# Reformed Incentives

and the

# Patient-Centered Medical Home

**Terry McGeeney, MD, MBA, FAAFP**

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**According to the Future of Family Medicine Report**:

*"unless there are changes in the broader healthcare system* ***and within the specialty****, the position of family medicine in the United States may be untenable in a 10-20 year time-frame, which would be detrimental to the health of the American public."*

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# Associated Press, 9/10/08

- only two percent of graduating medical students say they" were considering practicing as General Internists.

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# Modern Healthcare, 9/9/08

- Dr. Ebell found that **"family medicine had the lowest average salary ($185,740), and the lowest percentage of filled residency positions (42.1 percent),"** Modern Healthcare (9/9, Robeznieks) noted. And, "internists, with the third-lowest salary of $193,162, had the third-lowest residency fill rate: 55.9 percent." In contrast, "radiologists -- whose average salary was $414,875 -- had a residency fill rate of 88.7 percent; and orthopedic surgeons -- whose average salary was $436,481 -- had a fill rate of 93.8 percent." Dr. Ebell wrote that "the correlation between salary and primary-care physician shortages -- which, in turn, may be tied to higher all-cause cardiovascular, cancer-specific, and infant mortality rates -- has persisted since his original research on this issue was published" in 1989.

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# JAMA, 9/10/08

- "medical students are shying away from careers in general internal medicine, which could exacerbate the U.S. doctor shortage expected by the time the youngest baby boomers head into their senior years,"

# MEDICAL STUDENT DEBT IN THE CONTEXT OF PRIMARY CARE INCOMES IS NOT AN ISSUE TO BE IGNORED

# PRIMARY CARE LIFESTYLE IS NOT AN ISSUE TO BE IGNORED

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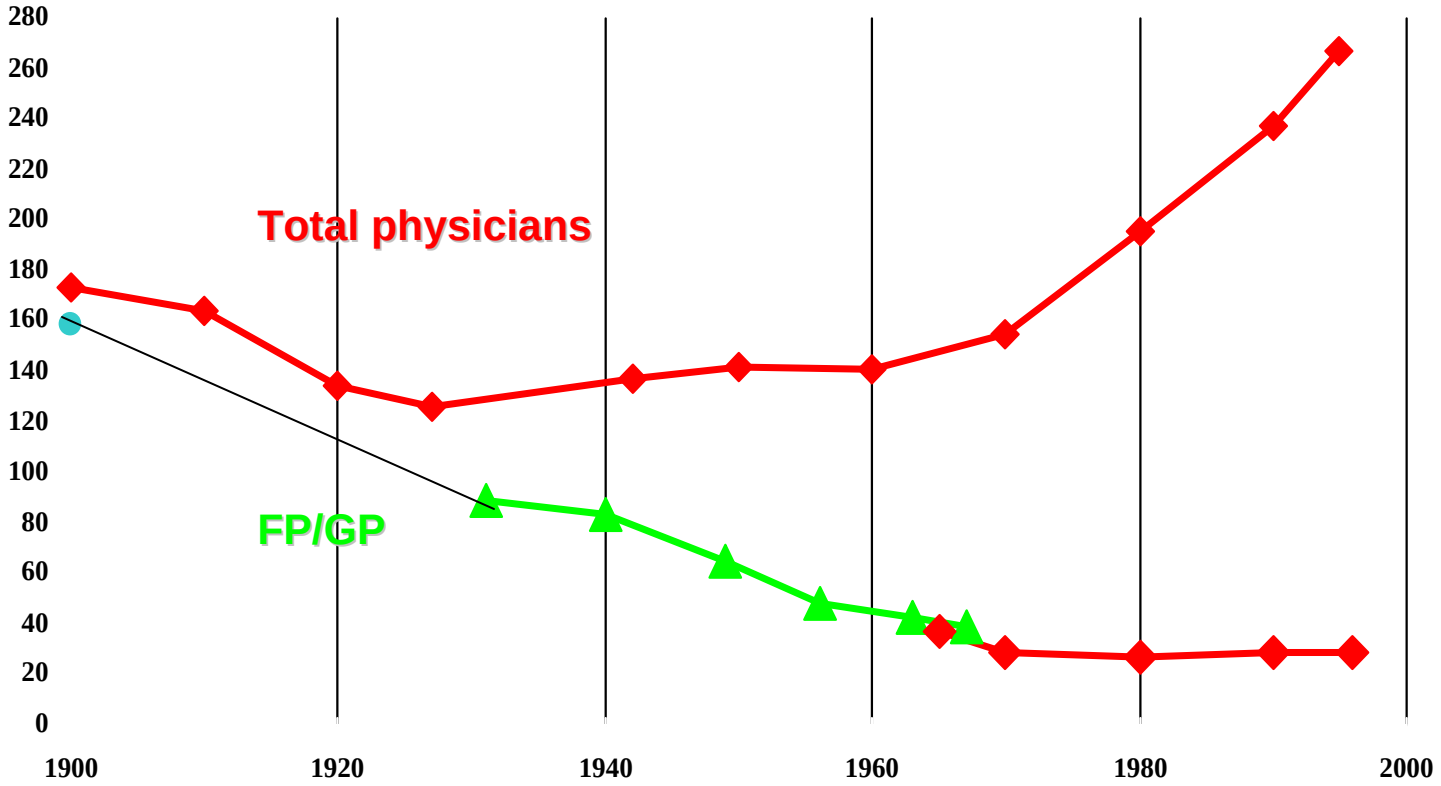
# Total Physicians and FP/GP per 100,000 Population




**Colwill JW, Cultice J. www.cogme.gov/00_8726.pdf**

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- Infant mortality rate is a crucial indicator of a nation's health care standing
  - US ranks 28th on Infant mortality rate
  - US comes behind Portugal, Greece, the Czech Republic, Northern Ireland, and 23 other nations

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# US Healthcare System

In 2006:

- The US health care expenses surpassed $2 trillion
- US health care spending was about $7K/person
  - Highest in the world
  - 20% more than Luxembourg's, the next highest
  - More than twice the average of 30 other wealthy countries
- US health care spending accounted for 16% of the nation's Gross Domestic Product (GDP).
- Total health care spending grew at a 6.7% annual rate, outpacing inflation and the growth in national income.

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- US healthcare system falls behind other developed countries:
  - Cancer survival (the US ranks behind Italy, Ireland, Germany and others)
  - Diabetes care
  - Only 50% get treatments that scientific studies show to work

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# Best in the World Myth

- 44,000 – 98,000 estimated annual deaths from medical mistakes in hospitals
- 101,000 estimated annual deaths from “amenable mortality” – deaths preventable by medical care.

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# WHAT PCMH IS AND IS NOT

- Patient Centered Medical Home is not about more new money for Primary Care
- It's not just about primary care
- It is not about just doing a better job of chronic disease management
- It's not about making more money for payers
- It is about redefining and redesigning the US Healthcare system focusing on the patient
- It's about the opportunity to fix what is broken

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# The Healthcare System Must Change

- The Patient Centered Medical Home creates a framework for change
- The Patient Centered Medical Home creates a common language for change
- The Patient Centered Medical Home creates an opportunity for change
- The Patient Centered Medical Home is not just for primary care—any practice could be a medical home

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# THE US HEALTHCARE SYSTEM IS PROVIDING EXACTLY WHAT IT WAS DESIGNED TO PROVIDE

High Volume

Excessive Procedures

Dr “Well Qualified”—consultations vs initial primary care visits

Focuses on Activity not outcomes

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# WHAT IF HEALTHCARE WAS A BASKETBALL GAME?

Reward for number of shots taken not number of baskets made

Greg Paulsen, NCQA

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# WHAT IF?

Auto repair shops were treated like healthcare providers and hospitals.

- Pay for repairs even though the car still doesn't start
- Get charged for 4 new tires when one tire had a leak
- Pay for "premium" when regular works just fine and there is no evidence that "premium" improves performance

A bottle of wine in a restaurant is bad but you have to pay for it anyway

A carpenter who is hired to shingle your roof but breaks the gutters and charges you for new gutters

You call your lawyer and ask him/her to fill out forms for free

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# THE PAYMENT INCENTIVE SYSTEM OF TODAY DOES NOT REWARD WHAT IS IMPORTANT TO PATIENT'S HEALTH

Coordination of Care

Collaboration on Care

Technology advancements

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# INCENTIVES ARE NOT CORRECTLY ALIGNED FOR PATIENT

Patients are disengaged from the cost and responsibility for their care----the do everything at any cost mentality, the “give me only the best mentality”’ the “more tests the better and the sooner the better mentality”

Patients associate “more” with quality, they associate expense with quality

Reward the patient for making good choices—smoking, obesity, generics

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# GOVERNMENT DOES NOT CREATE APPROPRIATE INCENTIVES

Lack of competitive bidding in the medicare drug program

Paying extra for procedures that could be done outpatient when they are done in hospitals

Paying for things that no real evidence  stint vs bypass, prostate ca treatments

Reward mistakes or bad care with extra pay

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# INCENTIVES ARE NOT CORRECTLY ALIGNED FOR VENDORS

Electronic Health Records that can't talk to each other

Lack of interactive data repositories

Lack of effective registry functions in EMR's

Lack of fully integrated E-Prescribing with updated/accurate information

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# INCENTIVES ARE NOT CORRECTLY ALIGNED BY PAYERS

Quality is judged by doing things to patients and the volume of those things not the outcome determines quailty

Pay for performance is really pay for showing up—doing a blood test not managing the results—HBA1C for Diabetics

Pay for Performance causes non-compliant patients to be eliminated from panelsPay for performance is really pay for showing up—doing a blood test not managing the results

Paying for checking boxes instead of performance—asthmatic/access

Only paying for face to face—bad for payers, bad for patients, bad for practice, bad for access—not enough primary care want to maximize skill

Paying for things that no real evidence  stint vs bypass, prostate ca treatments

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# PAYERS CONTINUED

Only paying for face to face—bad for payers, bad for patients, bad for practice, bad for access—not enough primary care want to maximize skill

Paying for checking boxes instead of performance—asthmatic/access

The system is such that Payers just want to keep patient costs down until the patient become Medicare's problem

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# INCENTIVES ARE NOT CORRECTLY ALIGNED FOR HOSPITALS

More is better mentality

ER visits and fragmentation of care as a revenue driver

Cost Shifting

Cost variability to patient based on payer or no payer

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# INCENTIVES NEED TO BE ALIGNED WITH THE NEEDS OF THE US HEALTHCARE SYSTEM AND PATIENTS

Reward for quality not doing things and volume

Reward for technology

Reward for process leading to improved outcomes

Reward for systems

Reward for things such as coordinating care

Reward patients for making the right decisions based on complete information such as which cardiologist does the most caths with no evidence of improved outcome

Reward for outcomes, not checking boxes

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# Key Attributes of Patient-Centered Care –Commonwealth Fund

- A high degree of consensus exists regarding the key attributes of patient-centered care. In a systematic review of nine models and frameworks for defining patient-centered care, the following six core elements were identified most frequently:

- Education and shared knowledge
- Involvement of family and friends
- Collaboration and team management
- Sensitivity to nonmedical and spiritual dimensions of care
- Respect for patient needs and preferences
- Free flow and accessibility of information

- None of these things are currently part of incentives

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# HOW SHOULD INCENTIVES BE ALIGNED ?

## The Patient Centered Medical Home

Around True Quality, real outcomes, real process change, effective technology

---Around what's best for the patient!

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# PCMH Pilots-proving the value/realigning incentives Medical Homes

- CMS
- Payers
- Employers
- State Medicaid

- (PCMH pilots and chronic disease management pilots are not the same)

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# PAYMENT MODELS BEING TESTED

Care Management Fee + Fee for Service + Pay for Performance

No risk primary care capitation with incentives for NCQA PCMH recognition and quality

Enhanced Fee for Service

Enhanced payment for things not previously paid for such as electronic visits or group visits

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# TransforMED℠ Patient Centered Medical Home

**Access to Care & Information**
- Health care for all
- Same-day appointments
- After-hours access coverage
- Lab results highly accessible
- Online patient services
- e-Visits
- Group visits

**Practice Management**
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

**Practice Services**
- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

**Health Information Technology**
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

**Care Management**
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Care coordination
- Patient engagement and education
- Leverages automated technologies

**Quality and Safety**
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

**Continuity of Care Services**
- Community-based services
- Collaborative relationships
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management

**Practice-Based Care Team**
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

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