Small Practices Can Become Medical Homes

VITALS

Major Finding: At 7 months, 17 of 18 supported practices met NCQA patient-centered medical home criteria. One practice did not report data at follow-up.

Data Source: Randomized, controlled trial of a 2-year medical home demonstration project.

Disclosures: The medical home demonstration was funded by insurer EmblemHealth. The outside evaluation was funded by the Commonwealth Fund. No other disclosures were reported.

BY MARY ELLEN SCHNEIDER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS

TORONTO — Small and solo practices can successfully transition to a patient-centered medical home model, but the change requires intensive outside support, according to early findings released at the annual meeting of the American College of Physicians.

In the first randomized, controlled trial evaluating the transition to the medical home, small practices that received hands-on support and financial incentives were able to rapidly transform to meet the National Committee for Quality Assurance (NCQA) criteria for a patient-centered medical home, according to Judith Fifield, Ph.D., who performed the external evaluation of the medical home project.

Dr. Fifield and her team at the Ethel Donaghue Center for Translating Research into Practice and Policy at the University of Connecticut, Farmington, are still evaluating data from the medical home project, but the initial findings show that, with proper support, the transition can happen in just over 6 months, even in very small practices.

The demonstration project involved 38 primary care practices in the New York City area. Half of the practices were randomized to receive intensive, in-person support and pay-for-performance incentive payments. The other 19 practices were given a $5,000 annual stipend and asked to make the transition to the medical home on their own.

Of the initial 19 supported practices, 1 practice withdrew. In the control arm, four practices withdrew before the study's end. At baseline, there were no significant differences between the supported and control arms of the study. Overall, about 40% of the participating practices were solo and 60% were small. About half of the practices had electronic health record (EHR) systems or were under contract to purchase one at baseline. The evaluation of the study was funded by the Commonwealth Fund.

Those practices in the supported group received on-site help from trained facilitators and nurse care managers. The facilitators provided guidance and training on how to use an EHR for patient communication, care coordination, and practice management. The practices without an EHR were given guidance on how to use their existing technology and paper-based systems to increase efficiency.

The nurse care managers, who were on site in the practices about once a week, helped staff members identify high-risk patients, assisted with care planning, and conducted group visits for patients with newly diagnosed diabetes. The nurses were often matched to the ethnicity and language of patients at the site, Dr. Fifield said.

The support teams "really became a big part of the care at the site," she said.

The supported practices also were eligible to receive up to $5 per member per month in addition to their regular fee for service payments. The incentives were based on meeting the NCQA criteria for the medical home, as well as meeting clinical quality and patient experience benchmarks.

'It requires a great deal of support. It is a very high-touch operation, especially to do it this quickly.'

DR. FIFIELD

Preliminary data from the first year of the project show that supported practices earned between $3,300 and $55,000 in total pay-for-performance incentives.

Of the 18 supported practices that completed the project, only 1 practice could meet NCQA criteria at baseline. After 7 months, 17 of the supported practices met the criteria and 10 qualified for the highest level of NCQA recognition. One supported practice did not report data at the 7-month follow-up.

Dr. Fifield did not discuss outcomes for the control group during her review of the study's preliminary results.

Conversations with study participants also revealed that providers and staff were happy with the transition to the medical home, she said. Although there was some frustration at the beginning of the project, that quickly changed. Physicians reported that they were excited to learn how to do more with their EHRs, and staff members said that the process to convert to a medical home gave them new skills and made them feel like a more valued part of the care team.

The biggest concern, Dr. Fifield said, is the sustainability of the change, since so much of it depended on assistance from outside contractors.

"It requires a great deal of support," she said. "It is a very high-touch operation, especially to do it this quickly." ■

POLICY & PRACTICE

WANT MORE HEALTH REFORM NEWS? SUBSCRIBE TO OUR PODCAST — SEARCH 'POLICY & PRACTICE' IN THE ITUNES STORE

Cancer Costs Double in 18 Years

The cost of treating cancer doubled over nearly 2 decades, and treatment has shifted to outpatient settings, according to a study from the Centers for Disease Control and Prevention. However, cancer accounts for about 5% of overall health care spending, a percentage that hasn't changed since 1987 despite the advent of more expensive cancer drugs, according to the study, published in the journal Cancer. The researchers determined that the increase in cancer costs—to $48.1 billion in 2005—came largely from the growing number of cancer patients. The share paid by private insurance increased and that paid out-of-pocket by patients fell. Medicare continued to pay about one-third of total treatment costs, the study found.

Bonuses Risk Medical Disparities

Rewarding primary care physicians for providing better care to patients could widen medical disparities experienced by poorer people and minority groups, according to a RAND Corp. study. Published in the journal Health Affairs, the research suggests that the average-size medical practice serving a vulnerable population would receive $7,100 less annually because of existing gaps in quality of care. "If you don't watch where the money goes, pay-for-performance programs have the potential to make disparities worse," lead author Dr. Mark Friedberg, an associate scientist at RAND, said in a statement.

Health Information Grants Set

Fifteen communities are splitting about $220 million in grant money from the Department of Health and Human Services to build their health information technology infrastructures and capabilities. The Beacon Community grants provide funding to "communities at the cutting edge of electronic health record adoption and health information exchange," the HHS said. For example, Delta Health Alliance in Stoneville, Miss., received about $14 million to electronically link systems for care management, medication therapy, and patient education in diabetes, while the Indiana Health Information Exchange in Indianapolis, the largest health information exchange in the country, received about $16 million to improve cholesterol and blood sugar control in diabetic patients and to reduce hospital readmissions through telemonitoring. The program is intended to demonstrate the advantages of health information technology to other communities.

Doctors Still Poor on Food Advice

Only about half of obese adult Americans were told by their doctors to cut down on fatty foods in 2006, a number that hasn't changed significantly since 2002, according to the Agency for Healthcare Research and Quality. The problem is especially acute in minority populations, the AHRQ said. Obese Hispanic patients received advice on healthy eating from their physicians 42% of the time, while obese black adults received advice 45% of the time, compared with 52% for whites. Doctors also were less likely to tell poor obese adults and those who did not finish high school to improve their diets, regardless of race or ethnicity, when compared with higher-income and better-educated counterparts. Black and Hispanic adults have higher obesity rates than whites, as do poor adults and those with limited education, the study noted.

Blues Plan Rewards Primary Care

Pennsylvania-based Independence Blue Cross said it will invest an additional $47 million to supplement compensation to the 1,800 primary care physicians participating in its network in an effort to improve the quality of care. More than $33 million of the added investment will enhance an incentive program for "better care, not more care," the health plan said. Independence will increase the base amount it pays primary care physicians by an average of 10% and will reward physicians who improve quality on measures such as cancer screenings, immunizations, and asthma management. With the new funds, primary care physicians can double their incentive earnings over 2009, according to Independence. Practices that meet some or all of the core requirements for a "patient-centered medical home" and physicians who provide effective care coordination will receive additional compensation, Independence said.

Doctors Asked to Find 'Bad Ads'

The Food and Drug Administration has launched a program to get health care providers to detect and report misleading drug ads. The "Bad Ad" program seeks to educate health care providers about their role in ensuring that prescription drug advertising is truthful and not misleading, the FDA said. Initially, FDA officials will meet with providers at selected medical conventions and will partner with a handful of medical groups to distribute educational materials. The agency said it will then expand its collaborations with medical societies. The FDA announcement encouraged health care professionals to report a potential violation in drug promotion by sending e-mails to badad@fda.gov. Reports can be submitted anonymously, according to the request, but the announcement also asked that providers include contact information so that FDA staff members can follow up.

—Jane Anderson