



# Connecticut State Innovation Model

STATE OF CONNECTICUT

Model Overview for Joint Care Delivery and  
Payment Reform Workgroup

# Agenda

Council 4 AFSCME, 444 East Main Street, in New Britain

Tuesday, October 22

6:00-8:00p US ET

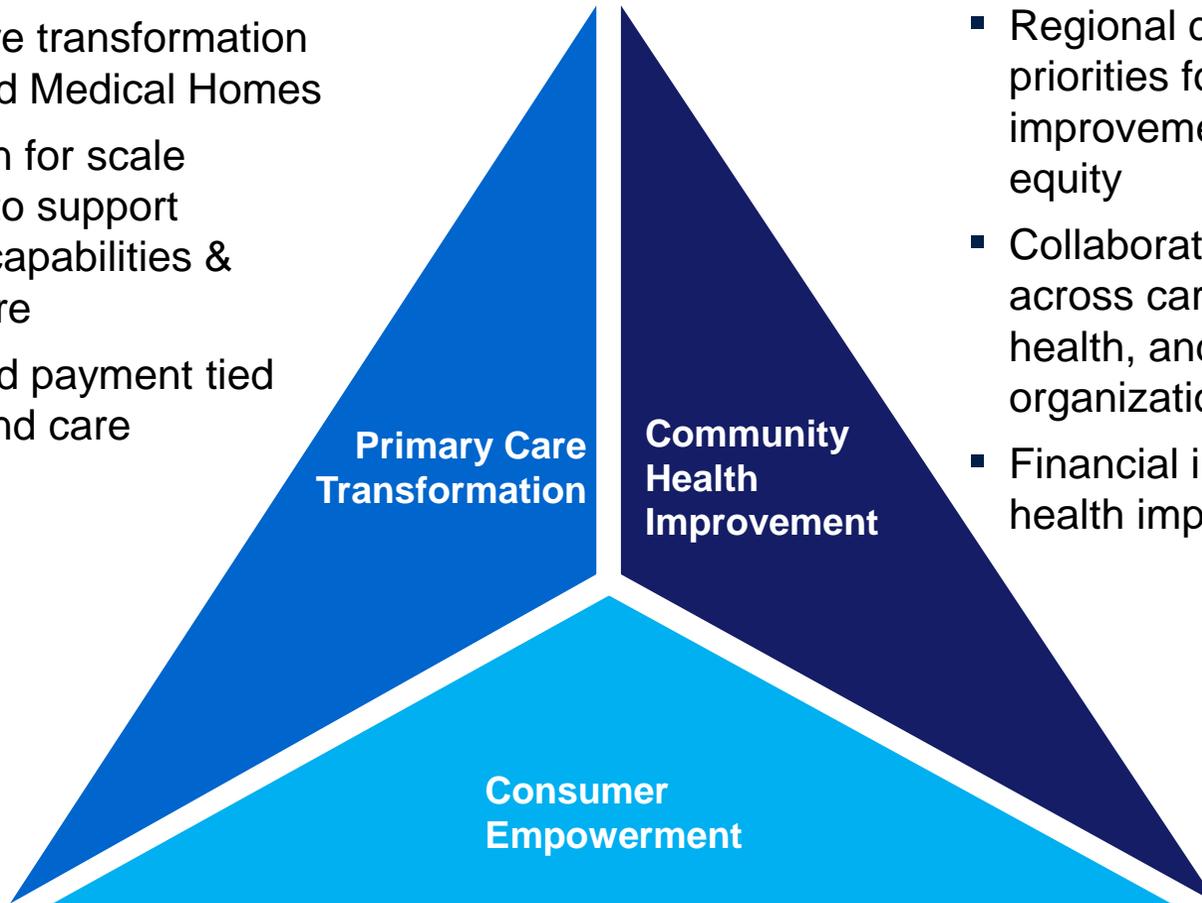
<u>Objective</u>	<u>Timing</u>
Overview of current SIM model	35 min
Discussion of proposed model design enhancements <ul style="list-style-type: none"><li>• Community Health Improvement</li><li>• Consumer Empowerment</li><li>• Health Equity</li></ul>	40 min
Discussion of key issues raised by steering committee and stakeholders	45 min

# Connecticut's Guiding Principles for SIM

- Understanding and consideration of what impacts health from a whole-person perspective
- Integration of primary care, behavioral health, population health, consumer engagement, oral health, and community support
- Accountability for health care quality and total costs in order to continuously improve quality while reducing (or controlling) costs
- 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 can work efficiently and effectively in our 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

# Connecticut's model brings together three complementary strategies to achieve the Triple Aim

- Primary care transformation to Advanced Medical Homes
- Aggregation for scale necessary to support enhanced capabilities & infrastructure
- Value-based payment tied to quality and care experience



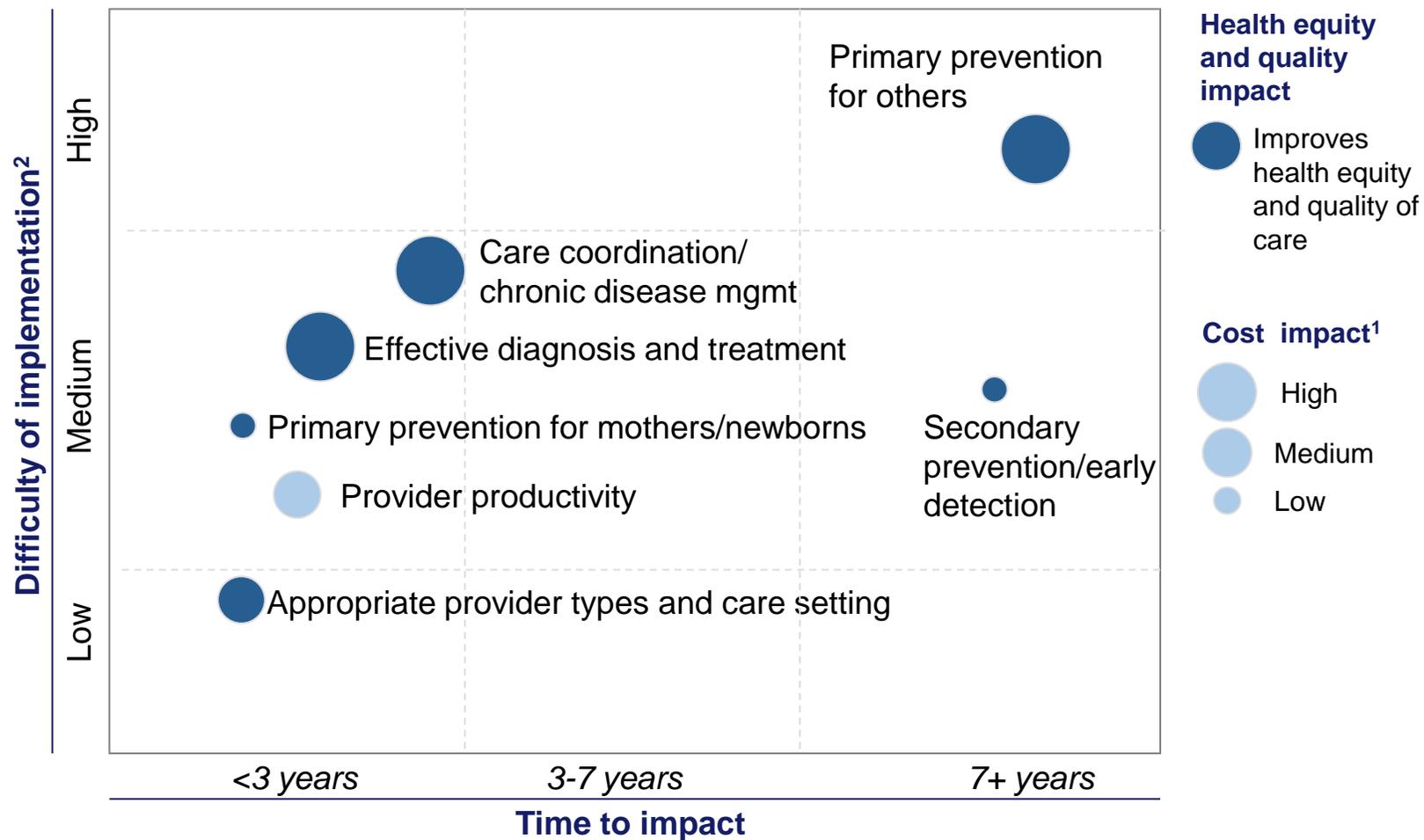
- Regional communities set priorities for health improvement and health equity
- Collaborative solutions across care delivery, public health, and community organizations
- Financial incentives tied to health improvement

- Transparent quality, consumer experience, and cost
- Shared decision making tools and programs (e.g., Choosing Wisely)
- Value-based insurance design and other consumer incentives

## Opportunities for Improvement

	Description	Examples
<b>Primary prevention</b>	<ul style="list-style-type: none"> <li>Prevention of disease by removing root causes</li> </ul>	<ul style="list-style-type: none"> <li>Smoking cessation</li> <li>Diet and exercise</li> </ul>
<b>Secondary prevention/ early detection</b>	<ul style="list-style-type: none"> <li>Early detection of disease while asymptomatic to prevent disease progression</li> </ul>	<ul style="list-style-type: none"> <li>Cervical cancer screening</li> <li>Identification and management of patients at high risk for heart disease</li> </ul>
<b>Appropriate provider types and care setting</b>	<ul style="list-style-type: none"> <li>Utilizing highest value provider types and care settings</li> </ul>	<ul style="list-style-type: none"> <li>Choice of care setting for immunization administration</li> <li>Optimized utilization of physician extenders</li> </ul>
<b>Effective diagnosis and treatment selection</b>	<ul style="list-style-type: none"> <li>Evidence-informed choice of treatment method/intensity</li> </ul>	<ul style="list-style-type: none"> <li>Enforcement of evidence-based inpatient clinical pathways</li> </ul>
<b>Provider productivity</b>	<ul style="list-style-type: none"> <li>Reducing waste at provider center</li> </ul>	<ul style="list-style-type: none"> <li>Improve flow in OR to increase number of surgeries performed daily</li> <li>Streamline emergency room triaging</li> </ul>
<b>Care coordination / chronic disease management</b>	<ul style="list-style-type: none"> <li>Ensuring patients effectively navigate the health system and adhere to treatment protocols</li> </ul>	<ul style="list-style-type: none"> <li>Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)</li> </ul>

## Opportunities for Improvement



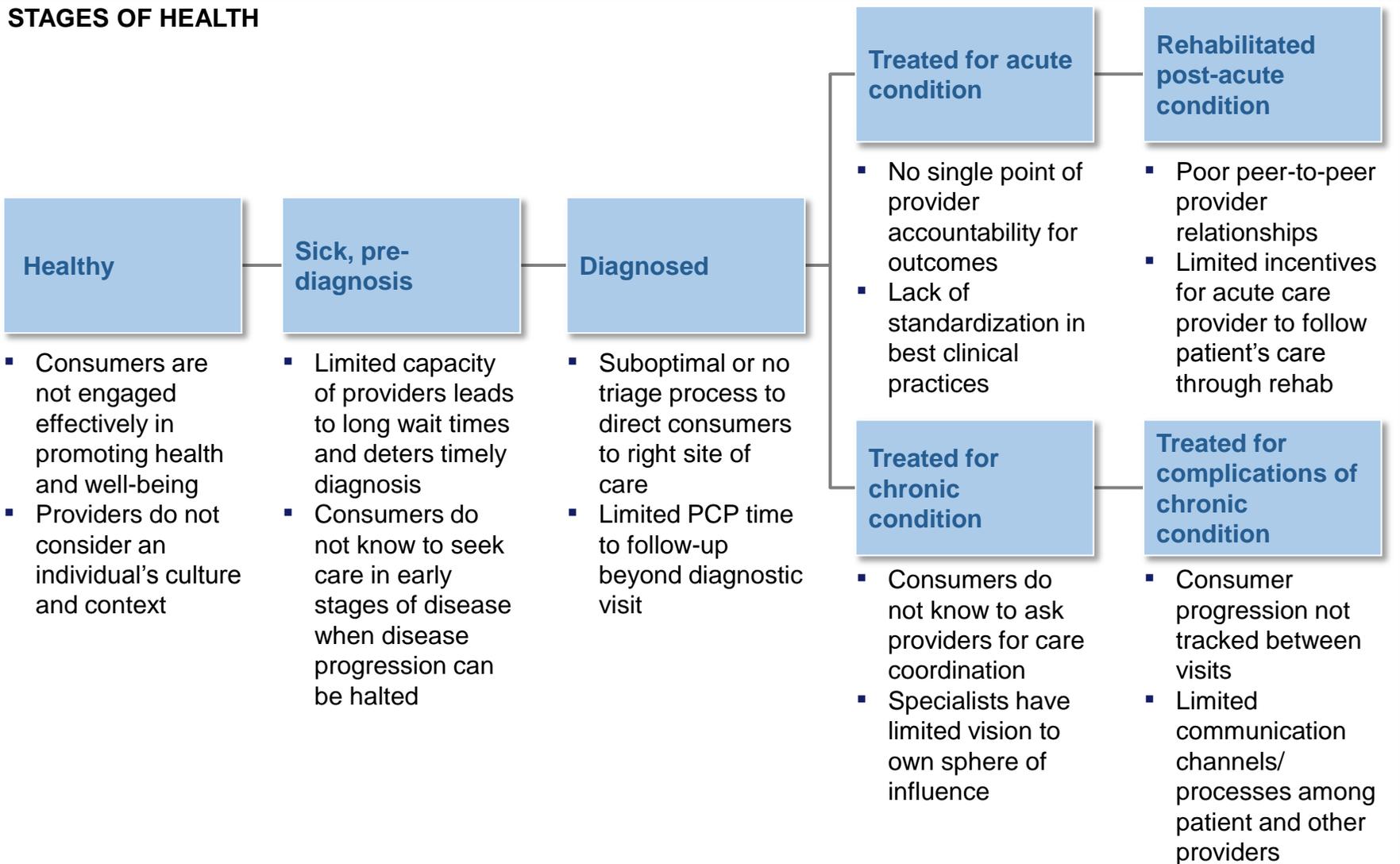
<sup>1</sup> Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics

<sup>2</sup> Includes assessment of historical success rates and execution risk

# Care Delivery Work Group

## Consumer Journey – Barriers to Care

### STAGES OF HEALTH



# Care Delivery Workgroup

## Learning from the Health Care Journey

### *A child with asthma*

Kathy is a six year old girl who came into the office for asthma. The exam doesn't consider important things about Kathy, such as her history of anxiety, violence in the home, and a parent with addiction problems. Her mother doesn't entirely understand the care plan, which contains many unfamiliar terms, and does not explain why and how conditions in the home might affect asthma. The PCP is also unaware of a longstanding infestation of mice. Kathy has a series of visits to the ED, ultimately leading to a hospitalization. The PCP learns of this several weeks after her discharge.

# **Primary Care Transformation**

# MODIFIED WORDING

## Connecticut's Advanced Medical Home Model

### *Core Elements*

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-based informed clinical decision making

### *OUR ASPIRATIONS*

- Better health for all
- Improved quality and consumer experience
- **Promote health equity and eliminate health disparities**
- Reduced costs and improved affordability

Performance transparency

Value-based payment

Health information technology

Workforce development

# Alignment on Advanced Medical Home Standards

- How do you get there?
  - Provider Transformation Workgroup defines Advanced Medical Home standards and elements
  - Payers participate in workgroup and voluntarily adopt standards
    - Subject to attestation and verification
  - Partial or Full reciprocity with national medical home accreditation bodies (i.e., NCQA, Joint Commission)
  - On-site validation survey conducted by common vendor

## Recommendations for advancing health equity, improving quality, and eliminating health disparities

- Promote and incorporate the Office of Minority Health's enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in order to advance health equity, improve quality, and help eliminate health disparities.
- Many of the CLAS standards (covering the areas of data collection, communication and language access, quality improvement, workforce, governance and community engagement/reporting) are being considered for implementation, including:
  - Core standards/elements of the Advance Medical Home model
  - Performance transparency
  - Consumer Empowerment
  - Value-Based Payment
  - Workforce Development
- The SIM Planning Team assumes responsibility for determining and ensuring the feasibility, sustainability and comprehensiveness of SIM's integration with the CLAS standards during the pre-testing phase

# Advanced Medical Home – Core Elements

1 Whole-person-centered care

## Prioritized interventions

- Assess whole person and family **with appropriate tools** to identify strengths and preferences; risk factors<sup>1</sup>; medical, behavioral health, psychosocial, and oral health and other co-occurring conditions; and ability to actively participate in care
- **Use assessment to develop and implement** person-centered care planning
- Implement shared decision-making tools
- **Collect and maintain accurate and reliable demographic data, including race, ethnicity, and primary language, to monitor health equity and outcomes and to inform service delivery**

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

# Advanced Medical Home – Core Elements

2

Enhanced access to care (structural and cultural)

## Prioritized interventions

- Improve access to primary care through
  - a) extended hours (evenings/weekends)
  - b) convenient, timely appointment availability including same day (advanced) access
  - c) non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance specialty care access (e.g. through non-visit-based consultations: e.g., e-Consult)
- Raise consumer awareness regarding most appropriate options for accessing care to meet routine and urgent health needs
- **Ensure practitioner cultural and linguistic responsiveness, including collecting and disclosing provider demographic information, such as race/ethnicity and languages spoken by clinical staff**

# Advanced Medical Home – Core Elements

2 Enhanced access to care (structural and cultural)

## Prioritized interventions

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### Expand communication and language assistance

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
  - Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
  - Ensure the competence of individuals providing language assistance, avoid using untrained individuals and never use minors.
  - Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
-

# Advanced Medical Home – Core Elements

2

## Population health management

### Prioritized interventions

- Collect and analyze health data about patient population **and utilize such data to improve care delivery and health equity**
- Regularly profile health patterns and improvement opportunities for particular patient sub-populations **(including those defined by health risk, condition, race, ethnicity, primary language, sexual orientation and other demographic data)**
  - **Aggregate de-identified data with State and payers to facilitate analyses, reporting and intervention**
  - **Offer data at the provider level to facilitate practice-based and/or provider-based improvement**
- Apply data insights strategically in the continuous improvement of care delivery processes.
- Translate population health trends and statistics to individual patients
- Maintain a comprehensive disease registry to track population health

# Advanced Medical Home – Core Elements

4

Team-based,  
coordinated care

## Prioritized interventions

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- Provide team-based care from a prepared, proactive, and diverse team
- Integrate **community, oral, and** behavioral health with primary care with “warm hand-offs”, particularly between behavioral health and primary care practitioners (on-site if possible)
- Develop and execute against a whole-person-centered, multi-disciplinary care plan
- Coordinate across all elements of a consumer’s care and support needs
- **Promote inclusion of community health workers as team members to allow health care team to be more easily “tuned” for sub-populations served by a particular care delivery system**

# Advanced Medical Home – Core Elements

## Prioritized interventions

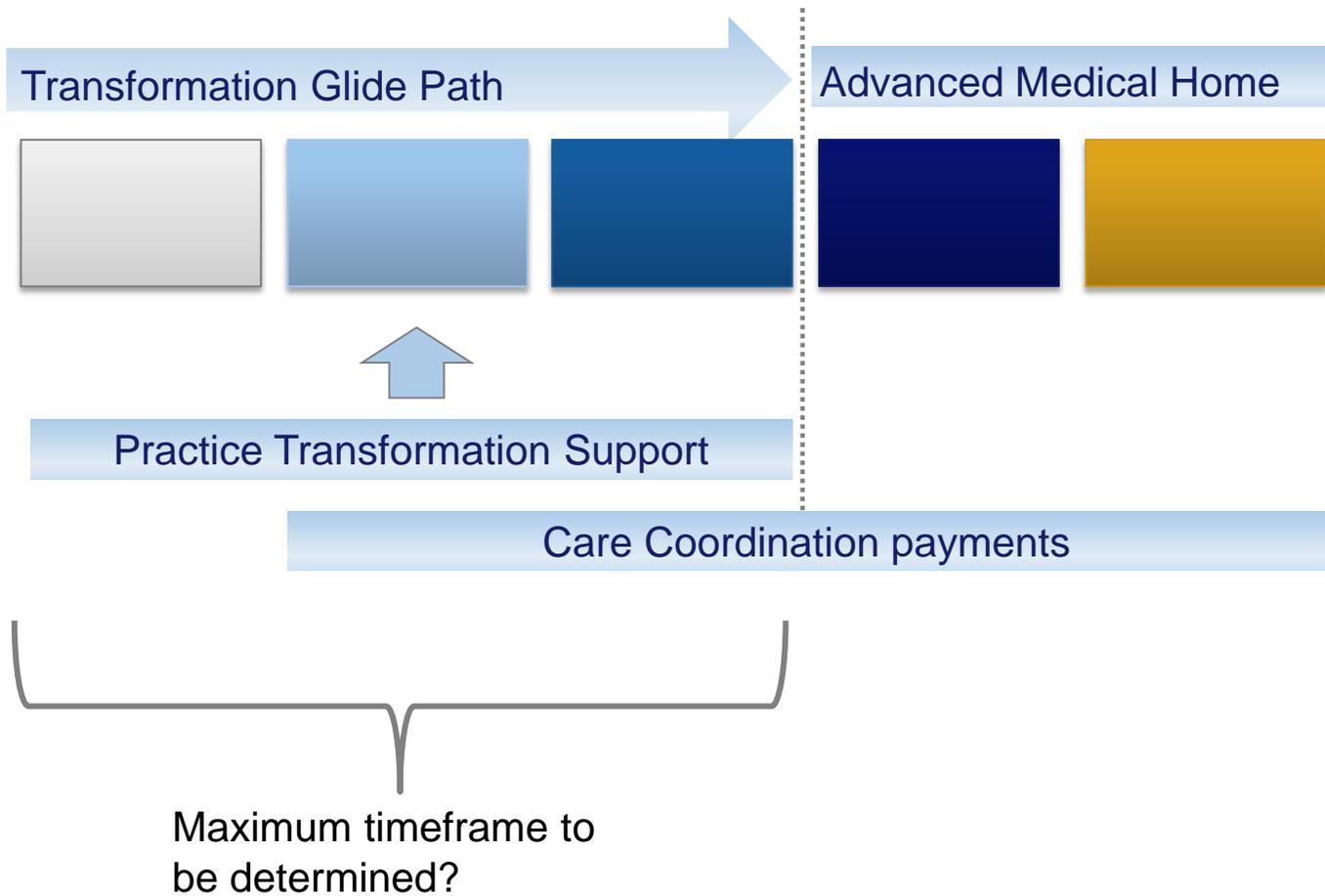
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- Apply clinical evidence and health economic data to target care and interventions to those for whom they will be most effective
- **Integrate disparity-specific recommendations from expert guidelines, comparative effectiveness research and community based participatory research**
- Leverage tools at the point of care to include the most up-to-date clinical evidence
- Promote new methods for rapid adoption and application of evidence at the point of care

Evidence-informed  
clinical decision  
making

5

# Transformation Support – Helping Practices Meet Advanced Medical Home Standards



Compliance with Standards

## Progression to IPAs, Integrated Networks and ACOs

- Promote migration to organized systems such as IPAs, clinically integrated networks, and ACOs
- Scale sufficient to support accountability for quality, consumer experience and cost
- Care coordination technology/infrastructure
- Integration of care delivery with community-based support (e.g., housing, personal care, nutrition)
  - Consumer centered interventions tailored to social contexts
  - Collaborative processes for consumer engagement

# Potential models for providers to gain scale and capabilities necessary to manage total cost of care and quality

- A** **Integrated Delivery System**
  - Physicians and hospitals legally and financially integrated
  - Capital, infrastructure, and clinical integration among physicians, hospitals, other providers
  - Potential to distribute payment through employment agreements

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- B** **Medical Group Practice**
  - Legally and financially integrated physician organization
  - Capital, infrastructure, and clinical integration among physicians
  - Potential to distribute payment through employment agreements

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- C** **Clinically integrated network**
  - Formal contractual relationship among otherwise independent physicians, hospitals, other providers
  - Capital, infrastructure, and clinical integration among physicians, hospitals, other providers

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- D** **Strong IPA**
  - Physicians derive most or all of their revenue through IPA
  - Capital, infrastructure, and clinical integration among physicians

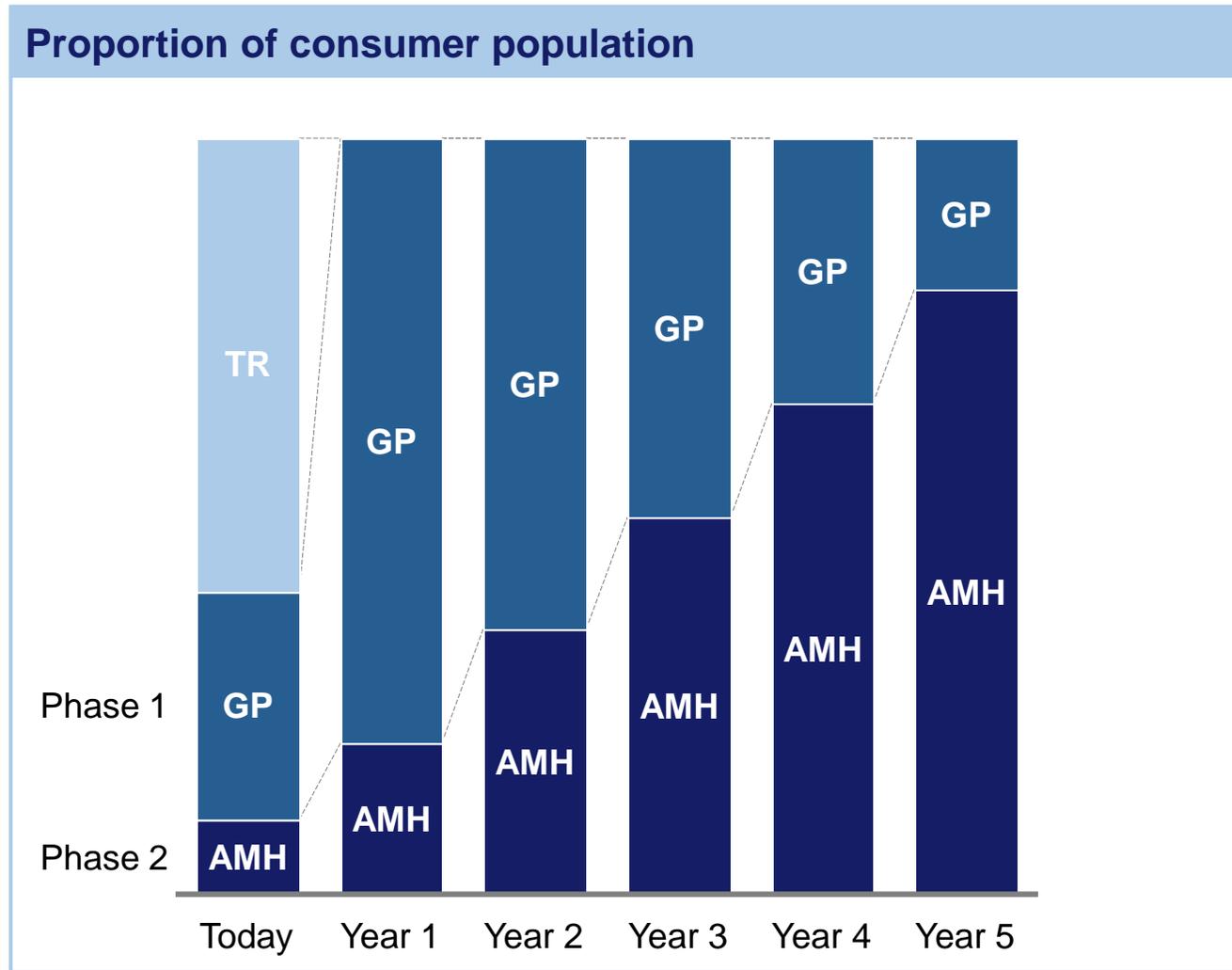
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- E** **Loose IPA**
  - Physicians and/or hospitals derive only part of their revenue through IPA
  - Limited capital, infrastructure, or clinical integration among physicians

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- F** **Regional cooperatives**
  - Regional cooperative provides clinical and technical resources
  - Limited capital, infrastructure among participating physicians independently
  - Regional cooperative may or may not be channel for distribution of risk sharing

# Advanced Medical Home Phase-in as Providers Complete Glide Path



**AMH = Advanced Medical Home**  
**GP = Glide Path**

**TR = Traditional practice**

# Community Health Improvement

# Community Health Improvement

- Geographic areas or regions for focused on health improvement, **health equity**, and prevention
- Focus on community needs and priorities
- Align metrics and financial incentives for all community participants
  - Care delivery networks/ACOs
  - Other community partners
- Financial incentives for grant based programs
- Pooled accountability to avoid risk selection (**e.g., socio-economic, race, ethnicity related risk for target conditions**)
- Financial incentives for grant based programs

# Certified Community-Based Entities

Certified Community-Based Entities are local organizations that have been designated by the state to support local primary care practices with a specified package of evidence-based, primarily preventive, community services.

- Provide one-stop shopping for quality, evidence-based prevention services
- Develop formal affiliations with primary care practices and share accountability for quality and outcomes.
- Demonstrate a unique understanding of community and population served and able to assist delivery of high quality, culturally and linguistically appropriate services.
- Employ and utilize community health workers
- Support IT-enabled integrated communication protocols. Collect and report data, and evaluate performance and relevant outcomes, stratified by race/ethnicity/primary language, and other demographic data.

# Certified Community-Based Entity

## Illustrative Core Services

- Asthma Home Environmental Assessments (putting on AIRS)
- Diabetes Prevention Program (DPP)
- Chronic Disease Self-Management Programs
- Falls Prevention Program
- Core Services foundational framework includes: DPH's State Health Assessment, CDC's four-domain framework on chronic disease prevention and health promotion, proven effectiveness, reduction of health disparities and return on investment potential.

# Primary care practices will be able to draw on support from certified community based entities

Certified community based entities (both state wide and local)

Certification, training, technical assistance, and sharing of best practices

Department of health and other state agencies



Reporting and sharing of best practices

Funding and patient referrals

Programs

Programs, services and patient referrals

Primary care

Independent practitioners



Clinically integrated networks & ACOs



Reporting and data sharing

# Consumer Empowerment

# Consumer Empowerment

Consumers will benefit from the following:

- Secure sharing of health data on consumer portal
- Person-centered approach where assessment of strengths and preferences are a basis of care management
- Self-management programs
- Shared decision making tools
- Provider quality and cost performance to inform consumer choices
- Community engagement through the certified community-based entity
- Incentives for positive health behavior

## Primary Drivers

## Secondary Drivers

## Interventions

DRAFT

**Consumer Empowerment**

Provide information and tools to enable health, Wellness and illness self - management

Improve access to health services

Introduce incentives to encourage healthy lifestyle and effective illness self-management

Implement mechanisms for consumer input and advocacy

- Expand Consumer Portals; ensure multilingual capabilities
- Implement illness self-management tools
- Implement shared decision-making tools (e.g., Choosing Wisely)
- Provide transparency regarding provider quality, care experience and cost
- Education regarding taking charge of one's health

- Implement e-Consults, extended hours, same-day options
- Expand non-visit based options such as text messaging, email, and phone calls
- Establish safeguards for equity, access, and appropriateness
- Enhance access to preventative services through Certified Entities

- Increase use of progressive value based insurance design
- Pilot employer reward for nutritional purchasing
- Pilot SNAP reward for nutritional purchasing
- Increase incentives for wellness in the workplace

- Care experience survey linked to value-based payment
- Ensure mechanisms for consumers to report denials of care
- Facilitate consumer participation in SIM advisory councils

# Enabling Initiatives

# Performance Transparency

- Collect, integrate, analyze and disseminate data for performance reporting on clinical indicators, health care quality and cost
- Analyze and report Statewide performance metrics on an on-going basis to identify and act on opportunities to improve over time
- Track AMH performance on quality, care experience, and equity measures on common scorecard. For use by payers to determine whether providers qualify for value-based incentive payments
- Track broader array of providers on quality, outcome and cost measure for use by consumers and providers in deciding where and from whom to obtain services
- Establish rapid cycle analysis of quality and consumer experience data to support continuous improvement

# Performance Transparency

- Statewide and provider specific health, healthcare quality and care experience metrics will be analyzed by race, ethnicity, primary language and other demographic data in order to—
  - Identify and address gaps,
  - Monitor and report the effectiveness of efforts to close gaps, and
  - reward providers for doing so.

# Performance Transparency

- Performance metrics across the various domains for disparity populations would align with measures used in national/federal initiatives, including the following—
  - HHS' Action Plan to Reduce Racial and Ethnic Disparities in Care
  - AHRQ's National Healthcare Disparities Report
  - Healthy People 2020 Leading Health Indicators
  - NQF's 2012 endorsed measures for language services and the Communication Assessment Tool

# HIT - Four Categories of HIT Capabilities to Support Reforms

Category	Description
<b>Payer analytics</b> (complemented by provider analytics)	<ul style="list-style-type: none"><li>Tools for payers to analyze claims and clinical data to produce payment-related analytics, assess quality / outcome / performance metrics</li></ul>
<b>Provider - payer - patient connectivity</b>	<ul style="list-style-type: none"><li>Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models</li></ul>
<b>Care management tools</b>	<ul style="list-style-type: none"><li>Provider tools (e.g., workflow, event management) and analytics to coordinate the medical services for a patient (focus on highest risk sub-populations)</li></ul>
<b>Provider to provider connectivity</b>	<ul style="list-style-type: none"><li>Integrated clinical data exchange among healthcare stakeholders (e.g, direct messaging), including the longitudinal patient registry that can be enabled by HIE</li></ul>

# HIT - Strategy to Develop Required HIT Capabilities

## Category

## Strategy



Payer Analytics  
(complemented by  
provider analytics)

- Begin with building on payer's own population-health analytics and continue to establish the full set of tools required in end state
- In the longer term, look to leverage APCD for system level analytics that informs public health policy and consumer facing cost/quality transparency



Provider-payer-patient  
connectivity

- Select and scale a single existing provider portal for use across multiple payers
- Leverage AccessHealth CT/APCD for consumer engagement
- Potentially form relationships with 3<sup>rd</sup> party patient tool vendors



Provider-patient care  
mgmt. tools

- Near term: Educate providers on process and technology adoption
- Medium term: Simplify procurement through creating a marketplace or pre-qualifying vendors
- Longer term: Host shared service for providers to access basic care management capabilities



Provider-provider  
connectivity

- Ensure alignment with eHealthConnecticut and HITE-CT strategies to accelerate EHR adoption and enable connectivity between providers (ongoing effort)

# Value-Based Payment

- Pay-for-performance (P4P)
  - Financial rewards for providers **that meet quality and care experience targets, including those for disparity populations**
  - Available to providers on the Glide Path<sup>1</sup>
  - Provides experience necessary for success with shared savings program
  - Must have 500+ attributed consumers

<sup>1</sup>Provider groups with sufficient attributed consumers may elect to negotiate a shared savings program arrangement with individual payers in advance of achieving AMH status.

# Value-Based Payment

- Shared Savings Program
  - Share in savings if provider **meets quality and care experience targets, including those for disparity populations**
  - Payer and providers negotiate whether to share in losses
  - Practices have met initial quality metrics and progressing on AMH standards
  - 5,000+ attributed consumers

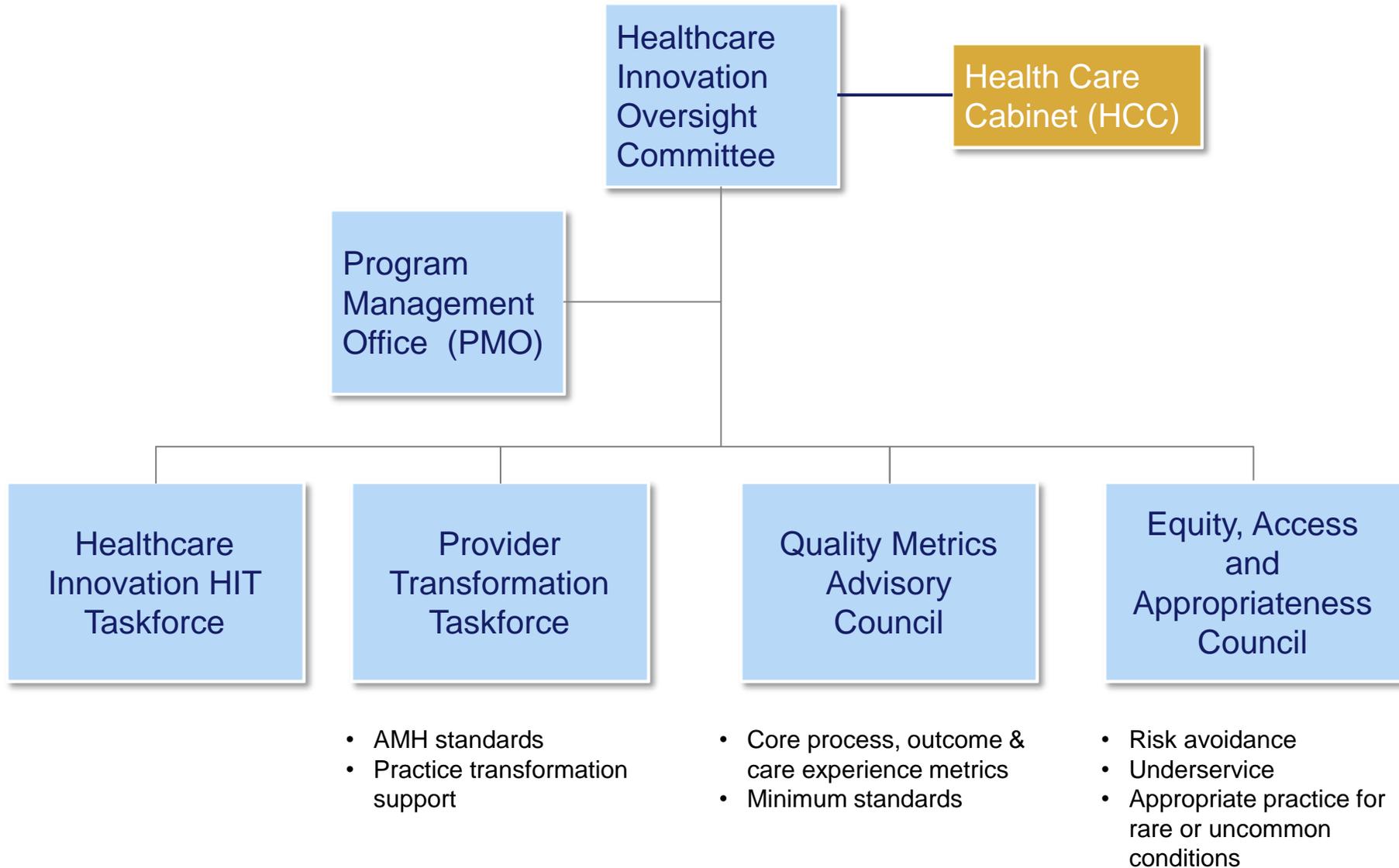
# Workforce Development

- Improved health workforce data collection and analyses, stratified by race, ethnicity, language spoken and other demographic data
- Connecticut Service Track: inter-professional training for team & population health approaches to health services
- Investment in workforce diversity initiatives across the educational pipeline
- Training program and certification standards for Community Health Workers and interpreters
- Development of core STEM curricula for baccalaureate degrees in the health field, and career ladders and career flexibility through comprehensive articulation agreements among schools that train health care professionals and allied health professionals

# Workforce Development

- Assistance for practicing primary care clinicians in adapting to care delivery models that emphasize teamwork, best practices, population health, patient engagement, learning collaboration, continuous improvement and the meaningful use of Health Information Technology (HIT)
- Assistance in developing primary care clinical skills for primary care clinicians who have been away from direct patient care and for specialists interested in primary care
- More innovative and compelling primary care GME programs

# **Governance and Operating Model**



# Quality Metrics Advisory Council

- Provider Quality and Care Experience Metrics
  - Process (e.g., HBA1C)
  - Outcome (e.g, fewer hospitals stays for ambulatory care sensitive conditions)
  - Care experience
  - Health equity

# Equity Access & Appropriateness Council

- Medicare/Medicaid/private payers – dedicated divisions focused on risks inherent to volume based payment
- Special SIM council – focus on methods for identifying and addressing concerns related to payment reforms that reward economy and efficiency, such as
  - Avoiding or inappropriately discharging higher risk clients
  - Systematic underuse/misuse/overuse (e.g., tests, procedures)
  - Appropriate care for rare or uncommon conditions

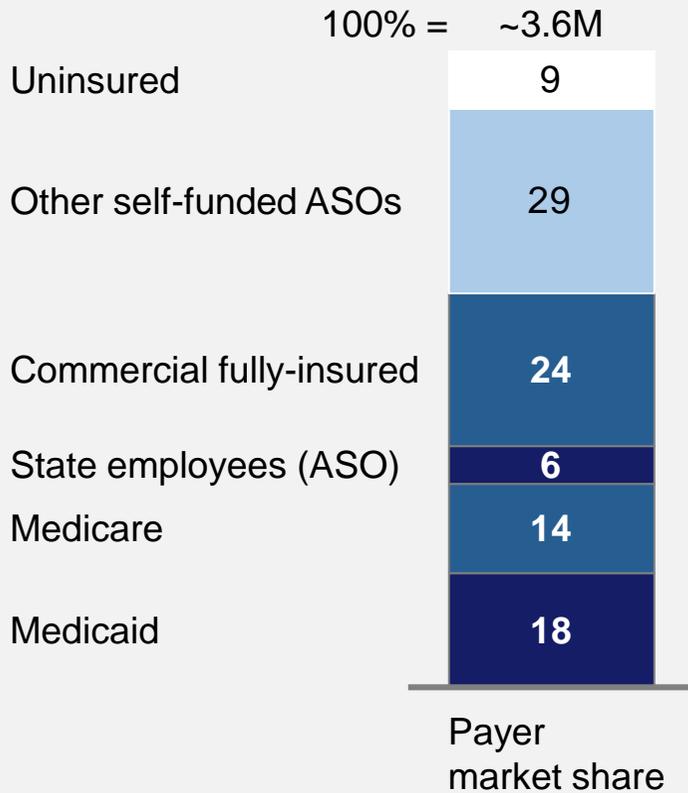
# Composition and high-level criteria for participation

	Composition	Criteria for participation
Oversight Committee	<ul style="list-style-type: none"> <li>▪ Similar to existing SHIP, plus additional provider, consumer, and/or consumer advocate</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commitment to shared aspirations</li> <li>▪ Formal authority or ability to influence</li> <li>▪ Awareness of related initiatives</li> </ul>
PMO	<ul style="list-style-type: none"> <li>▪ Program Director</li> <li>▪ 3-5 dedicated staff initially</li> <li>▪ Increase as necessary over time (10-15)</li> <li>▪ External consulting support as needed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aspirational mindset and bias for action</li> <li>▪ Analytic problem solving skills</li> <li>▪ Ability to influence without authority</li> <li>▪ Experience with transformational change</li> </ul>
HIT Taskforce	<ul style="list-style-type: none"> <li>▪ Similar to composition of SIM HIT Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>▪ Formal authority or ability to influence</li> <li>▪ Technical expertise with HIT</li> </ul>
Provider Transformation	<ul style="list-style-type: none"> <li>▪ 2-3 consumers or advocates</li> <li>▪ 2-3 physicians</li> <li>▪ 1-2 behavioral health providers</li> <li>▪ 1-2 hospital executives</li> <li>▪ 2-3 payer medical directors</li> <li>▪ 1 self-insured employer representative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Direct experience with provider transformation</li> </ul>
Quality Advisory Council	<ul style="list-style-type: none"> <li>▪ 2-3 consumers or advocates</li> <li>▪ 3-5 physicians</li> <li>▪ 2-3 behavioral health providers</li> <li>▪ 2-3 hospital medical directors</li> <li>▪ 2-3 payor medical directors</li> <li>▪ 1-2 statisticians from private payers</li> <li>▪ 1 epidemiologist from DPH</li> </ul>	<ul style="list-style-type: none"> <li>▪ Technical expertise and experience with measurement of health, quality, and consumer experience</li> </ul>
Equity Access and Appropriateness Council	<ul style="list-style-type: none"> <li>▪ 1-2 statisticians</li> <li>▪ 2-3 representatives from academic schools</li> <li>▪ 3-4 consumer advocates</li> <li>▪ 4-5 payer representatives from program integrity, fraud &amp; abuse, and/or audit division</li> <li>▪ 4-5 providers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Relevant experience and technical experience with audit methodologies</li> <li>▪ Expertise in standards of practice and evidence based practice</li> </ul>

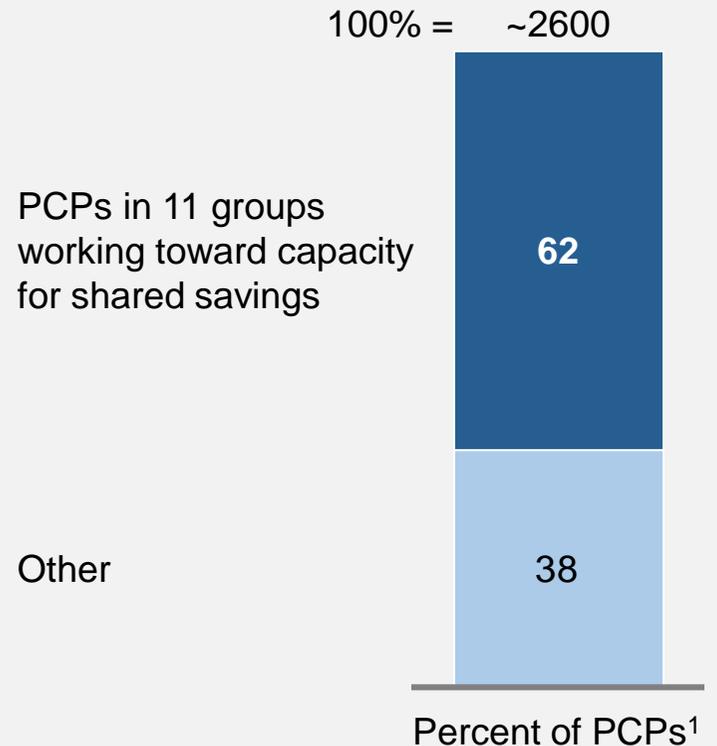
# **Pace of Payment Reforms**

# Breakdown of population by payer type, and PCPs by organizational affiliation

Insurance status of individual lives (2012)  
% of individuals in Connecticut

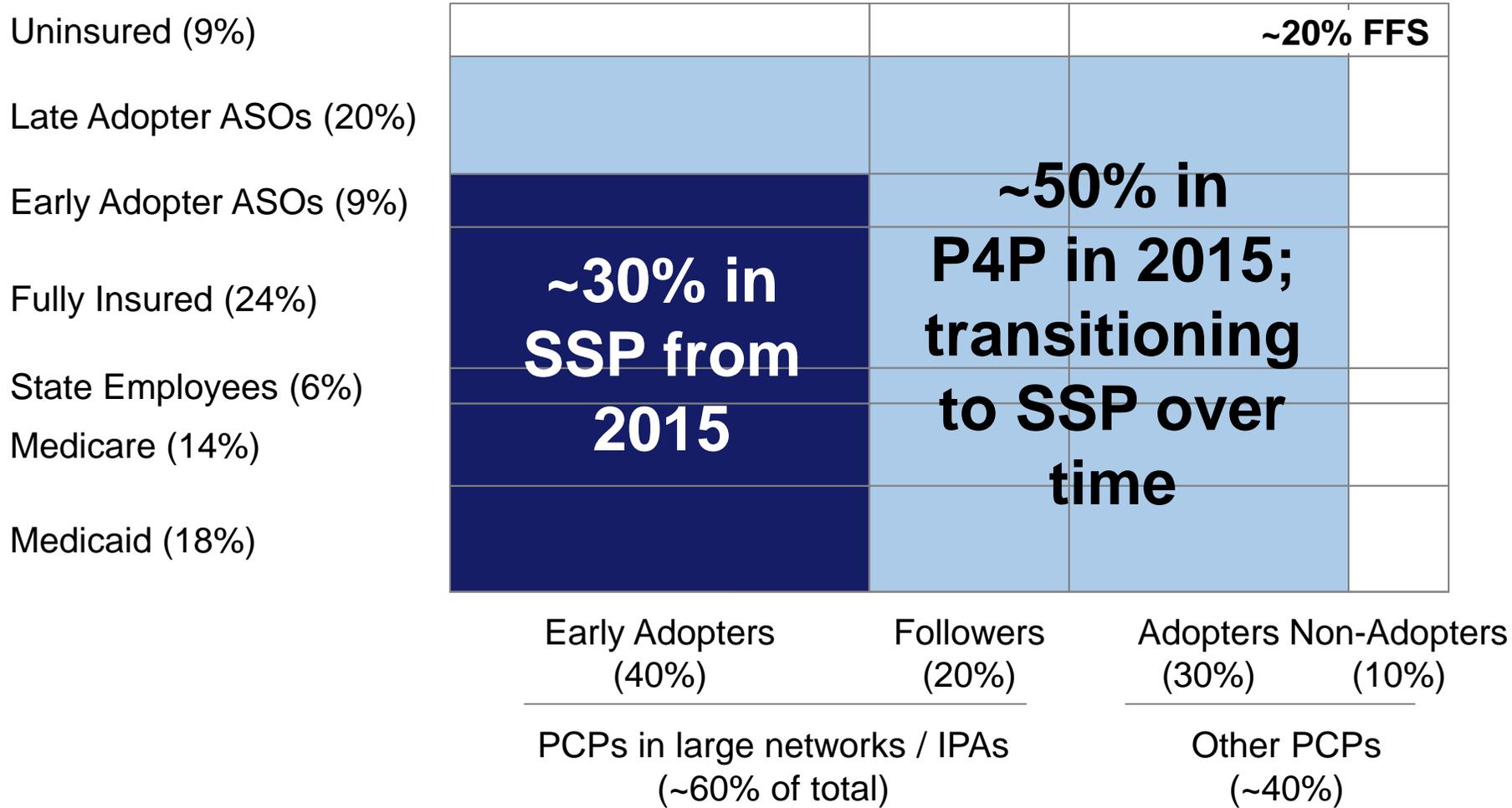


PCPs with groups making progress toward SSP  
% of PCPs in Connecticut (As of Sept 2013)



<sup>1</sup> PCP includes internal practice, general practice, family medicine, OB/GYN, and pediatrics, <sup>2</sup> Excludes dual eligibles

# Targeted percent of population attributed to PCPs in Shared Savings (SSP), Pay for Performance (P4P), or purely Fee-for-Service (FFS)



## Key Questions (1/3)

- Shared Savings Program/Payment reform
- Consumer safeguards—
  - Quality Council
  - Equity and Access Council
- Delinking primary care transformation from payment reform
- Getting to team-based care—reimbursing other members of the primary care team

## Key Questions (2/3)

- Settling on a name - AMH vs. PCMH
- Use of AMH standards
- Practice transformation support strategy
- Validation survey?
- Enticing providers to transform
- How to encourage graduates to stay

## Key Questions (3/3)

- Enhancing access
- Governance structure and operating model
- Stakeholder engagement strategy

# Care Delivery Workgroup

## Learning from the Health Care Journey

### *A child with asthma*

Kathy is a six year old girl who came into the office for asthma. The exam doesn't consider important things about Kathy, such as her history of anxiety, violence in the home, and a parent with addiction problems. Her mother doesn't entirely understand the care plan, which contains many unfamiliar terms, and does not explain why and how conditions in the home might affect asthma. The PCP is also unaware of a longstanding infestation of mice. Kathy has a series of visits to the ED, ultimately leading to a hospitalization. The PCP learns of this several weeks after her discharge.



When Kathy comes into the primary care office for symptoms of asthma, her nurse practitioner partners with her and her family to manage and coordinate her care. A concern for the well-being of Kathy and her family is expressed in verbal and nonverbal interactions. Kathy and her mom feel listened to. She is given a whole-person assessment to identify her mental health issues, changes in her living situation, other health conditions, and other social-determinants of her health and underlying causes of her asthma.

A Care Coordinator provides information to Kathy and her family about asthma triggers, and makes referrals to a mental health provider for the parent's addiction problems, as well works with them to address housing concerns.

**Team-  
Based,  
Whole-  
Person  
Centered  
Care**





The Care Coordinator connects Kathy and her family with a Certified Entity in their community which conducts a home assessment to identify asthma triggers that may be present. The home assessment reveals a mice infestation and actions are taken to address this important asthma trigger. Through electronic health information exchange, there is timely information flow about Kathy's progress from the Certified Entity to her primary care provider.

**Coordinated,  
Community-  
based**



A Community Health Worker follows up with Kathy's mother about her substance use problem and violence in the home. She meets several times with her to make sure that she is successfully connected to care and support.

Calls, texts, or/and emails are used as reminders for routine appointments. Kathy's mother uses the practice's consumer portal to ask questions about Kathy's medication. ED visits and hospital admissions are successfully avoided.

**Coordinated,  
Community-  
based**



Kathy's primary care provider is part of an Advanced Medical Home. The practice knows that it will be accountable for the care it provides, including the care experience for Kathy's mom and the effective control of Kathy's asthma.

The practice receives regular reports on quality, efficiency, and patient satisfaction. The practice uses this information to continuously improve the quality of service that they provide children like Kathy.