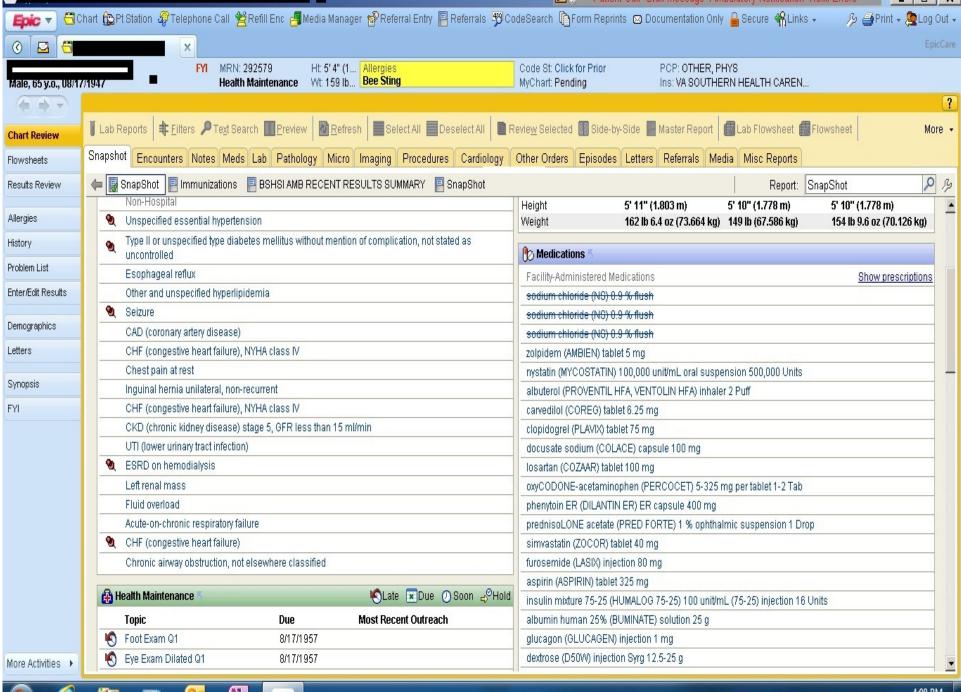
Why Patient Centered Medical Home?

- Improve Access
 - Expand hours of operation
 - TTNA improvement
 - Advice line and triage protocol
 - Coordinate Urgent Care access
- Increase Patient Engagement
 - Nurse Navigator Hotline
 - Care Team approach
 - MyChart offer eVisits and electronic access to care
- Improve Population Health
 - Use Registries for outreach
 - Incorporate HRA data into EMR
 - Use in Care Plan development

- Provide Care Management
 - Embedded Nurse Navigators
 - Discharge Registry for f/u
 - Identify Gaps in Care
 - Outreach to High Utilizers
- Use Evidenced Based Medicine
 - o ID top 3 conditions
 - Develop registry for each
 - Use appropriate medications
 - Reduce unnecessary tests, consults and procedures
 - Reduce use of sample meds
- Tracking and Coordination of Care
 - Use preferred specialists
 - Track and reconcile Referrals









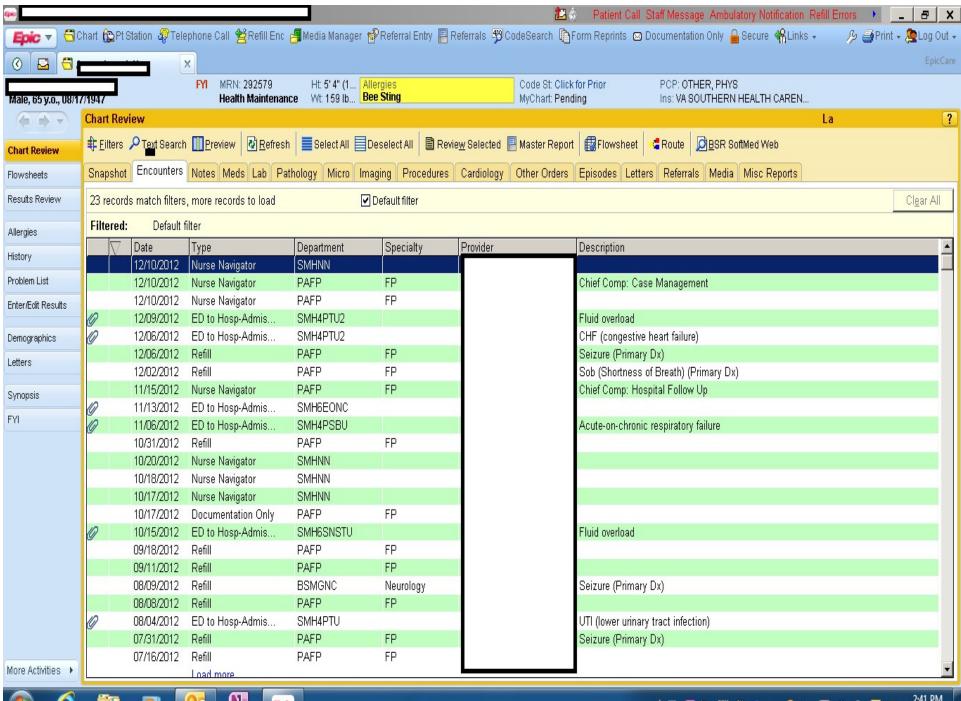




















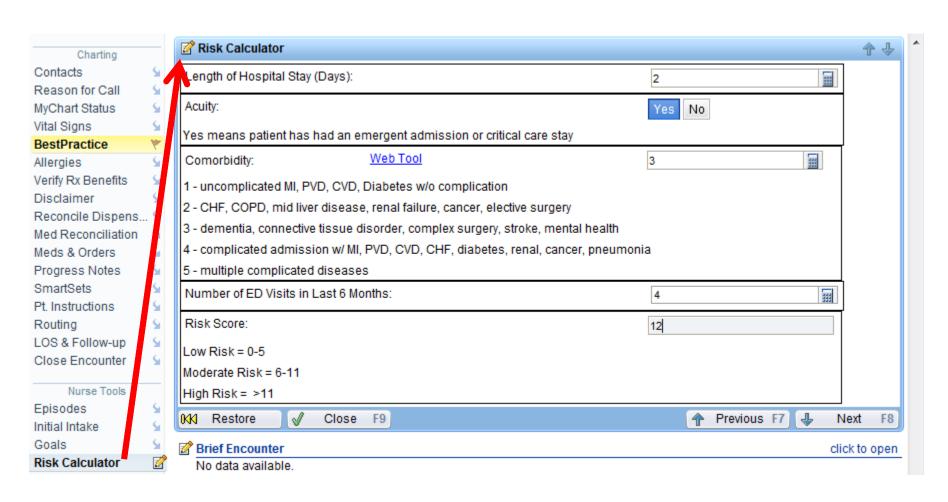








LACE Scoring Index to Reduce Readmissions



High Risk Patient

• He meets our criteria for high risk:

LACE score is greater then 11:readmission rate is risk.

In addition he is male, poor support system in place, he was discharged on a Friday and readmitted on a Sunday.

Charleston Co-morbidity Scale is 10 with a 50% survival rate in one year

Receiving his care in the Emergency Room and Hospital for the past year.

Month	Total Patients	# Reache d	# with at Least One Goal Set	One Goal	Total counted in Readmit Stats (Denominator)	# with Post Hosp Readmiss ion (Numerat or)	30 DAY READMISSIO N RATE	# with Other ED
Dec-11	182	104	63	22	138	0	0.00%	1
Jan-12	385	224	166	75	328	1	0.30%	2
Feb-12	499	325	322	177	439	13	2.96%	9
Mar-12	671	443	414	279	614	15	2.44%	11
Apr-12	587	402	361	194	546	9	1.65%	11
May-12	624	400	359	215	572	3	0.52%	5
Jun-12	556	362	273	153	494	4	0.81%	3
Jul-12	652	432	326	222	609	5	0.82%	8
Aug-12	763	502	429	300	685	2	0.29%	12
Sep-12	600	424	420	260	548	8	1.46%	11
Oct-12	820	533	590	315	746	10	1.34%	13
Nov-12	649	430	467	270	581	12	2.07%	11