CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

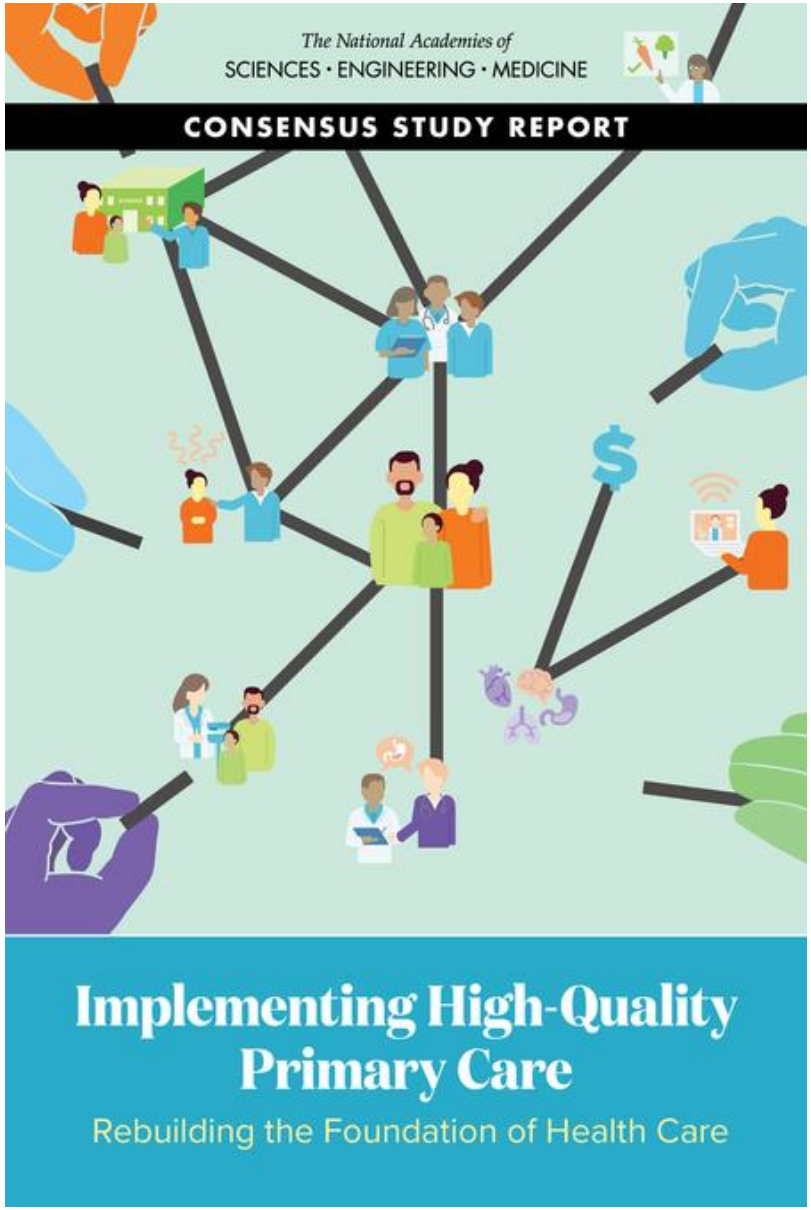
ADVANCING INTEGRATED HEALTHCARE

National Academies of Sciences, Engineering, Medicine "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care"

Care Transformation Collaborative of R.I.

CLINICAL STRATEGY COMMITTEE

MAY 21, 2021



- National Academy of Medicine's "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care" Released May 4, 2021

- Focus on IMPLEMENTATION, not conceptual design

- Five key themes – Summary Courtesy of D. Marriott, MI Multi-payer Initiative

1. Pay for Primary Care Teams to Care for People, Not Physicians to Deliver Services

Payers (e.g., Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.

Payers using a fee-for-service model should shift primary care payment toward hybrid (part fee-for-service, part capitated) models and make them the default payment model over time.

The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending on primary care.

States should implement primary care payment reform by facilitating multipayer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

2. Ensure That High-Quality Primary Care Is Available to Every Individual and Family in Every Community

All individuals should have the opportunity to have a usual source of primary care. Payers should ask all covered individuals to declare a usual source of primary care annually and should assign nonresponding enrollees. Community health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating.

The Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers [FQHC], FQHC lookalikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.

CMS should revise and enforce its fee-for-service and managed care access standards for primary care for Medicaid beneficiaries. CMS should also assist state Medicaid agencies with implementing and attaining these standards, as well as measure and publish state performance on standards.

CMS should continue to support the COVID-19–era rule revisions and interpretations of Medicaid and Medicare benefits that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non–in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.

Primary care practices should move toward a community-oriented model.

3. Train Primary Care Teams Where People Live and Work

Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve.

CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments.

4. Design Information Technology That Serves Patients, Their Families, and the Interprofessional Primary Care Team

The Office of the National Coordinator for Health Information Technology (ONC) and CMS should develop the next phase of electronic health record certification standards to align with the functions of primary care; account for the user experience of clinicians and patients to ensure that health systems are interoperable; ensure equitable access and use of digital health systems; include highly usable automated functions that aid in decision-making; ensure that base products meet certification standards with minimal need for modification; and hold health information technology vendors and state and national support agencies financially responsible for failing to meet the standards.

ONC and CMS should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

5. Ensure That High-Quality Primary Care Is Implemented

The HHS secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition.

HHS should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research.

Primary care professional societies and consumer groups at the national and state levels should assemble and regularly compile and disseminate a "high-quality primary care implementation scorecard," based on the 5 key implementation objectives.