Connecticut Primary Care Modernization Initiative: Unlocking the Promise of Primary Care

Presentation to the Consumer Advisory Board

Thursday, April 5, 2018, 6:00 - 8:00PM
Primary Care Modernization
## Opportunities for Primary Care Modernization (PCM)

<table>
<thead>
<tr>
<th>Patient Engagement and Support</th>
<th>Care Team Diversity</th>
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</thead>
<tbody>
<tr>
<td>Phone contact</td>
<td>Nurse care manager</td>
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<tr>
<td>E-mail/text support</td>
<td>Social Worker</td>
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<td>Telemedicine visits</td>
<td>Licensed BH clinician</td>
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<td>Home visits</td>
<td>Pharmacists</td>
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<tr>
<td>E-consult</td>
<td>Nutritionist/dietician</td>
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<td>Remote monitoring</td>
<td>Care coordinator (community health worker focused on community linkages)</td>
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<td>Group visits (illness self-management, prevention, lifestyle enhancement)</td>
<td>Health coach (community health worker)</td>
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<tr>
<td>Tweet/chats/on-line support groups</td>
<td>Patient navigator (community health worker)</td>
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<td>Patient/family advisory council</td>
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<tr>
<td>Communication with child care/school</td>
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Medication Adherence

“Drugs don’t work in people who don’t take them.” C. Everett Koop, MD

For every 100 Prescriptions written

50 – 70 Go to a pharmacy

48 – 66 Come out of The pharmacy

25 – 30 Are taken properly

15 – 20 Are refilled As prescribed

Christina Polomoff, PharmD, BCACP, BCGP
Assistant Clinical Professor
University of Connecticut School of Pharmacy
Population Health Clinical Pharmacist
Hartford Healthcare Integrated Care Partners
Medications in pillbox which patient is taking

- Alfuzosin 10 mg HS
- Aspirin 81 mg daily
- Isosorbide mononitrate 60 mg daily
- Klor-Con 20 mg BID
- Lisinopril 2.5 or 5 mg daily
- Metoprolol succinate 100 mg daily
- Prednisone 1 or 2.5 mg daily
- Vesicare 10 mg daily

Medications outside of pillbox which patient is taking

- Insulin regular U-500 40 units TID
- Proair HFA inhaler 2 puffs PRN

Medications found outside of pillbox which patient believes he is taking

- Advil 200mg (exp: 6/2016)
- Aspirin 81mg (exp: 8/2011) – Walgreens brand
- Aspirin 81mg (exp: 4/2012) – CVS brand
- Debrox ear wax removal (exp: 12/2015)
- ERO ear wax removal (exp: 09/2010)
- Ibuprofen 200 mg
- Mucinex (guaifenesin)
- Mucinex extra strength
- Mucinex D (guaifenesin + pseudoephedrine)
- Cortisporin otic suspension (exp: 2/2016)
- Pantoprazole 20mg tab
- Zolpidem tartrate 10 mg
Medications found that patient states he is NOT taking:

- Allopurinol 100 mg (exp: 9/2016)
- Aspirin 325mg enteric coated
- Acetaminophen ER 650 mg (exp: 7/2016)
- Centrum multi-vitamin
- Capzasin (capsaicin) no-mess applicator (exp: 10/2015)
- Diphenhydramine 25 mg (exp: 1/2015)
- **Furosemide 40 mg**
- Glucosamine + chondroitin + MSM
- Kim Tien Thao (desmodium styracifolium) 120mg – “for kidney stones and gallstones”
- Lisinopril 5 mg
- Metolazone 2.5 mg (not-labeled)
- Tussin DM (dextromethorphan 20 mg + guaifenesin 200 mg)
Investing in Primary Care: Promising Models

Innovative Delivery and Payment Models

• Commonwealth Care Alliance (CCA), Medicare/Medicaid eligibles, capitated
• Iora Health- risk adjusted budget, relies heavily on health coaches (CHWs)
• Evergreen Health- Category 4, risk-adjusted advanced payment, 10% primary care
• Kaiser Permanente- global budget

Comprehensive Primary Care (CPC)+

• National model that offers mostly non-FFS based payment through prospective bundles, care management fees, and the opportunity for quality bonuses
• Recommended by the SIM Practice Transformation Task Force but CT was not awarded
Conclusion and Recommendations

Evidence shows that the current payment reforms are not enough support the advancement of primary care needed to improve outcomes, reduce costs, and improve patient and care team satisfaction.

Recommend multi-payer demonstration organized around the following recommendations:
Recommendation 1: Connecticut’s payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

Recommendation 2: Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. Payers should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.

Recommendation 3: Primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care.
Primary Care Modernization

Sample Payment Model

- Up-front payment per patient
- Fee for Service payments for immunizations & ancillary services
- Care Management payment per patient
# Primary Care Modernization

Practice Capabilities and Care Team Composition – Options for Consideration

## 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

## New Technology
- Patient generated data & Remote patient monitoring
- Precision & Genomic Medicine

## Integration and Specialization
- Behavioral Health Integration
- Practice Specialization (e.g., geriatrics, HIV)
- E-Consults
Primary Care Modernization
Advisory Process – Draft for Discussion

Advisory Panels
- Practice Advisory Panel
- ACO Advisory Panel
- FQHC* Advisory Panel
- Employer Advisory Panel

Healthcare Innovation Steering Committee
- Practice Transformation Task Force
- Payment Reform Council
- Pediatric Practice Reform Study Group**

Special Engagements
- Payers
  Solicit input directly from each of the payers that has agrees to participate in planning

- Consumers
  Coordinate with Consumer Advisory Board (CAB) to host additional public input forums

*FQHC - Federally Qualified Health Center
**Supported by the Child Health and Development Institute of CT and the Connecticut Health Foundation
Discussion Questions

What questions do you have about the initiative?

What do you like?

What are you concerned about?
The Office of Health Strategy seeks public comment on the report and recommendations of the Practice Transformation Task Force (Task Force) entitled Primary Care Payment Reform: Unlocking the Potential of Primary Care. The Task Force recommends that Connecticut’s payers and providers implement reforms to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement. The Task Force urged the state to engage Medicare and the State’s public and private payers to examine how to make such reforms a reality in Connecticut.

Instruction for Providing Comment
Written comments, questions, and concerns regarding these recommendations may be submitted until April 9, 2018 to the SIM Program Management Office at sim@ct.gov. When submitting correspondence, please reference "Primary Care Payment Reform Report" in the subject line.
If you are providing comments on behalf of an organization, please include the organization's name and your contact information.
If you are commenting as an individual, please include your contact information.
Task Force Recommendations (2 of 4)

**Recommendation 4**: Primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.

**Recommendation 5**: Primary care payment models should include the cost of new services in prospective primary care bundled payments or care management fees, which should be exempt from cost-sharing.

**Recommendation 6**: Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.
Task Force Recommendations (3 of 4)

**Recommendation 7**: Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model to incentivize certain services and protect against under-service.

**Recommendation 8**: Primary care payment models should include a bundled payment option in which primary care practices receive resources to manage mental health and substance use conditions and assume accountability for associated outcomes.

**Recommendation 9**: Primary care payment models should maximize the flexibility that primary care teams have to expend resources on health promotion and coordination with community services, including the use of community health workers.
**Task Force Recommendations (4 of 4)**

**Recommendation 10:** Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change.

**Recommendation 11:** Primary care payment models should be multi-payer, cover the majority of a practice’s patient population, and provide practices with external coaching support and technical assistance.