Vermont Health Care Innovation Project
Health Data Infrastructure Meeting Agenda

June 22, 2016, 9:00-11:00am

Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex

Call-In Number: 1-877-273-4202; Passcode: 2252454

REGISTER NOW

To access this meeting as a webinar, please pre-register using the above link. After registering you will receive a confirmation email containing information about joining the Webinar.

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:00-9:05am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft May 18, 2016, Meeting Minutes	Approval of Minutes
2	9:05-9:15	Project Updates • VHITP Update • Home Health Agency Gap Remediation Project Update	 Georgia Maheras Larry Sandage and Susan Aranoff		
3	9:15-9:55	Data Quality Project Update	Judith Franz and Mike Gagnon	Attachment 3: Data Quality Project Update	
4	9:55-10:55am	OneCare Vermont Care Navigator Update	Sara Barry and Maura Crandall (OneCare)	Attachment 4: Care Navigator Implementation	
5	10:55-11:00am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	**Next Meeting**: Wednesday, July 20, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex **CANCELED:** August 17th HDI Work Group Meeting.	

Additional Materials: Attachment 5 – Making Comprehensive Shared Care Plans a Reality (Article)

Attachment 1: Draft May 18, 2016, Meeting Minutes

Vermont Health Care Innovation Project
HDI Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, May 18, 2016, 9:00am-11:00am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Simone Rueschemeyer called the meeting to order at 9:05am. A roll call attendance was taken and a quorum was present. Stefani Hartsfield moved to approve the March minutes by exception. Ken Gingras seconded. The minutes were approved, with two abstentions (Eileen Underwood and Brian Isham).	
2. Project Updates	Georgia Maheras provided an update on the submission of our Year 3 Operational Plan, which was submitted on April 28. Our CMMI project officer and other federal partners visited on May 2 and 3 for a very successful site visit. The compiled Operational Plan is available on the VHCIP website. Performance Period 3 begins on July 1, 2016. Sustainability is a significant focus of the plan, and will be a focus of Performance Period 3 activities. Please contact Georgia if you're interested in participating in a sub-group focused on sustainability. Legislative Update: Not much to impact this group's work. The Green Mountain Care Board will be discussing the HIT Strategic Plan tomorrow.	
3. Event Notification System Update and Demonstration	Jay Desai of PatientPing provided an update on Event Notification System (ENS) rollout and progress. The group discussed the following: • How does the Emergency Department or other providers who receive "pings" (alerts) access PatientPing? There is a web portal, and PatientPing is working with a number of EMRs to develop interfaces within the EMR. Standards are emerging to allow development of "apps" within EMRs to avoid clinicians having to sign in to multiple environments. The need to sign into multiple portals is a significant workflow issue for providers; participants noted that connections with EMRs are a critical.	

Agenda Item	Discussion	Next Steps
	• Patient Privacy: PatientPing gets a regular feed from VITL of patients who have opted out through the VHIE consent process and blacklists those individuals' information within PatientPing. Mike Gagnon noted that data covered by 42 CFR Part 2 is not included in the VHIE. • PatientPing has focused on creating a simple tool to support collaboration and data sharing. • PatientPing is helping to connect providers with hospitals and post-acute facilities outside of their usual service areas. Pings are now occurring across the country and across state lines – providers in Michigan and Massachusetts have received pings as patients have been admitted to Vermont hospitals. • How can providers get more information to follow-up on pings? Providers need to follow up through EMR or VITLAccess to get a fuller medical record. • How would pings work for DOC? DOC is a covered entity and could receive and initiate pings. This is something VITL will work with DOC to set up. • Providers can include standing notes for their patients with instructions, or flag patients as high-risk. • Some individuals will appear on multiple rosters if they're served by multiple organizations. PatientPing takes responsibility for merging patient rosters, and pings can show all of the providers/organizations touching a patient. Reconciliation occurs monthly. • What is PatientPing's experience with hospitals, especially EDs, actually looking at and using pings? This is context dependent. Payment models that incentivize community-based care and dis-incentivize hospital-based care make PatientPing a very valuable resource for providers; areas with value-based payment models have seen much greater uptake. Day-to-day use of pings requires a cultural shift at institutions, but once this is part of the workflow, PatientPing sees very high uptake. Note: Pings go *out* without provider action based on VITL feeds. • How does PatientPing push adoption and measure change? PatientPing has targeted strategies for different provider types and use cases to help providers learn about potential benefits to their organization. PatientPing sees very high engagement in receiving pings, but has had more challenges at the point of care. PatientPing does track engagement. • ROI: In the value-based reimbursement model, ROI is reduced total cost of care along with improved quality. Some quality measures (follow-up after ED visit, for example) are dependent on technology. In addition, post-acute care costs could be decreased by reducing length of stay and supporting improved home- and community-based care. This also supports providers in preventing readmissions and ensuring follow-up visits after ED visit. There is a case for patients to encourage providers to sign up for PatientPing and actively use pings to support increased coordination. • Pharmacy: This isn't yet part of PatientPing. • Does PatientPing cover episodic events within hospitals? PatientPing does cover transfers (ED to observation status to admission, for example). Mike Gagnon noted that providers assume that they understand patients' utilization patterns and can catch all interactions by connecting just to the local hospital, but this is often not the case.	

Agenda Item	Discussion	Next Steps
	• How far back does ADT history go? VITL is sharing all ADT data they have with PatientPing, including historical data. This sharing is limited by same consent process described earlier for patients who opt out.	
4. VCN Data Repository Update	Ken Gingras provided an update on the VCN data repository project. • The goal of this project is to collect information from VCN member agencies (DAs and SSAs) and compile it, but not exchange it. In the long-term, ideally this information could be shared within the VHIE. The repository is a good interim step and resource for member agencies, as well as an "on-ramp" to increased health reform participation. The group discussed the following: • VCN has worked with a contractor (NORC, the National Opinion Research Center) to create a "secure environment within a secure environment" to store and segregate data. • Phase I MSR Data: Prototypes are now complete (update from slides). Prototypes are tableau dashboards: an interactive reporting system. This allows VCN members to get significant benefit from minimal additional effort. This also helps track data quality progress. Member agencies can customize as well. • Could Work Group members get a list of dashboards? Interested members should reach out to Ken. There is a sub-group of DAs working on outcomes. VCN has collected a list of outcome measures from various State departments and programs as well as the master grant; this list drives the outcomes.	
5. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	There was no additional comment. **Next Meeting:** Wednesday, June 22, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury.	

Attachment 3: Data Quality Project Update

Data Quality Update

VHCIP HDI Work Group

Michael L. Gagnon, CTO

Judith A. Franz, VP Client Services

Background

- Today, VITL collects clinical data from numerous VT and some NH healthcare organizations as part of regular VHIE operations
- Over 4M clinical data messages per month are now being processed
- Data include patient demographics, patient events, labs, transcribed reports, medications, immunizations and care summaries

Background

- The data collected are used to:
  - Identify patients (MPI with 1.7M patients)
  - Provide clinical data at the point of care (provider portal: VITLAccess)
  - Process transactions (lab orders, results delivery, immunizations)
  - Send Notifications (PatientPing)
  - Aggregate population health data (Blueprint and VDH)
  - Support ACOs' clinical data needs

Need for Clinical Data Management, Warehousing and Analytics

- Needs for clinical data are changing
- What worked in the clinical setting is not always adequate for performance measures
- Data requirements are expanding (quality metrics are not always in a standard interface)
- Need to measure and improve data quality
- Not all data are coded to national standards
- Future claims and clinical data integration

Remediating Data

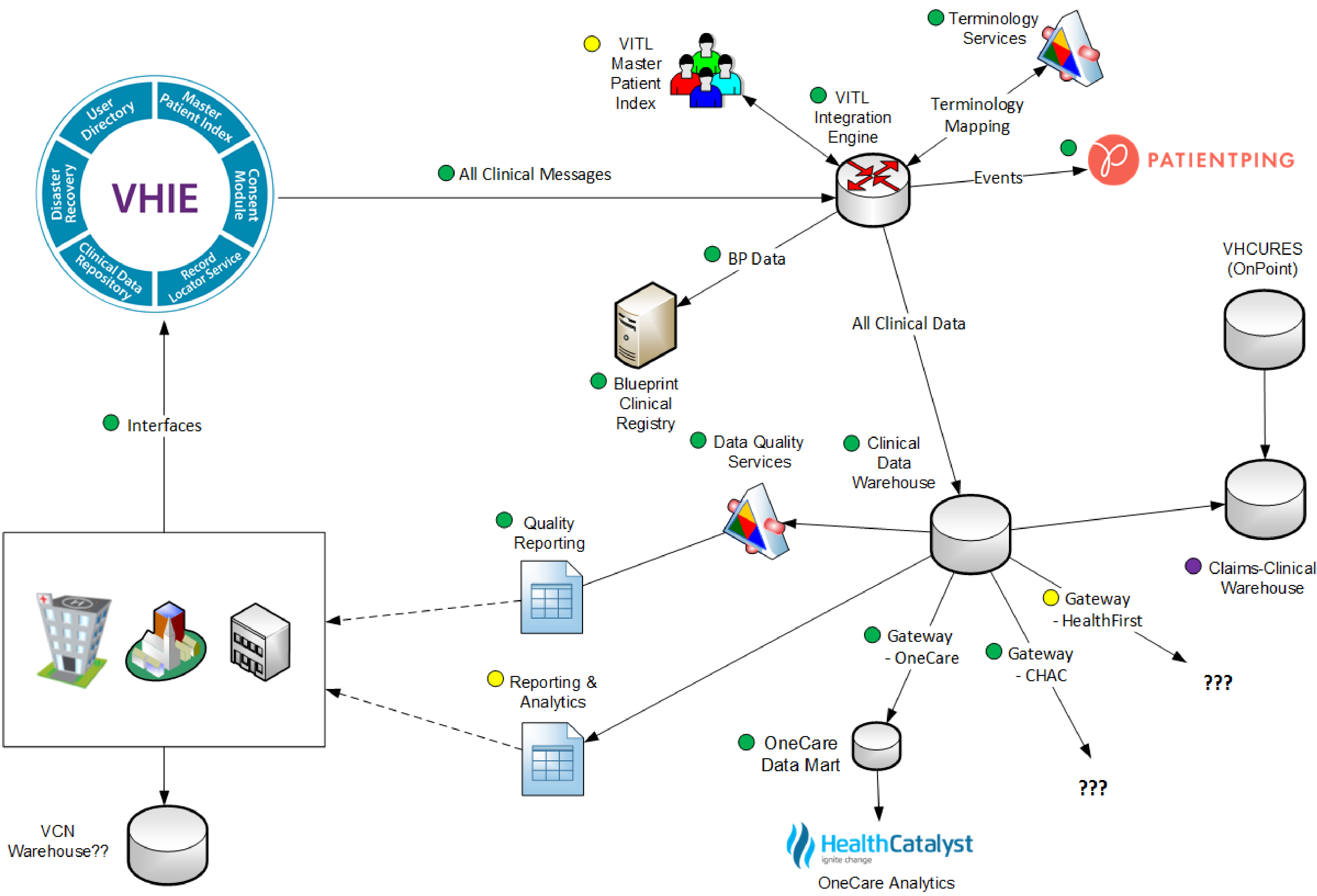
- The goal of data remediation is to improve the data quality - **complete, accurate and consistent**
- For analysis -
  - Data must be captured
  - Interfaces must exist
  - Data in the interface must be complete and accurate
  - Data must be formatted correctly
  - Data must be coded or normalized
- In data remediation the source organization, VITL and the destination organization all play a role
  - Data can be remediated at the source, in the network (VITL) or at the destination (analytics)

Steps to Data Quality

Step	Responsible Parties
Data must be captured in the EHR	Source Org, ACO
Interface must be developed to the HIE	Source Org, Vendor
Data must be included in the interface	Source Org, Vendor
Data must be in the right fields	VITL, Source Org, Vendor
Inbound interface must be formatted correctly	VITL, Vendor
Data must be coded correctly	VITL, Source Org
Outbound interface must be formatted for receiving system	VITL
Data must be complete, accurate, and consistent	Destination Org, ACO

Clinical Data Management Services

- Perform data translations as data are collected from sources using standard interfaces
- Collect data from source systems using "custom" formats
- Perform data normalization to map terms to standard code sets
- Analyze the data for quality and perform "cleansing"
- Provide "dashboards" of data quality to source organizations


VITL Clinical Data Management Infrastructure
VHIE
User Directory
Master Patient Index
Consent Module
Record Locator Service
Clinical Data Repository
Disaster Recovery
VITL Master Patient Index
Terminology Services
VITL Integration Engine
Terminology Mapping
All Clinical Messages
PATIENTPING
Events
BP Data
Blueprint Clinical Registry
All Clinical Data
VHCURES (OnPoint)
Interfaces
Data Quality Services
Clinical Data Warehouse
Quality Reporting
Claims-Clinical Warehouse
Gateway - HealthFirst
Gateway - OneCare
Gateway - CHAC
???
Reporting & Analytics
OneCare Data Mart
???
VCN Warehouse??
HealthCatalyst
ignite change
OneCare Analytics
Live
In Progress
Future

Measuring Data Quality

High Level View

Measure Set	Data Elements	Percent Populated	Percent Useable for PHM/Patient Care
Minimum	Patient identifier	100.00%	100.00%
Minimum	Patient Name	100.00%	99.57%
Minimum	Patient DOB	100.00%	100.00%
Minimum	Provider identifier	94.78%	94.64%
Minimum	Provider Name	94.64%	Unknown
Minimum	Facility identifier	100.00%	100.00%
Minimum	Facility name	100.00%	100.00%
Minimum	Place of Service (clinic, practice, ED, etc)	66.78%	Unknown
Minimum	Problem list (using standard code sets such as ICD9, ICD10, SNOMED, etc)	39.89%	66.72%
Minimum	Problem active/inactive	75.80%	0.00%
Minimum	Date of encounter or observation	49.34%	Unknown
Minimum	Type of encounter or observation (lab result, office visit, medication order, etc)	1.94%	Unknown
Minimum	Clinical service provided or procedure done (using standard code sets such as CPT, SNOMED, LOINC, etc)	49.34%	Unknown
Minimum	Code set identifier (CPT, SNOMED, LOINC, RXNORM, ICD9, ICD10, etc)	Unknown	Unknown
Minimum	Result/observation value (e.g. HbA1C value, BP, BMI)	100.00%	Unknown
Minimum	Units of service (if applicable, such as for medication order or procedure)	Unknown	Unknown
ACO 12	Discharge Date	NA	Na
	Medication Reconciliation	NA	Na
ACO 13	Screen for Falls	1.96%	1.96%
ACO 14	Allergy List	30.62%	30.62%
	Influenza Immunization	42.21%	42.21%

DATA QUALITY DASHBOARDS

Patient Level Demographic and Provider Analysis

- Each element is evaluated at the patient level for an organization. Multiple messages or entries for same patient are counted only once.
- The denominator is the population seen that had an ADT or CCD generated in the Month of April.

Population Evaluation

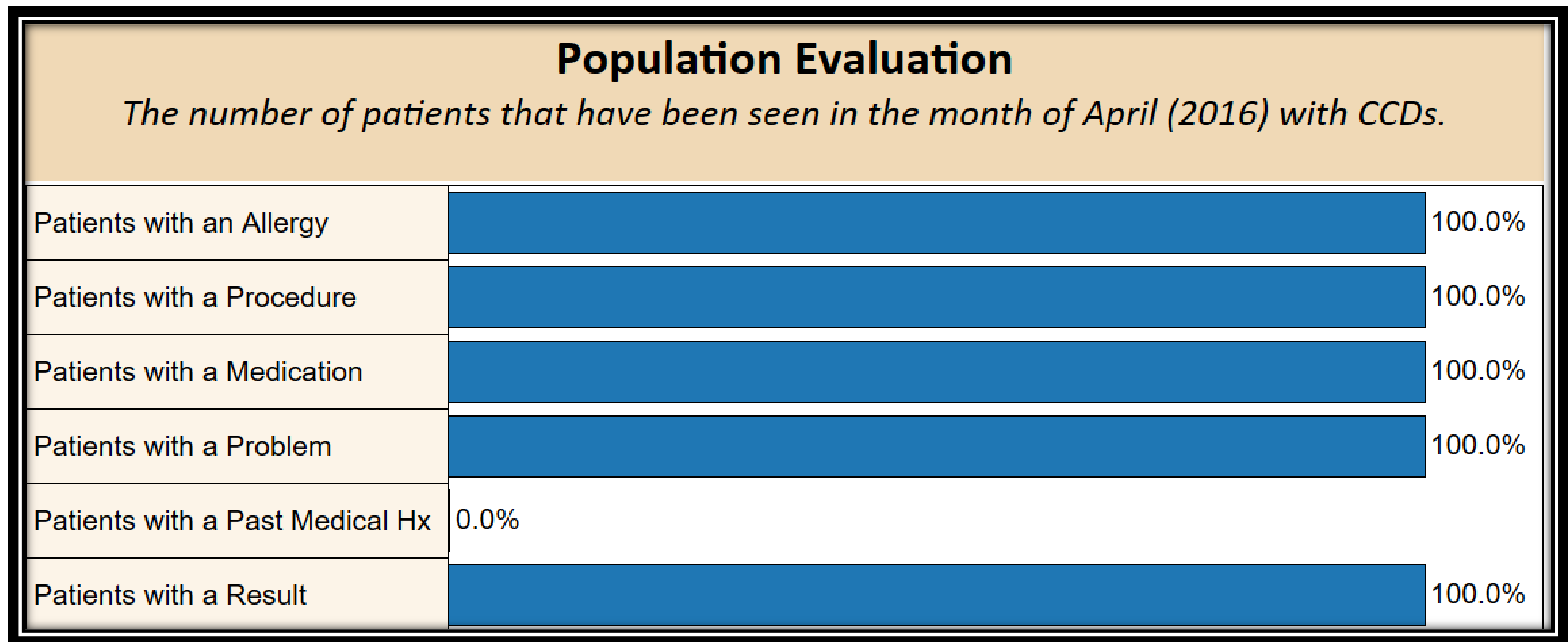
The number of patients that have been seen in the month of April (2016) with ADTs and CCDs.

Measure	Value
Total Patients	3,317
Valid Patient Name	99.97%
DOB	100.00%
MRN	100.00%
Provider Name	86.46%
Provider NPI	86.46%

* Valid patient name evaluates for 'Test', numbers, punctuation, inclusion of 'Zzz' combinations, identifies such as 'Do not use', and inclusion of a suffix in the last or first name position.

Patient Level Sectional Analysis

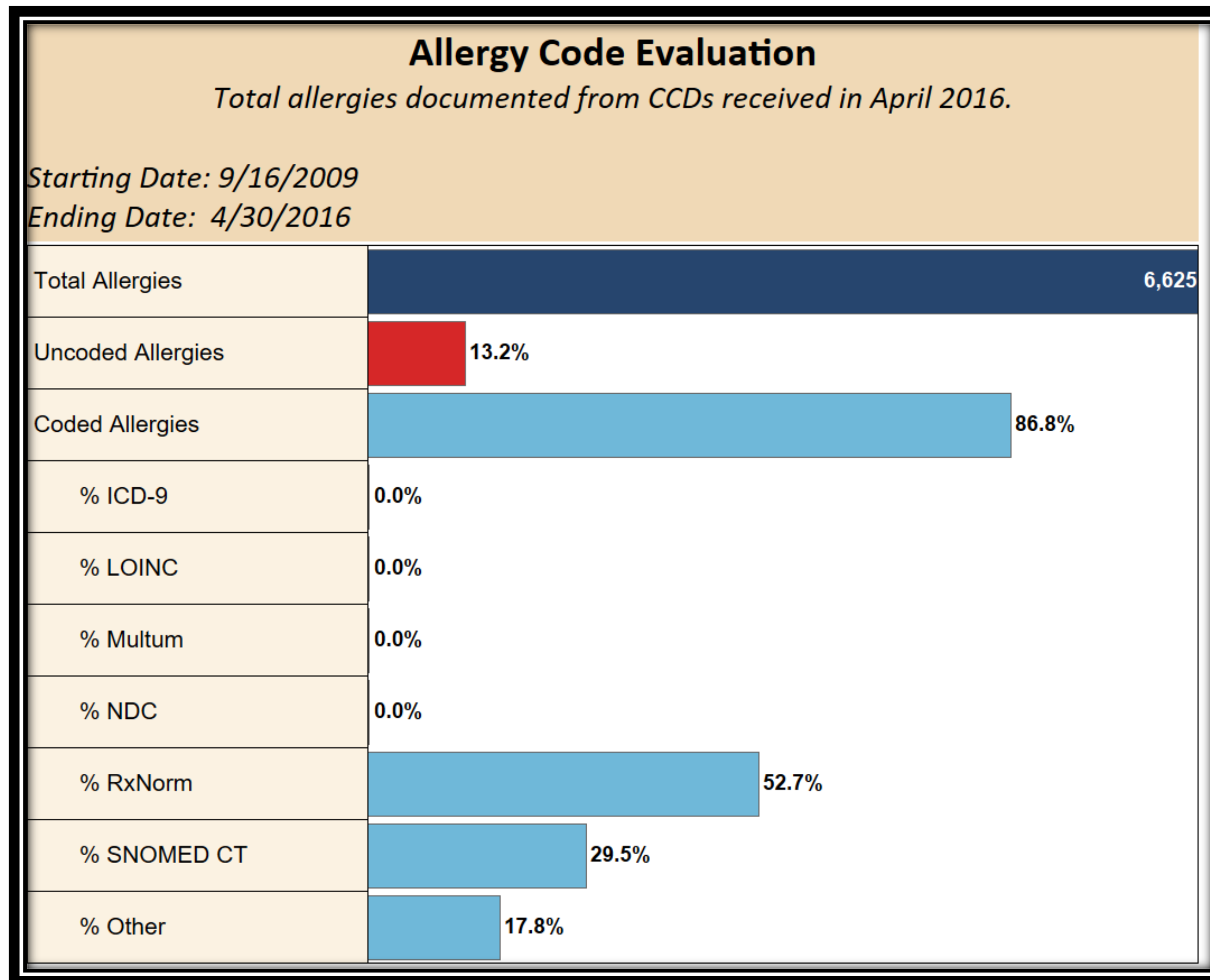
- Each section of the CCD was evaluated for the presence of data.
- The denominator is the population seen that had a CCD generated in the Month of April.



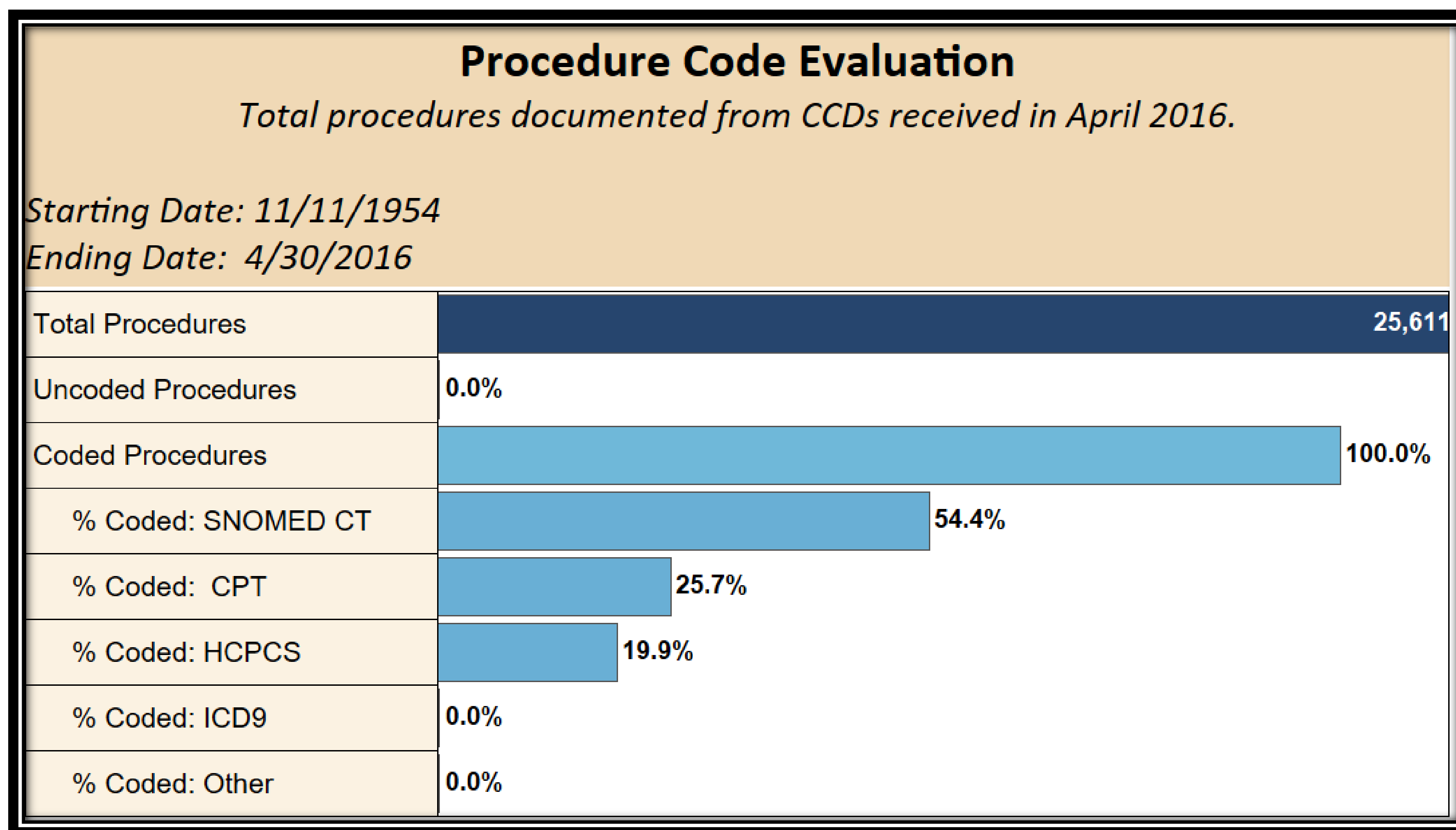
* Out of the 3,317 patients that had a CCD sent from during April.

Patient Level Entry Analysis

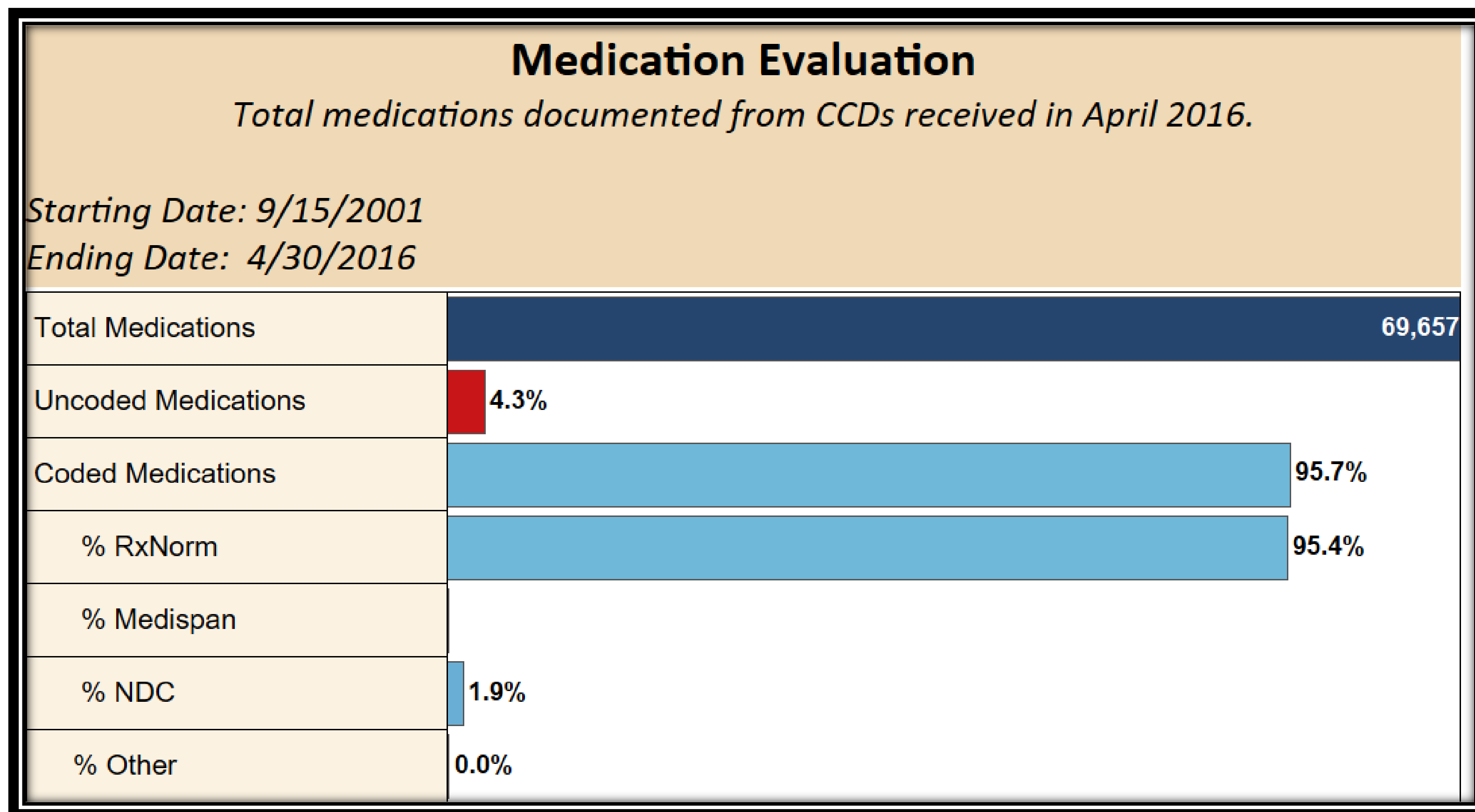
- Each section of the CCD was evaluated for at least one entry.
- A documented value of ‘Unknown’ or ‘No Known’ in the CCD are included in the evaluation for a code system.
- Uncoded data represents an entry with no associated code system.



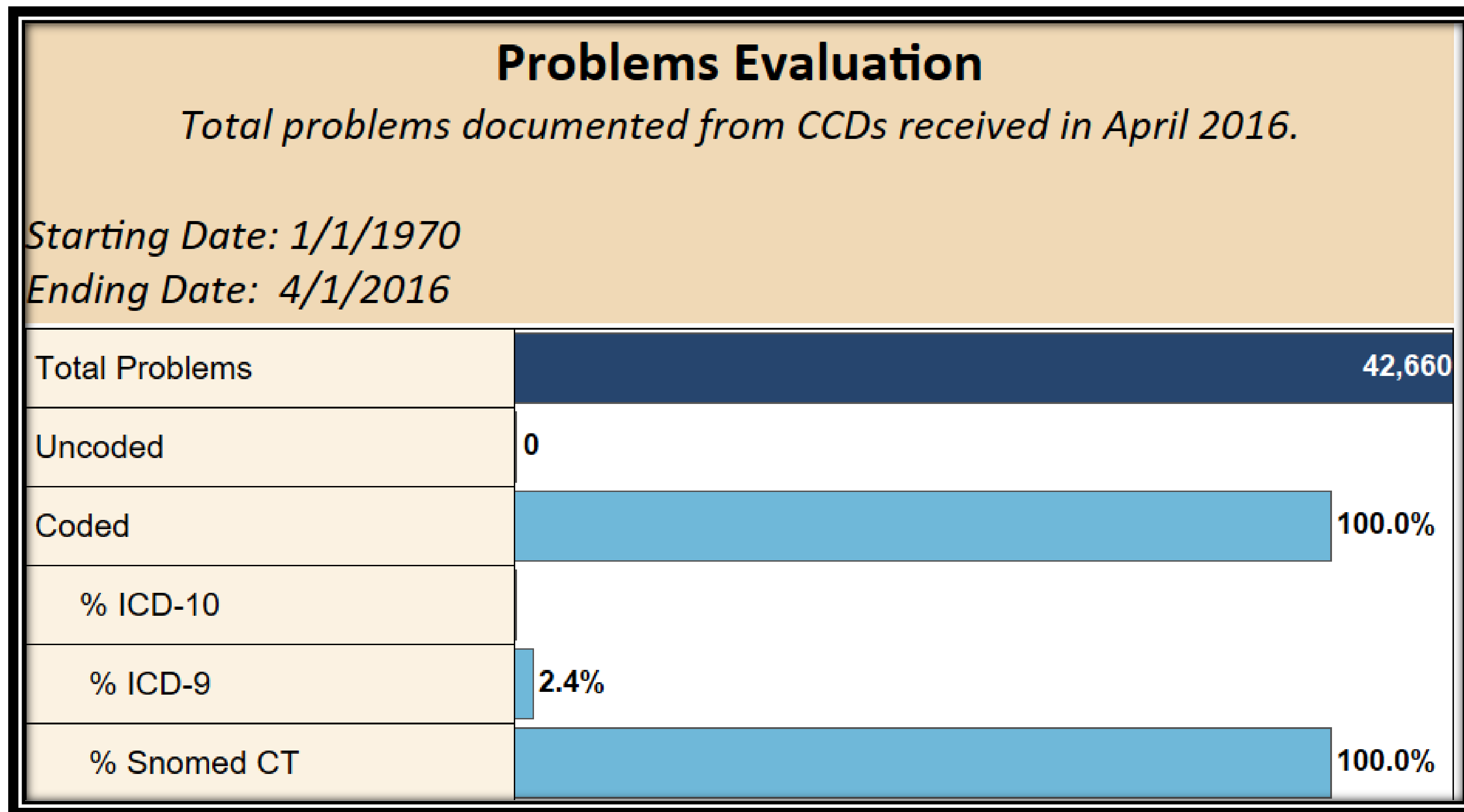
*Code types may add up to more than 100%, as each entry may have more than one code system associated with it.



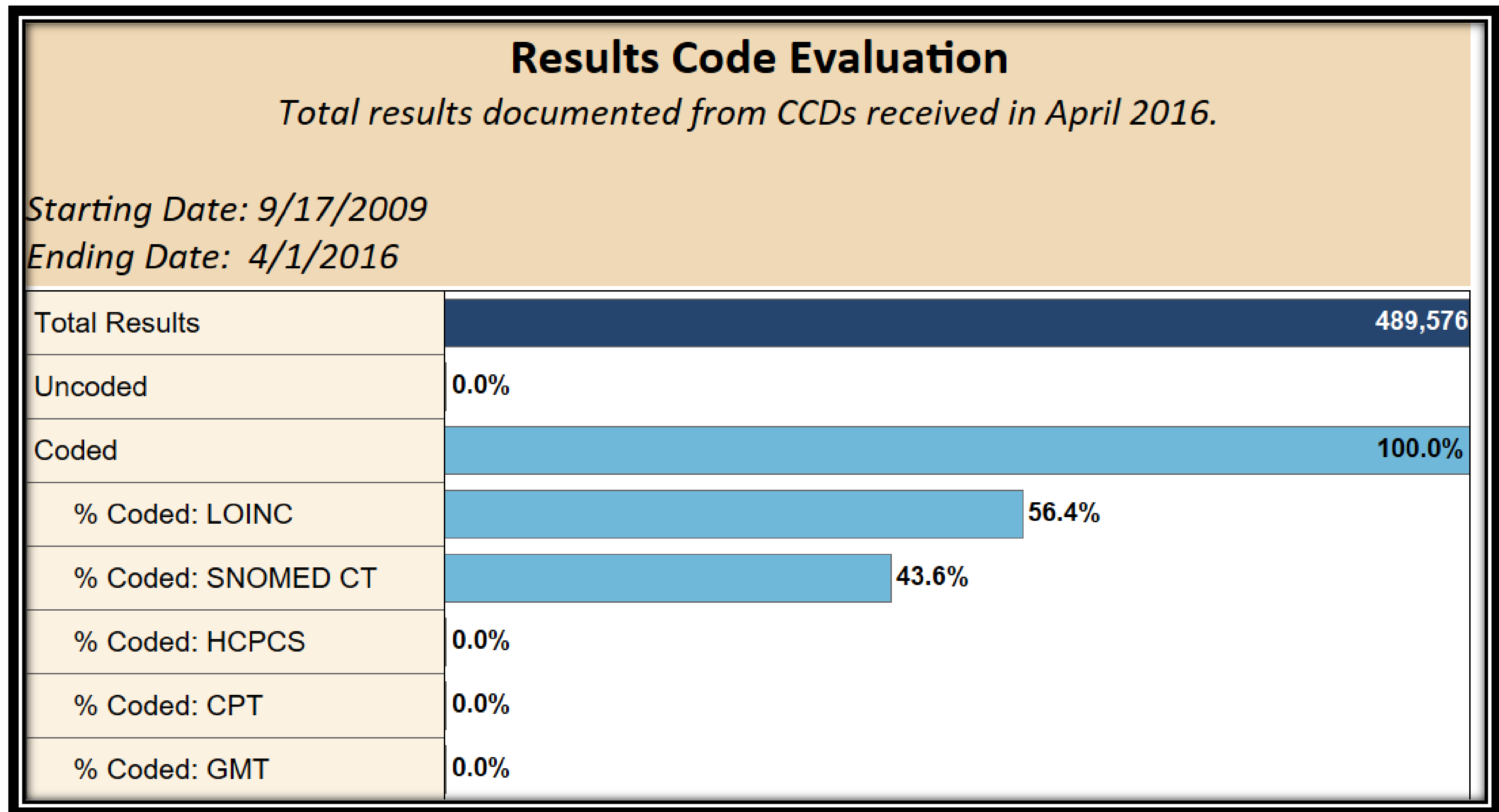
*Code types may add up to more than 100%, as each entry may have more than one code system associated with it.



*Code types may add up to more than 100%, as each entry may have more than one code system associated with it.



*Code types may add up to more than 100%, as each entry may have more than one code system associated with it.



*Code types may add up to more than 100%, as each entry may have more than one code system associated with it.

VERMONT CARE PARTNERS DATA QUALITY PROJECT

Vermont Care Partners Data Quality Project

	Original Project	Original Project Changes		New Project Request	
		Group A Completion by Nov 30th	Group A Completion (with extension) by Dec 31st	Group A	Group B (1 DA, 4 SSAs & 1 DDA)
Agencies	16	10 (37*)	10 (37*)	10 (37*)	6
Work/Scope	Phases 1, 2 & 3	Phase 1 & part of Phase 2	Remainder of Phase 2	Phase 3	Phases 1, 2 & 3
Funding	$200K	($135K) spent $65K balance		$150K	
* Number of sites					

Vermont Care Partners Data Quality Project

- Current State Analysis
  - Developmental/Specialized Service Agencies
    - They are progressing well with their development of MSR-specific templates for Intake and Discharge. They decided to finalize their Annual Review process after their June 13th EHR go-live.
    - Generic MSR training materials will be presented by VITL at the SSA Consortium Retreat at the end of June; date TBD.
  - Rutland Mental Health Service
    - First meeting was held on June 2nd.

Vermont Care Partners Data Quality Project

- Remediation and Training
  - Counseling Service of Addison County
    - Waiting for the agency to identify a training date
  - Health Care and Rehabilitation Services
    - Waiting for the agency to identify a meeting date to collaboratively develop training materials
  - Northeast Kingdom Human Services
    - The agency has received their Training Manual deliverable with updated MSR definitions.
    - Training was conducted on June 16th in both Derby and St. Johnsbury.
    - Other deliverables are in progress

Vermont Care Partners Data Quality Project

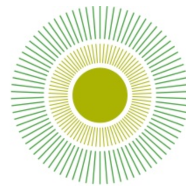
- Northwestern Counseling & Support Services
  - VITL met with the agency on May 5th and May 16th to determine their remediation and training plan.
  - Training was conducted (4 classes) June 21st and June 22nd for managers, and clinical, administrative and medical records staff.
  - Deliverables are in progress
- Washington County Human Services
  - VITL met with the agency on May 18th to determine their remediation and training plan.
  - Training was conducted on Monday June 20th for intake, other clinical, EHR Task Force staff, and medical records staff.
  - Deliverables are in progress

QUESTIONS?

Attachment 4: Care Navigator Implementation

Care Navigator Implementation 2016

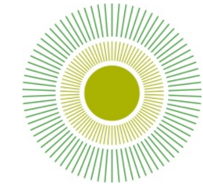
June 22, 2016



OneCareVermont

OneCareVT.org

Sara Barry, MPH; Director, Clinical and Quality Improvement
Maura Crandall, RN, BSN, CCM; Sr. Care Coordination Specialist

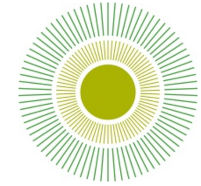


Microsoft
Health Users Group

Innovation Awards 2015
WINNER

Creating Connected Communities of Care with Care Navigator™

Goals of Care Coordination Software



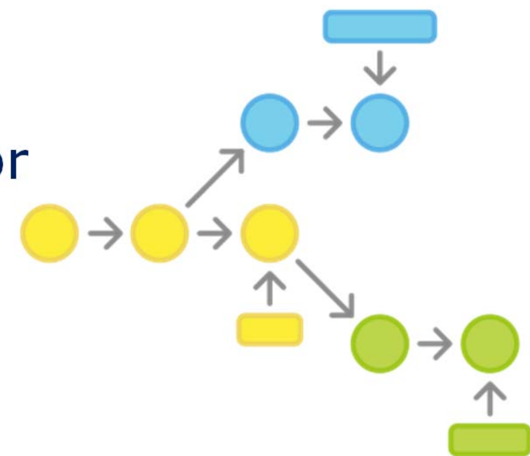
- Provide a software solution to support effective care coordination for OneCare Vermont attributed patients
- Streamline communication among care team members and with patients/caregiver(s)
- Build on the learnings from the Integrated Communities Care Management Learning Collaborative (ICCMLC)
- Coordinate tasks among multiple care team members

Goals of Care Coordination Software

- A single software platform for care coordinators across the continuum of care (i.e. PCMH, hospitals, community agencies)
- Tools that allow for identification of high/rising risk patient populations
- Shared care plans using a standard template
- Supports care of complex patients by automating follow-up tasks based on patient needs
- Customizable reports
- Complimentary to an EMR (non duplicative)

Care Coordination Software Features

- A central communication hub to coordinate care across care teams and with patients/caregivers
- Real-time updates as care team adds to the software
- Secure messaging with patients, families, and other providers
- Fed by existing claims & clinical data
- Automated work flows generate tasks for care team members



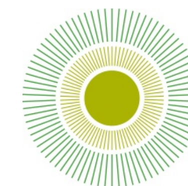
Care Coordination Software Features

- A library of assessment tools completed by patients and/or care team members
- Ability to add assessments with reportable fields
- Care team members can upload and share documents (e.g. labs, discharge plans)
- A customizable dashboard:
  - view and manage tasks
  - communicate with other care team members
  - monitor key indicators for assigned patient panels

Upcoming Features (Fall/Winter 2016-17)

- Mobile Application: provide remote access for field team and patient/caregiver(s)
- Additional clinical data
- Ribbon function for simultaneous viewing of software systems
- Patient education material library customized (e.g. community-specific resources, cultural and linguistic needs)
- Integrated event notification system

Data Flow for Care Coordination



Mobile App

future

Claims
(Dx, utilization including ED, IP, hospice for Medicare, Medicaid, & Commercial)

OneCare Data Warehouse
(Health Catalyst)

Clinical*
(VITL, direct EMR feeds)

future

Central Hub

Data Sources

Data Warehouse

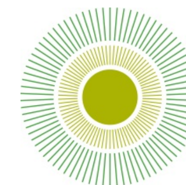
Care Navigator

Care Coordination Activities

(e.g. assessments, tasks, secure messages)

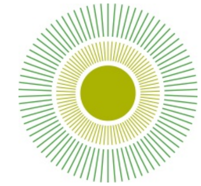
* Select clinical data will be available in Care Navigator beginning fall/winter 2016-17

Data Security



- HIPAA-compliant software system
  - supports the “minimum necessary” rule
  - secure messaging among care team members
- Care coordination work conducted on behalf of OCV
- All care team users have contracted relationships with OCV that allow for sharing of necessary patient data to support OCV’s business operations
- Existing patient consent, given at the participant level (e.g. PCP, hospital), allows sharing information among care team members
- Additional patient/caregiver consent needed to access the mobile app (future)

Who Will Have Access?



- OCV Participants:
    - Primary & specialty care practices
    - Hospitals
- OCV Collaborators & Affiliates:
    - Area Agencies on Aging
    - Home Health Agencies
    - Designated Agencies & Recovery Centers
    - Skilled Nursing Facilities
    - Housing Authorities
    - State of Vermont Agency of Human Services
    - Transit Organizations
    - School Nurses
    - Family Centers
- Patients & Designated Caregivers

Data Protections

OneCare

i.e. OneCare employees

Data Protections:

OHCA, Data Use Agreement,
Annual Compliance Training

Collaborator

e.g. SASH, HHA, AAA

Data Protections:

Collaborator Agreement and

Annual Compliance Attestation

Participant

e.g. PCP, Hospital

Data Protections:

Participant Agreement

Annual Compliance Attestation

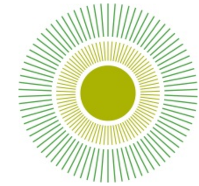
Patient

Data Protections:

Opt out Letter

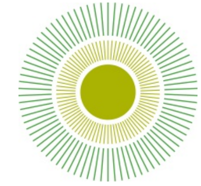
In Office Poster

User Access



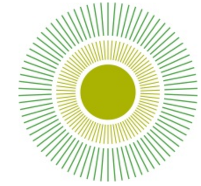
- System Administrators (OCV technical team)
- Care Coordination Supervisor
  - Assign patient panels to care coordinators
  - View HSA and/or agency-wide reports
- Care Coordinator
  - Manage patient panels
  - Assign tasks to care team members
- Support Services
  - Receive tasks, view limited patient information related to their area of responsibility (i.e. address for a transportation agency)
- Patients
  - Access to shared care plans, assessments, tasks, education materials, secure messaging
  - No access to clinical notes
  - Can designate family/caregiver access

Care Navigator Monitoring & Reporting



- Customizable views, reports, dashboards
- Standard reports to:
  - Identify tasks & priorities for individual patients
  - Identify high and rising risk patients
  - Inform panel management
  - Manage care coordination across an agency, HSA, OCV
  - Capture RWJF Evaluation metrics
- Replace existing OCV reports:
  - Beneficiary Detail Report (BDR)
  - High Risk Patient Reports
  - Quarterly Care Coordination Reports

Transforming Complex Care Grant



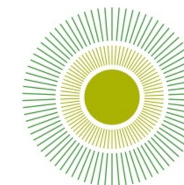
- Robert Wood Johnson Foundation
- May 2016 – May 2018
- Four pilot communities: Bennington, Berlin, Burlington, and St. Albans
- Supports communities to:
  - Refine and expand their approaches to providing care coordination for patients with complex care needs
  - Build upon and expand the work of the ICCMLC
  - Serve as the pilot communities for rollout of Care Navigator, informing the successful deployment and future enhancements

Expectations & Funding

- Engage OCV-attributed patients with complex care needs in care coordination activities and manage their care through Care Navigator
  - Participate in monthly user group calls
  - Utilize data and reports from Care Navigator
  - Participate in required grant evaluation activities
  - Year 1 target: engage 100 patients in care coordination activities by 05/14/17

- Funds are to set up sustainable structures and work flows to support care coordination
  - $40,000 per community over two years
  - Funds cannot to be used for care coordination of specific patients

2016 Care Navigator Timeline



May
Gather Focus Group feedback

June 30th CN early release to pilot communities

July
Outreach & training site visits to pilot communities

September
Expand CN to additional communities

October
Enhance patient engagement

December
Network-wide engagement

April
Set up CN software for OCV

June
Incorporate FG feedback into CN

July 29th
1st user group mtg

August 26
2nd user group mtg

September 30
3rd user group mtg

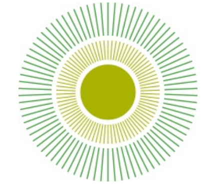
October 28
4th user group mtg

November 18
5th user group mtg

December 16
6th user group mtg

We are here

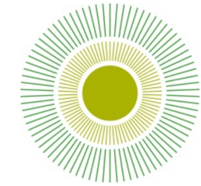
Contact Us



Leadership Contact	Sara Barry, MPH Director, Clinical and Quality Improvement	(802) 847-0932	Sara.Barry@onecarevt.org
Clinical Contact	Maura Crandall, RN, BSN, CCM Sr. Care Coordination Specialist	(802) 847-8062	Maura.Crandall@onecarevt.org
Technical Contact/ Help Desk	Kelley Beams Sr. Network Operations Specialist	(802) 847-0837	Kelley.Beams@onecarevt.org

CN Demo Patient Dashboard-

1. Patient Details and Activities and Notes



PATIENT : INFORMATION

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

Patient Details

General

First Name	Edwin	Gender *	Male
Middle Initial	P.	Race	--
Last Name *	Gonzalez	Preferred Language other than English	--
Date of Birth *	4/9/1950	Communication Challenge	Hearing Impaired
Marital Status	Married	COLST	No
Advance Directive	No		

Communication Details

Phone (Primary)	800-555-1212	Type (Primary)	Home	Address 1	250 Main St. St. Albans Vermont 08512
Phone (Secondary)	800-555-1215	Type (Secondary)	Mobile	Address 2	--
Email *	egonzalez@mycarenav.com			City	St. Albans Vermont
Preferred Contact Method	Mobile			State	Vermont
				ZIP	08512
				County	--

Activities and Notes

POSTS ACTIVITIES NOTES

All | Add Phone Call Add Task •••

Edwins-CarePlan1
Priority **Medium**
Modified by Ashuvinder Singh Yesterday

Edwin-Care-Plan
Priority **Medium**
Modified by Ashuvinder Singh Yesterday

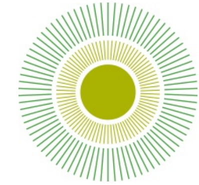
Placeholder
Priority **Medium**
Modified by Marvin Sugirin 6/9/2016 3:25 PM

Adequate rest
Adequate rest
Modified by Marvin Sugirin 5/31/2016 5:36 PM

Fatigue
Fatigue
Modified by Marvin Sugirin 5/27/2016 3:07 PM

Review patient goals
Add/update patient goals
Modified by Marvin Sugirin 5/27/2016 3:07 PM

CN Demo Patient Dashboard
2. Care Coordination Status



PATIENT : LAYOUT TEST

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Contact Method	Mobile	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

Care Coordination

Care Coordination Status Reengaged Acuity Level 3. Weekly contact

Care Coordination Status History

Created On	Care Coordination Status
6/13/2016 10:39 AM	Reengaged
6/9/2016 11:06 AM	Deceased
6/1/2016 2:05 PM	Engaged
6/1/2016 1:54 PM	Deceased

1 - 4 of 16 Page 1

Acuity Level History

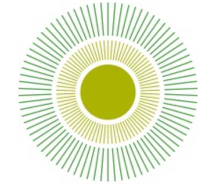
Created On	Acuity Level
6/1/2016 2:05 PM	3. Weekly contact
6/1/2016 1:18 PM	2. More than weekly contact
6/1/2016 1:18 PM	1. Needs daily contact

Care Plan

Patient	Created On
Edwin P. Gonzalez	4/14/2016 11:21 AM

CN Demo Patient Dashboard

3. About Me



PATIENT : INFORMATION

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

About Me

Preferred activities	Walking
How I learn	Verbal
Interaction Tips	I am hard of hearing
Communication Style	test1
Tips to avoid triggers/behaviors	test2
Physical Mobility	--
Mode of Transportation	Support Person
ED / Crisis Plan	I am hard of hearning so please write questions
Crisis Plan Uploaded	☐

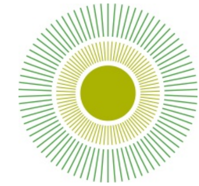
My Strengths

Strength ↑	Created On

You do not have permission to access these records. Contact your Micros...

CN Demo Patient Dashboard

4. Care Team Members



PATIENT : INFORMATION

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

Care Team Members

Care Coordinator Sandy Smith, CHW

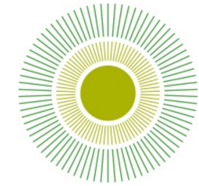
PCP Rajiv Patel, M.D.

Name ↑	Role (To) ↑	Mobile App Consent	Description
Betty Jones, RN	Nurse Care M...	Yes	Good Health Plan Nurse Care Manager
Evelyn Jimenez	Community H...	No	
Maria Gonzalez	Daughter	Yes	Edwin's daughter
Marvin Sugirin	Admin	Yes	

1 - 4 of 10 Page 1

CN Demo Patient Dashboard

5. ACO / Insurance Information



PATIENT : INFORMATION

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

ACO/Insurance Information

Attributed Health Service Area	St. Albans	Attributed TIN	--
Attributed ACO	--	Attributed provider	--
Payer	--	Attributed Practice	--
Member ID	--	Beneficiary Medicare Status	--
Opted out of data sharing	--	Dual Status Description	--
		Medicare Waiver Eligible	☑
		RWJF Grant	☑

Attribution History

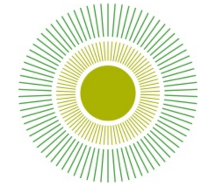
Date	Status
5/1/2014	Yes

Insurance Information

Insurance Plan ID	Group Name	Group Number	Insurance Company Nam...	Insured's ID Number	Plan Effective Date	Plar
CMS3456		99889	CMS-Medicaid	EG898989	1/1/2015	

CN Demo Patient Dashboard

6. Key Utilization Metrics



PATIENT : INFORMATION

Edwin P. Gonzalez

DoB *	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

Key Utilization Metrics- past 12 months

Risk Score	4
Risk Rank	--
Total Paid	--
In patient admissions past 12 months	3
All cause 30 day readmissions	0
Inpatient Total Days	25
ED Visits past 12 months	2
Skilled Nursing Facility Stays past 12 months	0
Hospice Days past 12 months	0
Home Health visits past 12 months	0

Hospitalizations

Discharge Date ↑	Admission Date	Hospital
4/29/2016	4/23/2016	Washington Hospital
4/9/2016	4/6/2016	Community Physicians Grou
1/27/2016	1/24/2016	University of Vermont Medi
6/16/2015	6/14/2015	Mercy Hope Hospital

1 - 4 of 5 Page 1

Risk Ratings

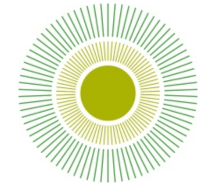
Date ↑	Risk Category	Risk Score
12/9/2014	High	9.0
3/16/2015	High	7.7
6/10/2015	Medium	4.0
9/24/2015	Medium	4.0

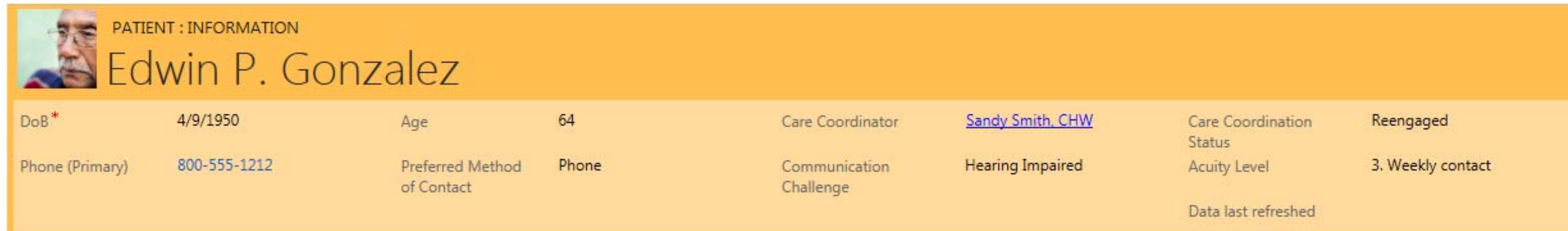
ED Encounters

Admission Date ↑	Hospital	Claim catego
3/30/2015	Mercy Hope Hospital	
2/18/2015	Mercy Hope Hospital	
12/30/2014	Mercy Mt. Healthy Hospital	

CN Demo Patient Dashboard

7. Documents / Encounters





Documents

Document Name	Document Type	Uploaded On ↓	Uploaded By
Transfer Summary	Clinical Summary	5/10/2016	Marvin Sugirin
Shared Care Plan - 26Jan16	Shared Care Plan	1/26/2016	Sandy Smith
Lab Results	Lab Results	4/9/2015	Sandy Smith
Clinical Summary	Clinical Summary	4/9/2015	Sandy Smith

1 - 4 of 4 Page 1 of 1

Patient Encounter Log

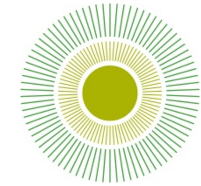
Date ↑	Type of Contact	Duration	Care Team Member	Was this encounter	No Show
11/17/2015 11:36...	Phone	15 minutes	Trish Ambrosio	Not Scheduled	No
11/18/2015 12:35...	In Person	15 minutes	Minute Clinic	Not Scheduled	No
11/20/2015 7:25 PM	In Person	45 minutes	Sandy Smith, CHW	Scheduled	No
5/26/2016 4:46 PM	In Person	15 minutes	Carl Cardiologist,...	Scheduled	No

1 - 4 of 5 Page 1

Active

Shared Care Plan

1. Goals- Personal / Treatment / Future



CARE PLAN : INFORMATION

Patient *	Edwin P. Gonzalez	DOB	4/9/1950	Age	64	Gender	Male
Phone (Home)	800-555-1212	Phone (Mobile)	800-555-1215				

Goals

Personal Goals

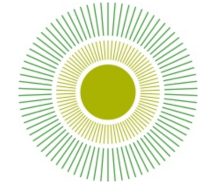
Goal Category	Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date
Alcohol / drug use	Placeholder	Edwin P....	Not Started		Medium		
Employment	Adequate rest	Edwin P....	Not Started	Patient	Medium	6/3/2016 2:55 PM	

Treatment Goals

Goal Category	Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date
	Review patient goals	Edwin P....	Not Started	Patient	Medium	2/11/2016 2:00 PM	1/27/2016 2:00 PM

Shared Care Plan

2. Referrals, Challenges/Barriers, and Appointments



CARE PLAN : INFORMATION

Patient *	Edwin P. Gonzalez	DOB	4/9/1950	Age	64	Gender	Male
Phone (Home)	800-555-1212	Phone (Mobile)	800-555-1215				

Medical Management

Referrals

Resources / Services

All Tasks

Challenges / Barriers

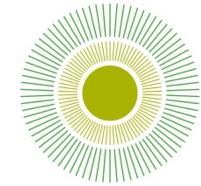
Barrier	Type of Barrier	Created On ↑
Transportation Issues	Access	7/20/2015 8:35 PM

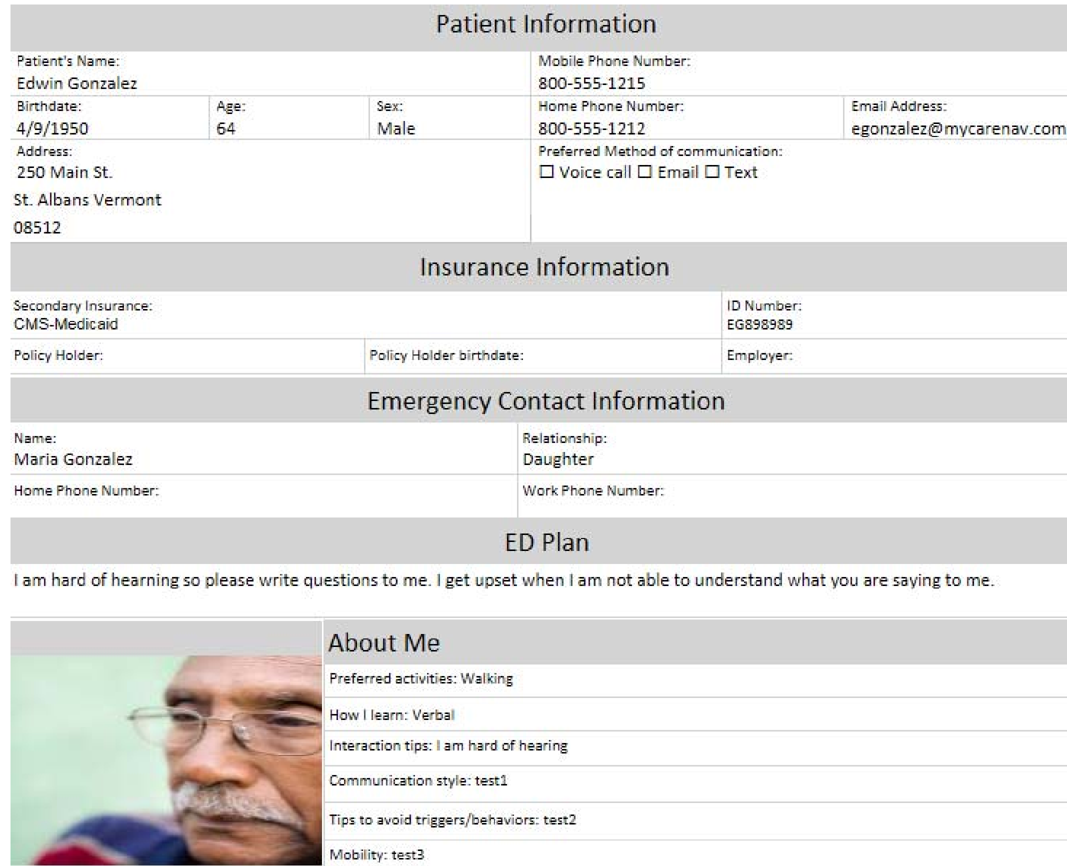
Appointments

Start Date ↑	Activity Name	Status	Duration	Required Attendees

No Appointment records found.

Shared Care Plan Document





Shared Care Plan

Patient Information				
Patient's Name: Edwin Gonzalez			Mobile Phone Number: 800-555-1215	
Birthdate: 4/9/1950	Age: 64	Sex: Male	Home Phone Number: 800-555-1212	Email Address: egonzalez@mycarenav.com
Address: 250 Main St. St. Albans Vermont 08512			Preferred Method of communication: ☐ Voice call ☐ Email ☐ Text	

Insurance Information		
Secondary Insurance: CMS-Medicaid		ID Number: EG898989
Policy Holder:	Policy Holder birthdate:	Employer:

Emergency Contact Information	
Name: Maria Gonzalez	Relationship: Daughter
Home Phone Number:	Work Phone Number:

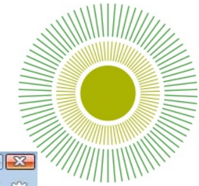
ED Plan
I am hard of hearning so please write questions to me. I get upset when I am not able to understand what you are saying to me.

About Me
Preferred activities: Walking
How I learn: Verbal
Interaction tips: I am hard of hearing
Communication style: test1
Tips to avoid triggers/behaviors: test2
Mobility: test3

My Care Plan

Edwin Gonzalez 4/9/1950

Assessments



https://onecarestaging.mycarenav.com/main.aspx#860974186

Patient: Edwin P. Gonzalez...

File Edit View Favorites Tools Help

Citrix Access Gateway haiku Suggested Sites Web Slice Gallery

Convert Select

Page Safety Tools

CARE NAVIGATOR Patients | Edwin P. Gonzalez | Create OneCareVermont Maura Crandall OneCare Staging

PATIENT : INFORMATION

Edwin P. Gonzalez

DoB*	4/9/1950	Age	64	Care Coordinator	Sandy Smith, CHW	Care Coordination Status	Reengaged
Phone (Primary)	800-555-1212	Preferred Method of Contact	Phone	Communication Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
						Data last refreshed	

+ New Questionnaire

Questionnaire: Food Insecurity Questions

- CAGE
- HRQOL
- HOMES
- Discharge Assessment
- PAM Survey
- Medication Adherence Survey
- Generalized Anxiety Scale
- Morisky Scale
- GAD-7 (Anxiety)
- PHQ-9 (Depression)
- Care Coordination Checklist
- Caregiver Strain Index Questionnaire
- Quality of Life Index
- Caregiver Self-Assessment
- Weight Management
- Diabetes Knowledge

1. Within the last 12 months we worried wheth... out before we got money to buy more.

2. Within the past 12 months the food we boug... we did not have money to get more.

Previous Next Save

1. Within the last 12 months we worried whether our food would run out before we got money to buy more.

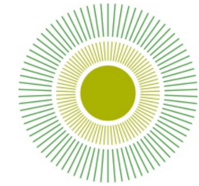
- Often true
- Sometimes true
- Never true

Notes

Save Note

Active

Care Coordinator Dashboard



My Tasks

Search for records

Activity Name	Regarding	Status	Assigned To	Priorit...	Estimated End Dat
Readmission risk eval	Edwin P....	Not Start...	Sandy Smith,...	High	
Stop smoking by 03/31...	Edwin P....	In Progress	Patient	High	3/31/2016 6:30 PI
About COPD	Carmela...	Not Start...	Patient	Med...	12/18/2015 4:26 PI
Administer GAD-7	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Administer PHQ2/9	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Administer PHQ2/9	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Assess sleep quality	Carmela...	Not Start...	Patient	Med...	12/18/2015 4:26 PI
Attend Diabetes Educat...	Edwin P....	Deferred	Patient	Med...	7/10/2015 5:00 PI

1 - 8 of 80 Page 1

My Appointments

Search for records

Start Date	Patient	Activity Name	Priority	Care P
6/13/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/13/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/14/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/14/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/15/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/15/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/16/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/16/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy

1 - 8 of 403 Page 1

My Patients

Search for records

Last Name	First Name	Date of Birth	Member ID	Risk Score	Inpa

No Patient records found.

what's new

POST

All records | Both Auto posts User posts

Welcome!

This is your personal wall, where you'll see news about the colleagues and records you follow.

1. Find and follow your colleagues
2. Comment on posts and other activity
3. Display your profile picture

0 followers

Start following c
and let people f
Learn more

Additional Materials: Attachment 5 – Making Comprehensive Shared Care Plans a Reality (Article)

Care Redesign

Making the Comprehensive Shared Care Plan a Reality

Article · May 18, 2016
Alex Baker, MPP, Kelly Cronin, MS, MPH, Patrick Conway, MD, MSc, Karen DeSalvo, MD, MPH, MSc, Rahul Rajkumar, MD, JD & Matthew Press, MD, MSc

U.S. Department of Health and Human Services

A central component of reforming the health care delivery system is improving the quality of care coordination, but clinicians and patients often lack the necessary tools. Care planning has always been a core part of nursing in acute care and institutional settings, and for patients with complex needs (e.g., dementia, end-stage renal disease, intellectual and developmental disabilities, HIV/AIDS). But many clinicians, including most physicians, are not familiar with using a care plan. Furthermore, although interventions that involve care plans have shown benefits, wide variation makes design and implementation challenging.

The care plan traditionally used in nursing has inspired interest in a new tool that is designed to support person-centered care by a multidisciplinary team: the comprehensive shared care plan (CSCP). As described by the National Partnership for Women and Families, the CSCP is not setting-specific; it uses information technology to enable the clinical team to collaborate seamlessly as they help address the full spectrum of the patient's needs across *all* care settings

and over time. Although barriers to widespread adoption still exist, we believe that robust collaboration between the health care and technology communities can help to advance this promising approach.

The Vision for Shared Care Plans

In April 2015, the U.S. Department of Health and Human Services (HHS) convened a diverse group of stakeholders (physicians, nurses, policymakers, and patient advocates) for a one-day listening session aimed at articulating a vision for CSCPs. Overall, this group conceived of a CSCP as a vehicle for secure, virtual exchange of information among clinicians who all care for a single patient, regardless of the clinicians' (and the patient's) locations.

People need a plan that anticipates changes in health status, links them to services early in their care trajectories, and helps them manage key transition periods in their lives."

The stakeholders concurred that today's care plans function more as "disaster recovery" efforts, initiated only after something has gone wrong. Instead, people need a plan that anticipates changes in health status, links them to services early in their care trajectories, and helps them manage key transition periods in their lives. Ultimately, the group concluded that a plan that focuses merely on clinical care is inadequate for meeting all of a person's needs — clinicians should instead strive to create a "total plan for health."

The group identified these key goals for a CSCP:

- It should allow a clinician to electronically view information that is directly relevant to his or her role in the care of the person; to easily identify which clinician is doing what; and to update other members of an interdisciplinary team on new developments.
- It should put the person's goals (captured in his or her own words) at the center of decision-making and give that individual direct access to his or her information in the CSCP.
- It should be holistic and describe both clinical and nonclinical (including home- and community-based) needs and services.
- It should follow the person through high-need episodes (e.g., acute illness), as well as periods of health improvement and maintenance.

Putting a CSCP into Practice

Some innovative communities and organizations have begun to implement tools that reflect this vision. Maimonides Medical Center's Brooklyn Health Home Consortium has developed an in-

teractive online tool for patients with multiple chronic conditions and serious mental illness, which enables multidisciplinary care teams across organizations to develop and maintain a dynamic plan of care in real time for enrollees. Different members of a care team across organizations can view the status of the care plan on a dashboard and make changes to the plan over time.

Through another New York City–based pilot initiative, under the Medicaid Delivery System Reform Incentive Program, physician practices are seeking to share and receive electronic care plans that are housed by qualified health-information exchange (HIE) entities in New York State. Clinicians who document a care plan for the patient can send it to their HIE, either as a structured clinical document or as a simple PDF. When a clinician requests a care plan, the qualified HIE will return any care plan it has on file and will query other qualified HIEs for care-plan documents for that patient. After completing interventions within the care plan or making other updates, the clinician can communicate these changes to a care manager, who will reconcile these for the next clinician's use. The end result: asynchronous collaboration among all members of the clinical care team.

The Path to Widespread Adoption

Interest in more widespread use of CSCPs is growing. To broaden the adoption of these tools, motivated organizations must confront three main barriers:

Operational. Implementing a CSCP in clinical settings is not easy. First, an organization must decide which individuals it serves are most likely to benefit from a CSCP. Care team members must agree on roles and responsibilities for accessing, exchanging, updating, and reconciling information in the plan.

They must also decide whether to designate an owner (curator) who manages access to the CSCP and reconciles changes. For example, some Medicaid health homes view the care manager as the driver of the care plan; others limit him or her to coordinating and implementing the decisions of the multidisciplinary care team. Organizations must also decide how patients can access and modify their CSCPs in a way that permits that access without overburdening clinicians.

To even begin to address these nuts-and-bolts issues, clinicians must become more familiar with CSCPs, learn what works for them and their patients, and then lead the way in defining CSCP design and function. Team-based care in medical education and training can help lay a foundation of knowledge and experience. Health services and implementation-science researchers also can help advance the field by rigorously evaluating care plans to identify their

most effective form and function.

The CSCP is not setting-specific; it uses information technology to enable the clinical team to collaborate seamlessly as they help address the full spectrum of the patient's needs across all care settings and over time."

Technological. Ensuring easy access to CSCPs, by patients and clinicians alike, and efficient integration into clinical workflows requires well-designed technology with user-friendly interfaces that foster patient, caregiver, and clinician engagement. Clinicians must also be able to seamlessly share CSCPs across settings that use different IT systems. In the past several years, public and private stakeholders have taken a first step toward developing a technical standard for exchanging CSCP documents, which is now included in the HHS Office of the National Coordinator Health IT Certification Program. Technology companies must be willing to innovatively build on this standard, driven in part by demand from the health care community and from patients, families, and caregivers.

Financial. Creating the right set of care-coordination tools will not happen without appropriate investments from both clinicians and technology developers. Alternative payment models that reward quality and value — including accountable care organizations (ACOs), advanced primary care medical homes, and bundled payments — are likely to play a major role in creating the demand for CSCPs and other care-coordination tools in coming years. To succeed in these models, clinicians must make measurable improvements in outcomes, service utilization, and costs. Better care coordination, enabled by tools such as CSCPs, will help them reach those goals.

Government's Role

Stakeholders have emphasized the importance of aligning CSCP requirements at the local, state, and federal levels — from Medicare requirements for home-health agencies, to state requirements for Medicaid health homes, to home- and community-based services (HCBS) performance measurement, to requirements for physicians who provide enhanced monthly care management to Medicare patients with chronic conditions through Medicare's Chronic Care Management code. Federal and state funding, such as federal Medicaid matching funds that states can access under the HITECH Act, might also be available to support CSCP adoption.

Alternative payment models that reward quality

Through efforts such as the Comprehensive Primary Care Initiative, the Transforming Clinical Practice Initiative, and the Testing Experience and Functional Tools grants, the

and value . . . are likely to play a major role in creating the demand for CSCPs and other care-coordination tools in coming years."

federal government can accelerate learning about CSCPs and other care-coordination tools. These efforts feature robust learning systems that offer technical assistance to participating providers and disseminate best practices from high-achievers. In addition, the Agency for Healthcare Research and Quality recently announced a funding opportunity for the development, implementation, and evaluation of care plans and related tools and strategies to promote care coordination in patients with multiple chronic conditions. Finally, HHS's Office of the National Coordinator for Health Information Technology and the Centers for Medicare and Medicaid Services are partnering with stakeholders to create a new framework for an electronic Long-term Services and Supports (eLTSS) plan. Six states are now testing eLTSS plans in Medicaid to improve the coordination of health and social services that support individuals' mental and physical health.

***

To realize the benefits of comprehensive shared care plans, government, private industry, consumers, academic communities, and an array of clinicians and other providers must work together, not unlike the way in which CSCPs enable clinicians to collaborate on a smaller scale. Only through such coordination can we achieve a more connected, person-centered health care delivery system.

The views expressed in this article are those of the authors and do not necessarily represent the views or policy of the Centers for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology.

Alex Baker, MPP

Senior Policy Analyst, Office of Care Transformation, Office of the National Coordinator for Health IT, U.S. Department of Health and Human Services

Kelly Cronin, MS, MPH

Director, Office of Care Transformation, Office of the National Coordinator for Health

IT, U.S. Department of Health and Human Services

Patrick Conway, MD, MSc

Principal Deputy Administrator and Chief Medical Officer, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Karen DeSalvo, MD, MPH, MSc

National Coordinator for Health Information Technology, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services

Rahul Rajkumar, MD, JD

former Deputy Director, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Matthew Press, MD, MSc

Senior Advisor, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

DISCUSS + ADD A RESPONSE

SHARE

13 68

TOPICS

Care Integration | Coordinated Care | Health Information Technology | Leading Teams | Medicare | Patient-Centered Care

NEJM Catalyst | MAYO CLINIC
Free Live Web Event
Leadership: Translating Challenge...
JUNE 2 2016
1:00 – 5:00 pm U.S. CT

Have an Article Idea for NEJM Catalyst?

Share It With Us

Connect

A weekly email newsletter featuring the latest actionable ideas and practical innovations from NEJM Catalyst.

FIRST NAME*

LAST NAME*

EMAIL ADDRESS*

PROFESSIONAL CATEGORY*

Please select the professional category that best describes your primary role.

- Please Select -

TYPE OF ORGANIZATION*

- Please Select -

NAME OF ORGANIZATION

COUNTRY*

- Please Select -

Stay Informed

LEARN MORE »

More From Care Redesign

Insights in Detail: Identifying the Barriers to Improving Care, and Overcoming Them

INSIGHTS REPORT *by* ANNA M. ROTH & EDWARD PREWITT

What do we mean when we say "value" in care?

Collaborative Care for Depression in a Safety-Net Health System

CASE STUDY *by* JESSICA BLACK, DAVE A. CHOKSHI, MONICA GOULD & JESSE SINGER

Integrating depression treatment into primary care in New York City's public system.

A Grassroots Approach to Care Redesign

BLOG POST *by* **KARL R. LASKOWSKI, SARAH K. ABBETT & JESSICA C. DUDLEY**

Brigham Care Redesign Incubator and Startup Program (BCRISP) draws out ideas from frontline clinicians to create real innovation in health care.

Immersion Day — Transforming Governance and Policy by Putting on Scrubs

ARTICLE *by* **RICHARD W. BOCK & RONALD A. PAULUS**

Board members and thought leaders spend hours 'behind the scenes' in an effort to better understand, and thus improve, their region's health.

How We Dramatically Reduced Suicide

CASE STUDY *by* **M. JUSTIN COFFEY & C. EDWARD COFFEY**

If depression care were truly perfect, no patient would die from suicide.

Health Care Organizations to Emulate

INTERVIEW *by* **THOMAS H. LEE & MARK R. CHASSIN**

Examples of organizations making leaps and bounds in safety, efficiency, culture, and cost.

Can Community Paramedicine Meet Patient Needs for Access and Quality?

ARTICLE *by* **LISA I. IEZZONI, STEPHEN C. DORNER & TOYIN AJAYI**

The growing use of emergency medical technicians (EMTs) and paramedics raises important questions about training, oversight, and care coordination. Communities and regulators should recognize the value of paramedicine and work to integrate it into the health care delivery system.

How We Improved Hospitalist-Patient Communication

CASE STUDY *by* **SUPARNA DUTTA, FRANCIS FULLAM & JAY M. BEHEL**

Easy-to-use tools, honest feedback, and incentives improved patient satisfaction scores.

Care Redesign Report: Why Population Health Management Is Undervalued

INSIGHTS REPORT *by* **AMY COMPTON-PHILLIPS**

Analysis of the first NEJM Catalyst Insights Council survey on the Care Redesign theme.

Engaging Physicians in Telehealth

ARTICLE *by* **ROBERT M. PEARL**

The what, the why, and the how

Connect

A weekly email newsletter featuring the latest actionable ideas and practical innovations from NEJM Catalyst.

FIRST NAME*

LAST NAME*

EMAIL ADDRESS*

PROFESSIONAL CATEGORY*

Please select the professional category that best describes your primary role.

- Please Select -

TYPE OF ORGANIZATION*

- Please Select -

NAME OF ORGANIZATION

COUNTRY*

- Please Select -

Stay Informed

LEARN MORE »

Topics

Population Health Management

30 Articles

Insights in Detail: Identifying the Barriers...

INSIGHTS REPORT *by* ANNA M. ROTH & EDWARD PREWITT

What do we mean when we say "value" in care?

Social Needs

18 Articles

Why Does Utah Rank So High...

ARTICLE *by* ELIZABETH GARDNER

The jury is still out, but demographics and the innovations of two large providers in...

Quality Management

22 Articles

The Pain That Results From Pain...

BLOG POST *by* THOMAS H. LEE

Pain measurement has been charged as a cause of the opioid epidemic. And in fact,...

Insights Council

Have a voice. Join other health care leaders effecting change, shaping tomorrow.

Apply Now

SEND ME NEJM CATALYST CONNECT BY EMAIL:

EMAIL

Submit

THEMES

Care Redesign
New Marketplace
Patient Engagement

BROWSE

Articles
Blog
Cases
Clips
Insights
Interviews
Talks
Topics

INSIGHTS COUNCIL

About
Sign In
Join

EVENTS

Explore

ABOUT

NEJM Catalyst
Thought Leaders
Sponsorship
Team
Contact Us
Press
Submissions
Reprints
Terms of Use
Privacy Policy

NEJM Catalyst is a product of NEJM Group, a division of the Massachusetts Medical Society.
Copyright ©2016 Massachusetts Medical Society. All rights reserved.