Patient Centered Medical Home: A Neighborhood Approach

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Palmetto Health

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Palmetto Health.. Who we are…

- Palmetto Health is the region's most comprehensive, locally owned, not-for-profit health care resource for the community
- Palmetto Health is a 1,138 bed integrated health system, a Joint Commission accredited institution, has more than 8,400 employees and 1,000 affiliated physicians

Palmetto Health Facilities

- Palmetto Health Richland (649 beds)
- Palmetto Health Baptist (489 beds)
- Palmetto Health Parkridge (under development)
- Palmetto Health Children's Hospital
- Palmetto Health Heart Hospital

Patient Volumes:

- 500,000 patients,
- 6,600 deliveries,
- 80,000 pediatric patients,
- 3,000 cancer patients,
- 160,000 Emergency Department visits,
- 32,000 home care visits.

Palmetto Quality Collaborative
What is an ACO?

1. **Infrastructure ACO-** Providers build an infrastructure such as IT, practice guidelines, data analytics
2. **Pre-ACO** - Integrated delivery system with infrastructure to mange populations and the ability to manage risk
3. **CMS Shared Savings ACO-** organization of providers accountable for costs and quality for a group of Medicare beneficiaries

How we began….

Total Optimal Integration

- In early 2009, Palmetto Health undertook *Total Optimal Integration (*TOI*)* to partner with physicians to improve quality and efficiency of care.
- TOI improves coordination of inpatient, outpatient and ambulatory care through redesigning patient care processes, services, physical location and patient convenience.
- Clinical Integration ultimately emerged as the best vehicle to implement TOI.

PHQC has established six key operating principles:

- We make the patient the focus of all our efforts.
- We invest the appropriate resources necessary for achieving quality patient outcomes and efficiency.
- We provide coordination across the continuum of care.
- We work as an integrated team, Palmetto Health and its physicians partners, to achieve the best results for our patients.
- We provide the highest value of care for our community.
- We operate in an ethic of trust, integrity, respect, stewardship, and open communication

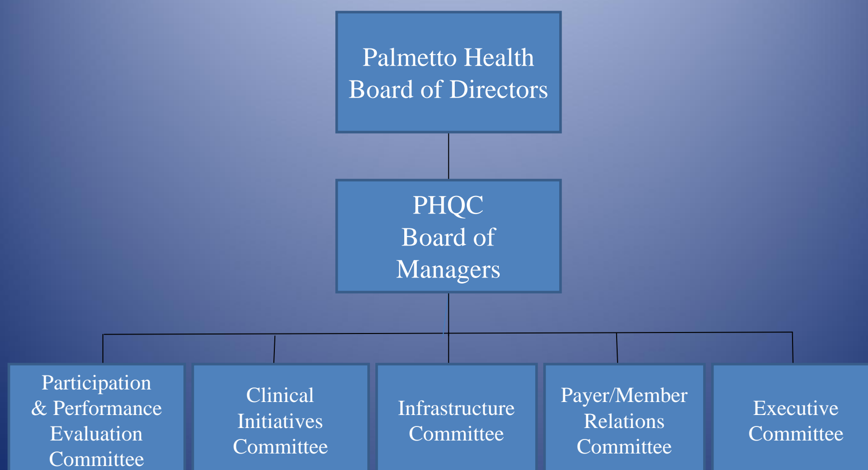
PHQC Organizational Structure & Governance

- PHQC is a South Carolina Limited Liability Company with Palmetto Health being the sole member.
- PHQC was formed to develop a physician network engaged in the process of clinical integration to better serve the health care needs of the citizens and communities served by the physician participants and Palmetto Health.
- The operations of PHQC are managed by a Board of Managers comprised of thirteen mangers
  - Ten of the thirteen managers are designated as "Physician Managers" representing primary care, surgical and medical specialties
  - Three of the thirteen managers are designated as "Hospital Managers"

PHQC Board of Managers

- Physician Managers include:
  - Ø Independent, community physicians
  - Ø Faculty members of the University of South Carolina School of Medicine
  - Ø Palmetto Health employed physicians
- Hospital Managers include:
  - Ø Dean, University of South Carolina School of Medicine
  - Ø Chief Executive Officer, Palmetto Health
  - Ø Member, Palmetto Health Board of Directors

Organizational Structure & Governance



Duties of the Board of Managers

- Responsible for the management and business affairs of PHQC
- Fiduciary responsibility for the affairs of PHQC, including the safekeeping and use of funds and assets
- Appoint and oversee the work of PHQC committees
- Create and submit annual capital and operating budgets to Palmetto Health
- Approve all purchaser contract terms and conditions

Committees of the Board

Clinical Initiatives Committee

- Identifies clinical initiatives and attendant performance measures for each specialty in PHQC
- Selects cross-specialty, cross-setting initiatives that move PHQC toward patient-centered, high-quality, cost-effective care

Participation & Performance Evaluation Committee

- Ensures that physician participants meet the standards outlined in the “Participation Requirements” section of the CI Program
- Recommends participation or termination of physician participants to the Board of Managers

Committees of the Board

Infrastructure Committee

- Establishes data collection sources and reporting methodologies for each selected quality performance initiatives.
- Ensures that data sources are reliable, objective and pose the least administrative burden possible to physician participants
- Seeks to continuously improve IT systems such that clinical documentation is useful for communication of patient care, data collection and compliance with federal regulations under health care reform.

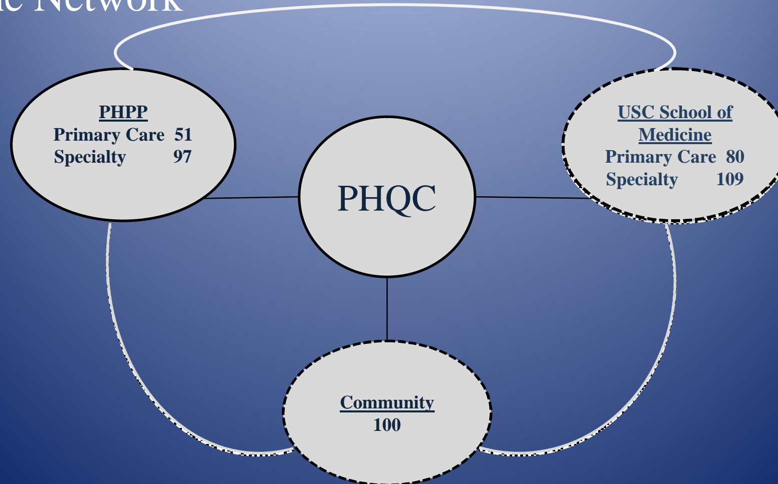
Committees of the Board

Finance & Purchaser Relations Committee

- Responsible for oversight of all financial matters related to PHQC, including:
  - annual operating and capital budgets
  - contracts with purchasers
  - distribution of monies received through quality adjusted purchaser contracts

The Network

- The CI program brings together physicians from the following practice environments:
  - Ø Independent, community physicians
  - Ø Faculty members of the University of South Carolina School of Medicine
  - Ø Physicians under contract to provide clinical services at Palmetto Health
  - Ø Palmetto Health employed physicians (PHPP)
- The CI program brings together physicians who historically and currently are not organizationally or financially integrated to cooperatively develop and implement quality and cost efficiency programs across the continuum of care and multiple specialties.



Palmetto Health Quality Collaborative

The Network Development Timeline

2011

Key Activities	Jan	Feb	Mar	Apr	May	June	July
•Physician Contracting							
•Initiative Selection							
•Information System & Metric Testing							
•purchaser Education & Negotiations							
•Operational Start Date							

Network Participation Benefits

- Participation in CI program allows access to quality incentives under purchaser contracts
- EMR offering to community physicians
- Access to group purchasing contracts for supplies, etc.
- Transitional care services
- CME Opportunities
- IHI Triple Aim Participation

The Quality Program

- Quality measures will be implemented for all physician participants to improve coordination of care, increase the quality and improve the efficiency of care across the continuum of care.
- Specific benchmarking targets will be used to measure physician performance for each quality measure.
- Metric performance and each measure's utility will be reviewed annually by appropriate PHQC physician committees for revision or replacement.
- The PHQC will work with purchasers to link physician performance to the financial reward potential within negotiated purchaser contracts.

The Quality Program

Physician Performance & Physician Participant Requirements

- Each physician participant s will have sufficient meaningful specialty specific metrics to measure performance
- Physician participants will comply with the established process for providing clinical data
- Physician participants will participate in required training around the quality metric process and performance targets

Measures by Category	Total	Anesthesiology	Cardiology	Cardiovascular Surgery	Emergency Medicine	Endocrinology	Gastroenterology	Geriatrics	Hematology/Oncology	Infectious Disease	Medicine	Nephrology	Neurology	Neurosurgery
Quality Processes	69	1	4	1	3	6	3	5	5	4	5	5	1	1
Clinical Outcomes	58	2	3	3	0	0	3	1	1	2	1	2	8	3
Administrative / Utilization / Efficiency	53	2	2	2	2	2	1	2	2	2	2	2	2	2
Total	**180**	**5**	**9**	**6**	**5**	**8**	**7**	**8**	**8**	**8**	**8**	**9**	**11**	**6**

Measures by Category	OB/GYN	Ophthalmology	Palliative Care	Pathology	Pediatrics (includes Peds Cardiology)	Pediatrics Surgery (includes Peds Urology)	Psychiatry	Pulmonology - Critical Care	Rheumatology	Surgery - Adult	Surgery - Colorectal	Surgery, Ortho (general and trauma)	Trauma Surgery	Urgent Care
Quality Processes	1	5	1	2	1	1	1	1	1	2	2	3	1	3
Clinical Outcomes	3	2	0	1	2	2	3	3	3	3	2	2	3	0
Administrative / Utilization / Efficiency	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Total	**6**	**9**	**3**	**5**	**5**	**5**	**6**	**6**	**6**	**7**	**6**	**7**	**6**	**5**

Initiatives Identification Process

- The Clinical Initiatives Committee comprised of physicians representing the three core constituencies developed the clinical initiatives
- The Committee worked collaboratively with specialists to develop measures for the specialties not represented on committee
- The measures proposed were vetted and approved by the Board of Committee members
- All measures were reviewed and approved by the Board of Managers

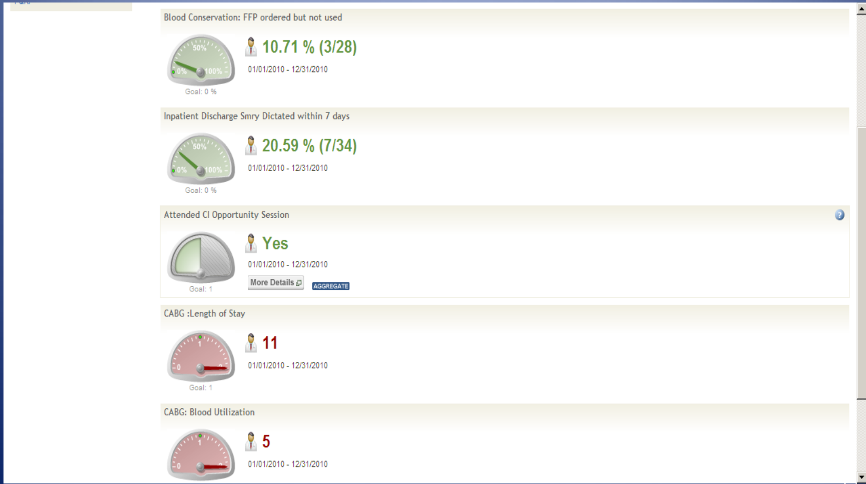
Information Systems Supporting the Program

- Crimson Clinical Advantage – Employed physicians using Practice Office Management (POM) system with Admit, Discharge and Transfer (ADT) interfaced demographic information with hospital systems and Centricity Electronic Medical Record
- Currently soliciting proposals for population and risk management IT solutions
- Actively negotiating with MDI for claims assessment tool

Information Systems Supporting the Program

- GE Healthcare's Centricity Enterprise with ePrescribing capability
- Patient Portal to be online 2011
- CPOE deployed via Cerner's EMR in ED, Med/Surgical Units, Ob/Gyn Units, Psych Units. Critical Care and Pediatrics scheduled for April 2011
- Beta Partner in SCHIEx

Miscellaneous Measures With Data

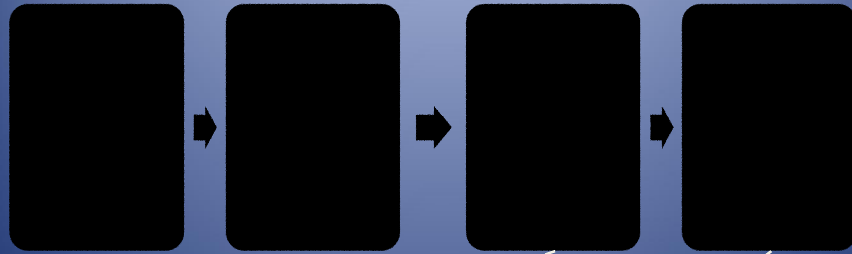


Physician Performance
Clinical Initiatives Data Implementation

Collect Clinical Initiatives Proposals	Review Initiatives for Guiding Principle Compliance	Draft Initiatives for Feasibility Analysis	Conduct Feasibility Analysis	Finalize Initiatives For Review	IT Work Group Review
•Receive current & proposed initiatives from PHQC	•Apply guiding principles to initiatives •Identify any gaps •Fill initiatives pool gaps with other metric sources ›Meaningful Use ›Specialty Based ›Global/ general measures	•Map initiatives to appropriate specialties •Create measure specifications to support feasibility analysis	•Clinical ›Standard of Care (SOC) ›Culture •Technical ›Collectability ›Data Quality ›Granularity	•Clinical & technical feasibility review •Overall review •Identify year 1 initiatives •Identify targets & thresholds	•Find feasibility review •Verify specialty mappings •Select Year 1 initiatives •Select targets & thresholds •Identify priorities for future year initiatives •Send recommendation to Board of Managers

Performance Improvement (PI)

Performance Improvement methodology is based on the Institute for Healthcare Improvement's Model for Improvement.



Process Engineer
+ PI Manager
PI Resources

Process Engineer: Primarily focused on working with individual pilot practices to evaluate and improve workflows related to selected Clinical Initiatives.

PI Manager: Primarily focused on working with learning forum participants to facilitate PI work related to selected Clinical Initiatives.

Physician Performance Management

- **Physician Forums** with each group of physicians (employed, faculty, independent) to educate them on the Collaborative and provide the participation agreement
- **Written communication** with all potential participants during the creation of the collaborative
- **Practice Manager Meetings** with the PHQC staff to offer support for implementing the initiatives
- **CME** that is designed based on physician input and aligned initiatives
- **Access to Data** for the physicians that is real time and continuous

- The **Participation and Performance Evaluation Committee** (PPEC) will report on a quarterly basis the performance of the physician participants
- **Physician participants** that fail to meet the quality benchmarks of the CI program will be notified by the Executive Medical Director
- A **physician participant representative (peer)** will be available to assist in establishing an improvement plan timeline
- Follow-up with **the EMD and peer** will occur on a bi-weekly basis

- If it is determined by the EMD and peer that the **participant failed to show improvement** the physician participant will be placed on immediate probation
- **The physician participant will sign an improvement plan** and the Board will be notified of a 6 month window for improvement
- At the end of the 6 month period with **no improvement the PPEC** will make a recommendation to the Board on either the release from probation or removal from the group
- The Board of Managers will **notify the group and individual of the decision**

Purchaser Engagement

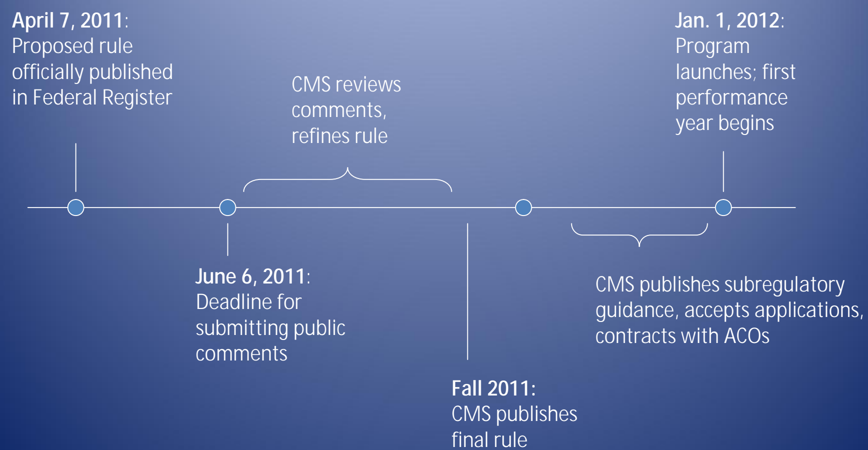
- Palmetto Health has committed to PHQC for its employee health plan, including claims analysis to identify focused cost and efficiency initiatives
- Purchasers including the following have approached PHQC to learn about our clinical integration program:
  - South Carolina Blue Cross Blue Shield
  - Cigna Healthcare
  - Coventry/Wellpath
  - Multiple Medicaid MCOs
- It is anticipated that contracts with purchasers will focus on innovative payment systems that are designed to drive better quality, more efficient, less costly care.
  - Initially, we anticipate that these innovative payment systems may include: quality enhanced fee-for-service, pay-for-performance and shared savings models.
  - Eventually, contracts will likely involve the sharing of greater economic risk including: partial capitation, global capitation or perhaps even bundled payment.

Future Goals

1. Program performance testing
   - Provider performance
   - IT capability enhancement
   - Purchaser contract negotiation & management
2. Regional expansion & collaboration
   - Selective geographic provider contracting to expand service area and meet purchaser needs
   - Strategic discussions with other health systems

Proposed Medicare regs
Medicare Shared Savings

Preface: Timeline of Next Steps



I. What is an ACO?

ACA: Shared Savings Program to encourage groups of providers to manage/coordinate care for assigned FFS Medicare beneficiaries

- Eligibility and governance
- Private sector preference
- Leadership and management structure
- Providers
- Infrastructure
  - Processes to promote evidence-based medicine
  - Health information technology

What: Leadership and Management Structure

ACA: Requires ACOs to have leadership/management structure, including clinical/administrative systems, but is silent on their definition.

- **Elements to be documented on application include:**
  - Executive management with ability to influence clinical practice
  - Clinical management and oversight by a medical director
  - Meaningful commitment to clinical integration
  - Physician-directed quality assurance and process improvement committee
  - Evidence-based medical practice/clinical guidelines/processes
  - Infrastructure, such as IT

Alternative: describe how innovative structures enable same result

What: Infrastructure—Processes

ACA: Processes to promote evidence-based medicine, patient engagement, report quality/cost, coordinate care, patient-centeredness

- Non-prescriptive – in application, must document processes for:

Evidence-based medicine	Beneficiary engagement	Internal cost, quality reports	Care coordination
Organization- wide use, regular updates	Shared decision making, health literacy, decision support	Demonstrate ability to modify care delivery based on population	May include predictive modeling, case managers; no access restrictions

- Must also meet 8 required patient-centeredness elements
  - Detailed requirements for patient experience survey; beneficiary involvement in governance, ID population health needs, individual care plans

What: Infrastructure—HIT

Does not incorporate Meaningful Use (MU) EHR Incentive Program – but requires certain MU metrics and PCP alignment with MU

- EHR-related quality metrics
  - % of PCPs Using Clinical Decision Support
  - % of PCPs who are Successful Electronic Prescribers Under the e-Rx Incentive Program
  - Patient Registry Use
- LT Objective: incent full participation in EHR Incentive Program
  - Future rulemaking will call for greater alignment
- Separate requirement: >= 50% of primary care physicians must meet MU criteria by the start of the 2nd performance year

III. How is the ACO paid?

ACA: ACOs eligible for portion of shared savings beyond a historical benchmark if quality performance standards are met

- Expenditure benchmark
- Shared savings/risk
- Performance standards – Quality metrics

Sample of Stakeholder Concerns

- What
  - 5K beneficiary minimum: insufficient sample size to measure performance
  - 50% PCPs meeting MU criteria: too ambitious
  - IT capabilities: May be greater than Stage 1 MU
- Who
  - Retrospective attribution: hampers care management
  - Aggregate data reporting: frequency should be monthly, not quarterly
- How
  - Downside risk in track 1: some ACOs may not be ready
  - 65 measures: extremely ambitious, many cannot be met with claims data
  - Shared savings rate: too low, should be 70-80%
  - No upfront funding: may preclude small providers' participation

Missing Pieces

Gaps between proposed rule and BCBSA principles

- -Upfront capital to help small/solo practices participate
  - CMS estimates $1.75M start-up and first-year operating costs per ACO
  - Assumed range of 75-150 participants à $131M-263M total
- -Flexibility to use varying risk-based payment (e.g., capitation)
  - CMS planning to test other risk-based approaches in CMMI
  - May incorporate into Shared Savings Program through future rule-making
- -Broad set of ambulatory and hospital quality measures
  - Limited inpatient-specific measures, although CMS plans to add later
  - Comparatively few clinical appropriateness/efficiency measures

Transitional Care

What is it and how does it work?

The Ambulatory Transitional Care Team (ACTT)

Purpose & Goal of ACTT

- Purpose: to establish a community based model of care for **high risk patients**, irrespective of payer source, that bridges the care between the hospital and the patient's medical home
- Goal: to improve the clinical care outcomes of high risk patients by using evidence based practice consistent with the clinical initiatives established as part of the Palmetto Health Quality Collaborative (our ACO)

What is a High Risk Patient?

- Frequent hospital admissions within a 30 day time frame
- Repetitive, inappropriate use of Emergency Room care
- Prolonged hospital stays for certain disease conditions above the national rate
- Social factors: lack of caregiver/support system, homelessness, limited funding, low health literacy, etc.

Need for Transition Team

- Direct link to PH Quality goal (Reduce the readmission rate by 2%)
- Changes in reimbursement by Medicare for readmissions
- Conditions with highest readmission rates to be targeted first at PH:
  - Heart failure
  - Acute Myocardial Infarction (AMI)
  - Pneumonia

ACTT Model

- Using basic "transitional care" ideas to develop our own model for our community
- Currently developing plan of care for each individual patient as opposed to applying same POC for all patients
- With enough patients, ACTT will be able to summarize different "types" of patients and connect resources often provided to these patients

Barriers Resulting in Readmits

¢
atient does not have a medical home

¢
nable to obtain timely follow up with provider post discharge

¢
ransportation to and from appointments (or to pharmacy)

¢
btaining medications post discharge

¢
onfusion over medication regimen

¢
ack of education of "red flags" that indicate worsening of their condition and how to respond

Tool for Inpatient Screening

- LACE tool
  - L: Length of Stay
  - A: Acuity of Admission (patient admitted from ED or community)
  - C: Comorbidities
  - E: ED Visits (total for last 6 months)
- Index used to predict early death or readmission after discharge from the hospital back into the community

Tool for Inpatient Screening

- Social Assessment:
  - Financial Resources (Limited financial resources, no payer source for medication care, disability through Soc. Sec. (SSI))
  - Healthcare/Utilization (No PCP, hx of readmits, hx of noncompliance, admission from another facility)
  - Medications (polypharmacy)
  - Psychosocial/Environmental (difficulty coping w/ dx, transportation, homelessness, social support, limited literacy)
  - Stages of Change

Patients Served (through 3/31/2011)

- Total: 69 patients
- Gender: 32% female, 68% male
- Age Range: 26-91 (majority of pts in 40s & 50s)
- Race: 85% African American, 15% Caucasian

High Intensity Patients

- Transition Coordinators currently keep caseload of 15-20 patients
- To date, majority of referrals are at high level of intensity (limits total # of patients served)
  - Multiple home visits and daily phone calls
  - Attendance at physician (primary care & specialty) appointments

PH Readmission Rates

- PH heart failure readmissions:
  - FY2009: 18.69%
  - July '09 - June'10: 17.8%
- FY2011 Quality Goal: Decrease the readmission rate for AMI, CHF and CAP by 2% to 14.68%
  - Actual YTD (Jan): 12.06%

ACTT Readmission Rates

- October 2010: 9.1%
- November 2010: 0%
- December 2010: 10.5%
- January 2011: 12%
- February 2011: 7.7%

Rates calculated using # of readmissions and # of active patients each month.

Current ACTT Staffing

- 2 Transition Coordinators (RN)
- Pediatric ACTT Manager/Transition Coordinator (RN)
- ACTT Manager (SW)
- Administrative Coordinator
- Social Worker (starting late April)

Current Funding

- Grant through COPA to provide ACTT services to patients in Richland and Lexington Co. for FY2011
- Additional grants that have been submitted:
  - Development of a chronic disease stabilization clinic (Duke Endowment)
- Development of contracts with insurance providers to manage high-risk patients with capitated payment
  - 2 Medicaid MCOs contracting for services

Improved Quality Care

- Workgroups on both campuses are focusing efforts to reduce readmissions
  - Avoiding duplication of efforts
  - Encouraging appropriate use of existing resources
- Patients receive guidance to navigate complex health care system (including disability, Medicaid, etc)
- Improved disease self-management and self-efficacy for ACTT patients

Opportunities

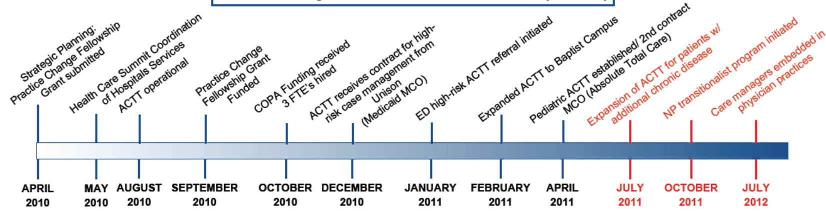
- Issues indentified:
  - Need for improved medication reconciliation at discharge
  - Low health literacy level of patients
  - Lack of primary care providers serving non-funded & Medicaid patients

Next Steps

- Three areas targeted to improve quality and patient care:
  1. Expand ACTT program
  2. Develop Ambulatory Care Center for Evaluation & Stabilization (ACCES)
  3. Work with PH-owned physician practices to obtain NCQA Patient Centered Medical Home recognition

TOTAL OPTIMAL INTEGRATION (TOI)

Ambulatory Care Transition Team (ACTT)

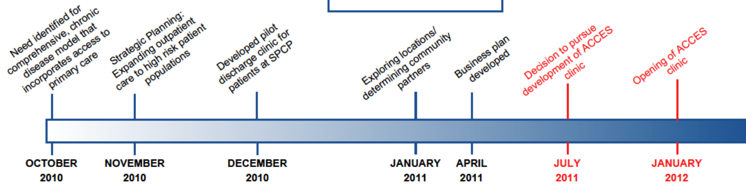


* Timeline in red is contingent on TDE Funding.

ACTT	
FY 2010 Expenditures	$ 221,471
FY 2011 Budget	$ 225,996
COPA funding	$ 450,000
Practice Change Fellowship Budget	$ 45,000
Total	**$ 942,467**

TOTAL OPTIMAL INTEGRATION (TOI)

ACCES



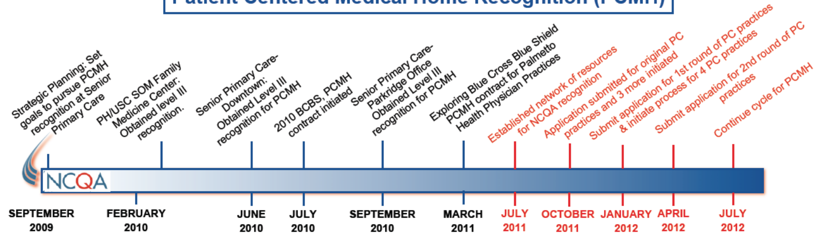
* Timeline in red is contingent on TDE Funding.

Ambulatory Care Center for Evaluation Stabilization (ACCES)

- Need identified for comprehensive, chronic disease model that incorporates access to primary care.
- For patients that lack a primary medical home
- For patients with complex medical or social issues
- Provided individualized plan of care by multidisciplinary team
- Coordination of the patient to a primary care medical practice
- Common record sharing between point of care providers for quality transition.

TOTAL OPTIMAL INTEGRATION (TOI)

Patient Centered Medical Home Recognition (PCMH)



The patient-centered medical home is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.

A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, physicians.
(www.NCQA.org)

✶ Timeline in red is contingent on TDE Funding.

What is a medical home?

- Model of care by physician practices that seeks to strengthen the physician patient relationship by replacing episodic based care illnesses and patient complaints with coordinated care and a long-term healing relationship

NCQA's Patient Centered Medical Home (PCMH) 2011

- Innovative program for improving primary care that gives practices information about organizing care around patients, working in teams and coordinating and tracking care over time

Why the Patient-Centered Medical Home?

This model of care holds significant promise for:

- Better health care quality
- Improved involvement of patients in their own care
- Reduced avoidable cost over time

PPC – PCMH Content and Scoring

Standard	Points	Standard	Points
Standard 1: Enhance Access and Continuity A. Access During Office Hours B. After - Hours Access C. Electronic Access D. Continuity E. Medical Home Responsibilities F. Culturally & Linguistically Appropriate Services G. Practice Teams	20 Pts. 4 Pts 4 Pts. 2 Pts. 2 Pts. 2 Pts. 2 Pts. 4 Pts.	Standard 4: Provide Self Care Support and Community Resources A. Support Self Care Processes B. Provide Referrals to Community Resources Standard 5: Track and Coordinate Care A. Test - Tracking and Follow up B. Referral Tracking and Follow up C. Coordinate Care with Facilities/Care Transitions	9 Pts. 6 Pts. 3 Pts. 18 Pts. 6 Pts. 6 Pts. 6 Pts.
Standard 2: Identify and Manage Patient Populations A. Patient Information B. Clinical Data C. Comprehensive Health Assessment D. Use Data for Population Management	16 Pts. 3 Pts 4 Pts. 4 Pts. 5 Pts.	Standard 6: Measure and Improve Performance A. Measure Performance B. Measure patient/Family Experience C. Implement Continuous Quality Improvement D. Demonstrate Continuous Quality Improvement E. Report Performance F. Report Data Externally	20 Pts. 4 Pts. 4 Pts. 4 Pts. 4 Pts. 4 Pts.
Standard 3: Plan and Manage Care A. Implement Evidence-Based Guidelines B. Identify High Risk Patients C. Care Management D. Manage Medications E. Use Electronic Prescribing	17 Pts. 4 Pts. 3 Pts. 4 Pts. 3 Pts. 3 Pts.	Red Items are Must Pass Elements. You must obtain 50% of the points on these items to achieve any level of recognition	

PCMH 2011 Scoring Summary

Recognition Levels	Required Points	Must-Pass Elements
Level 1	35-39 Points	• 6 of 6 elements are required for each level • Score for each Must-Pass element must be • 50%
Level 2	60-84 Points	
Level 3	85-100 Points	

Summary of PCMH Standards
Standard 1 (Enhance Access & Continuity)

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during office hours
- The practice provides electronic access
- Patients may select a clinician
- The focus in on team-based care with trained staff

Summary of PCMH Standards
Standard 2 (Identify/Manage Patient Populations)

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

Summary of PCMH Standards

Standard 3 (Plan/Manage Care)

- The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
- Care management emphasizes pre-visit planning, assessing patient progress toward treatment goals, and addressing patient barriers to treatment goals
- The practice reconciles patient medications at visits and post-hospitalization
- The practice uses e-prescribing

Summary of PCMH Standards

Standard 4 (Provide Self-Care Support/ Community Resources)

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during office hours
- The practice provides electronic access
- Patients may select a clinician
- The focus in on team-based care with trained staff

Summary of PCMH Standards
Standard 5 (Track/Coordinate Care)

The practice tracks, follows –up on and coordinates test, referrals and care at other facilities (e.g, hospitals)

The practice follows up with discharged patients

Summary of PCMH Standards
Standard 6 (Measure/Improve Performance)

- The practice uses performance and patient experience data to continuously improve
- The practice tracks utilization measures such as rates of hospitalization and ER visits
- The practice identifies vulnerable patient populations
- The practice demonstrates improved performance

Why PCMH?

Early evidence suggest that PCMH improve quality and returns savings

Summarized findings from a recent PCMH demonstration can be found at:

http://www.pcpcc.net/content/pcmh-outcome-evidence-quality