Care coordination as an extension of primary care

January 13, 2016

Introduction

PURPOSE OF THIS PAPER

Since July 2014, the Delaware Center for Health Innovation (DCHI) has been convening stakeholders to establish goals for primary care transformation as a key element of Delaware's Health Innovation Plan, contributing to our broader aspirations for improved health, health care quality and experience, and affordability for all Delawareans. While our early work has focused on primary care, in the future we hope to build on this foundation with improved behavioral health and specialty care, as well as better integration among primary care, behavioral health, and specialty care.

This spring, we published our perspective on primary care practice transformation (May 2015). In the following consensus paper, we further elaborate our perspective on care coordination. We believe coordinated care is foundational to achieving the Triple Aim. We believe there is a benefit to developing a common framework for the key elements of care coordination related to expectations, funding, support, and participation. We also recognize that the way in which providers implement care coordination may vary among providers based on differences in provider scale and structure, and in patient needs.

DCHI puts forward this consensus paper with several suggestions, including: (1) a vision for care coordination as an extension of primary care; (2) principles for funding care coordination; (3) principles for provider eligibility; and (4) support for providers in adoption of care coordination. DCHI seeks feedback from providers, purchasers, payers, and other health care organizations about the proposed approach and areas of alignment.

DELAWARE HEALTH INNOVATION PLAN

Delaware aspires to be a national leader on each dimension of the Triple Aim: better health, improved health care quality and patient experience, and lower growth in per capita health care costs.

In 2013, the Delaware Health Care Commission convened stakeholders across the state – including consumers, providers, payers, community organizations, academic institutions, and state agencies – to work together to build a strategy to achieve these goals. That work culminated in Delaware's State Health Care Innovation Plan followed by the award of a four-year, $35 million State Innovation Model Testing Grant from the Center for Medicare and Medicaid Innovation to support the implementation of the plan. Combined with additional investments by purchasers, payers, and providers of care in Delaware, grant funds

are intended to support changes in health care delivery to create more than $1 billion in value through 2020. DCHI was established in the summer of 2014 to work with the Health Care Commission and Delaware Health Information Network (DHIN) to guide the implementation of the strategy as described in the Innovation Plan as a partnership between the public and private sectors.

CARE COORDINATION FUNDING AS ONE OF THREE FORMS OF SUPPORT

Leaders in Delaware's provider community agree that better integrating and coordinating care for high-risk populations will require meaningful changes in operational processes and development of new capabilities among primary care providers. Over the past several months, DCHI has contemplated three forms of support for primary care providers, including independent providers and those working as part of a larger group, system or network. We provide working definitions below, as context for our recommendations in the pages that follow.

- **Practice transformation support** describes transitional financial support and/or technical assistance to help providers adopt changes in clinical and operational processes. While the transformation of primary care practices to population-based models of care delivery may be a journey of continuous improvement, we refer here to finite support over one or two years.

- **Care coordination funding** would help providers coordinate care between patients' office visits or other encounters with the health care system. Advances could include improved communication and coordination between patients and their providers, or among otherwise unconnected providers. Care coordination may be funded through fee-for-service payments tied to care coordination, fixed payments paid per member per month, or another method.

- **Outcomes-based payments** may be paid to providers for quality, experience, and efficiency. The Delaware State Health Innovation Plan reflects stakeholder consensus that payers should offer primary care providers (or their affiliated groups or systems) two types of outcomes-based payment models: Total Cost of Care (TCC) models that pay providers for controlling growth in the per capita total cost of care including primary care, medical care, behavioral health care, and pharmacy; as well as Pay-for-Value (P4V) models that pay providers for efficiency based on one or more measures of utilization as a proxy for total cost of care. Stakeholders recommended that under either model, providers should achieve standards for quality and patient experience to receive payments tied to the efficiencies achieved.

Vision for care coordination

Our vision is that all Delawareans should receive convenient, effective, well-coordinated care throughout the health care system, and do so in a way that supports the Triple Aim. Providers may integrate care coordination capabilities and processes with primary care in multiple ways, depending on providers' scale and structure, and patient needs. To help us develop an approach that could support the multiple models of coordinated care emerging across Delaware, we felt it was important to start with a shared working definition:

> *Care coordination is the deliberate organization of activities between the patient and those involved in the care of the patient, to facilitate appropriate delivery of health care services and to optimize health outcomes. Organizing care involves aligning personnel and other resources needed for all aspects of patient care and the exchange of information among the participants responsible for the different components of care.*

COMMON PROCESSES

DCHI has identified twelve common processes underpinning effective care coordination, derived from nationally recognized standards and guidelines[1], tailored to Delaware's needs and circumstances. While multiple approaches to care coordination are already emerging across Delaware, we aspire that over time, most models will embrace some or all of these twelve processes.
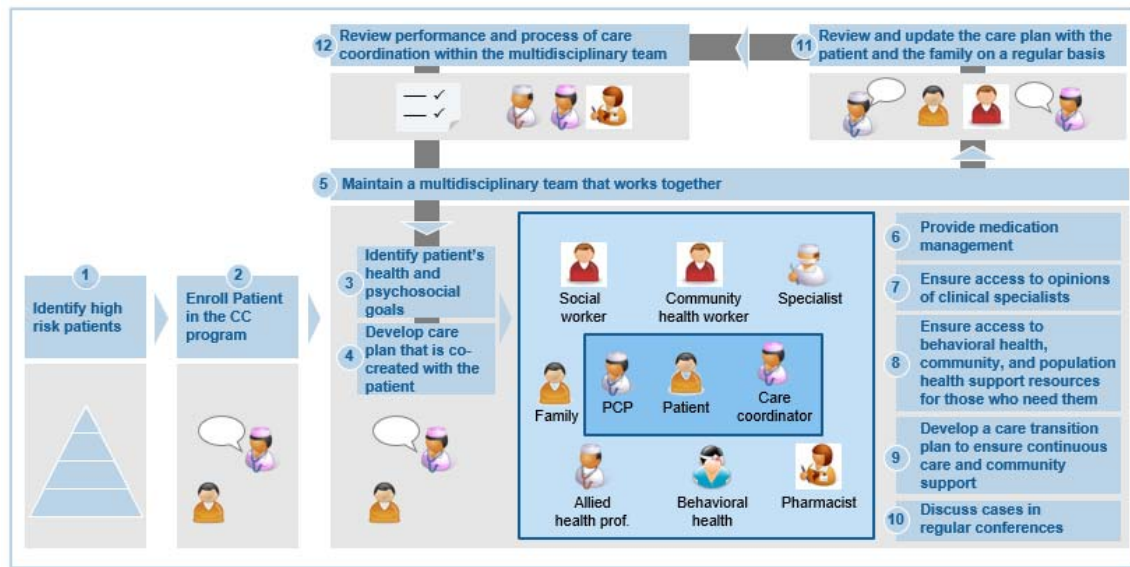
1. **Identify high-risk patients.** This process describes a practice's ability to develop and maintain a registry of high-risk patients likely to benefit from care coordination. The DCHI Primary Care Practice Transformation paper, published in May 2015, defines the approach to identifying the highest risk patients.[2] This process represents the foundation for coordinated care for a panel of patients.

2. **Enroll the patient in the care coordination program.** This process involves proactive outreach to high-risk patients to inform them about the practice's approach to care coordination and discuss how the practice, patient, and their family may work together to coordinate care. In some cases, this process may

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[1] From the National Committee for Quality Assurance, Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Quality, and Institute for Healthcare Improvement, among others

[2] The practice should have a documented definition of which patients it considers the highest risk and the highest priority for care coordination. Practices may choose to prioritize the highest-cost or highest-utilization patients, but each practice must develop a definition that suits its population and priorities. The practice should also document an evidence-based rationale for its definition

also involve a formal partnership or enrollment process between the patient and the practice. Effective communication and collaboration with patients and their families is critical to the success of any care coordination programs.

Exhibit: Common Processes of Care Coordination

3. **Identify the patient's health and psychosocial goals.** This process involves identification of patient-specific treatment goals in the context of the patient's lifestyle and preferences through discussion with the patient, family, and caregivers. Results of these conversations serve as an input to the care plan.

4. **Develop a care plan that is co-created with the patient.** The multidisciplinary team should be mindful of collaborating with the patient, the family, and everyone who works with the patient to develop a comprehensive, holistic, patient-centered, and achievable care plan. Care planning might require multiple activities, including, but not limited to, assessment for physical and behavioral health, selection of treatment options, and identification of potential barriers to pursuing the care plan.

5. **Maintain a multidisciplinary team that works smoothly together**. This process involves bringing together all relevant providers, organizations, and individuals who will provide care for the patient. A well-functioning multidisciplinary team can provide coordinated, continuous, comprehensive, and efficient health care services for patients.

6. **Provide medication management.** The process starts with careful documentation of the patient's medications history to enable appropriate medication selection for the care plan. Then it involves regular assessment of

medication component of the care plan and interventions as needed. Relevant multidisciplinary team members take into account medications' efficacy and safety, as well as interactions between multiple medications, to ensure appropriate, optimized medication therapy in a patient-centered fashion.

7. **Ensure access to opinions of clinical specialists**. This process describes the steps a multidisciplinary team follows to ensure seamless involvement of the relevant specialists into the patient's care. This may include, for example, soliciting specialists' input for care planning, establishing the patient's information flow to the specialists and across the multidisciplinary team, and ensuring timely access, interactions, and follow-ups.

8. **Ensure access to behavioral health, community, and population health support resources for those who need them**. This process involves providing necessary, adequate, and timely access to behavioral health clinicians and community support services, as well as necessary and adequate preventive measures to address preventive health needs and chronic disease management

9. **Develop a care transition plan to ensure continuous care and community support.** This process defines activities that the practice and multidisciplinary team might need to perform to ensure continuity during a transition of care and to reduce readmissions and resource utilization that might be due to a lack of coordination during that transition. The steps include, but are not limited to, identification of patients who are expected to undergo a care transition and working with relevant providers and organizations to develop a transition plan. The multidisciplinary team monitors follow-up appointments and actively reaches out to patients to ensure appropriate care is provided in a timely way.

10. **Discuss cases in regular conferences**. This process describes forums that multidisciplinary teams hold on a regular basis to review complicated cases. Such discussions involve complex cases, acute admissions, referrals of patients to relevant services, and changes in care plans, and cover other potential aspects of holistic patient-centered care in a team environment that enables coordinated care.

11. **Review and update the care plan with the patient and the family on a regular basis**. This process involves monitoring patients' adherence to the care plan and ensuring the patient and the family stay motivated and engaged in care, which increases the likelihood of treatment adherence, including behavioral and lifestyle changes, and can result in improved outcomes. Also, the multidisciplinary team identifies necessity to perform care planning changes and implements them in a collaborative manner with the patient.

12. **Review the performance and process of care coordination within the multidisciplinary team**. This process involves regular performance review sessions with the primary care practice and multidisciplinary team to continuously improve the performance of care coordination and increase the likelihood of better outcomes. Sessions include collaborative discussions of performance metrics dynamics, opportunities for improvement, and best practice learnings. Review outcomes are incorporated into further care coordination efforts to improve care quality.

SOURCING STRATEGY

Primary care providers may adopt very different strategies for how they source care coordination technology and services. Options include:

a. Having PCPs do care coordination themselves, spending more time with high-risk patients while either reducing their panel size or shifting some acute care to physician extenders, retail clinics or other alternatives

b. Hiring care coordinators to work within primary care practices and/or the community

c. Sharing care coordinators across multiple small practice sites, whether by directly hiring them or by accessing them through an Independent Practice Association (IPA), or another "aggregator"

d. Contracting with a health system or clinically integrated network (CIN) to utilize its care coordination resources and experience

e. Contracting with a commercial vendor to provide care coordination technology and/or services

While a small minority of PCPs may choose option (a) or (b), the recent growth in the Delaware market of Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs) across the state means that many providers are considering versions of "aggregation" to take risk and share resources to coordinate care.

Principles for funding care coordination

DCHI strongly recommends that all payers pay primary care providers for care coordination, treating it as a benefit expense like other reimbursable health care services.

By coordinating care for high-risk populations, PCPs may reduce preventable hospitalization, avoidable use of the emergency room, and other factors that contribute to the total cost of care. Under outcomes-based payment models, these providers may share in savings that represent a significant return on investment for care coordination. However, without up-front funding for care coordination, providers who lack working capital will be unable to invest in care coordination simply on the promise of potential for outcomes-based payments that are at least a year away and sometimes longer.

While specific care coordination funding arrangements are part of the contractual relationships between payers and providers, DCHI strongly recommends that payers and providers adopt the following funding principles:

1. **All payers should fund care coordination through payments to primary care providers.** By funding care coordination through payments to primary care providers, payers can afford PCPs (or the organizations that employ those PCPs) the ability to determine how best to organize care coordination in a way that can be fully integrated with primary care workflows. By funding care coordination through payments to PCPs, care coordination technology and services may be adopted in a manner that is consistent for patients within a PCP's panel, across multiple sponsoring payers.

2. **Primary care providers should retain discretion over how best to organize to deliver care coordination.** Primary care providers vary in scale, structure, and capabilities. Their approach toward organizing care coordination may therefore vary. Payers may make care coordination payments conditional upon demonstration of capabilities and processes that are likely to realize a return on investment. However, payers should not make payments conditional upon sourcing of care coordination capabilities from the payer or any other means that would impede the primary care provider from achieving consistent workflows for patients with different sponsoring payers.

3. **When possible, payers should structure care coordination payments as a risk-adjusted (or tiered) per member per month payment applied to all attributed patients.** Payers may structure payments for care coordination in multiple ways, including per member per month (PMPM) payments for all attributed patients or selectively for high-risk patients; through fee-for-service

payments tied to discrete care coordination activities, or an increase in the fee schedule for traditional office visits. The consensus among payers and providers participating in DCHI discussions has been that PMPM payment applied to all attributed patients will afford providers the greatest flexibility in deploying care coordination resources in the manner that has the greatest potential to improve quality and control costs.

4. **Funding for care coordination should be sufficient to cover the costs of technology and services based on shared expectations for the scope and intensity of care coordination.** Both payers and providers have an interest in ensuring that funding for care coordination is financially sustainable. While payment levels for care coordination may be negotiated independently by payers and providers, we believe it essential that payment levels be grounded in shared expectations for the scope and intensity of care coordination, and an estimate of corresponding costs [See Table 1: Care Coordination Costs].

5. **Care coordination funding may be super-ceded by broader capitation arrangements or other outcomes-based payments.** In some cases, well-capitalized health systems, IPAs, or ACOs may accept global capitation or risk sharing arrangements that super-cede care coordination payments from payers. These provider organizations may choose to themselves make care coordination payments to participating PCPs, or instead may offer care coordination technology and/or services to participating PCPs.

We believe that all payers should fund care coordination at a level sufficient to cover the costs of care coordination, based on common expectations for scope and intensity.

ESTIMATING COSTS BASED ON SCOPE OF CARE COORDINATION

Among 20 examples of care coordination payment in the U.S., funding levels varied widely, ranging from $1-2 PMPM at the low end to $20 PMPM or more for some high-risk populations. Making direct comparisons between these programs is confounded by two factors: (1) significant differences in the risk of populations and therefore the potential to achieve return on investment from care coordination; and (2) differences in expectations for the scope and intensity of care coordination.

Funding at the low end of this range may be sufficient to cover the costs of care coordination only for a small subset of the population at critical intervals; for example, immediately following discharge from the hospital with a chronic condition at risk for readmission. Funding at the high end of this range may be sufficient to fund care coordination throughout the year for a much broader cross-section of a population.

PCPs in Delaware differ markedly in their current capacity to assume responsibility for extensive care coordination. Some may be prepared to undertake care coordination for a high proportion of their patient panels and still deliver a meaningful return on investment. Others will prefer to focus care coordination on a small subset of high-risk patients who are most prepared to actively engage in their own care. Although up to 30-50% of Commercial/Medicaid and 70% of Medicare patients may benefit from Care Coordination, DCHI recommends that the initial focus of care coordination should be on a subset of the patients for whom it will be most feasible and beneficial. Some of the reasons for doing this include:

■ Some of the broader group of patients may be more difficult to engage and influence than others

■ It may be easier to establish evidence of near-term ROI based on focusing Care Coordination on the highest-risk patients who are willing to engage in their own care

■ Payers / purchasers being asked to invest in Care Coordination may require clear evidence of ROI in Year 1 and 2 of the program

Table 1 (below) illustrates three different examples for how the costs of care coordination may vary depending on expectations for scope and intensity.

DCHI believes that as a starting point, payers and providers should set their focus on care coordination models with "moderate" expectations for scope and intensity (as described in Table 1 below), with the understanding that these expectations may progress over time. DCHI is eager to foster further dialogue among providers, payers, self-insured employers and other plan sponsors regarding the appropriate funding level for care coordination.

Table 1: Matching Expectations for Scope and Intensity

Approach	Description
"High expectations"	Care coordination for 10-20% of patients in a panel has an estimated cost of $7-12 PMPM—about 1-2% of the total cost of care for a Commercial or Medicaid population, excluding those with dual eligibility for Medicare. Providers with strong commitment to population health management and significant capabilities and experience may achieve a significant long-term return on investment from deployment of care coordination at this scope and intensity (or even greater). However, PCPs who lack experience with care coordination may sometimes struggle to demonstrate a positive ROI in the near-term based on this level of investment.
"Moderate expectations"	Care coordination focused on 5% of patients has an estimated cost of $3-5 PMPM—about 0.5-1.0% of total cost of care for a non-Medicare population. By focusing on a narrower subset of the population with the greatest need for care coordination and a greater willingness to engage, PCPs may have a greater potential for near-term ROI at this scale of investment.
"Targeted expectations"	Care coordination focused on patients with chronic conditions immediately following discharge from the hospital or emergency department has an estimated cost of $1-2 PMPM, or about 0.1-0.2% of total cost of care for a non-Medicare population. Such a concentrated effort could capture quick wins in the short-term, but may have limited impact on total cost of care in aggregate.

Principles for provider eligibility for funding

Whether the level of funding for care coordination is the same or different among payers, we believe it is constructive for payers to align expectations for provider eligibility for the initiation of care coordination funding. For these reasons, DCHI offers the following principles as a starting point for further dialogue among Delaware's payer community and primary care community.

1. **Payers should define objective criteria based on which primary care providers shall be deemed eligible for care coordination funding.** Providers will be more apt to make investments in the adoption of new capabilities and processes if they feel confident that doing so will qualify them for care coordination funding and outcomes-based payment models. DCHI asks that payers define objective criteria for eligibility for care coordination (and outcomes-based payment) and communicate these criteria widely, so that PCPs may be broadly aware of these criteria as they weigh the decision of whether to take advantage of practice transformation support funded by the State Innovation Models (SIM) grant.

2. **Payers are encouraged to qualify PCPs for care coordination funding if they achieve reasonable performance standards for quality of care and demonstrate commitment and progress toward building the capabilities necessary for effective population health management.** Quality criteria should be based in whole or in large part on quality measures drawn from the DCHI Common Scorecard (version 2.0 adopted by DCHI in September 2015 for implementation in 2016, see Appendix A). Provider progress toward capability building for population health management may be demonstrated by successful completion of the 6- and 12-month DCHI milestones for practice transformation (as adopted by DCHI in May 2015, see Appendix B). By completing these milestones, primary care practices will lay a foundation to take full advantage of care coordination funding once initiated.

3. **Some providers may be deemed ready for care coordination funding in less than 12 months' time.** Some Delaware PCPs have already undertaken practice transformation, and accordingly may already be well prepared to take advantage of care coordination funding. Payers may elect to initiate care coordination funding immediately for all practices or select practices who demonstrate readiness, either through: (a) prior recognition by NCQA or another accrediting body; (b) past participation in practice transformation support pre-dating SIM; and/or (c) an assessment of practice capabilities by SIM-funded practice transformation vendors in the coming months. Some payers may choose to make PCPs eligible for care coordination funding

independent of practice transformation or capability assessment, based purely on demonstration of strong performance for quality and/or efficiency. In such instances, practices are nonetheless encouraged to engage in practice transformation in order to build the population health management capabilities that will enable them to succeed under outcomes-based payment models.

4. **Payers should establish objective criteria which need to be met by providers to sustain care coordination funding.** Funding of care coordination is meant to result in improvements in quality, patient experience, and efficiency. Payers may define the level of performance and/or performance improvement that must be achieved by providers as a condition for continuation of care coordination funding. Payers are encouraged to base these decisions on performance measures captured on the DCHI Common Scorecard.

5. **Care coordination funding may be super-ceded by broader capitation arrangements or other outcomes-based payments.** In some cases, well-capitalized health systems, IPAs, or ACOs may accept global capitation or risk sharing arrangements that super-cede care coordination payments from payers. These provider organizations may choose to themselves make care coordination payments to participating PCPs, or instead may offer care coordination technology and/or services to participating PCPs.

Support for providers in adoption

We recognize that the integration of care coordination into primary care workflows represents a new and different way of engaging with patients and the health system for many practices. DCHI, HCC, private payers and providers have already defined a number of resources to facilitate care coordination adoption. In this section we define the steps and available support for implementing care coordination and a set of options currently under consideration to provide support to providers.

CURRENT PROVIDER NEEDS

Following, we outline five practice needs: (1) projecting costs and funding; (2) selecting a sourcing strategy; (3) hiring and training staff (if applicable); (4) identifying and integrating with community resources; and (5) accessing data.

1. **Projecting costs and funding.** Primary care providers (or their sponsors in the transition to value-based care) will need to develop an estimate of the costs associated with care coordination, as well as an estimate of the potential funding available from payers and/or other sources to offset these costs.

2. **Selecting a sourcing strategy.** As described previously, providers face important choices in determining whether to hire coordinators into their practice or to source care coordination technology and/or services externally.

3. **Hiring/training staff.** Effective care coordination requires new ways of working together in teams and for many practices, hiring new staff (e.g., care coordinators). Providers may need support in (a) identifying potential new staff and (b) training their current staff while they are also working in the practice.

4. **Identifying and integrating with community resources.** Several of the common processes for effective care coordination require working collaboratively with patients to connect to resources outside the care delivery system; however, providers have raised that they often do not have transparency into available resources.

5. **Accessing data.** Several of the core processes of effective care coordination require timely access to data to identify patients at need for care coordination, support connectivity across providers on multidisciplinary teams, etc.

PROPOSED SUPPORT FOR PROVIDERS

When Delaware's State Health Care Innovation Plan was developed, it was originally proposed that technical assistance through pre-qualified vendors would

be helpful for practices to implement care coordination. However, there has been a rapid change in Delaware's landscape with the emergence of CINs and ACOs that are providing care coordination tools and resources. Payers are also providing coaching and other types of resources to providers to support elements of care coordination. As a result, DCHI does not believe there is a near-term need for additional technical assistance resources for providers to enable care coordination. Instead, DCHI recommends focusing on aspects of system-wide infrastructure that will benefit ongoing care coordination across all of the ongoing programs. In particular, DCHI proposes investing in the following areas of support (the first three of which are already underway by DCHI and its partner organizations at HCC and DHIN):

1. **Workforce training**

   Effective care coordination requires new ways of working together in teams and for many practices, hiring new staff (e.g., care coordinators). Providers may need support (a) identifying potential new staff and (b) training their current staff. This may include common curriculum for training/retraining on the skills and competencies for care coordination (in development with the DCHI Workforce and Education Committee).

2. **Practice transformation**

   Providers may require technical assistance to help adopt changes in clinical and operational processes that will enable them to successfully do care coordination. While the transformation of primary care practices to population-based models of care delivery may be a journey of continuous improvement, HCC has contracted 4 vendors who will provide support to PCP practices across the state over the next 1-2 years. For more information please see DCHI's Consensus Paper on Practice Transformation.

3. **Data and reporting**

   Several of the core processes of effective care coordination require timely access to data to identify patients at need for care coordination, support connectivity across providers on multidisciplinary teams, etc. Currently planned resources include:

   - Initial list of high-risk patients from payers

   - Admission, Discharge, Transfer (ADT) data from DHIN

   - Quarterly data on Common Scorecard performance

   - Training to make effective use of practice-level data from practice transformation vendors

■ Funding for EHRs for Behavioral Health providers

4. Identifying common processes

Payers, ACO leaders, and providers are currently investing in care coordination resources of varying types and degrees. This group should be convened to align on common approaches, procedures and templates to standardize care coordination across the state. For example, a common care plan may facilitate interoperability and minimize the burden on PCPs.

5. Identify opportunities to link to Healthy Neighborhoods

Given smaller panel size of independent practices, care coordination payments may not be sufficient for practices to effectively source care coordination resources or support. DCHI's Clinical Committee will collaborate with the Healthy Neighborhoods Committee over the next 6 months to evaluate the role Healthy Neighborhoods may play to enable improved care coordination and integration between primary care and community-based support services. One approach to improve care coordination is to build on the Community Health Team design employed by the Vermont Blueprint for Health model which connects primary care providers (PCPs) and community-based prevention programs for chronic disease. In this model, the team would assess patient's needs, coordinate community-based supports and provide multidisciplinary care for the Neighborhood.

Path Forward

By the second quarter of 2016, the Clinical Committee will make recommendations to the DCHI board on common processes that should be supported to standardize care coordination across the state. In the middle of 2016, DCHI recommends outreach to providers participating in practice transformation and provider organizations (e.g., ACOs) to reassess their needs related to care coordination and identify any additional support required.

DCHI will continue to work with payers to provide funding for care coordination and to align eligibility for this funding to practice transformation milestones or other objective criteria. Care coordination funding will be critical for providers to implement care coordination.

APPENDIX A: COMMON SCORECARD VERSION 2.0

Common Scorecard version 2.0- DRAFT

Category		Measures	Measure type	Data source	Type
Quality of care	1	Diabetes: HbA1c control	HEDIS (CDC)[1]	CPT-II	Reporting
	2	Diabetes: Medical attention for nephropathy	HEDIS (CDC)[2]	Claims	Accountable
	3	Medication adherence in diabetes	NQF #541[3]	Claims	Accountable
	4	Medication adherence in high blood pressure: RASA	NQF #541	Claims	Accountable
	5	Adherence to statin therapy for individuals with cardiovascular disease	HEDIS (SPC)	Claims	Accountable
	6	Medication management for people with asthma	HEDIS (MMA)	Claims	Accountable
	7	High risk medications in the elderly	HEDIS (DAE)	Claims	Accountable
	8	Colorectal cancer screening	HEDIS (COL)	Claims	Accountable
	9	Cervical cancer screening	HEDIS (CCS)	Claims	Accountable
	10	Breast cancer screening	HEDIS (BCS)	Claims	Accountable
	11	BMI assessment	HEDIS (ABA)	Claims	Reporting
	12	Screening and follow-up for clinical depression	NQF #418	G-code	Reporting
	13	Avoidance of antibiotic treatment in adults with acute bronchitis	HEDIS (AAB)	Claims	Accountable
	14	Appropriate treatment for children with URI	HEDIS (URI)	Claims	Accountable
	15	Childhood immunization status	HEDIS (CIS)	Claims	Accountable
	16	Developmental screening in the first three years of life	NQF #1448	Claims	Reporting
	17	Fluoride varnish application for pediatric patients	Custom	Claims	Reporting
	18	HPV vaccination in adolescents	HEDIS (HPV)	Claims	Accountable
	19	Adolescent well-care visits	HEDIS (AWC)	Claims	Accountable
	20	Well child care: 0-15 months	HEDIS (W15)	Claims	Accountable
	21	Well child care: 3-6 years	HEDIS (W34)	Claims	Accountable
Utilization	22	Follow-up within 7 days after hospital discharge	Custom	Claims	Reporting
	23	Plan all-cause readmissions	HEDIS (PCR)	Claims	Accountable
	24	Inpatient utilization	HEDIS (IHU)	Claims	Accountable
	25	Emergency department utilization	HEDIS (EDU)	Claims	Accountable
Total cost of care	26	Total cost of care per patient	Payer defined	Claims	Accountable

1 One component of the Comprehensive Diabetic Care specification; modified HEDIS definition: HbA1c < 9%
2 One component of the Comprehensive Diabetic Care specification
3 Proportion of Days Covered (PDC) specification for: diabetes, renin angiotensin system antagonists, and statins

APPENDIX B: PRACTICE TRANSFORMATION MILESTONES[3]

DCHI envisions a primary care model that effectively treats and coordinates the care of a population of patients throughout their health care experience. The capabilities and support model described earlier are meant to accelerate progress toward this vision. DCHI recommends a standard set of "transformation milestones" to measure progress towards this vision over a given period.

These milestones are grounded in the National Committee on Quality Assurance (NCQA)'s Patient Centered Medical Home (PCMH) certification program and tailored to the needs of Delaware. This approach ensures that DCHI's recommendation aligns with clear national standards as well as a commonly used approach among practices in Delaware today. An explanation is provided for each milestone, including the intent and the conditions that need to be met. (For more details about measurement and milestones, please see the Appendix.)

Practices should reach all transformation milestones in 18-24 months. Timelines should be used for reference only; they reflect the maximum expected amount of time for practices to achieve the milestones without previous transformation efforts. At the beginning of transformation, practices will work with vendors to develop individual transformation plans that adjust these timelines:

1. **Identify the 5% of panel at the highest risk and highest priority for care coordination (6 months).** This milestone describes a practice's ability to develop and maintain a registry of patients likely to benefit from care coordination. This milestone is a foundation of coordinating care for a panel of patients. To reach it, a practice must have clear criteria for identifying people at "high risk" who require care coordination and develop a process for regularly maintaining and updating a registry of those patients.

2. **Provide same-day appointments and/or after-hours access to care (6 months).** This milestone describes a practice's ability to improve access to primary care for their patients. Improved access helps reduce unnecessary trips to the emergency room and even hospital admissions. To reach this milestone, practices, even those with walk-in access today, must demonstrate that all patients can make same-day scheduled appointments for urgent issues. Patients may access the clinician and care team for routine and urgent care needs through office visits by telephone, secure electronic messaging or other technology.

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[3] From DCHI Practice Transformation Consensus Paper (May 2015)

3. **Implement a process for following up after hospital discharge (6 months).** This milestone describes a practice's capability to proactively engage with patients following an acute event. Effective transitions of care—between primary care and specialist providers, between facilities, between outpatient practices and institutional settings—ensure that patient needs are met over time and that information is effectively shared across people, functions and sites. To reach this milestone, practices must demonstrate that they regularly identify, reach out to, and schedule follow-up appointments (where appropriate) after patients have been discharged from a hospital.

4. **Supply voice-to-voice coverage to panel members 24/7 (e.g., patient can speak with a licensed health professional at any time) (12 months).** Along with milestone #2, this milestone describes a practice's capability to improve access to primary care. Improved access can help reduce unnecessary emergency room visits and hospital admissions. To reach this milestone, a practice must have a written process and defined standards for providing 24/7 access to clinical advice and implement this process using the defined standards.

5. **Document sourcing and implementation plan for launching a multi-disciplinary team working with the highest-risk patients to develop a care plan (12 months).** This milestone describes a practice's approach to implementation of transition to team-based, integrated, patient-centered coordinated care for the 5% of patients identified in milestone #1. This sets the stage for a transition to coordinated care and application for care coordination funding to support implementation. This is the planning stage for achieving milestone #8. To reach this milestone, a practice must define its approach for sourcing care coordination support (e.g., through vendor support or by hiring a care coordinator), identify the members of the care team, and document the practice's approach to implement team-based care and develop care plans for high-risk patients.

6. **Document plan to reduce emergency room overutilization (12 months).** This milestone describes a practice's ability to support patients to avoid unnecessary utilization of the emergency room. This milestone is important because unnecessary utilization is costly and increases the likelihood of a preventable hospitalization. To reach this milestone, the practice must document a specific plan that extends beyond implementing milestones #2 and #4 (to expand access). It may include identifying frequent ER users, establishing robust information flow between the practice and the ER, and closely tracking follow-up to prevent repeat unnecessary ER visits.

7. **Implement a process for contacting patients who did not receive appropriate preventive care (18 months).** This milestone describes a practice's ability to use registries and proactive reminders to address preventive care needs for their entire panel of patients, not just the high-risk patients identified in milestone #1. This can help with early identification of new conditions and disease progression and avoid costly acute complications. To reach this milestone, the practice must demonstrate that it regularly generates reports of patients who have not received preventive care according to evidence-based guidelines and that it uses these reports to remind patients about preventive services.

8. **Implement a multi-disciplinary team working with highest-risk patients to develop care plans (24 months).** This milestone describes a practice's implemented capability to deliver team-based, integrated, patient-centered care for those patients with the greatest need for care coordination (i.e., the 5% of patients identified in milestone #1). This requires a holistic and comprehensive approach to engaging with patients over time to help them navigate the health system. To reach this milestone, a practice must identify the care team, implement a regular process for that care team to coordinate care for high-risk patients, and develop care plans for all of its high-risk patients consistent with the CMS definition of a care plan (for details, please see the Appendix).

9. **Document a plan for patients with behavioral health needs (24 months).** This milestone describes a practice's ability to integrate primary care and behavioral health care for patients with behavioral health needs. Many high-risk patients have multiple chronic medical and behavioral health conditions, and siloes of primary care and behavioral health systems do not support the holistic care for these patients. To reach this milestone, a practice must develop and document a plan for managing patients with behavioral health needs, including approaches to identifying those with behavioral health needs, developing care plans, and establishing practice workflows to integrate primary and behavioral health care.