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Health Affairs, May 2010, theme Issue on Reinvention of Primary Care

I have read all the articles in this issue of Health Affairs which concerns primary care reform/reconstruction/redesign. The issue is very important if one wishes to look into the future of healthcare. But there are many articles so I have summarized 24 that I believe are the most salient articles. I have excerpted key statements from these 18 articles followed my own opinionated summary in *italics*.

The order in which articles appear here is alphabetical. References that appear in the text are excluded. You will have to pull the article to see those.

OVERALL IMPRESSIONS

These articles form the blueprint for the coming healthcare reform. The key changes are (1) the Medical Home which will vary widely from small primary care practice groups to larger Accountable Care Organizations; (2) mandatory participation in IT solutions such as EMRs and email; (2) reliance upon specific quality outcomes such as readmissions, that will be used to adjust payment schemes; (3) payment models that blend flat rate caps for primary care with risk-adjusted fee-for-service; and (4) the extension of mid-level providers who will handle much of the care formerly managed by MDs who will now focus on complex diagnoses, end of life, and managing primary care teams of NPs, MAs, extended MAs and everyone in between. Expect major changes to come quickly in who can do what and how payment will be realigned to cover services for the newly insured. Among the most interesting articles are the two at the end of this summary (especially Wu and Qliance) that describe innovative models for how to practice.

1. Reinventing Primary Care: A Task That Is Far ‘Too Important To Fail’. Susan Dentzer, volume editor

...skewed payment systems mean that the net present value of career-long earnings for primary care physicians, at just over \$2 million, is about \$3 million less than the comparable figure for cardiologists. the nation’s system of primary care is horribly broken—the victim of underinvestment, misaligned incentives, and malign neglect.. today’s enfeebled system will clearly be no match for the tides of change that are about to roll in. Not the least of these will be caring for millions of Americans who, as of 2014, will newly have health insurance.

SUMMARY: The editor for this issue makes the call to action right up front. The system is broken and will soon collapse. She lists the four basic sub-themes which include the untenable gap in how PC MDs are paid compared to specialists. She also sets the date for the collapse – 2014. As the uninsured become the newly insured the current system will be unable to adequately treat them. Let’s add to this the missing element in most of these articles – you cannot train enough mid-levels or permit enough IMGs to be licensed fast enough to fill the MD gaps. A new stratum of providers that is happy to accept lower pay scales in order to work in the mainstream must be identified.

2. The Struggle To Support Patients’ Efforts To Change Their Unhealthy Behavior. Richard J. Baron and Emily Desnouvee

WHO AND WHERE Urban, community-based, five-physician, general internal medicine practice serving about 9,000 economically and racially diverse patients in Philadelphia, Pennsylvania.

CORE INNOVATIONS We hired a health educator who trained medical assistants to help patients with chronic diseases set self-management goals. The patients’ personal action plans become part of their

electronic health records. An interactive Web site encourages patients to share home blood pressure and glucose measurements with physicians.

KEY RESULTS In the first six months, 770 diabetic patients made office visits, but only 230, or just under 30 percent, set self-management goals using action plans written down on paper. Few patients have used the Web site to share home management results. An electronic version of the action plan form has not yet been fully implemented.

CHALLENGES Incorporating self-management support into patient visits places increased demands on office staff, space, and work flow. Developing a customized electronic action plan form was costly. Fee-for service payments to the practice are not high enough to cover the salary of a health educator.

SUMMARY: The abstract says it all. We tried, we failed. It was the patient's fault. This is the MD's nightmare; more work for either not enough more or even worse the same \$\$\$. Electronic forms double the time needed (5 mins becomes 10 mins) for an MA to get the patient settled in the room and update the self-management data. We had to pay (\$7500) for our own software. And MDs don't get paid to learn software and help patients do self-management plans! But here is the kicker – "New categories of staff with new training are essential to incorporating self-management support into primary care." The need for a new kind of staff person in the outpatients setting is a recurring theme of many articles.

3. Primary Care: Current Problems And Proposed Solutions. Thomas Bodenheimer and Hoangmai H. Pham

A variety of strategies are being tried to improve primary care access, even without a large increase in the primary care workforce. If the primary care foundation of the health care system is not strengthened, true access and cost containment may be impossible. Because the decline in the workforce will take many years to reverse, we emphasize proposals that may improve access in the short term. Barbara Starfield, a leading authority on primary care, describes four pillars of primary care practice: first-contact care; continuity of care over time; comprehensiveness, or concern for the entire patient rather than one organ system; and coordination with other parts of the health system. There are also other attributes that patients, insurers, and policy makers expect primary care practices to provide. These include computerization of information; care that is measured regularly to ensure high quality; practice systems that focus attention on chronic and preventive care; concern for the entire population of patients; and a patient-centered culture that puts the needs of patients above all else. The Starfield pillars plus the new expectations for primary care have been conceptualized as the "**patient-centered medical home.**" Primary care practices are being challenged to implement the medical home in return for receiving enhanced payment. Concerns are mounting that without more primary care practitioners and serious practice reorganization, most patients will be unable to obtain the services of a true medical home.

Landscape Of Primary Care Practice Whereas general practitioners are the primary care physicians in many nations, in the United States primary care responsibilities belong to several categories of practitioners: family physicians, general internists, geriatricians, general pediatricians, nurse practitioners, and physician assistants. We use the term primary care practitioners to describe this workforce. Nurses, pharmacists, health educators, medical assistants, and other health workers add to the primary care workforce; this paper mainly focuses on primary care practitioners. Only 7 percent work in organizations of eleven physicians or more (Exhibit 1). Almost half of primary care physicians see their patients in offices of one or two physicians. This reveals that although multihospital systems and large insurance firms show the corporate side of health care, **primary care retains many elements of a cottage industry.** Primary care practices are **not paid for care coordination** and other services performed outside the patient visit. These realities have led to major discussions about the need for significant

physician payment reform. Even though 56 percent of visits to physicians' offices are for primary care, only 37 percent (287,000) of physicians practice primary care medicine. In 2005 an estimated 83,000 nurse practitioners (NPs) and 23,000 physician assistants (PAs) worked in primary care. It can be debated whether the current primary care practitioner-to-population ratio is adequate, but **two things are unquestioned: Adult patients are having difficulty gaining timely access to primary care, and a serious shortage of primary care practitioners is inevitable in the near future.** The 2006 health reform in Massachusetts expanded health insurance coverage to most state residents. However, the Massachusetts primary care workforce is unable to meet this new demand for services. The average wait time for a new patient to obtain an appointment to see an internist was thirty-one days in 2008, up from seventeen days in 2005.

These projections [of practitioner non-growth] are expected to lead to estimated shortages of 35,000–44,000 adult primary care practitioners. Figures on the numbers of NPs and PAs graduating from training programs each year, and the proportion of those entering primary care rather than specialty careers, reveal that their numbers will **not be sufficient to close the projected gap.** Adding primary care physicians, NPs, and PAs together, the ratio of primary care practitioners to population is expected to fall 9 percent from 2005 to 2020.²⁹ International medical graduates, who make up about 25 percent of the primary care physician workforce, have mitigated but not solved this crisis.

Community health centers have been highly successful in improving primary care access. For people at or below the federal poverty level, 16 percent of community health center patients used the emergency department in 2004, compared with 24 percent of poor patients of other providers. Fourteen percent of Medicaid recipients who used community health centers had an emergency department visit in 2004, compared with 21 percent for Medicaid patients of other providers. Some organizations are training medical assistants—practice staff with only six months of training—to become panel managers, who regularly cull the registry and contact patients overdue for services.

Medical assistants can be trained as health coaches to counsel patients on lifestyle changes and medication adherence, working in two-person “teamlets” with primary care practitioners. In the case of at least one chronic condition—depression—trained medical assistants have been shown **to improve the care of patients** compared with care by physicians alone.

SUMMARY: This is a must-read for every medical student. All the bad news is right here: not enough providers now or in the future; insufficient payments to existing providers who are leaving the field while being asked to do more (especially learning software and data mining tools) for less than every other specialist; increasing numbers of PC patients who want round the clock access, every hour of the day at least one patient in a panel of 2000 needs to talk to the doctor. But MDs do not get paid for that. Docs get paid for the face-to-face so make an appointment; hope you can wait a few weeks! One problem with this otherwise excellent if grim article is that the authors limit their focus to existing PC practitioners. They limit solutions to training more of the same-old-same-old which they admit will not get us there in time...a long time. It will take years they say; more like decades! Wait times in a Chronic Pain Clinic based in a safety-net clinic where I did the program evaluation were long as 90 days. The problem was triage which was managed by two MDs who each could only devote one half-day per week to the task. Triage is an entry-level task that requires exposure of 6 to 9 months with an MD or other experienced PC provider doing triage. The kicker in this article is the author's last paragraph proposal to train Medical Assistants to fill a bigger role on the primary care team. I just do not understand this. Why would you want an MA to step up when there are so many out of work providers with a higher level of medical training than an MA that would be willing to do the same thing for not much more \$\$? I am thinking of under-employed

(and in some cases unemployed) PTs, OTs, DCs, NDs and LAcS. Yes, acupuncturists. For that matter why not let DDSs work in a primary care role? At least they can already prescribe all kinds of PC meds and the newest grads are facing the same dilemma as med students.

4. Managing The New Primary Care: The New Skills That Will Be Needed. Richard M.J. Bohmer

Developing new models of primary care will demand a level of managerial expertise that few of today's primary care physicians possess. Yet medical schools continue to focus on the basic sciences, to the exclusion of such managerial topics as running effective teams. The approach to executing reform appears to assume that practice managers and entrepreneurs can undertake the managerial work of transforming primary care, while physicians stick with practicing medicine. This essay argues that physicians currently in practice could be equipped over time with the management skills necessary to develop and implement new models of primary care. Finally, as practices increase in size and diversity, the need arises for some practitioners to devote more of their time to management, bringing in less revenue as a result and creating two tiers of doctors within a practice. Managing all of these transitions usually falls to practice leaders, but all of the doctors in the practice are affected. Unfortunately, evidence to date suggests that existing primary practices are not well positioned to become the newer models that predictions of future primary care envisage. The infrastructure required to support proactive care—for example, information systems or care coordination staff and tools—is still not widespread. Nor are the activities and routines usually associated with coordinated care such as team meetings, performance feedback, and automated reminders.

SUMMARY: Pie-in-the-sky, ivory tower, think tank onanism. The author is a business school professor who needs to spend a few years in the med school. The author is correct in describing a practice system and curriculum that is completely unprepared to train MDs to be business managers. And it will stay that way. MDs are not going to hand over med school instruction to anyone outside medicine. It will never happen. Just like MDs are never going to embrace technology except on an individual basis because they like it or their discipline demands it, i.e., radiology, ophthalmology and any vertical highly dependent on images. Otherwise, docs – such as family practice kind - prefer a platform that pulls up the image and leave it at that. So it is with business management. I worked for an MD hired to manage an IPA. With a multi-million \$\$ startup bank he put it in the tank within four years. Great guy. Bohmer is right on every point except that you can turn a samurai warrior into a barracks sergeant.

5. A Martian's Prescription For Primary Care: Overhaul. The Physician's Workday. Lawrence P. Casalino

A new model for primary care should not be based on physicians' seeing a high volume of patients. On the contrary, physicians should see a relatively small number of patients, perhaps eight to ten daily. Thus liberated, they could spend more time with patients who need it; could have adequate time to communicate via phone and e-mail with patients, physicians, home health nurses, and other providers; and could actively coordinate the care of the practice's population of patients. Although articles about new care models such as the patient-centered medical home imply that physicians should work differently, they rarely mention this fundamental transformation of the workday. If someone would just pay me—and my medical assistant—to sit back and spend a good part of each day on the phone with patients... That way, we could take care of many more patients. Patients wouldn't have to take time off from work, or get a babysitter, or travel to my office, then wait in a room full of coughing people for a quick visit with me. And we could keep in closer touch with patients who would benefit from frequent contact with us." This model, like the other models described above, **advocates that practices rely heavily on health IT, including e-mail and telephone communication with patients.** It also promotes

the use of **nonphysician staff, coordinated by physicians**, to provide proactive, patient-centered care to the practice's population of patients... reasons why the issue of primary care physician workday redesign is rarely mentioned: **Payment Structure:** as long as practices are paid primarily for services provided by physicians during in-person visits, it will not be possible to fundamentally change the way physicians spend their time. Inertia: inertia—cognitive and cultural—may be a factor. It may be that most primary care physicians can't at present imagine a different way of practicing. **Patient-Centeredness:** the focus of practice redesign and quality improvement has been, and increasingly is, on "patient-centeredness." The thinking seems to be as follows: Practices have always been organized around physicians' preferences; now let's organize them around patients' preferences. **The patient centeredness framework is essential, but if little attention is paid to physicians' workday, it can lead to recommendations that would make that day even longer and more pressured.**

SUMMARY: Nice article that describes in very simple language the challenge of PC redesign at the office practice level. The message is single payer, flat rate \$\$ models so the MD and staff can do lots more communication and stop forcing wasteful face-to-face visits in order to get paid. Cautions against adding more demands on MD time and day length. Simple and sensible.

6. The Growing Financial Burden Of Health Care: National And State Trends, 2001–2006. Peter J. Cunningham

Data are from the 2006 Medical Expenditure Panel Survey (MEPS), the largest and most comprehensive source of information on out-of-pocket medical expenditures for both health insurance premiums and health services. The relative increase in high burden has been much greater among both middle- and higher-income privately insured people, which reflects in part their much lower burden levels to start with. Between 2001 and 2006, high burdens among the privately insured increased 17 percent for those below poverty, 56 percent among middle-income people, and 98 percent among higher-income people. An additional eleven million people with private insurance had high burdens in 2006 than in 2001; of these, 39 percent were high-income and 48 percent were middle-income. **A return to robust economic growth and declining unemployment alone will not reduce the financial stress on Americans resulting from high health expenditures.** Although attention has been focused on rising health care costs, the fact that **real median household income remained largely unchanged between 2000 and 2007**—hovering at about \$50,000—was an equally important contributor to increasing financial burden. subsidizing private coverage and expanding public coverage for lower- and moderate-income families alone is not sufficient to stem the increase in high financial burden or to reduce the variation in financial burden across states. To stem the increase in financial burden among families at higher income levels—and to sustain proposed subsidies to lower-income people—it will be essential to combine cost containment efforts in health care along with achieving real gains in family income. Market share: The combined market share of the top two private insurers is 76 percent, on average, in the five states with the highest financial burden among the privately insured, but only 65 percent in the six states with the lowest burden.

SUMMARY: A primer article on why systemic change in how healthcare is paid for is inevitable; that or anarchy in the streets. Healthcare costs are increasing as a percent of total income for everyone, including working people at every income level. Even a robust economic recovery will not change this. The authors cannot be fans of Obamacare given their concluding statement opposing more fed payments for uninsured care. They do seem to call out insurance companies for gouging out greater profits wherever they have the economic leverage.

7. Driving Quality Gains And Cost Savings Through Adoption Of Medical Homes. Daniel Fields, Elizabeth Leshen, and Kavita Patel

Evidence from seven of the largest medical home pilots shows that four factors are essential: dedicated care managers; expanded access; performance; management tools, and effective incentive payments. The model has at its core a focus on strengthening primary care, incorporating health information technology (IT), testing modified payment schemes, improving coordination of care. Four features of medical homes emerged consistently across the 7 demonstrations examined: the use of dedicated care managers, expanded access to health practitioners, data-driven analytic tools, and the use of incentives. Dedicated Nonphysician Care Coordinator Effective care coordination requires a dedicated nonphysician who is well trained and has an appropriate patient load. Nearly all experts we spoke with identified effective care coordination as essential to driving medical home success and said that providing this functionality required dedicated resources. To benefit from dedicated care coordinators, practices must perfect the difficult task of working in teams.

SUMMARY: A primer article on the medical home including 7 case studies. Unsuccessfully tries to describe the non-MD care coordinator. Big push for teamwork. Lots of ideas common to other articles on reform. Why do I feel so skeptical reading about what should be done? Because not one of the authors is a clinician?

8. Chicago: Using Evidence-Based Rules To Make Smarter Referrals. Barbara S. Fischer, Enrique Martinez, Mary Driscoll, and Terrence Conway

PRACTICE Cook County Safety Net Partnership.

WHO AND WHERE Twenty-three organizations providing primary and specialty care to uninsured and Medicaid patients in the Chicago area, including Cook County Health and Hospitals System, community healthcenters, several community hospitals, and the local health department.

CORE INNOVATION Providers use a Web-based system to request referrals to specialists or diagnostic services; specialists and others use the system to refer patients for primary care. **A software program applies evidence based rules to approve, expedite, or deny specialty referrals.** Denials can be appealed for clinical review; referrals are tracked electronically, allowing assessment of demand, wait times, and other measures useful for evaluation and planning.

KEY RESULTS Referral processing time was **reduced from an average of three months to 5.5 days**. A total of **23,000 referrals, or 22 percent of total requests, were screened out as inappropriate** during the first year of operation. Referral volume is now sevenfold higher than under the previous paper system but is managed by a smaller staff.

CHALLENGES Grant funding for the program expired after three years, resulting in a continuing shortage of money and in project delays. The referral system is not yet electronically integrated with other hospital information systems.

Has the Internet Referral Information System saved money? Without a benefit-cost analysis, we cannot claim overall cost savings. The project cost close to \$2 million over four years, with approximately 70 percent of the funds spent on initial design and development. Reduction in Referral Support Center staff saved \$1 million in salaries and benefits per year. Other savings are undoubtedly derived from the system's elimination of many inappropriate referrals.

SUMMARY: Many of the articles refer to or highlight EHRs and other e-tools to help with practice management, measuring outcomes (e.g., "driving quality") or data driven practice planning. However, this is radical, although neither surprising nor novel. EBM rules, i.e., clinical guidelines, are automated

and operationalized to conduct a form of triage. The outcomes are huge. What will MDs say? Those in private practice will reject the tool. Those in community clinics will at least give it a shot. It is the right IT idea for more reasons than I can go into.

9. Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care. Mark W. Friedberg, Peter S. Hussey, and Eric C. Schneider

Policy makers, professional organizations, and purchasers of health care have reached an unusual consensus on the importance of revitalizing primary care. This consensus stems from agreement that primary care is in a deepening crisis, but that effective primary care can improve health outcomes and contain health care costs. Some proposed solutions frame the crisis as a problem of insufficient numbers of primary care physicians. U.S. medical students are losing interest in primary care careers and Medicare beneficiaries are beginning to report difficulty finding new primary care physicians. Large income differences between specialties may deter medical students from pursuing careers in primary care. This has prompted the Medicare Payment Advisory Commission (MedPAC) to recommend a budget-neutral payment increase for “primary care services provided by practitioners who focus on primary care.”

Other proposals frame the primary care crisis as one of insufficient capability. These proposals include efforts to not only expand the number of patients who have a primary care provider, but also to give these providers new resources such as electronic health records and nonphysician care coordinators. The medical home and Chronic Care Model include sets of interventions intended to **enhance and extend the capabilities of primary care providers**. A third set of proposals attempts to reorient entire health care delivery systems toward primary care. Such proposals call for rebalancing primary and specialty care in the United States—a goal that may require interventions beyond increasing the number of primary care physicians. These proposals also call for basing system-level payment and organizational design on core principles of primary care.

10. Paying For Performance In Primary Care: Potential Impact On Practices And Disparities
Mark W. Friedberg, Dana Gelb Safran, Kathryn Coltin, Marguerite Dresser, and Eric C. Schneider

ABSTRACT Performance-based payments are increasingly common in primary care. With persistent disparities in the quality of care that different populations receive, however, such payments may steer new resources away from the care of racial and ethnic minorities and people of low socioeconomic status. We simulated performance-based payments to Massachusetts practices serving higher and lower shares of patients from these vulnerable communities in Massachusetts. Typical practices serving higher shares of vulnerable populations would receive less per practice compared to others, by estimated amounts of more than \$7,000. These findings suggest that pay-for-performance programs should monitor and address the potential impact of performance-based payments on health care disparities. Practices with low vulnerability on sociodemographic attributes had the highest performance scores.

SUMMARY: Clinics & MDs who treat the most uncooperative patients with the worst conditions will be unable to measure up and reap the \$\$\$. Are they blaming the patient? Maybe not but the statement that comes last above is a doozy. What a convoluted way to say poor people are least compliant and will tank your P4P scores. This means P4P cannot apply across the board and should not be allowed to become a de facto punishment for MDs who treat the most vulnerable populations. Interestingly, there is another article not reviewed here on the UK experience with PC redesign that encountered the same phenomenon and addressed it.

11. The Multi-Stakeholder Movement For Primary Care Renewal And Reform. Paul Grundy, Kay R. Hagan, Jennie Chin Hansen, and Kevin Grumbach

Large employers are becoming vocal in articulating their desire for a more primary care-oriented model of care. J. Randall MacDonald, **senior vice president for human resources of the IBM Corporation** [told the] House Committee on Ways and Means hearing, “Health Reform in the 21st Century.” IBM covers more than 450,000 employees, dependents, and retirees in the United States, at a cost of \$1.3 billion in 2008. The committee asked MacDonald what he considered the single most important repair to the health care system. He replied, “Strengthen primary care—transform it and pay differently using a model like the patient-centered medical home.” When MacDonald was asked to identify the next most important issue, he answered, “If you don’t fix the first issue and do not have a foundation of powerful primary care, then you can do nothing else... Primary care is foundational, but we need it to be smarter, with the tools and payment reform to allow it to be better integrated, continuous, coordinated, and comprehensive.” The nation’s lagging clinical outcomes and high rates of avoidable hospitalizations for patients with chronic conditions are particularly salient to public purchasers. This is the case because programs such as **Medicare and Medicaid cover a disproportionate share of the population with chronic illnesses**. State governments also have been spearheading innovations in primary care.

SUMMARY: PC reform is a movement with weighty multiple stakeholders, starting with Big Labor. Includes state and fed governments, consumers and PC providers. OK data but nothing we don’t know.

12. Current Yardsticks May Be Inadequate For Measuring Quality Improvements From The Medical Home. Eric S. Holmboe, Gerald K. Arnold, Weifeng Weng, and Rebecca Lipner

We found that **current conceptions and measures** of what constitutes “successful” practice systems and care **are incomplete, and have limited associations with measures of health care quality**. We found that characteristics such as physician’s age and ability, as well as practice region and racial composition, help explain the quality of patient care delivered. **Conclusion:** This study is unique as a national study that focuses on a comprehensive assessment of individual physicians across multiple patient conditions rather than on any one condition such as diabetes care. This study examined care delivered in mostly small practice settings, which is still the predominant way that primary care is delivered in the United States. Our initial findings demonstrate that the **structural elements of a practice that appear to be most meaningful for providing higher quality of patient care involve mostly “low-tech” tools and processes**. Assessment of quality must consider more than practice structure. It must also consider the physicians, nurses, and other staff working in that practice system; their patients; and the crucial interactions among the system, physicians, and patients. Additionally, these can be implemented by all practices, even as the physician community begins to adopt health IT more broadly. Future research should explore more fully the issues around physician competence, including competence in systems and quality improvement; the interactive nature of clinical practice; and other important system elements not captured by current tools. Ultimately, we should aspire to develop a fair, reliable, and valid assessment of practice performance to help us better understand the relationship among patients’ experiences of care, the clinical care provided by the physician and practice, and the structure of the practice.

SUMMARY: The MDs strike back! No policy wonk is going to tie these guys down to a bunch of standard performance variables. Guess what...current measurement tools fail to sufficiently measure Medical Home performance. What is interesting is the authors beat the data to death with big statistical sticks. There are multiple multiple regression analyses, a multifactorial analysis and tons of internal consistency analyses. What did they conclude? One size of evaluation models does NOT fit all. Do not apply one

mega model to assess MD performance. They want an evaluation approach that is more air but are not sure what that would be. They just know the ones being proposed are unfair.

13. Career Flexibility Of Physician Assistants And The Potential For More Primary Care. Roderick S. Hooker, James F. Cawley, and William Leinweber

Incentives, such as educational grants, could draw more physician assistants to work in primary care. These findings suggest that **an array of new incentives under health reform** could draw and retain more physician assistants into primary care medicine. As of January 2008, **the total number of individuals who ever graduated** from a U.S. physician assistant program was **80,688**. Each graduation year of PAs was defined. The first cohort of PAs numbered three in 1967; the forty-second cohort numbered **5,609 in 2008**. The percentage of PAs in family medicine grew to 40 percent during 1991–1996 and declined to 27 percent in 2008. Conversely, the percentage of PAs in surgery, including subspecialties, was 16 percent in 1995 and gradually increased to 27 percent in 2008. Four-fifths of all physician assistants have graduated since 1990, and the average age is 42 years. PAs were originally intended for primary care roles, but market forces—specifically, higher salaries—have drawn many to specialty practice.

SUMMARY: 2nd and 3rd authors are PAs working in PA school and national org. They assert if there is \$\$ to pay for more PAs to be trained then they will get trained in PC. PA growth is actually quite small. The trend in the mid 90s towards PAs in Fam Prx reversed in the next two decades towards surgery. This is a very good time to start a PA program as it dovetails perfectly with PC reform.

14. The End Of The Beginning: Enactment Of Health Reform. Health Affairs founding editor John K. Iglehart writes about the Patient Protection and Affordable Care Act and the many changes ahead for health insurance, the health care delivery system, and patients.

The measure will add an estimated fifteen million to the rolls of Medicaid, the federal and state insurance program primarily aimed at the poor. It also takes major steps to shore up employer provided coverage: **Large employers will face new fees if they don't help pay for health insurance for their workers,** while **small businesses get substantial tax incentives to provide coverage.**

Important health workforce investments include **new support for educating and training a range of health professionals under the National Health Service Corps,** as well as a separate pool of funds to help educate **and train thousands more registered and advanced practice nurses.** The law addresses health workforce issues with a potpourri of provisions but does not outline a well defined strategy for meeting far greater demand. Among the provisions, the law creates a **new health workforce commission and directs its fifteen members** to issue recommendations to Congress and the executive branch on national workforce priorities, goals, and policies.

...award **grants to expand primary care residency programs; establish “teaching health centers”** for the training of primary care residents **in community health centers;** provide Medicare payment bonuses of 10 percent to primary care practitioners and to general surgeons who practice **in medically underserved areas;** and increase Medicaid payments to primary care doctors to 100 percent of Medicare rates in 2013 and 2014. The Obama administration. The reform law creates a new nonprofit, nongovernmental entity, the **Patient-Centered Outcomes Research Institute,** to plan and possibly help carry out comparative effectiveness research that could potentially span almost the entire spectrum of health care.

SUMMARY: Brief article lays out current details of PPAC Act. Most favored status to primary care training, community clinics serving underserved pops. Having the data that shows % of uninsured served by clinic/prx site will be very important. Funding to expand teaching centers in community clinics presents opportunity to expand primary care training to CAMs and others non-MDs. These are the CURRENT projects for which funding is already secured.

15. Practice Redesign And The Patient-Centered Medical Home: History, Promises, And Challenges.

Charles M. Kilo and John H. Wasson. Charles M. Kilo (kilo@ohsu.edu) is **chief medical officer at Oregon Health and Science University in Portland.** He is the founder and former president of GreenField Health.

Over the past few years, the concept of the “medical home” has become central to these efforts. In effect, the concept represents more a change in labels than a real change in the model. From a historical perspective, the concept of a patient-centered medical home has been more of a branding success, as it crystallized features of practice redesign and was thus rapidly and widely adopted by health care reform advocates. Even some organizations around the country that were already carrying out well-established activities in practice redesign launched new “medical home” initiatives. The medical home addressed this by shifting away from the language of primary care toward something new.

SUMMARY: Nifty summary of development of Med Home concept that places the term and concept on a 40 year timeline. Bottom line is Med Home is rebranded “practice redesign” whose will be required for funding support under the new reform. These have been from the beginning: the importance of continuity of care; the use of consultations with patients by telephone; the notion of seeing patients in group medical visits, rather than individual encounters; patient behavioral interventions; and variation in the intervals between office visits. They also examined the use of clinical prediction rules and guidelines, which are derived from systematic clinical observations that help physicians identify patients who require diagnostic tests, treatment, or hospitalization. Practice-based research networks that used community practices “to carry out both clinical and management research” were established. The authors recognize there is a deficit of PC providers but do not offer ideas how to fill the gap.

16. Prospects For Rebuilding Primary Care Using The Patient-Centered Medical Home. Bruce E. Landon, James M. Gill, Richard C. Antonelli, and Eugene C. Rich

...the patient-centered medical home has become policy shorthand for rebuilding U.S. primary care capacity. It incorporates not only enduring primary care principles such as access, coordination, and comprehensiveness, but also twenty-first century approaches using new tools such as electronic health records; asynchronous communications independent of time or location, such as e-mail; and informed decision making. questions remain about how to best put these principles into operation and close the gap between the current primary care system and that envisioned under the medical home model. For instance, the principles do not specify an optimal reimbursement strategy with regard to the level or structure of payment, or the concrete steps that a practice should take to improve access to care. Policy makers and purchasers, however, remain concerned that practices might merely pocket the additional payments without changing how they deliver care. It is critical that patient centered medical home adoption be measured so that payment can be linked to achievement. Perhaps the most well-known and widely used is the Physician Practice Connections–Patient-Centered Medical Home tool from the National Committee for Quality Assurance (NCQA). This practice self-report measure is being used by nearly all current medical home pilot projects.⁵ The tool assesses nine standards, almost half of the tool’s items assess

functions that require health information technology (IT). Few items, however, measure core primary care components such as continuity of care and whole-person orientation, which requires that a personal provider take responsibility for providing for all of a patient's health care needs or arranging for care from other qualified providers as needed. The challenge is that many of the patient centered medical home principles are difficult to measure. However, other available tools may fill some of these gaps. Tools that were developed to measure core features of primary care as defined by the Institute of Medicine include the Primary Care Assessment Survey, the Primary Care Assessment Tool, and the Components of Primary Care Instrument. Tools that measure patient-centered features include the Patient Enablement Instrument, the Consultation and Relational Empathy measure, and the consultation Quality Index. A more comprehensive tool is the Medical Home Intelligence Quotient¹³ from the TransforMED National Demonstration Project. This tool is simpler to implement than the Physician Practice Connections–Patient-Centered Medical Home and is available for free. However, it has not been tested as extensively as the NCQA tool has been.

Fixing the reimbursement system is seen as a crucial component of primary care reform. Fee-for-service payment has never been a particularly efficient way to reward care that is comprehensive, coordinated, and accountable for the whole patient. Capitation has been problematic because the same payment is received regardless of the services delivered; as such, it presents incentives to stint on care. Because fee-for-service and capitation are imperfect ways to reward primary care, so-called hybrid payment models have been proposed. Such combinations of payments for face-to-face encounters and additional monthly payments for medical home services have a theoretical appeal. These models often include additional incentive payments based on measures of quality of care, patients' experiences, or shared savings. Key determinant of the success of the medical home is the establishment of payment levels. These fixed payments have to be sufficient to support the personnel and infrastructure required by an enhanced non-visit-based patient-centered medical home, while also increasing relative pay for primary care clinicians. Getting the payments right is vital if the medical home model is to attract adequate numbers of new physicians and other clinicians to the field. Whether these fixed payments should be entirely directed to the primary care practice or shared with a community-based organization that works with multiple practices is another unsettled policy conundrum. For instance, the community support model being implemented in North Carolina and Vermont might be an attractive option for small practices serving less densely populated communities.²⁰ In this model, some of the periodic patient-centered medical home payments are invested in a community based organization that provides infrastructure, such as care coordination services, that can be shared among several primary care offices. Another key decision that must be made at the outset of every medical home transformation process is whether upfront funds beyond payment reform will be needed for practices to begin the process of transforming into medical homes. For instance, some practices will lack basic capabilities such as an electronic health record or patient portal that will likely be required of a highly functioning medical home. Most observers agree that **opportunities to improve quality while also controlling cost exist**, especially with regard to **unplanned hospital readmissions, emergency department use for nonemergent health problems, and overuse of subspecialists**. However, the **incentives of other health care providers are not aligned with these goals**. Thus, as primary care settings develop the ability to attack these cost drivers, which are high-yield opportunities, subspecialists and allied care providers will need to have explicitly defined roles and appropriate incentives that support financially sustainable, collaborative links between providers. To achieve a broad sense of shared commitment to patient and financial outcomes of care, the creation of so-called **accountable care organizations** has been proposed, with a medical home as the foundation. Policy makers envision **the accountable care as a provider-led organization** whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.

SUMMARY: An important article that takes a good look into the financing issues of the Medical Home which is about changing the values of current healthcare. Also an evaluator's wet dream. Lists multiple evaluation tools that can and might be used to measure Medical Home outcomes. The article argues for the difficulties in measuring outcomes and the absolute need to do so as a guarantee for introducing flat payments to Med Home practices. Discussion of payment structures forecasts how providers will be paid under the Med Home model. Fee for service and capitation are dead. A hybrid model is proposed that pays FFS and capitation adjusted for patient type (e.g., treating chronically ill pays more, however, effective prevention also pays, risk managed). The inherent conflict of paying for quality outcomes that will take \$\$ from specialists who are paid for treating people in hospitals is delicately mentioned. The MD-led accountable care organization is proposed as a mechanism for controlling costs and ensuring quality data are collected. IMO allowing MDs to control costs and account for quality data is probably not a good idea.

17. Transforming Primary Care: From Past Practice To The Practice Of The Future. By David Margolius and Thomas Bodenheimer

Even if major increases in primary care reimbursement encourage U.S. medical students to flock to primary care, it would **be years before a new crop of primary care physicians could ameliorate the shortage**. The primary care practice of the future must adapt to **the reality of large panels**—the number of patients under the care of a single doctor. Panel-size reduction would require telling many patients that they can no longer see their primary care physician. As a population wide solution, **panel-size reduction is not an option**. The **patient-centered medical home** is a step in the right direction, but it **tends to ask more of physicians instead of recognizing that they already have too much work**. The bread and butter of primary care, **one-on-one, face-to-face visits, is no longer the sole mode** of caring for patients. Patients are cared for via **multiple encounter modes—phone visits, e-mail visits, visits to nonphysician team members, group visits**—that depend on patients' preferences and medical appropriateness. Some patients...require only preventive services; others have acute needs. Some patients have mental health or substance abuse problems; others are women's and children's health. Some have one or two chronic conditions; others have complex health care needs with multiple diagnoses and high risk of hospitalization, requiring intensive physician attention, or those at the end of life or needing palliative care. Each of these groups in a practice's panel requires different services; thus, the practice of the future organizes itself to tailor its services to the differing needs of these groups. It is **no longer possible for physicians to care for all of the patients in their panel**. The team that would be needed to assist in the care of the patient panel depends on the size of the practice; it may be a **physician and enhanced medical assistant, or it may include advanced-practice clinicians, nurses, pharmacists, and others**. In the future, all members of the primary care team—whether a three-person team in a small office or a large team in an integrated care system—would feel a shared responsibility for the health of the patient panel. **Pay-for-performance money would be distributed to all team members**, because all made the performance bonus possible. Patients could receive excellent care **without frequent face-to-face appointments**. Patients with less frequent follow-up visits have health outcomes equal to those of patients receiving more frequent followup visits. **A telephone call or e-mail** three days after a medication change may be more valuable than a follow-up appointment a month later. At **GreenField Health in Oregon, 80 percent of patient contacts occur via phone and e-mail**. **Trained medical assistants could screen patients' e-mail, handling messages requesting lab slips or appointment requests**. Different team members would focus on different groups of the patient panel. **Physicians** would concentrate their time and energy on diagnostic problems; patients with **complex health care needs**; those needing **palliative or end-of-life care**; and the **coordination of care with specialists, hospitals, and home care**

agencies. **Nurse practitioners and physician assistants** could take responsibility for **common acute and chronic care** issues. **Registered nurses and health coaches** could **schedule planned visits** for patients with **chronic conditions** to provide the **education, skills training**, and confidence building needed for successful **self-management**. **Pharmacists** could assist patients with **complex medication** regimens. **Medical assistants** trained as **panel managers** could repeatedly work the **electronic registry** and provide **outreach** to patients overdue for **preventive and chronic care** services. Naturally, small practices without a robust team would be limited in their capacity to institute such team based care. **Less trained team members would need to assume major responsibility** in the areas of **panel management** and **health coaching**. Most practice revenue would come from **risk-adjusted monthly payments** for each patient. A smaller but substantial portion of the revenue would be **performance based, aligning payment with improved outcomes**. With this payment method, care provided by non clinician team members and via phone and e-mail would be encouraged as less expensive to the practice.

SUMMARY: Only the sick people get to see the MD. Otherwise patients will see mid-levels, MAs, some in groups. Email and phone calls will cover many. The nature of the patient's illness determines who s/he gets to see if anyone at all. The future Med Home MD will coordinate a new team of mid-level providers who actually see the patient. The team is wide ranging from advanced trained MAs to pharmacists. Is this hopeful? Not clear. The authors call for lots of change in the culture of medicine...but they also open more doors to mid-levels. Once more, no mention of CAM.

18. Choice Of Specialties Among Physician Assistants In The United States. Christopher F. Koller, Troyen A. Brennan, and Michael H. Bailit

The U.S. health labor force includes approximately 820,000 clinically active physicians, two million registered nurses, and approximately 120,000 physician assistants (PAs) and nurse practitioners (NPs). With approximately 68,000 PAs practicing in the United States in 2007, these providers may now be reaching a critical mass to affect health policy and care delivery. There is now about one clinically active PA for every ten to twelve physicians. This ratio will likely tilt further toward PAs, who are entering the U.S. health workforce at a rate of about one PA for every five physicians completing postgraduate training each year. The productivity of PAs (in terms of patient visits per week) is on par with that of physicians. Analysts predict that PAs will continue to provide a growing amount of patient care for the next decade. Half of all PAs completed their training within the past decade, and two thirds did so within the past fifteen years. In 2007, approximately 37 percent of PAs worked in the primary care specialties (family/general practice, general internal medicine, general pediatrics, and obstetrics/gynecology). The largest segment of PAs (25 percent) was employed in family/general practice. This was followed by the surgical subspecialties, internal medicine. Policy approaches that address some of these factors could promote primary care roles for PAs. Financial approaches such as educational loan repayment programs through the **National Health Service Corps** and favorable reimbursement structures have been effective for influencing job placement for PAs. Several provisions of the 2010 health reform bill, including bonus payments for primary care services, **expanded loan repayment opportunities for primary care PAs who practice in underserved areas**, and increased funding for community health centers, may promote primary care practice for PAs. This legislation also restores funding for Title VII (Public Health Service Act) and **carves out 15 percent of the Section 747 primary care funds for PA training**. In the past, Title VII grants have been successful in promoting primary care emphasis in PA training programs. New policy approaches could include **PA program admissions policies that favor applicants likely to choose primary care practice**, tuition enticements for retiring military corpsmen and medics who commit to working in disadvantaged areas, and the establishment of joint family medicine-PA program residencies to enhance team experience in population health.

SUMMARY: Everything you wanted to know about where the PAs are. Documents why simply training more PAs is not a viable solution unless, as with other mainstream professions, these new providers are incentivized to choose primary care. They have been leaving primary care since the mid 1990s. A blueprint for funding a PA program.

19. The Role Of Nurse Practitioners In Reinventing Primary Care. Mary D. Naylor and Ellen T. Kurtzman

We recommend that nurse practice acts—the **state laws** governing how nurses may practice—**be standardized**, that equivalent reimbursement be paid for comparable services **regardless of practitioner**, and that performance results be publicly reported to maximize the high-quality care that nurse practitioners provide. The number of **licensed registered nurses (RNs)** in the United States has grown steadily to **2.9 million**. Advanced-practice RNs represent about **8 percent** of the nursing workforce and encompass four distinct roles: **nurse anesthetists, nurse midwives, clinical nurse specialists** (nurses with advanced knowledge and skills in the care of special patient populations based primarily in acute care settings), and **nurse practitioners (NPs)**. About **70–80 percent of advanced practice RNs work in primary care**—in pediatrics, adult health, gerontology, and nurse midwifery. Whether as few as 9.2 percent of all office visits turned into visits to nurse practitioners or physician assistants, or as many as 18.1 percent of all office visits did, savings were achieved...**increased use of retail clinics**, which are typically **staffed by NPs**. Substantial barriers prevent nurse practitioners from practicing to their fullest capabilities. The most significant of these is states' scope-of-practice laws that define nurses' roles, articulate oversight requirements, and govern practice and **prescriptive authorities**.

Payment policies that reimburse nurse practitioners only a portion of what is paid to physicians for the same services raise additional concerns. Medicare, Medicaid, and private insurers typically reimburse NPs at rates that are just **75–85 percent of what they pay physicians** for the same services. There are some exceptions: Under Medicare, for example, **nurse practitioners can bill 100 percent of the physician rate if they bill under a physician's provider number and are directly supervised by a physician** (that is, "incident billing"). **Yet nurse practitioners can bill Medicare just 85 percent of the physician fee under their own provider number.** Fearing increased competition, professional medical groups, health care systems, and managed care organizations have typically resisted expanding the practice scope of nurse practitioners. The Patient Protection and Affordable Care Act provides **\$50 million in fiscal year 2010 to expand operating nurse-managed health centers** with contingencies to extend funding through 2014. Although these options will maximize the use of nurse practitioners, they will do little either **to mitigate the professional discourtesies that plague nurse physician relationships** or to enhance coordination between professionals within and across sites of care.

SUMMARY: Revenge of 200K nurses (those currently working in PC)! They get everything they (well at least some) want when NPs function like and get paid equivalent to MDs. Expansion of NP scope is resisted by MDs and PAs. In the end NPS will get everything they want including prescription privileges when state laws all change at the same time.

20. Transforming The Role Of Medical Assistants In Chronic Disease Management. Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum

PRACTICE UNITE Health Center. **WHO AND WHERE** Multiservice health center in New York City, funded primarily by capitation, for union members and their families. Provides care to 10,000 patients,

who make 55,000 visits annually. **CORE INNOVATIONS** Medical assistants are trained to teach patients to manage their chronic diseases and facilitate behavior change. They monitor patients' progress and function as key members of medical home teams. Those who pass all modules of the **nine-month curriculum** are promoted to become health coaches, **who work with patients individually, lead support groups, and coordinate care.** **CHALLENGES** Medical assistants received training that included participation by nurses, other staff members, and consultants and required dedicated meeting time. An electronic health record system was essential for tracking patients. Monthly capitation payments permit the center to deliver innovative programs involving nonbillable services.

Transfer most of the responsibility for patient teaching to its patient care assistants, who are hired with medical assistant credentials... who typically share the patients' cultural backgrounds, would foster a level of comfort and trust that would enable them to **teach patients** how to **manage their chronic diseases**, at a **much lower cost than using registered nurses or certified diabetes educators.** The center **developed its own nine-month training curriculum**, including didactic sessions on **chronic disease management and interactive sessions to improve communications skills and teach self-management support and facilitation of behavior change.** Materials were drawn from evidence-based resources and from the American Diabetes Association and the New York City Department of Health and Mental Hygiene clinical guidelines. **Training was overseen by the center's nurses.** They then **work individually with patients.**

SUMMARY: A real-world example of how the MA role will be extended to a billable provider. The union established health center created its own training program and prepared MAs to work individually with diabetes patients. Heavy integration with disease registry software. Program evaluation shows the model worked. The center used cap payments to cover training costs. Prelim outcomes data suggests cost savings per pt over care. How would this work under the coming hybrid payment models? The MAs can be defended as useful providers and relieve MD or NP or PA of all chronic illness self-management work.

21. The Growth Of Retail Clinics And The Medical Home: Two Trends In Concert Or In Conflict? Craig E. Pollack, Courtney Gidengil, and Ateev Mehrotra

...it becomes clear that the medical home and retail clinics share a number of core principles. The medical home concept emphasizes improved access through open scheduling and enhanced hours. It is staffed by a team of providers, which may include nurses and other health professionals; is led by a personal physician; and focuses on coordination of the patient's care among providers. An integral component is an electronic health record that directly incorporates evidence-based medicine and decision support tools. Finally, proponents have emphasized the need for changes in the payment system to support a highly functioning medical home. **Retail clinics** are medical clinics typically **located within retail stores**, such as grocery stores or pharmacies. They are usually **staffed by nurse practitioners.** Their focus is on **convenience for patients**, and they are **open on evenings and weekends**, with **walk-in hours.** Retail clinics generally have a **limited scope of care**, which includes **minor infections such as sore throat and cough, immunizations, and routine preventive screening.** For conditions that fall outside their scope of care, retail clinics refer patients to other providers in the community. Almost universally, retail clinics use **electronic health records that directly incorporate evidence-based guidelines.** Care at retail clinics is **less costly than care at an emergency department or physician's office.** There were an **estimated 1,177 clinics** throughout the United States as of December 2009. Although some retail clinics are located in underserved communities, as a whole, they are more likely to be located in wealthier neighborhoods. Estimates of retail clinic use have varied widely in surveys, from 2.3 percent of the population to 13 percent of families. Compared to the general population, **retail clinic users are more likely to be**

uninsured and to lack a usual source of care. In **the integrated model**, retail clinics are **owned and operated by existing health care providers**. In 2008 more than twenty physician groups or hospital chains operated retail clinics, including Mayo Clinic and Geisinger Health System. For example, the Heritage Valley Health System in Pennsylvania operates three retail clinics in nearby **Wal-Mart stores**. Each retail clinic is linked to a primary care practice and the larger health system through a **shared electronic health record**, which gives the retail clinic provider access to the patient's medical history. **The hybrid model**, is characterized by a **formal collaboration between retail clinics and medical practices**; the clinics are **"co-branded."** However, the **clinics and practices remain separate financial entities**. Under **the independent model clinics are owned and operated by private companies** such as **MinuteClinic** (for most sites), **Target**, and **TakeCare**. There is **no shared electronic health record**, and communication to primary care providers is performed via faxes or printouts.

SUMMARY: Retail clinics have HUGE potential for every primary care practice. They are especially attractive if a profession wishes to expand its scope as the scope of practice is limited and the supervision of (CAM) providers is by NPs with affiliations with PC MDs.

22. Why Pharmacists Belong In The Medical Home. Marie Smith, David W. Bates, Thomas Bodenheimer, and Paul D. Cleary

ABSTRACT Pharmacists can affect the delivery of primary care by addressing the challenges of medication therapy management. Most office visits involve medications for chronic conditions and require assessment of medication effectiveness, the cost of therapies, and patients' adherence with medication regimens. Pharmacists are often underused in conducting these activities. They perform comprehensive therapy reviews of prescribed and self-care medications, resolve medication-related problems, optimize complex regimens, design adherence programs, and recommend cost-effective therapies. Pharmacists should play key roles as team members in medical homes, and their potential to serve effectively in this role should be evaluated as part of medical home demonstration projects.

In 2008, the National Committee for Quality Assurance (NCQA) developed standards...that the [medical home] practice implement evidence-based care plans, **use nonphysicians in care management**, coordinate care transitions, support patient self-management, and track test results and patient referrals.

Payment: A major barrier...has been the lack of reimbursement models. Payment for pharmacists' clinical services to date have been variable and often initiated as grant-funded pilot projects or demonstration programs. Another common model involves funding...by a pharmacy college or primary care or family practice residency program as a model for interdisciplinary care. Alternatively, provider groups with pay-for-performance or quality improvement initiatives may employ or contract with pharmacists, based on expected cost savings, to work with providers and patients on improved chronic disease and medication therapy outcomes, tailored medication adherence programs, or reduced medication-related hospital readmissions. Some state pharmacist associations and entrepreneurial companies have formed independent networks of trained pharmacists to conduct comprehensive clinical services on a fee-for-service contractual basis with provider groups, payers, health plans, and employers. For example, a Centers for Medicare and Medicaid Services (CMS) Medicaid Transformation Grant demonstration project in Connecticut is studying medication management services provided by a pharmacist network working with primary care offices. Lastly, pharmacist-specific Current Procedural Terminology (CPT) billing codes are available, yet infrequently used, to reimburse medication therapy services.

SUMMARY: Erosion of the MD role continues with extension of the pharmacists role in primary care. The model complies with the intent of reform. As usual, the big question who will pay for a pharmacist to work in a MD practice? Answers provided here are not new: grants, P4P savings, etc.

23. Practice Profile A Direct Primary Care Medical Home: The Qliance Experience. William N. Wu, Garrison Bliss, Erika B. Bliss, and Larry A. Green

PRACTICE Qliance Medical Group.

WHO AND WHERE A Seattle primary care practice accepting patients of all ages, staffed by internists, family physicians, and nurse practitioners.

CORE INNOVATIONS In this direct care practice, **in lieu of insurance**, patients pay an **age-adjusted monthly fee for unrestricted, comprehensive primary care**. Patients have **no copayments** for visits. Low overhead allows **providers to have small patient panels**, giving patients better access and allowing **more time per visit**. The objective is to **shift care away from expensive specialists and hospitals**.

KEY RESULTS Qliance has established a **viable, sustainable business model with low overhead and patient panels about a third the size of those of the average insurance-based family physician**. This has allowed patients to enjoy much greater access and clinicians to delve much more deeply into patients' health issues, do more research on health problems, work more closely with consultants when necessary, and work more intensively with patients on health change, leading to greater engagement of and satisfaction among clinicians.

CHALLENGES **Patients still need to have health insurance to cover specialty services, high-cost procedures, emergency treatments, and hospitalization**. Current patient expenses are less than prevailing insurance rates, but there are no quantified data yet on how this model affects overall health care costs. A proliferation of similar small-panel practices might exacerbate the shortage of primary care providers in the near term, although it might eventually attract more physicians to primary care.

Qliance provides comprehensive, same-day primary care for an **age-related fee of \$44–\$84 per month**. The **fee is paid directly to the practice by patients or is paid on their behalf by their employers or unions**. Rates are independent of health status or preexisting conditions. Qliance internists, family physicians, and nurse practitioners can **carry a panel of about 800 patients—about one-third the panel size in a typical practice**. Patients can get **office visits that last thirty to sixty minutes, any day of the week**, plus phone appointments, e-mail communications, and **twenty-four-hour telephone access** to a physician on call. **In a typical day, a Qliance provider sees about ten patients, handles three to ten phone calls, and interacts with one to five patients via e-mail**. Since the first clinic opened in mid-2007, there has been **no turnover among the thirteen providers**, except for one who took maternity leave.

SUMMARY: Reads like a family physician's wet dream. Can this be true in today's healthcare? What do these people earn? The authors say the system is not a concierge practice with high monthly and annual fees that boost the patient to the head of the line, nor is this "direct primary care medical home model" insurance based on fee-for-service reimbursement. They argue the \$60/month fee for unlimited primary care will pay the MD the same amount to manage 1/3 the number of patients required by a traditional insurance-based practice which means the MD can work less without decreasing income. In fact, a long lost appeal to becoming a physician seems to have returned under this model; increased personal and patient satisfaction! This is not a new model either; twelve years implemented in Seattle.

24. Practice Profile An Employer-Directed Health Plan That Seeks To Reenergize Primary Care. Raymond Zastrow, Thomas Van Gilder, and Leonard J. Quadracci

WHO AND WHERE An employer-directed health plan, a subsidiary of Quad/ Graphics, which is a large Wisconsin-based printing firm. Eleven workplace clinics in four states, employing forty-two full-time-equivalent providers, serve as preferred sites for members to receive primary care.

CORE INNOVATIONS Providers are salaried and receive bonuses based on clinical quality, customer service, and collegiality. Claims and pharmacy benefit data are used to monitor patient outcomes such as medication compliance and preventive screening. Premiums are reduced for members who participate in health promotion programs.

KEY RESULTS Actuarial studies indicate that Quad/Graphics' health care expenditures are 17–31 percent lower than those of similar employers in its region. Employees' participation in a health promotion program for two years or more was associated with increased physical activity; reduction in tobacco use; and reduction in cholesterol levels.

CHALLENGES It is likely that a major portion of the cost savings were produced by improved employee health, decreases in use of health care, and thorough preventive care.

The QuadMed **model focuses on prevention and wellness** for all employees and dependents. It aligns the incentives of everyone involved in providing, receiving, and paying for care. Primary care providers are salaried; however, all can receive bonus compensation, which is calculated based on a formula that emphasizes clinical quality, customer service, and **collegiality**, with productivity of secondary concern. Bonuses make up around 10 percent of compensation and are awarded on an “all or none” basis. There is no personal incentive for QuadMed employed providers to overuse treatments, as there is in the provider-owned indemnity model. Nor is there an incentive for underuse, as in the capitation model. Through reasonable copays, unhurried and timely appointments, and wellness incentives, QuadMed patients are encouraged to seek the right care at the right time. Ample time is allotted for each primary care visit. At least thirty minutes are allotted for episodic visits (such as care for an upper respiratory infection or minor injury), and sixty to ninety minutes for complete physicals, comprehensive visits, or complex problems. The extra time is meant to foster close relationships between patient and provider and to encourage the exploration of prevention and wellness issues.

Actuarial studies performed biannually **since 1998** have shown that Quad/Graphics has **consistently saved 17–31 percent on overall health care expenditures**, compared to similar employers in the Midwest. However, primary care services typically make up a greater percentage of total expenditures at Quad/Graphics than at similar Midwest employers. QuadMed's **costs for hospital inpatient care are 38 percent lower, and its pharmacy costs per covered life are 62 percent lower**, than the national norm. QuadMed's integrated design allows for powerful use of administrative data. By bringing together data on patient eligibility with on-site clinic claims and pharmacy benefit data, we have the ability to measure selected outcomes of care, such as medication compliance and adherence to preventive screening protocols. Measuring these variables helps guide our programs by allowing us, for example, to identify potential high-cost claimants and intervene to encourage better compliance and attention to preventive care. **QuadMed has evolved into an accountable care organization.**

SUMMARY: A primer on how healthcare financing could work without too much change in how things are done now. The model accommodates the Medical Home, extended roles for mid levels, quality measures, preventive care, contracted specialists and hospitals, and careful cost monitoring. The result is affordable healthcare with out of pocket costs between \$1500 and \$2500 annually with higher deductibles depending on whether you want to stay in network or outside. Annual costs close to what are current monthly rates! A must read for most head-in-the-sand providers who think the system is irrevocably broken and morally corrupt. Wondering what an ACO will do? Here it is.