When you redesign a practice around these principles, you can step off the productivity treadmill and focus on excellent patient care.

THE IDEAL MEDICAL PRACTICE MODEL:

Improving Efficiency, Quality AND THE Doctor-Patient Relationship

L. Gordon Moore, MD, and John H. Wasson, MD

If you are like most primary care physicians, you probably have had enough of third parties injecting themselves into the front lines of medical care in ways that offer marginal value and drive up costs. Pre-authorization requirements, productivity benchmarks, competing clinical guidelines and pay-for-performance initiatives are just a few of the challenges we face as primary care physicians.

What can we do to return the locus of control to our practices and ensure adequate compensation for our work? We have to redesign our practices to optimize efficiency and show that we can not only deliver superb care but also lower the total cost of health care. The "ideal medical practice" model can move us closer to this goal.

This article shares what we have learned to date as part of a national collaborative project designed to demonstrate the viability of the ideal medical practice model. It also launches a series of articles that will delve more deeply into the essential components of ideal medical practices.

IMP
Ideal Medical Practice Series

What is an ideal medical practice?

What do you get when you mix low overhead with high technology and wrap it around an excellent physician-patient relationship? You get an ideal medical practice – a practice model designed to enhance doctor-patient relationships, increase face-to-face time between doctors and patients, reduce physician workloads, instill patients with a sense of responsibility for their health and cut wasted dollars from the entire system.[1,2] The model encompasses the ideal *micro* practice model, which focuses on optimizing the smallest functional work unit capable of delivering excellent care: the solo doctor, even without any staff.[3] The key principles ideal medical practices pursue are high-quality, patient-centered, collaborative care; unfettered access and continuity; and extreme efficiency. (See "The mark of an IMP," below.) It is consistent with the AAFP's "new model of care" and the patient-centered medical home (see the related article on page 38).

In 2006, we began work on a national collaborative project, with support from the Physician's Foundation for Health Systems Excellence, to measure the outcomes of ideal medical practices and to demonstrate that motivated primary care physicians can adopt the tools and processes that result in high-quality care and vital and sustainable practices. Our initial work has focused on micro practices where a few people wear many hats. Although the majority of these practices are less than five years old and have not yet reached financial maturity, they are netting on average $123,000 per physician per year and seeing just 11 patients per day. (See the financial data on page 22.) These practices are performing particularly well in terms of quality. For example, nearly 60 percent of their patients agreed with the statements "I receive exactly the care I want and need exactly when and how I want and need it"

THE MARK OF AN IMP

IDEAL MEDICAL PRACTICES	TYPICAL PRACTICES
Care is driven by the patient's needs, goals and values.	Care is driven by the practice's priorities.
Access is 24-7.	Access is 9-5.
The care team uses technology to its fullest (e.g., electronic health records, e-mail, Internet scheduling).	The care team avoids new technology.
Patients can see their own physician whenever they choose.	Patients must see whoever is available.
The majority of the office visit is spent with the physician.	The majority of the office visit is spent waiting.
Overhead is low.	Overhead is high.
Patients are seen the same day they call the office.	Patients typically wait for an appointment.
Physicians are able to see fewer patients per day.	Physicians must generate high numbers of visits per day to cover overhead.
Practices measure themselves regularly.	Practices have little or no performance data.
Practices are proactive in their care of patients with chronic illnesses.	Practices are reactive in their care of patients with chronic illnesses.
Physicians are satisfied and feel in control.	Physicians feel harried and overbooked.

About the Authors

Dr. Moore is a solo family physician in Rochester, N.Y. He is also a clinical associate professor of family medicine at the University of Rochester School of Medicine and Dentistry and a faculty member for the Institute for Healthcare Improvement (IHI). Dr. Wasson is a professor of community and family medicine and the Herman O. West professor of geriatrics at Dartmouth Medical School in Hanover, N.H.; director of the Center for Aging; research director of the Dartmouth - Northern New England Primary Care Research Network (COOP); faculty member for the IHI; and co-developer of HowsYourHealth.org. Author disclosure: nothing to disclose.

and "Nothing about my care needs improvement – it is perfect." In typical practices, only half as many patients agreed with these statements. (See the data on page 23.)

We are now testing the model in larger groups where people work as a team. It is our belief that the concepts can succeed in any setting, large or small. This is not about "solo practice" but about working differently to achieve improved results.

The articles in this series

A number of upcoming articles about ideal medical practices will illustrate the work that is in progress and share key learnings:

1. Efficiency. Efficient practice design, including the wise use of technology and improved workflow, reduces staffing needs and enables ideal medical practices to reduce overhead. While overhead in a typical family practice is roughly 60 percent of revenue, overhead in ideal medical practices averages nearly 35 percent.

Because of the reduced overhead, these practices need to see fewer patients to cover their costs. Doctors can thereby spend more time with their patients and feel more in control, and they avoid the devastating

The "ideal medical practice" model is focused on high-quality, patient-centered, collaborative care; unfettered access and continuity; and extreme efficiency.

A national demonstration project is under way to prove the success of the model.

Data collected as part of the project indicate that patients are pleased with the performance of ideal medical practices.

AVERAGE MONTHLY REVENUE AND EXPENSES FOR 12 ONE-DOCTOR IDEAL MEDICAL PRACTICES

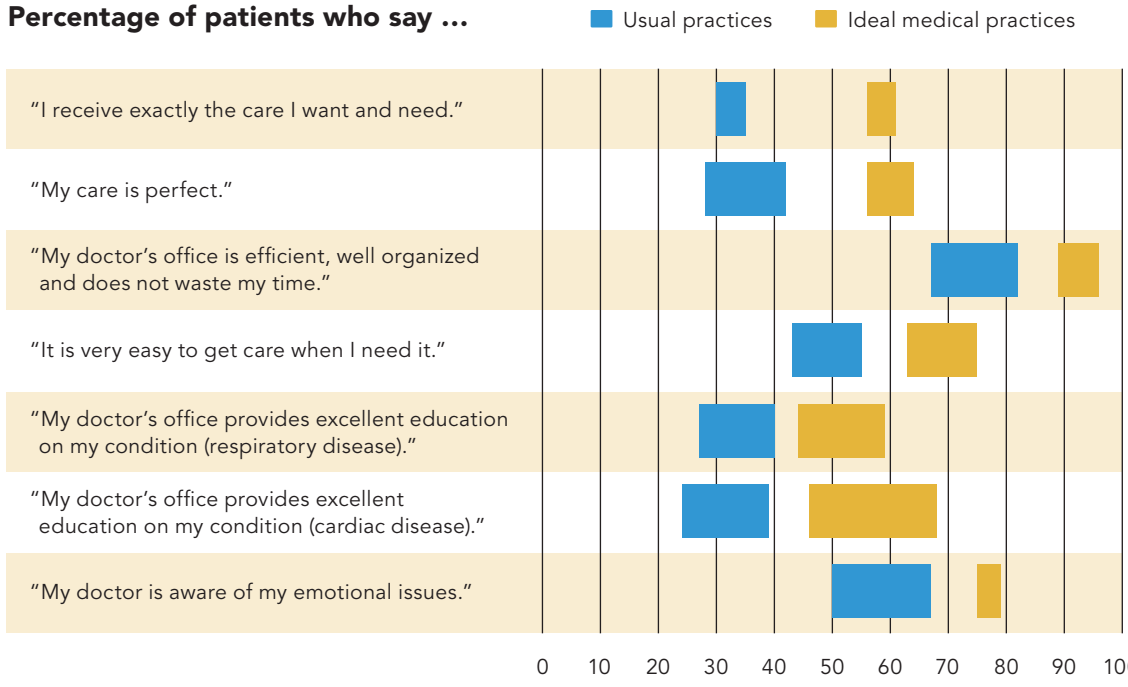
REVENUE PER MONTH	$17,829
Patients per day	11
Days per week	4.6
Weeks per month	4.05 (48.6 per year)
Average reimbursement per visit	$87
EXPENSES PER MONTH	**$7,562**
Employee	$2,160
Malpractice	$797
Rent	$1,547
Loans	$534
Telecommunication	$286
Medical supplies	$358
Dues/fees	$126
Billing	$297
Office supplies	$124
CME	$166
Office software	$148
Business insurance	$130
Accountant/legal services	$103
Marketing	$80
Computer technical support	$172
Computer hardware	$90
Personal/family insurance	$238
Disability/life insurance	$98
Auto insurance	$83
Other insurance	$25
NET REVENUE PER MONTH	**$10,267 ($123,204 per year)**

When reviewing the financial data for these 12 micro practices, it is important to acknowledge that although the model is financially sustainable for many, it is challenging in certain environments because of immense variation in payers' payment rates and policies, malpractice rates and cost of living. For example, average local payment for a 99214 visit can range from as little as $62 in one region of the United States to more than $140 in another. Similarly, a doctor in Eugene, Ore., may pay $1,000 per year for malpractice insurance while another in Chicago may pay $35,000 (neither including OB or special procedures).

The financial picture of these practices is further complicated by the fact that the majority of them have been open fewer than five years and have yet to reach financial maturity.

PATIENT DATA: IMPs VS. USUAL PRACTICES

Looking at patient responses for 50 practices (12 ideal medical practices and 38 "usual care" practices), we have found that patients of ideal medical practices generally report better care. The data shown here are derived from http://www.howsyourhealth.org and reflect the 25th to 75th percentile of responses. Patient reports of their health care experiences are important because they tend to correlate with patients' clinical outcomes.



consequences of "productivity fatigue."

Article one in the series (see page 27) describes one doctor's journey to office efficiency in a low-overhead setting using examples that translate to any practice.

2. Access. In an ideal medical practice, every aspect of the practice is designed around the patient's needs and the primary goal is to enhance the doctor-patient relationship. Unfettered access is a critical component. It requires that practices offer same-day appointments[4] and make themselves readily available to patients by phone or e-mail.

Article two in the series will describe how one practice is improving access by offering e-mail visits – and getting paid for them.

3. Quality. Third parties are attempting to measure the quality of our practices but often use suspicious methodologies or review tiny subsets of our patient populations. A key step in taking control of our practices is taking control of the measurement – that is, measuring ourselves to understand how we are doing and to demonstrate our value to others. Ideal medical practices build quality measurement into all patient interactions using a few key measures that focus not only on "what is the matter" with the patient but also "what matters" to the patient.[2,5] For example, we have found that in current micro practices about 60 percent of patients with chronic illnesses report that they have been helped "a lot" to live with their illnesses; in typical practices only 35 percent report as much help.

Article three in the series will describe how a practice can capture meaningful performance data and use the information to its benefit. ➤

Intense care coordination is a key strategy that ideal medical practices are pursuing.

This article launches a series that will share learnings from practices participating in the project.

4. Care coordination. We know from national use of HowsYourHealth.org (a free online health survey instrument) that about 40 percent of Americans aged 50 to 69 are seeing specialists in addition to their primary care physician. Once a referral is initiated, specialist visits and revisits can take on a life of their own.

To reduce costs, inefficiency and fragmentation of care, ideal medical practices are beginning to aggressively standardize and monitor referrals to and follow-up by other specialists. For example, looking at data for 238 patients aged 50+ from eight practices, we found that almost 30 percent of patients who had completed a referral visit said it was not very helpful, yet the majority continued to receive follow-up care from the referral specialist. These findings suggest that primary care practices need to better manage care for many of their patients, and doing so could save considerable health care dollars.[6] Ideal medical practices have the capacity to take on this important work.

Article four in the series will describe how to improve care coordination for your patient population using strategies such as better front-line support.

Whether you are looking to redesign your current practice or establish a new practice, we hope the lessons and principles gathered from these early ideal medical practices will help equip and inspire you. FPM

Send comments to **fpmedit@aafp.org.**

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