



# Patient-Centered Medical Home: From Concept to Reality

**Patient Centered Primary Care Collaborative  
Call-To-Action Summit  
November 7, 2007**

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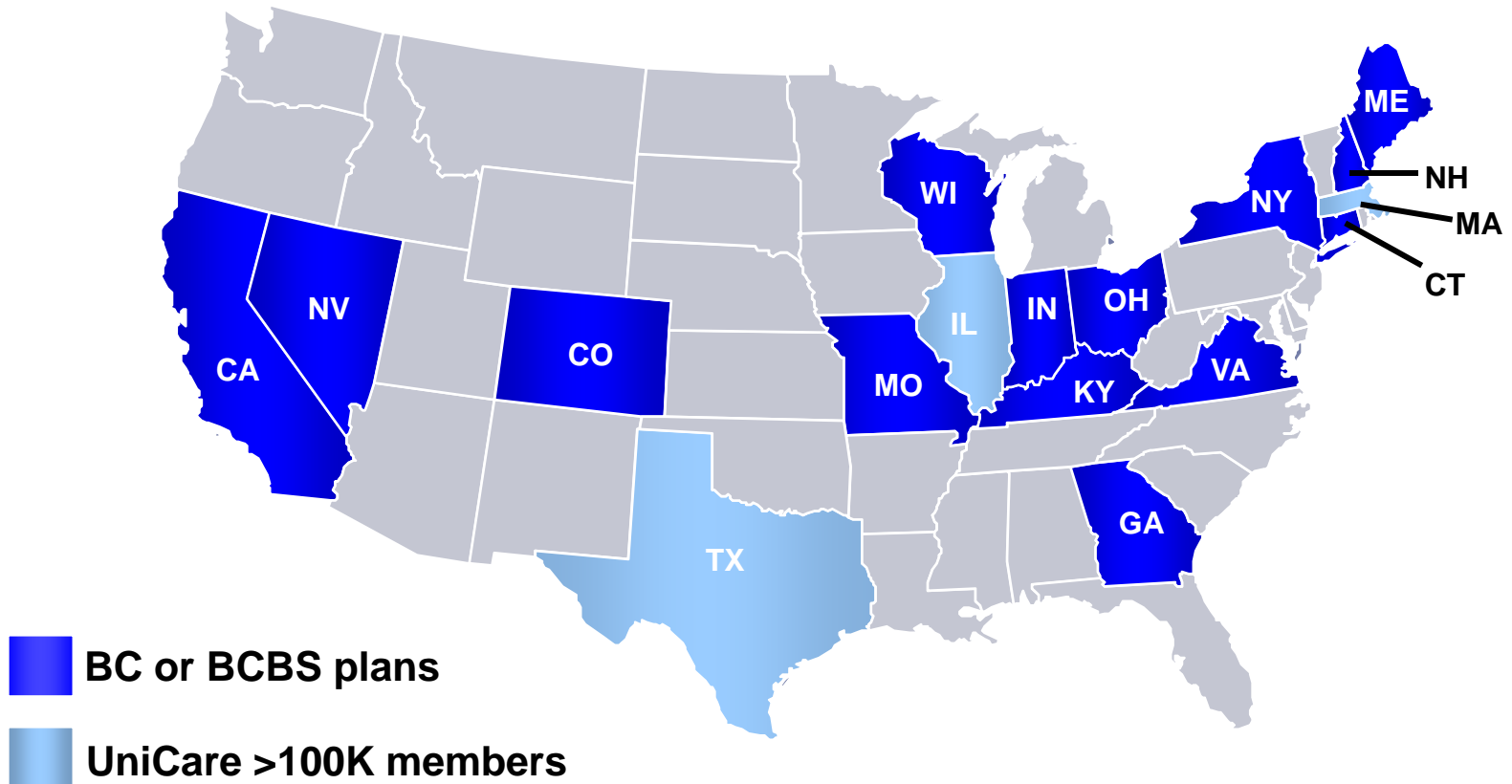
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# WellPoint: Improve Healthcare Quality and Affordability

- 35 million members; 1 in 9 Americans have WellPoint coverage; Blue Cross/Blue Shield Plans in 14 states
- Specialty medical companies:
  - WellPoint NextRx PBM
  - PrecisionRx Specialty Solutions
  - WellPoint Behavioral Health
- Lumenos
  - Consumer-driven health solutions
- Health Management Corporation
  - Disease and integrated care management
- HealthCore
  - Health outcomes and health services research
- American Imaging Management (AIM)
  - Radiology management



## *35 Million Members Across the Country*



# Patient-Centered Medical Home

- **Definition of an “Patient-Centered Medical Home” (PCMH):**

- A primary care practice that provides patients with accessible, continuous and coordinated care through a patient-centered, physician-guided, cost-efficient and longitudinal approach to care

- **What is a Medical Home:\***

- Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care
- Physician-directed medical practice in which a team of individuals collectively take responsibility for ongoing care of patients
- Whole-person orientation of care for all stages of life
- Care is coordinated and/or integrated across all elements of the health care system
- Quality and safety are hallmarks of the medical home
- Patients have enhanced access to care through systems such as open scheduling, expanded hours and new options for communication
- Payment appropriately recognizes the added value to patients who have a medical home

# Patient-Centered Medical Home

- **Medical Home is NOT necessarily:**

- Reemergence of capitation
- A model to increase reimbursement (although it will enhance primary care physician income)
- A sole panacea for rising health care costs
- Significant new dollars into the health care system

# Why the Medical Home

- Primary care is important to the delivery system – current crisis in primary care recruitment and retention
  - Medical home may be the (a) answer to increased quality, reimbursement and physician/patient satisfaction
- Aging population and increased prevalence of chronic diseases
- Current system emphasizes episodic treatment and more care, not better care
- Rising healthcare costs and gaps/variations in quality and safety; Goals to improve safety, quality, affordability, and experience of care
- Need for better coordination of care among providers; care coordinated by a personal physician is associated with better outcomes, especially in many chronic diseases
- Disease management as currently exists may not be the model for the future; DM activities most successful when integrated into a physician practice

# Patient-Centered Medical Home: Pilot Program Model

## Implementation

- **Broad geography**
- **Variety of practice sizes**
  - Large IPAs/ multi-specialty groups
  - Smaller PCP
  - Solo and Duo Practice
- **NQCQ Practice Designation - PPC**
- **Timing: Q1/Q2 2008**

## Coordination

- **Coordinate pilot sites with other payers, especially CMS**
  - Critical mass of patients necessary for PCMH success
- **Coordinate with other programs**
  - Pay for Performance
  - Disease Management
  - Transparency Programs
  - Health Information Technology
  - Decision-support

## Evaluation

**Care Coordination  
Health Information  
Technology**

**Clinical Process  
and Outcome  
Measures**

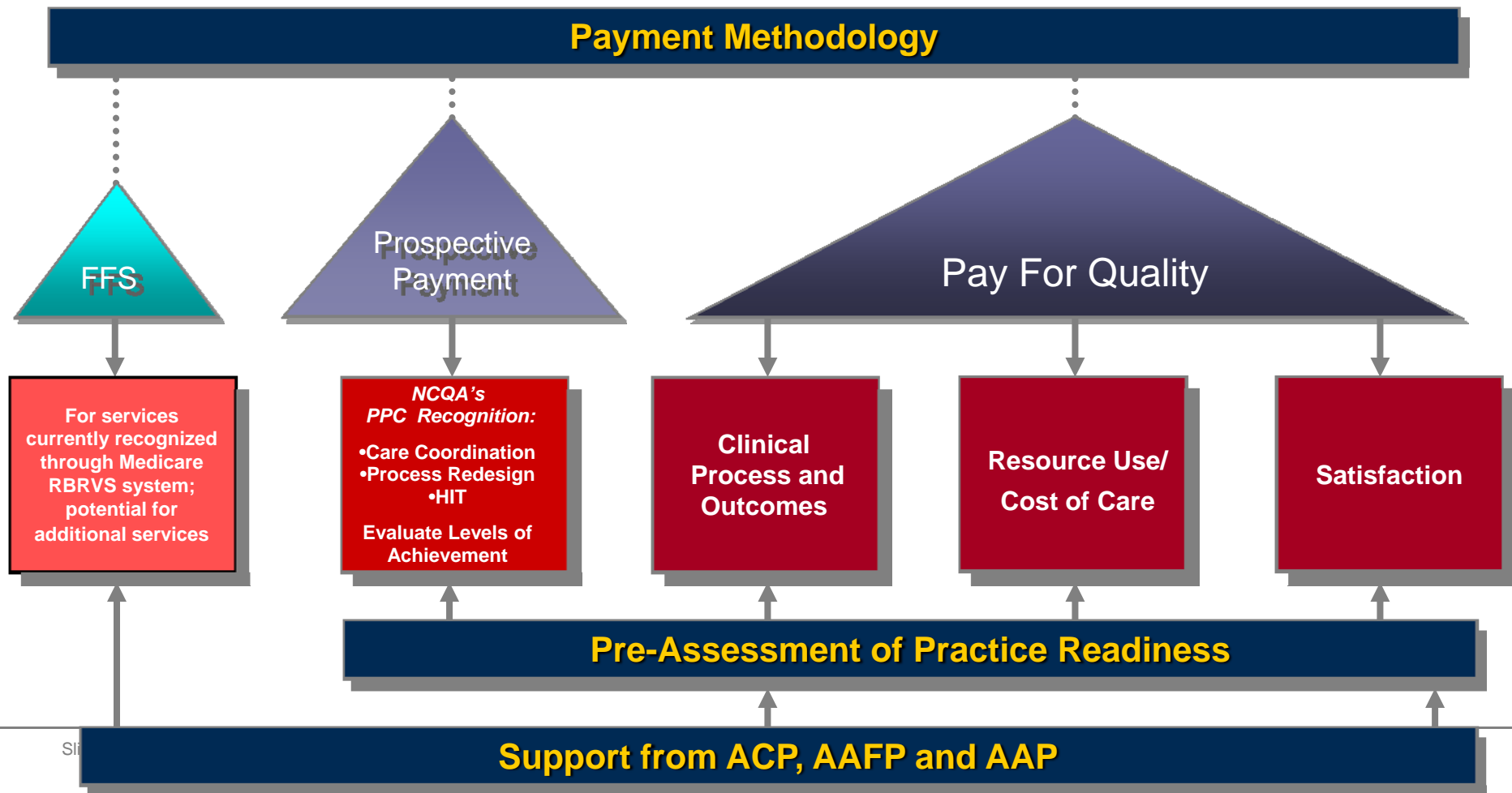
**Resource Use  
Cost of Care**

**Satisfaction**

- **Comprehensive evaluation**
- **Discussions with Commonwealth Fund, RAND**

# Personal Medical Home

**Reimbursement and incentive structure aligned to support practice transformation, clinical process/outcomes, cost of care and satisfaction**



# Patient-Centered Medical Home: The Path Forward

- **Practice Recruitment**

- ME, NH, WI, VA, CO, CA
- Coordinate with ACP, AAFP and AAP to identify practices
- Urban/suburban/rural
- The continuum of practice size
- What is critical payer mass for practice?

- **PCMH Designation**

- NCQA PPC Program – timelines
- Differences by level of designation attained; “Reward” for increasing levels
- Technical Support

- **Purchaser participation**

- Employee/member incentives to use Medical Home practices

- **Care Coordination Payment**

- All patients or just those with chronic illness? Which disease(s)?
- Payment amount
- Opt in or opt out model for patients

- **Timing of Program: Start, interim evaluation, final evaluation**

- At least 12-18 months for assessment of impact of PCMH
- Program expansion during this evaluation phase
- CMS demonstration projects and timelines Evaluation
- Success: Clinical, Satisfaction and Financial measures

- **Transparency**

- **Potential impact of success and mixed results**