A Leaders’ Guide to Creating the Business Case for Planned Care

A Toolkit

Authored by:
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Acknowledgement

This leader’s guide and toolkit is one of the work products resultant from two years of field work involving Federally Qualified Health Centers actively implementing the Planned Care Model as part of their work in the Health Disparities Collaboratives initiative sponsored by the Health Resources Services Administration (HRSA). The authors wish to thank HRSA for its vision in recognizing the need for tools and resources to assist health centers with this challenge of supporting organizational transformation. Specific recognition should be given to Fred Butler, HRSA Project Officer for the Finance and Redesign Pilot Collaborative where the evidence base for this toolkit was established. The authors also wish to thank those health centers that participated in the Finance and Redesign Pilot, including:

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- One World Community Health Center; Omaha, NE
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I. Introduction to Understanding the Business Case

**Background**

In 1999, the Health Resources Services Administration (HRSA) launched an ambitious initiative to change the predominant care delivery model in the Federally Qualified Health Centers (FQHC’s). The HRSA initiative, known as the Health Disparities Collaboratives (HDC), adopted the Wagner Care Model presented in Figure 1 as its new model for care delivery. Through implementation of this model, FQHC’s across the US have begun a journey toward organizational transformation and improved population health outcomes.

**Figure 1. The Wagner Care Model**

The Health Disparities Collaboratives initiative has done a lot to improve the historical perception about care delivered in the FQHC’s. The data that has been collected through this initiative has demonstrated improved clinical outcomes for patients with chronic conditions and in some cases shown that the care provided in the FQHC’s is superior to that provided in the private sector. An evaluation of the Collaboratives conducted by the Agency for Healthcare Research and Quality (AHRQ) reflected that, on balance, the health centers participating in the HDC process felt that it had a positive impact on their organization and their patient populations.

One of the major issues associated with a movement toward the Planned Care Model is the reality that there are costs associated with implementing and
sustaining the required practice changes. Throughout the history of the Health Disparities Collaboratives health center leaders have questioned how to subsidize the new work of Planned Care. The fundamental business case of any organization comes down to the simple equation of margin equals revenue minus expenses. To explore the business case for planned care, attention must be paid to both components of this equation.

**The Cost of Implementing the Care Model**

The implementation of the Planned Care Model does require a front end investment by the health center. The costs include such examples as the time and lost productivity of staff who participate in training activities, time to test changes and implement the change package; the costs associated with supporting clinical registries and data entry; time to provide patient education and other services such as group visits which might not be reimbursed by third party payers; max packing services that might not add to reimbursement.

A recent study funded by AHRQ focused on evaluating the impact of the Health Disparities Collaboratives from a variety of different perspectives. As part of that study conducted by Elbert Huang, M.D. and Marshall Chin, M.D., they quantified the aggregate costs for a health center to implement the Planned Care model. The cost was calculated on a per patient basis and ranged between $6.41 and $23.93 per patient for the first year. This amount translates to between 1.98% and 8.2% of the total health center budget. The wide range is attributable to both the size of the organization as well as its efficiency with its internal quality improvement and change management processes. Over time, the costs of planned care likewise vary, with 80% of the health centers reporting that after the first year, costs declined as a percentage of budget.

**The Business Case for Planned Care**

It is clear that a front end investment is needed in order to implement the Planned Care Model. This leads to the obvious question of whether there is a longer term return on investment for this initial investment. The nature of the HDC is such that clinical outcomes as well as process measures are tracked and reported by each participating health center. This data has reflected improvements across the board of both outcomes and process measures in most major disease categories. Unfortunately, these measures are not easily linked to financial measures of performance. Further, the nature of payment systems

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1 The Agency for Healthcare Research and Quality conducted a study of Health Centers who participated in the Health Disparities Collaboratives from the Midwest Cluster. Drs. Marshall Chin and Elbert Huang were the principal investigators from the University of Chicago. The results of the study have not been released publicly as of the end of 2005. However, the information referenced was presented by Drs. Huang and Chin at the September, 2005 Community Health Institute in Miami sponsored by the National Association of Community Health Centers.
makes systematic data collection of the financial impact of care delivery changes a challenge. Data can be presented showing systematic decreases in average HbA1c levels for patients in the diabetes registries, and there is a strong evidence base available for the impact even small decreases in HbA1c level on co-morbidities and overall mortality. However, it is not easy to make the further correlation to the financial impact resulting from this work.2

Nonetheless, an evidence base is starting to evolve as a result of the overall industry’s increased emphasis on disease management and chronic illness care. In November 2005, a meta-analysis of the disease management literature conducted by David Krause was published in Disease Management. This analysis sought to determine if there is an evidence base for a positive return on investment for disease management services which now represent a billion dollar market in the private sector. According to Krause’s analysis, an economic impact has been demonstrated in the literature, and disease management programs are more economically effective with severely ill individuals and are more economically effective when coordinated with disease severity.

In the health center arena, the most pertinent study was conducted in South Carolina by the Budget and Control Board.3 The study reviewed a comparison of health centers that have participated in the HDC compared to those who have not and to all primary care practices in the state. Figure 2 presents a summary of their findings for a large population of Medicaid patients.4

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2. The United Kingdom Prospective Diabetes Study (UKPDS) was a 10 year study of a large population of people with diabetes published in the British Annals of Internal Medicine. The study showed that a 1% decrease in HbA1c level had a corresponding 35% decrease in cardiovascular endpoints; an 18% reduction in myocardial infarctions; a 15% decrease in strokes, an 18% reduction in cataract extractions and a 17% reduction in mortality.

3. The study was conducted by Pete Bailey of the Office of Budget and Control. The study has subsequently undergone a validation by Mercer Benefits Consulting.

4. Adapted from Pete Bailey, South Carolina Budget and Control Board. 2005
Figure 2
Payment Profile for Patients with Diabetes from the Medicaid Billing System
South Carolina, 2000 - 2002

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selected FQHC</th>
<th>All Family Practice Physicians (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. total annual payment per patient</td>
<td>$1,340</td>
<td>$1,778</td>
</tr>
<tr>
<td>Avg. annual drug payment per patient*</td>
<td>$502</td>
<td>$576</td>
</tr>
<tr>
<td>Avg. office visit payment per patient*</td>
<td>$441</td>
<td>$168</td>
</tr>
<tr>
<td>Avg. inpatient hospitalization payment*</td>
<td>$172</td>
<td>$634</td>
</tr>
<tr>
<td>Average emergency room payment*</td>
<td>$15</td>
<td>$22</td>
</tr>
</tbody>
</table>

Source: South Carolina Office of Budget and Control 2004

The data from South Carolina are impressive as they show a dramatic difference in overall annual cost per patient. These reductions are due to decreased hospitalizations, emergency room visits and subspecialty referrals resulting from increased emphasis on evidence-based guidelines and preventive care.

In the December 2005 issue of Family Practice Management Dr. Philip Mohler reported that annual costs to support planned care in his private practice total $1,800 per physician, or $114 per diabetes patient per year.\(^5\) Using this cost figure, combined with the medical cost savings from the South Carolina data, yields a theoretical return on investment of 3.84 to 1. Although the practice settings and patient population characteristics in these two examples do not match, it is logical to assume that there is a positive ROI of some magnitude that can be derived from the work of planned care.

Another example of cost savings to the system comes from the state of Maine. The Maine Primary Care Association testified before the State Appropriations and Financial Affairs Committee and reported that the health centers who had participated in a collaborative and therefore implemented planned care experienced a 48% drop in hospitalizations associated with diabetes as compared to a 14% drop throughout the rest of the state. Hospitalizations for health center patients with depression dropped by 25% compared to 9% for patients statewide. The estimated savings attributable to this differential was in excess of $814,158.

As part of the AHRQ study previously referenced there was a cost effectiveness analysis (CEA) conducted to try to confirm the economic impact as a result of the Collaboratives. Data were collected from a randomized controlled study involving 34 health centers. They analyzed the impact of decreased complications as a result of better controlled diabetes care. The study concluded that there is a positive difference of $49,334 savings per Quality of Life Year.
(QALY) for those patients benefiting from the HDC experience as compared to those who did not.

The tension between downstream savings versus upstream costs

It is becoming clearer that the HDC are having a positive impact on health outcomes and that implementation of the Care Model has the potential to save the larger health care system significant resources over time. Unfortunately, a tension exists whereby the savings generated through improved outcomes and less use of hospital and ED resources accrue not to the primary care providers, but to payers in the form of managed care organizations, state Medicaid agencies, and the federal government. The dilemma lies in the fact that in order to generate these savings, the primary care providers must make a front end investment of time and monetary resources without any clear incremental revenue stream to subsidize the costs.

During the Finance and Redesign Pilot the faculty and participating health centers confirmed this dilemma and concluded that a primary care practice is at risk if they simply add the planned care work to their existing systems without stepping back and reengineering their organization. Costs would be added without the prospect of near term reimbursement. To address this challenge, health centers need to rapidly move forward and reexamine their operations to find ways to generate a business case. The toolkit that follows was designed to assist health centers in doing just that. It reflects the work of health centers that found ways to generate their own business case and are now positioned to take leadership positions in the new health care environment that is emerging.

As long as the old rules of the reimbursement game persist there is little incentive for primary care practices to adopt the Planned Care Model as an organizing framework. However, while change has not been rapid thus far, the health care environment is complex and dynamic and some of the old rules of the game are being modified through the confluence of several market forces.

The first force that is driving change is the increased transparency associated with performance measurement and the greater accountability being demanded by funding agencies. As resources continue to become constrained, decisions are increasingly favoring those who can use data to demonstrate their improved performance.

Linked to such efforts is the national wave of Pay for Performance (P4P) initiatives in which funding is being tied to defined performance measures. P4P programs offer the opportunity for primary care organizations to generate increased revenue as a result of better outcomes. Such revenue may be in the form of bonuses based on performance measures as well as increased patient
volume as a result of publicizing these measures. The downside of such programs, however, lies in the potential for P4P programs to evolve into economic credentialing where low performers start to become disadvantaged in both revenue and potential access to patients. To guard against such a possibility, health centers must work diligently on improving clinical outcomes—a clear objective that can be achieved through the implementation of Planned Care.

Lastly, the improved outcomes achieved by those who have adopted the Planned Care Model are slowly resulting in changes to the reimbursement system. There are numerous payers who have been launching programs to reimburse for portions of the Planned Care work. Examples include Dr. Mohler’s practice that received $120 per diabetic patient per year from a local health plan as an additional care management fee.\textsuperscript{5} Wellmark of Iowa has also been experimenting with varying reimbursement schemes for proper chronic illness care.

It is likely that the overall reimbursement system will ultimately catch up to the changes being made in the care delivery system. Those who have positioned themselves by adapting their systems in anticipation of this evolution will be able to seize the moment. Those who do not make efforts to stay ahead of the wave may find themselves at a competitive disadvantage.

\textbf{Making Your Own Business Case and Creating the Resources to Fund the Transformation}

Can you really generate your own business case without dramatic changes in the reimbursement system? The answer to this question is yes. It requires recognition that the work of Planned Care is intricately tied to the financial performance of the organization. One of the traps organizations fall into is seeing the Planned Care work simply as a clinical quality improvement project. When viewed in this light it just adds to the existing work of the care team of clinicians and support staff that are assigned to the project. Rarely does the team of those assigned to work on Planned Care include colleagues who work in the administrative and financial areas of the organization. As a result, silos are perpetuated and the full talents of the organization are not harnessed to actually redesign the systems and processes in order to deliver higher quality care at lower costs.

Those who have been successful in driving their business case have adopted the notion of "quality as business strategy." They have recognized that implanting the Planned Care model in their organization requires a total transformation of the organization. This work becomes an opportunity to understand the intersection of administrative, financial, and clinical systems and to use this knowledge to redesign all of these processes toward a leaner and higher
performing organization. They realize that the traditional model of primary care delivery all of us have grown up with is perfectly designed to achieve the suboptimal results it is achieving. Implementing Planned Care is not about simply tweaking our old systems to get them to perform better. Rather, it is about designing new organizations that produce better outcomes with fewer resources. Once armed with this knowledge, health centers have demonstrated they are capable of making this transition.

To follow is a change package that represents the high leverage opportunities to generate the business case. Following the change package is guidance on how to get started and then specific toolkits aimed at facilitating the spread of the change package.
II. The Change Package and Model for Transformation

If one steps back and examines the Planned Care model from the lens of the business case it is clear that every component of the model can have an impact either on cost or revenue. To follow are examples within each component of the care model to demonstrate the point:

Community Resources and Policies: Establishing new relationships in the community can reduce costs for an organization by generating new resources in the form of in-kind donations of supplies or, including expanding the care team with external members from the community. Influencing the policy of Medicaid and other payers can dramatically change the revenue stream.

Organization of Health Care: Aligning internal recognition and reward systems to support planned care work can enhance productivity which has an impact on both cost and revenue potential; policies that facilitate and encourage innovation and improvement can lead to new ideas to reduce costs; on the negative side, lack of support from leadership can lead to non-productive teams, significant rework down stream, and added cost.

Self-Management Support: One of the greater challenges of the Care Model is self-management support. Because self-management support requires care team member time, productivity and costs are impacted by which member of the care team is assigned this responsibility. At 10-20 minutes per patient visit over an entire patient panel, the difference between a physician performing this function versus a nurse can be as much as $50,000 - $60,000.

Delivery System Design: The access system is a huge driver of productivity in a primary care setting. Advanced access can decrease no show rates, thereby dramatically increasing revenue potential.

Clinical Information Systems: The management of data is a critical function in organizations. Having highly skilled clinical staff perform the data entry function or requiring redundant data capture can add cost to your system. Well thought through information systems can contribute to clinical productivity.

Decision Support: Standardization of decision making can streamline flow and reduce costs. Use of medication standing orders can reduce interruptions or provider time, streamline flow, and avoid unnecessary calls and lost productivity.
These are a few example of the interconnection of each component of the Care Model with the business case. Every change concept introduced with the Care Model likewise has elements of the business case underpinning it. Leadership must be diligent in the roll-out of the Care Model to ensure that resources are being properly utilized and that changes are evaluated in terms of their return on investment (ROI). Where appropriate. In addition, it is important to recognize that there are some changes that represent greater opportunities than others to impact the business case. At the end of the day, the business case comes down to that simple formula:

\[
\text{Margin} = \text{Revenue} - \text{Expenses}
\]

And to make revenue meaningful, it must be collected. The faculty and teams of the Finance and Resign Pilot identified four high leverage opportunities to influence this formula and drive the business case in primary care organizations. In addition, a framework was developed to assist health centers with implementing these high leverage changes. The high leverage opportunities include:

- **Optimizing the Care Team:** Labor typically represents more than 60% of the expenses of a health care organization. How staff are utilized to provide and support care delivery can therefore drive much of the economics of an organization. Matching skill sets with the work that must be done and allocating staff to support maximum productivity of the provider allows for greater panel sizes and ultimately greater revenue.

- **Eliminate waits and streamline workflow:** The traditional system of outpatient scheduling drives significant inefficiency, results in inordinately high no-show rates, and is a silent drag on the economics of an organization. Implementing advanced access principles wherein capacity and demand are balanced on a daily basis and today’s work is done today can result in dramatic reductions in no show rates and consequent improved revenue.

- **Enhance Revenue:** Revenue is impacted by how many services are billed, how much is billed for each service, and how much of the billings is actually collected. Service volumes, coding practices, documentation, billing systems, and processes for management of receivables all come into play. When these systems undergo close scrutiny, there are opportunities to generate both short and long term gains in revenue.

- **Eliminate waste and reduce costs (Creating a Lean Organization):** A strong evidence base has existed around a change package associated with the principles of “Lean” generated out of the Toyota Production System (TPS). These principles can easily be applied to healthcare and can be used to streamline flow, manage inventories, and minimize...
unnecessary motion of people, information and technology in order to recapture significant waste that occurs from the design of our existing care delivery systems.

To assist with the implementation of these broad concepts a specific change package was crafted through the harvesting of the Pilots focusing on the business case underpinning Planned Care. To facilitate tracking of these concepts they were organized under the “Delivery System Design” and “Organization of Health Care” components of the Planned care Model. It is important to re-emphasize that many opportunities for influencing the business case transcend all components of the Care Model and these other components should not be overlooked. A comprehensive explanation of the change concepts appears in the toolkit in Appendix A where each idea is expanded and examples and helpful hints provided.

The change package is summarized in Figure 3 below.

Figure 3: Business Case Change Package

<table>
<thead>
<tr>
<th>ORGANIZATION OF HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use data to understand your practice and its business case</td>
</tr>
<tr>
<td>• Focus leadership attention on improvement</td>
</tr>
<tr>
<td>• Enhance revenue*</td>
</tr>
<tr>
<td>• Eliminate waste and reduce costs*</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>DELIVERY SYSTEM DESIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Optimize the Care Team*</td>
</tr>
<tr>
<td>• Eliminate waits and streamline work flow*</td>
</tr>
<tr>
<td>• Provide seamless and coordinated care to patients</td>
</tr>
</tbody>
</table>

*Items in blue represent high leverage change concepts and economic impact drivers
III. GETTING STARTED

The implementation of the Planned Care Model is a daunting task for any organization. Adding the lens of the business case to this process increases complexity and provides additional challenges. A framework to assist organizations with implementing the change packages was developed and is presented in Figure 4. Before exploring the framework, however, a few observations on sequencing should be contemplated.

**Sequencing Changes in Your Organization:**

Early in the history of the Collaboratives, HRSA was supporting two different approaches to changing practice. The first was known as the Cycle Time Collaborative, focusing on office visit cycle time; the other was the Health Disparities Collaboratives, focusing on the Planned Care Model. In addition, the Institute for Healthcare Improvement (IHI) was supporting a Breakthrough Series on Idealized Design of Clinical Office Practice with a heavy emphasis on improving access. Health centers became exposed to these three different approaches and began asking: “which one should we do?” The direct answer to the question was that at some point an organization needs to address all three areas of focus—the care model, access, and cycle time or flow. This immediately raises the question as to whether there is a logical sequence to follow.

As with any debate worth pursuing, one can find proponents in each of the camps. There are health centers who first participated in the Cycle Time Collaboratives and remain convinced that this is the logical starting point. There are those who believe that Access is such a driver of a practice’s economics and efficiency that implementation of Advanced Access is a prerequisite to generate the resources to pay for Planned Care. Finally, there are those who started with the HDC and the Planned Care Model and found it to be the solid foundation and organizing framework necessary to guide all the work. The right approach will be dictated by local circumstances and the specific needs of the health center.

The Faculty guiding the pilots addressing the business case probed the participating teams to determine the logical sequencing for the work. In the end, the pilot teams factored in all the considerations they could and then recommended the following sequence:

- **Care Model:** Start with teaching the organization the Care Model and how to make rapid cycle changes through use of the Model for Improvement developed by Associates in Process Improvement. Use the Care Model as the overall organizing framework.
- Cycle Time and Flow: Understanding lean thinking and flow through such tools as process mapping facilitates the ability to evaluate any system and to introduce efficiencies into daily practice.
- Optimize the Care Team: Care team roles will inevitably change as the Care Model is implemented; having the context of the Care Model, along with some of the principles of lean provides context to facilitate the challenge of examining and changing the roles of the players in an organization.
- Advanced Access: Improving patient access can have a dramatic impact on the organization; however, this change can often be the most challenging to tackle without the external support of a Breakthrough Series or a coaching model.

**Getting Started: A Framework for Making Change**

Figure 5 presents a model for driving a business case with Planned Care. The model starts with understanding where you are, then identifies where you want to be and establishes priorities and an action plan for getting there. The first step in the process is to put together a comprehensive assessment of the current state of the practice across several measurement dimensions. It is only through this type of assessment that a rationale plan for implementing and tracking improvements can be made. Measures that should be included in the practice assessment include measures of patient characteristics such as payor mix, diagnosis distribution, and demographics; clinical process and outcomes measures, such as those that are tracked as part of the HDC initiative; measures of access, such as time to third next available appointment; measures of cost, revenue, and profitability by type of patient/service and overall; measures of patient and staff satisfaction; efficiency measures such as visit cycle time. In short, you need to understand where you are and where you compare to benchmarks and goals in order to know where to place your priorities. As this is done, the measures and data collected in the initial practice assessment can also become the basis for an ongoing set of system-wide performance measures that can be used to track a practice’s improvement and progress toward transformation. A list of potential measures for the initial practice assessment and ongoing performance tracking can be found in Appendix B.
**Gap Analysis**

After completing a baseline practice assessment, the next step is to complete the Gap Analysis. This phase focuses on your current state compared to industry benchmarks or to other goals that have been set. Some sample goals for various aspects of your business case are cited below:

- Cycle time: 1.5 times visit length*
- Access: 0 days to third next available appointment*
- Encounters per team/year: 4817**
- Panel size per provider: 1325 (Family Practice)**

*benchmarks from IHI work on Idealized Design of Clinical Office Practice
**75th percentile of UDS 2004

Comparative benchmarks can be obtained from a variety of sources including UDS data, State Primary Care Associations, HDC national data, and Medical group Management Association, to name a few.

Once you identify an area you want to focus on you can drill down further by completing a more detailed analysis of the priority area. Such tools as unit cost analysis, value stream analysis or process mapping (see toolkit) can assist in this effort. For process-driven areas, value stream analysis is a particularly powerful approach to flag your opportunities for improvement and to help you quantify the impact you might experience by focusing your energies in a particular area.

**Prioritize your action plan**

Once your opportunities for improvement have been narrowed down, you can prioritize your roll-out based on the specific needs of your practice and its underlying business case. Priorities, sequencing, and timeframe will also depend
on how much of a foundation the organization has already developed for accelerating change. The role of leadership in this effort is to assure that there is adequate capacity for improvement within the health center and that those working on improvement are afforded the time, training, and tools necessary to be successful in this work. With issues relating to the business case, it is particularly important to focus on communication as well as to getting the right team on the bus for the improvement activities. For example, the care team that has been working on implementing the Plan Care Model may need to be augmented by adding members that have greater involvement with a particular aspect of your business case. Working on collections might require back office staff and front desk staff as well as your care team. Scheduling and advanced access might require office management staff. A focus on cycle time might need to include medical records personnel, lab personnel or others.

Adding some of these non-clinical players to an established clinical improvement team may require up front preparation and training as many of these staff may not have been introduced to the three core models (the Learning, Improvement and Care models). It might also require opening lines of communications that have historically been compromised. Work on the business case requires the involvement of ALL health center staff and the support and encouragement of all health center leaders.

**Work on the Change Package**

The last step of the business case transformation journey is to begin work using the change package and toolkit included in this document. The description of the change concepts has been designed to provide concrete examples of ideas that can be tried, resources to facilitate your efforts, and case studies from the HRSA pilot work and FQHC’s participating in IHI’s Innovation Community. Specific Toolkits contain information and resources related to a given topic area. The Health Disparities web site at [www.HealthDisparities.net](http://www.HealthDisparities.net) includes the change package and most of the tools in an electronic form to assist your improvement efforts. All of these can be accessed via links within this document or through the Business Case/Redesign Topics page on the website.
TOOLKIT INDEX

- Use data to understand your practice and your business case
- Focus leadership attention on improvement
- Enhance revenue
- Eliminate waste and reduce costs
- Optimize the Care Team
- Provide seamless and coordinated care to patients
- Eliminate waits and streamline workflow
Planned Care Component: **Organization of Health Care**

Change Concept: **Use data to understand your practice and your business case**

Key changes you can make:

**Complete a comprehensive diagnostic profile of your practice**

**Establish system level performance aims and use them to drive your business plan**

- Use a spider diagram to track performance against goals
- Post dashboards on data walls
- Review and analyze industry benchmarks for business and clinical performance

**Promote transparency of data**

- Post financial results on an intranet site or virtual office
- Share reports on bill rejections with clinical and non-clinical staff
- Use run charts to track staff individual team performance

Case Study: Community Health Centers of Middletown, CT completed the pre-work assessment tool for their participation in the HRSA pilot on Finance and Redesign. The organization had already implemented advanced access in some of their clinics and had worked on cycle time as well. They had also made good progress with improving their clinical indicators. The data on their practice pointed them to explore their collections system where they saw great opportunities for improvement. They focused on the change package for collections. Self pay collections increased 23% in two months.

Contact: Stewart Joslin, CFO

Case Study: Clinica Campesina in Lafayette, Colorado developed system level aims for the organization. Each primary care site is set up in clinical pods and in the main area for all to see is a data wall where all the measures are posted. Staff are able to see their clinical and financial outcomes for the month. The key “Access and Outcome“ measures are also tied to group incentives.

Contact: Carolyn Shepherd, M.D.

Tools:

- Finance-Redesign Prework Assessment Tool
- RVU Manager available from American Express Tax and Business Services, Curt Degenfelder, curtis.e.degenfelder@aexp.com
- [Recommended measures from the HRSA Finance and Redesign Pilot](#)
- RedeFin system wide measures spider diagram example
- Community Resource Documentation Template
• Using Data to Drive the Business Case presentation
• Assessing Your Practices and Outpatient Settings presentation
• Clinical Microsystem Assessment Tool
• Diabetes Impact Tool--March 2004
• Chronic Care Outcomes Project document
• Assessing the Impact of Planned Care Implementation tool
• Testimony--Maine Governor's Proposed Budget and FQHC's
• Managing By Fact presentation
• Modeling the Impact of Redesign Changes presentation
• NCQA's Quality Dividend Calculator information
• CareSouth System Level Measures Example (*Leadership*)
• Employee satisfaction survey examples adapted from Gallup research (*Leadership*)
• Patient Satisfaction survey examples (*Leadership*)

_{Click here to view or download the above tools pertaining to ‘Using Data’ from the HDC website Library. A few of the tools overlap between topic areas and will be found elsewhere in the Library as noted._

References:

[Health Systems Measures Kit (IHI Tool)]. (February 18, 2005). Institute for Healthcare Improvement. [Electronic version cited 1 May 2006].


**Business and clinical performance benchmarks available through sources such as:**

The Institute for Healthcare Improvement (IHI). www.IHI.org

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). www.jointcommission.org

Medical Group Management Association (MGMA). www.mgma.com
Planned Care Component: **Organization of Health Care**

**Change Concept:** **Focus leadership attention on improvement**

**Key changes you can make:**

**Establish an Effective Communications Infrastructure**

- Use multiple media for communications
  - Use an intranet for internal communication
  - Establish a newsletter on your improvement efforts and get staff to volunteer to work on it
  - Set up a data wall for sharing reports
- Include all staff in the communications plan and make it two-way
  - Give computer access to all staff
  - Use a virtual office as a work site for improvement that all staff can contribute to
  - Use video conferencing for meetings to connect outlying sites
- Communicate improvement work as an agenda items in all organizational meetings
- Use communications vehicles to make the case for improvement, explain where the organization is going (vision the change), and each person’s role in the change.

**Visibly support improvement by aligning strategy, resources, and priorities for improvement**

- Include improvement as part of each report to the board
- Establish a budget for improvement activities
- Have members of senior leadership participate on improvement teams
- Leaders include reports from improvement teams at regular staff meetings Implement Leadership “Grand Rounds” focused on improvement work.

**Build Improvement Capability**

- Include care model and model for improvement in orientation of new employees
- Provide time for team activities, and periodic attendance and participation by senior leaders.
- Develop leadership authenticity by building deep leadership knowledge and capability – leaders become “coaches” for improvement and innovation.
• Visit another high performing organization to see the on site implementation of innovative improvements.
• Include all levels of staff on improvement team
• Create a culture in which all staff are appropriately empowered for improvement

**Develop staff to maximize their potential and create loyalty**

• Diagnose and assess the current workforce state
• Develop an action plan to develop a more engaged workforce
• Develop leaders who focus on each employee’s strength and individual development
• Develop the “human resource value chain” of attracting, selecting, orienting and developing employees.
• Establish a fair compensation system
• Use incentive systems to align individual goals with organizational goals

Case Study: CareSouth Carolina, Inc. In 2002, CareSouth Carolina began re-organizing the agendas, meeting agendas, and frequency of all staff meetings as tools for effective improvement communication. Monthly Management meetings whose agendas had been focused primarily on operational issues were replaced with monthly Senior Leader Improvement meetings whose sole agenda is focused on improvement efforts as measured by system level measures. (sample agenda attached).

In addition, bi-monthly half day staff meetings which include all staff were reorganized. These meeting agendas now have three components (sample agenda attached):

- An opening plenary by the CEO with a focus on organizational performance as measured by system level measures. Also during the plenary are team presentations on improvements that have sustained and spread. And finally, during the plenary, Innovation awards are made to individuals and teams that have tested, using the PDSA model, innovations which have sustained and proven to be ready for spread throughout the organization.
- Division breakouts which are opportunities for department specific training and for implementation of innovations for spread.
- Team action planning where microsystem teams meet, review system wide performance measures specific to their team performance, and plan for team activities, tests of changes, and focused improvements.

Case Study: CareSouth Carolina recognized the need to elevate the prominence and visibility of their improvement efforts. Updates on all aspects of improvement work are now included in their board agenda and reports. A system-wide dashboard is used to capture key trends and storyboards and team presentations.
at bi-monthly staff meetings are used to showcase focused improvement efforts.
Contact: Ann Lewis, CEO

Tools:
- Executive Review of Improvement Projects: A Primer for CEOs and other Senior Leaders
- Patient Brochure Example in English and Spanish
- Senior Leader Performance Improvement Sample Monthly Agenda
- CHIP Award Application example from Clinica Campesina
- Incentive Plans example
- Sample newsletters on improvements on the business case supporting planned care
- Performance Management Business Case Study presentation
- Departmental Staff Meeting Sample Agenda from CareSouth Carolina
- Staff Satisfaction Survey Tool examples
- Strategic Plan Pyramid example from CareSouth Carolina
- System Level Aim and Measures example from CareSouth Carolina
- System Level Measures Assessment and Planning Tool
- Achieving Workforce Excellence Prework Handbook
- The Zen of Teams presentation
- Sample newsletters on improvements on the business case supporting planned care
- Innovator Awards example from CareSouth Carolina

Click here to view or download the above tools pertaining to ‘Leadership’ from the HDC website Library.

References:


Planned Care Component: **Organization of Health Care**

Change Concept: **Enhance Revenue**

Key changes you can make:

**Bill accurately and completely**
- Analyze coding patterns and train providers on coding accuracy
- Share bill rejection information with clinical and non-clinical staff
- Establish a cost-based charge master
- Verify demographic information at each visit
- Account for all encounter forms at the end of each day

**Improve Collections**
- Use process mapping to reduce bill cycle time
- Establish a collection plan for each payor
- Establish policies on up front collections of co-pays and self pay amounts
- File claims electronically
- Facilitate patient application for any potential payment coverage
- Accept credit cards and debit cards
- Schedule appointments with financial counselor prior to a new visit
- Provide front desk staff a script for collecting money
- Establish a greeter position

**Use data to influence payors and Policymakers**
- Ask your state Medicaid office to model total costs for health center patients as compared to others
- Approach self insured employers and model cost reduction and productivity improvement

**Seek New Sources of Revenue**
- Contract directly with self-insured employer groups
- Establish on-site clinic services at employer worksites
- Contract with local hospitals to set up chronic disease centers of excellence
- Use outcomes data to apply for grants

Case Study: White River Rural Health Center in Arkansas recognized a need to focus on revenue enhancement. They used the RVU Master to develop coding profiles by provider and then used that information in provider training on appropriateness of coding. Because their charge master had not been recently
updated, they also used the RVU Master and their cost report data to develop charges that were based on cost. As a result of both of these initiatives, they were able to dramatically increase their billings per encounter.

Contact: Greg Wolverton, CIO

Case Study: G.A. Carmichael Health center in Canton, Mississippi discovered that Nissan was considering locating a new plant in one of eight locations in the south. The executive director used their HDC data and the UKPDS study metrics to model the impact on fewer medical claims and lost days of productivity if they located the plant near G.A. Carmichael. The leadership of Nissan was so impressed they located the plant several miles from the health center bringing 4000 new jobs into the community and new revenue opportunities for G.A. Carmichael.
Contact: Eddie Anthony, CEO.

Case Study: St. John Valley Hospital in Maine learned of an aggressive Medical Services Corps provider working in an FQHC and recruited him to set up a diabetes center for the local hospital. The business plan called for the operation to breakeven in 18 months. The new center opened and was breakeven within 9 months and had brought in $90,000 of new revenue to the hospital in the first nine months.
Contact: Dana Green, P.A.

Tools:
• Revenue
  • Getting Paid--Maximizing Collections presentation
  • Northeast Valley Health Center case study on maximizing revenue (Action Period 3 Update)
  • Toolkit for Billing Accurately and Completely
  • Billing and Collections in Health Centers presentation
  • Care Management Procedure Codes document
  • Improving Collections Toolkit
  • Pay For Performance--An Introduction Toolkit
  • An Introduction to Using RVUs Toolkit
  • Using RVUs to Diagnose Costs presentation
Collections
- Third Party Payors policy example from CareSouth Carolina
- Bad Debt Policy and Procedure example from CareSouth Carolina
- Sample Guidelines for CHC Staff on Collecting Money from Middletown
- Patient Collection Override Sheet example from Middletown
- Front Desk Collections Flow Chart
- Billing and Collections example from CareSouth Carolina
- Credit and Collection Policies example from Rural Health
- Front Office Script example from Rural Health
- Payment Agreement example from Middletown
- Sample Verbiage for Payment Sign from Rural Health
- Front Desk Collections Policy example from Middletown
- Greeter Position Form example

P4P
- Pay for Performance Incentive Programs in Healthcare 2003 presentation
- NCQA's Quality Dividend Calculator information (Using Data)
- Diabetes Impact Tool--March 2004 (Excel tool to calculate savings from diabetes care) (Using Data)
- Business Case Monograph (Leadership)
- Testimony--Maine Governor's Proposed Budget and FQHC's (Using Data)
- Simulating the Costs and Benefits of a Comprehensive Chronic Care Program for Whatcom County presentation by Jack Homer and Gary Hirsch

Click here to view or download the above tools pertaining to ‘Revenue’ from the HDC website Library. Some of the above resources are located in the ‘Collections’ and ‘P4P’ sub-folders within the Revenue folder. A few of the tools overlap between topics areas and will be found elsewhere in the Library as noted.

References:


P4P


29
Planned Care Component: Organization of Health Care

Change Concept: Eliminate Waste and Reduce Cost

Key Changes you can make:

Apply Lean Principles to core processes.
- Complete a process map of each core process
- Standardize forms and protocols
- Evaluate and improve inventory
- Streamline communications
- Minimize movement in the system
- Evaluate Pull vs. Push Systems
- Error proof your systems
- Focus on leadtime reduction
- Eliminate waiting
- Eliminate rework and needless inspection
- Minimize overproduction

Exploit Technology
- Use fax machines for medication refills
- Use hand held devices for medication prescriptions
- Evaluate the ROI for purchase of HbA1c analyzer on-site
- Do electronic billing

Renegotiate Contracts
- Re-visit mortgages, leases and loan agreements and explore opportunities to renegotiate for more favorable rates
- Standardize supply ordering to ensure that supplies are not being over-ordered and that vendors are not overcharging
- Develop protocols for referrals to costly services
- Work with your suppliers to improve your existing contracts and materials management systems

Case Study:
White River case study for Reduce Expenses

White River Rural Health Center, Inc. (WRRHC) realized a problem existed in its supply chain and delivery when costs sky rocketed to nearly $1 Million dollars during 2004. Utilizing the "Lean Manufacturing" methodology, WRRHC was able to lower its supply cost by over a half million dollars in purchases alone. As growth continued WRRHC utilized other change concepts to streamline the ordering and delivery process by educating clinic staff, supervisors and leadership on "Just in time" inventory models and by sharing utilization patterns
for various supplies such as drugs. This led to additional savings through fewer product expirations and better utilization of supplies throughout the system. In the last quarter of FY 2005, WRRHC has reduced these expenditures by 58% and increased delivery flow by 22%, over the same period of 2004.

Contact: Greg Wolverton, CIO

Tools:
- Applying Lean Thinking to Financial Processes presentation
- HDC Cost of Process Waste Worksheet
- Lean Thinking and Value Stream Mapping to Improve Flow presentation
- Lean Thinking in Healthcare--December 2004 presentation
- Understanding Costs: Getting Beyond Expenses presentation
- RedeFin Toolkit: Pharmacy as an Opportunity

*Click here to view or download tools pertaining to ‘Cost Reduction’ from the HDC website Library.*

References:


Womack, James., Jones, Daniel T. (2002, March) *Seeing the Whole: Mapping the Extended Value Stream (Lean Enterprise Institute).*
Planned Care Component: **Delivery System Design**
Change Concept: **Optimize the Care Team**

Key changes you can make:

**Assign a panel of patients for each provider and manage panel size and scope of practice**
- Use historical records to assign patients to a panel associated with a care team
- Assure the PCP is identified in the scheduling system
- Assign responsibility for PCP assignment
- Develop scripts for appointment schedulers to reinforce the panel concept
- Develop policies for closing panels and for assigning new patients to a provider’s panel

**Match Work to an Individual’s Capability and Licensure**
- Use medical assistants and CNAs rather than just LPN’s and RN’s
- Maximize the use of nurses in clinical care
- Add a lab tech or radiology tech to the team
- Use bi-lingual MA and front desk staff
- Use protocols for UTI/Immunizations and other high volume low risk conditions
- Use nurse visits
- Cross train staff
- Study how each care team member is spending time
- Test ways front office staff can assist in managing patients

**Redesign the Care Teams**
- Create consistent cross-functional teams around a panel of patients
- Create a matrix reporting structure where staff report functional to a care team and line to a manager
- Redeploy back office staff (medical records, scheduling, billing) to a care team
- Cross train front and back office staff to allow for flexibility in daily patient flow and meeting various patient needs
- Use promotoras or lay health case managers

**Maximize Provider Productivity for Each Visit**
- Move unnecessary work away from the provider
- Assign a panel of patients to each provider and schedule accordingly
- Hold a huddle to review patient and care team needs prior to a visit
• Ensure all equipment, data and manpower are available and the time of the visit
• Max pack where feasible

Case Study: Clinica Campesina in Lafayette, Colorado aggressively moved to a clinical pod concept. In their old paradigm the care team included a clinician and a nurse and medical assistant. They decided to move to a comprehensive care team around panels of patients. Their current ratio is 8:1. The teams include providers, medical assistants, casemanagers, social workers, medical records, nurses and front desk staff. A nurse leads each care team and they hold huddles daily to plan their work. Staff also report in a line model to their respective professional manager who is responsible for overall quality oversight and staff building and education. The organization has implemented a gain sharing incentive system providing reward for improved organizational performance and teams are able to see how they contribute to that process.
Contact: Carolyn Shepherd, M.D.

Tools:
• Business Case Modeling Tool for Shifting Staff Resources
• Increasing ROI for the Care Team presentation
• Huddle List template
• Integrating Behavioral Health and Depression Management in Primary Care presentation
• Medication Refill Protocols and Policy example
• Taking it to the Next Level: Optimizing the Workforce presentation
• Optimizing the Care Team in Clinical Office Practices presentation
• Optimizing the Care Team Toolkit
• Patient Self-Confidence in Managing Chronic Condition graph
• Pharmacy FAX Sheet Example from Community Health Centers, Inc.
• Pharmacy Toolkit
• Provider Fill-Time and Patients Turned Away Phone Worksheet
• Job Description: Referral Specialist example from Holyoke Health Center
• HRSA Redefin ROI calculator
• Medication Refill Standing Orders example
• Standing Orders: Chronic Medication Refills example
• Task Analysis Worksheet
• Incentive Plans PowerPoint presentation (Leadership)

Click here to view or download the above tools pertaining to ‘Care Team’ from the HDC website Library.
References:


Gans, D., MSHA, PACMPE & Walker, D., MBA, FACMPE. (April 8, 2004). (Audio) Rightsizing the Medical Group’s Staff: How many is too much, how few is not enough (CD) - #6134. [Electronic purchase information cited 1 May 2006]. MGMA (Medical Group Management Association).

Planned Care Component: Delivery System Design

Change Concept: Provide seamless and coordinated care to patients

Key changes you can make:

Integrate Behavioral Health into Primary Care

- Retain counselors and social workers and integrate them into your primary care team
- Administer PHQ screening to your chronic illness patients for early detection and intervention

Create a planned visit for each encounter

- Use the registry to plan a visit
- Use registry reminder systems to reach out to patients and manage their demand
- Review registry data in huddles prior to a morning or afternoon panel of patients
- Use visit agendas and review them with patients
- Daily huddles to plan care for patient’s coming in

Use a Care Manager to Coordinate Care

- Establish a care manager for a panel of patients
- Regularly review panel and patient level data
- Prepare for planned and acute visits using the registry data
- Coordinate logistics and care team needs prior to the visit
- Serve as primary point of contact for external case managers
- Follow-up with local referral sources to collect data on patients

Maximize the use of specialists

- Schedule specialists into the center for a half or full day rather than making referrals
- Establish a referral specialist to coordinate necessary referrals

Case Study: CareSouth Carolina recognized the impact behavioral health related issues was having on the quality of care and on productivity of the care team. Social workers and licensed clinical counselors were added (expanded from 4 to 12) with one per care team. Routine depression screening using the PHQ-9 tool was adopted. Care teams were formed to review panel level outcome data and plan for visits for chronic illness. The organization recognized it had forgone an opportunity for a revenue stream as visits to licensed behavioral health professionals was billable in their state. This addressed a
major quality and productivity problem and increased revenues for the organization. Contact: Liz Kerchner, LCSW

Tools:
- Care Manager Job Description example from CareSouth Carolina
- Using the Registry for Planned Care presentation
- Huddles--IHI 2004

Click here to view or download tools pertaining to ‘Seamless Care’ from the HDC website Library.

References:

Huddles (IHI Tool). Institute for Healthcare Improvement. [cited 8 May 2006].
Planned Care Component: Delivery System Design
Change Concept: Eliminate waits and streamline workflow

Key changes you can make:

**Access & Efficiency Change Package**

The change package for Access & Efficiency is a change package that has been well tested over the years by IHI and others. Many aspects of this change package are integrated into this Toolkit. You can access the complete Access & Efficiency Change Package and useful tools on [www.ihi.org](http://www.ihi.org).

Recalibrate the system by working down the backlog

- Eliminate unnecessary work!
- Pick a date (90 days into the future) and Establish a date after which time you only book future appointments for planned visits for preventive and chronic care (about 30% of your future schedule); all other appointments are given on the day of the request
- Comb the schedule and remove all unnecessary future visits from the schedule.
- Temporarily add patient visit slots at the beginning or end of the day, or on weekends

Understand and balance capacity and demand on a daily, weekly and long term basis

- Use huddles to make mid-course adjustments real time
- Study and decrease the number of appointment types
- Use centralized scheduling

Plan for Contingencies

- Cross train staff
- Establish policies on vacations
- Anticipate flu season and staff up
- Use group visits for Drop In medical group Appointments (DIGMAs) and school physicals
- Use Locum Tenems to fill for sick vacancy and scheduled leaves
- Use huddles to make mid-day corrections

Use Group Visits and other alternate visit types

- Use drop in medial group appointments (DIGMAS)
- Use group visits for chronic patients, physician and school exams, flu group visits and other logical affinity groups
- Use telephone and email visits
- Schedule follow-up with a nurse instead of a physician for certain protocols
- Use care managers to go into the homes

Reduce Cycle Time

- Decrease handoffs during the encounter
- Move check out to the nurse’s station
- Check charts, encounter note printouts, lab work, etc before each visit
- Telephonic or web registration
- Use walkie talkies to communicate
- Create line of site communication in the clinical pod so all staff can see each other
- Bring work such as blood draws to the exam room rather than asking the patient to move
- Increase clinician support
- Start all visits on time
- Standardize room supplies and equipment
- Get all the tools you need
- Do today’s work today!
- Eliminate unnecessary work!

Case Study: United Health Care of California studied their schedule and realized that with their 25 physicians there was enough sick leave, vacation and education time to be filled by two fulltime Locum Tenems. The original bias was that locums would be too expensive. When they realized the loss in productivity and revenue they realized they couldn’t afford not to hire two additional fulltime provider. The impact was in excess of $1M annual increased revenue.
Contact: Ron Yee, MD

Case Study: From the IHI Idealized Design List Serv:
“I am from a metropolitan area of over 500,000 and am the team physician for the largest high school in the county. We currently do school physicals with one of the local hospital clinics providing space and volunteer staff for check in and vitals. We have 10-11 local pediatric and med/peds residents do the physicals with myself. We do the high school and middle schools. Each one takes about 3 hours, and we do about 300-400 kids each time. The kids pay $10 up front, the residents get a nominal stipend, and the school takes the rest. They take in $1,500-2,000 each time and use it for athletic equipment. It’s a busy 3 hours, but the schools love it. FYI, pharmaceutical reps bring dinner for the residents.”

Tom Peterson, M.D.
Medical Director, MMPC
phone (616) 974-4455
tpeterson@mmpc.com
Tools:
- Advanced Access Scheduling: The "Who, What, Where, When ..." presentation
- Advanced Access: Beyond the Basics presentation
- Advanced Access References
- Measuring Demand presentation
- Ongoing Management of Supply & Demand to Achieve Access Goal document
- Group Visits In's and Out's presentation
- Comparison of Group Visit Models document
- Group Visits--Clinica Campesina presentation
- The Economics of a Group Visit comparison sheet
- Huddle worksheet
- “The Fifteen Minute Visit and the 45 Minute Wait: What’s Wrong with this picture” presentation by Christine St. Andre from HDC2005 LS3
- Unplanned Activity Form
- Exam Room Checklist Example
- Rooming Criteria Example from Dartmouth Godfrey and Nelson

Click here to view or download the above tools pertaining to ‘Access’ from the HDC website Library. Some of the above resources are located in the ‘Group Visits’ sub-folder within the Access folder.

References:


Topics Related to the Business Case for Planned Care
May 8 2006

Disease Specific Topics

Asthma


Diabetes


**Congestive Heart Failure**


Business and Organizational Related Topics

**Advanced Access (Also see below under Continuity of Care)**


**Business Case for Planned Care**


**Care Team**


Gans, D., MSHA, PACMPE & Walker, D., MBA, FACMPE. (April 8, 2004). *(Audio) Rightsizing the Medical Group’s Staff: How many is too much, how few is not enough (CD) - #6134.* [Electronic purchase information cited 1 May 2006]. *MGMA (Medical Group Management Association).*

Continuity Resources


Cost of Chronic Disease/Impact of Disease Management

Alcohol Cost Calculator. The George Washington University Medical Center. Ensuring Solutions to Alcohol Problems.


**Cost Reduction**


Womack, James., Jones, Daniel T. (2002, March) *Seeing the Whole: Mapping the Extended Value Stream (Lean Enterprise Institute).*

**Cycle Time**


**Grants and Philanthropy**


**Group Visits**


*Medical Economics*, 74-95.


**Leadership**


Lean


Revenue


P4P


Seamless Care

Huddles (IHI Tool). Institute for Healthcare Improvement. [cited 8 May 2006].

Studies of Health Center Cost Effectiveness


Telephonic Support and Disease Management


Lieu, TA., Quesenberry, CP. Jr., Capra, AM., Sorel, ME., Martin, KE., Mendoza, GR. (1997) Outpatient management practices associated with reduced risk of pediatric asthma hospitalization and emergency department visits [see comments]. Pediatrics, 100(3 Pt 1):334-41.


Richards, DA., Meakins, J., Tawfik, J. et al. (2002) Nurse telephone triage for same day appointments in general practice: multiple interrupted time series trial of effect on


**Using Data**

**Health Systems Measures Kit (IHI Tool).** (February 18, 2005). Institute for Healthcare Improvement. [Electronic version cited 1 May 2006].


**Patient Cycle Tool.** Institute for Healthcare Improvement (IHI). [cited 1 May 2006].


**Business and clinical performance benchmarks available through sources such as:**


The Institute for Healthcare Improvement (IHI). [www.IHI.org](http://www.IHI.org)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). [www.jointcommission.org](http://www.jointcommission.org)

Medical Group Management Association (MGMA). [www.mgma.com](http://www.mgma.com)

**Web Resources**


The Institute for Healthcare Improvement (IHI). [www.IHI.org](http://www.IHI.org)


Joint Commission on Accreditation of Healthcare Organizations (JCAHO). [www.jointcommission.org](http://www.jointcommission.org)

The Commonwealth Fund (CMWF). [www.cmwf.org](http://www.cmwf.org)

Medical Group Management Association (MGMA). [www.mgma.com](http://www.mgma.com)

Acknowledgements:

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- Patient Infosystems
- The West Central Cluster for the Health Disparities Collaboratives
- The National Association of Community Health Centers

For more information about this Leaders' Guide or the business case for planned care, please contact either Christine St.Andre cstandre@ptisys.com or Roger Chaufournier rchaufournier@ptisys.com.