PHMI All RAC Meeting

March 28, 2023

Agenda

01	Welcome & Introduction	5 mins *Elise*
02	Building the Foundation	5 mins *Nancy*
03	Care Teams	20 mins *Elise*
04	Business Case	20 mins *Art*
05	Discussion & Next Steps	10 mins *Elise*

Building the Foundation

Building the Foundation

In the Building the Foundation phase of implementation, CHCs will lay the groundwork necessary to effectively implement PHM for a selected population of focus. Building the foundation focuses on four competencies: business case development, data quality & reporting, empanelment & access, and care teams, workforce. CHCs will select competencies for focus where there is a combination of CHC priority and opportunity identified during the PHM capabilities assessment.

Business Case Development	Utilize business case and action plan templates to develop a business case for PHMI sustainability
Care Teams, Workforce	Assess current care team model roles and functions, identify gaps, and develop and execute a workforce plan
Data Quality & Reporting	Enhance capacity to report and monitor HEDIS/PHMI quality measures for populations of focus through use of standardized measurement specifications and a data mapping assessment
Empanelment & Access	Select and implement an empanelment methodology and develop continuity reports

CHC Implementation Supports

Practice coaching

Topic-specific subject matter experts

An implementation guide for each foundational competency

Building the Foundation: Care Teams

Care Teams Key Changes

1. Compare Current Care Team Roles and Functions to Model Care Team
2. Build the Initial Hiring Plan Based on Gaps & Financial Sustainability
3. Define & Share Care Team Tasks
4. Improve Teamwork
   - Promote Effective Communication
   - “Joy in Work” – Provider and Staff Vitality
5. Leverage Care Teams to Lead Continuous Improvement

Care Teams - Background

- The model care team is based on an article reviewing workforce data from 73 exemplary primary care practices and expert opinion*, and further evolved through feedback solicited from PHMI CHCs
- Includes the functions needed for successful population health management
- Model care team is intended as a guide to be used in tandem with the business case to determine what staffing is possible
- It represents an ideal care team model, but one-to-one matches are not expected

*Note: * Article available at [Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices - PMC (nih.gov)]*

Core Care Team: Provides Day to Day Care for Patient Visits

Care Team Role		Functions
Primary Care Providers	**Physician (MD/DO)** **Nurse Practitioner (NP)** **Physician Assistant (PA)**	Primary Care Provider (PCP) who does direct patient care including diagnoses and treatment. Leads and works collaboratively with the core and expanded care team
Medical Assistant (MA)		Assists the primary care provider with direct patient care and is responsible for patient flow on the day of a visit, including pre-visit and visit/room preparation, reviews and completes any overdue health maintenance or open orders, ensures any screenings are completed by the patient and results documented, and completes any needed follow up after the visit, Also prepares for, attends, and participates in daily huddles and other team meetings.
Community Health Worker (CHW) **Peer Support**		A frontline public health worker who is a trusted member or has a particularly good understanding of the community served. A Community Health Worker (CHW) serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery. CHWs are responsible for conducting outreach and providing community education, informal counseling, social support, and advocacy for moderate and high-risk patients. Peer Support Specialists is an individual having lived experience with the process of recovery from mental health or substance use concerns, or both, either as a consumer of these services or as the parent or family member of the consumer.
Behavioral Health Specialists	**Licensed Social Worker (LCSW)** **Marriage and Family Therapist (MFT)**	• Provides day-to-day support for care team & patients with behavioral health needs. Works with expanded are team members including the clinical psychologist and psychiatrist to manage patients with more complex needs. • A behavioral health specialist can be used to provide brief interventions using evidence-based techniques such as behavioral activation, problem-solving treatment, and motivational interviewing.

Expanded Care Team: Provides Care Across Multiple Panels

Care Team Role		Functions
Population Health Management/Data Analytics		
Panel Manager/Data Analyst		Duties include: • Management of the panel size including right sizing (opening/closing) of panels • Identifying patients across the risk continuum in need of preventive and chronic disease management services • Creates gap reports tracks improvements in population metrics.
Population Health Specialist		Duties include using care gap reports created by the panel manager to conduct proactive outreach to patients and schedule for needed follow up. Could work with clinic RN/leadership to run campaigns on needed preventive screening such as FIT colon cancer screening and vaccination fairs.
Access		
Triage Nurse and Clinic Oversight (RN)		Provide access to comprehensive primary care services based upon patient need and evidence-based clinical judgement. Oversees workflows within the clinic to assure equitable access to meet the patients' needs (i.e., same day visit, telehealth) or need for emergency/urgent care.
Behavioral Health Integration		
Behavioral Health Consultants	**Behavioral Health Consultants provide additional supports to Behavioral Health Specialists and the care team. The range of activities are dependent on the licensure**	
	Clinical Psychologist	Provides psychological evaluation, and can conduct more extensive testing than the BH specialists They work closely with the PCP and the other Behavioral Health Consultants but cannot prescribe medications. Treatment can range from cognitive behavioral therapy, family therapy, group therapy and hypnotherapy.
	Psychiatrist or Psychiatric Mental Health Nurse Practitioner (PMHNP)	Provides direct mental health and substance use diagnosis and treatment, including prescribing medications. Works closely with the primary care provider and the care team including the behavioral health specialists.

Expanded Care Team: Provides Care Across Multiple Panels *cont'd*

Care Team Role	Functions
Medication Management	
Clinical Pharmacist	Reviews medical record and assesses progress towards goals to improve patient health and makes suggestions and collaborates with providers on medication management. Completes patient visits for medication review and management, makes recommendations for medication adjustments, dosage titration, initiation, and discontinuation, monitors laboratory values in collaboration with providers and patients, and educates patients about use of their medications. Attends team meetings for chronic disease management and participates in development of patient care plans.
Care Coordination, Health Education and Care Management	
Care Coordinator/Referral Manager	Supports the care team to coordinate the care of the patient including completion of any needed paperwork, facilitation of patient access to appropriate medical and specialty providers as well as other care coordination team support specialists and ensures closed loop referral management.
Care Manager/ Program oversight ***Note:*** *Complex care management for high-risk patients is NOT included in this model.*	Works with care coordinators and health educators to oversee and provide support for rising risk patients with chronic conditions through patient education, goal setting, self-management teaching and coaching. Monitors specific patient activities, interventions, and chronic care protocols that make up the patient's care plan.
Self-Management Support & Health Educator	Assess the health needs of individuals and communities and develop programs and provide materials to teach patients and their families about health topics to manage their health conditions. Could facilitate and participate in group visits or community events for patients living with chronic disease conditions such as diabetes and hypertension. Provides expert consultation and supports the work of the care team and overall health of the patient.

Expanded Care Team: Provides Care Across Multiple Panels *cont'd*

Care Team Role	Functions
Quality Improvement	
Quality Improvement (QI) Lead	Leads the QI team and works with the care teams to improve the quality of care provided to the patient populations. Should be a QI champion and actively support the teams, pulls together the interdisciplinary oversight group, such as a quality council to keep momentum going, provide guidance and resources to the teams, and cultivate a quality improvement culture supported by training that encourages all staff to continuously improve the quality of services.
QI Data Analyst	Duties include monitoring performance metrics, creates reports, and tracks improvements. Responsible for identifying gaps or barriers in data mapping processes to enhance opportunities for continuous quality measurement and improvement.

Building the Foundation: Business Case

Business Case Key Changes

1. Take a multi-disciplinary approach to sustainability planning for the PHMI
2. Use the business case tool to develop financial projections for care team expansion (referencing PHMI care team recommendations)
3. Continue using the business case tool to monitor financial outcomes (actuals vs. projections) and make mid-course corrections

5 Steps to Implement the Business Case Key Changes

1. **Learn the Business Planning Tool**
   Group and individual mentoring so users understand the financial planning process and use of the tool
2. **Gather Data for Input Into the Tool**
   Clarify data definitions and sources
3. **Assess Baseline Financial Performance**
   Assure that the financial proforma accurately reflects financial performance; use results to inform site selection for PHMI
4. **Finalize the Composition of the Expanded Care Team**
   Test various scenarios for financial reasonableness to finalize the care team composition and model of care
5. **Monitor and Modify Implementation**
   Teach how to use actual experience to validate and modify assumptions, to reforecast outcomes and inform modification to the approach

Business Case Tool

The Business Case tool is an Excel file with 9 color-coded tabs.

Tab	Purpose
0. Instructions	Orientation to the purpose and use of the tool
1. Staffing and Salary Cost	Input of salary and benefit costs by staff position
2. Revenue and Visits	Physical and behavioral visits and revenue by payer category in 2022
3. Administrative Costs	Site specific administrative costs (fixed and variable) and corporate overhead allocation to the site
4. Incentive Information	Pay-for-performance incentive payments by metric and payer, earned and potentially earned, by the CHC
5. CY 2022 Financial Results	Site specific all-source revenue, expenses, and calculation of net margin
6. PHMI Expense and Grants	PHMI project-specific non-care team expenses and grant revenue
7. PHMI Clinical Recommendation	Expanded care team modeling
8. Ideal Care Team Simulation	Financial modeling using recommended or modified expanded care team with or without triggering change in scope and rebasing of PPS rate and with or without adoption of capitated FQHC APM

Discussion

- Do you have suggestions on how to introduce these ideas and concepts to the CHCs?
- Has the RAC worked on specific initiatives around care teams or financial sustainability models with the CHCs in the past that would be helpful to know about or build from?
- Other questions?

Next Steps

- Follow up / action items

- Next Meeting:
  - Thursday, April 20th, 11:00 am