<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions</td>
<td>5 min</td>
</tr>
<tr>
<td>Public Comment</td>
<td>10 min</td>
</tr>
<tr>
<td>Purpose of Today’s Meeting</td>
<td>5 min</td>
</tr>
<tr>
<td>Overview of Primary Care Modernization Project</td>
<td>5 min</td>
</tr>
<tr>
<td>Review Capability</td>
<td>60 min</td>
</tr>
<tr>
<td>Next Steps</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>
Introductions
Public Comment
Purpose of Today’s Meeting: Design Group Context
Connecticut State Innovation Model

Healthier People and Communities

Empowered Consumers

Better Care

Smarter Spending

Health Equity
Primary Care Modernization Model Design

Primary Care Modernization Goal
Create a 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

• Develop Primary Care Modernization program model that defines **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 and promotion process

• Complete the model design for consideration by the Governor-elect following the Nov. 2018 election
Primary Care Modernization Advisory Process

Consumer Advisory Board

STAKEHOLDER ENGAGEMENT
- Primary Care Practices
- Advanced Networks
- Federally Qualified Health Centers
- Employers
- Employees
- Individual Payers
- Hospitals/Health Systems
- Inter-professional Healthcare Training Programs

Healthcare Innovation Steering Committee

Practice Transformation Task Force

Payment Reform Council

DESIGN GROUPS
- Pediatric Practice Design Group
- Behavioral Health Design Group
- Other Design Groups, as needed

OTHER ADVISORY GROUPS
- HIT Council
- Quality Council
- CHW Advisory Committee
- Healthcare Cabinet
- Medical Assistance Program Oversight Council*
- Behavioral Health Partnership Oversight Council*
- Department of Labor, Office of Workforce Competitiveness

*Pending DSS initiated collaboration agreement
Proposed PCM Capabilities for Consideration

<table>
<thead>
<tr>
<th>Increasing Patients’ Access and Engagement</th>
<th>Expanding Primary Care Capacity</th>
<th>System Supports and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Diverse Care Teams</strong></td>
<td><strong>1. Capacities</strong></td>
<td><strong>1. BH Integration (adult)</strong></td>
</tr>
<tr>
<td>• Community health workers</td>
<td>• <strong>Practice specialization</strong></td>
<td><strong>2. BH Integration (pediatric)</strong></td>
</tr>
<tr>
<td>• Pharmacists</td>
<td>• Pain management and MAT</td>
<td><strong>3. Community Integration</strong></td>
</tr>
<tr>
<td>• Care coordinators</td>
<td>• Infectious diseases</td>
<td>• Social determinants of health</td>
</tr>
<tr>
<td>• Navigators</td>
<td>• Geriatrics (complex older</td>
<td>• Purchased community services</td>
</tr>
<tr>
<td>• Health coaches</td>
<td>adults)</td>
<td></td>
</tr>
<tr>
<td>• Nutritionists</td>
<td>• Persons with disabilities</td>
<td></td>
</tr>
<tr>
<td>• Interpreters</td>
<td>• Genomic medicine</td>
<td></td>
</tr>
<tr>
<td>• Nurse managers</td>
<td>• Subspecialists as PCPs</td>
<td></td>
</tr>
<tr>
<td><strong>2. Alternative Ways to Connect to Primary Care</strong></td>
<td><strong>2. Health Information Technology</strong></td>
<td><strong>4. Oral Health Integration</strong></td>
</tr>
<tr>
<td>• Phone/text/email</td>
<td>• E-consults</td>
<td></td>
</tr>
<tr>
<td>• Home Visits</td>
<td>• Remote patient monitoring</td>
<td></td>
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<tr>
<td>• Shared visits</td>
<td></td>
<td></td>
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<tr>
<td>• Telemedicine</td>
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</tr>
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</table>

Social determinants of health and health equity will be considered across capabilities
Approach to Developing Capabilities

Evidence and literature
- Expert opinion and experience
- Experience in other states

Skeleton Capabilities

PTTF recommendations
- Design group recommendations
- Stakeholder and consumer input

Stakeholder and consumer input

PTTF recommendations
- Design group recommendations
- Stakeholder and consumer input

Draft Capabilities Statements

Final Capabilities Statements
Capabilities Statement Development

• Begins with “skeleton” created by PCM Project Team, in consultation with subject matter experts

• Outline
  • Problem statement and contributing factors
  • Proven strategy
    • Consumer needs: Incorporates feedback from CAB consumer listening sessions and other consumer engagements
    • Health Equity Lens: Perspectives on how capability might address health disparities
    • Intended Outcomes
  • Implementation
    • Example clinical scenario
    • HIT Requirements
    • Implementation Concerns
  • Impact: Health promotion, quality of care and outcomes, patient experience, provider satisfaction, costs
  • State and National Scan: CT and national case studies, results and lessons learned
  • Additional Reading and Bibliography
Design Group Process

Design groups needed when:
- Multiple proven models with distinct ways to accomplish capability
- Emerging role in primary care

Design groups are open to the public and include:
- At least one member of Task Force
- Consumer representatives
- Local subject matter experts
- Project team experts

Design group goal:
- Make recommendation to the Practice Transformation Task Force as to whether this capability should be considered in the payment model
Does the evidence support including this capability in the PCM payment bundle?

→ *Based on health promotion/prevention, quality and outcomes, patient experience, provider satisfaction, lower cost*

Should this be a **core (universal/required)** or an **elective** capability?

Should this capability be deployed in **all practice sites**, or provided by a **subset of docs or practices** within each primary care network?
Capability Overview
CT Primary Care Payment Reform Proposal
Genomic Screening for CDC Priority Conditions

Mike Murray, MD
Center of Genomic Health at Yale
Yale School of Medicine
August 3rd 2018
# 10 Leading Causes of Death in Connecticut
**(CDC statistics 2016)**

<table>
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<tr>
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<td>2. Cancer</td>
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<td>3. Accidents</td>
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<td>4. Chronic Lower Respiratory Disease</td>
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<td>699</td>
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<td>8. Septicemia</td>
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<td>9. Influenza/Pneumonia</td>
<td>572</td>
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<tr>
<td>10. Kidney Disease</td>
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[https://www.cdc.gov/nchs/pressroom/states/connecticut/connecticut.htm](https://www.cdc.gov/nchs/pressroom/states/connecticut/connecticut.htm)
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[https://www.cdc.gov/nchs/pressroom/states/connecticut/connecticut.htm](https://www.cdc.gov/nchs/pressroom/states/connecticut/connecticut.htm)
Screening in Health Care

High Blood Pressure is a silent killer because there are no obvious signs or symptoms.

High Blood Pressure
The Silent Killer
- Heart Attack
- Stroke/Dementia
- Kidney Failure
- Vision Loss

When your blood pressure is high:
- You are 4x more likely to die from a stroke
- You are 3x more likely to die from heart disease
20% of adults with high blood pressure do not know that they have it.
[https://www.cdc.gov/bloodpressure/facts.htm]
Screening in Health Care

- Newborn Screening (NBS)
  - Over 50 years old
  - Started with one condition – now over 30 conditions
  - Adopted by all 50 states, and many countries
Screening in Health Care

• What should we screen for and when should we screen for it:
  • Important health problem
  • Not otherwise apparent
  • Approach has good tools for finding it
  • Screening program has good plan for management
Screening in Health Care

- USPSTF helps set the screening agenda for primary care:
  - 2005 they made recommendations on *BRCA* screening
  - Involving detailed family history acquisition and analysis, followed by potential referral for genetic testing
Screening in Health Care

- USPSTF helps set the screening agenda for primary care:
  - 2005 they made recommendations on BRCA screening
  - Involving detailed family history acquisition and analysis, followed by potential referral for genetic testing
Analysis of BRCA Genomic Screening in 50,000 Patients

- 20% Prior Clinical Testing
- 40% No Prior Clinical Testing, Meets Criteria for Testing
- 40% No Prior Clinical Testing, Does Not Meet Criteria for Testing
TIER 1 GENOMIC APPLICATIONS

Familial Hypercholesterolemia (FH)
Hereditary Breast and Ovarian Cancer Syndrome (HBOC)
Lynch Syndrome (LS)
In 2018: Screen 10 Genes for Three Genetic Conditions

<table>
<thead>
<tr>
<th>SCREENING FOR ELEVATED RISK OF</th>
<th>Heart Attack and Stroke</th>
<th>Breast, Ovarian, Prostate, Pancreatic Cancer</th>
<th>Colon and Uterine Cancer</th>
</tr>
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<td>Hereditary Breast and Ovarian Cancer (HBOC)</td>
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<td></td>
</tr>
</tbody>
</table>

~45,000 people in the Connecticut
~4.3M people in the United States
Management of Screening Results

• There is screening and management strategies in place of these primary care problems
• There are recommendations in place for management of these conditions in the face of identification of genetic risk
Genomic Screening in CT for 3 CDC Priority Conditions

• **Programmatic Costs:** In context, total budget is expected to be < two preventive medicine visits for each participating patient:
  • Test costs
  • Central care support team costs
  • Outcomes monitoring costs
  • HIT costs
Genomic Screening in CT for 3 CDC Priority Conditions

- Why now?
- Why just 10 of 20,000 genes?
- Why CT?
## Connecticut as an Important Pilot Site for the Nation

### 2010 US Census (Race and Hispanic Origin)

<table>
<thead>
<tr>
<th></th>
<th>Connecticut</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>White alone</td>
<td>80.6%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Black or African American alone</td>
<td>11.8%</td>
<td>13.3%</td>
</tr>
<tr>
<td>American Indian &amp; Alaska Native alone</td>
<td>0.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian alone</td>
<td>4.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Other Pacific Islander alone</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>2.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>15.7%</td>
<td>17.8%</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latino</td>
<td>67.7%</td>
<td>61.3%</td>
</tr>
</tbody>
</table>

Connecticut is ~1% of the US population and a reasonable model for the other 99%
Questions

Does the evidence support including this capability in the PCM payment bundle?

→ Based on health promotion/prevention, quality and outcomes, patient experience, provider satisfaction, lower cost

Should this be a **core (universal/required)** or an **elective** capability?

Should this capability be deployed in **all practice sites**, or provided by a **subset of docs or practices** within each primary care network?
Adjourn

Thank you!

If you have additional comments or questions, please send to:
Vinayak Sinha, vsinha@freedmanhealthcare.com