Becoming a Medical Home: Just Add Water

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Just kidding! It is not so easy to take a traditional family medicine practice and do a "PCMH make-over." In the broadening lexicon of health care reform, one word stands out: *transformation*. There is hardly a better example than the process of reinventing primary care on-the-fly. Transformation hurts, it changes everything, it is scary and it is the best thing to ever happen to family medicine since 1969 when our specialty was officially established. Let us take a deeper look at the notion of primary care transformation and explore both what we are up against and why it is so important for our quality of life.

Beyond Transformation

Consider briefly the breadth of the Patient Centered Medical Home (PCMH) practice changes: after-hours access, electronic health record (EHR) implementation, pre-visit planning, medical neighborhood development, tracking of orders and referrals, chronic disease registries, care coordination, group visits, standing orders, evidence based practice, quality improvement, performance reporting and data mining. With all this change codified in the Six Standards, 28 Elements and 100+ Factors of the National Committee of Quality Assurance (NCQA) PCMH Recognition program, there is something beyond practice transformation, something more powerful and important: a cultural metamorphosis best described as *personal transformation*.

The New Teammate

PCMH makes a big deal out of "hearing the patient voice," one that heretofore has been relatively muted and largely irrelevant in our physician-centric model of care delivery (to wit: we call them "waiting rooms" because we prioritize our schedules and our obsession with high-volume throughput over our patients' interests). At its core, practice transformation represents a quantum shift in the patient experience of health care. It brings to life the notion of patient centering: meeting our patients as persons first. An example of patient-centric care, open access scheduling — beginning with a virtually empty schedule every day — may be terrifying for practicing physicians but absolutely delightful to the patient.[1] Proactive approaches to patient activation such as patient self-management puts them front and center and empowers them as key members of the care team. Shared decision-making is a systematic and collaborative approach to important clinical decisions and balances the science of evidence based practice with the realities of patients' values and life circumstances.[2] Finally, the experience of care delivered by a prepared team (with huddles at the beginning of the day to ensure all are on the same care plan page and clear on the care gaps) conveys a respect for patients' time while ensuring that all the care that is needed is provided (e.g., as a patient is brought back for complaints of sinusitis, their flu vaccine is updated and overdue cholesterol labs ordered). Clearly, transformation begins with transforming our patients' experience of care.

The Voice of the Office Staff

Now there is a concept! There is power in empowering our team of nurses, medical assistants (MA), and other staff. Let us begin with the notion of "top of license" care.[3] Until recently, there was no question in my mind — or those of my non-licensed office staff — that an MA's job is limited to rooming

patients, making various phone calls and chasing after missing records. Advanced primary care challenges this norm and asks, "What roles should team members play to maximize effective and efficient teamwork?" This question is central to the reinvention of primary care. Patients and purchasers of health care are demanding evidence-based practice while providers protest, claiming there is just not enough time to provide all the preventive and chronic care indicated.[4,5]
There are solutions to this dilemma but they can only be found in the redesign of the care team called meta-teamwork, where you offload some of the significant, basic clinical work to other members of the care team though:

- Standing orders;
- Engaging MAs and front office staff in pre-visit planning;
- Empowering office staff in essential activities of population health (e.g., chronic disease registry management); and
- Training able staff in important and common counseling techniques (e.g., smoking cessation interventions) and techniques of patient self-management.

This is truly transformative work. It systematically relieves providers of tedious, though important, clinical work and meets growing market expectations for quality of care. Most importantly, it is empowering to critical members of our team while bringing new meaning to their work.[1,6] In my PCMH practice, I will never forget one care team member's personal transformation after her job changed from chart room supervisor, in the wake of our EHR implementation, to registry champion. Her sudden engagement and infectious enthusiasm seemed to happen all at once, during an all-staff meeting, when she saw the positive impact of her work on our population of 600 patients with diabetes. The hemoglobin A1c run chart said it all. She was an important member of the care team and her work was critical to both the patients' and the team's mission.

Achieving Professional Satisfaction

The fee-for-service business model is truly a toxic model for primary care. The demands of the market and the Centers for Medicare & Medicaid Services for the "triple aim" of improved care delivery and health outcomes, at a lower cost are a clarion call for transformation of both our systems of care delivery and their economic fuel (i.e., toward a value- and population-based payment system). Interestingly, I believe this transformation begins and ends with our personal transformation. First, desperation spurs many providers to look to PCMH. It is the promise of practice redesign to deliver on improved work-life balance and re-kindle the meaning and privilege of being a family physician that propels practices through the hard work of PCMH implementation. Finally, it is relief mixed with inspiration that the redesigned office practice, the medical home, really works. Office morale is boosted by meta-teamwork and its by-product, meaningful work. The patient-physician therapeutic bond strengthens as we better tune into the patient voice and practice-level empiric science — quality improvement and population management—provides powerful affirmation of family medicine's importance to the communities we serve.

The best part for me, however, is that advanced primary care makes room for my passion, where I make the most impact as a physician and develop nurturing, rich and effective relationships with patients and families while tackling diagnostic and therapeutic challenges.[1, 7]

The Soul of a Paradigm Shift

PCMH requires changing everything about the systems and structure of primary care delivery but ultimately it changes people – providers, MAs, patients – and the very definition of teams. Most importantly, these personal transformations are powerful and positive and lead to better outcomes, lower costs, better job satisfaction and improved patient experience. It was not until recently that I realized that this personal dimension of primary care reform is really its foundation.

References:

1. T Bodenheimer, "Lessons from the Trenches—A High Functioning Primary Care Clinic," N Engl J Med 365:1 (2011): 5-8.
2. Shared Decision Making National Resource Center, Mayo Clinic (shareddecisions.mayoclinic.org).
3. D Margolius, T Bodenheimer, "Transforming Primary Care: From Past Practice to the Practice of the Future," Health Affairs, 29:5 (2010): 779-784.
4. K Yarnell, K Pollak, T Ostbyte, K Krause, J Michener, "Primary Care: Is There Enough Time for Prevention?" American Journal of Public Health, 93 (2003): 435-441.
5. T Østbye, K Yarnall, K Krause, K Pollak, M Gradison, JL Michener, "Is there time for management of patients with chronic diseases in primary care?," Annals of Family Medicine. 2005:3(3):209-214.
6. T Bodenheimer, "Building Teams in Primary Care," California HealthCare Foundation, 2007.
7. R Reid, K Coleman, E Johnson, P Fishman, C Hsu, M Soman, C Trescott, M Erikson, E Larson, "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout for Providers," Health Affairs, 29:5 (2010): 835-843.