MAPOC Care Management Committee

DSS Primary Care Program Design Update

January 10th, 2024

Agenda

- Update on Primary Care Program Design Stakeholder Engagement

Reminder: Primary Care Stakeholder Engagement Plan

Primary care program design will be conducted in close partnership with stakeholders, leveraging newly established and existing stakeholder engagement forums.

	Description	Participation	Meeting Cadence
Primary Care Program Advisory Committee (PCPAC)	Newly established committee that will serve as the primary program design advisory body	A diverse array of representatives, including providers, advocates, and state agency partners	Monthly
Primary Care Program Advisory FQHC Subcommittee	Newly established subcommittee that will advise on FQHC-specific program design topics	Representatives from each FQHC	Monthly, following PCPAC meetings
MAPOC Care Management Committee	Ongoing updates to and engagement with MAPOC Care Management Committee	Existing forum	Established cadence, every other month
Non-FQHC Primary Care Provider Subcommittee	As needed forum for primary care provider engagement	Broad-based forum for Medicaid primary care providers	TBD, as needed
CHNCT Member Advisory Workgroup	As needed engagement with HUSKY members through existing member advisory workgroup	Existing forum	TBD, as needed

Update: Primary Care Stakeholder Meetings Held Since Last Update

Today, we'll provide an update on the primary care stakeholder meetings held since our November update to this committee.

Month	Primary Care Program Advisory Committee	FQHC Subcommittee	MAPOC Care Management Committee
November	***November 14th*** Primary Care Capabilities and Measurement (Part 1)	***November 21st*** Primary Care Capabilities and Measurement	***November 8th*** – Last Update to MAPOC Care Management Committee
December	***December 7th*** Primary Care Capabilities and Measurement (Part 2)		
January			***January 10th*** – Today's Update to MAPOC Care Management Committee
Update	***The Advisory Committee embarked on Phase 2 of program design, which has included preliminary discussions on care delivery priorities and performance measurement***	***The FQHC Subcommittee met in November to provide additional, FQHC-specific input on care delivery priorities and performance measurement***	***The MAPOC Care Management Committee has continued to receive regular updates on primary care stakeholder engagement***

Update: Primary Care Program Design Status

The Primary Care Program Advisory Committee has spent its last two meetings discussing priority primary care capabilities and performance measurement in more detail.

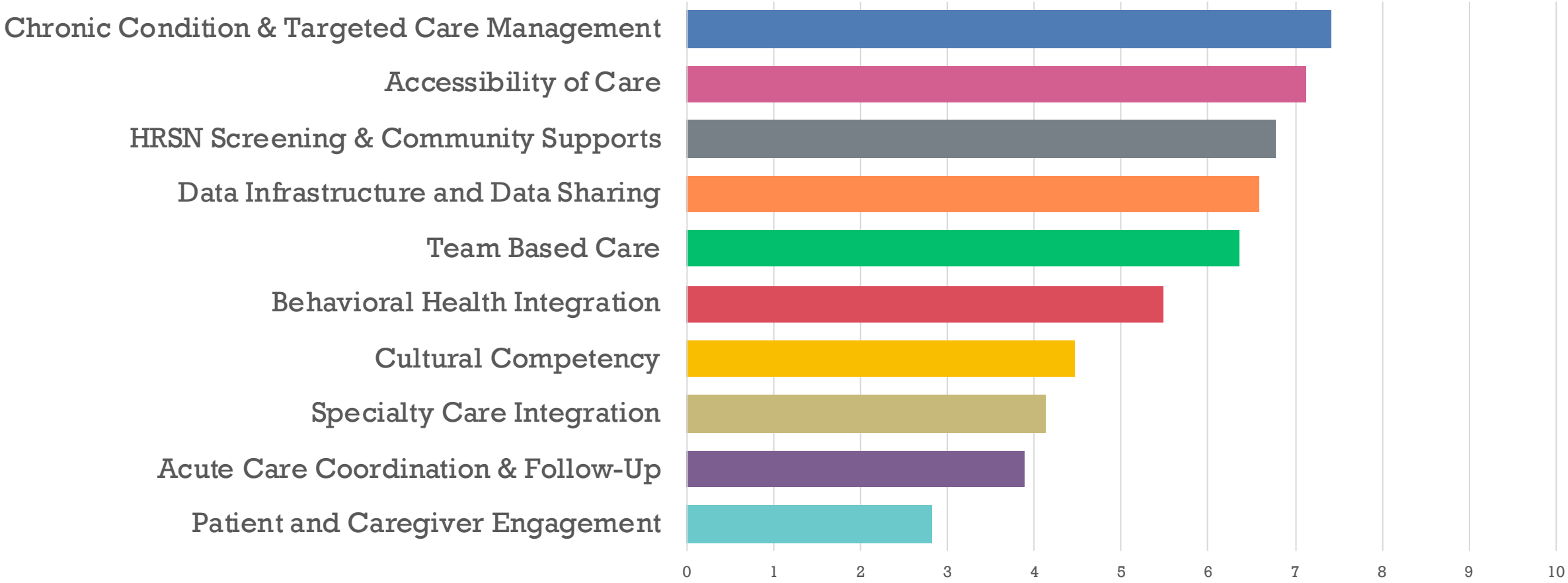
Care Delivery	*What are the key things that primary care should be doing differently or better to improve member health and well being?* **Oct 26th Meeting**	Chronic Condition & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care
Performance Measurement	*What is the definition of success? How should this be measured?* **Nov 14th Meeting** **Dec 7th Meeting**	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?* **Jan 18th Meeting**	***Next Step:*** *Review and discuss payment model options*

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

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)



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

Update: Primary Care Capabilities & Measurement Meetings

Nov 14th and Dec 7th Meetings

Goal

Collect directional feedback on the goals, examples, and approach to using measures and/or requirements in each of the priority capability domains:

- Accessibility of Care
- Chronic Condition & Targeted Care Management
- Data Infrastructure & Sharing
- Team Based Care
- Health Related Social Needs Screening & Community Supports

Process

For each domain, we:

- Reviewed a starting point **goal and ideal state** for the domain
- Reviewed **example measures, requirements, and equity strategies** we could use to hold primary care practices accountable to achieving these goals

Then the committee discussed:

- 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?

Accessibility of Care

Example

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

Example Measures (Program, Steward)		**Example Requirements** (Progr
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+)

Committee Feedback: Primary Care Capabilities & Measurement

Nov 14th and Dec 7th Meetings

Goals and Ideal State

The committee generally agreed on the goals and ideal state for each domain, raising some additional considerations, e.g.:

- For **Team Based Care:**
  - Supporting small practices and acknowledging potential challenges to embedding care coordination personnel
  - Considering how broadly the care team is defined, with emphasis on BH and Specialty Care integration
- For **HSRN Screening & Community Supports:**
  - Reflecting more specificity in the ideal state, acknowledging there are an array of considerations that will need to be taken into account as the HRSN screening and referral strategy is defined

Prescription vs. Flexibility

The committee generally agreed that the level of prescription vs. flexibility will vary by domain with a stronger emphasis on outcomes measures for certain domains (Accessibility, Chronic Conditions Management, and Team Based Care); and a **stronger emphasis on process measures and requirements for others** (Data Infrastructure and HRSN Screening)

Committee Feedback: Primary Care Capabilities & Measurement

Nov 14th and Dec 7th Meetings

Feedback on Example Measures and Requirements

The committee provided some specific feedback on example measures and requirements, e.g.:

- Concerns about using proprietary measures, specifically the Avoidable ED/Hospital measures stewarded by 3M
- Some alternative measure suggestions (e.g., timeliness of care/time to appointment measures)
- Interest in integrating more person-centered/individualized measures and requirements where possible

Additional Priorities

The committee raised a few other priorities to be considered as part of future discussions and/or broader efforts, e.g.:

- Attributing more members
- Addressing provider burnout
- Addressing member privacy concerns and data use protocols
- Considering DSS supports for data infrastructure

Next Steps

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

Appendix

Details from Nov 14th/Dec 7th Primary Care Capabilities & Measurement Meetings

Shown as an example above:

- Accessibility of Care

Included in this appendix:

- Chronic Condition & Targeted Care Management
- Data Infrastructure & Data Sharing
- Team Based Care
- HRSN Screening & Community Supports

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

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

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)		**Example Requirements** (Program)
Process		*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)
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	❑ Cultural competency and/or ADA training for care team members

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)	
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*
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

Example Requirements (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
❑ Report on identified needs by REL and IDD demographic information to measure disparities