Medical Home Improves Patient Quality of Care

BY MARY ELLEN SCHNEIDER
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At the Spanish Catholic Center health clinics in the Washington area, patients can access one-stop shopping for their chronic medical care.

The health clinics have on-site laboratories and pharmacies so patients can come in for an exam, have blood work performed, and pick up their medicine in a single visit. This type of access, which is especially appealing for the clinic's mostly uninsured population, is one way that the organization strives to provide a "medical home" to its patients, said Dr. Anna Maria Izquierdo-Porrera, an internist who serves as medical director of the Spanish Catholic Center.

"A medical home improves the quality of service that you receive, and whether you're insured or not, there are ways that we can look at how we deliver care [in order] to improve," Dr. Izquierdo-Porrera said during a press briefing sponsored by the Commonwealth Fund. "It needs to be in a place where the patient trusts you and will come back."

This approach has been yielding positive results in diabetes control. Physicians at the Spanish Catholic Center, who provide mainly charity care, have seen a drop in the number of diabetes patients with poor control. From 2003 to 2005, the percentage of diabetes patients with poor control fell from 29.6% to 13.7%, and the percentage of those with good control rose from 29.6% to 46.3%, she said.

And now researchers are finding that having access to a medical home makes patients less likely to experience health disparities. In a report released in June, researchers at the Commonwealth Fund said that having a regular provider or place of care that is accessible after hours and is efficiently run can improve the quality of both preventive and chronic care.

The findings are based on a 2006 survey of 2,837 adults aged 18-64 years. The national sample was designed to target black, Hispanic, and Asian households. The sample specifically excluded adults aged 65 and older who are eligible to receive Medicare coverage.

The survey found that overall health disparities persist. However, according to the report, strategies such as providing patients with a medical home and increasing health insurance coverage can reduce or even eliminate disparities.

The researchers defined a medical home as a regular provider or source of care that is accessible both during the day and on evenings and weekends. The setting should also be well organized and efficiently run. Only 27% of the survey respondents reported that they have a place of care meeting that definition, Dr. Anne Beal, the lead study author and a pediatrician, said during the press briefing.

The uninsured are the least likely to have access to a medical home, the researchers found. About 16% of uninsured respondents receive their care through a medical home, whereas 45% do not have a regular source of care.

Safety net facilities, such as community health centers and public clinics, are crucial to providing the uninsured with a medical home, according to the Commonwealth Fund report. Currently, however, safety net facilities are less likely to meet the criteria for a medical home than are private physician offices.

In analyzing the impact of the medical home, the researchers found that having a regular place of care really does matter. Nearly three-quarters of adults with a medical home report being able to get the care they need when they need it, compared with 52% of those with a regular provider that is not a medical home. Only 38% of adults without any regular source of care say they can get the care they need when they need it.

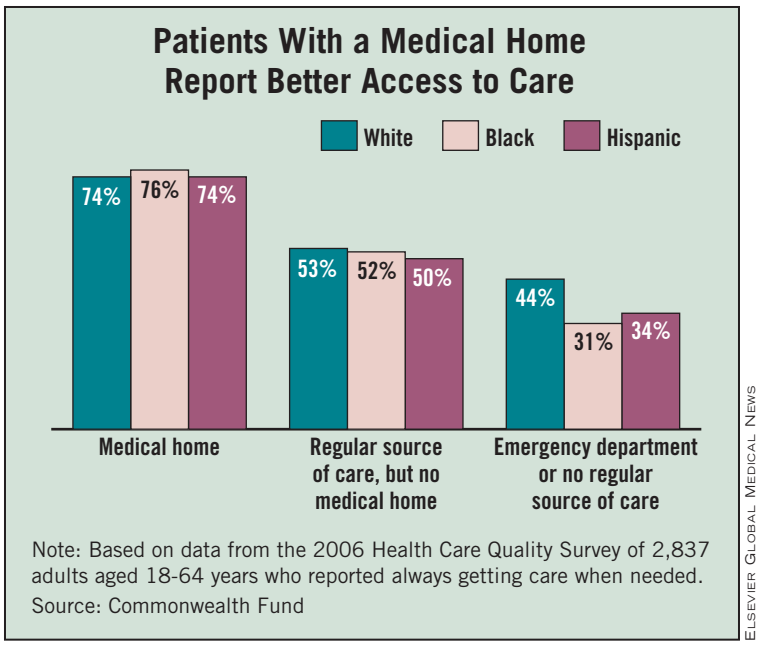
And when patients had a medical home, there were no disparities in access to care based on race, Dr. Beal said. Among patients who had a medical home, the same percentage of whites, blacks, and Hispanics—nearly 75%—reported that they always get care when they need it. In addition, about 65% of patients with a medical home, regardless of race, reported that they receive reminders for preventive care visits.

"Whenever a patient said that they were in a medical home, we found that there were no disparities in the quality of care that they received," Dr. Beal said.

The medical home is also important in terms of providing chronic care, the researchers said. The survey found that adults with a medical home were more likely to have a plan to manage their chronic health conditions at home, compared with those without a regular source of care. For example, among adults with hypertension, 42% of those with a medical home reported that they regularly check their blood pressure and that it is well controlled. In contrast, only 25% of individuals with a regular source of care that is not a medical home reported regularly checking their blood pressure and keeping it under control.

The Commonwealth Fund report calls on all providers to take steps to create medical homes for patients, especially among safety net providers. The researchers also call on physicians and policy makers to establish standards for medical homes and promote public reporting of performance.

The American College of Physicians has also been selling the idea of the "patient-centered" medical home. The organization issued a joint principles statement with the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association in February outlining the elements of a patient-centered medical home. ACP and AAFP officials are also in discussions with employers and payers to begin pilot projects testing the concept of the medical home, some of which could launch this year.



The findings of the Commonwealth Fund report were praised by Dr. Rick Kellerman, AAFP president, who called the results "outstanding and not unexpected." The findings showcase how important the medical home is, and add to the long list of reasons for changing how care is provided and paid for, he said.

Demonstration projects are also in the works at the federal level. As part of the Tax Relief and Health Care Act of 2006, Congress has authorized a 3-year demonstration project in eight states that would provide a care management fee to physicians who coordinate care as part of a medical home. That Medicare demonstration project is expected to launch in 2009.

Other pieces of legislation being considered by Congress contain references to the medical home and the need to coordinate care, Dr. Dora L. Hughes, health policy adviser to senator and presidential candidate Barack Obama (D-Ill.), said at the press briefing. But the real barrier to making the medical home more widespread throughout medicine is the reimbursement system, she said.

Physicians aren't reimbursed for coordinating care, answering patient e-mails, conducting telephone consultations, managing chronic diseases, or implementing health information technology. And primary care is generally not well paid, she said. ■

Medicare Coverage Expanded at Ambulatory Surgery Centers

BY ALICIA AULT
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Starting next year, federal health programs will cover any procedure performed at an ambulatory surgery center, with few but defined exclusions, according to final regulations released by the Centers for Medicare and Medicaid Services.

The payment formula for such procedures, to be phased in over 4 years, was also set by the regulations.

Previously, CMS covered approximately 2,600 procedures when they were performed at an ASC; now, an additional 790 procedures will be eligible in 2008. According to Dr. Charles Mabry, chairman of the American College of Surgeons' health policy steering committee and a member of the general surgery coding and reimbursement committee, as new procedures receive CPT codes, they too will be covered, unless they are specifically excluded.

CMS will not pay for a procedure if it falls within the following exclusion criteria:

- ► It poses a significant safety risk to the beneficiary.
- ► It would result in the patient's requiring active monitoring or an overnight stay.
- ► It directly involves major blood vessels.
- ► It requires major or prolonged invasion of body cavities.
- ► It results in extensive blood loss.
- ► It is emergent or life threatening.
- ► It requires systemic thrombolysis.
- ► It can be reported only with an unlisted code.

The change means that more patients will likely be able to have procedures done in an ASC, said Dr. Mabry, who is also a shareholder in an ambulatory surgery center in Pine Bluff, Ark.

CMS also decided to limit payment for procedures performed in an ASC that are done in a physician's office more than half the time. "CMS does not want to create inappropriate payment incentives for procedures to be performed in ASCs if the physician's office is the most efficient setting for providing high quality care," according to the agency.

FASA, the advocacy arm of the Foundation for Ambulatory Surgery in America, objected to this proposal and also to CMS's list of exclusions, arguing that the agency should pay for any procedure that is not covered under the inpatient system.

Medicare will make separate payments for ancillary services, such as radiology, and for some drugs and biologicals considered integral to a procedure. The agency will also make adjustments for procedures that have high device costs (that is, when the cost of the device accounts for more than half the median cost of the procedure). Those high device–cost procedures include placement of neurostimulators, pulse generators, or pacemakers.

The adjustment is already in effect under CMS's hospital outpatient payment system. ■