PCM Community Integration Design Group Meeting 1

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PCM Overview

1. Building the Primary Care System We Need
   a. We need a greater investment in primary care by improving costs and outcomes
   b. Integrated and expanded care teams
   c. Technology that connects patients with providers outside of office hours
   d. A Payment Reform Model can help primary care be more flexible and better meet the needs of patients
2. PCM Model Design
   a. Define practice capabilities and payment model options that support them
   b. Collaborate with leadership and support from providers, payers and consumers as partners in payment reform design
   c. Include participation from Medicaid, Medicare, Medicare Advantage and commercial health plans
   d. Model design for consideration by the governor elect following 2018 election
   e. If model moves forward, implementation would begin in 2020/2021
3. PCM: The Work to Date
   a. Stakeholders have identified many goals for a new model of PC in CT:
      i. Support patient-centered, coordinated care and a better patient experience
      ii. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed.
      iii. Expand care teams and improve access outside the traditional office visit.
      iv. Double investment in primary care over five years through more flexible payments.
      v. Reduce total cost of care while protecting against underservice and improving quality and patient experience.

Community Integration Definition and Recommendations

1. Consumer Needs
   a. Patients and families need a variety of support services beyond traditional medical care
   b. Support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions
   c. Support services beyond traditional medical care that connect patients with affordable solutions and community resources
   d. Improvement of health outcomes particularly in low-income communities

   e. Care and care teams that address religion/language barriers and other cultural differences
   f. Support securing transportation and child care for in-office visits and/or alternative ways to access care
2. What are we missing?
   a. State: How do we evolve EMS system? How do we better utilize EMS for non-emergency transports?
3. Community Integration
   a. Extends primary care services into the community and connects patients to community-based services for patients with high-risk, social determinants of health needs, and/or chronic conditions
      i. Consumer: If these are contracts, these are closed network→ how are organizations going to be identified? Is this based on a geographic area with a focus on prevention? What else are we looking for community organizations to bring to the table?
      ii. FHC: Advanced Networks and FQHS that are currently participating in a shared savings arrangement with payers (rather than single networks)
      iii. Consumer: Is the expectation that one organization is going to be able to respond?
         1. FHC: Not a single organization.
      iv. Consumer: How are these organizations identified by primary care?
      v. FHC: The network would need to work with the practice to determine needs assessment.
         1. Consumer: Consider in certain geographic areas that you are going to have a lack of available services (diabetes management, mental health support groups)→ once there's an identified need, there may be some capacity building in the community needed (gaps in services available depending on geographic areas)
         2. Consumer: If the assessment is largely based on those accessing care, we can exacerbate disparity for those who don't seek care (particularly men of color)
            a. Communication directly with CBOs for those not seeking care (data collection by practices is necessary)
      vi. Have multiple venues or at least more than one avenue to do the assessment
      vii. OHS: Distinguish the two grey boxes in diagram
         1. FHC: 1. In-home services or community delivers PC services; 2. people are linked to community-based services within medical settings
         2. OHS: Health Leads model use students or interns but could also be community health workers, they work within the primary care setting
            a. They are on-site
         3. Consumer: What kind of information system technology is monitoring this?
         4. Assess and monitor ED visits, hospitalization, post hospitalization appointments→ a robust electronic system that helps produce data

    a. We have a reporting mechanism as well.
    b. We do a year look-back and can conduct comparative analysis with patients
5. FHC: Do you share this with the primary care providers you work with or do you have the same EHR system as them?
    a. We use EHR and our APRN is able to connect with providers
6. Consumer: UPenn impact model
    a. FHC: We will investigate this
7. OHS: The clinical examples were biased to picking CT-based examples
8. OHS: FQHCs also have a method of tracking
9. OHS: If someone needs services that are not primary care in nature (healthy food or housing), the network wouldn't be contracting for those services they would either work with a CHW or contracting with a Health Leads organization
    a. Where does this fit into the diagram?
    b. Links to community-based services in primary care
        i. Primary care is doing the link to those community-based services→ call it links to community-based services and reports
        ii. Consumer: Feedback loop is important from consumer and provider perspective
            1. FHC: Annual survey?
            2. Consumer: No, someone that manages the network.
            3. Consumer: How CBOs will be brought in and what the network is going to look like→ to what extent are these initiatives going to really address SDOH risk patients not seeking care.
            4. FHC: How do we do those assessments? Needs-based and ongoing?
        iii. OHS: Payment Reform Council's work: the primary care modernization is focused on patients attributed to a network; being not attributed means you don't end up on an over-use of ED score card
            1. You don't allow people to be unattributed.
            2. Consumer→ Why would somebody try to extend into the ED to try and get these patients needs met? Mark: Get these people auto-assigned and they get put on a provider's roster.
            3. OHS: Paying for housing, food, cell phones→ not clear that we are trying to solve for a service is care-related (unsure if we can imbed non-health-related activities, suspect the feds

will say this is part of the shared-savings) Build-in of community supports = skeptical

4. Social Determinants of Health Screening
    a. Should all practices be required to screen for SDOH?
        i. Consumer: Yes.
        ii. OHS: Targeted screening is preferable to non-targeted screening because it takes admin time and energy to screen for anything
            1. Broad-based universal screening vs. targeted screening
            2. In the absence of a health problem- is it the role of primary care to screen for SDOH risk?
            3. Consumer: Isn't the point of this to screen for whole health outcomes?
            4. The ACC intervention is focused on screening for risk focused on acute to chronic illness and injuries
            5. FHC: There should be SDOH screening even for people who may not appear high risk to work towards healthier lifestyles
            6. FHC: What networks resources are needed to enable this? Screening tool? EHR that can capture this?
            7. Consumer: When someone gets attributed to a network, do they have to fill out info about themselves and where they are in their life?
                a. FHC: Get attributed based on PCP they've been seeing or if they visit an ED
                b. FHC: There's a need for patient engagement outreach
                c. Consumer: We must be careful how you find these people or who approaches the individuals → concern over engagement and initial introduction
                d. Consumer: Once our staff go into the home, they're welcomed, an assessment is done and then a social worker does a psycho social assessment.
                e. FHC: So, there's a need for the care team to do an outreach to the patient
                f. FHC: Approach we need to make sure we are considering?
                    i. Consumer: Who is that point of contact for the SDOH assessment and where it takes place? Needs to be culturally appropriate
                    ii. Consumer: Understanding the capacity of the CBOs is important
                    iii. Consumer: Training CHWs is also a certification process and unsure if this should happen in primary care
                        1. Better to have a CHW to do it than a PCP