Innovative Quality Improvement for Vulnerable Populations
Table of Contents

- Welcome and Introductions
- Building the Foundation
- Making it Happen
- Case Studies
- Organizational Assessment Tool
- Questions
Learning Objectives

Participants attending this presentation will be able to:

- Identify the foundational elements from PCMH and MU that enable successful population health management
- Learn to identify high-risk patients by stratifying your population using social determinants of health
- Describe at least two key interventions that can be taken to engage community resources to improve targeted outcomes
- Perform an organizational self-assessment of your readiness to effectively manage vulnerable populations and demonstrate improved outcomes
WELCOME AND INTRODUCTIONS
Jeanette Ball, RN, BSN, PCMH CCE
Principal Consultant

- >28 years of healthcare experience, with >10 years in ambulatory administration and >8 years in HIT
- Expertise: HIE development; EHR implementation; practice workflow efficiencies; NCQA Certified Patient-Centered Medical Home Content Expert
- Previously: Medical Center Administrator, large medical group and ambulatory health center; Senior Consultant, Community EMR Implementation; Experienced RN

Sarah Gardner, Associate Vice President
The Evergreen Association of Western NY

- Facilitator, Safety Net Association of Primary Care Affiliated Providers (SNAPCAP)
- Distinguished speaker on collaborative care for high-risk and high-need patients
- Former principal of EquiHealth Strategies, LLC; Director of Health Engagement and Business Development, P² Collaborative of Western New York; Vice President of Benefits and Employee Relations, Prodigy Healthy Group; and Senior Consultant, Aetna
- Featured in USA Today and CFO Magazine
• DSRIP is the main mechanism by which New York State will fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years.

• Safety Net Association of Primary Care Affiliated Providers (SNAPCAP) serves as an advocate for its members in Western New York.

• EHS has dedicated over thirty years to fostering healthy communities in WNY, offering a diverse range of medical, supportive and behavioral services.
Mission Statement

- We foster healthy communities by providing medical, supportive and behavioral services to individuals and families in Western New York, especially those in marginalized populations and/or challenged by chronic or life-threatening diseases.
BUILDING THE FOUNDATION
Feeling Adrift in Seas of Change?

DSRIP
Quality
ICD-10
MU Stage 1
System Upgrades
MU Stage 2
PQRS
PCMH
Patient Portal
BI Strategy
Population Health
Shared Care Plan
Connectivity
Leveraging PCMH and MU as Foundations

Improved Outcomes for SAFETYNET Providers

Improved Patient Safety and Focused Quality

DSRIP and SNAPCAP

• Key Foundational Elements for SAFETYNET Provider Success

DSRIP

SNAPCAP Organizations

Integrated Community Solutions

Foundation: PCMH 2014 and Meaningful Use Stage 2
A Marriage of Two Initiatives

- Access to Care
- Comprehensive Care
- Care Coordination
- High-risk Population Identification
- Population Health Management
- Patient Engagement

Clinical Improvements

Technology Enhancements

- EHR
- HIEs
- Interfaces
- Self-monitoring devices
- BI and Analytics
- Real-time Dashboards and Reporting
A Marriage of Two Initiatives

Clinical Improvements
- Access to Care
- Comprehensive Care
- Care Coordination
- High-risk Population Identification
- Population Health Management
- Patient Engagement

Technology Enhancements
- EHR
- HIEs
- Interfaces
- Self-monitoring devices
- BI and Analytics
- Real-time Dashboards and Reporting

PCMH + MU

The building blocks for PCMH and MU help establish the foundation for bridging these two initiatives
Using Technology for Clinical Improvement

**PCMH and MU bring the following building blocks to organizations…**

**PCMH**
- Patient-centered Access
- Team-based Care
- Population Health Management
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

**MU**
- Advanced Clinical Processes
- Discrete and Structured Data
- Coordination of Care across Continuums
- Patient Portal and Engagement
- Exchange of Information
- Electronic Performance Submissions
- Cross-continuum Care Processes
The Key to Functionality: Interoperability

HEALTHeLINK, the Western New York HIE, was created with the following goals:

- Improving Clinical Interoperability throughout the community
- Optimize the use of technology for chronic disease management through the HIE
- Decrease redundant unnecessary testing
- Point of Care access to up-to-date patient information
- Increase the number of PCMH-modeled practices to improve primary care
Health Information Exchange (HIE)—“The Noun”
## HEALTHeLINK Progress

### Success
- 700,000 patient consents
- 21 direct vendor interfaces
- All hospitals in the Western New York region
- Quest Diagnostics
- Home care monitoring
- Medical Home alerts

### Challenges
- Not accessible in EMR directly
- HL7 data inconsistent
- Normalizing CCD data
- Data analytics
- State connections to Medicaid
Connecting a Community

Result Delivery Practices

© 2015 CTG, Inc.
Finding the Answers

VHR Patient Queries 2014-2015

- VA
- XGateway
- Retrieve
- Rad Images
- Viewed
- Med
- Queries
- VHR
- Transcriptions
Interoperability: Other Options

What if you do not have the advantage of a strong regional HIE availability?

- Consider alignment/participation with an existing provider that has an HIE (Dignity, Sutter, UC system, Kaiser…)
- Consider exploring a State exchange (The CA Dept of Public Health maintains a state based exchange)
- Explore establishing your own HIE: CHeQ offers funding for establishment of rural HIE in CA
- Contact Regional Extension Center additional advice and assistance
- Consider opening a Direct Messaging Account as an interim solution utilizing Direct Messaging
MAKING IT HAPPEN
Our Approach for Assessing Readiness

1. Site visits (Understanding your needs)
2. Assessment Tools (PCMH, MU documentation)
3. Gap Analysis (Color-coded)
4. Dashboards (Monitoring progress)
5. Task Listings (Specific steps for each practice)
6. Project Management (Standard PM oversight)
Assessment Process: Individual Scoring

Based on Remediation Work Effort
- Green: Minimal effort anticipated
- Yellow: Moderate work effort expected
- Red: Intense work effort indicated

<table>
<thead>
<tr>
<th>Two levels of scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Detailed MU and PCMH (Measures and Standards)</strong></td>
</tr>
<tr>
<td>○ 6 PCMH Standards</td>
</tr>
<tr>
<td>○ Stage 1 and Stage 2 (Core, Menu, and CQMs)</td>
</tr>
<tr>
<td><strong>Criteria Evaluation of MU and PCMH</strong></td>
</tr>
<tr>
<td>○ Governance</td>
</tr>
<tr>
<td>○ Technology</td>
</tr>
<tr>
<td>○ Workflow</td>
</tr>
<tr>
<td>○ Reporting</td>
</tr>
<tr>
<td>○ Compliance</td>
</tr>
<tr>
<td>○ Audit</td>
</tr>
</tbody>
</table>
# Rapid Assessment: Six Criteria

<table>
<thead>
<tr>
<th>Categories</th>
<th>Support</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description and Work Effort</strong></td>
<td></td>
<td>Governance</td>
</tr>
<tr>
<td>PCMH - 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Standard 1 - Access</td>
<td>Min</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Practice does have same day access; needs to improve phone triage system for timeliness and remove VM systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Standard 2 - Team Based Care</td>
<td>Min</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Practice does consider continuity with scheduling; would like to improve teams; measures compliance though does not have clear path of improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Standard 3 - Population Health Management</td>
<td>Min</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Has reportable discreet fields; need to improve their use of templates; need to expand their pop health and QI program and use of CDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Standard 4 - Care Management and Support</td>
<td>Min</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Needs to identify high risk groups and patients in need of CM; has to firm up CM program to improve outcomes; need to document goals and barriers more effectively, and utilize shared care plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Standard 5 - Care Coordination &amp; Care Transitions</td>
<td>Min</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mod</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Area of largest improvements around test tracking work flow and supporting technologies; needs process for care transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Standard 6 - Performance Measurement and QI</td>
<td>Min</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Recent establishment of QI program needs to consider care coordination role and measuring effectiveness of role; needs to institute PDSA cycles and re-measurement cycles that effect improvements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Rapid Assessment: Summary

<table>
<thead>
<tr>
<th>Organization</th>
<th>Standard 1</th>
<th>Standard 2</th>
<th>Standard 3</th>
<th>Standard 4</th>
<th>Standard 5</th>
<th>Standard 6</th>
<th>Stage 1</th>
<th>Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Access</td>
<td>Teams</td>
<td>Pop Hlth</td>
<td>Care Mgt</td>
<td>Care Coord</td>
<td>Perf/QI</td>
<td>Core</td>
<td>Menu</td>
</tr>
<tr>
<td>1 Primary Care, Special POP</td>
<td>12</td>
<td>12</td>
<td>16</td>
<td>13</td>
<td>17</td>
<td>18</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2 FQHC-1</td>
<td>8</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>17</td>
<td>18</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>3 Article 28, 16, 31</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>4 Article 28, 16, 31</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>11</td>
<td>13</td>
<td>16</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>5 FQHC-2</td>
<td>12</td>
<td>17</td>
<td>18</td>
<td>14</td>
<td>17</td>
<td>18</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>6 FQHC-3</td>
<td>11</td>
<td>8</td>
<td>6</td>
<td>12</td>
<td>17</td>
<td>6</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>7 Article 28, 16, 31</td>
<td>11</td>
<td>8</td>
<td>13</td>
<td>17</td>
<td>14</td>
<td>16</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>8 FQHC-4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>9 FQHC-5</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>17</td>
<td>12</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>10 Hospital-based Clinic</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>15</td>
<td>15</td>
<td>17</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>11 Hospital-based Clinic</td>
<td>12</td>
<td>12</td>
<td>15</td>
<td>17</td>
<td>13</td>
<td>17</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

**Legend**

<table>
<thead>
<tr>
<th>Interval</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-9</td>
<td>Light Support</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate Support</td>
</tr>
<tr>
<td>15-18</td>
<td>Intense Support</td>
</tr>
</tbody>
</table>

© 2015 CTG, Inc.
Finding Synergies: Quality Measure Overlap

Identify overlaps to streamline processes
### Findings: MU/PCMH/UDS Cross Walk

#### CMS Adult and Pediatric Recommended Measures

<table>
<thead>
<tr>
<th>No.</th>
<th>2014 HRSA UDS Clinical Performance Measures</th>
<th>X - UDS CPMs aligned with eCQMs and PCMH</th>
<th>2014 CQM Name</th>
<th>Adult/Pediatric Recommended Core Set</th>
<th>PCMH 2014 Standards</th>
<th>CMS Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their third birthday.</td>
<td>X</td>
<td>CMS 117v2; NQF 0038 Childhood Immunization Status</td>
<td>Pediatric</td>
<td>PCMH Standard 6A1</td>
<td>Population/ Public Health</td>
</tr>
<tr>
<td>2</td>
<td>Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer</td>
<td>X</td>
<td>CMS 124v2; NQF 0032 Cervical Cancer Screening</td>
<td>Adult</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year</td>
<td>X</td>
<td>CMS 155v2; NQF 0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>Pediatric</td>
<td>PCMH Standards 3E4; 6A3</td>
<td>Population/ Public Health</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented.</td>
<td>X</td>
<td>CMS 69v2; NQF 0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Adult</td>
<td>Adult</td>
<td>PCMH Standards 3E4; 6A3</td>
<td>Population/ Public Health</td>
</tr>
<tr>
<td>5</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user</td>
<td>X</td>
<td>CMS 138v2, NQF 0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Adult</td>
<td>PCMH Standards 3E4; 6A2</td>
<td>Population/ Public Health</td>
</tr>
<tr>
<td>6</td>
<td>Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy</td>
<td>X</td>
<td>CMS 126v2, NQF 0036 Use of Appropriate Medications for Asthma</td>
<td>Pediatric</td>
<td>PCMH Standards 3E4; 6A</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>7</td>
<td>Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 to November 1 of the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic</td>
<td>X</td>
<td>CMS 164v2; NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>Adult</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>8</td>
<td>Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer</td>
<td>X</td>
<td>CMS 130v2; NQF 0034 Colorectal Cancer Screening</td>
<td>Adult</td>
<td>PCMH Standard 6A1</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>9</td>
<td>Percentage of patients aged 12 and older who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis</td>
<td>X</td>
<td>CMS 62v2; NQF 0403 HIV/AIDS: Medical Visit</td>
<td>Both</td>
<td>PCMH Standards 3A; 6B</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>10</td>
<td>Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1C (HbA1C) was less than or equal to 9% at the time of the last reading in the measurement year</td>
<td>X</td>
<td>CMS 122v2; NQF 0059 Diabetes: Hemoglobin A1c Poor Control</td>
<td>Adult</td>
<td>PCMH Standards 3A; 6B</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>11</td>
<td>Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading</td>
<td>X</td>
<td>CMS 165v1, NQF 0018 Controlling High Blood Pressure</td>
<td>Adult</td>
<td>PCMH Standard 3A</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>12</td>
<td>Additional Measures: In addition to the above UDS clinical measures, health centers must include one Oral Health performance measure of their choice.</td>
<td>X</td>
<td>CMS 75v3; NQF (TBD) Children Who Have Dental Decay or Cavities</td>
<td>Pediatric</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
</tbody>
</table>

#### 5 Pediatric Core CQMs Align with UDS Clinical Performance Measures
1. Childhood Immunization Status
2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
3. Use of Appropriate Medications for Asthma
4. Children Who Have Dental Decay or Cavities
5. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

#### 4 Adult Core CQMs Align with UDS Clinical Performance Measures
1. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
2. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
3. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
4. Controlling High Blood Pressure
### How are you identifying your high-risk populations?

- **Identification of high-risk patient populations**
  - Diagnosis, co-morbidities, utilization patterns, labs, demographics and social determinants…

- **Risk stratification**
  - Low, medium, and high

- **Interventions**
  - Highest risk consumes most resources

- **Coordination of care longitudinally**
CASE STUDIES
Meeting the Patient Where They Are!

Harm reduction model with non-judgment: wrap-around services to begin trust relationship
Holistic Approach to Addressing Changing Population Demographics

**WNY has the highest rate of refugee immigration in NYS**

- Many refugee patients: HIV+ patients from Burma
  - Burma: behind in science for HIV care
- First priority: improving viral load reduction
- Wrap-around services (providing safe entry for patients needing care)
- Many services added to address Burmese population
- Great entry to begin trust relationship for primary care
- Sustainability and transitional support
Case Study: Diabetic Health Outcomes

Challenge: Improve diabetic healthcare for high-risk, low-income populations in a manner that meets the patient where they are

Rural: Amish community
- No phones
- Cultural barriers
- Cooking restrictions

Urban: FQHC population
- High Medicaid
- Fast food diet
- High no-show rate
Case Study: Paper to EHR to PCMH Excellence

Start at the beginning

- CTG developed 45 project tools for distribution to each site
- Policy and procedures, call logs, and other PCMH tools were created
- Baseline statistics collected for PCMH using a standardized tools (APC)
- Each practice conducted Diabetic Outcome quality studies.
- Consistent sampling was conducted at each site using NCQA sampling selection methodology
Introduction of Technology

By applying key technology, practices were able to leverage advanced workflows to drive improved outcomes in a cost-effective manner.

**Introduction to EHR**
- Using PCMH improve workflows
- Remove paper flow
- Develop electronic messaging
- Reporting and quality measurement

**Access to HIE (HEALTHeLINK)**
- Interface for results delivery
- ADT for transitions in care
- Home care results download
- Medication reconciliation through SureScript Medication History
Building on progress and prior success

- The consultants demonstrated how chronic disease can be managed at a population level and patient point of care level by including EHR template changes.
- Practices began experiencing eye-opening opportunities to begin their journey towards quality, pay for performance, and meaningful use.
- Offered access to local HIE and as a result, additional community providers and services.
- Developed enhanced workflows with technology to drive better outcomes.
Diabetic Patient Outcomes

Objective:

- Demonstrate chronic disease can be managed at the population level as well as at the patient level

<table>
<thead>
<tr>
<th>Population Improvement</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall improvement in HgbA1C</td>
<td>77.4%</td>
</tr>
<tr>
<td>At or below HgbA1C of 7.0 or showed improvement.</td>
<td>77.4%</td>
</tr>
<tr>
<td>At or below LDL of 100 or showed improvement.</td>
<td>80.3%</td>
</tr>
<tr>
<td>Systolic BP was at or below 130</td>
<td>78.6%</td>
</tr>
<tr>
<td>Diastolic BP was at or below 80 or showed improvement.</td>
<td>83.7%</td>
</tr>
</tbody>
</table>
ORGANIZATIONAL SELF-ASSESSMENT TOOL
Self-Assessment: Governance

1. Governance
   - Is there a overall multidisciplinary governance structure in place to work with practices to:
     - Vision-driven decision process?
     - Identify and define goals?
     - Manage expectations against set goals?
     - Provide intervention and escalation as needed
   - Establish and drive PDSA cycles for improvement

2. Medical Home

3. Technology

4. Clinical Content

5. Reports
Self-Assessment: Medical Home

1. Governance
2. Medical Home
3. Technology
4. Clinical Content
5. Reports

- Do you have a comprehensive approach for encompassing and providing total patient care?
- Do you have a structure in place that supports same day access?
- Do you care team members provide care at the height of their license?
- Can you identify and manage high-risk populations
- Do I have Performance Measurements and Quality Improvements?
Self-Assessment: Technology

1. Governance
2. Medical Home
3. Technology
4. Clinical Content
5. Reports

- Is your technology sufficient to identify your target populations?
- Can your technology support transitions of care/summaries?
- Does your technology provide opportunities for pt engagement?
- Do you have an HIE for interoperability?
- Do you have CDS that guides clinicians to best practice?
Self-Assessment: Clinical Content

1. Governance
   - Are there standardized guidelines for capture of patient care data?

2. Medical Home
   - Are there target conditions that are actively managed and measured across all practices?

3. Technology
   - Is patient information captured in a consistent manner?

4. Clinical Content
   - Do you have a data governance approach to collecting and managing patient data?

5. Reports
Self-Assessment: Reports

1. Governance
2. Medical Home
3. Technology
4. Clinical Content
5. Reports

- Do you have adequate baseline reporting to support identified metrics?
- Are reports routinely internally validated?
- Can reports be created by end-users (self-serve reporting)?
- Do you have a decision process and prioritization method for identifying reporting needs?
Survival

Providing the right care, to the right patient, at the right time, in the right way and being able to prove it.

Evidence based content with decision support

Actionable Outcomes

EHR functionality
 Workflow integration by role

© 2015 CTG, Inc.
CONTACTS

Sarah Gardner  
Associate VP, Evergreen Health Services  
(716) 847-0212  
SGardner@evergreenhs.org

Linda Lockwood  
Solutions Director, Advisory Services  
(410) 310-6571  
Linda.Lockwood@ctghs.com

Jeanette Ball  
Principal Consultant, Advisory Services  
(716) 392-7623  
Jeanette.Ball@ctghs.com