

WHAT SB 393 (Hernández) DOES:

Adds a functional “medical home” definition to California state law.

WHY CALIFORNIA NEEDS A MEDICAL HOME DEFINITION:

By adding a functional definition for the set of best health care practices known as the “medical home” or “health home,” SB 393 will ensure uniform standards of quality and access, and make it more likely that California will receive crucial federal dollars.

Other states have leapt ahead in their commitment to the medical home model and are reaping the rewards: quality can improve and costs can decrease significantly (please see reverse side). States have also obtained substantial federal funding for the implementation of medical home demonstration projects.

Adding a definition of medical home to state law sends an important signal to health care providers and patients that California supports:

- Care that is patient-centered, cost-efficient, continuous, focused on prevention, and based on sound, evidence-based medicine rather than episodic, illness-oriented “siloes” care.
- A health care team (doctors, nurses, physician assistants, medical assistants, mental health providers, community health workers, social workers, etc.) working in partnership with one another, their patients and their patients’ families to coordinate care, navigate the complex and often confusing health care system and ensure that patients receive the right care at the right time.

THE MEDICAL HOME ADDRESSES CRITICAL HEALTH CARE NEEDS:

Three ominous trends in health care drive the need for the medical home:

- Out of control health care costs and diminishing state revenue;
- A growing shortage of primary care professionals and a mal-distribution of health care providers;
- A sharp increase in the demand for services for those with chronic disease and mental health disorders.

These obstacles must be addressed if proposals to expand health care coverage are to be successful. With the number of Americans with one or more chronic diseases projected to increase from 125 million in 2000 to 157 million in 2020, it is essential that we ensure effective management of these conditions. Given that almost \$1.8 trillion nationally is devoted each year to chronic disease, improved care management can have a profound effect on how our health care dollars are spent.

Far too often in our health care system, patients are confronted with health care providers working in independent silos, which impedes care coordination and causes patients with multiple health issues to fall through the cracks. A 2008 study by the Commonwealth Fund identifies fragmented care at the national, state and community levels as the main cause of the poor performance of the U.S. health care system. The report identifies the following characteristics of this fractured system:

- Patients are forced to navigate an exceedingly complex system with little or no guidance, seeing multiple physicians and other health care providers in various settings.
- The lack of communication and coordination of the care they receive increases inefficiency and the chances of medical errors, waste and duplication of costly services.
- An absence of accountability, quality improvement programs and clinical information systems leads to poor overall quality of care.

The medical home is the solution.

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Summary of Data on Outcomes from PCMH Interventions

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

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.

Veterans Health Administration

- 27% reduction in hospitalizations and ED visits for high-risk chronic obstructive pulmonary disease patients.
- Comparable reductions in ED and hospitalizations for other patients with chronic conditions.

HealthPartners Medical Group Best Care PCMH Model (Minnesota)

- 39% decrease in ED visits and 24% decrease in hospital admissions between 2004 and 2009.
- Overall costs for enrollees decreased from being equal to the state average in 2004 to 92% of the state average in 2008 in a state with costs already well below the national average.

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).

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.

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).

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.

Erie County PCMH Model (Michigan)

- Decreased duplication of services and tests, lowered hospitalization rates, with an estimated savings of \$1 million for every 1,000 enrollees.