

Patient Centered Medical Home: *Quality Improvement and Reimbursement*

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American Osteopathic Association of Medical Informatics

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The Triple Aim

- Improved Health
- Enhanced Patient Experience of Care
- Reduced Cost

[+1: Improved Productivity]

What Is a Patient-Centered Medical Home?

- A Patient-Centered Medical Home (PCMH) is an approach that provides comprehensive primary care across the lifecycle for children, youth, and adults.
- The PCMH team coordinates partnerships between individual patients and their physicians to meet all of the patients' healthcare needs.

Adapted from Joint Principles of the Patient-Centered Medical Home, March 2007. Available at:
http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf.

Source: Merck Medical Forums. "Trends in Healthcare: The Patient Centered Medical Home." Slide 2.

Recognize Medical Homelessness Exists

Higher Costs
Lower Quality

What's Driving the Change?

Country Rankings	
	1.00–2.66
	2.67–4.33
	4.34–6.00

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2,876*	\$3,165	\$3,005*	\$2,083	\$2,546	\$6,102

* 2003 data

Source: Calculated by The Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.



What's Driving the Change?

- Health needs
 - Americans living longer¹
 - Average lifespan: 77+ years
 - Chronic disease more prevalent
 - >40% with chronic conditions have >1²
- Quality of care
 - Patients not getting services and not achieving outcomes
 - A *New England Journal of Medicine* article from 2003 reported that 55% of adults did not receive recommended care for prevention, acute illness, or chronic conditions.³
 - Reports from the IOM, the US Department of Health and Human Services, and *Archives of Internal Medicine* reported that diabetes,² hypertension,² tobacco use,⁴ hyperlipidemia,⁵ asthma,⁶ and chronic atrial fibrillation⁷ were managed inadequately in up to 50% of patients.

IOM=Institute of Medicine.

1. US Department of Health and Human Services. *Healthy People 2010*. US Government Printing Office; 2000. 2. Institute of Medicine. *Crossing the Quality Chasm*. National Academy Press; 2000. 3. McGlynn EA et al. *N Engl J Med*. 2003; 348:2635–2645. 4. US Department of Health and Human Services. Treating tobacco use and dependence. surgeongeneral.gov/tobacco/treating_tobacco_use.pdf. Accessed May 5, 2011. 5. McBride P et al. *Arch Intern Med*. 1998;158:1238–1244. 6. Legorreta AP et al. *Arch Intern Med*. 1998;158:457–464. 7. Samsa GP et al. *Arch Intern Med*. 2000;160:967–973.

Source: Merck Medical Forums. "Overview of the Patient Centered Medical Home (PCMH)." 2011. Slide 8.



Cost of Chronic Care in the United States

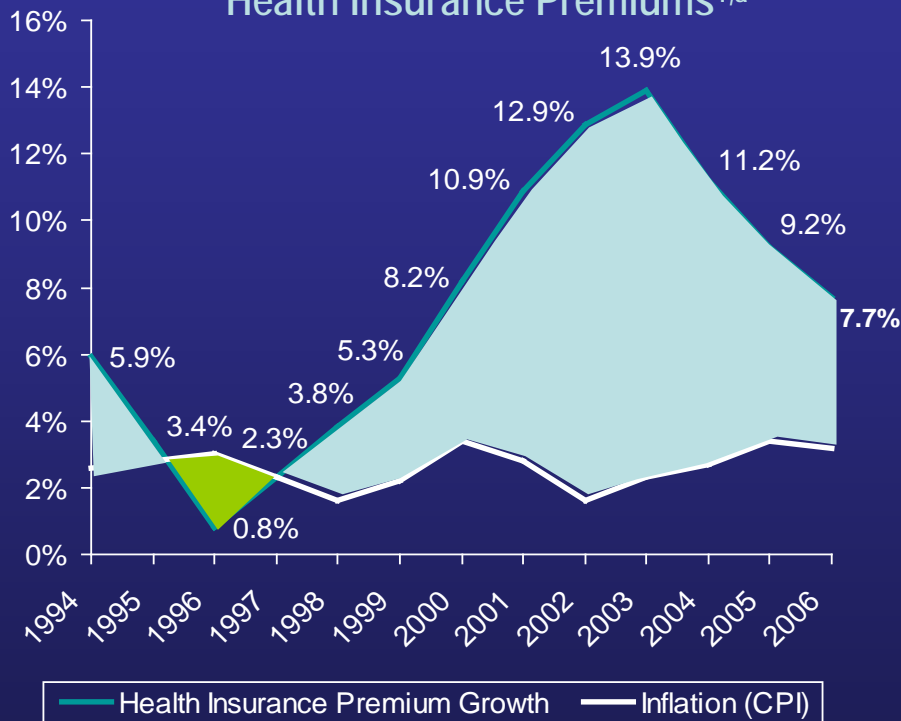
- In 2009, the United States spent >17% of its gross domestic product (GDP) on health care (\$2.5 trillion).¹
 - This is expected to climb toward 20% of the GDP by 2018.²
- The main cost drivers of health care are individuals with chronic conditions.³
 - 5% of beneficiaries account for 43% of Medicare spending.⁴
 - 25% account for 85% of total spending.⁴
- Costs are driven by fragmentation and inefficiency.⁵
 - 27% of Medicare patients discharged with a diagnosis of chronic heart failure were re-admitted within 30 days.
 - 50% of patients discharged with any medical diagnosis, who were readmitted within 30 days had no outpatient visit during the intervening time.

1. Centers for Medicare & Medicaid Services. National health expenditures. 2009 highlights. cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf. Accessed May 3, 2011. 2. National health expenditure projections 2008–2018. Centers for Medicare & Medicaid Services. cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf. Accessed May 3, 2011. 3. The Partnership to Fight Chronic Disease. The growing crisis of chronic disease in the United States. fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf. Accessed May 4, 2011. 4. High-cost Medicare beneficiaries. Congressional Budget Office. cbo.gov/ftpdocs/63xx/doc6332/05-03-MediSpending.pdf. Accessed May 3, 2011. 5. Jencks SF et al. *N Engl J Med*. 2009;360:1418–1428.

Health Insurance Premiums Continue to Grow at 2–3 Times Inflation: Unsustainable



Annual Growth in Employer-Sponsored Health Insurance Premiums^{1,a}



Despite the decline in health insurance premiums from 2003 to 2006, growth in premiums continues to outpace that of inflation.¹

^aAnnual health insurance premium for a family of 4.
CPI=consumer price index.

1. Adapted from "Employer Health Benefits 2006 Annual Survey – Chartpack," (#7561) The Henry J. Kaiser Family Foundation & HRET, September 2006. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

2. Arnst C. Survey: company health-care costs to rise 9% in 2010. businessweek.com/bwdaily/dnflash/content/jun2009/db20090618_304565.htm. Accessed May 3, 2011.

- Personal Physician-Patient Relationship
- Physician-Directed Medical Practice
- Whole-Person Orientation
- Coordinated Care
- Hallmarks of Care
 - Improved Quality and Safety
- Enhanced Access to Care
- Improved Physician Reimbursement

- Team Based Care
- Ideal Medical Home Team

Measuring Success

HIT \leftrightarrow Meaningful Use



NCQA PCMH 2011 Update¹

- Promotes patient-centered care
- Emphasizes language, culturally sensitive aspects
- Integrates behaviors affecting health, substance abuse, mental health, and risk factor assessment and management
- Integrates applicability to pediatric patients
- Aligns with CMS Meaningful Use requirements
- Emphasizes relationship with and expectations of subspecialists
- Increases importance of evaluating patient experience
- Underscores the importance of system cost savings
- Increases importance of using clinical performance measure results

CMS=Centers for Medicare & Medicaid Services; NCQA=National Committee for Quality Assurance.

1. NCQA. FAQs: NCQA's patient-centered medical home (PCMH) 2011. ncqa.org/LinkClick.aspx?fileticket=RMrNNFnKBYw%3d&tabid=1016&mid=5357&forcedownload=true.

Accessed May 5, 2011. Reprinted with permission.



Overview of PCMH 2011 Standards¹

PCMH1: Enhance Access and Continuity		Pts
A.	Access During Office Hours^a	4
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20
PCMH2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	Use Data for Population Management^a	5
		16
PCMH3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	Care Management^a	4
D.	Manage Medications	3
E.	Use Electronic Prescribing	3
		17

PCMH4: Provide Self-Care Support and Community Resources		Pts
A.	Support Self-Care Process^a	6
B.	Provide Referrals to Community Resources	3
		9
PCMH5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	Referral Tracking and Follow-Up^a	6
C.	Coordinate with Facilities/Care Transitions	6
		18
PCMH6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	Implement Continuously Quality Improvement^a	4
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
		20

^a= Must Pass Elements

PCMH=patient-centered medical home.

1. National Committee for Quality Assurance (NCQA). NCOA Standards Workshop. Patient-Centered Medical Home. PCMH 2011.

ncqa.org/LinkClick.aspx?fileticket=u4%2b1hCnv6pw%3d&tabid=1316&mid=5390&forcedownload=true. Last accessed May 5 2011. Reprinted with permission.

Source: Merck Medical Forums. "Overview of the Patient Centered Medical Home (PCMH)." 2011. Slide 31.



PPC-PCMH vs PCMH 2011 (*continued*)

PPC-PCMH¹

1. Access and Communication
2. Patient Tracking and Registry Function
3. Care Management
4. Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advance Electronic Communication

PCMH 2011²

1. Enhance Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Provide Self-Care and Community Support
5. Track and Coordinate Care
6. Measure and Improve Performance

PCMH=patient-centered medical home.

1. National Committee for Quality Assurance (NCQA). *Standards and Guidelines for Physician Practice Connections®–Patient-Centered Medical Home (PPC-PCMH™)*. Washington, DC: NCQA; 2008.

2. NCQA. Patient-centered medical home. ncqa.org/tabid/631/Default.aspx. Accessed May 5, 2011.



PCMH 2011 Recognition Levels¹

Level of Qualifying	Points	Must-Pass Elements at 50% Performance Level
Level 3	85–100	6
Level 2	60–84	6
Level 1	35–59	6

PCMH=patient-centered medical home.

1. National Committee for Quality Assurance (NCQA). NCOA Standards Workshop. Patient-Centered Medical Home. PCMH 2011. ncqa.org/LinkClick.aspx?fileticket=u4%2b1hCnv6pw%3d&tabid=1316&mid=5390&forcedownload=true. Last accessed May 5 2011.

Source: Merck Medical Forums. "Overview of the Patient Centered Medical Home (PCMH)." 2011. Slide 33.

Increased Access to Care

- Scheduling
- Response
 - In the Office
 - After Office Hours
- Proactive Calls for Follow-up Care
- Population Management

Home Insert Page Layout Formulas Data Review View Add-Ins Acrobat

Cut Copy Paste Format Painter

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B I U

Wrap Text Merge & Center

General \$ % , .0 .00 .00

Number

A1		ReportDate					
	A	B	C	D	E	F	G
1	ReportDate	practaskowner-rptpracticename	tasktask_action_de-entryname	taskpriority_de-entryname	Tasks	OnTime	%OnTime
2	10/01/2010	BALLY MEDICAL CENTER	Call Back	ASAP	7	3	42.9%
3	10/01/2010	BALLY MEDICAL CENTER	Call Back	Routine	200	169	84.5%
4	10/01/2010	BALLY MEDICAL CENTER	Call Back	Totals	207	172	83.1%
5	10/01/2010	BALLY MEDICAL CENTER	Follow Up	ASAP	5	4	80.0%
6	10/01/2010	BALLY MEDICAL CENTER	Follow Up	Routine	271	256	94.5%
7	10/01/2010	BALLY MEDICAL CENTER	Follow Up	Urgent	4	3	75.0%
8	10/01/2010	BALLY MEDICAL CENTER	Follow Up	Totals	280	263	93.9%
9	10/01/2010	BALLY MEDICAL CENTER	Hospital Call	ASAP	2	1	50.0%
10	10/01/2010	BALLY MEDICAL CENTER	Hospital Call	Routine	5	5	100.0%
11	10/01/2010	BALLY MEDICAL CENTER	Hospital Call	Totals	7	6	85.7%
12	10/01/2010	BALLY MEDICAL CENTER	Med Renewal Request	ASAP	3	2	66.7%
13	10/01/2010	BALLY MEDICAL CENTER	Med Renewal Request	Routine	53	45	84.9%
14	10/01/2010	BALLY MEDICAL CENTER	Med Renewal Request	Totals	56	47	83.9%
15	10/01/2010	BALLY MEDICAL CENTER	Medical Complaint Callback	ASAP	5	4	80.0%
16	10/01/2010	BALLY MEDICAL CENTER	Medical Complaint Callback	Routine	74	65	87.8%
17	10/01/2010	BALLY MEDICAL CENTER	Medical Complaint Callback	Urgent	1		0.0%
18	10/01/2010	BALLY MEDICAL CENTER	Medical Complaint Callback	Totals	80	69	86.3%
19	10/01/2010	BALLY MEDICAL CENTER	Miscellaneous	Routine	2	2	100.0%
20	10/01/2010	BALLY MEDICAL CENTER	Miscellaneous	Totals	2	2	100.0%
21	10/01/2010	BALLY MEDICAL CENTER	Totals		632	559	88.4%
22	10/01/2010	Totals			632	559	88.4%
23	Totals				632	559	88.4%
24							

Pottstown Medical Specialists, Inc.

1610 Medical Drive, Suite 310 - Pottstown PA 19464

Phone (610) 327-4200 - Fax (610) 327-8160

www.pmsiforlife.com

Daily Preventive Reminders

This report lists every patient who is on the schedule for an appointment today as of the beginning of the day.

Each patient is checked for eligibility for

Flu Shot

Eligibility: CDC age recommendations: 6m - 18yrs & 50 and over

Successful: If a flu shot has been given in the most recent flu season

Documentation: On the Immunizations page

Pneumovax

Eligibility: CDC age recommendation: age 65 and over

Successful: If a pneumovax has ever been given

Documentation: On the Immunizations page

Colorectal Cancer Screening

Eligibility for Colorectal Cancer Screening = All patients age 50 to 80 except post Total Colectomy

Successful:

Colonoscopy has been done within 10 years

Sigmoidoscopy has been done within 4 years

Fecal Occult Blood Testing has been done within 1 year

Documentation: Specifically identified scanned document; Specific Result; Up to date HMP item

Breast Cancer Screening

Eligibility for Breast Cancer Screening = All women age 42 to 89 except post Bilateral Mastectomy

Successful: If mammography has been done within 2 years

Documentation: Specifically identified scanned document; Specific Result; Up to date HMP item

Be sure to update the HMP if the patient needs the indicated item

For each intervention:

Dashes in a cell means that the patient is not eligible for the intervention by the criteria used in the report. There may be different published criteria by which a patient is eligible.

UpToDate

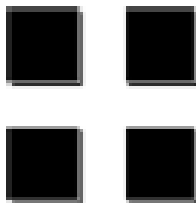
A Green "UpToDate" means that the patient is both eligible for the intervention and that the intervention is documented in the EMR within the desired time frame

NEEDS

A Red "NEEDS" means that the patient is eligible for the intervention but that it has not been done in the desired time frame, or it has not been documented in a reportable fashion.



A frowny face is used only in the case of the Flu shot. It is used when the patient is eligible for a Flu shot, a flu shot was not recorded in the last flu season, and the patient should NOT get a shot now because it is not flu season. As of September 1st, these will be replaced with a red "NEEDS" reminder.



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Daily Preventive Reminders

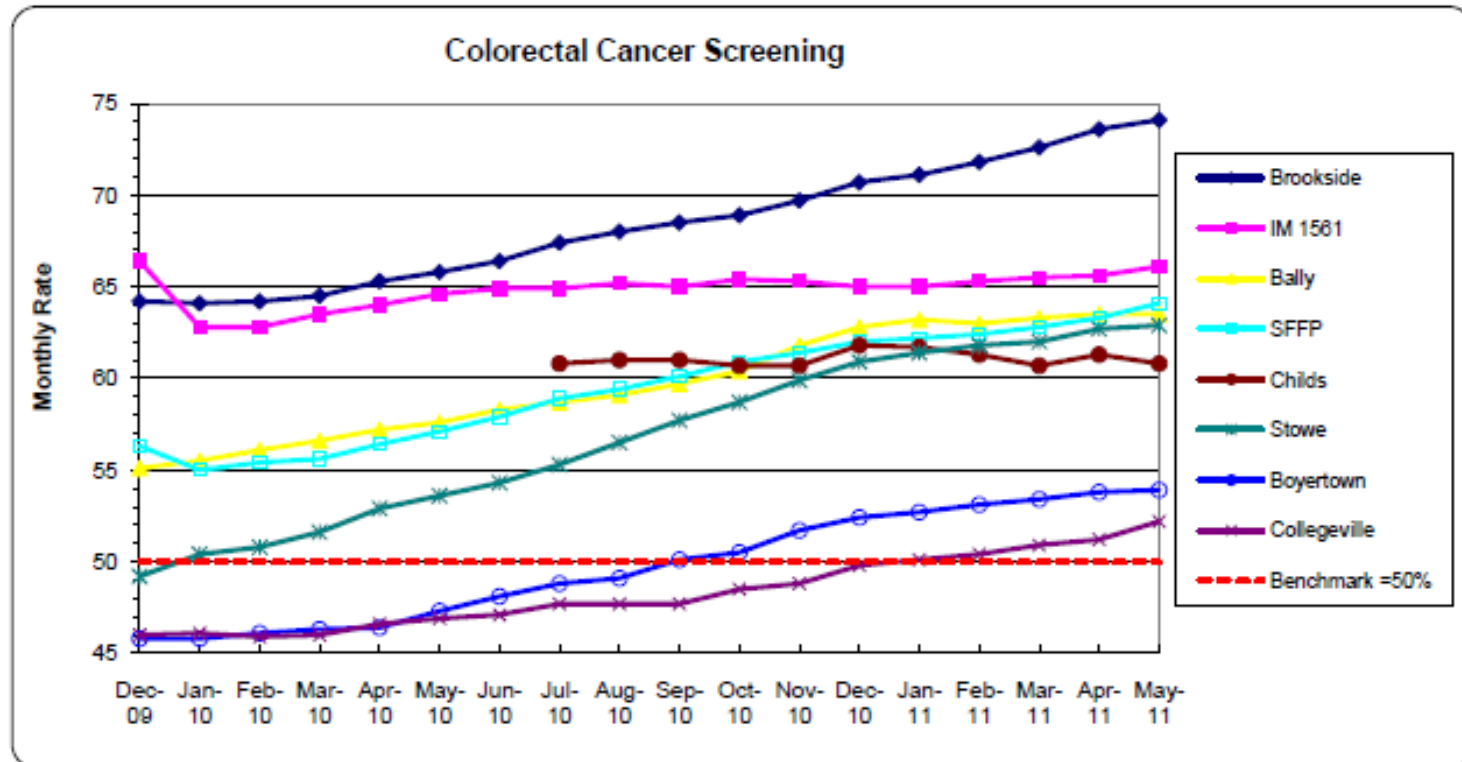
Today's Prescheduled Appointments at *STOWE FAMILY PRACTICE* *Henwood, Carol*

Appointment	Patient Name	DOB	Flu	Pneumo	CRC	Breast Ca
6/6/11 8:30 AM	[REDACTED]	6/6/1962	-----	-----	-----	NEEDS
6/6/11 8:40 AM	[REDACTED]	3/15/1957	UpToDate	-----	NEEDS	-----
6/6/11 9:20 AM	[REDACTED]	5/7/1979	-----	-----	-----	-----
6/6/11 9:30 AM	[REDACTED]	8/8/1933	UpToDate	UpToDate	UpToDate	-----
6/6/11 10:00 AM	[REDACTED]	5/30/1949	UpToDate	-----	UpToDate	UpToDate
6/6/11 10:30 AM	[REDACTED]	1/10/1925	UpToDate	-----	-----	-----
6/6/11 12:00 PM	[REDACTED]	10/7/1952	UpToDate	-----	UpToDate	UpToDate
6/6/11 12:30 PM	[REDACTED]	6/30/1933	UpToDate	UpToDate	NEEDS	-----
6/6/11 12:40 PM	[REDACTED]	12/26/1936	UpToDate	-----	UpToDate	-----
6/6/11 1:00 PM	[REDACTED]	9/9/1992	NEEDS	-----	-----	-----
6/6/11 1:30 PM	[REDACTED]	10/20/1929	NEEDS	-----	-----	-----
6/6/11 1:40 PM	[REDACTED]	4/15/1926	UpToDate	-----	-----	-----
6/6/11 2:00 PM	[REDACTED]	12/19/1963	-----	-----	-----	UpToDate
6/6/11 2:30 PM	[REDACTED]	7/28/1969	-----	-----	-----	-----
6/6/11 2:40 PM	[REDACTED]	8/8/1927	UpToDate	-----	-----	-----
6/6/11 3:00 PM	[REDACTED]	3/14/1953	UpToDate	-----	UpToDate	UpToDate

If you find documentation that the patient had any of these items done within the time frames for the indicators, put the information into the HMP (include done date) and if a document is found, index it into the appropriate sScan folder.

Colorectal Cancer Screening - Actual Percentage Rates By Office

	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11
Brookside	64.2	64.1	64.2	64.5	65.3	65.8	66.4	67.4	68	68.5	68.9	69.7	70.7	71.1	71.8	72.6	73.6	74.1
IM 1561	66.4	62.8	62.8	63.5	64	64.6	64.9	64.9	65.2	65	65.4	65.3	65	65	65.3	65.5	65.6	66.1
Bally	55.1	55.5	56.1	56.6	57.2	57.6	58.3	58.7	59.1	59.7	60.4	61.8	62.8	63.2	63	63.3	63.5	63.5
SFFP	56.3	55	55.4	55.6	56.4	57.1	57.9	58.9	59.4	60.1	60.9	61.4	62	62.2	62.4	62.8	63.3	64.1
Childs	--	--	--	--	--	--	--	60.8	61	61	60.7	60.7	61.8	61.7	61.3	60.7	61.3	60.8
Stowe	49.2	50.4	50.8	51.6	52.9	53.6	54.3	55.3	56.5	57.7	58.7	59.9	60.9	61.4	61.8	62	62.7	62.9
Boyertown	45.8	45.8	46.1	46.3	46.4	47.3	48.1	48.8	49.1	50.1	50.5	51.7	52.4	52.7	53.1	53.4	53.8	53.9
Collegeville	46	46.1	45.9	46	46.6	46.9	47.1	47.7	47.7	47.7	48.5	48.8	49.8	50.1	50.4	50.9	51.2	52.2
Benchmark =50%	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50



Diabetes mellitus: complete H&P

BP goals <130/80; LDL goals <80; ACE/ARB Rx; HgbA1c goal <6.5

Annual eye exam; monofilament foot exam; urine microalbumin annually at min

Flu vaccine annually; pneumovax at appropriate interval

Smoking cessation counseling; referral to group education

Hyperlipidemia: complete H&P

Lipid goals tchol<200; TG<150; LDL goal based on risk factors for

Hypertension: complete H&P

Systolic goal<130; diastolic goal <80

Patients Needing Contact

PCP	MRN	Patient Fullname	Registry	Need A1c	A1c7to9	A1c>9	Need BP	BP>129/78	Need LDL	LDL>100
HENWOOD	6702782	Pmsi, Patient 1	DM			A1c>9		BP>129/78	Need LDL	
HENWOOD	6004078	Pmsi, Patient 2	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	9670	Pmsi, Patient 3	DM					BP>129/78		
HENWOOD	206893	Pmsi, Patient 4	DM					BP>129/78	Need LDL	
HENWOOD	5381	Pmsi, Patient 5	DM					BP>129/78		
HENWOOD	6250064	Pmsi, Patient 6	DM		A1c7to9			BP>129/78		
HENWOOD	223482	Pmsi, Patient 7	DM					BP>129/78		LDL>100
HENWOOD	224518	Pmsi, Patient 8	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	238913	Pmsi, Patient 9	DM		A1c7to9			BP>129/78		
HENWOOD	8990	Pmsi, Patient 10	DM					BP>129/78		
HENWOOD	3033	Pmsi, Patient 11	DM		A1c7to9			BP>129/78	Need LDL	
HENWOOD	206210	Pmsi, Patient 12	DM					BP>129/78		
HENWOOD	6254136	Pmsi, Patient 13	DM							LDL>100
HENWOOD	241422	Pmsi, Patient 14	DM						Need LDL	
HENWOOD	3676	Pmsi, Patient 15	DM					BP>129/78		LDL>100
HENWOOD	208155	Pmsi, Patient 16	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	200206	Pmsi, Patient 17	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	201799	Pmsi, Patient 18	DM					BP>129/78		
HENWOOD	6009114	Pmsi, Patient 19	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	213274	Pmsi, Patient 20	DM					BP>129/78		LDL>100
HENWOOD	233316	Pmsi, Patient 21	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	219190	Pmsi, Patient 22	DM					BP>129/78		
HENWOOD	206173	Pmsi, Patient 23	DM	NeedA1c					Need LDL	
HENWOOD	212404	Pmsi, Patient 24	DM	NeedA1c					Need LDL	
HENWOOD	228911	Pmsi, Patient 25	DM					BP>129/78		LDL>100
HENWOOD	218804	Pmsi, Patient 26	DM	NeedA1c					Need LDL	
HENWOOD	6596	Pmsi, Patient 27	DM					BP>129/78		
HENWOOD	6010095	Pmsi, Patient 28	DM		A1c7to9					
HENWOOD	6005725	Pmsi, Patient 29	DM	NeedA1c				BP>129/78	Need LDL	
HENWOOD	234501	Pmsi, Patient 30	DM					BP>129/78		
HENWOOD	233903	Pmsi, Patient 31	DM		A1c7to9			BP>129/78		LDL>100
HENWOOD	202073	Pmsi, Patient 32	DM		A1c7to9			BP>129/78		
HENWOOD	6254399	Pmsi, Patient 33	DM							LDL>100

Providers	DMpt	Has A1c	NeedA1c	A1c<7	A1c7to9	A1c>9	%NeedA1c	%A1c<7	%A1c7to9	%A1c>9
Pmsi, Provider 1	49	36	13	14	19	3	26.5%	38.9%	52.8%	8.3%
Pmsi, Provider 2	322	180	142	106	61	13	44.1%	58.9%	33.9%	7.2%
Pmsi, Provider 3	150	86	64	57	25	4	42.7%	66.3%	29.1%	4.7%
Pmsi, Provider 4	321	252	69	186	52	14	21.5%	73.8%	20.6%	5.6%
Pmsi, Provider 5	160	120	40	88	25	7	25.0%	73.3%	20.8%	5.8%
Pmsi, Provider 6	130	97	33	73	17	7	25.4%	75.3%	17.5%	7.2%
Pmsi, Provider 7	134	85	49	47	33	5	36.6%	55.3%	38.8%	5.9%
Pmsi, Provider 8	107	82	25	34	33	15	23.4%	41.5%	40.2%	18.3%
Pmsi, Provider 9	208	139	69	77	50	12	33.2%	55.4%	36.0%	8.6%
Pmsi, Provider 10	2	2		2	0	0	0.0%	100.0%	0.0%	0.0%
Pmsi, Provider 11	144	109	35	48	46	15	24.3%	44.0%	42.2%	13.8%
Pmsi, Provider 12	173	118	55	55	51	12	31.8%	46.6%	43.2%	10.2%
Pmsi, Provider 13	203	155	48	92	50	13	23.6%	59.4%	32.3%	8.4%
Pmsi, Provider 14	129	71	58	42	19	10	45.0%	59.2%	26.8%	14.1%
Pmsi, Provider 15	310	240	70	179	53	8	22.6%	74.6%	22.1%	3.3%
Pmsi, Provider 16	159	97	62	57	37	3	39.0%	58.8%	38.1%	3.1%
Pmsi, Provider 17	5	4	1	3	0	1	20.0%	75.0%	0.0%	25.0%
Pmsi, Provider 18	96	64	32	48	14	2	33.3%	75.0%	21.9%	3.1%
Pmsi, Provider 19	24	15	9	8	4	3	37.5%	53.3%	26.7%	20.0%
Pmsi, Provider 20	219	169	50	103	60	6	22.8%	60.9%	35.5%	3.6%
Pmsi, Provider 21	1	1		0	1	0	0.0%	0.0%	100.0%	0.0%
Pmsi, Provider 22	5	3	2	2	1	0	40.0%	66.7%	33.3%	0.0%
Pmsi, Provider 23	159	115	44	75	33	7	27.7%	65.2%	28.7%	6.1%
Pmsi, Provider 24	40	30	10	22	7	1	25.0%	73.3%	23.3%	3.3%
Pmsi, Provider 25	158	123	35	96	23	4	22.2%	78.0%	18.7%	3.3%
Pmsi, Provider 26	91	70	21	39	27	4	23.1%	55.7%	38.6%	5.7%
Grand Total	3499	2463	1036	1553	741	169	29.6%	63.1%	30.1%	6.9%

PMSI "RATE YOUR MEDICAL PROFESSIONAL" SURVEY

Stowe Family Practice

Please tell us how satisfied you are with the following during your encounter TODAY. Circle only one answer per question, do not skip any questions and choose N/A if it does not apply.

1. Ability to make an appointment for routine care.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

2. Ability to make an appointment for illness or injury.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

3. Ability to contact a provider when the office was closed (nights or weekends).

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

4. The length of time waiting in the office to see the provider.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

5. Office staff was courteous and respectful.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

6. The provider listened carefully to the patient.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

7. The provider explained things in a manner that the patient could understand.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

8. Ability to obtain test results and follow up information.

Very satisfied Satisfied Neither Dissatisfied Very Dissatisfied N/A

Comment:

Would you recommend this provider or office to family members and friends? YES NO

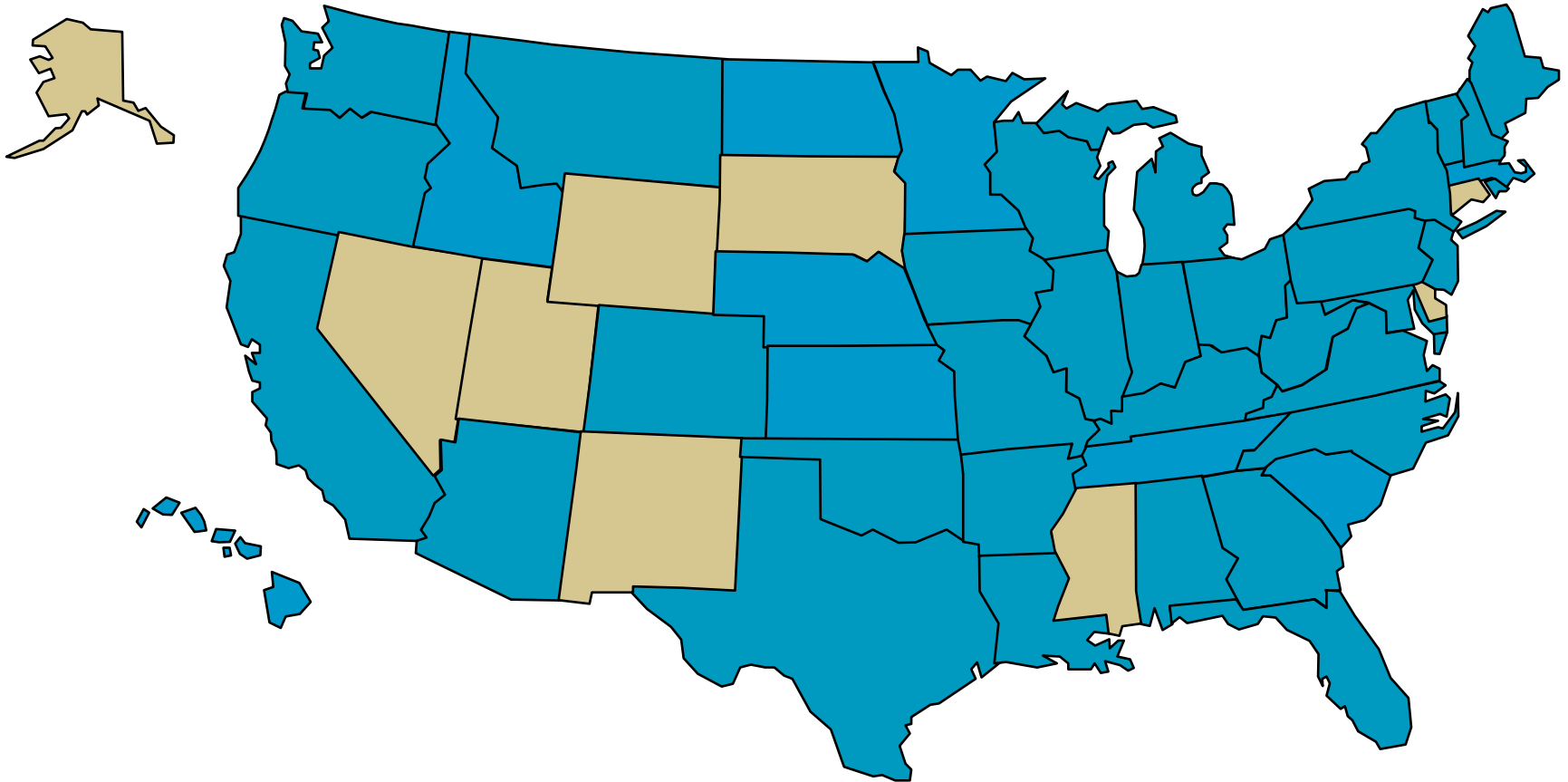
Please circle which medical provider you saw today:


Carol L. Henwood, D.O. Tracey L. Gemzik, PA-C John E. Reel, PA-C

Date: _____

Show Me the Money!

Overview of PCMH Commercial Pilot Activity

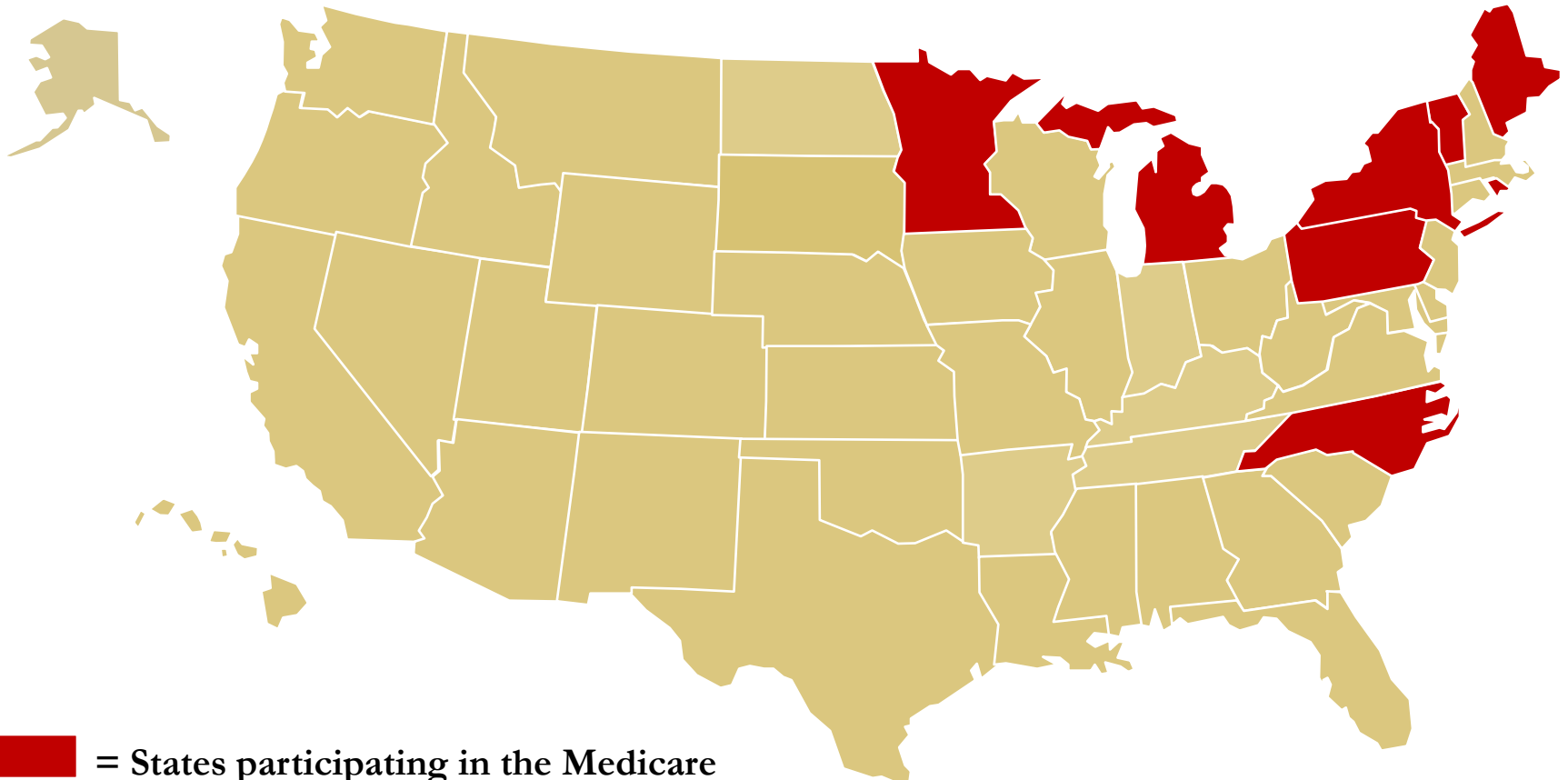


 = Identified to have at least one private payer medical home pilot under development or underway

* As tracked by the American College of Physicians (updated March 2011)

Source: Rogers, E. "Patient Centered Primary Care Collaborative and the National Patient Centered Medical Home Movement." April 2011.

Medicare Multi-Payer Advanced Primary Care Initiative States



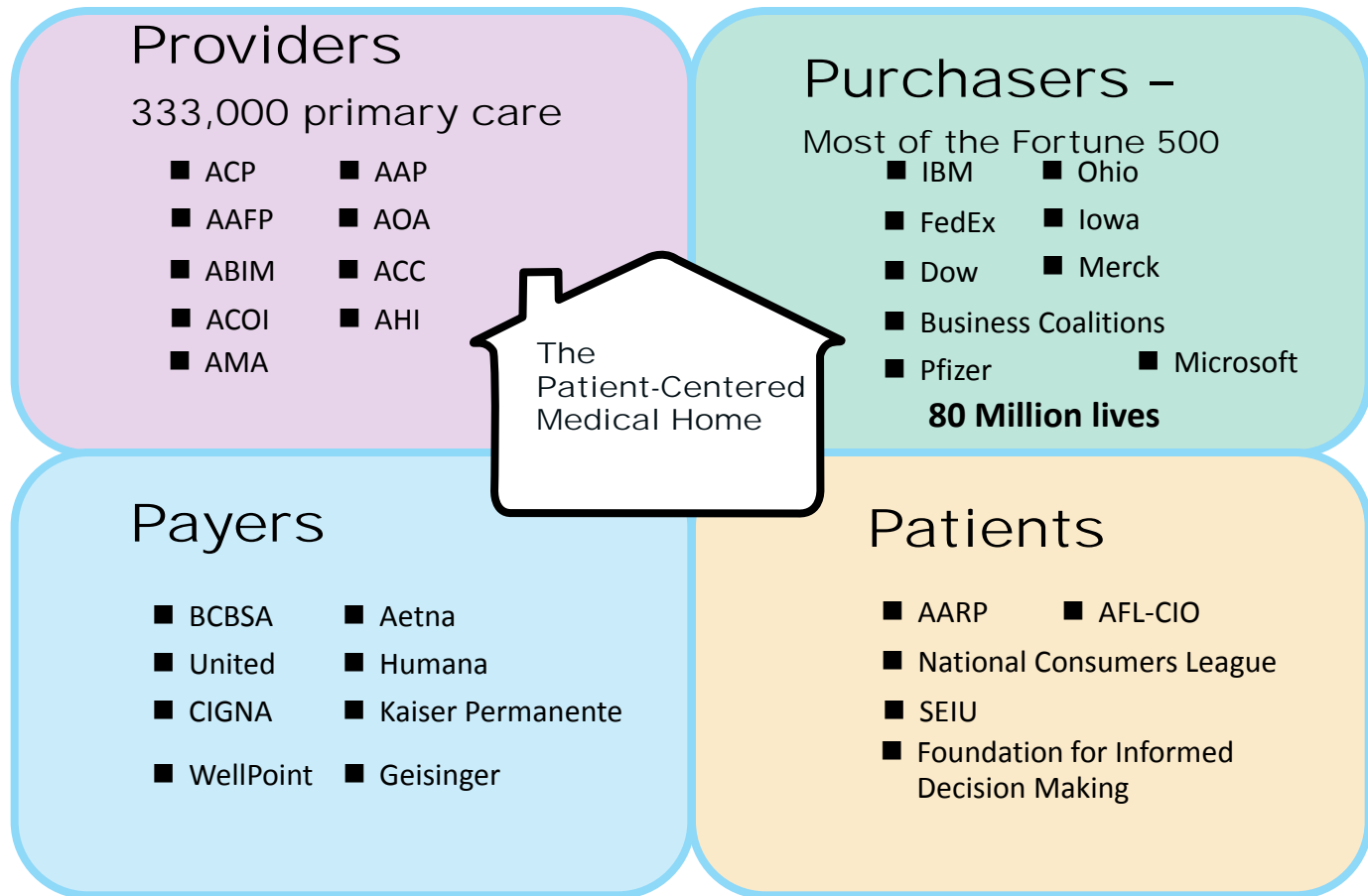
■ = States participating in the Medicare Multi-Payer Advanced Primary Care Initiative

Source: CMS, March 2011 (<http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1230016>)

Source: Rogers, E. "Patient Centered Primary Care Collaborative and the National Patient Centered Medical Home Movement." April 2011.

The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation



Source: PCPCC (www.pcpcc.net)

Source: Rogers, E. "Patient Centered Primary Care Collaborative and the National Patient Centered Medical Home Movement." April 2011.

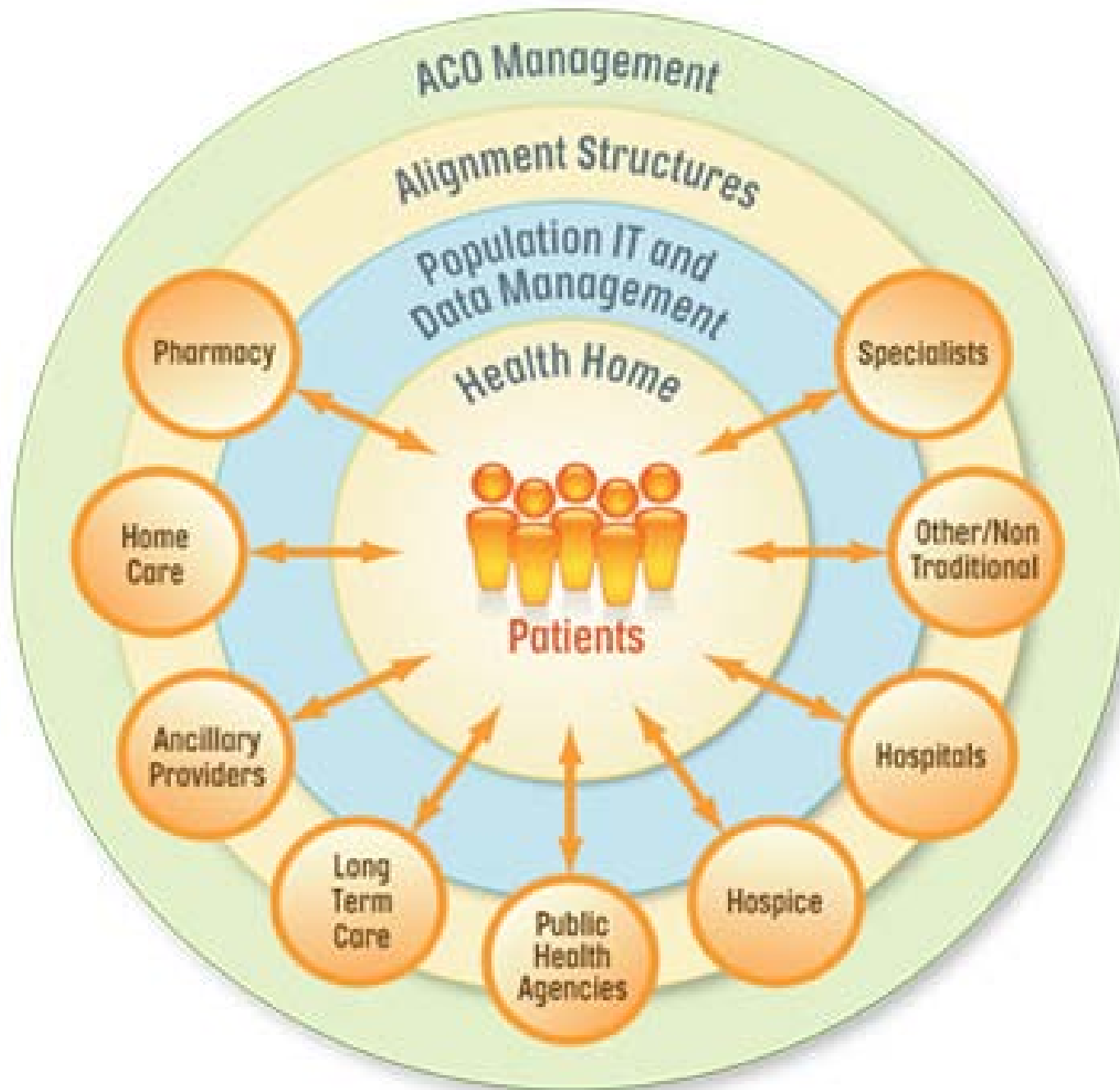
Community Implications - Published Results of PCMH Projects to Date

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits
- 16% reduction in hospital admissions
- Reduced cost

Geisinger Health System

- 18% decrease in hospital admissions
- Improvements in diabetes and heart disease care
- 7% reduction in costs





- Specialty Care**
- GI**
 - Dermatology**
 - Orthopedics**
 - Cardiology**
 - OB-GYN**
 - Ophthalmology**

- General Surgery**
- ENT**
- Neurosurgery**

Utilization Review

Hospital Services
ER
In-patient

The Patient Centered Medical Home...

**The New Primary Care
Model in Action**

It's Time for Action!