PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Expand and diversify care teams to make primary care more comprehensive and accessible, better meet the needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Ongoing support from a primary care team that understands how to help you in the doctor's office, at home, and at work
- More time with your primary care provider (PCP) when you need it
- Behavioral health services right away at your primary care office
- Help with your eating and exercise from a health coach or nutritionist to prevent or better manage chronic health problems
- Help with your medications from a pharmacist
- Help preparing for medical visits or following your care plan from a navigator or care coordinator
  - Help with transportation, food, housing, and other needs from a community health worker

PRIMARY CARE TEAMS CAN...

- Enable PCPs to spend more time with patients and less time on activities that could be supported by other care team members
- Better assist with lifestyle changes to prevent or manage chronic illness and achieve care plan goals
- Expand your ability to help patients schedule specialist appointments, prepare for visits, ensure timely follow-up, manage medication problems, and reduce barriers to care
- Use new team members to better manage patients with complex conditions
  - Improve access to language assistance and community supports to address problems like housing, transportation, and food security.
- Improve practice efficiency and care team satisfaction

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Martín is 66-years-old, has lung disease, high blood pressure and is overweight. He has unstable housing and no car. The network's quality improvement team recommends an in-person office visit because his high blood pressure is not well-controlled. Martín reluctantly agrees to come in.

Martín prefers speaking Spanish and needs assistance with transportation. Before the appointment, the patient navigator and a Spanish interpreter call him to arrange transportation. At his appointment, his primary care provider conducts an exam with help from a medical interpreter.

He meets with the nutritionist to create an action plan to help him eat healthier and be more active. The pharmacist reviews his medication list and determines the most cost-effective medications for managing his lung disease and high blood pressure.

Martín meets with a community health worker to apply for financial help for medications, food, housing, and utilities. The care team reviews Martín's progress through notes in the EHR and at weekly huddle meetings.

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HOW

Care Team and Network Requirements

- Hire care team members to provide acute, preventive and chronic care; comprehensive care management; care coordination; patient navigation; behavioral health integration; health promotion and chronic illness self-management and medication prescribing and management (see definitions of functions, activities and credentials)
- Provide population health analytic resources to develop, implement and refine operations and to support continuous health promotion and quality improvement
- Determine care team compositions, location of team members, and staffing ratios based on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, and team member role
- Deploy care team members on-site at the practice, in the community or patient homes, and/or at a central hub in the network or health center; partner with other organizations as necessary to provide appropriate services and care team capacity
- Ensure care team members apply their skills to the top of their training, but do not exceed their qualifications
- Train team members to deliver effective team-based care (see Principles for Team-based Care) including workflows and communications.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- EHR and protocols to ensure capture all interactions between patient and care team members, including non-office-based care
- EHR supports population and registry management and care management
- EHR includes a comprehensive care plan with role-based care team access
- Direct connection to support coordination with community-based services, including behavioral health

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care, provider support, discussing stress, and overall provider satisfaction

Quality

- Improved preventive care (e.g., cancer screening, immunizations), especially for individuals with complex illnesses or disabilities
- Improved chronic illness outcomes (e.g., diabetes control)
- Improve care plan adherence by reducing medication problems
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Lower out of pocket costs for patients when receiving services in primary care and by non-billable care team members
- Reduced ED and hospital utilization

Access

- Easier access to services in the practice, home, or community
- Assistance getting access to medical services and community supports

IMPROVING HEALTH EQUITY

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Diverse care teams help by:

✓ **Having community health workers** who reflect the patient's community and culture and medical interpreters who address language barriers.

✓ **Linking patients to housing, food, transportation** and other community resources.

✓ **Navigating billing and insurance issues** for people who have financial barriers to care

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