

Primary Care Modernization Diverse Care Teams Design Group Meeting 2

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Participants: Grace Damio, Robert Kryzs, Bradley Richards, Marie Smith, Liza Estevez, Stephanie Burnham, Mark Schaefer, Judy Levy, Linda Green, Alyssa Harrington, Vinayak Sinha, Pano Yeracaris, Ellen Bloom, Jenna Lupi, Kevin Galvin

What We Heard in Session 1:

Consumer Input Needs and Concerns

- Ongoing consumer voice is critical to PCM
- Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform
- Consumer need support learning to advocate for themselves in a medical setting
- Care teams need to go beyond being aware and respectful of cultural needs and norms.
- Communication with patients, should consider patients' socioeconomic, and sociocultural needs and norms
 - Consumer: Under first bullet, from the Consumer Advisory Board perspective, there should be a feedback loop in the system for the consumer voice.
 - FHC: Continued consumer input beyond just the planning phase?
 - Consumer: Yes, so we can learn as we go through this.

Additional principles for Team-based care

- Provider: Workflow processes, incorporating team members in the process (this was an original added principle and does not need to be added)

Approach to Care Teams

- Provider: Whether the role of the team member is direct patient care or more of a population health program or distributed care program.

Expanding Care Teams

- FHC: We did get some feedback for the pharmacist role in referrals and care coordination.
- FHC Expert: The role of the pharmacist is crucial as you have it, but sometimes in a less complex patient the nurse also does medication recommendation and management.
- Provider: Concur; I usually work with patients who have lower complex needs and try to specify which patients are of highest concern.
- FHC Expert: I see pharmacists working with patients with diabetes that do coaching and self-management. Pharmacists are very good at this.

Integrating Community Health Workers (CHWs)

- Consumer: There is an effort in CT to legislate certification requirements for standard CHW training and services. This will happen at the end of the month.

Questions for Discussion

-Should the network make this service available to the practice?

- What do you mean by network? System level or AN or FQHC?
 - Depends on the size and scope. In some practices, the needs may be a lot higher, so integrating them into the practice rather than having them external might make a lot more sense.
 - So, having them in network/practice depending on need.
 - Provider: Agrees. Also, where the socioeconomic needs are.
- FHC Expert: CHWs being able to also function outside of the office - Is that something we also want to emphasize?
- FHC: Sounds like there needs to be flexibility. CHWs available to be deployed at the practice level or in the community/home based on need
- FHC Expert: If the CHWs are not in the community and are not able to go into the patient's home, then they are not fulfilling their roles and how they've been trained (need to meet the patient where they are and be the eyes of the practice).
- FHC: Should we set some kind of standard for staffing in terms of SDOH?
- State: Do you mean ratios when you say staffing?
 - Yes.
- State: I would say yes. The Hispanic Health Council put out recommendations around CHW implementation
- FHC: The Hispanic health council gave us some guidance for CHWs
- FHC Expert: I think that as you are building a program, it's been my experience that ratios tend to increase, and I have seen them as high as 200+. It really depends on patient population, but even on Medicaid population, I've seen them grow higher than that.
- FHC: Perhaps there's a need for an annual evaluation.
- State: Doesn't it also depend on the role and the function because not all Medicaid patients are similarly situated? Is the role around community linkage in support of SDOH vs. if you're employing CHW in self-management; in what role or function are you having the conversation about case load or staffing ratio?
- FHC: I think that the role of the CHW varies, and the practices and the networks need the flexibility to define the role.
- State: It can be challenging to break it down. The case load estimator that the Hispanic counsel put together is great because it includes things like administrative time the CHW is attending, participation in the community, home visit time, etc. This could be a starting point.
- Provider: It also depends on the longevity of the program and how well-established CHWs are in that program
- FHC: I think we can provide the case load estimator as a way for practices based on their data (what their patient population needs are, how many CHWs they need, and so on)
- State: How many patients are you trying to serve? It matters how you stratify your population. In our experience, networks have different criteria for establishing high risk and are unsure if it's completely necessary to define that.
- FHC Expert: CHWs have the best track record of finding patients who have been missing appointments, helping them understand that it's important to make their appointments,

knowing where they are in the community, and getting them in. This is time consuming, and that's not just stratification, it's also understanding why people are not coming in for preventative and scheduled health, and missing appointments. This needs to be factored in as well.

- FHC: Does this group want to define which patient you are serving as a network or should that be left up to the network?
- State: I think what you have put together already as the function of the care team would help address an unmet need (I don't see it being possible since it could limit the capability of a CHW)
- FHC: They need to make community health workers available.

Role of pharmacists

- Provider: For the last bullet, is this within the scope?
 - Yes, it is, but there is a lack of knowledge as to what pharmacists can do. It must be a written agreement and it must designate the number of physicians and document the number of patients being served on the protocol.
- Provider: In a network, you could have everything from 1-2 practitioners, depends on the size and structure of your practice. It's not cost effective to have a pharmacist at every practice site especially if your practice is smaller. We use a .25 FTE per full-time provider.
- Provider: Other factors that come in - we could have patients in a practice that have a high degree of BH problems and chronic diseases, and who are seen by multiple prescribers. On an average use of the quarter FTE per provider, it's important to look at the patients that are not at goal and get them in for an appointment with a pharmacist (at least for a recommendation) to see if they can get to goal. It's a balance between direct patient-care referrals and higher value referrals.
- Provider: It's really helpful when pharmacists are on-site and on-hand, but we must realize that it's not feasible in smaller practices.
- State: These are helpful comments. Can we establish virtual access to basically network supporting pharmacists as a core feature of the model?
- Provider: Yes, if you're all on the same EHR, which you usually are. Internal e-consult is doable but doesn't necessarily need the machinery for an e-consult platform.
- Not sure we have the current platform to operationalize it, but it sounds like it could be a great opportunity.
- Provider: Telehealth would be considered in many states to be a form of direct-patient care.
- FHC: Telehealth can be used in many ways and one of them is pharmacists.
- FHC Expert: The transformation taskforce supported telehealth be supported at each practice level, but flexibility would be important.
- State: Flexibility will be there. In a typical practice, the Medicare population will have higher health risk and so forth, but maybe the Reform Council can model the .25 assumption and look at the varying PMPM in clinical risk (which would reflect a practice that predominantly serves Medicare). I think that having a basic assumption in a typical practice is a great starting point for the scenario model.
- FHC Expert: So, in terms of scope of practice and the total cost of care, I am wondering if you see in-scope and out-of-scope, do you ever pick up that there might be an opportunity in terms

of cost savings utilization? Some of the doctors that are ordering medications-question why someone is on brand.

- Provider: These are good points. The comments I've made are not generated just by claims but by quality.
- Provider: This is done more on the corporate side.
- State: It's critically important that we model each of the areas.
 - Provider, anything you can do to help us based on the functions we are prescribing pharmacists would be great.
- State: Pharmacists are more likely to have continuity of care opposed to having a pharmacist hub, and less of an opportunity for continuity.
- Provider: Yes, this is one model for smaller practices. A shared resource pharmacist might be another way.
- State: It's not uncommon in care management, but how can we assign pharmacists to help providers do less non-physician activities and spend more time with patients?
 - FHC: We have several guidelines and recommendations for pharmacists and what their role should be.

Enhancing patient care

- Should all practices be required to create diverse care teams?
 - State: I would hope there would be consensus support.
 - Provider: In support.
 - Provider: In support.
 - FHC Expert: In support.
- FHC: Should the practice be responsible for contracting for non-clinical services? There needs to be flexibility, but then the care team members should be on-site or available through telemedicine depending on each practice need.
- FHC: Should the network also be responsible for training diverse care team members?
- Every ACO or advanced network should have methods in place to promote and improve effective team-based care, and training is one aspect of that.
- Network capabilities that the network needs to provide?
 - Provider: Analytics need depending on the size, monitor how performance is going to provide feedback to the team too
- State: Concerns about consumer benefit or consumer protections; To determine intent of practice's support of panel; Recommending there be methods to reporting out and documenting will help account for how money is being spent and how patients are being supported.
 - Provider: I would agree. The data analytics team would be monitoring patients.
- Provider: Net promoter score - willingness of patient or customer to recommend service to others. This can be a powerful tool in measuring patient satisfaction.
- State: This is a new idea, and very much in line with what consumers are asking for.
- Other measures you would recommend?
 - FHC Expert: You can look at some of the standard measures being used now (how many outreaches did you make, measures of patient engagement, etc.). We will research specific measures.

- State: I propose we tie this back to the SIM quality counsel, and that we focus on the expectation that practices would improve on quality measures. The other is that we've done work in SIM and the Yale core to develop methods to measuring health disparities. You would see better performance on high-SDOH-risk populations if we specifically call out performance with respect to health disparities and disability disparities.
 - Consumer and FHC expert agree.
- FHC Expert: Its challenging to tie in too many measures and we should be careful we aren't extrapolating. I am struggling with how we can make it specific, but I agree we should be tracking something.
- Provider: If there are too many measures, it will be burdensome.
- State: We don't want to create more physician burden.
- Provider: We do have some models depending on the role.

Next Steps:

- FHC will put together these recommendations.