Primary Care Program Advisory Committee
Meeting Minutes
3/7/2024 11:00am-12:30pm

For all meeting materials (agendas, presentations, meeting minutes, and links to meeting recordings) to date, please see the **Primary Care Redesign Meeting website**.

Agenda

- Opening remarks
- Discuss and collect feedback on the crosscutting Equity Strategy
- Recap discussions on HRSN Screening & Community Supports, propose next steps, and collect additional feedback
- Wrap up

Part 1: Equity Strategy Review

- DSS walked through the cross-cutting equity strategy components discussed with the committee thus far; presenting those associated with care delivery priorities, performance measurement, and payment model.
- **DSS Discussion Question #1:** Are there other components that should be considered as part of the program's crosscutting equity strategy?

Member comments are summarized and organized by theme/topic below.

Data Collection on Race/Ethnicity/Language/Disability

- Lessons learned about asking for RELD data from the campaign *We Ask Because We Care*: 1) the importance of educating both clinicians and community members about why we're asking for those data (e.g. why are providers collecting this data, what it is used for, how is it going to impact them); 2) patients prefer to complete questionnaires privately, and 3) competency around disability/language is critical – we need to think about unique subpopulations (e.g., refugees and recently incarcerated) and what we mean by "competencies" for specific subpopulations.
- It could be incumbent on DSS to develop trainings and equip organizations with educational materials to disseminate out. We want to speak with one voice, with a common set of messaging and supports.
- Where providers have disparities by RELD – they should be expected to use resources to address these disparities and close gaps. Do we have the right data to stratify measures? Do we have tools at our disposal to outreach and engage through CHWs? This is key to being held accountable to closing gaps.
    - E.g., Digital enablement is a gap, we need to ensure members have access to things like remote patient monitoring and self-management.

Community Health Workers

- CHWs are the boots on the ground connecting and navigating patients/families to services - they are valuable in the medical and community context. Multiple members raised the need to ensure funding is going to where the workforce is, to support CHWs.
    - *DSS shared that they are finalizing a stakeholder plan for CHW services – noting that additional information on this engagement is forthcoming.*

- It is beneficial to educate in a primary care setting, but if CHWs are appropriately trained in the social and emotional drivers of health and are working in homes with families, they are well suited to provide this education, and can be very effective with hard to reach populations.
- Members agreed that health literacy is a key responsibility of CHWs – meeting patients where they are and helping them get to follow up appointments.

Evidence-Based Practices

- This first step of collecting and analyzing the information could be strengthened. It is important at this step that practices are doing analysis to identify opportunities and inform what interventions should be pursued.
- There is a ton of work going on to address disparities (e.g. disparities in cardiovascular death rates, diabetes, asthma, etc.). Some systems are looking at follow ups on cancer screenings as effective preventive measures, and it feels like HRSN screening and CHWs can't accomplish all of this alone. We should be looking to leverage evidence-based methods to address disparities.
- Need to incorporate the latest learnings for improving member engagement and health literacy barriers – members don't fully understand why certain prevention methods are needed. We need to be careful about how prescriptive we are but should be implementing state of the art clinical practices for addressing disparities.
    - *DSS commented that the use of outcome metrics could help drive a flexible approach, with more attention to specific evidence-based practices built into learning collaboratives.*
    - *DSS encouraged members to consider whether the cross-cutting equity strategy would create the conditions for success to close the equity gap – if a practice wants to focus on hypertension control, will the equity strategy components allow them to do this? There are evidence-based models for CHWs, there are performance measures we/can should track by member characteristics, and we have a range of payment model examples we've discussed. Do these components enable practices to succeed in closing gaps?*

Accountability to Existing Standards & Alignment with Existing Models

- Language competency is a huge issue – at a recent visit only 2 of 4 essential forms were available in Spanish and no interpreter was provided. Practices need to be held accountable for existing standards before we think about new standards. We have health enhancement communities and other cross sector models that have been put forth – this existing work should be utilized, so we are not constantly reinventing the wheel.
- Agreed, need to determine how this primary care work fits into other strategies and other state models, and we cannot assume practices will be ready day one. This list of health equity strategies isn't everything but it's a great place to start – collecting the data and getting providers to focus on equity in a different way will help us understand what we can apply and grow.

Additional Equity & Accessibility Concerns

- Black and brown people in the health care field are not being treated well – need to look at that and unlearn certain behaviors. This is to ease the strain on everyone.
- Ensure we make space for black and brown agencies to participate.

- Providers need access to flexible funds to understand the level of chronic stress families are experiencing (e.g., through trauma screening). Understanding the biological implications of high levels of stress is important to furthering health equity. Need to acknowledge the role of social connection and family.
- It is critical to ensure patient choice in HSRN providers. Referral options for patients shouldn't be constricted by health system corporate partnerships – financial, Board memberships, donor partners, etc. It's easier to make arrangements/connections with familiar, large entities over smaller, independent community organizations, but it could deny patients connecting with a better-fit HSRN provider that shares their culture, language, neighborhood, etc. Those connections are essential in ensuring that people trust and use the services.

Part 2: HRSN Screening & Community Supports

- DSS provided a recap of the HRSN-related discussions from July 2023 to date, summarized key committee feedback, and presented the following possible next steps:
    - 1) Move forward with a primary care program design that enables providers to address HRSN, integrate CHWs, and partner with community providers
    - 2) Participate in broader statewide efforts underway to invest in communities (i.e. AHEAD application)
- DSS elaborated on the potential opportunities for a broader, multi-agency effort to develop community-driven strategies to improve population health via the AHEAD model, should it be applied for and awarded. Furthermore, DSS recognized that a multi-phased, multi-pronged approach will be needed to support a more comprehensive community investment approach.
- **Discussion Question #2:** As DSS moves forward with primary care program design, what program features will be most important to enable integration with broader efforts?

Member comments are summarized and organized by theme/topic below.

State Resources & Successful Models

- HRSN screening in Medicaid primary care should be contingent on the state covering HRSN services. We have an unprecedented amount of screening happening, but we are experiencing a profound lack of capacity to connect people with resources. Do we want all the providers to screen if the state is not covering HRSN services?
    - *DSS commented on the value the HRSN screening process can have in helping practitioners provide the best care they can. Understanding a member's needs supports the development of meaningful person centered care plans. Acknowledging referrals are a challenge, there may still be value in the screening as an input to the care plan.*
- We are in year 3 or 4 of the IncK model and have done a ton of work, there is nothing like it across the country, we're going into people's homes and having needs-based conversations. What needs to be done is extraordinarily costly and we don't have full buy-in regarding the cost. We need proof of working models. It takes engagement, time, and money to be in the community – let's take what we've done and do it better. There needs to be state commitment to additional investment and braided/ blended funding.
- Cultural competency training needs to be prioritized; we need the right incentives for sustainable wellness.

- We need a better understanding of what it means to address disparities and health equity from a member perspective, because not everyone is comfortable sharing their full spectrum of needs. We need to be aware that we have a small sample, not the full picture.
- CT 211 has staffing challenges and a lot of referrals and that speaks to the overwhelming need and lack of support and infrastructure. Need to think about what exists for infrastructure and what is needed. Community action agencies have been a huge support.
- HRSN screening is being linked to referring nationally. The broader question of what is done with this information and how to improve care plans has yet to be fully defined.
- We know the locations that have high use of Medicaid, it would make sense for the state to look at population health strategies that are focused in these high density Medicaid areas and reroute resources to these locations. Need to maximize the results given the limited available resources.

AHEAD Model Feedback

- There are still a lot of unknowns about how this is affecting stakeholders and how this would fit with other efforts.
- DSS should bring experienced community organizations to the table sooner rather than later to talk about what it would take to scale up the work of community action agencies and shore up other infrastructure and supports.
- One member stated they would be interested in how pediatric primary care and children's hospitals (specifically freestanding children's hospitals re global budgeting) are affected by AHEAD.
- One member highlighted AHEAD as the most radical reform in hospital payment since DRGs were introduced in the 80s and noted DSS is moving forward with the application without having consulted substantially with the hospital association.
- One member noted that there is no funding associated with addressing HRSNs in AHEAD. There is nothing in the NOFO about mobilization of community assets/resources. AHEAD is not on its face responsive to everything that has been brought up in this committee.
- There will need to be more work with partners and further investment in Medicaid. At the same time, the system as is, is broken. Not disagreeing there are serious challenges with the AHEAD model, but we can't keep doing what we're doing. We need to invest more in Medicaid and think about the reforms that need to happen.
- Substantial incremental investment and reform is needed. From an organization that is committed to serving patients regardless of the payer – we need to have confidence that the models we're pursuing are going to meet the needs. We want to know more about the intentions of the AHEAD model and how it will fill some of the gaps that we've been talking about.
    - *DSS clarified that AHEAD is not intended to be wholly responsive. There are alignment opportunities with AHEAD, it would not be the whole solution.*
    - *DSS clarified that they don't know if CT will get approval for the AHEAD model, but noted there is a lot of flexibility regarding how state Medicaid programs can participate and opportunities for multi-payer alignment – DSS highlighted that the success of the application will not be a barrier to the redesign work being done; it is an opportunity, not a dependency.*

Closing Remarks

- DSS thanked the committee for its input on care delivery structures, performance measures, payment model, and equity strategy throughout Phase 2 and reminded the committee that the next meeting on April 4th will be in-person and will be dedicated to a review of Phase 2.