery solution need to be sensitive to these distinctions.

With respect to the proposed primary care bundled payment under PCM, the concern is that PCPs may have fewer visits or less contact with patients, especially vulnerable patients such as individuals with disabilities. Please see our response to this important concern in A.1 above in this document.

To reiterate our response above, the model would include proposed safeguards:

- Providing higher risk-adjusted payments for patients with complex medical and social needs;
- Monitoring the volume of patient encounters and "touches" to flag under-service;
- Consumer surveys to determine whether primary care services are more accessible and convenient;
- Deploying quality measures to hold providers accountable for good health outcomes.

For example, under the proposed contact/encounter reporting requirements, any provider that participates in PCM would need to provide regular reports of contacts or encounters per patient so that there will be full transparency and accountability with respect to level of services. Examples of such reports and a provider specific trend graph, shows how such public reporting might look. Such public reporting will make it obvious if a provider were to use the bundled payment flexibility to stint on access to the PCP or other members of the primary care team.

In addition, in our most recent round of stakeholder engagement, we have been asking stakeholders whether they feel the benefits of the Basic Bundle outweigh the risks in light of the proposed transparency reporting (see response to question B.4). We have sought input as to whether it would be better to ask all payers to adopt the new telehealth codes and fees rather than including telehealth capabilities in the Basic Bundle. This would support much (but not all) of the flexibility that we are trying to achieve via the Basic Bundle.

With respect to access, we believe that adjusting upward the amount of the bundled payments to take into consideration disability status and other complex medical and social needs will create incentives to accept people with disabilities into primary care. In addition, we are proposing to test out these access assumptions, by surveying individuals with disabilities to determine whether they have an easier time finding a PCP and also whether they are finding it more convenient to access the PCP or care team when support is needed.

Finally, as noted in our response to Question #1, although the Council is recommending that PCM bundled payments be combined with a total cost of care accountable payment model (e.g., shared savings), they are <u>not specifically recommending or requiring downside risk</u>. It is likely that the Council will leave the question of downside risk to the discretion of payers, whether Medicare, commercial or Medicaid, should they decide to participate in PCM. In the case of Medicare, the newly revised Medicare Shared Savings Program will require downside risk, regardless of whether CT implements the PCM initiative.

F. Consumer Input, Questions and Concerns for Implementation – Design Groups

Below is a listing of input provided by consumers during meetings of the Primary Care Modernization design groups. The bulleted information was collected and summarized in 2018 during the design process by SIM staff and consultants and was included in the February 14, 2019 and February 20, 2019 memo from Arlene Murphy and Kevin Galvin, Co-Chairs of the Consumer Advisory Board.

The design groups engaged in a robust, iterative process – design ideas were generated, input and discussion followed, and ideas were then revised and discussed further. Consumer representatives were members of each design group. All input was valued and considered. In the end, as in most participatory and iterative decision-making processes, there was broad consensus on many matters, but not unanimity on all of them. For example, in the case of the Design Group for individuals with disabilities, differences of opinion

were heard, discussed and not fully resolved; however, the deliberations informed the development of a capability for Individuals with Disabilities.

In many cases, the design group was provided with a draft “skeleton” or summary of the problem that the capability is intending to solve. The skeleton enabled the design groups to take into consideration the scope and purpose of the design group, the need and understanding of the health and service under consideration, proven strategies, consumer needs, health equity, implementation strategies, and HIT requirements, concerns and impact. A link to each design group’s draft skeleton is provided below as well as a link to the draft two-page summary of the capability that was the focus of the design group’s deliberations.

Some consumer representatives feel strongly that consumer input was not heard. We truly regret any weaknesses in communication or process that have led to this concern. Questions have been publicly raised about whether consumer input will still be incorporated into any final PCM model – the answer is yes. The feedback of consumers and other stakeholders will be considered by the Task Force and PRC as they oversee the preparation of a report for public comment, which we anticipate will be released in June/July 2019.

While it is not feasible to offer a point-by-point review of input and outcomes through the whole iterative design process, we offer two examples, below, of how consumer input led to specific design proposals.

1. **Genomics Design Group, consumer input notes**
   - Importance of population health data showing screenings reduce death
   - Importance of education form primary care physicians to understand these are screening tests
   - Need to understand lessons learned from Geisinger pilot program and how they would apply to CT
   - Need to ensure primary care practice capacity to provide sufficient infrastructure for patient education, counseling and support (and their genetic relatives who may also need to be screened), including appropriate, timely assistance interpreting results
   - Concern about the cost of testing
   - Need for secure data management and privacy protections
   - Need for additional medical surveillance and counseling/support for those who are “screened in”

   Genomics Design Group PCM Skeleton Draft: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Genomic-Medicine-Design-Group/Meeting-08-03-18/Genomic-Screening-for-CDC-Priority-Conditions_Design-group_073118.pdf

   Note: Genomic Medicine has not been recommended for inclusion in the PCM straw model. Accordingly, a two-page summary is not available.

   Examples of design elements incorporating consumer input, genomics:
   The Genomic Design Group reviewed multiple resources such as publications in peer-reviewed journals and articles from respected trade and popular press on genomic screening results, disparities in genomic screening, and stories of patients who tested positive in genomic screening for CDC Tier 1 conditions and genomic screening models. Based on input from consumer representatives, the Design Group reviewed case studies from Geisinger Healthsystem, included a case study from them in the design document, and incorporated learning from them in the elements of the design.

   Consumer representatives also offered suggestions regarding patient education, counseling and support and providing appropriate timely assistance in interpreting results and these important elements are

reflected in the skeleton draft as the "proven strategy" for the Genomic Screening for CDC priority conditions. In the Design, those who screen positive will be offered support to (1) understand their result, (2) take clinical steps to reduce risk and (3) get at risk family member screened. A central care support team (composed of geneticists, specialists, genetic counselors and others) will be created as a single central resource for the state in order to answer questions for patients or providers, guide decision making as needed, carry out consultation (telemedicine or in person) as needed. The intended outcomes include:

- *Identify among patients who are interested in screening those with detectable risk for cancers (including breast, ovarian, prostate, pancreatic, colon and uterine) and cardiovascular disease (including heart attack and stroke).*
- *Offer effective interventions to lower the risk of morbidity and mortality in these patients and their families*

The draft skeleton includes HIT requirements and addresses comments that were offered regarding secure data management and privacy protections. The HIT requirements will include:

- *Secure electronic portals for patient and provider to results and support materials (including provider CME opportunity).*
- *Capacity to securely deliver "positive result report" and "negative screening message" directly to EHRs, and to default to secure FAX or mail for patients and providers without HER.*
- *Secure telemedicine platform for multiparty consultation (e.g. patient, primary care provider, cardiologist, central care support team).*

One implementation concern was programmatic costs - a comment was raised by consumers. Based on the proposed design, the total budget is expected to be equal to or less than two preventative medicine visits for each participating patient.

2. Telemedicine, Phone, Text, Email Encounters, consumer input notes

- Has been a "godsend" for help with a sinus infection or UTI
- A consumer said: "I would support this concept but would go beyond this to include a way not only for Providers to provide services through video consult but also a way for the practice to connect to a CBO for consult care coordination, learning and providing triage support as well as a mechanism for training for Care Coordinators, CHW and caregivers (ECHO model)
- Phone, text, email encounters are the future of medicine as part of a larger telemedicine initiative. Youth/young adult will appreciate this options
- A consumer said "there is a telemedicine movement that we need to consider
- Telemedicine could be utilized to avoid duplication of services and to extend services beyond what is available now and utilizing tools such as Project ECHO.
- Bright Futures does practice under some medical homes and agrees this definition is more comprehensive.
- Expanding access to providers and providing patients with the convenience of accessing care from anywhere
- Expediting the timing of medical visits
- Reducing lost work time and travel costs

- Allowing for remote second opinions
- Lowering the patient cost of a physician appointment when compared to traditional office visits

Additional Consumer Needs, Concerns, Questions

- Expanding access to providers and providing patients with the convenient of accessing care from anywhere
- Expediting the timing of medical visits
- Reducing lost work time and travel costs
- Allowing for remote second opinions
- Lowering the patient cost of a physician appointment when comparted to traditional office visits

Draft Child Telemedicine Capability and Adult Telemedicine Capability.

Primary Care Modernization Telehealth Visits between Clinicians and Patients Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-04/Telehealth-visits-capability_PTTF_082818.pdf

Examples of design elements incorporating consumer input, telemedicine:

Consumers stressed the importance of expanding access to providers, convenience of accessing care from anywhere, and reducing lost work time and travel costs. As with all of the design groups, multiple resources, publications in peer reviewed journals and articles from respected trade and popular press were reviewed. The resulting design describes telehealth visits between clinicians and patients through virtual real-time communications such as video conference which may involve remote patient monitoring and other digital technologies such as smart phones to support patient care. The intended outcomes of this design are to 1) reduce avoidable Emergency Department Visits, 2) Expand access to specialists in Connecticut, 3) reduce hospitalizations, length of stay and readmissions, 4) Reduce need for office evaluations, 5) Improve care coordination between the patient and the caregiver team.

The example scenario provided in the implementation section of this design skeleton describes a daughter who takes care of her disabled mother who is homebound and who notices that her mother has developed a cough and fever. Instead of taking her mother to the Emergency Department she contacts the primary care doctor and schedules a virtual visit for the same day. Via a secure portal, the daughter sends the mother's health information to the doctor and has a video conference to discuss symptoms and evaluate the mother's condition. The doctor determines the course of treatment and the daughter continues to provide daily updates on her mother's condition electronically through a secure portal. The visit and information is recorded in the mother's electronic health record.

3. Oral Health Integration, consumer input notes

- Many children and adults go without simple preventative service that have been proven effective in preventing oral diseases and reducing poor oral health
- Education for caretakers and young children to establish strong tooth brushing habits
- Prevention strategies to minimize ED visits and tooth loss

- Oral health has important Health Equity Lens
- More dentists need to be aware that children with disabilities may have sensory issues
- Oral Health Integration complements school medical homes
- Oral Health integration is a great capability, quick and simple
- Oral Health in pediatric practices complements the CT legislation that provided for dental screenings in schools

Draft Oral Health Integration Capability.
Primary Care Modernization Oral Health Integration Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-11-13/Capability_PTTF_Oral-Health-Intergration_20180828.pdf

4. **Functional Medicine, consumer input notes**

- Medication and supplies to manage disease are too costly and can have significant side effects
- Hard to find resources for lifestyle changes
- Need for improved communication and listening between patients and care teams
- Need for support services from a care team beyond traditional medical care

- **Note: Functional Medicine has not been recommended for inclusion in the PCM straw model. Accordingly, a two-page summary is not available.**

Functional Medicine Skeleton Draft: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-04/Functional-Medicine-capability_PTTF_082818.pdf

5. **Adult Behavioral Health Integration Design Group, consumer input notes**

- Difficulty accessing primary care and specialty care (especially psychiatry)
- Need for expanded care teams
- Clinician awareness of the challenges of maintaining self-care for a person with chronic conditions (including behavioral health)
- Finding in-network clinicians whoa retaking new patients and accept insurance or finding affordable self-pay options
- Access to counseling for lifestyle issues associated with behavioral health (nutritional counseling for obesity)
- Clinicians' support and understanding that behavioral health recovery is not linear

Draft Adult Behavioral Health Integration Capability

Adult Primary Care Behavioral Health Integration Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Adult-Behavioral-Health-Integration/Meeting-08-29-18/BH-Integration--Adult-Design-Group-082018.pdf

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6. **Pain Management Design Group, consumer input notes**
   - Important to ensure alternative and preventative therapies are accessible
   - Multipronged approach that includes education is needed
   - Need to look at overcoming cost and transportation barriers
   - Need reimbursements for providers for longer appointments
   - CDC Guidelines are inefficient and have resulted in unintended consequences and unnecessary prescribing. Should take caution if following these guidelines. Recommend looking at FDA guidelines that will be released soon
   - Need to ensure all services for pain management are in network and covered by insurance
   - Need for more resources for providers to prescribe affordable medications for chronic pain
   - Patients and providers need education in pain assessment and management
   - Patient education about pain management should be provided at all levels of care, not just as part of preventive care

Draft Pain Management and Medication Assisted Treatment Capability

Primary Care Modernization Pain Management Design Group Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Pain-Management/Meeting-10-01-18/Pain-management-Design-Group-2-Skeleton_Revised_Final.pdf

7. **Community Integration Design Group, consumer input notes**
   - Need to define how Community Based Organizations (CBO) will be identified and what their roles will be
   - There will be gaps in what community services are available depending on geography and need for capacity building in those areas
   - If primary care practices are doing needs assessments largely based on those accessing care, we might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this
   - SDOH screening needs to be culturally appropriate and provided by the appropriate care team
   - Networks should respond, via partnering with CBOs to community needs, not just their specific patient needs as this can exacerbate disparities
   - Need to be inclusive of a variety of community organizations to connect their members/clients to healthcare, such as churches, barbershops, community centers, etc.
   - Need to evaluate disparities in care to provide access to appropriate community placed services
   - Need to establish a baseline of community health to understand whether services are meeting needs of patients
   - Non-medical meeting places should not be burdened as healthcare hubs, but rather be sources for information connecting to healthcare services (electronic feedback)

   Community Integration can address the following consumer needs:

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- Transportation barriers
- Access to community based services
- Improvement of health outcomes particularly in low-income communities
- Help for patients in navigating available/affordable resources
- Religion/Language barriers and other cultural differences
- Addressing a variety of support services beyond traditional medical care (i.e. mental health services, nutritional services, etc.)

Draft Adult and Child Community Integration to Address Social Determinants Capability

Community Integration: Primary Care Partnership with Community-Placed Services Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Community-Integration/Meeting-10-12-18/Community-Integration-DG-skeleton-Revised-for-PTTF_20181019.pdf

8. Diverse Care Teams, consumer input notes

- Ongoing consumer voice is critical to PCM
- Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform
- Consumer needs support learning to advocate for themselves in a medical setting
- Care teams need to go beyond being aware and respectful of cultural needs and norms
- Communication with patients, should consider patients' socioeconomic and sociocultural needs and norms
- There should be a feedback loop in the system for consumer voice beyond planning phase.

Draft Adult Primary Care Diverse Care Teams Capability

Draft Pediatric Primary Care Diverse Care Teams Capability
Primary Care Modernization Diverse Care Teams Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Diverse-Care-Teams-Capability_PTTF-Review_102518.pdf

Primary Care Modernization Diverse Care Teams Informational Appendices: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Diverse-Care-Teams-Informational-Appendices.pdf

9. Older Adults with Complex Needs Design Group, consumer input notes

- Primary caregivers (e.g. family members) need more support management care needs
- Expanded range of support services that go beyond traditional in office care, such as text, email, phone, telemedicine
- Barriers to care include transportation and getting to medical appointments especially if frail or disabled

- Hearing and cognition issues may impair understanding of self-management instructions as well as non-native language comprehension
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients
- Desire to keep existing physicians and better communication between physicians across systems and care settings
- Single point of contact in practice to connect with and coordinate care
- Need pharmacists, patient navigators, more community health workers to get connected to community programs and interpreters
- Challenges with suppliers fulfilling DME order and insurers covering supplies and delivery, primary care team should be aware of challenges and support patients with this
- Caregiving support for patients after leaving hospital or nursing home to follow up with them
- Home visits and care coordination are very important for people with complex needs
- Insurance is a challenge in terms of understanding filling and finding providers accepting Medicaid patients

Draft Adult Primary Care, Care for Older Adults with Complex Needs Capability

Adult Primary Care, Care for Older Adults with Complex Needs Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Complex-Older-Adults-Design-Group/Meeting-11-06-18/Capability-Summary_Care-for-Complex-Older-Adults_20181108.pdf

10. Pediatric Behavioral Health Design Group, consumer input notes

- Expand Care Team
  - Some parents felt community health workers could help navigate systems and tackle cultural differences; others expressed concern home visits because of the perceived risk of reporting to child protective services
  - My school severely lacked in helping me with my mental health issues. School was one of the biggest stressors
  - Cannot expect putting one person in a PCP office will solve problem of access to specially trained behavioral health professionals
  - Avoid duplication of care coordination services
  - Address overmedication in pediatrics and need for pediatric re-evaluation
  - Refer to ACCESS mental health model to avoid developing a parallel system
- Improve Access to Care
  - Address insurance limitations on access and coverage, including long wait times and clinicians who do not accept any insurance plan
  - Must measure accountability and performance
  - Ensure that payment methodology promotes robust access to treatment and recognizes time needed for implementation.
- PCP team training, standard periodic screening and awareness
  - Need for standard screening tools, including developmental, assess the “Family Health”

- Need for training for pediatric team to expand capability to provide first line care
- Break down silos across disciplines
- Pediatricians are too quick to call in department of children services – which parents felt made them less likely to share information with the pediatrician's office about behavioral health issues.

Draft Pediatric Behavioral Health Integration Capability

Pediatric Primary Care Behavioral Health Integration Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Pediatric-Behavioral-Health-Integration/Meeting-08-21-18/Preliminary-DG-Pediatric-Behavioral-Health-Skeleton-for-discussion-081718.pdf

11. Pediatrics Design Group Consumer Feedback, consumer input notes

Pediatric Primary Care Modernization Care Delivery Capabilities: page 32:https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCM-Capabilities-Compendium-updated.pdf?la=en

Diverse Care Teams, consumer input notes

- Expanded care team functions and roles support the goals of the pediatric medical home, and, at the same time, expanded care teams need to be clearly defined.
- All the diverse care team roles and functions should be core, including referrals and follow ups
- Parent navigators could be apparent with children who went through a similar experience; would love to see this type of role embedded in the practice to help patients
- Community Health Workers are critical and support care coordination
- The Subgroup defined community integration as 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 families' needs. In response to this definition, a consumer noted that this definition is okay but wanted more specificity around a standardized process for how CBOs will be selected and compensated. This needs to be a transparent and fair process so that smaller capable CBOs are not forgotten.
- Need to ensure that referral and follow up are parts of this model. This is where patients fall of the cliff. Help Me Grow is an essential part of that follow up piece.
- Networks should be required to have a population health specialist so that the care teams make this a priority.
- Consumers agreed that aligning the definition of care coordination with the AAP definition is good.
- Care coordinators should be making formal referrals and, like United Way 211, help families make connections to a medical home
- Care Coordinators can help fill gaps in services
- The programs I've seen that have been successfully in the state are through care coordinators. They aren't necessarily coming directly form a provider in the home. Collaborating with organizations that already have that cultural competence in the community is key (in fact, would pull equity and

cultural competence out to be its own goal). Wouldn't discount the ability of the CHWs that can be monitored to ensure quality and be carefully linked to the medical home. If it is a network level capability, that makes sense.

Draft Adult Primary Care Diverse Care Teams Capability

Draft Pediatric Primary Care Diverse Care Teams Capability

Primary Care Modernization Diverse Care Teams Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Diverse-Care-Teams-Capability_PTTF-Review_102518.pdf

Primary Care Modernization Diverse Care Teams Informational Appendices: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Diverse-Care-Teams-Informational-Appendices.pdf

Community-Placed Services, consumer input notes

- SDOH screening is vital but can go wrong if it's not done with some care.
- The capability should include community-placed services for youth, including those that support youth transitioning to adulthood.
- Regarding connections to school based care, community based services can provide more help and resources to the school nurse. A consumer said "Our communities are out schools for our children and this needs to be part of the conversation. More coordination between schools and practices
- Practices need flexibility in connecting families with community placed services; this coordination should not be required unless these services are necessary
- Would love to see contracts with community-based organizations as a requirement. CBOs lack funding. If contracts as required, those CBOs develop a standard process. Funding will help CBOs develop coordination and infrastructure mechanisms and help with measurement of outcomes of the interventions
- Must appropriately compensate community-based organizations and find a way for CHWs to be able to bill this work in coordination with the practices
- Need to develop accountability measures and how we are determining these functions are met.

The Community-Placed Services design group ultimately led to two distinct capabilities, Community Integration (required) and Community Purchasing Partnerships (elective). Two-page summaries of these capabilities are provided below.

Draft Adult and Child Community Integration Capability

Draft Child Community Purchasing Partnership Capability

Draft Adult Community Purchasing Partnership Capability

Community Integration Skeleton Draft: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-Community-Integration/Meeting-10-12-18/Community-Integration-DG-skeleton-Revised-for-PTTF_20181019.pdf

Oral Health Integration, consumer input notes

- More dentists need to be aware that children with disabilities may have sensory issues.
- Oral Health integration complements school medical homes
- Oral Health integration is a great capability, quick and simple
- Oral Health in pediatric practices complements the CT legislation that provided for dental screenings in school

Pediatric oral health integration is included in the draft Pediatric Primary Care Diverse Care Teams Capability

Care Modernization Oral Health Integration Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-11-13/Capability_PTTF_Oral-Health-Intergration_20180828.pdf

Universal Home Visits for New Parents, consumer input notes

- Home visitor should be seen as fully connected to the primary care practice
- In addition to the nurse-family partnership, home visits by CHWs have a positive effect
- Home visit team should include a community health worker who is a parent and understands the family's situation CBO's can help support the Home Visiting Team with support services that go beyond health care services such as advocacy in school issues and a variety of training that will help the caregivers become skilled advocates. They can also help with follow up which usually results in many hours beyond the medical or home visit.
- Bright Futures does practice under some medical homes and agrees this definition is more comprehensive.

Draft Child Universal Home Visits for Newborns Capability

Telemedicine, Phone, Text, Email Encounters:

- Has been a "godsend" for help with a sinus infection or UTI
- A consumer said: "I support this concept but would go beyond tis to include a way not only for Providers to provide services through video consult but also as a way for the practice to connect to a CBO for consult, care coordination, learning and providing triage support as well as a mechanism for training for Care Coordinators, CHWs and caregivers (ECHO Model)."
- Phone, text, email encounters are the future of medicine as a part of larger telemedicine initiative. Youth/young adult will appreciate this option
- A consumer said: "there is a telemedicine movement that we need to consider."
- Telemedicine could be utilized to avoid duplication of services and to extend services beyond what is available now and utilizing tools such as Project ECHO.

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Draft Child Telemedicine and Shared Visits Capability

12. People with Disabilities/Advocates for People with Disabilities, consumer input notes

- Phone, text, email and telemedicine visits could be very helpful to patients unable to drive and in need of transportation
- Exam rooms must have sufficient equipment to allow for a full exam including scales and lifts to support the patient onto the exam table. If not financially feasible to have all offices set up with this equipment, have some
- Providers need sensitivity and compassion. One way to show that sensitivity is by documenting the patient's disabilities, so they are not asked to stand when they cannot or do other activities they cannot do
- Providers need to recognize that a patient's disability might not be their sole concern, and that a patient with disabilities may have many other concerns.
- Many patients with disability need medication management (perhaps from a pharmacist). Other important capabilities include pain management expertise and coordination with providers of various services and community resources.
- All care team members need to understand behavioral health issues, social issues, and how they intersect with medical issues. Just adding a behavioral health team member is insufficient.

Draft Adult and Child - People with Disabilities Capability

Primary Care Modernization Persons with Disabilities Draft Skeleton: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-People-with-Disabilities/Meeting-11-02-18/Capability-Outline_Individuals-with-Disabilities-DG_101818_2.pdf?la=en

Primary Care Modernization Persons with Disabilities Capability Draft: https://portal.ct.gov/-/media/OHS/SIM/PTTF-Design-Groups/PCM-People-with-Disabilities/Meeting-12-07-18/People-with-Disabilities-Capability-Summary_120718.pdf

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