Embedded Case Manager

Joann Sciandra, RN, BSN, CCM

Medical Home Summit
ProvenHealth Navigator®
Geisinger Health System
An Integrated Health Service Organization

Provider Facilities

- Geisinger Medical Center
  - Danville Campus – includes Hospital for Advanced Medicine, Janet Weis Children’s Hospital, Women’s Health Pavilion, Level I Trauma Center, Ambulatory Surgery Center
  - Geisinger Shamokin Community Hospital

- Geisinger-Bloomsburg Hospital
- Geisinger Wyoming Valley Medical Center with Heart Hospital, Henry Cancer Center, and Level II Trauma Center
  - Geisinger South Wilkes-Barre campus with Urgent Care, Ambulatory Surgery Center and Inpatient Rehabilitation

- Geisinger Community Medical Center with specialized medical & surgical services, including Level II Trauma and comprehensive cardiac & orthopedic services
- Marworth Alcohol & Chemical Trtmt Center
- Mountain View Care Center
- Bloomsburg Health Care Center

Managed Care Companies

- ~298,000 members (including ~63,000 Medicare Advantage members)
- Diversified products
- ~30,000 contracted providers/facilities
- 43 PA counties
- PA Medicaid initiative
- Out of state TPA contracts

Physician Practice Group

- Multispecialty group
  - ~1,000 physicians
  - ~520 advanced practitioner FTEs
  - 65 primary & specialty clinic sites (37 Community Practice Sites)
  - Freestanding outpatient surgery center
- > 2.1 million clinic outpatient visits
- ~360 resident & fellow FTEs

Note: Numerical references based on fiscal 2012 budget plus impact of GSACH, GCMC and GBH acquisitions.
Partnership of PCP’s & GHP provides 24/7 360 degree patient care and navigation
## Geisinger’s PHN Model Has Five Core Components

<table>
<thead>
<tr>
<th>Patient-centered primary care</th>
<th>Integrated population management</th>
<th>Medical Neighborhood</th>
<th>Quality outcomes</th>
<th>Value-based reimbursement</th>
</tr>
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<tbody>
<tr>
<td>• Patient and family engagement &amp; education</td>
<td></td>
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<tr>
<td>• Enhanced access and scope of services</td>
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<tr>
<td>• <strong>PCP led team-delivered care</strong></td>
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<tr>
<td>• Chronic disease and preventive care optimized with HIT</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Population segmentation and risk stratification</td>
<td></td>
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<tr>
<td></td>
<td>• Preventive care</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• <strong>GHP employed in-office case management</strong></td>
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<tr>
<td></td>
<td>• Disease management</td>
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<tr>
<td></td>
<td>• Micro-delivery referral systems</td>
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<td></td>
<td>• <strong>360° care systems</strong> – SNF, ED, hospitals, HH, etc</td>
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</tr>
<tr>
<td></td>
<td>• Patient satisfaction</td>
<td></td>
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<tr>
<td></td>
<td>• HEDIS and bundled chronic disease metrics</td>
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<td></td>
<td>• Preventive services metrics</td>
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<td></td>
<td>• Fee-for-service with P4P payments for quality outcomes</td>
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<tr>
<td></td>
<td>• Physician and practice transformation stipends</td>
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<tr>
<td></td>
<td>• Value-based incentive payments</td>
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<td>• Payments distributed on Quality Performance</td>
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## PHN Expansion

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<th>Medicare members</th>
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<td><strong>28,000</strong></td>
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* 37 Geisinger CPSL practices & 9 non-Geisinger primary care practices

**Total Geisinger patients, non-Geisinger patients not quantified
Case Management

Identifying and Managing the Highest Risk in Your Population
Why Case Management?

- Fragmented care
- Poor care coordination
- Gaps in care
- Poor communication
- Health care is complex
- Aging population
- Multiple transitions of care
Medicare 30 Day Readmission Rates

- 30% readmitted from SNF to hospital
- 20% readmitted from home to hospital

Causes of Readmissions

• Heart Failure
  – 37% readmitted in 30 days
• COPD
• Sepsis
• Pneumonia
• Psychoses

The Acute Care Environment

- Unnecessary or short stay medical admissions
  - Pneumonia
  - HF
  - COPD
  - DM
  - UTI
  - A-fib
  - Dehydration

Ambulatory Care Sensitive Conditions (ACSC)
Geisinger’s Approach to CM

• High risk identification
• Targeted populations
  - HF, COPD, oncology, multiple trauma, ESRD, frail elderly
  - TOC
• Comprehensive assessment
  - Driving issue behind case
  - Frequent follow-up with patient/family
• Daily interaction with Provider and team
Embedded Case Managers are Key to Success

- Embedded Case Manager
  - 1 CM / 800 Medicare or 5000 commercial lives
  - **High risk** patient case load 15 - 20% for Medicare
  - 3 to 5% of commercial
  - Total case load 125 - 150 pts
  - NOT traditional disease management – focus on those at most risk and what is driving issue with the care

**Challenge of caseload management is gauging acuity and complexity**
Targeting CM at High Risk Populations

- High risk
  - Post Hospital Discharge
  - Predictive Modeling
- PCP referral
  - Site team: Nurse, Ancillary staff, etc.
- Self referral
- Targeted medical management referrals
- Targeted conditions
  - HF
  - COPD
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<td>$96,235.00</td>
<td>Renal Failure, Chronic &amp; Nephrosis</td>
<td>MH CL - CC</td>
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When to Refer to a Case Manager

- Complex chronic conditions
- Caregiver stress
- Coordination of services
- Psychosocial issues
- Home safety concerns
- Advancing Illness
- Outpatient management of an acute medical condition
Key Case Management Activities

• **Personal patient link**
  - Transitions follow up (discharges, ER visits)
  - Direct line access – questions, exacerbation protocols
  - Family support contact

• **Recognized site team member**
  - Regular follow ups for high risk patients
  - Facilitate access – PCP, specialist, ancillary
  - Facilitate special arrangements (emergency home care, hospice care)
Functions of Case Manager

- Transitions of care
- Chronic Care
- Exacerbation management
- Self management
- Telephonic and/or device monitoring
- Frequent follow up
Transitions of Care

- Pt contact within 24-48 hrs post discharge
- Telephonic outreach
  - Medication reconciliation and optimization
  - Ensure safe transition post discharge
    - with appropriate services in place
      - Home Health
      - DME
      - Safe to be in their home?
    - Facilitate post hospital PCP & CM appt within 3 - 5 days
- Close follow-up for 30 days
Chronic Care Management

Heart Failure
- Diuretic Titration Protocol
- Daily weights & Tele-monitoring
- Medication management
- Education
- Self management
- Outreach

COPD
- Rescue kit
- Symptom monitoring
- Medication management
- Education
- Self management
- Outreach
Target Ambulatory Care Sensitive Conditions (ACSC)*

- Angina
- Asthma
- Cellulitis
- COPD
- HF
- Dehydration
- Diabetes
- Gastroenteritis
- Seizures
- HTN
- Hypoglycemia

* AHRQ

Conditions best managed in the outpatient setting
Tele-Monitoring Tools

• Blue tooth scales
  - Managing HF
  - Transmits daily weights to EHR
• Nurse sees weight real time
  - Diuretic titration protocols
  - Trending
• Interactive Voice Response (IVR)
  - Outbound calls post discharge
  - HF IVR
• Blue tooth blood pressure cuff
Patient's Name: [Redacted] MRN #: [Redacted]

Blood Pressure monitoring schedule: [Redacted]
Blood pressure goal: [Redacted]

"Eating Right" Plan:
- No added salt; choose products with < 300 mg of sodium per serving: [Redacted]
- Low fat, low cholesterol; choose products with 3 grams or < of Saturated fat per serving. Cholesterol intake should be < 300 mg per day: [Redacted]

Monitoring the Symptoms of Heart Failure:
- Weight gain – weight gain of more than 2 lbs in one day or 5 lbs in 5 days
- Increased shortness of breath
- Increased swelling in feet, ankles or legs
- Chest pain or discomfort
- Increased cough – especially at night

Heart Failure Action Plan:
- Weigh yourself daily in the morning after emptying your bladder
- Record your weight daily
- Take all your medications as directed
- Call your health care provider if you experience any of the above listed symptoms of heart failure
- Diuretic titration protocol - Taking an extra dose of your diuretic (water pill) for one or two days when you experience weight gain or the above symptoms can be very helpful in the management of heart failure.
## Diuretic Titration Protocol

- **Case Manager**: DTP Documentation/Request to Provider  (multiple)
  - Diuretic Titration Protocol: Patient with Once Daily Diuretic
  - Diuretic Titration Protocol: Patient with Twice per Day Diuretic

- **Medications**
  - DTP: Metolazone PRN  (multiple)
    - METOLAZONE 2.5 MG PO TABS
    - HISTORICAL - METOLAZONE 2.5 MG PO TABS

- **Patient Instructions - Go to Pt Handouts Activity** (Tab)
  - Print from Patient Instructions Section - allows to print at your location  (multiple)
    - Patient Instructions - Right click here to complete (F2)

- **Diagnosis**
  - Diagnosis  (single)
    - CHF [428.0]

- **Chief Complaint**
  - Chief Complaint/Reason for Call  (single)
    - Case Management - Diuretic Titration Protocol
COPD Smart Set Tool

- Rescue Antibiotics (multiple)
  - AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your prednisone)
  - CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your prednisone)
  - DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of symptoms with your prednisone)
  - ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with your prednisone)

- Rescue Antibiotics - HISTORICAL MEDS (multiple)
  - HISTORICAL - AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your prednisone)
  - HISTORICAL - CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your prednisone)
  - HISTORICAL - DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of symptoms with your prednisone)
  - HISTORICAL - ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with your prednisone)

- Rescue Steroid (multiple)
  - PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of symptoms with your prednisone)
  - HISTORICAL - PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of symptoms with your prednisone)

- Patient Instructions - Go to Patient Handouts Activity (Tab)
  - Print from Patient Instructions Section - Allows to Print at Your Location (multiple)
    - COPD Rescue Patient Instructions (right click to make changes)

- Chief Complaint/Reason for Call
  - Chief Complaint/Reason for Call (multiple)
    - Case Management - COPD Rescue Kit

- Documentation
  - Notes (multiple)
    - COPD Documentation

COPD Rescue Kit
Vertical Build of Case Management

Care Transitions – 360 degree
- SNF
- LTC
- Deep dive into causes of readmissions
- Advanced illness management

On-Call – 24 / 7
- Nurses linked to providers, hospitalists, inpatient case managers, patients, and community resources
Case Management

Finding the Right Person for the Role
Choosing the Right Case Manager

Must be a good fit for clinic
Providers need to be involved in selection

- Prior case management experience not a must
- Hospital
- Home health nursing
- SNF/ LTC experience
- Clinic nurse

Often don’t find a case manager – rather you help create a case manager
Traits of a Good Case Manager

- Autonomous & self motivated
- Highly organized
- Good time management skills
- Understands and manages main driving force as well as all other complex issues
- Easily manages multiple tasks at one time
- Can shift focus easily, be pulled into different directions and still remain on task
- Willing to “nudge” the providers
Essential Skills and Competencies

- Strong communication skills
- “People” skills
- Problem solving skills
- Critical thinking skills
- Patient engagement and activation skills
- Negotiating and conflict resolution skills

Must be able to think out of the box
Skill Set of a Case Manager

- Interpret clinical information and assess implication of treatment
- Develop and implement Plan of Care
- Determine appropriate level of care
  - PCP office
  - Hospital
  - Assisted Living /SNF/ LTC
  - Palliative Care, Hospice
Investment in Case Management

- Dedicated staff needed to drive outcomes
  - Manager
  - Trainer
- Resources to support development
- Dedicated clinic space
- Dedicated phone line
- Administrative support
Training for Success

Considerations for the Orientation Process
Orientation Process

Time frame - 6-8 weeks

- Learn basic CM/DM role; begin to understand CM/DM functions
- Build beginning relationships with clinic and staff
- Community resources, facilities
  - Hospitals, HH agencies, DME providers, Skilled nursing facilities, pharmacies
- Understand health plan activities & benefits
- Understand IT tools necessary to perform job role
  - EHR, CM platform, disease registries, etc.
Ensuring Success – Right Preceptor

• Has accountability to provide foundation to CM functions and provide guided oversight to the new Case Manager

• Works under direction of the Director
  – Structured learning environment
  – Ensure that the is exposed to the necessary elements required to perform in the CM role

• Completion of the orientation checklist

• Reports gaps and areas of need to Director at weekly progress check points
Making Orientation Count

- Primary preceptor for training
- 2 weeks – didactic training in group session with other new CM
- 4 weeks – in clinic with preceptor
  - Observation
  - Record review
  - Case finding
  - Case review & planning
  - Case management
Integration into the Practice Site

• Key clinic activities/operations
  – Time with front office
  – Nursing
  – Ancillary services

• Key HP departments
  – Customer service
  – Utilization management
  – Provider network
As the nurse gains experience...

- Alternate exposure with another CM
- Forging partnerships in the Medical Neighborhood
  - Home health, nursing homes, hospitals
  - Pharmacies, community agencies
- Disease management skills
- Further emphasis on EMR and other communication tools
Ready to Transition into CM Role

• Transition targeted referrals at week 6 of orientation while still with preceptor
• Assist with transition into practice meetings
  - Practice staff meetings (nurses and front desk)
  - Provider
  - Site Medical Home meetings
• Keep “buddy” system with preceptor for 3 – 6 months
Maximizing Success of Your Staff

- Monthly 1:1 time with each staff
  - Reviewing cases/documentation
  - Evaluating CM’s understanding of the driving force of cases
  - Provider/staff interaction
  - Troubleshooting

- Productivity and caseload management
  - Nurse visit summary sheets
  - Areas of opportunity – Readmissions trending up - Why?
  - Gaps in role
  - Patient engagement and ongoing follow-up
Ongoing Staff Development

• Four CE days per year
  – All staff come on site for training
  – CE and CCM credits
  – Outside speakers
  – Topics relevant to disease and case management

• Learning packets
  – Current articles pertinent to chronic condition
  – Medications

• Outside CE programs
Local Team Building

• Regional meetings monthly
  – Less time away from office for staff
  – Provide updates, mini educational sessions
  – Pharmacy integration
  – Round table to discuss cases in more informal setting
  – Develop staff relationships

• 3 nurse educators
Management Tools
# Medical Home Case Manager Visit Summary

**Name:**

**Nurse Name:**

**GHP/PGP Open Members:** 150  
**Average:** 118

**Reporting Month:** August 2010

## GHP WISDOM REVIEW

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<th>GHP Average</th>
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## GHP WISDOM REVIEW (FACILITY)

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## GHP BUNDLE REVIEW

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## GHP TELEMONITORING

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<th>Metric</th>
<th>GHP Average</th>
<th>GHP TELEMONITORING</th>
<th>PGP Average</th>
<th>PGP TELEMONITORING</th>
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<td>Heart Failure</td>
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<td>TOM</td>
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<td>% of pt enrolled in HF monitoring</td>
<td>56.0%</td>
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<td>26.3%</td>
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## PGP WISDOM REVIEW

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<th>Metric</th>
<th>PGP Average</th>
<th>PGP WISDOM REVIEW</th>
<th>Average</th>
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<tr>
<td>Total Returns</td>
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<td>New or Return Caseload</td>
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<td>Screened</td>
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<tr>
<td>Referrals</td>
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<tr>
<td>Touches &gt;2</td>
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<td>Coordinates</td>
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<td>Caseload for this month</td>
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<tr>
<td>Current Identified Caseload</td>
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<tr>
<td>Current Open Caseload</td>
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# Caseload Summary

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<th>Nurse</th>
<th>Open GHP</th>
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<th>Open PGP</th>
<th>Identified PGP</th>
<th>Total Open</th>
<th>Total Identified</th>
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<tbody>
<tr>
<td>ANITA MCCOLE</td>
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<td>11</td>
<td>12</td>
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<td>134</td>
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<tr>
<td>ANNE SNYDER</td>
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<td>116</td>
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<td>BRENDA MAIDA</td>
<td>81</td>
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<td>14</td>
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<tr>
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<td>DAVE AUGUSTINE</td>
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</tbody>
</table>

**Geisinger Health Plan**

Current Caseload for Nurses

March 30, 2010
PHN Outcomes
Medicare
Risk Adjusted Acute Admissions/1000

<table>
<thead>
<tr>
<th>Year</th>
<th>PHN</th>
<th>Non-PHN</th>
<th>44 Current PHN Sites</th>
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<tbody>
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<td>2006</td>
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<td>2007</td>
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<tr>
<td>2008</td>
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<td>2009</td>
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<td>2010</td>
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<tr>
<td>2011</td>
<td>226</td>
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<td>276</td>
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</table>
Medicare
Risk Adjusted Readmissions/1000

<table>
<thead>
<tr>
<th>Year</th>
<th>PHN</th>
<th>Non-PHN</th>
<th>44 Current PHN Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>44</td>
<td>47</td>
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<tr>
<td>2007</td>
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<td>2008</td>
<td>30</td>
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<td>2009</td>
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<td>2010</td>
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<td>42</td>
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<tr>
<td>2011</td>
<td>31</td>
<td>41</td>
<td></td>
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</tbody>
</table>
Medicare
Risk Adjusted ER Visits/1000

- PHN
- Non-PHN
- 44 Current PHN Sites
Provider and Patient Satisfaction Survey Results
Effectiveness of the CM in working with the patient

- 79% Very good
- 20% Good
- 1% Poor
- <1% Very poor
Is quality of care different and better than the past?

- Yes: 72%
- No: 19%
- Don't know: 9%
PHN has allowed you to provide more comprehensive care than the previous system

- Agree: 55%
- Agree Strongly: 31%
- Neutral: 11%
- Disagree: 3%
- Disagree Strongly: 0%
Timely information is available regarding patients' transitions of care.

- **Agree**: 44%
- **Agree Strongly**: 38%
- **Neutral**: 13%
- **Disagree**: 5%
- **Disagree Strongly**: 0%
I would recommend PHN to other primary care physicians

- Agree: 68%
- Agree Strongly: 25%
- Neutral: 6%
- Disagree: 1%
- Disagree Strongly: 0%

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Questions