Building the BCBSM Physician Group Incentive Program and Patient-Centered Medical Home

May 2011

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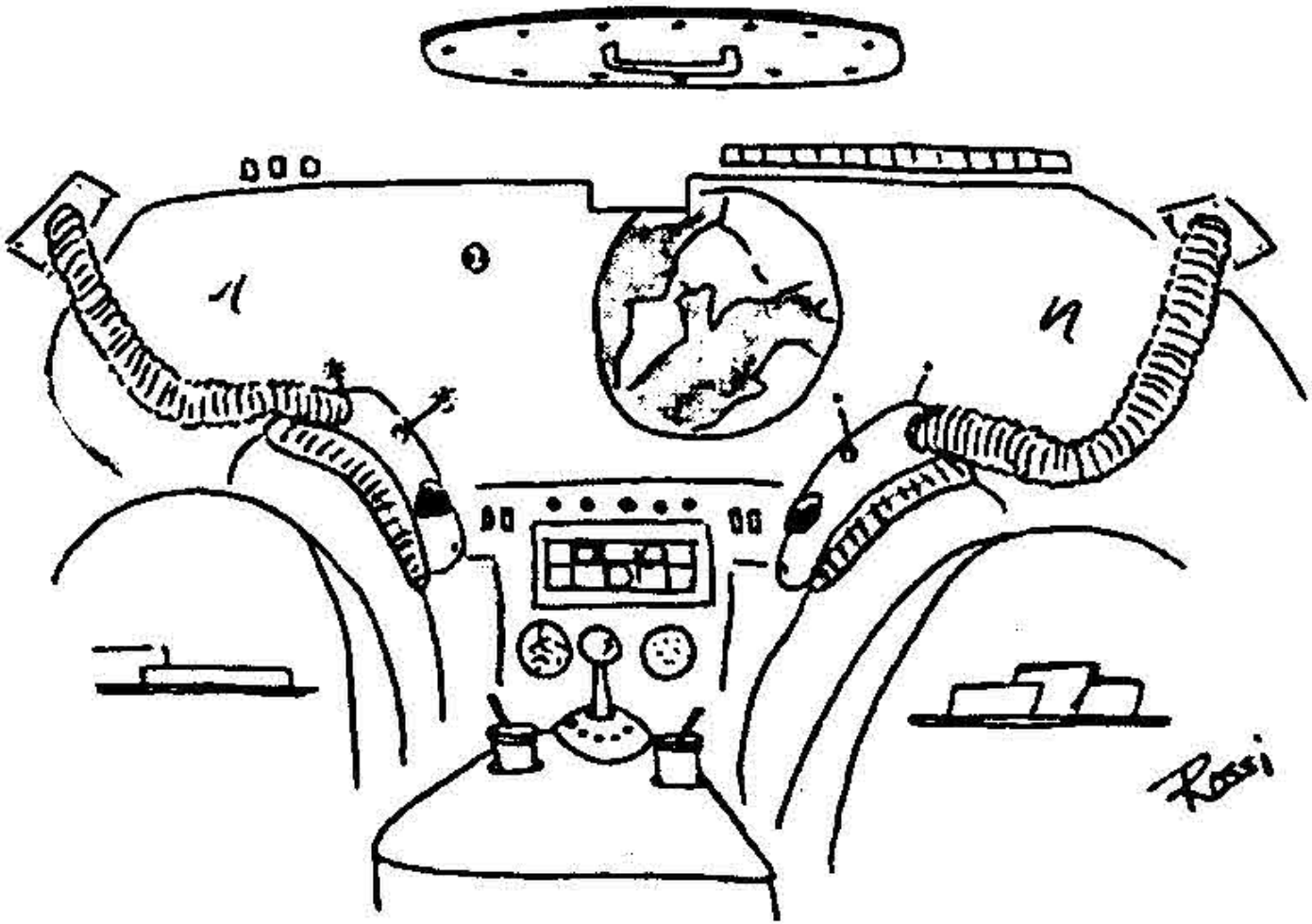


"Maybe there will be some primary care doctors available on *this* planet!"

What Can We Do Together?

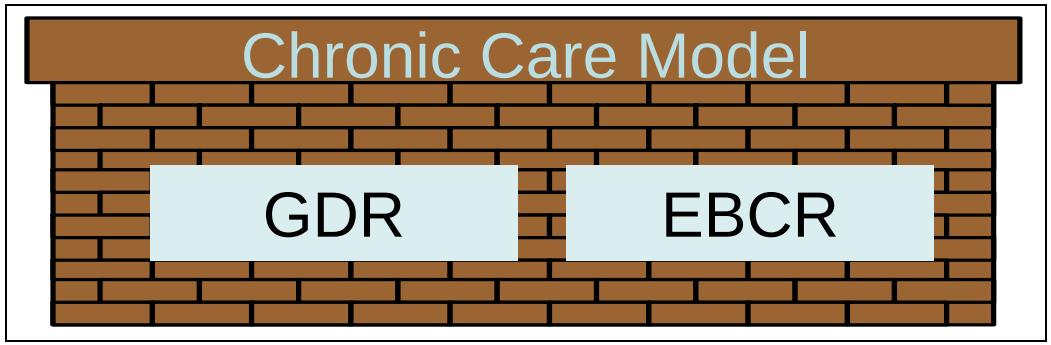
- 2004 meetings with Michigan State Medical Society, Michigan Osteopathic Association, & Council of Physician Organizations (POs)
  - ✓ Suggested that BCBSM establish partnership with POs
  - ✓ Harness the full measure of physicians' creative efforts


HOW COME WE PLAY WAR AND NOT PEACE?
TOO FEW ROLE MODELS.

"Relentless Incrementalism"

2005-2007

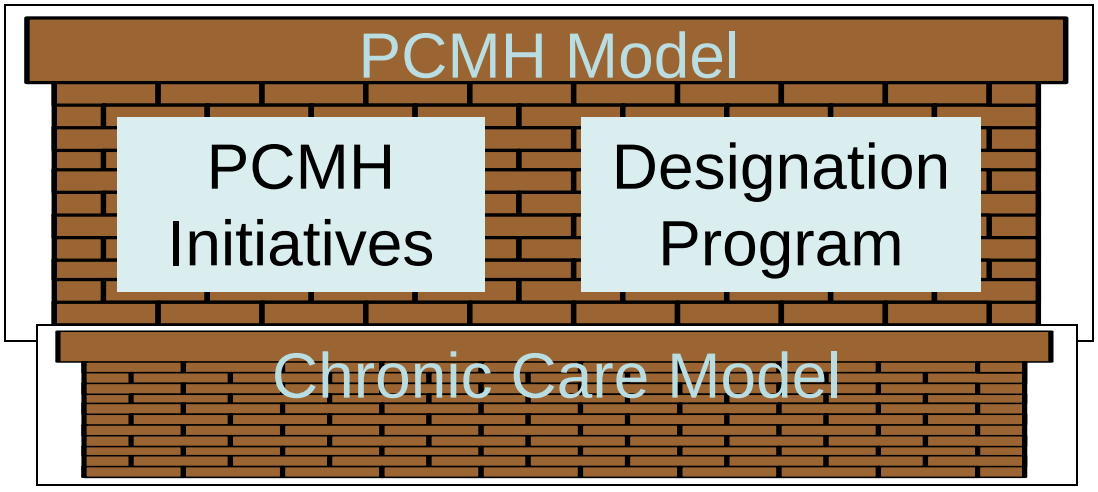
- Catalyze physicians to form "Physician Organizations"
- Focus on chronic condition management
- Encourage development of all-payer patient registries
- Open-ended "Progress Reports"
- Convene "Quarterly Meetings"



More Structure for Expanding Program

2008-2010

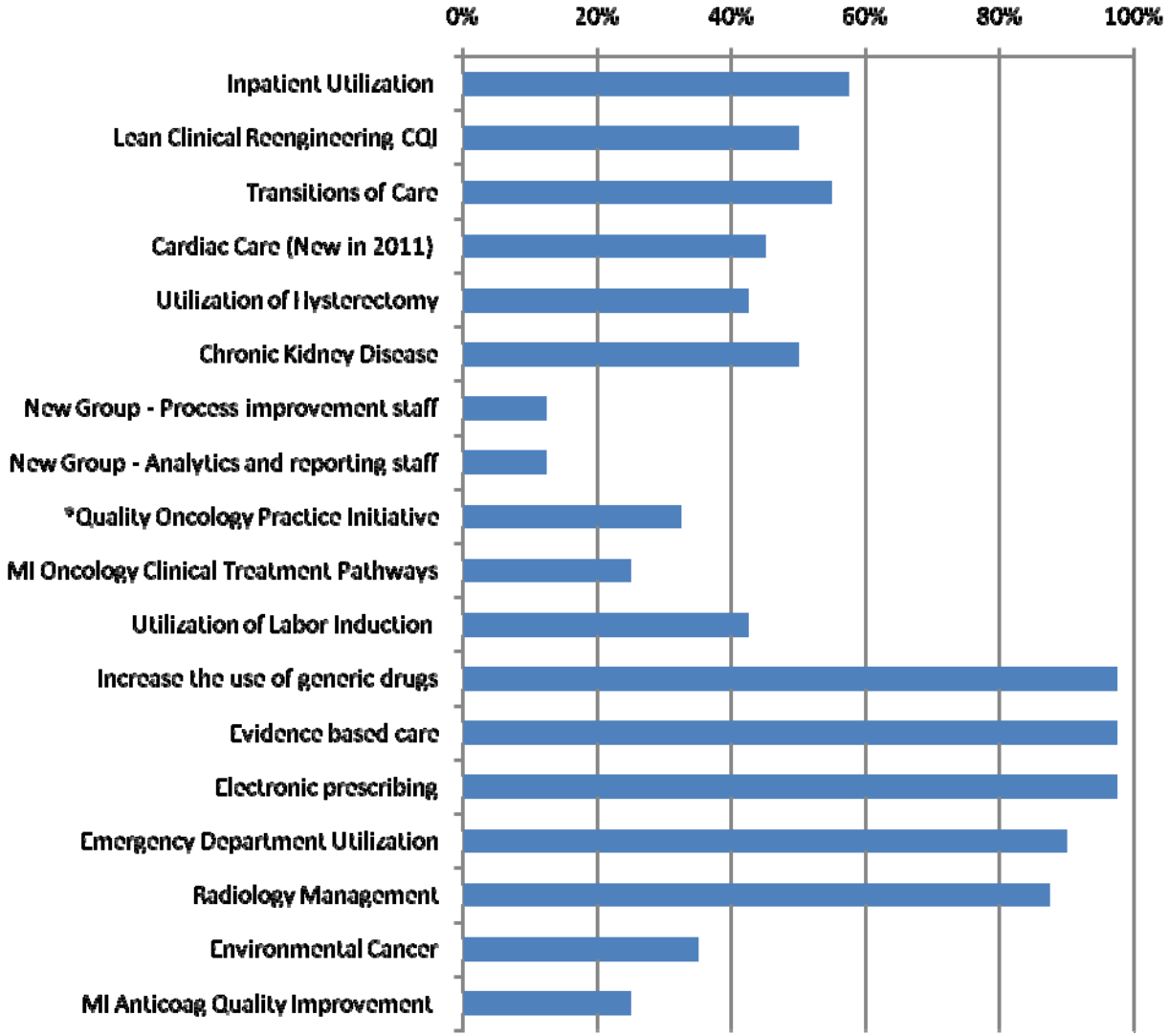
- POs participate in collaboratively-developed "Initiatives"
- PCMH Program with Interpretive Guidelines
- Collection of self-reported data on PO progress
- Clinical Epidemiology & Biostatistics Department creates reports for POs
- Primary Care Leadership Committee



Anatomy of a PGIP Initiative

- Eligibility criteria
- Description of the scope, focus and objectives
- Data, Metrics and Reports designed to:
  - Describe the improvement opportunity
  - Assist in diagnosing the process problems
  - Track progress of implementation effort
  - Measure improvement success
- Resources and services (educational materials, etc.)
- Incentive design

Percent of PGIP POs Participating in Quality, Use and Efficiency Performance-based Initiatives



Initiatives with PGIP Reporting

CORE CLINICAL

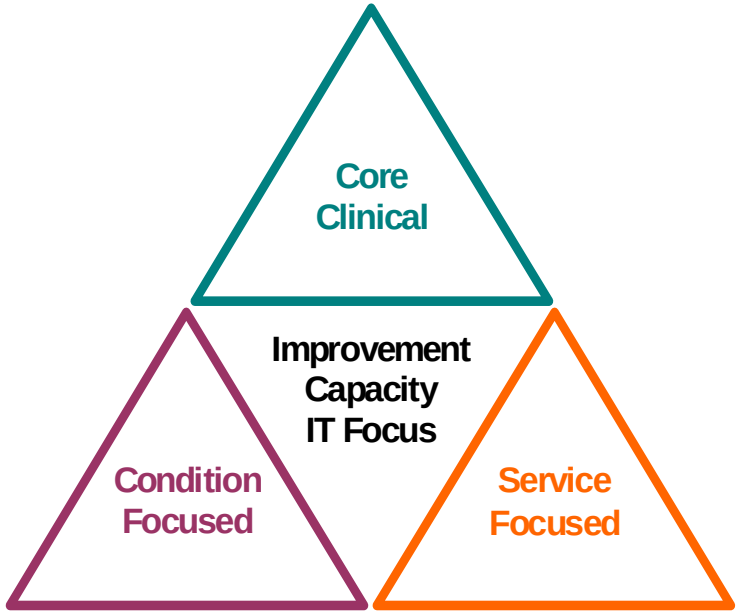
- Evidence Based Care Report
- Transitions of Care

SERVICE FOCUSED

- Pharmacy - Generic Dispense Rate
- Inpatient Utilization
- Emergency Department Utilization
- Radiology Use

CONDITION FOCUSED

- Cardiac Care
- Women's Health (Hysterectomy & Labor Induction)



Types of PGIP Reporting

- Dashboards
- Datasets

Both have 3-6 months of claims lag as the basis for the reporting.

- Claims Feeds
- Opportunity Analysis

PO effective use of data is key to PGIP success. New full-time analyst to train and assist POs with data.

PGIP Reporting – Dashboards

- Physician Organizations receive dashboard files semi-annually
  - Distributed to all POs regardless of participation
  - Includes data on all POs regardless of participation
- Includes:
    - Physician Organization demographics and attribution volumes
    - Risk adjustment comparisons (if applicable)
    - Tables & Figures to show POs' outcomes for initiative metrics
    - PGIP-Overall and Benchmark comparison
- ***Metrics at PO level: Allows for PO – PO comparison*****

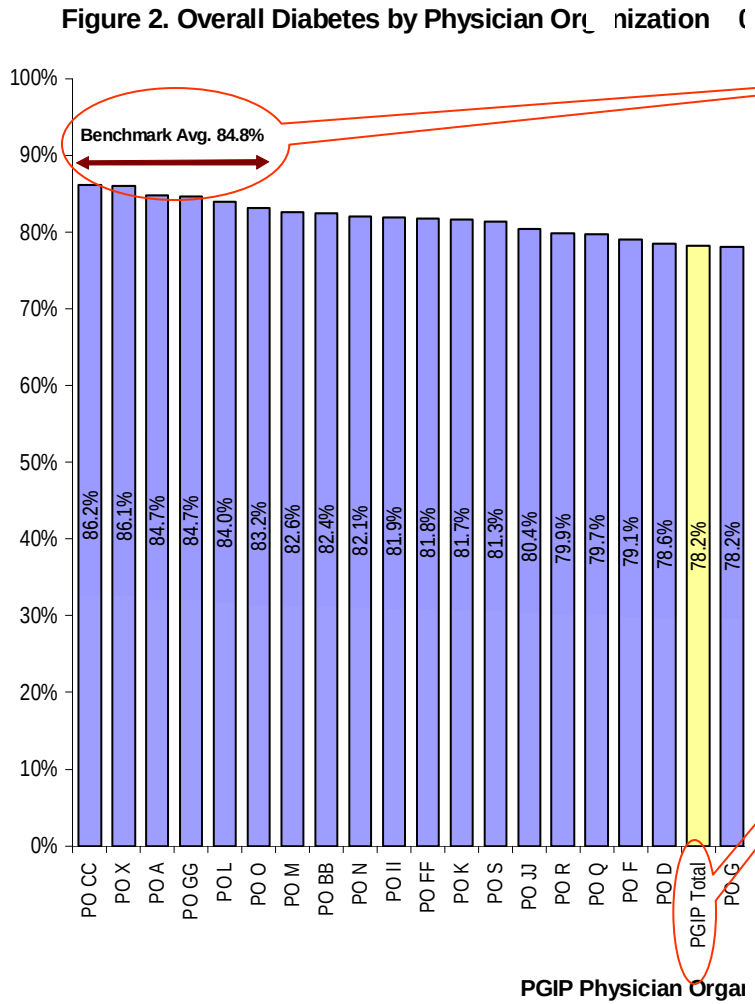
  **Some metric data are on a PO's Practice Unit level (GDR, ED and Radiology),
  but included only in ***that*** PO's dashboard and not shared among POs

Dashboard – Table Example

	Attributed Members		Diabetes												
PGIP Physician Organization	Total Attributed Members	Total Member Months	HbA1C denom	HbA1C num	HbA1C Testing	LDL-c denom	LDL-c num	LDL_C Testing	Nephropathy denom	Nephropathy num	Nephropathy Monitoring	lipid denom	lipid num	Lipid Lowering Drug Rate
PO A	31,497	301,652	649	550	84.7%	649	460	70.9%	649	547	84.3%	487	367	75.4%
PO B	33,829	330,752	1,006	764	75.9%	1,006	755	75.0%	1,006	789	78.4%	710	450	63.4%
PO C	23,276	232,419	597	459	76.9%	597	429	71.9%	597	469	78.6%	402	291	72.4%
PO D	40,673	402,382	1,404	1,103	78.6%	1,404	995	70.9%	1,404	1,089	77.6%	1,049	768	73.2%
PO E	14,311	135,899	654	473	72.3%	654	449	68.7%	654	525	80.3%	490	333	68.0%
PO F	35,875	344,419	1,452	1,148	79.1%	1,452	1,126	77.5%	1,452	1,153	79.4%	1,150	885	77.0%
PO G	15,807	153,923	563	440	78.2%	563	427	75.8%	563	441	78.3%	424	274	64.6%
PO H	35,048	339,117	1,019	773	75.9%	1,019	673	66.0%	1,019	820	80.5%	729	461	63.2%
PO I	12,404	123,648	178	125	70.2%	178	125	70.2%	178	142	79.8%	116	79	68.1%
PO J	30,172	302,541	847	656	77.4%	847	607	71.7%	847	662	78.2%	654	490	74.9%
PO K	42,246	419,645	665	543	81.7%	665	493	74.1%	665	543	81.7%	496	373	75.2%
PO L	24,591	242,173	639	537	84.0%	639	472	73.9%	639	524	82.0%	464	337	72.6%
PO M	25,656	248,855	665	549	82.6%	665	479	72.0%	665	564	84.8%	512	391	76.4%
PO N	8,902	85,993	285	234	82.1%	285	201	70.5%	285	227	79.6%	211	156	73.9%
PO O	15,965	154,178	588	489	83.2%	588	456	77.6%	588	492	83.7%	451	377	83.6%
PO P	44,486	422,360	1,654	1,218	73.6%	1,654	1,207	73.0%	1,654	1,294	78.2%	1,220	775	63.5%
PO Q	11,132	109,398	414	330	79.7%	414	307	74.2%	414	299	72.2%	306	198	64.7%
PO R	21,211	207,655	452	361	79.9%	452	365	80.8%	452	388	85.8%	336	270	80.4%
PO S	8,192	82,550	134	109	81.3%	134	106	79.1%	134	110	82.1%	108	84	77.8%
PO T	9,814	90,975	273	207	75.8%	273	193	70.7%	273	225	82.4%	180	136	75.6%
PO U	29,136	283,576	883	653	74.0%	883	629	71.2%	883	728	82.4%	690	504	73.0%
PO V	68,191	658,314	2,282	1,685	73.8%	2,282	1,668	73.1%	2,282	1,835	80.4%	1,665	1,136	68.2%
PO W	30,183	291,364	1,402	1,033	73.7%	1,402	1,074	76.6%	1,402	1,107	79.0%	997	713	71.5%
PO X	16,796	158,453	237	204	86.1%	237	189	79.7%	237	188	79.3%	164	113	68.9%
PO Y	33,069	333,809	1,037	804	77.5%	1,037	761	73.4%	1,037	845	81.5%	743	514	69.2%
PO Z	24,968	241,113	1,032	772	74.8%	1,032	799	77.4%	1,032	818	79.3%	795	574	72.2%
PO AA	25,589	250,055	733	556	75.9%	733	517	70.5%	733	585	79.8%	509	332	65.2%
PO BB	53,730	496,541	1,447	1,193	82.4%	1,447	1,075	74.3%	1,447	1,179	81.5%	1,074	826	76.9%
PO CC	12,823	131,395	391	337	86.2%	391	309	79.0%	391	354	90.5%	287	233	81.2%
PO DD	78,542	757,977	2,564	1,910	74.5%	2,564	1,947	75.9%	2,564	2,056	80.2%	1,850	1,251	67.6%
PO EE	29,208	283,620	916	705	77.0%	916	672	73.4%	916	745	81.3%	680	426	62.6%
PO FF	152,821	1,489,620	4,043	3,306	81.8%	4,043	3,256	80.5%	4,043	3,291	81.4%	3,037	2,124	69.9%
PO GG	30,556	301,924	589	499	84.7%	589	411	69.8%	589	495	84.0%	422	346	82.0%
PO HH	47,235	452,136	1,796	1,298	72.3%	1,796	1,318	73.4%	1,796	1,304	72.6%	1,254	865	69.0%
PO II	57,222	589,941	1,834	1,502	81.9%	1,834	1,196	65.2%	1,834	1,407	76.7%	1,328	977	73.6%
PO JJ	65,312	636,498	1,406	1,131	80.4%	1,406	1,032	73.4%	1,406	1,123	79.9%	1,023	774	75.7%
PGIP Total	**1,240,468**	**12,086,869**	**36,730**	**28,656**	**78.0%**	**36,730**	**27,178**	**74.0%**	**36,730**	**29,363**	**79.9%**	**27,013**	**19,203**	**71.1%**
Non-PGIP	**349,504**	**3,380,971**	9,987	7,501	**75.1%**	9,987	7,053	**70.6%**	9,987	7,397	**74.1%**	7,202	4,905	**68.1%**
ABC Benchmark					84.8%			80.6%			85.1%			80.3%

- Tables list POs alphabetically
- Metrics typically have raw numbers along with calculated rates
- PGIP Totals, Non-PGIP controls, & Benchmark comparisons included

Dashboards – POs Comparison



- Benchmark (if present) represents top performers with range to make up 10% total membership
  (20% total membership for Radiology)

- PGIP Total provided for comparison of PO's performance to average performance

PGIP Reporting – Datasets

- Physician Organizations receive their own MS-Access Datasets ***quarterly***
  - Distributed to all POs regardless of participation
- ***Allows Practice Unit to Practice Unit and/or Physician to Physician comparisons within a PO***
- Data tables included for member (patient) level activity information
  - Allows POs to create ad hoc queries as needed using initiative-specific data

PO Statistics - Emergency Department Utilization from Jan. 2009 to Dec. 2009

Attributed Members	Physician Organizatio Adults	Children	Totals	PGIP Overa Adults	Children	Totals
Number of attributed members	17366	7879	25245	955094	384158	1339252
Total number of visits	3800	1981	5781	209105	95312	304417
Percentage of members with at least 1 visit	14.9	17.2	15.7	16	19	16.8
Number of members with 5 or more visits	33	10	43	2233	539	2772
Percentage of visits accounted for by members with five or more visits	6	2.7	4.9	8.1	3.3	6.6
Primary Care Sensitive (PCS)						
Number of visits that were PCS	1848	848	2695	99092	41027	140119
Percentage of visits that were PCS	48.6	42.8	46.6	64.9	56.3	62.1

PO Top 10 ICD 9 Diagnosis Categories (mid level rollup)

Adults

ICD9 Mid level category	No of ED Visits
Chest pain	294
Abdomnl pain	251
Sprain	192
Headache/miq	146
Opn wnd extr	142
Ot up rsp in	142
Superfic inj	137
Other injury	118
Ot joint dx	107

Children

ICD9 Mid level category	No of ED Visits
Ot up rsp in	185
Superfic inj	146
Opn wnd head	123
Other injury	118
Sprain	96
Otitis media	96
Fx arm	75
Asthma	64
Abdomnl pain	60

PO Percentage of ED Visits by Day of the Week

Age Category	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
ADULT	14.6	14.9	14.3	13.5	14.6	13	15.2
CHILD	18.5	13.6	12.3	13.1	14.1	12.6	15.9

PO ICD 9 Diagnosis categories (high level rollup)

Asthma

Gender

- (•) ALL
- ( ) Female
- ( ) Male

View Data

ED Visits	Adult	Children	Totals
Number of ED Visits	40	64	104

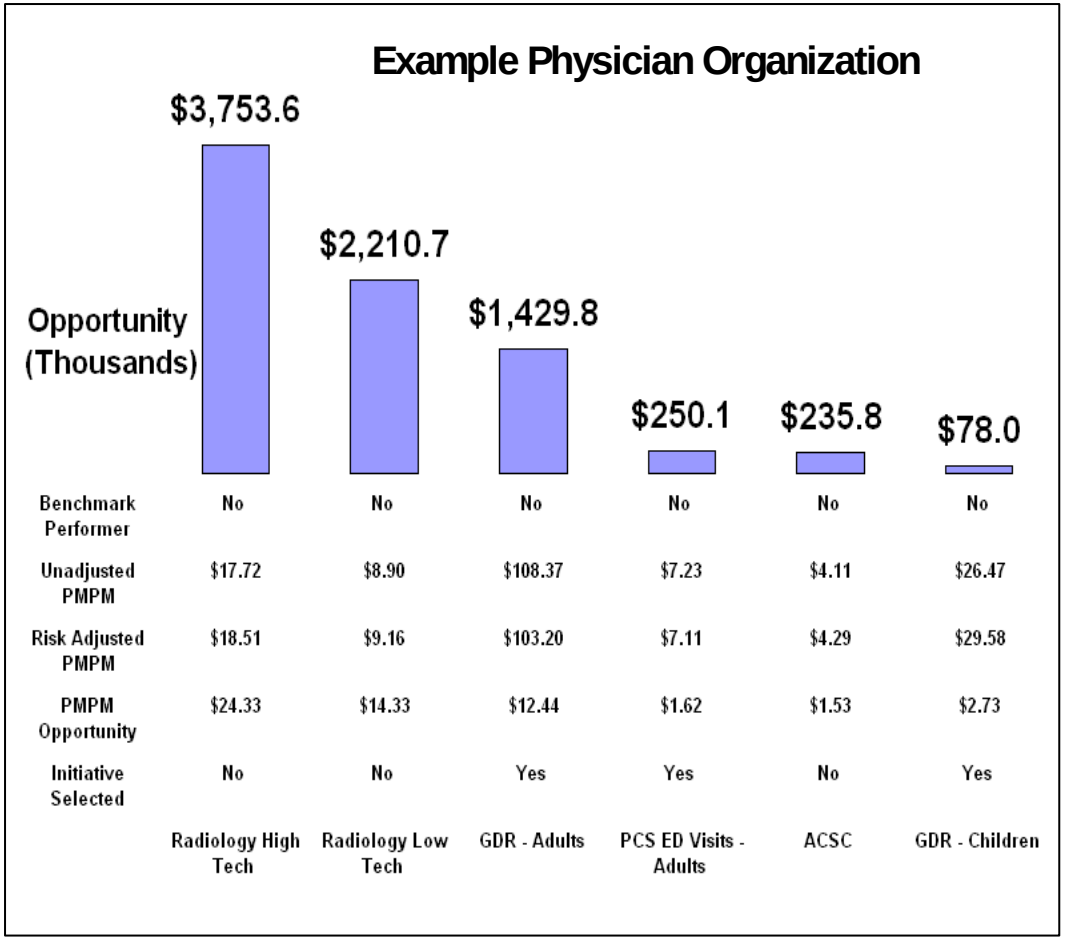
Percentage of ED visits by NYU categories

Non-emergent	0	0	0
Emergent, Primary care treatable	1.89	1.89	1.89
Emergent, ED needed, preventable	98.11	98.11	98.11
Emergent, ED needed, not preventable	0	0	0
Injury	0	0	0
Mental Health	0	0	0
Alcohol	0	0	0
Drug	0	0	0
Unclassified	0	0	0

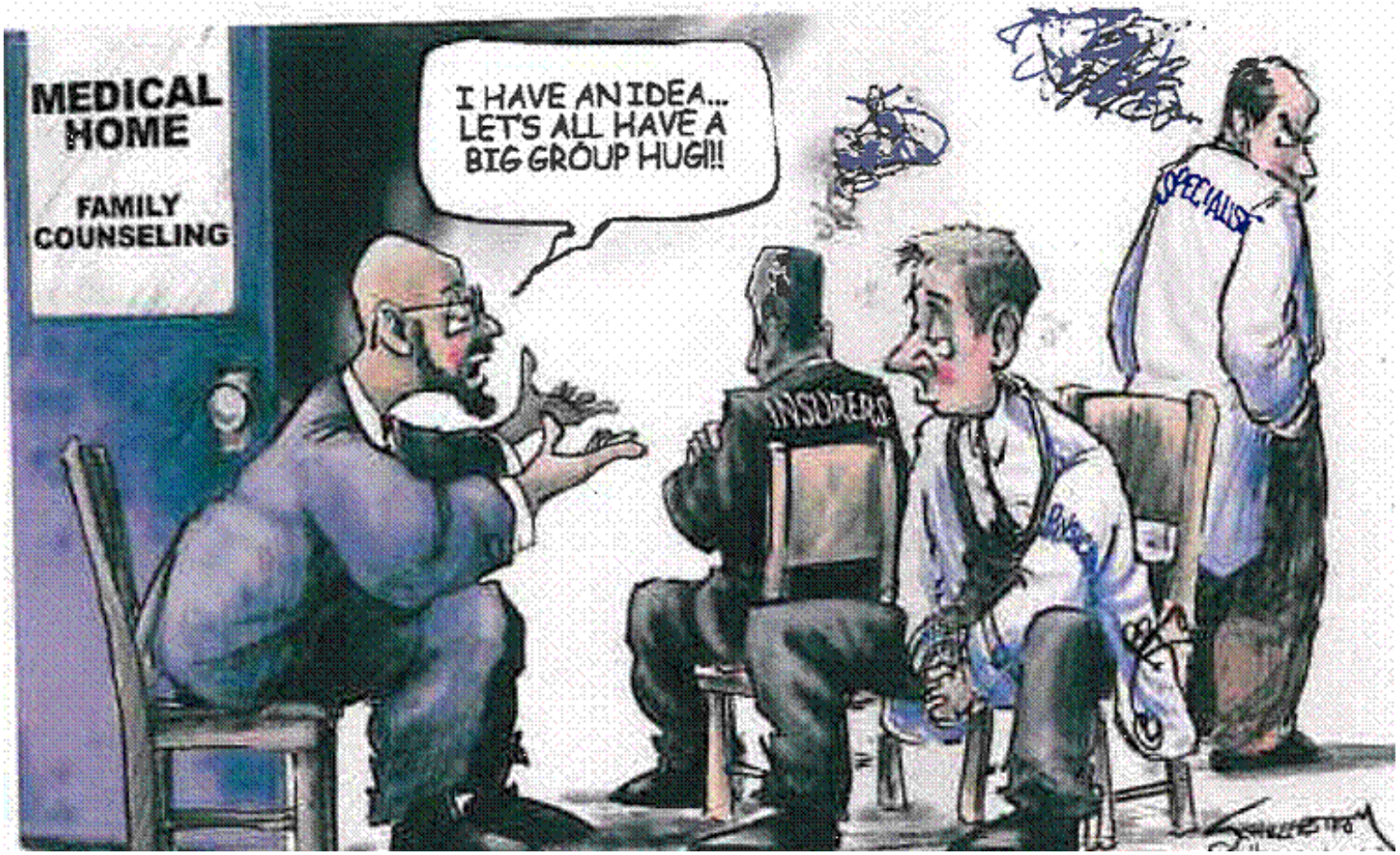
All ED Visits | % PCS by Physician

Opportunity Analysis

- Physician Organizations receive own Opportunity Analysis file semi-annually
- Describes key metrics for each PGIP Initiative and opportunity analysis of PO-specific metric outcomes versus PGIP Total and/or Benchmark metrics



Poof! You're a PCMH! [not]



BCBSM Incremental Approach to PCMH Developed in Collaboration with PGIP Providers

PGIP PCMH Initiatives

- Opportunity for PGIP POs to participate in **12 PCMH Initiatives** (started in 2008)
- All PCPs and Specialists in PGIP may participate
- Over 6,000 physicians currently working on implementing PCMH capabilities
- ***$ to POs via PGIP incentives***

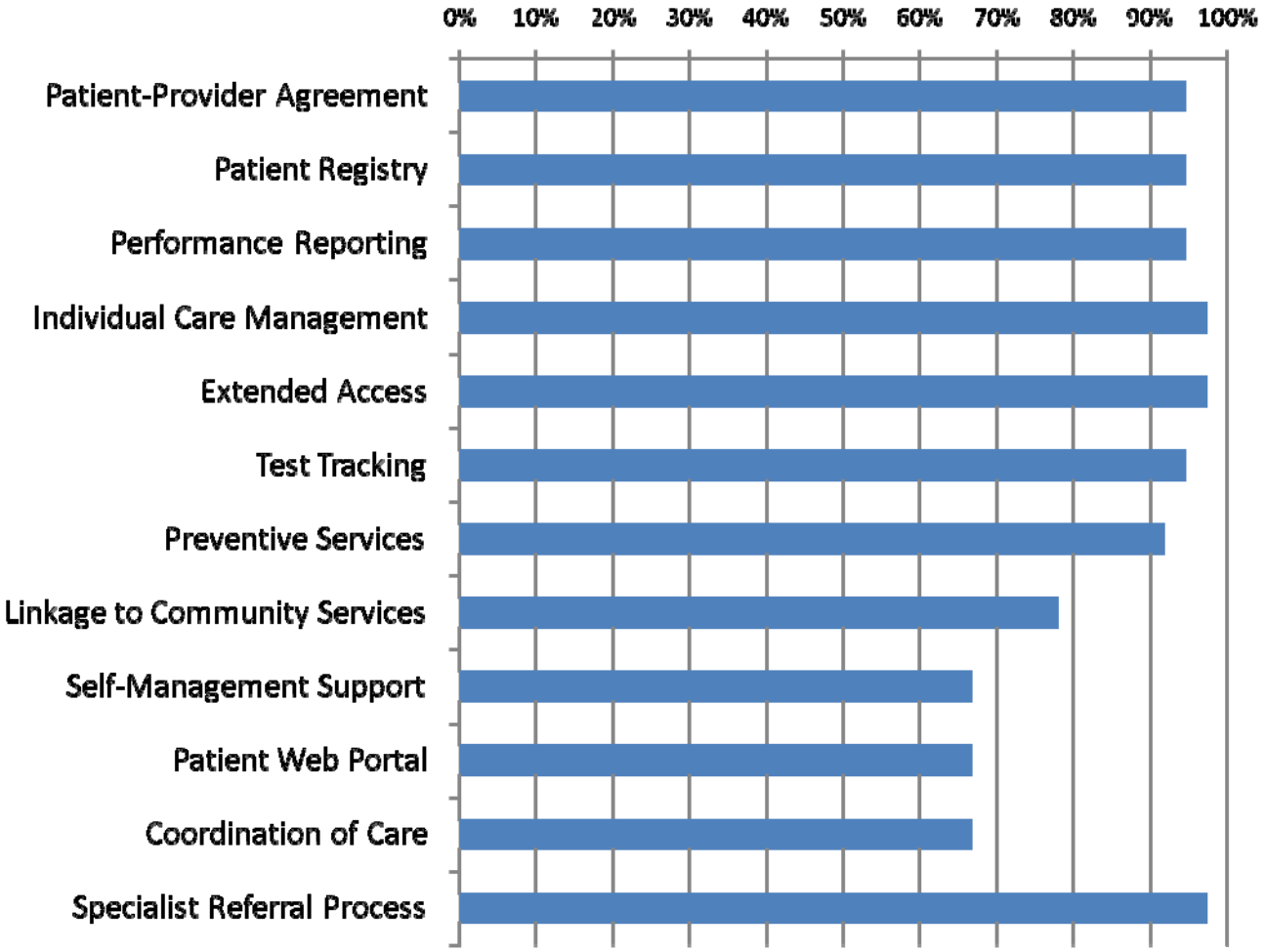
PGIP PCMH Designation Program

- Opportunity for PGIP Practice Units to be PCMH Designated by BCBSM and compensated for additional time and resources required (started in July 2009)
- Only PCPs are eligible
- ***$ to Practices via increased E&M fees***

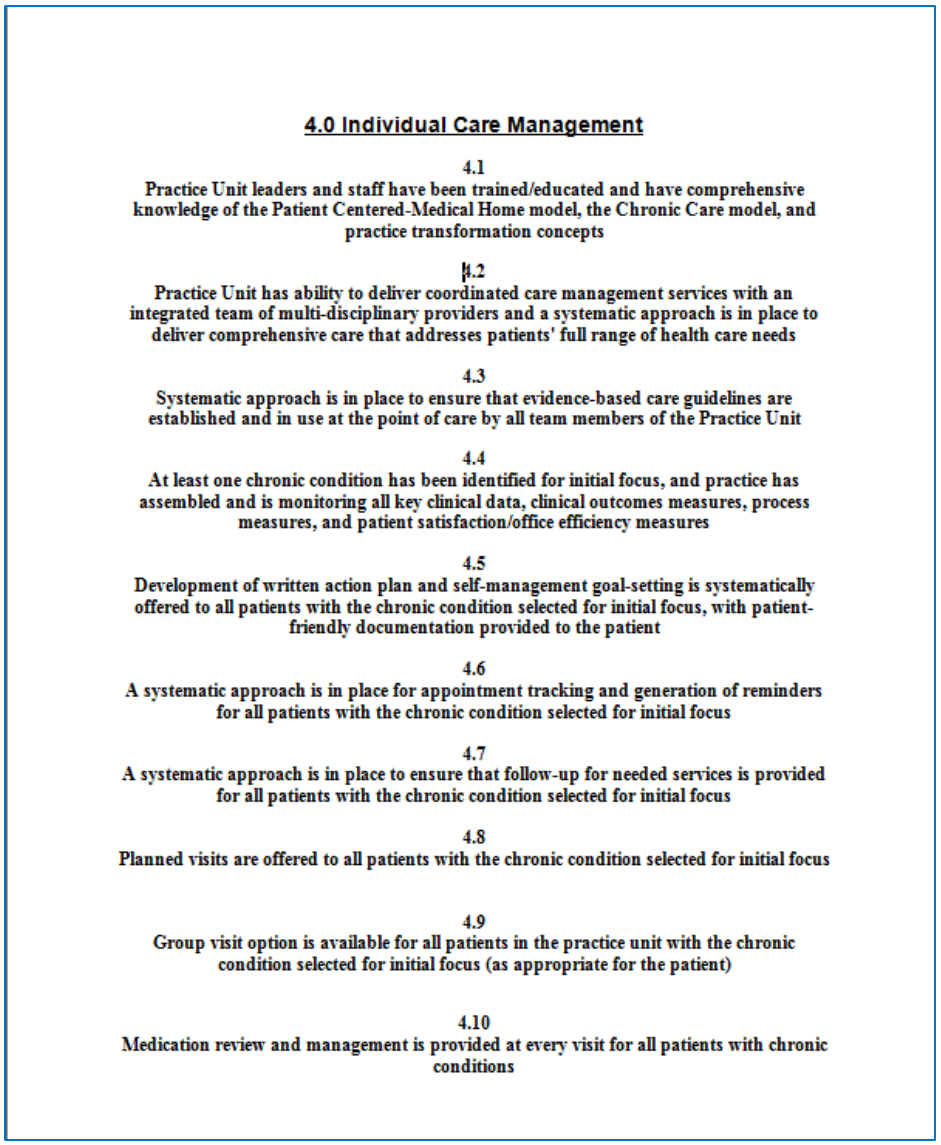
  Office visits → 99201 – 99215
  Preventive → 99381 – 99397

*POs working on **initiatives** with their practices leads to Practice **designation**.*

Percent of PGIP POs Participating in "Infrastructure Building" PCMH Initiatives



Each PCMH Initiative has “Capabilities” to be Implemented



4.0 Individual Care Management

4.1
Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts

4.2
Practice Unit has ability to deliver coordinated care management services with an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver comprehensive care that addresses patients' full range of health care needs

4.3
Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit

4.4
At least one chronic condition has been identified for initial focus, and practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures

4.5
Development of written action plan and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with patient-friendly documentation provided to the patient

4.6
A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus

4.7
A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus

4.8
Planned visits are offered to all patients with the chronic condition selected for initial focus

4.9
Group visit option is available for all patients in the practice unit with the chronic condition selected for initial focus (as appropriate for the patient)

4.10
Medication review and management is provided at every visit for all patients with chronic conditions

- Over 120 capabilities in total
- POs self-report implementation of capabilities at practice unit level (no required sequence)
- BCBSM uses self-reported data to pay incentives (validated via site visits selected by random sampling)
- Once all a PO’s practice units have implemented all capabilities in an initiative, no further incentives earned for that initiative.

40+ Pages of PCMH Interpretive Guidelines

BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home Domains of Function

Interpretive Guidelines

September 2010

valuepartnerships

"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."

5.0 Extended Access

5.1
Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

- Clinical decision-maker must be an M.D., D.O., P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising M.D. or D.O. on an immediate basis if needed
  - Clinical decision-maker may be, but is not required to be, the patient's primary care provider
- Clinical decision-maker has the ability to direct the patient regarding self-care or to an appropriate level of care.
- Clinical decision-maker communicates all clinically relevant information via phone conversation directly to patient's primary physician, by email, by automated notification in an EMR system, or by faxing directly to primary physician regarding the interaction within 24 hours (or next business day) of the interaction
- Clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)

5.2
24-hour patient access to clinical decision-maker (as defined in 5.1) is enhanced by enabling clinical decision-maker to access and update patient's EMR or registry info during the phone call

Guidelines:

- Clinical decision-maker should routinely have access to patient's EMR or registry information for all calls
  - Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.2 as long as access to the EMR or registry is typically and routinely available

5.3
Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week and, if different from the PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

PCMH Designation Program

1. Physician offices nominated by their PGIP PO
2. Scores calculated based on:
   - PCMH capabilities in place (50%)
     - Self-reported data validated through site visits
   - Performance on quality/use/efficiency measures (adult and pediatric) (50%)
     - Quality: Evidence Based Care and Preventive measures
     - Use: ED use for primary care treatable conditions and high-tech and low-tech radiology rates
     - Efficiency: Generic Dispensing Rate and trend
- Highest ranked practices are designated
  - Program expands each year

Practice Units that achieve PCMH Designation continue to participate in PCMH Initiatives and are expected to demonstrate ongoing progress towards fully implementing PCMH domains of function

2011 PCMH Designation Nominations

	2009	2010	2011
# PGIP Practice Units*	2738	3173	4192
# Eligible Practice Units**	2202	2561	2468
# Nominated Practice Units	670	738	975

+10% +32%

2009: 80% of PUs were eligible; 30% of eligible PUs were nominated

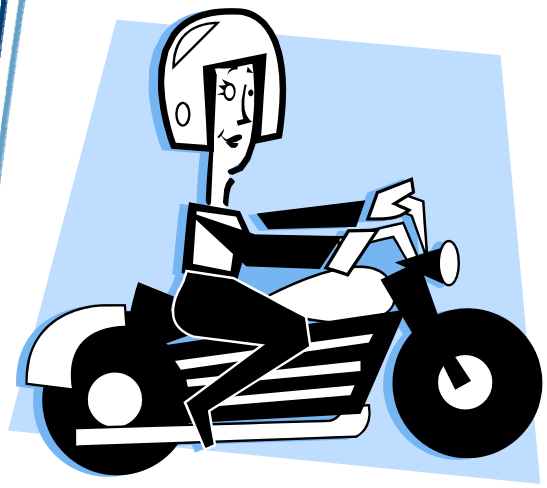
2010: 68% of PUs were eligible; 36% of eligible PUs were nominated

2011: 59% of PUs are eligible; 40% of eligible PUs are nominated

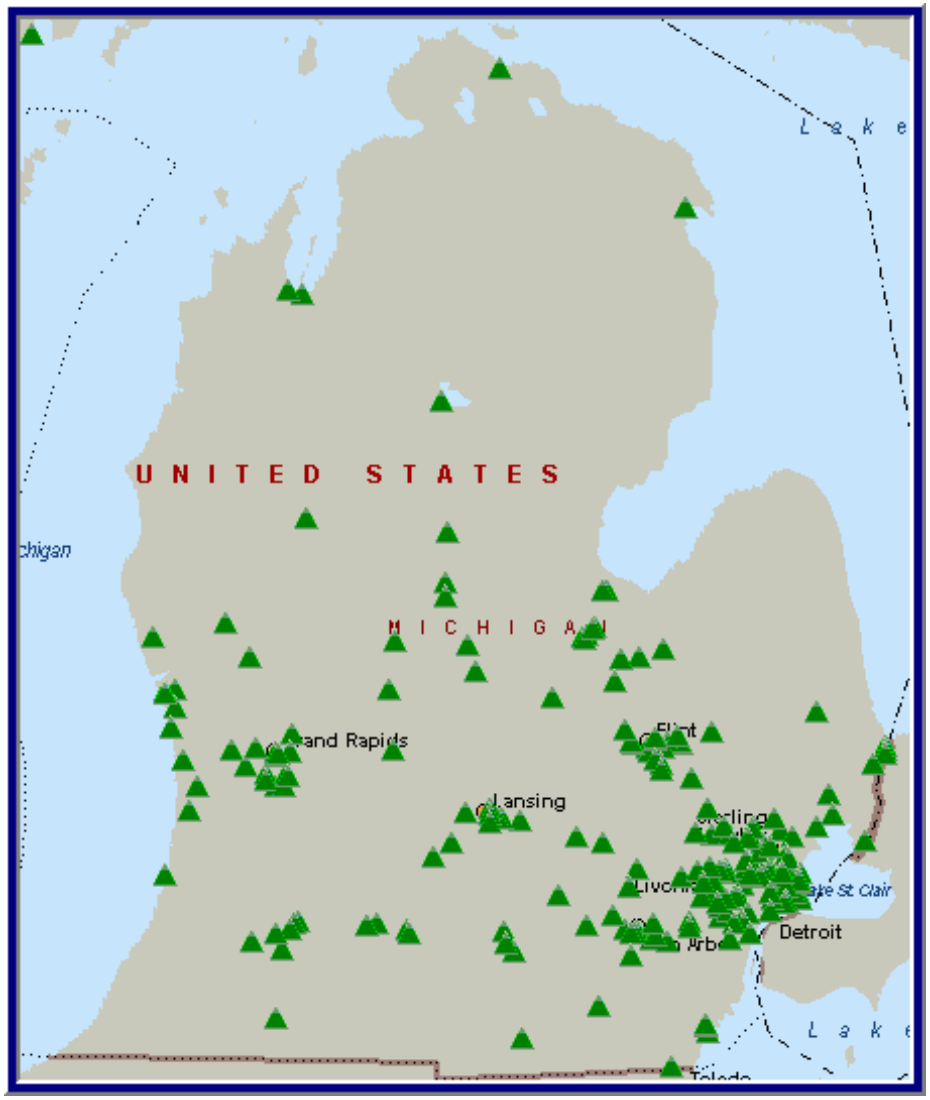
*excludes Physician Resource Management practice units
**For this analysis, "Eligibility" is defined as practices with as least one physician functioning as a PCP

SOURCES: AAA_PCMH_Designees_Physician_2009; Jan 2010 SAD; Winter 2011 SRD

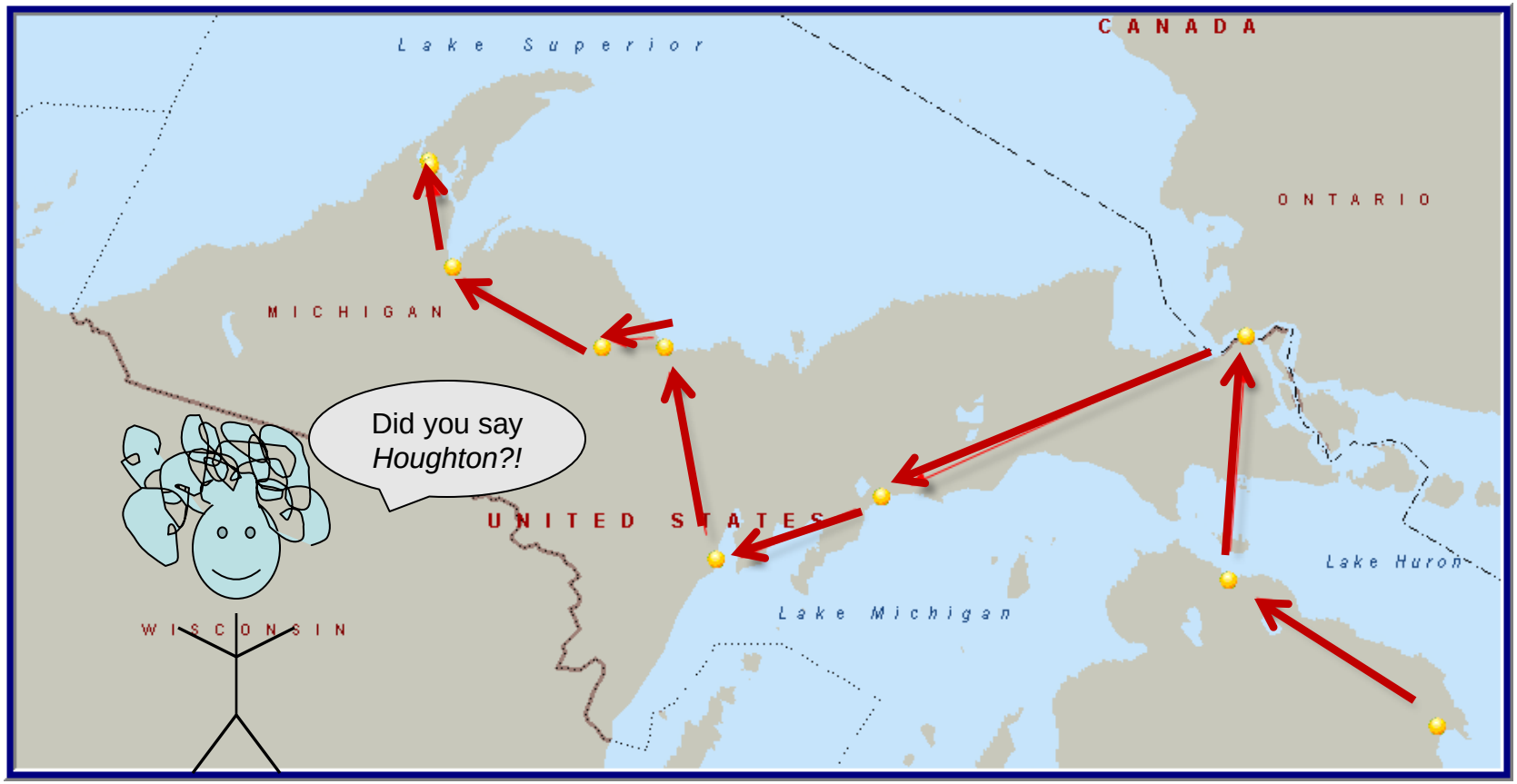
400 Validation Site Visits For 2011 PCMH Designation



POs are accountable for accurate reporting of practice unit progress



Visits are Educational ~ not “Audits”



Why Don’t We Just Use the NCQA Program?

- PGIP PCMH developed at the same time as NCQA, in collaboration with our PGIP partners
- Latest validation results demonstrate greater than 90 percent adherence to our interpretive guidelines
- We are able to assess and validate the association between the presence of specific practice capabilities and related performance measures, such as between after-hours access and ER visits
- High degree of satisfaction with site visits and support materials provided by the health plan and PO’s

Indicate your level of agreement with the following statements.

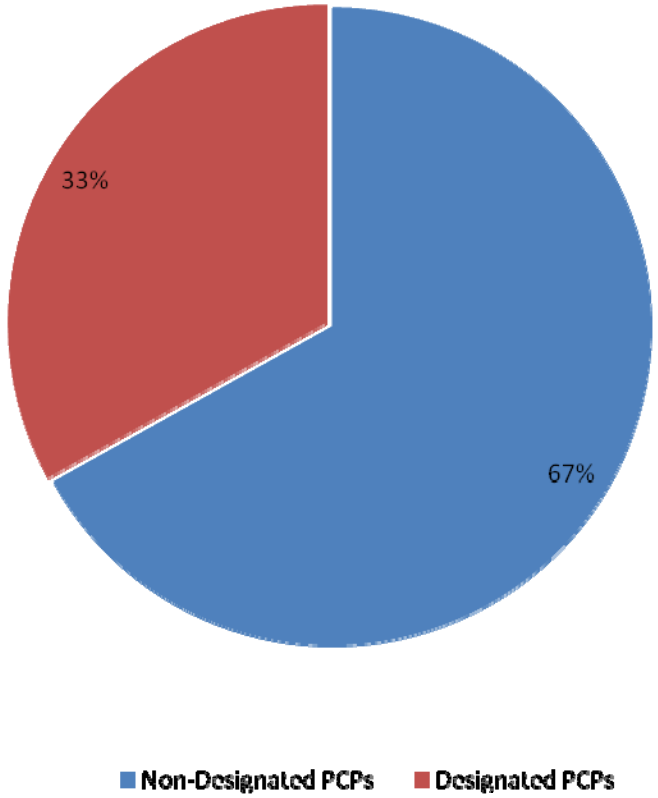
	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree	Rating Average	Response Count
Overall, I was satisfied with the site visit.	3.8% (5)	0.8% (1)	0.8% (1)	9.1% (12)	**85.6% (113)**	4.72	132
The PGIP field representative explained the purpose of the visit.	3.8% (5)	0.0% (0)	0.8% (1)	3.0% (4)	**92.4% (122)**	4.80	132
The PGIP field representative presented/discussed the information clearly and effectively.	3.8% (5)	0.0% (0)	0.8% (1)	6.1% (8)	**89.4% (118)**	4.77	132
The site visit was educational and increased my knowledge of PCMH and PGIP.	3.8% (5)	0.0% (0)	3.0% (4)	9.1% (12)	**84.1% (111)**	4.70	132
The PCMH material provided by my physician organization has had a positive impact on my understanding of PCMH.	3.8% (5)	2.3% (3)	3.0% (4)	9.8% (13)	**81.1% (107)**	4.62	132
					answered question		**132**

How many times during the year has your physician organization met with your practice to work on the PCMH program?

	Response Percent	Response Count
1 - 3	20.5%	27
4 - 6	**34.1%**	**45**
7 - 9	13.6%	18
10 or more	31.8%	42
	answered question	132

- Survey results show practices receive significant support from both the health plan and the physician organizations. Other processes, such as NCQA, lack programmatic support.
- Over 30 percent of practices were visited “10 or more times” by the physician organization to promote the transformation

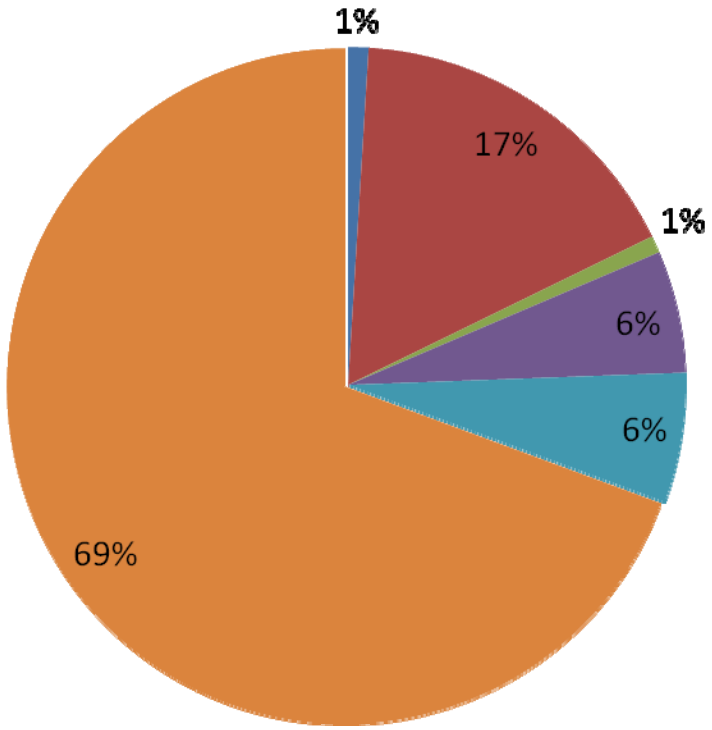
2010: 1,777 Designated PCPs*



Designated as compared to All PGIP	Designated	Non Designated
AVG number PCPs/ Practice Unit	3.66	2.24
AVG number members/ Practice Unit	1,220	717

*505 practices designated

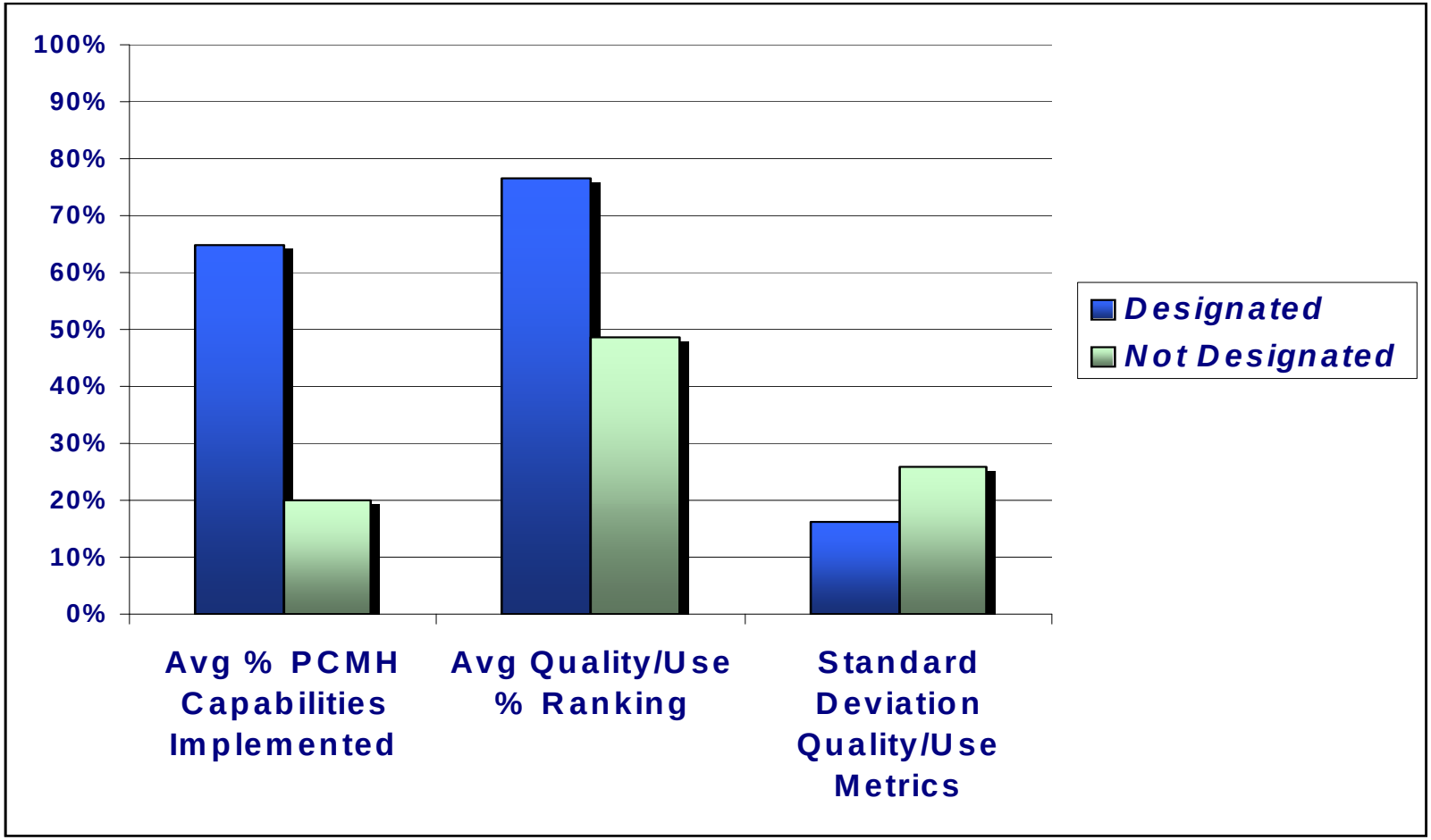
Majority of Designated PCPs are in Family Multi-Physician Practices

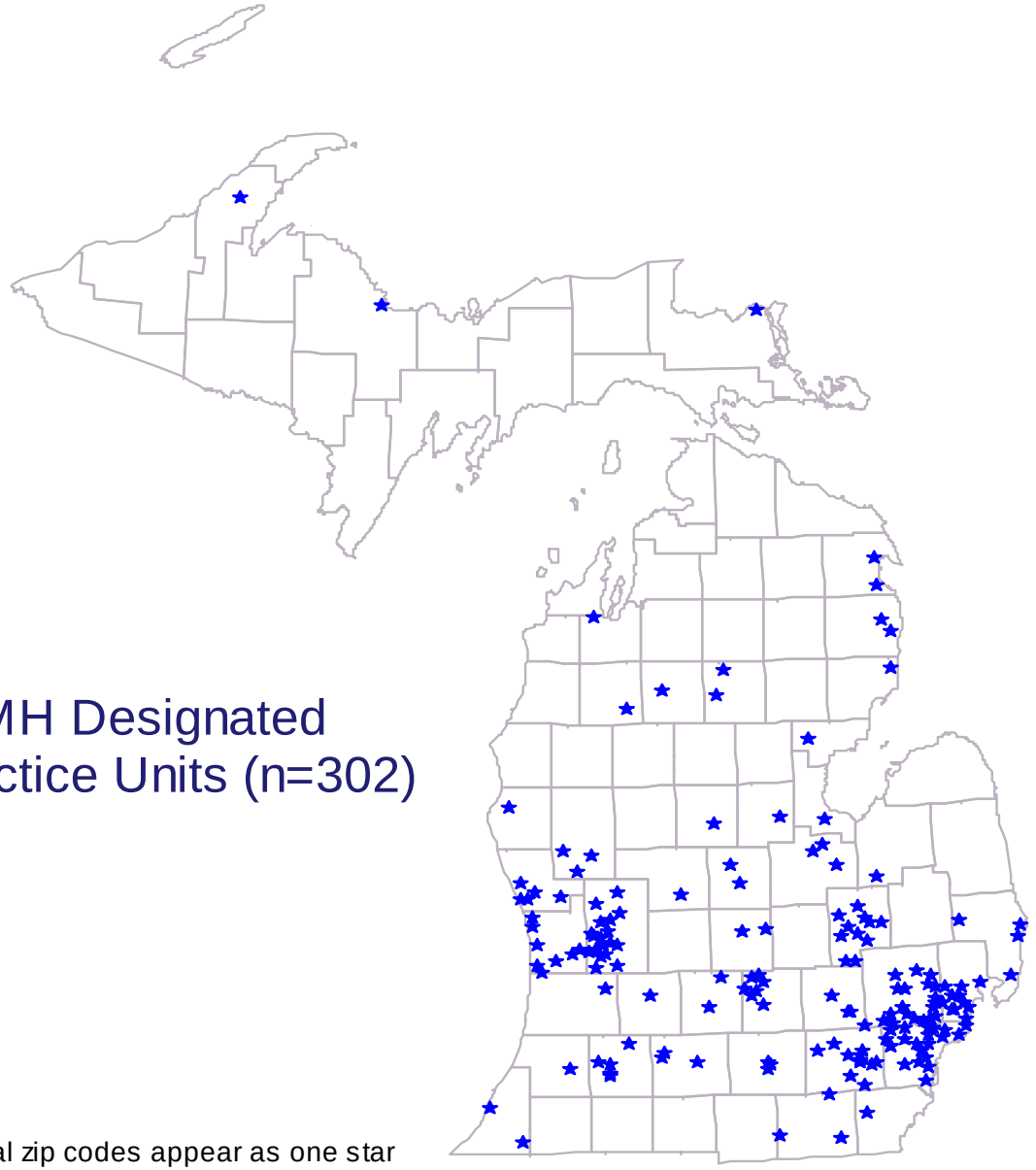


- Peds Solo
- Peds Multi-Physician
- Adult Solo
- Adult Multi-Physician
- Family Solo
- Family Multi-Physician

	Within PGIP
Peds Solo	3%
Peds Multi-Physician	12%
Adult Solo	4%
Adult Multi-Physician	5%
Family Solo	18%
Family Multi-Physician	57%

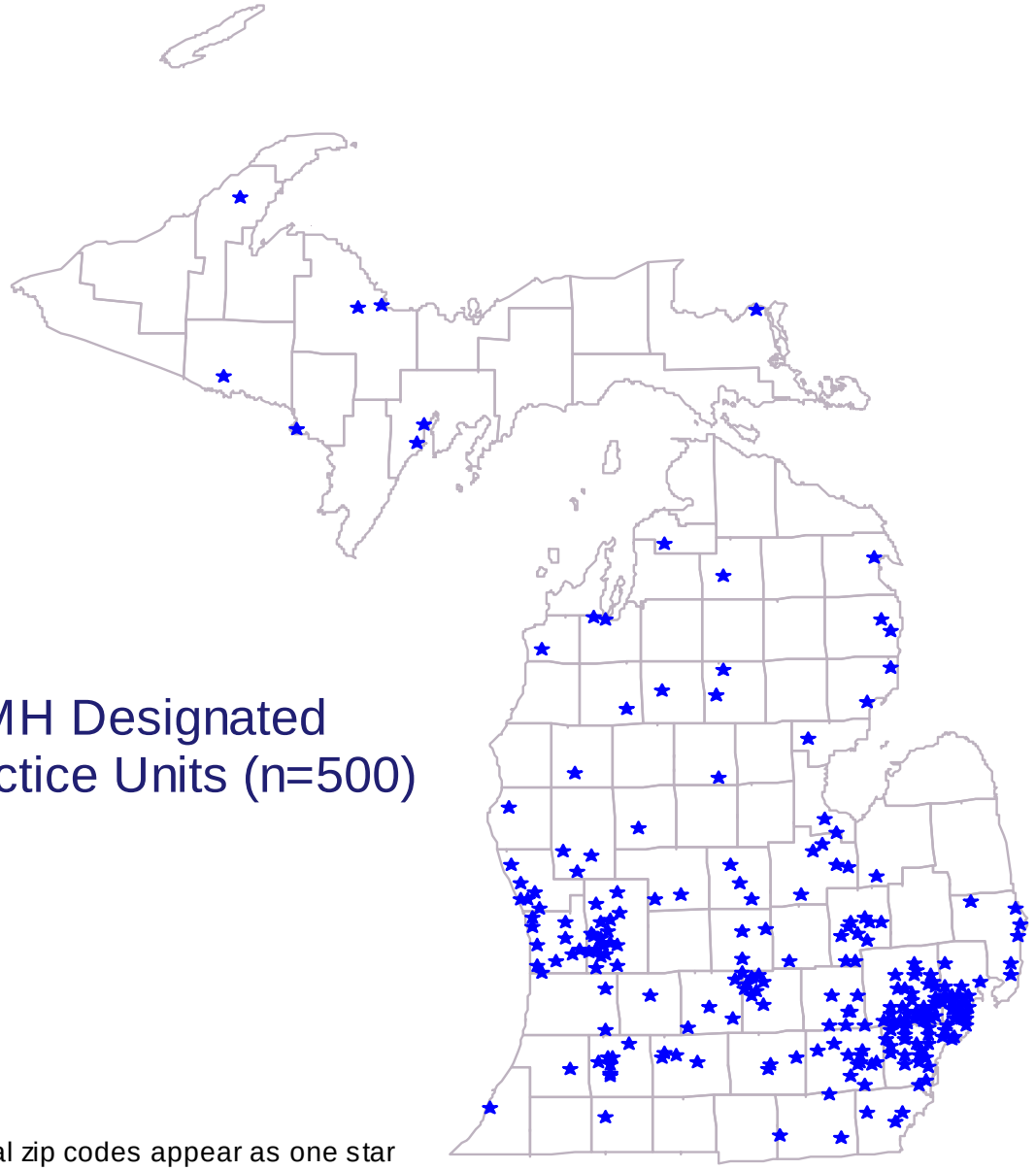
Goal: Strong PCMH Functionality and Quality/Use Performance in Designated Population





2009 PCMH Designated PGIP Practice Units (n=302)

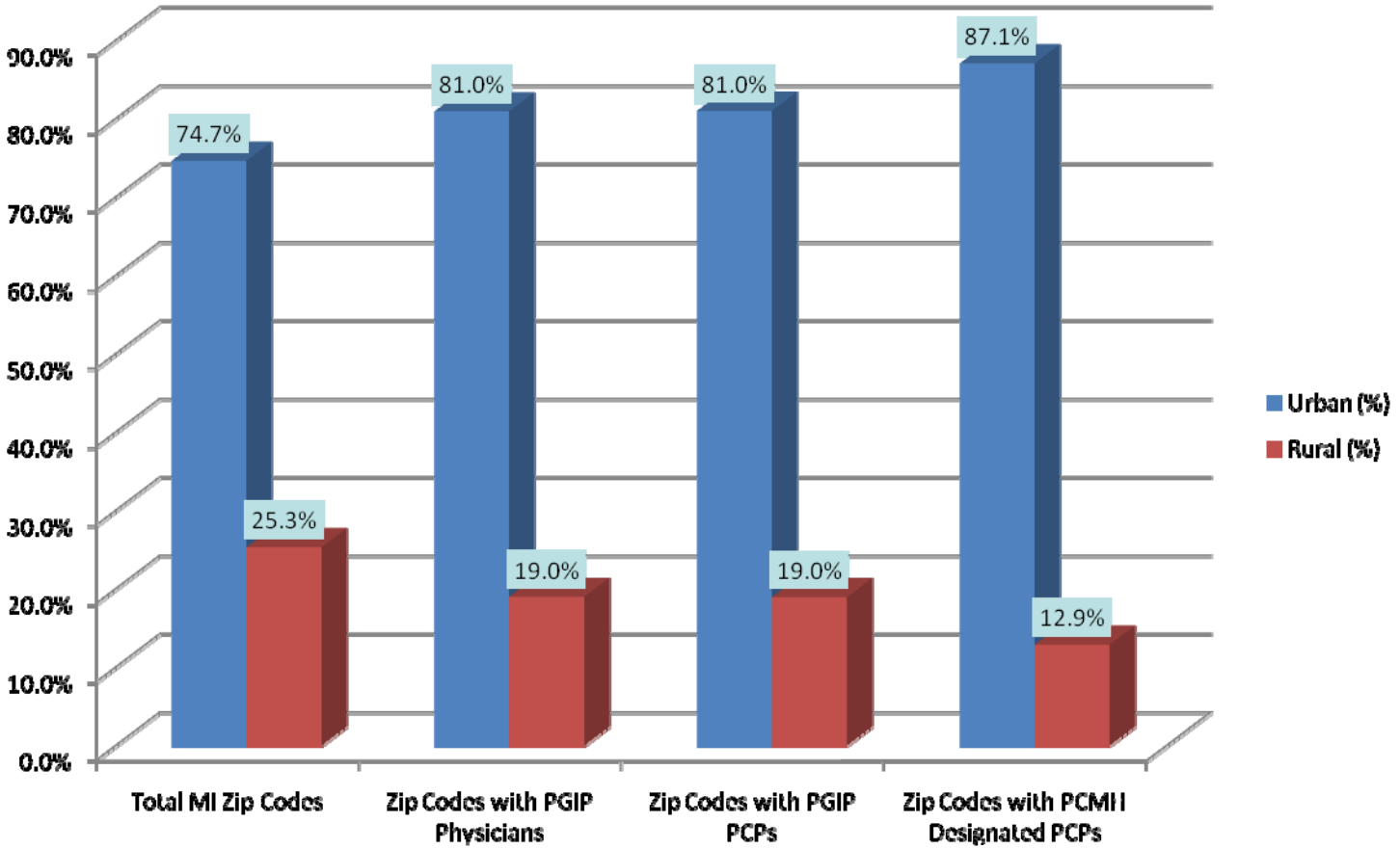
* Sites with identical zip codes appear as one star



2010 PCMH Designated PGIP Practice Units (n=500)

* Sites with identical zip codes appear as one star

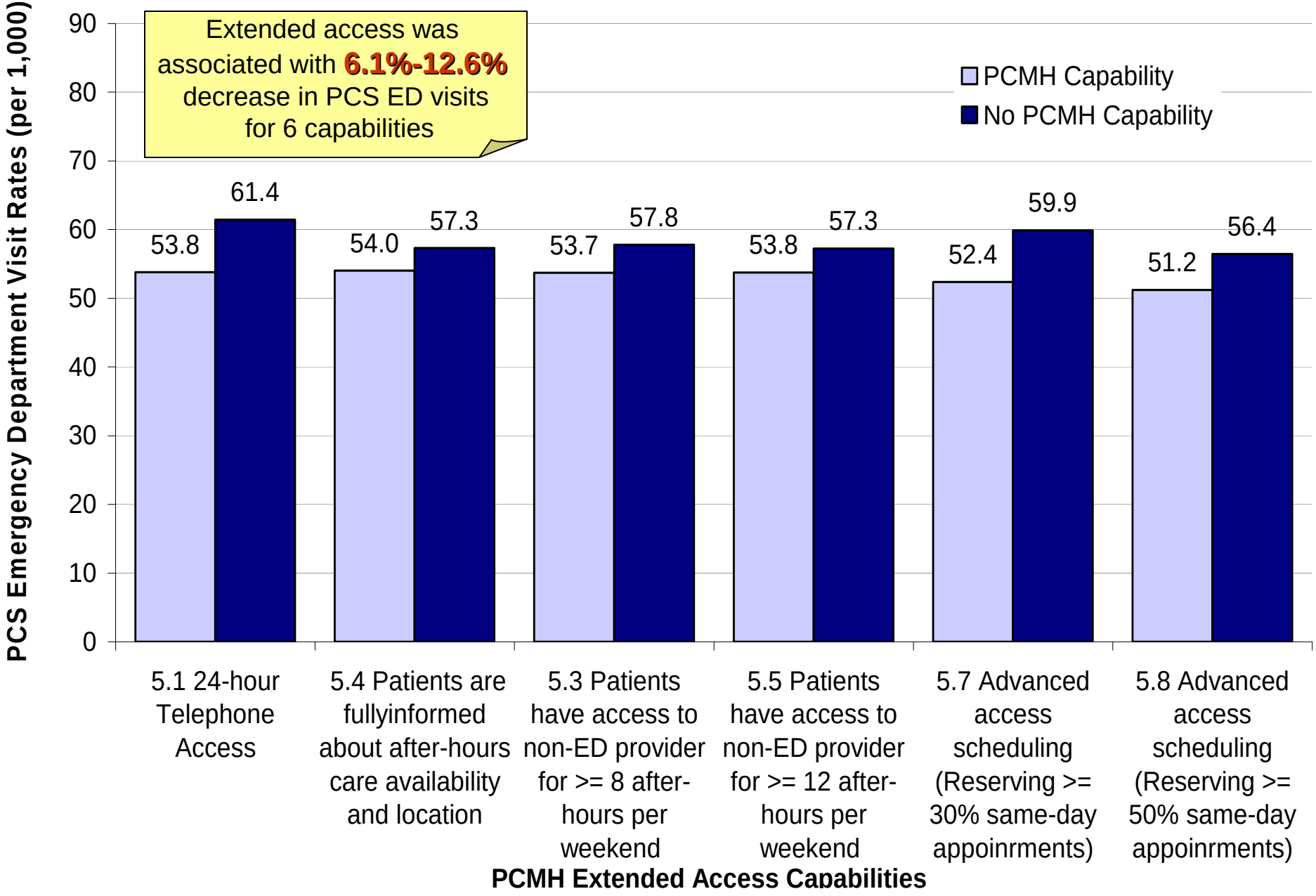
13% of PCMH Designated Physicians are in Rural Areas



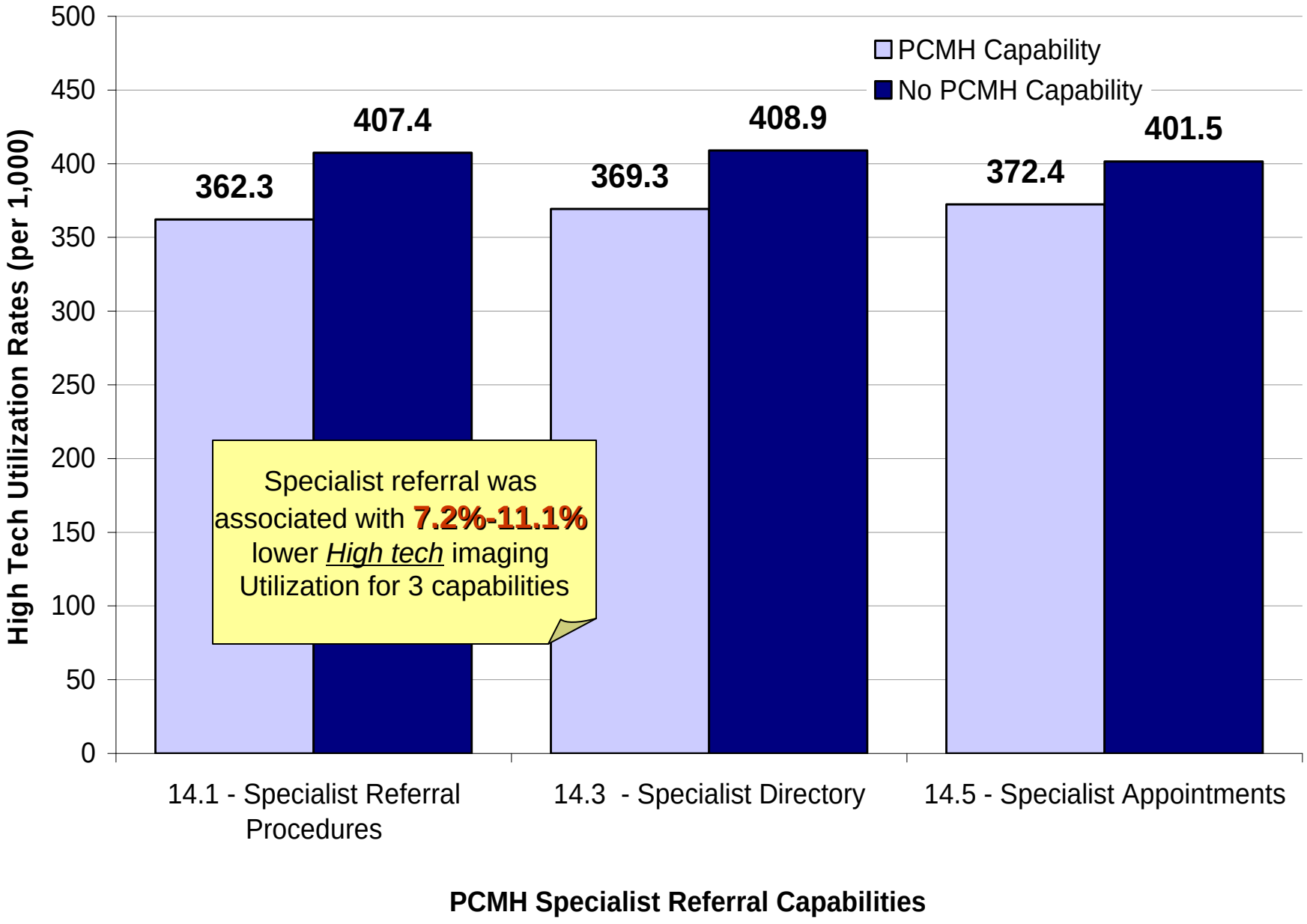
Performance of 2010 PCMH Designated Practices Compared to PGIP Primary Care Non-Designated Practices - Adults

Metric	2010 PCMH Designees Compared to PGIP non-PCMH Practices	
	Jan.- Dec. 2009	Jan.-June 2010
Adults (18-64)		
Emergency department visits (per 1,000)	-2.3%	-2.8%
Primary care sensitive emergency department visits (per 1,000)	-1.2%	0.8%
Ambulatory care sensitive inpatient discharges (per 1,000)	**-14.6%**	**-25.5%**
High tech radiology services (per 1,000)	-10.3%	-7.4%
High tech radiology standard cost PMPM	-6.8%	-4.3%
Low tech radiology services (per 1,000)	-7.4%	-8.4%
Low tech radiology standard cost PMPM	-7.9%	-8.8%
Generic dispensing rate	4.8%	4.2%
Outpatient standard cost PMPM	**0.7%**	**-1.1%**

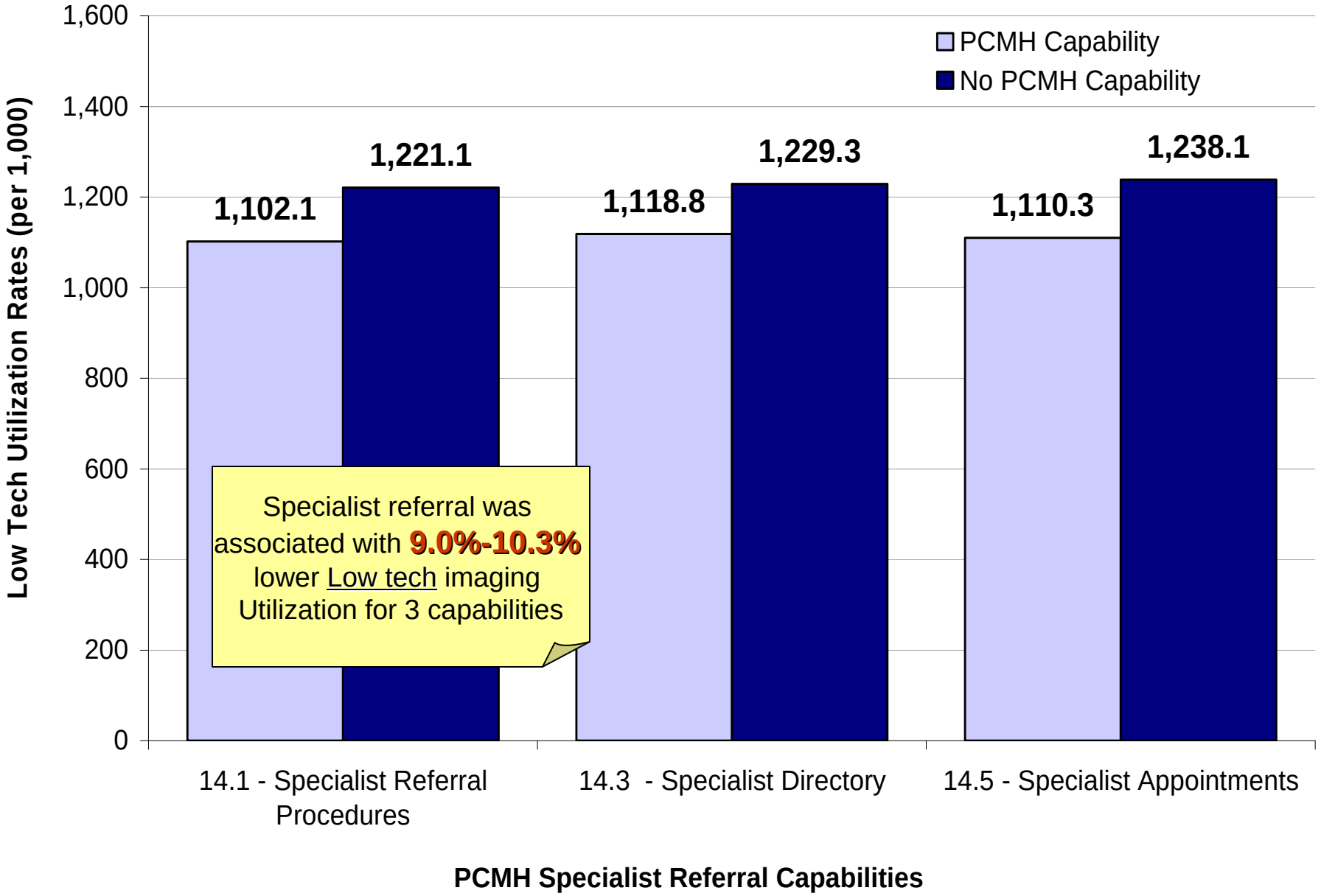
The Impact of Extended Access on Primary Care Sensitive (PCS) Emergency Department Visits, 2009



The Impact of Specialist Referral Capabilities on High Tech Imaging Utilization Rates (per 1,000), 2009



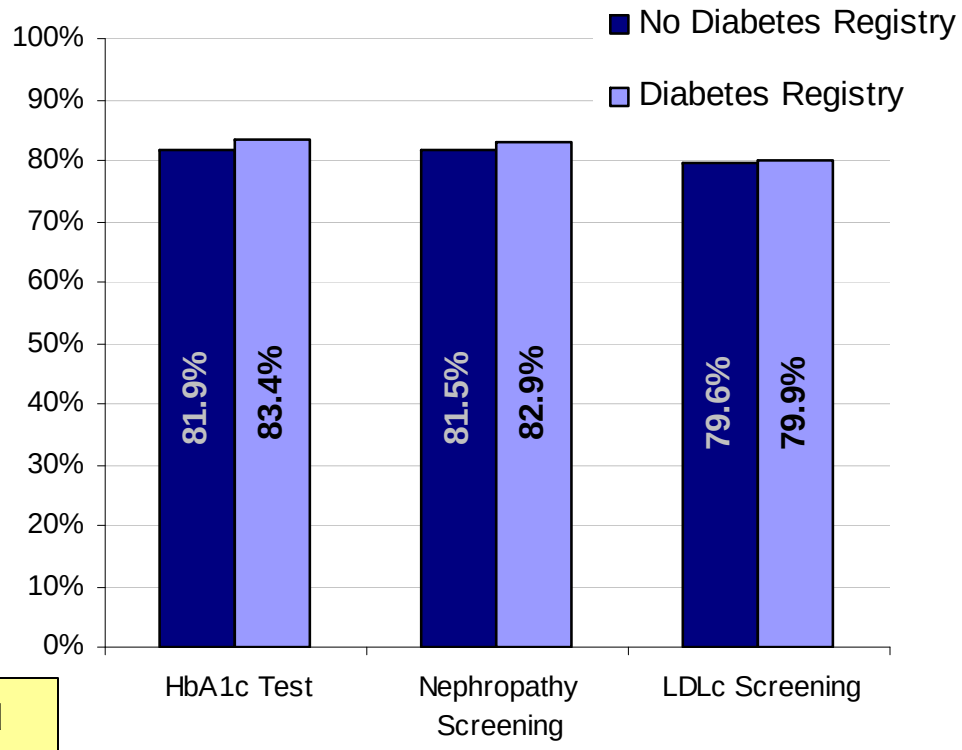
The Impact of Specialist Referral Capabilities on Low Tech Imaging Utilization Rates (per 1,000), 2009



Effectiveness of Registry in improving diabetes-related quality of care metrics

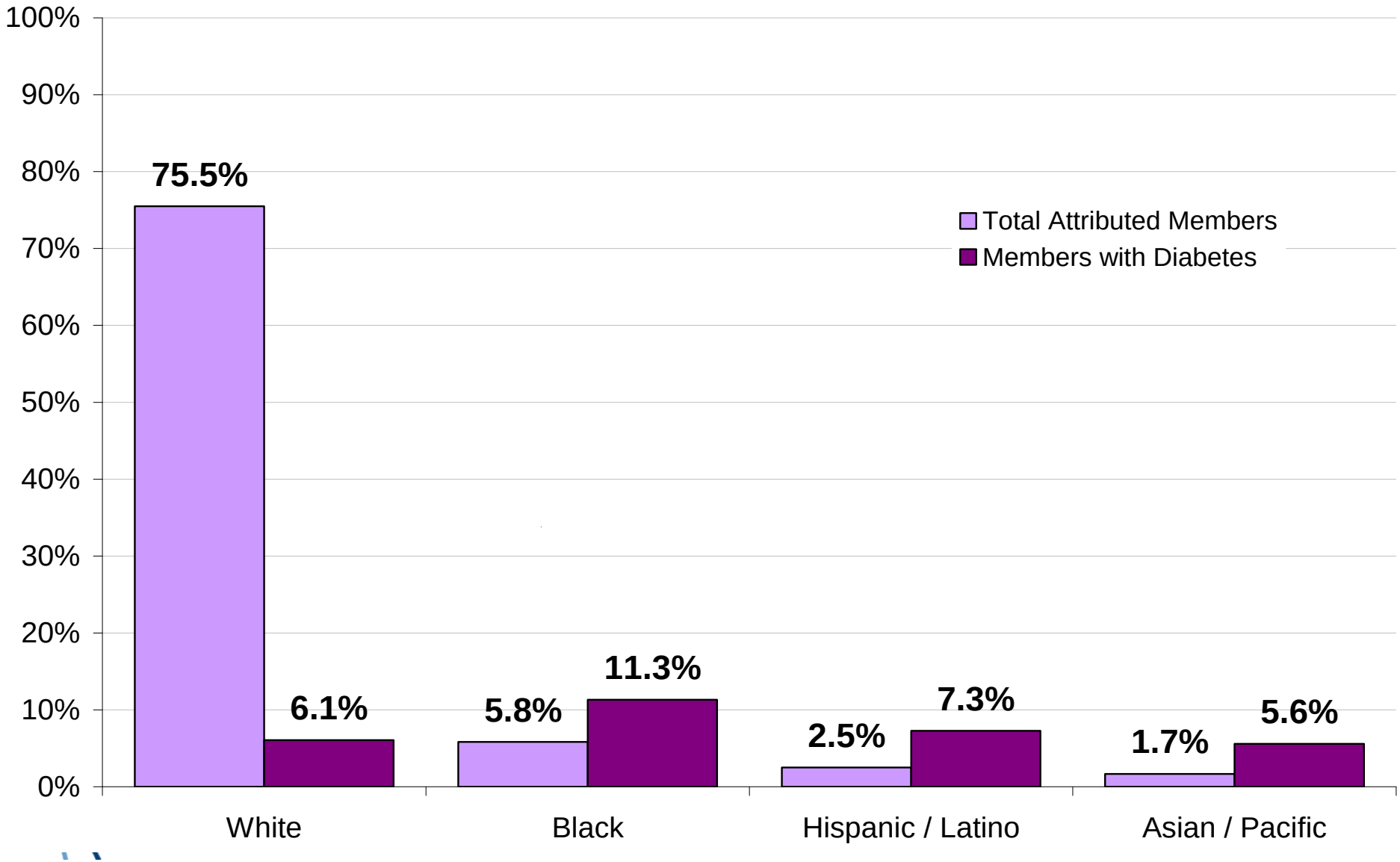
Among 68,250 Diabetic Members with a care relationship with a PCP participating in PGIP in 2009

Quality Indicator	No Registry	Registry	Diff
HbA1c Test	81.9%	83.4%	1.8%
Nephropathy Screening	81.5%	82.9%	1.7%
LDLc Screening	79.6%	79.9%	0.4%



Registries were associated with **0.4%-1-8%** higher quality of care for all 3 diabetes-related Indicators

Percent of Members (0-64) with a Care Relationship with a PGIP PCP and Prevalence of Diabetes by Race / Etnicity, 2009



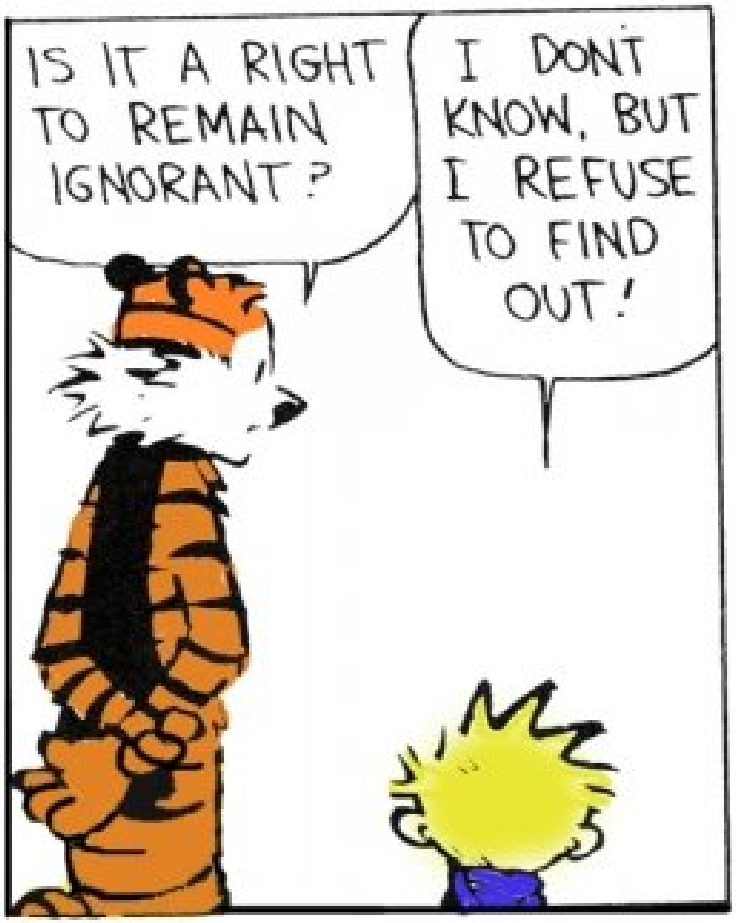
Effectiveness of Registries in improving quality of care metrics, by Race/Ethnicity

Among 68,250 Diabetic Members with a care relationship with a PCP participating in PGIP in 2009

Race / Ethnicity	HbA1c Testing			Nephropathy Screening			LDLc Testing		
	No Diabetes Registry	Diabetes Registry	Diff	No Diabetes Registry	Diabetes Registry	Diff	No Diabetes Registry	Diabetes Registry	Diff
White	81.5%	84.0%	2.5%	78.9%	78.0%	1.0%	79.5%	80.7%	1.2%
Black	75.8%	80.6%	**4.8%**	79.9%	83.2%	**3.3%**	77.9%	75.4%	2.5%
Hispanic / Latino	76.7%	81.6%	**4.9%**	82.3%	83.3%	1.0%	76.9%	78.1%	1.2%
Asian / Pacific Islander	82.9%	85.7%	2.8%	87.0%	91.4%	**4.5%**	85.7%	84.0%	1.7%
Unclassified	79.7%	81.8%	2.1%	81.6%	84.0%	2.4%	79.5%	79.2%	0.3%
Total Races	80.6%	83.4%	2.8%	79.4%	80.7%	1.3%	79.3%	80.0%	0.6%

Registries were associated with **0.3%-4.9%** higher quality of care for all 3 diabetes-related indicators across all race/ethnicity categories with a greater increase for Black and Hispanic members

Lessons Learned

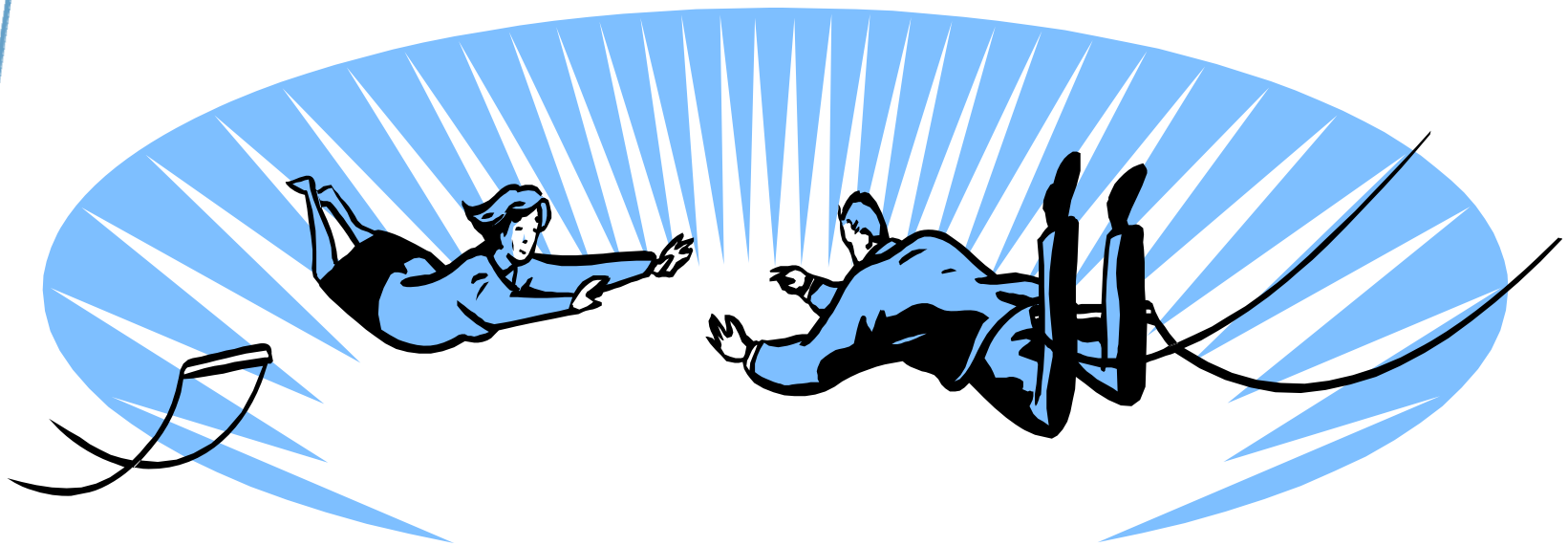


Don’t be afraid of failure

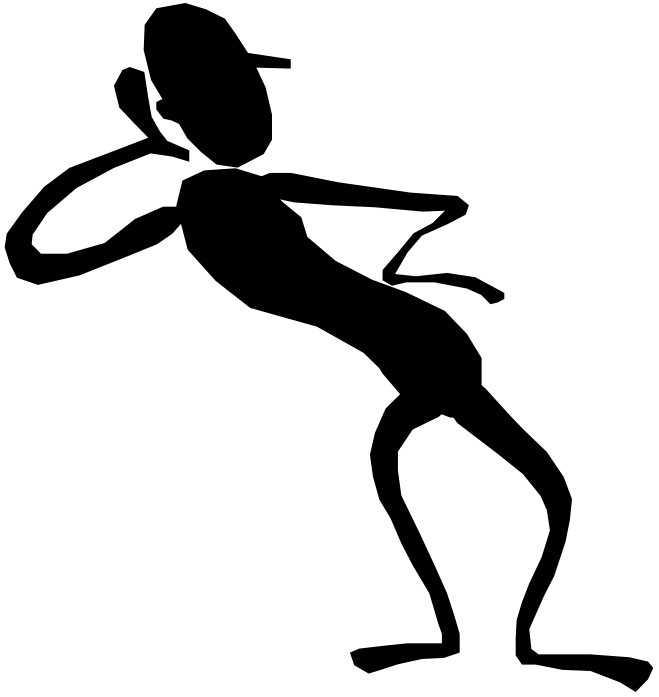
Top 3 Mistakes

1. *Too much transparency too soon can cause much anxiety* ~ should not have sent out preliminary PCMH designation results prior to site visits (year 1)
2. *Be prepared to revisit your most elegant solutions* ~"T codes" for non-physician care management were not widely adopted due to patient liability, inability for POs to bill, and administrative complexity since only BCBSM (and BCN) reimburse
3. *Don't forget about potato/potahto* ~ developed Interpretive Guidelines mid-way through first year site visits

Trust and Collaboration are Key



Maintain long-term vision but also listen and adjust



No ruby slippers

One Size Does NOT Fit All

Random Humor Helps

"Your husband's doing well, but we're going to need to keep him overnight because he's funny and I'm lonely."

Remember what it's all about

Eats, Shoots and Leaves

Patient, Centered

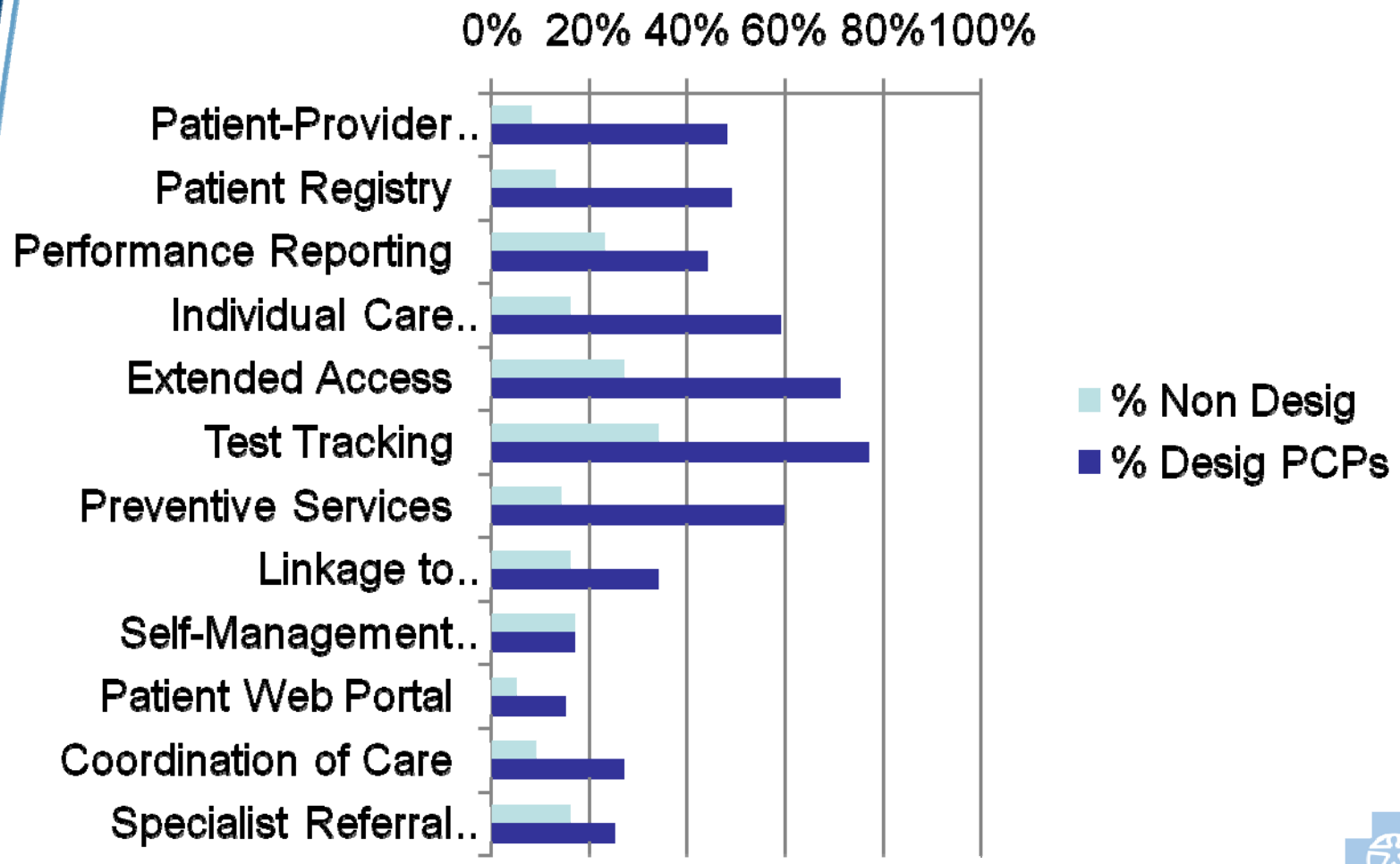
Care

Appendix

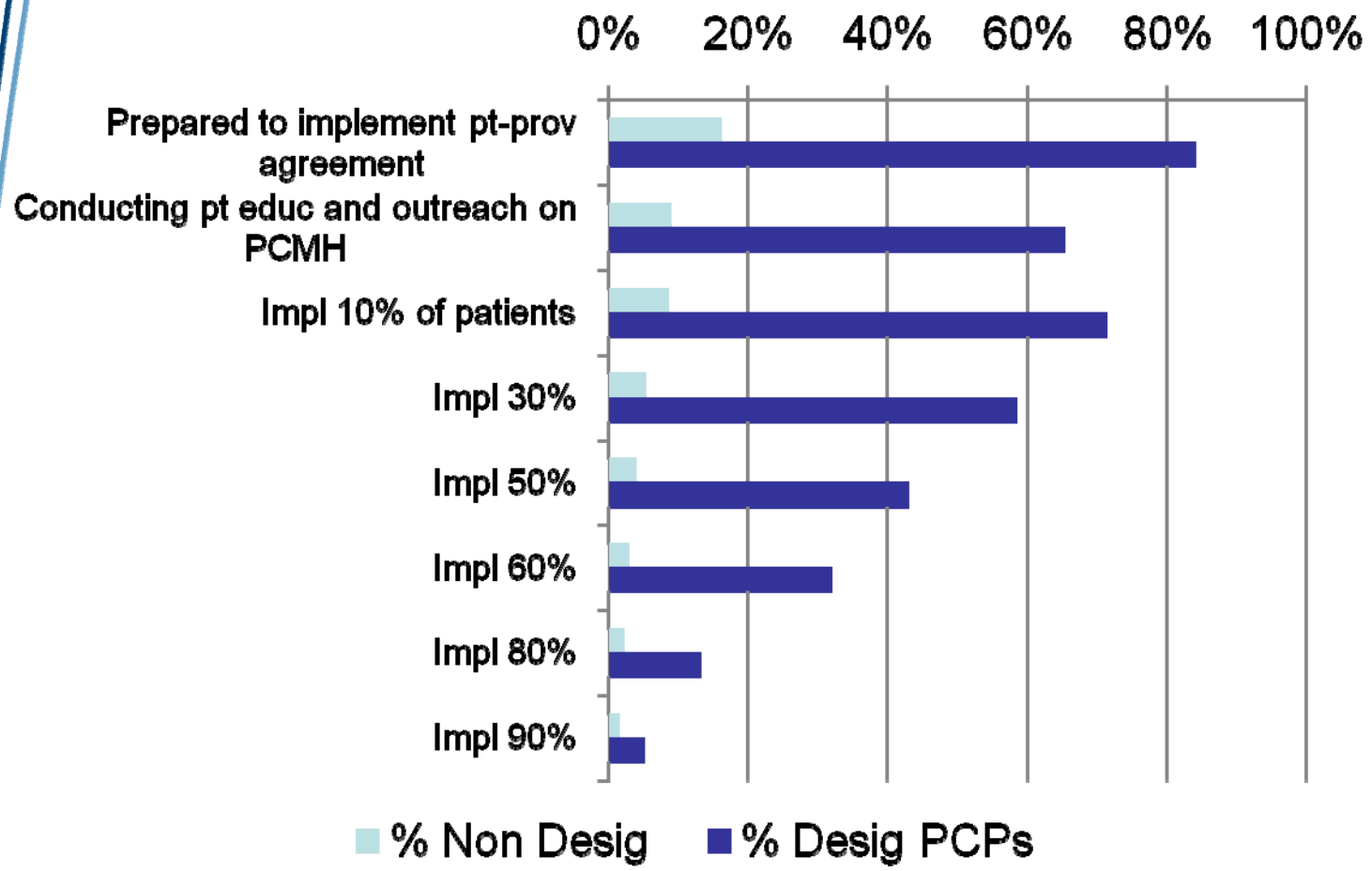
Percent of PCMH Designation-Eligible PCPs with PCMH Capabilities in Place, by Domain

2010 Designated vs. Non-Designated PCPs

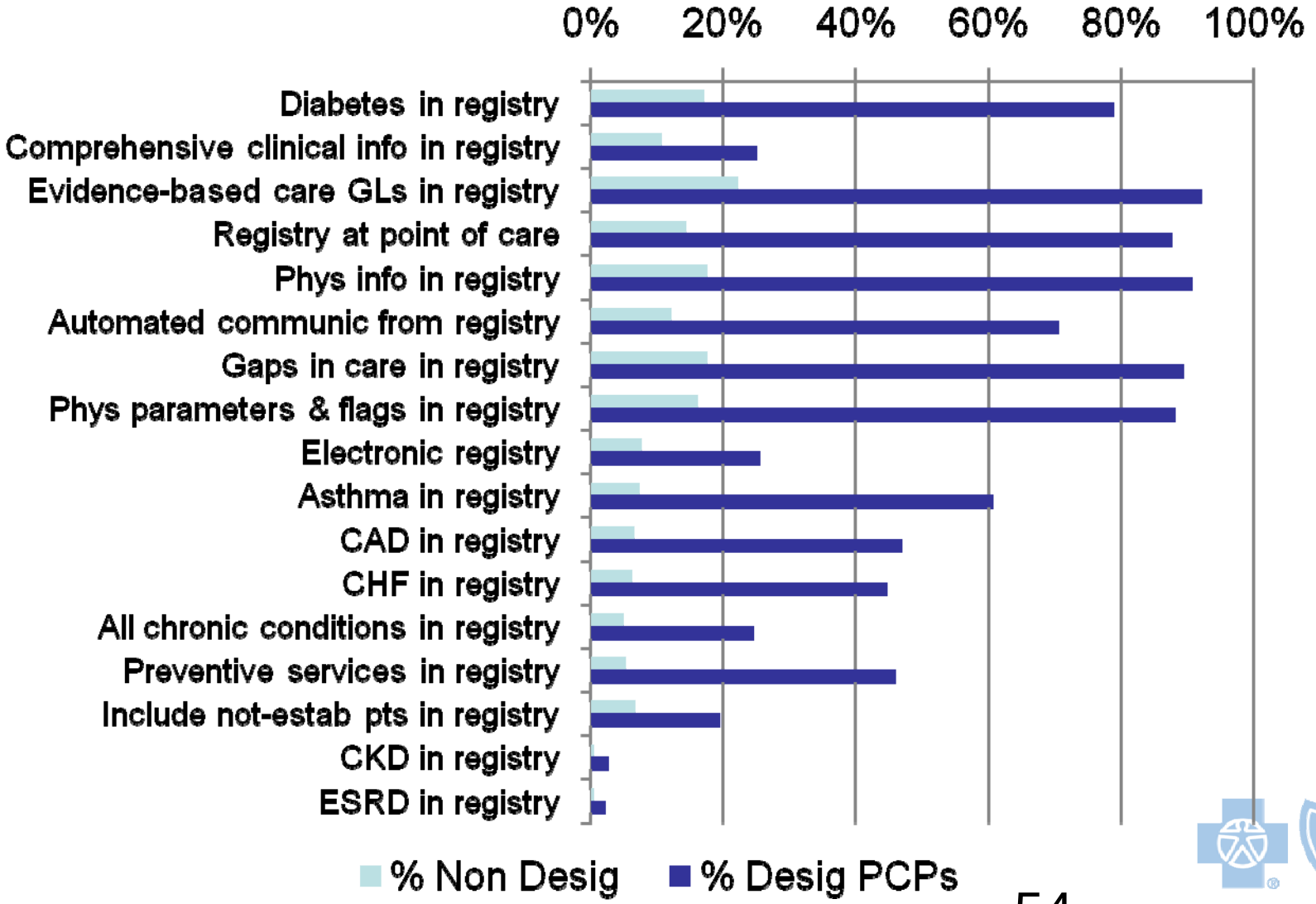
PGIP PCMH Infrastructure in 2010: Average Percent of PCMH Capabilities in Place Designated vs. Non-Designated Practices



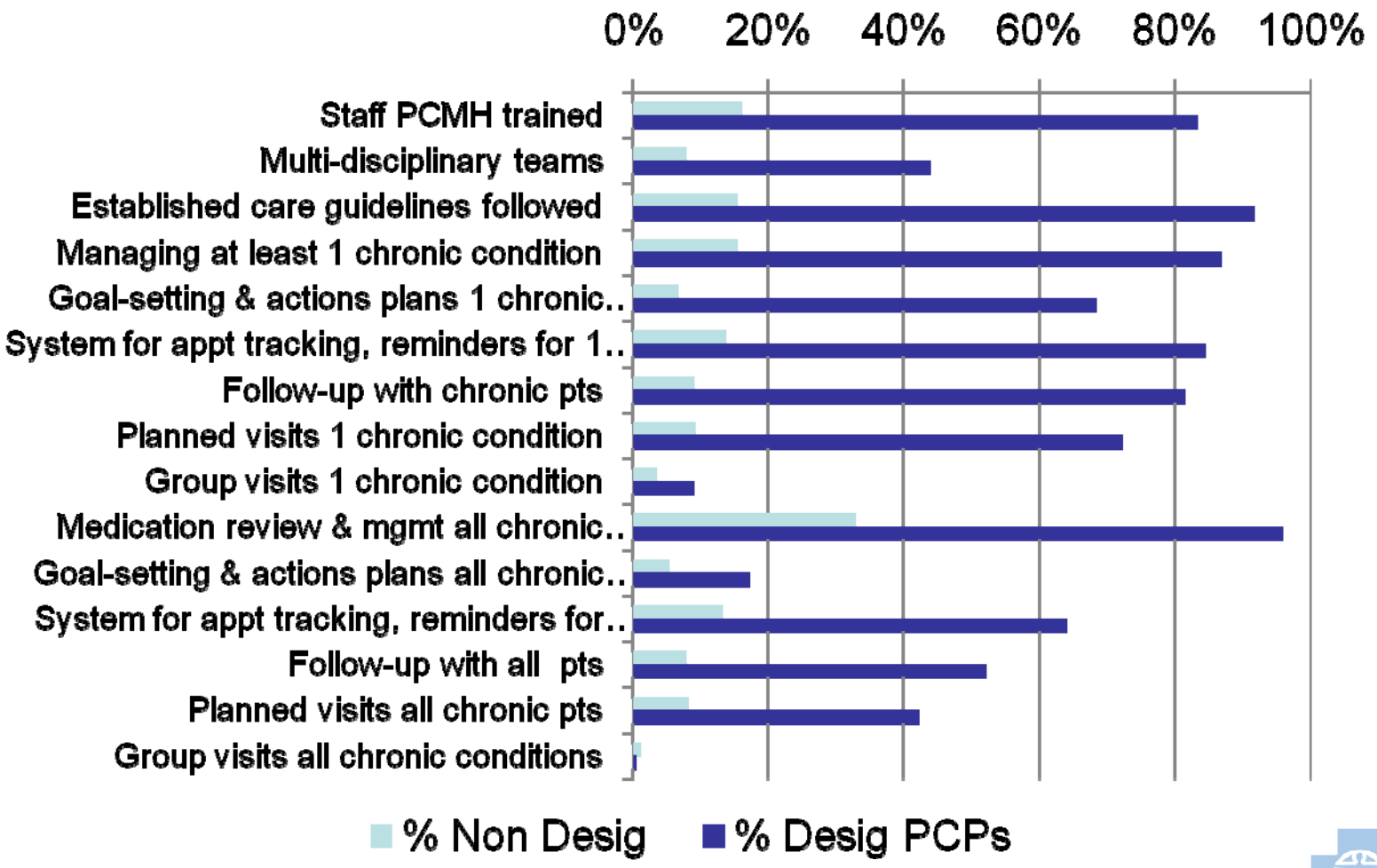
Patient-Provider Partnership



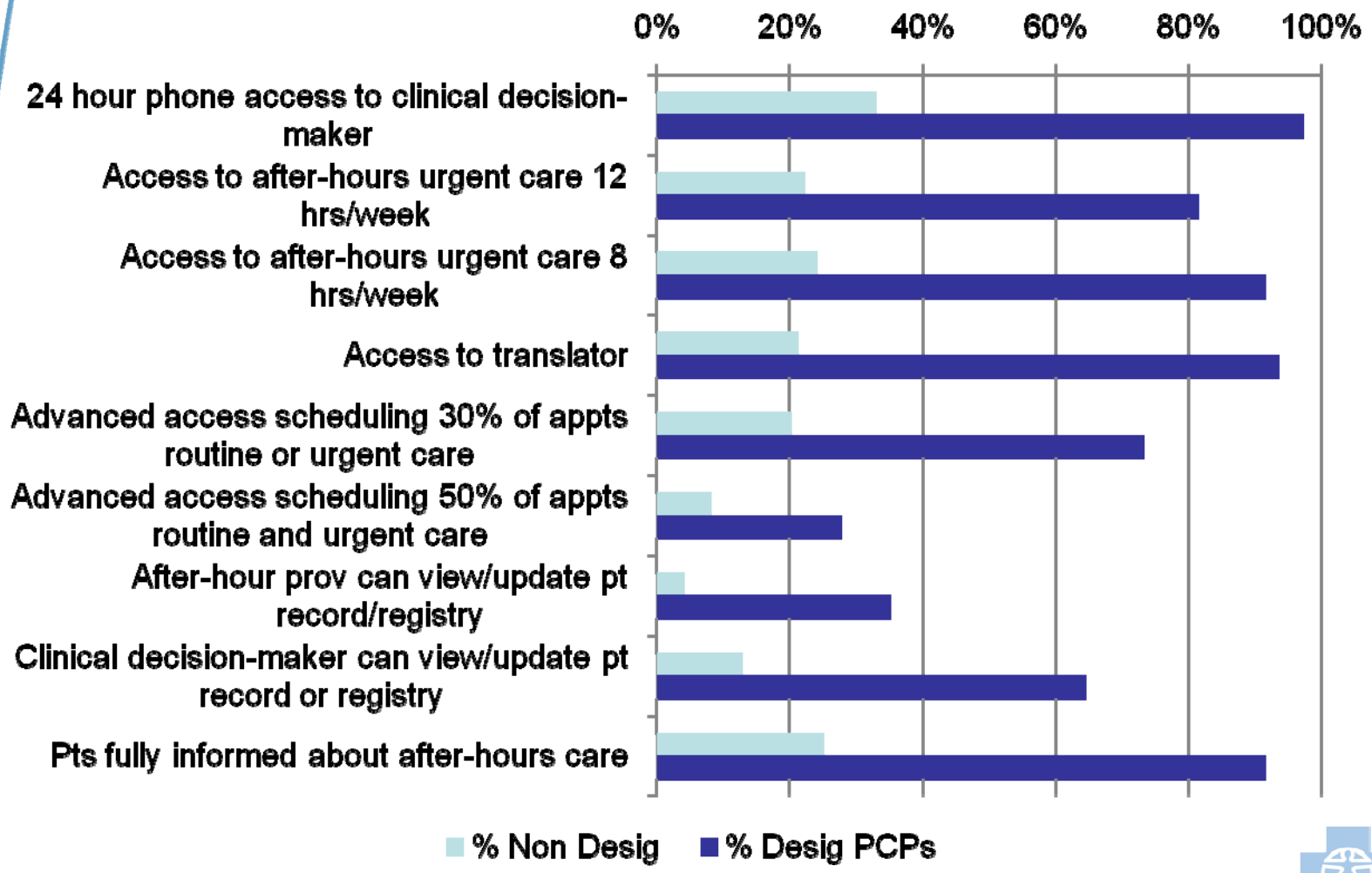
Patient Registry



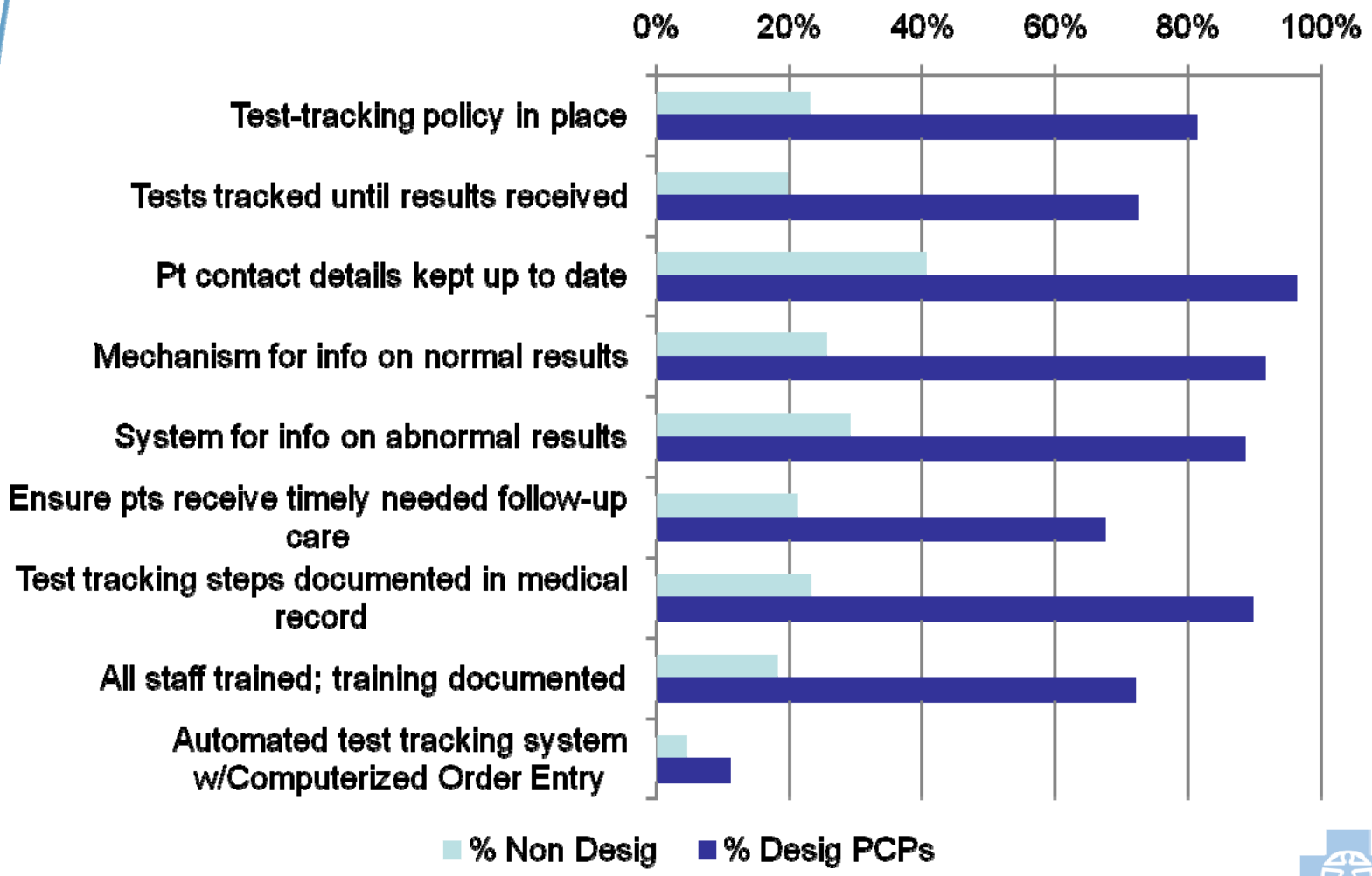
Individual Care Management



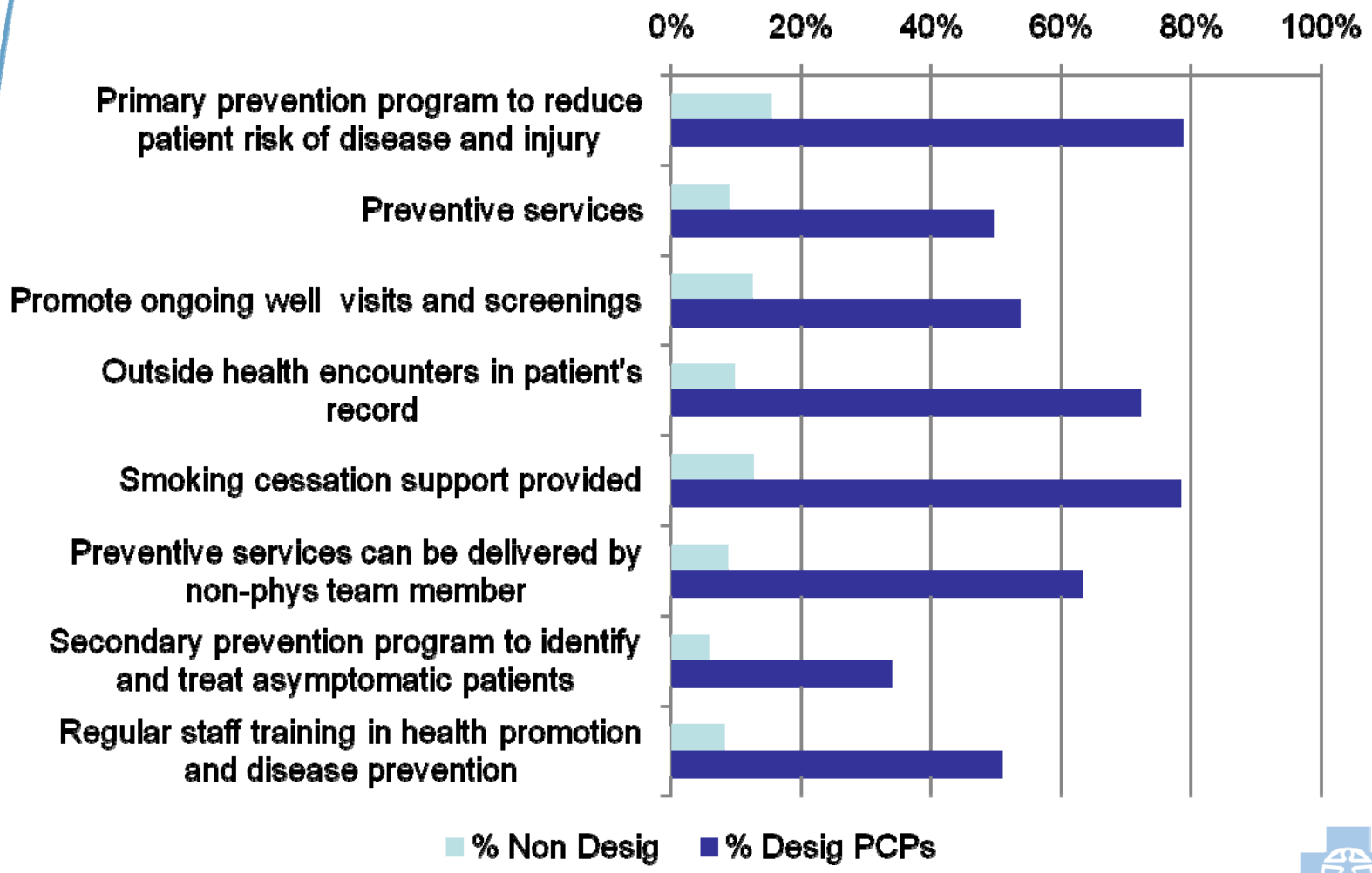
Extended Access



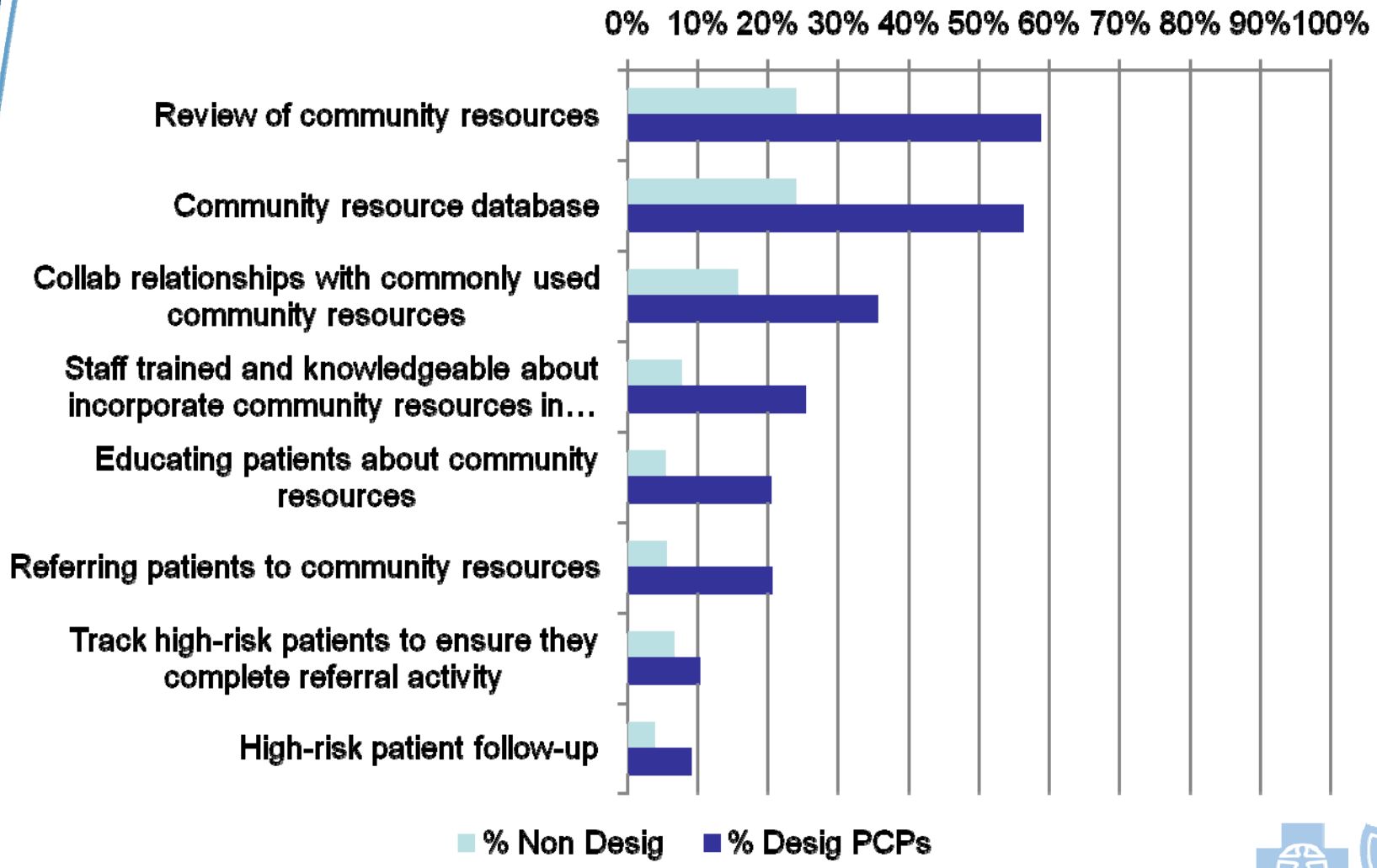
Test Tracking & Follow-up



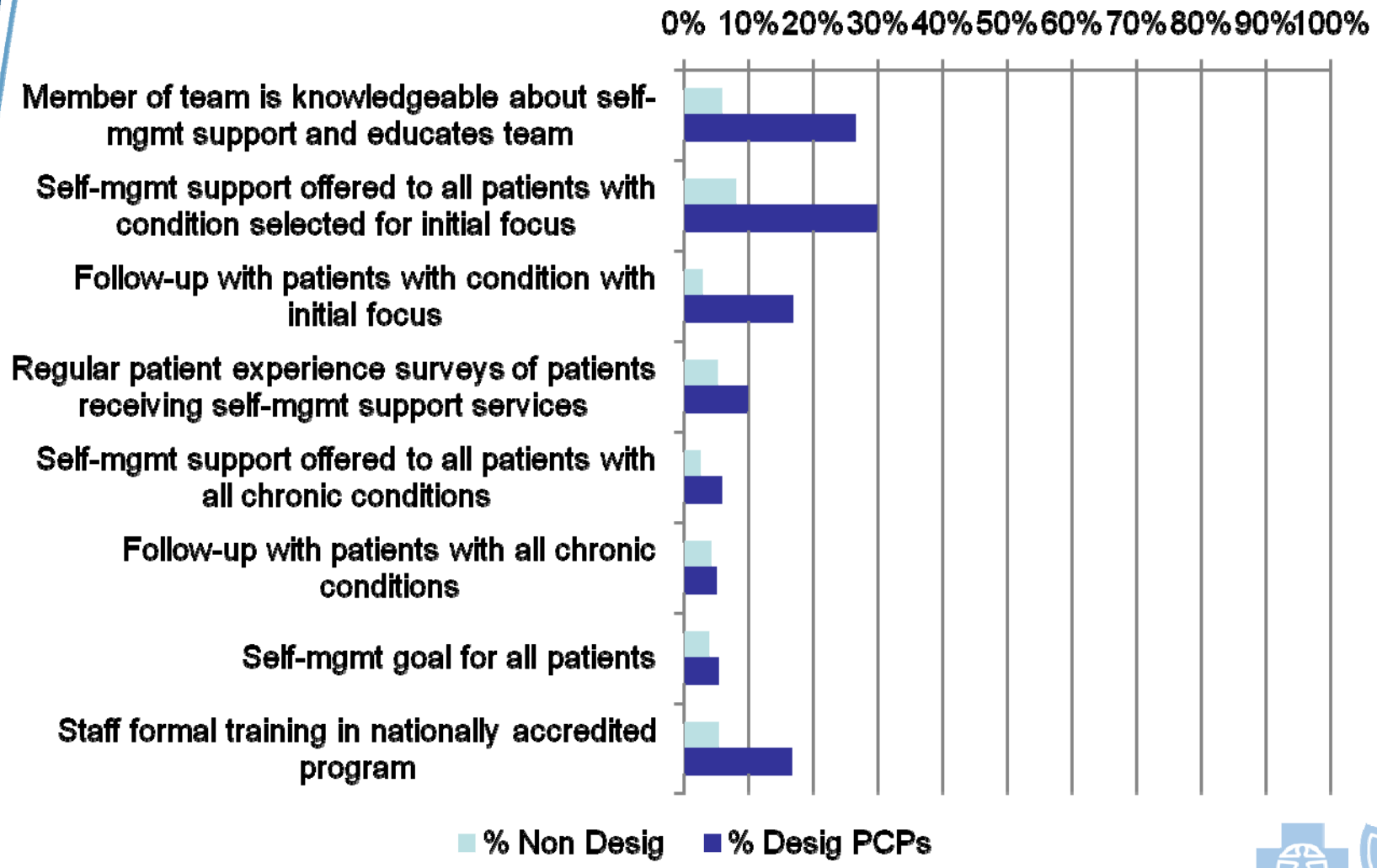
Preventive Services



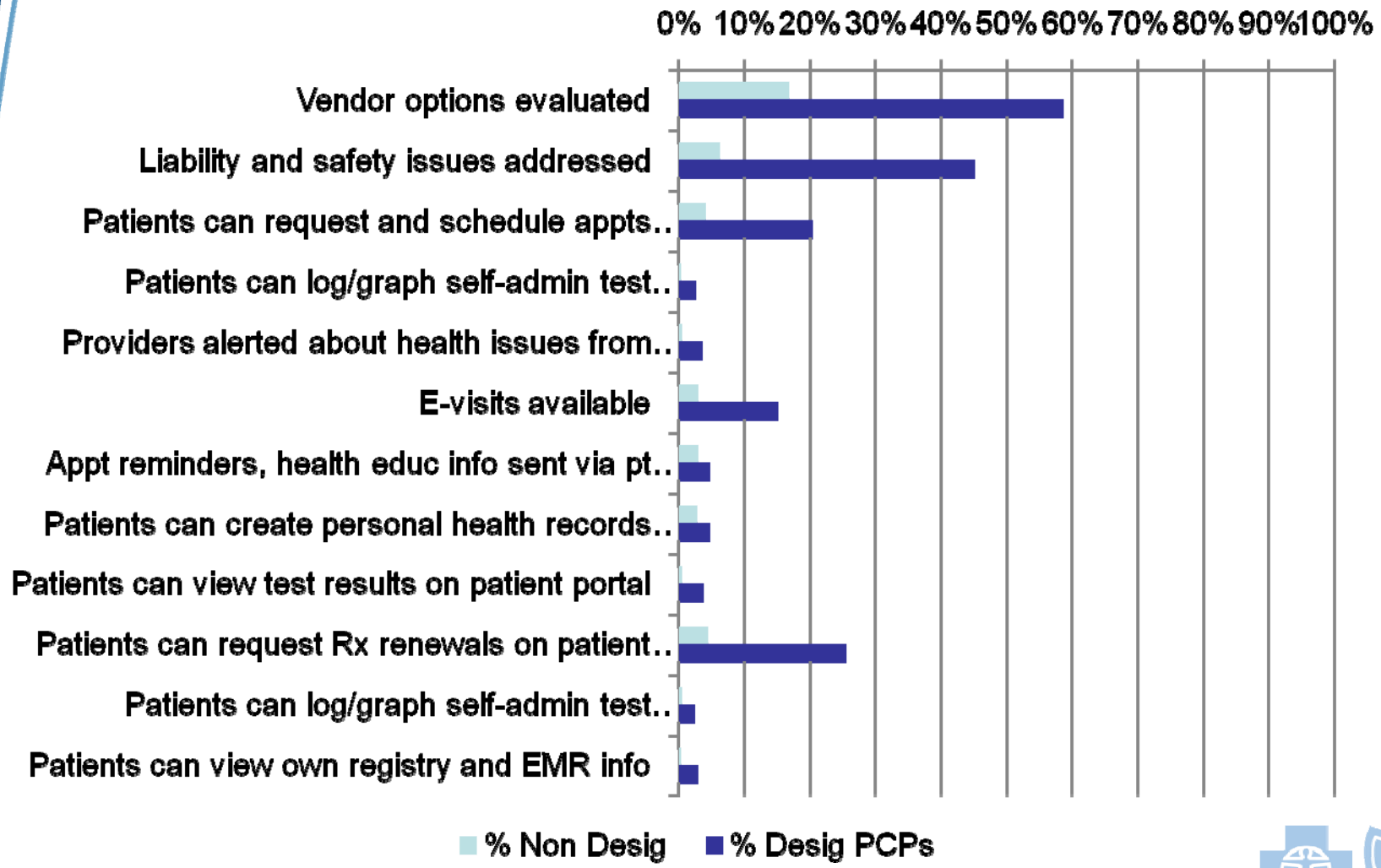
Linkage to Community Services



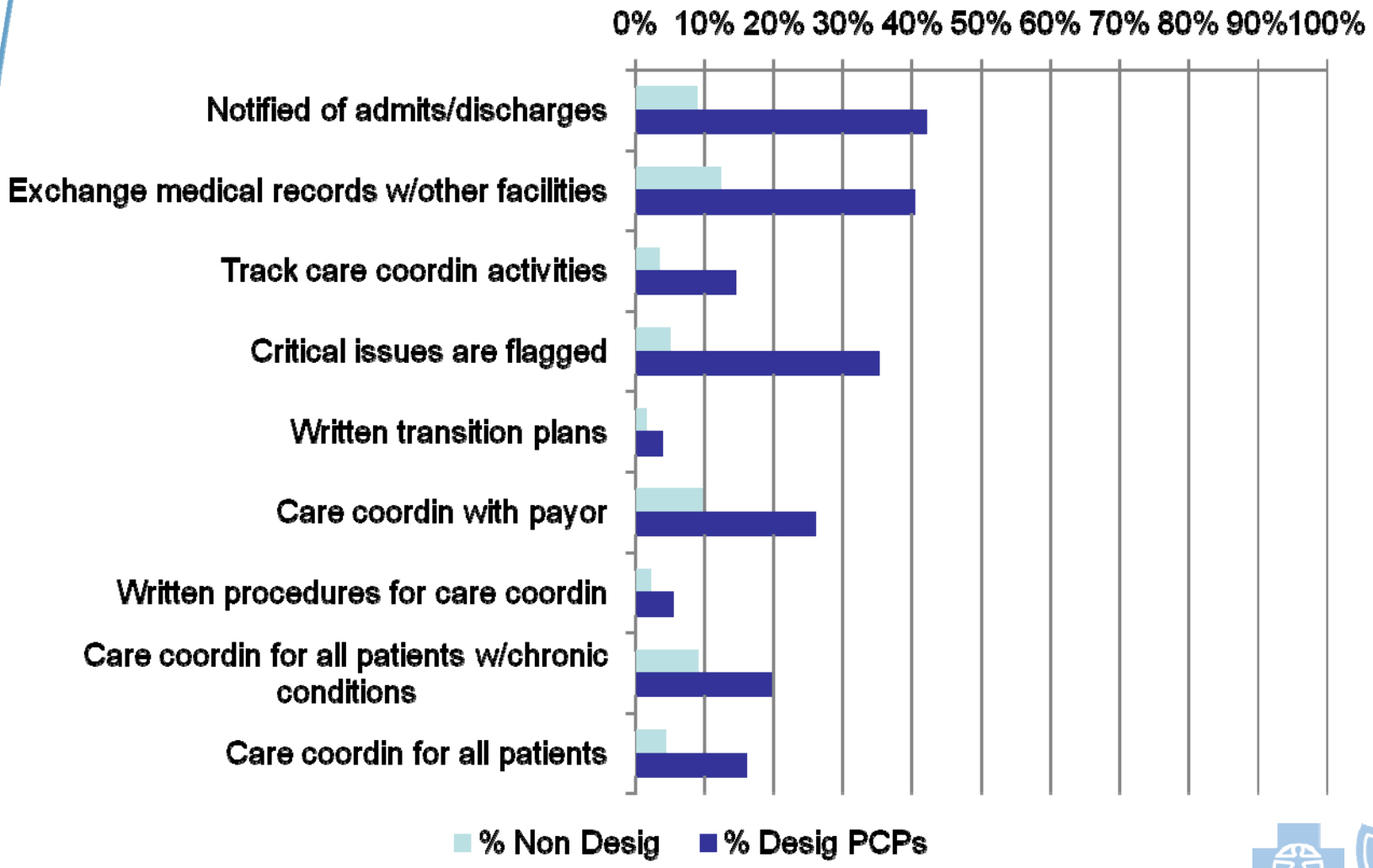
Self-Management Support



Patient Web Portal



Care Coordination



Specialist Referral Process