



ADVANCING INTEGRATED HEALTHCARE

# Adult Comprehensive Primary Care

Care Transformation Collaborative of R.I.

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DECEMBER 21, 2020



ADVANCING INTEGRATED HEALTHCARE

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# Background and Purpose

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In order to most effectively achieve the Quadruple Aim, all Rhode Islanders need access to strong and vibrant primary care that engages patients and families and contributes to community partnerships where they practice.

Comprehensive Primary Care Capitation (CPCC) and Total Cost of Care (TCOC) risk contracting offer the flexible reimbursement necessary to optimize primary care delivery.

From September to December 2020, the CTC Clinical Strategy Committee (CSC) guided the development of this compilation of best practices that maximize success in these models. This compilation includes a set of Common Standards that the group identified as “must have” and “nice to have” elements of an approach to CPCC and TCOC.

This work will support primary care providers and their systems of care as they expand their participation in these care delivery models as well as inform the work of the OHIC Payment and Care Delivery Advisory Committee.

# Adult Components of Care Delivery Models for CPCC/TCOC

## MUST HAVE

### Expanded care teams

- Integrated behavioral health
- Care management (Rx, nursing, infection control)
- Health/wellness support
- Community health teams (*HEZ, community-clinical linkages*)

### Specialist referral network

#### Telehealth

(video visits, phone, text, email)

**National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)**

## NICE TO HAVE

### Remote patient monitoring

### E-consult

**Specialized practices** (e.g., geriatric care, substance use disorder treatment )

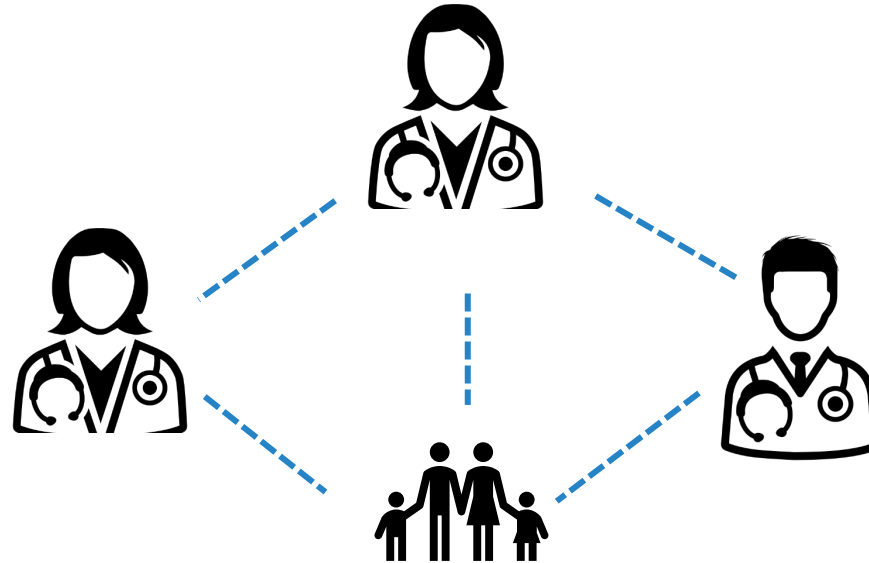
### Open access scheduling

# Expanded Care Teams

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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*

# 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

# EXPANDED CARE TEAMS

## Provisional Principles for Team Based Care

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- 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.



# EXPANDED CARE TEAMS

## Getting Started With Team Based Care

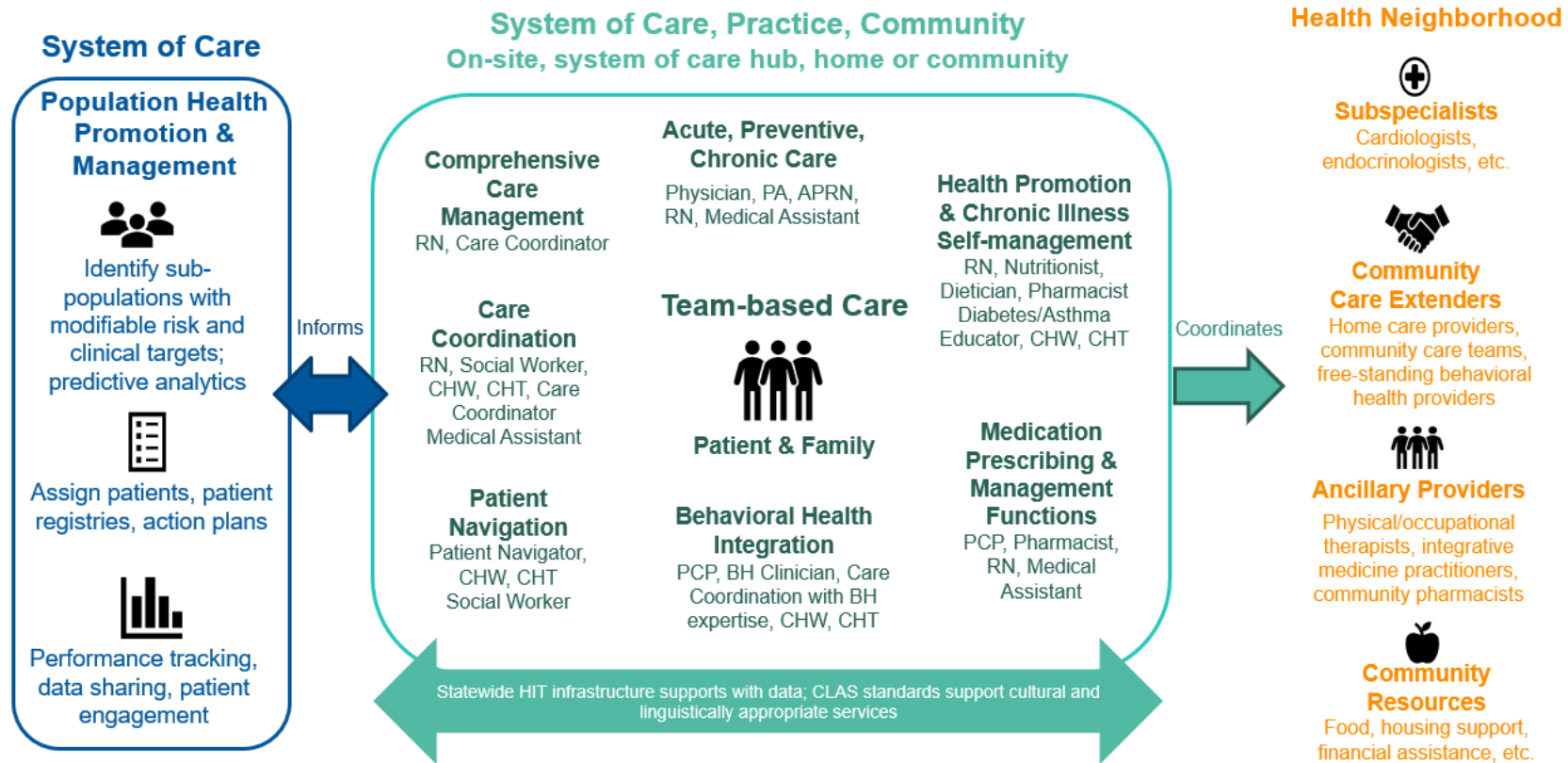
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### Getting Started:

- Developing a fully-enabled primary care team takes *time, planning and collaboration* with a system of care and/or community partners.
- To get started, most primary care provider practices or systems *begin with staffing to address a single need or set of needs* (e.g. care coordination or improved behavioral health access).
- *Build on successes and lessons learned;* add team members over time to address high priority needs.

# EXPANDED CARE TEAMS

## Who is on the team?



- Optional members of the care team
- This graphic is based on work in other states and adjusted slightly to reflect work in RI
- Different practices serve different patients with different care team needs

# 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)
<b>\$1,100,000</b>	<b>Decrease in spending due to reduction in inpatient admissions</b>
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)
<b>\$110,000</b>	<b>Decrease in ED spending, assuming 20% reduction</b>
<b>\$1,210,000</b>	<b>Total savings opportunity</b>

#### Incremental costs

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

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

# 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>

# 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
<b>Total</b>	<b>\$605,000</b>	<b>8.7</b>

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 at risk for admission/ED visit.



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# EXPANDED CARE TEAMS

## Possible Configurations

**FHC Adaptation of the PwC Model**

Diverse Care Teams	FTE	FTE Cost	Salary and Benefits
RN Care Managers	2.2	\$0.54	\$235,407
Care Coordinator	1	\$1.96	\$102,700
Behavioral Health Clinician	2	\$0.86	\$153,400
Pharmacists	0.5	\$1.28	\$80,178
Community Health Workers	3.5	\$0.67	\$207,298
Health Coaches	0.5	\$1.73	\$32,500
Nutritionists	0.8	\$0.27	\$64,813
<b>Total</b>	<b>10.5</b>	<b>\$7.30</b>	<b>\$876,295</b>

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

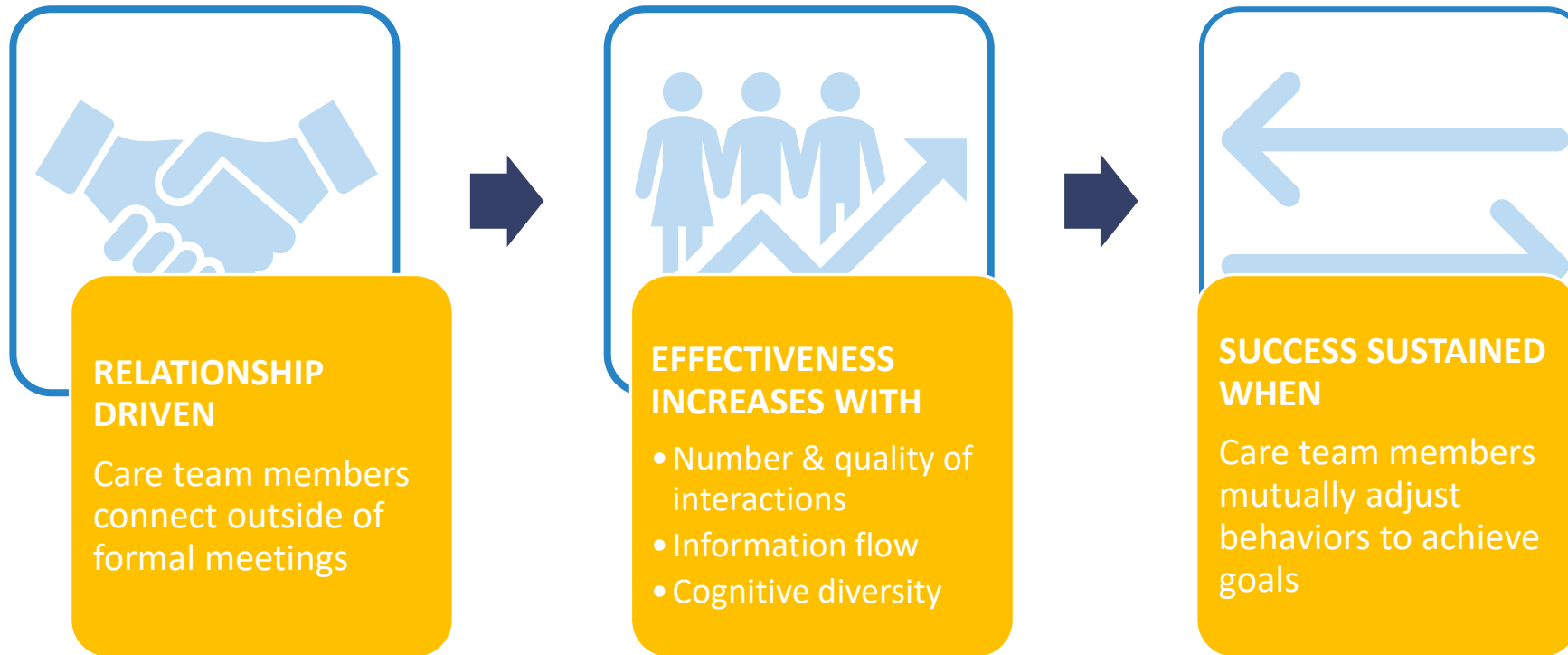
However, it envisions engaging a broader population, about half of all patients with multiple chronic conditions. This assumption was built on stakeholder discussions in other states and Milliman research showing the most successful ACOs engaged a broader pool of patients with “rising risk.”

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

# EXPANDED CARE TEAMS

## What Drives Success

Perspective from “Complexity Science”



***Care team members do not need to be co-located but do need to feel like a team with a shared accountability for results.***

<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3392-3>

# EXPANDED CARE TEAMS

## Best Practices in Implementation

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- ✓ 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.



# EXPANDED CARE TEAMS

## Changing Role of the Primary Care Provider

### HIGH PRIORITY PRIMARY CARE PROVIDER RESPONSIBILITIES

- Direct care for the most complex patients
- Coaching other team members providing care to patients with less complex acute and chronic conditions
- Supporting eConsult communications with specialists
- Ongoing professional development, expanding clinical knowledge and leadership skills

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0367>

# EXPANDED CARE TEAMS

## Integrated Behavioral Health

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### 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 the patient, caregivers, primary care provider, and specialists including behavioral health providers not integrated with the practice.

# EXPANDED CARE TEAMS

## Integrated Behavioral Health

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### 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

# EXPANDED CARE TEAMS

## Integrated Behavioral Health

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### 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

# EXPANDED CARE TEAMS

## Integrated Behavioral Health

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### 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

# 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

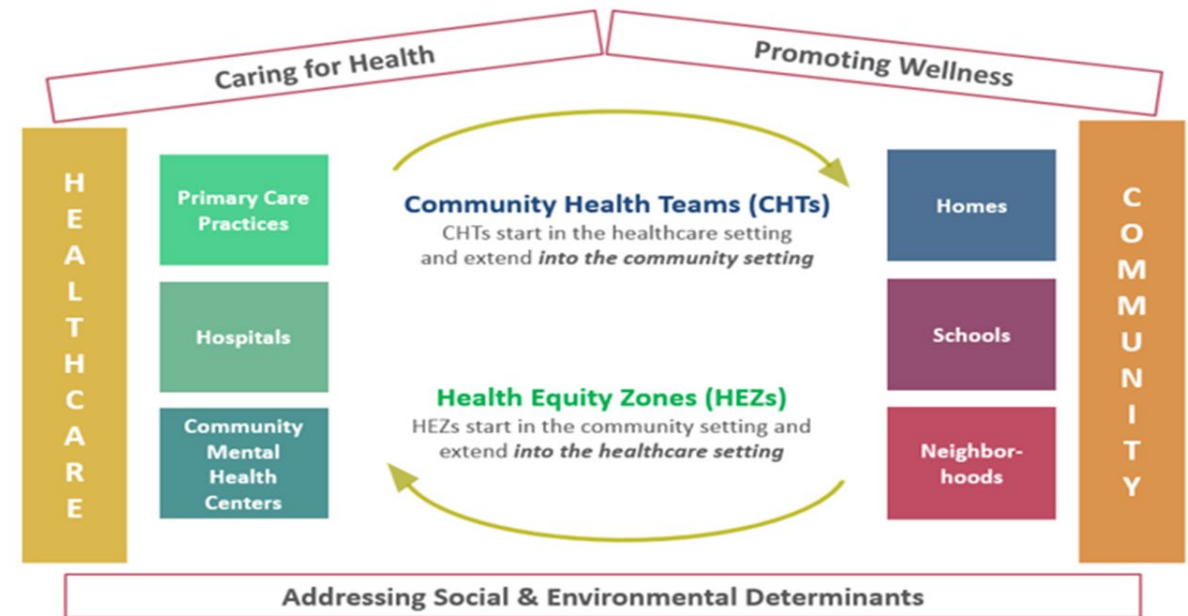
	Cohort 1	Cohort 2
<b><u>Utilization</u></b>		
ED Visits	↓ 12%*	↓ 20%*
Office Visits	↓ 50%*	↓ 25%*
<b><u>Costs</u></b>		
Total Cost of Care	↓	↓
ED Costs	↓	↓
Rx Costs	↓	↓
Professional Services	↓	↑

# EXPANDED CARE TEAMS

## Community Health Teams

### DEFINITION

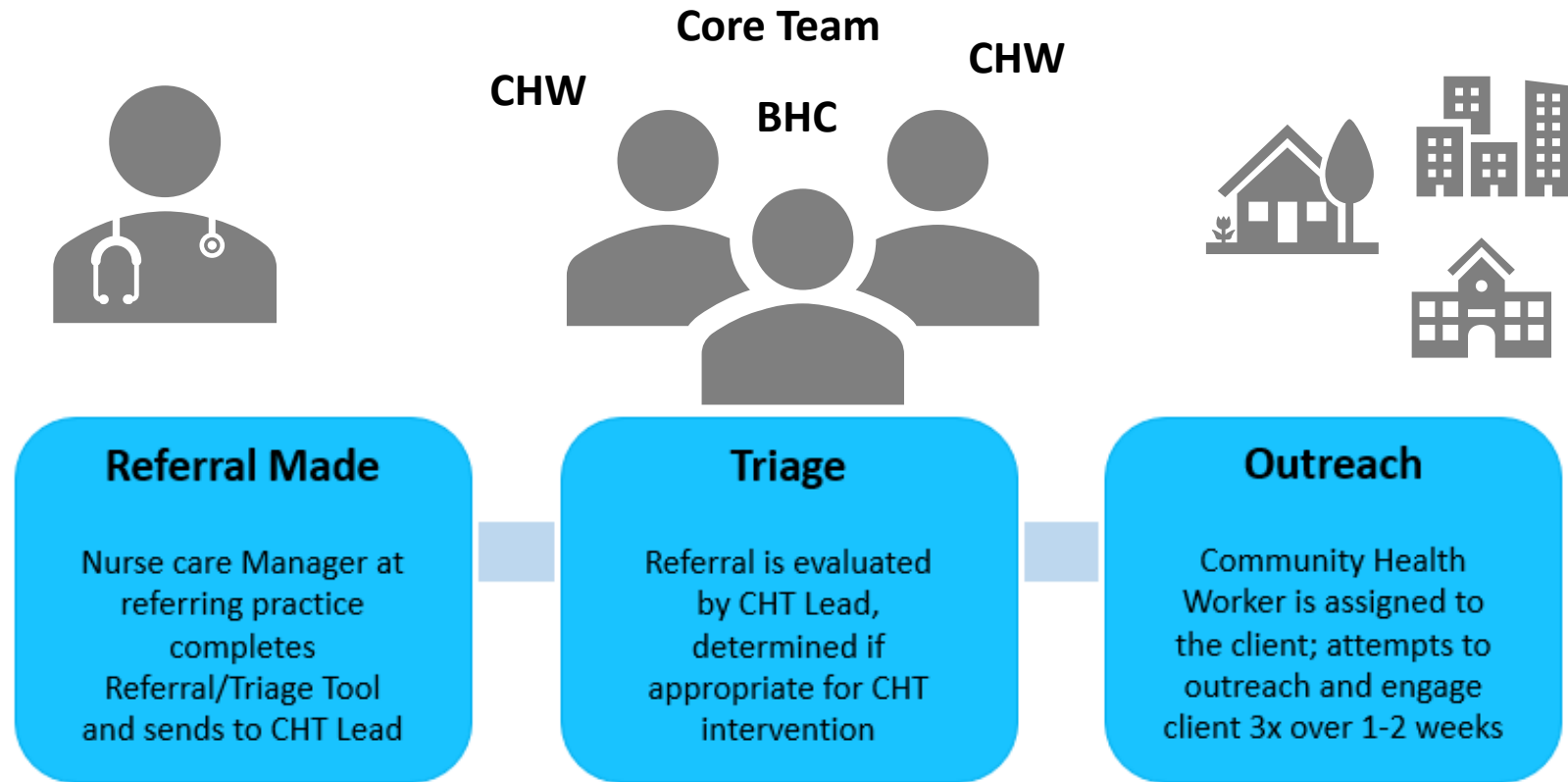
Regionally-based teams of behavioral health clinicians and community health workers that utilize care management processes to address the physical, behavioral, health education and social needs of high risk, typically adult, patients. Teams serve as an extension of primary care and are supported with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



# EXPANDED CARE TEAMS

## Community Health Teams

### BEST PRACTICES IN IMPLEMENTATION





# 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

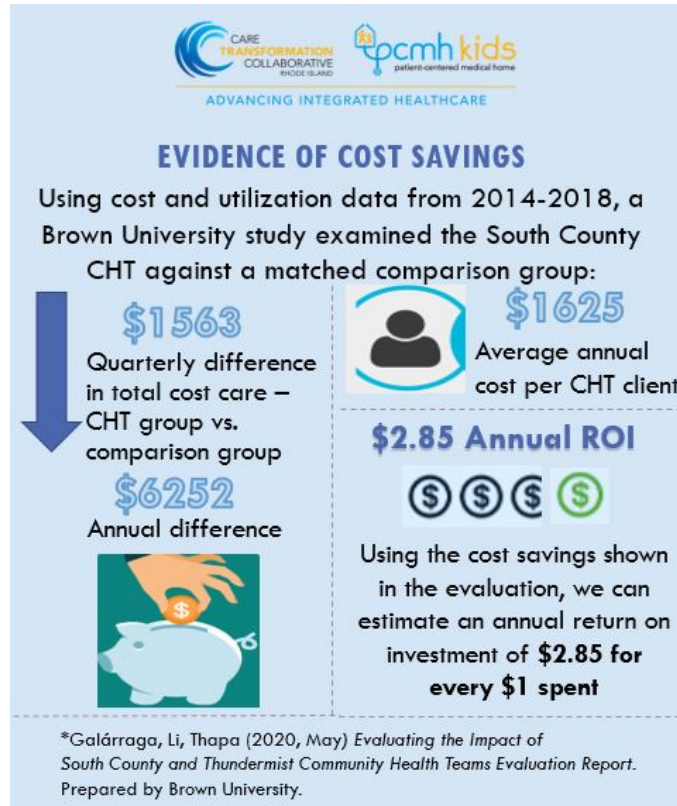
Researchers at the University of Rhode Island collected from 7 CHT teams at 4 sites over 9 months to assess:

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

# 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.

# National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)

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# CLAS STANDARDS

## Principle Standard

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### **Principal Standard**

Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

***Full set of standards provided in the Appendix***

# CLAS STANDARDS

## Why CLAS Standards Matter

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**Effective:** Culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, are increasingly recognized as one way to address health inequities by improving the quality of healthcare services.

**Structured:** The National CLAS Standards improve an organization's ability to address health care disparities by providing a free, publicly-available evidence-based guide, ["A Blueprint for Advancing and Sustaining CLAS Policy and Practice."](#)

National Standards for CLAS in Health and Health Care:  
*A Blueprint for Advancing and Sustaining CLAS Policy and Practice*



**National Standards for Culturally and Linguistically  
Appropriate Services in Health and Health Care:**

**A Blueprint for Advancing and Sustaining CLAS  
Policy and Practice**

Office of Minority Health

U.S. Department of Health and Human Services

April 2012



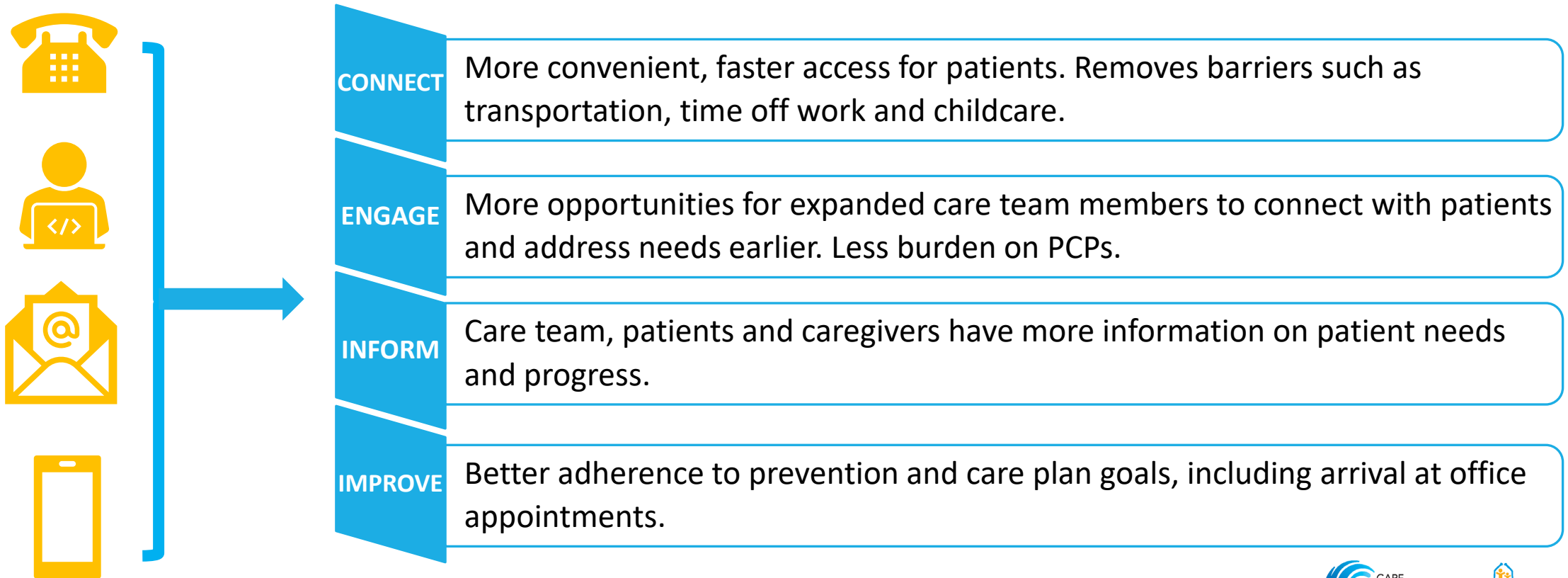
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# Remote Clinical Care

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# REMOTE CLINICAL CARE

## Goals



# REMOTE CLINICAL CARE

## Related Work in Rhode Island

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**HIT Roadmap:** The Rhode Island Statewide Health Information Technology (HIT) Strategic Roadmap and Implementation Plan lays out the vision for statewide HIT efforts over the next three years. It builds upon a long history of HIT innovation and progress, and will promote alignment among existing efforts, while guiding future investments in HIT.

**Primary Care Telehealth Practice Needs Assessment/Patient Engagement Surveys:** 47 practices have been recruited to participate with funding from UnitedHealthcare. Information from the Practice Needs Assessment/patient surveys will be used to help inform state policy, and the development of the 6-month webinar series and 12-month Telehealth Learning Collaborative.



# REMOTE CLINICAL CARE

## The Impact of COVID-19

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Will the COVID-19 pandemic offer a gentle nudge toward more use of remote clinical care or catapult innovative approaches into central components of care delivery?

Early data suggests somewhere in between.

However, the combination of pandemic pressures and new payment models is prompting many providers to think very differently about patient outreach and engagement.

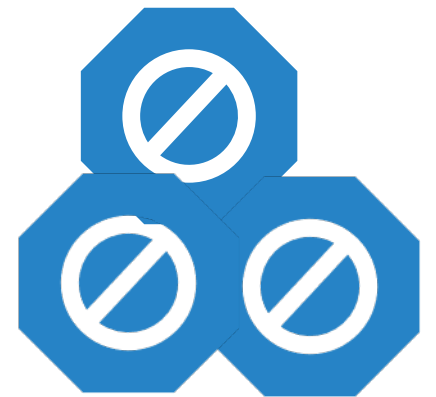
# REMOTE CLINICAL CARE

## The Impact of COVID-19

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### Possibilities for preventive care from [New England Journal of Medicine](#) :

1. Clinical registries identify patients due for preventive services
2. Annual prevention kits for patients facilitate home-based testing and shared decision making
3. Technology allows for self-scheduling of preventive screening tests and procedures in convenient and approachable community settings
4. Community-based navigators help to overcome health disparities in underserved populations



# REMOTE CLINICAL CARE

## The Impact of COVID-19

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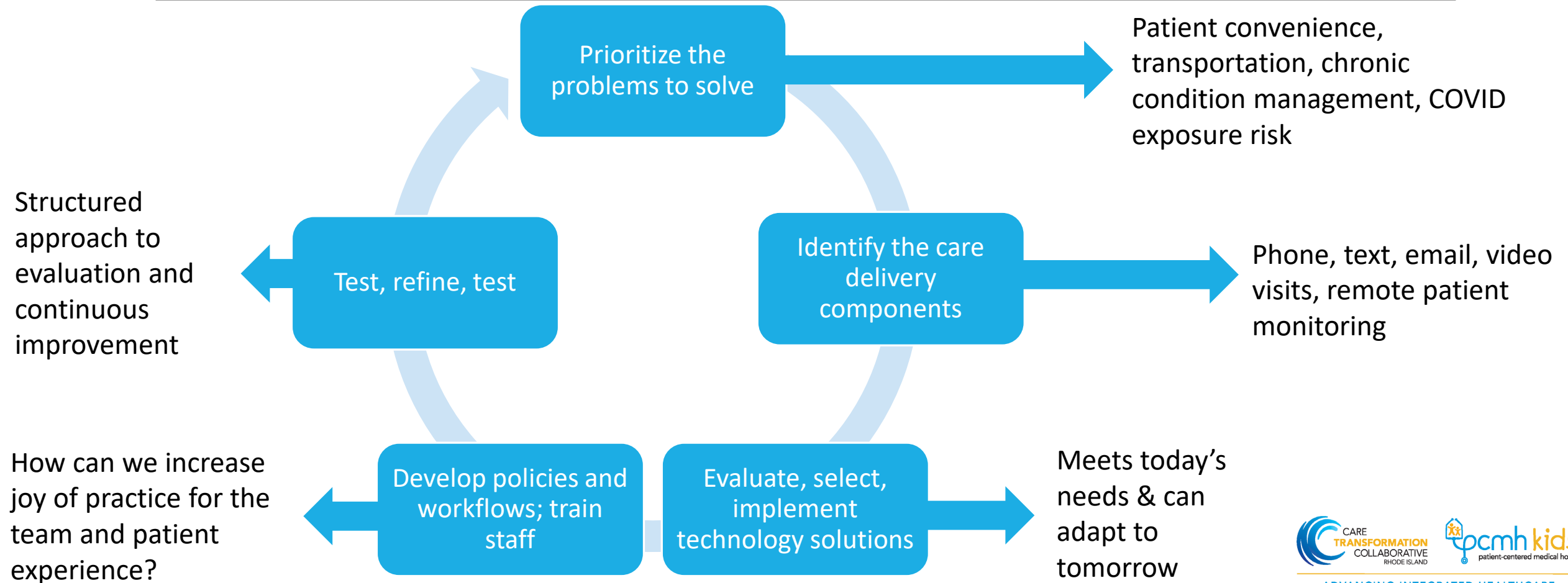
Patrick Conway, former director of the Center for Medicare and Medicaid Innovation, and now CEO of Care Solutions at Optum recently asked provider organizations to consider the following questions....

1. How precisely do your delivery models mirror the needs and preferences of members and patients?
2. How well do you employ a consumer-centric mindset as you make decisions about where to invest and where to divest?
3. How can you leverage data to understand the holistic needs of consumers?
4. How can emerging technologies and flexible staffing models help serve your most vulnerable populations with the most preventive approach?
5. What will it take to design a more resilient, efficient, and sustainable delivery?

*“A modern delivery model should be friction-free for the consumer — allowing in-person visits when they’re needed but supporting healthy habits and disease prevention as the primary objective.”*

# REMOTE CLINICAL CARE

## Developing a Strategy



# REMOTE CLINICAL CARE

## Examples of Implementation Guides



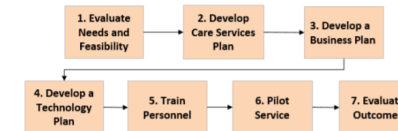
### NORTHEAST TELEHEALTH RESOURCE CENTER

#### Roadmap and Toolkit for Implementing Primary Care and Behavioral Telehealth Services during the COVID-19 Pandemic

—Compiled by Michael Edwards, PhD, Northeast Telehealth Resource Centers, August 17, 2020  
 Visit the NETRC Resource Library to explore more resources by category at <https://netrc.org/resources.php>

Integrating a telehealth delivery solution into a health care organization is often a prolonged and daunting endeavor involving many steps. Each step calls into play participation and varying levels of teamwork among clinical, administrative, and technical staff of the organization. A successful clinical telehealth program begins with proper preparation. Because of the COVID-19 pandemic and the relaxation of regulatory and reimbursement barriers to telehealth, health care must move quicker than usual in their planning and implementation. The planning steps in this guide remain the same, but strategies for more rapid deployment in the context of the pandemic are included in the new resource compilation section starting on page 8.

There are several overall guides for planning cited below, each varying in their emphases and sequencing steps. Through experience, we have come to favor that of Burgess with the following seven steps:



### A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice



SEPTEMBER 2020

This toolkit was developed in partnership with Manatt Health.



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# REMOTE CLINICAL CARE

## Phone, Text, Email

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### DEFINITION

Asynchronous communications through phone calls, text messages and emails are used in non-urgent situations between patients and an established care team to address patient needs outside of the office settings. These services can be available to all patients but may be most beneficial to patients managing chronic conditions and best if managed by a point person on the care team, such as a patient navigator.

# REMOTE CLINICAL CARE

## Phone, Text, Email

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### HIGH VALUE APPLICATIONS

**Check in on patients with chronic conditions:** Patients reported that asynchronous communication complements care received at visits, empowers patients to manage chronic conditions, clarifies the plan of care, and provides a health archive via secure messaging (Eschler et. al, 2015).

**Reminders to receive recommended preventive care:** Studies demonstrate two single-method telecommunications reminders, text messaging and telephone calls improve receipt of immunizations (Jacobson Vann et. al, 2018).

**Notifications regarding appointments and behavior change:** A literature review of 93 investigated medical compliance reminders and 56 investigated appointment reminders found that nearly all the SMS reminder studies helped improve patient medical compliance and appointment attendance. Researchers reported numerous benefits, including ease of use, relative inexpensiveness, and rapid and automated delivery (Schwebel, Larimer, 2018).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6112101/pdf/main.pdf>

# REMOTE CLINICAL CARE

## Phone, Text, Email

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### BEST PRACTICES IN IMPLEMENTATION

- ✓ Determine the clinical and administrative use cases where phone, text and email will be deployed
- ✓ Secure web-based platform (patient portal) where sensitive patient information can be exchanged between the patient and his or her care team.
- ✓ Secure integrated or complementary platform to support secure email and text communications
- ✓ Design office workflows to ensure timely responses to patient questions
- ✓ Train primary care team on workflows, handoffs and escalation processes to decrease after-hours workload for primary care clinician
- ✓ Update and maintain patient contact and language preferences; ensure communications are in the patient's preferred language
- ✓ Develop protocols to ensure all interactions between patient and care team members through phone, text, email and telemedicine are documented



# REMOTE CLINICAL CARE

## Video Visits

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### DEFINITION

Visits between clinicians and patients through virtual real-time communications such as video conference. These interactions may involve remote patient monitoring and other digital technologies (such as smart phones) to support provision of care. eConsults, phone, text and email communications, and remote patient monitoring are addressed elsewhere.

# REMOTE CLINICAL CARE

## Video Visits

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### HIGH VALUE APPLICATIONS

#### Highly Effective for Certain Patient Needs

- Check in on patients with stable chronic conditions
- Mental health and behavioral health counseling
- Medication reconciliation
- Worried well visits related to COVID-19
- Connecting with care team members such as health coaches, nutritionists and behavioral health clinicians

#### Less Effective for Other Patient Needs

- Well child visits
- Evaluation of injuries or accidents
- Treating patients with non-stable chronic conditions
- Evaluation of acute pain

<https://www.pcpcc.org/2020/06/04/new-survey-shows-higher-normal-use-primary-care-and-telehealth-patients>

# REMOTE CLINICAL CARE

## Video Visits

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### BEST PRACTICES IN IMPLEMENTATION

- ✓ Determine the clinical use cases where video visits will be deployed and by which team members; design scheduling workflows to reflect these decisions
- ✓ Secure web-based platform (patient portal) where sensitive patient information can be exchanged between the patient and his or her care team
- ✓ Secure integrated or complementary platform to support secure video communications
- ✓ Update and maintain patient access to high-speed internet and technology and preferences regarding video visits
- ✓ Develop protocols to ensure all interactions between patient and care team members video visits are documented

# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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### **Support**

Funded by UnitedHealthcare(UHC) and State of RI Cares Act Funding

### **Managed by CTC-RI/PCMH Kids**

Core Planning Committee/Subcommittees

CTC-RI Clinical Strategy Committee

Northeast Telehealth Resource Center

### **Participation**

34 adult sites

12 pediatric sites

More than 500 patients who had a telehealth visit and nearly 400 who had not.

### **Timing**

August 2020 – September 2020



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# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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### THEMES

**Benefits:** 1) Increased patient access, 2) reduction in no-shows, 3) staff ability to work from home, 4) ability to bill for on-call services

**Most common visit types:** 1) Sick visits, 2) Medication management, 3) COVID concerns, 4) Routine follow up for chronic conditions

**Most common video platforms:** Doximity, Doxy.me, Zoom, EHR specific platform, FaceTime

**Recommendations to improve telehealth:** 1) patient education, 2) better workflows, 3) improved internet in community, 4) staff training



# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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### FROM THE FAMILY PERSPECTIVE

- ✓ More than 90% never had a phone visit before March 2020 and more than 97% never had video visit.
- ✓ More than 80% said their issue was addressed and more than 78% said they were satisfied.
- ✓ Nearly 88% said they would have a phone visit again in the future; approximately 80% said they would have a video visit again in the future.
- ✓ Most patients still preferred an in-person visit.



# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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### FROM THE CLINICIAN PERSPECTIVE

- ✓ Providers had a slight preference for telephone versus video visits (55% to 45%)
- ✓ Patients inability to effectively use technology was the most frequent barrier reported by clinicians
- ✓ More than 84% of clinicians reported telehealth has improved work experience
- ✓ Most clinicians reported a neutral to positive experience with telehealth
- ✓ Patient education was listed most frequently as what would help improve the experience



# REMOTE CLINICAL CARE

## Remote Patient Monitoring

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### DEFINITION

Digital devices and technology collect patient health and medical information from one location, such as at a person's home, and transmit it to a healthcare provider in another location for assessment and recommendations. Transmission of health data to the care team may be automatic or may require the patient to actively enter information.

Collected data may include heart rate, weight, blood pressure, oxygen saturation, blood glucose levels, peak expiratory flow, and symptom severity.

Most common devices include for data collection and transmission include:

- Wearables (glucometers, blood pressure monitors, heart rate monitors)
- Biosensors (spirometers, oximeter)
- Smart phone and personal assistant devices
- Computer system that allows patient to enter data



# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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### FROM THE PATIENT PERSPECTIVE

- ✓ More than 90% never had a phone visit before March 2020 and more than 97% never had video visit.
- ✓ More than 80% said their issue was addressed and more than 78% said they were satisfied.
- ✓ Nearly 88% said they would have a phone visit again in the future; approximately 80% said they would have a video visit again in the future.
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# REMOTE CLINICAL CARE

## Rhode Island Telehealth Survey

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# REMOTE CLINICAL CARE

## Remote Patient Monitoring

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### DEFINITION

Digital devices and technology collect patient health and medical information from one location, such as at a person's home, and transmit it to a healthcare provider in another location for assessment and recommendations. Transmission of health data to the care team may be automatic or may require the patient to actively enter information.

Collected data may include heart rate, weight, blood pressure, oxygen saturation, blood glucose levels, peak expiratory flow, and symptom severity.

Most common devices include for data collection and transmission include:

- Wearables (glucometers, blood pressure monitors, heart rate monitors)
- Biosensors (spirometers, oximeter)
- Smart phone and personal assistant devices
- Computer system that allows patient to enter data

# REMOTE CLINICAL CARE

## Remote Patient Monitoring

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### HIGH VALUE APPLICATIONS

While there is strong enthusiasm for the opportunity for remote patient monitoring to improve patient outcomes, the evidence is limited.

Some of the most promising studies suggest remote patient monitoring may improve outcomes for patients with select conditions, including obstructive pulmonary disease, Parkinson's disease, hypertension, and low back pain.

The most successful efforts focus on pairing the data coming from the device with validated health behavior models, care pathways, and tailored coaching. Further, certain populations may be more likely to benefit. For example, one study found adults over age 55 were more likely to lower their blood pressure with the help of remote patient monitoring than younger adults.

<https://www.nature.com/articles/s41746-017-0002-4>

# REMOTE CLINICAL CARE

## Remote Patient Monitoring

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### RECOMMENDATIONS FOR IMPLEMENTATION

- ✓ Secure remote monitoring devices with mechanism to transmit data into EHR and clinical workflow; ensure ability to alert care team when data values exceed thresholds
- ✓ Use evidence to develop protocols to determine which conditions and which patients with those conditions will receive remote patient monitoring
- ✓ Establish systems and staff workflows for transmission and monitoring of health data; train care team members on these systems and workflows
- ✓ Ensure patients or their caregivers have the necessary tools and instruction
- ✓ Ensure nurse care managers or other qualified team members monitor the data and consult with a primary care clinician about treatment plan
- ✓ Determine legal liability for response protocols

# Ensuring Access

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# ENSURING ACCESS

## Changing Perspectives

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**Traditional view of access:**

“The doctor will see you now.”

**The new reality:**

“The patient will see you now.”

*If we cannot accommodate our patients when and how they want to be seen, someone else will.*

**TERRY “LEE” MILLS, MD, MMM, CPE, FAAFP**  
Author, How to Excel at Access – And Why It Matters

# ENSURING ACCESS

## Why It Matters

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*Increasing primary care access supports improved health and outcomes, and better performance in CPCC and TCOC contracts.*

### ***Benefits of Primary Care Access***

- Increased length of life, with fewer deaths due to heart and lung disease,
- Better preventive care,
- Reduced health disparities,
- Less emergency department, hospital use,
- Fewer tests,
- Lower medication use,
- Lower per capita costs of care



# ENSURING ACCESS

## Rethinking Open Access

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Open access scheduling may be a successful solution.  
Experience shows it may not work well in many practices.

Recognizing this, the Institute for Healthcare Improvement published six principles for shortening wait times that may be a more realistic approach for most practices.

# ENSURING ACCESS

## Six Principles for Shortening Wait Times

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- 1. Understand supply and demand** – Connect patients to the most appropriate care team member, at the most site of care e.g., phone, virtual, office, at a convenient time for the patient and the practice.
- 2. Recalibrate the system** – For a time, practices may need to take on heavier workloads to clear backlogs
- 3. Apply queuing theory** -- As much as possible, reduce the number of appointment types which opens more appointment times for more patients.

<http://www.ihl.org/resources/Pages/ImprovementStories/ShorteningWaitingTimesSixPrinciplesforImprovedAccess.aspx>

# ENSURING ACCESS

## Six Principles for Shortening Wait Times

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- 4. Create contingency plans** – Plan ahead for times of expected variation. Flu season follows the holiday season, when many doctors take vacations. So, they are catching up as well as handling increased demand.
- 5. Influencing the demand** - Cement the doctor- or clinician-patient relationship. Prioritize patients seeing their own providers every time. When patients see their own providers, there are fewer visits and there is less time with each visit.
- 6. Managing the constraints** - Free up providers to do the work they are unique and essential for.

# ENSURING ACCESS

## Analytics to Prioritize Access Needs

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### OPPORTUNITY

Readmissions



### STRATEGY

Improve transitional care management, post-acute follow-up

Urgent care, ED utilization



Emphasize same-day, weekend appointments paired with easier communication with the practice

Admissions for chronic disease



Offer patients with chronic conditions more frequent check ins via phone, text, video with most appropriate team member

# ENSURING ACCESS

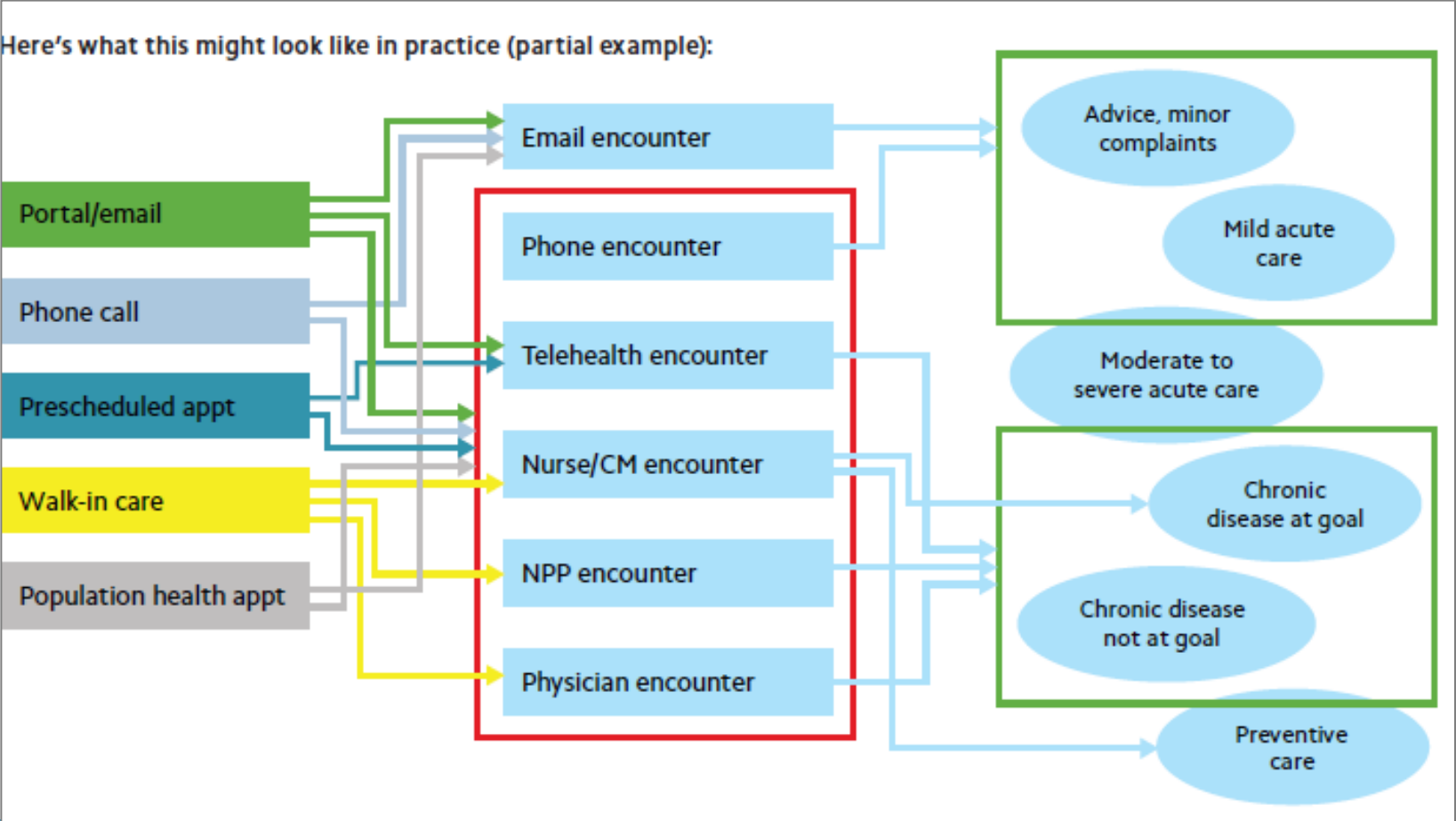
## Scheduling the Right Care at the Right Time

NEED	ENCOUNTER OPTION
Health question	Phone, portal/email/text
Acute illness (mild)	Phone, portal/email/text care pathway or protocol; nurse or non-physician provider (NPP) visit
Acute illness (sick)	NPP or physician visit
Preventive/wellness care gap	Phone, portal/email/text care pathway or protocol; nurse visit; or NPP or physician visit
Chronic disease at goal	Nurse care pathway or protocol; NPP visit; team outreach (e.g., nurse, care manager, pharmacist, health coach, social worker, behavioral health specialist)
Chronic disease not at goal	NPP or physician visit; team outreach (e.g., nurse, care manager, pharmacist, health coach, social worker, behavioral health specialist)

Source: <https://www.aafp.org/fpm/2018/0900/p27.html>

# ENSURING ACCESS

## Scheduling the Right Care at the Right Time



# Partnering with Specialists

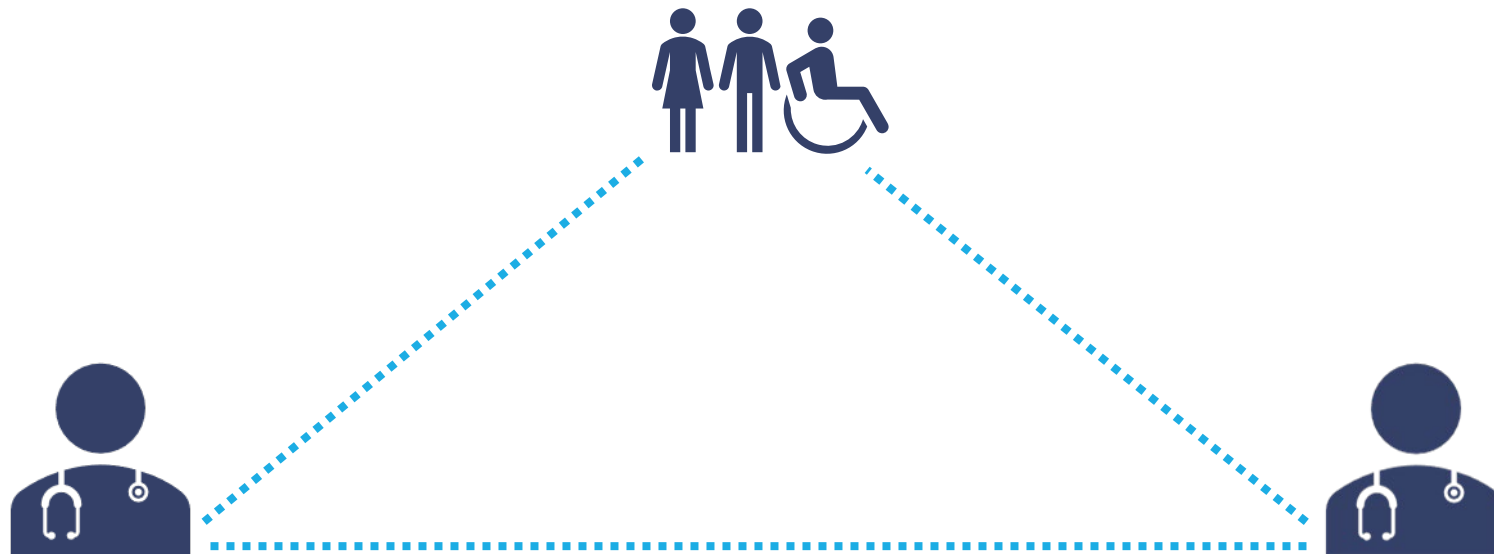
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# PARTNERING WITH SPECIALISTS

## The “Specialty Care Triad”

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“Successful coordination of specialty care requires understanding the perspectives of patients, PCPs, and specialists - i.e. the specialty care ‘triad’.”





# PARTNERING WITH SPECIALISTS

## Principles for Communication

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- ✓ Clarity and agreement on clinician roles, responsibilities are fundamental; templates help
- ✓ Leverage the shared goal of quality improvement to drive conversations; utilize data to identify opportunities and recognize progress
- ✓ Direct communication and strong clinician relationships should be prioritized to help overcome EMR limitations
- ✓ Acknowledge specialty care coordination occurs at multiple levels (e.g., patient & specialist, patient & PCP, PCP & specialist, across the care team)
- ✓ Determine who is primarily responsible for coordination of specialty care

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726433/>

<https://www.ajmc.com/view/tools-to-improve-referrals-from-primary-care-to-specialty-care>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726433/>



ADVANCING INTEGRATED HEALTHCARE

# PARTNERING WITH SPECIALISTS

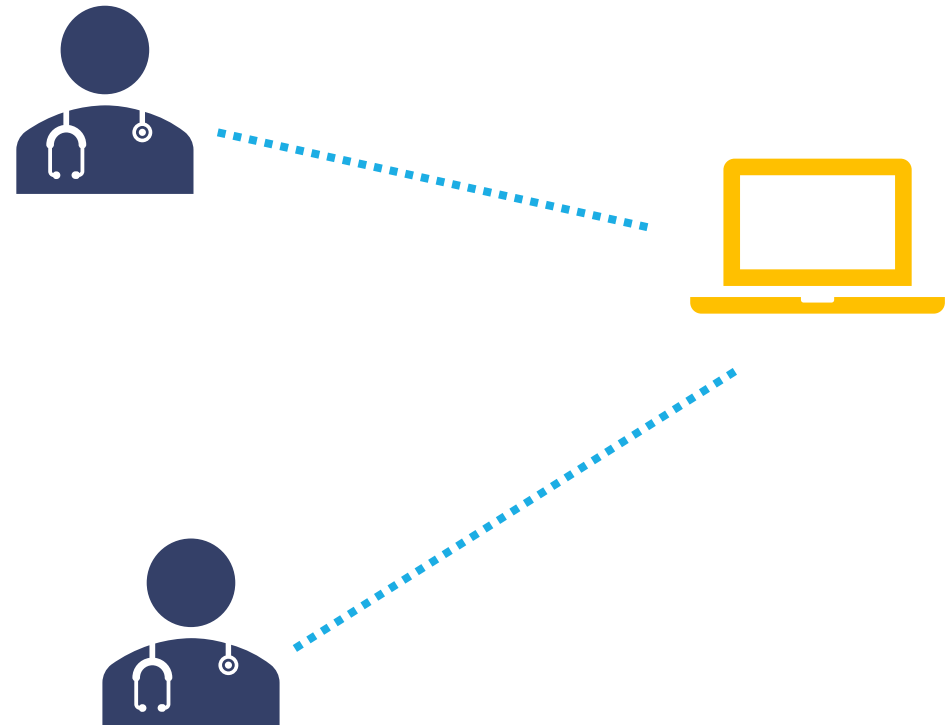
## eConsult

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A treating provider— typically a primary care provider — consults with a specialist via email, or other templated, secure communication to share information and discuss the care of a specific patient.

Typically asynchronous, eConsults are time-saving and cost-efficient way to gain a specialist provider’s insights into relatively straightforward, low-acuity issues.

eConsults also serve as a continuing education tool.



# PARTNERING WITH SPECIALISTS

## eConsult

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### EVIDENCE OF SUCCESS

**Population:** Community eConsult Network, now called ConferMED, published a study in 2018 of 369 Medicaid patients referred for cardiology consultations by PCPs.

**Methods:** Patients were randomly assigned to an eConsult or face-to-face visit.

**Results:** Six months later, eConsult patients had significantly lower mean unadjusted total costs by \$655 per patient, or lower mean adjusted costs of \$466 per patient. Cardiac procedures costs were significantly lower (\$81 per patient) in the eConsult group.

<https://www.ajmc.com/view/a-costeffectiveness-analysis-of-cardiology-econsults-for-medicaid-patients>

# PARTNERING WITH SPECIALISTS

## eConsult

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### EVIDENCE OF SUCCESS

Other studies on the effectiveness of eConsult have found:

- Most report reduced wait times before an initial specialist review, reduced wait times for a face-to-face visit if needed and improved rates of specialty care completion. However, reductions varied and methods to calculate them lacked rigor.
- Patients report high satisfaction with outcome and the convenience of e-consults
- PCP satisfaction is high, with 70-95% reporting high satisfaction across several studies. However, some express concerns that e-consults add to workflow issues.
- Specialist satisfaction was less uniformly high, but most still report being satisfied.

<https://pubmed.ncbi.nlm.nih.gov/29801079/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/>

<https://www.ajmc.com/view/what-do-primary-care-providers-really-think-about-econsult-systems>



ADVANCING INTEGRATED HEALTHCARE

# PARTNERING WITH SPECIALISTS

## eConsult

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### CONSIDERATIONS FOR CHOOSING A MODEL

- Timeliness and effectiveness of specialist clinical opinion.
- Minimal extra work for primary care providers, and minimal, if any, new technology or equipment required. Seamless integration into existing workflows.
- No risk of misaligned incentive for reviewing specialist to benefit financially from additional face-to-face visit.

<https://pubmed.ncbi.nlm.nih.gov/29801079/>  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/>

# PARTNERING WITH SPECIALISTS

## Project Core Model

### Project CORE: Coordinating Optimal Referral Experiences

**Enhanced Referral:** Point-of-care decision support for the referring health care provider through templates within the EMR. Templates prompt referring providers to clearly list expectations about duration of care and delegation of responsibility. This maximizes the effectiveness of the first specialty visit, thus preventing unnecessary follow-up visits for reviewing diagnostic tests.

**eConsult:** In lieu of an in-person visit, a specialist responds through the EMR to a PCP's inquiry within 72 hours. These exchanges use structured templates within the EMR to create a seamless, point-of-care pathway that facilitates high-quality coordination and communication between providers.

**Project Core has completed more than 16,000 eConsults, avoiding an estimated 7,360 unnecessary specialty referrals.**

TEMPLATE



eCONSULT



ADVANCING INTEGRATED HEALTHCARE

# PARTNERING WITH SPECIALISTS

## Specialized Practices

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Some patients with particularly complex needs may benefit from....

- **Care team members** with experience and proclivity to serve a particularly high needs population
- **Practice environment and workflows** designed with the population's specific needs in mind

[Project Echo](#) is one model some primary care providers have used to gain knowledge in particular area. It uses telemedicine, case-based learning, and disease management techniques to support primary care providers in building their knowledge of particular conditions and serve as expert consultants in their regions.

# Appendix

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***Comments and feedback welcome! Please send to:***

Pano Yeracaris, Chief Clinical Strategist, CTC-RI

[pyeracaris@ctc-ri.org](mailto:pyeracaris@ctc-ri.org)

Mary Jo Condon, Senior Consultant, Freedman Healthcare

[mcondon@freedmanhealthcare.com](mailto:mcondon@freedmanhealthcare.com)



# EXPANDED CARE TEAMS

## Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Population Health Promotion & Management	<ul style="list-style-type: none"> <li>Identify populations with modifiable risks</li> <li>Assign each patient to a specific provider and/or team who is responsible for their care</li> <li>Develop actionable steps using evidence based or clinical guidelines</li> <li>Conduct Pharmacy-focused population health analytics</li> </ul>	Physician, APRN, PA and Pharmacist work with Population Health Specialist to identify populations and action steps
Comprehensive Care Management	<ul style="list-style-type: none"> <li>Identify individuals with complex health care needs</li> <li>Conduct Person Centered Assessment (PCA)</li> <li>Develop, execute and monitor Individualized Care Plan (ICP)</li> <li>Establish annual training to successfully integrate and sustain comprehensive care teams.</li> <li>Assess individual readiness to transition to self-directed care maintenance</li> <li>Monitor individual need to reconnect with Comprehensive Care Team</li> <li>Evaluate and improve the intervention</li> </ul>	RN
Care Coordination	<ul style="list-style-type: none"> <li>Conduct Pre-visit Planning</li> <li>Develop Care Plans and address Gaps in Care</li> <li>Coordinate care with specialists and other providers</li> <li>Coordinate transitions of care</li> <li>Populate and update patient's care plan</li> <li>Link to community supports and resources</li> <li>Support patients and family members with managing care plans and appointments</li> </ul>	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	<ul style="list-style-type: none"> <li>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</li> <li>Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs</li> <li>Assist patients with pre-visit planning, getting to appointments, and follow up</li> <li>Ensure timely follow up and reduce delays in care throughout the continuum of care for a medical episode</li> <li>Facilitate communication between providers and patients</li> </ul>	Social Worker, Community Health Team, Patient Navigator (privately credentialed, specific training)

# EXPANDED CARE TEAMS

## Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Health Promotion and Chronic Illness Self-Management	<ul style="list-style-type: none"> <li>Identify the population who will benefit from self-management</li> <li>Health or lifestyle coaching and patient education</li> <li>Promote chronic illness self-management</li> <li>Develop programs that are culturally diverse and address SDOH and other barriers to self-management</li> <li>Nutritional education and counseling</li> <li>Basic screenings and assessments</li> <li>Work closely with patients and families (if available)</li> </ul>	RN, Dietician, Diabetic/Asthma Educator, Nutritionist, Pharmacist, Community Health Worker, Social Worker
Medication Prescribing and Management Functions	<ul style="list-style-type: none"> <li>Medication reconciliation/ best possible medication list</li> <li>Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies</li> <li>Initiating, modifying, or discontinuing medication therapy</li> <li>Comprehensive medication management</li> </ul>	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	<ul style="list-style-type: none"> <li>Behavioral health screenings and initial assessments</li> <li>Brief interventions, consultations, medication, and episodic care</li> <li>Referrals to extended therapy/counseling, medication and higher levels of care (day treatment, partial hospitalization)</li> <li>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</li> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Psychologist, APRN, LCSW</li> <li>Care coordination supported by care team member with behavioral health expertise</li> <li>Community health teams trained in specialized roles such as a Recovery Coach may support behavioral health integration</li> </ul>

# CLAS STANDARDS

## Full Set of Standards

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### Principal Standard

**1)** Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### Governance, Leadership and Workforce

**2)** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

**3)** Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

**4)** Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

# CLAS STANDARDS

## Full Set of Standards

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### **Communication and Language Assistance**

- 5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- 6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- 7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- 8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

# CLAS STANDARDS

## Full Set of Standards

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### **Engagement, Continuous Improvement and Accountability**

**9)** Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

**10)** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

**11)** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

# CLAS STANDARDS

## Full Set of Standards

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### **Engagement, Continuous Improvement and Accountability (cont'd)**

- 12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- 13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
- 14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
- 15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.