The physician as captain

The way to reform health care is through physician-led, patient-centered teams.

BY JULIE ANDERSON, M.D., FAAFP

My oldest son, Elliot, began playing Squirt hockey this year. For those not familiar with hockey, this is the first year when the kids take to the full ice rink and start learning their positions and running plays. It is a big change from the previous year, when as Mites 8-year-olds vie for the puck no matter where they are on the ice and just try to get it into the goal. There is not much teamwork at this level of play. The kids follow only a few basic rules and do their best to stay upright and score. Watching my boys move through the ranks of hockey has reminded me of the efforts that family physicians and other primary care specialists are undertaking to reform health care.

Just as Elliot’s knowledge of hockey has evolved, so has our understanding of the way health care services are delivered. In order to perfect our game, we physicians must not only know the rules, but we also must be the leaders who guide and coordinate complex plays. Our challenge is to move from playing an episodic, reactive and, at times, defensive game to one that is continuous, strategic and focused. I think you get the point. Although I could go on about icing and offsides, I will leave the hockey analogy and attempt to explain why I believe a physician-led, team-based model of patient-centered care (with patients as active participants) is the way to move medical care forward.

Understanding the game

Team-based care is commonly thought of as that in which two or more health care professionals, directed by a physician, work with the patient and their family, if appropriate, to achieve shared goals. This notion, as I see it, is just a small part of a much broader concept—that of the patient-centered “medical home,” which provides physician-led, coordinated, high-quality, patient-centered care.

The idea of the medical home was introduced by the American Academy of Pediatrics in 1967 as a way to provide coordinated services to children with special needs. It has gained traction in the last few years. In 2010, the state of Minnesota began certifying medical homes (called “health care homes”) and paying them to coordinate care for patients on Medical Assistance. The American Academy of Family Physicians (AAFP) has been a strong advocate for patient-centered medical homes since about 2004, contending that medical homes have the potential to address many of the problems that affect our current health care system. They even go so far as to call it the future of our specialty.

There are a number of well-recognized characteristics of patient-centered medical homes:

- Continuity of care with same-day appointments, after-hours coverage, and electronic and group visits
- Comprehensive care management for a particular population with an emphasis on disease prevention and chronic disease management
- Coordinated and managed care that makes use of community-based resources and collaborative relationships with other specialists, hospitals and care-transition teams
- Use of physician-led care teams that have a shared mission and vision, and emphasize effective communication and patient participation
- An emphasis on quality and safety that uses evidenced-based medicine when appropriate, considers patient satisfaction feedback, and measures and improves performance.

Recent studies in Minnesota and other states have shown that patient-centered medical homes that use a team-based approach to care can improve health, provide better care and reduce the overall cost of care delivery. Other studies have shown patient-centered medical homes lead to fewer hospital admissions and readmissions, decreased emergency department utilization, reduced hospital stays, better diabetes care, increased preventive screening rates and better access to care. Still others have shown lower outpatient costs per patient, particularly those with complex medical conditions, as well as improved patient and provider satisfaction. These studies highlight the fact that eliminating fragmentation can reduce the cost...
of care for a given population and improve outcomes. Wouldn’t we all like a system where abnormal test results are communicated correctly, work is not duplicated by multiple providers, care is documented and efficiently delivered to all involved with a patient, and potentially preventable hospitalizations are reduced?

Leading the team
We must acknowledge the fact that medicine has developed into more of a team sport. This concept is not new. We were all taught in school that there is no “I” in “team.” We learned that a winning team has a clear focus, defined roles and good communication. Members are efficient and accountable for their actions. They adhere to the rules and come up with innovative ways to succeed. As health care delivery becomes increasingly complicated and regulated, we must rely on our associates in nursing, administration, information technology, pharmacy and social services to assist us in our practices. Gone are the days of seeing a patient, writing a few words in their chart and moving on. We now must be fact-gatherers, analysts and care-plan designers as well as loop-hole closers. We simply cannot do it alone.

One could argue that this affects physician autonomy, and one would be right. I am the last one to want someone telling me that an A1C of 7.9 is better than 8 or that it is my fault that my patient won’t stop smoking. But I am coming around to the realization that with a team approach, I can do more for my patients.

Although I do not yet practice in a team-based patient-centered medical home, I firmly believe it takes a village to care for patients. I count on my front desk staff to remind patients to come in for appointments, I need my nurses to efficiently room and check vitals on my patients, and I see the benefit of having a nurse follow up with a patient who has many medical problems to remind them of what we discussed during a clinic visit and see if they followed through with specialty referrals. We must remember that as the practice of medicine gets increasingly complicated for us, so it does for our patients. They need our help more than ever to navigate the health care system. With more resources organized around a physician-led model, we can achieve more for our patients.

The question we should be asking is “How can I be a part of the solution?” rather than “How can I avoid transforming my practice?” If we as primary care physicians do not lead the way toward collaborative care, we will most certainly continue to have our future questioned, as nonphysician providers seek to fill our role in caring for our patients. We must remind ourselves and others that the major difference between us and these other professionals is that we are trained to diagnose and develop treatment plans; they are trained to follow through on those plans and implement the protocols we design. 6

So, what makes the captain indispensable to the hockey team? (So I love analogies, humor me!) Quite simply, the captain is the person chosen for leadership ability, communication skills and knowledge of the game. He or she is the person who leads by example—on and off the ice. The captain speaks up for the team, defends the actions of his or her teammates, adjusts play on the fly and is able to implement the overall game plan. He or she is the hardest working player on the team—the first one to arrive at practice and the last to leave.

In order to be the captain of our health care teams, we must develop our leadership skills starting in medical school and continuing throughout our careers. We have strayed somewhat from the concept of being leaders, and we must get back to playing this role.

Making the play
Now that I have convinced you that a primary physician-led patient-centered medical home offers the best future for health care delivery in our country, how do we make it a reality? The sad truth is that until the payment method changes, it will prove difficult for many clinics to offer this type of care even to patients with the most complex medical needs. Although clinics that have been certified by the State of Minnesota as health care homes offer coordinated care, it is limited to patients in certain health plans, and many private clinics cannot justify the cost of setting up these services without full support from third-party payers. We as physicians must convince purchasers of health insurance that this concept is worthy of notice.

At the American Medical Association’s meeting in Hawaii last November, delegates approved a resolution affirming recommendations in a report addressing the need for team-based care. The language in that resolution was similar to a statement put forth by the AAFP. In addition to these efforts, we need all of our physician colleagues to advocate for team-based care at the grassroots level. If we don’t succeed at creating a model of care led by physicians, I can assure you that we will be working under one led by administrators. MM

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REFERENCES