Primary Care Modernization Pediatrics Subgroup Design Session

12/10/18

Participants: Barbara Ziogas, Elsa Stone, Karen Reuben, Katie Piwnica-Worms, Nanfi Lubogo, Mark Schaefer, Karen Siegel, Hillary Deignan, Jeffrey Lasker, Arlene Murphy, Linda Green, John Freedman, Sandi Carbonari, Stephanie Burnham, Alyssa Harrington, Rob Zivoski**,** Lisa Honigfeld**,** Ellen Bloom

Recap: Vision of Pediatric Primary Care
(See provided meeting materials for diagram.)

Purpose of this Group: Refresher
Purpose: Make recommendations to the Practice Transformation Task Force about what core (required) and elective (optional) capabilities pediatric practices should have.
Payment Reform Council considers Task Force recommendations and makes recommendations for payment model options. The Council and Task Force will reconcile recommendations in January.

Consider: As we discuss capabilities for pediatric primary care practices:

- How do PCM capabilities support this vision of pediatric primary care?

Recap of Recommendations: November 29th
Discussed Diverse Care Teams

- Team-based approach is needed, with PCP and patient/family guiding direction
- All functions of the care team are interrelated and overlapping
- Care coordination across the practice and health neighborhood is critical
- Community Health Workers are critical and support care coordination
- Add to health neighborhood: child health care consultants, parent supports, developmental assessments and services for children not eligible for birth to 3

Recap of Recommendations: December 4th

- Universal Home Visits for New Parents: Required capability with the necessary resources from the network and expanded care teams in the medical home
- Partnerships with Home Visiting Services in the Community: Optional capabilities, with strong coordination between the medical home and the community
- Telemedicine (provider to patient): Required capability within the medical home, infrastructure provided by the network, only used in appropriate clinical scenarios
- Phone, Text, Email Encounters: Required capability with appropriate workflows established. Recommended getting input from consumers
- Group Well Child Visits: Optional capability for primary care provider and patients and families who want to participate
- eConsults (PCP to specialist): Required capability with infrastructure provided by the network

FHC:

- We will come back to a few of these as well since we did not finish the discussion from the November 29th meeting.
- Also, wanted to incorporate Home Visits and make sure that was noted as well.
- Do any consumers want to comment on the provided materials?

- Consumer: Important to include that CHW role and making sure patients are connected to community organizations.

Capabilities Discussion: Medical Home Care Teams
Feedback from Previous Session

- Care team focus is promoting strengths of families and best health for all children
- Desire for payment model to support evidence-based interventions for integrating other professionals into pediatric practice care team
- Strong coordination between practice-based care team and community, especially with schools
- Data sharing between the practice and services provided in the health community
- Functions of care team are overlapping and connected
- Population health and health promotion are overarching across the practice and community
- Community Health Workers are critically important for supporting all practice functions and connecting children and families to the community
- Add to health neighborhood: child health care consultant, parent supports, developmental assessments and services for children not eligible for birth to 3

Health Neighborhood
(See provided meeting materials for diagram.)

FHC:

- This is to suggest certain credentials that fulfill these functions.
- Not all team members need to be on-site within the practice.
- Are there any suggested changes to the functions?
- We shared a version of this in the last session and did make some changes based on the feedback we received.
    - What we tried to do was make the medical home in the center with the patient and family/ pediatrician. Tried to make the medical home fit within the neighborhood and point out the coordination back and forth between services in the community and the medical home.
    - CHWs are important to that liaison.
    - The medical home and the health neighborhood work together to achieve that vision of pediatric primary care.
    - All the functions are connected. The care team members, services, and functions are overlapping. They're all interconnected.

Expanded Medical Home Care Team Functions
(See provided meeting materials for list of functions and their descriptions.)

Key Questions
-Do these expanded care team functions and roles support our goals?

-Which, if any, of these functions should be required in every practice?

-Should the full array of expanded care team functions be available in the practice? The network?

-Should expanded care teams to support these functions be a core or elective capability?

- Consumer: All the above are core.
    - Yes, to all. Very strong yes.
    - Did we mention referral and follow-up? This is where patients fall off the cliff. For example, the Help Me Grow is the essential part of that follow up piece.

    - FHC: We will take a deeper dive into care coordination because that's the biggest focus for pediatrics.
- Provider: Population Health Promotion and Management – what was the concept here?
    - FHC: Population health promotion management would be something at the network level, there wouldn't need to be one for every single practice (unless this group feels strongly otherwise).
    - FHC Expert: It would depend on the population health management structure, likely to be at the network level. Somebody on the side helping the practice would likely happen.
- FHC: The key is understanding what you would propose and recommend.
    - Consumer: I would not want it to have it be elected. Not every single one of these functions must be elective, but every single one of these practices should have 3/5. I know it might not be possible to do all five.
        - If we are going to do this at the network level, we must make sure the population health specialist is a requirement.
        - If they don't have the concept at the higher level, they won't trickle down to all practices.

FHC: What do others think about these roles and questions?

- Provider: All the functions contained within the medical home box are very important functions. Will they have multiple smaller pediatric practices in them? We need to make sure not to have so many people take care of a relatively small population. The network can make the functions available to the practices, where they resign is a little less critical for the functions.
- Provider: Agrees. Well visits with acute and chronic care, these things happen now. They can be enhanced by a nutritionist, etc. Again, to have all these people available in a relatively smaller or medium-sized practice could be a challenge and it would have to be sorted out carefully to make it feasible for the patients and families to access them.
- Provider: The patient and management functions-unclear what that is?
    - FHC: It's less applicable in children and adults, but more so in children with complex needs. The work of pharmacists and the primary care clinician, where they mutually agree to terms, can take some of the burden off physicians. This function is the role the pharmacist is supposed to play.
- Provider: Would hope we can roll into some of the end results of what Access Mental Health is trying to do (i.e. with eConsults). To ease that burden on the child psychologist system in the state and consider that in the broadest perspective.
    - Medication and prescribing and management by a pharmacist are very different than what we do in Access Mental Health. With special needs kids, they are having medications prescribed by multiple specialists which may or may not have anything to do with mental health, so that's very different.
    - Centralized outside of a practice; these are more hospital-based.
- FHC Expert: The initial prescribing won't be done by a pharmacist, but a pharmacist deployed in a community that can look at medications and interactions (and may even improve medication choice). There are programs where pharmacists are deployed and used for patients in the community and not in the hospital.
    - Consumer: A good example of that are some clinics that handle primary care, they have those pharmacists
- Payer**:** UConn study-limited benefit to these programs that most patients don't use and don't think they're necessary.
    - In BH, when you have folks on multiple medications and are trying to balance them all (particularly anticoagulants), in a general population setting with adults, there is limited

uptake with the service. And among kids, I would be surprised to see an uptake with the service.

- Provider: I am not the primary prescriber for lots of medications. The primary prescribers were elsewhere. It would not be okay with pediatricians to call them up and tell them, "a pharmacist told me this is not the right medication".
- OHS: When the pharmacist is deployed as part of the PCT, they still may be seen by specialists, and the medications may be prescribed by multiple specialists. Working with the subspecialist to come up with a medication is more successful for the patient.
- Provider: In pediatrics, medication prescribing is different.
    - With BH, having a subspecialist expand the capacity for primary care (for example, with anxiety and depression) is a new co-management approach we are piloting soon, and it has a lot of potential. I look at it as co-management, to get more real-time feedback from the pharmacist.

FHC Summary: Hearing there's a need to be able to do consultation but may not need to be at every practice.

- OHS: We need to make choices about where the investment is made. Does the group want this on the grid as a diverse care team member?
    - Provider: I don't feel this is necessary for my practice. I have specialist consultants to talk to about my management. I seem to have enough support, especially with Access Mental Health in CT. I have other resources available to me.
    - Provider: Agrees. I don't think it's a vital part of the diverse team.
    - Provider: Agrees. Increasing our capacity to be able to care for kids is very different.

FHC Summary: Propose removing medication prescribing functions from the care team.

Care Coordination Feedback from Previous Session
(See provided meeting materials for slide content.)

FHC: Any refinement of any of these?

- Provider**:** Change a word-CHWs in the community need to be able to bill, concerned about the "to bill". More appropriate phrasing would be "supported by financial resources". This is one of those places where we must look at this in the broader context of what we are trying to do. Some Health Enhancement communities have a function that the primary care site buys, but do not bill for it. They support it in different ways.
- Provider: Agrees. The PRC will have to come up with how these things are financially supported.

Care Coordination Definition

- Key function of pediatric medical home
- AAP Framework for high-performing pediatric care coordination within medical home: "Patient- and family-centered, assessment driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes."
- Defining characteristics:
    - Patient and family centered
    - Proactive, planned and comprehensive
    - Promotes self-care skills and independence
    - Emphasized cross-organizational relationships

FHC: Is this the right definition? What's missing?

- Provider: Thinks it's good.
- Consumer: This is good. AAP is the standard we use for the medical home.
- Consumer: Agrees.

Care Coordination Functions

- Functions:
    - Provide separate visits and care coordination interactions
    - Manage continuous communications
    - Complete/analyze assessments
    - Develop care plans (with family)
    - Identify gaps in care and manage/track tests, referrals and outcomes
    - Coach patient/family skills learning using motivational interviewing techniques
    - Integrate critical care information
    - Support/facilitate all care transitions
    - Facilitate patient and family-centered team meetings
    - Use health information technology for care coordination (HIE, EHR)
- In Addition:
    - Coordination with other sites of care and care coordinators, especially schools
    - Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator

FHC: What else is missing? Should practice-based care coordinators be required to work with centralized care coordination recourses (i.e. DPH CYSHCN care coordination centers, United Way 211)?

- Provider: Provide separate visits, including home visits. Our coordinator did that and found it valuable.
- Provider: These things have a lot of the resources, what is required?
    - FHC: Avoiding duplication of care coordination services.
- Provider: Must make sure families do not have three care coordinators from three different sources.
    - Change the wording: "be required to work with"→ to "encourage to use".
    - Thinking about it from a family's perspective- leave it up to families.
    - We need efficiency in this system and we need to simplify it.
- Get as close to the medical home as we possibly can. We shouldn't be duplicating.
- Payer**:** For the ICM program in Medicaid, when there isn't a coordinator in place, they work with the primary care provider. When there is a coordinator in place, the provider steps aside and works with another family.
- Consumer: Agrees. I assume when they say care coordination centers, they're referring to the medical home. A proper referral process is needed. All the clinics should coordinate through the one source the referral comes from.
- Provider: This statement should be turned around. T medical home is based within the practice. Where you get a lot of disconnects is where patients are in other places and then get hooked into other systems. Then the coordination can lapse, and the duplication can happen.
    - Consumer: I think it does work that way. United 911 will connect with whichever Medical home.
    - Provider: Speaking more so to the practice-based care coordinator.
- Consumer: Every practice needs to have that care coordination capability. Some practices may contract that out. Maybe we should ensure the final wording reflects exactly what the provider said. Is it practice-based care coordinators? All our systems need to ensure they're using that person in some way.

    - FHC: This question is not worded well. Our goal is always to avoid duplication of care coordination.
- There's a lot of care coordination out there. The goal is to ensure it gets into practices.
- Provider: If you look at the care coordination functions listed, many of these functions don't happen outside of the practice. Don't see it being able to happen in a centralized or telephonic interaction.
    - Don't see this being able to happen in centralized coordination sources, so have this practice-based to be able to fill these functions.
- Provider: We have a care coordinator in our practice. She's great but there are times we lose our patients no matter how many times we try to reach out to them. That's when the ICM group comes in and tracks down patients. There should be levels of care coordination or supports. Those extra supports are helpful.

FHC Summary:

- There are different levels, some at the practice level.
- The ability to call on resources to make the connection to the community beyond the practice.
- OHS: We must have the specificity in terms of care management programs for ACOs.
    - FHC: We will do that.

Oral Health Integration

US Preventative Services Task Force Grade B recommendations:

- Primary care clinicians apply fluoride varnish for babies and children birth to 5 years
- Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

Oral Health Integration Activities:

- Oral Health Screening for oral health and active conditions
- Preventive interventions (fluoride varnish and supplementation)
- Communication and education about importance of good oral health and practices to maintain it
- Referral to dental care as needed and tracking outcomes

FHC: Should oral health integration be a required capability for pediatric practices?

- This is very different for children than for adults
- Provider: It should be. It's easy and cost effective. Should be mandatory.
- Provider: Agree. We do this in my practice. Easily incorporated into flow. No reason not to.
- Provider: Oral health champion for AAP chapter. Totally agree. From age 5-6 years works with 1st tooth and the dental health partnership to spread the use of fluoride. It's been very difficult to get this to happen. Its cost effective. Good for kids and families. Would change the last bullet to "referred to dental home at age one or when they get their first tooth".

FHC: What fraction of pediatricians include fluoride garnish?

- Provider: changing very slowly. 30% just off the top of my head. In the commercial, it's supposed to be paid for by all of them, there are all kinds of barriers practices will discuss.
- FHC: Can imagine insurance is difficult because you must bill dental insurance.
    - Provider: We do have medical codes now for fluoride varnish. In Medicaid we have two separate codes for the oral health screening and the varnish.
    - Medical insurance does not need to pay.
    - Having difficulty for insurance companies paying for developmental screenings.
- Provider: Won't share any claims data, have been unable to get claims data to have a sense of how many children are getting this service.

- If this goes into a bundle and we make it a requirement, we must improve the uptake of this service. Ensure that practices have the resources to be able to do that.
- Consumer - Agrees. It's a good idea. It complements the legislation that passed last year for dental screenings in schools.
- Consumer - Yes, I think this is a great capability. Children that have been on the receiving end of it see how beneficial it is. It's quick, it's easy, and it's a great practice.

FHC Summary: Group supports this as being a required capability for pediatric practices.

- Consumer: More pertinent to my community- the CT water company supplies water to my patients. They have less than 30,000 homes, but they're not required to put fluoride in the water. Some days patients have fluoride in the water and some days they don't. Too much and too little is bad. Recommend patients use fluoride-added water-would be stuck if this was a requirement because I can't always do that without harming my patients.
    - Provider: Should not be that prescriptive.
    - FHC: We will add "if appropriate".

Community Integration: Overview

- Group has emphasized:
    - Importance of pediatric care services within the community (via schools, care coordination services, developmental services, etc.)
    - Importance of medical home coordination with community-based services and resources
    - Importance of funding to support these services
- Community Integration supports pediatric care services in the community:
    - Advanced networks or Federally Qualified Health Centers (FQHCs) purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services

Community Integration: Types of Services
(See provided meeting materials for diagram.)

FHC: What other types of services should be included? Should pediatric practices be required to contract with community-placed services?

- Consumer: Cultural competence.
    - SDOH screening is vital but can go wrong if it's not done with some care.
- Provider: Should we have something that can address an issue that teenage kids might have?

FHC: What is the gap that needs to be filled?

- Provider: These are kids that need better mentoring and support, BH and developmental services.
- Provider: In schools, there must be a bridge to school nurses. This should be a community effort. Bridge between medical homes.
- That will put the schools into this. More pressure on some school systems (particularly the ones that struggle with resources) and make sure these things are getting done.
- Provider: School nurses can help with coordination of care. They see these kids every day.
- Provider: Oftentimes there's not communication between the school nurse and the doctor.
- Provider: School nurses are overwhelmed. We can help support them. It's a two-way street.
- We don't always have permission to even communicate with the school nurse.

- Provider: Want to echo the real need and the gaps now with communication between schools. Can see which kids are not going to school, especially those with chronic illness. Can alert PCP that it's going on and can intervene.
- Provider: They don't always sign that blue form.
- To have a good relationship with the school nurse is very valuable.
- Consumer -The youth adults support center before transition to adult services-would like to see something about youth services.

FHC: Do you have any comments on the connections to school-based healthcare?

- Consumer: Agree. It's a critical piece. When the school-based nurse needs more help/resources, community-based services can provide extra support.
- Provider: Ex. East Hartford schools are not allowing their teachers to fill out their part for early intervention and identification.
    - FHC: So, there needs to be policy change with the schools.
    - Provider: There is a lack of sharing this important information to help pediatric providers.
- Consumer: Would agree. 15-minute visit is not enough time to address everything.
- Provider: There should be some context that recognizes the value of the Health Enhancement communities, and those linkages should encompass those community-based services.
- Consumer: The BH integration can help here.
- Provider: Adolescents, providing supports to steer them, may be able to collapse them together (referring to graph) in getting them ready for transition.

FHC Summary: Strong need for services to help adolescents and teens transition into adult medical care. Need coordination for school nurses and schools in general and be culturally careful with SDOH screenings.

- Provider: What do you mean by "contract"? That might be a bit of a challenge for a small practice.
- Provider: I see this as a network function.
    - Are the networks community-based? Trying to look at this logistically, do the practices tell the networks which community services they need? Trying to figure out how this all will function.
- OHS: The approach we are testing out now for the Dept of Public Health is contracting for community-based services that might include CHWs and others that will improve chronic illness self-management. For example, there isn't much capacity for asthma in home services, so what the practices are doing because it's a shared savings program is investing in purchasing the capacity to enable better care of asthma patients in the home (to help identify triggers)
    - Ex. Contracting with Hispanic Health Council (adults)
- OHS: The idea would be you purchase services from community partners, rather than hiring care coordinators. You can contract with coordinators with ties to an organization and ties to the community. It would be an alternative to just building the capacity. If you support the concept, I would suggest it not be required, but the supplemental payment dollars could be used at the practice's discretion.
- Consumer: We mentioned including adolescents and teens, could you make that broader to adolescents and adults?
- Provider: That's happening in pediatrics now, should include transition age.

FHC: Any comments to the contracting OHS described?

- Consumer: Practices wouldn't be required to coordinate with these services unless that's necessary, right? There should be some flexibility for the practices in connecting families with these services.
- Consumer: Agrees. I would love to see it being a required contract. CBOs lack funding. If you do require contracts, you're making those CBPs develop a standard process and that's one of the biggest issues right now. Pediatric practices are referring out, but they don't really know where they are referring. Required coordination is needed. Community-based practices need that funding.
- Provider: For some organizations, their capacity is very low. If the infrastructure isn't there, we can't send referrals to these agencies. We really need to see what the outcomes of those interventions are.
    - There is a huge HIT problem. There is going to have to be some support for community-based organizations to develop that infrastructure.
- Provider: Agrees. Once we start screening and identifying needs, we must have capacity to fulfill that need.
- Provider: Which community-based services will be contracted with? Versus others that won't be?
    - Determined by the practice.
- Consumer: Responding to an RFP is a huge task. A lot of CBS respond to RFPs.
- Consumer: A lot of this comes back to accountability measures-how are we determining how these functions are met?
- FHC: That work is going on in the PRC- developing accountability measures

FHC Summary: Must make sure individual practices are not burdened with contracting yet must make sure the networks don't have a one-size-fits-all solution to this.

- OHS: It's important we distinguish the community-level investment and the support programs under ATC, more reasonable obligations for pediatrics to contract with services that help them achieve certain care goals. Over 5 years, we are talking about significant changes. Need the group to help determine the capabilities that can help pediatrics meet their goals. Is this a requirement? Are we simply talking about rounding our certain care teams' functions? Or, are we talking about a stronger requirement and what are the limits on that?
- Provider: Understand that need. How can we do this outside of the Health Enhancement communities and what can they bring to this?
    - OHS: To answer that question, we might need to have a conversation that ties these two things together and creates a more complete picture.
    - Consumer: The other group being the Health Enhancement community?
    - OHS: Yes, we have a Population Health Council facilitated by HMA involved investments in food security and other family support, school readiness, and housing. We are talking about millions and tens of millions of dollars invested in CT to promote child wellbeing. We must have a strategy around community investments. Per member per month fund to address gaps and their care responsibilities. How do other folks feel about this?
        - Provider: Needs to be elective.
        - Provider: Needs to be elective, to use per member per month resources- there must be some pretty significant decision making.
        - Provider: To do this kind of practice transformation and isolation is short-sited and incomplete. It's necessary to do this kind of practice-based work, but it's not enough to bring about change and transformation for better population health. Practices can't make a huge transformation in isolation of this community integration opportunity. Could not vote for elective for that reason.
            - Consumer: Agrees.

    - Provider: Would not want to sink the ship by burdening the pediatric practice so much that they can't function. It can be something we request from the networks.
- Provider: Pediatric practices contracting with services is vague. Logistically, how does that happen in an effective way? There would have to be a lot of support for practices to be able to do this even on a network level. Practices often have overlapping communities.
- FHC: The concepts we've talked about, the group believes they have value. The concern is how to get there that is not overly burdensome to the practice itself. If we can find a way to not burden the practices, would that allow you to feel more comfortable with this capability being required?
- Provider: Yes, but I'm just not sure how you're going to do this.
- Provider: I would like to see the network come up with a framework for what this would look like. It's not just financial. Understanding how to contract- if the network was able to figure out what the contribution collectively would look like and what it would look like in terms of cost and the admin. Would be at the network level and not at the practice level. Access to these community services is necessary to meet our goals in CT.
- Provider: Would a practice have to make a choice between fulfilling various functions? How are we going to be able to really have access to all the different services?
- Provider: Doubling investments in primary care, what portion of that total additional investment at a network level would that comprise?
    - FHC: Those are key questions for the development of the supplemental bundle which the PRC is looking at now.
- Provider: This group cannot answer this yet until that information is forthcoming.
- Provider: Unintended consequences could result if these services are preferentially available to practices in the network and other programs are crowded out.

Next Steps

- FHC: Seems like the takeaway is to come back with a consensus electronically.
- Design group will look at the last couple of slides and will send feedback to FHC electronically.