Clinical Documentation Improvement in the Outpatient Setting

Why It Matters

Purpose
To provide foundational knowledge of how current trends in healthcare have resulted in a significant need for documentation improvement in the outpatient setting.
A Snapshot

1. Healthcare Today: Snapshot
2. The Shifting Focus of the United States Healthcare System
3. The Evolution of Healthcare Reimbursement
4. Transforming Medical Documentation - From Paper to Electronic Health Records
5. Success in a Fee for Value World - The Missing Link
American Healthcare is Expensive:
The United States spends more than twice as much per capita on healthcare as the average developed country does.

Top Healthcare Service Utilizers in the United States

Total U.S. Healthcare Spending by Number of Chronic Conditions in 2010

Data Highlights:
- 86% of healthcare spending is for patients with one or more chronic conditions
- 71¢ of every dollar of healthcare spending goes to treating people with multiple chronic conditions

Source: Agency for Healthcare Research and Quality (AHRQ) Multiple Chronic Conditions Chartbook: 2010 Medical Expenditure Panel Survey Data
Many Americans Suffer from Chronic Health Conditions

Data Highlight:
- In 2012 half (49.8%) of Americans suffer from at least one chronic condition.
- One in four (25.5%) of Americans suffer from more than one chronic condition

The Prevalence of Multiple Chronic Conditions by Age

Data Highlights:
- The prevalence of multiple chronic conditions increases dramatically with age
- Almost half of all people aged 45-64 have multiple chronic conditions
- Over 60% of those aged 65 and over have multiple chronic conditions

Average Annual Healthcare Costs by Age

Source: Economics of RM: The Potential for Regenerative Medicine to Help Slow Rising Healthcare Costs © 2015 Alliance for Regenerative Medicine

The Institute of Medicine (IOM) defines quality of healthcare as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Source: Crossing the Quality Chasm: A New Health System for the 21st Century Committee on Quality of Health Care in America, Institute of Medicine Washington, DC, USA: National Academies Press; 2001

Overall Ranking of Selected Nations’ Healthcare Quality

<table>
<thead>
<tr>
<th>Overall Rank</th>
<th>Aus</th>
<th>Can</th>
<th>Fra</th>
<th>Ger</th>
<th>Neth</th>
<th>NZ</th>
<th>Nor</th>
<th>Swe</th>
<th>Swz</th>
<th>UK</th>
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<td>Overall Rank</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
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<td>11</td>
</tr>
<tr>
<td>Quality of care</td>
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<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>11</td>
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<td>8</td>
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<td>Efficiency</td>
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<td>6</td>
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<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
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<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
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</tbody>
</table>

| Health Expenditure Per Capita, 2011** | $3800 | $4522 | $4118 | $4495 | $5099 | $3182 | $5669 | $3925 | $5643 | $3405 | $8508 |

Notes: Includes ties. **Expenditures shown in $US PPP (Purchasing Power Parity). Australian $ data are from 2010.

30% of the United States Healthcare Dollar is Wasted
$750 Billion Dollars Annually

- Unnecessary Services, $210 Billion
- Excess Admin Cost, $190 Billion
- Inefficient Care Delivery,$130 Billion
- Inflated Prices, $105 Billion
- Fraud, $75 Billion
- Prevention Failures, $55 Billion

Part II: Shifting Focus
Moving Towards Prevention and Evidence Based Medicine

The Shifting Focus of Healthcare in the U.S.

1. Population Health
2. Evidence Based Medicine
3. The National Quality Strategy
4. Documenting Clinical Quality Measures (CQMs)
Determinants of Health:
Factors that Influence Healthfulness

- Genetic Predisposition
- Behavioral Patterns
- Healthcare Interventions
- Environmental Exposure
- Social Circumstances


Many Factors Determine Population Health

- Counseling & Education
- Clinical Intervention
- Long-Lasting Protective Interventions
- Changing Context to Make Individuals’ Default Decisions Healthy
- Socioeconomic Factors

- Ongoing: personalized nutrition & activity initiatives
- Ongoing: medication adherence, care coordination
- One time or infrequent: vaccination, colonoscopy
- Healthy school lunches, city-wide bike/walk paths
- Health insurance, Access to care, health insurance

A population health approach fosters better clinical outcomes across communities and organizations while lowering the total cost of care.

The Institute for Healthcare Improvement (IHI) Triple Aim:
- Improve the health of populations
- Improve the patient experience of care (quality and satisfaction)
- Reduce the cost of care (utilization)

Evidence-based medicine is a systematic approach to clinical problem solving which allows the integration of the best available research evidence with clinical expertise and patient values.


Improving care for acute heart disease events could at most prevent or postpone 8% of deaths in the U.S. population ages 30-84.

Taking full advantage of the benefits of good nutrition, adequate physical activity, and elimination of tobacco would prevent or postpone 49% of all deaths in the U.S. population ages 30-84.

The National Quality Strategy (NQS) was established by the Affordable Care Act and first published in 2011 and serves as a nationwide effort to improve health and health care across America.

The National Quality Strategy is to concurrently pursue three aims.
The IHI Triple Aim Aligns with the NQS Three Aims

Institute for Healthcare Improvement

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

National Quality Strategy

- Better Care: Improve overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.
- Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and, environmental determinants of health.


The IOM Six Components of Quality Healthcare Align with the NQS Six Priorities

Institute of Medicine

- Six components of Quality Healthcare
  - Patient Centered
  - Safe
  - Equitable
  - Timely
  - Efficient
  - Effective

National Quality Strategy

- Six Priorities
  - Safer Care
  - Patient and Family Engagement
  - Care Coordination
  - Effective Treatment and Prevention
  - Community Health
  - Affordable Care

The National Quality Strategy: 3 Aims, 6 Priorities, 9 Levers

Clinical Quality Measures

<table>
<thead>
<tr>
<th>National Quality Strategy Priorities</th>
<th>National Healthcare Initiatives Using Measure</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Affordable Care</td>
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<td>M080</td>
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<td>0032</td>
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</table>

Gauging Success with Clinical Quality Measures:
- Clinical Quality Measures (CQMs) are used to gauge the overall success of the National Quality Strategy.
- CQMs enable providers to track various aspects of patient care.
- CQMs can be tied to a variety of different quality initiatives.

Source: National Quality Foundation’s Community Tool to Align Measurement (Alignment Tool), developed in collaboration with the Robert Wood Johnson Foundation http://www.qualityforum.org/AlignmentTool/
National quality programs measure different dimensions of patient satisfaction, health outcomes and health plan performance

Common Quality Programs:

- PQRS – Physician Quality Reporting System
- Medicare Star Ratings
- CAHPS (Consumer Assessment of Healthcare Providers and Systems)
- National Committee for Quality Assurance (NCQA):
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - HOS (Health Outcomes Survey)

Part III: Reimbursement

The Evolution of Healthcare Reimbursement
The Evolution of Healthcare Reimbursement

1. Reimbursement for Healthcare Services is shifting from Fee for Service to Pay for Value
2. Understanding Fee For Service Vs. Pay for Value Models
3. Different Pay for Value Models Tied to Population Health

Fee For Service

- The most traditional of healthcare payment models
- Patients or payers reimburse healthcare providers for each service performed. Payments received after services are performed.
- Providers determine the prices for each service offered and payers negotiate payment rates based on payer fee schedules

Today’s Doctor Patient Relationship

“The patient is thinking: ‘I’m taking the afternoon off work for this appointment, I’ve waited three months for it, I’ve got a list of things to discuss.’ The doctor is thinking, ‘I’ve got 15 minutes.’”


Percent of Healthcare Services Used by People with Multiple Chronic Conditions - 2010

Data Highlight:
People suffering from multiple chronic conditions account for the majority of clinician visits, prescriptions, home health visits, and inpatient stays.

Source: Agency for Healthcare Research and Quality (AHRQ) Multiple Chronic Conditions Chartbook: 2010 Medical Expenditure Panel Survey Data
Value Based Payments

1. Value based payment systems are based on a payment per person, rather than a payment per service provided.
2. Providers are paid a fixed per member per month (PMPM) amount for each member served without regard to the actual number or nature of services provided to the member.
3. There are several types of value based payments

Types of Value Based Payments: Care Coordination

Care coordination is organizing and managing care between multiple providers, usually between the primary care provider and specialists.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Source: Centers for Medicare and Medicaid Services: https://www.medicare.gov/manage-your-health/coordinating-your-care/coordinating-your-care.html
A Patient Centered Medical Home (PCMH) is a centralized setting that assures patients receive indicated care when and where they need and want it in a culturally appropriate manner.

A practice certified as a PCMH receives a per member per month (PMPM) payment to deliver care coordination services.


Shared savings payments are incentive payments given when providers reduce health care costs for a patient population. (Bailit and Hughes, 2011, p. 1).

An Accountable Care Organization (ACOs) is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that assumes responsibility for the care of a population of patients (Schneider et al., 2011, p. 13).

The goal of the ACO is to deliver coordinated and efficient care.


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An accountable care organization (ACO) is a healthcare organization is both a care delivery and a payment model.

Provider reimbursements tied to:
- Meeting clinical quality care metrics (CQMs) and
- Reducing the total cost of care for the assigned population of patients.

In a full capitation payment model providers are paid to deliver all medical services needed to a group of patients for a defined period of time.

Payment rates are tied to expected usage regardless of what the patient actually uses.

A “single ‘bundled’ payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure” (Schneider et al., 2011, p. 13).
In full risk adjustment agreements, providers assume full responsibility for patient medical care. A single per-member per-month (PMPM) payment is made for all services delivered to a patient, with payment adjustments based on expected usage (Schneider et al., 2011, p. 13).

30% of Medicare Beneficiaries are covered under Medicare Advantage Plans, which are fully risk adjusted plans.

Hierarchical Condition Categories (HCCs) - Medical conditions are grouped and ranked in order of severity. Providers are reimbursed more for patients with multiple or more severe illnesses based on increased expected usage. Expected usage is determined by multiple factors including patient age, race, sex, lifestyle, and medical history.


Future Healthcare Reimbursements Favor Value Based Payments

CMS is RAPIDLY Phasing Out Fee For Service Payments in Favor of Value Based Payments

Source: Medicare: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/

Part IV: Documentation
Transforming Medical Documentation: From Paper to Electronic Health Records
From Paper to Electronic Health Records

1. Creation of the Modern Medical Record
2. Introducing Technology to the Medical Record
3. Meaningful Use

Creation of the Modern Medical Record
Dr. Lawrence Weed, delivering a lecture on the concept of Problem Oriented Medical Record at Emory University’s Internal Medicine Grand Rounds in 1971

Source: Video accessed here: https://www.youtube.com/watch?v=qMsPXSMTpFI
SOAP Notes: The Basis of the Modern Medical Record

SAMPLE “SOAP NOTE”:
Date: 10/14/04

S: 25 y.o. female c/o dysuria and frequency for six days. No previous occurrence. No back or flank pain. No fever. LMP 2 weeks ago, normal flow and duration. Parents alive and well, older brothers both well. 1 younger sister well. Husband of 1 year well. No children. NKDA.


A: Uncomplicated cystitis, probably bacterial, should resolve with therapy

P: Bactrim DS, tab BID x 5 days. RTC 2 weeks for re-check UA. Patient ed: force fluids and take all drugs even if sx resolve.


Problems Inherent to Medical Record Documentation

- The medical record is only as good as the information entered.
- The number of people involved in the care of a single patient creates problems in relation to accurate medical records.
- Separating medical information into individual sections organizes the information but makes it difficult to see across all data what is happening at a particular point in time.

“When I pick up a chart that is a bunch of scribbles, I say, “That’s not art. It certainly isn’t science. Now, God knows what it is. The physician who is creating it will have to give it a name.”—Dr. Lawrence Weed,
“To effectively deal with [frustrations in every phase of medical action], it will be necessary to develop a more organized approach to the medical record, a more rational acceptance and use of paramedical personnel and a more positive attitude about the computer in medicine” – Lawrence Weed, MD – 1968, Medical Records that Guide and Teach

By the late 1970s, “physicians were drowning in all the data that could be compiled with computers. There was so much there that providers couldn’t process it.” – Dr. Lawrence Weed

Meaningful Use: Improved Outcomes

HITECH - Health Information Technology for Economic and Clinical Health Act

- Enacted in 2009, HITECH offered incentives to providers to switch from paper charts to electronic health records (EHRs) while also focusing on improved patient outcomes and efficiency.
- Introduced the concept of Meaningful Use: using a certified EHR in a meaningful manner to:
  - Improve quality, safety, efficiency, and reduce health disparities;
  - Engage patients and families;
  - Improve care coordination, and population and public health;
  - Maintain privacy and security of patient health information

Source: https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
## Meaningful Use Incentives and Penalties

<table>
<thead>
<tr>
<th>First Year of Use</th>
<th>Total Amount Eligible</th>
<th>Penalty</th>
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<td>2011-12</td>
<td>$44,000</td>
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<td>2013</td>
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<td>2014</td>
<td>$23,530</td>
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<tr>
<td>2015</td>
<td>$0</td>
<td>-1%</td>
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<tr>
<td>2016</td>
<td>$0</td>
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<td>2017</td>
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<td>2018</td>
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<tr>
<td>2019 and on</td>
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<td>-5% (max)</td>
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</table>

Source: https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

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## Achieving Meaningful Use

![Achieving Meaningful Use Diagram]

Source: https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
# Meaningful Use and the National Quality Strategy

## National Quality Strategy

- **Six Priorities**
  - Safer Care
  - Patient and Family Engagement
  - Care Coordination
  - Effective Treatment and Prevention
  - Community Health
  - Affordable Care

## Meaningful Use documents provider implementation of the National Quality Strategy

- Beginning in 2015, to meet Meaningful Use standards, providers must attest to nine Clinical Quality Measures (CQMs).
- CQMs must cover at least three of six National Quality Strategy Priorities.


## Clinical Quality Measures

<table>
<thead>
<tr>
<th>CQM Measure #</th>
<th>National Quality Measure (NQM) Measure Title</th>
<th>National Quality Strategy Priorities</th>
<th>National Healthcare Initiatives Using Measure</th>
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<td>0511</td>
<td>Controlling High Blood Pressure</td>
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<td>1 1 1 1 1 2 1</td>
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<td>0021</td>
<td>Therapy monitoring annual</td>
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<tr>
<td>2971</td>
<td>Comprehensive Diabetes Care: HbA1c method 2</td>
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<td>1016</td>
<td>Post MI: ACE inhibitor or ARB therapy</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>

### Gauging Meaningful Use Participation with Clinical Quality Measures:

- Clinical Quality Measures (CQMs) are used to gauge the overall success of the National Quality Strategy.
- CQMs enable providers to track various aspects of patient care.
- CQMs can be tied to a variety of different quality initiatives, including Meaningful Use

Source: National Quality Foundation’s Community Tool to Align Measurement (Alignment Tool), developed in collaboration with the 16 Robert Wood Johnson Foundation http://www.qualityforum.org/AlignmentTool/
54% of Physicians Have Demonstrated Meaningful Use

Source: CMS EHR Incentive Program data, April 2015 and SK&A Office-based Provider Database, 2013

Part V: Future Success
Outpatient Clinical Documentation Improvement in a Pay For Value World
1. The current healthcare system is ineffective and too expensive to be sustainable for the entire population

2. A population health approach is changing the way healthcare is delivered in the United States

3. Healthcare reimbursement is changing to align with the population health strategy

4. Data from medical records is being used to measure the success of the population health strategy

5. Successful use of the medical record is critical to provider success in a population health delivery model.

**Healthcare Spending vs. Average Life Expectancy**

Healthcare Spending and Chronic Conditions

50% of Medicare spending is for the 15% of beneficiaries with 6 or more chronic conditions. 76% of Medicare spending is for the 36% of beneficiaries with 4 or more chronic conditions.


The National Quality Strategy

A New Vision of Healthcare

- The primary purpose of population health is to maximize our resources to secure the greatest possible improvement to the physical and mental health of the population

Source: The Agency for Healthcare Research and Quality
http://www.ahrq.gov/workingforquality/
Fee For Service Healthcare Reimbursement is Being Phased Out in Favor or Pay For Value Reimbursement

Electronic Health Records

Meaningful Use
- The establishment of the National Quality Strategy spurred the push to create electronic health records that enabled the meaningful use of health data and information.
Modern Healthcare Mandates Outcome Based Care

Providers are Caught in the Middle

- The time constraints of practice and the enormous scope of information associated with multiple problems in unique patients make it impossible for the human mind to integrate detailed patient data with comprehensive medical knowledge. – Dr. Lawrence Weed

Reasons For Physician Burnout in 2016

Providers are Overloaded with Data

<table>
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<th>Reason</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. Too many bureaucratic tasks</td>
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</tr>
<tr>
<td>2. Spending too many hours at work</td>
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</tr>
<tr>
<td>3. Increasing computerization of practice</td>
<td>4</td>
</tr>
<tr>
<td>7. Impact of Affordable Care Act</td>
<td>4</td>
</tr>
<tr>
<td>8. Too many difficult patients</td>
<td>3</td>
</tr>
<tr>
<td>9. Too many appointments in a day</td>
<td>3</td>
</tr>
<tr>
<td>10. Inability to provide patients with the quality care that they need</td>
<td>3</td>
</tr>
</tbody>
</table>

http://www.medscape.com/
To be successful by providers will need to demonstrate optimal healthcare value:

- Fully capture health status of patients in a usable way

Documenting Cost (Utilization) by accurately describing patient health status in the medical record

Source: Image adapted from: Dale Sanders Cayman Collaborative Care Initiative 26 March 2012
http://callitanything.blogspot.com/2012/03/cayman-collaborative-care-initiative.html

Outpatient Clinical Documentation Improvement
The missing link to success in a pay for value world

Outpatient Clinical Documentation Improvement Experts Help Providers:

- Document appropriately to match patients with services and benefits they need
- Fully capture health status of patients in a usable way
- Embrace Technology
- Operationalize processes that support a pay for value model and make data manageable
- Focus on Delivering Patient Centered Care and Increasing Patient Engagement
Outpatient Clinical Documentation Improvement Experts

Help providers:
- Document appropriately to match patients with services and benefits they need
- Fully capture health status of patients in a usable way through accurate and specific coding

“Data Drives Positive Patient and Financial Outcomes. The medical record is only as good as the information entered and transmitted.”

Outpatient Clinical Documentation Improvement

Help providers:

- Focus on Delivering Patient Centered Care and Increasing Patient Engagement

**Outpatient Clinical Documentation Improvement Experts Help Providers:**

- Fully capture health status of patients in a usable way
- Document appropriately to match patients with services and benefits they need
- Embrace technology
- Operationalize processes that support a pay for value model and make data manageable
- Focus on Delivering Patient Centered Care
- Increase Patient Engagement

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**Humana**

AAPC Healthcon 2016  67

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**Humana**

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Resources

- The Peter G. Peterson Foundation: http://www.pgpf.org/about/
- The United States Department of Health and Human Services Agency for Healthcare Research and Quality: http://www.ahrq.gov/
  - The Institute of Medicine: http://iom.nationalacademies.org/
    - CROSSING THE QUALITY CHASM: A New Health System for the 21st Century http://www.nap.edu/read/10027/chapter/1
- The Commonwealth Fund: http://www.commonwealthfund.org/about-us
  - The Institute for Healthcare Improvement: http://www.ihi.org/about/Pages/default.aspx
  - The IHI Triple Aim Initiative: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
  - Quality Alignment Tool: http://www.qualityforum.org/AlignmentTool/
  - Thomas Kottle, MD, MSPH and Nico Pronk, PhD, Creating Health: Finding the Path From Here To There, 01/30/2013 http://www.improvingpopulationhealth.org/blog/2013/01/creating-health-finding-the-path-from-here-to-there.html
- The National Committee for Quality Assurance http://www.ncqa.org/
  - Patient Centered Medical Home: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- HealthIT.gov
  - Meaningful Use: https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
- Centers for Medicare and Medicaid Services
  - Accountable Care Organizations: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/Aco
  - CMS EHR Incentive Program data, April 2015 and SK&A Office-based Provider Database, 2013
  - Coordinated Care: Centers for Medicare and Medicaid Services: https://www.medicare.gov/manage-your-health/coordinate-your-care/coordinate-your-care.html
Resources

- The Organization for Economic Cooperation and Development http://www.oecd.org/unitedstates/
- Medical Economics: http://medicaleconomics.modernmedicine.com/
- Cambia Health Foundation: http://www.cambiahealthfoundation.org/
- Steve Lesky, Patient-Centered Care: Beyond the Diagrams, June 23, 2014 http://www.cambiahealthfoundation.org/blog/beyond-the-diagrams