

# What will the PCMH Look Like in 2014?

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# What Is a Patient-Centered Medical Home?

- A Patient-Centered Medical Home (PCMH) is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship (NCQA).

# The Holy Grail of Health Care

- **Cost Reduction**
- **Quality Improvement**
- **Service Improvement**

# The Secret Sauce for Success in 2014

- Care becomes continuous access rather than episodic
- Care becomes proactive rather than reactive
- Patients become activated for self-management
- Care is delivered in organized delivery systems

58 y/o female with obesity and diabetes comes in with symptoms of fatigue, insomnia and back pain. She has a 15 minute appointment

HEDIS diabetes measures for this patient:

- Percent with an annual retinal exam
- Percent with one of more glycohemoglobin tests
- Percent of those having glycohemoglobin tests showing a level of <8.5 percent (goal <7.0)
- Percent with an annual screening test for microalbuminuria
- Percent with two or more blood pressure checks per year
- Percent of those with one or more blood pressure checks having a systolic BP <135 (goal <<130/80)
- Percent with an annual lipid panel
- Percent of those with an annual lipid panel showing an LDL level <130 mg/dL (goal << 100)

# Case con't

## Other Diabetes Measures:

- Flu vax
- Pneumovax
- Dental visit
- Cardiac screening test?
- Lab monitoring for side effects of meds
- Annual foot exam
- Baseline EKG?

# Case con't

## Cancer Screening needs:

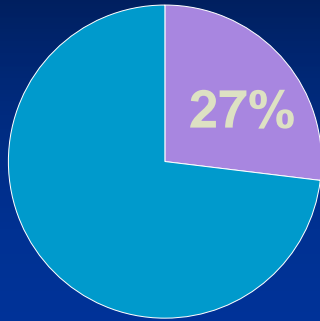
- Colon- needs colonoscopy (or 3 other types of screening)
- Cervical- needs pap if last <1-3 years prior
- Breast- needs annual mammogram

Osteoporosis screening and prevention

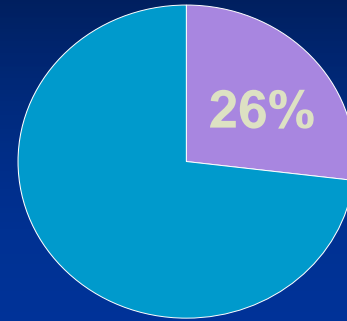
Depression Screening and Management

# Case con't

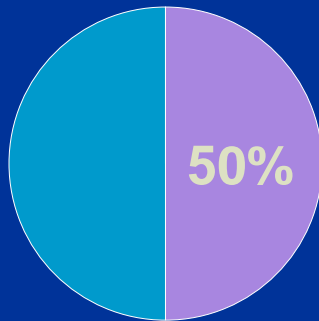
- General health issues:
- Adult Td
- Weight management
- Advance Directives/DPOA
- Culturally-sensitive care
- Patient Education for Self Management
- Tobacco Screen
- Alcohol screen
- Domestic violence screen
- What About her fatigue, insomnia and back pain?



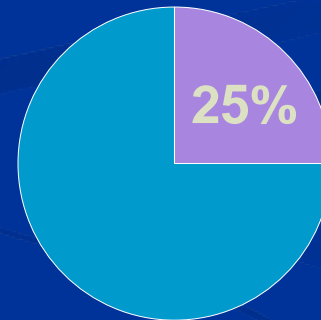
**Only 27% of hypertension is adequately controlled.**



**Only 26% of people with diabetes have blood pressures well controlled.**



**50% of patients hospitalized with congestive heart failure (CHF) are readmitted within 90 days.**



**Only 25% of people with depression receive treatment.**

# The Time Problem

- Time Needed for Chronic Illness Care
- Time Needed for Preventive Care
- Time Needed for Acute Care
- Total face to face time for 2500 patients
- 10.6 hours a day for 2500 patients
- 7.4 hours a day
- 4.6 hours a day
- 22.6 hours/day

Ann Fam Med 2005;3:209

Am J Pub Health 2003;93:635

# The First Rule of Redesign

Crossing the Quality  
Chasm

New Model of Medical  
Practice

Care is Based on  
Continuous  
Healing  
Relationships

Patient Centered  
Medical Home

# The Patient's Life

- 6000 hours a year awake
- 1350 hours a year making decisions important to diabetes
- 2 hours of episodic contact a year with the primary care physician and only urgent access between

## **Patient**

Preventive Care Needs

Health Problems/Comorbidities

Biopsychosocial Dimensions

Family Context

15-minute Visit

## **Family Physician**

Knowledge and Experience

Relationship with Patient

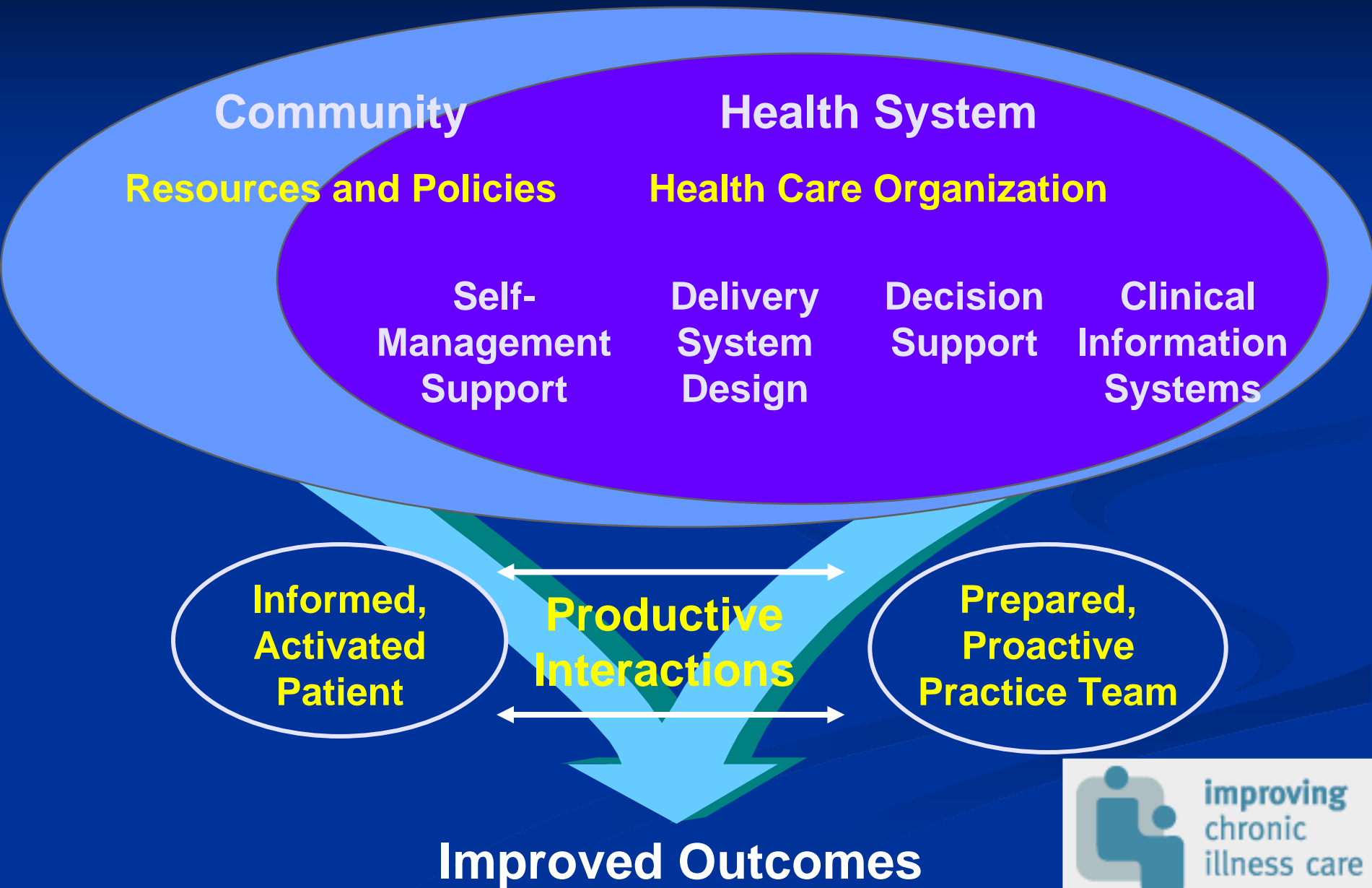
Coordination of Comprehensive Care

Resources

Figure 1. The Bottleneck of Brief Episodic Visits

# Chronic Care Model

<http://www.improvingchroniccare.org>



# Health Care Becomes Continuous

- Patients Live Their Health and Illnesses Every Day
- Quality Health Care Offers Continuous Access and Engagement
- Patients Will Drive the Innovation
- Patients Will Have Their Medical Records
- Patients Have Access to All Medical Information – The Return of the Public Library
- Patients Will Communicate Far and Wide for Care

# Stanford Chronic Disease Self-Management Programs

- Small groups of 10-16 people
- People with different diseases in the same group
- 2 ½ hours a week for 6 weeks
- Peer facilitated
- Content – symptom management, exercise, nutrition, problem solving, communications, advanced directives
- Process – self efficacy, action planning, problem solving, sharing

# Current Stanford Programs

- **Chronic Disease Self-Management**  
(English/Spanish with 16 other language translations)
- **Arthritis Self-Management**
- **Diabetes Self-Management**
- **HIV/AIDS Self-Management**
- **Pain Self-Management**
- **Cancer Survivor Self-Management**
- **All available over the internet**

# Outcomes of CDSMP

- Effective across a variety of chronic diseases (randomized trials done)
- Effective across socioeconomic and education levels – rich international experience
- Patients can manage progressive and debilitating illness
- Reduces physician visits, ER visits and hospitalizations
- Proven consistent results over 3 years
- Cost of program, \$100-200, Savings \$800-1000 per participant

# Physician Engagement is Critical

- Connection with personal physician the key to success
- Physician referral is the most powerful motivator
- Integrated physician and self-care critical for the outcomes

# **Kaiser Permanente HealthConnect**

**24 Hour Access to Accurate and  
Comprehensive Health Care  
Information and Services**

# Early Experience Kaiser Northern California

- Build off the self-management research of Kate Lorig and the chronic disease self-management team from Stanford
- David Sobel – Internist and Medical Director
- Cohort of patients receive basic education for greater self-management of chronic illness
- Health Connect platform allows patients to coordinate care with care team

# From Patient to Partner: Empowering the Hidden Health Care System

**David S. Sobel, MD, MPH**

Medical Director

Patient Education and Health Promotion

The Permanente Medical Group

Northern California

# Strategic Questions

- Where is the excess capacity and underutilized resource within the health care system?
- Where are the mismatches between patient needs and health care resources that result in ineffective and inefficient care?
- How can “win-win-win” solutions be created for consumers, providers, and health care systems?

# Strategic Questions

- What are the active ingredients in effective Self-Management?
- If Self-Management is the right thing to do, then why is it often so difficult to initiate, implement and sustain these beneficial interventions ... and what can be done?

# The Case for Self-Management Support

- Patients already self-manage and make decisions (for better or worse) about their chronic conditions 99% of the time
- Improved outcome depends on correct diagnosis, correct treatment, and an ongoing series of healthy choices, behaviors and decisions by patients.

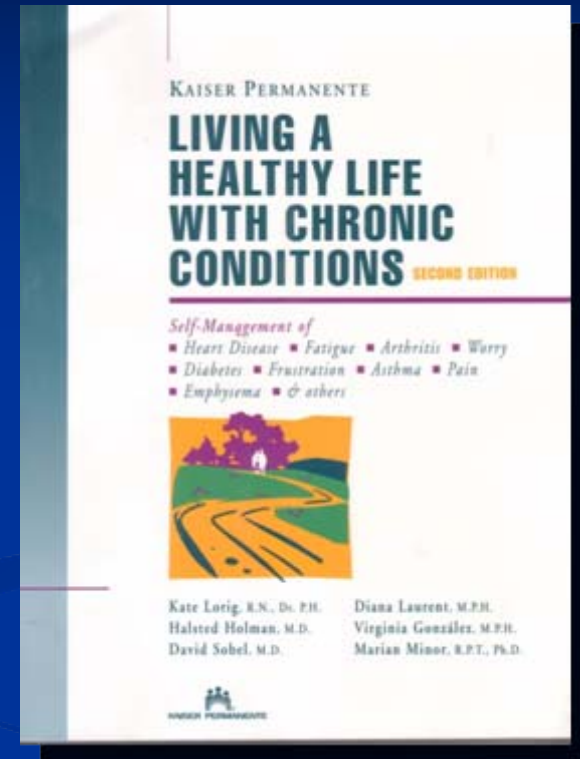
# The Case for Self Management Support

- To be an informed, activated patient and make healthy decisions, patients need self-management support including:
  - timely, accurate, understandable information
  - involvement in collaborative decision making
  - goal setting and problem-solving
  - help managing psychosocial issues

# Healthier Living:

## Managing Ongoing Health Conditions Workshop\*

- Small groups 10-16 people
- People with different diseases in same group
- 2 ½ hours a week for 6 weeks
- Peer taught
- Content: symptom management, exercise, nutrition, problem-solving, communication, advanced directive
- Process: Self-efficacy, action planning, sharing



Lorig K, Holman H, Sobel D, Laurent D, Gonzalez V, Minor M: *Living a Healthy Life with Chronic Conditions*, Palo Alto: Bull, 2006

\*Chronic Conditions Self-Management Program <http://www.stanford.edu/group/perc/>

# Healthier Living:

## What we learned about PROCESS

- General coping skills education for heterogeneous conditions complements disease specific information
- Involve patients in design process
- Patients are the “experts” in living and coping with chronic illness
- Modeling more effective than “save and rescue”
- No significant difference in participants’ outcome with lay vs professional leaders
- People benefit themselves from helping other people
- Process is more important than content

# Healthier Living:

## What we learned about OUTCOMES

- Improves health behaviors, self-efficacy and health status (pain, fatigue, health distress, role function, etc.)
- Cost effective (estimated 5:1 to 10:1 ROI) from reductions in hospital days, ED and physician visits
- Outcomes are long-lasting and robust (2+yrs.)
- Replicable and dissemination can yield outcomes as good, or better
- Confidence predicts health outcomes better than behavior change

Lorig K et al *Medical Care* 1999;37:5-14

Lorig K, Sobel DS, *Effective Clin Practice* 2001;4:256-262

Lorig K, et al *Medical Care* 2001;39:1217-1223

# Healthier Living:

## What we learned about IMPLEMENTATION

- Outcome data helpful, but not sufficient
- Early success important as early failures are hard to overcome
- “Just in time” training, dedicated staff with time and proactive anticipation of staff changes and turnover
- Direct to patient recruitment more effective than MD referral
- Treat your trainers well.
- Language extremely important to marketing to staff and patients (e.g. “workshop” vs. “class,” “condition” vs. “disease”)
- Balance of simple, standardized, quality-controlled program versus local innovation and adaptation

# Kaiser Experience

- The quality of the education materials not an important factor as long as they are accurate
- The quality of the education improves when all the professionals leave the room (social networking)
- The self-management cohort has the highest quality outcomes in the system
- The most dependent patients on physicians have the worst outcome
- Is physician dependence toxic?

**Patient Activation and Self  
Management are a New Frontier  
in Medicine Made Possible by the  
Information Age**

**The Primary Care Team Goes  
From Mandatory Caregiver to  
Advisor, Coach and Personal  
Resource**

# Patient, Heal Thyself: How the “New Medicine” Puts the Patient in Charge

Robert Veatch  
Professor of Medical Ethics  
Georgetown University  
Oxford University Press, 2008

# Resources

- Stanford CDSMP website:  
<http://patienteducation.stanford.edu/>
- Partners in Care Foundation, June  
Simmons, CEO [www.picf.org](http://www.picf.org)
- California HealthCare Foundation May 2009  
Report, Health Care Without the Doctor:  
<http://www.chcf.org/documents/policy/HealthCareWithoutTheDoctor.pdf>

**Whenever you see a  
successful business,  
someone once made a  
courageous decision**

**Peter Drucker**

**Change Is Disturbing When  
It Is Done To Us. Change Is  
Exhilarating When It Is  
Done By Us**

**Rosabeth Kantor**

**Harvard Business School**

**Give us control and we  
will use it, don't and  
you will lose us**

Google Rule # 1 from What Would  
Good Do? Jeff Jarvis

**There is an inverse  
relationship between  
control and trust**

Google Rule # 2

In 2014, patients will control and guide their care. The care team will inform, coach and advise, but not control the care