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PATIENT-CENTERED PRIMARY CARE

Transformation to a better state of health

OUT OF $3 TRILLION THE U.S. SPENDS ANNUALLY ON HEALTH CARE,

$750 BILLION IS WASTED.[1]

We rank last or next-to-last in quality, access, efficiency and equity.[2]

1 Institute of Medicine of the National Academies, September 2012 Report; Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.
2 The Commonwealth Fund, June 2010.

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With patient-centered primary care,

We're changing health care from the ground up.

BEGINNING WITH:
Improved Access
Payment Innovation
Information Sharing
Coordinated Care

IMPROVED ACCESS

Connecting employees to more effective health care—anytime, anywhere.

- **Care teams**
- **24/7 access to care**
- **Retail clinics**
- **Online technology and e-visits**
- **Resources for chronic-disease management, prevention and wellness**

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PAYMENT INNOVATION

We're changing the way physicians are paid — **Reinforcing value over volume-based care and Rewarding improved quality at reduced cost.**

Clinical Coordination fees compensate providers for preparing care plans for patients with multiple and complex chronic conditions.

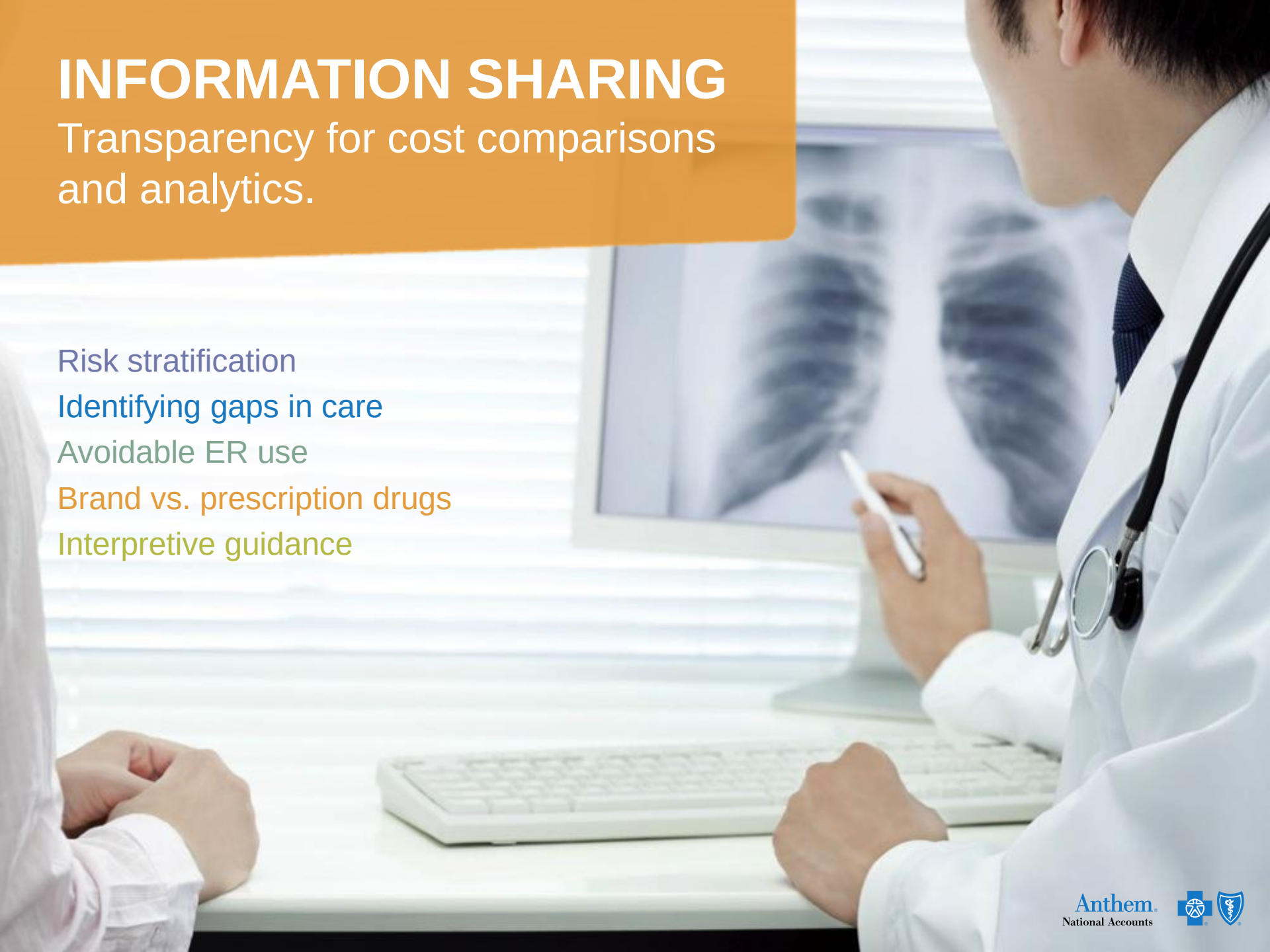
Once providers achieve established quality standards,

they are eligible for additional shared savings.

This adds up to a significant and highly motivating increase in take-home pay.

INFORMATION SHARING

Transparency for cost comparisons and analytics.



- Risk stratification
- Identifying gaps in care
- Avoidable ER use
- Brand vs. prescription drugs
- Interpretive guidance

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COORDINATED CARE

Managing quality health care for every employee and their family.

ANTHEM PROVIDES PRIMARY-CARE PHYSICIANS WITH:

Tools to support personalized care plans and wellness programs

Virtual care managers who work as an extension of the practice

Access to more complete medical history information on their patients

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PROVING IT—AGAIN AND AGAIN.

Pilot programs deliver lower costs while improving health across the country.

18% FEWER
HOSPITAL ADMISSIONS
15% FEWER
ER VISITS, IMPROVEMENT IN ALL DIABETES MEASURES

COLORADO
PCMH

3.6% FEWER
HOSPITAL ADMISSIONS
6.1% FEWER
ER VISITS, IMPROVEMENT IN ALL DIABETES MEASURES

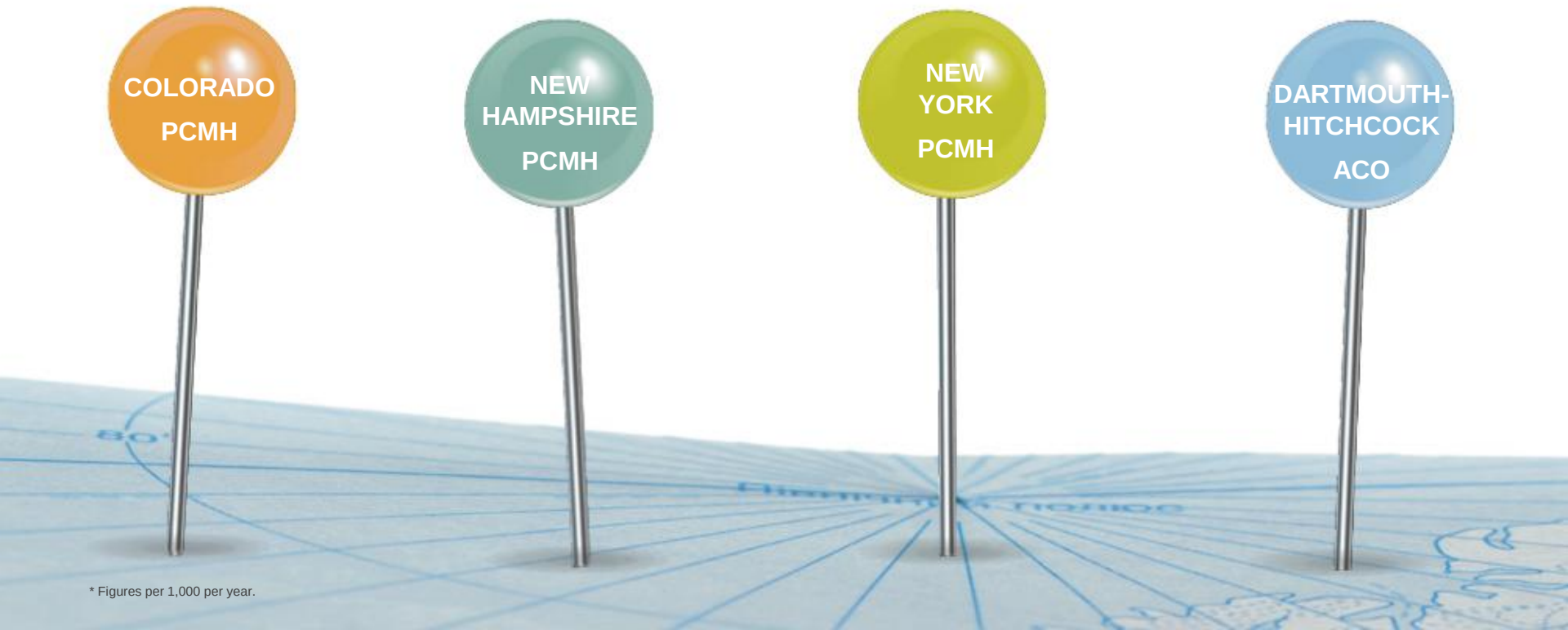
NEW HAMPSHIRE
PCMH

12-23% FEWER
HOSPITAL ADMISSIONS
11-17% FEWER
ER VISITS

NEW YORK
PCMH

5.81% FEWER
HOSPITAL ADMISSIONS
10.6-18% FEWER
ER VISITS

DARTMOUTH-HITCHCOCK
ACO



* Figures per 1,000 per year.

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TRANSFORMATION

Making change a reality through value-based contracting.

INCENTIVES
payments based on quality of care, not quantity

TRANSPARENCY
actionable information on costs and effectiveness

SUPPORT
clinical reinforcement for care coordination


CHANGE IS GOOD.
CHANGE IS HERE.
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