What does implementation of the PCMH model look like in a real-world practice?
Who Are We?
Myrtue Medical Center – Harlan, IA

- Critical access hospital/rural health clinic system, integrated since 1991
- Medical staff – 7 Family Physicians, 1 Med/Peds, 1 general surgeon, 3 PAs, 2ARNPs
- Nursing staff – 35, Office staff - 22
- Main clinic in Harlan, community of 5200 in rural Iowa, and 3 satellite clinics in Avoca, Shelby and Elk Horn
- Full scope of practice – Inpatient, ER, NH, OB, procedures, clinic coverage
Myrtue Medical Center
In 2006, we were struggling with a whole host of system and practice-wide problems, but still we wondered...... do we really have to change?

- “You don’t have to change, survival is optional”, C. Edwards Deming
Enter the TransforMed Project

• AAFP-funded National Demonstration Project - $8 million initial investment, millions more since then
  • Applied January 2006
  • Selected (1 of 36) April 2006
• 24 month project began June 2006 and ended May 31, 2008
• Evaluation period will end December 2008
What we agreed to:

- **Implementation** - all aspects of the New Model (PCMH) during the 24 months
- **Evaluation** – staff/patient satisfaction surveys, clinical/chart reviews, financial reviews, etc.
- **Dissemination** – lessons learned during the NDP will be shared in many venues
- **Staff commitment** – lead physician and staff member for learning collaboratives in KC, monthly phone calls, ongoing e-mails, on-site visits with TransforMed staff
What we received in return:

- A worthy vision – gets to the heart of medicine, especially primary care
- Practice Enhancement Facilitator – 1 for each 6 practices
- Exposure to best practice ideas in all areas of practice redesign
- Ongoing consultant support
- Some specific IT product assistance
The Personal Medical Home
A continuous relationship that cares for the whole person

Access to Care and Information
- Same Day Appointments
- After-hours Care Coverage
- Online Patient Services
- E-Visits
- Lab Results Via Phone & Web
- Nurse-Line or "Ask A Doctor"
- Culturally Sensitive Approach to Care

Continuity of Care Services
- Community Connected
- Coordinated Ancillary Services
- Collaborative Referral Relationships
- Comprehensive Care
- Hospital and Urgent Care
- Maternity Care
- Hospice Care
- Mental Health Care
- Services for All Stages of Life

Quality and Safety
- Evidence-based Best Practices
- Patient Safety Focused
- Medication Management
- Patient Satisfaction Feedback
- Evidence-Based Outcomes Analysis
- Quality Improvement
- Risk Management
- Regulatory Compliance

Point of Care Services
- Acute/Chronic Care
- Disease Prevention and Management
- Wellness promotion
- Procedures

Information Systems
- Affordable Electronic Health Record
- e-Lab and e-Prescriptions
- Disease Management Software
- Evidence-based decision support
- Population-based management software
- Point-of-care reminders
- Web-based patient history / PHR
- Website / Patient portal
- Interoperable / Adheres to standards

Practice Management
- Disciplined Financial Management
- Change Management
- Optimized Office Design/Redesign
- Cost-Benefit Decision-Making
- Revenue Enhancement
- Optimized Coding & Billing
- Personnel
- Facilities Management

Team-Based Care
- Physician Leadership
- Inter-disciplinary Care Team
- Collaborative Staff Relationships
- "Just-Right" Staffing
- Effective Communication
- Front/Back Office Shared Vision
Transformation to a PCMH

- Where to start?
  - How do you eat an elephant…??
- Projects prioritized by:
  - Easy wins/low-hanging fruit – needed practice at team design and needed confidence-builders
  - Largest obstacles to improved care tackled earlier
  - What made sense in the big picture – some projects built on others
Our transformation process – where and how to start

- **Team building/Vision sharing** – soft, but critical
  - Main focus in the first 2-3 months
- **Honest Self-Assessment** – brutal reality check
  - First month
- **Goal development/Timeline setting**
  - Started thinking about and discussing right away, details gradually took shape over the first 3-4 months
Our transformation process - Overview of the projects

- Projects – the work starts in earnest
  - Staff empowerment/redesign
  - Advanced Access Scheduling
  - EHR Implementation – Oh, the pain………..
  - Clinic process review
  - Chronic Disease Management
  - Clinical decision support/Point of care reports
  - Wellness integration
Transformation to a PCMH Projects

- **Staff redesign/empowerment** –
  - Daily nursing huddles – easy/effective
  - Lead nurse selection and development
  - Clinic manager – critical missing element
  - Immunization nurse – improved efficiency
  - Health coaches/Chronic Disease Management nurses – manage registries, proactive care;
Transformation to a PCMH Projects

- **Open/Advanced Access Scheduling**
  - Accurately matching supply with demand
  - Started with a 2 week internal study of
    - Supply – hours available by provider by day
    - Demand – appointments requested by provider and as a whole
  - Gave us an accurate picture of problem times – supply/demand mismatches
  - Made changes in scheduling to help – opened more open slots on busiest days/times, added evening hours
  - Continual reassessment and revision process
  - This can now drive good decisions on need for more staff as well as how to handle holidays, vacations, crunch times better
Transformation to a PCMH Projects

- **EHR implementation/use** – go live was 2/07
  - HUGE change for all, especially Med Staff
  - Planning, planning, more planning crucial – 2 yrs
  - Many benefits
    - Intraoffice e-messaging
    - E-prescribing
    - Real-time documentation with templates
    - Expanded access to information
  - Allows for a new level of population-based care, point of care improvements, etc
  - An extremely useful tool, but not an end
Transformation to a PCMH

Projects

- **Clinical process review** - started asking many hard questions
  - How does information flow around our office? How should it flow in an efficient, effective medical home? Who does what process, and should they?
  - rx refills, NH questions, phone messages, lab results
  - How can we as a Medical staff make group decisions to make our staff’s days (and patient’s care) better?
    - Standardized care - templates, flow sheets, standing orders
    - Moving towards true team care of patients – especially those with chronic diseases
  - **Not easy, but big returns in efficiency!**
Transformation to a PCMH Projects

- **Chronic Disease Management**
  - Diabetes, asthma, hypertension, CHF……who?
  - First had to develop **disease registries** – not easy
  - Foster a true **team approach** to care – OUR team of physician, nurse, scheduler, health coach (as opposed to calls from insurer’s nurse, CMS reviewer, etc.)
  - Allows flexibility – simple reminder calls to lengthy face-to-face interventions, either planned or opportunistic
  - **Health Coaches** to monitor populations of patients – get them in for needed care, provide proactive interventions, help give patients more empowerment and control
  - HUGE potential for improved care
Transformation to a PCMH
Projects

- Clinical decision support/ Point of care (POC) reports – 2008?
  - Offers enhanced disease registry functions not available in EHR
  - POC reports based on EHR data run through a protocol engine
    - Single page report
    - Makes visits much more productive
    - Easily identifies needed care
    - Can delegate which things nursing can do by standing order and which a physician/patient should discuss
  - When paired with CDM, much potential for large improvements in patient/population care quickly
  - However, another level of technology – cost/interface barriers
Transformation to a PCMH Projects

- **Office Redesign** – in process
  - Satellite clinic remodels
  - Plans for major clinic overhaul to optimize care under the PCMH model

- **Wellness integration** – in process
  - MMC funding/leading community Wellness Center project – open late 2009
  - Will offer many opportunities to encourage wellness and integrate into our practice
Continuing toward a PCMH
Future Projects

- Website enhancement/Patient portal
  - Scheduling and refill requests
  - Electronic bill pay
  - E-visits/e-mail communication
  - Secure lab results
  - Collect PMH on-line
- Referral tracking systems
- Enhanced communication with referring physicians and hospitals
- Kiosks in office – check-in, update demographics, enter symptoms, instant claims adjudication……
- The list keeps growing!
So………what have we learned? (at MMC and in the NDP)

- **Change is hard** and slow
  - Transformation on many levels
    - of practices – culture change
    - of physicians – personal change
    - of patient expectations
  - Practices not used to **system-level** changes
  - Personally, I think this will be a 3-5 year process, even with a motivated, unified practice with adequate resources
What have we learned?

- Relationships matter
  - Practice’s capacity for change and ability to follow through is heavily dependent on strong relationships within the practice
  - Need to build and foster strong relationships on all levels to be successful with changes
  - Especially important at times when practice under much stress – i.e. EHR implementation
What have we learned?

- Medical practices are extraordinarily complex
  - Small changes often have large impacts
  - Large, difficult changes may be necessary but have small impacts overall
- Change management is an essential skill that practices need to be successful
- Eidus’ theorem of change difficulty
What have we learned?

- **Leadership is Key**
  - Need strong leaders in all areas
    - Physician/mid-level
    - Clinic manager/nursing
    - Administration/financial
    - IT systems
  - If not all on the same page, ability to make changes hampered or halted
What have we learned?

- Transformation has to happen on the personal level also
  - Is a gradual change from physician-centered thinking and office practices to team-based, patient-centered approach to care
  - This is just as hard as (or harder than) the practice-level process changes
What have we learned?

- Technology has great potential, but several problems limit its current usefulness and widespread implementation.
  - lack of interoperability
  - expense
  - amount of resources and energy needed to make things work together
The old model of care just doesn’t make sense in the PCMH context

- Coordinated, not just episodic care
- Proactive, not just reactive care
- Emphasis on achieving and maintaining wellness, not just treating illness
- Team-based care - both within our office and between our office and specialists offices
- Comprehensive care including registries
- Service orientation
- IT support systems
- We need high tech and high touch