Primary Care Subgroup Meeting
May 25, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Welcome and Roll Call	Office of Health Strategy	1:00 PM
Public Comment	Members of Public	1:05 PM
Approval of the April 27th Meeting Minutes—Vote	Members of PCSG	1:15 PM
Stakeholder Engagement Update	Bailit Health	1:20 PM
April Subgroup Meeting Recap	Bailit Health	1:35 PM
Continuation of Roadmap Development	Bailit Health	1:50 PM
Next Steps and Wrap-up	Bailit Health	2:55 PM
Meeting Adjournment	All	3:00 PM

Roll Call

Public Comment

(2 minutes per person)

Approval of April 27th Meeting Minutes

Stakeholder Engagement Update

Stakeholder engagement update

- To ensure that we hear a broad array of…
  - primary care practice voices;
  - consumer perspectives, and
  - payer perspectives

  …OHS and Bailit Health have been holding interviews.
- In addition to collecting input, we have told those we have engaged that we will share draft recommendations coming from the Subgroup as they develop, and share them for review and comment.
- We will, in turn, bring that feedback back to you.

Stakeholder engagement update

Completed Meetings

- **Providers**: Community Health Center Association of CT, Community Health Center Inc., Eastern CT Health Network Medical Group, Hartford HealthCare Integrated Care Partners, Northeast Medical Group, SOHO HEALTH, Starling Physicians, Trinity Health of New England Medical Group
- **Medical Societies**: Connecticut Chapters of Academy of Family Physicians, Advanced Practice Registered Nurse Society, American College of Physicians
- **Payers**: Aetna, Anthem, ConnectiCare, Harvard Pilgrim
- **State Agencies**: Department of Social Services, Office of the State Comptroller

Planned Meetings

- OHS Consumer Advisory Council, Other Consumer Representatives, Independent Practice Associations, UnitedHealthcare

OHS continues to seek input on the new roadmap

Key messages heard from practices and payers:

- Certification for advanced primary care practice status seems reasonable to some, but unreasonable to others due to cost and administrative burden.
- Roadmap priorities should include the funding of infrastructure without practices having to front the investment.
- Primary care workforce challenges in CT (recruiting, salary disparities, pipeline) put roadmap implementation at risk.
- While some specialists now see the need for better primary care in CT, there are still too many patients who should be seen by a PCP, referred to specialists, and never "returned" to the PCP for ongoing management.

OHS continues to seek input on the new roadmap

Key messages heard from practices and payers:

- Initially interviewed payers expressed commitment to advancing primary care in CT and OHS' renewed charge.
- Prospective payments are attractive to many practices. Perceived happiness of colleagues operating under direct primary care is confirmatory for some of the benefit of prospective payment. Others, however, have concerns about readiness in CT and fear of decreased revenue under capitation.

April Subgroup Meeting Recap

We initiated roadmap development with step #1

Process Step	Description
1. Establish highest priority objectives for a strengthened primary care system	This should be a listing of only the highest priorities, such as those identified in the "Guiding Principles." It should not be all-inclusive.
2. Adopt an advanced primary care practice model	This should describe core, essential practice functionalities.
3. Decide how practices will be supported in adopting the practice model, and by whom	For example: learning collaborative, practice coaching, self-taught with learning aids, or a combination
4. Adopt a program for confirming practice model adoption	This is necessary for payers to support investment.
5. Adopt a payment model(s)	The payment model(s) should support the care model, sustain practices and align with objectives for high-value.
6. Adopt an implementation plan	The plan describes who will be responsible for doing what, and by when. Involved stakeholders should support the plan; commercial payers must commit to it.
7. Define a measurement and evaluation plan	To determine that the highest priority objectives were achieved, without any unintended adverse consequences.

We discussed draft “priority objectives”

1

Patients easily access comprehensive, patient-centered, equitable, evidence-based care that supports their health.

2

Primary care practices are supported in their efforts to deliver such care through a) removal of structural impediments to delivery of good care, b) technical assistance on best practice care and c) payment levels and structures.

3

Primary care professionals find their daily work, on balance, professionally gratifying.

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We heard your feedback, and offer responses

- We added "...primary care professionals ***and team members***" to objective #3 to reflect the burden that can trickle down to other team members.
- Some feedback will be considered later during the process, e.g., how enhanced practice infrastructure should be phased in over time.
- We heard and acknowledge that 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, however.
  - OHS is separately collaborating with the CT Department of Public Health to align on primary care workforce needs.

Revised draft "priority objectives"

1

Patients easily access comprehensive, patient-centered, equitable, evidence-based care that supports their health.

2

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Continuation of Roadmap Development

Today's focus: Steps #2, #3, and #4

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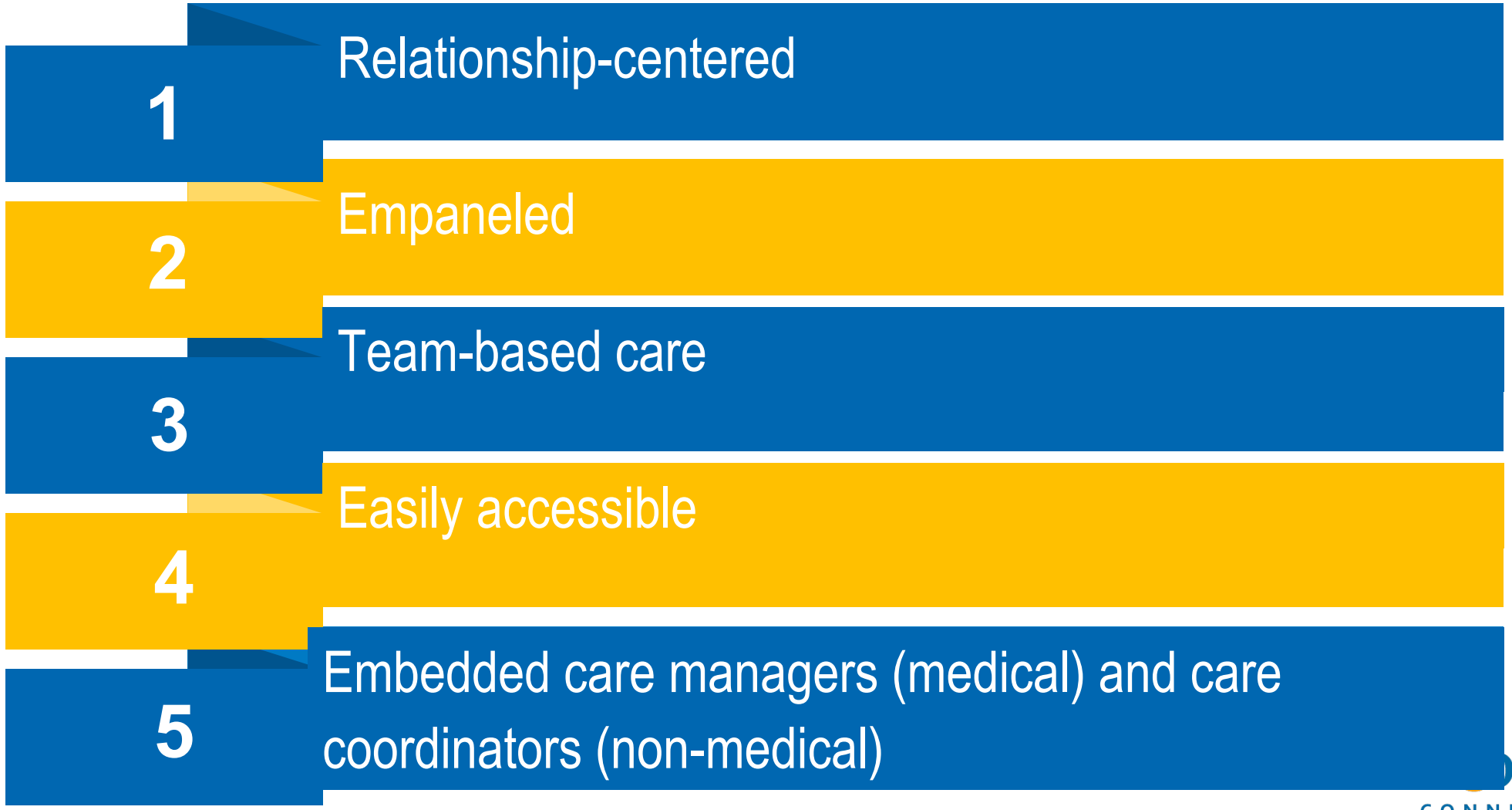
10 core practice functions

- Many of you responded to our request for suggested core, essential primary care practice functions. Thank you.
- There was significant alignment across the submissions.
- We synthesized your input, restricting the list of core functions to 10.
  - We recognize that some worthy ideas were not included in the list.
  - We stuck with 10 because we are committed to a roadmap that people can "put their arms around" and will result in meaningful, impactful action.

Proposed core practice functions



Proposed core practice functions

Proposed core practice functions

1. The practice is built around developing **relationships with patients**, making them feel heard and listened to, and patient-centered from the front desk to the follow-up.
2. Patients are **empaneled** with designated lead clinician who fosters a continuous, longitudinal relationship.
   - *Not a rotating workforce where the patient sees a different clinician every time.*
3. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, all with defined responsibilities and supporting the practice to the full extent of training and credentials.
   - *Not a hierarchy with a physician directing all activity and providing all direct care.*

Proposed core practice functions

4. Care is easily **accessible** and prompt, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours.
5. The practice team includes embedded **care managers** (medical) and **care coordinators** (non-medical). Care managers support patients with chronic conditions and disabilities and patients experiencing transitions of care. Care coordinators connect all patients with community supports to address social risk factors, and work with families and other caregivers.
   - *Not a centralized pool of telephonic care managers who are not part of the practice.*
6. The practice team delivers **planned care** at every visit.
   - *Not simply reacting to whatever the patient presents with at the time of care.*

Proposed core practice functions

7. Care delivery follows **evidence-based** guidelines, supported by EHR clinical decision support, and allowing chronically ill patients to be well-managed by the practice.
   - *Not a pattern of inappropriate referral of chronically ill patients to specialists for management.*
8. **Behavioral health** is integrated into the practice via embedded behavioral health clinicians.
   - *Not simply co-located behavioral health clinicians.*
9. **Patients are engaged** and supported for healthy living and self-management of chronic conditions.
10. The practice **utilizes data** from the EHR, HIE and payers to identify patient care needs, monitor change over time, and inform targeted **quality improvement** activity.

For discussion

- Does this proposed set of functions represent the highest priority primary care practice functions?
- Is there anything missing from this list that is an absolute priority?
- Are there any suggested modifications?

Proposed supports to help practices implement core practice functions

- Practices will benefit from support to implement and maximize core functions.
- We suggest a blend of supports from OHS and payers to help practices with their implementation:
  - Practice coaches
  - Learning collaborative

1. **Practice coaches provide direct support to practices**
   - Practice coaches are staffed by payers, with support from OHS to ensure a common curriculum, tools and templates.
2. **OHS offers a learning collaborative**
   - A forum for peer support, collaborative learning and problem solving, sharing best practices.

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For discussion

- Do you agree these supports will help practices with their implementation?
- Are there other critical supports you recommend?
- Other feedback?

Confirming adoption of core functions

- Our experience tells us that adopting a program for confirming practice core function adoption is necessary for payers to support enhanced investments in primary care.
- Practice feedback on this notion is decidedly mixed.
  - Some stakeholders understand or accept the need.
  - Others find having to confirm or certify practice model adoption unreasonable due to cost and administrative burden – a burden applied to primary care and not specialists.
- Potential options for adoption confirmation include:
  - National certification, e.g., NCQA, Joint Commission, URAC
  - State-developed certification, e.g., CT—OHS Advanced Medical Home Program, MN, OR
  - Practice self-attestation
  - Practice self-attestation with limited verification
  - Hybrid of any the above, e.g., RI

For discussion

- What is the pulse of the Subgroup? Should the Subgroup adopt a program for confirming practice model adoption?
- What are the pros/cons of the different options?
- Are there other options we should consider?

Addressing practice barriers

- Many of you responded to our request to identify structural impediments and other barriers to the delivery of high-quality primary care that need to be reduced or removed. Thank you.
- There was significant alignment across the submissions.
- We synthesized your input and grouped the barriers into five identified themes: **payment**, **workforce**, **administrative burden**, **technology**, and **access**.
- Throughout the roadmap development process, our goal is to minimize or remove those barriers within our scope.

Identified structural impediments and other barriers to high-quality primary care (1 of 3)

Theme	Cited Examples
Payment	- Inflexible payment models - Inadequate payment for comprehensive care or time outside of direct care - Misaligned models across payers; - Lack of support for staff training or coordination with social service providers
Workforce	- Inadequate supply of PCPs - Market competition (hospitals hire away from practices with higher pay) - Working knowledge of special populations - Increased referrals to specialists - Inadequate training for APPs

Identified structural impediments and other barriers to high-quality primary care (2 of 3)

Theme	Cited Examples
Administrative Burden	- Paperwork and reporting requirements - Paperwork only a physician can sign - EMR documentation - Pre-authorizations - Chart review requirements
Technology	- Lack of broadband access across the continuum of care - Lack of access to all patient information; - Lack of technology to administer electronic appointment check-ins - Lack of technology for telehealth

Identified structural impediments and other barriers to high-quality primary care (3 of 3)

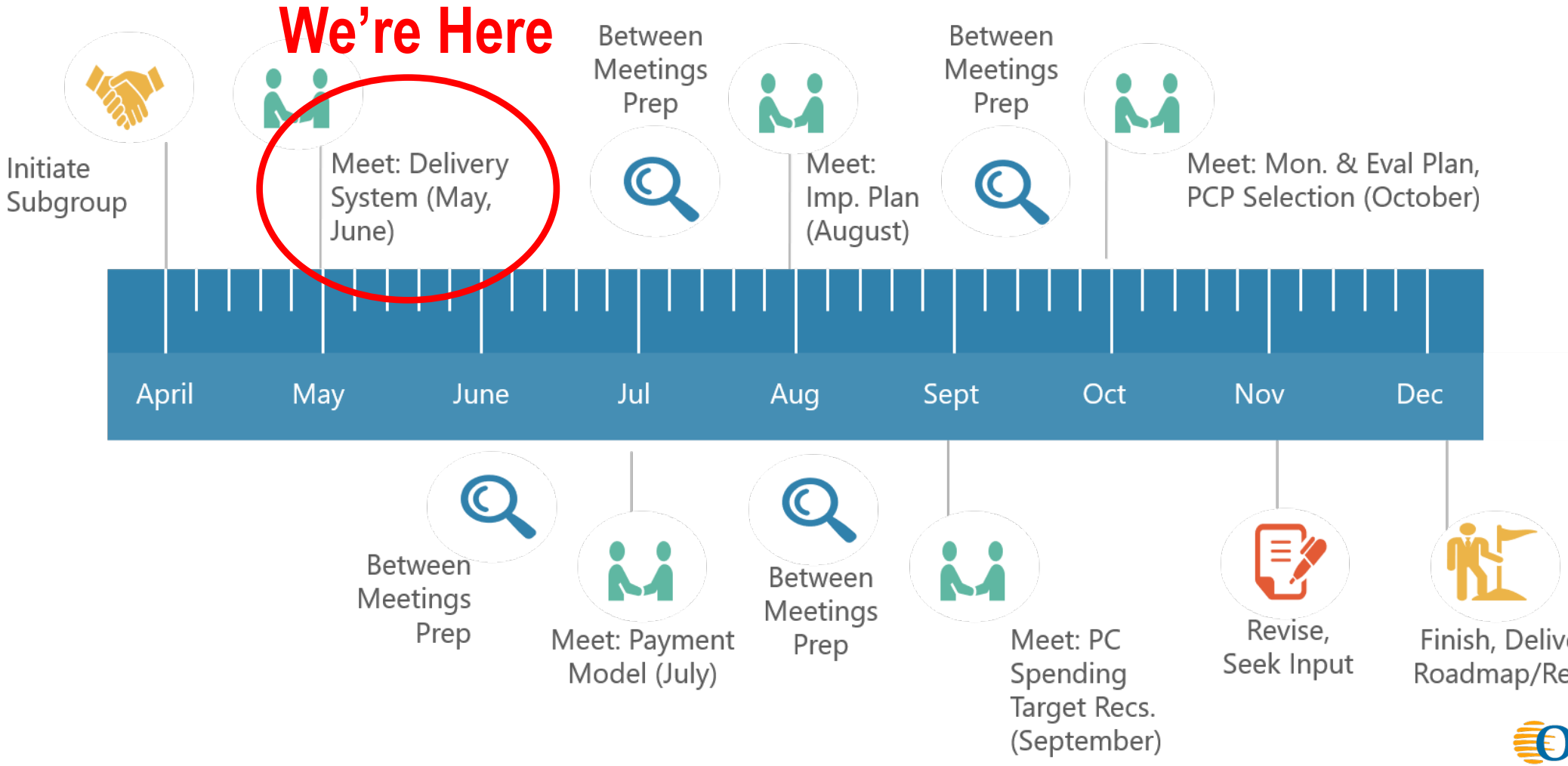
Theme	Cited Examples
Access	- Transportation - Parking availability - Hours of operation - Limited access to behavioral health services and to some specialists

For discussion

- Are there any additional important barriers worth citing?
- Which should we prioritize addressing because of their impact on practices?
- For those you prioritize, we will next ask you for ideas about how to address them.

Next Steps and Wrap-Up

Subgroup 2021 process and timeline



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Next steps

- The next Primary Care Subgroup meeting is scheduled to take place June 22nd at 1pm.


THANK
YOU