



# Care delivery model work group meeting #3

Discussion document  
June 10, 2013

# Agenda

Review outcomes from last week's work  
group meeting and set context for  
population health model exercise *30 min*

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Discuss in large and small groups  
population health model elements and  
interventions *75 min*

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Assess outcomes from today's meeting  
and open questions *15 min*

# Today's points for review and decision-making

## Review



- Updated care delivery work group roadmap/ calendar
- Barriers to health identified in last work group meeting
- How population health model can overcome barriers
- Advanced care delivery efforts ongoing in Connecticut
- How other states/organizations have implemented interventions

## Align and finalize



- Elements of population health model for Connecticut
- Prioritized list of interventions (behaviors/processes, structures)



# The care delivery work group will address the following questions

■ Today's discussion

## Care delivery model work group recommendation

### Focus of efforts

- Who are the target populations?
- What are the key sources of value to address?
- What barriers need to be overcome?

### Model design

- What interventions and changes in behaviors/ processes, and structures are required to capture sources of value?
- What roles will need to be fulfilled to implement these interventions?
- What entities are optimally positioned to fulfill these roles and which will be primary?

### Implementation plan

- What are the implications for:
  - Payment model
  - Data/ analytics
  - Workforce
  - Policy
- How will the care delivery model be phased?



# The care delivery work group process will span the next six weeks with analysis and prep work in between

## Workshop title

## Description

**June 10:**  
Interventions to eliminate barriers

- Define elements of a population health model
- Define interventions against each element that will address barriers to high-quality, efficient care in CT

**June 17:** Required roles

- Define roles and responsibilities required to conduct interventions in the new care delivery model
- Identify who could play these roles across payers, providers and community

**June 24:** Defining workforce needs

- Discuss how entities involved in health delivery can work together
- Review workforce capacity and capabilities against needs of new care delivery and payment model
- Discuss tools and other enablers required to support individuals in new delivery model

**July 8:** Defining tools and enablers

- Define how tools and enablers will be developed and/or promoted for future development
- Discuss strategy for meeting workforce capacity and capability needs

**July 22:**  
Implementing the care delivery model

- Align on care delivery implementation plan with phasing, including plan to support provider transition
- Align on communication plan

## **We will jointly align on a set of interventions to promote as part of Connecticut's population-health model using the following approach:**

- Review elements of a population health model that can begin to address barriers identified during our last work group meeting
- Populate elements of the model with interventions recommended by various bodies (e.g., accreditation bodies)
- Adjust/modify interventions in small groups, leveraging best practice examples from in-state and across the country
- Discuss the roles required to implement these interventions and the entities best positioned to fulfill them in the next work group meeting



# The barriers we identified in our last work group meeting (1 of 2) . . .

## Barriers

### 1 Lack of whole-person-centered care and population health management

- Lack of understanding of whole-person context (social, cultural, behavioral)
- Limited access to whole-person data at point of care to promote more accurate diagnosis and treatment planning
- Lack of infrastructure to risk-stratify consumers and prevent disease onset in high-risk consumers

### 2 Restricted access to appropriate care

- Limited capacity (e.g., limited time, inefficient use of time) of providers
- Lack of consumer access to appropriate care (e.g., primary, specialty, behavioral)
- Cost of treatment prevents adoption
- Limited availability of culturally/ linguistically accessible care

### 3 No team-based, coordinated, comprehensive approach to care

- No single point of accountability for consumer's total care
- Limited incentives for provider for admission, transfer, and discharge planning
- Suboptimal or no triage process to direct consumers to right site of care
- Providers do not interact with the consumer's community
- Providers (e.g., specialists) have limited vision to own sphere of influence
- Limited use and multiple formats of HIT systems across providers and care settings lead to medical errors/ redundancies
- No comprehensive treatment plan developed for consumers
- Poor relationships and communication among providers



## The barriers we identified in our last work group meeting (2 of 2) . . .

### 4 Limited consumer engagement

#### Barriers

- Consumers lack incentives and are not enabled to be involved in self-diagnosis, self-care, and healthy behaviors
- Consumers are not aware of available health care resources
- Consumers do not understand educational materials
- Consumers do not have quality and cost data to inform decisions (e.g., visit highest value provider)
- Consumers have difficulty being compliant with treatment/rehab plans
- Wellness resources are not readily accessible by consumers
- Lack, or limited distribution, of health literacy (including screening education) programs
- Policies and funding not in place to promote healthy behaviors
- Limited communication channels/processes among consumer and other providers involved in care

### 5 Insufficient use of evidence-informed clinical decision making

- Best clinical practices not standardized
- Limited health IT infrastructure to support clinical decision making
- FFS reimbursement rewards overtreatment

### 6 Inadequate performance management

- Limited quality and cost transparency data
- Multiple formats of information systems



## ... can be addressed by implementing the core components of a population health model (1 of 2)

### Description

#### 1 Whole-person-centered care and population health management

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to stratify consumer population and **identify high-risk consumers** for early interventions

#### 2 Enhanced access to care (structural and cultural)

- Provide consumers **access to culturally and linguistically appropriate routine/urgent care** and clinical and mental health advice **during and after office hours**
- Provide care to consumers that is **accessible in-person or remotely** (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)
- Improve **financially accessibility** of care (e.g., minimal co-pays)<sup>1</sup>

#### 3 Team-based, coordinated, comprehensive care

- Leverage **multi-disciplinary teams** and enhanced **data sharing** to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and **successful care transitions** across care settings and care disciplines (e.g., medical, social, behavioral)

<sup>1</sup> Specific interventions to improve financially accessibility will be determined on a payer by payer basis



## ... can be addressed by implementing the core components of a population health model (2 of 2)

### Description

#### 4 Consumer engagement<sup>1</sup>

- Appropriately **educate and encourage consumers** to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to **follow-through on care plans**, and administer self-care as needed

#### 5 Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of **evidenced-based care** reflecting clinical outcomes and cost-effectiveness

#### 6 Performance management

- Collect, integrate, and **disseminate data for care management and performance reporting** on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to **improve and compare performance** with other providers

<sup>1</sup> Specific consumer-incentives will be a payer-specific decision to be defined by each participating payer for their population



# There are a number of national population-health model accreditation programs and legislation that pre-define interventions

	Description
1 <b>Accreditation Association for Ambulatory Health Care (AAHC)</b>	<ul style="list-style-type: none"> <li>A private, non-profit organization which develops standards (including one for a PCMH) to advance and promote patient safety, quality care, and value for ambulatory health care through peer-based accreditation processes, education, and research</li> </ul>
2 <b>Affordable Care Act (ACA)</b>	<ul style="list-style-type: none"> <li>Outline of how community health teams can support the patient centered medical home in Section 3502 of the 2010 Affordable Care Act (ACA)</li> </ul>
3 <b>CT Public Health Committee</b>	<ul style="list-style-type: none"> <li>Act proposed by Connecticut's Public Health Committee in 2011 to give Sustinet authority to encourage use of patient-centered medical care for Sustinet members and define services offered by a PCMH provider, while also accepting ACA definition for PCMH</li> </ul>
4 <b>Joint Commission</b>	<ul style="list-style-type: none"> <li>Regulations used to accredit and certify more than 20,000 health care organizations and programs in the United States and offer guidelines for PCMH accreditation</li> </ul>
5 <b>National Committee for Quality Assurance (NCQA)</b>	<ul style="list-style-type: none"> <li>PCMH guidelines, jointly developed by 4 physician groups, defined by National Committee for Quality Assurance: a private, not-for-profit organization dedicated to improving health care quality</li> </ul>
6 <b>URAC</b>	<ul style="list-style-type: none"> <li>Regulations used for accreditation, education and measurement programs by URAC, an independent, global, nonprofit that promotes health care quality</li> <li>URAC's PCHCH (patient centered health care home program) ranges from voluntary education and self-assessment to comprehensive on-site validation</li> </ul>

SOURCE: Respective organizations' websites

# We will refine the interventions proposed by these agencies based on an understanding of population-health models we have in CT today ...



- Cigna built its collaborative accountable care program on the foundation of the principles of patient-centered medical homes
  - The program has a strong focus on high-risk individuals, including people with chronic health conditions such as diabetes or heart disease
  - Program includes registered nurse clinical care coordinators at physician practices aligned to Cigna case managers
- Cigna has 66 collaborative care programs in place across the country, 3 of which are in Connecticut (ProHealth, Day Kimball Healthcare, New Haven Community Medical Group)



- Anthem's Patient Centered Primary Care program assigns providers accountability for quality and for the total cost of care (typically upside only)
  - The program establishes metrics for physicians, hot spotter (consumers with chronic diseases) lists for care management, population risk scores and risk-adjusted budgets
  - Anthem supports practice transformation (e.g., learning collaboratives for sharing of best practices)
- Anthem plans to encompass 30-40% of their primary care providers in the program this year



- In 2011, the OSC initiated a state-funded Patient Centered Medical Home (PCMH) pilot
- In 2012, DSS established PCMHs for its HUSKY Health Program and Charter Oak Plan
- ProHealth is a primary provider for both initiatives
- The pilot included four areas of special intervention:
  - Formal protocols for transitioning consumers across sites of care
  - Improved access to primary care services within LTC facilities
  - Intensive care management services for at-risk consumers (multiple chronic conditions)
  - Expanded access to care through Extended Hour Facilities in each major service area for either scheduled or walk-in care



## ... as well as additional peer-state interventions we think could be effective and applicable to CT's goals (1 of 2)

### Bangor Beacon ACO



- Received grants from both the Office of the National Coordinator for Health Information Technology (ONC) and Center for Medicare and Medicaid Innovation (CMMI) to promote cost-effective care through care coordination, consumer self-management, and the use of health information technology

### CareOregon



- A non-profit health plan serving Medicaid and Medicare recipients in Oregon, developed two programs to improve the quality of care they deliver
  - CareSupport provides tiered, centralized case management for high risk groups
  - Primary Care Renewal provides a PCP-centered delivery model for the general population

### CareFirst BCBS



- A large, non-profit health insurer covering the mid-Atlantic region of Maryland, DC and Northern Virginia
- Introduced Patient-Centered Medical Home (PCMH) model to all of its members, particularly focused on consumers with multiple or complex long term conditions and those at risk of long term conditions

### Colorado Children's Healthcare Access Program



- Initiative, started in 2006, led by Colorado state government working with Denver Health, pediatric practices and other stakeholders
- The goal of the program is to maximize the number of Medicaid-eligible children in Colorado connected to a medical home with better access, quality, continuity and coordination of care

### CareMore



- A Medicare Advantage plan (acquired by WellPoint in 2011) as well as medical group (operates 26 care centers across CA, AZ, and NV)
- Provides nurse-led, tiered and coordinated care at centralized sites supported by 'extensivist' physicians in hospitals

### ChenMed



- A family-owned private primary care provider franchise based in Florida consisting of 13 health centers
- Targets low-to-middle income Medicare Advantage consumers with complex chronic disease needs
- Aims to reduce hospitalizations through high-quality, high-intensity, easy-to-access primary care with multiple services under one roof



## ... as well as additional peer-state interventions we think could be effective and applicable to CT's goals (2 of 2)

### Geisinger



- Geisinger Health System (integrated system) serves rural, central and NE Pennsylvania
- Geisinger has its own health insurance plan but also serves Medicare, Medicare Advantage and third party plans
- Created PCP centered medical home

### New York Care Coordination Program



- NYCCP is a not-for-profit collaborative project initiated in 2000 by 6 NY counties and NY Office for Mental Health
- Aim was to transform the care for Medicaid consumers with SMI (serious mental illness) to provide consumer-centered, recovery-focused, evidence-based care, and complex case management for those with highest risks/needs

### HealthSpring – Leon Medical Center



#### Leon Medical Center

- HealthSpring (Medicare Advantage coordinated care plan acquired by Cigna in 2012) and Leon Medical Center (Medicare only medical clinic in Miami-Dade County) entered into a partnership in October of 2007
- Worked to improve care of seniors by leveraging care coordination (emphasis on creating sense of community) and effective reimbursement model

## We will discuss in groups which interventions should be prioritized

### **BREAKOUT EXERCISE INSTRUCTIONS**

- **Group discussion:** Discuss overarching considerations and approach to defining Connecticut's population health model interventions (*5 min*)
- **Breakout:** Breakout into 3 groups to prioritize interventions against elements of the model (**2 per group**) (*35 min*)
  - Review outlined interventions of population health model (informed by accreditation agencies/ organizations)
  - Add interventions based on case examples and brainstorming
  - Prioritize critical list of interventions
- **Group debrief:** Each group to report out synthesis for full team discussion (*35 min*)
  - Share your overall thoughts on the assigned population health elements
  - Discuss which critical interventions should be included in Connecticut's population health model and why (e.g., which best support SHIP's vision to integrate primary care, behavioral health, population health, consumer engagement and community support)

# BREAKOUT GROUP: Whole person centered care and population health management – interventions

## 1 Whole-person-centered care and population health management

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to **identify high risk consumers**

### Behaviors/processes

- The practice identifies consumers with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
- The practice identifies vulnerable consumer populations
- The practice assesses and documents consumer risk factors
- The practice assesses consumer/family self-management abilities
- The practice assesses and provides or arranges for mental health/substance abuse treatment
- The practice gives referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups
- The practice uses strategies to address stresses that arise in the workplace, home, school etc.

### Structures

- The practice has the capability to collect demographic and clinical data for population management

# BREAKOUT GROUP: Enhanced access to care (structural and cultural) – interventions

2

## Enhanced access to care (structural and cultural)

- Provide consumers **access to culturally and linguistically appropriate routine/urgent care** and clinical and mental health advice **during and after office hours**
- Care should be **accessible in-person or remotely** (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

### Behaviors/processes

### Structures

- The practice provides consumers with access to culturally and linguistically appropriate (e.g., translation services) routine/urgent care and clinical advice during and after office hours (e.g., readily accessible 24-hour consultative services by telephone or quickly scheduled office appointments)
- The practice provides electronic access to data (e.g., consumers can receive a secure electronic copy of their health information, consumers and their families can correspond over email with providers, consumers can set up appointments online)

# BREAKOUT GROUP: Team-based, coordinated, comprehensive care – interventions

3

## Team-based, coordinated, comprehensive care

- Leverage multi-disciplinary teams and enhanced **data sharing** to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and **successful care transitions** across care settings and care disciplines (e.g., medical, social, behavioral)

### Behaviors/processes

- The practice focuses on team-based care with trained staff
- The practice coordinates and provide access to preventive, health promotion, and complementary and alternative services
- The practice emphasizes pre-visit planning, assessing consumer progress toward treatment goals, and addressing consumer barriers
- The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
- The practice provides discharge planning and counseling to consumers and their caregivers
- The practice reconciles consumer medications at visits and post-hospitalization

### Structures

- The practice uses e-prescribing (e.g., generates consumer specific alerts at site of care, including drug-drug interactions, informs clinicians of generic alternatives when appropriate)

4

## Consumer engagement

- Appropriately **educate and encourage consumers** to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to **follow-through on care plans**, and administer self-care as needed

### Behaviors/processes

- The practice works with consumers/families to develop a self-care plan and provides tools and resources, including community resources
- The practice clinicians counsel consumers on healthy behaviors
- The practice works to set and accomplish goals related to exercise, nutrition, use of tobacco, and sleep
- The practice advises consumers with chronic health conditions on methods to monitor and manage their own conditions
- The practice ensures consumers/caregivers are educated and actively engaged in their rights, roles and responsibilities in the shared decision-making process

### Structures

- The practice has a mechanism in place to engage consumers/care givers

# BREAKOUT GROUP: Evidence-informed clinical decision making – interventions

5

## Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of **evidence-based care** reflecting clinical outcomes and cost-effectiveness

### Behaviors/processes

- The practice adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines
- The practice has policies in place to assign and implement interventions for clinical condition based on clinical or evidence-based guidelines
- The practice ensures medication orders are clear and accurate

### Structures

6

## Performance management

- Collect, integrate, and **disseminate data for care management and performance reporting** on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to **improve and compare performance** with other providers

### Behaviors/processes

- The practice participates in external benchmarking activities that compare key performance measures with other similar organizations, or with recognized best practices
- The practice tracks utilization measures such as rates of hospitalizations and ER visits
- The practice uses performance and consumer experience data to continuously improve
- The organization demonstrates that ongoing improvement is occurring by conducting quality improvement studies
- The practice assess and monitors consumers/caregivers' capability and confidence in effectively performing self-care responsibilities

### Structures

- The organization has a current and comprehensive written quality management and improvement program
- The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records

# 1 Whole-person-centered care and population health management

Relevant interventions	Behavior/ process	Struc- ture
	<ul style="list-style-type: none"> <li>▪ Social worker provides community-based care management oversees psychiatric and clinical care and manages access to social resources</li> <li>▪ Team focuses on both clinical (e.g., diabetes, asthma) and non-clinical areas (e.g., disparity and safety)</li> </ul>	✓
	<ul style="list-style-type: none"> <li>▪ CareFirst assigns individual consumers an illness burden score using a diagnostic cost grouper and aggregates them into cohorts with different care management plans</li> <li>▪ CareFirst provides primary care workforce with training in behavior modification techniques</li> </ul>	✓ ✓
	<ul style="list-style-type: none"> <li>▪ A home team visits consumers in their own homes to understand issues affecting health and provides wrap-around support</li> <li>▪ Social services SWAT team - physicians, social workers, case managers, behavioral health professionals - supports the consumer/family in accessing needed social services, e.g. financial assistance, Medicaid coverage for board and care, and with overcoming other challenges</li> </ul>	✓ ✓
	<ul style="list-style-type: none"> <li>▪ CareOregon supports tiered, centralized case management targeted at the highest risk groups (3% of members responsible for 29% of spend) whatever their needs; deliberately not disease-specific</li> <li>▪ The care team, which includes a social worker and/or behavioral health manager, coordinates community resources</li> </ul>	✓ ✓
	<ul style="list-style-type: none"> <li>▪ CCHAP negotiated a long term commitment from community organizations to support primary care practices</li> <li>▪ CCHAP considers mental health and social services (e.g., developmental/behavioral, housing, nutrition, cultural, family support part of care it delivers)</li> </ul>	✓ ✓
	<ul style="list-style-type: none"> <li>▪ Healthy living centers attract consumers and increase their physical activity with recreational classes such as Latin Dance and staffed physical trainers</li> </ul>	✓
	<ul style="list-style-type: none"> <li>▪ NYCCP focuses on rehabilitation, recovery and cultural competency for consumers with serious mental illness (SMI) and addresses a broad range of determinants of mental health (e.g., engagement in gainful activity)</li> </ul>	✓

## 2 Enhanced access to care (structural and cultural)

	Relevant interventions	Behavior/ process	Structure
	<ul style="list-style-type: none"> <li>Network of technology-supported nurse care managers expands reach of primary care</li> <li>Technology improves access to care - remote monitoring technology tracks consumers after discharge from hospital, texts support mental health consumers, and tele-monitors give providers visibility to consumers' health status and compliance (e.g., through automated medication dispensers)</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>CareFirst removes cost barriers to primary care with no co-payments or deductibles to primary care services including screening, preventative health services and medicines for the management of long term conditions</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>CareMore offers free transportation for consumers to visit clinics</li> <li>CareMore delivers multi-disciplinary disease management programs at convenient one-stop-shop care centers</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>Care team assists consumers with Medicaid enrollment and eligibility issues</li> <li>CCHAP trains community stakeholders and provides ideas for improving local care delivery</li> <li>CCHAP provides cross-cultural communications training for practices that request it</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> </ul>	
	<ul style="list-style-type: none"> <li>ChenMed offers most services under one roof including primary care, outpatient care, diagnostics, dental care, pharmacy and complementary medicine including acupuncture</li> <li>ChenMed offers consumers free transportation to/from the health center to encourage attendance</li> <li>ChenMed sets up its medical centers to look/feel like a quiet emergency room (ER) with rapid access for unscheduled appointments to reduce consumer ER utilization</li> <li>ChenMed offers its consumers high-frequency consultations</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>Two Geisinger sites offer twenty-four-hour access to care services (enhanced through the use of nurse care coordinators, care management support, and home-based monitoring)</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>HealthSpring/Leon Medical Center offers complimentary transportation to encourage regular clinic visits for preventative care</li> <li>Care coordinators in medical center lobby direct and accompany consumers to appropriate care setting</li> <li>Medication delivered to consumers' homes improves likelihood of prescription compliance and at home specialist visits encourage appointment adherence</li> <li>Telephone contact enables consumer education, medication monitoring, and follow-ups</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>

### 3 Team-based, coordinated, comprehensive care

	Relevant interventions	Behavior/ process	Structure
	<ul style="list-style-type: none"> <li>Nurse care managers design care plans and coordinate care</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>PCPs create care plans for all consumers with multiple long term conditions and some at risk of long term conditions using tailored templates (e.g., for diabetes, asthma, chronic heart failure)</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>Nurse Practitioners lead clinics and are responsible for case management</li> <li>Extensivists based in hospitals focus on avoiding admissions, readmissions and managing transitions</li> <li>CareMore centers are part of a network of partner hospitals, outpatient centers, laboratories, dental practices, optometrists, skilled nursing facilities and urgent care centers</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>Care team is composed of a PCP, medical assistant, care manager, behavioral health practitioner, and team assistant (admin)</li> <li>Specialized teams manage transitional care (e.g., post-childbirth care)</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>Care coordinators coordinate necessary mental health and social services (e.g., developmental/behavioral, housing, nutrition, cultural, family support)</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>Care coordination teams use task-shifting to leverage trained, but “unqualified”, health assistants for routine clinical tasks such as blood pressure monitoring</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>Team of doctors, nurses, care managers, social workers and pharmacists oversee care</li> <li>Technology platform is synced between clinic reception, primary care practice, exam room, and in community settings such as urgent care centers and pharmacies</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>✓</li> </ul>
	<ul style="list-style-type: none"> <li>Each consumer is assigned to a primary care physician and care coordinator, consumers with complex needs are assigned to behavioral and psychiatric health practitioners</li> </ul>		✓

# 4 Consumer engagement

**Relevant interventions**

**Behavior/  
process**    **Struc-  
ture**



- In-clinic consumer education, at home consultations, and encouraged self-management ensure continuous consumer engagement



- Consumers receive incentives – reduced co-payments or deductibles – for enrolling in a Medical Home, complying with their care plan and following risk mitigation guidance



CAREMORE  
It's what we do™

- Remote monitoring technology (e.g. twice daily blood pressure readings for hypertension; daily weighing for chronic heart failure) empower consumer to participate in care



- Motivational coaching helps consumers define goals and empowers them to assess and address their own needs



- Care coordinator contacts the consumer and his/her family within 24 hours of being assigned to discuss referral reasons and conduct basic assessment



- CCHAP connects the consumer and his/her family to a local outreach worker



- Consumers access their electronic health records (EHR) to view lab results, schedule appointments, receive reminders, and e-mail providers directly



- Consumer education and ongoing support from care coordinators and social workers enable consumer self-management



- Clinics offer recreational and socializing opportunities to encourage consumer engagement in health



NYCCP

- NYCCP holds local community meetings for consumers and their family members



- Peer navigator makes connections to social and medical services and serves as a role model



# 5 Evidence-informed clinical decision making

## Relevant interventions

Behavior/  
process    Struc-  
ture



- Beacon focuses on applying evidence based medicine and reducing variability, particularly for diabetes, cardiovascular care, asthma, mental health, and immunizations



- Pre-formatted care plan templates help promote shared best practice in care planning design



CAREMORE  
It's what we do™

- CareMore utilizes clinically-proven pathways to downgrade and discharge consumer correctly and quickly



- Disease management programs prescribe steps that the data system and electronic medical records (EMR) prompt the Nurse Practitioners to execute



- CCHAP provides primary care practices with standardized screening tools



- Several best practice reminders are automated (e.g., immunization invites)



- Technology is used to support design of evidence based care plans and to ensure physicians have real-time, mobile access to consumer data



- A personal care navigator ensures consumers are receiving evidenced-based care



- Physicians and other clinical staff use portals to check the internet and the company's clinical resources at the site of care to provide consumers best practice care



# 6 Performance management

**Relevant interventions**

**Behavior/  
process**    **Struc-  
ture**



- PCPs share clinical performance data and office operational processes to establish regional target goals, standardize data, share best practices, improve performance and quality indicators



- CareFirst evaluates quality measurement and scoring along 5 dimensions: (1) engagement with consumers in need of Care Plans, (2) appropriate use of services (ER, admissions, readmissions, diagnostics), (3) effectiveness of care (HEDIS), (4) consumer access to primary care services, (5) structural capabilities



- Individual clinicians are rewarded for outcomes within their control: e.g. intensivists' bonus linked to ER admissions/readmission rates
- CareMore has developed their own in-house electronic medical record (EMR) system – QuickView – which integrates prescription, lab and utilization data to facilitate monitoring of activity, financial performance and clinical outcomes



- Clinical dashboards enable monitoring of utilization and quality at individual consumer level



- ChenMed views every ER attendance and unplanned hospitalization as a failure to be discussed in 3-times weekly case review meetings



- Geisinger provides monthly performance reports of quality and efficiency results to each medical home practice and ensures review by an integrated Geisinger Health Plan practice site team



NYCCP

- Care managers monitor consumer use of services weekly and conduct monthly reviews on consumer progress
- Tiered program of incentives rewards improvements in access to care, implementation of person-centered care practices, and recovery and community integration outcomes



# Care delivery work group: June 10 meeting areas of alignment and open questions

- Where did we land today on the specific interventions we want to implement as part of Connecticut's population health model?
  - *To be completed*
- What open questions do we need to address in the next work group meeting?
  - *To be completed*

**TO BE COMPLETED JOINTLY BY  
WORK GROUP**



## Next week, we will discuss options for Connecticut's end state care delivery model based on the entities best suited to fill roles required

PRELIMINARY

### Description

#### Advanced primary care

- Establish advanced primary care as base care delivery model
- Improve efficient, high-quality care via primary care providers driving volume to highest value specialist and acute center providers

#### Integrated delivery network

- Encourage integrated delivery networks as the base of the care delivery model, which likely includes advanced primary care
- Improve efficient, high-quality care from improved coordination/standardization of care and use of HIT and provider support tools

#### Advanced primary care then integrated delivery network

- First build advanced primary care foundation and over time encourage deeper integration with acute care settings and specialists (e.g., sub-contracting relationships)
- Improve efficient, high-quality care first due to optimized referrals then via improved coordination/standardization of care and use of HIT and provider support tools



- Begin brainstorming roles required to implement these interventions and which entities are best positioned to fill them
- Synthesize findings and prepare for next discussion on June 17<sup>th</sup>

# Appendix



## Details

### 1 Patient rights and responsibilities

- Patients are treated with respect, consideration and dignity
- Patients are provided appropriate privacy
- When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients
- Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons
- Information is available to patients and staff concerning
- Prior to receiving care, patients are informed of patient responsibilities
- Patients are informed of their right to change providers if other qualified providers are available

### 2 Governance

- The organization is a legally constituted entity, or an organized sub-unit of a legally constituted entity, or is a sole proprietorship in the state(s) in which it is located and provides services
- The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to
- Accredited organizations must notify AAAHC in writing within 15 calendar days of significant organizational, ownership, operational, or quality of care events, including criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) directly or indirectly involving the organization or any of its officers, administrators, physicians/health care professionals, or staff within their role in the organization. Any such change/event that negatively affects public perception of the accredited organization or AAAHC, as the accrediting body, must also be reported. An organization's duty to provide this information continues during the entire accreditation term
- Representation of accreditation to the public must accurately reflect the AAAHC-accredited entity
- The governing body meets at least annually, or more frequently as determined by the governing body, and keeps such minutes or other records as may be necessary for the orderly conduct of the organization
- If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined



## Details

### 3 Administration

- Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization
- Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization
- Health care workers are protected from biologic hazards, consistent with state, federal, and CDC guidelines. The organization has
  - A program is maintained to assess and reduce risks associated with occupational chemical exposures
  - A program is maintained to assess and, where necessary, reduce risks associated with physical hazards, such as ergonomic exposures, violence at the workplace, and external physical threats such as terrorism
- Records of work injuries and illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately
- The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken
- When students and postgraduate trainees are present, their status is defined in the organization's written policies and procedures

### 4 Quality of care provided

- All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization
- Health care professionals practice their professions in an ethical and legal manner
- All personnel assisting in the provision of health care services are appropriately qualified and supervised and are available in sufficient numbers for the care provided
- The organization has a current and comprehensive written quality management and improvement program
- The organization facilitates the provision of high-quality health care
- Health services available at the organization are accessible to patients and ensure patient safety



## Details

### 4 Quality of care provided (CONTINUED)

- The organization has policies and procedures for identifying, storing, and transporting laboratory specimens and biological products. The policies and procedures include logging and tracking to ensure that results for each specimen are obtained and have been reported to the ordering physician in a timely manner
- When the need arises, the organization assists patients with the transfer of their care from one health care professional to another
- When emergencies or unplanned outcomes occur, and hospitalization is indicated for the evaluation and stabilization of the patient, the organization shall have one of the following in place (see full document)
- Concern for the costs of care is present throughout the organization

### 5 Quality management and improvement

- The organization has a written quality improvement program for ensuring ongoing quality and improving performance when needed. The program is broad in scope in order to address clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients
- The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns
- The organization demonstrates that ongoing improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.B indicate that improvement is or may be warranted. Written descriptions of QI studies document that each study includes the following elements as applicable
- The organization participates in external benchmarking activities that compare key performance measures with other similar organizations, or with recognized best practices of national or professional targets or goals

### 6 Clinical records and health information

- The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records
- A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to
- An individual clinical record is established for each person receiving care
- Clinical record entries are legible and easily accessible within the record by the organization's personnel



## Details

### 6 Clinical records and health information (CONTINUED)

- If a patient has had three or more visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care
- The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified
- Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care
- Documentation regarding missed and canceled appointments must be added to the patient's clinical record
- Entries in a patient's clinical record for each visit include, but are not limited to (see full document)
- Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record, as required by the organization's policies
- Significant medical advice given to a patient by text, email, or telephone, including medical advice provided after-hours, is permanently entered in the patient's clinical record and appropriately signed or initialed
- Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care
- Discussions with the patient concerning the necessity, appropriateness, and risks of the proposed care, surgery, or procedure, as well as discussions of treatment alternatives, as applicable, are incorporated into the patient's clinical record
- The organization is responsible for ensuring a patient's continuity of care. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are shared
- Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. Patients are given the opportunity to approve or refuse release of records, except when release is permitted or required by law
- All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients
- Written policies concerning clinical records address, but are not limited to (see full document)



## Details

### 7 Infection prevention and control and safety

- The organization must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities
- The infection prevention and control program includes documentation that the organization has considered, selected, and implemented nationally-recognized infection control guidelines. The program is
- The infection control and prevention program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with
- The organization provides a functional and sanitary environment for the provision of services
- The organization adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to those related to the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants
- A written sharps injury prevention program must be present in the organization. Such a program will include (see full document)
- A safe environment for treating patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, supplies, and personnel
- Policies are in place for the isolation or immediate transfer of patients with a communicable disease
- Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques
- A written process is in place for the monitoring and documentation of the cleaning, high-level disinfection, and sterilization of medical equipment, accessories, instruments, and implants
- A written policy addresses the identification and processing of medical equipment and instruments that fail to meet high-level disinfection or sterilization parameters
- Sterile packs of equipment and instruments are handled and stored in a manner that maintains their sterility
- The organization's written policies address cleaning of patient treatment and care areas which, at a minimum, include
- Medical devices for use with multiple patients are cleaned and disinfected between patients, following the manufacturer's recommended guidelines or nationally recognized guidelines, whichever are more stringent



## Details

### 8 Facilities and environment

- The organization provides evidence of compliance with the following (see full document)
- The organization has the necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise
- The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment
- The organization conducts at least one drill each calendar quarter of the internal emergency and disaster preparedness plan.2 One of the drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan
- Smoking is prohibited within the facility
- Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are identified and addressed
- Provisions are made to reasonably accommodate disabled individuals
- Adequate lighting and ventilation are provided in all areas
- Facilities are clean and properly maintained.
- A system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes, whether solid, liquid, or gas
- The space allocated for a particular function or service is adequate for the activities performed therein
- Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site
- Policies and procedures regarding medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer's specifications
- Testing of fire alarm and inspection of fire suppression systems, including verification of signal transmission, are performed and documented
- When an organization undergoes demolition, construction, or renovation projects, the organization performs a proactive and ongoing risk assessment for existing or potential environmental hazards
- Ongoing temperature monitoring is performed for items that are frozen, refrigerated, and/or heated per product manufacturer's recommendations. Stated temperature ranges are readily available to staff performing the monitoring function



# SEC. 3502 of ACA outline for health teams which support PCMHs

## (1 of 3)

### Details

**1** Establish contractual agreements with PCPs

- N/A

**2** Support patient-centered medical homes

- Personal physicians
- Whole person orientation
- Coordinated and integrated care
- Safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements
- Expanded access to care
- Payment that recognizes added value from additional components of patient-centered care

**3** Coordinate care

- Collaborate with PCPs and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary

**4** Support primary care providers

- In collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary

**5** Incorporate stakeholders

- Incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight

# SEC. 3502 of ACA outline for health teams which support PCMHs



## (2 of 3)

### Details

#### 6 Support PCPs

- Coordinate and provide access to high-quality health care services
- Coordinate and provide access to preventive and health promotion services
- Provide access to appropriate specialty care and inpatient services
- Provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care
- Provide access to pharmacist-delivered medication management services, including medication reconciliation
- Provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services
- Promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services
- Provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners
- Collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement
- Establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary

#### 7 Manage care during transitions

- A transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting
- Discharge planning and counseling support to providers, patients, caregivers, and authorized representatives
- Assuring that post-discharge care plans include medication management, as appropriate
- Referrals for mental and behavioral health services, which may include the use of infolines
- Transitional health care needs from adolescence to adulthood

SOURCE: 2010. ACA. SEC. 3502. Establishing community health teams to support the patient-centered medical home

# SEC. 3502 ACA outline for health teams which support PCMHs



## (3 of 3)

### Details

#### 8 Serve as liaison

- Serve as a liaison to community prevention and treatment programs

#### 9 Leverage HIT

- Demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices

#### 10 Report

- Where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act

SOURCE: 2010. ACA. SEC. 3502. Establishing community health teams to support the patient-centered medical home

# CT public health committee introduced an act which defined PCMHs as including the following elements



## Description

### 1 Assisting plan members to safeguard and improve their own health

- Advising plan members with chronic health conditions of methods to monitor and manage their own conditions
- Working with plan members to set and accomplish goals related to exercise, nutrition, use of tobacco and other addictive substances, sleep and other behaviors that directly affect such member's health
- Implementing best practices to ensure that plan members understand medical instructions and are able to follow such directions
- Providing translation services and using culturally competent communication strategies in appropriate cases

### 2 Providing care coordination

- Managing transitions between home and the hospital
- Proactive monitoring that ensures that a plan member receives all recommended primary and preventive care services
- The provision of basic mental health care, including screening for depression, with referral relationships in place for those plan members who require additional assistance
- Strategies to address stresses that arise in the workplace, home, school and the community, including coordination with and referrals to available employee assistance programs
- Referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups
- For a plan member with complex health conditions that involve receiving care from multiple providers, ensuring that such providers share information about the plan member, as appropriate, and pursue a single, integrated treatment plan on behalf of the plan member

### 3 Providing access to care

- Providing readily accessible, 24-hour consultative services by telephone, secure electronic mail or quickly scheduled office appointments for purposes that include reducing the need for hospital emergency room visits

# The Joint Commission – 2011 Approved standards for Primary Care Medical Home Option – Ambulatory Care Accreditation Program



- Qualified individuals serve in the role of the primary care clinician
- Governance is ultimately accountable for the safety and quality of care, treatment, or services
- Leaders establish priorities for performance improvement
- Medication orders are clear and accurate
- The organization plans the patient's care
- The organization provides care, treatment, or services for each patient
- The organization effectively communicates with patients when providing care, treatment, or services
- The organization coordinates the patient's care, treatment, or services based on the patient's needs
- The organization provides patient education and training based on each patient's needs and abilities
- The patient has access to the organization 24 hours a day, 7 days a week
- The organization is accountable for providing patient care
- The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services
- The organization collects data to monitor its performance
- The organization improves performance
- The organization maintains complete and accurate clinical records
- The clinical record contains information that reflects the patient's care, treatment, or services
- The organization respects the patient's right to receive information in a manner he or she understands
- The organization respects the patient's right to participate in decisions about his or her care, treatment, or services
- The organization provides patients with information about the functions and services of the primary care medical home



# NCQA 2011 guidelines for PCMH

## Description

1

### Enhance Access/ Continuity

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- The practice provides electronic access
- Patients may select a clinician
- The focus is on team-based care with trained staff

2

### Identify/Manage Patient Populations

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

3

### Plan/Manage Care

- The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
- Care management emphasizes
  - Pre-visit planning
  - Assessing patient progress toward treatment goals
  - Addressing patient barriers to treatment goals
- The practice reconciles patient medications at visits and post-hospitalization
- The practice uses e-prescribing

4

### Provide Self- Care Support/ Community Resources

- The practice assesses patient/family self-management abilities
- The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
- Practice clinicians counsel patients on healthy behaviors
- The practice assesses and provides or arranges for mental health/substance abuse treatment

5

### Track/ Coordinate Care

- The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
- The practice follows up with discharged patients

6

### Measure/Improve Performance

- The practice uses performance and patient experience data to continuously improve
- The practice tracks utilization measures such as rates of hospitalizations and ER visits
- The practice identifies vulnerable patient populations
- The practice demonstrates improved performance

# URAC 2010 Patient Centered Health Care Home Practice Standards



(1/6)

## Details

### 1 Core Quality Care Management

- The Practice establishes ongoing training programs and initial orientation, which is documented and includes the following, if applicable: (a) Approach to patient engagement and shared decision-making; (b) Team member roles and responsibilities; (c) PCHCH culture and provision of courteous customer service in a culturally-appropriate manner; (d) Confidentiality and proper handling of individually identifiable health information; (e) Ethical training that includes prohibition of discrimination; (f) Maintenance of professional competency; and (g) Standards of the PCHCH that have been implemented.
- PCHCH ensures patients/caregivers are educated and actively engaged in their rights, roles and responsibilities in the shared decision-making process, and are provided with: (a) Consumer friendly, culturally/linguistically appropriate, educational information on their condition(s) and health care needs, as well as educational decision aids; and (b) Information about how to be actively engaged in their care.
- The PCHCH implements written policies and/or documented procedures to provide information that: (a) Conforms to the literacy levels of the patients, as practicable; (b) Helps patients be aware of what effect a health care decision may have for their daily lives; and (c) Presents and delivers information in a way that is appropriate to the diversity of the patient population, including: (i) Literacy levels; (ii) Language differences; (iii) Cultural differences; and (iv) Cognitive and/or physical impairments.
- Upon enrollment of a patient, the Practice conveys information on rights and responsibilities to patients including: (a) The right to know about philosophy and characteristics of the Practice; (b) The right to have personal health information shared with the Practice only in accordance with state and federal law; (c) The right to identify the staff member of the Practice and their job title, and to speak with a supervisor of the staff member if requested; (d) The right to receive current information from the Practice; (e) The right to decline, revoke consent or disenroll at any point in time from the PCHCH; (f) The responsibility to submit any forms that are necessary, to the extent required by law; (g) The responsibility to give accurate clinical and contact information and to notify the Practice of changes in this information; and (h) The responsibility to notify their treating clinician(s) of their participation in the PCHCH, if applicable.

### 2 Patient-Centered Operations Management

- The Practice has a mechanism in place to: (a) Engage patients/care giver in the PCHCH: (i) Concept; (ii) Advantages; and (iii) Patient and team roles/responsibilities; and (b) Provide patient communication tools.
- The Practice establishes patient-clinician partnership agreements that: (a) Ensure the patient/caregiver is able to verbalize their understanding of the patient-clinician agreement prior to executing the patient-clinician agreement; and (b) The agreements are implemented and documented in the patient's health record

# URAC 2010 Patient Centered Health Care Home Practice Standards



(2/6)

## Details

### 3 Access and Communications

- The Practice has a process to ensure that patients: (a) Have access to timely appointments with appropriate clinician(s); (b) Have access to referrals with appropriate specialist(s), if applicable; (c) Receive clearly specified hours of office operation and location(s); (d) Receive instructions about what to do in an emergency; and (e) How to access after hour-services, non-emergency, and urgent care needs
- The Practice uses the following processes to ensure a higher level of patient access and continuity of care by including: (a) A process for patient/caregiver to select a personal clinician or team, if applicable; (b) Maintains a record of the patient /caregiver's choice of clinician/team in the health record; (c) Uses standing orders for routine medication refills, tests, wellness/preventive services; (d) Documents clinical advice in the patient health records; (e) Provides a copy of health information upon request; (f) Provides care plan summaries for patient/caregiver at each office visit; and (g) Monitors proportion of patient visits that occur with assigned clinician/team
- The Practice establishes and: (a) Provides information to patients about community services and resources; (b) Maintains an updated list of community services and resources; and (c) Obtains input from patients and PCHCH team members for the community services and resources

### 4 Testing and Referrals

- The Practice has a documented process in place to manage all tests and imaging ordered that includes: (a) Establishing time frame for receiving results; (b) Flagging overdue results; (c) Flagging abnormal results, as well as duplicate results; (d) Establishing time frame for notifying patients of results; (e) Following-up with patients regarding abnormal results; (f) A mechanism in place for patients to receive information for normal results; and (g) Ensuring all test results are recorded in the health record
- The Practice has an established process to: (a) Identify patients who need a referral; (b) Coordinate referrals; (c) Ensure referrals are made to specialists and/or appropriate programs; and (d) Involve patients in selecting the clinician(s).
- The Practice employs the following mechanisms to track and follow-up on referrals to clinicians outside the Practice: (a) Provides the patient and/or caregiver and referral clinician with the reason for the consultation and pertinent clinical findings; (b) Tracks referrals electronically (preferably) and determines if and when the patient was seen by the specialist; (c) Documents the referral dates in the health record; (d) Conducts follow-up to obtain a report from the referral clinician; and (e) Contacts patient for follow-up if necessary based upon report from specialist

# URAC 2010 Patient Centered Health Care Home Practice Standards



(3/6)

## Details

- The Practice is proactive in promoting wellness and preventive care, which includes: (a) Use of health assessment tools; and (b) Educational information about lifestyle changes and risk factors
- The Practice has standing wellness and preventive services order protocols and ensure: (a) All patients receive appropriate wellness and preventive care information about: (i) Personal health lifestyle behaviors; and (ii) Reducing risk of disease and injury; (b) All patients receive appropriate well care visits and preventive screenings; and (c) Practice care team members are allowed to authorize and deliver preventive services according to clinician-approved protocols without examination by a clinician
- Practice conducts a baseline comprehensive health risk assessment for all patients to help identify health risks and needs as a foundation for establishing an individualized plan of care
- The Practice provides information and/or materials about wellness and health promotion to its patients, which: (a) Are evidence-based; (b) Inform and educate patient/caregiver about how the wellness services works; (c) Describe the benefits, the potential outcomes, and the interventions associated with the wellness program; (d) Are accessible and available to patients through multiple formats; and (e) Supports patient advocacy and empowerment
- The Practice sends reminders to appropriate patients: (a) For relevant preventive care; (b) Who did not schedule appropriate care within a specified timeframe, and (c) Who were previously contacted by a PCHCH team member
- The Practice addresses all of the following planning and follow-up stages of a patient's care, including pre-visit, during visit, and between visit follow-up: (a) Conducts pre-visit planning; (b) Develops an individualized care plan including treatment goals in collaboration with patients and caregivers that addresses patient's comprehensive care needs; (c) Incorporates evidence-based guidelines in the patient's care plan, as available; (d) Reviews care plan and assesses progress toward treatment goals at each visit; (e) Offers the patient a clinical summary of the visit and if accepted, provides a copy to the patient, at each office visit; (f) Assesses and arranges or provides treatment for behavioral health and substance abuse problems; (g) Follows up with patients when they have not kept appointments; (h) Follows up with patients when they have not followed through on referrals for diagnostic, therapeutic, or consultative services; and (i) Follows up with patients between visits as needed based upon identified clinical condition and health goals

## Care Management and Co-ordination

5



### Details

- The Practice establishes and implements policies and procedures to promote patient decision-making which specify: (a) The information the Practice will make available to support clinical decision-making of patients; (b) The decision support tools and materials it will make available to the patient; and (c) The process for engaging patients in decisions regarding the PCHCH program
- The Practice has implemented a documented procedure to: (a) Perform medication review at each patient's visit by a clinician(s); (b) Identify types of patient events that are eligible for a medication reconciliation by a clinician at select visits; and (c) Determine when clinically-equivalent generic substitutions can be recommended giving due consideration to cost and patients' benefits design
- The Practice communicates and coordinates care with a multi-disciplinary team to ensure: (a) Ongoing relationships; (b) Notification of treatments; (c) Collaborative plan of action for transfers between hospitals, facilities, and other acute or subacute care setting for patients; (d) Emergency room visits; and (e) Systematic tracking of care coordination activities
- The Practice has a process in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for all patients who are transitioning to and from various locations and/or levels of care, starting with the hospital
- The Practice has the following processes in place with local health care facilities to help ensure smooth transitions in care for its patients. The processes address the ability to: (a) Identify patients with an unplanned hospital admission or emergency department visit; (b) Transmit a patient's clinical information to a hospital or emergency department in a timely fashion; (c) Make contact with patients having unplanned hospital admissions or emergency department visits within reasonable time frames after being notified (as defined in PCHCH's policies); (d) Establish formal care agreements with hospitalists who provide care to PCHCH patients; and (e) Ensure hospitalizations and emergency department visits are documented in the patient's health record.
- The Practice has policies in place to assign and implement interventions for clinical condition based on clinical or evidence-based guidelines, where: (a) Rates of provision (implementation of guidelines) for services are tracked and compared to clinical guidelines; (b) Practice identifies gaps in care and takes appropriate action; and (c) Practice takes corrective measures, where indicated
- The Practice assesses and monitors a patient's/caregiver(s)' capability and confidence in effectively performing self-care responsibilities
- Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients

### Care Management and Co-ordination

5



(5/6)

## Details

- If the Practice has a bidirectional electronic communication portal, it provides the ability for patients to: (a) Create a personal health record; (b) View electronic health records; and (c) View test results, if applicable
- The Practice electronic communication portal allows: (a) Clinician to receive notification for patient's self-reported data with indications of potential health risk; (b) Clinician to send communication to patients that includes wellness care reminders and patient educational information; and (c) Patient and clinician to interact via electronic visits (e-visits)
- The Practice maintains written policies and documented procedures for implementation and maintenance of its electronic communications portal, which: (a) Address confidentiality, privacy and security; and (b) Are reviewed annually and updated as needed
- The Practice's electronic communications portal may be Practice-operated or vendor-based; however, either way the Practice must evaluate the portal's features and conduct a risk assessment prior to purchasing and implementing an electronic communications portal
- The Practice employs an electronic prescribing system that has the following capabilities: (a) Integrates with the electronic patient registry and/or health records; (b) Connects at least two (2) pharmacies and if possible, pharmacy benefit managers; (c) Receives renewal requests electronically; (d) Generates patient-specific alerts at the point-of-care, including drug-drug interactions, drug disease interactions, and drug-allergy alerts; (e) Informs clinician of generic alternatives when appropriate; and (f) Provides clinician with patient-specific formulary coverage information if available from the health plan.
- The Practice electronic health record includes Patient's: (a) Medical history; (b) Medication list; (c) Problem list; (d) Clinical notes; and (e) Viewable test and results
- The Practice advanced electronic health record integrates systems to: (a) Order diagnostic tests; (b) Request electronic prescriptions; (c) View digital images of ordered radiology tests; (d) Flag abnormal test results; (e) Remind clinicians of appropriate guidelines and wellness screenings; (f) Coordinate care; and (g) Include all elements in EHR-Basic Electronic Health Record Function.

6

## Advanced Electronic Capabilities



(6/6)

## Details

### Quality Performance Reporting and Improvement

7

- The Practice has the resources and mechanisms in place to produce and report on a periodic basis on:  
(a) Patients identified as having high prevalence and/or high-risk conditions; and (b) Non-high prevalence and/or high-risk conditions, if applicable

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- The Practice has a process in place to validate its performance data and ensure it accurately reflects the information

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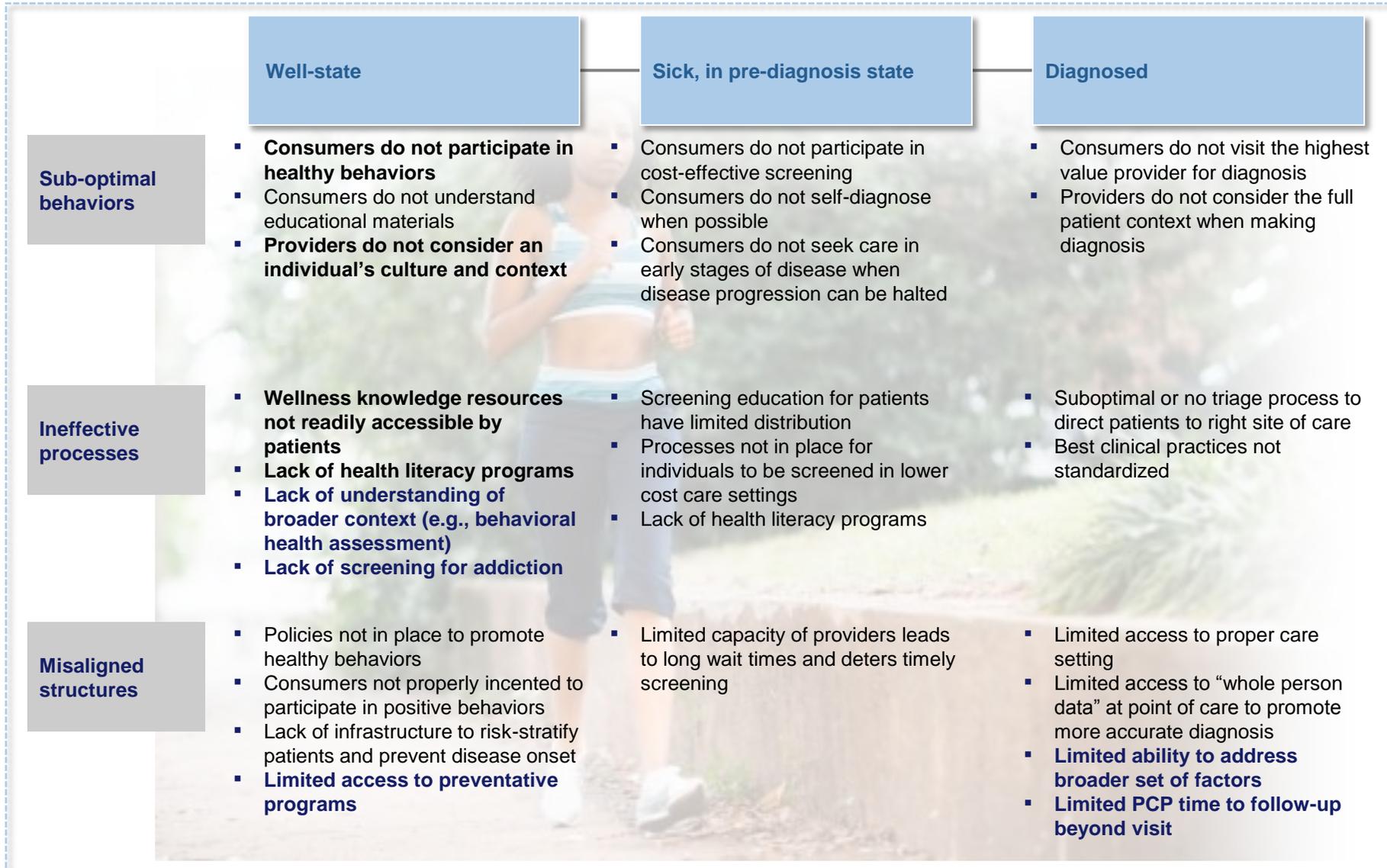
- The Practice's performance reports address: (a) All patients that received primary wellness/preventive services; (b) All patients that received secondary wellness/preventive services; (c) All patients identified as having a high-risk/high-prevalence chronic condition; (d) All patients who agreed to participate in the PCHCH program; (e) Services provided by specialists; and (f) Services provided by diagnostic testing facilities, hospitals, and other health care clinicians or providers

# Output Care Delivery Work Group #2: Barriers across the stages of health prior to treatment



abc Highlighted in break-out

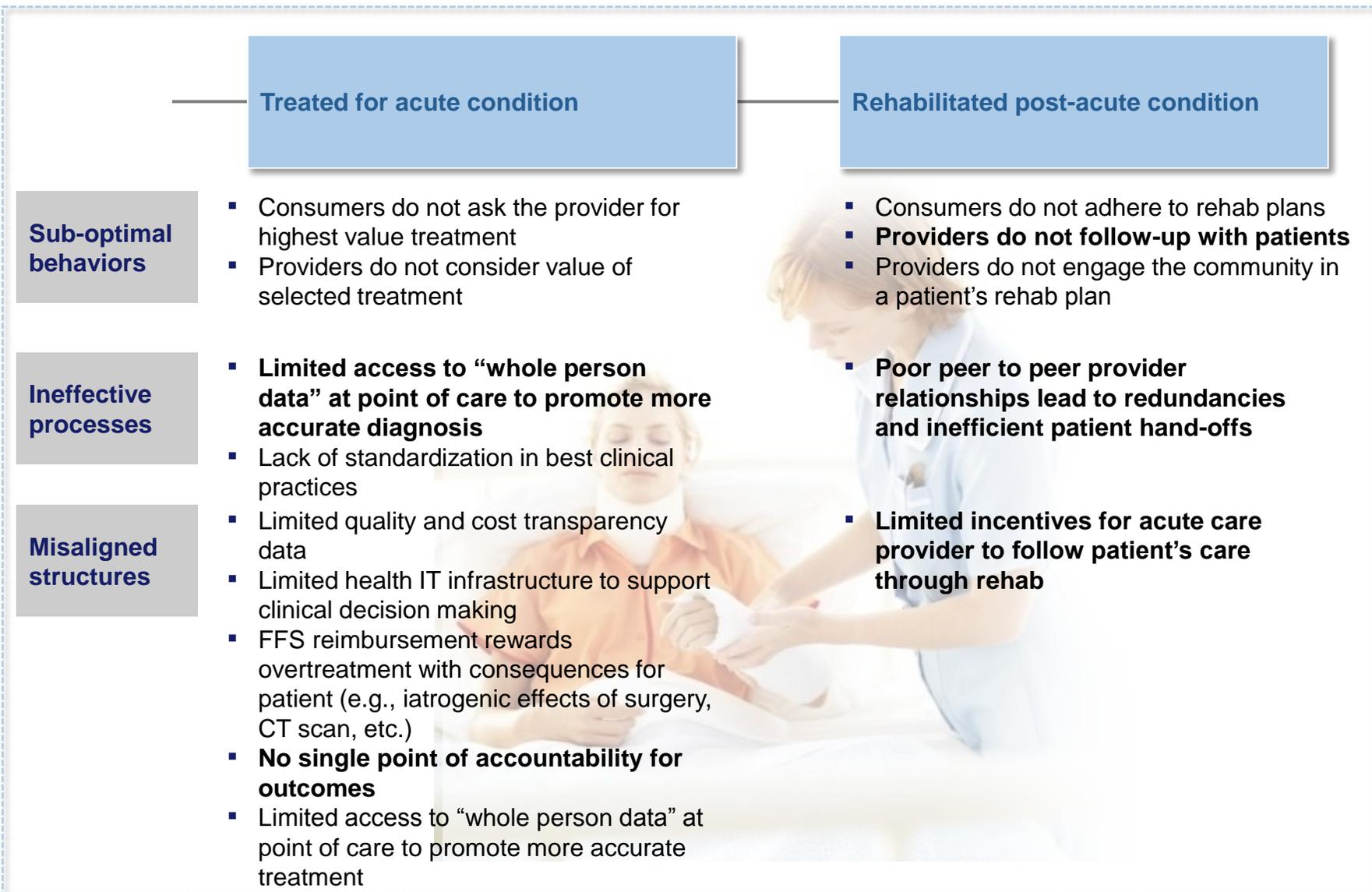
abc Added in break-out



# Output Care Delivery Work Group #2: Barriers across the stages of health during treatment of acute conditions



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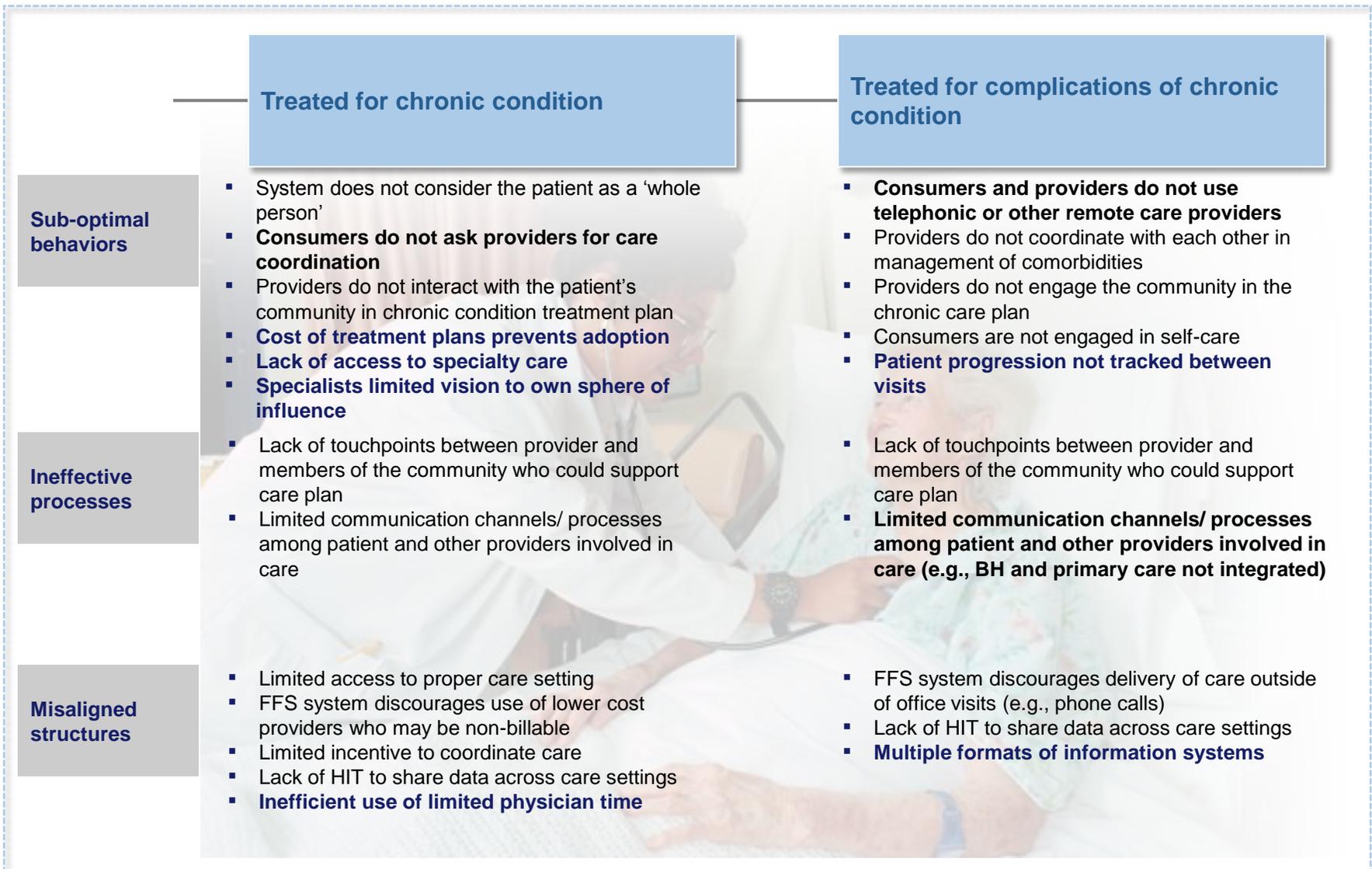


# Output Care Delivery Work Group #2: Barriers across the stages of health during treatment of chronic conditions



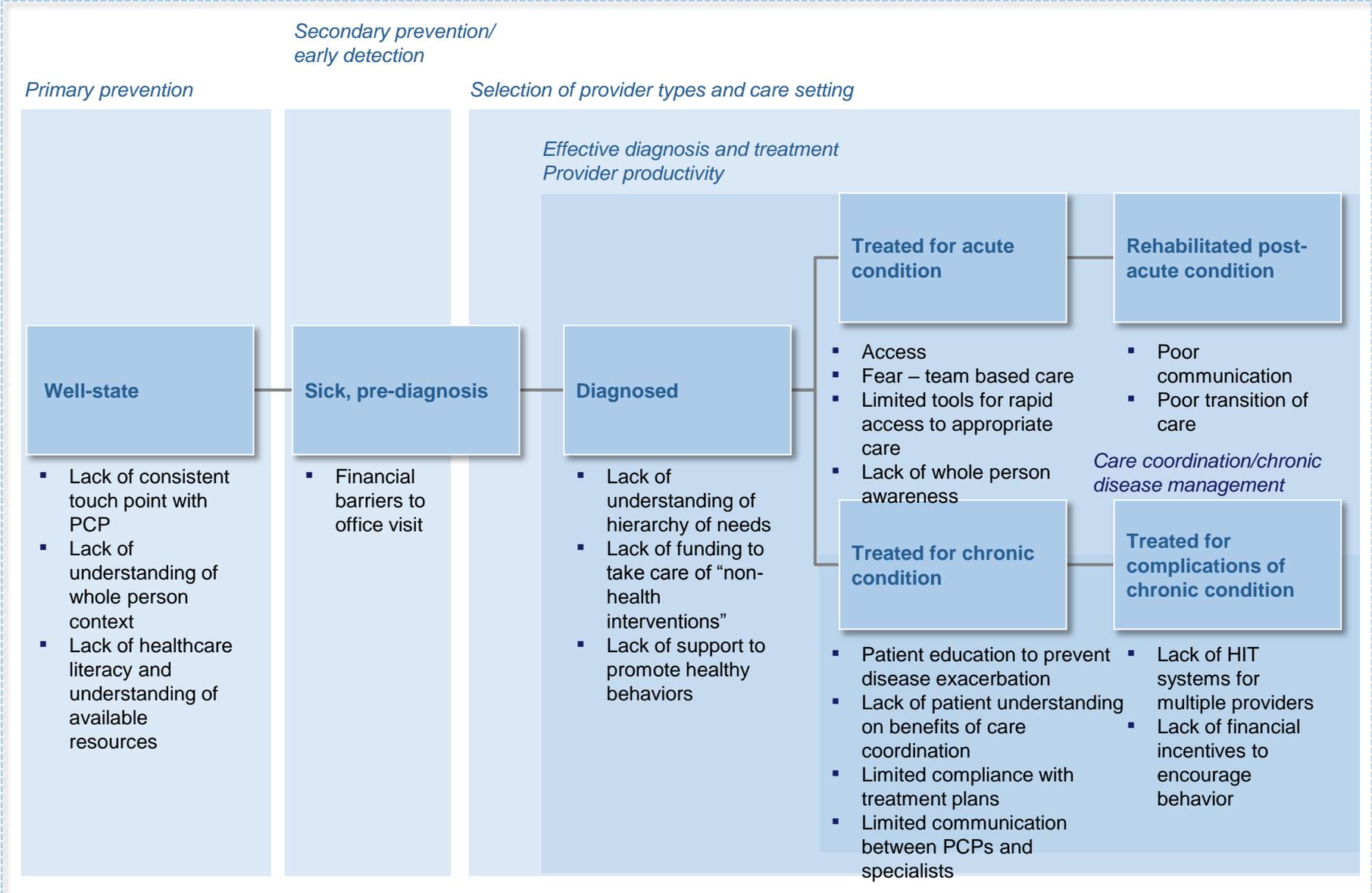
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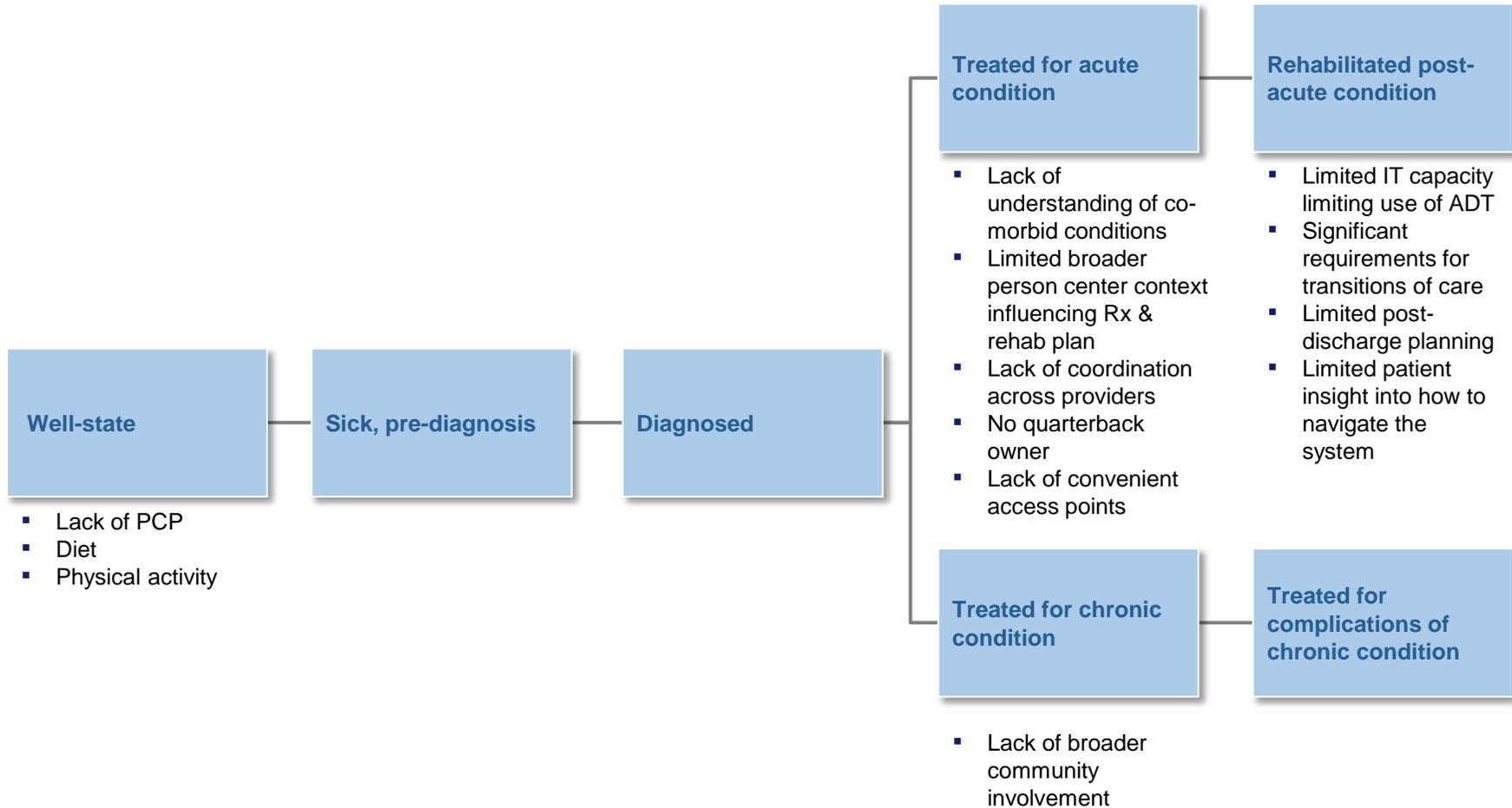


# Output Care Delivery Work Group #2: Sources of value along the stages of health





# Output Care Delivery Work Group #2: Sources of value along the stages of health





# Elements of the population health model elements promote capture of the sources of value

	Whole person centered care and population health management	Enhanced access to care (structural and cultural)	Team-based, coordinated, comprehensive care	Consumer engagement	Evidence-informed clinical decision making	Performance management
Primary prevention (general population)						
Primary prevention (pregnant women/newborns)						
Secondary prevention/ early detection						
Selection of provider types and care setting						
Effective diagnosis and treatment selection						
Provider productivity						
Care coordination/ chronic disease						