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NEWSLETTER

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Promoting a Culture of Change in a Patient-Centered Medical Home

The model of primary care in the United States is changing at a rapid pace. There are new expectations of primary care providers, namely the ability to focus on multiple issues during ever shorter visits, while simultaneously fostering a collaborative and enriching relationship with patients, many of whom are experiencing an increase in health-related risks and stressors. The increasing list of demands has led to frustration for clinical providers and patients, and underscores the need for new models of care that can adapt to improve the quality of care, contain costs, and improve the interaction between patients and providers. Healthcare systems that emphasize a robust primary care component have more comprehensive, better quality, and equitable care at lower cost.[1] These high-performing practices are often linked to the development and implementation of the Patient-Centered Medical Home (PCMH) model.

Key concepts being tested by the American Academy of Family Physicians (AAFP), along with other national agencies, include changing the context in which we take care of patients; moving from a systems-centered or physician-centered approach to a patient-centered approach, the Patient-Centered Medical Home. The National Committee for Quality Assurance (NCQA) defines a PCMH as "a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship."[2] The basic tenets of a PCMH include: access to care, strong relationship with a personal physician, team-based care approach, shared decision making, improved information sharing, the use of electronic health records, and care coordination and management.

Jefferson Family Medicine Associates (JFMA) achieved NCQA recognition as a Level 3 PCMH several years ago, and has adopted and fully implemented nearly all of the components of the PCMH model. This change and implementation is an ongoing process that requires dedication from all members of the care team. Creating an office culture that is open to change, communication, and collaboration is vital to continuing our journey in this process.

The process of change is not without bumps along the road. "Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign."[3] The PCMH model challenges each individual to change their identities and the way they view patient care. As a practice transforms, it is common to have periods of "change fatigue,"[1,4] whose symptoms include: "unresolved tension and conflict, burnout and turnover, and both passive and active resistance to further change."[4] In the face of change, we often see inconsistent motivation from physician providers and pushback from staff members that see any change as an increased workload without clear benefits to them. Change fatigue may be encountered by any practice and, if ignored, may lead to delayed progress or even reverting back to the more-comfortable, albeit less-efficient, norm.

The National Demonstration Project (NDP) is a group-randomized clinical trial of 36 independent clinical practices, examining the implementation of the PCMH model of care. The outcomes studied in this project have included patient experience, provider and staff experience, patient outcomes, and quality of care. The NDP has defined the ability of a practice to weather the processes of change as the "adaptive reserve factor."[3,4,5,7] Adaptive reserve includes: "healthy relationship infrastructure, aligned management model, and facilitative leadership."[4] "High-functioning teams with strong adaptive reserve have been characterized as having positive communication patterns; low levels of conflict; and high levels of collaboration, coordination, cooperation, and participation."[6] Those teams that had a high adaptive reserve fared better during the implementation phases of the PCMH transformation.

The care team at JFMA includes physicians, nurse practitioners, registered nurses, medical assistants, and students from many clinical disciplines. Although JFMA was not one of the practices included in the NDP, we have observed many of the same challenges that were presented in the NDP, and have had intermittent periods of "change fatigue." In developing our new model of care, we have focused on empowering staff members to fully participate in the patients' care by: having standing orders; participating in the quality care initiatives and patient education; linking quality scores to compensation; involving team members in the planning stages of change initiatives prior to implementation; and actively seeking feedback from all levels of providers along the implementation/transformation process.

Our patients are already seeing the benefits of our changes, with increased access to care through the open access scheduling system, and timely follow-up of laboratory and radiology testing. Accessing test results immediately through our computer system, and more accurate and faster prescription management through e-scripting, is another advantage. Additionally, efficient and complete medical records with our electronic health records link patient records across primary care and specialty care. Patients have expressed that they feel more comfortable knowing that their charts are more readily available and that their primary care provider has access to notes and treatment plans from the specialists within the Jefferson health system. We have recently started to implement our Care Management Team, whose goal is to track, outreach to, and advocate for our most at-risk patients. Although this program is at the early stages of implementation, we have seen an increase in patients who both make and keep their appointments after being discharged from the hospital, providing us with the opportunity to review any outstanding orders and medication changes that were instituted during their hospital stay. We are hoping to see that this program translates into a decrease in hospital readmission and healthier outcomes for our patients.

As we work to implement the necessary changes, we will focus on improving our adaptive reserve by working to improve our communication and support. In our effort to function as "facilitative leaders" we are attempting to foster a safe and supportive office culture that empowers staff to identify and suggest new ideas as well as discuss what is not currently working. As we look to

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further implement, revise, and enhance our own PCMH at JFMA, we will continue to focus on staff and team development, while promoting a culture of change in our practice. The transformation process is an ongoing endeavor and requires stamina and dedication of all the members of the care team. It will prove to be a challenge worth mastering. ■

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