



CONNECTICUT
Office of Health Strategy

Primary Care Modernization Project Genomic Medicine Design Group

Agenda

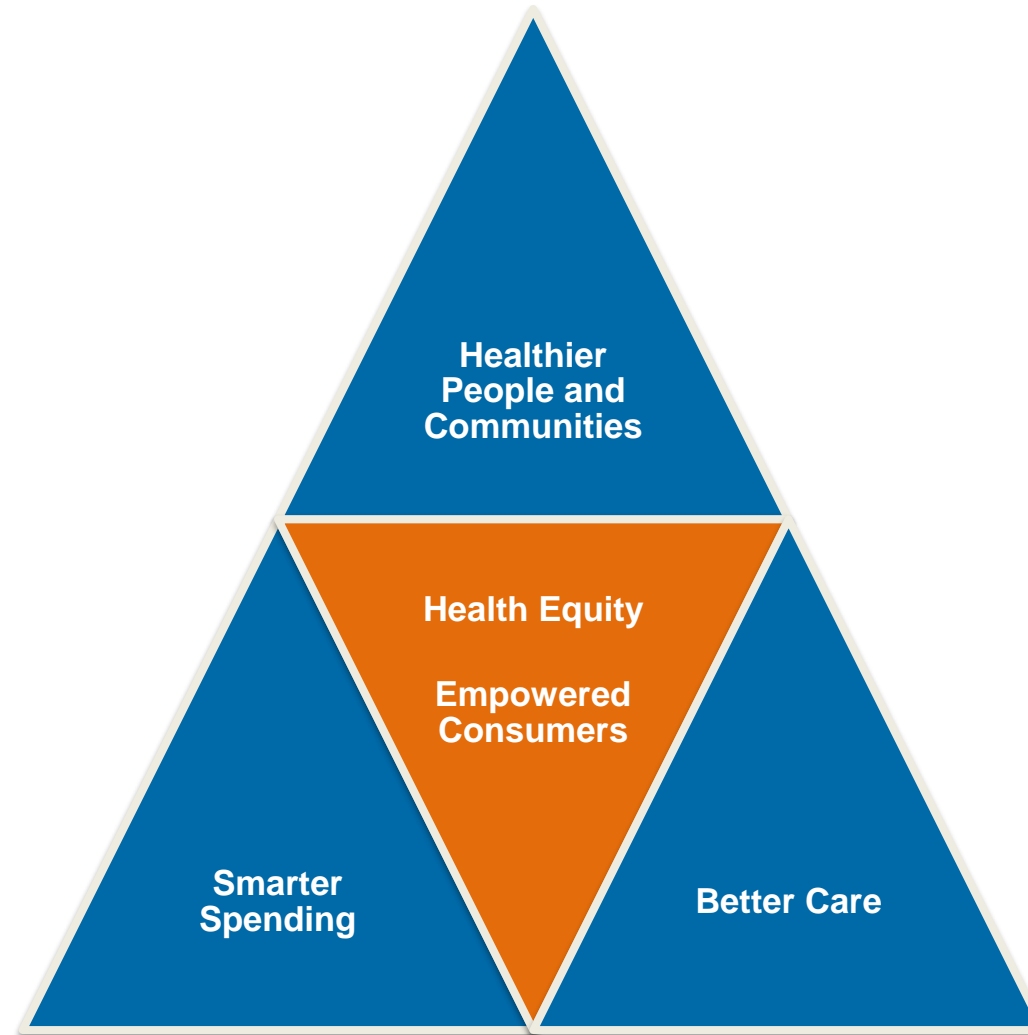
Introductions	5 min
Public Comment	10 min
Purpose of Today's Meeting	5 min
Overview of Primary Care Modernization Project	5 min
Review Capability	60 minutes
Next Steps	5 minutes

Introductions

Public Comment

Purpose of Today's Meeting: Design Group Context

Connecticut State Innovation Model



Primary Care Modernization Model Design

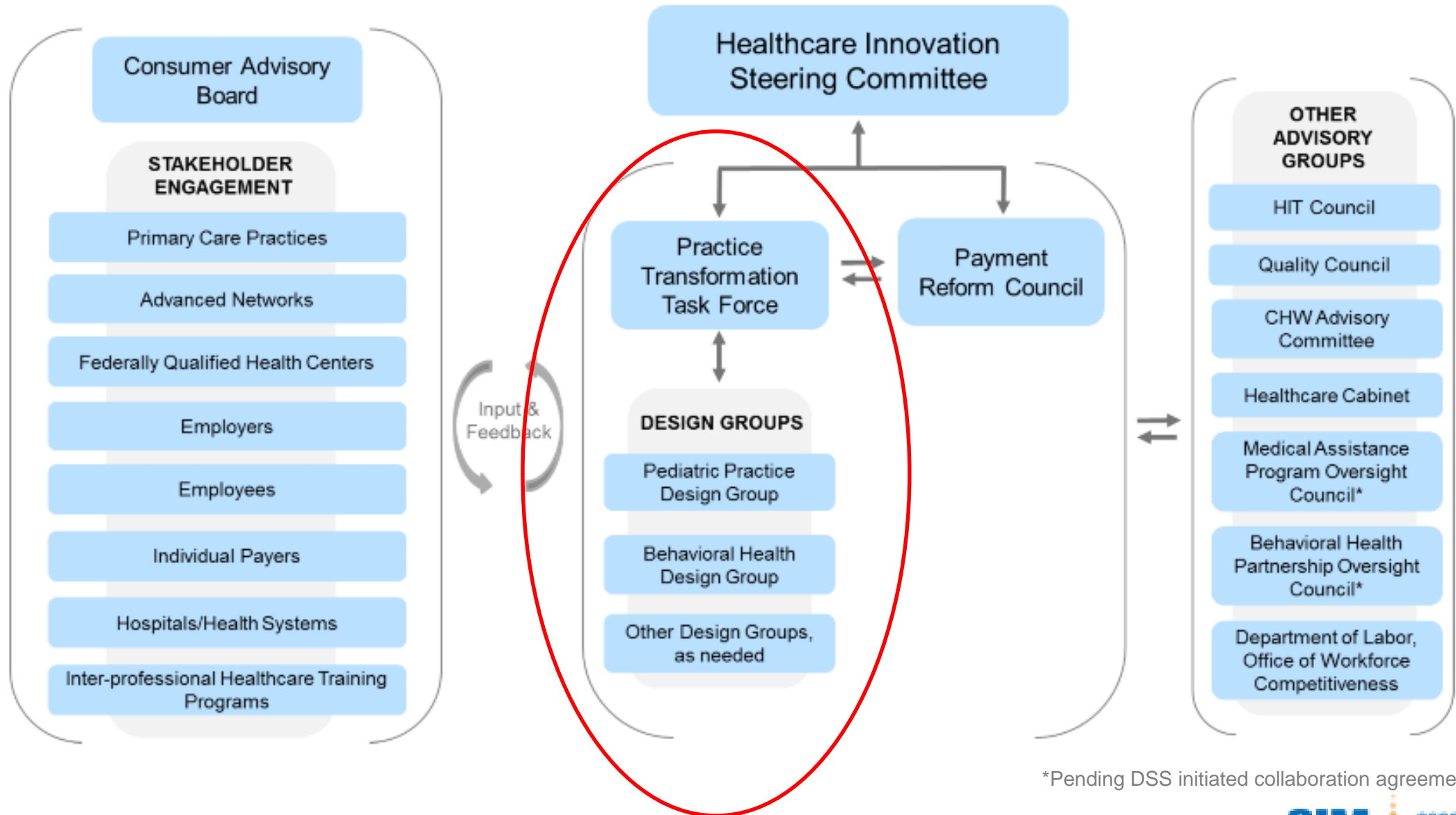
Primary Care Modernization Goal

Create a primary care payment reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Project Goals

- Develop Primary Care Modernization program model that defines **practice capabilities** and **payment model options** that support them
- Collaborate with leadership and support from providers, payers and consumers as partners in the payment reform design and promotion process
- Complete the model design for consideration by the Governor-elect following the Nov. 2018 election

Primary Care Modernization Advisory Process



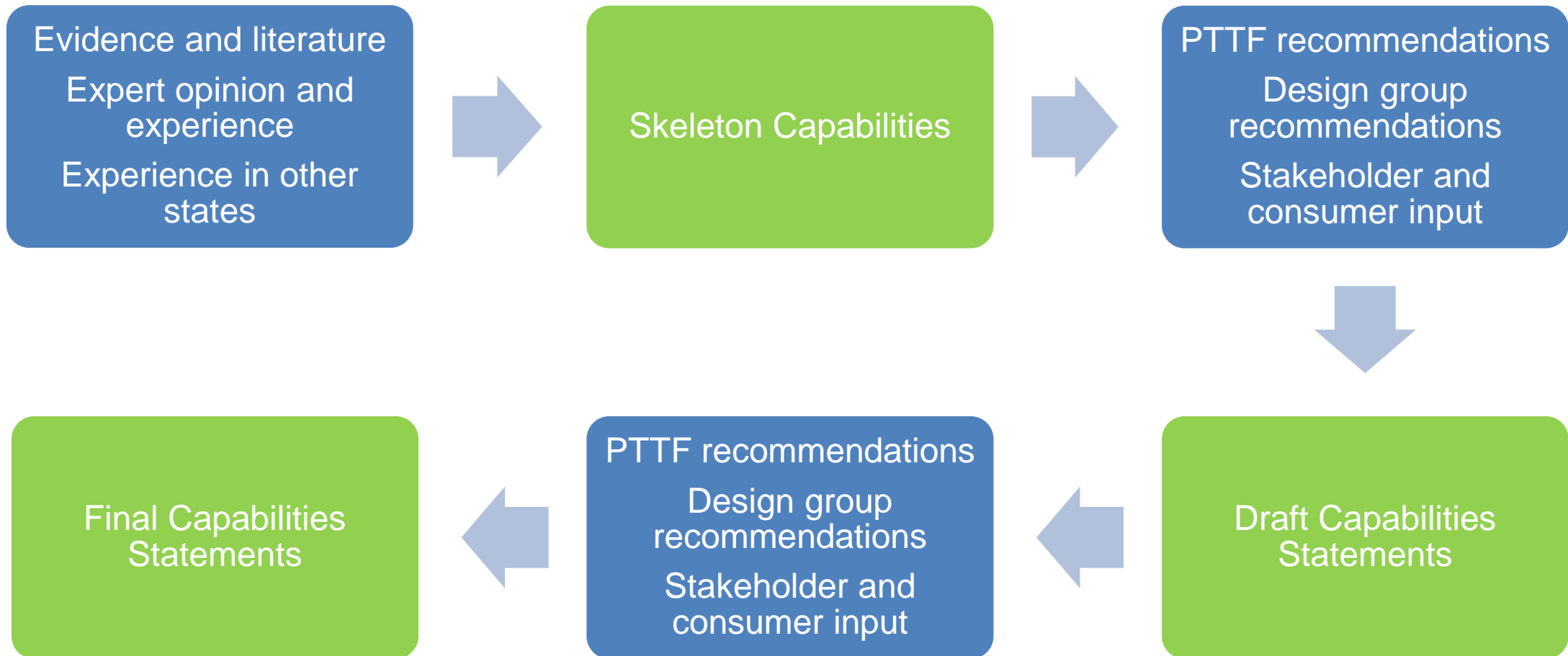
*Pending DSS initiated collaboration agreement

Proposed PCM Capabilities for Consideration

Increasing Patients' Access and Engagement	Expanding Primary Care Capacity	System Supports and Resources
<p>1. Diverse Care Teams</p> <ul style="list-style-type: none"> • Community health workers • Pharmacists • Care coordinators • Navigators • Health coaches • Nutritionists • Interpreters • Nurse managers <p>2. Alternative Ways to Connect to Primary Care</p> <ul style="list-style-type: none"> • Phone/text/email • Home Visits • Shared visits • Telemedicine 	<p>1. Capacities</p> <ul style="list-style-type: none"> • Practice specialization <ul style="list-style-type: none"> • Pain management and MAT • Infectious diseases • Geriatrics (complex older adults) • Persons with disabilities • Genomic medicine • Subspecialists as PCPs • Pediatrics considerations • Functional Medicine <p>2. Health Information Technology</p> <ul style="list-style-type: none"> • E-consults • Remote patient monitoring 	<p>1. BH Integration (adult)</p> <p>2. BH Integration (pediatric)</p> <p>3. Community Integration</p> <ul style="list-style-type: none"> • Social determinants of health • Purchased community services <p>4. Oral Health Integration</p>

Social determinants of health and health equity will be considered across capabilities

Approach to Developing Capabilities



Capabilities Statement Development

- Begins with “skeleton” created by PCM Project Team, in consultation with subject matter experts
- Outline
 - Problem statement and contributing factors
 - Proven strategy
 - *Consumer needs*: Incorporates feedback from CAB consumer listening sessions and other consumer engagements
 - *Health Equity Lens*: Perspectives on how capability might address health disparities
 - *Intended Outcomes*
 - Implementation
 - *Example clinical scenario*
 - *HIT Requirements*
 - *Implementation Concerns*
 - Impact: Health promotion, quality of care and outcomes, patient experience, provider satisfaction, costs
 - State and National Scan: CT and national case studies, results and lessons learned
 - Additional Reading and Bibliography

Design Group Process

Design groups needed when:

- Multiple proven models with distinct ways to accomplish capability
- Emerging role in primary care

Design groups are open to the public and include:

- At least one member of Task Force
- Consumer representatives
- Local subject matter experts
- Project team experts

Design group goal:

- **Make recommendation to the Practice Transformation Task Force as to whether this capability should be considered in the payment model**

How the PTTF Will Review Capabilities

Does the evidence support including this capability in the PCM payment bundle?

→ *Based on health promotion/prevention, quality and outcomes, patient experience, provider satisfaction, lower cost*

Should this be a **core (universal/required)** or an **elective** capability?

Should this capability be deployed in **all practice sites**, or provided by a **subset of docs or practices** within each primary care network?

Capability Overview

CT Primary Care Payment Reform Proposal
Genomic Screening for CDC Priority Conditions

Mike Murray, MD

Center of Genomic Health at Yale

Yale School of Medicine

August 3rd 2018

10 Leading Causes of Death in Connecticut

(CDC statistics 2016)

CT LEADING CAUSES OF DEATH	2016 DEATHS
1. Heart Disease	7,051
2. Cancer	6,696
3. Accidents	1,978
4. Chronic Lower Respiratory Disease	1,425
5. Stroke	1,269
6. Alzheimer's Disease	1,035
7. Diabetes	699
8. Septicemia	588
9. Influenza/Pneumonia	572
10. Kidney Disease	570

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Screening in Health Care

HIGH BLOOD PRESSURE IS A




**SILENT
KILLER**

because there are no
obvious signs or symptoms

High Blood Pressure

The Silent Killer



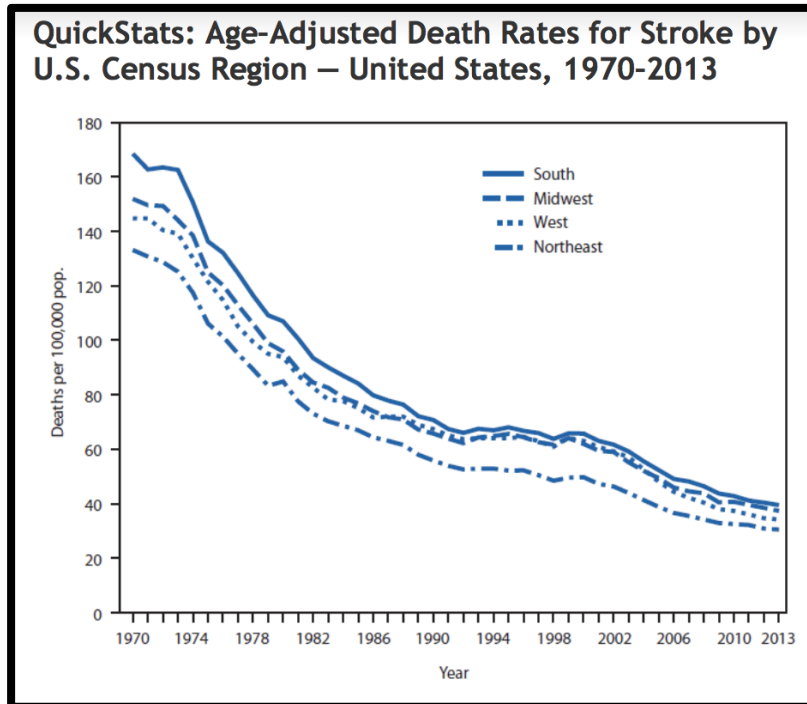
• Heart Attack • • Stroke/Dementia •
• Kidney Failure • • Vision Loss •

When your blood pressure is **high**:

You are **4x** more likely to die from a stroke 

You are **3x** more likely to die from heart disease 

Screening in Health Care



20% of adults with high blood pressure do not know that they have it.

[\[https://www.cdc.gov/bloodpressure/facts.htm\]](https://www.cdc.gov/bloodpressure/facts.htm)

Screening in Health Care

- **Newborn Screening (NBS)**
 - **Over 50 years old**
 - **Started with one condition – now over 30 conditions**
 - **Adopted by all 50 states, and many countries**

Screening in Health Care

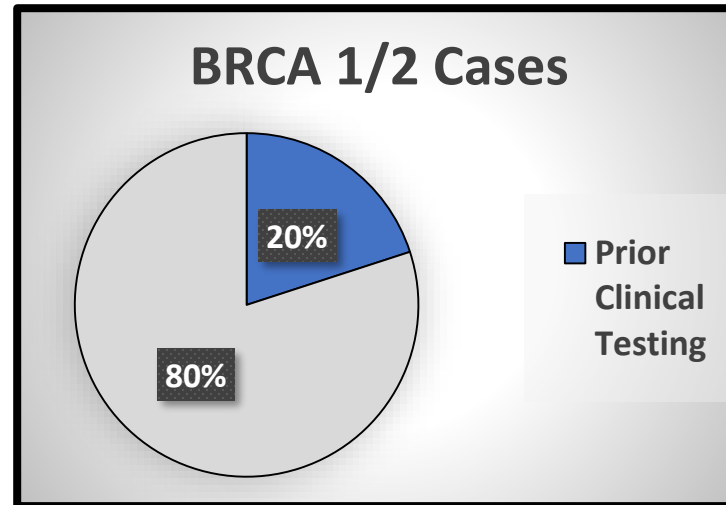
- **What should we screen for and when should we screen for it:**
 - **Important health problem**
 - **Not otherwise apparent**
 - **Approach has good tools for finding it**
 - **Screening program has good plan for management**

Screening in Health Care

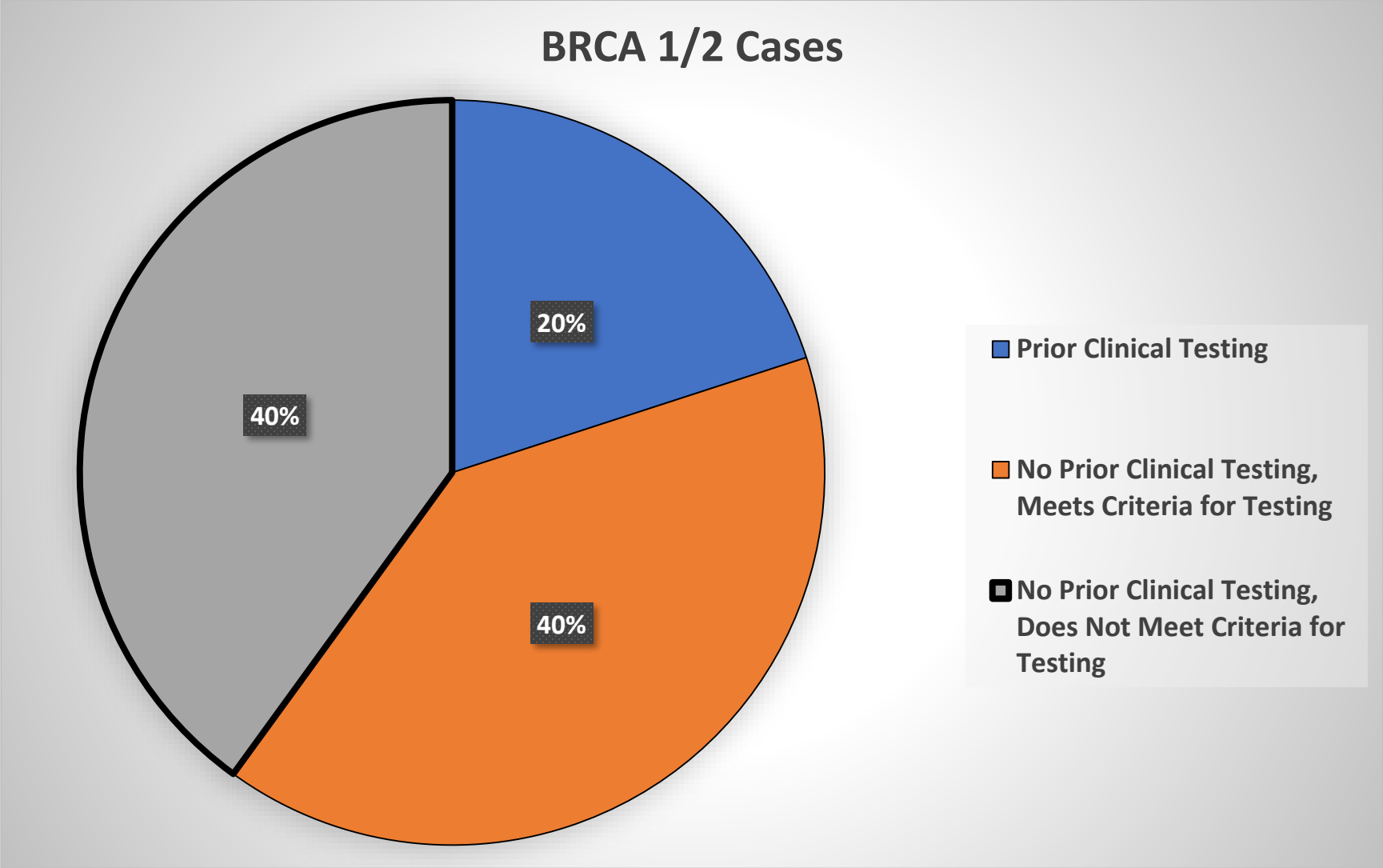
- **USPSTF helps set the screening agenda for primary care:**
 - **2005 they made recommendations on *BRCA* screening**
 - **Involving detailed family history acquisition and analysis, followed by potential referral for genetic testing**

Screening in Health Care

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Analysis of *BRCA* Genomic Screening in 50,000 Patients





Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Public Health Genomics

TIER 1 GENOMIC APPLICATIONS

Familial Hypercholesterolemia (FH)

Hereditary Breast and Ovarian Cancer Syndrome (HBOC)

Lynch Syndrome (LS)

In 2018: Screen 10 Genes for Three Genetic Conditions

SCREENING FOR ELEVATED RISK OF		
Heart Attack and Stroke	Breast, Ovarian, Prostate, Pancreatic Cancer	Colon and Uterine Cancer
Familial Hypercholesterolemia (FH)	Hereditary Breast and Ovarian Cancer (HBOC)	Lynch Syndrome (LS)

~45,000 people in the Connecticut

~4.3M people in the United States

Management of Screening Results

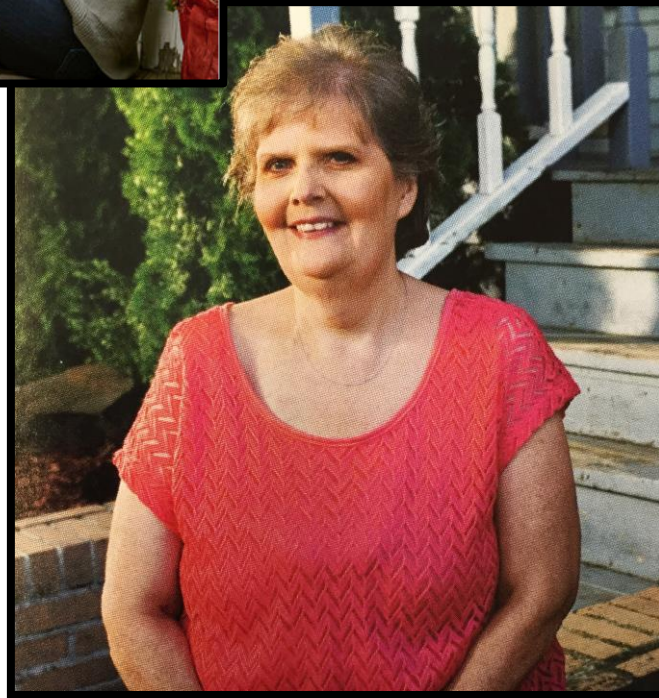
- There is screening and management strategies in place of these primary care problems
- There are recommendations in place for management of these conditions in the face of identification of genetic risk

Genomic Screening in CT for 3 CDC Priority Conditions

- **Programmatic Costs:** In context, total budget is expected to be < two preventive medicine visits for each participating patient:
 - Test costs
 - Central care support team costs
 - Outcomes monitoring costs
 - HIT costs

Genomic Screening in CT for 3 CDC Priority Conditions

- **Why now?**
- **Why just 10 of 20,000 genes?**
- **Why CT?**



Connecticut as an Important Pilot Site for the Nation

2010 US CENSUS (RACE AND HISPANIC ORIGIN)	CONNECTICUT	US
White alone	80.6%	76.9%
Black or African American alone	11.8%	13.3%
American Indian & Alaska Native alone	0.5%	1.3%
Asian alone	4.7%	5.7%
Native Hawaiian & Other Pacific Islander alone	0.1%	0.2%
Two or More Races	2.3%	2.6%
Hispanic or Latino	15.7%	17.8%
White alone, not Hispanic or Latino	67.7%	61.3%

***Connecticut is ~1% of the US population
and a reasonable model for the other 99%***

Questions

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Should this be a **core (universal/required)** or an **elective** capability?

Should this capability be deployed in **all practice sites**, or provided by a **subset of docs or practices** within each primary care network?

Adjourn

Thank you!

If you have additional comments or questions, please send to:
Vinayak Sinha, vsinha@freedmanhealthcare.com