

***Achieving High Quality and Lower Costs
Through Patient-Centered Medical Homes***

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Defining the medical home

The medical home is an *approach* to primary care that is:

Patient-Centered

Partners with patients and caregivers in managing decisions and care plans.

Comprehensive

Whole-person and population-based care provided by a team

Coordinated

Care is organized across the 'medical neighborhood'

Committed to quality and safety

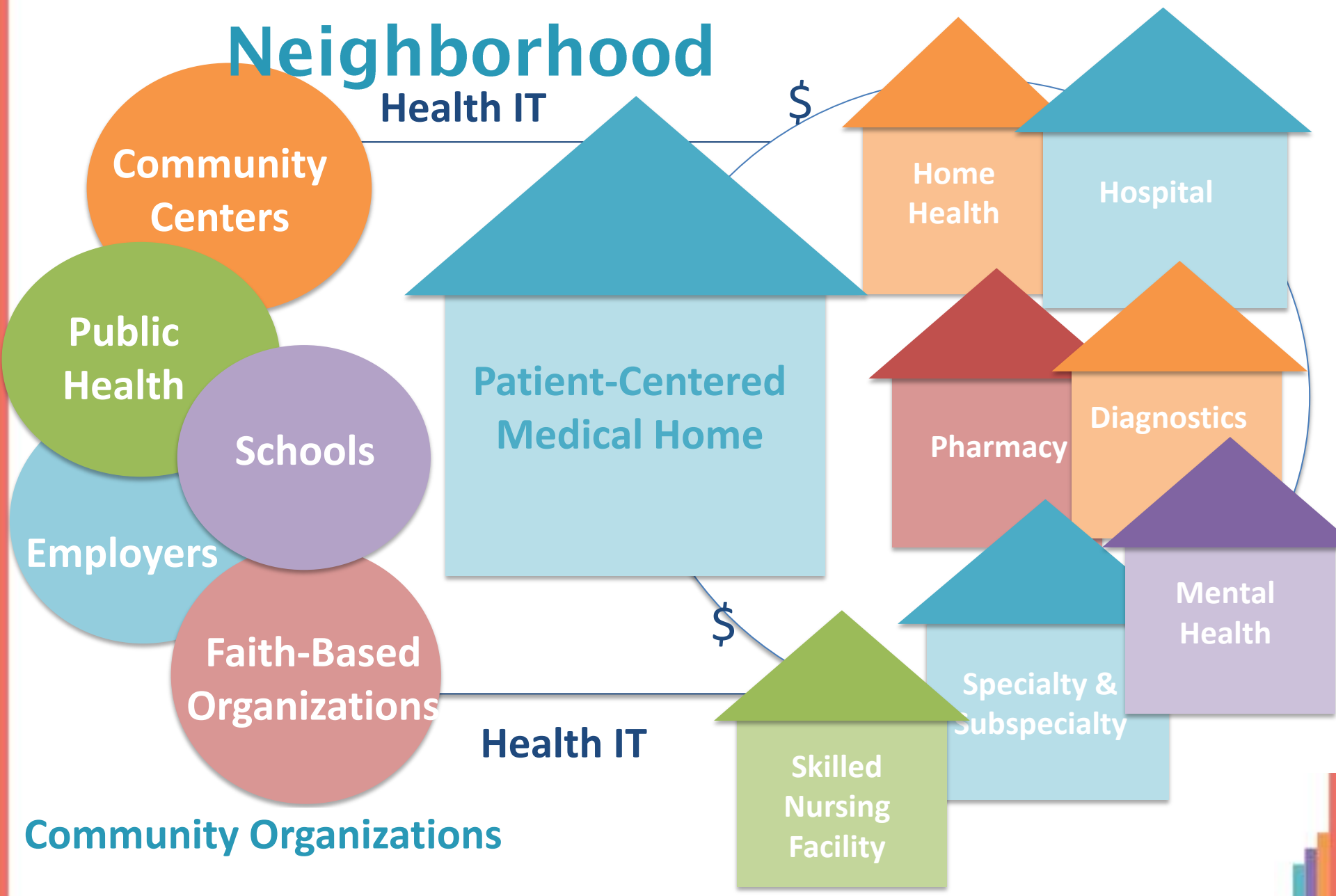
Maximizes use of health IT, decision support and other tools

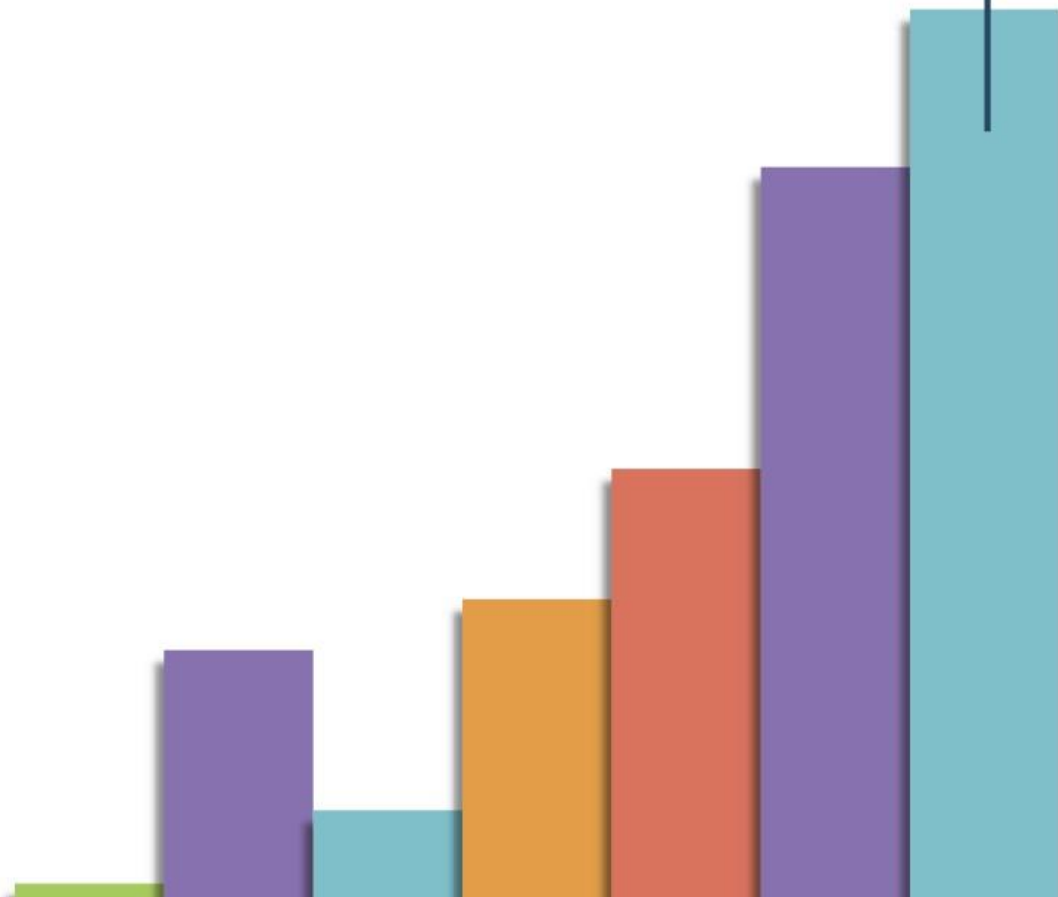
Accessible

Care is delivered with short waiting times, 24/7 access and extended in-person hours.



The Medical Neighborhood





**The
Patient-
Centered
Medical
Home's
Impact on
Cost &
Quality:**

An Annual Update
of the Evidence,
2012-2013

January 2014

PCMH Peer Reviewed Outcomes

- 61% of studies report cost reductions
- 61% report fewer ED visits
- 31% report fewer inpatient visits
- 13% report fewer readmissions

Cost &
Utilization



- 31% of studies report improved access
- 23% of studies report improved patient satisfaction

Care
Experience



- 31% of studies report increase in preventive services
- 31% report improvements in population health

Health
Outcomes



PCMH Industry Generated Outcomes

- 57% of studies report cost reductions
- 57% report fewer ED visits
- 57% report fewer inpatient visits
- 29% report fewer readmissions

Cost of Care
Utilization



- 14% of studies report improved access
- 14% of studies report improved patient satisfaction

Care
Experience



- 29% of studies report increase in preventive services
- 29% report improvements in population health

Health
Outcomes



Group Health Cooperative PCMH Program

Washington and Idaho



[Back to National Map](#) [Back to List](#) [Back to States](#)

* Featured in PCPCC Annual

Program Location: Seattle, WA
Payer Type: Commercial
Partner Organizations: Group Health Research Institute
Payers: Group Health Cooperative

Reported Outcomes

Description:
Group Health Cooperative is an integrated health plan and health care system that has been a leader in developing the medical home. Group Health has integrated into their primary care enhanced technology that has improved patient access and information sharing across a multi-disciplinary care team, dedicated care coordination services, preventive care and screening, and chronic condition management. During their initial medical home pilot, each primary care doctor claimed responsibility for a total of 1,800 patients as opposed to 2,300. The reduction in the number of patients allowed physicians time to coordinate care, have daily "team huddles" and allow for extended 30-minute office visits per patient. The reduction in patient-to-physician ratio also created a need to invest in extra staffing. As a result the study found that the medical home was investing \$16 more per patient over the following year. This meant the need for 72 percent more clinical pharmacists, 44 percent more physician assistants, 18 percent more medical assistants, 17 percent more registered nurses, and 15 percent more primary doctors. Evaluation of the model showed that costs were recouped within the year, primarily through emergency room savings.

Fewer ED / Hospital Visits:

- Declines in ED visits in early and late stabilization phases relative to trends in network practices (13.7% v. 18.5%)

Improved Access:

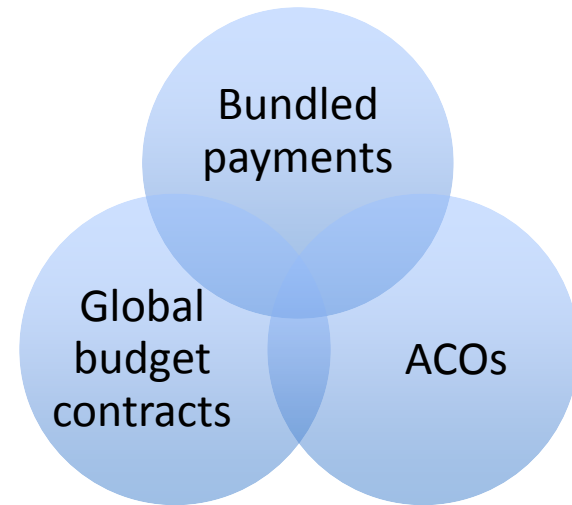
- 123% increase in secure message threads
- 20% increase in telephone encounters
- 4.5% fewer face-to-face visits

Cost Savings:

- For every dollar Group Health invested, mostly to boost staffing, it saved \$1.50

Source(s):
[Reported Outcomes Source](#)
[Peer Reviewed Journal Article](#)

Emerging Payment Reform Trends



Volume-based
reimbursement



Value-based
reimbursement

Ongoing Challenges to the PCMH

- Evaluation

- Need for better/more **patient satisfaction measures** of self-reported health status/well-being
- Measures need to account for **patient diversity**
- Need for standard **core measures**

- Resources

- Support for **practice transformation** to a PCMH
- New **payment** strategies to support team-based care, population health and quality outcomes

- Meaningful partnerships

- Health care providers
- Community-based organization
- Patients, caregivers and consumers in **ongoing quality improvement**

The Neighborhood – A Patient’s View

