PCM Diverse Care Teams Design Group 3

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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 and 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

- OHS: Will make refinements to the concept map and materials to address points of confusion and will avoid the misconception of care coordination.
    - FHC will circulate by email a paragraph for people to proofread.
- Will consult the Task Force, but before that, will circulate back to the design group in case there is a need for another discussion.