Practice Transformation using the Medical Home Approach:
Achieving improved quality, enhanced patient satisfaction and lower overall cost of care
Introduction

Practice Transformation is the term frequently used to describe the process for achieving the Triple Aim of medicine. This relatively new term, first defined by the Institute for Health Care Improvement, includes three goals: better care, higher patient satisfaction, and lower costs. Primary care providers and physician practices across a wide range of specialties are recognizing that to remain fiscally healthy they must seek to achieve practice transformation.

Of course, these demands are a continuous goal of the medical profession. But they are also challenges generated by a more consumer-driven health care market, the pressures of the Affordable Care Act and the requirements of payors, both public and commercial.

In this paper we review the essentials of practice transformation for primary care practices via the medical home model, including the necessary tools and the cultural changes on the part of every staff member.

What is Practice Transformation?

Practice Transformation is defined by the Centers for Medicare & Medicaid (CMS) as “a process that results in observable and measurable changes to practice behavior.” Such changes improve health outcomes, create a closer patient-provider relationship and help replace costly acute care episodes with preventive care management. They also result in new opportunities to participate in value-based reimbursement models.

What is a Medical Home?

A medical home is at heart a process rather than a place. It’s “a way of organizing primary care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.”

When a primary care practice adopts the medical home approach, the entire clinical team fully engages in treatment of each patient. Care is coordinated across appointments, home visits, and hospital stays. Technology makes possible the full use of evidence-based medicine and population health. Technology also permits the detailed reporting increasingly required by payors. And, at the same time, such technology and coordination enable a fiscal efficiency which permits additional practice improvements.

Practices using the medical home approach can achieve:

- **Quality improvement** through evidence-based medicine and clinical decision-support tools to guide shared decision-making with patients and families
- **Comprehensive care** treating the whole person
- A **patient-centered approach** focused on building an engaged relationship between patient and provider team
- **Coordinated care** across the entire healthcare continuum

### A Medical Home for the long term

Many primary care providers across the country have gained NCQA recognition as Patient-Centered Medical Homes. While it is certainly useful to achieve this recognition, it is only the beginning of real practice transformation, which is more of a journey than a single step. Real achievement of the Triple Aim, that is, improved care, greater patient satisfaction, and lower costs, calls for a long-term commitment by senior staff. It calls for culture change as well as investment in tools which over time will empower clinical transformation and the delivery of value-based healthcare.

### What makes a true Medical Home?

**Engaged Leadership**

Practice transformation calls for the full commitment of senior leadership. This requires engaged and motivated leadership focused on building a practice in which every member of the team is accountable for patient outcomes. In addition to shifting the cultural mindset, practice leadership must be willing to invest in data management and quality improvement tools, champion new workflows and processes based on LEAN operation principles, and provide ongoing staff training and development.
Strong Patient/Care Team Relationships

One of the most important components of an effective Medical Home is the bond built between the patient and the whole care team, not only the physician. In fact, it’s recognized that a well-trained support team delivers 95% of the patient’s care, and, with a focus on the whole person, is critical to successful outcomes. This shift from a task-oriented mentality to a patient-centered mindset creates a proactive focus on keeping patients well.

In a Medical Home, the Care Team includes the Patient

An effective Medical Home’s care team is patient-focused, with the team consisting of the patient as an active member, along with the lead physician and the support team. A growing body of evidence suggests that patients who are more actively involved in their health care often experience better health outcomes at lower costs.4 Provider care teams must understand a patient’s specific needs and preferences and include them in the decision-making process if they hope to actively engage a patient in managing health goals.

Improved Access

Provider care teams focused on keeping patients well find ways of making care more accessible for patients. This may include telephone consultations or secure messaging, extended office hours, access to clinical information and assistance with understanding insurance.

Quality Improvement Strategy

An effective improvement strategy that focuses on an organization’s service delivery approach or underlying systems of care is critical in achieving practice transformation. Patient-centered practices focus on improving four key areas related to quality: work systems and processes, patient needs and expectations, team

processes and use of patient data. To ensure that quality improvement is easier and more effective, practices should implement systems that provide automated patient, population and practice view dashboards, provider alerts and reminders, referral management and performance metrics and reporting.

**Patient Panel Management**

Patient panel management is based on access to a practice’s patient population data. Panel management allows providers to focus care by assessing patient needs and how best to meet them. This kind of efficiency not only raises the quality of care but also leads to lower costs. For example, by highlighting clinically high-risk patients, panel management allocates the most appropriate services, using the most expensive care only for the smaller percentage of patients most in need of such care.

Such fiscal efficiency also enables practices to expand the size of their patient panels, a value to growing practices and also a value to the nation-wide demand for increased numbers of primary care physicians.

Medical practices achieve effective patient panel management with available automated, best-of-breed technologies. These technologies employ workflows and other processes that directly reflect the needs of physician practices, rather than being adopted from other industries.

Finally, patient panel management ensures that patients are treated by the same provider and care team on a regular basis. This approach helps foster a stronger relationship between provider and patient and allows providers to better manage care, particularly among clinically high-risk patients. Research demonstrates that such consistency allows for both improved health and greater satisfaction, two of the three goals of the Triple Aim.

**Value-Based Metrics**

For physician practices seeking to put in place an effective medical home, technological tools and systems are essential. For example, a data-driven disease registry and user-friendly patient and population dashboards enable providers and their care teams to prepare a living care plan to meet each patient’s needs. They also alert providers to gaps in care, such as those indicated by Healthcare Effectiveness Data and Information Set (HEDIS) measurements.

Similarly, quality metrics and reporting and practice report cards are critical in allowing medical homes to benchmark their progress and meet public and commercial contract requirements, especially quality measures.
Centralized and Ambulatory-Centric Coordinated Care

Primary care physicians focused on the Triple Aim assume responsibility for the patient both within and outside the medical home and work closely with other providers, including specialists and hospitals, to provide care for the whole patient.

According to a Commonwealth Fund report, “effective care coordination involves helping patients find and access high-quality service providers, ensuring that appropriate information flows between the medical home and the outside providers, and tracking and supporting patients through the process.”5

Increasingly, physician practices are seeking outside services to provide effective care coordination, most often in the form of skilled nurses, working as part of the team, to maintain communication between patient and providers and ensuring attention to every part of care, from hospital admission and discharge to home visits and medication.

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Preparing for a Value-Based Future

A commitment to the Triple Aim for the long term, whether or not as a Medical Home, establishes a new ambulatory system of care designed to provide better care, greater patient satisfaction, and lower costs. Population health management, a whole-team approach to patient care, and a strong commitment by leadership are at the core of this new system of care. At the same time, technology is essential, and there are significant advances in technology available to achieve these goals.

Practices which undergo this transition improve the quality of care, enhance the patient experience and lower the overall cost, creating new opportunities to participate in value-based reimbursement models. These new revenue streams help further advance investments in clinical transformation, further supporting a new future in healthcare.

Continuum Health is a physician enablement company that optimizes value-based commerce through population health, practice transformation, applied analytics and network development services. The company offers proven, strategic business and clinical solutions empowering ambulatory and community-based enterprises and other providers to enhance patient access and experience, improve health and lower overall costs. Continuum serves 1,500+ primary care physicians, specialists and nurse practitioners caring for hundreds of thousands of patients across the country.