Health Care Innovation Initiative

Provider Stakeholder Group
January 27, 2016

Agenda

- **Patient Centered Medical Homes: requirements, quality measures, timeline, and scale up**
- Health Homes: requirements, quality measures, and timeline
- Care Coordination Tool
- Episodes of Care: Wave 5 Technical Advisory Groups

Primary Care Transformation: Overall Timeline

Tennessee's timeline for PCMH and Health Home rollout:

2016	2017	2018
• June - August: Pilot of Care Coordination Tool • July : Launch PCMH Wave 1 • July/Aug: Provider training and technical assistance begins • October: Launch Health Homes statewide for TennCare members with acute Behavioral Health needs	• Jan: Expand PCMH to Wave 2 practices • Provider training and technical assistance ongoing	• Jan: Expand PCMH to Wave 3 practices • Provider training and technical assistance ongoing

Tennessee's goal is to enroll 65% of TennCare members in a PCMH practice by 2020

TAG recommendation on requirements for PCMH

	What is required	What is not required (examples)
Eligibility requirements	• Stated commitment to the program • Minimum panel size requirement of [500] patients with a single MCO with vision to broaden as we scale up to be inclusive of multiple MCOs over time • TennCare practice type (i.e., adults, pediatrics, internal medicine, geriatrics) with one or more PCPs • Use of Care Coordination Tool – Create unique ID and identify roles – Completion of training – Use of Tool for care transitions • Designation of PCMH Director[1] – No licensure requirement – Ongoing physical presence required	• No EHR requirement • For personnel: – No licensure requirements within current scope of practice – No staffing ratio requirements Suggested ratios for care team to be provided to PCMHs
Activity requirements	• Register for NCQA • Complete Tennessee-specific framework of NCQA activities as follows	• NCQA recognition criteria (i.e., Levels 1, 2, 3)

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1 Practices to define roles of clinical and non-clinical members of practice team as an activity requirement

TAG recommendation on requirements for PCMH: Select NCQA elements

Clinical impact filter

Learnings from other states filter

Ease of administration filter

27 NCQA Elements → Activities recommen-ded by TAG → **20 elem-ents** → Activities shown to improve quality and value in other states → **14 el.** → Activities with effective reporting and collection methods → **11 elem-ents for discus-sion**

20 of 27 Elements recommended by TAG

- Feedback has focused on 3 questions:
  - What can physicians do differently to have a major impact on patients
  - What will have the greatest impact on total cost of care
  - State readiness (e.g., EHR)

PCMH examples in other states have demonstrated highest value elements

- Inputs case studies and research to identify most valuable Elements
- Amended some NCQA elements and factors to help meet TennCare goals

Tracking and monitoring of activities were worthwhile and not burdensome

- Elements and factors with high ease of documentation and execution in selection process preferred over alternatives

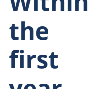
TAG recommendation on PCMH activity requirements (1/4)

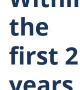
✓ Initial capability required
▲ Ongoing activity review

Standard	Elements with descriptions	Required factors	Within the first 6 mo.	Within the first year	Within the first 2 years	Ongoing beyond year 2
1 Patient-centered access	**Patient-centered appointment access (Element A)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on the required factors	• Provide same-day appointments for routine and urgent care[1]	✓	▲	▲	▲
		• Provide routine and urgent care appointments outside regular business hours[1]	✓	▲	▲	▲
	24/7 Access to Clinical Advice (Element B) The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:	• Providing timely advice by telephone[1]	✓	▲	▲	▲
	Electronic Access (Element C) The following information and services are provided to patients/families/ caregivers, as specified, through a secure electronic system	• Clinical summaries are provided within 1 business day for more than 50% of office visits[1]			✓	▲
2 Team-based care	**The practice team (Element D)** The practice uses a team to provide a range of patient care services by:	• Defining roles for clinical and nonclinical team members[1]	✓	▲	▲	▲
		• Identifying team structure and the staff who lead and sustain team based care	✓	▲	▲	▲
		• Holding scheduled patient care team meetings or a structured communication process focused on individual patient care	✓	▲	▲	▲

1 Recommended by TAG member

TAG recommendation on PCMH activity requirements (2/4)

 Initial capability required

 Ongoing activity review

Standard	Elements with descriptions	Required factors	Within the first 6 mo.	Within the first year	Within the first 2 years	Ongoing beyond year 2
3 Population health management	**Use data for population management (Element D)[1]** At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:	• At least three different chronic or acute care services[1]				
		• Patients not recently seen by the practice[1]				
	Implement evidence-based decision support (Element E)[1] At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines for:	• A mental health or substance use disorder[1] • A chronic medical condition[1] • An acute condition[1] • A condition related to unhealthy behaviors[1]				

1 Recommended by TAG member

TAG recommendation on PCMH activity requirements (3/4)

✓ Initial capability required
▲ Ongoing activity review

Standard	Elements with descriptions	Required factors	Within the first 6 mo.	Within the first year	Within the first 2 years	Ongoing beyond year 2
4 Care manage-ment support	**Identify patients for care management (Element A)** The practice [*shares a list developed through a systematic process as identified by the Care Coordination Tool of at least top 10% of patients*][1] who may benefit from care management. The process includes consideration of the following:	• Behavioral health conditions[2] • High cost/high utilization[2] • Poorly controlled / complex conditions • Social determinants of health[2] • Referrals by outside organizations				
	Care planning and self-care support (Element B) The care team and patient / family / caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for 75% of all patients prioritized for care management [*i.e., top 10% of patients across various factors*][3]:	• Incorporates patient preferences and functional / lifestyle goals • Identifies treatment goals • Assesses and addresses potential barriers to meeting goals[2] • Includes a self-management plan[2] • Is provided in writing to the patient / family / caregiver[2]				
	Use electronic prescribing (Element D) The practice uses an e-prescription system with one of the following capabilities[4]:	• More than 50% of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies • Performs patient-specific checks for drug-drug and drug-allergy interactions • Alerts prescribers to generic alternatives				

1 [Text] added to above NCQA Element A to specify target population as most high risk patients
2 Recommended by TAG member
3 [Text] is consistent with NCQA's intention to tie Element B with Element A above
4 NCQA does not specify "one of the following"; instead gives a higher score for meeting more factors

TAG recommendation on PCMH activity requirements (4/4)

✓ Initial capability required
▲ Ongoing activity review

Standard	Elements with descriptions	Required factors	Within the first 6 mo.	Within the first year	Within the first 2 years	Ongoing beyond year 2
5 Care coordi-nation and care transit-ions	**Referral tracking and follow-up (Element B)** The practice will do the following:	• Track referrals until the consultant or specialist's report is available, flagging and following up on overdue reports[1]		✓	▲	▲
	Coordinate care transitions (Element C) The practice will do the following:	• Consistently obtains patient discharge summaries from the hospital and other facilities[1]		✓	▲	▲
		• Proactively identifies patients with unplanned hospital admissions and emergency department visits[1]		✓	▲	▲
		• Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit[1]		✓	▲	▲
		• Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners			✓	▲
6 Perform-ance measure-ment and quality improve-ment	The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience[1]	No elements or factors required for this standard				

1 Recommended by TAG member

PCMH TAG recommendations on quality metrics

	Core measures used	Measures for reporting only
Quality metrics for adults	• Diabetes: Nephropathy • Diabetes: Retinal exam • Diabetes: BP < 140/90 • Asthma medication management • Adult BMI screening • Antidepressant medication management • Controlling high blood pressure	• Avoidance of antibiotics in adults with acute bronchitis • Influenza immunization • Tobacco use: screening and cessation intervention • Screening for clinical depression and follow-up plan • Substance abuse and intervention
Quality metrics for children	• Immunizations for adolescents • EPSDT screening rate[1] • Asthma medication management • ADHD/ADD follow-up care • Childhood immunizations • Weight assessment and nutritional counseling	• Appropriate treatment for children with URI • Substance abuse screening and intervention • Screening for clinical depression and follow-up plan • Influenza immunization
Efficiency metrics	• Total cost of care • Inpatient admissions per 1000 members • Emergency department admits per 1000 members • Generic dispensing rate • Outpatient specialty visits per 1000 members	• Avoidable ED share of ED visits • PCP visits per 1000 members • Inpatient average length of stay • Ambulatory sensitive inpatient admits per 1000 • Ambulatory sensitive ED visits per 1000

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1 Includes four separate measures

PCMH application and selection timeline

	Finalize and release PCMH application	PCMH applications due back to State	Selection of Wave 1 and 2 practices
Timing:	*By March 15, 2016*	*By April 15, 2016*	*By May 15, 2016*
Stage:	Discuss potential PCMH application and provide information for potential respondents	Practices to submit applications, with State fielding questions as needed	Select and inform practices for Wave 1 and Wave 2 inclusion
Key milestones:	• Finalize PCMH application • Publish supporting information on website to provide context for potential applicants • Open application to potential respondents	• State to field questions as needed	• State to synthesize results of application and communicate initial waves to practices and other stakeholders

PCMH scale-up: Five-year road map

	2016	2017	2018	2019	2020	2021

Wave 1
- Practices identified by application[1]

First wave to be a soft launch to align with care coordination tool pilot

Wave 2
- All practices meeting requirements eligible to enroll[2]

Wave 3

Wave 4

Wave 5

PCMH reporting begins

PCMH pooling begins

State-led capability building

End of SIM grant period

View shown includes:
- 3-month enrollment period: Oct to Jan
- 12-month performance period: Jan to Jan

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[1] Total cost of care to be calculated on an 18 month basis to ensure that cohorts are on a common timeframe

2 State may exercise ability to cap enrollment depending on rate of applications

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- Care Coordination Tool
- Episodes of Care: Wave 5 Technical Advisory Groups

TAG recommendation on Health Home provider requirements

Recommendations not yet final

Potential requirements

Eligibility require-ments

- **Provider type:** CMHC (all are eligible) _or_ other qualified Health Home provider (i.e., mental health clinic, FQHC, PCP, BH specialty, or BH residential facility) with at least [250] patients[1,2]
- **Stated commitment** to collaboration with primary care (i.e., documentation of agreement of collaboration with PCP)
- **State care coordination tool:** Adoption of care coordination tool (i.e., creation of ID and identification of roles)
- **e-Prescribing:** Documented plan to progress toward CMS e-prescribing requirements by October 2018[3]

Personnel

- **1 identified Health Home administrator** to act as point of contact
- **Identification of a care team, including:**
  - Clinical care coordinator(s): Employed Registered Nurse to coordinate with medical professionals
  - Case manager(s) to be primary point of contact for patient and family relationship
- **Capability to provide behavioral health services** onsite (i.e., either on staff or through affiliation), with either:
  - A **psychiatrist**, or
  - **Psychologist** and an **MD**
- **Training / continuous learning** participation

Suggested guidelines for staffing ratios to be provided to Health Homes

Activities (*detail in appendix*)

- **Integrated care plan**
- **Patient relationship**
- **Transitions of care**
- **Engage medical providers**
- **Engage behavioral health providers**
- **Engage supportive services**
- **Population health management**

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1 Based on Health Home assignment process
2 Exceptions may be made for rural areas or counties in which there wouldn't otherwise be a Health Home
3 CMS e-prescribing requirements include exchange of medication history, formulary and benefit information, and fill status notification, among others

Health Home TAG recommendations on quality metrics

Recommendations not yet final

Behavioral health quality measures

Core measures used

- 30-day Psychiatric Hospital / RTF Readmission rate
- 7-day Psychiatric Hospital / RTF Readmission rate
- Follow-up after hospitalization for mental illness within 30 days
- Follow-up after hospitalization for mental illness within 7 days
- Suicide Risk Assessment[1]
- Antidepressant Medication Management[1]
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents[2]

Measures for reporting only

- Prescription fill rate for behavioral-health related medications
- Use of Multiple Concurrent Antipsychotics[1]
- Initiation and engagement of alcohol and other drug dependence treatment
- Care transitions: Timely transmission of transition record (i.e., within 24 hours)
- Social heath metrics (e.g., employment, housing)
- Substance use screening performed
- Rate of substance use disorder identification[1]

Physical health quality measures

Core measures used

- Nephropathy for patients with diabetes[1]
- Retinal exam for patients with diabetes[1]
- BP < 140/90 for patients with diabetes[1]
- Asthma medication management
- Adult BMI screening[1]
- Controlling high blood pressure[1]
- Immunizations for adolescents[2]
- EPSDT screening rate[2]
- Childhood immunizations[2]
- Weight assessment and nutritional counseling[2]

Measures for reporting only

- Diabetes screening for people prescribed antipsychotic medications[1]
- Cardiovascular health screening for people prescribed antipsychotic medications[1]
- Annual monitoring of patients on persistent medications[1]
- Infections disease (e.g., Hepatitis C, HIV, TB) screenings performed[1]

Efficiency measures

Core measures used

- Rate of inpatient psychiatric admission
- Psychiatric inpatient days
- ED utilization for behavioral-health related causes
- Inpatient admissions per 1000 members
- ED visits per 1000 members
- All-cause readmission rate
- Rate of residential treatment facility admissions

Measures for reporting only

- Rate of residential substance abuse admissions
- Rate of crisis stabilization service admissions
- Efficiency measures for populations with history of previous admissions
- Use of home and community based services
- Use of after-hours care

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1 For adults only
2 For children/ adolescents only

Health Home provider application and selection timeline

	Provider Readiness Assessment	Health Home Application	Health Home implementation
Timing	*January – March 2016*	*April – May 2016*	*June – Oct 2016*
Objective	Identify preparedness of likely Health Home providers for the upcoming application and determine level and nature of support required	Identify qualifying Health Home providers in Tennessee based on a set of objective criteria	Finalize each provider's member panel and prepare for October 1 go-live
Key milestones	• Short list of likely Health Home providers identified • Communication sent to providers • Readiness assessment released (mid-February) • Providers complete readiness assessment	• Health Home applications open to providers • Providers complete Health Home application • State approves Health Home applications • Final Health Home designations shared with providers	• MCO-provider contract amendments • Health Home member identification and assignment to Health Homes by MCOs • Communication of Health Home assignment to patients • MCOs reassign patients to preferred Health Homes • Health Home go-live

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- **Care Coordination Tool**
- Episodes of Care: Wave 5 Technical Advisory Groups

Request For Proposal for Care Coordination Tool

EVENT	DATE (all dates are state business days)
Response Deadline	January 14, 2016
Contractor Signature Deadline	February 10, 2016
Contract Start Date	March 1, 2016

Care Coordination Tool RFP can be found here: https://www.tn.gov/assets/entities/generalservices/cpo/attachments/RFP_31865-00410_Base_through_Amend_5.pdf

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- **Episodes of Care: Wave 5 Technical Advisory Groups**

Episodes of Care – Wave 5 Technical Advisory Groups

The Tennessee Health Care Innovation Initiative is seeking nominees for clinical experts to advise on the design of Wave 5 episodes of care.

We are looking for clinicians in the following specialties who are thought leaders in their fields, representative of practicing providers, enthusiastic about improving care delivery, and available to attend all TAG meetings (for the topic they are nominated) in Nashville.

The next episodes of care to be designed and implemented in Tennessee will be:

- Breast cancer mastectomy
- Breast cancer medical treatment
- Breast biopsy
- Tonsillectomy
- Otitis
- Anxiety
- Chronic depression

Episodes of Care – Wave 5 Technical Advisory Groups

TAG Topic	TAG Member Specialties	TAG Schedule
Breast Cancer Mastectomy, Breast Cancer Medical Treatment, and Breast Biopsy	PCPs, breast radiologists, interventional radiologists (who perform guided biopsies) breast surgeons, pathologists, medical oncologists, radiation oncologists, palliative care specialists, plastic surgeons, anesthesiologists, OB/GYNs, general surgery, reproductive endocrinologists	• Tuesday, March 15, 2016 (1PM-4PM CT) • Tuesday, April 5, 2016 (1PM-4PM CT) • Tuesday, April 26, 2016 (1PM-4PM CT) • Tuesday, May 10, 2016 (1PM-4PM CT)
Tonsillectomy and Otitis	Pediatricians, ENTs, pediatric anesthesiologists, audiologists, pediatric infectious disease	• Wednesday, March 23, 2016 (9AM-12PM CT) • Wednesday, April 13, 2016 (9AM-12PM CT) • Wednesday, May 4, 2016 (9AM-12PM CT)
Anxiety and Chronic Depression	PCPs, psychologists, psychiatrists, licensed clinical social workers and/or therapists, (providers that treat children, adolescents, and adults)	• Wednesday, March 30, 2016 (9AM-12PM CT) • Wednesday, April 20, 2016 (9AM-12PM CT) • Wednesday, May 11, 2016 (9AM-12PM CT)

Instructions for nominating

For each nominee, please provide the following information. All nominations are due to payment.reform@tn.gov by **Friday, January 29**.

- Nominee name:
- Name of TAG nominated for:
- Email address:
- Phone number:
- Nominee specialty and subspecialty:
- Practice location (City):
- Practice name/Facility affiliation:
- A brief description (one paragraph is fine) of why the nominee would be a good TAG member:

Clinicians can nominate themselves. Nominees are not required to be familiar with episodes of care. There is no reimbursement for participating in the TAG.

Appendix:
Detail on PCMH quality measures
Detail on Heath Home activity requirements

PCMH TAG recommendations on core quality metrics for adults (1/2)

Recommended measure	Details	Source
Diabetes: Nephropathy	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy	• HEDIS
Diabetes: Retinal exam	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who had an eye exam (retinal) performed	• HEDIS
Diabetes: BP < 140/90	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	• HEDIS
Asthma medication management	• The % of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure would be the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment	• HEDIS

PCMH TAG recommendations on core quality metrics for adults (2/2)

Recommended measure	Details	Source
Adult BMI screening	• % of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	• HEDIS
Antidepressant medication management	• % of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime; report • Acute phase - % who remained on meds 84 days (12 weeks) • Continuation phase - % who remained on meds for 180 days (6 months)	• HEDIS
Controlling high blood pressure	• % of patients ages 18-59 and 60-85 who had a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90) during the measurement year	• HRSA, HEDIS

PCMH TAG recommendations on adult quality metrics for reporting only

Recommended measure for reporting	Details	Source
Avoidance of antibiotics in adults with acute bronchitis	• The % of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	• HEDIS
Influenza immunization	• The % of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	• NQF
Tobacco use: screening and cessation intervention	• The % of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	• NQF
Screening for clinical depression and follow-up plan	• The % of Medicaid enrollees age 18 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen	• HEDIS
Substance abuse screening and intervention	• The % of patients aged [18 years][1] and older who were screened at least once within 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	• NQF[2]

Additional measures may be added for reporting only [e.g., pneumococcal vaccine for high risk patients]; core and reporting only measures may change over time

1 Medical record review is required to determine exclusions for denominator

PCMH TAG recommendations on core quality metrics for children (1/2)

Recommended measure	Details	Source
Immunizations for adolescents	• The % of adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap or one Td by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.	• HEDIS, CHIPRA
EPSDT screening rate	• The % of members who turned 15 months old during the measurement year and who had 6 or more well child visits with a PCP from 31st day from birth to 15 months of life[2] • The % of members 16 months - 3 years who 2 or more well child visits with a PCP during the measurement year • The % of members 4 years – 11 years of age who had 1 or more well child visits with a PCP during the measurement year • The % of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	• HEDIS / HEDIS-like
Asthma medication management	• The % of members 5-64 years of age during the measure-ment year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure would be the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment	• HEDIS, CHIPRA
ADHD/ADD Follow-up Care	• The % of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed (including both Initiation Phase of 30 days and Continuation and Maintenance phase of 270 days for members 6-12 years of age)	• HEDIS, CHIPRA

1 HEDIS "Well Child visits in the first 15 months of life" measure does not cover prenatal, newborn, 3-5 day, and 'by 1 month' preventive visits listed in the Bright Futures periodicity schedule

PCMH TAG recommendations on core quality metrics for children (2/2)

Recommended measure	Details	Source
Childhood immunizations	• The percentage of children 2 years of age who had 4 DTaP), 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	• HEDIS, CHIPRA
Weight assessment and nutritional counseling	• Weight assessment and counseling for nutrition and physical activity for children/adolescents ages 3-17 including BMI	• HEDIS, CHIPRA

PCMH TAG recommendations on children quality metrics for reporting only

Recommended measure for reporting	Details	Source
Appropriate treatment for children with URI	• The % of children 3 months—18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription	• HEDIS
Substance abuse screening and intervention	• The % of patients aged [18 years][1] and older who were screened at least once within 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	• NQF[2]
Screening for clinical depression and follow-up plan	• The % of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	• NQF
Influenza immunization	• The % of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	• NQF

Additional measures may be added for reporting only [e.g., AAFP lipid screening measure, rotavirus]; core and reporting only measures may change over time

1 NQF measure is for 18 and older; can use a younger age range, e.g., 12-18, for children's measure
2 Measure steward: American Society of Addiction Medicine

TAG recommendation on Health Home activity requirements (1/3)

	Activity requirements for Health Home providers	Required starting Year 1	Required starting Year 2	Core element of L2 CM
Care plan	**Create and update care coordination plan** in collaboration with the patient, which addresses barriers to treatment adherence and crisis management	✓		✓
	Develop behavioral health treatment plan within 30 days of patient engagement and incorporate input from communication with PCMH / PCP within 90 days	✓		
	Participate in medical treatment plan development	✓		
Patient relationship	**Check ins with patient** to support treatment adherence	✓		✓
	Provide high-touch in-person support to ensure treatment and medication adherence (e.g., medication drop-off, transportation to appointments)	✓		✓
	Provide additional high touch support in crisis situations when other resources are unavailable, or as an alternative to ED / crisis services	✓		
	Educate the patient and his/her family on independent living skills with attainable and increasingly aspirational goals	✓		

TAG recommendation on Health Home activity requirements(2/3)

	Potential activity requirements for Health Home providers	Required starting Year 1	Required starting Year 2	Core element of L2 CM
Transitions of care	**Receive ADT notifications** for the patient	✓		
	Participate in development of discharge plan for each hospitalization, beginning at admission	✓		
Engage medical care providers	**Supports scheduling and reduce barriers to adherence for medical appointments**, including in-person accompaniment to some appointments	✓		✓
	Follow up with PCP to understand significant changes in medical status, and translate into care plan	✓		
	Proactive outreach with PCP regarding specific gaps in care	✓		
Engage behavioral health providers	**Supports scheduling and reduce barriers to adherence for behavioral health appointments**, including in-person accompaniment to some appointments	✓		✓
	Follow up with behavioral health provider to understand behavioral health needs, and translate into care plan	✓		

TAG recommendation on Health Home activity requirements(3/3)

	Potential activity requirements for Health Home providers	Required starting Year 1	Required starting Year 2	Core element of L2 CM
Engage supportive services	**Facilitates access to community supports** (food, shelter, clothing, employment, legal, entitlements), including scheduling and follow through	✓		✓
	Communicate patient needs to community partners	✓		
Population health manage-ment and supporting capabilities	**Track and report on program's quality outcomes**	✓		
	Continuously identify highest risk patients and align with organization to focus resources and interventions	✓		
	Participate in practice transformation training and learning collaboratives on such topics as patient / family education, recovery education, and evidence-based medicine	✓		
	Participate in regular inter-disciplinary care team meetings with PCMH / PCP		✓	
	Meet CMS e-prescribing requirements		✓	