Seven Medical Home Experiences

While there are common elements to every medical home, there are many ways to start, adapt, and maintain one. This chapter examines a variety of experiences. Some practices are starting from the ground up as medical homes, while others are converting their existing systems and approaches to embrace medical home principles. Some of these are finding their commitment paying off while others are regrouping to try again. All of them are convinced they are onto something important for primary care.

Chapter in Brief:

- *Physicians seeking better ways to deliver chronic care management are implementing the medical home model with some success; however, taking on computer systems or struggling for reimbursement sometimes shifts the delicate financial balance into the red. To make a medical home work, think creatively in terms of revenue streams; ancillary businesses are one option.*
- *Teamwork, one of the hallmarks of a medical home, can work by streamlining the practice and giving patients a way to get quick, preventive care. Physicians benefit by putting their training to work with patients with complex treatment needs.*
- *No matter the size of the practice, physicians need determination and flexibility to stick with their medical home experiment.*

When is the right time to transition into becoming a medical home? Despite the challenges, expenses, and initial lack of extra compensation, some physicians have decided the time may as well be now. In this chapter we profile seven practices that are testing the medical home. Their

MEMO-Snap™
Medical Memo & Coding Management

Capture and Code all-new CPT 2008 Telephone Services

Documenting telephone calls while on the go is a Snap with New MEMO-Snap™ Pocket Data Pads!

A quick and inexpensive way to ensure accurate medical records and follow-up for telephone, online, and after-hours patient consultations.

- Keep MEMO-Snap™ with you for telephone notes while on call or on the go. The pad's vinyl cover has a pocket for storing completed forms.
- Capture and document telephone encounters for completion of the patient medical record.
- Check boxes to alert support staff to patient follow-up, new medications, transcription, coding/billing.
- Visit *www.memo-snap.com* for tips on using *MEMO-Snap™* and for up-to-date information on coding and reimbursement for telephone care.

To order MEMO-Snap™, go to *www.memo-snap.com* and receive free downloads of calendar inserts as well as tips on how use MEMO-Snap™ pads in your practice. While you're there, learn about new *MEMO-Snap Message Mates* for your office staff!

MEMO-Snap™ and MEMO-Snap Message Mates *are produced by Brandofino Communications, the publisher of* Doctor's Digest.

experiences vary: Some are getting extra pay, some aren't. Some are struggling financially more than others. The first three were sites in the AAFP's TransforMED national demonstration project (see Chapter 1), while the remainder made the change on their own. But in all cases the physicians are finding that practice-specific solutions—along with the awareness that comes with real-world experience—are keys to running a successful medical home.

Optimistic Despite the Challenges

Family Medicine, Geriatrics, and Wellness—Lower Gwynedd, Pa.

These days family physician Joseph F. Mambu, MD, sees about 20 complex patients a day rather than the 30 to 50 (ranging from average to complex) a day that he says is standard in a traditional practice. Even though his medical home practice is still struggling to find its financial footing, he is optimistic that it will all work out—eventually.

A former nursing home administrator, Dr. Mambu had never been happy with how primary care handles chronic disease. So when he set up shop in 2001, he went with a team—adding a nurse and a nurse practitioner—and resolved to deliver care differently and better. He didn't realize at the time that he was creating his own version of a patient-centered medical home.

Although he was satisfied with how his practice was doing, Dr. Mambu added what he calls "rocket fuel" to his practice in 2006 by becoming part of TransforMED, the AAFP's primary care project. As part of the test group, he received consulting services and coaching on such issues as time management and patient metric development.

All was financially well until about 2007, when the practice started installing an EMR system. While the system has now started to deliver the expected benefit, at that time the extra cost upset the practice's financial balance.

Extra money is starting to come in now as a result of the practice's medical home status. It's receiving some extra payments from insurers as a result of a medical home pilot project in southeastern Pennsylvania. Ultimately, Dr. Mambu expects a 10- to 12-percent increase in gross revenues from being part of the pilot project. And because his patient panel includes many aged

65 or older, he's keeping his fingers crossed that Medicare will adopt the medical home model of reimbursement. "That would put us over the top and give us money to invest," he says.

Meanwhile, the practice received its NCQA Level 3 medical home recognition in late 2008—one of the first practices in the country to do so. Dr. Mambu also is reaping the rewards of having the practice function just the way he always envisioned. Now that there are three physicians, two nurse practitioners, a registered nurse, and several medical assistants who are certified to draw blood and administer vaccines, most of the practice's patient care—sore throats, runny noses, and athletics physicals, for example—is handled by non-physicians.

The extra hands make it easier to offer a modified open-access schedule and to keep the office open three nights a week and on Saturday mornings. Dr. Mambu can even make the occasional house call.

"I think the doctors of the future will see fewer patients, send more e-mail, and concentrate their clinical work on patients who really need a doctor," he says.

Teamwork Pays Off

Trinity Clinic Whitehouse—Whitehouse, Tex.

Teamwork gained new meaning when Trinity Clinic Whitehouse, part of Trinity Mother Frances Health System in Tyler, Tex., was accepted into the TransforMED project in 2006.

The practice had been experimenting with being a medical home since about 2000 with open-access scheduling and an EMR. As part of the project, staffing changed so that each of the three physicians was matched up with a nurse. Patients now see the same doctor-nurse team whenever they come in. Because every team member has a specific job, it's easier to keep tabs on specific patients, and the practice can see more patients overall.

For example, the clinic offers special "QuickSick" same-day visits—a dozen slots around lunchtime and two at the end of the day—specifically for upper respiratory infections. It promises a half-hour turnaround for patients who choose to take one of these appointments.

The practice now has a panel of about 5,000 patients and the equivalent of two full-time physicians (three part-timers). "If

you'd asked me three years ago if that was too many [patients], I would have said yes, but now I don't think so," Melissa S. Gerdes, MD, says.

She's also changed her mind about what it means to be a medical home. "We thought it was principally about online services and group visits and open access," she says. "But it's the attitude that your practice has, not fearing change and transformation, and everyone working together."

"We thought [the medical home] was principally about online services and group visits and open access," Dr. Gerdes says. "But it's the attitude that your practice has, not fearing change and transformation, and everyone working together."

The clinic is doing reasonably well financially thanks to a supportive parent organization and decent reimbursement from local payers, according to Dr. Gerdes. None of the clinic's payers has offered any extra reimbursement for its medical home activities, but Dr. Gerdes is comfortable with the present arrangement for now.

"The expense is a big barrier, and I know a lot of practices are struggling, but each one has to look inside itself," she says. "It's my philosophy not to go after that bigger payment until you've done everything you can to increase your efficiency."

Other Business Opportunities

Romeo Medical Clinic—Turlock, Calif.

The Romeo Medical Clinic has found a way to be a medical home even though reimbursement models can't pay all the bills right now. Its solution: auxiliary businesses that subsidize the family practice, including a sports medicine practice and a corporate wellness and occupational medicine program.

The physicians—two brothers and a sister—also have an ownership interest in the Tower Health and Wellness Center, the building where the clinic has its home. The sandstone-colored building, adorned with wrought iron and Italian tile, is meant to evoke the feeling of Tuscany. It also houses a flower shop, an

Italian restaurant, a pharmacy, a dentist, and other tenants associated with a healthy lifestyle. A full-service health club may be in its future.

The Romeo Clinic served as a control or "self-directed" practice in the TransforMED National Demonstration Project because it had already been pursuing most of the recommended strategies on its own.

It has found that those extra businesses enable it to balance the books, allowing the practice to subsidize medical home-style care for its 2,000 patients with the help of eight medical assistants, a part-time dietitian, and a part-time behavioralist. Here are some examples:

- New patients or those having a physical get an hour-long appointment; everyone else gets half an hour.
- Patients can e-mail their physicians.
- The practice is working on a Web portal so patients can access their records. Meanwhile, a medical assistant calls them with lab results that are automatically entered into the practice's EMR system.
- In keeping with the practice's emphasis on wellness, its Website includes a form that patients can fill out to get matched up with a fitness buddy for the sport or workout of their choice.
- The waiting room offers multiple gaming systems, wireless Internet access, fresh-brewed coffee, multiple TVs, and music.

In addition, the physicians get to run the practice the way they planned when they opened their doors seven years ago. "Our practice is fun," says president and co-founder Mike Romeo, MD. "We're not frustrated, we're not disenchanted, and we enjoy what we do."

Learning to Make—and Adapt to—Big Changes

Renaissance Health—Arlington, Mass.

Rushika Fernandopulle, MD, quit his job brainstorming ideas on how to transform primary care away from today's volume-driven, reactive system to do something radical: actually put those ideas into practice.

In 2004, he left the Harvard Interfaculty Program for Health Systems Improvement, a health policy research group. He and Pranav Kothari, MD, took out second mortgages and invested

$1 million in a primary care practice in the Boston suburb of Arlington, Mass. They operated on a model they believed combined the best of the small-town doctor tradition with 21st-century information technology, and christened their endeavor Renaissance Health. The practice had all the hallmarks of what's now called the medical home: personalized health assessments, group visits, online medical records, and lots of communication.

"We would call people to see if they were taking their antibiotics," Dr. Fernandopulle says. "We caught lots of potentially bad things by calling people up."

They also offered Pilates and yoga classes, talks on health topics, and even a group that got together to walk every day.

The practice charged a monthly membership fee—ultimately $55 though adjusted for those who couldn't afford it—on top of whatever it billed insurers for care provided, a format Dr. Fernandopulle calls "concierge lite." The two doctors both worked a part-time schedule and had built up to about 450 patients by 2006.

But the practice started to get negative feedback from insurance companies, which ultimately either dropped the practice or made it difficult to use. Dr. Fernandopulle believes that happened because he and his partner regarded themselves not as agents of the insurers but as advocates for their patients, and, unlike most physicians in the state, weren't part of a large group or network.

The doctors called it a day in late 2006, taking away several lessons from the experiment. First, they felt that they had to go to another state, and they are now implementing their care model on a consulting basis for various organizations, including Boeing Corp. and the Local 54 Trust Fund, which provides health coverage for unionized Atlantic City casino workers.

Second, they needed to concentrate their efforts on the chronically ill, who would benefit most from the kind of intense personal attention that the model provided.

And third, they took a firmer stand on the need to restructure the financing system to encourage desirable behavior. As part of their work with the casino workers' union, Drs. Fernandopulle and Kothari started a practice in 2007 within the Atlantic City-area healthcare system Atlanticare to test the concept with 800 to 900 invitation-only, chronically ill patients. The practice has

the two physicians, a nurse practitioner, four health coaches, a part-time nutritionist, and a part-time mental health worker. Co-pays are waived for medications and office visits.

Big Player Makes it Work

Geisinger Health System—Danville, Pa.

Large-scale change is possible. Just ask the physicians at Geisinger Health System, which began experimenting with the patient-centered medical home in 2007 and has since expanded to include half of its 40 primary care sites. Its success—e.g., hospitalizations have decreased 15 to 20 percent, and the investment has returned $2.50 for every dollar spent—has attracted the attention of provider and payer groups nationwide.

Geisinger is a big player in central Pennsylvania. It's an integrated system with its own health insurance plan and a lot of physicians on staff. It's also a leader in installing and using EMRs. All those advantages give the organization latitude to try out care innovations.

Geisinger focused its medical home experiment on coordinating outpatient and clinic visits, hospital stays, home care, and

Geisinger's primary care physicians (all employed by the organization) received a salary bump of $1,800 a month, and each practice site is receiving an extra $5,000 to $10,000 a month to redesign care. In addition, if physicians beat the health plan's targets for quality and cost of care, they receive half of any savings.

end-of-life care for Medicare beneficiaries. Each of the 20 practice sites got at least one on-site case manager, who works aggressively with the 15 percent of patients who are most seriously ill and their families, developing an individual plan for monitoring symptoms and taking action to head off crises. For example, those with chronic lung disease get a kit of antibiotics and steroids that they can use at home to ward off infections. Other staff members focus on getting less-ill patients in for routine exams and screenings.

The experiment has wrapped in a network of preferred specialists and ancillary providers who have the most cost-effective contracts with the health plan. Patients can go anywhere, but the

preferred providers are clued in to the medical home aspect of their care; and the primary care physicians are encouraged to refer patients to them.

For these changes, Geisinger pays fairly generously. Primary care physicians (all employed by the organization) received a salary bump of $1,800 a month, and each practice site is receiving an extra $5,000 to $10,000 a month to redesign care. In addition, if physicians beat the health plan's targets for quality and cost of care, they receive half of any savings.

From Diabetic Management to Medical Home

MeritCare Health System—Fargo, N.D.

In 2005, MeritCare Health System, an integrated network on the North Dakota/Minnesota border, told its largest insurer, Blue Cross Blue Shield of North Dakota, that it could manage its diabetic patients better than the disease management company that Blue Cross Blue Shield was contracting with.

"We didn't see that the company was helping, and it created lots more paperwork," says Julie Blehm, MD, MeritCare's managing physician partner of clinic internal medicine. "One of our best doctors just said, 'This is a pain.'"

When Blue Cross Blue Shield accepted MeritCare's challenge, it was the first step in turning four of the system's 30-plus clinic locations into patient-centered medical homes. The initial pilot project involved four physicians and 200 diabetic patients, with a comparably sized control group. Blue Cross Blue Shield paid $20,000 in seed money for changes in office procedures,

Patients stay in the exam room after the physician leaves, and the scheduler and a nurse come in to arrange the next appointment, give flu shots or any other scheduled immunizations, and answer questions.

funded a half-time disease management nurse, and paid an annual care management fee of just over $100 per patient. Blue Cross Blue Shield found itself saving $500 per diabetic patient per year and split the savings equally with MeritCare.

Next the project expanded to 18 to 21 healthcare providers in three locations and included patients with heart disease and

hypertension. It saved $300 per patient. Recently MeritCare added its family practice residency clinic, where 25 residents rotate, into the new model. A patient with one or more of the target diseases meets with a care management nurse, who cares for and tracks that patient from then on. If the patient agrees, the nurse commits to a regular schedule of phone reminders about tests, appointments, and anything else that needs tracking.

The participating practices have eliminated the previous two-step reception and registration process for all patients. Now it's all done at once, substantially reducing patients' waiting room time. Patients stay in the exam room after the physician leaves, and the scheduler and a nurse come in to arrange the next appointment, give flu shots or any other scheduled immunizations, and answer questions.

Even though the test was conducted only with Blue Cross Blue Shield, the practices treat all chronically ill patients the same, regardless of insurance. They're also tracking preventive measures for all patients, chronically ill or not, including colonoscopies, mammograms, and use of generic drugs.

In the statewide medical home pilot project that's coming up (see Chapter 4), MeritCare will continue to get a management fee per patient, but that fee will be subtracted from its share of any savings that it splits with Blue Cross Blue Shield.

Building What You Want from Scratch

Whole Child Pediatrics—Lakewood Ranch, Fla.

Whole Child Pediatrics is an experiment in building an ultimately profitable patient-centered medical home from the ground up.

Fresh out of residency in 1999, pediatrician Xavier Sevilla, MD, went to work in a community health center, where his ideals of partnering with his patients for their care collided with reality. "We had very long waits, frustrated and angry patients, and basically an uncoordinated, chaotic care environment," he says. He soon became involved in trying to fix what was wrong

with the center. That effort led him to join the AAP's quality improvement steering committee and later the four-society committee that devised the medical home principles described in Chapter 1.

He was so fascinated that when his center wanted to open a satellite office, he jumped at the chance to build a medical home from scratch. He opened the practice in 2007 and grew it to 1,500 patients within a year, adding a nurse and a nurse practitioner. All along he experimented with the various elements of a medical home, like open access, electronic communication, quality measurement, and comprehensive care.

The practice reached the financial break-even point last summer and is now starting to show a profit. While Dr. Sevilla attributes part of the rapid growth to his acceptance of Medicaid and uninsured patients, he says that can't be the whole story, and he thinks his relatively novel model of care must have something to do with it.

Just as he always hoped, collaboration with patients is one of the hallmarks of Dr. Sevilla's practice. "This is what I thought practice would be like when I was a medical student," he says.

If a child develops a chronic condition, for example, Dr. Sevilla will explain all the possible treatment options and make a recommendation. If the patient's family decides to do something different, he normally abides by that decision.

"My role is to be an information broker," he says. "I find that when patients have the information in front of them, they generally make the same decision that I would, but they really appreciate being given an opportunity for control."

His affiliation with the community health center simplifies his life. First, he can use the organization's EMR system and its billing and collection services, which together represent a huge savings. He can also swap call duty with the pediatricians on staff there, so that he can have weekend time off and even the occasional vacation.

None of the payers in his market pay extra for his medical home service, but Dr. Sevilla says it doesn't matter. "You don't need any money to do open-access, patient-centered care, coordinated care, and comprehensive care," he says, although some tools, like a patient registry or an EMR, help.