NEVADA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NEVADA

# PATIENT-CENTERED MEDICAL HOME (PCMH)

- The patient-centered medical home is a widely used and well validated model of care that:
  1. Improves overall quality of care while lowering health care cost
  2. Offers comprehensive care through all stages of life
  3. Enhances access to care
  4. Coordinates care across the healthcare delivery system
  5. Utilizes a team approach led by a primary care physician
  6. Embraces evidence-based medicine

- 44 states and the District of Columbia have passed legislation relating to the medical home with bipartisan support.

- Public and private sponsored medical home initiatives have consistently shown improved health outcomes and reduced health care costs. These initiatives have involved more than a million patients cared for in thousands of diverse practice settings (See reverse side for examples of PCMH outcomes in other states).

## To Improve the Health of Nevadans, We Need To:

1. **Adopt** a functional medical home definition to Nevada State Law (See reverse side for a sample PCMH definition).

2. **Authorize** the appropriate state agency to lead a multi-stake holder collaborative to guide Nevada's transformation to a medical home model.

3. **Allow** public and private payers in the state of Nevada to adopt payment models which are more appropriately aligned with higher quality and improved outcomes.

For more information about Patient Centered Medical Home, see the links below:

http://www.pcpcc.net/evaluation-evidence

http://www.pcpcc.net/content/north-carolina-community-care-press-release

http://hcr.vermont.gov/sites/hcr/files/pdfs/BP2009AnnualReport2010_03_29.pdf

**EXHIBIT I – HEALTH CARE**
**Document consists of 2 pages.**
**Entire exhibit provided.**
**Meeting Date: 08-29-12**

www.nvafp.com

**TO LEARN MORE ABOUT THE PATIENT CENTERED MEDICAL HOME CONTACT THE NEVADA ACADEMY OF FAMILY PHYSICIANS AT 775-826-5100**



326 W. Liberty Street • Reno, NV 89501 • nafpreno@aol.com
Phone: 775-826-5100 • Fax: 775-826-4475

# Selected Data on Outcomes from PCMH Initiatives

*(Source: http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf)*

## Medicaid Sponsored PCMH Initiatives

Community Care of North Carolina

- Cumulative savings of $974.5 million over 6 years (2003-2008). 40% decrease in hospitalizations for asthma and 16% lower ED visit rate.

Colorado Medicaid and SCHIP

- Median annual costs $785 for PCMH children compared with $1,000 for controls. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median annual costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

## Private Payer Sponsored PCMH Initiatives

BlueCross BlueShield of South Carolina-Palmetto Primary Care Physicians

- 10-12% reduction in inpatient hospital days and ED visits.
- Total medical and pharmacy costs PMPM 6.5% lower in the PCMH group vs. control group.

Metropolitan Health Networks-Humana (Florida)

- Hospital days dropped by 4.6% in PCMH group; control group increased by 36%.
- Emergency room expense rose by 4.5% for PCMH group; control group increased by 17.4%.
- Diagnostic imaging expense for PCMH group decreased 9.8%; control group increased by 10.7%.
- Pharmacy expense increased 6.5% for the PCMH group versus 14.5% for the control group.
- Overall medical expense for the PCMH group rose by 5.2% versus 26.3% for control group.

## Integrated Delivery System PCMH Models

Group Health Cooperative of Puget Sound (Washington)

- $10 per member per month (PMPM) reduction in total costs.
- 16% reduction in hospital admissions; 29% reduction in emergency department (ED) use.

Geisinger Health System Proven Health Navigator PCMH Model (Pennsylvania)

- 18% reduction in hospital admissions relative to controls.
- 7% reduction in total PMPM costs relative to controls.
- Comparable reductions in ED and hospitalizations for other patients with chronic conditions.

Intermountain Healthcare Medical Group Care Management Plus PCMH Model (Utah)

- $640 net reduction in total costs per patient per year ($1,650 among highest risk patients).

## Other PCMH Programs

Johns Hopkins Guided Care PCMH Model (Maryland)

- 24% reduction in hospital inpatient days, 15% fewer ED visits, 37% fewer skilled nursing facility days.

Genesee Health Plan (Michigan)

- 50% decrease in ED visits and 15% fewer inpatient hospitalizations.

## Functional Medical Home Definition

A Patient Centered Medical Home is defined as:

A model of health care delivery that focuses on forming strong relationships between patients and their personal primary care physician, with a physician-lead care team that provides ongoing, comprehensive and evidence-based care throughout all stages of life, while offering enhanced access, communication and coordination of patients' health care needs throughout the healthcare system, while continually improving processes through utilization of health information technology, with a goal of improving individual and population health outcomes in a cost effective manner, and recognizing the value of higher quality and improved outcomes with appropriately aligned physician payment.