Proposed Provider Accountabilities for Model Success
Reference for June 2021 HCA Stakeholder Survey

Accountability #1

Whole-person care. Provider is accountable for providing or coordinating a full range of primary care services to attributed patients

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Reports that it routinely offers all the following categories of services: 1) acute care for minor illnesses and injuries 2) ongoing management of chronic diseases including coordination of care 3) office-based procedures and diagnostic tests 4) preventive services including recommended immunizations 5) patient education and self-management support	Practice has established care management agreements with specialists, medical, behavioral health, and community support resources, and members of the care team can document how to use the agreements Practice has integrated care and/or has established care management agreements as necessary with specialists and community support resources, and members of the care team know how to use those care management agreements to ensure prompt access to care 24/7	Systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level Provision of comprehensive care, and a process for coordination of care, has led to measurable changes in quality and cost of care

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Accountability #2

A team for every patient. Active patients are assigned or attributed to a primary care team for advanced clinical judgment. The primary care team may or may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team.

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Care is organized by teams responsible for specific patient panels. Practice reviews payer attribution lists on a quarterly basis Reports the percentage of patients empaneled or attributed to a high-functioning care team to provide and coordinate care Utilizes written job descriptions including defined roles and responsibilities for all members of the care team	Achieves goal of 75% of patients attributed to a high-functioning care team to provide and coordinate care Consistently implements team-based care strategies (huddles, care management meetings, high risk patient panel review, etc.). Practice has designed and implemented processes for validating care team assignments	Achieves goal of 95% of patients attributed to a high-functioning care team to provide and coordinate care Care teams consistently address physical and behavioral health needs using shared operations, workflows, and formal protocols. Practice policies support empanelment including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage

Accountability #3

Behavioral health screening and follow-up. Practices uses an evidence-based tool to screen for behavioral health issues AND has a documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up.

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Has evaluated and identified behavioral health resources for patients/families	Actively tests use of an evidence-based screening tool for behavioral health concerns (including depression, maternal depression, developmental delays, substance use disorders, tobacco use, and other unhealthy behaviors) Has documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up	Practice screens and follows up as needed with at least 90% of patients/families for substance use disorder and/or other behavioral health needs.

Accountability #4

Risk stratification. Practice has and uses a documented risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs.

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Has a documented risk stratification strategy	Has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families Proactively manages patient panel and documents outcomes	Stratifies 95% of its patient population according to health risk such as special health care needs or health behavior Has a documented care plan for high-risk patients and families reflected in EHR

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Accountability #5

Patient support. Ensure patients' goals, preferences, and needs are integrated into care through advance care planning (Transformation Metric)

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Has identified mechanisms for patients to provide input and feedback, including on transformation activities and progress Ensures patient feedback is documented, reviewed on a quarterly basis, and used to improve care	Has established mechanisms for patients to provide input and feedback, including on transformation activities and progress (such as regularly convening patients and families) Identifies subpopulation(s) of patients and caregivers for engagement in advance care planning Engages in shared decision making that respects their personal goals	Has established workflows and protocols for use of shared decision aids and self-management support tools Has established mechanisms for patients to provide input and feedback, including on transformation activities and progress Convenes patients and families at least 2 times per year Engages subpopulations of patients in advance care planning

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Accountability #6.

Care coordination strategy. Practice has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families, AND proactively manages care gaps and documents outcomes, for example, using and documenting care plans.

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Demonstrates basic ability to track referrals to consulting specialty providers Contacts 90% of patients within 72 hours of hospitalization or ED visit, including medication reconciliation	Builds out capacity and documentation for care coordination strategies with team and with external health and social supports Routinely reviews all available cost data to identify utilization and cost drivers for majority of empaneled patients Practice has a QI/Operations team that documents, implements, and track improvements to reduce total cost of care, and appropriate utilization	Provides description of approach and demonstrates its process for identifying and providing or arranging the care of 90% diverse patients with complex care needs Provision of comprehensive care, and a process for coordination of care, has led to measurable changes in quality and cost of care.

Accountability #7

Expanded access. Same day appointments, 24/7 clinical advice, 24/7 e-health, telephonic access, and communication through IT innovations are offered for both physical AND behavioral health and integrated into care modalities.

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Basic capacity includes access to at least 50% of expanded access strategies listed above are in place	At least 50% of expanded access strategies listed above are in place for both physical and behavioral health	Expanded access capabilities fully in place for both physical and behavioral health

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Accountability #8

Culturally attuned care. Provides access to care that is culturally supportive in location, translation services, and demographic composition. Practice regularly offers at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours in early mornings, evenings, and weekends.

Translation services for languages common among the patient population are available that include:

- providers who speak a patient and family's language,
- presence of a certified interpreter, or
- telephonic interpreter.

Family or friends are not used to translate during a clinical encounter

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Translation services for languages common among the patient population are available	Translation services for languages common among the patient population are available At least one alternative to traditional office visits is available on a limited basis	Translation services for languages common among the patient population are available Provider composition reflects patient composition Multiple alternatives to traditional office visits are regularly available

Accountability #9

Health literacy. Patient-facing forms and information that are:

- Are readable at an 8th grade reading level
- Are available in languages that reflect the patient population
- Are available in accessible formats (e.g., braille, large print, audio)
- Use inclusive, non-stigmatizing language
- Reaffirm the confidentiality of information

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Patient-facing forms and information are written at the appropriate level and are available in languages that reflect the patient population	Patient-facing forms adhere to all standards and are available in several accessible formats.	Patient-facing forms adhere to all standards and are available in all accessible formats.

Accountability #10

Data capacity. Build capacity to query and use data to support clinical, population health, and business decisions. Including:

- Clinical decisions.
- Population Health. Data from care delivery sites is collected and aggregated to understand variation in care and look for underlying issues such as disparities in access or services.
- Quality and Performance monitoring. Data on performance is regularly reviewed and used to inform practice processes
- Interconnectivity. Connection of providers to the broader health care ecosystem through some mechanism that supports interoperability, such as a Health Information Exchange (HIE) that supports a longitudinal patient-centric record and near/real time alerts to support

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Processes exist for incorporating data informed process changes. Reviews data at least quarterly and conducts regular QI activities Has capacity to send and receive data to plans	Incorporates analytic tools into team workflows Has identified model and process for quality improvement using data Ensure accurate and up to date provider data to payers for overall network monitoring Uses EHR clinical quality measures to provide regular panel reports on measures.	Demonstrated bidirectional data exchange capabilities with plans and other data sources. Uses data to inform practice strategy and interventions. Is connected to HIE and receives alerts. Uses available resources including payer claims data to drive quality improvement processes and sustain outcomes. Applies data-driven quality improvement processes for all patients and all providers (e.g., not limited to identifying gaps in care and closing them one patient at a time).

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Accountability #11.

Aligned measurement of value. Use aligned metrics to measure value

Level 1: Meets Minimum Participation Standards	Level 2: Working Toward Transformation	Level 3: Implementing Model with Fidelity
Has a documented plan to systematically measure and track physical health outcomes Practice has built capacity for continuous quality improvement	Has a documented plan to systematically measure and track both physical and behavioral patient outcomes Systematically measures and tracks patient physical and behavioral health outcomes at population level	Provide timely metric data to show progress from investment Systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level Routinely documents and implements protocols to identify and manage care of high-risk patients, including those with behavioral health conditions Practice can document measurable changes in quality and cost of care.