Medical Home Model for Improved Patient Care

BY TIM DRINAN

In an effort to provide better patient care at a lower cost, Milwaukee-based Ministry Health Care has established three Ministry Medical Group medical home pilot programs in Wisconsin and plans to adopt the model at all of its locations by the end of 2012. The system is aiming for Level 3 National Committee for Quality Assurance (NCQA) accreditation by the end of 2013.

The result will assure that the health care system is in the forefront of offering primary care according to the new model. It will also provide two major benefits to patients: assurance of quality, as well heightened education and support — one of the requirements of NCQA accreditation.

"The patient-centered medical home is designed to give patients the help and support they need to be involved in their own health care," said Mark Fenlon, MD, regional vice president of Ministry Medical Group and a family medicine physician in Stevens Point. "I'm convinced this is the primary care model of the future."

The health care system serves most of the upper half of Wisconsin and a portion of southeastern Minnesota and includes 15 hospitals and 17 Ministry Medical Group clinics among its health care services. The pilot programs are located in Waupaca and Stevens Point in central Wisconsin and Tomahawk in northern Wisconsin.

DEFINING THE MODEL

A patient-centered medical home care model replaces episodic care with coordinated care. Each patient has a relationship with a primary care team that takes collective responsibility for the patient's health care needs. The new model is intended to deliver personalized care that is coordinated, effective and efficient. Ministry Health Care intends to use patient-centered medical home care to improve clinical outcomes, improve efficiency and lower costs, while increasing the satisfaction of patients.

Ministry's model is based on a concept that the Institute for Healthcare Improvement developed for clinical office practices. It focuses on four key themes:[1]

- **Access:** Patients have unlimited access to the care and information they need, when they need it
- **Interaction:** Interaction between the patient and care team is deep and personal. The care team has "memory" of the patient
- **Reliability:** The system exhibits high-level reliability in that it provides all and only the care known to be effective
- **Vitality:** The practice has a happy staff, a spirit of innovation and financial stability

Many believe the traditional approach to primary care delivery, which was developed over many decades, cannot be sustained. It's a challenge for primary care doctors to find the time to provide all the necessary care a patient needs. "Say you're a family health care provider with a patient panel of 2,000. It would take more than 17 hours per day to care for all of the acute or chronic needs of this patient population as well as all of the preventive care services that are recommended.[2] You just can't get it done," said Fenlon.

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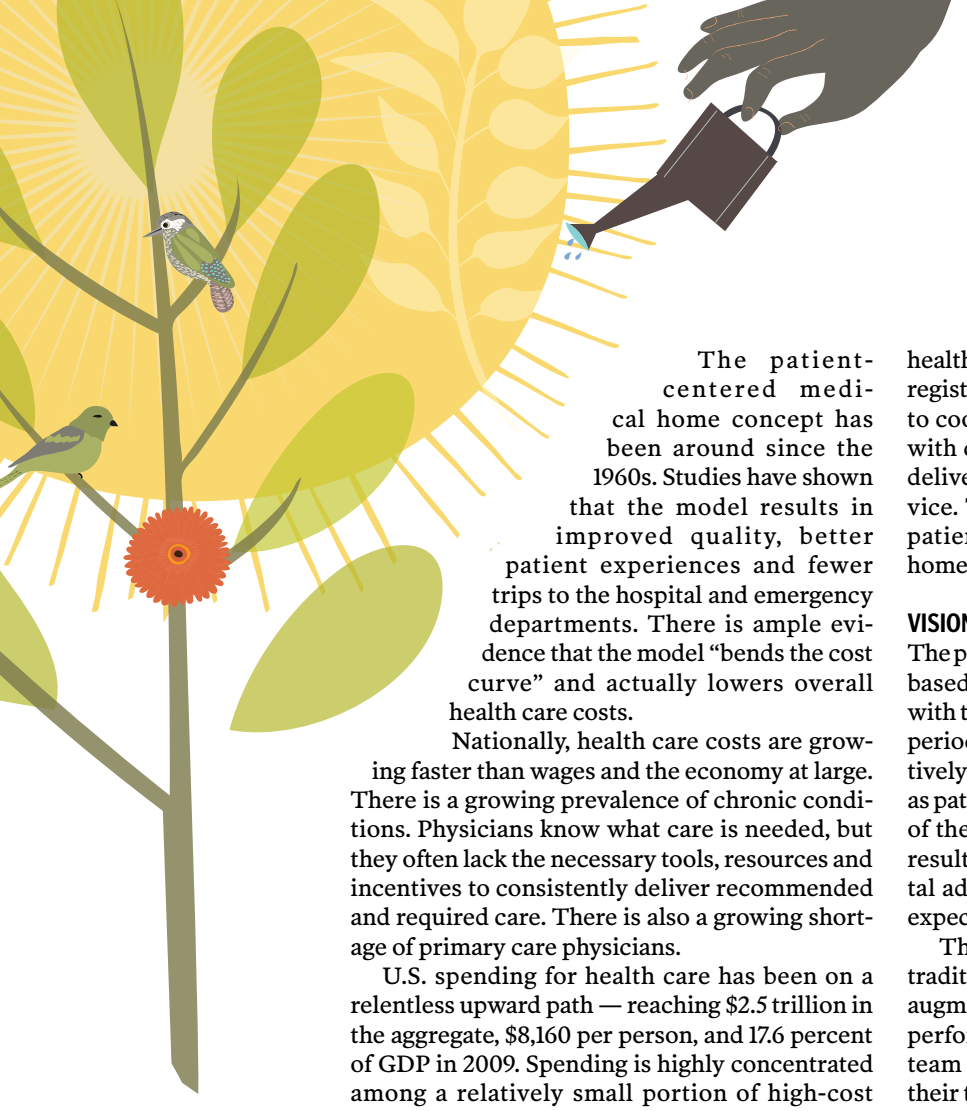

The patient-centered medical home concept has been around since the 1960s. Studies have shown that the model results in improved quality, better patient experiences and fewer trips to the hospital and emergency departments. There is ample evidence that the model "bends the cost curve" and actually lowers overall health care costs.

Nationally, health care costs are growing faster than wages and the economy at large. There is a growing prevalence of chronic conditions. Physicians know what care is needed, but they often lack the necessary tools, resources and incentives to consistently deliver recommended and required care. There is also a growing shortage of primary care physicians.

U.S. spending for health care has been on a relentless upward path — reaching $2.5 trillion in the aggregate, $8,160 per person, and 17.6 percent of GDP in 2009. Spending is highly concentrated among a relatively small portion of high-cost users, with about 10 percent of the population responsible for 63 percent of spending for health services. At the other end, half of the population accounts for just 3 percent of spending.[3]

Fenlon said a healthy 25-year-old woman coming to a patient-centered medical home for an annual exam is unlikely to notice a big difference in her care. "But those patients who have chronic obstructive pulmonary disease, or are on oxygen, or have diabetes or coronary heart disease, or need a walker or can't pay their bills, are going to see a huge difference. The patient-centered medical home team can engage all the resources a patient needs to deal with their issues. So patients will notice a bigger difference if they have multiple co-morbidities than if they're perfectly healthy," he said. "Our PCMH model integrates a registered nurse case manager within the practice to coordinate and manage care in these patients with complex needs. A traditional primary care delivery model cannot provide that level of service. The goal is to provide better value for our patients within the patient-centered medical home; higher quality at a lower cost."

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VISION AND GOALS

The primary care medical home model is practice-based team care. Its goal is to provide a patient with the complete spectrum of needed care over a period of time and to assure that the care is effectively coordinated. Primary care providers serve as patient advocates, and care coordination is part of the job for which they are compensated. As a result, unnecessary tests and procedures, hospital admissions and avoidable complications are expected to be averted.

The medical home model requires that the traditional primary care staffing complement be augmented to provide the resources necessary to perform the job. The model is designed so that team members function to the fullest extent of their training and ability. The model uses defined protocols to streamline workflow (Lean Six Sigma), and it requires positive, timely, effective communication and conflict management, along with cross-training and flexibility. The medical home model also allows a practice to manage a larger patient panel than under the traditional primary care approach.

"For us, the patient-centered medical home's key themes correspond nicely to Ministry Health Care's values of presence, service, vision and justice," said Fenlon. "Our promise at Ministry is to keep patients first in everything we do, so instead of the term 'patient-centered medical home,' we could call it a 'patients first' medical home. In our system, those two things fit perfectly. Access from the idealized design of the clinical office practice means patients have unlimited access to the care and information they need, when they need it."

"In the traditional model, I can tell someone they have diabetes and should be on a diet and exercise five days a week and lose 15 pounds and come back to see me in six months, but it's not very successful," said Fenlon. "In this new model, the physician will ask questions like, 'What do

you think is important? What do you think you can accomplish? Is it reasonable to think you can walk 30 minutes a day, five days a week to get your 150 minutes of exercise? What are your barriers to get there? How can we overcome those barriers?' It's more motivational interviewing. The team-based approach allows for additional resources for patients to help them achieve their goals."

To test the model, Fenlon's team originally picked two pilot sites — Tomahawk, in the northern region of Wisconsin, with eight clinicians, and Waupaca, in the central part of the state, with four clinicians. The team later added to the pilot group a five-clinician, family medicine site in Stevens Point with a particularly large patient panel.

Ministry Medical Group's approach is to first make positive improvements to the patient experience through process improvements and workflows. Next will come attention to the NCQA patient-centered medical home accreditation process, a checklist with numerous requirements. Ministry is using resources and tools from multiple sources, including TransforMed, a subsidiary of the American Academy of Family Physicians, to assist with the transformation process.

"The analogy is that moving to a patient-centered medical home is like rebuilding an airplane while it's in flight," said Fenlon. "It's essentially a total redesign of your primary care delivery model. And you're doing that at the same time you're struggling to remain in the air with the existing practice structure."

NEW MODEL BRINGS CHANGES

Prepare to manage these kinds of challenges:

- Change is hard, 'you go first'
- Redefined roles for staff
- New workflows
- Payment reform
- Redefined roles for clinicians
- Communication
- Health information technology

OVERCOMING OBSTACLES

Embracing the new model requires Ministry Medical Group to redesign the entire process of how it has traditionally worked with patients. It expects to achieve better quality, better management of chronic disease, better overall management of its patient population, higher satisfaction for patients, staff and physicians and improved operating efficiency and cost savings.

But the new model and quest for certification will bring inevitable changes — and sometimes conflict — that an office must be prepared to manage. For example, in the outpatient clinic world, many employees, including nursing staff, come from hospitals. Part of the reason they like working at the clinics is because the office hours traditionally set a 9-a.m.-to-5-p.m., weekday-only routine. However those are the same hours many patients work, affecting when they can obtain health care. Translation: emergency room or urgent care visits rather than scheduled visits with their established primary care doctor.

With its focus on the patient, the medical home model drives the recognition that patients need access to service during non-traditional business hours, including evenings and weekends. Extending office hours requires alteration in staff work schedules, sometimes producing resistance and conflict.

There are many change management techniques and models that show the importance of changing the sense of urgency while building a coalition of staff and physicians who are willing to change, difficult as it may be. Strong physician leadership is needed. Communicating the vision for change over and over again, celebrating short-term wins and removing obstacles are important. The change process occurs one step at a time.

"We've taken the NCQA elements that are needed for NCQA certification and have asked, 'Which of these are most important for you and your patients? What is the best place to start at your site?' You must have a process to manage conflict. People are going to disagree. It's just part of change management," said Fenlon.

FINANCIAL IMPLICATIONS

There's a paradox in establishing the patient-centered medical home model in today's environment. In today's fee-for-service world of health care delivery, physicians and hospitals are paid on volume. "If I approach our regional CEO and say, 'In two years, I'm going to have 20 percent fewer admissions for you,' he'll say, 'But that's how I get paid'," said Fenlon. "The reimbursement system must change in order to provide the patient-centered medical home with the proper financial incentives. Otherwise we will be hurting our own bottom line even as we do a better job for our patients. We have a way that we can deliver higher

value for our patients today, but that value does not immediately translate to financial returns for our system."

Instead, savings accrue to the insurance company or the governmental payer. A means to align incentives and assure that all parties benefit from the change practice is needed. Ideally, when the medical home model results in lower use of hospitals and emergency rooms, insurers will reduce premiums while rewarding providers for the improved outcomes.

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Along with the aging U.S. population come increasing illnesses and mounting health care costs. Forty-five percent of the U.S. population has a chronic condition.[4] Within the Medicare population, 83 percent of patients have at least one chronic condition;[5] almost 25 percent of Medicare patients have at least 5 conditions — diabetes, hypertension, coronary heart disease, obesity, smoking, etc. These patients are high risk and responsible for a large proportion of our health care costs.

Financially, the patient-centered medical home is good for patients, but it is not good for providers under a fee-for-service payment methodology.

PHYSICIAN ENGAGEMENT/ALIGNMENT

According to the American Academy of Family Physicians, between 1999 and 2009 there were 46 percent fewer graduates entering family medicine residencies.[6] It predicts a shortage of nearly 40,000 family physicians by 2020.[7] There also are fewer and fewer general internists; graduates are instead sub-specializing because they can earn better pay. Adult primary care shortages thus are going to be a real challenge to fill in the traditional model — and the first baby boomers reached Medicare age 65 on January 1, 2011.

Advance practice clinicians and a team-based approach will be necessary to fit with the patient-centered medical home model. Given the shortage of primary care doctors, clinics won't be able to compete for the few that are out there if they don't have this model. There's a realization that the incentives for reimbursement are activities that aren't necessarily direct patient contact-generating relative value units, but they improve quality and outcomes.

Ministry Medical Group's goal is better quality, better staff satisfaction and lower costs. If it can demonstrate better care at a lower cost, it can add value.

"If I'm coming out of family medicine residency today, and I have an opportunity to go to a traditional primary care delivery model or a well-oiled, patient-centered medical home, I'm going to the medical home," said Fenlon.

"Physicians understand the current primary care delivery model and the problems with it. They get it. We'll probably have some staff turnover. The physicians understand patient-centered medical homes. Everyone wants it," added Fenlon.

ROLE OF PATIENTS

The patient-centered medical home leverages its team-based approach to have a much more sophisticated method of tracking admissions, where patients have been, what's happening to them, what they need and maintaining a proactive treatment plan. That does not typically happen in the traditional care model, where care is determined by what a patient presents today and how much time the doctor has available. The other piece is the respect to patients' wants, needs and preferences. Patient-centered care is a collaborative model, making sure physicians are meeting patients' needs and expectations and not running the visit based on the physician's expectations.

Patient access means anything from answering an email that comes in through a patient portal from an electronic health record to electronic visits. Patients want access to lab results and other information online, day or night. Nurse practitioners say patients frequently ask to have lab results texted to them, and some patients prefer to avoid

office visits, if possible. For example, nurse-driven procedures or a standing order set can take care of recurring conditions such as strep throat or urinary tract infections. That could open up the physician's time for patients with more urgent cases.

Because patients are an integral part of the patient-centered medical home team, their input is necessary. Ministry Medical Group patients will soon be asked to participate in the development of a patient advisory panel so they can offer direct and ongoing input about what's important to them and how they view their care. This will assist with performance measurement and improvement.

Getting patients engaged in their own health care and taking on more responsibility is an important piece of the puzzle. The interaction between the patient and the care team is deep and personal. Patients want a team-based, proactive care approach experience. That's what the patient-centered medical home model will provide.

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NOTES

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