Primary Care Program Advisory Committee

December 7, 2023

Agenda

Topic	Timing
Opening Remarks and Welcome	5 Minutes
Recap and Goals for Today	10 Minutes
Topic 1: Team Based Care	30 Minutes
Topic 2: Health Related Social Needs Screening & Community Supports	30 Minutes
Next Steps	15 Minutes

Quick Recap and Process Overview

During the October 26th meeting we got valuable feedback from the committee on things primary care should be doing differently or better to improve member health and well being – and discussed whether DSS should be more prescriptive or flexible in defining what primary care should be doing.

Last Meeting: We discussed goals, measures and requirements for three priority domains:

- Accessibility of Care
- Chronic Condition & Targeted Care Management
- Data Infrastructure & Data Sharing

Reminder: Oct 26th Primary Care Capabilities Survey Results

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

Please rank the below domains in order of importance (#1 being the most important)

Chronic Condition & Targeted Care Management
Accessibility of Care
HRSN Screening & Community Supports
Data Infrastructure and Data Sharing
Team Based Care
Behavioral Health Integration
Cultural Competency
Specialty Care Integration
Acute Care Coordination & Follow-Up
Patient and Caregiver Engagement

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Reminder: Key Feedback from Oct 26th Committee Discussion

- Ideally, we would **be prescriptive about outcomes**, and **flexible about how** practices achieve those outcomes
- **When reliable outcome measures are available, we can be more flexible**; when they are not, we may need to rely on priority process measures or requirements
- The level of prescription vs. flexibility we want will likely **vary by domain**
- There is a lot of variation amongst practices in terms of starting point – consider how the program structure will **give providers the flexibility and the time** to build out targeted capabilities
- The capabilities practices are developing should be **applicable across payers**
- We should avoid creating Medicaid specific processes and **use existing processes and requirements** where possible
- We need to be **careful not to create barriers to access** by putting more restrictions on providers
- We also need to consider what **implementation supports** practices will need

Goals for Today

Review a starting point and collect directional feedback from the committee on the remaining priority capability domains:

- Team Based Care
- Health Related Social Needs Screening & Community Supports

For each domain, we will:

- Ground ourselves in the **goals**
- Review **example measures and requirements** we could use to hold primary care practices accountable to achieving these goals – and think about how to embed an **equity strategy**

Then we will discuss:

- Are these the right goals?
- Are there other measures, requirements, or equity strategies that we should consider?
- For this domain, can we rely primarily on measures? Are there any requirements that are particularly important?

Purpose of Today's Discussion

From today's discussion we hope to get:

- **Directional feedback** on the goals, examples, and approach to using measures and/or requirements in each domain

It is important to note that we are:

- **NOT** deciding on a final set of measures or requirements – these examples are intended to bring more specificity to the discussion and give committee members something to react to
- **NOT** suggesting that we would use ALL of these measures or requirements – acknowledging that we need to be thoughtful about how many measures and/or requirements we include overall
- **NOT** finishing this work today – this discussion will give us a starting point that we will return to in subsequent discussions

Today's discussion will be focused on expectations of primary care practices.
We will have more discussion about the role DSS can play in developing the infrastructure, payment, and incentive structure to support these capabilities in future meetings.

Team Based Care

Goal

Enhance team-based care with a focus on improving the care experience and providing care coordination driven by person centered goals and needs.

Ideal State

- Care delivery is team-based, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials. (OHS)
- The practice team includes a) qualified, embedded clinical care management personnel to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) embedded non-clinical care coordination personnel to connect all patients with community supports to address social risk factors, and work with families and other caregivers. (OHS)

Team Based Care: Example Measures and Requirements

Example Measures (Program, Steward)	
Process	

Outcome	*Hospitalization*
	❑ Plan All-cause Readmission (OHS, NCQA)
	❑ Avoidable ED (PCMH+, 3M; RI Medicaid, NYU/JHU Algorithm)
	❑ Avoidable Hospitalization (PCMH+, 3M); Hospitalization for Potentially Preventable Complications (Medicare, NCQA)
	
	Member Experience
	❑ PCMH CAHPS Survey (OHS, CAHPS)
	  ❑ *In the last 6 months, how often did [your provider] seem informed and up-to-date about the care you got from specialists?*
	  ❑ *In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?*
	❑ PCPCM Survey (PCMH+, PCPCM/ABFM)
	  ❑ *My practice coordinates the care I get from multiple places*
	  ❑ *The care I get in this practice is informed by knowledge of my community*

Equity Strategy	❑ Segment measures by REL and IDD demographic information to measure disparities

Example Requirements (Program)
Employ a care coordinator or other team-based staff role ❑ Employ a full-time care coordinator dedicated to care coordination activities, assign care coordination activities to multiple staff within a practice, or contract with an external agency to work with the practice to provide care coordination. (PCMH+) ❑ Maintain at least one team-based staff role dedicated to the specific primary care site - i.e., CHW, Peer, Social worker, Nurse case manager (MassHealth) *Integrate community health workers (CHWs)* ❑ Expand role of CHWs and support full integration of interdisciplinary teams. (PCMH+) ❑ Offer community-based CHW services directly or through partnerships (Maine PCPlus) ❑ Utilize CHW or equivalent professional with shared lived experience to deliver services to higher need patients (Making Care Primary)
❑ Cultural competency and/or ADA training for care team members

For Discussion – Team Based Care

- Are these the right goals?
- Are there other measures, requirements, or equity strategies that we should consider?
- For this domain, can we rely primarily on measures? Are there any requirements that are particularly important?

HRSN Screening & Community Supports

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.

Ideal State

The practice team identifies social risk factors affecting its patients and is knowledgeable about community resources that can address social needs (OHS).

HSRN & Community Supports: Example Measures and Requirements

	Example Measures (Program, Steward)	**Example Requirements** (Program)
Process	❑ Social Determinants of Health Screening (OHS/MassHealth/RI Medicaid/CPC+/Primary Care First/Making Care Primary*) **This measure has been used in many programs, and is typically defined/stewarded by the state/program*	*Use SDOH data to implement interventions and prioritize needed community resources* ❑ Monitor social determinants of health at the population level and implement care interventions based on these data (PCMH) ❑ Use information on the population served to identify and prioritize needed community resources (e.g., food banks, support groups) (PCMH) *Maintain an inventory of community supports and refer, coordinate or partner with social service providers* ❑ Maintain an inventory of services and supports in the community (CPC+, Primary Care First, MassHealth) ❑ Develop and implement referral and/or coordination workflows (Making Care Primary, MassHealth) ❑ Partner with social service providers (CPC+, Making Care Primary, RI Medicaid) *Integrate community health workers (CHWs)* ❑ Specific program examples included in the Team Based Care domain
Outcome	*Hospitalization* ❑ Plan All-cause Readmission (OHS, NCQA) ❑ Avoidable ED (PCMH+, 3M; RI Medicaid, NYU/JHU Algorithm) ❑ Avoidable Hospitalization (PCMH+, 3M); Hospitalization for Potentially Preventable Complications (Medicare, NCQA)	
Equity Strategy	❑ Segment measures by REL and IDD demographic information to measure disparities	❑ Report on identified needs by REL and IDD demographic information to measure disparities

For Discussion – HRSN Screening & Community Supports

- Are these the right goals?
- Are there other measures, requirements, or equity strategies that we should consider?
- For this domain, can we rely primarily on measures? Are there any requirements that are particularly important?

Reminder: The Essential Questions of Program Design

Care Delivery

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

Performance Measurement

What is the definition of success? How should this be measured?

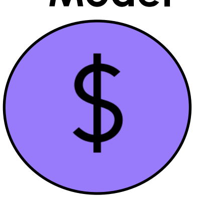
Payment Model

How is primary care paid and incentivized for doing things that improve member health and well being?

Cross Cutting Equity Strategy: How do we reduce inequities and racial disparities?

Primary Care Program Design Status

We've established a starting point for care delivery and performance measurement in our recent discussions – next, we will discuss payment model options to support these priorities.

Care Delivery	*What are the key things that primary care should be doing differently or better to improve member health and well being?*	Chronic Condition & Targeted Care Management · Accessibility of Care · HRSN Screening & Community Supports · Data Infrastructure & Data Sharing · Team Based Care
Performance Measurement	*What is the definition of success? How should this be measured?*	Each domain is associated with a definition of success – and select measures and requirements that will be used to drive progress towards success.
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	***Next Step:*** *Review and discuss payment model options*

Cross Cutting Equity Strategy: *How do we reduce inequities and racial disparities?*

Care Delivery Priorities

As we review and discuss payment model options, we will be thinking about how primary care is paid and incentivized to accomplish these care delivery priorities.

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in management of chronic conditions. Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.	Care is easily accessible and prompt, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally and linguistically competent.	The practice team identifies social risk factors affecting its patients and is knowledgeable about community resources that can address social needs.*	The practice team utilizes patient information in conjunction with data from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform targeted quality and equity improvement activity, including design and implementation of quality improvement plans.	Care delivery is team-based, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.*

**Definition of success to be refined based on today's discussion*

Next Steps

		Primary Care Program Advisory Committee Meeting Topics
Phase 1	April 6	Background & Introductions
	May 4	Primary Care Goals and Strategies
	June 1	Scope of Primary Care Design and Prior Work
	July 13	Listening Session: Strategies for Addressing Community Needs
	August 3	Review of Primary Care Program Examples and Discussion of Supplementary Data
	August 24	Supplementary Data Review Meeting
Phase 2	October 5	Process Check In and Review of Program Examples
	October 26	In Person Meeting: Care Delivery Redesign
	November 14	Primary Care Capabilities and Measurement
	December 7	Primary Care Capabilities and Measurement
	January 18	In Person Meeting: Payment Model
	February 1	Equity Strategy Review *(cross-cutting elements to be discussed within each topic area)*
	March 7	Program Structure Review

Note: Topic areas are subject to change; this schedule will be adapted as needed