



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

**A Blue Cross and Blue Shield Association Presentation**

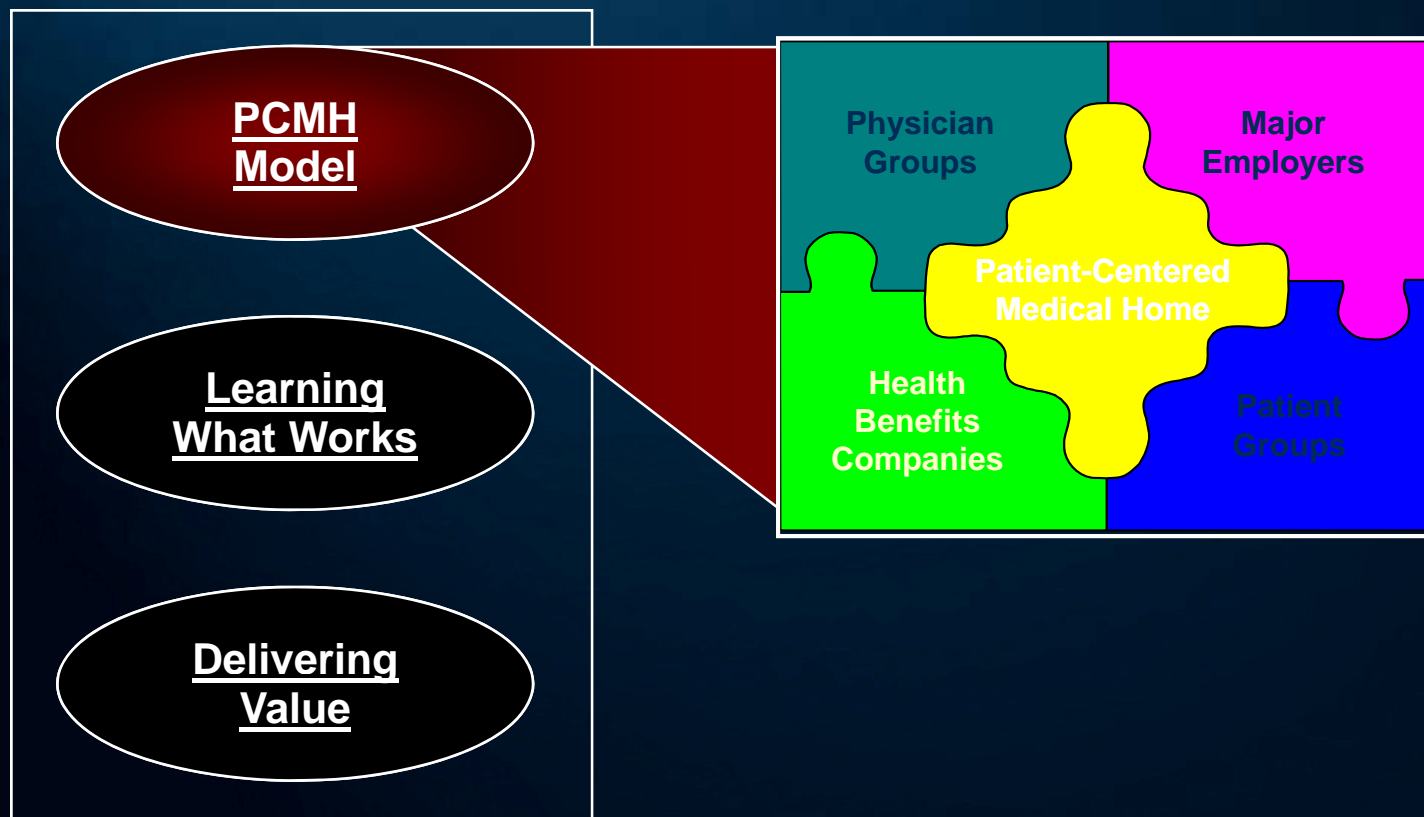
# The Patient-Centered Medical Home BCBS Pilot Initiatives

**Carole Flamm, MD, MPH  
Executive Medical Director  
Office of Clinical Affairs**

# Translating PCMH Concept into Results

Building the business case for future sustainability

## Strategy



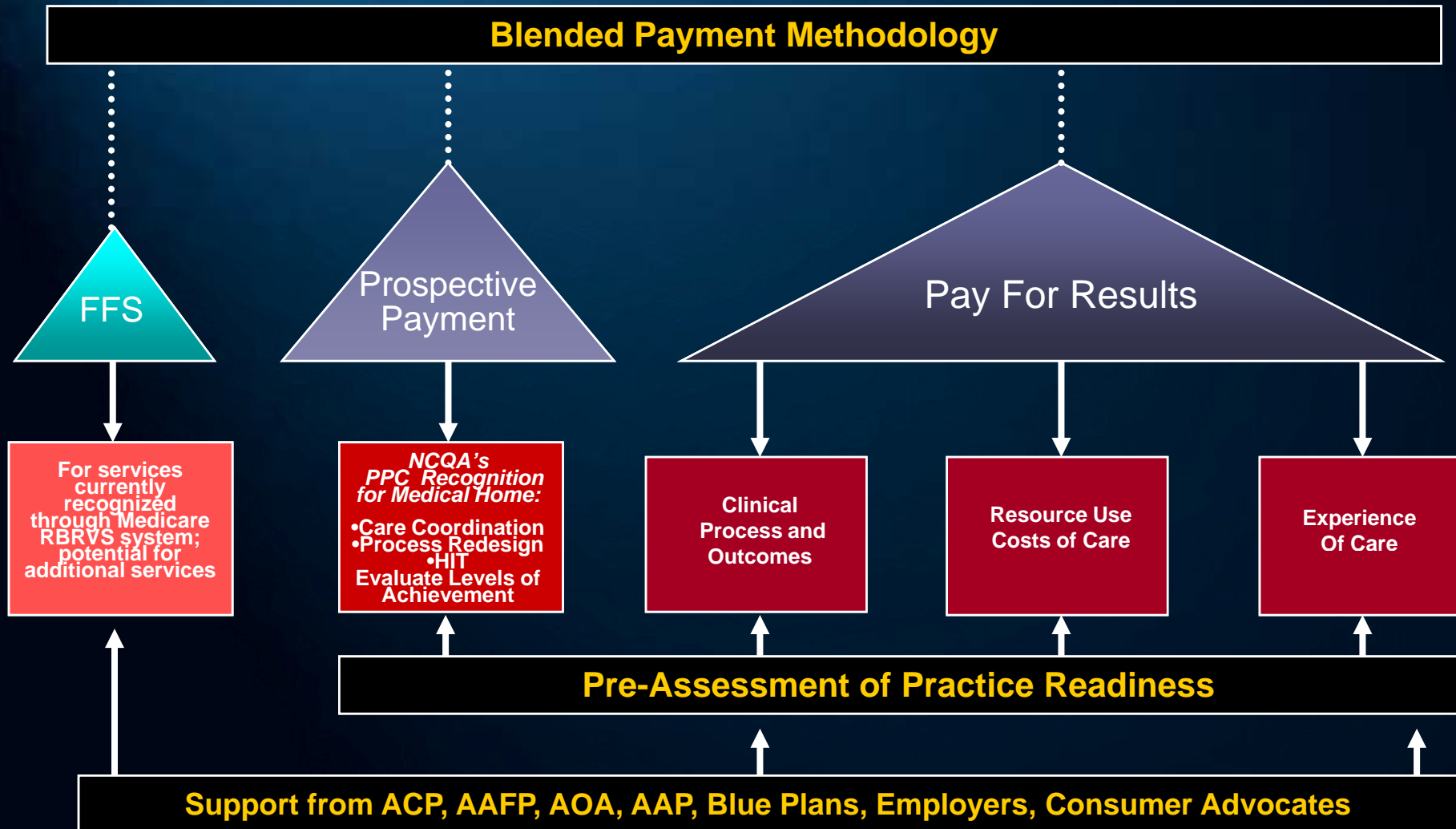
# The Patient-Centered Medical Home

## *Revised Reimbursement Model*

**Model reflects the value of physician-led care management that falls outside of a face-to-face visit including:**

- Coordination of care
  - Longitudinal care
  - Personalized care anticipates patient needs
  - Enhanced communication access
  - Adoption of health information technology
  - Measurable improvements in the quality of care provided
- The PCMH is a care *facilitator*, not a gatekeeper
- The goal is not to restrict access to specialists but to *facilitate and integrate specialty care*
  - Voluntary - Patients are not “locked” into the PCMH

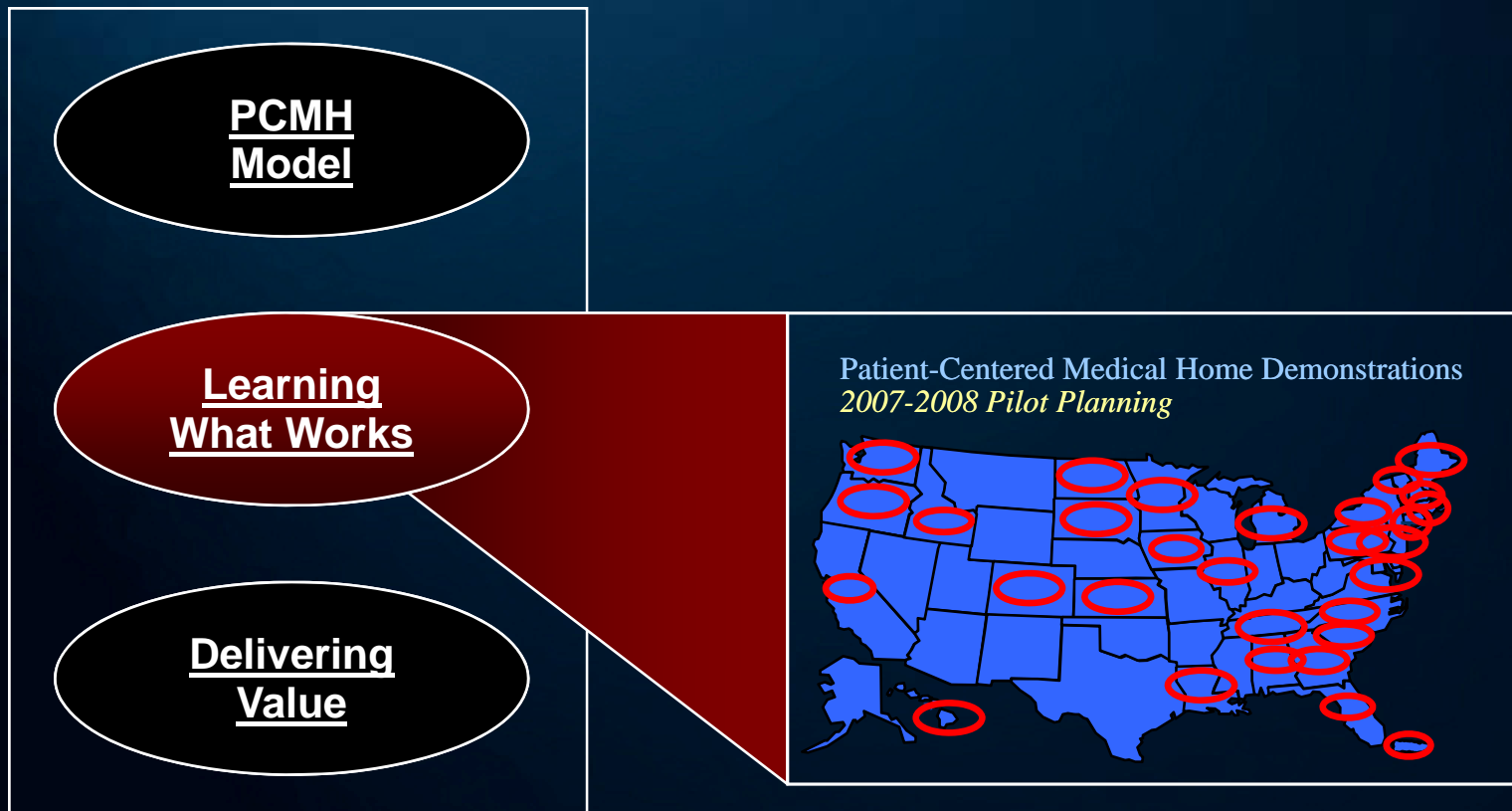
# Model supports practice transformation, care coordination, and value



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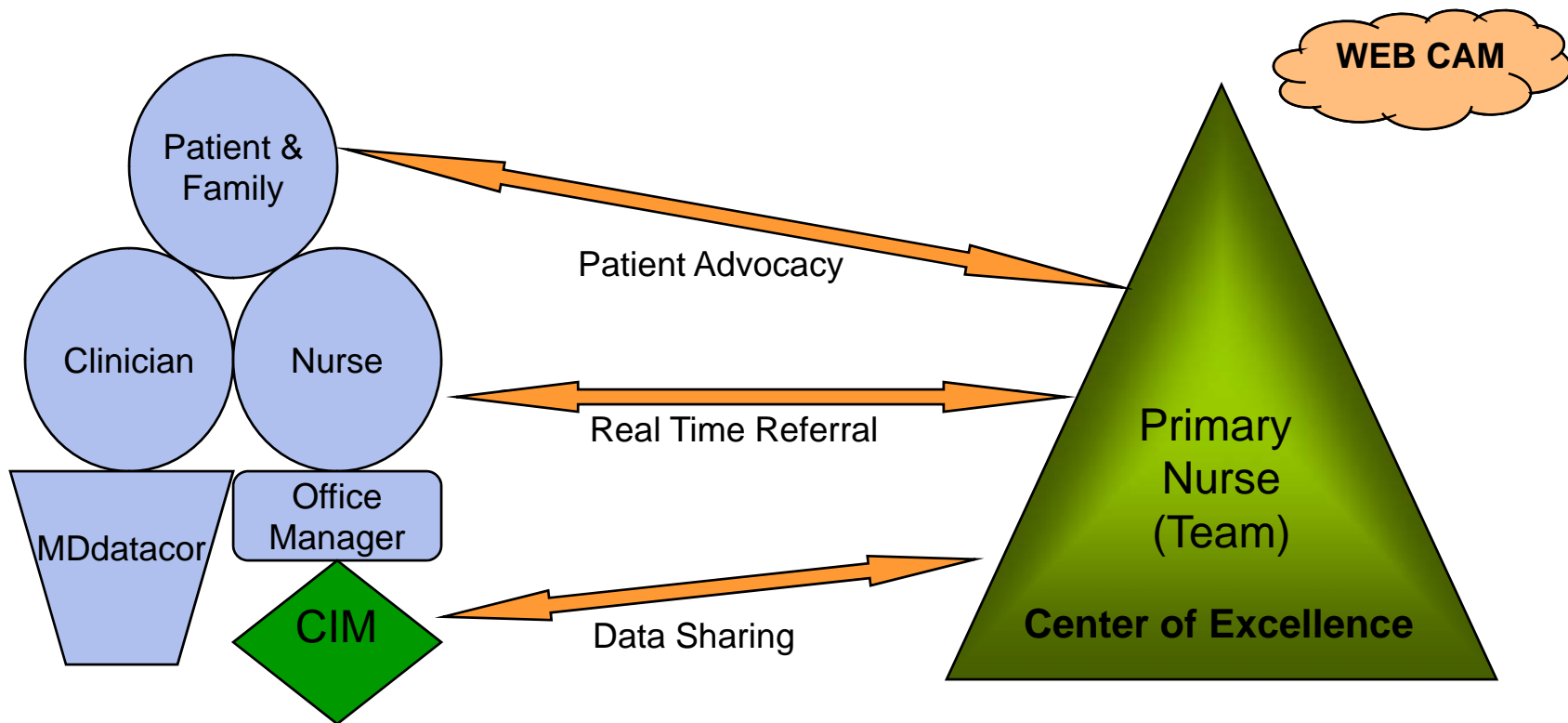


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Permission from Wellmark Blue Cross and Blue Shield, Dr. Barbara Muller

# Clinical Integration Model



## Registry Opportunity Reports

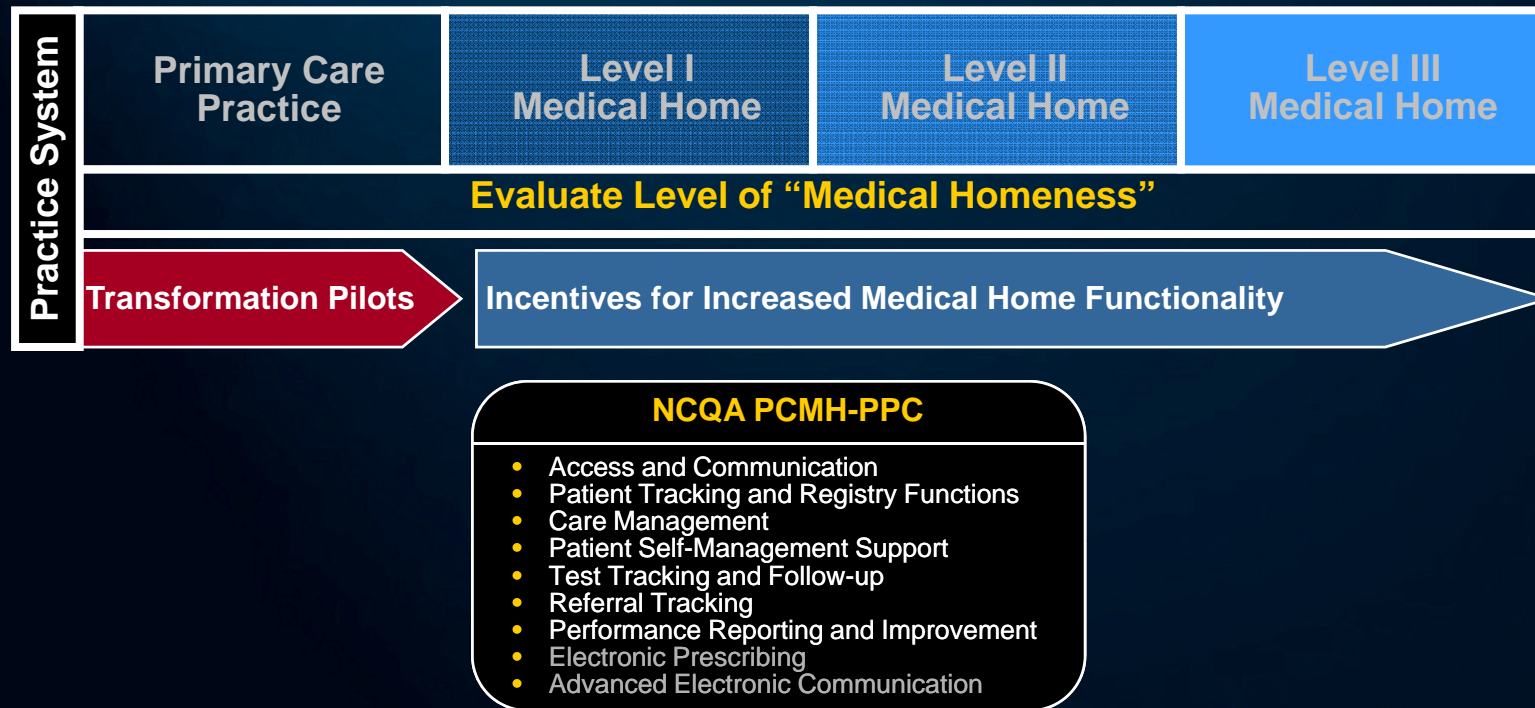
- Customized Care Planning
  - Population Management
  - CoQ (Achieve Higher Quality)

## Population Management

\*Refer back to Medical Home

**Whole Health Dimensions Programs**

# Spectrum of PCMH Pilots

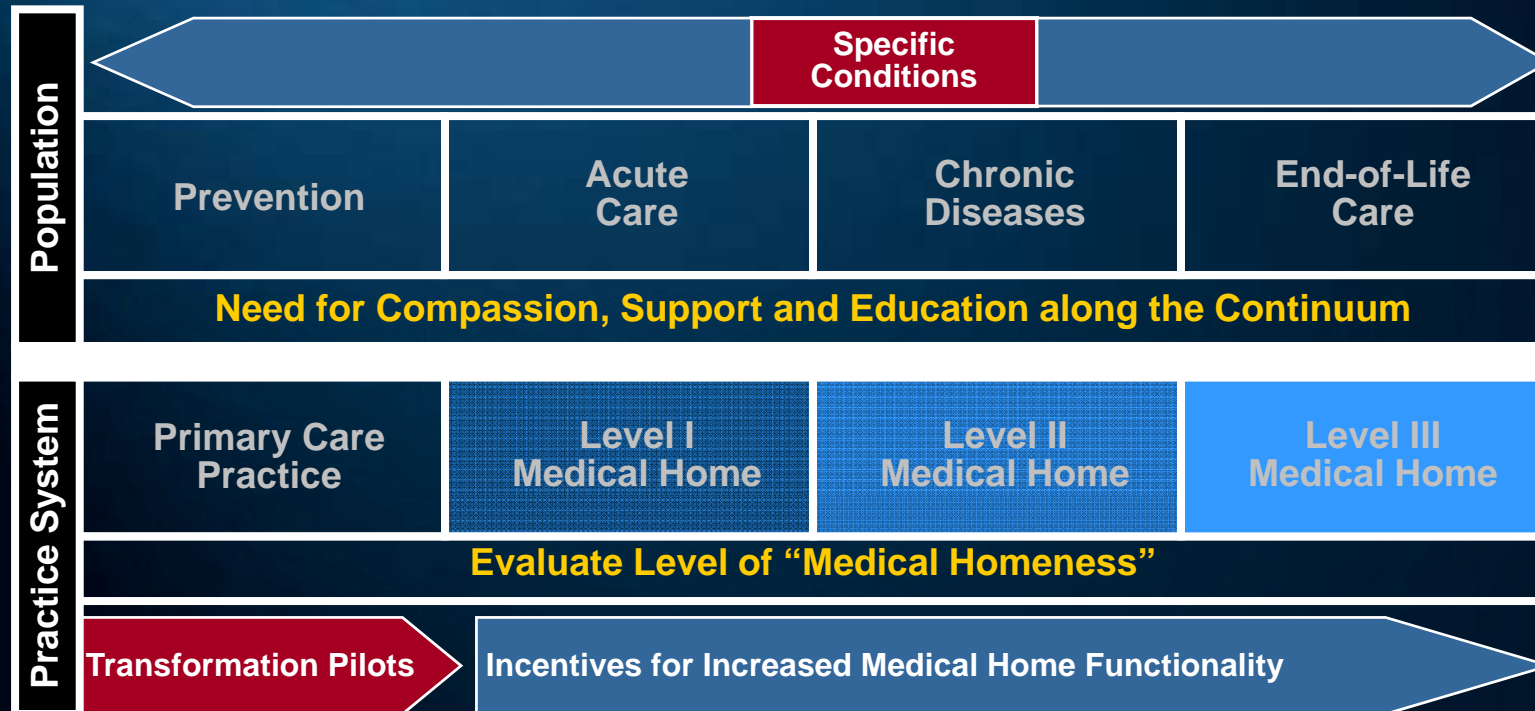


# Patient-Centered Care Management

Compassion, Support and Education along the Continuum



# Spectrum of PCMH Pilots



## NCQA PCMH-PPC

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Test Tracking and Follow-up
- Referral Tracking
- Performance Reporting and Improvement
- Electronic Prescribing
- Advanced Electronic Communication

# MeritCare-BCBS ND Diabetes Management Program

## (Advanced Medical Home)

**Selected as BlueWorks for  
Providers winner by BCBS  
Association in partnership with  
Harvard Medical School  
Department Health Care Policy**



# Starting Point

- Two IM clinics in F-M area (control vs. intervention)
- BCBSND provided study clinic with small grant and agreed to share average cost savings from first year
- On-site Disease Management Nurse
- BCBSND as a partner in improving care
- Use of electronic medical record

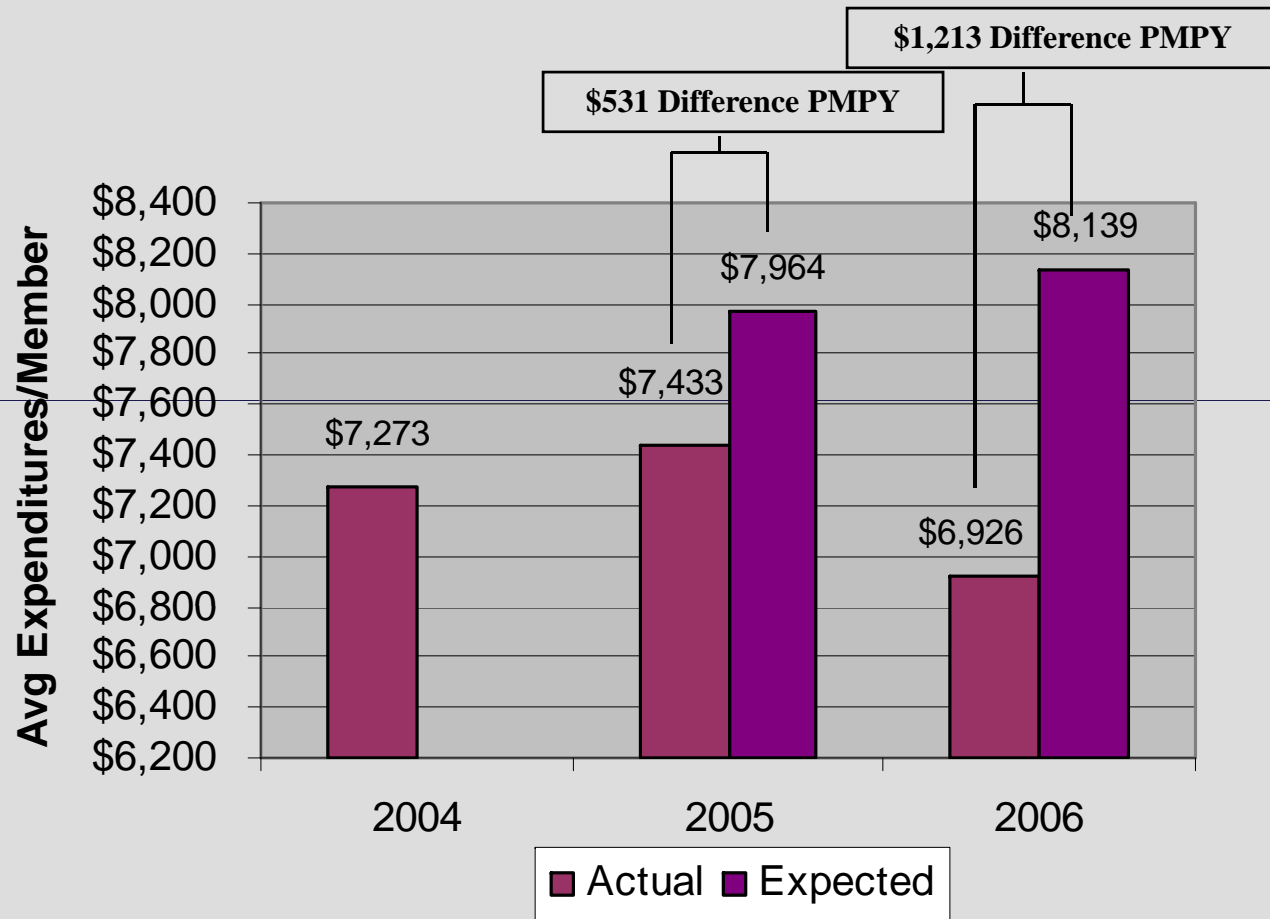
# Intervention

- Patients with diabetes referred to RN-CDM by MDs at study site
- One-on-one meetings with patient
  - assess knowledge of disease
  - establish readiness for follow-up and frequency
  - set goals
  - refer as needed to diabetes educator, dietitian, etc.
  - follow-up by phone or at next visit

# Results

- Improved patient satisfaction with care
- Improved satisfaction of RNs and MDs (anecdotal)
- Improved results for comprehensive diabetes care
- Financial reward to Meritcare Health System
- Financial advantage to payer to support CDM at site of care

**Figure 6. Study Population Average Savings per Member Calculation**



**Overall Savings:**

2005:  $\$531 \times 192 \text{ members} = \$101,940$

2006:  $\$1,213 \times 192 \text{ members} = \$232,923$

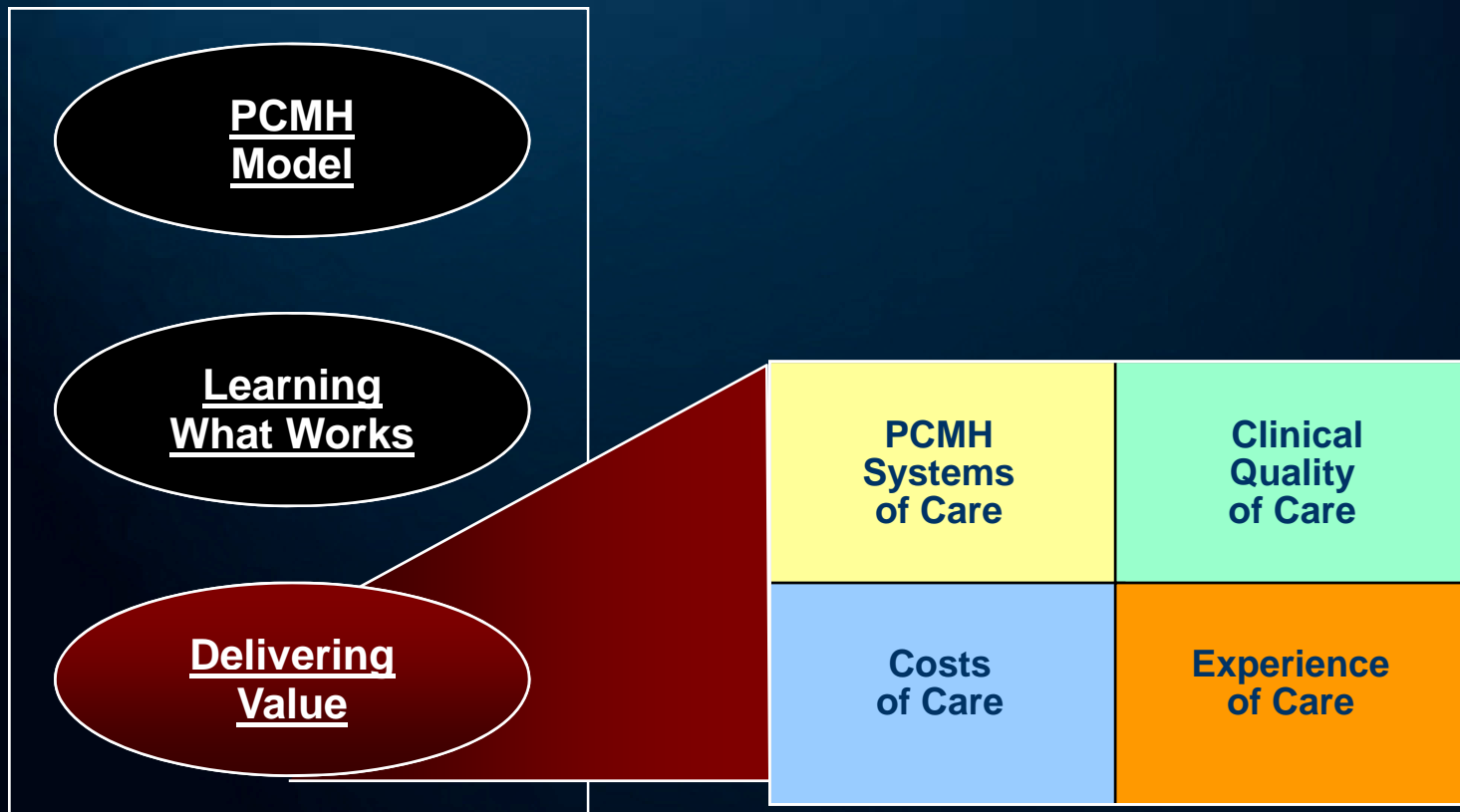
# Future Direction

- Expansion of pilot within F-M area
  - 4 sites, including one family medicine
- Increasing number of chronic diseases in pilot
  - Diabetes, Hypertension, CAD
- Changing financial model
  - Continue to share savings 50/50
  - PMPY management fee in addition to routine FFS structure
  - Development of generic drug incentive

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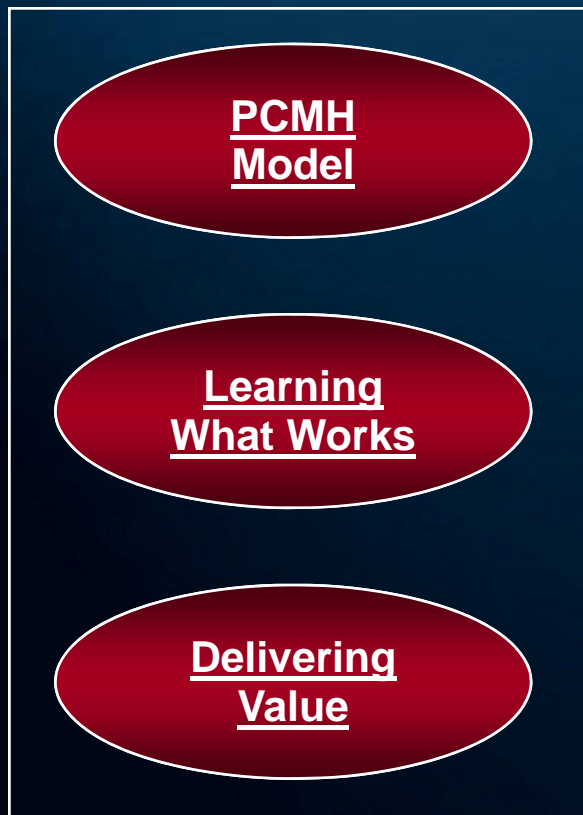
## Strategy



# Translating PCMH Concept into Results

Building the business case for future sustainability

## Strategy



- Multi-stakeholder, patient-focused collaboration
- Develop reimbursement innovations
  
- Demonstration pilots across U.S.
- Support practice transformation, patient-centered care, and examine results
  
- Define investments needed to achieve PCMH
- Define results in terms of value for all stakeholders