McKESSON
Empowering Healthcare

Patient Centered Medical Homes

A Call To Action

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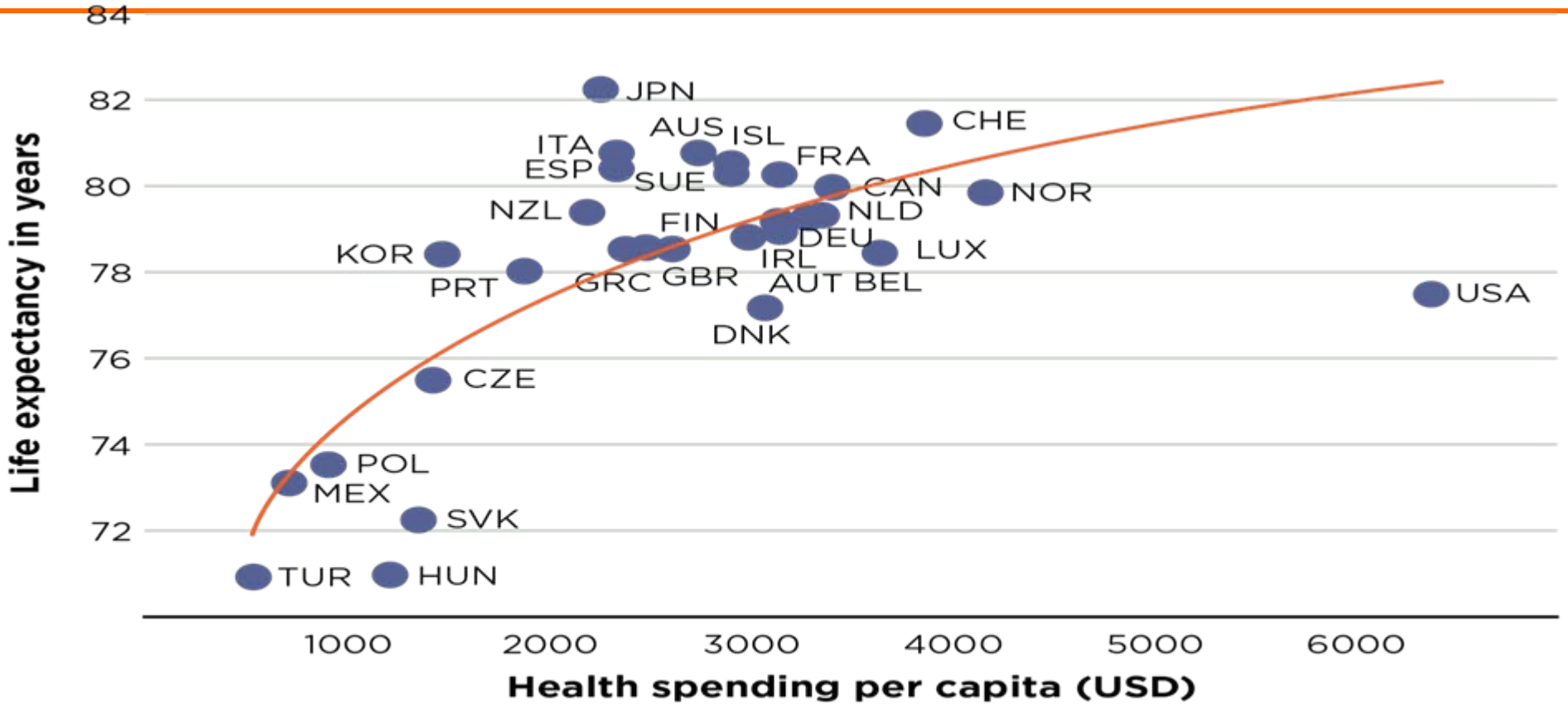
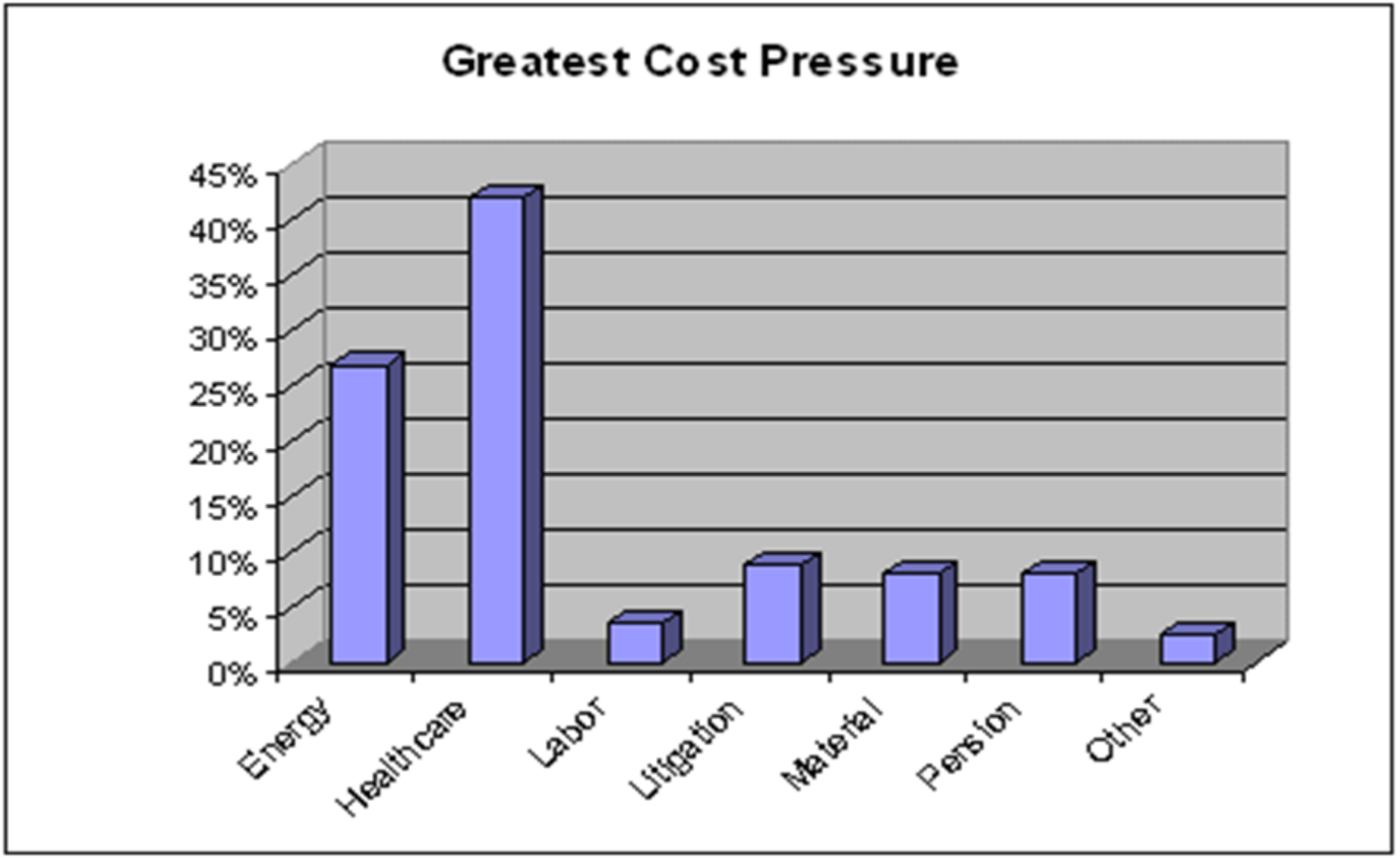
March 2012

Poor health despite high spending



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.

Health care is a business issue



The Facts and the Research

Key sources of waste[1]	% of total medical cost that is waste
Admin and system inefficiencies	4 - 6%
Provider inefficiencies and errors	3 - 4%
Lack of care coordination	1 – 2%
Unwarranted use	11 - 21%
Preventable conditions and avoidable care	1 - 2%
Fraud and abuse	5 - 8%
	~30%

- **Thompson Reuters 2011**

Conservatively, 30% of the $2.5T US healthcare spend is estimated to be waste, equating to approximately $700B annually.

Your aspiration should be to take 50-70% of waste or 15 – 20% of medical cost out of the system over time

Solutions to the US healthcare system
all pointing to Primary Care

US Healthcare system fraught with issues…

Rising Healthcare Costs
→ $2.5 trillion (17% of GDP)

Gaps/variations in **Quality and Safety**

Poor Access to PCPs → Due to worsen in 2014 with exchanges

Below average **Population Health** judged by life expectancy & mortality rates

Aging population and increased prevalence of **chronic disease**

… many experiments underway in an attempt to improve system…

- PPACA and ARRA legislation
- Value Based Reimbursement
- PCMH's
- ACO's
- EHR/HIE Investment
- Disease Management Pilots
- Alternate 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

Milestones in PCMH Development

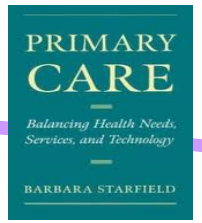
1967
"Medical Home" Term
Standards Child Health Care
Council on Ped. Practice

1978
Alma Ata
Declaration

1978-79
"Medical Home" Hawaii Child Health Plan
Calvin Sia MD

1987
Surg. Gen. Koop
Conf. Report
MH for CSHCN

Medical Home Policy Statement



2002
Future Family Medicine

2004

2006
Adv. Medical Home

TransforMed

Pilots

2007
MH Pilots

2008
PPC®-PCMH

Baucus
White Paper

Joint Principles
Medical Home

NBGH Award

IOM on PC

PPACA 2010

The Patient-Centered Primary Care Collaborative

Patient Centered PRIMARY CARE Collaborative

Providers 333,000 primary care

- ACP
- AAP
- AAFP
- AOA
- ABIM
- ACC
- ACOI
- AHI

Purchasers –

Most of the Fortune 500

- IBM
- General Motors
- FedEx
- General Electric
- Pfizer
- Merck
- Business Coalitions
- McKesson Corporation

80 Million lives

Payers

- BCBSA
- Aetna
- United
- Humana
- CIGNA
- HCSC
- WellPoint
- MVP
- Kaiser

Patients

- NCQA
- AFL-CIO
- National Partnership for Women and Families
- Foundation for Informed Decision Making
- SEIU

PCMH Demonstrating Value during Pilot Phase (’08 -’11)

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Pilot	Cost Savings PMPY	Cited Quality Impact
Group Health – Puget Sound	$216	Fewer Hospitalizations / ED Visits
HealthPartners	$368	Fewer Hospitalizations / ED Visits Dramatic Increase in EBM adherence Reduced waiting time
VISN 23	$593	Fewer Hospitalizations / ED Visits
InterMountain Health	$640	Fewer Hospitalizations / ED Visits Lower Mortality Rates
ProvenCare (Geisinger)	$500	Improvement in Preventative Care Fewer IP Admissions
BCBS of SC-Palmetto PCPs	$530	Increased EBM Adherence Fewer Hospitalizations / ED Visits Fewer ED Visits
Colorado Medicaid	$215	Fewer Hospitalizations / ED Visits

Source: Center for Excellence in Primary Care, CSBD Analysis

PCMH Demonstrating Value in Medicaid Programs

- **Oklahoma -** *Reduced costs* for Medicaid $29 per patient per year from 2008 to 2010. *Use of evidence-based primary care*, including screening for breast and cervical cancer *increased*

- **Colorado** - *Expanded access to primary care.* Before the initiative, only 20 percent of pediatricians in the state accepted Medicaid; as of 2010, 96 percent did *and at a lower total cost*

- **Vermont** - *inpatient care use and related costs decreased* 21 percent from July 2008 to October 2010. *ER use and related costs decreased* 31 percent.

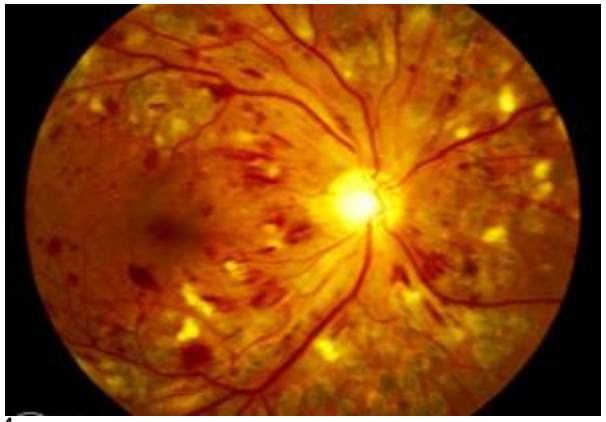
- **Washington state** - Acute care spending was 18 percent below the national average. Inpatient stays per beneficiary were 35 percent below the national average.

M. Takach, "Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results," *Health Affairs*, July 2011 30(7):1325–34; State of North Carolina Press Release , December 2

PCMH Demonstrating Value in Medicare Advantage

CareMore Results

- A hospitalization rate 24 percent below average
- Hospital stays 38 percent shorter
- An amputation rate among diabetics 60 percent lower than average
- Most remarkable of all, these improved outcomes have come without increased total cost
- With this kind of care, would we see the outcomes we see today?



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Continued and Impressive PCMH Results
Continue to Pour Out almost Weekly!

COLORADO

NEW HAMPSHIRE

New York

- **18% *decrease* in acute IP admissions/1000, compared to 18% *increase* in control group**
- **15% *decrease* in total ER visits/1000, compared to 4% *increase* in control group**
- **Specialty visits/1000 remained around flat compared to 10% *increase* in control group**
- **Overall Return on Investment estimates ranged between 2.5:1 and 4.5:1**

The World Changed Jan 27th 2012

Primary care is the foundation of medicine, and it can and should be the foundation of our members health"

– Harlan Levine MD , EVP, Comprehensive Health Solutions, WellPoint

Insurer WellPoint to revamp primary care

- PCMH model of care emphasized

"The Scale is so much bolder that things have seen - this isn't an experiment"

– Paul Ginsburg, Center for Studying Healthcare Change

Entering the Rollout Phase for PCMH as Foundation (2012-2014)

WellPoint *(Jan 27, 2012)* - more than a billion dollars for national rollout through increased revenue opportunities, enhanced information sharing, and providing care management support

Aetna *(Feb 2012)* **-** Launches National PCMH Program in Connecticut and New Jersey; to expand nationally during 2012

Horizon BCBS *(Feb 2012)* - invests 1 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 Patient Centered Medical Home Program to roll out statewide in 2012

Why Change?

> If you don't like change, you're going to like irrelevancy even less."
>
> GENERAL ERIC SHINSEKII, 2003

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Innovation is Critical for Survival

The End of Health Insurance Companies

By EZEKIEL J. EMANUEL and JEFFREY B. LIEBMAN Jan 30th 2012

health care reform, Health insurance, Medicine and Health

Here'

"Already, most insurance companies barely function as insurers thanks to the accountable care organizations provided for by the health care reform act"

"A new system is on its way, one that will make insurance companies unnecessary" - the way we know them today……

Medical Group Management Association 2011 Report

- The PCMH model offers great promise to patients, providers, employers and payors. Quality improvement is a central focus and PCMH initiatives have found the greatest cost savings through the reduction of hospital admissions and emergency room visits.
- The medical home concept is considered foundational as accountable care organizations (ACOs) become operational.
- PCMH is the Standard of Care in DOD, VA, HRSA, IHS
- The delivery of effective, more efficient care is the future of healthcare. Providers and payors are looking to the PCMH as the foundation of care

Patient Centeredness and the PCMH

The key difference between the traditional and the emerging worlds of primary care is patient centeredness

The concept of interdisciplinary teams in healthcare is not new. What is changing is that the team model is shifting from the physician at the center of the team, to the patient at the center of the team *with the physician playing a leadership role*

OPM $39 Billion Book with Accountable Care

Patient at the Center

- 24-7 clinician phone response
- Provide open scheduling.
- Provide care management and care coordination by specially-trained team members.
- Use an EHR with decision support.
- Use CPOE for all orders, test tracking, and follow-up.
- Medication reconciliation for every visit.
- Prescription drug decision support.
- Implement e-prescribing.

- Pre-visit planning and after-visit follow-up for care management.
- Offer patient self-management support.
- Provide a visit summary to the patient following each visit.
- Maintain a summary-of-care record for patient transitions.
- Email consultations.
- Telephone consultations.
- The development of care plans.
- Performance outcome measures.

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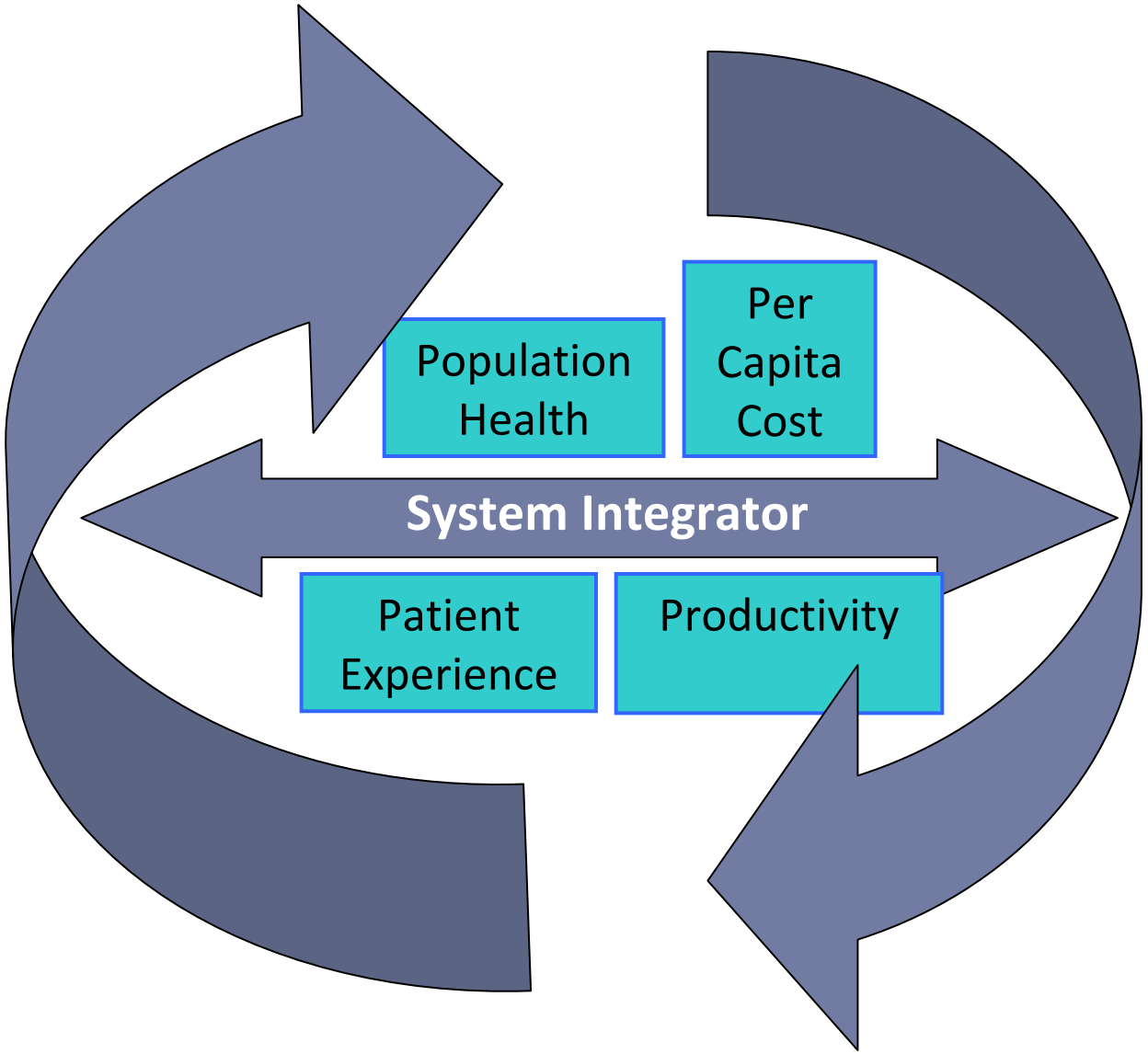
PATIENT CENTERED MEDICAL HOME IN THE VA

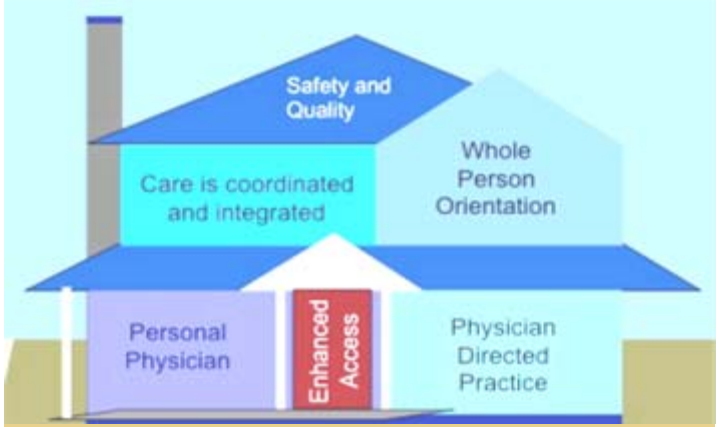
VHA Patient Aligned Care (PAC)Team

Replaces episodic care based on illness and patient complaints with coordinated care and a long term healing relationship

Military Health Services

Readiness, Experience of Care, Population Health, Cost





The System Integrator

Creates a partnership across the medical neighborhood

Drives PCMH primary care redesign

Offers a utility for population health and financial management

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The Foundation : Patient Centered Primary Care

BCBS strategy will drive transformation to a patient-centered care model by aligning economic incentives and giving primary care physicians the tools they need to thrive in a value-based reimbursement environment.

Benefit design tied to measurable behavior changes and outcomes

Expanded access through innovation

Aligning care management with the delivery system

Exchange of meaningful information

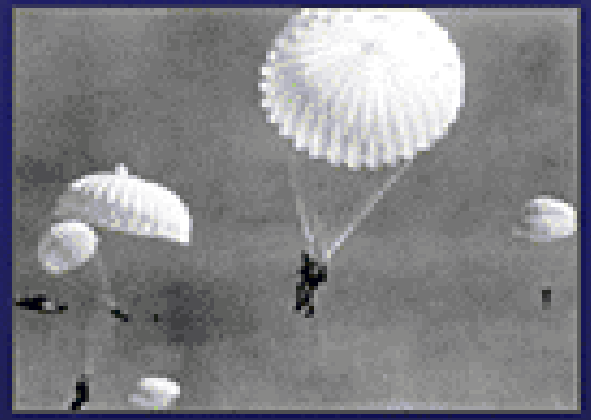
Four Foundational Pillars

Does It “Work”?

- Most previous reviews of the evidence for this young model have limitations, but the early returns are quite impressive
- AHRQ commissioned a systematic review
  - “Early Evaluations of the Medical Home: Building on a Promising Start.” Peikes D, Zutshi A, Genevro J, Parchman M, Meyers D - *American Journal of Managed Care,* February 2012
  - Check http://www.PCMH.AHRQ.gov for forthcoming white papers
    - The Medical Home: What Do We Know, What Do We Need to Know?: A Review of the Earliest Evidence on the Effectiveness of the Patient-Centered Medical Home Model - Peikes D, Zutshi A, Smith K, et al., forthcoming 2012.
    - Early Evidence on the Patient-Centered Medical Home - Zutshi A, Peikes D, Smith K, et al., forthcoming 2012.

Did Data Lead Us to Clean Indoor Air?

Parachute Use to Prevent Death and Major Trauma Related to Gravitational Challenge: Systematic Review of Randomized Controlled Trials



Objectives

- To determine whether parachutes are effective in preventing major trauma related to gravitational challenge

Results

- We were unable to identify any randomized controlled trials of parachute intervention

Conclusions

- As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomized controlled trials. Advocates of evidence-based medicine have criticized the adoption of interventions evaluated by using only observational data.
- We think that everyone might benefit if the most radical protagonists of evidence-based medicine organized and participated in a double-blind, randomized, placebo-controlled, crossover trial of the parachute.

BMJ 2003; 327:1459-61

Do we really need randomized controlled trials to do the right thing – to provide patient centered coordinated care with good access that has results?

How much longer will we continue this…..

PCMH – the Parachute – the safety net – the foundation of accountable care

Smith GC, Pell JP. BMJ 327:1459-1461; 2003.

Patient Centered Primary Care

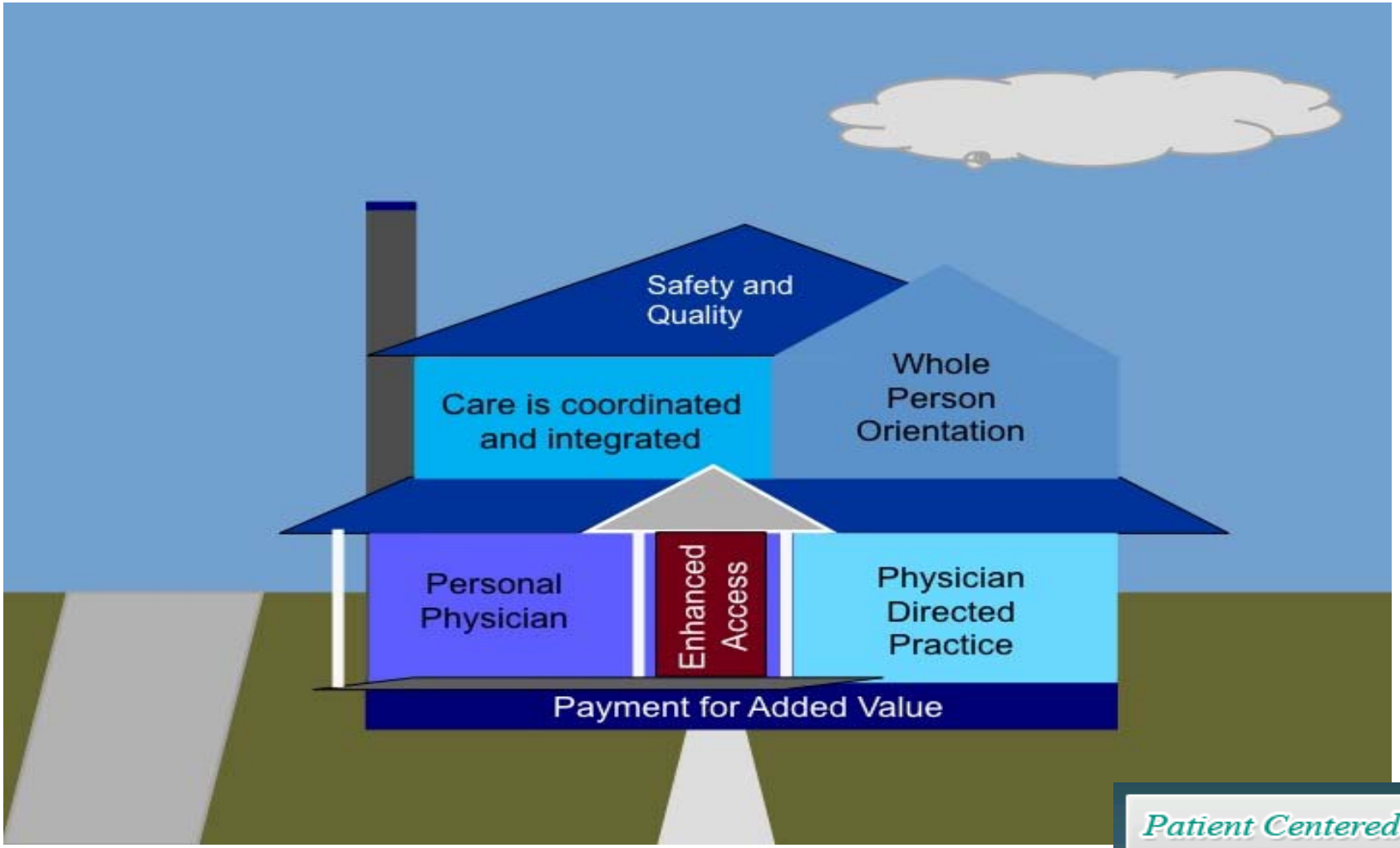
A bold and aggressive plan

Drive the transformation to a patient centered care model that promotes access, coordination across the continuum, prevention and wellness by collaborating with primary care physicians in ways that allow them to successfully manage the health of their patients and thrive in a value based reimbursement environment.

This strategy represents an aggressive and fundamental shift in how we interact with and engage primary care physicians on all levels: ***clinically, contractually, operationally and culturally*.**

Time to Act – Support the Rollout

The Time is now!



Patient Centered PRIMARY CARE Collaborative