

Primary Care Modernization Pediatrics Design Group 2

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Pediatric Design Group Session 1 Recap

- *During session 1, discussed community integration, home visits, diverse care teams*
- *Feedback from group*
 - *Need to understand how primary care capabilities fit into system and are applied in practice to think about these*
 - *Make connection between Health Enhancement Communities and Primary Care Modernization*
 - *Build off the work that the Pediatric Practice Reform Study Group has already developed*
 - *Leverage existing pediatric programs in CT*
 - *Pediatrics is distinct from adult primary care and needs specific approaches that are tailored to pediatric practices*

Opportunity for Pediatric Practice Transformation

**Refer to provided meeting materials for slide content.*

A consumer noted that financing for HECs is primarily through philanthropy, grants, and state funding. Those payers fund the CHWs and share resources, whether it's the Hartford Care Collaborative or others. An FHC Expert agreed and stated the issue is embedding child services within the system. Child health providers aren't going to make it on their own, they need to be embedded in a system that supports them. Prevention is good, but promotion should also be our focus.

PCM Payment Model Options

**Refer to provided meeting materials for slide content.*

A consumer inquired, "We are making these recommendations, yes? What's our charge? Is this the only option available to us?" FHC explained that the design groups are focused on the capabilities, i.e. what needs to change in practice to better improve health models. The payment model piece will then support those capabilities. The Task Force developed a report for direction for what payment model options should be explored and the Payment Reform Council is exploring these options now. One provider explained that the 2½ -page report that addresses pediatric care outlines specific things that would address that. The attendees then expressed concern over the provided PCM payment model (basic bundle, supplemental bundle, and fee-for-service). FHC explained that this portion of the project is for the Medicare demonstration and then recommendations for others will be given. The decided payment model options specifically for pediatrics will be shared with the design group. A consumer noted the payment model can't drive development of the system, it must be the reverse. We must know what the delivery system reform should be. We want the payment model to work towards the desired outcomes (and not limit them to Medicare).

A payer stated that CT Medicaid is also doing some very cutting-edge things and emphasized the importance of being careful. It's important not to incentivize things that haven't been thought through. Medicare will not go into this in a big way unless Medicaid follows, the payer explained. So, this is a Medicaid discussion as well. FHC explained this would be a multiplayer demonstration, the group will focus on the capabilities now, and FHC will come back with the payment model options. In reference to the provided pediatric diagram, the payer agreed with what was being proposed, but cautioned against doing a one size fits all reform and integration because everything will not fit into every practice.

A provider explained they work with many practices across the country where the capabilities are widely variable, and the key is defining the core components that must be present. The payer emphasized the importance of getting patients serviced quickly before they get lost in the system. Another provider then

stated that having a collocated practitioner may not be able to fulfill this need, and that you still need that capacity to be able to service patients well. FHC emphasized that this effort is trying to build flexibility for the network and that this design group is to help define what care teams in pediatrics should be responsible for. The provider explained it might help to look at this from a systems lens: What are they guaranteeing and providing for payers? FHC specified this will, at first, be based on historical claims data, and then going forward, prospective claims data, and that this effort is going to need to enhance that attribution method used by carriers. A consumer noted that this is going to be a challenge if you talk to community health centers. A payer explained that community health centers are given a bundled payment already, and that as we move forward, we need to keep in mind that this model in part already exists (and some would argue it is not working well). A consumer explained this is unit cost versus outcome cost, and it was discussed how this development is working with FQHCs. The belief that payment doesn't drive the delivery system was reiterated, and the group moved on to expanding care team capacity and expanding care team members.

Diverse Care Teams

**Refer to provided meeting materials for slide content.*

FHC agreed that as recommendations are made, definitions and capacity should be identified. One provider emphasized the importance of supporting the family more so than providers, to which another provider responded that with Title 5 funding, the number of children screened must be reported, however, there are no limitations on coordination centers for how to operationalize that. Therefore, the opportunity varies. This provider's center in North Central will take on any child and any family, and there is also the capacity to directly support pediatric practices. This center will place a care coordinator in a pediatric practice if the volume and the need indicate. At the very least, they provide telephone support. The linkage between the care coordination centers and the information line means children and families can gain access to services whether they're eligible or not. They can also gain access to the full range of services, so there is a unique capacity here that has not been brought to optimal scale and impact. The host agencies have not prioritized this, explained a provider. We have the criteria that defines excellence in care coordination and all five regions should have the support and coordination to adhere to that. The care coordination model is a key system.

All ineligible children should be referred to community-based services. A consumer noted that this is an important piece. In early intervention services in Connecticut (IDEA, for example), a consumer discussed how talking to families about how this works for them is very interesting. One provider discussed how this used to be done with a screener, and anyone with high needs would be referred directly to an onsite care coordinator who would have an actual relationship with families. Having families set priorities and ensuring families are linked to services they find useful is key. The benefit of CHWs was voiced, but an attendee was unsure if they're preferred over high quality, early-intervention providers. A provider noted that home visitors are valuable and are game changers for families. Blending resources to increase capacity is what this effort needs to focus on. Programs like Healthy Grow are great as far as getting the connection between families and services, but what we can improve on are kids with complex needs. That 12-15% of children need all the support they can get, a provider noted. From a population health standpoint, that is where the investment resides. There are cost benefits and savings there that exist, the provider stressed. This group doesn't have to reinvent the wheel, what we need to figure out is how to bring all of this together. FHC offered that this is what this effort is trying to get at, and inquired whether this is a funding issue and what the overall challenges are? One of the most efficient things we can do here is think about these things in the context of health-enhancement community work. FHC summarized that it sounds like there's a continuum for care coordination, a resource that's helping with population health and then you have the children with complex needs who may need onsite care coordination support. The same is true for CHWs, noted an attendee. Not every family needs a CHW. There's a continuum of level of risk and vulnerability.

A provider explained that we have a variety of strategies that can be brought to scale and impact. When you think about co-management, referral guidelines, CHDI and EPIC educating practices in the community, maintenance for certification is supported externally with no cost to the practice. These things are available and are not being implemented to the fullest across the state. Then, this effort can focus on

the real opportunity, which is the 30-40% who are at risk. FHC asked how this would be brought to scale? A provider explained it would be brought to scale as a resource, in addition to support within a practice. A provider reminded that this effort needs to avoid reinventing the wheel, to which an attendee noted that blending state funding must be considered. A provider noted that blending administrative and financial resources of four state agencies is unique, and it was recommended that each of these states consider having a slice of the pie of population health. The concept that all practices are different is important to remember, and if strong care coordination comes in without community-based services, this project will fail.

An attendee noted that for HEC, the roles should be coordinating clinical care (not just gardening and exercising programs). When you can facilitate access to community-based services, you save money. Services for kids not on Medicaid have not improved, but instead have gotten worse. We need to think about all kids who are not on Medicaid. There's a lot of need in that population as well. A provider stated that this was a good argument. An all-payer's solution is needed here, the provider explained. Another provider agreed.

A provider stated that families who make too much money to qualify for Medicaid, but don't make enough to receive quality healthcare, need to be incorporated into this effort. The provider explained that their organization is a part of the medical home grant, and they have great partnerships with some of the care coordination centers, but others they don't, so it depends on the relationship. A payer added that if you want savings to accrue, the state can't do that. The savings go back to the general fund. PCMH+ shared savings program is successful; the savings go to the general fund. So, we may need to change the way the state operates. A provider explained that Oregon, for example, requires a percentage of dollars saved to be reinvested to expand mental health capacity. The CT behavioral plan implementation advisory board created a map that shows who participates. It shows you a piece of where the resources lie. The opportunity to embed programs like United Way 211 and Healthy Grow into primary care in Connecticut is so enormous. The group expressed its reliance on SIM to guarantee this is going to happen.

A consumer discussed how public schools are a universal system for all kids, and how we must bring kids together and systematize them in a similar way that primary care is a part of. A consumer expressed the importance of braided and blended funding. It was discussed how pediatricians should be responsible for mitigating this impact. A provider counterpointed and stated that this group is not talking about measures and metrics. They cannot drive exactly what the consumer described.

Pediatric Behavioral Health Integration

**Refer to provided meeting materials for slide content*

In reference to the Draft Concept Map provided on slide 21, an attendee noted that all these services are critically important, but these would depend on the size and scope of the practice. You want to keep everything within the medical home for that child. If patients don't come back, then you've lost them. There're several places where these linkages need to be understood more widely so that pediatric practices know where a child goes to school, then there's an opportunity to make that linkage. It's also important to develop mechanisms to strengthen and solidify that linkage.

A provider questioned if this is really a population health approach and explained that it's hard unless you get pediatricians better tools to work with. Some of the most effective models' partner with organizations like the African American alliance, who bring trust to needy communities. The pediatrician is not the barrier. There are places to catch kids that present in different ways. Where are these portals? Doing SDOH screening and trauma screening wherever a patient enters the system, and then completing those linkages, is key. We must identify those who are vulnerable and at risk, and intervene to prevent the emergence of problems, the provider continued. Behavioral health clinicians are overwhelmed by children in crisis. This effort needs to look at this holistically. For example, there is a great opportunity in pediatric care in preventing and treating childhood obesity. We are selling our child health services short.

A simple, accessible, robust definition of health promotion and prevention was then urged, as well as the need to address what the family wants to address in primary care (i.e. Bright Futures). In 1967, the family-led visit was first addressed, and we are still trying to accomplish this in healthcare. The assumption is

that a positive screen means you need to intervene, and that's wrong. How many providers do prenatal and don't get paid for it?

FHC then asked the group how we create the provided feedback into recommendations and priorities. A provider explained this effort needs to be thought of at the highest level. Child health services transformation will occur when the primary function of the child health provider is to strengthen families. Screenings should only be done in the context of an integrative, comprehensive approach, developmental promotion, and linkage. FHC reiterated that the PCM is trying to define what the practices and networks will be responsible for. The provider then inquired over the goals of this project from a population health stand point. FHC reviewed the goals provided in the meeting materials (Slide 7). Promoting families and children's health and wellbeing needs to be considered in order to achieve increased flexibility. The provider stated that mirroring New York's declaration of what they're looking for in terms of outcomes in the first 1,000 days of life would be a good idea. It was then asked if the HEC was the overarching goal or if the PC is the center of everything? The provider reinstated that New York, Oregon, and Washington state are good examples to mirror.

FHC agreed that this is hard to divorce from the HEC conversation. A provider noted that family resilience determines outcomes, and that thinking about this project as a lifespan model is critically important. A consumer asked FHC what recommendation was needed from the group going forward? The group then asked about the SIM initiative, the holistic design of the work, and how it will all fit together and feed off each other (in addition to the connection between payment reform and how it is building and linking communities). The group emphasized the importance of ensuring a continuity and that the other recommendations make sense in conjunction with the pediatric design group. FHC responded by explaining this effort wants to prioritize the pediatric health approach on population health promotion for this focus group. FHC acknowledged that this effort needs to change its approach a bit and confirmed there is a role for expanded care teams and how they interact with community resources.