

# Transformation into a Patient Centered Medical Home: The view from the trenches



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**Manatee County Rural Health**  
**Services Inc.**



# Whole Child Pediatrics

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- Whole Child Pediatrics
- Opened November 2007
- Using the Principles of a PCMH from creation.
- 2 Pediatricians
- 2 Nurses
- 2.5 Clerical



[www.wholechildpediatrics.com](http://www.wholechildpediatrics.com)





# Whole Child Pediatrics

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- Number of active patients 3393
- Affiliated with a FQHC
- Payer Mix
  - Medicaid/CHIP 55%
  - Commercial 30%
  - Uninsured 15%



# What do we know about implementing a PCMH?

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- National Demonstration Project
  - Launched by AAFP June 2006
  - 36 small independent practices
  - Randomized into facilitated/non-facilitated
  - Transformed in 2 years to PCMHs
- *Transforming Physician Practices to PCMHs: Lessons from the National Demonstration project. Nutting et al, Health Affairs 30, No 3(2011)*



# Lessons learned from NDP

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1. Successful implementing components which did not interfere with current processes, practice staff roles
  - Same Day appointments, e-prescribing
2. Struggled with components that required fundamental changes in established routines.
  - Population management, team based care, integration with community services



## Lessons learned from NDP

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3. Transformation is more than a series of incremental changes
4. Two years is not enough to totally transform work processes
5. Internal practice relationship systems need to be addressed before transformation can occur.



# Transformation of Primary Care

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- Primary care needs a leap not a step, to bridge the chasm between what we have and what we need.
- There needs to be a total transformation of the way we deliver care.



# The medical home is a journey

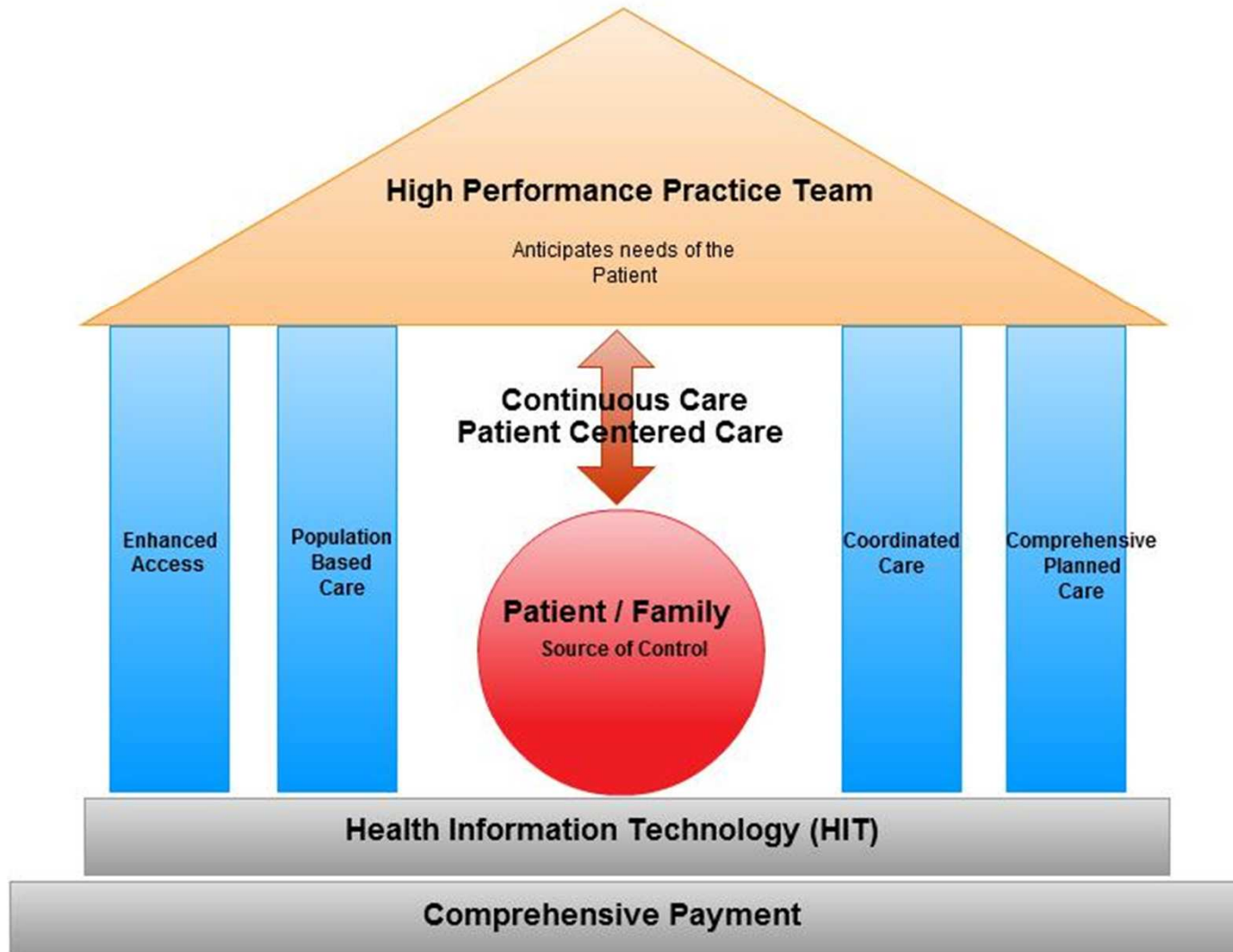
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- The medical home is like success. It is not an end result. It is an ongoing process. It's a journey...
- Success (like the medical home) is the act of trying to improve upon the things you're already doing.

# Home sweet Home...



- **Roof:** is the most important element of the home. Protects the building and its contents from the weather.
- **Weight bearing pillars and walls** support the roof. Joints are tight.
- **Foundation:** Is the structure that keeps the house from sinking





# The Paradigm Shift

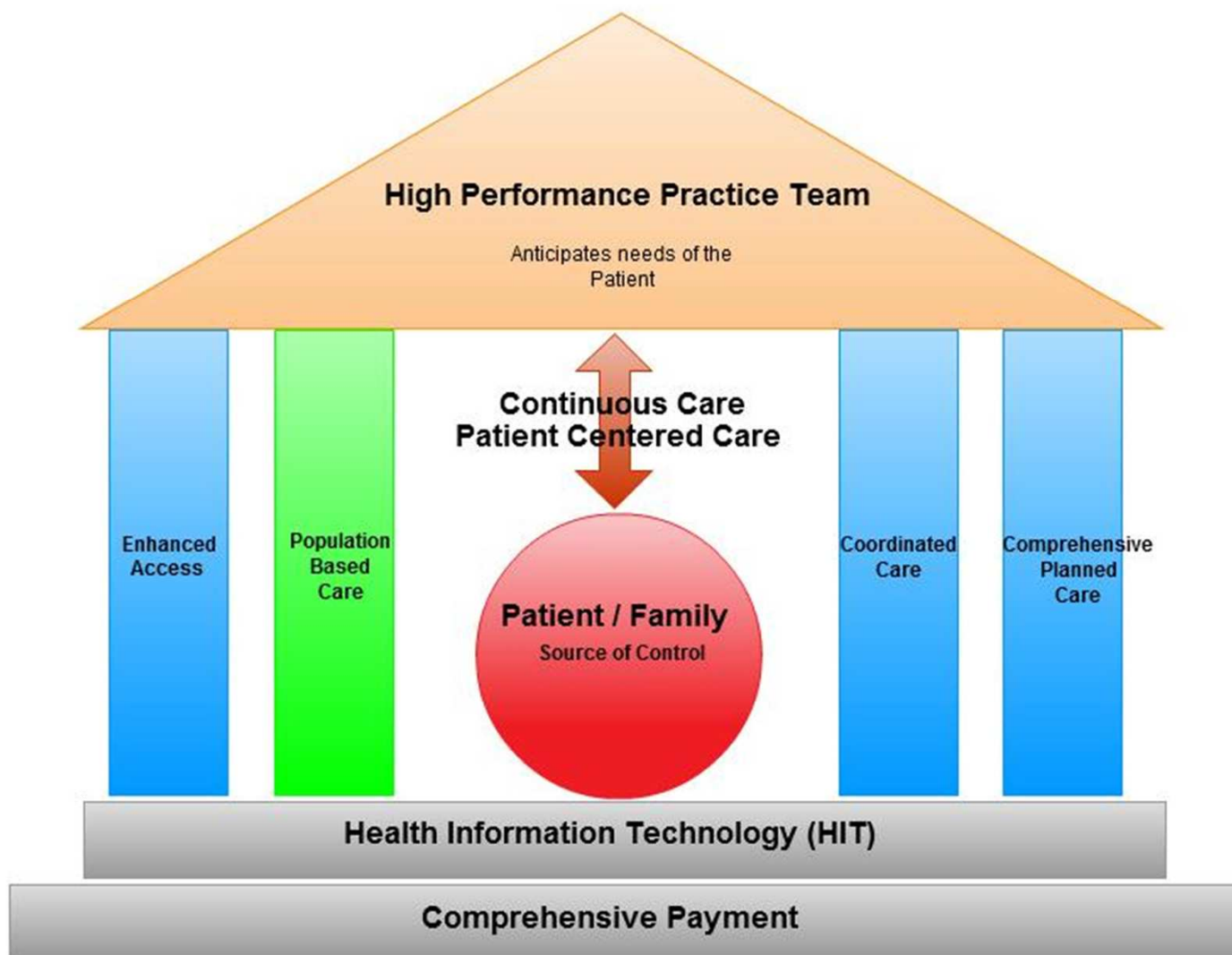
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1. From Individual to **Population**
2. From Physician to **Team-Based**
3. From Episodic to **Continuous** care
4. From Episodic payment to **Comprehensive payment**
5. From Clinician Centered to **Patient Centered.**



# 1. Individual to Population Care

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# From caring for the Individual to Population Based Care

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## ■ **The VISION**

- The goal for our practice team today is to keep the whole practice panel as healthy as possible.
- The team is not only focused on the patients that have an appointment that day but **all** patients assigned to the practice.
- The whole team, not only the physician, assumes responsibility for the health of the patients.



# From caring for the Individual to Population Based Care

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- **My JOURNEY**

- Access:

- The practice team knows how many patients require same day appointments every day.
- Schedules are modified to reflect this

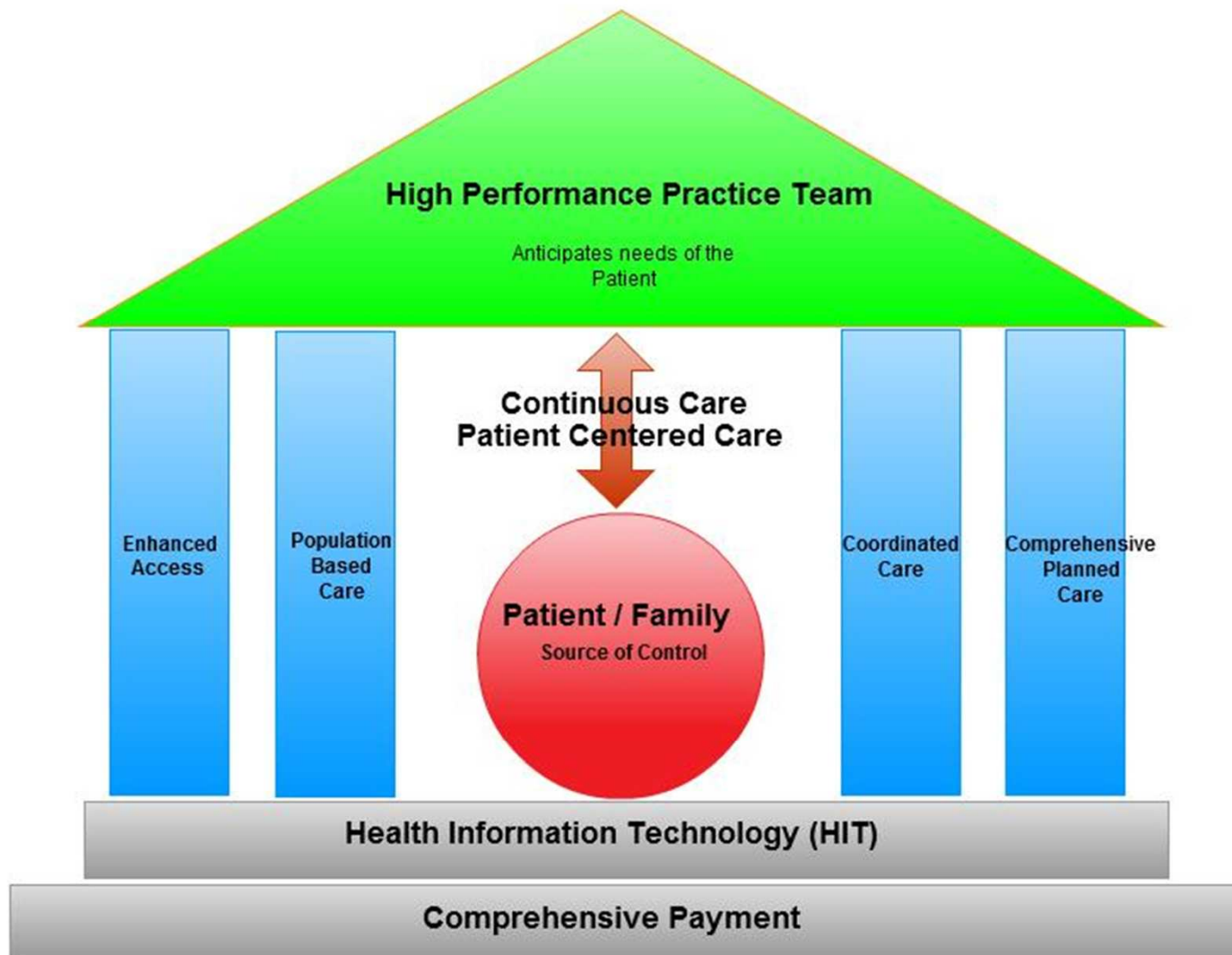
- Asthma Care

- 251 patients with asthma
- Practice team checks on them regularly. Sends reminders to bring them into the office for services.



## 2. Physician to Team-Based Care

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# Just like a superb jazz ensemble..



- Everyone gets their solo moment with creative accompaniment
- Well-executed passing off
- Attention to rhythm of action, contemplation and relationship.



# From Physician to Team-Based Care

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## ■ **The VISION**

- Physicians focus on patients that require a higher level of expertise or have complex conditions.
- Less Complicated patients can be handled by non-physician team members.
- Physician would act as a team leader and a clinical teacher.



# From Physician to Team-Based Care

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- **My JOURNEY**

- Daily Huddles
- Regular Practice meetings.
- Nurses do outreach, recall, follow up
- Have dedicated care coordinator for high-risk patients, patients with special needs and chronic conditions.

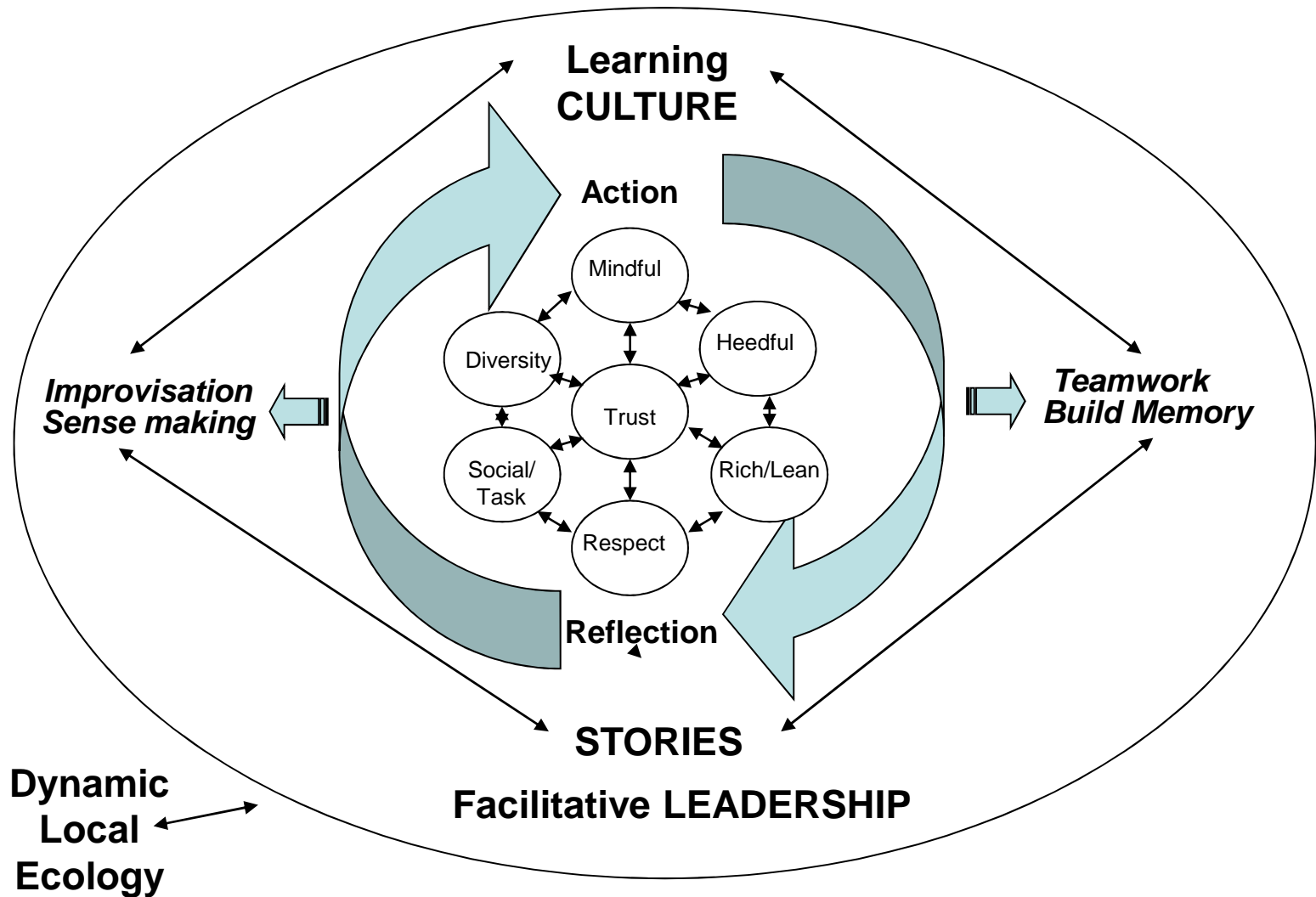


# Practices are Complex Adaptive Systems

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- Dynamic network of agents ( individuals, teams) with multiple feedback loops.
- Quality of the **relationships** of the agents is more important than the quality of the agents
- What works in one practice may not work in another.
- There are many ways to achieve the same outcome

# Relationship-Centered Capacity Model



*Safran, Miller et al J Gen Intern Med 2006:21:S9-15*



# Relationship Centered Functioning in Primary care

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1. **Mindfulness:** awareness of self and relationships with others.
2. **Diversity:** valuing multiple ways of thinking.
3. **Heedful:** individual awareness of how their work and that of others affects practice goals.
4. **Rich** face to face communication ( emotionally charged issues) **Lean** impersonal communication for clear simple messages (email)
5. Mix of **Social and Task** ( work related) interactions in the practice



# Relationship Centered Functioning in Primary Care

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6. **Mutual Respect:** between all members of the team valuing each other's contribution.
  7. **Trust** in other members of the practice being capable and committed.
- These 7 relationship qualities are interdependent and mutually reinforcing and create a **supportive and collaborative organizational culture.**



# Relationship Centered Functioning in Primary Care

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- Web of relationships forms basis for cycles of action and reflection.
- Practice needs dedicated time for reflection (share knowledge, fortify relationships and solve problems)



# From Physician to Team-Based Care

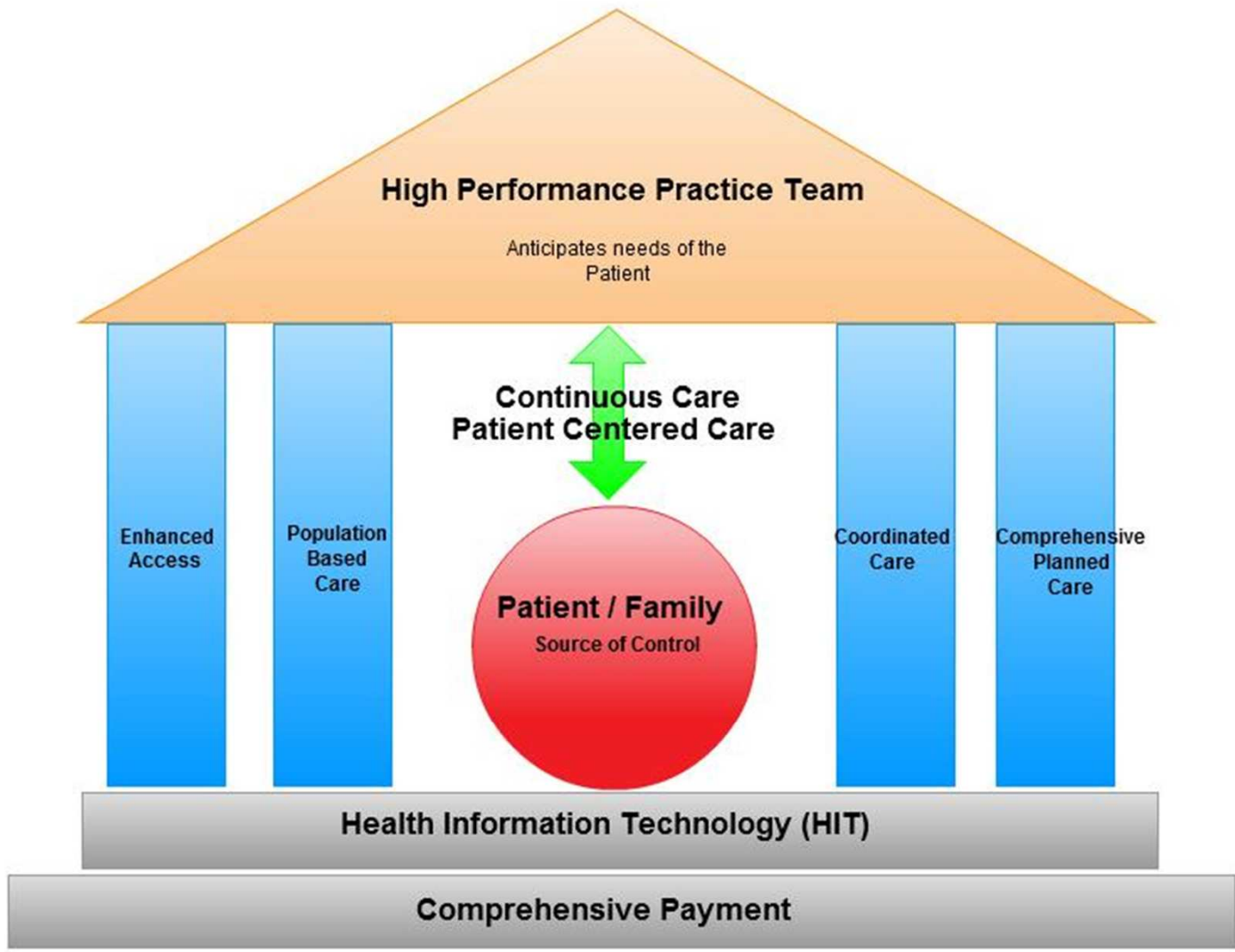
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- Primary care activities required of PCMHs have exceeded the capacity that a single discipline can handle.
- Behavioral approaches to healthcare, mental health, nutrition need to be integrated into the team.



## 3. Episodic to Continuous Care

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## Patients want a Continuous Relationship not just visits

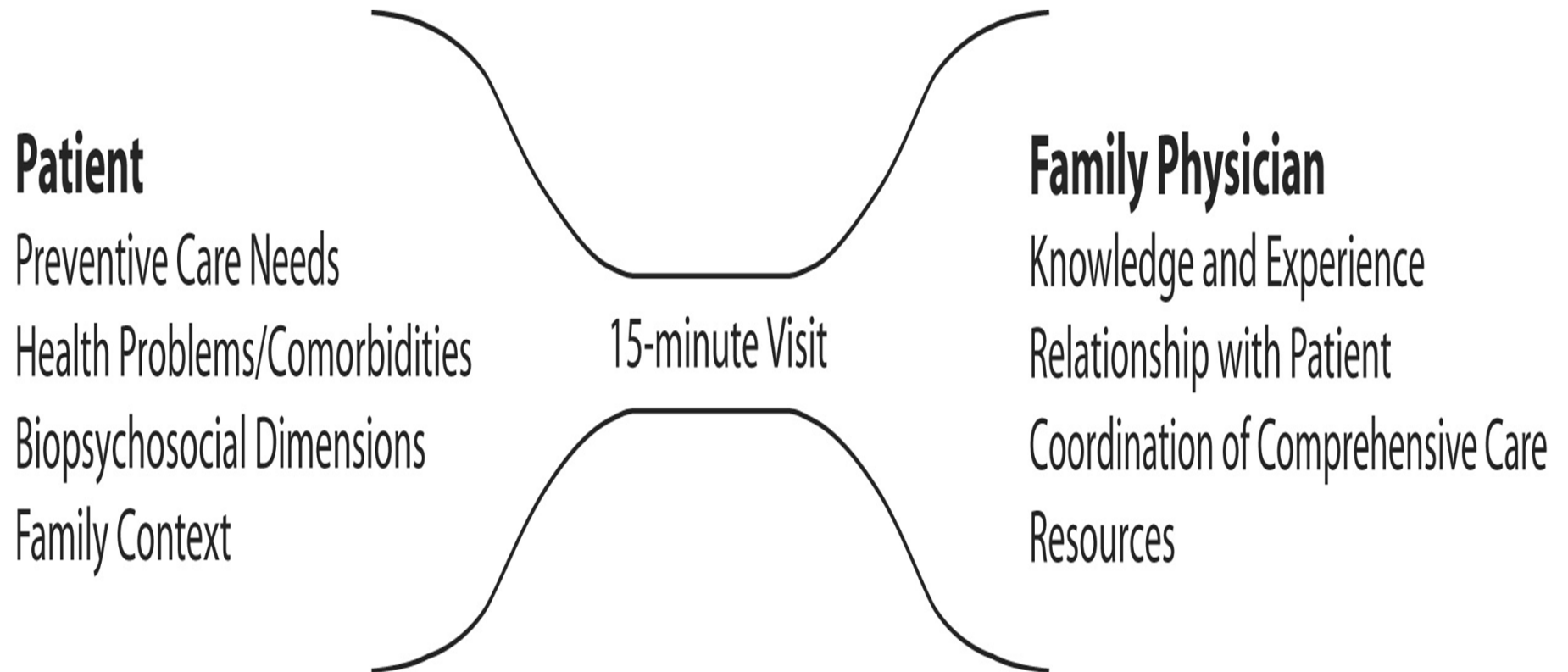


Figure 1. The Bottleneck of Brief Episodic Visits



# From Episodic Care to Continuous Care

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## ■ **The VISION**

- Each practice team improves the health of 100 patients per day.
  - There may be only 10 face-to-face visit for complex patients.
  - MD may manage problems of 20-30 patients through other channels of care:
    - Telemedicine, Email, Group visits, E visits



# From Episodic Care to Continuous Care

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- Other team members contribute to the care of 60-70 patients
  - Counseling on lifestyle modifications and medication adherence
  - Outreach for overdue preventative care or chronic disease
  - Following up on acute conditions



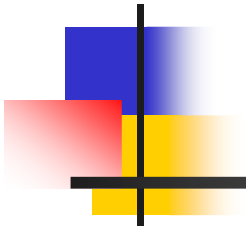
# From Episodic Care to Continuous Care

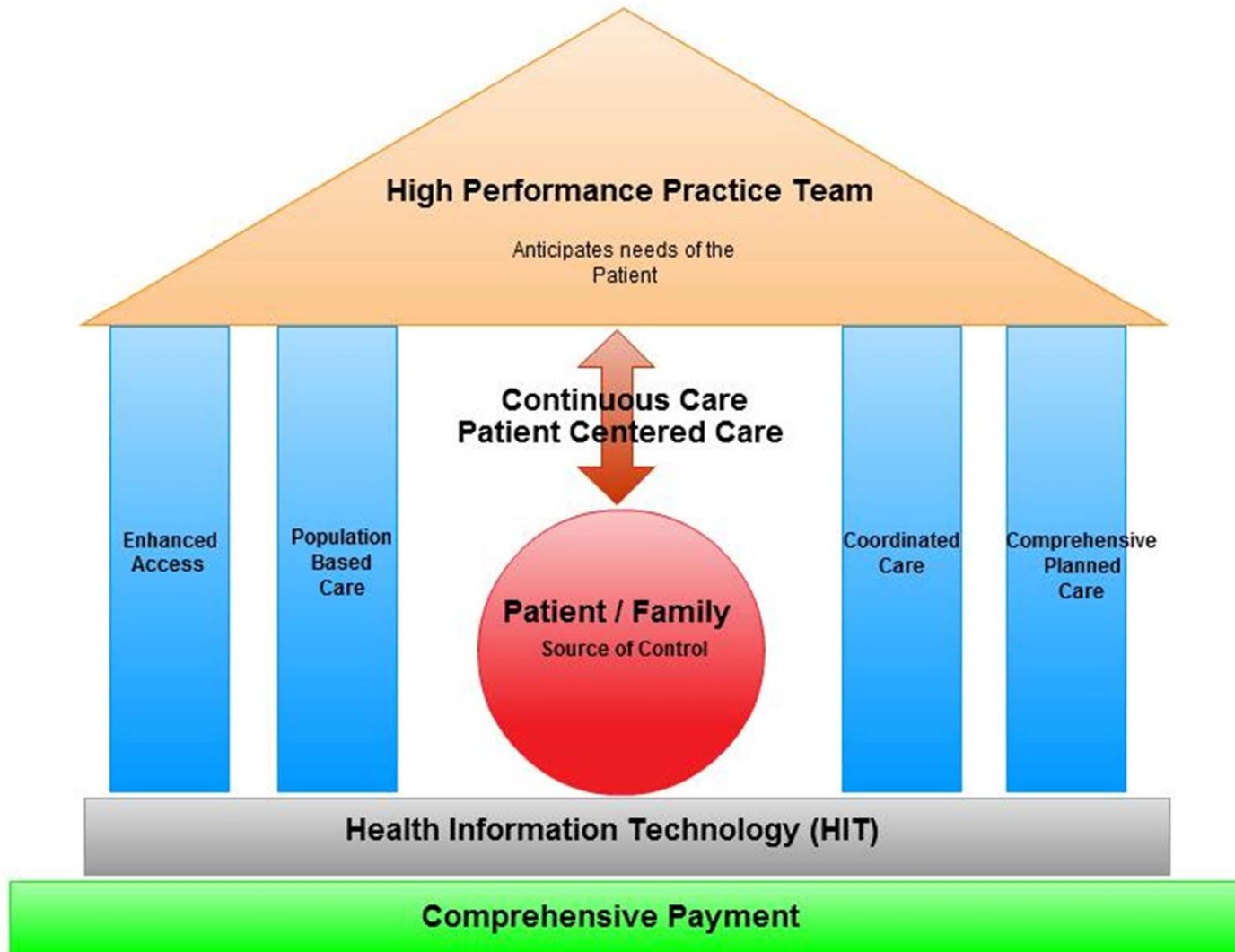
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- **My JOURNEY**

- Secure e-mail for patients
- Nurses do follow up and outreach calls on sick and special needs children.
- e-Newsletter

# 4. Episodic to Comprehensive Payment





Has the office ever felt like this?





# Current Payment System

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- Encourages quantity over quality
- Rewards procedures over evaluation and management E&M
- RBRVS 100% Medicare
  - 99214 \$100.20 25-40 minutes
  - 17110 \$102.51 5 minutes



# Current payment system does not support the medical home

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1. Payment is made only for services administered by clinicians
2. Only covers services performed in the office setting with the patient present.
  1. Negates care coordination, non-visit communication with patients.



# The Ideal Payment System

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1. Improve Quality of Care
2. Support practice transformation
  1. Population-based care
  2. Team-based care
  3. Continuous care
3. Incent Care Coordination
4. Practical to implement and Sustainable



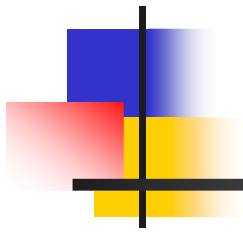
# From Episodic to Comprehensive Payment

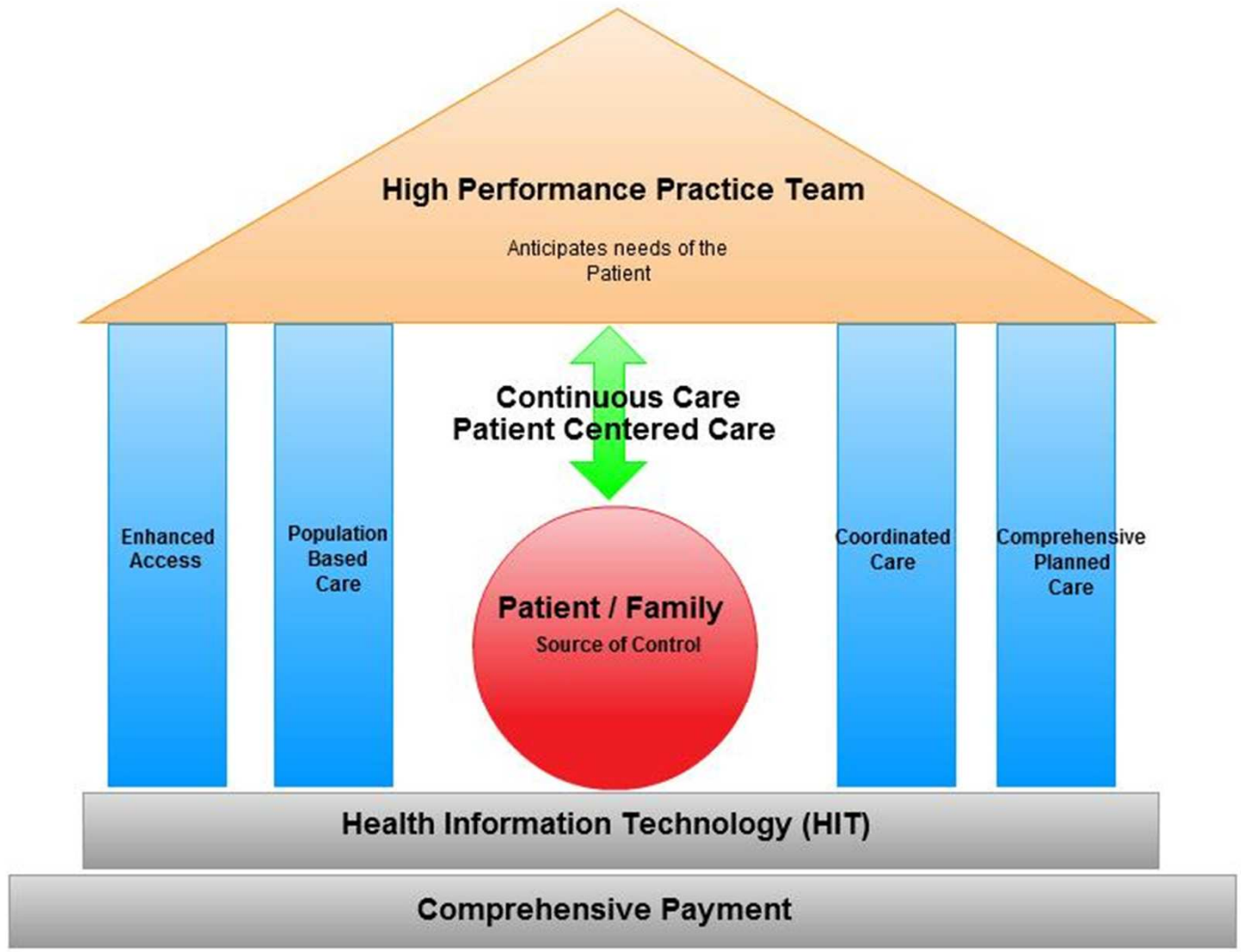
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## ■ **The VISION**

- Risk adjusted monthly payments for each patient.
- Performance-based added payment (P4P) for outcomes, quality measures
- P4P payments are shared with all team members.

# 5. Clinician centered to Patient Centered







# Clinician centered to Patient Centered

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- **The VISION**

- Patients/Families are active participants in their care.
- Patients receive services designed to focus on their individual needs and preferences.



# Physician centered to Patient Centered

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- **The JOURNEY**

- **Respect:**

- Patient/Family's informed choice is treated as equal to M.D.

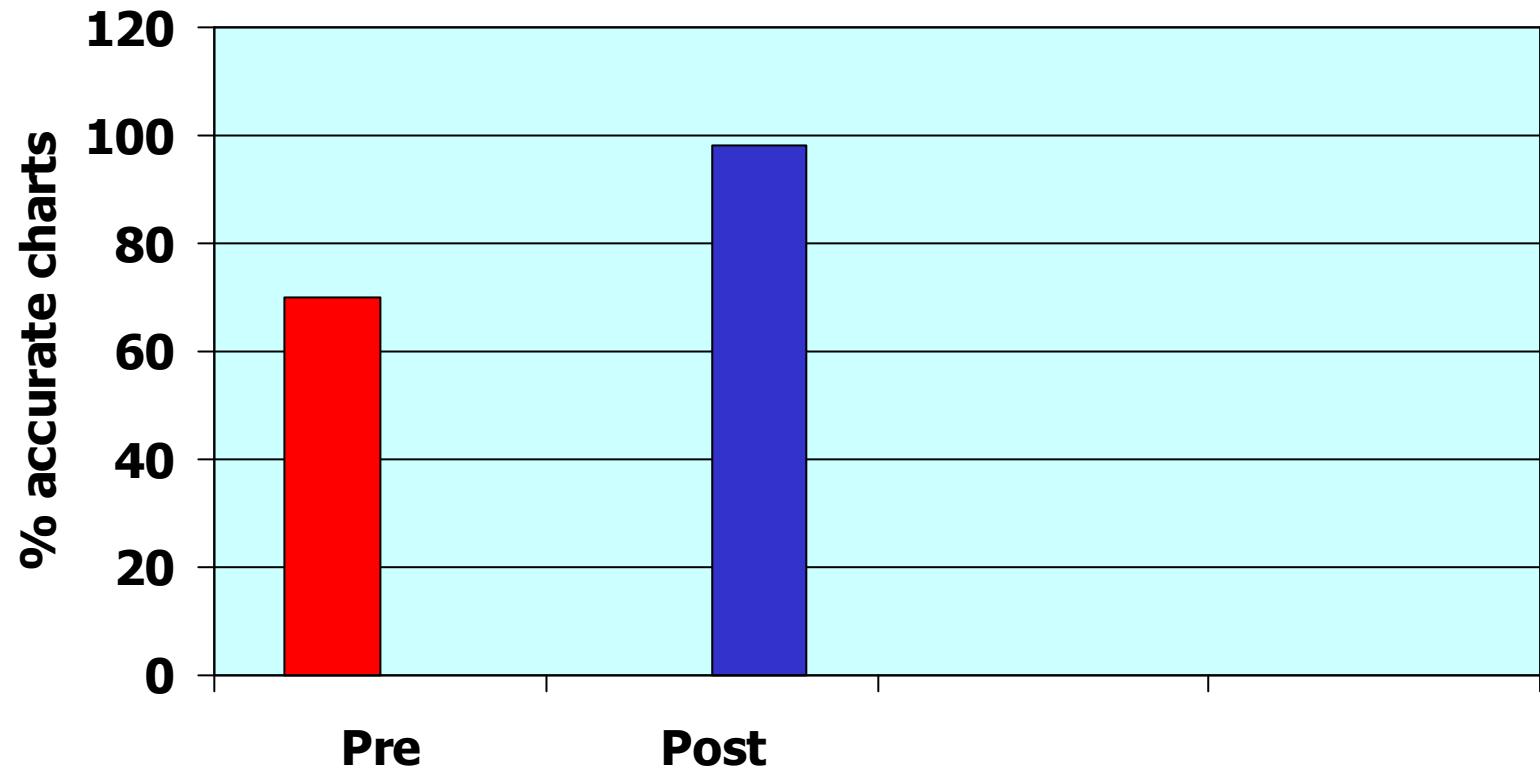
- **Information Sharing**

- All patients review their Medical Record after each visit for corrections.



# Medical Record Reconciliation

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# Physician Centered to Patient Centered

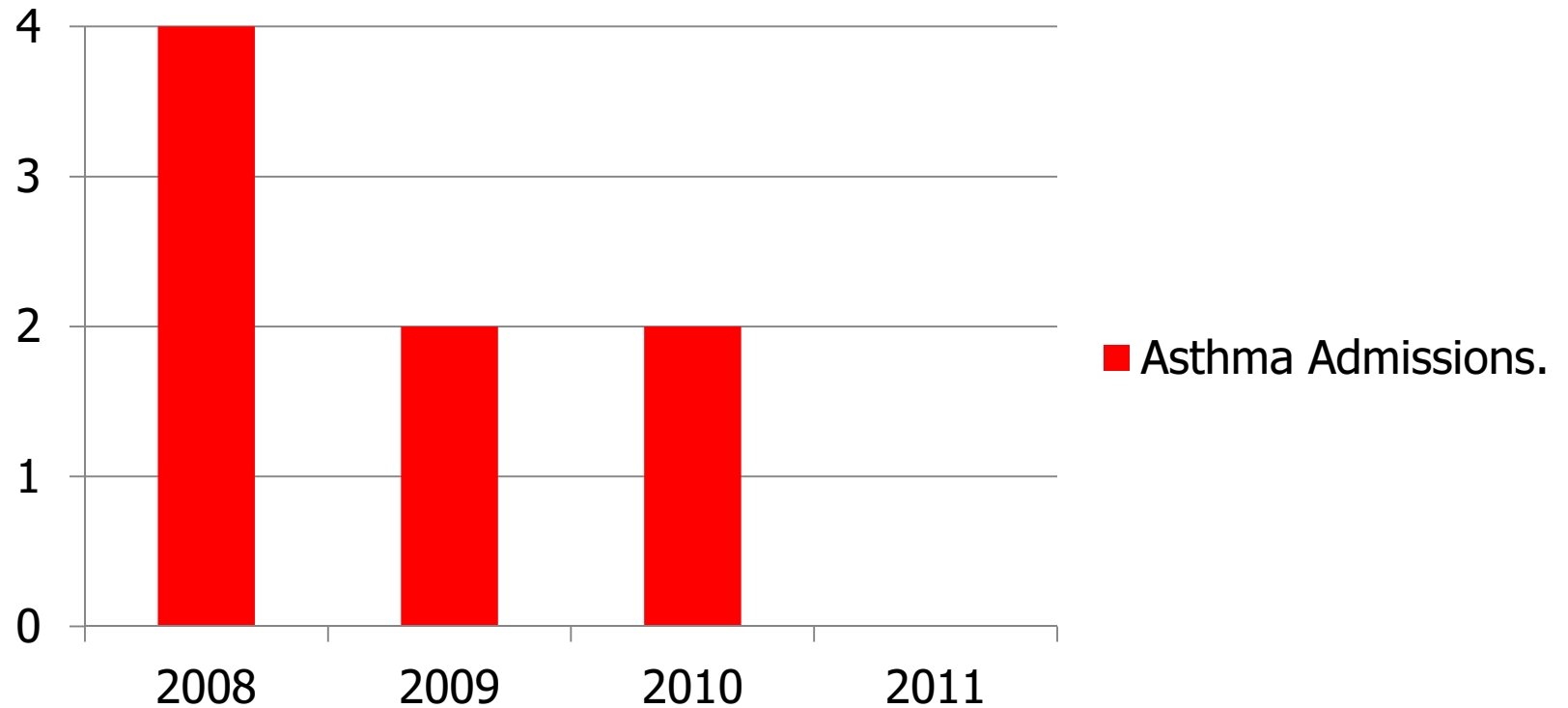
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- Participation:
  - Asthma Individualized Health Plan created in collaboration with the family.
  - It allows the family to adjust the treatment regimen and the act in case of an emergency.



# Asthma Hospitalizations

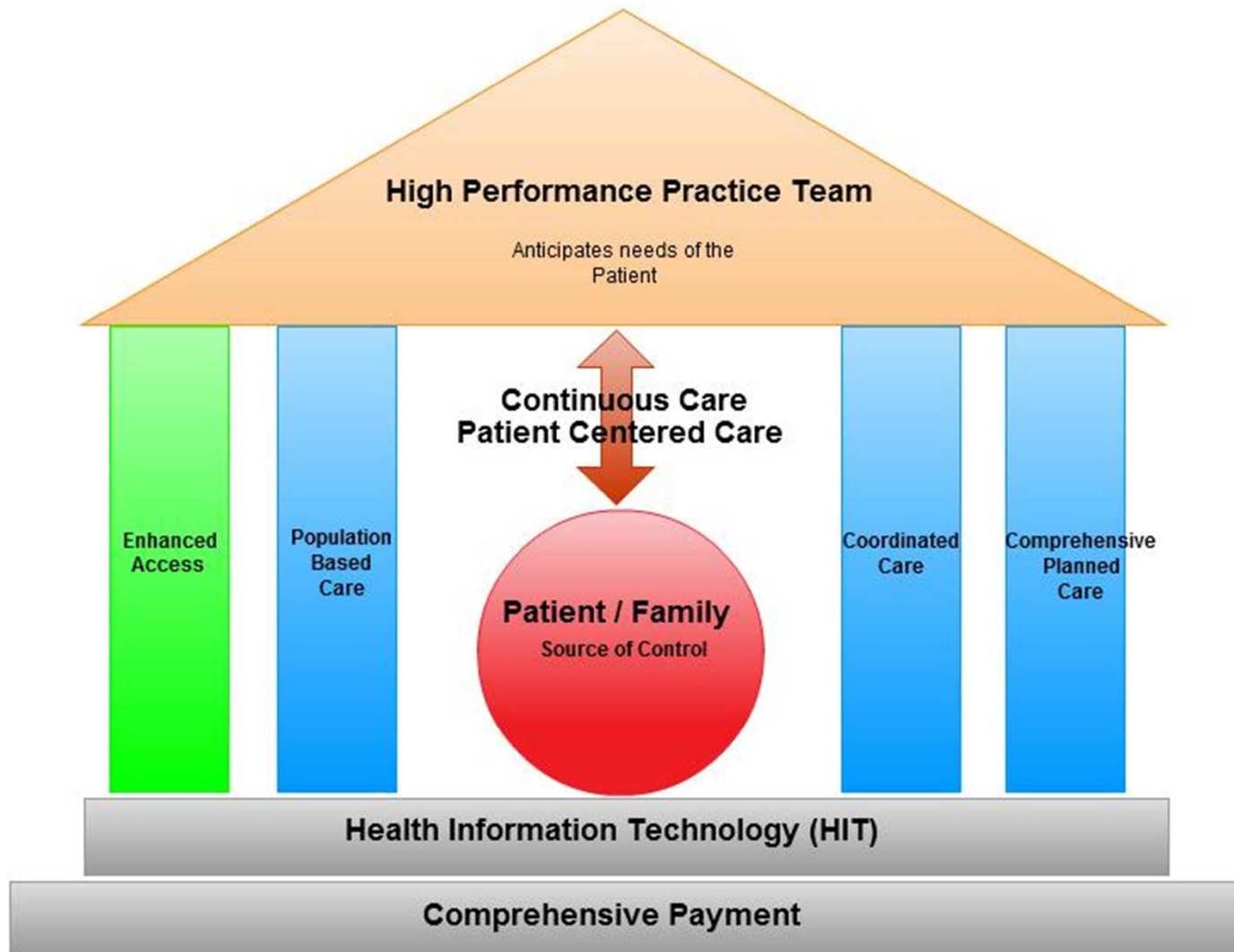
**Asthma Admissions.**





# Enhanced Access

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# Access in other Industries

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- Toyota: matches supply and demand within seconds
- Panera Bread: Matches supply and demand within 6 minutes
- Fast Food: McDonalds
  - Every 6 seconds of wait represents 1% of market share



# What is Enhanced/Advanced Access

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- Not Open Season on Physicians!
- A set of principles and processes to eliminate delays from the primary care office.
  1. Reduce delay getting an appointment
  2. Reduce delays at the appointment



# Is reducing delay important?

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- Access is #1 in Customer satisfaction
- Decreased waits improve staff satisfaction
- Reducing appointment delays improves clinical outcomes ( *Pediatrics 116,1 7/05* )
- Delays Cost a lot of Money
  - Large waits = large No shows
  - Nurses time( triage), Receptionist (time)
  - It takes 30s to say Yes, 9 minutes to say NO
  - Gives the impression of lack of resources



# Enhanced Access

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## ■ **THE VISION**

- The family gets the service they need when they need it.
- Patients and families are able to access the office all the time including after hours, weekends.
- The family has minimal waiting to get an appointment, and at the appointment.



# Enhanced Access

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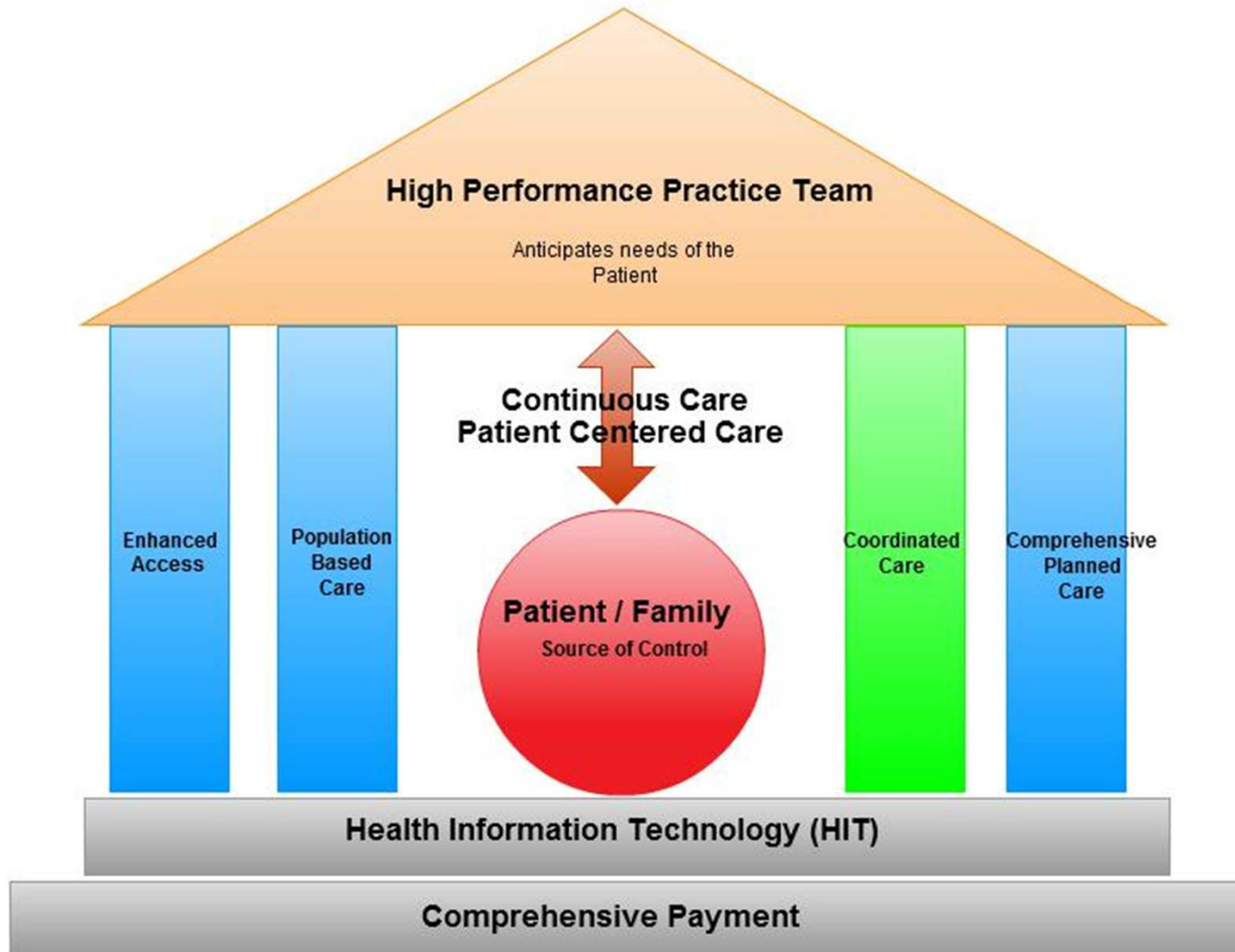
- **My Journey**

- Every patient can be seen in the office, the same day they call.
- Average waiting in the office 14.8 minutes
- 0 days to the next Well Child check
- Virtual visits (secure email)



# Coordinated Care

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# Coordinated care

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## ■ **The Vision**

- The practice exchanges and shares information seamlessly with specialists, hospital, emergency room.
- The practice tracks referrals, labs and other tests
- The practice team is an active partner in co managing the care of special needs children with specialists



# Coordinated care.

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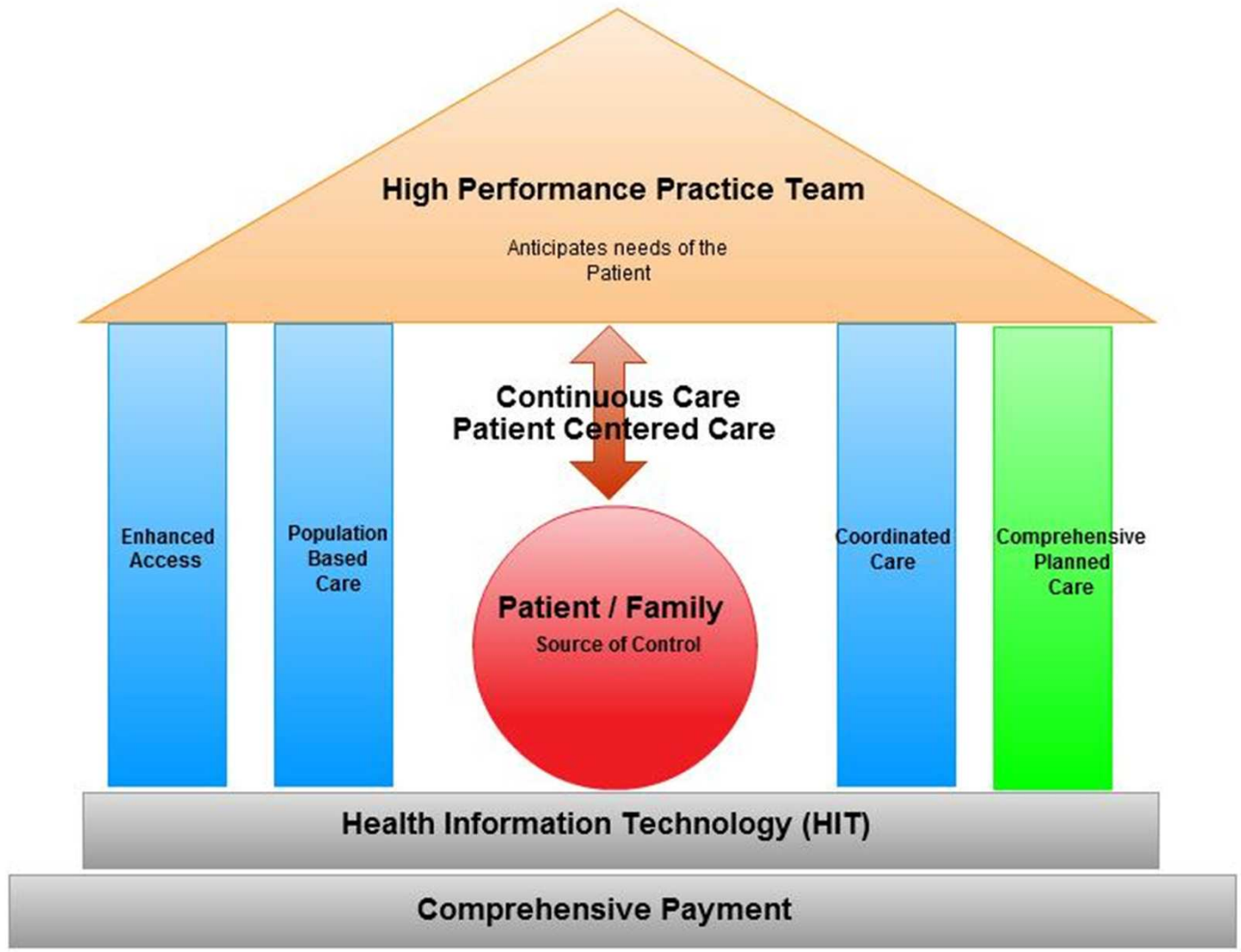
- **My Journey**

- Electronic tracking of all referrals, labs, imaging



# Comprehensive Planned Care

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# Comprehensive Planned Care

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## ■ **The Vision**

- The practice provides “one-stop shopping” for behavioral, urgent, preventative and chronic care. The team is able to manage the majority of patients with special needs.
- The team plans the visit ahead with the family, and develops treatment goals and a plan of care



# Comprehensive Planned Care

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- **My Journey**
- Ancillary Services: On site lab
- Acute Conditions
- Chronic Illness Management
  - Chronic Care Model
  - Asthma Registry
- Wellness Prevention



# Comprehensive Planned Care

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- Daily huddles to prepare for appointments.
- Reminders for care that is needed.
- Different appointment times for children with special needs.



## Primary Care:

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- Choose a job that you love and you will never have to work a day in your life...
- Confucius



# Payment Reform

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- No Margin, No Mission
  - Sister Irene Kraus

# Thank You! Questions?

