

Medical Home Physician Collaboration

For the Health of Texas

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Patient-Centered Medical Home (PCMH)



"A model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians*."

Primary Care Medical Home (PCMH) Standard Model

Redesigning the Way Primary Care is Delivered and Financed



Trusted personal physician

Physician who provides, manages and facilitates care

Care is coordinated or integrated across healthcare system

More accessible practice with increased hours and easier scheduling

Payment mechanisms that recognize the added value of delivering care through the PCMH model

Assistance to practices seeking transformation Support to practices adopting HIT for QI

The Patient-Centered Medical Home Model



Changes in Clinician Incentives

Blended Payment

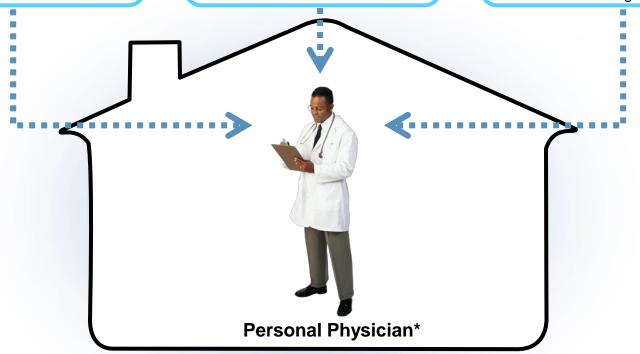
- Fee for service
- Prospective payment
- Pay for outcomes

Better Work Environment

- Team effort
- Increased responsibility for clinicians
- Real time claim & clinical information

Improved Patient Interaction

- More time for patients
- Better communication and access
- Care/Case/Chronic disease management



^{*} Includes the PCMH team

BCBSTX PCMH Model

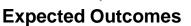


- Built off of NCQA Medical Home Standards
- Focuses on Preventive Care and Chronic Conditions
 - Cervical, Colorectal, Breast Cancer Screenings
 - Asthma, Coronary Artery Disease, Diabetes
- Family Medicine, Internal Medicine, Pediatrics

Current Status

- 2 year Pilot
- Two Groups in North Texas
- Total Membership = approx. 20K
- Medical groups and BCBSTX reconciling data
- 2/1/2010 and 3/1/2010 launch dates

BCBSTX Metrics



- 1. Reduced Hospitalization
- 2. Reduced ER Utilization
- 3. Improved Clinical Outcomes
- 4. Improved Patient Satisfaction

BEST HEALTH AT BEST VALUE