

## NEW PERSPECTIVES

## Implementing a Results-only Work Environment in a Patient-centered Medical Home

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In efforts to reduce health care costs and improve quality, there has been a growing push to deliver care in more innovative ways, including through the patient-centered medical home (PCMH) concept as well as more novel initiatives, such as the results-only work environment (ROWE).

The PCMH concept incorporates several core features, including providing care that is team based, patient centered, and coordinated across the health care system and patients' communities. This model has demonstrated some promising results in both civilian and US military medical practices.<sup>1-4</sup>

The Walter Reed National Military Medical Center (WRNMMC) in Bethesda, MD, began to implement the PCMH concept in its internal medicine clinic in 2008. A recent evaluation of the WRNMMC PCMH showed positive results, with an 11% and 7% cost reduction among patients with chronic and without chronic medical conditions, respectively, and increased patient satisfaction with overall care within the PCMH.<sup>4</sup>

WRNMMC initiated a pilot of the ROWE concept within a single team in its internal medicine PCMH starting in 2011. In a ROWE environment, employee performance is judged based on results produced, not hours worked. Autonomy is essential. Teams work more effectively because members cross-train more to ensure coverage of key functions. The ROWE model began

at Best Buy, a consumer electronics store, in 2003,<sup>5</sup> and several recent studies have revealed positive aspects of the ROWE model, including decreased employee turnover<sup>6</sup> and positive changes in health behaviors, such as getting an extra hour of sleep on work nights.<sup>7</sup> The ROWE concept offers a unique opportunity to help reduce physician burnout<sup>8</sup> and improve satisfaction by giving staff more flexibility over their work schedules while maintaining access, continuity, satisfaction, and high-quality patient care.

The clinic leadership gave the team the autonomy to implement ROWE in the manner that best worked for the team. There were two primary ROWE-specific changes that precipitated other changes for the team at WRNMMC. First, providers were given the opportunity to telework from home one day per week and did not have a minimum number of appointments for other clinic days. Second, the team was given more control over its own appointment schedule for patients. (Vice is a centralized scheduling system for all appointments.)

The providers had a set telework schedule that they followed, which was coordinated and adjusted as needed by registered nurses. When providers were teleworking, they could focus on disease prevention by using a clinical database to query and call patients who required age-appropriate cancer screenings. Providers also used the database to identify patients with chronic condi-

tions who were not at established goals, such as hemoglobin A1c levels for diabetes mellitus type 2. Providers could then offer phone counseling, referrals, and laboratory tests as needed. They could also conduct more telephone consults and respond to secure e-mail messages from patients, which gave patients alternatives to the standard in-office visit for communicating with their providers.

Since the team had more control over its own schedule (vice centralized scheduling), it could determine which appointments were most appropriate for in-person visits and which could be handled by phone or secure e-mail message. By eliminating unnecessary office visits, the team had more availability to see patients for same-day appointments and more time to work on population health.

In order to begin to understand the impact of ROWE, we used a difference-in-difference approach that allowed us to compare changes in the ROWE team before (January 2010 through January 2011) and after (September 2011 through May 2012) implementation minus changes in the other non-ROWE teams over the same time period. We examined the overall impact for all patients and the impact for patients with and without chronic conditions. The data source for this assessment was the Military Health System Management Analysis and Reporting Tool (M2).

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During this time period, there were approximately 3,500 patients enrolled to ROWE team providers (intervention group) and 36,000 patients enrolled to non-ROWE team providers (comparison group). To account for demographic differences between the groups, we statistically controlled for characteristics such as age, gender, and whether or not the patients had chronic conditions.

Overall, controlling for trends among the non-ROWE teams, we found that implementation of ROWE was associated with reduced utilization and costs for its patients. These changes were largely among patients with chronic conditions. Patients without chronic conditions saw increases in most utilization and cost metrics, which may have been due to increased referrals for preventive screening tests. For example, among the overall ROWE team patients, after the implementation of ROWE, we found reductions in emergency room and urgent care clinic visits (ER/UCC) (-9.4%), pharmacy (-21.4%), ancillary costs (-7%), and per-person per-month costs (-4.5% or -\$43). The only overall increase was for specialty care encounters (5.5%).

Among patients with chronic conditions, there were even greater decreases in most utilization and cost measures than what we saw in the overall population. For example, we found a 6% decrease in costs per-person per-month (-\$77) and an 11% decrease in specialty care encounters. Among patients without chronic conditions, we saw increases in some utilization and cost measures, including a 51.3% increase in specialty care encounters and a 40.9% increase in per-person per-month costs (\$185). However, we found a 16.3% decrease in ER/UCC.

Given that one of the hallmarks of ROWE is increased flexibility in

work hours and location, we examined the use of telephone consults (TCONs) and provider continuity. We found that there was an increase in TCON use in the overall population (12.2%), among patients with chronic conditions (8.5%), and among patients without chronic conditions (23.5%). These increases were driven by an increase in the number of users rather than an increase in the amount of use for existing users. For provider continuity, we found a decrease among the overall population (-16.6%) as well as among patients with chronic conditions (-20.4%) and patients without chronic conditions (-15.7%). Since team members may fill in for providers on telework days, future research should assess team continuity as well.

In a rapidly changing health care system, the ROWE concept offers an innovative approach to the delivery of care. Our preliminary study showed that ROWE reduced utilization and costs, particularly among patients with chronic medical conditions. Given that ROWE is an extremely novel concept in health care, these findings are promising. In the era of primary care burnout and dissatisfaction, ROWE may be a good model to help improve provider satisfaction and allow providers more flexibility in their work schedule with the goal of better work-life balance. With increased flexibility, providers may be able to focus more on improving patient outcomes. In addition, the ROWE concept and its flexibility are not limited to providers; they can also be applied to other staff in health care settings, and each setting can adapt the concept to its environment. Future research should also continue to examine the effect of ROWE on staff and patient satisfaction as well as patient health outcomes.

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