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Patient Centered Medical Home: The Nuts and Bolts

Presenter

Lori A. Francis, B.S.,
NCQA PCMH Certified Content Expert
NCQA PCMH Reviewer
Provider Performance Consultant, BCBST
DISCLOSURE

- Lori Francis has no financial relationships to disclose relating to the subject matter of this presentation.
AGENDA – PATIENT-CENTERED MEDICAL HOME (PCMH)

- What is PCMH?
- Evolution of PCMH
- NCQA PCMH 2017 Overview
- PCMH Recognition Process
- Care Team Members
- PCMH Benefits
- Evidence PCMH Works

Questions – Comments – Feedback

KEY ISSUES DRIVE HIGH COSTS AND POOR PERFORMANCE

Drivers of a Fragmented, Reactive and Costly U.S. Healthcare System

- A payment system that rewards volume rather than value.
- A reactive focus on symptoms rather than proactive health management.
- Fragmentation – poorly coordinated care, and no champion to help patients navigate the system.
- Limited transparency and information sharing – physicians lack the complete picture necessary to manage their patient’s health.
- Insufficient resources directed to primary care, contributing to a primary care shortage.
- Treatment decisions that aren’t always based on the best available clinical evidence.
The 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.

“The Patient-Centered Medical Home is a model of 21st century primary care that combines access, teamwork, and technology to deliver quality care and improve health.” Margaret E. O’Kane, President, NCQA

Source: https://www.pcpcc.org/about/medical-home

The American Academy of Pediatrics (AAP) introduced the term “medical home” in 1967.

Initially it was used to describe a single source of medical information about a patient but gradually grew to include a partnership approach with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.

https://www.aafp.org/dam/AAFP/documents/about_us/initiatives/PCMH.pdf
INSTITUTE FOR HEALTHCARE IMPROVEMENT – THE TRIPLE AIM 2007

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance.
- New designs must simultaneously pursue three dimensions
- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations (both chronic conditions and preventive health)
  - Reducing the per capita cost of health care

Better Health – Better Care – Lower Cost

Design of a Triple Aim Enterprise
IOM’S TEN RULES WERE FOUNDATIONAL TO NCQA PCMH

- At the core of PCMH is “whole-person” care and PCP (Personal Care Provider)
- Follow treatment or not follow treatment – a change in philosophy of patient care
- Involve the patient in their care – educate them
- More transparency of information
- Shared patient medical record information (another change in philosophy of patient care)
- Cooperation of healthcare professionals – exchange of information (Health Information Exchange)

Taken from NCQA Facilitating PCMH 2014 Recognition May 13-14, 2014; Tampa, FL

INSTITUTE OF MEDICINE (IOM) PUBLISHED IN 2001:
CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY

Ten Rules that were foundational to development of a better healthcare system:
- Care based on continuous health relationships
- Care based on patient needs and values
- Patient as the source of control
- Patient access to medical information and clinical knowledge
- Evidence-based decision making
- Patient safety
- Transparency of information
- Anticipation of needs
- Continuous decrease in waste
- Cooperation among clinicians
SEVEN PRINCIPLES OF PCMH (2007)

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

SEVEN PRINCIPLES OF PCMH (2007), CONT.

**Quality and safety** are hallmarks of the medical home:

- **Practices advocate** for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- **Evidence-based medicine and clinical decision-support** tools guide decision making.

- **Physicians** in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- **Patients actively participate** in decision-making and feedback is sought to ensure patients’ expectations are being met.

- **Information technology** is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

- **Practices** go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- **Patients and families participate** in quality improvement activities at the practice level.
SEVEN PRINCIPLES OF PCMH (2007), CONT.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should **reflect the value** of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should **pay for services** associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should **support adoption** and use of health information technology for quality improvement.
- It should **support** provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should **recognize the value** of physician work associated with remote monitoring of clinical data using technology.
- It should **recognize** case mix differences in the patient population being treated within the practice.
- It should **allow** physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting and additional payments for achieving measurable and continuous quality improvements.

https://www.aafp.org/dam/AAFP/documents/about_us/initiatives/PCMH.pdf

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EVOLUTION OF PCMH
Evolution of PCMH

- The earliest organization to formally recognize a PCMH practice was the NCQA, which modified an existing program to create the Physician Practice Connections – Patient-Centered Medical Home (PCPC-PCMH) assessment tool to fit within The Guidelines for the Patient-Centered Medical Home.

- The AAAHC, Joint Commission and URAC created their programs subsequent to the publication of the guidelines, which explains why the four programs are in substantial compliance with the guidelines.

AAAHC: Accreditation Association for Ambulatory Health Care, Inc.
URAC: Utilization Review Accreditation Commission

HEALTH CARE IS A CHANGING INDUSTRY FROM DISEASE-CENTERED CARE TO PATIENT-CENTERED CARE

Where we have been
- Fragmented care
- Practice-centered care
- Paper charts
- Patients as passive participants
- Facility-based visits
- “What’s the matter with you?”

Where are we going
- Coordinated care
- Patient-centered care (Person- and family-centered care)
- Electronic Health Records (EHR)
- Patients are fully engaged
- Innovative care delivery strategies
- “What matters to you?”
NCQA – BRIEF INTRODUCTION

- National Committee on Quality Assurance (NCQA) is a private, independent not-for-profit health care quality oversight organization founded in 1990
- NCQA is committed to measurement, transparency, and accountability
- NCQA unites diverse groups around a common goal: improving health care quality

MISSION
To improve the quality of health care

VISION
To transform health care through quality measurement, transparency, and accountability

ncqa.org

NCQA RECOGNITION PROGRAMS

- **Practice Programs**
  - [Patient-Centered Medical Home Recognition](http://www.ncqa.org/programs/recognition) (PCMH)
  - [Patient-Centered Specialty Practice Recognition](http://www.ncqa.org/programs/recognition) (PCSP)
  - [Oncology Medical Home Recognition](http://www.ncqa.org/programs/recognition)
  - [Patient-Centered Connected Care](http://www.ncqa.org/programs/recognition)
  - [School-Based Medical Home Recognition Program](http://www.ncqa.org/programs/recognition) (SBMH)
  - [Government Recognition Initiative](http://www.ncqa.org/programs/recognition) (GRIP)

- **Distinction Programs**
  - Distinction in Behavioral Health Integration
  - Distinction in Patient Experience Reporting

- **Clinician Programs**
  - [Diabetes Recognition Program](http://www.ncqa.org/programs/recognition) (DRP)
  - [Heart/Stroke Recognition Program](http://www.ncqa.org/programs/recognition) (HSRP)

Source: [http://www.ncqa.org/programs/recognition](http://www.ncqa.org/programs/recognition)
NCQA PCMH 2017 Standards

- The patient-centered medical home is a model of care that puts patients at the forefront of care. PCMHs build better relationships between people and their clinical care teams.

- Foundational Concepts
  - Team-based Care and Practice Organization (TC)
  - Knowing and Managing Your Patients (KM)
  - Patient-centered Access and Continuity (AC)
  - Care Management and Support (CM)
  - Care Coordination and Care Transitions (CC)
  - Performance Measurement and Quality Improvement (QI)

- Criteria
  - Core Criteria – 40 Core – Required for Recognition
  - Elective Criteria (Credits) – 25 Credits – Required from at least 5 of the 6 Concepts
CONCEPTS, COMPETENCIES, CRITERIA AND SCORING

Concepts, Competencies and Criteria

Replaces the model of Standards, Elements and Factors

- **Concepts**: Over-arching components of PCMH
- **Competencies**: Ways to think about/bucket criteria
- **Criteria**: The individual things/tasks you do to make up a PCMH

NCQA PCMH 2017 CONCEPTS

- **Team-based Care and Practice Organization (TC)** – the practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work at the top of their license and provide effective team-based care.

- **Knowing and Managing Your Patients (KM)** – the practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

- **Patient-centered Access and Continuity (AC)** – the PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.
NCQA PCMH 2017 CONCEPTS

Care Management and Support (CM) – the practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Care Coordination and Care Transitions (CC) – the practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Performance Measurement and Quality Improvement (QI) – the practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

CARE TEAM MEMBERS

- Patient Scheduling Representative
- Triage
- Front Office Staff
- Medical Assistant
- Nurse (RN, LPN)
- Lab Tech (Phlebotomist)
- Clinician (MD, DO, NP, PA)
- Referral Clerk
- X-Ray Tech
- Patient Services Representative
- Case Manager
- Medical Records
- Billing
- Outreach and Enrollment & Marketing
- and Management, IT, and Maintenance

Patient, Family, Caregiver
ADDITIONAL PCMH TEAM MEMBERS

- Many practices are beginning to enhance their services by including additional support staff to ensure patients receive the whole-person care outlined in the PCMH model.

- This may include incorporating the following health care professionals as part of the PCMH team:
  - Behavioral health practitioners
  - Social workers
  - Palliative care practitioners
  - Physical, occupational and speech therapists
  - Community Health Workers
  - Dieticians
  - Pharmacists
  - Specialists

HIGH QUALITY PRIMARY CARE PRACTICE CARE TEAMS

- Surround their clinicians with skilled and empowered staff

- Heavily involve non-provider staff in meeting fundamental patient needs (e.g., immunizations, self-management support, care coordination, follow-up, standing orders)

- Involve staff in quality improvement
E-PATIENTS

- Transformation of our healthcare system
- Advances in technology and the internet bring us closer to information and each other. A new world of “Participatory Medicine” is evolving in which networked patients are shifting from mere passengers to responsible drivers of their health.
- Today, these E-patients are...

Empowered
Engaged
Educated
Equipped
Enabled

http://www.healthit.gov/patients-families/video/health-it-you-giving-you-access-your-medical-records
Learn it. Download the NCQA standards and guidelines and begin learning the concept areas and required criteria. NCQA also offers online and in-person training to help practices understand the recognition process.

Apply PCMH concepts to your practice. Begin to implement changes to align with the NCQA PCMH standards.

Enroll through Q-PASS. When you are familiar with the standards and have started to transform your practice, create an account, enroll in the recognition process at qpass.ncqa.org, complete an initial questionnaire and pay the enrollment fee. Learn more about what will be required at enrollment.

Virtual introduction with an NCQA representative. After you enroll, NCQA assigns a representative as your single point of contact to guide you through recognition. Your representative schedules an initial introductory call to discuss the recognition process and develop a schedule of up to three virtual reviews over the course of your practice’s transformation.

Begin working with Q-PASS. You will use NCQA’s new Quality Performance Assessment Support System—Q-PASS—to gather evidence, prepare documentation and track your practice’s progress toward recognition. You can upload documentation (for criteria that require it) to prepare for your check-ins, or indicate that you prefer to demonstrate capabilities during a live virtual review, using screen-sharing (where applicable).
PCMH: The Nuts and Bolts

SUCCEED

- Earn Recognition. Your practice and clinicians will be listed in the NCQA directory on the NCQA website and you can begin promoting your practice as a recognized PCMH.

- Annual Reporting. Each year, your practice will check in with NCQA to demonstrate that your ongoing activities are consistent with the PCMH model of care. Annual Reporting has far fewer requirements than your initial recognition. It is meant to ensure that your practice continues to function as a PCMH and is performing ongoing quality improvement initiatives. Part of this process includes attesting to certain policies and procedures, as well as submitting some data to NCQA. The annual reporting process will sustain your recognition and foster continuous improvement. That means your practice succeeds in strengthening its transformation, and as a result, strengthens patient care.

PATIENT CENTERED MEDICAL HOME

BENEFITS
BENEFITS OF NCQA PCMH RECOGNITION – FOR PATIENTS

Stay healthy. Patients who are treated in PCMHs tend to receive preventive services and screenings at a higher rate than patients who are not in PCMHs, helping them stay healthy.

Better communication. Communication with patients and their families/caregivers is a core concept of the PCMH model, which also emphasizes enhanced patient access to clinical advice and medical records.

Better management of chronic conditions. According to research, PCMHs are especially helpful for patients with complex chronic conditions.

Have a better experience. When medical home attributes are described to people, they say it is the type of care they want to receive.

Source: NCQA – TOOLKIT - Getting Started with NCQA Patient-Centered Medical Home Recognition; 2017

BENEFITS OF NCQA PCMH RECOGNITION – FOR PRACTICES

- Align with where health care is headed. Payers continue to move from the fee-for-service model towards rewarding integration and quality care. They are increasingly contracting with organizations that can show they have a strong infrastructure and quality improvement initiatives. NCQA PCMH Recognition prepares you to succeed.

- Integrate services across your entire organization. If you are a health system or clinically integrated network with specialty practices, urgent care centers and other types of practice sites, NCQA's Patient-Centered Specialty Practice (PCSP) and Patient-Centered Connected Care programs mean your whole organization can evolve into a high-functioning medical home neighborhood. These other programs are built off of the PCMH model and complement NCQA PCMH Recognition.

- Support revenue growth. Many Federal, state and commercial payers offer incentive programs to practices that achieve NCQA PCMH/PCSP Recognition.

- Improve your practice. Use NCQA PCMH Recognition to perform gap analyses and to implement processes and procedures that improve care for patients and make your practice more efficient.

- Keep staff happy. The PCMH model helps streamline processes and standardize procedures that keep practice staff at the top of their knowledge, skills and ability. It has been shown to result in higher staff satisfaction.4

- Market your practice. NCQA publishes a list of all recognized practices and clinicians in its Recognition Directory. Use the NCQA seal to market your accomplishment to patients and partners. We can even help you distribute a press release to local press, touting your achievement.

Source: NCQA – TOOLKIT - Getting Started with NCQA Patient-Centered Medical Home Recognition; 2017

BENEFITS OF NCQA PCMH RECOGNITION – FOR CLINICIANS

- **Earn higher reimbursement.** More than 100 payers nationwide offer either enhanced reimbursement for recognized clinicians or support for practices to become recognized.

- **Succeed in MACRA.** The Centers for Medicare & Medicaid Services (CMS) acknowledges both NCQA’s PCMH and PCSP Recognition programs as ways to receive MACRA credit. Clinicians in NCQA-Recognized PCMHs/PCSPs automatically earn full credit in the MIPS Improvement Activities category, and are likely to do well in other MIPS categories. The PCSP Recognition program is the only specialty-focused evaluation program in the country recognized by CMS in MACRA.

- **Earn Maintenance of Certification (MOC) credits.** Several medical boards award clinicians in NCQA-recognized practices Maintenance of Certification (MOC) credits, reducing the burden on clinicians to take on additional activities. Find out whether your board offers credits.

- **Focus on patient care.** The PCMH model ensures that team members operate at the highest level of their knowledge, skills, abilities and license, within their assigned roles and responsibilities.

Source: NCQA – TOOLKIT - Getting Started with NCQA Patient-Centered Medical Home Recognition; 2017

PATIENT CENTERED MEDICAL HOME

EVIDENCE PCMH WORKS
NCQA Patient-Centered Medical Homes with Financial and Technical Support Produce Sustained Reductions in Utilization: Colorado Multi-Payer HealthTeamWorks PCMH Pilot

A study of Colorado’s HealthTeamWorks PCMH pilot found meaningful reductions in ED utilization that were sustained into the third year of the pilot. These reductions translated to nearly $5 million per year in savings for the approximately 100,000 patients touched by the pilot.

Key Study Characteristics

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<tr>
<th>Size</th>
<th>Variables of Interest</th>
<th>Findings</th>
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<tbody>
<tr>
<td>• 15 NCQA PCMH practices</td>
<td>• ED utilization&lt;br&gt;• Cancer screening rates&lt;br&gt;• Ambulatory-care-sensitive inpatient admissions</td>
<td>After third year of PCMH pilot:&lt;br&gt;• 9.3% reduction in ED utilization (resulting in approx. $5 million in savings per year)&lt;br&gt;• 9% increase in cervical cancer screenings&lt;br&gt;• 10.3% reduction in ambulatory-care-sensitive inpatient admissions for patients with two</td>
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NCQA Patient-Centered Medical Homes Drive Quality Improvement, More Effective Utilization of Primary Care and Fewer Hospital and Emergency Department Visits: Northeastern Pennsylvania Chronic Care Initiative

NCQA PCMHs that included shared savings for practices performed better on four process measures related to diabetes and breast cancer screening. They also increased primary care utilization and lowered the use of emergency departments, hospital, and specialty care.

Key Study Characteristics

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<td>• 27 NCQA PCMH practices; 17,921 attributed patients&lt;br&gt;• 29 control practices; 12,894 attributed patients</td>
<td>• 4 process measures related to diabetes care quality&lt;br&gt;• 1 process measure related to breast cancer screening&lt;br&gt;• Utilization of hospitals and Emergency departments&lt;br&gt;• Utilization of primary vs. specialty care</td>
<td>NCQA PCMHs outperformed control group on all 4 diabetes measures:&lt;br&gt;  - 4.2-8.3% better on HbA1c testing&lt;br&gt;  - 4.3-8.5% better on LDL-C testing&lt;br&gt;  - 15.5-21.5% better on nephropathy monitoring&lt;br&gt;  - 9.7-15.5% better on eye examinations&lt;br&gt;• PCMHs produced an average of 4.1-6.8% more breast cancer screenings&lt;br&gt;• PCMHs produced 1.7 fewer all-cause hospitalizations and 4.7 fewer ED visits per 1000 patients per month&lt;br&gt;• PCMHs produced 77.5 more primary care visits and 17.3 fewer ambulatory-care sensitive specialist visits per 1000 patients per month</td>
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NCQA PATIENT-CENTERED MEDICAL HOMES CUT GROWTH IN MEDICARE EMERGENCY DEPARTMENT USE: MEDICARE CLAIMS & ENROLLMENT DATA

NCQA PCMHs cut the growth in outpatient ED visits by 11% over non-PCMHs for Medicare patients. The reduction was in visits for both ambulatory-care-sensitive and non–ambulatory-care sensitive conditions, suggesting that steps taken by practices to attain patient-centered medical home recognition may decrease some of the demand for outpatient ED care.

**Key Study Characteristics**

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<td>308 NCQA-recognized practices</td>
<td>Rate of growth in Emergency Department (ED) use</td>
<td>The rate of growth in ED payments per beneficiary was $54 less for 2009 patient-centered medical homes and $48 less for 2010 patient-centered medical homes relative to non–patient-centered medical home practices</td>
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<td>1,906 control practices</td>
<td>Rate of growth in costs of ED visits for all causes and ambulatory-care-sensitive conditions</td>
<td>The rate of growth in all-cause and ambulatory care-sensitive condition ED visits per 100 beneficiaries was 13 and 8 visits fewer for 2009 patient-centered medical homes and 12 and 7 visits fewer for 2010 patient centered medical homes, respectively</td>
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PATIENT CENTERED MEDICAL HOME

Why does it work?
Why the Medical Home Works: A Framework

<table>
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<tr>
<th>Feature</th>
<th>Definition</th>
<th>Sample Strategies</th>
<th>Potential Impacts</th>
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<td>Patient-Centered</td>
<td>Supports patients and families to manage &amp; organize their care and participates as fully informed partners in health system transformation at the practice, community, &amp; policy levels.</td>
<td>• Dedicated staff help patients navigate system and create care plans&lt;br&gt;• Focus on strong, trusting relationships with providers and care team, open communication about decisions and health status&lt;br&gt;• Compassionate and culturally sensitive care</td>
<td>Patients are more likely to seek the right care, in the right place, and at the right time.</td>
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<td>Comprehensive</td>
<td>A team of care providers is wholly accountable for patient’s physical and mental health care needs – includes prevention and wellness, acute care and chronic care.</td>
<td>• Care team focuses on 'whole person' and population health&lt;br&gt;• Primary care could co-locate with behavioral and/or oral health, vision, OB/GYN, pharmacy&lt;br&gt;• Special attention is paid to chronic disease and complex patients</td>
<td>Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated.</td>
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<td>Coordinated</td>
<td>Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services &amp; supports, &amp; public health.</td>
<td>• Care is documented and communicated across providers and institutions, including patients, specialists, hospitals, home health and public health/social supports&lt;br&gt;• Communication and connectedness is enhanced by health information technology</td>
<td>Providers are less likely to order duplicate tests, labs, or procedures.</td>
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<td>Accessible</td>
<td>Delivers consumer-friendly services with shorter wait times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations</td>
<td>• More efficient appointment systems offer same-day or 24/7 access to care team&lt;br&gt;• Use of e-communication and telemedicine provide alternatives for face-to-face visits and allow for after hours care</td>
<td>Better management of chronic diseases and other illness improves health outcomes.</td>
</tr>
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<td>Committed to quality and safety</td>
<td>Demonstrates commitment to quality improvements through use of health IT and other tools to ensure patients and families make informed decisions.</td>
<td>• EHRs, clinical decision support, medication management improve treatment &amp; diagnosis&lt;br&gt;• Clinicians/staff monitor quality improvement goals and use data to track populations and their quality and cost outcomes</td>
<td>Focus on wellness and prevention reduces incidence/severity of chronic disease and illness.</td>
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TIPS FOR SUCCESS

**Culture**
- Become a continuous learning organization
- Develop staff and communication skills

**Change**
- Monitor "change fatigue"
- Be practical
- Recognize staff and resource limitations

**Communications**
- Keep everyone in the loop – staff, patients, community, and payers
- Work with peer organizations

**Continue**
- Reassess your progress, expectations and timelines
- Modify plans as necessary
- Report your progress to practice, patients and community

Source: Patient Centered Primary Care Collaborative
QUESTIONS – COMMENTS – FEEDBACK