



# Care delivery model work group meeting #5

Discussion document  
June 24, 2013

# Agenda

Review prioritized interventions and roles identified in last week's break out groups *10 min*

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Review landscape of select roles in Connecticut *20 min*

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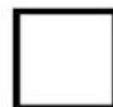
Define criteria, if any, for entities to participate in new care model *80 min*

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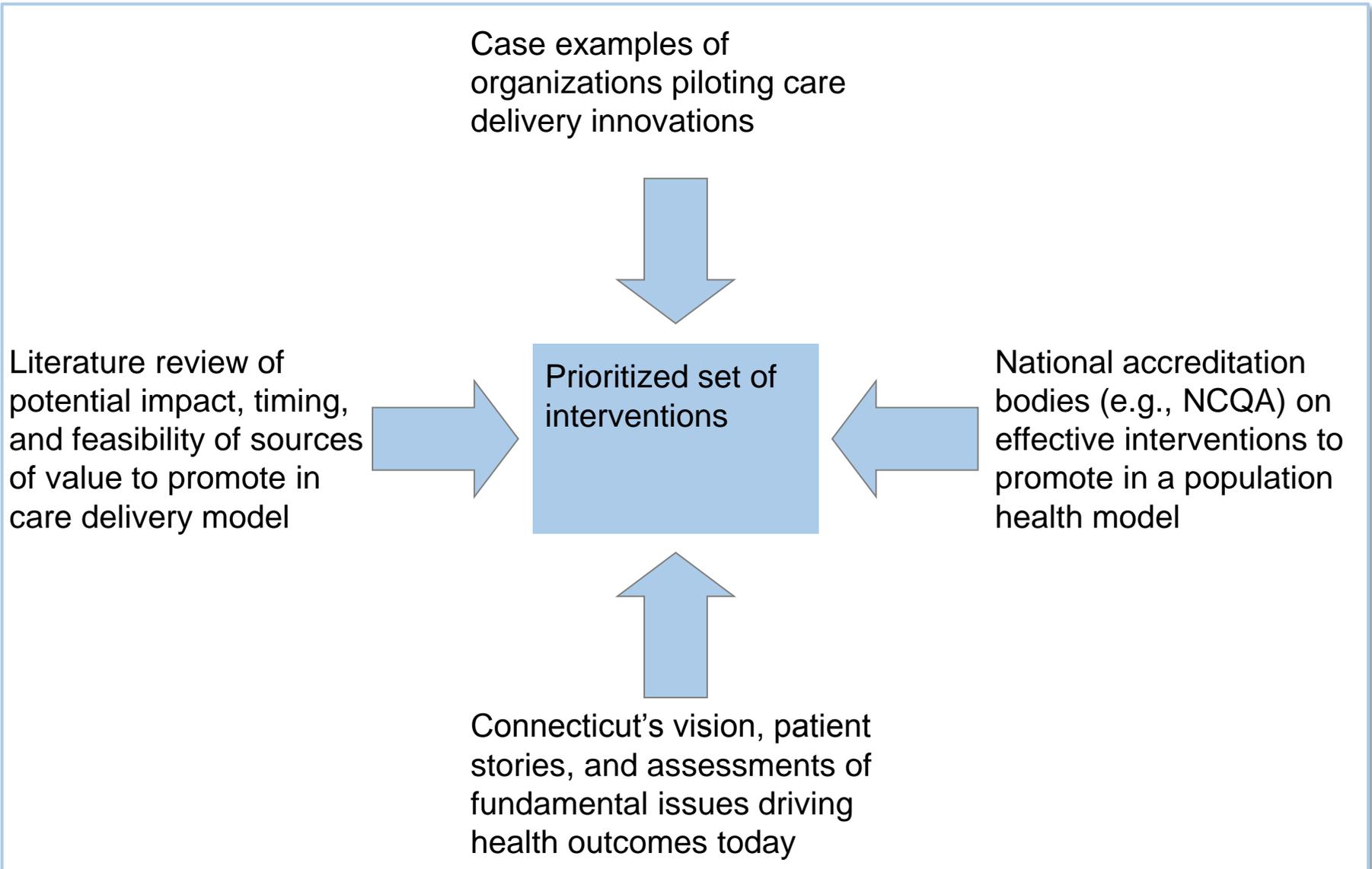
Assess outcomes from today's meeting and outline open questions *10 min*

## Today we will align on outstanding decisions for Connecticut's care delivery model

- Align on what, if any, guidance to provide around care team structure and composition
- Decide whether we will pre-qualify entities to participate in the new care delivery model
- If we decide to pre-qualify, establish criteria to do so



## We have used several inputs over the past 4 work group meetings to arrive at prioritized interventions within a “medical home plus” model



# Last week we prioritized the most critical interventions along each element of the model (1 of 2)

## Prioritized interventions<sup>1</sup>

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

- Identify consumers with high-risk or complex care needs
- Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors<sup>2</sup>, behavioral health and other co-occurring conditions, and ability to self-manage care

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

- Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers
- Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours)

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

- Provide team-based care from a prepared, proactive team
- Integrate behavioral and primary care with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)<sup>3</sup>
- Develop and execute against a whole-person-centered treatment plan<sup>4</sup>
- Coordinate across all elements of a consumer’s care<sup>3,4</sup>

1 Refined with care delivery break out group representatives

2 Including history of trauma, housing instability, access to preventive oral health services

3 See appendix for full list of interventions (e.g., intensive case management)

4 Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

# Last week we prioritized the most critical interventions along each element of the model (2 of 2)

## 4 Consumer engagement

### Prioritized interventions<sup>1</sup>

- Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice<sup>2</sup>
- Use person centered care planning methods to develop and support implementation of self-management care plan<sup>2</sup>
- Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal

## 5 Evidence-informed clinical decision making

- Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice – ensure data is actionable and timely
- Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression)
- Maintain disease registry
- Implement evidence-based guidelines<sup>3</sup>

## 6 Performance management

- Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks
- Use performance and consumer experience data to continuously improve whole person centeredness
- Establish learning collaboratives to disseminate best practices

1 Refined with care delivery break out group representatives

2 See appendix for full list of interventions (e.g., “choosing wisely” campaign)

3 Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

# We identified a range of individuals involved in a consumer's care

## Care providers raised in break-out groups

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### Primary care

- Home care nurse or aide
  - PCP advanced practice registered nurse (APRN)
  - PCP nurse
  - Primary care medical assistant
  - Primary care physician
  - Primary care physician assistant
- 

### Specialist care

- Mental health and substance abuse counselor
  - Psychiatric APRN
  - Psychiatric nurse
  - Psychiatrist
  - Psychologist
- 

### Social/ community care

- Agency representative (e.g., addiction support)
  - Church leader/volunteer
  - Community health worker (CHW)
  - Licensed clinical social worker (LCSW)
  - Licensed family therapist (LFT)
  - Social worker
- 

### Other

- Customer outreach representative at health payor
- Data analyst
- Employer
- Front desk receptionist
- Personal care attendant
- Pharmacist

# UConn Health Center (UCHC) and the Area Health Education Center (AHEC) will provide context on several of these roles in Connecticut



## Topics for discussion

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- Comparison of health worker supply in CT vs. nationally
- Distribution of primary care physicians across Connecticut counties
- Supply and projected demand for critical primary care and behavioral health providers in state



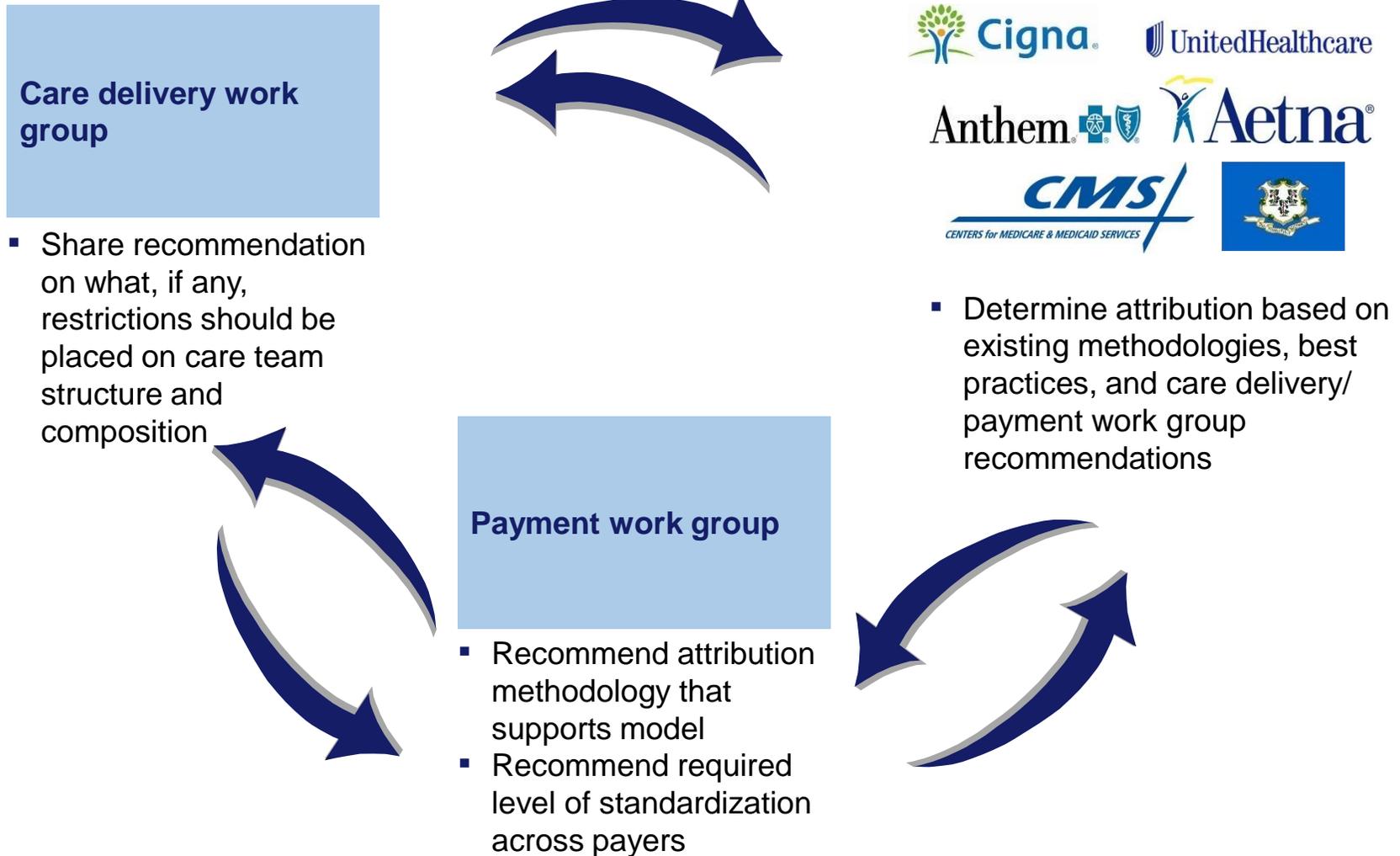
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- Role of community health workers (CHWs) in Connecticut
  - Business case for CHWs including calculated return on investment (ROI)

# The advanced practices we profiled include a range of caretakers on their care teams, though the majority place a primary care clinician at the core

	Care team core	Care team
	Primary care physician	Mental health, home health services and inpatient care management teams
	Primary care physician	Community based care team
	Nurse practitioner	Case manager; social services SWAT team made up of physicians, social workers, case managers, behavioral health professionals; home care team
	Primary care physician	Nurse case manager, social worker, behavioral health manager; specialized teams for transitional care, emergency post-partum, neonatal intensive care
	Pediatrician or family practice PCP	Care coordinator, nurse administrator
	Primary care physician or specialist (typically cardiologist, orthopedist, or oncologist)	Care coordinator; diagnostics, dental care, pharmacy and complementary medicine including acupuncture offered on site
	Primary care physician	Care coordinator
	Primary care physician	Nurses, case managers, social workers, and pharmacists
	Primary care physician	Care coordinator for all, dedicated behavioral health specialist for complex case management

SOURCE: Organization's websites and literature review

# Attribution will be defined by individual payers and the payment work group, with input from our work group



# Setting aside attribution accountability, what guidance do we want to provide on care team structure and composition?

## STRAWMAN

- Recommend that care teams have a set of "core providers" who provide primary care (e.g., PCPs, APRNs)
- Provide no other limitations on structure or exact composition of the care team, e.g.,
  - The entity can define a structure for itself, as long as it is capable of fulfilling the responsibilities of our population health model (interventions on pgs. 4 and 5)
  - Specialists, behavioral health providers<sup>1</sup>, and physician extenders can be included on the care team as the entity deems necessary
  - “Leader” of the care team can be selected by each entity; leadership may be fluid and vary with consumer's health needs



<sup>1</sup> If not part of care team, at minimum a close working relationship will be required

# Do we want to establish criteria to pre-qualify entities to participate in our new care delivery model?

VOTING EXERCISE

Options	Supporting considerations
<b>1 Yes</b>	<ul style="list-style-type: none"><li>▪ Predominant choice across other states (e.g., Oregon, Massachusetts)</li><li>▪ Support directed (e.g., testing grant funding) to practices which are committed and best positioned to take advantage of them</li><li>▪ Desired changes communicated tangibly</li><li>▪ Payers can focus on tracking and rewarding a select number of practices</li></ul>
<b>2 No</b>	<ul style="list-style-type: none"><li>▪ Few examples</li><li>▪ Participation encouraged from wider range of practices</li><li>▪ Even if provider participates, may need to meet performance metrics to be eligible for payment</li></ul>

# If yes, what criteria will we use to pre-qualify entities to take part?

VOTING EXERCISE

Options	Considerations	Examples
<p><b>1</b> PCMH certification by established accreditation body</p>	<ul style="list-style-type: none"> <li>▪ PCMH certification may not be truly indicative of advanced care delivery</li> <li>▪ Well known by providers, and achieved by several already</li> <li>▪ Potentially onerous for providers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Vermont’s multi-payer Blueprint for Health uses NCQA standards to determine practice eligibility</li> <li>▪ Maine’s Aligning Forces for Quality (AF4Q) uses NCQA standards to certify primary care practices</li> </ul>
<p><b>2</b> PCMH certification by established accreditation body plus select CT specific interventions/guidelines</p>	<ul style="list-style-type: none"> <li>▪ As above</li> <li>▪ May place additional burden on providers as well as state entity to certify</li> <li>▪ More tailored to CT’s goals and needs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Massachusetts’ Medicaid Primary Care Payment Reform Initiative requires participants to achieve NCQA certification and additional criteria of behavioral health integration and medical home transformation</li> </ul>
<p><b>3</b> CT specific criteria (e.g., self-reported and validated with audits or claims based process metrics)</p>	<ul style="list-style-type: none"> <li>▪ More tailored to CT’s goals and needs</li> <li>▪ May place additional burden on state entity/ payors to certify</li> <li>▪ Can be designed in “less onerous” method for providers if relies largely on claims/ shorter set of self-reported criteria</li> </ul>	<ul style="list-style-type: none"> <li>▪ Oregon uses own standards to determine if practices are considered a Patient-Centered Primary Care Home (overseen by advisory committee)                             <ul style="list-style-type: none"> <li>– If practice is a NCQA accredited PCMH, it only needs to fill out subset of application<sup>1</sup></li> </ul> </li> </ul>
<p><b>4</b> Other</p>		

SOURCE: State government websites and SIM testing grant applications

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

# There are four major Patient Centered Home accreditation bodies nationally; NCQA is most widely used in CT with 20% of practices certified

	<u>Description</u>
<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>
<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>
<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>
<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

# The interventions we prioritized last week are captured at some level by NCQA patient centered medical home guidelines (1 of 3)

-  Fully captured
-  Partially captured
-  Not captured

EXAMPLE MAPPING<sup>3</sup>

	Prioritized interventions <sup>1</sup>	Covered by NCQA
1	Whole-person-centered care and population health management	
	<ul style="list-style-type: none"> <li>▪ Identify consumers with high-risk or complex care needs </li> <li>▪ Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors<sup>2</sup>, behavioral health and other co-occurring conditions, and ability to self-manage care </li> </ul>	
2	Enhanced access to care (structural and cultural)	
	<ul style="list-style-type: none"> <li>▪ Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication </li> <li>▪ Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers </li> <li>▪ Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours) </li> </ul>	

1 Refined with care delivery break out group representatives

2 Including history of trauma, housing instability, access to preventive oral health services

3 A similar exercise could be performed for other accreditation body guidelines

# The interventions we prioritized last week are captured at some level by NCQA patient centered medical home guidelines (2 of 3)

-  Fully captured
-  Partially captured
-  Not captured

EXAMPLE MAPPING<sup>4</sup>

Prioritized interventions <sup>1</sup>	Covered by NCQA
<p><b>3</b> Team-based, coordinated, comprehensive care</p>	<ul style="list-style-type: none"> <li>▪ Provide team-based care from a prepared, proactive team </li> <li>▪ Integrate behavioral and primary care with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)<sup>2</sup> </li> <li>▪ Coordinate across all elements of a consumer’s care<sup>2,3</sup> </li> <li>▪ Develop and execute against a whole-person-centered treatment plan<sup>3</sup> </li> </ul>
<p><b>4</b> Consumer engagement</p>	<ul style="list-style-type: none"> <li>▪ Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice (e.g., Choosing Wisely)<sup>2</sup> </li> <li>▪ Use person centered care planning methods to develop and support implementation of self-management care plan<sup>2</sup> </li> <li>▪ Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a consumer health care portal </li> </ul>

<sup>1</sup> Refined with care delivery break out group representatives <sup>2</sup> See appendix for full list of interventions

<sup>3</sup> Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

<sup>4</sup> A similar exercise could be performed for other accreditation body guidelines

# The interventions we prioritized last week are captured at some level by NCQA patient centered medical home guidelines (3 of 3)

-  Fully captured
-  Partially captured
-  Not captured

EXAMPLE MAPPING<sup>3</sup>

Prioritized interventions <sup>1</sup>	Covered by NCQA
<div data-bbox="116 424 491 637" style="background-color: #ADD8E6; padding: 10px; display: inline-block; vertical-align: top;"> <p><b>5</b> Evidence-informed clinical decision making</p> </div> <ul style="list-style-type: none"> <li data-bbox="508 431 1435 468">▪ Implement evidence-based guidelines<sup>2</sup> </li> <li data-bbox="508 510 1435 616">▪ Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice – ensure data is actionable and timely </li> <li data-bbox="508 637 1435 707">▪ Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression) </li> <li data-bbox="508 742 1435 777">▪ Maintain disease registry </li> </ul>	
<div data-bbox="116 844 491 1057" style="background-color: #ADD8E6; padding: 10px; display: inline-block; vertical-align: top;"> <p><b>6</b> Performance management</p> </div> <ul style="list-style-type: none"> <li data-bbox="508 854 1435 958">▪ Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks </li> <li data-bbox="508 1000 1435 1071">▪ Use performance and consumer experience data to continuously improve whole person centeredness </li> <li data-bbox="508 1127 1435 1162">▪ Establish learning collaboratives to disseminate best practices </li> </ul>	

1 Refined with care delivery break out group representatives

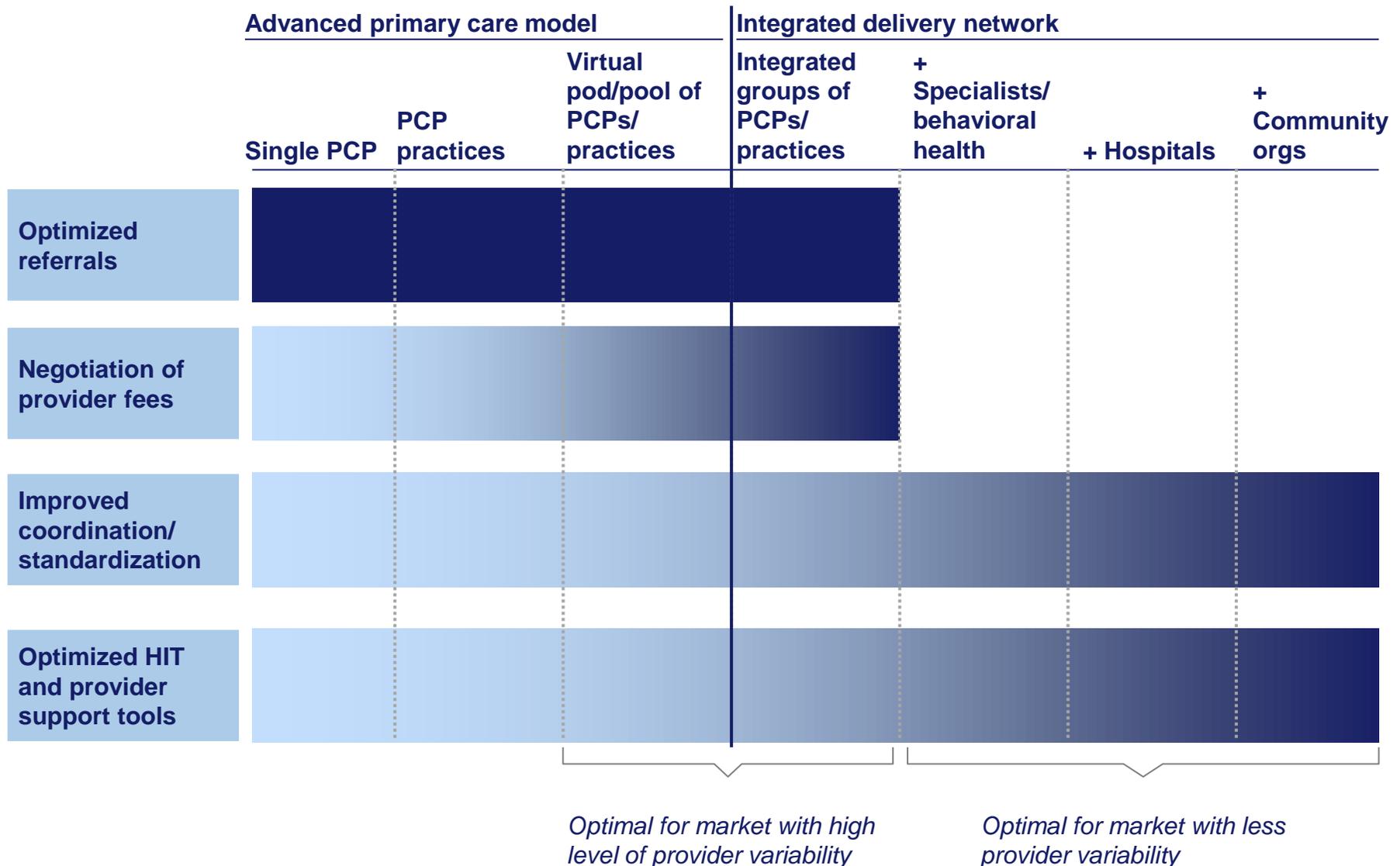
2 Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

3 A similar exercise could be performed for other accreditation body guidelines

# As long as entities have lead provider and meet pre-qualification criteria we outlined, we are not prescriptive about required levels of integration

	Advanced primary care model			Integrated delivery network			
	Single PCP	PCP practices	Virtual pod/pool of PCPs/practices	Integrated groups of PCPs/practices	+ Specialists/behavioral health	+ Hospitals	+ Community orgs
Clinical integration							
Shared infrastructure (e.g., HIT)	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Focus of HIT work group</div>						
Financial integration (ability to bear risk, scope of accountability)	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Focus of payment work group</div>						

# Differences in level of clinical/financial integration and data sharing have implications on how care is delivered and total cost of care is optimized



- What guidance will we provide on the structure/composition of a care team?
  - *To be completed*
  
- Will we pre-qualify entities to participate in the new model, if so how?
  - *To be completed*
  
- What open questions do we need to address in our next work group meeting?
  - *To be completed*

**TO BE COMPLETED JOINTLY BY  
WORK GROUP**

# Appendix

# Output care delivery work group 4: Whole person centered care and population health management

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

### Prioritized interventions

- Identify consumers with high-risk or complex care needs
- Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors<sup>1</sup>, behavioral health and other co-occurring conditions, and ability to self-manage care

### Individuals delivering interventions & their interactions

- Primary care physician, Physician Assistant, Advanced Practice Nurse, Nurse, Medical Assistant, Pharmacist, Licensed Clinical Social Worker, Community Health Worker

<sup>1</sup> Including history of trauma, housing instability, access to preventive oral health services

# Output care delivery work group 4: Enhanced access to care (structural and cultural)

## 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)

### Prioritized interventions

- A** Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication
- B** Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers
- C** Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours)

### Individuals delivering interventions<sup>1</sup> & their interactions

- A** Improved access to primary care requires convenient, same day access, extended hours, and non-face to face communication between consumers and members of the primary care team. The team may include a primary care physician, nurse practitioner/APRN, nurse, behavioral health practitioner, and a care coordinator
  - Team needs to be big enough to ensure consumers have adequate access to their team
  - Each member of the team needs to be empowered to operate at the top of their license, matching appropriate person to each service provided (including workers within and outside care practice)
- B** Requires an eConsult platform: secure messaging, file attachments from EHR, exchanged between primary care providers and specialists
- C** Consumers should all have a PCP and a whole person centered primary care practice in the post-reform world of expanded coverage
  - Once consumers are in a practice, they will be directed to appropriate site of care
  - Payors and community health workers can play a role directing consumers to a PCP

<sup>1</sup> Focus on prioritized interventions

# Output care delivery work group 4: Team-based, coordinated, comprehensive care

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)

### Prioritized interventions

- Provide team-based care from a prepared, proactive team
- Coordinate across all elements of a consumer's care<sup>1</sup>
  - Coordinate care across all disciplines including sub-specialty, inpatient, oral health, behavioral health, and complementary medicine
  - Emphasize pre-visit planning to ensure all care needs are met
  - Assess consumer progress toward treatment goals and address consumer barriers
  - Use intensive case management across time and care settings for highest complexity consumers
  - Track, follow-up on and coordinate laboratory tests, diagnostic imaging, and specialty referrals
  - Provide post hospital discharge transition care management
  - Reconcile consumer meds at visits and post-hospitalization
  - Engage/coordinate with community resources and other non-medical services (e.g., housing, domestic violence resources) and other support groups (e.g., collaboratives) as appropriate
  - Ensure consumer adherence with medications, lifestyle changes, and other care plan goals
- Develop and execute against a whole-person-centered treatment plan<sup>1</sup>
- Integrate behavioral and primary care with “warm hands offs” between BH and primary care practitioners (on-site if possible)
  - Deliver care at sites of intervention conducive to consumers' environment (e.g., community centers) to be most effective
  - Leverage peer support for consumers with chronic conditions or behavioral health issues

### Individuals delivering interventions & their interactions

- Care is delivered by a primary care provider-led team including medical assistants, nurses, care coordinators, and primary care providers. The team uses data to manage the entire consumer panel and to conduct pre-visit planning
  - Certain consumers might benefit from care coordination based in a behavioral health practice
- The care coordinator is a critical part of the team, likely a nurse but could explore possibility of non-clinical person fulfilling role. The care coordinator engages with more complex consumers to help manage their care
- Behavioral health roles include "prescribers" (psychiatrists and psychiatric APRNs), and non-prescribers (licensed clinical social workers (LCSW), licensed family therapists, psychologists, others). Behavioral health and primary care are closely integrated either through co-location or enhanced communication and partnership

<sup>1</sup> Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

# Output care delivery work group 4: Consumer engagement

## 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

### Prioritized interventions

- A** Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice, enabled by:
  - A1** Use “Choosing wisely” campaign as a means to raise broad awareness; possibly other supplementary health education materials developed jointly by insurers
  - A2** Use “Choosing wisely” campaign and other treatment option information provided at the point of care
  - A3** Ensure provision of quality and cost information when consumer chooses treatment type, setting and provider
- B** Use whole person centered care planning methods to develop and support implementation of self-management care plan<sup>2</sup>
  - Ensure self-management care plan takes into consideration individual strengths, co-morbidities, risk factors, individual and cultural factors (e.g., health literacy, English as a second language, cultural norms, cognitive limitations), and barriers to adherence (e.g., stigma, transportation)
- C** Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal

### Individuals delivering interventions & their interactions

- A1** Employers, churches, other community org, and insurers<sup>1</sup>
- A2** Primary care and specialty MD, APRN, RN, physician’s assistant, at the point of care, and medical assistant, community health worker in health care settings.<sup>2</sup>
- A3** Primary care and specialty MD, APRN, RN, physician’s assistant, medical assistant, community health worker
- B** Direct care providers within the practice including primary care MD, APRN, RN, physician assistant, medical assistant, licensed behavioral health clinician; home care nurses, aides, personal care attendants; care coordinator; and community health workers, employers

<sup>1</sup> May be accomplished in part through a sponsored media campaign

<sup>2</sup> Consider education strategy designed to engage consumers from the moment they walk in the door

# Output care delivery work group 4: Evidence-informed clinical decision making

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

### Prioritized interventions

- Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression)
- Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice – ensure data is actionable and timely
- Maintain disease registry
- Implement evidence-based guidelines<sup>1</sup>

### Individuals delivering interventions & their interactions

- Full primary care office staff (e.g., primary care physician, nurse, front desk staff) and a data analyst or back office support (for predictive modeling) involved<sup>2</sup>
- Community health workers help target high risk, high spend populations who do not engage with primary care practice

<sup>1</sup> Added or edited after syndication with break out groups to reflect interventions fundamental to element of model

<sup>2</sup> Open question as to whether staff would be based in practice or be part of administrative arm of larger system

# Output care delivery work group 4: Performance management

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

### Prioritized interventions

- Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks<sup>1</sup>
- Use performance and consumer experience data to continuously improve whole person centeredness
- Establish learning collaboratives to disseminate best practices

### Individuals delivering interventions & their interactions

- Physician leader of practice or designee responsible for tracking utilization measures, using data<sup>2</sup> to improve and establishing learning collaboratives

<sup>1</sup> Requires ability for provider to dispute outcomes

<sup>2</sup> Methodology on obtaining consumer data to be determined

# 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

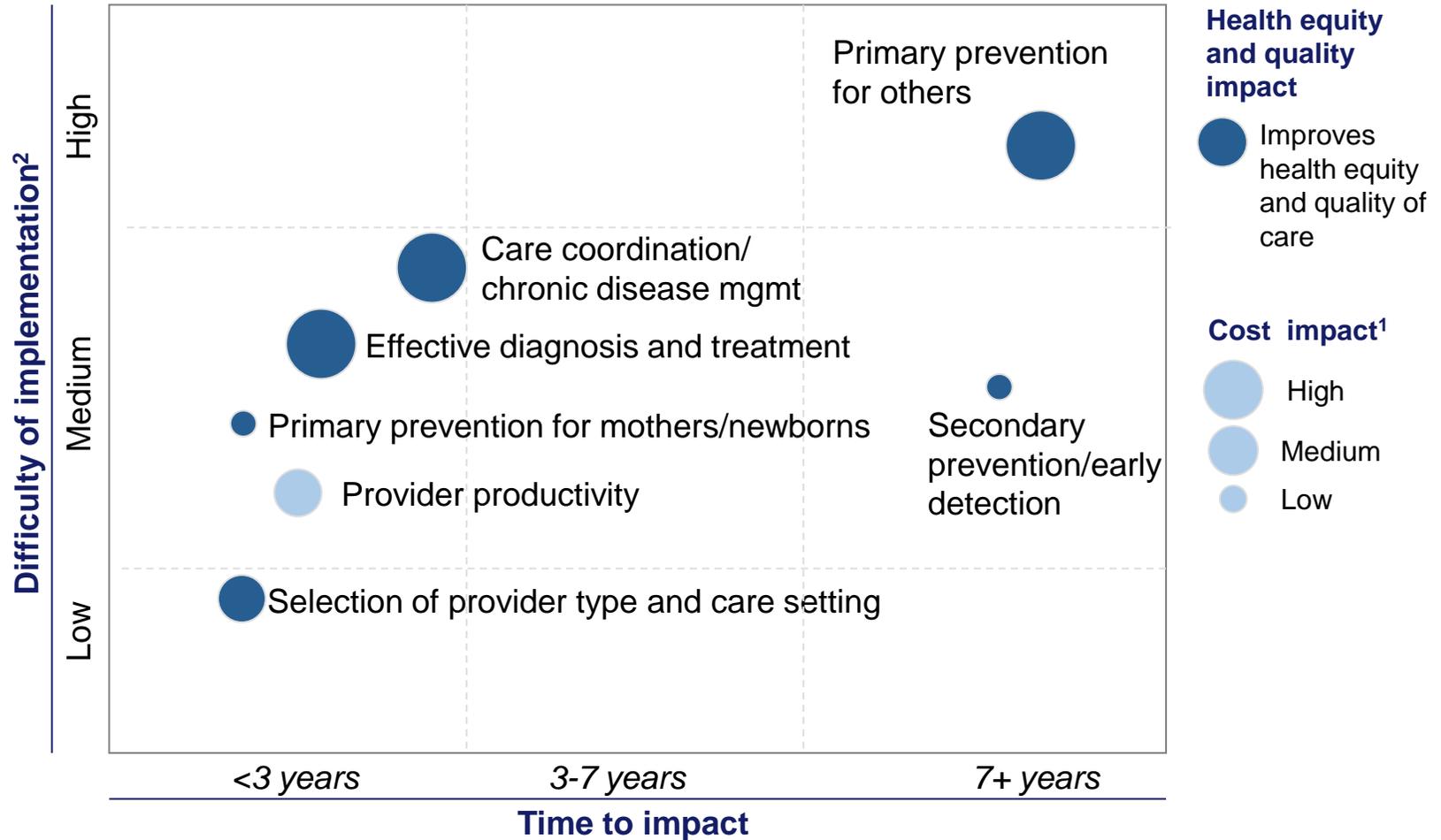
### 6 Measure/Improve Performance

- 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

# 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						

# Difficulty of implementation, timing, and impact of sources of value



1 Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics

2 Includes assessment of historical success rates and execution risk

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

	Relevant interventions	Behavior/ process	Structure
	<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	Struc- ture
	<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



- 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 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. extensivists' 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



## System-level changes raised, not included in provider-level list of interventions

- Attract primary care doctors and advanced practice registered nurses with loan forgiveness and other creative solutions
- Embed whole person care approach in medical system (e.g., throughout training, incentives)
- Enhance primary care practice for common clinical presentations to improve outcomes and/or reduce unnecessary reliance on specialist care
- Give provider practices quality improvement, outreach, and practice transformation support
- Improve health equity and preventive care
- Increase provider acceptance of Medicaid consumers
- Leverage minute-clinic model
- Provide portable data which follows the consumer
- Reduce paperwork burden on primary care practices
- Remove co-payments for preventive care<sup>1</sup>
- Support value based insurance<sup>1</sup>

<sup>1</sup> This will need to be a payer-specific decision