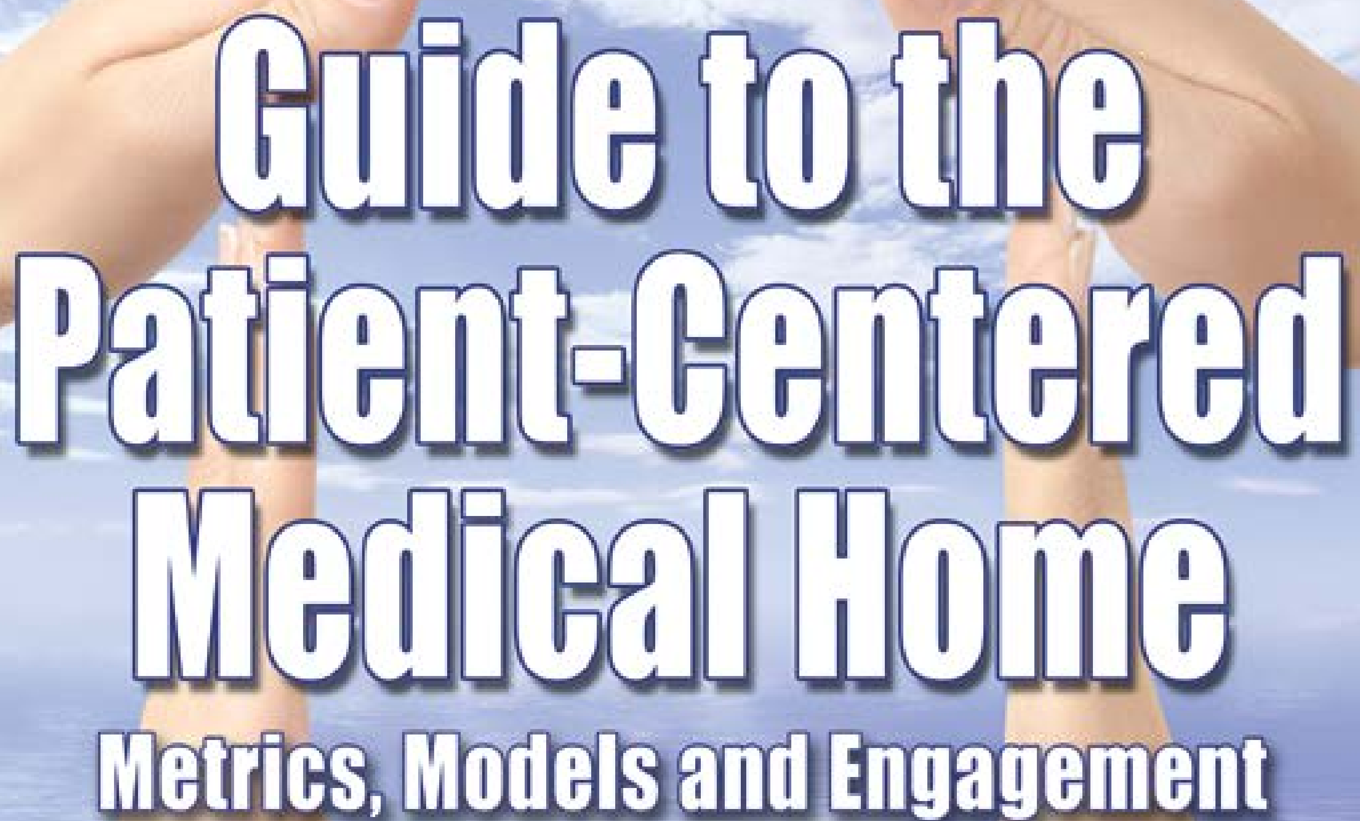

Note: This is an authorized excerpt from the *Guide to the Patient-Centered Medical Home*. To download the entire guide, go to http://store.hin.com/product.asp?itemid=4611 or call 888-446-3530.

The Healthcare Intelligence Network
800 State Highway 71, Suite 2
Sea Girt, NJ 08750

Guide to the Patient-Centered Medical Home:

Metrics, Models and Engagement

presented by the
Healthcare Intelligence Network

A publication of:
The Healthcare Intelligence Network
800 State Highway 71, Suite 2
Sea Girt, NJ 08736
Phone: (732) 449-4468
Fax: (732) 449-4463
http://www.hin.com

Guide to the Patient-Centered Medical Home:

Metrics, Models and Engagement

Contributors

Jay Driggers, director of consumer experience and engagement, Horizon Blue Cross Blue Shield of New Jersey
Barbara Haasis, RN, CCRN, senior clinical lead for quality reward and recognition programs at Florida Blue
Diane Littlewood, RN, BSN, CDE, regional manager of case management for health services at Geisinger Health Plan
Geralyn Prosswimmer, MD, medical director of primary care services, Hunterdon Healthcare, and medical director, Hunterdon Healthcare Partners
George Roksvaag, MD, chief medical officer, Hunterdon Healthcare
Joann Sciandra, RN, BSN, CCM, regional manager of case management for health services at Geisinger Health Plan

Executive Editor

Melanie Matthews
HIN executive vice president and chief operating officer

Contributing Editors

Patricia Donovan
Jackie Lyons
Jessica Fornarotto

Cover Design

Jane Salmon

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Executive Editor's Note

Welcome to the Healthcare Intelligence Network's *Guide to the Patient-Centered Medical Home: Metrics, Models and Engagement*. The patient-centered medical home (PCMH) has become a hallmark of healthcare delivery. Its team-based model is a mainstay of care coordination for thousands of physician practices that have already transformed themselves into medical homes — many of which are poised to step into an accountable care organization (ACO), according to 2012 market data.

In a nod to the PCMH's potential for improving care and controlling cost, many payors have placed case managers in medical homes to assist with stratification and care coordination of high-risk patients.

This guide provides an overview of PCMH adoption and results and examines nuances of the model that have emerged in recent years — including the embedding of case managers on medical home teams.

Besides a complete set of benchmarks from almost 100 organizations on medical home adoption and program components, HIN's sixth annual PCMH analysis, this 155-page guide offers snapshots from four thriving medical home programs, including the following.

- ✓ The statewide rollout of Florida Blue's medical home program, from practice selection to reimbursement models;
- ✓ The comprehensive PCMH consumer engagement and education effort underway at Horizon Blue Cross Blue Shield of New Jersey to position the Blues plan for accountable care;
- ✓ Advice on achieving Level III NCQA medical home recognition, joining an ACO, and participating in the CMS Comprehensive Primary Care initiative from Hunterdon Healthcare;
- ✓ Roadmap to the embedding of case managers: Geisinger Health Plan's selection, training, skill set, processes and benefits of case managers embedded within the payor's medical home practices, a model that has become an industry template for co-located case management.

The trends and best practices contained in the *Guide to the Patient-Centered Medical Home: Metrics, Models and Engagement* will help healthcare organizations to raise the bar on care coordination and population health management of high-risk patients and high-cost health events.

Melanie Matthews, HIN executive vice president and chief operating officer

2012 Healthcare Benchmarks: The Patient-Centered Medical Home

This special report is based on results from the Healthcare Intelligence Network's sixth annual "Patient-Centered Medical Homes in 2012" e-survey administered in May 2012.

Executive Editor

Melanie Matthews

HIN executive vice president and chief operating officer

Project Editors

Patricia Donovan

Jackie Lyons

Jessica Papay

Document Design

Jane Salmon

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2012 Healthcare Benchmarks: The Patient-Centered Medical Home

95 healthcare organizations discuss the latest metrics and measures on current and planned PCMH initiatives, as well as PCMH effectiveness, targeted populations and conditions, medical home team members, health IT in use and more.

"[The biggest challenge we faced in medical home creation] was educating the patients as to the meaning of a medical home, as well as getting participation and buy-in."
> Community health center

"The diabetes and COPD populations [are our targeted individuals for our planned medical home]."
> Healthcare consulting company

"[The most effective tool in use in our medical home] is a patient profile, which includes all providers, specific care gaps, etc."
> Care coordination organization

"In the year to come, healthcare reform will strengthen the medical home by providing new revenue sources that support the care of more patients in innovative ways."
> Hospital/health system

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About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.

In 2012, 52% of survey respondents have established medical homes for their population.

Executive Summary

The rise in medical home starts over the last six years has been accompanied by a steady climb in patient satisfaction. This metric has risen from 49 percent in 2006 to 79 percent in 2009 to 86 percent in 2012, according to 95 healthcare companies who completed the sixth annual Healthcare Intelligence Network survey on Patient-Centered Medical Homes (PCMH).

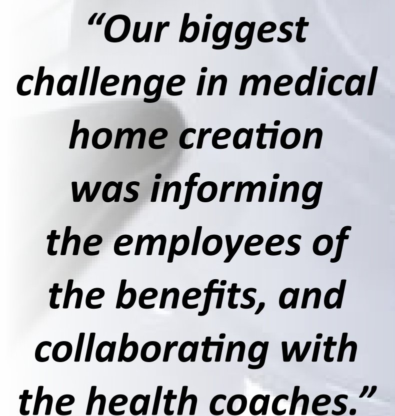
When asked in 2006, only 33 percent of respondents were trying to establish a medical home. However, by 2012, 52 percent have established medical homes for their populations. And 59 percent of existing medical homes are now or soon will be part of an accountable care organization (ACO).

With increased patient accountability in the PCMH, ACOs and other emerging healthcare delivery models, healthcare organizations need to engage patients in ways that increase quality, reduce cost and improve their overall healthcare experience. The top three reported ways to educate and engage patients in the medical home are physician training (79 percent), health coaching (76 percent) and patient outreach (66 percent).

Medical home occupancy is on the rise, too. The majority of respondents in 2006 and 2009 reported that only 0 to 5 percent of their members/patients were assigned a designated medical home, but in 2012 the highest percentage of respondents (28 percent) said participation was at 21 percent or more.

Time for medical home conversion has dropped for most, from 12-18 months in 2009 to less than a year in 2012.

Electronic health records (EHRs) remained the top health IT used from 2009 (74 percent) to 2012 (90 percent). Other top tools in 2012 are e-prescribing, patient registries and e-mail or text message.



"Our biggest challenge in medical home creation was informing the employees of the benefits, and collaborating with the health coaches."

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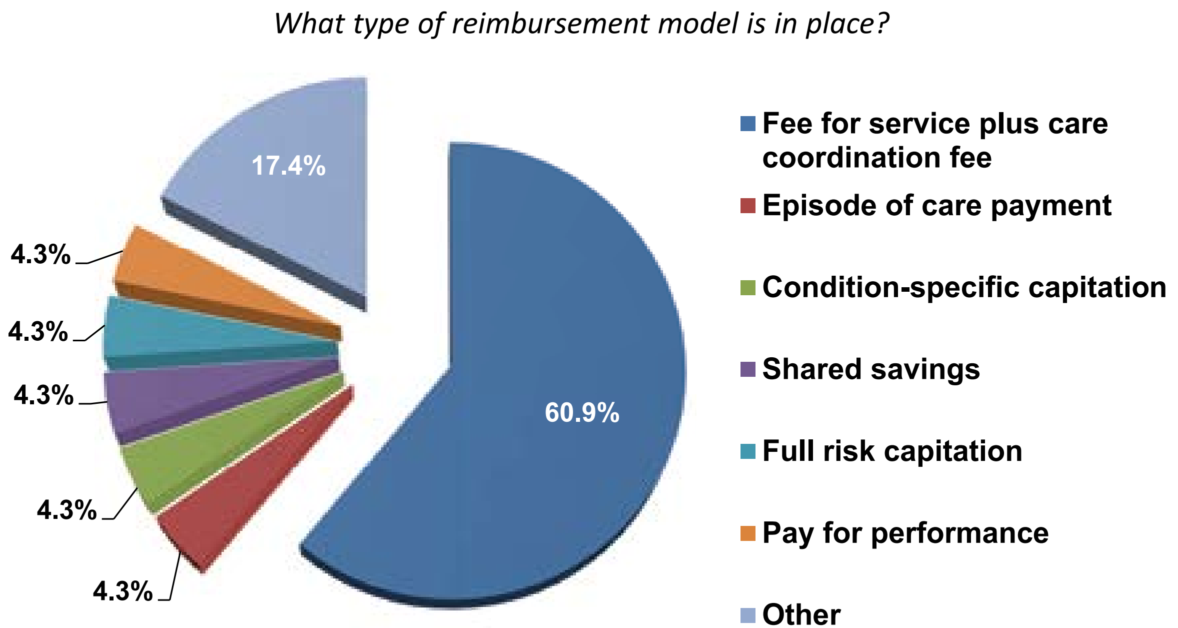
Figure 15: All - Reimbursement Model

What type of reimbursement model is in place?



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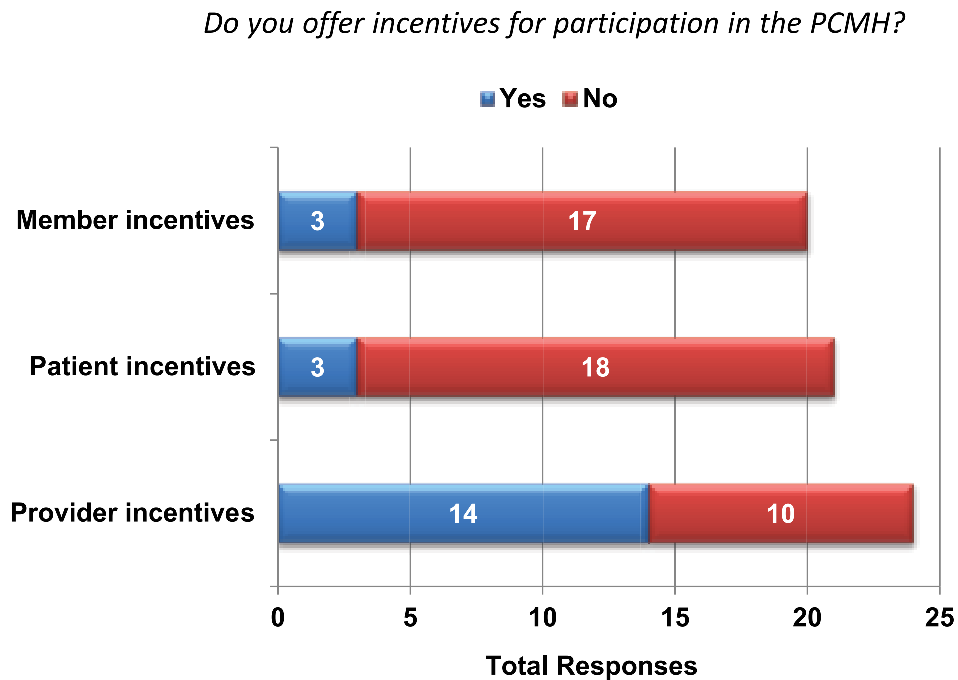
May, 2012

Figure 16: All - Incentives for PCMH Participation

Do you offer incentives for participation in the PCMH?



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May, 2012

New Models in the Patient-Centered Medical Home:

Incentives, Infrastructure and IT to Support Accountable Care

presented by the

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The Healthcare Intelligence Network
800 State Highway 71, Suite 2
Sea Girt, NJ 08750
Phone: (732) 449-4468
Fax: (732) 449-4463
http://www.hin.com

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New Models in the Patient-Centered Medical Home:

Incentives, Infrastructure and IT to Support Accountable Care

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This special report is based on two 2012 Healthcare Intelligence Network (HIN) webinars hosted by Melanie Matthews, HIN executive vice president and chief operating officer, with additional content from HIN's sixth annual Patient-Centered Medical Home survey and interviews with survey respondents. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

Contributors

Jay Driggers, director of consumer experience and engagement, Horizon Blue Cross Blue Shield of New Jersey
Barbara Haasis, RN, CCRN, senior clinical lead for quality reward and recognition programs at Florida Blue
Geralyn Prosswimmer, MD, medical director of primary care services, Hunterdon Healthcare, and medical director, Hunterdon Healthcare Partners
George Roksvaag, MD, chief medical officer, Hunterdon Healthcare

Moderator

Melanie Matthews
HIN executive vice president and chief operating officer

Editor

Patricia Donovan

Contributing Editors

Jackie Lyons
Jessica Papay

Cover Design

Jane Salmon

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New Models in the Patient-Centered Medical Home:

Incentives, Infrastructure and IT to Support Accountable Care

Post-ACA, patient-centered medical home (PCMH) initiatives continue unabated around the country. Fifty-two percent of 2012 respondents to HIN's sixth annual survey on the PCMH, highlights of which are included in this report, have established medical home programs for their populations; 59 percent of these are now or soon will be part of an accountable care organization (ACO).

Having had several years to test the patient-centered care delivery for a while, the industry is making a considerable effort to engage and educate patients and health plan members, fortify the model with a framework of IT and infrastructure and indoctrinate doctors in the medical home's dual priorities of care coordination and healthcare quality.

2012 Survey Results: Patient-Centered Medical Home

The rise in medical home starts over the last six years has been accompanied by a steady climb in patient satisfaction. This metric has risen from 49 percent in 2006 to 79 percent in 2009 to 86 percent in 2012, according to 95 healthcare companies who completed the sixth annual Healthcare Intelligence Network survey on Patient-Centered Medical Homes (PCMH).

When asked in 2006, only 33 percent of respondents were trying to establish a medical home. However, by 2012, 52 percent have established medical homes for their populations. And 59 percent of existing medical homes are now or soon will be part of an accountable care organization (ACO).

With increased patient accountability in the PCMH, ACOs and other emerging healthcare delivery models, healthcare organizations need to engage patients in ways that increase quality, reduce cost and improve their overall healthcare experience. The top three reported ways to educate and engage patients in the medical home are physician training (79 percent), health coaching (76 percent) and patient outreach (66 percent).

The Medical Home Case Manager:

Profiting from Patient-Centered Care

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800 State Highway 71, Suite 2
Sea Girt, NJ 08750
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Fax: (732) 449-4463
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The Medical Home Case Manager:

Profiting from Patient-Centered Care

This special report is based on 2009 and 2010 Healthcare Intelligence Network (HIN) webinars hosted by Melanie Matthews, HIN executive vice president and chief operating officer. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

Authors

Diane Littlewood, RN, BSN, CDE, regional manager of case management for health services at Geisinger Health Plan

Joann Sciandra, RN, BSN, CCM, regional manager of case management for health services at Geisinger Health Plan

Moderator

Melanie Matthews

HIN executive vice president and chief operating officer

Editors

Patricia Donovan

Jessica Papay

Cover Design

Jane Salmon

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The Medical Home Case Manager: Profiting from Patient-Centered Care

In a new survey of healthcare organizations on the patient-centered medical home model, 60 percent of respondents include case managers on the medical home care team, with more than half of these respondents embedding these case managers within the primary care practice. An early adopter of this trend is Geisinger Health Plan. This special report provides an inside look at the selection, training, skill set, processes and benefits of Geisinger Health Plan's embedded case managers who are working on site in the payor's medical home practices.

Payoffs of Placing Geisinger Case Managers at Primary Care Sites

Diane Littlewood, RN, BSN, CDE, and Joann Sciandra, RN, BSN, CCM, are regional managers of case management for health services at Geisinger Health Plan.

Geisinger Healthcare System is an integrated health service organization. We are linked with providers, facilities, physician practice groups and managed care companies, which comprise the Geisinger Health Plan (GHP). We are in central Pennsylvania, and our main hospital is in Danville.

Figure 1 on page 5 illustrates our integrated service organization. We have over 40 community service practice sites with 700 physicians and our practice group also entertains 200 interns and a residency program as well.

The success of our patient-centered medical home (PCMH) model is from the relationship that we have with our physician practice group and the GHP. Our physician practice group brings to this model the physicians, the practice sites and the patient population. As a managed care company, we employ 70 case managers who are integral to the PCMH model. We also have a robust clinical reporting department and an actuarial department that bring success to the model. We're fortunate to be in partnership with our physician practice group.

As a health plan, population profiling and segmentation are part of our service. We use predictive modeling in profiling and segmentation, and we have case management on site. We have a disease management (DM) department with traveling nurses and a remote monitoring system for heart failure (HF) and transitions of care.

Our focus is on embedded case managers — how we choose them and train them and some of the skill sets necessary and valuable in providing case

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