

Ambulatory Practice of the Future

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The Ambulatory Practice of the Future is a bold experiment by the Massachusetts General Hospital to innovate in health care delivery and payment. This Primary Care internal medicine practice's population is MGH employees and their adult dependents. By focusing on employees within one large self-insured employer, considerable freedom exists to create and run the practice without having to focus exclusively on RVUs and reimbursement.

Check In & Physical Space

Upon arriving at the APF, located a brisk 5 minute walk from the MGH main campus, I was immediately taken aback by the sheer beauty of the place. Beautifully appointed and furnished with large waiting room with educational slides on the large screen television, work kiosks for employees, and a full service coffee machine/snack bar, this practice really is a sight to behold. Immediately upon arriving one has the choice of either interacting with a staff member sitting at a welcome desk to the left or a check in kiosk to the right. Actually one must interact with the kiosk; the greeter is just there to guide you through the process.



The kiosk serves as a dedicated check in system—patients key in either with a card or entering personal identifiers, much like checking in for a flight. With information updated, copays paid, they are directed to the waiting room as described above. Due to the patient volumes and relative efficiency of the practice, patients are often left alone in the beautiful waiting room, for very short periods of time.



The physical space continues to impress all the way through the practice. There is innovation space and offices near the front, a large divisible conference room in the center of the practice for huddles & meetings, and approximately 15 11x11

well furnished exam rooms, with a two-bay urgent care/infusion room (with breathtaking views of Boston) arrayed around a central “bullpen.” The bullpen is an array of desks and workstations, which allow for open communications within and between teams.

The exam rooms themselves are unique design. On the outside of the room is a flag system, with the role of the person who either is in the room, or ought to be in the room (MA, Provider, Coach), etc. Within the room, my eyes were immediately drawn to the two large 24” flat screen monitors on the wall, with a semicircular table immediately beneath. More about this when I get to the provider visit. Off to the side site a mobile exam light and standard exam table and curtain so that the patient may disrobe in private. The emphasis is on the collaborative space in the room, rather than the traditional exam room. Again, beautiful views from this 10th floor downtown Boston office building.. The use of natural light in the most patient-prevalent areas was a unique and deliberate space design feature to take advantage of and helps deliver a richer patient-centered experience.



Of note, the offices, innovation space and phone booths in the front of the practice, while well designed, seem so far from the action that they are rarely used during the work day. The innovation space is noteworthy as a small collaborative work area with a wall of white board initially designed for group visits, patient and team brainstorming. It has become a bit of a general-purpose room now as there is exercise equipment, donated by a local fitness company, so that the practice can explore health coach driven exercise instruction. The offices are used by the MDs for non-clinical/administrative work. Phone booths are present for staff members to make private calls. There is an entire bank of computers/phones not currently in use, which looks a bit like I imagine an emergency military bunker would—fully stocked and awaiting the arrival of teams 2 & 3. The practice anticipates greater utilization of these spaces with a full compliment of clinical staff.

Huddle

The day begins with a team huddle. The huddle takes place in the smaller half of the central conference room, close to the bullpen. The team looks on a communal large flat screen monitor (a common theme in the design of the practice) at the day’s list of patients. Control of the screen was



passed between members of the team, all whom were present. The huddle starts as rounding on the patients coming in that day, starting notes, and dividing up work. One of the physicians comes in a few minutes early and pre-rounds on his list, which results in a physician-led huddle. There is some education, awareness of patients not coming in today, and practice improvement goals baked in to the 30-minute huddle. In the 2 weeks between the huddles I observed, there was already an increasing trend towards education and population management through awareness of ill patients not slated for today's visits. Appendix A contains the most recent huddle template.

The Team

After a year open, the practice has one team consisting of 2 MDs, 1 NP, 2 RNs, 2 MAs and a health coach with physical space and plans to expand to 2 additional teams as volume increases. There tends to be one MD around at a time, each with a part time schedule. Patients are officially assigned to one of the MDs by Partners for the purposes of tracking clinical outcomes, effectiveness, process measures, etc. Internally, the practice takes a more holistic approach, as each patient is the Team's responsibility, rather than an individual physician. The result is a greater likelihood of seeing one physician over another, without strict scheduling limitations. The NP, sees both urgent & follow-up visits, but does not have a separate panel due to Partner's decisions around NPs. There are some patients who see her primarily that are technically empanelled to a physician. I was not able to clearly delineate the RN role during my time, but it seems to be more of a population management role than direct care.



The MAs are responsible for rooming patient, vital signs (using digital scanning equipment they are able to auto-populate vital signs into the medical record). They also begin with medicine reconciliation, agenda setting and correcting information within the record. Crucial to the MA role is reconciling all age-appropriate health maintenance issues, counseling and screening for depression, and then making appropriate plans based on these issues. At the end of the visit, they ensure patients are set up with Quicksilver/MyHealth the messaging system & patient portal; draw labs where needed, send prescriptions and arrange follow up. One the MAs that has been working with Dr. Judge for quite some time had a truly inspiring quote about process improvement: "Well we won't know until we start doing, then see how the flow goes."

The health coach has a background/Masters in Exercise Physiology as well as formal health coach training. He has worked with stress testing and other physiology, but moved in to health coaching to change his impact on patients. He starts with a 4 page Individual Health & Wellness Assessment, designed within the practice, which covers multiple domains of health and wellness. From there he and patients identify problems and goals, and begin setting 3 week, 3 month and 1-year goals. He checks in mostly by phone, but also in person, and helps patients facilitate setting and achieving their own goals. On a phone visit I observed with him, he was quite adept at avoiding a paternalistic relationship with a patient, having her instead set her own goals (example below). He currently tracks his work in a cut & paste note template within the medical record as well as an elaborate homegrown Excel spreadsheet, but would like more formalized data management tools. He also runs the IMPACT depression management program within the practice. There is a bit of parallel play between the health coach and other team members, with warm handoffs only happening some of the time. Otherwise, he receives referrals from one of the providers or direct requests from patients and often meets with patients during a separate visit. The team RN and NP are also close to completing health coaching certification.

Health Coach Visit Template:

1. Review old goals & update
2. Identify barriers
3. Set new goals

Goals are specific, measurable and have a confidence score #/10. Goals are reworked/reworded by the patient in an attempt to increase confidence to >7/10. “Lose weight,” becomes “lose 2 pounds per week for 6 weeks” which in turn becomes “Lose 2 pounds per week for 6 weeks by exercising 3 times per week and keeping ice cream to once weekly.” Check-ins happen every 2-3 weeks minimum and they are keeping data on effectiveness, which is too young to analyze just yet.

The Visit & the shared Computer Screen

The patient visits at APF are truly unique. By the nature of the dual monitor/semi circular table, patient and provider start by interacting with each other, but evolve into a triangulated 3 way visit with the medical record as an active guest. I saw varying degrees of dyad vs. triad visits, but inevitably the patient and provider end up pointing to things on the screens to ensure the record is accurately updated. This is like nothing I have ever seen in terms of melding human and data interaction during a visit. One point of criticism is that filling out the visit note (especially in



initial visits) becomes the focus of the visit. Because the note structure has not evolved (APF uses the same EMR as the rest of MGH), the visits can feel a bit constrained and artificially structured. When this feeling becomes palpable, I observed each provider turn away from note completion and focus directly on the patient, often switching to handwritten notes. Again, a fantastic concept, but the underlying note structure can push the visit in the wrong direction. Nevertheless, the providers at APF are on to something very special here, and the patients are appreciative that they can see what is being written about them.

Visits proceed in a traditional fashion, opening history & agenda confirmation; physical exam; assessment/plan and visit closing with the MA starting and closing each visit. There is a degree of education about the practice with every patient, reminding patients of the ability to review the portal, email providers and generally communicate in a more seamless fashion.

In addition to traditional in office visits, made easier by their proximity to the main campus, patients can schedule virtual visits in the form of phone calls or video chats, with the former predominating. Asynchronous communication is also encouraged through secure messaging via the aforementioned patient portal.

Measurement, Quality & Payment

Although I had limited opportunity to dive into the metrics, the practice is actively utilizing a survey about the practice and their governing Physician Organization uses HEDIS measurements to track all practices. Internally they use watch lists for patients with specific chronic diseases so that absence from physical visits does not translate into poor care. They also watch patient ED visits, CAHPS scores and general utilization.

There is a disconnect between the goals & potential of practice and their current tracking system. For instance, although they are globally budgeted for their patients, doctors must generate a visit note, code and sham bill for each visit for MGH tracking purposes. They are still measured on production (number of visits) by their supervising bodies.

There is something community/special about the MGH employee connection. In a large city, this is not just people who live here, but rather an identified community, of which the entire team is part, that comes to get care.

Conclusions

APF is a truly special place—the attempt by a health care system leader to remake itself from the inside out. It appears to have all of the benefits and challenges of an innovator within a large system. On the positive side, initial capital support and design time have

allowed for a unique and beautiful practice environment. The staff is all truly professional, innovative and dedicated. The interaction with the larger MGH facilities allows patients to experience unique care without sacrificing the large network of world experts at their fingertips. Finally, there is something special about an MGH team caring for the MGH community. Patients are colleagues and family, and that level of intimacy helps create a more robust practice environment, often lost in large system practices.

On the challenge side, APF's ability to innovate is constrained by its host's choices. The medical record, appointment system and billing/coding requirements are fixed. Finally, the relatively small eligible population has contributed to a modest ramping up of the practice size.

Appendix A:
Huddle Template

Procedure:

The staff at the APF will meet before a session begins every morning and some afternoons to discuss patient flow, issues of the day, and issues of the week. The purpose of the huddle is to anticipate the needs of the work day by collecting information that will support the patient care of the day, support each other in our workday, and plan for other days of the week.

Place: APF Conference Room

Time: 8:30 AM and if appropriate 1:45 PM

When: Daily

Who: We will invite different members of the team to "drive" the process being sure to allow each member of the team an opportunity to lead this meeting.

Process:

1) Patient run- through:

- a) Individual patient- share what we know briefly.
- b) Use "across practice" list and
- c) Watch time so that all patients can be discussed.
- d) Each provider including health coach and nurse as well.

2) Decisions

- a) Do we need to collect other information to help make the visit go more smoothly? (i.e., information from a paper chart, labs sent on paper, etc.)
- b) Do we need any special set-up in the room to help the visit go smoothly?
- c) Run through our Hypertension list to look for patients who might be coming in today.

- d) Run through our Diabetes list to look for patients who might be coming in today and make sure to identify care needs and assign.
 - e) Run through a health maintenance list on every patient- note need for pap, mammogram, immunizations etc., even if this is not a complete physical exam visit- never miss an opportunity!
- 3) Follow up issues with patients either on our Watchlist or to do lists.
- 4) Update inpatient activity including readmissions, known ED visits and known MWI visits
- 5) Report on any left over issues from the patient care session the day before.
- 6) Report variations of the day and how we will plan around those variations. Will there be visitors today? Is there a meeting in the conference room? Does staff have outside professional or personal appointments?
- 7) Report on the projects of the day- does a team member need help to complete a project? How are we going to support that team member to help make that happen?
- 8) Who will be the “closing staff” today?
- 9) Any anticipation for issues for the following day or following week especially if it is a Friday?
- 10) Weather report from each staff person (personal check in).