

Putting Theory into Practice



A PRACTICAL GUIDE TO PCMH
TRANSFORMATION RESOURCES



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Introduction

Over the past few years, we have had the opportunity to speak about the patient-centered medical home to audiences of primary care clinicians and administrators across the country. The initial response has been uniformly positive and supportive. Health care professionals are genuinely excited at the prospect of delivering comprehensive, effective, and efficient patient-centered care. In some cases though, clinicians react with trepidation, for the act of transforming a primary care practice into a medical home can be a daunting, complex process, and a practice must accomplish this transformation while continuing to serve patients. We recognize that this is not a simple task.

The good news for primary care practices is that you don't have to travel the path to PCMH transformation alone. There are many organizations that have developed the expertise and capacity to guide primary care practices through the transformation process using a variety of tools and services. The purpose of this Resource Guide is to identify those organizations for primary care practices so that you can get support as you begin the journey of becoming a medical home.

In this publication, you will find:

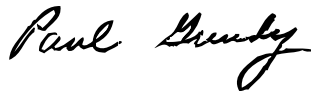
- A directory of more than 45 PCMH transformation support organizations. The entry for each organization includes a description of the organization's product or service, geographic scope, staff qualifications, and references.
- A bibliography of publications and articles that describe PCMH transformation studies, processes, and outcomes.

Now that the patient-centered medical home is an accepted national health policy goal, the real work begins. It is time to put policy into practice and support the formation of medical homes in communities across the country, and the organizations listed in this Resource Guide stand ready to support that process.

We hope that this Resource Guide will help you to identify partners to help you transform your practice into a PCMH. We encourage you to pick up the phone and talk with some of the organizations listed here about how they can work with you to begin the journey.



John Crosby, JD
Chair, PCPCC



Paul Grundy, MD, MPH
President, PCPCC

Acknowledgments

This report was developed by Discern LLC on behalf of the Patient Centered Primary Care Collaborative (PCPCC) with the support of an unrestricted grant from Merck and produced with assistance from Health Diagnostic Laboratory, Inc.

We would like to acknowledge and thank the PCPCC staff members and PCPCC Board of Directors who provided valuable insight in the development of the Resource Guide.

In addition, we would like to thank Shari Erickson, co-chair, and members of the Center for Multi-Stakeholder Demonstrations for their contributions.

Methodology

The PCMH Practice Transformation Resource Guide has been developed as a tool to connect primary care practices with resources that can support their PCMH transformation efforts. Significant planning, research, and preparatory work was dedicated to this Resource Guide to provide valuable information about products and services that may help primary care practices meet their PCMH goals.

In December 2010 and January 2011, Discern LLC (the PCPCC's contractor for this project) worked with PCPCC stakeholders, including the Center for Multi-Stakeholder Demonstrations, to develop a survey to collect information about organizations that support PCMH transformation. The goal was to collect information to help primary practices identify potential PCMH transformation resources and partners, while recognizing that only limited information can be included in the Guide.

Through the survey process, the PCPCC also developed criteria for inclusion of organizations in this Guide. To be included, an organization must:

- Provide at least one service related to PCMH transformation;
- Have provided PCMH-related services to at least ten different practices or organizations, or Serve as an organizational member of the PCPCC Executive Committee or Board of Directors;
- Have provided for inclusion in this Guide three client references.

On January 12, 2011, the PCPCC notified the thousands of organizations and companies in its database that the application survey for the PCMH Practice Transformation Resource Guide was available. The PCPCC asked organizations to complete the online survey to provide information about the scope of their product or service, with a deadline of February 4, 2011.

The online application survey included twenty questions to obtain information about the organization's product or service. Some of the main questions included:

- What kinds of PCMH products or services does the organization offer to practices?
- Which type(s) of primary care practices does the organization support?
- Does the organization support practice transformation by working with organizations other than primary care practices?
- In which areas does the organization support PCMH activities? (i.e., medication management, care management, health information technology support, etc.)
- How many primary care practices have utilized the organization's product or service?

- How many other organizations have utilized the organization's product or service?
- In which state(s) is the organization's product or service currently in use?
- In which state(s) is the organization's product or service available?

Submitting organizations were required to complete the online application by February 4, 2011, and more than 70 applications were received from organizations across the country. Following the deadline, Discern LLC worked with the organizations to clarify and edit their submissions (for example, promotional language had to be removed). Each submitting organization was provided a final version of its information, as it has been listed in this Guide.

We recognize that as the demand increases for professionals that can guide primary care practices in the process of becoming a PCMH, more organizations are entering the field to meet this demand. In order to inform our members of the many organizations who have developed the expertise to work with primary care practices on practice transformation, we plan to update this Guide quarterly. If at any time you would like your organization to be considered for inclusion in the Guide, please submit all of the required information electronically by following the links on the PCPCC Web site at: www.pcpcc.net/center-multi-stakeholder-demonstrations.

How to Use This Guide

This Guide is intended to serve as a starting point for primary care practices that need help navigating the PCMH transformation process. The indexes at the end of this Guide can help a primary care practice to identify organizations for partnership opportunities. The individual entries for each organization provide more details that will help a primary care practice to identify potential partners.

This Guide is only the beginning of the process. We encourage primary care practices to contact more than one of the organizations listed here, talk with them about their PCMH support services and fees, and check their references. Spending time to identify the right partner will be worth it. To help with this process, please refer to the list of follow-up questions to ask a prospective PCMH support partner.

Also, at the back of this Guide, you'll find a bibliography of third-party and peer-reviewed articles that address PCMH transformation and operational issues. We encourage you to refer to this bibliography for information that might provide additional insight in the journey to become a PCMH.

Patient-Centered Medical Home

Implementation: What Does It Take?



Patient-Centered Medical Home Implementation: What Does It Take?

Key attributes of the Patient-Centered Medical Home

The key attributes of the PCMH are concisely laid out in the Joint-Principles of the Patient-Centered Medical Home. In practice implementation this translates to nine core elements:

- Patient centeredness
- Access to care and information
- Practice based services
- Care management
- Care coordination
- Practice based care team
- Practice management
- Health information technology
- Quality and safety

Five Factors for Successfully Implementing the Patient-Centered Medical Home in Your Practice:

1. An effective leadership team to oversee the change from start to finish. This team will develop a compelling, inspiring vision and communicate it amongst key stakeholders. The leadership team will be comprised of a physician champion, a practice administrator, as well as both clinical and clerical leads.
2. Staff engagement and empowerment leads to active, engaged and creative members of the change management team. The practice needs to make the shift from being physician centered to team centered.
3. Integration and management of change takes constant and active monitoring, building on what is working well, changing and modifying what is not working well.
4. Agree on and establish a common framework of measuring the impact of the transformation. As organizational change experts have said for decades “What gets measured, gets managed.”¹ Publicly celebrating milestones and small wins throughout the project allows the practice to stop and appreciate everyone for a job well done.
5. Actively solicit honest feedback to learn about how things are progressing. Change can bring issues to the surface that have been simmering below the surface.

¹ Drucker, Peter F. The Practice of Management. New York, NY: Harper Business, 1954.

Strategies for Positioning for Transformation

Here are a few steps you can take before launching a PCMH implementation initiative to best prepare for a complex and sometimes straining transformational process.

- Conduct a thorough review of existing PCMH transformational resources. This can include online content review and assessing your local market. Check if any of your payers or employer sponsors have PCMH initiatives or advanced reimbursement models. Use your research to build a common understanding and vision of what PCMH should mean in your practice.
- Assess the current state of your practice management. Consider undertaking some preliminary self-analyses such as a Strengths-Weakness-Opportunities-Threats (SWOT), a Value-Stream Mapping exercise, or use online assessment tools such as TransforMED's Medical Home Implementation Quotient (MHIQ) or Institute for Healthcare Improvement's (IHI) Improvement Map.
- Identify and energize key physician leaders within your practice. Identifying and empowering physician leadership within the practice to champion the PCMH transformation is the most important step in generating provider buy-in.
- Start working to ensure that your practice is patient-centered by asking the question "What would our patients think?" often and regularly.

This brief was written by TransforMED on behalf of the Patient-Centered Primary Care Collaborative to identify and outline critical transformational processes that each and every successful, sustainable transformation has shared. Understanding these concepts are the first steps for any practice undertaking the journey of patient-centered medical home (PCMH) transformation.

PCMH Transformation Resources



9g Enterprises, Inc.

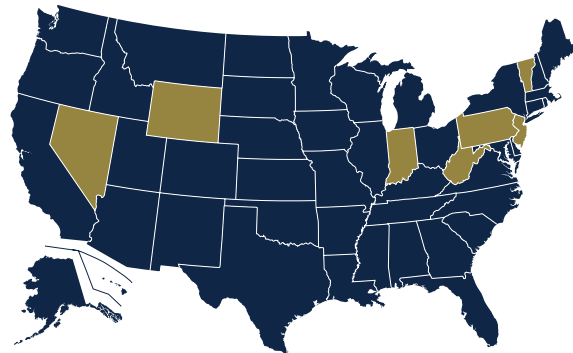
Surveys, Workshops, Coaching, Keynotes

2723County Rd., #3672
Springtown, TX 76082

www.surveyvitals.com

Robert Vosburgh
940-748-2600
bob@9gs.org

Incorporated 2002
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

41

primary care practices have utilized the organization's product/service.

532

other organizations have utilized the organization's product/service.

About:

Via scientific surveying of Patients, Employees and Professional Peers, Survey Vitals provides administrators and practitioners a 360 view of internal and external satisfaction perspectives in critical areas such as appointments, reception, facility, staff, providers and overall. The solutions is primarily designed to track the patient experience. Surveys can be administered via email, kiosks, tablets or on paper. The portal solution also provides a PCMH checklist to assist practices in tracking their compliance. This real-time solution provides an entirely new level of situational awareness for administrators and practitioners by producing immediate alerts from concerned parties. A robust reporting functionality allows Practices to immediately pinpoint opportunities for improvement. In fact, the solution uses a gap analysis to provide a rank-ordered list of improvement suggestions on a provider by provider basis and lists changes that need to be resolved based on the perspectives and feedback of the surveyed parties.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

9G Enterprises staff has a wide range of experience and expertise. Bob Vosburgh, President, MS, Sam Westbrook, VP, MS, Jim Shipley, VP, Ph.D., Grady Dougless, VP, MS. The majority of the staff has graduate degrees with significant experience in business and information technology. Their experience includes positions from engineering and IT experts to Corporate CEOs.

References:

Gratiot Family Practice; Dr. Gregg Stefanek; (989) 463.301;
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Moscow Family Medicine; Jeff Geier, Administrator; (208) 882.2011
ext.230; jgeier@moscowfamilymedicine.net

Capital Medical Group; Carol Amick, Administrator; (502)875.0872;
amick_cp@yahoo.comexperience includes positions from engineering and IT experts to Corporate CEOs.

Accordant Health Services

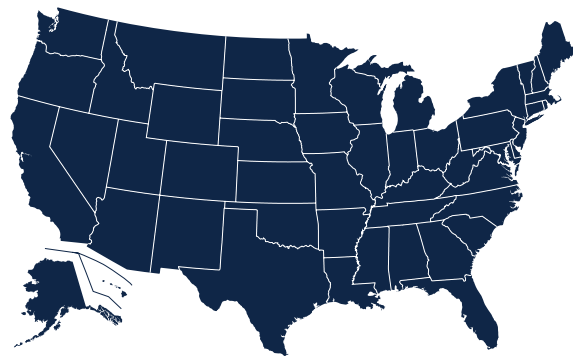
Disease Management

4900 Koger Blvd., Suite 100
Greensboro, NC 27282

www.accordant.net

Andrew Krueger, MD
336-217-0737
akrueger@accordant.net

Incorporated 1995
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

35,124

primary care practices have utilized the organization's product/service.

13,337

other organizations have utilized the organization's product/service.

About:

Accordant Health Services Disease Management program focuses on providing support services to patients with targeted complex, chronic diseases. Goals: to improve the quality of life of our patients, prevent complications, better manage crisis events when they occur, and to enhance communication.

The program offers population-based disease management, with phone, mail and internet service options: personalized health evaluations, 24/7 nurse access, risk stratification, website access, and disease & general wellness education with monthly mailings to reinforce health/wellness. Accordant utilizes a multidisciplinary team approach to provide comprehensive DM services. Each team is managed by a Clinical Operations Manager and is comprised of Health Management Nurses, Case Managers and support staff.

The Health Management Nurse functions as the primary nurse for the member and is responsible for on-going member support, education risk assessments, physician communication, level of intervention evaluation, and care plan development and implementation.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Health Management Nurses & Case Managers are RN's with at least 3 yrs clinical experience; over 75% hold CM certification. Medical Director is board certified in internal medicine, with experience in managed care and DM. Resource Specialists have a degree in health-care related field and social work experience preferred. All are employees of AHS.

References:

Marvin S. Segal, M.D.; Medical Advisor, Minnesota Comprehensive Health Association; 5775 Wayzata Boulevard, Suite 910; St. Louis Park, MN. 55416

Betsy A. Asher; HealthPartners;
Betsy.A.Asher@HealthPartners.com; 952.883.6233

Dr. Eunah Fischer, Medical Director; Medical Management; BCBS of North Dakota; 4510 13th Avenue South Fargo, North Dakota 58121-0001; eunah.fischer@bcbsnd.com

Agency for Healthcare Research and Quality

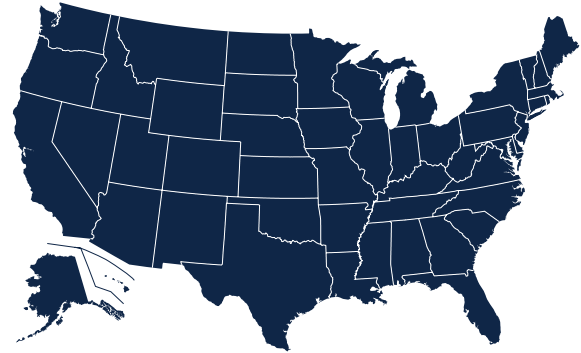
Medical Office Survey on Patient Safety Culture

540 Gaither Rd.
Rockville, MD 20850

www.ahrq.gov/qual/patientsafetyculture/mosurvindex.htm

Surveys on Patient Safety Culture Tech. Asst.
1-888-324-9749
SafetyCultureSurveys@ahrq.hhs.gov

Incorporated 1989
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

470

primary care practices have utilized the organization's product/service.

0

other organizations have utilized the organization's product/service.

About:

The Agency for Healthcare Research and Quality (AHRQ) developed and released the Medical Office Survey on Patient Safety Culture in 2008 to enable medical offices to assess their culture of patient safety from the perspectives of providers and staff. The survey and associated toolkit materials are free and available in the public domain. Medical offices can use the survey results to identify areas for patient safety culture improvement, and a comparative database enables comparison of results to other medical offices.

AHRQ provides technical assistance to users who may have questions regarding the content, administration, and data analysis of the survey, or regarding use of the survey for patient safety improvement.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

The key staff includes the AHRQ Project Officers, Contractor Project Director, and Project research staff. The staff has graduate degrees, extensive patient safety culture knowledge, research experience, and experience in survey toolkit development and support.

References:

Cleveland Clinic; John Hickner; 216-445-8915

HealthTexas Provider Network, a wholly owned subsidiary of Baylor Health Care System; Sunni Barnes; 214-265-3634

Oregon Health & Science University; Lyle Fagnan; 503-494-1582

Agency for Healthcare Research and Quality (AHRQ)

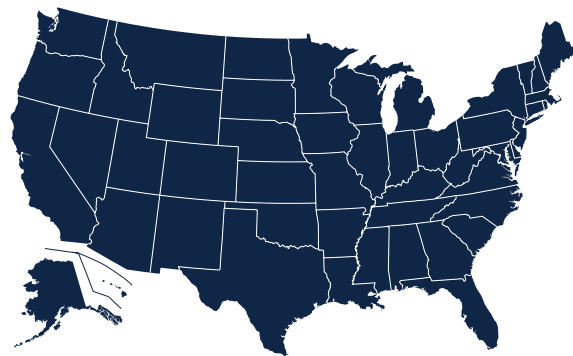
Technical Assistance: CAHPS Clinician and Group (C&G) Survey

540 Gaither Rd.
Rockville, MD 20850

www.cahps.ahrq.gov

CAHPS technical assistance representative
800-492-9261
cahps1@ahrq.gov

Incorporated 1989
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1,107

primary care practices have utilized the organization's product/service.

3,492

other organizations have utilized the organization's product/service.

About:

AHRQ supports the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and tools which are available to the general public for the advancement of patient-centered care. Healthcare organizations, public and private purchasers, consumers, and researchers use CAHPS results to assess the patient-centeredness of care; compare and report performance; and improve quality of care. CAHPS surveys are currently available to assess patient experience with clinician and group practices through the CAHPS C&G Survey. A new version of the survey is being developed and tested for use in patient-centered medical homes and will be available in Summer 2011. Through the CAHPS User Network, technical assistance is available to users who may have questions regarding the content or implementation of CAHPS surveys, or the use of CAHPS surveys for consumer reporting or quality improvement.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

AHRQ's CAHPS program is supported by AHRQ staff, AHRQ grantees, Yale and RAND who are responsible for conceiving, developing, testing, and refining the CAHPS survey products. AHRQ contracts Westat to support the CAHPS User Network and manage the National CAHPS Benchmarking Database.

References:

Lisa Libbay; llabbay@intermed.com; 207-347-2847; InterMed, P.A.
Stewart Peterson; speterson@nrcpicker.com; 402-475-2525; NRC Picker
Debbie Dobbins; ddobbins@qdmnet.com; 440-526-8633; Quality Data Management, Inc.

AIMS Center

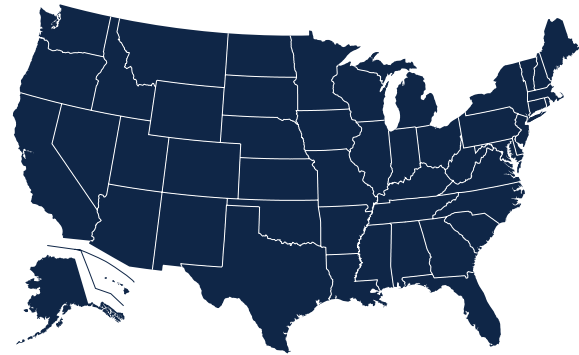
Training and Technical Assistance in Integrated Behavioral Health Care

University of Washington School of Medicine
1959 NE Pacific St., Box 356560
Seattle, WA 98195-6560

www.uwaims.org

Diane Powers, MA
206-685-7095
uwaims@uw.edu

Incorporated 2004
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

470

primary care practices have utilized the organization's product/service.

38

other organizations have utilized the organization's product/service.

About:

The AIMS (Advancing Integrated Mental Health Solutions) Center provides training, technical assistance and implementation support to help implement evidence-based integrated behavioral health programs. Through its IMPACT Implementation Center, it assists organizations interested in adapting IMPACT care for depression and other common mental disorders for their clinical practice. IMPACT is a patient-centered, team approach that integrates depression treatment into primary care and other medical settings. This model of care was tested in a randomized control trial in 8 healthcare systems across 5 states. Results from the study show that IMPACT is more than twice as effective as usual care for depression. It also improves physical and social functioning and patients' quality of life while reducing overall health care costs over a four-year follow-up. To date, the AIMS Center has trained over 4,000 individuals and supported implementation of this evidence-based program in nearly 500 sites.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Jürgen Unützer, MD, MPH, MA, Director, AIMS Center; Diane Powers, MA, Manager, AIMS Center. Consultants: Rita Haverkamp, MSN, PMHCNS-BC, CNS, Clinical Nurse Specialist, Kaiser Permanente; Virna Little, PsyD, LCSW-R, SAP, VP for Psychosocial Services & Community Affairs, Institute for Family Health

References:

Virna Little, PsyD, LCSW-R, SAP; Vice President for Psychosocial Services and Community Affairs; The Institute for Family Health; New York, NY; vlittle@institute2000.org

Marty Adelman, MA, CPRP; Mental Health Program Coordinator; Community Clinics Health Network (a subsidiary of the Council of Community Clinics); San Diego, CA; madelman@ccc-sd.org

Erin Hafer; CHP Project Manager; Community Health Plan of Washington; Seattle, WA; Erin.Hafer@chpw.org

Alere Health

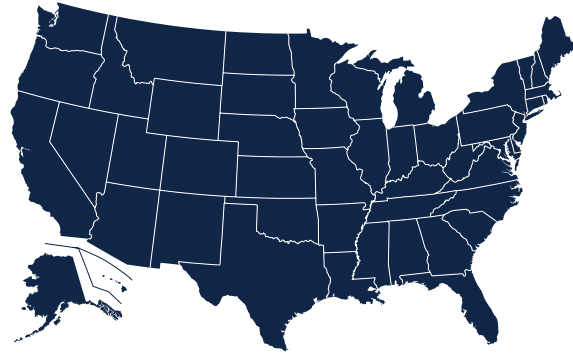
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Geoff Hyatt
303-888-2658
geoffrey.hyatt@alere.com

Incorporated 2001
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1,400

primary care practices have utilized the organization’s product/service.

800

other organizations have utilized the organization’s product/service.

About:

Alere Health, LLC, is a wholly-owned subsidiary of Alere Inc.—a global leader of rapid point-of-care diagnostics with 11,000 employees worldwide. Alere connects individuals and providers through diagnostics, biometric collection devices and health management services. Our focus is to enable better health management, reduce urgent medical interactions, and lower costs. Alere’s Collaborative Care Solutions® (CCS) help attain and demonstrate quality improvement by integrating information from various data sources, and providing reporting on a range of metrics, across multiple conditions. CCS makes it easy for a practice to qualify for NCQA PPC-PCMH Level 2 (or higher) recognition, and provides a connected clinical registry with evidence-based care plans; reporting functions that help quantify performance; inter- and intra-practice care coordination tools; collection, aggregation, storage and sharing of clinical data; and a patient portal.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Alere is publicly-held, and our staff and management collectively represents decades of healthcare-related experience with a range of depth and breadth. A list of key staff applicable to our PCMH offerings can be provided on request. All key staff members are employees (not contractors).

References:

Allyson Gottsman; Health TeamWorks; agottsman@healthteamworks.org
Dr. Ellen Burkett; SouthPark Internal Medicine; 720-266-6900
Sherrie Whistler; Southeast Pennsylvania Chronic Care Commission; swhisler@pafp.com

American Academy of Pediatrics

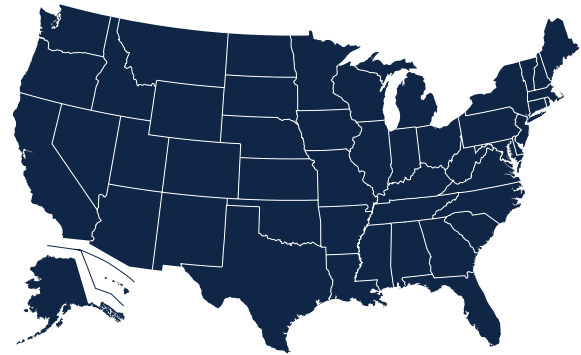
Educational Tools/Resources

141 Northwest Point Blvd.
Elk Grove Village, IL 60007

www.aap.org

Sherry Fischer
847-434-7106
sfischer@aap.org

Incorporated 1930
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

121

primary care practices have utilized the organization's product/service.

0

other organizations have utilized the organization's product/service.

About:

The American Academy of Pediatrics (AAP) is a national professional membership organization dedicated to the health, safety and well-being of infants, children, adolescents and young adults. The AAP first developed the concept of the medical home in 1967, and continues to strongly advocate for a medical home for all children. The AAP currently provides a broad range of education and resources related to evidence-based clinical practice guidelines, quality improvement, practice management, payment and financing, HIT, and various clinical topics to help support member practices. The AAP has worked directly with practices through its Chapter Quality Network and its Quality Improvement Innovation Network. In addition, the AAP is working to expand its service offerings related to PCMH, and plans to have additional practice transformation resources available in mid-2011. The AAP also has a Child Health Informatics Center, which provides HIT-related advocacy and education (www.aap.org/chic).

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Errol Alden, MD, FAAP CEO; Fan Tait, MD, FAAP, Assoc Executive Director, Dept of Community & Specialty Pediatrics, Co-PI, Bright Futures; Judy Dolins, MPH, Assoc Executive Director, Dept of Community, Chapter & State Affairs; Ed Zimmerman, MS, Director, Dept of Practice, Co-PI, Bright Futures.

References:

C. Eve J. Kimball, MD, FAAP; All About Children Pediatric Partners PC; info@aacpp.com

P. Cooper White MD, FAAP; Locust Pediatric Care Group; 1 Perkins Square; Akron, OH 44308

Wes Stubblefield, MD, FAAP; Pediatric Associates of Auburn; 411B Opelika Rd; Auburn, AL 36830

American College of Physicians

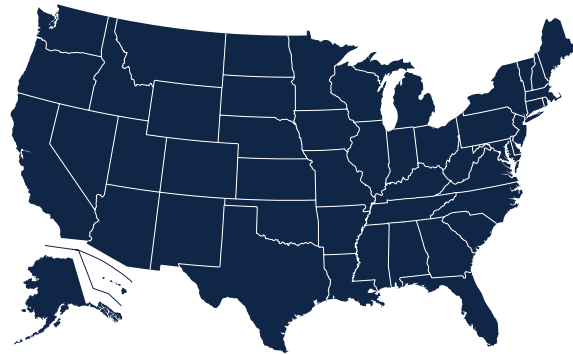
ACP Medical Home Builder

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paulaw@acponline.org

Incorporated 1915
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

3,488

primary care practices have utilized the organization's product/service.

22

other organizations have utilized the organization's product/service.

About:

The American College of Physicians (ACP) is a national organization of internists—physicians who specialize in the prevention, detection and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 130,000 includes internists, internal medicine subspecialists, and medical students, residents, and fellows. ACP has gathered a comprehensive collection of information, resources and demonstration projects to assist clinicians in planning for a complete Patient-Centered Medical Home. In addition, the College is continuously improving upon these existing resources and testing new ones. This particular resource, the ACP Medical Home Builder, was designed to assist primary care practices prepare for PCMH recognition by providing background information about various topics in a modular format, a comprehensive practice self assessment tool, and dynamically linked resources that the practice can use to improve its performance.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

The contributors to the Medical Home Builder include staff and contractual writers and include a broad spectrum of health care providers: physicians, nurses, medical editors, etc.

References:

Department of Veterans Affairs; Gordon Schectman MD; 202 461-7181

Western NY Clinical Information Exchange HEALTHeLINK; Margaret Cosentino; 716-206-0993 x 325

CT State Medical Society IPA; Ken Lalime, CEO; 203-225-1291

American College of Physicians

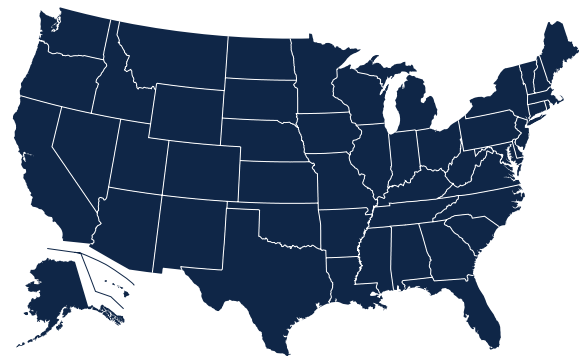
QI: Closing the Gap and ACPNet

190 N. Independence Mall West
Philadelphia, PA 19106-1572

www.acponline.org/running_practice/quality_improvement/

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Incorporated 2001
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1,790

primary care practices have utilized the organization's product/service.

100

other organizations have utilized the organization's product/service.

About:

ACP offers two Web-based quality improvement (QI) programs, ACPNet and Closing the Gap, that focus on specific clinical conditions. ACPNet teaches clinical QI tools and techniques and educates office-based physicians on evidence-based best practices. ACPNet is registered as a practice-based research network with the Agency for Healthcare Research and Quality (AHRQ). Designed for the practice team, Closing the Gap helps physicians and staff to develop and improve strategies for creating systems change in their practices and to improve the care they provide to their patients. Our QI programs are designed to provide an avenue for physicians and their teams to achieve their practice-improvement goals. Closing the Gap and ACPNet programs provide practices with guidance and support as they embark on quality-improvement initiatives and work towards implementation of the Patient-Centered Medical Home (PCMH) model. Our approach to quality improvement emphasizes the need for improved process measures and enhanced clinical outcomes--principles central to the PCMH. Our programs ensure that practices work as a team towards the common goal of providing a superior quality of care to the patient.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Michael Barr, MD MBA: Senior Vice President, Medical Practice Professionalism & Quality Closing the Gap: Cara Egan Reynolds, MHS: Senior Projects Administrator Lia Bennett, MPH: Grants Coordinator ACPNet: Jillian Scavone, Ph.D.: ACPNet Administrator.

References:

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Doron Schneider, MD DSchneider@amh.org
Kim Dixon, MD kimcdixon@yahoo.com

American College of Physicians (ACP) and Cientis Technologies

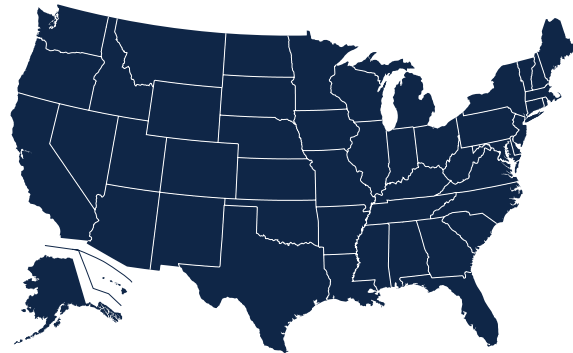
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William Underwood
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wunderwood@acponline.org

Incorporated 2010
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

5,500

primary care practices have utilized the organization's product/service.

1,500

other organizations have utilized the organization's product/service.

About:

AmericanEHR Partners (www.AmericanEHR.com) is a free, web-based resource that helps the medical community with the selection, implementation, and effective use of health IT. The use of health IT is a critical component of any medical home. AmericanEHR Partners was founded by ACP and Cientis Technologies. The site provides a number of tools to help practices adopt and use health IT. These resources include: an interactive EHR Readiness Assessment which provides customized recommendations to guide your EHR adoption; a comparison tool allows you to compare EHR systems side by side; dynamic EHR Ratings based on verified clinicians; an educational blog posts information and tips on adopting/using health IT; a biweekly educational newsletter; specialty and sub-specialty society specific information and resources; and educational resources including podcasts and webinars. The AmericanEHR Partners does not endorse any EHR system, and strives to provide unbiased information on all EHR vendors.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Content on AmericanEHR Partners is collected from a number of different sources. Information on the sources is sited on the site. The editorial process is managed by ACP and Cientis technologies and can be viewed on the site in the About section.

References:

Thomas Zimmerman DO tgz@e-medconsultants.com

Russell B. Leftwich, MD; P.O. Box 128010; Nashville, TN 37212; 615 279-8050; ehealth@pobox.com

John R. Maese, MD, MACP; 420 Lyndale Avenue; Staten Island, New York 10312; 718-966-9626; john@johnmaese.md

APS Healthcare

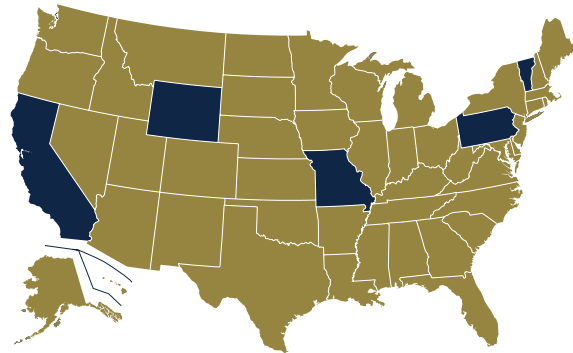
Complex Care Management, Utilization Management and Review, Behavioral Health Services, and Other Services

44 S Broadway, Suite 1200
White Plains, NY 10601

www.apshealthcare.com

Megan Cormier
307-286-2949
mcormier@apshealthcare.com

Incorporated 1993
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

100

primary care practices have utilized the organization's product/service.

350

other organizations have utilized the organization's product/service.

About:

By connecting all the players in the healthcare equation—participants, practitioners and payers—APS Healthcare delivers person-centered, provider-supportive services that optimize expenditures and improve health for multiple payer types. APS has more than five years of experience in five different states facilitating the success of the Person-Centered Medical Home (PCMH) model as promulgated by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). Our PCMH work ranges from consulting with high-level systems to implement programs—including large state Medicaid agencies and health plans—and helping community and patient stakeholder groups understand the implications of PCMH in providing direct support and services to providers. Our services have demonstrated positive clinical as well as financial outcomes.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Most APS staff are employees. Our Chief Medical Officer is an MD, MPH. Our COO is an MD. Service Center Directors require a Bachelor's, Master's/Ph.D. preferred, in a healthcare discipline, 8 years experience in the field and 6 years management experience. Health Services Directors must be RNs.

References:

Pennsylvania Department of Public Welfare, Bureau of Fee-for-Service Programs, Jennifer Basom, Director, Division of QM/ACCESS Plus, (717) 433-2042

Oregon Division of Medical Assistance Programs, Susan Good, Disease Management/Prevention Coordinator, Phone: (503) 945-6921

California Department of Health Care Services, Systems of Care Division, John Kaylen, RN, MSN, Nurse Consultant III, (916) 552-9229

The Briggs Group

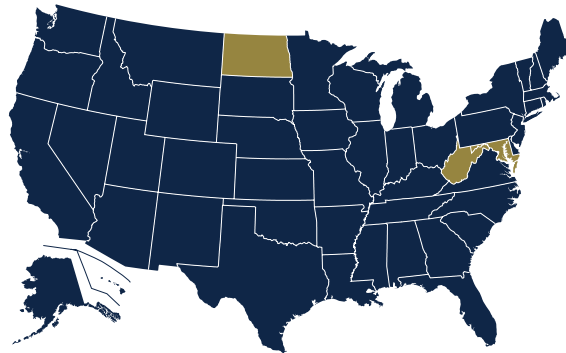
Health Care Consulting, PCMH, MSO, Operations, Marketing, Planning

7601 Jefferson St., Suite 340
Albuquerque, NM 87109

www.briggsgroupmd.com

Lou Bruno
505-338-3851
lbruno@briggsgroupmd.com

Incorporated 2010
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

5

primary care practices have utilized the organization's product/service.

1

other organizations have utilized the organization's product/service.

About:

The Briggs Group, led by Philip D. Briggs, MD, MBA, is comprised of professionals, both employed and contracted, who are experts in the particular facets of healthcare—medicine, medical business, medical policy, operations, marketing, insurance contracting, billing, credentialing and overall practice analysis. Dr. Briggs, a new Executive Committee Member of the Patient Centered Primary Care Collaborative, has two medical facilities that were recently recognized by the NCQA for systematic use of Patient Centered, Coordinated Care Management processes—of the very first in the state of New Mexico. Having been successful in receiving recognition in these facilities, adopting the PCMH criteria as directed by NCQA and the application process, the Briggs Group is uniquely qualified to assist in the complex and often arduous tasks in converting a traditional practice to PCMH compliance. Once practice protocols meet PCMH standards, the Briggs Group can also assist with the application process.

Partners with:

- Small and/or independent practices
- Large physician practices or groups

Staff Qualifications:

Philip D. Briggs, MD, MBA, Founder -the Briggs Group, Atrine Health and Santa Fe Medical Group. 32 years Family Practice; Mike Ries, Director of Operations, 25 years Executive and Financial Operations; Lou Bruno, Director of Marketing and Development, 33 years Marketing and Advertising; Roger O'Brien, Management Consultant, 35 years Corporate Management.

References:

Santa Fe Family Health Center, Joanna Anaya. 505-474-0120
Atrine Health, Kelly Street. 480-295-4880
Corazon Family Health, Kathy Leyba. 505-629-4400

Care Management Technologies, Inc.

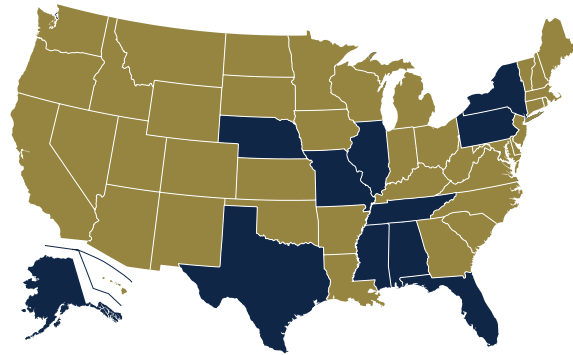
Improving Quality Prescribing of Behavioral Health Medication

1 Copley Parkway, Suite 500
Morrisville, NC 27560

www.cmthealthcare.com

Leigh Steiner, Ph.D.
217-891-1439
lsteiner@cmthealthcare.com

Incorporated 1999
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

10,000

primary care practices have utilized the organization's product/service.

38

other organizations have utilized the organization's product/service.

About:

CMT delivers actionable information to medical homes to improve quality of behavioral health care and reduce costs. Proprietary clinical algorithms, called Quality Indicators™, are run against claims data—pharmacy, diagnostic, and medical services—to identify gaps in care and deviations from evidence-based guidelines. Physicians are alerted through collegially written Clinical Considerations™ which include supporting citations from the medical literature. CMT solutions address quality prescribing (including inappropriate prescribing patterns for opioid analgesics), patient adherence, and care coordination. When multiple clinicians are treating a patient or when a patient has multiple comorbidities, CMT's technology systematically analyzes all pharmacy, diagnostic and medical service data to support a patient-centric medical home and compile an Integrated Health Profile, which is made available to all clinicians treating that patient.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

President: Ph.D. licensed psychologist, 24 years healthcare experience. VP Clinical Services: Consulting Professor of Psychiatry, Duke University School of Medicine. VP IT: over 25 years' experience in software engineering and quality management.

References:

Missouri Department of Mental Health; Joseph Parks, MD; (573) 751-2794
HealthSpring, Inc.; Mark Just; (615) 565-9110 ext 8783
Gateway Health Plan; Dennis Sebastian; (412) 255-4547

Child and Family Services of Saginaw County

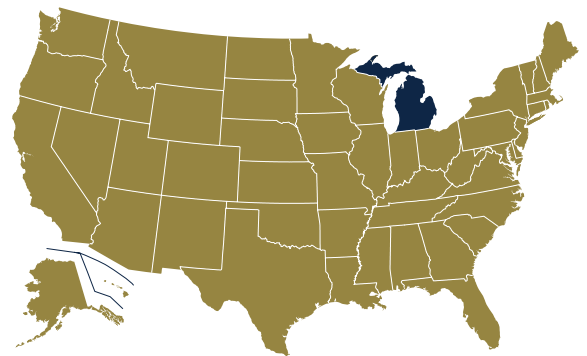
Outpatient Mental Health

2806 Davenport Ave.
Saginaw, MI 48602

www.childandfamilysaginaw.org

Maureen Burns
989-790-7500 x242
mburns@cfs-saginaw.org

Incorporated 1958
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

43

primary care practices have utilized the organization's product/service.

71

other organizations have utilized the organization's product/service.

About:

Child & Family Service of Saginaw is an outpatient mental health practice working with over 47 medical practices in the Great Lakes Bay Region. We partner with the patient, family members, and other medical professionals towards the journey to personal growth and emotional health. This is also done through team development, care management, referral and care transition, medication management and patient self-management/support. The counseling process includes goals established by the patient and input from other professionals invested in the progress. Annually we serve over 1,500 patients and received referrals from more than 114 diverse primary care physicians and professional practices/facilities.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Employees- Licensed Master Social Workers, Licensed Professional Counselors, Limited Licensed Psychologist.
Contractors- Psychiatrist-M.D.

References:

Partners in Pediatric (Group Practice); Ann Brandow; 989-793-6373
Dr. James LaFleur (Single Practice); Amy Schultz P.A.; 989-793-2555
Covenant Hospital; Rebecca Sovansky; 989-583-2781

CMHI (Center for Medical Home Improvement) of Crotched Mountain Foundation

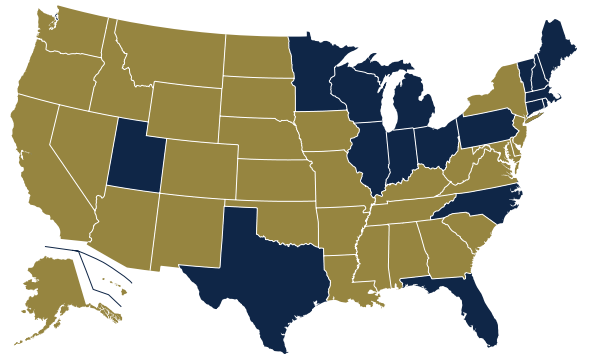
CMHI Medical Home TAPPP™ (Gap) Analysis, ©2009, Quality Improvement and Learning Collaborative Efforts, Presentations/Workshops, Development of Facilitation or Coaching Capacity

18 Low Ave., Suite 1
Concord, NH 03301-4902

www.medicalhomeimprovement.org

Lori Keehl-Markowitz, RN, BSN
603-228-8111 x 13
Lori.Keehl-Markowitz@CrotchedMountain.org

Incorporated 1997
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

100	primary care practices have utilized the organization's product/service.	8	other organizations have utilized the organization's product/service.
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About:

The mission of CMHI is to promote high quality primary care in the medical home and secure the health policy changes critical to the future of primary care. Since 1993, CMHI has touched and or provided expert based assistance to well over hundreds of primary care practices in their development of patient and family-centered medical homes. CMHI has also led multiple demonstration projects and research efforts while providing expert content to many others who do the same. Currently CMHI holds a cooperative agreement between the US Maternal and Child Health Bureau/ HRSA to establish and operate Got Transition?, the new National Health Care Transition Center focusing on the implementation and dissemination of health care transition best practices in primary care medical homes and specialty settings for youth and young adults. Additionally CMHI is leading an AHRQ funded 2 year research effort—Studying Transformation in the Pediatric Primary Care Medical Home.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

W. Carl Cooley, MD, CMHI Medical Director, Chief Medical Officer, Crotched Mountain Foundation, developmental pediatrician, and Jeanne W. McAllister, BSN, MS, MHA, Director and Co-founder of CMHI collectively have over thirty years of experience promoting the patient and family-centered medical home.

References:

Dr. Jennifer Lail; Chapel Hill Pediatrics and Adolescents, P.A.; 205 Sage Road, Suite 100; Chapel Hill, NC 27514; 919-942-4173; jlail@chapelhillpeds.com

Kitty Kidder, ARNP and Sean Lyon, ARNP; Life Long Care; 46 Newport Road, The Gallery, Suite 107; New London, NH 03257; 603-526-4094

Dr. Greg Prazar; Exeter Pediatrics Associates, CORE Pediatrics; 9 Buzell Avenue; Exeter, NH 03833; 603-772-8900; gprazar@ehr.org

CSI Solutions, LLC

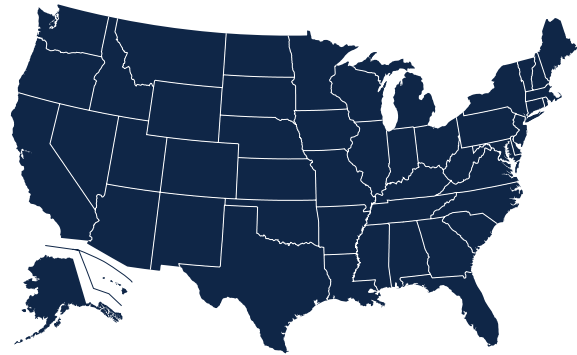
Strategic Consulting/ Technical Assistance

6701 Democracy Blvd., Suite 300
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rchaufournier@spreadinnovation.com

Incorporated 2007
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

365

primary care practices have utilized the organization's product/service.

18

other organizations have utilized the organization's product/service.

About:

CSI Solutions, LLC is an innovation company whose vision is the transformation of health care through the spread of innovation. The company focuses on primary care and innovative delivery models, the business of health care, health information technology, population health, and safety net systems. Services include strategic consulting, technical assistance, education and training, stakeholder management, and technology solutions. All service offerings have been applied to patient-centered medical home initiatives. Examples of specific client engagements include: Medicaid strategy for medical home implementation; provider training on the PCMH model as a driver of transformation; education and individual practice coaching on care coordination, self-management support, improving access, using data, and other topics to support function as a PCMH; technical assistance on aligning meaningful use objectives and PCMH; and leadership and team development. CSI's clients include federal and state government agencies, the National Association of Community Health Centers, state Primary Care Associations, payers and provider organizations.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

CSI's three Principals/Owners have 75+ combined years of experience in senior leadership positions in various settings within the health care industry including managed care plans, federally qualified health centers, academic medical centers, and a public population health company. All possess advanced degrees and one is a primary care physician.

References:

Julie Schilz BSN, MBA; Colorado Beacon Consortium;
Julie.Schilz@coloradobeaconconsortium.org

Nancy Atkins MSN, RN, NP-BC; Commissioner, WV Bureau for Medical Services; Nancy.V.Atkins@wv.gov

Sarah Chouinard, MD; Medical Director, Community Care of West Virginia, Inc.; sbchouinard@gmail.com

CureMD Healthcare

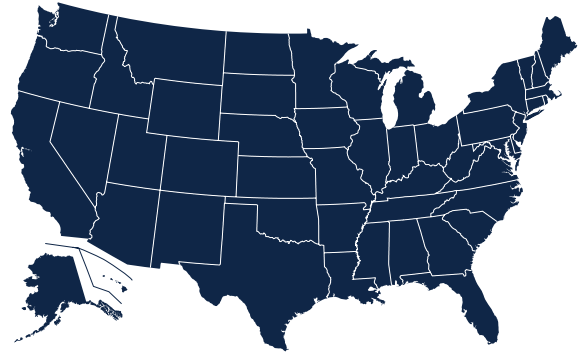
EHR, Practice Management and Patient Portal

55 Broad St.
New York, NY 10004

www.curemd.com

Bill Hashmat
718-360-0597
bill.hashmat@curemd.com

Incorporated 1997
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1,406

primary care practices have utilized the organization's product/service.

312

other organizations have utilized the organization's product/service.

About:

CureMD Healthcare is a leading provider of pure web based all-in-one CCHIT 2011 and ONC Certified electronic health records, enterprise practice management and patient portal system and accompanying services that empowers care providers to improve the quality and value of healthcare while optimizing efficiency and profitability. Nationwide, thousands of providers turn to CureMD to “Demonstrate Meaningful Use”™ drive outcomes and subsidy payments to maximize value and returns. CureMD helps PCMH adoption through its combination of people, processes and technology that introduce collaborative care management, optimize care delivery by enabling patient relationship at the center of your practices. Sharing and accessing information efficiently and electronically. Moving from reactive to proactive care. Motivating staff and providers while creating a productive and fulfilling care environment.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Dr. Aizid Hashmat, Board Chairman, founded CureMD Healthcare. Robert Goff, President Corp. Strategy & Dev., oversees strategic direction and planning. Kamal Hashmat, CEO, oversees the development of CureMD for health information management. Fred Melroy, COO, with over 30 years experience, responsible for the functional leadership of various departments.

References:

Genesis Internal Medicine; khanhuma29@yahoo.com; 585-243-5109

V Thomas Sanderson, MD; vtsand@aol.com; 718-523-7186

Atlantis Medical Group; michelle.ranallo@dmgny.com; 718-238-2040

DAH Solutions

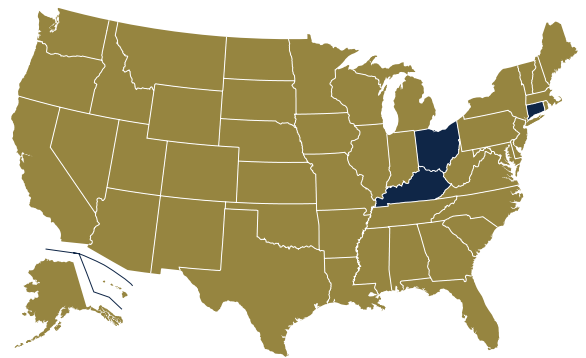
Consulting

321 Alexandersville Rd.
Miamisburg, OH 45342

www.DAHSolutions.com

Donna Hedrick
937-219-8322
donnaledrick@ameritech.net

Incorporated 2009
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

35

primary care practices have utilized the organization's product/service.

5

other organizations have utilized the organization's product/service.

About:

DAH Solutions provides consulting services to assist organizations or physician groups in redesigning their healthcare delivery methods, improving quality care and desired outcomes. Over the last 2 years we have offered assistance to: organizations, collaboratives and physician groups in strategic development; training and coaching support for Patient Centered Medical Home (PCMH)-NCQA Recognition. DAH Solutions offers a detailed assessment and work plan to support practices in meeting their PCMH-NCQA targets. Regular meetings are scheduled to review progress and determine next steps. Level of support desired is determined by the organization.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

President/CEO and lead consultant has a clinical background and experience in quality improvement and coaching practices through the PCMH process to recognition. Provides both direct and telephonic support.

References:

Family Medical Group; Mark Witte; CEO; 513-619-5004 Office; Mark_Witte@thefamilymedicalgroup.com

Fairfield Medical; Dr. Tony Behler; Medical Director and Lead Physician; 513-313-3839; afbehler@aol.com

OSU-Ohio State University; Karen Towslee Keenan; Director OSU Primary Care Network; 614-293-3681; Karen.Towslee@osumc.edu

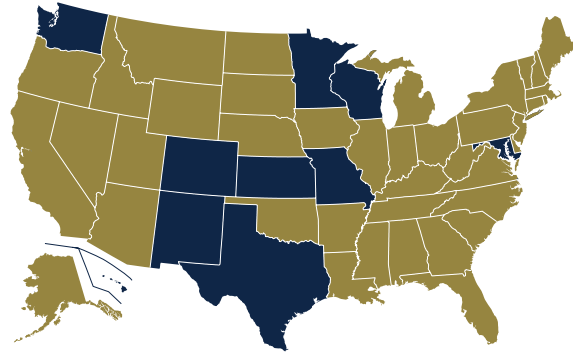
Deborah L. Trout Ph.D., LLC

Consulting

7533 Lupine Court
Arvada, CO 80007

Deborah Trout Ph.D.
303-263-1115
dltrout@mywdo.com

Incorporated 2008
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

2

primary care practices have utilized the organization's product/service.

10

other organizations have utilized the organization's product/service.

About:

Deborah L. Trout, Ph.D., LLC provides consultation to health and managed care companies, state agencies and related organizations on the effective integration of behavioral and general medical services. Services include policy & strategic planning, program & training development, research & evaluation, contract compliance/audit and staff development. Services assist direct care practices and health management organizations to implement evidence based practices in the effective integration of behavioral health and general medical/surgical care. Examples of PCMH-related services include the development and assessment of: the integration of behavioral health specialists into a primary care medical home (on site or virtual), the associated structural and training requirements for such integration, integrated care and disease management programming, and all aspects of patient-centered medical homes for patients with serious mental illnesses.

Partners with:

- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Deborah Trout, Ph.D., LP is an independent managed health care consultant with over 20 years executive level experience in national MBHOs and a state human services agency, as well as 10 years of direct, on site clinical experience in the provision of behavioral health and medicine services within medical primary care practices and hospital systems.

References:

James Van Halderen PsyD; Senior VP & Chief Clinical Officer; New Directions Behavioral Health; JVanhalderen@ndbh.com

Scott Craven MSW, MBA; Vice President; UnitedHealthcare; scott.m.craven@uhc.com; 651-283-6693

Jerry Smallwood; Manager, Medicaid Reform; Colorado Department of Health Care Policy & Financing; 1570 Grant Street; Denver, CO 80203; 303-866-5947

Department of Vermont Health Access

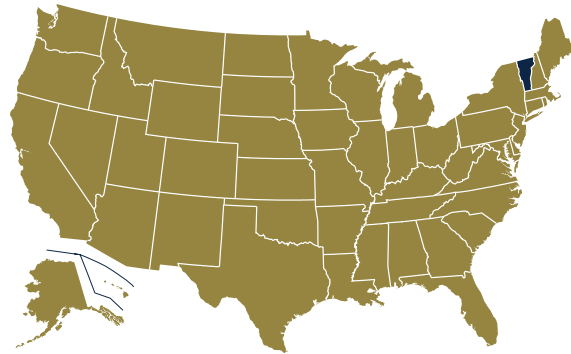
Vermont Blueprint for Health

312 Hurricane Lane
Williston, VT 05495

www.hcr.vermont.gov

Lisa Dulsky Watkins, MD
802-872-7535
lisa.watkins@ahs.state.vt.us

Incorporated 2003
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

226

primary care practices have utilized the organization's product/service.

0

other organizations have utilized the organization's product/service.

About:

Vermont's Blueprint for Health is leading statewide Health Care Reform with an Advanced Model of Primary Care. This program includes nationally recognized Patient Centered Medical Homes (PCMHs) supported by Community Health Teams (CHTs), and a health information technology infrastructure that supports guideline based care, population reporting, and health information exchange.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices

Staff Qualifications:

Exec. Director and Associate Director both MDs, Assistant Director MSW, Program Manager MPA.

References:

Aesculapius Medical Center; Jennifer Gilwee, MD; 802-847-4714
Northeastern Vermont Regional Hospital; Loral Ruggles (Project Manager, St. Johnsbury); 802-748-7590
United Health Alliance; Dana Noble (Project Manager, Bennington); 413-443-9780

Discern Consulting

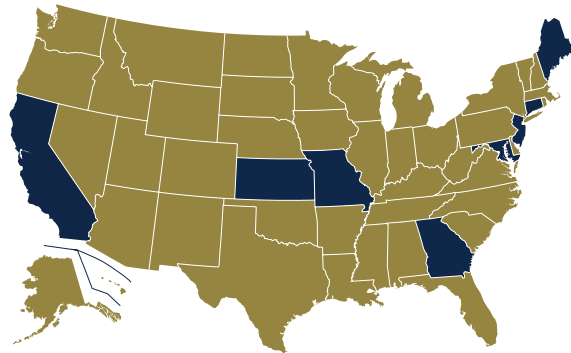
Health Care Consulting

1501 Sulgrave Ave., Ste. 302
Baltimore, MD 21209

www.discernconsulting.com

Linda Shelton
410-542-4470 ext. 5
lshelton@discernconsulting.com

Incorporated 2004
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

80

primary care practices have utilized the organization's product/service.

15

other organizations have utilized the organization's product/service.

About:

- Transformation: Discern has coached dozens of practices through PCMH transformation, using both onsite coaching and virtual and in-person learning events. We teach them to implement PCMH concepts and provide nuts-and-bolts tools to help them. We partner with the Georgia Academy of Family Physicians to train and supervise contracted coaches for individual practices in Georgia, and can do so in other locations. We also provide back-up training and support for large health care organization's own practice coaches.
- NCQA Recognition: Meeting the requirements of the National Committee for Quality Assurance's (NCQA) recognition requires practices to implement change in an organized, data-driven way. With extensive experience with the NCQA process, we provide guidance, a roadmap, and templates for performance on the standards.
- Payment Models: Discern designs and administers new payment models and incentive systems to reward PCMH and shared savings programs, focusing on ACOs and the medical neighborhood. We work directly with practices, health systems, and other organizations promoting new models.
- Information about PCMH: Discern is the co-author of two PCPCC publications: "What is a Medical Home" and "What does a Medical Home mean for you?"

Partners with:

- Small and/or independent practices
- Physician associations
- Large physician practices or groups
- Hospital-owned groups
- State agencies
- Pediatric practices
- Other

Staff Qualifications:

Linda Shelton, lead partner on PCMH, is an NCQA PCMH certified content expert with 30 years' experience in health care and a 20-year association with NCQA, focused on physician practice quality and IT adoption. Managing Partner Guy D'Andrea provides expertise on payment models designed to reward PCMH recognition and improved patient outcomes. Peggy Oehlmann, Project Director, has experience working with safety net providers on PCMH, and is trained on Patient-Centered Specialty Recognition.

References:

Sharon Gibson; Director, Healthcare Practice, Internet Business Solutions Group; Cisco Systems; sgibson@cisco.com

Fay Brown; Executive Vice President; Georgia Academy of Family Physicians; fbrown@gafp.org

Phyllis Torda; Vice President; Strategic Initiatives and Quality Solutions Group; NCQA; Torda@ncqa.org

DocInsight

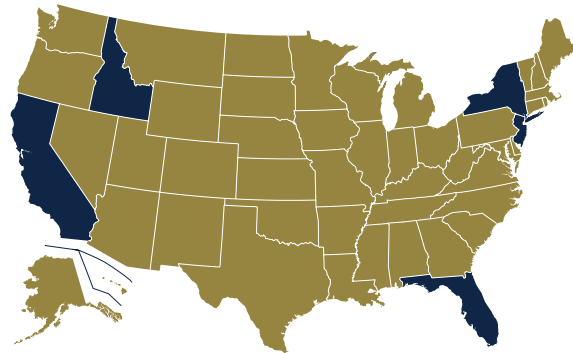
Health Information Technology Solutions

1211 Hamburg Tpke., Suite 301
Wayne, NJ 07470

www.docinsight.com

Mark Dumoff
973-692-0710
mdumoff@docinsight.com

Incorporated 2006
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

50

primary care practices have utilized the organization's product/service.

5

other organizations have utilized the organization's product/service.

About:

DocInsight is a HIT strategy, development and services company focused on the linkage of patient experience and transitions in care. Our Patient-Centered Communications Strategy increases patient acquisition and retention—simplifies care planning & self-management—and streamlines performance measurement & reporting. Our unique services help create better patient experiences... resulting in better communication... better transitions... better outcomes... and reduced hospital readmissions, risks and costs. For medical practices, doctors, hospitals and payers, this can serve as a catalyst for transformation and value creation as Patient Centered Medical Homes (PCMH's) and Accountable Care Organizations (ACO's) emerge. As health reform and national attention focus on quality, access, value and cost... there is a compelling need for innovative solutions that improve patient experience measurement... linking the soft side of medicine with powerful business intelligence tools that enhance quality reporting/transparency and empower consumer decision-making.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

The senior team of DocInsight (President; Chief Strategy Officer, Chief Financial Officer and Director of Technology & Operations) have over a century of combined leadership and operational experience across healthcare; strategic planning; business development; financial management; sales, marketing, research and product development; information services; and administration. Key staff members are employed and contractors are engaged on a supplementary basis.

References:

Riverdale Family Practice; 3125 Tibbett Ave; Bronx, NY 10463
Bedford Stuyvesant Family Health Center; 1413 Fulton Street; Brooklyn, NY 11216
EmblemHealth; 55 Water Street; New York, NY 10041

Health Diagnostic Laboratory Inc.

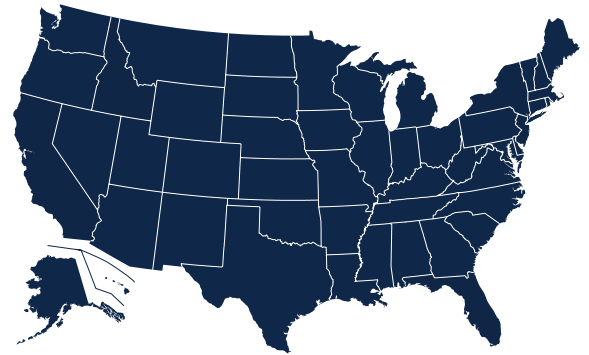
Testing for Cardiovascular and Related Disease, Disease Management, Health Coaching.

737 N. 5th Street, Suite 103
Richmond, VA 23219

www.hdlabinc.com

Anna McKean
804-343-2718, ext. 735
amckean@dhlabinc.com

Incorporated 2009
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

5,000

primary care practices have utilized the organization's product/service.

4

other organizations have utilized the organization's product/service.

About:

HDL, Inc. is a full-service clinical laboratory that has integrated its laboratory functions with disease management activities as a means of providing tools for practitioners (e.g., clinical managers, physicians, nurse practitioners, physician assistants) to design and implement personalized plans of care for their patients. The HDL, inc. approach emphasizes prevention of exacerbations and complications utilizing evidence based practice guidelines and patient empowerment strategies. Services include: a complete health risk assessment; blood and urine laboratory analysis; chronic DM programs consistent with nationally accepted protocols for diabetes, hypertension, cholesterol, stress, obesity, and smoking cessation; advisory services including the interpretation/integration of test results into the patient's health management plan; health education tailored to the specific risks of each patient to ensure health literacy in those areas; HIPAA compliant population-based reporting to enable physicians to monitor patient progress, and a web-based personal health record and portals for patients and their health providers.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Tonya Mallory, BS, MS, President & CEO; Joseph P. McConnell, PhD, Chief Medical Officer, former Director of Cardiovascular Medicine at Mayo Medical Laboratory; G. Russell Warnick, MS, MBA, Chief Scientific Officer, serves on advisory panels of the American Association for Clinical Chemistry (AACC), and the National Cholesterol Education Program.

References:

Riverdale Family Practice; 3125 Tibbett Ave; Bronx, NY 10463

Bedford Stuyvesant Family Health Center; 1413 Fulton Street; Brooklyn, NY 11216

EmblemHealth; 55 Water Street; New York, NY 10041

Health Dialog

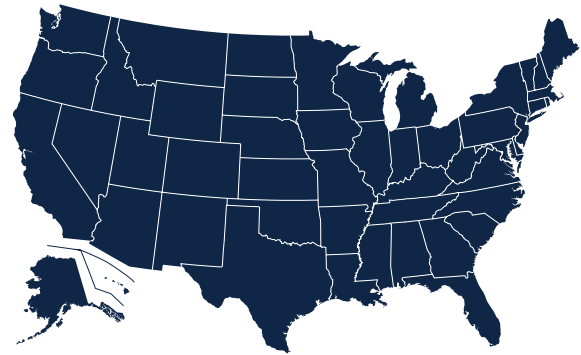
Health Coaching, Provider Performance Measurement, and Practice Analysis/Reporting

60 State St., Suite 1100
Boston, MA 02109

www.healthdialog.com

Patrick Jacxsens
617-217-5618
pjacxsens@healthdialog.com

Incorporated 1997
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

51

primary care practices have utilized the organization's product/service.

50

other organizations have utilized the organization's product/service.

About:

Health Dialog is a leading provider of healthcare analytics and decision support. Company offerings include health coaching for medical decisions, chronic conditions, and wellness; population analytic solutions; and consulting services. We provide a range of services to support PCMH planning, implementation, and operations:

- Population analyses to identify the best opportunities for pilots
- Data aggregation across physician practices and health plans to provide a total population assessment and profile
- Assessment of healthcare quality and efficiency at the patient, provider, group, and pilot levels, including assessment of unwarranted variations in care;
- Health coaching and/or training to support chronic condition management, care coordination, and shared decision-making between patients and physicians
- Expanded patient registries with patient risk identification and stratification Health Dialog is supporting certified PCMHs and practices in the early stages of certification.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

All key staff are employees and include: physicians, registered nurses, licensed social workers, and healthcare management professionals.

References:

Maine Health Management Coalition; Elizabeth Mitchell, CEO; 207-899-1971

PeaceHealth Medical Group; Mary Minniti, Quality Improvement Director; mminniti@peacehealth.org

Ninth Street Internal Medicine; Marjorie Miller, Director of Policy and Planning; 215-440-8681 ext 317

HealthPower Associates

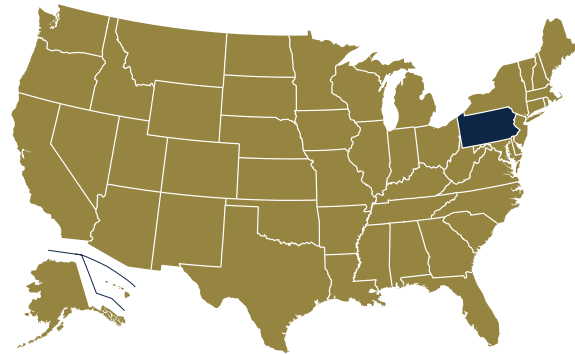
Health Care Consulting

1810 Rittenhouse Square # 1503
Philadelphia, PA 19103

www.healthpowerassociates.com

Nancy Meisinger
215-893-0263
Info@healthpowerassociates.com

Incorporated 1987
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

26

primary care practices have utilized the organization's product/service.

4

other organizations have utilized the organization's product/service.

About:

HealthPower Associates was founded in 1986 to provide educational and management services to physicians, hospitals, and academic health centers. As the health care market place has evolved, HealthPower's mission has expanded to include EHR system selection, technology design and implementation, and development of the patient centered medical home. We have been actively involved in pilots, demonstrations, and collaboratives focused on development of patient-centered care. HealthPower helps clients redesign processes, standardize documentation, develop quality reporting, assist with submission of information to certifying agencies, and manage change. In addition to physicians, clients include a wide variety of organizations and institutions that are a part of the medical community. These include continuing care residential communities, physician organizations, and specialty societies.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Marjorie Miller, BEd (Principal), Benjamin Levin, BSSc (Business, Marketing, HealthCare Administration) MSIS Information Systems(Principal), Nancy Meisinger RN, BSN, MBA, CCP-Senior Consultant (Principal).

References:

Allan Crimm, MD, FACP; Managing Partner, Ninth Street Internal Medicine; Clinical Assistant Professor, University of Pennsylvania School of Medicine; 215-440-8681

Maurice D Gross, MD; North Willow Grove Family Medicine; 215-672-7070

Erin Donahue; Director of Clinical Services, InterMountain Medical Group; 570-714-4030

HealthTeamWorks

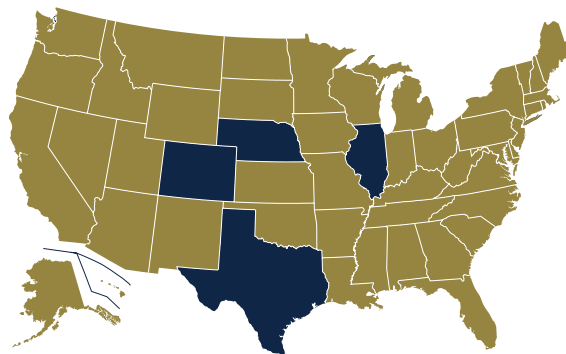
PCMH Transformation, Practice Coaching, Consulting and Training

274 Union Blvd., Suite 310
Lakewood, CO 80228

www.HealthTeamWorks.org

Allyson Gottsman
720-297-1681
AGottsman@healthteamworks.org

Incorporated 1996
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

215

primary care practices have utilized the organization's product/service.

19

other organizations have utilized the organization's product/service.

About:

HealthTeamWorks, formerly known as CCGC, is a non-profit multi-stakeholder collaborative working to redesign the healthcare delivery system and promote integrated communities of care, using evidence-based medicine and innovative systems. Our goals are to optimize health, improve quality and safety, reduce costs, and improve the care experience for patients and their healthcare teams. HealthTeamWorks actively facilitates the transformation to the PCMH model of care including the development of a functionally integrated medical neighborhood. Our practice coaches are devoted to empowering excellence in others, be they practices, communities, or regions. We believe leadership, practice coaching and technology are all essential to make the transformation required. HealthTeamWorks has expertise in both practice coaching, and EHR optimization to support PCMH, Meaningful Use, PQRI, and NCQA recognition. Additional areas of expertise include: Coach Training, strategic consulting and the use of Health Information Technology, including registry functionality, to address gaps in care and quality measurement.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

HealthTeamWorks' highly educated and experienced staff can facilitate transformations in care delivery. Our key executives, consultants and coaches are mainly employees, with varied backgrounds including physicians, nurses, MBAs and numerous other credentials, all detailed on our website.

References:

Sue S. Bornstein, MD, FACP; Executive Director; Texas Medical Home Initiative ; 214-709-7642; ssbornstein@yahoo.com

Perry Dickinson, MD; Principal Investigator, Colorado PCMH Family Medicine Residency Program; University of Colorado Denver; Department of Family Medicine; Mail Stop F496, Academic Office 1; 12631 East 17th Avenue, Room 3223; Aurora, CO 80045; Perry.dickinson@ucdenver.edu

Chet Cedars, MD; Lone Tree Family Practice; Ste G23, 10103 Ridgeway Parkway; Lone Tree, CO 80124-5524; chester@lonetreefp.com

Healthways

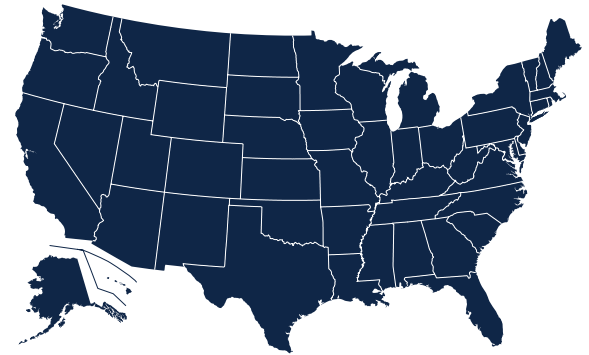
Wellbeing

701 Cool Springs Blvd.
Franklin, TN 37067

www.Healthways.com

Maureen Tressel Lewis
425-201-3275
maureen.lewis@healthways.com

Incorporated 1981
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1,500

primary care practices have utilized the organization's product/service.

3

other organizations have utilized the organization's product/service.

About:

Healthways partners with our customers to provide comprehensive solutions that improve well-being (physical health, social and emotional factors), decrease healthcare costs, enhance performance and generate economic value. Our solutions keep healthy people healthy, reduce risks by changing health-related behaviors, and optimize care for those with serious health concerns. Our integrated technology platform ensures timely intervention while our personalized approach strengthens outcomes. Healthways' Medical Home approach creates value by bridging missing linkages in patient care and reducing cost while maintaining our relationship with the member. Because physicians often focus primarily on treating the symptomatic patient at hand, an important benefit is that our strategies and tactics to prevent, delay, or mitigate further disease states can continue to be incorporated into the member relationship.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Medical Director Licensed physician Board Certified ABMS specialty Operations Leader Bachelor's degree. Advanced business or clinical degree preferred Physician practice management experience Leadership experience in remote organization Care Coordinator Healthcare background and Bachelors degree. Current RN licensure Clinical experience Employees.

References:

Dexter Shurney, MD, MBA, MPH. Medical Director, Employee Health Plan/ Assistant Professor Division of Public Health, Vanderbilt University. dexter.w.shurney@vanderbilt.edu

Dr. Paul Grundy, IBM. pgrundy@us.ibm.com

Amy Gibson, PCPCC. agibson@pcpcc.net

Hooper Holmes, Inc.

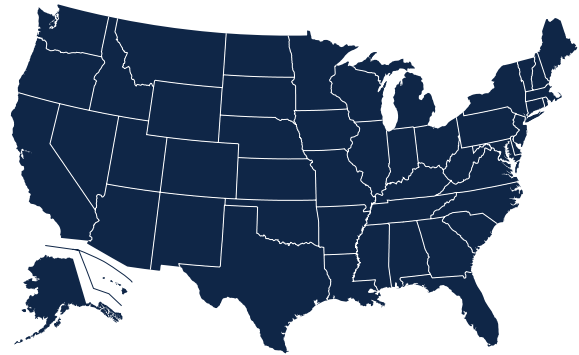
Remote/Local Healthcare Services

170 Mt. Airy Rd.
Basking Ridge, NJ 03087

www.hooperholmes.com

Burt Wolder
908-953-3839
burt.wolder@hooperholmes.com

Incorporated 1899
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

2

primary care practices have utilized the organization's product/service.

68

other organizations have utilized the organization's product/service.

About:

Founded in 1899, Hooper Holmes engages patients and collects health information needed to enable wellness, prevention and new models of patient-centered medical care. Our services are designed to extend the reach of providers, expand access to care, fill gaps and promote early risk identification. To do this, we leverage our national network of 9,000 local medical professionals, at-home laboratory test kits manufactured and tested by our Kansas City lab, and our call centers in Kansas City and Omaha. We provide a complete health screening service including scheduling, fulfillment of supplies, blood collection kits, medical screenings, lab testing and data transmission. We help healthcare organizations reach patients anywhere, gather health data on entire populations, assess health risks and target interventions. Services include biometric screenings; on-site health coaching; transitions in care support services; at-home tests for diabetes and other disease markers; Portamedic® remote blood draw and exam services.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Our 9,000 medical professionals are employees or direct contractors with a variety of credentials. All are phlebotomists approved to draw blood in their jurisdictions. Approximately 1,500 are nurses (RN, LPN, LVN) and 500 are MDs. Over 3,500 have been trained to conduct preventive screenings or deliver onsite health coaching.

References:

Healthways; Nathan King; 615-614-4803
Nationwide Better Health; Bill Zahn; 410-919-7417
Bravo Wellness; Jim Pshock; 440-934-9821

Houck & Associates, Inc.

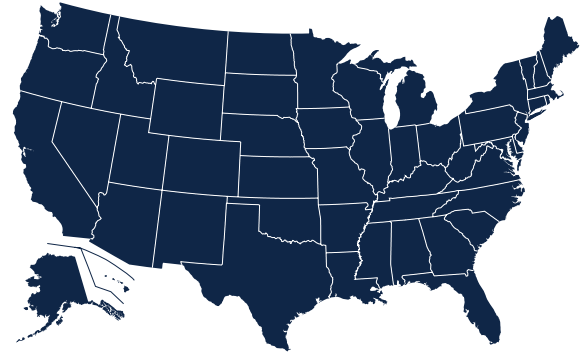
Clinical Operations Improvement

1820 Hawthorn Ave., Suite 200
Boulder, CO 80304

www.houckhealthcare.com

Sue Houck
303-443-9597
shouck@houckhealthcare.com

Incorporated 1999
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

143

primary care practices have utilized the organization's product/service.

47

other organizations have utilized the organization's product/service.

About:

Clinical office practice improvement and redesign. Provided consulting and training assistance to AAFP and CMS patient-centered medical home and other national and regional projects. Over ten years experience facilitating improvement and innovations in care delivery including group visits, planned chronic illness care, EHRs and advanced access for large and small medical groups, hospitals, academic, community health centers, Indian Health, and the VA. CEO, Suzanne Houck authored, *What Works*, a book on clinical office redesign and national best practices that's received a 5 star rating by users at the Institute for Healthcare Improvement website. Experience includes managing and leading healthcare organizations and even providing care. Developed and presented Redesign Boot Camp training for practice coaches nationwide.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Key staff have experience as primary care physicians and nurse practitioners, managers, healthcare leaders, authors and speakers. Key staff are both employees and contractors.

References:

Margy Walbolt; Vice President, Administrative Services; NorthBay Healthcare; 707-646-4196

Lynn Pezzullo; Senior Program Administrator; Quality Partners of Rhode Island; lpezzullo@riqio.sdps.org; 401-528-3200

Julie Schilz; Project Manager; Beacon Collaborative; julie.schilz@coloradobeaconconsortium.org; 303-877-2723

IBM

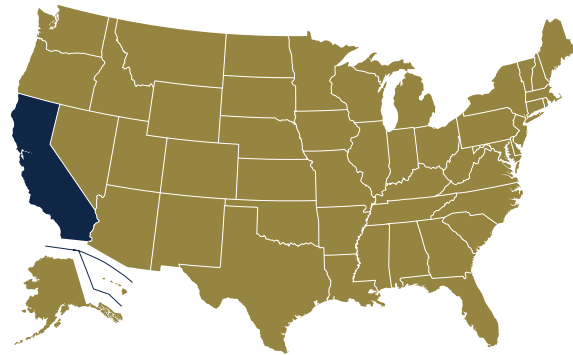
Solutions for Collaborative Care, PCMH and ACO Strategy and Implementation Services Surveys, Workshops, Coaching, Keynotes

1 New Orchard Rd.
Armonk, New York 10504-1722

www.ibm.com

Dr. Paul Grundy
802-750-7306
pgrundy@us.ibm.com

Incorporated 1911
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

19

primary care practices have utilized the organization's product/service.

5

other organizations have utilized the organization's product/service.

About:

IBM offers technology to support the PCMH—including clinical quality metrics tools, data interoperability and exchange platforms, clinician and patient portals, security and hardware, financial analytics and predictive modeling tools. We also offer implementation and ROI services for the PCMH, and strategy and consultation services for organizations building ACO's.

Partners with:

- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Strategists include provider and payer executives and Primary Care Physicians. Implementation teams are led by clinicians and PMP certified project managers in clinical transformation and change management. Technology teams include leadership from NHIN and members of HITSP working groups.

References:

Geisinger; Data warehouse and analytics that support patient centered care; Thomas Graf, M.D., chairman of community practice for Geisinger, director of primary care; trgraf@geisinger.

Client Southeast Texas Medical Associates; IBM analytics for medical home reporting; Dr. Larry Holly, CEO and Managing Partner; 409-833-9797

Sharp Community Medical Group; PCMH Strategy engagement 2009; Dr. John Jenrette CEO; 877-518-7264

Iowa Chronic Care Consortium

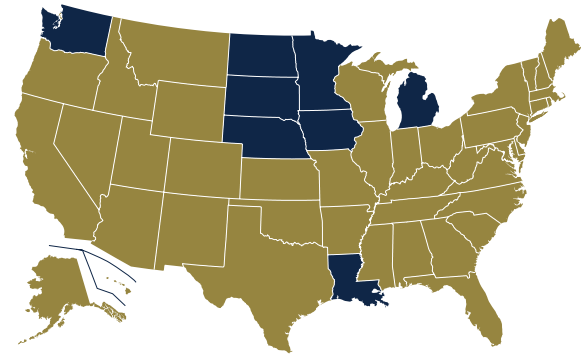
Clinical Health Coach Training Program

5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266

www.iowaccc.com

Kathleen Kunath
515-971-3234
kathy.kunath@iowaccc.com

Incorporated 2003
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

50

primary care practices have utilized the organization's product/service.

10

other organizations have utilized the organization's product/service.

About:

The Consortium was organized to build capacity in other organizations to manage population health for those with chronic conditions. Founded in 2003 as a non-profit partnership among leading providers, payers and large employers, it has expanded to include physicians, public health and health plans. Sensing the critical gap around proactive care, evidence based interventions, and the pivotal role of patient behaviors and self-management, ICCC partnered to create the Physician Office Health Coach training in 2007 with Mercy Clinics in Iowa. More recently, it has deepened that training to create the Clinical Health Coach™ training. Providing designs for practice improvement, patient registries, pre-visit reviews, coaching skills for communication, behavioral change and self-management, and patient outcome and quality reporting, it has attracted clinic systems nationally. Participating clinics are working toward becoming qualified patient-centered medical homes. Successful participants are awarded a Certificate of Competency as a Clinical Health Coach™ upon completion.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Key ICCC staff offer a wide skill mix in healthcare policy, healthcare administration, clinical skills, health coaching, health promotion and education. Additional faculty have either graduate or medical degrees and/or specialized certifications. All staff and faculty are contracted.

References:

- Sanford Health; Vanessa Taylor; 605-328-0094
- Iowa Clinic Internal Medicine; Tom Luft, MD; 515-875-9192
- Ochsner Health Center, North Shore; Sandra Palmisano; 985-875-2750

Janus Enterprise International LLC

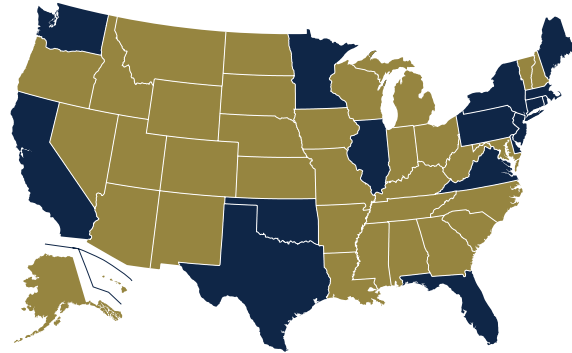
Janus Strategy Laboratory®, Healthcare Management Consulting

P.O. Box 635
New Providence, NJ 07974

www.janusllc.com

Darius Sabavala
908-464-4256
darius.sabavala@janusllc.com

Incorporated 1992
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

1

primary care practices have utilized the organization's product/service.

42

other organizations have utilized the organization's product/service.

About:

Janus Enterprise International (JEI) is a management consulting firm with deep and broad experience in market analytics and strategy execution in the healthcare and technology sectors. Original concepts, analytical tools, and results-oriented processes enable our clients to progress through PCMH transformation and to meet multiple strategic challenges more effectively. Janus Strategy Laboratory® (JSL) is a virtual healthcare environment in which teams practice analysis and decision-making, enhancing their leadership capabilities for addressing challenging problems in the real world. JSL is ideally suited to help healthcare professionals and physician practices in the areas of leadership development, change management, and organizational integration as they move toward PCMH. JEI's analytical tools provide data-based decision support for various purposes ranging from benchmarking clinical and financial performance to estimation of demand for therapies and assessing competition.

Partners with:

- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices

Staff Qualifications:

The healthcare core team has over 50 years of academic and industry experience with advanced degrees. Key employees are Darius Sabavala (BTech Honors, Ph.D.), Sivakumar Sankaranarayanan (BTech, MS), Bruce Rothenberg (MA, MBA). John H. Drury, MD, FACC, FACP is an Advisor.

References:

Sheila C. Bushkin, MD; sbushkin@nycap.rr.com
John H. Drury, MD; johndrury@boomerangme.com
Timothy W. Willox, MD; teeww59@gmail.com

Kearsarge Healthcare Consulting, Inc.

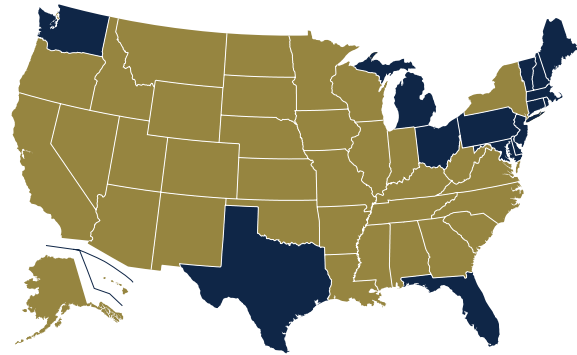
Healthcare Consulting/Health Data Management

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Georges Mills, NH 03751

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Michael Deyett, MHA
888-783-5280 ext 700
mtd@kearsargeconsulting.com

Incorporated 2003
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

30

primary care practices have utilized the organization's product/service.

80

other organizations have utilized the organization's product/service.

About:

Consulting: KHC helps practices with operational workflows, general business operations, and financial performance. KHC compares EHR applications and defines application gaps, and practice work flows. KHC assesses billing processes and software of EMR companies, insurance, and practices to help with restructuring and retooling. From the front office to the back office, KHC assessments have changed the way practices manage their business. Healthcare Information Technology: KHC leverages their strong medical information technology background to focus on serving medical group practices. We are a PQRI registry. We submit quality data reporting to CMS, Insurance plans, and Hospitals. We have used healthcare information to develop physician profiling tools and reports utilizing case mix methodologies, episode treatment groupers, and industry leading healthcare metrics. We have empowered practices through EHR selection, financing, implementation and data conversions. We offer data repositories and warehousing custom built to client specifications and needs.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Key Staff: Each Consultant has more than 15 years of experience and masters of health administration or business administration. Data engineer with 20 plus years of experience.

References:

Scott Thomas; 314-288-5589
Central Ohio Primary Care; Bill Wulf; 614-865-8011
Martin's Point; Jeff Bland; 207-856-1819

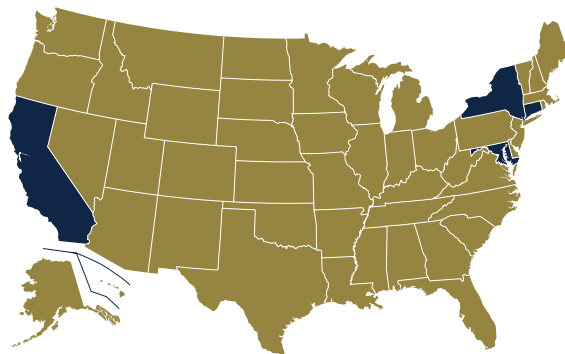
LKS Consulting

Health Care Consulting

5 Lighthouse Ct.
Salem, SC 29676

Linda Shelton
864-557-2595
lindashelton@lksconsulting.com

Incorporated 2006
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

16

primary care practices have utilized the organization's product/service.

7

other organizations have utilized the organization's product/service.

About:

Linda Shelton has been consulting, solo and as a sub-contractor, since 2006. Many of her projects focus on medical home transformation. For eHealth Initiative, she is leading a project to improve care coordination with medical homes in New York and Connecticut. She also works with Discern Consulting on the state of Maryland's PCMH pilot project, assisting practices to attain the state's incentives for transformation. From 2006-2009 she managed a groundbreaking program in the Silicon Valley that rewarded practices for using IT to improve patient care. During her 13 years with NCQA as an assistant VP, Linda led the creation of Physician Practice Connections, which is now the PCMH recognition program. She managed operation of all 3 NCQA national physician recognition programs from 2003 to 2006. Consulting with NCQA, she developed standards for care coordination in Medicare.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Linda K. Shelton, MA, sole proprietor, has 30 years' experience in health care including 9 years' involvement in physician practice quality and IT adoption. Linda has an MA in health care administration from George Washington University and a BS from Tufts University.

References:

Sharon Gibson; Director, Healthcare Practice, Internet Business Solutions Group; Cisco Systems; sgibson@cisco.com

Jennifer Covich Bordenick; Chief Executive Officer; eHealth Initiative; Jennifer.Covich@ehealthinitiative.org

Phyllis Torda; Vice President, Strategic Initiatives and Quality Solutions Group; NCQA; Torda@ncqa.org

McKesson Corporation

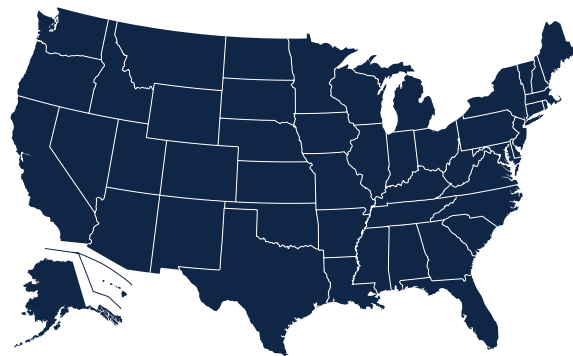
McKesson Health Solutions, Care Management

329 Interlocken Parkway
Broomfield, CO 80021

www.mckesson.com

Jerry Miller
303-664-6371
Jerry.Miller@McKesson.com

Incorporated 1833
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

3,000

primary care practices have utilized the organization's product/service.

50

other organizations have utilized the organization's product/service.

About:

McKesson Health Solutions Care Management serves Medicaid and Commercial populations using local, provider-driven care teams that work with the Medical Home. Core to this is the placement of our nurses in provider offices to help coordinate the care and community needs for patients with chronic diseases. McKesson facilitates systems and processes in the medical home to maximize quality and promote guideline-based care. We've developed strategies to: work with the PCP to create a whole-person Member Care Plan to address health needs/barriers to care; make providers/community stakeholders integral to the program; connect members to appropriate resources. Our staff lives and works in the communities they serve and they interact with the medical homes with which members are engaged.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Staff includes Medical Directors (M.D.), Registered Nurses, Licensed Clinical Social Workers, Pharmacists, Lay Health Workers, Behavioral Health Specialists, Medicaid Resource Coordinators, and Certified Nutritionists. Key staff are generally employees.

References:

- Texas Medicaid Wellness Program; Lupita Villarreal; 11209 Metric Blvd. Building H, Mailcode H320; Austin, Texas 78758-4021
- Illinois Academy of Family Physicians; Vincent D. Keenan, CAE, Executive vice president; 4756 Main Street Downers Grove, IL 60515
- Illinois Department of Healthcare and Family Services; Michelle Maher, Bureau of Managed Care; 201 S. Grand Ave. East Springfield, IL 62763

McKesson Corporation

McKesson Practice Care Services

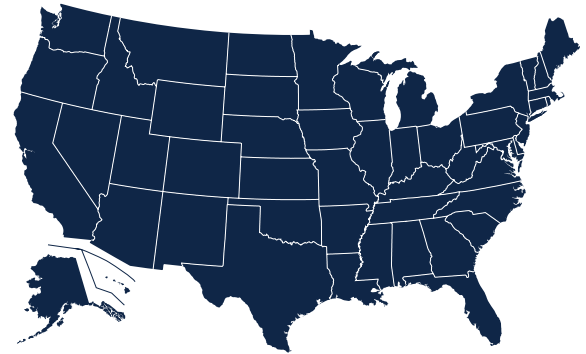
1145 Sanctuary Parkway
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Incorporated
• 1833 (McKesson)
• 1995 (PPRNet)

For-profit—McKesson
Not-for-profit—PPRNet



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

184

primary care practices have utilized the organization's product/service.

180

other organizations have utilized the organization's product/service.

About:

McKesson Practice Care PCMH Services is a collaborative effort between McKesson Corporation and Practice Partner Research Network (PPRNet). McKesson's Physician Practice Solutions, a business unit of McKesson Corporation (NSYE: MCK), develops and installs electronic health records, medical billing and scheduling systems. PPRNet is a practice based research network (PBRN) that strives to improve the quality of healthcare in its member practices and elsewhere in the US. The network is unique from other PBRNs in the sense that all of its members use McKesson's EHR systems to capture their patient information. PPRNet has 3 primary aims: to translate research into practice; to empirically test theoretically sound quality improvement interventions; and to disseminate successful interventions to both member and non-member practices across the country. The network provides members with quarterly performance reports on nearly 100 clinical measures, conducts federally funded research projects involving our member practices, and hosts annual network meetings that allow members to discuss and share "best practice" approaches.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Pediatric practices

Staff Qualifications:

McKesson—Tim Caver, MBA, VP of Practice Care; Melissa Coovert, PMP, CMPE, Dir. Implem. Svcs
PPRNet—Lynne Nemeth, Ph.D., RN; Cara Litvin, MD, MS; Steve Ornstein, MD; Andrea Wessell, PharmD; Ruth Jenkins, Ph.D., Dir. of Informatics of PPRNet.

References:

Family Practice Partners; Dr. Sue Andrews; 615-890-9194
Mercy Westshore Family Medicine; Dr. Kristen Brown; BROWNK@trinity-health.org
Hillside Family Practice; Dr. Ken Sperber; 401-729-4520

MDdatacor, Inc.

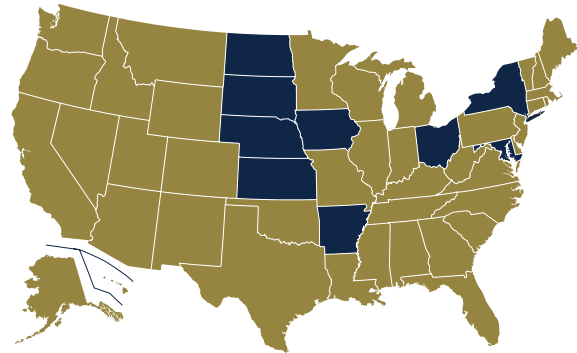
MDinsight

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Atlanta, GA 30022

www.mddatacor.com

Heather McLarney
678-689-0280
heather.mclarney@mddatacor.com

Incorporated 2001
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

219

primary care practices have utilized the organization's product/service.

10

other organizations have utilized the organization's product/service.

About:

MDinsight aggregates clinical data from practices' existing disparate systems (lab, practice management, EMR and registry systems and transcribed notes) and analyzes it against evidence-based guidelines for both process and outcome measures. Clinicians can view web-based reports identifying chronic and wellness Care Opportunities—patients in need of a test, or who have had a test but the value was too high per the clinical guidelines. MDinsight automatically generates patient outreach letters, and allows the sharing of data across care settings including primary care and specialists. Every time a patient sees a physician, fills a prescription, or has a lab test, the information is added to MDinsight, producing a longitudinal, evolving view of patients' health and yielding cost savings and outcome improvements.

Partners with:

- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

The executive management team has a proven track record of developing market-leading solutions. The team's experience includes serving in senior positions within healthcare, technology, clinical research and biomedical organizations. Their vast experience and strategic vision contribute to the company's strong growth.

References:

Blue Cross Blue Shield of North Dakota; Dr. David Hanekom; (701) 282-1350

Blue Cross Blue Shield of Nebraska; Dr. Bill Minier; (402) 390-1898

Alegent Health—The McAuley Center; Myra Ricceri; (402) 343-4521

Microlife Medical Home Solutions, Inc.

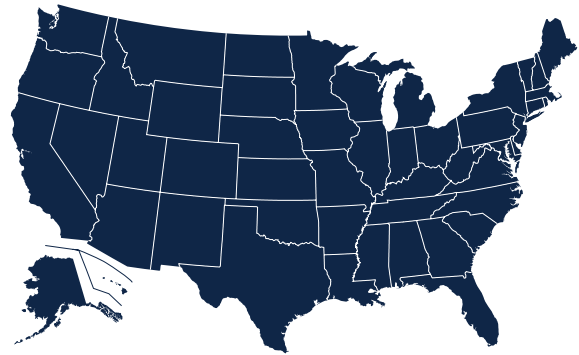
WatchBP®, WatchWT®, & The Fast Track to The Patient-Centered Medical Home

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Golden, CO 80401

www.mimhs.com

Loan Kim Hau
303-274-2277 ext. 106
loan.hau@mimhs.com

Incorporated 2005
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

209

primary care practices have utilized the organization's product/service.

760

other organizations have utilized the organization's product/service.

About:

Microlife is dedicated to supporting physicians in their journey to become NCQA Patient-Centered Medical Home practices through the Fast Track to the Patient-Centered Medical Home program. This program assists the practice in reaching Level 1 NCQA recognition within 3 to 6 months. This program provides the documents, tools, and resources that will help define a vision, create a team building approach, and assist with effective communication in a practice. The program includes 2 advanced solutions for assessing and treating hypertension and obesity. These two programs will also facilitate the recognition process.

- WatchWT™—is a turn-key program for the initiation, assessment, implementation and treatment of overweight and obese patients that is evidence-based, cost-effective, and practical.
- WatchBP® is a solution-based program for comprehensive in-office and out-of-office blood pressure measurement to improve treatment outcomes through patient self-management and advanced diagnosis.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Loan Kim Hau—PCMH Sales Associate & Marketing Specialist. Project Manager for PCMH Fast Track Pilot Study. Project Management for Colorado Academy of Family Physicians. Health Information Representative for Rose Family Residency. Scott McDoniel—Director of Clinical Affairs, Ph.D., EPC, FACN.

References:

Westminster Medical Clinic; R. Scott Hammond, MD, FFAFP; 303-428-7449
Miramont Family Medicine; John L. Bender, M.D., FFAFP; 970-482-0213
DTC Family Health; Timothy Dudley, MD; 303- 771-3939

ModernMed

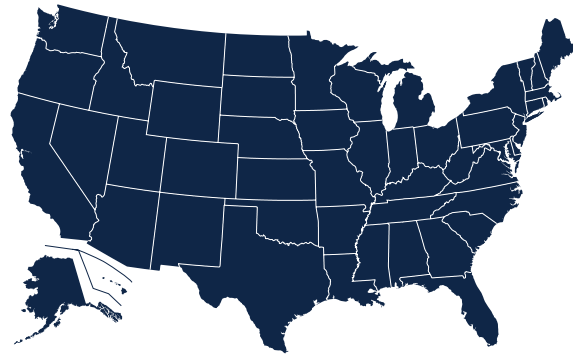
Concierge Medicine

N19 W24400 Riverwood Dr., Suite 340
Waukesha, WI 53188

www.modernmed.com

Craig Pyne
480-502-6777
cpyne@modernmed.com

Incorporated 2007
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

50

primary care practices have utilized the organization's product/service.

5

other organizations have utilized the organization's product/service.

About:

ModernMed is a forward-thinking health care service firm designed to create a better health care experience for patients, physicians and businesses. We establish and maintain modern primary care practice environments across the country that are unlike any traditional practice. As we transition and support practices in a concierge medicine model, we feel that we are creating an enhanced patient-centered medical home with every practice we transition or create.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Key staff are employees. As an executive group, we have greater than 60 years of health care service experience, including more than 10 years working in the concierge medicine industry. Our CEO is a physician.

References:

Dr. Mark Niedfeldt; 262-643-4720

Dr. Art King; 414-831-0694

Dr. Ira Warshaw; 561-626-1000

National Center for Medical Home Implementation

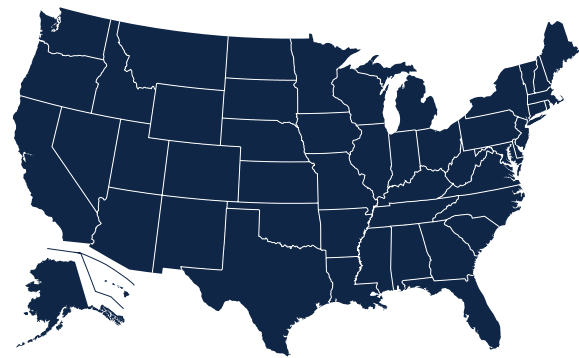
Federally Funded Clearinghouse of Medical Home Resources/Tools

141 Northwest Point Blvd.
Elk Grove Village, IL 60007

www.medicalhomeinfo.org

Angela Tobin
847-434-7621
atobin@aap.org

Incorporated 2008
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

3,000

primary care practices have utilized the organization's product/service.

3,000

other organizations have utilized the organization's product/service.

About:

The National Center for Medical Home Implementation is a cooperative agreement between the Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP). The mission of the National Center for Medical Home Implementation is to work in cooperation with federal agencies, particularly the MCHB, and other partners and stakeholders to ensure that all children and youth, including children with special needs, have access to a medical home.

- Enhancing policies and operational standards that guide implementation of the medical home through partnerships at the national level.
- Providing resources and tools that increase implementation of the medical home at the practice level.
 - Enhancing the collaboration for medical home system change at the state and community levels.
- Leveraging the AAP structure—chapters, committees, councils, and sections—to further maximize medical home implementation at all levels from local to national.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Fan Tait, MD, FAAP Principal Investigator of the National Center for Medical Home Implementation; Michelle Esquivel, MPH Director, National Center for Medical Home Implementation; Angela Tobin, AM, LSW Medical Home Policy and Education Analyst; Heather Stob Program Coordinator.

References:

UIC--Division of Specialized Care for Children; Rita Klemm, MSW; 217-558-2350
Plateau Pediatrics; Suzanne Berman, MD, FAAP; 931-707-8700
Meridian Pediatrics; Mary McAteer, MD, FAAP; 317-844-5351

New Jersey Academy of Family Physicians

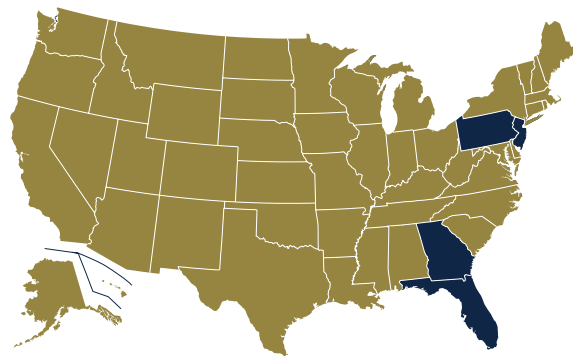
PCMH Recognition and Transformation Services

224 West State St.
Trenton, NJ 08608

www.njafp.org

Cari Miller
609-394-1711
cari@njafp.org

Incorporated 1985
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

121

primary care practices have utilized the organization's product/service.

14

other organizations have utilized the organization's product/service.

About:

The New Jersey Academy of Family Physicians (NJAFP) has been advancing the cause of family physicians and their patients for more than 50 years. With nearly 2,000 members, including practicing family physicians, residents in Family Medicine, and medical students interested in the specialty, NJAFP is the largest primary care medical specialty society in New Jersey. NJAFP is also a constituent chapter of the American Academy of Family Physicians (AAFP), the largest medical specialty association in the United States. NJAFP strongly supports and seeks to advance the adoption of the Patient-Centered Medical Home (PCMH) model of care in primary care practices throughout the United States. NJAFP works with physicians, health plans, healthcare systems and stakeholders to plan and implement tactics to meet the challenges of the ever-changing healthcare delivery environment. NJAFP's mission is to advance and promote the specialty of family medicine through education and advocacy which serves to benefit the health of the public and the practice environment of our members.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

NJAFP staff form a multidisciplinary team to collaboratively assist clients in PCMH education, recognition & transformation. The team has experience in all healthcare settings & expertise in clinical assessment, quality improvement, health information technology, practice management, adult learning, communications, program design & research.

References:

Farmingdale Family Practice Associates, LLC; 43 Main Street; Farmingdale, NJ 07727; 732-938-6471; Joseph W. Schauer III, MD; jschauer3@aol.com

Memorial University Medical Center—Family Medicine Residency Program; Robert (Butch) Pallay, MD; Residency Director, Family Medicine at Memorial University Medical Center; 912-350-8404; 1107 E 66th St, Savannah, GA, 31404

St. Anthony's Primary Care; Emily Callaway, Executive Director; 1200 7th Avenue N; St. Petersburg, Florida 33705; emily.callaway@baycare.org

Pharos Innovations

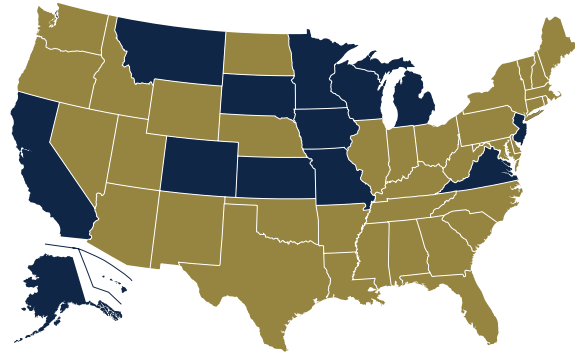
Telehealth and Communication Platform for Care Coordination of Chronic Conditions

2 Northfield Plaza, Suite 201
Northfield, IL 60093

www.pharosinnovations.com

Mr. Kelly Keegan
800-997-3367
kkeegan@pharosinnovations.com

Incorporated 1995
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

11

primary care practices have utilized the organization's product/service.

11

other organizations have utilized the organization's product/service.

About:

Pharos Innovations was founded in 1995 with the belief that consistently engaging patients in their daily self-care is the optimal path to improving outcomes, such as reducing avoidable, costly re-admissions. In response, Pharos developed Tel-Assurance®, IVR and Web-based behavior change/remote patient monitoring services and tools that enable providers to cost-effectively and efficiently manage their patients with chronic conditions. Like the Pharos Solution, the Medical Home was developed in response to the need for better healthcare value—better quality care for less cost. Also like the Pharos Solution, the Medical Home approach shifts the medical model from an episodic, acute care to proactive, continuous care. We support the Medical Home by offering an easily accessible, easy-to-use solution that increases and personalizes care coordination, allows care access from remote locations between physician visits, facilitates a team approach to care coordination and emphasizes quality and safety.

Partners with:

- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

The majority of Pharos' key staff are full time employees with vast experience in healthcare and chronic care management. This includes Pharos' founder, MD; EVP of Sales; vice president of client services, an RN; vice president of finance, a CPA and chief technology officer.

References:

Henry Ford Health System; Dr. Richard Dryer; 313-982-8296

Veteran's Health Administration—VISN 4; Chuck Tyler, RN, BSN; 717-272-6621, ext. 4082

Park Nicollet Health Services; Judy Ryan; 952-993-2131

Primary Care Development Corporation

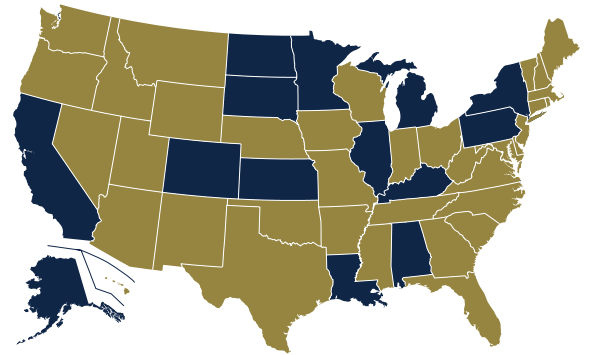
Consulting Services—Medical Home and Meaningful Use

22 Cortlandt St., 12th Floor
New York, NY 10007

www.pcdc.org

Peter Cucchiara
212-437-3921
pcucchiara@pcdcny.org

Incorporated 1993
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

150

primary care practices have utilized the organization's product/service.

10

other organizations have utilized the organization's product/service.

About:

Founded in 1993, the Primary Care Development Corporation (PCDC) is a nonprofit organization dedicated to ensuring that every community has timely and effective access to primary care. Our goal is to increase the capacity and quality of primary care in underserved communities to achieve our vision of "Excellent Healthcare in Every Neighborhood." To achieve its mission, PCDC relies on three strategies aimed at improving health outcomes, reducing health disparities, and lowering healthcare costs in communities where primary care is needed most. These strategies are investing in primary care facilities; strengthening service delivery; and leading policy initiatives. PCDC helps primary care providers expand access to care, improve productivity, and qualify for Medical Home recognition and EHR Meaningful Use certification. Using proven strategies, we work side by side with our clients, helping them assess and understand their operational issues; develop customized strategies for change; define measurable outcomes; and establish processes to sustain these improvements.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Peter Cucchiara, Director of Performance Improvement, Health Information Technology; Cari Reiner, MPA—Senior Program Manager Performance Improvement; Vanessa Rudin, MUP, Senior Program Manager, Performance Improvement; Deborah Johnson Ingraham, Senior Program Manager, Performance Improvement.

References:

Montefiore Medical Group; Jorge Rodriguez; (718) 405-4250

Health Care Choices—Independent Community Living; Maria Siebel; (718) 234-0073

New York Children's Health Project; Deborah Snider; (718) 588-4460

PRISM

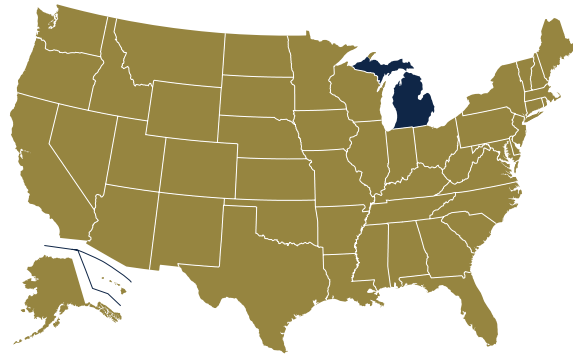
Practice Transformation Coaching

4555 Investment Dr., Suite 204
Troy, MI 48098

www.prism1.org

Joseph A. Fortuna, MD
248-709-6669
jaf@prism1.org

Incorporated 2010
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

20

primary care practices have utilized the organization's product/service.

3

other organizations have utilized the organization's product/service.

About:

PRISM is a non-profit, physician-led medical practice change management team. With a mission of sustainably improving the performance and culture of primary care practices, PRISM provides our partners with no-risk access to a full range of effective, validated change management and process improvement services aimed at helping medical practices to achieve sustainable clinical, operational, cultural and financial excellence. PRISM strategically engages with primary care practices to non-intrusively assist them in meeting today's challenges: from qualifying as a PCMH, to improving their HEDIS or CAPS scores, to assuring their long-term financial viability, etc. Our role is to facilitate sustainable, practice-driven change management activities in the practice. We deploy highly qualified and experienced professional coaches who use proven techniques and methodologies to help practices. Our services are unique and customized—fully tailored for each of our engagements.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

Prism's Team is comprised of highly skilled process improvement and change-management specialists with extensive experience in industry and healthcare. They all use only validated, proven techniques. Its leaders, Joe Fortuna, MD, and John Casey have led many successful practice transformations.

References:

Mansoor; Imad Mansoor, M.D.; 248-454-1004

Oxford Family Practice; Larry Cowsill, D.O.; 248-338-5353

St. Joseph's Mercy Medical Group; Kevin Taylor, M.D.; 734-712-5753

Qualis Health

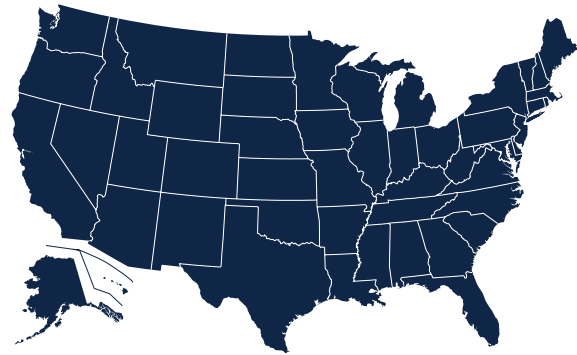
Patient-Centered Medical Home Consulting Services

10700 Meridian Ave., North Suite 100
Seattle, WA 98133

www.qualishealth.org
www.qhmedicalhome.org

Kathryn Phillips, MPH
206-288-2462
kathrynp@qualishealth.org

Incorporated 1974
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

500

primary care practices have utilized the organization's product/service.

50

other organizations have utilized the organization's product/service.

About:

Qualis Health, a nonprofit 501(c)(3), provides consulting and care management services to improve the quality, safety, efficiency, and cost-effectiveness of healthcare for individuals and populations. We have extensive experience supporting PCMH transformation, particularly in the safety net, and currently lead the national Safety Net Medical Home Initiative. We provide custom-tailored support to large and small practices, and to health plans, foundations, and others interested in supporting PCMH transformation, quality improvement, or P4P programs. We offer clinical, process improvement, health IT, and data analytic expertise to assist practices in PCMH advancement. Our consulting and technical assistance services include intensive workshops; on-site and telephonic consultation; assessment and ongoing monitoring; and resources and tools to help practices understand and implement patient-provider panels, team-based care, and other PCMH components. We also provide comprehensive support for practices pursuing NCQA PCMH recognition, including application preparation and review.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Our team of employed consultants includes experienced practice coaches, clinicians, health system administrators, public policy experts, epidemiologists, and informaticists, most with advanced degrees. We also have a large network of subcontractors with specialized expertise, including change management and leadership development.

References:

The Commonwealth Fund; Melinda Abrams; 212-606-3831
The REACH Healthcare Foundation; Betsy Topper; 913-432-4196
Community Partners; Bridget Hogan Cole; 213-346-3238

RelayHealth, Inc.

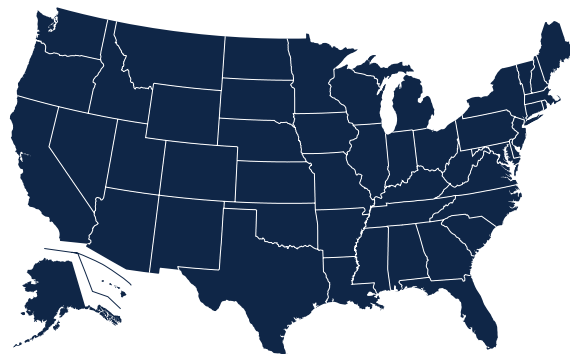
Healthcare Connectivity Services

1564 Northeast Expressway
Atlanta, GA 30329

www.relayhealth.com

Donna Scott
770-237-7111
donna.scott@relayhealth.com

Incorporated 1999
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

85,000

primary care practices have utilized the organization's product/service.

2,000

other organizations have utilized the organization's product/service.

About:

RelayHealth's web-based solutions provide a secure and interoperable platform to support the healthcare IT infrastructure necessary to enable a PCMH environment. RelayHealth operates as a neutral partner in an open network environment, offering connectivity services and integration among healthcare organizations, systems, and solutions. The core PCMH principles of clinical integration, care collaboration, patient access, and health data analytics are all integral to the RelayHealth solutions. For example, RelayHealth can ensure that patients' relevant health data is available when needed at the primary care level from various sources, including pharmacies, clinical labs, hospitals, and other medical providers. RelayHealth partners with services firms to offer a comprehensive approach to transitioning healthcare practices to the PCMH model, including the underlying workflow and process transformation required. By addressing both technology deployment and the underlying practice transformation as complementary processes, we enable our clients to create the foundation for a successful certified PCMH and for future care models.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

All key staff members are employees. The executive team has a proven track record of developing market-leading solutions. The team's experience includes serving in senior positions within healthcare, technology, clinical research and biomedical organizations. Credentials vary but include MD, Ph.D., and MBAs—the vast experience and strategic vision contribute to the company's strong growth.

References:

Lyle Berkowitz, MD; 1913 W. North Ave; Chicago, IL, 60622

Hill Physicians Medical Group; San Ramon, CA; Marci Littlefield or Alan Fink; Marci.littlefield@hpmg.com/alan.fink@hpmg.com

Medical Network One; Ewa Matuszewski, CEO; EMATUSZEWSKI@mednetone.net

Remedy Healthcare Consulting, LLC

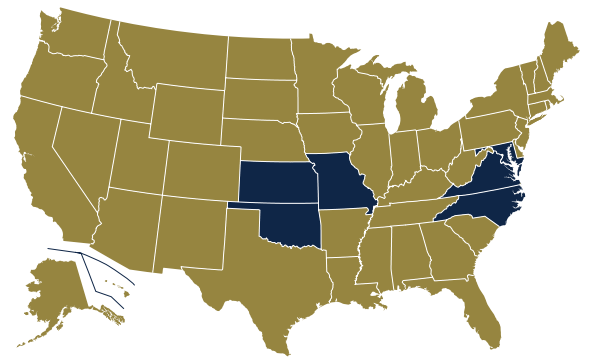
Clinical Transformation and Medical Practice Consulting

PO Box 484035
Kansas City, MO 64145

www.RemedyHealthcareConsulting.com

Sheila Richmeier
913-634-0466
Sheila@RemedyHC.com

Incorporated 2010
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

19

primary care practices have utilized the organization's product/service.

5

other organizations have utilized the organization's product/service.

About:

Remedy Healthcare Consulting provides assistance to medical practices for both primary and specialty care. Expertise in the clinical side of the practice makes this consulting company unique. The staff has a thorough understanding and extensive work experience in business and clinical management that can maximize efficiencies and metrics. Not only has staff worked with practices of all sizes, ownership structure, and specialty, but also as a facilitator and subject matter expert with TransformMED in pilot projects and practices, designing and implementing various components of the TransformMED model, designing and presenting at national, regional and local conferences, and writing and publishing PCMH and practice management expertise. Remedy staff has a thorough understanding of the national stage in both PCMH and practice management. Not only has the staff helped transform practices, but has provided assistance to multiple practices with NCQA recognition, most often to obtain Level 3 recognition. Remedy Healthcare Consulting can provide cost-conscious services tailored to meet the needs of any primary care practice.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Sheila Richmeier, owner, MS, RN, FACMPE.

References:

MedPeds; Jill Rosenstock MD; 301-498-8880

Holland Hospital; Connie Gnergy, Director of Physician Practices & Medical Staff Development; 616-546-4973

Calvert Internal Medicine; Keith Kelley, Practice Administrator; 410-535-2005

Resource Partners, LLC

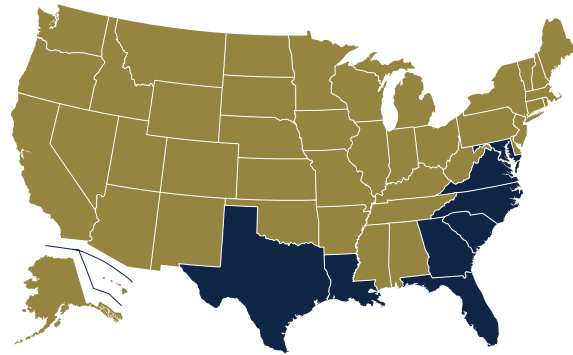
The Medical Home Development Group

334 East Bay St., Suite 168
Charleston, SC 29401

www.ConsultResourcePartners.com

Audrey Whetsell
866-448-7776
awhetsell@consultresourcepartners.com

Incorporated 1995
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

2,375

primary care practices have utilized the organization's product/service.

50

other organizations have utilized the organization's product/service.

About:

After 16 years in the business of providing healthcare technology solutions Resource Partners, LLC restructured in 2006 to provide additional ancillary support services to its healthcare clients. With that restructuring, Resource Partners, LLC grew its network of healthcare clients to well over 500 with a vertical market of over 2,000 providers. Its Co-founder and President began the original company in 1989 primarily providing health technology services through practice management applications and electronic health records. Today, Resource Partners through its partner companies provide clinical/administrative support, practice assessment and audits, staff education and training, payer credentialing/contract negotiations, comprehensive design and implementation development strategies to enhance organizational effectiveness and implementation for overall practice and organizational transformation. In August of 2010 Resource Partners launched a significant partnership, The Medical Home Development Group to specifically address NCQA PCMH Recognition.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

Internal staff members: Employees: MBA, JD, RHIA, CHC and CPC, Certifications in Microsoft Office Suite, Lotus Notes, SPSS, SAP, Oracle, BAAN, MDM, Engagement Management Toolset. Contracted: Health Disparities Scholar, Health Literacy coach and published expert.

References:

Adriana Castro, MD; Adriana Castro PA; dramcastro@hotmail.com
Paula Orr, MD; Charleston Women's Wellness Center; peobabymd@aol.com
Lemar Marshall, CEO; North Oaks OBGYN; lmarshall@no-obgyn.net

RMS Healthcare—RMS, Inc.

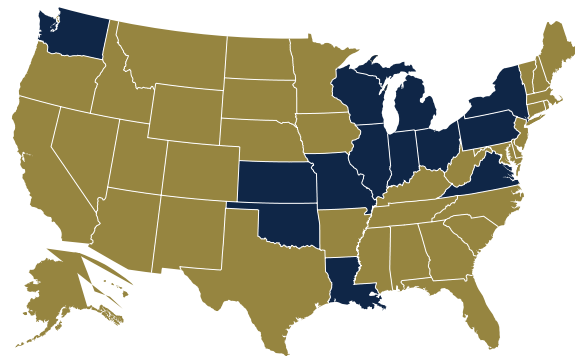
Health Care Transformation Services

15 E. Genesee St., Suite 210
Baldwinsville, NY 13027-2539

www.RMSresults.com

Mark Dengler
315-635-9802 x 222
866-567-5422 x222
markd@rmsresults.com

Incorporated 2002
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

45

primary care practices have utilized the organization's product/service.

24

other organizations have utilized the organization's product/service.

About:

RMS Healthcare, a division of Research & Marketing Strategies, Inc., is focused on assisting healthcare clients with optimizing their operations. The firm has a dedicated, trained staff with direct healthcare operations experience. Staff backgrounds include managed care, practice management, and clinical activities. RMS Healthcare understands that healthcare providers must be able to produce superior clinical results while managing patient care in an effective and efficient manner. Our organization provides hands-on consultative and operational support for healthcare organizations in their practice transformation activities. We have experience in conducting healthcare practice quality and safety reviews, staff education, and have assisted healthcare organizations with strategic planning and change management support. We are also an approved CMS CAHPS® vendor, currently administering patient satisfaction surveys for hospitals, physicians, and home health agencies. The organization, based in Upstate New York, is able to provide high quality resources at affordable rates.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

All staff is employed. Mark Dengler, MPA, President, has over 30 years experience in strategic planning and managed care operations. Susan Maxsween, MSHA, has over 15 years experience in healthcare and regulatory oversight. Megan O'Donnell, MBA, has over 15 years experience in healthcare analytics and medical practice management.

References:

Dryden Family Medicine; William Klepack, MD, ABFP; Carol Klepack, RN; 607-844-8181; 5 Evergreen Street; Dryden, NY 13053; carol@drydenfamilymedicine.com

UNYHEALTH Systems, Inc.; Michael Johns; Senior Director Operations and Network Management; 315-432-1846, extension 25; 5000 Campuswood Drive, Suite 102; East Syracuse, NY 13057; mjohns@vha.com

Greenwood Pediatric Clinic; Diane Chapman; Dr. Naseer Humayun, MD; 517-784-9104; 720 W. Franklin #1; Jackson, MI 49201; Diana@greenwoodpediatric.comcastbiz.net

SuccessEHS

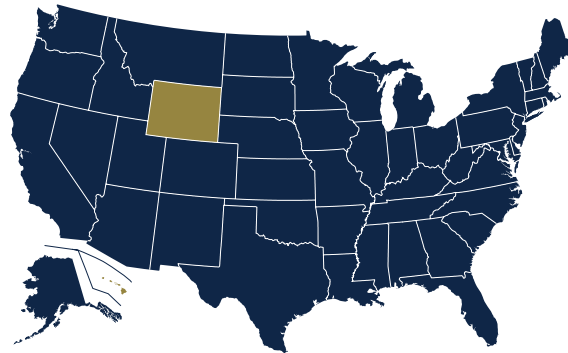
Ambulatory PM and EHR

One Metroplex Dr., Suite 500
Birmingham, AL 35209

www.sucsessehs.com

David Turner
888.879.7302
davidt@sucsessehs.com

Incorporated 1995
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

446

primary care practices have utilized the organization's product/service.

207

other organizations have utilized the organization's product/service.

About:

SuccessEHS, Inc. develops practice management and certified electronic health record solutions for healthcare organizations of all sizes. We provide technology solutions to 42 specialties in 48 states, the U.S. Virgin Islands, and Puerto Rico, which includes over 3,300 primary care physicians and over 400 Community Health Centers, FQHC and Rural Health Center sites. We provide the technology and services needed by physicians, physician assistants and nurse practitioners to adopt an ONC certified EHR technology, achieve Meaningful Use and become a NCQA-PPC-PCMH. Through professional practice redesign, SuccessEHS can strengthen the physician-patient relationship and move care delivery from episodic care to coordinated care and an on-going relationship with a physician-led "care team." SuccessEHS affords clinics the tools needed by a PCMH to provide all the patient's health care needs, including referral management, open scheduling, and strong communication between patients, physicians, and staff.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

SuccessEHS employees include 7 executives, 17 sales and marketing resources, 62 training and implementation resources, 59 research and software developers, 10 product managers, 16 technical support resources, and 30 customer support resources, all located in the U.S.

References:

Tulane University Community Health Center; At Covenant House; 611 North Rampart Street; New Orleans, LA 70112; 504-988-1514; Angie Alley, Sr. Section Administrator; aalley@tulane.edu

Southern Health Associates; 801 S. Franklin Avenue; P.O. Box 1185; Troy, AL 36081; 334-566-9800; Lois Sexton, Practice Manager; lcred2@yahoo.com

St. Thomas Community Health Center; 1020 Saint Andrews Street; New Orleans, LA 70130; 504-529-5558; Phuong Tran, M.D.; pntran@gmail.com

Taconic IPA

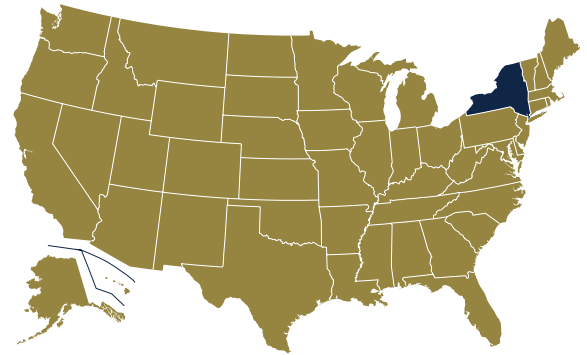
Medical Home Transformation Services

300 Westage Business Center Dr.
Suite 320
Fishkill, NY 12524

www.hudsonvalleyinitiative.com
www.taconicipa.com

Annette Watson
845-896-9301
awatson@taconicipa.com

Incorporated 1989
For-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

10 primary care practices have utilized the organization's product/service.

11 other organizations have utilized the organization's product/service.

About:

The Taconic IPA has provided services in team based, patient centered medical home (PCMH) transformation by providing practice re-design strategies that enable practices to become PCMH's and providing standardized evidence-based protocols and processes for managing chronic and complex illness, including integration of medical and behavioral care through integrating care coordination into practice workflow; embedding RN case managers into practices to manage the highest cost and highest risk patients; developing transitional support strategies to coordinate care across settings; supporting practices in the implementation of patient self management strategies; identifying and monitoring quality, utilization and satisfaction metrics for comparative analysis and benchmarking; utilizing HIT to enhance care coordination and improve safety; assisting with NCQA accreditation and quality improvement efforts; and promoting population management, value based purchasing and pay for performance strategies.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices
- Other

Staff Qualifications:

A. John Blair III, MD—President, Taconic IPA; CEO; Paul Kaye, MD, Medical Director, Taconic IPA; Annette Watson, RN,BC,CCM, MBA, Consultant, Taconic IPA.

References:

- Nancy Beran MD; Chief Medical Officer; Westchester Health Associates; 645 Marble Ave.; Thornwood, NY, 10594
- Betty Jessup RN MSN; Director of Quality and Patient Safety; Crystal Run Healthcare; 155 Crystal Run Road; Middletown, New York 10941; 845-703-6159
- Darren Wu MD; Chief Medical Officer; Open Door Family Medical Center; 165 Main St; Ossining NY; 914-941- 1263

The Roger C. Lipitz Center for Integrated Health Care

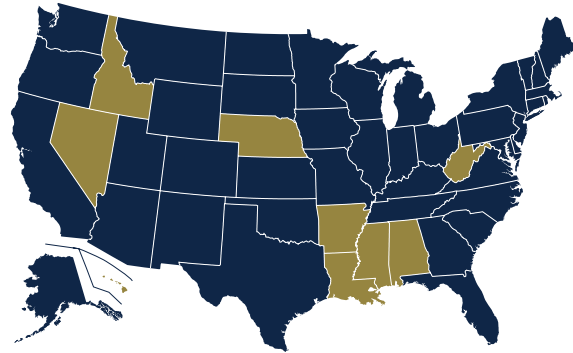
Technical Assistance for Adopting the Guided Care model

624 N. Broadway, Room 697
Baltimore, MD 21205

www.GuidedCare.org
www.GuidedCare.org/adoption.asp

Tracy Novak, MHS
410-614-1932
tnovak@jhsphe.edu

Incorporated 2001
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

10

primary care practices have utilized the organization's product/service.

1,740

other organizations have utilized the organization's product/service.

About:

A multi-disciplinary team of researchers from the Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health developed Guided Care, a form of a patient-centered medical home for people with multiple chronic health conditions. A Guided Care nurse, based in a primary care practice, works in partnership with several physicians to provide coordinated, patient-centered, cost-effective care to 50-60 of their chronically ill patients. Results from a randomized controlled trial indicate that Guided Care improves the quality of patients' care, reduces family caregiver strain, improves physicians' satisfaction with chronic care, and tends to reduce the use and costs of health care, especially in health care systems that are well managed. Primary care practices can fully implement Guided Care in 6-to-9 months. Through a grant from the John A. Hartford Foundation, several forms of technical assistance are available for free to practices that wish to adopt Guided Care or the principles of Guided Care as they transform into patient-centered medical homes.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups

Staff Qualifications:

Project leader is a Professor of Medicine and a geriatrician with expertise in the development, evaluation, and dissemination of novel models of care for older adults. Team includes a masters-level communications professional with experience in diffusing Guided Care and supporting its technical assistance program. All staff are employees.

References:

Linda Dunbar, Ph.D.; Vice President, Care Management; Johns Hopkins HealthCare LLC; 410-424-4689; ldunbar@jhhc.com

Denise Kress, MS, GNP, BC, CRRN; Director, Care Management Programs for Senior Products; Tufts Health Plan; 617-923-5868x3620; denise_kress@tufts-health.com

Barbara Saul, DO, FFAFP; Senior Staff Physician; Troy Family Medical Center; Henry Ford Health System; 248-835-7367; bsaul1@hfhs.org

TransforMED, LLC

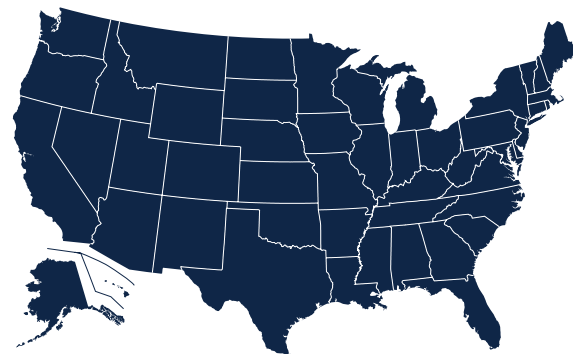
Facilitated Medical Home Design, Transformation and Outcomes Analysis, Tools and Resources

11400 Tomahawk Creek Pkwy
Suite 340
Leawood, KS 66211

www.transformed.com

Dan McKean
913-906-6330
dmckean@transformed.com

Incorporated 2005
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

250

primary care practices have utilized the organization's product/service.

37

other organizations have utilized the organization's product/service.

About:

Created in 2005 as a not for profit subsidiary of the American Academy of Family Physicians, TransforMED has been a leading authority on transforming primary care practices into Patient-Centered Medical Homes. TransforMED strongly believes that a stronger future for primary care practices, health systems, and the health of the patients they serve can be achieved, in large part, through transformative practice redesign. TransforMED's experienced staff is comprised of experts with a wide competence in areas of clinical and business improvement, as well change management. TransforMED also collaborates with outside researchers, consultants and a diverse group of specialty, industry and policy stakeholders. In the current health care environment, affecting sustainable changes in delivery models and stakeholder behavior requires more than subject area competence, it requires the fundamental trust from participating providers and their staff. As a part of the AAFP and as a physician led Patient-Centered Medical Home implementation organization TransforMED has built a reputation as an advocate of practices and providers across the nation.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Other

Staff Qualifications:

All TransforMED key staff members are employees of the company. Most of our Practice Facilitation Team members have experience either as a clinical provider or a practice administrator. Team members hold credentials such as Ph.D.s, MBAs, MSNs, or MHAs. They come from backgrounds in practices or health systems, with major employers, and academia.

References:

Eugene Patrick Heslin, MD; Taconic IPA; 16 W Bridge Street; Saugerties, NY 12477; 845-246-3000

Denis Ernest Chagnon, MD; Community Care Physicians Family Practice; 713 Troy Schenectady Road; Latham, NY 12110; 518-785-5881

Theresa A. Osborne, MD; Spectrum Health; 4069 Lake Drive; Suite 117; Grand Rapids MI 49546- 616-726-8700

UPMC Health Plan

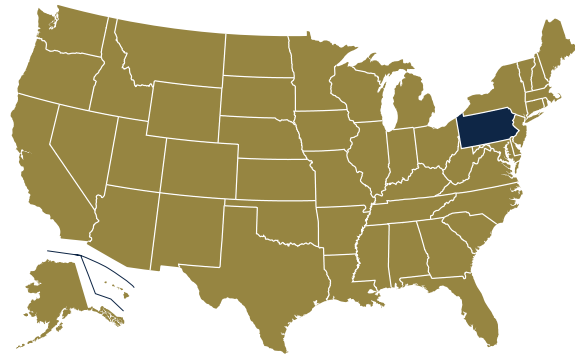
PCMH Program

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com

Dr. Cynthia Rosenberg
412-454-5906
rosenbergcn@upmc.edu

Incorporated 1986
Not-for-profit



Service Area ■ Has provided PCMH services ■ Is available to provide PCMH services

500

primary care practices have utilized the organization's product/service.

0

other organizations have utilized the organization's product/service.

About:

UPMC Health Plan (UPMCHP) is owned by the University of Pittsburgh Medical Center (UPMC), one of the nation's top-ranked health systems. As part of an integrated health care delivery system, UPMCHP partners with UPMC and community network providers to improve clinical outcomes as well as the health of the greater community. UPMCHP takes seriously our responsibility to help each of our members enjoy the best quality of life and health possible. UPMCHP's PCMH Program is a health care delivery system focused on patient centricity and founded on the principles of the patient-centered medical home and the Wagner Chronic Care Model. With the assistance of UPMCHP's integrated care coordination team and practice-based care managers, physicians are better able to deliver continuous, accessible, high quality, patient-oriented primary care. Through UPMCHP's work with PA Reach, the Practice Transformation team works with individual practice offices to achieve meaningful use certification.

Partners with:

- Small and/or independent practices
- Large physician practices or groups
- Hospital-owned groups
- Pediatric practices

Staff Qualifications:

The team interfacing with the practices in the PCMH Program consists of RNs and CDEs working at the individual practices. All of whom have received training in process improvement techniques. Physician Account Executives on the team have received training in the Toyota process and Six Sigma.

References:

Dr. Wishwa Kapoor; General Internal Medicine; UPMC Montefiore 9 South; 3459 Fifth Avenue; Pittsburgh, PA 15213; 412-692-4888

Dr. Francis Solano; Solano & Kokales Internal Medicine; Suite 100A; 120 Lytton Avenue; Pittsburgh, PA 15213; 412-647-4545

Dr. Kathleen Werner; Renaissance Family Practice, Penn Hills; 5769 Saltsburg Road; Verona, PA 15147; 412-793-8870

PCMH Accreditation Programs



Accreditation Association for Ambulatory Health Care, Inc (AAHC)

Medical Home On-Site Certification

Ron Smothers
Assistant Director, Accreditation Services
847-853-6067
rsmothers@aaahc.org

www.aaahc.org

Year of Launch 2010

About

As an alternative to accreditation, the AAAHC now offers Medical Home On-Site Certification. The AAAHC has specific standards that address what is required to attain medical home certification; these standards specify that the medical home be patient centered, physician directed, comprehensive, accessible, provide for a continuity of care and is organized to meet the individual needs of the patient. The certification program varies from that of traditional AAAHC Accreditation. A certification survey consists of a pre-conference call between an organization and an assigned surveyor; followed by a one-day on site review. The AAAHC will continue to work with organizations to arrange a convenient date/time for the pre-conference call, as well as an agreed upon date for the on-site review. The Medical Home On-Site Certification Handbook can assist organizations in their efforts to prepare for a certification survey; the Handbook contains the applicable standards relevant to the medical home certification survey.

NCQA

Physician Practice Connections®-Patient-Centered Medical Home™ (PPC-PCMH)

Mina Harkins
202-955-1727
harkins@ncqa.org

www.ncqa.org

Year of Launch 2003

About

NCQA is a private, not-for-profit dedicated to improving health care quality. NCQA's newest medical home standards, PCMH 2011 offers practices a roadmap for organizing care that is responsive to patients' needs, working in teams, and coordinating and tracking care. PCMH 2011 sets high expectations for patient-centered care, aligns closely with the CMS Meaningful Use Requirements and integrates behavioral healthcare and care management for high-risk patients. PCMH 2011 builds on NCQA's 2008 Physician Practice Connections®-Patient-Centered Medical Home™ (PPC-PCMH) program, developed in collaboration with the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association. NCQA's standards reflect tenets of the Joint Principles. PCMH 2011 standards are available for free at www.ncqa.org/tabid/629/Default.aspx#pcmh.

The Joint Commission

Ambulatory Care Accreditation Program, Primary Care Home Option

Michael Kulczycki
630-792-5286
AHCQuality@jointcommission.org

www.jointcommission.org/PCHI

Year of Launch 1975

About

This accreditation program uses ambulatory-specific standards, and delivers an educational on-site evaluation process to assist almost 2000 ambulatory health care organizations in achieving improved operations. Recognizing the benefits of increased access to health care, continuity of care, and patient-centered care, The Joint Commission's launch of our Primary Care Home designation for accredited Ambulatory Care customers is planned for mid-2011. This Initiative will enable the improvements in quality of care and patient safety achieved through accreditation to be combined with increased reimbursement when the additional requirements of a Primary Care Home are met. Assessing compliance with the additional requirements for a Primary Care Home will occur as part of the on-site survey process, with the outcome publicly posted on the Joint Commission's Quality Check website. Learn more! Visit www.jointcommission.org/PCHI or Call 630-792-5286 today.

URAC

Patient Centered Health Care Home (PCHCH) Program Toolkit

Michelle Phipps
Director of Standards, URAC
202.216.9010 ext. 8805
mphipps@urac.org

www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx

Year of Launch 2011

About

URAC's PCHCH Program Toolkit provides educational step-wise, self-paced standards to guide practices in transforming themselves into a PCHCH and help sponsoring health plans, insurers, and pilot programs determine which practices qualify for medical home incentives.

Questions to Ask Potential Partner Organizations



Questions to Ask Potential Partner Organizations

The Resource Guide provides primary care practices with a listing of organizations' products and services that support PCMH transformation efforts. This list is the first step in identifying a PCMH transformation support partner. Primary care practices should exercise due diligence in selecting such a partner and request additional information about organizations and their services and qualifications before making a final decision.

A contact person and website is included for each of the organizations listed in this Guide, both of which are resources that will help practices to obtain the necessary information to make an informed decision. The following list of questions summarizes some of the additional information that primary care practices should request from potential PCMH transformation support partners. These are details that are not covered in this Guide, but which may be important to the primary care practice.

- Is there a fee for your service? What is the amount and structure of the fees?
- How is your PCMH transformation support service delivered? (e.g., on site or remotely)
- What types and sizes of primary care practices have you worked with before?
- What are the biggest challenges that you helped primary care practices to overcome?
- What are the specific features or benefits of your services? Is there anything about your services that is especially innovative?
- How will the product or service help with my specific patient population?
- How will this product or service integrate with my existing practice processes?
- How long does it typically take for a primary care practice like mine to go through the PCMH implementation process?
- Which members of my staff need to be involved, in what capacity, and how much of their time is required?
- What elements of PCMH transformation, if any, does your organization NOT support? Where do you recommend I get support for those elements?
- What is the track record of your clients in achieving accreditation or recognition as a PCMH?
- Please provide any additional references of previous clients for me to contact to better understand your services. (Note: three references for each organization have been published in the Guide; however, these references have not been contacted, and individual primary care practices should carefully check the references of potential PCMH partners).

Publications & Articles



Relevant Publications and Articles

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Gilmer, TP, et al. Improving treatment of depression among Latinos with diabetes using Project Dulce and IMPACT. *Diabetes Care*. 2008 Jul; 31(7):1324-6.

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Index



Alphabetical List of PCMH Transformation Support Organizations

9g Enterprises, Inc.
Accordant Health Services
Agency for Healthcare Research & Quality
Agency for Healthcare Research & Quality
AIMS Center
Alere Health
American Academy of Pediatrics*
American College of Physicians*
American College of Physicians*
**American College of Physicians (ACP)
& Cientis Technologies***
APS Healthcare
The Briggs Group
Care Management Technologies, Inc.
Child & Family Services of Saginaw County
CMHI (Center for Medical Home Improvement)
of Crotched Mountain Foundation
CSI Solutions, LLC
CureMD Healthcare
DAH Solutions
Deborah L. Trout Ph.D., LLC
Department of Vermont Health Access
DocInsight
Health Dialog
HealthPower Associates
HealthTeamWorks
Healthways
Hooper Holmes, Inc.
Houck & Associates, Inc.
IBM
Iowa Chronic Care Consortium
Janus Enterprise International LLC
Kearsarge Healthcare Consulting, Inc.
LKS Consulting
McKesson Corporation
McKesson Health Solutions
MDdatacor, Inc.

Microlife Medical Home Solutions, Inc.
ModernMed
National Center for Medical Home Implementation
New Jersey Academy of Family Physicians
Pharos Innovations
Primary Care Development Corporation
PRISM
Qualis Health
RelayHealth, Inc.
Remedy Healthcare Consulting, LLC
Resource Partners, LLC
RMS Healthcare- RMS, Inc.
SuccessEHS
Taconic IPA
The Roger C. Lipitz Center for Integrated Health Care
TransforMED, LLC*
UPMC Health Plan

List of Organizations by Types of Practices Supported

Organizations that Support Small &/or Independent Practices

9g Enterprises, Inc.
Accordant Health Services
Agency for Healthcare Research & Quality
Agency for Healthcare Research & Quality (AHRQ)
AIMS Center
Alere Health
American Academy of Pediatrics*
American College of Physicians*
American College of Physicians*
**American College of Physicians (ACP)
& Cientis Technologies***
APS Healthcare
The Briggs Group
Care Management Technologies, Inc.

* Bolded organizations are representative of or affiliated with national primary care physician associations.

Child & Family Services of Saginaw County
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 CSI Solutions, LLC
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 Microlife Medical Home Solutions, Inc.
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 Remedy Healthcare Consulting, LLC
 Resource Partners, LLC
 RMS Healthcare- RMS, Inc.
 SuccessEHS
 Taconic IPA
 The Advisory Board Company
 The Camden Group
 The Roger C. Lipitz Center for Integrated
 Health Care
TransforMED, LLC*
 UPMC Health Plan

Organizations that Support Large Practices or Groups

9g Enterprises, Inc.
 Accordant Health Services
 Agency for Healthcare Research & Quality
 Agency for Healthcare Research & Quality
 AIMS Center
 Alere Health
American Academy of Pediatrics*
American College of Physicians*
American College of Physicians*
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Organizations that Support Hospital-Owned Groups

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Organizations that Support Pediatric Practices

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Produced with assistance from Health Diagnostic Laboratory, Inc.
Development of this document was supported with
an unrestricted grant from Merck.

