Primary Care Modernization Capability Summary
Diverse Care Teams

Design group meeting notes are attached to the end of this document.

Definition of the Capability: The National Academy of Medicine defines team-based care as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

Goal of the Capability: Team-based care aims to make primary care more comprehensive and accessible, better meet the diverse needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction.

Consumer Input, Questions and Concerns:

- Patients need support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions and making their environments healthier.
- Patients need support learning to advocate for themselves to access and secure affordable, necessary medical care and community support services, and to be provided skilled, trained medical interpreters, as needed.
- Care teams should ideally be representative of the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms.
- Care team members need adequate training and qualifications to fulfill necessary functions and avoid patient underservice. For example, not all care team members have adequate training to provide care coordination, or certain care coordination related functions, for patients with complex needs.
- PCM needs feedback loop with consumers throughout design and implementation to ensure ongoing consumer voice.
- Designate a care team member to follow up with patients after appointments about their experience, or some way to capture care experience on a regular basis as a feedback loop.
- Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform. Care team assessments of adequate service and patient experience should factor into shared savings.

Summary of Capability Based on Design Group Recommendations

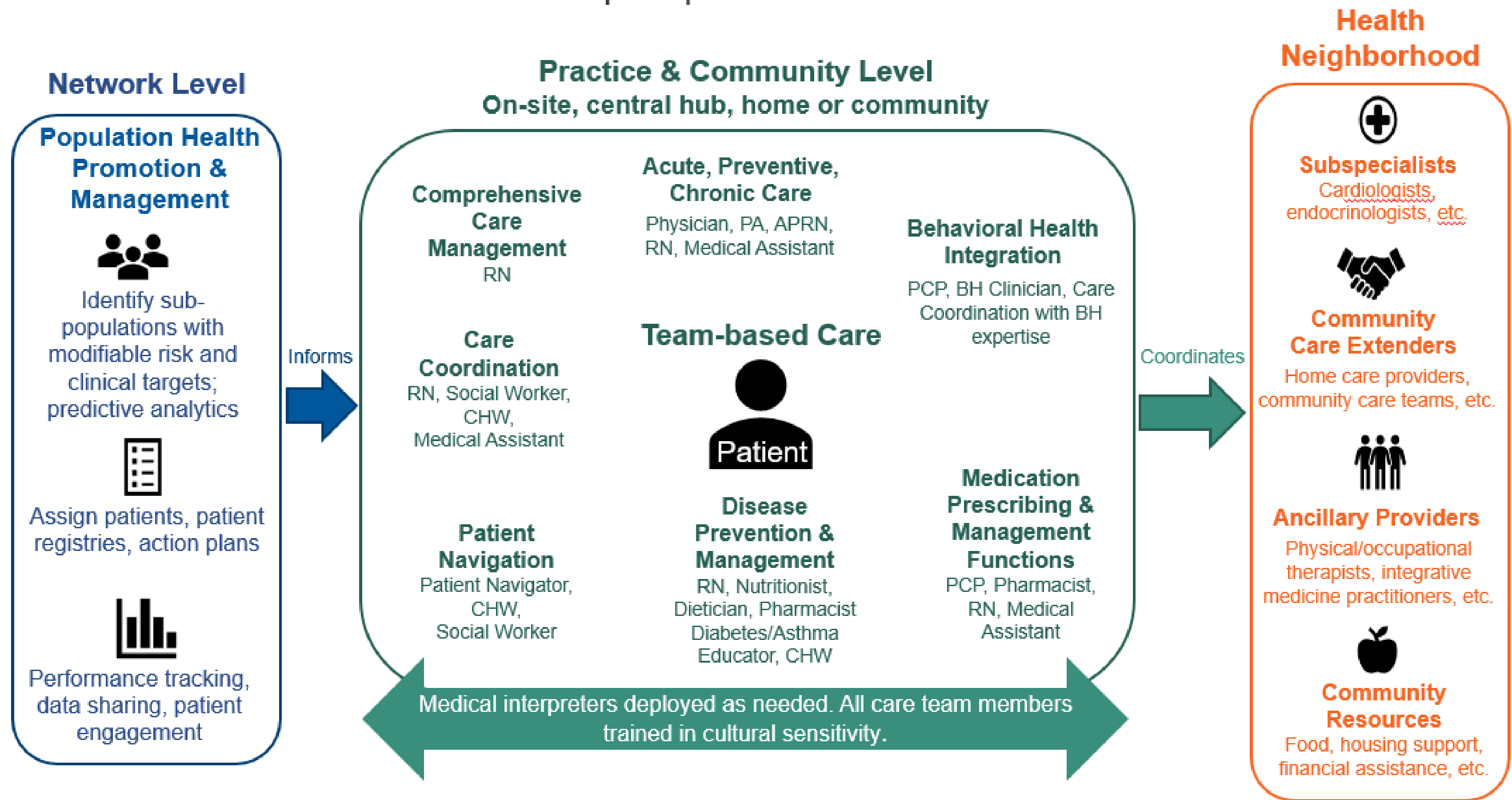
Capability Requirements

- Supplemental bundle supports all practices in diversifying care teams to support the identified primary care team core functions.

- Advanced Networks/FQHCs have flexibility to deploy care team members on-site at the practice, in the community and patient homes, and/or at a central hub.
- Care team compositions, location of team members, and staffing ratios depend on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, team member role (direct patient care or supporting care management).
- Payments should support training care teams on efficient communications, care team member roles and functions, and workflows that support team-based care.
- Every Advanced Network/FQHC should establish processes to promote and improve effective team-based care.
- Practices adhere to the following Principles for Team-based Care
    - Patient is at the center of the care team
    - Care teams are ideally representative of the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms when working with patients. Care team members are trained in cultural sensitivity and awareness.
    - Care teams enable all professionals to perform at the top of their training and better meet patient needs through expanded roles and workforce
    - Advanced Networks/FQHCs work with practices to compose care teams depending on their patient population
    - Care team members may be embedded within the practice site or centralized at the network level to serve multiple practices based on individual practice needs
    - Care teams have a collaborative structure that values and encourages each team member's contribution. Care team members are trained on the roles and functions of other team members.

Recommendations for Consumer Protections

- Care team members are assigned to fulfill roles and functions that take full advantage of their skills and qualifications but do not extend beyond what they are trained or qualified to do to in order to protect against patient underservice. The primary care provider in collaboration with the patient and care team determines the degree of intensity of services needed for each patient and the care team members most appropriate to meet these needs.
- Care experience is a recommended element of performance measurement as a consideration in determining the extent to which providers qualify for shared savings, as is currently the case with the Medicare and Medicaid shared savings programs, MSSP and PCMH+, respectively.
- The Payment Reform Council should consider including the conduct of an annual care experience survey and a mechanism for ANs/FQHCs to gather and respond to consumer complaints among the AN/FQHC conditions of participation.



Care team functions, activities and credentials that may support functions are provided in the Table 1. Table 2 defines the care team functions.

Table 1: Care Team Functions, Activities and Credentials

Function	Activities	Credentials
Population Health Promotion & Management	• Identify populations with modifiable risks • assign each patient to a specific provider and/or team who is responsible for their care • Generate patient registries • Develop Actionable Steps Using Evidence Based or Clinical Guidelines • Conduct Pharmacy-focused population health analytics	Physician, APRN, PA and Pharmacist work with Population Health Specialist to identify populations and action steps
Comprehensive Care Management	• Identify individuals with complex health care needs • Conduct Person Centered Assessment (PCA) • Develop Individualized Care Plan (ICP) • Establish Comprehensive Care Team • Establish annual training to successfully integrate and sustain comprehensive care teams. • Execute and Monitor ICP • Assess individual readiness to transition to self-directed care maintenance • Monitor individual need to reconnect with Comprehensive Care Team • Evaluate and improve the intervention	RN
Care Coordination	• Conduct Pre-visit Planning • Develop Care Plans and address Gaps in Care • Coordinate care with specialists and other providers • Coordinate transitions of care • Populate and update patient's care plan • Link to community supports and resources	Care coordination activities should be directed by the PCP or an RN/Social Worker or equivalent serving in the role of Care Coordinator. CHWs and MAs may provide care coordination support, under the direction of the PCP or Care Coordinator.

Patient Navigation	• Identify individual barriers to accessing care, including insurance related barriers to care, such as high cost of prescribed medications, understanding how to use benefits and how benefits can impact decisions regarding choice of provider • Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs • Assist patients with pre-visit planning, getting to appointments, and making follow up appointments • Ensure timely follow up and reduce delays in care throughout the continuum of care for a medical episode • Facilitate communication between providers and patients	Social Worker, Community Health Worker, Patient Navigator (privately credentialed, specific training)
Disease Prevention and Management	• Identify the population who will benefit from disease management program • Health or lifestyle coaching and patient education • Promote chronic illness self-management • Develop programs that are culturally diverse and remove barriers • Nutritional education and counseling • Basic screenings and assessments	RN, Dietician, Diabetic/Asthma Educator, Nutritionist, Pharmacist, Community Health Worker, Social Worker
Medication Prescribing and Management Functions	• Medication reconciliation/ best possible medication list • Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies • Initiating, modifying, or discontinuing medication therapy • Comprehensive medication management	PCP, Pharmacist, RN, MA – scope of delegation determined by the practice/PCP; in the case of pharmacists, scope should be established in a collaborative practice agreement (CPA)
Behavioral Health Integration	• Behavioral health screenings and initial assessments • Brief interventions, consultations, medication, and episodic care • Referrals to extended therapy/counseling, medication and higher levels of care (day treatment, partial hospitalization • Dedicated behavioral health care coordination to help patients make connections to treatment and community-based services, follow up and track process, and facilitate care team communication with behavioral health clinicians	Psychologist, APRN, LCSW Care coordination supported by care team member with behavioral health expertise

Table 2: Definitions of Care Team Functions

Function	Definition
Population Health Management	"Population health refers to addressing the health status of a defined population. A population can be defined in many different ways including demographics, clinical diagnoses, geographic location, etc. Population health management is a clinical discipline that develops, implements and continually refines operational activities that improve the measures of health status for defined populations." (Richard J. Gilfillan, MD, President and CEO, Trinity Health)
Comprehensive Care Management	"Complex care management is a person-centered process for providing care and support to individuals with complex health care needs. The care management is provided by a multi-disciplinary Comprehensive Care Team comprised of members of the primary care team and additional members, the need for which is determined by means of a person-centered needs assessment." (CT SIM Clinical & Community Integration Program)
Care Coordination	"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (Agency for Healthcare Research & Quality). Care coordination also includes community focused care coordination to link individuals to needed social services and supports to address social determinants of health needs and culturally and linguistically appropriate self-care management education. Care coordination would support other PCM capabilities, including behavioral health integration and practice specialization in geriatrics, chronic pain and individuals with disabilities (CT Community & CT Clinical Integration Program).
Patient Navigation	Patient navigation may be defined as the process of helping patients to effectively and efficiently use the health care system ("Translating the Patient Navigator Approach to Meet the Needs of Primary Care," by Jeanne M. Ferrante, MD, MPH, Deborah J. Cohen, PhD and Jesse C. Crosson, PhD)
Disease Prevention and Management	"Disease management programs are designed to improve the health of persons with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations." (Bodenheimer, T. (1999). "Disease Management -- Promise and Pitfalls," The New England Journal of Medicine, 240(15): 1202-1205.)
Medication Prescribing and Management Functions	Medication related functions, such as medication reconciliation, routine medication adjustments, initiating, modifying, or discontinuing medication therapy and medication monitoring/follow-up care

	coordination that other care team members can perform to assist the primary care clinician as delegated by the PCP/care team, including comprehensive medication management. Comprehensive Medication Management “A process of whole-person care that begins with the individual and seeks to optimize medications by identifying and resolving medication-related problems that stand in the way of reaching the patients’ therapy goals.” (cited from http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf (2014) in presentation by Marie Smith, “Primary Care Medication Management as a Team Sport” http://www.ehcca.com/presentations/medhomesummit8/smith_t2_1.pdf) Comprehensive Medication Management services may be implemented through collaborative practice agreements (CPAs) between physicians and pharmacists. CPAs are written documents between physicians and pharmacists that have the ability to increase access to care, expand available services to patients, increase the efficiency and coordination of care, and leverage pharmacists’ medication expertise to complement the skills and knowledge of the other health care team members. A variety of patient care functions—such as initiating, modifying, or discontinuing medication therapy; ordering lab tests; and administering medications—can be delegated to a pharmacist using a CPA (allowed in CT; will vary on a state-by-state basis).
Behavioral Health Integration	A team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions (from PCM Behavioral Health Integration Design Group)

Primary Care Modernization Diverse Care Teams Design Group Meeting 1
09/06/2018

Participants: Grace Damio, Robert Kryzs, Daren Anderson, Bradley Richards, Marie Smith, Liza Estevez, Stephanie Burnham, Mark Schaefer, Judy Levy, Linda Green, Alyssa Harrington, Vinayak Sinha, Ellen Bloom, Kate Dangremond, Andy Selinger, Michael Vessicchio, Jenna Lupi

Discussion:

- Consumer: Would say this is a good list. As plans are implemented, the continuing voice of the consumer is important, so there should be some discussion of what has been mentioned by the PCM (i.e. the ability to monitor the impact, track the experience of consumers, and differentiate between type of networks (independent practices or some of the larger ACOs)
- Consumer:
  - Advocating for themselves (patients) in use of healthcare, we need to be able to do that to better equip patients to use available services.
  - We need to be aware of socio-cultural needs and norms (need to go beyond awareness and respect and talk about communication skills)

Principles for Team-based Care

- *What are we missing?*
  - Consumer: The care team operates in a non-hierarchal way. Each member's participation is equally valued.
  - Provider: Add a principle around members of a care team being aware of each member's contribution to the team.

Care Team Functions and Members

- *Which team member should be deployed and how?*
  - Either by embedding or integrating
- Which function, or care team members, must be available in primary care?
  - State: There is a distinction between care coordination (just making sure appointments are made and people get to their appointments) and medical care management
  - Should care coordination be distinguished from medical care management?
  - Consumer: Agrees one is more clinical than the other.
  - FHC Expert: I think it depends on the definition, and there is a lot of overlap. A patient navigator is a care coordinator, and in other models, a care manager does a lot of care coordination. It depends on how you want to define it and there's no wrong definition.
  - FHC: In the skeleton we sent, there were definitions of roles. Distinct role between care coordination vs care management.
  - FHC Expert: If that's the way you want to define it, that's fine.
- Preferred care team perspective: Is a care manager on its own? (ex. Nurses, Care manager role)
- Patient navigator: Is it only appropriate to have it as a function?
- Other functions to provide to patients?
  - Should consider care management as part of professional functions.
  - Provider: A patient navigator does have distinct roles between patient navigator and care management.

    - Consumer: Patient navigator, the term does exist and is being used
- Is there any other care team member that should be added to primary care?
    - Consumer-No; what is a scribe?
        - Someone who takes notes during a medical appointment.
        - Consumer-Good idea.
- State: Patient navigator does have certifications and is an actual title
- Are any of these not essential to primary care?
- Provider: I am interested to see that scribe was listed here as a core function of the care team. The number of practices using scribes is relatively small; Scribe is optional and not a critical core function of all primary care. This function may disappear.
- Which care team members must be embedded in the practice?
    - Consumer: Hired by the practice and full time? How do you define embedded? Is it who hires them or how they work?
    - FHC: On site with other members of the care team.
- Provider: Depends on the size of practice. It's hard to answer that.
- Provider: Health coach, is this a function or team member? There are many people on the care team who could fill this role.
    - Consumer: I agree and it's also a function of community health workers.
- Provider: Once we agree on core functions, it doesn't matter whose inside the walls or outside the walls.
- FHC Expert: Meeting the patient where they are in their home or shelter; The value of a CHW- they often spend much more time in a community than in an office. As long as they're integral in the care team then it doesn't matter if they are in the office space, but they must be core team-based (where they are is less important than their function).
- Pharmacists:
    - Provider: Highly variable; There are lots of examples where an office has a fulltime pharmacist, and if it's a smaller office than they can have a shared resource model; for high-risk patients they also do home visits on their own and sometimes in conjunction with a PCP. It's variable, and according to the needs of the organization. They function in a primary care setting embedded.
- Are there any populations that should have specific care team members?
    - Provider: Navigators, coaches, and CHWs are essential for more in-need populations.
    - Consumer: It's hard to go through each function and each type of population. Certainly, CHWs for people with SDOH-risk.
    - FHC Expert: For care manager, there should be an asterisk under medication management. Sometimes a BH specialist can go into a home or shelter as well.
        - FHC: There is a design group working on how BH should work.
- Any suggestions for staff to patient ratios?
    - Provider: This work is too new to be able to mention that. Medical assistants generally practice 1:1. It's very dependent on site and population.
    - Provider: Some work done on staffing ratios for primary care; some benchmarks look at PCPs, panel sizes (especially if they're risk-adjusted)
    - Provider: Also looked at models for CHW; typically ranges anywhere from 20-25 patients.

    - Consumer: Spreadsheets that put in every hour of the year help an employer determine caseloads. Our model is up to 40 on the caseload but varies based on duration and intensity of service model.
        - I would put a range that can vary quite a bit; can send caseload estimator also.
    - Consumer: The core team is one thing, but the ancillary team members must be available in a flexible way.
    - Provider: I agree that populations vary quite a bit. Their function might vary depending on cost.

Discussion: Approach to Expanding and Integration Care Teams

- How Do We Get There?
    - Needs assessment should be conducted in each practice.
    - Practices must develop new workflows that coordinate care.
    - What else is needed to enable practices to move to team-based care?
        - Provider: A funding system; If you provide the mechanism, practices will adapt it.
        - FHC: So, what would that look like?
        - Provider: Global capitation, shared savings, shared risk
        - FHC: Framework will be a primary care bundle and a case management fee intended to address this.
        - Have you had experience with a care management fee?
            - Provider: No.
- FHC Expert: It's important to talk about having a champion in a practice.
- Consumer: We may not have enough, and we may have too many. It's important if we design the core team (and even get to a payment reform model) that we can fund the team, then we have some team members we can hire and throw into the mix.
- Consumer: It's important that members of the team are trained in recognizing their role. This goes beyond training and removing hierarchies.
- FHC Expert: There will need to be a culture shift in how people look at care teams now, and what the expectation are in terms of the end product of a core and care team. How you get there in terms of shifting culture (that's not easy).

Next Steps:

- FHC will put together a model or approach and will share at next session.

Primary Care Modernization Diverse Care Teams Design Group Meeting 2
09/11/18

Participants: Grace Damio, Robert Kryzs, Bradley Richards, Marie Smith, Liza Estevez, Stephanie Burnham, Mark Schaefer, Judy Levy, Linda Green, Alyssa Harrington, Vinayak Sinha, Pano Yeracaris, Ellen Bloom, Jenna Lupi, Kevin Galvin

What We Heard in Session 1:
Consumer Input Needs and Concerns
-Ongoing consumer voice is critical to PCM
-Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform
-Consumer need support learning to advocate for themselves in a medical setting
-Care teams need to go beyond being aware and respectful of cultural needs and norms.
-Communication with patients, should consider patients' socioeconomic, and sociocultural needs and norms

- Consumer: Under first bullet, from the Consumer Advisory Board perspective, there should be a feedback loop in the system for the consumer voice.
- FHC: Continued consumer input beyond just the planning phase?
- Consumer: Yes, so we can learn as we go through this.

Additional principles for Team-based care

- Provider: Workflow processes, incorporating team members in the process (this was an original added principle and does not need to be added)

Approach to Care Teams

- Provider: Whether the role of the team member is direct patient care or more of a population health program or distributed care program.

Expanding Care Teams

- FHC: We did get some feedback for the pharmacist role in referrals and care coordination.
- FHC Expert: The role of the pharmacist is crucial as you have it, but sometimes in a less complex patient the nurse also does medication recommendation and management.
- Provider: Concurs; I usually work with patients who have lower complex needs and try to specify which patients are of highest concern.
- FHC Expert: I see pharmacists working with patients with diabetes that do coaching and self-management. Pharmacists are very good at this.

Integrating Community Health Workers (CHWs)

- Consumer: There is an effort in CT to legislate certification requirements for standard CHW training and services. This will happen at the end of the month.

Questions for Discussion
-Should the network make this service available to the practice?

- What do you mean by network? System level or AN or FQHC?
    - Depends on the size and scope. In some practices, the needs may be a lot higher, so integrating them into the practice rather than having them external might make a lot more sense.

    - So, having them in network/practice depending on need.
    - Provider: Agrees. Also, where the socioeconomic needs are.
- FHC Expert: CHWs being able to also function outside of the office - Is that something we also want to emphasize?
- FHC: Sounds like there needs to be flexibility. CHWs available to be deployed at the practice level or in the community/home based on need
- FHC Expert: If the CHWs are not in the community and are not able to go into the patient's home, then they are not fulfilling their roles and how they've been trained (need to meet the patient where they are and be the eyes of the practice).
- FHC: Should we set some kind of standard for staffing in terms of SDOH?
- State: Do you mean ratios when you say staffing?
    - Yes.
- State: I would say yes. The Hispanic Health Council put out recommendations around CHW implementation
- FHC: The Hispanic health council gave us some guidance for CHWs
- FHC Expert: I think that as you are building a program, it's been my experience that ratios tend to increase, and I have seen them as high as 200+. It really depends on patient population, but even on Medicaid population, I've seen them grow higher than that.
- FHC: Perhaps there's a need for an annual evaluation.
- State: Doesn't it also depend on the role and the function because not all Medicaid patients are similarly situated? Is the role around community linkage in support of SDOH vs. if you're employing CHW in self-management; in what role or function are you having the conversation about case load or staffing ratio?
- FHC: I think that the role of the CHW varies, and the practices and the networks need the flexibility to define the role.
- State: It can be challenging to break it down. The case load estimator that the Hispanic counsel put together is great because it includes things like administrative time the CHW is attending, participation in the community, home visit time, etc. This could be a starting point.
- Provider: It also depends on the longevity of the program and how well-established CHWs are in that program
- FHC: I think we can provide the case load estimator as a way for practices based on their data (what their patient population needs are, how many CHWs they need, and so on)
- State: How many patients are you trying to serve? It matters how you stratify your population. In our experience, networks have different criteria for establishing high risk and are unsure if it's completely necessary to define that.
- FHC Expert: CHWs have the best track record of finding patients who have been missing appointments, helping them understand that it's important to make their appointments, knowing where they are in the community, and getting them in. This is time consuming, and that's not just stratification, it's also understanding why people are not coming in for preventative and scheduled health, and missing appointments. This needs to be factored in as well.
- FHC: Does this group want to define which patient you are serving as a network or should that be left up to the network?

- State: I think what you have put together already as the function of the care team would help address an unmet need (I don't see it being possible since it could limit the capability of a CHW)
- FHC: They need to make community health workers available.

Role of pharmacists

- Provider: For the last bullet, is this within the scope?
    - Yes, it is, but there is a lack of knowledge as to what pharmacists can do. It must be a written agreement and it must designate the number of physicians and document the number of patients being served on the protocol.
- Provider: In a network, you could have everything from 1-2 practitioners, depends on the size and structure of your practice. It's not cost effective to have a pharmacist at every practice site especially if your practice is smaller. We use a .25 FTE per full-time provider.
- Provider: Other factors that come in - we could have patients in a practice that have a high degree of BH problems and chronic diseases, and who are seen by multiple prescribers. On an average use of the quarter FTE per provider, it's important to look at the patients that are not at goal and get them in for an appointment with a pharmacist (at least for a recommendation) to see if they can get to goal. It's a balance between direct patient-care referrals and higher value referrals.
- Provider: It's really helpful when pharmacists are on-site and on-hand, but we must realize that it's not feasible in smaller practices.
- State: These are helpful comments. Can we establish virtual access to basically network supporting pharmacists as a core feature of the model?
- Provider: Yes, if you're all on the same EHR, which you usually are. Internal e-consult is doable but doesn't necessarily need the machinery for an e-consult platform.
- Not sure we have the current platform to operationalize it, but it sounds like it could be a great opportunity.
- Provider: Telehealth would be considered in many states to be a form of direct-patient care.
- FHC: Telehealth can be used in many ways and one of them is pharmacists.
- FHC Expert: The transformation taskforce supported telehealth be supported at each practice level, but flexibility would be important.
- State: Flexibility will be there. In a typical practice, the Medicare population will have higher health risk and so forth, but maybe the Reform Council can model the .25 assumption and look at the varying PMPM in clinical risk (which would reflect a practice that predominantly serves Medicare). I think that having a basic assumption in a typical practice is a great starting point for the scenario model.
- FHC Expert: So, in terms of scope of practice and the total cost of care, I am wondering if you see in-scope and out-of-scope, do you ever pick up that there might be an opportunity in terms of cost savings utilization? Some of the doctors that are ordering medications-question why someone is on brand.
- Provider: These are good points. The comments I've made are not generated just by claims but by quality.
- Provider: This is done more on the corporate side.
- State: It's critically important that we model each of the areas.

    - Provider, anything you can do to help us based on the functions we are prescribing pharmacists would be great.
- State: Pharmacists are more likely to have continuity of care opposed to having a pharmacist hub, and less of an opportunity for continuity.
- Provider: Yes, this is one model for smaller practices. A shared resource pharmacist might be another way.
- State: It's not uncommon in care management, but how can we assign pharmacists to help providers do less non-physician activities and spend more time with patients?
    - FHC: We have several guidelines and recommendations for pharmacists and what their role should be.

Enhancing patient care

- Should all practices be required to create diverse care teams?
    - State: I would hope there would be consensus support.
    - Provider: In support.
    - Provider: In support.
    - FHC Expert: In support.
- FHC: Should the practice be responsible for contracting for non-clinical services? There needs to be flexibility, but then the care team members should be on-site or available through telemedicine depending on each practice need.
- FHC: Should the network also be responsible for training diverse care team members?
- Every ACO or advanced network should have methods in place to promote and improve effective team-based care, and training is one aspect of that.
- Network capabilities that the network needs to provide?
    - Provider: Analytics need depending on the size, monitor how performance is going to provide feedback to the team too
- State: Concerns about consumer benefit or consumer protections; To determine intent of practice's support of panel; Recommending there be methods to reporting out and documenting will help account for how money is being spent and how patients are being supported.
    - Provider: I would agree. The data analytics team would be monitoring patients.
- Provider: Net promoter score - willingness of patient or customer to recommend service to others. This can be a powerful tool in measuring patient satisfaction.
- State: This is a new idea, and very much in line with what consumers are asking for.
- Other measures you would recommend?
    - FHC Expert: You can look at some of the standard measures being used now (how many outreaches did you make, measures of patient engagement, etc.). We will research specific measures.
    - State: I propose we tie this back to the SIM quality counsel, and that we focus on the expectation that practices would improve on quality measures. The other is that we've done work in SIM and the Yale core to develop methods to measuring health disparities. You would see better performance on high-SDOH-risk populations if we specifically call out performance with respect to health disparities and disability disparities.
        - Consumer and FHC expert agree.

- FHC Expert: Its challenging to tie in too many measures and we should be careful we aren't extrapolating. I am struggling with how we can make it specific, but I agree we should be tracking something.
- Provider: If there are too many measures, it will be burdensome.
- State: We don't want to create more physician burden.
- Provider: We do have some models depending on the role.

Next Steps:

- FHC will put together these recommendations.

PCM Diverse Care Teams Design Group 3

10/19/18

Participants: Gail Sillman, Robert Kryzs, Judy Levy, Daren Anderson, Lesley Bennett, Grace Damio, Jenna Lupi, Marie Smith, Mark Schaefer, Shirley Girouard, Linda Green, Stephanie Burnham, Ellen Bloom, Alyssa Harrington, Pano Yeracaris

Recap from Previous Sessions

One consumer highlighted two points. Their first point was detailing who the established care team member is that is going to be given the responsibility of the feedback loop. Their second point was the concept of shared savings should be addressed by the Payment Reform Council, and the extent of adequate and under service should be signaled as well. The consumer emphasized that this should be a part of the assessment of the shared savings model.

FHC asked how often the group thought the patient navigator should conduct the patient experience survey (i.e. every 6 months). A consumer responded that every time a care team member touches a patient, they should ask how their last appointment went to obtain some kind of entry that can go on record and assess care experience. A provider and consumer explained that this should already be a normal part of the primary care process, and that they did not believe this effort needs to tell providers to do this. OHS agreed, and stated they were worried about getting too prescriptive. Care experience is embedded in the performance measurement for Medicare and Medicaid in terms of the quality gate, so this effort is already asking about consumer experience. The provider and consumer reinstated that when a provider sees a patient, they should always ask how the patient feels about their care experience. These assessments should really focus on care. FHC summarized that care experience would have to be a part of the measurement and that this effort must make sure there is a care team member designated to do this. OHS explained that typically, accountable organizations do their own surveys, and that this is separate from what payers sometimes do (what factor qualifies for shared-savings). Accountability and measurement are something this effort is solving for through a separate process, and a performance measurement strategy is being laid out.

Recap from Previous Sessions

Consumer Input Needs and Concerns Diverse Care Teams Can Address

- Patients need support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions and making their environments healthier.
- Patients need support learning to advocate for themselves to access and secure affordable, necessary medical care and community support services, and to be provided skilled, trained medical interpreters, as needed
- Care teams should ideally be representative of the communities they serve and take into account socioeconomic, and sociocultural needs and norms- included as care team principle.

Additional Consumer Feedback

- PCM needs feedback loop with consumers throughout design and implementation to ensure ongoing consumer voice-to be addressed as implementation consideration
- Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform-to be addressed by Payment Reform Council.

Approach

- Developed principles for team-based care (see Appendix)
- Every Advanced Network (AN)/Federally Qualified Health Center (FQHC) should establish processes to promote and improve effective team-based care
- Ans/FQHCs have flexibility to deploy care team members on-site at the practice, in the community and patient homes, and/or at a central hub
- Care team compositions, location of team members, and staffing ratios will depend on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, team member role (direct patient care or supporting care management)
- AN/FQHC will need sufficient funding for training care teams on patient engagement and effective communication skills among team members and patients, population health and care coordination and new office-based workflow design that support team-based care

Are we missing anything?

A provider and consumer pointed out that the Health Profession Core Competencies would be a nice framework here since there appears to be some redundancy. A provider added that there has been a lot of work at the National Academy about team-based care and that might be helpful here. FHC reassured that they will be looking at these resources. A provider and consumer warned that this effort must be careful about the difference between a competency and a function. OHS assured that function will be substituted for competencies here.

Purpose of Today's Session

- Confirm competencies of care teams and how they relate to each other
- Confirm care team member roles
- Prioritize core competencies for Ans/FQHCs
- Gather input on approach to diverse care team's capability requirements

Capability Requirements

- ANS/FQHCs determine how to meet core competencies through care team compositions at the network and practice level
- Team-based primary care core competencies:
    - *Available in provided meeting materials.*

An FHC expert explained the importance of looking at data and seeing, for example, diabetics having difficulty getting an eye exam. It's important to look at the data to make sure we are on target for certain populations. A provider and consumer then expressed their confusion about comprehensive medication management and suggested this should include pharmacists <u>and</u> anyone else prescribing for a patient. A provider asked if this effort was drawing from the SIM practice standard, and that if it was, then it was certainly appropriate and explained that certain professions have different definitions for medication management (refer to Collaborative Practice Agreement). OHS explained that this list of functions is not a list of all the functions carried out by primary care providers and specialists, and that the provided list focuses on some of the new functions that this effort is recommending be included as part of the core team capability. In terms of the comprehensive medication management standard, this effort is trying to solve for what the PTTF recommended. A provider explained that most of these other functions do not indicate what other providers should be delivering and it sends the message that AN primary care practices are required to have a pharmacist. This provider recommended that it might be better to leave out the pharmacist-specific concept. FHC explained that this is from the clinical and community integration work that was done but can be changed to reflect what has been suggested.

An FHC expert explained that this idea of the supplemental bundle was to provide or arrange, and that this effort is not saying everyone must have a pharmacist on staff. However, it's reasonable to say pharmacists should be available, but this doesn't mean it has to be a full-time or on-site requirement, just provided within the system. A provider and consumer explained that the care team needs to be involved with the medication aspect, and that in

the previously given diabetics example, it's important to remember that patients don't like to be defined by their diagnosis.

Care Team Members and Roles

- Upfront payments in the form of a supplemental bundle support new staff and functions for care team members other than physician, PA, APRN
- Care team members may be deployed at the practice site, a network hub, in the home or in the community
- Care team members fulfill functions based on stated roles and their qualifications and skills
    - *See chart in provided meeting materials.*

A consumer asked for the care team manager and care coordinator to be defined and explained that these members are basically the ones responsible for care coordination within a practice. Therefore, these need to be clearly defined. OHS identified care coordination as a core function, and the definition of care coordination doesn't map specifically to care coordinator. The issue is what's involved in care coordinating and how it's not traditionally healthcare-based (SDOH-risk and community linkages) and can a practice meet the requirement of that function without hiring a care coordinator (through an RN). Or, does every practice have to have a care coordinator? It was confirmed that there can be certification for a care coordinator, and that care coordination *roles* should be enabled by a diverse care team. A provider explained that, for example, nurses can serve as care team managers, and that perhaps this effort should just focus on function over title. Some people would prefer their care coordination done by someone who is an RN, and not done by someone who has a minimum amount of training. A member of the state referred to the C3 model and how there is more of a primary role in care coordination as opposed to the community health worker. With community health workers, there isn't a national certification, and this effort should be cautious not to get too prescriptive. A provider and consumer reminded the group that the goal is to protect the patient, and that allowing care coordination to be done by people with minimal training is not good. This role needs to be clearly defined to avoid underservicing patients.

OHS offered up a patient example to the group: "You have a patient with asthma, and it is not as well-controlled as it could be due to SDOH-related barriers (transportation, triggers in the home, etc.). As a result, a care coordinator arranges for care in this patient's home." With a focus on function, care coordination is needed for that patient, and the practice is going to have to figure out what level of training is needed to support that patient. It was stated that the regulation of practice functions and delivery of healthcare in practice settings is an uncertain demand and that this effort is primarily focused on what practices aren't receiving financial support for today. This effort is simply calling out some of the individuals they may hire to support those functions. A consumer explained a patient can be referred to a CHW, and then the CHW reinforces what is being provided in primary care. It could be a clinical linkage. An expert then stated that this is not just team-based care, but person-centered care. This effort needs to think about who the best fit for patients on a team is. It's an important factor that cannot be decided outside of a PCP team. This expert stated that what we want to ensure is that patients are getting to appointments and are being seen by PCPs, and that role could very well be filled by the CHW. OHS replied they would hope it would be because of the patient's individual level of need.

Diverse Care Teams DRAFT Concept Map

FHC reviewed the provided concept map.

A consumer repeated that the care coordinator needs to be clearly defined. FHC then enquired over a care coordinator being a certified role and referenced how a patient navigator is a certain role but that it could also be filled by another member of the care team. OHS pointed out that on the provided graphic under where it says care coordination, the provided physician types all could be used to fulfill this function.

It was confirmed that this effort defines care management as dealing with a complex care group, and a consumer noted that there should be someone in charge of care coordination or else there, again, is potential for underservice. The supervisors need to be specified and their role clearly defined. One provider, again, believes care coordination is a function and that there are different levels of intensity in that care coordination. Care coordination may be provided by a medical assistant, for example. An elderly patient with multiple complex needs may be managed by a nurse. This provider stated that the graphic does a nice job of describing the functions without being too prescriptive. It was then confirmed that the provider does not act as the care coordinator, but the provider is interacting with the team.

FHC asked if it would be helpful to add a statement about the degree of intensity and/or level of skill required, to which a consumer replied that it would be helpful to perhaps replace care coordinator with care coordination team. OHS explained that some practices use a social worker as a care coordinator. At a minimum, OHS believes this effort should add "RN" to the list of people who do care coordination and ensure there's an overall direction of the care team by the PCP (without telling the providers how to do their job). Individuals should be deployed in such a way that's no greater than the top of their training. OHS and FHC will come up with a statement that's featured to respond to the ambiguity.

A consumer insisted an RN be included, and that this effort get rid of the term "care coordinator" because it's confusing to a lot of consumers. Consumers believe care coordinators are RNs at a minimum. A provider rejected to removing care coordinator and stated that they have never met a patient who assumes a care coordinator is a nurse. OHS then asked this provider if care coordinators typically have credentials in their practice, and the provider explained that those that fill this role in their practice are generally RNs.

OHS confirmed that eliminating care coordinator might be helpful, but if its always going to be somebody without a designated certification, maybe this role doesn't belong in this effort. It was stated that there are certain academies that do trainings, but it's not well-established. It's an emerging area. An FHC expert then offered that care coordination and patient navigation overlap a fair amount. A provider explained that from a career-ladder standpoint, there are national programs that bring in a medical assistant role to take on more care coordination activities. OHS repeated their conclusion to remove care coordinator as a credential (for there are functions that need to be filled, and then there are credentials that can fill those functions). FHC warned that this effort does not want to exclude certain people because they can have a valuable role on a primary care team. An FHC expert explained that there are protocols that arrange who gets assigned to what, and this process usually results in better care.

FHC enquired over people who are not on the presented graphic (members of the extended care team), to which an FHC expert replied that this group belongs in the medical neighborhood. They're referrals and belong outside of the primary care system. The FHC expert agreed that they consider subspecialists as part of the extended care team, but that this is different from the expanded primary care team. OHS then proposed a box on the side of the provided graphic that contains essential members of the medical neighborhood. It was summarized that it's nice to acknowledge the providers of integrative medicine, even if they're not part of the care team.

A provider made one last note regarding medication and prescribing and how pharmacy technicians and medical assistants fill this role as well.

Next Steps

- Will circulate back to the design group in case there is a need for another discussion.