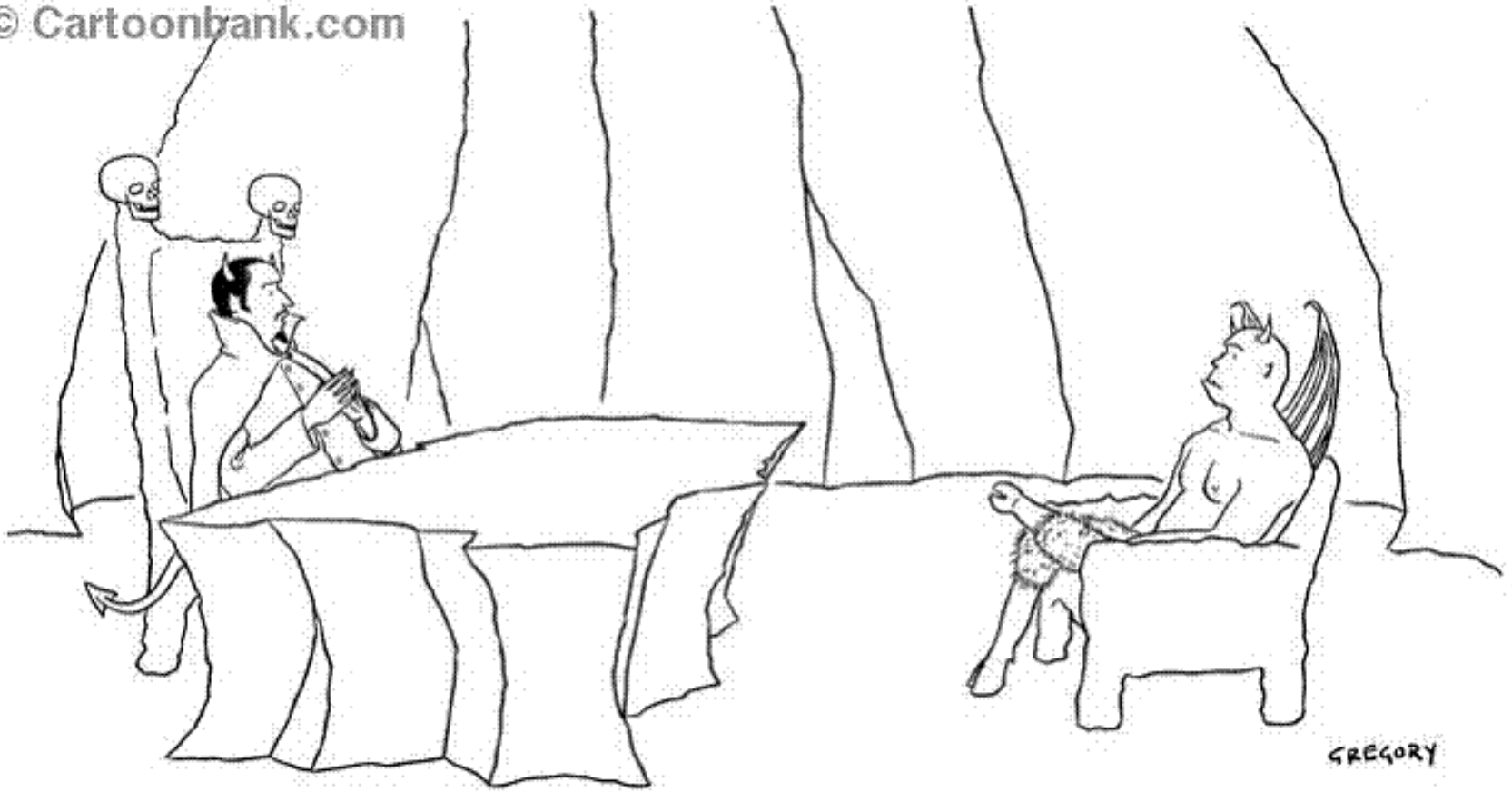


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“I need someone well versed in the art of torture—do you know PowerPoint?”

Building an Organization Plan for Healthcare Reform: Guidelines for Consideration

For

Mental Health Corporations of America

By

Bob Dyer, Ph.D. , Mel Smith, Th.M., M.S.W. &
Wes Davidson, M.S.

November 9, 2011

Agenda

- Planning Outline
- Critical Reform Elements for Inclusion in Planning
- Intelligence Needed:
 - Positioning, Product, Promotion, Price/ Performance
- Organization Plan Considerations
- Affiliation Plan Considerations:
 - Care Management or Benefits Management
- Resources: (including ACO Final Rules Resources)
- Peer Positioning Presentations
 - Erv Brinker- Summit Pointe
 - Gary Bembry- Lakeview Center
- Next Steps



Health Care Reform- We have to be on the boat



And that's what happened to the dinosaurs...

4 “P” Strategic Planning Process Outline

- **Positioning:** Are we in favorable position for desired results?
 - Do we have intelligence needed to identify market demands and key decision makers?
 - Are we included in critical decision making events?
 - Do we represent a compelling, significant value for decision makers?
 - Are we “professional” (have the right credentials/ accreditations)?
- **Product:** Do we offer what the market is moving toward the way it wants to purchase it?
 - Do we offer customer satisfying, cost effective solution(s)?
 - Do we bundle and contract the way we need to?
- **Promotion:** Do decision makers (bulk and retail) know of our interest?
 - How do we keep our interest obvious to critical decision makers?
- **Price/ Performance:** Are we facile at proving our competitiveness?
 - Can we price and contract quickly?
 - Do we have readily available proof of performance?
 - Can we connect electronically?

Promotion is good- but not sufficient

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"Got to admit, as far as mission statements go, it's pretty damn bold."

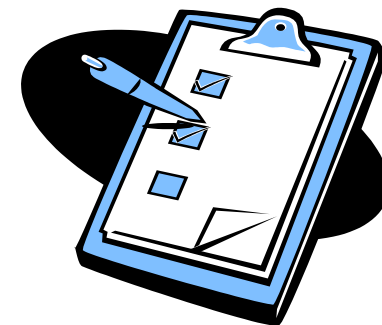
Essential Reform Elements for Inclusion in Organization Plan

- **Increased demand:** Anticipate nearly 30% increased coverage
 - Will be adults with acute issues and pent up demand
- **Health Insurance Exchanges:** Place newly covered individuals will most likely receive coverage
- **Accountable Care Organizations**
- **Patient Centered Medical Homes**
- **Federally Qualified Health Centers**
- **Health Cooperatives**
- **Medicaid changes**
 - Dual Medicare/ Medicaid changes to health oversight
 - CHIP kids to parents plans
- **Information Technology/ Information Exchange changes**
 - EHR and “meaningful use”
 - IT networks
- **Training/ Pilot opportunities**

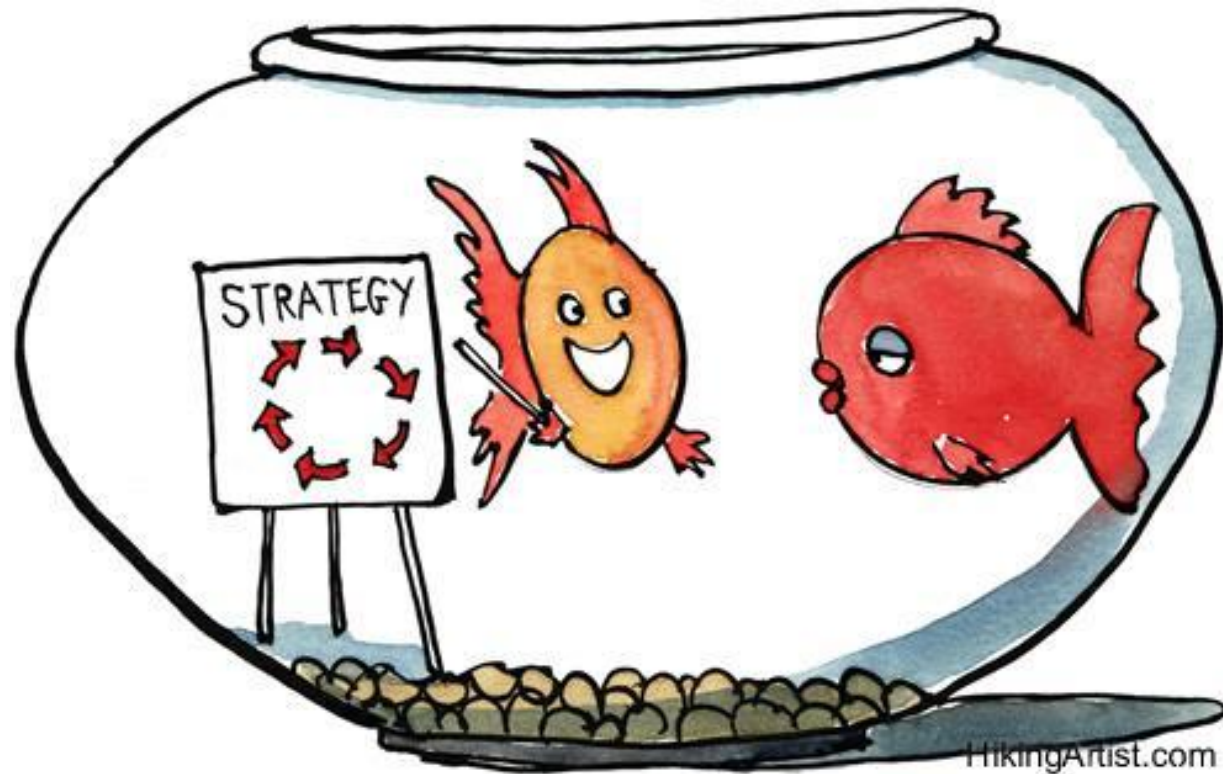


Building an Internal Process for Planning & Change

- Use your affiliation. This is a “big deal” make sure your peers are moving forward as well. Share expertise (and expense). Seek to build regional and state solutions.
- Dedicate “experts” to cover and keep management informed on specific areas (hold experts accountable) * AspenPointe strategy!
- Concurrently focus by working groups on separate market movements, i.e. insurance coverage, ACOs, PCMHs, dual coverages, accreditation, etc.
- Have a conscious health integration strategy. Focus on decision makers. Both medical providers and medical health plans.
- Seek wholesale business relationships, i.e. benefits management via affiliation. Fit business offerings to market footprint and seek significance in bundling.



The key is always execution

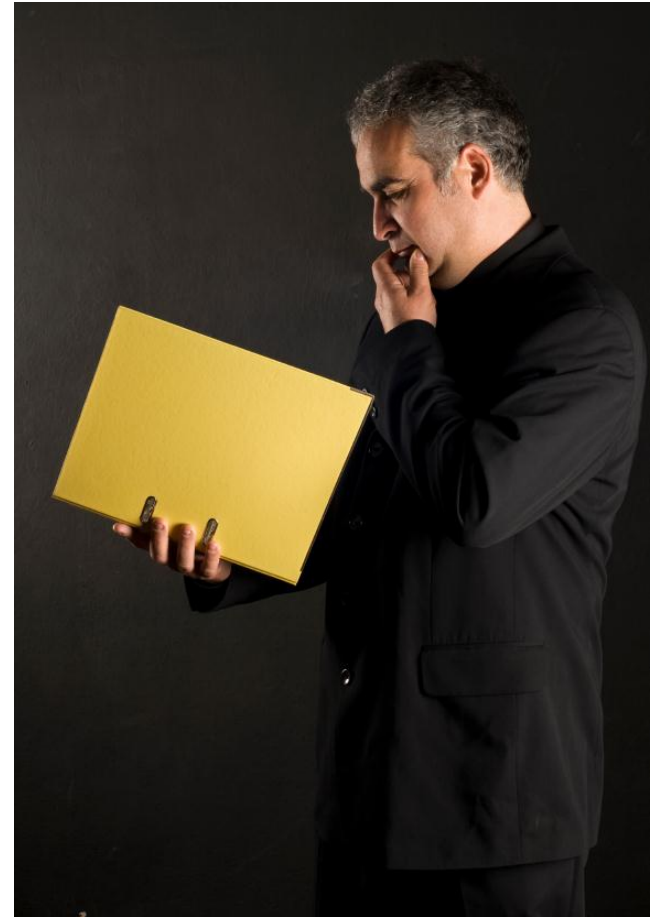


HikingArtist.com

We Are at a Special Moment in History: **Change Is Occurring!**

Power of the Person

- Recognize in this period of change individuals are going to make policy level decisions that sweep away history.
- You must assure the decision makers know your agenda.
- **Change is a contact sport. Keep in contact with decision makers!**
- Put serious energy into offering wholesale solutions. Big decisions are being made.
- You must make room for significant change; clarify what you do now that can be eliminated.



Find Inefficiencies to Offer for Change

- Offer ways to decrease your administrative overhead. The future for providers is to be as similar as possible to a medical practice model.
 - Seek less than 30% overhead (MGMA level).
 - National accreditation in place of state process regulations
 - Deemed status to be benefits manager



“You must learn to let go.”

Planning Guidelines: External Intelligence Needed

Public business:

- Will basic Medicaid change?
- Will more funds/ coverage be blended (i.e. general fund, SA)?
- How will dual Medicare/ Medicaid be handled?
- How will children whose parents are now covered be handled?
- How will SPMI Patient Centered Medical Homes be done?



- How will children's Patient Centered Medical Home BH issues be resolved?
- Will Health Insurance Exchange support public providers?
- Are there opportunities for you to cover more public populations or consolidate?
- Will funding of autism change? Is that a market for you?

Health Insurance Exchange

- What plans are being listed for individuals to purchase? Are you in their networks?

Planning Guidelines:

External Intelligence Needed- continued

ACOs/ Health Coops

- Who is organizing in your market? Are you planning with those decision makers?
- Should/ can you be part of ownership?
- Can you offer benefit or care management strategy?
- What are their IT plans?

PCMH

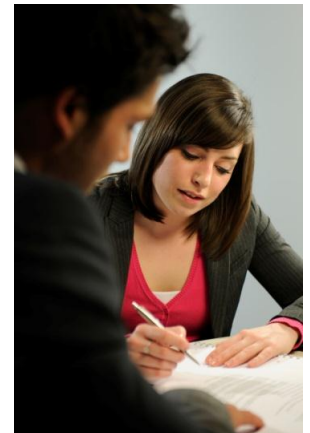
- Who is seeking NCQA recognition in your market?
- What BH services are desired?
- Do you have business model for primary care groups?
- Should you offer primary care services?

FQHC

- Are you providing BH services to FQHCs in your market?
- Should you seek FQHC status for your population (and a defined market)?

Training/ Pilot Opportunities

- Should you seek funding for training or pilot?



Planning Guidelines: Internal Intelligence Needed

Increased Coverage & Demand

- Can you handle 25% increase in admissions (for adults with acute disorders)?
- What is your reputation for treating depression, anxiety disorders and substance abuse?
- Patient hours in group care
- Waiting list time
- Reputation for depression care

HIE/ ACO/ Health Coop

- Do you need accreditation or state license as a provider or benefits manager?

PCMH/ FQHC

- Do you have a primary care business contracting strategy and behavioral health benefit package?

Performance/ IT

- Can you interface with “meaningful use” health networks in your market?
- Can you contract quickly?
- Can you price service packages quickly?
- Do you maintain outcome/ impact measures?

Training

- How do you train and monitor awareness of regulatory changes and critical relationships? With management, with service staff?

Organization Plan Considerations

Governance & Management

- Planned briefings in core elements and requirements of ACA
- Should Board/ Management composition change to accommodate new markets or business methods?
- Should Board or Operations committees focus on new entities in market?

Affiliations

- Can affiliation independently contract your organization services?
- Can organization have role in benefits management offerings?

Organization Internal Development Considerations

Increased Demand

- Demand/ test 5 day routine admission policy
 - Gear up for depression and anxiety care for adults
 - Establish CBT or other evidence based depression program
 - Implement training & incentives for structured group care.
 - Advertise/ promote your depression treatment solution
- Can you assure substance abuse access and quality?
 - Do you do autism services?
 - Can you grow those?



Scope Checklist for Your Organization Plan: Does Your Plan Address the Following?

Positioning

- Public funding
 - Medicaid/ general fund changes
 - Dual eligibles
- Commercial opportunities
 - Individual coverage market
 - New mandates, i.e. autism

Product

- Increased demand strategy
- Revenue opportunities strategy



Promotion

- Public funding
 - Are you shaping reforms
- Commercial opportunities
 - Care management or benefits management

Price/ Performance

- Improved efficiency
- Information technology
 - Meaningful use interface
- Pricing efficacy

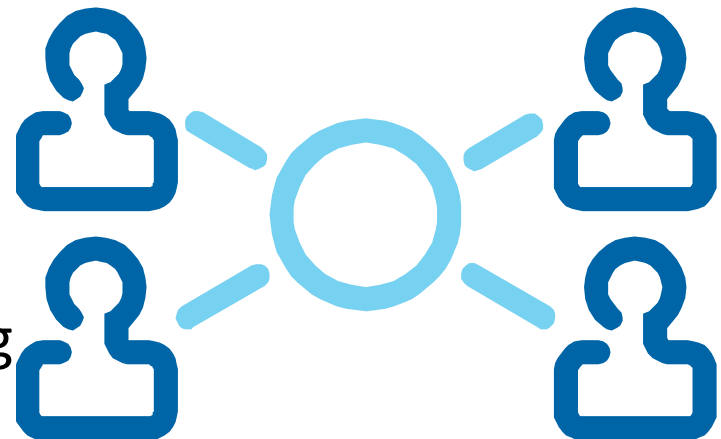
Affiliation Role in Reform

Healthcare markets in reform are:

- at the practice level for PCMHs,
- the regional level for ACOs and
- the state level for HIE and Health Coops

Affiliations are the answer for ACOs and Health Coops- IF your affiliation can contract for solving a complete issue, i.e. all behavioral health

Demand accreditation compete as experts!



Affiliation Plan Considerations: Organizing for Network or Benefits Management Services

Care (Network) Management

- Behavioral health
- Autism services
- Child welfare rehabilitation services
- Veterans BH services
- School (or juvenile center) BH services
- Prison BH services
- Emergency room(s) BH diversion services

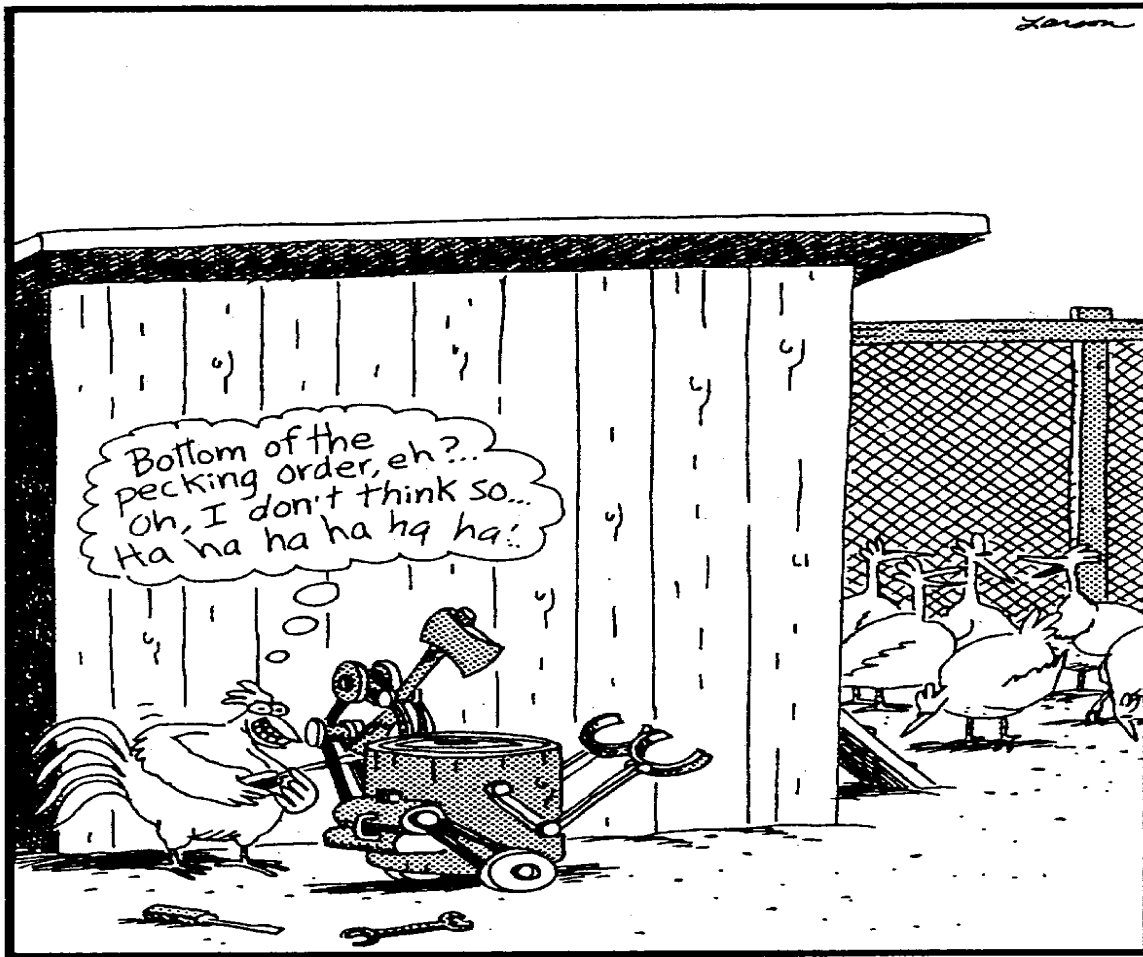
Benefits Management

- Nervous and mental disorder benefits
- Nonmedical autism benefits
- Rehab services for psychiatrically disabled

Benefits Management Organization (ASO) Core Systems

- ✓ Member Services
 - ✓ Advocacy/ Orientation
 - ✓ Prevention/ self management programs
- ✓ Provider Services
 - ✓ Contracting, orienting, appeals
- ✓ Medical/ Clinical Policy/ Education
 - ✓ Utilization management, Clinical guidelines
- ✓ Performance Improvement/ Quality Assurance/ Program Evaluation
- ✓ Account Management
- ✓ Claims Administration
- ✓ Information Technology
- ✓ Marketing & Sales
- ✓ Finance/ banking





Planning Caveats

- ACA has slow rollout. Keep in contact with decision makers.
- Seek multiple referrals to decision makers. Go see them on the arms of multiple “friends”. (Show multiple reasons why you should work together.)
- Aggregate your service bundle to achieve “significance” (a double digit answer to decision maker needs).
- Focus on decision makers “wants”
- Look at how you “contract”; solve a problem for potential clients.





Peer Presentations

Samples of peer organization
anticipating changes in the
market:

Erv Brinker, Summit Pointe,
Battle Creek, MI



Gary Bembry, Lakeview
Center, Pensacola, FL



... helping people overcome life's challenges.

Peer Presentation 1:



Summit Pointe

*Mental Healthcare Dedicated to
Making Life Work.*

Health Care Reform Tactics **Summit Pointe and Healthcare Reform**

MHCA: November Conference, Scottsdale, Arizona

Erv Brinker
Chief Executive Officer

Strategy

- Strategy for Increased Demand
 - Navik Solutions
- Strategy for Health Integration
 - Summit Healthcare Group
- Strategy for Benefits Management
 - URAC accreditation for Venture Behavioral Health

Anticipating Increased Demand

- Issue: Anticipate 30% increase in demand
- Service Standard: Assure 5 day access
- Solution: Replicable, structured, skill building groups for high incidence issues

Navik Solutions

- Brio: depression
- ReUnion: adolescent issues
- Aspire: SPMI

Purchased

- Stanford Chronic Disease Self Management Program: Healthy coping with chronic disease

Anticipating Increased Health Integration

- Issue: Extend physical medicine supports to SPMI with concurrent medical illnesses
- Service Standard: Assure care coordination and adequate medical coverage of chronic illnesses
- Solution: Medical practice corporately integrated in primary clinic
- Physician practice created in same clinic site as major service setting.
- Work with local PHO (Integrated Health Partners) in collaborative project on adequacy of care.
- Seeking Patient Centered Medical Home status

Anticipating Role as BH Benefits Manager in Carve In Delivery System

- Issue: Need to be broker and overseer of behavioral health benefits manager for purchasers of care.
- Service Standard: Commercial accreditation
- Solution: Created BHMO (Venture Behavioral Health) and acquiring URAC accreditation as a Health Plan and for utilization Management
- Venture Behavioral Health is a prepaid inpatient health plan for Medicaid. Is organized for other health plans. Is member of Michigan Association of Health Plans.
- Is seeking accreditation via URAC.

Peer Presentation 2:

Lakeview Center



BAPTIST HEALTH CARE

... helping people overcome life's challenges.

Health Care Reform Tactics Strategy – Diversify Revenue Base

MHCA: November Conference, Scottsdale, Arizona

Gary Bembry
President & Chief Executive Officer

Product – Initiative 1:

- Commercial Psychiatric Service
 - Strategic Goal:
 - Diversify Our Total Revenue Base:
 - Reduce Dependence on Public Funding
 - Increase Command of Commercial Health Care Market
 - Service Description
 - Medical Practice composed of:
 - 11 Psychiatrist and 4 Mid-Levels
 - » Current Practice Mix: 5 Child and 6 Adult Psychiatrist
 - Provided in multiple sites location across 2 counties
 - Supporting an annual aggregate panel of 15,000 + patients

Positioning – Initiative 1:

- Commercial Psychiatric Service
 - Strategic Goal:
 - Position service to expand our commercial market share reflecting command of:
 - No less than 65% and
 - Preferably 75% of the total behavioral health care market
 - Critical/Key Service Design Elements:
 - All Physicians
 - Either Board Certified or Board eligible*
 - *Required to pass Board with in a fixed timeline.
 - Employment Contracts articulate:
 - » Employer/Employee Responsibilities**
 - **Required to practice in inpatient and/or outpatient setting and Obligated to participate in inpatient on-call rotation.
 - » Minimum Productivity Expectations
 - » Compensation Arrangements
 - » Non-Compete Agreement

Positioning – Initiative 1:

- Commercial Psychiatric Service
- Critical/Key Service Design Elements (Continued):
 - Medical Record
 - Documentation requirements do not equate to clinical quality
 - » Public Payers -- Highly prescriptive requirements may need to be reconsidered relative to application with
 - » Commercial Payers -- Private practice model oriented service
 - Service Access Capacity
 - Same Day or Next Day appointments for incoming referrals
 - Established Separate Private Practice Office
 - With unique branding to insulate service from Lakeview's community identity of serving everyone that presents.

Promotion – Initiative 1:

- Commercial Psychiatric Service
 - Defined Market Area
 - Escambia and Santa Rosa counties (450,000 population)
 - 21 practitioners (excluding Lakeview’s medical group)
 - » 6 to 8 week reported wait time for 1st appointment post referral
 - » Our service capacity offers same day or next day appointments
 - Marketing Strategy
 - Initial Phase
 - Direct referral of commercial patients from Baptist Hospital’s Inpatient Psychiatric Unit
 - Secondary Phase
 - » Direct marketing to Primary Care Practices
 - » Deployment of telemedicine to support Primary Care integration
 - Tertiary Phase
 - Evaluate acquisition of larger private practice groups

Price – Initiative 1:

- Commercial Psychiatric Service
 - Critical/Key Factors:
 - “Market” (defined by payer sources) for the most part dictates pricing of services
 - However our service has been designed to enhance our
 - » “Negotiating Position” based on
 - Practice size and scope
 - Ability and willingness to cover inpatient psych units
 - Etc.
 - » “Managing Cost/Unit” specific to physician compensation with focused attention on:
 - Recruitment and retention
 - Productivity based compensation*
 - *63% Productivity experience prior to redesign
 - 90+% Productivity experience currently

Resources For Building Your Organization Plan For Healthcare Reform

The Law

Health Exchanges

ACOs



PCMHs

FQHCs

Health Coops

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten*

An Act

Entitled The Patient Protection and Affordable Care Act.

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act

The Quick Course: The Patient Protection and Affordable Care Act

P. L. 111-148	Passed into law March 30, 2010
Insurance for Young Adults Sec 2714	Requires coverage for dependent children until age 26 (effective 10/1/ 2010).
Insurance for Young Adults Sec 2004	Allows former foster care adults qualification in Medicaid until age 25 (1/1/2019).
Pre-Existing Medical Conditions Sec 2704	Prohibits not enrolling because of pre-existing conditions (1/1/2014).
High Risk Insurance Pool Program Sec 1101	Establishes high risk pool for people who have lost coverage for six months (7/1/2010) Expires 1/1/2014. \$5 billion for care.
Lifetime & Annual Limits on Benefits Sec 2711	Prohibits lifetime and annual limits on care received (10/1/2010 & 1/1/2014).

The Quick Course: The Patient Protection and Affordable Care Act P. 2

Medicaid Expansion Sec 2001	Medicaid programs cover all individuals 65 or younger with incomes up to 133% of poverty. Limited benefit packages (including BH benefits). Fed. Govt. finances at least 90%. 1/1/2014
Medicaid Medical Home Pilot Sec 2703	Provides (limited) funding for states to establish medical homes for chronic condition (including SPMI) Medicaid eligibles. 1/1/2011
Medicaid Accountable Care Organizations Pilot Sec 2706	Allows qualified Pediatric providers revenues for meeting performance standards. 1/1/2012
Medicaid Emergency Psychiatric Pilot Sec 2707	Funds psychiatric hospitals in support of medical assistance needed to treat psychiatric conditions. 10/1/2011

The Quick Course: The Patient Protection and Affordable Care Act P. 3

Medicaid Community Based Services Sec 2401, 2402, 10202	Establishes program for expanded attendant care services . 10/1/2011
Medicare Medical Home Pilot Sec 3502	Establishes program to fund community health teams for coordinated community based care. 1/1/2012
Co-Location of Primary Care in Community Based BH Sec 5604	\$50 million for co-locating primary care in community based BH settings.
Training for BH Professionals Sec 5306	Grant monies for Social Work, graduate Psychology as well as child MH professionals and paraprofessionals.
Incentives for Pediatric BH Specialists Sec 5203	Establishes loan repayment program for serving rural and BH needs in pediatric medicine

The Quick Course: The Patient Protection and Affordable Care Act P. 4

Mental Health & Addiction Care Parity Sec 1311 & 1562	Applies mental health and addiction care parity to all health plans.
Health Insurance Options Sec 1322, 1323, 1324	Establishes Consumer Operated and oriented Health Plans.
Individual Responsibility Sec 1501	Requires individuals to maintain minimum essential health insurance. 1/1/2014
Employer Responsibility Sec 1501	Requires employers with more than 50 full time employees to offer or pay into insurance funds. 1/1/2014
Community Living & Assistance Services Sec 8002	Establishes long term care insurance for community living assistance services for disables (at least \$50/ day). 1/1/2011

The Quick Course: The Patient Protection and Affordable Care Act P. 5

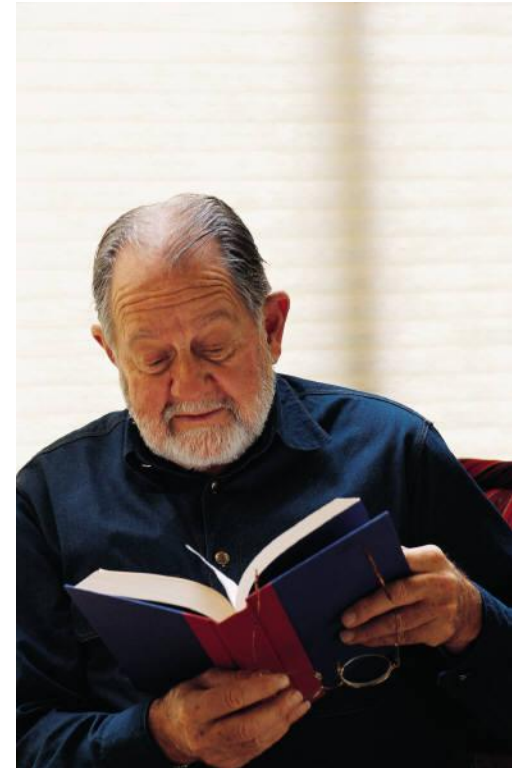
Health Plan Exchanges Sec 1311, 1321	Funds states to create Health Benefits Exchanges open for individuals and small groups. 1/1/2015
Individuals in Medicaid Sec 2201	Allows individuals to enroll in Medicaid (or Exchanges).
Behavioral Health Coverage Mandate Sec 1302, 1311	Requires Exchanges and Health Plans to offer essential BH services.
Individual Hardship Limits Sec 1401, 1402	Premium assistance for less than 400% of poverty level. Payment of any overage beyond 2% of income for those below 133% of poverty level. 1/1/2014
Medicare Accountable Care Organizations Sec 3022	Allows organizations meeting care standards to receive special payments from Medicare. 11/1/2012

The Quick Course: The Patient Protection and Affordable Care Act P.6

BH Education to Primary Care Providers Sec 5405	Funds for Primary Care Extension program to train about chronic disease mgt., BH services and evidence based care.
Community Transformation Grants Sec 4201	Competitive funds for programs that promote health and decrease incidence of chronic disease.
Community Health Grants Sec 5313	Funds to promote positive health behaviors in underserved communities

Resources for PL 111-148

- U.S. Government- Dedicated website: www.healthcare.gov
- U.S. Government- The Bill: www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html
- Kaiser Family Foundation: www.kff.org
- National Council: www.thenationalcouncil.org/cs/healthcare_reform
- Perednia, D.A. Overhauling America's Healthcare Machine. FT Press: Upper Saddle River, NJ, 2011.



Health Insurance Exchange

- A government-administered marketplace or portal (via a website) where private or public insurance policies are sold.
- Goal: Make it easy for individuals and small businesses to purchase insurance.
- Each state to start a Health Insurance Exchange by 1/1/2015.
- Functions as a clearinghouse for plans.
- Anticipate 9 million enrollees on HIEs by 2019.
- Final Rules: http://docs.house.gov/rules/health/111_ahcaa.pdf
- Kaiser resources:
<http://www.kaiserhealthnews.org/Stories/2011/July/11/Health-Insurance-Exchange-Regulations-Released.aspx>

Accountable Care Organizations

- Final Rules from CMS: http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf
- CMS release and comparison to earlier proposed rules: <http://www.hhs.gov/news/press/2011pres/10/20111020a.html>
- Shared savings final rule: www.ofr.gov/inspection.aspx
- CMS fact sheet on ACOs: www.cms.gov/center/press.asp
- Kaiser ACO resources: <http://healthreform.kff.org/Scan/2011/October/CMS-Issues-Final-Accountable-Care-Organizations-Rule.aspx>
- Commonwealth Fund ACO resources: <http://www.commonwealthfund.org/Blog/2011/Oct/Accountable-Care-Organization-Final-Regulations.aspx>

Exhibit 1. Accountable Care System Models and Core Capabilities

<u>Accountable Care System Models</u>	Redesign Care Processes	Teamwork	Care Coordination	<u>Core Capabilities</u>			
				Performance Accountability	Information Technology	Knowledge Management	Change Management
(1) Multi-Specialty Group Practice (MSGP) ^a	High	High	High	High	High	High	Medium
(2) Hospital Medical Staff Organization (HMSO) ^b	Medium	Medium	High	High	High	Low to Medium	Low to Medium
(3) Physician Hospital Organization (PHO) ^c	Medium	Medium	Medium	High	High	Medium	Medium
(4) Interdependent Provider Organization (IPO) ^d	Low	Low	Low to Medium	Medium	Low	Low	Low
(5) Health Plan Provider Organization / Network (HPPO/HPPN) ^e	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium

^a 17-26 percent of practicing physicians in groups of 100 plus including institutionally based; 35 percent in groups of 20 plus

^b Almost all 718,000 practicing physicians

^c Estimated 37 percent of practicing physicians; see text

^d 48% of office-based in solo or 2 person partnership; 89% in arrangements of 10 physicians or less; 38% members of IPA's

^e 38% members of IPA's

Partnering With ACOs

ACO Operating Model



NACHC: <http://www.nachc.org/AccountableCareOrganizationToolkit.cfm>

NCCBH: <http://www.thenationalcouncil.org/galleries/default-file/ACOs%20and%20Health%20Homes%20Exec%20Summary.pdf>

NCCBH Webinar: http://www.youtube.com/watch?v=D0z1T3CRh_8

Cigna: <http://www.hc21.org/files/McLaughlin%202011.pdf>

CA Healthcare Foundation:

<http://www.chcf.org/~media/Files/PDF/B/PDF%20BetterFasterSafetyNetProvidersRedesigningCare.pdf>

HealthSystemChange: <http://www.hschange.com/CONTENT/1030/1030.pdf>

Commonwealth Foundation

http://www.brittenassociates.com/documents_pcmh/Commonwealth%20Fund/Commonwealth%20Fund_Building%20Medical%20Homes%20in%20State%20Medicaid%20and%20CHIP%20Programs.pdf

Patient Centered Medical Homes: Accreditation & Recognition

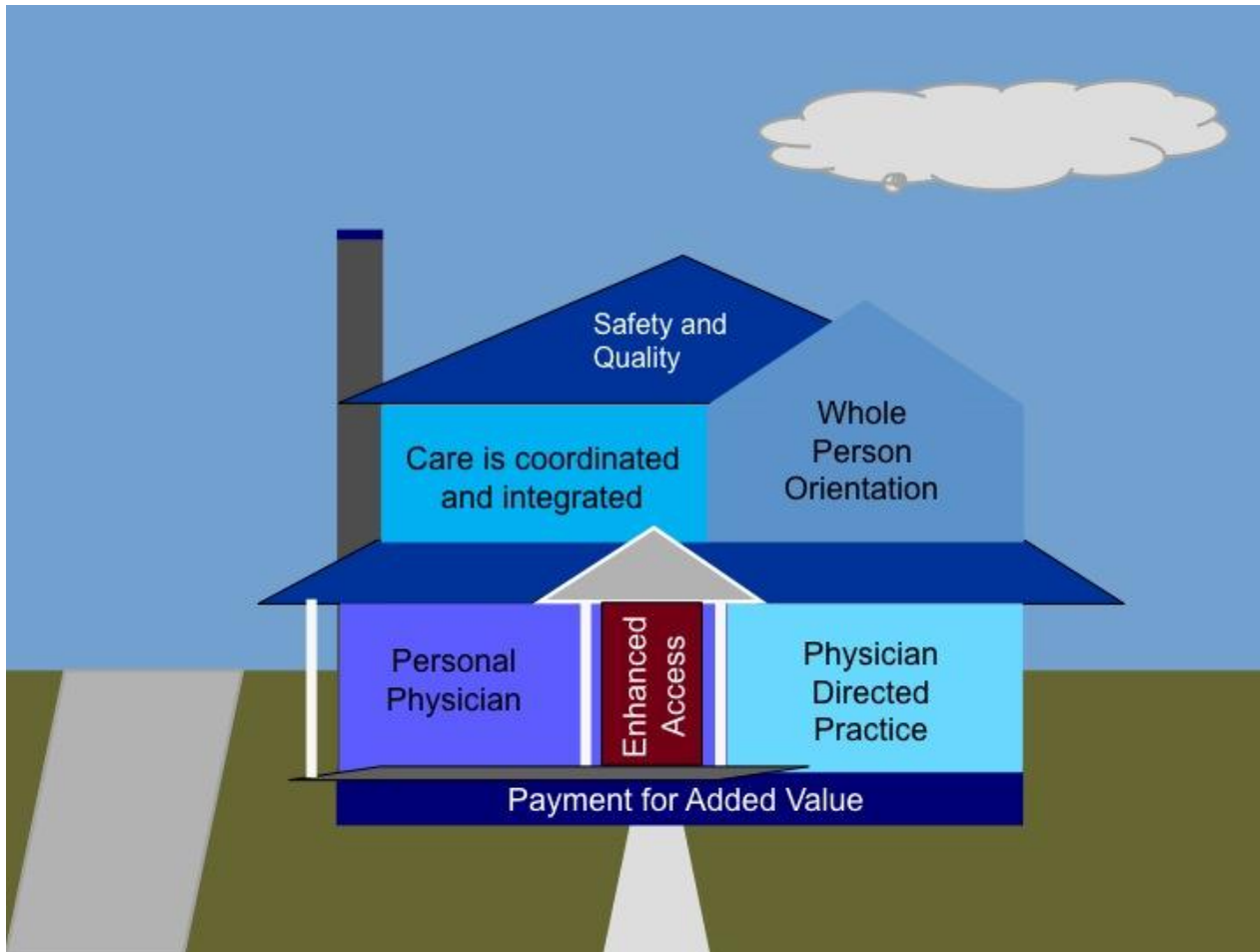
Common standards are emerging:

- The [Accreditation Association for Ambulatory Health Care](#) (AAAHC) began accrediting medical homes in 2009 and is the only accrediting body to conduct on-site survey for organizations seeking Medical Home [accreditation](#).
- The [National Committee for Quality Assurance](#) released *Physician Practice Connections—Patient-Centered Medical Home* (PPC-PCMH), a set of voluntary standards for the recognition of physician practices as medical homes.

Resources

- Accreditation Association for AHC:
http://www.aaahc.org/eweb/dynamicpage.aspx?site=aaahc_site&webcode=accred_program
- National Committee for Quality Assurance PCMH Recognition Program:
<http://www.ncqa.org/tabid/631/Default.aspx>

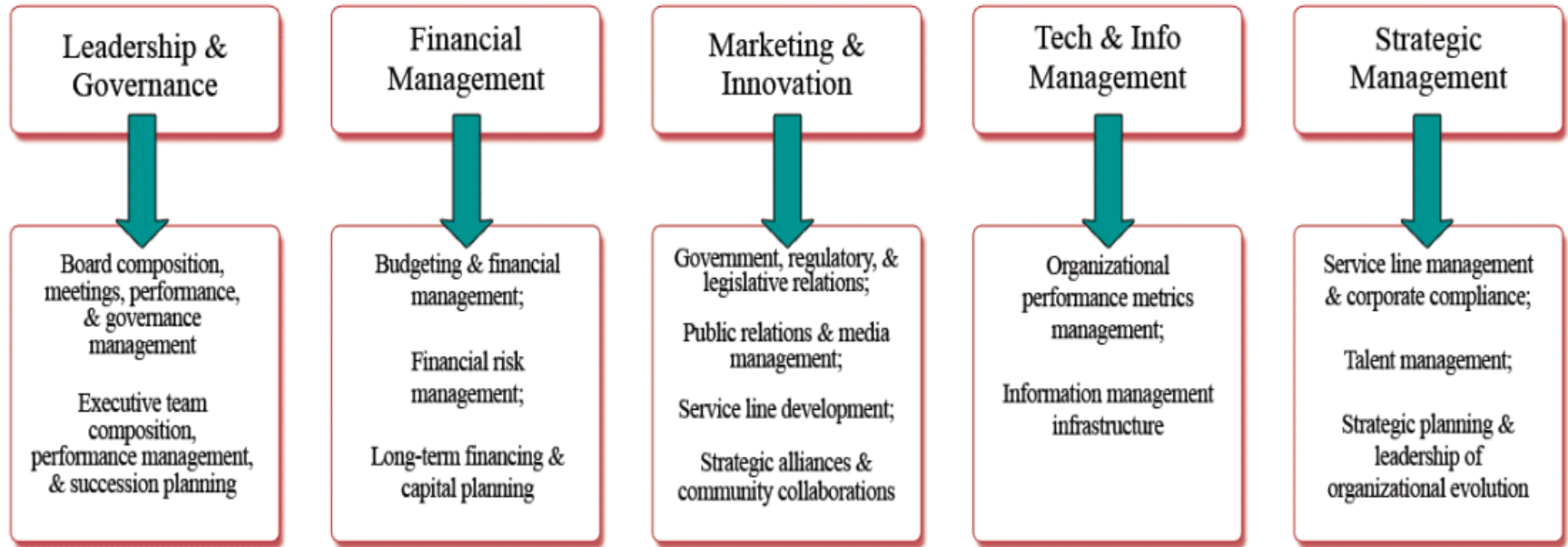
Patient Centered Medical Home



Health Cooperatives

- Regulations re Health Coops:
<http://www.gpo.gov/fdsys/pkg/FR-2011-07-20/pdf/2011-18342.pdf>
- CMS guidance on Health Coops:
<http://cciio.cms.gov/resources/regulations/index.html#coopp>

The Five Pillars of Management Competencies for Behavioral Health & Social Service Managers



Planning For Reform

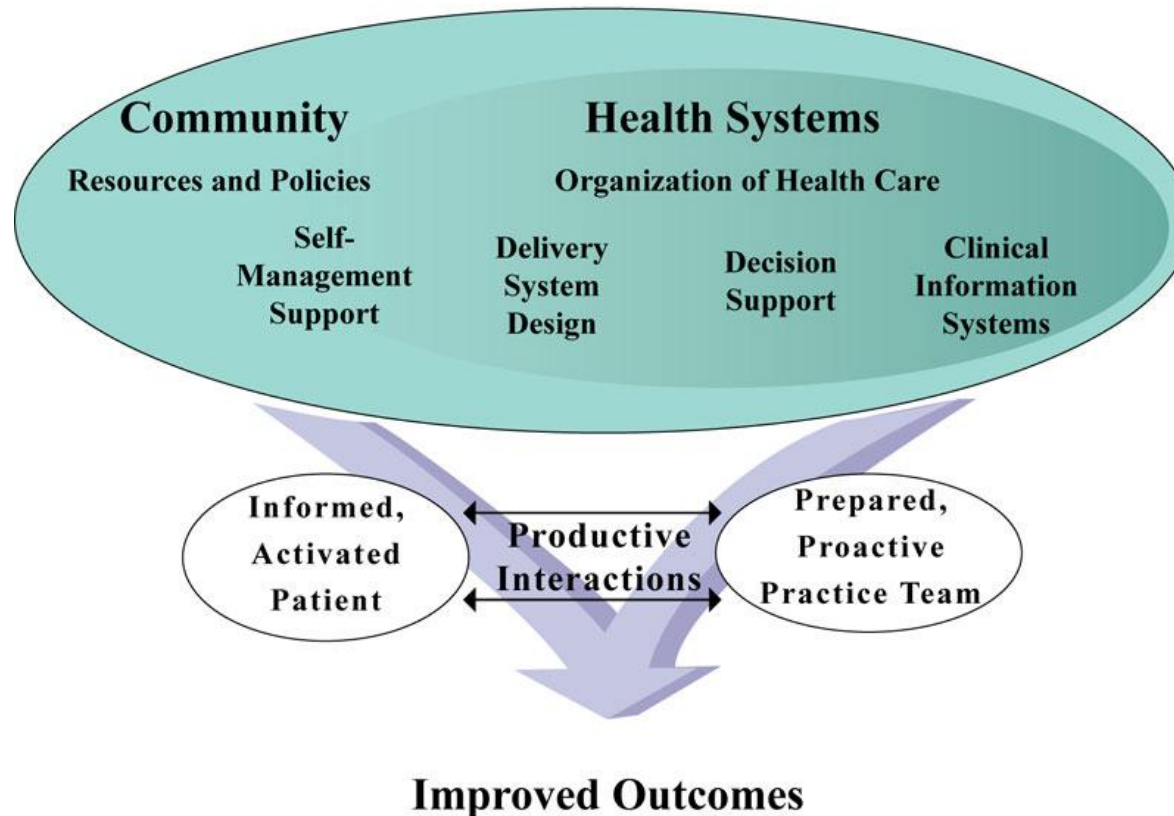
1. Does your organization have the knowledge, skills and commitment to assess and respond to risks and opportunities in healthcare reform?
2. Have integration and alignment strategies between physicians and the hospital been developed to address new requirements, including quality provisions along the continuum of care?
3. Have you developed a quality and outcomes dashboard?
4. Have key operational, financial and quality benchmarks been established and agreed upon at the executive and board levels?
5. Do you have an active, evolving strategic plan?
6. Do you have a current information systems strategic plan?
7. Have you benchmarked the hospital/health system's debt structure, debt capacity, and credit rating?
8. Does your organization have core competency in revenue cycle activities, including the status of major commercial payor contracts, and RAC audits?
9. Do you have an ongoing health care reform education plan for your board and leadership team?
10. Have you developed a community benefits reporting status and strategic plan in anticipation of new regulations?

From: Plante & Moran Health Care Reform Readiness "Top Ten Checklist" for Hospitals/Health Systems

Chronic Care Model

[http://www.improvingchroniccare.org/index.php?p=The Chronic Care Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

The Chronic Care Model



Developed by The MacColl Institute
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