Primary Care Modernization Draft Capability Summaries Compendium

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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.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Recieve ongoing support from a primary care team that understands how to help you in the doctor's office, at home, and at work
- Spend more time with your primary care provider (PCP) when you need it
- Access behavioral health services right away at your primary care office
- Get help with your eating and exercise from a health coach or nutritionist to prevent or better manage chronic health problems
- Get help with your medications from a pharmacist
- Get help preparing for medical visits or following your care plan from a navigator or care coordinator
  - Get 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 health 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 a 66-year-oldwith lung disease, poorly controlled high blood pressure and obesity. He is often homeless and without a car. Martín reluctantly agrees to come in for an office visit recommended to him by the network quality improvement team.

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

With the help of the interpreter Martín creates an action plan by meeting with a nutritionist to eat healthier and the pharmacist to select the best value medications to treat his high blood pressure and lung disease.

Martín meets with a community health worker who speaks Spanish to apply for financial help for medications, food, housing, and utilities. The care team huddles together weekly to review Martín's care recorded in the EHR.

DRAFT

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 of 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, care team communication and coordination, access to BH care, provider support, discussing stress, and overall satisfaction with provider

★ 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)
- Improved care plan adherence by through medication reconciliation
- 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, and sub-specialty care

Access

- Easier access to services in the practice, home, and 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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DRAFT

ADULT DIVERSE CARE TEAMS

PRIMARY CARE MODERNIZATION

Adult Behavioral Health Integration

CORE CAPABILITY

A team-based, primary care approach to identifying and managing common behavioral health conditions, co-occurring health conditions, and lifestyle behaviors that affect health.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and worry can affect your physical health and how chronic illness can affect your emotional health and wellbeing
- Meet with a care coordinator to connect you to community-based support and additional behavioral health treatment services
- Have primary care and behavioral health clinicians who share information before your visits

PRIMARY CARE TEAMS CAN...

- Offer behavioral health assessment and brief treatment services (e.g. motivational interviewing)
- Offer cognitive and behavioral strategies to manage stress, anxiety, sleep problems and pain, and make lifestyle changes to support chronic illness management
- Access practice-based behavioral health expertise to improve the care of patients with behavioral health conditions and co-occurring medical conditions
- Access psychiatric consultation to support primary care prescribing and behavioral health management
- Coordinate access to behavioral health, medical and community-based services
- Access behavioral health care information on your Electronic Health Record (EHR)

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Nate is 62 years old and lives alone after his divorce. He has diabetes and is overweight. He tries to eat healthy but hates cooking. He tries to take walks on weekends when his son visits, but he's mostly alone.

When Nate goes to his primary care office for his diabetes check-up, the nurse administers the PHQ9 (Depression Screening Tool). His score indicates a possible moderate depression. He says that he just wants to watch TV all the time.

He agrees to see the licensed clinical social worker in the practice. His doctor walks him down the hall to introduce them. They make an appointment for him to come see her when he comes back for blood work in a few weeks.

When Nate returns, the social worker introduces him to the practice's behavioral health care coordinator. She connects Nate to a local support group for divorced men and a walking club and records this in his medical record.

DRAFT

HOW

Care Team and Network Requirements

- Standardized screenings to identify depression, substance use, anxiety, and social determinants of health
- Dedicated behavioral health clinician, on-site or via telemedicine, responsible for assessment, brief interventions, and care team consultation
- Protocol for "warm-hand off" to and telemedicine visits with behavioral health clinician
- Care coordinator with behavioral health expertise
- Referral assistance and tracking to support access to community behavioral health specialists, higher level behavioral health services, behavioral supports (e.g., peer support) and community resources (e.g., housing, legal assistance)
- eConsult arrangement with community-based psychiatrist or psychiatric APRN
- Memorandum of Understanding with at least one behavioral health clinic if behavioral health specialty services are not available within the network.
- Bi-directional communication as needed between primary care team and community-based behavioral health specialists and community supports.
- Care team training on behavioral health teaming, chronic illness, and care coordination.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for primary medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR configuration and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR configuration to support outcomes measurement
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Bi-directional communication solution to support coordination with community-based BH specialists
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care (practice-based and/or community), provider support, discussing stress, and overall satisfaction with provider
- Less time off from work, improved functioning at work

★ Quality

- Earlier identification and treatment of behavioral health conditions
- Improved behavioral health outcomes (e.g., depression remission rates)
- Improved chronic illness outcomes (e.g., A1C control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Lower out of pocket costs for patients when treated in primary care
- Reduced avoidable physical health utilization related to unmet BH needs
- Reduced ED and hospital utilization

Access

- Easier access to BH services and reduced wait time for treatment
- Assistance with referral and linkages to community-based behavioral health specialty services and community supports

IMPROVING HEALTH EQUITY

Patients with behavioral health needs face obstacles in getting care. To reduce this disparity, primary care will change in the following ways:

✓ **Improved access for populations** who might be less inclined to seek behavioral health treatment in other settings due to stigma.

✓ **Expanded connections** with culturally appropriate behavioral health services and coordination to address social determinant barriers.

✓ **Care coordinators and medical interpreters** improve communication between primary care and behavioral health providers.

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DRAFT

ADULT BEHAVIORAL HEALTH INTEGRATION

ALL PRIMARY CARE PROVIDERS TEAM-BASED CARE

Patient & Family

Standard screening for behavioral health and social determinants

Dedicated behavioral health clinician (LCSW or APRN)

- Available on-site or via telemedicine
- Performs assessments, brief treatment services and care team consultation

eConsult arrangement with community-based psychiatrist or advance practice registered nurse (APRN)

Team-based, biopsychosocial approach to care, health promotion, and prevention

Medication management

Practice team training

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialists

HEALTH NEIGHBORHOOD

Connects patients via established relationship with clinics, psychiatrists, psychologists/APRNs/LCSW to provide extended therapy, counseling, and higher level of care

Connects to community-based organizations

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

PRIMARY CARE MODERNIZATION

Phone, Text, Email and Telemedicine

CORE CAPABILITY

Telemedicine visits, phone calls, text messages, and emails expand patient access to primary care team for diagnosis, treatment, advice, check-ins and coaching.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Connect with your primary care team remotely, at your choice of time and device, more easily than traveling to the doctor's office
- Have a telemedicine visit with your primary care provider (PCP) for diagnosis and treatment, medical advice, or to determine whether you need to be seen in person
- Check in with your primary care team to get your questions answered and stay on track with your care plan and medications
- Save money compared to most office visits
- Avoid a costly emergency department or urgent care visit when it's not a medical emergency
- Take less time off work while reducing stress and worry about your health

PRIMARY CARE TEAMS CAN...

- Expand capacity for routine and urgent care via telemedicine, improve convenience and help reduce avoidable emergency department visits and hospital admissions
- Offer timely advice to patients about following care plans, adjusting medications, addressing medication problems, and determining the need for an office visit
- Connect patients with care team members such as health coaches, nutritionists and behavioral health clinicians
- Remind patients about immunizations, tests, follow-up visits, and self-management via text and email
- Enable more efficient and flexible patient support while ensuring stable practice revenue

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Jeannie is newly diagnosed with asthma. Her PCP sends her home with two inhalers and instructions on how and when to use them. Jeannie can call, email or text her PCP or her health coach if she has any questions.

After a few days, Jeannie still isn't feeling better. She's not sure she's using the inhalers properly. Jeannie calls her health coach and they arrange to have a video chat at a convenient time.

During the video chat, the health coach reviews the use of the inhalers and asks Jeannie to demonstrate. Afterwards, the health coach sends Jeannie encouraging texts and reminders to call her right away if Jeannie starts to feel worse.

The health coach and Jeannie continue to exchange texts to check in on Jeannie's progress. After a few days, Jeannie reports that she is feeling better.

DRAFT

HOW

Care Team and Network Requirements

- Establish secure platforms for phone, text, email and telemedicine visits; provide technical support resources
- Design office workflows to ensure timely responses to patient questions
- Train primary care team on workflows, handoffs and escalation processes to decrease after-hours workload for primary care clinician
- Update and maintain patient contact and language preferences and, for telemedicine, confirm access to high-speed internet and technology
- Ensure that communications are in the patient's preferred language
- Ensure that all contacts are documented in the electronic health record (EHR)

Health Information Technology Requirements

- Access to common EHR platform
- Secure web-based platform (patient portal) where sensitive patient information can be exchanged between the patient and his or her care team.
- EHR or complementary platform to support secure email and text communications
- EHR protocols to ensure all interactions between patient and care team members through phone, text, email and telemedicine are documented
- EHR to support outcomes measurement and performance accountability by logging and reporting all contacts and results

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care, provider support, and overall satisfaction with provider
- Less time off work

★ Quality

- Improved engagement in chronic illness self-management
- Improved timely response to new symptoms or change in condition
- Reduced admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned readmissions

$ Cost

- Reduced costs associated with avoidable ED visits and hospital admissions
- Reduced out-of-pocket costs associated with in-person visits, ED and hospitals visits, and time off from work, childcare and travel

Access

- Faster, more convenient connections to culturally competent health resources
- Improved access to primary care with reduced need for travel

IMPROVING HEALTH EQUITY

Patients with lower wage jobs, limited access to childcare, disability or frailty-related mobility challenges, or living in underserved communities may find it harder to take time off from work, arrange childcare, leave the home, or get transportation to a doctor's office. To reduce this disparity, primary care will change in the following ways:

✓ **Offer more ways to receive care** without physically going to the office

✓ **For patients with internet access, use text, email and telemedicine** to build a stronger relationship with the primary care team

✓ **Provide more timely response** to questions and access to care for routine needs management in primary care.

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PRIMARY CARE MODERNIZATION

eConsults and Co-management

CORE CAPABILITY

Primary care provider electronically consults with specialists[1] for non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit. When appropriate co-management can support continued collaboration between the PCP and the specialist.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Begin treatment sooner in primary care for some health problems rather than waiting for an appointment with a specialist
- Get the benefits of a specialist's expertise without having to see a specialist
- Have a primary care team that effectively manages more of your healthcare needs
- Pay less out of pocket by having more of your needs met in primary care

PRIMARY CARE TEAMS CAN...

- Access specialist consultations to support evaluation and treatment in primary care and improve quality of care
- Manage a wider range of health problems and changes in condition without referring to a specialist
- Enable patients to avoid unnecessary specialist visits, testing and procedures
- Enable patients to start treatment for some problems more quickly by avoiding the delays associated with scheduling specialty visits and barriers to accessing specialty care (e.g., transportation, time off work, childcare)
- Offer expanded capacity to treat patients with co-occurring conditions that might otherwise require different specialties

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Donna has congestive heart failure and is feeling tired. She can't drive and her cardiologist's office moved to a big medical center far from her home. Donna does not like the side effects of her diuretics. Donna likes her primary care team and keeps her appointments.

The primary care clinician examines Donna. They discuss how she's been feeling recently. Together, they review her latest EKG, a test that records the electrical activity of the heart, and her bloodwork.

With Donna's permission, the primary care provider requests an eConsult with a cardiologist. The next day, after reviewing the patient's medical information, the cardiologist suggests increasing the patient's medication and following up with blood work in four weeks.

A nurse from her primary care office calls Donna to explain the treatment plan, including how to handle medication side effects. Donna is relieved. She doesn't have to figure out how to get to the big medical center. She follows the new medication plan and feels better.

HOW

Care Team and Network Requirements

- Determine which specialties would be best suited to participate in an eConsult program based on evidence and knowledge about the Network's patients and providers
- Develop arrangements with specialists in relevant disciplines
- Create protocols that maintain clinician autonomy and support identifying appropriate patients, receiving patient consent, scheduling, receipt and review by the specialist, communication of the outcome back to the primary care team and follow up with patients
- Create protocols to guide co-management of patients following an eConsult, when appropriate.
- Train primary care team staff in using secure portals and technology
- Engage clinician champions to promote use and answer questions
- **OPTIONAL** Offer a "fast track" system for patients who have received an eConsult and need a face-to-face visit with a specialist.

Health Information Technology Requirements

- Access to common, secure technology platform such as an Electronic Health Record (EHR) to share information between primary care providers and specialists, including test results and imaging, as appropriate **- OR -**
- Network engages a vendor providing eConsult services to support deployment of the program and meeting HIT requirements
- EHR configuration and protocols to capture eConsult recommendations and treatment plan as presented by specialists
- EHR system able to supply data for measurement and accountability
- Appropriate consent and confidentiality protections

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with shorter wait times
- Reduced presenteeism and time away from work
- Increased satisfaction with provider

★ Quality

- Earlier diagnosis and treatment for some health problems
- Improved chronic illness outcomes
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Lower out of pocket costs for patients treated in primary care
- Reduced duplicative or unnecessary testing
- Reduced avoidable ED visits and hospitalizations

Access

- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist
- Eliminates access barriers for visits avoided (e.g., transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Many patients lack adequate access to specialty care due to geography and lack of specialist availability. To reduce this disparity, primary care will change in the following ways:

✓ **Allow access to timely, high-quality specialty care** through primary care consultation with specialists.

✓ **Reduce patients' access barriers** including provider scarcity and maldistribution, transportation, time off work and childcare.

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rebrand.ly/logine6fd3

[1] "Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.

PRIMARY CARE MODERNIZATION

Remote Patient Monitoring

CORE CAPABILITY

Remote patient monitoring uses connected digital devices and technology to move patient health information from one location, such as at a person's home, to a healthcare provider in another location for assessment and recommendations, usually at a different time. It is most helpful for patients with certain conditions including congestive heart failure, often called CHF.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have certain health conditions monitored from home by the primary care team without the need for transportation, child care and time off work
- Benefit from early detection of changes in their health conditions and timely adjustments to the care plan
- Be assured that their care team has information about how their conditions are responding to treatment
- Transition to home from the hospital with more help from primary care teams
- Avoid some emergency department visits and hospital stays through better management of health conditions

PRIMARY CARE TEAMS CAN...

- Better support patients with more complex needs between visits and after hospital stays for improved clinical outcomes
- Have real-time information about changes in condition and response to treatment in order to inform care plan adjustments
- Have the data necessary to inform patient coaching (e.g. medication compliance, lifestyle changes) without the need for an office visit
- Enable patients to avoid unnecessary emergency department visits and hospital admission

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Diane is a grandmother who takes care of her daughter's two children full time. She has congestive heart failure (CHF), but caring for the children, she doesn't have much time to go to the doctor's office.

Recently, she was having chest pain and shortness of breath and was admitted to the hospital for four days. After being discharged, a nurse care manager from her primary care practice made a home visit.

The nurse set her up with a remote patient monitoring system to check her weight, blood pressure and other vital signs daily. The nurse showed her how to use it and how it automatically sends information to her primary care team.

Diane's weight went up quickly, a sign she was retaining water and needed to change her medication. Her nurse saw the change in data and called to talk about adjustments to Diane's diet and medications.

DRAFT

HOW

Care Team and Network Requirements

- Use evidence to develop protocols to determine which conditions, in addition to congestive heart failure (e.g., chronic obstructive pulmonary disorder) and which patients with those conditions will receive remote patient monitoring based on level of risk
- Establish systems and staff workflows for transmission of health data from the patient to the provider
- Establish systems to enable care team members to receive and monitor data
- Ensure patients or their caregivers have the necessary tools and instruction to participate in remote patient monitoring and transmit data through a secure platform
- Nurse care managers or other qualified team members monitor the data and consult with a primary care clinician about treatment plan
- Facilitate trainings for designated members of the care team with respect to use of technology and related clinical protocols work flows
- Process actionable, clinically-relevant data with trends identified for use in routine clinical practice
- Determine legal liability for response protocols

Health Information Technology Requirements

- Remote monitoring devices with mechanism to transmit data to healthcare provider
- Data transmission method incorporates data into EHR and clinical workflow
- Platform has ability to alert care team when data values exceed thresholds
- Data is received on platform compatible with practice's electronic health record (without a separate login)

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, provider support, care outside of office hours, and overall satisfaction with provider

★ Quality

- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions
- Lower out of pocket costs for patients able to avoid unnecessary services

Access

- Reduced wait time to address changes in condition and response to treatment
- Eliminates access barriers by allowing visits to be avoided (e.g., cost-share, transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Many patients with chronic conditions experience health disparities. These disparities may result from less engagement with care teams and social determinant barriers such as transportation, child care, or out of pocket costs. Remote patient monitoring can reduce chronic illness disparities in the following ways:

✓ **Offer ways for care teams to monitor patients** without requiring an office visit.

✓ **In conjunction with telemedicine and diverse care teams** it will improve engagement of under-served patients experiencing barriers to care and health disparities with respect to chronic illness outcomes.

LEARN MORE!
rebrand.ly/dropb11Of1

[1] Health Resources and Services Administration (September 2017). Telemedicine and Telehealth. Retrieved from: https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth

PRIMARY CARE MODERNIZATION

Care for Older Adults with Complex Needs

CORE CAPABILITY

Enhanced primary care from a practice specially designed to improve outcomes for patients age 75+ with multiple chronic conditions, functional challenges, trouble traveling to in-office visits, and more likely to have potentially avoidable emergency department (ED) visits and require nursing home placement.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have a primary care team that understands how to care for older patients with complex health needs
- Get care at home to help you follow your care plan or when you have difficulty leaving your home
- Use phone, text, email, and telemedicine to get more convenient care, coaching, medication adjustment and support
- Avoid unnecessary trips to the emergency department or hospital
- Get help from a care coordinator or community health worker to connect with community-based resources or medical providers
- Get help when you go home after staying in a hospital, nursing facility or rehabilitation center

PRIMARY CARE TEAMS CAN...

- Include an array of staff with special expertise and training in caring for older adults with complex health needs
- Tune your practice workflows and accommodations to better address the problems commonly encountered by older adults such as hearing and cognitive issues, including dementia
- Offer home visits, telemedicine, and remote patient monitoring to support patient engagement, improve self-management, optimize the living environment to improve chronic illness outcomes and reduce risk (e.g., falls prevention)
- Improve Advanced Care Planning and access to palliative care
- Improve care coordination and patient navigation across systems and care settings

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Dan is an 85-year-old patient with high blood pressure and diabetes. Recently, his wife has noticed he gets confused sometimes. He visits his primary care provider, who specializes in geriatrics care, after an unexpected hospital stay.

During the visit, his doctor reviews his medical record and notices three emergency department visits in the past six months. One time he fell. Another time his blood sugar got too high. The third visit was for a urinary tract infection.

During a risk assessment, Dan and his wife say he forgets about appointments and his medications. Also, they don't drive anymore, so office visits require planning. Dan agrees to a home-based primary care plan written by his physician and a nurse home care provider.

A nurse visits Dan's home weekly to support him in taking his medication properly. A community health worker shows Dan how to have a video visit with his doctor and arranges transportation for office appointments. She connects Dan's wife to a caregivers' support group.

DRAFT

HOW

Care Team and Network Requirements

A subset of primary care providers specialize in advanced primary care for older adults with complex conditions:

- Hire and train an expanded, diversified care team with expertise in geriatric care
- Provide home-based primary care services
- Coordinate access to subspecialists and community-based supports, link to community-based services
- Develop practice workflows and accommodations to better address the problems commonly encountered by older adults such as functional impairments, including durable medical equipment needs, hearing and cognitive issues, problems associated with multiple medications and age-related medication considerations, and common mental health issues such as depression and loneliness
- Provide access via phone, text and email and telemedicine when appropriate
- Prioritize practice locations that are accessible for the communities they serve
- Establish remote patient monitoring for patients with Congestive Heart Failure for post-acute care and eConsults with subspecialists as needed
- Provide specialized care for patients with dementia
- Receive advanced training in and offer palliative care and end of life services to minimize discomfort, provide referrals to and coordination with hospice care
- Establish clinical links to institutional care settings, rounding by primary care providers to transition patients back to home setting and coordinated aftercare
- Subset of providers supported by Project Echo guided practice and technical assistance for Advanced Care Planning

Health Information Technology Requirements

- Electronic Health Record (EHR) that is accessible by all care team members and on mobile devices outside the office
- Health Information Exchange (HIE) to communicate with all members of the patient's care team
- Scheduling system accessible to all members of the patient's care team.
- Remote patient monitoring technology as needed for patients

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience regarding timely care, communication, coordination, specialists, provider support and overall satisfaction with provider
- More convenient patient access to care

★ Quality

- Earlier diagnosis and treatment for some conditions
- Improved preventive care (e.g. influenza immunization)
- Improved chronic illness outcomes
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions
- Improved care plan adherence
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced avoidable visits, tests and procedures
- Reduced urgent care, ED, nursing facility and hospital utilization
- Lower out of pocket costs for services in primary care and by non-billable care team members

Access

- Easier access to high quality support from primary care team outside of traditional office visits
- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist

IMPROVING HEALTH EQUITY

Early life stressors increase risk of dementia and other health conditions, which puts patients with greater social needs at higher risk of nursing home placement and uncoordinated care. To reduce these disparities, primary care will change in the following ways:

- ✓ **Text, phone, email, telemedicine care avoids barriers** to in-office visits like transportation.
- ✓ **Reduced out-of-pocket expenses,** which can be a barrier to care for fixed income patients.
- ✓ **Primary care provided at home or in the community** helps older adults with complex needs receive needed care and stay in their homes.
- ✓ **Practices specialized in geriatrics care** improve coordination between providers and community services.

LEARN MORE!
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SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities

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ADVANCED NETWORK/FQHC TEAM-BASED CARE

Patient & Family

ALL PRIMARY CARE PRACTICES IN AN/FQHC

- Diverse Care Teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
- Telemedicine visits
- eConsults between PCPs and specialists
- Remote patient monitoring for CHF, post-acute care
- Phone/text/e-mail encounters

SUBSET OF PRIMARY CARE PRACTICES

Specialize in Geriatrics for Patients with Complex Needs

Specialized geriatrics expertise supported by Project Echo guided practice, practice experience expertise in geriatrics care and technical assistance for Advance Care Planning

- Home-based Primary Care
- Dementia Care
- Palliative Care
- Advance Care Planning (Project Echo)
- Acute care setting rounding & care transitions support

HEALTH NEIGHBORHOOD

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

Specialty Care
Subspecialists (e.g. cardiologist, pulmonoglist, etc.), acute care settings

Community & State Services for High Risk Older Adults
Home care/aides, hospice providers, assisted living facilities, Connecticut Community Care support programs

Community Supports for all Older Adults
Meals, transportation, housing, handyman (hand rails, etc.), community centers

PRIMARY CARE MODERNIZATION

Pain Management and Medication Assisted Treatment

CORE CAPABILITY

Preventive, routine and advanced pain management in primary care. All practices have basic competence in pain management while a subset have specialized expertise, supported by Centers of Excellence in pain management. Some practices specialize in Medication Assisted Treatment for opioid addiction.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Learn how to manage acute and chronic pain as part of regular primary care
- Work with your primary care team to reduce your pain and address its causes
- Avoid opioids with access to traditional and alternative therapies for pain, including affordable medications
- Meet with a behavioral health clinician in the primary care office to address emotional contributors to pain and learn new pain management strategies
- Receive Medication Assisted Treatment (MAT) for opioid addiction or see a specialist for treatment

PRIMARY CARE TEAMS CAN...

- Develop expertise in evidence-based pain prevention and the routine management of chronic pain with reduced reliance on opioids
- Use decision support and analytics to identify patients who have severe chronic pain or are at risk of opioid addiction
- Apply a team-based approach that may combine physical medicine, behavioral health and alternative therapies
- Offer options for pain management to practices with pain management expertise in your primary care network or to a Center of Excellence

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Michelle's shoulder and back still hurt months after falling on the ice. The pain is so intense that she can't go to work, sleep or get anything done. Her prescription for pain relievers ran out and no one will refill it.

Michelle goes to see a new primary care team who she heard specializes in pain management. She hopes they offer her a stronger dose. The primary care provider takes a detailed history and screens Michelle for risk of addiction.

The primary care provider follows FDA opioid prescribing guidelines. After consulting with the pharmacist, her primary care provider offers Michelle an effective but less addictive pain medication.

The primary care provider also suggests that Michelle try other therapies. The care coordinator assists with making appointments for cognitive behavioral health therapy, physical therapy, and acupuncture.

DRAFT

HOW

Care Team and Network Requirements

All primary care practices

- Offer routine care for patients with acute and chronic pain in the primary care practice, including patient education on pain management
- Train teams on bio-psycho-social approach to pain management that promotes patient activation and self-management and appropriate prescribing for pain, especially when starting or continuing opioid therapy
- Establish protocols for referrals and hand offs to primary care practice with specialized pain management expertise
- Provide access to clinical decision support tools at the point of care and provide web- and phone-based self-management resources for patients
- Referral assistance and tracking to support access to primary care providers that specialize in advanced primary care pain management and those who provide MAT for opioid addiction.
- Formal pain management training arrangement with Centers of Excellence
- Two-way communication between primary care team and MAT clinicians

Subset of primary care providers specialize in advanced primary care pain management and or MAT

- Receive advanced training through Project Echo/Centers of Excellence
- eConsults with pain management experts for complex cases and ongoing knowledge development
- Connect patients with complementary community-based therapies
- Provide re-assessments of patients with chronic pain and refer back to routine primary care provider

Health Information Technology Requirements

- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR process to ensure capture of all interactions between patient and care team members, including non-office-based care
- Analytic tools to identify patients with chronic pain and those at risk for opioid abuse
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to care team's caring and concern, communication, provider support and overall satisfaction with provider
- Less time off from work; improved functioning at work

★ Quality

- Reduced use of opioid painkillers and less opioid addiction
- Earlier recognition of risk for opioid addiction
- Improved opioid use disorder treatment outcomes

$ Cost

- Reduced avoidable visits and treatments for chronic pain
- Reduced emergency department visits
- Reduced costs associated with time off work due to acute pain

Access

- Easier access to high quality pain management support from primary care team
- Improved access to medication assisted treatment resulting from increased in-network capacity and improved identification of patients who would benefit

IMPROVING HEALTH EQUITY

People of color and other historically underserved communities face disparities in pain assessment and treatment. To reduce this disparity, primary care will change in the following ways:

✓ **Networks track pain prevalence and treatment** across populations to identify disparities and overprescribing in vulnerable populations.

✓ **Community health workers available** to help find transportation and childcare for appointments.

✓ **Provide options** for more affordable medications, behavioral health services, and alternative treatments through integrated pain management in primary care.

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DRAFT

INCREASE EXPERTISE IN PAIN MANAGEMENT

All Primary Care Providers

PREVENTIVE CARE TO AVOID ACUTE TO CHRONIC PAIN PROGRESSION

- Basic assessments, diagnosis and care planning
- Self care, e.g. nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

ROUTINE CARE FOR ACUTE AND CHRONIC PAIN

- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Subset of Primary Care Providers

with specialized expertise in pain management or MAT. Manage complex patients and provide reassessment services and consultative support to all network PCPs

ADVANCED PRIMARY CARE CHRONIC PAIN MANAGEMENT

- Chronic pain management and re-assessment
- Specialized expertise in alternative therapies, e.g. behavioral health, acupuncture, self-management, etc.

MEDICATION ASSISTED TREATMENT (MAT)

- Treatment for opioid addiction

Primary Care Referrals

to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

CENTERS OF EXCELLENCE IN PAIN MANAGEMENT

- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

ADVANCED NETWORK / FQHC

PATIENT EDUCATION AND ENGAGEMENT AT ALL LEVELS OF CARE

INCREASING PAIN ACUITY AND TREATMENT COMPLEXITY →

CENTERS OF EXCELLENCE PROVIDE	**All PCPs**: Training and technical assistance in pain assessment and management	**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management

PRIMARY CARE MODERNIZATION

Community Purchasing Partnerships

ELECTIVE CAPABILITY

Primary care practices contract for home and community-placed services that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Get help from your doctor's office to find community resources to help you meet your health goals
- Get help adopting a healthy lifestyle from organizations in your town or neighborhood
- Get help managing your chronic illness in your home or your community, possibly with others who have similar health problems
- Connect to services such as early intervention or community care programs that are important to getting and staying healthy

PRIMARY CARE TEAMS CAN...

- Engage community resources such as community centers, churches, barbershops, and schools to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with complex care needs by partnering with community care teams or community paramedicine providers
    - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Constance is eighty years old and has struggled with her health since complications from a hip replacement two years ago. She manages living alone at home but is not very mobile and driving is uncomfortable.

Constance wakes up one night in extreme pain. She has felt like she has to go the bathroom all the time for a few days. Not wanting to go to the Emergency Room, she calls her primary care's hotline to speak to a nurse on call.

The nurse dispatches a community paramedic, contracted with the practice, to her house. The paramedic takes a urine sample and tests it with a portable kit. He calls the nurse to confer on results and treatment.

After conferring with the nurse, the paramedic gives Constance an injection of antibiotics to treat a urinary tract infection and a pill to relieve her symptoms. The next day, Constance's primary care provider calls to check on her.

DRAFT

HOW

Care Team and Network Requirements

- Identify service gaps and needs for community-placed services
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex needs
  - Segment evaluation based on population characteristics such as race, ethnicity, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and secondary prevention, chronic illness self-management, care management for patients with complex health needs, and in-home support for patients as needed
- Clinical protocols and analytics to support identification of patients that require these services
- Referral management protocols including determining whether individuals were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient experience, healthcare outcomes and cost

Health Information Technology Requirements

- Electronic health record (EHR) that captures population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your health"

★ Quality

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions
- Averted or reduced length of stay in skilled nursing facilities with coordination of home-based supports

Access

- Faster, more convenient connection to local, culturally competent health resources

IMPROVING HEALTH EQUITY

Patients experience barriers to care that result in health disparities. Access to culturally appropriate community-placed care can reduce these disparities in the following ways:

✓ **Community-placed providers can address health and preventive care needs** in the home or in a convenient, culturally appropriate and trusted community setting.

✓ **Community-placed providers can better address social and environmental risks,** language preference and health literacy gaps.

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DRAFT

ADULT COMMUNITY PURCHASING PARTNERSHIPS

CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services
[See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness Self-management Services	Complex Care Coordination for High Risk Patients, Often with SDOH Needs	Support for Patients with Acute or Chronic Medical Risk at Home
EXAMPLES OF MODELS	Health Leads or Project Access	Community Meeting Place Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/Community Paramedicine

PRIMARY CARE MODERNIZATION

Oral Health Integration

ELECTIVE CAPABILITY

Provide dental prevention services in a primary care doctor's office during regular checkups, including screenings, fluoride varnish, oral hygiene education, and when necessary, referrals to oral health providers.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have a care team that understands how problems with your teeth and mouth affect your overall health and well being
- Be screened for oral health problems as part of a general physical exam
- Learn how health behaviors can affect or improve oral health
- Learn how to take care of your teeth and mouth, especially when you have other chronic medical conditions.
- Receive fluoride therapy or fluoride varnish treatment to prevent more serious problems

PRIMARY CARE TEAMS CAN...

- Train care team in oral health risk assessment, exams and prevention
- Screen individuals for oral health risk factors and symptoms of oral disease
- Educate patients about the importance of good oral health and practices to maintain oral health
- Provide information and education that recognizes culture, language and perceived oral health barriers.
- Provide fluoride varnish or fluoride therapy, as needed
  - Assess patient's medications for risk of negative effect on teeth and gums, and make changes if needed
- Facilitate patient navigation to oral healthcare services with referrals and track outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Marianne checks in for a diabetes wellness appointment. As part of her medical record update, Marianne says that she does not have a regular dentist and hasn't had a check-up in a long time.

During the physical exam, Marianne's primary care provider notes signs of oral disease. The provider explains that researchers have found people with diabetes are more likely to have oral health problems and these problems can make it harder to control diabetes.

Marianne and her provider discuss Marianne's options. Marianne agrees to meet with the team's trained dental health educator. They discuss brushing, flossing and the damaging effects of sugar and carbohydrates on her teeth.

Marianne mentions that she can't afford dental care because she doesn't have dental insurance. The health educator connects Marianne to the team's care coordinator who helps her make an appointment at a dental clinic with lower fees for uninsured patients.

DRAFT

HOW

Care Team and Network Requirements

- Conduct patient-specific oral health risk assessments that ask about symptoms or risk factors to screen for oral disease
- Conduct oral health exams that look for signs indicating poor oral health and active problems
- mplement preventive oral health strategies which may include prescribing or changing medications that protect teeth and gums, fluoride therapy, application of fluoride varnish, dietary counseling, and in-house or co-located dental cleanings
- Develop targeted patient education about the importance of good oral health and practices to maintain it, particularly for communities disproportionately affected by dental problems
- Develop a process and protocols to make, manage and close out referrals including connecting patients without dental coverage to safety providers of dental services
- Primary care providers exchange patient information and coordinate care with dental providers, track referrals and oral health outcomes

Health Information Technology Requirements

- Electronic health record includes modules to capture answers to oral health questions, document information regarding the patient's mouth, build an in-house risk assessment, order referrals, and track patient outcomes over time.
- Patient portal provides educational materials and after visit summaries

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, coordination, access to dental care, provider support, and overall satisfaction with provider

★ Quality

- Improved preventive oral health care
- Reduced restorative treatments

$ Cost

- Lower out of pocket costs for patients when receiving services in primary care
- Reduced preventable ED visits and hospital admissions for severe dental conditions

Access

- Easier access to preventive dental care services
- Assistance getting access to comprehensive dental care through primary care referrals as needed

IMPROVING HEALTH EQUITY

Rural and underserved communities are disproportionately affected by dental problems and have limited access to dental care in the community. To reduce this disparity, primary care will change in the following ways:

✓ **Dental and oral health services provided** in primary care offices increase access to dental care.

✓ **Integration of primary care and dental care** improve care coordination.

✓ **Reduce need for additional appointments** to receive certain basic dental services.

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PRIMARY CARE MODERNIZATION

Shared Medical Appointments

ELECTIVE CAPABILITY

Shared Medical Appointments are a form of group visit for patients with similar medical conditions during which a clinical team provides physical exams and education about ways patients can help manage their own conditions such as lifestyle changes and how to use community resources to reduce barriers to care.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have routine, condition-specific check-ins at a convenient location and time of day
- Get support and coaching to help change health behaviors
- Talk regularly with others who have a similar medical condition and socio-economic backgrounds and learn from their experience
- Improve your knowledge about your medical condition
- Receive guidance in a preferred language
- Have a primary care team that helps with "real life," day-to-day challenges about a medical condition

PRIMARY CARE TEAMS CAN...

- Help patients improve self-management through coaching, discussion, and peer-to-peer interactions
- Offer more convenient meeting times and locations compared to conventional appointments and potentially improve compliance for patients who do not otherwise keep appointments
- Offer supports and strategies to help patients overcome cultural barriers, health literacy challenges, and social isolation, which may hinder self-management.
- Build relationships with patients and help support engagement and commitment to lifestyle changes
- Improve provider experience and practice efficiency by using expanded care team members prevention or condition related shared visits

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Lenny arrived for a routine appointment to check his diabetes, weight and high blood pressure. He's busy and has had trouble keeping on track with exercise and diet. He has also missed some primary care check-ups.

Lenny's primary care provider suggested he try a shared visit at a community center near his home. Unsure whether he wanted to talk to others about his health, Lenny was reassured by the confidentiality agreements everyone signed.

At the evening meeting, after work and before kids' homework started, a medical assistant recorded Lenny's blood pressure and other vital signs in a private area. A health coach gave a short talk about building more exercise into daily routines.

Lenny and others in the group met to share suggestions and ideas that Lenny thought might work. When it was time for questions, Lenny asked for tips on how to eat at a family barbeque. After this meeting, Lenny attended regularly and with the group's support, achieved his goals.

HOW

Care Team and Network Requirements

- Develop protocols and analytic methods to identify patients who might benefit from peer group coaching and support
- Designate and train care team staff to perform initial health checks, collect and record information, provide health instruction and facilitate discussion.
- Designate and train support staff to recruit and confirm participants, coordinate transportation, provide materials, set up the room and organize supplies and equipment, if needed
- Establish policies regarding privacy and confidentiality for patient participants
- Develop or identify an appropriate curriculum and provide training for staff in education, teaming, and facilitation
- Establish a regular meeting time at a conveniently located, accessible private meeting place

Health Information Technology Requirements

- Electronic Health Record configured to record patient vitals, notes and group-based encounters
- Accurate and up-to-date patient contact information to send invitations and meeting reminders

MEASURING IMPACT

✓ Patient Experience

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

★ Quality

- Improved preventive care compliance (e.g., colonoscopy screening)
- Improved chronic illness outcomes (e.g., diabetes control)
- Improved care plan adherence
- Reduced preventable hospital admissions for ambulatory care sensitive conditions

$ Cost

- Potential reduction in out-of-pocket costs
- Reduced emergency department, urgent care and hospital utilization

Access

- Easier access to primary care support and peer resources

IMPROVING HEALTH EQUITY

Patients with complex medical conditions feel brief office visits don't allow enough time to answer questions and support self-management. Patients may face social isolation, low health literacy, and cultural barriers that affect their ability to effectively access care and manage conditions. To reduce this disparity, primary care will change in the following ways:

✓ **Interactions with peers from own community** may reduce stigma, address cultural barriers, enable peer support and reduce social isolation

✓ **Care team supports** may include medical translators or others with cultural insight, such as community health workers

✓ **May reduce health literacy barriers** through discussion with questions and answers (rather than lectures)

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PRIMARY CARE MODERNIZATION

Health Equity Improvement

CORE CAPABILITY

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

DRAFT

85%

of the practices in your network have fully implemented the policy and procedure.

GOALS

Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Process Measures

1. Increased collection of all specified data documented in the EHR
2. Completed analyses that identify at least three disparities
3. Completed interventions to address the three disparities

KEY ELEMENTS OF HEALTH EQUITY IMPROVEMENT

COLLECT AND ANALYZE

- Expand collection, reporting, & analysis of demographic data
- Identify and prioritize opportunities to reduce healthcare disparities

IMPLEMENT

- Implement intervention to address identified disparity

EVALUATE

- Evaluate the intervention

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HOW

Expand the collection, reporting, and analysis of standardized demographic data stratified by sub-populations

1. Collect race and ethnicity categories for all patients that go beyond the broad OMB categories. The selection of additional categories must:
   a. Draw from the recognized "Race & Ethnicity–CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS) or a comparable alternative;
   b. Have the capacity to be aggregated to the broader OMB categories;
   c. Be representative of the population it serves based on (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members
2. Collect information regarding preferred language, sexual orientation and gender identity (SOGI), and disability status for all patients
3. Collect information regarding health literacy and social determinants of health
4. Identify valid clinical and care experience performance measures to compare clinical performance between sub-populations; such measures should meet generally applicable principles of reliability, validity, sampling and statistical methods
5. Analyze the identified clinical performance and care experience measures using variables identified in 1-3 above and geography/place of residence
6. Establish methods of comparison between sub-populations and in relation to the network's attributed population or a benchmark
7. Conduct a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population's linguistic and cultural needs, and implementing a plan to address workforce gaps

Identify and prioritize opportunities to reduce healthcare disparities

1. Document opportunities to reduce healthcare disparities identified through data analysis
2. Prioritize opportunities by engaging members of the sub-population.

Implement three interventions to address identified disparities

1. Conduct root cause analyses for the identified disparities and develop interventions. To conduct the analyses, utilize:
   a. Relevant clinical and patient data
   b. Input from the focus sub-population for whom a disparity was identified
2. Design pilot interventions that will meet the needs/barriers identified in the root cause analysis
3. Involve members of the sub-population who are experiencing the identified disparities in the intervention design
4. Implement the interventions in at least five practices

Evaluate intervention

1. Demonstrate that the interventions are reducing the healthcare disparities identified by:
   a. Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed
   b. Achieving improved performance on measures
   c. Sharing evaluation findings with the focus sub-population
2. Identify opportunities for quality and process improvement design

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PRIMARY CARE MODERNIZATION

Community Integration to Address Social Determinants

CORE CAPABILITY

Identify social determinants of health and other barriers that may affect patient's healthcare outcomes and address those barriers by connecting patients to community resources.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Talk to your care team about life circumstances that make it hard to get preventive care or to manage a chronic illness
- Get help finding solutions from a community health worker or care coordinator
- Get connected to community organizations that can help with housing, access to healthy food, financial support, legal services, transportation, heat for your home and other needs.

PRIMARY CARE TEAMS CAN...

- Better understand the social determinants of health that make it hard for your patients to participate in preventive care or manage their chronic conditions.
- Incorporate social determinants of health into the care plan such as connections to food, housing, clothing and fitness programs
- Improve the quality of care by addressing common problems that may contribute to poor outcomes
  - Reduce burden on primary care team members by providing support in addressing problems that affect patient engagement

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Eva is a single mother of two. She does not make enough money to buy enough food for her family and she struggles to pay other bills. She also prefers speaking and reading Spanish to English. Eva goes to her primary care provider's office for a regular checkup.

While waiting to see the doctor, Eva answers some questions about her housing, food and other health factors, called a social determinants of health (SDOH) screening tool. A community health worker trained in SDOH assessments and community linkages reviews her SDOH risk and enters it into her electronic health medical record.

After Eva meets with her doctor, the community health worker meets with her to talk about her needs. She connects her with a local food pantry. They also talk about her diabetes and her struggles to eat healthy and measure her glucose levels daily.

The community health worker refers her to a program at the local community center that holds diabetes self-management courses in Spanish. The community health worker calls Eva the following week to confirm she was able to enroll in the diabetes self-management course.

DRAFT

HOW

Care Team and Network Requirements

- Implement a standardized process for screening patients for social determinants of health using a screening tool that is linguistically and culturally appropriate and that addresses food insecurity, housing instability, utility needs, financial resource strain, transportation, exposure to violence and other areas such as childcare, education, employment, health behaviors, and social isolation/engagement
- Establish protocols for documenting in the care plan the social determinant barriers and the plan to address them
- Designate a care team member (such as a Community Health Worker) with training in social determinants of health, cultural sensitivities, and community services to address the identified social determinant barriers
- Create referral relationships with those community organizations whose services are most frequently utilized
- Establish a process for accessing an up-to-date resource directory (such as 211)
- Establish referral management protocols that include determining whether individuals were successfully linked to and served by community resources
- Track outcomes including assessment of the impact of community resources on patient experience, healthcare outcomes and cost.

Health Information Technology Requirements

- Access for all team members to electronic health record (EHR) or interoperable software that enables the capture of coded social determinants of health risk assessment results
- Analytics that enable the analysis of performance with respect to social determinants of health
- EHR configuration or software to support referral management with respect to community resources
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

√ Patient Experience

- Improved provider satisfaction ratings with respect to medical home support such as "asked you if there were things that make it hard for you to take care of your health"

★ Quality

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions

Access

- Improved access to community resources to address social determinant barriers

IMPROVING HEALTH EQUITY

Patients experience social determinant barriers to care that result in health disparities. These disparities disproportionately affect individuals who are lower income and of certain race/ethnic groups. Improving the identification of social determinant barriers and linkage to community resources that help resolve these barriers will reduce disparities. Patients that experience disparities will be better able to engage in preventive health and management of chronic conditions.

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PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Create diverse care teams that are guided by the primary care provider in collaboration with the patient and family, integrate other professionals, coordinate with community supports, and promote the strengths of families and best health for all children.

DRAFT

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Ongoing support from a primary care team that is accessible in the doctor's office, at home, and in your community
- More time with your pediatric primary care provider when needed
- Behavioral health services right away in the pediatric office
- Help with childcare, nutritious food, transportation and other needs from a community health worker
- Connected to early intervention services from a navigator or care coordinator
- Help with school or childcare center from a care coordinator who knows your child's health needs
  - Fluoride treatment at the pediatric office to prevent cavities without having to go to a dentist

PEDIATRIC CARE TEAMS CAN...

- Enable PCPs to spend more time with patients and families and care teams to efficiently support the provider
- Expand capacity to support parenting, strengthen families and promote child well-being
- Improve coordination with schools, childcare centers, and other settings that playing a role in child health and development
- Expand PCPs' abilities to manage children with complex needs through tele-mentoring
- Improve access to language assistance and community supports to address family needs like housing, transportation and food security
- Improve practice efficiency, cultural effectiveness and care team satisfaction

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Jenny is almost three years old. Her parents are worried that she is not talking yet, and her daycare says she is being aggressive towards other kids. With full-time jobs and two more kids at home, her parents aren't sure how to help her.

Jenny's father takes time off work to take her to the doctor. They meet with her PCP, who recommends a developmental assessment and a home visit to understand Jenny's behavior. The visit is scheduled so that her parents don't miss work.

They meet with the social worker at the office who does a developmental screening. She refers them to a service near their house that supports children with developmental delays and has weekend hours.

The social worker visits Jenny's family at home to assess her behaviors. She visits her at daycare to learn more about her aggressive behaviors. She works with Jenny's primary care provider and her parents to develop a care plan.

HOW

Care Team and Network Requirements

- Hire care team members to provide functions defined by the American Academy of Pediatrics, including: well visits and preventive care; acute and chronic care; care management; care coordination; patient navigation; behavioral health integration; oral health integration; and chronic illness self-management
- Deploy care team members in the practice, in the community or patient homes, and/or at a network central hub
- Coordinate with community services and other places where patients receive care (e.g. schools, childcare centers)
- Utilize Community Health Workers to link patients and families to culturally appropriate community resources, track follow-up, and provide support
- Ensure care team members apply their skills to the top of their training
- Train team members to deliver effective team-based care, including workflows and communications
- Provide access to tele-mentoring programs for care teams (e.g. Project ECHO) in collaboration with community-based organizations to expand ability to manage more complex cases

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- Analytic resources to identify populations at risk, develop, implement and refine operations and to support continuous health promotion and quality improvement
- EHR and protocols to ensure capture of 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
- Data sharing systems between practices, community care settings (e.g. school health centers), and centralized care coordination resources when possible

MEASURING IMPACT

✓ Patient Experience

- Improved patient and family experience through more timely, culturally effective, coordinated, and family-centered care, including behavioral health care; increased community and provider support for stress and worries

★ Quality

- Increased screenings and follow-up (e.g. oral screenings, developmental assessments)
- Improved preventive and well-child care
- Improved health promotion outcomes (e.g. school readiness, healthy weight)
- Improved chronic illness outcomes (e.g. asthma, childhood obesity)
- Reduced risk for development of chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for services in primary care and by non-billable team members
- Reduced healthcare costs over lifetime by identifying and preventing risks in childhood

Access

- Easier access to services including behavioral and oral health, in the practice, home, or community
- Assistance accessing culturally appropriate medical services and community supports

IMPROVING HEALTH EQUITY

Health disparities, such as those faced by communities of color or non-English speakers, start early in life. They can be reduced in part by pediatric care that identifies and address health and social determinant risks early. Care teams can help by:

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

✓ **Linking families to childcare, nutrition services, developmental supports** and other community resources.

✓ **Using peers to provide culturally appropriate support** to families, such as parenting support.

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PEDIATRIC DIVERSE CARE TEAMS

Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care

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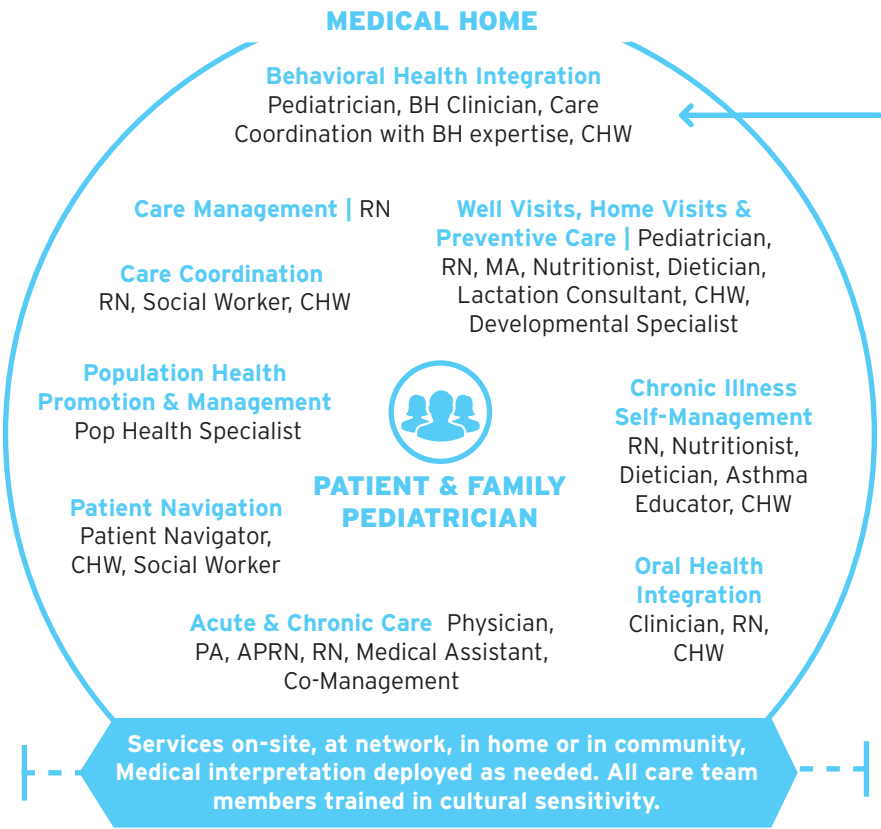

COORDINATION

HEALTH NEIGHBORHOOD

- Developmental assessment services and supports
- Parental support
- Community Pharmacists
- Early intervention services
- Child care health consultants
- HEC supported services
- Specialists, BH providers, and Ancillary Providers
- Community based organizations
- Schools: Health Centers, Nurses
- Urgent care
- Head Start, child care centers
- Care coordination centers, United 211
- WIC, Nutrition Programs
- Help Me Grow
- Access Mental Health CT
- Social services and family supports

PRIMARY CARE MODERNIZATION

Behavioral Health Integration

CORE CAPABILITY

A team-based approach to prevention, early identification and promotion of developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community.

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HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and trauma impact your child's development and health later in life
- Meet with a care coordinator to connect you to community-based supports and additional behavioral health and developmental services
- Get coaching on managing your child's behaviors
- Access the behavioral health clinician through video visits
- Get help communicating with your child's school or childcare center about development and behavior
- Have a single point of contact to coordinate all of your child's providers

PEDIATRIC CARE TEAMS CAN...

- Expand capacity to provide behavioral health screenings, brief interventions, and medication management
- Improve early identification and treatment of behavioral health and developmental issues, and ability to provide trauma informed care
- Coordinate with schools and childcare centers and facilitate access to behavioral health and related community services
- Better address the preventive and medical care needs of children with serious behavioral health conditions
- Access psychiatric consultation to support prescribing and management of behavioral health and health behaviors
- Access behavioral health care information on your EHR

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Andre is in sixth grade and having trouble concentrating in school. His teacher says he is disruptive in class and doing poorly on assignments. Andre's parents have noticed he is more active than his peers and distractible at home.

Andre and his mom Marie go to the pediatrician's office for an annual check-up. The PCP sends his mom home with the Vanderbilt ADHD Diagnostic Rating Scale to complete and return. With permission, the PCP sends the scale to Andre's teacher.

The practice's care coordinator follows up with Marie and Andre's school to get the completed scales and gives them to Andre's PCP at their weekly meeting. The PCP has an eConsult with a child psychiatrist about whether medication is indicated.

At a follow up visit, Andre's PCP introduces Andre and Marie to the psychologist at the office to determine if counseling is needed. The care coordinator reaches out to Andre's school regularly to keep the care team informed about his progress.

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HOW

Care Team and Network Requirements

- Dedicated behavioral health clinician (BHC) on-site or via telemedicine
- Dedicated care coordinator with expertise in coordinating access to services in support of BH and SDOH needs of children and parents, and who coordinates across all service systems (e.g., schools, Title V, child welfare)
- Administer universal screenings to assess developmental and socio-emotional health; behavioral health and health behaviors; and social and environmental factors
- Provide brief interventions for behavioral health and health behaviors and promote trauma-informed care
- Provide referrals to and coordinate with community BH specialists, higher level BH services and supports, developmental services and community resources (e.g., housing)
- Train primary care teams and BHCs in core competencies, effective teaming and cultural sensitivity
- Establish arrangements with community-based child psychiatrist or psychiatric APRN for telephonic and eConsults, such as through Access Mental Health CT
- Develop and track outcome measures assessing effectiveness of the practice in addressing BH needs; including health equity and disparities

Health Information Technology Requirements

- Access to common EHR platform for medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR configuration and protocols to ensure capture of all interactions between patient/family and care team members, including nonoffice-based care
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with BH specialists and community-based organizations
- Bi-directional communication solution to support coordination with BH specialists and community care settings (e.g. school health centers)
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient/family experience with respect to timely care, communication, coordination, access to BH care, and provider support
- Single point of contact for services received at practice and community settings
- Less time off work or school for parents and children

★ Quality

- Earlier identification and intervention for behavioral health and developmental conditions
- Improved behavioral health outcomes (e.g., remission of disruptive behavior disorders)
- Improved school outcomes (e.g., school readiness, attendance)
- Improved family functioning (e.g. reduced exposure to adverse childhood events)
- Reduced risk of developing chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for patients and families when treated in primary care
- Reduced ED and hospital utilization

Access

- Easier access to BH services and reduced wait time for treatment
- Assistance connecting to community-based BH specialty services and community supports

IMPROVING HEALTH EQUITY

Children and families who have BH needs face obstacles accessing care. Childhood BH conditions that go untreated can negatively impact health in adulthood. BH integration will:

✓ **Improve access for families** who, for reasons related to culture, stigma or SDOH barriers, may not access behavioral health treatment in other settings.

✓ **Expand connections with culturally appropriate community services** to address BH and SDOH needs for children and their parents.

✓ **Use care coordinators and medical interpreters** to improve communication between primary and behavioral health providers.

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PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

ALL PEDIATRIC PRIMARY CARE PROVIDERS TEAM-BASED CARE

Child & Family

Standard screening for behavioral health and social determinants

Dedicated pediatric behavioral health clinician (LCSW or APRN)

- Available on-site or via telemedicine
- Performs brief screenings and assessments, brief treatment services and care team consultation
- Conducts phone consultations through Access Mental Health CT

eConsult arrangement with community-based psychiatrist or advance practice registered nurse (APRN)

Team-based, biopsychosocial approach to care, health promotion, and prevention

Medication management

Practice team training

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialist
- Avoids duplication of care coordination services

HEALTH NEIGHBORHOOD

Connects patients via established relationships with pediatric behavioral health clinics, psychologists/APRNs/LCSW to provide extended therapy, counseling, and extensive evaluation

Connects to community-based organizations, schools, and child care

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

PRIMARY CARE MODERNIZATION

Alternative Ways to Engage Patients and Their Families

CORE CAPABILITY

Offer alternative ways for patients and families to engage with the pediatric medical home beyond individual office visits, such as telemedicine visits, phone calls, text messages, emails, and group visits.

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HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Connect with your child's PCP or care team between in-office visits as needed
- Arrange a telemedicine visit with your child's PCP for diagnosis and treatment, medical advice, or to determine if an in-person exam is needed
- Get timely answers to parenting questions
- Save money with virtual visits compared to most in-office visits
- Avoid an emergency department or urgent care visit when it's not an emergency
- Take less time off work to bring your children to visits and reduce worry
- Get more time with care team and other families in group visits for wellness or managing a condition (e.g., asthma)

PEDIATRIC CARE TEAMS CAN...

- Have more time to offer advice to patients and families about care plans and parenting using phone, text or email
- Expand capacity for routine and urgent care via telemedicine to support more timely and convenient care and reduce avoidable emergency department visits and hospital admissions
- Enhance relationships with patients and families through more continuous care
- Remind patients and families about immunizations, well child visits, screening results and follow-ups, and self-management activities via text and email
- Enable practice efficiencies and flexible methods of support while ensuring stable practice revenue

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Darren is five years old and loves to play soccer. His father Marty, who works full-time and is a single parent, has noticed lately that Darren has been wheezing during soccer practice and complaining that his chest hurts.

Marty and Darren take time off work and school to go to Darren's pediatrician. His PCP asks about Darren's symptoms, and does a lung function test after having Darren do jumping jacks. She diagnoses him with exercise-induced asthma.

The PCP sends Marty and Darren home with an inhaler prescription and spirometer. She instructs Marty to have Darren blow into the spirometer before and after taking his inhaler and report readings and symptoms via secure email.

A week later, Marty and Darren have a video visit with the PCP to watch how Darren takes the inhaler. She gives Marty more instructions and sets up a time to have a phone call in two weeks to check-in on Darren's symptoms.

HOW

Care Team and Network Requirements

- Establish protocols and workflows to support scheduling:
  - Telemedicine and phone visits with the PCP for routine and urgent care and the care team for coordination of care, navigation, coaching, screening and information
  - Groups visits with the PCP or care team (*optional*)
- Establish protocols and workflows to support:
  - Email, text, phone, and voicemail communications with PCPs and care team
  - Timely responses to patient inquiries and questions
- Train care team on new workflows; handoffs and escalation processes; when telemedicine is appropriate, i.e. for established patients and clinical scenarios
- Update and maintain patient contact, visit and language preferences and, for telemedicine, confirm access to high-speed internet and technology
- Ensure communications are in the patient's preferred language
- Ensure telemedicine visits are with patient's care team (not third-party providers)
- **If** group visits are adopted, establish:
  - procedures to recruit and group patients, document participation and schedule time for individual follow-up
  - private, convenient space for group visits
  - staff training on group visits and privacy and confidentiality protections

Health Information Technology Requirements

- Network provides secure web-based platform to support
  - telemedicine scheduling and encounters
  - the electronic exchange of sensitive patient information between the patient or family and care team
- Configuration of electronic health record (EHR) or web-based platform and protocols to ensure all patient and family contacts through telemedicine, phone, text, email, and group visits are automatically documented
- EHR supports outcomes measurement and performance accountability by logging and reporting all contacts, follow-up, and outcomes

MEASURING IMPACT

✓ Patient Experience

- Improved patient and family experience through more timely care, more accessible and family-centered care, coordination and communication; increased provider support
- Less time off work or time spent arranging for childcare or transportation
- More continuous engagement with the care team

★ Quality

- Improved engagement in preventive care and chronic illness self-management
- Improved timely response to new symptoms or change in condition
- Reduced preventable ED visits and admissions for ambulatory care sensitive conditions

$ Cost

- Reduced costs associated with avoidable ED and urgent care visits and hospital admissions
- Reduced out-of-pocket costs associated with in-person visits, ED, urgent care and hospitals visits

Access

- Faster, more convenient connections to culturally appropriate health resources
- Improved access to medical home with reduced need for travel, time off work or childcare

IMPROVING HEALTH EQUITY

Families with lower income, disability related mobility challenges, or living in underserved communities may find it harder to take time off from work, arrange childcare, leave the home, get transportation to a doctor's office, or pay for co-pays. Primary care can help by:

✓ **Offering more ways to receive care and get questions answered** without physically going to the office.

✓ **For patients and families with a smart phone, using text, email and telemedicine** to build a stronger relationship with the pediatric medical home.

✓ **Facilitating support from peers** from the same community in group well child visits.

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PRIMARY CARE MODERNIZATION

eConsults and Co-management

CORE CAPABILITY

Pediatric primary care providers partner with specialists[1] via electronic consults (eConsults) or collaborative care programs (co-management) for treating non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit. When appropriate co-management can support continued collaboration between the PCP and the specialist.

DRAFT

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Begin treatment sooner in primary care for some health problems rather than waiting for an appointment with a specialist
- Avoid the need for travel, time off work or school or childcare to see a specialist
- Get the benefit of a specialist's advice more quickly and easily, without having to schedule a separate visit
- Have a primary care team that effectively manages more of your healthcare needs
- Pay less out of pocket by having more of your needs met in primary care

PEDIATRIC CARE TEAMS CAN...

- Access specialist expertise to support evaluation and treatment in primary care and improve quality of care
- Manage a wider range of health problems and changes in condition without referring to a specialist
- Expand capacity for prescribing and management of behavioral health and health behaviors through specialist consultation and guidance
- Enable patients to avoid unnecessary specialist visits, testing and procedures
- Enable patients to start treatment for some problems sooner by avoiding delays associated with scheduling specialty visits and other barriers to accessing specialty care (e.g., transportation, time off work, childcare)

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Erin is fifteen and has childhood onset Type II diabetes. She and her mom go to her pediatrician's office for a checkup. Her PCP is concerned that she is bordering on morbid obesity and her blood sugar remains uncontrolled.

Erin's PCP has talked with Erin and her family about diet and exercise many times. Erin's mother says the food at school that she gets for free is unhealthy but she can't afford to buy many fruits and vegetables. Erin hates sports.

Erin's PCP has an eConsult with a pediatric endocrinologist who recommends a medication regimen. Her PCP requests another eConsult for advice when Erin has initial side effects to the medication.

Guided by established co-management protocols, Erin's PCP and the pediatric endocrinologist continue working together to manage Erin's condition. Erin's blood sugar control improves with the medication and it is not necessary for her to visit the specialist.

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HOW

Care Team and Network Requirements

- Determine which specialties would be best suited to participate in an eConsult or co-management program based on evidence and knowledge about the Network's patients and providers
- Develop arrangements with specialists in relevant disciplines
- Create protocols that maintain clinician autonomy and support identifying appropriate patients, receiving patient consent, scheduling, receipt and review by the specialist, communication of the outcome back to the primary care team and follow up with patients
- Create protocols to guide co-management of patients following an eConsult, when appropriate.
- Train primary care team staff in using secure portals and technology
- Engage clinician champions to promote use and answer questions
- **OPTIONAL** Offer a "fast track" system for patients who have received an eConsult and need a face-to-face visit with a specialist.

Health Information Technology Requirements

- Access to common, secure technology platform such as an Electronic Health Record (EHR) to share information between primary care providers and specialists, including test results and imaging, as appropriate **- OR -**
- Network engages a vendor providing eConsult services to support deployment of the program and meeting HIT requirements
- EHR configuration and protocols to capture eConsult recommendations and treatment plan as presented by specialists
- EHR system able to supply data for measurement and accountability
- Appropriate consent and confidentiality protections

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with shorter wait times
- Reduced time away from work and/or school for parents (due to travel) and children
- Increased overall satisfaction with provider

★ Quality

- Earlier diagnosis and treatment for some health problems
- Improved outcomes for behavioral health and other conditions that typically require specialty care
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Lower out of pocket costs for patients and families treated in primary care
- Reduced unnecessary use of specialists and duplicative or unnecessary testing and procedures
- Reduced avoidable ED visits and hospitalizations

Access

- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist
- Eliminates access barriers for visits avoided (e.g., transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Some populations may experience health disparities due to barriers to accessing specialty care. The disparities may result from transportation or other social determinant risks as well as out-of-pocket costs and limited specialist capacity due in part to reimbursement rates. eConsults and co-management arrangements will:

✓ **Allow easier access to timely, high-quality specialty care** through electronic consultation with specialists.

✓ **Reduce patient and family access barriers** related to provider scarcity and maldistribution, transportation, time off work and childcare.

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[1] "Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.

PRIMARY CARE MODERNIZATION

Community Purchasing Partnerships

ELECTIVE CAPABILITY

Advanced Networks or FQHCs facilitate arrangements for home and community-placed services on behalf of pediatric practices that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

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HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Get help from your pediatric provider's office to find community resources to help your family achieve your health goals
- Get help supporting your child's health from organizations in your town or neighborhood
- Get help parenting or managing your child's chronic illness in your home or your community, possibly with others who have similar issues
- Get help coordinating your child's care with services in your community
  - Connect to services such as early intervention, developmental supports and transitional services for adolescents that are important to strengthening your family and supporting your child's long-term health

PEDIATRIC CARE TEAMS CAN...

- Engage community resources such as schools, childcare centers, and recreation centers to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients and families experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with special health care needs by partnering with community care coordination resources and home visiting programs
  - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Candace is twenty years old and has a one-month old baby girl with her boyfriend Devan. Growing up in the foster care system, she has struggled with anxiety and depression. She has part time jobs but lives paycheck to paycheck.

Candace's primary care practice offers home visits to families of newborns through a program in the community and has prioritized Candace for home visits because of her social determinant of health needs and mental health history.

A nurse and social worker visited Candace twice since she became pregnant to talk about prenatal care and planning for the baby. They have another visit with Candace and Devan today to provide positive parenting support.

At Candace's home, they talk about the joys and struggles of being a new parent and show Candace and Devan ways to respond when the baby cries. The nurse screens Candace for depression and anxiety. The home visiting team meets with their primary care team to discuss next steps.

HOW

Care Team and Network Requirements

- Identify service gaps and needs for community-placed services:
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex health and SDOH needs
  - Segment the evaluation based on population characteristics such as race, ethnicity, country of origin, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and developmental services, chronic illness prevention and self-management services, complex care coordination for high-risk patients and families, parental support services, and transition services for adolescents
- Clinical protocols and analytics to support identification of patients and families that require these services
- Referral management protocols including determining whether families were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient/family experience, healthcare outcomes and cost

Health Information Technology Requirements

- Electronic health record (EHR) that captures above population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your child's health"

★ Quality

- Improved preventive and well-child care (e.g. immunizations, developmental and BH screenings)
- Improved chronic illness and behavioral health outcomes (e.g., asthma control)
- Reduced preventable hospital admissions for asthma

$ Cost

- Reduced emergency department visits and hospital admissions

Access

- Faster, more convenient connection to local, culturally effective health resources

IMPROVING HEALTH EQUITY

Patients and families experience barriers to care that result in health disparities. Health disparities start early and can be reduced through interventions in childhood. Access to culturally appropriate community-placed care can reduce disparities in the following ways:

✓ **Address health and preventive care needs in the home** or in a convenient, culturally appropriate and trusted community setting.

✓ **Better address social and environmental risks**, language preference and health literacy gaps.

✓ **Support pediatric practices** by filling gaps in services for patients and families experiencing barriers to care.

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PEDIATRIC COMMUNITY PURCHASING PARTNERSHIPS

MEDICAL HOME

Uses person-centered assessments (including culturally appropriate SDOH screening) and/or analytics to identify patients and families whose needs are best met through community placed services. [See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-Management Services	Complex Care Coordination for High Risk Patients and Families, Often with SDOH Needs	Parental Support Services	Transition Services for Adolescents
EXAMPLES OF MODELS	Health Leads	The Village Model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD Model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition