Primary Care Program Advisory Committee
Meeting Minutes
10/26/2023 8am – 12:00pm

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 from the Commissioner
- Review of opportunities
- Discuss and collect feedback on three key care delivery decisions:
    - Topic 1: What are the key things that primary care should be doing differently or better to improve member health and well being?
    - Topic 2: What role should primary care practices play in addressing health related social needs?
    - Topic 3: Should the approach to defining what primary care practices need to do be prescriptive or flexible?
- Wrap up and next steps

Opening Remarks

- The Commissioner welcomed PCPAC members, reviewed the primary care program goal and thanked participants for their engagement in Phase 1 program activities, which focused on review and discussion of data and identification of opportunities for improvement.
- Members were asked to use this time to raise concerns around if the committee is going in the right direction and to begin thinking together about solutions and developing a program that supports primary care in improving member health and well-being (Phase 2 Program Design).
- The Commissioner emphasized the need to get to issues that allow the committee to make the most progress in an initial phase.

Review of Opportunities

- DSS reviewed six opportunities identified by the PCPAC and asked the committee if any key opportunities were missing. Below is a non-exhaustive list of opportunities that PCPAC members emphasized:
    - Add “prevention” to chronic condition management
    - Make it easier for providers to work with Medicaid
    - Raise mental health/behavioral health to be more prominent
    - Better define “access” and address access issues beyond Medicaid population
        - CT has an aging provider population beyond what’s normal in other states
        - Majority of BH providers do not take any insurance, huge issue
    - Prioritize standardized, reliable data by race, ethnicity, and language
- Members asked for clarification regarding the inclusion of sub-populations in this program, specifically I/DD and dually eligible individuals.
    - DSS stated the inclusion of these sub-populations is an open policy question.

- DSS acknowledged challenges that go beyond the scope of Medicaid to address and stated that these issues will need to be taken to another forum to decide how to handle them.

Topic 1: What are the key things that primary care should be doing differently or better to improve member health and well being?

- DSS reviewed ten key primary care capability domains with examples and asked members to discuss which domains should be prioritized. Below is a summary of considerations raised by members:
    - There are existing models that integrate multiple primary care domains that could be built upon (e.g., population care management model pilot, integrated data systems with Unite Us, integrating with SDOH data in schools, data from DCYF).
        - Groups with long standing PCMH status have been doing a lot of this
        - FQHCs cover many of these domains and aren't paid for it (e.g., hiring CHWs, and the like)
    - Core issues are 1) management and prevention of chronic disease 2) collection of race, ethnicity data 3) care coordination in community based organizations. Could think about which primary care capabilities would support these issues most.
    - Smaller programs with limited opportunities pose a challenge for practices with multiple demands. Need to think about a threshold to surpass that is substantial enough to have provider buy-in.
    - Strategies and outcomes should have a frame around the disability community.
    - **Discussion of Priority Domains**
        - Data - Providers are not seeing Medicaid data – need to start here.
        - Accessibility - In the next 10 years, PCPs are going to be even harder to find. Need to focus on this.
        - HSRNs - FQHCs are already working really hard to address HRSNs but are having trouble gaining patient trust.
            - Other practices don't have this additional funding like FQHCs to address these issues - need to discuss graded/blended funding to address this.
            - DSS agreed on the need for multi-payer alignment acknowledging Medicaid and CHIP members have unique needs but there is opportunity for alignment.
        - Chronic Conditions - Could start slow and gradually build on program goals - A1c and hypertension control are entirely aligned with the disparities we're seeing – looking at cardiovascular outcomes, poor outcomes are hitting black communities at far greater rates.
            - Addressing chronic conditions is a good starting point as this would require data, care coordination and other components, but need to think about how these innovations/strategies can help the whole population – not stop at chronic conditions.

- After member discussion on priority capabilities, DSS asked members to rank the 10 domains in order of importance to improve member health and well-being. Results of the survey showed the following top 5 domains:
    - Chronic Condition Management
    - Accessibility
    - HRSN
    - Data Infrastructure
    - Team Based Care

Topic 2: What role should primary care practices play in addressing health related social needs?

- DSS shared options and examples regarding how PCPs can play a role in addressing HSRN, ranging from having no role (option 1), some role (option 2), to having full responsibility (option 3). DSS also shared detailed examples on HRSN care delivery requirements for established state and federal programs.
- The Topic 2 question was then presented to the PCPAC members for discussion. Below is a non-exhaustive summary of key considerations raised regarding the role PCPs should play in addressing HSRN:
    - Ideal state: HSRN services available, accessible, and can support the need
    - 100% in support of screen, refer, and close the loop
    - Most common refrain: providers don't have resources to deliver HRSN services or appropriately refer
    - The linkage is what is most challenging for practices due to resource limitations – screen and refer is more successful, but the linkage isn't happening. There are people in the community that can do this very well.
    - Need to think about what we are requiring providers to do in a short 15 minute appointment.
    - Referral system – providers of color who are most likely to provide care with cultural competency are not in the referral database. Can DSS provide a platform for those entities to opt into?
    - Employing, training, recruiting purposefully - very important for providers to look like those who they are providing services for, to gain patient trust and improve data integrity.
    - CHWs have proven successful and need additional support.
    - DSS can't do it all/ take the blame – also need community-based supports.
    - Providers have been thinking about food insecurity specifically – housing is the most challenging to address but is most impactful in addressing patient issues.
    - **Data collection**
        - EHR and claims based measures are not complete (e.g., no indicator for a negative screen).
        - How do we expand the data infrastructure so community-based orgs have access to data to fully close the loop (e.g., establish linkage between housing authority and EHRs so someone exiting the ED with homelessness can get support).
        - Patients may not be giving true information out of fear of how it will be used.

- **Considerations for small practices**
  - Need to be realistic about what we're requiring of providers.
  - Many already struggling due to resource limitations.
  - Organizational and practice capacity readiness is required to implement the strategy – need instruments to assess readiness and have a team that can address gaps.
  - How integration is defined is important – small practices will need flexibility to do this in an efficient way (e.g., virtual or shared services) - there are not enough resources to put BH providers in every practice.
- **Integrated systems beyond DSS**
  - Thinking about all the assets that we have across the state – health systems and community orgs – a partnership model beyond primary care is needed to build capacity. Need to be conscious of duplication and co-develop the solutions.
  - Would 211, UniteUs or CHNCT help increase the confidence that linkage will happen, even with the smallest providers?
    - There are limitations to the UniteUs in terms of who can integrate due to provider capacity; the timeline is difficult (might take a couple days to know about availability of a service).
    - 211 is already above capacity.
  - Regional collaboratives – can we develop a funding solution that enables local/ community-based actors?

- After member discussion on HSRN responsibilities, DSS asked members to fill out a survey indicating the level of primary care practice involvement in addressing HSRNs. Results of the survey showed:
  - Over 80% of respondents chose Option 2: Primary care practices are expected to perform certain functions related to screening, referral, and/or coordination.
  - Remaining respondents chose Option 3: Primary care practices are expected to deliver select HRSN services.

Topic 3: Should the approach to defining what primary care practices need to do be prescriptive or flexible?

- DSS presented options and examples regarding how primary care delivery requirements can be more prescriptive vs more flexible. DSS also shared detailed examples on care delivery requirements and accountability structures for established state and federal programs.
- The committee revisited the results of the primary care capabilities survey (topic 1) and PCPAC members were asked to discuss preferences for prescriptive vs flexible requirements with respect to the top 5 capabilities. Below is a summary of key considerations raised:
  - **Principles for adopting prescription vs flexibility:**
    - Can be prescriptive about outcomes but endorse flexibility in the process - allow practices to achieve goals in the manner they think is best.
    - Hold providers accountable to the function; but be less prescriptive about the process (e.g., PCMH is very prescriptive about how to accomplish the

function – don't want to re-create that model; don't want to create barriers to entry; think about things that are applicable across payers)
        - Want to create a model that suits as many providers/practices as possible and avoid creating a single process just for Medicaid patients, rather utilize existing processes/requirements.
        - Want to think about the implementation (education and tools to support) and timeline for practices – smaller practices may need more time.
        - We don't want to put more restrictions on providers that will further limit access.
        - Want to pay for outcomes when we can measure them (when we have good, validated measures); when we can't do that, we may need prescription.
    - **Chronic Condition Management (Capability #1)**
        - Continuum of process to outcomes – sometimes we need to stick with process because we can't measure outcomes – depends on the provider and the condition (e.g., diabetes can be outcomes based at this point using A1c; some others are harder); want to think about a glide path for practices with varying capabilities.
        - Healthy food access - what can social services, hospitals, PCPs do to help people fill those prescriptions? Need requirements for retailers to make themselves more accessible in food deserts and swamps.
    - **Accessibility (Capability #2)**
        - Need to define accessibility goals more specifically to define the practice capabilities.
        - Can look at the clinical outcomes and process measures (a practice might have to develop a mechanism for connecting to social services - what it is could be practice defined).
        - Want to understand what is preventing people from getting to primary care visits and who is going to the ED - focus on those people.
        - 2006 BH accessibility example - established an enhanced care clinic that had to ensure access within 2 weeks (or 2 days for an urgent condition). Access got to better than 90% for every clinic in 6 months – with a different access status and pay differential.
            - Could measure time to appointment and empanelment - if this is a multi-year program, providers can be rewarded based on the number of patients they take on (i.e., a measure for newly empaneled patients).
        - Need to consider larger community needs with respect to accessibility and come up with a wholistic representative measures that gets us to our expected outcomes. Need to be more community based than medically based.
    - **HRSN (Capability #3)**
        - Need to be somewhat prescriptive – have screening and demonstrate integration through linkage to community supports.
        - Practices don't have the same capability by size or by staff to take this on.
    - **Data Infrastructure and Data Sharing (Capability #4)**

        - Likely need a base requirement – some components need to be very prescriptive to ensure data reporting is functional.
    - **Team Based Care (Capability #5)**
        - How a team is organized could be a place where practices have latitude and innovations can arise.
    - **SDOH** might not be in the wheelhouse of primary care – but primary care needs to be an enabler; root cause upstream Medicaid planning could include this.
        - SDOH is a state/federal responsibility – need to promote a collaborative state forum to address these issues. It's important for this process to include the other groups that are addressing BH, SDOH, etc.
        - Need to better integrate both funding and agencies.
        - Some agencies with successful programs during COVID lost their funding – we should look back at those programs and see if there are opportunities (e.g., meals on wheels is available in some areas but not all; ask orgs that were providing transport about medication delivery).

Wrap Up

DSS concluded the meeting by highlighting a few key themes from the discussion, including:

- Review of Opportunities
    - Identified a need to develop a robust definition for access and noted access-related challenges regarding health workforce.
    - Discussed how best to uplift behavioral health in the context of our six key opportunities.
    - Need to pay more attention to data and be mindful of the associated administrative burden on practices.
    - Discussed keeping subpopulations in mind when analyzing strategies, specifically dually eligible and intellectually and developmentally disabled individuals.
- Topics 1 & 2: 10 Capabilities & HSRN
    - Are we thinking about the idealistic or realistic? We landed in the middle.
    - Need to circulate data to DSS and providers for targeted outreach.
    - How do we approach functions and capabilities? Specific vs general.
    - Found a lot of consensus regarding an approach to HSRN (largely Option 2 – some PCP functions/responsibility).
    - Discussed HSRN access regarding linkage capability and linkage accountability.
- Topic 3: Prescription vs Flexibility
    - Generally landed on the idea that prescription vs flexibility will vary by capability.
        - There is some role for prescriptiveness but we largely want to focus on outcome and allow flexibility for practices to achieve outcomes as they see best.
        - Also discussed phasing requirements to meet practices where they are.
    - Need to understand and utilize existing strengths (i.e., what is happening now and how can we build on those pieces).
    - Identified the need for a separate conversation with respect to SDOH – there are drivers that are causing these issues, and primary care has an opportunity to partner and support.

Next Steps

- Share survey results and notes
- Draft a definition of accessibility for committee input
- Provide meeting materials with more advance notice to ensure that PCPAC members have ample time for review