

CT Primary Care Payment Reform

Design Group Capabilities Skeleton: Diverse Care Teams

This Draft: September 4, 2018

Scope and Purpose of the Design Group

Thank you for joining the conversation about Primary Care Modernization in Connecticut. The Practice Transformation Task Force is currently reviewing the capabilities that should be incorporated into a primary care payment model.

The purpose of the Design Group is to consider whether the capability should be included in a primary care payment bundle. During the Design Group meetings, we will have an opportunity to confirm the group's understanding of the proposed approach for diversifying care teams within primary care and the option's overall impact in terms of better health, better care, patient experience, provider satisfaction and cost. With a shared understanding of the option, the group will also consider whether the option should be elective or required and, if so, how it should be delivered – by all practices, by some practices, by the network, or some combination. The Design Group's conclusions will be presented to the Practice Transformation Task Force, which is responsible for making a formal recommendation to the Payment Reform Council (PRC).

Some considerations to keep in mind:

- The CT SIM primary care payment initiative is directed at provider groups that participate in shared savings contracts and the pediatric practices within those groups.
- The payment model will include recommendations about risk adjustment (so that providers are fairly compensated for populations with higher needs) and attribution methodologies.

Questions for this Design Group's First Meeting

- Should anyone else be added to the "core team" for all practices and populations?
- Are we missing any critical functions or roles?
- Do we have the right preferred care team members for each role?
- Should this model recommend certain care team compositions for specific populations?
- Should this model recommend specific ratios (full time equivalent) for care team members for all populations? Specific populations?
- The proposed model allows networks to embed care team members or care teams within individual practices or centralize them at the network level depending on needs. Is this feasible? What works about this approach or what doesn't work?
- Should certain roles be required at the practice level?

Understanding the Need

The Problem:

The current primary care infrastructure and workforce is unable to effectively meet population management needs to improve overall population health. Studies have shown that not only do primary care physicians not have enough time in the day to address the diversity of patient needs on their panels, but almost half of patients are not receiving recommended acute, preventive, and chronic care.

Lack of primary care leads to worse health outcomes, increased sickness and death and higher costs (Cambridge Health Alliance). There are also numerous patient barriers to improving population health and controlling chronic disease, such as lack of family support, failure to adhere to treatment, lack of support for self-management, lack of access to care and being uninsured, differences in perceptions of health that are culturally based, the complexity of treatment, costs of transportation and other expenses, and an insufficient focus on prevention and on support from social and health care systems.

Provider burnout has also become a greater concern with greater administrative demands, limited time to meet with patients, and limited training to address patient education, lifestyle change, and social determinants of health. Provider burnout has been associated with a decrease in care quality, increase in medical errors, poorer health outcomes, lower patient satisfaction scores, overuse of resources and increased health care costs (Kim, 2018). Expanding the care team and roles of nurses and other health care professionals helps reduce burden on physicians and better care for patients.

Proven Strategy:

Name: Diverse Care Teams

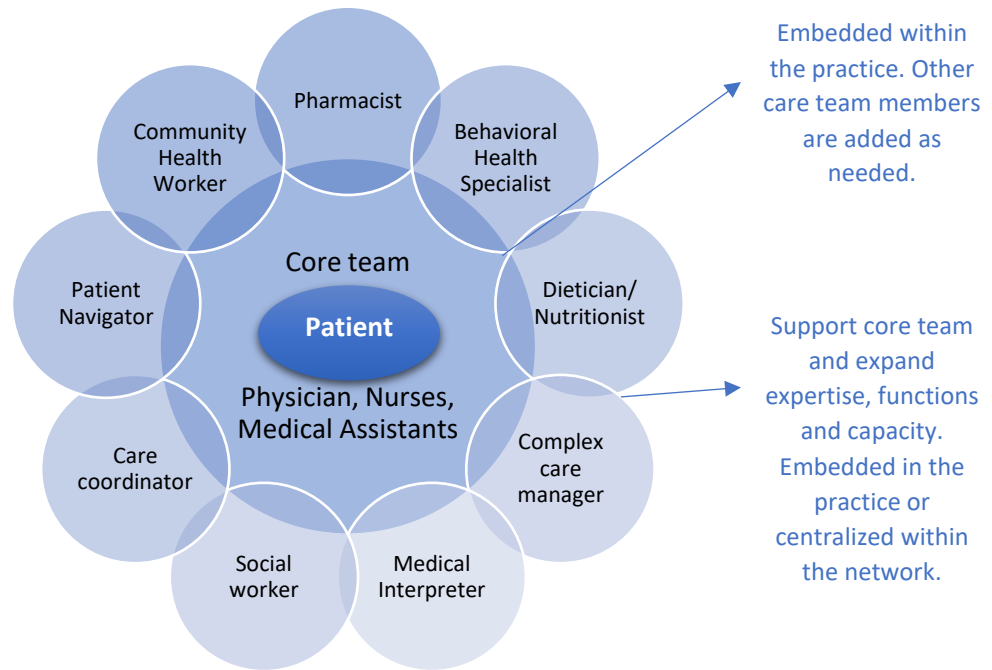
Definition: The National Academy of Medicine defines team-based care as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish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

Approach:

Networks implement patient-centered team-based care models, with functions and compositions of primary care teams based on their patient populations and providers' needs (CT stakeholder feedback, Wohler & Liaw).

- Networks work with practices to compose care teams that allow all professionals to perform at the top of their license and better meet patient needs through expanded roles and workforce.
- Care teams and members may be embedded within the practice site or centralized at the network level and serve multiple practices based on individual practice needs at different times. (State of Vermont, 2018). Practice size as well as efficiencies of scale can help decide the structures.
- At the center of the care team is the patient. The core primary care team is comprised of at a minimum: a physician, or in some cases a nurse practitioner or physician assistant, nurses, and medical assistants, and is based within the practice (AMA implementation manual).
- Additional care team members such as pharmacists, community health workers, behavioral health specialists, or care coordinators, and/or care teams, such as community health teams or complex care management teams, support the core team. Recommended care team ratios based on experience in other states and expert feedback are:
 - Practices with three PCPs have a full-time nurse care manager (based on 5-10% of a patient panel requiring care management and other supports), access to services of a part time pharmacist (through the network or community based), at least one Community Health Worker (CHW), at least a half time behavioral health clinician, and other services as indicated.

- Practices with higher concentrations of Medicare or Medicaid patients with high burdens of chronic disease should consider additional nurse care manager staff and pharmacist services.
- Ratios can be adjusted if the network provides centralized services such as complex care management, transition of care, community health teams, pharmacy services, etc.



Functions and roles may include but are not limited to:

Function	Role	Preferred care team member
Scribe	Take notes during the visit to allow the provider to have uninterrupted time with the patient (CT stakeholder feedback, AMA Implementation Manual)	<i>Medical Assistant or Nurse</i>
Care coordination	<ul style="list-style-type: none"> • Pre-visit planning: confirm visits, schedule preventive services, order labs, conduct medication reconciliation, order refills • Care gap planning: following up with patients who are overdue for services or whose measures are out of range • Transitions of care, such as calling the patient upon discharge 	<i>Medical Assistant, Nurse, Community Health Worker</i>
Patient navigation	<ul style="list-style-type: none"> • Identify barriers and increase access to care • Address social/emotional, financial, practical, and/or family needs 	<i>Medical Assistant, Nurse, Community Health Worker</i>

	<ul style="list-style-type: none"> • Negotiate complex administrative and clinical decisions 	
Disease prevention and management	<ul style="list-style-type: none"> • Health or lifestyle coaching and patient education • Motivation and self-efficacy training • Linkage to community resources • Nutritional education and counseling • Basic screenings and assessments 	<i>Care manager, Nutritionist, Community Health Worker, Health coach</i>
Medication Management	<ul style="list-style-type: none"> • Medication reconciliation • Comprehensive medication management • Medication monitoring and follow up • Tailored medication action plans for patients • Pharmacy-focused population health analytics 	<i>Pharmacist</i>
Addressing social determinants of health	<ul style="list-style-type: none"> • Connecting patients with community resources • Providing social support • Assisting with securing necessary services such as transportation, housing, food assistance, utility assistance, job training, education resources • Patient advocacy 	<i>Community Health Worker, Social worker</i>
Medical interpretation and translation	Interpretation services between providers and patients who speak different languages	<i>Medical Interpreter</i>
Behavioral health	Behavioral health screenings, assessments, brief interventions and referrals	<i>Licensed behavioral health specialist, Social worker, Nurse</i>
Home and community-based visits	Meets patients within the community or their preferred location to provide outreach or basic services	<i>Community Health Worker, Care Manger, Social worker</i>

To establish effective team-based care, networks and/or practices would¹:

1. Establish a multi-disciplinary change team that includes patients, clinicians, organizational leaders and other care team members to lead the process. This may be done at the network and practice levels.
2. Conduct a needs assessment with practices to determine needed functions in each practice
3. Determine care team composition and plan for how care teams will be implemented, including:
 - a. What functions are needed, and which care team members will fulfill these roles
 - b. Which care teams will be embedded in which practices, and which care teams will be centralized
4. Estimate the cost and savings of implementing the care team model (using a tool such as the American Medical Association’s Steps Forward [Team Based Care Calculator](#))
5. Develop team-based care workflows to increase efficiency and ensure consistency

¹ Adapted from American Medical Association’s Steps Forward Implementation Manual for team-based care

6. Develop communication processes, such as regular huddles and team meetings, to promote efficient and effective communications with patients and between care team members.
7. Train care team members on their role, and new workflow processes.
8. Gradually implement the model. This may involve starting with a pilot of the model in a single practice or with one team.

Intended Outcomes:

- Provide more coordinated, efficient care that better meets patients' needs and expands services
- Expand patients' access to high quality care
- Improve engagement between providers and patients
- Improve care management for routine and complex patient care
- Address social determinants of health and other non-clinical needs of patients
- Reduce unbalanced workloads and physician burnout by redistributing roles across the care team
- Increase job satisfaction across care team members

Consumer Input, Questions and Concerns (*feedback from consumers during the design group will be incorporated following the design group*):

- Patients need support navigating the healthcare system, making lifestyle changes, connecting with other providers, coordinating care, managing chronic conditions and making their environments healthier.
- Provide support services beyond traditional medical care.
- Include making care more affordable as a goal (e.g. care team members doing medication management should help patients find the least costly options that will work for them., and patient navigators should be trained and ready to explain billing, health insurance and costs.
- Patients want to be connected with community support services to make lifestyle changes and better manage their conditions but it all needs to be affordable.
- Provide support securing transportation and child care for going to in-office doctor's visits
- Care teams should ideally be representative of the communities they serve and at a minimum be aware and respectful of cultural needs and norms.
- Skilled, trained interpreters are needed.

Health Equity Lens:

- Helps to identify social determinants of care as well as cultural and linguistic barriers possibly interfering with self-care.
- Reduces access barriers such as transportation and ability for caretaker to manage getting patient to appointments.
- Improves chronic condition management and self-management for traditionally underserved populations and those with disproportionate disease burdens.

Implementing the Strategy

A patient with COPD and depression has not been attending her scheduled medical appointments. The nurse care manager calls the patient to find out why she has missed her appointments. The

patient tells her that she has been having trouble paying for her visits because she has a high deductible health plan. She is also running low on medication and is concerned that some of the drugs prescribed to her are interacting and causing side effects. The nurse care manager schedules an appointment with the network’s pharmacist for a day he is coming to the practice to review her medications. When the patient comes in, the nurse care manager coordinates with a medical assistant in the practice who is trained in helping patients with support for medical bills to meet with her to address her financial concerns.

HIT requirements

- Ideally, shared Electronic Health Record that:
 - All care team members have access to and can work on asynchronously and from different physical locations
 - Allows care team members to update the same patient charts simultaneously and from different physical locations
 - Is optimized for population and registry management and care management
 - Allows for a distinct and recognizable place for sharing and updating of care plan
- Communications technologies such as direct messaging and task management software for coordination and communication between care team members

Implementation Concerns:

- Lack of workforce availability that constrains the ideal care team composition, especially with shortages among primary care physicians in rural and poor communities, and among nurse practitioners, physician assistants and pharmacists
- Providing sufficient resources, structures, processes and support to facilitate effective communication between care team members
- Adequate training for care team members on building and maintaining good intra-personal relationships
- Potential to compromise trusted patient relationship with single clinician when shifting to team-based care model
- Transition may focus too heavily on process rather than skills and capacity building to provide patient centered care across team members
- Establishing effective communication and efficient coordination between care team members (Schottenfeld, et al., 2016)

Impact

Aim	Summary of Evidence
<i>Health promotion/prevention</i>	A systematic review of the literature indicated using patient navigators was effective for increasing cancer screening rates for colorectal cancer and breast cancer in low-income, medically underserved populations (Paskett, 2011).
<i>Improved quality and outcomes</i>	Randomized controlled trials have shown use of health coaches to be effective in improving health outcomes for obesity

	<p>(Wadden, et al., 2011; Boudreau, 2013) and improving hemoglobin A1c and cholesterol levels for diabetes control (although not blood pressure) (Willard-Grace, 2015)</p> <p>Results that team based primary care reduces Emergency Department use and hospitalizations have been mixed. A meta-analysis of quality control strategies to improve care coordination, including changes to the primary care team composition and functions, found these strategies reduced ED and inpatient utilization compared to the control group for patients with chronic conditions other than mental illness (Tricco, et al., 2014). However, CMS demonstration projects of primary care medical homes that use team-based care have resulted in unclear evidence of reduced utilization (Wohler & Liaw, 2016).</p>
<i>Patient experience</i>	<p>In a randomized controlled trial, patients who received education, care and medication management assistance from a care manager for depression experienced greater rates of depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment and greater quality of life (Unutzer, 2002)</p>
<i>Provider satisfaction</i>	<p>An observational study of high performing primary care practices suggests that a shared-care model with team-based care and a higher level of clinical support staff per physician and frequent forums for communication improved professional satisfaction and greater joy in practice (Sinsky, 2013).</p>
Lower Cost	<p>CMS' demonstration projects that utilize team based primary care in a PCMH setting have not yet generated sufficient cost savings. The Comprehensive Primary Care Initiative demonstrated enough cost savings in the first year to cover care management fees, but did not generate net savings. The Multi-Payer Advance Primary Care Practice demonstration that provided a PMPM fee for Medicare beneficiaries to support community health team implementation decreased expenditures among two of the eight demonstration states (Wohler & Liaw, 2016). These results should be interpreted with caution as other aspects of PCMH care in addition to team based care are factored into these results.</p> <p>A study of Vermont Blueprint for Health's medical home model with integrated community health teams reported reduced overall utilization by 8.9% and PMPM costs by 11.6%.</p>

Appendix

Learning from Others

Case Study: Vermont's Blueprint for Health is a statewide public-private initiative that combines a medical home model with community health teams to deliver comprehensive, well-coordinated care while improving health outcomes and controlling costs. Community health teams provide comprehensive support to advanced primary care practices within an identified geographic health service area of about 20,000 people. Community health teams are staffed by five full-time equivalent employees including registered nurses, a behavioral health counselor, community health workers, dietitians and public health specialists. Community health teams provide individual care coordination, health and wellness coaching, behavioral health counseling, and community connections to social and economic support services. They also provide direct support to primary care clinicians by supporting clinical duties and tracking patient appointments, managing short-term care for high needs patients, and following up with patients on medication adherence and health management goals. The model aims to help patients improve self-management and support primary care clinicians with connecting patients to needed resources.

Primary care practices continue to receive fee-for-service payments but also receive a PMPM payment based on a risk adjusted score against patient-centered medical home standards. Payments range from \$1.20 to \$2.39. The cost of the care team is \$350,000 annually and is funded by a Medicaid, Medicare, commercial insurers, and some self-insured businesses, based on the total number of eligible patients in the Health Service Area. Access to the Community Health Teams is offered at no cost to patients and practices (Bielaszka-DuVernay, 2011).

Results: An initial evaluation of pilot sites found:

- Patients with chronic conditions were seen more frequently
- Patients were more likely to be referred to mental health services and actually obtain them
- Providers reported feeling they could better respond to a range of patient needs, including non-clinical needs
- Inpatient use decreased 21% and PMPM costs decreased 22%
- ED use decreased 31% and PMPM costs decreased 36%
- Overall utilization fell by 8.9% and PMPM costs fell by 11.6%

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