

PROSPECTUS



Better Health and Lower Costs for Patients with Complex Needs

An IHI Triple Aim Collaborative

July 2015 - June 2016



Institute for
Healthcare
Improvement



Contents

Executive Summary	3
Why Participate?	5
Who Should Participate?	5
Approach	6
System of Measurement	8
Learning Activities	9
Expectations of the Participating Sites	11
To Enroll	12
To Learn More	12
Appendix	13
References	15

Executive Summary

Overview

To accelerate the improvement of care for complex and high-cost patients, IHI invites you to join *Better Health and Lower Costs for Patients with Complex Needs (BHLC)*, an IHI Collaborative beginning July 2015. This initiative will help you plan and implement comprehensive care designs that serve the needs of your most complex, high-risk, and costly patients, resulting in better health outcomes, a better care experience, and lower total cost. Whether your organization has already established a program or is just starting this work, our goal is to help you make a positive and sustainable difference for this population.

This second year for the BHLC Collaborative will have two tracks. Organizations can customize participation by engaging in one or both tracks according to what will support their work. Here is a description of the two tracks:

Foundations of Care Redesign: The focus of this track will be to move through a well-tested process to design services to impact outcomes and costs for individuals with complex needs within each organization's unique context. Teams will be supported in robust, iterative learning about their complex population, testing of interventions that are necessary to reduce high utilization and improve outcomes, and the development of a care model to deliver necessary services. Using IHI's improvement methods, teams will learn on a small scale to develop confidence that the care model is likely to impact outcomes and costs before devoting significant resources to scaling it up. The development of measurement and robust learning systems is a key aspect of the Foundations of Care Redesign track.

The goals of the Foundations of Care Redesign track within 12 months are as follows:

- Identify a specific high-risk population that will be the focus of your work;
- Deeply understand the assets and needs of your target population to inform the services needed to improve outcomes;
- Develop and execute new care designs to test for impact and cost savings;
- Increase the scale and reach of successful care designs, and learn what is needed for operational and financially sustainable programs; and
- Establish process and outcome measures to track health, patient experience, and cost savings using available data.

Participation in this track is best suited for organizations that are in the process of developing and testing care models to impact their target complex populations before committing resources to scale up the program to serve more individuals. In addition, organizations that have existing care designs and wish to further refine their models for greater impact can use the methods in this track. New members of teams that participated in the first year of this Collaborative will also benefit from this track.

Scale-up and Sustainability: The focus of this track will be on supporting teams to expand existing care models so that they are able to serve more individuals who need the enhanced care until all individuals who need the care are reached. A focus on deep and iterative learning to ensure operational and financial sustainability and continued impact on outcomes and costs will drive this

track. This track is for organizations that have a care model in place and some degree of confidence that the model will improve outcomes at lower costs for their target population. Case-based learning from the teams in the Collaborative and real-time coaching of teams on calls and will characterize this track. Monthly webinars will be team driven, as teams share aspects of their care model and their efforts to reach scale. Faculty will offer real-time coaching to foster progress and resolve challenges.

The goals of the Scale-up and Sustainability Track within 12 months are as follows:

- Achieve scale-up of enhanced care designs and approach full scale, i.e., reach all individuals who would benefit from the care model;
- Develop reliable work processes to support effective delivery of enhanced care to the target population at scale;
- Develop robust learning systems during scale-up to support operationally and financially sustainable enhanced care programs for the target population; and
- Demonstrate positive outcomes in at least two of the three prongs of the Triple Aim: health outcomes, patient experience, and costs.

Timeline

Better Health and Lower Costs for Patients with Complex Needs will begin in July 2015 and will last 12 months. Participants will build and use a robust infrastructure for measurement and improvement, whether they are new to this work or focused on scale-up.

July through August 2015: Teams continuing in the BHLC Collaborative from year 1 will be supported in doing a "mid-action review." The goals of the mid-action review will be to assess progress from year 1, identify strengths and gaps, and develop goals and an action plan for year 2. IHI will offer a structured assessment tool to support this work. Each continuing team will have individual team calls with IHI faculty to support this process.

New teams and new team members will prepare for the work of the BHLC Collaborative by focusing on the following activities: set-up, prework, and learning about the Triple Aim framework under which this work resides. Structured prework guidance will be provided and a series of calls will support the new team preparation.

September 2015 through June 2016: Full Collaborative learning activities are described below.

Participation Criteria

This Collaborative is appropriate for organizations committed to better and more cost-effective care of their most complex and costly populations. Typically, these organizations are physician groups managing risk, integrated health systems, or health plans, but they may also be coalitions of health care providers, health plans, safety net systems, and community partners. Community coalitions seeking to improve the health of their communities and reduce overall health care costs are also appropriate groups to participate.

Program Fee

The cost for one year of participation is \$20,000. Interested organizations are encouraged to partner with health care, health plan, and community participants. A limited number of partial scholarships are available for safety-net organizations.

Contact

For further information, please e-mail BetterHealthLowerCosts@ihi.org.

Why Participate?

Health care organizations across the United States and the world recognize that a small percentage of the population generates a disproportionately large portion of health care costs. In the United States, 5 percent of the patient population generally represents 50 percent of total cost across all payers. This portion of the population is complex and dynamic. These patients may struggle with factors such as chronic physical and mental illness, poverty, and social isolation, and they may move in and out of the high-need category as their circumstances change. High utilization rates coupled with poor outcomes tell us that the standard care system is not working for these individuals. As a result, care of this population is often chaotic, wastes resources, and places significant burdens on patients and staff. Communities are also harmed by ever-rising health care spending as there are fewer resources to devote to other significant needs such as education, job development and training, human services, and infrastructure development, to name a few. The urgency to improve care for these patients is growing as systems in the United States and other countries place more emphasis on care continuity, patient-centeredness, and reducing overall cost.

IHI has been working with more than 180 organizations around the world for a number of years on population management with a focus on improving care, cost, and health for the population of patients with complex needs. Organizations that listen deeply to patients' stories are able to co-design care approaches with patients to boost health and experience while driving down total cost. This work shows that, in many cases, better care designs and greater patient and community engagement can result in financially sustainable programs that improve health outcomes at lower cost.

Who Should Participate?

Organizations that provide (or plan to provide) care for defined population groups while bearing the financial risk of caring for those groups will benefit from participation in this Collaborative. Typically, participants are health systems, but community organizations working to improve the welfare of a geographically defined population will also benefit. Participants may include the following:

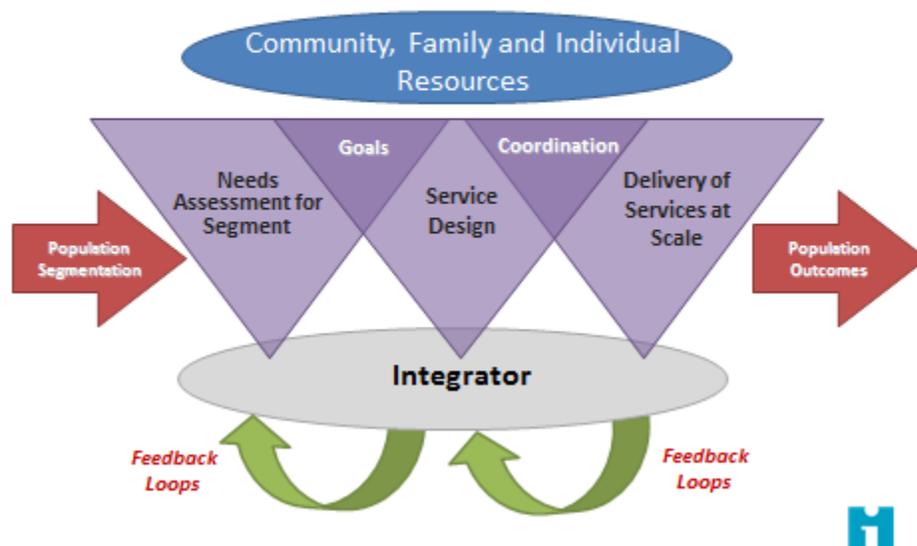
- Integrated systems of health delivery and financing operating anywhere in the world
- Accountable Care Organizations (ACOs) or integrated delivery systems that are pursuing other new payment models
- Physician group ACOs
- Private or public employers seeking better health and value for employees

- Private or publicly funded health plans committed to improving value
- Organizations embarking on innovative, population-focused designs
- Safety-net health care systems facing rising demand and flat budgets
- Regional coalitions collaborating on a community-wide health issue or working to ensure access for all while controlling costs
- Public health departments or social agencies focused on populations with complex health issues
- Primary care or multi-specialty physician groups interested in risk sharing and cost savings arrangements

Approach

Better Health and Lower Costs for Patients with Complex Needs is based upon the framework of the IHI Triple Aim and incorporates key lessons from over eight years of intensive work in this area (<http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.asp>). The diagram below depicts the framework that participants will use to develop new models of care for their complex populations. Organizations participating in the Collaborative will ideally seek to manage this sequence of steps—needs assessment, service design, and delivery of services at scale—in coordination with a broad set of stakeholders and community resources to produce improved outcomes at a population level. IHI calls these coordinating organizations “integrators.”

Managing Services for a Population



Population Identification and Segmentation

Many patients who generate very high costs in a given year are experiencing temporary crises that will be resolved in a short period of time. Others, however, may have complex needs over an extended time. This Collaborative will focus on the latter group. IHI recommends using a blend of methods to identify the persistently high-risk segment of the population, including reviewing past utilization and cost data, engaging with front-line providers to gather qualitative information about high-risk patients, and engaging in direct dialogue with individual patients with complex ongoing needs.

Strengths and Needs Assessment

After teams select a segment of their population with complex and costly needs, they will assess the specific strengths and needs of this segment. For example, a team focusing on a “tri-morbid” population—that is, a population coping with mental health issues, chronic physical illness, and substance abuse—would account for all three areas of need, coping strategies, and existing supports in their assessment. The function of the assessment is to clearly articulate the goals in caring for this population and to begin to outline key community partners who will be integral to fostering better health and cost outcomes.

Service Design

This phase focuses on the actual design of care for the population of focus. It includes all relevant stakeholders and addresses the needs and goals articulated in the previous phase. In some cases, teams will discover that new services need to be created. However, teams often find that many or most of the right services already exist in some form in their organization or community, but that these services are not well integrated or available at the necessary scale. Similarly, teams learn from patients why certain interventions are not impactful, and are able to co-design new approaches that are more likely to succeed. At a high level, this phase will help teams address system-level challenges related to mobilizing the support of leadership, using reliability science, promoting effective teamwork across care settings, employing human-centered care designs, and developing an understanding of the social determinants of health.

Delivery of New Services at Scale

Once teams understand their population’s needs and redesign services, their next challenge is to find a way to deliver these services efficiently to all individuals in the population. Many failures occur when organizations attempt to jump directly from a successful pilot to full-scale implementation. IHI recommends increasing the scale of testing and learning in fivefold (5x) increments (e.g., 5 patients to 25 patients to 125 patients and so forth). This enables teams to discover and address previously unknown system constraints; it also allows teams to spot opportunities for efficiency. The Foundations of Care Redesign track will help teams design an impactful care model to scale up, and the Scale-up and Sustainability track will help teams learn their way to delivering the successful and sustainable care model to all those in their population who will benefit from it.

Expanding Capabilities of “Integrator” Organizations

In addition to developing new care designs for the chosen complex population, teams will learn ways to coordinate the efforts of many stakeholders who are working together to improve outcomes for their population. For instance, participants will learn to build and support effective multi-disciplinary and multi-stakeholder teams.

Project leaders for BHLC teams will be supported in their development as a leader of improvement through a series of calls focused on leading improvement with other BHLC team leaders. The goal of these calls is to support the development of leadership, management, and project implementation skills among change leaders. In addition, BHLC team leaders have ready access to IHI staff to talk through issues and challenges.

System of Measurement

Participants in the Collaborative will develop measures of outcomes at the population level related to care, health, and cost. Sample measures are shown below. A more detailed description of measurement strategies for the IHI Triple Aim is available on the IHI website.¹

Component	Measures
Population Health	Self-rated health status
Cost	Total per capita cost; hospital and emergency department utilization rates
Experience of care	Individual perception of experience (survey); control of physiological factors such as blood pressure; readmissions and ambulatory care-sensitive hospitalizations

Participants will begin the process of developing measures by identifying and exploring currently available data from a range of sources. Next, they will identify appropriate project-level measures for both outcomes (e.g., percent of the population achieving health goals or placed in permanent housing) and processes likely to lead to those outcomes (e.g., number of patients referred to a community health worker or percent of patients screened for depression). The project-level measures will link logically to the care designs being tested and will be used throughout the Collaborative to track progress towards intended outcomes. Participants will gather and display time series data on process and outcome measures and will integrate the data to drive further improvement in care.

The focus for sites scaling up will be on increasing evidence of improvement through measuring the impact the work with complex needs patients has on the outcomes for the total population. The use of comparison groups to increase evidence will also be included.

Learning Activities

Better Health and Lower Costs for Patients with Complex Needs is patterned on IHI’s Breakthrough Series Collaborative Model.² Using an “all teach, all learn” philosophy, Collaboratives include pre-work, team coaching, face-to-face meetings, and web-based meetings where teams learn from our expert faculty (see Appendix) and each other. The schedule of activities is below. Some of these activities will focus on topics relevant to all teams, and others will focus on special topics.

2015-2016 Schedule of Activities

	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016
Mid-Action Review for teams continuing from BHLC Year 1	●	●										
Getting Started Pework Calls	●	●										
Building Infrastructure Call Series		●	●									
Collaborative Kick-Off			●									
Scale-up and Sustainability Track				●		●	●			●		●
Foundations of Care Redesign Track				●		●	●			●		●
Measurement Calls			●	●	●		●		●		●	
BHLC Project Leaders Calls		●		●		●	●		●	●		
Learning Sessions					●			●			●	
Action Periods												

- **Mid-Action Reviews for teams continuing from BHLC Year 1:** Teams continuing in the BHLC Collaborative from year 1 will be supported in doing a "mid-action review." The goals of the mid-action review will be to assess progress from year 1, identify strengths and gaps, and develop goals and an action plan for year 2. IHI will offer a structured assessment tool to support this work. Each continuing team will have individual team calls with IHI faculty to support this process.
- **Getting Started:** Getting Started activities are for teams new to the BHLC Collaborative, independent of which track(s) they will be engaged with. New team members to teams continuing in the BHLC Collaborative will also benefit. The activities will orient participants to the overall Collaborative activities, faculty and staff, and communication methods. Participants will organize their improvement teams, gather data on potential focus populations, identify data sources and measures, identify partners and assets within their communities, and assess their team's current level of expertise in using improvement methods. During this period, teams will also begin to connect to the learning community and gain access to IHI's Extranet and listserv for participants.
- **Building and Enhancing Infrastructure:** Sites will participate in a series of webinars focused on building the infrastructure necessary to pursue population management and achieve better health outcomes and better patient experience of care at lower costs for this population of focus. Using web-based calls, the IHI faculty will introduce principles and coach teams through a sequence of key activities, including population selection, development of a cogent purpose, team formation, development of a measurement system and a portfolio of projects, and approaches to reducing costs. The infrastructure phase will yield a specific plan for each site that will be the focus of their work for the remainder of the Collaborative.
- **Learning Sessions:** Teams will convene for one in-person and two all-day virtual Learning Sessions. These meetings provide an opportunity for learning, networking, and refinement of action plans. We strongly encourage the participation of two to five members of your team at all three meetings. For those who cannot attend the in-person meeting, there will be an option to participate virtually in selected sessions. Teams will come to Learning Sessions with a summary of their work to date, usually in the form of a storyboard presentation that will be shared with all of the other participants. Learning Sessions will be structured with some all-Collaborative content and activities and focused time in each track.
- **Action Periods:** During the action periods between Learning Sessions, all teams will test interventions using rapid Plan-Do-Study-Act (PDSA) cycles to advance their individual program plans. Action periods are devoted to testing new changes and to spreading those that have shown success. The intent is for participants to scale up from smaller to larger populations as quickly as possible. Teams will participate in the all-team calls described below. Teams will report bi-monthly on their activities and measures using a Storyboard format that will build over time. Reporting will include what the team is testing, learning, challenges, and data over time based on their measurement strategy.
- **BHLC Webinars:**
 - Scale-up and Sustainability Track
 - Foundations of Care Redesign Track
 - BHLC Project Leaders Calls

- **Special Topics:** In addition to a focus on the BHLC process and Change Package, special topics that support the teams in their work will be built into the call and Learning Session structure. Topics will be chosen based on the needs of the teams. Potential topics include:
 - Trauma-informed care
 - Guiding principles for developing a business case for the enhanced care model
 - Forming successful and strategic partnerships and engage stakeholders
 - Strengthening the leadership/governance structure
 - Palliative care
 - Peer-delivered services
 - Behavioral Health Integration (Mental Health, Substance Abuse)
 - Impacting social determinants of health
- **Links to Other IHI Programming:** As needed, IHI faculty members will refer teams to additional IHI improvement training related to their content focus.

Throughout the Collaborative, participants will have access to:

- Guidance from our expert faculty on the key content and methodologies necessary to design care models that deliver cost savings and higher-quality care. This guidance will be customized to each organization's unique context and population of focus.
- Guidance on testing, implementing, and scaling up new care models, with a focus on achieving financial sustainability.
- Support around measurement strategies and data collection.
- Coaching to build each team's capability to learn what works in its setting, using the methodologies and knowledge in the Collaborative.
- Opportunities to explore additional onsite and virtual coaching services beyond the activities of the Collaborative.
- Expertise of colleague organizations participating in the Collaborative.

Expectations of the Participating Sites

To succeed in the *Better Health and Lower Costs for Patients with Complex Needs* Collaborative, participating sites will need to exhibit certain characteristics:

- **Senior Leadership Support:** Because of the strategic and challenging nature of improving care, cost, and health for complex populations, participating teams must have the explicit support of their senior leadership, and these leaders must stay actively connected to the team's work. To maximize results, the Collaborative should be a recognized priority supported by each organization's senior leadership and governing board. The IHI team will convene the senior leaders periodically through a series of calls and will dedicate time during Learning Sessions to discuss leadership and governance.
- **Dedicated Project Resources:** The organization's identified senior leader should appoint a high-level project leader to head the Collaborative team. This project leader will oversee the day-to-day activities of the team and needs the time, resources, and accountability to succeed.

Because of the challenges in securing population-level data, we strongly recommend also designating a data and measurement lead. Depending on the scope of the project, we estimate this project leader will need to dedicate 20% to 40% of their time. A multidisciplinary team focused on the activities of the Collaborative generally consists of 6-10 members who may represent a wide range of stakeholders, including clinicians, workers providing wrap-around care to patients, executive leaders, patients, community partners, and payers.

- **Improvement Skills and a Record of Successful Improvement:** Succeeding in this work requires strong improvement capabilities. Successful participants will commit to learning quality improvement methods or already be skilled and agile in using the Model for Improvement or other improvement methods. These include iterative learning through running small tests of change, testing new designs at ever-increasing scale, and implementing change throughout the system or community. IHI has a wide array of programming that can help bolster the improvement skills of team members and community partners.
- **Dedicated Support for Measurement and Data Infrastructure:** Few organizations or coalitions have all the data they need to understand and improve care for their patients with complex needs. In addition to using the data already available, most participants will need to develop new ways to collect and use data, including looking beyond their own data systems to external sources. The IHI team will convene the measurement leads from each team via periodic coaching calls to work through common measurement challenges.
- **Partnering and Inclusion:** Participating organizations will need to reach beyond their usual boundaries to develop multi-stakeholder partnerships. Partnering relationships often include health care organizations and groups such as social service agencies, local governments, public health departments, educational institutions, employers, and other community groups. These partnerships may also include civic, religious, and other non-profit or voluntary organizations focused on improving the health of the community. IHI encourages participating sites to include patient, family, and community representatives as active team members.

To Enroll

If your system or coalition is interested in enrolling in the *Better Health and Lower Costs for Patients with Complex Needs Collaborative*, please e-mail BetterHealthLowerCosts@ihi.org. We welcome new teams to join the Collaborative through August 2015. Teams are encouraged to enroll at least one month prior to the September kick-off to allow sufficient time for onboarding and pre-work.

To Learn More

Join an upcoming informational call, led by faculty members Catherine Craig and Cory Sevin, on March 31 from 1:00 PM - 1:45 PM EST. A second informational call will be held on May 12 from 1:00 PM - 1:45 PM EST. Visit ihi.org/BetterHealthLowerCosts or e-mail BetterHealthLowerCosts@ihi.org for connection details.

IHI faculty members are also available for individual calls with interested organizations. If you would like to set up a conversation with a member of our faculty to talk about this opportunity, please e-mail BetterHealthLowerCosts@ihi.org.

Appendix

Core Faculty

Catherine Craig, MPA, MSW, has more than 15 years of experience in systems change and bridging research and practice. She has been Triple Aim faculty since 2009, and was a founding managing director of Community Solutions, a national nonprofit where she served as the director of healthy communities. Before that, she was a research scientist at the New York City Department of Health and Mental Hygiene, where she designed and led learning Collaboratives to boost mental health outcomes, and a consultant to the Fire Department of New York in its successful effort to boost minority applicants to the firefighting academy. Ms. Craig has deployed her clinical social work skills with diverse populations in inpatient and community settings in the United States and Latin America. She is currently an independent consultant based in France.

Dr. Alan Glaseroff, MD, is Co-Director of Stanford Coordinated Care, a service for patients with complex chronic illness. He is a member of the Innovation Brain Trust for the UniteHERE Health and a Clinical Advisor to the PBGH “Intensive Outpatient Care Program” CMMI Innovation Grant that began in July 2012. Dr. Glaseroff served on the NCQA Patient-Centered Medical Home Advisory Committee in 2009-2010, and the “Let’s Get Healthy California” expert task force in 2012. He was named the California Family Physician of the Year for 2009. His interests focus on the intersection of the meaning of patient-centered care, patient activation, and the key role of self-management within the context of chronic conditions.

Ann Lindsay, MD, is Co-Director of Stanford Coordinated Care (SCC). SCC is capitated for primary care of Stanford employees and adult dependents with complex chronic health conditions. Care is provided through a partnership between patients and families and their multidisciplinary care team including physical therapy, behavioral health, nutrition therapy and clinical pharmacy and primary care. Emphasis is placed on the patient’s own goals, care coordination with specialists, and helping patients gain the skills to be healthy with whatever conditions they faced with. SCC has developed a dashboard that pulls from EPIC EHR to risk-assess patients and identify care gaps and a Team Training Center to share the model of care.

Prior to moving to Stanford in 2011, Dr. Lindsay shared a family practice with her husband, Dr. Alan Glaseroff, in rural Northern California for 28 years. During this time she served as County Health Officer for 18 years and was active in the leadership of the California Conference of Local Health Officers in Sacramento. In 2006 she received the Plessner Award from the California Medical Association as the physician who best exemplified the practice and ethics of a rural practitioner.

She currently serves on the Clinical Advisory Committee for the Pacific Business Group on Health CMMI-supported project, Intensive Outpatient Care Program, which seeks to enroll 27,000 patients in three states by 2015. She is a fellow in the California Health Care Foundation Leadership Program.

Kevin Nolan, Mstat, MA, is a statistician and consultant at Associates in Process Improvement and a Senior Fellow at IHI. He has focused on developing methods to help organizations accelerate their rate of improvement, both within and outside of the field of health care. He has served on the faculty of various IHI Breakthrough Series Collaboratives and large system spread projects. He has been part of the IHI team for the Triple Aim since 2008. Kevin holds a bachelor’s degree in mechanical engineering from The Catholic University of America, a master’s degree in

measurement from the University of Maryland, and a master's degree in statistics, also from the University of Maryland. He is a co-author of the book *The Improvement Guide: A Practical Approach to Improving Organizational Performance* and co-editor of the book *Spreading Improvement Across Your Healthcare Organization* published by Joint Commission Resources.

Cory B. Sevin, RN, MSN, NP, a Director at the Institute for Healthcare Improvement (IHI), has worked with both individuals and health care organizations in supporting change for improvement for 30 years, including 20 years as a nurse practitioner working with adolescents and their families in the areas of health risk behavior change as well as with adults with chronic conditions. Ms. Sevin has experience designing healthcare services in a variety of settings including office based, community and home based care. Ms. Sevin is also faculty with the Centre for Collaboration, Motivation and Innovation and is certified in Brief Action Planning. Ms. Sevin led primary care practice transformation as Vice President of Operations at Clinica Campesina Family Health Services prior to coming to IHI.

Matthew C. Stiefel, MPA, MS, Senior Director, Center for Population Health, Care Management Institute, Kaiser Permanente (KP), was a 2008-2009 George W. Merck Fellow at the Institute for Healthcare Improvement. He started with KP as a medical economist in KP's program offices before becoming Director of Measurement of the Care Management Institute and then Associate Director. Previously, he held various management positions in KP Northwest, directing planning, marketing, and medical economics. Prior to joining KP, Mr. Stiefel served as a policy analyst on the Carter administration domestic policy staff and in the US Department of Health, Education, and Welfare and as a local health planner in the San Francisco Bay Area. His primary areas of focus include individual health status and population health measurement and improvement.

References

¹ Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx>

² *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHI'sCollaborativeModelforAchievingBreakthroughImprovement.aspx>

³ Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx>