**Strengthen Primary Care-** Support the transition to and continuation of a Medical Home/Health Home care model that is partnered with a Community Care Team. This support consists of technical assistance with the transition, certifications needed and Learning Collaboratives for the transition and continuation of the care model. For large population based models, ACOs, quality metrics will be the standard for assessing effectiveness and value.

Additionally there will be data collection, analysis and reporting that empower this model of care to advance beyond the one patient visit to a more broad population based approach to care management.

* Long-term use of Learning Collaboratives
* Change in the functionality of a medical office to include care management and use of social support structures
* Long-term use of Community Care Teams for high utilization and at risk patients with chronic conditions
* Accountability for attaining quality standards
* Use of EMRs

**Integrate Physical & Behavioral Health-** Support the transition to and continuation of a Behavioral Health Home. This is an entity which goes beyond supporting and caring for a person’s behavioral health condition and incorporates care and management of the person’s physical health. This support includes technical assistance with the transition to a Behavioral Health Home model as well as use of Learning Collaboratives for the transition to and continuation of the care model. Unique to this new model is the integration with primary care through data sharing and established means of communication. Unique to BHH will be the initiation of Electronic Health Records through support from SIM grant funds.

* Behavioral Health Quality Metric development and utilization
* Long-term use of Learning Collaboratives
* Connection with a medical Health Home for each BHH patient
* EHR utilization
* Use of treatment modalities
* Accountability for attaining quality standards
* Workforce will understand and manage Behavioral Health issues and information

**Develop New Workforce Models-** This will involve both re-educating workers within the current healthcare delivery system and creating new roles for future healthcare workers. To this end leadership skills must be developed in change agents and new skills for current workers to meet the new expectations placed upon them in the new Health Home model of care. Additionally, a new role of Community Healthcare Worker will need to be developed and implemented.

* Establish a pilot project for Community Health Workers
* Establish a training program for Leadership Development
* Learning Collaboratives
* Case Managers will better understand and manage integration with medical, behavioral health, and LTS services for individuals with Intellectual and Developmental Disabilities

**Develop New Payment Model-** New models of payment will be in place to match the new delivery of care model. Reimbursement will follow value and value will be placed on quality & outcome as opposed to volume. New models of potential insurance design will be developed. Reimbursement for quality and outcome will replace volume.

* Bundled Payments
* PMPM payments allowing for use of non-billable interventions
* Payment for outcome measures
* Payment for quality metrics
* Shared Savings

**Centralized Data and Analytics-** Consensus will exist around what data to use for analysis, transparency of analysis and reports will be the norm and information for patients, providers and the public will be actionable.

* Practice level reports
* Provider level reports
* Notification of utilization patterns
* Metrics for tracking cost of care
* Alignment of metrics and reduction of the number of metrics used

**Engage People & Communities-** Patients will have access to their personal health information and the public will have access to information on quality and cost. For the community there will be a new workforce( Community Health Worker) and a new program- Diabetes Prevention Program. The community will become part of the health outcomes of its people.

* Diabetes Prevention Program
* Community Health Workers
* Connection between community services and health homes, both medical and behavioral
* Patient Provider Partnerships
* Shared Decision Making

In short healthcare will no longer be about the single office visit and the care of the immediate concern. Instead healthcare will strive for best outcome at the correct cost utilizing a comprehensive engagement of all.