Diverse Care Teams Core Competencies

The following are core competencies of diverse care teams:

I. Population Health Management:

Definition:

"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."
Source: Richard J. Gilfillan, MD, President and CEO, Trinity Health

"Population health is a management approach to redesigning the care for a group of people with the aims of making their care better and more efficient."
Source: Peter Slavin, MD, President, Massachusetts General Hospital

"Population health means taking an analytical approach to understanding the health needs, disparities and outcomes of the community and to align improvement initiatives."
Source: Kathryn Ruscitto**,** CEO, Joseph's Hospital Health Center

Goal: The goal of PHM is to improve the health outcomes of a group (patients with chronic and costly diseases) by using IT solutions that track and manage their care, by reviewing such sources as laboratory, billing, electronic health record and prescription data. The Care Team will have access to an IT solution that will track and address patient needs, and give them real-time insights, allowing them to identify and address care gaps within the patient population.

Role:

1. **Identify populations with modifiable risks**: Practices would implement risk stratification tools to identify targeted population and develop predictive models to support the risk stratification tool. For example, a risk stratification tool may first identify all diabetics, but then focus on diabetics who are not receiving a particular preventive service (such as foot examinations) and discuss why rates for this service are lower than expected and how the practice might boost them. Or they may seek to identify a broader classification of patients such as all patients who have had an acute inpatient admission, who are at risk for readmission within the next 90 days, and who have one of five chronic conditions: heart disease; diabetes; hypertension; asthma, or chronic obstructive pulmonary disease (COPD) and reach out to this population and more closely manage their treatment.
2. **Patient Assignment**: Before a care team can begin managing a patient population, it must assign each patient to a specific provider and/or team who is responsible for their care.
3. **Patient Registries**: After patients are assigned, (EHRs) can generate patient registries—lists of patients who share selected characteristics, paired with key data elements relevant to their condition and care. Some sites use centralized staff to review registries and send reports to care teams. Others have their front office reception staff, MAs and nurses working with individual providers to review registries (or reports based on registries), identify patients needing service and contacting them.

4. **Actionable Steps Using Evidence Based or Clinical Guidelines**: For each population and data element, the care team must decide on the criteria for action, which is based on clinical guidelines. For example, if the practice wants to provide better follow up for patients with uncontrolled hypertension, it must specify what it means to be beyond the optimal range (e.g., blood pressure higher than 140/90) and actionable steps (e.g., office visit if last visit was more than six months ago).
5. **Pharmacy-focused population health analytics** to inform and direct attention to populations in need of the comprehensive medication management and other pharmacist functions

Preferred Care Team Member: Physician, APRN, PA and Population Health Specialist
Preferred Location: At the Advanced Network/FQHC level to develop patient registries and follow-up steps based on clinical guidelines.

II. **Comprehensive Care Management:**

Definition: "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."

"Individuals with Complex Health Care Needs: Individuals who have one or more serious medical conditions, the care for which may be complicated by functional limitations or unmet social needs, and who require care coordination across different providers, community supports and settings to achieve positive healthcare outcomes."

Source: CT SIM Clinical & Community Integration Program

Goal: To comprehensively address identified barriers to care and healthy living and engage the individual directly in the direction and management of their care.

Role:

- 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

Preferred Care Team Member: Nurse Care Manager, may direct comprehensive care team
Preferred Location: At the practice level to play a direct role in patient care.

Care Coordination:

Definition:
The Agency for Healthcare Research and Quality defines care coordination as "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". 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.
Source: Adapted from Agency for Healthcare Research and Quality and Community & CT Clinical Integration Program

Goal: To facilitate delivery of the right health care services in the right order, at the right time, and in the right setting.

Role:

1. **Pre-visit Planning**: Track patients to confirm visits, to schedule preventive services, to order labs, to fill or refill prescriptions and to generally monitor patient adherence to mutually agreed-upon diagnostic and treatment plans.
2. **Develop Care Plans and Gaps in Care**: Identify high risk patients and gaps in care for prevention opportunities and develop a plan of care that is jointly created and managed by patients, their families and health care team.
3. **Coordination of Specialist Care**: Develop systems and services that monitor whether recommended specialty referrals have taken place; establish a feedback loop of specialists (via consultation reports) to primary care physicians and patients; disseminate information about the availability and quality of specialty services and community resources.
4. **Transitions of Care**: Identify social and clinical challenges faced by the patient that lead to avoidable hospital visits, and if the patient is admitted, track the patient and work with the hospital discharge staff to ensure patient is discharged to a preferred site (home, rehab, SNF), with a follow-up visit by their primary care physician.
5. **Data Entry**: Populate and update a care registry regarding member activities, problem lists, medication reconciliation, resources, and observed utilization.
6. **Links to Community Services:** Identify culturally appropriate care and resources in the community including, for example, transportation services, counselors, language translators, hospice care workers or representatives who assist with financial support to address social determinants of health needs and other needs that may be met by community-based services.
7. **Behavioral Health:** See behavioral health integration capability

Depending on practice needs, care coordination will also support practice specialization in Geriatrics, Individuals with Disabilities, Chronic Pain depending on practice needs and specialization.

Preferred Care Team Member: Care Coordinator, Medical Assistant, Social Worker, Community Health Worker, some functions may be done or supervised by a Nurse Care Manager
Preferred Location: At the practice level for coordination and intervention.

III. **Patient Navigation:**

Definition:

"Patient navigation is a process by which trained individuals proactively guide patients through and around barriers in a complex cancer care system to decrease fragmentation of care and to coordinate services"
Source: Freeman HP. A model patient navigation program. Oncology Issues. September/October 2004: 44-46

"Patient navigation may be defined as the process of helping patients to effectively and efficiently use the health care system."
Source: "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

Goal: To assist patients to "navigate" the maze of clinics, administrative systems and patient support services and reduce barriers that may keep them from obtaining timely treatment.

Role:

1. **Identify barriers and increase access to care**: Identify barriers to accessing the health care system and increase preventative screenings (breast, cervical and colorectal cancer) by providing individualized advice regarding importance of preventive screening and compliance.
2. **Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs**: Improve knowledge outcomes and possibly other outcomes related to preventing disease in underserved minority populations and provide access to culturally appropriate care and resources to the community including, for example, transportation services, counselors, language translators, hospice care workers or representatives who assist with financial support. Link patients to community services and supports and help apply for assistance (e.g. SNAP, utilities, public housing) to address social determinants of health
3. **Negotiate complex administrative and clinical decisions**: Advise patients—particularly those facing severe health literacy issues—regarding their selection of health insurance plans and in completing necessary applications. Also, help them choose, use, and understand different types of health care providers and services.
4. **Improve satisfaction with team communication and increase sense of partnership with professionals**: Change office workflow for collaboration and integration of new team members.

Preferred Care Team Member: Patient Navigator, Community Health Worker, Social Worker
Preferred Location: At the practice level to facilitate care in the best and most efficient, coordinated fashion, or in the community/home to address social determinants, emotional or financial needs.

Disease Prevention and Management:

Definition:

"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."
Source: Bodenheimer, T. (1999). "Disease Management -- Promise and Pitfalls," The New England Journal of Medicine, 240(15): 1202-1205.

Goal: To prevent another disease from developing or progression of an existing disease. For example, people with diabetes are at risk of developing heart, nerve or eye problems. Disease management programs are intended to prevent the occurrence of an additional co-morbidity and to help patients better manage their underlying condition, by understanding and monitoring their symptoms more effectively, and possibly, changing their behavior.

Role:

1. **Identify the population who will benefit from disease management program**. Programs are designed to target individuals with a specific disease based upon certain demographic characteristics, health care use and expenditures. Many programs will focus on costly chronic conditions (i.e., asthma, diabetes, congestive heart failure, coronary heart disease, end-stage renal disease, depression, high-risk pregnancy) as well as focusing on individuals with multiple conditions.
2. **Health or lifestyle coaching and patient education**: Disease management programs are based on the concept that individuals who are better educated about how to manage and control their condition receive better care. To assist in self-management, it may be recommended for patients to participate in behavior modification and support groups. Health coaching may also be used to make lifestyle changes to help prevent onset of diseases for patients who are at risk of developing chronic conditions.
3. **Programs must be culturally diverse and remove barriers:** To successfully address the burden of chronic disease among a broad range of disparate population groups, interventions should be developed in a culturally competent manner. For example, the Vermont Blueprint for Heath reduced barriers to health care in Vermont, by eliminating copayments, prior authorization or eligibility restrictions.
4. **Nutritional education and counseling**: Educating patients about their disease is critical. A diabetic educator or nutritionist, for example, will not only obtain physical data (i.e.,height, weight, blood pressure and waist circumference) at each visit, but may provide nutritional counseling, smoking cessation counseling (if not previously given) and provide documentation of self-management education with goals and timeline. He or she may also assist the patient in completing a functional skill and a quality of life assessment at baseline and post intervention.

5. **Basic screenings and assessments**: In addition to cancer screenings, these programs are intended to screen for common chronic conditions and they may screen for drug/drug, drug/food, drug/lab and drug/disease interactions and adverse drug reactions.

Preferred Care Team Member: Physician, Nurse, Dietician, Diabetic Educator, Nutritionist, Pharmacist, Health Coach, Community Health Worker, Social Worker
Preferred Location: Both at the Advanced Network/FQHC to identify the targeted population and at the practice level for interventions.

VI. Comprehensive Medication Management:

Definition:

"[Comprehensive Medication Management] is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The CMM evidence-based model was approved by 11 national pharmacy organizations and is dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines." CMM services should align with patient population and practice needs (from PCM Pharmacist Skeleton developed with UConn School of Pharmacy)
Source: CT Clinical & Community Integration Program

Goal: To assure safe and appropriate medication use by engaging patients, caregivers/family members, prescribers, and other health care providers to improve medication-related health outcomes.

Role:

1. From CCIP:
    a. Identify patients requiring comprehensive medication management (CCIP)
    b. Pharmacist consults with patient/caregiver in coordination with PCP or comprehensive care team (CCIP)
    c. Develop and implement a person-centered medication action plan (CCIP)
    d. Follow-up and monitor the effectiveness of the medication action plan for the identified patient (CCIP, PCM pharmacist skeleton)
    e. Medication regimen optimization (e.g., most effective dosing, evidence-based treatment guidelines) (PCM pharmacist skeleton)
    f. Decrease medication waste (e.g., meds with no indication, meds patient not filling or taking) (PCM pharmacist skeleton)
    g. Prevent potential medication interactions or adverse events (PCM pharmacist skeleton)
    h. Improved medication adherence (PCM pharmacist skeleton)
    i. Cost-effective therapy (PCM pharmacist skeleton)

Medication management services should not be selected simply based on administrative claims review for highest utilization or costs. Here are some patient selection criteria that should be considered in the implementation process:

- high-risk patients with chronic conditions and multiple comorbidities
- patients with high-risk medications
- patients with complex medication regimens, have difficulty taking medications as intended
- patients who have not achieved a treatment goal for a chronic condition
- patients with frequent care transitions
- patients who need to be monitored for treatment outcomes or adverse drug events between primary care office visits
- patients with multiple prescribers and multiple pharmacies

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).

Preferred Care Team Member: Pharmacist
Preferred Location: Both at the Advanced Network/FQHC level and the practice level

Other Medication & Prescribing Support Functions

Definition: Other medication related functions that are not part of comprehensive medication management but that other care team members can take on to assist the primary care clinician.

Objective: Assist the primary care clinician with medication reconciliation and monitoring functions.

Role

1. Medication reconciliation/ best possible medication list
2. Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies

Preferred team member: Nurse, Pharmacist

Preferred Location: Practice level

VII. **Behavioral Health Integration**: Developed by adult behavioral health integration design group.

Definition: A team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions

Goal: Increase PCP capacity and resources to improve access to behavioral health services and achieve better patient outcomes.

Roles:

- 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

Preferred Care Team Member: Behavioral Health Clinician (psychologist, APRN, LCSW), care coordinator with behavioral health expertise
Preferred Location: Practice level on-site or available via telemedicine