Learning to Fly
Building De Novo Medical Home Practices to Improve Experience, Outcomes, and Affordability

Rushika Fernandopulle, MD, MPP

Abstract: While most approaches to improving primary care delivery involve making incremental improvements to existing practices, for the past decade we have been engaged in a different approach—to build new practices from the ground up to demonstrate a vision of what is possible. Our Iora model of care combines a new payment model which does away with all fee for service billing, a new delivery model focused on robust team-based population management, and a new IT system to drive this very different care. We have demonstrated in several pilots improved experience, outcomes, and lower total cost of care. Key words: health care IT, innovation, medical home, care innovation, new payment models, primary care redesign

Imagine for a moment that it is 1902, and we are in New York and need to get to London in less than a week. And the only way we can currently do it is by ship, but even the fastest ships take more than a month to reach there. We can try as hard as we can to achieve our goal by thinking small—tweaking the design of the ship’s hull, putting in a better engine, studying the tides, or calling the boat builders to a conference, etc. And none of these will work. What we need to do, and what happened the next year, is to start to think big—to reframe the problem not as how do we make boats go faster, but to ask if there an entirely different way to cross the ocean. And the answer, which is obvious to us now, is to do what the Wright brothers did, and not tweak the boat, but have the vision and courage to leave the ground and build an airplane. And now, we can cross the Atlantic in hours and not days or weeks.

We are at a similar moment today in health care. There is growing consensus that the current US health care system performs embarrassingly poorly. The experience of care is often suboptimal. Outcomes are shockingly inconsistent—with error rates at alarmingly high levels—for instance, the average 30-day readmission rate for Medicare patients is almost 20% (Jencks et al., 2009). And much of this is at obscenely high costs that are bankrupting individuals, companies, and our nation. The Institute of Medicine (2001) summarized, “Between the healthcare we have and the care we could have lies not just a gap but a chasm”.

There is also growing agreement that if we want to improve the performance of the health care system, there is perhaps no better place to start that than with Primary Care. Primary Care done right can help patients receive their preventive care, meet most of their acute needs, manage their...
chronic conditions, and help navigate the rest of the health care system. It is clear to almost everyone, however, that the field faces a significant crisis: quality and patient experience are poor, and morale among doctors continues to fall (Linzer et al., 2009). Indeed, both the lay (Sanders, 2008) and professional press (Bodenheimer, 2006) for years have pronounced “the death of primary care.”

As a response to this, many policy makers have proposed transforming existing practices along the lines of the Patient-Centered Medical Home model (Davis et al., 2005). While this sounds promising in theory, several recent studies have pointed out why this sort of fundamental change is in reality very difficult especially for small practices (Nutting et al., 2012).

For the past decade or so, we have been trying a different approach—instead of trying to improve the boats (make marginal improvements to existing practices), we have been simply working on building an airplane—building new practices from scratch, which are designed to improve experience, outcomes, and overall affordability of care.

THE IORA CARE MODEL

Our “airplane,” the Iora model of care, has 3 main components, which are like 3 legs of a stool, all of which are important to make it work. The first is to change the payment model. Current primary care doctors get paid largely fee for service—a small amount per doctor sick visit. We instead ask for a fixed risk-adjusted fee per patient (primary care capitation) that allows us to be creative in how to deliver services. In addition, we ask to increase the resources going into primary care. On average, in the United States, primary care is 4% to 5% of health care spending (Phillips & Bazemore, 2010); we believe this is a very poor investment philosophy to spend 95% on essentially failures of primary care, so we ask to double this to 10% roughly of total spending, and then only need to save 5% of downstream costs to break even. Finally, in terms of payment, we get rid of all primary care copayments, to remove any financial barriers for patients to interact with us. This is actually a fairly trivial cost in terms of overall health care spending (much less than 1% of total health care expenditure) so does not significantly change the break-even requirements.

This new payment model then allows us to deliver the second component—a completely redesigned care delivery model. We start by giving each patient a shared care plan, and customized information about their health issues. Every patient gets a personal health coach who speaks their language and is chosen for their interpersonal skills. These coaches help our patients with the hard work of understanding and managing their health. They work one on one with patients, as well as with the doctors to deliver group visits for those with chronic conditions like diabetes or common issues such as aging well or trying to lose weight.

We allow patients easy access to us. Adult education theory shows that learning needs to be an active, and not a passive process, and true education is a dialog, not a monolog. This cannot be done if the only way to reach us is to come in for a 15-minute appointment scheduled a week or more in advance. We provide e-mail directly to each member of our team, give direct phone access to the doctor 24/7, use open access scheduling to guarantee same day appointment availability, and also communicate by text message, video chat, and do home and office visits as needed.

We have also put in place mechanisms to proactively check in with patients, rather than simply waiting for them to reach us as is typical. If we are depending on patients to be self-managing, we ought to be periodically checking in to make sure they are doing well. We call or e-mail after every visit or encounter to make sure what we suggested actually worked, and we also proactively check in at regular intervals from once a quarter to once a week, depending on how sick or active a patient might be. We actively co-manage specialty and hospital care with a small group of doctors chosen for their service, outcomes,
and efficiency. We provide a number of feedback loops for patients to tell us how to do this better. We survey our patients on a variety of issues, and perhaps more importantly, hold regular patient advisory dinners to hear their advice and seek their counsel.

Perhaps most fundamentally, we have built a different culture. In too many practices where staff and physicians are overworked, the patient is seen as the enemy, and the incentive is to push as many widgets off the end of the line as possible. In some ways, the most important thing we have done is select the right physicians and staff and create an environment where our only goal is to meet the needs of our patients. This may be an obvious statement in other industries, but really it is quite radical in our field.

To deliver this very different care, we learned we needed a third component, a fundamentally different IT platform to allow us to engage with our patients, manage the population, and gather the data we needed to improve our performance. Despite the hype over electronic health records, they are largely built to document, code, and bill for visits (Fernandopulle & Patel, 2010). When we asked existing vendors to modify their systems for us, their common reply is that "no one is asking for it." So, we decided to build it ourselves and are continuing to evolve it to improve its functionality.

PRACTICES AND RESULTS

This model is not just a theoretical one—we have built and are operating a number of practices from scratch based on this model across the country. As part of a predecessor company, called Renaissance Health, we worked with existing health systems to implement the model, for example, for the Boeing Company and Virginia Mason, the Everett Clinic, and Valley Medical System in the Seattle area (Schilling, 2011), and for AtlantiCare and the UniteHere Fund in Atlantic City, New Jersey (Blash et al., 2010). We have subsequently build several practices ourselves—in Las Vegas, Nevada, with the Culinary Trust; in Hanover, New Hampshire, with Dartmouth College (Boutwell, 2011); and in Brooklyn, New York, with the Freelancers Insurance Company (Tozzi, 2012).

We have had no problems convincing patients to leave their current physicians and come to our new practices. While patients typically like their current doctors, they often are quite dissatisfied with their practices and how they are treated, and like in other facets of life, many are willing to move to a better alternative.

Our pilot practices have shown improved patient satisfaction, improved clinical outcomes, reduced racial disparities, better functional status, and reduction in absenteeism. For instance, patients in the Atlantic City practice rated their doctor on average 9.62 of 10 possible points, compared with a rating of 7.75 points of 10 for their prior physician. Patients who came in with a systolic blood pressure in poor control (>160) dropped an average of 42 points after 6 months in the practice, and those who came in with poor blood sugar control (A1c>9) dropped an average of 2.38 points of A1c over their first 6 months. At entry into the practice, Hispanic patients had on average 2.8 points higher systolic blood pressure, 9.8 points higher low-density lipoprotein, and 0.13 points higher A1c than non-Hispanic whites. After 6 months in the practice, all these disparities were reversed. In the Seattle practices, 12-Item Short Form Health Survey physical function scores improved 14.8% and mental functions scores improved 16.1% compared with baseline, and patients reported 56.5% fewer missed workdays in the last 6 months because of illness compared with before entering the practice.

Independent analysis has shown these improvements in outcomes were accompanied by significant reductions in total health care spending. For instance, in our Boeing pilot, net medical spending was 20% lower than for a set of well-matched controls (Milstein & Kothari, 2009). In Atlantic City, a case control study in 2009 showed a 12.3% net lower spending relative to controls, driven largely by a 41% drop in inpatient admissions and a 48% drop in ER visits (AHRQ Health Care Innovations Exchange, 2012).
DISCUSSION

There are a number of caveats when thinking about how to scale this model. In practical terms, this approach requires a purchaser or payer (eg, employer, union trust, or health plan) willing to change the way they pay for primary care, with enough lives in a given geography to fill a practice, although we are now building practices to allow multiple, smaller payers. Overall, we need approximately 3600 patients to fill a practice and, given we make the practice a choice for patients, would need more covered lives to make it make sense.

Also, the cost-saving data mentioned earlier were from practices where we selectively recruited the sickest 10% of the patients in a population—those with multiple chronic conditions who on average cost at baseline about four times the average. While we are still building some practices based on this model (eg, Las Vegas), the problem is that every day we end up turning away patients telling them, “you aren’t sick enough—stay with your old care and when you get sicker then we will care for you.” Thus, for other sponsors, we have now opened the practice to all comers; these use a similar delivery model but with larger panel sizes for doctors and health coaches, and a careful stratification of patients to target interventions. While we believe there is still room to generate similar savings for a general population, the time course may prove to be longer.

This primary care model bears some similarity to those of closed staff model HMOs such as Kaiser, Group Health Cooperative of Puget Sound, and the former Harvard Community Health Plan. Like us, these systems by taking more global payments are able to invest more in primary care and go beyond reactive doctor visits to deliver care. We do not take global risk, so avoid any perception or temptation to skimp on care, and continue to allow patient choice of provider, although we use relationships and not rules to get patients to the right downstream providers. We also keep our doctors purely on salary, and do no visit-based coding, so remove any incentives at that level to churn or favor visits.

Some compare our care to concierge physicians, who charge patients an additional fee in return for smaller panel sizes and more time with their doctors. While we try to deliver the same or better levels of service as these practices, we believe the biggest problem in US health care is that there is too much money in the system and we need to get it out and put it back in patient’s pockets; thus, asking patients to pay more is not solving the real problem. We also have much more fundamentally changed the practice model—this is much more than simply having fewer patients—it is completely rethinking how we deliver care.

By starting from scratch and changing the payment model, delivery model, and IT infrastructure, we have been creating radically better practices and delivering better experiences and outcomes at a much lower total cost of care.

It is comforting to think we can fix primary care and our health care system by thinking small, by a series of small improvements or tweaks to existing practices. But perhaps this is wrong. “Between the healthcare we have and the care we could have lies not just a gap but a chasm.” To cross this chasm, we need to think big like the Wright brothers and go beyond tweaking our boat designs and studying the tides, and have the courage to learn how to fly.

REFERENCES


