Primary Care Program Advisory Committee

Meeting 7

October 26, 2023

Agenda

Topic	Time
Meet & Greet	8:00-8:15
Opening Remarks – The Need for Reform and Opportunities Ahead	8:15-8:45
Process and Goals for Today's Meeting	8:45-9:00
Topic 1: Primary Care Capabilities	9:00-9:50
Break	9:50-10:00
Topic 2: Health Related Social Needs	10:00-10:50
Break	10:50-11:00
Topic 3: Primary Care Requirements and Accountability	11:00-11:50
Closing Remarks	11:50-12:00

Reminder: Primary Care Program Design Goals

Primary Care Program Goal

Primary care program design is being conducted with the overarching goal to:

Improve the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members and in a way that reduces inequities and racial disparities.

While primary care is not the whole solution, it is a foundational piece of a high-functioning health care system that is oriented towards improving member health and well-being.

This Committee's Charge

This committee is charged with engaging critically to help DSS develop a primary care program that promotes health equity and improves the health and well-being of members.

- We appreciate your engagement in Phase 1 of this process – our review and discussion of data and identification of opportunities for improvement will lay the groundwork for primary care program design
- As we transition to program design, we will be thinking together about solutions and developing a program that supports primary care in improving member health and well-being

We hope to leave today's meeting with the following recommendations

Your feedback on these three key care delivery decisions:

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

B. What role should primary care practices play in addressing health related social needs?

C. Should the approach to defining what primary care practices need to do be prescriptive or flexible?

What we will have by the end of the meeting:

1. A list of the top things that we want primary care to be doing differently or better to improve member health and well being
2. The committee's preferences on a spectrum of options around the role primary care will play in addressing health related social needs
3. The committee's preferences on a spectrum of options around the level of prescription vs. flexibility in care delivery

Opportunities for Improvement

1. **Address disparities** in quality of care and member outcomes.

2. **Ensure members have easy and timely access to care** and address the range of barriers that make it challenging for members to access care.

3. Acknowledge the role that social determinants of health play in member health and well-being and **better identify and address health related social needs.**

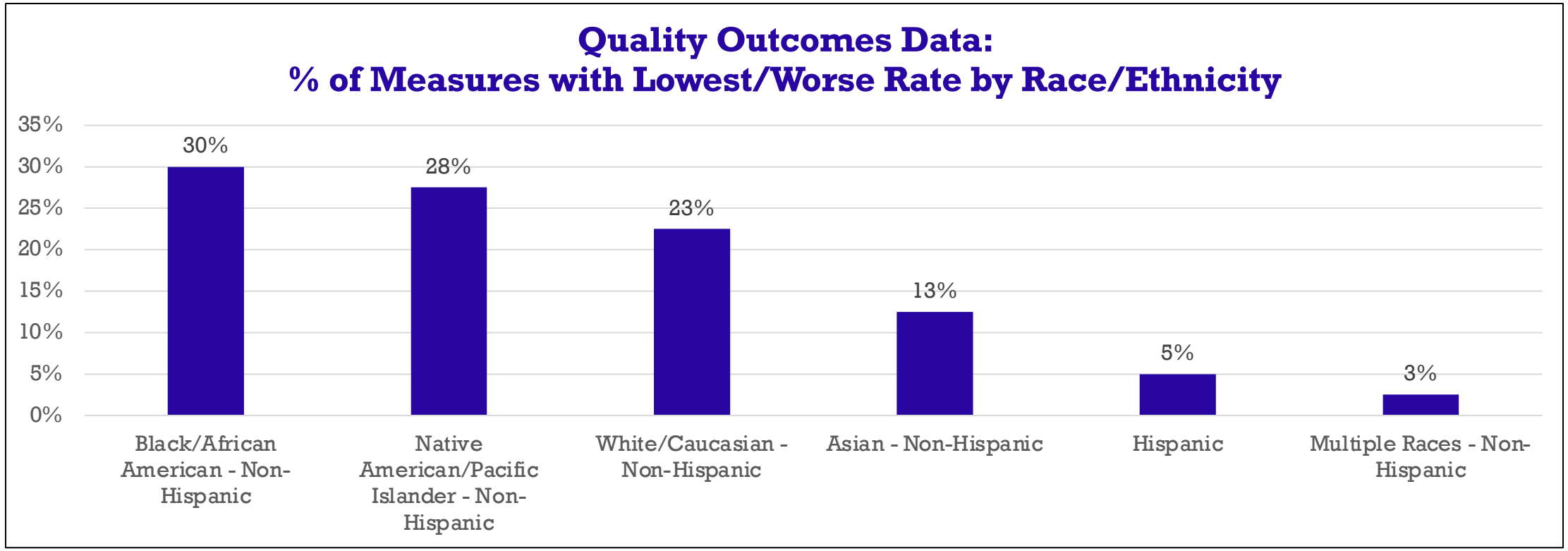
4. **Enhance care coordination and team-based care** with a focus on integrating community health workers.

5. **Improve chronic conditions management** with a focus on reducing unnecessary inpatient and ED utilization.

6. **Invest more in primary care as a percent of total spend** with the intent to increase preventive care spending and decrease acute care spending.

Opportunity 1: Address disparities in quality of care and member outcomes.

Out of 40 total measures, Black/African American HUSKY members and Native American/Pacific Islander HUSKY members have the highest share of quality measures with the lowest or worse rate.



Source: CHNCT, Inc. – MY 2021 Summary of Health Measures by Race/Ethnicity (excluding Unknown)

Opportunity 2: Ensure members have easy and timely access to care and address the range of barriers that make it challenging for members to access care.

Access data demonstrates the importance of both maintaining – and improving – easy and timely access to care.

- **93% of HUSKY members are within 15 miles of a** HUSKY Health PCP or Pediatrician with an **open panel** (vs. limited or closed).

- **~80% of members surveyed reported that they *usually or always get routine care quickly.***

DSS Primary Care Assessment Focus Group Findings

"I really like telehealth, it's a great addition. Sometimes I don't need to go to the office, I can just do a quick, last minute telehealth call." (Member)

Major barriers *that impact the equitable delivery of care and member health outcomes:*

- access to transportation
- translation supports
- technology enabled care
- behavioral health access
- extended care hours
- disability access
- cultural competency
- workforce diversity

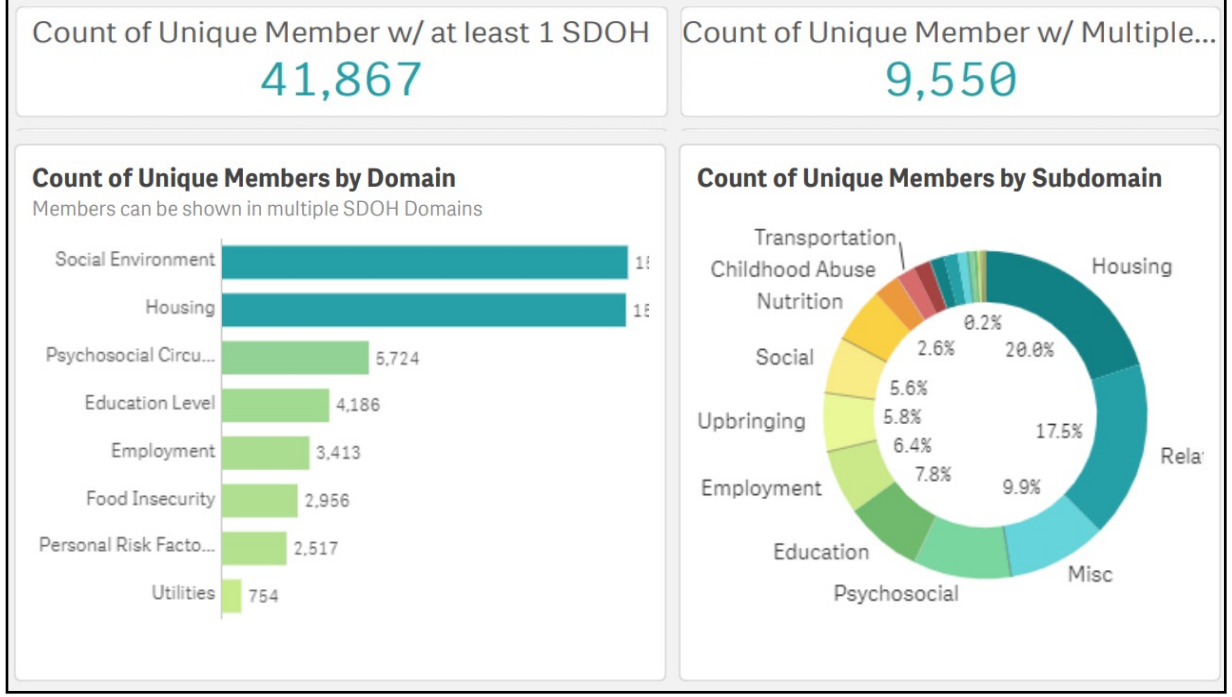
Source: CHNCT, Inc., Gap and Network Adequacy Analysis, July 2023
CAHPS, 2022 Summary Rates, Q6 (Getting routine care)

Source: DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 3: Acknowledge the role the social determinants of health play in member health and well-being and better identify and address health related social needs.

In a **non-random sample** of members in 2022 there were 41,867 unique members with at least one SDOH need. The top three domains were:

1. **Social Environment** – 38%
2. **Housing** – 37%
3. **Psychosocial Circumstances** – 14%



Source: CHNCT, Inc. SDOH Dashboard (Member Level); sources include claims and CHNCT, Inc. staff interactions with members

DSS Primary Care Assessment Focus Group Findings

"If you need insulin to manage your diabetes, and you don't have a refrigerator to keep your insulin cold, that's a huge barrier - but it's hard for me to fix that." (Provider)

"We do an SDOH screening and have a resource list to hand to patients, but we need more resources - the social work connection is really challenging." (Provider)

Source: DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 4: Enhance care coordination and team-based care with a focus on integrating community health workers.

Feedback from this committee during the July listening session, and during last year's focus groups, emphasized the importance of integrating community health workers to provide effective care coordination.

Primary Care Advisory Committee July Listening Session - SDOH/HRSN Screening, Referral, and Outreach

- **Build capacity of CHWs and CBOs:** Given the large volume of HUSKY members with HRSN, there is a critical need and opportunity to expand use, access, and capacity of community health workers (CHWs) and community-based organizations (CBOs).
- **Increase community representation:** CHWs should have community-based connections and be representative of the HUSKY population served. Effective care coordination and case management requires developing trusting relationships.
- **Integrate CHWs into care teams:** CHWs are more likely to be trusted messengers than healthcare providers and staff. CHWs should partner with primary care providers to help HUSKY members navigate their care and benefits.

DSS Primary Care Assessment Focus Group Findings

"Care coordination is a huge need, especially in this population. Members have trouble navigating the system, and that falls on office staff." (Provider)

"We need to connect community health workers to primary care doctors – they can support patients with questions, figure out what insurance covers, and help find specialists." (Advocate)

Sources: Primary Care Program Advisory Committee Meeting 5 Materials, August 3, 2023
DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 5: Improve chronic conditions management with a focus on reducing inpatient and ED utilization.

Top Chronic Conditions

1. Behavioral Health
2. Hypertension
3. Asthma
4. Diabetes

HUSKY **members with chronic conditions utilize ED and Inpatient care substantially more often** than HUSKY members overall.

- ED utilization = 2x overall rate
- Inpatient utilization = 2.7x overall rate

Acute Care Utilization – Members with Chronic Conditions, 2022

Condition	Condition Member Count	ED Visit Count**	ED Visit Rate / 1000 Members	Inpatient Visit Count***	Inpatient Rate / 1000 Members
Asthma	105,703	148,387	1,404	18,580	176
Behavioral Health	325,577	334,798	1,028	51,007	157
Cancer - Breast - Female	2,764	2,166	784	574	208
Cancer - Colon	1,140	1,321	1,159	711	624
Cancer - Prostate	914	811	887	228	249
Cancer Other	8,965	9,453	1,054	4,588	512
Chronic Heart Failure (CHF)	9,636	15,665	1,626	8,644	897
COPD	14,695	25,927	1,764	8,695	592
Coronary Artery Disease (CAD)	14,511	23,981	1,653	8,994	620
Diabetes	52,714	60,285	1,144	15,120	287
HIV	3,582	4,894	1,366	1,140	318
Hypertension	106,342	125,477	1,180	28,957	272
Sickle Cell	1,914	2,591	1,354	801	418
Total	**648,457**	**755,756**	**1,165**	**148,039**	**228**
HUSKY Members Overall			**590**		**86**
Comparison - HUSKY Members Overall vs. Members with Chronic Conditions			**2.0**		**2.7**

**Limited Benefit Excluded and Data based on the CY2022 QM Evaluations Condition Report*

***ED Visits counts captured from Care Analyzer. ED visits include all visits regardless of primary diagnosis.*

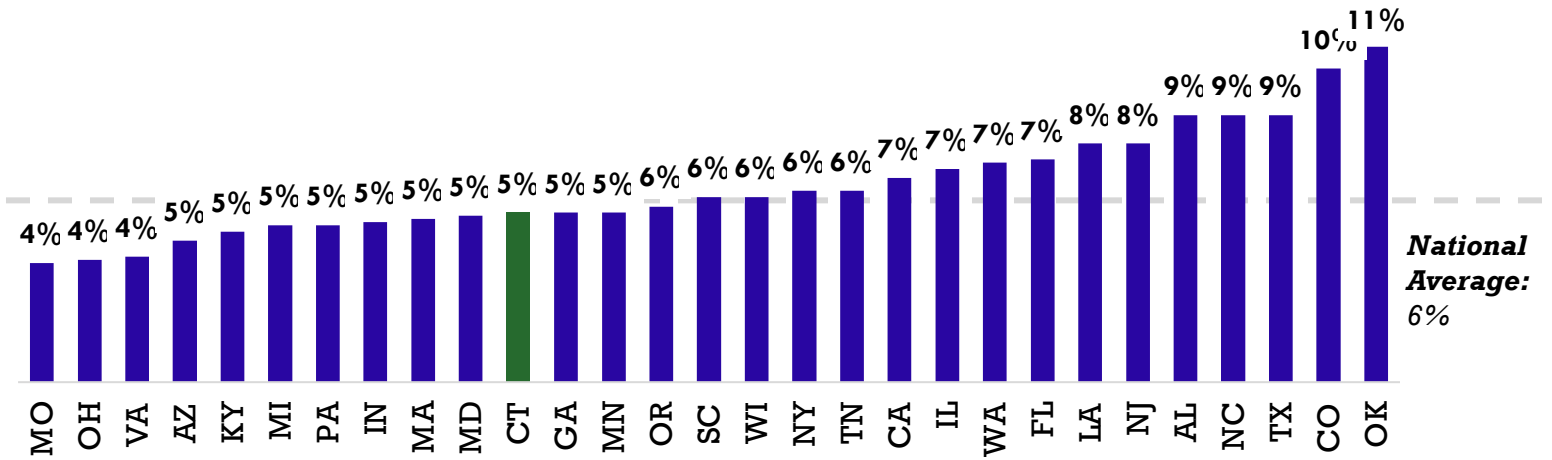
****Inpatient visit counts captured from CY 2022 Readmission Report with 5 months run out. Inpatient visits include all visits*

Source: CHNCT, Inc., PCPAC Additional Data – Chronic Conditions (CY2022 QM Evaluations Condition Report)

Opportunity 6: Invest more in primary care as a percent of total spend with the intent to increase preventive care spending and decrease acute care spending.

DSS has an opportunity – and a target - to increase the percent of total Medicaid spend on primary care.

Percent Medicaid Primary Care Spend (Narrow Definition) - Across States, 2019



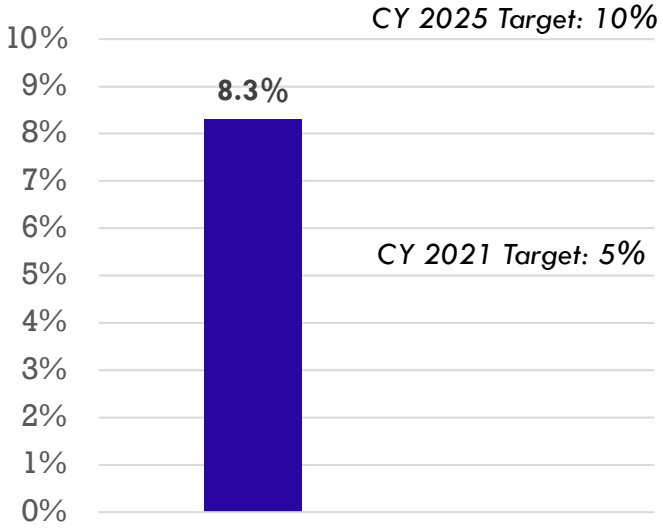
Note: The narrow definition of primary care restricts primary care services to physicians identified in MEPS as practitioners of family medicine, general practice, geriatrics, general internal medicine, and general pediatrics.
Source Listed: Medical Expenditure Panel Survey (2011-2016); Includes 29 states.

% Medicaid Primary Care Spend (2019)	Patient-Centered Primary Care Collaborative Study (for Multi-State Benchmarking)	CT Score	National Average	State Rank/ Total Reporting States
	Percent Medicaid Primary Care Spend (Narrow Definition)	5%	6%	19 / 29 (bottom half)
	Percent Medicaid Primary Care Spend (Broad Definition)	10%	11%	17 / 29 (bottom half)

Red shading indicates score is worse than the national average; *green shading* indicates score is better than the national average

Source: Investing in Primary Care, A State-Level Analysis; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center

Percent Medicaid Primary Care Spend (OHS Definition), 2021



Executive Order No. 5 established a statewide target to increase primary care spending to 10% by calendar year 2025.

Source: OHS, Healthcare Cost Growth Benchmark Steering Committee Meeting, March 27, 2023

Opportunities for Improvement

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2. **Ensure members have easy and timely access to care** and address the range of barriers that make it challenging for members to access care.

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4. **Enhance care coordination and team-based care** with a focus on integrating community health workers.

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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?

Today's Focus

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

Reminder: Timeline for Primary Care Program Design

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – Feb 2024***	***Mar – Dec 2024+***
✓ Establish advisory committee and FQHC subcommittee ✓ Review prior work with committees ✓ Respond to requests for additional starting point data and information ✓ Host listening sessions to understand priorities	❑ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including: ❑ Care Delivery Requirements ❑ Performance Measurement ❑ Payment Model ❑ Equity Strategy	❑ Review key decision points in the development of program technical specifications and incorporate feedback ❑ Discuss key budget, authority, and program implementation model decisions

Reminder: We hope to leave today's meeting with the following recommendations

1. A list of the top things that we want primary care to be doing differently or better to improve member health and well being
2. The committee's preferences on a spectrum of options around the role primary care will play in addressing health related social needs
3. The committee's preferences on a spectrum of options around the level of prescription vs. flexibility in care delivery

Capturing Other Great Ideas

Our program design discussions will need to be targeted and solutions oriented.
We will maintain a "parking lot" for topics that are not directly related to primary care program design.
This feedback will be incorporated in other relevant efforts.

Example topics from discussions to date:

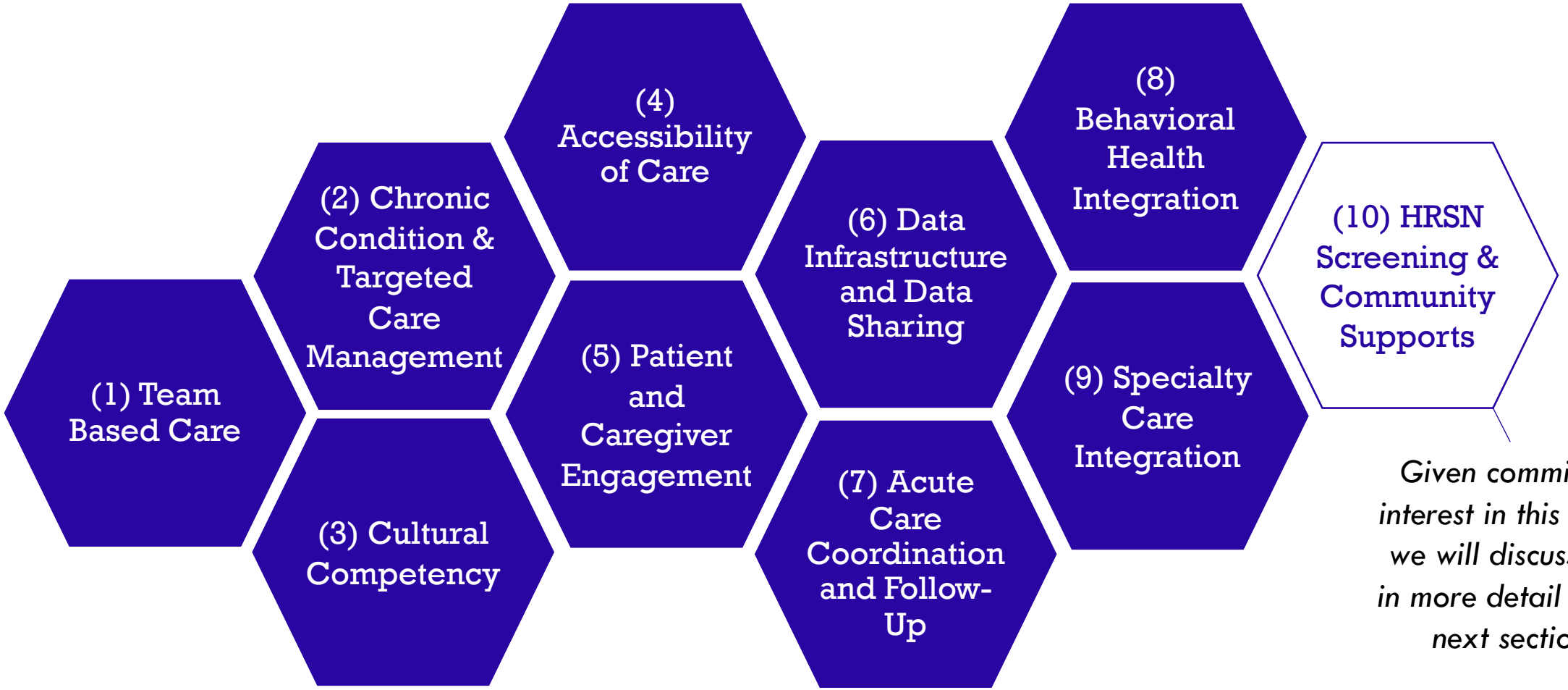
- Medicaid financing and authority to pay directly for social services (e.g., housing and nutrition supports authorized by an 1115 waiver)
- Statewide efforts to address social determinants of health such as physical environment, education, employment opportunities, or affordable housing stock
- Primary care physician education and recruitment
- Specialty care rates and policies

Topic 1: Primary Care Capabilities

1. **Review Primary Care Capabilities and Illustrative Examples**
2. **Discuss:**
   - What are the key things that primary care should be doing differently or better to improve member health and well being?
   - Which of these functions or capabilities is most important to advancing our equity goals?

Primary Care Capabilities – Key Domains

Primary care programs articulate care delivery expectations across a range of domains.



Given committee interest in this topic, we will discuss this in more detail in the next section

Primary Care Capabilities: Key Domain Examples

These examples are drawn from different primary care programs; details can be found in the appendix.

Domain	Examples
(1) Team Based Care	• Practice team requirements, including integration of community health workers and other non-clinical care coordination personnel
(2) Chronic Condition & Targeted Care Management	• Self-management support services for chronic conditions • Empanel and risk stratify patients and deliver targeted care management
(3) Cultural Competency	• Care is culturally and linguistically competent; access to Translation and Interpreter Services
(4) Accessibility of Care	• 24/7 access, after-hours or weekend session, same-day urgent care capacity, video telehealth capability
(5) Patient and Caregiver Engagement	• Patient and Family/Caregiver Advisory Councils and processes for patients and caregivers to advise on practice improvement
(6) Data Infrastructure and Data Sharing	• Process for electronic exchange of information; referral management; use of electronic health record (EHR) or participation in Health Information Exchange (HIE)
(7) Acute Care Coordination and Follow-Up	• Identifying Unplanned Hospital and ED Visits and follow-up after Hospital and ED Visits
(8) Specialty Care Integration	• Specialist e-consults; time-limited co-management
(9) Behavioral Health Integration	• Practice team personnel (e.g., care coordinator with BH experience, consulting BH clinician with prescribing capability); specific BH services (e.g. Brief intervention for BH conditions)
(10) HRSN Screening & Community Supports	• Screen for health related social needs; maintain an inventory of services and supports in the community; referral and/or coordination; partner with social service providers

For Discussion – Primary Care Capabilities

- What are the key things that primary care should be doing differently or better to improve member health and well being?
- Which of these functions or capabilities is most important to advancing our equity goals?

Topic 2: Health Related Social Needs

1. **Review Spectrum of Options to Address HRSN in Primary Care and Illustrative Examples**
2. **Discuss**
   - What role should primary care practices play in addressing health related social needs?
   - What tools or supports do primary care practices need to support patients who have HRSNs that are impacting their care or outcomes?

Health Related Social Needs

What role should primary care practices play in addressing health related social needs (HRSN)?

Context: This committee has broadly discussed the importance of addressing health related social needs (HRSN) – as we move forward, we will need to consider what role primary care plays in addressing HRSN.

Illustrative Options and Examples

Option 1	**Option 2**	**Option 3**
Primary care practices have no responsibility for identifying or addressing HRSN	*Primary care practices are expected to perform certain functions related to screening, referral, and/or coordination*	*Primary care practices are expected to deliver select HRSN services*
No Role		***Full Responsibility***
Traditional "medical only" model of care	*Range of specific strategies and examples from state and federal programs (see next slide)*	*Rare at the practice level; funding would require additional federal authority*

Health Related Social Needs

What role should primary care providers play in addressing health related social needs (HRSN)?

Context: State and federal programs have articulated a range of HRSN related care delivery requirements.

Option 2 – Detailed Examples

HRSN Care Delivery Requirements	CMMI Primary Care Programs			Medicaid Primary Care Programs	
	Comprehensive Primary Care+ (CPC+)	Primary Care First (PCF)	Making Care Primary (MCP)	MA Primary Care ACO	RI Accountable Entities
Screen for HRSN	✓	✓	✓	✓	✓
Maintain an inventory of services and supports in the community	✓	✓		✓	*Statewide referral system*
Develop and implement referral and/or coordination workflows			✓	✓	
Partner with social service providers	✓		✓		✓
Utilize CHW or equivalent professional with shared lived experience			✓	✓	

For Discussion – Health Related Social Needs

- What role should primary care practices play in addressing health related social needs?
- What tools or supports do primary care practices need to support patients who have HRSNs that are impacting their care or outcomes?

Topic 3: Primary Care Requirements and Accountability

1. **Review Spectrum of Options and Illustrative Examples**
2. **Key Discussion Topics**
   - In general, should practices be expected to fulfill specific requirements, or should practices have more flexibility to define what works with greater accountability for broader outcomes?
   - Referring back to the domains we prioritized in Topic 1, should we be more prescriptive or flexible in these areas?

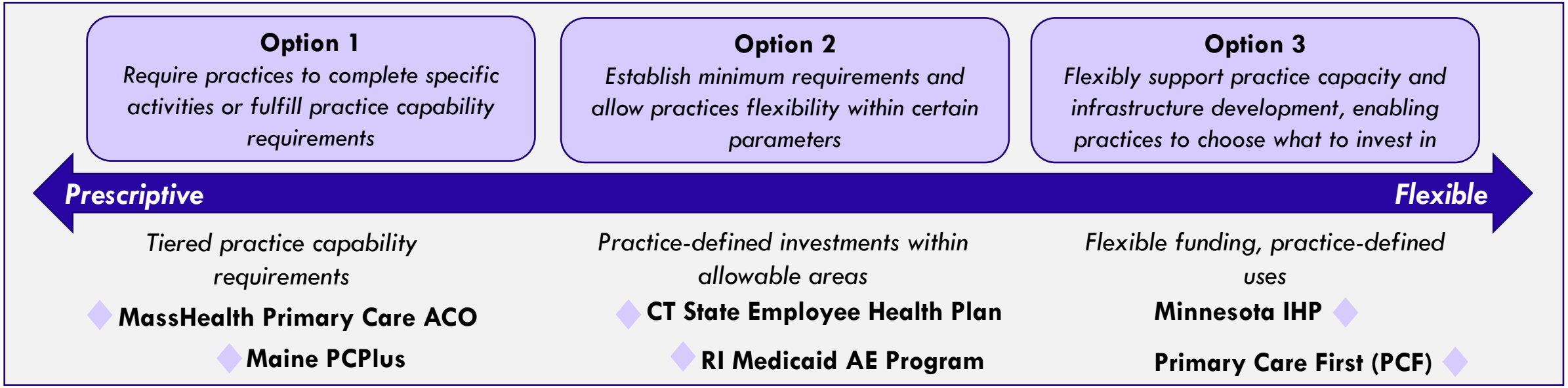
Primary Care Requirements and Accountability

How prescriptive vs. flexible should primary care delivery requirements be?

Context:

- A more prescriptive program might hold providers accountable to having certain capabilities
- A more flexible program might hold providers accountable to achieving certain outcomes

Illustrative Options and Examples



Primary Care Requirements and Accountability

How prescriptive vs. flexible should primary care delivery requirements be?

Context: The programs below illustrate a range of options.

Illustrative Options and Examples

	MassHealth Primary Care ACO	RI Medicaid AE Program	Primary Care First (PCF)
	(1) Tiered practice capability requirements	*(2) Practice-defined investments within allowable areas*	*(3) Flexible funding, practice-defined uses*
Structure of Care Delivery Requirements	3-tiered structure including detailed requirements for practices related to staffing, care integration, care coordination, and service provision in the primary care setting	AEs define investments within 8 allowable domains of expenditure and develop project plans with project specific performance measures and targets	Specific approaches to care delivery are determined by practice priorities; there is a limited set of capabilities practices must attest they have to participate
Care Delivery Accountability	Provider tier level based on attestation; optional 10% payment withhold can be implemented by MCOs	Achievement of project milestones and quality measure performance determines funding earned	Practices are incentivized to deliver patient-centered care that improves performance on defined accountability measures
Overall Accountability	Quality; Total Cost of Care; Reporting (at the ACO level)	Quality; Total Cost of Care; Reporting (at the AE level)	Quality; Acute Hospital Utilization or Total per Capita Cost

For Discussion – Primary Care Requirements and Accountability

- In general, should practices be expected to fulfill specific requirements, or should practices have more flexibility to define what works with greater accountability for broader outcomes?

Primary Care Capabilities: Key Domain Examples

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For Discussion – Primary Care Requirements and Accountability

- Referring back to the domains we prioritized in Topic 1, should we be more prescriptive or flexible in these areas?

Wrap Up

Today we have developed:

1. A list of the top things that we want primary care to be doing differently or better to improve member health and well being
2. The committee's preferences on a spectrum of options around the role primary care will play in addressing health related social needs
3. The committee's preferences on a spectrum of options around the level of prescription vs. flexibility in care delivery

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	Payment Model
	December 7	Performance Measurement
	January 18	Equity Strategy Review *(cross-cutting elements to be discussed within each topic area)*
	February 1	Program Structure Review

Appendix – Detailed Examples

(1) Primary Care Capabilities: Examples by Domain

(2) Detailed Program Examples

CT Programs

- CT DSS PCMH (PCMH)
- CT DSS PCMH+ (PCMH+)
- CT OHS Roadmap (OHS)

CMMI Programs

- Making Care Primary (MCP)
- Primary Care First (PCF)
- Comprehensive Primary Care Plus (CPC+)

State Medicaid Programs

- MassHealth Primary Care ACO (MA)
- Maine PCPlus (ME)
- Rhode Island Accountable Entities (RI)

Primary Care Capabilities: Examples by Domain

Domain	Illustrative Program Examples
Team Based Care	• **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) • **Utilize community health workers (CHWs)** or equivalent in navigating and coordinate health-related and social support services to high-need patients (MCP) • **Offers community-based community health worker services** directly or through partnerships (ME) • **Team-based staff** role (MA)
Chronic Condition & Targeted Care Management	• Identify staff and develop workflow to deliver individualized self-management **support services for chronic conditions,** emphasis on hypertension and diabetes (MCP) • Practices engage and support patients in healthy living and in **management of chronic conditions** (OHS) • **Targeted care management:** Empanel and risk stratify patients (MCP, PCF, CPC+)
Cultural Competency	• Care is accessible to persons with **disabilities** and is **culturally and linguistically competent.** (OHS) • Access to **Translation and Interpreter Services** (MA)
Patient and Caregiver Engagement	• Use **Patient and Family/Caregiver Advisory Councils** and other strategies to inform the design and improvement of care (CPC+) • Implement **processes for patients and caregivers to advise** on practice improvement (PCF)

Primary Care Capabilities: Examples by Domain

Domain	Illustrative Program Examples
Data Infrastructure and Data Sharing	• **Process for electronic exchange of information** (PCMH) • **Referral Management:** The practice manages referral by providing the specialist/consultant with information regarding the clinical issue, patient demographics, clinical information, any test results and the care plan; and continued tracking of referrals until the report is available. (PCMH) • **Lab and Imaging Test Management:** The practice has processes in place to manage lab/ imaging tests (PCMH) • 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. (OHS)
Acute Care Coordination and Follow-Up	• **Identifying Unplanned Hospital and ED Visits:** The practice has a process for monitoring unplanned admissions and ED visits and receiving timely notification of patient visits (PCMH) • **Post Hospital/ED Visit Follow-Up:** The practice contacts patients/families for follow-up, within an appropriate period following the admission or emergency department visit (PCMH) • Identify staff and develop workflow for timely **follow-up for high-risk patients following ED/hospital visit** (MCP)
Accessibility of Care	• 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 (OHS) • **After-hours or weekend session** (MA) • **Same-day urgent care capacity** (MA) • **Video telehealth capability** (MA) • **Provide 24/7 access** to a care team practitioner with real time access to the EHR (PCF, CPC+)

Primary Care Capabilities: Examples by Domain

Domain	Illustrative Program Examples
Specialty Care Integration	• **E-consults are available** for a defined number of specialties (MA, MCP) • Establish enhanced relationships with high-quality specialists thru **time-limited co-management** (MCP)
Behavioral Health Integration	• Employ a **care coordinator with behavioral health experience** who serves as a member of the interdisciplinary team and conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of physical and behavioral health care needs. (PCMH+) • **Behavioral health is integrated into the practice team** through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment. (OHS) • Maintain a **consulting BH clinician with prescribing capability** (MA) • **Array of BH services available:** Brief intervention for BH conditions, Active Buprenorphine Availability, Active Alcohol Use Disorder (AUD) Treatment Availability (MA)
HRSN Screening & Community Supports	• The practice team identifies social risk factors affecting its patients and is knowledgeable about community resources that can address social needs. (OHS) • **Screening for HRSN** (CPC+, PCF, MCP, MA) • **Maintain an inventory** of services and supports in the community (CPC+, PCF, MA) • **Develop and implement referral and/or coordination** workflows (MCP. MA) • **Partner with social service providers** (CPC+, MCP)

CT DSS PCMH

The PCMH program requirements are based on the care coordination requirements for NCQA PCMH recognition.

There are five core requirements that all practices must achieve and maintain for their NCQA recognition based on the NCQA Standards.	There are sixteen additional criteria. These criteria are elective. Practices can choose any of them for credit towards recognition. They are not required but illustrate the practice's enhanced care coordination activities. The criteria are summarized as follows:
1. Lab and Imaging Test Management: The practice has processes in place to manage lab and imaging tests by: a. Tracking lab tests until results received. Having a process for follow up for results. b. Tracking imaging tests until results received. Having a process for follow up for results. c. Flagging all abnormal test results, alerting the clinician. d. Notifying patients/families of normal and abnormal results. 2. Referral Management: The practice manages referral by: a. Providing the specialist/consultant with information regarding the clinical issue, patient demographics, clinical information, any test results and the care plan. b. Continued tracking of referrals until the report is available. 3. Identifying Unplanned hospital and ED Visits: The practice has a process for: a. Monitoring unplanned admissions and ED visits. b. Receiving timely notification of patient visits 4. Sharing Clinical Information: Clinical information is shared with hospitals and emergency departments. 5. Post Hospital/ED Visit Follow-Up: The practice contacts patients/families for follow-up, within an appropriate period following the admission or emergency department visit.	1. Newborn Screenings – obtaining hearing and blood screening results from hospital. 2. Uses clinical protocols to determine necessity of labs and imaging. 3. Uses clinical protocols to determine necessity of specialist referrals. 4. Identifies specialist most used by the practices. 5. Considers referral specialist performance information when making referrals. 6. Works with frequently used non-behavioral health specialist to determine process for sharing information and patient care. 7. Works with frequently used behavioral health specialists to determine process for sharing information and patient care. 8. Integrates behavioral health providers into the practice site. 9. Monitors timeliness and quality of referral response. 10. Documents co-management of patients who see specialists regularly in medical record. 11. Connects patients to financial resources. 12. Process for acute care coordination after hours 13. Exchanges patient information with the hospital during hospitalization 14. Process for consistently obtaining patient discharge summaries from hospitals and other facilities. 15. Develops a written care plan for practice transitions in collaboration with patients/families (i.e., pediatric to adult care) 16. Process for electronic exchange of information

CT DSS PCMH+

Enhanced care coordination activities are required of both FQHCs and ANs participating in PCMH+. Additional care coordination activities are required of FQHCs receiving care coordination add-on payments.

Enhanced care coordination requirements include detailed requirements in the following categories:	Care coordination add-on activities required of FQHCs include:
• Behavioral Health/Physical Health Integration • Culturally Competent Services • Care Coordinator Staff Requirements • Children and Youth with Special Healthcare Needs • Competencies in Care of Individuals with Disabilities	• Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed. • Develop WRAPs or other behavioral health recovery planning tools in collaboration with the member and family. • Develop and implement care plans for TAY (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY). • Use an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position, and that has the capacity to fully integrate across the entire organization to facility member care. • Physical and behavioral health integration, conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of physical and behavioral health care needs.

CT OHS Roadmap

1. Care delivery is centered around what matters to the patient, developing **trusted relationships** with patients, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.
2. 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.
3. Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship. A lead clinician is a designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN.
4. Practice teams coordinate care for its patients between visits and across the continuum of care. To support such work, 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. "Embedded" refers to staff who are dedicated to specific practices. They may be physically located full or part-time at the practice site or should the practice site not afford sufficient physical space, physically located elsewhere.*
5. **Behavioral health** is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.*
6. Practice teams deliver **"planned care"** at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.
7. 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.
8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.
9. Practices **engage and support** patients in healthy living and in management of chronic conditions.
10. 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.
11. The practice team identifies social risk factors affecting its patients and is knowledgeable about community resources that can address social needs.

*Alternative approaches are permitted on an exception basis for very small practices and *may* include exclusively virtual care delivery by some practice team members, formal referral arrangements instead of embedded care for integrating behavioral health into the practice, and shared care management and coordination responsibilities within a practice. Alternative approaches will be defined through subsequent OHS guidance.

Making Care Primary (MCP)

		Track 1	Track 2 *+ Track 1 Reqs.*	Track 3 *+ Track 2 Reqs.*
Care Management	**Targeted CM**	• Empanel and risk stratify patients • Identify staff and develop workflow for chronic care management for high-risk pts, emphasis on hypertension and diabetes • Identify staff and develop workflow for timely follow-up for high-risk pts following ED/hosp. visit	• Implement chronic care management for pts most likely to benefit, emphasis on hypertension and diabetes • Implement episodic care management for high-risk pts following ED/hosp. visit	• Implement individualized care plans for pts most likely to benefit, emphasis on hypertension and diabetes
	Chronic Condition Mgmt.	• Identify staff and develop workflow to deliver individualized self-management support services for chronic conditions, emphasis on hypertension and diabetes	• Implement individualized self-management support services for chronic conditions, emphasis on hypertension and diabetes	• Expand self-management services to include group education and linkages to community-based supports
Care Integration	**Specialty Care Integration**	• Use MCP data tools to identify high-quality specialists	• Participants identify high-quality specialty care partners thru Collaborative Care Arrangements and Specialty Care Partner List • Provide MCP e-Consult services with 1+ specialists	• Establish enhanced relationships with high-quality specialists thru time-limited co-management
	BH Integration	• Identify staff and develop workflow to initiate BH Integration (BHI) approach grounded in measurement-based care (MBC)	• Implement BHI approach using MBC and standardized measurement tools/data to inform treatment decisions • Screen for key BH conditions, incl. depression and SUD	• Optimize BHI workflows using a quality improvement (QI) framework
Community Connection	**HRSN Screening & Referral**	• Implement universal HRSN screening, provide referral resources • Develop workflows for referring pts with unmet HRSNs to social service providers/CBOs	• Implement clear roles/responsibilities for social service referral workflow for participant and provider partners	• Optimize referral workflow using QI framework to improve approaches to assessing and managing socially complex pts through social service partners
	Supporting Whole Person Care through Community Supports & Service Navigation	• Explore provider/CBO partnerships to meet HRSN • Identify CHW or equivalent to navigate and coordinate health-related and social support services to high-need pts, such as addressing social isolation; supporting stress management, chronic disease management; monitoring for gaps in care; accessing low -income benefits, and others.	• Establish partnerships with social services providers • Utilize CHWs or equivalent in navigating and coordinate health-related and social support services to high-need pts	• Strengthen partnerships with social service providers • Optimize the use of a CHW/ equivalent professional with shared lived experience, using a QI framework, in navigating and coordinating health-related and social support services to higher need beneficiaries

Primary Care First (PCF)

Specific approaches to care delivery are **determined by practice priorities.**

- Relative to CPC+, Primary Care First is designed for primary care practices that have already developed advanced primary care capabilities and are prepared to take on **greater financial risk in exchange for reduced care delivery requirements and the possibility of higher performance-based payments**.
- Practices are incentivized to deliver patient-centered care that reduces acute hospital utilization or total per capita cost.
- PCF is oriented around the same five primary care functions as CPC+

5 Primary Care Functions	Care Delivery Requirements
Access and Continuity	• Provide 24/7 access to a care team practitioner with real time access to the EHR • Practices serving complex, chronic beneficiaries (Groups 3 & 4) must provide timely callbacks to patients and their providers who contact the practice
Care Management	• Provide risk-stratified care management and timely ED and hospital follow-up • Groups 3 & 4 must engage high-risk beneficiaries in health care planning, ensuring they receive appropriate services from other providers (e.g., DME items and services)
Comprehensiveness and Coordination	• Integrate BH care and assess psychosocial needs • Groups 3 &4 must ensure coordinated referral management when patients seek specialty care and create an inventory of services and supports in the community to address their complex psychosocial needs.
Patient and Caregiver Engagement	• Implement processes for patients and caregivers to advise on practice improvement • Groups 3 & 4 must engage families and caregivers in patient care for all beneficiaries
Planned Care and Population Health	• Set goals and continuously improve upon key outcome measures

Comprehensive Primary Care Plus (CPC+)

5 Functions	Requirements For: Both Tracks	Track 1	Track 2
Care Management	• Empanel and risk stratify patients • Identify those most likely to benefit from longitudinal, relationship-based care management • Identify event triggers for episodic care for all patients	• Build capabilities in behavioral health, self-management support, and medication management	• Provide more intensive care management for patients with complex needs, build additional capabilities in assessment and management of these patients, such as those with cognitive impairment, frailty, or multiple chronic conditions
Access and Continuity	• Provide 24/7 access to a care team member with real time access to EMR • Assign all patients to a practitioner or care team to provide the opportunity to build a therapeutic relationship, and practitioners understand their patient population		• Explore alternative means of access to reduce barriers to timely care such as e-visits, group visits, or visits in alternate locations (e.g., senior centers and assisted living centers)
Planned Care & Population Health	• Using team-based care, proactively offer timely and appropriate preventive care and reliable, evidence-based management of chronic conditions • Develop capability to measure and act on the quality of care at the practice and panel level		• Integrate support for self-management of care to address health disparities in patient population
Patient & Family Caregiver Engagement	• Use Patient and Family/Caregiver Advisory Councils and other strategies to inform the design and improvement of care • Engage patients in goal setting/shared decision-making, using decision aids, specific techniques (e.g., motivational interviewing)		• More directly involve patients and families in quality improvement initiatives and provide self-management support as well as support for caregivers of persons with functional disabilities (e.g., dementia)
Comprehensiveness & Coordination	• Understand where patients receive care and organize the practice to facilitate coordination that care	• Address opportunities in improving care transitions by working more closely with hospitals, emergency departments, and at least one high volume specialty service provider	• Track 2 practices are paid additional resources to offer the most comprehensive care, which must include a systematic assessment of patients' psychosocial needs and inventory of resources and supports to meet those needs. Practices will also be encouraged to provide referrals to identified community/social services as needed

MassHealth Primary Care ACO

	Tier 1	Tier 2	Tier 3
Care Delivery Requirements	• Traditional primary care • Referral to specialty care • Oral health screening and referral • Behavioral health (BH) and substance use disorder screening • BH medication management • Health-Related Social Needs (HRSN) screening • Care coordination • Clinical Advice and Support Line • Postpartum depression screening • Use of Prescription Monitoring Program • Long-Acting Reversible Contraception (LARC) provision, referral option	• Brief intervention for BH conditions • Telehealth-capable BH referral partner	• Clinical pharmacist visits • Group visits • Designated Educational Liaison for pediatric patients
Structure and Staffing Requirements	• Same-day urgent care capacity • Video telehealth capability • No reduction in hours • Access to Translation and Interpreter Services	• E-consults available in at least three (3) specialties • After-hours or weekend session • Team-based staff role • Maintain a consulting independent BH clinician	• E-consults available in at least five (5) specialties • After-hours or weekend session • Three team-based staff roles • Maintain a consulting BH clinician with prescribing capability
Population-Specific Requirements	• EPSDT required screenings and assessments • Screen for SNAP and WIC eligibility • Children's Behavioral Health Initiative (CBHI) • Coordination with MCPAP • Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M) • Fluoride varnish • Buprenorphine Waivered Practitioner Requirement	• On-site staff with children, youth, and family-specific expertise • SNAP/WIC application assistance • Buprenorphine Waivered Practitioner Requirement • LARC provision, at least one option • Active Buprenorphine Availability • Active Alcohol Use Disorder (AUD) Treatment Availability	• Full-time, on-site staff with children, youth, and family-specific expertise • LARC provision, at least one (1) option • Active Buprenorphine Availability • LARC provision, multiple options • Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up

Maine PCPlus

Base Tier	Intermediate Tier	Advanced Tier
• Has 24/7 coverage • Has a certified EHR • Participates in technical assistance • Assesses and addresses behavioral and physical health integration • Educate members about primary care vs. urgent care vs. ED use	**Base AND** • PCMH accreditation or participating in Primary Care First • HealthInfoNet connection (bidirectional/HL7) • Collects and track social health needs • Holds a practice agreement with at least one Behavioral Health Home • Refers to a Community Care Team (CCT) • Offers telehealth • Offers Medications for Opioid Use Disorder (MOUD) or has a cooperative referral and co-management process with an MOUD provider • Includes MaineCare members and/or their families in practice improvement efforts • Offers community-based community health worker services directly or through partnerships (e.g., CBOs) – April 2024	**Intermediate AND** • HIN connection includes data elements that support clinical quality measurement • Participates in MaineCare's Accountable Communities (AC) program • Has a Joint Care Management and Population Health Strategy with AC and any contracted CCT

RI Accountable Entities

	Domains	Allowable Uses of AEIP Funds
A. Readiness	**Breadth and Characteristics of Participating Providers**	Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community-based organizations (CBOs) Developing full continuum of services, Integrated PH/BH, Social determinants, including robust referral process and workflow for complex and high need patients
	Corporate Structure and Governance	Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise
	Leadership and Management	Establishing an initial management structure/staffing profile Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk and responsibility
B. IT Infrastructure	**Data Analytic Capacity and Deployment**	Building core infrastructure: EHR capacity, patient registries, Current Care Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management Analytics for population segmentation, risk stratification, predictive modeling Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice
C. System Transformation	**Commitment to Population Health and System Transformation**	Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors Implementation of contracts with social service organizations to address key SDOH gaps and needs Implementation of evidence based BH integration and consultation services Healthcare workforce planning and programming
	Integrated Care Management	Systematic process to ID patients for care management Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations Individualized person-centered care plan for high-risk members
	Member Engagement and Access	Defined strategies to maximize effective member contact and engagement Use of new technologies for member engagement, health status monitoring and health promotion Implementation of tele-health
	Quality Management	Defined quality assessment & improvement plan, overseen by quality committee Implementation of clinical data exchange and aggregation for quality measure (hybrid and EHR based measures).