New Mexico Stakeholder Summit
June 17, 2015
New Mexico Health System Innovation
Stakeholder Summit
June 17, 2015
9:30 am – 4:00 pm
Coral Ballroom, DoubleTree Hotel, Albuquerque, NM

9:30-10:00  Registration

10:00-10:05  Welcome
Retta Ward, MPH, Cabinet Secretary, Department of Health

10:05-10:10  Summit Objectives and Introduction of HSI Staff
Shannon Barnes, SIM Project Director, Department of Health

10:10-10:20  Framing the Transformation of the NM Health System
Tres Schnell, Director, Office of Policy and Accountability

10:20-10:50  The Patient-Centered Medical Home (PCMH) Approach
Jane McGrath, Director, Envision New Mexico; Chief of Adolescent Medicine, University of New Mexico, Health Science Center

10:50-11:00  Break

11:00-11:40  Integrated Approaches in New Mexico:
Panel discussion on Community-Centered Health Home, Health Homes, and Patient-Centered Medical Home
Moderator Amy Wilson, Chief Nurse, Public Health Division, Department of Health

-Marsha McMurray-Avila, Bernalillo County Community Health Council
-Robyn Viera, Human Services Department
-Jane McGrath, Director, Envision New Mexico; Chief of Adolescent Medicine, University of New Mexico, Health Science Center

11:40-12:00  Overview of HSI Committee Work
Tres Schnell, Director, Office of Policy and Accountability

12:00 - 1:00  Lunch on your own
1:00 – 3:00  **Stakeholder Committees Convene**

- Population Health (red): Coral Salon I
- Healthcare (light blue): Coral Salon II
- Integration of Public Health and Primary Care (yellow): Coral Salon III
- Health Information System (orange): Crystal Room I
- Tribal (navy blue): Crystal Room II
- Workforce and Training Needs (green): Copper Room
- Payment Models (no color): Copper Room

3:00 – 3:15  **Break**

3:15 – 4:00  **Stakeholder Committee Reports, Wrap-Up, and Next Steps** *(Coral Ballroom)*

Tres Schnell, Director, Office of Policy and Accountability
Shannon Barnes, SIM Project Director, Department of Health

Check out the website for all things *New Mexico Health System Innovation*, resources, committee work, and information on the developing design.

[www.nmhealthsysteminnovation.org](http://www.nmhealthsysteminnovation.org)
Highlights: Health System Innovation for a Healthier New Mexico Stakeholder Summit
May 19, 2015

SIM Summit Committees

- Population Health
- Alignment and Integration of Public Health, Behavioral Health, Health Care *(did not meet in Summit 1)*
- Workforce and Training Needs
- Health Care, *meeting together with*
- Payment Reform
- Health Information Systems
- Tribal
Cross-Cutting Themes from Committees

- Tribal representative on each work group
- Ensure “all voices” heard—that they have input
- Address “what’s in it for participants?” question
- Need to help people understand concepts and components of the plan, especially…
  - What “population health” and “population health outcomes” are
- Language and literacy are obstacles to overcome
- Interoperability of health information systems critical
- Demonstrate cultural sensitivity and responsiveness

Cross-Cutting Themes from Committees

- Address disparities in geographic areas (data to help with this)
- Find balance between needs of young and aging population
- Address health system navigation needs of consumers
- Address big issues re behavioral health service scarcity
- Address integration, alignment, diversity, and training quality of workforce
- Want relevant information from existing models to analyze pros and cons for NM
Different Foci of Certain Committees

- **Health Care/Payment Reform:**
  - Need for “backbone” (administrative) support in SIM process

- **Population Health:**
  - Must address social determinants of health and “power” factors

- **Workforce and Training Needs:**
  - Address or present workforce development as an economic development issue

- **Tribal:**
  - Questions on the SIM process of consulting with the tribal governments

- **Health Information Systems:**
  - Issues to be addressed include interoperability of systems, “off the grid” and lack of broadband access in rural areas, sharing of and analysis of data

Who Should be Added to the Table:

- Representatives or advocates for
  - those with disabilities,
  - those with behavioral health issues,
  - veterans,
  - oral health providers
  - youth,
  - faith-based organizations,
  - social services and public safety
  - institutes of higher education
  - nursing home care and early childhood home visiting programs
  - State Workforce Committee
  - administrators and finance people
  - CYFD
Highlights: Tribal Group

- How does SIM fit with tribal (IHS and 638) health system models
  - Perception that SIM will be imposed on tribes/pueblos/nations
  - Perception that federal government “bailing” on its responsibilities
  - Who represents and handles care of urban Native Americans
  - What feedback processes exist if policies “don’t work” for Native Americans
  - How to integrate traditional means of healing
  - How to fit payment models
- Focus on people’s access to and use of services; many have coverage
- Obstacles to address:
  - Frequent change in tribal/pueblo/nation governments
  - Language, literacy (visual learning), health system navigation
  - Access issues: lack of transport, no electricity (no computers), isolation
  - Consultation policy implementation on government to government basis

Highlights: Workforce and Training Needs

- Not just about academics. Need field-level training, mentoring, training via technology (ECHO), cross-sector training/education
- Address diversity, quality, skill needs in training
- Address recruitment and retention issues:
  - “stressors” faced by providers and job burnout
  - lack resources/support in rural areas
  - potential incentives
  - job design and support to keep paraprofessionals “in the field”
- Need cost-effectiveness data on different approaches
- Payment for CHWs fits “fee for service” model SIM wants to avoid
- Need lessons-learned and data on what works in NM
Highlights: Health Care and Payment Reform

- How to best engage “small” providers in process
- Need to inventory state assets and policies, identify barriers
  - Payment reform needs information on existing models
- Need for strong administrative and facilitation support in process
- Address how to best fit behavioral health into the care continuum
- Address health literacy, access, levels of care, non-traditional times for health services, protocols, and community delivery systems
- Consider a physician network communicating with EMS and telemedicine people

Highlights: Population Health

- Must address social determinants of health – poverty, in particular
  - Prevention not well funded in NM
- Be aware of power issues—among providers, hospitals, race/ethnicity
- Address health care system navigation issues for patients
- Bring counties/municipalities to the table; incorporate local planning assessments at county/sub-county levels
- Consider not just PCMH, but also community-centered wellness sites
- Look at who “owns” the data and how we share health data
- Nurses and EMS to be better integrated into system, especially in prevention
Highlights: Health Information Systems

- Health data for policy maker, clinical manager, patient use
- Adopt electronic health records (HER) statewide
- Address rural technology infrastructure needs (telehealth, EHRs)
- Educate health workforce in use of health information technology
- How to get data from IHS, Veterans Admin, behavioral health and non-traditional partners (Walmart pharmacies)
- Payers fear losing competitive edge so reluctant to participate
- Consider use of personal digital devices for patients’ medical info
Welcome
HEALTH SYSTEM INNOVATION DESIGN

Summit objectives

- To introduce and describe the Patient-Centered Medical Home model of care and wellness.
- To learn about integrated models of care and wellness.
- To continue a dialogue with stakeholders to collaboratively design an integrated system of care and wellness.
Framework for Achieving Health System Innovation in New Mexico

The End in Mind Result

- An Integrated and Aligned Health System

  ✓ Public health (health promotion/primary prevention/early intervention);
  ✓ Behavioral health (mental health, substance misuse);
  ✓ Oral Health (preventive, treatment); and,
  ✓ Primary Care aligned with Pharmacy, Acute, Long Term, Home and Hospice Care.
The Vision
Proposed Health System Components for Improved Health Status and Health Outcomes

**Align & Integrate PH, BH, OH and PC**

- Performance Management (Metrics/Measures)
- Workforce Development
- Person Centered System
- Health Information System
- Payment Model(s)
- Improved Access Address Social Determinants
- Focus First on Populations with Less Desirable Health Status
- Tribal Collaboration and Input

Committee Work
Understanding and Assessing Components

- Establish Measures to Evaluate / Improve PH, BH, OR, PC performance
- Develop a Person Centered Care Model - PH, BH, OH, PC Team Members
- Understand Patient Centered Care Model (e.g. PCMH)
- Capability to collect, access, exchange, analyze, use health data
- Develop payment models that support the integrated system
- Engage diverse partners to address social and community infrastructure needs
- Collaborate with communities to address areas of high need
- Create Government to Government Opportunities
- Person Centered System Model and Community Centered Wellness Home
Overview of Patient Centered Medical Home

Jane McGrath, MD
Division Chief, Adolescent Medicine

PCMH Principals

1. A personal clinician has an ongoing relationship with patients and follows them through the care process.

2. Whole-person orientation in which the care team helps the patient plan out goals for all phases of their care needs. The office takes responsibility for facilitating future appointments and appointments with other providers.

3. Quality and safety are the top goals and patients have an active say in all decisions make about their care.

4. Clinician-directed medical practices where the MD captains a team of care providers who all share responsibility for treating a patient.

5. Coordinated care that uses a proven system for sharing information (like electronic health records) and information is clearly relayed to patients. Also, patients have the opportunity to receive care when and where they need it.

6. Enhanced access means that patients have greater ability of make appointments and that spots are held open for patients to meet needs.
NCQA PCMH 2014 Content
(6 standards/27 elements)

1: Enhance Access and Continuity
   A. *Patient-Centered Appointment Access
   B. 24/7 Access to Clinical Advice
   C. Electronic Access

2: Team-Based Care
   A. Continuity
   B. Medical Home Responsibilities
   C. Culturally and Linguistically Appropriate Services (CLAS)
   D. *The Practice Team

3: Population Health Management
   A. Patient Information
   B. Clinical Data
   C. Comprehensive Health Assessment
   D. *Use Data for Population Management
   E. Implement Evidence-Based Decision-Support

4: Plan and Manage Care
   A. Identify Patients for Care Management
   B. *Care Planning and Self-Care Support
   C. Medication Management
   D. Use Electronic Prescribing
   E. Support Self-Care and Shared Decision-Making

5: Track and Coordinate Care
   A. Test Tracking and Follow-Up
   B. *Referral Tracking and Follow-Up
   C. Coordinate Care Transitions

6: Measure and Improve Performance
   A. Measure Clinical Quality Performance
   B. Measure Resource Use and Care Coordination
   C. Measure Patient/Family Experience
   D. *Implement Continuous Quality Improvement
   E. Demonstrate Continuous Quality Improvement
   F. Report Performance
   G. Use Certified EHR Technology

PCMH Payment Methodology

1. Multiple insurers (ideally all insurers) must pay for enhanced primary care in same (or at least) similar way

2. Aligning payers is the only way to make practice transformation expectations manageable for Primary care practices.
Single Payer Changes are not Adequate to Support Required Changes

Costs of Practice Transformation

- Provider time for transformation, care management activities (non-reimbursed via FFS): $50K
- RN care manager: $100K
- 1 additional MA: $50K
- EMR/data management: $50K
- TOTAL: $250,000

Current Payment Possibilities

- Medicare: $7/ppm X 1000 pts X 12 = $84,000
- Medicaid: $12 ppmp X 500 pts X 12 = $72,000
- Commercial payers: $3 ppmp X 1000 pts X 12 = $36,000

Total (all payers): $192,000
Total (Medicaid only): $72,000

PCMH Payment Methodology

Alternative primary care payment models

- Additional codes within current fee-for-service (FFS) system – e.g. Chronic Care Management fees
- Supplementation payment on top of FFS
- Shared savings on top of FFS
- Comprehensive primary care payment (partial capitation)
- Episode of care payments
- Direct Primary Care (subscription/retainer fee)
Blended Model – less potential for unintended consequences

Risk-adjusted Comprehensive Primary Care Payment (e.g. monthly payment)

Per Visit (FFS) Payments

Incentive payments for quality targets

Shared saving

PCMH Status by State

Medical Home Activity
States with medical home activity for Medicaid/CHIP since 2006

- None
- Medical home activity, no payments to medical homes
- Payments to medical homes underway

Map of US: http://www.nashp.org/medical-homes-map/
What has been done in New Mexico

• Medicaid has worked with the MCOs to incentivize practices to work towards PCMH certification

• HRSA has established expectations that FQHCs achieve PCMH certification

• Many commercial insurance plans have PCMH programs

• Indian Health Service – Improving Patient Care (IPC)

PCMH Certified Practices in New Mexico

73 NCQA certified practices
7 AAHC certified practices
3 Joint Commission Certified
The Challenges

- Lack of a uniform model
- Year to year
- Not payer blind
- Costly to practices without clear cut benefits
- Different measures, reporting requirements, and payment methods for each payer
- Changing expectations

The seven domains of PCMH readiness include:

- **Knowledge of PCMH** – including the respondent’s familiarity with the concept of PCMH and certification requirement and knowledge of and ability to report on Centennial Care’s Performance Measures.

- **Access and Continuity** – including the practice’s polices around providing after-hours services and monitoring and recording clinical advice given by telephone and/or after hours, and the use of care teams to coordinate patient care.

- **Identify and Manage Patient Populations** – including the practice’s use of electronic systems to record patient information and generate reminders for patients.

- **Plan and Manage Care** – including the practice’s ability to coordinate referral services for following up and tracking patients with hospital admissions and/or emergency department visits.

- **Track and Coordinate Care** – including the practice’s ability to coordinate referral services by following up and tracing patients with hospital admissions and/or emergency department visits.

- **Measure and Improvement Performance** - including the practice’s ability to maintain performance data around specific preventive and chronic care services and to obtain and use patient and family feedback to improve care.
PCMH Knowledge

<table>
<thead>
<tr>
<th>How familiar are you with the concept of PCMH?</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10.1%</td>
<td>15.9%</td>
<td>39.1%</td>
<td>34.8%</td>
</tr>
<tr>
<td>How familiar are you with PCMH certification requirements?</td>
<td>32.4%</td>
<td>25.5%</td>
<td>33.8%</td>
<td>7.4%</td>
</tr>
<tr>
<td>How familiar are you with Centennial Care Performance Measures?</td>
<td>39.1%</td>
<td>33.3%</td>
<td>21.7%</td>
<td>5.8%</td>
</tr>
<tr>
<td>How well can you report on Centennial Care Performance measure?</td>
<td>48.5%</td>
<td>26.5%</td>
<td>23.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Pediatric Council

2013 PCMH Workgroup was developed

- Medical Directors from all Medicaid Managed Care entities
- Practicing pediatricians – Albuquerque, Gallup, Silver City, Taos, Roswell
- Department of Health, Family Health Bureau
- Human Services Department, Quality Bureau

- Objectives:
  - Develop a standard model for the state that was accessible to even the smallest most remote practice site
  - Uniform PCMH requirements
  - Defined Payment model
PCMH Work Group

• Reviewed models from other states

• Revised 2014 NCQA standards to make them easier

• Developed a model similar to Connecticut with a “Glide Path” towards PCMH certification

• Reviewed and discussed payment methods

A Shared Vision for PCMH

New Mexico’s PCMH model is uniform across payers and tailored to the diverse needs and capacities of primary care practices, large and small, urban, rural and frontier. The NM model is based upon nationally accepted standards. We propose a blended model that builds upon the work that has already been done by practices that have achieved certification through NCQA and other nationally recognized PCMH certification programs. This blended model will include a pathway towards certification for those practices that do not currently have the capacity to attain certification.
A Shared Vision for PCMH

• The NM PCMH program will provide technical assistance, benchmarks and financial support to practices in order to move them along the pathway towards national recognition. Payment to NM PCMH practices is standardized and based on level of PCMH achievement and continued evidence of quality care to patients and reduced cost. New Mexico PCMH will include state specific goals tailored to the unique needs of communities and patients.

A Shared Vision for PCMH

• Integration of Public Health services – ex. Children’s Medical Services (CMS) care coordination for children with special healthcare needs, Women Infants and Children (WIC), sexually transmitted infection treatment and contact tracing, etc.
• Integration of behavioral health – mental health and substance misuse - including SBIRT
• A focus on culture, place and language
• Use data to inform the health system
  o All payer claims data base
  o Health information exchange
  o Employ evidence based interventions
• Providers report on measures that reflect State-level health priority areas and utilizes health equity as a foundational lens
• Commitment to data integration and sharing information in real time to improve quality and lower costs, and to improve population health
A Shared Vision for PCMH

- Core values of the NM PCMH model include:
- Team-based care – includes community health workers, lactation consultants, public health, behavioral, and oral health staff, and others
- Patient-centered care - engage patients in their own healthcare decisions, respect for patient values and inclusion of patient care givers
- Coordination of care
  - Risk stratified care management
  - Prioritize communities of highest need
  - Support for social services, i.e., housing, food, transportation, etc.
  - Seamless transition between services and providers

Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care

- 27 practices in the Pennsylvania Chronic Care Initiative
- All reached NCQA certification most at level 3
- Structured supports included: practice coaching, payments to support care managers, disease registries, practice transformation and
- Shared savings incentive (up to 50% of savings contingent on meeting quality targets
Outcomes

• Improved quality of diabetes care – 4 measures
• Improved quality breast cancer screening
• No improvement in colorectal cancer screening rates
• Statistically significant reductions in:
  • All cause hospitalizations,
  • All cause Emergency Room visits
  • Ambulatory care sensitive emergency department visits
  • Ambulatory visits to specialists
• Increased rates of ambulatory primary care visits

Conclusions

Evaluation results were related to:
• Shared savings incentives

• Timely availability of data on emergency department visits and hospitalizations

• Encouraged and allowed practices to work to contain unnecessary or avoidable care in these higher level settings
Next Steps

• Develop a more detailed plan
  • Structure of PCMH for New Mexico
  • Define payment model, shared savings?
  • Develop a plan for technical assistance and practice coaching
  • Team based care – including workforce beyond what is traditionally found in a clinic
  • Identifying a core measurement set that reflects the life course of patients, birth to old age
  • Integration of mental health, substance abuse, oral health, social supports such as transportation, housing

Community-Centered Health Homes: Bridging Prevention & Health Services
What are we paying for?

“America’s health care system is in crisis precisely because we systematically neglect wellness and prevention.”

—Senator Tom Harkin
Existing Clinician Skills

**Transferable to Community Prevention**

**PATIENT INTAKE**
- Capture and identify population level health trends

**DIAGNOSIS**
- Analyze and prioritize relevant community conditions

**TREATMENT**
- Engage in advocacy and translate clinic priorities into action

**INQUIRY**
- **ASSESSMENT**
- **ACTION**
Clinical/Community Population Health Intervention Model

Data Collection
- Partnership Formation
  - Health Care
  - Public Health
  - Community Organizations

Identify Priority Health Issues

Environmental & Policy Change

Outcomes
- Improved Health
- Cost Savings
- Evidence-Based for Effective Practice

Inquiry

- Collect data on social, economic, & community conditions
Inquiry

- Aggregate symptom and diagnosis prevalence data

Assessment

- Systematically review health and safety trends
Assessment

- Identify priorities and strategies with community partners

Action

- Establish model organizational practices
Action

◆ Advocate for community health

Overarching Systems Recommendations

◆ Structure health care payment systems to support CCHHs

◆ Leverage current opportunities for government, philanthropy, and community benefits to support CCHHs

◆ Consistent metrics for evaluation and continuous quality improvement

◆ Networks to support peer-to-peer learning

◆ A cadre of health professionals prepared to work in CCHHs
Resources

- Video of Larry Cohen on Community-Centered Health Homes
  https://www.youtube.com/watch?v=zQPRINEhwI8
- Prevention Institute resource articles
  http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html

Marsha McMurray-Avila, Coordinator
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New Mexico Health Homes:
Patient-Centered Medical Home (PCMH) Comparison

<table>
<thead>
<tr>
<th>Component</th>
<th>New Mexico Health Home</th>
<th>Patient-Centered Medical Home*</th>
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</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Enhanced Medicaid reimbursement for services to all individuals with approved chronic conditions for 8 quarters.</td>
<td>Serves all populations across the lifespan</td>
</tr>
<tr>
<td>Typical Providers</td>
<td>May include primary care practices, community mental health organizations, addiction treatment providers, Federally Quality Health Centers, IHS clinics, 638 facilities, health home agencies, etc.</td>
<td>Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as Nurse Practitioners</td>
</tr>
<tr>
<td>Payer(s)</td>
<td>Currently a Medicaid-only construct</td>
<td>Exist for multiple payers (e.g., Medicaid, commercial insurance)</td>
</tr>
<tr>
<td>How is Care Organized</td>
<td>Team-based, whole-person orientation with explicit focus on the integration of behavioral healthcare and primary care; includes individual and family support services as well as peer-based services.</td>
<td>Team-based, whole person orientation achieved through care coordination</td>
</tr>
<tr>
<td>Provider Requirements</td>
<td>State Medicaid determined</td>
<td>State Medicaid and NCQA determined</td>
</tr>
<tr>
<td>Payment</td>
<td>Usually Per Member/Per Month (PMPM) for 6 required services with more intensive care coordination and patient activation</td>
<td>Payment is in line with added value; usually small PMPM</td>
</tr>
<tr>
<td>Information Technology (IT)</td>
<td>Use of IT for coordination across continuum of care as well as for measurement and evaluation of the initiatives.</td>
<td>Use of IT for traditional care delivery</td>
</tr>
</tbody>
</table>

Thank You!

Upcoming Summit:

July 15, 2015
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm (tentative)
https://www.surveymonkey.com/r/JulySIMSSummit
www.nmhealthsysteminnovation.org
Introduction

Operating as a medical home requires increased non-reimbursed activity (e.g., care team meetings, patient self-management education, care coordination, data analysis, communication with other clinicians) and care management. In order for patient-centered medical home (PCMH) practice transformations to be sustainable, there must be payment reform to incentivize high-value, first-contact, primary care, and support medical home costs that are traditionally not reimbursed (e.g., non face-to-face encounters). Together with the “Health Reform and the Patient-Centered Medical Home: Policy Provisions and Expectations of the Patient Protection and Affordable Care Act” brief, this publication provides an introduction to a series of policy briefs focusing on payment reform opportunities to support and sustain the medical home.

PCMH Payment Models: An Overview

The current method of paying for healthcare, fee-for-service (FFS), rewards volume over value. New models of payment offer opportunities for infrastructure support and incentive alignment to spur and sustain practice transformation. The goal of payment reform is to align incentives to support and promote the delivery of high-value primary and preventive services and reward improved health outcomes, while stabilizing or reducing total healthcare costs. Many payment models are available to support and sustain medical home transformation. There is no suggested hierarchy in the order of models, and in the real world, practices may be supported by a combination of models.

Policy Brief Issue 1

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The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, the SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute.
The following 10 payment models are ways to support enhanced PCMH payment.

**Figure 1: Ten Payment Models to Support Patient-Centered Medical Homes**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>FFS with new codes for PCMH services</strong>&lt;br&gt;Payment for non-traditionally reimbursed codes, such as T codes; new HCPCS codes were created for medical home payments effective 1-1-10 (HCPCS T1017 pays for targeted case management).</td>
</tr>
<tr>
<td>2</td>
<td><strong>FFS with higher payment levels</strong>&lt;br&gt;Enhanced rates paid to qualifying practices.</td>
</tr>
<tr>
<td>3</td>
<td><strong>FFS with lump sum payments</strong>&lt;br&gt;Periodic lump sums are paid to qualifying practices; lump sum payment often covers pre-work and/or recognition of NCQA PPC®-PCMH™ achievement.</td>
</tr>
<tr>
<td>4</td>
<td><strong>FFS with PMPM payment</strong>&lt;br&gt;PMPM fee is often referred to as a “monthly care coordination payment” and can cover care management, care coordination, and/or Rx consultations paid to PCPs or PCP networks.</td>
</tr>
<tr>
<td>5</td>
<td><strong>FFS with PMPM payment and P4P</strong>&lt;br&gt;PMPM fee is often referred to as a “monthly care coordination payment” and P4P is based on predetermined outcome or process measures.</td>
</tr>
<tr>
<td>6</td>
<td><strong>FFS with PMPY “shared savings” payment</strong>&lt;br&gt;Shared savings model which is informed by internal return-on-investment (ROI) analysis.</td>
</tr>
<tr>
<td>7</td>
<td><strong>FFS with lump sum payments, P4P, and shared savings</strong>&lt;br&gt;Practices do not need to meet any criteria for lump sum payment, but practices that meet quality metrics qualify for shared savings, roughly adjusted for patient case mix.</td>
</tr>
<tr>
<td>8</td>
<td><strong>FFS with PMPY payment and shared savings</strong>&lt;br&gt;Includes an initial lump sum infrastructure investment, FFS payment, and an evaluation of savings; the next year (or step) assesses a prospective disease management (DM) PMPY payment (billed by S code) informed by the savings evaluated from year 1 pilot, with FFS payment plus shared savings.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Comprehensive payment with P4P</strong>&lt;br&gt;Risk adjusted PMPM comprehensive payment covers all primary care services; payments support investment in medical home systems to improve care, unlike traditional primary care capitation.</td>
</tr>
<tr>
<td>10</td>
<td><strong>Grants</strong>&lt;br&gt;Provider sites receive a grant to support PCMH transformation.</td>
</tr>
</tbody>
</table>
In an effort to understand how these 10 payment models relate, we can break them down into five different payment models: FFS with adjustments, FFS plus, shared savings, comprehensive, and grant-based payments.

**FFS with Adjustments Model:** FFS with discrete codes and FFS with higher payment levels comprise the “FFS with Adjustments” model. Texas Medicaid demonstrates the FFS with adjustments model in their initiative to pay for traditionally non-reimbursed care management services for children (Texas Medicaid Health Steps EPSDT program).

**FFS Plus Model:** The second category is comprised of “FFS Plus” payments, which include FFS with lump sum payments, FFS with a PMPM payment, and FFS with a PMPM payment and P4P. EmblemHealth and Colorado’s Multi-Payer Initiative are examples of the FFS with PMPM payment and P4P model (in this example, the PMPM payment incentivizes care management). This payment model is endorsed by the Patient-Centered Primary Care Collaborative (PC-PCC) and several physician professional associations.

**Comprehensive Payment Model:** This model is similar to a capitation model, but includes enhanced payment to support medical home systems. The Capital District Physician Health Plan of New York is piloting this approach with risk-adjusted PMPM payments covering all primary care services with 15%–20% of annual payments based on performance and paid as a bonus.

**Shared Saving Model:** This category encompasses all models that include a shared savings component, for example FFS with PMPY shared savings payments; FFS with lump sum payment, P4P, and shared savings; and FFS with PMPY and shared savings. To illustrate, a practice could be made eligible for FFS with lump sum payment, P4P, and shared savings; in this example, the lump sum payment, offered as a forgivable loan, is only kept by the practice if it meets pre-determined performance measures on time. In this model, practices that meet payer-specified quality metrics can qualify for 50/50 shared savings using a formula that roughly adjusts for case mix and compares expected expenditures against total practice cost. Pennsylvania has two programs using the FFS with lump sum payment, P4P, and shared savings model: the Northeast Regional Rollout of the Pennsylvania Chronic Care Initiative and Geisinger Health Plan.

**Grant-Based Payment:** The final category is grant-based payment enhancements. An example of this payment model is the Texas Medicaid Health Home Initiative for Children pilot, in which pilot sites receive traditional FFS plus quarterly grants over a 24 month period. Grant payments are intended to cover all medical home transformation costs and are based on an approved budget.

Figure 3 on page 4 demonstrates the feasibility of payment reform methods for different-sized organizations and helps illustrate the challenges in making payment reform appropriate and beneficial to providers.

The more integrated a health care organization is, the larger the bundle of patient care for which they can assume responsibility. In general, the assumption of risk in global or bundled payment models creates both financial opportunities and challenges. If a health center or private practice has a large enough patient population for statistical stability in cost and quality performance measures, it can succeed under the performance-based reimbursement models, including shared savings and global payment. In order to realize the financial benefits, providers must have strong leadership, good data management, strong medical home operations, and patient care management expertise for high-risk patients. When a provider group is not large enough to assume the risks associated with performance-based payment, it would need to be grouped with one or more other groups of providers for performance assessment purposes.

Under the health reform law, Medicare and Medicaid will both have bundled payment demonstrations in multiple states. The Medicaid demonstration will be based on bundled payments for an episode-of-care, supporting both hospital and physician services, and will be modeled in up to 8 states beginning in 2012. The Medicare pilot program will bundle payments for acute, post-acute care, and ambulatory conditions for 10 selected conditions, beginning in 2013. The infusion of federally led, global and bundled payment demonstrations may decrease the power and prevalence of FFS, both in the short term in states where the demonstrations occur, and, in the long term, at the national level.
### Figure 2: Attributes of 10 PCMH Payment Models

<table>
<thead>
<tr>
<th></th>
<th>Public Sector or Safety Net Demo in Place</th>
<th>Feasible for Small Practice Size</th>
<th>Includes Upfront Payment</th>
<th>Financial Support for Traditionally Non-Billable Services</th>
<th>Typically Requires PCMH Recognition or Certification</th>
<th>Emphasizes Value Over Volume</th>
<th>Simplifies Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FFS with new codes</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>2. FFS with higher payment levels</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>3. FFS with lump sum payments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>4. FFS with PMPM payment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
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<tr>
<td>5. FFS with PMPM payment and P4P</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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<tr>
<td>6. FFS with PMPY payment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>7. FFS with lump sum payments, P4P, and shared savings</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>8. FFS with PMPY payment and shared savings</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>9. Comprehensive payment with P4P</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>10. Grants</td>
<td>✓</td>
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### Figure 3: Relationship Between Payment Methods and Organizational Models

- **Payment Method**
  - Fee-for-Service
  - Medical Home Payments
  - Global Case Rates
  - Full Population Prepayment

- **Outcome measures; large % of total payment**
- **Care coordination and intermediate outcome measures; moderate % of total payment**
- **Simple process and structure measures; small % of total payment**

- **Practice/Organization Type**
  - Small practices; unrelated hospitals
  - Independent Practice Associations, Physician Hospital Organizations
  - Fully integrated delivery system

Less Feasible

More Feasible
What Should Community Health Centers Do to Prepare for Transformed Payment?

Community Health Centers (CHCs) must prepare to operate in a system that is not FFS. CHCs can and should actively participate in the national dialogue on payment reform. To prepare for the future of primary care payment, we recommend CHCs and other safety net providers:

1. **Implement the PCMH model** and seek recognition for medical home achievement (NCQA PPC®-PCMH™, state recognition, etc.). Like private practices, most CHCs will need to engage in significant practice redesign before achieving the high-performing, patient-centered, medical home status required by most enhanced payment programs.

2. **Participate in discussions on payment redesign.** Many state-based medical home initiatives involve multiple payer and provider representatives. These multi-stakeholder groups often develop payment design through a collaborative process. CHCs should make their voices heard in these discussions, as they can sometimes come to be dominated and directed by payers. CHCs should also make their need for enhanced payment known. While some will argue that CHCs receive higher payments than independent physicians, these payments are typically for costs other than those required of a medical home.

3. **Prepare for performance-based payment.** While most early medical home initiatives provide supplemental payments, there is a strong trend towards performance-based payments. Under these arrangements, there is either a) a sizable P4P component linked to quality and/or efficiency measures, or b) a shared savings arrangement, under which eligibility for sharing any savings, or the extent of sharing, is contingent on performance on quality and, sometimes, efficiency measures.

The models described in this paper span the breadth of enhanced medical home funding provisions. As the healthcare landscape continues to change, some of these models will be tested on a larger scale and other models may be developed. The Safety Net Medical Home Initiative will provide updates on payment reform and other policy initiatives pertinent to medical home transformation in the safety net. For updates and additional information, refer to: [www.qhmedicalhome.org/safety-net](http://www.qhmedicalhome.org/safety-net)
Glossary

ACOs
Accountable Care Organizations (ACOs) will be comprised of providers who voluntarily meet specified criteria, including reporting quality measures. ACOs will share in or fully retain the cost-savings they achieve for Medicare and Medicaid programs depending on the adopted payment model. ACOs are expected to manage the full continuum of patient care and are held accountable for overall costs and quality of care for a defined population. ACOs may be comprised of a variety of networks, from large integrated delivery systems to physician-led hospital groups, multispecialty practice groups, group physician practices or health center networks. ACOs may receive bundled or global payments for services, or contract on a shared savings basis.

Bundled Payments
Bundled payments occur at the chronic care condition or episode of care level. They make a single payment for all services related to a treatment or condition, potentially spanning multiple providers in multiple settings and may be adjusted for case severity. Providers assume financial risk for the cost of services associated with a particular condition or treatment as well as costs associated with preventable complications, but not for the occurrence of the medical conditions (insurance risk). Bundled payment supports coordination of care by sharing payment for treatment/condition across multiple providers in multiple settings. Financial risk is mitigated by reinsurance or other ways to limit or cap risk. Bundled payments are seen as the middle ground between fee for service and global payment for all services.

Global Payment
Global payments, or capitation, bundle the payment at the patient level and are fixed dollar payments for the care received during a time period (month, year). Partial global payments cover primary care and/or specialty services. Full global payments cover primary, specialty, hospital, and other covered services. Global payments place providers at some risk for the occurrence of medical conditions (insurance risk) as well as management of occurring conditions (clinical risk). Providers are protected from the total insurance risk by risk adjustment of payments, reinsurance and other models which limit or cap risk. Global payments are designed to contain costs, encourage integration and coordination and reduce unnecessary services. Global payments may include added incentives for improving the quality of care. Global payment systems can be administratively complex for providers and require additional infrastructure to help manage financial risk. The risk and administrative burden in global payment potentially excludes small provider groups or solo practitioners.

Shared Savings
Shared savings arrangements are similar to global payment arrangements, except that the provider entity bears no risk for financial losses should expenditures exceed what was budgeted or targeted. Also, rather than have the provider entity retain all of the savings that it might generate through its efforts, those savings are shared with the payer. The extent to which savings are shared is often dependent upon performance on metrics that can assess access, patient experience, clinical quality and/or efficiency. Finally, shared savings arrangements are more likely than global payment arrangements to exclude some services (e.g., mental health).
Resources

The following are websites and journal articles that provide more information about payment models and the Patient-Centered Medical Home.


Terms

ACO: Accountable care organization
FFS: Fee-for-service
P4P: Pay for performance
PMPM: Per member per month payment
PMPY: Per member per year payment
PPACA: Patient Protection and Affordable Care Act
PPS: Prospective payment system, a reimbursement mechanism where providers are paid a flat rate per case
PQRI: Physician Quality Reporting Initiative

References


The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.

Recommended Citation

Population Health Components of State Innovation Model (SIM) Plans: Round 1 Model Testing States

*Chart updated November 19, 2014
Larry Hinkle

As we noted in a previous analysis, the State Innovation Model (SIM) Testing Awards that HHS awarded to six states (Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont) were to support states’ work on multi-payer payment and delivery system reform. Strategies to improve the population’s health were a critical aspect of the SIM awards. The SIM Funding Opportunity Announcement (FOA) required that states explain how the model would improve the population’s health in a number of areas including: health disparities, determinants of health, mental health, and substance abuse. The FOA also noted that states should describe how their State Health Care Innovation Plan integrates community health and prevention into their delivery system and payment models.

This chart lays out the population health strategies the selected states plan to implement through their SIM initiatives. These strategies are based on the states’ proposals and other SIM documents that you will find linked in the text below and in our document library. For information on the payment and delivery system reforms that these states are testing, their health information technology and data capabilities, as well as the scope of their models, please see our previous chart. Please note that because the information in both of these charts was abstracted from early documents, we anticipate that this information may change as the states implement their models.

We encourage our community to share and discuss more details, ideas, issues and emerging products and results on State Reforum. Especially on SIM documents, we anticipate that this information may change as the states implement their models.

State | Arkansas | Maine | Massachusetts | Minnesota | Oregon | Vermont
--- | --- | --- | --- | --- | --- | ---
Project Narrative | X | X | X | X | X | X

Arkansas’ primary strategy for population health is through its medical home and health home initiatives. Arkansas plans to expand access to medical homes within 3-5 years. These medical homes will proactively examine the patient’s health with a focus on preventive services and chronic disease management. Arkansas will also change the payment mechanism to underwrite the costs of primary care practice transformation and reward providers for effective population health management.

Maine’s model will deliver care through patient-centered, primary-care accountable, multi-payer Accountable Care Organizations that are responsible for improving population health, patient experience of care, and controlling healthcare costs. These ACOs will also integrate primary care and behavioral health, align healthcare and public health systems to support improving chronic disease outcomes and address health disparities, and improve health measures and equity. These ACOs will also build on the model of MaineCare (state Medicaid program) Accountable Communities (SIM plan 7-8).

Massachusetts will integrate public and population health into its multi-payer model. The state defines primary care providers broadly to include not just primary care practices and hospital-based providers, but also community health/mental health centers that provide primary care services. These provider organizations may be embedded in larger organizations, ranging from integrated delivery systems to independent practice associations to ACOs. Additionally, the Department of Public Health serves with the four other departments as an Implementing and Strategic Partner (see pg. 7).

Minnesota’s Health Care Delivery System (HCDS) demonstration aligns with ACO models from other public and private payers creating financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services. Participating organizations are given incentives to partner with community organizations to create 15 Accountable Communities for Health that integrate medical care with behavioral health, mental health, public health, long-term care, social services, and other providers and share accountability for population health.

Oregon’s primary focus is the reduction of chronic diseases and the risk factors that contribute to them. Oregon is using SIM to accelerate population health goals in 3 areas:
1. Advancing the spread of the Coordinated Care Model – with emphasis on prevention and proactive population health management;
2. Providing targeted support for a handful of local “flood the zone” collaborations aimed at creating changes in practice around leading causes of death and disease.
3. Enabling increased population health performance measurement.

Vermont’s SIM model seeks to reach the three overarching priority areas for health improvement as identified in Vermont’s 2012-2015 State Health Improvement Plan including:
1. Reduction in the prevalence of chronic disease through improving physical activity, nutrition and decreasing the rates of tobacco use.
2. Reduction in the prevalence of Vermonters with or at risk of substance abuse and/or mental illness.
3. Improvement of childhood immunization.

Vermont also believes that the primary models it will pursue through SIM--Shared Savings ACOs, Bundled Payments, and Pay for Performance--will help build provider capacity to better manage population health.

Oregon is poised...
<table>
<thead>
<tr>
<th>Strategies in the Model to Address Social, Economic, and Behavioral Determinants of Health and Health Equity</th>
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<tr>
<td><strong>Arkansas</strong> is designing interventions to specifically address and support challenges faced by its communities such as poor rankings in smoking, early prenatal care, preventable hospitalizations, as well as reducing the disease burden presented by rising rates of obesity and Type 2 diabetes (SIM plan 13). Accountable Communities are <strong>required to serve</strong> a minimum number of MaineCare (Medicaid) members and must include MaineCare enrolled providers. Maine notes that in order to change and prevent disparities a multi-level approach such as the one envisioned by its model is required to eliminate health disparities and reach health equity. The reduction of health disparities is a goal of the Prevention and Wellness Trust Fund (see below). Additionally, the Massachusetts SIM operational plan (see pp. 65-66) notes that there is substantial evidence that a strong primary care base delivered through PCMH – as the state is doing – will reduce disparities in care and narrow racial disparities in health outcomes. The fifteen Accountable Communities for Health will form with a priority on communities in areas with a lower level of ACO penetration, greater disparities, and greater health care needs. The payment structure and incentives for ACOs will encourage them to adopt strategies such as coordinated and integrated health care and multi-payer Health Care Homes, Community Health Teams, and Service Coordination Teams, which will provide the infrastructure to address social and behavioral determinants of health. In <strong>Oregon</strong>, SIM to implement the Congregate Housing with Services model. This approach targets a low-income population living in subsidized housing apartments or other highly concentrated, naturally occurring communities with a greatly coordinated and efficient model of support. This strategy will target social determinants of health, include prevention and wellness programs, and seek to prevent unneeded emergency and acute health care. Oregon’s model also builds on, and provides operational support to, its existing Regional Health Equity Coalitions. These coalitions seek to reduce disparities and address social determinants of health. SIM support will also be used to expand health care interpreters and other efforts to enhance communication and education across all populations, and to reduce barriers to services. <strong>The Vermont Department for Health</strong> (VDH) is actively developing strategies that can be used by all programs in the model to reduce health disparities. The Department is taking the lead, but is collaborating with other agencies and partners to achieve health equity.</td>
</tr>
<tr>
<td><strong>Arkansas</strong> will use the <strong>health home model</strong> for those with developmental disabilities, long-term services and supports, and behavioral health issues. Arkansas’ health home functions match the CMS definition and aim to ensure provider accountability for the full client experience including health outcomes, and will coordinate all health care and support services needed by a client over time. Maine’s model expands the use of patient-centered medical homes, and develops Health Homes for people with chronic conditions and significant behavioral health needs. The model also builds on Community Care Teams, which are already being used in some medical home pilots in the state. Mental health is integrated into the model by including mental health providers among those whose services qualify as primary care, and are subsequently integrated into its patient-centered medical home initiative and integrated delivery system models. In phase two of its model the services for which ACOs participating in Medicaid HCDS and Hennepin Health (safety-net ACO) are held accountable will be expanded by the Minnesota Department of Health Services (DHS) to include intensive mental health, long-term care, and home and community-based services. <strong>Oregon</strong> is using SIM to provide to CCOs in order integrate mental health and addiction services. Oregon has also identified measures related to mental health and substance abuse that CCOs will be required to report. <strong>Community Health Teams</strong> are the heart of Vermont’s Blueprint Model. Under the model these teams may be expanded to include the identification of, and coordination of care for, high-risk individuals with multiple chronic conditions and people living with mental health and substance abuse disorders.</td>
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The model builds...
Engaging and Integrating Community Health and Prevention into Delivery System: Reform Models

Maine will employ several strategies to activate consumers and communities including: increased use of shared decision making tools, learning collaboratives to disseminate patient engagement tools, and increased public awareness of shared decision making and health care self management. The model also builds off of existing strategies including consumer supports such as Better Health, Better ME and Get Better Maine and existing patient supports including: peer navigators, peer supports, and community health workers.

Arkansas will monitor progress indicators and intermediate outcomes including: decreased outcomes including: intermediate indicators and disease decreased including: outcomes and indicators.

Referrals to community and social supports are a critical function of Health Homes in the CMS definition. Health Homes will work in collaboration with medical homes to coordinate across all types of care for individuals, and to support them on care transitions, adherence to a care plan, and access to community and social supports (SIM plan 17).

MaineCare will be submitting an SIM plan 17 off of Chapter 224, passed in 2012. This law created the Prevention and Wellness Trust Fund, and provides the fund with $57 million over 4 years. This fund is administered by the Department of Public Health and supports community-based partnerships including municipalities, healthcare systems, business, regional planning organizations, and schools to work together to provide interventions that: reduce rates of the most prevalent and preventable health conditions, increase healthy behaviors, increase the adoption of workplace-based wellness or health management programs, and address health disparities.

SIM funds will support the development of an electronic open-source referral system to nine community health centers (CHCs) with a minimum of four different community resources. Additionally, 30 CHCs have committed to transforming into PCMH.

Accountable Communities are explicitly set up to be guided by local needs assessments, with wide flexibility in determining which community organizations to partner with and which services to prioritize, as well as how to integrate various health care streams and determine financial allocations. Minnesota’s SIM plan will also link with Health Care Homes and Community Care Teams already underway in Minnesota. Minnesota has also created a Community Advisory Task Force, focused on engaging communities and patients.

Oregon’s model integrates Non-Traditional Health Care Workers (NTHWs), which include Community Health Workers, Peer Wellness Specialists, Patient Navigators, Doulas and Health Care Interpreters.

A core requirement for CCOs is that they collaborate with local hospitals, public health agencies, social services organizations, and others to conduct community health needs assessments, and develop a community health improvement plan based on the needs and resources identified.

Vermont’s SHIP cites its state health assessment (Healthy Vermonters 2020) to describe priority indicators. These include:

- Increase the percentage of adults who meet physical activity guidelines from 59 to 65%.

- Reduce coronary heart disease deaths from 112 to 99 per 100,000 people.
Population Health Metrics Used in Model

- Disease progression (e.g. diabetes, congestive heart failure), greater control of hypertension, reduced re-hospitalization rates and ambulatory sensitive hospitalizations (e.g. pneumonia, asthma), and fewer late-stage cancer diagnoses. (SIM plan 13).
- Specific goals include: reducing premature deliveries (before 39 weeks) to less than 10% statewide, achieving 50% adherence rate of comprehensive diabetes metrics, and measuring and improving documentation of blood pressure control in PCMHs. (SIM plan 15).

Integrated Care Model state plan amendment for its Accountable Communities initiative. This will include a quality framework with goals and objectives, specific quality measures, and how quality measurement will be used to improve care. MaineCare’s Health Homes State Plan Amendment will also include an alignment with CMS Adult and Children’s Core Measure sets. To measure patient experience of care, Maine will conduct a statewide CG-CAHPS survey.

Massachusetts selected measures that are externally validated and already in use, such as measures compiled by HEDIS, AHRQ, CMS, and private payers in the state. These metrics focus on: adult prevention and screening, health and care coordination (adult and pediatric), adult chronic conditions, access (adult and pediatric), and behavioral health (adult and pediatric). Measures developed for Primary Care Payment Reform (PCPR).

For Minnesota Accountable Communities for Health include: reduction in chronic condition exacerbations, chronic disease management, patient satisfaction with quality and care coordination, patient engagement in health care and health, health disparities, preventive care utilization, access to care, community services and partnerships, behavioral and mental health services resources, and others.

Notes:
Produced by Larry Hinkle

Topics:
State Innovation Models
Population Health Components of State Innovation Model (SIM) Plans: Round 2 Model Testing States

*Chart updated March 6, 2015

Amy Clary

The Round Two State Innovation Model (SIM) Test Awards granted by HHS to eleven states (Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Rhode Island, Ohio, Tennessee, and Washington) support state efforts to build multi-payer models of health system transformation. As noted in a previous analysis, population health improvement is an important component of the SIM awards. The SIM Funding Opportunity Announcement (FOA) required states to describe how their models would improve population health in a number of areas, including prevention, health equity and the social determinants of health, rates of obesity and diabetes, and healthy behaviors, including reduced tobacco use. The FOA also required states to incorporate new delivery system models into their population health improvement plans.

This chart contains population health strategies, as defined by the states, that the states plan to implement through their SIM Round Two Model Testing initiatives. The information in the chart is derived from the states’ proposals and other documents that you will find linked in the text below. Information on the population health components of the Round One SIM Model Test Awards can be found in our previous SIM population health chart. Please note that because the information in these charts was abstracted from early documents, we anticipate that this information may change as the states implement their models.

We encourage our community to share and discuss more details, ideas, issues and emerging products and results on State Reforum. Do you know of state activity or analyses that we should add to this chart? Eager to update a fact we’ve included? Your contributions are central to our work. Please email aclary@nashp.org with your suggestions.

<table>
<thead>
<tr>
<th>State</th>
<th>Population Health Objectives in the Model</th>
<th>Strategies in the Model to Address Social, Economic, and Behavioral Determinants of Health and Health Equity</th>
<th>Engaging and Integrating Community Health and Prevention into Delivery System and Payment Reform Models</th>
<th>Population Health Metrics Used in Model</th>
<th>Strategies in the Model to Integrate Primary Care and Mental Health and Substance Abuse Disorder Services</th>
</tr>
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<tbody>
<tr>
<td>Colorado</td>
<td>Colorado seeks to improve population health by establishing a close partnership between public health, behavioral health, and primary care, and prioritizing ten population health focus areas including obesity, substance use, and mental health (SIM p.1).</td>
<td>Colorado state agencies are collaborating to address the social determinants of health using a “life stages” approach to targeting resources. The plan will include data collection on disparities in tobacco use, diabetes, and obesity (SIM p. 2, 11, 62).</td>
<td>Colorado will examine the possibility of long-term reimbursement models for population-based prevention and wellness services (SIM p. 25).</td>
<td>Population Health Transformation Collaboratives made up of community health leaders will work with the state's new Health Extension Service on local community health initiatives (SIM p. 4-5, 10). Targeted local public health agencies will receive funding for community prevention activities and to link practices, community resources, and public health (SIM p. 2).</td>
<td>The program’s shared risk and savings payment model will incentivize integrated physical and behavioral health services (SIM p. 2, 12-13, 23). A child mental health coordinator will develop prevention and early intervention programs for mental health challenges in children (SIM p. 5-7).</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Connecticut plans to strengthen primary care and integrate community and clinical care. It also aims to improve prevention and screening, including mental health and substance abuse screening, and rheumatic illness.</td>
<td>Connecticut will convene a multi-sector Population Health Council tasked with setting priorities for health improvement areas, focusing on the barriers most likely to contribute to health disparities. The Health Enhancement Communities initiative focuses resources on the areas of the state with greatest disparities and will include payment</td>
<td>Connecticut plans to develop sustainable Prevention Service Centers (PSCs) that will offer community-based preventive services. Reimbursement for Community Health Workers (CHWs) may also be part of the plan (SIM p. 2-3; 8). The state will also augment its use of Value-Based Insurance Design (VBRID) and shared</td>
<td>Connecticut will report measures for statewide population health targets including tobacco use, obesity, and diabetes (SIM p. 25). The plan also includes quality targets on preventive screenings, asthma, and premature death from cardiovascular disease. The state will</td>
<td>The model will complement the state’s existing Behavioral Health Home initiative, which coordinates physical and mental healthcare for Medicaid recipients with serious and persistent mental</td>
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<tr>
<td>State</td>
<td>Approach</td>
<td>Specifics</td>
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<td>Iowa</td>
<td>Chronic illness management (SIM p. 1; 22-23).</td>
<td>Iowa will provide support and technical assistance to encourage ACOs to develop workforce models, including telehealth, that address provider shortages and reduce the disparities between rural and urban areas (SIM p. 1). New Community Care Teams will connect ACOs with social services and local public health resources to address social determinants of health. Value-based payments will be used to incentivize prevention, health improvement, and management of chronic diseases (SIM p. 12-13). Iowa’s model seeks to expand care delivery into the community setting, and will track communities’ progress on population health initiatives. Community Care Teams will integrate public health and local ACOs to improve outcomes, and will facilitate connections with non-ACO providers (SIM p. 2-3). Iowa will measure progress in six population health target areas: reducing tobacco use, obesity, hospital-associated infections, and early elective deliveries; and improving patient engagement and health literacy, including diabetes self-management (SIM p. 3-5). Iowa will continue to incorporate behavioral health providers into its ACO structures, including the use of integrated health homes for individuals with mental illness (SIM p. 7-11).</td>
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<td>Idaho</td>
<td>Delaware aims to integrate population health with value-based payment models. It seeks to attribute every patient to a primary care provider (PCP) who is incentivized to address population health issues (SIM p. 1-8).</td>
<td>Delaware emphasizes cross-agency collaboration as part of its strategy to address social determinants of health. Also, as part of its Healthy Neighborhoods strategy, the Delaware Division of Public Health (DPH) will support staff health equity training (SIM p. 1-6). Delaware’s Healthy Neighborhoods will support a multi-stakeholder community coalition focused on identifying and addressing health needs (SIM p. 5-6). The proposed population health metrics include measures related to smoking; nutrition; physical activity; prevalence of hypertension, obesity, and diabetes; cancer deaths per 100,000; heart disease deaths; 30-day post-PCI mortality rate; and infant mortality (SIM p. 37). Delaware’s model will focus on providing team-based, integrated physical and behavioral health care for high-risk patients, including by providing incentives for EHR use to behavioral health providers. It will complement the existing PROMISE program that coordinates care for beneficiaries with mental illness.</td>
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<td>Idaho</td>
<td>Idaho is planning to develop a virtual PCMH telehealth initiative to serve remote communities. The state’s seven public health districts will also form Regional Collaboratives to integrate public and physical health locally to improve access to care. Idaho will collect data on the social determinants of health as part of a statewide health assessment.</td>
<td>Idaho will use the following population health performance measures to monitor the success of the Model Test: depression, tobacco use, asthma ED visits, hospitalizations, hospital readmissions, avoidable ED use without hospitalization, elective deliveries, low birth weight, adherence to antipsychotic meds for people with schizophrenia, weight counseling for children and adolescents, diabetes, childhood immunizations, adult BMI, and rate of prescribed opioid use for non-cancer pain. PCHMs will coordinate care with Medical Neighborhoods of ancillary providers, including behavioral health providers. The state’s multi-payer common performance measures include screening for depression, adherence to antipsychotics for people with schizophrenia, and rates of prescribed opioid use for non-cancer pain.</td>
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<td>Iowa</td>
<td>Iowa will build upon its existing ACO model to improve performance in six population health priority areas, including tobacco use, obesity, prevention and health literacy (SIM p. 1-3). The state’s plan also seeks to use ACOs to integrate public health providers with acute care delivery systems.</td>
<td>Iowa will continue to incorporate behavioral health providers into its ACO structures, including the use of integrated health homes for individuals with mental illness (SIM p. 7-11).</td>
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<td>State</td>
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<td>Michigan</td>
<td>Michigan plans to improve wellness and reduce health risks on a population level through the use of Community Health Innovation Regions. PCMHs and integrated care networks called Accountable Systems of Care are also key elements (Blueprint p. 4-6). Michigan is considering payment models that incentivize efforts to address social &amp; environmental determinants of health. They are also planning greater use of and support for Community Health Workers to help reduce disparities (Blueprint p. 10-11, 37-41, 131-135). Michigan’s Community Health Innovation Regions will work with local public health and cross-sector partners to engage patients and community members in wellness and health promotion activities. Michigan will also explore sustainable financing models for population-level prevention and wellness efforts. Michigan will also seek to allow providers to practice at the top of their license and training to increase access to primary care (Blueprint p. 4-5, 10, 132, 157). Michigan’s plan includes monitoring access to primary care, clinical quality, patient experience of care, utilization, and other measures from the Michigan Health and Wellness dashboard, including measures related to birth outcomes and teen birth rates, obesity, alcohol consumption, nutrition, physical activity rate, tobacco use, dental health, mental health, STDs (Blueprint p. 72-75; p. 146-151). Michigan plans to integrate behavioral health providers into person-centered health care teams. (Blueprint p. 126-127).</td>
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<td>New York</td>
<td>New York’s plan has five primary population health goals: 1. Prevent Chronic Disease 2. Promote Healthy and Safe Environments 3. Promote Healthy Women, Infants and Children 4. Promote Mental Health and Prevent Substance Abuse; and 5. Prevent HIV, STDs, Vaccine-Preventable Diseases and Healthcare Associated Infections (SIM p. 1). New York aims to pay for 80% of advanced primary care under a value-based payment model. Further, the project’s Public Health Consultants will also connect the community with public health and clinical resources (SIM p. 2-3). The state will also work to ensure that providers are practicing at the top of their license to improve access to care. The project, including the advanced primary care model, will be evaluated according to an evolving statewide set of industry-standard quality and efficiency metrics, which includes progress toward prevention and public health goals (SIM p. 20-21). New York will focus on integrating primary and behavioral health care, and will convene a workgroup to analyze gaps in behavioral health services and make recommendations. Initiatives supported by the new Public Health Consultants may include tobacco cessation for people with mental illness and other efforts to address mental illness and substance abuse disorders (SIM p. 2, 4, 7).</td>
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<td>Ohio</td>
<td>Ohio plans to target the prevention or reduction of obesity, chronic disease, tobacco use and exposure, and infant mortality; and plans to expand patient-centered primary care (SIM p. 5). Ohio is testing ways to share data to improve population health, such as building on its current ability to use vital statistics data to indicate when a mother or infant may be at risk of poor health outcomes (SIM p. 6). Ohio’s episode-based payment model and statewide use of PCMHs are intended to incent providers to work with community-based and public health resources to address social determinants of health (SIM p. 12). Ohio’s SIM outcome metrics will include population health measures such as flu immunization and tobacco use, as well as care coordination and chronic conditions measures. Measures will be aligned across quality initiatives (SIM p. 24-28). Ohio merged the formerly separate departments overseeing mental health and substance use disorders. The state is focused on integrated, person-centered care and care coordination for Medicaid beneficiaries with mental illness and other populations (SIM p. 5).</td>
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<td>Rhode Island</td>
<td>With the help of community leaders, Rhode Island will develop a population-based plan that responds to the Rhode Island will work with the community to develop community-driven goals for the healthcare system, and use Community Health Teams to help Rhode Island will rely on input from community-based leadership to guide the transformation of Rhode Island’s care delivery system, Increasing prevention activities, statewide quality measurement and patient engagement tools are included in Rhode Island’s plan (SHIP p. 73-74), as are reducing over- Rhode Island will build on current efforts to</td>
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<td>Rhode Island</td>
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<td>Implement a set of core measures that includes tobacco use, obesity and diabetes (SIM p. 22).</td>
<td>Washington will implement regional Accountable Communities of Health (ACH) to integrate the delivery of social services and healthcare services. ACHs will work across sectors, aligning housing, education, local government and the private sector to advance population health and address the social determinants of health (SIM p. 2, 6). Washington also plans to increase the number of communities with environments that promote physical and behavioral health and health equity (SIM p. 5).</td>
<td>Washington plans to reduce tobacco use, obesity and diabetes (SIM p. 6). It will also incorporate the “Results Washington” performance targets, including children’s vaccination rates, reducing preterm birth and cesarean section rates, increasing the number of residents with a personal healthcare provider, and increasing rates of services for post-discharge mental health consumers (SIM p. 27).</td>
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<td>community organizations coordinate with primary care practices to support healthy lifestyles and address the social and environmental determinants of health and health disparities (SHIP p. 69, 75; SIM p. 4-5).</td>
<td>Primary care and patient-centered medical homes, with Community Health Homes initiative that will incentivize prevention and primary care. PCMHs will be evaluated on outcomes such as preventing avoidable ED visits and hospitalizations, controlling diabetes and high blood pressure, and screening for depression (SIM p. 22).</td>
<td>Tennessee seeks to improve population health in five priority areas: obesity, diabetes, tobacco, child health, and perinatal health (SIM p. 2, 13).</td>
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<td>Mentoring and training of unnecessary services, increasing screening and prevention, reducing health disparities, and renewing focus on the social determinants of health, among other aims (SHIP p. 94, 110).</td>
<td>PCMH providers will be incentivized to address social determinants of health through activities such as addressing enviromental asthma triggers, tobacco cessation, and connecting patients to social services (SIM p. 4). Tennessee’s project will also facilitate the sharing of real-time hospital Admitting/Discharge/Transfer (ADT) data with primary care providers and care coordinators to analyze gaps in care and prioritize resources for the most at-risk patients.</td>
<td>Tennessee plans a population-based, multi-payer patient-centered medical home initiative that will incentivize prevention and primary care. PCMHs will be evaluated on outcomes such as preventing avoidable ED visits and hospitalizations, controlling diabetes and high blood pressure, and screening for depression (SIM p. 22).</td>
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<td>Integrate behavioral health and primary care through the use of health homes and co-location (SHIP p. 90; SIM p. 8).</td>
<td>At minimum, Tennessee will measure the program's impact on rates of child immunization, self-reported health status, tobacco use, obesity, and the proportion of diabetics with 2 or more A1C tests in the past year (SIM p. 25-26).</td>
<td>By 2020, Washington will require integrated physical and behavioral healthcare purchasing (SIM p. 10-11).</td>
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Notes: Chart produced by Amy Clary

Topics: State Innovation Models
ABSTRACT Implementation of the Affordable Care Act is unleashing historic new efforts aimed at reforming the US health system. Many important incremental improvements are under way, yet there is a growing recognition that more transformative changes are necessary if the health care system is to do a better job of optimizing population health. While the concept of the Triple Aim—dedicated to improving the experience of care, the health of populations, and lowering per capita costs of care—has been used to help health care providers and health care systems focus their efforts on costs, quality, and outcomes, it does not provide a roadmap for a new system. In this article we describe the 3.0 Transformation Framework we developed to stimulate thinking and support the planning and development of the new roadmap for the next generation of the US health care system. With a focus on optimizing population health over the life span, the framework suggests how a system designed to better manage chronic disease care could evolve into a system designed to enhance population health. We describe how the 3.0 Transformation Framework has been used and applied in national, state, and local settings, and we suggest potential next steps for its wider application and use.

The US health system is both expensive and inefficient, producing less value at a higher cost than the health systems of most other developed countries while yielding strikingly large health disparities across population subgroups. These shortcomings ripple across society, affecting not only the health of the population but also the productivity of the workforce; the competitiveness of products in the global marketplace; and the ability to invest in education, economic infrastructure, and the future vitality of the nation.

The Affordable Care Act (ACA) provides an unprecedented opportunity to transform the current health care system into a multisector health system focused on producing population health. Population health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is understood that population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. Already many disruptive innovations are emerging in the form of novel payment strategies, new delivery mechanisms such as accountable care organizations (ACOs), and the rapid expansion of health information technology that have a transformative influence on the health care system. This new environment is transforming the current volume-driven payment model to one that rewards value, improves the experience of care, and promotes population health.
Making the big shift from a health care system focused on producing medical care toward a health system focused on producing health is unlikely to succeed without a strategy that is capable of aligning multiple players—across health, social, and other key sectors—in common purpose and working toward well-defined goals. The strategy must be aspirational so that people can think outside the constraints of the current system but also scientifically grounded so that there is a foundation for taking the next steps. Without a shared framework for a desired future design—something to aim for—the health care system’s complexity, geographic and organizational diversity, and shifting alliances are likely to stymie much-needed progress.

To stimulate thinking, planning, and deployment of the next generation of the US health system, we developed the 3.0 Transformation Framework. We use this operating-system metaphor to indicate the level of transformative change that is necessary and as a framework to describe the operating principles for a health system capable of optimizing health and well-being. In this article we highlight the potential utility of the 3.0 Transformation Framework using examples at the national, state, health system, and community levels. We conclude with a discussion of promising opportunities for further development and use of the 3.0 Transformation Framework to help drive transformative change at the state and local levels.

The 3.0 Transformation Framework builds on Lester Breslow’s notion that health care systems evolve and mature in response to external and internal pressures.10,11 Exhibit 1 provides an overview of how the US health system has matured over three eras and how its capability is evolving with progressive operating logics, each with its own design features and goals. The first era (1.0) emerged with modern medicine in the mid-1800s and extended through the 1950s to address infectious diseases and other immediate health threats, emphasizing acute, emergency, and rescue care to save lives. As life expectancy for men increased from forty-eight years in 1900 to sixty-six years by 1950 (fifty-one years in 1900 and seventy-two years by 1950 for women)12 and noncommunicable chronic diseases began to dominate the epidemiologic landscape, a second era (2.0) developed in response to newly attainable goals of prolonging life and decreasing disability. The emphasis was chronic disease treatment and management, together with new strategies focused on secondary prevention.

With life expectancy now approaching eighty years,12 the health system is already evolving toward a third era (3.0), with an operating logic informed by breakthroughs in life-course health science. Life-course health science explains developmental origins of health and disease patterns by elucidating how environmental exposures and social experiences, often occurring during sensitive periods of development early in life, are embedded into the function of biological and behavioral systems. The third era is par-

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**EXHIBIT 1**

<table>
<thead>
<tr>
<th>Three Eras Of Health And Health Care—Three Operating Systems</th>
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<tr>
<td><strong>First era—1.0: medical care and public health services (1850s to 1960s)</strong></td>
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<tr>
<td><strong>Definition of health</strong></td>
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<td><strong>Goal of health system</strong></td>
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<td><strong>Model of health and disease causation</strong></td>
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<td><strong>Primary focus of services</strong></td>
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<td><strong>Organizational operational model</strong></td>
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<td><strong>Dominant payment mechanisms</strong></td>
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<td><strong>Role of health and health care provider/organization</strong></td>
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<td><strong>Role of individual and community</strong></td>
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**SOURCE** Authors’ analysis.
particularly focused on these life-course influences and on optimizing population health development. The online Appendix provides a more detailed description of the evolution and characteristics of the three eras and the 3.0 Transformation Framework.13

Exhibit 2 adapts a diagram developed by the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) team to illustrate how the 3.0 Transformation Framework can be used to distinguish era-specific system design elements and to guide transformation to 3.0 systems. The transformation from a 1.0 sick care system to a 2.0 system to prevent and manage chronic disease is being driven by innovations such as the patient-centered medical home and ACOs that promote value-based care. Exhibit 2 also shows how further transformation could produce a health system more consistent with 3.0 principles: emphasizing community-accountable health systems, focusing on population health goals, and adopting new financing mechanisms.

**Making 3.0 Assumptions Explicit**

The 3.0 Transformation Framework portrays a sequential evolution of a complex health system, but it does not assume that change has been or will be inevitable or linear. The continuing metamorphosis of this complex system is in response to rapidly changing epidemiology, to policy jolts such as the implementation of Medicare and Medicaid and the passage of the ACA, and to scientific breakthroughs and disruptive innovations that are altering medical practice.

As described in Exhibit 1, the 3.0 Transformation Framework assumes that the definition of success in the health system will evolve beyond...
just improving life expectancy and minimizing disability to optimizing population health. The new 3.0 operating logic builds upon the biomedical and biopsychosocial models of disease causation, using recent breakthroughs in social epidemiology to focus more attention on the upstream social, behavioral, and developmental (that is, earlier in the life course) determinants of health. By emphasizing primary prevention, health promotion, and the multisector production of optimal lifelong health outcomes and by capitalizing on inputs from the education and housing sectors, the 3.0 Transformation Framework also suggests how the development of health, human capital, and community economics can be linked in a common purpose. For example, a 3.0 system would help individuals and community populations understand the long-term impact of their current choices (and personal and community environments) related to food intake and physical activity. Such a system would engage communities in supporting conditions such as neighborhood safety and norms such as walking and exercise. The system would also align preventive medical care with community-based health supports in the Y (formerly called the YMCA), schools, and child care centers to improve calorie intake and physical activity across the continuum of risk and need. Finally, a 3.0 system would employ innovative financing mechanisms that encourage and provide incentives for all of these actions.

Creating local systems that are capable of comprehensive approaches to health will require new ways of pooling and allocating resources, as well as innovative financing models that incorporate the long time period necessary between investment in health and accrual of long-term health, social, and economic benefits. The Robert Wood Johnson Foundation Commission to Build a Healthier America highlighted the importance of focusing health system reform strategies in this manner in two of its three recommendations in its 2014 update: Create communities that foster health-promoting behaviors, and broaden health care to promote health outside of the medical system. The specific design elements and the leadership required for significant reengineering into a 3.0 health system are still emerging. The design elements and leadership required for significant reengineering into a 3.0 health system are still emerging.

The 3.0 Transformation Framework recognizes that the health care system is evolving from simple relationships among hospitals, doctors, patients, and health insurers to complex, interdependent organizational and financing models that use complicated pricing formulas, risk-adjustment equations, and patient attribution schemes to pay for services. The next generation of the health system will require financing strategies that distribute accountability for addressing the social and developmental conditions across multiple health and human service sectors. This will likely require payment reforms such as multisector risk-based contracting or health trusts, organized to pool funds from different sectors and designed to incentivize the collaborative production of health and well-being.

If the 3.0 Transformation Framework health system is going to emerge and thrive, it will also require supportive policies that incorporate longer time horizons, in ways that are similar to other sectors such as national defense, energy, and transportation. Today, the policy framework for the health care sector prioritizes short-term rewards for existing agents and organizations. This is exemplified when the volume of services provided is rewarded irrespective of the value of the care received, when responsibility for care ends with a patient leaving a hospital, and when patient and family voices are excluded from policy development and decision making.

How The 3.0 Transformation Framework Is Being Deployed
In this section we provide early examples of how the 3.0 Transformation Framework is being used at the national, state, and local levels to advance efforts aimed at long-term transformative change. Each example represents a work in progress that will continue to evolve over time.
CENTER FOR MEDICARE AND MEDICAID INNOVATION

The CMMI was launched in 2010 with the understanding that sustainable increases in health care coverage would require transformative change in the performance of the health care system. While Triple Aim goals were adopted as the primary measure of system success, the CMMI needed to communicate the rationale for broad change to a diverse set of audiences, including providers, payers, policy makers, and the public, so the center’s population health team adapted the 3.0 Transformation Framework to provide a context for the type of innovations it hoped to catalyze (see Exhibit 2 and the Appendix). Recognizing that most current health care delivery reforms are moving the system from 1.0 to 2.0 by reengineering medical care models (for example, ACOs and medical homes) and promoting value-based purchasing and payment arrangements, the CMMI population health team saw the need to also advance 3.0 health system change strategies and facilitate early experiments to learn what works.

Starting in early 2012 the 3.0 Transformation Framework was used by the CMMI staff to frame the center’s population health strategy, as well as to describe innovative new delivery models. Using the 3.0 Transformation Framework, the CMMI staff communicated how investments in the medical home and ACO were facilitating the transition from 1.0 to 2.0; the opportunity to incorporate population health goals more explicitly into those models; and the need for community-accountable, multisector collaborations to drive the transition from the 2.0 health care system toward the 3.0 health system focused on producing population health.

Recognizing the crucial role that states will play in ACA implementation, the CMMI created the State Innovation Model program to encourage states to accelerate transformative change that would generate Triple Aim outcomes. The 3.0 Transformation Framework was used to draft the State Innovation Model Funding Opportunity Announcement, although an explicit reference to the framework was not included in the final announcement. Several states, including Maryland, Minnesota, Michigan, California, and Washington, have responded by explicitly including the development of Accountable Health Communities or equivalent local entities as part of their transformation plans. Activities in Michigan are discussed further below.

The versatility and value of the 3.0 Transformation Framework was demonstrated in the way it guided the formulation of strategy, shaped the design of models, and informed the implementation of interventions. One of the 3.0 Transformation Framework’s key attributes is how it is readily understood by a wide range of professional and lay audiences, creating a compelling vision of a desired future. Creating such common vision is essential to building and sustaining the momentum of reform.

MICHIGAN STATE INNOVATION MODEL

In Michigan, which began its State Innovation Model planning efforts in March 2013, the expansion of Medicaid under the ACA instilled a sense of urgency about the need for health system transformation and payment reform. Over the past three years Michigan’s ACOs and provider groups have increased the number and distribution of patient-centered medical homes and developed the infrastructure and care management models for patients with chronic diseases. The Michigan State Innovation Model proposal was seen as an opportunity to leverage the state’s medical home expansion initiative, creating more accountable and integrated systems and care networks. Through its Michigan State Healthcare Innovation Plan, Michigan’s State Innovation Model aspires to achieve 3.0 transformations by combining four health system elements: patient-centered medical homes, community-integrated Accountable Systems of Care, Community Health Innovation Regions, and a statewide health information exchange and performance-reporting infrastructure.

Patient-centered medical homes will manage and coordinate patient care and will be accountable for patients’ disease prevention and wellness. Accountable Systems of Care will serve as organized, vertically integrated networks that employ and contract with patient-centered medical homes. They will be responsible for facilitating cross-sector care management and health information exchange, as well as for integrating health care services over the continuum of care required by the patients and populations they serve. Accountable Systems of Care will also link the provider network to community service systems and social and economic resources, including public health and behavioral health services. Michigan’s Accountable Systems of Care model builds on the 2.0 ACO model, moving it toward 3.0 functions by addressing the social and economic determinants of health and upstream community risk factors.

The Community Health Innovation Regions are Michigan’s community organizing and engagement platforms, serving as the vehicle to connect Accountable Systems of Care with health-promoting community assets. They bring community stakeholders together to set community health improvement priorities, address community health risk factors and raise the “healthy living” capacity of the community, and act as innovation incubators.
The final component of this emerging 3.0 delivery system design is the e-health infrastructure and health information exchange backbone, allowing electronic health information to be aggregated and securely exchanged from the patient care level to the community health level.

Payment reform in Michigan aligns risk and financial rewards to incentivize the accelerated evolution toward 3.0 design elements. By moving from a fee-for-service to shared-risk and reward-based payment that incentivizes long-term health improvement, Michigan intends to provide the financial wherewithal to support sustainable transformation. While the Michigan State Innovation Model is still a plan and time will tell how well it will be implemented, the 3.0 Transformation Framework proved essential in generating a clear vision and design ideas for changing how health care is organized and paid for in the state.24

**Children in Delaware and Florida: Nemours**

Nemours, a children’s health system operating in the Delaware Valley and Florida, expanded its focus in 2003 to encompass optimal health through a vision consistent with the 3.0 Transformation Framework model. To execute this strategy, Nemours Health and Prevention Services was established to work with all systems that care for children in promoting and optimizing their health.

A community health assessment led Nemours to focus on reducing childhood obesity. Assuming the role of “integrator,” Nemours worked with partners across multiple sectors—schools, child care, primary care practices, and community-based organizations—at a population level to positively influence behavior and instill healthy eating and physical activity habits early in children’s lives. Nemours established partnerships with the early-learning community to implement new health-promoting tools at early care and education sites to engage children and families in obesity-preventing behaviors. The partnerships also promoted policy changes in state licensing regulations, improving the nutrition and physical activity standards in licensed and family child care affecting 54,000 children in Delaware.28 Through a strong partnership with the Delaware state Child and Adult Care Food Program, Nemours and partners in early care and education created learning sessions for providers implementing these standards.

In addition to changes in clinical data systems that enable improvement in the management of obese children, Nemours galvanized cross-sector partnerships with a public information campaign. The comprehensive multisector approach included working with the Delaware Parks and Recreation Department to offer healthier food options in park vending machines; helping communities institute community walk days; and spreading policy and practice system changes to schools, child care centers, youth-serving and community-based organizations, and various levels of government throughout the state. This community partnership strategy is leading to the emergence of community-accountable systems aligned intentionally to improve population health outcomes.

Despite these programmatic successes, Nemours, as a health care system, is experiencing challenges in sustaining the changes. It has come to recognize that new payment models, such as those envisioned in the 3.0 Transformation Framework, are needed to incentivize payers and providers to focus on wellness and preventive strategies instead of continuing to pay based on the volume of clinical services used to treat illnesses.

**The Magnolia Community Initiative**

The Magnolia Community Initiative near downtown Los Angeles is a prototype of a transformed system of health and human services in partnership with an engaged community.29 It strives to optimize population health outcomes by improving the conditions and long-term health trajectories for 35,000 children and their families within a 500-square-block area.

The initiative is a voluntary network of seventy organizations from multiple, diverse service sectors that include county agencies, the public school district, patient-centered medical homes, Head Start, and other social and economic support programs, working in partnership with families and other local residents. It views population health as a shared responsibility of a complex community system. Network partners strive to align their resources into a continuum of wellness supports. They use their shared understanding of health determinants (and root causes of disparities) to work as a single system to create the conditions and behaviors that influence well-being across the life course.

The Magnolia Community Initiative introduced design concepts and service delivery functions consistent with the 3.0 Transformation Framework. Instead of establishing a single, formal structure across the many sectors and organizations to direct the transformation, the partners cooperate to align the health and related services and supports that they provide. They focus on transformations that can scale, spread, and be sustained over time. For example, cross-sector partners from health, mental health, and social services use collaborative learning cycles to improve protocols for client linkage and referral across the many organizations. Another example is pooling expertise in emerging life-
The framework can facilitate transformation by providing a common language and a directional scheme to support change.

course science and practice (such as early brain development and response to toxic stress and trauma) across sectors. This enables diverse partners in health, social services, child care, and other services to incorporate new knowledge into their training and care protocols so that families experience the transformation across all types of services.

The initiative purposefully works at multiple levels (individual, neighborhood, and health system), providing care across a network of organizations to mitigate family stressors and barriers; activating people to manage their health needs; and engaging neighborhoods in change. Partner organizations and neighborhood resident champions act as a “point of entry” into a network designed to help families take advantage of local resources. A Community Dashboard, displaying population health outcomes, health behaviors, and family and social conditions, is shared regularly with leaders and staff of partner organizations to encourage systems thinking, show real-time monthly progress, promote shared accountability for results, and engage partners in a common change process. Families and residents also use run charts (graphs that display changes over time) to track their progress.

The Magnolia Community Initiative learning system equips partners in health care, education, social services, and economic and financial services to continually innovate and improve. In this way, this complex community system acts rather than plans its way toward a system that is capable of improving population-level health.

Advancing 3.0 Principles And Design Strategies

The previous examples show how the 3.0 Transformation Framework can create an expectation for transformative systems change and spark needed innovations. The 3.0 Transformation Framework design concepts and change strategies will continue to evolve as new approaches are developed and tested in practice.

The framework can also facilitate transformation by providing a common language and a directional scheme to support change. The examples show how the 3.0 Transformation Framework concepts can be applied by states, regions, and localities to adopt shared goals for optimizing health at the population level; integrate a range of health and health-related services, horizontally across sectors and longitudinally over time; use system integrators and navigators; embed services within broader systems; develop prototype design ideas for innovative 3.0 organizing structures; and engineer financing schemes that reward health improvement. By providing a vision of what a transformed health system might look like, the 3.0 Transformation Framework can also create demand for disruptive changes and new approaches to ensure that the innovations of early adopters can take hold and be sustained.

Advancing the US health care system to version 3.0 at scale will require additional work focused on four key design elements.

COMMUNITY EMPOWERMENT AND ENGAGEMENT

The 3.0 health system emphasizes not only activated patients but engaged communities and motivated populations focused on creating local conditions that support health over the life course. For individuals, this means moving beyond a 2.0 role as activated and informed patients to become designers and co-producers of their lifelong health development. This shift in how people interact with the health system is crucial for designing a more responsive system that meets population needs while personalizing care. Engagement with community partners and institutions (such as cities and community health councils) as co-developers of new health system functions is critical because 3.0 health care will increasingly focus on upstream determinants of health and will rely on this local infrastructure to engage and inform residents in ways that address these determinants.

COMMUNITY INTEGRATION FUNCTIONS

While 2.0 health systems focus mostly on the vertical integration of health care services, by intensity and cost, 3.0 systems are attempting to achieve collective and cross-sector improvements in population health through the horizontal alignment and integration of clinical, public health, and population health services and supports. To achieve collective impact, these alignment and integrating functions can be organized by a single entity (a “quarterback” organization that
serves in a connecting, integrating, and guiding role), they can be shared across different organizations, or they can be structured into what has been termed an Accountable Health Community.27,32,33

The diversity of local systems demands flexibility in how these integration functions are organized, structured, and deployed. Experimentation across a range of organizational forms and structures is needed to identify efficient ways of providing these functions, which may include stewarding an organized, cross-sector change process that spans an entire community system, the way that many community coalitions have banded together to address the obesity epidemic; facilitating agreement among multisector stakeholders on shared definitions, goals, and metrics, the way education, health, and early childhood sectors are coming together to define, promote, and measure healthy development and kindergarten readiness; building relationships across sectors to align or integrate services and collaboratively introduce new and improved interventions, the way some communities are approaching the needs of high-cost, high-need, frequent users of emergency services; and continually assessing and managing local resources to extend prevention and health optimization to the entire population, the way some communities are implementing health-in-all-policies strategies.

**FINANCING APPROACHES** While the 2.0 system focuses on achieving value, defined as the efficient production of high-quality health care services, the 3.0 system expands the concept of value to include the production of population health as a social investment. Realizing this new value proposition requires a shift in financing goals from paying for health care to paying for health. This means that a 3.0 health system requires payment methods that prioritize preventive services; health promotion efforts; and service coordination across health, social service, education, and other sectors, as well as allowing for longer time horizons. Meeting the health needs of a given community will require a broad portfolio of fiscal tools that reward investments in the development of health capital for individuals and populations across the life span. Financing tools for population health interventions are starting to be developed, including Triple Aim payment models, such as ACOs and shared-risk contracting, and new sources of capital, such as social impact bonds, as well as new ways of financing desired outcomes, such as community health and wellness trusts.17,34,35

**INFORMATION AND MEASUREMENT** Current measures and data systems are inadequate for the population health assessment, improvement, and innovation requirements of a 3.0 system. To optimize population health, the 3.0 system will need to measure population health trajectories and demonstrate the return on health investments by linking investments to health, social, community, and economic outcomes. A 3.0 health information system will need to link outcomes over time to measure the impact of longitudinal integration on health trajectories; to measure how multisector interventions affect health determinants and improve health assets; and to link individual, population, and systems measures to gauge overall system progress and performance.

**Conclusion**

Fully capitalizing on this historic opportunity to create the next version of the US health system—one that is more effective, efficient, and equitable—requires a roadmap to an alternative future. The 3.0 Transformation Framework is a useful tool for communicating how the next generation of the health system can emerge; for planning, designing, and developing the kinds of innovation and improvement strategies that might be deployed; and for organizing a learning system that can guide diverse actors, agencies, and sectors toward common health optimizing goals. Although the work will continue to be challenging, the path to a better US health system is within reach.


New Mexico Health System Innovation

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The citations listed below are examples of evidence-based activities, expert opinion, and seminal reports from the published literature that provide insight on the progress of the national healthcare transformation initiative. This list will be included on the New Mexico Health System Innovation web site: www.nmhealthsysteminnovation.org and updated on an ongoing basis. Citations about New Mexico–specific activities will be added in forthcoming editions. All information is correct as of 06/15/2015.

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Agency for Healthcare Research and Quality

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http://www.pcmh.ahrq.gov/

The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation’s primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The “primary care medical home,” also referred to as the “patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care. This web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.

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federal and state regulations and statutes related to data collection and release, and state experience with the legislative process.

Institute of Medicine, Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records; Board on Population Health and Public Health Practice
Capturing Behavioral and Social Domains in Electronic Health Records, Phase 1, 2014
Capturing Behavioral and Social Domains in Electronic Health Records, Phase 2, 2015
http://www.iom.edu/Reports/2014/EHRdomains2.aspx

Electronic health records (EHRs) provide crucial information to providers treating individual patients, to health systems, including public health officials, about the health of populations, and to researchers about the determinants of health and the effectiveness of treatment. Inclusion of social and behavioral health domains in EHRs is vital to all three uses. The Health Information Technology for Economic and Clinical Health Act and the Patient Protection and Affordable Care Act place new importance on the widespread adoption and meaningful use of EHRs. "Meaningful use" in a health information technology context refers to the use of EHRs and related technology within a health care organization to achieve specified objectives. Achieving meaningful use also helps determine whether an organization can receive payments from the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program.

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METRICS

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For the Public’s Health: The Role of Measurement in Action and Accountability, 2010
This report reviews current approaches for measuring the health of individuals and communities and suggests changes in the processes, tools, and approaches used to gather information about health outcomes and their determinants. The IOM recommends developing an integrated and coordinated system in which all parties—including governmental and private sector partners at all levels—have access to timely and meaningful data to help foster individual and community

EDM Forum
http://repository.academyhealth.org/cgi/viewcontent.cgi?article=1132&context=egems
This article describes building a framework for performance measurement of population health.

Institute of Medicine, Committee on Core Metrics for Better Health at Lower Cost
Vital signs: core metrics for health and health care progress, 2015
http://www.nap.edu/download.php?record_id=19402
This new report presents a set of core measures for health and health care defined by the above Committee and describes how their focused implementation can contribute to reducing the burden of measurement on clinicians; enhancing transparency and comparability, and most critically, improving health outcomes nationwide.

National Quality Forum
Person- and Family-Centered Care Final Report – Phase 1, March 2015
http://www.qualityforum.org/Publications/2015/03/Person--and_Family-Centered_Care_Final_Report_-_Phase_1.aspx
Ensuring that every patient and family member is engaged as partners in their care is one of the core priorities of the National Quality Strategy (NQS). Despite recent and ongoing efforts to shift the healthcare paradigm from one in which patients are passive recipients of care to one in which they are empowered to actively participate in their own care, the current state of the system has a long way to go before this shift is realized. This project sought to review measures that captured the essence of person- and family-centered care including patient and family engagement in care, care based on patient needs and preferences, shared decision-making, and activation for self-care management. NQF is undertaking this project in two phases. Phase 1, detailed in this report, examines 12 (1 newly submitted and 11 measures undergoing maintenance) experience-of-care measures. Phase 2 will review measures of functional status, both clinician and patient-assessed.

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SELECTED TERMS

Accountable Care Organization
An Accountable Care Organization is a broad spectrum of health care providers who agree to be held accountable for health care spending, quality of care and outcomes for a defined population of patients. ACOs coordinate care across multiple levels and providers, making sure patients get the care they need while aiming to eliminate waste and inefficiency.

All Payer Claims Database (APCD)
An All Payer Claims Database (APCD) is a statewide database that systematically collects health care claims data from all health care payers in order to further cost containment and quality improvement efforts. APCDs may be either mandated by state law or be private or voluntary data collection efforts.
From: http://www.healthinfolaw.org/article/APCD

Behavioral Health Care and Integrated Behavioral Health Care
Integrated behavioral health care is an emerging field within the wider practice of high-quality, coordinated health care. In the broadest use of the term, “integrated behavioral health care” can describe any situation in which behavioral health and medical providers work together. However, for the purpose of the IBHC Measures Atlas integrated behavioral health care specifically addresses the integration of behavioral health and primary care and is defined as follows:

The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

The following points serve to clarify the language used in the definition of integrated behavioral health care and to provide guidance on the contexts in which the definition can be applied.

- The term “behavioral health” is used to emphasize the broad applicability of integrated health services in medical care. Behavioral health encompasses behavioral factors in chronic illness care, care of physical symptoms associated with stress rather than diseases, and health behaviors, as well as mental health and substance abuse conditions and diagnoses. This choice was made with recognition that the term “behavioral health” may be less familiar to some audiences than the term mental health. It is also recognized that, in some circles, “behavioral health” may be used differently than it is being used here. The intention in the IBHC Measures Atlas is to be broad and inclusive in thinking about the role of behavioral health clinicians in medical settings, not to create a debate about proper terminology.

- The term “patient-centered care” reinforces that the patient is a key stakeholder in integrated care. Patient-centered care is defined as health care that establishes a
partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.[i]

- The use of the term “systematic” indicates that integration needs to be a routine part of care. Integration should be used reliably whenever appropriate for the care of the patient.
- Integrated behavioral health care teams and services do not have to be present or delivered in the same physical location to meet the definition of integrated care. While there appear to be advantages to bringing behavioral health services on site in primary care settings, such as increased likelihood that patients referred for services will follow through and the opportunity for medical and behavioral health providers to build their relationships and skills through informal interactions, increased integration can occur between clinicians and organizations that are physically separate but use shared care plans and workflows that achieve integration of care. This is considered an acceptable variation as long as the care team can fulfill the required functions of integrated behavioral health care from separate locations.

http://integrationacademy.ahrq.gov/atlas

Electronic Health Records (HER)/Electronic Medical Records (EMR)
An electronic health record (EHR), or electronic medical record (EMR), is a systematic collection of electronic health information about an individual patient or population. It is a record in digital format that is theoretically capable of being shared across different health care settings.
From: Wikipedia, accessed on 06/15/2015

Health Home
Health Home Model for Service Delivery
The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. This provision supports CMS’s overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities).

The health home service delivery model is an important option for providing a cost-effective, longitudinal “home” to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. While there is still much to learn, we expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual. Health homes can play a particularly pivotal role in improving the health care delivery system for individuals with chronic conditions. Consistent with the intent of the statute, we expect States that provide this optional benefit, and the health home providers with which the State collaborates, to operate under a “whole-person” philosophy – caring not just for an individual’s physical condition, but providing linkages to long-term community care services and supports,
social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.

From: Center for Medicaid, CHIP and Survey & Certification
Letter to State Medicaid Directors, Re Health Homes for Enrollees with Chronic Conditions, November 2010

**Health Information Technology**

Health information technology (HIT) is information technology applied to health care. It provides the umbrella framework to describe the comprehensive management of health information across computerized systems and its secure exchange between consumers, providers, government and quality entities, and insurers. HIT includes the use of Electronic Health Records instead of paper records to maintain people’s health information.

From: Wikipedia (accessed on 06/15/2015)

**Patient-Centered Medical Home**

The (patient-centered) medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient’s needs.

In 2007, the major primary care physician associations developed and endorsed the Joint Principles of the Patient-Centered Medical Home. The model has since evolved, and today the PCPCC actively promotes the medical home as defined by the Agency for Healthcare Research and Quality (AHRQ).

**Features of the Medical Home:** Adapted from the AHRQ definition, the PCPCC describes the medical home as an approach to the delivery of primary care that is:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.

- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
Accessible: Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.

Committed to quality and safety: Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

From: Patient-Center Primary Care Collaborative  https://www.pcpcc.org/about/medical-home

Meaningful Use
"Meaningful use" in a health information technology context refers to the use of Electronic Health Records (EHRs) and related technology within a health care organization to achieve specified objectives. Achieving meaningful use also helps determine whether an organization can receive payments from the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program.


Population Health
Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. Note - that population health is not just the overall health of a population but also includes the distribution of health

Upcoming State Innovation Model (SIM) Summits

June 17, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
9:30 am to 4 pm
https://www.surveymonkey.com/r/JuneSIMSummit

July 15, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/JulySIMSummit

August 19, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/AugustSIMSummit

September 16, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/SeptemberSIMSummit

October 21, 2015
Albuquerque, NM
Albuquerque Convention Center, 401 2nd St NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/OctoberSIMSummit

November 18, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/NovemberSIMSummit
December 15, 2015
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/DecemberSIMSummit
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