Visions for the Primary Care Transformation Roadmap

An initial compilation of the opportunities and desires communicated by Primary Care and Related Reforms Work Group (PCRRWG) participants for improving population health and advancing the primary care delivery system in Connecticut. Information was collected through the PCRRWG Member Survey, the September PCRRWG Meeting, and member interviews.

***Bold =** areas for integration of population health and community partnerships within primary care transformation.

Category	Examples of Key Elements
Improves Primary Care Capacity	• Timely access including same day visits and 24/7 coverage • **Team based multi-disciplinary services (e.g. MSWs, CHWs)** • **Data guided approaches to population management and proactive outreach** • More complete recommended and preventive services • De-adoption and a reduction in low value health services • **Integration/coordination of behavioral health and social needs services** • **Coordination with community-based organizations (CBOs)** • Use of health IT and data to support daily operations and ongoing improvement • Routine review of performance and quality improvement in the practice • **Opportunity for shared learning of effective practices across practices and communities**
Reduces Provider Burden and Improves Satisfaction	• Reduction in administrative requirements • Fewer reporting requirements • Focus on a limited core set of meaningful measures • Aligned focus across payers to reduce provider burden (e.g. clinical and quality priorities, incentive design, administrative and reporting requirements)
Addresses Health Related Social Needs	• **Advancement of the Health Enhancement Communities (HEC) framework and implementation strategies**[1] • **Capacity for primary care (PC) to routinely conduct assessments & refer to CBOs** • **Capacity to track referrals with CBOs – closed loop** • **Capacity for PC and CBOs to share appropriate levels of information & care plans**
Improves Access and Participation with Programs that Address Self-	• **Self-management support that coordinates closely with or is embedded in PC settings to address behavioral health, healthy lifestyles, engagement with care plans, etc.**

[1] https://portal.ct.gov/-/media/OHS/SIM/Population-Health-Council/Resources/CT-SIM-HEC-Framework---final.pdf

Management and Health Promotion	**PC can provide patients and care givers with ready access to evidence-based support programs such as Healthier Living Workshops**
Results in Measurable Benefits for Health, Wellness, & Prevention	Increase rates of recommended care Reduce rates of low value care Reduce hospital care for ambulatory care sensitive conditions (ACSCs) **Address health related social needs that impact overall health and wellness**
Includes Enhanced Coverage and Access to Primary Care	Coverage provides timely access to comprehensive PC for all citizens Coverage is extended to include currently insured and uninsured Coverage addresses all medical needs including pre-existing conditions
Daily Operations Supported by Health IT and a Culture of Data Use	Access to most complete longitudinal record to guide care management **Risk profiling and stratification informs care delivery and population health initiatives** Data is used to guide outreach, preventive services, and to reduce low value services **Health IT supports well-coordinated closed loop referrals for medical and non-medical services (e.g. CBOs), including shared care plans** Data is used to support ongoing monitoring and performance measurement with a focus on core meaningful measures PC has access to actionable insights generated from measurement and drill downs, with support for use of results to guide decision making, operations, and ongoing improvement **Shared learning strategies are used to support ongoing improvement including participation in natural learning networks**
Payer Alignment and Incentives Support Primary Care Transformation and Community-oriented Health Model	Investments are structured in a way to support needed PC capacity and to transform daily operations Payers align on incentive design to optimize opportunity for PC practices to transform operations and focus on key priorities **Alignment on priorities, core measures, and a single point of whole population reporting helps to reduce provider burden and facilitate transformation** Investments in data sharing, analytics, generation of actionable insights, and learning support are leveraged to guide decision making and operations **Use of the HEC Framework financial strategies to ensure a sustainable community health model of care**