OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

February 14, 2019

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Population Health Council Appointment	5 min
5. Primary Care Modernization Proposed Capabilities	95 min
7. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Population Health Council Appointment

Population Health Council Appointment

Representative of the Community Action Agencies

Deborah Monahan, Executive Director, Thames Valley Council for Community Action

Primary Care Modernization Proposed Capabilities

Primary Care Modernization: The Work To Date

Stakeholders have identified many goals for a new model of primary care in Connecticut, including:

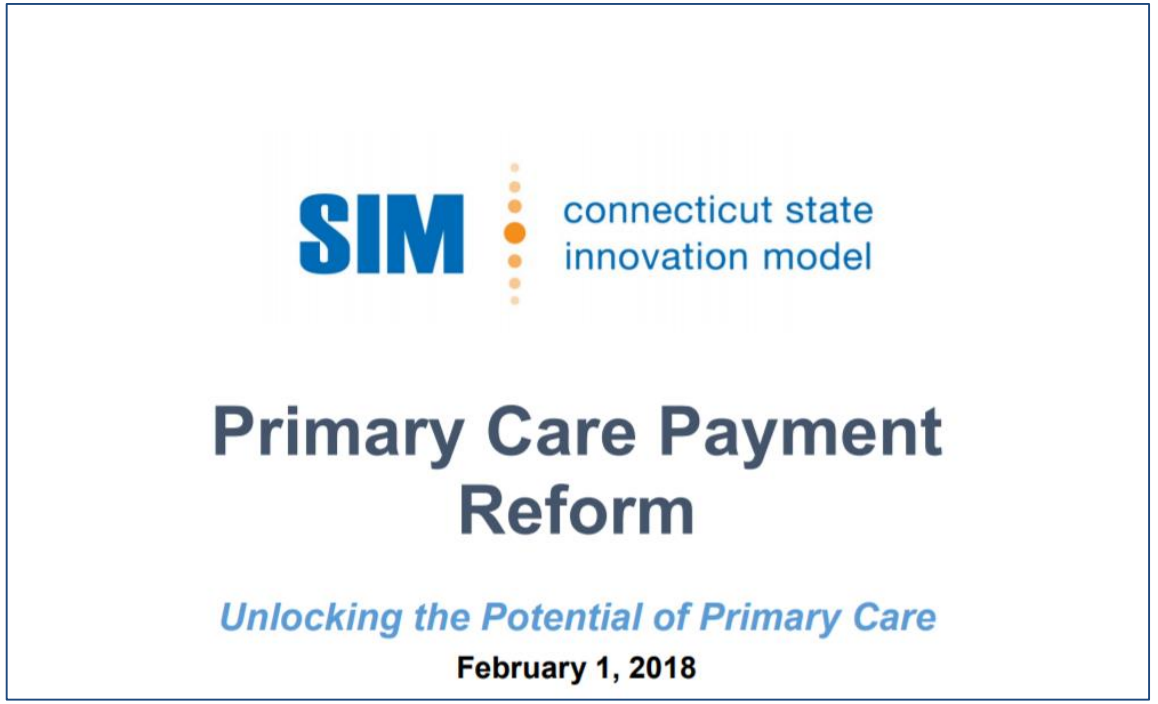
1. Support patient-centered, coordinated care and a better patient experience

2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed

3. Expand care teams and improve access outside the traditional office visit

4. Grow investment in primary care over five years through more flexible payments

5. Reduce total cost of care while protecting against underservice



Primary Care Modernization: Designing the Model

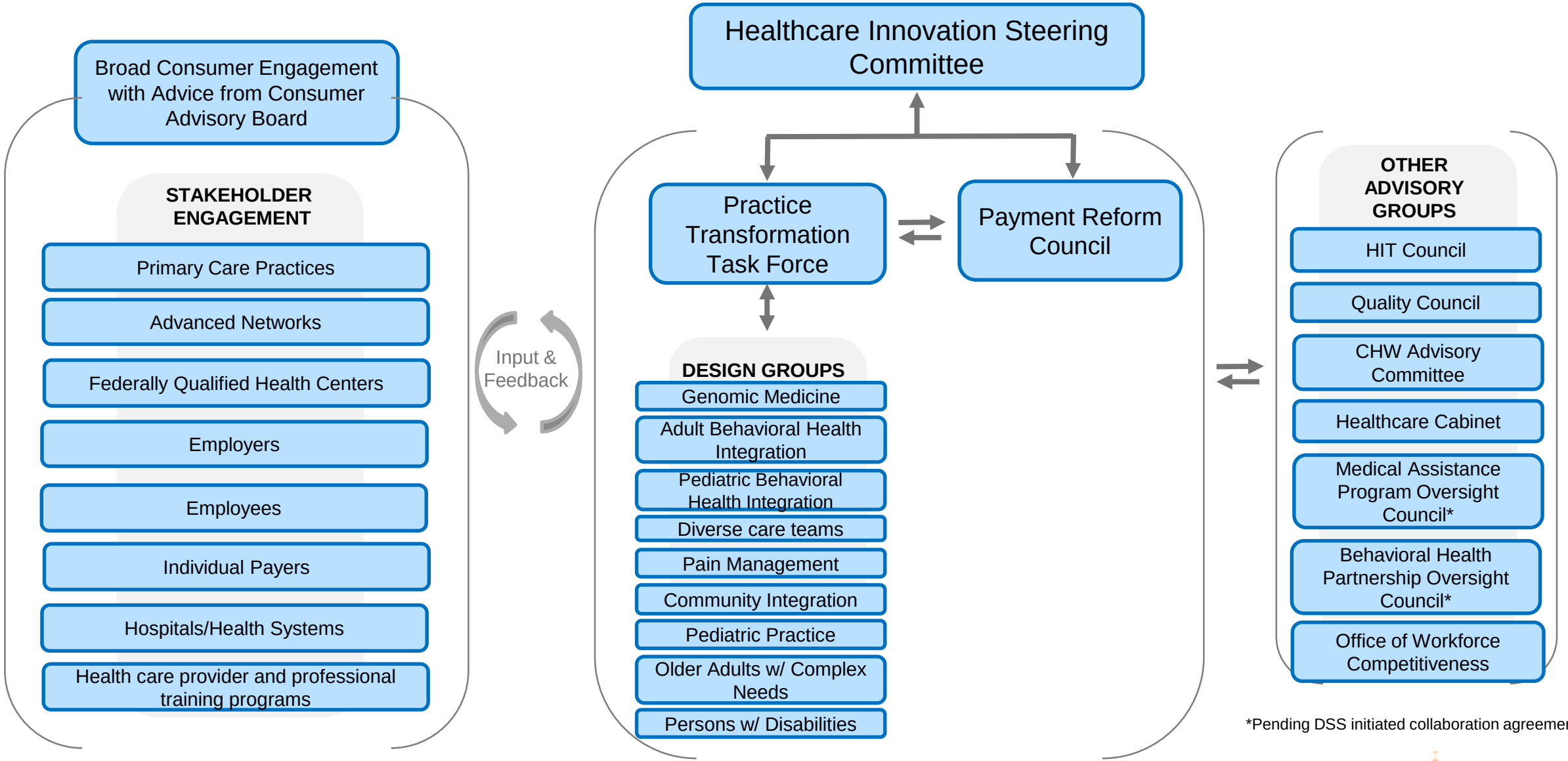
Assumptions:

- Eligibility limited to practices in Advanced Networks and FQHCs
- Multi-payer
- Existing MSSP or other shared savings arrangements remain in place

Questions We are Discussing Today:

- What new primary care capabilities will Advanced Networks and FQHCs be able to provide?

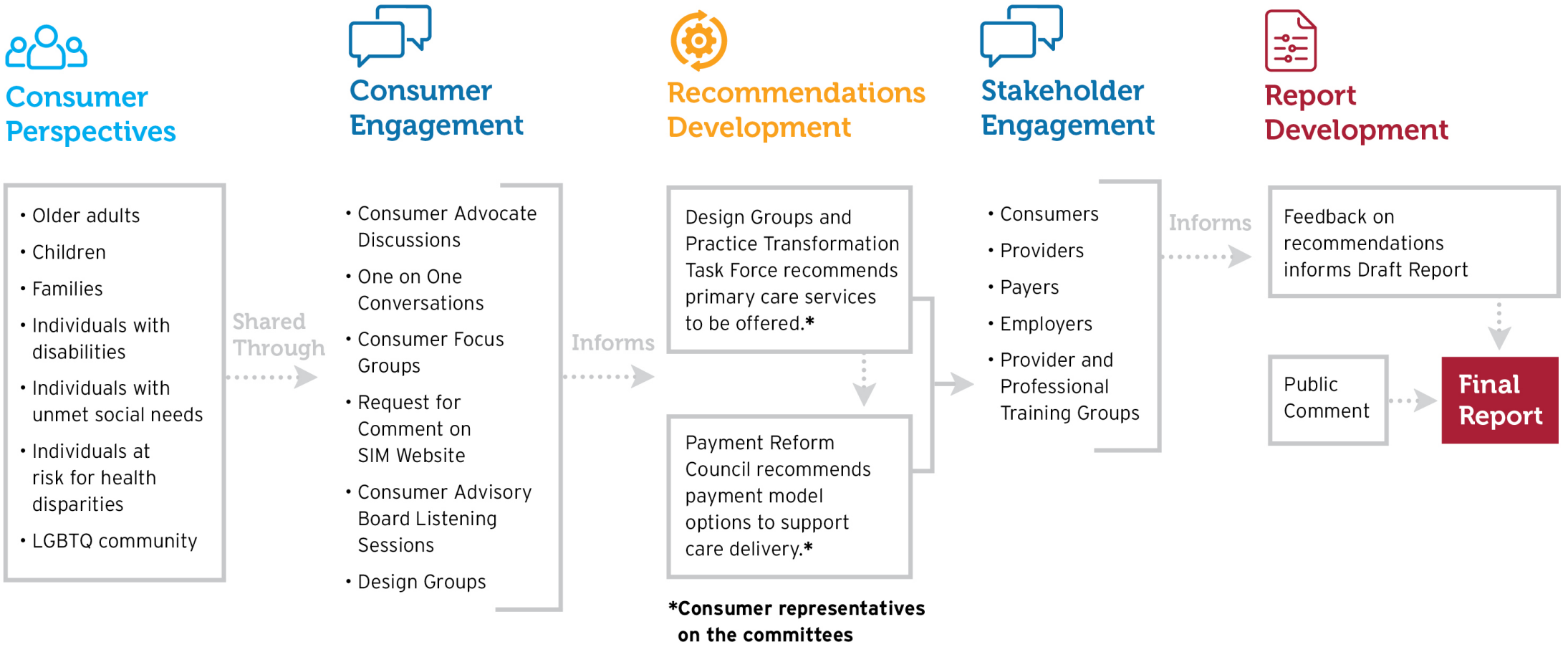
Stakeholder Engagement Progress



*Pending DSS initiated collaboration agreement

SIM connecticut state innovation model

Primary Care Modernization Process



Those Who Receive, Provide and Pay for Healthcare Participating in Every Phase of the Work

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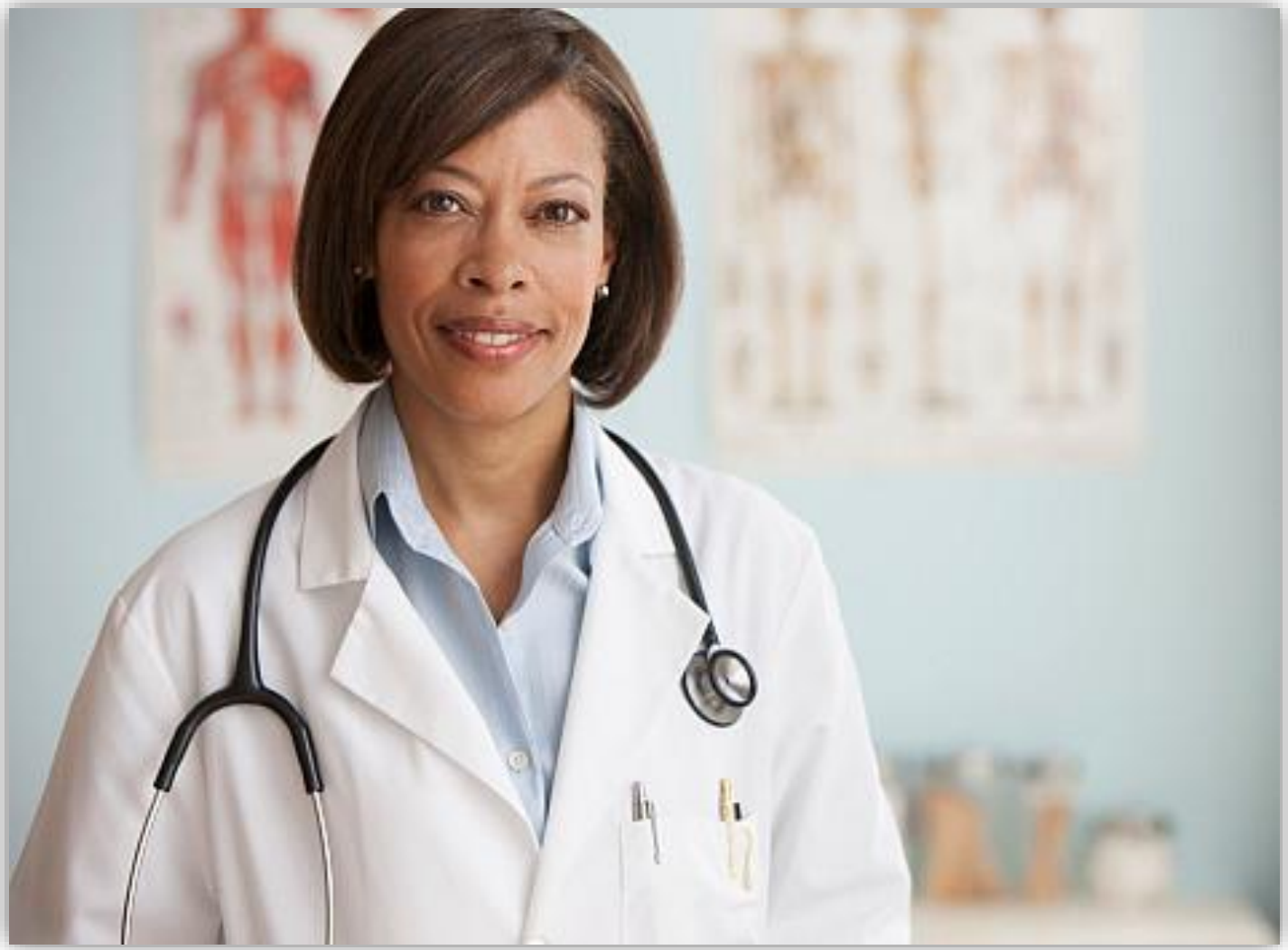
SIM connecticut state innovation model

Dr. Neil



Dr. Neil's Adult Patients

Kahn's Story

Kahn's Needs

- A trusted provider that understands her unique needs
- Help understanding and managing her depression and PTSD
- Help understanding and managing her chronic conditions
- Access to food, housing, and unemployment support

Dr. Neil's Practice Solutions

- Contract with community partner for Community Health Worker support
- Depression and trauma screening & part-time LCSW
- Referrals to local community organizations to help with SDOH needs

Mr. Jones's Story

Mr. Jones's Needs

- Help managing prescriptions for diabetes, congestive heart failure, kidney disease
- More frequent and closer monitoring of changes in condition
- Fewer avoidable trips to the doctor due to stroke related mobility challenges

Dr. Neil's Practice Solutions

- Home-visit by part-time Pharmacist
- E-Consult option with cardiologist
- Video check-in visits with PCP and/or RN care manager
- Remote patient monitoring for congestive heart failure
- Communication with care team through phone and email

Mr. Jones

Christina Polomoff,
PharmD, BCACP, BCGP

Assistant Clinical Professor

University of Connecticut School of Pharmacy

Population Health Clinical Pharmacist

Hartford Healthcare Integrated Care Partners

Clara's Story

Clara's Needs

- Physical Therapy to improve her symptoms related to ME/CFS
- Access to behavioral health support
- In-home care to reduce the challenges of leaving the house

Dr. Neil's Practice Solutions

- LCSW who can conduct home visits
- Multi-disciplinary team with access to a physical therapist
- Remote patient monitoring of vital signs
- Routine video visits with PCP

Luis's Story

Luis's Needs

- Help managing diabetes, cardiovascular conditions, and depression, on top of dementia
- Support for his daughter and son-in-law in understanding and caring for his conditions
- Cultural and Language specific care
- Help with Advance Care Planning

Dr. Neil's Practice Solutions

- Connect Luis and his family with a nearby PCP specializing in care for older adults, including:
  - Expertise in dementia and geriatric care
  - Advance Care Planning and palliative care expertise
  - Spanish-speaking Community Health Worker that provides guidance to Luis and his family about community resources

Chris's Story

Chris's Needs

- Help managing his Crohn's flare-ups
- Support for his depression
- More coordinated care to reduce the number of specialists he is seeing
- Fewer days of missed work and fewer ED visits

Dr. Neil's Practice Solutions

- Part-time LCSW to identify behavioral health needs and make referrals
- Coordinated care between the GI specialist, PCP, and LCSW
- E-Consult to dermatologist to address emerging skin problems

Adult Primary Care Capabilities

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Health Equity Improvement	Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Core	• Diverse Care Teams • Behavioral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Remote Patient Monitoring • Integrative/functional medicine	• Older Adults w/Complex Needs • Pain Management and Medication Assisted Treatment • Individuals with disabilities
Elective	• Community Purchasing Partnerships • Oral Health Integration	• Shared Medical Appointments	

ADULT DIVERSE CARE TEAMS

CORE

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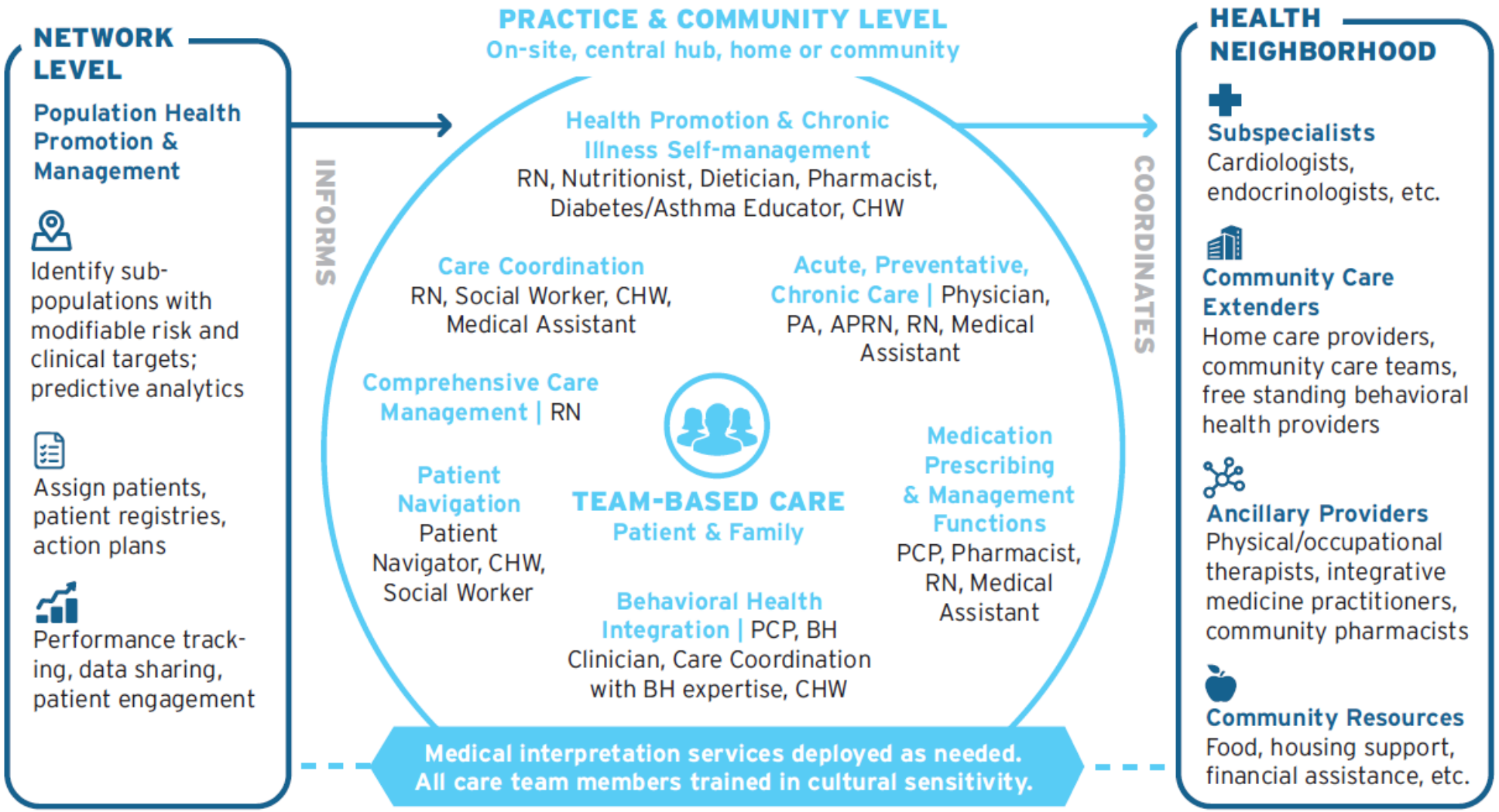

ADULT BEHAVIORAL HEALTH INTEGRATION

CORE

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ALL PRIMARY CARE PROVIDERS TEAM-BASED CARE

Patient & Family

Standard screening for behavioral health and social determinants

Dedicated behavioral health clinician (LCSW or APRN)

- Available on-site or via telemedicine
- Performs assessments, brief treatment services and care team consultation

eConsult arrangement with community-based psychiatrist or advance practice registered nurse (APRN)

Team-based, biopsychosocial approach to care, health promotion, and prevention

Medication management

Practice team training

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialists

HEALTH NEIGHBORHOOD

Connects patients via established relationship with clinics, psychiatrists, psychologists/APRNs/LCSW to provide extended therapy, counseling, and higher level of care

Connects to community-based organizations

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

ADULT COMMUNITY PURCHASING PARTNERSHIPS

ELECTIVE

DRAFT

CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services
[See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness Self-management Services	Complex Care Coordination for High Risk Patients, Often with SDOH Needs	Support for Patients with Acute or Chronic Medical Risk at Home
EXAMPLES OF MODELS	Health Leads or Project Access	Community Meeting Place Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/Community Paramedicine

INCREASE EXPERTISE IN PAIN MANAGEMENT

CORE

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All Primary Care Providers

PREVENTIVE CARE TO AVOID ACUTE TO CHRONIC PAIN PROGRESSION

- Basic assessments, diagnosis and care planning
- Self care, e.g. nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

ROUTINE CARE FOR ACUTE AND CHRONIC PAIN

- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Subset of Primary Care Providers

with specialized expertise in pain management or MAT. Manage complex patients and provide reassessment services and consultative support to all network PCPs

ADVANCED PRIMARY CARE CHRONIC PAIN MANAGEMENT

- Chronic pain management and re-assessment
- Specialized expertise in alternative therapies, e.g. behavioral health, acupuncture, self-management, etc.

MEDICATION ASSISTED TREATMENT (MAT)

- Treatment for opioid addiction

Primary Care Referrals

to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

CENTERS OF EXCELLENCE IN PAIN MANAGEMENT

- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

ADVANCED NETWORK / FQHC

PATIENT EDUCATION AND ENGAGEMENT AT ALL LEVELS OF CARE

INCREASING PAIN ACUITY AND TREATMENT COMPLEXITY →

CENTERS OF EXCELLENCE PROVIDE	**All PCPs**: Training and technical assistance in pain assessment and management	**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management

SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities

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ADVANCED NETWORK/FQHC TEAM-BASED CARE

Patient & Family

ALL PRIMARY CARE PRACTICES IN AN/FQHC

- Diverse Care Teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
- Telemedicine visits
- eConsults between PCPs and specialists
- Remote patient monitoring for CHF, post-acute care
- Phone/text/e-mail encounters

SUBSET OF PRIMARY CARE PRACTICES

Specialize in Geriatrics for Patients with Complex Needs

Specialized expertise supported by Project Echo guided practice, practice experience expertise and technical assistance for Advance Care Planning

- Home-based Primary Care
- Dementia Care
- Palliative Care
- Advance Care Planning (Project Echo)
- Acute care setting rounding & care transitions support

HEALTH NEIGHBORHOOD

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

Specialty Care
Subspecialists (e.g. cardiologist, pulmonoglist, etc.), acute care settings

Community & State Services for High Risk Older Adults
Home care/aides, hospice providers, assisted living facilities, Connecticut Community Care support programs

Community Supports for all Older Adults
Meals, transportation, housing, handyman (hand rails, etc.), community centers

Other Adult Capabilities

- Telemedicine, Phone, Text & Email **(CORE)**
- eConsults and Co-management **(CORE)**
- Remote Patient Monitoring **(CORE)**
- Shared Medical Appointments (ELECTIVE)
- Oral Health Integration (ELECTIVE)
- Under Consideration
  - Individuals with Disabilities
  - Integrative/Functional Medicine

Universal Capabilities for Adult and Pediatric Primary Care Practices

CORE

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All Practices

Health Equity Improvement

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures. Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Community Integration to Address Social Determinants

Every practice and network will identify social determinants of health and other barriers that may affect patents' healthcare outcomes and address those barriers by connecting patients to community resources.

Pediatric Primary Care Capabilities

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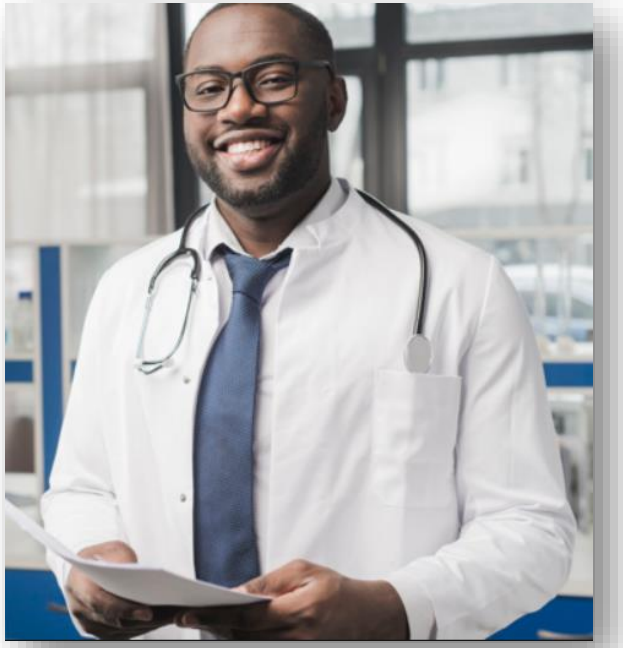
		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Oral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Universal Home Visits for newborns	• Individuals with disabilities
	Elective	• Community Purchasing Partnerships	• Shared Medical Appointments	

Dr. Bell’s Pediatric Patients



The Beck Family Story

The Beck Family's Needs:

- A pediatric provider who can support them in parenting for the first time
- Support for breastfeeding
- Connection to other new parents
- Monitoring of neonatal jaundice
- Information about: crying, bathing, and feeding

Dr. Bell's Practice Solutions:

- Lactation consultant who can talk with them by phone and make home visits if helpful
- Group well child visit for babies of the same age
- Nurse visit to monitor jaundice
- Parenting group and community health worker with expertise in infant care and child development.

Jesse's Story

Jesse's needs:

Jesse is a 15 y being seen by her provider for a well child visit. As part of the confidential, validated screens administered via tablet before the visit, her provider notes:

- A PSC-17 with an increased internalizing score: a follow-up PHQ-9 indicates mod-sev depression.
- Discussing the results with Jesse, she confirms feeling stressed and depressed but denies suicidality.
- Jesse is interested in counseling and her parents are supportive

Dr. Bell's Practice Solutions:

- PCP contacts the on-site pediatric behavioral health clinician and there is a warm hand off at the end of the well child visit.
- The behavioral health clinician will do an assessment along with a brief behavioral intervention centered around sleep and increased exercise and contracts with Jesse for safety.
- She will develop a plan with Jesse and her parents which will be documented in the EHR.
- After 3 months, she re-administers the PHQ-9 to track progress.

Jesse's Story

Jesse is a 15 yo being seen by her provider for a well child visit. As part of the confidential, validated screens administered via tablet before the visit, her provider notes:

- A PSC-17 with an increased internalizing score: a follow-upPHQ-9 indicates mod-sev depression.
- Discussing the results with Jesse, she confirms feeling stressed and depressed but denies suicidality.
- Jesse is interested in counselling, but doesn't want her father to know…

Dr. Bell's Practice Solutions:

- Dr. Bell does a brief behavioral intervention centered around sleep and increased exercise and contracts with Jesse for safety.
- Makes an referral to the SBHC therapist at Jesse's school using her electronic health record.
- Sets an alert for her nurse to follow up with Jesse in a month to make sure she has gotten into treatment
- After 3 months, she re-administers the PHQ-9 to track progress.

Isaac & Gina's Story

Isaac & Gina's Needs

- Transportation support for doctor's visits
- Help understanding and managing Isaac's uncontrolled asthma
- Fewer doctor's visits to avoid missed work and school

Dr. Bell's Practice Solutions

- Community Health Worker support to arrange transportation
- Connection to a CBO that administers Putting on Airs
- Phone and email communication to reduce office visits

Billy's Story

Billy's Needs

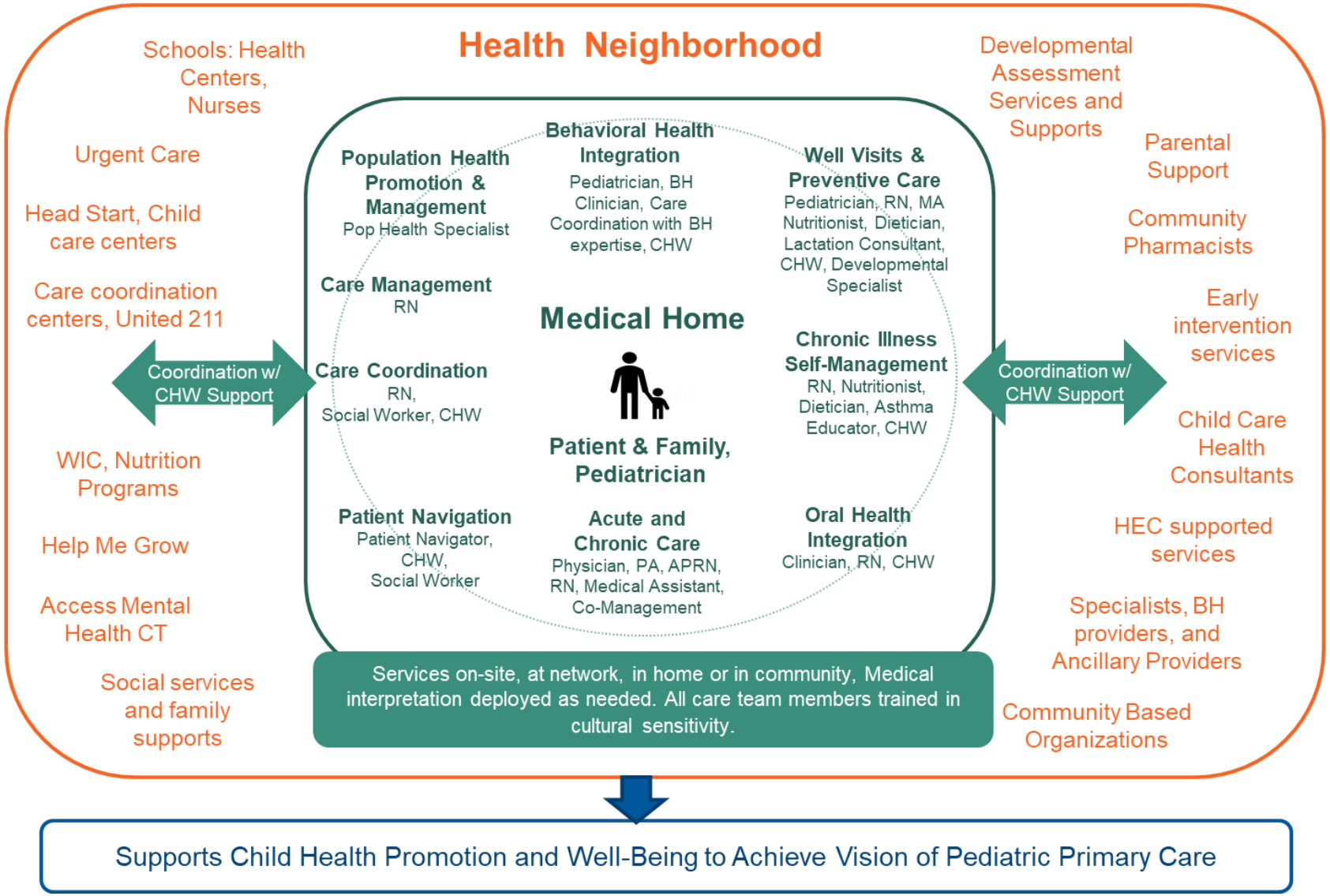
- Frequent visits with specialized surgical team
- Comprehensive care coordination to manage medical appointments for surgery, neurology, behavioral health, PT and OT
- Help managing medications
- Care-giver support for Billy's mom
- Fewer trips to specialist appointments in Boston

Dr. Bell's Practice Solutions

- Using telemedicine and e-consults to reduce the need for PCP and specialist office visits
- A diverse care team who specialize in caring for patients with complex conditions
- Proactive care coordination with specialists to reduce burden on patient and family

Pediatric Diverse Care teams

CORE



PEDIATRIC DIVERSE CARE TEAMS

Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care

CORE

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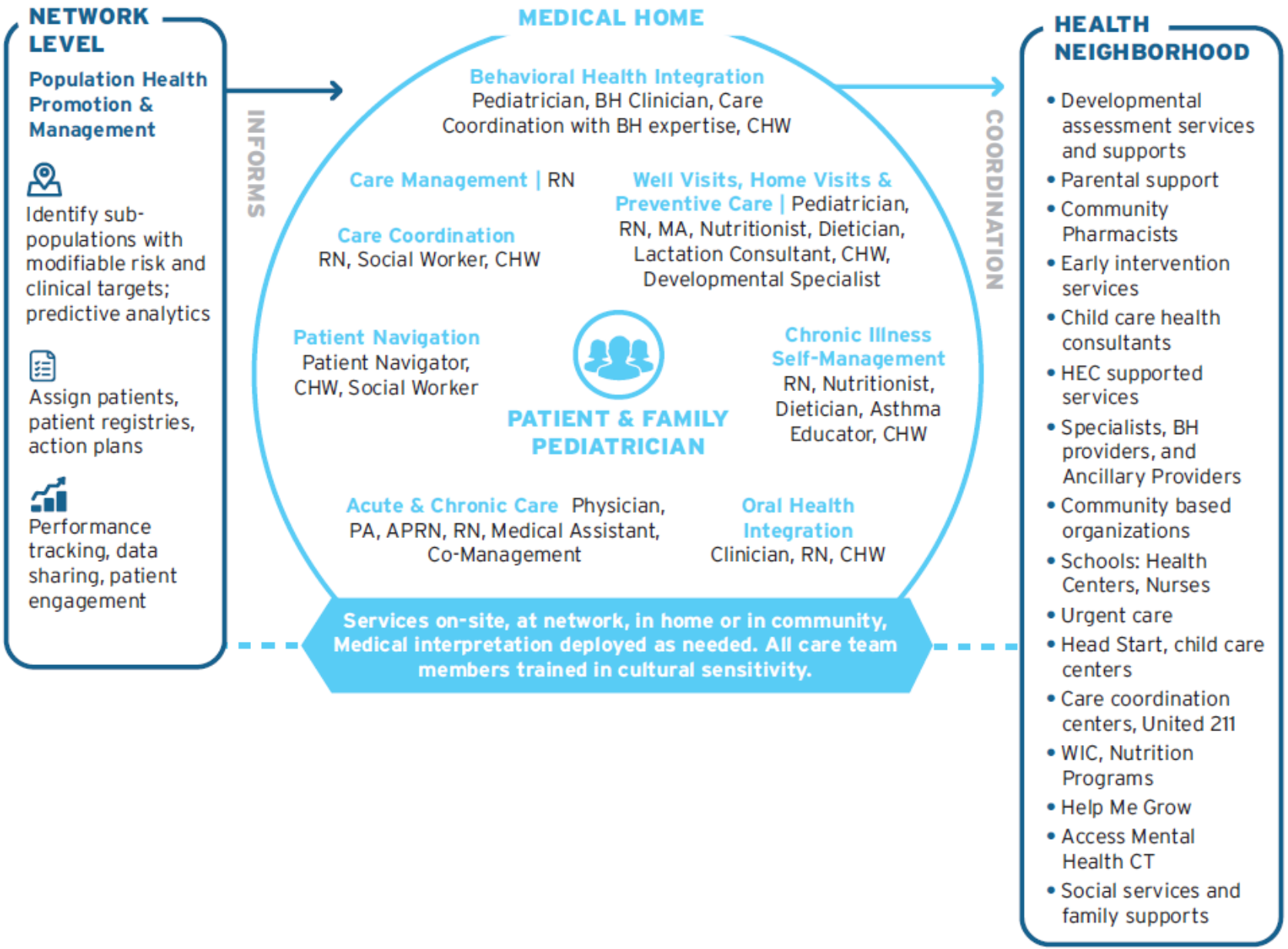

PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

CORE

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ALL PEDIATRIC PRIMARY CARE PROVIDERS TEAM-BASED CARE

Child & Family

- **Standard screening** for behavioral health and social determinants
- **Dedicated pediatric behavioral health clinician (LCSW or APRN)**
  - Available on-site or via telemedicine
  - Performs brief screenings and assessments, brief treatment services and care team consultation
- **eConsult arrangement** with community-based psychiatrist or advance practice registered nurse (APRN)
- **Team-based,** biopsychosocial approach to care, health promotion, and prevention
- **Medication management**
- **Practice team training**

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialist
- Avoids duplication of care coordination services

HEALTH NEIGHBORHOOD

- **Connects patients via established relationships** with pediatric behavioral health clinics, psychologists/APRNs/LCSW to provide extended therapy, counseling, and extensive evaluation
- **Connects to community-based organizations, schools, and child care**

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

PEDIATRIC COMMUNITY PURCHASING PARTNERSHIPS

ELECTIVE

DRAFT

MEDICAL HOME

Uses person-centered assessments (including culturally appropriate SDOH screening) and/or analytics to identify patients and families whose needs are best met through community placed services. [See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-Management Services	Complex Care Coordination for High Risk Patients and Families, Often with SDOH Needs	Parental Support Services	Transition Services for Adolescents
EXAMPLES OF MODELS	Health Leads	The Village Model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD Model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition

Other Pediatric Capabilities

CORE

- Oral Health Integration **(CORE)**
- eConsults and Co-management **(CORE)**
- Telemedicine, Phone, Text & Email **(CORE)**
- Shared Medical Appointments (ELECTIVE)
- Under consideration
  - Universal Home Visits for Newborns and their Families
  - Individuals with disabilities

Next Steps

- Continue to solicit feedback from stakeholders – Meetings scheduled for March
  - Key questions to discuss
    - Will these capabilities create meaningful change for those you engage?
    - Is anything missing?
    - Is there anything in the capabilities that you cannot live with?
- Incorporate feedback into capability summaries
- Late Spring: Draft a report for public comment based on revised capabilities

Questions?

- Vinayak Sinha
- vsinha@freedmanhealthcare.com

Adjourn