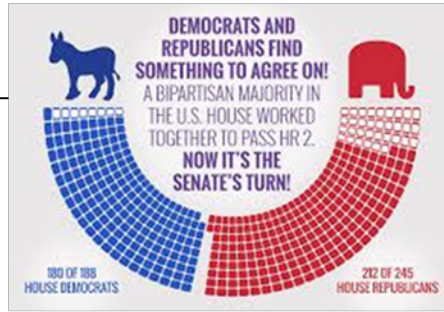
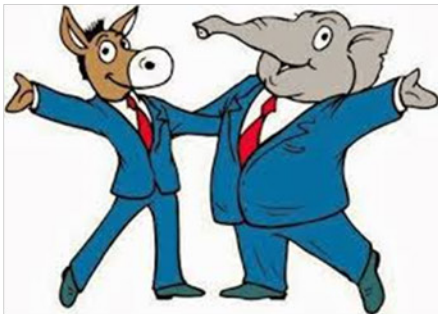






Nearly 1/3 traditional Medicare tied to alternative reimbursement models—such as Patient Centered Medical home (PCMH)/ accountable care organizations (ACOs) or bundled payments—by the end of 2016 --- 50% by end 2018

And end of 2018 90% of traditional Medicare payments to quality or value through programs such as the Partnership for Patients Hospital, Value Based Purchasing and the Hospital Readmissions



Senate 92 to 8

<https://www.youtube.com/watch?v=UY088YyQ6uA>

<https://www.youtube.com/watch?v=UY088YyQ6uA>



# Payment Reform Goals

## U.S. Department of Health and Human Services

Tie 30% of Medicare payments to value-based care models by the end of 2016, and 50% by the end of 2018.

## Health Care Transformation Task Force members

Tie 75% of operations to value-based contracts by 2010.

## Aetna

Tie 50% of payments to value-based care models by 2018, and 75% by 2020.

## CIGNA

Tie 90% of payments to value-based arrangements and 50% to alternative payment models by 2018.

## Dignity Health

Tie 50% of its payments to ACOs by 2018, and 75% by 2020.

## Humana

Tie 75% of Medicare Advantage members to ACOs by the end of 2017.

## United HealthCare

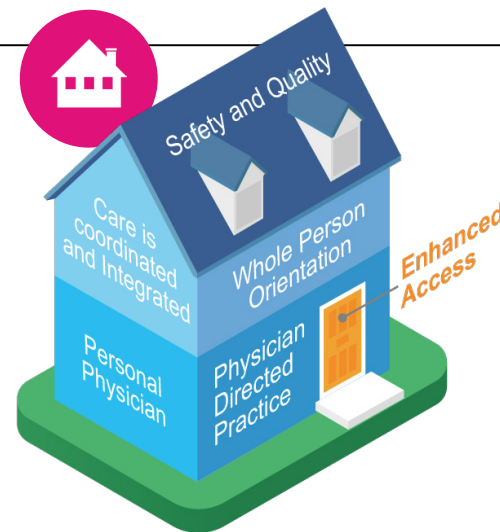
Tie \$65 million in payments to value-based care models by the end of 2018.

Across a great deal  
of SICKcare,  
processes are  
**wasteful** and  
**unsustainable.**

The system delivers  
greater value when  
there is a **relationship  
of trust** between the  
Healer and the Patient.



# Away from Episode of Care to Management of Population with Data



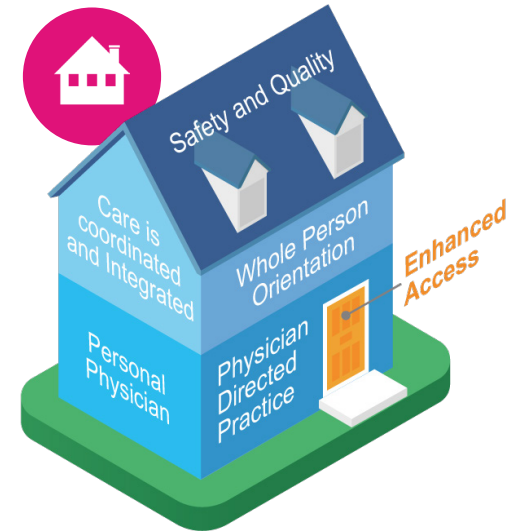
## The System Integrator

- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management



# Key principles

- **Personal healer** – each patient has an ongoing personal relationship with a physician for continuous, comprehensive care
- **Whole person orientation** – physician is responsible for providing all the patient's health care needs or arranging care with other qualified professionals
- **Care is coordinated and integrated** – across all elements of the complex healthcare community
- **Quality and safety are hallmarks of the medical home** – Evidence-based medicine and clinical decision-support tools guide decision-making
- **Enhanced access to care is available** – systems such as open scheduling, expanded hours, and new communication paths between patients, their physician and practice staff
- **Payment is appropriate** – added value provided to patients who have a patient-centered medical home

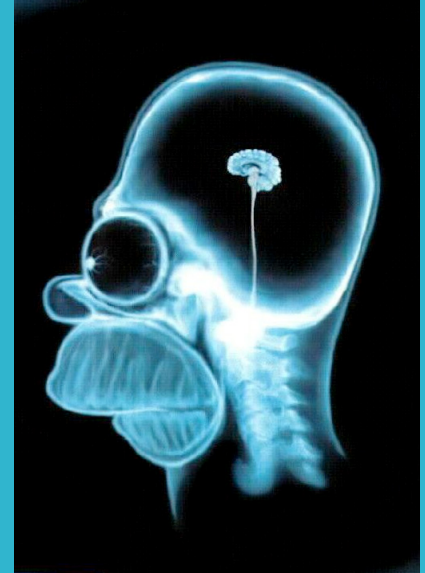


# Smarter Healthcare



|        |                                        |
|--------|----------------------------------------|
| 36.3%  | Drop in hospital days                  |
| 32.2%  | Drop in ER use                         |
| 12.8%  | Increase in chronic medication         |
| -15.6% | Total cost                             |
| 10.5%  | Drop in inpatient specialty care costs |
| 18.9%  | Ancillary costs down                   |
| 15.0%  | Outpatient specialty down              |

**Outcomes of Implementing Patient Centered Medical Home Interventions:** A Review of the Evidence from Prospective Evaluation Studies in the US – PCPCC Oct 2012



## 24 April 2015, Michigan patient-centered medical home program shows statewide transformation of care YEAR 6



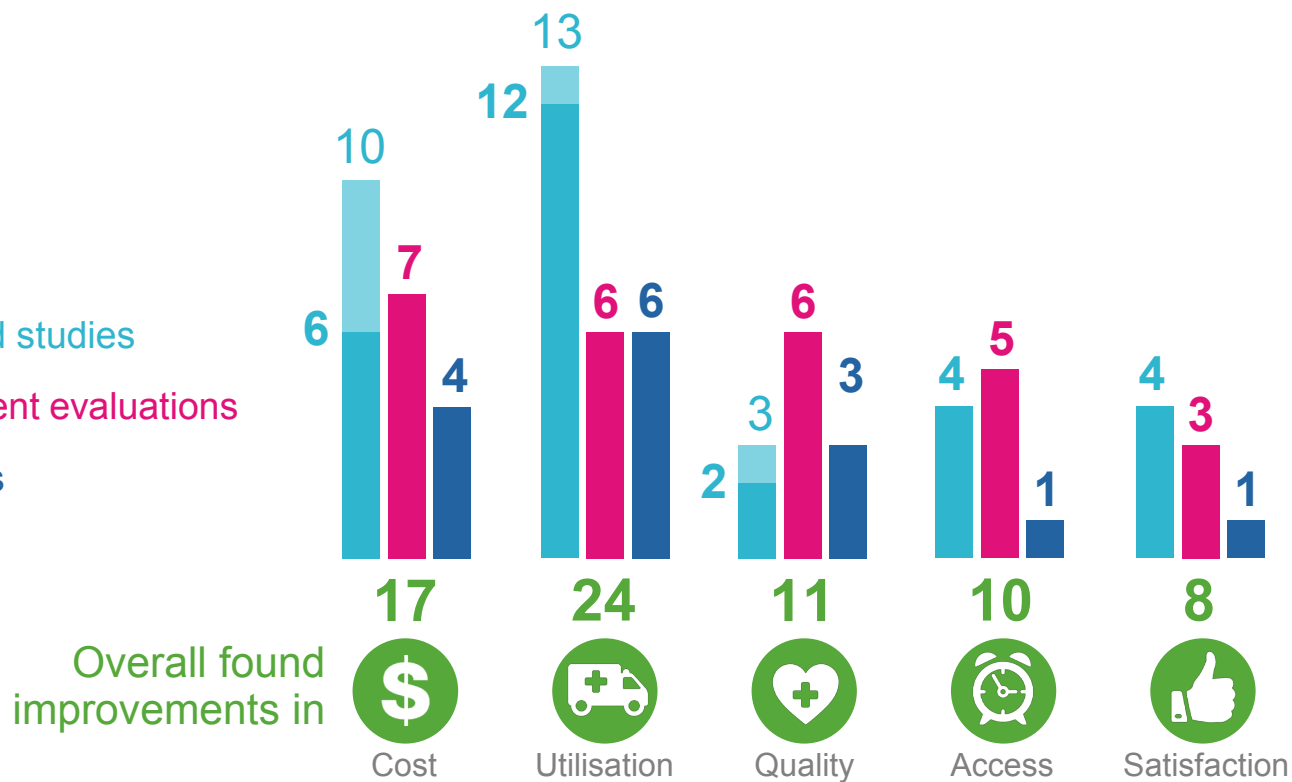
|       |                                                             |
|-------|-------------------------------------------------------------|
| 9.9%  | Decrease in adult ER visits                                 |
| 27.5% | Decrease in adult ambulatory care sensitive inpatient stays |
| 11.8% | Decrease in adult primary care sensitive ER visits          |
| 8.7%  | Decrease in adult high-tech radiology usage                 |
| 14.9% | Decrease in paediatric ER visits                            |
| 21.3% | Decrease in paediatric primary-care sensitive ER visits     |

**4,022 primary care doctors** at **1,422 practices** around the state in its sixth year of operation.  
These practices care for more than **1.2 million** BCBSM members.



# Outcomes

-  14 Peer-reviewed studies
-  7 State government evaluations
-  7 Industry reports



# Articles

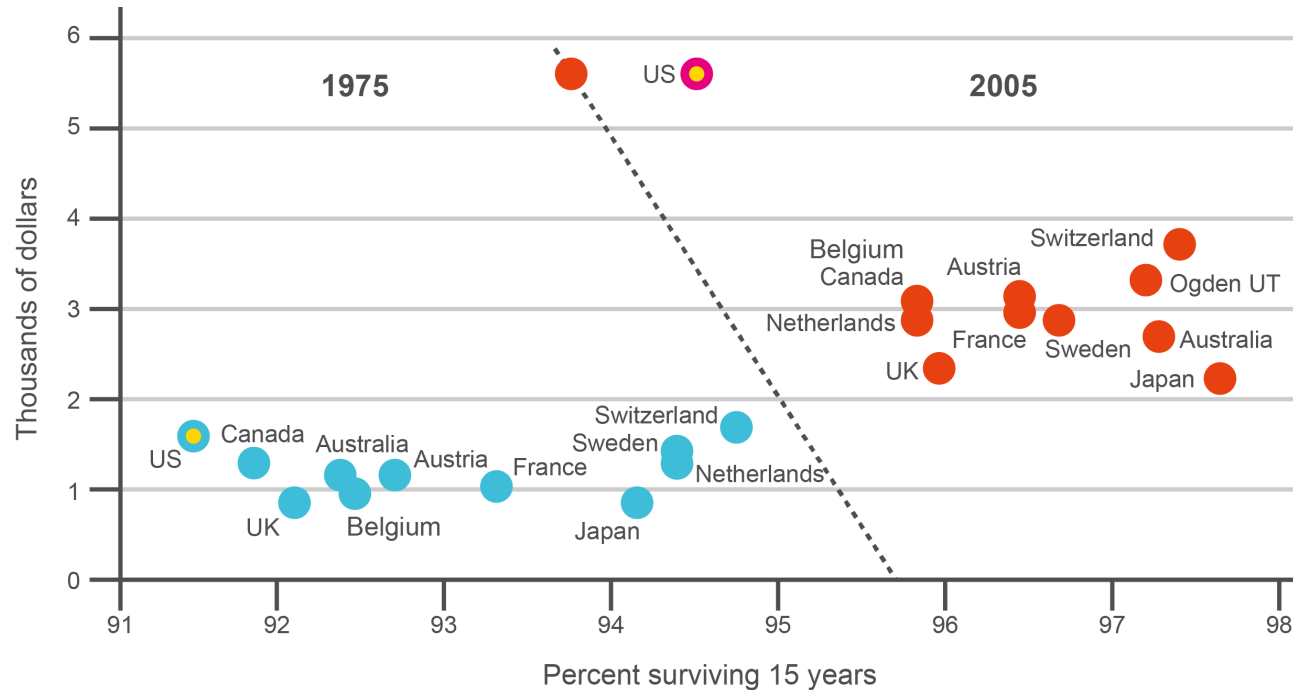


- Survey of 5 European Countries Suggests that Patient-Centered Medical Homes Could Improve Primary Care.
- The Patient-Centered Medical Home In Europe.
- Ontario Family Health Teams/the Patient-centered Medical Home.
- Adapting the Medical Home Concept to Canada – Progress of Family Health Team Model: A Patient-Centered Medical Home.
- Patient-Centered Medical Home and its Application in the Australian Primary Care Setting.

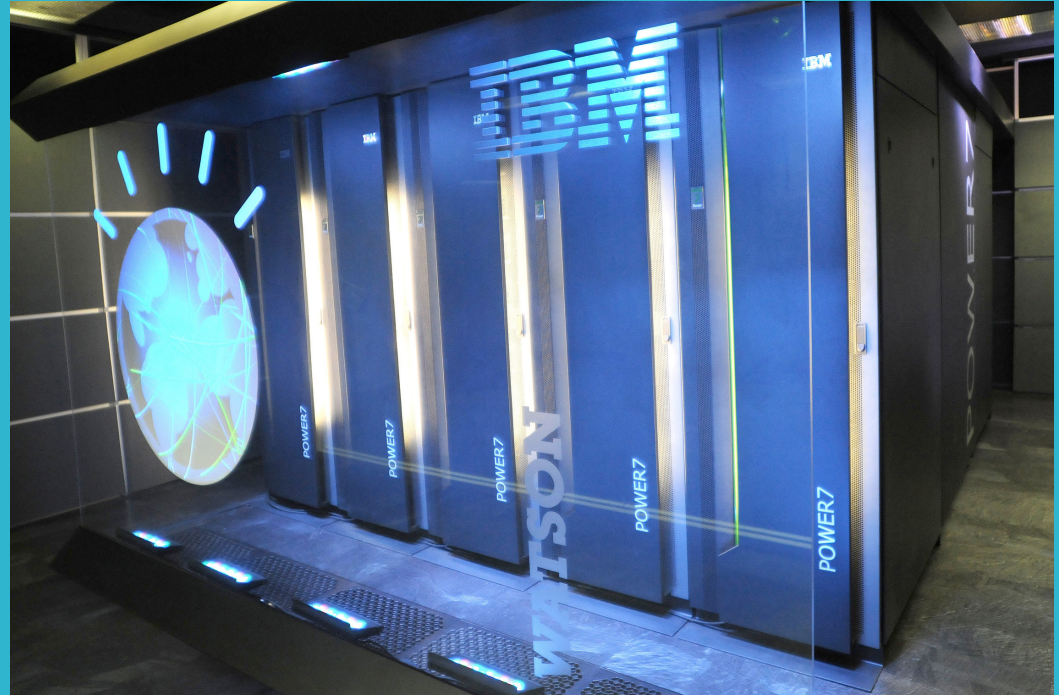
Faber M, Voerman G, Erler A, Eriksson T, Baker R, De Lepeleire J, Grol R, Burgers C.Fleming J Health Aff (Millwood). 2013 Apr;32(4):797-806.  
Can Fam Physician. 2010 Mar;56(3):300, 299.  
Ann Fam Med. 2011 Mar; 9(2): 165–171.  
The Medical journal of Australia 201.3 (2014): S69-73. 6.



## Driving factor 1: **Unsustainable Cost** (USA 2012)



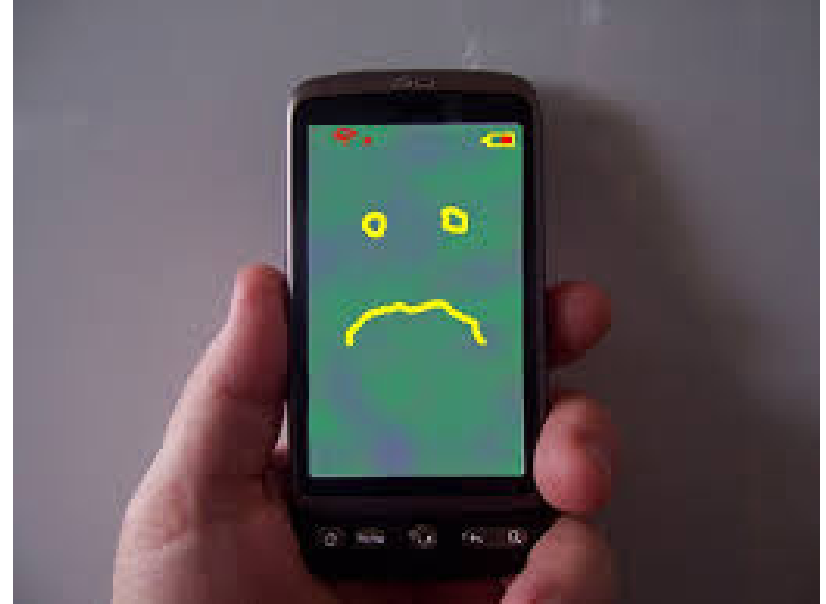
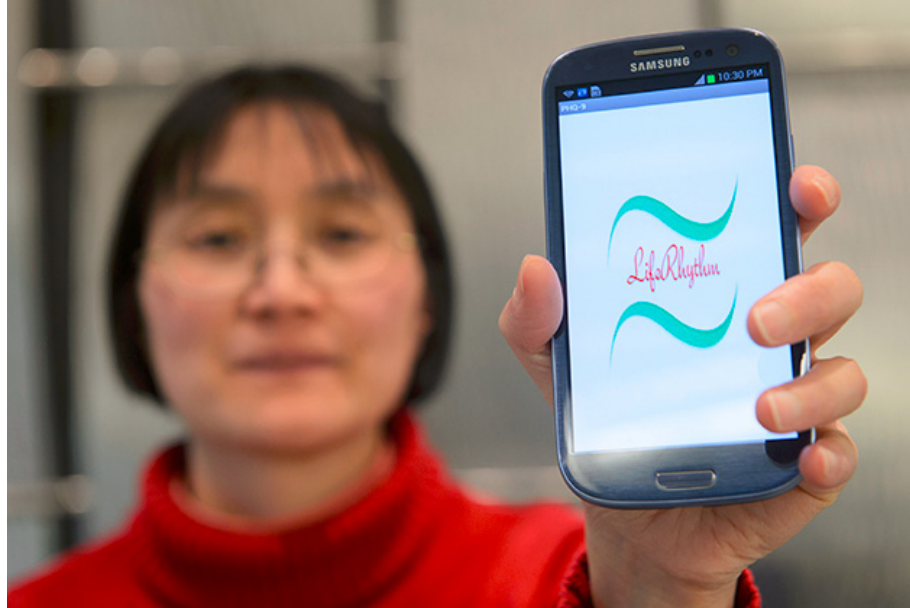
## Driving factor 2: Data



# Driving factor 3: Communication



## Smartphone Tells if You're Depressed



# Through smart mobile technology, individualized healthcare can be administered more efficiently and more effectively. Healthcare Revolution!!

Millennials are driving healthcare change: **And the Baby Boomers singing along**

Speedy delivery: If they can not get in NOW - TODAY – they will move !!

Provider reviews: 76% read online reviews prior to choosing a doctor.

Comparison shopping: 57% checked their insurance options online.

Upfront estimates: 41% requested estimates for a procedure in advance.

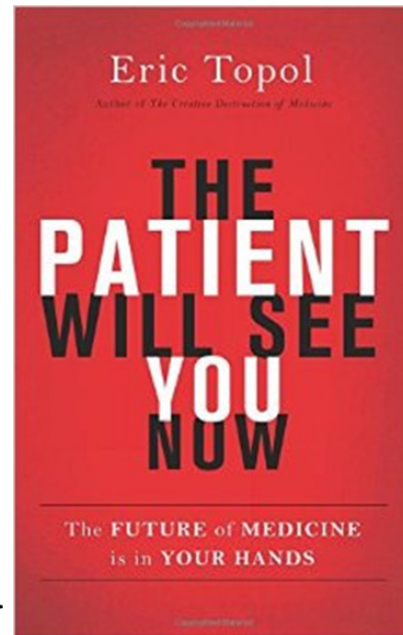
Procrastination care: 50% said they've put off care because of high costs.

74% value the ability to book appointments and pay bills online.

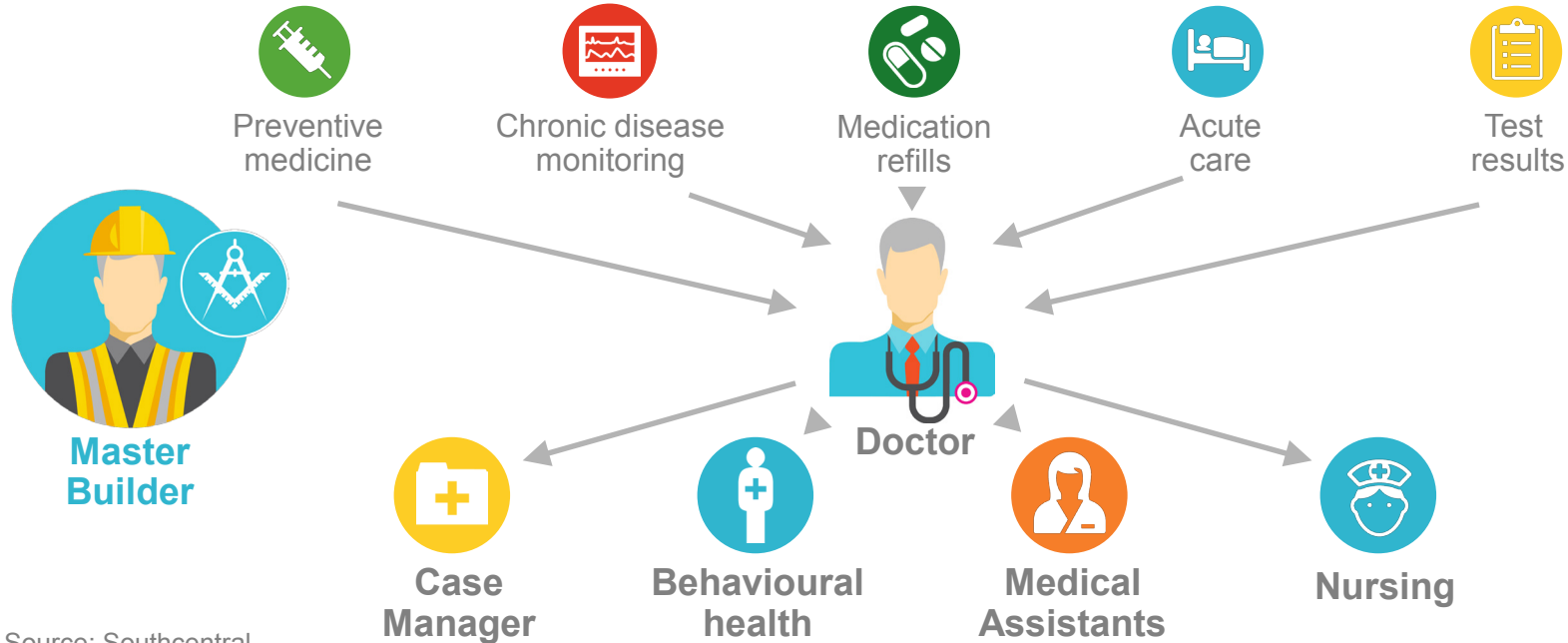
73% interested in their doctor using mobile devices during appointments to share info.

71% interested in a doctor-provided app for preventive care, health records, and scheduling.

63% interested in providing health data from devices to aid in monitoring their well-being.



# Practice transformation away from episode of care



Source: Southcentral  
Foundation, Anchorage AK



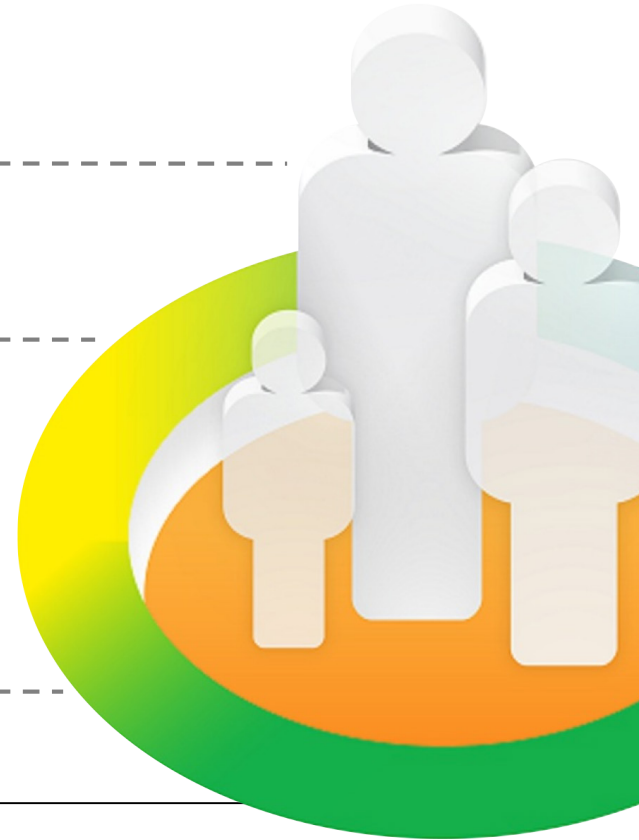
# New model of care – putting the patient first



Source: Southcentral  
Foundation, Anchorage AK



# Future healthcare transformation





## Today's Care

My patients are those making appointments to see me

Care is determined by today's problem and time available today

Care varies by scheduled time and memory/skill of the doctor

I know I deliver high quality care because I'm well trained

Patients are responsible for coordinating their own care

It's up to the patient to tell us what happened to them

Clinic operations centre on meeting the doctor's needs



## PCMH Care



Our patients are the population community

Care is determined by a proactive plan to meet patient needs with or without visits

Care is standardised according to evidence-based guidelines

We measure our quality and make rapid changes to improve it

A prepared team of professionals coordinates all patients' care

We track tests & consultations, and follow-up after ED & hospital

A multidisciplinary team works at the top of our licenses to serve patients

Source:  
Slide from Daniel  
Duffy MD School of  
Community Medicine  
Tulsa Oklahoma



# Defining the care centered on the patient



# Delivering the key principles



# Payment reform requires more than one dial

## Fee for...



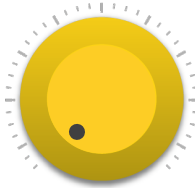
health



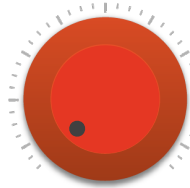
value



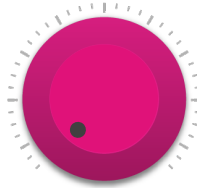
outcome



process



belonging



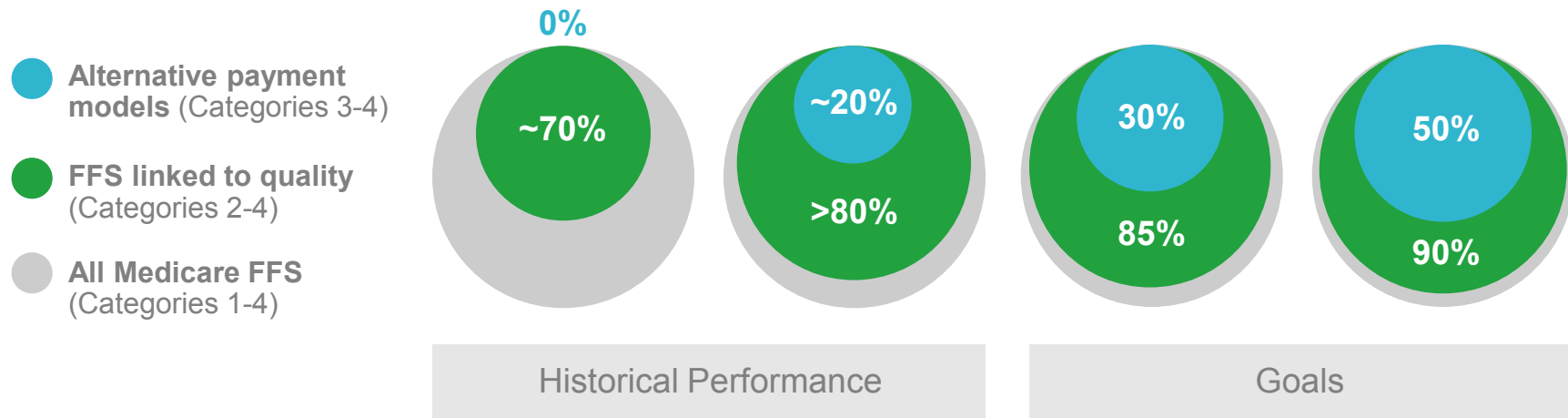
service



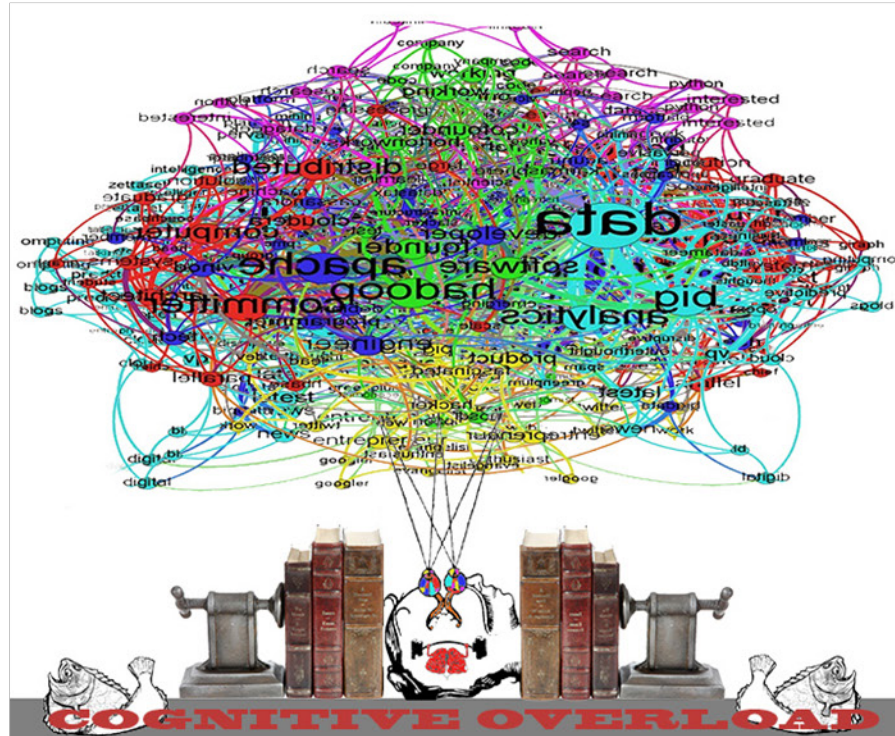
satisfaction



## Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018

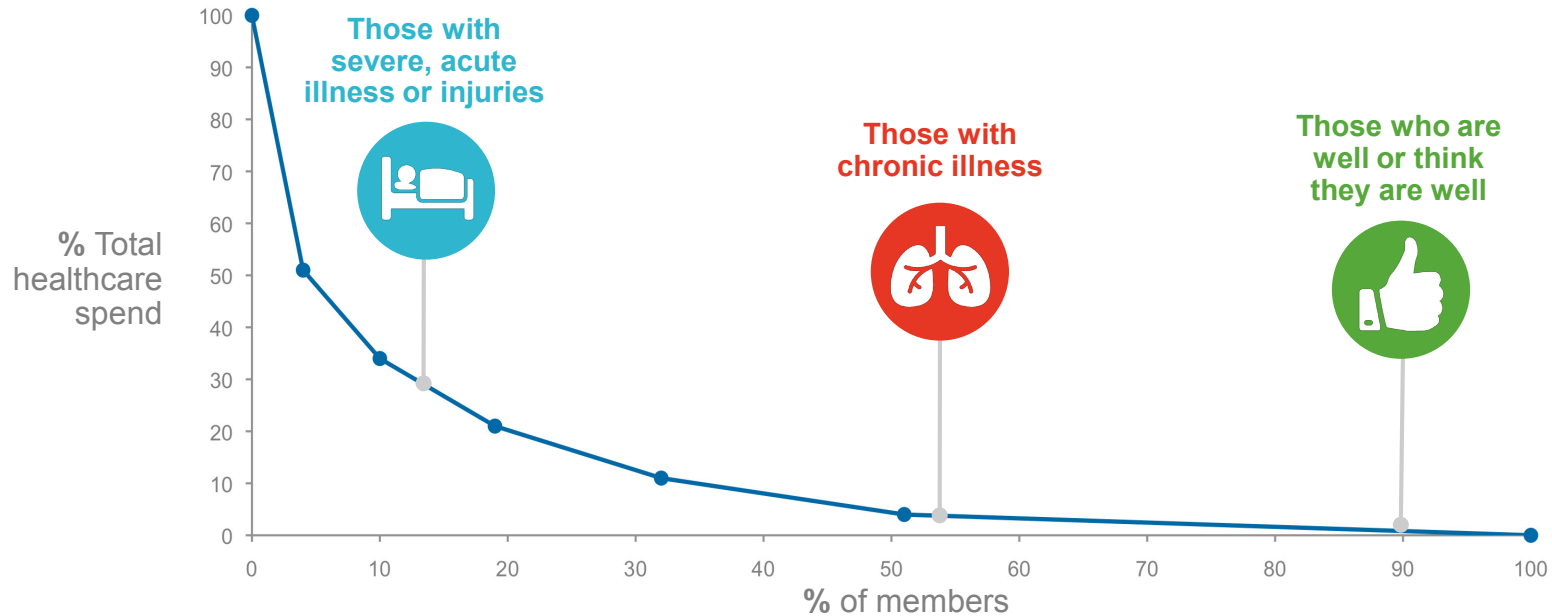


30% waste / 31% administrative overhead == Market Failure -- Cognitive failure **IBM**



# Benefit redesign – Patient engagement

## Different strategies for different Healthcare spend segments



# PCMH 2.0 in action



# Call and Check to provide support and care for the community



# Thank you

