

Primary Care Modernization Diverse Care Teams Design Group Meeting 1

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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-hierarchical 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.