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Health care reform: Possibilities & opportunities for primary care

Amid the swirl of change in today's US health care system, there are opportunities for new care delivery models to slow rising costs and improve outcomes in family medicine. This review summarizes the possibilities.

Pressure to reform our health care system is at an all-time high, driven by relentlessly rising costs and fragmentation of care. These persistent problems have led to lower quality care and limited access to care for a large proportion of the US population—issues that accountable care organizations (ACOs), as well as other value-based models, are designed to address.

While the terms used to describe the means by which health care systems attempt to do more to meet the needs of those they serve may vary, the importance of reorganizing care delivery to better integrate services is gaining traction nationwide. As we move to new models, primary care takes center stage.

ACOs (or ACO-type arrangements) anchored by primary care networks can help meet the goals of health care reform by responding to changes in reimbursement, reducing fragmented care, and focusing on improving the quality of care for defined patient populations. In addition, these delivery models can take advantage of new health information technology (IT) and the move toward patient-centered medical homes (PCMHs).

In the pages that follow, we examine opportunities for new care delivery models to slow rising costs and improve population health in family medicine. The introduction of these models has important implications for patients, physicians, and provider orga-

nizations, and our aim is to ensure that family physicians are prepared to take these vital steps toward achieving health reform goals.

Shifting from volume-based to value-based reimbursement

According to the Congressional Budget Office, ACOs are expected to save \$5 billion during their first 8 years of existence.¹ After one year of ACO activity, the Centers for Medicare and Medicaid Services (CMS) reported savings of \$30 million.² The expected savings will be driven by the increased provider accountability associated with ACOs.

Various means of increasing provider accountability through changes in reimbursement strategies have been proposed; several are new, while others are improvements on—or variations of—methods that have been tried before. The most common approaches—shared savings, shared savings plus penalty, capitation, episodic payment, prospective payment, pay-for-performance, and hospital-physician bundling—are detailed in **TABLE 1**.³⁻⁷ Broad implementation of any of these reimbursement mechanisms within a new model of care would represent a shift away from the traditional volume-based provider payment model to a value-based system—a key step in slowing the rise in health care costs.

TABLE 1

Reimbursement strategies designed to promote physician accountability³⁻⁷

Model	Description	Implications for FPs
Shared savings	FFS plus a portion of dollars saved relative to predicted costs if quality and patient satisfaction are enhanced ³	Focus on population health incentivizes well care and preventive services
Shared savings plus penalty	Same as shared savings, plus a penalty if expenses exceed spending targets; bonus potential is increased to account for increased risk ³	Potential for care coordination payments in addition to shared savings
Capitation	Flat payments plus bonuses and penalties; provider organization assumes full risk for a defined patient population ³	A better understanding of population management and IT now makes capitation a viable strategy in certain settings
Episodic payments	Reimbursement is for defined episodes of care, which may extend from time of admission to days or weeks after discharge; may also include home health, extended care, or ancillary services ⁴	No incentive for prevention or PCMH coordination
Prospective payment	Reimbursement for inpatient services based on a prepaid amount that covers a defined period of time; uses DRG system that bases payment on disease classification by CMS ⁵	It is important for FPs to partner with specialists willing to share reimbursement commensurate with the value of care provided
Pay-for-performance	Reimbursement is tied to achievement of metrics (eg, number of patients immunized for a specific disease, desired clinical outcomes, high patient satisfaction scores) mutually agreed upon by ACO and payer ⁶	Be sure any agreed-upon “targets” are achievable and patient-focused
Hospital-physician bundling	Reimbursement is based on the cost of a procedure or diagnosis that includes both hospital and physician components. One payment is made for the collective services associated with a hospitalization ⁷	Similar to prospective payment from FP perspective; it is important to work with those who value the care of FPs

ACO, accountable care organization; CMS, Centers for Medicare and Medicaid Services; DRG, diagnosis-related group; FFS, fee-for-service; FPs, family physicians; IT, information technology; PCMH, patient-centered medical home.

Although it is too soon to be certain of the effect such changes will have on the earnings of family physicians, it is reasonable to think that new payment strategies—and a larger role for primary care providers—will improve their financial standing.

Moving toward population health management

New ACO-type models also make it easier to improve health care for specific populations, using strategies designed to organize, provide, and manage care for defined groups. In addition to controlling the cost of caring for specific groups, well-designed and implemented population health management strategies can increase continu-

ity of care by ensuring oversight of patients across the spectrum of health care settings.

■ **Five broad categories of population health management** are most prominent: lifestyle management and demand management (both for relatively healthy people), disease management (for those with chronic conditions), catastrophic care management (for patients with rare or catastrophic illness or injury), and disability management (for groups of employees).⁸ TABLE 2⁸ describes the population targeted and activities associated with each. It is important to remember, however, that no single strategy is mutually exclusive for a particular group.

■ **Comprehensive Primary Care (CPC) initiative.** In a collaboration made pos-

TABLE 2
Population health management strategies⁸

Strategy	Target/goal	Key elements	Evidence of effectiveness
Lifestyle management	To help relatively healthy individuals make good choices about health behaviors and risks	<ul style="list-style-type: none"> • Prevention • Risk reduction • Self-care 	<ul style="list-style-type: none"> • Adherence to guidelines for clinical screenings • Reduced costs resulting from prevention programs
Demand management	To help relatively healthy individuals take an active role in decisions about health and medical care; aims to reduce inappropriate demand for services	<ul style="list-style-type: none"> • Telephone triage • Advice and referrals • Decision and behavioral support • Education to promote self-care 	<ul style="list-style-type: none"> • Reduced variation in care unexplained by morbidity • Improved understanding of perceived need for care • Improved access, better outcomes, lower cost
Disease management	To identify and target chronically ill patients (eg, those with diabetes, heart failure, or asthma) with specific interventions	<ul style="list-style-type: none"> • Clinical oversight/management of patients with chronic disease • Education and self-care • Coordination of care/providers 	<ul style="list-style-type: none"> • Reduced costs for treatment of chronic diseases • Decreased complications associated with chronic illness
Catastrophic care management	To identify those with rare or catastrophic illness or injury and provide services needed to improve outcomes	<ul style="list-style-type: none"> • Immediate referral to appropriate providers • Coordination of care • Medical/care management 	<ul style="list-style-type: none"> • Reduced hospitalizations and total claims costs • Reduced morbidity; improved QOL • Realistic, patient-specific goals
Disability management	To develop and deliver employer-driven initiatives for employees to reduce lost time from work, improve productivity, and optimize health and well-being	<ul style="list-style-type: none"> • Disability prevention programs • Return-to-work programs • Employer-based lifestyle management programs • Coordination of care/providers for employees with chronic disease, disability, and/or serious illness or injury • Absence management programs (ie, designed to control/limit unexplained, unscheduled, or excessive absenteeism) • Workplace rehabilitation 	<ul style="list-style-type: none"> • Lower workers' compensation/disability benefit costs • Reduced number of injuries • Reduced lost time from work • Increased productivity

QOL, quality of life.

sible by the Affordable Care Act, CMS initiated the CPC initiative in 2012.⁹ A 4-year project designed to test and further identify the benefits of population health management and strengthen coordination of care for Medicare patients within primary care settings, the CPC initiative involves 497 sites and 2347 providers caring for approximately 315,000 Medicare beneficiaries.⁹ More information is available at <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>.

Building infrastructure and leveraging IT

ACOs and ACO-type models will take a variety of forms, depending in part on geographic need and local demographics. Yet, all share a common need for a strong infrastructure to support improved transitions, integration, and coordination of care. Incorporation of a strong health IT system is critical so that data regarding the process and cost of care, as well as outcomes, can be collected and put to optimal use.¹⁰⁻¹³

Across health care settings, health IT innovations are being successfully implemented in efforts to enhance physician decision support, improve patient safety, increase guideline adherence, and improve chronic disease treatment.^{11,13} In primary care, for example, an IT infrastructure can create disease registries so that data on patients with specific conditions can be tracked and acted upon—eg, a diabetes registry could be used to identify and contact patients who have an hemoglobin A1c >9 and have not been seen in 9 months or more.

Similarly, an IT system with the ability to identify patients at high risk for disease decompensation, hospitalization, and/or increased morbidity and mortality linked to progression of a chronic disease is needed. Identifying medical conditions associated with higher costs would make it possible to focus care coordination and chronic care management efforts on this targeted population.

As health IT continues to evolve, additional means of interacting with patients and improving patient care will be developed. Physicians and organizations that are ready to take advantage of these advances in technology will be well positioned to address the goals of health reform. (See “Health care reform: Recommendations for family physicians” on page 302.^{3-7,14,15})

How the patient-centered medical home fits into the picture

The implementation of ACOs and other new models of care has promising implications for the establishment of PCMHs. Consistent with the goals of health reform, the PCMH movement focuses on a coordinated team-work approach, anchored within a general practice or family medicine setting.

■ **An evaluation of the PCMH National Demonstration Project** funded by the American Academy of Family Physicians found that the adoption of more components of the PCMH at the practice level was associated with improvement in patient outcomes, as measured by the Ambulatory Care Quality Alliance starter set¹⁶ (a compilation of clinical performance measures developed by a broad

coalition of providers, payers, consumers, and government agencies).

■ **A recent look at the Southeastern Pennsylvania Chronic Care Initiative¹⁷** found less promising results. “A multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA [National Committee for Quality Assurance] certification, was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years,” Friedberg et al¹⁷ concluded. The authors did note, however, that NCQA recognition was what the practices involved in this initiative were rewarded for—not PCMH activity.

It is also important to keep in mind that PCMH activity has been shown to improve care and reduce costs—not NCQA recognition in and of itself. In fact, a large body of evidence clearly demonstrates the positive patient care outcomes and reductions in overall cost associated with the PCMH. These findings were compiled by the Patient-Centered Primary Care Collaborative—which issues annual reports on the progress of the PCMH—in a January 2014 update.¹⁸

In a PCMH model, the focus shifts away from the procedure(s) or treatment to the whole person. However, all components of care (eg, primary and specialty care, hospital, ancillary services, laboratory, and radiology) are vital and need to be connected to increase efficiency and reduce cost—creating what is sometimes referred to as a “medical neighborhood.”¹⁹⁻²¹

What’s in the neighborhood?

In a medical neighborhood, such as an ACO, each patient is cared for by a team of providers at multiple locations. The PCMH serves as the base, ensuring that all providers work together toward a common goal. In addition to providing primary care, the PCMH coordinates each patient’s specialty and support services and communicates the care plan to all involved.

Successful implementation of a medical neighborhood requires a close working relationship among providers, payers, and community resources. For example, payers can provide real-time information about patients who have been admitted to the hospital or



Coordinated delivery models that integrate primary care and mental health services have been shown to be cost-effective.

Health care reform: Recommendations for family physicians

Given the emerging opportunities for new care delivery models to advance primary care, we urge family physicians to respond positively to these changes and challenges. Here's what we recommend:

Carefully consider payment methodologies. Changes in the way physicians are paid will vary by payer source, as well as geographic market.³⁻⁷ Regardless of the reimbursement model you're offered, however, do not agree to it until you have the opportunity to evaluate it, along with your particular circumstances, to ensure that you have the infrastructure to support whatever changes the new model will require.

Read the fine print. Look out for your own interests by carefully reading the terms you are presented with. Consider seeking advice from those who understand the particular nuances faced by family physicians under particular reimbursement strategies. Just because a payment method benefits a particular specialty does not mean it will be favorable to family physicians.

Before you join an ACO

Before joining an accountable care organization (ACO) or a similar entity, find out whether it supports primary care principles and the patient-centered medical home (PCMH). Some questions to ask:

- Does the ACO have the infrastructure necessary to be successful, including the requisite health information technology, administrative support, actuarial knowledge, and experience with population health management?
- Is the ACO founded on primary care principles? Find out, for example, whether primary care physicians are represented at all levels of the organization and provide appropriate input on all important issues.

If you practice in a rural area ... The growth of ACO activity is expected to be slow in both rural and underserved metropolitan markets. To address this issue, the Centers for Medicare and Medicaid Services is allowing primary care physicians in such markets to participate in more than one Medicare ACO and providing financial incentives in the form of savings exemptions to smaller, rural ACOs.^{14,15} Another option for rural providers is the adoption of a "virtual ACO"—a loosely organized group of providers, united in the effort to achieve high-quality care and reduced costs and willing to submit to computer analysis that will determine their relative contributions to efficiency and the distribution of savings.¹⁴

Get involved

It is important for all family physicians to engage in discussions about health care reform, and to represent both their patients and their specialty. Familiarity with what is happening is essential. One way to do that is to become an active member of your state or local American Academy of Family Physicians affiliate.

More information is available at:

- www.aafp.org
Practical information with regard to health reform, in addition to suggesting ways to get involved
- <http://www.tafp.org/Media/Default/Downloads/practice%20resources/aco-guide.pdf>
Information to consider before joining or forming an ACO
- <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>
and <http://www.transformed.com/>
Resources for practitioners considering transformation to a PCMH
- <http://innovation.cms.gov>
Information, including webinars and forums, on innovative payment and service delivery models.

discharged from the emergency department, which enables close follow-up and coordination across multiple systems.

■ **Nontraditional settings.** Another facet of the medical neighborhood is the provision of health care services in nontraditional settings. For example, some grocery stores in our area

employ nutritionists to whom we refer patients for nutritional counseling regarding their health in general or a disease process in particular.

Changes in reimbursement also will affect how care is delivered within the medical neighborhood. As we move away from fee-for-service (volume-based) to value-based

payments, physicians who have made the transition from working individually with a panel of patients to providing team-based care within a PCMH will be better positioned to meet the goals of health care reform. (See “Team-based care is key inside the PCMH, too”²² [right].) Nonetheless, the transition is a dynamic process. With changes in reimbursement and delivery models, physicians also will be expected to develop and implement continuous quality improvement measures so patient care can be continually evaluated and improved.

Now comes the hard part

While a PCMH requires primary care physicians to collaborate with other health professionals, it has the potential to lead to conflicts and debates about who is at the head of the health care team. This is particularly true within mental health services because, while primary care visits are frequently related to psychosocial issues, the mental health and general practice sectors have traditionally been distinct. In recent years, however, coordinated delivery models that integrate primary care and mental health services have been shown to increase access and reduce the stigma associated with mental health services—and to be cost-effective.²³

In many ways, moving the primary care culture from the traditional focus on the physician as “captain of the ship” to a physician-led, team-based approach is one of the most difficult tasks for organizations attempting to transform their care delivery models.^{3,24} Physicians historically have been autonomous providers of medical care, relying on their own experience, expertise, and beliefs to guide decisions about patient care. Now they’re being asked to give up some of the direct control they may have had over patient care decisions and learn to work more collaboratively with other providers, as well as nonclinicians (eg, health coaches), to achieve desired outcomes.³ A successful transition depends on a reimbursement framework in which patient care goals are properly aligned with incentives for primary care physicians to work in a team-based environment.^{3,25-27}

Team-based care is key inside the PCMH, too

In addition to operating as a team with providers in other settings in the medical neighborhood, innovative primary care practices—typically those that have already achieved patient-centered medical home (PCMH) status—have strong teams within their walls. In “In search of joy in practice: A report of 23 high-functioning primary care practices,” Sinsky et al²² highlight a number of ways in which the practices they studied are maximizing this approach.

Nonphysician care. A number of practices expanded the roles of medical assistants (MAs), nurses, and even nonclinician health coaches. In one case, MAs nearly tripled the time they spend with each patient, to enable them to do medication review, fill out forms, give immunizations, and book appointments for screening tests such as mammography. In another, registered nurses were given standing orders to treat routine problems such as ear infections and urinary tract infections; at a third, health coaches counsel patients with chronic conditions and MAs conduct depression screening, as needed.

Documentation and computerized order entry—which ties up many hours of physician time—is another area in which some practices have adopted a team approach. A number of practices use nurses or MAs as scribes, entering orders and preparing after-visit summaries, for example. Not only are the physicians more satisfied, but the MAs and nurses are happy to have more involvement in patient care, the researchers report.

Communication is crucial to a successful team approach. In some practices, this is accomplished with weekly physician-clinical staff meetings; in others, with brief group “huddles” or by an office design featuring “co-location.” In one example of the latter, MAs and physicians sit side-by-side, so they can easily talk to each other—the doctor could communicate key patient information that the MA would then follow up on, for example. Regular analysis of workflow to identify and address undue delays is an effective team function, as well.

■ Helping patients help themselves.

Moving toward more patient-focused care will also require a concerted effort to increase patients’ engagement in their own health and medical care. In practice, very little of an individual’s time is spent in a physician’s office. Thus, optimal outcomes can be achieved only when patients are actively involved. Helping patients become proactive—ie, by arming them with the knowledge, skill, and confidence to do their part in staying healthy²⁸—also represents a major shift in primary care culture, as patients become active partici-

pants in medical decision making rather than passive recipients of physicians' advice.

■ **Alternative approaches.** To deliver the continuum of care that is central to new care delivery models and shift the culture of primary care toward a PCMH, physicians can implement a number of clinic-based engagement approaches—interacting with patients via e-visits such as e-mail through a secure portal, telemedicine, and group medical visits, for example. Physicians can encourage patient participation by starting patient interest groups and advisory panels²⁹—recommend-

ed by the NCQA and the Agency for Healthcare Research and Quality and used at our institution—and conducting patient needs assessments on a regular basis. Opportunities for primary care practices to engage with the community include partnering with local health departments, churches, nonprofits, and advocacy organizations to conduct health promotion and educational activities. **JFP**

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Moving primary care culture to a physician-led, team-based approach is one of the most difficult tasks when transforming an organization's care delivery model.