Delaware Practice Transformation Milestones,
Goal-Mapping, and Associated Sub-criteria

1. Identify 5% of panel that is at the highest risk and highest priority for care coordination

- *PERFORMANCE: Person-Centered Care → Population Management → Stratify Risk*

a. The practice has a systematic process and documented criteria for identifying highest-risk patients (as it best suits the unique practice needs and goals (NCQA PCMH)

b. The practice has established documented data sources and data-handling processes to identify the highest-risk patients. Potential sources of data include claims information, electronic medical records, practice management systems, staff recommendations

c. The practice successfully updates its documented list of the top 5% highest-risk patients at least semi-annually (NCQA PCMH)

2. Provide same-day appointments and/or extended access to care

- *PERFORMANCE: Person-Centered Care → Enhanced Access → Meet Patient Scheduling Needs*
- *QUALITY: Continuous, Data-Driven QI → Optimal Use of HIT → Innovate for Access*

a. The practice has a documented process and defined standards for reserving time for same-day appointments and appointments outside its typical daytime schedule (NCQA PCMH)

b. The practice has a process for informing patients/families about the role of the Advanced Primary Care Practice and gives patients/families materials that contain the instructions for obtaining care and clinical advice during office hours and when the office is closed (NCQH PCMH)

c. The practice collects patient experience and satisfaction data on access to care and uses these data to develop an access improvement plan (CMS)

3. Implement a process of following-up after patient hospital discharge

- *PERFORMANCE: Person-Centered Care → Coordinated Care Delivery → Manage Care Transitions*
- *PERFORMANCE: Person-Centered Care → Practice as a Community Partner → Use Community Resources*

a. The practice shares clinical information with admitting hospitals and EDs (NCQA PCMH)

b. The practice proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit (NCQA PCMH)

c. The practice offers or refers patients to structured health education programs, such as group classes and peer support (NCQA PCMH)

4. Supply voice-to-voice coverage to panel members 24/7 (e.g., patient can speak with a licensed health professional at any time)

- *PERFORMANCE: Person-Centered Care → Enhanced Access → Provide 24/7 Access*
- *QUALITY: Continuous, Data-Driven QI → Optimal Use of HIT → Innovate for Access*

a. The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times (NCQA PCMH)

b. The on-call provider has continuous computer access to patient records through remote log-on to the practice's EMR (NCQA PCMH)

c. The practice regularly assesses its performance on (NCQA PCMH):
    i. Providing continuity of medical record information for care and advice when office is closed
    ii. Providing timely clinical advice by telephone
    iii. Providing timely clinical advice using a secure, interactive electronic system

5. Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan

- *PERFORMANCE: Person-Centered Care → Team-Based Relationships → Enhance Teams*
- *SUCCESS: Sustainable Business Operations → Efficiency of Operation → Streamline Work Flows*

a. The practice has identified practice-level organizational structure and staff leading and sustaining team-based care (NCQA PCMH)

b. Practice has defined its approach for sourcing care coordination (e.g., through vendor support or hiring a care coordinator)

c. Practice has documented its approach to implement team-based care and develop care plans for high-risk patients

6. Document plan to reduce emergency room overutilization

- *PERFORMANCE: Person-Centered Care → Organized, Evidence-Based Care → Reduce Unnecessary Tests*
- *QUALITY: Continuous, Data-Driven QI → Transparent Measurement and Monitoring → Use Data Transparently*

a. The practice provides patients with materials for obtaining care and clinical advice during office hours and when the office is closed (NCQA PCMH)

b. The practice proactively identifies patients with unplanned admissions and ER visits (NCQA PCMH)

c. The practice proactively contacts patients / families for follow-up care after discharge from hospital / ER within an appropriate period (NCQA PCMH)

7. Implement the process of contacting patients who did not receive appropriate preventive care

- *PERFORMANCE: Person-Centered Care → Population Management → Identify Care Gaps / Decrease Care Gaps*

a. The practice uses panel support tools (registry functionality) to identify services due (CMS)

b. At least annually, the practice proactively reminds patients or their families/caregivers of needed care (using evidence-based guidelines) for preventive care services, immunizations, and patients not recently seen by the practice (NCQA PCMH)

c. The practice uses reminders and outreach (e.g., phone calls, emails, postcards, patient portals, template letters, etc.) to alert and educate patients about services due (CMS)

8. Implement a multi-disciplinary team working with highest-risk patients to develop care plans

- *PERFORMANCE: Person-Centered Care → Population Management → Assign to Panels / Assign Accountability*
- *SUCCESS: Sustainable Business Operations → Efficiency of Operation → Streamline Work Flows*

a. The practice monitors the risk-stratification method and refines as necessary to improve accuracy of risk status identification (CMS)

b. The practice assigns members of the care team to coordinate care for individual patients (NCQA PCMH)

c. The practice assigns members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change (NCQA PCMH)

9. Document plan for patients with behavioral health care needs

- *PERFORMANCE: Person-Centered Care → Population Management → Identify Care Gaps / Decrease Care Gaps*
- *PERFORMANCE: Person-Centered Care → Coordinated Care Delivery → Manage Care Transitions*
- *PERFORMANCE: Person-Centered Care → Practice as a Community Partner → Use Community Resources*

a. The practice has a process for informing patients / families about the role of the Advanced Primary Care Practice and gives patients/families materials describing the scope of services available within the practice, including how behavioral health needs are addressed (NCQA PCMH)

b. The practice ensures regular communication and coordinated workflows between primary care clinicians and behavioral health clinicians (CMS)

c. The practice uses a registry or certified health information technology functionality to support active care management and outreach to patients (CMS)