CONNECTICUT
Office of Health Strategy

Practice Transformation Task Force

January 8, 2019

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 Pediatric Behavioral Health & Universal Home Visits for Newborns	45 min
7. Review Selected Adult Capabilities	45 min
8. 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

Today's Discussion Topics

- Review Pediatric Behavioral Health Capability
- Follow up on Pediatric Universal Home Visits for Newborns
- Review and approve selected Adult Capabilities

Pediatric Behavioral Health

Definition of Pediatric Behavioral Health Integration

- Unify pediatric behavioral health and primary care to focus on developmental, socio-emotional, and mental health promotion, prevention and early identification for child and family.
- The practice supports full integration of dedicated behavioral health clinicians and care coordination functions into primary care
- Care coordination:
  - Organizes patient care activities and information sharing among all care team participants to achieve safer and more effective care.
  - Identifies the patient's needs and preferences which are communicated at the right time to the right people who can provide safe, appropriate, and effective care to the patient.
  - Connects children and their families to specialty services and community supports to ensure optimal health and development, address social determinants of health needs and provide culturally and linguistically appropriate health promotion and self-care management education.

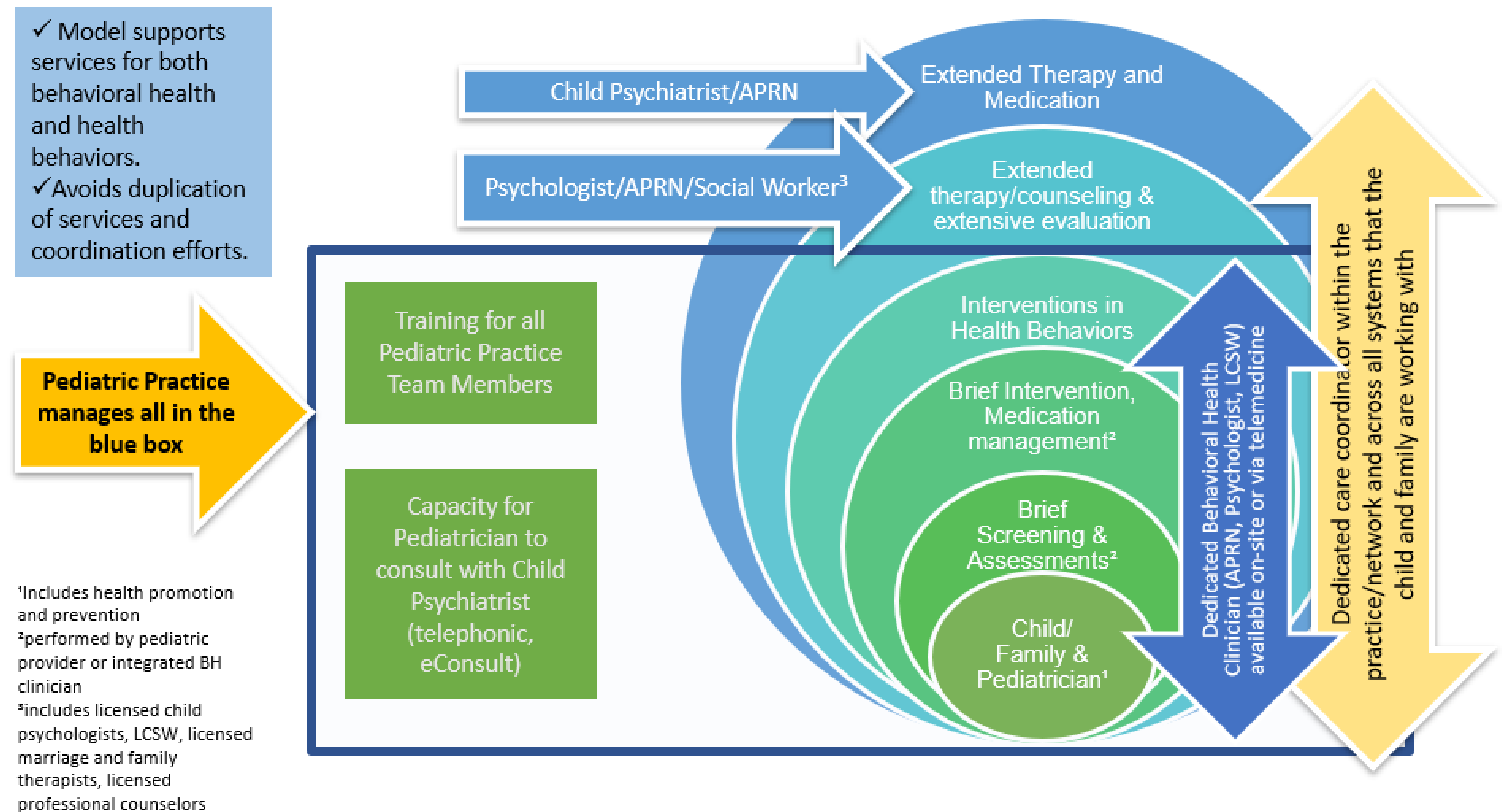
Goal of Pediatric Behavioral Health Integration

- The child, family and pediatric clinician are at the center of a well-coordinated, set of behavioral health services integrated within the practice, available in the network and tied to services and resources in the community.
- This model does not intend to enable pediatric primary care to treat individuals with serious behavioral health conditions, although it does aim to enable primary care to better address these individual's preventive and medical care needs.

Pediatric Behavioral Health Concept Map

- Increases resources within the pediatric practice for both behavioral health and health behaviors
- Avoids duplication of services and coordination efforts.

Pediatric Behavioral Health Integration



Care Team and Network Requirements

- Specific universal screenings at defined intervals to assess developmental and socio-emotional health, behavioral health and health behaviors and social and environmental factors that affect the child/family
- Dedicated behavioral health clinician (BHC) for each practice; clinician is integrated into the practice or available via "Warm Handoff" through phone or telemedicine visit
- Dedicated care coordinator with expertise in behavioral health who coordinates within the practice/network and community for child and family; establishes two-way information flow between community and practice. Level of support adjusted based on higher illness burden and social determinants of health.
- Treatment and brief interventions; referral for further treatment if needed
- Medication management expertise within the practice and access to e-consultations with child psychiatrists
- Patient-to-clinician telemedicine visits (especially for adolescents)
- Tracking outcomes in EHRs
- Training for clinical staff on BH teaming and BH issues and for BH staff on chronic illness
- Referral and coordination with community-based BH specialists for extended therapy, counseling, evaluation and medication

Building Team-based Care

- Training for pediatric care team for full integration of behavioral health clinicians and care coordinators
  - Train primary care team to reduce stigma for patients with behavioral health issues; administering behavioral health screens, enhanced role-based training, and effective teaming with integrated behavioral health clinicians (BHCs), cultural sensitivity and awareness
  - Train BHCs in defined core competencies, such as population care, culture of primary care, common chronic medical conditions, psychopharmacology, brief screening/assessment, brief intervention, brief documentation and effective teaming with pediatric team staff
  - Care coordinator has expertise in addressing both the child *and adult* needs related to behavioral health and social determinants of health
- Prioritize on-site behavioral health clinicians with an option for smaller practices to use telemedicine; use a common EHR platform

Measurement

- Measurement design will consider SDOH and other health equity indicators and the relationship to outcome measures. (The Payment Reform Council will develop a measurement and accountability framework).
- Develop outcome measures that reflect the effectiveness of the practice in addressing behavioral health needs through actions and activities led by the practice. Include measures that measure the impact on health equity and disparities between populations.
- Develop an implementation plan and measurement strategy
- Create meaningful, actionable measurement and monitoring mechanisms to measure practice's progress in achieving defined goals and capabilities

Questions

- Is there anything that should be added to this description?
- Does the group support including Pediatric Behavioral Health as a core component in the pediatric medical home?

Follow Up: Universal Home Visits for New Parents

Evidence-based Outcomes[1]

- Evidence suggests improved prenatal and post-natal outcomes including lower infant mortality
- Potential long-term benefits: fewer unwanted pregnancies, reduced maternal criminal behavior, decreased use of welfare, decrease in verified incidents of child abuse and neglect, less maternal behavioral impairment attributable to alcohol and drug abuse

- **Features of successful programs[2]**
  - Families consent to visit
  - Focus on families in greater need of services
  - Flexibility and family specificity
  - Active promotion of positive health-related behaviors and infant care-giving
  - Broad multi-problem focus to address the full complement of family needs
  - Measures to reduce family stress by improving its social and physical environments

[1] http://pediatrics.aappublications.org/content/140/3/e20172150
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4503253/
https://www.ncbi.nlm.nih.gov/pubmed/27980028

Universal Home Visit Capability

How

- At least one home visit for all newborns and their families
- Visits by a nurse and a community health worker (CHW)
  - Emphasis on community health workers who are parents and can provide peer-to-peer support
- Clear connection with the pediatric medical home
  - Bi-directional communication between visitors (nurse and CHW) and pediatric medical home
  - Information recorded in Electronic Health Record (EHR)
- Networks and practices may arrange for nurse and community health worker services

Questions

- Is there anything that should be added to this description?
- Does the group support including Universal Home Visits for Newborns as a capability within the proposed pediatric medical home expanded care team?

Selected Adult Capabilities Summary Documents

Purpose of the Capabilities Documents

- Provide a summary of the capability in a concise, attractive format for diverse audiences
- Recaps the concepts as developed by the Design Group and as previously reviewed by the Task Force
  - First page: General audience
  - Second page: More specific language about the approach
- Plan to review all capabilities as a group at the next Task Force Meeting
- For the samples provided, is the amount and type of information in this document sufficient to communicate the initiative to a wider audience?

Adult Behavioral Health Integration

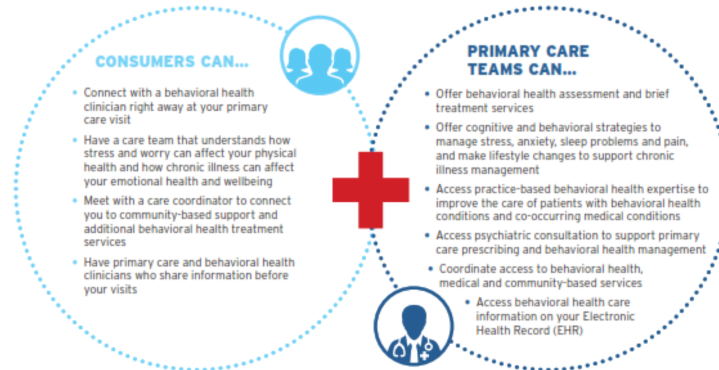
PRIMARY CARE MODERNIZATION

Adult Behavioral Health Integration

CORE CAPABILITY

A team-based, primary care approach to identifying and managing less complex behavioral health conditions, co-occurring health conditions, and behaviors that affect health.

HOW CARE WILL IMPROVE



PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Nate is 62 years old and lives alone after his divorce. He has diabetes and is overweight. He tries to eat healthy but hates cooking. He tries to take walks on weekends when his son visits, but he's mostly alone.

When Nate goes to his primary care office for his diabetes check-up, the nurse administers the PHQ9 (Depression Screening Tool). His score indicates a possible moderate depression. He says that he just wants to watch TV all the time.

He agrees to see the licensed clinical social worker in the practice. His doctor walks him down the hall to introduce them. They make an appointment for him to come see her when he comes back for blood work in a few weeks.

When Nate returns, the social worker introduces him to the practice's behavioral health care coordinator. She connects Nate to a local support group for divorced men and a walking club and records this in his medical record.

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HOW

Care Team and Network Requirements

- Standardized screenings to identify depression, substance use, anxiety, and social determinants of health
- Dedicated behavioral health clinician, on-site or via telemedicine, responsible for assessment, brief interventions, and care team consultation
- Protocol for "warm-hand off" to and telemedicine visits with behavioral health clinician
- Care coordinator with behavioral health expertise
- Referral assistance and tracking to support access to community behavioral health specialists, higher level behavioral health services, behavioral supports (e.g., peer support) and community resources (e.g., housing, legal assistance)
- E-Consult arrangement with community-based psychiatrist or psychiatric APRN
- Memorandum of Understanding with at least one behavioral health clinic if behavioral health specialty services are not available within the network.
- Bi-directional communication as needed between primary care team and community-based behavioral health specialists and community supports.
- Care team training on behavioral health teaming, chronic illness, and care coordination.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for primary medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and e-Consult
- EHR configuration and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Bi-directional communication solution to support coordination with community-based BH specialists
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience
- Improved patient experience with respect to timely care, communication, coordination, access to BH care (practice-based and/or community), provider support, discussing stress, and overall provider satisfaction
- Less time off of work, improved functioning at work

★ Quality
- Earlier identification and treatment of behavioral health conditions
- Improved behavioral health outcomes (e.g., depression remission rates)
- Improved chronic illness outcomes (e.g., A1C control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost
- Lower out of pocket costs for patients when treated in primary care
- Reduced avoidable physical health utilization related to unmet BH needs
- Reduced ED and hospital utilization

Access
- Easier access to BH services and reduced wait time for treatment
- Assistance with referral and linkages to community-based behavioral health specialty services and community supports

IMPROVING HEALTH EQUITY

Patients with behavioral health needs face obstacles in getting care. To reduce this disparity, primary care will change in the following ways:

✓ **Improved access for populations** who might be less inclined to seek behavioral health treatment in other settings due to stigma.

✓ **Expanded connections** with culturally appropriate behavioral health services and coordination to address social determinant barriers

✓ **Care coordinators and medical interpreters** improve communication between primary care and behavioral health providers.

LEARN MORE!
https://bit.ly/2U69IC9

Diverse Care Teams

PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Expand and diversify care teams to make primary care more comprehensive and accessible, better meet the needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction.

HOW CARE WILL IMPROVE

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Martín is 60-years-old, has lung disease, high blood pressure and is overweight. He has unstable housing and no car. The network's quality improvement team recommends an in-person office visit because his high blood pressure is not well-controlled. Martín reluctantly agrees to come in.

Martín prefers speaking Spanish and needs assistance with transportation. Before the appointment, the patient navigator and a Spanish interpreter call him to arrange transportation. At his appointment, his primary care provider conducts an exam with help from a medical interpreter.

He meets with the nutritionist to create an action plan to help him eat healthier and be more active. The pharmacist reviews his medication list and determines the most cost-effective medications for managing his lung disease and high blood pressure.

Martín meets with a community health worker to apply for financial help for medications, food, housing, and utilities. The care team reviews Martín's progress through notes in the EHR and at weekly huddle meetings.

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HOW

Care Team and Network Requirements

- Hire care team members to provide acute, preventive and chronic care; comprehensive care management; care coordination; patient navigation; behavioral health integration; health promotion and chronic illness self-management and medication prescribing and management (see definitions of functions, activities and credentials)
- Provide population health analytic resources to develop, implement and refine operations and to support continuous health promotion and quality improvement
- Determine care team compositions, location of team members, and staffing ratios based on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, and team member role
- Deploy care team members on-site at the practice, in the community or patient homes, and/or at a central hub in the network or health center; partner with other organizations as necessary to provide appropriate services and care team capacity
- Ensure care team members apply their skills to the top of their training, but do not exceed their qualifications
- Train team members to deliver effective team-based care (see Principles for Team-based Care) including workflows and communications.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- EHR and protocols to ensure capture all interactions between patient and care team members, including non-office-based care
- EHR supports population and registry management and care management
- EHR includes a comprehensive care plan with role-based care team access
- Direct connection to support coordination with community-based services, including behavioral health

MEASURING IMPACT

Patient Experience
- Improved patient experience with respect to timely care, communication, coordination, access to BH care, provider support, discussing stress, and overall provider satisfaction

Quality
- Improved preventive care (e.g., cancer screening, immunizations), especially for individuals with complex illnesses or disabilities
- Improved chronic illness outcomes (e.g., diabetes control)
- Improve care plan adherence by reducing medication problems
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost
- Lower out of pocket costs for patients when receiving services in primary care and by non-billable care team members
- Reduced ED and hospital utilization

Access
- Easier access to services in the practice, home, or community
- Assistance getting access to medical services and community supports

IMPROVING HEALTH EQUITY

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Diverse care teams help by:

- ✓ **Having community health workers** who reflect the patient's community and culture and medical interpreters who address language barriers.
- ✓ **Linking patients to housing, food, transportation** and other community resources.
- ✓ **Navigating billing and insurance issues** for people who have financial barriers to care

LEARN MORE! https://bit.ly/2BYSvT6

Questions for Discussion

- For the samples provided, is the amount and type of information in this document sufficient to communicate the initiative to a wider audience?

- Vote to approve these capabilities

Next Steps on Capabilities

- Task Force will receive three more packets of capabilities over the next three weeks
- Review and vote at the next meeting on January 29

Capability	Summary Document	Detailed Document	Concept Map	Approved
Adult Core Services				
Behavioral Health Integration		https://bit.ly/2AtwUSN	https://bit.ly/2VqOS0W	☐
Diverse Care Teams		https://bit.ly/2BYSvT6	https://bit.ly/2VqOY8O	☐
Pain Management				☐
E-Consults				☐
Older Adults with Complex Needs				☐
Phone/Text/Email/Telemedicine				☐
Remote Patient Monitoring				☐
Adult Elective Services				
Community Integration				☐
Oral Health Integration				☐
Shared Visits				☐
Pediatrics Core Services				
Behavioral Health Integration				☐
Pediatric Medical Home				☐
Community Integration				☐
Alternative Methods of Patient Engagement				☐

Questions

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Adjourn