CARE DELIVERY INTERVENTIONS GUIDE

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Table of Contents

Acronyms

Acronym	Term
AIMS	Advanced Integrated Mental Health Solutions
AHRQ	Agency for Healthcare Research and Quality
BH	behavioral health
BHI	Behavioral Health Integration
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
DME	durable medical equipment
e-Consults	Electronic Consultations
ED	Emergency Department
EHR	electronic health record
HVCC	High Value Care Coordination
IHI	Institute for Healthcare Improvement
MDD	major depressive disorder
DM2	diabetes mellitus type 2
PCF	Primary Care First
PCMH	Patient-Centered Medical Home
PFACs	Patient and Family Advisory Councils
SAMHSA-HRSA	Substance Abuse and Mental Health Administration–Health Resources and Services Administration
SIP	Seriously Ill Population
SMS	self-management support
SDM	shared decision-making
SDOH	social determinants of health

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Introduction

The *Primary Care First Care Delivery Interventions Guide* provides the following information:

- Definitions of the model's care delivery interventions to establish shared terminology among Primary Care First (PCF) stakeholders, including practices, payers, and CMS.
- Descriptions of why these care delivery activities are important and tied to model outcomes of improved quality and reduced cost.
- A list of useful resources for your reference. Please note that this is not intended as a comprehensive bibliography of relevant literature. For more information, we encourage you to review resources on the PCF Connect library and share ideas and best practices with other PCF practices on PCF Connect.

The PCF care model and this Guide are organized into five Comprehensive Primary Care Functions:

1. Access and Continuity
2. Care Management
3. Comprehensiveness and Coordination
4. Patient and Caregiver Engagement
5. Planned Care and Population Health

To support delivery of these primary care functions, your practice will use your health IT, continuously improve your performance through actionable data, and leverage PCF's enhanced, accountable payment to make investments to meet model aims.

This Guide outlines the care delivery interventions, highlighting which are relevant to the various Primary Care First Payment Model Option participant types:

- **PCF Practice**: Refers to practices participating in the PCF Component of Primary Care First, including hybrid practices (practices also participating in the Seriously Ill Population (SIP) Component of PCF.
- **PCF Groups 3 and 4 Practice**: Refers to practices assigned to Practice Risk Group 3 and 4 of the PCF Component of Primary Care First, and therefore serve, on average, a patient population with complex, chronic needs.
- **SIP Practice**: Refers to practices participating in the SIP Component of PCF.

These care delivery interventions are designed as "corridors of work" for your practice, but should be viewed as the floor, and not the ceiling of your innovation. CMS encourages practices to apply these interventions, prioritize those that matter most given your practice's unique infrastructure and patient population. You may even identify new strategies that impact acute hospital utilization and quality. We look forward to learning with and from Primary Care First practices about what work most impacts cost and quality.

Access and Continuity

Access and Continuity builds on the patient-practitioner relationship to ensure patients receive the right care at the right time from the right care team member. All Primary Care First (PCF) practices must provide 24/7 access to a care team practitioner with real-time access to the practice's health information technology (IT), including the electronic health record (EHR) and any other applicable health IT system used by the practice. Practices serving complex, chronic beneficiaries (Groups 3 & 4 practices) and those that have been attributed Seriously Ill Population (SIP) beneficiaries must deepen this work by additionally providing timely callbacks to beneficiaries and their other healthcare providers who contact the practice.

What Are the Primary Care First Access and Continuity Activities?

- 24/7 access to care, including timely callbacks
- Empanelment
- Continuity of care

Care Delivery Interventions

- **All Practices:** Provide 24/7 access to a care team/practitioner with real-time access to the EHR.
- **PCF Groups 3 & 4 and SIP Practices**: Ensure timely callbacks for high risk complex patients (PCF Groups 3 & 4) and SIP beneficiaries (SIP practices).
- **SIP Practices:** Empanel all assigned SIP beneficiaries to a practitioner/care team.
- **SIP Practices:** Ensure SIP beneficiaries receive continuity of care from their assigned practitioner.

Access

Why Is Access Important?

For primary care to have meaningful impacts on the cost and quality of care, primary care practices should be at the center of that care—providing an effective "first contact" for patients, supporting patients in their management of care, and coordinating across different settings of care. Achieving this level of access to primary care requires timeliness and an effective relationship with those in the practice who are providing that care. True access is fully informed by knowledge about the patient and their care, which is only possible through real-time access to the patient's own electronic health information.

Access to primary care, informed by the health IT, makes the right care at the right time possible, potentially avoiding costly urgent and emergent care.

What Are Effective Strategies to Ensure Enhanced and Timely Access to Primary Care?

- **Use the health IT to inform after-hours access to care.** Practices can achieve 24/7 access to care informed by health IT through call coverage by a practitioner with health IT system access. This can be a practitioner from the practice or a covering practitioner who has system access. Many practices and systems use nurse call lines working with standard protocols to provide the initial point of contact after hours and effectively address common problems. In this situation, an escalation protocol will engage a practitioner with access to system when needed for decision making. Other successful practices expand hours, add urgent care services or partner with other practices to

provide these services, or contract with existing urgent care providers to manage and coordinate care after regular office hours.

- **Provide timely access to care during office hours.** Practices use a variety of scheduling strategies to prioritize same-day or next-day access for acutely ill patients and to provide timely follow-up for patients experiencing care transitions. Successful practices are those that are able to strike the right balance between timely access to visits and the offering patients a provider of their choice (Continuity of Care).
- **Ensure timely callbacks.** Establishing standardized protocols and pathways to improve and ensure responsiveness and timely callbacks to patients is an effective way to impact patient–practitioner/care team communication and to ensure a safeguard for addressing emergent and urgent patient phone calls. Successful practices routinely evaluate the degree to which patients' phone calls are answered promptly or returned within a practices' established guidelines (e.g., non-urgent, emergent, urgent) and routed to the appropriate practitioner or care team member, incorporating patients' clinical needs and preferences.[1,2] Such strategies are paramount for PCF Groups 3 and 4 practices, hybrid, and SIP practices whose patients may be contacting the practice with care needs that require care team prioritization and urgent reply.
- **Offer alternatives to office visit-based care.** Moving care out of traditional office visits can reduce demand and open supply for prioritized visits. By changing where and how care is delivered, your practice may have increased availability for patients with complex needs who may be better served by more time intensive visits in the office, at home, in a nursing home, for example.
- **Modify compensation strategies to support new care delivery modalities.** The PCF payment structure should provide practices with the flexibility to test and implement creative options to improve access to care. As practices shift your care delivery approaches, you should recognize these new strategies by compensating care team members in ways that reward performance and limit the use of traditional volume-based incentives.

Useful Resources

- Advanced Clinic Access (Retrieved in 2019)
    - Developed by the Institute for Healthcare Improvement (IHI), this toolkit describes how to implement "Advanced Clinic Access," a model that seeks not to control the daily patient demand for care but to predict it and respond to it. This model is based on the principle that when supply and demand are in balance, there is no need for waits within the system.

- Enhanced Access: Providing the Care Patients Need When They Need It (2013)
    - Developed by the Safety Net Medical Home Initiative, this implementation guide describes enhanced access as a fundamental concept of the Patient-Centered Medical Home (PCMH) model of care. It provides detail on providing 24/7 access, reducing barriers to care, and increasing capacity. This guide also provides case studies to demonstrate enhanced access.
- Open Access Scheduling for Routine and Urgent Appointments (2017)
    - This Agency for Healthcare Research and Quality (AHRQ) guide helps practices understand and get started with open access scheduling models. It describes the benefits of the open access model and how to implement it and provides examples of successful implementation of open access scheduling.
- After-Hours Care and Its Coordination with Primary Care in the U.S. (2012)
    - This resource is a Commonwealth Fund-supported analysis of primary care practices that provide after-hours care to patients. The analysis found that success in delivering this service was closely linked to physician buy-in; effective communication bolstered by use of EHRs; adjustments to scheduling and staffing capacity, including the use of nurse triage phone lines; and an overall commitment to improving access and continuity in patient-provider relationships.

Empanelment

Why Is Empanelment Important?

Empanelment is a series of processes that assign each active patient to a practitioner and/or care team, with consideration of patient and caregiver preferences. Empanelment allows practices to build effective and responsive care teams to optimize patient care and to address the preventive, chronic, and acute care needs of all patients.[3]

What Are Effective Empanelment Strategies?

The central goal of empanelment is to enhance the relationships between patients and their practitioners and/or care teams while shifting the team's focus toward the health of a defined patient panel.[4]

- Empanelment is an active, continually updated process meant to ensure that patients can identify who (practitioner and/or care team) knows them and their needs. For practitioners, empanelment enables the provision of proactive care to all members of a panel, not just those with in-person visits.
- Successful practices assign each active patient to a practitioner and/or care team, then confirm the assignment with the patient and the practitioner and/or care team, which is

particularly critical for SIP beneficiaries who have received fragmented care before they were attributed to your practice.

Empanelment provides several benefits, including:

- A formalized continuous relationship between patients and practitioner-led care teams;
- A population denominator for important practice measures, including quality of care; and
- A way for practices to identify care gaps and proactively reach out to patients who have not been seen or contacted in a while.

Useful Resources

- Empanelment: Establishing Patient-Provider Relationships (2013)
    - This implementation guide, developed by the Safety Net Medical Home Initiative (which was supported by The Commonwealth Fund), provides guidance on how practices can implement empanelment. It offers step-by-step instructions for assigning and managing panels and strategies for sustaining the effort over time.

Continuity of Care

Why Is Continuity of Care Important?

Continuity of care refers to the ability of patients to receive care from practitioners who know them and are known by them. This continuity builds and reinforces a relationship based in trust and shared experience that is highly valued by both practitioners and patients. Practice focus on continuity of care can translate to improved preventive and chronic care, patient and practitioner satisfaction, lower hospital utilization, and lower costs.[5-10]

What Are Effective Continuity of Care Strategies?

Practices have found it valuable to think in terms of three components of continuity that improve patient outcomes and experience, depending on the type and setting of care:[8]

- ***Relational continuity*** is defined as the "ongoing therapeutic relationship between a patient (and often their family/caregiver)," which is foundational in primary care settings. For SIP-only practices, SIP beneficiaries should receive high levels of continuity by an assigned practitioner at your practice, which results in less fragmentation and disjointed care.
- ***Informational continuity*** means that practitioners have access to information on patients' past events and personal circumstances to inform current care decisions.
- ***Longitudinal continuity*** refers to ongoing patterns of healthcare visits that occur with the same practice over time.

A key strategy related to continuity is ensuring that all practitioners and/or the care team have access to the same patient information to guide care within health IT. Practices can develop the

capability to measure relational continuity for empaneled patients using health IT, such as their EHR or additional health IT systems, practice management software, or other tracking mechanisms. Measuring continuity of care between the patient and the practitioner/care team allows a practice to track improvements over time.

Although there are a variety of strategies to optimize continuity, successful practices start with a review and discussion of the practice-level data developed through measurement of continuity.[9,10]

Useful Resource

- Higher Primary Care Physician Continuity Associated with Lower Costs and Hospitalizations (2018)
    - This *Annals of Family Medicine* article describes how higher primary care continuity is significantly associated with lower total expenditures and hospitalization rates.

Care Management

Care Management supports patients with complex care needs. All practices participating in Primary Care First are expected to provide targeted care management, using risk stratification approaches to identify those individuals most likely to benefit. PCF practices in Groups 3 and 4 serving a population with increased health and social complexity and SIP practices, will need to invest more deeply in care management by engaging high-risk beneficiaries in personalized care planning and ensuring that beneficiaries receive appropriate services from other healthcare providers (e.g., durable medical equipment [DME] items and services).

What Are the Primary Care First Care Management Activities?

- Risk stratification
- Care management, including personalized care planning
- Timely follow-up after Emergency Department (ED) visits and hospitalizations

Care Delivery Interventions

- **All Practices:** Provide risk-stratified care management for all empaneled patients with complex needs and likely to benefit.
- **PCF Groups 3 and 4 and SIP Practices:** Collaborate with all high-risk patients to develop and maintain documented personalized care plans addressing their goals, preferences, and values.
- **All Practices**: Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations.

Risk Stratification

Why Is Risk Stratification Important?

Risk stratification enables practices to target resources to patients demonstrating the greatest needs and most likely to benefit. It is a dynamic process that allows a practice to maintain a perspective of the entire patient population while developing strategies to address those patients at high and/or rising risk. Assigning a risk status or score to each empaneled patient should give practices an actionable view into the needs of their patient population.

What Are Effective Risk Stratification Strategies?

Risk stratification is a systematic approach to define risk of harm or adverse health outcomes for individuals in your practice population, particularly to identify patients who are at increased and rising risk and most likely to benefit from targeted, proactive, relationship-based care management and other strategies.

Algorithm-based risk stratification using structured data alone is efficient but often misses patients (up to 20 percent) who might benefit from care management services.[11] The addition of clinical intuition (i.e., practitioner and care team judgment) adds sensitivity and specificity to the identification of these patients by incorporating the care team's knowledge of patients and context[12] and significantly improves the ability of practices to find those patients most at risk of serious adverse health events.[13] Successful practices implementing risk stratification:

- **Select a risk stratification algorithm or process.** Practices have effectively used claims data, diagnoses clusters, clinical data in structured fields within the electronic health record (EHR), and combinations of the above to stratify their population according to risk. In choosing and weighting the data elements in the risk stratification algorithm, the practice is identifying those factors that they believe drive adverse outcomes in their population and that they can act on through care management and other strategies.
- **Add clinical intuition/care team perception to refine the identification of risk.** This adds a step in the process in which clinical judgment can be used to adjust the risk score based on information that is not available through the structured fields and data sources used in the algorithm. In some practices, this is a formal process with pre-defined criteria and in others it is more intuitive; information might include patients' social needs, health literacy, activation, family or caregiver support, or a behavioral or medical need not accounted for in the algorithm.
- **Embed the process within the health IT system and monitor and refine regularly.** Some practices use functionalities built into their EHR or additional health IT systems integrated with their EHR. Attempt to automate as much of the process as possible and build adaptable systems that can adjust risk as new information is available.

Useful Resources

- Risk Status Assignment Practice Implementation Guide (2014)
    - Developed by HealthTeamWorks, this guide describes common risk stratification methods and provides a sample method for risk stratification that can be used in primary care practices.
- Risk Stratification Methods and Provision of Care Management Services in Comprehensive Primary Care Initiative Practices (2017)
    - This article from the *Annals of Family Medicine* describes risk stratification patterns and their association with care management services for primary care practices in CPC Classic. The authors review four primary methods CPC practices used to stratify their patient populations.
- Implementing Risk Stratification in Primary Care: Challenges and Strategies (2019)
    - This article from the *Journal of the American Board of Family Medicine* is a study of risk stratification processes in primary care practices. The authors review three decisions that are important in shaping practices' experiences with risk stratification, challenges associated with those decisions, and practice successes in implementing risk stratification.
- Predict, Prioritize, Prevent – Nine Things Practices Should Know About Risk Stratification and Panel Management (2013)

- This issue brief, developed by the Colorado Beacon Consortium, describes nine things practices should know about risk stratification and panel management, including the purpose of risk stratification, use of data and clinical intuition, and impact on workflow.

Care Management

Why Is Care Management Important?

Care management is a process of working with patients, generally outside of face-to-face office visits, to help them understand and manage their health, navigate the health system, and meet their health goals. Practices working with patients who have complex care needs have found care management to be an effective and necessary strategy for mitigating risk and improving health outcomes.

What Are Effective Care Management Strategies?

Care management is a resource-intensive intervention and will have its greatest impact when it is targeted toward those most likely to benefit. Practices have found it valuable to think in terms of two broad types of patients who might benefit from different approaches to care management:

- Patients with some combination of multiple comorbidities, complex treatment regimens, frailty and functional impairment, behavioral and social risks, and serious mental illness often benefit from long-term, proactive, and relationship-based **longitudinal care management**.
- Patients who are otherwise stable will benefit from short-term, goal-oriented **episodic care management** during periods of increased risk like transitions of care; diagnosis of a new, serious illness or injury involving complex treatment regimens; or newly unstable chronic illness.

Longitudinal Care Management. Successful practices use on-site, non-physician, practice-based, or integrated shared care managers to provide longitudinal care management for the highest risk cohort of patients, with assistance from other practice staff, as needed. Multiple team members may engage in care management, but each patient identified as eligible should have a clinically trained individual in the practice who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment.[14] Longitudinal care management:

- **Is captured in structured fields within the EHR or additional health IT systems.**
- **Includes providing proactive care that moves beyond traditional office visits or crisis-driven care (e.g., ED care or hospitalization) and is not primarily visit-based.** Although office visits are opportunities to define goals, plan patient care, engage in shared decision making, and build a trusting relationship, most care management

activities take place by phone, patient portal, e-mail, mail, or home visits (and through visits to skilled nursing facilities or hospitals to support transitional care).

- **Includes a process of personalized care planning.** The personalized care planning process helps practices engage and collaborate with patients to ensure that their care aligns with patient preferences, goals, and values.[15,16]
    - A **care plan** is a mutually agreed-upon document that outlines the patient's health goals, needs, and self-management activities and is accessible to all team members providing care for the patient. The care plan should be patient-friendly, accessible to the patient, and should limit use of unfamiliar medical jargon and acronyms. The care plan should also be structured and standardized, documented within the practice's health IT to enable sharing among patient, caregivers, and care team members.

      Critical Elements of a Care Plan May Include:

      - Treatment goals and interventions
      - The patient's overall health goals and an action plan to achieve those goals
      - Advance directives and the patient's preferences for care
      - Key contact information for the practice
      - Actions that the patient and their care team will be taking, and the most important contingencies (e.g., "if/then" for the specific patient and their conditions).
    - All high-risk patients receiving longitudinal care management should have a personalized care plan developed in a joint, open-ended conversation between the patient and care team.
    - Personalized care planning is a dynamic process; therefore, the care plan document should be updated at regularly defined intervals by the care team and patient. In addition, when patients' health status, preferences, goals, and values change, their plans of care should, too.

Episodic Care Management. **Practices use the concept of Episodic care management to identify patients who have acute or urgent needs using "triggering events"** (e.g., hospital discharge, new diagnoses, medical crisis, major life event, decompensation in otherwise controlled chronic condition) for short-term, problem-focused care management services. Episodic care management is generally time limited and problem focused and most often includes coordination of services and follow-up, patient education and support for self-management, and medication reconciliation.

Useful Resources

- CPC+ Personalized Care Planning Video (2018)
    - This CMS on-demand animation, developed for CPC+ participants, guides practices through a set of core elements to consider during care planning implementation and to build on based on patients' needs.

- Michigan Care Management Resource Center (Retrieved in 2019)
    - Developed by the Michigan Institute for Care Management and Transformation, this site provides guides and toolkits for care management, including resources for care manager training, chronic condition management, transitions of care, and more.
- Care Management: Implications for Medical Practice, Health Policy, and Health Services Research (2015)
    - Developed by the Agency for Healthcare Research and Quality, this issue brief highlights three key strategies to enhance existing or emerging Care Management programs.

Timely Follow-up after ED Visits and Hospitalizations

Why Is Follow-up after ED Visits and Hospitalizations Important?

The flow of patient information between transition care settings is often limited,[17] and primary care practices are often uninformed about the transitions in care when patients are discharged from EDs and hospitalizations. Without appropriate post-discharge follow-up and referral management, patients are at risk for post-discharge complications and worsening of their conditions.[18]

What Are Effective Strategies to Achieve Timely Follow-up after ED Visits and Hospitalizations?

Key aspects of follow-up after ED visits and hospitalizations include **identifying and partnering with target hospitals and EDs where the majority of a practice's patients receive services to achieve timely notification and transfer of information** following hospital discharge and ED visits. When developing a standardized process for data exchange and timely follow-up, successful practices include the following processes:

- Information and data exchange about patients seen in an ED or admitted to/discharged from a hospital (e.g., via health information exchange [HIE], hospital portal, hospital-generated report, her, or additional health IT system)
- Definition for "timely" follow-up after discharge (e.g., no later than within 2 days of discharge from hospital admission or observation stay and within 1 week of discharge from the ED)
- Protocols for when follow-up will be done (e.g., before discharge or following a standardized follow-up protocol)
- Process of incorporating into the patient's medical record so the information is available at the time of the follow-up visit or other patient contact

- Practices should use standardized processes and protocols for data exchange and formalized partnerships to develop an efficient workflow to ensure timely follow-up and facilitate efficient and safe transitions of care.

Useful Resources

- Timely Exchange of Hospital and Emergency Department Data (2017)
    - A presentation on sources of hospital and emergency department (ED) data and how to identify processes for improving hospital and ED follow-up

Comprehensiveness and Coordination

Comprehensiveness and Coordination increases the breadth and depth of primary care while facilitating care for patients that occurs outside of the practice. All practices will integrate behavioral healthcare and assess patients' psychosocial needs. PCF practices in Groups 3 and 4 and SIP practices will deepen this work by ensuring coordinated referral management when patients seek specialty care and by creating an inventory of services and supports in the community to address their patients' complex psychosocial needs.

What Are the Primary Care First Comprehensiveness and Coordination Activities?

- Integrate Behavioral Health (BH)
- Coordinate with Specialty Care
- Address Health-Related Social Needs

Care Delivery Interventions

- **All Practices:** Integrate BH into primary care services.
- **PCF Groups 3 and 4 and SIP Practices:** Ensure coordinated referral management through formal relationships and agreements with specialty groups and other care organizations for high-risk patient populations.
- **All Practices**: Assess and support patients' psychosocial needs.
- **PCF Groups 3 and 4 and SIP Practices**: Create and maintain an inventory of services and supports in the community to meet patient health-related social needs.

Behavioral Health Integration

Why Is Behavioral Health Integration Important?

Behavioral Health Integration (BHI) refers to members of a primary care team and BH practitioners working together with patients and families while using a systematic, cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.[19]

What Are Effective Strategies to Integrate Behavioral Health?

Care Management for Patients with Mental Illness (also referred to as the Collaborative Care Model [CoCM]) and the **Primary Care Behaviorist Model** are two practice-based approaches for integrating BH into primary care that improve outcomes. These approaches may be used together to meet a broader range of patient needs. Both approaches facilitate specialty care engagement for serious mental illness. Core approaches common to both strategies are as follows:

- Select mental health or substance use conditions to prioritize and a method to identify patients to target for care management or for referral to the primary care behaviorist. Targeted patients are often higher severity or more complex (e.g., major depressive disorder [MDD], diabetes mellitus [DM2] with poor glycemic control).

- Identify a credentialed BH practitioner (e.g., psychologist, social worker) or team member (e.g., nurse, BH clinician) who is trained in the integrated care model.
- Provide proactive follow-up using validated rating scales (e.g., Patient Health Questionnaire-9 [PHQ-9], Generalized Anxiety Disorder 7-item [GAD-7]).
- Assess the level of BHI (using tools like the Integrated Practice Assessment Tool [iPAT©]) to inform next steps to advancing integration of BH.[20]
- Use data effectively to guide the approach and assess the effectiveness of the integrated BH services.

In **Care Management for Patients with Mental Illness**, individuals with an identified mental health condition are offered proactive, relationship-based care management with specific attention to care management of the mental health or substance use condition. CoCM is an example of a robust, highly effective approach to care management and is supported by separate billing codes.[21]

In addition to the core approaches described above, practices that develop CoCM capabilities are as follows:

- Identify or develop stepped care, evidence-based treatment algorithms for mental health condition(s) identified for care management that incorporate principles of shared decision-making (SDM) and self-management support (SMS); and
- Develop a workflow for screening, enrollment in integrated care services, and communication among clinicians providing integrated BH services.

In the **Primary Care Behaviorist Model**, BH is integrated into the primary care workflow through warm handoffs to a co-located BH professional to address mental health or substance use conditions in the primary care setting and behavioral strategies for management of chronic general medical illnesses.

In addition to the core approaches described above, practices that develop capabilities to deliver the Primary Care Behaviorist Model:

- Identify space in the primary care practice for the BH practitioner and test and implement a method for engaging BH services; and
- Develop a workflow to integrate referrals (warm handoffs) to the BH specialist and communicate among clinicians providing integrated BH services.

Other approaches to enhancing behavioral healthcare include the following:

- **Effective coordination with BH Specialty Care**. High-quality referral and coordination with BH specialty care is another approach that may enhance BH care and meet the full spectrum of BH needs (even for practices that have implemented care management or primary care behaviorist models). Refer to Coordinated Referral Management in the next section.

- **Telehealth.** An emerging technology, telehealth has been used in care management and primary care behaviorist strategies, and to facilitate specialty behavioral healthcare.

Useful Resources

- Behavioral Health Integration Resource Companion Guide (2019)
    - This document, compiled for CPC+ participants, provides an updated list of valuable BHI resources, including training options, billing and reimbursement information, and implementation toolkits for care managers and primary care behaviorists.
- Assessment Tools for Organizations Integrating Primary Care and Behavioral Health (Retrieved in 2019)
    - These assessment tools, compiled by the Substance Abuse and Mental Health Administration – Health Resources and Services Administration (SAMHSA-HRSA), relate to the primary care behaviorist strategy and help measure an organization's readiness to embark on the path to integration.
- Collaborative Care Implementation Guide (2014)
    - The University of Washington's Advanced Integrated Mental Health Solutions (AIMS) developed an implementation guide and other resources for collaborative care. It provides an approach that uses care management and a "stepped care" approach to enhance BH services.
- Care Manager Role Training Module (Retrieved in 2019)
    - This AIMS-developed training module describes the care manager's role as part of a collaborative care team, including team communication, patient engagement, treatment options, and patient outcome tracking.

Coordinated Referral Management

Why Is Coordinated Referral Management Important?

Coordinated referral management with specialty groups and other community or healthcare organizations ensures referrals are properly managed, coordinated, and communicated. These efforts will help your practice achieve goals of enhancing the quality of patient care, improving the patient's care experience, and lowering cost, particularly for practices serving high-risk patient populations. Evidence suggests that the development of formal relationships (e.g., collaborative care agreements) between the primary care practice and referred groups/organizations that define shared goals and responsibilities, facilitate the coordinated referral management process.[22]

What Is an Effective Referral Management System?

The foundation of successful coordinated referral management with specialty groups and other community or healthcare organizations is the development of processes and procedures to ensure high-value referrals.

The following tools can facilitate coordinated referral management with specialty groups and other care organizations:

Elements of a High-Value Referral Management Process

Elements of a high-value referral process include the following:

- Ensuring the referral is clinically necessary and appropriate
- Articulating a specific referral question, or "ask"
- Making pertinent patient clinical data available
- Defining and communicating the patient's appointment responsibilities
- Ensuring that the referral engagement took place ("closing the loop") and results of the referral are received back to primary care
- Ensuring that input resulting from the referral is documented and addressed

- **Collaborative Care Agreements.** Establishing clear and agreed-upon expectations regarding communication and clinical responsibilities with specialty practices and other care organizations, through a collaborative care agreement, improves the process. Collaborative care agreements often include the following elements:
    - Defining the types of referral, consultation, and co-management arrangements available;
    - Specifying who is accountable for which processes and outcomes for care within the referral, consultation, or co-management arrangement; and
    - Specifying what clinical and other information should be provided, how the information is transferred, and timeliness expectations.

- **Electronic Consultations (e-Consults).**[23] This electronic process is typically conducted through a system-wide electronic health record (EHR) or a secure, web-based system by which a practice receives guidance from a specialty provider or other care organization. In this process, a practitioner sends a clinical question and relevant clinical information to the specialist (or other care organization), who responds by providing a clinical opinion and guidance and/or confirms the need for a face-to-face appointment with the patient. This tool and process has the potential to streamline consultations, reduce cost and burden for patients, and improve access to specialty care for high-value referrals. Recently implemented Medicare procedural codes support payment both to the referring (primary care) practitioner and the receiving specialist who engage in e-Consults.

Useful Resources

- Care Collaborative Agreement Facilitation Guide (2011)
    - This guide, developed for general distribution by the Westminster Medical Clinic with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative, provides guidelines for primary and specialty care collaboration. It includes collaborative care agreement templates, key questions, suggested action plans, surveys, and workflows that practices can adapt.
- High Value Care Coordination (HVCC) Toolkit (Retrieved in 2019)
    - The toolkit, developed by the American College of Physicians, provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. It includes a variety of tools, including referral checklists and collaborative care agreements.
- Project CORE: Coordinating Optimal Referral Experiences (2018)
    - The Association of American Medical Colleges' (AAMC's) Project CORE aims to improve the quality of care and patient experience while reducing the overall cost by enhancing communication and coordination between primary care providers and specialty physicians.

Addressing Health-Related Social Needs

Why Is Addressing Health-related Social Needs Important?

Extensive research has demonstrated the impact of social factors (e.g., income, education, access to food and housing, employment status) on a person's ability to reach their health goals.[24] In fact, evidence suggests that many health outcomes are related more to social, environmental, and economic factors than to clinical interventions.[25] Strategies for addressing common health-related social needs for a practice's high-risk patients include conducting needs assessments at regular intervals, creating a resource inventory for the most pressing needs of the patient population, and establishing relationships with key community organizations.

What Are Effective Strategies to Address Health-Related Social Needs?

- **Use and integrate a health-related social needs screening tool or question(s).** Identify community and social service needs among the patient population through universal screening of all patients or targeted screening for patients at high risk or with complex needs. Practices can identify and adapt a tool for standardized assessment of patients' health-related social needs (e.g., food, housing, social isolation, insurance, interpersonal violence, emotional wellbeing, and transportation).
- **Develop or access an existing database of community and social services that is updated regularly.** Practices can develop a process to ensure reliable resource

connections for patients with social needs common in the patient population. Practices can also take advantage of local or state organizations that maintain and regularly update databases of community-based resources. Practice staff can identify community resources through previous experience and by staying apprised of new resources that become available. Patients, caregivers, and colleagues are also valuable sources of information on how responsive and effective they find local services.

- **Establish relationships with effective community resources.** Practices can focus on developing relationships with community-based organizations that support patients' most significant health-related social needs.
- **Coordinate referrals to community and social service organizations; follow up with patients referred for services.** Practices can seek to find common ground with these community groups, focus on the structure and process of referrals, and develop a bidirectional flow of information. Successful practices work with their patients to ensure there is a shared understanding of the purpose of the referral and aim to understand bottlenecks and barriers to meeting their needs through the process. Many practices identify a care team member to be a community referral resource for their patients.
- **Track the success of linkages of patients to community resources.** Successful referrals can help practices determine the most useful and available resources in their community. It is better to have a few quality and accessible resources for patients than to have extensive lists of unused and unverified resources.
- **Integrate functionalities of social needs screening, referral, and results tracking into health IT systems**. This integration makes tracking and follow-up easier and more reliable.

Useful Resources

- Health Leads Health-Related Social Needs Library (Retrieved in 2019)
    - The Health Leads library includes resources and templates to assist practices in screening for health-related social needs, making and tracking referrals to community supports, and applying clinically validated guidelines for implementing social needs programs.
- National Center for Complex Health and Social Needs (2017)
    - Developed by the Camden Coalition, this webpage provides a compilation of resources and case studies, including referral guides and templates to address health-related social needs for patients with complex medical, psychological, and social needs.
- A Model for Integrating SDOH Screening and Referral in the EHR (2019).
    - This resource describes a model for integrating social determinants of health (SDOH) screening and referral in the EHR that was conducted by Boston Medical Center using the THRIVE screening tool. The study showed success in

using EHR technology to streamline SDOH screening and referrals to hospital and community resources.

- The Accountable Health Communities Health-Related Social Needs Screening Tool (Retrieved in 2019)
    - Developed by CMS for the Accountable Health Communities model, this is a tool practices can use to screen for health-related social needs.

Patient and Caregiver Engagement

Patient and Caregiver Engagement occurs when the care team, patients, and caregivers work together to improve experiences of care and health outcomes. All Primary Care First practices must implement a regular process for patients and caregivers to advise practice improvement.

What Are the Primary Care First Patient and Caregiver Engagement Activities?

- Engage patients and caregivers

Care Delivery Intervention

- **All Practices**: Implement a regular process for patients and caregivers to advise practice improvement.

Engage Patients and Caregivers

Why Is Engaging Patients and Caregivers Important?

Patient and caregiver engagement puts patients and families at the center of care, involving them in the management of their own care and in the design and improvement of care delivery. Patients want to be involved in decisions that impact their health, and those involved in decision making tend to be healthier and have better outcomes.

What Are Effective Strategies to Engage Patients and Caregivers in the Design and Delivery of Care?

Practices can use a variety of strategies to gain insight into patient and caregiver perspectives on the organization and delivery of care, including use of office-based surveys, focus groups, and Patient and Family Advisory Councils (PFACs).

Successful practices have used PFACs as an effective tool to engage patients and caregivers and to identify improvement opportunities. PFACs bring together patients and caregivers on a regular basis as a structured means of incorporating patient perspective and experience in the design and delivery of care. Some of the important elements to ensure effective PFACs include the following:

- **Establish and maintain a PFAC.** The PFAC should be practice-specific, regularly scheduled, and ongoing so that PFAC members can help improve care at the location where they receive their care.
- **Recruit patients and their caregivers.** PFACs should consist of patient and caregiver advisors who represent the practice's patient demographics (e.g., ethnicity, race, cultural groups, socioeconomic status, gender identities, sexualities, age). PFAC advisors do not need special qualifications or expertise to contribute. An individual's experience as a patient or caregiver in the practice is most critical.
- **Establish expectations for PFAC participation.** Practices should work with your PFACs to keep up-to-date expectations of participation, including responsibilities of the

patient advisor role, term limits, frequency and location of meetings, and anticipated time commitment outside of in-person meetings.

- **Ensure patients are meaningfully involved in the design and improvement of care delivery.** Practices should use PFAC meetings to solicit ideas directly from patient advisors about how to improve practice functions. Consider inviting two or three patient advisors to participate in practice improvement activities, like attending meetings with the practice's quality improvement team and providing feedback on improvement activities. Collaborate with the quality improvement team to determine what improvements to prioritize.
- **Regularly review practice data with the PFAC and assess how changes are improving care.** Consider using the data you are gathering and collecting on patient outcomes (e.g., cost and utilization data, clinical quality measures, Patient Experience of Care Survey data) for the practice to provide direction on process improvement. Educating PFAC patient advisors in understanding how practices use data will increase PFAC effectiveness and value for practices. Also consider developing subgroups led by patient advisors to work on projects based on the PFAC patient advisors' areas of interest.
- **Communicate to patients and their caregivers about the changes being implemented by the practice.** Inform patients and their caregivers of the ideas and changes at the practice and the role of the PFAC in those results. Practices can use multiple methods to convey this information effectively, like a practice newsletter, website, patient portal, posters in the waiting room, social media, or updated hold messages on phone lines. PFAC patient advisors can make recommendations on which method is best to convey information to patients.

Useful Resources

- STEPSforward: Forming a Patient and Family Advisory Council (2017)
    - This resource is a step-by-step guide from the American Medical Association's STEPS*forward* practice transformation curriculum focused on getting started with establishing a PFAC.
- Key Steps for Creating Patient and Family Advisory Councils (PFACs) in CPC Practices (2013)
    - This document, which outlines the key steps for creating a PFAC, was authored by the National Partnership for Women and Families for CPC Classic practices.

Planned Care and Population Health

Planned Care and Population Health capabilities enable practices to meet the preventive and chronic care needs of their entire patient population. All Primary Care First practices must set goals and continuously improve upon key outcome measures.

What Is the Primary Care First Planned Care and Population Health Activity?

- Continuous improvement

Care Delivery Requirement

- **All Practices:** Set goals and continuously improve upon key outcome measures.

Continuous Improvement

Why Is Continuous Improvement Important?

Outcome measures drive the Primary Care First model and influence practice payments through the PCF performance-based adjustment and/or the SIP quality adjustment. Improving upon key outcome measures requires engaged clinical and administrative leadership and a commitment to continuous, data-driven improvement.

What Are Effective Continuous Improvement Strategies?

Using data resources and developing workflows and analytics to guide practice changes can help practices achieve reductions in total utilization and cost of care, and improvements in patient experience and quality of care.

- **Engage staff broadly across the practice.**
    - Care teams include a variety of disciplines and skillsets that bridge the practice's clinical and administrative functions. Practice care teams can be organized to take on specific initiatives and use practice- and panel-level data to guide their work.
    - Teams can generate ideas for changes to patient care, test these ideas, and use panel-specific data to understand whether the changes are resulting in improvement.
- **Conduct regular, structured team meetings.**
    - Focus on testing tactics to improve care and achieve practice goals.
- **Acquire and develop improvement strategies and analytic processes to use data to guide practice change.** Effective use of data includes doing the following:

- Identifying outcome, process, and balancing metrics that will be used to guide actionable changes in the practice and to understand whether these changes result in improvement;
- Reviewing payer data regularly to identify areas of opportunity; setting goals to improve care, reduce utilization, and improve patient experience; and monitoring and adjusting the effort according to performance; and
- Sharing data with care teams, improvement teams, and patients or caregivers.

- **Use a systematic approach to manage change.**
    - This allows practices to be more efficient and effective in managing change and sustaining efforts over an extended period of time.
    - Training in effective process improvement, including use of improvement methods and tools such as process mapping, facilitates staff engagement and effectiveness.
    - Engaging administrative and clinical leadership in the allocation of resources (both time and money) is essential for success.

Useful Resources

- Quality Improvement Essential Toolkit (2017)
    - IHI's QI Essentials Toolkit includes the tools and templates you need to launch a successful QI project and manage performance improvement.
- Practice Facilitation Handbook - Module 4. Approaches to Quality Improvement (2013)
    - This resource is a concise guide from the Agency for Healthcare Research and Quality (AHRQ) for understanding and getting started with formal QI initiatives.
- Basics of Quality Improvement (Retrieved in 2019)
    - This practice-oriented compilation resource was developed by the American Academy of Family Physicians and is designed for practices just getting started with QI models.

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