PCM Pediatric Design Group 1

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Participants: Kevin Galvin, Andrew Falacci, Hillary Deignan, Ellen Bloom, Linda Green, Alyssa Harrington, Karen Siegel, Glenn Focht, Tiffany Donelson, Tesha Tramontano-Kelly, Robert Zaviski, Paul Dworkin, Pat Baker, Monica Ordway, Mark Schaefer, Lisa Honigfeld, Jesse, Sandi Carbonari, Jeff Lasker, Elsa Stone, Arlene Murphy, Erin Rice, Jerry Calnen, Ryan Calhoun, Robert Seifert, Peter Bowers, Katherine Piwnica-Worms, Hilary Deigan, Eminet Gurganus

PCM 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.

1. Care delivery goal: Increase the Ability of Primary Care to Meet Patient's Needs
2. Community Integration
    a. Extends primary care services into the community and connects patients to community-based services for patients with high risk, SDOH needs, and/or chronic conditions
    b. Practices provide access to appropriate community-based services by:
        i. Purchasing community-based services to extend primary care services in the community setting or providing community-based services within primary care
        ii. Training community members to link patients to primary care
            1. Ex. Community paramedicine
3. Tracking of referrals to community-based services and outcomes
4. Provider: What is an example of this?
    a. OHS: Health departments having limited capacity→ supporting contracts so they can purchase capacity to more effectively serve patients with asthma who are not responding to treatment
    b. OHS: Payment Reform Council will deliberate payment methods
        i. Payments will probably go directly to the practice, depends on the arrangement and what the PRC recommends
        ii. Wherever the money goes, the expectation is that it will be apart of the core business administration
        iii. FHC: This will be a multi-payer project
        iv. FHC Summary: How are we going to pay for needs of pediatric patients
5. In terms of data reporting, each practice will have different needs; prefer to do practice by practice
    a. This will not change because reporting will have to be done at the practice-level.
    b. In child care, promoting health development survey is very good tool and is an example of the numerous surveys that already exist in pediatrics
    c. FHC Summary: How are we going to identify needs of pediatric patients
6. Behavioral health aspect important in health needs
7. What is the definition of community resources in health needs
    a. Basic needs important
8. United 211 data good example

    a. Every hospital is required of identifying needs assessment → this could be a source of data also
9. Daycare should be added to health needs
10. There are needed buckets beyond traditional medical care
11. Addressing the needs of culturally diverse patients
12. FHC: How do we define community resources→ care team members make referrals for issues related to SDOH, nutritional and healthy weight intervention, asthma disease management, ADHD related services, behavioral health testing, coordination with schools
13. FHC: Are any of these services more efficiently provided through a CBO rather than in primary care?
    a. BH is critical and important piece → greater demand from families
    b. Too often these services get fractionated in primary care
    c. What's best in community vs. practice is important to identify
    d. FHC: SDOH = all practices should screen all patients
        i. Provider: SDOH should only be performed if it addresses family's needs and then links patients with services
        ii. Provider: Illegal to deliver preferential care to a subgroup in MA
            1. Paul: Can screening be done in the context ensuring that patients benefit and done in a context that can support the screening
        iii. Provider: AAAP guidelines are good example but is silent on the how
            1. Applications of technology can be our friend
        iv. Communication can't be a one-way street, there must be a feedback system in place
        v. Some CBOs already have mechanisms in place for referrals in primary care
        vi. OHS: Traditional community services vs. traditional primary care services, the health enhancement community is focused on improving child well being and reducing adverse events, and that includes contracting with major payers like Medicaid to provide a return on investment
            1. If health enhancement community moves forward, there will be a push to fund solutions in addition to addressing developmental risk like housing instability and set a net new investment target
14. Diverse Care Teams
    a. Which expanded care team members are critical to pediatric care?
        i. Nurses
    b. What roles should they perform in pediatrics?
    c. Can you define diverse care team? Where's this team located?
        i. Adult diverse care team → there should be flexibility but have these resources available; whether they're deployed onsite in the practice
        ii. Imagining these diverse care teams are supporting primary care docs in their network, and then you can't divorce this modernization effort from the adult population effort; as we talk about and design it, you must think about the system integration
            1. May be able to measure 5 things a pediatric practice can do to measure things like BMI

2. Ultimately, we are trying to get value-based payment, that's not about interactions
3. You're going to leave pediatricians asking what else can we do?
    a. How is this different in the pediatric setting?
4. Looks like this is to improve care in critical conditions for the child, but this looks more focused on whole-family
    a. FHC: Different way to think of this is team-based care; non-hierarchal structure; by diversifying care teams you take some of the burden off primary care providers & better meet the needs of patients
    b. This is unrealistic-where is this diverse care team in?
        i. Need to say the AN will provide diverse care teams in their network
        ii. This must be standardized
        iii. Provider: These capacities are not easily accessible, but they are there, an isolated approach that creates a linkage to a CHW is not the best approach; comprehensive system is better → CT has the capacity now to do this
        iv. Team-based care has worked in the past in my experience: CHWs in network documented and helped them become the highly functioning team and were able to leverage each other's strengths
        v. FHC summary: We need to look at these not in isolation and be careful to focus on the right areas

15. Home visits
    a. Should home visits be limited to high risk populations?
        i. We must clarify the high-risk piece, different families have different needs
        ii. OHS: Are there other home visiting that should be undertaken by the pediatric practice itself?
            1. In other countries, home visits are universal
            2. Early head-start programs also go into the home and do home visits
            3. Moved away from home visits in fee-for-service
            4. We must teach parents to be advocates and care coordinators
                a. Every family is different
            5. How are we looking at the assets of CT in terms of what exists and a systems approach?
                a. How do you strengthen the connection?
    b. Should home visits be required for newborns and their families?
    c. Should pediatric practices conduct home visits or connect families to resources that provide this service?
    d. Will it be the responsibility of pediatric team care managers to make the connections with the HEC program? How should this be facilitated?

Closing Comments

- What does success look like for the group?
    - FHC: Are there any capabilities that need to be a part of this payment model specifically for pediatrics.