Endocrinologists Face Medical Home Challenge

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.

Endocrinologists, for example, face challenges in qualifying as the medical home. The average endocrinologist spends about 50%-60% of his or her time treating and managing diabetes patients, and the remaining time consulting on other conditions, according to Dr. R. Mack Harrell, an endocrinologist in Fort Lauderdale, Fla., and a member of the board of directors of the American Association of Clinical Endocrinologists.

The AACE and the American College of Rheumatology are among a handful of medical specialty societies that have not signed on to the concept of the patient-centered medical home. "We're a little bit frustrated about where we fit in," added Dr. Karen Kolba, a rheumatologist in solo practice in Santa Maria, Calif., and chair of the ACR's Committee on Rheumatologic Care.

It's not that ACR members don't support increased access for patients or coordinated care; rather, Dr. Kolba 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.

"It's hard to see how you could completely give up your consulting role so you could fit into a medical home–type model for half your practice," added Dr. Harrell.

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The AACE is working to get endocrinologists, and all physicians, paid for those administrative burdens that take up so much time. The organization is currently working to generate a new CPT code for preauthorizations. "We're looking for other avenues to get paid for what we do," he said.

As tests continue on the value of the medical home, Dr. Harrell said the key will be to ensure that primary care physicians and specialists find better ways to communicate with one another. But he anticipates that communication will be an ongoing challenge, especially since Medicare is no longer paying specialists more to perform consultations. "None of the codes, as they are presently written, are specifically constructed to pay for communication between physicians, which could potentially exacerbate an already difficult situation," he said.

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, 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 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.

One group that has given a lot of thought to how specialists could and should function in the medical home model is the American College of Physicians, whose membership includes both subspecialists and primary care physicians.

Dr. Michael S. Barr, the ACP's vice president for practice advocacy and improvement, said the medical home model is set up so that some subspecialists would have the opportunity to qualify. For example, a nephrologist who cares for patients with end-stage renal disease would certainly be a good candidate. Whether that physician would want to go through the recognition process is a separate issue, he said.

"There is definitely a place in the restructuring of the way we deliver health care for general internists, family physicians, pediatricians, and all of our subspecialty colleagues," Dr. Barr said. "This is about providing better care for people and populations."

Down the line, subspecialists are also likely to play a role as part of a medical home neighborhood, he said. That concept is still being defined, but the idea is to improve communication among physicians on patient hand-offs and find a way to reimburse physicians for some of the interactions that currently go unrecognized, Dr. Barr said. For example, a conversation between an orthopedic surgeon and an internist about managing a patient's back pain could save the health care system a significant amount of money on unnecessary procedures. Right now these conversations are done on a collegial basis, but in the future, the medical home neighborhood model might allow payment to both physicians for this type of early collaboration, he said.

The hope is that the money to fund additional payments for specialists and primary care physicians could come from overall health system savings, such as reductions in unnecessary emergency department visits and hospital admissions and readmissions, Dr. Barr 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).

Dr. Bove said he suspects that cardiologists are acting as medical homes for a larger number of patients than cited in that study. But either way, he thinks a system could be developed that would allow cardiologists who are willing to invest the time in qualifying as medical homes to be recognized and paid, even if another portion of their practice is devoted primarily to procedural services.

For its part, the ACC has established a Patient Centered Care Committee that is working on cardiology models for the patient-centered medical home. The committee is setting up protocols so that cardiologists who are interested can apply to medical home pilots being set up under the new health care reform law. ■