OHS CONNECTICUT Office of Health Strategy

Practice Transformation Task Force

September 25, 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 Adult Behavioral Health Integration Capability	15 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

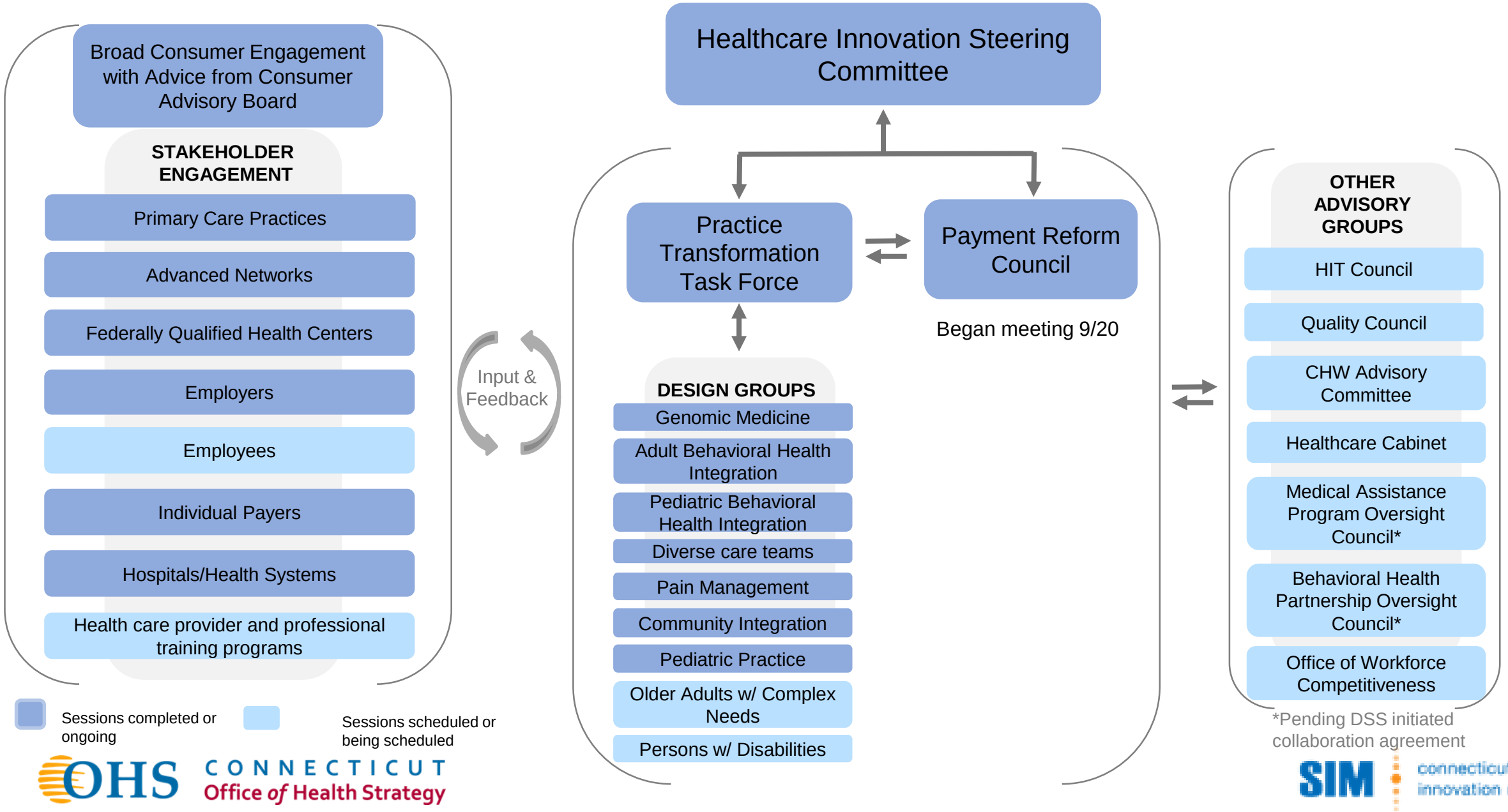
1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (less than 2 minutes if possible) and to the point/agenda item (*the chair will interrupt if the speaker strays off topic or talks 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 updates on consumer and stakeholder engagement, design groups and Payment Reform Council
- Review adult behavioral health integration design group recommendations

PCM Activities Recap

Stakeholder Engagement Progress



OHS CONNECTICUT Office of Health Strategy

SIM connecticut state innovation model

Payment Reform Council Consideration of Task Force Model Options

Basic Bundle + **Supplemental Bundle** + **Fee for Service Payments**

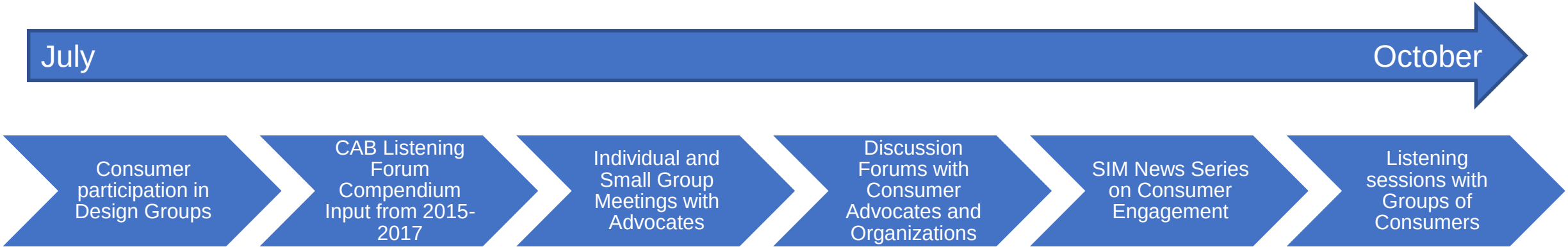
MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

Payment Reform Council Key Questions

1. Hybrid bundle or no hybrid or options?
2. Should the supplemental bundle (formerly care management fee) be separate?
3. How should patients be attributed to providers?

Consumer Engagement Strategies
Developed with Advice from Consumer Advisory Board

Timing



Consumer participation in Design Groups	CAB Listening Forum Compendium Input from 2015-2017	Individual and Small Group Meetings with Advocates	Discussion Forums with Consumer Advocates and Organizations	SIM News Series on Consumer Engagement	Listening sessions with Groups of Consumers
Purpose					
Focused input on specific topics	Incorporate rich discussions to date	Hear directly from advocates including those that provided public comment on PTTF report	Engage additional consumer advocates and organizations in broader discussions of primary care in CT **Sept 17th, 18th, 25th**	Share highlights of consumer strategy with broader CT health policy audience	Gain insights of consumers from various perspectives e.g. housing authority residents, **parents, older adults, people with disabilities**, employees.

Highlights from Consumer Discussions to Date

- We need a system that makes providers want to answer the phone quickly and eliminate the frustration of calling the office. We need to access easier and more convenient care for patients. Broader issues of access based on payment need to be addressed, even if outside of this work.

- Care coordination needs to be a top priority. Specialty care, particularly oncology, seems to do this better than primary care. What can we learn from them in implementation?

- Practices will need a different mix of care team members and other capabilities depending on the patients they serve. There will need to be flexibility here or there will likely be additional, unnecessary cost.

- Current measures of quality do not have the sophistication to provide real accountability for this type of care delivery model. We need better measures of access, patient satisfaction and outcomes and they need to be publicly reported.

- The model will need to prove it can protect patients from care being withheld and providers shying away from high needs patients. Adjusting for differences in social, medical and behavioral health needs and making end of year adjustments in payments for outliers could be helpful. Excluding certain services from the bundle will also be helpful. Providers will need to clearly understand the model's protections so they don't practice as if those protections don't exist.

- Behavioral health needs should just be treated like another health need. We all have them at some point.

Design Group Updates and Process

- Allows more time for design group participants to review materials, give input and make recommendations
- Establishes feedback loop from Task Force back to design groups

PCM Capabilities: Where We Are

Increasing Patients' Access and Engagement	Expanding Primary Care Capacity	System Supports and Resources
1. Diverse Care Teams DG • Community health workers • Pharmacists • Care coordinators • Navigators • Health coaches • Nutritionists • Interpreters • Nurse managers 2. Alternative Ways to Connect to Primary Care ✓ Phone/text/email ✓ Home Visits ✓ Shared visits ✓ Telehealth	1. Capacities ✓ Genomic screening DG ✓ Subspecialists as PCPs • Practice specialization ✓ Infectious diseases • **Pain management and MAT DG** • **Older adults DG** • **Persons with disabilities DG** • **Pediatrics considerations DG** ✓ Functional Medicine 2. Health Information Technology ✓ E-consults ✓ Remote patient monitoring/Patient generated data	1. BH Integration (adult) DG **2. BH Integration (pediatric) DG** **3. Community Integration DG** ✓ Oral Health Integration

DG = Design Group, Bold text = ongoing design group work

Review Adult Behavioral Health Design Group Recommendations

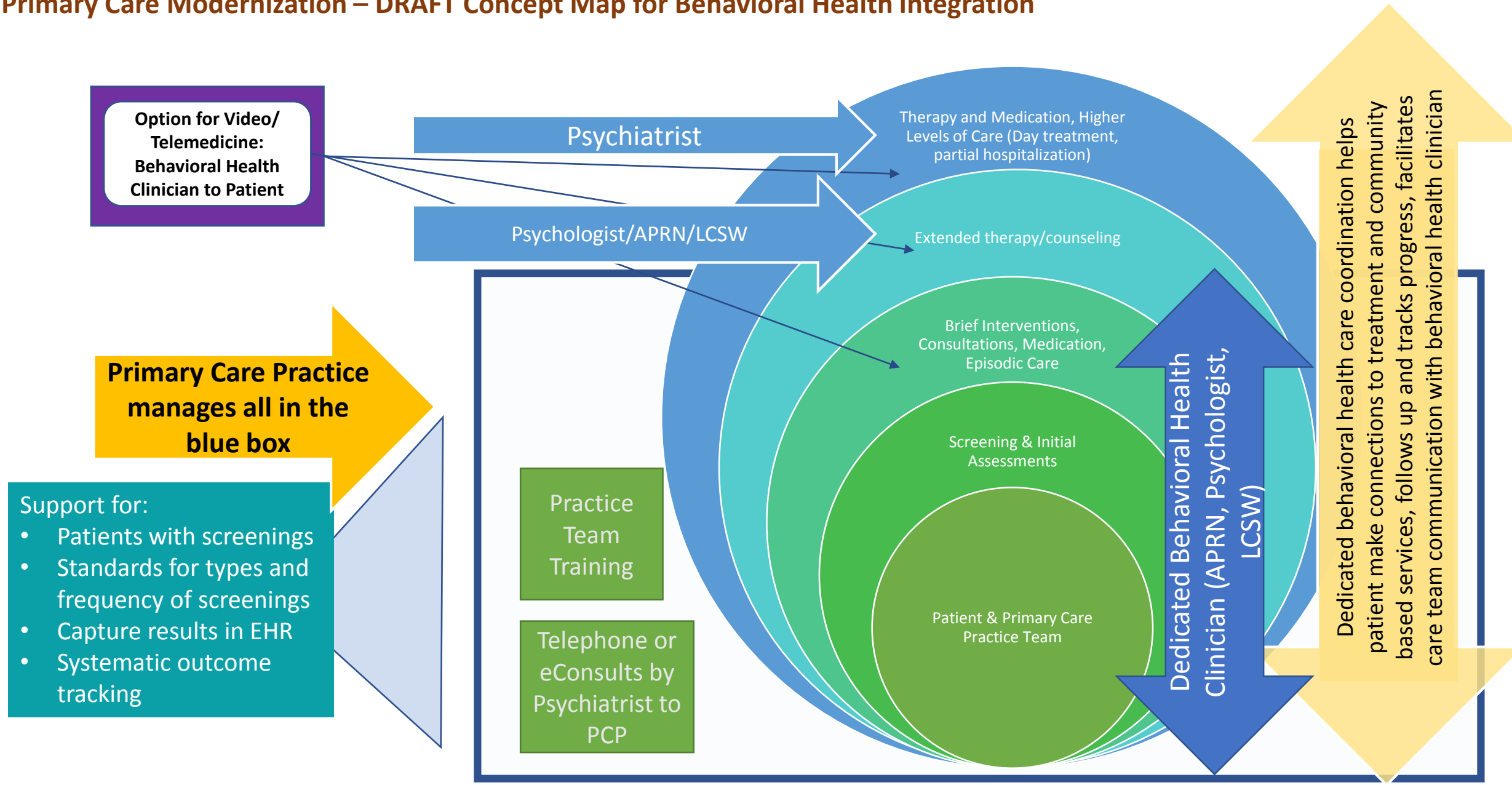
Adult BHI Consumer Input, Needs and Concerns

- Must screen for more than just depression and substance abuse; must include social determinants of health
- Recognize the opioid crisis
- Address co-occurring behavioral health and physical health to extend life expectancy
- Clinicians need training in initial mental health assessment and treatment
- A co-located mental health clinician (SW, APRN) can improve appropriate treatment options
- Inadequacies in the behavioral health system may lessen the impact of additional connections through primary care: Insurance companies provide inadequate information lists for referrals to behavioral health services and causes delays in treatment; many behavioral health service providers do not accept insurance
- Ensure that payment methodology promotes robust access to treatment.
- Reimbursement for behavioral health providers needs to be adequate to support integration

Adult BHI Design Group Recommendation

Support full integration of dedicated behavioral health clinicians (BHCs) and care coordinators with behavioral health expertise into primary care

Primary Care Modernization – DRAFT Concept Map for Behavioral Health Integration



Adult BHI Design Group Recommendations

Specific Elements of the Capability

● Responsible
◆ Needs Infrastructure

Type of Service in the Model	Provided by: Practice	Network
Screenings: depression, substance use[1], anxiety[2]	●	
Dedicated Behavioral health clinician (BHC) for each practice to work with patients and care team; clinician is on-site[3] at practice or available via "Warm Handoff" through phone or telemedicine visit	●	
Dedicated care coordinator with expertise in behavioral health	●	
On-site assessment	●	
Treatment and brief intervention in primary care; referral for further treatment if needed	●	
Patient-to-clinician telemedicine visits	◆●	◆
e-Consult - Primary care provider-to-BH specialist	◆	◆
Tracking outcomes in EHRs	◆	●◆
Training for care team on BH teaming and on chronic illness for BHC and care coordinator	●	●

Adult BHI Design Group Recommendations

Additional Recommendations

- Develop outcome measures that reflect a PCP's progress towards defined goals
- Implement bidirectional communication as needed between the care team and community-based BH specialist and community supports
- Create meaningful, actionable measurement and monitoring mechanisms
- If sufficient behavioral health services are not in network, the network executes a Memorandum of Understanding with at least one behavioral health clinic and/or practice and develops processes and protocols for other behavioral health clinicians

Considerations for Payment Reform Council

- Supplemental bundle accounts for illness burden, severity and SDOH needs to encourage practices to work with those with more serious behavioral health conditions

Question for the Task Force

- Does the Task Force support the design group recommendations?

Next Steps

Next Steps

- October PTTF Meeting Schedule
- Design groups ongoing in September & October
- Payment Reform Council begins meeting

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Adjourn

Appendix

Task Force Recommendations to Date

Capability	Included in Model	Core or Elective	Deployed in All Practices or Subset
Phone/text/email	Yes	Core	All
Telehealth	Yes	Core	All
Remote Patient Monitoring	Yes for certain conditions	Core for conditions w/ efficacy & cost savings	
eConsults	Yes	Core	All
Oral Health Integration	Yes	Core	Maybe only pediatrics
Home Visits	Yes	Elective	For certain populations
Shared Medical Appointments	Yes	Elective	
Infectious Diseases	No	N/A	
Genomic Screening	Tabled until further evidence	N/A	
Functional Medicine	No but explore integrative medicine	N/A	
Diverse Care Teams			
Pain Management and Medication Assisted Treatment			
Adult Behavioral Health Integration			
Pediatric Behavioral Health Integration			
Community Integration			
Older Adults			
Persons with Disabilities			
Implications of Capabilities for Pediatric Practices			