Practice Transformation Task Force

October 30, 2018

Meeting Agenda

Agenda item	Time
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. Review Capabilities: Diverse Care Teams, Community Integration, Genomic Screening Update	60 min
7. Review Payment Reform Council Provisional Recommendations	25 min
7. Next Steps	5 min
8. 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

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- Review community integration capability definition and requirements based on design group recommendations
- Review diverse care teams capability definition and requirements based on design group recommendations
- Provide feedback on Payment Reform Council provisional recommendations to date

Review Capabilities

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
		✓ BH Integration (adult) **DG**
		1. **BH Integration (pediatric) DG**
		2. **Community Integration DG**
		✓ Oral Health Integration

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

Diverse Care Teams Consumer Input, Questions and Concerns

- Patients need support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions and making their environments healthier.
- Patients need support learning to advocate for themselves to access and secure affordable, necessary medical care and community support services, and to be provided skilled, trained medical interpreters, as needed.
- Care teams should ideally be representative of the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms.
- Care team members need adequate training and qualifications to fulfill indicated necessary functions and avoid patient underservice. For example, not all care team members have adequate training to provide care coordination, or certain care coordination related functions, for patients with complex needs.
- PCM needs feedback loop with consumers throughout design and implementation to ensure ongoing consumer voice.
- Designate a care team member to follow up with patients after appointments about their experience, or some way to capture the care experience on a regular basis as a feedback loop.
- Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform. Care team assessments of adequate service and patient experience should factor into shared savings.

Diverse Care Teams Definition

- **Definition**: The National Academy of Medicine defines team-based care as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

- **Goal**: Team-based care aims to make primary care more comprehensive and accessible, better meet the diverse needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction

Diverse Care Teams Key Capability Requirements

- Supplemental bundle supports all practices in diversifying care teams to support identified primary care team core functions.
- Advanced Networks/FQHCs have flexibility to deploy care team members on-site at the practice, in the community and patient homes, and/or at a central hub.
- Care team compositions, location of team members, and staffing ratios depend on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, team member role (direct patient care or supporting care management).
- Payments should support training care teams on efficient communications, care coordination and care team member roles, and establishing new workflows that support team-based care.
- Every Advanced Network/FQHC should establish processes to promote and improve effective team-based care.

Key Capability Requirements

- Practices adhere to the following Principles for Team-based Care
  - Patient is at the center of the care team
  - Care teams are ideally representative of the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms when working with patients. Care team members are trained in cultural sensitivity and awareness.
  - Care teams enable all professionals to perform at the top of their training and better meet patient needs through expanded roles and workforce
  - Networks work with practices to compose care teams depending on their patient population
  - Care team members may be embedded within the practice site or centralized at the network level and serve multiple practices based on individual practice needs
  - Care teams have a collaborative structure that values and encourages each team member's contribution. Team members are trained on the roles of other team members.

Recommendations for Consumer Protections

- Care team members are assigned to fulfill functions and roles that take full advantage of their skills and qualifications but that in no way extend beyond what they are trained or qualified to do to in order to protect against patient underservice. The primary care provider in collaboration with the patient and care team determines the degree of intensity of services needed for each patient and the care team members most appropriate to meet these needs.

- Care experience is a recommended element of performance measurement as a consideration in determining the extent to which providers qualify for shared savings, as is currently the case with the Medicare and Medicaid shared savings programs, MSSP and PCMH+, respectively.

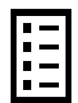
- The Payment Reform Council should consider including the conduct of an annual care experience survey and a mechanism for ANs/FQHCs to gather and respond to consumer complaints among the AN/FQHC conditions of participation.

Adults Diverse Care Teams DRAFT Concept Map - Revised

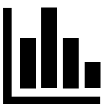
Network Level

Population Health Promotion & Management

Identify sub-populations with modifiable risk and clinical targets; predictive analytics



Assign patients, patient registries, action plans



Performance tracking, data sharing, patient engagement

Informs

Practice & Community Level

On-site, central hub, home or community

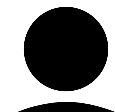
Comprehensive Care Management
RN

Acute, Preventive, Chronic Care
Physician, PA, APRN, RN, Medical Assistant

Behavioral Health Integration
PCP, BH Clinician, Care Coordination with BH expertise

Care Coordination
RN, Social Worker, CHW, Medical Assistant

Team-based Care



Patient Navigation
Patient Navigator, CHW, Social Worker

Disease Prevention & Management
RN, Nutritionist, Dietician, Pharmacist Diabetes/Asthma Educator, CHW

Medication Prescribing & Management Functions
PCP, Pharmacist, RN, Medical Assistant

Medical interpreters deployed as needed. All care team members trained in cultural sensitivity.

Coordinates

Health Neighborhood

Subspecialists
Cardiologists, endocrinologists, etc.

Community Care Extenders
Home care providers, community care teams, etc.

Ancillary Providers
Physical/occupational therapists, integrative medicine practitioners, etc.

Community Resources
Food, housing support, financial assistance, etc.

Care Team Functions

- **Population Health Promotion & Management**: Identify populations with modifiable risk, assign patients and develop registries, develop action steps based on clinical guidelines
- **Direct Patient Care**: Routine, acute, preventive, chronic care provided by PCP (clinician)
- **Care Management**: Person-centered process for providing care and support to individuals with complex health care needs
- **Care Coordination**: Organizing patient care activities and communicating patient's needs and preferences, linking to community services and supports, includes coordination in support of geriatrics, BH, chronic pain
- **Patient Navigation**: Identify and address barriers to care including insurance barriers; assist patients with social, emotional, practical, familial, and other needs; assist with patients getting to appointments and follow up; facilitate communication between patients and providers
- **Disease Prevention & Management**: Prevents disease from developing or progression of an existing disease through health coaching, nutritional counseling, education and self-management
- **Medication Prescribing & Management Functions**: Medication reconciliation, monitoring and coordination, comprehensive medication management, initiating, modifying, or discontinuing medication therapy
- **Behavioral Health Integration**: Screenings, assessments, brief interventions, medication, episodic care

Points for Discussion

- Is there a distinction between comprehensive care management and care coordination?
- Should patient navigation functions be expanded?
- Is disease management inclusive of chronic illness self-management, lifestyle modifications and addressing SDOH risks?
- What is the role of pharmacist under a Collaborative Practice Agreement?

Sense of the Task Force:

- Does the Task Force support this as a core capability, i.e. the supplemental bundle supports all practices in diversifying care teams to provide identified primary care team core functions?

- Does the Task Force support the design group recommendations?

Community Integration Consumer Input, Questions and Concerns

- SDOH screening needs to be culturally appropriate and provided by the appropriate care team member
- Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
- There will be gaps in what community services are available depending on geography and need for capacity building in those areas
- Networks should respond, via partnering with CBOs, to community needs, not just their specific patient needs as this can exacerbate disparities. Attribution methodologies should address this.
- Need to establish a baseline of community health to understand whether services are meeting needs of patients and to evaluate disparities in care
- Need to be inclusive of a variety of community organizations to connect their members/clients to healthcare, such as churches, barbershops, community centers, etc.
- Non-medical meeting places should not be burdened as healthcare hubs, but rather be sources for information connecting to healthcare services *(electronic feedback)*

Community Integration Definition

- **Definition**: Advanced networks or Federally Qualified Health Centers (FQHCs) purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services.

- **Goal**: Promote the use of community-placed services when it is better for the patient and more efficient for these services to be provided by community programs than the primary care practice or network.

Draft Concept Map for Community Integration

Primary care

Network uses person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services

Community

	Contracts 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	Barbershop Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/ Community Paramedicine

Community Integration Key Capability Requirements

- Practices identify service gaps and needs for community-based services
  - Assess chronic care management, care transitions, complex condition management, high utilizers, and social determinants of health screening for community assessment and baseline establishment

- Practices partner with appropriate community-placed health services
  - Support evidence-based and pilot services including, but not limited to: community placed navigation or linkages, early intervention and secondary prevention, chronic illness self-management services, complex care coordination for high risk patients, support for patients with acute or chronic medical risk at home

- Practices track referrals and outcomes
  - Assess individual and community impact of services such as, ED utilization, readmissions, costs, and reduction in social determinants of health risks

Key Capability Requirements

- The PCM supplemental bundle would provide upfront payment for networks to invest in new capabilities. Purchasing community placed services may be an optional use of supplemental bundle payments
- How needs are identified is determined by the network (analytics, care teams, health risk stratification)
- Purchasers wouldn't be required to implement any particular service to allow flexibility
- There are several models put forth that networks could develop with community partners, but these are not the only options
- The State would offer Technical Assistance similar to the Prevention Services Initiative to help networks develop these capabilities

Sense of the Task Force:

- Does the Task Force support this as an elective capability, i.e. purchasing community placed services may be an optional use of supplemental bundle payments?

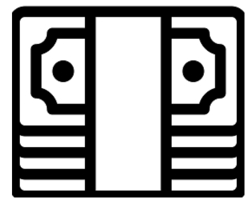
- Does the Task Force support the design group recommendations?

Genomic Screening Capability Update

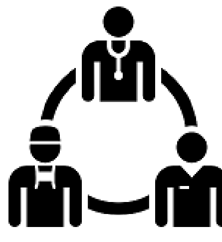
Payment Reform Council Provisional Recommendations

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. Who is qualified to participate in PCM?
2. Hybrid bundle or no hybrid or options?
3. What is included in the basic and supplemental bundles? What will remain fee for service?
4. How should patients be attributed to providers?
5. How will bundles be adjusted for differences in patient populations and over time?

Qualifications for Participation in PCM

Advanced Network

- Has the legal ability and administrative organization to contract with payers
- Responsible for the care (typically total care) of a defined population
- Is able to effectively measure the quality and efficiency of care delivery
- Coordinates clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities)
- Will participate in Medicare programs (MSSP, Next Gen) risk criteria TBD, or similar program via Medicaid/Medicare/Commercial

Rationale:

- Include participants that are well-positioned for success
- Put sufficient pressure on total cost of care

Qualifications for Participation in PCM

Practice (as defined by TIN) within AN

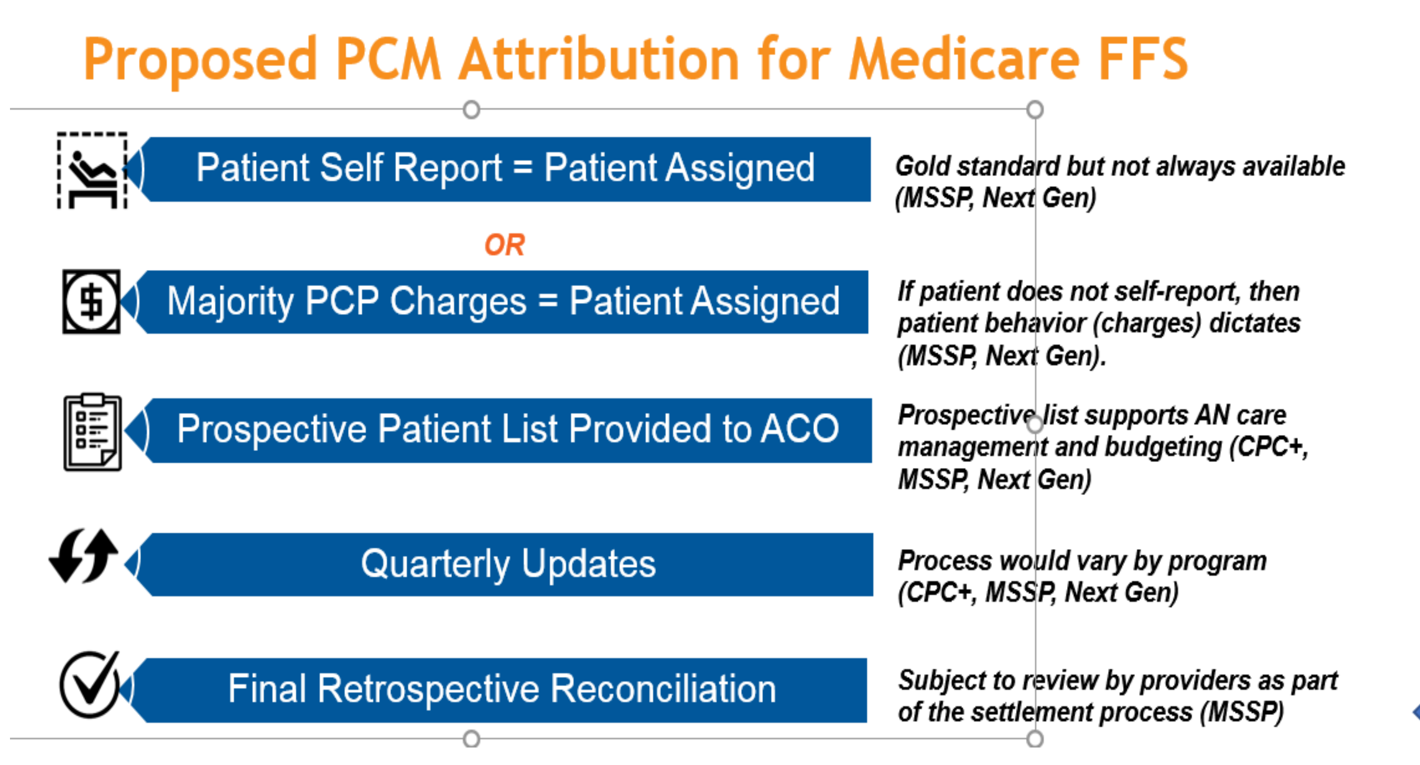
- Providers will have a primary care specialty
- All practices must meet core capability requirements
- Should be able to be clearly defined to ensure bundles are calculated and paid appropriately
  - Medicare: If participating in MSSP/Next Gen, needs to participate in PCM and vice versa
  - Other Payers: Commercial plans will leverage existing contracting structures.

Rationale:

- Ensure primary care bundle represents a meaningful portion of care provided
- Include participants that are well-positioned for success
- Limit administrative complexity

Attribution

PCM will leverage payers existing prevailing attribution methodologies.



To be determined

Basic Bundle

- Payment for a set of common primary care services, such as office visits.
- Will support transitioning some PCP patient care to phone, email, text or telemedicine.
- Give the PCP greater flexibility to spend time managing care team members, participating in learning opportunities and collaborating with colleagues
- Can represent all the costs for services in the bundle definition OR partial costs.
- Will be calculated using historical claims data and adjusted over time

Basic Bundle

"Strawman" Services Included in the Basic Bundle:

- **Included for all Practices:** Office Visit, new or established patient, Prolonged Encounter, Encounter Payment for FQHC Visit, Behavioral Health Screening, Cognition Assessment, Phone/Email/Text, Telemedicine, Home Visits (only relevant in limited circumstances and for certain populations – pediatrics, older adults and people with disabilities) and Shared Visits (optional and only applicable in some circumstances).
- **Not Included at this Time:** Hospital, SNF Rounding, Immunization Administration, Preventive Medicine Visit, Preventive Counseling, Annual Wellness Visit

Rationale:

- Include services that comprise meaningful portion of patient care (CPC+ as framework)
- Increase flexibility for care delivery as clinically appropriate and preferred by the patient
- Base on historical spend and adjust over time to account for differences in patient populations and limit administrative complexity

Next Steps

Next Steps

- Next PTTF Meeting: November 13th
- Design groups ongoing, aim to wrap up in November
- Payment Reform Council meetings through early January

Adjourn

Appendix

PCM Work Plan Update

	Jul	Aug	Sept	Oct	Nov	Dec
Practice Transformation Task Force						
Design Groups Review Capabilities						
Payment Reform Council						
1st Round Stakeholder Engagement						
1st Round Consumer Engagement						

- Practice Transformation Task Force: Complete review of capabilities by December
- Design Groups: Complete design groups in November
- Stakeholder and Consumer Engagement: Wrapping up first round in October
- Payment Reform Council: Meeting October – early January

Stakeholder Engagement Progress

Broad Consumer Engagement with Advice from Consumer Advisory Board

STAKEHOLDER ENGAGEMENT

- Primary Care Practices
- Advanced Networks
- Federally Qualified Health Centers
- Employers
- Employees
- Individual Payers
- Hospitals/Health Systems
- Health care provider and professional training programs

Sessions completed or ongoing

Sessions scheduled or being scheduled

Input & Feedback

Healthcare Innovation Steering Committee

Practice Transformation Task Force

Payment Reform Council

Began meeting 9/20

DESIGN GROUPS

- Genomic Medicine
- Adult Behavioral Health Integration
- Pediatric Behavioral Health Integration
- Diverse care teams
- Pain Management
- Community Integration
- Pediatric Practice
- Older Adults w/ Complex Needs
- Persons w/ Disabilities

OTHER ADVISORY GROUPS

- HIT Council
- Quality Council
- CHW Advisory Committee
- Healthcare Cabinet
- Medical Assistance Program Oversight Council*
- Behavioral Health Partnership Oversight Council*
- Office of Workforce Competitiveness

*Pending DSS initiated collaboration agreement

OHS CONNECTICUT Office of Health Strategy

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	Yes with revisions	Core	Basic training for all, subset specialize
Adult Behavioral Health Integration	Yes but continue development		
Pediatric Behavioral Health Integration			
Community Integration			
Older Adults			
Persons with Disabilities			
Implications of Capabilities for Pediatric Practices			

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