STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Taskforce

Meeting Summary
Tuesday, October 9, 2018
6:00 – 7:30 p.m.

Meeting Location: This was a Webinar/Conference Call

Members Present: Maria Dwyer; Shirley Girouard; Susan Adams; Randy Trowbridge; Elsa Stone; Douglas Olson; Grace Damio; H. Andrew Selinger; Kate McEvoy; Anita Soutier; Anne Klee; Lesley Bennett

Members Absent: M. Alex Geertsma; Garrett Fecteau; Heather Gates; Alta Lash; Mark Vanacore; Eileen Smith; Jesse White-Frese; Rowena Rosenblum-Bergmans; Leigh Dubnicka

Other Participants: Mary Jo Condon; Linda Green; Alyssa Harrington; Pano Yeracaris; Judy Levy; Ellen Bloom; Lisa Honigfeld; Stephanie Burnham; Arlene Murphy; Shaina Smith; Stephanie Burnham; Abe Burnham; Mark Schaefer; Ken Lalime; Ron Preston

1. Call to Order
The meeting was called to order by Lesley Bennett at 6:05pm.

2. Public Comment
Ms. Arlene Murphy submitted a public comment on behalf of the Consumer Advisory Board. Ms. Murphy expressed her concern over the Consumer Advisory Board being described at the previous Practice Transformation Task Force Meeting as being satisfied with the consumer engagement process in the Primary Care Modernization (PCM) Design Groups. The Consumer Advisory Board expressed appreciation for consumer representation in the PCM Design Groups, but there are concerns about time frames, materials not getting to participants with enough time to prepare, and the need to know what happens with consumer questions, comments and issues raised in the Design Group discussions. Ms. Murphy acknowledged she was aware that the time frames on this project are very difficult and that this is a work in progress. Ms. Murphy acknowledged that Freedman HealthCare has been very supportive of consumer participation in the PCM Design Group discussions.

Ms. Murphy's full public comment as submitted is below:

Public Comment to Practice Transformation Task Force Meeting
October 9, 2018

I am writing to express my concern that Consumer Advisory Board was described at the last Practice Transformation Task Force Meeting as being satisfied with the consumer engagement process in the Primary Care Modernization (PCM) Design Groups.

Consumer Advisory Board has expressed appreciation for consumer representation in the PCM Design Groups but there have been serious concerns raised about time frames, materials not getting to participants with enough time to prepare and the need to know what happens with consumer questions, comments and issues raised in the Design Group discussions.

I know the time frames on this project are very difficult and that this is a work in progress. Freedman Healthcare has been very supportive of consumer participation in PCM Design Group discussions. But it is important that the concerns that have been described are addressed through the following.

1) Consumer Representatives must receive materials with enough time to review and consider them.

2) Questions and issues raised by Consumer Representatives must be documented, answered and addressed.

3) Consumer Representatives must receive updates, decisions and amended materials related to their Design Group work.

Many thanks to the Practice Transformation Task Force for your commitment to improving the health of Connecticut individuals, families and communities.

Respectfully Submitted by
Arlene Murphy
Consumer Advisory Board

3. Review and Approval of Meeting Summary
Motion: to approve the September 25th meeting summary of the Practice Transformation Taskforce – seconded
***Discussion*:** There was no discussion.
Vote: All in favor.

4. House Rules Refresh
Ms. Lesley Bennett reviewed the house rules with members.

5. Purpose of Today's Meeting
Ms. Alyssa Harrington reviewed the purpose of the task force meeting, which was to review the pain management capability definition and requirements based on design group recommendations. Ms. Harrington went over the progress of the PCM capabilities and indicated that the design groups will be given more time to provide input on the capabilities. Ms. Harrington reminded the group that they will be adding a November 13th meeting to continue review of capabilities.

6. Review of Pain Management Capability
Ms. Harrington first reviewed consumer input, needs and concerns and defined the capability as integrated preventative, routine and advanced care management of acute and chronic pain in primary care, with support from the Centers of Excellence in pain management. Ms. Harrington reviewed the key capability requirements.

Ms. Harrington reviewed the DRAFT Concept Map for Pain Management, including the three levels to the pain management capability (all primary care providers, a subset of primary care providers, and primary care referrals to subset of providers and Centers of Excellence). Ms. Harrington explained that the first level is what all primary care providers would do in pain management, with a focus on preventive care to avoid pain progressing from acute to chronic. Additionally, providers would deliver routine care for acute and chronic pain. The second level consists of a subset of primary care providers who have specialized expertise in pain management and medication-assisted treatment for opioid addiction. The third level consists of primary care referrals to subspecialty care and the Centers of Excellence for pain for most complex cases. Patient education and engagement happen across all levels of care, with an emphasis on destigmatizing pain. Ms. Kate McEvoy asked if alternative therapies were included at the highest level alongside the Centers of Excellence. Ms. Harrington confirmed this. Ms. McEvoy asked if there would be standards or further definition of what primary care provider expertise in alternative therapies was supported by PCM for the subset of primary care providers. For

example, there is a distinction for Medicaid between a licensed acupuncturist and another member of the care team providing this service. Dr. Douglas Olson emphasized the importance of defining this and connecting patients as they transition from preventive care to the Center of Excellence. Dr. Olson asked the group to circle back electronically to come up with solutions and guidance on these matters.

Dr. Mark Schaefer noted that advanced networks have cautioned balancing being too prescriptive and allowing some room to innovate and asked whether we should be defining who exactly would be permitted to provide these roles and functions. Ms. Shirley Girouard explained that if we are trying to be patient-centered, we must think about what is best for the individual. For example, maybe a Native American patient would be more comfortable seeing a healer versus a medical assistant. Ms. McEvoy stressed the importance of illustrating a range of options and keeping flexibility, while defining the outer boundaries of what is permitted under the payment model.

Ms. Harrington reviewed the key capability requirements. She highlighted why this effort recommends that providers use FDA guidelines when it comes to appropriate prescribing due to feedback received over CDC guidelines and how they've resulted in unintended consequences and unnecessary prescribing. Having a subset of primary care providers with specialized expertise in alternative interventions (e.g. behavioral health, acupuncture, self-management) will help address consumer access to alternative and preventative therapies and will provide chronic pain management and re-assessment services to patients. It was discussed how a subset of primary care providers should provide MAT to patients with opioid addiction and how more resources are needed for providers in prescribing affordable medications to patients for chronic pain (with training and support from a subset of primary care providers who specialize in pain management/from the Centers of Excellence).

Ms. Shaina Smith discussed how future FDA guidelines can continue to inform providers, and discussed the importance of utilizing the National Pain Strategy, especially around prescribing practices. The CDC guidelines did have some inadequacies and unintended consequences, but the FDA guidelines have not yet come out. Ms. Harrington explained that many of the recommendations aligned with the National Pain Strategy as recommended by the design group, and they would clarify this in the capability statement.

Ms. Harrington explained how across different levels of care, primary care providers and primary care teams would be trained to reassess and diagnose pain. Ms. Harrington emphasized the importance of the option access to services via telemedicine to overcome barriers like transportation, child care, and taking time off work. It was discussed how payment model options would support reimbursements, and the move to upfront payments would address the issue of longer visit times.

Dr. Randy Trowbridge stated that this project's purpose is aimed at preventing pain, which is a huge element in primary care. It is bigger than cancer and diabetes. Primary care providers are going to be trained to assess and diagnose pain, but pain is not a diagnosis. There must be something in this effort that helps identify the root causes of pain and this must be done at the outset. The focus of not letting acute pain move into chronic pain needs to be present in the beginning of this effort.

Dr. Rebecca Andrews stated that there seems to be a shortage of primary care providers who are interested in treating chronic pain. While the emphasis should be on prevention, treating chronic pain has become a challenge, and this is why we need specialization in chronic pain in primary care and Centers of Excellence. Mr. Trowbridge then stated his earlier point was not meant to minimize the seriousness or complexity of pain management.

Ms. Harrington then summarized the provided materials on the design group recommendations, adding that this effort goes beyond primary care delivery, and how this effort needs to ensure all services for pain management are in-network and covered by insurance. Ms. Harrington then took a poll of the Task Force on the questions below (not a formal vote).

Summary of Poll:
Should this capability be core or elective, or not included?
-89% of Task Force members say core
-11% of Task Force members say elective

Does the Task Force support the design group recommendations?
-Most Task Force members said Yes, with the goal of stopping the progression of acute to chronic pain

7. Next Steps
Ms. Harrington reviewed next steps which included the next scheduled, in-person Practice Transformation Task Force meetings on October 30th and November 13th. The Task Force Members were reminded of the Payment Reform Council meetings as well.

8. Adjourn
Dr. Mark Schaefer thanked the Task Force for contributing their time and expertise.

Motion by Susan Adams: to adjourn the meeting
Seconded by Ms. Elsa Stone.
Ms. Bennett adjourned the meeting at 6:58pm.