



Patient-Centered
Medical Home
DEMONSTRATION PILOT

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Current Challenge



The Environment: Primary Care currently operates on a transaction-based model and reimbursement does not recognize the value of and specifically reimburse for **individualized, comprehensive care management.**

The Result:

- Significant reductions in physicians entering into and remaining in Primary Care Specialties
- Poor access to Primary Care
- Escalation of care unnecessarily into higher cost settings (e.g., Emergency Care, frequent Specialist visits, Inpatient)
- Suboptimal resource management
- Diminished health outcomes – particularly for those with chronic disease and behavioral health issues



Patient-Centered Medical Home Defined*

Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care of adults, youth and children. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

Principle Characteristics of PC-MH:

Personal Physician

Physician Directed Practice

Whole Person Care Orientation

Coordinated Care

Quality and Safety

Enhanced Care Access

Full Value Payment

*As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)

Collaboration Announced



NEWS RELEASE



UNITEDHEALTH GROUP, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AND AMERICAN COLLEGE OF PHYSICIANS JOIN TO ADVANCE INNOVATIVE PRIMARY CARE MODEL


UnitedHealth Group and physician groups to launch “medical home” pilot program to reward primary care doctors who improve patients’ total health

MINNEAPOLIS – (Aug. 6, 2007) – UnitedHealth Group (NYSE: UNH), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American College of Physicians (ACP) are announcing a pilot program to accelerate the implementation of a primary care model, called the patient-centered medical home, designed to improve patients’ total health and care delivery.

For the first time, UnitedHealth Group, with the support of the professional societies, will provide enhanced payment to reward primary care doctors whose care is based on this model, and who demonstrate measurable improvements in the *overall* health of their patients.

UnitedHealthcare's PC-MH Solution

PRACTICE QUALIFICATIONS

<p>24 x 7 Care Access</p> <ul style="list-style-type: none"> ▪ Timely Appointment Scheduling ▪ Evening, Weekend and Holiday Hours ▪ After-Hours Support 	
<p>Care and Chronic Condition Management</p> <ul style="list-style-type: none"> ▪ Specialty Referral Coordination and Tracking (with Q&E physicians) ▪ Disease and Case Management Enrollment ▪ Coordination of Care Across the Healthcare Continuum 	
<p>Team Care</p> <ul style="list-style-type: none"> ▪ Physician-directed team both in and outside of the practice setting ▪ Quality & Efficiency (Q&E) specialists 	
<p>Performance Measurement, Assessment & Improvement</p> <ul style="list-style-type: none"> ▪ Practice in accordance with clinical evidence ▪ Performance Evaluation Based on Medical Best Practices ▪ Measurement of Clinical Processes and Outcomes 	
<p>Clinical Information Systems</p> <ul style="list-style-type: none"> ▪ Care Management ▪ Decision Support ▪ Electronic Prescription Filling 	



Benefits

- Improved Quality at Lower Cost
- Increased Patient Satisfaction
- Improved Patient Safety
- Care Continuity & Improved Care Transitions
- Improved Practice Profitability and Satisfaction
- Value-based Payment
- Simplified and Coordinated Healthcare Experience

UHC OFFERS: ENABLING TECHNOLOGY & CLINICAL SUPPORT

<p>Technology & Tools</p>  <ul style="list-style-type: none"> ▪ POC Registry ▪ Personal Health Record ▪ ER POC Data & Event Notification ▪ Electronic Prescriptions ▪ Physician Dashboard 	<p>Care Coordination Management & Support</p>  <ul style="list-style-type: none"> ▪ Medical Home Care Advocate ▪ Educational Materials ▪ Patient Activation Tools ▪ Practice Redesign Support 	<p>Care Access</p>  <ul style="list-style-type: none"> ▪ 24-Hour NurseLine ▪ Group Visits ▪ eConsultation
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Health Information Technology and Tools

UnitedHealthcare will support PC-MH pilot practices with the following Health Information technologies and tools:

- ePrescribing
- Electronic registry
- Physician dashboard with information on:
 - ✓ Quality & Efficiency (Q&E) specialty physician lists
 - ✓ List of attributed patients
 - ✓ Notifications/alerts
 - ✓ Recent ER visits
 - ✓ Inpatient admissions
 - ✓ Medication adherence issues
 - ✓ Patient level EBM gaps
 - ✓ Interface with EMR, eConsults/visits, and disease management programs
 - ✓ Physician and practice performance data
 - ✓ Office-based measures from pilot practices
 - ✓ Care management and patient activation tools
 - ✓ PC-MH reference tools and best practices



Data Drives Physician Dashboard

Clinical Data Collection

Data Analytics

Physician Dashboard

Payer-Sourced

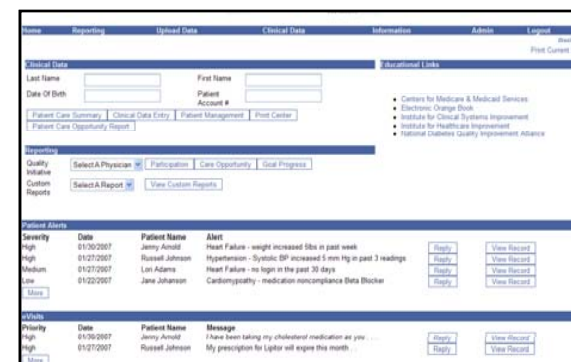
Medical	Behavioral
Rx	Patient Attribution

Physician-Sourced

EMR	Transcription
Registry	Labs

Other Systems-Sourced

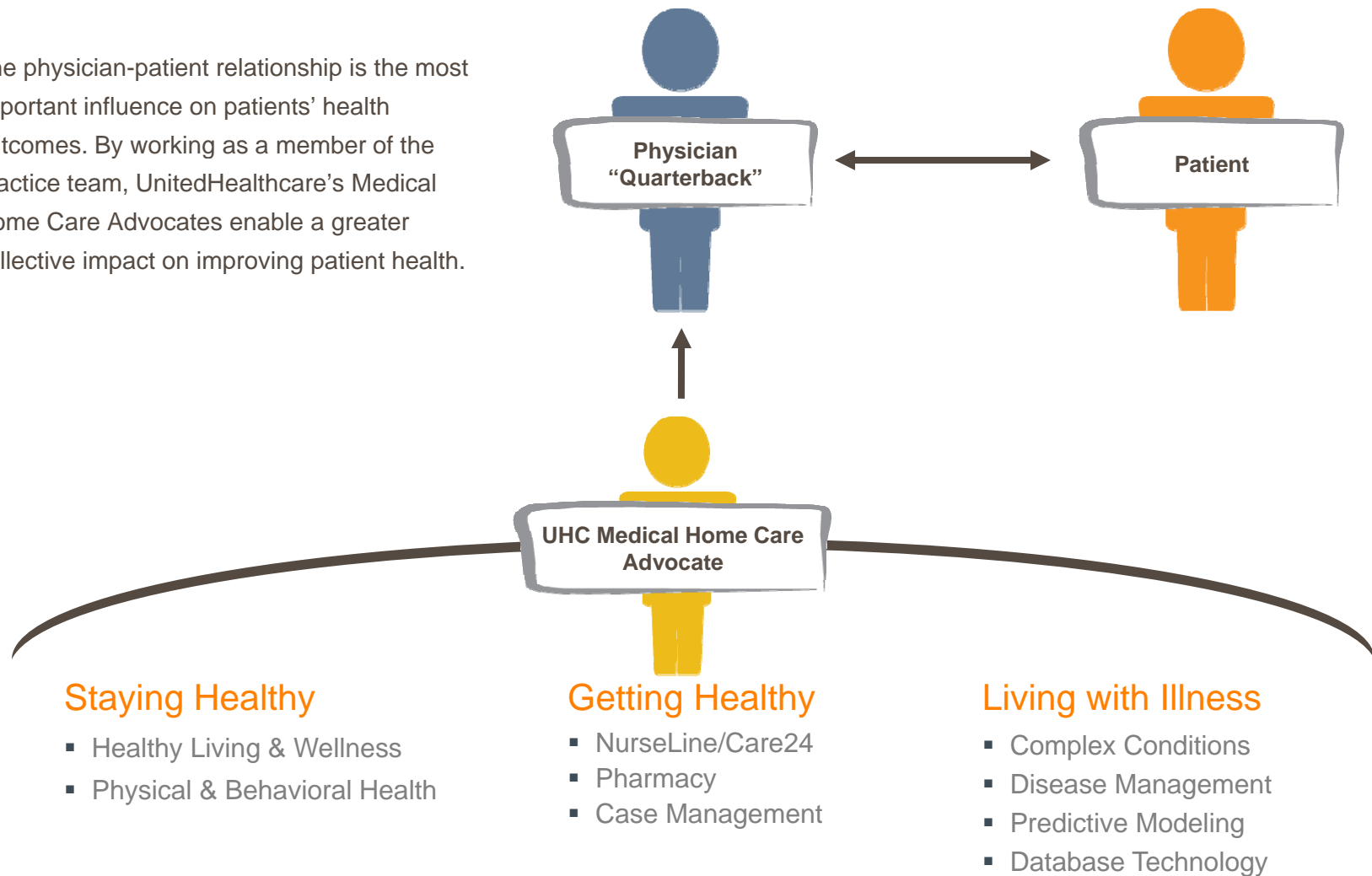
EBM Gaps	PHR
Referral	Hospital & ER



Advocate Model Puts Physician in Driver's Seat



The physician-patient relationship is the most important influence on patients' health outcomes. By working as a member of the practice team, UnitedHealthcare's Medical Home Care Advocates enable a greater collective impact on improving patient health.





Reimbursement Model

Reimbursement will be a combined Fee for Service (FFS) and PMPM Fee for all attributed practice patients.

- Enhanced payment derived through improved resource utilization (within the care system).
- Physicians remain on current contracted fee schedules and will be reimbursed based on services provided.
- Monthly PMPM supplement based upon quality, efficiency, and satisfaction improvements.
- PC-MH is grounded in providing more comprehensive and coordinated care; it is not about delivering less care to the patient – it is not capitation.
- We project primary care FFS reimbursement may increase by approximately 10 - 15%.
- Potential upside gain sharing will be explored based on pilot practice performance and actual medical cost savings realized.



Practice Assistance for PC-MH Pilot Launch

UHC will provide pilot launch assistance to PC-MH practices through the following:

PC-MH Education Session

a venue to provide education and important information:

- Tools to meet key qualifications
- Pilot expectations
- Use of health information technology tools such as the Physician Dashboard
- Practice improvement planning

Assigned Mentor

to provide consultation based on specific areas of need

Pilot Peer-Group Learning

pilot practices within a market will be brought together to discuss common issues, problem solve and learn from other practice group's experiences.

Ongoing Assistance

support the practice after initial ramp-up period:

- Monthly performance metrics
- Redesign and change management assistance
- UnitedHealthcare designated project coordinator to assist and answer questions



Pilot Approach

In early 2008, UnitedHealthcare's PC-MH national pilot is proposed to launch in the Denver, Colorado; Providence, Rhode Island; and Tampa, Florida markets

RANDOMIZED DESIGN

In order to validate the success of the PC-MH model, practice groups meeting the PC-MH pilot qualifications in each market will be randomly assigned to participate as a pilot practice site. A subset of those practices meeting the qualifications, but not selected as a pilot practice site, will serve as the comparison ("control") group.

- 24,000-30,000 patients split evenly between intervention and control practices
- Total of 12-15 unique intervention practice sites
- Pilot will focus on adult practices (Internal Medicine and Family Physicians)
- The pilot duration is 24 months

Pilot Markets



TAMPA

- multi-payer initiative
- includes Medicare Advantage



PROVIDENCE

- multi-payer initiative
- led by Rhode Island quality improvement organization
- includes Americhoice (Medicaid)



DENVER

- multi-payer initiative
- includes Medicare Advantage



Consumer and Physician Practice Research



Research Overview

Qualitative research was conducted to test the PC-MH program concept with consumers, primary care physicians and clinic administrators to assess level of interest and acceptance of this program in the market.

Purpose of the Research:

- Gain insight into the role primary care physicians play in the lives of their patients and clarify the value they provide
- Explore reactions to the PC-MH concept to determine its possible impact on the perceptions patients have of Primary Care
- Gauge reactions to the PC-MH concept among PCPs and clinic administrators
- Understand key factors that positively impact patients' perceptions and attitudes toward Primary Care in the context of the PC-MH concept
- Determine how to most effectively position and communicate the value and benefits of the PC-MH concept to both consumers and physicians



Consumer Reactions to PC-MH Model

Most respondents were favorable about the PC-MH concept. Regardless of whether they had a PCP or not, the idea of seeing one doctor who would be responsible for their healthcare was appealing. The concept seemed to offer the personalized care they thought was important in a PCP. Among the specific advantages respondents thought the PC-MH held for them:

- Positive Impact to Quality and Cost
- Coordinated Care
- Central Repository for All Healthcare Information
- Team Approach
- Online Access to Tools and Resources
- Enhanced Care Access
- Educational Materials





Consumer Reactions to PC-MH Model

“If what seems to be change turns out to make physicians and their offices more efficient and starts to save them time and it translates to money and filters down to the consumer, then I’m really in favor of it.”

Consumer with Chronic Condition



“The one piece that I like about is the coordinated care, it talks about being able to have your health records go from a clinic to a hospital to home healthcare. Online medical records are big. I do a lot of traveling and just in case I might need to go to the doctor when I am out of town instead of them having to pigeon carry records, they can send them electronically. That’s huge.”

Consumer with Chronic Condition



“I like the idea of a patient education program. . . I’ve gotten lots of pamphlets from my doctor, but I have never had them say the hospital down the road is offering a clinic on childhood asthma that you might like to attend. I’ve never had anything like that before. I don’t get information emailed to me or links to websites.”

Consumer – Child with Chronic Condition



“They’re taking more responsibility to make sure we schedule appointments or remind us of necessary screenings. Some of you have that already, but I don’t. So that part, (I like the ideas of)the coordinated care and more communication.”

Consumer with Chronic Condition





Pilot Success – Measurement Criteria

Physician & Patient Experience

- Patient Satisfaction
- Access to Care
- Self-Reported Patient Health
- Physician and Care Team Satisfaction

Quality

- Preventive and Chronic Care Screening
- Behavioral Health Coordination
- Use of EBM Guidelines
- Medication Adherence
- Coordination of Care Transitions: ER, IP, and Specialists
- Use of Q&E Specialists

Resource Use

- Hospital
- Emergency Care
- Pharmacy
- Imaging
- Physician Office

Data Sources: Claims Data, Clinical Data, Qualitative Interviews with Physicians, Observation, Qualitative Surveys of Physicians and Patients



Every vine needs a trellis. Without a trellis, irrepressible human activity and initiative remains on the ground in a tangle.

PEEK AND HEINRICH (1993)