How to Engage Your Physicians in Growing an Innovative Primary Care Network

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Learning Objectives

- Describe the strategic planning framework to **grow and sustain highly engaged primary care physicians**
- How to invest in **evidence-based models of PCMH practice** that will work for your health system

Agenda

- **Overview**
- **Introduction**
- **Topics for Discussion:**
  - ❑ Discovering Sources of Competitive Advantage in an Integrated Primary Care Provider (PCP) Network
  - ❑ Texas Children's Pediatrics and Impact of Research
  - ❑ The Evidence-Based Pediatric Medical Home
  - ❑ NCQA and Impact of Research
- **Conclusion**

Discovering Sources of Competitive Advantage in an Integrated Primary Care Provider (PCP) Network

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The Resource Based Theory

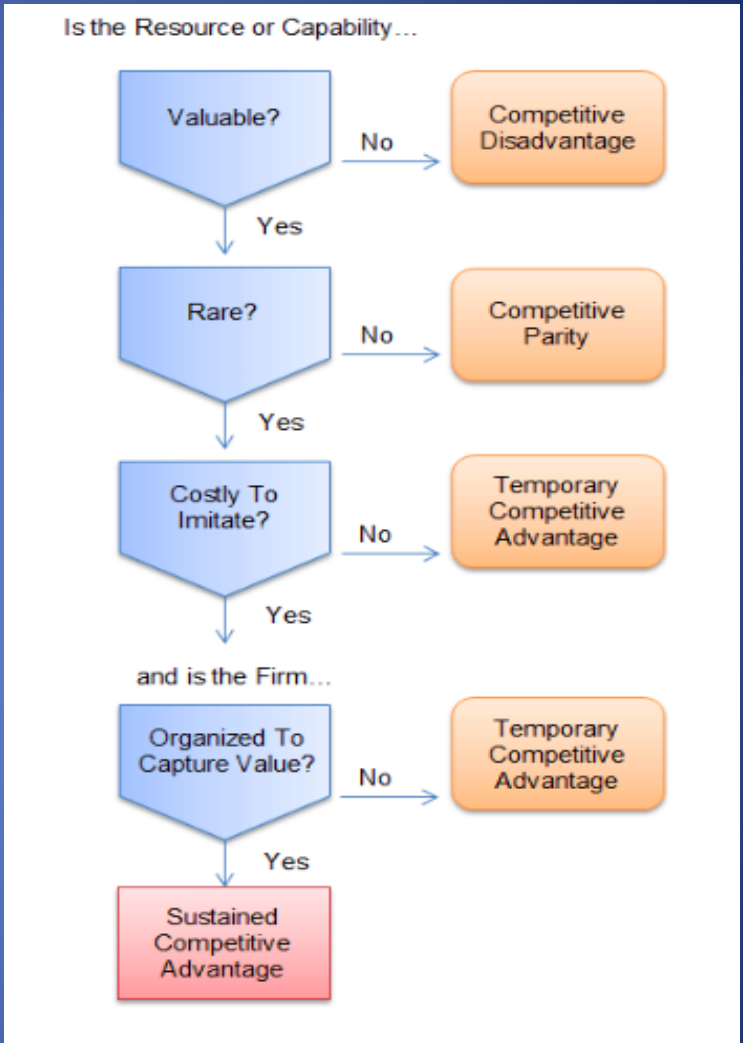
Determine Potential Sources of Competitive Advantage By Asking 4 Questions:

1. Is the key PCP network element highly valued by physicians?

2. Is the key PCP network element unique to Texas Children's Pediatrics (TCP)?

3. Is the key PCP network element difficult to replicate elsewhere?

4. Is the key PCP network element sustainable long-term?



Phase 1 - Identification of Key Elements and Consensus

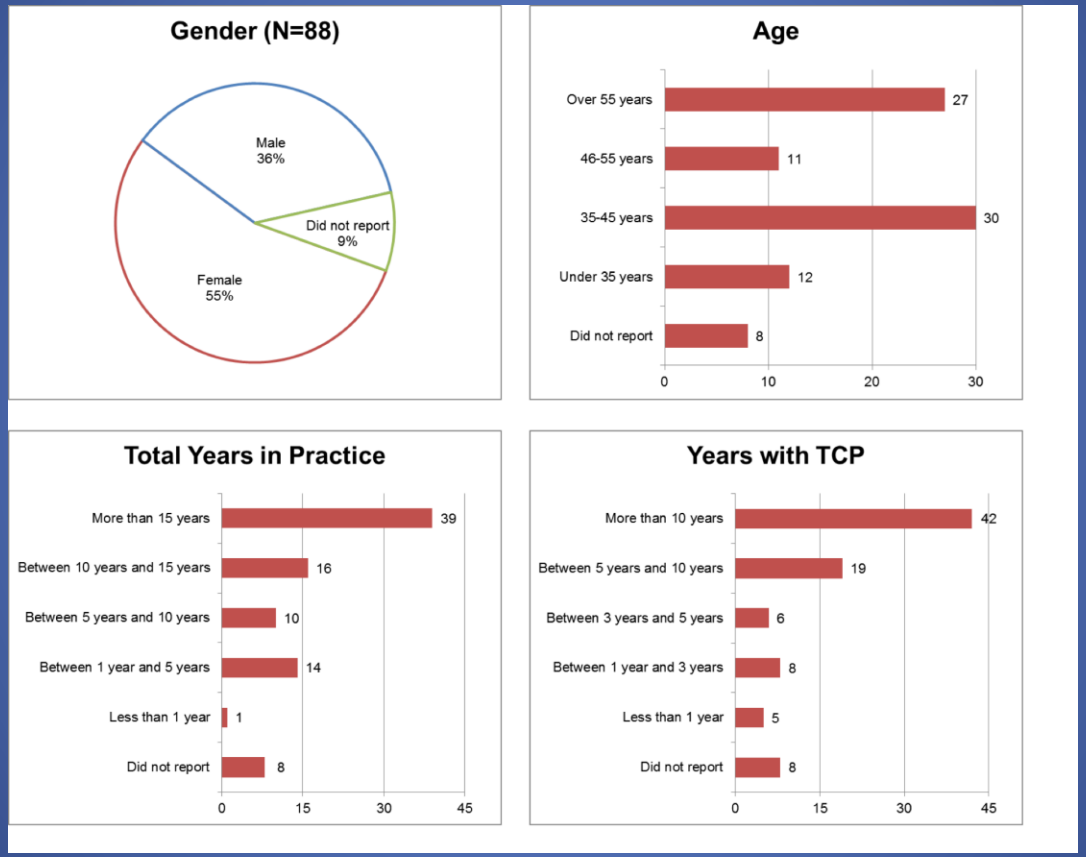
- Researchers utilized a **modified Delphi panel method** to identify a list of PCP network model elements and **capabilities that were both highly valued and highly utilized** by TCP physicians

Phase 2 - Internal Stakeholder

- Phase 2 consisted of an electronic survey administered to all 243 TCP network physicians.
- Using Likert scales, physicians were asked to rate utilization; perceived value; uniqueness to TCP; difficulty to replicate elsewhere; and sustainability for each of the 13 elements identified during Phase I (Delphi Study).

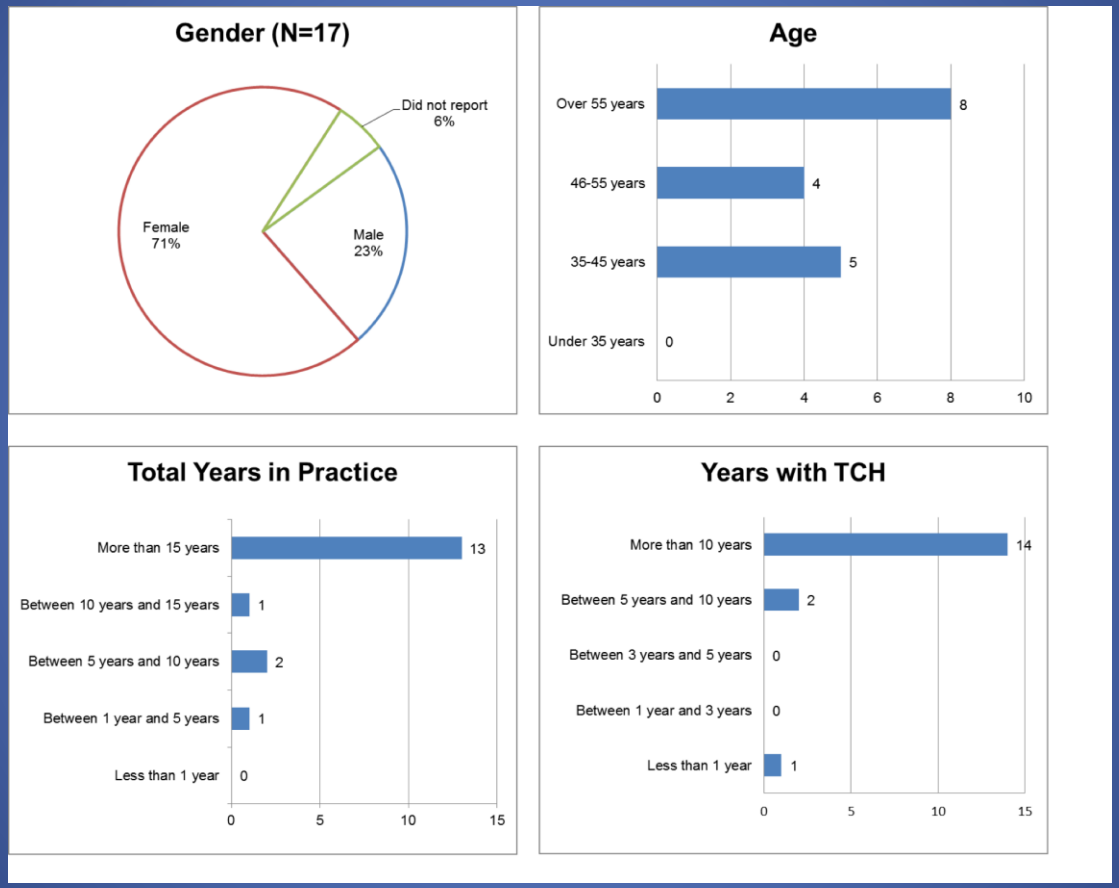
Phase 2 - Internal Stakeholder

Survey Respondents Profile for TCP Employed Physicians (N=88)



Phase 3 - External Stakeholder Validation - Pediatricians Not Employed by TCP

Survey Respondents Profile for TCH-Affiliated (non-employed) Physicians (N=17)



Phase 1 Results: Identification of Key Elements

13 key elements identified as being "highly valued" from the modified Delphi method included:

1. **Best Practice Alerts**
2. **Capability to Use Direct Scheduling with TCH Specialists**
3. **Care Coordination between TCP and Texas Children's Hospital**
4. **Care Team Approach Utilizing Mid-level Providers and/or Social Workers**
5. **Case Management for High-Risk Patients**
6. **Integrated EMR Capabilities**
7. **Involvement with Information Systems (IS) Department at TCH**
8. **Managed Care Contracting**
9. **Online Prescription Ordering**
10. **Physical Co-Location of Primary Care Practices and Specialists**
11. **Physician Compensation Structure**
12. **Physician Feedback to System Administration Through Committees**
13. **Standardized Clinical Pathways / Protocol for Disease Management**

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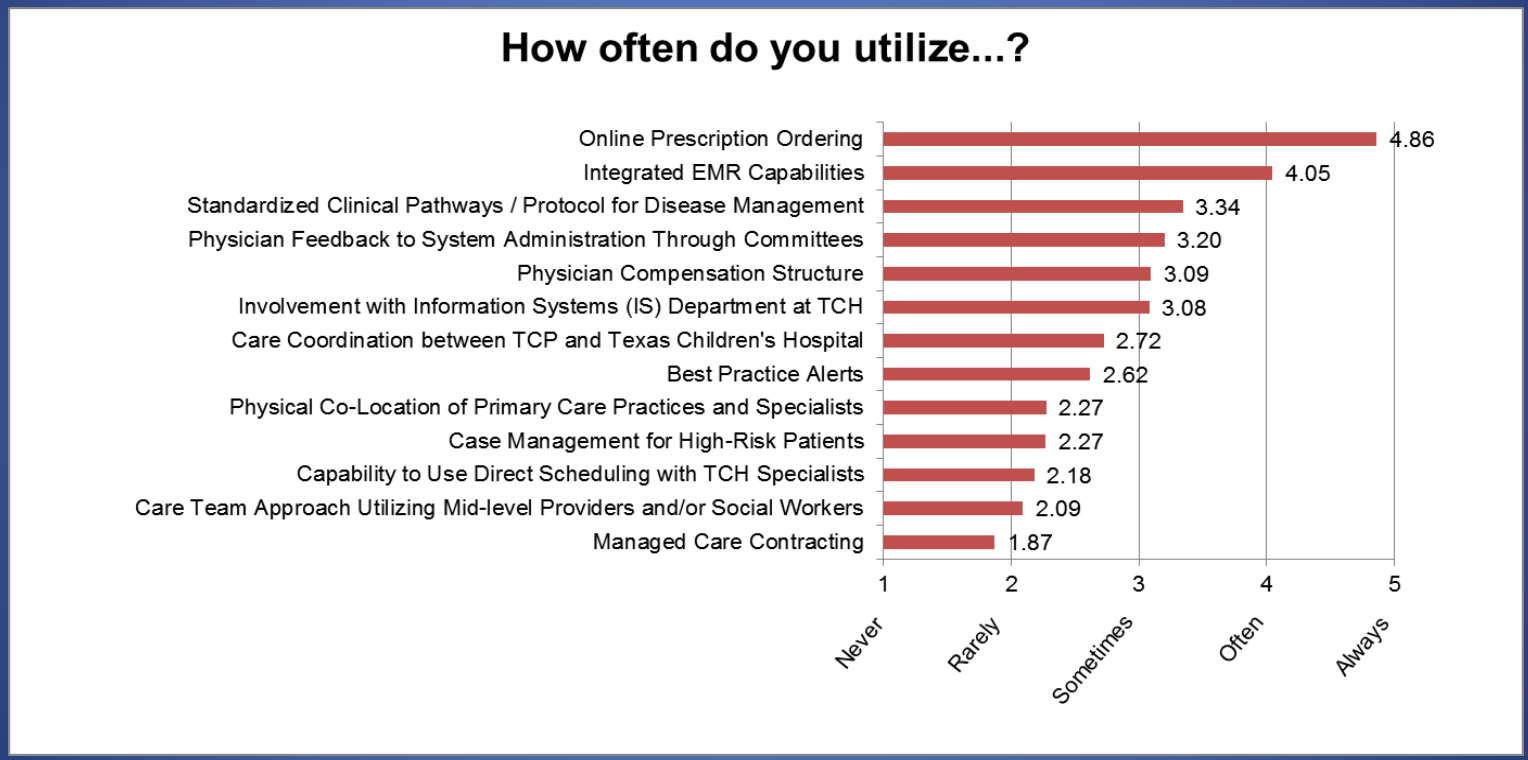
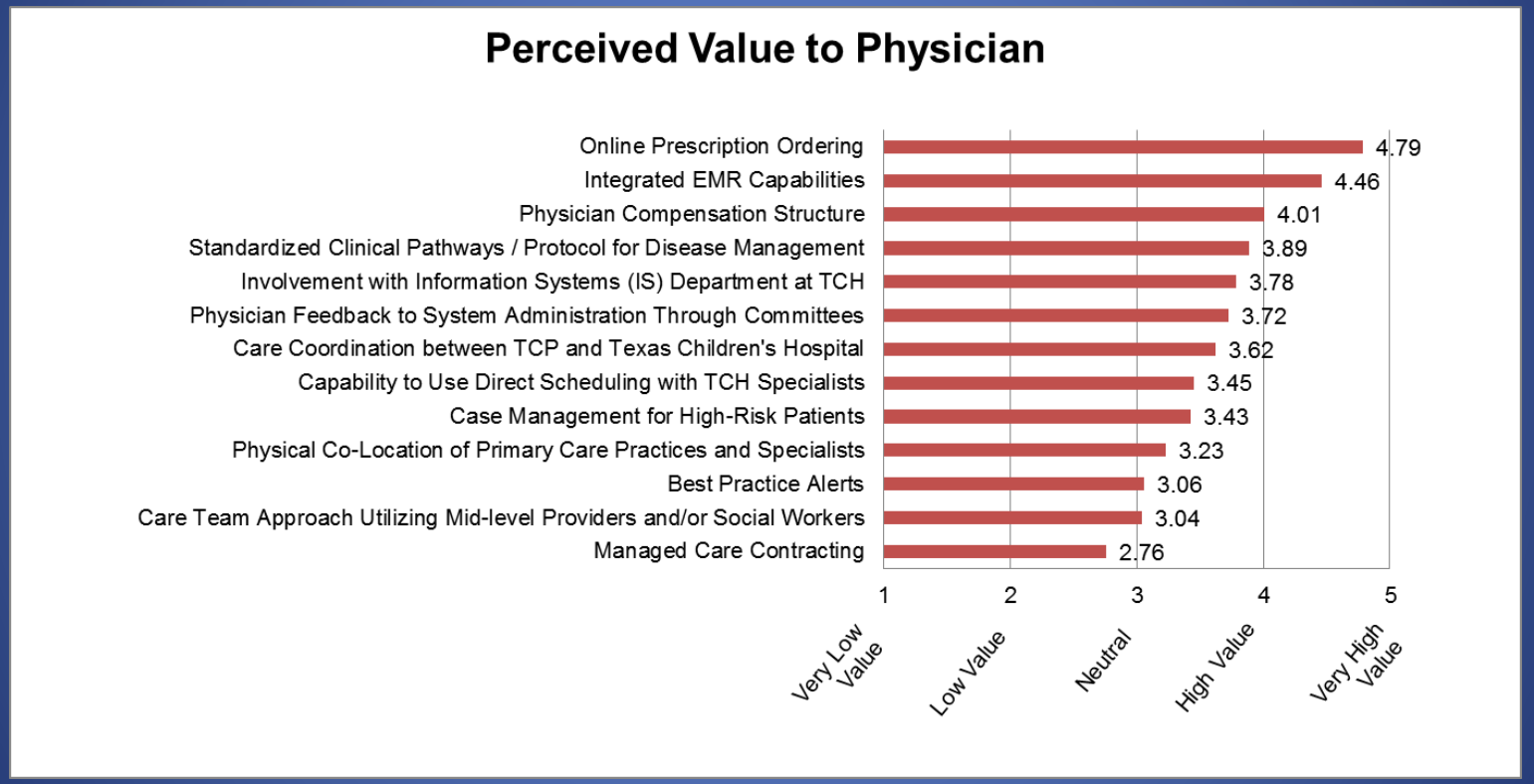
Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Utilization of Elements of TCP's Integrated PCP Network Model: The View of Internal Stakeholders



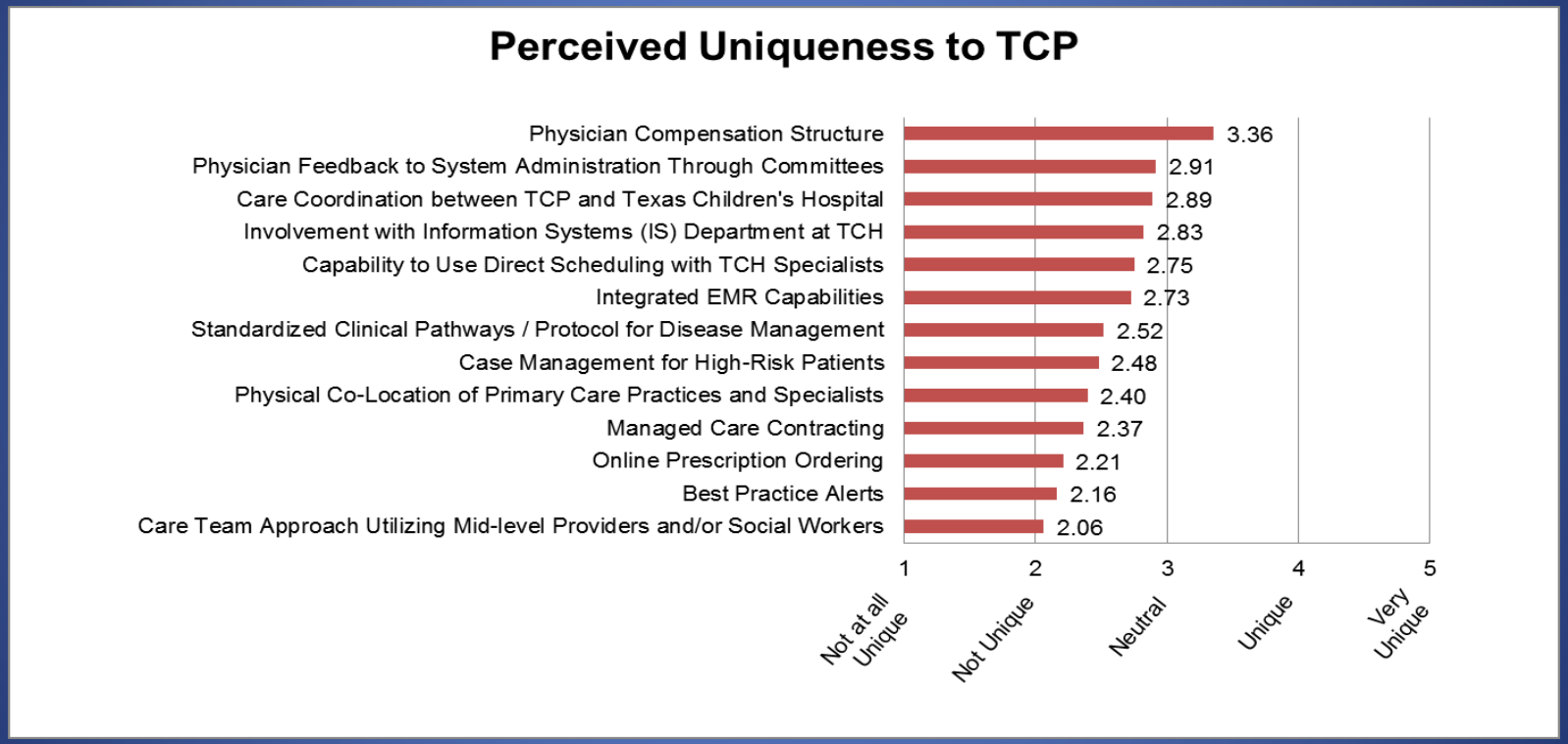
Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Perceived Value of Element of Elements of TCP's Integrated PCP Network Model



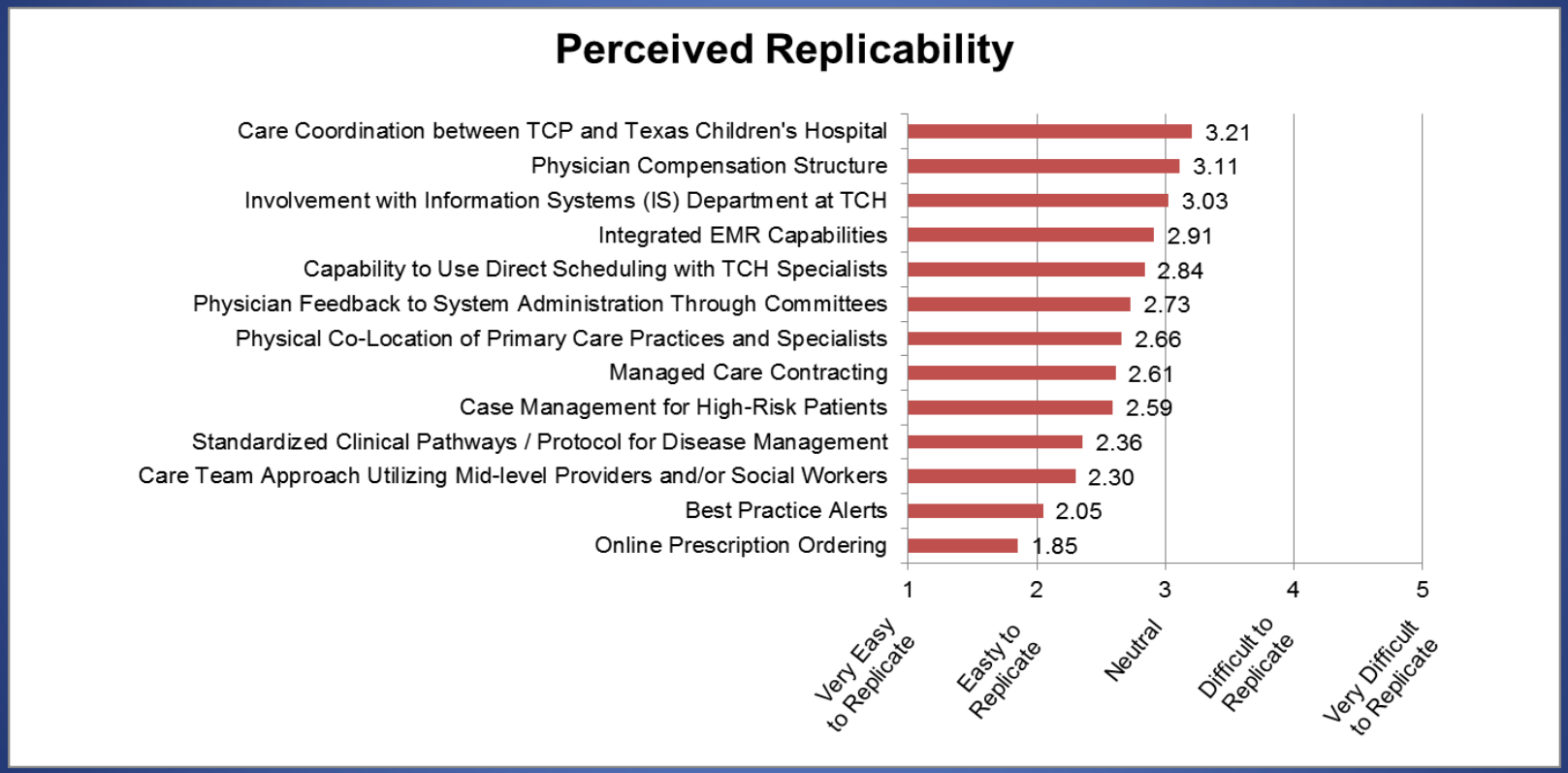
Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Perceived Uniqueness of Elements of TCP's Integrated PCP Network Model



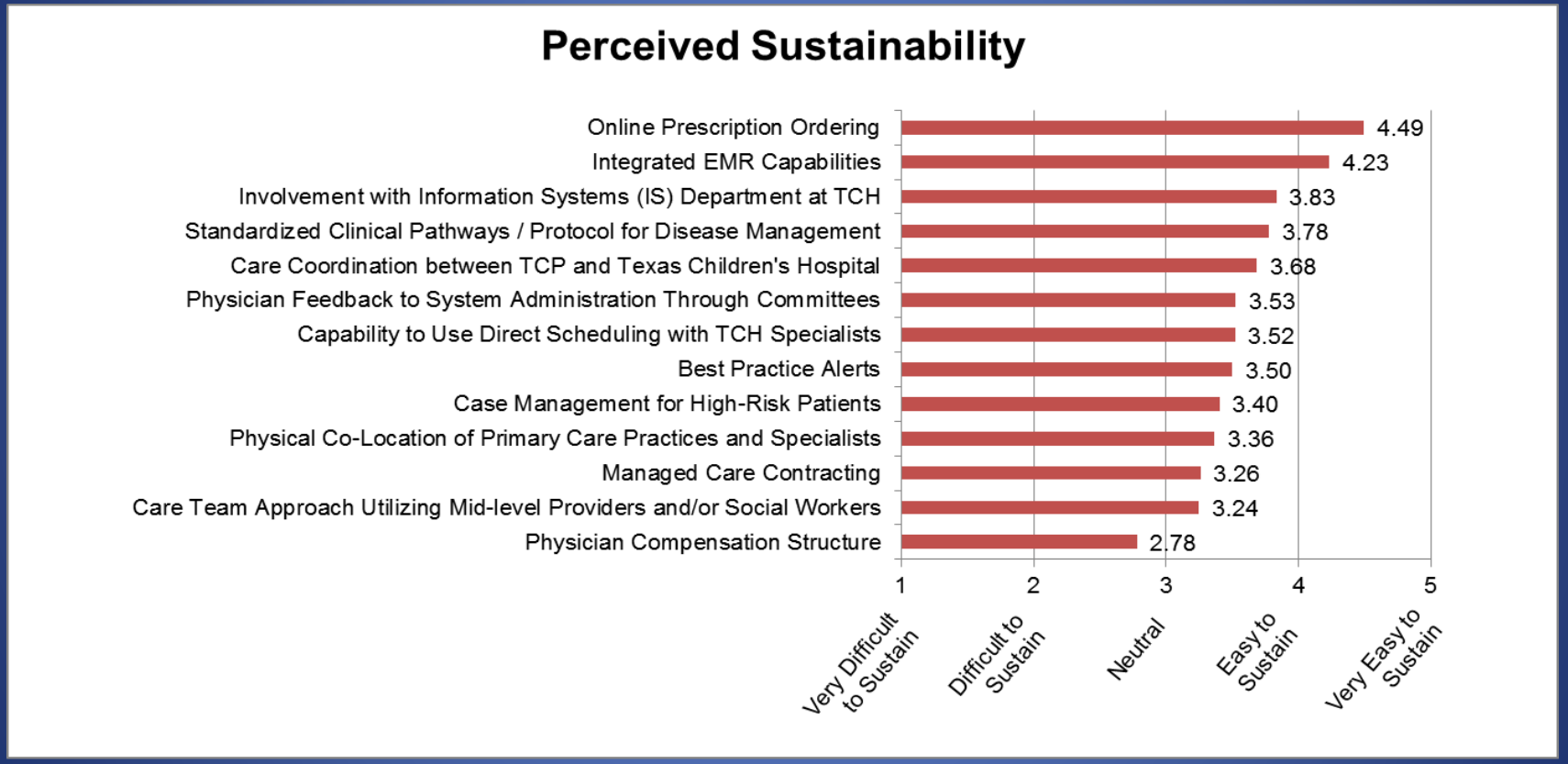
Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Perceived Difficulty to Replicate Elements of TCP's Integrated PCP Network Model

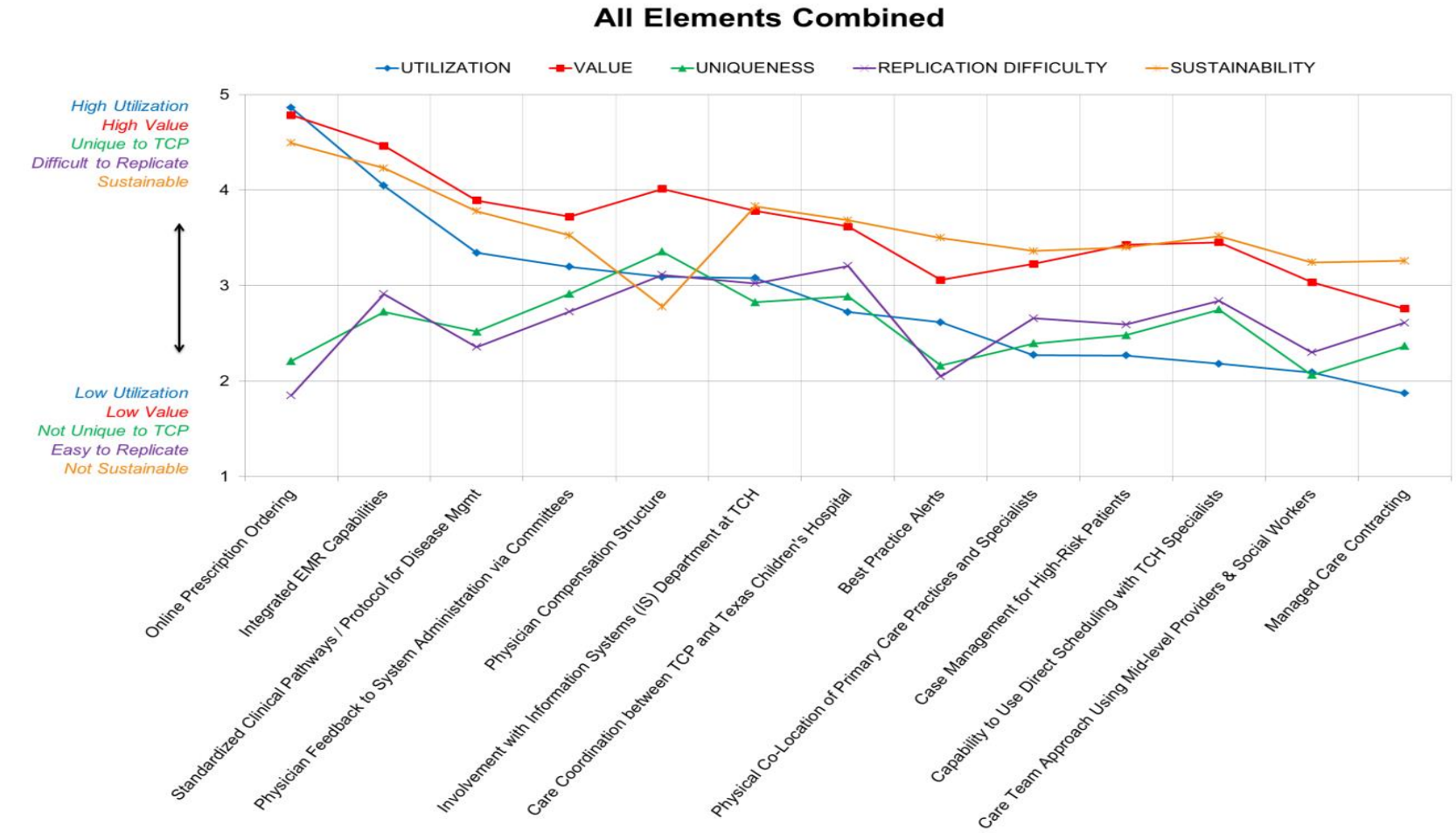


Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Perceived Sustainability of Elements of TCP's Integrated PCP Network Model



Phase 2 Results: Internal Stakeholder



Phase 2 Results: Internal Stakeholder

Perceived Value By Gender

- Male TCP physicians valued **best practice alerts, direct scheduling, care coordination, care team approach, case management, integrated EMR, IS department, physical co-location and protocols for disease management** slightly more than female TCP physicians.
- Female TCP physicians valued **managed care contracting, compensation model, and committee involvement** more than their respective counterparts.
- Both male and female TCP physicians valued **online prescription ordering** most. In addition, both male and female TCP physicians valued **managed care contracting least** (3.41).

Phase 2 Results: Internal Stakeholder

Utilization By Gender

- Male TCP physicians utilized **best practice alerts, care coordination, care team approach, case management, integrated EMR, IS department, and protocols for disease management** more than female TCP physicians.
- Female TCP physicians utilized **online prescription ordering, physical co-location, and committee involvement** more than male TCP physicians.
- Both male and female TCP physicians utilized **direct scheduling** equally. Further, both male and female TCP physicians utilized online prescription the most (4.86) and physical co-location the least, both not statistically significant.

Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Perceived Value By Organization Tenure

- All TCP physicians found online prescription ordering to be of extraordinary value, regardless of years in the organization.
- TCP physicians who have been in the organization **for less than a year** valued case management the least.
- TCP physicians who have been in the organization **between 1 year and 3 years** found managed care contracting to be less valuable.
- TCP physicians who have been in the organization **between 5 and 10 years** found integrated EMR to be of second highest value.
- TCP physicians who have been in the organization **for longer than 10 years** valued an integrated EMR second to online prescription ordering, and managed care contracting the least.

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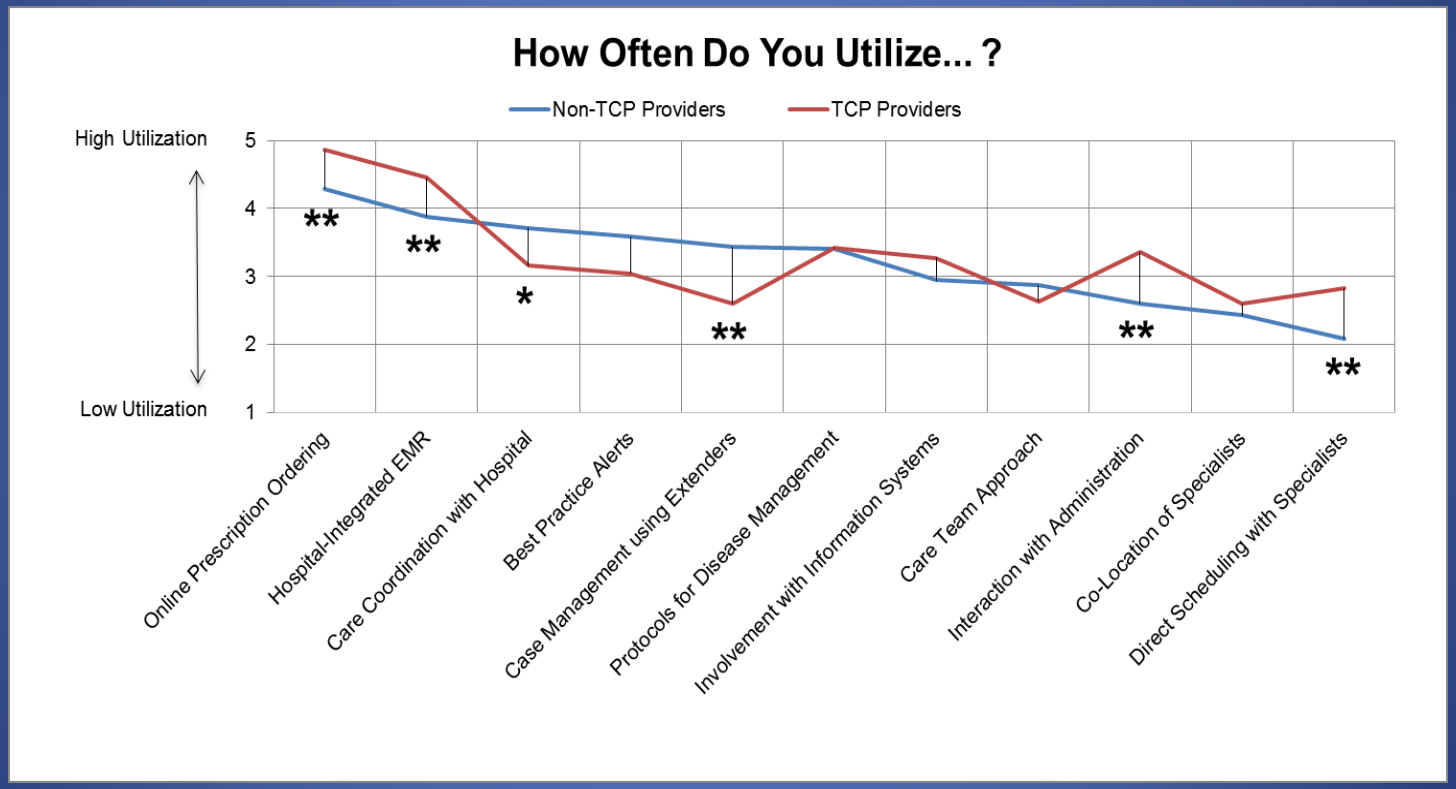
Phase 2 Results: Internal Stakeholder Validation – TCP Employed Physicians

Utilization By Organization Tenure

- TCP physicians who have been in the organization for **less than a year** utilized care team approach the least.
- TCP physicians who have been in the organization **between 5 and 10 years** also greatly utilized integrated EMR, but utilized physical co-location the least.
- TCP physicians who have been in the organization for **longer than 10 years** utilized integrated EMR second to online prescription ordering, but utilized care team approach the least.

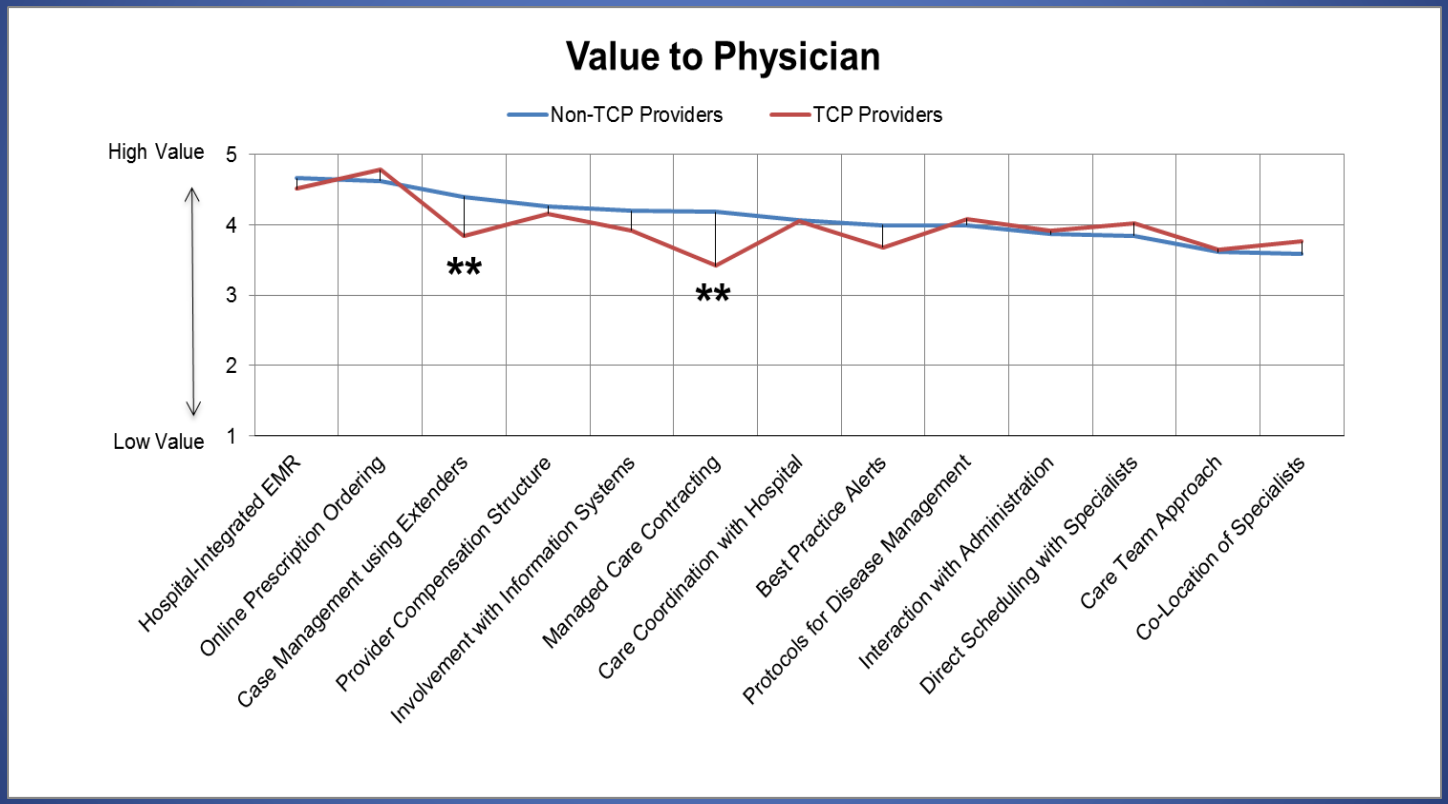
Phase 3 Results: External Stakeholder Validation – Comparison of Pediatricians Not Employed by TCP (External) and TCP Pediatricians (Internal)

Figure 13. Utilization Comparison: Non-TCP Physicians vs. TCP Physicians



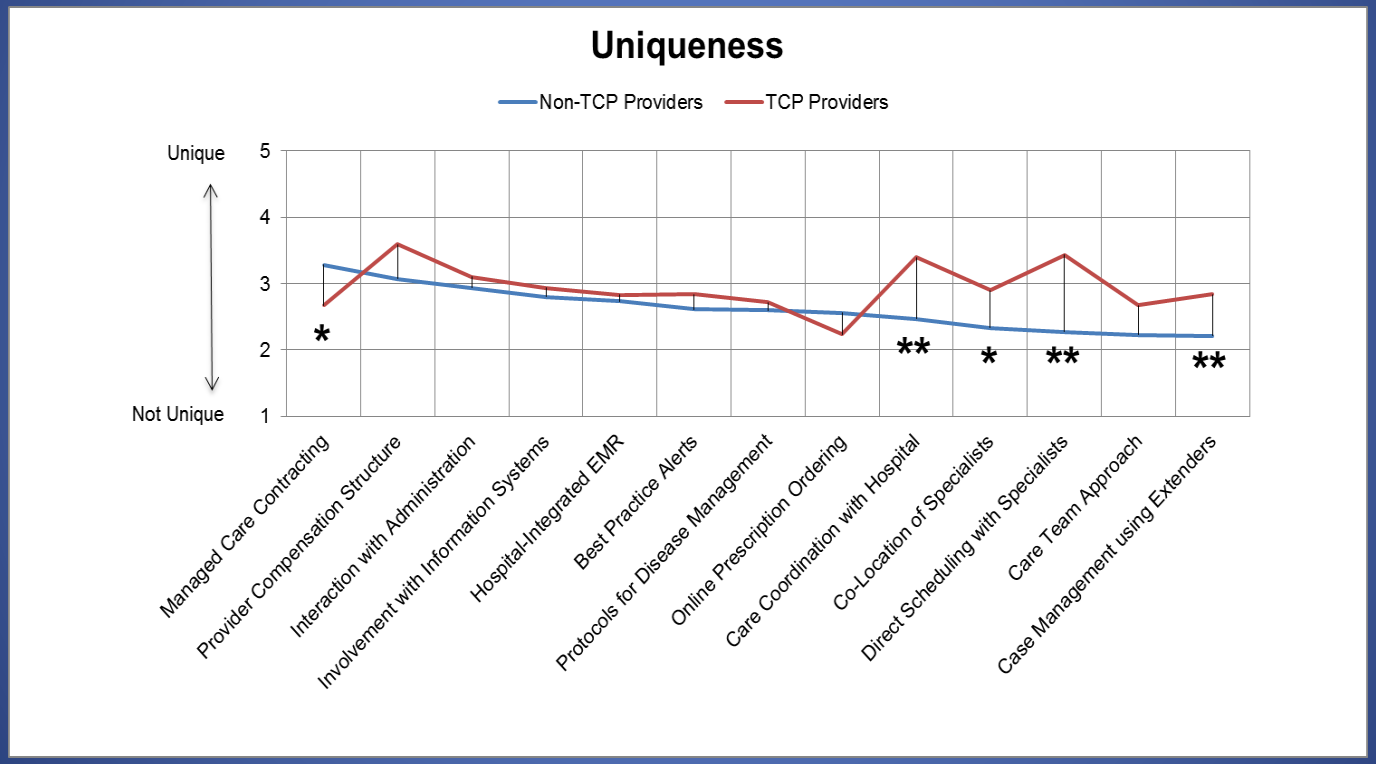
Phase 3 Results: External Stakeholder Validation – Comparison of Pediatricians Not Employed by TCP (External) and TCP Pediatricians (Internal)

Figure 10. Value Comparison: Non-TCP Physicians vs. TCP Physicians



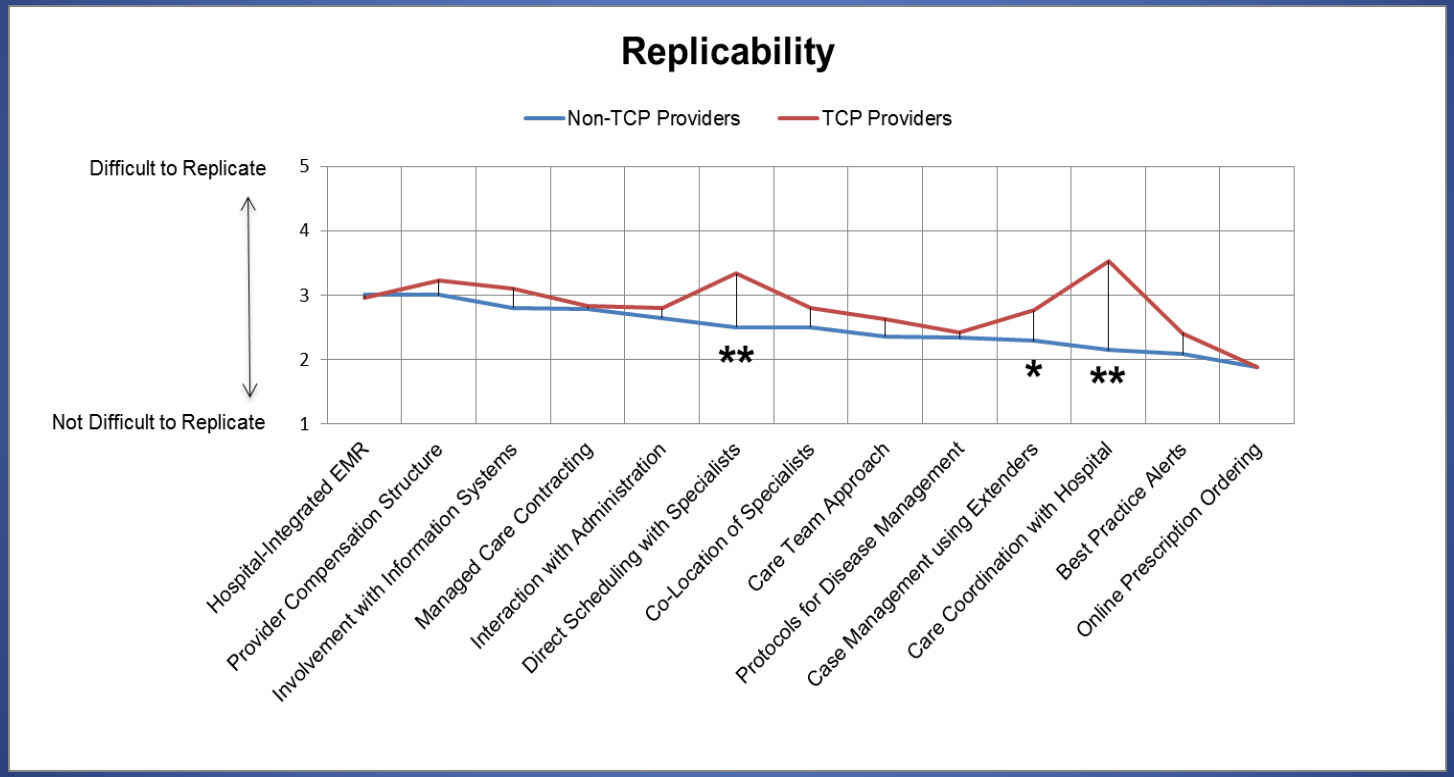
Phase 3 Results: External Stakeholder Validation – Comparison of Pediatricians Not Employed by TCP (External) and TCP Pediatricians (Internal)

Figure 14. Uniqueness Comparison: Non-TCP Physicians vs. TCP Physicians



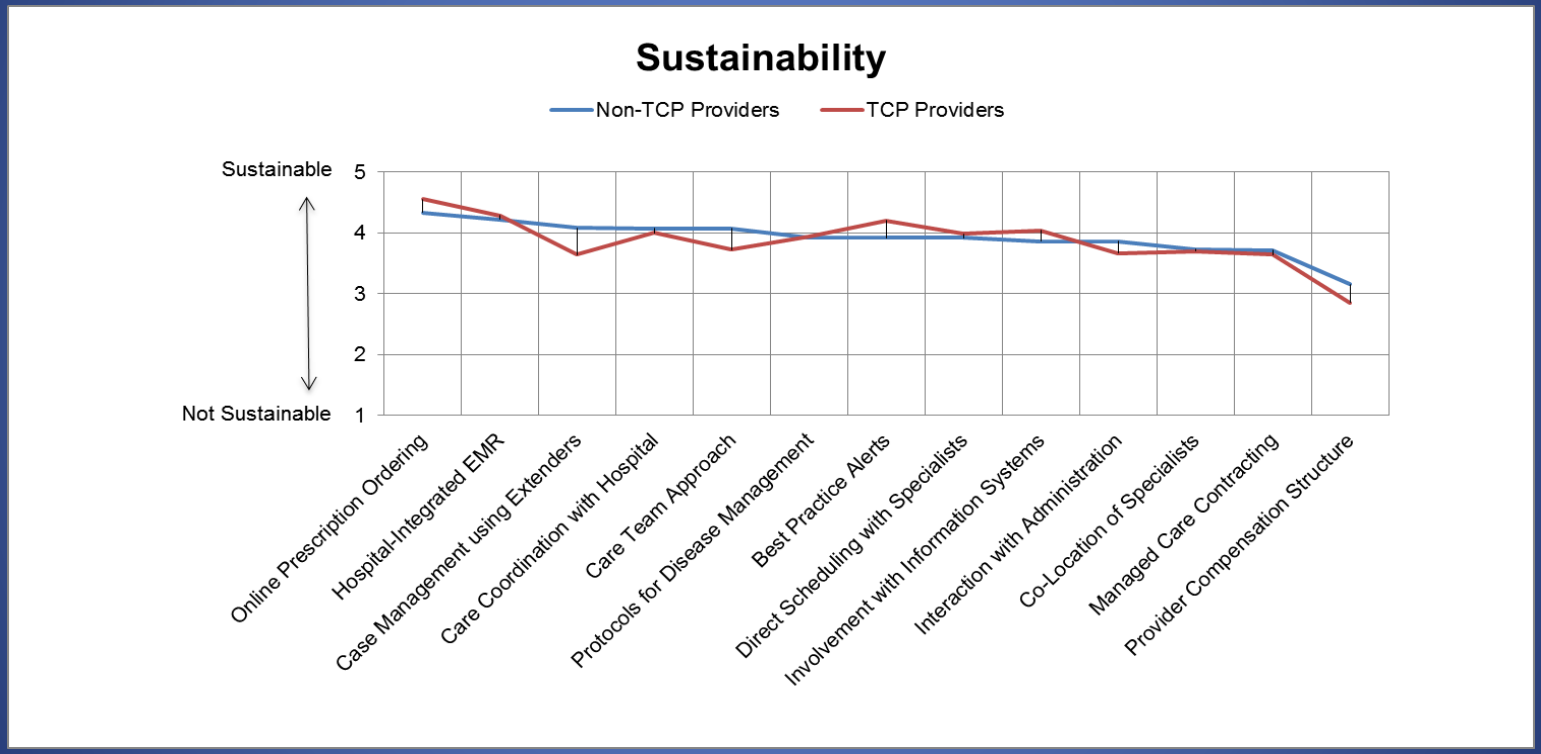
Phase 3 Results: External Stakeholder Validation – Comparison of Pediatricians Not Employed by TCP (External) and TCP Pediatricians (Internal)

Figure 15. Replicability Comparison: Non-TCP Physicians vs. TCP Physicians



Phase 3 Results: External Stakeholder Validation – Comparison of Pediatricians Not Employed by TCP (External) and TCP Pediatricians (Internal)

Figure 16. Sustainability Comparison: Non-TCP Physicians vs. TCP Physicians



Texas Children's Pediatrics

- Incorporated August 1, 1995 as a subsidiary of Texas Children's
- Started at the request of community pediatricians
- 49 practices
- Over 250 physicians
- Over 900 staff
- 1 million plus patient encounters per year

Fast Forward 2014

- Physician Changes
  - Increase in requests for part time options
  - 47 % of pediatricians starting their career with our organization
- Technology Impact
- Increased Focus on Quality
- Patient Experience

Impact of Research

- Strategic Planning
- Identify Areas of Importance
- Prioritize Initiatives

The Evidence-Based Pediatric Medical Home

- Concept first introduced by the American Academy of Pediatrics (AAP) in 1967
- Based on the "Patient-Centered Medical Home"

What We Know

- Studies in peer-reviewed literature have shown
  - Dissimilar results
  - Inconsistencies in the definition of the medical home
  - Variation in the assessment of the medical home
- Room for learning and **research informed decision-making** when considering the development and implementation of pediatric primary care models

Objective

- To help make **evidence-based pediatric care models** easier to implement using a patient-segmentation approach
  - Porter, Pabo & Lee, 2013
- Not "one-size-fits-all"
- To define **operational, staffing, and financial details** of relevant models for future medical home implementation

Methods

- **Systematic Literature Review:**
  - Identified best practices of innovative pediatric primary care models
- **Research Framework:**
  - Applied results to Porter and colleagues' patient segmentation approach

PRIMARY CARE

By Michael E. Porter, Erika A. Pabo, and Thomas H. Lee

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HEALTH AFFAIRS 32,
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ANALYSIS & COMMENTARY

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs

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ABSTRACT **Primary care in the United States currently struggles to attract new physicians and to garner investments in infrastructure required to meet patients' needs. We believe that the absence of a robust overall strategy for the entire spectrum of primary care is a fundamental cause of these struggles. To address the absence of an overall strategy and vision for primary care, we offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be organized around subgroups of patients with similar needs. Second, team-based services should be provided to each patient subgroup over its full care cycle. Third, each patient's outcomes and true costs should be measured by subgroup as a routine part of care. Fourth, payment should be modified to bundle reimbursement for each subgroup and reward value improvement. Finally, primary care patient subgroup teams should be integrated with relevant specialty providers. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system.**

Primary care is widely recognized as essential to any health care system, but the field remains beleaguered.[1] Many primary care practitioners feel frustrated and underappreciated, and fewer than one in ten US medical school graduates enters primary care residency programs.[2] Primary care practices are starved for investment. Meanwhile, patients have difficulty finding primary care physicians and are often disappointed with the ability of primary care practices to meet their needs.[3,4]

We believe that a fundamental cause of these problems is the absence of an organizational framework for primary care that is connected directly to any robust strategy beyond that of increasing the volume of services for reimbursement. As we have asserted elsewhere,[5,6] we believe that the overarching strategy for health care should be to improve value for patients, where *value* is defined as patient outcomes achieved relative to the amount of money spent.

Only through achieving better outcomes that matter to patients, reducing the costs required to deliver those outcomes, or both can we unite the interests of all key stakeholders. Unless primary care is organized to deliver and demonstrate measured value, it will never command the respect and investment it needs. It will remain the underappreciated stepchild, recognized as necessary but not rewarded.

As organized today, primary care is a mission impossible. Most primary care practices attempt to meet the disparate needs of heterogeneous patients with a single "one size fits all" organizational approach. This leads to frustration for

Systematic Literature Review Approach

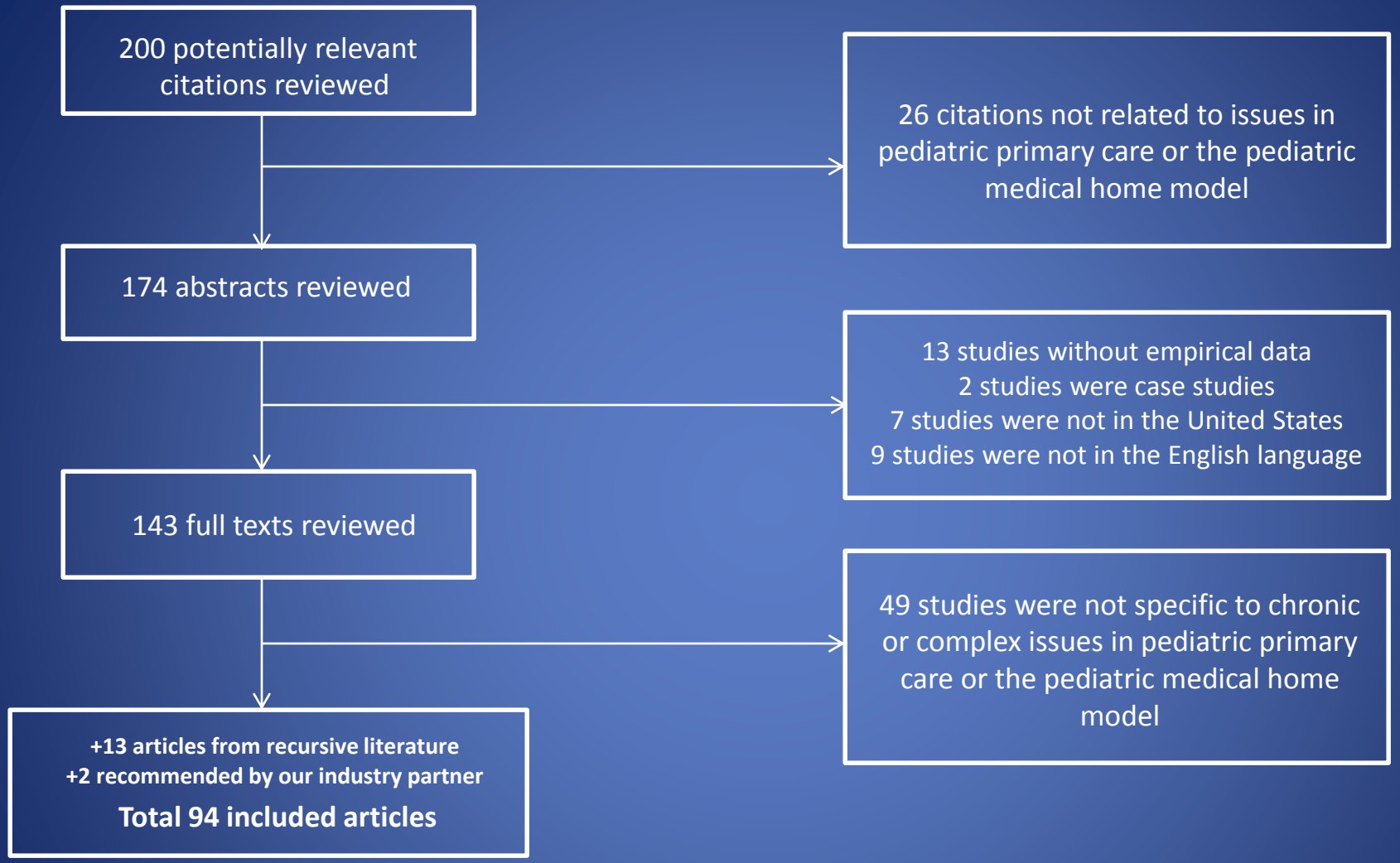
- **Inclusion criteria included**
  - (i) data specific to pediatric primary care
  - (ii) data specific to the pediatric medical home
- **Exclusion criteria included**
  - (i) non-empirical data
  - (ii) non-peer reviewed articles
  - (iii) medical case studies
  - (iv) articles not in the English language
  - (v) published abstracts

Research Framework

Example of application of Porter et al. framework

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members
Healthy	Children in good or excellent health with no ongoing physical, emotional, or social health care needs	6-year-old healthy boy with no known medical problems, but hurts himself playing soccer on the weekend	Maintenance of health	Age- and gender- appropriate preventive and screening care as well as urgent care for minor medical issues such as an ear infection	Primary care physician, pediatrician, practice-based nurse, medical assistant, medical technicians
Healthy With A Complex Acute Illness	Children in good overall health with a complex acute illness	4-year-old girl with onset of coughing, wheezing, shortness of breath and chest tightness	Early detection of potentially life-threatening issues, accurate diagnosis	Rapid access and evaluation that allows triage of issues	Primary care physician, pediatrician, specialty physician, practice-based nurse, care coordinator, social worker
At Risk	Children who are currently in good health but at elevated risk for developing acute or chronic disease and require a higher-level of service	13-year-old overweight boy with history of poor diet and lack of exercise but no major medical problems	Primary prevention of disease and maintenance of health as well as modification of high-risk status	Interventions to avoid increase in risk and ready identification of development of acute or chronic disease	Primary care physician, pediatrician, practice-based nurse, patient education specialist, mental health clinician
Chronically Ill	Children with one or more chronic conditions with ongoing impact of functional status or pose risk for long-term complications	7-year-old obese boy with hypertension, hyperlipidemia and non-insulin dependent diabetes	Disease management, prevention of secondary complications of chronic disease and maintenance of other aspects of health	Management of chronic disease and coordination of care with specialty providers.	Primary care physician, pediatrician, practice-based nurse or nurse practitioner, pharmacist, patient education specialist, mental health clinician
Complex	Children with multiple chronic diseases with complications or otherwise disabling conditions that require care from multiple specialty services and frequently lead to hospitalization or emergency department use	14-year-old boy with a congenital heart defect, diabetes, chronic kidney disease, and depression who has been hospitalized twice in the last year	Preventing and/or managing secondary complications of disease, avoiding emergency room services, inpatient admissions, and other escalations in level of health care services	Frequent interaction with primary care team including, but not limited to intensive disease management support and prompt intervention for disease flair-ups to help avoid need for escalation of services	Primary care physician, pediatrician, specialty physician, case manager, education specialist, mental health clinician, social worker

Results


200 potentially relevant citations reviewed
26 citations not related to issues in pediatric primary care or the pediatric medical home model
174 abstracts reviewed
13 studies without empirical data
2 studies were case studies
7 studies were not in the United States
9 studies were not in the English language
143 full texts reviewed
49 studies were not specific to chronic or complex issues in pediatric primary care or the pediatric medical home model
+13 articles from recursive literature
+2 recommended by our industry partner
Total 94 included articles

7 Evidence-Based Pediatric Primary Care Models

1) Limited English Proficiency Latina Mothers: Pediatric Medical Home
2) High Functioning, Quality Primary Care Practices
3) Pediatric Emergency Care Model
4) Building Healthy Children: Home Visitation Integrated W/ Pediatric Medical Home
5) Mental Health Issues In The Medical Home
6) Clinical Quality Improvement for Identification and Management of Overweight in Pediatric Primary Care Practices
7) Responding to the Developmental Consequences of Genetic Conditions

Healthy Children Population:

1) Limited English Proficiency Model

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric Primary Care Models From Literature	Impact
Healthy	Children in good or excellent health with no ongoing physical, emotional, or social health care needs	4-year-old Latina girl with onset of the flu from a family with limited English proficiency (LEP)	Child and family engagement Provider continuity Care coordination with referrals to specialty care High quality parent/provider relationship	Walk-in-system due to volatility of child illness Shorter wait times Evening and weekend clinic hours After hours phone care for questions or assistance with management of illnesses Increased language services for specialty and emergency care	Parents or caregivers Pediatric primary care providers Nursing staff Office staff Translator Health System Navigator	Limited English Proficiency Latina Mothers: Pediatric Medical Home	Approximately half (19) of mothers in the study were satisfied with the care their child/children received The remainder had negative assessments of their current PCP due to dissatisfaction with provider, clinic services or both

Healthy Children Population:

2) High Functioning, Quality Primary Care Model

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric PC Models	Impact
Healthy	Children in good or excellent health with no ongoing physical, emotional, or social health care needs	2-year-old healthy boy with no known medical problems	Work life satisfaction for physicians Low level of physician burnout Organization of practice environment (Relief from paperwork and administrative hassles) Opportunity to form meaningful relationships with patients Ability to provide high functioning, quality care to patients Improving team communication and functioning	Reducing work through previsit planning and preappointment laboratory tests Transformation of roles of medical assistants, registered nurses, and health coaches Telemedicine to alleviate projected primary physician shortages Reengineering prescription renewal work out of the practice	Parents or caregivers Pediatric primary care providers Medical assistants Registered nurses Pharmacists Health coaches Office staff	High Functioning, Quality Primary Care Practices	14% Increase in patient satisfaction scores After 1 year in the new model, average daily visits increased from 21 to 28, improving access and continuity Revenue increased 20% to 30% Decrease in administrative work from 90 minutes to a few minutes per day

Healthy Children Population:

3) Pediatric Emergency Care Model

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric Primary Care Models From Literature	Impact
Healthy	Children in good or excellent health with no ongoing physical, emotional, or social health care needs	9-year-old healthy boy with no known medical problems but hurts himself playing soccer and is taken to the ED by his parents	Office-based self-assessment Office readiness Documentation and standardization	Availability of all appropriate equipment such as airway equipment and medications Clear response plan Preparation of mock codes or simulated exercises	Parents or caregivers Pediatric primary care providers Nursing staff Hospital/office staff Local EMS personnel (First responders or emergency medical technicians) Child advocates	Pediatric Emergency Care Model	Reduction in mishaps Increase in staff satisfaction Decrease in staff turnover

Healthy W/ A Complex Acute Illness Children Population:

4) Building Healthy Children

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric PC Models	Impact
Healthy With A Complex Acute Illness	Children in good or excellent health but have emotional, or social health care needs	Infants born to young, low-income mothers	Engagement of eligible families in home visitation services Communication and care coordination between medical providers and "Building Healthy Children" agencies	Broadened range of services to address issues such as maternal depression, interpersonal violence, and parent-child attachment Home visits by pediatrics and family medicine residents, and social workers Team discussions and weekly team conferences with collaborative partners to discuss goals and treatment plans for families Psychosocial and maternal educational support Parenting education Therapy for parent-child trauma Enhanced family functioning	Parents or caregivers Pediatric primary care providers Outreach workers Social workers	Building Healthy Children: Home Visitation Integrated W/ Pediatric Medical Home	60% of young moms engaged in therapy and reduced depressive symptoms 79% connected with services and achieved treatment goals 98% of BHC treatment families kept all of their well-child visits in first 24 months of life 85% retention rate

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At Risk Children Population:

5) Mental Health Issues In The Medical Home

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric PC Models	Impact
At Risk	Children who are currently in good health but have behavioral health conditions and require a higher-level of service	13-year-old boy with ADHD, but no major medical problems	Family-centeredness Collaborative care Anticipatory guidance Preventing or mitigating mental health and substance problems	Timely intervention to avoid increase in risk Redesigning care team to incorporate behavioral health specialists Modifying EHRs to accommodate behavioral health information Increase in training and skills to detect and address mental health and behavioral challenges	Parents or caregivers Pediatric primary care providers Nurse and medical assistants Education specialist Behavioral health specialists (Clinical and behavioral psychologists)	Mental Health Issues In The Medical Home	Screening to increase number of children identified with mental health issues Promote management of symptom clusters Increase in child and parents' feeling of trust and satisfaction with provider(s)

Chronically Ill Children Population:

6) Clinical Quality Improvement for Identification and Management of Overweight in Pediatric Primary Care Practices

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric PC Models	Impact
Chronically Ill	Children with one or more chronic conditions with ongoing impact of functional status or pose risk for long-term complications	7-year-old obese boy with hypertension, dyslipidemia and depression	Assisting patient and family self-management goals Patient-centered communication	Early screening and prevention Support of telehealth clinic with a focus on multidisciplinary didactic education Patient consultation specific to issues of pediatric overweight medical management Coaching calls to each site to discuss improvement plan Counseling of lifestyle behaviors (Nutrition and physical activity)	Parents or caregivers Pediatric primary care providers Life coaches Nutritionist	Clinical Quality Improvement for Identification and Management of Overweight in Pediatric Primary Care Practices	Documented BMI percentile increased from 30% to 85% by second review, and 95% by third review Rates for weight and counseling for physical activity and nutrition among high-risk patients improved to better than 90% Referrals, follow-up visits, and lab work improved slightly

Complex Children Population:

7) Responding to the Developmental Consequences of Genetic Conditions

Segment	Definition	Example	Key Priorities	Key Primary Care Services Needed	Key Potential Members	Innovative Pediatric PC Models	Impact
Complex	Children with multiple chronic diseases with complications or otherwise disabling conditions that require care from multiple specialty services and frequently lead to hospitalization or emergency department use	14-year-old boy with cerebral palsy, who has been hospitalized twice in the last year	Screening for developmental differences in primary care Early intervention for children with established conditions causing developmental delays Support for families of children with disabilities Avoiding emergency room services, inpatient admissions, and other escalations in level of health care services	Formation of child development diagnostic team Chronic condition management in primary care Frequent interaction with primary care team including, but not limited to intensive disease management support and prompt intervention to avoid need for escalation of services	Parents or caregivers Pediatric primary care providers Developmental pediatrician Physical therapist Occupational therapist Speech pathologist Special educator	Responding to the Developmental Consequences of Genetic Conditions	Parent satisfaction increased from 25% to 100%

Implications

- The child **population segmentation** framework can be applied to the pediatric medical home model to address all optimal aspects
- There is still much to be done in advancing the pediatric medical home model
- Pediatric medical home implementation remains complex and there is ongoing need **for evidence-based, data-driven studies** for the pediatric medical home concept

NCQA

- Established in 1990
- Initially focused on Health Plans and associated quality metrics
- Expanded to Medical Home Recognition
- Standards updated every 2-3 years
- Each update works to move organization to a new level
  - Example: 2014 standards include integration of behavioral health in primary care

NCQA Medical Home Standards

- Enhance Access and Continuity
- Identify and manage patient populations
- Plan and manage care
- Provide self care support and community resources
- Track and coordinate care
- Measure and improve performance

Impact of Research

- Building a Care Team
  - Key to success in achieving Medical Home recognition
  - Review roles
  - Licensure issues
  - Training needed
  - Physician and employee satisfaction
  - Patient satisfaction

Thank You!

Questions?

Contact Info

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www.texaschildrenspediatrics.org

Biography

Bita Kash, Ph.D., FACHE, is an associate professor at Texas A&M University, Department of Health Policy and Management and Joint Associate Professor at the College of Medicine's Department of Internal Medicine. Dr. Kash conducts research that informs, validates, and facilitates implementation of major management, clinical, and information technology innovations in healthcare delivery.

Dr. Kash received a Master's in Business Administration from The Citadel in Charleston, SC. She completed a two-year administrative fellowship at MUSC and later worked as a management consultant with RSM McGladrey, Inc. before pursuing a PhD in Health Services Research from Texas A&M University. She currently teaches healthcare strategic planning and marketing for MHA and MPH programs, the MHA Capstone course, and serves on multiple PhD student committees. Dr. Kash is also a fellow of the American College of Healthcare Executives (ACHE) and an active member of AcademyHealth, the Gerontological Society of America, and Academy of Management. She has recently been appointed to serve as Editor-in-Chief for the *Journal of Healthcare Management*.

Dr. Kash, as Director and PI of the National Science Foundation's (NSF) Center for Health Organization Transformation (CHOT), conducts research to support the implementation of evidence-based transformational strategies within healthcare organizations. Dr. Kash's research model relies on the knowledge and experience of healthcare leaders to guide academic research. This cooperative model ensures that the research is both meaningful and applicable to the healthcare industry and provides immediate decision support for CHOT's Industry Members, such Texas Children's Hospital, the American Society of Anesthesiologists, and Studer Group. Dr. Kash's areas of research include organizational capacity for change and transformation, implementation of new innovative models of care in primary care and surgical settings, nursing home staffing and cost, and healthcare strategic planning and management. Her most recent research projects, funded by the NSF Center for Health Organization Transformation (CHOT), focus on examining elements of integrated primary provider networks as potential sources of competitive advantage using resource based theory (RBT), and surgical care coordination models internationally to achieve better clinical outcome at reduced cost of care. Dr. Kash's research has been funded primarily by NSF, AHRQ, NIH, industry, and the State Department of Health and Human Services.

Biography

Kay Tittle, MS, RN, FACHE is President of Texas Children's Pediatrics (TCP) and Texas Children's Urgent Care (TCUC). Kay leads the organization in assuring high quality, customer focused care in over 50 practice sites throughout the greater Houston area. All of the eligible practices carry the NCQA Medical Home Recognition.

Kay previously served as Vice President and Chief Operating Officer of TCP from 1995 (when TCP was formed) until 2007 when she was promoted to president. During those years she oversaw the acquisition and operation of the first 41 practices.

She has over 20 years experience in the nursing field beginning as a staff nurse, nurse manager and director at various Houston hospitals. Ms. Tittle holds a Master of Science from Texas Women's University and a Bachelor of Science in Nursing from the University of Texas at Houston. She has published articles in two publications: *Journal of Pediatric Nursing* and *Nursing.*

Kay is a Fellow of the American College of Healthcare Executives and is a member of the American Medical Group Association and the Society of Pediatric Nurses. Just this year she was honored by the Houston Chronicle as one of their "Salute to Nurses Top 150 Honorees".