

Delivery Model

Advanced Primary Care



small-med independent practices
physicians: 1,120 # patients: 1.4m

Community & Clinical Integration



Advanced networks, FQHCs and practice groups
physicians: 1,680 #patients: 2.1m

Transformation Support

Advanced Medical Home Glide Path



HIT Adoption

- ONC-certified eHR
- eRx
- Secure Email

Care Coordination & Management Tools

- Shared Decision Making
- Referral Tracking and follow-up
- Chronic illness gaps, alerts
- Chronic illness self-management
 - Disease Registries
- Health Risk Stratification
- Care coordination

Structural Standards

- EHR
- Extended business hours
- CLAS
- Use of data

Analytics

- CQI Reporting

Targeted Technical Assistance

Innovation Grants?

+

Learning Collaboratives

Community Care Integration Approach

- Expanded care team w/Health Coaches & Patient Navigators
 - Home Visiting / Outreach
- Linkage to Prevention Service Centers & Health Depts
 - Community Care Teams / Hotspotter
- Linkage to Long Term Supports & Services
- Linkage to Housing and other Social Supports

Clinical integration and Advanced Care Management

- Provider access to electronic data
- Timely information exchange
- Monitoring practice patterns
- Clinician/provider detailing
 - Behavioral Health
 - Oral Health
- Medication therapy management
 - Expanded care registries
- Home visits and monitoring
 - Process for care transitions
 - e-consults
 - Telemedicine

Structural Standards

- E.g., URAC, NCQA
- CLAS
- Consumer portal
- Personal health record
- Consumer decision aids

Analytics and Quality Improvement

- Integration and use of data
- Rapid Cycle CQI (quality, experience, cost)
- Population health analysis
- Data to assess & improve disparities

Payment Model

Pay for Performance (P4P)

Pay for Performance (P4P) +
Advanced Payments for Care Coordination

Shared Savings Plan (SSP) +
Advanced Payments for Care Coordination, New Services & Non-Visit Based Activities and/or Shared Service Solution (e.g., insurer, ASO)

Cross-payer common quality performance scorecard, care experience inclusion in value based payment calculation

whole-person-centered, enhanced access, team-based coordination, evidence-based, population health

Notes

- * Practice may already be on NCQA PCMH glide path
- ** Practice may be an IPA, ACO, Medicare ACO, CIN, etc
Practice may have achieved NCQA Level 3