

**The CMS Innovation Center's Approach to Person-Centered Care: Elevating Care Experience  
Across Models to Improve Outcomes and Equity  
November 15, 2023**

**>>Alexis Malfesi, CMS:** Good afternoon everyone, and welcome to the CMS Innovation Center session Approach to Person-Centered Care, Elevating Care Experience Across Models to Improve Outcomes and Equity. Next slide, please.

Before we get started, we have just a few administrative items to address. First, I want to let you know that this session is being recorded. Second, closed captioning is available for this event by clicking the CC button at the bottom of the screen. Third, I want to point out that we have a Q&A function available to us during the meeting, and I encourage everyone to use it. Due to the size of the event, we may not be able to respond to everyone's questions. However, we will be monitoring the Q&A closely and capturing any follow-ups there.

Lastly, if there are any press on the call please submit questions through the CMS Media Inquiries, Portal. That link is being shared now, thanks, Jake. I will now hand things over to Dr. Liz Fowler, Deputy Administrator and Director of the CMS Innovation Center. Next slide. Please.

**>>Dr. Liz Fowler, CMS:** Thanks so much, Alexis. And thanks to everyone who joined us today. We're really excited and grateful to have all of you here, and really looking forward to hearing your thoughts and perspectives in our discussion.

In terms of the agenda, I'm going to give a brief overview of the Innovation Center's strategy and speak to the Center's efforts to integrate patient perspectives across all of our models. Dr. Purva Rawal, who is our Chief Strategy Officer, will provide updates on how we are using patient journey mapping, patient reported outcome measures, and messaging on value-based care to achieve our aims. Then Kate Davidson, who leads our Learning and Diffusion Group, and Dr. Rawal will facilitate a panel discussion focused on partnerships with community-based organizations, pediatric care, and care transitions. And a special thanks, and call out to our guest speakers, we really appreciate your participation. And then, lastly, we'll close with a few summary remarks based on all of the feedback we hear and on otherwise you other ways, you can engage with the Innovation Center. Next slide, please, next slide. Thank you.

In 2021, the Center, the Innovation Center laid out our vision and a new strategy. Our vision is a health care system that achieves equitable outcomes through high quality, affordable, person-centered care. The Strategy Refresh consists, consists of five strategic objectives that carry and guide the Center's work. I'll go through those quickly. First, drive accountable care that promotes delivery of whole-person care, whole-person integrated care. For beneficiaries in traditional Medicare, who aren't in a Medicare Advantage plan, we want them to have integrated coordinated care and patient navigation that leads to better outcomes and improved quality. We set a goal of having 100% of Medicare beneficiaries in accountable care by 2030.

Second, we're focused on advancing health equity. We're committed to embedding equity into every aspect of our work. A few examples include new trainings for social drivers of health, engaging safety net providers, requiring participants in all our models to develop health equity plans, and other policy innovations focused on caring for underserved populations.

Third, we're focused on supporting innovation that enables the delivery of person-centered, integrated care. What more can we do to help model participants be successful? And this objective connects to knowledge sharing, peer-to-peer learning, collaboration, and closing care gaps.

Fourth, we're focused on affordability by addressing health care prices, and reducing duplicative or unnecessary care. And that also means out-of-pocket costs not just program. One recent example is the \$35 a month insulin model that became part of the Inflation reduction act and is now a permanent part of the Medicare program.

And finally, we need to partner to truly achieve health system transformation. We need to be working with other payers in the system, Medicare, Medicaid and commercial payers, but also hearing from other stakeholders in the system, like all of you. And we've made a real effort to reach out to as many audiences as we can to talk about our work and hear everyone's perspectives about it. In the past year we held a series of meetings with stakeholders across four states. We asked about their challenges and successes implementing health equity initiatives on a state and local level. And we're using those insights as we continue to embed health equity as a fundamental component of each model. That's just one example. Next slide, please.

A year ago, in November 2022, we released a One-Year Strategy Update Report that outlines our progress on implementing the strategy, articulates areas of focus for the coming years and includes metrics for how we're measuring our progress against our objectives. One of our five top, on top of our five strategic objectives and renewed vision, we're committed to strengthening our communication with stakeholders and solicit more balanced stakeholder feedback during our model development process. We did this for models launched this year, including the Making Care Primary model, the GUIDE dementia model and the AHEAD state total cost of care model, and we'll continue to do so with future models. We'll talk about this a bit more today in this session, in more detail. And in partnering to achieve system transformation we aim to align priorities and policies across stakeholders, especially from the patient and beneficiary perspective to make sure, we're meeting their needs. Next slide, please

To deliver on the Center's vision of a health system that delivers high quality, equitable, person-centered care to everyone we need to keep the patients at the heart of everything we do. And we need to make sure that we understand the patient and caregiver perspectives and build them into the foundation of our models at the outset. We want to consider quality measures that address patient experience and priorities, and how the models will impact the priorities identified by patients and families, including affordability, access to care, and equitable care.

During recruitment for our models we want to be thoughtful about what kind of information patients want to know about our model test, and how we can communicate what that model might mean for improving care, for the experience that patients receive when they get care. As our models are launched and patient care is impacted, we need to understand how they are experiencing changes in care delivery, quality of life, and experience. And lastly, we can consider how scaling up model affects patients and how we can ensure that the benefits that patients gain are built into new programs after a model test ends.

With that, I'm going to stop and hand it over to Dr. Purva Rawal to speak more to our patient and caregiver strategies. Next slide, please.

**>>Dr. Purva Rawal, CMS:** Thank you. Liz. Next slide, please.

The Innovation Center is working to place patients and caregivers at the center of everything we do to improve experience and quality of care which in turn will hopefully drive better outcomes and advance health equity. During our listening session last March we shared our key areas of focus in 2023 to help us first, understand patient and caregiver perspectives through engagement opportunities that promote rich patient, and caregiver feedback. Second, help us act on the information that we receive about the experience of care from patients and caregivers. Third, to help us communicate how we are acting on the feedback that we're receiving. And fourth, to help us harness that feedback over time and sustain engagement.

Today we'll share some of the progress we've made this summer and fall in terms of being inclusive and capturing a range of perspectives that reflect the different parts of our health care system. We've made progress in working on promoting a partnership approach for understanding patient experience, to solicit real-world feedback and to support ongoing improvement, and being transparent about how that gets translated, how that feedback gets translated into our programs and our models. Next slide, please.

In particular, today we're going to share some examples of where this is happening across the Innovation Center, such as through our increased use of journey mapping strategies to inform model design, development, implementation and evaluation. How we're leveraging patient reported outcome measures in our models to ensure that we are measuring what matters most to patients and their families. And how we're engaging patients and caregivers in value-based care, including a webpage centered around educational content and narratives gathered from real experiences. These are all steps towards the goal, the end goal, of ensuring that all of our models are built and implemented from the perspective of how they will impact patients and improve their experience, and towards strengthening our relationships with patients and caregivers to make sure they're getting the care they want and need. Next slide, please.

We piloted the use of journey mapping strategies in the Guiding an Improved Dementia Experience or our GUIDE model to elevate the importance of improving patient experience and its relationship to improving quality, outcomes, and equity. What this means is that we're exploring how patients and caregivers that are eligible to receive care under the model are experiencing that care. We're trying to understand where there are challenges and barriers along this path, and we're identifying how the model, once it will be implemented, is going to help address those challenges and barriers. And so for the GUIDE model, we used information gathered from interviews, listening sessions, and other research to better understand challenges that patients with serious illness and their caregivers experience along the continuum of care to identify key areas, to inform the design of our model, particularly as it's related to patient support, caregiver support, health equity, and education.

We're now expanding our use of journey mapping to inform the development of more of our models, our outreach, our implementation, and the evaluation of our models across our portfolio. Our goal is that using these strategies will help us convey key features of the model from the perspective of what patients care about, as well as support us being able to gather real world feedback throughout the model life cycle, to help us create a continuous feedback loop with patients and caregivers, and ultimately to build better measures with patient data. Next slide, please.

The Innovation Center is also using patient-reported outcome measures, or PROMs, to elevate patient care experience and outcomes across our models. The Innovation Center's PROM strategy supports a more person-centered quality strategy in Innovation Center models by measuring what matters most to

patients and by capturing the caregiver perspective. A PROM strategy supports our broader initiatives by driving innovations in care that facilitate again person-centered care, and that increase the likelihood that people receive care that's aligned with their goals, values, and preferences. And, it just helps us assess how the center is impacting more dimensions of beneficiary experience and improving them. Next slide, please.

So, I'm especially excited today to be able to speak to some of the concrete examples of where this work is happening in our models and really, the ways in which the feedback that we've heard from patients, caregivers and advocates is being used to make our models hopefully work better. First example is the Kidney Care Choices model, we're working on reducing fragmentation for more seamless care. A single set of providers will be responsible for a patient's kidney care. We're also using shared decision making to support patients with receiving care that honors their values and preferences. We're also aiming to capture patient voices using gains and patient activation scores after 12 months to understand the model's impact on patient knowledge, skill, and confidence for self-management.

Second, in our Making Care Primary model, care providers are going to be responsible for identifying health-related social needs through screening, but also with connecting patients and caregivers to community supports to help meet those needs. We're also planning to capture patient voices using the patient-centered primary care measure, or the PCPCM, to understand the high-value aspects of primary care based on a patient's relationship with the clinician or the practice that they, that they're seeing.

And third, in our GUIDE model as in MCP, Making Care Primary, and all of our new models, patients' social needs will also be screened for and met through connections to services and resources in communities. And the model also provides support for addressing unpaid caregiver needs, like payment for respite care for patients with moderate to severe dementia, up to an annual respite cap amount. That's something that we heard about over and over from caregivers and beneficiaries with dementia, that the need to better support caregivers.

And last, in the States Advancing All Payer Health Equity Approaches and Development are more simply said, AHEAD model, we have a formal model governance that requires representation from patients or advocates and community organizations. And, we are focusing on increasing investments in primary care, to improve access to critical services, outcomes, and most importantly, to advance equity. Next slide, please.

We're also making changes to how we talk about patient-centered care, which is designed to focus on quality, how providers deliver care and the patient experience, the things that matter most to patients. The Innovation Center is working on a strategy to reach new audiences and to build awareness and understanding of our work in improving quality and the care experience through better care coordination and addressing patients' unique needs. To support this, we've developed key concepts, many of which are listed here that help briefly explain the work of the Innovation Center, like person-centered care, health equity and care coordination. You can access these on our website. Next slide, please.

We're also developing vignettes that showcase different aspects of patient-centered care from the perspective of patients and caregivers with lived experience. By gathering these narratives, we can learn more about how to improve our work and how we are impacting people, and we can also help improve people's understanding of patient-centered care and what it means for individuals and for care teams.

You can listen to Lamont's story and Connor's story by clicking on the links that we shared in the chat. Next slide, please.

We want to shift gears and hear from patients and caregivers and community representatives and researchers on a few key priority areas for the Center. So I'm going to hand things off, over to Kate Davidson, the director of our Learning and Diffusion Group at the Innovation Center to kick us off. Next slide, please.

**>>Kate Davidson, CMS:** Thanks so much, Purva. We're pleased to welcome three experts to participate in today's panel and provide their perspectives on patient-centered care. Our speakers include Desiree Collins Bradley, Patient Engagement Network Lead at ATW Health Solutions, Leena Sharma, Deputy Director for the Center for Community Engagement and Health Innovation at Community Catalyst, and Marisa Scala-Foley, Director of Aging and Disability Business Institute at USAging. We are grateful for your time and willingness to join us today and are excited to hear your input. Next slide, please.

We hope to focus today's conversation on three areas that the Innovation Center would like to learn more about from the patient and caregiver lens. Our first panelist, Desiree Collins Bradley, from ATW Health Solutions, let's start with a discussion on pediatric care experience. For example, we know that people want to feel heard by their care teams, trust their doctors and have access to the care that they need, and that their care is affordable. But what are the aspects of patient experience that are most important to keep in mind as we think about ways to improve outcomes for families with children? What do families value most? Desiree?

**>>Desiree Collins Bradley, ATW Health Solutions:** Yeah, thank you, thank you so much. So you know me being a mom, I'm a mom of three in the Houston metropolitan area. So I've had a lot of experience in this space with pediatrics. But you know a lot of times you know what works for me, what I've heard around the country, is that again, families who want to be heard, but they also want to be a part of the planning. So if there's an intervention, if there is a new care plan being created, we want to be able to kind of provide that input, have that shared-decision making model so that we can be successful. Not only whether that's inpatient, in clinic, but at home, because if we're prescribed the plan or a medication, and it's not accessible, we can't afford it, or we are not able to adhere, we're labeled as non-compliant. But there are social factors that kind of go into play here that will affect you know how I treat my child, if I have the resources available. And so, making sure that, you know, we have that open dialogue to say, okay, this is what we're thinking, what are your thoughts?

And then also keeping in mind to include the patient voice as well. Yes, I am the voice of, for my children, but as I have a 12-year-old and a 16-year-old they are able to say, hey, you know, do I want to take a pill, or do I want to take liquid? You know, having them be a part of their care plan.

And then the other aspect of it is, is taking culture into account. So, depending upon where you eat, work and play determines whether you know what my cultural beliefs are, making sure that someone starts that dialogue and do it in a way that I'm comfortable, that it's not an awkward conversation to say, okay, what are the social needs that that go into play, that you need to be successful at home? So, is housing an issue, or do you have enough, adequate food. But making sure that you know the messenger matters. So who's asking me these questions and the way they ask me these questions make it a more comfortable environment.

>>**Kate Davidson, CMS:** Thank you so much, Desiree. You hit on a number of key points, and I think that it's, it resonates even more when we're talking about things in the pediatric space that you're engaging with parents, families, as well as children in that shared-decision making. And really thinking about how culture impacts the ability to have an open and trusted dialogue with your care team. Wondering what types of patient and caregiver outcomes we should be considering when we're evaluating the patient experience within the pediatric care space? Do you have any thoughts on that, Desiree?

>>**Collins Bradley, Desire, ATW Health Solutions:** So I do. And so, you know, I love that, you know early on in the discussion we're talking about those patient reported outcomes, and I honestly believe we can blow that up, right. So there's two factors here, a lot of times patients aren't even aware that there is a term versus, you know, patient reported outcomes to really share what their needs are for their family or their pediatric patients. So making sure that one, it's transparent, and that it's more of common knowledge. Right, so not saying, we need to put it on billboards everywhere, which for me, I would love to see that, but making sure that the families are aware that this is actually something that they can do.

And then the other aspect is, taking into account, I'm going to speak culture here, you know what is, what is the cultural outcome that I want to see, right, so that resonate with me and my family. So I'll use an example, so my daughter is deaf, my daughter, we utilize sign language in all that we do. So when things come up, and making sure that we translate that into terms that she can understand, making sure that we have those, appropriate language for her. But when we're coming up with a plan is like, okay, what does that look like in my everyday life? How does that affect her diet? What are some of the diets that we're actually, you know, utilizing in my home. I'm from deep south Louisiana. And so really taking it that it's not a check the box in a one size fits all. But how can we take those outcomes and put that in a way that everyday patients can kind of translate that? And I know that's like a big pie in the sky task. Because, you know, we want to roll this out as a nation. But I do feel like we really need to take cultural aspects into account, and do it in a way where people feel comfortable and they don't feel like it's going to be punitive or shame, like I'm able to kind of share what's culturally appropriate for my family.

>>**Kate Davidson, CMS:** You found some really important points, I think. Number one, really, I think one of the challenges we've had is making sure that there is a clear connection, and there's a transparent connection between how we're measuring outcomes and the way that that care teams are really being incentivized for improved outcomes as well. And so making that connection that through line for patients and families and caregivers is so important. So thank you for calling that out.

And then I think the other piece first of all, thank you for being so open about your own experience with your daughter, and being very clear about how it's not a one size fits all. That we have to think about the conditions that individual is experiencing, how that has implications for the family, and for the community in which they reside. So thank you calling all that out and giving us a really clear example of how that has all played out for your family.

>> **Desiree Collins Bradley, ATW Health Solutions:** Thank you, thank you. And there's one more point, I want to add before you continue, is that, you know, making sure that it is a co-created model. Right, so you know, I've done a lot in the space of measurement and all things health care quality improvement, elevating the patient voice. And sometimes, it is an afterthought, right. So we build something and then we bring it to the patients and families and say, okay, what do you think? Let's back that up and make sure that family caregivers, patients are involved and really co-creating what exactly works for them. And then we can go into that whole, you know implementation phase, and everything else. But I really feel like patients, families, caregivers should be at the beginning of really building what we measure,

building what those outcomes really look like. Because it's going to save us all a lot of time, and at the end of the day, a lot of money. And so I really feel like, you know, we need to kind of really take a step back and really elevate the patient voice in every aspect of our quality improvement efforts here. So, I'm sorry to cut you off.

>>**Kate Davidson, CMS:** No, I'm so glad you added that point Desiree, actually, because I think it's so important, and it's at the foundation, at the heart of everything that we've been trying to do with the Innovation Center. And I will tell you it's not easy. It takes, it's transformation is messy, developing new models is messy. And so we just so appreciate having partners like you, who will continuously give us that feedback. So thank you so much and really appreciate you being here today. And with that hand it back over to Purva to follow-up with our next panelist.

>>**Dr. Purva Rawal, CMS:** Our next panelist, who I'm really excited is with us today is Leena Sharma from Community Catalyst. Leena, I know you have experience as an advocate for a long time, for better, equitable, patient-centered care, so it's really wonderful to have you with us today. The first question I have for you is, from your perspective, who do patients and caregivers trust and rely on during care transitions, so for instance, when a patient is being discharged from the hospital?

>>**Leena Sharma, Community Catalyst:** Great question. Thank you so much, Dr. Rawal, and the Innovation Team for having this listening session. I'll start with a couple of things. One I wanted to sort of ditto to everything Desiree said, because I think a lot of our points are going to be in sync.

Some of the key attributes of what is considered trustworthy, someone who's reliable, there's accountability, transparency, honesty, humility, and attitude. A lot of what we've learned in our work, where we've conducted a number of listening sessions and focus groups with people who are on Medicare and Medicaid, older adults, people with disabilities, people with complex medical and social needs, and so to them, trustworthy means not trying to take advantage of people's vulnerability. And reliability means that they can be trusted to show up, and caring, and that's part of you know the attitude piece. Participants that we've talked to place really high importance on mutual respect between people who are receiving care and people who are giving care and communication, and bi-directional communication is critical. People trust and rely on people who show these attributes consistently. And it's not limited to just a set of providers like doctors and nurses. But it's also family caregivers, it's social workers, it's family members. It's those in the community that they have an established relationship with.

I think, another important point that I would raise, and I know Desiree raised too, is around language access, and cultural humility. Speaking the language that the person is most comfortable in, having a care transition coordinator or social worker who really understands culture, respects their beliefs, even to the type of food that they prefer, goes really a long way in building that trust and keeping it. And just speaking from personal experience, when my family was taking care of our grandmother, the cultural belief, the food that she was receiving, really helped in her understanding, okay, this is, you know, my current situation right now, but I have people around me whom I can trust and understand what's important to me.

And I think the other really critical point, especially in the care transit, care transition piece, is that continuity. So the communication between, you know, when you're in the hospital or in the nursing home or in the rehab center, and then you're going home, how is that communication happening? Are all the right folks involved, and understanding what that care plan looks like? Especially, is a patient

involved? Are there family members involved, and others in the community whom they trust involved? And is there a feedback mechanism to ensure that those needs and services are being met?

>> **Dr. Purva Rawal, CMS:** Thank you. I actually have a follow-up for you. So to me, like one of the things I took away from your remarks is just trust. And how do we build trust in different, like layers of the system? And so I'm wondering if, from your work, you could talk about some of the best practices for supporting patients in building those strong and trusting relationships? So, for instance, with transition coordinators, social workers, that you mentioned, community health workers and others that hopefully are those trusted people at these care transition, these points in time, where people are transitioning from hospital to the home or other care transitions, and sometimes might be at their most vulnerable.

>> **Leena Sharma, Community Catalyst:** Yeah, I think that's a great question. And a couple of ways to kind of get at that question. One, I think, you know, there's training that's really critical, I think. You know, building power with the patients and their family caregivers and empowering them with the information that they need, is critical to helping them to also learn the skills to communicate. But the training also goes the other way. So training the care navigators, training community health workers, training others who are going to be providing those transitional services. You know, it's a simple concept, but it could be, you know, there's a lot of layers to that. How do you communicate that type of care, how do you communicate about care in a, you know, challenging situation? How do you act in reliable, accountable and honest ways in trying to navigate those transitions, and external pressures? So I think the training piece goes, is a two-way piece.

I think the other piece that is also important, I think you know, you talked about this in earlier slides, but really, a thriving person-centered system is one where paid workers are support supported in unison with family caregivers, right. The compensation piece, skill building is really necessary. It benefits the person who's receiving the care, the family caregivers, those who are supporting in the transition pieces, when there is training, there's oversight, and there is compensation for the family workers.

I think the other piece that I would raise here is funding mechanisms. Right, the availability really varies for community health workers and care navigators, and that really needs to be consistent, and accessible. I think highlighting the piece around workforce and ensuring livable wages, compensation for workers, that has a really significant impact on you know, who's available for those care transitions. So when you think about urban communities versus rural communities, that availability really matters.

>>**Dr. Purva Rawal, CMS:** Yeah, that was really helpful. And it actually brings up another question I have. So, we talked a little bit about best practices. But those best practices are really, and maybe I should have flipped the order of these, but those best practices are supposed to help address barriers that people face. So, from your perspective, what are some of those, the biggest barriers just to successful transitions, you know, between settings? So we talked about hospital to home or hospital to nursing home again, those are critical points in the lives of patients and in their families. And so what are some of the biggest things that we should, we should be thinking about?

>>**Leena Sharma, Community Catalyst:** Yeah, I can raise two, I think, two points.

One, I think there's probably, you know, a lack of access to understandable and accessible information, and follow through, I think, both on the side where, who's providing the services, so providers, but also on the beneficiary side. In terms of, you know, they might be unclear about what to ask, or who to ask or, where to go. And so asking ourselves the questions about, you know are hospitals, providers, and



others aware of the community-based services that are out there within their communities? Are there, are they well versed in making those referrals? Do beneficiaries and their family caregivers have access to understandable information where they can follow-up about services and community-based services. I think one of the biggest pieces that came up in some of the focus groups and listening sessions we've done over the years, is that the barrier is larger where there's distrust within the community. So if there's no established trusting relationships, if not trusting the hospital, or if they're not trusting, you know, from where they're transitioning to where they're going. I think that lack of access and information also plays a pretty big role.

I think the other piece is, you know, not having well planned out transitional services, not having a care plan in place, and the provider communication. You know, does the primary care physician, or where this person is getting their usual source of care, do they know about the discharge planning? You know, did the hospital or the nursing home connect patient and families to the different community-based organizations? Is there a plan in place, where it was like, as Desiree pointed out, was it co-created with the patients and the family caregivers? And is there transparency and accountability? And a feedback loop around how those transition services are going to take place, and that plan is going to take place.

**>>Dr. Purva Rawal, CMS:** Great. So I think, I'll just give you, I'm going to ask you one more question. So we talked a little bit about, you know, we have kind of talked or covered barriers, we covered a little bit about best practices, and then we really started out by talking about who people trust during these critical points in their care journey. So, if we pull all of those pieces together, what do providers, so health care organizations, whether it's hospitals or primary care practices, providers, but also patients and families, what do they need from the Innovation Center? So, we think about new value-based care models or models that are trying to drive improved quality outcomes and equity, what do they need from us, what can we do to support those improved care transitions?

**>>Leena Sharma, Community Catalyst:** Yeah, I would say, you know, the intentional efforts that the Innovation Center is making around meaningful community and beneficiary engagement is critical. And I would emphasize that, you know 200%, having mechanisms in place for this type of engagement across services, across models. And you know, you talked about that in some of your earlier slides.

Intentional integration of community-based organizations with provider groups, with beneficiaries, right. So, having funding mechanisms in place, I think, in some of the models that have happened in the past and current models, you know, mechanisms that fund community-based organizations, integrated care teams that include navigators and community health workers and family caregivers. And the engagement of beneficiaries and family caregivers in, you know, the process from design to implementation to oversight, which I think you also mentioned earlier.

I think the other really important piece, which we haven't talked about, is a data sharing piece, and being able to share data across different settings, being able to have valid, reliable data that can inform, you know, different aspects of care and care delivery, and I would also say, evaluation. And, I think you know, there's the large-scale evaluations that happen around, you know, the models for the models that the Innovation Center has developed. But, there's also rapid cycle evaluation. What are we learning, and where can we course correct? And how are we doing that, you know, with beneficiaries and with family caregivers and community organizations. I think I would highlight those three points.

**>>Dr. Purva Rawal, CMS:** I really like that sort of intentionality and how we're engaging and taking in feedback, data and data transparency, in a way that's utilized, not only to providers, but also to people

and to caregivers and families, and then really thinking about evaluation. And what I like to think of is like building that learning kind of health system approach where we're constantly iterating and improving. Thank you, Leena. And with that, I'm going to turn it back over to Kate. Thank you.

**>>Kate Davidson, CMS:** Thanks so much, Purva and Leena. I'm going to do our next panelist, Marisa Scala-Foley from USAging. We've heard a lot, Marissa, already about some of the thoughts around shared-decision making, the importance of considering culture and social needs, as we're thinking about a care plan for both pediatric populations, but really across the board. And then we also just heard from Leena about the importance of really taking into consideration the care transitions, and taking that health-related social needs screening and taking that into care plan for discharge.

And so I want to focus a little bit more like, very squarely on that health-related social needs screening, and making the connection to community-based organizations. And so we'd love to hear your perspective on how patients that have health-related social needs, such as transportation or housing support can connect with community organizations. And, in your view, how and when should health care providers ask about health-related social needs, and support connections to community-based organizations?

**>>Marisa Scala-Foley, USAging:** Alright, thank you so much. Thank you to CMMI for the invitation to be part of this really thoughtful and engaging discussion. I have loved what Leena and Desiree have said so far in terms of some of the systemic needs, in terms of co-design and data transparency and so forth.

So, I represent USAging, which is a national association that represents and supports the network of Area Agencies on Aging around the country. We also advocate for Title VI Native American Aging programs. And our members are everyday in their communities helping older adults and people with disabilities and caregivers to live with optimal health and well-being in their homes and communities. So, we bring that community-based organization perspective. And I, you asked some really important questions in terms of how are the connections being made right now, between individuals and community-based organizations. And then, where the health care sector fits in and where health care providers fit in.

And the reality right now, is that people with health-related social needs connect with community-based organizations through a variety of different ways right now. It could be through word of mouth from other people in their communities who are receiving services that community-based organizations might offer. It could be through state, no wrong door systems. Or, in the case of older adults and persons with disabilities, Aging and Disability Resource Centers that work with individuals to determine their eligibility for long-term services and supports, that work with them on a person-centered plan to receive those long-term services and supports and so forth. They connect with community-based organizations through community events that organizations may be putting on. They connect with them through faith communities. Through, as Leena pointed out, through community health workers, or, you know, in in the aging network, often these folks are called navigators or outreach workers. So really, there's a there's a lot of different ways that people, individuals with health-related social needs, are connecting with community-based organizations.

And one of those other ways is through health care providers and payers. There's a lot of call right now, both from CMS, through quality reporting metrics and the new models that are being developed, as well as through accrediting bodies, that are pointing toward the need to screen people for health-related social needs in health care settings. And while, you know, we certainly applaud the measures and the

kind of systemic elements that point toward these, the need for these, this screening and for connections, you know, we would say that while these screenings, you know, are important to identify some initial needs, what really needs to happen, at that point, is for screenings to lead to fuller assessments that community-based organizations like Area Agencies on Aging, like Aging Disability Resource Centers, and others can offer.

Often, when someone, when a patient, an individual has one need, they often have multiple other needs that might or might not be captured through a screen, you know, a screening tool that may focus on only a few items, such as nutrition and transportation, interpersonal violence, and so forth. So we really advocate for the screening just to be sort of the walk through the door, right. The entry point that leads to a fuller assessment, a care plan, as both Leena and Desiree pointed out, that is co-designed with all of the members of the team, the individual being served, the community-based organization as well as the health care team that is working with them.

>> **Kate Davidson, CMS:** I also want to check. I think I heard something really interesting that that you said in this Marissa, which is many times patients, families in communities are already connected to those community-based organizations where they have a trusted relationship. And at the same time, from the health care system perspective, we're really putting a lot of accountability on providers to do the health-related social needs screening. And so what you're really advocating for here is making that connection between where people already have those relationships, creating a more robust, fuller care plan, and like looking for the gaps for where they're not already connected and trying to make some of those connections with the existing community-based organizations in, where people live and where they're receiving care. Is that a fair summary of what you said?

>> **Marisa Scala-Foley, USAging:** Yeah, absolutely. You know, and I'm, you know, we actually have a story from one of our members that I think really sort of illustrates that. An Area Agency on Aging, AgeSpan, in northeast Massachusetts pointed toward a, you know, a story they had from a referral they had received from a health care provider. A client named Johanna, she was an 83-year-old Spanish-speaking woman who lived in an urban setting. She had type 2 diabetes, congestive heart failure, and arthritis. Her sole source of income was Social Security, and she had lived in public housing for more than 20 years. She had her 34-year-old grandson, who lived with her, who suffered with sub, who suffered from substance use disorder had moved in with her, and was not leaving. She was fearful of him and knew that he had been stealing both pain medication and money from her, and as consequence she was three months behind on her rent. She didn't have a family, a reliable family caregiver, and was missing medical appointments. So, after four ER visits in two months, the hospital made a referral to the local community-based organization to address, you know, the nutrition and housing needs, which were part of the screen that they had done.

Well, what community-based organizations really bring to the table in all of this, in addition to the sort of deep community trust that both Desiree and Leena talked about, they're also really expert in blending and braiding services that come from a variety of different funding sources. So, they were able to access a host of services for Johanna, from medically tailored meals, and protective services that were funded by the Older Americans Act, to grocery shopping assistance and rent assistance that were provided by her accountable care organization, SNAP application assistance that was paid for by a local philanthropy, access to an evidence-based program that addressed depression, that was paid for by a federal grant, eviction assistance that they were able to arrange through a referral to another community partner, and transportation that was paid for by a state grant. So, while that limited screen that was offered in the, you know, at the hospital pointed toward a couple of needs, in reality she had a

host of needs, which that deep trust that, you know, trusting relationship that existed between Joanna and the community-based organization she was working with allowed for that fuller assessment that led to all of her needs being met, all of her health-related social needs being met through a variety of different kinds of systems and programs.

**>>Kate Davidson, CMS:** Thank you so much, Marisa. It's always so helpful when we use a patient experience to help drive some of our understanding of what's happening in communities. And you gave such a really rich example of how community-based organizations are uniquely positioned, not to just have a fuller understanding of the people that are, they are seeing their programs, but also to have a rich understanding of the different services that are available within their communities as well. So thank you for painting that picture and giving us a very concrete example.

I am going to hand it back over to Purva. I think we have a couple of follow-up, time for a couple of follow-up questions, Purva, if that works for you.

**>>Dr. Purva Rawal, CMS:** Yeah, I was actually going to go back to Desiree for a moment, if that's okay. I, you said something that just kind of stuck with me, and I wanted to ask you a quick follow-up. You talked a little bit about the opportunity to engage children in their care plans as they get older. And if you've noticed that with your own children, as they get older. And you know, there's different challenges, obviously, with engaging children in their care plans, but there's also an opportunity, I assume, to really help, that help people early on navigate the health care system and be advocates for their own needs and making their health care choices. And so, just wanted to ask you about different strategies that either you've used, or that you've seen that help engage children as they get older in their care, and how we might be able to think about that at the Innovation Center.

**>>Desiree Collins Bradley, ATW Health Solutions:** Wonderful, Yes, I love this question. So, my daughter has very complex medical needs, so she'll be, I use the term lovingly, a frequent flyer of the health care ecosystem forever. And so we, as a family started with her very young being, empowering her to be her own advocate. I think that was the number one first step is making sure that not just her parents, but her care providers are all on the same page to empower her to be a part of the team. And I'll share a quick little story. So, we were seeing a new physician and he, you know, she's got a complex medical history, so he's got to acclimate to that. He comes into the office and he's directing all his attention to mom, going through the history with mom, mom, mom, mom, mom. Naturally, she's very upset, and she's signing to me that she doesn't like him. And I'm like, oh, don't do that right now. And so he asked like, what is she saying? And I reluctantly told him, she said, she doesn't like you. And he was a wonderful clinician, however, he didn't engage her. Right, so it was a teaching moment, not just for her, but him as well.

So, long story short, now she is fully integrated in all aspects of the care plan, and it's documented. So if you think about, we see 13 different specialists at our local children's hospital, that's a lot of docs, that's a lot of coordinating going on. But it is documented in her electronic health record that she is a voice in her care plan. And how I know this is, even when we've gone into the ER, we've gone in-patient for certain procedures, they have said that, oh yeah, we know that she does this, she's a part of her care, you know. And they'll ask her, hey, we're going to do this, what are your thoughts on this? And she is always included in that. So I think building the culture in your family, in your system, in that care team very early on to include the patients.

And then I'll take my son. My son does not have complex medical needs, but because he sees were so proactive with his sister, he's become a part. So now we go into his well visits, which is, you know, once a year to have as well checks, or ear infections, he's fully integrated in his care because he sees the model and the culture that we're building. So as he's gotten older as well, he's more, you know, included in the care plan as well. So I'll say that's the number one step.

And then two, lead with an open heart. Right, so yes, she has disabilities. She has, she's deaf, so she'll need those supports. What can we do to support her so that she's successful? Making sure there's an interpreter in that office, and knowing that she knows that's her right to ask for an interpreter in all of your interactions in health care. And so, knowing that she knows that and we're ready to go. So I know that's a little long answer for your question.

**>>Dr. Purva Rawal, CMS:** No, it was great. And I think that's it really helps when there's like real life examples and lived experience that help illustrate. And Marisa story did that really well as well. It just brings it to life in a different way, just like the journey mapping does. I think it helps us figure out where there are pain points in the system right now, and the role that we might be able to play in smoothing some of those out.

So, Kate, if you didn't have any other follow-ups, I think we've gotten a number of questions in from the audience and folks that are joining us. And since we have a little bit of time, we thought we would turn to some of those questions. We're not going to be able to get to all of them, but we'll try to get to a few of them at least.

And there's been several questions that have come in about increasing access to primary care, which was actually a topic that we covered in one of our previous beneficiary listening sessions as well to really help us inform some of our primary care efforts, including our Making Care Primary model that we announced in June. And there are a number of things that we're doing to try to increase access to primary care. We know that access to high quality primary care is associated with better outcomes, lower mortality, often better experience. And we also know that primary care and high quality primary care is the foundation of any high performing health system. And so that's a really core part of what we're trying to do at the Innovation Center, across our entire portfolio, is to identify ways to increase access to primary care. And there are three principles that we're really centering on in that work.

The first is financing. So we know that primary care, historically, has been undervalued and underpaid. And if we, if we want primary care providers to be able to spend the time that they need with an individual patient or family, we want to, you know, support their ability to screen for health-related social needs, make those referrals back to trusted community-based organizations, we have to be able to change their financing structure. So we need to invest more in primary care. And we also need to provide what we think of as what we call prospective payments. So, not having to always be billing on a particular code to be able to get revenue. Right, so to be able to do those things that we don't have billing codes for, the talking to folks, the speaking to specialists the coordination of care that's often the things that patients really need. And so the first is looking at ways to change that financing environment for primary care. And we're trying to do that multiple ways, starting with our Making Care Primary model that I mentioned in June and future efforts as well.

The second is health equity. And if we want to improve quality and outcomes, that means we need to increase access to high quality primary care in underserved areas and for more of the people that we serve. And so across all of our models, we're thinking about, how do we advance health equity in our

primary care models, whether it's payment adjustments, the kinds of measures, etc. How are we really thinking about advancing equity? And again, across the models, there's not just one way to do it, and we have to be mindful about that in every aspect of model design.

And then the third is sustainability. We're the Innovation Center, so we run time-limited model tests, they don't last forever. We want to be testing things and then seeing if they work, and are they working better for patients and providers in the health system. And so we also want to be very, thinking on the front end, about sustainability. As we're running these model tests and providers, we've seen this happen in our other models and our primary care models, they, we see more team-based care, we see more care coordination. So as providers and practices are investing in those kinds of care delivery changes to better connect with and support patients, are we making sure that those are, or how are we making sure that those transformations are sustainable? And you can do that by aligning across multiple payers? So not just Medicare, but Medicaid and commercial payers, and trying to see if people can be moving, we can all be moving in the same direction, which makes it easier for providers to invest and sustain transformation.

So I'm going to stop there and turn it over to Kate to take the next question.

**>>Kate Davidson, CMS:** Yeah, we got some interesting questions about alignment with what health plans are doing around patient reported outcome measures and patient reported experience measures, and what CMS is planning on, supporting some of that work. There's a couple of things that I would just want to point to.

Number one, is that CMMI has set a goal in all of our models to have at least one patient reported outcome measure or patient reported experience measure in our quality measure set. In addition to that, the, to support some of the alignment efforts that we have going on, we've made a commitment to adopt, where possible, the Universal Foundation Measures that we announced as an agency, I think of March of this year. And then, finally, I think there's a number of activities that the CMS Innovation Center as well as the larger CMS agency is involved with related to the LAN.

Number one, is a National Plan Work Group that CMS is sitting as part of that is really geared toward ensuring that all of the major national plans are trying to move in the same direction around quality measurement adoption, which includes things like data collection and measure specifications. And so there's a real commitment from a number of plans across the country, as well as from CMS to try to drive some of those alignment efforts at the national level.

We're also testing through the LAN an opportunity to create alignment and join forces with a lot of the innovation that's happening at the state and local level. So the State Transformation Collaborative, so we're engaged in four states through the LAN the through California, Arkansas, North Carolina, and Colorado, where we're really being participating in some of the efforts that they already have going on there around measure alignment, measure development, etc., And then we also are supporting through a number of organizations that are representing stakeholders across the country through the Accountable Care Action Collaborative and those folks are really trying to drive alignment in each of the member organizations that they represent.

And then a final piece of the LAN is focusing on is just recently launched, a Person's Perspective Council, which will really advise on all of the strategic initiatives which will be inclusive of things like any quality measurement initiatives that we have going on. And I think this echoes a lot of the recommendations

that we heard from all of the speakers which is engage with patients and caregivers early and throughout the process. And so we're really intending to do that through the LAN as well.

And then the final piece that I would just add, is that and we set a goal at the Innovation Center to have 100% of our models, where applicable, have a multi payment strategy. And we are we are really dedicated to ensuring that we have the elements and infrastructure in place to support convening, because alignment takes time and it takes, there's a long-time horizon. You can't just flip a switch on and make it happen overnight. And so we at CMS are committed to our payer partners and defragmenting the payment system, so that it's more accessible for patients.

And so with that, I'm going to pause and hand it back over to Purva for any of your final thoughts, or closing remarks or themes.

>>**Dr. Purva Rawal, CMS:** Yeah, I guess just thinking, covered a lot of ground, and we asked questions in a couple of different buckets or targeted areas. But I feel like there were some themes that came out, whether we're talking about pediatrics or care transitions or health-related social needs.

And a couple of themes that really jumped out to me today were, first, inclusion. So inclusion when it comes to care planning, that means that we need to, you know, make it possible for providers to be including trusted providers, trusted care providers, whether it's community health workers, transition coordinators, etc. And that as part of that inclusion we need to acknowledge culture, language, other aspects that really again, allow people to be engaged in their care planning, whether they're young or older, or their caregivers.

And that inclusion leads to, I think the second theme, which was trust. And that trust then also allows a different kind of dialogue and engagement that helps providers and patients be able to recognize what people need. So, for instance, you know, really being able to use a screening for health-related social needs to then form a deeper relationship and work with the community-based organization that might be well positioned to meet people's health-related social needs more holistically.

And then, I think about our role at the Innovation Center, and how do we do that? And I think Leena summed, summed it up really well, with intentionality in our design, and who we are listening to, how we are incorporating and reaching out to patients and advocates and experts. The second, data transparency in a way that's accessible to all parties, and then evaluation, figuring out what's working what's not, so that we are in a state of constant, continual iteration and improvement.

So with that, I want to thank everyone on this call for joining today's listening session. I think it was a productive conversation, hopefully, Kate does too. And we look forward to future dialogue. We're going to be synthesizing today's conversation, curating key insights and feedback and using that and on our own work and continue dialogue with all of you.

Please participate in the survey for today's event by clicking in the link in the chat window. And you know, please also take note for continued engagement to learn more, sign up to receive regular email updates. Please visit our website, our model specific web pages and follow us @CMSInnovates. So with that this concludes, today's listening session. I want to thank you all for joining on behalf of Liz and Kate. And I hope you have a great rest of your day.

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