VIRGINIA CENTER FOR HEALTH INNOVATION

REPORT TO THE SECRETARY

SFY 2023

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Special thanks to the members of the Virginia Task Force on Primary Care and subcommittees

VIRGINIA TASK FORCE ON PRIMARY CARE

VIRGINIA CENTER FOR HEALTH INNOVATION

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EXECUTIVE SUMMARY

Investing in primary care has been shown to increase life expectancy, reduce costly admissions to hospitals, and lead to a healthier population.[i] In recognition of the importance of primary care, the Virginia Task Force on Primary Care (VTFPC) was launched in August of 2020 by the Virginia Center for Health Innovation to assess the current state of primary care in the Commonwealth, to support primary care providers through the immediate needs of the COVID-19 pandemic, and to identify gaps in resources and opportunities for investment for long-term primary care improvement and infrastructure development.

In state fiscal year (SFY) 2023, the VTFPC was tasked with addressing primary care clinician retention concerns, improving quality measurement, reviewing payment mechanisms, addressing social determinants of health, and developing a series of reports to better understand current trends in primary care. Recommendations from the VTFPC based on these tasks are outlined on the next page.

VTFPC 2023 RECOMMENDATIONS

1. **Develop a Virginia Institute for Healthcare Research** to improve transparency in health analytics and maximize the use of the Commonwealth's research and data analytics resources

2. Become the first state in the country to launch a **statewide AMA Joy in Medicine ™ program** to improve retention of primary care providers and reduce burnout

3. Pilot a payment model to support the **integration of behavioral health and primary care for children and adolescents** and evaluate pilot once implemented

4. Conduct a pilot of the **Patient-Centered Primary Care Measure** to evaluate the newly certified measure

5. Develop **annual reports** to monitor the primary care workforce over time

6. Support development of a nonprofit **Community Care Hub** to expand integration of healthcare and social care across Virginia by contracting with healthcare entities, developing networks of social care providers, and providing infrastructure support for community-based organizations (CBOs)

7. **Update Medicaid contracts** to better support primary care:
   a) Require managed care entities to provide DMAS with PCP assignment/attributed PCP and panel data
   b) Include assigned/attributed PCP as a required field in the Emergency Department Care Coordination (EDCC) Program
   c) Monitor data integrity of provider directories through revisions to current Secret Shopper survey
   d) Publish results of Secret Shopper survey to increase transparency of current wait times and data accuracy
   e) Consider a corrective action plan or liquidated damages if managed care entities do not meet current primary care timeliness standards, network requirements, or data accuracy standards
   f) Consider including a per capita measure of network adequacy in addition to time and distance standards
   g) Update VBP status report requirements to include reporting on behavioral health integration
   h) Consider issuing guidance through a provider bulletin further describing expectations of primary care "health home" as currently described in managed care contracts
   i) Clarify current cost reporting and medical loss ratio guidance to promote managed care financial support of behavioral health and health related social needs infrastructure

1. BACKGROUND

A robust primary care infrastructure is associated with increased life expectancy, fewer avoidable emergency department visits, fewer preventable inpatient admissions, higher vaccination rates, and overall better health.[ii,iii] Additionally, primary care is critical to achieve the Quadruple Aim: 1) improve the patient experience of care, 2) improve the health of the population, 3) reduce costs, and 4) improve the well-being of providers.[iv] Primary care is the backbone of the healthcare system, often functioning as an entry point and coordinating care for complex patients. Investment in practitioners and infrastructure is critical to ensure the longevity of the profession and support the well-being of our population.

In Virginia, primary care is a small portion of total medical spend, often falling below national averages, depending on the source definition of primary care. Virginia tends to perform worse as the definition for primary care is broadened to include advanced practice practitioners, such as nurse practitioners and physician assistants.[v] The VTFPC Primary Care Spend Report describes statewide and regional primary care expenditures based on VTFPC consensus definitions.

While there is no consensus on the appropriate spend on primary care, the Organisation for Economic Co-operation and Development (OECD) reports that on average, OECD countries spend 10-18% of healthcare dollars on primary care.[vi] Additionally, several states have begun setting targets up to 16% of total healthcare expenditures. Regardless of definition, Virginia falls short of these targets, reporting between 3-11% of total spend allocated to primary care. Spend on primary care may be increased by raising primary care reimbursement rates or through increasing utilization of primary care services. Increasing use of primary care will also require investments in the primary care workforce, with many areas of Virginia having significant workforce shortages.

Virginia Task Force on Primary Care Overview

The Virginia Task Force on Primary Care (VTFPC) was launched in August of 2020 by the Virginia Center for Health Innovation (VCHI) as a multi-stakeholder collaboration. VTFPC is tasked with addressing the sustainability challenges facing primary care that came to light during the COVID-19 pandemic and continue to challenge our communities today.

The Task Force, made up of 30 members and an additional 44 subcommittee members, has representation from providers and medical professionals, health insurers, employers, beneficiary representatives, and state officials.

In SFY 2023, the VTFPC staffed 4 committees:

1. **Clinician Retention and Well-Being**: Establishes recommendations for workforce retention and clinician well-being to ensure adequate primary care access for Virginians. The committee aims to ensure Virginia is the best place to practice medicine and receive care.

2. **Performance Measurement**: Defines performance measures to evaluate high value and high-quality primary care. The committee aims to reduce measurement burden while better linking assessment more directly to improvements in value.

3. **Spend Reports**: Describes trends in the primary care landscape in Virginia and identifies resource needs.

4. **Payment Reform**: Convenes stakeholders to define and align payment strategies and priorities for innovative payment approaches to support primary care.

KEY VTFPC ACCOMPLISHMENTS

- Built a strong collaborative partnership that includes primary care clinicians, employers, health plan representatives, patient advocates, and state government leaders from the executive and legislative branches.
- Developed reports describing trends in primary care, including:
  - Total Cost of Care Report
  - Primary Care Spend Report
  - Behavioral Health Spend Report
  - Telehealth Spend Report
- Developed a Virginia Primary Care Scorecard to compare Virginia's primary care infrastructure to the rest of the county and identify differences in primary care by locality.
- Launched the Virginia Primary Care Innovation Hub.
- Developed a *Roadmap for Clinician Retention and Well-Being for Virginia* that includes plans for a statewide AMA Joy in Medicine™ Collaborative.
- Documented the ideal state of primary care from each stakeholder perspective and employed this information to identify seven essential measurement categories for future value-based purchasing contracts.
- Launched a pilot for the *Person-Centered Primary Care Measure* and the *What Matters Index* in 40 Virginia primary care practices.
- In collaboration with Virginia Health Information, successfully advocated for funding to purchase immunization tracking software and develop the Smarter Care Virginia *Improving Vaccination Rates Program* – a pilot program to implement practice-level vaccination reports with 500 primary care practices.
- Successfully advocated for $151 million to increase Medicaid primary care rates to 80% of Medicare rates.

2. VIRGINIA'S PRIMARY CARE WORKFORCE

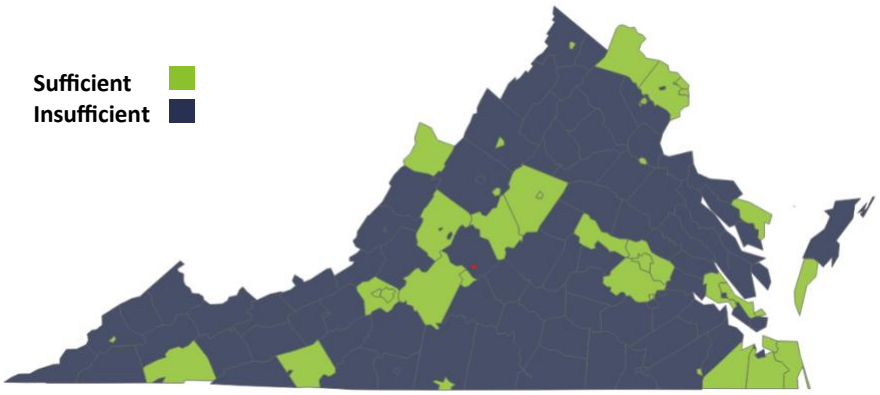
A healthy primary care workforce is critical to ensure a healthy Virginia. Research indicates that ten additional primary care providers (PCP) per 100,000 residents can increase life expectancy by 51.5 days.[vii] It is clear that primary care faced challenges before the COVID-19 pandemic, but the pandemic has exacerbated these challenges by increasing provider shortages and burnout.

The Virginia Health Workforce Development Authority (VHWDA) reports growing gaps between the supply of primary care physicians and demand in Virginia, with gaps expected to increase through 2030. VHWDA finds that overall, the primary care workforce is aging, younger providers face significant debt, and while Virginia ranks 25th in terms of primary care workforce per capita, providers are generally concentrated in metropolitan areas of the Commonwealth.[viii]

Statewide, Virginia has 76.0 primary care physicians (PCPs) per 100,000 residents. This rate is slightly better than the national average of 75.6 PCPs per 100,000 residents. However, Virginia's primary care workforce is not evenly distributed across the Commonwealth. In medically underserved areas, Virginia performs far worse than the national average with only 46.0 PCPs per 100,000 residents compared to 55.6 PCPs nationally.[ix]

Research by Virginia Commonwealth University (VCU) Department of Family Medicine Ambulatory Care Outcomes Research Network (ACORN) found that on average, PCPs in Virginia cared for 1,368 patients per year. This "real panel size" suggests that previous literature that considers a maximum panel of 1,400-1,750 patients per year in determinations of the number of patients a provider can see, may be overestimating the capacity of the current primary care workforce. Based on this research by VCU, 71% of counties in Virginia do not have a sufficient primary care workforce for their current population (at least 1 PCP per 1,368 residents). See Figure 2.

Figure 2. Localities with Sufficient PCPs Based on



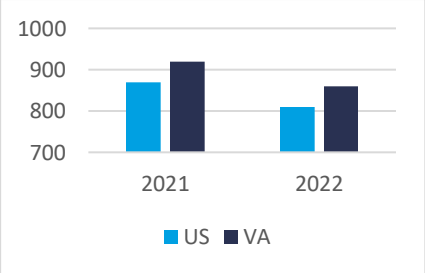
The workforce shortages and capacity constraints are most acutely seen in patient wait times. On average nationally, patients must wait 20.6 days for an appointment as a new patient requesting routine care.[x] The Centers for Medicare and Medicaid Services (CMS) recently published a notice of proposed rule-making that would require Medicaid managed care entities to ensure sufficient primary care networks to reduce wait times to 15 days for routine primary care. This wait time standard is also proposed to be implemented in Marketplace health plans in 2025.[xi] In general, Medicaid wait times tend to be longer than commercial plans, with Virginia Medicaid currently requiring a standard wait time of 30 days. There is no public information on how often this standard is met. With federal regulations requiring strict wait times for both Marketplace and Medicaid, it will be critical for Virginia to develop a robust primary care workforce to ensure access is maintained and improved for all Virginians.

One way to increase the capacity of the primary care workforce in a resource efficient manner is to increase the number of advanced practice practitioners (APPs), or nurse practitioners (NPs) and physician assistants (PAs), in the field. Virginia currently lags well behind other states in terms of the percent of NPs and PAs practicing in primary care[xii] and the number of advanced practice practitioners per 100,000 residents. In fact, many localities do not have any advanced practice practitioners practicing primary care. The Virginia Department of Health Professions projects that NPs and PAs will become a greater proportion of the overall primary care workforce based on current supply trends, as both NP and PA workforces are increasing, whereas family medicine, pediatrics and OB/GYN physician workforces are declining.[xiii] Increasing the proportion of NPs and PAs who practice primary care and increasing the overall number of advanced practice practitioners would enable primary care practices to accommodate a greater patient panel size and maintain access or serve more Virginians. See Table 1 and Figure 3.

Table 1. Percent of Advanced Practice Practitioners in Primary Care, 2020

	US	VA
NPs	34.3%	32.7%
PAs	28.2%	26.9%

Figure 3. Number of Residents per Advanced Practice Practitioners (more residents per APP suggests worse access)



Clinician Retention and Burnout

With the onset of the COVID-19 pandemic, clinician retention and high rates of clinician burnout have come to the forefront of workforce discussions. Since 2018, the rate of primary care practices losing a clinician has more than tripled from 13% to 42%.[xiv] Much of this increase may be attributable to high rates of burnout. As of 2021, more than 50% of Virginia's primary care providers report feeling burned out. Additionally, the primary care workforce in Virginia is aging. A report by VCU Department of Family Medicine found that only 12% of the primary care workforce in Virginia is under the age of 40, while the VHWDA reports that 40% of primary care providers are 55 years or older.

To address the emerging concerns from front line primary care clinicians and determine the leading causes of burnout, the VTFPC added a Clinician Retention and Well-Being committee in SFY 2023. The committee began its work by identifying the unaddressed key contributors to burnout, which were exacerbated during the pandemic and do not appear to be abating. See Table 2 below.

Table 2: Defining the Clinician Retention and Well-Being Key Contributors to Burnout

For Individuals	For Organizations	For the Profession
• Increasing burdens of paperwork and documentation • Electronic Health Record (EHR) inbox overload • Poor functionality of EHR • Constant feeling of being rushed • Fatigue from too many hours and night calls • Extra hours and night calls "don't count" towards payment • Lack of inclusion in key decisions from practice/system administration that impact well-being • Misaligned reimbursement incentives • No payment for many primary care services that are deemed essential to patients (changing medications, completing referrals, answering clinical questions after visits) • Little help/few resources for patient social issues • Increased burden of behavioral health needs without necessary resources for referral	• Staffing shortages, especially in nursing • Poor staff morale • Declining staff retention • Loss of experienced staff putting pressure on less experienced staff • Difficulty maintaining continuity of care • Misaligned values and loss of trust in practice/system administration • Financial losses of system assume to lead to lower pay and further affecting retention • Well-being is not a priority of the practice/system	• Lack of collegiality • Lack of primary care advocacy and leadership • Concerns with diminished quality of patient care due to inexperienced workforce • Moral duress and moral injury due to inability to care for extensive patient loads • Misuse and misinterpretation of professional role • Concerns with future recruitment of professionals into primary care

In addition to the reported key contributors to burnout listed above, the Payment Reform committee also issued a Request for Information in which providers offered leading causes of burnout in their practices. Findings generally reflected the sentiments listed above, with a significant focus on stressors placed on providers due to lack of resources to address behavioral health and health related social needs of patients, as well as data infrastructure constraints that lead to burdensome data reporting and sharing practices. Additional details are described in section VBP and behavioral health, social needs, and data infrastructure.

Based on the findings from the Clinician Retention and Well-Being committee key contributor evaluation, the committee identified four emerging needs that must be addressed across the Commonwealth to effectively improve clinician retention and reduce burnout (see Table 3 below). Any initiative to improve clinician retention and well-being put forth by the Task Force should address these needs.

Table 3: Emerging Needs in the Commonwealth to Effectively Improve Clinician Retention and Well-Being

Need to Improve Culture, Communication, and Decision-Making	Need to Address Administrative Burden	Need to Realign Resources Dedicated to Recruitment, Retention, and Well-Being	Need to Gather Data to Better Access Where We Are, Where We are Going, and What We Still Need to Improve Clinician Retention and Well-Being
• Need to improve bidirectional communication between leadership and clinicians • Need to enhance clinician voice • Need to address poor morale and relieve exhaustion • Need to address misaligned values and the loss of trust • Need to provide evidence of organizational commitment to well-being • Need to reduce toxicity in the workplace • Need to address moral injury, violence against providers, and childcare challenges	• Need to streamline workflows and use teams more effectively • Need to share effective practices across groups • Need to ensure new technologies improve workload and enhance the patient experience, not create new burdens with limited gains	• Need resources for practices not owned or affiliated directly with health systems, especially if we are going to address primary care challenges • Need resources/incentives to address the challenges of rural and underserved areas • Need additional support for undertrained new graduates (due to Covid training limitations) who are now replacing highly experienced departing staff • Need to revisit the allocation of resources for retention versus recruitment	• Which parts of our health care workforce are most in jeopardy? • Which retention strategies are most effective? • How can we better disseminate information to serve Virginia's collective advantage? • Can statewide resources be leveraged to improve the experience for all?

Upon identification of the needs reported by primary care providers, the committee turned its attention to reviewing existing supports and services both within Virginia and at the national level. The goal of the committee was to leverage existing supports, implement best practices, and promote well-being in primary care settings across the Commonwealth. Specifically, in reviewing potential program options for implementation, the committee identified three sets of ideal capabilities that any elected program should encompass. The program must be:

1. **Responsive to primary care providers in diverse practice settings**, across credentials (e.g., MD, DO, PA, NP), across disciplines (e.g., pediatrics, family medicine, general internal medicine), and across structures (affiliated, independent, FQHC, large to small).
2. **Ready for rapid implementation** in primary care with quick start strategies, ability to grow over time, and have formal recognition be an option but not a requirement of participation.
3. **Ready to spread what works in primary care**, with open communication channels and learning collaboratives to check in on the needs of primary care, identify promising practices, and spread information on effective strategies.

Clinician Retention Pilot Initiative

After reviewing several existing programs, the committee recommends launching a Virginia Joy in Medicine™ Collaborative. The program incorporates the curriculum of the AMA's Joy in Medicine™ program, while working closely to better advance two existing Virginia programs: the ALL In: Caring for Virginia's Caregivers initiative and Safe Haven™. The AMA's Joy in Medicine™ program is a practice recognition program in which participating providers conduct a self-assessment and take steps to address organizational achievement in 6 competency areas: 1) Assessment, 2) Commitment, 3) Efficient of practice environment, 4) Leadership, 5) Teamwork, and 6) Support. The 6 core competencies are intended to demonstrate an organizational commitment to monitoring and reducing burnout, such as addressing hours spent on administrative tasks. Practices may achieve recognition based on their self-assessment and ability to work through the various competencies. If implemented, Virginia would be the first state to implement a statewide Joy in Medicine™ program, leading the country in leveraging group resources to improve the well-being of the primary care workforce.
VTFPC aims to use the Virginia Joy in Medicine™ Collaborative to complement other related initiatives across the Commonwealth. While individual health system or settings have specific initiatives, the statewide nature of the program, focus on primary care settings, and aim to shift the culture of organizations helps to fill gaps in current initiatives and support practices that may not otherwise have access to similar programs. See Figure 3 on the next page for additional details on the proposed initiative and related activities.

Figure 3. Vision for a Virginia Joy in Medicine ™ Collaborative

Vision for a Virginia Joy in Medicine ™ Collaborative	
The Collaborative will aim to strengthen primary care in Virginia by providing coordination support, data support, and learning support to help member organizations design and implement effective strategies for supporting clinician retention and well-being.	
Strategies from the AMA Joy in Medicine Health System Recognition Program ™ [1]	
1. Systematically measure organizational wellness and burnout and use results to inform action	✓
2. Develop an organizational strategic plan to address clinician well-being and retention	✓
3. Optimize efficiency of practice environment to support clinician well-being and retention, including EHR design	✓
4. Optimize teamwork to support clinician well-being and retention	✓
5. Implement a customized leadership development program to support clinician well-being and retention	✓
6. Develop structured programs to actively cultivate a supportive community at work	✓
Strategies from Complementary Virginia Initiatives	
7. Incorporate relevant strategies from **All-In: Caring for Virginia's Caregivers (VHHA, MSV, VNA)**. (e.g. culture of wellness, efficiency of practice, personal resilience). [2]	✓
8. Spread awareness of **MSV Safe Haven™** supports as part of the organizational strategy (professional support, mental health support, legal and financial support).[3]	✓

In its *Roadmap to Clinician Retention and Well-Being: Restoring Joy in Medicine* (see Appendix A) the Clinician Retention and Well-Being Committee recommends VCHI serve as the lead convener of a statewide collaborative, which would begin with a minimum of five and a maximum of 15 practice partners. These partners could be health systems, clinically integrated networks, federally qualified health systems (as a group), independent practice associations, larger primary care practices, and residency programs. Partner recruitment would begin July 1, 2023 and the first cohort of participating organizations would be secured by September 30, 2023. An informational webinar would be held to share participation requirements with all interested entities.

The initiative aims to meet providers where they are, enabling access to the program for both advanced practices and practices just beginning their efforts to address burnout. The program

includes three tiers of recognition: Bronze, Silver, and Gold, depending on the practice's current level of achievement. Selected partners would agree to work with the AMA staff to achieve at least bronze level certification by December 31, 2025, silver level certification by December 31, 2026, and gold level certification by December 31, 2027.

Project partners will sign a participation agreement with VCHI and would be provided with limited financial resources to support the work of a well-being committee and limited data collection at each participating organization. In order to support practices with strained resources, VCHI will serve as the compiler and broker of the completed assessment data, protecting individual entity data, but sharing statewide aggregated information to secure additional infrastructure supports as needed. VCHI will also initiate the sharing of successful strategies across entities, leveraging the Virginia Primary Care Innovation Hub and other partnerships to promote Virginia's enhanced clinician retention and well-being culture across the nation. As information is disseminated, VCHI anticipates additional opportunities for recruitment.

VTFPC recommendations to support the primary care workforce

1. **Launch Virginia Joy in Medicine™ Collaborative** – Establish Virginia as the first state to implement a statewide program aimed at improving the culture of primary care practices and reduce key contributors to clinician burnout. Details described above.
2. **Develop a Virginia Primary Care Scorecard** – Create an annual scorecard to monitor the health of the primary care landscape over time.
3. **Pilot a payment model to integrate behavioral health in primary care** – Develop a payment model aimed at supporting primary care providers in addressing behavioral health needs of their patients. Lack of capacity to address behavioral health needs was reported to be a leading cause burnout among primary care providers. See additional details in section Pilot payment model to integrate behavioral health and primary care for pediatric populations.
4. **Support development of a Community Care Hub** – A Virginia Community Care Hub would promote integration of healthcare and social care across Virginia by centralizing contracting with healthcare entities for community-based organizations (CBOs), developing networks of social care providers, and providing infrastructure support CBOs that want to serve as referral centers for healthcare entities. See additional details in section Community Care Hub.

3. DATA INFRASTRUCTURE AND ANALYTICS

The Virginia Task Force on Primary Care has placed a specific focus on research and analytics through the Spend Committee. This committee is tasked with evaluating available data on primary care and healthcare expenditure, creating functional and meaningful data definitions, and identifying relevant and actionable measures. In SFY 2023, the Spend Committee developed four reports on expenditures in Virginia and created a Virginia Primary Care Scorecard, becoming only the second state in the country to measure the health of primary care at the state level and the first to measure primary care by locality.

In addition to the various reports created by the Spend Committee, the committee has identified deficiencies in the data infrastructure of the Commonwealth, leading to missing, misleading, and confusing data available on primary care.

Spend Reports and Primary Care Scorecard

In response to the growing need to better understand how healthcare dollars are spent, the Spend Committee identified four priority areas for an analysis on expenditures: overall expenditures, primary care, behavioral health, and telehealth. These areas were identified based on feedback from providers, health services researchers, payers, employers, and beneficiary advocates. The resulting Spend Reports are intended to provide transparency regarding healthcare resources across the Commonwealth and identify gaps and opportunities for investment.

The four spend reports are described below:

1. Total Cost of Care Report – This report assesses total healthcare expenditures by payer, setting, and regional variation. The report was first conducted in SFY 2022 and updated to include data through 2021. The Total Cost of Care report allows for trending expenditures over time, identifies cost drivers, and reveals disparities across regions and payers.

2. Primary Care Spend Report – This report, focused on primary care expenditures, provides information on how Virginians use primary care, identifies gaps in investment, and describes regional variation in the primary care landscape. This report was first conducted in SFY 2022 and updated to include data through 2021 to enable trending over time.

3. Behavioral Health Spend Report – This report describes trends in behavioral health expenditures, including provider specialty, most common conditions, variations in services by payer, and expenditures by region. This report is new as of SFY 2023. The Spend Committee identified behavioral health as a growing concern among primary care providers. The report aims to provide greater transparency on the current landscape of behavioral health in Virginia.

4. Telehealth Spend Report – This report provides information on utilization and expenditures related to telehealth services since the beginning of the COVID-19 pandemic. This report is new as of SFY 2023. Due to the dramatic and speedy increase in telehealth services with the onset of the pandemic, the Spend Committee identified telehealth as a critical priority area to better understand utilization and expenditure patterns, including how it has been used in primary care.

In addition to the four spend reports, the Spend Committee identified a need for an overall Primary Care Scorecard to bring together various data sources, measures and trends to describe a more wholistic perspective of primary care in Virginia. The Virginia Primary Care Scorecard is modeled after the Health of US Primary Care Scorecard, which was published earlier in 2023 as the first scorecard to assess the health of the primary care landscape in the U.S. Since its publication, only one other state has created a state-level primary care scorecard.[xv] Virginia is the first state to include assessments of primary care at the locality level. The VTFPC recognizes that primary care investment, workforce and utilization varies greatly across the Commonwealth and understanding geographic disparities is critical to improving the overall health of the Commonwealth.

The VTFPC recognizes value in development of actionable reports built through collaborative processes across stakeholder groups. This year, based on the reports put forward by the VTFPC, as well as the need for future research, the **Task Force recommends the establishment of a Virginia Institute for Healthcare Research**. The Institute would aim to advance innovation in healthcare payment and delivery, improve transparency, and provide cost-effective healthcare research to the Commonwealth (see more details in section Monitoring, Reporting, and Research).

Data Infrastructure

Based on research reviewed by the VTFPC, as well as the work of the Spend Reports Committee, the Clinician Retention and Well-Being Committee, and the Payment Reform Committee,[xiv] primary care practices are devoting more attention to behavioral health needs and health-

related social needs for their patients. Effectively managing these growing needs requires adjustments to care models, team roles, team workflows, and community referral connections. Fundamental to this work is the ability to use data systems to identify at-risk populations and document screenings and services across primary care, behavioral health, and social needs. However, developing these integrated data capabilities in each local practice setting is cost-prohibitive and difficult to scale.

Community Care Hub

Virginia's primary care providers recognize the importance of identifying and addressing health-related social needs as part of the care plan for patients. In fact, the inability to effectively screen and provide concrete referral, leaving a feeling of helplessness, was reported numerous times as a leading cause of burnout and provider stress. A recent study found that 80% of dually eligible Medicaid-Medicare and 48% of Medicare-only recipients reported a health-related social need, such as housing or food insecurity.[xvi] In Virginia, a study by VCU Department of Health Behavior and Policy found that half of Medicaid members in the Commonwealth Coordinated Care Plus program (CCCP) reported food insecurity. Additionally, 66% of new Medicaid members reported being worried about housing costs.

The US Department of Health and Human Services recently identified Community Care Hubs as a key strategy to address health-related social needs.[xvii] In 2021 VAAA Cares/Bay Aging in collaboration with VCHI received grant funding from the U.S. Administration for Community Living to begin development of a statewide Community Care Hub (CCH) for Virginia. The purpose of the CCH is to expand integration of social care in healthcare settings by supporting contracting efforts between community-based organizations (CBOs) and healthcare entities or directly contracting on behalf of the CBO, developing networks of social care providers, and providing infrastructure support, such as billing infrastructure, for CBOs that have not previously received reimbursement from healthcare entities. By centralizing billing and contracting processes, CCHs allow CBOs to connect with a multitude of payers and providers, and vice versa, without the burden of managing numerous contracts and systems.

Within Virginia, there is a growing number of regional and community networks in which healthcare payers and providers are partnering with CBOs. These networks are often supported by an e-referral platform, such as Unite Virginia, which has been funded in part with funds appropriated by the Virginia General Assembly. Integrated service networks are still evolving and future potential is currently limited by the lack of scalable financing models, interoperability challenges, and operations capacity to support integrated service delivery. Barriers to scalability could be reduced through development of a Community Care Hub, interoperability requirements, and expansion a health information exchange.

Development and expansion of a Community Care Hub would allow more primary care practices to connect with CBOs by serving as a single connection point to a variety of social care resources, immediately offering scalability. Instead of using costly resources to identify and connect with individual social care resources, primary care practices could join an integrated service network, create positive working relationships with network partners, and use the network's e-referral system to connect patients with organizations that can provided health-related social supports.

Emergency Department Care Coordination Program

The Emergency Department Care Coordination (EDCC) program, managed by VHI ConnectVirginia Health Information Exchange, was established by the General Assembly in 2017 to reduce overutilization of emergency departments. The program connects providers in real-time to promote provider communication and collaboration across settings. As of 2021, 106 hospital emergency departments, all commercial and Medicaid health plans, multiple federally qualified health centers (FQHCs) and many other providers had registered to participate in the EDCC. Virginia Medicaid requires all managed care organizations to participate in the program and utilize alert systems to improve care coordination.[xviii]

Enabling primary care providers to more readily identify patients with high utilization of emergency department services is an important component of supporting primary care's goal of comprehensive care for an individual. However, few primary care providers currently have access to EDCC and typical workflows do not currently incorporate data alerts into daily practice. Supporting primary care providers to shift business practices to better incorporate data alerts could improve quality of care and reduce utilization of high-cost emergency department services.

Medicaid managed care organizations (MCOs) are currently required to participate in the EDCC, while providers are not. However, MCOs have authority to promote the use of the EDCC among primary care providers by supporting financial and non-financial incentives to participate in the EDCC. While MCO care coordinators generally use EDCC data alerts to identify high-utilizers of emergency services, outpatient and primary care providers are often missing from communications and collaborations. While primary care providers may be named on a patient's record in EDCC transmissions, this field is often left blank, leading to little accountability for primary care providers or way for providers to easily identify their own patients. By requiring inclusion of primary care information, MCOs may be able to better engage primary care providers and improve the comprehensive care of individuals who frequent emergency departments.

VTFPC recommendations to support data infrastructure for primary care

1. **Develop a Virginia Institute for Healthcare Research** to improve transparency in health analytics and maximize the use of the Commonwealth's research and data analytics resources.
2. **Support development of a Community Care Hub** – Centralizing billing, contracting and communications for CBOs enables primary care providers to more readily access numerous resources to support health-related social needs.
3. **Update Medicaid contracts to require inclusion of primary care provider information in EDCC data feeds** – Including the patient's primary care provider on the EDCC data feed enable better care coordination and supports engagement of primary care in the identification of patients that may be over-utilizing emergency department services.
4. **Incentivize participation in EDCC in primary care payment models** – Medicaid MCOs have the authority to provide primary care providers financial and non-financial incentives to participate in the EDCC. Future payment models for primary care should incorporate promotion of the EDCC and support training needs that may be associated with new participants.
5. Update cost reporting guidance to **clarify that capacity building expenditures to promote health infrastructure may be included in quality incentive expenditures** – Promote the use of managed care funds to aid primary care providers to build data infrastructure necessary to connect members to needed resources.

4. PRIMARY CARE IN VIRGINIA MEDICAID

In recent years, Virginia Medicaid has increased payments for primary care, recognizing the unique challenges facing these providers. In response to concerns resulting from the COVID-19 pandemic, Virginia Medicaid directed all managed care entities to temporarily increase payments for primary care by 29% for services provided between March 1, 2020 and June 30, 2020.[xix] Additionally, based on the VTFPC recommendation, the state legislature increased appropriations for primary care providers by $151 million over the biennium. The increased funds allowed Medicaid to increase reimbursement rates from approximately 65-70% of Medicare rates to 80% of Medicare rates for primary care. Increased reimbursement may also increase participation in Medicaid networks. As of 2019, while 76% of Virginia's primary care providers report accepting Medicaid, only 58% reported accepting new patients.[xx] Current network participation rates are not publicly available.

The Virginia Department of Medical Assistance Services (DMAS) currently measures adequacy of primary care access through a time and distance standard that varies by program (Commonwealth Coordinate Care Plus vs Medallion 4.0) and region of the state. Current standards require that at least one primary care provider be within 15-30 miles or 30-45 minutes driving distance, depending on rurality or region of the state. There is no requirement that the provider within the designated distance be accepting new members nor any adjustment based on the population of the given area.

In addition to time/distance standards, DMAS also requires that managed care entities ensure that members are able to access a primary care appointment for routine care within 30 days. To assess compliance with this standard, DMAS conducts an annual secret shopper survey in which an external quality review organization calls providers to determine actual wait times. Results from these assessments are not publicly available. The Centers for Medicare and Medicaid Services (CMS) recently proposed regulations that would reduce allowable wait times from 30 days to 15 days. The regulations would also set specific guidelines for the secret shopper survey, including that data be used to verify accuracy of provider directories, and that all findings be publicly available.[xxi] Provider directory data accuracy has been a national challenge in Medicaid programs. While no specific findings have been published by DMAS, other states with similar secret shopper surveys have found that 33%-85% of provider directory information was inaccurate, resulting in members having significant challenges in accessing primary care.[xxii]

Medicaid Payment Models

Improving access to primary care may be addressed through multiple methods, with payment mechanisms considered a central tool. Medicaid programs may choose to pay providers using various methods to align financial incentives with desired outcomes. For instance, paying providers based on services provided (typically referred to as fee-for-service), incentivizes providers to offer more services, regardless of quality by paying for each individual service provided. Capitation payments, or a set fee per person regardless of services provided, may incentivize providers to offer fewer services even if more services would benefit the health of the patient. Medicaid programs must navigate potential incentive structures and may combine various models to best achieve their desired outcomes.

What is value-based purchasing?

Value Based Purchasing (VBP) is a broad term that refers to any healthcare payment mechanism that is at least partially based on performance in terms of quality and/or cost containment. These payments made be made by any payer to any provider type.

In primary care, the use of VBP payment models as opposed to the largely fee-for-service arrangement that Virginia currently uses could benefit the Commonwealth in 3 major ways:

1. Allow primary care providers to spend more time directly with patients by guaranteeing funds or providing more flexibility in billable time.
2. Decrease provider burnout by reducing the number of non-billable hours required to support practice administration.
3. Improve the quality of care by aligning incentives with desired health outcomes.

In states with Medicaid managed care, like Virginia, the state can direct two types of VBP programs: 1) programs that hold managed care organizations (MCOs) accountable for their performance as managed care entities (e.g. the Virginia Medicaid Performance Withhold Program), and 2) programs that require managed care entities to hold providers accountable for performance (Nursing Facility Value-Based Purchasing Program). Some states set thresholds for MCOs where a certain percentage of all managed care payments must be paid to providers through VBP contracts. Virginia does not currently have any of these requirements. In addition to state-directed VBP, MCOs have the flexibility to establish their own VBP programs with providers at their discretion. DMAS requires that MCOs describe these MCO-initiated arrangements in reports provided to the state.

Virginia Medicaid has three VBP programs in which the Department holds MCOs accountable for their performance. These initiatives include:

1. Performance Withhold Program – Withholds a portion of capitated payments based on performance on designated quality measures.
2. Clinical Efficiencies – Designates a portion of capitated payments to be paid based on performance on rate of readmissions, potentially preventable emergency department utilization, and potentially preventable admissions.
3. Discrete Incentives Transition Program – Provides MCOs with a bonus payment for members that are successfully transitioned from a skilled nursing facility to a home and community-based setting.

Virginia Medicaid has one state-directed VBP program for provider payments. This program is the Nursing Facility Value-Based Purchasing Program, which requires MCOs and the Department to set aside a percentage of payments based on quality targets for skilled nursing facilities.

Virginia's MCO-initiated VBP arrangements

Per DMAS reports on MCO VBP strategies in 2021 (the most recent data available), MCOs described three types of VBP programs: 1) pay for performance bonuses based on quality measures, 2) upside-only shared savings programs; and 3) direct infrastructure support, wherein insurers pay directly for care coordination personnel to work within provider practices. However, few programs were described across all MCOs.

Financial reporting also reflects limited VBP expenditures. VBP arrangements and healthcare quality improvement programs continue to make up a small proportion of MCO expenditures, with most plans reporting $0 paid through VBP arrangements. In SFY 2022, the most recent full year of publicly available data, managed care entities reported withholding $1.3 million in VBP payments from providers, totaling their VBP expenses for the year. With reported $12 billion in underwriting expenses, VBP withholds comprise a small fraction of total expenses. Additionally, of their reported $13 billion in revenue, 2.2% was spent on other healthcare quality improvement initiatives.[xxiiii] It is not evident from cost reports what percentage of these programs are related to primary care or other provider types.

VBP, behavioral health, and social needs

To better inform the Task Force's work on primary care payment reform, VCHI issued a Request for Information (RFI) for providers and payers from December 2022 – February 2023. Questions were separately tailored to payers or providers with the intent to gain understanding of stakeholder priorities for payment reform and potential outcomes that may be improved through a new payment model. The Task Force received 55 responses from primary care practices and payers. Additionally, VCHI conducted focus groups with the Virginia Academy of Family Physicians and a subcommittee of Task Force participants. The focus groups and RFI provided insight into current stressors for primary care, potential barriers to future payment models, and the type of payment models that could further support improvement of primary care and minimize workforce constraints.

The most commonly reported stressor for primary care providers was lack of capacity to care for behavioral health needs, followed closely by health-related social needs. PCPs reported concern that lack of capacity to care for these needs were negatively impacting patient health. Additionally, PCPs frequently shared their perception that resources outside of primary care practices were also lacking, leading to additional concerns among providers about referral options and feeling of helplessness to meet the need of patients.

While a 2019 survey of primary care practices in Virginia suggests that only 21% of primary care practices have co-located behavioral health specialists, responses to the RFI demonstrated that

a number of primary care providers report some comfortability in providing general behavioral health services. Indeed, analysis of data provided by the VHI All Payer Claims Database suggests that approximately two-thirds of all behavioral health care in the Commonwealth occurs during a primary care office visit. However, while some primary care providers may regularly screen for and treat many behavioral health conditions, as conditions become more severe (as they are currently trending), providers report concern about timely access for serious mental illness and for patients with substance use disorder. Still, other practices need more support incorporating basic behavioral health service delivery into their daily routines, either due to overwhelming volume or lack of comfort with behavioral health services. In particular, providers caring for children and adolescents reported needing more support. **The Task Force recommends that future primary care payment models focus on the critical need of behavioral health capacity in primary care clinics** and supporting the expansion of current support programs, such as the Virginia Mental Health Access Program (VMAP) – which connects pediatric providers to consulting psychiatrists.

In addition to workforce capacity and training, lack of statewide data infrastructure has led to increased challenges addressing both behavioral health and health-related social needs. As more providers need the capability to screen at-risk patients, connect them to resources, and share data with partners to ensure needs are met efficiently and without confusion, data infrastructure is critical. A statewide health information exchange, standardized reporting and data sharing processes, a data platform that allows for screening of at-risk patients, and closed loop referral systems are critical components to effectively building a robust and effective primary care workforce that meets the needs of Virginians. While several platforms currently exist or are being developed to meet components of these needs, such as ConnectVirginia, Community Care Hub, Unite Virginia, and Find Help, interoperability and participation in these platforms remain barriers. **An effective payment model for primary care would support the expansion of interoperable data platforms and aid providers in purchasing, implementing, and adapting their workflows to better utilize these platforms**.

Pilot payment model to integrate behavioral health and primary care for pediatric populations

As described above, VTFPC identified a unique need among family practice and pediatric physicians related to the increasing behavioral health needs among children and adolescents. Providers serving children and adolescents reported significant concerns about increasing volume and severity among children with behavioral health needs, and importantly, a perception of few resources to support primary care providers when needs are identified. In total, VTFPC found that 67% of behavioral health treatment occurred in primary care in 2021, with startling increases among children.[xxiv] In Medicaid alone, behavioral health expenditures

for children under 22 years increased from $537.4 million in 2020 to $616.9 million in 2021. While Medicaid is by far the leading payer for child behavioral health services in Virginia, commercial payers similarly saw an increase in expenditures for child and adolescent behavioral health services. Based on data from the VHI APCD, commercial plan expenditures are estimated to have increased from $270.5 million in 2020 to $314.7 million in 2021.

Addressing the behavioral health resource needs of primary care providers requires a shift in how primary care is reimbursed. Building capacity to address these new significant behavioral health needs requires additional hiring, time intensive screening, referral and treatment procedures, updates to workflows, new trainings, and a culture shift for many primary care practices. These types of organizational changes cannot be accomplished in the current fee-for-service environment, which only provides payment for services and rewards quantity over quality. Training, hiring and culture shifts require a heavy investment of time and resources. Payment reform is required to feasibly accomplish such significant shifts in practice. As the largest payer of child behavioral health services, Medicaid managed care may be in the best position to shift payment models to more flexibly use funds and allow primary care practices to hire new staff and set up new workflows and trainings for clinicians.

The VTFPC Payment Reform committee recommends that VCHI develop a pilot payment model in collaboration with providers and payers to better integrate primary care and behavioral health for children and adolescents. Pilot objectives would be:

- Support the primary care workforce, the entry point for most children with behavioral health needs; and

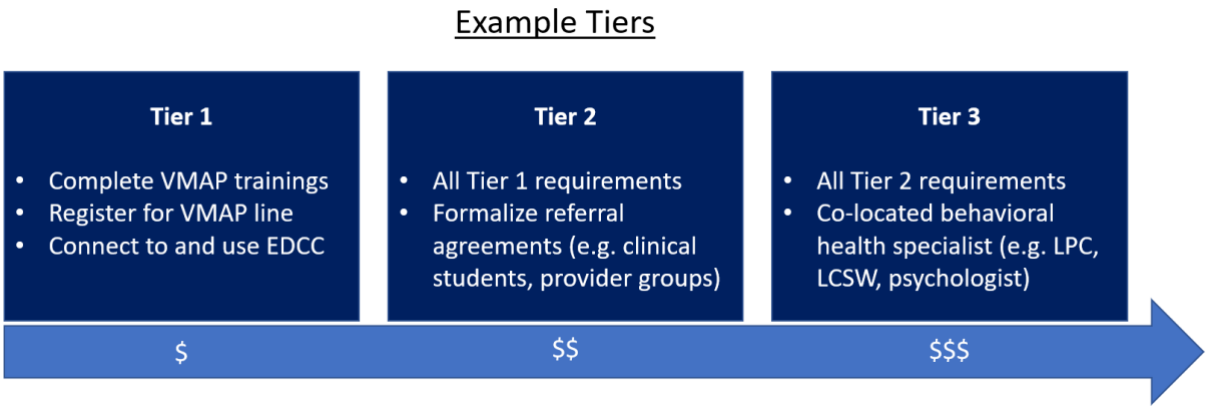
- Expand behavioral health workforce capacity through increasing training of primary care providers and expanding time and resources available for primary care to address behavioral health needs.

The Pilot would encompass 3 major components (see Figure 4.).

Figure 4. Components of Pediatric Pilot to Integrate Behavioral Health and Primary Care

Specific criteria for defining behavioral health integration may be determined in conjunction with providers, payers, and other partners. The goal of the pilot is to expand capacity, which requires participation be open to providers that may have less current capacity to care for behavioral health needs, as well as to more advanced practices. It is especially important to ensure that independent and rural primary care providers have access to the pilot. Therefore, the pilot may best be designed to include a tiered approach to integration. In addition to capacity funds that may be paid to help providers initiate integration, a per member per month payment would be based on the level of integration and the tier of the practice. See Figure 5 for additional details on a potential tiered approach.

Figure 5. Tiers of Behavioral Health Integration with Primary Care



The VTFPC recommends the above payment model be piloted on a voluntary basis with Medicaid MCOs and primary care providers to integrate behavioral health and primary care for children and adolescents.

Key Components for Primary Care Payment Models

The VTFPC Payment Reform Committee collected stakeholder input through a Request for Information and targeted focus groups. In addition to discussing the major stressors for primary care practices and areas providers would like support, stakeholders also offered insight into key components that any payment model would need to address:

- Reporting requirements should align across MCOs, DMAS, and be consistent for all PCPs
- Expansion of capacity and equitable access to supportive social services, potentially including positive patient incentives to enhance engagement
- Development of data infrastructure and interoperability of data platforms to enable better care coordination, practice management, and communication with MCOs, such as those implemented in North Carolina, Maryland, Arkansas, and New York. Data

exchange could also be improved through standardized data exchange protocols between MCOs with claims and practices with EHR data such as those used successfully in Oklahoma[xxv]

- Attribution of patients to primary care providers is a common challenge for all VBP programs and continued improvement on attribution methodologies is a key driver of success
- Primary care providers with few Medicaid patients as a proportion of their total population are unlikely to participate in any voluntary VBP program or pilot initiative
- VBP programs targeted at improving primary care must, on net, increase payment rates relative to Medicare or commercial rates

Landscape of primary care payment models in the US

The Center for Medicare and Medicaid Services (CMS) has signaled an increased focus on alternative payment models for primary care through several recent announcements and regulations. VCHI issued an analysis on two recently proposed Medicaid regulations that focus heavily on primary care, including rate transparency, network adequacy, and encouraging payment strategies that would support greater network participation, such as VBP arrangements. Additionally, CMS recently announced the Making Care Primary model, a new primary care payment model for Medicare and Medicaid focused on care coordination and supporting primary care providers address health-related social needs. The Making Care Primary model is the first payment model introduced by the Biden-Harris Administration and includes significant funds for the 8 participating states.

While federal initiatives indicate an increased focus on primary care and alternative payment initiatives, the 2022 Commonwealth Fund survey of primary care practices found that only 46% of PCPs report receiving any VBP payments across all payers. Larger practices in urban or suburban areas are more likely to participate in VBP arrangements, further increasing disparities between rural and non-rural areas and small independent practices. Practices participating in VBP arrangements are more likely to report efforts to provide whole-person comprehensive care, as well as reduce burnout among providers.[xxvi] Payment strategies may vary depending on the goals of the initiative, examples of potential payment models seen across the country are described on the next page.

Per Member per Month (PMPM) payments and Capitation

As opposed to fee-for-services, in which a payment is based solely on services provided, a capitation payment or per member per month (PMPM) is a monthly lump sum payment per person attributed to or assigned to a primary care physician or practice. The capitated payment may include expected payments for all services or can be paired with fee-for-service payments and cover basic care and care coordination activities.

Capitation may incentivize clinicians to efficiently provide effective care and eliminate unnecessary care. It also provides some level of guaranteed payment/certainty and allows for more flexibility in how providers spend their time. Payment may be adjusted for patient/population acuity, past performance on quality metrics, or commitment to certain standards and services.

Capitation shifts risk from insurers to clinicians, as patients could cost more than the monthly payment provided. This risk may be challenging for some providers to manage. Relatedly, there is risk that providers offer fewer services to patients in order to manage their costs per patient and stay within their allotted capitated payment. Finally, providers often report concerns about how a patient is attributed, when many patients see many providers or no provider at all.

Shared savings

Shared savings programs calculate a payment based on an expected spending forecast or target across provider settings. Multiple provider types then come together to coordinate care across the settings, aiming to reduce costs, thereby sharing in the resulting savings. In the primary care context, shared saving programs generally refer to “upside risk only,” meaning that that clinicians may earn more if savings are realized, but will not earn less if the coordinate group of providers does not meet expected spending targets.

Shared savings payments are typically conditional on quality and utilization metrics. They also require high levels of coordination across provider settings, lending themselves best to larger institutions. Additionally, in certain populations seen by primary care, such as pediatric populations, opportunities for savings are limited while maintaining high quality care. Finally, patient attribution and identifying the responsible provider can be a significant challenge, especially if a shared savings component is related to provider accountability.

Pay for Performance

Pay for performance is a broad term used to describe any payment model that includes payment based on quality improvement or spending targets. These programs were among the

first deviation from fee-for-service payments for many health insurers and systems. Payments typically begin with payment for reporting quality metrics and then move to pay for performance on process measures and clinical outcome or utilization measures (e.g., eye exams for diabetics, follow-up care after hospitalization, benchmarks for immunizations across a provider's panel).

Research has shown that pay for performance programs must have significant financial incentives, have predictable and clear reporting requirements and benchmarks, and align with provider priorities to be effective.[xxvii] While some programs have been highly effective, programs that do not align payers, require burdensome reporting, and cause confusion due to frequent programmatic changes tend to add to administrative burden and provider burnout.

Additional Resources for Primary Care Payment Models

- In the 2022 Virginia Task Force on Primary Care Report, VCHI described several Medicaid payment models for primary care in select states, including Arkansas, New York, Colorado, Delaware, Oregon, Maryland, and by CMMI's Primary Care First Model.
- The federal Office of the Assistant Secretary for Planning and Evaluation (ASPE) Physician Focused Payment Model Technical Advisory Committee (PTAC) published a series of resources describing current payment arrangements available through various payers and state strategies. ASPE PTAC also publishes data files that may be useful for providers aiming to participate in VBP arrangements.
- Center for Health Care Strategies published a tool kit designed to support state with Medicaid managed care to better use their resources and contract levers to design and implement primary care VBP strategies.

VTFPC recommendations to improve primary care in Medicaid

- **Develop pilot initiative to integrate behavioral health and primary care for children and adolescents** – In collaboration with payer and provider partners, VTFPC has proposed a per member per month payment methodology to support primary care providers in improving their capacity to care for children with behavioral health needs
- Update cost reporting guidance to **clarify that capacity building expenditures may be included in quality incentive expenditures** – Promote the use of managed care funds to aid primary care providers to build capacity to better integrate behavioral health in primary care through adopting data infrastructure or supporting staff hiring

- **Update Medicaid managed care secret shopper survey to improve transparency and compliance with current standards contracts PCP network standards** – Revise current Secret Shopper survey, in a manner consistent with federal regulation, to promote compliance and transparency with current standards and ensure Medicaid members have adequate access to primary care. **Specific suggestions include:**
    - **Publish secret shopper survey data** to promote data transparency
    - Consider **corrective action plan or liquidated damages** if certain percentage of primary care wait times are not within current 30 day standard to enforce current standards
    - Include **provider directory data accuracy** as a full component of the Secret Shopper survey, and consider liquidated damages if a certain percentage of data is not accurate
- Consider including a **per capita measure of primary care network adequacy** – Add a measure to current time/distance standards that accounts for population density and panel capacity
- **Update current managed care VBP report** to include reporting on programs that promote behavioral health integration – Revise current reporting requirements to gain additional information on current programs
- Consider issuing guidance to **describe DMAS expectations of primary care "health home" responsibilities** – Current managed care contracts describe primary care as a "health home," but do not clarify the current expectations

5. MEASURING SUCCESS IN PRIMARY CARE

The Virginia Task Force on Primary Care defines **success** of the Task Force as:

- Clinicians and payers establish a better relationship in order to partner in seeking better health and lower costs for Virginians
- Primary care services are accessible, integrated, equitable, convenient, and affordable for patients in all Virginia communities
- Virginia promotes a positive primary care practice experience for clinicians, leading to retention and growth in the number of primary care providers

- The viability of primary care practices is safeguarded, primary care payment is predictable and tied to meaningful performance measurement in order to advance better health care value, and primary care is less susceptible to changes in the economy
- Positive primary care innovations, such as telehealth, adopted during the pandemic are maintained and advanced where needed

Primary care should be accessible, integrated, equitable, convenient and affordable. The core functions of primary care have often been described by the Starfield Four C's of Primary Care: first Contact, Continuity of care, Comprehensive care, and Coordination of care. [xxviii] While these 4 C's provide a goal for primary care providers, measuring success in these areas has often led to significant administrative burden and misguided shifts in reimbursement and resources.

The Virginia Task Force on Primary Care has concluded that primary care clinicians are asked to report on far too many measures. VCHI collected reportable measures from a sample of primary care value-based payment contracts from providers and payers across the Commonwealth and identified more than 200 measures that primary care providers may be asked to report, with 131 of these being required by only one contract. Furthermore, even if two payers required the same measure to be reported, payers frequently required slightly different reporting methods, such as reporting against a benchmark, using total volume vs percentage, or reporting measures by sub-populations. These variations quickly add up to onerous reporting requirements that often do not result in meaningful understanding of care provided to patients. By requiring reporting on more than 200 measures, primary care providers are unable to prioritize their time to meaningfully improve any given quality measure.

In addition to the extensive administrative burden, VTFPC noted that many measures are not fully under the control of primary care clinicians, and measures that incorporate patient perspective were often missing. Therefore, the VTFPC continued its efforts to advance measure reduction and simplification by recommending a pilot of the recently approved Person-Centered Primary Care Measure (PCPCM) and the What Matters Index (WMI).

With oversight from VCHI and the VTFPC Performance Measurement Committee, the faculty and staff of the VCU Department of Family Medicine and Population Health are overseeing a pilot and comprehensive evaluation of both of these measures in 40 Virginia primary care practices. The pilot launched in April of 2023, and will run through 2024. After the evaluation is complete, Virginia health plans will be reviewing both measures for use in their future value-based payment contracts, with an eye to replacing many of measures presenting in use.

Monitoring, Reporting, and Research

This year, the VTFPC recognizes growing value in its collective efforts to produce actionable reports for Virginia's policy leaders - including the Virginia Primary Care Scorecard, Primary Care Spend Report, Total Cost of Care Spend Report, Behavioral Health Spend Reports and Telehealth Spend Report. In an effort to continue to advance the Commonwealth's ability to use high-quality healthcare research to drive policy, the **Task Force recommends establishing a new Virginia Institute for Healthcare Research**. The principle aims of the institute would be to advance innovation in healthcare payment and delivery, improve transparency, and provide cost-effective healthcare research to the Commonwealth.

The goals of the Institute include:

- Build upon existing research and data infrastructure to maximize the usability of current resources in Virginia including a collaboration with the Office of Data Governance and Analytics;
- Create a hub to reduce administrative burdens associated with contracting and data sharing with state entities;
- Further improve data transparency to the Commonwealth, state partners and the general public;
- Match data sources with analytic and policy expertise to provide timely, rigorous research;
- Reduce cost of state-directed research initiatives;
- Disseminate research funds among experts at state universities;
- Connect researchers to subject matter experts to produce high quality research and promote applicability of findings; and
- Advance a cohesive research strategy that enables Virginia researchers to have a competitive advantage when applying for federal grants, by submitting a single application with the strengths of all partners.

The VTFPC will be seeking funding to support the proposed institute in its SFY 2025 and SFY 2026 legislative agenda.

VTFPC recommendations to measure success of primary care

- **Establish the Virginia Institute for Healthcare Research** – In partnership with VHI, VCHI should develop a research institute to bring research expertise, data repositories, and

subject matter experts together to produce actionable research for policy makers in Virginia. Institute may produce annual reports, conduct evaluations of pilot programs, and investigate priority topics.

- **Pilot the Patient Centered Primary Care Measure (PCPCM) and What Matters Index (WMI)** – Identify 40 pilot sites to conduct an evaluation of the PCPCM and WMI measures to determine usability of measures

CONCLUSION

Virginia's primary care infrastructure faces a number of challenges, including high rates of burnout, workforce shortages, inadequate and inflexible payment models, increasing demand for behavioral health and social services, and lack of data infrastructure. Based on the work of the VTFPC, its committees and stakeholder input, the VTFPC makes the following recommendations to improve primary care in Virginia:

1. **Develop a Virginia Institute for Healthcare Research** to improve transparency in health analytics and maximize the use of the Commonwealth's research and data analytics resources
2. Become the first state in the country to launch a **statewide AMA Joy in Medicine ™ Program** to improve retention of primary care providers and reduce burnout
3. Pilot a payment model to support the **integration of behavioral health and primary care for children** and evaluate pilot once implemented
4. Conduct a pilot of the **Patient-Centered Primary Care Measure** to evaluate the newly certified measure developed by VCU
5. Develop **annual reports** to monitor the primary care workforce over time
6. Support development of a nonprofit **Community Care Hub** to expand integration of healthcare and social care across Virginia by contracting with healthcare entities, developing networks of social care providers, and providing infrastructure support for community-based organizations (CBOs)
7. **Update Medicaid contracts** to more directly support primary care:

    A. Require managed care entities to provide DMAS with PCP assignment/attributed PCP and panel data

    B. Include assigned/attributed PCP as a required field in the EDCC

    C. Monitor data integrity of provider directories through revisions to current Secret Shopper survey

D. Publish results of Secret Shopper survey to increase transparency of current wait times and data accuracy

E. Consider a corrective action plan or liquidated damages if managed care entities do not meet current primary care timeliness standards, network requirements, or data accuracy standards

F. Consider including a per capita measure of network adequacy in addition to time and distance standards

G. Update VBP status report requirements to include reporting on behavioral health integration

H. Consider issuing guidance through a provider bulletin further describing expectations of primary care "health home" as currently described in managed care contracts

I. Review current cost reporting and medical loss ratio guidance to promote managed care financial support of behavioral health and health related social needs infrastructure

What's next for the Virginia Task Force on Primary Care?

Over the next year, VTFPC will focus on 7 key initiatives to support primary care in Virginia.

1. Conduct annual reports identifying trends in Virginia healthcare expenditures and a Virginia Primary Care Scorecard

2. In collaboration with stakeholders, design a payment model to support primary care providers in integrating behavioral health into pediatric practices

3. Launch of the *Virginia Joy in Medicine* clinician retention initiative with at least 5 primary care organizations in partnership with the AMA

4. Evaluate a pilot of the Person-Centered Primary Care Measure (PCPCM) and What Matters Index (WMI) measures with 40 Virginia practices

5. Begin development on primary care Total Cost of Care report that may be used at the practice-level

6. Maintain and expand the Virginia Primary Care Innovation Hub to support innovation across primary care practices, targeting 500 engaged members

7. Launch of the *Smarter Care Virginia Improving Vaccination Rates* initiative with 500 practice sites

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Appendix A — The Roadmap to Clinician Retention and Well-Being: Restoring Joy in Medicine

Our Purpose:

To improve the well-being and retention of the clinician members (MDs, DOs, NPs, PAs, and RNs) of Virginia's health care teams, to include, but not limited to addressing the distress caused by pandemic-related patient care for a group already experiencing significant distress prior to the pandemic, with a focus on strengthening the support structures for both individuals and organizations.

Defining the Need:

The Pain Points Are Many		
For Individuals	**For Organizations**	**For the Profession**
▪ Increasing Paperwork & Documentation ▪ EHR inbox overload /poor functionality ▪ Constant feeling of being rushed ▪ Fatigue/too many hours/night call "doesn't count" ▪ Lack of inclusion in key decisions that impact well-being ▪ Misaligned reimbursement incentives ▪ Failure to secure payment for many primary care services that are deemed essential to patients (changing medications, completing referrals, answering clinical questions after visits) ▪ Little help/few resources for patient social issues	▪ Staffing shortages, especially in nursing ▪ Poor staff morale ▪ Declining staff retention ▪ Loss of experienced staff putting pressure on less experienced staff ▪ Difficulty maintaining continuity of care ▪ Misaligned values and loss of trust ▪ Financial losses - likely to lead to lower pay and further affecting retention ▪ Well-being is simply not a priority	▪ Lack of collegiality ▪ Lack of primary care advocacy & leadership ▪ Concerns with diminished patient care due to inexperienced workforce ▪ Moral duress and moral injury as unable to care for patient load ▪ Misuse and misinterpretation of professional role ▪ Concerns with future recruitment of professionals into primary care

We identified four emerging needs:

1. Need to Improve Culture, Communication, and Decision-Making
    a) Need to improve bidirectional communication between leadership and clinicians
    b) Need to enhance clinician voice
    c) Need to address poor morale and relieve exhaustion
    d) Need to address misaligned values and the loss of trust
    e) Need to provide evidence of organizational commitment to well-being
    f) Need to reduce toxicity in the workplace
    g) Need to address moral injury, violence against providers, and childcare challenges

2. Need to Address Administrative Burden
    a) Need to streamline workflows and use teams more effectively
    b) Need to share effective practices across groups
    c) Need to ensure new technologies improve workload AND enhance the patient experience, not create new burdens with limited gains

3. Need to Realign Resources Dedicated to Recruitment, Retention, and Well-Being
    a) Need resources for practices not owned or affiliated directly with health systems, especially if we are going to address primary care challenges
    b) Need resources/incentives to address the challenges of rural and underserved areas
    c) Need additional support for undertrained new graduates (due to Covid training limitations) who are now replacing highly experienced departing staff
    d) Need to revisit the allocation of resources for retention versus recruitment

4. Need to Gather Data to Better Access Where We Are, Where We are Going, and What We Still Need to Improve Clinician Retention and Well-Being
    a) Which parts of our health care workforce are most in jeopardy?
    b) Which retention strategies are most effective?
    c) How can we better disseminate information to serve Virginia's collective advantage?
    d) Can statewide resources be leveraged to improve the experience for all?

We also identified three sets of ideal capabilities to be part of any selected program recommendation:

4. Responsive to primary care providers in diverse practice settings
    a) Across credentials (e.g., MD, DO, PA, NP)
    b) Across disciplines (e.g., pediatrics, family medicine, general internal medicine)
    c) Across structures (affiliated, independent, FQHC, large to small)

5. Ready for rapid implementation in primary care
    a) Quick-start strategies
    b) Grow structures over time

c) Formal recognition an option but not a requirement

6. Ready to spread what works in primary care
   a) Check in to determine what primary care needs
   b) Identify promising practices
   c) Spread information on what works

Using This Framework, We Reviewed the Following Programs Already Underway:

A. National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience

NAM released a National Plan for Health Workforce Well-Being in October of 2022. This plan has 3 goals and 7 priority areas:

Goals:

1. Raise the visibility of clinician anxiety, burnout, depression, stress, and suicide
2. Improve baseline understanding of challenges to clinician well-being
3. Advance evidence-based, multidisciplinary solutions to improve patient care by caring for the caregiver

Priority Areas:

1. Create and sustain positive work and learning environments and culture
2. Invest in measurement, assessment, strategies, and research
3. Support mental health and reduce stigma
4. Address compliance, regulatory, and policy barriers for daily work
5. Engage effective technology tools
6. Institutionalize well-being as a long-term value
7. Recruit and retain a diverse and inclusive health workforce

Perceived Strengths of the NAM Action Collaborative:

- Builds on almost six years of collective work among NAM's network of organizations committed to reversing trends in health worker burnout
- Was launched with a series of high profile events
- Includes a vetted resource compendium for health care worker well-being

Possible Limitations:

- Unclear next steps following the launch. Only 50 organizations across the nation have signed on – none from Virginia
- Appears under-resourced to move from plan to implementation

B. ALL IN: Caring for Virginia's Caregivers

Partnership between VHHA, VNA, MSV and the ALL IN: Well-Being First for Healthcare Coalition which seeks to support Virginia hospitals and health systems in redesigning their workplace environments to help team members feel valued and supported. Hospitals and health systems participating in the initiative commit to:

- Use the ALL IN Licensure and Credentialing Toolkit to eliminate barriers to mental health access;
- Publicly declare an organizational commitment to workforce well-being and to invest in and cultivate an environment where health workers feel valued and supported;
- Define at least one organizational goal to improve workforce well-being drawn from the NAM National Plan for Health Workforce Well-Being; and
- Utilize initiative programming and resources offered and contribute to the community of shared learning and improvement.

Perceived Strengths:

- Compliments and reinforces the NAM National Plan for Health Workforce Well-Being with Virginia partners
- Significant focus on making tangible tools readily available to physicians and being a safe, understanding place to get guidance on how and where to seek well-being and mental health support without judgment or punishment

Possible Limitations:

- Focused on hospitals and health systems, and does not appear to directly address some of the significant challenges facing primary care practices
- Limited in scope – may not address many of the emerging needs raised by our committee members

C. SafeHaven™: Medical Society of Virginia

In 2020, the Medical Society of Virginia introduced new legislation to help clinicians get the emotional support they need. In response, on March 8, 2020, Governor Ralph Northam signed into effect HB115 and SB120, providing for the creation of the SafeHaven™ program. The SafeHaven™ legislation offers professional support, emotional support, and legal &

financial support to physicians, nurses, pharmacists as well as student of each of these professions.

Perceived strengths:

- Confidential and comprehensive
- Offers both coaching and counseling

Possible Limitations:

- Focused on helping the individual, not changing the system or organizational cultures
- Unclear how many have been helped. Data is not readily available on uptake of services.

D. American Medical Association Joy in Medicine Health System Recognition Program

The American Medical Association developed the Joy in Medicine Health System Recognition Program to empower health systems to reduce burnout and build well-being so that physicians – and their patients – thrive.
The strategic aims of the program are to:

- Provide a roadmap for health system leaders to implement programs and policies that support physician well-being
- Unite the health care community in building a culture committed to increasing joy in medicine for the profession nationwide
- Build awareness about solutions that promote joy in medicine and spur investment within health systems to reduce physician burnout

The program has five core competencies:

- *Research* - Expand knowledge of organizational drivers through peer review research and application
- *Measure* - Access organizational drivers with validated tools and question sets
- *Act* - Activate strategic interventions focused on improving organizational well-being over time
- *Recognize* - Promote exceptional organizations that attest to criteria which prioritize system level well-being
- *Convene* - Foster shared learning and sustainable change

It utilizes criteria from 6 domains and is intended for health systems with 100 or more physicians and/or advance practice providers. These criteria are summarized in Appendix A.

It appears that this program could address many of the needs identified by our committee - but would need to be modified to better serve our statewide primary care focus.

We have met with the AMA leadership to discuss a modified approach. We are now proposing a strawman concept for committee consideration.

Strawman for Consideration:

VCHI would serve as the lead convener of a statewide collaborative, which would begin with a minimum of five and a maximum of 15 partners. These partners could be health systems, clinically integrated networks, federally qualified health systems (as a group), independent practice associations, larger primary care practices, and residency programs. Partner recruitment would begin July 1, 2023 and the first cohort of participating organizations would be secured by September 30, 2023. An informational webinar would be held to share participation requirements with all interested entities. Selected partners would agree to work with the AMA staff to achieve at least bronze level certification by December 31, 2025, silver level certification by December 31, 2026, and gold level certification by December 31, 2027. Project partners would sign a participation agreement with VCHI and would be provided with limited financial resources (up to $10,000 per year per organization) to support the work of a well-being committee and limited data collection at each participating organization.

VCHI would serve as the compiler and broker of the completed assessment data, protecting individual entity data, but sharing statewide aggregated information in such a way as to secure additional infrastructure supports as needed. VCHI would also work to enhance the sharing of successful strategies across entities and the promotion of Virginia's enhanced clinician retention and well-being culture across the nation. This should further improve recruitment opportunities at participating entities.

AMA staff have agreed to provide all of their program services as an in-kind contribution to this *first in the nation* statewide program. VCHI would seek funding from both public and private funders to support a full-time project director and the promised resource support for each of the participating partner organizations. It is estimated that this would cost $200,000-$250,000 per year, for each of four years, depending on the number of participating organizations.

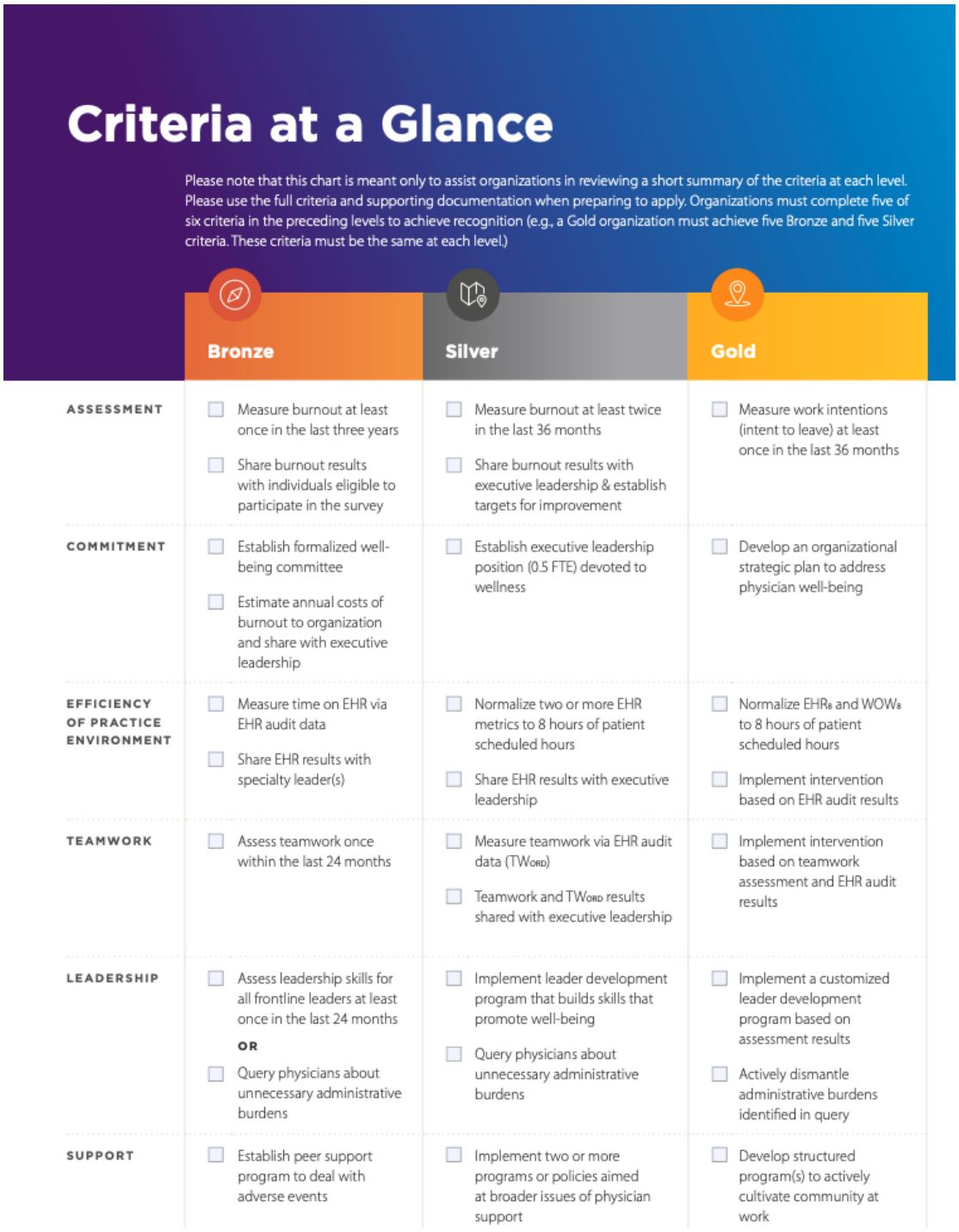
By adopting the AMA framework and associated resources as a starting platform, the collaborative could help the initial set of practice partners accelerate their work toward creating practice settings that support clinicians in effective ways. The practice partners would be encouraged to Implement key requirements of the AMA model, and they would

also have the flexibility to strategically incorporate helpful elements of ALL IN or any other Virginia-based support programs. In this context the collaborative can be viewed as complementary to other Virginia-based programs while also serving as strategic catalyst and accelerator for the participating partner organizations.

This initial collaborative model would be viewed as a phase one strategy focused on optimizing design, building capacity, and demonstrating positive impact. This would set the stage for developing a phase two strategy in which smaller practice organizations could be welcomed into the collaborative with a development model that makes sense for their size, needs, and capabilities. The phase two strategy would be developed for implementation in year two or three depending on level of interest. The committee fully recognizes the importance of having a model that provides assistance to smaller size entities.

Recommended Next Steps:

1. Prepare for recruitment and engagement by developing an ROI package and test with targeted system leads.
2. Convene an advisory group to assist with the development of a governance plan for the collaboration and to think through the data and measurement rules.
3. Use the domains from the AMA program to drive the preparation of a workplan.
4. Develop a proactive communications plan for the collaboration, covering key events and disseminating key indicators of success.



Criteria at a Glance

Please note that this chart is meant only to assist organizations in reviewing a short summary of the criteria at each level. Please use the full criteria and supporting documentation when preparing to apply. Organizations must complete five of six criteria in the preceding levels to achieve recognition (e.g., a Gold organization must achieve five Bronze and five Silver criteria. These criteria must be the same at each level.)

	Bronze	Silver	Gold
ASSESSMENT	☐ Measure burnout at least once in the last three years ☐ Share burnout results with individuals eligible to participate in the survey	☐ Measure burnout at least twice in the last 36 months ☐ Share burnout results with executive leadership & establish targets for improvement	☐ Measure work intentions (intent to leave) at least once in the last 36 months
COMMITMENT	☐ Establish formalized well-being committee ☐ Estimate annual costs of burnout to organization and share with executive leadership	☐ Establish executive leadership position (0.5 FTE) devoted to wellness	☐ Develop an organizational strategic plan to address physician well-being
EFFICIENCY OF PRACTICE ENVIRONMENT	☐ Measure time on EHR via EHR audit data ☐ Share EHR results with specialty leader(s)	☐ Normalize two or more EHR metrics to 8 hours of patient scheduled hours ☐ Share EHR results with executive leadership	☐ Normalize EHRs and WOWs to 8 hours of patient scheduled hours ☐ Implement intervention based on EHR audit results
TEAMWORK	☐ Assess teamwork once within the last 24 months	☐ Measure teamwork via EHR audit data (TWORD) ☐ Teamwork and TWORD results shared with executive leadership	☐ Implement intervention based on teamwork assessment and EHR audit results
LEADERSHIP	☐ Assess leadership skills for all frontline leaders at least once in the last 24 months OR ☐ Query physicians about unnecessary administrative burdens	☐ Implement leader development program that builds skills that promote well-being ☐ Query physicians about unnecessary administrative burdens	☐ Implement a customized leader development program based on assessment results ☐ Actively dismantle administrative burdens identified in query
SUPPORT	☐ Establish peer support program to deal with adverse events	☐ Implement two or more programs or policies aimed at broader issues of physician support	☐ Develop structured program(s) to actively cultivate community at work

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