Most Hit Quality Targets, but Not Cost Goals

BY MARY ELLEN SCHNEIDER
New York Bureau

Preliminary results of a demonstration project that allows physician groups to share in savings they earn for the Medicare program has also resulted in quality gains, according to the Centers for Medicare and Medicaid Services.

The Medicare Physician Group Practice Demonstration is a 3-year project that encourages group practices to improve coordination of care for patients with chronic diseases. The project offers the practices financial incentives that meet clinical targets and save the Medicare program money above a certain threshold. In the first year, 10 participating practices were assessed based on their performance on evidence-based diabetes measures.

In the first year (April 2005–March 2006), all participating practices improved their clinical management of diabetes and met targets on at least 7 of 10 measures; two practices improved on all 10 measures.

Measures for the first year included hemoglobin A_{1c} management and control, blood pressure management, lipid measurement, LDL cholesterol level, urine protein testing, eye exam, foot exam, influenza vaccination, and pneumonia vaccination.

In addition to improving care, the demonstration saved the Medicare program about $9.5 million, Herb Kuhn, CMS acting deputy administrator, said during a press conference to announce the first-year results.

The demonstration includes 10 large, multispecialty group practices with a total of about 224,000 Medicare beneficiaries. The 10 group practices are Dartmouth-Hitchcock Clinic, Bedford, N.H.; Deaconess Billings (Mont.) Clinic; the Everett (Wash.) Clinic; Geisinger Health System, Danville, Pa.; Middlesex Health System, Middletown, Conn.; Marshfield (Wisc.) Clinic; Forsyth Medical Group, Winston-Salem, N.C.; Park Nicollet Health Services, St. Louis Park, Minn.; St. John's Health System, Springfield, Mo.; and University of Michigan Faculty Group Practice, Ann Arbor.

The demonstration encourages physicians to coordinate Part A and Part B Medicare services, invest in new care management programs, and redesign care processes. If these investments save money for the Medicare program, the physician groups are able to share in a portion of the savings. These performance payments are in addition to the regular fee-for-service Medicare payments received. Physician groups may share up to 80% of the savings, which are distributed based on financial performance and achievement of benchmarks in care quality measures, Mr. Kuhn said.

To receive a performance payment, the practices' total Medicare spending growth rate must be more than 2 percentage points lower than a comparison population of Medicare beneficiaries in their local market area.

While all the practices met clinical targets for at least seven diabetes measures, only two practices received performance payments.

The Marshfield Clinic, and the University of Michigan Faculty Group Practice earned performance payments for quality and efficiency improvements. In total, the two groups earned $7.3 million in payments; however, the two practices that met benchmarks in every clinical area—St. John's Health System and the Forsyth Medical Group—did not receive payments.

While other participating practices did achieve lower Medicare spending growth rates than comparison populations in their local markets, their savings did not meet the 2% threshold to share in the Medicare savings, Mr. Kuhn said.

Part of the problem may be that not all practices were able to fully deploy their initiatives in the first year, Mr. Kuhn said. "I think, overall, it's trending in a very positive way."

The first-year evaluation has revealed an emphasis among the practices on care coordination, chronic disease management, efforts to avoid unnecessary hospitalizations, proactive case management, timely follow-up after hospital stays, and the use of health information technology.

In the second and third years of the program, the group practices will be assessed on additional measures related to heart failure, coronary artery disease, hypertension, and cancer screening. ■

Medical Home Improves Quality of Care for Uninsured

BY MARY ELLEN SCHNEIDER
New York Bureau

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."

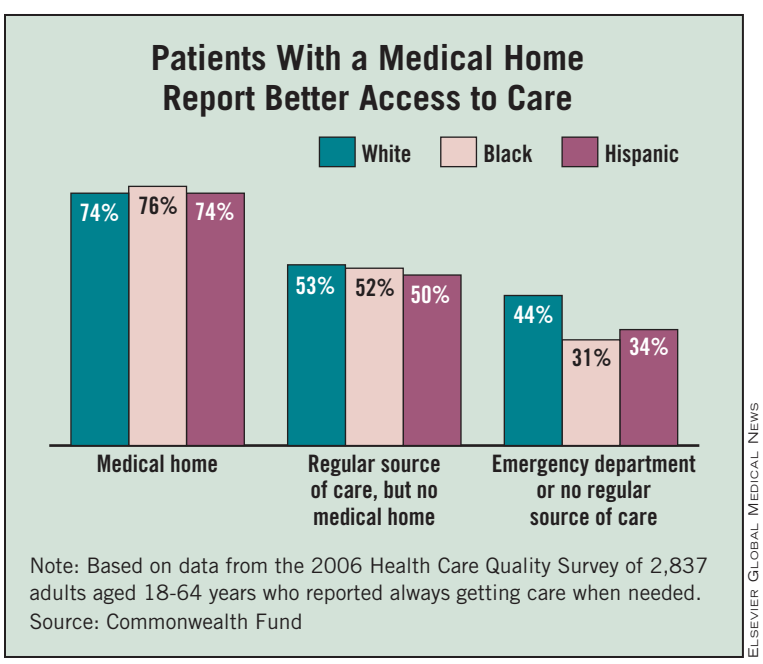
This approach has been yielding positive results in diabetes control. Physicians at the Spanish Catholic Center have seen a drop in the number of diabetes patients with poor control (hemoglobin A_{1c} levels greater than 9%) and an increase in the number of patients with good control (HbA_{1c} levels less than 7%). 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, and 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 respondents reported having a place of care meeting that definition, Dr. Anne Beal, the lead study author and a pediatrician, said during the press briefing.



Note: Based on data from the 2006 Health Care Quality Survey of 2,837 adults aged 18-64 years who reported always getting care when needed.
Source: Commonwealth Fund

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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.

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.

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In a medical home everyone has the same access to care, said Dr. Izquierdo-Porrera.

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 receiving 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. ■