



CONNECTICUT
Office of Health Strategy

Practice Transformation Task Force

September 4, 2018

Meeting Agenda

1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of Minutes	5 min
4. House rules refresh	5 min
5. Purpose of Today's Meeting	5 min
6. Recap of PCM Activities to Date	10 min
7. Review of Capabilities Skeletons	75 min
8. Next Steps	5 min
9. Adjourn	

Introductions/ Call to Order

Public Comment

Approval of the Minutes

House Rules

House Rules for PTTF Participation

1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (less than 2 minutes if possible) and to the point/agenda item (*the chair will interrupt if the speaker strays off topic or talks longer than 2 minutes*)
4. *Members should avoid speaking a second time on a specific issue until every PTTF member who wishes to speak has had the opportunity*
5. *Members should take care to minimize interference (please mute all phones, turn off cell phones, limit side conversations or loud comments)*
6. Please read all materials before the meeting and be prepared to discuss agenda/issues
7. Please participate in the discussion—ALL voices/opinions need to be heard
8. *Participation in the meetings is limited to Task Force members and invited guests; all others may comment only during the initial public comment period*
9. After the meeting, please raise any concerns with meeting process/content or other issues with members of the Executive Team (Elsa, Garrett, Lesley)

Purpose of Today's Meeting

- Provide update on consumer and stakeholder engagement
- Review capabilities skeletons for inclusion in payment reform model options

PCM Activities Recap

Work Plan Updates

- **PTTF Meetings**

- September 25th: Continue review of capabilities skeletons
- **New Meeting October 9th**: Finish review of capabilities skeletons
- October 30th: Revisit and confirm where we landed with capabilities
- November 27th: Review draft payment model
- December 18th: Comments on final report draft

- **Design Groups: Ongoing**

- Still scheduling: Older adults, Persons with disabilities

- **Payment Reform Council:**

- Solicitation for members due today
- Health Innovation Steering Committee will choose members on Sept. 13th
- Council will meet Sept. 17 – Oct. 19, and likely again in Nov.

Consumer Engagement Strategies

Developed in Collaboration with Consumer Advisory Board

- Consumers **participate** in the process
 - Design Groups, Practice Transformation Taskforce, Payment Reform Council, Healthcare Innovation Steering Committee, Individual and Small Group Discussions
- Consumer **input is captured and informs** each step of the process, and recommendations
 - Invite identified consumers to meetings, work around their schedules
 - Offer clear, accessible materials to support meaningful engagement
 - Feedback is incorporated into specific, designated sections of meeting materials to be easily identified by participants and discussed
 - Consumer representatives are asked to offer their comments throughout meetings and at wrap up
 - Issues that arise that are not currently addressed in the project will be documented
 - Consumer input is included in feedback tables that inform development of model

Planning for Consumer Engagement

Developed in Collaboration with Consumer Advisory Board

- In partnership with the Consumer Advisory Board, the team will:
 - Host a series of discussions with consumer advocate leaders
 - Facilitate meetings with organizations representing perspectives including but not limited to: older adults, patients with behavioral health conditions, persons with disabilities, members of the LGBTQIA community, children, and citizens facing poverty, homelessness or other unmet social needs.
 - Host a separate series of discussions with consumers representing various perspectives

Gaining Input from Stakeholders

Partnership with
CAB

Consumers Advocate Organizations

Consumers Representing Various Perspectives

Primary Care Practices

Advanced Networks

Federally Qualified Health Centers

Employers

Individual Payers

Hospitals/Health Systems

Health care provider and professional training programs

Stakeholder engagement to date: Initial Meetings with:

- Individual commercial payers
- Advanced Network CEOs
- FQHCs (executives and physicians)
- Employers

Upcoming Meetings:

- Advanced Network primary care physicians
- Hospitals
- Health care provider and professional training programs

Stakeholder input is included in feedback table that informs development of model. Some key points so far:

- Increased flexibility in primary care is critical
- Some consumers have concerns about how incentives can lead to underservice
- Need to balance accountability with reporting burden and feasibility of implementation
- Alignment with existing attribution preferred if possible

Review Capabilities Skeletons

PCM Capabilities: Where We Are

Increasing Patients' Access and Engagement	Expanding Primary Care Capacity	System Supports and Resources
<p>1. <u>Diverse Care Teams</u> DG</p> <ul style="list-style-type: none"> • Community health workers • Pharmacists • Care coordinators • Navigators • Health coaches • Nutritionists • Interpreters • Nurse managers <p>2. Alternative Ways to Connect to Primary Care</p> <ul style="list-style-type: none"> ✓ Phone/text/email ✓ Home Visits ✓ Shared visits • Telehealth 	<p>1. <u>Capacities</u></p> <ul style="list-style-type: none"> • Genomic screening DG • Subspecialists as PCPs • Practice specialization <ul style="list-style-type: none"> ✓ Infectious diseases <ul style="list-style-type: none"> • Pain management and MAT DG • Older adults • Persons with disabilities • Pediatrics considerations DG • Functional Medicine <p>2. Health Information Technology</p> <ul style="list-style-type: none"> ✓ E-consults ✓ Remote patient monitoring/Patient generated data 	<p>1. BH Integration (adult) DG</p> <p>2. BH Integration (pediatric) DG</p> <p>3. Community Integration DG</p> <ul style="list-style-type: none"> • Assessment of SDOH risks • Community linkages • Purchased community services such as community paramedicine <p>4. Oral Health Integration</p>

DG = Design Group

Reviewing the Capabilities

Does the evidence support including this capability in the PCM payment bundle?

→ *Based on health promotion/prevention, quality and outcomes, patient experience, provider satisfaction, lower cost*

IF YES

Should this be a **core (universal/required)** or an **elective** capability?

AND

Should this capability be deployed in **all practice sites**, or provided by a **subset of docs or practices** within each primary care network?

CT Primary Care Payment Reform Proposal
Genomic Screening for CDC Priority Conditions

Mike Murray, MD

Center of Genomic Health at Yale

Yale School of Medicine

September 4th 2018

10 Leading Causes of Death in Connecticut

(CDC statistics 2016)

CT LEADING CAUSES OF DEATH	2016 DEATHS
1. Heart Disease	7,051
2. Cancer	6,696
3. Accidents	1,978
4. Chronic Lower Respiratory Disease	1,425
5. Stroke	1,269
6. Alzheimer's Disease	1,035
7. Diabetes	699
8. Septicemia	588
9. Influenza/Pneumonia	572
10. Kidney Disease	570

<https://www.cdc.gov/nchs/pressroom/states/connecticut/connecticut.htm>

Screening in Health Care

HIGH BLOOD PRESSURE IS A




**SILENT
KILLER**

because there are no
obvious signs or symptoms


High Blood Pressure

The Silent Killer



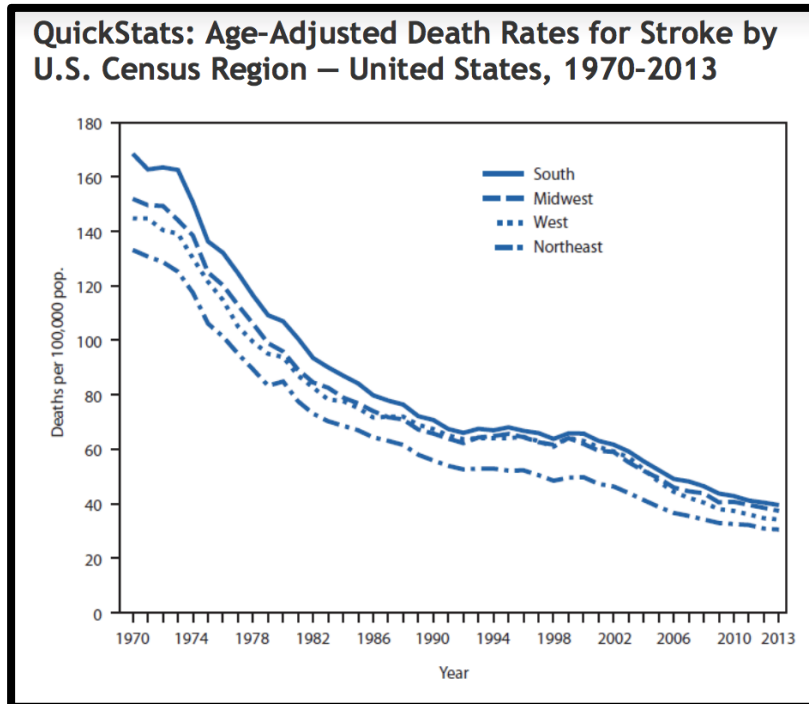
• Heart Attack • • Stroke/Dementia •
• Kidney Failure • • Vision Loss •

When your blood pressure is **high**:

You are **4x** more likely to die from a stroke 

You are **3x** more likely to die from heart disease 

Screening in Health Care



20% of adults with high blood pressure do not know that they have it.

[\[https://www.cdc.gov/bloodpressure/facts.htm\]](https://www.cdc.gov/bloodpressure/facts.htm)

Screening in Health Care

- **Newborn Screening (NBS)**
 - **Over 50 years old**
 - **Started with one condition – now over 30 conditions**
 - **Adopted by all 50 states, and many countries**

Screening in Health Care

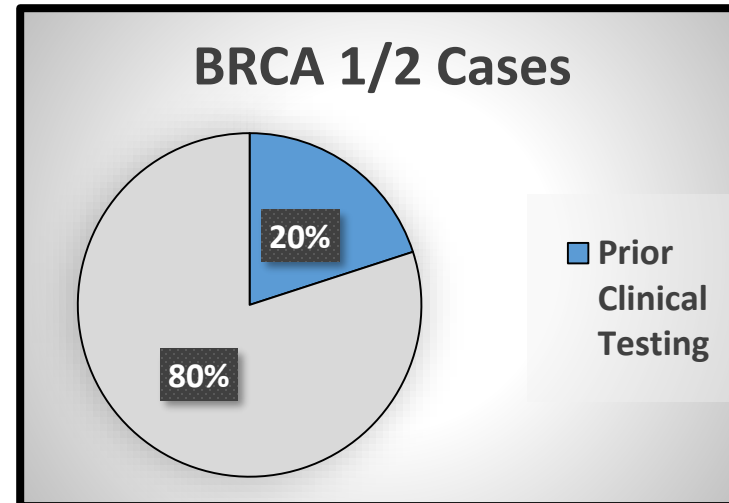
- **What should we screen for and when should we screen for it:**
 - **Important health problem**
 - **Not otherwise apparent**
 - **Approach has good tools for finding it**
 - **Screening program has good plan for management**

Screening in Health Care

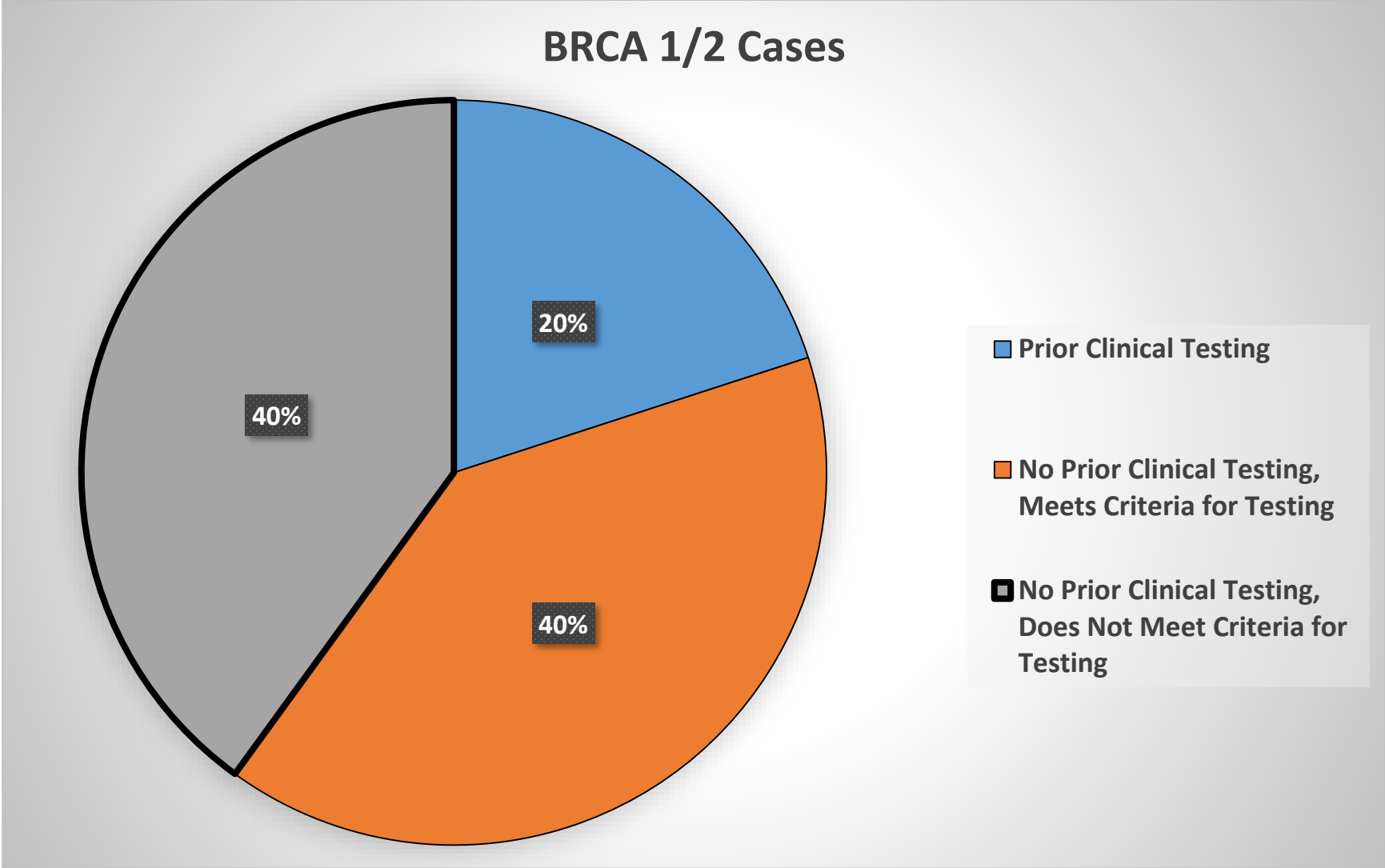
- **USPSTF helps set the screening agenda for primary care:**
 - **2005 they made recommendations on *BRCA* screening**
 - **Involving detailed family history acquisition and analysis, followed by potential referral for genetic testing**

Screening in Health Care

- **USPSTF helps set the screening agenda for primary care:**
 - **2005 they made recommendations on *BRCA* screening**
 - **Involving detailed family history acquisition and analysis, followed by potential referral for genetic testing**



Analysis of *BRCA* Genomic Screening in 50,000 Patients





Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Public Health Genomics

TIER 1 GENOMIC APPLICATIONS

Familial Hypercholesterolemia (FH)

Hereditary Breast and Ovarian Cancer Syndrome (HBOC)

Lynch Syndrome (LS)

In 2018: Screen 10 Genes for Three Genetic Conditions

SCREENING FOR ELEVATED RISK OF		
Heart Attack and Stroke	Breast, Ovarian, Prostate, Pancreatic Cancer	Colon and Uterine Cancer
Familial Hypercholesterolemia (FH)	Hereditary Breast and Ovarian Cancer (HBOC)	Lynch Syndrome (LS)

~45,000 people in the Connecticut

~4.3M people in the United States

Management of Screening Results

- There is screening and management strategies in place of these primary care problems
- There are recommendations in place for management of these conditions in the face of identification of genetic risk

Genomic Screening in CT for 3 CDC Priority Conditions

- **Programmatic Costs:** In context, total budget is expected to be < two preventive medicine visits for each participating patient:
 - Test costs
 - Central care support team costs
 - Outcomes monitoring costs
 - HIT costs

Genomic Screening in CT for 3 CDC Priority Conditions

- **Why now?**
- **Why just 10 of 20,000 genes?**
- **Why CT?**

Connecticut as an Important Pilot Site for the Nation

2010 US CENSUS (RACE AND HISPANIC ORIGIN)	CONNECTICUT	US
White alone	80.6%	76.9%
Black or African American alone	11.8%	13.3%
American Indian & Alaska Native alone	0.5%	1.3%
Asian alone	4.7%	5.7%
Native Hawaiian & Other Pacific Islander alone	0.1%	0.2%
Two or More Races	2.3%	2.6%
Hispanic or Latino	15.7%	17.8%
White alone, not Hispanic or Latino	67.7%	61.3%

Connecticut is ~1% of the US population and a reasonable model for the other 99%

Genomic Screening Design Group Recommendations

- Design Group recommendations:
 - Include genomic screening in primary care bundle for all adults ages 18-65 for three CDC priority conditions
 - Provide resources at network level (e.g., referrals to appropriate subspecialists, access to genetic counselors)
 - Train practice level clinical staff to assist with educating patients about screening and results
- Consumer input, questions and concerns for implementation:
 - Importance of population health data showing screenings reduce death
 - Importance of education for primary care physicians to understand these are screening tests
 - Need to understand lessons learned from Geisinger pilot program and how they would apply to CT
 - Need to ensure primary care practice capacity to provide sufficient infrastructure for patient education, counseling and support (and their genetic relatives who may also need to be screened), including appropriate, timely assistance interpreting results
 - Concern about the cost of testing
 - Need for secure data management and privacy protections
 - Need for additional medical surveillance and counseling/support for those who are “screened in”

Last Meeting's PTF Feedback: Infectious Disease Capability: Subspecialist as PCP

1. Does the evidence support including this capability in the PCM payment bundle?

	High	Medium	Low
Health promotion/ prevention	2	1	2
Improved quality and outcomes	1	3	1
Patient experience	2	2	1
Provider satisfaction	1	3	1
Lower cost	1	3	1
Total	7	12	6

2. Should this be a **core (universal/required)** or an **elective** capability?

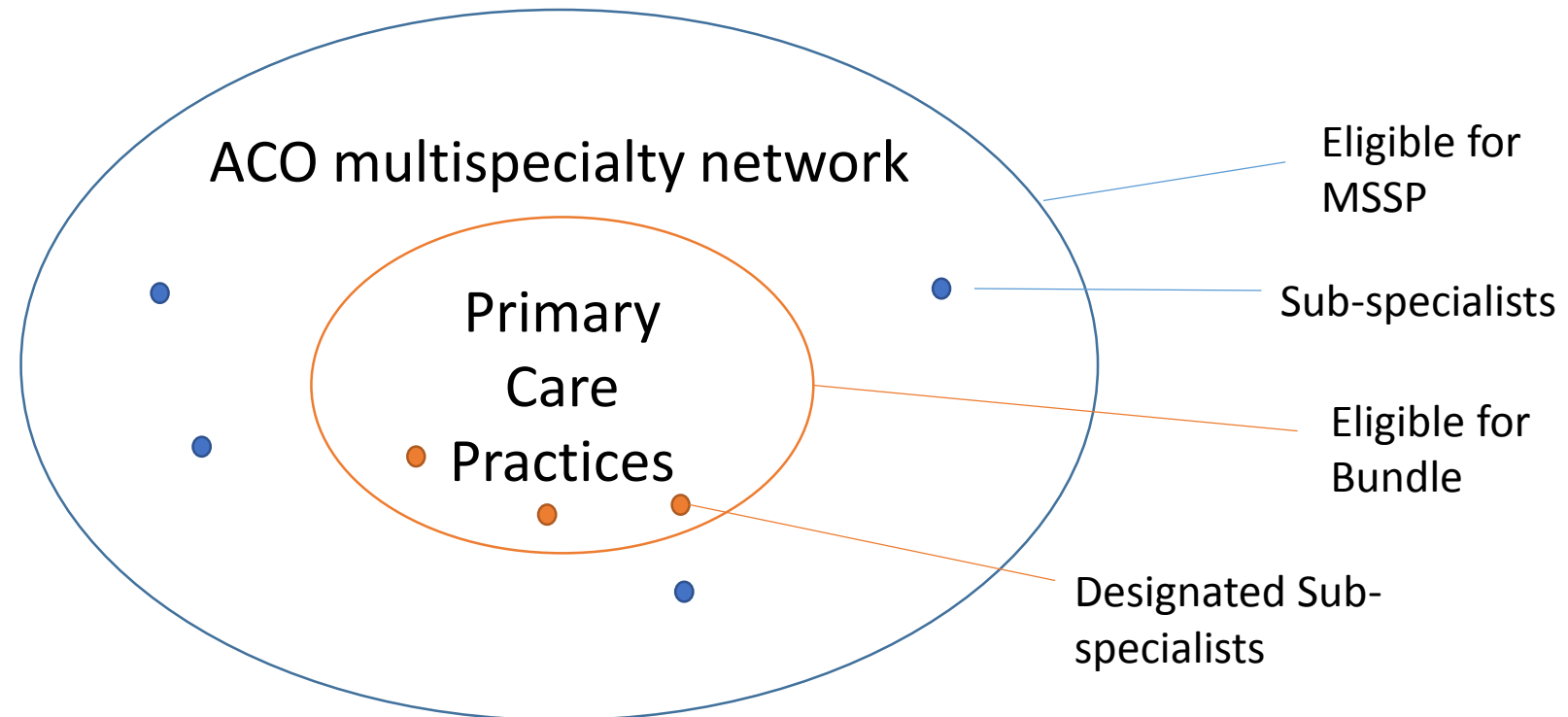
Core	Elective
0	5

3. Should this capability be provided by all practice sites, by a subset of docs or practices within each primary care network, or by the primary care network?

Opportunities to Integrate Specialty Care Into Primary Care: Subspecialists

Should subspecialists be eligible to participate in PCM for patients for whom they provide primary care?

This diagram illustrates how subspecialists providing primary care might be included in the payment model



Opportunities to Integrate Specialty Care Into Primary Care: Subspecialists

Should subspecialists be eligible to participate in PCM for patients for which they provide primary care?

A FEW THINGS TO CONSIDER:

- Subspecialists have a limited number of patients for which they provide primary care, which will make it difficult to transform their practice for this small subset.
- Research suggests subspecialists more likely to refer to other subspecialists for management of other comorbid conditions (diabetes, hypertension) and less likely to perform evidence-based, prevention screenings.
- Providing primary care via subspecialists likely to increase costs as subspecialists likely to have higher negotiated rates for E&M visits.
- Most patients surveyed said they prefer to receive all their care in one place and see the specialist as the preferred location.
- MSSP allowed specialist participation for attributed members without PCPs. Even if subspecialists are not eligible for PCM, they may still be eligible for MSSP.

Specialization: Functional Medicine

1. Does the evidence support including this capability in the PCM payment bundle?

	High	Medium	Low
Health promotion/ prevention			
Improved quality and outcomes			
Patient experience			
Provider satisfaction			
Lower cost			
Total			

2. *If Yes*, should this be a **core (universal/required)** or an **elective** capability provided by a subset of docs or practices within each primary care network?

Core	Elective	Not Included

Telehealth Visits between Clinicians and Patients

1. Does the evidence support including this capability in the PCM payment bundle?

	High	Medium	Low
Health promotion/ prevention			
Improved quality and outcomes			
Patient experience			
Provider satisfaction			
Lower cost			
Total			

2. *If Yes*, should this be a **core (universal/required)** or an **elective** capability?

Core	Elective	Not Included

3. *If Yes*, should this capability be deployed **in all practice sites**, or provided by a **subset of docs or practices** within each primary care network?

Oral Health Integration

1. Does the evidence support including this capability in the PCM payment bundle?

	High	Medium	Low
Health promotion/ prevention			
Improved quality and outcomes			
Patient experience			
Provider satisfaction			
Lower cost			
Total			

2. *If Yes*, should this be a **core (universal/required)** or an **elective** capability?

Core	Elective	Not Included

3. *If Yes*, should this capability be deployed **in all practice sites**, or provided by a **subset of docs or practices** within each primary care network?

Next Steps

Next Steps

PTTF

- Next meeting September 25th: Continue review of capabilities skeletons
- Design groups ongoing in September

FHC Project Team

- Continue refining skeleton capabilities
- Continue stakeholder and consumer engagement efforts

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Adjourn