

TriHealth West Chester Medical Group

At-a-Glance



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Location: West Chester, OH

Practice Type: Primary care clinic, part of larger health system

Primary Care Physicians: 4 (2 internists, 2 family physicians)

Approximate Annual Patient Visits: 17,000

Reimbursement Model: Primarily fee-for-service, part of the CMS Comprehensive Primary Care Initiative, which funds the care coordinator

Located in suburban Cincinnati, this practice was established more than 30 years ago by the most senior physician in the group. The practice joined TriHealth's system in 2006, and has retained significant autonomy. West Chester's four physicians are supported by one registered nurse (RN), three medical assistants (MAs), one case manager (who is also an RN) and one care coordinator (who is also an MA).

What Makes the Practice a Provider of America's Most Valuable Care?

The practice has a deep commitment to care continuity and access. The office is open six days a week and sets aside considerable time for same-day appointments. Physicians each have their own panel of patients and take calls for their own patients five days a week. On weekends, one doctor takes calls for the whole practice, using the electronic medical record (EMR) to access patient files and information. By sharing call responsibilities and staying in close contact, physicians care for and know each other's patients well. The structure of the group (both internal medicine and family practice) has enabled the physicians to handle a fairly large number of activities in their offices, thus improving access, convenience and timeliness. They see all age groups—from newborns to complex geriatric patients. In addition, several members of the practice are adept at handling common procedures that might otherwise be referred to specialists. Practice leaders say the combination of access and continuity have reduced emergency department (ED) utilization, increased illness prevention and effectively reduced cost of care practice-wide.

The practice also employs a unique approach to identify and treat the highest-risk five percent of the practice's patients. Risk factors include chronic disease diagnoses, ED visits and/or hospitalizations within the last year, as well as physician judgment about the patient. High-risk patients are offered a care management program that includes educational materials and classes, same-day appointments and, when necessary, references to outside agencies that can provide additional health and social support. The program, which is directed by the case manager, has improved clinical outcomes and reduced total cost of care.

How Do They Do It?

The practice has developed a comprehensive set of symptom-based protocols for use by both front desk and back office staff. The front desk is staffed by MAs, which means they're well-qualified to employ protocols to rapidly assess and triage a wide variety of patient issues. The staff has also been trained to gather as much information as possible from patients when they call to help strengthen physician follow-up. The senior physician has a large patient panel, but works very closely with a dedicated RN. She takes a more detailed history and does a brief physical examination, which she enters into the patient record. She also is able to handle a broader range of telephone calls and patient care requests. The result is that the physician spends less time in completing the chart and more time addressing patient care needs, enabling him to see 22–25 patients a day despite the age and complexity of his panel. The practice functions efficiently in just 4,000 square feet of office space, which keeps real estate costs low, and enables greater spending on support staff.

Finally, the practice has autonomy, but is well-integrated within the TriHealth system. The practice is responsible for its on-site

economics, including physician compensation and staffing levels. Quality measurement and use of the EMR as a disease registry are supported centrally and there is an emphasis on keeping referrals in the system, with an EMR-based flag to help drive specialist choice. There is a team of inpatient nurse navigators to coordinate both inpatient care, as well as the first 30 days after discharge from the hospital. After this, they hand off to the care manager in the practice. They are assisted by the information system, which alerts the care manager when a patient is seen in the ED or is hospitalized.

Q&A:

Kevin Bundy, MD, answers questions about the model for providing high-quality care and keeping costs low.

Q: How does your risk-stratification system improve patient care while reducing costs?

A: “We initially stratify patients based on diagnosis, correlated with the number of ED visits and hospital admissions. Physicians then have the opportunity to adjust risk up or down, depending on their personal opinions and assessments of the patient. The patient is then assigned to a provider depending on his or her risk level. The better we’re able to give patients the exact care they need, the more we can reduce and prevent visits to the hospital, which ultimately improves outcomes with the added benefit of bringing down costs too.”

Q: How has your practice been able to remain culturally distinct despite becoming part of a larger system?

A: “We’re lucky in that a corporate goal of TriHealth is to keep its primary care offices looking and feeling like small practices that are reflective of the community in which they are located. The physician who founded the practice more than 30 years ago is still with us and has been a continuous, unifying force throughout name and corporate changes. For many people in this community, we are still known as ‘Dr. Drohan’s office.’”

Q: You have many measures in place to stay close to your patients’ care if they are referred out to a specialist or are admitted to the hospital. Are there challenges in providing this level of care?

A: “Medicine isn’t necessarily known for always communicating well between channels, and communication gaps can be very detrimental to patient care. We see information gaps most frequently after a hospital admission, so we work extremely hard to prevent this. When a patient is admitted within our health system, care is seamless. We share a computer system, and care coordinators on both ends communicate about the patients and their discharge needs. When a patient is admitted outside our system, it’s much harder, but our care coordinators have worked hard to establish contacts within those hospitals so we can better coordinate care.”

Q: In your opinion, why is your practice successful?

A: “Our founding physician sets the tone and continues to foster our commitment to quality and providing exemplary care to our patients. For a 30-year-old practice, we’re uniquely resilient about change and willingly adapt when needed. If something isn’t working, we’re good about sitting down to discuss the problem and come up with a better solution. I think that defines us.”

Features Highlighted:

- Always on
- Moderately adjustable care intensity
- Responsible in-sourcing
- Adherence to quality guidelines
- Investment in people, not space and equipment



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