OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization
Diverse Care Teams
Design Group Meeting 3

October 19, 2018

Agenda

Introductions	5 minutes
Quick Recap of Previous Sessions	15 minutes
Today's Purpose	5 minutes
Discuss Diverse Care Teams Capability/Concept Map	50 minutes
Group Recommendations	10 minutes
Next Steps	5 minutes
Adjourn	

Recap from Previous Sessions

Consumer Feedback

- 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 patients' 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*

Recap from Previous Sessions

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?

SIM connecticut state innovation model

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 teams 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
  - **Population Health Management**: Identify populations with modifiable risk, assign patients and develop registries, develop action steps based on clinical guidelines
  - **Direct Patient Care**: Routine, acute, preventive, chronic care provided by PCP (clinician)
  - **Care Management**: Person-centered process for providing care and support to individuals with complex health care needs
  - **Care Coordination**: Organizing patient care activities and communicating patient's needs and preferences, linking to community services and supports, includes coordination in support of geriatrics, BH, chronic pain
  - **Patient Navigation**: Helps patients effectively and efficiently use the health care system, identify and address barriers to care; social, emotional, practical, familial, and other needs, make clinical decisions
  - **Disease Prevention & Management**: Prevents disease from developing or progression of an existing disease, health coaching, nutritional counseling, education and self-management
  - **Comprehensive Medication Management**: Process of care provided by pharmacists to optimize drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences
  - **Other Medication Prescribing & Support Functions**: Medication reconciliation, monitoring follow up, coordination
  - **Behavioral Health Integration**: Dedicated behavioral health clinician, screenings, assessments, brief interventions, medication, episodic care; behavioral health care coordination

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 teams members fulfill functions based on stated roles and their qualifications and skills

Primary Care Team Members	
Population Health Specialist	Care Coordinator
Physician, APRN, PA	Patient Navigator
Nurse	Health Coach
Nurse Care Manager	Nutritionist/Dietician
Medical Assistant	Community Health Worker
Medical Interpreter	Social Worker
	Diabetes/Asthma Educator

*Possible ancillary team members: physical and occupational therapists, chiropractors, acupuncturists, integrative medicine practitioners, dentists

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Diverse Care Teams DRAFT Concept Map

Network level

Population Health Management

Identify sub-populations with modifiable risk and clinical targets; predictive analytics

Assign patients, develop patient registries and action plans

Performance tracking, data sharing, patient engagement and self-management

Practice and community level

On site, in home or community setting or central hub

Comprehensive Care Management
Nurse care manager

Care Coordination
Care Coordinator, CHW, Social Worker, Medical Assistant

Patient Navigation
Patient Navigator, CHW, Social Worker

Team-based Care

Disease Prevention & Management
Nurse, Nutritionist, Dietician, Health Coach, Diabetes/Asthma Educator, CHW

Comprehensive Medication Management
Pharmacist

Community Care Extenders

Medication & Prescribing Support Functions
Nurse, Pharmacist

Patient

Acute, Preventive, Chronic Care
Physician, PA, APRN, RN, Medical Assistant

Behavioral Health Integration
PCP, BH Clinician, Care Coordinator

On-site or telemedicine, home or community for select populations

Medical interpreters deployed as needed. All care team members trained in cultural sensitivity.

Questions for Discussion

- What elements of this diagram would you change?
- Are these the right core competencies? Are there any you would add or not require?
- Is this the right way to organize the competencies?
- Are these the right care team member roles?
- Where would physical and occupational therapists, chiropractors, acupuncturists, integrative medicine practitioners go?
- Are any definitions or competencies or care team member roles unclear? Do any not align with your experience in practice?

Patient Scenario Example:

The **Population health team** analyzes their diabetic patients to determine who is in the most need of care management and identifies John Doe as needing care management. He is 66-years-old, diagnosed with Type 2 diabetes, obese, has high blood pressure (greater than 140/90) and his hemoglobin A1C test is 9.0. He also has unstable housing and does not have a car.

John Doe is referred to the care coordination team. The **care coordinator** contacts the patient and requests an in-person office visit.

A week before the appointment, the **patient navigator** calls John Doe to confirm that he can make his appointment, and asks if he has any transportation needs or would benefit from a **medical interpreter**. John Doe is advised how to use public transportation to get to his appointment, and a **medical interpreter** is assigned to his case, as English is not his primary language.

When John Doe arrives for the appointment, he meets with a **nurse** who takes his vitals, reviews his medications and draws labs. Afterwards, the **medical assistant** directs him to the examining room for a preliminary check-up by his **primary care physician (PCP)**. There is a **medical interpreter** in the room with the PCP, and the medical assistant remains in the exam room, taking notes during the PCP's visit.

Following the exam, John Doe meets with the **diabetic educator**, who provides education and an action plan to help him adopt healthy eating habits and increase his activity level. A **pharmacist** is also assigned to his case to review his medication list and determine the most cost effective medication for managing his diabetes and high blood pressure. He also meets with a **CHW** to help him apply for financial assistance for medication assistance, food, housing, utilities etc. They agree to meet the following week at his community center to show him affordable Farmer's Markets and healthy food stores and walking paths in his area.

During the teams' weekly huddle, they review all patients seen in the office that week that were on the care management team list, and discuss John Doe's case among all team members.

John Doe is monitored by a diabetic educator for the next several months. At his follow up visit several months later, John Doe returns to the office. He has lost 35 pounds, his A1c is 5.8 and he no longer needs to take medication to manage his high blood pressure.

Next Steps

- Revise based on today's feedback and circulate to design group
- Task Force makes recommendation to Payment Reform Council (PRC)
- Send design group Task Force recommendations

Questions?

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11

Appendix

Principles for Team-based Care

- At the center of the care team is the patient
- 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 allow all professionals to perform at the top of their license and better meet patient needs through expanded roles and workforce
- Networks 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 and serve multiple practices based on individual practice needs
- Care teams do not have a hierarchal structure. Each team member's contribution is valued and deliberately encouraged. Team members are trained on the roles of other team members