Primary Care Subgroup Meeting
June 22, 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 April 27 & May 25 Meeting Minutes—Vote	Members of PCSG	1:15 PM
Stakeholder Engagement Update	Bailit Health	1:20 PM
Adopting a Primary Care Definition	Bailit Health	1:25 PM
May Subgroup Meeting Recap	Bailit Health	1:30 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

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Roll Call

Public Comment (2 minutes/person)

Approval of April 27 & May 25 Meeting Minutes

Stakeholder Engagement Update

Stakeholder engagement update (1 of 3)

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

  …OHS and Bailit Health have continued holding interviews to seek input on the new roadmap.
- Since our last meeting we met with a small group representing Independent Practice Associations and with UnitedHealthcare.
- Additionally, we shared the draft Subgroup primary care recommendations to date with those stakeholders with whom we previously met, for their review and comment.
  - We have incorporated their feedback into today's presentation.

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Stakeholder engagement update (2 of 3)

New insights heard from IPAs on behalf of small, independent practices:

- 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, including:
  - No capacity to run multiple payment systems
  - Difficulty assembling a team for team-based care (but agree it is the right approach)
  - Limited resources to develop EHR expertise and work through day-to-day technical and operational challenges with payers
  - Providing after-hours coverage to expand access to care

Stakeholder engagement update (3 of 3)

New insights heard from IPAs on behalf of small, independent practices:

- Infrastructure and technology are hugely needed.
- Uniform quality metrics would help significantly.
- Any program for confirming practice adoption of core functions requires simplification for smaller practices.

Adopting a Primary Care Definition

During the last meeting a member requested we adopt a definition of primary care

- Bailit Health proposes adopting the National Academy of Sciences updated definition of primary care:
  - *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.*[1]

Do you support adopting this primary care definition?

[1]National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

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May Subgroup Meeting Recap

The group reached consensus on 10 core practice team functions (1 of 3)

1. Care delivery is centered around what matters to the patient, developing **trusted relationships with patients**, making them feel heard and listened to, and instilling patient-centered practices from the front desk to post-visit follow-up
2. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, all with defined responsibilities that are clear to the patient and supporting the patient and the practice to the full extent of training and credentials.
3. Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship.
    - CAFP requests the Subgroup consider "primary care provider" instead of "lead clinician."

The group reached consensus on 10 core practice team functions (2 of 3)

4. The practice team includes a) an **embedded clinical care management function** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) an **embedded non-clinical care coordination function** to connect all patients with community supports to address social risk factors, and work with families and other caregivers.*
5. **Behavioral health** is integrated into the practice team through behavioral health clinicians who are members of the practice.*
6. The practice team delivers "**planned care**" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.

*Alternative approaches involving virtual care may be required for very small practices, including those in rural communities

The group reached consensus on 10 core practice team functions (3 of 3)

7. 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.
8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by EHR clinical decision support.
9. **Patients are engaged** and supported for healthy living and self-management of chronic conditions.
10. The practice team **utilizes data** from the EHR, HIE, and payers to identify patient care needs, monitor change over time, and inform targeted **quality improvement** activity.

The group proposed an additional 11th core practice team function

- **Community-oriented primary care** (COPC) defined:
  - COPC is a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services.[2]
- Proposed COPC core practice team function (based on initial group feedback):
  - 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.

[2]Fitzhugh Mullan and Leon Epstein, 2002:**Community-Oriented Primary Care: New Relevance in a Changing World** *American Journal of Public Health* **92**, 1748_1755, **https://doi.org/10.2105/AJPH.92.11.1748**

For discussion

- Stakeholder feedback for the group's consideration:
  - "For solo practitioners or small practices, it is difficult to maintain a team of ancillary support staff internal to the organization. We can see the workgroup sought to address this by adding that the supports can be virtual. We also would like to add that these supports can exist in the community, e.g., Youth and Family Services, VNA social worker, Agency on Aging, school counselor, etc."
    - Is this suggestion consistent with our definition of a practice team?
  - Consider systemic bias and racism in the draft core functions, perhaps as "Systems that actively work to reduce racism and systemic bias."
    - How would the Subgroup like to address this recommendation?
- Does the group have any final feedback on the other core practice team functions?

Continuation of Roadmap Development

Today's focus: #3 and #4

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.

During May's meeting, we proposed supports to help practice teams implement core functions

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

1. **Payer practice coaches provide direct support to practice teams**
   - 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.

What we heard from the group

- Expressed concerns:
  - Whether payers have the required deep expertise to assist practices. One coach usually does not have expertise in several core functions.
  - Costs to practices to participate in learning collaboratives.
- Offered suggestions:
  - Payers provide financial support, but an independent, neutral source delivers uniform technical assistance across all practices.
  - Alternatives to a “one coach” strategy include using a generalist practice coach with a cadre of SMEs who support core function topics.
  - The learning collaborative be an online webinar series on each core function and emerging topics, and include an online portal for shared information.

For discussion

- Should practice coaching 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?
- Should a learning collaborative be coordinated by OHS, if funded?
- Should there be a simple evaluation to determine each practice's needed level of support?
- Are there other supports you recommend, or other feedback you wish to share?

Confirming adoption of core functions

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 has been 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.
- 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 of the above, e.g., RI (NCQA or completion of approved transformation program + demonstrated excellence or improvement on quality measure set, as assessed by state)

Pros and cons of options for adoption confirmation (1 of 2)

	Pros	Cons
National Certification	▪ Widespread use by practices and payers; off-the-shelf products available ▪ Most comprehensive assessment of advanced primary care practices ▪ No state intervention or costs required	▪ Certification fee for practices ▪ Time-intensive for practices, including burdensome documentation requirements and potential site visit ▪ Multi-year process to achieve and maintain certification
State-Developed Certification	▪ Establishes common requirements across participating CT practices; can be tailored to OHS Primary Care program ▪ Meaningful option to satisfy payer expectations while potentially creating less burden for practices	▪ Resource-intensive and high cost for the state ▪ Some documentation requirements for practices, but could be less than for national certification

Pros and cons of options for adoption confirmation (2 of 2)

	Pros	Cons
Practice Self-Attestation	▪ Less burdensome on practices and state than external review ▪ State resources required for practice survey, but less so than other options	▪ May not satisfy payer expectations for verifying practice achievement
Practice Self-Attestation with Limited Verification	▪ Less burdensome on practices and state than more robust external review	▪ Will generate some admin expense for practice and state or payers for verification process ▪ May not satisfy payer expectations for verifying practice achievement

For discussion

1. Should the Subgroup adopt a program for confirming practice model adoption?
2. If so, which of the aforementioned options is most appealing?
    - Are there other options the group should consider?

Addressing practice barriers

- Many of you responded to the 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 - Medicaid payment policies
Workforce	- Inadequate supply of PCPs - Underutilization of highly trained clinicians as expanded care team members - 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)

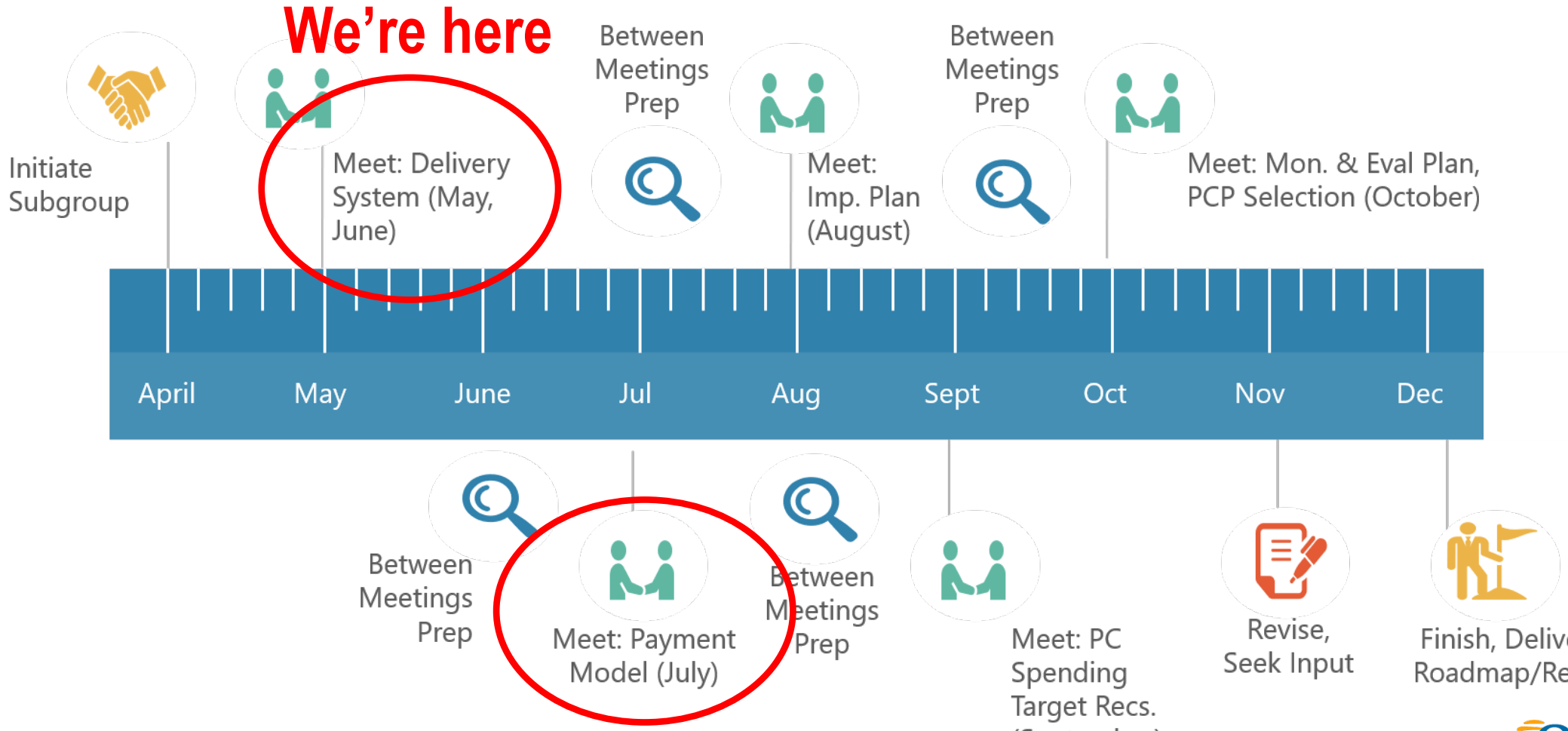
Theme	Cited Examples
Access	- Access to what is ordered/prescribed by primary care but beyond the financial means of a patient - Transportation - Parking availability - Hours of operation - Limited access to behavioral health services and to some specialists

For discussion

- Are there any additional important barriers worth citing?
- Which barriers should we prioritize addressing because of their impact on practices *and* our ability to impact them?
- 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



Next, we'll transition to payment

Next steps

- The next Primary Care Subgroup meeting is scheduled to take place July 27 at 1pm.


THANK
YOU