Delaware Center for Health Innovation

Primary Care Practice Transformation

May 17, 2015

Introduction

Since July 2014, the Delaware Center for Health Innovation (DCHI) has been convening stakeholders to establish goals for primary care practice 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.

In this white paper, we summarize the consensus of local stakeholders, as adopted by the DCHI Board of Directors, with respect to: (1) a vision for primary care; (2) milestones and timeframes for practice transformation; (3) recommendations for the type of practice transformation support to be made available to providers through the State Innovation Models (SIM) Testing Grant awarded by the Centers for Medicare and Medicaid Innovation and administered by the Delaware Health Care Commission (HCC); and (4) recommendations to payers for the alignment of provider eligibility for care coordination funding and outcomes-based payment models with achievement of practice transformation milestones.

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 (HCC) 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 this 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. The Delaware Center for Health Innovation was established in the summer of 2014 to work with the Health Care Commission and the Delaware Health Information Network (DHIN) to guide the implementation of the strategy as described in the State

Health Care Innovation Plan as a partnership between the public and private sectors.

PRACTICE TRANSFORMATION 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 new capabilities for 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. Working definitions are provided 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 the introduction of fee-for-service payments tied to activities, fixed payments paid per member per month or some similar basis. **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.

New Capabilities Required in Primary Care

As part of Delaware's State Health Innovation Plan, our vision is that all Delawareans should receive convenient, effective, well-coordinated care throughout the health care system in a way that supports the Triple Aim. DCHI recognizes that multiple models of coordinated care are already being adopted by Delaware PCPs, including Patient-Centered Medical Homes, and models that colocate primary care and specialists. Many PCPs have already begun to transform some parts of their practices and will continue making advances from a variety of starting points.

Primary care providers, regardless of their coordinated care model, should demonstrate the following nine capabilities and be supported by all payers across Medicare, Medicaid and commercial segments:

1. **Panel management: Understanding the health status of the patient panel and setting priorities for outreach and care coordination based on risk.** Practices define and identify the highest-risk members of the patient panel. Providers develop and execute on an outreach plan for identified high-risk patients. The practice prioritizes these patients for care coordination, appropriate care interventions, and self-management education.
2. **Access improvement: Introducing changes in scheduling, after-hours care, and/or channels for consultation to expand access to care**. Providers develop and implement approaches to expanding access to care, and adapt based on identified patient needs and preferences. Approaches to expanding access may include after-hours and same-day appointments, phone consultations with licensed health professionals, and consultation by email, text or other technology.
3. **Care management: Proactive care planning and management for high-risk patients.** Practices identify high-risk patients, develop team-based interventions to deliver appropriate care, coordinate resources external to the practice when necessary, and track progress. Providers use information on patients' health risks and tailor responses accordingly.
4. **Team-based care coordination: Integrating care across providers within the practice, across the referral network, and in the community**. Practices identify a multi-disciplinary care team that may include physicians, nurses, medical assistants, pharmacists, social workers, and other clinical staff. Practices coordinate activities and promote communication across the team involved in a patient's care and integrate specific approaches for this collaboration into their operating model (e.g., by setting up case conferences). Practices also develop systems to coordinate with external stakeholders, such as outpatient specialists, hospitals, emergency rooms and urgent care centers,

rehabilitation centers, community resources, and the patient's support system. Coordination improves care planning, diagnosis and treatment, management through transitions of care, and patient coaching to improve treatment adherence. This capability includes integration of primary care practices with behavioral health providers where possible.

5. **Patient engagement: Outreach, health coaching, and medication management.** Practices develop a culture centered on understanding and responding to patient needs. Further, practices offer patient engagement tools and self-management programming. Approaches may include patient education, incentives, and/or technology enablement. Practices develop and execute on patient engagement plans focusing on high-risk patients in particular.
6. **Performance management: Using reports to drive improvement and participation in value-based payment models**. Practices integrate a performance management approach into their daily operations, building on Delaware's Common Scorecard. Performance management involves tracking relevant metrics, utilizing performance measurement data to inform, design, and/or improve interventions; and developing a culture of continuous improvement.
7. **Business process improvement: Budgeting and financial forecasting, practice efficiency and productivity, and coding and billing**. Practices implement business management and financial planning processes required to participate in incentive payment structures and shared savings models. Practices incorporate budgeting and financial forecasting tools to: 1) develop quarterly and annual budgets; 2) forecast resource allocation required to operate during and after transformation; and 3) estimate financial impact of incentive payments. Practices may consider making structural changes in their workflows to ensure efficient, productive team-based care delivery. Practices also adjust billing and coding processes where necessary to support transformation, including reporting requirements for performance measurement on the Common Scorecard.
8. **Referral network management: Promoting use of high-value providers and setting expectations for consultations**. Practices seek out timely information on providers that are part of their patients' extended care teams from open sources as well as Delaware stakeholders (e.g., health systems, payers, other practices) to identify providers that deliver care consistent with the goals of the Triple Aim. Practices regularly strengthen the performance of their referral network through a number of approaches that may include, for example, setting clear expectations for partners, and establishing and tracking performance metrics.

9. **Health IT enablement: Optimize access and connectivity to clinical and claims data to support coordinated care**. To coordinate care, practices use health IT tools, including electronic health records, practice management software, and data from DHIN. Practices effectively interpret data, use health IT as a component of their workflow, and support expansion of the Community Health Record with clinical data.

Practice Transformation Support

Consistent with Delaware's State Health Innovation Plan and State Innovation Model (SIM) Testing Grant application, DCHI strongly recommends that support be provided to primary care practices to build the capabilities and adopt the processes outlined here. This will help equip them to manage the health, health care, and associated costs for their entire patient panels across all payers.

Here we outline the DCHI Board's recommendations for the use of SIM-grant funds for practice transformation support, and for the overall funding model including co-funding by payers, health systems, or other stakeholders.

1. **Technical assistance should be provided to primary care providers.** Only a small fraction of primary care providers in Delaware have developed the full range of capabilities in population-based primary care described here. DCHI strongly supports the need for technical assistance to providers to transform their practices and the Health Care Commission's plans to provide this support through contracting with one or more vendors (see the Request for Information issued in February, 2015.)

2. **A limited number of vendors should be contracted.** Contingent on vendor qualifications and interest, practices should be able to choose between at least two practice transformation vendors, both to support provider choice and to promote vendor accountability. Given the "competing demand" for practice transformation support nationwide, we recommend that the total number of vendors should be kept small (e.g., 2 - 4) to ensure that the value of the Delaware contract is concentrated enough to draw strong interest from vendors and sustained commitment the beyond contract award. We also believe that a limited number of vendors will minimize complexity.

3. **Contracted vendors should provide a standard level of support, but the curriculum should be tailored to individual practice needs.** A practice's specific needs for transformation support may vary. We recommend that vendors be asked to provide a standard level of support to all practices participating in the program and be able to tailor support to a practice's needs. By standard level of support, we mean for example that all practices may have access to the same frequency of webinars, learning collaboratives or larger format training programs, for example, as well as on-site coaching. But the focus of support—particularly on-site coaching—should be tailored to each practice's needs and preferences as determined by an assessment conducted by the vendor and through close and ongoing collaboration between the practice and the vendor.

4. **All PCP practices should be eligible to apply for practice transformation support, independent of practice size or affiliation.** While practice transformation support is especially critical for small independent practices that lack the scale or working capital to undertake transformation independently, we believe that all primary care providers should be eligible to apply for grant-funded practice transformation support, regardless of scale or organizational affiliation. We anticipate, however, that some health system-owned practices may choose to access transformation support independent of the grant-funded program.

5. **Grant funding should help practices achieve the basic capabilities necessary to prepare to make full use of care coordination and outcomes-based payment.** We recommend that SIM grant-funded support be prioritized for practices requiring basic capabilities necessary to prepare to make full use of care coordination and outcomes-based payment. Practices that already have transformed or earned certification from NCQA or another nationally recognized organization may forgo participation in SIM grant-funded practice transformation support and instead work with one or more payers to initiate care coordination funding and/or outcomes-based payments.

6. **Enrollment in practice transformation support should be staged in two or three "waves" over the next two to three years.** We anticipate that transformation support may begin this fall or winter to help practices prepare for care coordination payments in 2016. Many practices may benefit from practice transformation support who are unable to make the time commitment in the coming year and may appreciate support at a later date. We therefore recommend two or more "waves" of practice transformation support, with the second wave starting 6 to 12 months after the beginning of the first.

7. **Practice transformation support should be structured as a one-year program, renewable for a second year if funding is available.** We anticipate that SIM grant funds allocated for practice transformation will be sufficient for nearly all primary care practices in Delaware to receive at least one year of support, although some practices may not take advantage of this support for reasons previously cited. We recommend that vendor contracts be renewable for a second year, and that practices be eligible to apply for a second year of practice transformation support, subject to: sustained practice interest and commitment; achievement of early transformation milestones; adoption of outcomes-based payment for one or more major payers aligned with the principles for outcomes-based payment as embraced by DCHI; and the availability of funds.

Transformation Milestones and Pace

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.

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.

Eligibility for Care Coordination Funding and Outcomes-Based Payments

As noted, practice transformation support is one of three forms of support to help primary care providers improve capabilities and performance, the other two being funding for care coordination funding and outcomes-based payments. DCHI strongly recommends that all payers offer some form of care coordination funding as well as outcomes-based payments for primary care providers tied to the DCHI Common Scorecard, based on detailed design still in development by DCHI in consultation with the DHIN and local stakeholders.

Outcomes-based payments may enable practices to make long-term investments in more advanced practice transformation and to self-fund care coordination. But for many providers new to population health management—particularly small independent physician practices who lack working capital—outcomes-based payments may seem too uncertain to justify investments in care coordination. We therefore recommend that payers offer some form of up-front funding for care coordination.

Funding of care coordination represents a meaningful investment that has the potential to reduce the total cost of care, but many practices will find that the costs associated with care coordination may not be fully offset by savings in the first year. Payers and purchasers of health insurance may therefore wish to establish criteria for determining which primary care providers have the basic capabilities in place to maximize the potential for return on investment from care coordination funding. We recommend that they use the practice transformation milestones defined by DCHI, with input from practice transformation vendors, to assess practices' readiness for care coordination funding.

Between June and August, DCHI will continue to work with payers and other stakeholders to align eligibility for care coordination funding with achievement of DCHI-recommended practice transformation milestones. We will also work to define in further detail our expectations for the scope and intensity of care coordination, as well as the associated costs, so that payers and providers entering into new arrangements have a shared understanding of what will be expected of providers, and the funding level necessary to match those expectations.

Appendix

CONDITIONS FOR REACHING TRANSFORMATION MILESTONES

A practice should meet all of these conditions to reach a milestone. These milestones were developed based on NCQA PCMH Standards and Guidelines from 2014, adjusted for Delaware-specific considerations. Several milestone descriptions rely on language from NCQA:

1. **Identify 5% of panel that is at the highest risk and highest priority for care coordination (6 months)**
   - **Definition:** The practice has 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 document an evidence-based rationale for its definition.
   - **Criteria:** The practice has specific documented criteria for identifying the highest-risk patients. These criteria may include the frequency of ER visits, hospital readmissions, numbers of imaging or lab tests ordered, numbers of prescriptions, high-cost medications, secondary specialist referrals, and notifications from health plans indicating high cost or high utilization.
   - **Data sources and processes:** The practice has established documented data sources and data-handling processes to identify the highest-risk patients. The most basic version could imply working with a payer to source a list of the 5% of patients with the highest risk. Practices may develop or tailor the list of highest-risk patients using claims information, electronic medical records, practice management systems, recommendations of key staff, or other data sources. In addition, the practice has a process to allow for referrals by external entities and/or families and caregivers.
   - **Data lag:** The lag in the data that the practice uses to develop its list of highest-risk patients is short enough (e.g., 6 months or shorter) to allow for timely identification of patients needing focused care coordination.
   - **Frequency:** The practice updates its documented list of the top 5% highest-risk patients at least semi-annually.

2. **Provide same-day appointments and/or after-hours access to care (6 months)**
   - **Reserving time for same-day appointments:** The practice reserves time for same-day appointments (also referred to as "same-day scheduling") for routine and urgent care based on patient preference and need. In this approach, the practice prioritizes urgent care. Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. The practice has a documented policy of reserving time for same-day appointments.
   - **Scheduling same-day appointments:** The practice has implemented a process for scheduling same-day visits for patients with routine and urgent needs. The practice monitors use of same-day appointments to ensure that patients can use this feature. In this approach, the practice prioritizes urgent care. The practice has a documented policy on same-day scheduling.
   - **Scheduling with extended access:** The practice schedules appointments outside its typical daytime schedule. For example, it may open for appointments at 7 AM or remain open until 8 PM on certain days, or it may be open on two Saturdays each month. Provision of 24/7 access is not required to meet this milestone. A documented approach to reasonable extension of office hours beyond the regular schedule could meet the requirement. If a practice is too small to provide care beyond regular office hours, it may arrange for patients to schedule appointments with other (non-ER, non-urgent care) facilities or clinicians. Providing extended access does not include offering daytime appointments when the practice would otherwise be closed for lunch, or offering daytime appointments when the practice would otherwise close early, such as on a weekday afternoon or holiday.
   - **Patient needs-centered approach:** The practice provides appointment times that meets patient needs. Practices are encouraged to assess patient need for appointments outside normal business hours. Suggesting that patients locate the nearest ER or urgent care facility does not meet the intent of this requirement. The practice has a documented approach or policy to ensuring access that meets patient needs.
3. **Implement a process of following up after patient hospital discharge (6 months)**
   - **Identification:** The practice or external organization has a process for obtaining patient discharge summaries, such as directly or through a vendor. The practice has a documented approach to systematically obtain timely discharge information.

- **Follow-up:** The practice implements a documented approach for contacting patients following an ER visit or hospital discharge. Follow-up should include an evaluation of patient status and scheduling of a follow-up appointment, if appropriate. Proactive contact includes offering patients appropriate care to prevent worsening of their condition and encouraging follow-up care. In addition to scheduling an appointment, follow-up care includes, but is not limited to, physician counseling; referrals to community resources, and disease, case management or self-management support programs. The practice has a documented policy of contacting patients upon an ER visit or hospital discharge, including definition of an appropriate timeframe for follow-up.

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)**
   - **Coverage availability:** Patients can seek and receive interactive clinical advice by telephone or other technology with a licensed health professional, with questions answered in real time. Consultation with a clinician by phone or through other technology meets the requirement; recorded messages do not. The clinician returns calls in the timeframe defined by the practice to meet the clinical needs of the patient population. The practice's approach includes a method for ensuring access by practice clinicians when the office is closed. The practice may have different standards for when the office is open and when the office is closed.

5. **Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan (12 months).**
   - **Sourcing plan:** The practice documents the approach to securing resources for transition to and implementation of care coordination services, including:
     - Identifying resources for care coordination, such as external vendors, medical neighborhood shared care coordinators, and own care coordinators
     - Operational plan to retain care coordination resources, such as a vendor retention timeline and plan and care coordinator hiring plan.
   - **Implementation plan:** The practice documents the approach to launching its transition to coordinated care, including :
     - Plan for setting up and developing care coordination infrastructure, such as a care team and care planning

- Operational plan of integration of care coordination resources with practice processes.

6. **Document plan to reduce emergency room overutilization (12 months)**
   - **Definition:** The practice has a documented definition of patients with high ER utilization. It typically includes patients with the highest ER utilization or highest ER costs, but the practice should develop a definition that best suits its population and care priorities. The practice also documents an evidence-based rationale for its definition.
   - **Identification of high utilizers:** The practice has a documented approach to working with hospitals, freestanding ERs, and health plans to identify patients who visited the ER. Documentation specifies how data sources, such as claims information, will be used to identify high utilizers.
   - **Access to urgent care:** The practice has a documented approach to providing urgent care through same-day and after-hours access as a substitute to ER visits. Patients with high ER utilization may receive priority access to available appointments.
   - **Patient education:** The practice has documented approach to educating patients about ER alternatives, with a focus on patients with high ER utilization.
   - **Follow-ups:** The practice has documented approach to contacting patients after discharge from an ER. Practice policies define the appropriate contact period. Proactive contact includes scheduling a follow-up appointment, as appropriate. In addition to appointment scheduling, proactive contact includes, but is not limited to:
     - Physician counseling
     - Referrals to community resources
     - Referrals to disease management, case management, or self-management support programs.
7. **Implement the process of contacting patients who did not receive appropriate preventive care (18 months)**
   - **Patient identification:** The practice proactively identifies populations of patients who need preventive care based on patient information, EHR and clinical data, health assessments and evidence-based guidelines. The practice generates reports for at least two preventive care services beyond routine immunizations, such as well-child visits, pediatric screenings, mammograms, fasting blood sugar, and stress tests.

- **Reminders:** The practice uses reports to remind patients or their families or caregivers about preventive services. Any channel may be used for reminders, including mail, email, telephone, and text messaging.
- **Frequency:** The practice conducts patient identification and reminds patients about preventive services at least annually.

8. **Implement a multi-disciplinary team working with highest-risk patients to develop care plans (24 months)**
   - **Elements of a care plan.** CMS defines a care plan as "the structure used to define the management actions for the various conditions, problems, or issues." A care plan may consider or specify:
     - Patient problem (focus of the care plan)
     - Treatment goals, such as a defined target or measure to be achieved
     - Assessment of potential barriers to meeting goals and strategies for overcoming these barriers
     - Current medications and medication allergies
     - Instructions that the provider has given to the patient
     - Care team members, including the primary care provider of record and team members beyond the referring or transitioning provider and the receiving provider
     - Patient preferences and functional and lifestyle goals
     - A self-care plan.
   - **Care team:** The practice uses a team to provide a range of patient care services by:
     - Identifying the team structure and the staff who lead and sustain team-based care. The practice delineates responsibilities for sustaining team-based care and how care teams align to provide care. Specific team units may focus on coordinating care across and beyond the practice. They may use an organizational chart to illustrate how a care team fits in the practice.
     - Defining roles and responsibilities for clinical and nonclinical team members. Job descriptions emphasize a team-based approach to care and support each member of the team in meeting the highest level of function.
     - Holding scheduled patient care team meetings and a defining a structured communication process to support individual patient care. Teams may meet daily or schedule reviews with follow-up tasks. A

structured communication process may include regular e-mail exchanges or communication through notations in the medical record. Practice documentation should define how the clinician or team leader is engaged in the communication structure.

- **Care plan:** The care team and the patient, family or caregiver collaborate to develop and update an individual care that includes the features described above. In particular, the care plan should:
  - Incorporate patient preferences and functional and lifestyle goals. The practice works with the patient, family or caregiver to incorporate patient preferences and functional lifestyle goals into the care plan on an ongoing basis.
  - Identify treatment goals. The practice works with the patient, family or caregiver and other providers to develop treatment goals using evidence-based guidelines.
  - Assess and address potential barriers to meeting goals. The practice works with the patient, family or caregiver, other providers, and community resources to assess and address potential barriers to achieving treatment and functional and lifestyle goals.

9. **Document plan for patients with behavioral health needs (24 months)**
   - **Identification criteria:** The practice sets specific criteria for identifying patients with behavioral conditions. They may include:
     - Diagnosis of a behavioral issue based on behavioral health visits or medications
     - Two or more psychiatric hospitalizations in the past year
     - Counseling or treatment for substance abuse
     - A positive screening result from a standardized behavioral health screener, including substance abuse.
   - **Care plan:** The practice has documented approach to developing and updating an individual care plan that includes integration with behavioral health care.
   - **Access to a behavioral health provider:** The practice can take one of three approaches to ensuring access to behavioral health care:
     - A documented plan to maintain at least one agreement with a behavioral health provider. A practice must hold an agreement if it shares a facility or campus with the mental health professional but has separate practice management and clinical information systems.

- A documented plan to integrate with a behavioral health care provider, either partially, such as though co-location with some shared practice management and clinical information systems, or fully, with all systems shared.
- Integration of behavioral health care services, such as through co-location with a behavioral health provider with at least some shared practice management and clinical information systems.