Practice Transformation Task Force

March 5, 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 of Outstanding Capabilities	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

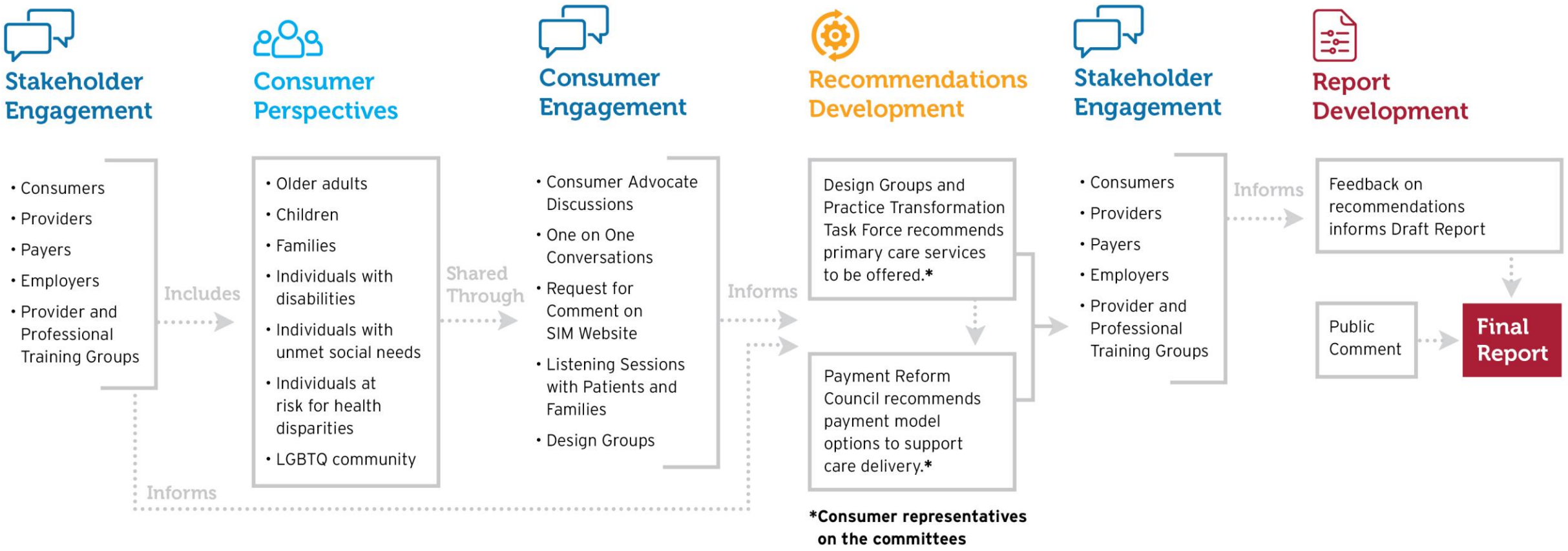
1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (less than 2 minutes if possible) and to the point/agenda item (*the chair will interrupt if the speaker strays off topic or talks 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

- Process Update
- Review Draft Capabilities for:
  - Universal Voluntary Home Visits for Newborns and their Families
  - People with Disabilities

Primary Care Modernization Process



Draft Capability Summary: Universal Voluntary Home Visits for Newborns and Their Families

Discussions to Date

- Home visits (occasional, not universal) included as a component of Diverse Care Teams
- Design Sub-Group recommended that universal home visits for families with newborns be established as a separate capability
- Task Force members:
  - Expressed concern about the cost of providing a visit to all families
  - Recommended offering visits to parents of newborns, not requiring them
- Deferred a final decision
- Today's question: Do Universal Home Visits make sense for Pediatric PCM?

How Newborn Care Typically Works Now

- Early days with an infant can be chaotic, exhausting, even terrifying
- Pediatric practices often connect with parents before the baby is born
- Pediatrician visits mom and baby in the hospital; provides contact information for the pediatric office
- In-office weight check, jaundice at 1 week
- Subsequent visits for weight and immunizations

Proposed Capability

- **Goal:** Connect new families with pediatric practice and provide direct coaching in a familiar environment
- Pediatric practice sends a nurse and a community health worker (CHW) from the practice to the home
  - Emphasis on community health workers who are parents and can provide peer-to-peer support
  - Nurse trained in lactation support
- Ideally within 1-3 days of family's returning home
- Check on jaundice and weight
- In-home observation and coaching on feeding issues, post partum depression

Home Visiting Models

- Minding the Baby – Yale Child Study Center
  - Designed for first time young parents living in low income settings
  - Nurse and mental health professional alternate visits starting before birth and continuing until child's second birthday
  - Visits begin as weekly and transition to every other week
  - Evidence of improved child and maternal health
- Child First
  - Focus on high-risk young children and families
  - Mental health/developmental clinician and care coordinator team
    - Comprehensive assessment of child and family needs
    - Observation and consultation in early care and education settings, a family and child plan of care, a parent-child mental health intervention, and care coordination.
  - Typically lasts 6 to 12 months, visit twice per week in first month, weekly thereafter
- Connecticut Maternal, Infant and Early Childhood Home Visiting Program
  - Oversees home visiting programs around the state
  - Example: Nurturing Families Network– local programs offering home visit by trained home visitors to families of first born children in at-risk communities.

Other Program Examples

- Durham Connects, Durham, NC
  - 4 to 7 session nurse home visit program to assess family needs and connect parents with community resources to improve infant health and well-being.
  - Participants used 59% less emergency care in the first six months of life than other families with babies.

  https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301361

- First Born Program, Santa Fe, NM
  - Combines health care workers and lay parent educators as home visitors
  - In their first year of life, treatment group children were one-third less likely to visit the emergency department

  http://pediatrics.aappublications.org/content/139/1/e20161274

Evidence

- Nurse Family Partnership estimate: 85,149 children avoiding maltreatment annually for a combined lifetime savings of $16.0 billion from the societal cost perspective
  https://cbexpress.acf.hhs.gov/index.cfm/assets/scripts/index.cfm?event=website.viewPrinterFriendlyArticle&articleID=5096

- RAND found that high-fidelity home visiting programs for at-risk families have a $5.70 return for every tax dollar spent from reduced spending for health care and welfare services.
  http://www.pewtrusts.org/~/media/legacy/uploadedfiles/wwwpewtrustsorg/reports/home_visiting/HomeVisitingAugust2011Reportpdf.pdf

- Durham, North Carolina reported saving $3.00 for every $1.00 spent on the program during an infant's first six months due to reduced emergency care visits.
  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4011097/.

- California's Welcome Baby had a higher number of ED visits in Year One and Year Two.
  http://www.urban.org/sites/default/files/publication/88516/2001162-effects-of-welcome-baby-home-visiting-on-maternal-and-child-medical-enrollment-and-utilization.pdf

- "Nurse-visited children….lived in homes with fewer hazards for children; they had 40% fewer injuries and ingestions and 45% fewer behavioral and parental coping problems noted in the physician record; and they made 35% fewer visits to the emergency department than did children in the comparison group."
  http://pediatrics.aappublications.org/content/93/1/89?download=true

Discussion

- Does the Task Force recommend including Universal Voluntary Visits for Newborns and Their Families as a capability?
- Should it be core or elective?

Draft Capability Summary: People with Disabilities

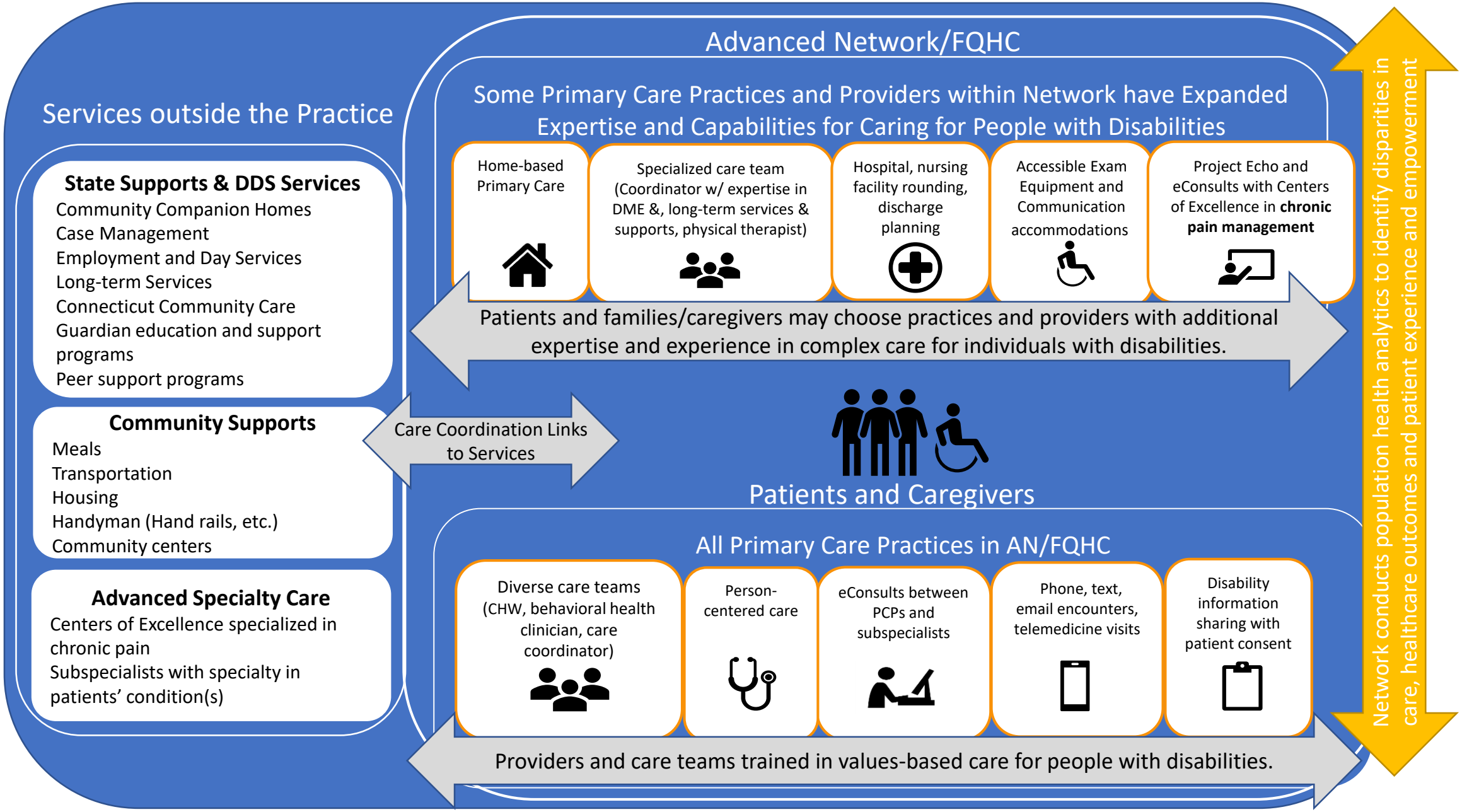
People with Disabilities: Approach to Recommendations

- Meetings
  - October 5, 2018
  - November 2, 2018
  - December 7, 2018
- Public Comment letter received December 17, 2018
  - Recommendations do not represent an endorsement by participants in the design discussions of the payment model options under consideration for the Primary Care Modernization initiative.
  - This capability represents principles and standards of care.
  - Further stakeholder discussions to review overall model

PCM Capability: People with Disabilities

- **Proposed: Universal (all ages Adults and Children) Core for Networks and Practices**
- **Definition of the Capability:** Enhanced primary care for people with a disability that includes: access to preventive screenings and care, primary care provider training, accessible services, and home- and community-based services and care teams
- **Goal of the Capability:** Increase primary care capacity and resources to provide high-quality and comprehensive preventive, acute and chronic care focused on the needs of people with disabilities to support them in achieving their best health and quality of life

PTTF Concept Map for Primary Care for People with Disabilities: Network/Practice Level Requirements*



Best in Class Primary Care

- Person centered, high quality preventive and routine care for all
- Accessibility:
  - Exam equipment: Supports such as hi-lo tables, wheelchair scales, transfer equipment, lifts, specialized mammography equipment
  - Communication devices for people with speech impairments, signers for people with hearing impairments, interpretation services for non-English speakers
  - Alternative methods of patient engagement (phone, text, email, telemedicine) as appropriate
  - Office locations accessible via public transit or practice arranges transportation
  - Practices accept patients with disabilities, including those with complex needs, regardless of their insurance
- Establish validated metrics to measure patient experience and empowerment and health equity
- Avoid financial incentives to reduce care for people who have disabilities

Primary Care Team

- Clinicians and care teams are trained in and have experience caring for people with disabilities to reduce implicit bias and assumptions
  - Training focused on “values-based” care, involves people with disabilities who speak from their perspective
  - Clinicians and care teams understand unique needs of people with various disabilities (e.g. physical, neurologic, developmental)
  - Clinicians and care teams establish how to work with “surrogates” and who to communicate with during encounters
- Expanded care team functions and members (care coordinator, nurse care manager, community health worker, etc.) to better meet the needs of diverse patients and reduce burden on the primary care provider
- Person-centered care: PCPs and care teams are trained in how to care for and communicate with people with disabilities, how to engage surrogates, pre-visit planning and how to address the unique needs of people with varying types of disabilities; e.g., consider “able lives” programming.
- eConsults between PCPs and subspecialists: Electronic communications between primary care providers and subspecialists before or instead of referring patient to subspecialist
- Exchange of disability information between PCPs and other services (with patient consent): PCPs have access to patient personal health records **with person’s consent** and some DDS disability information and LTSS care plan information within their Electronic Health Record and other providers (e.g. LTSS) have access to person’s medical information, **with person’s consent**

Primary Care with Enhanced Expertise and Experience

Many consumers consulted during this process supported having a subset of practices/PCPs with enhanced expertise and experience in caring for people with disabilities, with the following provisions:

- Providers and practices with specialized expertise see all patients, not just those with disabilities. They are recommended based on how their unique expertise matches patients' needs.
- Specialized practices are not "disabilities only" clinics and they do not restrict access to certain clinic dates/times based on disability type or status.
- Patients, families and caregivers choose which provider and practice they go to (who may or may not be specialized)

Provider expertise and experience in complex care for people with disabilities is supported by additional capabilities:

- **Home-based primary care services**: Physician supervised care teams provide primary care services in the home for patients who cannot leave the home due to acute medical issues, such as following discharge from a hospital or nursing facility
- **Specialized care team**: Care coordinator has expertise in long-term services and supports and Durable Medical Equipment coordination, physical and occupational therapists, other care team members based on practice population
- **Established clinical liaisons between primary care team and facilities**: Primary care team communicates with hospital and nursing facility staff, rounding by primary care providers with support from the care team for care transitions
- **Project Echo and eConsults with Centers of Excellence in chronic pain management**: Specialized expertise in chronic pain management and treatments

Additional Recommendations

Measuring Patient Empowerment

- Current patient experience measures (e.g. CAHPS) do not adequately capture person-centered care
- Important to measure that person feels in control of their health decisions and is leader of their care plan
- Aim to align with Dept. of Developmental Services research on validated measures to capture this
- Public Scorecard for primary care practices that includes accessibility score

Health Information Technology

- Sharing personal health record between primary care providers, specialists and LTSS providers, with person's consent
- Sharing DDS information with primary care provider
  - Gets at what person's capabilities are, not just what they can't do
  - Understand the person's vision for the future
- Include information important to primary care team that wouldn't otherwise be captured in Electronic Health Record
    - E.g. Timing for changing and dressing a wound based on who is in the home and care plan or understanding when a person takes their medications

Discussion

- Is anything missing from this description?
- What elements of this model might be more challenging to accomplish (and need more time to implement)?
- Does the Task Force support including this capability as universal (all ages) in PCM?
- Does the Task Force support including this capability as Core or Elective?

Next Steps

Next Steps for Proposed Capabilities Compendium

- Proposed Capabilities to be discussed with stakeholders in next round of meetings in March and April
- Suggestions and edits about the capabilities welcome and to be reviewed after stakeholder meetings are completed

Questions

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Adjourn