


Patient-Centered Medical Home The Evidence and the Model

Second Anniversary Dinner
Partnership for Peak Healthcare Performance
Dallas, Texas
November 17, 2009

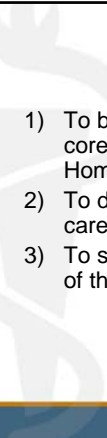
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President-elect, American Academy of Family Physicians



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Goals


- 1) To briefly review the history, evolution, and core attributes of the Patient Centered Medical Home Model
- 2) To discuss the evidence supporting a primary care based health care system
- 3) To share recent outcomes of implementations of the patient centered medical home model



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Patient Centered Medical Home


A model to provide primary care of the future



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Joint Principles of PCMH

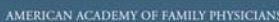
- Personal physician
- Physician directed medical practice
- Team approach
- Whole person orientation
- Coordination of care
- Quality & safety
- Enhanced access
- Payment for added value



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Milestones in PC Transformation

Martin Sepulveda- IBM 2009




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Medical Home is Built on Primary Care Foundation

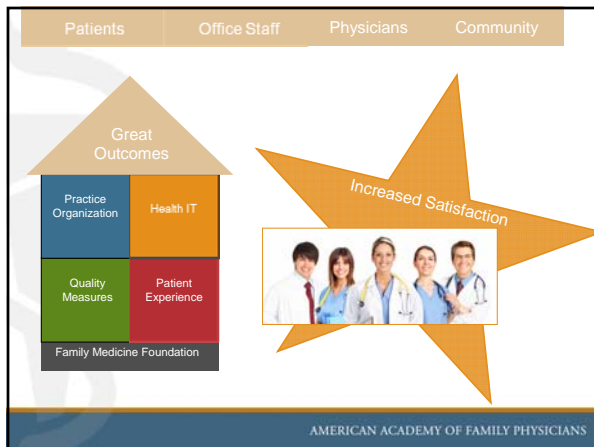
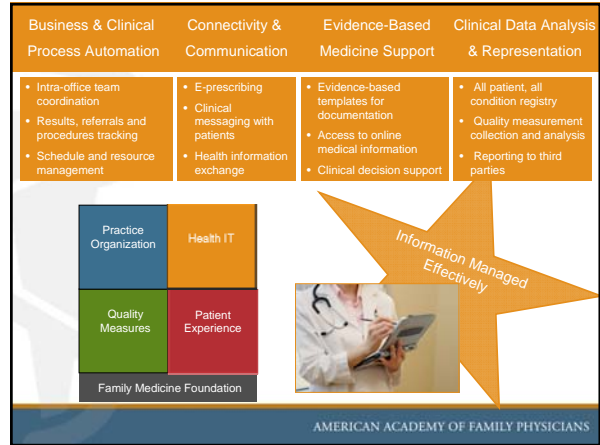
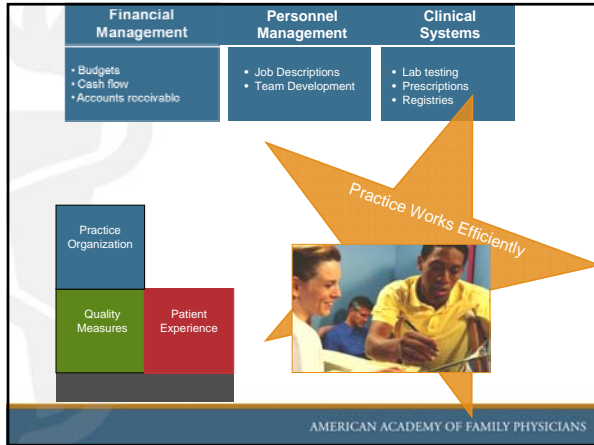
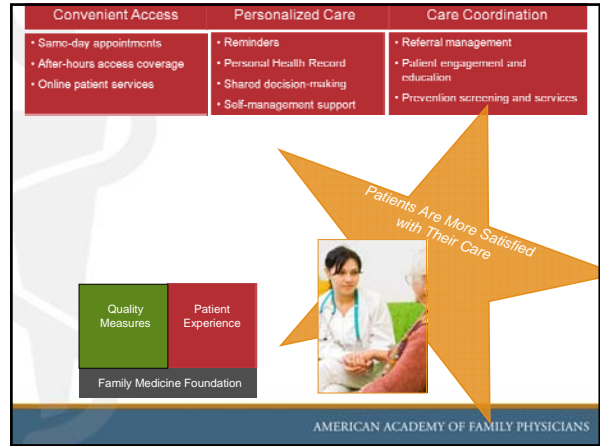
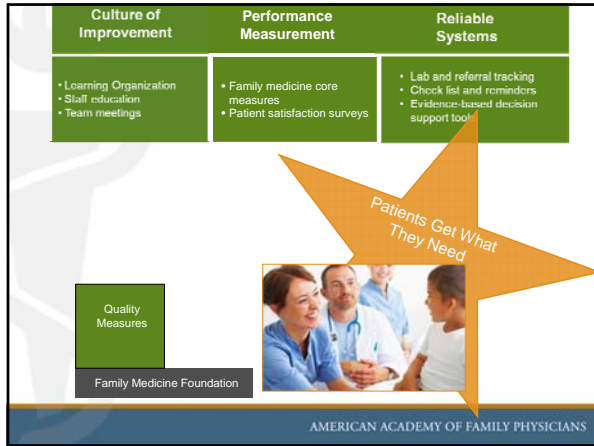
Core Values of the Discipline

- Continuous Healing Relationship
- Whole-person Orientation
- Family and Community Context
- Comprehensive Care

Primary Care Foundation

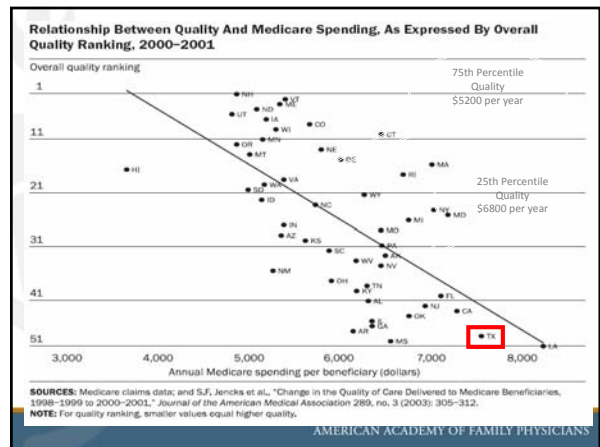
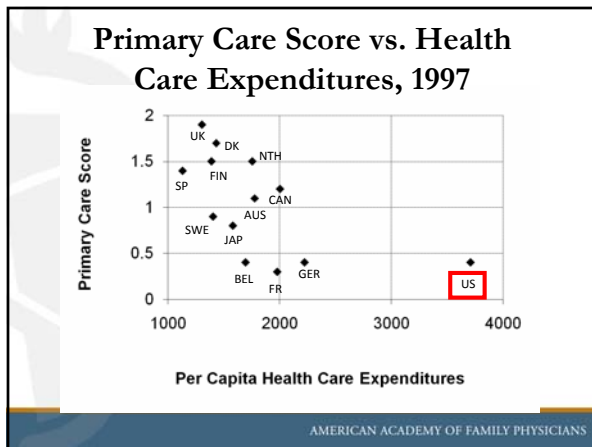
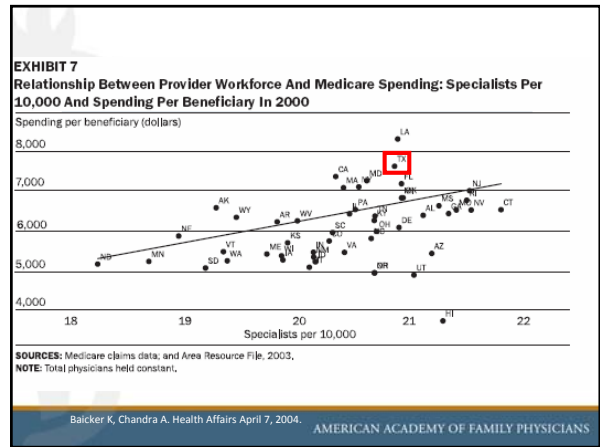
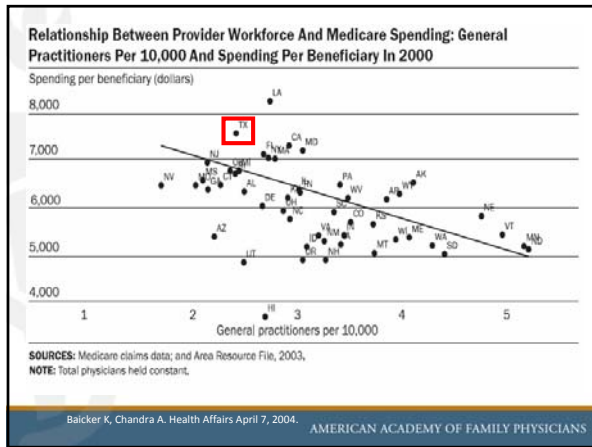
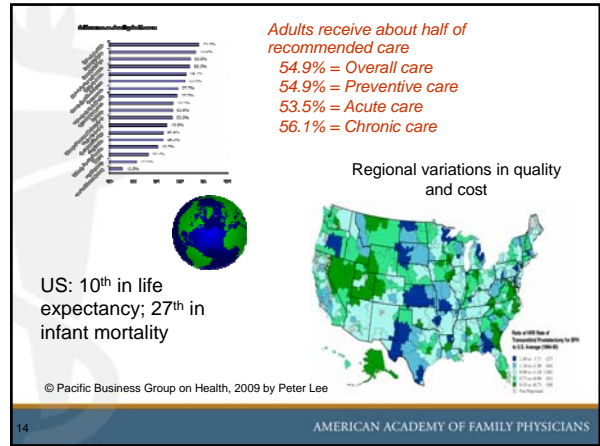
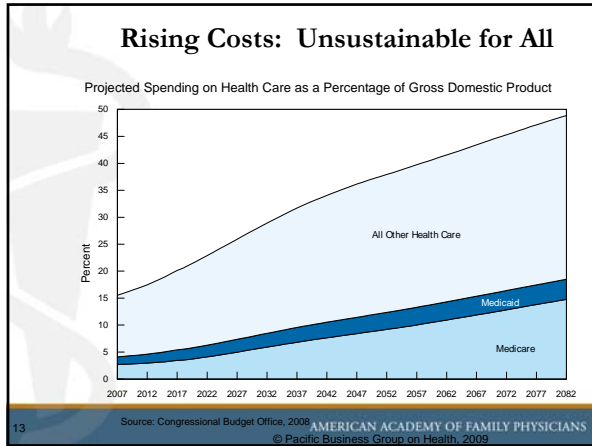


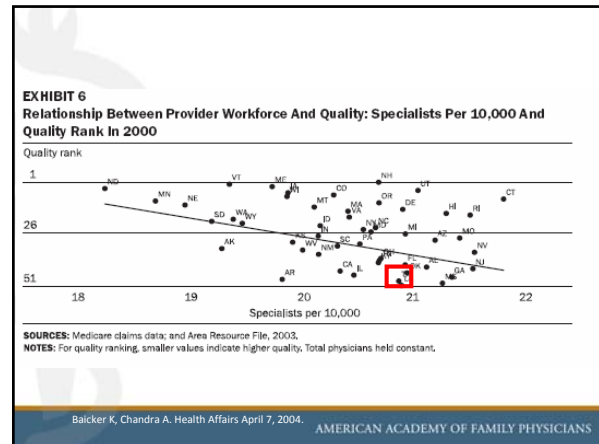
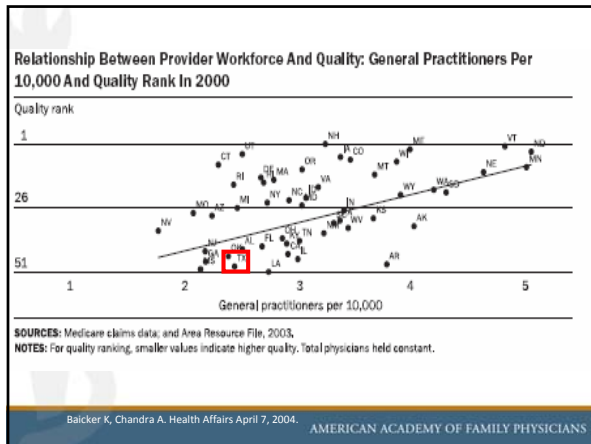
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System Problems and Evidence for a Primary Care Foundation

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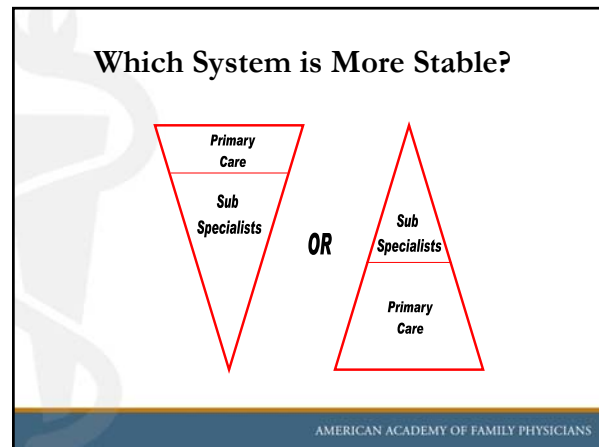


Research Demonstrates the Value of the PC

Having a regular source of primary care is associated with:

- Lower emergency room utilization
- Fewer hospital admissions
- Fewer unnecessary tests and procedures
- Less illness and injury
- Lower per person costs
- Improved quality of care
- Higher patient satisfaction

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A move toward primary care medicine, a key to better quality and lower costs, is impeded by the health care system's current financing mechanisms

- GAO, February 2008

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American Primary Care Has Been Severely Damaged

- General internal medicine is all but extinct as a primary care discipline (ACP survey) (The true impending crisis)
- The primary care workforce is inadequate for the task at hand
- Frustrated primary care providers
- Many primary care practices are failing to deliver on the essential attributes of primary care
- Primary care reimbursement creates perverse incentives
 - Incentivizes visits not outcomes
 - Whom you care for matters more than how good a job you do
 - Drives excessive practice overhead costs

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Outcomes of Implementations of the Patient Centered Medical Home model

Based on Data Collected by the Patient Centered Primary Care Collaborative (pcpcc.net)



Group Health Cooperative of Puget Sound (Northwest)

- 29% Reduction in ER visits
- 11% Reduction in Ambulatory Sensitive Care Admissions
- 4% more patients achieved target levels on HEDIS quality measures
- Improved staff satisfaction
- 24 month study

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Community Care of North Carolina

- 40% Reduction in hospitalizations for asthma
- 16% Lower ER visit rate
- \$535 million savings state Medicaid most vulnerable populations

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HealthPartners Medical Group BestCare PCMH Model

- 39% Reduction in ER visits
- 24% Reduction in hospitalizations
- 8% Cost reduction compared to average in a state that already had well below average costs

(Minnesota)

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Geisinger Health System ProvenHealth Navigator PCMH model

- 14% Reduction in total hospital admissions
- 9% Reduction in total medical costs at 24 months into pilot
- \$3.7 million net savings
- ROI of 2:1

(Pennsylvania)

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Genesee Health Plan HealthWorks PCMH model

- 50% Reduction in ER visits
- 15% Fewer inpatient hospitalizations
 - Total hospital days per 1000, 26.6% lower than competitors

(Michigan)

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Colorado Medicaid and SCHIP

- 25% Reduction in cost of care for children
 - Decreased ER use
 - Decreased hospitalizations

Intermountain Healthcare Medical Group Care Management and PCMH

- 10% Reduction in total hospitalizations
 - Greater reduction in populations with more complex and chronic illnesses
- \$640 per patient per year net reduction in total health care costs
- \$1,650 per patient per year net reduction for populations at highest risk (Utah)

Summary

- History of Patient Centered Medical Home and its Core Attributes
- Evidence Supporting Primary Care and the PCMH Model

Questions??