OHS CONNECTICUT Office of Health Strategy

Practice Transformation Task Force

November 13, 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. Review Capabilities: Older Adults, Oral Health Integration Recap, Genomic Screening Update	85 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 older adults with complex needs capability based on design group recommendations
- Revisit oral health integration and make recommendation for core or elective capability
- Provide update on genomic screening capability

Review Capabilities

PCM Capabilities: Where We Are

Increasing Patients' Access and Engagement	Expanding Primary Care Capacity	System Supports and Resources
✓ 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** ✓ Community Integration DG ✓ Oral Health Integration

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

What we Heard from Consumers about Older Adult Needs

Feedback from consumers on Design Group, AARP, CT Alliance for Retired Americans

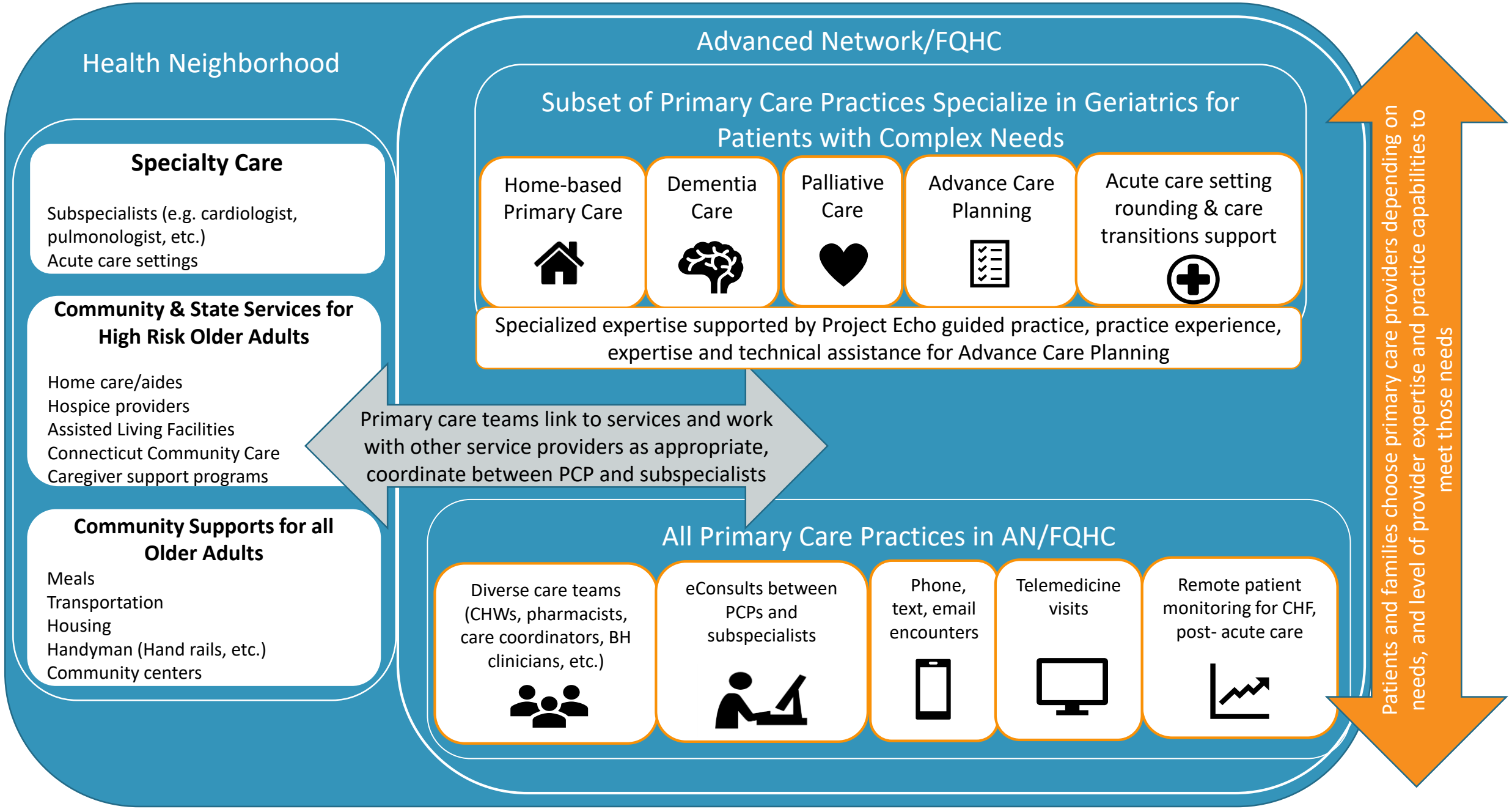
- Primary caregivers (e.g. family members) need more support managing care needs.
- Expanded range of support services that go beyond traditional in office care, such as text, email, phone, telemedicine.
- Barriers to care include transportation and getting to medical appointments especially if frail or disabled
- Hearing and cognition issues may impair understanding of self-management instructions as well as non-native language comprehension.
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients
- Desire to keep existing physicians and better communication between physicians across systems and care settings
- Single point of contact in practice to connect with and coordinate care
- Need pharmacists, patient navigators, more community health workers to get connected to community programs and interpreters
- Challenges with suppliers fulfilling DME orders and insurers covering supplies and delivery, primary care team should be aware of challenges and support patients with this
- Caregiving support for patients after leaving hospital or nursing home to follow up with them.
- Home visits and care coordination are very important for people with complex needs.
- Insurance is a challenge in terms of understanding billing and finding providers accepting Medicaid patients

Older Adults with Complex Needs

- **Definition**: Enhanced primary care for aging patients (over age 75) who are high risk through expanded capabilities for all practices and a subset of practices within the Advanced Network or FQHC that specialize in geriatrics for patients who are high risk. Patients who are high risk are those who may have multiple chronic conditions, frailty, functional challenges, report difficultly traveling to in-office visits and are more likely to have preventive emergency department (ED) visits, and/or may qualify for nursing home placement.

- **Goal**: Increase primary care practice and network capacities and resources to provide person-centered primary care for older adults with complex needs. The purpose of practices that specialize in geriatrics care for those with complex needs is to build centers of expertise within Advanced Networks and FQHCs to provide primary care services such as home-based preventive and chronic care and closing care gaps that meet the unique needs of this population.

Concept Map for Primary Care for Older Adults with Complex Needs



Older Adults Key Capability Requirements

Capabilities for all Primary Care Practices

- Expanded and diversified care team to address care coordination, navigation, medication, behavioral health and social determinants of health needs
- eConsults with subspecialists for improved communication between PCPs and subspecialists and to increase PCP expertise
- Phone, text and email encounters and telemedicine visits when appropriate to address barriers to care
- Care coordination between PCP and subspecialists, during transitions between care settings
- Remote patient monitoring for post-acute care for CHF

Older Adults Key Capability Requirements

Subset of Practices Specialize in Geriatrics (for older adults with complex needs):

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

Capabilities for Specialized Geriatrics practices

- Home based primary care for preventive and acute care
- Clinical links to institutional care settings, (hospitals, skilled nursing facilities), rounding by PCPs with support from primary care team to transition patients back to home setting and coordinated aftercare
- Expertise in Advance Care Planning and making complex care and end of life decisions
- Expertise in Palliative Care and End of Life Services: Services to minimize discomfort, referrals to and coordination with hospice care as needed
- Specialized Care for Patients with Dementia: initial assessment and diagnosis, develop treatment plans, refer to subspecialists as needed, care coordination, connection to resources

Implementation Recommendations

- Maintain patient/family choice of providers while providing resources and education about benefits of primary care and specialized practices
  - Patients may choose to continue to see a subspecialist as their primary care provider,
    - Subspecialists are not eligible to participate in PCM and would be paid fee-for-service for patients attributed to them
    - Networks may provide education to patients about the importance of having a primary care physician
  - Patients who are attributed to a practice that is participating in PCM should receive information about the demonstration

- Avoid duplication in care coordination and other services that are provided through Medicaid waivers and other community support programs
  - Individuals decide whether the practice's nurse care manager is needed, in consultation with his or her circle of support, PCP and LTSS care coordinator
  - Advanced Networks should develop coordination protocols with Medicaid waiver programs that set mutually agreeable processes for determining who is responsible for supporting the coordination of an individual's acute and chronic medical needs

- Consider providing a financial incentive for providers who avoid nursing home placement for Medicare beneficiaries and for whom there are associated cost savings

Sense of the Task Force:

- Does the Task Force support this as a core capability for a subset of practices?
- Does the Task Force support the design group recommendations?

Oral Health Integration Summary of Capability Review

- Summary of Task Force review of capability at previous meeting
  - Supported concept of oral health integration and many members supported capability as core
  - Task Force raised questions to come back to before making recommendation
    - Is universal screening needed or identification of high risk patients who should be screened?
    - How is this implemented in a commercial population when many patients do not have dental coverage?
    - What is the experience of CCIP participating entities?
    - Should this be only required for a subset of practices?

CCIP Feedback on Oral Health Integration

- One CCIP entity (CHC) is pursuing the oral health integration standard:
  - Already provide dental services in the same location as other services, so using co-location model
  - Integrated through process, active patient and staff education, dental outreach and warm handoffs

- CCIP entities not pursuing oral health integration cited the following challenges:
  - Limited short term financial benefit or incentive
  - Degree to which dental care is truly integrated with the other areas of clinical care across care settings is inconsistent
  - For most populations, dental and medical insurance, payer contracting and care delivery are completely separate.
  - Would require very large effort and cost to build systems that could measure provider compliance with encouraging patients to have good oral health and conducting oral exams as part of the routine physical exam, or whether the patients have seen a dentist regularly

- Key Takeaways:
  - Pediatrics and many FQHCs are already doing this
  - CCIP entities cite many challenges to implementing oral health integration due to lack of dental coverage in their populations and inability to measure oral health services

Potential Recommendations for Oral Health Integration

- Oral integration health integration is an elective capability to give networks flexibility but support those already integrating oral health integration
- For future, PRC may recommend payers include medical insurance coverage for preventive oral health services

Genomic Screening Capability Update

Next Steps

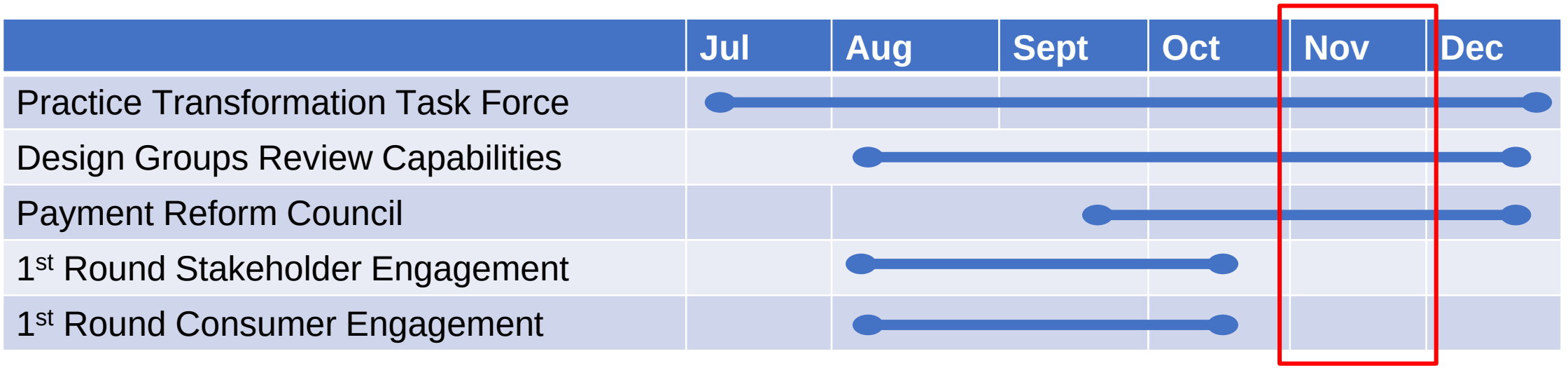
Next Steps

- Next PTTF Meeting: November 27th
- Design groups:
  - Pediatrics and People with Disabilities: aim to wrap up in early December
  - All other design groups complete
- Payment Reform Council meetings through early January

Adjourn

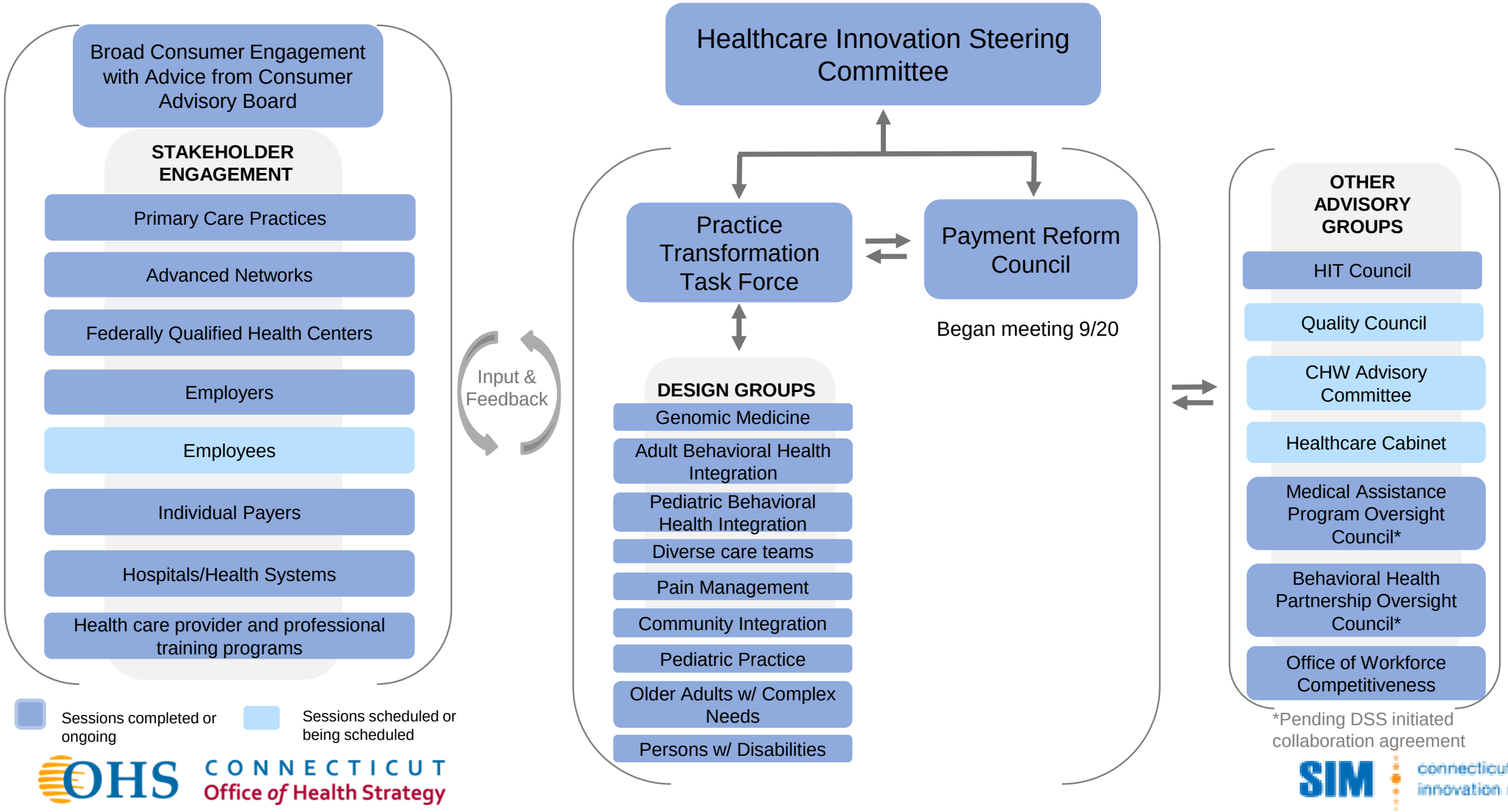
Appendix

PCM Work Plan Update



- Practice Transformation Task Force: Complete review of capabilities by January
- Design Groups: Complete design groups in December
- Payment Reform Council: Meeting October – early January

Stakeholder Engagement Progress



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SIM connecticut state innovation model

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	Yes	Core	All
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	Yes	Elective	
Older Adults			
Persons with Disabilities			
Implications of Capabilities for Pediatric Practices			

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