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The Medical Home: Disruptive Innovation for a New Primary Care Model

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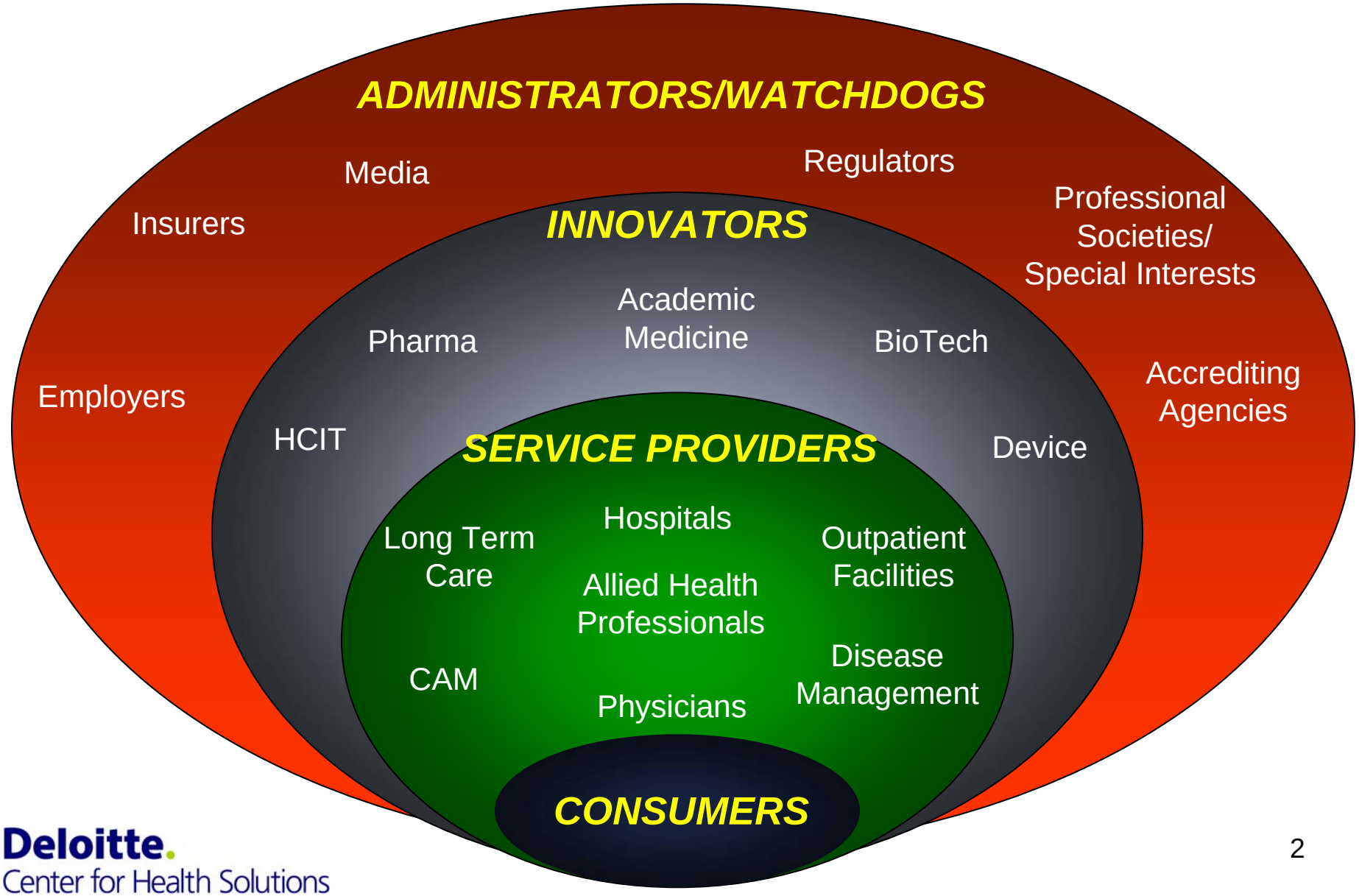
Framework: Four major roles in developed systems



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Disruptive innovation: better, cheaper

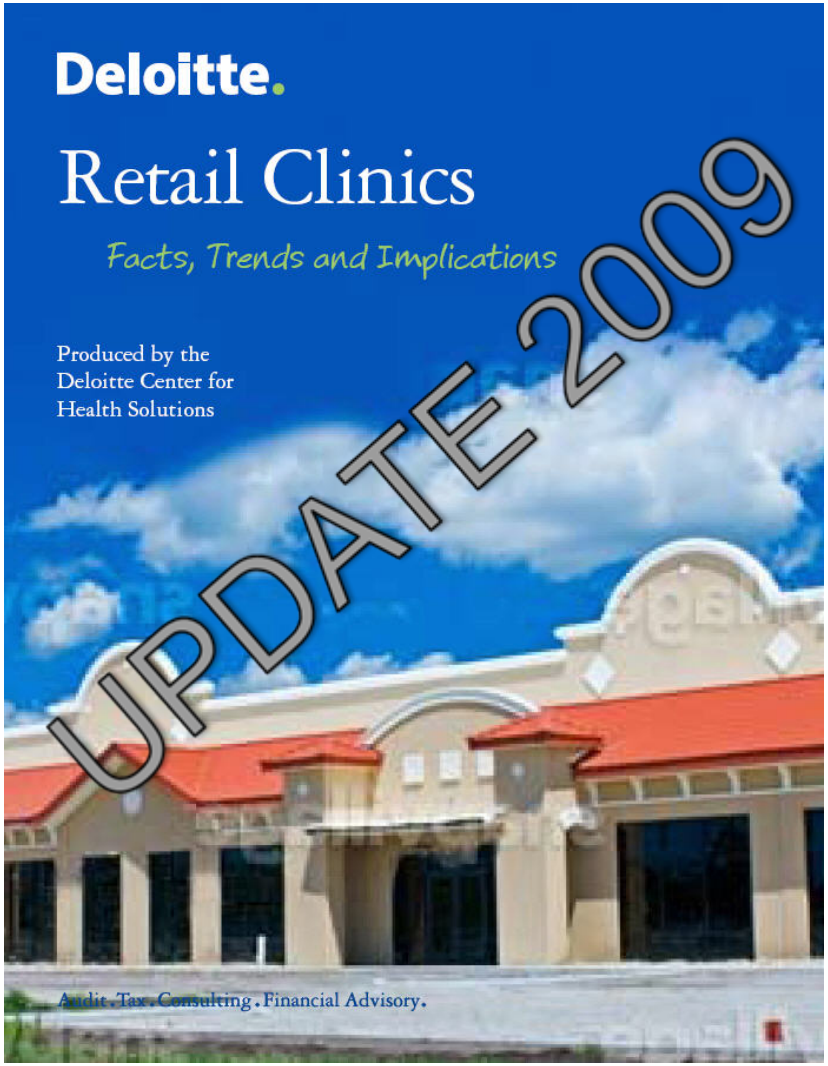
According to Clayton Christensen, Harvard Business Professor and author of *The Innovator's Dilemma and The Innovator's Solution*, a **disruptive innovation is a technology, process, or business model that brings to a market a much more affordable product or service that is much simpler to use. It enables more consumers in that market to afford and/or have the skill to use the product or service. The change caused by such an innovation is so big that it eventually replaces, or disrupts, the established approach to providing that product or service.**

Health care exists along a spectrum: from judgment/specialist-based medicine to a simpler rules-based medicine. Most health care today is concentrated at the specialist end of the spectrum**, creating a situation that not only excludes many who need the care but also resists any downward pressure on costs. "The opportunity for change lies in the simplicity and diagnostic power of rules-based medicine"**

Providing solutions patients want and see as better alternatives is the driver for disruption to occur.

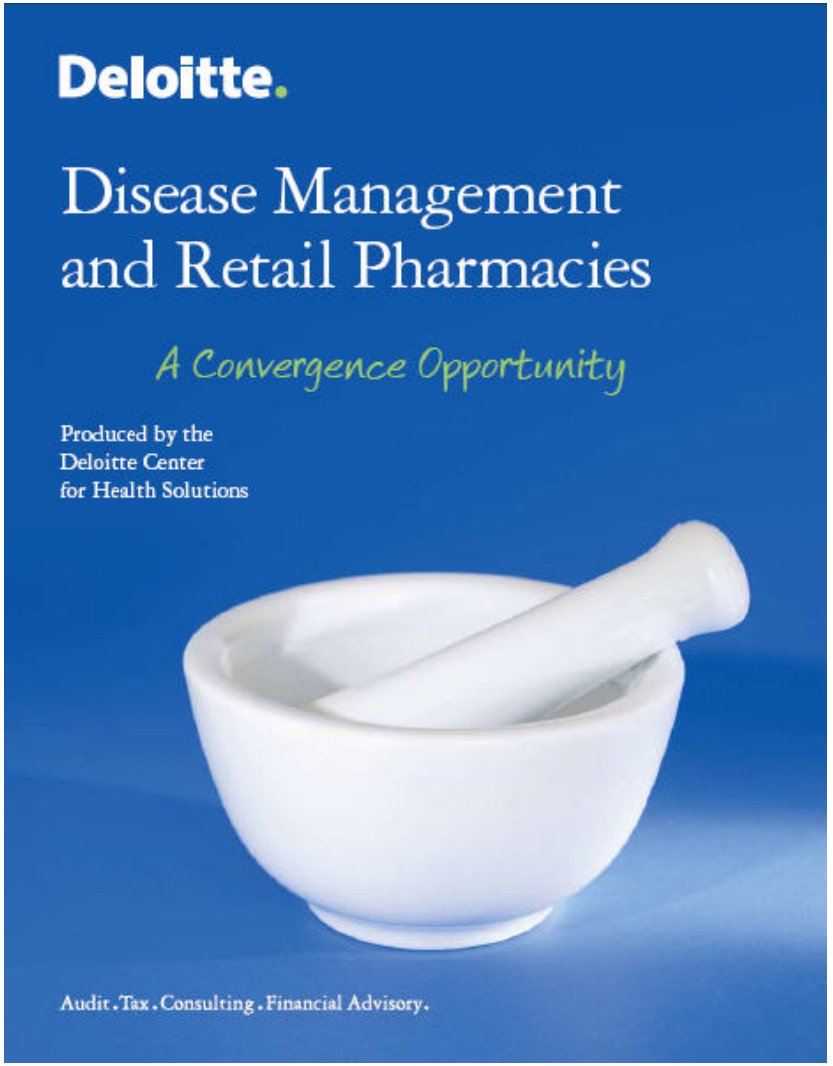
Retail Medicine

- 1,300 operating 12/08, increasing to 5,000 by 2011
- Strong consumer satisfaction: driven by convenience (not substitutionary care)
- Unique business model: incremental revenues from front store sales, et al
- Sticky issues:
  - —Scope of practice constraints
  - —Competition & program scalability



Disease Management and Retail Pharmacies: A Convergence Opportunity

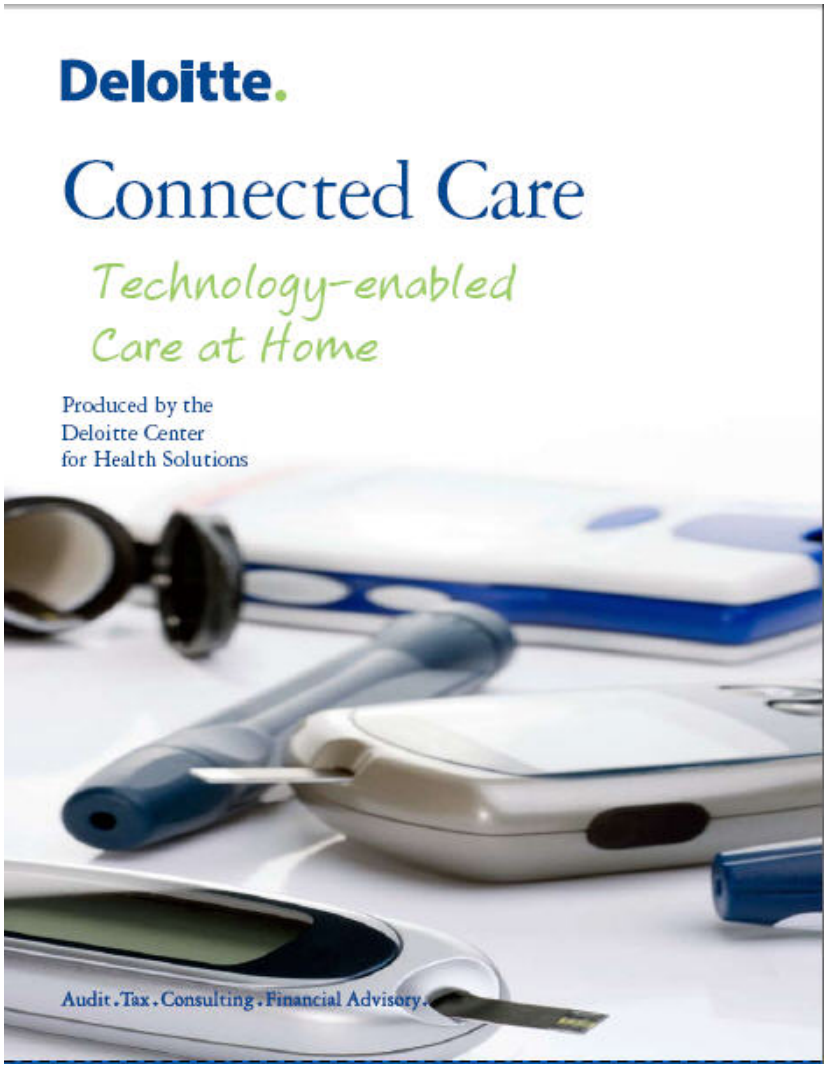
- 13,400 retail pharmacies with capacity for patient engagement
- Medication management and self-care coordination key focus of cost containment with strong consumer and payer support
- Potential to enter population-based care management sector (esp in tandem with primary care clinics)
- Sticky issues:
  - –Regulation
  - –Liability



Released July 2008

Connected Care: Technology-enabled Care at Home

- Use of technology for diagnostics and monitoring
- Two targeted applications: chronic patients in established treatment programs, post-acute coordination
- Strong support across all consumer segments & payers
- Sticky issues:
  - –Liability
  - –Privacy
  - –Payments



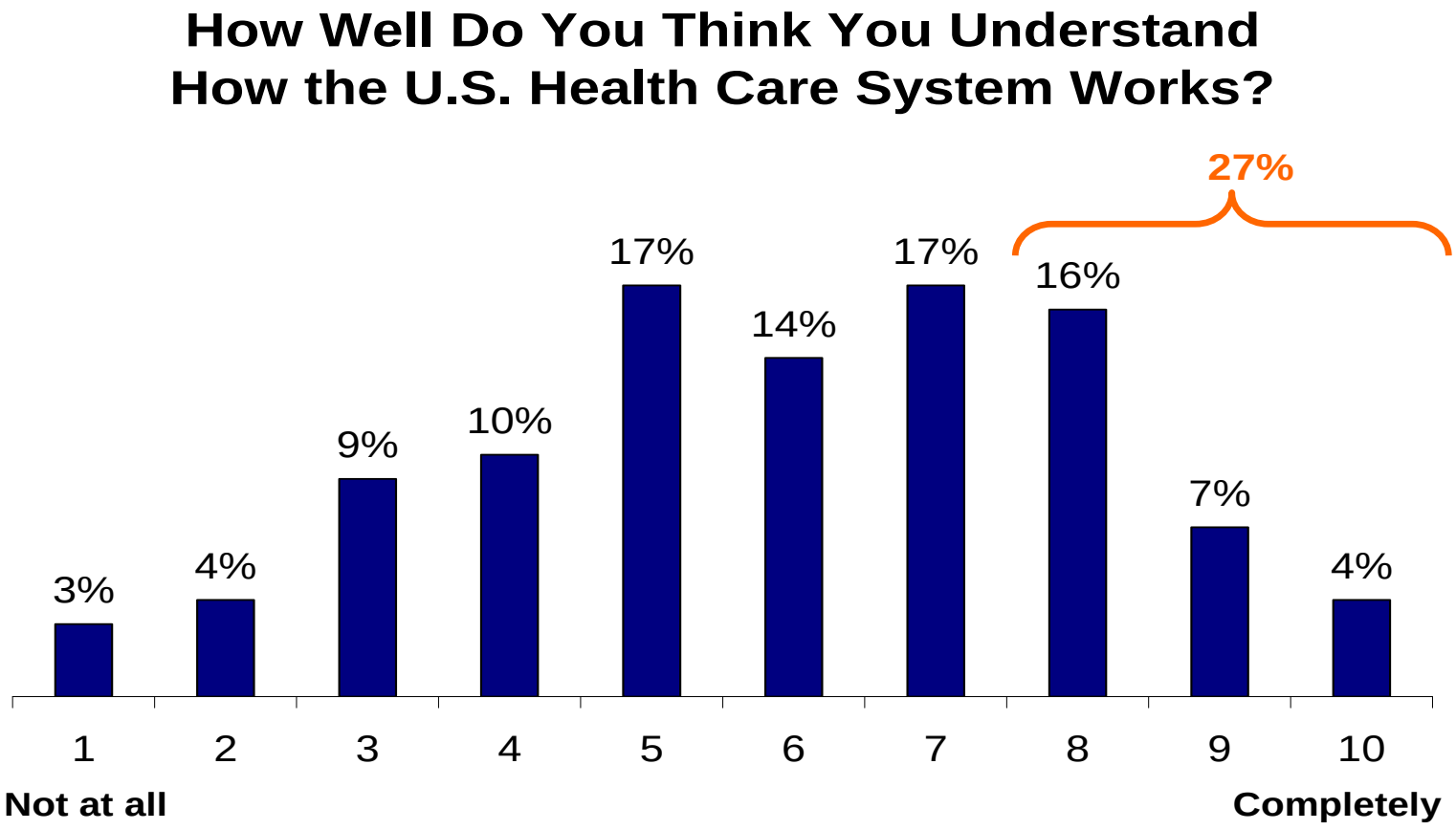
Released March 2008

2009 Survey of Health Care Consumers

- Six distinct segments of consumer market: 53% lean “traditional, 19% prefer innovations, 28% don’t engage
- Strong support for transparency (price and quality), use of technology by providers, and “universal care”
- Use of alternative providers, disruptive innovative channels growing and significant
- “Trusted source” up for grabs
- Sticky issues:
  - —Lack of knowledge
  - —Lack of consensus re: reform

The public view: “The system is confusing…”

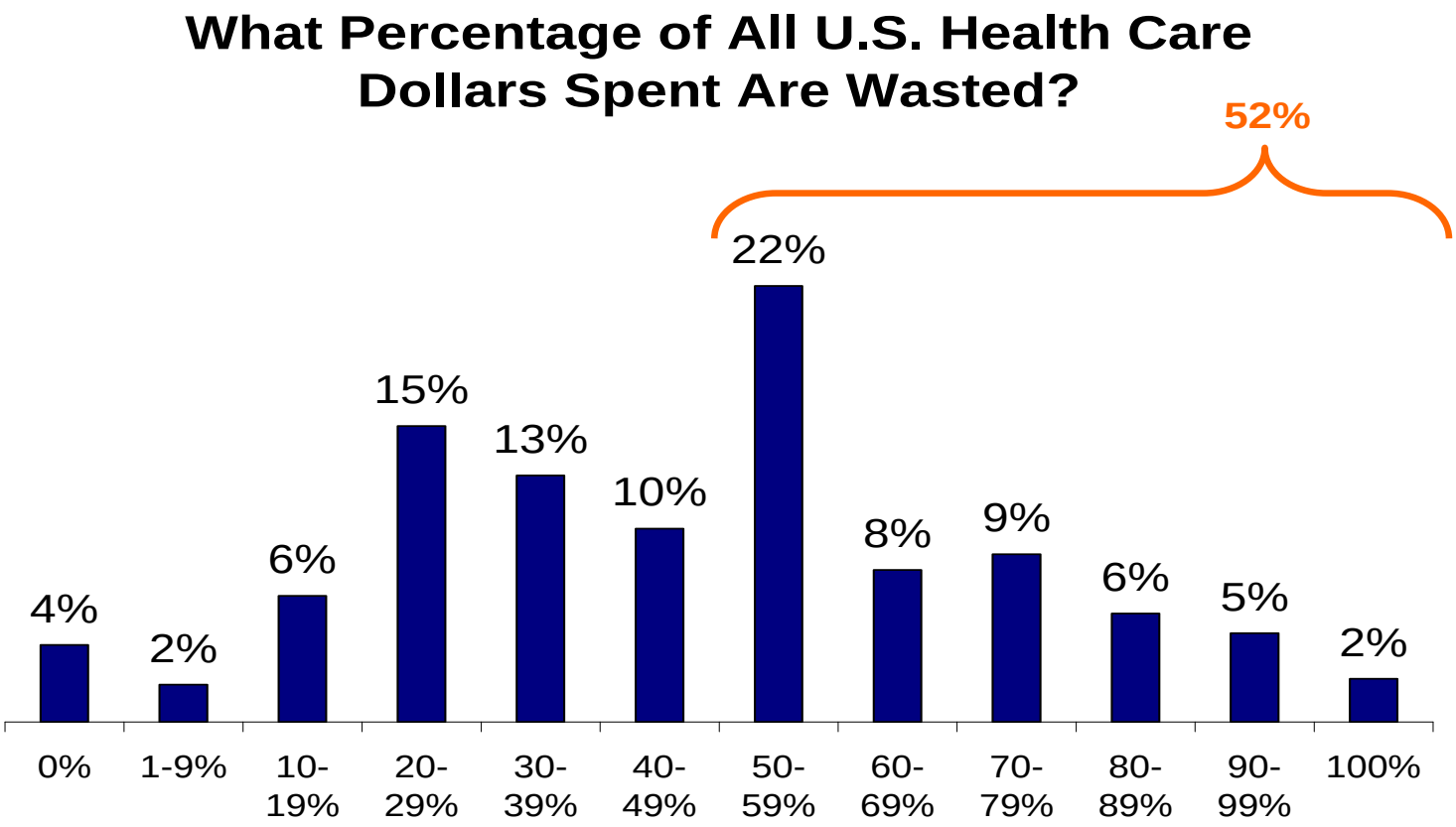
Only 3 in 10 consumers feel they know how the U.S. health care system works.



Source: 2009 Survey of US Health Consumers

The public view: “And it wastes a lot of money…”

52% of Americans feel that at least half of health costs are wasted.

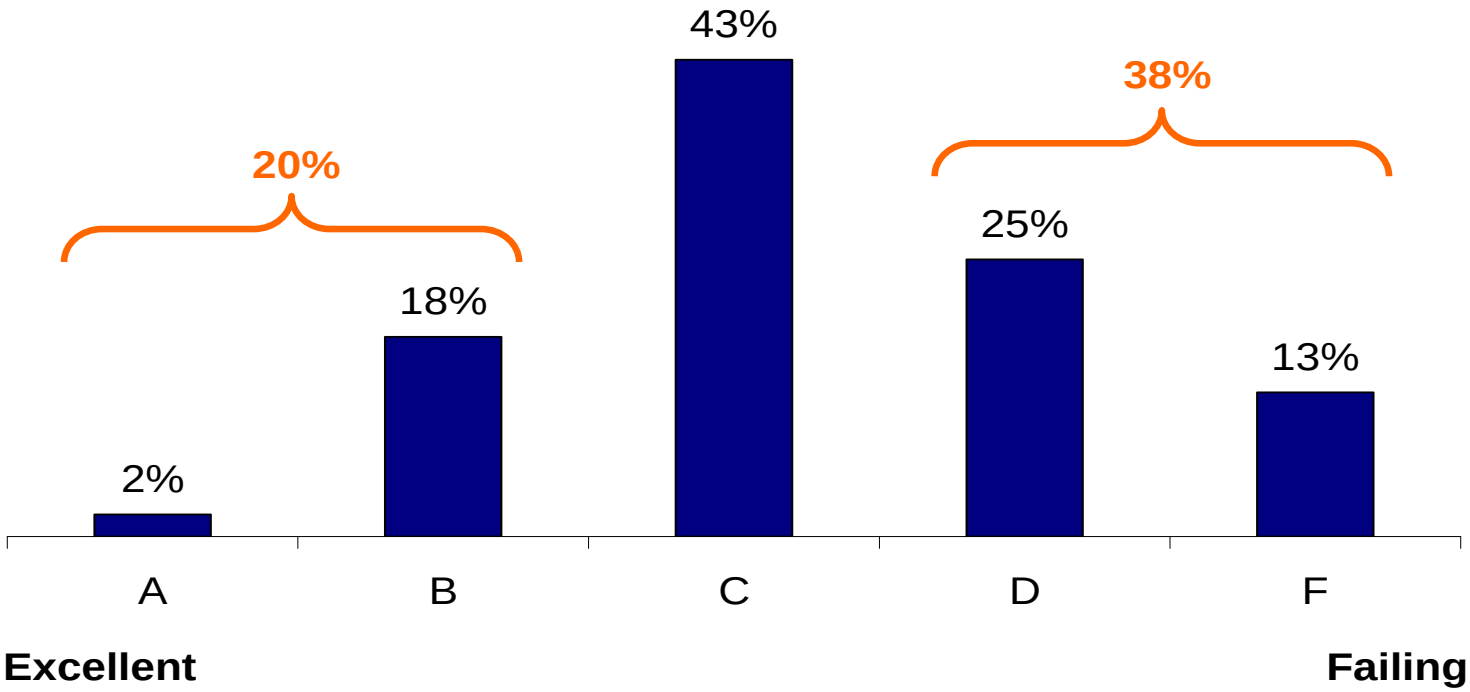


Source: 2009 Survey of US Health Consumers

The public view: “The system isn’t working very well…”

Only 1 in 5 consumers give the U.S. health care system an above-average report card grade; those grading the system “F” outnumber those giving it an “A” by 6 to 1.

How Would You Grade the Overall Performance of the U.S. Health Care System?



Source: 2009 Survey of US Health Consumers

Consumers views of health reform: medical court system, employer mandate, mental health coverage, expanded scope of practice for nurses popular

Reform	U.S.	
	Favor	*Oppose*
Improve health insurance / care for military	77%	5%
Expand teaching programs in U.S. schools of medicine to increase the supply of PCPs	74%	5%
Establish special court system to address medical malpractice issues	54%	12%
Require every employer to provide health insurance for their employees	53%	17%
Pass state laws to allow consumers to purchase drugs directly from Canada	49%	15%
Increased federal funding for mental / behavioral health services	49%	17%
Allow nurses to diagnose problems and administer care for uncomplicated conditions	47%	21%
Increase government funding and incentives to support adoption of EMRs by providers / plans	41%	21%
Allow FDA to compile information about individuals who take Rx medications to monitor	41%	24%

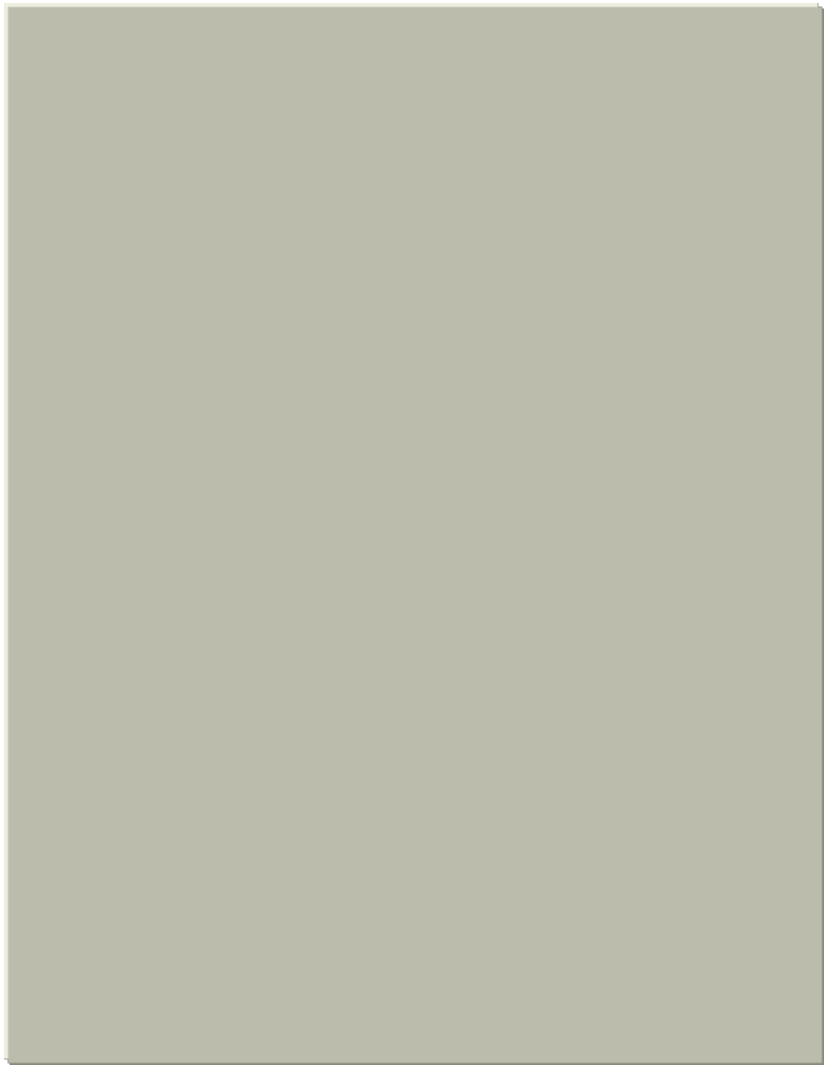
EMR use, performance-based payment popular; increased taxes for uninsured coverage unpopular

Reform	U.S.	
	Favor	*Oppose*
Pay doctors and hospitals based on clinical results and outcomes rather than number of patients served or services provided	39%	21%
Require holistic and non-traditional methods of care to be taught in U.S. medical schools	38%	20%
Require every American to have health insurance via purchase / employer / government	37% *	25% *
Establish national program that provides financial incentives for doctors who follow scientifically-proven approaches to treatment	33%	23%
Assign every American to a PCP who will assist in coordinating care and referring to specialty	27%	38%
Have federal government assume responsibility for and control over Medicaid	26%	31%
Increase taxes to help provide health insurance coverage for the uninsured	25%	43%

* Statistically significantly different from the U.S. average ($p < .05$)

The Medical Home

- Four basic models
- Primary care paid for coordinating care, managing population-based outcomes and costs
- Pilots projects underway by most major plans, Medicare
- Tricky issues:
  - —Scope of practice and liability for PCPs, mid-levels
  - —Compensation and risk sharing
  - —Metrics: process vs outcomes



Released January 2008

Traditional Primary Care vs. Medical Home

	Primary Care Practice	Medical Home
Primary Provider	Primary Care Physician	PCP with health coaches
Provider Accountability	Limited incentives for quality	Increased incentives through transparency
Physician's Role	Trusted source	Trusted source supplemented by others; member of a collaborative health care delivery team
Care	Fragmented	Integrated, whole person oriented, anywhere/anytime
Care coordination	Disintermediated to disease management industry	Responsible and reimbursed
Primary Incentive	Visits & procedures (volume)	Patient adherence to self-care regimen
Decision Support	Limited, largely physician-patient relationship	Customized, internet and personal coaching, EMR & EBM guided

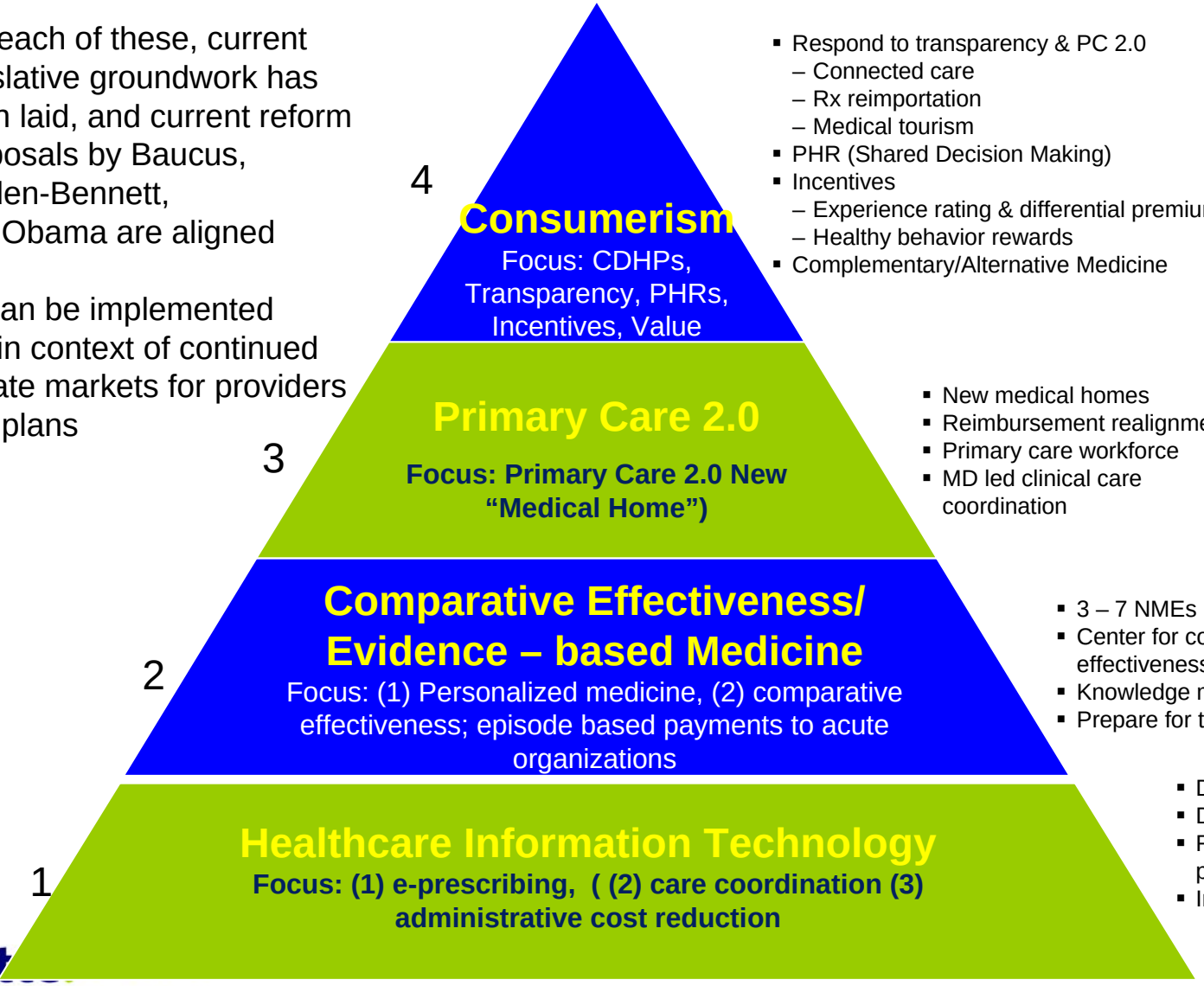
Economic Impact: Costs

	Incremental Cost	Assumption
EMR with Registry Functionality and Knowledge Management Tools for Clinicians	$80-120K initial investment, $5-20K ongoing maintenance per medical home	EBM and Clinical Decision Support Guided Practice – 300,000,000 US Population / 1-2,000 patients per medical home * incremental costs
Physician Revenue for care coordination	$100-115 K per PCP	$50-100 per patient in panel
Health Coach	$78K + 56% load	Load for benefits, coaching tools, etc
Data Manager	$65K / 3 FTE	1/3 FTE per medical home
Panel size		1-2K, depending on prevalence and intensity of chronic care management requirements
Physician Incentive	$150-400K	$500/patient in panel, inclusive of clinical performance bonus, current state $350-600K vs. future state $.5-1MM

Four programmatic areas bend the curve to reduce cost and improve care

For each of these, current legislative groundwork has been laid, and current reform proposals by Baucus, Wyden-Bennett, and Obama are aligned

All can be implemented within context of continued private markets for providers and plans



- Respond to transparency & PC 2.0
  - Connected care
  - Rx reimportation
  - Medical tourism
- PHR (Shared Decision Making)
- Incentives
  - Experience rating & differential premiums
  - Healthy behavior rewards
- Complementary/Alternative Medicine

- New medical homes
- Reimbursement realignment
- Primary care workforce
- MD led clinical care coordination

- 3 – 7 NMEs per year
- Center for comparative effectiveness
- Knowledge management
- Prepare for tort reform

- Decreased errors
- Decreased care gaps
- Reduced malpractice premiums
- Improved efficiency

Long term: Health reform in two stages

Stage One:2009-2011

Stimulus Package Inclusions

- Focus will be expansion of benefits to newly unemployed, executive orders that extend coverage (SCHIP 2/2/09) and jobs related programs
- In additon, certain programs that buoy states against expected increases in Medicaid enrollment
- A few campaign promises: EX. HCIT

Stage Two: 2010-2016

Systemic Reforms—Long Term

- Insurance market reforms
- Individual mandate + employer pay or play + FEHP2
- Comparative effectiveness
- Episode based payments
- Medical Home
- Expansion of role: FDA, CDC
- Medicare eligibility
- Federalization of Medicaid

During Stage One and into Stage Two, the banking system correction under the Fed Reserve Board, US Dept of Treasury will be a key parallel process: deployment of $700+B TARP funds, mortgage market stability focus

Potential Savings

	Metric
Acute	10% fewer hospital admissions; 20% fewer ER visits; 10% less absenteeism
Diagnostic	20% fewer tests
Therapeutic	Prescriptions should increase with more patient adherence, but overall medical costs should decrease ~30%[1]

Breakeven Scenario

- Medical cost drivers:
  - Health coaching and increased effectiveness in patient enrollment in disease management programs.
  - Health coach can manage 250 disease management patients on average
  - 150K new medical homes (300 million US population / 2K panel size) with total system cost = 150K x cost drivers
  - Future medical cost trend 8%, non medical cost trend 4%
- 4 years to breakeven

Key Questions

- Is the current model of the medical home better-cheaper?
- Is the primary goal of the medical home to recruit physicians to primary care or manage population-based care?
- How can/should the medical home fit within the context of health reform and transformational change in the industry?

For more information

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