**Primary Care Program Advisory Committee**
Meeting Minutes
12/07/2023 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**.

**Meeting Goals**

- To continue building off the progress of the October 26th meeting, the key goals for this meeting are to review and collect directional feedback on the goals, examples, and approach to using measures and/or requirements for each of the remaining priority primary care capability domains:
    - Team Based Care
    - Health Related Social Needs Screening & Community Supports
- For both domains, DSS leaned on OHS core team functions to create draft goals and ideal state definitions.
- DSS noted that today's conversation should focus on the expectations of primary care practices. There will be future discussions regarding DSS' role to support primary care and provider practices in developing the infrastructure, payment, and incentive structures needed to support the proposed practice capabilities.
- In response to a question about the primary care program design timeline, DSS indicated that they anticipate extending the timeline to prioritize in-depth stakeholder discussions. Program design will consist of an iterative design phase, followed by a more technical design phase.
- In response to a question about stakeholder engagement, DSS described the current process of updating the advisory committee, the MAPOC Care Management Committee, and an FQHC subcommittee. As suggested by a committee member, DSS is open to publishing program details to solicit feedback from other stakeholders. However, the process for doing so should be informed by the program design that this group proposes and revisited for later discussion.

**Team Based Care**

- Domain Goal: Enhance team-based care with a focus on improving the care experience and providing care coordination driven by person centered goals and needs.
    - *Care Management Flexibility:* Some members raised questions around the phrase "embedded non-clinical care coordination personnel", noting that embedded care management may pose challenges for smaller practices or practices with multiple office sites.
        - Alternatively, members suggested promoting central care management, in which care coordinators act as central resources for care teams.
        - DSS agreed that there should be flexibility in how practices provide and operationalize care management.
    - *Care Team Definition:* One member proposed being more explicit about the inclusion of behavioral health and specialty care integration – highlighting that

primary care requires robust accountability and integration with specialists in order to effectively manage chronic conditions. Another member suggested that the care team description be expanded to acknowledge the full range of participating clinicians.

- Committee members provided the following feedback on example measures and requirements:
    - *The proposed requirements may be cost-prohibitive for small practices.* Two members noted that while the outcome measures are consistent with team based care, the example requirements may be expensive to implement. As such, the reimbursement model should consider infrastructure support for small practices.
    - *DSS should require disability training*. Members also emphasized the importance of requiring both cultural competency and ADA (or other disability-related) trainings as part of the domain's equity strategy.
    - *DSS should consider and prioritize the patient experience for this domain.* Members expressed:
        - Patients should have the ability to select their care managers, and patients should have access to multi-lingual care managers.
        - In addition to the patient experience questions proposed, DSS should consider other patient experience questions, such as whether patients believe they are receiving valuable quality of care or whether patients feel that their health is improving.
        - DSS should measure the average wait time for patients to make an appointment with their primary care provider.
            - DSS responded that it is very challenging to collect data on appointment wait times; however, DSS could use other proxy measures to incentivize better timely access to care.
    - *Outcome measures should be transparent, reliable, and reasonable.* Members cautioned against the use of proprietary measures (e.g., Avoidable Hospitalization by 3M). DSS should also ensure that response rates for CAHPS measures are reliable and appropriate for use. Lastly, non-health measures, such as measures related to housing or food security, are not appropriate for primary care practices to be responsible for. These types of measures correspond to larger systematic issues beyond healthcare systems.
    - *DSS should create a team based care survey for this group to prioritize team based care elements*, such as behavioral health or pharmacy. The survey could provide DSS with a better sense of what investments practices should make to achieve program goals. It would also help DSS prioritize resource allocation accordingly, rather than incentivize investments that may not be necessary within specific practices.
    - *One member highlighted the value and utility of selecting outcome and preventative care measures that can be utilized across multiple domains*. For example, improved care delivery via better access to care and team based care should reduce avoidable Emergency Department/Hospital utilization.

**Health Related Social Needs (HRSN) Screening & Community Supports**

- Domain Goal: Acknowledge the role that social determinants of health play in member health and well-being and better identify and address health related social needs.
    - A few members expressed that while practice teams can identify social risk factors, practices often face challenges with connecting patients to resources. Another member recommended against provider accountability for connecting patients to resources because various factors impact whether the patient's HRSN is fulfilled (e.g., providers can refer patients to resources, but their referral may go unanswered).
    - One member recommended revising the goal statement to reflect this group's majority preference for practices to adopt a screen and refer approach to address HRSNs. Recommended language: screen patients for social factors; maintain a directory of community resources; facilitated a referral that enables a closed loop.
        - DSS initially aligned this goal with OHS' recommendation; however, this may be an opportunity to edit and move past their recommendation.
    - DSS also acknowledged that the department is currently engaged in separate, ongoing discussions about Medicaid's role in addressing HRSNs. Depending on those conversations, there may be opportunities for DSS to build community capacity, which would enhance the benefits of the screen and refer approach.
        - One member commented that they would like DSS to use Medicaid resources to address a pipeline of social determinants of health (SDOH) issues that patients typically present with.
- One member asked about DSS' willingness to design a program with various tracks that can accommodate different levels of readiness and capabilities among primary care practices (e.g., Making Care Primary). This would prevent setting a low bar of program expectations based on the need to ensure small practices can meet program requirements.
    - DSS acknowledged that designing a program with practice tracks is on their radar, but further stakeholder discussions are needed before making this decision.
    - One member cautioned against use of tracks out of concern that tracks may create unequal quality of care and practice standards for Medicaid members.
- Committee members provided the following feedback on example measures and requirements:
    - *DSS should incorporate process measures for this domain*. Several members favored process measures and survey questions for this domain. They explained that addressing HRSN/SDOH requires long time horizons to achieve noticeable change, and DSS should focus on the HRSN process and core capabilities of practices since this work is newer.
    - *DSS should focus on evidence-based HRSN strategies.* During the State Innovation Models (SIM) initiative, DSS explored care delivery strategies that practices could implement. For example, one successful strategy linked children to home based care to remove asthma triggers. Similarly, DSS should prioritize evidence-based

HRSN strategies that drive positive health outcomes and fulfill HRSNs relatively quickly.

- *Practices should connect patients to existing community resources.* One member recommended starting this work by building more community connections and utilizing existing resources that patients may not know about. We shouldn't assume patients know of all available community resources or supports.
- *DSS should outline patient protections regarding the collection and use of patients' HRSN information.* Patients may be reluctant to share their personal information due to concerns over who is collecting the information and how it may be used. Recommendations to mitigate against these concerns include:
    - Require staff training to ensure that patients are asked about their HRSN(s) with respect and cultural humility.
    - Recommend the use of community health workers to collect this information.
    - Clearly outline how HRSN information should be used to the practice and to the patients.
    - DSS agreed and acknowledged that more discussion and consideration regarding these concerns should take place in the future.
- One member requested clarification of the example requirement "Partner with social service providers".
    - In the RI Medicaid example, practices are expected to identify at least one social service provider to partner with and pass through 10% of incentive funding.

**Next Steps**

- The next PCPAC meeting is scheduled for January 18th. The meeting will be held in-person/hybrid.