

Primary Care Modernization Pediatrics Subgroup Design Session

12/04/18

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What are we trying to achieve?

See provided materials for diagram.

Vision of Pediatric Primary Care (*See provided meeting materials.*)

- FHC: Is this vision the right vision?
 - AAP Medical Home Characteristics
- Provider: Want to make sure we recognize that PCP is primary care provider and not necessarily physician. We have several types of primary care providers who work in pediatric primary care sites and work at the top of their license.
- Provider: Regardless of the license, a single individual must take responsibility for steering the course of that person's care.
- Provider: Agree with PCP steering the course, but also must have practice-based care team. The entire practice must be dedicated and motivated to do that. It's too much for one person to do.
- FHC: We can reflect this when we talk about care teams again.
- Provider: This is a strong vision statement (referring to provided materials). This really says what we have all been talking about.
- FHC: Anything else you would add to this?
 - Want to return to how the capabilities are making care more accessible.

Achieving the Vision (*See provided meeting materials.*)

- Provider: These are things that we do, but we do things other than health promotion (referring to provided materials). These are themes, they are not exclusive.
 - FHC Expert: This is only the promotion part of it. The medical home encompasses much more.
 - FHC: We can clarify that these wouldn't be the only function.
- This combined with AAP medical services achieves the vision in what pediatric services provide

Home Visits: New Parents (*See provided meeting materials.*)

Should there be universal home visits for newborns?

- Group consensus: It would be wonderful.
 - How would we accomplish this?
- Provider: Love home visits and I've done home visits. It takes a lot of resources, however. The travel, time spent communicating with the PCP, etc. It's a lot of time you'd spend in the home. It wouldn't be a quick visit.
- Provider: Agrees. The idea of universal home visits would be hard due to resources, but perhaps an initial home visit to assess the need of the family. Assumptions are made based purely off SDOH, but mental health and addiction issues could possibly be much more evident.

- Provider: There is a group of patients out there who need this based on socioeconomic reasons, but that's different from universal. Some families benefit from it, and others benefit from it more. Being in the hospital, mothers don't see their babies as often.

Does it need to be the primary care provider or member of the care team?

- FHC Expert: The family needs to see that person as an extension of the practice. A connection between those two is needed.
 - Whoever is doing it needs to be connected to the care team.

FHC Summary: In an ideal world, we should do this. Wouldn't need to be the actual primary care clinician, but simply connected to the team.

Should it be that the medical home must find a way to provide home visits to all families of newborns?

- Provider: If we can work out the funding for it, I think it should be required.
- Provider: This is the time to say it. Take advantage of this opportunity in payment reform. The funding should be available, so practices can do this.
- OHS: Some of the employers are keen on the idea of universal primary care home visits based on a study in Brazil. Physicians are looking for new approaches. Agrees with the provider that this is the time to raise it. When we talk about return on investment, we'll have to look more broadly. This function might also help identify the candidates.
- FHC: Sense of the group is that this should be required.
- Provider: Our resources should support it. I suspect there are a lot of hidden costs.
- Consumer: In addition to the nurse family partnership, there are other organizations in the state with the resources to do this. The work I did in global health showed positive effects of CHWs going into the home, and more cost-effective, too.
 - FHC: We'll go into those specific kinds of home-visits.
- Could the practice contract with a service and still have that connection to the medical home?
 - Provider: Depends on how that organization works with the medical home. I can see an external organization doing it as long as they are reporting back and keeping in touch.
- Provider: When you have home-skilled nursing visits-it's the same thing. Is there a curriculum for this? How will this ensure the right kinds of information/support are given to the family? The more degrees of separation, the more chance there are for a disconnect.
- FHC: Preferable to have it be someone from the practice.
- Provider: Newborns are a lot more complex when determining the needs of the mother/newborn.
- FHC Expert: Would you want to extend the practice or the advanced network? The service could be provided by the practice or the advanced network.
- Provider: I think that sounds great, but I don't want to lose sight of the fact that hopefully this will role out with the State Enhancement Community work. For now, I'd like that extension to be advanced network, but let's be open-minded for how things role out here in CT.
- Provider: To give an update on how the baby is doing would be great. A brief discussion with someone from the care team would be good. This would be hard on small practices, though.

Home Visits: Integration with Community Services (*See provided meeting materials.*)

- FHC: There are a lot of community-based services that provide this. This list is not meant to be exhaustive (referring to provided materials).

- Provider: What does “providing” mean? Would the PCP have to actively be part of minding the baby program? How logistically can a practice provide a community-based service?
- OHS: Mostly primary care reform has been envisioned to augment the effectiveness of ACOs and FQHCs by enabling them to do a better job with quality care and quality care experience by strengthening the foundation of primary care. These strengths lie outside the primary care practice, too. For example, Commonwealth Care Alliance helps support sicker patients in the home. In CT, FQHCs are contracting with organizations for asthma patients. Hispanic Health Council provides diabetes self-management support. The ACO’s could purchase services with community partners to get better outcomes than they could on their own.
- Provider: So, this is a financial arrangement?
 - OHS: A portion of funding could be utilized for this
 - Provider: The financial support on the AN end, and the capacity and the services out there that would be available?
 - OHS: Absolutely, right.
 - Provider: Those practices in these networks would have an advantage over the practices not in the program?
 - OHS: Yes.
- Provider: That’s interesting because we are trying to develop an asthma initiative with a screener, then make a referral. This is the first I’ve heard of a special arrangement that can be made. I’ve heard capacity is an issue.
- FHC: If there is funding coming from the practice/network, that is building the capacity for these organizations to provide the service and be paid for them.
- Provider: Would be interesting to see what that pricing looks like. Is it feasible?
 - Would it be proportional to the covered lives you have?
 - OHS: The PRC is recommending you get a supplemental bundle quarterly or monthly to support certain capabilities. You wouldn’t necessarily be required, but you’d have the flexibility with the money built in to provide these capabilities. A flexible funding use is the idea.
- FHC: Should it be required to provide home visits beyond the universal home visits for newborns?
 - Could have the flexibility to use payments that way, but doesn’t have to be required
 - Provider: Should be optional.
 - Provider: Could we put this in the category of let’s see what happens with the Health Enhancement Communities? The Health Enhancement Communities are going to have child well-being. There could be a lot of synergy.
 - Provider: Worry it won’t be practical or feasible.
- Provider: Many of us have made home visits (hospice children for example). Things like obesity, going to the house, watching them prepare a meal→home visits are a great way to tackle diseases like obesity and asthma. This might be the right time to promote health in a greater way that can have lasting effects. However, I don’t have the resources in my practice to do this in the home. However, with an outside agency, if it’s not me, that’s also not ideal.
 - Provider: I wonder if some of these requirements could be of the network as opposed to the practice.
 - Provider: Last meeting we discussed local care coordinators and professional care coordinators, maybe we can think about a training initiative for the local care coordinators, so they can go into a home as an extender of a provider?
 - Other provider: I would like this.

- Provider: Home visits would be good to “clean the cabinets”.
- FHC: The practice must have the capacity to do home visits.
- There is a lot of trust involved in opening your home to someone.
- Consumer: The programs I’ve seen that have been successful in the state are through care coordinators. They aren’t necessarily coming directly from a provider in the home. Collaborating with organizations that already have that cultural competence in the community is key. Wouldn’t discount the ability of the CHWs that can be monitored to ensure quality and be carefully linked to the medical home. If it is a network-level capability, that makes sense.

FHC: Require the network to enable home visits for the practice?

- Yes. This should be an option.

Telemedicine (*See provided meeting materials.*)

Should all pediatric primary care practices be required to use telemedicine?

Are there guardrails on telemedicine that the group suggests?

- Provider: Why would it take less of the provider’s time? Also, when an in-office visit is not available, that means a provider is not available. We only have so much time in a day.
 - Provider: We’ve been having this same conversation. Not that telemedicine is an add-on, just another mode of care delivery. This is really about the new generation and this is what they will be wanting
- Provider: Face-to-face is needed for some things
- Provider: Patients value convenience over quality. There truly are visits that are doable through telemedicine. There are some good reasons to do telemedicine. For example, patients with depression.
 - Provider: What are those types of patients and conditions in which this would make a lot of sense and meet the needs of the patients and families you serve.
 - FHC: Converting those visits that don’t really need to be in-office into telemedicine visits and incorporate it into the provider’s schedule.
 - Obviously can’t be anything that’s hands on.
- FHC Expert-AAP talks about telemedicine. Not aware of any guidelines. What generally happens is you set up some guidelines and they work 90% of the time. After a while, you get a sense of what works and what doesn’t work.
- Provider: New patients really need to be face-to-face.
- Provider: Where does this stand legally?
 - FHC Expert: Many states do allow it.

FHC Summary: Connected to the medical home; for established patients when appropriate; providers can determine when a telemedicine visit can be used

Should all PCPs be required to use telemedicine?

- Provider: Does telemedicine mean a video component also?
 - Telemedicine is a face-to-face virtual visit.
 - OHS: Medicare just created the option to bill for phone visits without an in-office visit.
- Provider: Prescribing antibiotics over the phone or other treatments we would consider appropriate

- Provider: Special lights with tongue depressors can visualize the back of someone's mouth and help diagnose patients through telemedicine. We don't want to narrow our definition of telemedicine.
 - Provider: These technologies will expand. Very good point.
 - Is there anyone who thinks this should not be a requirement?
- Provider: There is an expense associated with this capability.
- FHC: The PRC is working on the supplemental bundle now and moving towards investments.

FHC: No one is opposed. There needs to be financial support in all practices.

Phone, Text, Email Encounters *(See provided meeting materials.)*

What beyond current PCP-parent/guardian phone calls is a must-have?

- Provider: It's texting. HIPAA-secure texting options are available.
- Provider: We must be where our patients are.
- Provider: Confidentiality, how do we incorporate that?

Is confidentiality a concern for adolescent patients in pediatric practices?

- Provider: It should be required
- Provider: It'll be interesting to see if there is some way to see what Medicare is doing.
- Provider: For the emails, you can copy and paste in EHRs because its real-time, that communication should be captured.
- A lot of potential beyond an urgent text message.

FHC: None opposed to making this required.

Group Well Child Visits *(See provided meeting materials.)*

- Provider: Prenatal group visits are interactive and a little dynamic. This is a great way to pool resources and save the provider's time.
- Provider: I think it's a wonderful option to have. I don't think it should be required. Families need to have some private time as well. Something to be encouraged, but not required.
- Provider: Agrees.
- Consumer: The guidelines I am familiar with are provider choice and patient choice.
- A Pediatrics article of January 2018 discusses this.

FHC: The group agrees this should be an option.

E-Consults *(See provided meeting materials.)*

Should all pediatric primary care practices be required to have eConsult capabilities?

- OHS: The original innovation in CT obtained subspecialists at UConn; Primary care providers obtaining a subspecialist was the original idea.
- Provider: You can attach relevant clinical information. Experience we have show a lot of promise. It's about 20 minutes on average. Not only really answers the question but adds some educational value as well.
- Successful related to behavioral health issues.

- OHS: Provider, do you have an opinion as to whether this should be fee-for-service/ on the billing process in general?
 - Provider: Current fee-for-service environment doesn't incentivize well.
 - OHS: Dr. Daren Anderson just published results on adults in Health Affairs. Thrilled you're seeing positive results on the pediatric side. The adult consults reported an average of 7 minutes. It's interesting the pediatrics were 20 min.
 - Provider: We really are teachers. The way we were rated by the PCPs was much higher.

Summary:

- Required by the network, but not the practice.
- Need the infrastructure to really manage it.
- Subspecialists would have to develop the protocols.

Next Steps:

- Next meeting will be on the morning of Monday, December 10th