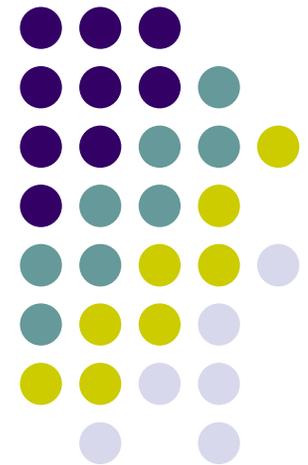


# Redesigning the Practice of General Internal Medicine and the Patient Centered Medical Home

Association of Chiefs of General Internal Medicine  
Winter Summit  
December 7, 2008

Richard P. Lofgren  
VP Healthcare Operations  
University of Kentucky





# Goals

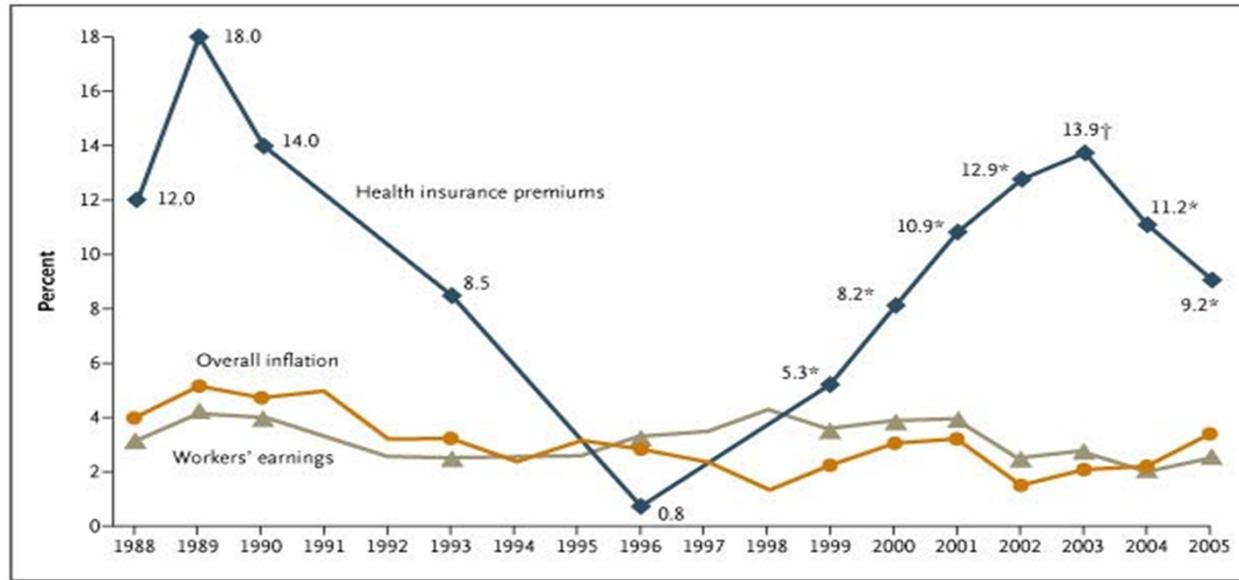
- Challenge us to build a better mouse trap
  - The system is dated and fails its stakeholders
- Outline the Clinical Practice Committee (CPC) initiatives to support the Patient Centered Medical Home Work Group
  - Solicit your support and involvement
- Understand how SGIM (CPC) can help best support your clinical programs
  - What do you need? What tools would be useful?

# Patient Centered Medical Home Explosion of Interest



- The “burning platform”
  - Social Demand
    - Can not afford the health systems
    - Below average outcomes despite high expenditures
  - Physician (primary care) dissatisfaction
    - Dramatic decreased interest in the practice of GIM
    - ACP and SGIM call to arms
  - Patient are dissatisfied – high cost, so-so value
- Google search “patient centered medical home” yields 2.3 million results

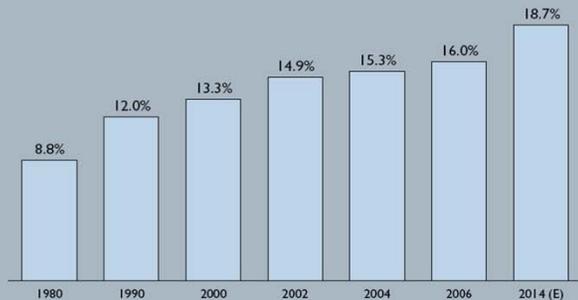
# Financial/Social Pressures



## Blowing Past 15%

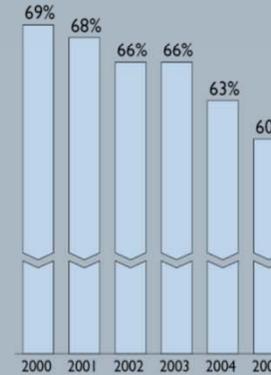
Health Care Expenditures as a Percentage of GDP

1980–2014 (E)



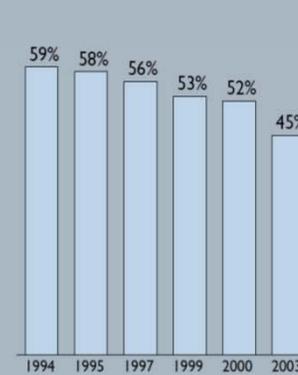
## U.S. Firms Offering Health Benefits

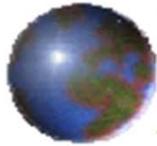
2000–2005



## Percentage of Private Sector Workers With Employer Health Benefits

1994–2003





| Type of system        | % GDP for health care | Health expen per cap (\$) | % paid by government | Health System Performance |
|-----------------------|-----------------------|---------------------------|----------------------|---------------------------|
| <b><u>NHS</u></b>     |                       |                           |                      |                           |
| UK                    | 7.6                   | 1989                      | 82                   | 92                        |
| <b><u>Soc Ins</u></b> |                       |                           |                      |                           |
| Australia             | 9.5                   | 2699                      | 68                   | 88                        |
| Canada                | 9.5                   | 2792                      | 71                   | 88                        |
| Germany               | 10.8                  | 2820                      | 75                   | 90                        |
| Japan                 | 8.0                   | 2131                      | 78                   | 96                        |
| Singapore             | 3.9                   | 993                       | 33                   | 97                        |
| Sweden                | 8.7                   | 2270                      | 85                   | 91                        |
| <b><u>Entrep.</u></b> |                       |                           |                      |                           |
| US                    | 14                    | 4887                      | 56                   | 84                        |

# Patient Centered Medical Home May be the Answer – It Makes Sense



- Patient Centered Medical Home promises to address the concerns of the stakeholders
- But what is the Patient Centered Medical Home?
  - Principles outlined in the official joint statement
  - Elements has been defined by NCQA
  - Yet each interest group appears to have their own variation of the details and vision/model
- Google search “patient centered medical home model” yields 408 thousand results

# Patient Centered Medical Home Movement Potential Issues SGIM Can Address



1. What is the model of care?
  - What is it designed to accomplish (the value proposition)?
  - How will it work or function?
2. What are the pre-condition or external needs necessary before a PCMH program can be implemented?
  - IT, finances, reimbursement and other resources
3. What are the health policies and other political implications?
4. How will we assess the success of the PCMH?
5. What are the implications for our teaching programs?

# Time to Build a Better Mouse Trap



Need to transition from a concept → to guiding principles → to defined elements → to arrive at a working/functional model of care

- New functional care model needs to:
  - Address the value proposition (WIIFM) for all stakeholders
  - Address the burden of chronic diseases
    - Unique and special role for the General Internist
  - Be revolutionary, robust yet realistic
    - Virtual or expanded services
- If not SGIM – then who?

# Patient Centered Medical Home Stakeholder Concerns



- Primary Care Physicians
  - Not professionally satisfied: work hard but feel lousy
    - Stop being a slave to the 15 minute appointment
    - Increased interest in concierge medicine
  - Not financially viable
  - Lots of hassles
- Payers
  - Inefficient care with mediocre outcomes
  - High costs especially for patients with chronic conditions
- Patient
  - Hard to navigate the system with poor access & lots of hassle
  - Inadequate information/education
  - Not affordable
- Misc. Special Interest Groups – opportunity
  - Specialists
  - Mid level providers including pharmacist
  - Patient advocacy groups

# Patient Centered Medical Home - Back to Basics

## Any New Approach Must Address the Value Proposition

### The “Give-Get” Equation



- Physicians - Give
  - Improved access
  - Chronic conditions management
  - More services within the practice
  - Coordination of care & help navigate the health care systems
  - ↑ patient family involvement
- Payers - Give
  - Allocate or devote more resources to the medical home
  - Provide the needed administrative infrastructure including decision support tools
- Patients and Families - Give
  - Actively enroll in a PCMH
- Physician – Get
  - Better infrastructure
  - ↑ job satisfaction
  - ↑↑ income
  - ↑ impact
  - ↓ ↓hassle
- Payers – Get
  - ↓ ↓↓cost of care
  - ↑ clinical outcomes
  - ↑ adoption of best practices
  - ↓ reduction unnecessary variation and waste
- Patients and Families – Get
  - Improved access and more education
  - More participation
  - Less hassle
  - ↑ satisfaction
  - ↑ functional capacity with a ↓ in disability and suffering related to their chronic diseases

# Designing Health Care System

## One Size May Not Fit All



- Different systems for different populations
  - Young and healthy
    - As a population limited health care needs
  - Chronic Disease
    - Expensive, fragmented, poor application of advanced technology, inefficient, suboptimal outcomes
    - Special and critical role of the General Internist
  - Special and Vulnerable Populations
    - Disabled
    - Homeless
    - Immigrants
    - Chronic mental illness

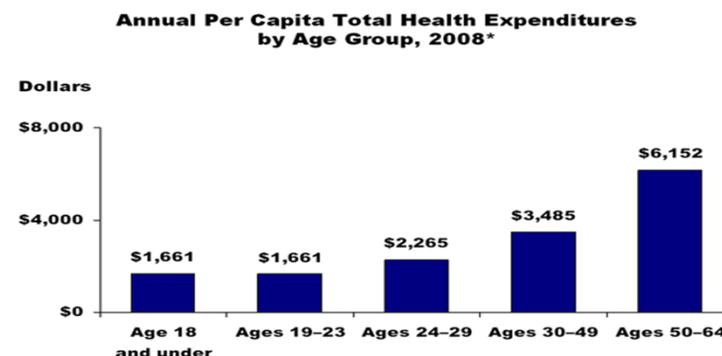


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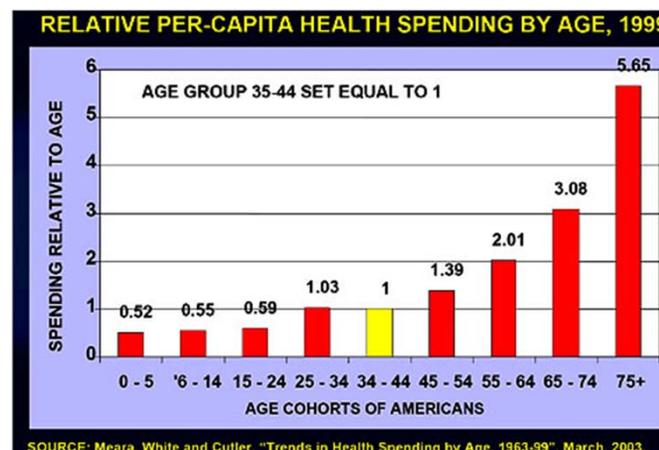
# A (the) major driver for change is the burden and cost of chronic diseases



- Affects 133 million people American
- > 75% of the nation's \$2 trillion medical care costs.
- 1/3 years of potential life lost before age 65.
- Diabetes costs = \$174B/year.
- Arthritis costs = \$128B/yr.
- In 2008, the cost of heart disease and stroke in the U.S. is projected to be \$448 billion.



\* Inflated to 2008 dollars using actual and estimated annual growth rates in national health expenditures.  
Source: Analysis of the 2005 Medical Expenditure Panel Survey by S. Glied and B. Mahato for The Commonwealth Fund.



# Clinical Practice Committee Agenda

## Redesigning Practice of General Medicine

### 4 Work Groups



- Clinical Management
  - Managing chronic diseases
  - Coordination of care
  - Managing interfaces and transitions of care
  - Communication among practitioners
- Practice Infrastructure
  - Personnel: team membership, leadership
  - Space
  - HIT Implementation – user group and technical support
  - Decision support and management metrics and tools

# Clinical Practice Committee Agenda

## Redesigning Practice of General Medicine

### 4 Work Groups (con't)



- Patient and Family Collaboration
  - Access – scheduling, electronic; and other non traditional modes of care
  - Communication
  - Managing expectations (demand management)
  - Self care
- Practice Financing and Payment
  - Infrastructure costs
  - Physician/Practice Compensation
  - Face to face care
  - Non face to face care (e-care, phone care)
  - Care management

# Concluding Thoughts



- Developing a more rational and organized system to care for complex sick patients is imperative (a unique opportunity and responsibility of GIM).
- The new model needs to fulfill the value proposition and includes:
  - Providers – more professionally and financially rewarding
  - Patients and their families – more personal and coordinated system of care that is easy to navigate with improved access to needed care and information (more care, more information, less hassle)
  - Payers – reduce total cost of care with an increase in value for the health care dollar (cost/quality/satisfaction).



- We are from the government (I mean the CPC)
- What can we do to help?