

New training in “Patient-Centered Medical Homes”

Resident Revolution: Family Medicine Bids to Reshape Health Care

By Tyler Smith

The Anschutz Medical Campus is at the heart of a movement that is quietly altering the health care landscape.

Amid loud debates and uncertainty about health care's economic future, the Department of Family Medicine at the University of Colorado School of Medicine is steadily laying the foundation for what could be a new paradigm for delivering care. And the department's faculty is working from the ground up, starting with new ways to educate its residents.

Elite status. Their residency program is one of just 14 in the nation in the P⁴ (Preparing the Personal Physician for Practice) program, a six-year demonstration project launched in 2007 by the American Board of Family Medicine and the Association of Family Medicine Residency Directors.

One key goal: to train and prepare residents to work in a “patient-centered medical home” (or PCMH). It's a concept that supporters say offers a solution to inefficiencies and perverse financial incentives that have helped to send health care costs in an unending upward spiral.

The medical home model itself challenges the present fragmented system of care, in which primary care physicians and specialists tend to operate in isolation, concerned only with the next office visit or procedure, and communicate only sporadically with others involved in care for a patient.

At a medical home, physicians and other providers place the tasks of patient care in broader contexts: managing chronic diseases, encouraging patients to manage their own health, helping them change unhealthy behaviors, and increasing physicians' involvement in their communities, where the roots of poor health often lie.

The approach also hopes to change fundamentally how physicians and other health care providers are reimbursed. Rather than being rewarded for performing more tests and procedures or seeing

more patients, providers in a PCMH would receive additional compensation for managing their patients' health better, and achieving improved outcomes.

It's a challenge not only to the foundation of the U.S. health care system, but also to the longstanding systems used to educate the physicians of tomorrow.



Burke heads the Family Medicine Residency Program.

Forging the future. “The question is, ‘Are the ways we have been training family physicians for 40 years the best way to do so for the 21st century?’” says Family Medicine Residency Program Director Dan Burke, MD. “Our hypothesis is no.”

The Family Medicine residents' curriculum focuses on the PCMH throughout their three years of training. The approach is both conceptual and practical.

In their first year, residents are introduced to the concepts and philosophy of the model. During years two and three, residents apply the concepts to the real world. They work in teams and with other disciplines to deliver care, develop quality-improvement projects and connect to patients in the community.

Burke and others in Colorado and around the country hope that residents trained in this new way will help transform the ideas of the PCMH into new delivery systems that serve the needs of individual communities.

At AF Williams. The effort has long been underway at University of Colorado Hospital's AF Williams Family Medicine Clinic, one of the department's major teaching clinics. Burke and his colleagues



Green sees PCMH model slowly gaining traction.

have set up interdisciplinary care team meetings to manage complicated patient care cases, for example.

“We hold weekly patient presentations and dissect issues with residents, faculty physicians, nurses, physician assistants, pharmacy, psychiatry, and case managers,” he explains. “The team comes up with a comprehensive care plan. We try to come at it from all angles.”

Yet Burke and other medical home proponents face a daunting task, says Family Medicine Professor Larry Green, MD, because there is little experience on which to draw.

“The challenge for the residency director is to teach residents to work in a delivery model that doesn’t yet exist,” Green asserts. “It’s a conundrum. The new system is immature and not well developed. We’re saying, ‘Let’s work in a PCMH,’ but we don’t have one. We have to train in a model we don’t yet have.”

To grapple with that issue, the state’s nine family medicine residencies in December 2008 launched the Colorado Family Medicine Residency PCMH Project, which has support from the Colorado Health Foundation. It’s part of the Patient-Centered Primary Care Collaborative – an initiative to help residency clinics meet criteria to become federally designated PCMHs.

The National Committee on Quality Assurance (NCQA) defines a PCMH as “a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.”

The NCQA’s key goal, according to one of its publications, is to “recognize practices that successfully use systematic processes and information technology to enhance the quality of patient care.” Ultimately, a clinic that qualifies as a NCQA-recognized PCMH could receive additional bonuses or payments from both private and public payers.

The effort of the state’s family medicine residencies to meet the NCQA standards, Burke says, “is a parallel project to P⁴. NCQA wants to see if we have systems for patient follow-up, like communicating lab results, ensuring that tests get done,

implementing information systems and having policies and procedures that make us accountable to our patients.”

Payment problems. The P⁴ project, in turn, made CU’s residency program a choice to coach other programs and clinics in PCMH concepts and how to implement them.

Family Medicine Professor Perry Dickinson, MD, serves as primary investigator for the project, learning the characteristics of each residency and passing that information along to “practice change coaches.”

Selecting AF Williams as a P⁴ project site “got the attention of the other eight family medicine residencies,” Green notes, and helped to drive the Colorado Health Foundation’s decision to support the collaborative. While the overarching objective is to create a PCMH, he adds, the job of the coaches is to help each practice create its own path to the goal.

“Redesign work is highly customized work,” he says. “It has to be done town by town, system by system and hospital by hospital. The coach’s job is to involve residents, faculty, nurses and others and step in and provide insight and energy to help get it done.”

Green and Burke both concede that even the most determined efforts to create internal operational efficiencies, build ongoing relationships with patients and forge strong links with specialists inside and outside the practice, however, won’t count for much without changing how payers reimburse for health care.

“A tipping point? As it stands, nobody is paid to engage people about ways to improve their health or to create the infrastructure needed to communicate with patients consistently, Burke notes. Trying to figure out how to redesign the systems for health care delivery and payment at the same time, Green adds, is “akin to flying by passenger jet with every seat filled while rebuilding the airplane. And of course everyone wants their drinks served promptly.”

Still, Burke believes the changes will come. “Much of the groundwork is getting done. We’re at a tipping point where small changes are adding up.”

It’s true that the idea of paying for health care on the basis of quality, efficiency and outcomes – however difficult those are to define – rather than on the *quantity* of care has federal support. In addition to NCQA’s championing of PCMHs, the Centers for Medicare and Medicaid Services continue to move toward a so-called value-based system that rewards providers who adhere to

best practices, minimize the number of hospital-acquired conditions and so on.

Moreover, the Patient Protection and Affordable Care Act – otherwise known as health insurance reform legislation – encourages the creation of accountable care organizations (ACOs), which dovetail neatly with the PCMH concept.

The idea is that providers and facilities in the ACO would assume responsibility the health care of an assigned population of patients for a per-capita rate that CMS sets. If it meets quality-of-care standards, such as minimizing 30-day hospital readmission rates, and holds its costs of care below CMS's rates, the ACO could share in the savings.

Slow turning. Many large businesses, Burke adds, are demanding more accountability from providers for the money they spend for health care. As evidence, he points to Paul Grundy, director of healthcare, technology and strategic initiatives for IBM. He's a leading proponent of the PCMH model and an important member of the Patient-Centered Primary Care Collaborative.

"He's a convener of issues in that regard," Burke says, "and he puts force behind the ideas. IBM is a worldwide purchaser of health care, and [Grundy] sees the company gets more bang for its buck [outside the U.S]."

Grundy co-authored an August 2009 report that detailed outcomes of PCMH "interventions" in 10 states, including Colorado. Each demonstrated improvements in coordination and quality of care, and access, along with cost savings and reductions in utilization.

In a relatively short time, Green adds, the number of states with PCMH pilot projects has grown from two to 44.

"Now it's a contagion, not a stand-off," he says. "And there are examples of progress. It began with fits and starts and considerable angst, but it's happening bit by bit, piece by piece."