Patient-Centered Team Care℠: A Medical Home Model Designed for and with Patients

Henry Ford Medical Group, Detroit, Michigan

Keywords: *ambulatory primary care, care team, chronic care, chronic disease management, Detroit, evidence-based medicine, Henry Ford Medical Center, medical home, Michigan, patient support, safety, telemedicine, treatment, value*

To improve the management of patients with chronic disease, Henry Ford developed an advanced medical home model in 2007 for ambulatory primary care, implementing the first phase at 3 sites. Each site identified 4-6 patients to serve as patient advisors to the multidisciplinary design team of physicians, nurses, medical assistants, customer service representatives, social workers, case managers, etc. The patient advisors selected the program name "Patient-Centered Team Care℠," finding the Medical Home term too confusing, and helped to improve patient educational materials and the patient Plan of Care form used in clinic. To assess the effectiveness of the practice model, Henry Ford tracked chronic disease measures (e.g., low density lipoprotein, hemoglobin A1c, blood pressure, weight) before and after implementation of patient-centered team clinics. Patients showed improvement in low density lipoprotein and hemoglobin A1c after receiving case management services for 90 days or greater.

Patient-Centered Team Care℠: A Medical Home Model Designed for Patients

http://www.henryford.com/body.cfm?id=53112

Aim

- To include our patients in the design and implementation of care processes developed as part of the patient-centered medical home for our ambulatory primary care clinics
- To implement patient-centered team care clinics and improve chronic disease management of adult patients

Measures

- Chronic disease measures (e.g., LDL, hemoglobin A1C, blood pressure, weight, etc.) before and after implementation of patient-centered team clinics

Changes

Four patients at each of the three participating clinic sites agreed to serve as "patient advisor" to the multidisciplinary design teams. Patient advisors attended design team meetings held quarterly and were available for consultation between meetings for immediate feedback. Patient advisors were instrumental in the design of several practice changes:

- **Program Name and Patient Education Materials:** Our patient advisors recommended against using the "medical home" term as part of our program name. They believed the general patient population would confuse the word "home" with "nursing home" care. With their input, we selected "Patient-Centered Team Care" and developed marketing/education materials to help communicate to the general patient population the benefits of team care. A series of plan-do-check-act (PCDA) cycles

beginning in 2007 through October 2008 resulted in a finished package of patient education materials which are now distributed to new patients at the three clinics.

- **Patient Plan of Care:** We developed a Plan of Care form to engage patients in their care and to introduce the patient to additional members of their health care team. Our patient advisors helped design the form and the communication process that physicians use to introduce each patient's unique care team. The form has completed 16 PDCA cycles and is now part of the electronic medical record.
- **Chronic Disease Management:** We designed and implemented case management interventions to meet the needs of high-risk patients. Our patient advisors strongly recommended that we establish mechanisms to ensure that communication between the case manager and physician was visible to the patient to further illustrate the concept of team care. Weekly meetings between case managers and physicians are held, with physician endorsement of the case manager's first outreach to the patient if done outside of the office visit between physician, case manager, and patient.
- **Telemedicine for Heart Failure:** We implemented a telemedicine service for patients with heart failure to assist case managers in monitoring patients' symptoms in an effort to provide immediate interventions designed to avert emergency department (ED) visits and hospital admissions. Our patient advisors were included in the decision-making process, endorsing the selected vendor and implementation plan.

Results

- **Chronic Disease Measures:** Patients showed improvement in key clinical metrics (e.g., LDL and A1c) after receiving case management services for 90 days or greater. However, patients did not show significant improvement in weight loss.

Next Steps/Lessons Learned

- We are currently working with senior leadership to spread key medical home concepts and new interventions across other primary care sites. The participation of our patient advisors will continue to be the cornerstone of our change plan.
- The key to our success is team work. We learned to value each other's opinions and appreciate the unique skills and talent each person can bring to a team. We learned that everyone's support or "buy-in" is essential before proceeding with a practice change or the change will not be sustained.

Contact Information: Katherine Scher, Office of Clinical Quality and Safety, Henry Ford Health System, kscher1@hfhs.org.

FOR MORE INFORMATION:

Dwight Angell
Director of Public Affairs
Henry Ford Health System
One Ford Place
Detroit, Michigan
tel.313-876-8709
Dangell1@hfhs.org
www.henryfordhealth.org