STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
March 5, 2019
6:00 – 8:00 p.m.

Meeting Location: CTBHP, Litchfield Room, Suite 3D, Rocky Hill

Members Present: Supriyo Chatterjee; Maria Dwyer; H. Andrew Selinger; Elsa Stone; Grace Damio; Douglas Olson; Mark Vanacore; Anita Soutier; Susan Adams; Daniel Lawrence; Juan David Ospina; Lesley Bennett; Randy Trowbridge; Alta Lash; Beth Cheney; Shirley Girouard; Heather Gates; Anne Klee; Doug Olson; Jesse White-Frese

Members Absent: Kate McEvoy; Rowena Rosenblum-Bergmans; Leigh Dubnicka

Other Participants: Mark Schaefer; Stephanie Burnham; Linda Green; Vinayak Sinha; Mary Jo Condon; Beth Bye; Laurie Doran; Lisa Honigfeld; Steven Angelo

1. Call to Order
The meeting was called to order by Ms. Lesley Bennett at 6:00 p.m.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Ms. Lesley Bennett asked for a motion to approve the January 8th meeting summary of the Practice Transformation Task Force meeting. Dr. Andy Selinger made a motion to approve the minutes. Mr. Supriyo Chaterjee seconded the motion.

4. House Rules Refresh

5. Purpose of Today's Meeting
The purpose of the meeting was to provide an update of the discussions on Primary Care Modernization capabilities. Then, the Task Force was to move on to review three specific capabilities. Additionally, it was noted that the second stakeholder engagement phase of provisional recommendations was underway.

6. Review Draft Capability Summaries
Ms. Green reviewed the adult and pediatric capabilities graphics centered around patients and families. Ms. Green explained that the medical home is informed by promotion and analytic resources at the network- level and coordinates within the health neighborhood. Dr. Schaefer mentioned that this effort is happy to receive feedback on these. Ms. Shirley Girouard mentioned that this was very helpful when looking at the goals and objectives of the capabilities. Dr. Schaefer then brought up the PCM logic model that also includes information on the impacts of PCM and explained how it will be shared at the next PTTF meeting.

a. Universal Home Visits for Newborns

Ms. Green mentioned that the pediatric design sub-group felt that the Universal Home Visits for Newborns capability should be separated from the diverse care team capability. Ms. Bennett described how there is a fear that these visits may be to check in on the parents and potentially result in children being taken into social services. She mentioned that there are other organizations using federal funds for pediatric home visits and to avoid an overlap of services.

Commissioner Beth Bye mentioned that there is a lack of information for parents, resulting in many parents going home without much support. Commissioner Bye further explained how research shows that parents do not fully understand what their newborns can and cannot do. Commissioner Bye went on to add that there are currently state and federally-funded programs that provide home visits, but that the need is much greater than what is currently in place. Commissioner Bye explained that there may be a $2 to $6 return on investment (ROI) for every invested dollar.

The Task Force discussed how, currently, when someone comes into the home, it is often in response to a problem. Universal home visits may help take this stigma away and allow for a level setting for parents of varying backgrounds. To ensure a relaxed environment, Ms. Bennett added that this effort should discuss who specifically is entering a home, and what their specific purpose is. Ms. Bennett warned that if low-income families refuse these visits, current disparities could worsen. Commissioner Bye added that building this into well-child visits will be helpful in the public acceptance of home visits as beneficial to newborns and parents. Ms. Bennett then stressed that this effort should build-in some parent protections.

Ms. Girouard explained that, in her experience, parents have been very receptive to home visits for newborns. Dr. Elsa Stone mentioned how this capability is to connect to the pediatric medical home, rather than the government. Ms. Beth Cheney added that she ran a pediatrics clinic for some years and believes home visits could be very beneficial to families and to patient satisfaction. Ms. Susan Adams explained that certain populations are fearful of home visits, particularly those who have difficulty speaking English, have lower educational attainment levels, and/or live in unstable housing. Ms. Adams then stated that it may be helpful for the parents to meet the home visiting team at the pediatrician's office first and establish a relationship between the parents and the team before home visits begin.

Ms. Green went on to discuss the goals and basic functions outlined by the capability, and how the nurse and community health Worker (CHW) would be from the pediatric practice. Dr. Schaefer added that a CHW would be able to connect the parents to additional supports in the community, if needed, and that the team and timing of each visit could be recommended in PCM, rather than prescribed. Ms. Bennett responded that the flexibility of timing is helpful to the parents and is something that is currently being contemplated in the state of California. Ms. Girouard added that there should be collaborations with current services conducting home visits. Ms. Heather Gates explained how she conducts home visits through the Nurturing Families program and warned that nurses may be an expensive choice for carrying out this capability. Ms. Gates described a model in Hawaii that may be of assistance when looking into the evidence. Dr. Stone then added that this effort may want to keep this within the medical

home. Ms. Girouard concluded that this effort should ensure the evidence is strong, whichever model is chosen.

Dr. Anne Klee asked how many people regularly go into the home? Commissioner Bye responded that it is usually one, but the intention is to have two – one connecting with the family and the other connected to the medical home. Ms. Anne Klee explained how at the VA, there is a push to send only one person since, usually, the nurse can bill, but not the CHW. Dr. Schaefer reassured that the reimbursement would be a part of an advanced bundle payment granting flexibility in billing to the practice. Dr. Klee explained that even though that is the case at the VA, there is still an issue with trying to send only one person. Dr. Schaefer agreed with Ms. Girouard's statement to not be too prescriptive and pointed to provisional best practices.

Ms. Alta Lash asked whether any private insurance carriers would pay for something like this? Ms. Lash mentioned that she would like to see everyone on the same page, and for the state to receive funding for the Medicaid population. If it is going to be universal, Ms. Lash continued, everyone should be able to get this, and private carriers should offer it. Ms. Girouard responded that this is included in many health plans. Dr. Schaefer then added that if universal home visits for newborns are included in the capabilities, then this effort would ask commercial payers for their feedback. Dr. Lisa Honigfeld mentioned that recent data released from Zero-to-Three showed how Connecticut home visiting programs are currently only reaching a small proportion of the population. Dr. Honigfeld went on to explain how PCM can better tie home visits to the medical home and that this capability is a great start.

With an eye to implementation, Dr. Doug Olson pointed out that many of the FQHCs throughout the state do not have pediatric providers doing rounds for the hospitals, so the CHW may be the first point of contact for patients from an FQHC. Dr. Olson went on to explain how there is a severe shortage in the workforce when it comes to conducting home visits for the roughly 32,000 children in Connecticut. Therefore, he concluded, this effort should consider the possibility that home visits may not be able to be implemented as a mandatory (core) capability. In terms of the practical implications of getting to the full realization of the medical home concept, Dr. Schaefer explained how there is an incremental increase in the supplemental bundle practices and that there will need to be Plan-Do-Study-Act cycles that allow for scaling up as the workforce and workflows are able implement over time. Dr. Schaefer mentioned that once this effort reaches implementation, the Office of Health Strategy will have to work with the Department of Labor to fully understand the ability to ramp up. Dr. Randy Trowbridge mentioned that the principle here is almost an essential part in moving forward as an innovative model and that this effort will have to eventually consider how to implement this.

Dr. Stone added that the home visit option is often cheaper than the in-person provider visit. Ms. Adams asked if this capability would only be for first time mothers or if it would be utilized for subsequent births as well. Dr. Stone agreed that this capability would serve both needs. Ms. Girouard mentioned that having subsequent children change parental concern and subsequent children newborn visits shouldn't be eliminated to ensure that changing parental circumstances are addressed. Commissioner Bye went on to explain that if there are concerns over the parents' ability to care for their newborn, then there needs to be a system in place that connects these families to resources within the community and/or a referral for additional services.

Dr. Elsa Stone motioned that the PTTF supports the capability. Dr. Selinger seconded. The vote for inclusion of universal home visits was unanimous. The Task Force then voted to include it as a core capability.

b. Individuals with Disabilities

Ms. Green mentioned that the group decided to make best in class recommendations on the capability and wanted to review the model of care but did not support the payment model. Ms. Green reviewed the definition, goals, and concept map provided in the materials. Ms. Green emphasized that a patient can go to any primary care practice and that additional services would be provided at specialized practices. Ms. Green reviewed best in class primary care concepts and the primary care team composition for all practices. Ms. Green then reviewed requirements for specialized primary care practices with enhanced expertise and experience in treating people with disabilities and any additional recommendations brought forth.

Ms. Lash asked for more emphasis on transitions because the PCP sometimes does not know what goes on in a nursing home and that the transition can be very difficult, therefore the practice needs to be more involved in understanding the durable medical equipment and prescription management. Ms. Bennett mentioned that there should be access to nursing home records to understand patient activity. Ms. Cheney mentioned that there is often little coordination (but there should be more). Dr. Schaefer added that this is a good use case for information technology initiatives currently in development by Mr. Allan Hackney.

Ms. Gates then asked for the definition of people with disabilities. Ms. Bennett mentioned this came out of a concern for those with physical disabilities. Ms. Gates mentioned that this seems like it is for physical, intellectual and developmental. Dr. Schaefer agreed. Ms. Bennett explained that this effort should not only be linking to the Department of Developmental Services, but to other services as well. Dr. Trowbridge mentioned that he felt PCPs do not have the ability to do all of this and, therefore, a team-based approach is key, in addition to communication between team members. Dr. Schaefer added that the planning group said to have one or more experts and leverage their expertise through eConsults. Ms. Girouard stated that primary care gets neglected in specialty practices, such as immunizations, therefore, encouraging dialogue between primary care and rehabilitation is critical. Ms. Cheney supported the idea to help develop infrastructure for those who have a physical disability. Ms. Bennett and Ms. Cheney also supported the idea that the primary care team needs to coordinate a lot of specialty and primary care work. Additionally, Ms. Bennett stated that it is important that there is physical access for patients to avoid unnecessary complications. Ms. Girouard mentioned that there are other creative ways for integration into primary care. The PTTF then voted for the capability to be included into PCM as core.

c. Integrative Medicine

Ms. Green reviewed the definition and description of the integrative medicine capability with the Task Force. Dr. Selinger mentioned that he shadowed Dr. Kathy Mueller, a member of St. Francis Hospital, and saw a variety of patients, new and existing, during his shadow. After this experience, Dr. Selinger believes integrative medicine is an opportunity and a pathway for patients who advocate for their symptom-based needs. The Task Force went on to describe how integrative medicine respects conventional medicine and provides four domains of care: mind, body, nutritional, and alternative therapies (i.e. massage and acupuncture, dietary and lifestyle

modification). Dr. Selinger mentioned that treatment plans may include externally sold supplements and appropriate alternative treatments as follow-ups. Dr. Selinger explained how this could be an elective for willing patients and could allow for the formalized provision of evidence-based integrative medicine therapies. Dr. Schaefer then thanked Dr. Selinger and Dr. Trowbridge for their work in helping the Task Force better understand this capability.
Dr. Trowbridge went on to explain how integrative medicine varies greatly in measurement and practice, but functional medicine is more formalized. Ms. Lash added that one of PCM's focus areas is to reduce socio-economic disparities and emphasized how these services need to be available to everyone. Mr. Supriyo Chaterjee emphasized the cultural element to some of these therapies, and that this needs to be considered during implementation. Dr. Schaefer asked if this was a type of sub-specialty or a form of primary care? Dr. Selinger responded that Dr. Mueller specifically mentioned she is not the patient's PCP, but rather is referred to patients by their PCPs. Ms. Cheney explained that this occurs as a sub-specialty in her work as well. Dr. Stone added that some of these therapies are included in pain treatment as well and have been included in the pain management capability in PCM.

Dr. Schaefer concluded that integrative medicine therapies require patient readiness and shouldn't be mandatory as this would go against integrative medicine principles regarding motivational interviewing. Dr. Schaefer went on to discuss that if PCM permitted the use of the supplemental bundle to be used to have care team members provide integrative medicine therapies, this would allow some practices the ability to build this capability. Dr. Selinger then motioned to allow for the use of supplemental bundle funds for integrative medicine care team member training. Dr. Elsa Stone seconded the motion. The Task Force then unanimously voted to allow supplemental bundle funds to be used for evidence-based integrative medicine therapies.

7. Adjournment
A member gave the motion to adjourn the meeting.
Dr. Andy Selinger seconded the motion.

The meeting adjourned at 8pm.