Primary Care Subgroup Meeting
May 25, 2021

Meeting Date	Meeting Time	Location
May 25, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

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

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

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Hanna Nagy**
	Hanna Nagy called the meeting to order at 1:02pm. Jeannina Thompson administered a roll call.	
2.	**Public Comment**	**Hanna Nagy**
	Hanna Nagy welcomed public comment. None was voiced.	
3.	**Approval of the April 27th Meeting Minutes**	**Hanna Nagy**
	Given there was no quorum at the outset of the meeting, the Subgroup postponed approval of the April 27th meeting minutes until its next meeting on June 22nd.	
4.	**Stakeholder Engagement Update**	**Erin Campbell**
	Erin Campbell summarized the meeting goals and reviewed the meeting agenda. **Stakeholder Interviews** Erin Campbell reminded the Subgroup that Bailit Health and OHS had been conducting stakeholder interviews to collect input on the Roadmap. Erin shared the list of completed and planned meetings with providers, medical societies, payers, and state agencies. Erin shared feedback from various interviews, including feedback on: certification of advanced primary care practice status; infrastructure investment; primary care workforce challenges; the increasing number of referrals to specialty care; payer commitment to advancing primary care in Connecticut; and prospective payments. Erin Campbell asked the Subgroup for their reactions to the feedback received in the stakeholder interviews. • Alex Geertsma noted that the American Academy of Pediatrics (AAP) was not on the list of stakeholder interviews. Michael Bailit shared that the CT AAP chapter was invited to participate in an interview but did not accept. Alex shared that the AAP chapter had recently gone through organizational changes and may be more inclined to participate now. Michael said that OHS and Bailit Health would try reaching out to the AAP again. • Shirley Girouard suggested interviewing the CT Nurses Association, School Nurses Association and OBGYN groups (although noted that CT does not recognize OBGYNs as primary care providers). Shirley also expressed concern about whether the Subgroup had a formal definition of	

primary care. Erin Campbell said she would reach out to the groups Shirley mentioned and look into whether the Subgroup had adopted a definition of primary care in the past.

- Leslie Miller said she was surprised that direct primary care was addressed in stakeholder interviews. Leslie also asked if OHS and Bailit Health had spoken to anyone who studies direct primary care in other states. Erin Campbell said that OHS and Bailit Health had not spoken to anyone who is actively participating in direct primary care, although it had been raised in stakeholder meetings that providers in other states are happy with the direct primary care model and welcomed more information and perspectives on the topic.
- Lisa Trumble highlighted the administrative burdens placed on primary care, particularly the burden of documenting quality metrics. Lisa said that there are very few plans in CT that require member to designate a PCP, which contributes to the referral issue. Lisa said that variation in quality metrics between plans adds complexity to the practice environment.

5. April Subgroup Meeting Recap — **Erin Campbell**

Priority Objectives

Erin Campbell reminded Subgroup members that at the April 27th meeting they initiated the Roadmap development process and discussed draft "priority objectives." Erin reviewed the Subgroup's feedback and clarified that while building the primary care workforce is critical to strengthening and sustaining primary care, this strategy is not part of OHS' assigned scope for the Roadmap. Erin presented the proposed changes to the priority objectives and asked the group if they had any additional feedback on the priority objectives.

- Shirley Girouard suggested that priority objective #3 be revised to read "all team members in primary care" rather than "primary care professionals and team members." Michael Bailit suggested the objective be revised to read "all primary care team members." Shirley agreed.
- Alex Geertsma suggested, regarding priority objective #2, that the Subgroup consider how it defines "best practice care" and what quality and outcome measures are best for patients. Michael Bailit said the Subgroup will return to quality measures at later meetings. Alex asked how this work related to the OHS Quality Council work. Michael explained that the Quality Council maintains a core measure set intended for use by advanced networks and most measures are primary care-focused, so one idea is to identify a subset of core measures specific to primary care and align use of those measures across payers with primary care practices.
- Lisa Honigfeld said that quality measures differ from outcomes and community services play a role in producing good outcomes. Alex Geertsma clarified that not all quality measures are predictive of good outcomes. Leslie Miller agreed that outcomes are most important and said that quality measures are sometimes burdensome for primary care physicians and electronic medical records are not helpful to providers because they often hide information. Shirley Girouard said that structure and process measures can be useful for enhancing good outcomes. Brad Richards said that quality measure fatigue is captured within the priority objectives, particularly within priority objective #3.

6. Continuation of Roadmap Development — **Michael Bailit/Erin Campbell**

A. Proposed Core Practice Functions

Michael Bailit presented 10 proposed core practice functions, which were synthesized based on what Subgroup members submitted to OHS and Bailit Health prior to the meeting. Michael shared that although there was a fair amount of agreement across submissions, some ideas were not included. Michael asked for feedback and modifications to the proposed core practice functions.

1. **Relationship-centered**
   - Shirley Girouard said what matters most are the values of the patient and what matters to the patient. Shirley suggested a revision to the core function akin to "the practice is built

around what matters to the patient." Ken Lalime added the core function could be further revised to read "trusted relationships."

2. **Empaneled**
   - Leslie Miller said that requiring a patient to stay with one group is not the right thing to do because team members have different personalities and patients do change practices to find the clinician that most meets their chemistry. Michael Bailit clarified this core function envisions internal empanelment by the practice, not externally imposed requirements placed upon the patient.
   - Shirley Girouard said she did not like the word "empaneled" and thought the Subgroup needed another word for public consumption. Michael Bailit agreed.
   - Alex Geertsma raised the primary care workforce issues related to recruitment, training, and education and said there may not be adequate readiness in the workforce to dedicate itself to this kind of commitment. Michael Bailit clarified that there is a difference between having a primary relationship and exclusive relationship with a primary care physician.
   - Marie Smith asked for clarification around the term empanelment and if the intent was attribution. Michael Bailit explained that empanelment is about the practice identifying who within the practice holds lead responsibility for the patient relationship with each individual patient, and attribution is usually a payer practice of imputing a patient and provider relationship based on past utilization information.
   - Karen Hlavac emphasized that empanelment is especially important for individuals with intellectual disabilities.
   - Leslie Miller asked how the lead clinician would be chosen. Michael Bailit clarified that the practice would decide on the designated team member internally, in part based on the patient's preference.

3. **Team-based care**
   - Shirley Girouard suggested revising the core function to read "and supporting both the patients and the practice."
   - Naomi Nomizu said the team-based approach is common in the hospital setting and that in the primary care setting the clinician on the team should be aware of all medical decisions happening on the team.
   - Heather Gates said team-based communication takes time and the reimbursement structure has to support this extra time. Michael Bailit agreed.
   - Leslie Miller said there are legal considerations for team-based primary care practice. Michael Bailit said that team members should only be providing care for which they are qualified and trained.

4. **Easily accessible**
   - There was no comment on this core function from Subgroup members.

5. **Embedded care managers (medical) and care coordinators (non-medical)**
   - Michael Bailit explained the care managers and care coordinators, as envisioned by this core function, would be part of the practice ("embedded") as opposed to telephonic care coordinators and would extend across adult and pediatric populations.
   - Shirley Girouard said that trying to describe all the ways care can be managed or coordinated with two titles (care manager and care coordinator) may be too prescriptive given care management can be done by other team members too. Shirley suggested the

core function to be broadened to "practice includes care management functions." Brad Richards expressed support for this change.

- Alex Geertsma said care coordination necessitates training at least at the level of a nurse. Michael Bailit suggested adding the concept of training to this core function so that whoever is performing care coordination has requisite training.
- Ken Lalime asked whether community health workers fell under the definition of care coordinator. Michael Bailit confirmed that they did.
- Naomi Nomizu asked if telephonic care management done by the provider counted toward this core function. Michael Bailit said that although telephonic coordination by providers is allowed, there should be an option for face-to-face interaction because telephonic care coordination if used exclusively is less effective than in-person coordination.
- Lori Pennito said, from the payer perspective, the embedded care manager model with face-to-face interaction, and with telephonic management as needed, is the superior model.
- Ken Lalime said payers will want to play a role in managing care, especially for risky patients.
- Alex Geertsma said in general there is a tendency for providers to decrease care coordination when they come under financial stress, but they are less likely to cut care coordination if the coordinators are part of the practice.

6. **Planned care at every visit**
   - Lisa Honigfeld said the core functions did not strike her as being specific to primary care adding that the real strength of primary care is its focus on health promotion and prevention. She expressed a desire to see health promotion and prevention highlighted more in the core functions. Naomi Nomizu agreed with Lisa's suggestion and together offered a revision: delivers planned care with an eye towards holistic preventive care and health promotion at every visit.
   - Leslie Miller said family practitioners are trained to deliver planned care at every visit, but patients often have different plans. Alex Geertsma said there are software options to help patients raise issues before they walk through the door to help with planning ahead of time.

7. **Evidence-based care**
   - Alex Geertsma said workforce support and development will be necessary for this core function.

8. **Behavioral health integration**
   - Alex Geertsma wondered how consistent of a need behavioral health integration is for certain socioeconomic strata, although believing it to be a constant need for the Medicaid population and pediatrics.
   - Ken Lalime said behavioral health integration for the Medicaid and pediatric populations is critical but there are payment issues with providing services on the same day but payers not allowing payment for both of those services on the same day. Ken added that it would be advantageous to the patient to have both services under the same location.
   - Brad Richards said rural locations may struggle having a physically located behavioral health clinician, noting that offering behavioral health virtually may be necessary in such cases.

- Naomi Nomizu said behavioral health needs cross all socioeconomic classes but agreed with Ken that payment is an issue in a fee-for-service model. Naomi added that behavioral health telehealth virtual visits work very well.
- Steph Caiazzo said payers will pay for multiple visits if there are two separate services, which works for a fee-for-service model, not a capitated model since it is the PCP being capitated not the behavioral health provider. Steph added that health insurance companies are increasingly looking at a delivery care system that incorporates behavioral health in the PCP model.
- Heather Gates agreed with Naomi Nomizu. She asked if embedding behavioral health is for the purpose of treatment or for assessment and consultation because the level of need can be mild and episodic or very significant, and telehealth is an important tool for improving access. Ken Lalime said patients should not leave an in-person visit without the benefit of an assessment because many patients do not get to a second visit with a community provider. Brad Richards said there should be some flexibility with a baseline floor of what is expected from behavioral health in primary care, with the floor being assessment, brief treatment, and referral.
- Shirley Girouard said age-specific behavioral health needs should be integrated in the primary care practice and language about "age-appropriate care" could be added to the core function. Michael said there are many patient characteristics that should shape care in multiple core functions. Alex Geertsma said the care team will need to thoughtfully incorporate levels of behavioral health along the spectrum of care.

9. Patient engagement and support

- Alex Geertsma said patient engagement and support includes giving early advice to parents about healthy childhood behaviors.
- Leslie Miller said the Subgroup needed to think about how to get patients engaged in healthy living and self-management, perhaps using incentives. Michael said research indicates that incentives do not work for sustained behavior change.
- Brad Richards offered the idea of community-oriented primary care.[1] Alex Geertsma said community-connected care is consistent with American Academy of Pediatrics efforts to get pediatricians more involved with local public policy.

10. Utilization of data and targeted quality improvement

- Naomi Nomizu said this core function could incorporate community-connected care by indicating the data should include social and community demographics. Naomi added with respect to core function #9 that there are structural issues that prevent patients from managing chronic conditions.
- Alex Geertsma said the challenge is getting beyond easy proxy measures and using the full capabilities of the EHR and HIE.
- Lisa Honigfeld said data on school attendance is important to include for pediatric primary care. Michael Bailit said school attendance information is not already available to primary care practices, and this core function is about using what is available. Alex Geertsma suggested schools have input on what is included in an HIE, such as individual educational planning (IEP) reports.

[1] Subsequent to the meeting, Brad shared the following resources on community-oriented primary care: https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/copc-curriculum/COPCModule1-Introduction.pdf and https://ajph.aphapublications.org/doi/10.2105/AJPH.92.11.1748

- Shirley Girouard said she was watching a National Academies series on transitioning health care related to financing that rewards better health and offered to share the information with the Subgroup.

Michael reminded the Subgroup about CT's primary care spend target and said the increase in primary care spending can go towards implementing these core practice functions.

Michael observed that the Subgroup seemed to have reached consensus on the 10 proposed core practice functions (with language modifications), and with agreement to add reference to community-oriented primary care, as suggested.

B. Proposed Supports
Erin Campbell gave an overview of two proposed supports to help practices implement the core practice functions and invited feedback from Subgroup members.

1. **Practice coaches provide direct support to practices**
   a. Marie Smith said she agreed with the two supports but questioned whether the practice coaches staffed by payers will have the expertise needed to support these core practice functions and asked if the Subgroup should consider broader technical assistance. Michael Bailit clarified this option came out of conversations with payers who indicated they already have staff working with practices and providing technical assistance, but the question of whether they have the best expertise was a fair one and a common curriculum could be considered.
   b. Lisa Trumble said her experience with practice coaches had been variable. She believed there needed to be an independent source providing coaching and resources, adding she would like to see payers financially supporting this transition rather than implementing it.
   c. Shirley Girouard said the geriatric workforce enhancement efforts of HRSA could serve as a model and emphasized the need for training the workforce.
   d. Leslie Miller recommended involving the state's medical schools in workforce training.

2. **OHS offers a learning collaborative**
   a. Lisa Honigfeld said there have been variations of the learning collaborative model across CT and she had learned that it costs practices time and money to participate in learning collaboratives and to make these changes.
   b. Alex Geertsma said that CHN had done a lot of work promoting the model of patient-centered medical homes and implementing meaningful practice change. Ken Lalime agreed and said funding was critical.
   c. Vicki Veltri said OHS was working with DPH on its primary care assessment and it may be reaching out to Subgroup members for ideas and input.

Erin closed the discussion due to time constraints, indicating the Subgroup would revisit this topic at its next meeting.

7.	**Next Steps and Wrap-up**	**Erin Campbell**
	Erin Campbell reviewed the next steps in the Subgroup 2021 process and timeline and welcomed additional Subgroup member feedback outside of official meetings. The next Primary Care Subgroup is scheduled to take place June 22nd at 1pm.	
8.	**Meeting Adjournment**	**Hanna Nagy**

	Ken Lalime made a motion to adjourn the meeting. Shirley Girouard seconded the motion. There were no objections. The meeting adjourned at 2:58pm.