Housekeeping Tips

- Live questions will be taken at the end of the program and questions can also be asked during the program by clicking on the Q&A tab above.

- Your feedback is greatly appreciated, so we ask that you take a few minutes and complete the survey that will appear on your screen after the Q&A session.

- Foley will apply for 2.5 general CLE credits for today's program. All New York attendees applying for CLE credit must fill out an Attorney Affirmation form and insert the two course codes that will be given during today's web conference. Please remember CLE processing can take up to 16 weeks to get approval and credit for the program.

- If you have any questions please contact zrahi@foley.com
The Role of Medical Homes in Care Transformation

Introduction and Overview

Presented By:
C. Frederick (“Fred”) Geilfuss
Foley & Lardner LLP
fgeilfuss@foley.com
414.297-5650
CARE TRANSFORMATION

- Economics of Health Care Require a New Approach
- Participants in Health Care Recognize Compelling Need for Change in Care Delivery
- Payment Change is Critical to Care Transformation
- Not Whether, But When
- Result of Supreme Court and 2012 Presidential Election Do Not Matter

CARE TRANSFORMATION (cont’d)

- Moving Away From Volume Based, Fee-for-Service Payment to System Paying for Value and Outcomes
- Key Goals: Restrain Cost Increases and Achieve Better Quality for Populations and Individuals
CARE TRANSFORMATION (cont’d)

- What Form Will it Take?
- Today: Conversations/Testing/Demonstrations
- Increased Collaborations
- Providers Taking More Risk; Payors Getting Into Provider Business
- Transitions: How Best to Get from Where We Are to Where We Need to Be?
- What Will Care Delivery Look Like in 7-10 Years?

THE ROLE OF MEDICAL HOMES

- Significant Activity
- Numerous Demonstrations and Much Discussion
- Initial Positive Results
- What Are Opportunities and Challenges?
WHAT IS A PATIENTED CENTERED MEDICAL HOME?

- First Introduced by American Academy of Pediatrics in 1967
- Concept Has Expanded
- Definition: Not a Building, Home, Hospital or Home Health Care, But an Approach to Providing Comprehensive Primary Care with the Goal to Pro-Actively Manage a Population of Patients with Better Access and Quality

WHAT IS A PATIENTED CENTERED MEDICAL HOME? (cont’d)

- Key Components:
  - Primary Care Physician-Led Team
  - Use of Care Managers, Mid-Level Providers on Team
  - Require EMR and Reporting Systems
  - Open Scheduling/Expanded Hours
  - Preventative Services and Management of Chronic Care
MEDICAL HOME

- JOINT PRINCIPLES/ATTRIBUTES
  - Personal Physician
  - Coordinated Team of Professionals
  - Whole Person Orientation
  - Coordinated Care
  - Quality and Safety
  - Enhanced Access
  - Pay Reflective of Value

---

**Figure 3: Analysis of Seven P4P Pilot Programs**

| Program Medical Home for Children | n of Patients | Description | Results | % in Top Quartile of Performance | Top Quartile of Payment
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>CommunityCare of North Carolina</td>
<td>197,511</td>
<td>Medicaid CDP</td>
<td>Pay for Performance: 95%</td>
<td>15%</td>
<td>71%</td>
</tr>
<tr>
<td>George Health Cooperative</td>
<td>9,200</td>
<td>Medicaid</td>
<td>Pay for Performance: 68%</td>
<td>41%</td>
<td>19%</td>
</tr>
<tr>
<td>Virginia Health Care (Cigna)</td>
<td>4,150</td>
<td>Medicare</td>
<td>Pay for Performance: 68%</td>
<td>50%</td>
<td>27%</td>
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<tr>
<td>Wisconsin Health System</td>
<td>181</td>
<td>Diabetes</td>
<td>Pay for Performance: 68%</td>
<td>4%</td>
<td>24%</td>
</tr>
<tr>
<td>New Mexico Health Care</td>
<td>62,992</td>
<td>High Value</td>
<td>Pay for Performance: 68%</td>
<td>11%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Impact of Medical Homes on Quality of Care

Percent of adults reporting

<table>
<thead>
<tr>
<th>Has medical home</th>
<th>No medical home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very/somewhat difficult to get off-hours care outside the ER</td>
<td>61</td>
</tr>
<tr>
<td>Medical records not available or duplicated</td>
<td>16</td>
</tr>
<tr>
<td>Experienced medical, medication, or lab error</td>
<td>21</td>
</tr>
<tr>
<td>Doctor gives written plan for managing care at home</td>
<td>55</td>
</tr>
<tr>
<td>Receive reminder for preventive/follow-up care</td>
<td>76</td>
</tr>
</tbody>
</table>

Adults with a chronic condition

Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care. Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors.
Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

MEDICAL HOMES: PAYMENT STRUCTURES

Reimbursement is Key to Success of Medical Homes. Tried Approaches:

- Monthly Care Coordination Payments Plus Fee-For-Service Payments and Performance Based Incentive Payments
- Enhanced Fee-For-Service E&M Payments
- Creation of New CPT Codes For Medical Home Activities
- Per-Patient Per-Month Medical Home Payment in Addition to E&M Fee-For-Service Payment
- Single PMPM Payment (Risk Adjusted) For All Primary Care Services
The Current and Future Role of Medical Homes

Presented By:

Marci Nielson
Executive Director
Patient Centered Primary Care Collaborative
mnielson@pcpcc.net

The Patient-Centered Medical Home (PCMH)

- Why?
- What?
- When?
- Where?
- Who?
Health care expenditure per person by source of funding, 2007*

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket spending</th>
<th>Private spending</th>
<th>Public spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>3,307</td>
<td>2,618</td>
<td>3,326</td>
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<td>3,092</td>
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<tr>
<td>SWITZ</td>
<td>720</td>
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<tr>
<td>CAN</td>
<td>4,005</td>
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<td>589</td>
<td>2,446</td>
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<tr>
<td>GER</td>
<td>510</td>
<td>2,056</td>
<td>2,370</td>
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<tr>
<td>SWE</td>
<td>369</td>
<td>38</td>
<td>432</td>
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<tr>
<td>AUS*</td>
<td>79</td>
<td>571</td>
<td>528</td>
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<tr>
<td>UK</td>
<td>571</td>
<td>441</td>
<td>446</td>
</tr>
<tr>
<td>ITA</td>
<td>3,056</td>
<td>88</td>
<td>343</td>
</tr>
</tbody>
</table>

* 2006
*Adjusted for Differences in Cost of Living

Source: OECD Health Data 2009 (June 2009)
Cost of Health Care by Government

Revenues and Primary Spending, by Category, Under CBO’s Long-Term Budget Scenarios Through 2080

- Total Primary Spending
- Actual
- Projected
- Other Noninterest Spending
- Medicare, Medicaid, CHIP, and Exchange Subsidies
- Social Security

Source: Congressional Budget Office, “The Long Term Budget Outlook”, August 2010

Conservatively, 30% of the annual $2.5 trillion U.S. health expenditure is estimated to be waste, equating to approximately $700B each year.

Key sources of waste:

- Admin and system: 4 - 6%
- Provider inefficiencies and fraud: 3 - 4%
- Lack of care coordination: 1 - 2%
- Unwarranted: 11 - 21%
- Preventable conditions and avoidable care: 1 - 2%
- Fraud and abuse: 5 - 8%

1Thomson Reuters, 2011
Opportunity Cost for Investments

**OECD Health Data, 2009.** Life expectancy at birth in different countries versus per capita expenditures on health care in dollar terms, adjusted for purchasing power. The United States is a clear outlier on the curve, spending far more than any other country yet achieving less.

---

**Solutions point to primary care**

**Significant problems**
- Rising healthcare costs → $2.4 trillion (17% of GDP)
- Gaps/variations in quality and safety
- Poor access to PCPs
- Below-average population health
- Aging population
- Chronic disease

**... Experiments underway**
- PPACA and ARRA legislation
- Value-based reimbursement
- PCMHs
- ACOs
- EHR/HIE investment
- Disease-management pilots
- Alternative care settings
- Patient engagement
- Care coordination pilots
- Health insurance exchanges
- Top-of-license practice

**... Primary care-centric projects have proven results**

Across 300+ studies, better primary care has proven to increase quality and curtail growth of healthcare costs.
What?

AHRQ: Definition of PCMH

- Comprehensive team-based care
- Systems approach to quality and safety
- Patient-centered orientation
- Superb access to care
- Care that is coordinated
Enhancing Health and the Patient Experience

Medical home model of care that is accountable

Team-based healthcare delivery
Access to care
Population health
Patient-centered care
Patient & physician feedback
Refocused medical training
Advanced IT systems
Decision support tools

Patient is the center of the medical home

Enhancing Health and the Patient Experience

Trajectory to Value-Based Purchasing
It is a journey, not a fixed model of care

Value-Based Purchasing: Reimbursement tied to performance on value
Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination
Value/Outcome Measurement: Reporting of quality, utilization and patient satisfaction measures
Supportive Base for ACOs, PCMH Networks, and Bundled Payments

Primary Care Capacity: Patient Centered Medical Home
Information Technology Infrastructure: EHRs and Connectivity
### A Change in Paradigm

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
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</thead>
<tbody>
<tr>
<td>Treating Sickness / Episodic</td>
<td>Managing Population</td>
</tr>
<tr>
<td>Fragmented Care</td>
<td>Collaborative Care</td>
</tr>
<tr>
<td>Specialty Driven</td>
<td>Primary Care Driven</td>
</tr>
<tr>
<td>Isolated Patient Files</td>
<td>Integrated Electronic Record</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Evidence-Based Medicine</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>Shared Risk/Reward</td>
</tr>
<tr>
<td>Payment for Volume</td>
<td>Payment for Value</td>
</tr>
<tr>
<td>Adversarial Payer-Provider Relations</td>
<td>Cooperative Payer-Provider Relations</td>
</tr>
<tr>
<td>“Everyone For Themselves”</td>
<td>Joint Contracting</td>
</tr>
</tbody>
</table>

### PCMH and Accountable Care: Two Sides of the Same Coin

![Diagram showing PCMH and Accountable Care: Two Sides of the Same Coin](image)

- Hospitals
- PCMH
- Specialists
- Care Coordination
- Care Managers
- Public Health
- Shared Services
- Health IT Infrastructure
- PCMH
- PCMH
- PCMH
- PCMH
- PCMH
- PCMH
When?

Milestones in PCMH Development

1967
“Medical Home” Term
Standards Child Health Care
Council on Ped. Practice
Calvin Sia, MD

1978-79
“Medical Home” Hawaii Child Health Plan
Calvin Sia, MD

1987
Conf. Report
MH for CSHCN

1978
Alma Ata Declaration

2002
Future Family Medicine

2004
Transformed

2006
Medical Home Policy Statement
Adv. Medical Home

2007
Pilots

2008
PPC®-PCMH

1992

2010
ACA

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

NBGH Award
Shift to Accountable Care

- Some people are watching and waiting...
- Some people just putting a toe in...
- Some people diving in head-first.
- Some people are taking laps...
- Some people have taken the deep plunge.

Where?
**Group Health of Washington**

- **Reduced emergency care:**
  - 29% fewer emergency department visits & 11% fewer hospitalizations for ambulatory care-sensitive conditions (Reid et al, 2009).

- **Less staff burnout:**
  - 10% in PCMH program vs. 30% among control group that reported high emotional exhaustion (Reid et al, 2009).

- **Medication changes:**
  - 18% reduction in use of high-risk medications among elderly; 36% increase in cholesterol lowering drugs; 65% increase in use of generic statin drugs (McCarthy et al, 2009).

- **Improved patient experiences:**
  - 83% of patient calls were resolved on the first call compared to 0% pre-PCMH in one clinic (Meyer, 2010).

**Sources:**

---

**Geisinger Health System (ProvenHealth Navigator):**

- **Cost savings:**
  - Recent 2012 study found longer exposure to medical homes resulted in cost savings. Total cumulative cost savings for period of 2006 to 2010 was 7.1% with an return on investment of 1.7:1 for this patient population (Maeng et al, 2012).

- **Reduced emergency care among best practices reported in 2009:**
  - 23% reduction in hospital length of stay; 25% decrease in hospital admissions; and 53% reduction in hospital readmissions following discharge (Steelo, 2009).

- **Improved care reported in 2009:**
  - 74% improvement in quality of preventive care; 22% improvement in coronary artery care; and 35% improvement in diabetes care (Geisinger Health System, 2009).

- **Reduced health care costs reported in 2009:**
  - $3.7 million estimated net savings equaling a return on investment of 2:1 (Grumbach et al, 2009).

- **Reduced emergency care:**
  - Cumulative reductions of 18% (p < .01) for inpatient admissions and 36% (p = .02) for readmissions over the study period of 2005 through 2008. Reduction of 7% (p = .21) in cumulative total spending (Gilfillan et al, 2010).

**Sources:**

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Veterans Administration

- **Improved chronic disease care:**
  - 27% reduction in ER visits and hospitalizations among chronic disease patients and a $595 per patient cost savings (Grumbach & Grundy, 2010).

- **Reduced emergency care:**
  - Urgent care visits by patients enrolled in VHA primary care facilities decreased by 8% after rollout of the PCMH model in 2011, and there was a 4% decrease in acute admission rates to VHA facilities in 2011 (Arvantes, 2012).

Sources:

HealthPartners Medical Group (MN)

- **Reduced emergency care:**
  - 39% decrease in ER visits and 24% reduction in hospitalizations

- **Improved access:**
  - 350% reduction in appointment wait time; down from 26 days to 1 day

- **Improved care:**
  - 129% increase in optimal diabetes care; 48% increase in optimal heart disease

- **Integrating behavioral health:**
  - 20% reduction in inpatient costs due to outpatient case management program for behavioral health

Sources:
BCBS of South Carolina – Palmetto Primary Care Physicians

- Reduced emergency care:
  - 14.7% fewer inpatient hospital days per 1,000 enrollees per year; 25.9% fewer emergency department visits per 1,000 enrollees per month

- Reduced costs:
  - Total medical and pharmacy costs PMPM were 6.5% lower among PCMH patients.


Community Care of North Carolina

- Cost savings:
  - Since 2007, state savings have increased every year and have now reached nearly a billion dollars (Mahoney, 2011).

- Reduced emergency care:
  - By 2006, ER usage decreased by 23% (Steiner, 2008).

- Improved care:
  - Since initiation, program experienced a 21% increase in asthma staging and 112% increase in number of asthma patients receiving influenza inoculations (Steiner, 2008).

Source:
Cost savings:
- Decrease of 10% in per member per month costs.

Reduced emergency care:
- 26% fewer ER visits, 25% fewer hospital readmissions, and 21% fewer inpatient admissions.

Improved care:
- Preliminary data found the medical home improved diabetes control by 8%. Screenings for breast and cervical cancer also increased by 6%.

Source:

Reinventing Medicaid

Oklahoma’s patient-centered medical home initiative has reduced Medicaid costs by $29 per patient per year from 2008 to 2010. Moreover, use of evidence-based primary care, including screening for breast and cervical cancer, increased.

Vermont inpatient care use and related per-person per-month costs decreased 21% and 22%, respectively, from July 2008 to October 2010. ER use and related per-person per-month costs decreased 31% and 36%, respectively.

Colorado has seen an increase in provider participation in the CHIP program from 20% to 96%. Health care costs for children decreased by $215 per year and well-care visits for children increased from 54 to 73%.

Washington’s PCMH program’s in-state acute care spending was 18% below the national average. Inpatient stays per beneficiary were 35% below the national average.


Source:
Entering the Rollout Phase for PCMH

- **WellPoint (Jan. 27, 2012)**
  - More than a billion dollars for national rollout through increased revenue opportunities, enhanced information sharing, and by providing care management support.
- **Aetna (Feb. 2012)**
  - Launches National PCMH Program in Connecticut and New Jersey; to expand nationally during 2012.
- **Horizon BCBS of New Jersey (Feb. 2012)**
  - Invests a million dollars to train medical home care coordinators in collaboration with Duke University and Rutgers Nursing College.
- **BCBS Florida (Feb. 2012)**
  - Introduces first-of-its-kind PCMH Program to roll out statewide in 2012.

Who?
The Patient-Centered Primary Care Collaborative

- The mission of the Collaborative is to advance an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH).

- Today 1,000 members and growing; began with primary care physician associations and large employers, supported by leadership of IBM.

- Joint Principles feature prominently – AAFP, AAP, ACP, and the AOA.
Campaigning for the PCMH

Role of The Collaborative

Lead from the front

- Challenge the status quo
- Disseminate timely information
- Provide networking opportunities
Evolving Medical Home Standards

Presented By:
Mina Harkins
Assistant Vice President for Recognition Programs
NCQA
harkins@ncqa.org

A Strategy for Quality Improvement

Address these challenges
1. Eliminating harm
2. Eradicating disparities
3. Reducing disease burden
4. Removing waste

...by acting on these priorities.
1. Engage patients and families in managing health, making decisions
2. Improve the health of the population
3. Improve safety, reliability
4. Ensure patients receive coordinated care within and across organizations, settings and levels of care
5. Guarantee appropriate, compassionate care for patients with life-limiting illnesses
6. Eliminate overuse while ensuring the delivery of appropriate care

Source: National Priorities and Goals: Aligning Our Efforts to Transform America’s Healthcare, 2008
What is the Health Care System Supposed to Do?

A: Move people from right to left—and keep them there

A value-based health care system

Source: HealthPartners

Opportunities for Improvement

Current challenges confronting primary care

- Emergency room visits increased by 36% between 1996 and 2006: 47% of ED visits could have occurred in a physician’s office.
- 20% of patients are re-admitted within 30 days of hospitalization, most of which are avoidable.
- 50% of patients that are re-admitted do not see a physician after their first hospitalization.
- 75% of health care spending is for patients with chronic diseases.
- Over two years, the typical Medicare patient sees 2 different primary care doctors and 5 different specialists.
- Millions of additional Americans will enter the primary care system with healthcare reform.

Advanced primary care models like medical homes can provide the coordination mechanisms and decision support to improve quality, cost, and satisfaction.

Source: Nace, D. iHT2 Conference Proceedings. May 12, 2010
How Are We Doing?

- Medical homes have yielded promising results...
  - 29% reduction in ED visits at Group Health
  - 20% reduction in hospitalizations at Geisinger
  - Achieve 94% of diabetes patients having ≥2 primary care visits per year for NC Medicaid
  - Over $400 million saved over 4 years for NC Medicaid
  - 3.8% total cost savings in Iowa
  - 11% expected cost savings in VT
  - $640/year saved per patient for the community at Intermountain

- ... and are being widely adopted across the country

45 states are involved in medical home pilot activity


Published and Ongoing Research on PCMH

- Key features of successful medical home pilots:
  - Use of non-physician care coordinators
  - Expanded access to health practitioners
  - Data-driven analytic tools
  - Use of payment to incentivize change (Fields, Leshen, Patel, 2010)

- Access to care through visits outside of regular hours and same day access shown to reduce emergency department use (Bodenheimer and Pham, 2010)

- A PCMH in integrated group practice showed significant improvements in patients’ and providers’ experiences in the quality of clinical care (Reid 2009).

- Clinical systems are associated with decreased use of inpatient and emergency care but not ambulatory care utilization in diabetes (Flottemesch, under review)
NCQA PCMH Recognition

- NCQA has the most widely-adopted evaluation model
- States/health plans/practices can get on board with a system that has a strong track record, Federal initiatives are expanding to military and FQHCs
- 4220 sites recognized, over 20,000 clinicians
- NCQA provides goals and guidelines for practice transformation based on evidence
  - Practices decide how best to reach goals based on their size, location, area conditions
- Gives clinicians a roadmap to improve quality with a systematic approach to preventive and chronic care delivery
- Focuses on evidence-based requirements to improve quality and reduce costs

Federal Initiatives with NCQA’s PCMH

- **HRSA Patient-Centered Medical Health Home Initiative**
  - Focus on Community Health Centers - serve rural, underserved, often nurse-led practices
  - Covers Recognition costs and technical assistance
  - Up to 500 Community Health Centers per year; 5 year contract

- **CMS Advanced Primary Care Practice Demonstration**
  - Federally Qualified Health Centers (FQHCs)
  - 500 FQHCs in 3-year
  - Track progress toward being a Medical Home
  - CMS reimburses for managing Medicare beneficiaries

- **Military Health System - Military Treatment Facilities (MTF)**
  - Initially a PCMH self-assessment initially; then Recognition
  - 50 per year over 3 years
  - Includes: Internal Medicine, Family Practice, Pediatrics
Theoretical Frameworks
Informing Development

Chronic Care Model
- Clinical information Systems
- Decision Support
- Patient Self-Management
- Delivery System Redesign
- Community Linkages
- Health Systems

Patient Centered Care
- Respect Patient Values
- Accessible
- Family-Centered
- Continuous
- Coordinated
- Community Linkages
- Compassionate
- Culturally Appropriate
- Emotional Support
- Information and Education
- Physical Comfort
- Quality Improvement

Cultural Competence
- Culturally competent interactions
- Language services
- Reducing disparities

Medical Home
- Personal physician
- Physician directed team
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety
- Enhanced access

NCQA PCMH 2011 Evolution
- Enhances patient-centeredness
- Emphasizes language, culturally sensitive aspects
- Integrates behaviors affecting health, substance abuse, mental health and risk factor assessment and management
- Enhances applicability to pediatric practices
- Aligns with CMS Meaningful Use requirements
- Emphasizes relationship with expectations of subspecialists
- Enhances evaluation of patient experience
- Underscores the importance of system cost-savings
- Enhances use of clinical performance measure results
PCMH 2011 Key Components

- **Access**
  - Evening/weekend hours, agreement with facility for after-hours care

- **Coordination of care**
  - Information to/from specialists/facilities/patient, update care plan

- **Team-based care**
  - Defined roles and responsibilities, training, communication

- **Role of medical home**
  - Discuss roles/expectations for medical home, patients, primary clinician

- **Care management**
  - Pre-, post-visit planning, care planning during visit, patient self-care
  - Medication management
  - Include mental health/substance abuse/behaviors affecting health

- **Community resources/referrals**

- **Identify/address population needs/risks**

- **Quality improvement**
  - Ongoing performance measurement and improvement
  - Patient experience

---

**Distinction in Patient Experience Reporting**

**Purpose:** Acknowledge practices that put in the extra effort to collect and report patient experience information in a standardized way

- Provides PCMH Recognized practices with **Distinction**
- Requires the **CAHPS Patient-Centered Medical Home (PCMH)** survey which assesses:
  - Access
  - Communication
  - Coordination
  - Whole person care/self-care management support
  - Shared decision-making
- Requires a **standardized sampling** approach
- Requires use of **approved data collection** methodologies
### PCMH 2011 Alignment with HIT Meaningful Use Requirements

- **E-prescribing** – medication list, allergies
- **Patient tracking/registry** – demographics, diagnoses, vital signs, smoking, population management, insurance
- **Care management** – reminders for follow-up care, decision support, RX reconciliation
- **Electronic capability** – e-health info. to patient, visit summary, e-access to health information, provider information exchange
- **Performance reporting/improvement**

---

### 2011 PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Enhance Access and Continuity</th>
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<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
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<tr>
<td>B. After-Hours Access</td>
<td>4</td>
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<tr>
<td>C. Electronic Access</td>
<td>2</td>
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<tr>
<td>D. Continuity</td>
<td>2</td>
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<tr>
<td>E. Medical Home Responsibilities</td>
<td>2</td>
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<tr>
<td>F. Culturally and Linguistically Appropriate Services</td>
<td>2</td>
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<tr>
<td>G. Practice Team</td>
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<tr>
<td>A. Patient Information</td>
<td>3</td>
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<tr>
<td>B. Clinical Data</td>
<td>4</td>
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<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
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<tr>
<td>D. Use Data for Population Management**</td>
<td>5</td>
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<td>A. Implement Evidence-Based Guidelines</td>
<td>4</td>
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<tr>
<td>B. Identify High-Risk Patients</td>
<td>3</td>
</tr>
<tr>
<td>C. Care Management**</td>
<td>4</td>
</tr>
<tr>
<td>D. Medication Management</td>
<td>3</td>
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<tr>
<td>E. Use Electronic Prescribing</td>
<td>3</td>
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<th>Standard 4: Provide Self-Care Support and Community Resources</th>
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<td>A. Support Self-Care Process**</td>
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</tr>
<tr>
<td>B. Provide Referrals to Community Resources</td>
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</table>

<table>
<thead>
<tr>
<th>Standard 5: Track and Coordinate Care</th>
<th>Pts</th>
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<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 with Facilities/Care Transitions</td>
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<table>
<thead>
<tr>
<th>Standard 6: Measure and Improve Performance</th>
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<tr>
<td>A. Measure Performance</td>
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<tr>
<td>B. Measure Patient/Family Experience</td>
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</tr>
<tr>
<td>C. Implement Continuously Quality Improvement**</td>
<td>4</td>
</tr>
<tr>
<td>D. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
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<tr>
<td>E. Report Performance</td>
<td>3</td>
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<tr>
<td>F. Report Data Externally</td>
<td>2</td>
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<tr>
<td>G. Use of Certified EHR Technology</td>
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</tr>
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</table>

**Must Pass Elements**

---

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NCQA PCMH Scoring

6 standards = 100 points
6 Must Pass elements

NOTE: Must Pass elements require a ≥ 50% performance level to pass

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
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</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>85 - 100</td>
<td>6 of 6</td>
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<tr>
<td>Level 2</td>
<td>60 - 84</td>
<td>6 of 6</td>
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<tr>
<td>Level 1</td>
<td>35 - 59</td>
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<tr>
<td>Not Recognized</td>
<td>0 - 34</td>
<td>&lt; 6</td>
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</table>

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

Must Pass Elements

Rationale for Must Pass Elements
- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes “Recognition”

Must Pass Elements
- 1A: Access During Office Hours
- 2D: Use Data for Population Management
- 3C: Manage Care
- 4A: Self-Care Process
- 5B: Referral Tracking and Follow-Up
- 6C: Implement Continuous Quality Improvement
Why Does the NCQA’s Medical Home Program Succeed?

1. It’s practical. Provides a plan for practice transformation, a definition of what is best about primary care
2. It’s evidence based. Built on solid research
3. It’s collaborative. Improves team-based interactions
4. It’s flexible. Applicable to a spectrum of practices (basic to complex, small to large)
5. It addresses/solves a problem. Common solution for states, health plans and practices

Factors that Affect Patient-Centered Care

- **Health Information Technology**
  - Electronic systems facilitate patient-centered systems, care coordination, quality measurement
- **Patient Populations/Practice Organizations**
  - Disadvantaged populations require more extensive care management resources, more intensive self-management efforts and more coordinated community resources
- **Team Culture**
  - Strong team commitment facilitates quality improvement, communication internally and coordination externally
- **Barriers**
  - Lack of training for staff and clinicians
  - Lack of coordination with other facilities
  - Lack of reimbursement/resources, time for education/follow up
The PCMH model cannot achieve its goal of improved care coordination/integration without effective collaboration with the other physicians, healthcare professionals and healthcare entities providing care to their patients – the medical home neighborhood.

“Effective care coordination … requires not only full access to all the necessary clinical information obtained at multiple sites, but also a willingness by all the physicians involved in a patient’s care to participate in collaborative decision making … There are (currently) no incentives for other physicians or hospitals to share information, improve coordination, or support shared decision making for patients who are in the medical home.”


The typical PCP has 229 other physicians working in 117 practices with which care must be coordinated. (Pham et. al., Ann Int Med. 2009)

In the Medicare population, the average beneficiary sees seven different physicians and fills upwards of 20 prescriptions per year. (Partnership for Solutions, Johns Hopkins Univ. 2002)

Among the elderly, on average two referrals are made per person per year. (Shea et al. Health Service Research, 1999)

In the nonelderly population, about one in three patients each year is referred to a specialist. (Forrest, Majeed, et al. BMJ 2002)

Visits to specialists constitute more than half of outpatient physician visits in the United States. (Machlin and Carper, AHRQ. 2007)
A 2020 Vision of Patient-Centered Primary Care

- Superb access to care
- Patient engagement in care
- Clinical information systems that support high-quality care, practice-based learning, and quality improvement
- Care coordination
- Integrated and comprehensive team care
- Routine feedback to clinicians
- Publically available information
  (Davis, et al, 2005)

Paths to Reforming the Delivery System

- Improving quality, cost, patient experience
- ACOs
  - Assumes organizational accountability for cost, quality
  - Base is PCMH
- Incremental steps toward integration
  - Patient-Centered Medical Home
  - Accountable care partner (medical home neighbor)
  - Patient experience assessment
  - Looser version of ACO (perhaps Accountable Care without the Organization)
The Primary Care Perspective on Medical Homes

Presented By:
Dr. Leonard Fromer
Executive Medical Director
Group Practice Forum
LenF@thejcompany.com

How do you start to fix the foundational issue around why our healthcare system is so expensive and yet so broken??

Average health spend per capita ($US PPP)

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

Your patient's journey.....
What does success look like tomorrow:

- The healthcare team has updated information on recent patient/provider encounters
- The healthcare team has the most recent (even hours old) imaging studies
- The healthcare team has the most recent lab data
- The healthcare team and patient actually have accurate medication lists
- The healthcare team and Patient know who is responsible for coordinating the patient’s care
- The healthcare team can manage and coordinate a patient’s care without face to face contact
- Technology is utilized to capacity
- The healthcare provider actually knows which specialists were most effective and efficient

The “Medical Village”

- Collaborative Care
- Coordinated Care
- Shared Responsibilities
- Community Resources
- Team Care in and outside the practice
- Interoperable Technology
- Shared vision/alignment
- Education
A Medical Home for All

Access to Care & Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits
Practice-Based Services

- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies
Care Coordination

- Community-based services
- Collaborative relationships
  - Emergency room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care transition

Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options
Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal
Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Great Outcomes

- Quality Built In
- Patient Service
- Practice Management
- Health IT
- Primary Care
Benefits of a Team Based Approach:

- Reduce Inappropriate Medications and Medication Errors
- Improve Patient Engagement & Provider Care Coordination
- Reduce Unnecessary or Redundant Testing
- Leverage Community Resources
- Improve Patient Experience
- Reduce Referrals
- Increase Adherence
- Improve Quality
- Manage “Transitions” in Care
- Improve Provider Care Coordination
Team Members

- **Medical Director/Provider** (Team Leader)
- **Medical Assistant** (preventative medicine standing orders—labs, mammograms, colonoscopies; data form completion)
- **Clinical Pharmacist** (reviews protocols, runs lipid, Coumadin, pain, and smoking-cessation clinics)
- **Nurse** (provides self-management support)
- **Clinical Psychologist** (runs anxiety clinic)
- **Registry Specialist** (data entry, population-based queries)
- **Office Manager** (initiates queries as requested by provider)
- **Social Worker** (helps patients without insurance identified at free clinics)
- **Clinical Pharmacist** (reviews protocols, runs lipid, Coumadin, pain, and smoking-cessation clinics)

Community–Part of the Team Approach

- **Community**
  - A Collaborative Care Model for Change
    - Health Systems
      - Self-Management Support
      - Delivery System Design
      - Decision Support
      - Clinical Information Systems
  - Informed, Activated Patient
  - Prepared, Proactive Practice Team
  - Functional and Clinical Outcomes

As the numbers of people involved in a communication increases, so does the complexity of the communications and the potential for misunderstanding:

Chaos is Part of the Process
PCP-Consultant Agreements

- Incentives may be aligned with what specialist spends not actual referral – some insurers are providing such data
- Patient is seen in a timely manner
- Information is received in a timely manner
- Testing and procedures are discussed before ordered
- Further referrals are coordinated through the PCP
- Medication changes are reviewed and discussed
- ***Include hospitalists***

Technology Solutions

- Practice portals
- Patient portals
- Patient personal health record
- Interoperability
- Secure provide e-mail and messaging capabilities
- Electronic health record
Payment Methodologies

- Enhanced fee for service
- Care management fees
- Capitated, no risk models
- Shared savings
- Targeted incentives for quality and efficiency
- Global or bundled payments
- Accountable care organizations
- HIT stimulus incentives

Clinical Integration

- Prevention and Wellness
- Chronic Diseases
- Population Management
- Care Teams
- Your Patients

The Patient Journey
Chronic Care Model (CCM)

Health System
- Clinical Information Systems
- Decision Support
- Delivery System Design
- Self-Management Support

Resources & Policies

Community

Informed, Activated Patient

Prepared, Proactive Practice Team

Productive Interactions

Improved Outcomes

Patient Journey Creates a Map of the Patient Experience through the Healthcare System

My Practice — New Considerations:

Diagnosis
- Patient Encounter
  - Patient Identification
  - Medical History
  - Physical Examination

6-Month Follow-Up Visit
- Patient Encounter
  - Patient Identification
  - Medical History
  - Physical Examination

3-Year Follow-Up Visit
- Patient Encounter
  - Patient Identification
  - Medical History
  - Physical Examination

Coordinated care team
- Patient empowerment
- Health literacy
- Patient population management
- Electronic medical records

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Value

- Quality / Cost
  - Maximize the numerator
  - Decrease the denominator
Building a Complimentary Special Medical Home

Presented By:
Dr. John Sprandio
Chief of Medical Oncology and Hematology
Delaware County Memorial Hospital
jsprandio@mainlineoncology.com
[insert slides]
Today’s Agenda

- Rationale for Specialty Transformation to PCMH
- Practice Background (CMOH)
- Oncology Patient Centered Medical Home (OPCMH)
- American College of Physicians PCMH-Neighbor
- Building a Medical Neighborhood
  - Horizontal & Vertical integration of OPCMH model
  - Coordination of Care Agreements
- Oncology Management Services

Rationale for Specialty Practice Transformation

Era of Health Care Reform

- **Value** will win the day (Quality/Cost)
- High Reliability Organizations
  - Incorporation of High Reliability Principles
  - Prepare for Value-based contracting
  - Data transparency, accountability, rapid learning
- **Reduction of unnecessary** resource utilization
  - Failures of **delivery**
  - Failures of **coordination**
  - Failures of **overtreatment**
CMOH: 2003 – 2011
Clinical Integration

- Re-engineer processes of care - IT infrastructure/support
- Streamline and standardize care
- Minimize clinically irrelevant physician activity
- Maintain a patient-centric approach
- Fix accountability at the patient-physician locus
- Communication, coordination, access, engagement
- Documentation of Value
  - Superior quality of care and lower cost
- Needed Credentials

CMOH: First Hematology Oncology Practice
Recognized by NCQA as a Level III Medical Home

- NCQA PPC-PCMH™ Level III recognition 4/15/10
- Coordination of all hematology & oncology services
  - From diagnostic, surgical, radiation, chemotherapy, through survivorship or End-of-Life phase of care
  - Primary care team remains engaged addressing non-oncologic medical issues
Oncology Patient-Centered Medical Home®

OPCMH™ Criteria

- Ownership of cancer care needs
- Focus on education, engagement, compliance
- Use of standardized Plans of Care (guidelines)
- Facilitate of an interdisciplinary approach
- Provide appropriate self-management
- Real-time physician/practice reporting
  - ER & admissions PCPPY, document turnaround
  - Screening, treatment & Survivorship guidelines, EOLC
- Auto-dissemination of information
- Coordinate management of high-risk populations
Sources of OPCMH™ Quality Parameters

- ASCO - QOPI standards
- NCCN Guidelines
- American College of Surgeons, NQF
- CMS - PQRS, e-Rx
- NCQA – PPC-PCMH™
- OPCMH™ – services
- Institute of Medicine
  - 1999 Ensuring Quality Cancer Care
  - 2001 Improving Palliative Care for Cancer
  - 2006 From Cancer Patient to Cancer Survivor: Lost in Transition
  - 2009 Assessing & Improving Value in Cancer Care

Oncology Patient-Centered Medical Home®

Care coordination and delivery model that:
- Facilitates physician accountability
- Encourages Clinical Integration
- Enhances coordination with primary care PCMH
- Focus on patient needs and evidence based care
- Framework for a new Value Proposition
- Promotes collaboration with payers
OPCMHTM
Service and Operations

Physician Led Care-Team
- Patient Engagement/Orientation
- Financial Navigation
- Nurse Practitioners
- Physicians
- Patient Navigators
- Chemotherapy Nurses

Mutually Reinforcing Care Team Approach
- Collaboration - clinical support/treatment team
- Adherence - evidence based guidelines
- Prevention - complications of disease/therapy
- Access to care – clinical calls, unscheduled visits
- Patient Education = Active patient engagement
  - Medication, evaluation & treatment compliance
  - Proactive reporting of symptoms, early treatment of complications of disease and therapy
  - Promotion of patient directed goals of therapy
Merger of Operational and Clinical Decisions

Processes of Care
- Standardized patient assessment
- CDSS – data presentation/documentation
- Prompt communication
- Patient navigation/tracking
- Telephone triage/Patient portals

Disease Management
- Reduce unnecessary resource utilization
- Palliative Care Coordination
- On-Demand access

OPCMH™
Quality Parameters

- **Process Measurement:**
  - Adherence to EB treatment guidelines
  - Performance Status documentation
  - Medication Reconciliation
  - Palliative Care/Symptom management
  - Disease management standards
  - Communication/Coordination
  - End of life care/Shared decision making
  - Outcomes/Relative dose intensity
  - Utilization of Disease/High-Risk registry
OPCMHTM
Outcome Measures

- **Patient Experience**
  - AHRQ CAHPS: Consumer Assessment of Healthcare Providers and Systems

- **Utilization**
  - Chemotherapy guideline adherence
  - Emergency room evaluations
  - Hospital admissions/length of stay
  - Outpatient visit reduction
  - End of Life Care parameters
  - Diagnostics: imaging/laboratory

Outcomes of Clinical Phone Calls to the Nurse Triage Line from 2006 to 2010 (n=13,881)

- Manage Symptom(s) at home: 75.98%
- Go to nearest ER: 5.54%
- Direct Admission: 0.14%
- Office visit today: 5.74%
- Chemo Suite Intervention: 0.69%
- Office visit tomorrow: 4.49%
- Referred to Primary/Specialist: 5.92%
- Sent for Radiographic Study: 1%
- Refer to patient at home: 4.49%
Average emergency room (ER) Evaluations per chemotherapy patient per year (APCPPY) for the CMOH patient population, 2004-2011.

USON/Milliman: Approximately 2 emergency room visits per chemotherapy patient per year (n=14 million commercially insured; 104,473 cancer patients)

Average Admissions per Chemotherapy Patient Per Year (APCPPY) for CMOH patient population, 2007-2011

USON/Milliman: Approximately 1 hospital admission per chemotherapy patient per year (n=14 million commercially insured; 104,473 cancer patients)
OPCMH™ End of Life Care

Preliminary Data

- Hospice Average Length of Stay:
  - 2009: 26 days
  - 2010: 32 days
  - 2011: 35 days

  \{34\% increase\}

- Place at time of death: 70\% home 2010
  74\% home 2011

- ER visits & hospital admissions last 30 days of life:
  - 2010: 39.3\% practice Admissions
  - 2011: 36.4\% practice Admissions
  - 2010: 23.8\% practice ER visits
  - 2011: 20.1\% practice ER visits

OPCMH™ End-of-Life Care

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Dartmouth</th>
<th>OPCMH™</th>
<th>QOPI</th>
<th>Measure</th>
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<tr>
<td>Death in hospital %</td>
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<td>ICU admissions, last 30 days, %</td>
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<td>Hospice days, last 30 days</td>
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<td>Hospice within 7 days of death, %</td>
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<td>Hospice enrollment, %</td>
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<td>ACP discussion with metastatic disease</td>
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<td>Advanced care plan documented, %</td>
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<td>Practice</td>
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<td>ECOG performance status documented at each visit</td>
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<td>X</td>
<td>Practice</td>
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</tbody>
</table>
OPCMH™

Impact on Cost of Cancer Care

- Projected % Reduction in Cancer Care Cost
  - 1-3 %  Chemotherapy pathways program
  - 4-6.3 %  Inpatient hospitalizations (5-25% reduction)
  - .6-1.1 %  ER evaluations (20-40%)
  - .1-.4 %  Diagnostics
  - .9-1.9 %  End-of-life care coordination

- Total  6.6 – 12.7 % reduction
- Annual cancer “spend” $125B = $8-16B savings

Adapted from international consultants evaluation of OPCMH™ application to cancer care

Building a Medical Neighborhood

Horizontal and Vertical Integration
Coordination of Care Agreements
What is a Medical Neighborhood?

Policy Paper, ACP Council of Subspecialty Societies (CSS)

- Addressed relationship between primary care PCMH model and specialty/subspecialty practices
- Published October 2010
- Highlights:
  - Established definition of Patient Centered Medical Home Neighbor
  - Approved a framework to categorize interactions between PCMH and PCMH - N
  - Approved guiding principles of the development of care coordination agreements between PCMH and PCMH - N

Neil Kirschner, Ph.D.
American College of Physicians, Senior Associate
Regulatory and Insurer Affairs

Oncology Patient Centered Medical Home®_t Horizontal Integration
Replication of Model

- Initial Practice Assessment & OPCMH® “Gap Analysis”
- Common processes of care and disease management
- Standardized data points within shared/separate EMR
- Measure potentially avoidable complications
- Changing delivery of care based on actionable outcomes data meets FTC criteria for Clinical Integration
- Develop regional Clinically Integrated Network (CIN)
Incentives Driving OPCMH™
Phases of Construction

1. Laying the foundation
   - Workflow analysis, IT assessment, policy & procedure, job descriptions, baseline data
   - FFS + prior authorization relief

2. Introduction of new services
   - Access, telephone triage, care coordination, communication, manage transitions, portals
   - Phase I enhancements + case management fee

3. Optimization of performance
   - Phase II enhancements + gain sharing model


OPCMH™: Vertical Integration
ACO, Primary PCMH, Health System CIN

- Transparency of data, enhancing management of:
  - Initial hematology/oncology consultation
  - Symptoms - establishment of “point of first triage”
  - Potentially Avoidable Complications
  - Process of care = Case Management
  - Diagnostic studies - Laboratory and radiographic
  - Transitions of care: acute – non-acute setting
  - Survivorship phase of care
  - High risk populations – screening, genetic evaluation
  - End of Life care
- Formal Coordination-of-Care agreement
  - PCMH - OPCMH
Coordination of Care Agreements

- **Discussion of referral & expectations:**
  - Pre-consultation exchange
  - Care Management Agreement
    - Management with Principal care
      - Defined or extended period
  - Initial Consultation
    - Standardized patient orientation and delineation of patient responsibilities
    - Comprehensive care planning & execution

Coordination of Care Agreements (continued)

- Commencement of treatment
  - Monitoring of co-morbid conditions
  - Prevention of potentially avoidable complications
- Oncology practice as point of first triage
  - Re-direction of symptom related calls
- Consistent, standardized communication
  - Documentation turn-around monitored
- Scheduling (and follow through) of diagnostic testing and referral to primary care, specialists
Coordination of Care Agreements (continued)

- ER and hospital admission tracking
- Standardized End of Life Care program
  - Based on Performance Status
- Survivorship Care Planning
  - “Hand off” agreements to primary PCMH
- Identification of high risk populations
  - Directed screening, genetic consultation

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Specialty PCMH Value Proposition

- OPCMH – clinical & business methodologies
  - Achieves practice/patient care efficiencies
  - Community or hospital based practices
- OPCMH - organizational construct
  - Oncology “plug-in” to PCMH as a PCMH-N
  - Establishes care management accountability
  - Communications that bridge specialists and PCMH
- OPCMH – as PCMH bridge
  - Aligns oncologists for ACO, Clinical Integration, etc
  - Establishes a platform for pricing oncology bundled or episode of care payment

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**Goal 2012: Expand & Verify OPCMH**
- Engage
  - Centers for Medicare & Medicaid Innovation
  - National & Local Payers
  - Regional Oncology practices (CIN)

**Goal 2012: Refine & Modify OPCMH**
- Collaborate
  - Primary Care PCMH, Payers, Health Systems
  - Pioneer ACO
    - Renaissance Medical Management Company
  - NCQA, ASCO, COA, ACCC

**OMS provides**
- OPCMH™ Practice Educational programs
- Practice Assessment & Gap Analysis
- Work-flow and Process of Care Analysis
- “Tool-kit” customization for practice
- IT consultation for creation of or adoption of (IRIS™)CDSS tool or other enabling software support
- Guidance of practice through training/transformation

**OMS/practices/payer establish & monitor results**
- Share benchmarking, manage information exchange
- Rapid Learning cycle & continuous improvement
Questions?

For more information on OPCMH™ educational sessions, readiness assessments, implementation, and payer contracting strategies contact

info@opcmh.com
About Humana

- 2011 revenues of $36.8 billion; total assets of approximately $17.7 billion
- Leading health care company that offers a wide range of insurance products and health and wellness services; founded in 1961; headquartered in Louisville, KY
- Over 25 years of experience in the Medicare program
- One of the nation’s top providers of Medicare Advantage benefits with approximately 1.9 million members
- Approximately 11.2 million medical members nationwide
- Approximately 7.3 million members in specialty products
- Operates more than 300 medical centers and 240 worksite medical facilities

Humana and Medical Home

1. Humana is supporting Medical Home arrangements in FL, OH, CO, IL, MI, KY, TX, TN, SD

2. These Medical Homes cover over 95,000 Commercial and Medicare Members and over 100 physician practices

3. Humana also participated in PCMH multipayer collaboratives in Ohio and Colorado

4. Humana is also proud to support the Patient Centered Primary care Collaborative (PCPCC) founded by Dr. Paul Grundy.
Roles and Resources: Defining Capabilities and experience in building the Medical Home

<table>
<thead>
<tr>
<th>Elements Description</th>
<th>Capabilities</th>
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<tbody>
<tr>
<td>Membership Attribution</td>
<td>Humana</td>
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<tr>
<td>Define population</td>
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<tr>
<td>Identification of Key quality and utilization indicators</td>
<td>Humana/Provider</td>
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<tr>
<td>Measure performance and improved efficiency</td>
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<tr>
<td>Daily Hospital Census Reporting</td>
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<td>Cost analytics</td>
<td>Humana</td>
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<tr>
<td>Cost information for trend analysis</td>
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</tr>
<tr>
<td>Infrastructure to support Clinical Re-engineering</td>
<td>Humana/Provider</td>
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<tr>
<td>Clinical support</td>
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<tr>
<td>Disease management Support</td>
<td></td>
</tr>
</tbody>
</table>

Sample Pilot Results – Atlanta

Hemoglobin A1c Management

Blood Pressure Management

Baseline data from chart review from patient visits between January 2007 and March 2008

Current data from chart review from patient visits between March 2008 and February 2011
Sample Pilot Results - Cincinnati

<table>
<thead>
<tr>
<th>Metric</th>
<th>12/1/08-3/31/11 Physician Group</th>
<th>12/1/08-3/31/11 Control Group</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits/1000</td>
<td>↓ 34%</td>
<td>↓ 14%</td>
<td>Emergency room trend better by 20%</td>
</tr>
<tr>
<td>Pharmacy Expense</td>
<td>↑ 3.8%</td>
<td>↑ 1.9%</td>
<td>Expected</td>
</tr>
<tr>
<td>Diagnostic Imaging Expense</td>
<td>↓ 1.1%</td>
<td>↑ 49.3%</td>
<td>Trend reduced 50%</td>
</tr>
</tbody>
</table>

Humana Medical Home EHR Rewards Program

- Humana supports both the Medical Home concept and advancing the national goal of adoption of electronic medical records for physician practice.
- Through our partnership with strategic EHR vendors, Humana helps
  - Subsidize the implementation or upgrade cost for selected primary care practices in alignment with the HITECH Act
  - Practices implement physician engagement programs to maximize financial incentives that promote quality, prevention and improved outcomes while encouraging efficiency and lower overall costs

- Structured clinical data exchange
- Clinical decision support at point of care

Support for Health Information Technology Infrastructure
Questions?

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