The Ten Building Blocks of High Performing Primary Care: A Framework for Achieving the Patient Centered Medical Home

European Forum on Primary Care Annual Meeting
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J. Nwando Olayiwola, MD, MPH, FAAFP
Associate Director, Center for Excellence in Primary Care
Assistant Professor, Department of Family & Community Medicine
University of California, San Francisco
CEO, Inspire Health Solutions LLC
About me

- Associate Director, UCSF Center for Excellence in Primary Care
- Associate Professor, UCSF Department of Family & Community Medicine
- CEO and Founder, Inspire Health Solutions, LLC
- Former Chief Medical Officer, Community Health Center, Inc. First org in US with both Level 3 PCMH NCQA and Joint Commission
Marshall Memorial Fellowship

- Flagship leadership development program of GMF
- Founded in 1982
- Builds capacity for transatlantic understanding and cooperation
- 30 American fellows a year
- 5 countries in about a month
About my colleagues

Ms. Janet Samuel, Asst. Director, Danish Regions, Denmark

Mr. Julien van Geertsom, President, Belgian Federal Public Planning Service for Social Integration

Mr. Hans Erik Henriksen, CEO, Healthcare Denmark
Objectives

By the end of the session, attendees should:

• 1. Understand the principles and standards of the Patient-Centered Medical Home (PCMH) movement in primary care in the United States, with new and emerging data on outcomes.

• 2. Understand a new framework for high performing primary care, the Ten Building Blocks, their evidence base, and their relationship to PCMH

• 3. Understand the four foundational building blocks and their importance in stabilizing a Patient-Centered Medical Home

• 4. Learn examples of how healthcare organizations can apply Building Blocks to actual primary care practice settings in Europe
Are We There Yet?
Are We There Yet?
Standards, Incentives & Standards

- NCQA
- AAAHC
- Joint Comm
- URAC
- MU
- Evidence-based standards
- Payer standards
- State standards
- Organizational standards
"It's bad news - your illness isn't on our performance targets."
## PCMH Defined - AHRQ

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Care</strong></td>
<td>The PCMH is designed to meet the majority of a patient’s physical and mental health care needs through a team-based approach to care.</td>
</tr>
<tr>
<td><strong>Patient-Centered Care</strong></td>
<td>Delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.</td>
</tr>
<tr>
<td><strong>Coordinated Care</strong></td>
<td>The PCMH coordinates patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions.</td>
</tr>
<tr>
<td><strong>Accessible Services</strong></td>
<td>The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email.</td>
</tr>
<tr>
<td><strong>Quality &amp; Safety</strong></td>
<td>The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management. Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.</td>
</tr>
</tbody>
</table>

Source: Agency for Healthcare and Research Quality
“Joint Principles” of the Patient-Centered Medical Home

- A personal physician who coordinates all care for patients and leads the team.
- Physician-directed medical practice – a coordinated team of professionals who work together to care for patients.
- Whole person orientation – this approach is key to providing comprehensive care.
- Coordinated care that incorporates all components of the complex health care system.
- Quality and safety – medical practices voluntarily engage in quality improvement activities to ensure patient safety is always being met.
- Enhanced access to care – such as through open-access scheduling and communication mechanisms.
- Payment – a system of reimbursement reflective of the true value of coordinated care and innovation.

Source: Joint Principles of the PCMH 2007 - AOA, AAP, AAFP, ACP
<table>
<thead>
<tr>
<th>JOINT PRINCIPLES</th>
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<tbody>
<tr>
<td><strong>Personal physician</strong></td>
<td><strong>Practice Team</strong></td>
<td><strong>Physician or physician-directed health care team</strong></td>
<td><strong>Designated Primary Care Clinician</strong></td>
</tr>
<tr>
<td><strong>Physician directed medical practice</strong></td>
<td><strong>Plan and Manage Care</strong></td>
<td><strong>Physician-directed health care team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Whole person orientation</strong></td>
<td><strong>Provide Self-Care and Community Support</strong></td>
<td><strong>Relationship between patient and Medical Home</strong></td>
<td><strong>Patient-centered care</strong></td>
</tr>
<tr>
<td><strong>Care is coordinated and/or integrated</strong></td>
<td><strong>Track and Coordinate Care</strong></td>
<td><strong>Continuity of Care</strong></td>
<td><strong>Continuity of Care</strong></td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td><strong>Measure and Improve Performance</strong></td>
<td><strong>Quality</strong></td>
<td><strong>Systems-based approach to quality and safety</strong></td>
</tr>
<tr>
<td><strong>Enhanced access to care</strong></td>
<td><strong>Enhance Access and Continuity</strong></td>
<td><strong>Accessibility</strong></td>
<td><strong>Access to care</strong></td>
</tr>
<tr>
<td><strong>Identify and Manage Patient Populations</strong></td>
<td></td>
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</tr>
</tbody>
</table>
PCMH Transformation in Context

- Structural
- Clinical
- Financial
- Cultural
Brief History Of The PCMH

1960s
- AAP "Medical Home" Records

1990s
- AAP Medical Home Provider Policy
- AAFP Future of Family Medicine
- PCPCC
- Joint Principles of PCMH

2000s
- NCQA-PCMH
- PPACA
- CMMI
- ACOs
- Private Payer Initiatives

2010s

Future
- Direct Primary Care
- CPCII
- Advanced Primary Care
- Ten Building Blocks
PCMH Evangelism
# PCMH 2014 Content and Scoring

(6 standards/27 elements)

<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
<td>4.5</td>
</tr>
<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
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<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>2.5</td>
</tr>
<tr>
<td>D. *The Practice Team</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
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<thead>
<tr>
<th>3: Population Health Management</th>
<th>Pts</th>
</tr>
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<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td>D. *Use Data for Population Management</td>
<td>5</td>
</tr>
<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<thead>
<tr>
<th>4: Plan and Manage Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. *Care Planning and Self-Care Support</td>
<td>4</td>
</tr>
<tr>
<td>C. Medication Management</td>
<td>4</td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>E. Support Self-Care and Shared Decision-Making</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th>5: Track and Coordinate Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>B. *Referral Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>C. Coordinate Care Transitions</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<table>
<thead>
<tr>
<th>6: Measure and Improve Performance</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
</tr>
<tr>
<td>B. Measure Resource Use and Care Coordination</td>
<td>4</td>
</tr>
<tr>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. *Implement Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>F. Report Performance</td>
<td>3</td>
</tr>
<tr>
<td>G. Use Certified EHR Technology</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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**Scoring Levels**
- Level 1: 35-59 points.
- Level 2: 60-84 points.
- Level 3: 85-100 points.

**Must Pass Elements**
Scoring
Total 100 Points

Recognition requires achieving all 6 “must pass” elements with a ≥50% score

<table>
<thead>
<tr>
<th>Level</th>
<th>Points</th>
<th>Required Must Pass</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 35</td>
<td>6 Must Pass</td>
</tr>
<tr>
<td>2</td>
<td>≥ 60</td>
<td>6 Must Pass</td>
</tr>
<tr>
<td>3</td>
<td>≥ 85</td>
<td>6 Must Pass</td>
</tr>
</tbody>
</table>
THE LANDSCAPE: PCMH MOMENTUM

90+ commercial and not for profit health plans leading PCMH initiatives

Largest U.S. employers offering APC and PCMH benefits to employees

Public sector expansions of PCMH care – 25 state MCD, FEHBP, MCR, US Military, VA

Private practices, CHCs, hospital practices, IPAs
NCQA-Recognized Practices Across the United States - 2012

As of November 2014, **8386 practices** have received NCQA PCMH recognition

4,937 sites & 23,396 clinicians as of 10/31/2012

Overview of Medicaid Medical Home Activity

42 State Medicaid/CHIP Programs Planning/Implementing PCMH
27 Making Medical Home Payments

Significant activity for Medicaid/CHIP PCMH advancement (15 states)
No PCMH Medicaid activity (8 states)
States making payments for PCMH (27 states)

PCMH Conversations or Pilots: An International Snapshot

- Belgium
- Denmark
- Germany
- Ireland
- Netherlands
- United Kingdom

- China
- Singapore

SOURCES:
<table>
<thead>
<tr>
<th>Principle</th>
<th>What this means</th>
<th>How this may be achieved</th>
<th>Patient outcome</th>
</tr>
</thead>
</table>
| Primary Care plays a key role | Primary Care at its best helps a person to remain healthy and well and living at home in his/her community and is able to address most of the patient’s health and well-being issues. | The services in Primary Care need to be relevant, understandable, accessible and responsive.                                                                 | Primary Care minimises the effects of ill-health and prevents the patient from having an unplanned admission to hospital for issues such as:  
  - Acute infections  
  - Acute medical problems  
  - Chronic disease or multiple chronic diseases  
  - Flare up of a chronic disease  
  - Mental health issues  
  - Substance misuse issues |
| GP led Primary Care       | Patients know their GP and the GP knows them personally and coordinates their care when required. Often the GP knows the patient’s family history. Each patient has an ongoing relationship with a registered, personal, indemnified GP, trained to provide prompt first contact, continuous and comprehensive care. | The GP leads trained staff in the practice, who collectively take responsibility for the ongoing care of patients. Other members of the Primary Care team are available when required and the GP will organize and coordinate their input. | If the patient requires assistance outside normal working hours, they have prompt and direct access to a GP led, out of hours co-operative, which is linked electronically to their own GP’s practice. |
| Comprehensive care        | At the outset of ill-health and during periods of illness a patient often enjoys the support of family and friends in his/her community, with often one or more of these acting as an informal carer for the patient. When the patient, or his/her carer, is not able to do so, the GP team will take responsibility for ensuring that the patient’s health care needs are met in accordance with the patient’s preferences in his/her community as far as |
|                           | The GP team arranges appropriate care and supports for the patient, or his/her carer, with other qualified professionals.                                                                                           |                                                                                                                                                           | This includes care for all stages of life; acute care; chronic care; disease prevention; and end of life care. |
Principles of better patient healthcare

Co-ordinated care
Each patient has his/her own secure, electronic, up to date health record, eventually accessible on his/her personal computerised device.
The GP has access to comprehensive patient records on computer and these, with the consent of the patient, are shared with and updated by other health professionals.
Care is coordinated and integrated across the complex healthcare system and in the patient’s community. The patient’s pathway through the healthcare system is both efficient and effective and the patient is fully informed at all times during their journey. More care of patients will be moved from hospital and provided in the community, as Primary Care capacity increases.

General practice
Enhanced access to care is available through planned appointments, expanded hours, out of hours co-operatives and responsive electronic communications between patients, their GP, practice staff, other primary care professionals and hospitals/other care providers involved in the patient’s care.
Access to diagnostics
The GP arranges diagnostic tests for the patient in a timely fashion. Diagnostic reports are issued promptly and, where necessary, arrangements for urgent access and immediate reporting are available.
Access to hospital specialists
When problems arise that cannot be managed in the community the patient attends a secondary or tertiary hospital if the specialist is located there. The arrangement to attend hospital or specialist care is made by the GP on behalf of the patient. Reason and urgency of the referral is clearly communicated to the Specialist. Integrated and agreed referral pathways are in place to ensure the process is effective for the patient.

Accessible care
Where appropriate, GPs and hospital specialists work together for the benefit of patients at community level. Occasionally GPs and hospital specialists work together at hospital level. GPs will have availability to participate actively in case meetings and team meetings, both for the care of individual patients, and for assisting with planning and development of appropriate care pathways.
When patients attend hospital they are seen by a specialist, who will endeavor to improve their health as speedily as possible. They are discharged home at the earliest opportunity and their GP is informed about the services and care provided, and appropriate continuing after care. Where a discharge plan needs to be put in place requiring the input of a number of healthcare professionals this is organized and mobilized by the members of the patient’s Primary Care team.
If a patient requires rehabilitation, recuperation or long-term care, it is arranged for the patient in facilities as close as possible to the patient’s home, as soon as acute hospital care is no longer required. Ongoing care is provided by a GP and if this care is not provided in the patient’s home arrangements to continue the patient’s own GP’s involvement, where practicable, are made.
Where patients are terminally ill they receive the highest standard of care and comfort in their own home as far as possible, or very close to home. The hospice, GP and other healthcare professionals will liaise to achieve this outcome for the patient, his/her carer and his/her family.
**Principles of better patient healthcare**

**Quality and safety**
- GPs have an essential role in monitoring the health and wellbeing of their practice population and their local community.
- All GPs have an electronic register of patients, which is pro-actively used for alerts, recalls and the monitoring of chronic illness. It is an important safety net in circumstances where the patients have difficulty looking after their health.

**Fair and reasonable funding**
- Patients differ in their ability to afford and to pay for daily expenses and taxes and insurance. Inability to pay is never to be a reason for the patient not to receive healthcare or obtain required medicines.
- When health insurance, including State provided or supported insurance, is available patients are made aware of a fund that supports their health and made aware of its benefits. GPs advocate with insurance providers for their patients to support good patient-centred outcomes, driven by a compassionate, robust partnership between physicians, patients, and the patient’s family/carer.

**Fair and reasonable payment:**
- will reflect work that falls outside of the face-to-face interaction with a patient.
- will enable use of health information technology for service delivery.
- will support provision of secure e-mail and telephone consultation,
- will recognise the value of managing comprehensive patient data, including data maintained by the patient,
- will enable the care of complex patients
- will support the achievement of measurable and continuous quality improvements,
- will enable GPs to be involved in planning and implementing service development,
- will enable GPs to take part in the governance of the healthcare delivery system, including hospitals.
- will be continuously reviewed to deliver the services and outcomes of an advanced healthcare system, itself characterised by continual development and innovation.
Reality of Primary Care in the US: The Medical Neighborhood

Community Centers
Public Health
Employers
Schools
Faith-Based Organizations
Community Organizations
Connected via Health IT
Patient-Centered Medical Home
Home Health
Hospital
Diagnostics
Pharmacy
Mental Health
Specialty & Subspecialty
Skilled Nursing Facility

Source: Patient-Centered Primary Care Collaborative
Study Authors:
- Marci Nielsen, PhD, MPH
- Amy Gibson, RN, MS
- Lisabeth Buelt
- Paul Grundy, MD, MPH
- Kevin Grumbach, MD
Description of Methods

- Examined medical home/PCMH studies published between September 2013 and October 2014
  - Peer-reviewed scholarly articles
  - State government program evaluations
  - Industry reports

- Explored relationship between “medical home/PCMH” model of care and Triple Aim outcomes
  - Predictor variable: “Medical home”, “PCMH”, “advanced primary care”, or “health home”
  - Outcome variable: “Cost” or “Utilization”

- Resulted in 14 peer reviewed studies, 7 state PCMH program evaluations, and 7 industry reports
Key Points from Study

• **Key Point #1:** New evidence demonstrates improvements in cost and utilization associated with the PCMH

• **Key Point #2:** The health care marketplace must invest in primary care in new ways to achieve the Triple Aim

• **Key Point #3:** Future direction for the PCMH & primary care -- include clinical integration (inside and outside of the PCMH), increased financial support, team-based training, consumer engagement & technology.
“This is not a technical change with financial costs. This is a cultural change with a personal cost. So it is really about the people, and reorganizing how you work.”

- Medical Economics, May 2014
History of the CEPC

• Formed in 2005
• Co-founders: Drs. Kevin Grumbach and Tom Bodenheimer
Why the CEPC?

External Threats

Internal Threats

Primary Care Endangerment
Background: What Were the Threats?

External
- Inadequate investments in primary care
- Insufficient access to primary care

Internal
- Lack of nimble innovation in primary care
- Increasing clinical demands of practice
Background: What Were the Threats?

- PCP hamster syndrome
- Practice complacency
- Misaligned financial incentives
- Inadequate support
- Substandard care and quality
- Accreditation constraints
- Shrinking PCP pipeline
“Maybe there will be some primary care doctors available on this planet!”
Our Mission

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to:

- **I**mprove the patient experience,
- **E**nhance population health and health equity,
- **R**educe the cost of care, and
- **R**estore joy and satisfaction in the practice of primary care.
The Three Pillars

- **Practice Transformation**
  - Train and educate the healthcare workforce and leadership on practice change, quality improvement and primary care redesign
  - Provide direct coaching to practices undergoing transformation
  - Shape the pipeline of future healthcare professionals through improving teaching and training environments

- **Research and Evaluation**
  - Build the evidence base for primary care transformation by testing new models of care and studying strategies to optimize primary care delivery
  - Studying the process of system redesign

- **Policy and Emerging Issues**
  - Identify emerging opportunities and challenges to primary care
  - Summarize innovations and issues
  - Help ensure that relevant research is in the hands of policy makers
  - Contribute to regional and national initiatives promoting primary care
Faculty and Staff

Our Faculty

Practice Coaching and Training Team

Research and Evaluation Team
PRACTICE TRANSFORMATION
10 Building Blocks of High-Performing Primary Care

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future
The Ten Building Blocks - Practice Transformation Umbrella

Training
- Indirect
- Whole program

Coaching
- Direct
- Specific needs

Health coaching
Panel Management
Complex care mngt
Practice Transformation
Our Goals Have Evolved: A New National Imperative

**Triple Aim**
- Population Health
- Per Capita Cost
- Experience of Care

**Quadruple Aim**
- Population Health
- Per Capita Cost
- Experience of Care
- Provider Experience

Sources:
From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD
Christine Sinsky, MD

1Department of Family Medicine, University of California San Francisco, San Francisco, California
2Medical Associates Clinic and Health Plan, Dubuque, Iowa
3American Medical Association, Chicago, Illinois

ABSTRACT

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus impedes the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.


INTRODUCTION

Since Don Berwick and colleagues introduced the Triple Aim into the health care lexicon, this concept has spread to all corners of the health care system. The Triple Aim is an approach to optimizing health system performance, proposing that health care institutions simultaneously pursue 3 dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.1 The primary Triple Aim goal is to improve the health of the population, with 2 secondary goals—improving patient experience and reducing costs—contributing to the achievement of the primary goal.

In visiting primary care practices around the country, the authors have repeatedly heard statements such as, “We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims.” These sentiments made us

In visiting primary care practices around the country, the authors have repeatedly heard statements such as, “We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims.”
10 Building Blocks of High Performing Primary Care & Share the Care

Sources:
The Biggest Challenge of the PCMH

Transformation Process

Sustaining Transformation

10 Building Blocks of High Performing Primary Care & Share the Care

Sources:
Some Inspiration…

“WE CANNOT SOLVE OUR PROBLEMS WITH THE SAME THINKING WE USED WHEN WE CREATED THEM”
Think Differently!
My son Darius at 7 years old

https://youtu.be/ub8Tsrg4gy0
My daughter Nissi at 4 yrs old

https://youtu.be/-A6jRVgbnxo
Thinking Differently—Quadruple Aim and the Building Block Crosswalk

Implement team documentation: associated with greater physician and staff satisfaction, improved revenues, and the capacity of the team to manage a larger panel of patients while going home earlier.

Use pre-visit planning and pre-appointment laboratory testing: reduces time wasted on the review and follow-up of laboratory results.

Expand roles allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching under physician-written standing orders.

Standardize and synchronize workflows for prescription refills: can save physicians 5 hours per week while providing better care.

Co-locate teams: increases efficiency and can save 30 minutes of physician time per day.

The Transatlantic Connection: Realizing the Building Blocks in Europe
Thank you!

J. Nwando Olayiwola, MD MPH, FAAFP
Associate Director, Center for Excellence in Primary Care
Associate Professor, Department of Family and Community Medicine
University of California, San Francisco
Nwando.Olayiwola@ucsf.edu
http://cepc.ucsf.edu
Twitter: @UCSFCEPC
CEO, Inspire Health Solutions LLC
jancony@gmail.com
www.inspirehealthllc.com
Twitter: @DrNwando
+1-646-281-1651