Primary Care Program Advisory Committee

November 14, 2023

Agenda

Topic	Timing
Opening Remarks and Welcome	5 Minutes
Recap and Goals for Today	10 Minutes
Topic 1: Accessibility of Care	30 Minutes
Topic 2: Chronic Condition & Targeted Care Management	30 Minutes
Topic 3: Data Infrastructure & Data Sharing	15 Minutes

Quick Recap and Process Overview

Last Meeting: 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.

What We Have Done for Today: Taking the feedback we received, we have articulated the goals for priority primary care capability domains and proposed starting point measures and requirements for holding primary care practices accountable to achieving these goals.

Goals for Today

Review a starting point and collect directional feedback from the committee.

For priority capability domains we will discuss:

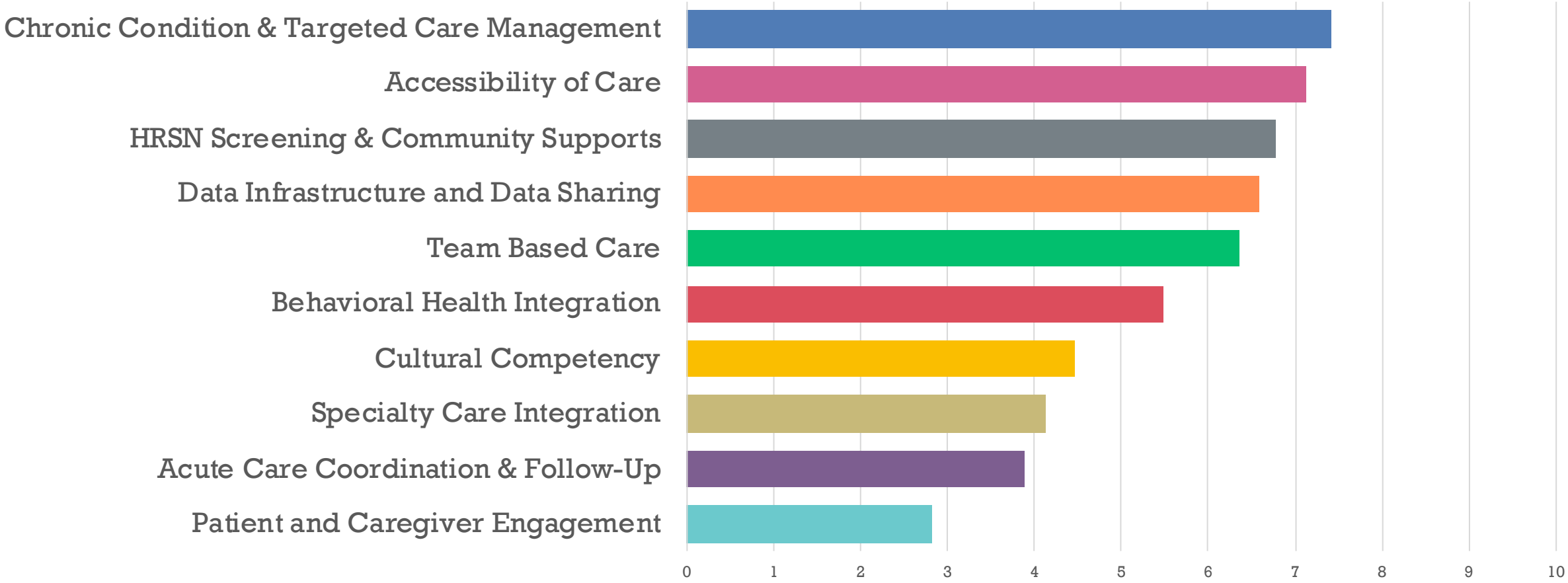
- Are these the right goals?
- Are there other measures, requirements, or equity strategies that we should consider?
- For this domain, can we rely primarily on measures? Are there any requirements that are particularly important?

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.

Reminder: 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)



Reminder: Key Feedback from 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

Committee Informed Approach

We are going to start by focusing on the top ranked domains identified by this committee.

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

Accessibility of Care

Goal

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

Ideal State

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. (OHS)

Accessibility of Care: Example Measures and Requirements

Example Measures (Program, Steward)		**Example Requirements** (Program)
Process	❑ *Child/Adolescent Preventive Care:* Child and Adolescent Well-care Visits (OHS, NCQA), Developmental Screening in the First Three Years of Life (OHS, OHSU), Immunizations for Adolescents, Well-Child Visits in the First 30 Months of Life (OHS, NCQA) ❑ *Cancer Screenings*: Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening (OHS, NCQA)	❑ Same-Day Appointments (PCMH) ❑ Telehealth Capability (MassHealth) ❑ After-hours or weekend session (MassHealth) ❑ 24/7 Access to a care team practitioner (PCF, CPC+)
Outcome	❑ *Hospital Utilization:* Avoidable Emergency Department (ED) visits (PCMH+, 3M), Avoidable Hospitalizations (PCMH+, 3M), Ambulatory Care - ED Visits (PCMH+, NCQA) ❑ *Member Experience:* PCMH CAHPS Survey - e.g., *did you receive information about what to do if you needed care during evenings, weekends, or holidays* (OHS, CAHPS), CAHPS Survey – e.g., *getting needed care quickly* (HUSKY Health, CAHPS), PCPCM Survey – e.g., *my practice makes it easy for me to get care* (PCMH+, PCPCM/ABFM)	
Equity Strategy	❑ Segment measures by REL and IDD demographic information to measure disparities	❑ Competencies in Care of Individuals with Disabilities (PCMH+) ❑ National Standards for Culturally and Linguistically Appropriate Services (CLAS) (PCMH+)

For Discussion – Accessibility of 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?

Chronic Condition & Targeted Care Management

Goal

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

Ideal State

- Practices engage and support patients in healthy living and in management of chronic conditions. (OHS)
- Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support. (OHS)

Chronic Condition & Targeted CM: Example Measures and Requirements

Example Measures (Program, Steward)		**Example Requirements** (Program)
Process	❑ Asthma Medication Ratio (OHS, NCQA) ❑ Eye Exam for Patients with Diabetes (OHS, NCQA) ❑ Kidney Health Evaluation for Patients with Diabetes (OHS, NCQA) ❑ *Behavioral Health Screening and Management:* Follow-up After Emergency Department Visit/Hospitalization for Mental Illness (OHS, NCQA), Screening for Depression and Follow-up Plan (OHS, CMS); Use of Opioids at High Dosage (OHS, NCQA); Metabolic Monitoring for Children and Adolescents on Antipsychotics (OHS, NCQA); Substance Use Assessment in Primary Care (OHS, IEHP)	❑ Define a protocol to identify patients who may benefit from care management (PCMH) ❑ Complete specific activities to advance behavioral health/physical health integration (PCMH+) ❑ Deliver individualized self-management support services for chronic conditions, emphasis on hypertension and diabetes (MCP)
Outcome	❑ Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (OHS, NCQA) ❑ Controlling High Blood Pressure (OHS, NCQA) ❑ *Hospital Utilization:* Avoidable Emergency Department (ED) visits (PCMH+, 3M), Avoidable Hospitalizations (PCMH+, 3M) ❑ *Member Experience:* PCPCM Survey – e.g., *over time, my practice helps me to stay healthy* (PCMH+, PCPCM/ABFM) ❑ Chronic Condition Cost of Care (Colorado APM 2)	
Equity Strategy	❑ Segment measures by REL and IDD demographic information to measure disparities	❑ Cultural competency training for chronic conditions management team

For Discussion – Chronic Condition & Targeted Care Management

- 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?

Data Infrastructure & Data Sharing

Goal

Develop the data infrastructure and data sharing protocols to support performance measurement and program monitoring and enable practices to make progress in addressing identified opportunities.

Ideal State

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)

Data Infrastructure & Sharing: Example Measures and Requirements

Example Measures (Program, Steward)		**Example Requirements** (Program)
Process	❑ Participation in an Alerting Exchange System – Pass/Fail (Minnesota Department of Human Services)	❑ Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system. (PCMH) ❑ Sharing Clinical Information: Clinical information is shared with hospitals and emergency departments. (PCMH) ❑ Designate and agree to use of a single EMR or utilize interoperable arrangements to enable seamless sharing of health information for efficiency and improved quality of member care. A PCMH+ member's medical record and electronic health information must be accessible to all care coordination team members for care coordination purposes. (PCMH+) ❑ Participate in state health information exchange (Maine PCPlus) ❑ Health information exchange connection includes data elements that support clinical quality measurement (Maine PCPlus)
Outcome		
Equity Strategy	❑ Pay for Reporting: member level REL and IDD demographic information (RI Accountable Entities; MassHealth Primary Care ACO)	❑ Implement a process for collecting and reporting member level REL and IDD demographic information

For Discussion – Data Infrastructure & Data Sharing

- 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?

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