

# Putting It All Together

## Chapter FastFACTS

- 1. Although Group Health reduced patient panels and lengthened office visits for its medical homes, it still saw overall savings.**
- 2. Geisinger leveraged its EHR system so staff could act on information when it was most useful.**
- 3. Mean emotional exhaustion scores for physicians at one PCMH pilot clinic were 12.8 after two years, compared with 25 at the two control clinics.**
- 4. Geisinger's physicians receive an additional \$18,000 a year for applying the principles of the PCMH.**
- 5. Transitioning to a patient-centered model can be difficult for patients.**

**A**t Seattle-based Group Health Cooperative's 26 primary care clinics, a typical workday starts with a team huddle. Every day, physicians, nurses, medical assistants (MAs), and front-desk personnel go over the day's schedule. They review patients' EHRs for data on follow-up lab tests or imaging studies, check for any needed preventive care, and—if needed—contact patients to clarify expectations for their visit. By the time of the scheduled visit, all the preparation work has been done, leaving the physician free to have a productive, comprehensive conversation with the patient.

This scenario became typical once Group Health, a nonprofit health insurance/care delivery system with operations in Wash-

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ington and Idaho, had all of its practices function as medical homes. Group Health has been rolling out the model to its clinics, which range from large urban to small rural practices, given compelling data from its 2006 medical home pilot. Compared with other non-PCMH Group Health clinics, after 24 months,



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**Robert J. Reid, MD, PhD**

Associate Investigator

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patients in the PCMH pilot clinic had 29% fewer emergency visits and 6% fewer hospitalizations, says Robert J. Reid, MD, PhD, associate investigator at Group Health Research Institute and associate medical director for preventive care at Group Health Cooperative.

In addition, physicians experienced less burnout (measured by online survey tools); and, despite spending more on patient care, the prototype clinic recorded savings equal to an average of \$10.30 per member per month, Dr. Reid and colleagues report in the May 2010 issue of *Health Affairs*. Moreover, he adds, quality, as measured by patient surveys (which reported improvements in coordination, access, goal setting, quality of doctor-patient interactions, and patient involvement), improved at a greater rate at the PCMH compared with control practices. Nonetheless, he recognizes that changing to a PCMH is a major undertaking for any practice. “It’s a big transformation,” Dr. Reid says. “We asked [each office] to reinvent the way they did care and the way teams operated and intersected with patients in really substantial ways.”

Group Health facilitated the transformation by reducing

physicians' patient panels from 2,300 to 1,800 and increasing the standard office visit from 20 to 30 minutes. In addition, the group hired more physicians and clinical staff, gave more care-management responsibilities to nurses and clinical pharmacists, and gave MAs responsibility for pre-visit, outreach, and follow-up activities. Those adjustments made patient care more expensive compared with non-PCMH clinics; but those costs were offset by fewer urgent-care visits and inpatient admissions, resulting in overall savings, Dr. Reid says.

Group Health's PCMH experiment may be seen as the ultimate destination for practices starting to engage in QI. (See "Group Health: A Medical Home Prototype.") For the small percentage of practices that have achieved medical home status—1,246 sites representing 6,534 physicians have been recognized as PCMHs by the NCQA—QI isn't one initiative or group of measures but an overarching philosophy that guides how they practice medicine. "The PCMH is a general redesign of the practice with the idea that you are more patient-centered and address all issues at the same time," Dr. Reid says. "Along with that, you should see QI; and that's what we experienced."

## Customizing The Medical Home

Geisinger Health System chose the medical home model as a path to improving quality and cost efficiency when it was selected to participate in Medicare's PGP Demonstration. As discussed in Chapter 4, PGP groups received incentives for meeting quality and cost goals, using whatever strategies and tools they considered most effective. That model was built around five elements:

**1. Physician-directed, team-delivered care.** All staff members work at the top of their license and use home-based strategies to improve outcomes. Geisinger implemented systems to completely monitor the sickest patients when they are admitted to the hospital or nursing home or transitioning from the emergency department, calling them within 24 hours of discharge and seeing them in the office within three to five days.

**2. Leveraging systems.** Geisinger's EHR system sends nurses alerts around process measures, such as when a patient is due for a flu or pneumonia vaccine; front desk staff get alerts around

## Group Health: A Medical Home Prototype

### Virtual medicine:

- Secure e-mail messages and telephone encounters to enhance access and to prepare for, follow up from, or substitute for in-person visits.
- Use EHR to promote patient engagement, including lab test results review, electronic health risk appraisal, and online prescription refills.
- Consistently use “after-visit summaries” and make them accessible to patients after their visits via the EHR.

### Chronic care management:

- Use electronic registries, health maintenance reminders, and best-practice alerts.
- Use motivational interviewing and brief negotiation skills.
- Create collaborative care plans to guide patient and care-team activities.
- Promote self-management support resources, including group visits, behavior-change programs, and peer-led chronic illness workshops.

### Visit preparation:

- Contact patients in advance of visits in order to clarify concerns and visit expectations.
- Review record for follow-up tests, referral notes, and outside records.
- Review quality-deficiency reports for unmet care needs.
- Prepare the physician with education materials and other resources for visit.

Source: *Health Affairs*, May 2010, 29:5, <http://content.healthaffairs.org/cgi/content/abstract/29/5/835>.

scheduling visits, tests, or procedures; and physicians get alerts around medical management, such as responding to information that a patient’s blood sugar has spiked. “We don’t tell physicians how to practice, but we prompt them to make active medical decisions by sending them actionable information at a time when it’s useful,” Dr. Graf says. Geisinger recently went live with its “happy birthday” program, which automates preventive care for all adult patients. In their birthday month, patients get a letter listing all the services they will be due for during the year, followed by an automated call triggering them to schedule needed tests or screenings. When the patient comes into the office, the physician already has the test results; and the discussion can

focus on next steps.

**3. Population management.** Geisinger uses utilization metrics from health plans—for example, how many patients per 1,000 who went to the emergency department were readmitted in one month—to create predictive models based on patients’ age, sex, diseases, and past medical experience. The result is a list that ranks patients according to risk, which can be modified by physicians based on their knowledge of individual patients. Case management nurses then start calling the highest-risk patients to discuss their health and medications. This strategy avoids admissions 70% to 80% of the time, Dr. Graf says.

**4. ACO-like interventions.** Although Geisinger owns two hospitals, it also has relationships with 14 other area hospitals and outside specialists. Geisinger has focused on connecting its primary care physicians with all affiliated hospitals as well as nursing homes, durable medical equipment companies, and specialty offices. One example is its skilled nursing facility program, which embeds nurse practitioners or PAs on-site full time to monitor Geisinger patients; this had reduced hospital admissions from nursing homes by 20% to 50%, Dr. Graf says.

**5. Quality measures.** Measurements focused on prevention and chronic diseases are “the quality gate on any savings we generate,” Dr. Graf says. Geisinger’s focus on prevention and disease management has helped it reduce overall hospital admissions by 50% on average, qualifying it for significant Medicare incentive payments.

While most primary care practices don’t have the resources of a large system like Geisinger, it’s still possible to improve quality without breaking the bank. Dr. Meyers of AHRQ recommends using free patient survey tools and offers other tips for practices on tight budgets. (See “Improving Quality on a Budget: 6 Essential Tools.”)

## Motivating Physicians

Not surprisingly, both Group Health and Geisinger found that improving physicians’ work environment and compensation packages was critical to the successful implementation of the PCMH model. After Group Health reduced physicians’ panel sizes and extended time for office visits, for example, there was

a measurable decline in physician burnout. “We realized that [physicians] initially didn’t have time to do all the new things and reinvent care the way we envisioned,” says Dr. Reid.

Another solution introduced by Group Health was standard time during the day for “desktop medicine” activities, such as e-mailing and calling patients. After two years, the mean emotional exhaustion scores for the pilot clinic were 12.8 compared with 25 at the two control clinics, Dr. Reid reports in *Health Affairs*. “Physicians and care teams require reasonable-size practice populations to allow physicians to know their patients better, comprehensively address their needs, and avoid burnout,” the authors conclude.

Changing pay structure can also be a motivating factor. Group Health eliminated productivity-based salary bonuses in medical home clinics and realigned incentives around quality, patient satisfaction, and resource stewardship. Geisinger also took steps to align doctors’ pay with quality of care. Under its basic compensation for the medical home model, 80% of physicians’ pay

### Improving Quality on a Budget: 6 Essential Tools

David Meyers, MD, director of the Center for Primary Care, Prevention, and Clinical Partnerships at AHRQ, offers these tips for small practices aiming to improve quality on tight budgets:

- Use free or low-cost survey tools to get patients’ views on how you’re doing, and use the results to target practice improvements.
- Invite patients and families to accompany you on a walk-through of the office as they tell you about the registration process, the waiting room, exam room, etc.
- Create an advisory board made up of patients who meet once every six months for dinner and discuss what works and what doesn’t.
- Use registries to understand your practice panel and to get information out of your EHR.
- Contact your Regional Extension Center for free advice on health information technology and implementation of EHRs.
- Look to specialty societies (i.e., ACP, AAFP, AAP) for online tools, resources, chat rooms, etc. Contact your state’s Medicare QIO as these groups often seek practices that need help with QI.

is based on productivity (the traditional fee-for-service model) and 20% is based on quality metrics. Since the PCMH was introduced, physicians also receive an additional \$18,000 a year for applying the principles of the PCMH. “We look at whether the doctor is participating in transforming care,” Dr. Graf explains.



**“We look at whether the doctor is participating in transforming care. If the doctors are getting good results, they get paid; if they try really hard and are not getting great results, they still get paid. But if they aren’t trying, we hold the money.”**

**Thomas Graf, MD**  
Chair

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The quality-based portion of compensation is somewhat controversial, Dr. Graf concedes, because physicians must meet targets on “bundled metrics” of care in order to qualify for the full incentive. The standard bundle consists of nine elements monitored on a monthly basis, including administering flu shots and controlling blood pressure. Physicians and other members of the care team receive bonuses based on the percentage of their patients who meet all nine elements. If a patient meets eight of the metrics but still smokes, for example, that patient cannot be counted toward the incentive. “Doctors don’t control [whether a

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patient quits smoking], but we think those who influence it more should get paid more,” Dr. Graf says.

Despite the controversy, the model is making it easier than ever to recruit new physicians. “Five years ago I would start with 25 open positions and hire 6 people,” he says. “After we rolled out the medical home model at 10 sites, we filled every position and had multiple good candidates for every one.” Over the past year, Dr. Graf had only 16 open positions in June and had filled 4 of those by the time recruitment season started in September. He attributes his success to word’s getting out about the perks of working in a medical home. “Physicians may not agree with every single measure; but at the same time, they recognize the value of knowing exactly how all [their] patients are doing,” he says. “It really has liberated them to focus on complex medical decision making and patient relationships—and that’s the part they really like.”

### **Engaging Patients**

The traditional patient education model of handing a patient a brochure or directing him or her to a Website or community resource has no place in a patient-centered practice, experts say. Instead, physicians should construct a care plan that integrates best practices with the unique needs and circumstances of each patient. It’s important for physicians to be aware that transitioning to a patient-centered model can be difficult for patients, too, Dr. Boudreau notes. Most patients are used to following “doctor’s orders” without participating in a discussion. New tools help keep patients engaged by allowing them to access test results and make appointments via a patient portal, for example, or schedule virtual visits. Medical home practices are also being proactive in contacting patients to schedule follow-up tests or procedures or to manage their chronic diseases.

What that all means is that despite all the positive aspects of running a medical home, it can take time for both patients and physicians to adjust, Dr. Reid of Group Health says. “Patients are their own biggest care providers; and we need to assist them in delivering care, and that’s a challenge and a transition from traditional medical practice,” he says.