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A National Web Conference on the Impact of Implementing Novel Health IT Interventions for Cancer Screening, Diabetes, and Childhood Illnesses

July 31, 2014
2:30pm – 4:00pm ET

Moderator and Presenters Disclosures

Moderator:

Ed Lomotan, M.D.*

Agency for Healthcare Research and Quality

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*Have no financial, personal, or professional conflicts of interest to disclose.

† Dr. Atlas would like to disclose that he is a beneficiary from a royalty arrangement with SRG Technology for the commercialization of the population management system, although no payments have been made to date.

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The Role for Population Health Management in Primary Care Network: Preventive Cancer Screening as a Case Study

Steven J. Atlas, M.D., M.P.H.
Director, Practice Based Research & Quality Improvement
Massachusetts General Hospital
July 31, 2014

Today's Goals

- Population health management in primary care
  - Preventive cancer screening as a model
- Proof-of-concept study: Massachusetts General Hospital (MGH) Mammography FastTrack study to improve breast cancer screening
- Demonstration trial: TopCare for comprehensive cancer screening(breast, cervical, colorectal)
- TopCare Implementation at Partner's Healthcare

Population Health Management

- Is this something new?
- Application of public health principles to the private health care system
  - Well-defined populations
  - Focus on vulnerable groups: leading to interventions outside of traditional care settings
  - Importance of surveillance
  - Role of prevention
  - Impact of chronic disease on health
  - Need to assess outcomes of care

Population Health Management

- Why now?
- Population health is at the heart of the Affordable Care Act (ACA)
  - Extend insurance coverage to more individuals
  - New payment models to control costs
  - New ways to deliver high-quality, affordable care [for example, accountable care organizations (ACOs)]
- Primary care transformation using patient-centered medical home models
- Dissemination of health information technology (IT) (HITECH Act)

Cancer Prevention Background

- Despite benefits of preventive cancer screening, rates among eligible individuals remain suboptimal
- Shortcoming of existing office-based IT reminders
  - Patients may miss regular follow-up visits or
  - Screening may be overlooked because of competing demands due to limited time during encounters
- Population-based reminders not requiring office visits may increase use of recommended services
  - Information technology can automate processes
  - Payment reform supports care redesign efforts

Proof-of-Concept: Mammography FastTrack*

- Study goal: increase mammography rates in women overdue for screening
- Study period: 3/20/07 – 3/19/10
- Physician/practice case manager reviewed overdue list
  - Selected patients for reminder letter
- Study design: 6 of 12 practices randomly assigned to use tool (control practices = usual care)
  - 4,487 patients in intervention practices
  - 59 of 64 (92%) intervention providers used tool
  - Actions taken: 64% letter, 12% deferred, 24% none

* NCI R21 CA121908

Your Mammography Quality Report and List of Potentially Overdue Patients – Please Open! - Message (Rich Text)

File Edit View Insert Format Tools Actions Help

Paste All Items

Send Attach as Adobe PDF Options...

Times New Roman 12

To... Atlas, Steven J, M.D.

Cc...

Subject: Your Mammography Quality Report and List of Potentially Overdue Patients – Please Open!

Mammography data is now available for your primary care panel.

We have identified all women between the ages of 42-69 years that are directly linked to you and linked them to their mammography results for the past 2 years.

Please select the following link to review the results for your panel and to take action to electronically order mammograms for your overdue patients.

http://oncall.partners.org

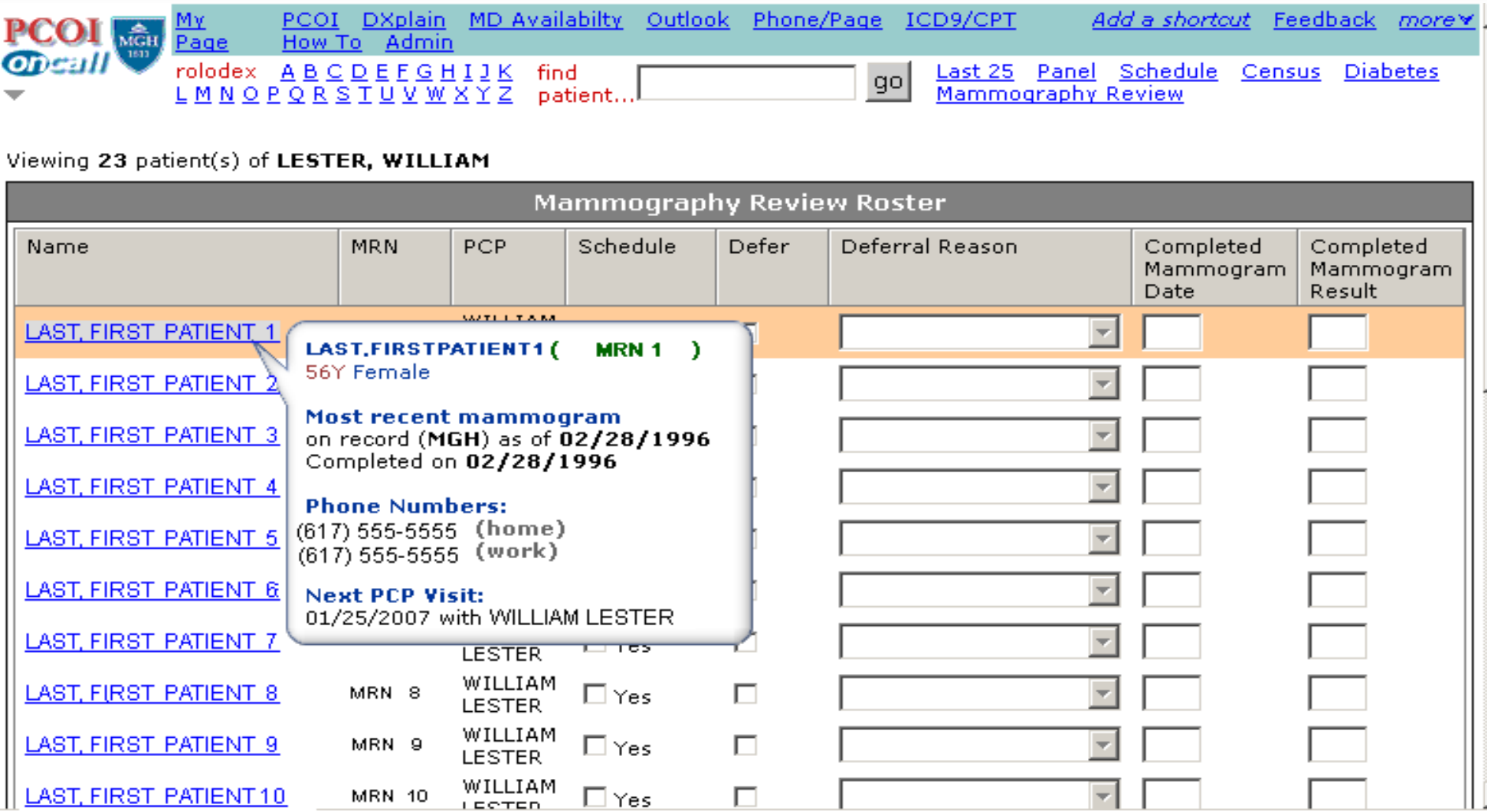
We hope this information is helpful to you. Please don't hesitate to contact me with any questions or comments.

Sincerely,

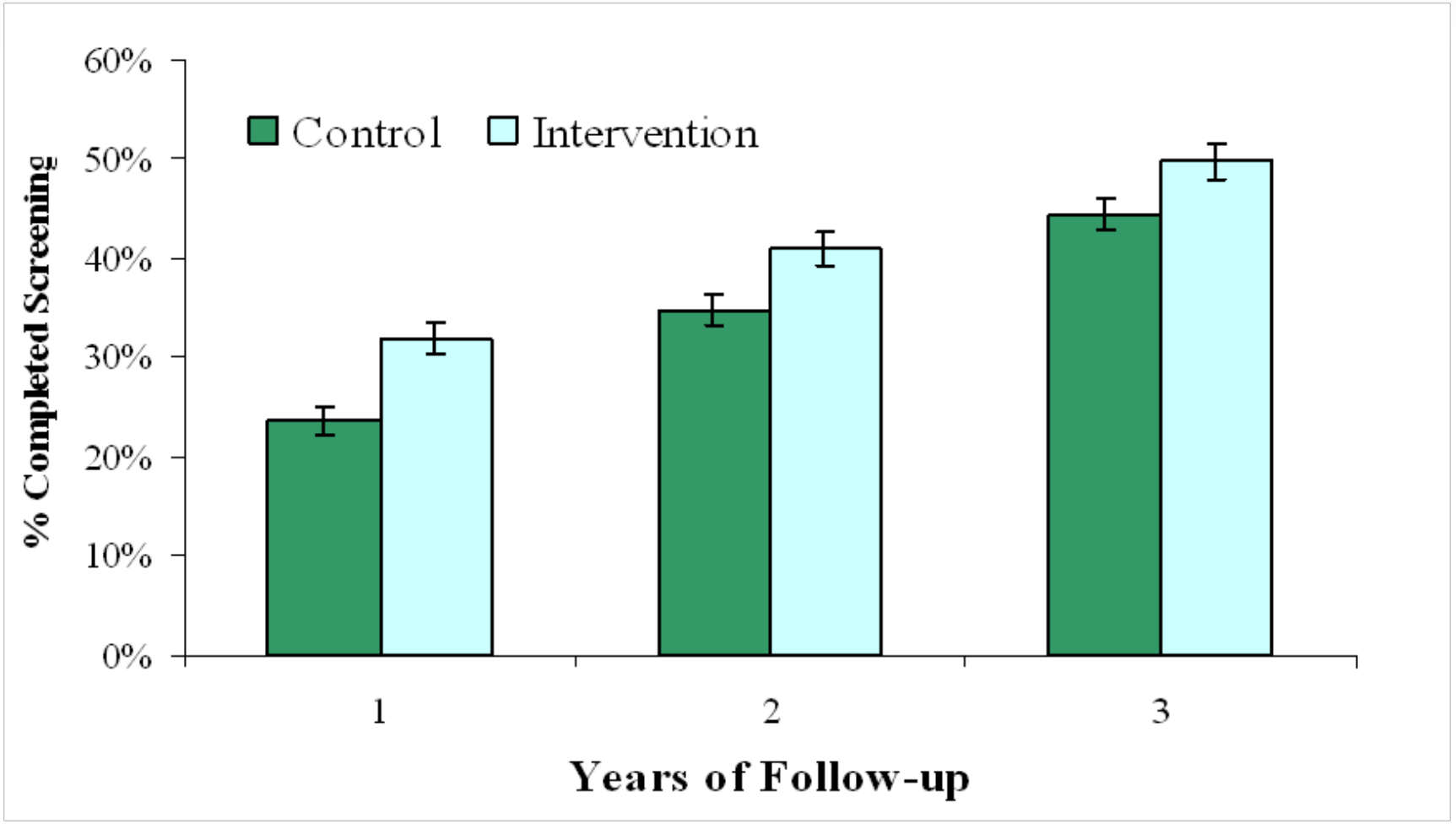
Michael J. Barry
Director, MGH Primary Care Operations Improvement

Start \\Sf... SA... Inb... Gm... Ins... Em... You... Fas... 12:21 PM

Provider Tool Interface



Overdue Patients Completing Screening by Year



Atlas et al., J Gen Intern Med 2011; Am J Manag Care 2012

TopCare*

Technology for Optimizing Population CAre in Resource-Limited Environment

- **Comprehensive cancer screening:** breast, cervical, colon
- **Population-based surveillance:** for all eligible patients seen in MGH primary care practices
- **Nonvisit based IT system:** complements existing visit-based/specialty efforts
- **Population health proof-of-concept:** IT supporting care redesign to improve outcomes in real-world setting
- **Demonstration project:** assessing provider's unique knowledge as catalyst for improved care

* AHRQ R18-HS018161

TopCare: Key System Features

- **Patient identification**: overdue for cancer screening
- **Patient attribution**: assigned to primary care provider (PCP) or practice
- **Outreach**: automated reminder letters
  - Intervention: provider can also send directly to delegate, patient navigator, or defer screening
  - Central call center for patients to report outside tests
- **Active surveillance**: tracking tests and outreach
- **Contact management**
  - Practice delegates make/receive outgoing/ingoing calls
  - Navigators for patients at high risk for noncompliance

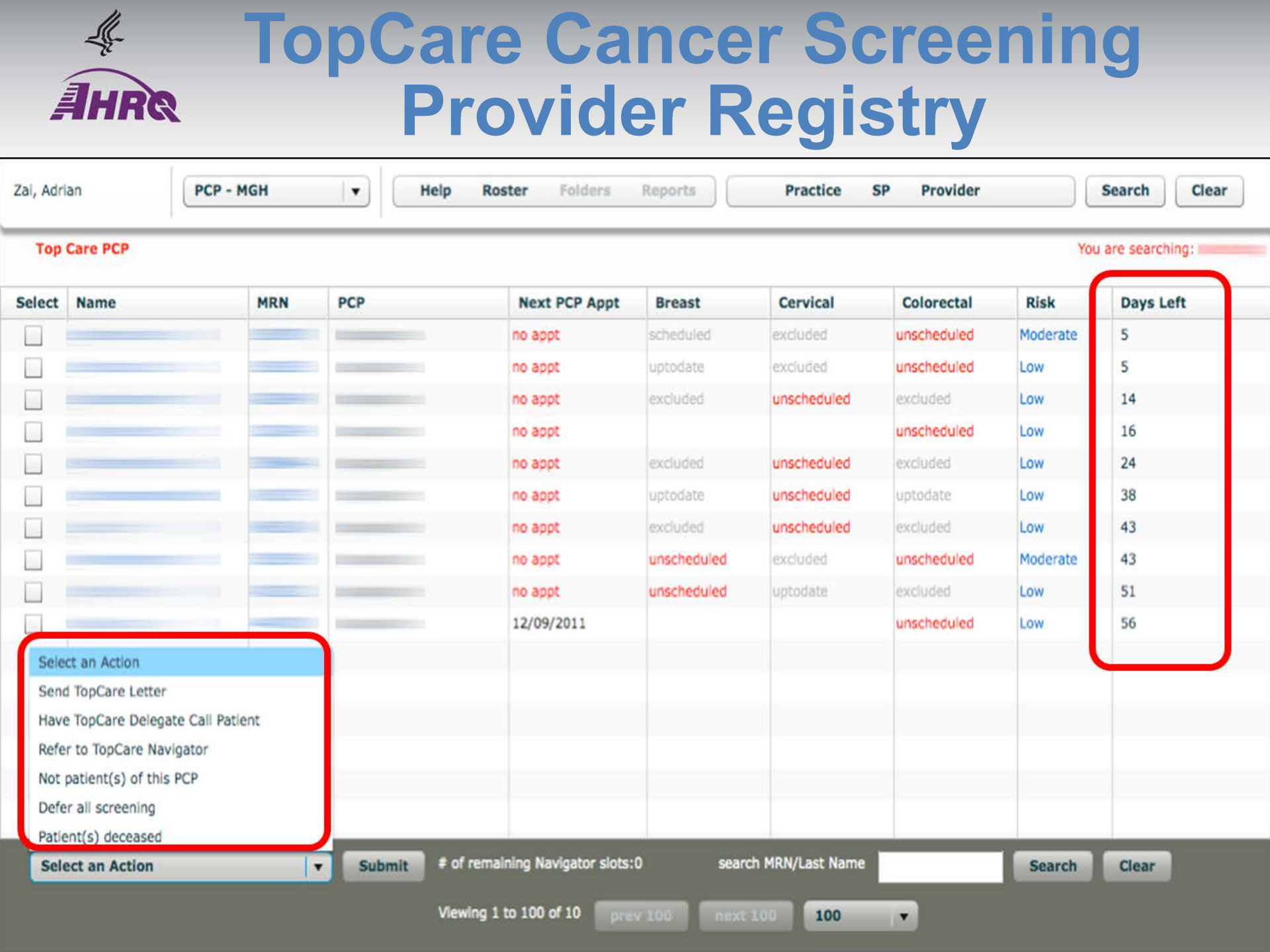
Study Design

- Cluster randomized trial of 18 practices sites in MGH primary care practice-based research network to the intervention (n=9) or control (n=9) groups
- TopCare implemented in all study practices for 1 year (6/15/2011 – 6/14/2012)
- Eligibility criteria:
  - Breast: women 42–74 years, no mammogram in past 2 yrs
  - Cervical: women 21–64 years, no Pap smear in past 3 yrs
  - Colorectal: men/women, 52–75 years, no colonoscopy in past 10 years, or sigmoidoscopy/CT colonography in 5 yrs

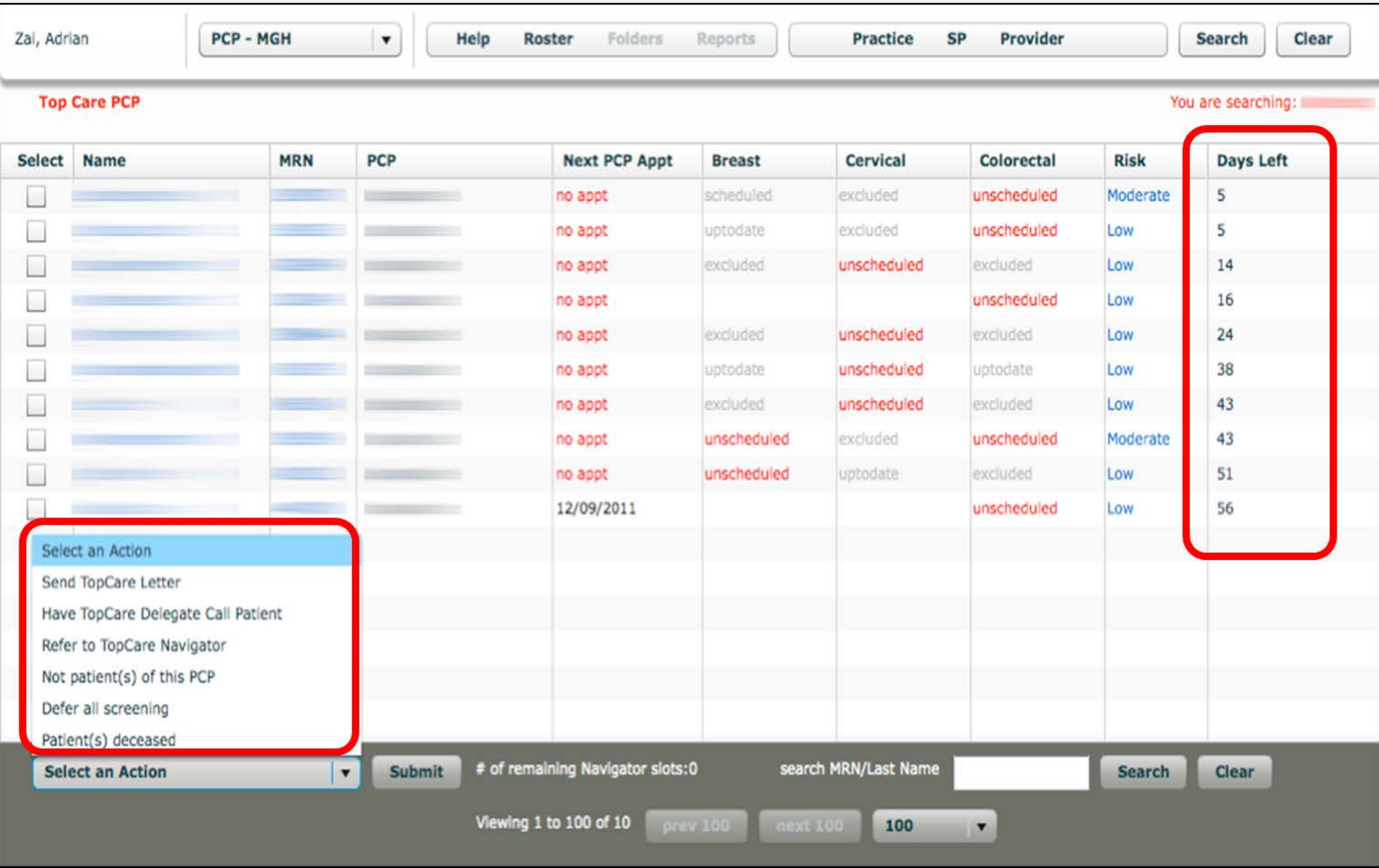
TopCare Interventions

- Control group: augmented usual care (AUC)
  - Automated application identified all patients overdue for cancer screening and mailed reminder letters
- Intervention group: AUC with PCP input
  - Physicians or population managers used the application to screen a list of overdue patients
  - Hypothesis: involving PCPs would lead to more effective and efficient cancer screening

TopCare Cancer Screening Provider Registry



Web Page with Additional Information/Options



Custom Letters

Massachusetts General Hospital
Attn: Evanthia Kartsagoulis
Founders 736
55 Fruit Street
Boston, MA 02114-2696

MASSACHUSETTS GENERAL HOSPITAL

To: Maria Gonzales

Sep 11, 2011

pruebas de detección de cáncer. EL objetivo de estas pruebas es el de prevenir
tarlo tempranamente, antes que aparezcan síntomas que el paciente o el
y curarlo. Quiero asegurarme de coordinar una cita para realizar la prueba, si
registros si nuestra información no es correcta.

ografía al menos cada dos años para detectar cáncer de mama. Si ya está
artamento de Radiología al **617-724-XRAY (9729)** o visite:

enos cada tres años para detectar cáncer cervical. Si ya debería hacerse la
colaou, por favor llame al consultorio del médico donde rutinariamente se lo

berán hacerse una prueba de detección de cáncer de colon al menos cada diez
a cita para una colonoscopía, por favor llame a nuestro equipo especialista en

cúne los requisitos para realizarse las siguientes pruebas de detección de
ás recientes, y si ya debería hacerse pruebas adicionales:

del cáncer	Fecha más reciente	Estado
a	Fecha no documentada	Atrasado
u	Fecha no documentada	Atrasado
	Fecha no documentada	Atrasado

con sus pruebas de detección de cáncer, por favor, envíenos un correo
al **617-643-0287**para hacérnoslo saber. Puede dejar un mensaje privado en
ara que actualicemos los registros. Cuando deje un mensaje, por favor,
fecha de la prueba, qué prueba se realizó, dónde se la realizó y cuáles fueron
i no está seguro de todos estos detalles, deje toda la información que conozca.
e resultados que tenga al **617-228-4560**, o por correo a:

Massachusetts General Hospital
Attn: Evanthia Kartsagoulis
Founders 736
55 Fruit Street
Boston, MA 02114-2696

MASSACHUSETTS GENERAL HOSPITAL

To: Jane Doe
25 Home Street
Cambridge, Massachusetts 02142
United States

Sep 18, 2011

Dear Jane Doe,

I am writing to check on whether you are up-to-date on cancer screening test(s). The goal of screening is to prevent cancer from developing in the first place, or to find it early, before there are any signs a patient or doctor can see, when it is easier to treat and cure. I want to make sure we schedule a screening test if you are overdue, or update your records if our information is not correct.

Women should consider having a mammogram at least every two years to screen for breast cancer. If you are overdue, please contact our Radiology department at **617-724-XRAY (9729)** or *www.massgeneralimaging.org/mymammo.*

Women should have a Pap test at least every three years to screen for cervical cancer. If you are overdue and would like to schedule a Pap test, please call the doctor's office where you routinely get your Pap test done.

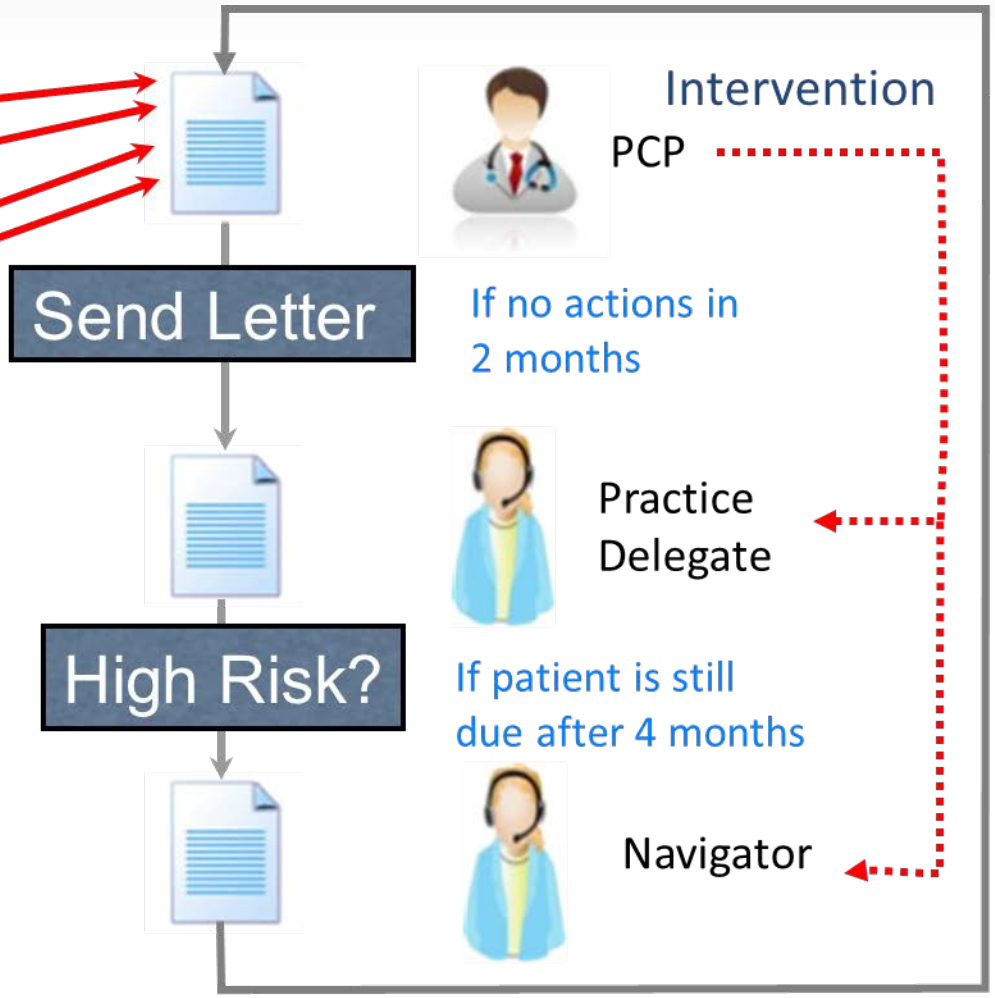
All eligible patients should have colon cancer screening at least every ten years. If you are overdue and would like to schedule a colonoscopy, please call our gastroenterology specialist group at 617-726-2426.

Your medical records here show that you are eligible for cancer screening for the following tests, the date of your most recent test, and whether you are due for additional testing:

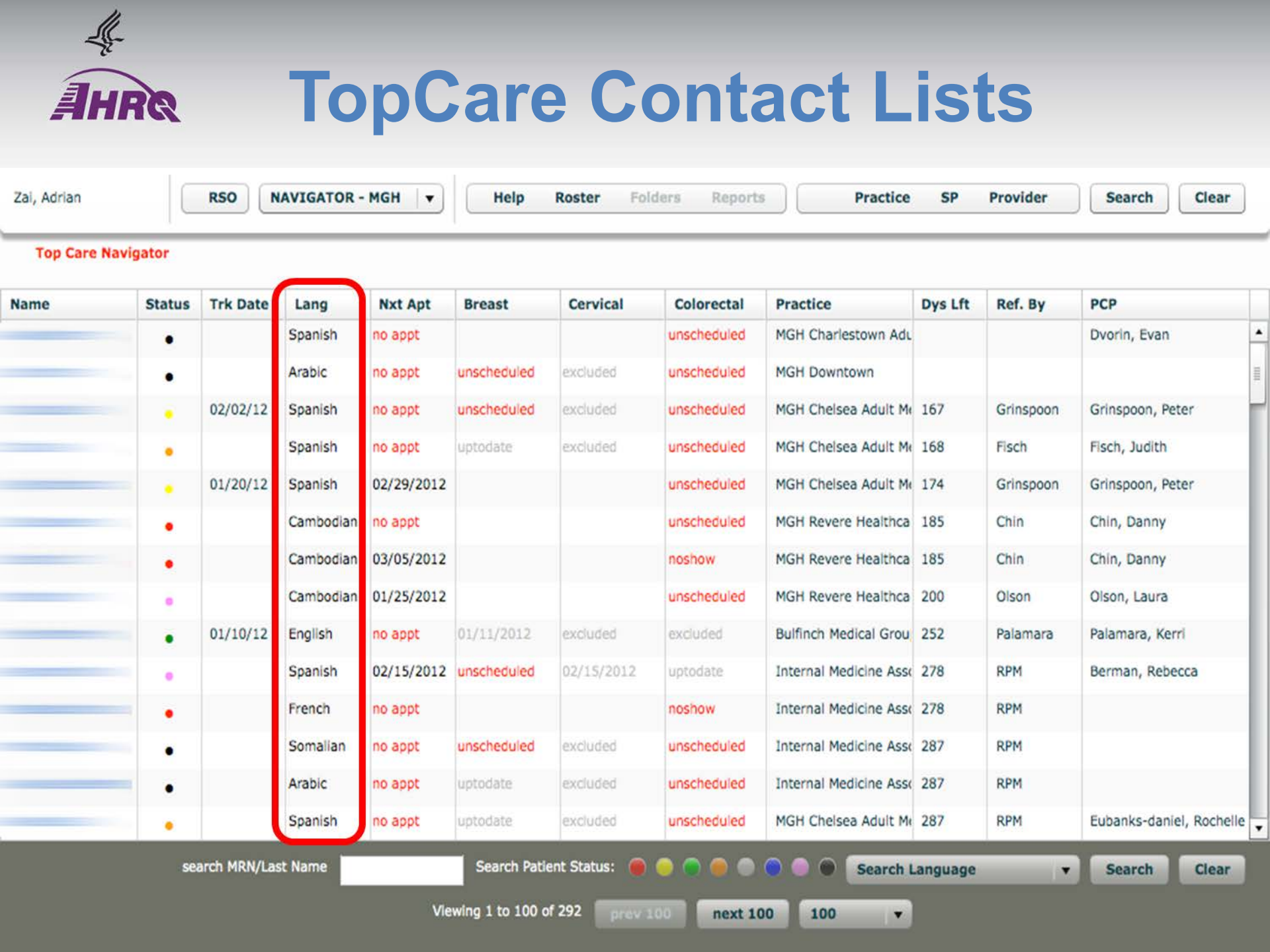
	Cancer Screening Test	Most Recent Date	Status
Breast:	Mammogram	No date recorded	Overdue
Cervical:	Pap Smear	No date recorded	Overdue
Colon:	NA	No date recorded	Overdue

If our records are incorrect and you are up to date on your cancer screening, please email us at *careupdate@partners.org* or call **617-643-0287** to let us know. You can leave a private message with our Care Update Service so that we can update your medical record. When you leave a message, please tell us your name, medical record number, the date of the screening test, what the test was, where you had it done, and what the results were (if it was not done here at MGH). If you are not sure of all the details, just leave as much information as you can. You may also send us any reports of your screening test by fax (**617-228-4560**) or mail:

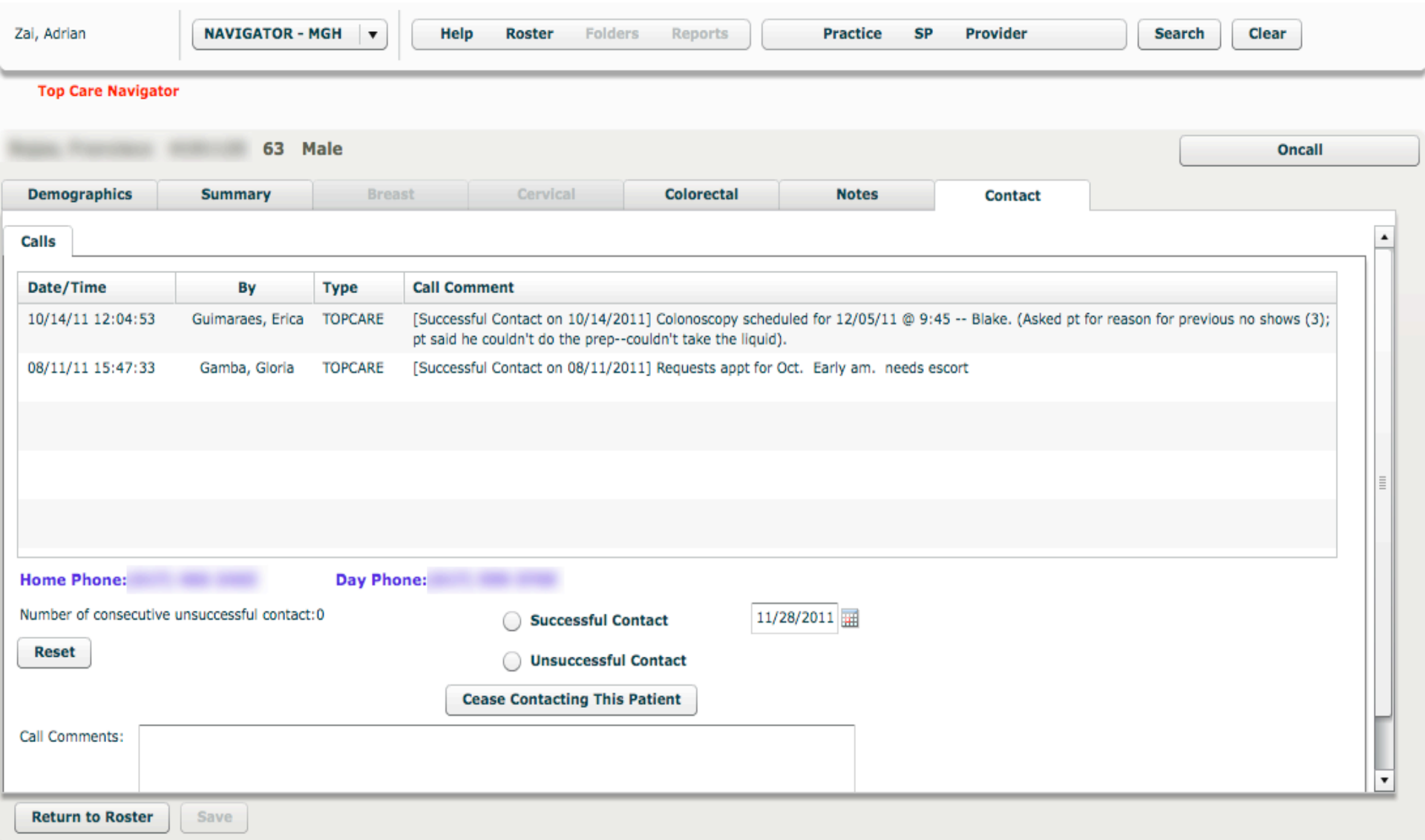
TopCare has an Active Surveillance System



TopCare Contact Lists



Contact Management



TopCare Intervention Trial

88 out of 101 (87%) providers
reviewed 9784 of 16573 (48%) patients

PCP

Defer/Exclude :
1662 (21%)

5874

Letters

401

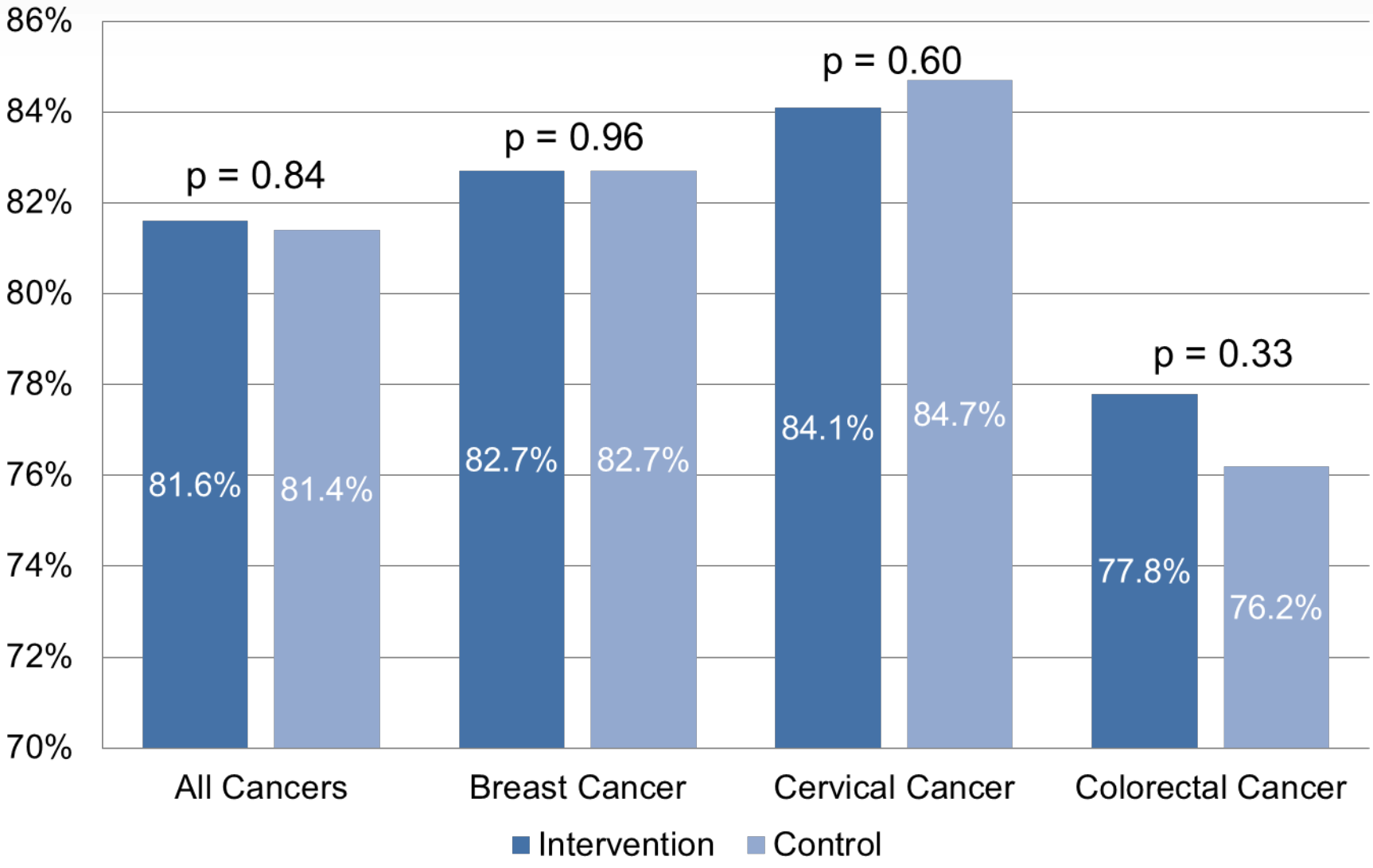
Practice
Delegate

47

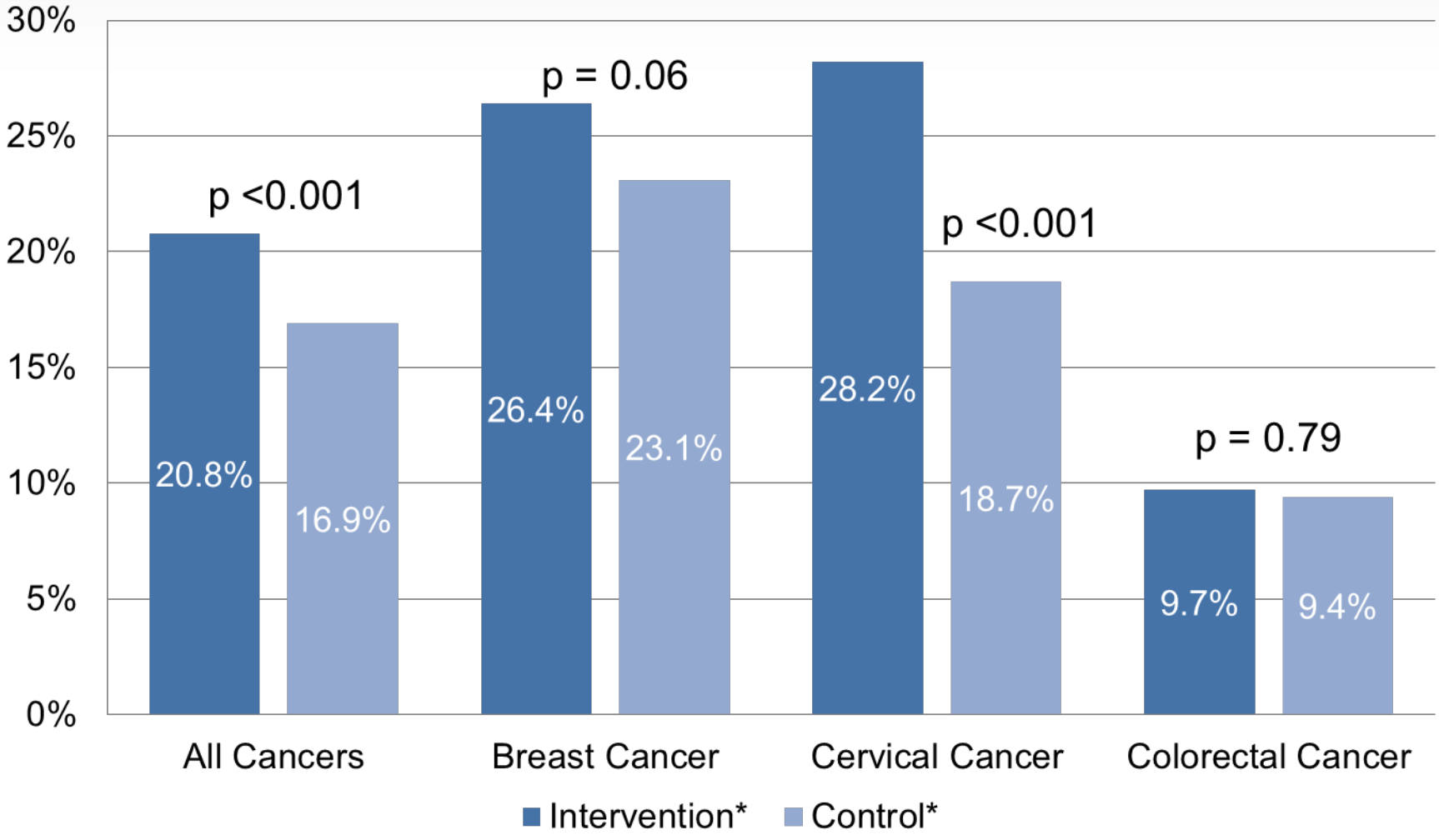
Navigator

Total intervention letters: 5874+6128=12,002 (24%)
Total control letters: 16,378 (31%)

1-Year Outcomes: Average Screening Rates Among All Eligible Patients

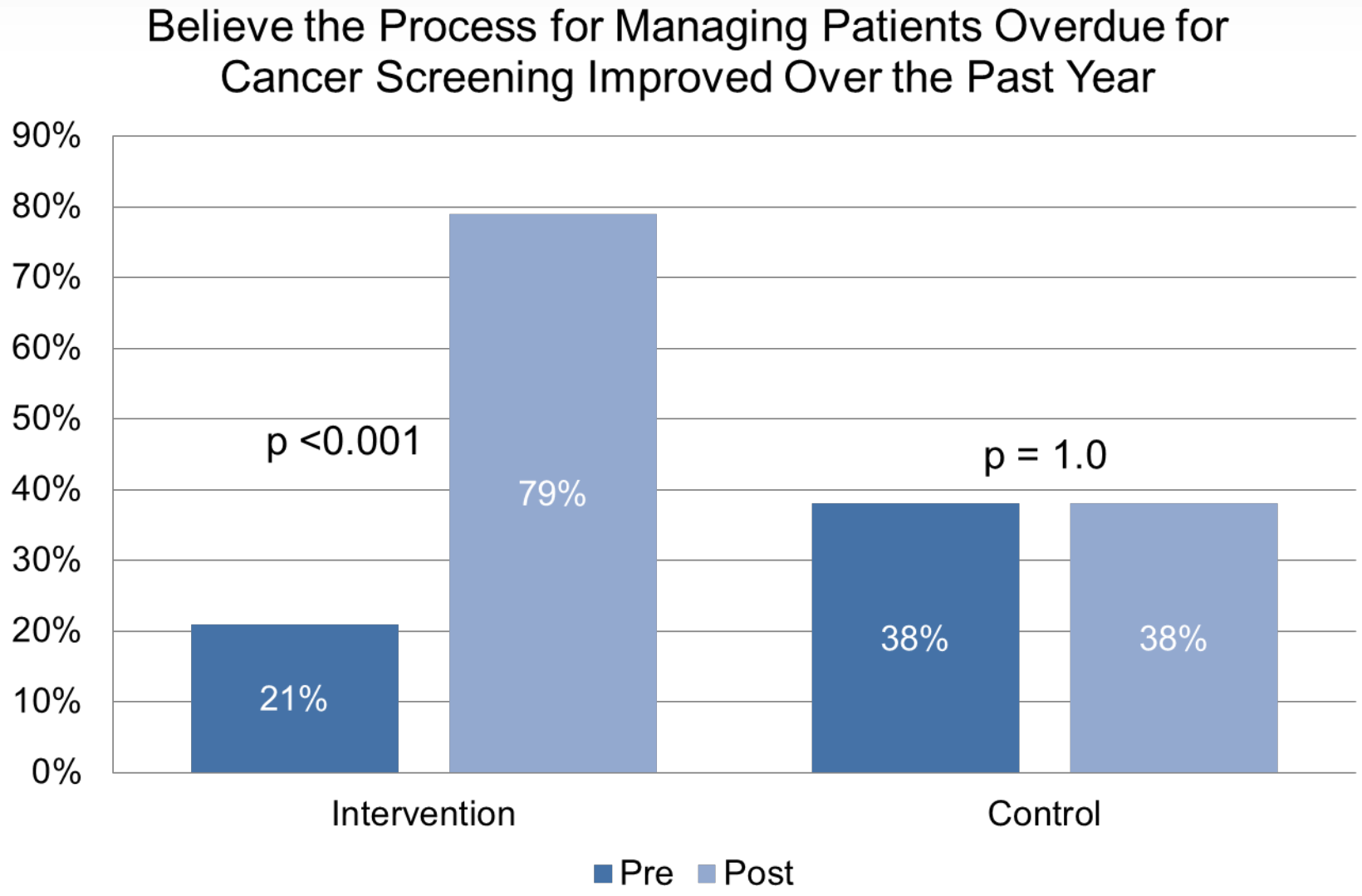


1-Year Outcomes: Average Screening Rates Among Overdue Patients

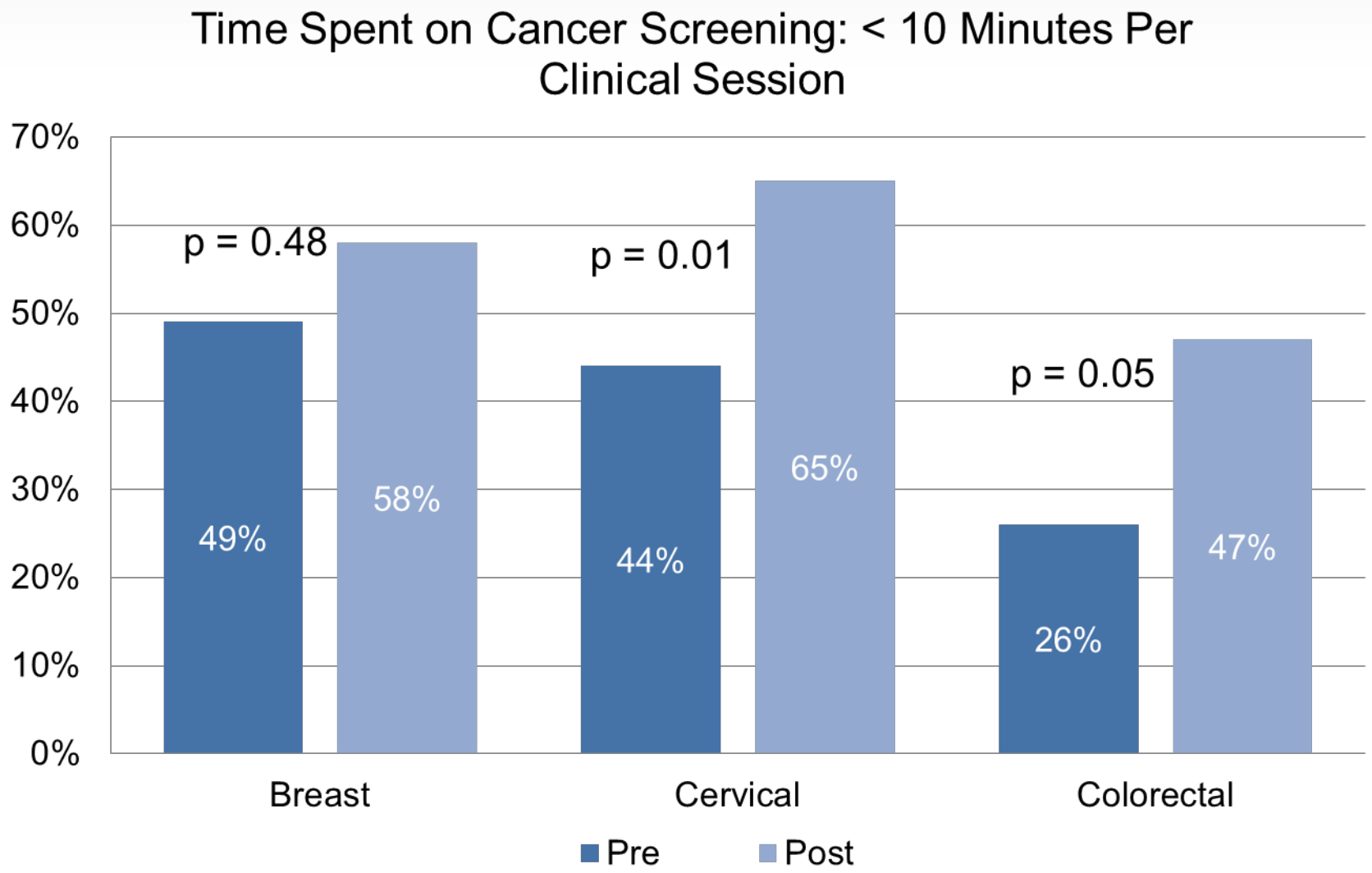


* Among practices in the top tertile of delegate use

Provider Survey: Satisfaction



Survey Response: Intervention Providers*



* No significant differences in responses for PCPs in control practices

Conclusions

- Involving PCPs in a visit-independent, population management health IT system did not increase screening rates compared to an automated reminder system.
  - However, similar rates were achieved with fewer patient contacts in intervention practices.
  - Among practices where delegates used TopCare more, improved screening rates were found among overdue patients in intervention group.
  - Intervention PCPs thought process for managing cancer screening improved and spent less time on it during clinic visits.

Post-Study Implementation

- All practices continue cancer screening
  - Choice of using reviewing list (PCP or designee) or not
- Addition of diabetes registry
  - Overdue for testing
  - Referral to diabetes champion for insulin management
- Rollout of TopCare v2.0
  - New registries: heart disease, hypertension, panel management

Nightly Maintenance Tomorrow at 2:00 AM (more...)

TopCare

Steven Atlas Support Profile Tasks (0), Messages (0) Help

[Last Logged On: Jul 23, 2014 10:28 AM]

HOME | WORKSPACE | REGISTRIES | ADMIN

Populations
Interventions

CardioVascular Events (PHM)
Cervical Screening (PHM)
Colorectal Screening (PHM)
Diabetes (PHM)
Hypertension (PHM)
Mammo Screening (PHM)
My Panel (PHM)

My Profile

Steven Atlas
Director, Primary Care Rese
Improvement
MGH

Edit My User Account
Edit My User Profile

Need Help?

Send us a help desk request

- **Help Desk Requests**
- Frequently Asked Questions

Training Materials & Discussions

News & Announcements

7/15/2014

New TopCare reports are out!
Hi team,For those who have access to TopCare reports, I just want to inform you that the reports are all in production now. Check them out!Please be ... Read More

7/1/2014

TopCare 2.0 Official Rollout at MGH –Please Read
Dear Colleagues, I'm writing to remind you that on Wednesday, July 2nd, we will be turning on the TopCare 2.0 functionality to all users at... Read More

5/29/2014

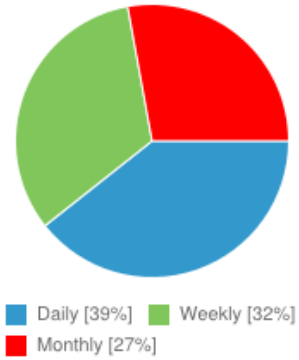
New CVE roster is up!
Hi team,As usual, let the beta testing begin.Thanks,Adrian Read More

All News

Pulse Check

Thank you for participating.
How often do you use TopCare?

Poll Results:



Have ideas to improve TopCare?

- New Patient Registry
- New Registry Risk Criteria
- Application Enhancement
- Research Interest
- General Question

TELL US!

Contact Information

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Advancing Excellence in Health Care • www.ahrq.gov

Impact on Implementing Novel Health IT Interventions for Diabetes

July 31, 2014

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Chief Officer for Population
Health & Equity, BSWH

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Member, National Advisory Council, AHRQ

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Medical Director of Clinical Operability,
BSWH Quality Alliance
Sr. VP Medical Informatics,
Health Texas Provider Network

Topics to be Covered

1. EHR deployment research – areas of interest:
   a. Financial productivity effects
   b. Clinical effectiveness
2. Deployment and utilization of an EHR in a provider network
3. EHR clinical effectiveness for diabetes care
   a. Intervention: specific diabetes care-related functionality
   b. Lessons learned—diabetes care process and outcomes
4. Future plans

Research Study I: Financial Productivity and Effects

- Title: Impact of Health IT on Primary Care Work-flow and Financial Measures: 1R03HS018220-01
- Funding timeline: 09/30/2009 – 09/29/2011
  - Aim 1: to estimate the effect of the EHR on workflow outcome measures.
  - Aim 2: to estimate the effect of the EHR on financial measures.
  - Aim 3: to quantify financial and nonfinancial costs of health IT implementation and maintenance, contributing knowledge about perceived barriers and facilitators to EHR adoption and implementation.

Financial Productivity and Effects

Total Cost Of Implementation Of Electronic Health Record System For An Average Five-Physician Practice In The HealthTexas Provider Network Through First Year Of Use

Expenditures	Costs through 60 days after launch	First-year costs[a]	Total costs[b]
FINANCIAL COSTS (DEPRECIABLE CAPITAL EXPENSES)			
Hardware costs (fixed)	$25,000	$0	$25,000
Hardware costs (variable)	$35,290	$0	$35,290
Software license, hosting, etc. (variable)	$14,250	$85,500	$85,500
NONFINANCIAL COSTS			
HealthTexas network implementation team (fixed)	$28,025	$0	$28,025
Practice implementation team (fixed)	$7,413	$0	$7,413
Practice end user (variable)	$51,657	$0	$51,657
TOTAL			
Per practice	$162,047	$85,500	$232,297
Per physician	$32,409	$17,100	$46,659

SOURCES Authors' interviews with key informants; authors' analysis of HealthTexas documents and salary data. **NOTES** Data are from the twenty-six primary care practices in the network that implemented the electronic health record between June 2006 and December 2008. Fixed costs are constant across practices, regardless of size. Variable costs depend on the number of physicians in a practice. [a]Includes costs for first sixty days after launch. [b]Not all totals in previous columns sum to total because of double counting of some operating costs.

Research Study II: Clinical Effectiveness

- Title: Impact of Health IT Implementation on Diabetes Process and Outcome Measures
  - AHRQ grant: R21 HS20696-02
  - Funding timeline: 06/01/2011 – 05/31/2013
- Objective: to assess the impact of EHR implementation on the primary care of diabetes
- Data sources: charts were abstracted semiannually for 14,051 diabetes patients seen in 34 primary care practices.

Clinical Effectiveness: Specific Aims

- Primary aim: to estimate the impact of an EHR on diabetes outcomes, measured by the proportion of patients meeting the Health Partners Optimal Diabetes Care measure.*
- Secondary aim 1: to estimate impact of an EHR on specific patient outcomes and compliance with recommended process of care related to diabetes.
- Secondary aim 2: to estimate the prevalence of physician use of the Diabetes Management Form (DMF), and the effect of the DMF on patient outcomes related to diabetes as measured by the Optimal Diabetes Care measure.

*Optimal Diabetes Care Measure = HbAlc ≤ 8 percent; LDL cholesterol < 100 mg/dl; blood pressure < 130/80 mmHg; not smoking; and documented aspirin use (for patients ≥ 40 years).

Clinical Effectiveness: Intervention 1

Deployment of the HealthTexas Provider Network (HTPN) Electronic Health Record

Impact of EHR Exposure on the Delivery of Optimal Diabetes Care

Setting: HealthTexas Provider Network

211 care delivery sites including

- 69 primary care centers
- 103 specialty care centers
- 32 satellite specialty care clinics
- 7 hospitalist programs
- 3 pulmonary critical care units
- 8 liver disease outreach clinics
- 5 advanced heart failure clinics
- 1 kidney outreach clinic
- 3 senior health centers
- 26 cardiovascular care sites
- 2 MRI centers

> 780 practitioners including:

- 647 physicians
- 134 physician extenders

Plus:

- 71 registered nurses
- 102 licensed vocational nurses
- 610 medical assistants

Clinical Effectiveness: Data Collection

What made this study possible is the contemporaneous collection of data on diabetes patients.

- In 2007 HTPN established and began populating a retrospective diabetes prevalence cohort database using the AMA Physician Consortium Adult Diabetes Performance Measure set.
- Each cohort was defined by the claims-based algorithm used by the Centers for Medicare & Medicaid Services (CMS)
- All patients with ≥2 ambulatory care visits ≥7 days apart with a diabetes-related billing code (CMS National Measurement Specifications Diabetes Quality of Care Measures [2002]: ICD-9-CM Diagnosis Codes 250.xx) during the preceding 12 months were identified from administrative data.

Clinical Effectiveness: Study Population

All patients who :

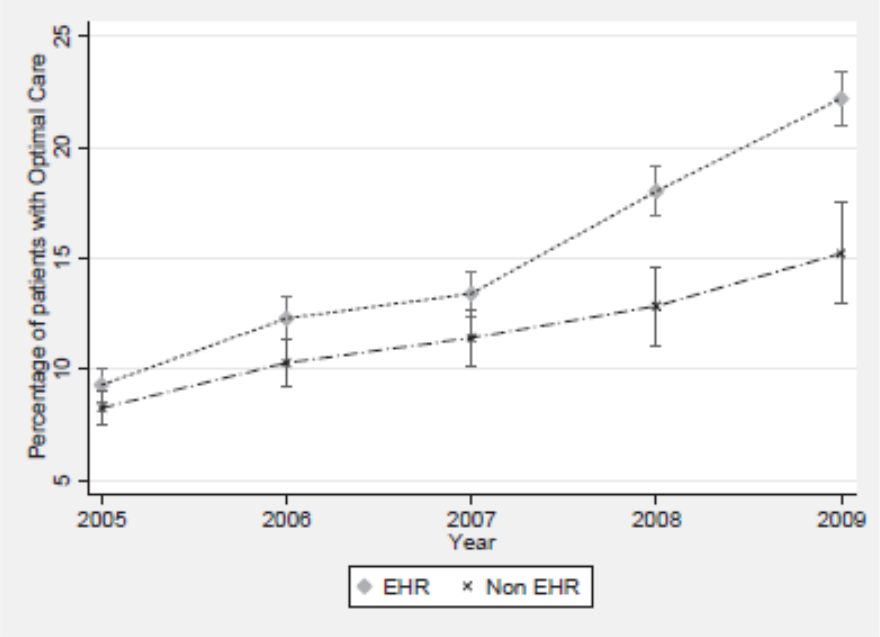
- Were 40 years or older
- Had at least two diabetes-related visits in 2007
- Had no DMF “exposure” in 2007 or prior
- Had at least two diabetes-related visits in 2009

Know:

age, sex, insulin usage, number of visits

Clinical Effectiveness: Intervention 1 Implementation of EHR

Figure 1: Percentage of Diabetes Patients with "Optimal Care"* Each Year, According to Whether Their Practice Ever Implemented the Electronic Health Record (EHR).



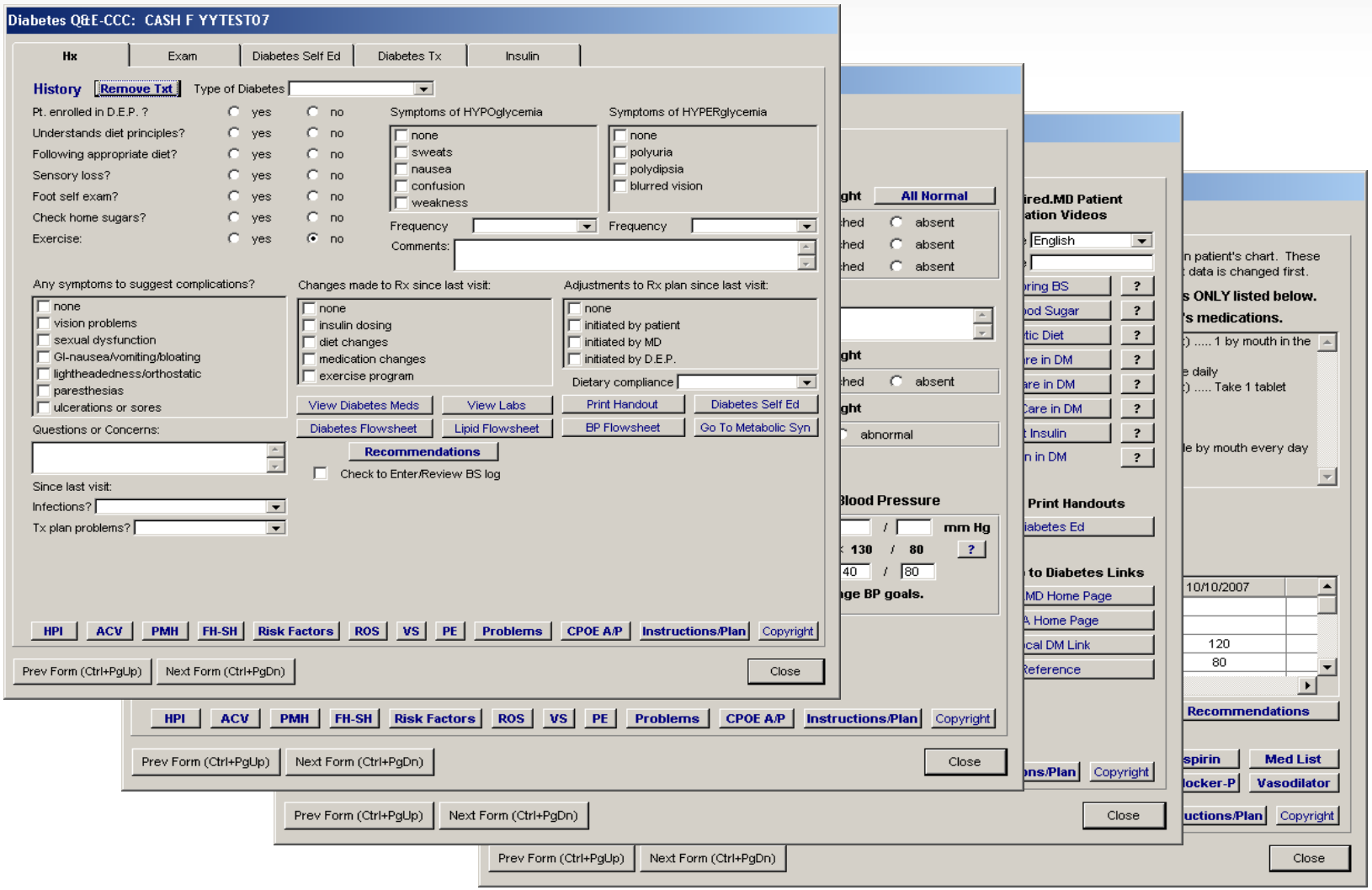
Notes. *HbA1c ≤ 8 percent; LDL cholesterol < 100 mg/dl; blood pressure < 130/80 mmHg; not smoking; and documented aspirin use (for patients ≥ 40 years).

Findings: Among patients exposed to the EHR, all process and outcome measures except HbA1c and lipid control showed significant improvement.

Clinical Effectiveness: Intervention 2

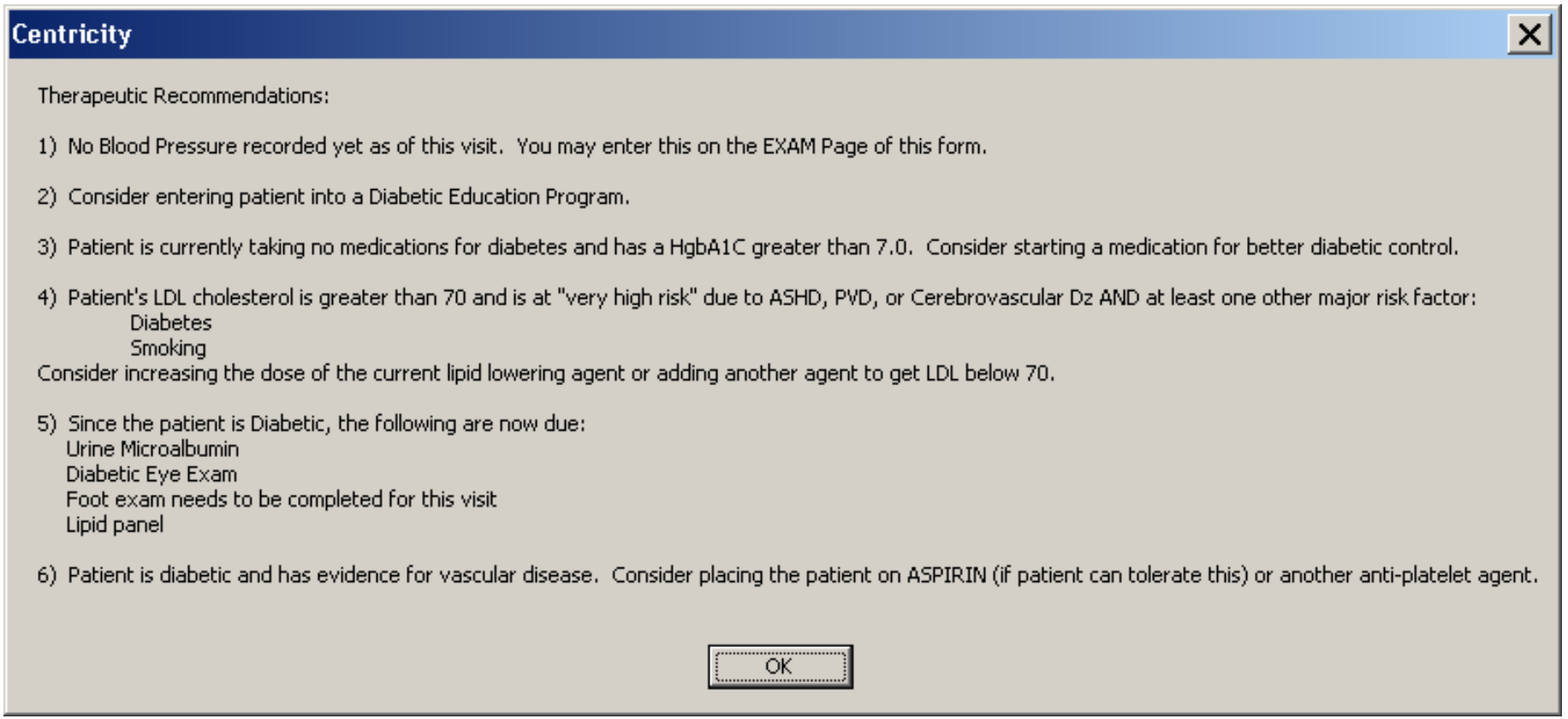
- Same population as for intervention 1
- Include only those patient visits after EHR implementation
  - Compare those patients for whom DMF was used with those for whom the form was not used

Clinical Effectiveness: Intervention 2



Clinical Effectiveness: Intervention 2 (cont.)

- A key element was the last dialogue box.



Clinical Effectiveness: Intervention 2 Results

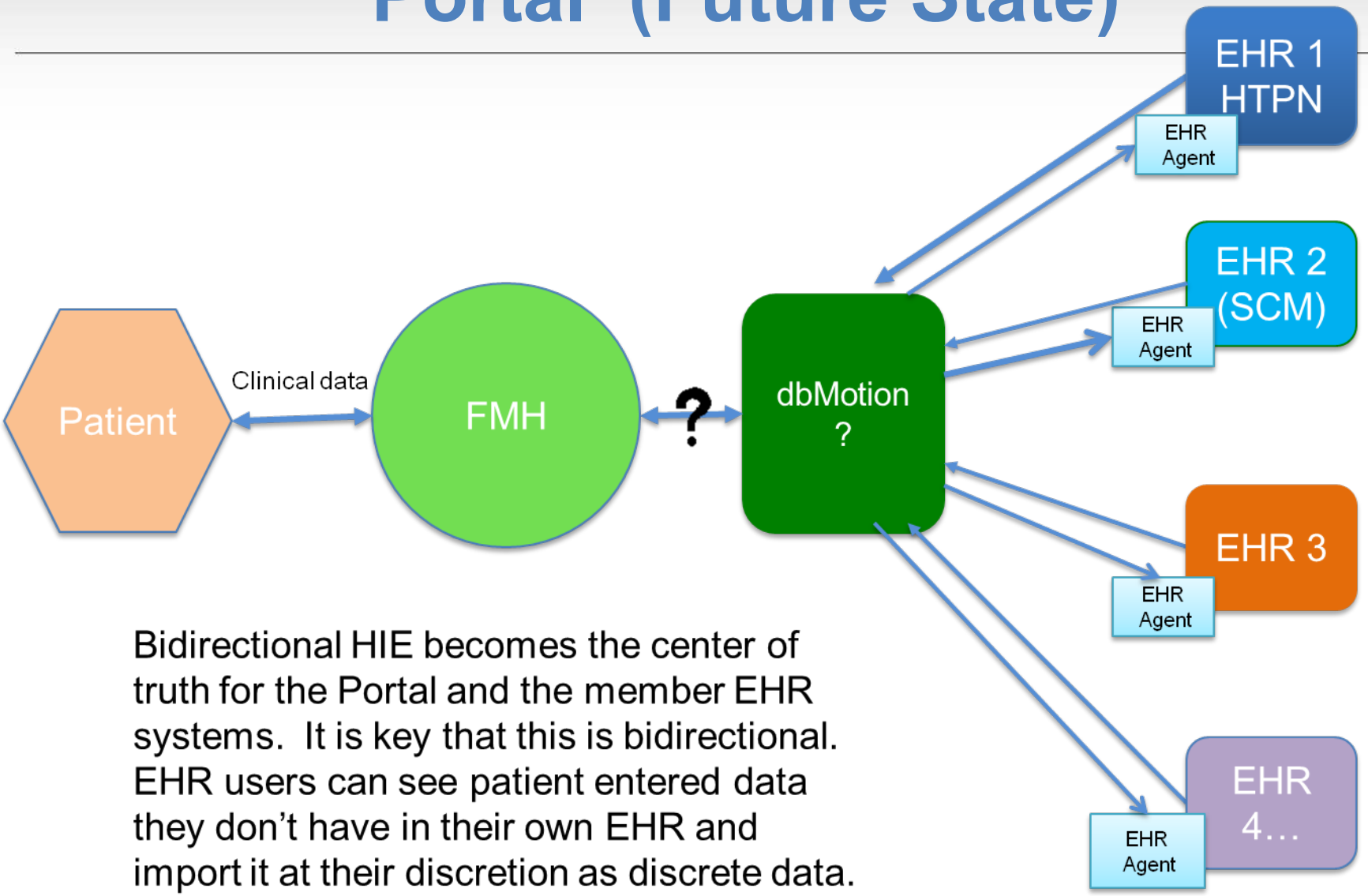
Summary

- Unadjusted results show larger improvement in unexposed group for primary and most secondary outcomes
- Adjusted results confirm that:
  - DMF has **negative effect** on optimal care bundle
  - DMF has **negative effect** on LDL, total cholesterol, blood pressure, and flu vaccines
  - DMF has **positive effect** on prescribing aspirin, checking microalbumin, foot exams, eye exams

HealthTexas Provider Network Portal Strategy

- Current state: Allscripts (Eclypsis) in acute environments—35 hospitals
- GE Centricity in HTPN (680 employed physicians)
- The Quality Alliance: 2,800 physicians, 74 different EHRs
- *Ideal goal:* one patient, one personal health record

Bidirectional HIE with Integrated Portal (Future State)



Bidirectional HIE becomes the center of truth for the Portal and the member EHR systems. It is key that this is bidirectional. EHR users can see patient entered data they don't have in their own EHR and import it at their discretion as discrete data.

References

Herrin, J, Nicewander D, Fullerton C, Aponte P, Stanek G, Cowling T, Collinsworth A, Fleming NS, Ballard DJ. The effectiveness of implementing an electronic health record on diabetes care and outcomes. 2012. *Health Serv Res* **47**(4): 1522-1540

Herrin J, da Graca B, Aponte P, Stanek HG, Cowling T, Fullerton C, Hollander P, Ballard DJ. Impact of an EHR-based Diabetes Management Form on quality and outcomes of diabetes care in primary care practices. 2014 Jan 7. *Am J Med Qual.*

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Implementation and Evaluation of Health IT for Care of Children with Acute Illness

Kenneth M. McConnochie, M.D., M.P.H.

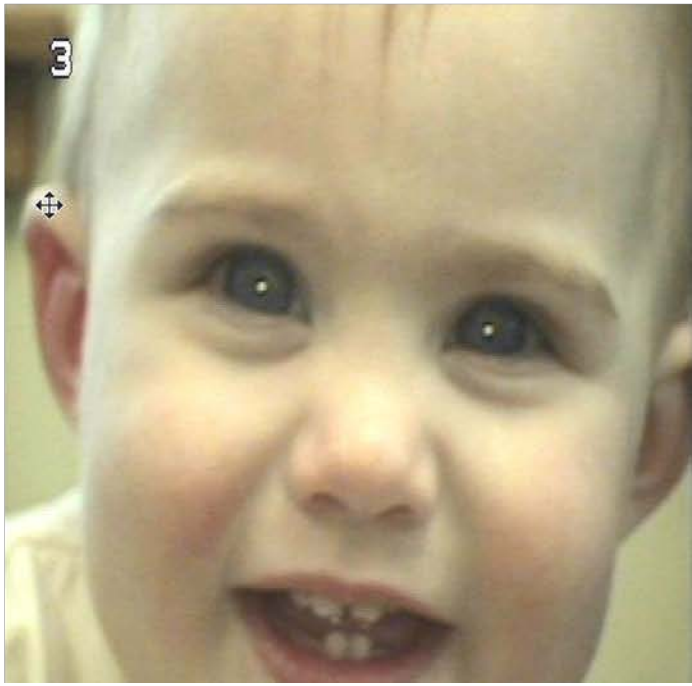
July 31, 2014

Primary Care, Patient-to-Provider Telemedicine: Health-e-Access

- 9 months old, temperature 104 on waking from nap at child care
- Well when dropped off at 7:30 that morning, except for sniffles

Diagnosis:
acute otitis media

Next day



Health-e-Access

Child site

Secure internet connection

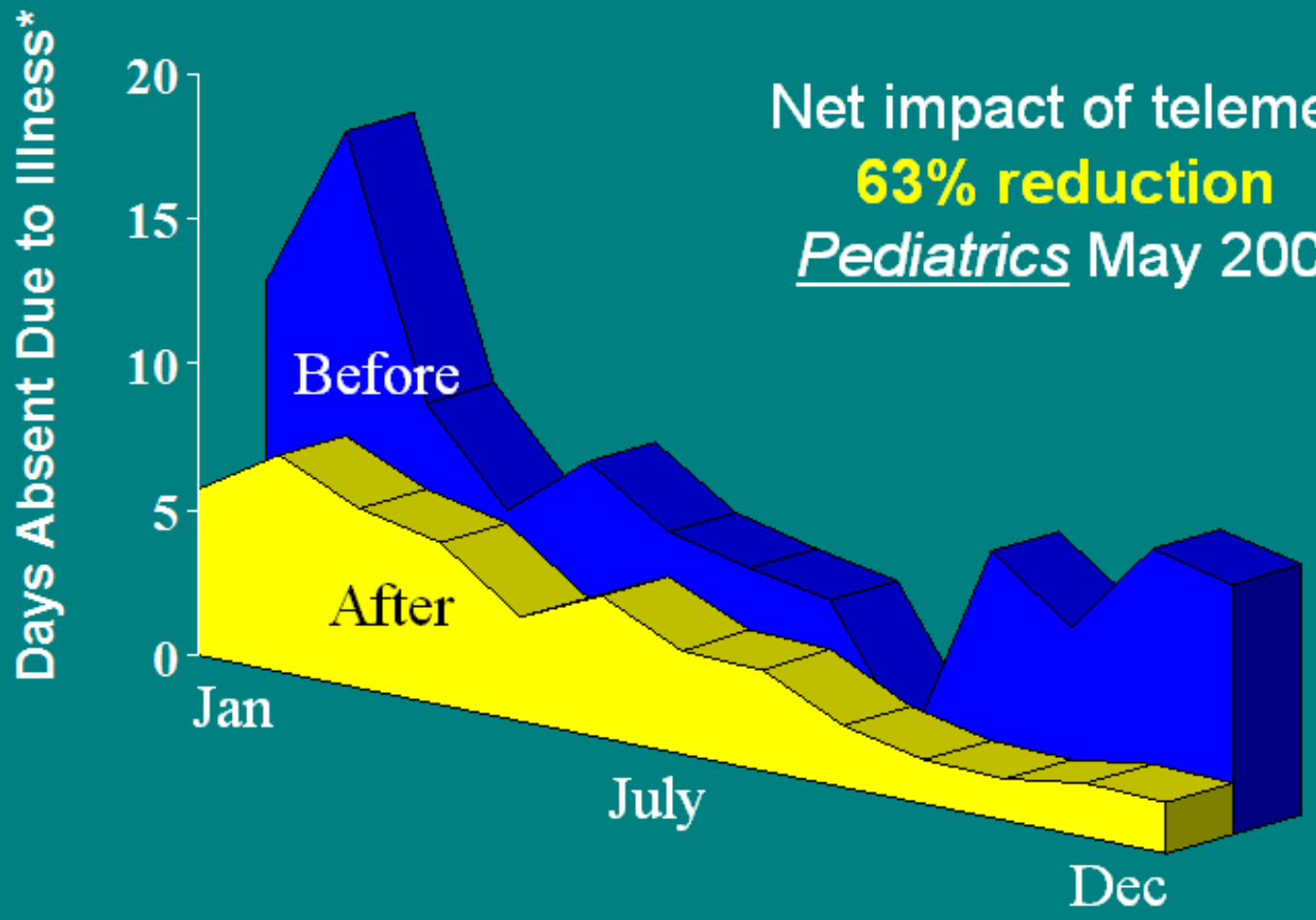
Provider site

Health-e-Access

Video conference window - view at clinician site

Video conference window - view at child site

Effectiveness:
Absence from Child Care Due to Illness



* Absence due to illness in mean days per week per 100 registered child-days.

Effectiveness and Efficiency

- Reduction in absence from child care due to illness: **63%**
- Visits completed in child care, schools, child development center: **> 14,000**
- Completion rate: **97%** (3% referred to higher level of care)
  - Would otherwise have gone to emergency department (ED), urgent care, or office: **94%**
  - Allowed parent to stay at work/school: **93%** (estimated time saved, mean = 4.5hr/visit)
  - Would choose child care with telemed over one without: **92%**

Effectiveness and Efficiency (cont.)

- Continuity with primary care medical home: **83%**
- Community access sites **> 70** (includes all Rochester City Schools)
- Provider participation and commitment:
  - Providers **> 70**
  - Primary care practices = **10**
  - Primary care practice goal **>25%** of illness seen via telemed
- Payer reimbursement:
  - City children covered **~ 85%**
  - Not yet paying: FFS Medicaid (**6%**), Fidelis (**6%**)
  - Uninsured **~ 4%**

Effectiveness and Efficiency (cont.)

- Observed reduction in ED visits:
  - Fewer visits among children in regular city elementary schools and child care: **at least 22%**
  - Fewer visits among special needs children attending a child development center: **almost 50%**
- Pediatric primary care office visits appropriate for telemedicine **= 85%**
- Pediatric emergency department visits appropriate for telemedicine **= 40%**

Value to the Community

Usual Care

Child seen 4 hrs. later, at best

First dose of medication 6 hrs. later

Health-e-Access Care Model

Child seen now

First pain medication now

First antibiotic 1-2 hrs. later

Cost to the Community

Usual Care

- Office, urgent care, or ED physical space
- Personnel costs: nurses and med-techs
- Parent misses ½ day of work
- Transportation costs, often ambulance
- Payment for ED visit $750

Versus

Health-e-Access Model

- Little or no cost for space
- Patient-end equipment and connectivity
- Personnel costs: med-tech, coordinator
- No transportation or parking cost
- Parent misses no work
- Payment for telemed visit = $75

No difference

- Medication cost
- Provider cost

Newer Primary Care Applications

Pediatric acute-illness care

- Neighborhood/after-hours access—**avoid ED**

Pediatric chronic problem care

- Asthma management—**avoid school absence, ED, hospital**
- ADHD management—**avoid grade retention, school dropout**

Pediatric dentistry

- Dental screening—**avoid extensive dental work, tooth loss**

Geriatric acute-illness care

- Senior living communities—**avoid ED, hospital**

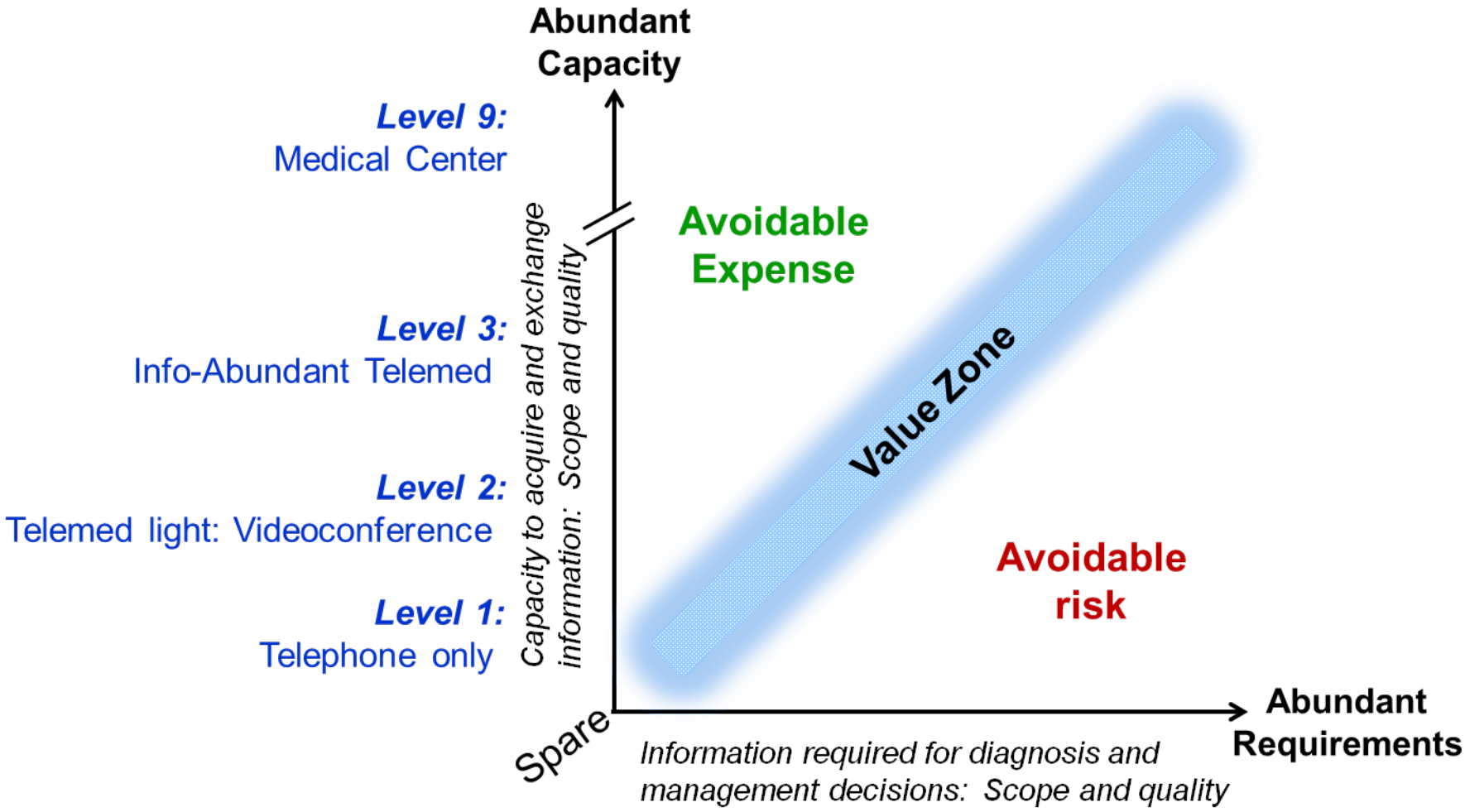
Primary Care Apps: Vision

- Unlimited
- At some point in the care process for any concern, it is advantageous to patients to engage at a distance.
- Health care: a process of information acquisition, interpretation, and exchange

Barriers

- Deeply entrenched care processes
- Human response to uncertainty
- Provider scarcity
- Fee-for-service financing
- Productivity measured as units of service
- Lack of relevant regulations
- Lack of established best practices

Value and the Continuums of Information Requirements and Capacity



Facilitators

- Organize into Integrated Practice Units (IPUs)
- Measure and focus on outcomes that are most meaningful to patients

Financial Incentives' Effect on Care Delivery

Hospital Chain Said to Scheme to Inflate Bills

By JULIE CRESWELL and REED ABELSON JAN. 23, 2014 The New York Times

Every day the scorecards went up, where they could be seen by all of the hospital's emergency room doctors.

Physicians hitting the target to admit at least half of the patients over 65 years old who entered the emergency department were color-coded green. The names of doctors who were close were yellow. Failing physicians were red.

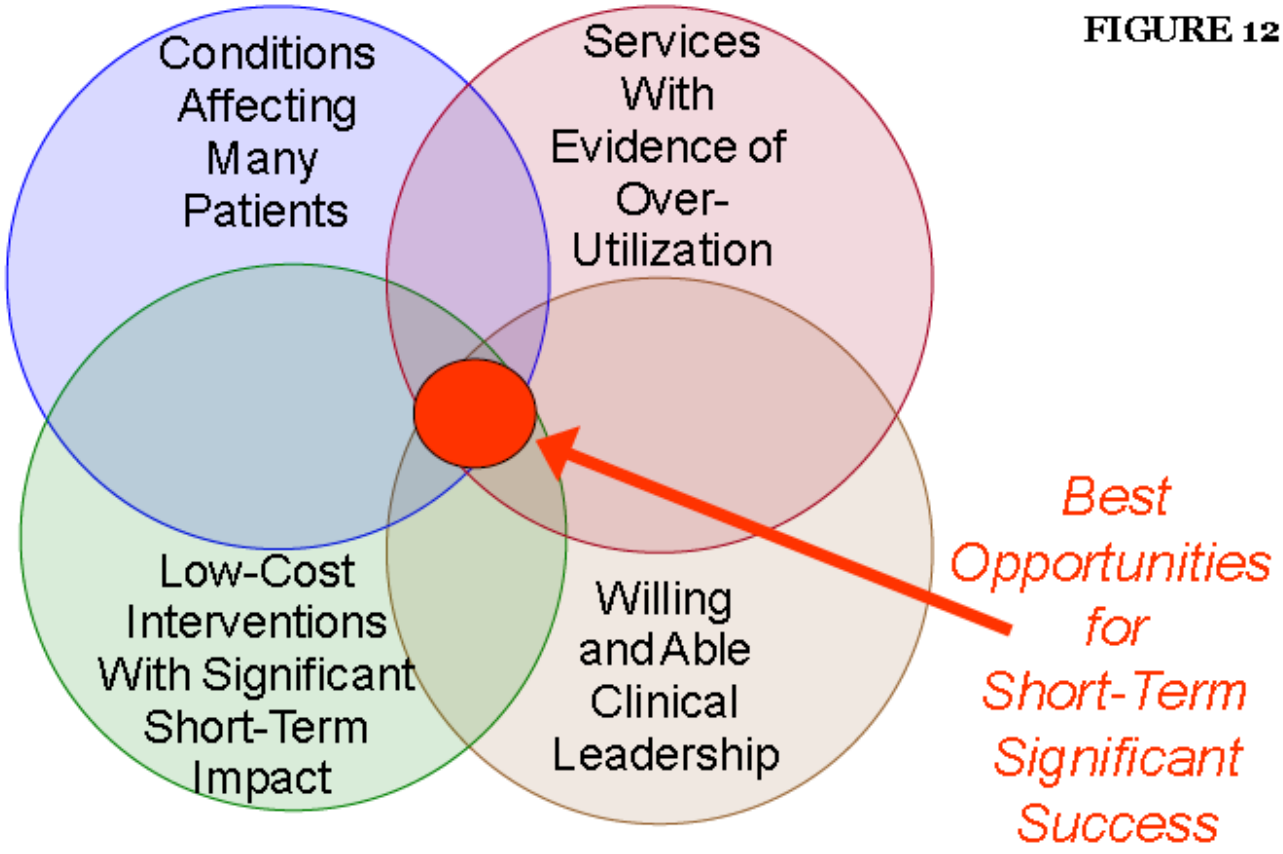
The scorecards, according to one whistle-blower lawsuit, were just one of the many ways that Health Management Associates, a for-profit hospital chain based in Naples, Fla., kept tabs on an internal strategy that regulators and others say was intended to increase admissions, regardless of whether a patient needed hospital care, and pressure the doctors who worked at the hospital.

Facilitators

- Organization using IPUs
- Measurement and focus on outcomes most meaningful to patients
- Bundled payment for care cycles
- Cost-based accounting
- Enabling information technologies (the continuum)
- Care guidelines (best practices) and regulations enabling all the above

Implementing Health IT

FIGURE 12



Miller HD, Transitioning to Accountable Care. 2011.

Thank You

- Miller HD. *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*. Center for Healthcare Quality and Payment Reform, 2011.
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Q & A

Please submit your questions by using the Q&A box to the right of the screen.

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