Practice Transformation Task Force

January 29, 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 Draft Capability Summaries	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

Purpose of the Meeting

- Review the Draft Capability Summaries
- Pass the Draft Capability Summaries to the Payment Reform Council to confirm supplemental bundle design

Draft Capability Summaries

About the DRAFT Capabilities Summaries

- Consolidates input and feedback from:
    - Design Groups
    - Consumer feedback
    - Task Force comments at initial presentations at prior meetings
- Intended audience is the stakeholder community engaged in design of the PCM initiative, including payers, providers, consumers, etc.
- Stakeholder input process continues, and the capabilities will continue to evolve
- Final report will include additional sections and descriptive materials

Tonight's Discussion

- Review each of the capabilities for inclusion in the payment model
  - Note any adjustments that have been made in response to feedback from consumers and others
- Review Task Force feedback requested in advance of this meeting
  - General Comments
  - Issues for discussion
- This deck contains information received as of January 25; subsequent feedback will be provided at the meeting

ADULT CORE CAPABILITIES

Capabilities Recap – Adult Primary Care

		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Community Integration to Address Social Determinants • E-consults and Co-management	• Telemedicine, Phone, Text & Email • Home Visits • Remote Patient Monitoring	• Older Adults w/Complex Needs • Pain Management and Medication Assisted Treatment
	Elective	• Community Purchasing Partnerships • Oral Health Integration	• Shared Medical Appointments	

Community Integration to Address Social Determinants

CORE

Identify social determinants of health and other barriers that may affect patient's healthcare outcomes and address those barriers by connecting patients to community resources.

Changes since last Task Force review:

- Previously one component of an overall Community Integration capability
- Requires care teams to implement a deliberate and focused process, including screenings, care plan documentation, care team responsibilities, establishing referral relationships, maintaining resource directories, referral management protocols and outcomes tracking.

Health Equity Improvement

CORE

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures. Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Changes since last Task Force review:

- Previously one component of an overall Community Integration capability
- Will measure:
  - Increased collection of all specified data documented in the EHR
  - Completed analyses that identify at least three disparities
  - Completed interventions to address the three disparities

Community Purchasing Partnerships

ELECTIVE

Primary care practices contract for home and community-placed services that extend the reach of primary care in order to better meet the needs of diverse communities, address social determinants of health or fill gaps in services.

Changes since last Task Force review:

- Previously one component of an overall Community Integration capability
- Requires care team to:
  - identify service gaps and needs for community-placed services
  - contract for services such as navigation, coordination, early intervention and secondary prevention, chronic illness self-management, care management and –in-home supports
  - Implement clinical protocols and analytics to identify patients who require community-placed services
  - Implement referral management protocols
  - Create outcomes tracking

Pain Management and Medication Assisted Treatment

CORE

Preventive, routine and advanced pain management in primary care. All practices have basic competence in pain management while a subset have specialized expertise, supported by Centers of Excellence in pain management. Some practices specialize in Medication Assisted Treatment for opioid addiction.

Changes since last Task Force review:

- **None**

Older Adults with Complex Needs

CORE

Enhanced primary care from a practice specially designed to improve outcomes for patients age 75+ with multiple chronic conditions, functional challenges, trouble traveling to in-office visits, and more likely to have potentially avoidable emergency department (ED) visits and require nursing home placement.

Changes since last Task Force review:

- **None**

Telemedicine/Phone/Text/Email

CORE

Telemedicine visits, phone calls, text messages, and emails expand patients' access to primary care team for diagnosis, treatment, advice, check-ins and coaching.

Changes since last Task Force review:

- Consolidated Telemedicine with Phone/Text/Email to reflect new CMS payment rules

Remote Patient Monitoring

CORE

Remote patient monitoring uses connected digital devices and technology to move patient health information from one location, such as at a person's home to a healthcare provider in another location for assessment and recommendations, usually at a different time. It is most helpful for patients with certain conditions including congestive heart failure, often called CHF.

Changes since last Task Force review:

- **None**

Shared Medical Appointments

ELECTIVE

Shared Medical Appointments are a form of group visit for patients with similar medical conditions during which a clinical team provides physical exams and education about ways patients can help manage their own conditions such as lifestyle changes and how to use community resources to reduce barriers to care.

Changes since last Task Force review:

- **None**

eConsults

CORE

Primary care provider electronically consults with specialists for non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit.

> *"Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.*

Changes since last Task Force review:

- **None**

Previously Discussed

CORE

Adult Behavioral Health

- **Task Force's General Comments**
  - Should define what brief treatment services primary care teams perform
  - Should define which types behavioral health, medical, and community-based services primary care teams coordinate access to

Diverse Care Teams

- **Task Force's General Comments**
  - Functions of care team are greatly improved through expansion.
- **Task Force's Issues for Discussion**
  - Does an expanded care team improve preventive care for those with complex illnesses and disabilities, as mentioned in the impact section?

Oral Health Integration

ELECTIVE

Provide dental prevention services in a primary care doctor's office during regular checkups, including screenings, fluoride varnish, oral hygiene education, and when necessary, referrals to oral health providers.

Changes since last Task Force review:

- **None**

Capabilities Recap – Pediatric Primary Care

Health Equity Improvement	Team-Based Care	Alternative Ways to Engage Patients and Their Families
Core	• Diverse Care Teams • Behavioral Health Integration • Oral Health Integration • Community Integration to Address Social Determinants • E-consults and Co-management	• Telemedicine, Phone, Text & Email • Home Visits (for newborns)
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Pediatric Diverse Care Teams

CORE

Create care teams within the pediatric medical home that are guided by the primary care clinician in collaboration with the patient and family, integrate other professionals, coordinate with community supports, and promote the strengths of families and best health for all children.

Changes since last Task Force review:

- **None**

Pediatric Behavioral Health Integration

CORE

A team-based approach to prevention, early identification and promotion of developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community.

Changes since last Task Force review:

- **None**

ELECTIVE

Pediatric Community Purchasing Partnerships

Advanced Networks or FQHCs facilitate arrangements for home and community-placed services on behalf of pediatric practices that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health, or fill gaps in services.

Changes since last Task Force review:

- Previously one component of an overall core pediatric Community Integration capability
  - This aspect is now elective, with Community Integration to Address Social Determinants and Health Equity Improvement remaining core
- If selected, requires care team to:
  - identify service gaps and needs for community-placed services
  - contract for services such as navigation, coordination, early intervention and secondary prevention, chronic illness self-management, care management and –in-home supports
  - Implement clinical protocols and analytics to identify patients who require community-placed services
  - Implement referral management protocols
  - Create outcomes tracking

Pediatric eConsults and Co-management

CORE

Pediatric primary care providers partner with specialists via electronic consults (eConsults) or collaborative care programs (co-management) for treating non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit.

> *"Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.*

Changes since last Task Force review:

- Combined eConsults and co-management; similar options for pediatrician to engage with a specialist and expand primary care capacity.

Pediatric Alternative Ways to Engage Patients and Their Families

CORE

Offer alternative ways for patients and families to engage with the pediatric medical home beyond individual office visits, such as home visits, telemedicine visits, phone calls, text messages, emails, and group well child visits.

Changes since last Task Force review:

- **None**

Capabilities Recap – Adult Primary Care

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Discussion

- Next steps after the PTTF's review
  - Payment Reform Council reviews capabilities relative to supplemental bundle financing and provides that to the PTTF.
  - PTTF will review the Payment Reform Council's approach at a February meeting.

- Does the Task Force recommend that the Payment Reform Council review these capabilities – core and elective – for inclusion in the supplemental bundle?

Next Steps

Next Steps

- Capabilities with PTTF comments will be sent to Payment Reform Council
- Next PTTF meeting in late February
- Health Innovation Steering Committee briefing on Capabilities on February 14th
- Feedback will be collected and recorded for PTTF review

Questions

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Adjourn