Advancing A Model of Value Based Care:

Person-Centered, Population Focused, Team Led

If we can **improve health**, **close care gaps**,
achieve better outcomes,
reduce health disparities and
achieve overall cost savings for individuals
enrolled in value-based health insurance plans,
we can do it for everybody
regardless of income, insurance, or SDH.

Community Health Center, Inc.

Federally Qualified Health Centers (FQHCs)

- Nation's largest safety net setting
- Located in designated high need communities
- Caring for 24 million patients annually
- 93% served are below 200% poverty and 35% uninsured

CHCI Profile

- Founding year: 1972
- Primary care hubs: 14; Sites: 204; Staff: 1,000
- Patients/year: 100,000
- Specialties: Onsite psychiatry, podiatry, chiropractic
- Specialty access by eConsult to 20+ specialties

Elements of Model

- Fully Integrated teams and data
- Integration of key populations into primary care
- Data driven performance
- "Wherever You Are" approach to care delivery

Weitzman Institute

- QI experts; national coaches
- Project ECHO®—special populations
- Formal research and R&D
- Clinical workforce development

CHCI Locations in Connecticut

CHCI Foundational Pillars

Panel Management Defined

- Panel management is an organized, **population-based**, data driven multidisciplinary **team** approach in which a primary care team jointly plans and manages the care of clients with high risk, complex healthcare needs and/or poorly controlled chronic disease, using a **registry** (dashboard/report) to identify client's unmet care needs, to gather summary information for care interventions, and to communicate with clients.

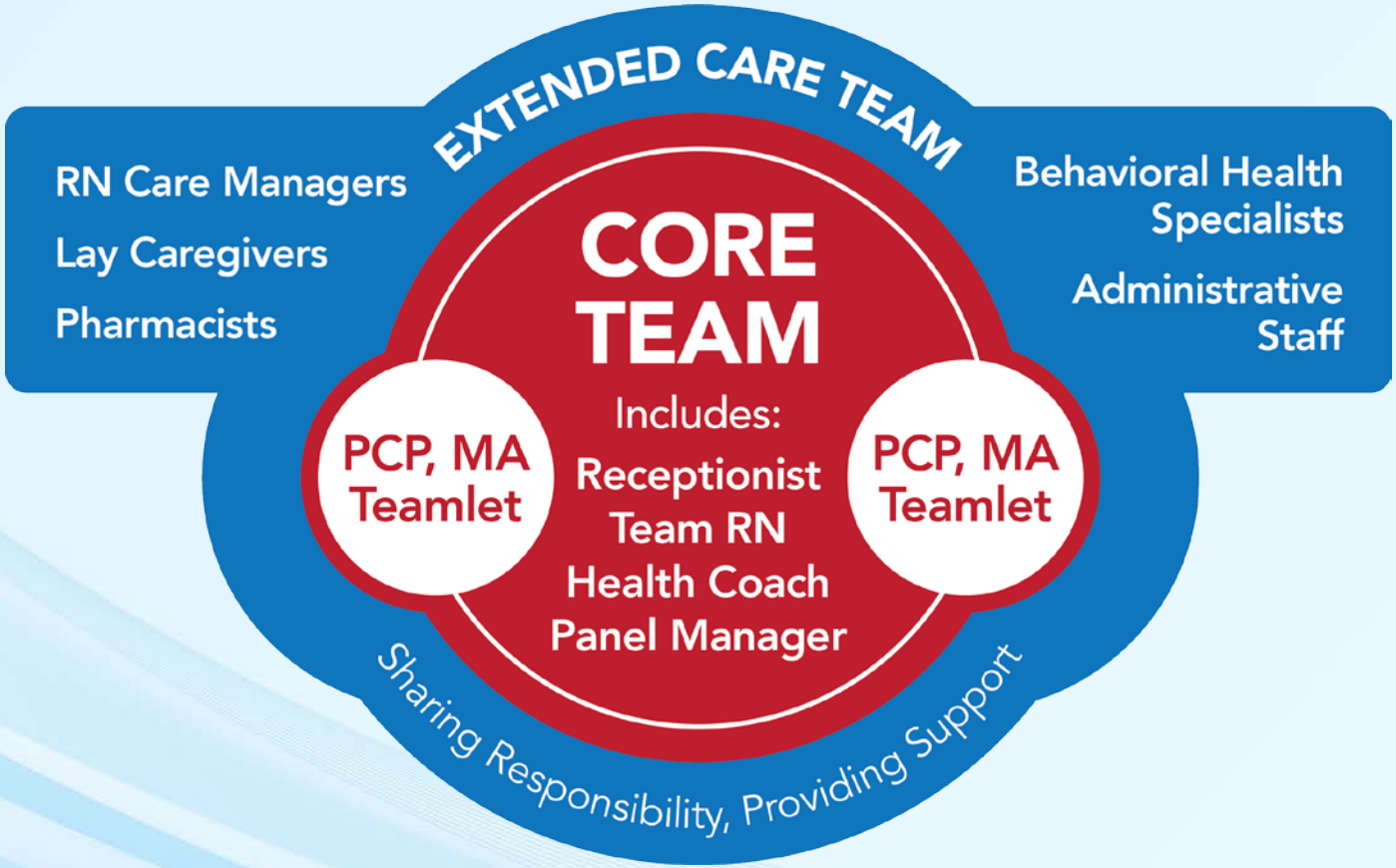
Transforming Practice: Population Focused, Practice Led Playbooks

#1 Outreach, Well Child Visits for 0-36 months	**#11 Planned care dashboard for MAs, BH, RD**
#2 Identifying children due for WCC	#12 Outreach: Adolescent WCC (12–21 years)
#3 Triaging calls from high risk PCMH+ pts	#13 Outreach: Other Care Gaps
#4 Post-hospital admissions follow up	#14 WRAPs (wellness recovery action plans)
#5 Population management: high risk patients	#15 Psychiatric Advanced Directives
#6 Integrated Care Meetings	#16 Intensive complex care management
#7 "Circle of Car—community expanded team	#17 Population management: Transition aged youth
#8 After hours telephonic advice, triage, and follow up	#18 Increased behavioral health screening in medical for pediatric patients
# 9 Managing inactive and transferred patients	#19 Real-time transition management and follow up: implementing "Patient Ping"
#10 Population management: CYSHCN	****

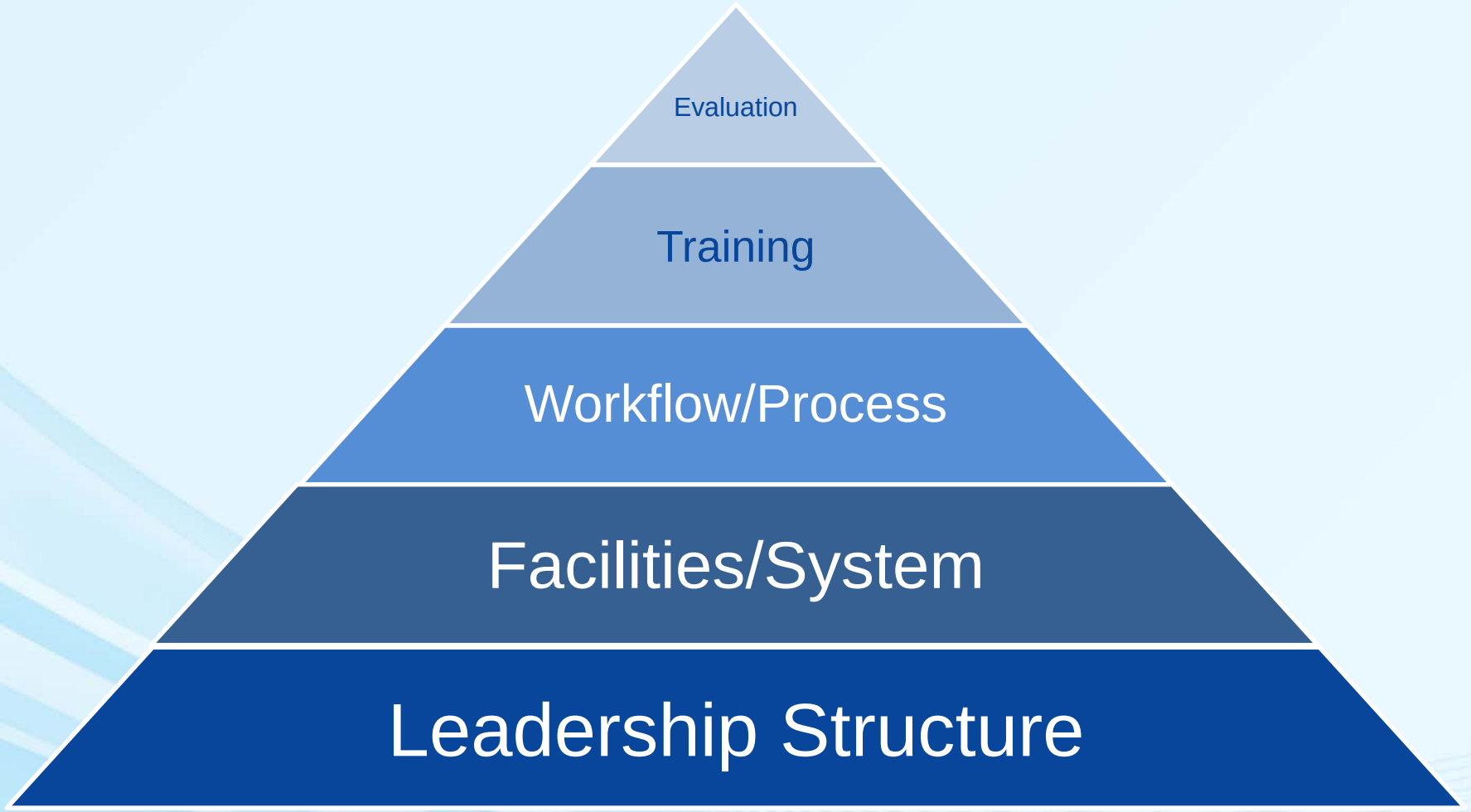
Team Structure: Major Findings From Site Visits

- Providers and their panels supported by core teams consisting of MAs, front desk, and others.
- All core teams supported by RN care managers, behavioral health specialists, pharmacists, etc.
- Medical assistants, receptionists, and lay-persons play key patient care roles.
- Roles are expanded. All staff work at the top of their license and skillsets.

Primary Care Team



The Components of Integration



Domains of RN Nursing Practice

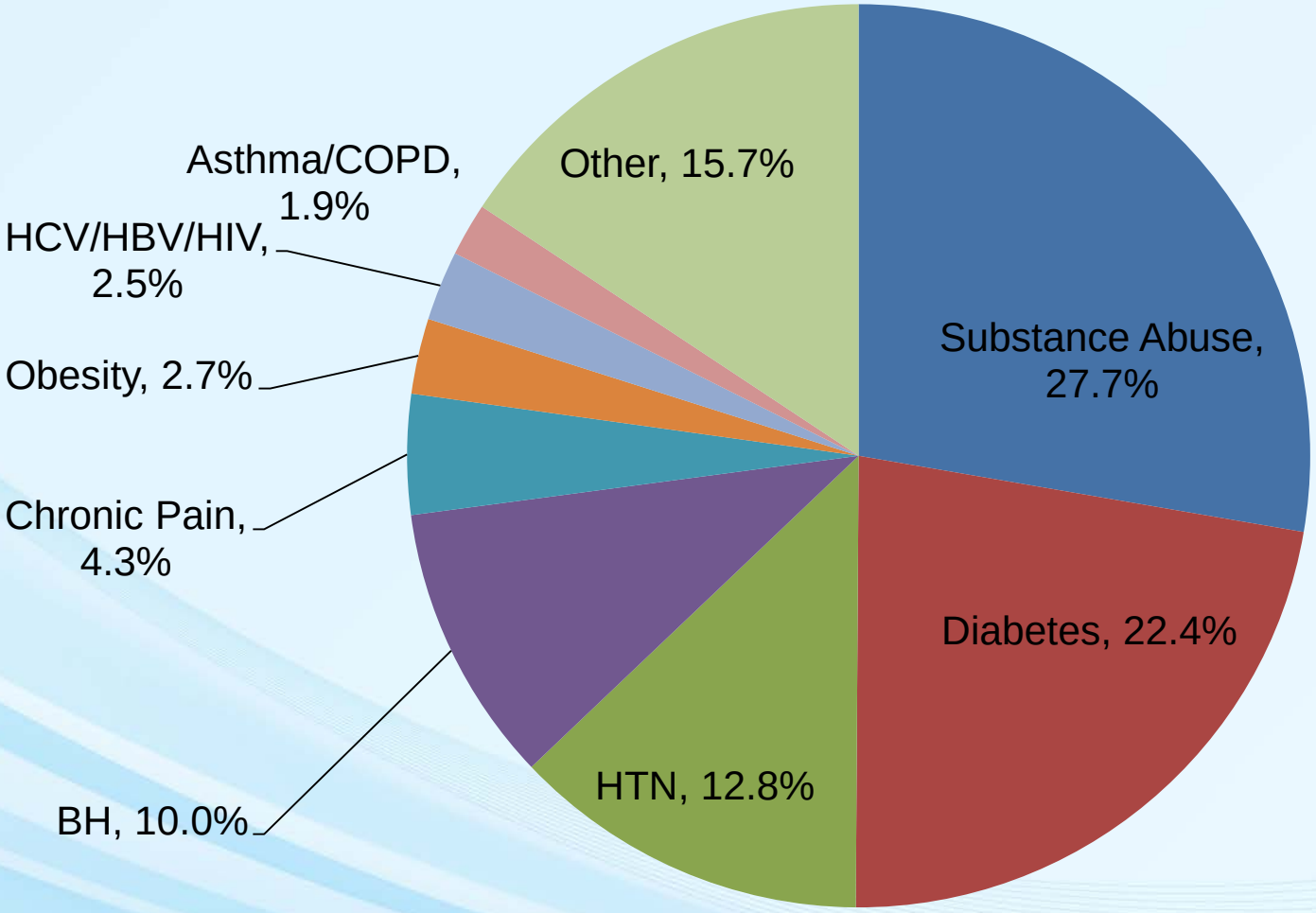
Essential member of the primary care team and inter-professional activities:

(1)Primary Care RN supports (2) primary care panels

Key functional activities:

- Patient education and treatment within provider visits
- Independent nurse visits under standing orders
- Chronic illness management under delegated order sets
- Health promotion, education, and support
- Complex care management; coordination and planning,
- Telephonic advice, triage, and transition management
- Quality improvement leaders, coaches, and participants
- Emergency preparedness and response, individual and community
- Clinical mentoring of RN students; supervision and mentoring of medical assistants

Chronic Illness Care



Screening in Medical Visits

There are many pathways to Behavioral Health care, one of the most robust and reliable is regular screening by PCPs, nurses and MAs in medical visits.

Nurses and MAs screen for multiple conditions including:

- Substance abuse (DAST, AUDIT)
- Depression (PHQ-9)
- Domestic Violence (HITS and HARK)
- and more as required by HRSA, P4P Plans, quality initiatives

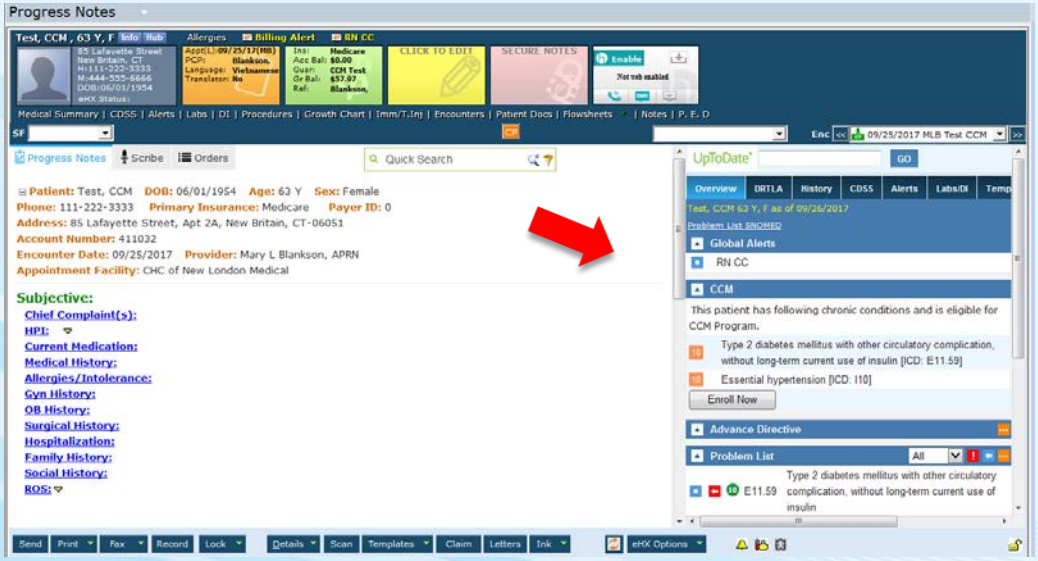
All of these identify patients in need of support from Behavioral Health

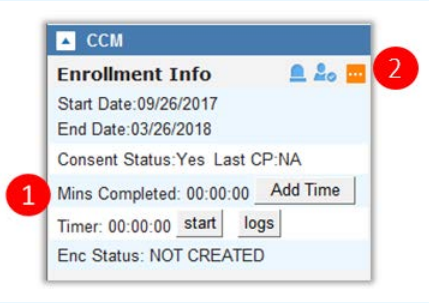
Nurse-led Complex Care Management Panel Review

- The goal of Complex Care Management (CCM) Panel Review is to:
  - Connect the PCP with current care plan information for active CCM patients, including all orders needed for nursing visits, sign off on action plans, etc.
  - Identify CCM patients in need of additional support and presentation to Project ECHO® CCM
  - Identify new CCM patients
  - Enhance Nurse-Provider collaboration
- The expected outcome of CCM Panel Review is to:
  - Improved rates of chronic illness control
  - Reduced ED utilization and admission
  - Improved adherence to defined treatment plans
  - Improve Interprofessional Collaboration

Medicare CCM

Goal: Enroll eligible patients in Medicare Chronic Care Management (CCM), perform Social Determinants of Health (SDOH) screen, and document a comprehensive care plan utilizing tools in the Electronic Health Record (EHR), eCW.





Group Therapy and Medical Integration

Group therapy offers additional services to patients who may have common needs. While those common needs can be things like depression or trauma, often identified in behavioral health care, but they might also be problems commonly identified in medical visits.

- **Smoking cessation**
- **Chronic pain**
- **Suboxone groups as a part of integrated Medication Assisted Treatment**
- **Insomnia**
- **Weight loss**

All of these and more serve to better integrate care between medical and behavioral health services.

Community Care Teams: Beyond our walls

- The “team” goes beyond the primary care practice

Training the Next Generation

- Dedicated Education Units (DEU) for

  for BSN students
- Postgraduate NP Residencies
- Postgraduate NP Fellowship
- Postdoctoral Clinical Psychology Residency Program
- National Institute for Medical Assistant Advancement (NIMAA)
- Administrative Leadership Fellowships
- Project ECHO for on-going RN development

Training All Providers to a New Model of Care

Weitzman ECHO®

Weekly, distance, case-based learning with a team of experts in the care and management of patients in chronic Pain, HIV, Hepatitis C, pediatric behavioral health, and opioid addiction treatment.


laughter
Gratitude
cultivates
JOY!
family
Sharing my Passions & creative expression with others brings me
My family and friends

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