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ADVANCING INTEGRATED HEALTHCARE

Pediatric Comprehensive Primary Care

Care Transformation Collaborative of R.I.

DECEMBER 21, 2020

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Background and Purpose

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.

Pediatric 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
  (schools, community-clinical linkages, HEZ)

Specialist referral network

Telehealth
(*video visits as well as phone, text, email*)

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

NICE TO HAVE

Open access scheduling

E-consult

Oral health

Group medical appointments

Infant home visits

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PEDIATRICS
Provisional Principles for Pediatric CPPC

In 2002, the American Academy of Pediatrics, wrote in a policy statement on the services that should be included in comprehensive health care for infants, children, and adolescents.

These services, edited for space, are provided on the following two slides as “Principles for Comprehensive Pediatric Primary Care.”

American Academy of Pediatrics

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PEDIATRICS
Provisional Principles for Pediatric CPPC

- Family-centered care is provided by developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life.

- Care team members share clear and unbiased information with the family about the child's medical care and management and about specialty and community services they can access.

- Primary care, includes but is not restricted to acute and chronic care and preventive services, including breastfeeding promotion and management, immunizations, growth and developmental assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues.

- Ambulatory care for acute illnesses will be continuously available (24 hours a day, 7 days a week, 52 weeks a year).

- Care will be provided over an extended period to ensure continuity. Transitions, including those to other pediatric providers or into the adult health care system, should be planned and organized with the child and family.

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PEDIATRICS
Provisional Principles for Pediatric CPPC

- Primary care providers identify the need for consultation and appropriate referral to pediatric medical subspecialists and surgical specialists. (In instances in which the child enters the medical system through a specialty clinic, identification of the need for primary pediatric consultation and referral is appropriate.)

- Primary, pediatric medical subspecialty, and surgical specialty care providers should collaborate to establish shared management plans in partnership with the child and family and to formulate a clear articulation of each other's role.

- Care teams should interact with early intervention programs, schools, early childhood education and childcare programs, and other public and private community agencies to be certain that the health-related social needs of the child and family are addressed.

- Care coordination services should be organized so the family, the physician, and other service providers work to implement a specific care plan as an organized team.

- Care teams should maintain an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.

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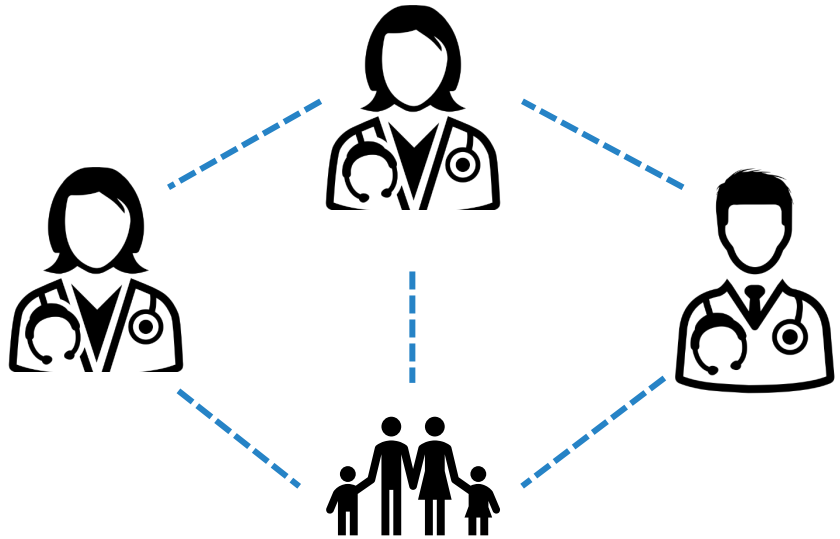
Pediatric Expanded Care Teams

PEDIATRIC EXPANDED CARE TEAMS Overview

DEFINTION AND GOALS

Practices establish care teams within the pediatric medical home that are guided by the primary care clinician in collaboration with the patient and family, integrate other professionals, and coordinate with community supports.

Care teams promote the strengths of families and best health for all children by making primary care more comprehensive and accessible, better meeting the diverse needs of patients and families, improving care coordination, efficiency, effectiveness and increasing patient/family and provider satisfaction.



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PEDIATRIC EXPANDED CARE TEAMS
Getting Started With Team Based Care

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.

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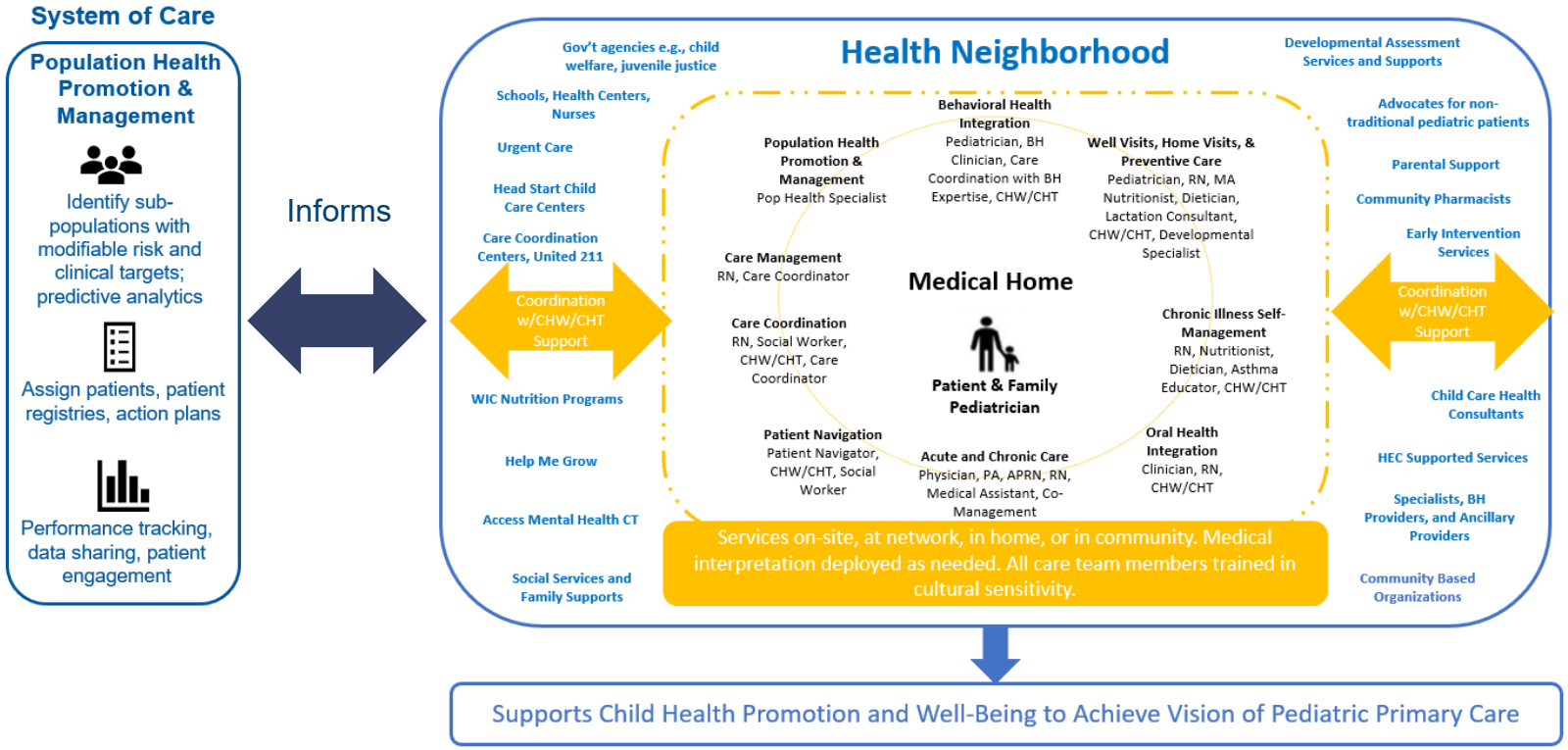
PEDIATRIC EXPANDED CARE TEAMS
Who is on the team?



- 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 may require different care team compositions
- Statewide HIT infrastructure supports improved quality and efficiency

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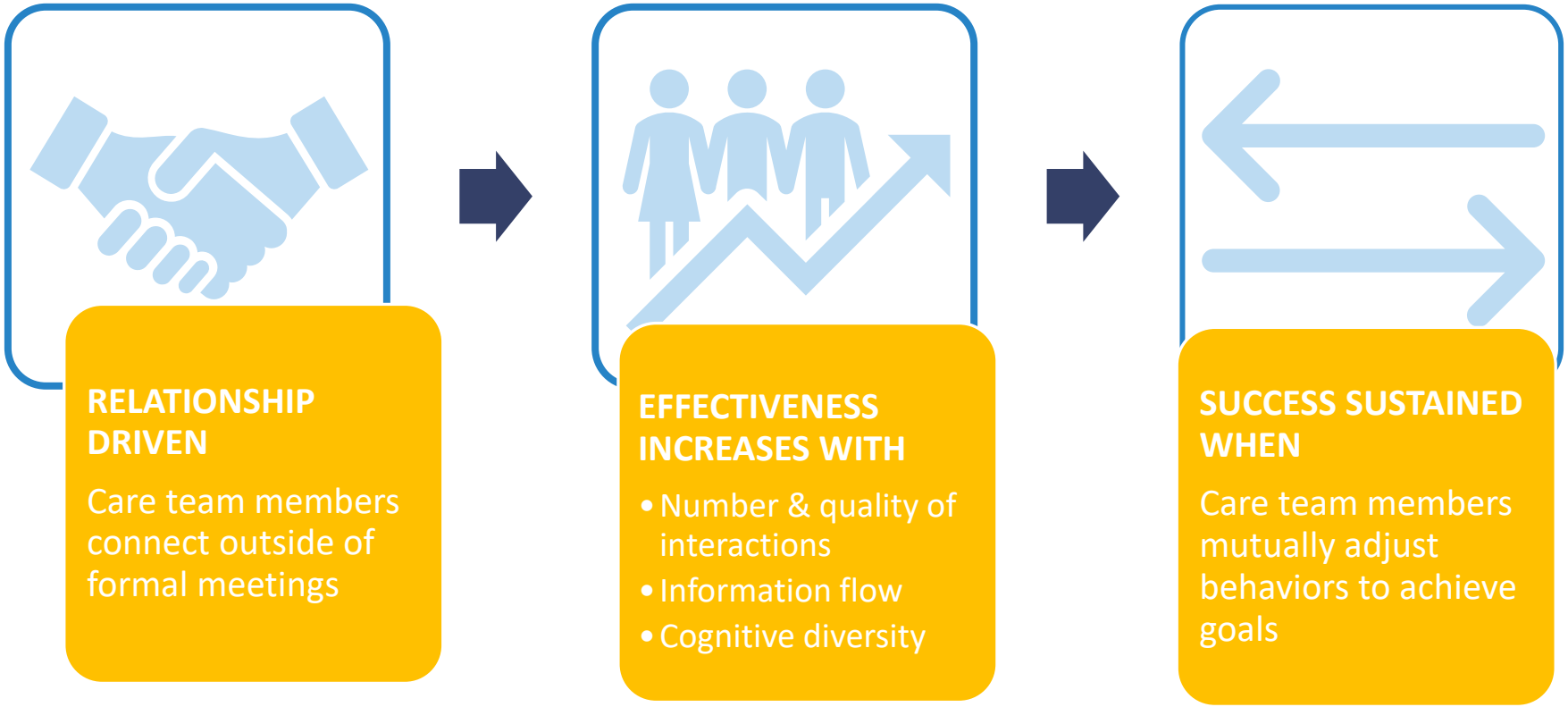
PEDIATRIC EXPANDED CARE TEAMS
What Drives Success

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

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PEDIATRIC EXPANDED CARE TEAMS Best Practices in Implementation

- ✓ Hire care team members to provide functions defined by the American Academy of Pediatrics, including well visits and preventive care; acute and chronic care; care management; care coordination; patient navigation; behavioral health integration; oral health integration; and chronic illness self-management
- ✓ Flexible funding supports expanding and diversifying care teams to fulfill recommended functions. Care team members may be onsite in the practice, centralized at the system of care or accessed through community partnerships.
- ✓ Deploy care team members in the practice, virtually, in the community, and in patient homes
- ✓ Utilize Community Health Workers and Community Health Teams to link patients and families to culturally appropriate community resources, track follow-up, and provide peer support. Coordinate or partner with community services and other places where patients receive care (e.g. schools, childcare centers);
- ✓ Train team members to deliver effective team-based care including workflows and communications. Ensure care team members apply their skills to the top of their training, but do not exceed their qualifications

PEDIATRIC EXPANDED CARE TEAMS Possible Configuration

CARE TEAM MEMBER	% FTE	SALARY, BENEFITS	PMPM
RN Care Manager	0.5	$53,502	$0.45
Care Coordinator	0.5	$51,350	$0.43
Behavioral Health Clinician	3.5	$268,450	$2.24
Community Health Worker/Lactation Consultant	3	$177,684	$1.48
Asthma Educator	2	$130,000	$1.08
Nutritionist	0.5	$40,508	$0.34
Total	***10***	***$721,494***	***$6.01***

PMPM is achieved by dividing salary and benefits by 120,000 member months.

Expanded care team shared via Community Health Teams and/or across a system of care.

Care team expansion envisioned to occur over time.

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PEDIATRIC 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

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

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PEDIATRIC EXPANDED CARE TEAMS
Integrated Behavioral Health

DEFINTION

Provide additional resources and capacity for the pediatric practice to unify pediatric behavioral health and primary care to focus on developmental, socio-emotional, and mental health promotion, prevention and early identification for child and family. This model does not intend to enable pediatric primary care to treat individuals with serious behavioral health conditions, although it does aim to enable primary care to better address these individual's preventive and medical care needs. Care team members may be onsite in the practice, at the system of care or in the community, such as through a Community Health Team.

PEDIATRIC EXPANDED CARE TEAMS
Integrated Behavioral Health

BEST PRACTICES IN IMPLEMENTATION

Practice Level:

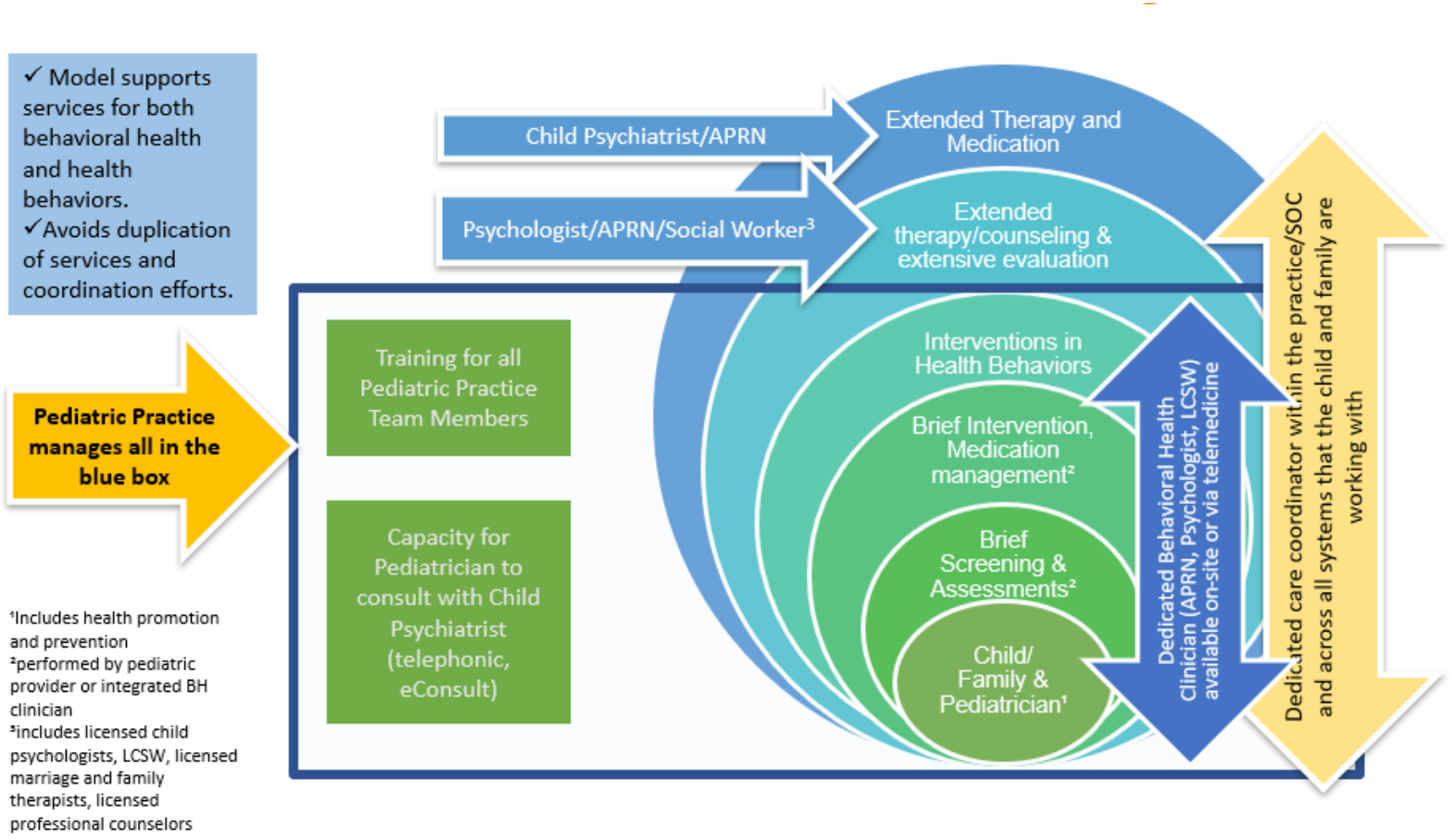
- ✓ Specific screenings assess developmental and socio-emotional health, behavioral health and health behaviors and social and environmental factors that affect the child/family
- ✓ BH clinician offers brief treatment and interventions; referral for further treatment if needed
- ✓ When feasible, practices prioritize on-site availability of BH services and use common EHR platform; otherwise provided via partnership with system of care or Community Health Team.
- ✓ Dedicated care coordinator with expertise in behavioral health who coordinates within the practice/system of care and community for child and family; establishes two-way information flow between community and practice.

Practice/System of Care/Community:

- ✓ Medication management expertise within the practice and access to consultations with child psychiatrists
- ✓ Patient-to-clinician video visits (especially for adolescents)
- ✓ Tracking outcomes in EHRs
- ✓ Training for clinical staff on BH teaming and BH issues and for BH staff on chronic illness
- ✓ Referral and coordination with community-based BH specialists for extended therapy, counseling, evaluation and medication

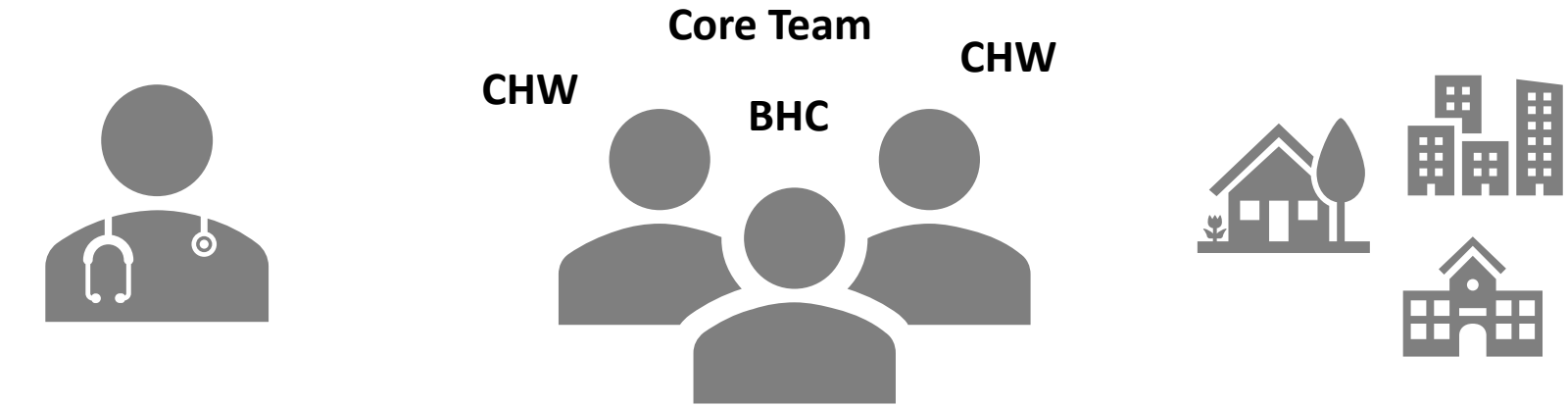
PEDIATRIC EXPANDED CARE TEAMS
Integrated Behavioral Health

CONCEPT MAP



PEDIATRIC EXPANDED CARE TEAMS
Community Health Teams

CURRENT WORKFLOW TO PLACE-BASED CHTs AS EXAMPLE



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

CLAS STANDARDS
Principle Standard

Principal Standard

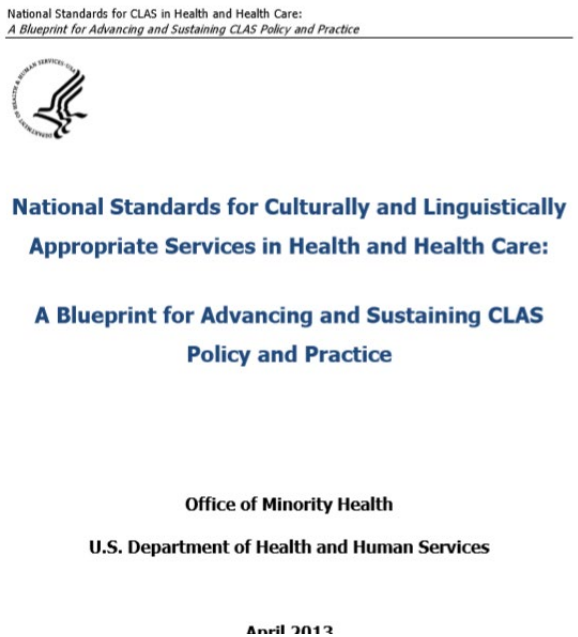
Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Full set of standards provided in the Appendix

CLAS STANDARDS
Why CLAS Standards Matter

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 2013

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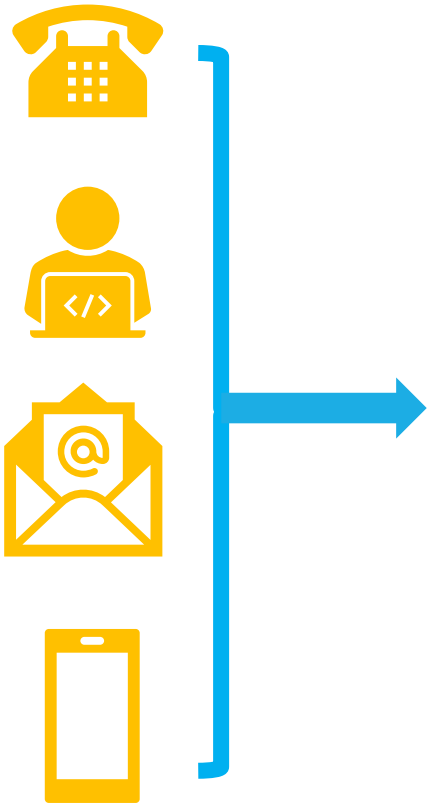
Remote Clinical Care

REMOTE CLINICAL CARE
Goals



CONNECT More convenient, faster access for patients. Removes barriers such as transportation, time off work and childcare.

ENGAGE More opportunities for expanded care team members to connect with patients and address needs earlier. Less burden on PCPs.

INFORM Care team, patients and caregivers have more information on patient needs and progress.

IMPROVE Better adherence to prevention and care plan goals, including arrival at office appointments.

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REMOTE CLINICAL CARE
The Impact of COVID-19

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

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 patients and families?
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?

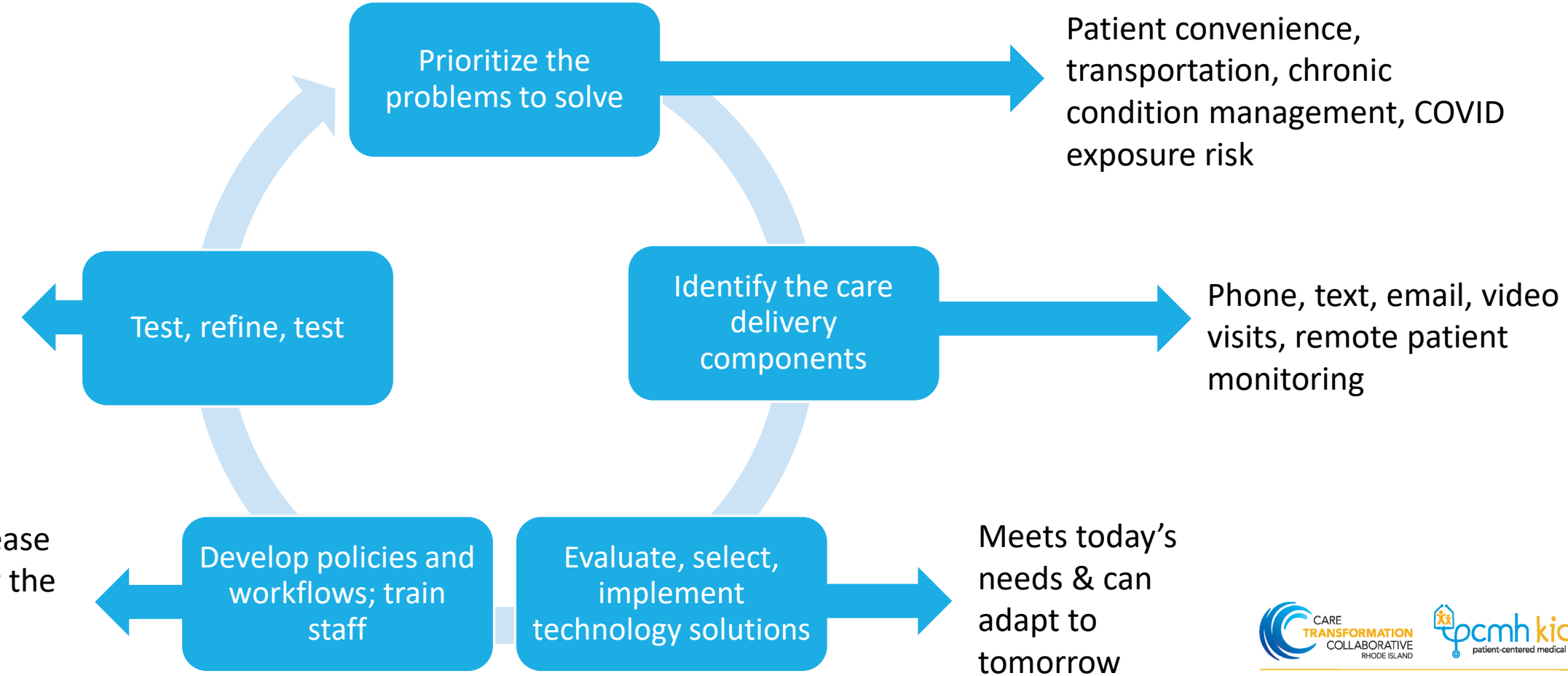
“A modern delivery model should be friction-free for the consumer — allowing in-person visits when they’re needed but supporting healthy habits and disease prevention as the primary objective.”

REMOTE CLINICAL CARE
Related Work in Rhode Island

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
Developing a Strategy



Patient convenience, transportation, chronic condition management, COVID exposure risk

Phone, text, email, video visits, remote patient monitoring

Meets today's needs & can adapt to tomorrow

How can we increase joy of practice for the team and patient experience?

Structured approach to evaluation and continuous improvement

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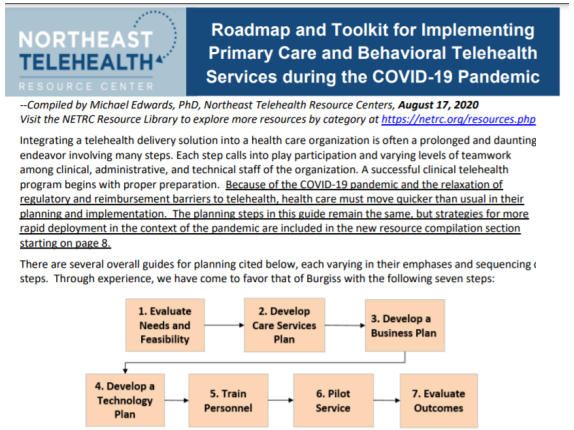
REMOTE CLINICAL CARE
Examples of Implementation Guides



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REMOTE CLINICAL CARE
Phone, Text, Email

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

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).

REMOTE CLINICAL CARE
Phone, Text, Email

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

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

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

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

REMOTE CLINICAL CARE
Video Visits

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

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

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

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REMOTE CLINICAL CARE
Rhode Island Telehealth Survey

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.

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REMOTE CLINICAL CARE
Rhode Island Telehealth Survey

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

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REMOTE CLINICAL CARE
Remote Patient Monitoring

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

HIGH VALUE APPLICATIONS

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

Some of the most promising studies suggest remote patient monitoring may improving outcomes for patients with select conditions, including obstructive pulmonary disease, Parkinson's disease, hypertension, and low back pain (Noah, Keller, Mosadeghi, et al, 2018).

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 remote patient monitoring than younger adults (Noah, Keller, Mosadeghi, et al, 2018).

REMOTE CLINICAL CARE
Remote Patient Monitoring

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
Changing Perspectives

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

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Ensuring Access

ENSURING ACCESS
Rethinking Open Access

Open access scheduling may be a successful solution. Experience shows full implementation of open access 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

1. **Understand supply and demand** – Connect patients and families 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.ihi.org/resources/Pages/ImprovementStories/ShorteningWaitingTimesSixPrinciplesforImprovedAccess.aspx

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ENSURING ACCESS
Six Principles for Shortening Wait Times

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.

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ENSURING ACCESS
Analytics to Prioritize Access Needs

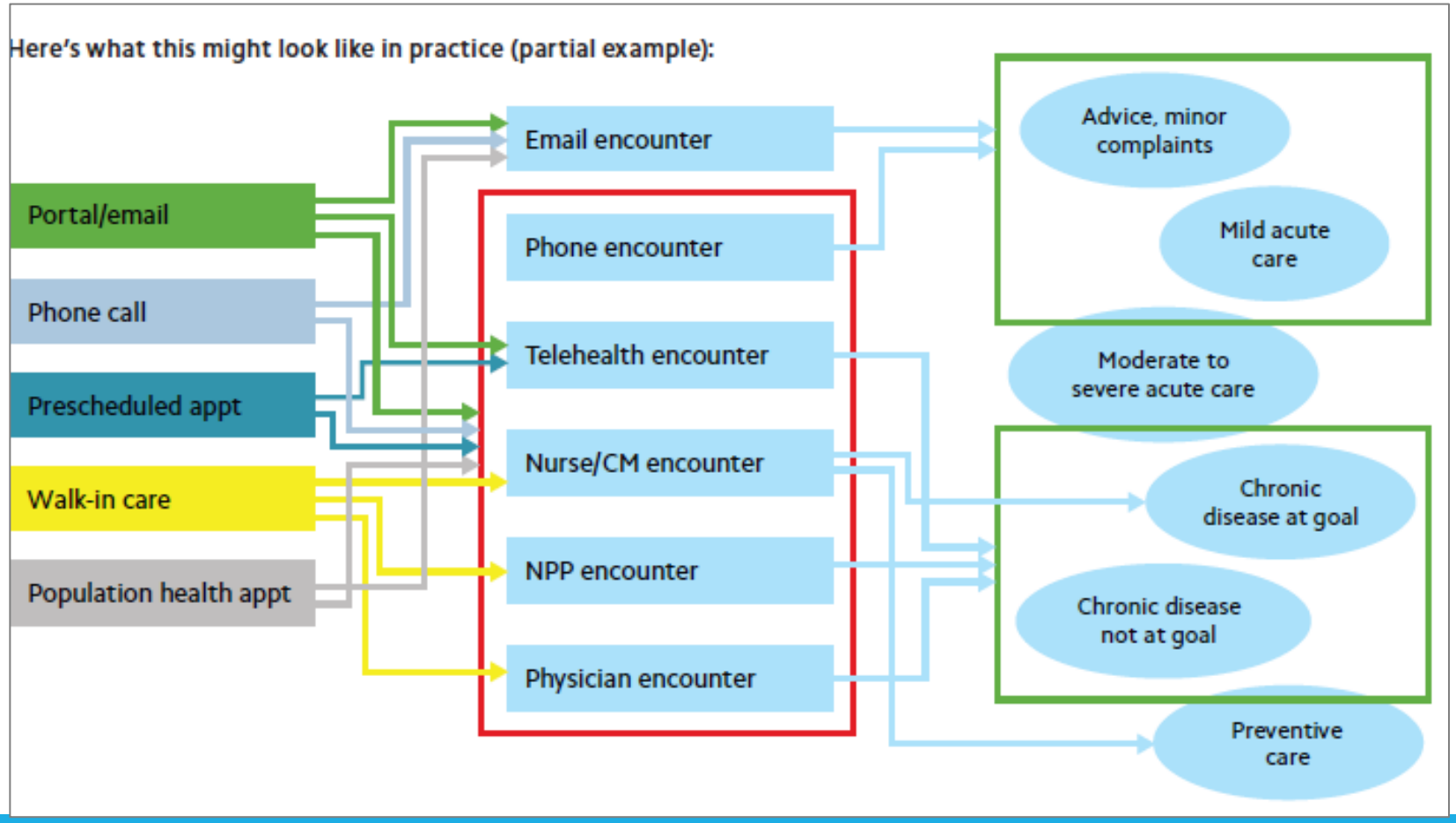
OPPORTUNITY	STRATEGY
Urgent care, ED utilization	Emphasize same-day, weekend appointments paired with easier communication with the practice
Admissions for acute conditions	Consider whether additional follow-up could prevent some admissions
Admissions for chronic disease	Offer patients with chronic conditions 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, connection to health neighborhood support	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



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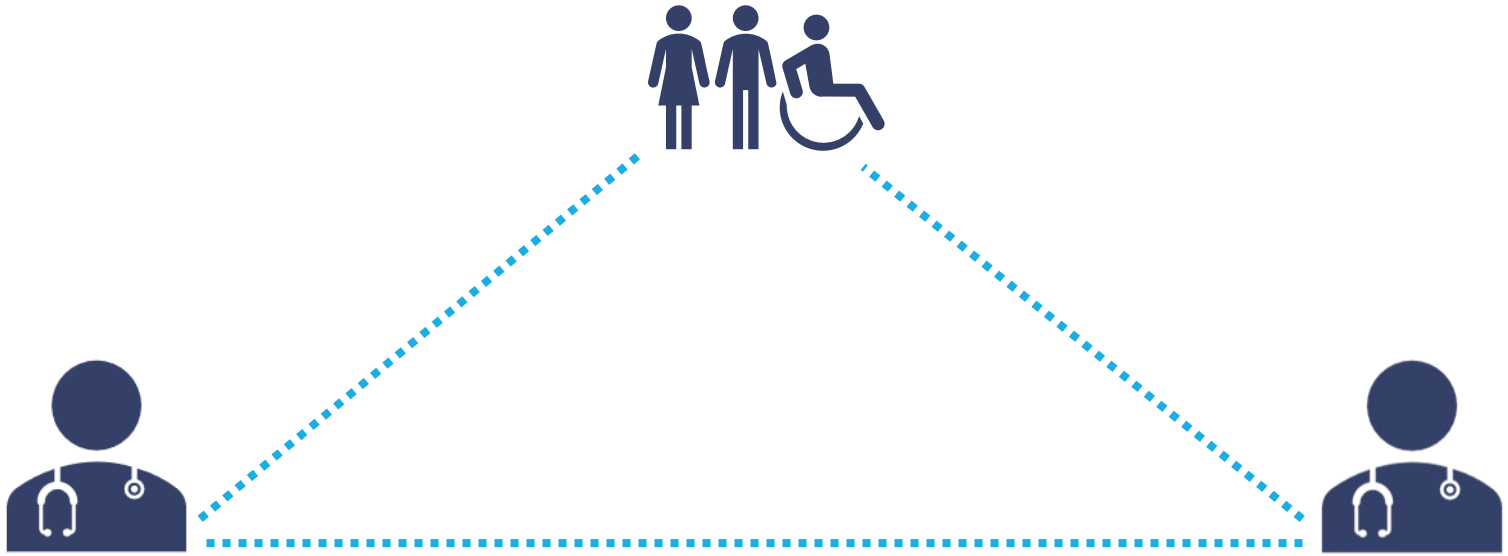
ADVANCING INTEGRATED HEALTHCARE

Partnering with Specialists

PARTNERING WITH SPECIALISTS
The “Specialty Care Triad”

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



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

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PARTNERING WITH SPECIALISTS
Principles for Communication

- ✓ 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

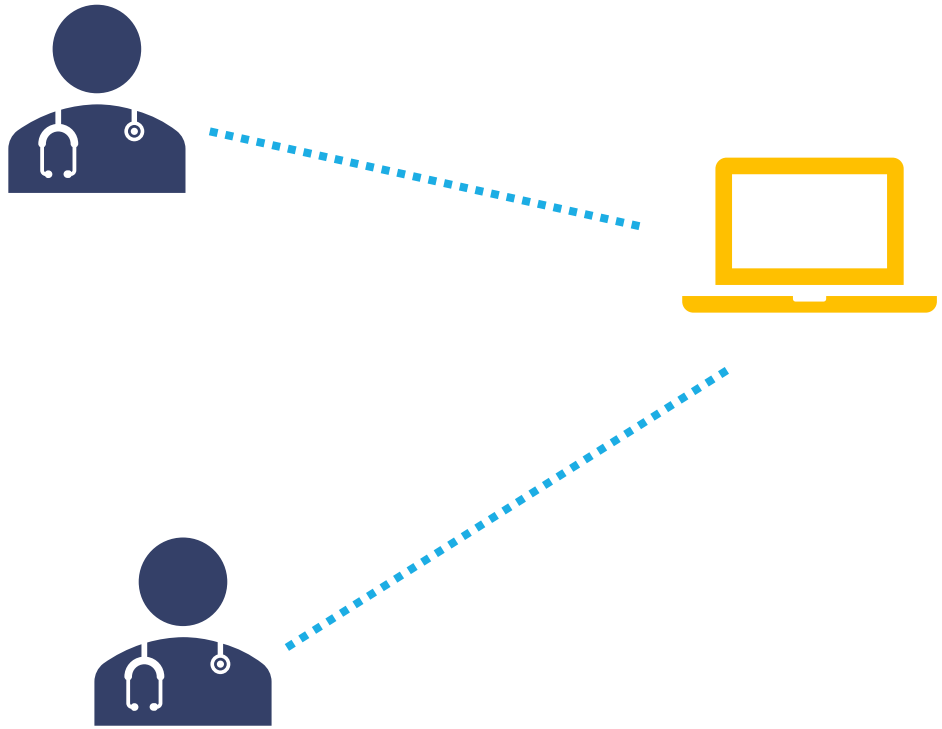
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726433/
Https://www.ajmc.com/view/tools-to-improve-referrals-from-primary-care-to-specialty-care
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726433/

PARTNERING WITH SPECIALISTS
eConsult

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.



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PARTNERING WITH SPECIALISTS
eConsult

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.

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

PARTNERING WITH SPECIALISTS eConsult

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.

Sources: 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

PARTNERING WITH SPECIALISTS eConsult

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.

Source: 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

TEMPLATE

+

eCONSULT

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.

CORE®

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

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ADVANCING INTEGRATED HEALTHCARE

PARTNERING WITH SPECIALISTS
Specialized Practices

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.

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Oral Health

Oral Health

THE PROBLEM

Healthy teeth and mouths are important for overall health, yet millions of Americans do not receive adequate oral healthcare.

Nearly one quarter of children ages 2-5 and one half of those 12-15 have some degree of tooth decay.

Oral Health

THE ROLE FOR PRIMARY CARE

Oral health in primary care refers to providing ***essential dental screening and prevention*** in a primary care doctor's office.

During regular checkups, patients can be screened, given simple treatments like fluoride varnish, educated on oral hygiene, and when necessary, referred to oral health providers.

Oral Health

KEY COMPONENTS OF ORAL HEALTHCARE IN PRIMARY CARE

- **Risk Assessments**: The care team conducts a patient-specific oral health risk assessment that asks about symptoms suggesting oral disease or factors which increase disease risk.
- **Oral Health Screenings**: Care team performs oral health screening that looks for signs indicating poor oral health and active conditions. Examples may include assessing salivary flow, white spots or cavities, gum recession, and signs of poor hygiene.
- **Preventive interventions**: Implement appropriate patient-centered preventive oral health strategies.
- **Communication and Education:** Provide targeted patient education about the importance of good oral health and practices to maintain it. Communications take into consideration health literacy and perceived oral health barriers.
- **Interprofessional Collaboration:** Primary care providers exchange meaningful information with dental providers and facilitate patient navigation through the oral healthcare delivery system by ordering appropriate referrers and tracking oral health outcomes.

https://www.qualishealth.org/sites/default/files/Executive-Summary-Oral-Health-Primary-Care.pdf

Infant Home Visits

Infant Home Visits

CONNECTING WITH FAMILIES AT AN IMPORTANT TIME

New mothers face the physical and emotional strains of childbirth, and the challenge of caring for a newborn at a time when resources are most limited.

Evidence-based models have been developed to provide community and social support to families during this time of transition.

Many of these models provide specialized support to parents and children in high-priority families, such as families with low incomes or young parents, or to individuals serving in the military. However, others take a universal approach, supporting all families.

Infant Home Visits

CASE STUDY: FAMILY CONNECTS, DURHAM, NC

Family Connects is a brief (4- to 7-session) community-based, infant home visitation program to assess family needs and connect parents with community resources to improve infant health and well-being.

Two randomized controlled trials have been conducted. Results include:

- ER and hospital stays were reduced by 50% in the first year of life; these results were sustained but did not increase through the second year of life.
- Mothers were 28% less likely to report possible postpartum clinical anxiety and reported significantly more positive parenting behaviors, like hugging, comforting and reading to their infants;
- Families had 44% lower rates of Child Protective Services investigations for suspected child abuse or neglect through the second year of life.

Results from research on the Family Connects model has been published in Pediatrics, American Journal of Public Health, and JAMA Network Open.

Group Medical Appointments

Group Medical Appointments

GROUP WELL CHILD VISITS

Pediatric practices may find it more efficient and beneficial to conduct group well-child visits for patients and families who want to participate. In group well child visits, families with similarly aged children are seen together for well-child visits. Individual exams, measurements and immunizations may precede or follow the group appointment.

Outcomes: Some studies suggest early evidence for group well child visits, such as:

- Group well child visits are at least as effective as individual well child visits
- Resulted in fewer sick visits and less advice seeking by parents between well visits
- Parents in one study reported the following benefits:
  - Support from other parents
  - Comparisons to development of peers
  - Learning from other participants' experiences
  - Enhanced parental involvement during the visit
  - More time with provider

APPENDIX

Comments and feedback welcome! Please send to:

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mcondon@freedmanhealthcare.com

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PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Population Health Promotion & Management	• Assess health promotion and health outcome measures for the population • Establish appropriate targets for each • Identify patients and sub-populations not achieving the targets and those who require specific services due to age • Develop actionable steps using evidence based or clinical guidelines • Incorporate health outcomes and health promotion measures into patient registries	Pediatrician, APRN, or PA utilize data and collaborate with other members of the care team to identify populations and action steps
Care Management	• Identify children with complex health care needs • Conduct Family Centered Assessment • Develop Individualized Care Plan (ICP) • Establish Comprehensive Care Team • Establish annual training to successfully integrate and sustain comprehensive care teams. • Execute and Monitor ICP • 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

PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF

Well Child Visits, Home Visits and Preventive Care	• Activities related to the Bright Futures Health Promotion themes:
	  • Promoting lifelong health for families and communities
	  • Promoting family support
	  • Promoting health for children and youth with special healthcare needs
	  • Promoting healthy development
	  • Promoting mental health
	  • Promoting health weight, nutrition and physical activity
	  • Promoting oral health
	  • Promoting healthy sexual development and sexuality
	  • Promoting the health and safe use of social media
	  • Promoting safety and injury prevention
	• Home visits are universally provided to all newborns and their families at least once.
	• Gain families' consent to visit
	• Actively promote positive health-related behaviors and infant caregiving
	• Discuss measures to reduce family stress by improving its social and physical environments
		• Primary care clinician (Physician, PA, APRN) supported by RN, MA, Nutritionist/Dietician, CHW, Lactation Consultant, Developmental Specialist as needed
		• Home visits are conducted by an RN and CHW
		• Community Health Team members may also support these functions

PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Behavioral Health Integration	• Brief Behavioral health screenings and initial assessments • Brief interventions, medication management • Interventions in health behaviors • Referrals to extended therapy/counseling, extensive evaluation, medication and higher levels of care (day treatment, partial hospitalization) • Dedicated care coordination across all systems that the child and family work with • Linkages to and coordination with community BH specialists, higher level BH services, behavioral supports (e.g., peer support), developmental services and community resources (e.g., housing)	• Psychologist, APRN, LCSW • Care coordination supported by care team member with expertise addressing the child and adult's BH and social determinants of health needs • Community Health Workers and Community Health Teams support linkages to community services

PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Care Coordination	• Provide separate visits and care coordination interactions • Manage continuous communications • Complete/analyze assessments • Develop care plans (with family) • Identify gaps in care and manage/track tests, referrals and outcomes • Coach patient/family skills learning using motivational interviewing techniques • Integrate critical care information • Support/facilitate all care transitions • Facilitate patient and family-centered team meetings • Use health information technology for care coordination (HIE, EHR) • Coordination with other sites of care and care coordinators, especially schools • Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator	PCP, RN or LCSW Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator. Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities.

PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Patient Navigation	• Identify family barriers to accessing care, including insurance related barriers to care, 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 making follow up appointments • 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 Worker, Community Health Team, Patient Navigator (privately credentialed, specific training)
Chronic Illness Self-Management	• Identify the population who will benefit from disease management program • Health or lifestyle coaching and patient education • Promote chronic illness self-management • Develop programs that are culturally diverse and remove barriers • Nutritional education and counseling • Basic screenings and assessments	RN, Dietician, Asthma Educator, Nutritionist, Pharmacist, Community Health Worker, Social Worker, Community Health Team

PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

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PEDIATRIC EXPANDED CARE TEAMS
Core Care Team Functions

DOMAIN	TASKS	APPROPRIATE STAFF
Oral Health	• Oral health screenings for oral health and active conditions • Preventive interventions • Apply fluoride varnish for babies and children birth to 5 years • Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride as appropriate • Communication and education about importance of good oral health and practices to maintain it • Referral to dental home at age one or when first tooth comes in and tracking outcomes. Referral lists should include dentists who work with children with special needs who have sensitivity issues.	• Primary care clinician, RN • Community Health Worker or Community Health Team supports linkage to dental services in the community

PEDIATRIC EXPANDED CARE TEAMS
Care Coordinator Job Description

Key Responsibilities

The care coordinator links patients and families to systems of services available within health care, education, early childcare, and family support. An important component of care coordination is the creation of individualized care plans, informed by a comprehensive needs assessment and including clear goals, roles and responsibilities and expected outcomes. *The level of care coordination required to implement the care plan will vary and is determined by a stratification model. based on the needs of the patient and family. The care plan is continuously monitored and updated. To be most effective, care planning must be supported by team-based care.*

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PEDIATRIC EXPANDED CARE TEAMS
Care Coordinator Job Description

Key Care Coordination Activities

1. Establish relationships with children, youth, and families through introductory visits, like a warm hand-off, dedicated to setting expectations for care coordination.
2. Promote communication with families and among professional partners and establish frequency of communication.
3. Complete a child/youth and family assessment *that includes family status and home environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth and family) and growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance/needs, and emotional/behavioral strengths and needs).*
4. Working with the family, develop a written care plan, including a medical summary, action plan, and, if needed, an emergency plan, that reflects mutual goals. *Update the written care plan on a regular basis.*

PEDIATRIC EXPANDED CARE TEAMS
Care Coordinator Job Description

Key Care Coordination Activities

5. Ensure the set up and coordination of *all medical, developmental, behavioral health, and social* referrals, and track referrals and test results. *Examples of care coordinator activities include working with the patient or parent/family member to schedule a referral appointment; contacting the school to obtain information on support services; contacting a government agency, such as SSI, to determine service eligibility; scheduling appointments with a hospital or clinic, clarifying coverage with a payer; arranging for participation in vocational or training programs and providing medication reconciliation. Additional examples include conferring with the PCP; doing a chart review, or doing patient-focused research.*
6. Provide condition-specific and related medical, financial, educational, and social supportive resource information, while promoting health-management skills and self-care skills.
7. Ensure the health care team integrates multiple sources of health care information; provide the *patient/caregiver with a summary of this information*, thereby building caregiver skills and fostering relationships between the health care team and families.

PEDIATRIC EXPANDED CARE TEAMS
Care Coordinator Job Description

Key Care Coordination Activities

8. Coordinate care with and referrals to the state-designated community health team, if available in your area.
9. Support and facilitate all care transitions, including to and from hospital and emergency rooms, practice to practice and pediatric to adult systems of care.
10. Coordinate family-centered team meetings, across organizations as needed.
11. Use health information technology to effectively deliver and continually monitor care coordination and the effectiveness of service delivery.

CLAS STANDARDS
Full Set of Standards

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

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

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

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.