Family Medicine, LSUHSC
Mary Thoesen Coleman, MD, PhD
Director Community Health

PATIENT-CENTERED MEDICAL HOME

Pre Assessment

- List 3 NCQA standards for PCMH.
- List 3 Joint Principles for PCMH.
- Estimate the percent increase in cost of health care per patient between 2001 and 2009.
- Estimate the average annual cost percent savings due to PCMH implementation.
- Provide 2 reasons for high health care cost and poorer outcomes encountered in the US.
- According to theory, name two things that are necessary for patients to make a behavioral change.
- What statement can be used in an effective teach feedback method?

Objectives

- Identify key elements of PCMH
- Provide evidence that PCMH provides value
- Practice Key Skill important to the PCMH related to
  - Patient Self Management/Literacy

Agenda

- 10 min Introduction/Pre Assessment
- 10 min PCMH Introduction
- 4 min Video
- 10 min Large Group discussion about PCMH and its importance
  - What is here? What is missing?
- 10 min Brief Overview of Evidence for Value of PCMH (power point)
- 5 min Overview of Self Management/Literacy Skill Exercise
- 10 min Tools (Goal and feedback)
- 10 min Discussion/Reflection
- 5 min Evaluation

The Joint Principles: Patient Centered Medical Home

- Personal physician
- Physician directed medical practice (team-based)
- Whole person orientation (all health needs)
- Care is coordinated and integrated across all elements of the complex healthcare community

The Joint Principles: Patient Centered Medical Home

- Quality and safety are hallmarks: Evidence based and clinical support tools guide decisions.
- Enhanced access to care: open scheduling, expanded hours, new communication options
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home

NCQA Standards: "IMPACtS"

- **I**mprovement and performance measurement
- **M**anaged and planned care
- **P**opulation identification and management
- **A**ccess/Continuity
- **C**oordination and Tracking of care
- **t**eam care
- **S**elf Care and **S**upport from Community
  - 6 standards, 27 elements, 149 factors

PCMH: A New Framework

Medical Model		Patient-Centered Model
Patient's role is passive *(Patient is quiet)*	→	Patient's role is active *(Patient asks questions)*
Patient is the recipient of treatment	→	Patient is a partner in the treatment plan *(Patient asks about options)*
Physician dominates the conversation *(Does not offer options)*	→	Physician collaborates with the patient *(Offers options; discusses pros & cons)*
Care is disease-centered *(Disease is the focus of daily activities)*	→	Care is quality-of-life centered *(The patient focuses on family & other activities)*
Physician does most of the talking	→	Physician listens more & talks less
Patient may or may not adhere to treatment plan	→	Patient is more likely to adhere to treatment plan *(Treatment accomodates patient's cultures & values)*

Video

- Information about a PCMH geared toward a patient's point of view
- http://www.emmisolutions.com/medicalhome/acp

Group Discussion

Why PCMH? Triple Aim

- Better health care
- Better patient care experience
- Lower costs

Why Innovate → Affordability

The Elephant in the room--Grundy

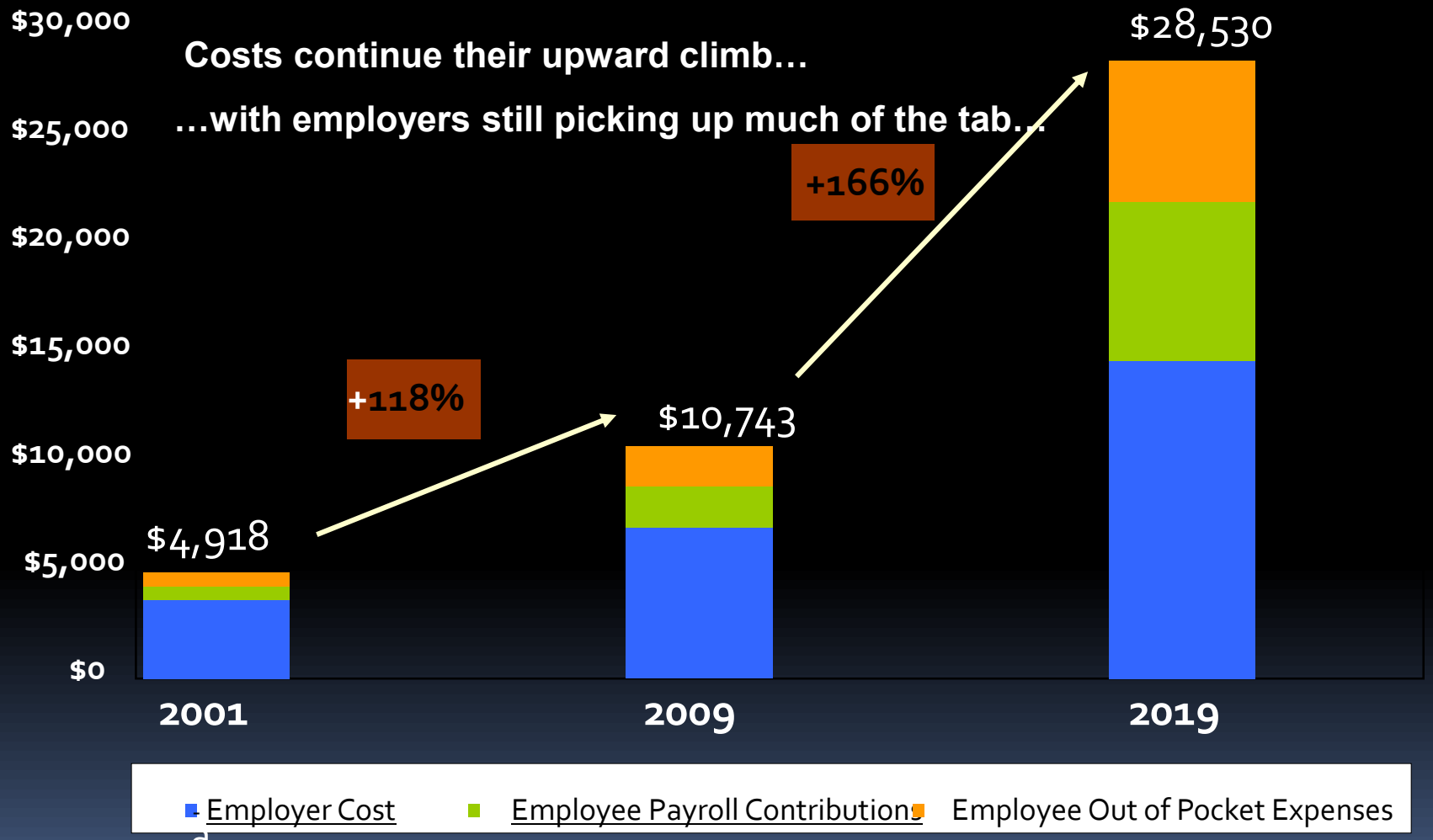


Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00



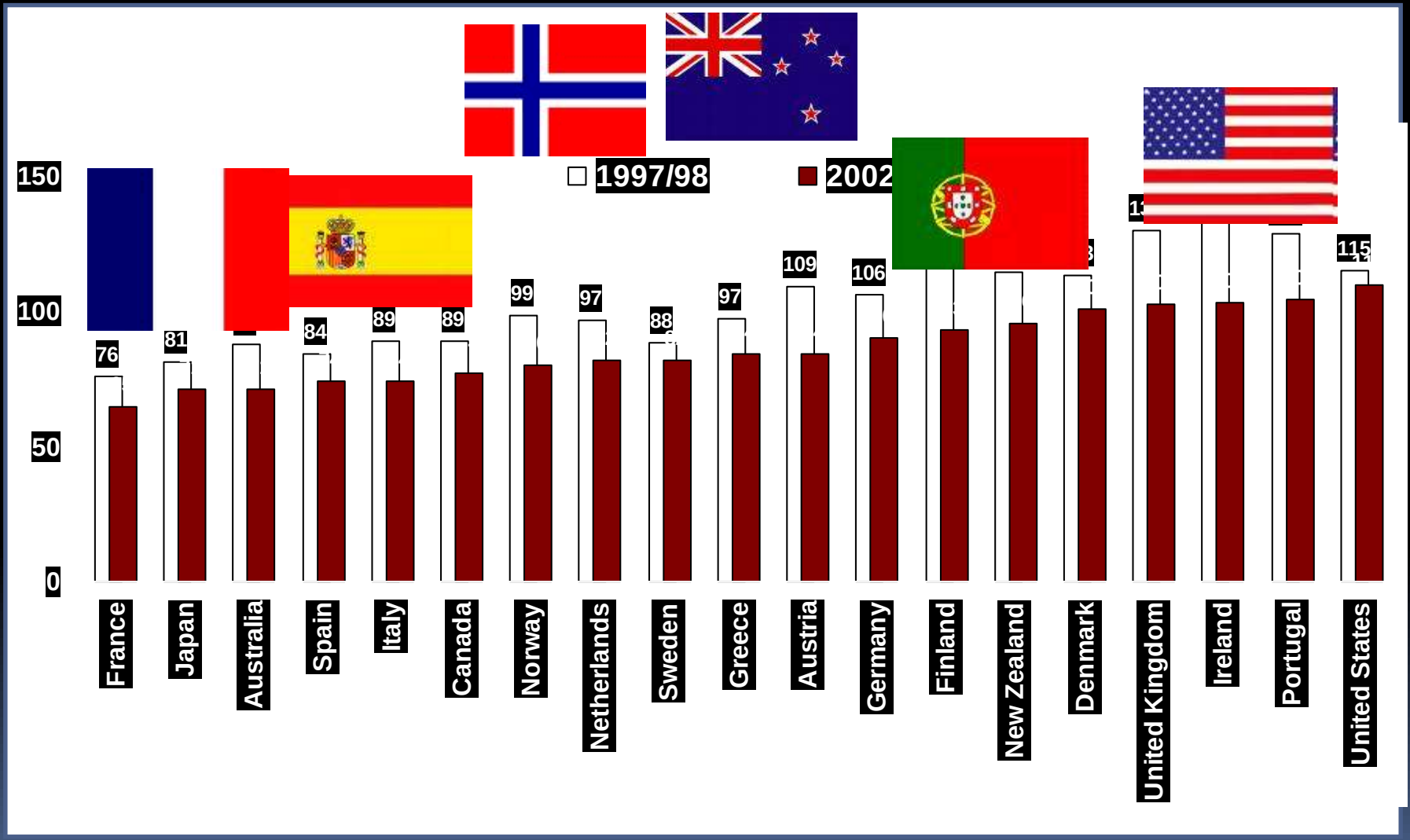




	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

ote: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
ource: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International ealth Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; ommonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for conomic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

The World Health Organizations ranks the U.S. as the 37th best overall healthcare system in the world

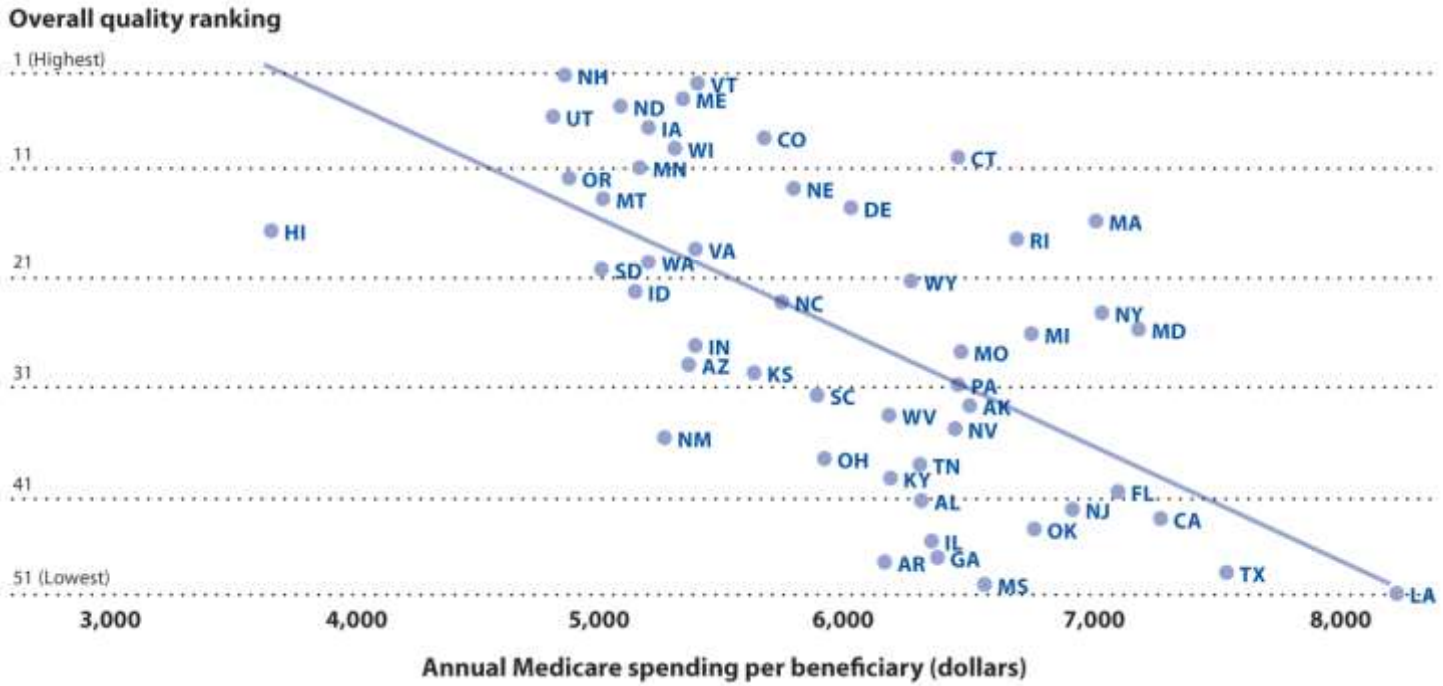


Countries' age-standardized death rates, list of conditions considered amenable to health care Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58–71

Relationship Between Quality of Care and Medicare Spending

States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.

Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001

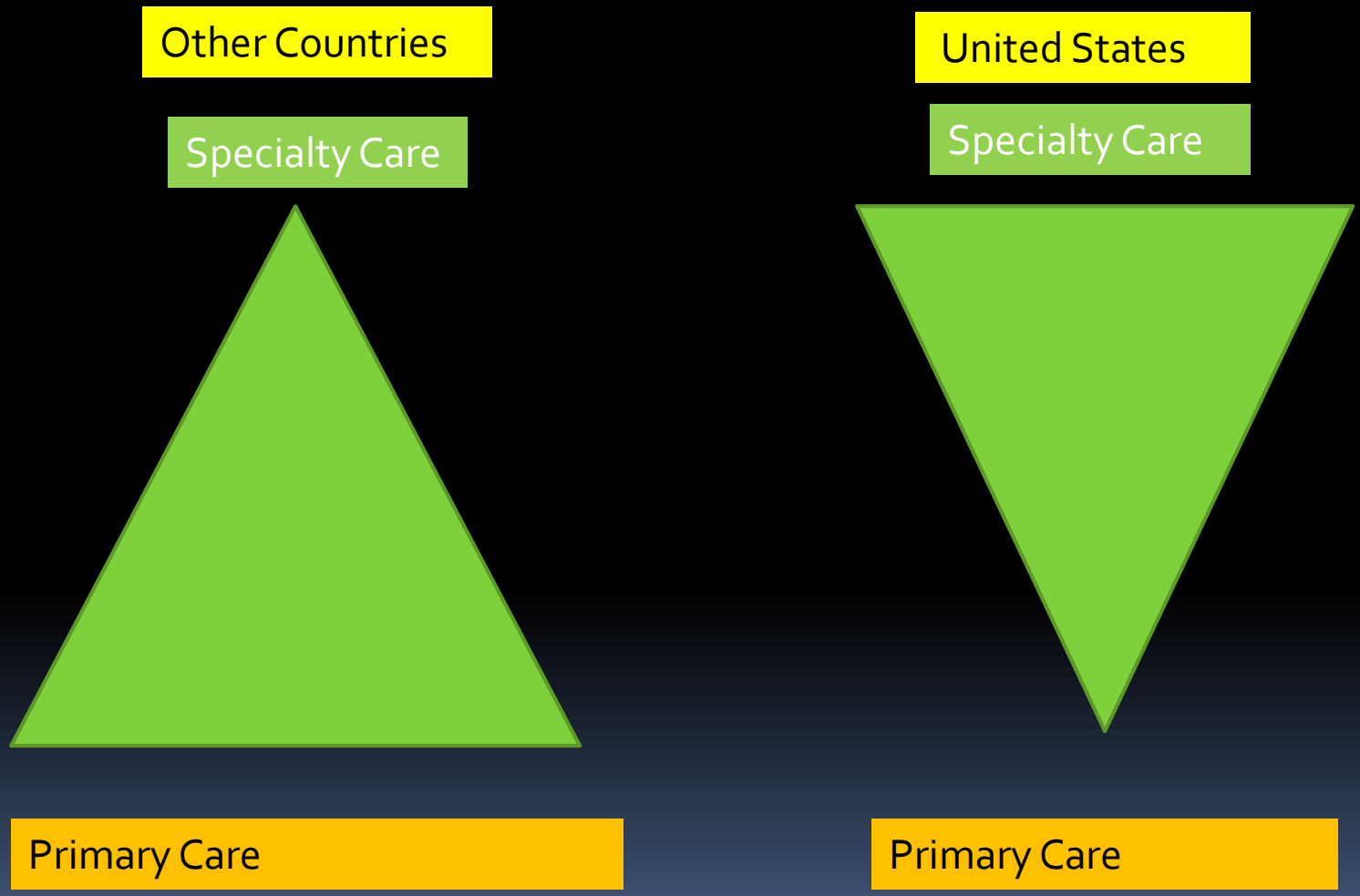


Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every $1,000 increase in Medicare spending per beneficiary, a state's quality ranking dropped by 10 positions. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare spending, the physician workforce, and beneficiaries' quality of care" (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.

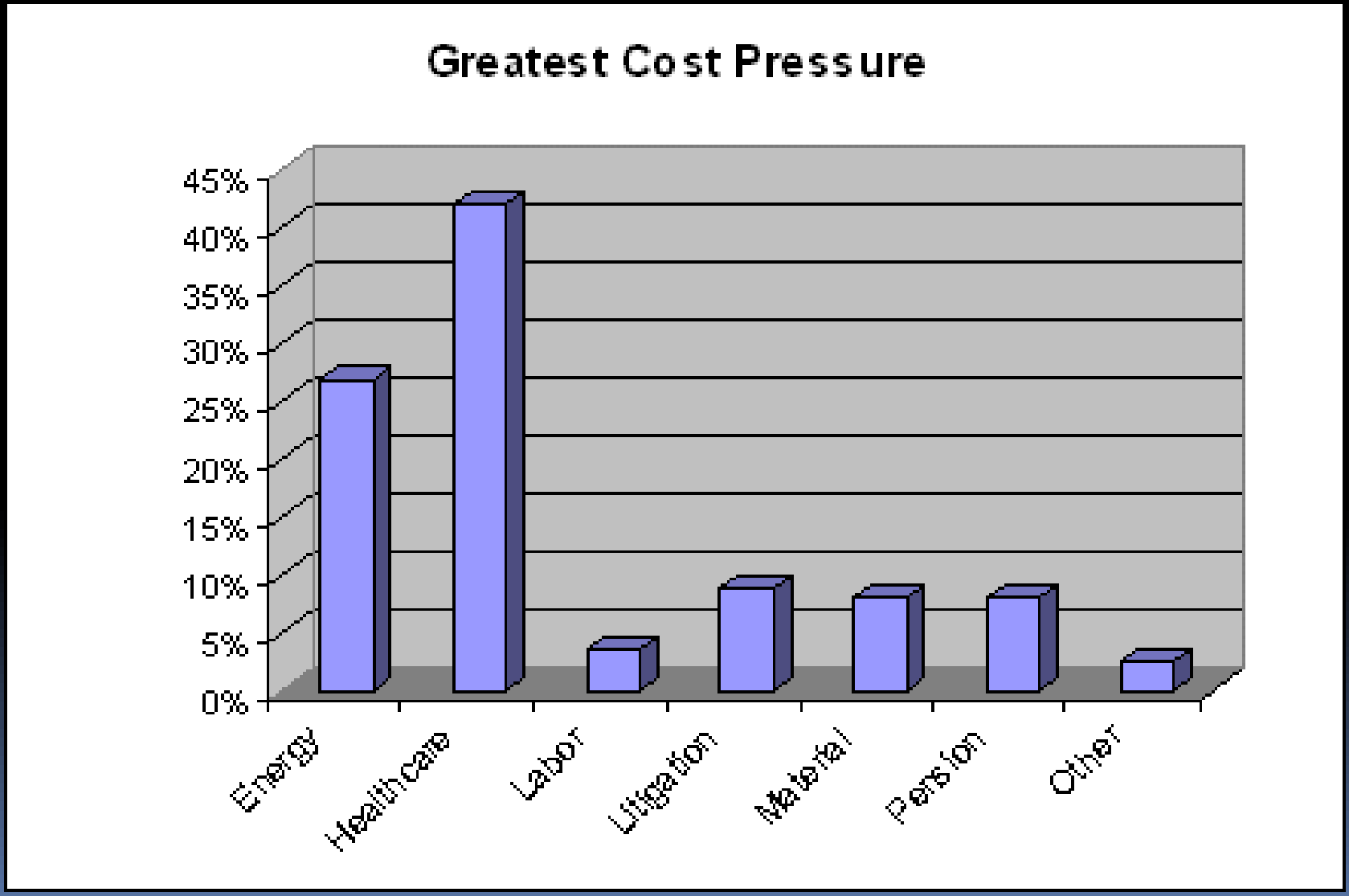
Why such high cost?

Fee For Service Encourages Events

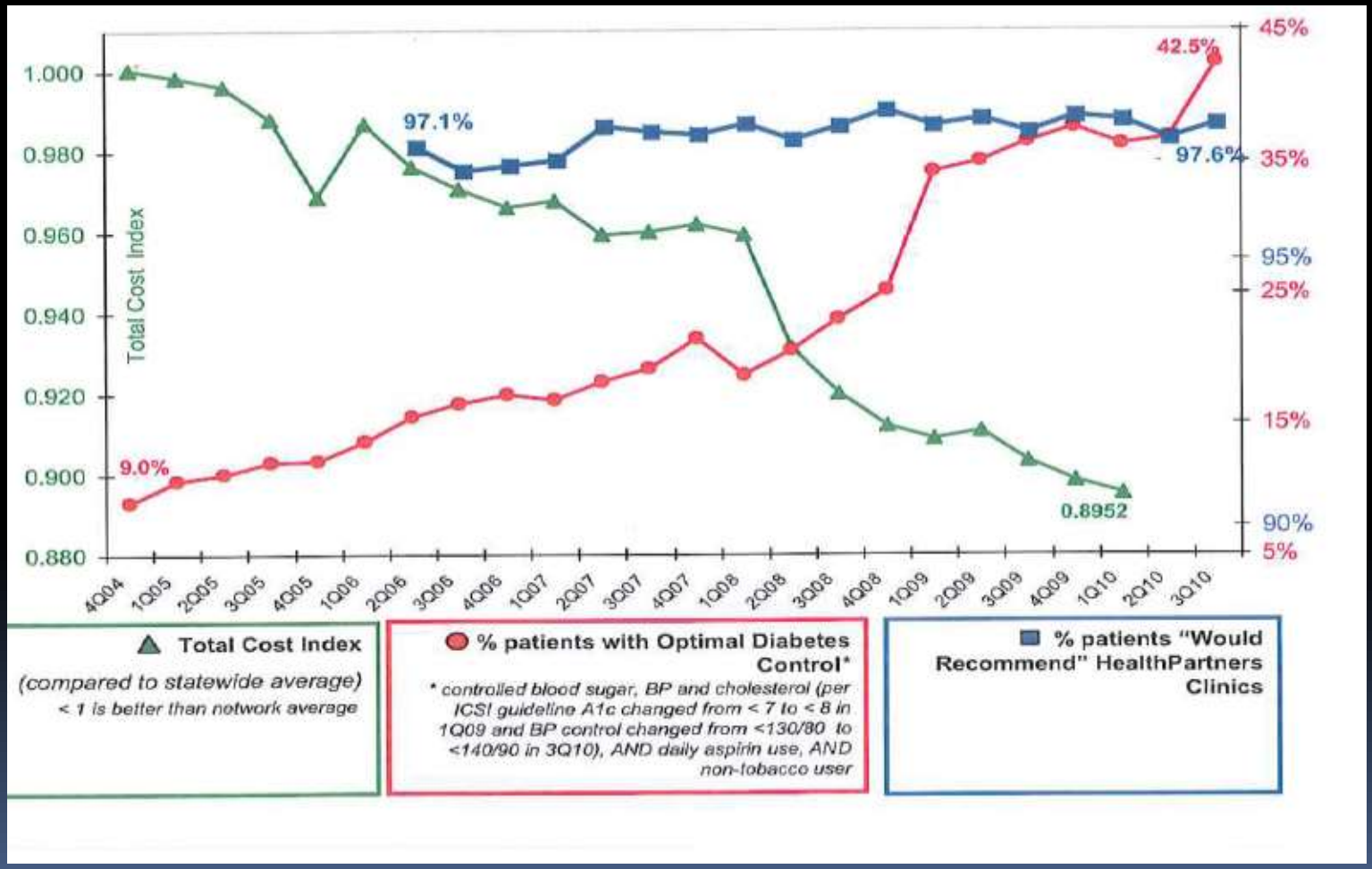
Over Reliance on Specialty Care



Health care is a business issue, not a benefits issue



Triple Aim: Health, Experience, Affordability—Health Partners Clinics



Smarter Healthcare…

36.3% Drop in hospital days

32.2% Drop in ER use

9.6% Total cost

10.5% Inpatient specialty care costs are down

18.9% Ancillary costs down

15.0% Outpatient specialty down

Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US,
K. Grumbach & P. Grundy, November 16th 2010

Patient-Centered Primary Care Collaborative
The Homer Building • 601 Thirteenth Street, N.W. • Suite 400 •
Washington, D.C. 20005
www.pcpcc.net

Patient Centered Medical Home

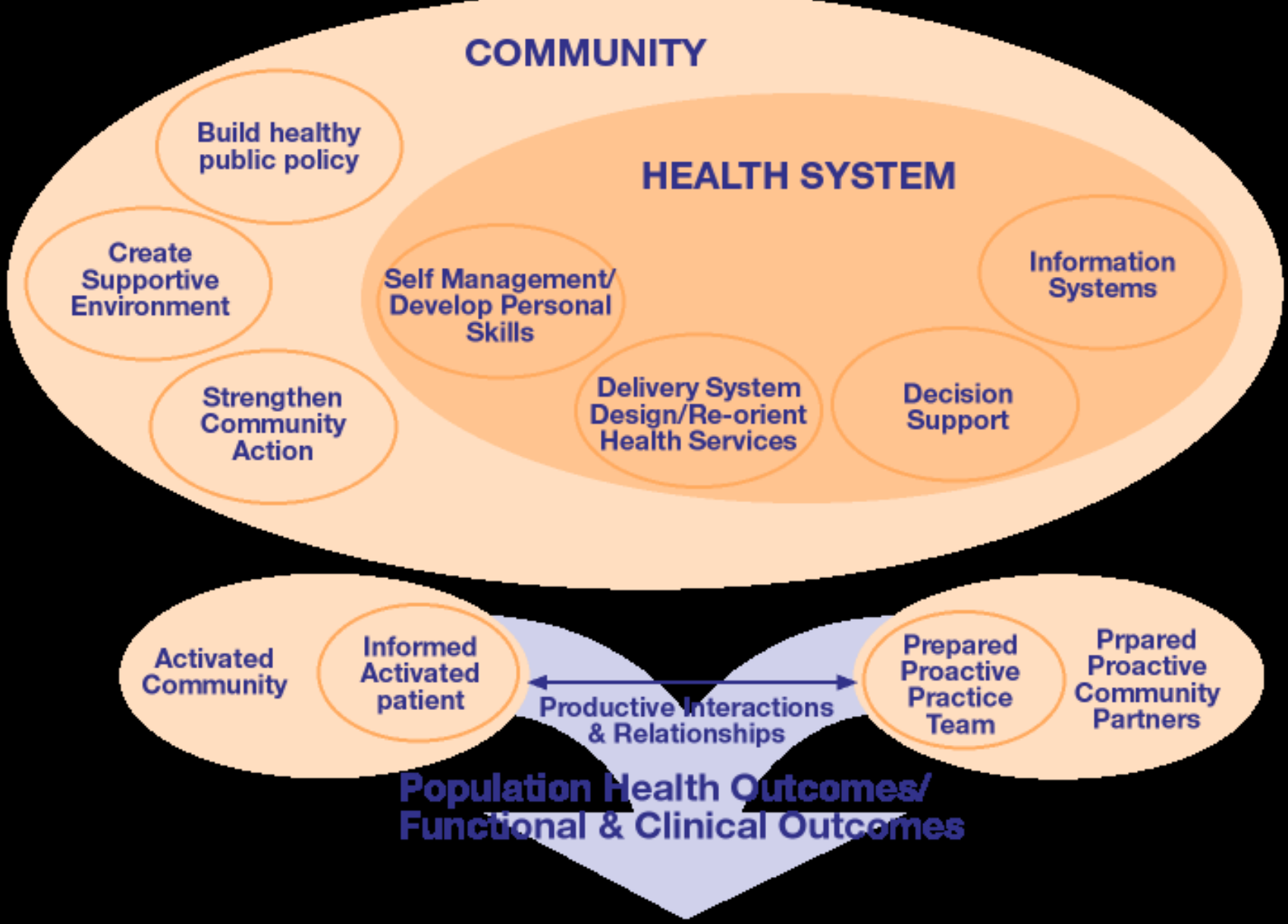
- » The Intermountain Healthcare Medical Group in Utah:
  - 39 percent decrease in ER admissions,
  - 24 percent decrease in hospital admissions
  - Net reduction in overall per-patient spending of $640.
- » The Veterans Health Administration,
  - 27 percent reduction in both ER visits and hospitalizations,
  - 13 percent lower median health-care costs for veterans.

Greater New Orleans Primary Care Access and Stabilization Grant

- Federal grant program started 9/21/07 for 3+ years
- 91 practices IM, FP, Peds; 160,000 lives/year
- 13 of 25 organizations achieved recognition by NCQA as PCMH at 36 clinic locations in 2008
- All have 24/7 access and same day appts

Patient centered medical home and Medical neighborhood– Differences

- Care Coordination
- Access to care (time, location, availability)
- Health Information Technology (portals, online access, QI measures)
- Payment reform (accountable high quality, patient centered care)



Created by: Victoria Barr, Sylvia Robinson, brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly. 79(4), *and* World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Logistics

- Patient calls for appt or advice, has access after hours to team
  - Offered same day appt or telephone advice
- Patient uses web portal for advice
- Patient called in for appt for chronic illness
- Team of folks insure chronic ill patient
  - Gets preventive care (immunizations, mammogram, etc)
  - Gets disease management guidelines (education re: diet, exercise, self management goal setting,
  - Sees doctor for high level management decisions

Logistics

- Electronic record or manual record tracks patients with chronic illness so registries with contact information and quality indicators are available
  - Providers know which patients need attention and team takes steps to make sure they get appropriate interventions
- Teams provide care to patient, MA does foot exam, gives immunizations, performs POC bs, reviews medications
- Team reviews data on patients in registry and makes system changes to improve outcomes on regular basis
- Patient sees the same providers and team and knows them
- Patient is instructed on self management of health.
- Patient engages community resources for assistance.

Payment Models

- **Risk-Adjusted monthly care coordination payment** ("bundled care coordination fee")
  - for **work outside of a face-to-face visits** and for **heath information technologies**
- **Visit-based fee-for-service**
  - recognizes visit-based services to see the patient in an office-visit when appropriate.
- **Performance-based component**
  - to reward quality and efficiency

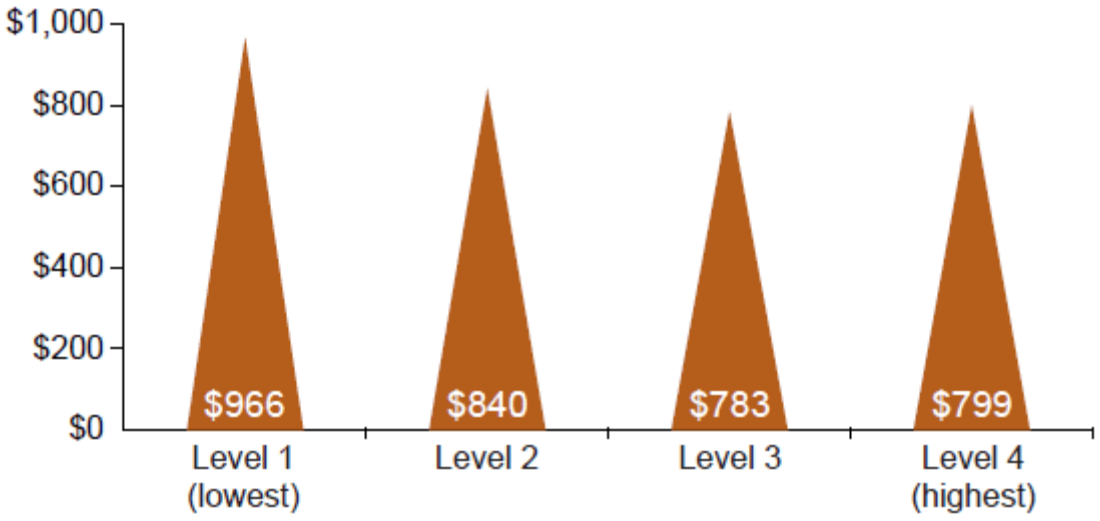
One Area in Which Medical Students Can Contribute

- Patient Self Management

Patient Self Management

Patients Who Are More Actively Engaged in Their Care Have Lower Costs Than Patients Who Are Less Engaged

Predicted per capita billed costs in dollars, January–June 2011, by patient activation method (PAM) level



Notes: Inpatient and pharmacy costs not included. Dollar amounts are adjusted for differences in disease severity and demographics.

Source: Adapted from J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores,'" *Health Affairs,* Feb. 2013 32(2):216–22.

Patient Scenario/Exercise

- A 54 year old Hispanic woman presents to your office because she wants to lose weight. She is worried about getting diabetes because diabetes runs in her family and has heard that losing weight will reduce her risk. She admits that she drinks a lot of colas and she doesn't like vegetables. She smokes a half pack of cigarettes per day. Her exercise consists of walking around the block about gwice a week with a neighbor. She speaks English but she is less fluent than in Spanish.

Care Management: Patients Setting Goals

- Principles:
- Conviction that something is important
- Confidence to make the change

MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:

_____Work on something that's bothering me:

_____

_____Stay more physically active!

_____Take my medications.

_____Improve my food choices.

_____Reduce my stress.

_____Cut down on smoking.

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:

10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

_____

How much: _____

When: _____

_____

How often: _____

_____
(Signature)

_____
(Signature of clinician)

Repeat Scenario

Try the exercise using the personal action plan to assist in the conversation.

A 54 year old Hispanic woman presents to your office because she wants to lose weight. She is worried about getting diabetes because diabetes runs in her family and has heard that losing weight will reduce her risk. She speaks English but she is less fluent than in Spanish. With a partner, one of you role play the patient and the other the clinician. Engage in a conversation about weight loss.

Assessment of Self Management Abilities: Teach Back Method

- The teach-back method is a way of assessing whether a patient understands information.
- Instead of asking "Do you have any questions?"
  - I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?
  - What will you tell your wife (husband/partner/child) about the changes we made to your medications today?
  - In your own words, please review what we talked about. How will you make it work at home?
    - (North Carolina Program on Health Literacy, n.d.)

Post Assessment

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- According to theory, name two things that are necessary for patients to make a behavioral change.
- Write down a statement that could be used in an effective teach feedback method.

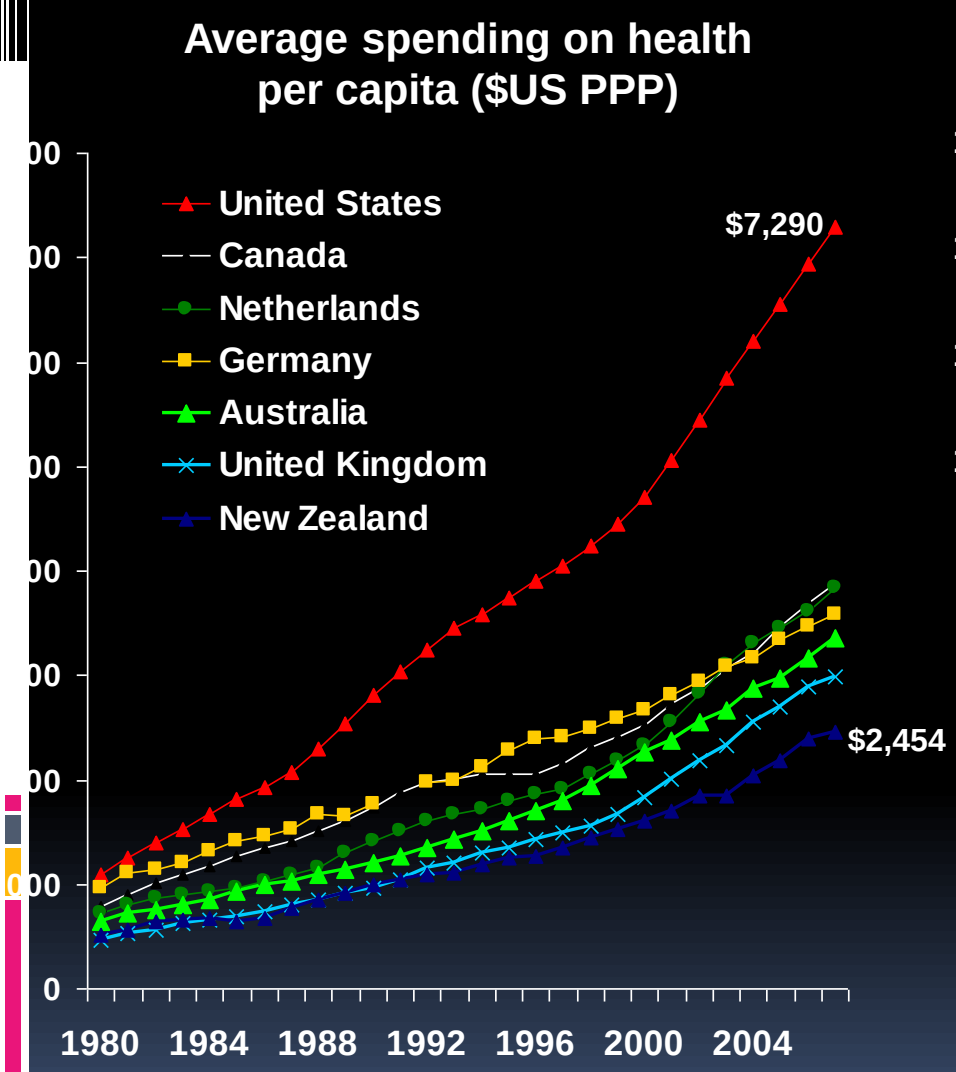
Summary

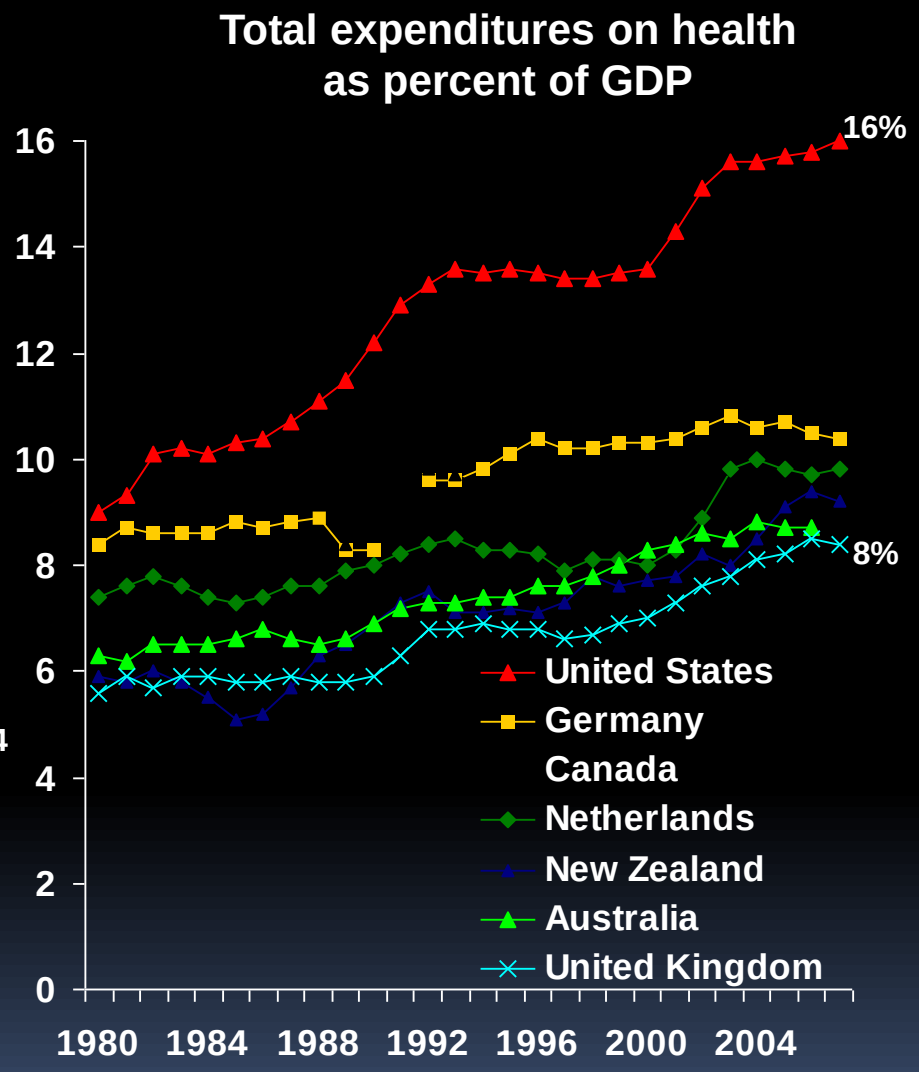
- Patient centered medical home is a new model that has several key elements (IMPACTS)
- PCMH addresses the triple aim of better care, better health, lower costs.
- Medical students can contribute to the medical home is in helping with patient self management.
- Tools such as an action plan and teach back techniques can assist patients to manage their own health.

Evaluation of Today's Session

- What went well?
- What could be improved?
- Suggestions

Exhibit 1. International Comparison of Spending on Health, 1980–2007

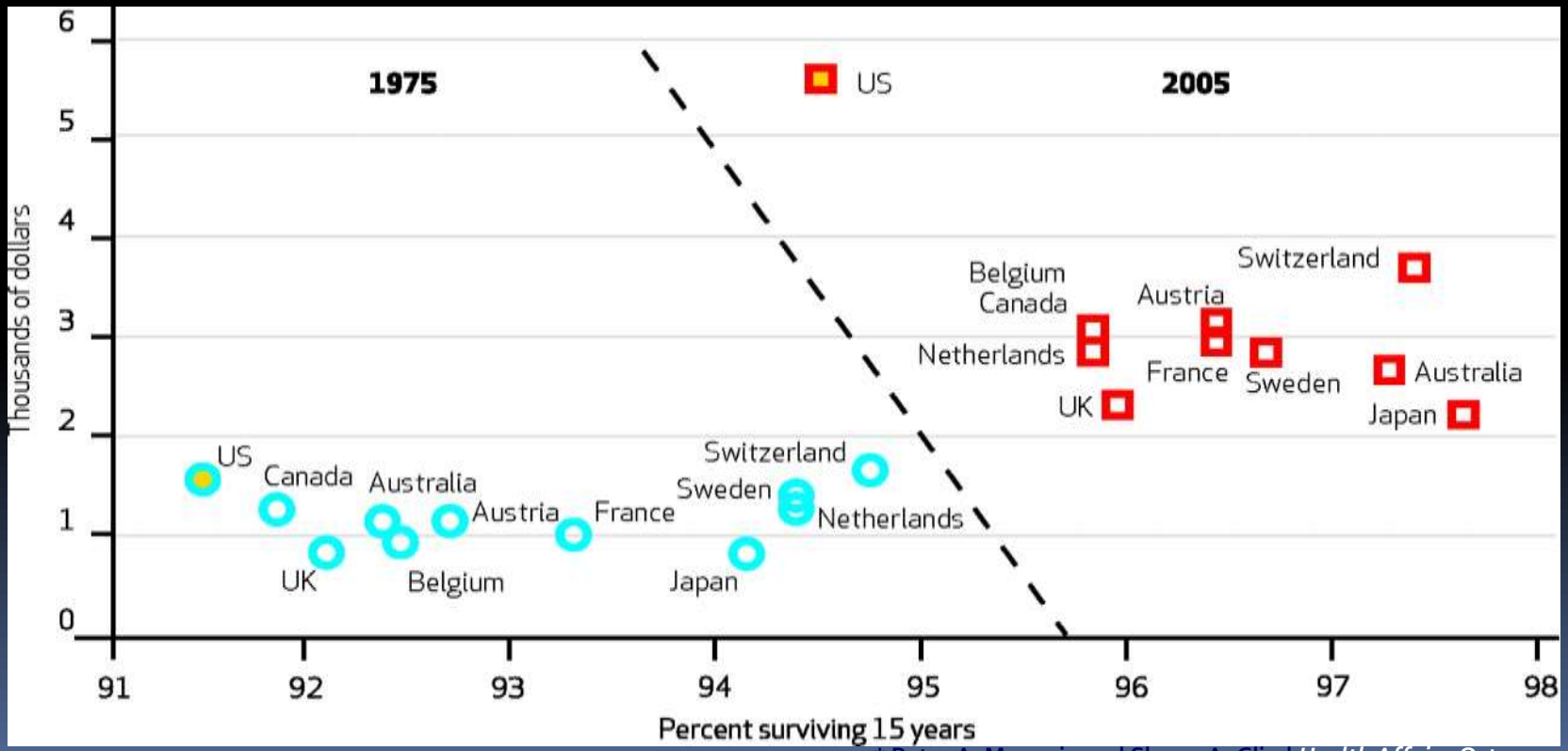




Note: $US PPP = purchasing power parity.

Source: Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

Comparison of cost vs survival

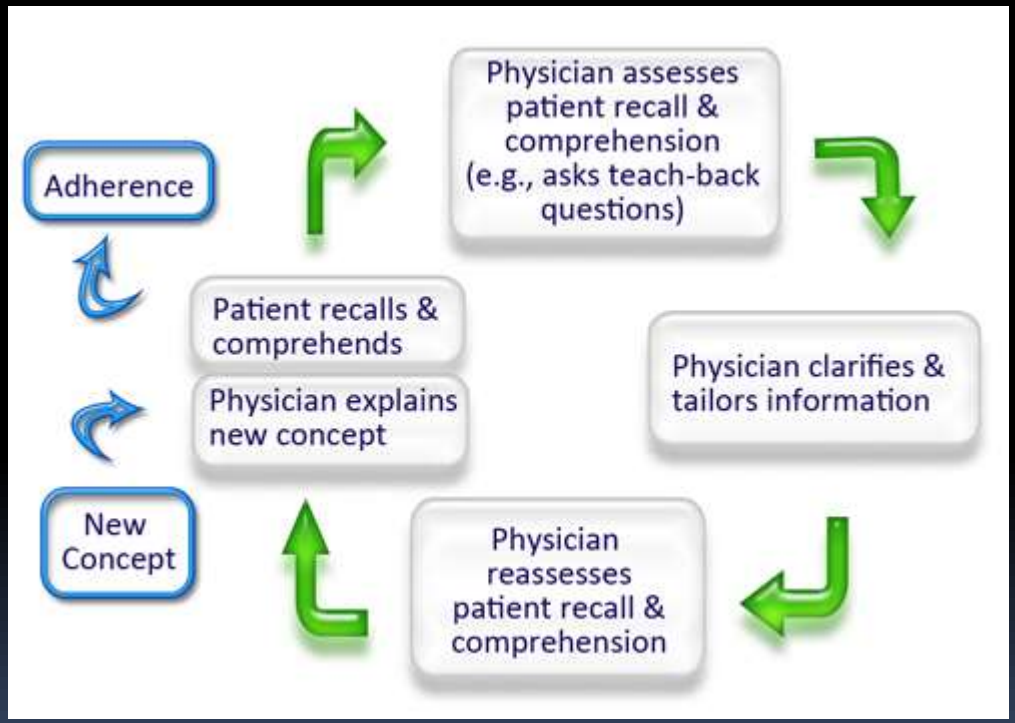


* Peter A. Muennig and Sherry A. Glied *Health Affairs* Oct. 7, 2010

Teach Back

- The teach-back method should be practiced in chunks, checking each time new information is presented. Here the doctor takes time to be a learner rather than a teacher, to find out whether his or her communications have been effective.
  - (Schillinger et al., 2004)

Teach Back


Physician assesses patient recall & comprehension (e.g., asks teach-back questions)
Physician clarifies & tailors information
Physician reassesses patient recall & comprehension
Patient recalls & comprehends
Physician explains new concept
Adherence
New Concept

Repeat Scenario

Reverse roles and try the exercise again, using the Teach Back method.

A 54 year old Hispanic woman presents to your office because she wants to lose weight. She is worried about getting diabetes because diabetes runs in her family and has heard that losing weight will reduce her risk. She speaks English but she is less fluent than in Spanish. With a partner, one of you role play the patient and the other the clinician. Engage in a conversation about weight loss.