Primary Care Modernization Pediatrics Subgroup Design Session

11/29/18

Participants: Gerry Calnen, Lesley Bennett, Elsa Stone, Hillary Deignan, Nanfi Lubogo, Tesha Tramontano-Kelly, Jeffrey Lasker, Katie Piwnica-Worms, Karen Siegel, Karen Rubin, Sandi Carbonari, Stephanie Burnham, Linda Green, Patricia Joyce, Rob Zavoski, Lisa Honigfeld, Jesse White-Frese

Goals of Primary Care Modernization

The Practice Transformation Task Force identified primary care redesign to achieve the Quadruple Aim

1. Expand care and diversify care teams
2. Support non-visit-based care, patient support and engagement
3. Double investment in primary care over five years through more flexible payments
4. Reduce total cost of care while protecting against underservice.

Questions Stakeholders are Discussing Now:

- What new capabilities and services will primary care need to provide?
- How will primary care providers be paid for these in a way that supports achieving the goals and is fair to consumers, providers, employers and health plans?

Discussion:

Ms. Nanfi Lubogo asked if the group is informing the work of the Payment Reform Council? Ms. Harrington explained this group's recommendation will go to the PTTF which is a SIM group overseeing this process. These recommendations will then go to the Payment Reform Council (design groups→PTTF→PRC). Ms. Harrington then reviewed the capabilities under consideration, and the purpose of the group, which is to make recommendations to the Practice Transformation Task Force about what core (required) and elective (optional) capabilities pediatric practices should have.

Ms. Harrington reviewed the pediatric primary care vision provided materials, with a potential starting point of Bright Futures guidelines for health supervision of infants, children, and adolescents. Dr. Gerry Calnen asked what do we want to transform pediatric practices into? What does this say that we don't already know, he enquired. Look at the American Academy of Pediatrics model. It gives a clearer idea of what we are trying to transform care into (family centered, compassionate, etc.). This should replace the Bright Future mission statement, he explained. Dr. Calnen warned that the group must decide what the capabilities are designed to do.

The Medical home model is what we are trying to do in SIM, an attendee explained, and Dr. Calnen responded that just having the definition there to start us off is important. Dr. Carbonari agreed, and warned that this effort needs to be careful when using the term "medical home". Ms. Harrington reassured that this is exactly what this discussion will be focused on (the AAP

Medical Home model definition). Dr. Carbonari pointed out that Bright Futures is a part of Medical Home. Ms. Lubogo agreed and stated that Bright Futures do practice under some medical homes and that this definition is more comprehensive.

Ms. Harrington explained the challenge is that the current payment model and care delivery system doesn't support pediatric primary care practices in achieving the Bright Future's mission.

- Not enough time during
- visits
- Pediatricians are overburdened, and burnout is increasing
- Historic focus on acute episodes and disease rather than prevention and health promotion
- Lack of support for integrated and coordinated care

Ms. Harrington explained that the capabilities aim to help pediatric practices (based on feedback from previous sessions):

- Promote children and families' health and well-being
- Expand access and equity
- Make primary care more convenient, community-based and responsive to the needs of patients
- Increase flexibility for providers to allocate necessary resources where truly needed
- Ensure a return on investment in the long-term

Ms. Lubogo pointed out that culturally competent and culturally diverse were missing. Considering the cultural effect is important. Dr. Rubin agreed, and said she would pull equity and cultural competence out to be its own goal. Ms. Tesha Tramontano-Kelly agreed. Dr. Sandi Carbonari did not agree with the idea that a pediatrician's historic focus has been on acute episodes and disease over prevention and health promotion. Pediatricians have always had a major focus on this, she explained. Dr. Calnen agreed, but Dr. Lasker reassured that the provided materials are simply meant to say reimbursements have not focused *enough* on what Dr. Carbonari described. Dr. Carbonari agreed and stated that the payment is what drives the focus. Ms. Harrington added that none of the provided materials are saying pediatricians aren't fulfilling certain functions, and that it's more so about how this effort can support pediatricians in reaching these goals.

- Ms. Lubogo: Would they consider innovation and other modern things being implanted into Medicaid right now (EHRs)?
    - Is this a challenge?
    - Dr. Calnen would say it's a challenge. We haven't been able to keep up with the radicle changes and as a result, are overburdened with these huge agendas. So, we end up focusing more on the computer than we do on our patients. We are not centered on the patient, we are centered on the computer.
    - Ms. Lubogo: Can we put this on there?
    - Dr. Elsa Stone: The medical record is essentially a billing record. If you're tied to fee-for-service, you're tied to the computer.

    - Dr. Schaefer: This should be called out as one of the barriers.
- EHRs and tech are not enablers to better care, while there's an opportunity there, it hasn't helped yet
- Dr. Carbonari: EHRs were never developed with pediatrics in mind, getting worse and not improving
- Dr. Rubin: This is a generic problem, not only in primary care but across the board. There's a great perspective in the New England Journal of Medicine called "Getting Rid of Stupid Stuff". There needs to be an investment in IT to do this.
- Ms. Lubogo: Telemedicine movement that we need to consider in this and I'm sure it's a challenge in some practices.
- Ms. Harrington: We'll discuss telemedicine in the next session. What is needed in the EHR (while not increasing documentation burden) is on our radar.

Ms. Harrington reviewed the vision and key questions with the group:

- Is this the vision of pediatric primary care we should aim for? What are we missing?
- How can new capabilities help pediatric primary care practices achieve this vision? Be supported to achieve these goals?

Ms. Harrington reviewed the Diverse Care Teams key questions:

- Do diverse care team functions and roles support our goals?
- Which, if any, of these functions should be required in every practice?
- Should the full array of diverse care team functions be available in the practice? The network?
- Should diverse care teams be a core or elective capability?

Ms. Harrington then reviewed the Diverse Care Teams Diagram with the group, explaining that its purpose is to help define the functions of the care team and is not trying to dictate who needs to be on the care team.

- Dr. Stone: Arrow that goes from practice to community level over to neighborhood needs to be a two-way arrow
- Dr. Rubin: At the practice and community level, should be arrows going in a circle between every element
- Ms. Harrington: These are meant to overlap too, these are all connected and overlapping
- Population and health at the network level should be at the top; interconnectivity and data sharing are needed for population health between services in the community and the practice
- Dr. Rubin: Could put community health worker in any of those boxes (CHWs could support any of these functions) ideally connecting everyone doing care coordination
    - CHW is well positioned to be coordinated with the community services, so they play a critical role in that way. .

- Dr. Lisa Honigfeld: Nothing on the list provided by Bright Futures about promoting parenting, supporting parenting, promoting development, skewed towards finding the problem, rather than promoting the best universally.
- Dr. Calnen: How does this get into a typical well-child visit?
    - Can't do this with computerized medicine.
    - What about screening for poverty SDOH, substance abuse, breast feeding management, sleep hygiene; we don't touch on them.
    - Pediatricians need guidance on what we can get accomplished
    - We need to focus on what the patient is worried about.
- Dr. Lasker: Not intended to be comprehensive in any way, Dr. Honigfeld's comments were accurate as well. The capabilities discussion should allow pediatricians to have more time
    - Dr. Carbonari: Everything that they're doing is taking from positions of promoting strengths of families. 6 months visit is parents and teachers/family relationships in every single visit. The things that we have listed here are easy to measure because you can check it off on an EMR, but it's the other underlying ways of how you approach things that are more difficult to capture. You can check off all these boxes and still be given crummy care.
- Ms. Tesha Tramontano-Kelly: There is nothing on here about school. Our communities are our schools for our children. Not sure how it fits in, but it needs to be a part of the conversation.
- Dr. Lasker: This is more to build to the structures and the processes, there needs to be guidelines and we must have minimum standards. Must support networks and community services to accomplish our goals
- Dr. Honigfeld: Do we mean care supported in the expanded care team?
    - Anticipatory guidance-instead of bicycle helmets, I would put safety, these conversations vary across patients and families

Ms. Harrington: How can pediatric practices be supported to improve prevention and health promotion? FHC heard longer visits were needed because its not being billed on a fee-for-service visit.

- Dr. Rubin: A German study just demonstrated that the weight trajectory between 2 and 6 is the biggest associated with kid obesity (and then long-term obesity); for certain babies just by virtue of their birth weight and history of obesity, that intervention could occur right when the baby is born, and a care team member trained in this could really have an impact
- Dr. Carbonari: It's important to have that effective program available and those resources available to the patients.
- Dr. Rubin: If it's in the office, it's easier for the family and a BH could be trained; a pediatrician could explain that the parents should want the intervention and appreciate how helpful it can be

- Dr. Calnen: So much of a provider's time is held up in paperwork that other people can take care of, but we can't hire those people because those aren't billable services. Free up the provider's time to do what they are paid to do.
    - Dr. Stone: This is the exciting part about payment reform.

Ms. Harrington reviewed the integrating existing programs into practices provided materials and gave Healthy Steps as an example, Project Dulce, etc.

- Dr. Calnen: The key to paying any practices is the coding
    - There are some that focus on care coordination and integrated mental health care, but insurers are not covering those costs. Take a look at how we can change CPD codes and find a way of requiring all insurers to abide by those codes
    - Dr. Honigfeld: Thought we were talking about what might be in a bundled payment
    - Dr. Calnen: It's going to take some time to get there, we should be talking about episode of care payments utilizing a team-based approach
    - Ms. Harrington: Making sure time is covered by a bundled payment so you get that flexibility
    - Dr. Carbonari: My understanding is that this is going to be for some families
        - It would be a multiplayer demonstration
        - What if some payers decline, then do you have to kick those people out of your practice?
        - Dr. Schaefer- No payer is committed to participation yet. We haven't defined the capabilities and we don't have the proposed payment model. As this work gets further along in January, we'll circle back with payers and providers to kick the tires on the proposed approach. If the payers are not participating, the practice could continue to do what it does on a fee-for-service basis and they might have to make a decision if certain practices aren't participating. It's a great question I don't have an answer for. The more that participate the better it works out.
- Dr. Karen Rubin: One time we had five payers at once and we couldn't treat the other children differently, so we stretched resources. Must be more mature in areas where you're doing this with CHWs. How will you come up with a bundled rate without having this baseline information?
    - Dr. Schaefer: We are working with the comptroller's office to do some analysis, to support your vision for pediatric primary care. Well be able to model it using state employee health data to figure out what additional money might be needed
    - Every individual payer will ultimately have to do the math themselves because we aren't going to set rates on their behalf. Each payer paying into a fund and then establishing a universal fund would be easier, but probably not realistic.
    - Dr. Rob Zavoski: How would that be done for Medicare under a waiver?
    - Dr. Schaefer: For pediatric primary care, we won't have a piece for this. Medicare would have to do a demonstration for adult primary care.

Ms. Harrington summary: It sounds like people supported integrating functions into the care team if there are corresponding payment models.

- Coordinating with prevention and health promotion services within the community
    - Again, this is a good role for the CHW in the office
- Ms. Lubogo-I would agree. This is another way community-based organizations can do a big part and one of the ways of doing that is compensating them for it; finding a way for CHWs to be able to bill this work in coordination with the practices
- Ms. Lubogo: More coordination between schools and practices; funding issue
- Dr. Rubin: It would be great if there was communication in real time (asthma, for example)
- Dr. Calnen: Maybe technology would be helpful. Open notes technology for patients to be able to access portals, print health records, and bring to the doctor's office.
- This is a critical opportunity to be able to tighten up that loop between the various places where a child is receiving their care; cross communication is important; sharing EHRs would be ideal but that's not where we are right now
- Dr. Carbonari: Agrees. School nurses do a lot and they don't overlap
    - The PCP, the school nurse, and school-based-health center = the more coordination between the three, the better.
- Kids are getting various types of care at urgent care, we can't ignore this because it's not going away.
- Similar to the independent telehealth vendors
- Some of the urgent healthcare senders might be sending info to the PCP

Ms. Harrington summary: 1. There is a strong need for care coordinator and a CHW who are coordinating all the places that children and families get care with the practice. 2. There is a need for sharing data between those different places and if that can be done in HIE or a shared HR system

- Dr. Joyce: Sharing information between early childhood center (including Head Start, etc.)
- Lisa Honigfeld: **Childcare health consultants** the yellow forms make sure they're up to date, help the staff deal with specific children who have requirements, let's not forget them in all of this
    - How is the communication back to primary care?
- Dr. Carbonari: A lot of it would get lost, this could be tightened
- Dr. Calnen: Referrals we make birth-3, a lot of times providers get notes back saying a patient doesn't qualify. These kids that are referred have problems that don't meet the threshold
    - Dr. Rubin: That's where the CHW could address those kids who don't qualify.
- Dr. Carbonari: What's a developmental specialist?
    - Do they do assessments?
    - Ms. Lubogo: Developmental specialists are usually specialists in developmental and BH. They do a lot of screening for oxygen, but they're MDs.

    - Not a lot in the state.
    - Dr. Honigfeld: I thought this was referring to the Healthy Steps?
    - Ms. Harrington: That's right. It was not meant to be an MD but based on the Healthy Steps model.
    - Do they do assessments or just screenings?
        - They don't do assessments.
- Dr. Calnen to Dr. Honigfeld, could you talk about the mid-level developmental assessment?
    - Dr. Honigfeld: We do have a pilot test to put these people in pediatric care. They're trained to do assessments.
    - The Village in Hartford has developed a streamlined developmental assessment and uses United Way 211 line to connect kids to services.
    - Dr. Carbonari: They do not do a full evaluation.
    - The school systems are not all prepared for three-year-old's
- Dr. Honigfeld: It's a set of services that are reimbursed care (like a subspecialty service). So, if you go to the Village, they're going to bill Medicaid and bill for that service. It's a referred service, so unsure if it would go over to the health neighborhood box
- Dr. Calnen: It would be for those kids for whom we question if the birth to 3 evaluation is necessary, this would be a very nice alternative
- Dr. Carbonari: We need to make sure there are some services available for the child, a lot of times there are services that are already present in the community that the pediatrician might not be aware of
    - Ms. Lubogo: Agrees.
    - We need to put it in the health neighborhood
- Pediatricians have very little knowledge about school issues, but are being asked and are spending a lot of time on how to support these families
- Dr. Honigfeld: Put something like next-level assessment in the neighborhood
- Ms. Lubogo: This goes beyond assessment
- Dr. Calnen: Mid-level developmental assessment places a lot of reliance on working with Help Me Grow
- Dr. Joyce has used the mid-level developmental assessments a lot. BH related to parenting has helped, whether it's to stimulate the child for an actual developmental delay. Meeting the parent in the community about that is critical.
- Dr. Schaefer: There are a range of community-based support needs that families may have. And I think we should flag those capability issues. The kind of programs and supports that can then be referred to the health enhancement community process. There are tools that are out there for facilitating the assessment of SDOH needs and ensuring that practices have a deep understanding of what those barriers are and how to link back to the community resources
- Ms. Harrington: This really points towards the role of the CHW; To be linking to that community-based support.

Ms. Harrington reviewed the Care Coordination provided materials.

- Dr. Calnen: It's the responsibility of the medical home to provide care coordination services. This doesn't mean the care coordinator needs to be a highly trained social worker. There must be someone embedded in the practice and their services need to be reimbursed.
- Dr. Carbonari: It's not just coordinating between specialties in the community, its more encompassing than this and we should add school
- Ms. Harrington: Care coordination should really be in the pediatric practice
    - Make sure the patient and the family can connect with the specialist
- Dr. Carbonari: The most important thing is to make sure the child gets there and gets the feedback
- Dr. Rubin: The next time you see that patient all the care can be focused on health
    - Dr. Schaefer: Do you see this as part of care coordination role and assessment of environmental and SDOH risk?
    - Dr. Rubin: In our primary care project with the Village, we have developed rules and responsibilities for a full-time care coordinator and screening for SDOH. The situation can change between one visit and another
- Ms. Lubogo: Agrees this is a role the care coordinator could play, time factor in a 15 min visit would help this gap in services
- Dr. Honigfeld: I plead and beg- it's impossible for a practice-based care coordinator to know everything that's going on in the community. Make it a requirement that care coordinators are tied to larger care coordination systems
    - If anything, we need to coordinate the care coordinators
    - Dr. Schaefer: Dr. Rubin, can you describe the care coordination function?
    - Dr. Rubin: They want to avoid redundancies; care coordinators know when its over their head and are also working with Center for Care Coordination when it's a case that really needs linkage to community services; they're doing SDOH screenings
- Ms. Lubogo: We get a lot of calls to work with the care coordinators
- Dr. Calnen: I think health information exchange will enable practices to get information from multiple providers in real time and that will go a long way in reducing redundancies
- Dr. Carbonari: There's a lot of inconsistency in this even though we are a small state, it would be nice to have too many services available
- Ms. Lubogo: 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
- Ms. White-Frese: Clinical social workers are doing the care coordination because there isn't anyone else to do it
- Dr. Rubin: Care coordinators in the practices will further define these roles and share best practices

Next Steps

- Next session is next Tuesday evening, 6pm-730pm
- Will come back to this at the third session.