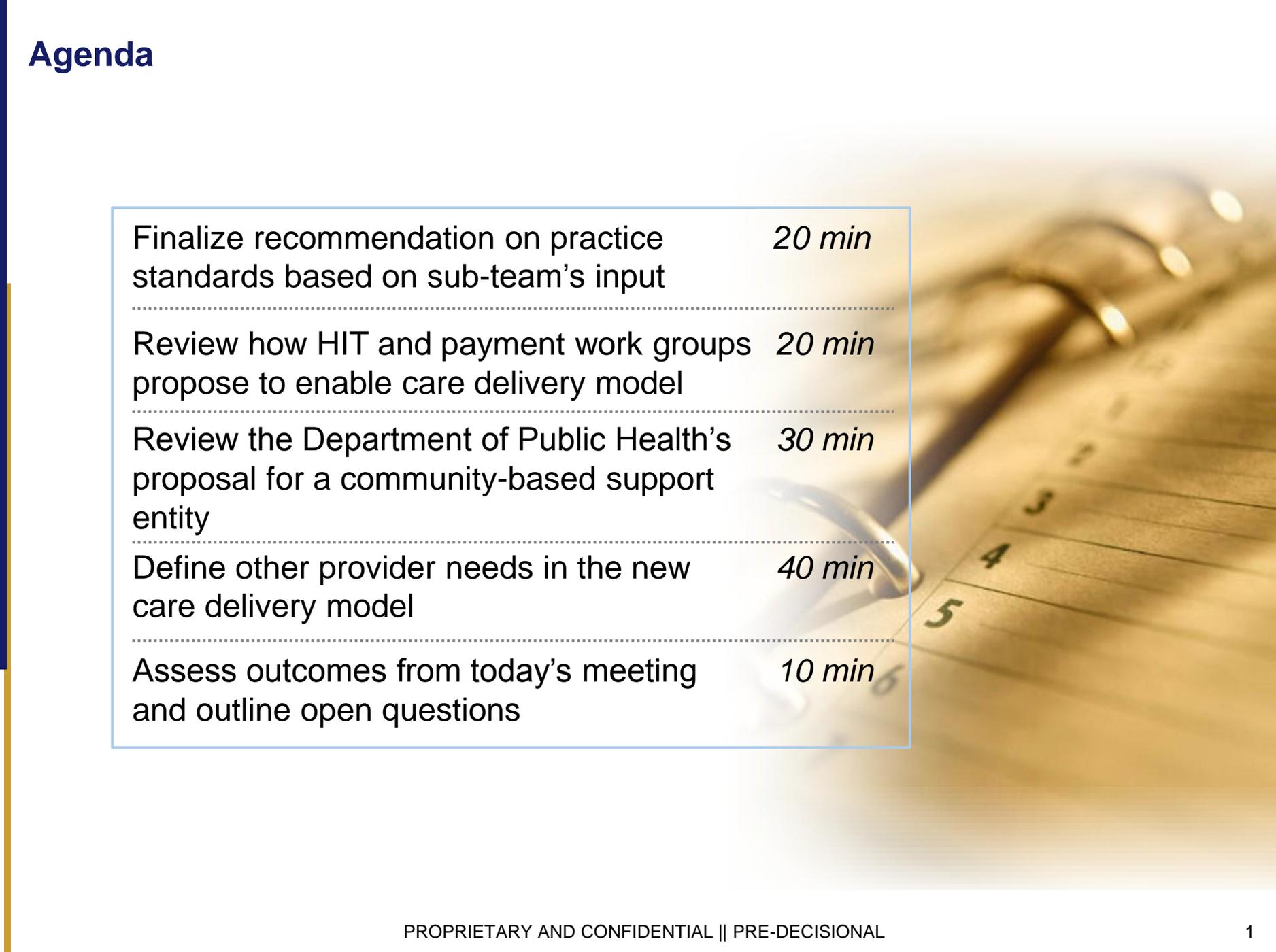




Care delivery model work group meeting #6

Discussion document
July 8, 2013

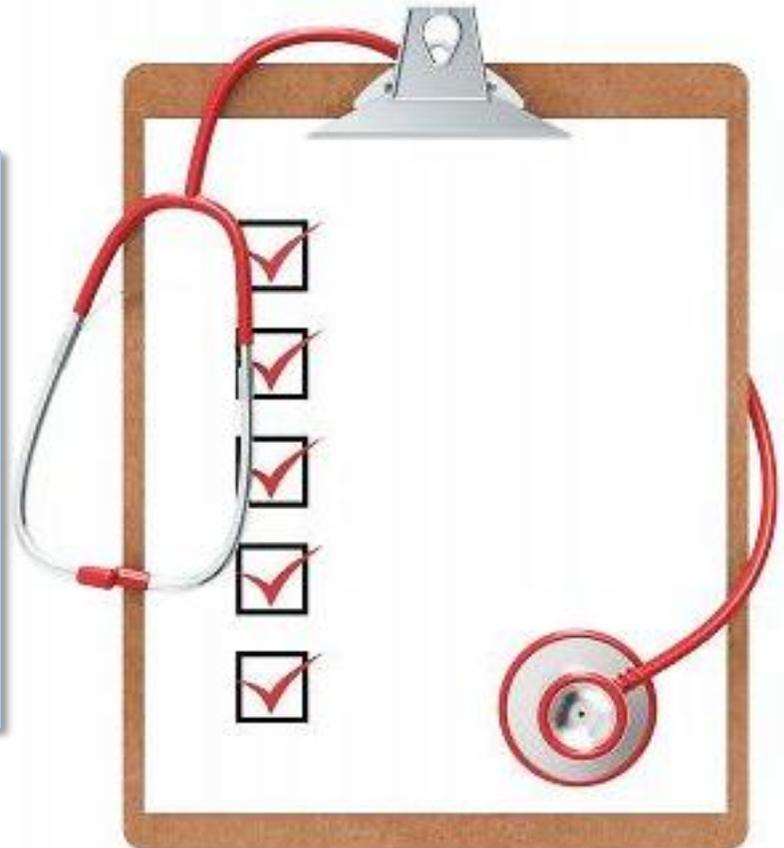
Agenda



Finalize recommendation on practice standards based on sub-team's input	<i>20 min</i>
Review how HIT and payment work groups propose to enable care delivery model	<i>20 min</i>
Review the Department of Public Health's proposal for a community-based support entity	<i>30 min</i>
Define other provider needs in the new care delivery model	<i>40 min</i>
Assess outcomes from today's meeting and outline open questions	<i>10 min</i>

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

- Finalize recommendation on practice standards
- Define ways to enable providers to participate in model
- Recommend plan for community engagement



Last meeting, we decided not to be prescriptive in defining the leader, or composition, of care teams

Recommendation

- We recommend that care teams have a set of "core providers" who provide primary care (e.g., PCPs, APRNs)
- We do not provide any other limitations on the 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 medical home model
 - Specialists, behavioral health providers¹, 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

- Offers flexibility for practices to define own care team and reduces barriers to participation
- Leads to need to define capabilities to participate



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

The care delivery work group sub-team aligned on developing CT specific practice standards (1 of 2)

■ Recommendation of sub-team

Options	Considerations	Examples
<p>1 PCMH certification by established accreditation body</p>	<ul style="list-style-type: none"> ▪ PCMH certification may not be truly indicative of advanced care delivery ▪ Well known by providers, and achieved by several already ▪ Potentially onerous for providers 	<ul style="list-style-type: none"> ▪ Vermont’s multi-payer Blueprint for Health uses NCQA standards to determine practice eligibility ▪ Maine’s Aligning Forces for Quality (AF4Q) uses NCQA standards to certify primary care practices
<p>2 PCMH certification by established accreditation body plus select CT specific interventions/guidelines</p>	<ul style="list-style-type: none"> ▪ As above ▪ May place additional burden on providers as well as state entity to certify ▪ More tailored to CT’s goals and needs 	<ul style="list-style-type: none"> ▪ Massachusetts’ Medicaid Primary Care Payment Reform Initiative requires participants to achieve NCQA certification and additional criteria of behavioral health integration and medical home transformation
<p>3 CT specific criteria (e.g., self-reported and validated with audits or claims based process metrics)</p>	<ul style="list-style-type: none"> ▪ More tailored to CT’s goals and needs ▪ May place additional burden on state entity/ payors to certify ▪ Can be designed in “less onerous” method for providers if relies largely on claims/ shorter set of self-reported criteria 	<ul style="list-style-type: none"> ▪ 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"> – If practice is a NCQA accredited PCMH, it only needs to fill out subset of application¹
<p>4 Other</p>		

SOURCE: State government websites and SIM testing grant applications

The care delivery work group sub-team first aligned on developing CT specific practice standards (2 of 2)

TO BE FINALIZED 7/3

Recommendation

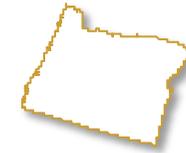
- Initial barrier to entry will be low (e.g., self-assessment and statement of commitment) for initial period of program (e.g., first 1-2 years)
- CT will define practice standards (likely pulling from NCQA or CMMI core measures, with potential additions) which will be tied to practice transformation support
 - Details on overseeing body and validation process to be determined
 - Practice standards will become increasingly rigorous and outcome based over time
- Practices which are already NCQA (or other nationally accreditation body) certified will have to meet most important CT specific standards to ensure all practices reach same high bar at end point

Testing states Arkansas and Oregon chose a similar approach

	Arkansas 	Oregon 
Description	<ul style="list-style-type: none"> ▪ Patient centered medical home program (PCMH) with payment mechanism to underwrite the cost of practice transformation ▪ Practice has no barriers to enroll and begin receiving a PMPMs but must meet state-defined process and structure milestones (see next page) to continue receiving them 	<ul style="list-style-type: none"> ▪ Patient centered primary care home model (PCPCH) ▪ Practice completes a self-assessment tool ▪ It applies for recognition at one of 3 tiers online through Oregon's Health Care Quality Co. website <ul style="list-style-type: none"> – Similar to NCQA 2011 standards – 10 must pass elements – Point system to allow practices flexibility ▪ Almost 50% of practices in state PCPCH certified less than 2 years of program opening enrollment
Infra-structure	<ul style="list-style-type: none"> ▪ Market of pre-qualified vendors to support practice transformation ▪ Portal for practices to report on process metrics – currently hosted by Blue Cross Blue Shield <ul style="list-style-type: none"> – Open access to all payers ▪ Currently no state auditing infrastructure in place 	<ul style="list-style-type: none"> ▪ OHA maintains a web-based reporting process which enables practices, plans or other entities to submit data on behalf of the practice to minimize burden on practice and leverage data already being collected (e.g., for quality improvement) ▪ OHA¹ performs random audits to validate contractual attestation measures ▪ ~6 FTEs support program – 1 director of program, 2 policy analysts, 2 site visitors, 0.5 clinical advisors, and support of several residents and grad students
Financial support	<ul style="list-style-type: none"> ▪ Care coordination PMPMs <ul style="list-style-type: none"> – No barriers to enrolling and starting to receive payments – To continue receiving payments must track on activity and process metrics (see next page) – No tiering – either certified PCMH or not ▪ Practice transformation PMPMs <ul style="list-style-type: none"> – Must meet activity and process metrics (see next page) 	<ul style="list-style-type: none"> ▪ Aetna provides PMPM incentives based on PCPCH tiers ▪ Public Employees' Benefit Board provide an age-adjusted, PMPM to Tier 2 or Tier 3 recognized primary care homes ▪ Medicaid pays PMPM payments for members with certain chronic conditions to recognized PCPCH for services not covered via FFS such as care coordination <ul style="list-style-type: none"> – Tier 1: \$10 PMPM – Tier 2: \$15 PMPM – Tier 3: \$24 PMPM

¹ Oregon legislature established Oregon Health Authority (OHA), Oregon Health Policy Board (OHPB) and a PCPCH Program within the Oregon Health Policy and Research in 2009

SOURCE: State testing grant applications and interviews with Oregon state official and McKinsey Arkansas expert



Potential lessons from Oregon's experience

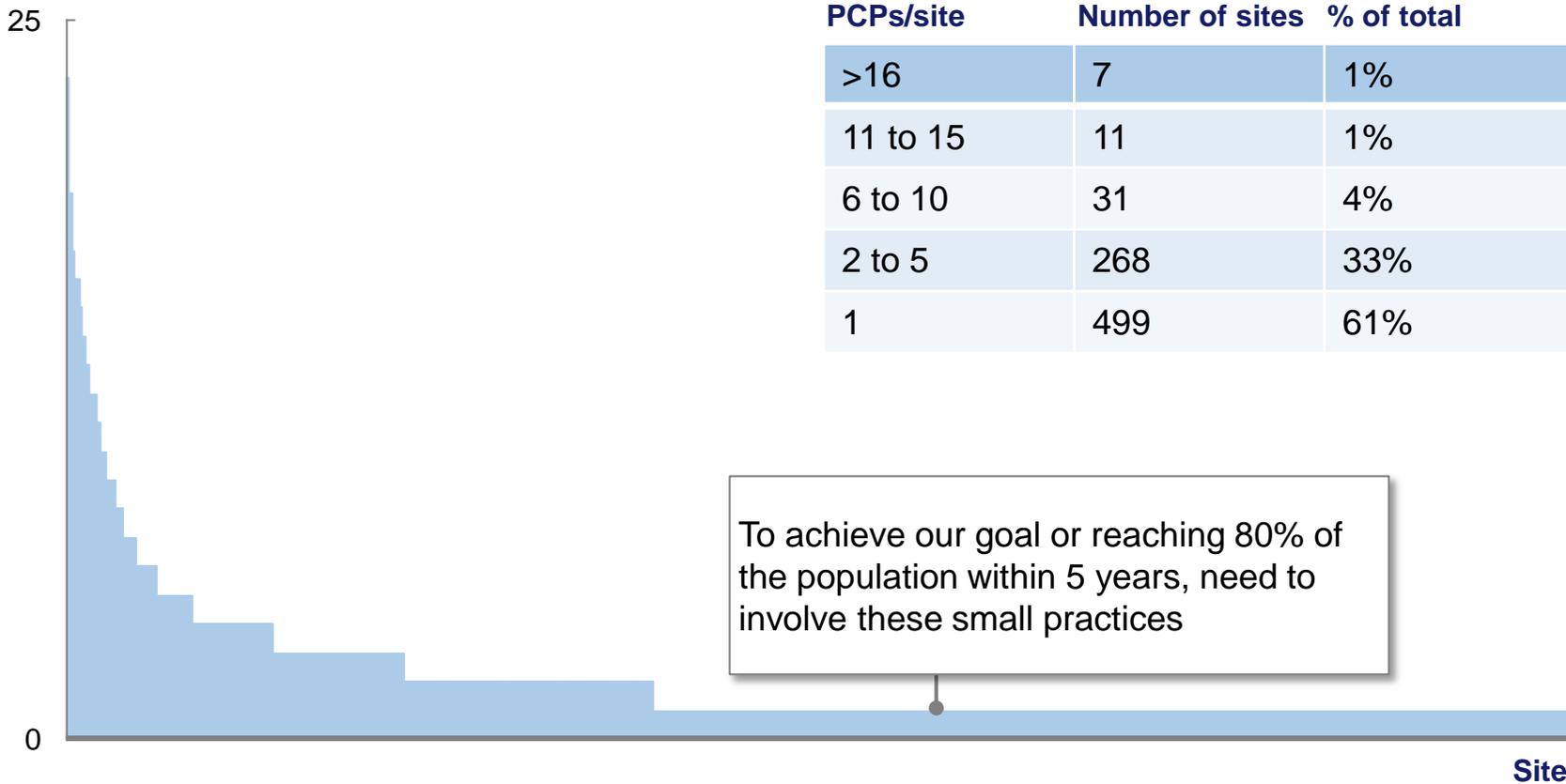
- **Consider leveraging NCQA or other national guidelines to take advantage of its supporting evidence base and regular updates**
 - Oregon developed own extensive list of standards because 2008 NCQA standards were not sufficient, ones developed ended up being close to 2011 NCQA version
 - Oregon is currently refreshing standards and backing up with evidence base
- **Consider using established guidelines, from NCQA or other national accreditation body, as this will allow us to ease administrative burden on providers**
 - Oregon achieved high participation (almost 50% of practices participating within 2 years) by allowing practices to self-report and validating with audits
- **Co-develop detailed implementation plan with payers to transition practices to managing total cost of care**
 - Oregon may run out funding for Medicaid PMPM payments and is working on raising additional funding

Last week, we discussed how ~60% of PCPs in CT are the only PCP at their site of care, which informs how we approach provider support

PCP fragmentation¹

PCPs per site in Connecticut (n=~800 sites, ~1740 PCPs)

PCPs on site



¹ PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists

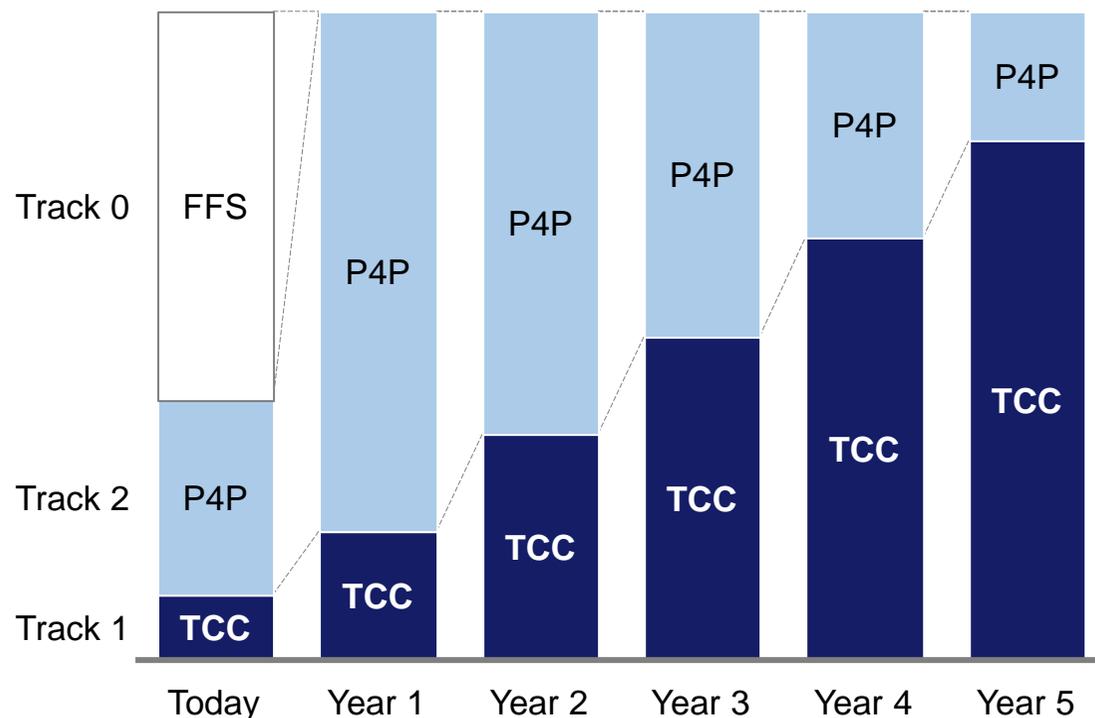
² Total number of sites = ~800 sites in Connecticut with at least one PCP. Does not separate sites with same parent company

SOURCE: SK&A data (~800 sites captured). Methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

The payment work group aligned on a two-track approach to enable these smaller practices to eventually manage total cost of care

ILLUSTRATIVE

Proportion of consumer population



Work group to define necessary milestones (e.g., provider adoption, legislative action to facilitate transformation) over 3-5 years of testing grant in upcoming sessions

Definitions

- **Fee for service (FFS):** a discrete payment is assigned to a specified service
- **Pay for performance (P4P):** physicians are compensated based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)
- **Total cost of care (TCC):** agreement to share responsibility for the value of patient care by tying a portion of payment to achievement of total cost and quality metrics

Specific characteristics of CT model to be defined by work groups in upcoming sessions

Note: Total Cost of Care model (TCC) may include upside gain sharing, full risk sharing, and/or capitation and does not assume a level of provider integration

They are working to define the metrics which will apply to both pay for performance and total cost of care models

	Track #1: Pay-for-performance	Track #2: Total cost of care
Basis for estimating savings	<ul style="list-style-type: none"> Resource utilization (e.g., hospital days/1,000, ER visits/1,000, generic prescribing rate) 	<ul style="list-style-type: none"> Total cost per member per year (including IP Facility, Professional, OP pharmacy, Behavioral Health, other)¹
Basis for qualifying for payouts	<ul style="list-style-type: none"> Consumer experience Quality of care (e.g., structure, process, outcome, care coordination measures) 	<ul style="list-style-type: none"> Consumer experience Quality of care (e.g., structure, process, outcome, care coordination measures)
Basis for risk-adjustment	<ul style="list-style-type: none"> Health risk factors Prevalence of illness and injury 	<ul style="list-style-type: none"> Health risk factors Prevalence of illness and injury
Informational purposes	<ul style="list-style-type: none"> Total cost per member per year (including IP Facility, Professional, OP pharmacy, Behavioral Health, other)¹ 	<ul style="list-style-type: none"> Resource utilization (e.g., hospital days/1,000, ER visits/1,000, generic prescribing rate)

¹ Total cost of care inclusive of all payer and member liabilities

The HIT work group is proposing staged technical provider support and considering how some may be offered as shared services

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 yrs)	Stage 3 (3+ yrs)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
Provider-payer-patient connectivity	Multi-payer online communication tool for providers to receive static reports; basic patient portal to allow consumers to enter quality metric data	Bi-directional provider-payer communication tool with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange ¹ solutions	Potentially integrate state-wide Health Information Exchange ¹

¹ HITE-CT will drive adoption of provider-provider connectivity tools and eventual creation of a state-wide health information exchange

The Department of Public Health will share today their concept of a certified community-based practice support entity



- Community resources can play a critical role in helping meet Connecticut's vision for its new care delivery model
- There is a lack of structures and incentives to drive clinical-community collaboration and coordination in Connecticut
- One possible solution is to operationalize the integration of public health and primary health care through the creation of Certified Community-Based Practice Support Entities

Discussion questions

- Do we want to put in place a structure similar to one DPH proposes for providers to engage with the community most effectively?
- If not, what role should SIM play in facilitating interactions (e.g., provide director of community organizations to providers?)

Our work group can brainstorm what other needs providers may have, to share back with HIT, payment, and workforce work groups

Breakout exercise instructions

- Break out into 3 groups and discuss what providers need to participate and thrive in new care delivery model (**20 min**)
 - Refer to proposals of testing grant states
 - Refer to updated SHIP vision for Connecticut
 - Refer to prioritized list of interventions

- Report back to group findings (**20 min**)
 - Align on priority 3-4 needs which HIT, payment and workforce groups should consider



Testing states plan to support providers in a variety of ways

Provider support

- | | | |
|--|------------------|---|
|  | Arkansas | <ul style="list-style-type: none"> ▪ Provide access to vendors pre-qualified by the state to support individual practice transformation ▪ Enable small practices to voluntarily affiliate to reach the scale required for risk-based incentive structures to be effective ▪ Create learning collaboratives where innovative providers across the state can learn from each other about the transformation experience |
| | | |
|  | Mass. | <ul style="list-style-type: none"> ▪ Set up structure for regional and statewide learning collaboratives for both providers and payers |
| | | |
|  | Maine | <ul style="list-style-type: none"> ▪ Support ACO , PCMH, and health home learning collaboratives ▪ Develop RFPs for the provision of support services (e.g. leadership Development, ,and local Evaluator who will provide data to CMMI and harmonize measures to facilitate data collection/ minimize respondent burden |
| | | |
|  | Minnesota | <ul style="list-style-type: none"> ▪ Helps with implementation of quality improvement activities ▪ Support for integration of new providers, such as community health workers, community paramedics, and advanced dental therapists into clinical practices ▪ Support for practices that wish to transform into Health Care Homes |
| | | |
|  | Oregon | <ul style="list-style-type: none"> ▪ Plan to test, accelerate and spread innovations through state's transformation center ▪ Developed concept of Innovator Agents (IAs) who will help break down barriers between coordinated care organizations (CCOs) and the state, serve as a conduit for data, share best practices, and bring technical assistance to assist CCOs in adopting and adapting the model ▪ Plan to facilitate CCOs' partnerships with local public health authorities and other local organizations to improve health and reduce health care costs in communities. |
| | | |
|  | Vermont | <ul style="list-style-type: none"> ▪ Learning Health System Activities is one of four principle aims of innovation plan <ul style="list-style-type: none"> – Expanded team of skilled facilitators to support transformation and ongoing cycles of continuous improvement – Enhanced shared learning forums at the local, regional, and state level |

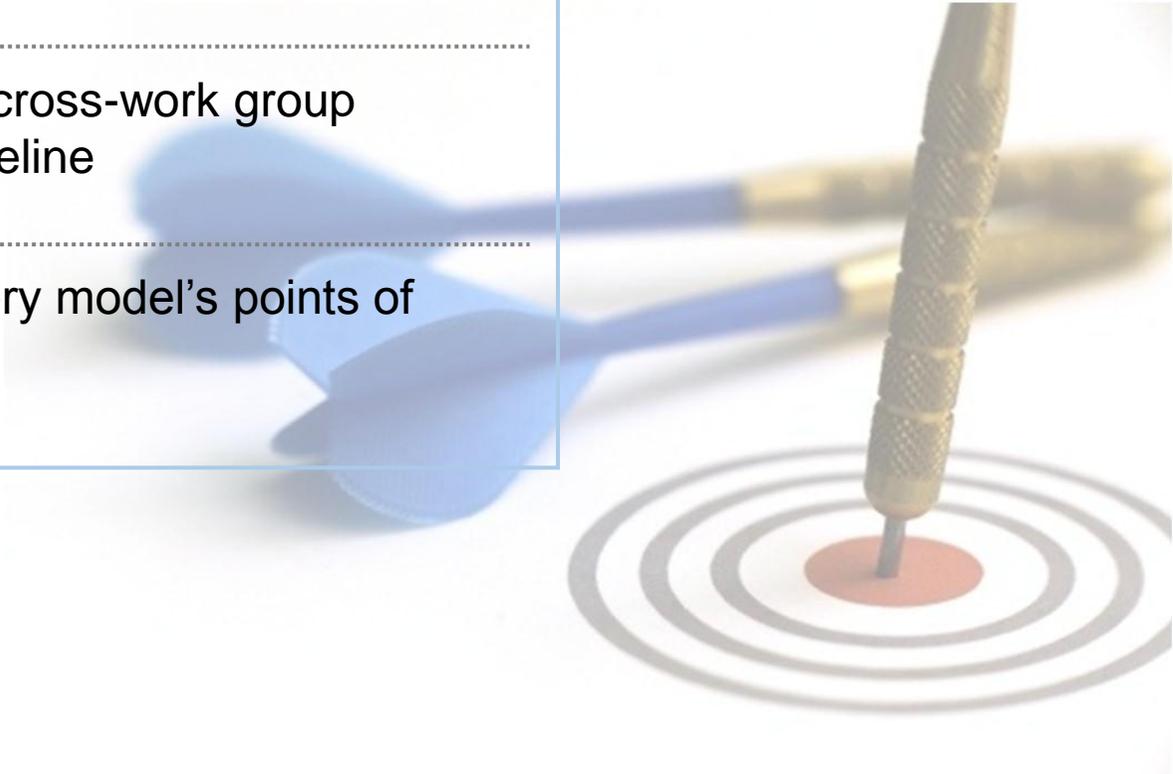
- What approach to practices standards are we recommending?
- What are our thoughts on the Department of Public Health's proposal to establish community-based support entities?
- What are our 3-4 recommendations for practice support?
- What open questions do we need to address in our next work group meeting?

Topics for our July 22nd Care Delivery Work Group

- Review and refine synthesis of all care delivery work group recommendations

- Review and refine cross-work group implementation timeline

- Finalize care delivery model's points of distinctiveness



Appendix

We have outlined a vision for care delivery and payment innovation in Connecticut

Establish a whole-person-centered health care system that promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability

- Understanding and consideration of the needs of a whole-person that impact health
- Integration of primary care, behavioral health, population health, consumer engagement, oral health, and community support
- Shared accountability for total cost that controls the cost of health care and ensures quality health care
- Increased access to the right care in the right setting at the right time
- Continuously improving workforce development to support a diverse well trained workforce that is prepared to work efficiently and effectively in our rapidly evolving care delivery environments
- Health information technologies that support continuous learning, analysis, performance, communication and data usability at the point of care
- Supported by Medicaid, Medicare, and private health plans alike

Prioritized list of interventions (1 of 2)

Prioritized interventions¹

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 factors², 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)³
- Develop and execute against a whole-person-centered treatment plan⁴
- Coordinate across all elements of a consumer’s care^{3,4}

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

Prioritized list of interventions (2 of 2)

Prioritized interventions¹

4 Consumer engagement

- Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice²
- Use person centered care planning methods to develop and support implementation of self-management care plan²
- 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 guidelines³

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

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 factors¹, 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

¹ 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 interventions¹ & 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

¹ 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 care¹
 - 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 plan¹
- 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

¹ 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 ²
 - 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 insurers¹
- 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.²
- 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

¹ May be accomplished in part through a sponsored media campaign

² 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 guidelines¹

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) involved²
- Community health workers help target high risk, high spend populations who do not engage with primary care practice

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

² 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 benchmarks¹
- 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 data² to improve and establishing learning collaboratives

¹ Requires ability for provider to dispute outcomes

² Methodology on obtaining consumer data to be determined

In CDWG4, we identified a range of key individuals involved in a consumer's care

UPDATED AFTER CDWG5

Care providers raised in break-out groups

Primary care

- Home care nurse or aide
- PCP advanced practice registered nurse (APRN)
- PCP nurse
- Personal care assistants
- 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
- Medical specialist (e.g., endocrinologist)

Social/ community care

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

Other

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

Peer-state example of phasing: Arkansas

● In line with a CPC requirement¹ ● Completion of activity and timing of reporting

Activity	Commit to PCMH Month 0/ Pre-enrollment	Understand your starting point and start your journey Month 6	Evolve your processes Month 12	Continue to innovate Month 18	Month 24
<ul style="list-style-type: none"> Identify office lead(s) for both care coordination and practice transformation 	●				
<ul style="list-style-type: none"> Assess operations of practice and opportunities to improve 		●			●
<ul style="list-style-type: none"> Develop strategy to implement care coordination and practice transformation improvements 		●			●
<ul style="list-style-type: none"> Identify top 7-15% of high-priority patients 		●		●	
<ul style="list-style-type: none"> Identify and address medical neighborhood barriers to coordinated care at the practice-level 		●			
<ul style="list-style-type: none"> Provide 24/7 access to care 		●			
<ul style="list-style-type: none"> Document approach to expanding access to same-day appointments 		●			
<ul style="list-style-type: none"> Document approach to contacting patients who have not received preventative care 			●		
<ul style="list-style-type: none"> Document investment in healthcare technology or tools that support practice transformation 			●		
<ul style="list-style-type: none"> Join SHARE to get inpatient discharge information from hospitals 			●		
<ul style="list-style-type: none"> Incorporate e-prescribing into practice workflows 				●	
<ul style="list-style-type: none"> Integrate EHR into practice workflows 					●

¹ These activities have goals that match a Comprehensive Primary Care Initiatives (CPC) milestone but have been adapted to reduce administrative burden and/or to empower all practices