Models for Payment Advised

Medical Homes *from page 1*

hensive care (Ann. Fam. Med. 2010; 8 [Suppl 1]:s57-67. doi:10.1370/afm.1121).

Patients may not have liked watching physicians work through the many changes, suggested Dr. Carlos Roberto Jaén, the principle investigator for the study's independent evaluation team. For example, a physician getting used to a new electronic medical record system may at first spend more time looking at the computer than at the patient, said Dr. Jaén, a professor of family and community medicine at the University of Texas Health Science Center at San Antonio.

The decline in patient satisfaction may also be due to the short evaluation period. "It's probably a combination of the rapid implementation and change, and no one likes change," he said.

But overall, the evaluation is good news for the feasibility of adopting the components of the patient-centered medical home, he added, especially in light of the fact that practices received no additional payments for the new services they were providing, such as increased access, e-visits, group visits, and coordination of care.

"The good news is that small practices can implement a large proportion of the components, and that's something we didn't know before," Dr. Jaén said.

Nevertheless, the evaluators recommended that the current medical-payment system be changed to accommodate the new model of care. Currently, the only way get paid is to see a patient, which means there is no financial incentive for a physician or nurse to e-mail or call a patient, even if those actions might negate the need for a hospitalization.

The current system puts physicians in a trap of seeing 30 to 40 patients a day, Dr. Jaén said, adding that payment reform might allow physicians to take care of 50 people but see only 10 face-to-face. The independent evaluation team recommended that payers consider new models for paying physicians such as capitation and payment bundling (Ann. Fam. Med. 2010;8[Suppl 1]:s80-s90. doi: 10.1370/afm.1107).

Dr. Robert Eidus, a solo family physician who participated in the facilitated arm of the study, said payment reform is essential to move the medical home model forward.

In his Cranford, N.J., practice, he and his staff were able to implement many of the medical home elements, such as team huddles and a disease registry, without additional funds, he said. But the practice didn't have the resources to make much progress in areas such as team care. He used existing staff as much as possible to create a care team, but without increased funding couldn't afford to hire other providers such as a pharmacist or a full-time care coordinator.

"We were operating with one hand tied behind our back," Dr. Eidus said. Both payers and physicians will have to be willing to move forward on the model, he said. Payers must identify what physicians need to do to qualify for payments, and practices must make whatever changes they can without additional reimbursement.

Payers are beginning to recognize the need to reimburse physicians for their role in providing medical homes, said Dr. Terry McGeeney, president and CEO of TransforMED, which ran the demonstration project. TransforMED, an AAFP subsidiary, helps primary care practices make the switch to a medical home model.

Since the demonstration project ended, many payers have launched projects to test alternative physician reimbursement schemes and patient incentives that could work with the medical home.

Dr. McGeeney said that these payers are looking closely at the medical home in ways they haven't done before. "Not just the practices are changing and not just the payment incentives are changing, but actually the payers are changing," he said.

At the same time, health reform has advanced the concept of accountable care organizations, in which multiple providers join to treat patients and are paid based on the cost and quality of the care provided. Many health systems are looking closely at the concept of the medical home as a way to position themselves as accountable care organizations, Dr. McGeeney said.

"The [demonstration project] basically made the whole medical home concept credible," Dr. McGeeney said. "Now as we're getting outcome data and with health care reform, it has just absolutely exploded." ■

One FP's Experience in the Demo

When Dr. Theresa Shupe became a part of the National Demonstration Project to test implementation strategies for the patient-centered medical home in 2006, she hadn't even opened the doors of her new family medicine practice.

Four years later, her staff has tripled, her practice is financially stable, and she's starting to outgrow her office space. It hasn't been an easy process, but Dr. Shupe said she's proud of the fact that she can offer her patients a medical home, complete with longer than average visits, same-day access, a patient portal, and a focus on chronic disease management.

"I'm kind of on a mission to prove this works," she said.

Around the time that the demonstration project was coming together, Dr. Shupe was preparing to leave the 12-provider group practice where she worked in Manassas, Va. She had signed a lease for a new office in Haymarket, Va., and was already planning to incorporate many aspects of the medical home model. After being chosen for the demonstration project, she was randomized to the self-directed arm, so despite her involvement in the project, she was largely on her own to implement the new model (see story).

Some changes were easier to make than others. Early on, Dr. Shupe implemented an electronic health record and a patient portal. She also began open-access scheduling, with most patients getting appointments within 24 hours. But other elements, such as group visits and extended hours, weren't a good fit for the practice. There just wasn't space in the office to do group visits, she said, and since all three of the physicians in the practice are working mothers, keeping the practice open for extra hours at night and on the weekends hasn't been feasible either. But Dr. Shupe tries to make up for that by not having an answering service so that patients can speak directly to their physician after hours. Patients can also send messages through the patient portal and have those messages returned over the weekend.

The biggest challenge hasn't been the medical home implementation, she said, but fighting with insurance companies over payments. As an employee in a larger practice, Dr. Shupe had never been involved in managing a practice's finances and working with insurance companies to resolve rejected claims. It took her about a year-and-a-half to learn what she needed to know to keep money flowing in.

Another frustration is the lack of payment for coordination of care. Dr. Shupe said that with payment for those services, she would be able to spend more time with patients. Additional funding for the medical home would also allow small practices to provide chronic disease management.

"It's just not financially viable to do everything that needs to be done to keep people healthy," she said.

—Mary Ellen Schneider

Specialist Frustrated By Lack of a Role in the Medical Home

BY MARY ELLEN SCHNEIDER

As implementation of health reform gains momentum, subspecialist physicians are concerned about their lack of a role in care coordination and the patient-centered medical home model.

"We're a little bit frustrated about where we fit in," said Dr. Karen Kolba, a rheumatologist in solo practice in Santa Maria, Calif., and chair of the American College of Rheumatology's Committee on Rheumatologic Care.

The ACR is one of a handful of medical specialty societies that has not signed on to the concept of the patient-centered medical home. It's not that the college doesn't support increased access for patients or coordinated care; rather, she said, they feel they have been excluded from the model.

In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association issued a paper outlining the principles of the patient-centered medical home, which seeks to provide comprehensive primary care to children and adults.

Under the model, each patient has a personal physician who directs a practice-based care team and is responsible for providing all of the patient's health care needs or coordinating that care with another provider. The model also emphasizes evidence-based medicine and clinical decision support, enhanced access for patients, and additional payment for the personal physician for providing care coordination and improving quality.

A voluntary recognition program created by the National Committee for Quality Assurance (NCQA) aims to operationalize the model; physicians who meet the program's standards can qualify for additional payment from certain health plans. The standards measure a practice on access and communication, patient tracking and registry functions, care management, referral tracking, and electronic prescribing, among others.

Although the medical home model doesn't specify that only a primary care physician can qualify, the criteria make it nearly impossible for specialists to act as a medical home, Dr. Kolba said. For example, rheumatologists frequently are the main point of medical contact for patients with chronic rheumatologic diseases and they provide a significant amount of coordination of care, she said. However, few perform or coordinate nonrheumatologic care such as a patient's regular mammogram. And that's a sticking point in being able to qualify as a personal physician under the medical home, she said.

Dr. Kolba said she supports increasing payment for primary care, but not at the expense of other physicians. And she said primary care physicians ought to be entitled to additional pay for the work they do, without creating a new system to justify the increases.

AAFP leaders defend the medical home model and specialists' role in it. The patient-centered medical home was very purposefully defined to include a "personal physician"—not a primary care physician, said Dr. Terry McGeeney, the president and CEO of TransforMED, a subsidiary of the AAFP that helps primary care practices transition to the medical home model.

Although most practices using the medical home

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model will be led by primary care physicians, not all will be. The personal physician could be an infectious disease specialist, a neurologist, or an oncologist, he said.

But the key, Dr. McGeeney said, is that the physician must provide a medical home for the whole patient, and not focus on a certain disease or organ system. That means that a neurologist, for example, must keep track not only of the neurologic care, but also the patient's cholesterol levels and mammogram results. They don't have to perform these services themselves, but they have to coordinate and track them, he said. In the medical home, the personal physician is the "quarterback" for the patient's care and there's no "free pass" on those responsibilities for specialists, he said.

Specialists who do want to provide a medical home may even have an advantage, according to Dr. McGeeney, who pointed out that specialty practices tend to have more resources to invest in practice transformation. That said, specialists often have not been trained to provide the types and level of care required of medical homes.

Where specialists may fit in more easily, Dr. McGeeney said, is in the "medical home neighborhood," which includes all the physicians caring for a patient, as well as the emergency department, the hospital, and the pharmacy.

TransforMED is encouraging medical home practices to have letters of agreement with specialists regarding care coordination. As part of the agreement, the primary care physician promises to send all the patient's information to the specialist and to communicate with them about tests and results. These agreements aren't legally binding on either party, but they force everyone to have a conversation about coordination of care, he said.

Some specialists remain skeptical about their role in the medical home and the medical home neighborhood. Dr. Alfred Bove, past president of the American College of Cardiology and emeritus professor of medicine at Temple University, Philadelphia, said cardiologists frequently act as a medical home for heart failure and transplantation patients, for example, and don't want to be left out. For years, many cardiologists have worked in multidisciplinary care teams, used electronic health records, and provided immunizations and screening, he said.

"We have all the ingredients needed to be a patient-centered medical home in an area of chronic disease that probably is better done by cardiologists that have a lot of experience in managing very sick heart failure patients than in a primary care practice where there's a broad spectrum of different kinds of patients," Dr. Bove said.

The ACC has been advocating for specialty-based patient-centered medical homes in specific areas where the cardiologist's expertise is unique and they would be willing to assume responsibility for preventive care.

But another issue is what to do about specialty practices that act as a medical home for only a portion of their patients. In a recent article in the New England Journal of Medicine, researchers looked at single-specialty practices in cardiology, endocrinology, and pulmonology to find out to what extent those specialty practices function as medical homes.

They found that a large percentage of the practices provided both primary care and specialty care, but generally for a subset of patients. For example, 81% of the 373 practices surveyed said they served as primary care physicians for 10% or fewer of their patients. Only 2.7% of the practices said they act as primary care physicians for more than 50% of their patients (N. Engl. J. Med. 2010;362:1555-8). ■