Medical Home Lowers Cost of Care in Trial

BY JOYCE FRIEDEN

WASHINGTON — Results from trials of a patient-centered medical home suggest that such arrangements result in cost savings and reduced hospital readmissions, according to Dr. Barbara Walters, senior medical director of southern New Hampshire community group practices at the Dartmouth-Hitchcock health care system.

Dr. Walters' organization is involved in a medical home trial sponsored by the Centers for Medicare and Medicaid Services that includes 10 multispecialty groups operating in a fee-for-service environment. During the trial, the practices are responsible for the entire cost of care for their Medicare patient population; they receive per-patient monthly fees for care management.

Dartmouth-Hitchcock got a $6.8-million bonus in 2008 because of the money the groups saved Medicare, and the 3-year project has been extended an additional 2 years. "On 35,000 Medicare patients, we saved $10 million for the Medicare trust fund," she said at the sixth annual World Health Care Congress.

Key to the clinical intervention was the transformation of the registered nurses' role. "Our nurses used to be 'triagers' and traffic cops. We didn't take their licensure and their scope of their ability to practice into account," Dr. Walters said. "Now they are health coaches, patient advocates, and referral coordinators."

Training staff in proper coding also helped. "We needed to train all of our doctors" because, like it or not, severity adjustment and the total cost of care is assessed by the diagnoses that go on the claims form, she said.

Dartmouth-Hitchcock also developed a registry that "allows you to look at [an] individual patient and get a snapshot of all the key indicators that help their health," Dr. Walters said.

Protocols were developed for postdischarge phone calls. "The nurse calls the day after you get out of the hospital, checks to make sure patients understand which medications they're supposed to take, which medications they're no longer supposed to take, and gets them into their primary care doctor, their medical home," Dr. Walters said.

As a result of these changes, every single practice in the pilot had lower risk-adjusted costs of care and admission rates and better quality measures than a comparison group, she said.

In addition, while hospital readmission rates are typically upwards of 20%, "we talked to the Cleveland Clinic; they got theirs down to 14%. In one of our communities where we're the only provider, we got it down to 9%," Dr. Walters said.

'On 35,000 Medicare patients, we saved $10 million for the Medicare trust fund.'

DR. WALTERS

The results have spurred Dartmouth-Hitchcock to partner with CIGNA in developing a pilot medical home project. In that project, the practice hopes to improve on the Medicare model and get primary care physicians to reap more financial benefit from any money saved. Dartmouth-Hitchcock wants to include ongoing payments for care management, "which is the biggest [implementation] issue across every group that we talked to," Dr. Walters said. "There's lots and lots of nonvisit care that you can apply" if the payment system allows for it.

That's easier to do in a system like Kaiser Permanente, where one entity owns the whole delivery system, she continued, "but those of us who practice in a fee-for-service world, where we only get reimbursed for individual-based care when patients come in, we need some slack in the system for us to be able to build the infrastructure so we can do e-visits, nurses can develop care plans, and nurses can call patients before a visit and have the lab work done when they show up" to visit the doctor. The CIGNA program began in April, so no results are available yet, she said.

Health care organizations increasingly are looking at patient-centered medical homes, according to Edwina Rogers, executive director of the Patient-Centered Primary Care Collaborative in Washington, D.C., whose 475 members include large employers, primary care physician associations, health insurers, trade associations, academic centers, and health care quality improvement associations.

Ms. Rogers cited research from Johns Hopkins University showing that adults who have a primary care physician coordinating their care had 33% lower costs of care and were 19% less likely to die.

The 3-year-old collaborative is currently involved with 22 pilot medical home projects in 16 states. The model used by the collaborative includes a monthly care coordination fee in addition to fee-for-service payments and performance bonuses.

Figuring out which outcomes to analyze and report on "is the hardest part to do," Ms. Rogers said. A group led by the U.S. Department of Health and Human Services is "trying to figure out standard outcome measures." ■

Medicare Panel Debates Coverage for Genetic Testing

BY JOYCE FRIEDEN

BALTIMORE — If Medicare is going to pay for genetic tests, what criteria should it use to decide which to cover?

That was one of the questions tackled by a Medicare Evidence Development and Coverage Advisory Committee panel. The 17-member panel included an ethicist, a patient advocate, representatives from the insurance and genetic-testing industries, and experts in cancer, ophthalmology, and cardiology.

Panel members heard presentations on various aspects of genetic testing. Dr. W. Gregory Feero, senior adviser to the director of genomic medicine at the National Human Genome Research Institute, argued that a good family history was vital to deciding which patients should receive particular genetic tests. "Family history is still the cheapest, most time-tested way to get an idea of disease risk," he said.

Although several new practice guidelines call on physicians to collect family histories, "family history collection by primary care clinicians is actually quite poor," said Dr. Feero, a board-certified family physician. "I would argue that it's going to get worse with [the advent of] electronic health records, as most systems are not well set up to enable clinicians to collect family health information."

The Centers for Medicare and Medicaid Services seems to be conflicted on the genetic-testing issue, including its relationship to family history, he continued. On the one hand, at a meeting of the Secretary's Advisory Committee on Genetics, Health, and Society, Dr. Barry Straube, director of CMS's Office of Clinical Standards and Quality, said that Medicare does not cover genetic tests based on family history alone. "In the year 2009, [Medicare] may need to rethink this," Dr. Feero said.

On the other hand, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) allows Medicare to consider covering diagnostic tests, as long as the test is reasonable and necessary and has been given a grade A or B recommendation from the U.S. Preventive Services Task Force, Dr. Feero noted. Currently, the only genetic test addressed by the USPSTF is the test for the BRCA1 or BRCA2 genetic mutations that increase the risk of breast cancer; however, the task force's guidance recommends only counseling about the test, and does not address how to decide whether the test should be given.

A panel member asked Dr. Feero if using family history to determine whether a beneficiary needs a genetic test would mean that the family history itself becomes the screening test. "That is why I [support] the idea of having a [procedure] code for family history," Dr. Feero replied, adding that family history can mean different things in different contexts.

Panel members also heard from fellow panelist Dr. Steven Teutsch, chief science officer of the Los Angeles County Public Health Department. Dr. Teutsch is a member of the EGAPP (Evaluation of Genomic Applications in Practice and Prevention) working group, an independent body organized in 2004 by the Centers for Disease Control and Prevention to provide guidance on the appropriate use of genetic tests in clinical practice.

"At the end of the day, the question is whether genetic tests can modify outcomes," he said. Dr. Teutsch also urged panel members to consider the potential harm caused by some of these tests, including labeling, anxiety, additional testing, and false reassurance from negative tests.

"For preventive applications for genomic tests, the bar should be high" for their use, he said. "We want to screen for something important [and] common, and [something] that you can do something about."

During the public participation section of the meeting, Dr. Richard Wenstrup, chief medical officer of Myriad Genetics Inc., noted that guidelines on hereditary breast and ovarian cancer from the National Comprehensive Cancer Network recommend performing genetic testing on high-risk individuals.

He also said that an analysis of his company's own data from 2000-2009 showed that 5.6% of patients with deleterious mutations developed cancer after age 65. "It's presumable that if they had been identified and tested before developing the cancer, they could have taken preventive measures to reduce their risk," he said.

Panel member Dr. Neil Holtzman, professor of public health at Johns Hopkins University in Baltimore, said that there had been confusion among some speakers about the definition of screening. He noted that a panel convened by the National Academy of Sciences during the 1970s had defined genetic screening as "a search in the population."

"A number of speakers have concluded that [in] individuals who have been identified through family history but who are asymptomatic, availability or use of [genetic] tests is defined as screening," Dr. Holtzman said. "I don't think that kind of testing is screening. It would save a lot of confusion if we defined screening as a search in the population … and not in a high-risk situation where there's a family history."

During the formal voting, panel members generally agreed that rigorous evidence on survival outcomes would be "sufficient to infer whether or not screening genetic testing is effective for the prevention or early detection of illness or disability." In terms of the most desirable measures of cost-effectiveness of genetic screening tests, they ranked gains in quality-adjusted life years higher than decreases in incidence of illness or net changes in lifetime illness costs. ■