Components of an Integrated Delivery System

Managing Populations in a Safety Net Environment

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CONTEXT AND INTRODUCTION

The purpose of this document is to assist health care organizations, especially safety net organizations that are striving to meet the challenges of health care reform and the changing health care landscape. These organizations are being directed and incentivized to reorganize their delivery and financing systems to improve quality of care, health outcomes, and the patient experience, while lowering the costs of care.

Concurrent with these new pressures for change, health insurance coverage is expanding for safety net populations, which provides an opportunity for additional revenue for safety net organizations that provide care to the previously uninsured. However, reimbursement is also transforming, moving away from payment for volume to payment for value. This value-based payment will likely increasingly be in the form of capitation, which will entail some risk to providers. Organizations will be held financially accountable for higher quality of care and health outcomes of populations, rather than for just volume of services.

What health systems will succeed in such a reformed health care landscape? Experience has shown systems that include the full range of services and provide integrated and coordinated care are more likely to succeed in meeting accountability requirements. Smaller health care organizations are less likely to be able to meet these delivery challenges alone and may have to join with others to create a system that can provide comprehensive care. Regardless of their size, safety net systems will also have to redesign and transform their care model to provide proactive, continuous, and efficient care for a defined population rather than providing reactive and episodic care.

The health care systems that successfully provide integrated, accountable care will not be cast in identical forms and structures. However, some elements and constructs are common to integrated systems that provide accountable care. Successful accountable care systems:

- are developed and operate based on a deep and thorough understanding of a defined population—including its demographics, health status and trends, and health risks—and the health care and policy environment in which the system operates;
- are built around a core of continuous and accessible primary care where the staff works in high-functioning care teams;
- coordinate and integrate care for their population and measure and hold themselves accountable for the population's health outcomes;
- use information technology to provide evidence-based care to individuals; and
- continually monitor quality and cost at every stage of the care they deliver.

Accountable Care Manual

This manual presents an overview of, and approaches to, designing and implementing key components of integrated delivery systems capable of providing accountable care. These approaches are based on Health Management Associates’ (HMA’s) experience in helping safety net health care organizations transform their delivery systems. This manual is not a how-to guide.
Rather, it presents an overview of the key areas that must be addressed when developing accountable care systems and provides guidance based on what HMA has found works in real-world settings.

This manual specifically presumes that a system providing accountable care contains the full continuum of health care services and that all of these services are integrated. We recognize, however, that few safety net organizations currently offer the range of health services necessary to provide the full continuum of care and that they, therefore, will need to partner and collaborate with other organizations. This means that a framework must be created to show how different providers can fit into an integrated delivery system. This is a delicate yet critical task, as many systems include providers with little history of collaboration or joint planning for a population, even though the providers may have cared for the patients within that population. The manual addresses the creation of an integrated delivery system and calls for incorporating different levels of services, cultures, and methods of practice. It also includes a major focus on Patient-Centered Medical Homes because they are the foundation upon which effective accountable care systems must operate.

LEGAL AND GOVERNANCE

Across the nation, multiple providers have come together to develop integrated delivery systems that take the form of Accountable Care Organizations (ACOs). ACOs are provider-based entities through which providers agree to work together and be responsible for patient care for a designated population and to share in risk and/or savings derived from improved health outcomes and lowered costs.

While there is no standard legal or governance model required for ACOs, some patterns are emerging in federal and state laws and regulations with regard to functional requirements. These patterns provide some guidance for developing accountable care systems.

Under the final Medicare Shared Savings Program (MSSP) rule, an ACO must be a legal entity for purposes of all ACO program functions. A corporation (profit or non-profit), partnership, limited liability corporation (LLC), foundation, or any other entity recognized under federal, state, or tribal law can be an ACO legal entity. Therefore, in many states, an ACO may take on any legal structure as long as it can perform the functions necessary to be an ACO under the applicable law. Entities will need to make decisions about whether they need to create a new legal entity and if so, what form it should take. These decisions will be necessarily influenced by the status of the entities that decide to form an ACO, as well as by financial and tax considerations and applicable law.

ACOs contemplating participation in multiple-payer ACO initiatives will want to establish a single governance structure that meets the requirements for all of them. Medicare often leads the way for Medicaid and commercial insurance, making it worthwhile to consider what the MSSP regulations require.
State approaches include Oregon’s version of accountable care called Coordinated Care Organizations (CCOs). CCOs must be local, community-based organizations or statewide organizations with community-based participation in governance, or a combination of the two. The CCO may be a single corporate structure, or it can be a network of providers organized through contractual relationships. The overarching theme of Oregon’s CCOs is that they must be local and their governance must include consumer involvement. Massachusetts and New Jersey also include a requirement for consumer representation.

Safety-net providers may be subject to unique governance and legal structure constraints that must be taken into account as they consider participation in ACOs. They must consider how participation could impact their current structures, allocation of governance and leadership, and how to address liability for losses.

In addition to concerns about legal structure and governance, there are other legal issues for potential ACO participants to consider before embarking on this path. To implement the MSSP program, the federal government has established certain protections and “safe harbors” with respect to federal anti-trust, fraud, and abuse laws. However, if the ACO does not participate in the MSSP, these protections do not technically apply. In addition, ACOs (even if they participate in the MSSP) must also consider the applicability of similar laws at the state level—which have not been pre-empted—as well as state laws concerning health plan regulation and the corporate practice of medicine.

There are two significant factors for all providers to consider when deciding whether to participate in an ACO: the potential benefits compared to the costs, and the burdens of participation. The lack of federal pre-emption of state fraud and abuse laws, as well as the existence of an established regulatory framework, may add another level of complexity and create challenging compliance issues.

FINANCE

Safety net providers face an uncertain future under payment reform. Existing payment mechanisms are subject to intense review under the Accountable Care Act. Innovative safety net providers are taking the lead by developing and adopting value-based payment models that require greater accountability for quality, health outcomes,
and costs but also enhance their ability to produce those outcomes. There is a continuum of accountability model based on degree of risk: pure shared savings without downside risk, two-sided risk with additional upside potential in exchange for limited downside risk, partial capitation, and full capitation. It is critical that safety net providers progress gradually along the reimbursement continuum in order to build the infrastructure needed to generate savings and not assume undo risk. This transition usually starts with fee-for-service (FFS) reimbursement that is supplemented by care coordination fees and/or significant pay-for-performance incentives and the potential for shared savings. This up-front funding should be aimed at initiating processes that will generate savings, such as cost-effective pharmaceutical use, reduced duplication of testing, improved patient safety, and improved transitions of care that reduce inappropriate emergency room and inpatient utilization. Often, shared savings will not be generated—and, therefore, payable—until midway through the second year at the earliest, and likely later. Generating savings by improving the model of care usually takes a year.

Once they are available, shared savings payments should be distributed based on a formula that takes into consideration membership, the source of savings, the principal drivers of the savings, and achievement of quality metrics that detect inappropriate under-utilization. A portion of those shared savings must eventually pay for subsequent care coordination fees and pay-for-performance incentives.

Providers should also retain some of their savings to create the reserves necessary to assume downside risk and eventually transition to capitation. This is because shared savings with downside risk, partial capitation, or full capitation, shifts financial risk beyond “performance risk” to “insurance risk.” Insurance risk entails assuming financial responsibility for health service costs and, therefore, requires substantial capital reserves in the event of unanticipated medical expense losses. Experience shows that explicit regulatory safeguards and financial reserves requirements are necessary when entities assume insurance risk, quite possibly along the lines that CMS promulgated in the late 1990s for Provider Sponsored Organizations or that states like California require for providers assuming full risk.

ACOs will be successful only if they can meet their financial benchmarks and quality standards. An ACO must perform better than its budgetary benchmark to qualify for shared savings or, under the full capitation model, have revenues that exceed its costs. Quality scores will affect shared savings payments to ACOs, with poor performance triggering financial consequences.

Payment reform will not be successful unless it is coupled with the new innovations in the healthcare delivery model that it accommodates. New payment and delivery models must be designed and implemented in ways that deliver on the promise of coordinated, patient-centered care that generates improved value for dollars spent.
INFRASTRUCTURE AND CAPACITY BUILDING

Administrative Infrastructure
Health reform will mandate new requirements for ensuring—and documenting—quality and effectiveness. Safety net public systems have seldom had the resources available to private systems to invest in the reporting and data systems that document quality and utilization. Health reform will require new systems be put in place to facilitate better management of patients across care settings and to implement new payment methodologies.

These public systems must establish new infrastructures and new approaches to administrative functions. This requires new skills and tools. For many, this will be a total system transformation. As integrated health systems develop, they will have to decide whether to build or buy these essential administrative components. The key components and considerations are described below.

Eligibility Screening/Enrollment
All patients that enter the integrated system, whether through the Emergency Department (ED) or a walk-in clinic, must be screened to determine if they are eligible for Medicaid or any third-party insurance coverage. For those that may be Medicaid or Medicare eligible, the health system must facilitate enrollment into the appropriate plan. For those ineligible for third-party coverage, the system should "enroll" the uninsured into the health system (and a Patient-Centered Medical Home [PCMH]), thus providing access to a managed system of care. It is also important that the eligibility/enrollment screening be a one-stop process, rather than triaging patients to various "offices, workers, or rooms" based on the program for which they are eligible. Whoever begins the screening/enrollment process should be equipped to handle all enrollment options and complete the process, regardless of program eligibility.

Assignment to a PCMH
As patients access health care services, the infrastructure in place must be able to facilitate assignment to a PCMH, with patient input weighing into the selection process. As part of the assignment process, patients should receive information about what a PCMH is and how best to access services, and a PCMH team member should help make the initial appointment. For the system’s existing patient base, the health system should have an ongoing set of policies and procedures and corresponding data flow that results in (1) each patient being able to identify his or her primary care provider (PCP) and care team and, (2) the system being able to identify whose panel the patient is on.

PCMH Support
For the PCMH model to function effectively, the health system must provide the administrative components required to support the team. The PCMH team works to guarantee all assigned patients get the right services and supports at the right time, in the right amount, and for as long as they need them. Examples of support include:

- verifying PCMH assignment for internal and external providers
• managing PCMH changes at patient request
• managing panels (open, closing, monitoring)
• 24-hour call center, utilizing an automated call distributor system, so patients and their PCMH can communicate with each other
• a web-based portal for patients to access their health information and communicate with their PCMH (request appointments, send and receive notices, etc.)

Managed Care Contracting/Other Programs Required Support
As safety net systems move towards participation in ACOs, care coordination, and managed care plans, they will need to acquire the technical expertise to negotiate agreements with Managed Care Organizations. Moreover, the process must directly involve PCMH team members and other clinicians. Without their direct participation, the health system may not be able to take full advantage of, or successfully manage, such agreements or programs. It is critical that the PCMH teams and other clinicians understand each managed care agreement (and other program agreements) and have input into decisions around whether to participate. Once finance and PCMH teams have a mutual understanding of their contractual obligations, it will be possible to align health system policies and incentives to fully benefit from these arrangements.

Financial Systems
Health systems must have the capacity to evaluate the emerging alternative reimbursement model’s impact on their system, both in the short and long term. Safety net providers that are cash-strapped must recognize the absolute necessity of building the infrastructure to move gradually along the risk reimbursement continuum. Doing so will generate savings and avoid undo risk. The correct financial systems must be in place to monitor this transition and provide feedback to the system along the way.

Information Technology (IT)/Reporting
IT capacity must be sufficient to support integrated delivery systems. This includes IT systems to support care coordination and delivery across settings, as well as to track and document care delivered. It includes generating financial reporting to track new reimbursement methodologies while monitoring costs. Safety net providers must recognize the need to monitor and report performance, not only for insured populations, but also for those that remain uninsured even after the Accountable Care Act is implemented. Providing IT support for the PCMH functions is required. This support may include:

• a patient registry that is linked to the PCMH team and empanelment database
• the ability to generate “day of care plans” that display patient risk level, alerts for gaps in care, and trends in key clinical measures
• the ability to produce real-time information that enables PCMH management of transitions of care

This expanded information technology capacity will be critical to total system transformation. The administrative functions listed above are not all-inclusive, but they demonstrate the necessity of
alignment between strategy, delivery system design, performance monitoring, and feedback that are required to move forward successfully.

**Workforce Development**

**Skills Development**

Integrated delivery systems have started to transform the health workplace in ways that have important implications for health care providers and workers of all types. Coordinated care initiatives in both outpatient and inpatient safety net settings have resulted in new job titles, responsibilities, and combinations of jobs in health teams.

The development of new skills in the health workplace is driven by several interrelated factors. Health providers and staff must perform new tasks to provide effective population health care and high-quality personal care. New skill sets in communication, technology, and process improvement are increasingly required, and are unlikely to be part of past health worker training. To help manage these changes requires new leadership skills for administrative and care coordinators in outpatient and inpatient settings. Resource limitations have often prevented safety net systems from providing up-to-date training and experiential learning to enhance these skills.

**Population Health**

Increased accountability for care of a population emphasizes the need for a wide variety of supports to help providers develop new skills in patient care, outreach, and education. Health care providers and staff need to be reorganized so they transition from individually focused work to team-based work. The provision of patient care by a single individual, so prized in earlier generations of health care providers, is now superseded by expectations that providers function and enhance care in a multidisciplinary team setting. To facilitate this change, explicit job expectations and roles need to be specified for each team member to ensure both accountability and efficiency of operations.

Managing an entire population’s health places increased demands on practice management skills, both within the health care setting and when reaching out to patients. Many patients in a defined population do not have regular contact with health care providers, so health workers must now be the leaders in contacting and communicating with patients and reinforcing a more proactive and preventative approach to care. In addition, within the group of members currently served, more intensive contact with patients may often be necessary. It is critical that health workers possess the skills needed to accomplish these tasks.

With this variety in population needs, some specific skillsets will be most useful:

- communication in a variety of media
- data management skills and acquaintance with IT output interpretation
- implementation of evidence-based protocols for care

The ability to regularly assess skill efficacy with a Plan-Do-Study-Act (PDSA) methodology will be needed.
Leadership and Staffing
The goals of staffing will be to provide flexibility and comprehensive support to providers. A variety of tools recently have been developed to assess staffing effectiveness in the outpatient clinical setting. Though each patient population is different, so that staffing needs will differ, the ability to provide appropriate staffing guidance will be a first step in organizing an effective approach to workforce development. Benchmarks are starting to become available for some settings.

The roles of office and support staff will need to be enhanced to increase the scope and capabilities of health workers to perform higher-level functions. For example, clinical assistants will have roles in gathering data, providing interventions, and interacting with patients, thereby freeing licensed clinical staff for higher-level interventions with patients and families requiring more attention.

The increasing role of information technology to better coordinate care is also impacting health workers’ roles. The technology required to manage populations has increased the demand for health workers who are familiar and comfortable with information technology. Every level of the health care workforce interacts with electronic data and communications, a reality heightened by the growing spread of electronic medical records.

Leaders of these multidisciplinary teams must have hands-on skills and managerial abilities. A key leadership skill is the ability to organize flexible staffing that can be realigned to focus on improving health outcomes. Leaders must possess the ability to lead performance improvement processes and help every worker perform at the highest level allowed by their license or certification. Ensuring that all staff is performing at their full potential is critical to efficient resource utilization.

Quality Improvement and Care Coordination
The focus on quality is a key part of coordinated care. Quality management is a major part of each piece of the integrated delivery system. Identifying and responding to quality metrics is a crucial element of many health workers’ tasks, from the office assistant to the physician. Effectively addressing quality issues relies on performance improvement methodology. Health workers need to be familiar with process improvement teams and functions.

Although current providers and staff must acquire new skills, new categories of health workers will be needed. Chief among these is the care coordinator. People with these skills are often given different titles in different settings, including “care coordinator,” “case managers,” and “care managers.” All of them can function in a variety of settings. For example, care coordinators are frequently used in integrated delivery systems as managers of a practice population. (See Appendix C for a sample care coordinator job description.)

The background and training a care coordinator needs will depend on the population served. One of the key concepts for integrated delivery systems is implementation of risk assessment and risk stratification for individual patients. Staffing must be matched to the identified needs of the patient population. For most groups of patients seen in the PCMH, a clinical background as a nurse will be most appropriate for a care coordinator. For other populations, such as the seriously mentally ill, a background in social work may be more advantageous. For generally healthy populations, a strong
clinical background may be less necessary. For safety net populations—which typically have complex medical, behavioral health, and social problems—care coordinators need additional skills in identifying the appropriate cluster of problems and marshaling the often-limited community resources that the patient needs.

Changing the Workforce

No changes in the workforce can be expected without controversy and even resistance. Developing new health care roles is perhaps the least contentious issue because it represents an expansion of opportunities for employment in health care. On the other hand, changes in the job duties and expectations of current staff may provoke concerns. For example, needs for flexibility and cross-training for certain functions may collide with organizational or union concerns about diminishing opportunities for some staff or changes in staffing needs. Careful attention to communication with current staff and education about how changing job functions allow health workers to continue to stay relevant in the new health care workplace is important. Of great use are well-prepared training modules that allow staff to comfortably reach competency in the skill sets demanded.

A number of academic centers across the U.S. have acquired experience and proficiency in training workers for these new functions. The key educational philosophy is often based on a competency-based curriculum that matches educational programs to needed skills in the workplace. Skills must be transferable, but there are several sets of skills that have been consistently identified. They include skills in communication, health information technology, process and quality improvement, interdisciplinary team training, population health management, and patient education.

A variety of formats are being tried. The concept of competency-based training emphasizes the need to closely match training to job need. Modular formats have been used to develop faculty and learning material for discrete subject areas. Early work on effectiveness assessment has been published in a number of centers.

Among the keys to success are partnerships between workplaces and educational training venues to verify skill acquisition. Examples include academic institutions such as nursing schools, residency programs for physicians, and other educational facilities for licensed providers. Vocational training schools are partners for certified medical assistants and other staff providing hands-on experience. Provider institutions such as hospitals and medical centers should have the strongest commitment to this training because the success of their workforce depends on the quality of training.

In safety net institutions, resources for training are often limited, so partnerships are vital. Payers, such as commercial insurance plans, may be good resources for training in care coordination skills in better-compensated health settings. The federal government and states, as public funders of Medicaid and Medicare, have expressed interest in new workforce training models, but they are just starting to offer support to workplace training.

Measuring and Improving Performance

An integrated delivery system will have to develop measures and methods for monitoring and reporting performance, as well as policies and procedures for ensuring continuous improvement.
Performance monitoring and the communication of findings/trends should be performed by an executive-level person that reports directly to the health system CEO.

Performance measures must address the domains of the Triple Aim, a framework that describes an approach to optimizing health system performance. The goals of the Triple Aim are improving the patient experience of care (including quality and satisfaction), improving the health of the defined population, and reducing the per capita cost of health care.

Examples of performance measures include:

- **utilization/cost (by payer class):**
  - hospitalization rates for empanelled patients
  - 30-day and 7-day re-hospitalization rates for empanelled and non-empanelled patients
  - ED use per 1,000 patients
  - specialty visit consultations per provider, per 1,000 patient-equivalents (defined in registry section)
  - rate of non-generic drug use per provider
  - charges per patient by provider per applicable payer class

- **improved health:**
  - percent of patients with blood pressure at goal at last measurement
  - percent of patients with A1c > 9 by provider, by site
  - percent of diabetic patients in reasonable control (BP< 140/90, A1c<9, LDL < 130) and in near ideal control (BP<130/85, A1c <7.4, LDL <100)
  - process outcomes: influenza vaccination rate, rate of metformin use per 100 diabetics, rate of ACE inhibitor/ARB use per 100 diabetics, retinal screening for diabetics, mammography

- **patient experience:**
  - satisfaction per provider/per site

Performance measures that are determined to be at a substandard level are targeted for quality improvement efforts. Some health systems may benefit from a quality/research arm and funding to support testing of new innovations and improvement efforts.

**ASSIGNMENT TO A HEALTH CARE DELIVERY MODEL**

Because patients have different needs and utilize services differently, it is important to assign patients to a specific model of care. Within integrated delivery systems, there are generally three care delivery models to which a patient can be assigned:

- **A specialty-only model for patients that have non-contracted primary care but need specialty services only, or for whom it is appropriate for the specialist to act as the primary care provider.**
• An episodic primary care model for patients who are generally in good health and do not need regular coordinated care.
• A Patient-Centered Medical Home (PCMH) model for patients who need ongoing coordinated care. (See next section for a more detailed description.)

Optimally, a system would be able to provide a PCMH for all patients. However, if resources are limited, it is acceptable to assign patients to episodic care as long as it is done in an organized and intentional manner.

Patients who are not already assigned to a PCMH are assigned based on results of a brief set of questions and patient data. If a PCMH model is appropriate for the patient, then he or she will be assigned based first on choice and then by geography to an internal PCMH or to an externally contracted PCMH.

For services provided by a system (rather than externally), patient access will not vary by payer but by health care delivery model. For example, there may be formulary restrictions for those receiving episodic care or specialty care authorization processes for external PCMHs. For services not provided by the system—but rather contracted, such as behavioral health services—patient access may differ by both health care delivery model assignment and payer source.

PATIENT-CENTERED MEDICAL HOME

The following sections describe operations of key elements of infrastructure and care for patients assigned to Patient-Centered Medical Homes (PCMHs).

Team-Based Care

Team-based care within a PCMH is a significant departure from traditional methods of care delivery. It can be defined as the “provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals, within and across settings, to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable.”

Teams can be configured in a variety of ways, but the goal is to move away from relying solely on physicians to deliver care. Instead, roles and responsibilities are distributed among different health professionals and staff, including nurses, medical assistants, licensed practical nurses, care managers, behavioral health providers, and community health workers. Teams are assembled according to a staffing model, with individual team members having defined roles and responsibilities that align with the PCMH model of care.

In order for teams to operate efficiently, all team members should be operating at the “top of their license” (i.e., each provider and clinical staff person is focused on the work that is at the highest

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level of his or her qualifications, expertise, and professional license). Team members coordinate their care through a team “huddle” prior to patient sessions and through electronic registry alerts that assign individual staff members to carry out population management activities. PCMH clinic teams are consistently scheduled to work together to the greatest extent possible.

**Staffing Model**

The staffing model for delivery of care is critical. Labor is the single largest expense for health care organizations, accounting for close to half of healthcare delivery costs. A health care organization will not survive in the new era of accountable care without an adequate number of staff properly trained to reliably hit quality targets while providing excellent patient service. On the other hand, overextending staffing beyond the point of positive return on investment will quickly lead to poor financial performance. Ensuring that staff members work to the top of their license is as important as the number of staff.

The PCMH must plan to determine how many employees with each type of license, training, and function are needed within the model of care delivery, and it must then monitor employees’ ability to meet outcomes standards. This planning needs to be global (e.g., how many nurses need to be hired in total), granular (e.g., how much of a particular nurse’s time needs to be spent with a particular physician), and related to activities (e.g., how much time a particular non-licensed staff person, such as a medical assistant, needs to spend in care coordination). This task is a challenging but necessary step to accurately assess the outcome of a hiring and training plan. (See the workforce development section for additional discussion.)

Many functions needed for the delivery of primary care also must be addressed, including administrative functions such as materials management, time and attendance, and budgeting, as well as basic functions for supporting clinical flow, such as re-stocking rooms.

Staff scheduling is also critical for defining roles and responsibilities of team members and deploying the right number of each type of staff. A PCMH needs a structured process for implementing a team-focused schedule. (See Appendix A for a staff model worksheet at the “current reality stage” and Appendix B for a staffing worksheet for an individual provider.)

**Empanelment**

Empanelment is the process of creating and maintaining a relationship between each patient and a primary care provider (PCP). Empanelment is the cornerstone in the foundation of clinical and financial accountability. The goal of empanelment is to ensure that each PCMH care team has a group of patients for whom they are responsible and that each patient can identify to whom they can turn for their health care needs. It is a proven method for creating continuity for providers and patients and ensuring that patient population health is managed. (See HMA’s Empanelment Guide: http://www.healthmanagement.com/assets/Publications/Empanelment-Implementation-Guide-January-2013-FINAL.pdf.)
**Using Technology**

Technology helps organize and facilitate PCMH operations. Key technologies for PCMHs are electronic medical records (EMR) and an electronic registry. The difference between an EMR and a registry is that an EMR contains a patient’s entire history, whereas a registry is focused on aggregating and organizing a limited set of information with an emphasis on certain conditions, populations, and/or health care activities (e.g., a hospitalization). Registries are critical to managing the care of patients and populations.

**Initial and On-Going Risk Assessment**

A standardized approach to care delivery requires that care management activities be defined and driven by risk assessment for empanelled patients. Upon assignment to the PCMH, an initial risk assessment is conducted for every patient. Risk is reassessed in response to defined trigger events that reveal changes in patients’ conditions and require a defined response.

Once patients have completed a risk assessment, they are assigned a level of risk. The level of risk is used as an independent variable to drive care management activities. For example, a high-risk patient (e.g., a patient with a hospital admission for congestive heart failure in the past year) who misses an appointment will get a call within 24 hours, whereas a low-risk patient (e.g., one with well-controlled diabetes) will not get a call after a missed appointment until a screening test is overdue.

**Care Management within the PCMH**

Care management within the PCMH includes evidence-based preventive care/health maintenance, utilization triggers and transition care programs, and disease-specific management, outlined below. Also within the scope of care management (and addressed in this section) are self-care, self-management support, complex care management, enabling services, and tele-monitoring. Position descriptions for PCMH practice-based care coordinators and RN care managers are presented in Appendix C and D, respectively.

**Evidence-Based Preventive Care**

The electronic patient registry produces a Day-of-Care Plan, which is a printable summary of patient data with directions to the care team about the activities that need to be completed for the patient. This alerts the team to address issues highlighted in the plan. For example, a health screening may be indicated as outstanding on the Day-of-Care Plan. The team member is alerted and conducts the screening. Once the screening is completed, the team member documents the result of the screening test into the EMR. Interfaced with the EMR, the registry pulls this data to alert the team the next time the patient is due for this screening.

Standard registry reports for cancer screening, diagnostic screening, and behavioral health screening are used to measure overall PCMH performance in reaching preventive care goals for PCMH teams.

For patients without a scheduled appointment, the Certified Medical Assistant (CMA) prints standard reports of preventive measures due for empanelled patients by the first of every month to
identify patients in the panel that are due for particular preventive screening and other health maintenance measures. When patients are due for screening, a team member contacts the patient by mail or telephone to schedule a screening appointment. Follow-up care for patients who screen positive follows current health center protocols.

Utilization Triggers and Transition Care Programs
Unplanned hospital admissions and ED visits are linked to poor outcomes for many patients. During the care transition between the hospital and the PCMH, opportunities for error and incomplete communication can lead to adverse events or readmission to the hospital. To prevent this, a standard process is required to assure a timely transition to the PCMH after hospital admissions and ED visits. The registry flags PCMH patients who have been seen in the ED or admitted to the hospital and pushes an alert to the care management nurse assigned to that patient.

Post-Discharge Protocols
The focus of transition care is to avoid readmissions. A number of evidence-based interventions have been shown to reduce readmissions. They include medication reconciliation and adherence, care transition with follow-up, and patient activation and engagement. A PCMH will need a system in place to notify them when their patients are discharged from the hospital, as well as defined protocols for all follow-up interventions.

Post-Emergency Department Visit Program
A PCMH also will need a system in place to notify them when their patients have an ED visit, along with protocols for all follow-up interventions.

Disease-Specific Management
A PCMH needs to have evidence-based protocols for the management of patients with specific diseases. Conditions that warrant high priority for protocol development include diabetes, congestive heart failure, hypertension, asthma, and depression.

Self-Care and Self-Management Support
Support for self-care and self-management is a key responsibility of the PCMH team. Self-care includes preventive health measures such as smoking cessation, healthful eating, and exercise, as well as health system navigation (e.g., how and when to access care at the PCMH during and after clinic hours, who their PCMH team is, and how to contact them). Patients with chronic diseases such as heart failure, asthma, or diabetes are provided with self-management support. Areas of emphasis include understanding the disease process and treatment plan, medication adherence, recognition of signs and symptoms of worsening illness, and skills for managing a particular condition. All members of the clinical team participate in equipping patients with necessary skills and providing ongoing support for patients in self-care and self-management.

Complex Care Management
Nowhere is the link between cost and quality more clearly demonstrated than in the care of the medically complex patient. Patients who are poorly managed are more likely to be hospitalized, which results in poor health outcomes and drives up health care costs. In fact, the two-thirds of
Medicare beneficiaries with multiple chronic conditions account for 96% of Medicare expenditures.²

In addition to patients with multiple chronic diseases, patients with complex health needs include persons with disabilities, frail elderly, and patients with serious mental illness. Among Medicare patients in the U.S., it is estimated that one-third have four or more chronic conditions.³ Medically complex patients are at the highest risk for the multitude of poor outcomes associated with fragmented care. These patients access their healthcare services across multiple settings with multiple providers of care. They have higher risk for adverse health outcomes, including death, functional limitation and disability, frailty, nursing home placement, diminished quality of life, treatment complications, and avoidable inpatient admissions.⁴

Caring for medically complex patients within a PCMH creates a particular set of challenges and opportunities. For example, the PCMH model requires that the majority of the patient’s health needs and problems be addressed and treated within the PCMH. For complex patients, for whom this may not be possible, the PCMH needs to manage care provided outside the walls of the health center, particularly during transitions in care.

Ongoing monitoring and screening for health risk and changes in functional health status inform care priorities and drive decision-making and interventions.

Care coordination and management for medically complex patients typically requires a registered nurse or licensed social worker care manager, who partners with the patient and the PCMH team in the design and delivery of the patient’s individualized care plan. The care manager works closely with the patient and the patient’s caregivers to identify the patient’s values and current health status and to set realistic goals for the patient.

Adding the complex care management component to the PCMH allows medically complex patients to be managed within a primary care setting by their primary care provider. Care delivery through the PCMH model has the potential to significantly benefit this population by providing improved quality of care at a lower cost.

**Enabling Services**

PCMHs within integrated care systems also need ways to provide enabling services such as transportation, interpretation, and home visits to patients. This is especially critical for safety net populations. Federally Qualified Health Centers (FQHCs) are required to provide enabling services as part of their federally-defined scope. However, integrated systems need to determine how these services will be provided regardless of whether or not an FQHC participates in the system.

³ Ibid
PCMH ACCESS

PCMHs need to ensure appropriate access to services and define how they will measure and monitor patient access. Ways to support patient access that are consistent with the PCMH model include the following:

- an advanced phone system, which may include “Central Scheduling” with routing capability and a mechanism for handling calls after hours
- extended health center hours to ensure evening and weekend hours
- patient scheduling approaches, such as “Simplified Patient Scheduling,” which allow for same-day and next-day appointment access
- minimizing no-show rates created by limiting the amount of time between booking appointments and actual appointments and by consistently making reminder calls
- enhanced workflow and throughput and systematic identification and elimination of bottlenecks in patient flow
- longer appointment intervals for patients with good chronic disease control, which could include non-visit follow-up via phone or other means if feasible, including secure e-mail or text messaging
- non-provider visits for selected issues (e.g., nurse visits to implement stepped therapy for chronic disease control and standing orders for immunizations)
- evidence-based group visits for patients

SPECIALTY AND DIAGNOSTIC SERVICES

Background

Access to specialty consultation and diagnostic services is an integral component of the safety net delivery system. However, gaining that access can prove challenging. As Medicaid expansions move forward, previously undiagnosed or untreated conditions that require specialty consultations and diagnostic evaluations will be identified. The resulting increased demand for referrals will further stress already burdened specialty and diagnostic entities.

Integrated health systems must work aggressively to optimize processes for referrals, appointments, pre-visit testing, appointment reminders, follow-up appointments, and discharge from specialty care. Specialty and primary care providers will need to better coordinate care to ensure the best use of valuable—and sometimes limited—specialty care and diagnostic resources. Integrated health systems will have to solicit outside partners for key specialties, diagnostic tests, and procedures that the system cannot otherwise provide in a timely manner.

Specialty and Diagnostic Authorization Procedures

Integrated systems need to employ an evidence-based set of clinical referral rules to ensure a tightly managed authorization process. These rules help ensure a patient is accurately diagnosed with a clinical problem, assigned to receive the appropriate tests, and is referred to the right specialist.
These referral rules may be operationalized through a web-based portal. An ideal specialty/diagnostic referral system accomplishes the following functions:

- clarifies reasons for the referral
- provides a patient condition-specific dialog with the ordering provider concerning the reason for referral and the specific question to be answered
- identifies and ensures a complete work-up by the primary care provider prior to the specialty consultation
- communicates standards for appropriate referrals in the network
- directs referrals to the most appropriate service
- assigns priorities based on clinical conditions and ensures high priority cases are quickly addressed
- identifies and manages documentation requirements

Referring providers’ patients may or may not be granted an appointment if their condition does not meet standards for appropriate referral, or if the provider did not perform a pre-referral work-up. This restriction helps primary care physicians make appropriate referrals. Often, when a pre-referral work-up is performed, the primary care provider’s concern is answered or resolved. An inappropriate referral is avoided, and the provider gains valuable insight for future referrals, ultimately enhancing his or her practice.

The referral system also provides administrative decision support by generating useful reports. Reports contain:

- total volume of referral orders trafficked across the user's network
- the average elapsed time to process referral requests and the number of orders that have exceeded the target processing deadline
- real-time performance tracking of the total unscheduled backlog
- source of referral and demand generated
- within a generating clinic, a summary of each provider’s orders over any specified time, with linked access to the details of any individual order detail

**Expansion of Specialty Care Capacity**

Ideally, process improvements and service enhancements focus on high-demand/low-capacity services. Scheduling templates for all priority outpatient specialty clinics are modified to ensure a high percentage of all appointment slots are dedicated to new referrals. Follow-up visits are limited to one visit unless more are specifically authorized. If the patient maintains ongoing consultant care, the interval between follow-up visits can be longer as the patient is co-managed with the PCMH.

Patients are discharged from the care of specialty clinics to primary care providers with a thorough care plan. Tracking new referral scheduling and the number of discharged patients is critical for determining whether the utilization of specialty care is appropriate.

In high-priority specialty clinics, patients need to be contacted with pre-visit calls/texts/e-mails to remind them of appointments, ensure they intend to keep the appointment, and to determine if
ordered tests have been completed. Pre-visit “scrubbing” (i.e., cancelling appointments for patients not prepared for a visit) maximizes show rates, reduces needless overbooking, allows other patients to fill cancelled appointments, and reduces ineffective visits for patients who have not had ordered tests completed. Pre-visit contact with patients can reduce the number of unproductive visits, creating additional capacity for specialty consultation.

Many patients referred to specialists do not need an in-person appointment. Electronic messaging and electronic consults have proven to be effective ways for patients to consult a specialist at a convenient time, without the need for a formal office visit. Such electronic consultations can be secure and can include an effective way to document the referral request and consultation. The e-consult process is an effective communication tool that allows the specialist and primary care provider to co-manage a patient. The improved communication between the specialist and the primary care provider can expand in-office appointment capacity.

**Expansion of Specialty Care Access via Community Partnerships**

To meet access standards, integrated systems need to develop partnerships with hospitals or specialty groups to fill gaps in services. These specialty care partners should be carefully selected using criteria that include:

- location
- ease of referral
- ability to refer uninsured and insured patients
- effective communication of specialty reports to referring providers
- use of an effective electronic referral system
- agreement on a financial model

Establishing an effective partnership requires integrated plan officials to monitor the relationship to ensure that contract requirements are being met and utilization patterns are appropriate.

**Access to Diagnostic and Procedural Services**

It is important that specialty (and primary care) providers receive the results of indicated diagnostic tests and procedures in a timely manner. Appropriate access to tests and procedures produces better patient outcomes, reduces ineffective and unneeded specialty visits, and expedites the return of patient care management to the PCMH.

Referrals to diagnostic and procedural services that are expensive and difficult to access should require more rigorous prior authorization. Utilization patterns of individual and group practices that make these referrals should also be carefully reviewed. Combined use of the empanelment process and the patient registry makes it possible to calculate and compare utilization rates for all providers—for example, CT scans per 1,000 patients per year. Prior authorization should be instituted for high-utilizing providers and should be standard for providers referring from partner organizations.
To meet access standards, the health system may need to form partnerships with hospitals or other diagnostic centers to fill gaps in diagnostic services. These partnerships are developed and monitored as described above.

**Monitoring Access to Specialty Care, Diagnostic Testing, and Procedures**

An enhanced clinical utilization reporting system monitors access to specialty care and diagnostic and procedural services, as well as their usage. The health system needs to track new appointments, discharges from specialty clinics, specialty service productivity, and diagnostic testing and procedural service productivity. Tracking access and utilization rates of partnership sites for specialty care and diagnostics is also necessary. Reports need to be prepared and formatted to easily allow comparison of wait times, productivity, and utilization. A dashboard tracks key elements of the provision of specialty care, diagnostic, and procedural services.

**Specialized Medical Home and Integrated Care**

Too often, appointments made with specialists are follow-up appointments that might be appropriately handled within the PCMH with specialty support. In addition, patients may want to continue seeing the specialty care providers they have been seeing exclusively.

There are two approaches for dealing with these problems. The first is the Specialty Medical Home, where subspecialists serve as the primary care provider, and the specialty clinic becomes the patient’s PCMH. The second approach is to deliver the specialty and primary care in both settings as appropriate to the patient population. The influenza vaccine—typically a primary care responsibility—may be administered in the specialty setting, while an assessment of complex disease control—typically performed by the specialist—may be done in the primary care office. This particular type of integration focuses on sharing care responsibilities. The second approach is most commonly used for patients with severe and persistent mental illness. Regardless of the model used, it is necessary for the different types of specialists to define their role, as has been done for primary care.

Specialist-based PCMHs should have to meet the same standards as primary care-based medical homes. This includes requirements for providing first-contact, continuous, and comprehensive care, and using systematic processes to improve the health of a practice's patient population.

The PCMH population and availability of specialty mental and behavioral health services will dictate how mental health, behavioral health, and primary care are integrated. Evidence-based models, such as the IMPACT model for depression care, or other demonstrations conducted by the National Council on Community Behavioral Health Care, will help determine the approach.

**Behavioral Health**

Integrated delivery systems need to provide for the behavioral health needs of their population, including mental illness and substance abuse services. Although the nature of behavioral health services varies by state (partly because of state regulation) or by organization, there are common elements any system adopting accountable care practice must address.
When starting to plan for behavioral health services, an integrated delivery system must assess the likely prevalence of mental illness and substance abuse disorders among its population. It is estimated that 20% of the population in the United States will need some behavioral health intervention or treatment yearly and that 5% of the population suffers from serious and persistent mental illness. However, the prevalence of mental and behavioral health disorders will differ widely among different populations depending on factors such as age, race, socio-economic status, and ethnicity. Assessment of the population will reveal the amount and type of resources the integrated delivery system must be able to provide.

Most mental health or substance abuse conditions are currently managed within a primary care setting. It is widely acknowledged that these conditions are underdiagnosed and inadequately addressed. Every patient in an integrated delivery system should be screened to identify behavioral health conditions. The intake assessment should identify past history of diagnoses, hospitalizations, or treatment for these conditions. Screening should be repeated routinely to capture changes in patients’ needs. Because of the high prevalence of depression, all members of a PCMH should be screened annually for this condition. One useful instrument is the PHQ9, although others may be used. Beyond screening, a PCMH must be adequately prepared to provide evidence-based clinical treatment of identified needs, as well as care management and care coordination appropriate for behavioral health issues.

Collaborative care is perhaps the most effective method for providing mental health, behavioral health, and substance abuse services within primary care. The Impact Model is the best example of collaborative care for depression in primary care; however, this approach can be applied to other conditions, such as Post-Traumatic Stress Disorder or anxiety disorders. In this model, universal primary care screening for specific behavioral conditions is followed by a brief, standardized primary care diagnostic assessment for those who screen positive. The medical home team functions in two main ways: 1) the individual’s primary care physician works with a care manager/behavioral health specialist to develop and implement a treatment plan, and 2) the care manager/behavioral health specialist and primary care provider consult with the psychiatrist to change treatment plans if individuals do not improve. A registry is used to prompt follow-up sessions and outreach and to track behavioral health outcomes.

Providers treating either primary care or behavioral health patients should use available tools to screen for smoking and substance abuse. They should provide brief interventions effective in treating patients identified with problematic or risky substance use.

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**Elements of Collaborative Care of Depression**

**Routine Screening for Depression**

Care manager/behavioral health specialist who provides and monitors success of evidence-based counseling and therapy with primary care physician.

Consultation by a psychiatrist who reviews cases periodically and consults on those resistant to therapy.
Patients with severe and complex, persistent mental illness are referred to the subspecialty mental health resources within the integrated delivery system. It is important that the mental health sector of the integrated delivery system employ evidence-based models of care, such as the Medication Management Approaches in Psychiatry, Illness Management and Recovery model, and Assertive Community Treatment teams. Access to additional resources for crises, housing, and supportive care are obtained through the subspecialty sector.

To improve health and control health care costs for patients with serious behavioral health conditions, it is critical to recognize that these patients are also likely to have chronic physical conditions. Severe mental illnesses, such as schizophrenia or bipolar disorders, are associated with excessive morbidity and early mortality from physical conditions such as heart disease and cancer. Likewise, the effects of unrecognized depression, anxiety, and substance abuse are among the most prominent contributors to poor control of chronic physical illness.

Unfortunately, the behavioral health and physical health needs of patients traditionally have been managed and treated in separate systems with inadequate coordination for a person’s total care. Practitioners in both primary care and mental health feel unprepared to address the clinical issues with each other and lack time and readily available methods to communicate across their professional boundaries. In addition, mental health practitioners capable of managing care for the sickest, most complex patients are in short supply, especially in poor communities. For patients with co-occurring conditions, this fragmented approach generates excessive use of health care and high costs.

**Integration of Behavioral and Physical Health and the Health Home**

Integrating behavioral health and primary care can improve health outcomes and help avoid excess cost for patients with behavioral health issues, especially those with co-occurring chronic conditions. It is helpful to have a conceptual model of treatment before proceeding to actual integration within a delivery system.

Complete integration of primary care and behavioral health into one health care unit offers the most potential for delivering the highest quality, lowest cost of care. However, usually the primary care and specialty behavioral health resources and services operate separately within different organizations. The challenge, then, is to design care delivery that effectively identifies persons with co-occurring conditions (usually from screening) in both physical and behavioral health settings—and delivers the needed care.

Achieving this goal will require:

1) planning where patients receive care for each condition
2) ensuring that there is coordination, communication, and collaboration between each clinical site involved
3) providing a system of care management for this population

One model for doing this is the Health Home, a term used for a PCMH that has been enhanced to manage or coordinate the behavioral health needs of its population through coordinating, co-locating, or integrating with behavioral health services. Likewise, the Health Home may be a behavioral health facility that coordinates or manages the primary care needs of its population. It is also responsible for coordinating all of the patient’s/client’s care, is a continuous source of care, and ensures the entire continuum of care is available.

**Identifying Where an Individual Receives Care**

Where is the Health Home?

Within an integrated delivery system, it is assumed that each member has a Medical/Health Home. However, for patients with both physical and behavioral conditions, care for both conditions must be provided at one main site. This facility will be the entity where the client/patient spends—or chooses to spend—the most time. The primary site coordinates care and is the site of accountability. The Four Quadrant Integrated Model (shown below) is a helpful planning tool. While it is not prescriptive, it can help guide the decision-making process for where care might best be provided for persons with both physical and behavioral conditions.

<table>
<thead>
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<th>Four Quadrant Integrated Model</th>
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<tr>
<td>I. Low Mental Health Needs/</td>
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<td>Low Physical Health Needs</td>
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<td>II. High Mental Health Needs/</td>
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<td>Low Physical Health Needs</td>
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<tr>
<td>III. Low Mental Health Needs/</td>
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<td>High Physical Health Needs</td>
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<tr>
<td>IV. High Mental Health Needs/</td>
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<td>High Physical Health Needs</td>
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Traditionally, persons in Quadrants I and III are the most appropriate candidates for Health Home care provided in a PCMH. Persons in Quadrant II are most appropriate for a Health Home within behavioral health. Persons in Quadrant IV represent a particular challenge since they have severe and persistent behavioral health issues as well as severe, complex, and chronic physical illnesses. Interpreters of the Four Quadrant model often indicate that specialty behavioral health centers are the ideal Health Home for those in Quadrant IV. Managing the care for persons with complex illnesses is a challenge in any setting, but the best health outcomes for patients with severe behavioral and physical conditions have been achieved in integrated delivery systems.

Fully integrated Health Home teams have the expertise to prepare and implement a care plan that is truly patient-centered and shared by everyone who cares for the patient. They use the same records, plan together, and work as one team. Often, integrated care is located in a larger system of care. This provides the greatest opportunity for delivery design, an organized change management method,
and infrastructure to support the integrated approach. As stated earlier, full integration of behavioral health and physical health is an exception. Most delivery systems have started to address integration only recently and are at different stages of this process.

**Models of Integration**

There are several models that represent different levels of integration. Experience in each of these models offers insight about their effectiveness and the kind of system redesign needed to implement them. Each model requires new staff roles and competencies, as well as retraining or hiring new staff. The three levels of integration are: collaboration of services, co-location of services, and fully integrated models.

**Collaboration of Services**

This is the first level of integration between independent primary care and behavioral health entities located in separate places. This should be the minimum required of primary care and behavioral health facilities within an integrated delivery system.

At this level, the two entities relate to each other via referrals which they use to delegate aspects of care. There are agreements and processes that define and facilitate referrals in both directions, and communication occurs on individual cases with release of information sought each time. In addition, there is some formal attempt to understand and define each entity's role and model of care. Expanded duties for each are usually included (e.g., screening for medical conditions in the behavioral health entity or psychiatric medication management in primary care).

Care management staff at each entity has a particular role in fostering and supporting the collaboration. One entity is designated the Health Home. The other entity has more of a secondary role as a consultant. Information technology, databases, and medical records are separate. Reimbursement and governance are typically separate, and true sharing of a care plan is not complete.

**Co-location of Services**

Close consultation between primary care and behavioral health in a collaborative model is an improvement over current practice. However, many health systems have found gaps in continuity and communication that can negatively impact patient care. When services are separately located, some duplication of services and costs are unavoidable. Patients cannot receive their needed care without some travel and must become accustomed to a second location’s design and processes. As a result, important and effective services can be missed. To address this, systems have co-located a practitioner in the other setting to serve patients with co-occurring conditions.

Often a primary care nurse practitioner is embedded in a behavioral health setting, or a licensed clinical social worker is embedded in a primary care setting. This improves patient convenience and enhances the use of informal consultation between staff. The embedded practitioner provides care with the collaboration and consultation of a psychiatrist or primary care physician at their “home” site.
The embedded clinician may serve to support collaborative care models or provide direct treatment and service to a limited case load. The clinician also acts as a liaison between the entities. The informal relationships the clinician maintains help increase understanding and communication. Patients are more likely to adhere to scheduled visits with this one-stop arrangement and a warm hand off that can occur upon referral to the embedded clinician. When consultations with subspecialists are necessary, the consultant is usually better prepared, and the process is more efficient.

However, this is not full integration. Medical records usually are separate, as is billing and the reporting and evaluation of the practitioner to another facility. While the nurse practitioner or licensed clinical social worker is embedded in another setting, they are not actually full-fledged members of that care team. Communication is improved, but formal communication approaches, such as a shared care plan, are usually lacking. One of the entities is the Health Home and is accountable for patient care and coordination of care and outcomes, no matter where the care is delivered. Substantial agreement must occur between the facilities on policies, designation of responsibilities, availability, and access.

**Fully Integrated Models**

Although it is not widespread, the fully integrated approach treats all persons with mental illness, including serious mental illness, in one organization that contains both primary care and subspecialty behavioral health. These clinical services are integrated, and the single entity is responsible for governance, administration, and financing. The design of integrated services is simply the design of the organization's model of care and an organization-wide effort. Behavioral health and primary care providers are on the same staff and interact frequently. They share a single medical record, care plan, information system, database, and quality program.

An integrated delivery system with global funding or capitation for a population is the easiest environment for implementing these integrated models. In many other instances, requirements for billing for services, such as carve-outs for mental health, may be an obstacle to full integration by denying reimbursement for two services that would be available to two different organizations providing the same services. Confidentiality criteria in state laws and federal substance abuse standards need to be considered, and the conflicts they represent must be resolved.

Perhaps the greatest challenges to integration are the different cultures, work styles, and practice paces of behavioral health and primary care. For instance, primary care has developed much more of a population focus, while behavioral health is more focused on the individual. A core component and activity in the PCMH model is “panel management,” which recognizes that a population is being impacted, not just individuals, whereas panels (as opposed to caseloads) are generally not part of the behavioral health framework. Another difference is the role of consumer input. Including consumers in the entity’s operations (through peer treatment) and governance (through structured consumer input) is generally more central to the culture of a behavioral health institution. While many behavioral health appointments are non-structured, with the client directing the focus of the
time, primary care's pace is rapid and focuses on brief, effective interventions with supported patient self-management.

Moving the two kinds of organizations toward fuller integration is not an easy task, but evaluations of organizations with high levels of integration indicate health outcomes improve and costs decline.

**HOSPITAL AND INPATIENT CARE**

While enhancing primary care is essential for an effective integrated delivery system, hospitals and inpatient care are clearly part of the continuum of care. This is why most successful integrated systems own or have a strong affiliation with a hospital. Likewise, long-term care is an essential component of an integrated delivery system.

**Hospitals**

Integrating hospitals into the organization of an integrated delivery system can pose challenges. In the current financial environment, hospital leaders feel tremendous pressure to ensure their beds are occupied, which causes them to focus on maintaining high volume. This focus runs counter to the goals of offering high-quality, cost-effective integrated care. However critical it is at certain times, a hospital's contribution to the overall health of a population is limited. Hospitalization is an unwelcome incident in the lives of patients and is often considered to be a symptom of failure by the primary care and outpatient sectors.

It is well beyond the scope of this section to address the challenges of redesigning and transforming hospital operations or outcomes. Instead, the discussion below concerns: 1) the hospital’s role in the integrated system; 2) the necessary communication and coordination; and 3) the requirement that the hospital share the goals of and participate in the system that is accountable for costs, quality, and patient engagement. Hospital leaders, including clinical leaders, must understand and mutually support the goals of the system—and perhaps be members of its governing body—if those goals are to be achieved.

One condition clearly must be met in an integrated delivery system. The hospital ED cannot be the default entry point for gaining access to the system. Rather, when a patient goes to the ED, the following conditions must be met:

- ED staff readily and routinely identify a patient’s PCMH.
- The ED has access to the patient’s risk status, care plan, and relevant clinical information through an electronic connection such as a shared registry or other software.
- When appropriate, ED clinicians defer diagnostics and specialty referrals to the PCMH.
- ED care managers or utilization managers are responsible for transmitting records and medication lists to the PCMH and ensuring that the patient leaves with an appointment and the PCMH’s contact information.
• When appropriate, ED staff work with a PCMH team to transfer or refer a patient to skilled nursing care, long-term care, or home- and community-based care without having to admit the patient.

Consistent application of these conditions can prevent many unnecessary hospitalizations.

Although many inpatient hospitalizations are clearly necessary, many could be prevented with appropriate provision of primary care. The inpatient service of the hospital should participate in achieving the integrated system's goals by:

• understanding the PCMH’s central role and functions and complementing them through communication, deferring patient care risk to the PCMH, and reliably repatriating
• participating in the assessment of the reason for admission or readmission of each patient
• transforming its current inpatient utilization management staff into inpatient care managers who routinely and consistently work with the PCMH and the long-term care plan of the patient
• constructing a discharge plan with the PCMH care management staff, communicating information, and including the patient in the planning and the hand off
• providing centralized hubs for placement services (e.g., to skilled nursing or home health) as well as ordering services such as durable medical equipment and transportation for inpatients, ED patients, and patients in the PCMH
• providing actionable information to the integrated system such as tracking (e.g. discharge locations), trending (e.g. rates of readmission), and predictive capabilities (e.g. risk for readmission using granular inpatient data), as close to real time as possible

**Long-Term Care**

Long-term care (LTC) is clearly a fundamental part of an integrated system within the safety net. The appropriate role for LTC and its effects on the efficacy, quality, and cost of care are complex issues that go beyond the scope of this document. Appropriate use of LTC can reduce costs, improve quality of care, and enhance quality of life. When LTC is part of the patient’s care mix, coordinating communication among the patient, family, and providers and among the LTC provider, primary care providers, emergency care, and hospital care becomes more complex. The division of responsibilities between Medicaid and Medicare increase the complexity of coordination. The system must have mechanisms in place to answer why, how, when, and where LTC services are delivered.

Types of LTC service might include home care along with home health and home care services/community supports, such as all-inclusive approaches like the PACE program. Residential care includes short-term skilled nursing and long-term custodial settings, extending to supporting end of life, palliative care, and hospice care. All of these must be linked to the PCMH when possible, and they should share the goals and approaches of the integrated system to improve quality, control costs, and engage patients and families. Optimally, an integrated care system would have the following LTC features:
• A single entry point to LTC services that can offer access to multiple providers and a variety of services without depending on individuals within the system (such as hospital-unit-based social workers) who have limited knowledge of available LTC resources.

• A single assessment measurement process, based on the client’s functional autonomy, coupled with a case-mix classification system to determine appropriate LTC needs.

• The ability to use innovative LTC approaches such as Long-Term Acute Care hospitalization, Hospital-at-Home approaches, and PACE-like programs.

• Individualized service plans integrated with the patient’s care plan. Electronic means should be used for communicating these plans between LTC institutions and the full range of professional providers, including those providing social services, transportation, home health nursing, etc.

• The ability to ensure that decisions made by different organizations and service providers are coordinated and compatible and that the care management process includes patients and families.

• A transition care program that guarantees patients are moved into LTC efficiently and appropriately whenever necessary. A care plan that seeks to move the patient back to a community setting as soon as possible must be fashioned and shared among the LTC organization, clinical providers, and the PCMH.

• When appropriate, treatment plans should include end-of-life planning so services such as hospice and palliative care can be integrated into the LTC plan to avoid unnecessary, unwanted, and painful hospitalizations.

SUPPORT FOR SPECIAL POPULATIONS

Integrated delivery systems will eventually cover a range of populations, some of which may have very complex physical, emotional and/or social challenges. Examples include persons with developmental disabilities, severe mental illness, and those newly released from incarceration. As delivery systems take on increased risk, they will face the challenge of generating cost savings and maintaining quality of care for these populations. Most of the cost savings will result from reducing unnecessary emergency department visits and hospitalizations, and assuring that patients are cared for at the right level of care (out of the institution and into the community as appropriate).

Among the most effective ways to control costs is to ensure smooth transitions between levels of care. Successfully creating these transitions requires expertise with the population and ongoing support services. Community organizations that develop this expertise and provide these services can play a critical role in generating cost savings and maintaining quality of care for the integrated delivery system. However, these community organizations need to make themselves known to key institutions in the community (e.g. hospitals, long-term care organizations) by advocating for what they can bring to the delivery system. Once the institutions are informed, they should welcome the participation of community organizations, as they often do not have sufficient experience with many of the special populations identified and will benefit from such partnerships.
CONCLUSION

Mounting economic and fiscal pressures—and the recognition that the current reimbursement system often does not produce good value for money spent—spotlight the critical need for creating widely available, viable new options for the health care system that are able to lower cost, improve the patient experience, and enhance health outcomes. A fundamental transformation in the way providers coordinate services, collaborate in planning, and share accountability for the patients they serve is required.

Positioned between fee-for-service and traditional capitation, integrated delivery systems/ACOs represent an important new opportunity to create models of care that change incentives and provide the basis for measuring both financial and clinical performance.

This document seeks to provide support to health systems, especially those in the safety net, as they move toward building integrated delivery systems/ACOs. It provides guidance on governance, finance, infrastructure and capacity building, as well as a transformation of primary care, specialty and diagnostic services, and hospital and inpatient care that is consistent with this approach.

Integrated delivery systems/ACOs will be successful if they can enhance the patient experience, improve health outcomes, and reduce cost. There are different accountable care models, and their relative success is yet unproven. The models will almost certainly require significant refinement as payers, providers, and beneficiaries gain experience.
## APPENDICES

### Appendix A

Main staff model worksheet at the “current reality” stage

<table>
<thead>
<tr>
<th>INSTRUCTIONS</th>
<th>RESULT</th>
<th>WHAT THE NUMBER MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 1</td>
<td>Enter total Physician Full Time Equivalents</td>
<td>1</td>
</tr>
<tr>
<td>Line 2</td>
<td>Multiply by 9 to get total 1/2 sessions</td>
<td>9</td>
</tr>
<tr>
<td>Line 3</td>
<td>(actual sessions may be more w/residents - their 1/2 day session don’t have as many patients scheduled - suggest PGY1 0.3, PGY 2 0.5, PGY 3 0.7)</td>
<td></td>
</tr>
<tr>
<td>Line 4</td>
<td>Enter number of non-licensed staff that can support clinical flow staff (MA, HA, PCA)</td>
<td>2</td>
</tr>
<tr>
<td>Line 5</td>
<td>Divide line 2 by 10</td>
<td>0.9</td>
</tr>
<tr>
<td>Line 6</td>
<td>Subtract line 6 from line 5</td>
<td>1.1</td>
</tr>
<tr>
<td>Line 7</td>
<td>Enter # of LPNs</td>
<td>2</td>
</tr>
<tr>
<td>Line 8</td>
<td>If line 7 is positive enter 0; if Line 7 is negative enter the same number without the positive sign</td>
<td>0</td>
</tr>
<tr>
<td>Line 9</td>
<td>Subtract line 10 from line 9</td>
<td>2</td>
</tr>
<tr>
<td>Line 10</td>
<td>Divide line 2 by 20 (round to one decimal point)</td>
<td>0.5</td>
</tr>
<tr>
<td>Line 11</td>
<td>Subtract line 11 from line 12</td>
<td>1.5</td>
</tr>
<tr>
<td>Line 12</td>
<td>Enter # of RNs</td>
<td>1</td>
</tr>
<tr>
<td>Line 13</td>
<td>If line 11 is positive, enter 0. If line 11 is negative enter the same number without the positive sign</td>
<td>0</td>
</tr>
<tr>
<td>Line 14</td>
<td>Subtract line 16 from line 15</td>
<td>1</td>
</tr>
<tr>
<td>Line 15</td>
<td>Enter number of clerical FTEs</td>
<td>4</td>
</tr>
<tr>
<td>Line 16</td>
<td>Divide line 2 by 20 (round to one decimal point)</td>
<td>0.5</td>
</tr>
<tr>
<td>Line 17</td>
<td>Subtract line 21 from line 20</td>
<td>3.5</td>
</tr>
<tr>
<td>Line 18</td>
<td>If line 16 is zero, enter 1.0; if not zero, then add lines 5, 9 and 16 and divide total by 1/10th of line 2</td>
<td>1.0</td>
</tr>
<tr>
<td>Line 19</td>
<td>If line 18 is positive, enter 0.5; if negative then enter [line 11 if positive+line 17 divided by 1/10th of line 2]</td>
<td>0.5</td>
</tr>
<tr>
<td>Line 20</td>
<td>If line 16 is zero, enter 1.0; if not zero, then add lines 5, 9 and 16 and divide total by 1/10th of line 2</td>
<td>1.0</td>
</tr>
<tr>
<td>Line 21</td>
<td>Add together just positive values in lines 11, 18 &amp; 22, then divide by line 1; if all negative enter zero</td>
<td>6.10</td>
</tr>
<tr>
<td>Line 22</td>
<td>If line 20 is positive, enter 0.5; if negative then enter line 20 divided by 1/10th of line 2</td>
<td>0.5</td>
</tr>
<tr>
<td>Line 23</td>
<td>If line 18 is positive, enter 0.5; if negative then enter [line 11 if positive+line 17 divided by 1/10th of line 2]</td>
<td>0.5</td>
</tr>
<tr>
<td>Line 24</td>
<td>If line 16 is zero, enter 1.0; if not zero, then add lines 5, 9 and 16 and divide total by 1/10th of line 2</td>
<td>1.0</td>
</tr>
</tbody>
</table>

---

Your "Present Reality" Staffing Model per FTE for care management and coordination and per session for clinical flow:
### Appendix B

#### Staffing worksheet for individual provider

**STEPS:** 1. Fill in provider type 2. Fill in the orange button boxes with the total per each session 3. Fill in the solid orange with the total across all cells

<table>
<thead>
<tr>
<th>Provider</th>
<th>Name</th>
<th>Instructions</th>
<th>Enter Value or total per session</th>
</tr>
</thead>
<tbody>
<tr>
<td>George Mason, MD</td>
<td>Enter FTEs: 0.67</td>
<td>Mon AM</td>
<td>Mon PM</td>
</tr>
</tbody>
</table>

**Provider type for this provider (X in 1)**
- Attending NP or PA: PGY 3
- PGY 2
- PGY 1

**Main person in role of non-licensed staff clinical flow**
- Larry Smith
  - For sessions when provider is present you will see orange boxes when too few resources scheduled, red when too much
  - 1.0 per session

**2nd Non-licensed staff clinical flow**
- Sally Jones
  - For sessions when provider is present you will see orange boxes when too few resources scheduled, red when too much
  - 0.8 per session

**Other staff doing non-licensed clinical flow**
- Fran Quinn, RN
  - For sessions when provider is present you will see orange boxes when too few resources scheduled, red when too much
  - 0.2 per session

**Main staff doing care coordination**

**2nd staff doing care coordination**

**3rd staff doing care coordination**

**Nurse 1 Clinical Flow**
- Fran Quinn, RN
  - For sessions when provider is present you will see orange boxes when too few resources scheduled, red when too much
  - 0.5 per session

**Nurse 2 Clinical Flow**

**Nurse 1 Care Manager**

**Nurse 2 Care Manager**

**Clerk**

**Clerk**

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*Health Management Associates – Accountable Care Institute*
Appendix C

Medical Home (Practice-Based) Care Coordination - Position Description

The care coordinator works within the context of a primary care medical home, from a team approach, and in continuous partnership with families and physicians to promote: timely access to needed care, comprehension and continuity of care, and the enhancement of child and family well-being.

Care Coordination Qualifications
The care coordinator shall have:

- bachelor’s preparation as a nurse, social worker, or the equivalent with appropriate past experience in health care
- three years relevant experience, or the equivalent, in community-based pediatrics or primary care, particularly in the care and service of vulnerable populations such as children/youth with special health care needs (CYSHCN)
- essential leadership, advocacy, communication, education and counseling, and resource research skills
- core philosophy or values consistent with a family-centered approach to care
- culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs

Care Coordination Responsibilities
The care coordinator will:

- demonstrate and apply knowledge of the philosophy/principles of comprehensive, community-based, family-centered, developmentally appropriate, culturally sensitive care coordination services
- facilitate family access to medical home providers, staff, and resources
- assist with or promote the identification of patients in the practice with special health care needs (such as CYSHCN); add to registry and use it to plan and monitor care
- assess child/patient and family needs and unmet needs, strengths and assets
- initiate family contacts; create ongoing processes for families to determine and request the level of care coordination support they desire for their child/youth or family member at any given point in time
- build care relationships among family and team; support the primary care-giving role of the family
- develop care plan with family/youth/team (emergency plan, medical summary and action plan as appropriate)
- carry out care plans, evaluate effectiveness, monitor in a timely way and effect changes as needed; use age appropriate transition timetables for interventions within care plans
- serve as the contact point, advocate and informational resource for family and community partners/payers
• research, find, and link resources, services and supports with/for the family
• educate, counsel, and support; provide developmentally appropriate anticipatory guidance; in a crisis, intervene or facilitate referrals appropriately
• cultivate and support primary care and subspecialty co-management with timely communication, inquiry, follow-up and integration of information into the care plan
• coordinate inter-organizationally among family, medical home, and involved agencies; facilitate “wrap around” meetings or team conferences and attend community/school meetings with family as needed and prudent; offer outreach to the community related to the population of CYSHCN
• serve as a medical home quality improvement team member; help measure quality and identify, test, refine and implement practice improvements
• coordinate efforts to gain family/youth feedback regarding their experiences of health care (focus groups, surveys, other means); participate in interventions which address family/youth articulated needs

Appendix D

Medical Home (Practice-Based) RN Care Manager - Position Description

Position Description: The Patient-Centered Medical Home (PCMH) Nurse Care Manager (CM) focuses on applying extensive knowledge and skills to consistently provide comprehensive care to patients in a variety of settings. The CM demonstrates an in-depth understanding of health and illness issues/problems for the patient and family. Possessing a vast background of experience, the CM recognizes and responds to dynamic situations by using past experiences to synthesize and interpret multiple—sometimes conflicting—sources of data. The CM performs analyses to demonstrate and support optimal patient, system, and professional outcomes.

The CM focuses on each care episode in the context of the continuum of care for that patient and their unique needs. The CM focuses on a small percentage of high-risk/high-cost patients at a high level of service intensity. The CM collaborates with all team members around their focus areas and facilitates development and implementation of a comprehensive, interdisciplinary treatment plan focused on the ambulatory setting.

General Duties

1. Facilitates assignment of risk level for each medical home patient.
   a) Reviews and collects information on risk factors from the patient and the patient’s medical record to assess risk status.
   b) Adjusts risk level according to reassessment of patient status.

5 McAllister J, Presler E and Cooley WC. Medical Home: Practice-Based Care Coordination: A Workbook Center for Medical Home Improvement (CMHI) Crotched Mountain Foundation & Rehabilitation Center Greenfield, New Hampshire June 2007
2. Participates in the development, implementation and evaluation of a multidisciplinary and individualized plan of care (based on risk, medical diagnoses, clinical status, psychosocial and emotional needs, language and culture) that includes:
   a) risk categorization
   b) plan for education and motivation appropriate to level of risk
   c) prompts for evidence-based health interventions
   d) linkages to other needed services

3. Updates plan of care as patients’ status changes.

4. Acts as a liaison by collaborating and communicating with the primary care provider (physician, nurse practitioner or physician assistant), patient, family and other members of the healthcare team.

5. Facilitates interdisciplinary team conferences and consultations, as necessary.

6. Prepares and follows tailored care management interventions for the following conditions/areas including but not limited to:
   a) CHF
   b) type 2 diabetes
   c) asthma/COPD
   d) coronary heart disease
   e) depression
   f) high ED/hospital utilization
   g) transitions of care

7. Facilitates patient engagement with appropriate medically necessary services (e.g., specialty and diagnostics), and coordinates communication between these providers, the primary team, and the patient.

8. Actively participates in the coordination of care for PCMH patients which includes, but is not limited, to:
   a) assessing patient equipment and service needs
   b) discussing needs with providers and obtaining necessary orders
   c) following appropriate process to facilitate coordination of care needs.
      Example: communicates with internal and/or external departments to fulfill patient needs
   d) following up with patient/responsible party to ensure coordination of care needs are met


11. Documents all patient encounters whether face to face, telephone, or other forms of communication in the appropriate registry and/or medical record.

   a) Manages a patient caseload using the DHS Registry (patient information database), including the proper documentation:
      i. assessments
      ii. care plans
      iii. tasks
      iv. appointments and follow-ups

12. Ensures all activities related to plan of care are completed in a timely manner.

13. Identifies the variance from established plans of care, pathways and guidelines, and facilitates the development of plan/do/study/act cycles to decrease variance.

14. Collects avoidable admission data and other relevant information, and plans follow-up interventions with team.

15. Collects and reports data and elevates critical concerns to appropriate leadership.

16. Identifies learning needs of care team and incorporates the role of educator into daily activities, thereby facilitating the development of the multidisciplinary team members in the principles of care management.

17. Knowledgeable of community resources.

18. Maintains a strong relationship with health care and community and social service organizations.

19. Facilitates service coordination of patients with community resources, such as housing, employment, nutrition, mental health, and substance abuse.

20. Prepares for, and participates in, PCMH team and care management meetings:
   a) discusses operational/program challenges/solutions
   b) discusses patient case load
   c) provides ongoing training
   d) actively participates in program development/assigned projects and report on progress

21. Other duties and responsibilities defined as the program matures.
AUTHORS

TERRY CONWAY, MD
MANAGING PRINCIPAL

Dr. Conway has more than thirty years of experience as a physician in leadership positions in community health centers, academic medical centers, staff model managed care organizations, as well as public hospitals and health systems. He has focused on developing strategies, organizational structures, providers, and clinical leaders that are capable of meeting the needs of underserved and vulnerable populations.

His practice at HMA has been to provide consulting assistance in the areas of health system development and operations, medical staff organization, hospital/medical school relationships, behavioral/primary care integration and clinical approaches to disease management, including a focus on specialty care organizations. In the last five years at HMA he has been the clinical lead for large strategic projects for the local governments in such metropolitan areas as Memphis, Dallas, New Orleans, San Mateo, Austin, Miami, Los Angeles, Orange County and San Francisco. He has completed operational projects in clinical areas spanning from emergency room function, inpatient length of stay, outpatient system quality and efficiency, operating room utilization, and the function of postgraduate medical training in a community hospital. He has provided mentoring to Chief Medical Officers in several large public health care systems. He has been part of teams that have recommended changes in public health system governance, as well as clinical/fiscal policy recommendations for chronic hepatitis. He is currently the director of an effort to redesign and improve the care of chronic illnesses within all 33 prisons within the State of California Department of Corrections and Rehabilitation.

Prior to joining HMA, Dr. Conway was the Chief Operating Officer of the Ambulatory and Community Health Network, Cook County Bureau of Health Services. He is an Associate Professor of Medicine at Rush Medical College and has been the principal investigator conducting intervention to improve community based physician asthma care to inner city patients, and has participated in NIH and AHRQ research projects to study and change minority patient behavior in diabetes and asthma care. At Cook County he conceptualized and designed a web based specialty referral system that improved referral flow and efficiency through the use of a set of clinical algorithm based referral rules. Dr. Conway has conducted research and published in the area of the role of primary care and violence, predictors of physician attitudes towards managed care, as well as a number of topics in prevention in physician practice.
Linda is an Advance Practice Nurse (APN) and board certified Family Nurse Practitioner with many years of clinical experience.

Linda works as part of the Emergency Medicine Group at Advocate Christ Hospital in care coordination in one of the busiest Emergency Departments in the state. While there, Linda served on the Advocate Medical Group (AMG) APN/PA Advisory Board addressing the incorporation of APNs into Advocate system clinical practice. Prior to her arrival at AMG, she served as the Clinical Director of Asthma for the Bureau of Cook County where she created a new role for advanced practice nurses and linkage for asthma care in the Cook County system, a population most severely affected by asthma and access to care. She has worked as a Nurse Practitioner (NP) and the Clinical Services Manager for Evercare (a division of United Health Group), as part of their new site development team for IL. While there she implemented best practices for vulnerable patient populations in nursing homes and chronic disease management in the community. Linda has also worked as a NP and the Clinic Manager at the Chicago Family Health Center (FQHC). Linda also served as a NP at the Joliet Correction Center and Stateville Penitentiary, maximum security prisons in the state of IL.

Linda has expertise in billing and reimbursement for APNs both inpatient and outpatient and has served on the board of ISAPN and the APN Multi-State Reimbursement Alliance.

Linda was named the Advanced Practice Nurse of the Year for the state of Illinois in 2009 by the Illinois Society for Advanced Practice Nursing.

Linda also served on the board for the American Lung Association of Metropolitan Chicago. Linda was recognized in 2006 by the American Lung Association of Metro Chicago (ALAMC) and presented with a service award for her work that helped to pass the legislation that made Chicago and Illinois smoke-free.

Linda has served as Graduate School adjunct faculty for Loyola University, UIC, Rush University and the University of St. Francis in Joliet, IL.

Linda earned her Bachelor of Science degree in Nursing and Master of Science degree at St. Xavier University, and is all but dissertation and PhD candidate at the School of Public Health division of Biostatistics and Epidemiology at the University of Illinois – Chicago.
Dr. Greg Vachon is a Principal with HMA, providing consulting assistance in system approaches to prevention and chronic disease management including the patient centered medical home (PCMH) model of care, payment structures to promote the triple aims of quality, access and efficiency, and design and implementation of clinical care innovations.

Dr. Vachon’s work in system approaches include development, evaluation and implementation of patient registries for large health systems, assessment of information technology capacity and requirements for ACO and ACO-like entities, and the creation and use of patient empanelment systems. Dr. Vachon’s work has spanned developing strategic plans, to writing business rules for coding, to training staff to use technology effectively within the patient centered medical home. Payment structure consultation has included work with ACO and ACO-like organizations in several states as well as with State leadership. Dr. Vachon has assisted many organizations with clinical care innovations and is founder and CEO of a company offering a groundbreaking wellness incentive model.

Prior to joining HMA Dr. Vachon served over ten years as Medical Director of Austin Health Center of Cook County in Chicago. There he developed a novel group-care model for diabetics incorporating components of the chronic care model including registry use to monitor quality improvements. As a Chair of the Diagnostic Services Committee for the Ambulatory and Community Health Network (ACHN) of the Cook County Bureau of Health Services (CCBHS), he provided lab contract oversight, improving quality while lowering costs. He served as the Chair of the Information Technology Committee for the Care Improvement Collaborative, a quality improvement project that developed capacity in health centers throughout the network to enhance chronic disease management. Dr. Vachon was the 2007 Peterson Scholar at the University of Illinois at Chicago’s School of Public Health where he focused on health care economics and policy analysis. His current clinical practice is at an FQHC on the south side of Chicago.
As a senior consultant with Health Management Associates, Lori Weiselberg provides consulting assistance in the areas of health system development, approaches to disease management, and the development of public health initiatives.

Ms. Weiselberg has over 20 years of employment experience related to the improvement of the health and health care of medically underserved populations in both rural communities and urban centers. She worked for the State of Wisconsin’s Department of Education promoting a comprehensive school health program with emphasis on HIV/AIDS prevention. She also directed a federally-funded Area Health Education Center (AHEC) to improve the capacity and quality of primary health care services through health professions training in New York City. Ms. Weiselberg worked with a city health department to develop a primary care outreach campaign for the NYC Childhood Asthma Initiative.

Ms. Weiselberg has also assisted healthcare providers, academic institutions and public/private entities to implement disease management programs for chronic conditions in underserved neighborhoods in Chicago/Cook County. The projects she managed involved community engagement, patient empowerment, health center reorganization and provider practice change. Prior to joining HMA, she managed a National Center of Excellence for the Reduction of Asthma Disparities. Ms. Weiselberg holds a bachelor’s degree from Cornell University and a Master of Public Health from the University of Michigan.

Ms. Weiselberg works out of HMA’s Chicago office.
Health Management Associates (HMA) has amassed a wealth of on-the-ground experience that is important to share more widely as the nation undergoes the dramatic changes anticipated over the next several years. To that end, it is forming the Accountable Care Institute (ACI). The ACI will:

- provide a venue in which to share experiences and best practices from across the country related to the development of community-specific integrated delivery systems, new financial strategies to incentivize value, and innovative partnerships between providers and payers to ensure effective care for the unique populations they are both trying to serve;
- develop and offer resources to others to help spread lessons learned in the development of these new approaches to the delivery of accountable care;
- facilitate the training of new leaders in health system change; and
- translate delivery system lessons learned on the ground into policy and policy into change at the delivery system level, whether financial, legal, clinical or organizational.

Over the past decade, HMA has been assembling a growing practice of senior health care clinicians and administrators, finance experts, behavioral health professionals, managed care leaders, long term care innovators and others committed to developing new approaches to delivering health care services, particularly to populations and communities that have traditionally been underserved. HMA has worked for large health systems, consortia of providers, individual hospitals and ambulatory providers, states and counties, foundations and managed care plans to assess current delivery of care, plan new approaches and assist in implementation. This work has been growing in volume as the country has started to seriously grapple with how to assure access and quality—and the improvement of health status—while rolling back the cost trajectory which is universally agreed to be unsustainable. Expertise in integrated and accountable care as it applies to the delivery of care to those funded by public dollars is in demand; it is anticipated that the ACI will provide a vehicle for meeting that demand.