Module 1: Introduction to Advanced Primary Care & The PCMH Model

Primary Care Training Sites Program Curriculum

Learning Objectives

At the end of this module, the learner will be able to:

1. Define Advanced Primary Care (APC) and Patient-Centered Medical Home (PCMH) and explain its significance in healthcare delivery.

2. Utilize knowledge of APC to critique your current clinical placement for areas of strengths and weaknesses based on the Primary Care Collaborative's (PCC) seven shared principles.

Introduction to Advanced Primary Care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Advanced Primary Care (APC)** is an integrated healthcare model that combines comprehensive in-person care and digital care for patients anytime and anywhere.
- The ultimate goal is to enhance the patient's experience, lower costs, and improve health outcomes.

- **Articles:**
  - Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care | The National Academies Press
  - Attributes of Advanced Primary Care

Patient Centered Medical Home (PCMH)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- The PCMH is a model of care in which patients are engaged in a direct relationship with a chosen clinician who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified clinicians and community resources as needed.

- Reference:
  - Patient-Centered Medical Home - Association of Clinicians for the Underserved

Patient Centered Medical Home (PCMH)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- PCMH practices develop transdisciplinary care teams to improve care coordination and care management of patient populations aiming to improve safety, efficiency, and quality in patient care. By becoming a recognized PCMH, practices can improve care delivery and take advantage of private or public incentive payments that reward patient-centered medical homes.

- The Patient Protection and Affordable Care Act (ACA) offers enhanced federal funding to states for health homes serving Medicaid beneficiaries. Clinician groups and healthcare organizations can visit their federal and state government and private insurers' websites for information on funding and reimbursement initiatives.

- NCQA Value of PCMH video (4 min)
- NCQA PCMH from a Health Center Perspective video (5:45 min)
  - NCQA PCMH Model

Shared Principles - Primary Care Collaborative (PCC)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

1. Person & Family Centered - Whole-person care respecting patient values.
2. Continuous - Long-term patient-clinician relationships.
3. Comprehensive & Equitable - Addresses all health needs.
4. Team-Based & Collaborative - Multidisciplinary teamwork.
5. Coordinated & Integrated - Reducing fragmentation.
6. Accessible - Improved access to services.
7. High Value - Cost-effective care.

- **Article:**
  - Shared Principles of Primary Care: A Multistakeholder Initiative to Find a Common Voice

Aspect	Advanced Primary Care (APC)	PCMH 1.0 (Traditional PCMH)	PCMH 2.0 (Advanced PCMH)
Definition	A high-quality, patient-centered healthcare model that enhances accessibility, coordination, and comprehensive care.	The initial framework of the Patient-Centered Medical Home (PCMH), emphasizing care coordination and improved access to primary care.	An evolved version of PCMH, integrating advanced technology, payment reforms, and team-based care to improve population health outcomes.
Primary Focus	Value-based, proactive care that integrates technology, patient engagement, and team-based strategies to improve outcomes.	Enhancing access, care coordination, and patient-centered care within traditional primary care settings.	Expands on PCMH 1.0 with a stronger focus on payment models, data analytics, and whole-person care integration.
Care Model	Comprehensive, whole-person care with proactive disease prevention and chronic care management.	Emphasizes a strong patient-clinician relationship, continuity of care, and coordination across clinicians.	Utilizes predictive analytics, risk stratification, and social determinants of health to drive personalized care.
Technology Use	Extensive use of EHRs, AI-driven care insights, population health tools, and remote monitoring.	Basic electronic health record (EHR) adoption and patient portals.	Advanced interoperability, real-time data analytics, and patient-centered digital tools (e.g., telehealth, remote patient monitoring).
Team-Based Care	Strong emphasis on multidisciplinary teams, including pharmacists, behavioral health specialists, and community-based care.	Focuses on physician-led teams but may lack extensive interdisciplinary collaboration.	Highly structured team-based care with defined roles, expanding to social work, behavioral health, and home-based care.
Access & Patient Engagement	24/7 access to care via telehealth, chat, and digital platforms; proactive outreach strategies.	Offers extended hours and better appointment availability but limited digital options.	Enhances accessibility through integrated telemedicine, on-demand consultations, and mobile health tools.
Payment Model	Shifts toward value-based payments (VBP), alternative payment models (APMs), and outcome-driven reimbursement.	Primarily operates within fee-for-service (FFS) but incorporates some pay-for-performance elements.	Stronger emphasis on full capitated and shared savings models to incentivize preventive care and chronic disease management.
Quality & Outcomes Measurement	Uses real-time analytics, risk-adjusted care models, and social determinants of health data to optimize care.	Tracks patient satisfaction, preventive care compliance, and chronic disease management through limited EHR integration.	Utilizes predictive modeling, AI, and population health metrics to drive precision-based primary care.

Operational Principles of Advanced Primary Care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE

RHODE ISLAND DEPARTMENT OF HEALTH

- Teams & team-based care
- Access to care & patient engagement
- Use of electronic health records (EHR) and technology
- Payment reform in APC

Team-Based Care Operational Toolkits

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Multidisciplinary teams improve patient outcomes.

- Team-Based Care Toolkits to explore:
  - AHRQ TeamSTEPPS
  - AMA STEPS FORWARD
  - PCC Resources
  - ACP Toolkit
  - AAFP Article

Access to Care & Patient Engagement

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Extended hours, telehealth, and patient portals enhance accessibility.

- **Telehealth Access for Medicare Beneficiaries at Risk**
  - 67 million Medicare recipients may lose telehealth benefits if Congress does not act, Medicare telehealth benefit set to expire October 2025. Stay up to date on telehealth rules.
  - Expiration of telehealth coverage could increase healthcare costs due to more in-person visits and hospitalizations.
  - Advocates urge legislative action to maintain virtual care access, ensuring better patient outcomes and cost savings.

EHR & Technology

- EHRs improve care coordination and data-driven decisions.

- **Articles & Resources:**
  - The Promise and Pitfalls of AI in Primary Care
  - *The impact of electronic health records on patient care and outcomes: A comprehensive review*
  - Healthit.gov

Payment Reform in APC

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Shift from Fee-for-Service to Value-Based Care** – Traditional reimbursement models prioritize volume over quality, necessitating reforms that reward improved patient outcomes and efficiency.
- **Underfunding of Primary Care** – Primary care often receives inadequate financial support, limiting its ability to provide comprehensive, proactive care.
- **Alternative Payment Models (APMs)** – Approaches like capitation, bundled payments, and shared savings realign financial incentives to prioritize quality, prevention, and chronic disease management.
- **Incentivizing Care Coordination** – Payment reforms encourage integrated, team-based care that enhances patient engagement and reduces unnecessary hospitalizations.
- **Investment in Technology & Innovation** – Value-based models enable primary care practices to adopt health IT, telehealth, and data analytics for improved patient monitoring and population health management.
- **Sustainable & Equitable Healthcare** – Reforming primary care payment structures strengthens its role as the foundation of an efficient and accessible healthcare system.

Payment Reform in Rhode Island

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Rhode Island Selected for AHEAD Model** – Rhode Island will participate in the **States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model** by CMS.
- **Healthcare Cost Control & Population Health** – The model holds participating states accountable for **curbing healthcare cost growth** and **improving population health outcomes**.
- **Funding Support** – Rhode Island will receive a **cooperative agreement from CMS**, with potential funding of up to **$12 million** over five to six years for implementation.
- **Primary Care Investment** – A key focus of the model is **enhancing primary care across all payers**, including **new Medicare investments in primary care practices**.
- **Hospital Global Budget Payment Model** – The model introduces a **predictable, stable revenue structure** for hospitals through a **global budget payment model** for facility services.
- CMS: Evolution of previous RI initiatives (Medicare/Medicaid)
- OHIC Resources

Conclusion

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- APC and Advanced PCMH enhance healthcare quality and efficiency.

- Integrating patient-centered approaches, technology, and payment reforms aims to ensure sustainable primary care.

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Module 2: Team-Based Care & Coordination

Primary Care Training Sites Program Curriculum

Learning Objectives

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

At the end of this module, the learner will be able to:

1. Analyze the distinct roles and interprofessional contributions of members of a collaborative healthcare team, emphasizing scope of practice, leadership, and impact on patient outcomes.

2. Demonstrate leadership and clinical decision-making in team-based care by effectively engaging in interdisciplinary huddles, utilizing the SBAR framework to synthesize and communicate critical patient updates.

3. Evaluate and implement evidence-based strategies to integrate patient-centered perspectives into care planning, fostering shared decision-making and optimizing health outcomes.

Shared Principles of Primary Care Collaborative

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

1. Person & Family Centered - Whole-person care respecting patient values.
2. Continuous - Long-term patient-clinician relationships.
3. Comprehensive & Equitable - Addresses all health needs.
4. Team-Based & Collaborative - Multidisciplinary teamwork.
5. Coordinated & Integrated - Reducing fragmentation.
6. Accessible - Improved access to services.
7. High Value - Cost-effective care.

- **Article:** Shared Principles of Primary Care: A Multistakeholder Initiative to Find a Common Voice

What is Team-Based Care?

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- NCQA emphasizes Team-Based Care and Practice Organization as a foundational concept in the PCMH model. This approach structures a practice's leadership and delineates care team responsibilities, fostering effective partnerships with patients, families, and caregivers.

- Implementing team-based care has been associated with improved patient satisfaction, enhanced health outcomes, and more efficient use of healthcare resources. By fostering collaboration among healthcare professionals, this approach seeks to reduce care fragmentation and ensure that patient care is seamless and well-coordinated.

Resource: NCQA PCMH Recognition Concepts

Roles and Responsibilities of Team Members

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Introduction to key team roles:
  - **Primary Care Clinician (PCC):** Leads and coordinates patient care
  - **Registered Nurse/Nurse Care Manager:** Chronic disease management, patient education
  - **Behavioral Health Clinicians:** Mental health integration, crisis management
  - **Community Health Workers:** Addressing social determinants of health
  - **Pharmacists:** Medication management and reconciliation
  - **Quality Improvement Specialists:** Driving clinical excellence
  - **Family Specialists:** Enhancing support for caregivers and patients

Primary Care Clinician (MD, DO, NP, PA)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: The leader of patient care in outpatient and community settings, ensuring continuity and comprehensive management.
- Key Contributions:
  - Diagnoses, treats, and manages acute and chronic conditions.
  - Collaborates with the care team to create and oversee care plans.
  - Leads shared decision-making discussions with patients and families.

- 💡 Example: A PCC coordinates care for a patient with uncontrolled diabetes, working with the pharmacist to optimize medications, the nurse care manager to improve adherence, and the behavioral health clinician to address stress-related glucose fluctuations.

Registered Nurse (RN)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Roles: Provides clinical nursing care, patient education, and care coordination within the team.
- Key Contributions:
  - Administers treatments, medications, and vaccinations.
  - Conducts health education and chronic disease management support.
  - Assists with triage and care planning alongside clinicians.

- 💡 Example: An RN follows up with a heart failure patient weekly, monitoring weight trends, adjusting medications per protocol, and escalating concerns to the PCC.

Medical Assistant (MA)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Supports the clinical team in direct patient care and workflow optimization.
- Key Contributions:
  - Gathers vital signs, medical history, and assists with examinations.
  - Prepares lab work, referrals, and documentation to streamline clinician workflow.
  - Supports patient education and ensures follow-up adherence.
- 💡 Example: An MA screens a patient for depression using the PHQ-9 tool and alerts the behavioral health clinician when the score is elevated, prompting timely intervention.

Behavioral Health Clinicians (BHCs)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Provide mental health and substance use disorder treatment as part of primary or specialty care teams.
- Key Contributions:
  - Conduct screenings, assessments, and interventions for mental health conditions (e.g., depression, anxiety, PTSD).
  - Collaborate with PCC to integrate behavioral and medical care.
  - Offer brief interventions, crisis management, and referrals to specialized care.

- 💡 Example: A patient presents with uncontrolled hypertension but has high levels of stress and undiagnosed depression. The BHC provides counseling and stress management techniques while coordinating with the PCC for medication adjustments.

Community Health Workers (CHWs)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Serve as a bridge between healthcare teams and the community, addressing social determinants of health (SDOH).
- Key Contributions:
  - Conduct home visits and health education sessions.
  - Help patients navigate insurance, transportation, and housing resources.
  - Assist with culturally appropriate health promotion efforts.
- 💡 Example: A patient misses multiple appointments due to a lack of transportation. A CHW connects them with a local ride service, ensuring continuity of care.

Pharmacists

- Primary Role: Optimize medication therapy and patient safety.
- Key Contributions:
  - Perform medication reconciliation to prevent errors.
  - Educate patients on proper medication use and adherence.
  - Collaborate with clinicians to adjust medication plans based on patient response.
- 💡 Example: A pharmacist notices that an elderly patient is on multiple blood pressure medications that may cause dizziness. They collaborate with the PCC to deprescribe unnecessary meds and prevent falls.

Quality Improvement (QI) Specialists

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Focus on enhancing care delivery processes and patient outcomes.
- Key Contributions:
  - Analyze patient data trends to improve clinical outcomes.
  - Implement evidence-based protocols for chronic disease management.
  - Lead performance improvement initiatives within healthcare teams.

- 💡 Example: A QI specialist identifies that patients with uncontrolled diabetes are not receiving proper follow-up care. They work with the team to implement a diabetes management workflow that improves A1C levels across the clinic.

Family Specialists

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Provide family-centered support services for patients with complex needs.
- Key Contributions:
  - Assist families in navigating care transitions and long-term care planning.
  - Provide counseling and advocacy for caregivers of pediatric or geriatric patients.
  - Coordinate with PCC to ensure holistic, family-inclusive care.
- 💡 Example: A parent of a child with autism struggles with accessing specialized care. A family specialist helps them find local services and support groups.

Community Resource Partners (CRPs)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary Role: Connect patients with external services that address social and economic needs.
- Key Contributions:
  - Work with food pantries, housing organizations, transportation services, and employment agencies.
  - Ensure patients receive the non-medical resources essential for their well-being.
  - Collaborate with CHWs and social workers to coordinate holistic patient care.
- 💡 Example: A CRP assists a homeless patient with diabetes in securing stable housing, which improves their ability to store insulin properly and attend medical appointments.

Pre-visit Plan & Team Huddle

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- At minimum, watch the videos linked below. If you have time, complete the companion activity:
  - Pre-visit Planning AMA STEPS FORWARD
  - Morning Huddle AMA STEPS FORWARD

SBAR

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Situation, Background, Assessment, Recommendation (SBAR)
  - A structured communication framework
  - Ensures clear, concise, and effective communication
  - Particularly useful during patient handoffs, urgent updates, and interdisciplinary team discussions, reducing errors and improving patient safety.

Resources:

- TeamSTEPPS SBAR Video
- TeamSTEPPS SBAR in Inpatient Medical Teams Video

Team-Based Care Operational Toolkits

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Multidisciplinary teams improve patient outcomes.
- Team-Based Care Toolkits to explore:
  - TeamSTEPPS Pocket Guide
  - STEPS FORWARD
  - PCC Resources
  - ACP Toolkit
  - AAFP Article

Shared Decision Making (SDM)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

► SDM is a collaborative process in which clinicians and patients work together to make healthcare decisions that align with the patient's values, preferences, and medical evidence. It ensures that patients are active participants in their own care.

► **Benefits of SDM**

- ► Improves Patient Satisfaction – Patients feel more engaged and empowered.
- ► Enhances Treatment Adherence – Patients who participate in decisions are more likely to follow through with care plans.
- ► Reduces Healthcare Disparities – Encourages culturally sensitive care and personalized treatment.
- ► Leads to Better Health Outcomes – Patients make more informed choices that align with their lifestyle and values.

Article: **Shared Decision Making: A Model for Clinical Practice**

Communication for SDM

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

►Motivational Interviewing (MI) is a patient-centered communication style that enhances motivation for change by exploring a patient's ambivalence and strengthening their commitment to a health goal.

►Key MI Strategies:

- ►Open-Ended Questions – Encourages the patient to share their thoughts and concerns.
- ►Reflective Listening – Helps patients feel heard and validated.
- ►Affirmations – Reinforces the patient's strengths and ability to change.
- ►Summarization – Ensures clarity and agreement on next steps.

Motivational Interviewing - Video Examples (You Tube 9 mins)

Conclusion

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Interprofessional Collaboration** improves patient safety, reduces errors, enhances efficiency, and fosters holistic care through teamwork.
- **SBAR Communication (Situation, Background, Assessment, Recommendation)** standardizes information exchange, prevents misunderstandings, and strengthens teamwork in critical situations.
- **Shared Decision-Making** engages patients in their care, builds trust, improves adherence, and enhances outcomes by aligning treatments with patient values and evidence-based practices.

Remember to track completion of Modules and Learning Activities on the Student Tracking Sheet

Module 3: Integrated Behavioral Health (IBH)

Primary Care Training Sites Program Curriculum

Learning Objectives

At the end of this module, the learner will be able to:

1. Demonstrate appropriate screening for depression, anxiety, substance use disorder (SUD), and postpartum depression by applying evidence-based tools within a simulated patient case
2. Conduct a warm handoff to a behavioral health clinician using standardized communication protocols within a role-play exercise.

Defining IBH in the APC Model

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Integrated Behavioral Health (IBH):**
  - A model that embeds behavioral health services into primary care settings to improve access and coordination.
  - It focuses on treating the whole person by addressing physical and mental health needs.
- **Advanced Primary Care (APC) Model:**
  - A patient-centered approach emphasizing prevention, coordination, and evidence-based management.
  - Incorporates multidisciplinary teams to enhance patient outcomes.
- **Who is Involved?**
  - **Primary Care Clinician (PCC):** Conducts screenings, initiates treatment, and coordinates referrals.
  - **Behavioral Health Clinician, Social Worker, Psychologist, Psychiatrist:** Provides mental health assessments, therapy, and referrals.
  - **Care Coordinator/Nurse Navigator:** Helps with patient follow-ups, social needs, and referrals.
  - **Community Health Workers (CHWs):** Assist with social determinants of health, patient education, and engagement.
  - **Pharmacist:** Supports medication management for psychotropic drugs.
  - **Patients & Families:** Central to care planning and decision-making.

Agency for Healthcare Research & Quality (AHRQ) Resource - https://integrationacademy.ahrq.gov
Care Transformation Collaborative of RI (CTC-RI) Resource - https://ctc-ri.org/integrated-behavioral-health

Management of Primary Care Patients

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Evidence-Based Management Tailored to Patient Needs**
  - Data-driven decision-making
  - Personalized treatment plans
  - Technology-enabled care coordination
  - Patient education and empowerment
- **Aligns with APC Principles**
  - Whole-person, team-based care integrating behavioral health
  - Focus on prevention and proactive screening rather than reactive treatment
  - Utilizing interdisciplinary teams, including behavioral health specialists

Evidence-Based Management Tailored to Patient Needs

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Data-driven decision-making**
  - Uses validated screening tools such as PHQ-9, GAD-7, and AUDIT-C to guide diagnosis and treatment planning.
- **Personalized treatment plans**
  - Incorporates patient preference, cultural considerations, and social determinants of health.
- **Technology-enabled care coordination**
  - Leverages EHR-based decision support tools and referral tracking to streamline communication among team members.
- **Patient education and empowerment**
  - Educates patients on self-management strategies for mental health conditions.

Case Example #1

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Evidence-Based Management Tailored to Patient Needs

David is a 45-year-old male here with Hypertension, mild obesity

Data-Driven Decision-Making

- During David's annual wellness visit, the primary care clinician (PCC) administers the PHQ-9 (for depression), GAD-7 (for anxiety), and AUDIT-C (for alcohol use).
- Results indicate moderate depression (PHQ-9: 13) and risky alcohol use (AUDIT-C: 6).
- The PCC discusses the results with David and flags him in the EHR-based decision-support tool for a behavioral health referral.

Personalized Treatment Plans

- The behavioral health clinician (BHC) meets with David the same day as part of the warm handoff model in the clinic.
- During the assessment, David expressed that stress from his job, his wife, and financial struggles contribute to his alcohol use and mood.
- A personalized treatment plan is developed that includes:
    - Medication: PCC starts a low-dose SSRI (escitalopram) for depression.
    - Brief Cognitive Behavioral Therapy (CBT): BHC schedules biweekly therapy sessions to focus on stress management and coping mechanisms.
    - Motivational Interviewing (MI): Used to address David's ambivalence about reducing alcohol use while respecting his personal values and goals.
    - Social Determinants of Health (SDOH) Considerations: A care coordinator helps David access financial counseling services and connects him with a community support program.

Case Example #1 Continued

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Technology-Enabled Care Coordination**
  - EHR-based decision support tools track David's depression scores over time and alert the care team if symptoms worsen.
  - A referral tracking system ensures that David follows up with behavioral health appointments and that notes from the BHC are integrated into his primary care records.
  - The PCC and BHC conduct monthly case reviews using population health dashboards to assess trends in depression screening scores and treatment adherence.
- **Patient Education & Empowerment**
  - David receives a digital patient education toolkit through the patient portal, including:
    - Videos on mindfulness and stress reduction techniques
    - Guidance on self-monitoring depression symptoms
    - Resources on safe alcohol reduction strategies
  - The BHC uses shared decision-making to help David set realistic goals for reducing alcohol intake and improving mental well-being.
- **Outcome & Follow-Up:**
  - After three months, David's PHQ-9 score decreases to 6, indicating mild depression.
  - His AUDIT-C score drops to 3, showing a reduction in risky alcohol use.
  - Blood pressure improves as he adopts healthier coping mechanisms, leading to a reduction in medication dosage.
  - David expresses increased confidence in managing his mental health and continues periodic behavioral health check-ins.

This Integrated Behavioral Health (IBH) approach within the Advanced Primary Care (APC) model effectively blends data-driven decision-making, personalized care, technology-enabled coordination, and patient empowerment—ensuring whole-person, value-based care.

Aligning Care with APC Principles

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Whole-person, team-based care integrating behavioral health:**
  - Recognizes that mental health conditions impact physical health and vice versa.
  - Encourages collaboration among primary care clinicians, behavioral health clinicians, and other specialists to deliver seamless patient care.
- **Focus on prevention and proactive screening rather than reactive treatment:**
  - Early identification of behavioral health conditions leads to better patient outcomes and lower healthcare costs.
  - Standardized screening protocols help flag high-risk individuals before conditions escalate.
- **Utilizing interdisciplinary teams, including behavioral health specialists:**
  - Expands the role of primary care by incorporating social workers, psychologists, and community health workers.
  - Facilitates warm handoffs and real-time consults within the primary care setting.

Case Example #2

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Integrated Care for a Patient with Diabetes and Depression

Maria, 52, a female with hypertension (HTN) and type 2 diabetes mellitus (T2 DM), has been struggling with her diabetes management, missing appointments, and not adhering to her medication regimen. At a routine visit, her PCC notices that Maria seems withdrawn, reports fatigue and has lost interest in daily activities. Recognizing the link between her depression and worsening physical health, the PCC refers Maria to the on-site behavioral health clinician within the practice.

Integrated Screening & Diagnosis:

Maria completes a PHQ-9 screening, confirming moderate-to-severe depression.
The PCC and behavioral health clinician meet to discuss treatment options.

Collaborative Treatment Plan:

Medical Management: The PCC prescribes a selective serotonin reuptake inhibitor (SSRI) to help manage her depression while continuing metformin and blood pressure medications.
Behavioral Health Support: The embedded behavioral health clinician provides brief cognitive-behavioral therapy (CBT) sessions focused on motivation, coping strategies, and adherence to diabetes care.
Care Coordination: A care manager checks in weekly via phone to assess Maria's mood, ensure medication adherence, and address any barriers to care.

Case Example #2 Continued

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Integrated Care for a Patient with Diabetes and Depression

Outcome & Follow-Up:

Over three months, Maria's depression scores improve, and she begins to engage more actively in her diabetes care.

She attends group visits for diabetes education and learns strategies for meal planning and stress management.

Her A1C levels decrease, and she reports improved energy and motivation.

This team-based, patient-centered approach ensures that Maria's mental health and physical health are addressed together, leading to better overall health outcomes and improved quality of life.

Pediatric Case Study

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Integrated Care for a Child with Asthma and Anxiety

Jake, a 9-year-old male with moderate persistent asthma, and his mother, are at his PCC's office for frequent asthma flare-ups. She reports that Jake is afraid to participate in gym class and avoids playing outside, fearing that physical activity will trigger an asthma attack. His anxiety has also led to difficulty sleeping, frequent school absences, and reluctance to use his inhaler in front of peers.

Integrated Screening & Diagnosis:
During the well-child visit, the pediatrician notices Jake appears tense and withdrawn.
A pediatric behavioral health clinician conducts an assessment using the Screen for Child Anxiety-Related Disorders (SCARED) tool, confirming significant anxiety about his asthma and other life stressors.

Collaborative Treatment Plan:
Medical Management: The pediatrician reviews Jake's asthma control, adjusts his medication regimen (introducing a daily controller inhaler), and teaches proper inhaler techniques to increase his confidence.
Behavioral Health Support: The behavioral health clinician begins brief cognitive-behavioral therapy (CBT) sessions focused on relaxation techniques, exposure therapy to gradually increase physical activity, and coping strategies to manage anxiety.
School Collaboration: The care coordinator communicates with Jake's school nurse and teacher to ensure he has an asthma action plan in place and receives support for managing his anxiety at school.

Pediatric Case Study, Continued

Integrated Care for a Child with Asthma and Anxiety

Outcome & Follow-Up:

Over several months, Jake learns deep breathing techniques and self-monitoring strategies for both his anxiety and asthma symptoms. He starts participating in PE with confidence, and his school attendance improves.

His asthma is better controlled, with fewer ER visits, and his anxiety symptoms lessen as he becomes more comfortable managing his condition.

This integrated approach ensures that Jake's physical and mental health needs are met, leading to better asthma control, reduced anxiety, and improved overall well-being.

Integration Strategies for Warm Handoff

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Warm Handoff to a Behavioral Health Clinician

- A structured approach to transitioning a patient from primary care to behavioral health services.
- **Key Components:**
  - Real-time, face-to-face introduction of the patient to the behavioral health clinician.
  - Ensures patient engagement and reduces the likelihood of lost referrals.
  - There are several communication frameworks available:
    - SBAR (Situation, Background, Assessment, Recommendation)
    - IPASS (Illness severity – Patient summary – Action list – Situation awareness & contingency plans – Synthesis by receiver)

Integration Strategies for Warm Handoff

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Developmental Service Referrals for Children

- Early identification of developmental concerns via **SWYC (Survey of Well-being of Young Children)**.
- Referral pathways include:
  - **Family Visiting Services**
  - **Early Intervention (EI) Services** (Ages 0-3 for speech, motor, and cognitive development delays)
  - **School-based services (IEP/504 Plans)** (For children over age 3)
  - **Community-based therapy programs** (OT, PT, Speech, and behavioral therapy)

Addressing Health-Related Social Needs (HRSN)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Screening for Social Determinants of Health (SDOH)

- Standardized screening tools: **PRAPARE, AAFP SDOH Toolkit**.
- Common SDOH risk factors:
  - Housing instability
  - Food insecurity
  - Transportation barriers
  - Employment challenges
  - Access to healthcare

American Academy of Family Physicians (AAFP) FPM Journal Toolkit
https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/social_determinants.html

AMA STEPS FORWARD Podcast:

The Importance of Screening for Social Determinants of Health (30 mins)

Margaret Bavis, DNP, Assistant Professor, Rush University College of Nursing, discusses how CommunityHealth, one of the largest volunteer-based health centers in the nation, assesses and optimizes social determinants of health to improve patient care.

Conclusion

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- IBH embeds behavioral health into primary care to enhance coordination and access.
- The APC Model emphasizes prevention, team-based care, and evidence-based management.
- Key team members include PCCs, Behavioral Health Clinicians, Care Coordinators, CHWs, Pharmacists, and Patients.
- Use evidence-based tools (PHQ-9, GAD-7, AUDIT-C) for screening and treatment planning.
- Warm handoff strategies improve patient engagement and care transitions.
- Addressing SDOH (housing, food insecurity, transport) is crucial for primary care.

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Module 4: Care Coordination & High-Risk Patient Management

Primary Care Training Sites Program Curriculum

Learning Objectives

At the end of this module, the learner will be able to:

1. Develop a care coordination plan for a complex patient requiring multidisciplinary care.
2. Analyze a chronic disease management case and identify evidence-based interventions to optimize patient outcomes.

Introduction to High-Risk Patient Management

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Who are high-risk patients?
  - Only about 5-10% of patients are high-risk
- Impact on healthcare outcomes and cost
  - 2009 – 1% of population accounted for 22.7% of healthcare cost
  - 5-10% of the high-risk account for 50% for overall healthcare spending

Role of primary care in reducing complexity -

Statistical Brief #455: The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions, 2012

Why High-Risk Patient Management Matters

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- High-risk patients make up a small portion of the population but drive the majority of healthcare utilization and costs.
- Common features: multiple chronic conditions, functional limitations, social vulnerability, behavioral health needs.
- Poor coordination leads to:
  - Medication errors
  - Unnecessary hospitalizations/ER visits
  - Conflicting care plans
  - Gaps in care

Challenges in Healthcare

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Multiple Chronic Illness
  - Congestive Heart Failure (CHF), chronic obstructive pulmonary disease (COPD)
  - Comorbid psychosocial challenges - housing insecurity, transportation barriers, or unmanaged mental health needs
- Practice is in Silos
  - Specialists, hospitals, primary care, and community resources don’t interface.
  - This leads to redundant prescriptions, duplicate lab tests and imaging, conflicting advice, and poor outcomes.

Role of Primary Care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Primary care is the foundation of high-risk patient management.
- PCCs are uniquely positioned to be the central hub for these patients.
- Reduce duplication, improve quality of life, and prevent avoidable hospital use.
- **Goal: Improve health outcomes while reducing preventable utilization and cost.**

Screening & High Risk Patient Identification

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Knowing what to look for:
  - **Clinical Indicators** – multiple chronic conditions, polypharmacy (>10 meds), frequent ER visits or hospitalizations (≥2 in 6 months)
  - **Behavioral & Social Factors** – unmanaged mental health or substance use, poor health literacy, lack of social support, housing or food insecurities

Screening Tools and Data Sources

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- LACE index (length of stay, Acuity, Comorbidities, ED visits) - Predictor of readmission
- HCC Coding and Risk Adjustment
- EHR Dashboards, ADT feeds
- PRAPARE tool - *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences*
    - Assesses social determinants like housing, stress, and food security

Developing a Coordinated Care Team

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Start with the Patient's Story**
  - Identify clinical, behavioral, and social complexity
  - Clarify goals of care (from patient and clinician perspectives)
- **Key Components of a High-Quality Care Plan**
  - Medical: Evidence-based interventions and medication reconciliation
  - Behavioral Health: Mental health or substance use management
  - Social Support: Housing, transportation, nutrition, literacy
- **Coordinate at Least Three Core Services**
  - Example services: Primary care, behavioral health, pharmacy, home care, nutrition, social work, specialty care, etc.

Developing a Coordinated Care Team

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Ensure Communication and Shared Documentation**
  - Unified care plan across disciplines
  - EHR tools: shared notes, task assignments, alerts
- **Include Follow-up and Monitoring**
  - Define who follows what (case manager, primary care clinician, nurse) - utilize effective resources
  - Timeline for follow-ups and check-ins/closing the loop on orders/referrals
  - Metrics for success (e.g., no Emergency Department (ED) visits for 90 days)

Risk Identification

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Example 1: Clinical Risk**
  - A 74-year-old with congestive heart failure (CHF), chronic kidney disease (CKD) stage 3, insulin-dependent diabetes, and 14 medications. Two hospitalizations in the past 3 months for fluid overload. Lives alone.
  - High risk due to clinical complexity, polypharmacy, and lack of home support.
- **Example 2: Social Risk**
  - A 42-year-old with stable human immunodeficiency virus (HIV), mild depression, and asthma. Missed two follow-up visits and lost insurance coverage. Reports food insecurity.
  - Social factors increase risk of poor disease control and loss to follow-up.
- **Example 3: Utilization Risk**
  - A 59-year-old with chronic obstructive pulmonary disease (COPD) who's been in the ED 5 times in the past 2 months for exacerbations. Not seeing a pulmonologist. No inhaler education documented.
  - Identified through ED visit tracking and gaps in care coordination.

Risk Assessment

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Jaxson, Age 4 - Severe persistent asthma, eczema, and recent weight loss

Medications: Albuterol, Fluticasone, Montelukast, topical steroids

Recent Utilization:
3 ED visits in the past 2 months for respiratory distress
One hospitalization for status asthmaticus
Missed last two primary care follow-ups

Social History:
- Lives with grandmother who struggles to manage medications
- Non-English-speaking household
- Family reports mold in their apartment and no air conditioning

Why This Patient is High-Risk:
Clinical complexity: Severe asthma requiring multiple medications and recent hospitalization
Utilization: Frequent ED use and missed appointments
Social risk factors: Environmental exposure (mold), caregiver strain, language barrier, low health literacy

Leveraging the Strength of Multidisciplinary Collaboration

- **Who Should Be at the Table?**
  - Primary care clinician (MD/DO/NP/PA)
  - RN care manager or nurse navigator
  - Behavioral health clinician (LCSW, psychologist, psychiatric NP)
  - Clinical pharmacist
  - Social worker or community health worker
  - Specialty consultants (as needed)

Multidisciplinary Collaboration and Coordination

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Best Practices for Team Coordination**
  - Weekly or bi-weekly case conferences/huddles
  - Shared documentation and communication platforms
  - Use of “warm handoffs” during care transitions
- **Key Communication Strategies**
  - Define roles and responsibilities clearly
  - Use SBAR or other structured communication tools
  - Keep the patient’s goals central to the discussion
- **Barriers to Coordination & Solutions**
  - Fragmented systems → Use shared EHRs, Health Information Exchange (HIE) access
  - Role confusion → Care team charters and checklists
  - Scheduling challenges → Asynchronous communication, centralized dashboards

Communicating to Prevent Redundancy

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Why De-Duplication Matters**
  - Redundant labs and imaging increase cost and patient burden
  - Risk of medical errors (e.g., contrast exposure, medication overlaps)
  - Contributes to fragmentation of care
- **Strategies to Prevent Duplicative Services**
  - Confirm prior tests before ordering (check prior visit notes, HIE, consult reports)
  - Encourage patients to carry a list of recent imaging or tests
  - Use centralized care plans and shared task lists
- **Leveraging EHR Interoperability**
  - Health Information Exchange (HIE) for access across systems Rhode Island's HIE Current Care
  - Query patient records from outside hospitals/labs
  - Use clinical summary documents in referrals and care transitions

Transitional Care Management (TCM)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Reducing Hospital Utilization

- **Primary Care Interventions**
  - **Nurse Care Managers**: Conduct outreach within 48–72 hours post-discharge
  - **Timely Transitional Care Visits:** within 7 days of discharge
  - **Medication Reconciliation**: Identify changes made during hospitalization
  - **Telehealth Follow-Ups**: Ideal for mobility-limited patients or rural settings
  - **Care Plan Adjustments**: Address root causes of hospitalization (e.g., med nonadherence, caregiver fatigue, social determinants/drivers)

TCM Process

- Help patients transition from an **inpatient** setting back to the community while reducing hospital readmissions. Reimburse clinicians for managing a patient's care during the 30 days after discharge.
- Within 2 business days, must contact the patient, address needs, and book appt

CPT Code	Description	F2F Visit Required?	Timeframe	Medical Decision-Making (MDM) Level
99495	Moderate Complexity TCM	Yes	Within **14 days** of discharge	**Moderate MDM**
99496	High Complexity TCM	Yes	Within **7 days** of discharge	**High MDM**

TCM Reimbursement Codes

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

CPT Code	Description	Average Total Faculty Relative Value Units (RVU)	Average Reimbursement Amount
99214	Established patient office visit, moderate complexity	2.68	$86.69
99215	Established patient office visit, high complexity	3.50	$113.23
99495	TCM with moderate complexity, face-to-face within 14 days	4.65	$150.41
99496	TCM with high complexity, face-to-face within 7 days	6.19	$200.17

CMS Medicare Learning Network (July 2024): Additional TCM Billing and Coding

TCM Reimbursement

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- If you make two or more separate and unsuccessful attempts to contact the patient within 2 business days of discharge, you can still bill for TCM as long as you document your attempts and continue trying until contact is made.
- Even if you reach the patient after 2 business days, you can still provide and bill for TCM services as long as the face-to-face visit occurs within the required timeframe (7 or 14 days based on complexity).

Conclusion

- **High-risk patients need proactive, team-based care**
  - Use tools like LACE, HCC, and PRAPARE
  - Consider social factors as much as clinical ones
- **Multidisciplinary teamwork is essential**
  - Involve nurses, pharmacists, social work, behavioral health
  - Use care huddles and shared plans to align care
- **EHR and HIE tools help reduce waste**
  - Check for recent labs, visits, and notes from outside clinicians
  - Share key info across care settings
- **Collaborate intentionally with specialists**
  - Send clear referrals and share the care plan
  - Follow up to reconcile medications and confirm next steps and close the loop
- **Primary care leads in reducing hospital use**
  - TCM and Chronic Care Management (CCM) support post-discharge care
  - Timely outreach prevents readmissions

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Module 5: Special Topics and Community-Based Integration & Practice Improvement

Primary Care Training Sites Program Curriculum

Learning Objectives

At the completion of this module the student will be able to:

1. Identify at least three community-based services that support primary care patients and describe the referral process.
2. Identify a care gap within the clinical site and describe the PDSA process and a potential solution.

Coordination & Collaboration

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Remember that coordination and collaboration with other healthcare clinicians are key components of Advanced Primary Care (APC).
- There are many agencies and Community Based Organizations (CBOs) that can assist to improve care outcomes depending on patient/family needs.

Community Resources to Explore

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

These are only a few resources to explore. Talk to your clinical site staff to see what resources are frequently accessed.

- Family Visiting Program RIDOH
- Early Intervention (EI)
- School Based Health Centers RIDOH
- Emergency Info for People with Special Needs
- RI United Way 2-1-1
- Environmental Lead Program
- CurrentCare (You will need your preceptor to access this portal)
- RI Food Bank
- Quit Works RIDOH (Tobacco Cessation)
- Department of Children, Youth and Families

Formal and Informal Referral Pathways

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Many agencies have referral mechanisms within their organizations or across related organizations. Referrals outside of formal mechanisms can be established with outside agencies by initiating relationships and asking what the referral process is. It is important for clinicians to establish relationships across many agencies to accommodate a patient's needs.

Article:

Exploring the collaboration between formal and informal care from the professional perspective

Articles

- Distributed leadership in health quality improvement collaboratives
- Enhancing Medical Education Through Quality Improvement and Patient Safety
- Process Improvement in Healthcare: A Comprehensive Guide to Enhancing Efficiency and Patient Care

Quality Improvement (QI)

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

How does QI work?

- **Analyze**: Evaluate performance and identify opportunities for improvement
- **Improve**: Make changes to processes, products, or services
- **Measure**: Assess the results of changes to determine if they are effective
- **Standardize**: Promote consistency and reduce variability in processes

QI models

- **PDSA**: A repetitive four-stage model that stands for **Plan, Do, Study, Act**
- **DMAIC**: A five-phase method - **Define, Measure, Analyze, Improve, Control**
- **Six Sigma**: A data-driven methodology that uses statistical tools to identify and eliminate defects

Benefits of QI

- Improved **efficiency**, patient **safety**, clinical **outcomes**, and better preparation for value-based payment models.
- Participation in public reporting of healthcare quality data: QI is important for organizations that want to improve the quality of their products, services, or outcomes.

Leveraging EHR and Practice Data for QI

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- Data drives the justification of making changes to procedures or policies.
- There are many sources of healthcare data to identify gaps in patient or practice outcomes:
  - Electronic Health Records (EHR)
  - KIDSNET
  - CurrentCare
  - Rhode Island Department of Health

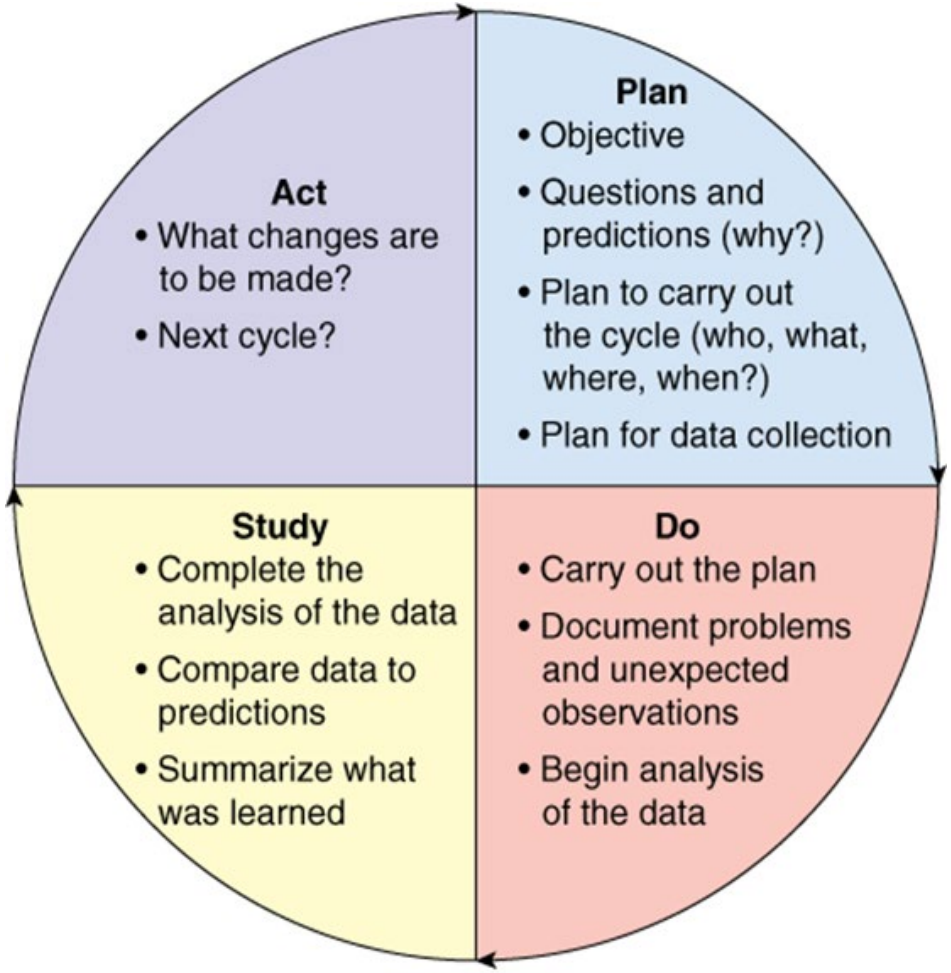
Article - Quality Improvement into Practice

Using Data for Rapid Cycle Improvement in APC

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

PDSA –
Plan, Do, Study, Act

[AMA STEPS Forward: PDSA Video]

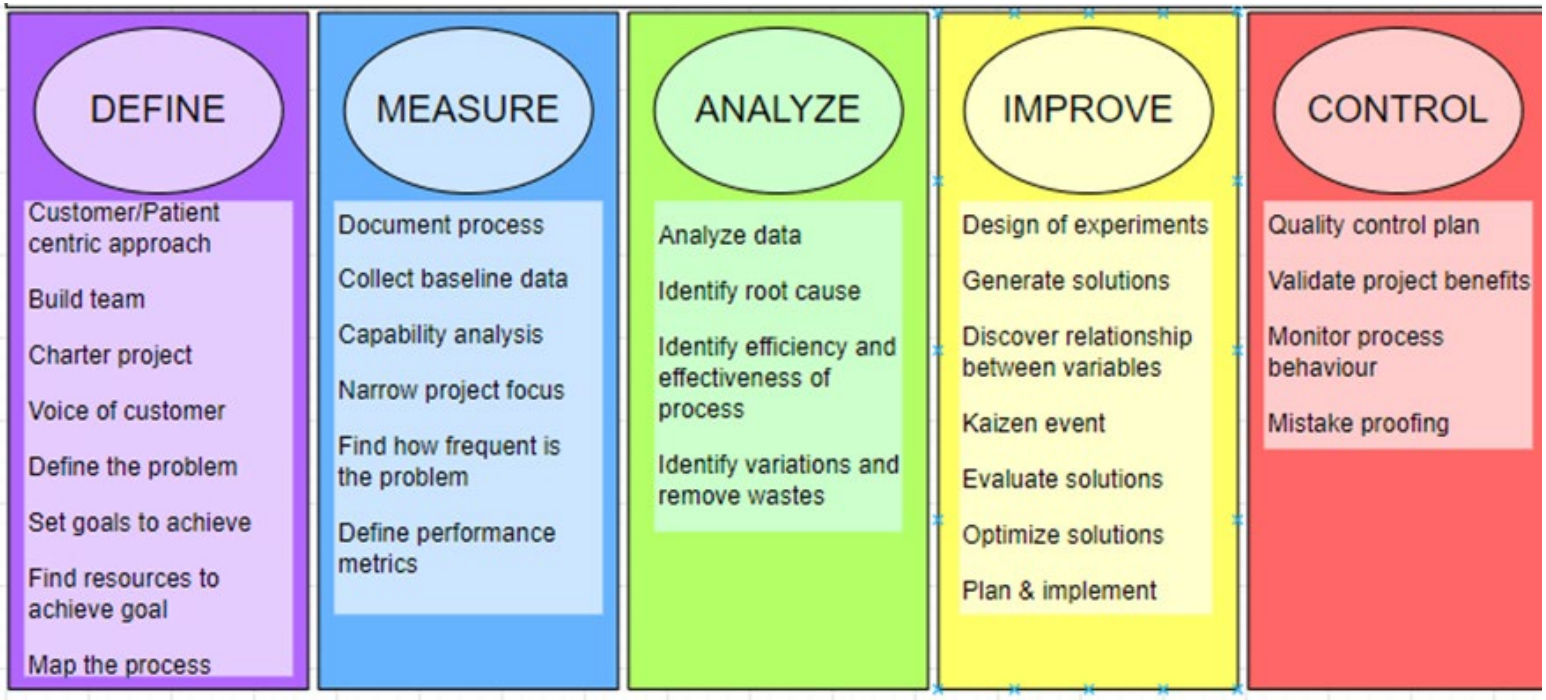


Source: McKean S, Ross JJ, Dressler DD, Brotman DJ, Ginsberg JS: *Principles and Practice of Hospital Medicine*: www.accessmedicine.com

Using Data for Rapid Cycle Improvement in APC

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

The DMAIC model is a structured, data-driven methodology used to improve existing processes, particularly within Six Sigma and Lean Six Sigma, encompassing five phases: **Define, Measure, Analyze, Improve, and Control**



The Role of Data in Equitable, Patient-Centered Care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

Data Sources Supporting Advanced Primary Care:

- **Rhode Island Department of Health (RIDOH):**
  Population health data, immunization registries, and health equity zones (HEZ) insights
- **Claims-Based Data (Payers/CTC-RI):**
  Utilization patterns, cost analysis, high-risk patient identification
- **Behavioral Health & Social Determinants Modules**
  Integrated behavioral health screening, housing/food insecurity, ACE scores
- **EHR Dashboard Analytics:**
  Real-time gaps in care, quality metrics (e.g., A1C, screenings), risk stratification
- **Patient-Reported Outcomes (PREMs/PROMs):**
  Satisfaction, shared decision-making, functional status

Transforming Data into Actionable Care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE
RHODE ISLAND DEPARTMENT OF HEALTH

- **Team-Based Approach:**
  All members of healthcare team collaborate using shared data
- **Risk Stratification & Outreach:**
  Target high-risk populations (e.g., uncontrolled diabetes, missed screenings) for proactive intervention
- **Care Coordination:**
  Data-driven referrals to wraparound services (e.g., housing, behavioral health)
- **Continuous Quality Improvement:**
  Monitor trends, close disparities, and tailor interventions to vulnerable populations
- **Patient Engagement:**
  Use data to drive meaningful conversations around preferences, barriers, and goals

Conclusion

- Coordination and collaboration with other healthcare clinicians are key components of APC.
- Primary care clinicians must familiarize themselves with community resources.
- Familiarize yourself with formal and informal referral pathways used in your clinical setting.
- QI is important for organizations that want to improve the quality of their products, services, or outcomes. The PDSA model for rapid improvement is a frequently utilized repetitive process in healthcare.