CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Expanded Care Teams

Care Transformation Collaborative of R.I.

CLINICAL STRATEGY COMMITTEE MEETING
OCTOBER 16, 2020

Discussion Questions

In addition to general input and feedback, we request your input on the following questions….

1) Slides 5 offers provisional principles for practices participating in Comprehensive Primary Care Capitation. Are these the right principles for CPCC practices in RI or what edits would you recommend?

2) Slides 6, 9-10 and 23-24 offer information on possible members of the care team, two sample care team configurations and tasks for various care team members.
   - Do you agree that care team members do not need to be co-located in the practice?
   - If not co-located, what do you see as necessary to achieve coordination, collaboration?
   - Thoughts on the possible configurations? Right people? Not enough or too much time?
   - Any concerns or suggestions regarding the recommended tasks assigned to care team members in the Appendix?

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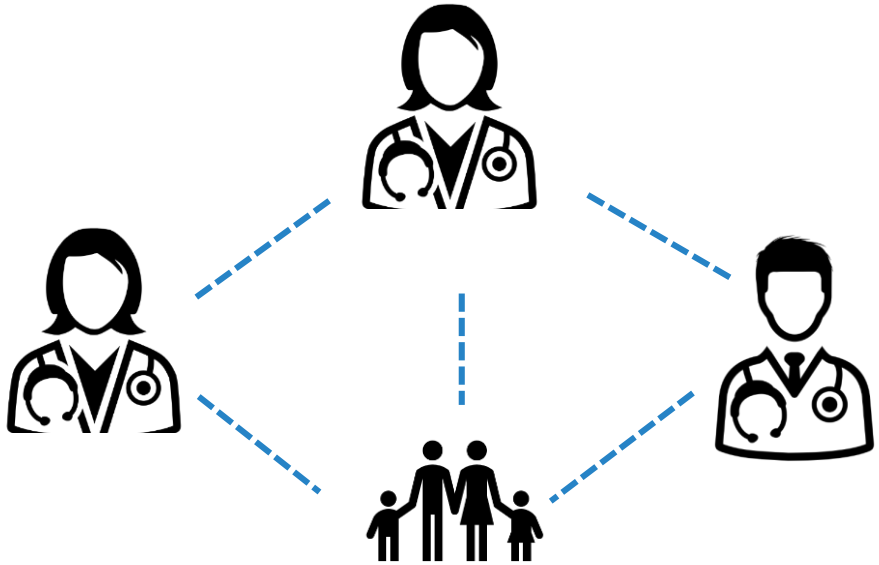
EXPANDED CARE TEAMS Definition



DEFINITION

The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care, ***National Academy of Medicine***

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EXPANDED CARE TEAMS
Benefits and Barriers

BENEFITS

Improve patient and family connections to a wide range of health professionals and social support with diverse knowledge, skills and experiences

Enhance care coordination, efficiency and effectiveness

Increase patient and provider satisfaction

BARRIERS

No payment and/or limited payment flexibility

Workforce, workspace and technology

Culture, workflows

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EXPANDED CARE TEAMS
Provisional Principles for Team Based Care

- Patient and family are at the center and actively engage.
- Care teams ideally represent the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms.
- It is the responsibility of the practices and systems of care to make sure those services are available
- All professionals perform at the top of their training.
- Care team members may be embedded within the practice site or centralized at the system of care to serve multiple practices based on individual practice needs
- Care teams collaborate and encourage each team member's contribution.

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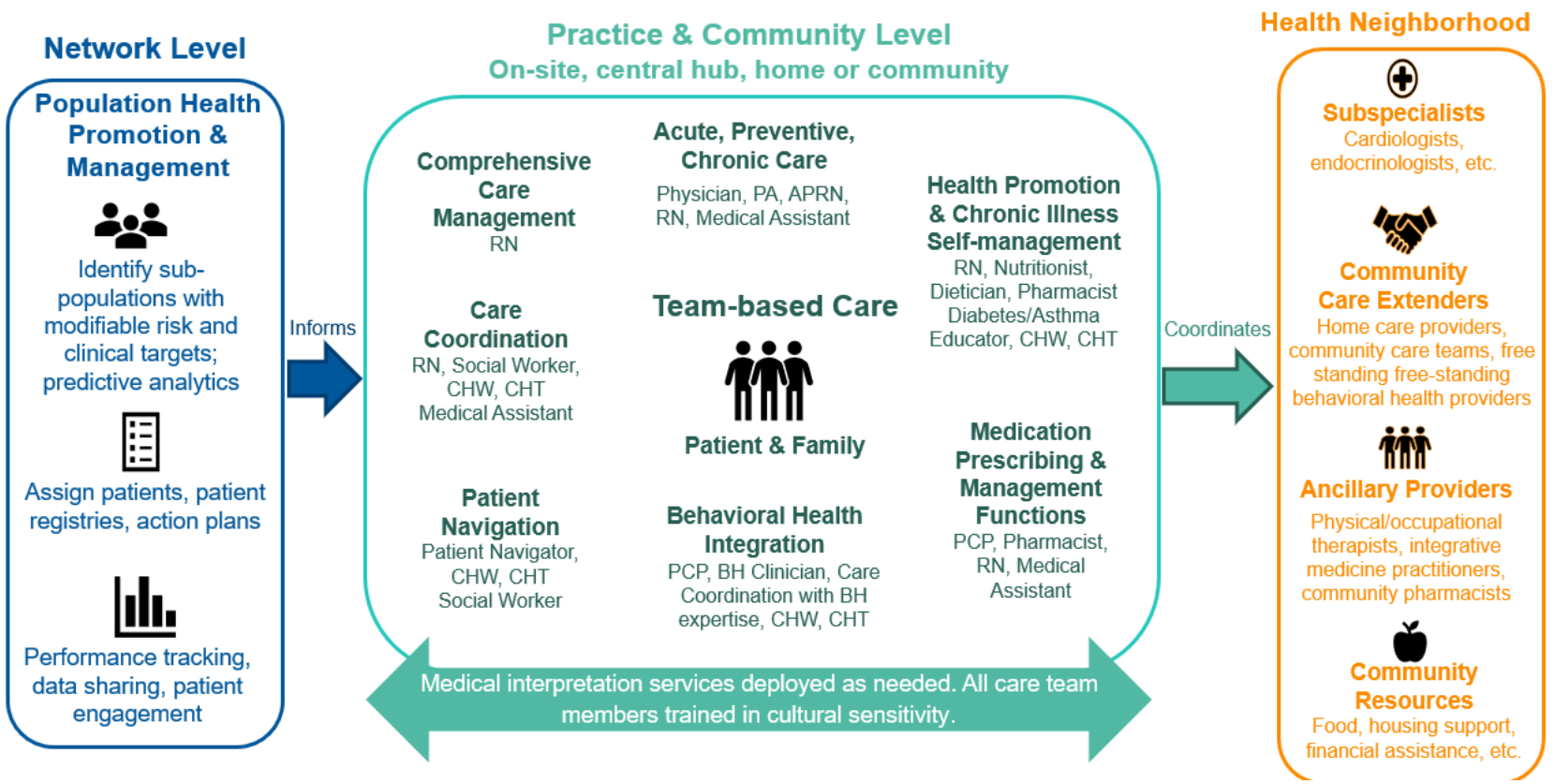
EXPANDED CARE TEAMS
Who is on the team?



- Options, not requirements
- This graphic is based on our work in CT and adjusted slightly to reflect work in RI
- Different practices serve different patients with different care team needs

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EXPANDED CARE TEAMS
Evidence of Success

EXAMPLE OF THE EVIDENCE

In its analysis, the PwC's Health Research Institute found that a primary care dream team designed around the needs of complex chronic consumers, for example, could potentially result in $1.2 million in savings for every 10,000 patients served.

Opportunity generated by a primary care dream team for complex chronic disease consumers

10,000	Total patients served
800	Total complex chronic patients
240	Total complex chronic admissions
$44,000	Spending per admission among complex chronic top spenders (20% of complex chronic patients account for 70% of spending)
24	Assume 10% reduction in admissions is achievable (based on leading models)
$1,100,000	**Decrease in spending due to reduction in inpatient admissions**
400	Total complex chronic ED visits
$1,400	ED spending per visit
80	Assume 20% reduction in ED visits is achievable (based on leading models)
$110,000	**Decrease in ED spending, assuming 20% reduction**
$1,210,000	**Total savings opportunity**

Incremental costs

$121,000	Network management, additional overhead (10%)
$605,000	*Incremental care team labor (50%)*
$484,000	**Reinvest (e.g., profit, technology, etc.) (40%)**

Source: https://www.pwc.com/us/en/health-industries/health-research-institute/weekly-regulatory-legislative-news/pdf/pwc-hri-primary-care-roi.pdf

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EXPANDED CARE TEAMS
Evidence of Success

EXAMPLE OF THE EVIDENCE

This roadmap from PwC offers primary care practices an informative and thought-provoking guide on how to succeed in this new model for primary care including innovative ways to think about their patient populations, suggested staffing models and strategies for communicating the need for increased primary care within integrated systems, which may stand to lose ED visits and admissions.

Source: https://www.pwc.com/us/en/health-industries/health-research-institute/weekly-regulatory-legislative-news/pdf/pwc-hri-primary-care-roi.pdf

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EXPANDED CARE TEAMS Possible Configurations

PwC's Health Research Institute Analysis

Possible configuration of incremental staff to form a primary care dream team for complex chronic disease consumers (based on staffing ratios of leading programs)

Role	Labor cost	FTEs
Nutritionists	$62,000	0.8
RN care managers/navigators	$290,000	3.2
Social workers	$57,000	0.8
Pharmacists	$31,000	0.2
Behavioral health specialists	$42,000	0.8
Community health workers	$123,000	2.9
Total	**$605,000**	**8.7**

Source: HRI analysis of the 2013 Medical Expenditure Survey data and staffing and outcomes ratios of leading care models.

Notes: This is an illustrative example. Results will vary based on market dynamics, technology capabilities, and risk tolerance. Excludes potential incremental primary care or specialty care revenue. Excludes potential impact of remote patient monitoring technology or the use of community paramedics, which could result in additional savings. Assumes that hospitals can replace lost inpatient volume by redirecting pent up demand and continue to operate at high capacity and improve their returns on fixed costs.

Assumes 10,000 patients in practice/SOC panel.

Care teams focus on approximately 800 patients with complex chronic conditions and most a risk for admission/ED visit.

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EXPANDED CARE TEAMS Possible Configurations

FHC Adaptation of the PwC Model

Diverse Care Teams	Cost	FTE
Nutritionists	$68,900	0.8
RN care Managers	$381,162	3.2
Behavioral Health Clinician	$158,000	2
Pharmacists	$37,240	0.2
Community Health Workers	$161,000	3.5
Health Coaches	$24,500	0.5
Total	**$806,302**	**10.2**

The FHC adaptation envisions more support for behavioral health, social needs and wellness than the PwC model.

FHC adaptation uses PWC as a foundation. Model remains based on 10,000 patient practice/SOC.

However, it envisions engaging a broader population, about half of all patients with multiple chronic conditions. This assumption was built on stakeholder discussions in other states and Milliman research showing the most successful ACOs engaged a broader pool of patients with "rising risk."

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EXPANDED CARE TEAMS
What Drives Success

Perspective from “Complexity Science”

RELATIONSHIP DRIVEN

Care team members connect outside of formal meetings

EFFECTIVENESS INCREASES WITH

- Number & quality of interactions
- Information flow
- Cognitive diversity

SUCCESS SUSTAINED WHEN

Care team members mutually adjust behaviors to achieve goals

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EXPANDED CARE TEAMS
Best Practices in Implementation

- ✓ Flexible funding supports expanding and diversifying care teams to fulfill recommended primary care functions.
- ✓ Care team compositions, location of team members, and staffing ratios 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). This includes flexibility to deploy care team members on-site at the practice, in the community and patient homes, and/or at a central hub.
- ✓ Partnerships with community-based organizations and Community Health Teams may provide staff with the appropriate training and qualifications to help fulfill care team functions.
- ✓ Care team members are assigned to fulfill roles and functions that take full advantage of their skills and qualifications but do not extend beyond what they are trained or qualified to do to in order to protect against adverse outcomes and patient underservice.
- ✓ The primary care provider in collaboration with the patient and care team determines the degree of intensity of services needed for each patient and the care team members most appropriate to meet these needs.

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EXPANDED CARE TEAMS
Integrated Behavioral Health

DEFINITION

A team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions. Integrated services often include:

- **Screening** for depression, anxiety, substance use disorder and social needs, an important contributor to behavioral and physical health needs.
- **Brief Interventions** to address issues such as anxiety, depression, substance abuse, pain control, prevention and intervention with health risk behaviors, suicide, and others.
- **Screening, Brief Intervention, Referral and Treatment** (SBIRT) programs for substance use.
- **Care Coordination** supports communication and collaboration across the care team including thee patient, caregivers, primary care provider, and specialists including behavioral health providers not integrated with the practice.

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EXPANDED CARE TEAMS
Integrated Behavioral Health

BEST PRACTICES IN IMPLEMENTATION

- ✓ Train primary care and behavioral health clinicians on team-based care and collaboration
- ✓ Build flexibility to provide services across settings: virtual, office, home or shelter
- ✓ When feasible, prioritize on-site availability of BH services and use common EHR platform
- ✓ Utilize care coordinator with BH expertise to make connections to treatment and community-based services, follow up and track patient progress, and facilitate communication with the behavioral health clinician
- ✓ Implement standard screenings at defined intervals to identify issues at an early stage
- ✓ Develop outcome measures that reflect a PCP's progress towards defined goals

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EXPANDED CARE TEAMS
Integrated Behavioral Health

LESSONS FROM RHODE ISLAND

Intervention: Three-year program, 2 cohorts, with a total of 10 practices serving 42,000 adults

Goals:

- Reach higher levels of quality through universal screening
- Increase access to brief intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions
- Provide care coordination and intervention for patients with high emergency department (ED) utilization and/or behavioral health condition
- Increase patient self care management skills: chronic condition and behavioral health need
- Determine cost savings that primary care can achieve by decreasing ED visits and inpatient hospitalization

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EXPANDED CARE TEAMS
Integrated Behavioral Health

LESSONS FROM RHODE ISLAND

Key Program Components:

- **Onsite IBH Practice Facilitation**: support culture change, workflows, billing
- **Universal Screening**: depression, anxiety, substance use disorder
- **Embedded IBH Clinician**: warm hand-offs, pre-visit planning, huddles
- **3 Plan-Do-Study-Act (PDSA) Cycles:** screening, high ED, chronic conditions
- **Quarterly Best Practice Sharing**: data-driven improvement, content experts

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EXPANDED CARE TEAMS
Integrated Behavioral Health

LESSONS FROM RHODE ISLAND

Brown University used a “matched” comparison group and overall findings suggest positive effects of the IBH intervention

	Cohort 1	Cohort 2
Utilization		
ED Visits	↓ 12%*	↓ 20%*
Office Visits	↓ 50%*	↓ 25%*
Costs		
Total Cost of Care	↓	↓
ED Costs	↓	↓
Rx Costs	↓	↓
Professional Services	↓	↑

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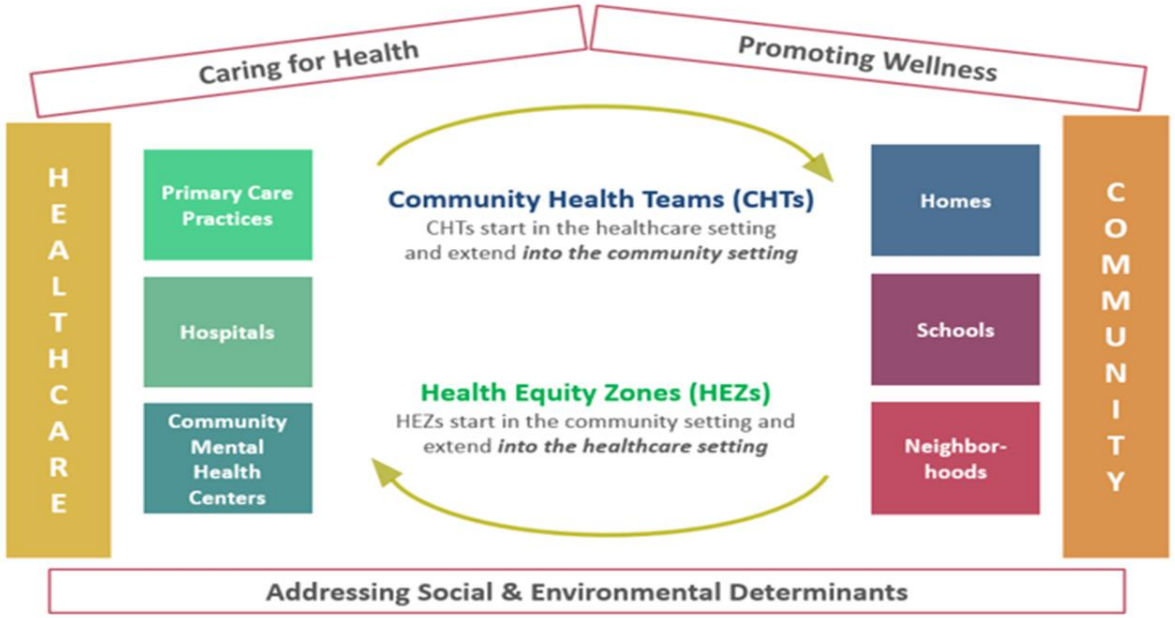
EXPANDED CARE TEAMS
Community Health Teams

DEFINITION

Regionally-based teams of behavioral health clinicians and community health workers that utilize care management processes to address the physical, behavioral, health education and social needs of high risk, typically adult, patients. Teams serve as an extension of primary care and are supported with grants and funding from payers.



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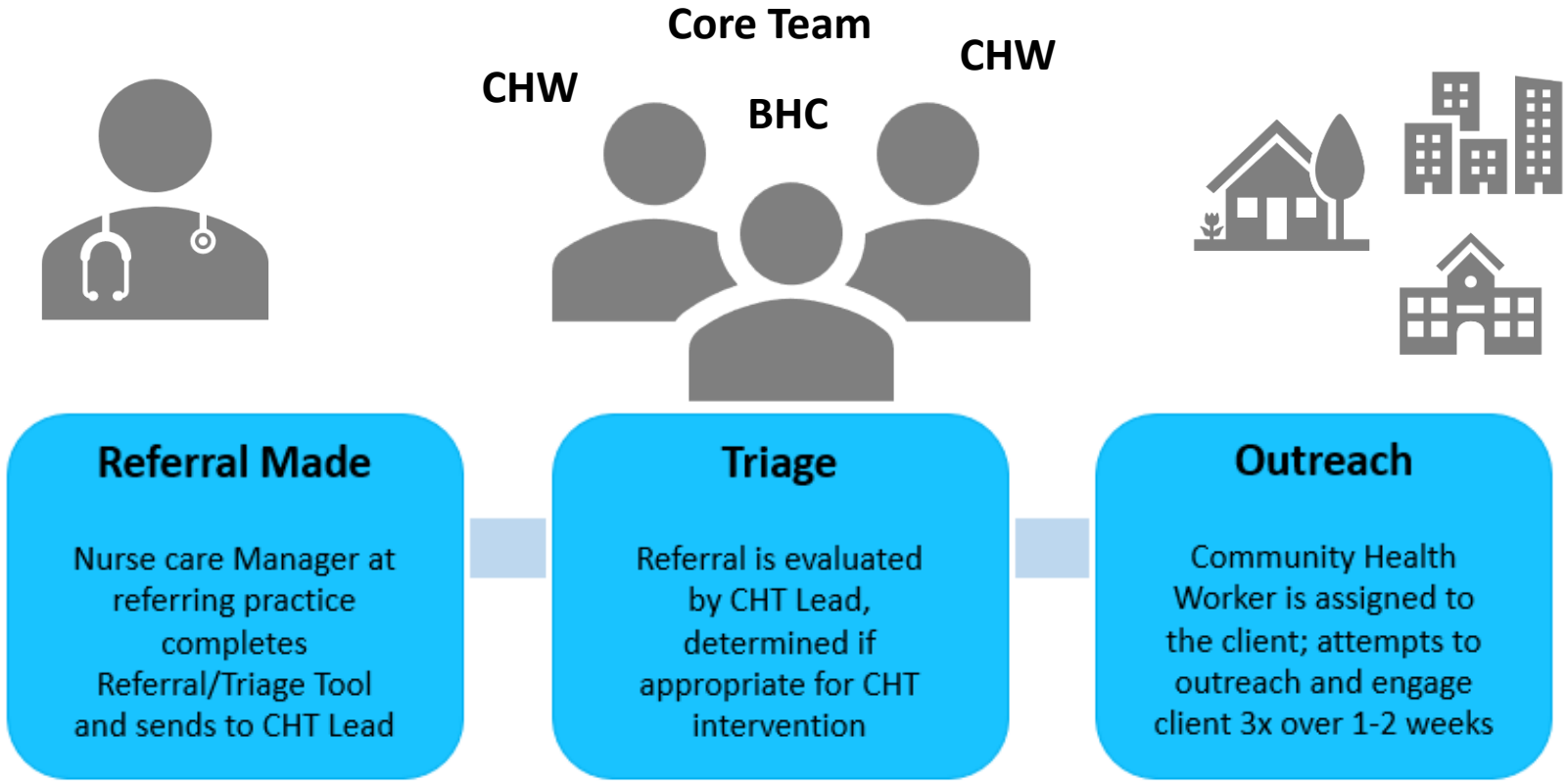
EXPANDED CARE TEAMS
Community Health Teams

BEST PRACTICES IN IMPLEMENTATION



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EXPANDED CARE TEAMS
Community Health Teams

EXAMPLES OF THE EVIDENCE

33% Reductions Health Risk, Depression, Anxiety

30-40% Reduced Substance Use

Improvements in All SDOH categories

Improvements in Numbers of Unhealthy Days /Quality of Life & Wellbeing categories

Improvements in Health Knowledge & Information, Support, Health Confidence, Adherence, Current & Future Life Evaluation

Excellent Patient Satisfaction & Experience with CHT Care

Researchers at the University of Rhode Island collected from 7 CHT teams at 4 sites over 9 months to assess:

- Health Risks
- Social Determinants of Health
- Behavioral Health Risks
- Health Literacy, Health information & Knowledge, Health Confidence, Support, Adherence, Quality of Life & Wellbeing.

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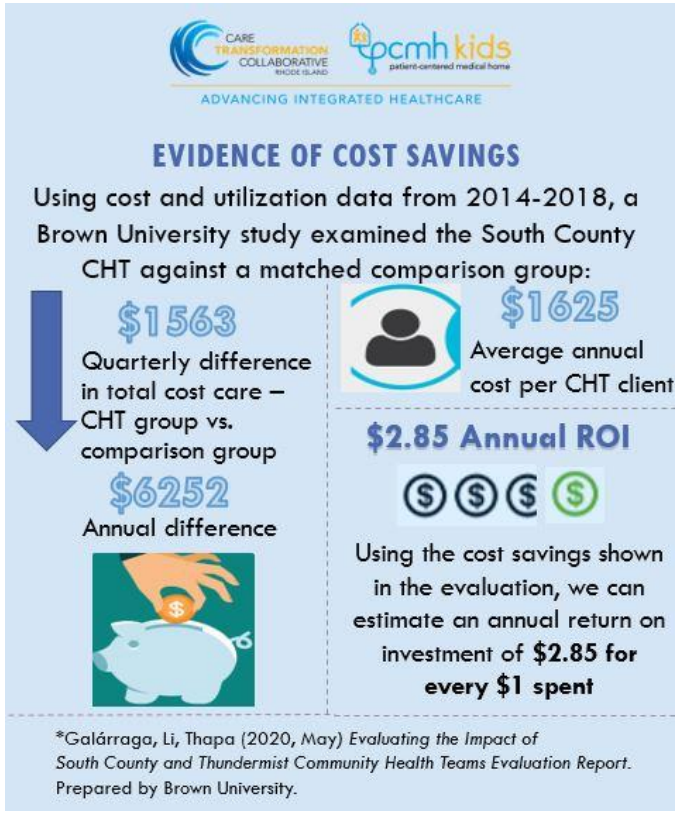
EXPANDED CARE TEAMS
Community Health Teams

EXAMPLES OF THE EVIDENCE



A Brown University study examined the South County Community Health Team (CHT) using the All-Payer Claims Database information (2014-2018) against a matched comparison group using a difference in differences analysis to compare the CHT cohort and a control cohort.

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Appendix

Comments and feedback welcome! Please send to:

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EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Population Health Promotion & Management	• Identify populations with modifiable risks • Assign each patient to a specific provider and/or team who is responsible for their care • Develop actionable steps using evidence based or clinical guidelines • Conduct Pharmacy-focused population health analytics	Physician, APRN, PA and Pharmacist work with Population Health Specialist to identify populations and action steps
Comprehensive Care Management	• Identify individuals with complex health care needs • Conduct Person Centered Assessment (PCA) • Develop, execute and monitor Individualized Care Plan (ICP) • Establish annual training to successfully integrate and sustain comprehensive care teams. • Assess individual readiness to transition to self-directed care maintenance • Monitor individual need to reconnect with Comprehensive Care Team • Evaluate and improve the intervention	RN
Care Coordination	• Conduct Pre-visit Planning • Develop Care Plans and address Gaps in Care • Coordinate care with specialists and other providers • Coordinate transitions of care • Populate and update patient's care plan • Link to community supports and resources • Support patients and family members with managing care plans and appointments	Care coordination activities should be directed by the PCP or an RN/Social Worker or equivalent serving in the role of Care Coordinator. Community Health Teams and MAs may provide care coordination support, under the direction of the PCP or Care Coordinator. Although patients' family members may choose to take on care coordination roles, they should have access to a qualified Care Coordinator
Patient Navigation	• Identify individual barriers to accessing care, including high cost of prescribed medications, understanding how to use benefits and how benefits can impact decisions regarding choice of provider • Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs • Assist patients with pre-visit planning, getting to appointments, and follow up • Ensure timely follow up and reduce delays in care throughout the continuum of care for a medical episode • Facilitate communication between providers and patients	Social Worker, Community Health Team, Patient Navigator (privately credentialed, specific training)

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EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Health Promotion and Chronic Illness Self-Management	• Identify the population who will benefit from self-management • Health or lifestyle coaching and patient education • Promote chronic illness self-management • Develop programs that are culturally diverse and address SDOH and other barriers to self-management • Nutritional education and counseling • Basic screenings and assessments • Work closely with patients and families (if available)	RN, Dietician, Diabetic/Asthma Educator, Nutritionist, Pharmacist, Community Health Worker, Social Worker
Medication Prescribing and Management Functions	• Medication reconciliation/ best possible medication list • Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies • Initiating, modifying, or discontinuing medication therapy • Comprehensive medication management	PCP, Pharmacist, RN, MA – scope of delegation determined by the practice/PCP; in the case of pharmacists, scope should be established in a collaborative practice agreement (CPA)
Behavioral Health Integration	• 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 • Linkages to behavioral health community-based services, such as free-standing behavioral health providers: outpatient services, Assertive Community Treatment Teams, crisis intervention, Community Support Teams, evidenced based in-home teams for children, families and adults, and case management services	• Psychologist, APRN, LCSW • Care coordination supported by care team member with behavioral health expertise • Community health teams trained in specialized roles such as a Recovery Coach may support behavioral health integration

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