



How does population health work? With a team.

By Lia Novotny and David Levine | November 14, 2016

Many healthcare organizations are eyeing the shift to outcomes-based care. Cambridge Health Alliance's Union Square Family Health has already done it, using a team-based structure that involves physicians, nurses, case managers, educators, social workers, translators, and the front desk staff.

What makes it work is a cultural understanding, says Kirsten Meisinger, M.D., a medical director at CHA Union Square. At the community health center in Somerville, Mass., no one team member is more important than any other to a patient's care.

athenaInsight spoke to Meisinger, who co-chairs CMS's Transforming Clinical Practice Initiative, about how Cambridge Health Alliance has been able to create better quality outcomes, reduce costs, and prevent physicians and staff from burning out – all while practicing real population health management.

Q What led CHA Union Square to transform its practice, long before the Affordable Care Act?

A We had less to lose, actually. We were working in a broken system with poor resourcing. We had the motivation to change before the rest of the medical system because we were so resource

poor, which is actually a gift. Necessity is the mother of invention.

Q How does a team-based model of family medicine work?

A You have to have a strong structure in place. We have team meetings for 30 minutes every week. Each meeting addresses a different health topic. We have the team managing registries, which is the mechanism of integrating population management into primary care and other clinical environments. We sit as a group and discuss the cases and what we need to do next, and because the bulk of the work has been done ahead of time by staff and organized for us by the quality lead, it's very fast.

Q The team includes medical and non-medical staff?

A Right. Even before you do medical home transformation, your staff are giving patients advice all the time. We do a lot of training with them. If they hear a red flag – chest pain, suicidality, violence – those are the scary things, but there are much subtler things, baby with

a fever — they know that that is an immediate clinical situation, and they need to get to the nurse right away. We've empowered them to figure it out.

Q Can you give an example of how this plays out in practice?

A Nydia is this absolutely wonderful receptionist we have. She is one of those people that you can just sit with and feel calmer. And she has this therapy session with this patient when he comes in. He would happily spend an hour just sitting at her desk telling her everything if he could. She has a relationship with him. And Nydia gets to share everything she learned with the team, and the patient knows that that's part of the care. We want our team to know it's your relationship with the patient. Let us know how we can support you with that.

Q What do you do if a team is not coalescing?

A It doesn't take very long to realize that it's not working and you have a disconnect between your providers and your staff. We just switched team members around because a medical assistant was not working optimally with her provider — and the change was initiated by the medical assistant. One of the most important things about the transformed practice is the recognition that your staff are just as important in providing good care to your patients as the doctor is, and that, in fact, without them you can't get your job done.

We have flattened the hierarchy as much as we can within what the American medical system will let us do. My preference would be to not have any hierarchy, but that's not possible structurally. So we've tried to make it as flat as possible.

Q Are you achieving a better work/life balance now?

A Yes. I see my children at night now. I mean, it's so sad, but that's really what I'm saying. Now, 20 or 30 minutes after I see my last patient, my notes are closed. My in-basket is empty. I can let go of the clinical work. The emotional stuff I carry, right, because we all do. We have this incredibly deep relationship with patients and their heart-rending stories. But the mechanics [allow me] to finish the work at the end of the day and go home and start the next day without a backlog of work.

Q When you think about the future of the medical system, what keeps you up at night?

A I worry that the significant gains we've made in the American medical system, the lessons that we've learned through these practice transformation efforts in the past 10 years, are not going to get universally adopted. And I worry that the work is going to stall because the ACA goes away or some other big, cataclysmic change happens. If we have to go back to an unsupported place, I will be very, very sad.

Q What advice do you have for organizations transitioning to outcomes-based care?

A I didn't think I was going to be successful until I got to this place of joy where I can then say, "I am actually much happier now." You're going to be fine. Close your eyes, hold your nose and jump into the water, because you're not going to drown. You're going to swim. We weren't sure that we were going to swim, but we did!

*David Levine is a writer based in Albany, N.Y.
This interview has been edited and condensed.*



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