CONNECTICUT
Office of Health Strategy

Pediatric Design Group

September 2018

Agenda

Introductions and Purpose of the Meeting	10 minutes
Background	15 minutes
Discuss Capabilities	65 minutes
Next Steps	10 minutes
Adjourn	

Purpose: Primary Care Modernization

Primary Care Modernization Model Design

Primary Care Modernization Initiative: Design a multi-payer primary care payment reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Project Goals

- Define practice capabilities and payment model options that support them
- Collaborate with leadership and support from providers, payers and consumers as partners in the payment reform design
- Include participation from Medicaid, Medicare, Medicare Advantage and commercial health plans
- Model design for consideration by the Governor-elect following the Nov. 2018 election
- If model moves forward, implementation would begin in 2020/2021

Why Focus on Primary Care?

1. Research, experience of others shows us it works

2. CT providers and patients tell us its needed

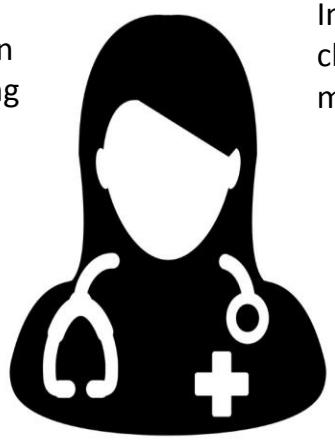
3. Aligns with national focus on primary care as critical path to achieve overall savings while improving health and outcomes

Building the Primary Care System We Need

Primary care's challenges…

Insufficient coordination and coaching

Ineffective chronic care management



Too little revenue dedicated to primary care, inflexible FFS payment

Limited consumer support between visits

Inconvenient; limited access via phone, email, text = more time away from work, family

Poor integration of mental health and substance use services

How we've tried to fix them….

Shared "savings" with no downside financial risk

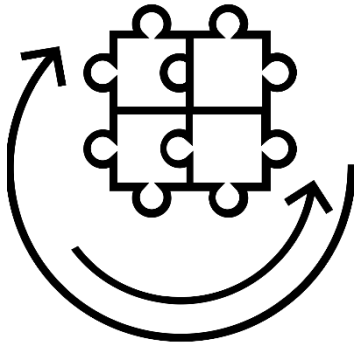
Llifestyle coaching, decision support and help navigating the system

Investments in onsite clinics, biometric screening, EAPs, nutritionists, fitness centers, national telemedicine

Carrier and third-party administered programs to manage chronic conditions, complex cases, care transitions and care gaps

What we really need…..

Integrated, expanded care teams that engage patients in their health, identify risks and manage conditions



Technology to keep providers connected with each other and their patients

Convenient, accessible care with options for email, phone, text and virtual visits

Increased investment in primary care; bundled payment; downside risk to drive reductions in total cost of care

Primary Care Modernization: The Work To Date

Stakeholders have identified many goals for a new model of primary care in Connecticut, including:

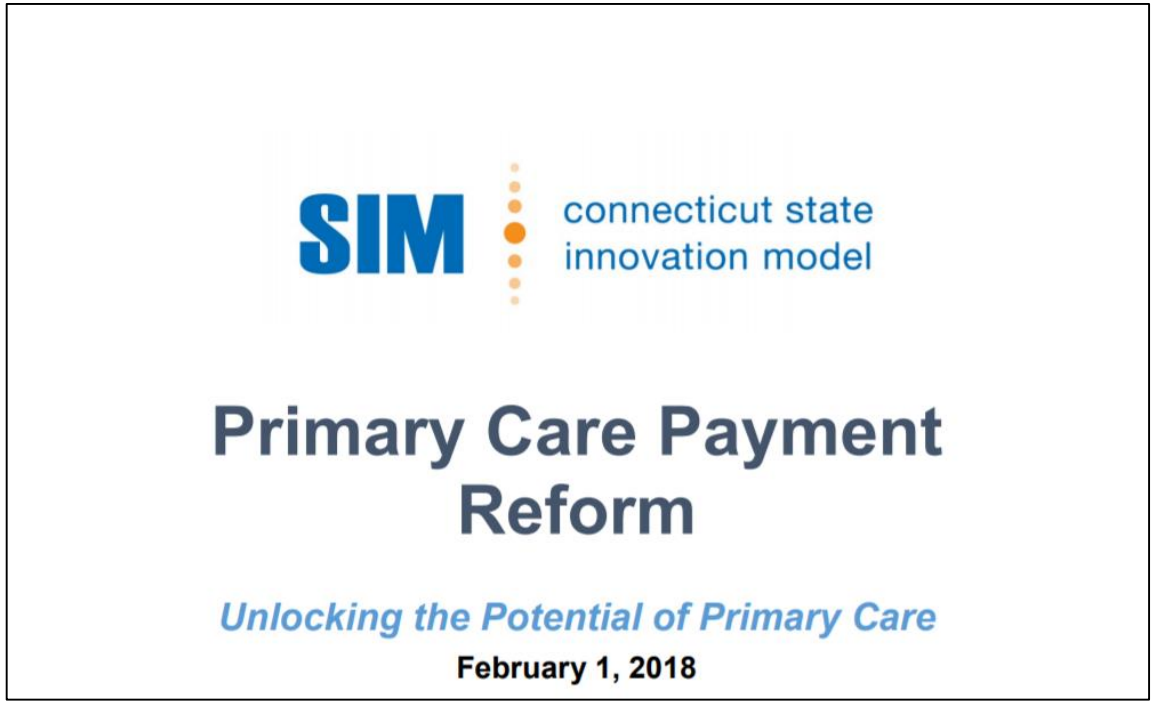
1. Support patient-centered, coordinated care and a better patient experience.

2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed.

3. Expand care teams and improve access outside the traditional office visit.

4. Double investment in primary care over five years through more flexible payments.

5. Reduce total cost of care while protecting against underservice and improving quality and patient experience.



Aligns with Pediatric Reform Study Group's payment reform recommendations

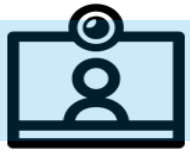
OHS CONNECTICUT Office *of* Health Strategy

Purpose of today's discussion

- Review applicability of Primary Care Transformation capabilities to Pediatrics
- Provide recommendations to Task Force
  - What are the special considerations for pediatrics?
  - Are there specific models for pediatrics that should be considered?

Gathering Input on Capabilities

Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients' Needs

Diverse Care Teams	 Pharmacists, Nurses	 Care Coordinators, Community Health Workers, Navigators	 Health Coaches, Nutritionists
Alternative Modes of Support & Engagement	 Phone/Text/e-mail	 Home Visits	 Telemedicine
Technology	 Patient generated data & Remote patient monitoring	 Precision & Genomic Medicine	 E-Consults
Integration and Specialization	 Behavioral Health Integration	 Practice Specialization (e.g., geriatrics, chronic pain)	 Community Integration

Community Integration

Definition: 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.

1. Practices identify care gaps and needs for community-based services

2. Practices provide access to appropriate community-based services by:
    a. Purchasing community-based services to extend primary care services into the community setting or providing community-based services within primary care
    b. Training community members to link patients to primary care

3. Tracking of referrals to community-based services and outcomes

Consumer Input, Questions and Concerns:

- Patients and families need a variety of support services beyond traditional medical care.
- Support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions
- Support services should connect patients with affordable solutions and community resources.

Community Integration for Pediatrics

Special Considerations for Pediatrics

Care team members must be capable of making referrals for issues related to social determinants of health, chronic conditions, and access to care barriers. Other community resources include:

- Newborn and family support and lactation counseling
- Nutrition and other interventions to promote healthy weight
- Asthma disease management
- ADHD related services such as behavioral counseling, psychoeducational testing, coordination with schools

Question:

Should all pediatric practices screen for social determinants of health?
Which services are more efficient to provide by purchasing through community-based organizations?
What are best in class models/programs to recommend?

Diverse Care Teams

Definition: Expanded primary care services and supports to include roles and functions such as (but not limited to) nurse care managers, clinical pharmacists, community health workers, interpreters, behavioral health providers, nutritionists, patient navigators and care coordinators.

Consumer Input, Questions and Concerns

- Diverse care teams should include making care more affordable as a goal
- Patients want to be connected with community support services
- Need support securing transportation and child care for in-office visits and/or alternative ways to access care
- Care teams should ideally be representative of the communities they serve
- Consumers need support learning to advocate for themselves in a medical setting
- Communications with patients should take into account their socioeconomic, and sociocultural needs and norms
- Skilled, trained interpreters are needed

Questions for Discussion:

- Which expanded care team members are critical to pediatric care?
- What roles should they perform in pediatrics?

Home Visits

Definition used in adult care: Combines home-based primary care for medical needs with intense management, care coordination, and long-term services and supports (LTSS) when needed.

Consumer Input, Questions and Concerns:

- Address barriers to access (transportation, time off work and school, limited mobility or behavioral issues)
- Support making environments healthier (e.g. for asthma)
- Caregivers and families need more information so they know how they can support the care plan and ask the right questions.

Special Considerations for Pediatrics

- Often preventive for children and families: Maternal/newborn and early childhood home visits to support parenting and child development improve health outcomes.
- Improves outcomes for children with special healthcare needs such as severe developmental disabilities
- Effective for common pediatrics conditions such as asthma, behavioral problems, etc.
- Health Enhancement Communities will create a variety of home visit services; Pediatrics team will connect with families and stay engaged.

Home Visits for Pediatrics

Questions:

- Should home visits be limited to high risk populations?
- Should home visits be required for newborns and their families?
- Should pediatric practices conduct home visits or connect families to resources that provide this service?
- Will it be the responsibility of pediatric team care managers to make the connections with the HEC program? How should this be facilitated?

Shared Medical Appointments

Definition: A group visit for patients with similar medical conditions that typically includes physical check-ins, education about self-management, life style coaching and prevention.

Consumer Input, Questions and Concerns

- More frequent access to medical/social services; adds peer supports
- Schedule at more convenient times (evenings, weekends) than conventional medical appointments
- Coaching and navigation; assistance connecting to community support services
- Reduce long wait times for appointments, a barrier identified by consumers

Questions:

- Are there any special considerations for conducting shared medical appointments in pediatrics?
- Is there applicability for use of shared medical appointments in well child care? Socioemotional development?

Pediatric Behavioral Health Design Group Recommendations – Work in Progress

Design Group met on August 21 and September 5; scheduled to meet on September 18

Recommendations are in development:

- Integrate pediatric behavioral health and primary care to improve treatment and outcomes and reduce health disparities
- Leverage frequent well child visits to screen and engage children and their families as needed with a focus on prevention.
- Identify required screenings
- Provide behavioral health care coordinators with strong community connections as a resource to the practice
- Co-locate or provide warm handoffs to nearby behavioral health resources
- Provide telehealth consultative services to psychiatrists for advice about treatment plans, including medication management

Consumer Input, Questions and Concerns:

- "Whole child" and family approach
- Reduce stigma for accessing pediatric behavioral health services
- Address child BH issues before needs become acute
- Improve access, reduce wait times
- Coordination with schools and other social service agencies

Next Steps

- Project team will summarize the group's discussion today
- This group will review additional capabilities on September 24 (webinar meeting)
- Present to Task Force on October 9
- Task Force will review and forward recommendations to Payment Reform Council

Questions?

Contact Information

- Alyssa Harrington, Project Director
  aharrington@freedmanhealthcare.com
- Vinayak Sinha, Project Associate
  vsinha@freedmanhealthcare.com