Primary Care Subgroup Meeting
June 22, 2021

Meeting Date	Meeting Time	Location
June 22, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

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

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, OHS**
	Hanna Nagy called the meeting to order at 1:01pm. Jeannina Thompson administered a roll call.	
2.	**Public Comment**	**Hanna Nagy, OHS**
	Hanna Nagy welcomed public comment. None was voiced initially, but at 1:40pm Mark Schaefer offered a delayed public comment that issues of racism and disparities could be integrated within Core Function 10.	
3.	**Approval of the April 27th and May 25th Meeting Minutes**	**Hanna Nagy, OHS**
	Elsa Stone moved to approve the minutes from the April 27th meeting and Shirley Girouard seconded. The minutes were approved. Alex Geertsma moved to approve the minutes from the May 25th meeting and Lisa Honigfeld seconded. The minutes were approved. Elsa Stone abstained from the vote to approve the May 25th meeting minutes because she was not present at the meeting.	
4.	**Stakeholder Engagement Update**	**Erin Campbell, Bailit Health**
	Erin Campbell shared that since the last Subgroup meeting in May, Bailit Health met with a small group representing independent practice associations, with American Academy of Pediatrics chapter representatives and with UnitedHealthcare. Erin also said that Bailit Health shared the draft Subgroup primary care recommendations with those stakeholders not on the Subgroup and with whom OHS had previously met for their review and comment and had incorporated their feedback into the presentation. Erin summarized new insights heard from the Independent Practice Associations, including that: OHS' primary care strategy must work for practices of all sizes and should recognize primary care as "the	

	quarterback of a patient's care;" small, independent practices face specific challenges; infrastructure and technology are hugely needed; uniform quality metrics across payers would help significantly; and any program for confirming practice adoption of core functions requires simplification for smaller practices. Erin asked if Subgroup members had any feedback or additional thoughts to share on the stakeholder feedback. There were none.	
5.	**Adopting a Primary Care Definition**	**Erin Campbell, Bailit Health**
	Erin Campbell reminded the Subgroup that during the May 25th meeting a member requested that the Subgroup adopt a definition of primary care. Bailit Health proposed adopting the National Academy of Sciences updated definition of primary care, which reads: • *High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.* **Discussion:** • Leslie Bennett suggested that Bailit Health consider the American Academy of Family Physicians (AAFP) definitions of primary care, which may be more consumer friendly. Shirley Girouard agreed and also suggested Johns Hopkins' definition. • Brad Richards suggested the Subgroup could adopt both a technical definition and a more consumer-friendly definition. • **Next Step**: Erin Campbell said Bailit Health and OHS will look at the suggested definitions and bring them back to the Subgroup for additional consideration.	
6.	**May Subgroup Meeting Recap**	**Michael Bailit, Bailit Health**
	Michael Bailit reminded the Subgroup that at its May meeting the group came to consensus on 10 core practice team functions and a member suggested an 11th core practice function to address community-oriented primary care. Michael noted the functions had been modified since that meeting to reflect Subgroup and stakeholder feedback and the list had been reordered based on natural groupings of functions. Michael reviewed the functions, noting any additional stakeholder feedback and suggestions that warranted the Subgroup's input and decision-making. Core Function 3: Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship. • The Connecticut Chapter of the Academy of Family Practice (CAFP) requested the Subgroup consider using "primary care provider" instead of "lead clinician." • Michael asked the Subgroup for feedback on the suggested substitution. **Discussion:** • Elsa Stone said she did not like the word "provider." • Shirley Girouard said she liked the phrase "primary care provider." • Alex Geertsma said he was concerned with how "primary care provider" would be interpreted by stakeholders without an understanding of primary care. • Brad Richards suggested "lead primary care clinician." Shirley Girouard disagreed. • Shirley said the Subgroup should provide a definition of lead clinician.	

- **Next Step**: Michael Bailit said the Subgroup would retain the current function but provide a footnoted definition of "lead clinician."

Proposed Core Function 11: The practice team takes steps to understand the health needs of its community through assessment of both quantitative and qualitative data and implements, with community participation, community-oriented interventions to address health needs.

Discussion:

- Michael said he was concerned about what the core function would require from small practices.
- Brad Richards said the idea for this functionality comes from a public health framework, specifically how community concerns can be identified by and acted upon by primary care clinicians (e.g., as occurred during the Flint, MI water crisis).
- Michael reiterated his concerns about the burdens of community-oriented interventions on small practices. Brad Richards responded by suggesting a rephrasing to "community-oriented care" from "community-oriented interventions."
- Lesley Bennett said she was concerned about the burden on small practices but suggested looking at definitions of primary care that reflect community needs (e.g., AAFP's definition) rather than adding another core function. Michael said the primary care definition is not to be operationalized within the Roadmap, whereas the core functions are.
- Shirley Girouard said she thought practice understanding of the community in which it practices and community-oriented care are important principles but expressed concern about the burden on small practices. Shirley also suggested rewording the function to read "practice should demonstrate an awareness of health and social issues in the community and participate in health care issues in the community."
- Leslie Miller agreed about the potential burden on small community practices and added that small community practices treat patients from different communities and often keep the price of medicine lower.
- Mario Garcia said he appreciated the idea of the function and said he was not sure how the function would create a burden.
- Alex Geertsma said he would like to see this function be used to help larger health systems partner with clinicians on community needs.
- **Next Step**: Michael said that Bailit Health and OHS, with help from Brad Richards, will reconsider how to integrate community-oriented primary care into the core functions and send a revised proposal to the Subgroup.

Additional stakeholder feedback

Michael shared stakeholder feedback that it is hard to maintain a practice team and suggested community resources (e.g., Youth and Family Services, VNA social worker, Agency on Aging, school counselor, etc.) be viewed as part of the practice team. Michael asked the Subgroup whether they thought community resources should be viewed as part of the practice team. Michael added that he viewed community resources as being essential community partners but not part of the practice team.

- Heather Gates said community resources could be used as a source for referrals, but they have their own missions and challenges and not enough resources to be considered part of the practice team.
- Elsa Stone said community resources should not be considered part of the practice team because virtual support is not enough to see real benefits.

Michael shared a stakeholder suggestion that the Subgroup consider systemic bias and racism in the draft core functions, perhaps as "systems that can actively work to reduce racism and systemic bias." Michael asked the Subgroup how they would like to address this recommendation.

- Brad Richards said he concurred that systemic racism is a huge issue in healthcare, but he was not sure how to address it within the scope of the practice functions.
- Elsa Stone suggested integrating education on racism and biases into the state's training programs.
- Mark Schaefer said health equity and health disparities could naturally fit within Core Function 10, regarding quality improvement and data use. *(Delayed public comment)*
- Michael suggested modifying Core Function 10 to read: "inform targeted quality and equity improvement activity."
- Shirley Girouard said the Johns Hopkin's definition of primary care may be useful for integrating disparities.
- Mario Garcia highlighted the difference between identifying health disparities and addressing the myriad intertwined causes of disparities, including racism.
- Mario Garcia posted links to Jeffrey Brenner's faculty profile and to the CHNA CHIP Matrix.
- **Next Step**: Michael proposed that Bailit Health and OHS modify Core Function 10 to include equity and share it in a redlined revision for finalization during the next meeting.

Other Discussion:

- Shirley Girouard said the core functions were missing care coordination across the healthcare system. Karen Hlavac agreed with Shirley. Michael said there is language in Core Function 4 that address coordinating functions. Shirley said Core Function 4 does not address when a patient sees multiple provider types and indicated someone in the practice would need to be responsible coordinating all care for the patient. Brad Richards said this idea could fit within Core Function 4 with some modification. Randy Trowbridge and Alex Geertsma agreed with Brad.
- **Next Step**: Michael said Bailit Health and OHS will modify Core Function 4 and redistribute the functions with the changes redlined.

6.	**Continuation of Roadmap Development**	**Erin Campbell, Bailit Health**

Erin Campbell summarized the next two steps in the Subgroup's roadmap development process (steps three and four). The third step in the roadmap development process was to "*Decide how practices will be supported in adopting the practice model and by whom*." The proposed supports were: (1) payer practice coaches who provide direct support to practice teams and (2) OHS offers a learning collaborative.
The fourth step in the roadmap development process was to "*Adopt a program for confirming practice model adoption*."

Erin summarized the concerns and suggestions received from Subgroup members on the first proposed support (payer practice coaches). Erin Campbell asked Theresa Riordan from Anthem if she would share Anthem's recent feedback on practice coaches.

- Theresa Riordan said Anthem has found the needs of practices to vary and Anthem has invested time and resources in understanding each practice's individual needs. Theresa also said Anthem has not found learning collaboratives to be useful, as compared to the learnings resulting from 1:1 coaching.
- Alex Geertsma said learning collaboratives on a large scale are difficult to implement, but smaller regional groups followed-up by in-practice practicums are more successful. Alex also said care coordinators were helpful in DPH Patient-Centered Medical Home (PCMH) for Children with

Special Health Care Needs program, but only when funds were available to support care coordinators.
- Lisa Honigfeld said the last thing a practice needs is a separate coach from each health plan and this effort would need to be well-organized and work across all payers.
- Michael Bailit shared that Bailit Health had been involved in other large scale primary care transformation efforts that include practice coaches and learning collaboratives and found both supports to be helpful, but only if practices are participating because they are eager to learn.
- Shirley Girouard said practice coaches may seem like an added cost but may actually result in more efficient and effective care.
- Ken Lalime mentioned CMS's Transforming Clinical Practice Initiative (TCPI), which used practice coaches and was successful.
- Leslie Miller said practice coaches should be centralized and neutral, with respect to health plans.

Erin asked Subgroup members how practice coaching should be provided: by leveraging existing plan resources already working with network practices on workflow redesign and other related activities, or through a third-party resource with shared financial support across commercial and Medicaid payers.
- Theresa Riordan said a multi-tiered approach would make sense, because payers have developed relationships with practices but streamlining support could still be useful.
- Michael invited payers to think about how to develop a combined approach that is supportive of practices but also streamlined across payers.
- Shirley Girouard expressed concern about the complexity of a multi-tiered approach and said she wanted to see the content of the practice coaching. Michael clarified the coaching would be to help practices achieve the core functions.
- Leslie Miller said practice coaches might be overburdened by coordinating multiple practice coaches and suggested keeping the coaching centralized and providing it virtually.
- Alex Geertsma asked (in the chat) what percentage of primary care practices in CT have participated in the PCMH recognition process, given that would be the core curriculum in practice reform.
- Ken Lalime offered to share resources from CMS TCPI program with the Subgroup.
- Lori Pennito said practices take their work personally and have varying levels of readiness for change. She suggested practice coaching be done in a unified manner with a personalized approach for each practice. Randy Trowbridge and Elsa Stone agreed with Lori.
- Randy Trowbridge highlighted the utility of functional medicine.
- **Next Step:** Bailit Health and OHS will consider Subgroup feedback on the proposed practice supports and bring a proposal to the next Subgroup meeting.

Michael moved on to the fourth step in the roadmap development process (program for confirming core practice team functions adoption), summarized the mixed feedback received on the concept, and shared four potential options for adoption confirmation and summarized their pros and cons. Michael said a hybrid approach was a potential fifth option.
1. National certification
2. State-developed certification
3. Practice self-attestation
4. Practice self-attestation with limited verification

Discussion:

- Alex Geertsma said using billing measures to confirm PCMH status was arduous and said he was intrigued by using software applications built into EMR to document engagement in clinical processes.
- Leslie Miller said she was concerned about long-term unintended consequences, specifically the added cost of licensure for small practices and maintaining community orientation.
- Ken Lalime highlighted the DSS PCMH+ program as a potential model. Michael noted that DSS builds its program off of NCQA PCMH recognition, and said deeming practices with NCQA recognition is one option, but the Subgroup may want to create another pathway for non-NCQA-recognized practices.
- Shirley Girouard asked what percentage of practices is already NCQA-recognized. Michael said he was not sure but from experience in other states it is not close to all practices. Shirley said she was loath to come up with a new way to accredit practices and would like to know current NCQA statistics.
- Brad Richards said he was at a practice that had NCQA designation and there is heterogeneity between NCQA certified practices. He also stated that having a standard was important. Based on his experiences, Brad expressed interest in a hybrid approach.
- Theresa Riordan said adoption of the practice functions is most important and certification itself is less important. Theresa said it there was attestation there would need to be pre-defined requirements. Theresa also indicated Anthem would be open to exploring practice self-attestation as an option.
- Lori Pennito agreed with Brad Richards regarding NCQA certification and said of the three alternatives she would prefer to start off with a state-supported option versus a standardized NCQA PCMH certification.
- Shirley Girouard said she was impressed by the rigor of the NCQA standards and cautioned against trying to develop new standards.
- Wendy Ashe said she preferred a hybrid approach, perhaps building off NCQA certification with a measurement and feedback period. Wendy also said attestation alone is not going to change the way providers practice.
- April Greene said she echoed Wendy Ashe's comments and added that there needs to be consideration of quality metrics already established in value-based arrangements.
- Lesley Bennett said the Subgroup should consider which state agency will be responsible for oversight and raised concerns about budgetary and staffing concerns.
- Alex Geertsma asked to hear what Mark Schaefer had to say about PCMH and burden of certification. Mark Schaefer said check-box-based credentialing is not effective and suggested designing reimbursement programs that reward achieving health and health equity. Mark also said, based on his experience with SIM, technical assistance and learning collaboratives were very effective.
- Michael reminded the Subgroup that it was not considering payment models yet, but would be considering payment during future meetings. He also summarized what he heard from the Subgroup on the topic as total self-attestation was too much, and some hybrid between self-attestation with limited review and a state-developed option might be a better fit.
- **Next Step**: Michael said Bailit Health and OHS will come back to the Subgroup with a proposal for confirming practice model adoption at the next meeting and will share the proposal in advance of the meeting for Subgroup members to consider and confer with colleagues if beneficial.

9.	**Next Steps and Wrap-Up**	**Erin Campbell, Bailit Health**
	The next Primary Care Subgroup meeting is scheduled to take place July 27th at 1pm. Erin Campbell indicated the intent of the next meeting was to transition to a discussion on payment models. Michael	

	Bailit noted that while the Subgroup did not resolve today's topics, the Subgroup will continue to iterate on those topics until sufficient progress is made, in parallel with discussions on payment models.	
10.	**Meeting Adjournment**	**Hanna Nagy, OHS**
	Lesley Bennett made a motion to adjourn the meeting. Elsa Stone seconded the motion. There were no objections. The meeting adjourned at 2:54pm.	