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Disruptive Innovation and the Evolution of the Medical Home

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Health and Performance Improvement/Continuous Value Enhancement

BY LES C. MEYER, M.B.A.

As innovators, employers and healthcare leaders continuously seek to improve the efficiency, quality, affordability, integration and value of healthcare services, the team-based, family care model has rapidly evolved into medical group neighborhoods and community-based, organized systems of care, also known as the medical home.

The overarching vision of the medical home is the notion that keeping people healthy is a good business strategy for employers, employees, providers, government, and taxpayers alike. The goal is to refine prevention and treatment strategies as part of a long-term, comprehensive, patient-centered primary care connection. This arrangement fosters meaningful and productive interactions between clinicians and patients that forge a link to the medical group's care team and sustain positive behaviors, resulting in better overall family health.

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Paul Grundy, M.D., director, healthcare transformation at IBM and president of the Patient-Centered Primary Care Collaborative, encourages medical groups and organized systems of care to build smarter systems that provide team-based medicine and community health assurance options. He says, "What America needs is a patient-centered medical home model of care that redesigns the way primary care is delivered and financed." The medical home model will provide incentives for doctors to spend more time with their patients and offer better coordinated higher-quality medical care.

Kurt C. Stange, M.D., Ph.D., who edits *Annals of Family Medicine,* lauds President Obama's attempts to take a long-term perspective and futurist pathway as medical groups and community-based organized systems follow the road less traveled to achieve a high-performance U.S. health system in the 21st century. "True transformation takes time and resources," he says, "but if we want health care to really be different from the current dysfunction, transforming primary care and building the larger system on this foundation is what will be required."

Disruptive Innovations

"Disruptive innovation is a business framework which describes the process by which a product or service takes root initially in simple applications at the bottom of a market and then relentlessly moves 'up market,' eventually displacing established competitors," states Clayton M. Christensen, a professor at Harvard Business School. Medical group clinicians need to stay ahead of the

game by identifying and deploying as many disruptive innovations as possible—particularly those that will augment current neighborhood health assurance outcomes and position medical groups in the forefront of physician-led, organized systems of care.

One disruptive innovation relates to an expansion beyond traditional Western medical practices. Medical groups that are successful in delivering a patient-centered model will require a cultural shift. "The real disruptive innovation that we need is the integration of evidence-based, complementary, and alternative practices within conventional medical group practices," says Dr. Archelle Georgiou, a senior fellow with University of Minnesota's Center for Spirituality and Healing and former chief medical officer of UnitedHealthcare. "We must address the mental, emotional, and physical aspects of the healing process if we truly want to improve the breadth and depth of patient-centered care and promote the nation's health."

Another disruption centers on better coordination of care. "In order to get the outcomes and savings needed for the growing number of older adults with complex health conditions, we need care coordination that is intense, comprehensive, and linked closely to primary care," according to Chad Boult, M.D., M.P.H., M.B.A., a geriatrician professor at Johns Hopkins Bloomberg School of Public Health and author of *Guided Care: A New Nurse-Physician Partnership in Chronic Care*.

Dr. Boult and colleagues developed one form of the patient-centered medical home for older adults with multiple chronic conditions called "Guided Care." As part of this approach, a specialty trained registered nurse, based in the practice, works closely with two to five primary care physicians to provide coordinated, patient-centered, cost-effective care to 50 to 60 of their high-risk patients. In a federally-funded, multi-site, randomized trial in the Baltimore-Washington, D.C. area, Guided Care has shown impressive results that include higher quality of care, lower net healthcare costs, improved physician satisfaction, and reduced stress for family caregivers.

The medical group model continues to dramatically reinvent itself.

Perhaps the most promising critical disrupter is the Health and Performance Improvement/ Continuous Value Enhancement (HPI/CVE) approach, which seeks to improve the quality, safety, efficiency, and transparency of healthcare delivery by focusing on each individual's lifelong personal health accountability, the health and per capita cost of a defined population, and patient satisfaction initiatives through which consumers define their own needs and concerns. HPI/CVE advocates enhanced access to comprehensive, coordinated, evidence-based, interdisciplinary care delivered in the context of family and community and created to align consumer incentives, information, and choice. The HPI/CVE process is able to achieve significant and measureable results in communities because of several unique attributes (see Figure 1).

Peter C. Dandalides, M.D., an organized system of care consultant, considers the HPI/CVE balanced scorecard "the most critical piece" in a focused approach to HPI/CVE standards and measurement. Its domains include sustained engagement rates, refined clinical outcomes, customer service, and utilization or cost impact. The HPI/CVE balanced scorecard is built around eight components that include coalescing a group of covered lives, evaluating their baseline health status by all available means, devising health and performance improvement goals, establishing incentives for both patients and their physicians to meet or exceed these goals, using various methodologies to measure their progress, and ensuring that the value-based purchasing system is continually adjusted to reward health status improvement, personal and job-based achievements, and performance.

Team-Based Medicine Comes of Age

In response to the market's quest for a system that improves the quality, safety, efficiency, and transparency of healthcare delivery, the medical group model continues to dramatically reinvent itself. Innovative medical group administrators and clinicians have found a new niche by adding team-based, family care models to their community-based, medical group management systems of care. Medical group administrators are enhancing the expertise of clinicians and beginning to create team-based medicine approaches to patient-centered primary care through collaboration with healthcare systems. As such, the systematic, relationship-centered, team-oriented, family model of care has emerged as a leading positive disruptive innovation in neighborhood medical groups and organized systems of care.

Medical Home Gains Support

Four recent studies reported that Obama's healthcare reform agenda supports community-based, team-based medicine, and that the medical home model is gaining national support from providers, patients, purchasers, payers, and policymakers.

The first, an advanced primary care medical home study in Vermont, according to the U.S. Department of Health and Human Services, demonstrated improvements in care for patients, gave primary care providers better information about their patients, and achieved greater value for the health dollars spent.

The second, IBM's "Patient-Centered Medical Home: What, Why and How?" study, describes how medical homes can serve as

a foundation for transformation of the U.S. healthcare system—if appropriately conceived and properly implemented. The IBM study makes the realistic case for why and how stakeholders can participate in healthcare home initiatives, identifies critical issues, and makes recommendations for medical group management best practices to increase the likelihood of initial success and sustainability.

The third, the Institute for Clinical Systems Improvement's "Recommendations of Health Care System and Patient Outcomes to Consider in the Evaluation of Health Care Homes" study, provides a robust review of available scientific evidence (and standards of practice) with explicit recommendations to audiences who were most likely to be directly involved in implementing and evaluating medical homes.

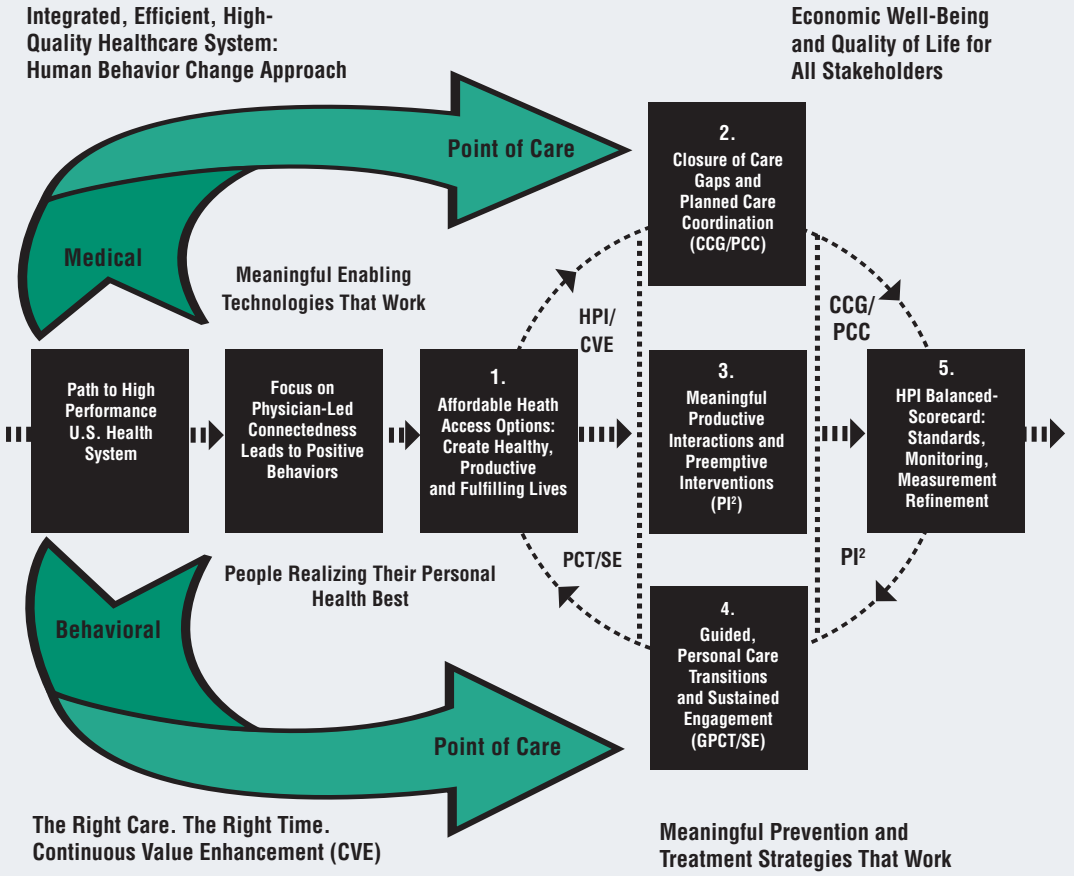
The fourth, the Patient-Centered Primary Care Collaborative's "The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies" White House August 2009 report, found that across diverse settings and patient populations, evaluation findings consistently indicated that investments to redesign the delivery of care around a primary care, patient-centered medical home yield an excellent return on investment: (1) Quality of care, patient experiences, care coordination, and access are demonstrably better and (2) investments to strengthen primary care result within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases, appear to produce a reduction in total costs per patient.

American Ingenuity at Work in Colorado

Despite a contentious debate about how to implement U.S. healthcare reform, pundits on both sides of the issue agree that the system is broken. Its evolution requires rethinking process

FIGURE 1

HPI/CVE Program Design and Implementation



improvements and integrating American ingenuity to improve the individual patient experience so that entire communities receive health care at an affordable cost. The challenge of the 21st century is how to give consumers the knowledge and power to work with their family physician and make informed decisions. Today, the masters of innovation—those who stand apart from traditional group practice—are HPI/CVE enterprises that have listened to the explicit needs of the patient and have responded by guiding patient-centered primary care clinicians to robust, team-based, family care models in neighborhoods to optimize care and achieve community health assurance systems of care.

Minnesota Commissioner of Health Sanne Magnan, M.D., says the healthcare evolution also requires understanding that "as health care costs go up, affordability goes down. As affordability goes down, access goes down. As access goes down, the number of insured goes down, as does quality. It's a vicious spiral that affects the very health of our population." Given the complexity of the political healthcare battle in Washington, many communities and individual health organizations have begun reform on their own.

The strong entrepreneurial and risk-oriented spirit that is at the very heart of Colorado is evident in the innovative approach to health care found in organizations throughout the state. Over the years, Colorado's health leaders and medical group pioneers have continuously faced a series of great opportunities brilliantly disguised as insolvable problems. For example, in 2008 Governor Bill Ritter established the Center for Improving Value in Health Care (CIVHC) as a core group of of consumers, business leaders, healthcare providers, insurance companies, and state agencies created to identify and pursue strategies to improve health care, contain costs, discuss quality improvement initiatives underway throughout the state, and identify opportunities for increased collaboration among these initiatives. Today, Colorado's healthcare leaders are utilizing the HPI/CVE approach to deliver improved individual health, community health assurance, and enhanced economic well-being and quality of life for all stakeholders.

Many communities and individual health organizations have begun reform on their own.

Denver Health's Dr. Patricia Gabow

Jim Molpus, who edits *Health Leaders Magazine*, says, "If you're looking for an example of a system that meets its mission as best it can, then hold up Denver Health and a very select few. Its crushing mission [as an integrated, efficient, high-quality, healthcare system that serves as a model for other safety net institutions across the nation] is made ever more urgent with so many people being thrown into the uninsured ranks."

In July 2007, The Commonwealth Fund, a private foundation that aims to promote a high-performing healthcare system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable members, suggested in its *Commission on a High Performance Health System* that Denver Health was a leadership "center of excellence," a "learning laboratory without walls." The commission, which includes nationally recognized physicians, business leaders, academicians, health plan executives, and healthcare policy leaders on its board, noted, "Denver Health has succeeded providing coordinated care to the community, promoting a culture of continuous quality improvement, adopting new technology and incorporating it into everyday practice, taking risks and making mid-course corrections, and providing leadership and support—and accepting accountability—both at the top and throughout the organization."

Denver Health CEO Patricia Gabow, M.D., knows exactly how to keep an organization financially viable. In fact, Denver Health has remained in the black for the past 10 years even after providing $2.1 billion in care for the uninsured and undergoing a major facility and technology renovation. She says, "People were in love with integrated systems a while ago and then they sort of fell out of favor because they didn't work, but I say they didn't work because none of them were [truly] integrated delivery systems."

Molpus believes the secret to Denver Health's success is that it comprises an integrated system like no other. "With control over its own network of clinics, employed physicians, a savvy IT plan, a health plan, and even leadership of the city's public health department, Denver Health can make the pieces fit the city," he says.

Marillac Clinic's Dr. Steve Hurd

It costs less to treat people in the last two years of their lives in Grand Junction/Mesa County, Colorado, where the Marillac Clinic has been operating since 1988, than anywhere else in the U.S., according to the influential Dartmouth Atlas study of healthcare systems. Since 1996, the Dartmouth Atlas of Health Care, which is part of the Center for Health Policy Research at Dartmouth College, has been examining patterns of healthcare delivery and practice across the United States, as well as evaluating the quality of health care Americans receive. But there are other equally compelling reasons to study this region of the country.

For starters, a long history of collaboration between providers and community leaders who are deeply

committed to universal access and willing to make small sacrifices associated with achieving this lofty goal has enabled everyone in the county—including the uninsured, lowest wage earners, and people with the most challenging disabilities—to enjoy mainstream access to care and coordinated services.

According to Dr. Steve Hurd, Ph.D., executive director for the Marillac Clinic, "Patient-centered care is leading the way in delivering high-quality health care and bringing down costs. The region's unique blended-compensation system for providers makes payments equivalent for commercial insurance, Medicare, and even Medicaid, whereas reimbursement for government-assisted care is obviously lower in most contemporary markets."

How is this possible? Simple: by creating a system that compensates physicians with their fair share of a health plan's profits or losses based on *performance* and not merely the number of procedures rendered. This, in turn, creates a strong incentive for close communication, coordination, and quality oversight. In keeping with this philosophy, all parties agree to operate as not-for-profit entities, facilitating a "shared success/shared sacrifice" orientation toward partnership.

From an operational standpoint, the clinic bundles medical, dental, vision, mental health, social care, and pharmaceutical services under one roof to meet as many patient needs as possible in a single visit. Moreover, horizontal process teams help eliminate waste, reduce treatment variability, and improve workflow.

Perhaps not surprisingly, an open-access philosophy has significantly reduced the no-show rate for this patient population to about 6 percent, which is considerably lower than the national average for safety net clinics. Open access recognizes that the low-income patients who the clinic serves often encounter difficulties arranging child care or a ride to their appointment, or last-minute temporary job assignments that they would be hard-pressed to decline.

Quality of care is enhanced when staffers learn as much as they can about patients beyond lifestyle risk factors, including their accomplishments and hobbies. It is common for team members to assist providers and meet patients' needs by entering an examination room and completing a "warm hand-off." This human touch helps facilitate coaching for patients who feel embarrassed about their condition or struggle with weight loss, exercise, or smoking cessation.

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The Marillac Clinic has earned kudos from a number of key industry observers, including Michael E. Huotari, vice president, legal and government affairs for the Rocky Mountain Health Plans. He notes that stakeholders in Mesa County's healthcare system "have a longstanding commitment to meet the health care needs of the entire community regardless of payer source or ability to pay. Marillac Clinic is a critical part of achieving that goal because its primary focus is the uninsured."

Adds Raymond Fabius, M.D., president at HealthNEXT: "Since many of the clinic's uninsured patients are also in the community workforce, employers truly benefit by improved on-the-job employee work performance."

Conclusion

As politicians and the architects of public policy continue to grapple with ways to find agreement on how to reform the nation's ailing healthcare system, the medical home model enables businesses and communities to lay a new foundation for refining prevention and treatment strategies as part of a long-term, comprehensive, patient-centered primary care connection. It also fosters meaningful and productive interactions between clinicians and patients that produce better overall family health. Research shows that this approach is gaining national support from multiple stakeholders who seek more meaningful solutions in the 21st century to longstanding problems that have conspired to produce a dysfunctional system long overdue for a substantive overhaul. One promising path along the road less traveled to healthier communities will be through HPI/CVE, whose unique attributes have enabled advocates of this process to achieve significant and measureable results. At a time when healthcare delivery needs to be as transparent and efficacious as possible, this winning formula will continue to turn the heads of healthcare leaders across the nation.

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