Ten Steps to a Patient-Centered Medical Home

Anton J. Kuzel, MD, MHPE

Presentation, Institute for Professionalism Inquiry

October 13, 2010, Summa Health System
Lots of attention to PCMH!

- National Business Coalition on Health
- Patient Centered Primary Care Collaborative
- President Obama
- Congress
- AAFP - TransforMed
- National Committee for Quality Assurance
The current reality

• Overworked, underpaid PCPs
• About 1% of practices are at level 3 PCMH status (2009)
• No idea of how to get to an idealized model without special financing
Hamster wheel medicine
The coming Tsunami

- OMG – 32,000,000 more people with insurance!
- Declining PC workforce!
- Massachusetts on a national scale!
Response options?

Monty Python might recommend:

Run away!    Run away!
There is hope, and a way forward

• We need to get off the hamster wheels
• A significant minority of practices are doing remarkably well
  – Physician, staff, patient satisfaction
  – Ambulatory quality measures
  – Physician income
• We need to learn from these practices!
Step 1: Documentation and coding

- Stop leaving money on the table
- 28% of FM established patient codes are level 4
- 60+% of FM established patient codes could/should be level 4
- Using Medicare payment rates, this would generate about $50,000 per year per physician in extra income (more if average payment exceeds Medicare rates)
- Little/no extra work/time from physician
- Why not? Don’t know how, or afraid of audit
- Coding from the bottom up; memorize 99214
- This is low hanging fruit!
Step 2: Add staff, with a purpose

- Physicians are the ones generating income
- Physicians should not be doing things that don’t require their expertise
- Nurses, other staff should take non-physician work AWAY from the physicians
- All people working to the top of their license
- Systematic attention to prevention, CDM (Sinsky article, FPM)
- Adds capacity, increases quality, creates opportunity for increased income
Step 3: Rapid access scheduling

- Requires information system to know panel sizes
- Balance supply and demand
- Choose easier ways of working down the backlog
- Improves continuity, which supports coding to higher levels of care
- Do today’s work today
- Patients love it
Step 4: Increase patients seen per day

- Typical FP sees 20-25 per day
- Adding 5 per day: $85,000 per year
- Adding 10 per day: $170,000 per year
- We need more PC capacity!
- Can be done without adding work hours!
- (Assumes we continue with a fee for service financing model)
- (Could be a good bridge model until we have more PCPs and a more rational financial model for health care)
But if this takes the wind out of your sails...

- It’s OK – Just doing the first three steps will lead to better care and happier patients, staff, and docs
- Put it off until you feel ready to reopen your practice
Step 5: Extend hours

- Only reasonable if part of a group practice, though could imagine doing this among multiple solo practices for evening, weekend urgent care
- Patients love it
- DOES reduce overall costs of care (less ED care, “doc in a box” care – no continuity, more tests)
- Should not result in physicians working more hours per week, just different hours than is now typical
- You MIGHT be able to get creative bonus financing – talk to payers, or better yet, employers
Step 6: Buy and implement EMR

- Wait until you have established a highly functional, paper-based team
- Can be expensive, will almost certainly create a temporary drag on productivity
- Creates opportunities for important next steps
- Necessary for many “bonus” payment programs
Step 7: Start doing population QI work

• Up to now, doing it right, one patient at a time
• Depending on how well that is going, registry may be more of a way to catch “errors” – i.e., patients who haven’t been in for their annual visit for prevention, CDM
• Can lead to enhanced reimbursement
Step 8: Patient portal

- Integrated with EMR
- Allows for secure, two-way communication
- Can allow for patient entry of history, scheduling of appointments, obtaining lab results, even e-visits (if compensated for same)
Step 9: E-link with other providers

- Can happen if in same network and with same platform
- May involve Health Information Exchanges (HIEs)
- Reduces your work (tests, consults automatically populate EMR)
- Improves care coordination
- Reduces cost (unnecessary testing)
- Improves patient safety
- Requires outside financing and support
Step 10: Help costliest patients

- Kaiser data: 1% of patients account for 36% of costs
- Kaiser data: 10% of patients account for two-thirds of costs
- May require more staff than your office has, and regional collaboration
- Community Care of North Carolina is proven model – saving NC hundreds of millions of dollars annually
- Johns Hopkins, Geisinger – large ROI for care managers
- **Alternative option:** focus on patients least confident in ability to manage their health ([HowsYourHealth.org](http://HowsYourHealth.org))
- A MUST DO for controlling inflation of health care costs
Key enablers

• Overcoming obstacles to documentation, coding

• Office culture: getting relationships right

• Getting political support to reduce risk of pushback from payers (PC spend could go from 5% to 6-7%; this might be less of a worry, given recent healthcare reform legislation)

• Creating and sustaining “communities of practice” – helping one another solve shared problems
But...

This ten-step model is a strategy, and we all know that

Culture trumps strategy

every time!
My response:

• What I am proposing is cognitive-behavioral therapy for family physicians who feel overworked and underpaid
• I have seen healthy cultures re-emerge when practices undergo these changes – taking care of business, staffing appropriately and with a purpose, and creating improved access for their patients
• Maybe, strategy can reinvigorate culture
• Besides, in this case,
• HEARTS ARE TRUMP!
More nay-saying

• This feels like PCMH for Dummies! It can’t be this simple!
• My response: Take it one day at a time, one step at a time
• I have seen examples of this with my own eyes (our Fairfax residency has finished the first eight steps – recently quoted in AP)
• I am seeking grant funding to demonstrate that this can work in a large multisite medical group in Virginia
Resources

- Sinsky C. Working Smarter, Not Harder. FPM Nov 2006
- Anderson P. Team Care. FPM July 2008
- Weida T. Coding from the Bottom Up. FPM Nov 2008
- Kuzel A. Ten steps to a PCMH. FPM Nov 2009
- Kuzel A, Engel J. Restoring Primary Care. Radcliffe 2011
- AAFP website – practice redesign resources
- Key meetings – state/local chapters, FMEC, IHI (outpatient)
- Well run offices in your general area – take the office manager and lead physician out to dinner and learn what they are doing that is working
Go out there and have some purposeful fun!

I know you can do it!
Slideshow redesigned by Kathryn Kuzel, senior in Advertising Design at Syracuse University