Family Medicine: Preparing for a High-Performance Health Care System

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As policy leaders seek to lower costs, increase access, and improve quality in the American health care system, strengthening primary care has become a key strategy for achieving high performance. Health reform proposals under consideration in Congress include provisions that increase Medicare and Medicaid payment rates for prevention and primary care services, spread the patient-centered medical home (PCMH) model in the Medicare program, and create a payment innovation center to test and share savings with innovative primary care practices. There is wide consensus that primary care is at the center of a high-performing health care system.

The health professional community is leading change. The Future of Family Medicine report in 2004 set forth a new model of family medicine that is the foundation of a high-performance health system. In 2007, 4 primary care professional associations endorsed joint principles for the PCMH. Policy leaders have responded to the argument for the benefits to patients and the nation from a new model of care, and they are increasingly willing to commit resources to primary care with the expectation that such investment will yield returns not only in better care for patients, but also in greater value for the resources dedicated to health care. Primary care will need to undergo fundamental change in the design and delivery of care to meet these high expectations. The National Demonstration Project, launched by the American Academy of Family Physicians in 2006, is already gaining valuable experience with transforming care delivery and yielding important lessons.

How Does the United States Compare on Attributes of Patient-Centered Primary Care?

Despite the leadership of the health professional community, change is difficult and resistance can be expected. Perhaps the greatest barrier to change is a belief that physicians are already delivering patient-centered care. A review of the performance of the health system along key dimensions is, therefore, instructive in identifying gaps in performance that can be addressed by a new model of care. In 2005, my colleagues and I set forth a “2020 Vision of Patient-Centered Primary Care,” with 7 attributes of patient-centered primary care that are likely to yield cost and quality outcomes valued by patients and sought by policy leaders. These include:

- superb access to care;
- patient engagement in care;
- clinical information systems;
- care coordination;
- integrated, comprehensive care;
- ongoing, routine patient feedback; and
- publicly available information about practices.

This list builds on several decades of professional research and recommendations that identify prioritized areas for measurement and improvement. Family physicians in a high-performance health care system will need to deliver on all 7 metrics to provide care that is truly patient centered.

The United States lags far behind other countries on many of these 7 attributes of patient-centered primary care. Access is a particular problem in a country that remains the only industrialized nation that does not guarantee its citizens access to basic medical care. Only two thirds of American adults younger than age 65 report having an accessible primary care provider. In addition, nearly three quarters of all adults were not able to see their doctor quickly (ie, the same or day or the next day) when they fell sick, found it difficult to get through...
to their doctors by phone, or said it was difficult to get care after regular work hours without going to the emergency department.12

Patient engagement in care in the United States is mixed relative to international benchmarks. Just more than half of those with complex medical needs report that their regular doctor always explained treatment options and involved them in decision making, well beneath comparable rates in the Netherlands and New Zealand.13 Meanwhile, according to a recent Commonwealth Fund survey of primary care physicians, just half of patients in the United States received reminder notices for preventive or follow-up care.14 One bright spot is the number of sicker American adults who were provided with written plans to manage their care at home—66% of respondents in the United States received written instructions, compared with less than half of those in 7 other industrialized countries.13

Clinical information systems such as electronic medical records hold great promise for improving quality and lowering costs by facilitating quality reporting and improvement activities, empowering individual patients, and expanding provider access to evidence and clinical decision-support tools.15 The United States is far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on the adoption of electronic medical records and the functionality of health information technology in the primary care setting.16 The contrast between the United States and the Netherlands is particularly stark, with 98% of Dutch primary care physicians reporting the use of electronic medical records compared with only 28% of their American counterparts. This general pattern persists when examining the prevalence of other information technology functions, such as electronic prescribing, decision support, and computerized access to test results.

Fragmentation within the US care delivery system leads to waste, duplication, and substandard outcomes that are not only expensive, but dangerous.17 A recent Commonwealth Fund study showed that nearly half of all adults have experienced at least one care coordination problem, including not being contacted about test results and primary care and specialist doctors failing to share information.18 The United States also trails international peers on key measures of care coordination, including health records being available during visits and undergoing duplicative medical tests.12

Numerous Commonwealth Fund case studies have shown that integrated, comprehensive care delivery models reduce care coordination problems and ultimately improve patient experience while lowering costs.19 Care management by support staff is an important indicator of integration and one strategy for smooth information transfer among medical teams. Thirty-three percent of sicker adults report that a nurse is regularly involved in the management of their treatment.13 The United Kingdom leads among 7 other industrialized nations, with 48% of respondents reporting nurse-based care management.

The United States also trails the United Kingdom in the number of family medicine physicians that report receiving data about patients’ clinical outcomes and surveys of patient satisfaction and experiences. Just 43% of American primary care physicians reported receiving clinical outcome data compared with 78% in the United Kingdom.14 Meanwhile, 48% of primary care doctors in the United States receive patient satisfaction surveys compared with 89% of those in the United Kingdom.

Finally, a high-performing health system provides cost and quality information about practices so that patients can make informed decisions when choosing among health care providers. Currently, no federal all-payer database exists for patients who want to know and compare the relative performance of physicians.20 Again, the United States trails other industrialized countries in health systems innovation; in the United Kingdom, this type of information is available through the Internet.21

In short, reform of the US financing and delivery system is needed to improve the accessibility and accountability of primary care. Reform that provides the financial and technical assistance necessary to overcome these shortcomings must improve patients’ experiences of care, clinical outcomes, and physician satisfaction with the practice of medicine.

What Are the Models: How Can the United States Improve Performance?

During the past 3 years, numerous demonstrations of the PCMH model have been implemented. The first national demonstration project, Trans-
forMED, sponsored by the American Academy of Family Physicians, was launched in 2006 and engaged 36 family medicine practices in transformation of care during a 2-year period. Eighteen practices received facilitated implementation of the TransforMED patient-centered model and 18 practices engaged in self-directed implementation. The goal of the demonstration was to assess the usefulness and impact of the PCMH on quality of care and business performance.

The model included components on access to care and information (eg, same-day appointments); practice management (eg, optimized office design); practice services (eg, prevention screening and services); health information technology (eg, including not only automated systems and support for physicians but patient portal access to information); care management (eg, managing a population of patients, including outreach to ensure wellness promotion, disease prevention, and chronic disease management); quality and safety (eg, medication management and feedback about patient satisfaction); continuity of care (eg, collaborative relationships with providers external to the practice, such as hospital care, behavioral health care, and physical therapy); and practice-based team care (eg, task designation by skill set).

Participants were assisted with identifying the most efficient and effective way to implement transformative practice redesign. Initial evaluation results have produced lessons useful for practices that wish to engage in transformation, and enhancement tools and processes have been developed to assist practices across the country. An evaluation of the impact of the new model on quality of care and business performance is ongoing. The Commonwealth Fund provided funding for the patient experience component of the evaluation.

A recent evaluation of a PCMH demonstration within Group Health Cooperative in a metropolitan Seattle clinic shows encouraging results. A practice serving 9200 adult patients was redesigned using the principles of a PCMH. Change components included: structural and team changes (eg, size of patient panels reduced from 2327 to 1800, scheduled visits increased from 20 to 30 minutes, dedicated “desktop medicine” time, and increased staffing); point-of-care changes (eg, real-time specialist consulting and extensive use of electronic information systems); patient outreach changes (eg, reminders, emergency visit follow-up, abnormal test result follow-up); and management changes (eg, daily team huddles, rapid process improvement cycles). The intervention was motivated in part by a desire to decrease primary care physician dissatisfaction caused by large patient panels and heavy workload.

The evaluation compared patients in the clinic before and after implementation in 2007 with patients in 19 other clinics (or 2 clinics in the case of patient and clinician surveys). The intervention practice experienced significantly improved results on the clinical quality of care; patient experiences (eg, quality of doctor-patient interactions, shared decision making, coordination of care, access, patient activation/involvement, and goal setting/tailoring); reduced clinical staff emotional exhaustion for physicians and physician assistants; and reduced use of emergency services by patients. Savings from reduced use of emergency departments were offset by higher payments to primary care. In other words, the intervention improved patient experiences, clinical outcomes, and clinician satisfaction at no additional cost.

The Geisinger Health System in rural northeastern Pennsylvania has also begun implementing a medical home program. Their “personal health navigator” model is targeted to high-risk Medicare patients and is motivated in part by a desire to reduce expenditures for Medicare beneficiaries covered either by the Geisinger Medicare Advantage health plan or by Geisinger participation in the Medicare Physician Group Practice Demonstration, which provides shared savings to practices by slowing the growth in Medicare outlays. The model has been implemented on a staggered rollout basis in 2 practices (one initiated in October 2006 and the other in January 2007). Each site typically has 5 to 7 physicians, physician assistants, or advanced practice nurses serving 1500 to 2000 Medicare patients.

Components of the Geisinger model include: patient-centered primary care team practice (including an embedded nurse who was previously with the Geisinger disease management program); integrated population management (eg, case management, remote monitoring, transitions of care management, and pharmaceutical management); microdelivery systems (eg, value-based referral system); performance reporting (eg, regular reporting and review of quality metrics and patient satisfaction); and value reimbursement (practices receive
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Some private insurers are beginning to support

medical home initiatives. In Iowa, Wellmark Blue

Cross and Blue Shield is supporting a medical

home demonstration project to promote patient-

physician collaboration and care coordination, pro-

viding financial rewards for physicians who excel at

diabetes care. It also sponsors learning collabora-

tives to help primary care practices establish teams
to improve the quality of diabetes care through

process improvement and disease management

techniques. Blue Cross Blue Shield of North Da-

kota has supported a pilot program with a chronic

disease management nurse stationed in a Merit-

Care primary care clinic. Preliminary results in-

cude a 6% reduction in hospital admissions, a 24%

decrease in emergency department visits, and a

reduction of per-member costs of $530 annually. Blue

Cross Blue Shield of Michigan allocated $64

million in fiscal year (FY) 2009 to an incentive pool
to reward practices building medical home capability after seeing significant cost and quality improve-

ments under the Physician Group Incentive Pro-

gram and PCMH Initiative the prior year. The

Commonwealth Fund is funding ongoing evalua-

tions of medical home initiatives, with participation
diode in 5 states to help them become PCMHs. The goal of

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form safety net primary care practices into

PCMHs and to achieve benchmark performance in

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taken by a team headed by Marshall Chin, MD, at

the University of Chicago.

With Commonwealth Fund sponsorship, the

National Academy of State Health Policy is part-

nering with states interested in spreading the

PCMH model. Thirty-one states are also currently

working to advance medical homes in Medicaid or

the Children’s Health Insurance Program. Perhaps the oldest and best known initiative is Com-

munity Care of North Carolina, which supports 14

networks that blanket the state and engages 3,200

physicians serving 800,000 Medicaid patients. The

state Medicaid program provides financial support of $3 per Medicaid beneficiary per month to each

network. The networks hire case managers and

medical management staff who work on care im-

provement for asthma, diabetes, and the screening/

referral of young children with developmental

problems. Case managers also identify and facilitate

management of costly patients. In addition, the

state pays primary care practices $2.50 per Med-

icaid beneficiary per month to serve as a medical

home and to participate in disease management.

Estimated savings to the Medicaid program were

$60 million in FY 2003; $124 million in FY 2004;

$77 to $85 million in FY 2005; and $154 to $170

million in FY 2006.

Vermont is also moving to support medical

homes as part of its Blueprint for Health initiative.

Pilot programs in 3 counties involve private insur-

ers, Vermont Medicaid, and Medicare with en-

hanced reimbursement on top of negotiated rates
to providers that meet certain medical home stan-

dards. The program also incorporates direct finan-

cial assistance to local multidisciplinary community
care teams that extend support to participating

medical practices through direct services, care co-

ordination, population management, and quality

improvement activities.

Similar efforts can be found in other countries. In 2000 Germany launched disease management

programs and clinical guidelines for chronic care,

with financial incentives from insurance funds to

develop and enroll patients and to be held account-

able for care. Providers receive financial incentives

for enrolling patients and for offering chronic care

services like patient self-management education.

Early results show positive effects on quality.

Although most of these initiatives are in early

stages, the preliminary evaluation results are en-

coading. That the specific model and interven-
ition varies widely from initiative to initiative is notable. Most practice sites engaged in pilot programs benefit from extensive support, whether financial payments, technical assistance, or in-kind assistance. In some cases, primary care practices are part of larger integrated delivery systems that are able to provide information systems, quality improvement, care process redesign, and financial rewards for assuming this expanded role.

Policies to Advance the Spread of PCMHs
The goals of reforming the delivery of primary care are to (1) improve the accessibility and coordination of care for patients; (2) increase accountability for health outcomes and the receipt of essential preventive and chronic care; (3) reduce avoidable utilization of care (eg, emergency department care) for issues that could be treated in a primary care setting and hospitalization of ambulatory sensitive conditions; and (4) bring all providers up to attainable benchmarks of quality and value by narrowing the variation in practice and adoption of best practices. The pilot programs outlined above demonstrate that the medical home model offers considerable promise in helping to achieve these goals.

Commonwealth Fund-supported evaluations show that advancing the spread of PCMHs will require:

1. certification of primary care practices as PCMHs;
2. incentives for enrollee designation of medical homes
3. new payment methods for PCMHs
4. support PCMHs within actual or virtual organized care system; and
5. support for adoption and implementation of information systems.

Fortunately, a number of the items listed above are becoming available for primary care physicians and groups. The National Committee for Quality Assurance has adopted a certification program for patient-centered practices. The Bridges to Excellence program offers financial rewards for meeting the National Committee for Quality Assurance standards. The link between payment reform and delivery system reform is now well-established. Similarly, the need to narrow compensation levels between primary care and specialty care is reflected in health reform provisions in both the House of Representatives and the Senate. Health reform represents a historic opportunity not only to close the gaps in health insurance coverage, but to align financial incentives and transform care delivery in ways that enhance clinical quality, patient experiences, and value.

Policy leaders agree that a robust and organized system of primary care is at the center of a high-performance health system. As reform advocates seek to lower costs, increase access, and improve quality in the American system, family physicians will continue to be called on to lead change and advance patient-centered care models. Although the United States as a whole has not performed well on key metrics of patient-centered care, numerous demonstration projects and areas of excellence provide important lessons for the health professional community going forward. The PCMH model is a promising avenue for reform that improves patient experiences of care, clinical outcomes, and physician satisfaction with medical practice. National leaders must continue to seek out and provide the financial and technical assistance necessary to spread its adoption.

References