IMPROVING THE OVERSIGHT AND MONITORING OF PSYCHOTROPIC MEDICATION FOR CHILDREN AND YOUTH IN THE PUBLIC SECTOR

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SAMHSA Technical Assistance Network
September 11, 2015
Agenda

- Ohio Minds Matter Overview
- Quality Improvement Collaborative
- Engagement Strategies
- Ohio Minds Matter Web Demo
- Early Results, Lessons Learned, and Next Steps
- Q&A
National Perspective

• Improved use of psychotropic medication by children JOINTLY prioritized across federal agencies:

✓ Centers for Medicare & Medicaid Services (CMS)
✓ Administration for Children & Families (ACF)
✓ Substance Abuse & Mental Health Services Administration (SAMHSA)

➢ Call to Action (November 2011)
Research Findings

Evidence of Increasing Need for Mental Health Services Among Youth

Source: Ohio Medicaid Data, 2006–2010. Population of youth (0–18) continuously enrolled in Medicaid for 1 year period. Percentage represents percent of children with a mental health diagnosis or receiving at least one mental health service in each year (Cynthia Fontanella, 2013).
Limited Access to Child Psychiatry Services

The majority of psychiatric services are delivered by primary care providers\(^1\).

Physician visits for mental health conditions:
- Pediatricians (61%)
- General Practitioners (29%)
- Psychiatrists (3%)

The average wait time to see a child psychiatrist is 50 days\(^2\)

\(^1\)Source: Cynthia Fontanella, Clinical Profile of Children with SED (Ohio Medicaid Data 2006–2010)
\(^2\)Source: Kelly Kelleher and Kenny Steinman (2012), Children’s Access to Psychiatric Services
29% of children treated for mental health conditions receive psychotropic medications.

- 5.4% received $\geq 4$ psychotropic medications.
- Of those receiving AAPs, 4.2% receive $\geq 2$ AAPs.
- 0.60% of preschool children between 2–5 years of age receive an AAP.

Polypharmacy rate is 2 – 3 times greater among children in foster care.

Source: Cynthia Fontanella, Clinical Profile of Children with SED (Ohio Medicaid Data 2006–2010.) Rates for children continuously enrolled in Medicaid.
Approximately 13,000 Ohio children living in out-of-home placements.

Based on a National Study:

- 12% of maltreated children are taking a psychotropic drug.

- 22% of foster children will take a psychotropic medication at some point.

- Foster children = only 3% of the Medicaid child population.

- Antipsychotic medication prescriptions for foster children = nearly 9x the rate of other children enrolled in Medicaid.

Quality Improvement Approach

- Preferred to a regulatory approach
  - Assures responsiveness to unique needs from each community
  - Builds awareness and knowledge
  - Fosters collaboration among stakeholders
  - Assures access to children in need of treatment
- Promising early results
- Public and Private Partnership
Ohio Minds Matter Overview

• $1 million, 3 year investment by the Ohio Office of Health Transformation.
• A public–private partnership: state departments, health systems, providers, community representatives, child & family advocates.
• Goals:
  • Increase timely access to safe & effective psychotropic medications & other treatments;
  • Improve pediatric health outcomes;
  • Reduce potential adverse effects.
Unique needs:

- Many children on Medicaid have complex behavioral health care needs.

- Foster Children:
  - More likely to experience trauma;
  - Increased social–emotional issues early in life;
  - Higher prescribing rates of AAPs;
  - More likely to receive multiple medications.
Priorities

Education

Safety

Empowerment
Measurement Targets

- Use of 2 or more AAPs for over 2 months duration.
- Use of 4 or more psychototropic medications in youth under the age of 18.

25% reduction
Leadership Team & Partnership

State Leaders and Planning Team
- Office of Health Transformation (Sponsor)
- Department of Medicaid
- Department of Mental Health and Addiction Services
- Department of Job and Family Services
- Health Services Advisory Group (HSAG)
- Ohio Colleges of Medicine, Government Resource Center (GRC)
- Ohio State University, Department of Psychiatry

Public and Private Partnership
- BEACON (Best Evidence for Advancing Child health in Ohio NOW!)
- Ohio and national leaders in pediatrics, psychiatry, pharmacology, healthcare, children services, foster care, consumer and family advocacy, and Psychotropic Medication for Children and Children in Foster Care Learning Collaborative (CHCS)
Clinical Advisory Panel

17 national & state academic & clinical experts:

- Clinical guidelines, technical resources development & implementation;
- Guidance to the QI Team;
- Faculty for clinician training;
- Clinical, collegial support/second opinions to outreach teams.
Regional Champions

Primary Care, Pediatric and Behavioral Health Providers, Child-Caring Agencies, Managed Care Plans, Schools, Juvenile Justice System, and Consumers

• Role and Responsibility:
  ✓ Subject matter expertise
  ✓ Pilot community leadership
  ✓ Identify/recommend resources and support for local pilot sites
  ✓ Stakeholder buy-in and community outreach
  ✓ Consensus building & conflict resolution
Learning and community collaborative approach

- The Institute for Healthcare Improvement (IHI) Rapid Cycle Quality Improvement Model
- Family centered and population based
- Strategies focusing on providers, consumers, and community to address *social determinants of health*
- Design, test, and implement evidence-based quality interventions in pilot communities
- Statewide rollout of community tested strategies
IHI Model for Improvement

- Three Fundamental Questions
- Plan–Do–Study–Act (PDSA) Cycle
### Setting Aims - (Goals)

- What are we trying to accomplish?

### Establishing Measures

- How will we know that a change is an improvement?

### Selecting Changes - (Interventions)

- What changes can we make that will result in improvement?

### Testing Changes

[Diagram: Act, Plan, Study, Do]

- After testing a change on a small scale, learning from each test and refining the change through several PDSA cycles, the team can implement the change on a broader scale—for example, for an entire pilot population or on an entire unit.

### Implementing Changes

- March to May 2013
- June to July 2013
- August to Oct 2013
- November to January 2014
- February 2014 to March 2015

### Spreading Changes - Future Step (April 2015 – November 2015)

- After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.
• Provider Engagement
  ▪ Clinical Decision Support
  ▪ On-line educational resources and training
  ▪ Early adopter learning collaborative

• Consumer and Community Engagement
  ▪ Shared decision-making tools
  ▪ Culturally competent and linguistically appropriate resources
  ▪ Partnerships and resources for local efforts and systems of care

• Rapid Cycle Quality Improvement
  ▪ Clinical data feedback
  ▪ Faculty-lead and peer-reviewed learning
  ▪ Pilot and refine strategies using PDSA
  ▪ Scale proven approaches statewide.
Provider Engagement
## Resource Audiences
- Prescribers
- Parents
- Consumers
- Schools
- Agencies

## Resource Topics
- Psychotropic medication guide
- Inattention, hyperactivity, impulsivity
- Disruptive behavior and aggression
- Moodiness and irritability
- Shared decision making (SDM)

## Resource Types
- Decision algorithms
- Quick reference guides
- Evidence-based guidelines
- Fact Sheets
- Online, on-demand learning modules
- Quick learning podcasts
- SDM toolkit and training module
6 Decision Algorithms

A • Antipsychotic medication management in children under 6 years of age
B • Avoiding the use of more than one AAP medication in children under 18 years of age
C • Avoiding polypharmacy
D • Inattention, hyperactivity, and impulsivity
E • Disruptive behavior and aggression
F • Moodiness and irritability
<table>
<thead>
<tr>
<th>Recognition, assessment, and diagnosis</th>
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<tr>
<td>• Medication algorithm, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria</td>
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<th>Treatment</th>
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<tr>
<td>• Evidence-based treatment guidelines, medication resource tables</td>
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<th>Monitoring</th>
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<td>• Side effects and intervention monitoring charts</td>
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<tr>
<td>• Fact sheets, links to existing clinical resources</td>
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OMM Resources for Algorithms

Quick Reference Guides
- Essential considerations for assessment, diagnosis, monitoring and duration of treatment

Learning Modules
- Incorporates case study review and shared decision making
- Can be completed for MOC, CEU, or CME credits

Quick Learning Podcasts
- Quick case scenarios and decision making for on-the-go learning

Tools and Clinical Resources
- Fact sheets, charts and links to existing resources
Sample Decision Support Algorithms

Algorithm A

Antipsychotic Medication Management in Children Under 6 Years of Age


A.2. Does the assessment reveal target symptoms and/or a diagnosis that suggests that antipsychotic medications may be helpful?

YES

A.3. BEFORE PRESCRIBING

- Might the existing treatment be exacerbating the child’s behavior?
- The potential benefits and risks of psychotropic medication use must be weighed against the risks of untreated adolescents given that their long term consequences are poorly understood.
- Are other, less risky psychosocial treatments available in the community?
- Have these treatments been utilized?

NO

A.5. Do not prescribe.
Oppositional Defiant Disorder and Conduct Disorder Treatment Guide

DSM Criteria

Diagnostic criteria for 313.81 Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults’ requests or rules
4. often deliberately annoys people

(5) often blames others for his or her mistakes or misbehavior
(6) is often touchy or easily annoyed by others
(7) is often angry and resentful
(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Diagnostic criteria for 312.8 Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

**Aggression to people and animals**

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity

**Destruction of property**

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed others’ property (other than by fire setting)
Sample Personal Decision Guide

What symptoms concern you?
- Poor attention
- Hyper
- Depressed or sad
- Angry
- Acts out
- Poor listening
- Moody
- Worried
- Other

What are your goals?

Is there a diagnosis?  Yes  No

What is it?

Think about options.

Treatment Option 1

Treatment Option 2

Treatment Option 3
Demonstration

Provider Resource

www.ohiomindsmatter.org
Early Adopter Learning Collaborative

3 Multi–county pilots, 44 practice sites, 119 prescribers:

- Standard of Care Guidelines;
- Collaborative case reviews;
- Clinical performance measures to monitor progress & refine interventions.
Practice Level Prescribing Data

- Notify clinicians when prescribing practices exceed guidelines.
- Support rapid cycle quality improvement.
- Prompt prescribers to indicate planned changes/provide rationale.
- Identify common challenges to prescribing within guidelines.
### Patient Roster

Click here to identify the top three reasons for the prescribing patterns identified in this roster.

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<tr>
<th>Obs</th>
<th>NPI</th>
<th>Acronym</th>
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<th>Last Name</th>
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Examples:
- Not my patient now
- Not responsible for on-going prescribing
- Unaware of other prescribers
- Knowledge deficit, now improved
- Patient/parent refuses
- Lack of access to psychiatric medication expertise
- Lack of access to non-medication alternatives
- Patient poses risk to others
- Currently in gradual cross tapering
- Failure of multiple attempts to stabilize on just one atypical
Top Reasons for Prescribing Outside Guidelines

- Not responding to psychotropic medication: 90%
- Patient poses risk to self or others: 78%
- Currently in gradual cross tapering: 35%
- Not responding to psychosocial treatment: 32%
- Request by patient/caregiver or other to continue medication(s): 21%
- Patient/caregiver resistant to change in medication(s): 18%
- Other: complex cases: 16%
Consumer and Community Engagement
Consumer and Community Engagement Goals

Building community collaboration:

- Facilitates communication among agencies;
- Broadens resources available to clients; improves service coordination;
- Connecting with Medicaid Managed Care Plans:
  - Clarifies prior authorization processes;
  - Enhances care coordination opportunities;
  - Promotes sharing of prescribing data.
Consumer and Community Engagement Goals

Enhancing consumer understanding & shared-decision making:

- Encourages communication among providers, youth, families, child welfare, school staff & courts.
- Provides a “one stop shop” for families, clinicians & agencies to access trusted information and resources.
- Empowers youth & families to participate in their health care, including use of medications.
Shared Decision Making

A collaborative process that provides support and communication strategies for Consumers, Parents, and Caregivers to make decisions regarding treatment

- Culturally & linguistically appropriate resources.
- Multi-pronged:
  - Education about diagnoses;
  - Medical and non-medical options;
  - Informed decisions about healthcare;
  - Personal choice.
Community Partnerships

Critical to addressing social determinants and health

- Facilitate collaboration among stakeholders & providers.
- Identify shared goals & opportunities to leverage resources.
- Improve regional service coordination.

Key partners:

- Community leaders (strong champions)
- Providers – hospitals, community behavioral health, primary care/family medicine
- Child Welfare,
- Education System,
- Courts,
- Advocacy groups, consumers, families
- Payers (Medicaid Managed Care Plans)
- Other community organizations (housing, vocational providers,...)
Community Collaboration

Number of Providers
- Behavioral Health
- Children’s Hospital
- Pediatric Primary Care

Number of Stakeholder Organizations
- Academic Leaders
- Child Welfare
- Education System
- Juvenile Courts
- Managed Care Plan
- Parent/Advocate

Montgomery County

Summit County

Franklin County
Resources for Consumers, Workers and Schools

- Shared decision making toolkit
- Parent’s guide to youth mental health
- Psychototropic medication fact sheet
- Inattention, hyperactivity, and impulsivity fact sheets and resources
- Disruptive behavior and aggression fact sheets and resources
- Moodiness and irritability fact sheets and resources
Shared Decision Making Materials

• **Tools** to empower consumers to actively participate in the shared decision making process
• Preparing for Mental Health Visit Questions
• Personal Decision Guide
• Information Sharing Checklist
• Medication Side Effects **Watch List**
• **Video** for parents/caregivers/youth
• **Training module** for workers in utilizing the tools with parents/caregivers/youth
• **Fact sheets** for parents/caregivers/youth
Any medications may cause common, general side effects such as:

**Tips about medications**

- Medications treat the symptoms of mental conditions.
- They cannot cure the condition, but they can help you feel and function better.
- Medications work differently for different people.
- There may be other uses for medications which is called “off-label.”
- You should have therapy along with your medication.

**About side effects**

If these happen right after starting medication, they might be side effects. Some side effects go away with time.

**About this watch list**

Common side effects are listed, but there may be others you want to discuss with your doctor.
Customized for youth in Foster Care

If you are turning 18:

Keep your health insurance:

- You can still get free Medicaid. Apply at medicaid.ohio.gov/forohioans/programs/fostercare.aspx
- Know your social security number.
- Keep the phone number for your health plan.

Phone #: ____________

If you have to change doctors:

- Get your medical records.
- Keep a list of your past doctors and your prescriptions.
- Call your health plan to get a new doctor.
- Visit your new doctor for regular check-ups and to discuss any health issues.
Interactive Training Module

Start
Demonstration Community and Consumer Resource

www.ohiomindsmatter.org
Ohio Minds Matter Website

www.ohiomindsmatter.org
Early Results and Lessons Learned

*A formal Evaluation is in progress*
Longitudinal analysis

Cohort: Children with Rx patterns exceeding the following thresholds when providers joined the Minds Matter collaborative in October 2013.

- ≥ 4 psychotropic medications
- ≥ 2 AAPs
- AAP medications < age 6

Prescribing patterns were followed for the following 12 months of the collaborative.

Source: Ohio Medicaid Fee-for-Service (FFS) Pharmacy Claims
Longitudinal Analysis of Children Serviced by OMM Providers vs State Comparison

October 2013

OMM Providers
105 with Psych Rx exceeding threshold

State Comparison
1,385 with Psych Rx exceeding threshold

October 2014

Psych Rx exceeding threshold: 23%
Psych Rx within guideline: 39%
No Psych Rx: 44%
No Rx or service in 3 months: 6%
30%
55%

Source: Ohio Medicaid FFS Pharmacy Claims
Survey distributed during pilot to help refine tool resources:

- **25 completed surveys (response rate 32%)**
  - 40% Psychiatrists;
  - 20% General/developmental pediatricians;
  - 20% Psychiatric Advanced Practice Nurses & Certified School Nurses.

- **Population served:**
  - Median caseload: 200–299 ;
  - Proportion Medicaid: 61–80% ;
  - Foster care: 11–20%.
Toolkit Resources

- Identified uses:
  - 52% determine best course of action with specific patients
  - 52% communicate about the toolkit resources with other clinicians in the practice
  - 44% provide to patients and families
  - 8% educate residents

- Module Completion rate: mean: 2.5 modules; median: 1

- Most helpful features:
  - Treatment algorithms
  - Case scenarios
  - Guidelines for titrating
  - Availability of information for quick reference/to reaffirm current practice
### Overall Assessment

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<th>Questions</th>
<th>Agree/Strongly Agree</th>
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<td>Recommend to others (2 questions)</td>
<td>80%</td>
</tr>
<tr>
<td>Value of participation (2 questions)</td>
<td>78%</td>
</tr>
<tr>
<td>Scientific evidence (2 questions)</td>
<td>80%</td>
</tr>
<tr>
<td>Commitment to continue participation (4 questions)</td>
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## Benefits of Participation

<table>
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<tr>
<th>Participation in Ohio Minds Matter has...</th>
<th>Non Psychiatrist (n=15)</th>
<th>Psychiatrist (n=10)</th>
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<tbody>
<tr>
<td>increased my <em>confidence</em> to address the needs of children with serious emotional disorders (SED).</td>
<td>67%</td>
<td>40%</td>
</tr>
<tr>
<td>increased my <em>knowledge</em> about safe and effective treatment for children with SED.</td>
<td>60%</td>
<td>44%</td>
</tr>
<tr>
<td>improved my <em>communication</em> with parents and caregivers of children with SED.</td>
<td>53%</td>
<td>30%</td>
</tr>
<tr>
<td>enabled me to do a better job of <em>engaging parents and caregivers</em> in treatment decisions.</td>
<td>53%</td>
<td>40%</td>
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Children in Medicaid continue to have disproportional and complex behavioral health care needs

Children in foster care:

- More likely to experience trauma and/or social–emotional issues
- Higher prescribing rates of AAPs and psychotropic polypharmacy

Limited access to timely child psychiatry services, psychosocial treatment, and integrated physical and behavioral health care

These children are more likely to be seen by primary care providers; there is a need to increase mental health care capacity for these providers

Impacts of social determinants of health (e.g., lacking stable home/housing, foods, and other living needs) signify the needs of systems of care support
Lessons Learned

- Systems of care are fragmented and/or lacking coordination.
- There is a need to bridge system gaps, integrate care, and establish public and private partnerships.
- Culturally & linguistically appropriate shared decision making for youth, family & doctors is essential to facilitating personal responsibility for health care.
- There is a need to improve the understanding & the prescribing of psychotropic meds among systems of care workforce.
- Education alone does not change behaviors/improve access.
- Meaningful and rapid data feedback to clinicians and practices may help to improve clinical accountability.
Lessons Learned

- Large scale participation is needed to impact change:
  - Make participation for busy clinicians feasible, desirable and/or necessary.
  - Use champions to reach out to new clinicians/ resistant providers.
  - Non-engaged outliers may adversely impact results.

- Public–private partnerships with high impact providers, multiple points of access & other systems of care helps bridge gaps for children with complex needs.

Early results from the pilot are promising!
Next Steps

- Finalize evaluation study and ROI.
- Integrate in larger, systematic effort to improve prescribing patterns and child health outcomes:
  - Policy, incentives & disincentives may be necessary to impact greater levels of change.
  - Harness current care delivery systems & operations.
  - Improve health plan & practice accountability by aligning industry performance measures & standards.
  - Improve consumer engagement, activation & responsibility.
  - Support value based purchasing, ACOs, PCMHs & payment reform to help achieve practice & system transformation.