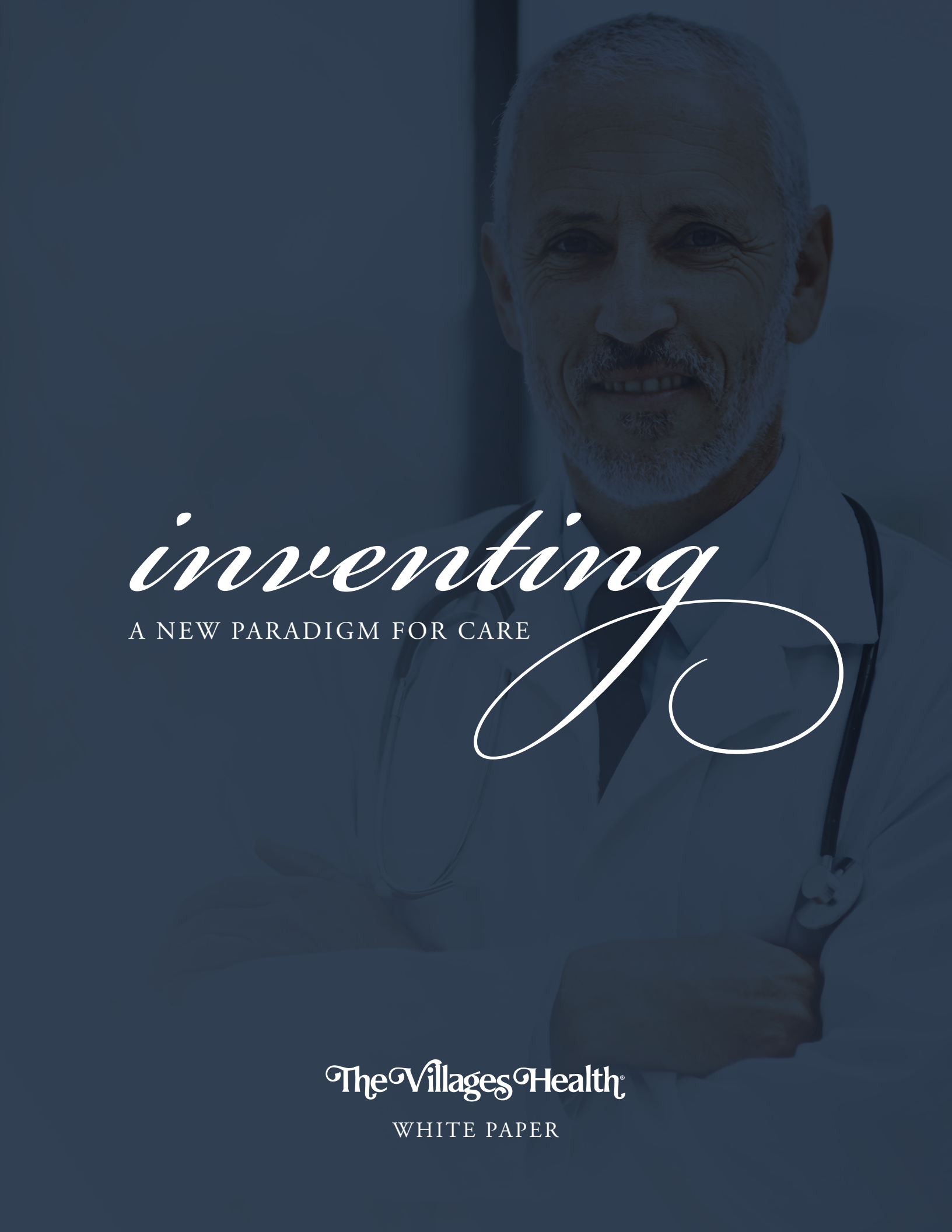

inventing

A NEW PARADIGM FOR CARE

The Villages Health®

WHITE PAPER

BACKGROUND

Health Care in the U.S. is complex, contradictory, and frequently exasperating to patient and provider alike. On the one hand, there is excellence, such that many travel from distant lands to undergo treatment within our hospitals and treatment centers (Ehrback, Ceani & Mango, 2008).

On the other hand, we expend more financial resources on health care than any other people on the globe, only to find our clinical outcomes and overall health status to be far inferior to many systems which expend less (Squires, D. A., 2012). In recent decades, as the biologic revolution has fueled greater knowledge and medical specialties have evolved, sometimes becoming silos unto themselves, the import and attraction of the traditional doctor-patient relationship has declined (Dugdale, Epstein & Pantilat, 2001). Increasingly fewer physicians have been attracted to primary care (Geyman, 2011). Meanwhile, the business aspect of health care has placed its top priority on technology, and given the predominant fee-for-service payment model, on volume. The result, then, presents no surprises: a health care "system" (note well the quotation marks) characterized by voluminous and liberal application of technical services—both diagnostic and therapeutic (in many cases "technology for technology's sake") often independent of any measurable improvement in clinical outcome (Relman, 1980).

Diagrams, clinical programs, and federal initiatives all seem to revolve around where the money goes, with hospitals and academic health systems at the epicenter, surrounded by burgeoning surgery centers, imaging centers, and the like. The "system" is provider-centered (Relman, 1980). Less real attention is paid to the formal, meaningful assessment of quality or value or patient-satisfaction. Patients report feeling like the objects of the "system" rather than the reason for it.

The upshot is that health care as it is currently delivered in the U.S. is felt by many to be characterized as lacking intelligent design. It too often lacks real integration. It is confusing to its users and even to its providers. It is expensive. The relationship between payor and provider is typically deeply dysfunctional. It is provider-driven, delivering high volumes of high tech, and low volumes of high touch (Lesniak, 2005). And its ultimate "work-product" is disappointing both in terms of clinical outcomes and patient-satisfaction.

THE VISION

The Villages® is a phenomenon, becoming the largest over 55 community by far in the U.S. in only 30 years. In a league of its own, The Villages has taken the concept of a "planned community" to a level never before seen—anywhere. Yet, The Villages has suffered what our nation suffers: an unhealthy health care "system," in which patients consistently express considerable dissatisfaction with everything from care-access to care-quality.

Thankfully, a new vision for a health care system has been brought forth. Those who reside within and near The Villages can now enjoy both a world-class model of a planned community, and a novel and profoundly superior health care system, as noteworthy and exemplary as the community itself. America's Friendliest Hometown® is becoming America's Healthiest Hometown®.

The Villages Health replaces the current paradigm with one that is delightfully simple. It is Patient-Centered, where the components revolve around the patient's experience. It is Community-Based, where the great majority of health care services are rendered close to home. It is Primary Care-Driven, in which each patient has a relationship with a primary care physician and receives care delivered by a team led directly by that physician based in a Medical Home model. It is Academically-Illuminated in the sense that the care rendered enjoys the benefit of modern science and ongoing learning through a formal relationship with a research university. It is Innovative, routinely implementing fresh ideas and methods—a process which has so consistently characterized the culture behind The Villages' success. It is Integrated, in which the primary elements of a comprehensive system are intelligently connected. And it is predicated upon Value in which both quality and cost remain the clear and unabashed focus of attention in the delivery of care. In this respect, new and innovative technology is embraced to the extent that it supports the creation of greater value to the patients who are served.

PRIMARY CARE

The focus of this document is the primary care component of The Villages Health System. While The Villages Health necessarily involves numerous elements and components, the most prominent, most pervasive and most visible incarnation of this new paradigm is the introduction of a group of primary care physicians based in accredited PCMH's, comprising a primary care network in which residents—if they so choose—have access to a care center within ten minutes by golf cart from where they live. Care by medical specialists other than primary care may involve travel to where such care is clustered along with the supportive diagnostic and therapeutic technologies and facilities that they employ. But a patient's care center is expected to be literally near one's home where the majority of health care the population requires is provided.

Today seven such facilities operate (six within The Villages), each featuring five to eight primary care physicians (and associated professionals). Each is formally recognized as a Level 3 "Patient Centered Medical Home" by the NCQA.

The service delivered through the primary care component of The Villages Health embraces the six domains of care as articulated by the Institute of Medicine: Patient-Centered, Safe, Effective, Timely, Efficient, and Equitable (Institute of Medicine, 2001). For purposes of the present state, several key themes are described so as to sketch something of a "profile" of what is being delivered by the primary care component of the system. What follows is by no means a comprehensive treatise of the primary care component of The Villages Health as much as a collection of highlights intended to represent the whole. In other words, there is more.

PORTAL OF ENTRY

When care is needed, one starts with one's primary care center, even if the services required do not fall within the realm of primary care. The initial, intake visit for one hour is with the chosen primary care physician. Subsequently, it depends on the patient's needs. A patient who suspects that it is time to undergo a knee replacement does not have to rely on billboards, yellow-pages or anecdotal stories by acquaintances to choose a course of action. Each patient should think of his or her primary care center as the first call to make, no matter what the topic or concern. Whether it be routine preventive care (such as a flu shot in the Fall) or the obvious need for surgery for an enlarging hernia, access into the health care system generally is through the "front door." Indeed, if appropriate or if a patient prefers, a call to the primary care office may result first in a conversation or appointment with a member of the team other than the physician, such as a nurse or health-coach working under direct supervision of the physician.

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ADVOCACY

Related to the above concept is the role of advocacy. Even a well-designed health care system can seem overwhelming and even frightening to many patients. The primary care provider, then, is intended to function as the friendly, familiar face who might lift the allegorical lantern and say "I know just where we to go with this. Come with me and I'll get you where we need to be." Less allegorically, then, that role might translate into preceding any referral to another specialist with written and/or personal communication summarizing the work-up performed to date, background clinical information, relevant personal information, and a defined question being put to the consultant—something many providers of specialty care desperately wish would occur more regularly by referring physicians.

COORDINATION AND THE EHR

A coordinating role is also essential when numerous other providers of care are concurrently required (Kaufer, 2000). Key to this role and to the others specified above is the existence of a single information system that ties together all the members of the team serving patients in each of the care centers, as well as to and from the Specialty Center, and finally to either the local community hospital or to the tertiary care center. This IT infrastructure (in the form of an electronic health record) is deployed and operational in all care centers.

EMPOWERMENT

A Primary Care provider in one of The Villages care centers might be heard to say the following about the care rendered. The statement may beget a double-take initially, but should eventually make complete sense: "We do not treat diabetes here. We do not treat high cholesterol. We do not treat heart failure. Or emphysema. Or gout. [pause for effect] Our patients do. We show them how."

> *We do not treat diabetes here. We do not treat high cholesterol. We do not treat heart failure. Or emphysema. Or gout. Our patients do. We show them how.*

In other words, if there is a pole-vault athlete and a coach, it does no one any good for the coach to throw the athlete over the bar at practice day after day. The primary care physicians play a teaching role, convincing patients of the absolute importance of gaining control of a given disease, explaining how this can be done, and putting the whole process within the patient's reach. Compliance levels within such a model are found to be orders of magnitude greater than in more paternalistic systems, with accompanying superior clinical outcomes. For those patients who are in good health and without chronic conditions, the empowerment focus is on primary prevention, health promotion, and the maintenance of wellness (Menon, 2001).

SHARED DECISION-MAKING

Patients want to understand the medical issues affecting them (Adams & Drake, 2006). Rather than having a medical assistant hand them a prescription written by a physician who scampered away after only a few moments in the patient's company, patients prefer to have things explained fully. What are the other diagnostic possibilities in need of ruling-in or out? What diagnostic or therapeutic alternatives exist? What are the key pros and cons of those alternatives? What are the costs? Of course, there will be patients (becoming rarer and rarer) who prefer to simply hand over the keys and say, "Doc, just tell me what to do. I trust you. No need to walk me through it all." Most

patients prefer to function as active participants in their health care decision-making, and the teams functioning in The Villages Health care centers embrace this approach in all they do. To the extent desired by a patient, family is invited into the medical decision-making process (Teno, Casey, Welch, Edgman-Levitan, 2001).

ZILLION-STOP SHOP

Patients are routinely delighted to discover a physician both expertly capable and willing to treat most of the patient's health care needs. In the care center, a patient is able to undergo routine cervical cancer screening, yet also go to that same provider about carpal tunnel syndrome, osteoarthritis, migraine headaches, depression, or to discuss menopausal symptoms or asthma. While conceivable, addressing all such items in a single visit could perhaps be attempted, but is usually logistically quite unworkable, and both patient and provider likely become overwhelmed. So the phrase "one-stop-shop" would emphatically not apply to the care center. A very broad range of health matters are able to be expertly managed through the care center (with specialist referral whenever patient and physician agree it is appropriate). The point is that the "service line" available through the care center is as broad as it is expert, such that the great majority of the most common health care services may be accessed again and again at a local facility by patients seeing providers with whom there is mutual familiarity.

ACCESS

The Primary Care component of The Villages Health system sets a new standard in access to care. Access to quality health care has been shown to impact quality of life, life expectancy, and prevention of disease and disability (U.S. Department of Health and Human Services, 2010). Whether it is same-day urgent care, extended routine hours (mornings and evenings), weekend hours, after-hours telephone availability, or even the opportunity for patients to communicate electronically about anything from appointment management to clinical concerns, the care center and the care rendered therein is known for its accessibility. Access is such a key element of the care center that a bold goal of The Villages Health from the start is to render the "urgent care center" obsolete, and to revolutionize the status quo in local hospital Emergency Departments such that the clinical material addressed in that setting, becomes almost exclusively, emergencies.

POPULATION HEALTH MANAGEMENT

While there may be any number of ways to approach a given disease state or medical condition, there is usually a best way. More and more, certain well-studied approaches to the care of specific conditions are emerging as clearly the most appropriate or effective (Kitson, A., Harvey, G., & McCormack, B., 1998). If it is appropriate to manage a given diabetic patient according to a specific evidence-based guideline or plan, then it is probably appropriate to manage all diabetics

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according to that same plan ("population health management") achieving optimal outcomes with minimized variability from the standards of care. The providers of Primary Care at The Villages Health implement Evidence-Based guidelines in employing population health management. Similarly, active awareness of ongoing Comparative Effectiveness Research is maintained with plans to routinely implement whatever modifications to existing care protocols appear appropriate, such that patients enjoy the benefit of such knowledge.

SCIENCE OF PREVENTION AND LIFESTYLE MODIFICATION

While the idea that it is better to prevent health problems than to treat them is simple, preventive health care is surprisingly complex. Some preventive measures can themselves cause harm. Still others are so expensive or so unpleasant that their value is questionable, particularly when applied to patients for whom risk of the target condition is low. Preventive services have traditionally been provided indiscriminately, driven by the unsophisticated or naive belief that if preventive services are, by definition, good, then the more the better. Such is certainly not the case. What's more, personal ideology or preference plays a prominent role in how aggressively or conservatively one may wish to utilize certain preventive services. It is not the case that one-size-fits-all. The care centers host the incarnation of the science of prevention, including primary, secondary, and tertiary prevention (Smith, T., Jenkins, C., & Orleans, C., 2004). The providers enthusiastically strive to help individual patients implement preventive strategies appropriate for them.

Without question, the most underutilized interventions in the treatment of the most common medical conditions fall within the category of therapeutic lifestyle change (TLC). Overwhelming evidence indicates that the first steps in the management of the most prevalent and burdensome medical conditions do not directly involve the provider, but the patient, the two most dominant being cardiovascular fitness activity and consumptive selection (exercise and diet), in that order. Whether treating chronic fatigue, high

blood pressure, high cholesterol, diabetes, obesity, depression, insomnia (the list is virtually endless), the first and often most effective treatment is the participation in regular, prudent physical activity (Pate R.R., Pratt M.P., Blair S.N., et al, 1995).

One of the elements which makes The Villages Health revolutionary is the fact that the promotion and support of a vigorous, active lifestyle has been so central to the culture created and nurtured in The Villages.

Traditionally, a chasm has existed between health care provider and, ironically, the implementation of the first step in care, due primarily to the fact that such implementation does not directly involve the provider other than in the role of recommending participation in such activity. One of the elements which makes The Villages Health revolutionary is the fact that the promotion and support of a vigorous, active lifestyle has been so central to the culture created and nurtured in The Villages. It is only natural that The Villages Health engineers a direct connection between its health care providers and the participation in such a lifestyle.

INTEGRATION WITH HOSPITAL CARE AND COLLEAGUES IN OTHER MEDICAL SPECIALTIES

There is a somewhat disconcerting trend in which many primary care physicians are choosing to forgo any involvement whatsoever in the care their patients receive while hospitalized (Lakhan & Laird, 2009). Indeed, many of the physicians who choose to practice within the care center environment in The Villages choose to restrict their care to the outpatient setting. They are welcome. However, a core contingent of physicians within The Villages Health remain actively involved in inpatient care such that when patients who routinely receive their outpatient care from The Villages Health do eventually require hospitalization, they will be cared for, at least in part, by physicians who practice in the care center network in addition to "hospitalists" who are involved in outpatient care and principally engaged in the hospital setting. Similarly, efforts are invested in maintaining relationships with specialist colleagues, including regular personal contact with those specialists as featured guests at the care centers addressing current issues, case presentations, and seeing selected patients together.

CONTINUOUS QUALITY MANAGEMENT

In addition to the medical conditions under the direct management of the teams within the care centers, an equally essential focus of management is management itself. That is, an explicit strategy of data collection operates whereby the care centers continuously monitor the effectiveness of their activities and initiatives, making strategic adjustments based upon those data in a process of continuous quality improvement, a hallmark of any excellent learning organization (Gaynes, et al, 2001).

A COMMUNITY OF LIFETIME LEARNERS

It is envisioned that a culture can be maintained in which all members of the care team are continuously and actively learning. Advantage is taken of the university affiliation so that trainees – primarily medical students and nursing students – have opportunities to participate in the care centers (Ogrinc, Headrick, Mutha, Coleman, O'Donnell, & Miles, 2003). The emphasis and

systematic support of primary care in The Villages Health may catalyze renewed interest in choosing a primary care career for physicians and other health professionals (Cardarelli, R., 2009).

COST-CONTROL

The Villages Health system is structured around the patient experience. The elements described exist in support of this purpose. A convenient and concurrent result is the expected favorable impact upon health care costs. In the status quo, when resources are focused on heroic technical intervention (such as surgical repair of a broken hip), providers capable of preventing hip fracture in the first place languish without the necessary resources.

The initiatives of The Villages Health, taken in their totality, are expected to reduce health care expenditures. From the formal systematic application of evidence-based guidelines in population health management by a large and organized physician workforce, to more effective implementation of preventive services, to same day access—all of this may have a profound impact on medical costs (American College of Physicians, 2008). Hospital admissions and readmissions may be obviated while lengths of stay may be shortened. Inappropriate care will be decreased, particularly unnecessary and repetitive diagnostic testing. Recurrent and costly visits to the hospital emergency department will be avoided. It is expected that patient engagement with the process and resulting compliance levels will become transformative.

It is the intent that a portion of these savings will be reinvested in reimbursing the primary care services which create such savings in the first place, correcting current financial inequities in reimbursement, which have had such a negative impact on the primary care workforce (Cardarelli, 2009).

PRIMARY CARE DONE RIGHT

The primary care component of The Villages Health system represents a transformed delivery model where patients feel that they get the service and the time they desire from their physicians. Similarly, physicians have the time, tools, and support necessary to serve their patients in a manner they find fulfilling and enjoyable. This represents a departure from the typical scenario of the status quo in which primary care physicians consistently report frustration at inadequate time resources, unmanageable panel size (Oelke et al., 2006), and feeling more like traffic managers, gate-keepers, or triage officers than the caring providers they hoped they could be.

THE PROGRAM

Key programmatic activities have been referred to in the immediately preceding section. An abbreviated description of the sorts of activities that are happening within the care centers follows.

THERE'S NO PLACE LIKE HOME.

Within the confines of The Villages, there are six freestanding facilities of approximately 20,000 square feet supporting the delivery of medical care characterized above. The first site located at the Colony shopping area, opened in December 2012, followed soon thereafter by new care centers at Mulberry, Pinellas, Spanish Springs, Creekside, Brownwood and Lake Deaton. It is also likely that care actually rendered in the patient's home (as appropriate) will become a significant aspect of overall care delivery as well.

MARCUS WELBY, MD LIVES. HIS NURSE, HOWEVER, HAS BECOME AN ENTIRE CAST.

The central programmatic element remains the personal encounter between patient and physician, but the spaces and activities around that encounter represent a substantial evolution away from current, typical, physician office experience. Care delivery within the care center is a team process (Kellerman & Kirk, 2007). While there have always been nurses, medical assistants, lab techs, transcriptionists, physician assistants, and nurse practitioners, the team of caregivers is more robust with each team member by design, functioning at the highest level of training (and/or license). Group Health in Seattle and the Indian Health Service, both embracing the patient-centered medical home model, reported increased quality of care, increased patient satisfaction and cost reduction as a result of building collaborative capacity through teamwork (Miller & Cohen-Katz, 2010).

APPROPRIATE APPLICATION OF MEDICAL TECHNOLOGY

Sophisticated and uncommonly required diagnostic services are not expected to be delivered in the care center, although chest and bone plain films and a range of more common ancillary interventions (ECG, basic pulmonary function testing, audiology, etc.) are conveniently available without requiring the patient to travel elsewhere. Limited-menu lab testing is performed on site, but the specimens, which are sent elsewhere, are still collected at the care center. Similarly, emerging personal medical technologies supporting "tele-health" and other methods of patients contributing to and participating in the gathering of medical information is anticipated shortly.

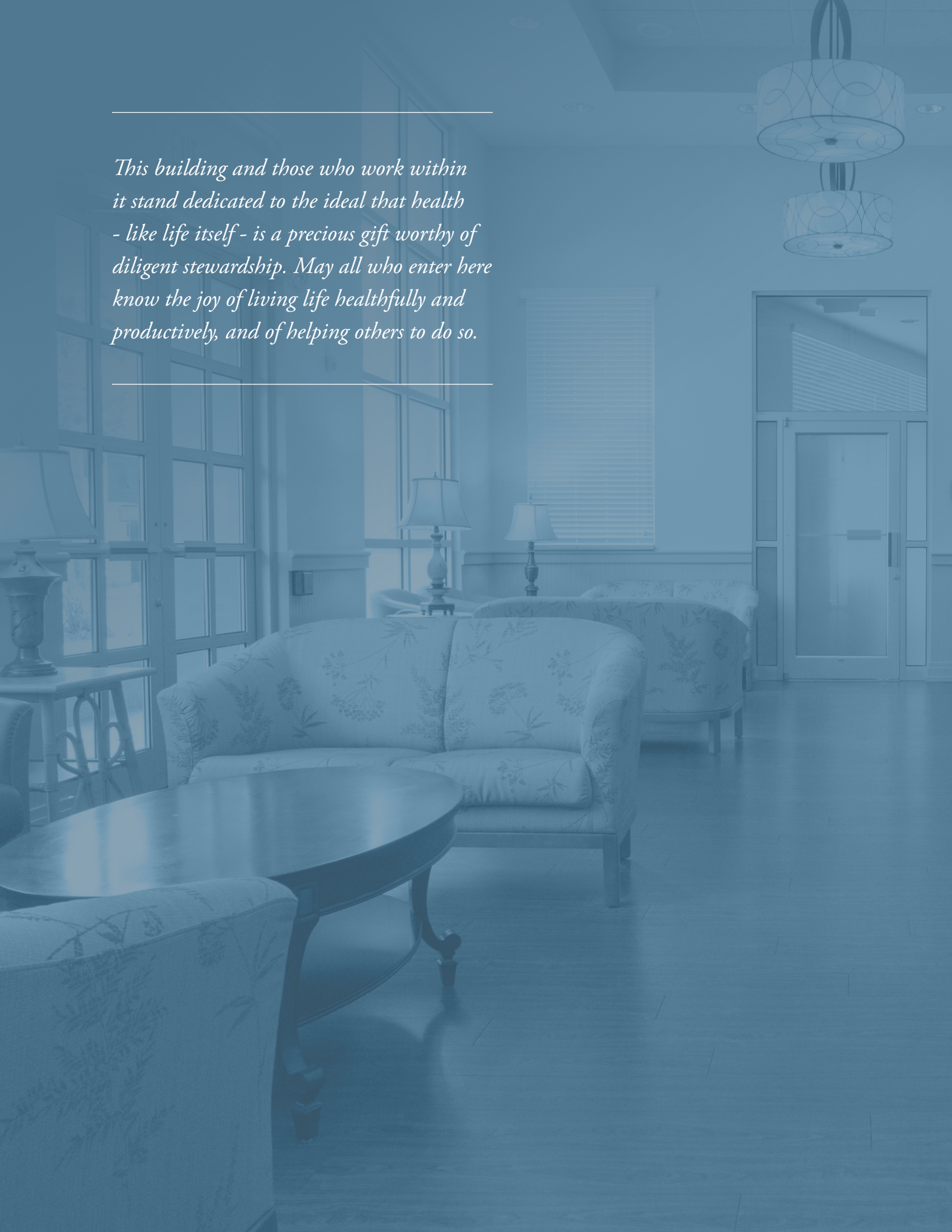
CONTINUOUS LEARNING AND TEACHING

The care center is a place of both teaching and learning at all levels for patients and staff. Medical and nursing students are currently involved in the process. Other academic programs could be represented such that nursing and team-members-in-training could gain clinical experience under direct supervision. To accommodate this function, each care center features a learning center.

STRETCHING THE ENVELOPE

There is often considerable resistance on the part of patients when referral to a behavioral science professional becomes necessary. The sheer idea of walking into the office of a mental health professional is profoundly stigmatizing to some—often to those who are most in need of such care

(Bathje & Pryor, 2011). The opportunity to receive counseling services or related care at the very place where the patient routinely goes regarding blood pressure or bronchitis can be a delightful relief, enabling many to take advantage of such care who might otherwise have declined. As such, providers of care that stretch beyond the traditional realm of primary care have a place within the care center, certainly involving mental health providers, but also involving dietary counseling, audiology and other services needed by large numbers of patients visiting the care center and that can effectively and efficiently be delivered there.



This building and those who work within it stand dedicated to the ideal that health - like life itself - is a precious gift worthy of diligent stewardship. May all who enter here know the joy of living life healthfully and productively, and of helping others to do so.

THE PLACE

The care centers of The Villages Health are unique. They are not easily mistaken for any of the other professional spaces currently in use in the community. They look different from the curb. They feel different on the interior. And they function differently, in terms of internal operations.

They have a signature appearance at a distance as identifying and self-declaratory as a Pizza Hut, but which celebrates the tasteful vitality and continuity so consistent throughout The Villages. Their interior is warm, welcoming, open and feels like home. Waiting is brief, but time spent in the lobby and the attached living room is calm and pleasant. The triage process (including obtaining vital signs, weight, etc.) is efficient, respectful, and appropriately private. Way-finding and navigation is intuitive and functional. Flow is predominantly unidirectional such that the stream of patients into the clinical care areas does not oppose the stream of those completing their visit.

While many patients are welcomed in the course of service, at no point does a patient feel as if he or she is one of a crowd being herded.

SOMETHING OLD, SOMETHING NEW

There is a strong resemblance to the traditional outpatient physician office experience in the sense that there is a reception area, examination rooms, procedure rooms, business/clerical activity, and other familiar elements. However, these features are fresh in their implementation. Reception, for example, is open, welcoming, and human, specifically devoid of the frosted-glass window. While there is certainly a "lobby" there is not a "waiting room," as idle time in the patient experience is intended to be minimized.

FIRST IMPRESSIONS

Distinctive branding is recognizable from the street and conveys the ideology that this is a place where patients come first. Not only do patients intuitively understand that they receive the kind of integrated care they need and want, this transpires with actively minimized hassle and confusion. The living room adjacent to the reception area offers multiple seating options. There is natural light and views of outdoors and nature. The focus is on life and wellness rather than illness.

RETHINKING THE EXAM ROOM

Traditionally, the space in which the great majority of outpatient medical care is rendered has been a room dominated by an examination table at its epicenter, often without any other seating option available for the patient. Such unspoken prominence of this medical tradition may exacerbate patient anxiety or anticipation of unpleasant or uncomfortable experiences. Lighting may be glaring, and any actual communication between patient and physician almost seems secondary to the dreaded "exam." In fact, the very name of the space itself reflects this focus: the exam room. Ironically, a complete physical examination is necessary in only a small percentage of office encounters, whereas a fruitful conversation between patient and physician is necessary in virtually every one.

As such, the space in which the patient and physician accomplish their core activities is completely redesigned in the care center of The Villages Health. It is renamed the "Visit Room," and its design reflects a more appropriate set of priorities. While still completely enabling examination of the patient, the focus is on

bidirectional communication, and this is reflected in everything from seating arrangements, to include one or two family members, to furniture selection and lighting. A computer monitor is placed such that physician and patient can easily view it together when necessary. The physician and patient always face each other.

THE HUDDLE ZONE

Present day health care facilities often involve considerable segregation of the providers of care, where nurses might be confined to nursing stations, physicians into physician dictating areas, while still others such as ancillary technicians or schedulers may be relegated to areas far away from those they are charged to support. Written into the DNA of the Patient-Centered Medical Home is meaningful integration of the caregiver team, such that powerful collaboration toward superior collective work-product is enabled.

Toward that end, the care center is designed in such a way that the members of the provider teams are literally (and symbolically) together, physically accessible to each other. Without compromising the need for quiet concentration or personal work-space, effective communication among providers of care is enhanced by proximity among a given team, and even between teams. The routine, then, of literally "huddling up" at the beginning and end of each work session is facilitated in an area termed, obviously enough, the Huddle Zone. This Huddle Zone is transparently nestled into the very epicenter of the Visit Room area as an obvious demonstration to all that patient care is a direct function of highly collaborative, integrated teamwork.

THE LEARNING CENTER

Whether it is an asthmatic patient being shown the most effective technique for using an inhaler, or a set of nurses learning a new feature of the electronic medical record, teaching and learning is a way of life in the patient care center. Reflective of this, space within the facility is dedicated to the process. As such, in addition to what teaching occurs in the Visit Room, a zone within the facility features a cluster of contiguous spaces, collectively referred to as the "Learning Center." This space consists of a Seminar Room, a Health Coach Office, and a Knowledge Pharmacy, each serving to support a specific element of the educational program, summarized below. The Learning Center is accessible directly from the Living Room as well as from the area where the Visit Rooms are located. The components of The Learning Center are described below.

Seminar Room

This section of the Learning Center is versatile, accommodating up to 12 people. It is used for predominantly didactic sessions, such as nutrition classes for a group of diabetic patients, "Welcome to the Practice" orientation sessions for all new patients, or in-service training for a set of medical assistants about the proper use of a new piece of medical equipment.

This Huddle Zone is transparently nestled into the very epicenter of the Visit Room area as an obvious demonstration to all that patient care is a direct function of highly collaborative, integrated teamwork.

Communication and idea-sharing among the staff is essential if continuous improvement is to occur, and to the extent that the design of a facility can impact that process, intense effort has been made to do so.

Health Coach Office

Some patients readily grasp the concept of keeping a "headache diary" in planning migraine management, or a "log of basal body temperature data" in the evaluation of infertility. Recommending such activity, then, by the physician in the Visit Room is quick and mutually effortless. Other patients, however, may require more time or personal attention, even for straightforward material. In those situations, the physician needs someone to whom to pass the baton—to pick up where the physician left off as a direct extension of the physician's intended plan of care.

A tremendous amount of what needs to happen in order for patients to achieve optimal health involves lifestyle modification. Smoking cessation, for example— if it is to be effective/successful —invariably requires close follow-up with the patient, periodic updates, patient-specific advice, encouragement, emotional support, and guidance as to how to navigate common pitfalls or setbacks—the list of such care elements is long.

Physicians (and even their clinical assistants) report that such services represent "a bridge too far"—more than they can reasonably attend to among the myriad other patient needs they strive to meet. The result, at least traditionally, is that patient-compliance with such recommendations is notoriously poor. The upshot is that—in the status quo—patients do not receive as much support, guidance, or assistance in implementing recommended care plans as they require. In order to actually achieve intended clinical outcomes, patients want more help than can be provided in the course of an office visit with the physician. Meanwhile, physicians and their clinical assistants need a resource that can pick up where they leave off at the end of a visit and in the interval between office visits.

In the Patient-Centered Medical Home that resource finally exists: the "Health Coach." The Health Coach Office supports small (one-on-one or one-on-two) sessions, and considerable telephone and electronic contact with patients between visits.

Knowledge Pharmacy

Often, what patients need from the physician more than a prescription for medication is simply education about a condition or answers to common questions (Kiesler & Auerbach, 2006). Quite commonly, the information needed cannot be delivered effectively in the course of a visit in the Visit Room (Bodenheimer, 2006). It may require more time than is workable in that setting. It may involve detail that requires that it be heard/reviewed more than once. It may be best to receive the information in the company of others not present during the appointment (Ballard-Reisch & Letner, 2003). To provide for this reality, the patient care centers feature a "Knowledge Pharmacy." That is, the physician can "prescribe" that a specific item (or items) of educational content be delivered to the patient. This prescription, then, can be "filled" at the Knowledge Pharmacy nearly exactly the same as filling a traditional prescription for a medication, including doing so when it "works" for the patient to do so: literally on the way out of the office following a physician visit, or returning at a more convenient time. A record is maintained

of just what has been prescribed and filled (or not filled) so patient and physician can work together at achieving shared decision-making and the empowerment that results when information is effectively conveyed.

CARING ABOUT THE CAREGIVERS

If the needs of patients are to be met or even exceeded, the needs of those serving their needs need to be met or exceeded (Joseph, 2006; West, et al, 2011). Toward that end, care has been taken to provide the creature comforts of home and to provide for simple human needs such as personal space, storage, a kitchen/lounge, and private outdoor space, as examples. Communication and idea-sharing among the staff is essential if continuous improvement is to occur, and to the extent that the design of a facility can impact that process, intense effort has been made to do so.

As a learning community, accommodations have been provided to enable staff and trainees to assemble for teaching, learning, and discussion in spaces throughout the building. Televideo conferencing is available for access to "distance learning" with a special emphasis on connecting to academic health center faculty whether in Tampa or elsewhere. Shower and changing areas for those who bike or run to work or exercise at lunch is provided. There is even a "Quiet Room" for staff to "get away from it all" for a private moment when the need arises. Those who choose to devote their professional lives to the delivery of excellence in service to patients will sense that their decision to do so is valued as evidenced by enthusiastic effort to provide for the human needs of the team.

AN EFFICIENT HOME IS A SUCCESSFUL HOME

The decisions made in designing the care centers have been driven, first and foremost, by the patient experience. All anticipated interactions or encounters have been deconstructed and reconstructed to ensure that the environment is safe, effective, efficient, equitable, and above all, patient-centered. Rather than drawing attention to itself as a striking structure, the facility functions more as a stage, facilitating and enhancing the service being provided. The priority has been to create a place that feels like what it is: home.

REFERENCES

Adams. J. & Drake, R. (2006). Shared Decision-Making and Evidence-Based Practice. *Community Mental Health Journal*, 42, 87-105.

American College of Physicians. How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? Philadelphia: American College of Physicians; 2008: White Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

Allen, S. (2009). Tobacco smoking in older people. *Reviews in Clinical Gerontology*, 19 (3), 185-192.

Ballard-Reisch, D.S., & Letner, J.A. (2003). Centering families in cancer communication research: acknowledging the impact of support, culture and process on client/provider communication in cancer management. *Patient Education and Counseling*, 50.

Bathje, G.J., & Pryor, J.B. (2011). The Relationships of Public and Self-Stigma to Seeking Mental Health Services. *Journal of Mental Health Counseling*, 33(2), 161-176.

Bedenheimer, T. (2006) Primary Care—Will It Survive? *The New England Journal of Medicine*.

Cardarelli, R. (2009). The primary care workforce: a critical element in mending the fractured US health care system. *Osteopathic Medicine and Primary Care*, 3.

Christoffel, K. (2000). Public health advocacy: process and product. *American Journal of Public Health*: 90, 722-726.

French, M., Homer, J., Klevay, S., Goldman, E., Ellmann, S., & Kahn, B. (2010). Is the United States ready to embrace concierge medicine? *Population Health Management*, 13(4), 177-182.

Gaynes, R., Richards, C. Edwards, J., Emori, G., Horan, T., Alonso-Echanove, J., Fridkin, S., Lawton, R., Peavy, G., Tolson, J. & the National Nosocomial Infections Surveillance (NNIS) System Hospitals (2001). Feeding Back Surveillance Data to Prevent Hospital-Acquired Infections. *Emerging Infectious Diseases*, 296.

Institute of Medicine (2001). Crossing the quality chasm: A new health system for the 21st century. Washington DC: *National Academy Press*.

Joseph, A. (2006). The Impact of Light on Outcomes in Healthcare Settings. *The Center for Health Design*, 2.

Kellerman, R., & Kirk, L. (2007). Principles of the patient-centered medical home. *American Family Physician*, 76(6), 774-775.

Kiesler, D.J., Auerbach, S.M. (2006). Optimal matched of patient preferences for information decision-making and interpersonal behavior: Evidence, models and interventions. *Patient Education and Counseling*, 61.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: a conceptual framework, *Quality in Health Care*, 7, 149-158.

Lakhan S. & Laird C. (2009). Addressing the primary care physician shortage in an evolving medical workforce. *International Archives of Medicine*, 2(1),14.

Menon S.T. (2001). Employee empowerment: an integrative psychological approach. *Applied Psychology: An International Review*. 50, 153–180.

Miller, W. L., & Cohen-Katz, J. (2010). Creating Collaborative Learning Environments for Transforming Primary Care Practices Now. *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, 28(4), 334-347.

McGlynn, E. Asch, S, Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., & Kerr, E. (2003). The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*, 348, 2625-2645.

Oelke, N. D., Thurston, W. E., Dipalma, R., Tink, W., Mazonde, J. N., Mak, A., & Armitage, G. D. (2006). Understanding issues in primary care: perspectives of primary care physicians. *Quality in Primary Care*, 14(4), 253-258.

Ogrinc G, Headrick LA, Mutha S, Coleman MT, O'Donnell J, & Miles PV. (2003). A framework for teaching medical students and residents about practice-based learning and improvement, synthesized from a literature review. *Academic Medicine*. 78, (7), 748-56.

Pate, R., Pratt, M., Blair, S., Haskell,W., Macera, C., Bouchard, C., Buchner, D., Ettinger, W., Heath, G., King, A., Kriska, A., Leon, A., Marcus, B., Morris, J., Paffenbarger, R. Patrick, K., Pollock, M., Rippe, J., Sallis, J., & Wilmore, J. (1995). Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medication Association*, 273, 402–407.

Petrella, R. J., Koval, J.J., Cunningham, D.A., & Paterson, D.H. (2003). Can primary care doctors prescribe exercise to improve fitness? The step test exercise prescription (STEP) project. *American Journal of Preventive Medicine*, 24 (4), 316-322.

Smith, T., Jenkins, C., & Orleans, C. (2004). Prevention and Health Promotion: Decades of Progress, New Challenges, and an Emerging Agenda, *Health Psychology*, 23, 2, 126–131.

Squires, D. A. (2012). Explaining high health care spending in the United States: an international comparison of supply, utilization, prices, and quality. Issue brief, *Commonwealth Fund*, 10, 1-14.

Teno, J., Casey, V., Welch, & M. Edgman-Levitan, S. (2001). Patient-Focused, Family-Centered End-of-Life Medical Care. *Journal of Pain and Symptom Management*, 22(3), 738-751.

U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/default.aspx]. Accessed [February 27, 2012].

Vanderklipp, M (2006). Develop a Successful Wayfinding System. *Buildings*, 100 (4), 28.

West, M., Dawson, J., Admasachew, & Topakas, A. (2011). NHS Staff Management and Health Service Quality. *Results from the NHS Staff Survey and Related Data*.

Woolf S. & Atkins D. (2001). The evolving role of prevention in health care: Contributions of the U.S. Preventive Services Task Force. *American Journal of Preventative Medicine*. 20, (3S):13-20. (http://www.elsevier.com/locate/ajpmonline).

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