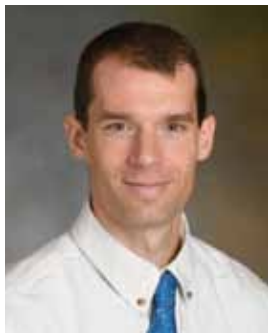


A PRIMARY CARE PERSPECTIVE ON U.S. HEALTH CARE PART 2: THINKING GLOBALLY, ACTING LOCALLY



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INTRODUCTION

In our first article,¹ which discussed the development of medicine in the twentieth century, we demonstrated how the success of a system that arose to treat acute infectious and surgical diseases had other systemic effects. It created a physician-centered system that was not only characterized by increasing specialization, fragmentation, and unsustainable costs, but one that was also poorly adapted to meet the new realities of patient-centered care and management of chronic diseases. We also highlighted comparisons with other developed countries, which indicated that our system has much higher costs and delivers significantly worse outcomes.

Reform of our current dysfunctional system will not be simple or easy, and cannot succeed if focused solely on controlling costs. Reform, rather, must be guided by what the Institute for Healthcare Improvement (IHI) has called the “Triple Aim:” increased access, improved quality, and decreased costs.² In the current environment of rapid change, there are several proposals for reform that are “on the table,” and are in fact being implemented locally and nationally. These reforms-in-process are attempts to implement the Triple Aim in concrete ways, and, in turn, are guided by the principles of population health.

Population health addresses health outcomes, the social and economic determinants of health, and the policies that impact those determinants at the level of populations rather than individuals.³ It challenges the fragmentation and structural silos which currently characterize the health care system, and reveals patterns and connections within communities that often turn out to be the most important determinants of the health of a given individual. A focus on population health has given rise to reform models, like the patient-centered medical home (PCMH) and accountable care

organizations (ACOs), and primary care research and quality improvement efforts, each of which directs our focus to communities and populations. In this second part of the series, we turn our attention to these efforts of health reform, with particular attention to local efforts to implement these models.

PATIENT-CENTERED MEDICAL HOME

As noted, a physician-centered system has led to a focus on specialization, and fragmentation of medical care into silos without coordination and integration. Managing populations and caring for patients in such a system is demonstrably ineffective, with shorter life expectancies and higher costs, while systems based on robust primary care have demonstrated just the opposite. In the attempt to practice population health and address the lack of focus on primary care within the US healthcare system, one of the reform efforts is the Patient Centered Medical Home (PCMH) model, which interestingly is not a new model but one that is rooted in a primary care base.

In 1967, the American Academy of Pediatrics first introduced the medical home model⁴ to address the need for a child's medical record to be archived in a central location that would facilitate standard care for infants and children. In 1978, the PCMH began gaining increasing traction when the World Health Organization proposed that the medical home be at the center of all primary care models. In the 1990's, the Institute of Medicine proposed that Family Medicine providers should model their practices using the medical home concept. However, the current interest in the medical home model dates from 2004, when the Future of Family Medicine project offered detailed suggestions to address the current fragmented and inefficient health care system.⁵ While Family Medicine has taken the lead on the initiative, cooperation among

the primary care disciplines has led to a single definition of a PCMH, emphasizing several joint principles:⁶

- a personal physician,
- a physician-directed medical practice,
- whole person orientation,
- continuity over time,
- coordinated and integrated care,
- quality and safety,
- enhanced access,
- payment reform.

The importance of a personal physician as the first principle of the PCMH is rooted in an evidence-base that has demonstrated the value of primary care in comparative studies in a variety of settings. Primary care has been shown to provide access, reduce costs (in both national and international data), satisfy the patient's desire for a relationship with a provider, and—when this provider is a primary care physician—improve quality. In a review of more than 30 studies that examined the relationship between continuity and health outcomes, nearly 2/3rds of outcomes were improved.⁷

Beyond the emphasis on a personal primary care physician, the other principles of the PCMH may be more difficult, since they require not simply delivery of care, but transformation of practice. For instance, the guidelines of the National Committee for Quality Assurance (NCQA) encourage practices to provide several alternatives for access, so that care is available whenever it is needed.⁸ There must be open access scheduling, after-hours access to the medical team, and alternative methods for availability and care through email, portals, and phone. Most importantly, the team concept encourages the entire staff to take an active role in care of the patient; nursing and clerical staff are expected to practice to the full scope of their training by performing tasks traditionally handled by clinicians. These tasks might include measuring a patient's proprioception with monofilament testing, noting the need for routine disease-specific testing, and ordering overdue screening tests. The intent of this delegation of routine tasks is to free the patient and the physician to use their limited time together in an optimal manner.

As the concept of PCMH has evolved over the past several years, practices wishing to be recognized as a PCMH are expected to demonstrate adherence to its principles and practices. For all practical purposes, recognition as a PCMH currently requires a complex certification process through the National Committee for Quality Assurance (NCQA). While

such recognition demonstrates a commitment to the principles of the PCMH, its concrete implications are not yet clear. For patients, PCMH will hopefully translate into improved quality of care and greater satisfaction. For providers, it may eventually translate into higher reimbursement, but public and private payers are just beginning to experiment with methods of “enhanced reimbursement” that reward quality and not just volume.

Locally, the Lancaster General Health System has committed to the concept of PCMH. Lincoln Family Medicine and Strasburg Family Medicine were granted PCMH recognition by NCQA in 2010, followed by Roseville Pediatrics in 2011, and Downtown Family Medicine, Twin Rose Family Medicine, and Lititz FM in 2012. Currently, LGHP (Lancaster General Health Physicians) has submitted a system-wide application for PCMH recognition, which will ease the application process for individual practices within LGHP, and should lead to most LGHP primary care practices becoming PCMH-designated over the next year.

PCMH growth within our system has been facilitated by the simultaneous adoption of a robust electronic medical record. EPIC aids information gathering and care integration, which are key components of a medical home. EPIC can also help identify effective patterns of care, as well as opportunities for improvement. One LGHP practice learned, for example, that patients with asthma were not consistently receiving their flu vaccines, and subsequently was able to dramatically increase its vaccination rates. Increasingly, monthly reports are sent to clinicians detailing such things as overdue screening tests, unfilled prescriptions, and LDL cholesterol and HgbA1c measurements that are not at goal. Soon this information gathering will hopefully expand to include patient-oriented outcomes, such as Emergency Room visits and hospitalizations for exacerbations of chronic diseases. Once we can measure and track these adverse outcomes, we will finally be in a position to improve them.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

ACOs have been developed to realign incentives through payment reform, and move away from a fee-for-service system, while also hopefully addressing quality and cost issues. They grew out of the Patient Protection and Affordable Care Act of 2010 (PPACA—“Obamacare”) and the Medicare Shared Savings Program (MSSP). CMS defines an ACO as a “legal entity that is recognized and authorized under

applicable state, federal, and tribal law and is composed of certified Medicare providers or suppliers. These participants work together to manage and coordinate care for a defined population of Medicare fee-for-service (FFS) beneficiaries and have established a mechanism for shared governance that provides appropriate control over the ACO's decision-making process. ACOs that meet specified quality performance standards are eligible to receive payments for shared savings if they can reduce spending growth below target amounts."

In regard to the MSSP, CMS expanded the list of providers eligible to apply for the program beyond the original four specified in the Affordable Care Act:

- 1) professionals (i.e., physicians and other clinicians) in group practice arrangements;
- 2) networks of individual practices;
- 3) joint venture arrangements between hospitals and professionals;
- 4) hospitals employing professionals.

In addition to these four, "eligibility" will be open to a subset of critical access hospitals (CAHs), rural health clinics (RHCs) and federally qualified health clinics (FQHCs).

The eligibility of CAHs is limited to those that are paid by Medicare in a manner that supports the collection of cost and utilization data needed to assign patients to providers. It should also be noted that while other providers (such as home health agencies, hospice facilities, and dialysis centers) cannot independently participate in the ACO program, any provider can participate in the program by partnering with eligible providers. For example, a home health agency can partner with a network of individual practices. This will allow for participation from a broad range of provider configurations."

On a simplified level, ACOs address quality through specific quality measures, and costs through attention to inappropriate and over-utilization.⁹ These objectives are accomplished via three mechanisms: better coordination of care, reduced overutilization, and incentives for prevention and better management of chronic diseases.¹⁰ Although somewhat reminiscent of the health maintenance organizations (HMOs) of the 1990s, the ACO model is intended to ensure that cost savings come through improved quality as opposed to stinting on needed care.

The care structure is often a product of, or dependent on, the larger payment structure within which an ACO operates. The majority of ACOs work under a partially or fully capitated model, but some receive

fee-for-service payments, and the physicians share cost savings achieved in comparison with the risk-adjusted projected spending target for their patient population.¹¹ The intended focus, however, is not solely directed at the cost savings; rather, the focus remains on quality metrics that fall under several domains—patient/caregiver experience, care coordination/patient safety, preventive care, and care of at risk populations.¹² These measures are fortunately aligned with other CMS quality programs such as the Physician Quality Reporting System (PQRS) and the Electronic Health Record Incentive program, as well as National Quality Forum (NQF) and National Committee on Quality Assurance (NCQA).

Such a care model translates into an approach that is much more population-focused than the fractionated care that occurs in the visit-to-visit routine that typifies the fee-for-service system. Coordination of care, prevention of disease, and avoidance of overutilization require a team effort among all who participate in the ACO, so the effort does not simply fall to a single provider or specialty type; ideas and methods of care must be freely exchanged within the system. Responsibility for an entire population necessitates an understanding of the community that the ACO serves, rather than a narrow focus on the patients who happen to be on the day's schedule. Additionally, the providers who participate in the ACO must be those who meet the needs of the patients within a particular population. Community resources, partnerships with community organizations and public health agencies, and a shared approach to care is critical when assuming responsibility for ensuring that high quality ACO care is provided.

Care Connections, LG's expansion of the Superutilizer Program, represents a model-of-care structure that can meet the needs of a select population, although its payment structure is not typical. In fact, such a clinic challenges the assumption that ACO models would place vulnerable populations at further risk by being excluded from the benefits. Integrating medical care with care management, social work, nursing, and lay health workers within a community context is exactly a model that is needed to practice appropriate population health. However, ACOs call for transformation of care to a model that addresses more than a subset of the population served by a health care organization. This means that for an ACO model to be successful, traditional clinic and practice models will need to be uprooted and upgraded to provide the type of care that an ACO demands.

THINKING OUTSIDE THE BOX

As we have demonstrated, visionary prescriptions for improving and refining the reach of primary care are being adapted on the local level to undergird the promise of a healthier society. At the same time, the marrow of the family medicine philosophy, that primary care providers are part of the communities they serve, facilitates an awareness of each community's needs. If generalist providers are to become specialists in the locale and population they serve, educational entities must give their learners the tools that will help them adapt to the needs of the communities they may encounter after they leave the training environment. For student physicians to be poised to care for the variety of populations they may encounter, they must be adept at integrating into a community, at networking with care providers, social welfare suppliers, and health-care coordinators, and at harnessing the power of electronic resources.

The Accreditation Council on Graduate Medical Education (ACGME) thus mandates that Family Physicians in training pursue a research interest during their residency. Outside of obligations necessitated by the ACGME, Lancaster General's Family Medicine program has further fostered community awareness by developing a Community Medicine Curriculum that has given rise to many resident-initiated programs to better serve the Lancaster community. Sustained programs such as the IMPLICIT Interconception Care Project and the local adoption of the nationally recognized CenteringPregnancy curriculum have grown out of the recognition that there is a community demand for care of underinsured and uninsured women. Further, if these women are taught good health practices within a group, they will not only build community relationships that enable them to learn from their caregivers and from each other, but these lessons will hopefully be passed on to their growing children.¹³ Strengthening bonds between clinical staff and patients and within the patient community, IMPLICIT and Centering programs have improved outcomes for preterm and low birth weight infants.^{14,15} The initiation and maintenance of these models invoke the spirit of a whole-practice commitment, in which not only physicians but all clinical staff perform up to the full capacity of their training and contribute to the care of the program and the population.

CHALLENGES AND LIMITATIONS

The PCMH model¹⁶⁻¹⁸ and the ACO model¹⁹ have touted success in both quality metrics and cost containment. The health literature is studded with articles that discuss the promising opportunity these models offer for a future of better health care delivery, but it is important to note that while they have demonstrated early success improving population health, neither model alone provides a solution to the current health care crisis.

While the PCMH model stresses the importance of a health system with a foundation in primary care, the ACO model makes no specification about specialty, and aligns incentive and accountability for all providers in the care spectrum. But though ACOs do not specifically single out primary care, they cannot be operational without a strong, supportive primary care base, so these models complement each other quite well.

The paradox of primary care is that for individual diseases, specialists provide higher quality care, yet comprehensive care for patients with multiple chronic diseases is provided at higher quality and lower cost by primary care providers, which makes them best suited to address population health.²⁰ This should not be surprising, as specialists train in hospitals, often academic centers, without an opportunity to learn about the ecology of medical care²¹ and how illness presents within a community.

Because the system in which these two models currently operate does not have a strong primary care foundation, system-wide improvement will require more than mere rebranding. Efforts touted as "patient-centered" sometimes do everything but place the patient at the center of care. Programs often focus on improving quality metrics or achieving recognition based on fulfilling national criteria, but do not address or even ask what patients desire from their health care.

Furthermore, the criteria established to certify both PCMHs and ACOs is set up to focus largely on disease-specific entities, yet further perpetuates the disease-oriented model of care that feeds a specialty-driven medical system. Meanwhile, both PCMH's and ACO's require that primary and specialty care physicians change the way they are providing care and do so in a more integrated way. Although medical schools and residencies, largely in the primary care fields, are beginning to change their curricula to address this need, there is no large scale education process that will provide such a significant cultural frameshift. Furthermore, integrated care is being demanded from hospitals and health systems that have been shaped by

years of previous dependence on an old system and an old way of doing things.

Finally, while research in primary care and ventures in quality improvement are at work establishing new models of health care, they are not strongly supported by national initiatives, and they struggle for funding in a scientific climate geared toward rewarding technological breakthroughs. Indeed, reimbursement for “slow medicine” ideas such as group care and continuous quality improvement is rarer and harder to come by than reimbursement for ideas with potential for immediate pay-off. Patience generally comes with the wisdom of experience, and it is only as our health care system (and in fact our society) has matured that we are beginning to recognize its value.

CONCLUSION

Questions therefore remain whether simple efforts to meet the triple aim (increased access, improved quality, and decreased costs) can transform health care or whether they simply represent mechanisms to band-aid an already broken system. If the latter, reform must be directed at “blowing up the model” and moving to a new system of care that isn’t predicated on the current delivery structure. In the next/final article of this series, we will discuss the pros and cons of several opportunities the US health system should consider—including expansion of primary care training programs, community based research, and a single payer model—to strengthen the role of primary care, and to improve access and quality while appropriately managing costs.

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