

# ***Knowledge Into Care... and Care into Knowledge***

*“Quality and Community  
Partnerships”*

**Hawaii Primary Care  
Association  
October 10, 2008**

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Medical Director  
Community Benefit,  
Kaiser Permanente

# Community/Quality: COPC = CHCs (1965 - ??)

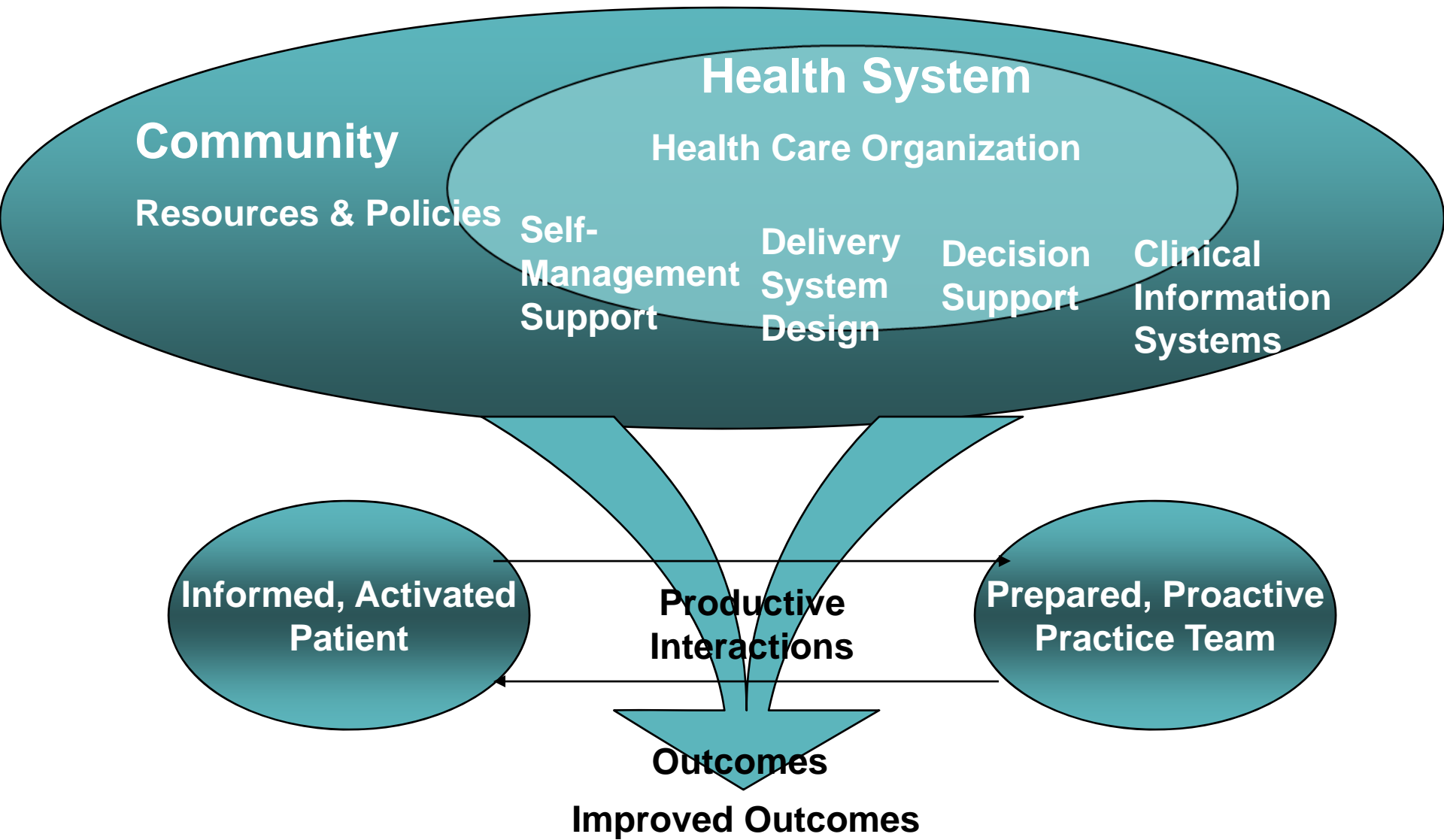
- Differentiates community health centers from other delivery systems of care for the poor and vulnerable, including privatized charity care, sole providers, last resort providers
- Emphasized community engagement, impacting social determinants of health, multi-disciplinary approach to health care, prevention and primary care
- Care tailored to the needs and characteristic of target population

# Medicaid, FFS, and Cost Based Reimbursement impact the delivery model (1987 – 2000)

- Competition for Medicaid populations
- Necessity to capture cost centers and revenue generators
- Generate business case for services that should be reimbursed for caring for populations and patients with “special needs”, e.g., translation, case management
- Revenue streams don't generally mirror priorities of community oriented care

# Enter: the Chronic Care Model (1995 – Present)

- Independent streams:
  - Group Health Model (Ed Wagner, M.D.) of providing chronic care management; model of idealized care
  - Institute of Healthcare Improvement: Collaborative model of change, rapid change cycles
  - Increasing pressure upon BPHC to demonstrate clinical quality measures
  - Demonstrate capacity of community health centers to provide quality care



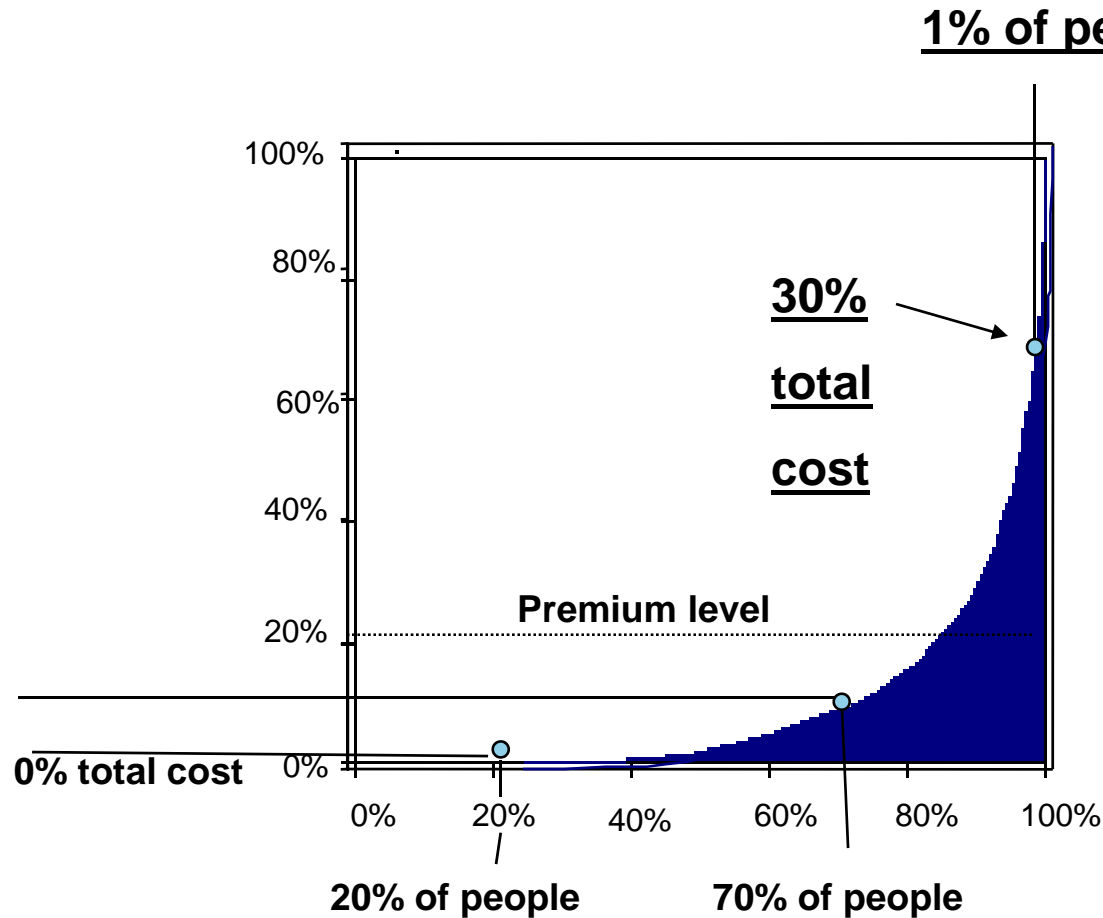
# CHCs and the Chronic Care Model: Questions

- Is the model sustainable independent of federal support?
- Does reimbursement (the “organization of care”) align with the model of care, i.e., does the current system of care support the chronic care model?
- How applicable is the CCM to populations with multiple conditions? Can it be readily adaptable to populations rather than independent conditions and diseases?
- Why do some organizations succeed, and others stall?

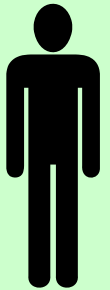
# It was the best of times, it was the worst of times...

- By year 2025, 31% of the U.S. population will be over 65
- 17% of GNP is now related to health care expenditures
- About 1 of every 8 Americans is medically uninsured
- There is an acute shortage of primary care providers and nurses
- There are about 22 million Americans with diabetes, 8 million who don't know it.
- 1% of the population consume 30% of all health care costs, whether they're "insured" or not

# Who consumes and who pays?



- Diabetes
- Heart Failure
- Coronary Artery Disease
- Depression
- Chronic Pain
- Cancer
- Asthma and COPD
- Dementia
- Falls
- Obesity
- ...



## ■ Value = Quality/Cost

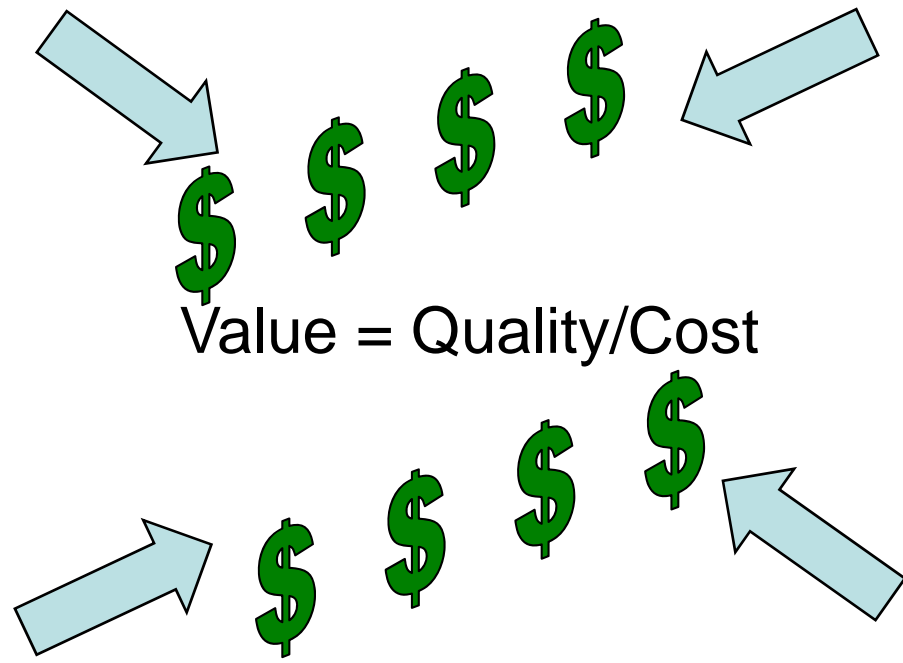
- Quality agenda is effectuated by health care reform
- Quality impacted by access and delivery design
- Government pays for 40% of all U.S. healthcare expenditures
- No public consensus on what constitutes “quality”
  - Quality “report cards” are not generally used by individual consumers (patients)
  - Most consumers associate “quality” with “choice” and “availability”
- Implications for social unrest/political reform?

- E.H.R. : \$\$\$ for “quality” as defined by the patient, the purchaser, and/or clinician; who pays and who gains most?
- P4P: \$\$\$ incentive for desirable outcomes or penalize for adverse selection; burden on whom? PCPs, specialists, delivery institutions and organizations
- Shift of responsibility (burden?) to consumers/patients: patient self management; co-payment; HSAs
- Patient Centered Medical homes: Reconfigure the delivery system intentionally, and align reimbursement streams accordingly

# Is it really about “Quality”?

E.H.R. to decrease variation in practice and reduce duplicity

Medical homes: decrease dependency on highly resourced care



$$\text{Value} = \text{Quality} / \text{Cost}$$

P4P to pay for validated processes and outcomes

Patient accountability : self serve is cheaper than table service

# Hypothetical example

- 44 year old Native Hawaiian, single Mom with 3 school aged children with diabetes and anxiety attacks for 12 years, receiving care from Community Health Center, suffers stroke at home and hospitalized at community Hospital, and discharged with on-going occupational and physical therapy needs. Now on additional medications for post stroke prophylaxis and muscle spasms. Lives with brother and sister-in-law, and ex-husband (alcoholic) occasionally visits when visiting from mainland.
- How do you build an accessible, affordable system that provides this patient with first rate care?

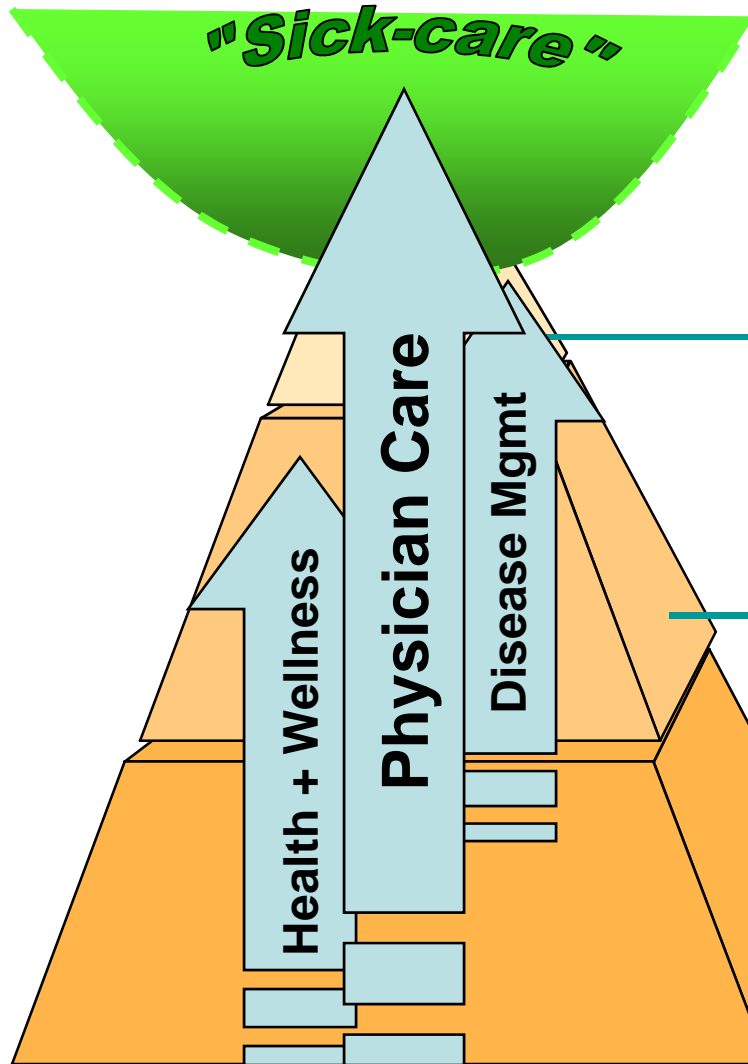
# Menu of Scenarios

- Primary care provider addresses patient's needs through 15 minute visits every month
- Health care team made up of RN, MD, MA, and caseworker set up appointments, call and check in to see how she is doing, and provides her with emergency phone numbers
- Care manager works with team to coordinate care
- MD relies on community agencies to supplement medical care
- Patient asked to “take control” of her care

# Questions

- How do you minimize variation in care and expected outcomes?
- How do you manage efficiency?
- How do you know that therapy is effective?
- How do you allocate resources effectively?
- How do you incorporate and integrate non-medical factors associated with better long term outcomes?
- How do you accumulate data for better planning?

# One strategy: population management



## ***Intensive Management***

Frequent contact and coaching;  
coordination of care

## ***Care Management***

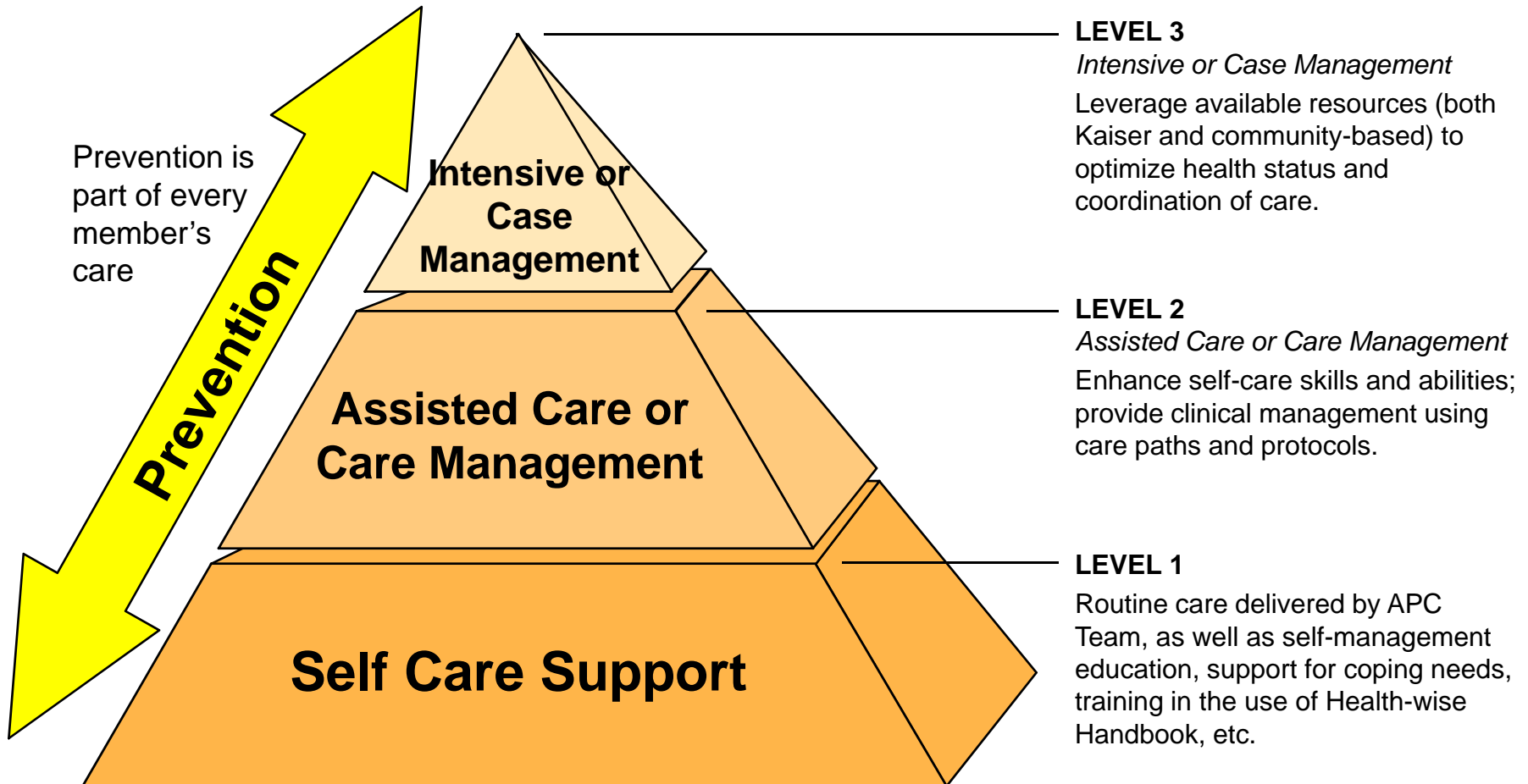
Coaching and support for meds  
and other care needs

## ***Self-care Support***

Coaching and support to assist  
members in self-care skills and  
healthy behaviors

# Population Management & Levels of Care

Under the principles of population management, the first step in developing proactive strategies for the chronic conditions populations is to define their service needs. These needs generally fall into 3 service levels.



# Asthma Population Management Program

**Level 3 Intensive Care**

- Complex medical issues
- Psycho-social barriers to self-management

**Asthma Specialist**

- Confirms diagnosis
- Identifies co-morbidities
- Optimizes medication regimen
- Mentors Case & Care Managers

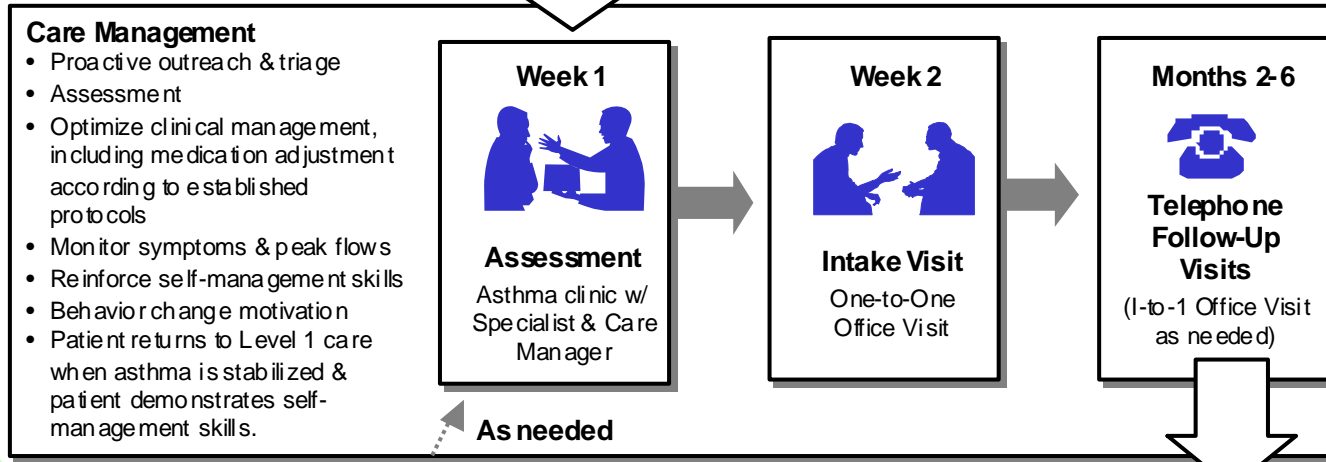
**Respiratory Case Manager**

- Coaches members in crisis
- Manages access to specialty & ED care
- Coordinates care across continuum

**Level 2 Assisted Care**

- ED visits
- Hospitalization
- Beta-agonist over-use
- Asthma in poor control

EMERGENCY



**Level 1 Self Care**

- Asthma is well-controlled
- Member practices effective self-care

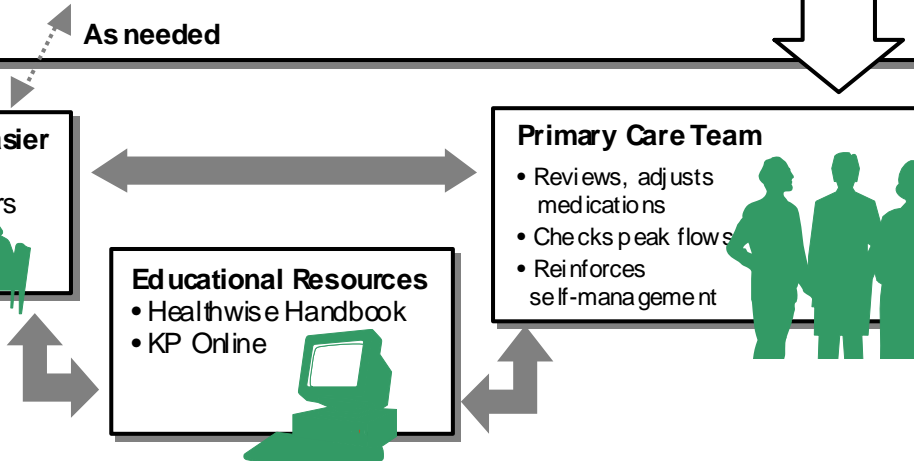
**Breathe Easier Class and others**

**Educational Resources**

- Healthwise Handbook
- KP Online

**Primary Care Team**

- Reviews, adjusts medications
- Checks peak flows
- Reinforces self-management



- Utilize computer derived scenarios
- Input pertinent data
- Input evidence based knowledge
- Identify optimal efficacy (how much bang for the buck)
- Highlight efficiencies, and build into the delivery model
- Achieve population outcomes (as opposed to individualized care plans)

# What is A.L.L?

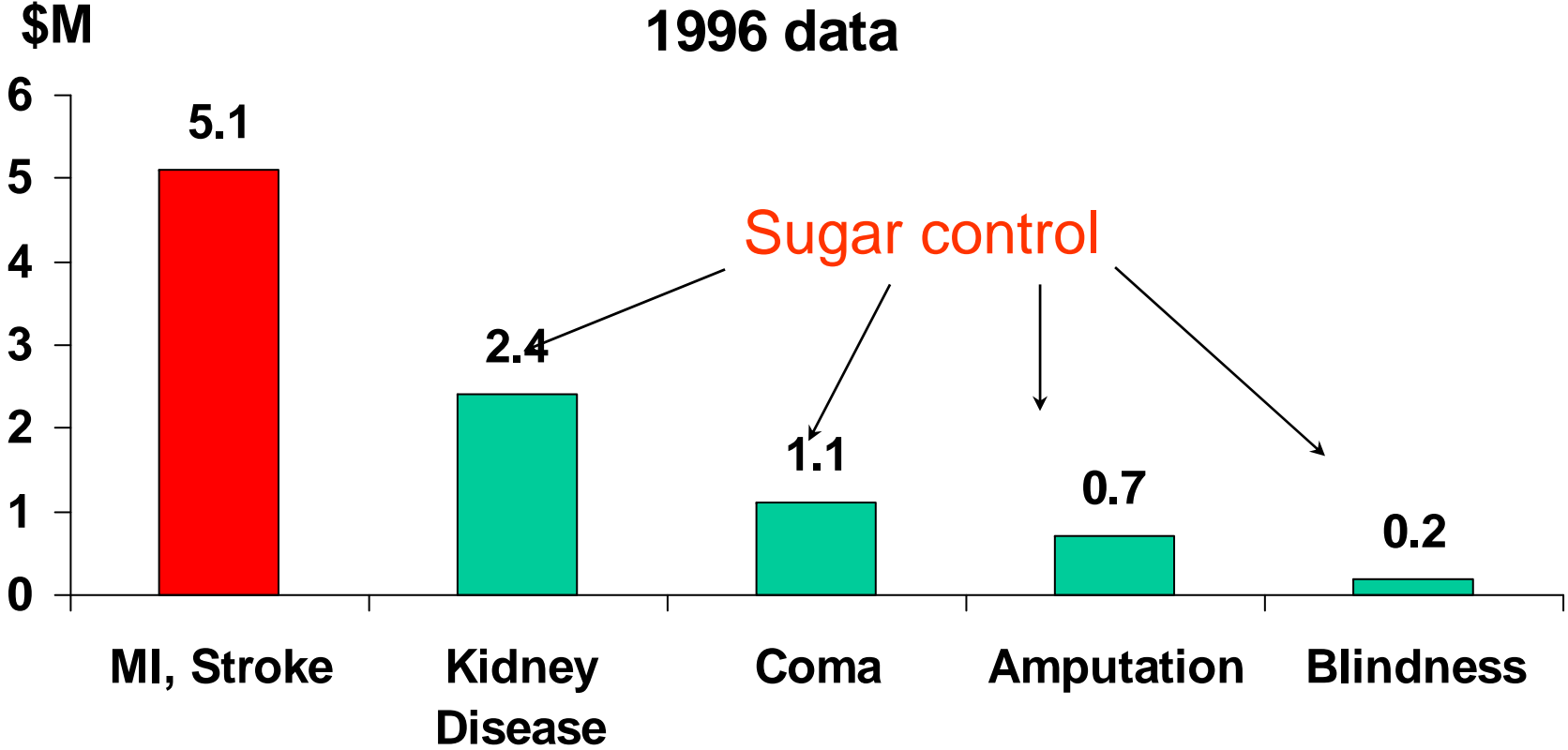
- **A.L.L. is about harnessing. . .**
  - *Evidence based, population management principles*
  - *to optimize efficient and effective care*
  - *To DRAMATICALLY reduce cardiovascular mortality among patients with diabetes*

# What is ALL?

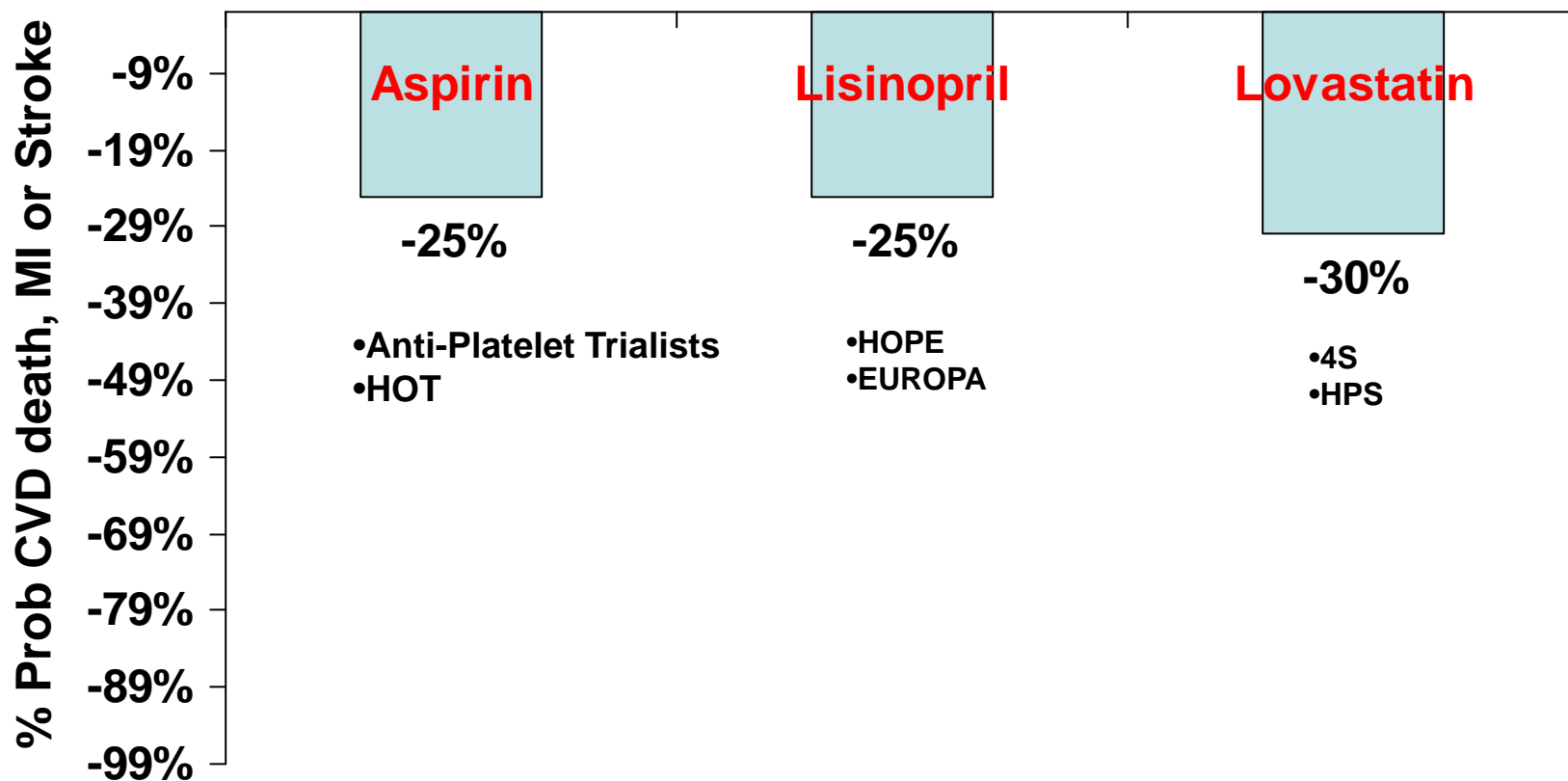
- **ALL stands for Aspirin, Lisinopril, Lovastatin**
  - A for Aspirin
  - L for Lisinopril
  - L for Lovastatin
- **There is strong and powerful evidence for the clinical and cost effectiveness of increasing ALL use in CAD and diabetes (55+) populations**
- **ALL reduces the risk of future cardiovascular disease in patients with diabetes >55 years old OR prior cardiovascular disease**

# Costs/10,000 Diabetic Patients

Based on No. Cal. KP  
1996 data

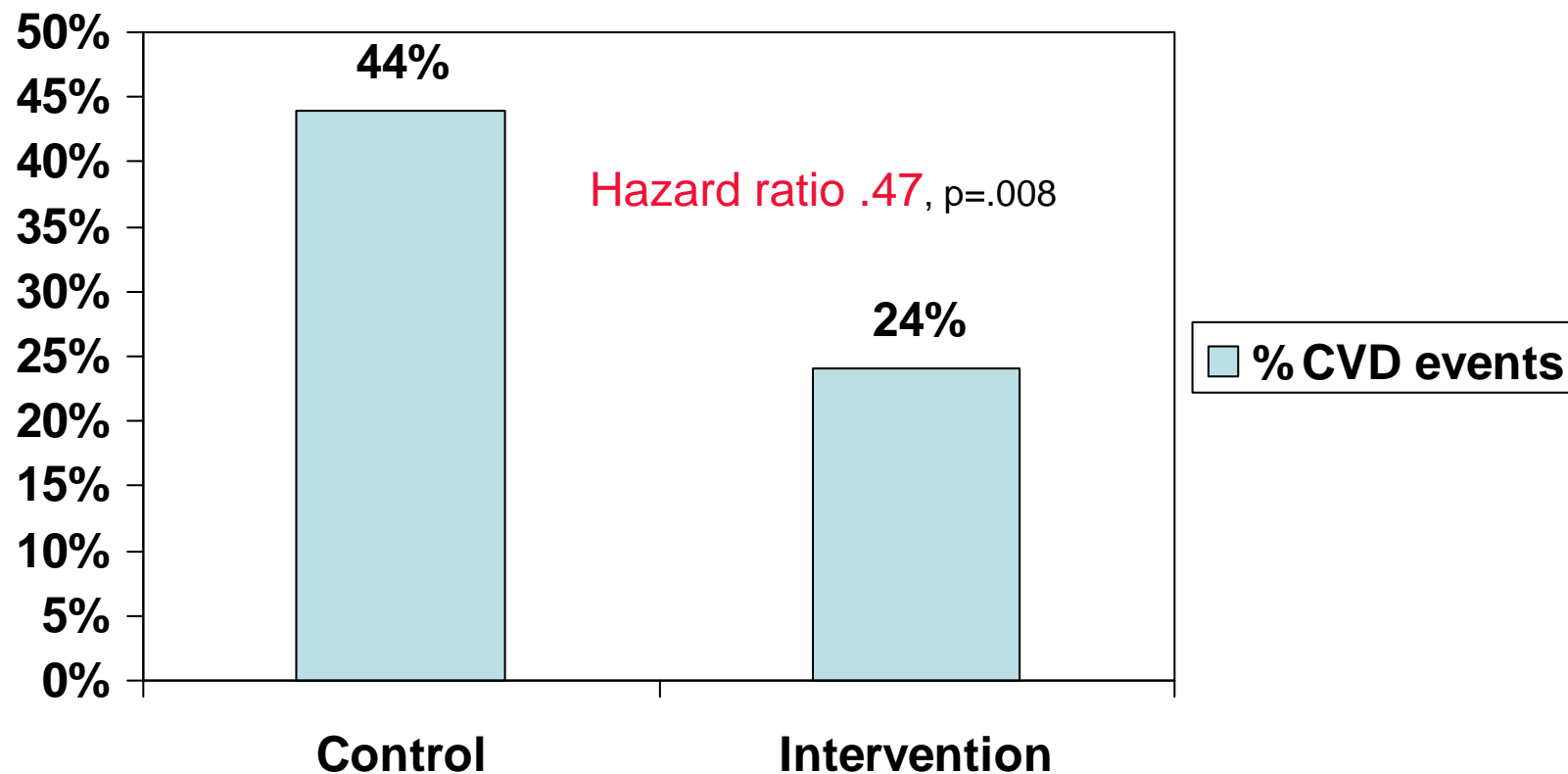


# Strong evidence that aspirin, lisinopril, and lovastatin decrease CVD death, MI or stroke in high risk patients



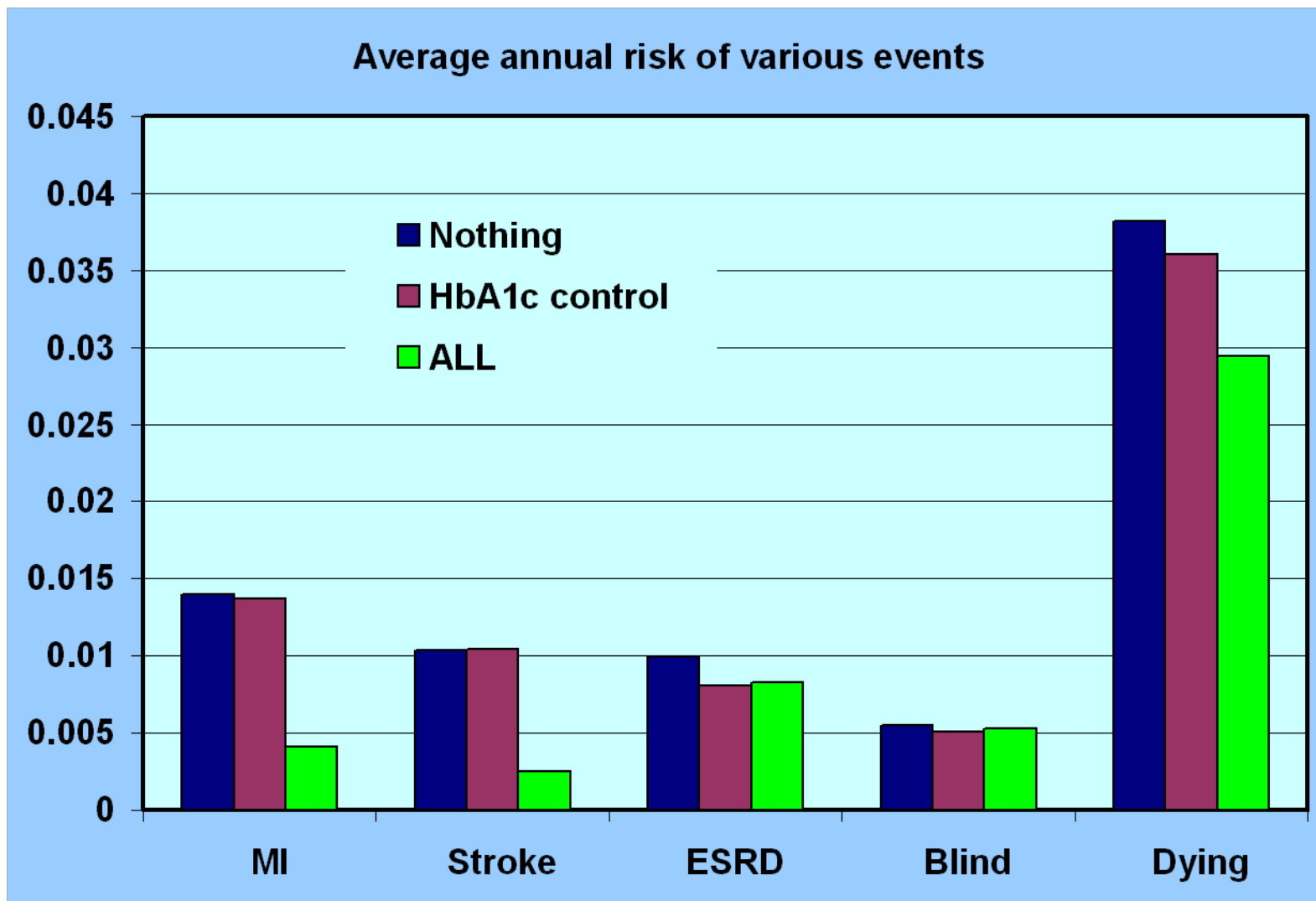
Yusuf, S. Lancet 360: July 6, 2002

## Combining ALL reduces CVD by nearly 50% over 8 years

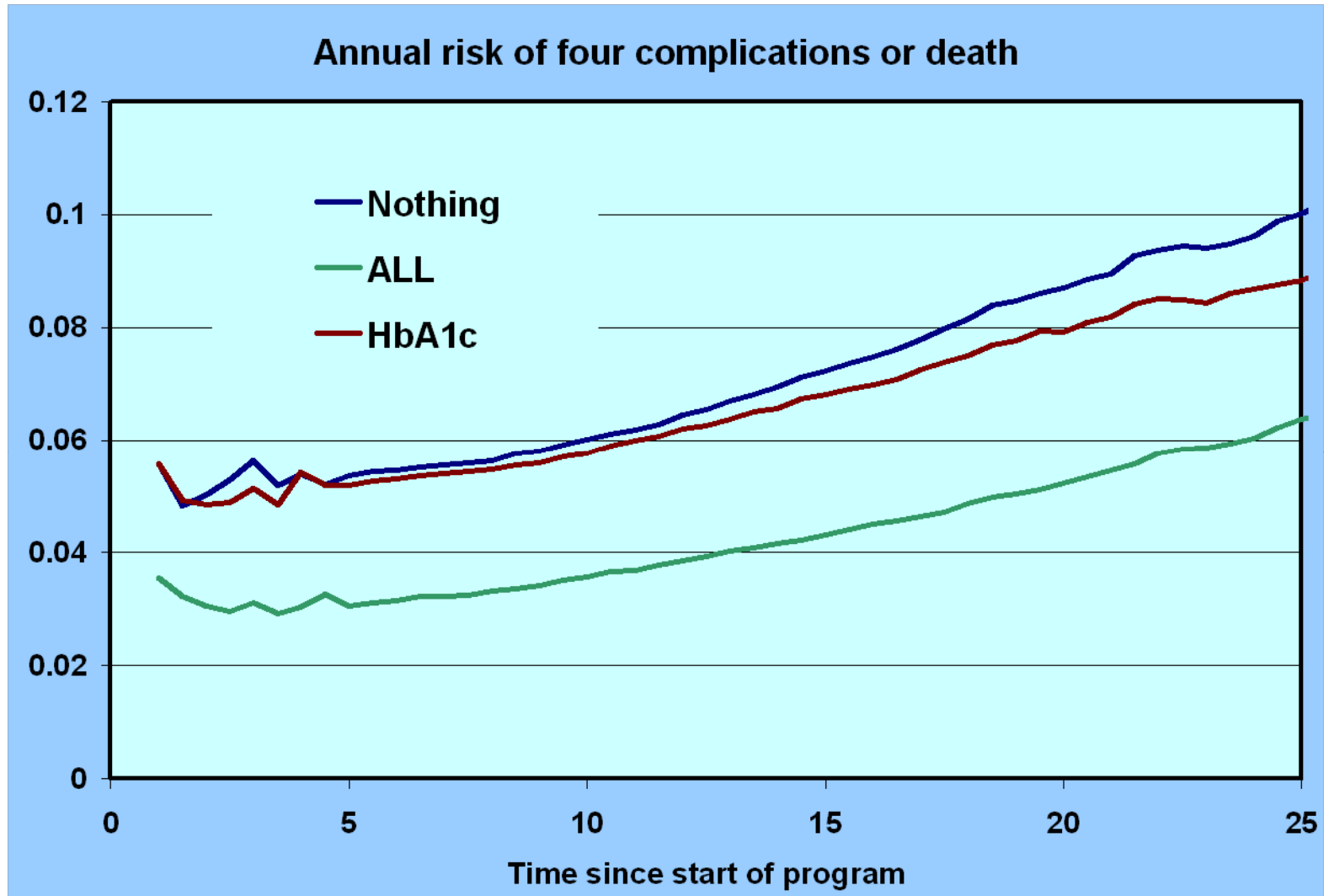


NEJM 2003;348:383-93

# Archimedes: ALL has a much bigger effect than A1c control in DM pts (55+)



# And it begins immediately



# What if?

	Visits	50/visit	\$ 200	50
	Calls	20/call		20
	Labs	40/lab	\$ 160	40
sum			\$ 1,370	\$ 205
<b>cost/mon</b>			<b>\$ 114</b>	<b>\$ 17</b>
<b>cost/mon meds only</b>			<b>\$ 84</b>	<b>\$ 8</b>
<b>cost/mon process only</b>			<b>\$ 30</b>	<b>\$ 9</b>
Added ben				
efficient care		Year 1		years 2-5
	asa		\$ 10	no change
	lova 40		\$ 51	"

# KP Community Partnership

- ALL/PHASE is now implemented in Alameda, SF, Santa Clara, San Diego, Riverside and soon to be in Pasadena, Los Angeles County, Atlanta and Portland.
- Over 3000 underserved patients now on the program with increases in ALL regimen approximately 30%
- Adherence rates to regimen as good as 95%
- Projected reduction in CV events: over 100 over the course of 3 years.

# Managing a population

- Utilizing *panel management tools*, populations can be targeted for improved processes and outcomes
- Provide physician and a health care team with updated and accurate information to close “care gaps” for groups of patients
- Technology can provide readily accessible tools to leverage time and resources of physicians and health care teams

## The Panel Support Tool

choose a provider

specialty

search / panel view

disease

risk factor

visit info

panel vitals

## Complete Panel View

PCP: DEMO DOC Panel Size : 1107

Y Indicates in the registry

F/U

Report	MRN	NAME	Age	Sex	Dx	Prev	Gap	DM	CVD	CHF	HTN	CKD	Last Seen	Rev'd
<input type="checkbox"/>	<a href="#">000000161</a>	<a href="#">DEMO161</a>	76	F			20	Y				Y		
<input type="checkbox"/>	<a href="#">000000564</a>	<a href="#">DEMO564</a>	51	F			16	Y			Y	Y	12/16/2004	
<input type="checkbox"/>	<a href="#">000000951</a>	<a href="#">DEMO951</a>	42	M			15	Y						
<input type="checkbox"/>	<a href="#">000000931</a>	<a href="#">DEMO931</a>	48	F			13	Y			Y			
<input type="checkbox"/>	<a href="#">000000473</a>	<a href="#">DEMO473</a>	80	F	R		12	Y			Y	Y	9/3/2005	
<input type="checkbox"/>	<a href="#">000001098</a>	<a href="#">DEMO1098</a>	41	F			12	Y			Y		1/7/2006	
<input type="checkbox"/>	<a href="#">000000905</a>	<a href="#">DEMO905</a>	73	M	R		11	Y	Y		Y		3/20/2006	
<input type="checkbox"/>	<a href="#">000000256</a>	<a href="#">DEMO256</a>	54	M			11	Y			Y		12/13/2005	
<input type="checkbox"/>	<a href="#">000000226</a>	<a href="#">DEMO226</a>	50	F			11	Y					12/28/2005	
<input type="checkbox"/>	<a href="#">000000714</a>	<a href="#">DEMO714</a>	39	M			10	Y			Y	Y	10/24/2005	
<input type="checkbox"/>	<a href="#">000000362</a>	<a href="#">DEMO362</a>	29	F			10			Y			11/21/2005	
<input type="checkbox"/>	<a href="#">000000360</a>	<a href="#">DEMO360</a>	78	M			8		Y		Y	Y	4/5/2006	
<input type="checkbox"/>	<a href="#">000000491</a>	<a href="#">DEMO491</a>	62	F			8	Y	Y	Y	Y	Y	5/22/2006	
<input type="checkbox"/>	<a href="#">000000218</a>	<a href="#">DEMO218</a>	57	M			8		Y		Y		2/5/2005	
<input type="checkbox"/>	<a href="#">000000829</a>	<a href="#">DEMO829</a>	45	M			8	Y			Y	Y	4/30/2005	
<input type="checkbox"/>	<a href="#">000000098</a>	<a href="#">DEMO98</a>	42	M			8	Y					10/5/2005	
<input type="checkbox"/>	<a href="#">000000464</a>	<a href="#">DEMO464</a>	74	F			7		Y			Y	8/14/2006	

# Panel Ownership & Complete Care

## The Panel Support Tool

[choose a provider](#) | [service](#) | [search / panel view](#) | [disease](#) | [risk factor](#) | [visit info](#) | [panel vitals](#)

### Complete Panel View

PCP(s): DEMO DOC2

Total Patients : 1358

<input type="checkbox"/>	Y Indicates in the registry														<b>F/U</b>		
Report	MRN	NAME	Age	Sex	Dx	Prev	Gap	DM	CVD	CHF	HTN	CKD	Asth	Remarks	Last Seen	Rev'd	PCP
<input type="checkbox"/>	<a href="#">010413830</a>	<a href="#">DEMO2010413830</a>	48	F			17	Y			Y						DOC2
<input type="checkbox"/>	<a href="#">002147461</a>	<a href="#">DEMO2002147461</a>	49	M			15		Y	Y				Y	01/07		DOC2
<input type="checkbox"/>	<a href="#">002195717</a>	<a href="#">DEMO2002195717</a>	79	F	R		12		Y						07/06		DOC2
<input type="checkbox"/>	<a href="#">001743772</a>	<a href="#">DEMO2001743772</a>	51	M			12		Y		Y	Y			02/07		DOC2
<input type="checkbox"/>	<a href="#">001569302</a>	<a href="#">DEMO2001569302</a>	80	F			11	Y			Y				09/07		DOC2
<input type="checkbox"/>	<a href="#">001401813</a>	<a href="#">DEMO2001401813</a>	80	F			11		Y						07/07		DOC2
<input type="checkbox"/>	<a href="#">010528491</a>	<a href="#">DEMO2010528491</a>	58	F			11	Y							07/07		DOC2
<input type="checkbox"/>	<a href="#">002027135</a>	<a href="#">DEMO2002027135</a>	44	F			10	Y				Y		Y	08/07		DOC2
<input type="checkbox"/>	<a href="#">001532723</a>	<a href="#">DEMO2001532723</a>	64	F			9		Y		Y				02/07		DOC2
<input type="checkbox"/>	<a href="#">001608054</a>	<a href="#">DEMO2001608054</a>	63	F			9	Y			Y	Y			02/07		DOC2
<input type="checkbox"/>	<a href="#">010709126</a>	<a href="#">DEMO2010709126</a>	60	M			9		Y						11/07		DOC2
<input type="checkbox"/>	<a href="#">001756660</a>	<a href="#">DEMO2001756660</a>	42	F			9	Y			Y				07/07		DOC2
<input type="checkbox"/>	<a href="#">002056621</a>	<a href="#">DEMO2002056621</a>	36	M			9	Y			Y				04/07		DOC2
<input type="checkbox"/>	<a href="#">010566975</a>	<a href="#">DEMO2010566975</a>	67	M			8					Y			02/06		DOC2
<input type="checkbox"/>	<a href="#">010472748</a>	<a href="#">DEMO2010472748</a>	65	F			8						Y				DOC2
<input type="checkbox"/>	<a href="#">001761963</a>	<a href="#">DEMO2001761963</a>	60	M	R		8	Y		Y	Y				02/07		DOC2

# Specific Treatment Recommendations

## The Panel Support Tool

[Patient Snapshot](#) | 
 [Return to list](#) | 
 [Copy MRN to Clipboard](#) | 
 [Mark as Reviewed](#) | 
 No Follow-up  | 
 No remarks

Name: **DEMO2002056621**  
 MRN: **2056621**    Age: **36** Sex: **M**

Home: **123-4567**    Last PC Visit - **4/20/07**  
 Work: **123-4567**    Next PC Visit -

PCP: **DEMO DOC2**  
 Last Reviewed -

[kp.org](#)  
**INACTIVE**

DM	CVD	CHF	HTN	CKD	Asth	Gap
Y			Y			9

ATENOLOL TAB 50MG Date: 5/24/07 Daily  
 Dose: 50.0

** LDL	95	3/20/05
HDL	28.0	3/20/05
TRI	96	3/20/05
CHOL	142	3/20/05
** A1C	6.4	1/8/06
** FBG	114	3/20/05
ALT	20	1/8/06
** CRE	1.0	2/19/06
BUN	15	2/19/06
GFR	89.9	2/19/06
** ALB/CRE	7	2/21/06
** PRO/CRE		
HGB	17.0	2/19/06
HCT	51.8	2/19/06
NA	141.0	3/20/05
K	4.8	3/20/05
TSH	0.48	3/20/05

Last Discharge - 1/8/06  
AC STOMACH ULCER W HEM

Last ER Visit -

Last Flu Date -

Last Pneumo -

Last Tetanus -

**Bolded drugs are dispensed in the last 3 months**

BP Meds - LAST 3 BPs >= 140/90; ON < 2 BP MEDS. CONSIDER ADDING ANOTHER BP MED?

- Foot Screen **OVERDUE**
- HBA1C **OVERDUE** Last: 6.4 08-JAN-06.
- LDL **OVERDUE** - Last done: 3/20/05
- Renal screening due - Last test was Microalb/Cr ratio: 7 21-FEB-06

- Flu Shot due
- Tetanus-Diphtheria due
- Pneumovax due

\*\* Avg BP 148 / 94

Pulse 76 - 5/24/07

Weight 219.0    Height 67.3

BMI 34.0    5/24/07

Ten Year Cardiac Risk    7%

\*\*Hover over the result to see trended results if available

# Sort by Contact Modality or Utilization

## The Panel Support Tool

[choose a provider](#) | [service](#) | [search / panel view](#) | [disease](#) | [risk factor](#) | [visit info](#) | [panel vitals](#)

### Utilization View - Complete Panel

Email:  = Active on kp.org

PCP(s): DEMO DOC2  
Total Patients : 1358

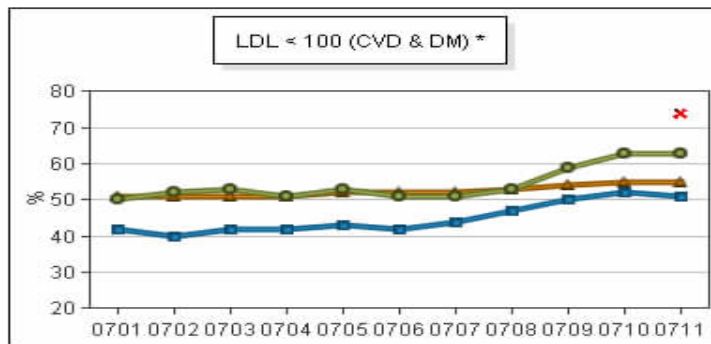
<input type="checkbox"/>	Report	MRN	NAME	Dx	Gap	PC Next Vis	PCP (2yr) Last Enc	PC (2yr) Last Vis	Primary Care in Last 12 mo				Specity (12mo) #	ED (12mo) #	Inpatient (12mo) Vis	Bed days	Remarks	Rev'd	PCP	<span style="color: red;">E</span> / <span style="color: green;">U</span>	
									Vis	Unsch Ph	Sched Ph	Letter	Email								
<input type="checkbox"/>		010548235	DEMO20105482		0		09/07	09/07	3	1	4		19	6						DOC2	
<input type="checkbox"/>		010379708	DEMO20103797		0		10/07	04/07	1	1	3		18	7						DOC2	
<input type="checkbox"/>		010433189	DEMO20104331		1			07/06					18	4						DOC2	
<input type="checkbox"/>		002106804	DEMO20021068		1		12/07	12/07	5	1	3		15	3						DOC2	
<input type="checkbox"/>		001662681	DEMO20016626		2		10/07	10/07	1	1	2		14	12						DOC2	
<input type="checkbox"/>		001816727	DEMO20018167		3		09/07	09/07	2				13	1						DOC2	
<input type="checkbox"/>		001669228	DEMO20016692		2		11/07	11/07	3			1	11	3						DOC2	
<input type="checkbox"/>		001436855	DEMO20014368		6	01/04/08	08/07	08/07	4	1	3		8							DOC2	
<input type="checkbox"/>		001474842	DEMO20014748		0		11/07	11/07	5		7		8	8		1	7			DOC2	
<input type="checkbox"/>		010653751	DEMO20106537		0		06/07	12/06	1	1	2		7	2						DOC2	
<input type="checkbox"/>		010489540	DEMO20104895		1		10/07	10/07	4		5	1	6	3						DOC2	
<input type="checkbox"/>		001371104	DEMO20013711		1	12/20/07	05/07	05/07	6				5	1						DOC2	
<input type="checkbox"/>		001649566	DEMO20016495		4		05/06	06/07	1	1		1	4							DOC2	
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<input type="checkbox"/>		001307445	DEMO20013074		2		11/07	10/07	1		2		3	9						DOC2	
<input type="checkbox"/>		001698505	DEMO20016985		1		05/07	05/07	1			1	3							DOC2	

# Monthly Performance Feedback

## Vitals for DEMO DOC2

■ All Panels 
 ■ PCP 
 ■ HCT 
 ✗ Max

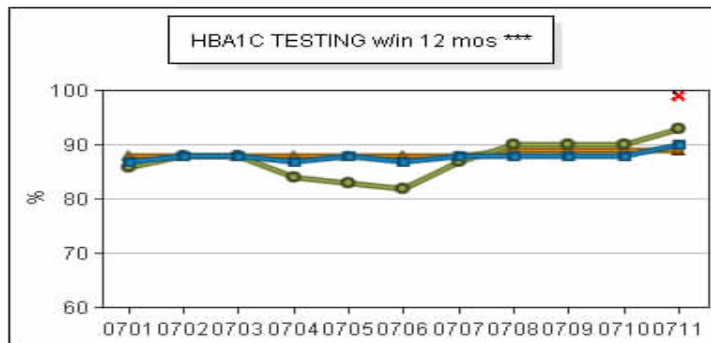
### Intermediate Outcome



[Print](#) % CVD and DM pts with LDL LT 100

[Click Here to see All Intermediate Outcomes Graphs](#)

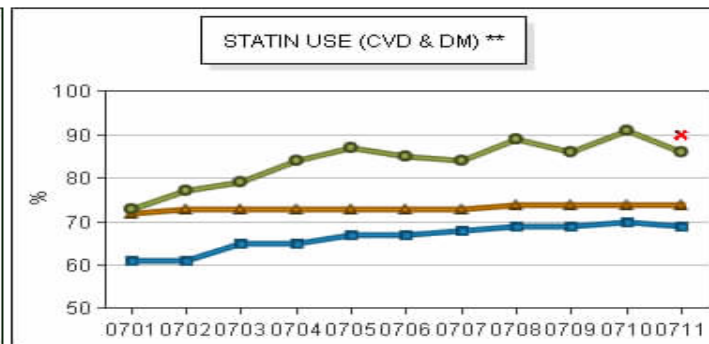
### Chronic Condition Monitoring



[Print](#) % DM pts with HbA1c Test in last 12 months

[Click Here to see All Chronic Condition Monitoring Graphs](#)

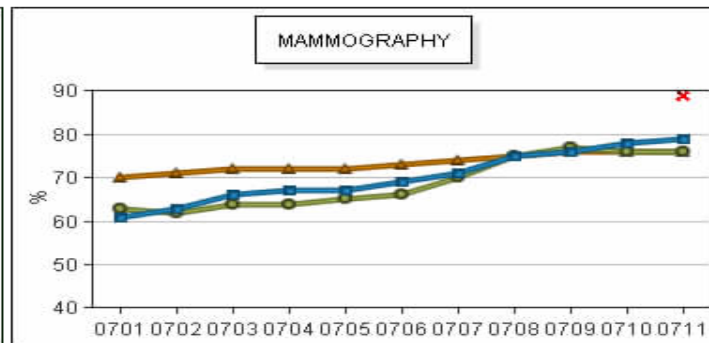
### Therapy



[Print](#) % CVD and DM pts age 40-80 with recent Statin at min. Lovastatin 40 or equiv.

[Click Here to see All Therapy Graphs](#)

### Primary Prevention



[Print](#) % Women age 40-70 w mammo in last 2 yrs

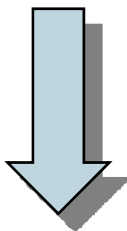
[Click Here to see All Primary Prevention Graphs](#)

# KP Community Partnership

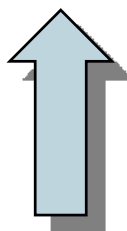
- In California, in collaboration with the California Healthcare Foundation, supporting massive deployment of i2i disease registry tool among community health centers
- In S. Cal, through “Building Clinical Capacity for Quality” effort, CHCs are involved in KP sponsored applied learning collaboratives to harness capacity of PMTs.
- PMTs will be a core component of ALL implementation in the Northwest KP region

# What next for SNPs?

**SHRINKING  
REVENUE  
SUPPORT**



**INCREASED  
EXPECTATIONS  
OF QUALITY**



- NO free pass: SNP must demonstrate proficient if not superior care in delivering quality care and service if they are to survive
- SNPs will have to prove they provide proficient primary care that is coordinated across the patient experience
- “Patient Centered Medical Homes” will be codified as basis for assessing quality and associated with payment
- Stakes are high for vulnerable populations...the patient experience; community engagement/empowerment; coordination of social services and patient support services

Delivery System Design	<b>P P C</b>	<b>Patient-Centered Medical Home</b>			
Clinical Information Systems					
Decision Support					
Self-Management Support					
Community Support					
		<b>Wagner CCM</b>			
	<b>What's Included? (Infrastructure)</b>	<b>How Much Used? (Extent)</b>	<b>What Functions? (Implementation)</b>	<b>Evidence and Scoring (Verification)</b>	

<p><b>Standard 1: Access and Communication</b></p> <p>A. Has written standards for patient access and patient communication**</p> <p>B. Uses data to show it meets its standards for patient access and communication**</p>	<p>P</p> <p>4</p> <p>5</p> <p>9</p>	<p><b>Standard 5: Electronic Prescribing</b></p> <p>A. Uses electronic system to write prescriptions</p> <p>B. Has electronic prescription writer with safety checks</p> <p>C. Has electronic prescription writer with cost checks</p>	<p>Pt</p> <p>3</p> <p>3</p> <p>2</p> <p>8</p>
<p><b>Standard 2: Patient Tracking and Registry Functions</b></p> <p>A. Uses data system for basic patient information (mostly non-clinical data)</p> <p>B. Has clinical data system with clinical data in searchable data fields</p> <p>C. Uses the clinical data system</p> <p>D. Uses paper or electronic-based charting tools to organize clinical information**</p> <p>E. Uses data to identify important diagnoses and conditions in practice**</p> <p>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</p>	<p>P</p> <p>2</p> <p>3</p> <p>3</p> <p>6</p> <p>4</p> <p>3</p> <p>2</p>	<p><b>Standard 6: Test Tracking</b></p> <p>A. Tracks tests and identifies abnormal results systematically**</p> <p>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</p>	<p>Pt</p> <p>7</p> <p>6</p> <p>13</p>
<p><b>Standard 3: Care Management</b></p> <p>A. Adopts and implements evidence-based guidelines for three conditions **</p> <p>B. Generates reminders about preventive services for clinicians</p> <p>C. Uses non-physician staff to manage patient care</p> <p>D. Conducts care management, including care plans, assessing progress, addressing barriers</p> <p>E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities</p>	<p>P</p> <p>3</p> <p>4</p> <p>3</p> <p>5</p> <p>5</p> <p>2</p>	<p><b>Standard 7: Referral Tracking</b></p> <p>A. Tracks referrals using paper-based or electronic system**</p>	<p>PT</p> <p>4</p> <p>4</p>
<p><b>Standard 4: Patient Self-Management Support</b></p> <p>A. Assesses language preference and other communication barriers</p> <p>B. Actively supports patient self-management**</p>	<p>P</p> <p>2</p> <p>4</p> <p>6</p>	<p><b>Standard 8: Performance Reporting and Improvement</b></p> <p>A. Measures clinical and/or service performance by physician or across the practice**</p> <p>B. Survey of patients' care experience</p> <p>C. Reports performance across the practice or by physician **</p> <p>D. Sets goals and takes action to improve performance</p> <p>E. Produces reports using standardized measures</p> <p>F. Transmits reports with standardized measures electronically to external entities</p>	<p>Pt</p> <p>3</p> <p>3</p> <p>3</p> <p>3</p> <p>2</p> <p>1</p> <p>15</p>
<p><b>Standard 9: Advanced Electronic Communications</b></p> <p>A. Availability of Interactive Website</p> <p>B. Electronic Patient Identification</p> <p>C. Electronic Care Management Support</p>	<p>Pt</p> <p>1</p> <p>2</p> <p>1</p> <p>4</p>	<p><b>Standard 9: Advanced Electronic Communications</b></p> <p>A. Availability of Interactive Website</p> <p>B. Electronic Patient Identification</p> <p>C. Electronic Care Management Support</p>	<p>Pt</p> <p>1</p> <p>2</p> <p>1</p> <p>4</p>

\*\* Must Pass Elements

**Pay for Performance**  
Quality, Resource Use and Patient Experience

**Fee Schedule for Visits/Procedures**

**Payment per Patient for Qualified Medical Homes**  
(services not normally reimbursed)

# In summary . . .

- CHCs can play a critical role in defining the Quality agenda, since Value/Cost equation is particularly pronounced
- Partnerships in improving quality are defined by populations and communities
- Access reform (universal coverage) is critical to address the needs of 47 million uninsured, but without delivery reform, we will still deliver fragmented, sub-optimal care, especially for vulnerable populations
- Partnerships must consider delivery design, e.g., the Patient Centered medical home as a strategic imperative

Thank you for your leadership!

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