

Medical Home

NEWS

Prescription for Pennsylvania -- A Multi-Stakeholder Chronic Care Initiative

By Ann Torregrossa, Esq. Director, Governor's Office of Health Care Reform, Commonwealth of Pennsylvania

In 2007, Governor Edward G. Rendell announced his comprehensive health care reform package, *Prescription for Pennsylvania*, to increase access to quality affordable health care for all Pennsylvanians. In doing so, he made reforming the way chronic illness is treated and paid for a priority, because of its potential to significantly improve the health of persons with chronic conditions while reducing costs by eliminating avoidable emergency room visits and hospitalizations.

Research has shown that twenty percent of persons with chronic conditions result in 75 percent of all health care costs, including 80 percent of hospitalizations, 76 percent of physician visits, and 91 percent of filled prescriptions.

In 2007, the Pennsylvania Health Care Cost Containment Council reported that Pennsylvania hospitals charged more than \$4 billion for potentially avoidable hospital charges for chronic illnesses, which could have been reduced or eliminated if the patients had received needed care from their primary care providers.

continued on page 4

In This Issue

- 1** Rx for Pennsylvania -- A Multi-Stakeholder Chronic Care Initiative
- 1** Family Medicine Residents and the MH: A Colorado Initiative to Prepare the Physician Leaders of Tomorrow
- 2** Subscriber's Corner
- 2** Editor's Corner
- 3** The Last Resort? The Case for Direct Practice Models in Primary Care
- 9** Thought Leader's Corner
- 11** Industry News
- 12** Catching Up With... Kevin Grumbach, MD

Family Medicine Residents and the Medical Home: A Colorado Initiative to Prepare the Physician Leaders of Tomorrow

By Deb Barnett, RN, MS, FNP, CCGC Coordinator, Grants Management & Program Development; Julie Schilz, RN, BSN, MBA, CCGC IPIP and PCMH Manager; and Bonnie Jortberg, RD, MS, CDE, Senior Instructor, University of Colorado Department of Family Medicine

As successful tools and techniques are gathered to assist family medicine physicians in leading their respective practices in transformation into medical homes, a natural next step is to channel energy and resources into the family physician during residency training. During these formative years, skills for leadership in practice transformation can be built from the ground up. In order for this learning to take place, the primary care setting where the resident practices ultimately must become a well-oiled machine for robust and sustainable change.

Practice transformation in the family medicine residency setting brings with it a host of challenges not seen in private primary care practices. Residency practices involve a large number of moving parts primarily related to revolving three-year resident tenures, resident away rotations, resident work hour restrictions, and the part-time availability of residents and attending faculty in the clinic. Attending resources are also often augmented by the use of multiple community physicians, which adds another set of variables to the mix. The complexity of attempting transformation in residency practices is often magnified by an affiliation with a sponsoring organization that brings with it many common system-level barriers to change.

continued on page 6

The Last Resort? The Case for Direct Practice Models in Primary Care

By Garrison Bliss, MD

“You can always count on Americans to do the right thing - after they've tried everything else.”

– *Winston Churchill*

The Congress of the United States is currently enmeshed in a confused, hectic exercise in policy by committee. They have heard the arguments from the “stake holders” and are rapidly accelerating towards mammoth legislation that will likely make American medicine more expensive and less effective year over year for the foreseeable future, even while accomplishing the laudable goal of insuring all Americans. This is occurring not because the Congress is uninformed, nor because it desires to create an economic debacle that could dwarf the current banking crisis. It is because almost nobody seems to be aware of the fact that health insurance is not health care – and these bills are about health insurance. We have spent the last 50 years trying to tune up health insurance so that the health care works, and every time we fix it, care gets more expensive, less accessible, and less effective. You would think that we would have figured it out by now.

What should we all know about health care to clarify and simplify the right next steps before it is too late? The first and foremost principle is that primary health care is not just a good thing; it is a critical element without which health care doesn't happen, at least not inexpensive, effective, and safe health care. There is mounting and hard to dispute global evidence that the more primary care physicians there are, the less expensive and safer the health care systems is. The second and more subtle principle is that health insurance kills primary care. The reasons for this are not visible to policy makers, but are obvious to those of us who are primary care physicians. At least 40% of every dollar spent on primary care in the US goes toward transaction costs – the bookkeepers, the computer systems, the forms being filled, emailed, faxed, and reviewed daily in every medical office and every insurance company. When the claims are for expensive items like bone marrow transplants and heart surgery, it makes sense to peruse the charges carefully, but what about the charge for the hemocult or the \$60 office visit? It has recently been demonstrated that a primary care physician who works a 40 hour week has to spend over 60 hours of staff and physician time to get paid. The complexity of getting paid is greater for primary care physicians than for any specialist. The bottom line for insurance supported primary care physicians is bleak and getting bleaker.

In order to make a living in a fee-for-service insurance environment, physicians are seeing 25-35 patients a day. This means that the quality of primary care declines and that the interest in primary care specialties is hitting an all-time low. Primary care residencies have been declining in number and they do not fill. Now over half of the residency spots that do fill are occupied by foreign medical school graduates. As more and more of our medical students become hospitalists, anesthesiologists, surgeons, and emergency room physicians, the absence of primary care physicians drives more and more patients (who are now sicker and sicker because they can't get primary care) to these newly minted specialists, dramatically increasing the cost of health care as the quality, access, and safety of that care drops. As they are herded into the hands of the specialists, the number of CAT scans, MRI scans, invasive procedures, and aggressive treatments increase. Since there is nobody to coordinate this frenetic specialty activity, the number of coordination errors increases. Patients end up on more medications with more interactions and no referee in sight.

As primary care slips into a death spiral, it behooves us to ask: What could we do to stop this? Is there anything that could reverse this process or is it too late to save health care and the primary care physicians who could bring it back under control? This was the question that spawned the Qliance Medical Group, and it remains the source of our inspiration. Qliance is a shot at the center of the health care target. It is a simple and powerful idea. We are primary care physicians who work for our patients. They pay us an affordable monthly fee (currently \$39-79 per month depending on age) and we provide their primary care. We are a Direct Practice: we charge the patient a monthly fee and we do NOT bill their insurance company for anything. We do it 7 days a week – yes, Saturday and Sunday office hours too. We are open 12 hours a day Monday through Friday. If you are a member, you can get an urgent same or next day appointment when you call us. There is always a physician on call if you call after hours. If you buy something from us, we charge you our cost. Our X-rays are free, but the radiologist will charge you \$17 to read any set of films. We have a formulary of generic medications for patients who don't want to stop and wait at the pharmacy. We charge our cost for the medication. Liquid nitrogen and suturing is free. If you need a wrist splint or any kind of brace, you pay our cost. If you pay cash for lab work, you get our discount (50-75% off). Cool, right?

Even more important, we want you to see *us* when you are sick, not the ER docs. We value our patients, work for our patients, and realize that if we don't provide real palpable service, they will stop paying their monthly fee. That is why we are open on weekends and why we talk to our patients at night. When was the last time that doctors were incentivized to do the right thing? When was the last time that patients had power in a medical office? When was the last time you saw a patient without considering coding?

Besides trying to please and amaze our patients, we also aim to satisfy the needs of our physicians. As we grow, our physician salaries will be comparable to those of insurance supported physicians, but they will be seeing patients for 30-60 minute office visits (not the current 7-10 minute version that is the “norm” in America). They will have the time to practice real medicine and have time for their families and hobbies. We limit their patient panel size to make it possible for us to keep our promises to our patients.

continued on page 4

The Last Resort...continued

We are also investing in technology that makes health care efficient, unlike the current crop of Electronic Medical Records that make insurance billing efficient. Wouldn't you like to see an EMR that facilitates timely recall and communication with your patients? How about a rules-based reminder system that lets the physician and the patient know when it is time to do maintenance work, and that makes sure the work actually gets done?

Currently Qliance is small – 2 clinics in the Seattle area, a third coming on line in December or January. But we now have ways to package our monthly fee primary care with insurance products that complement our service, saving individuals as much as 50% on their health care expenses and companies from 20-35% while offering their employees Qliance care 7 days a week.

It may seem ironic, but our avoidance of insurance money makes us the perfect partner for an innovative insurance company that wants to join forces with a primary care provider interested in cutting down the number of specialty visits, ER visits, and hospital admissions. If we can make even a small dent in unnecessary downstream costs, then the insurers can sell less expensive policies that provide better care because the patients have real primary care on the front end. This is how we fix the health care system, on the ground from the bottom up – combining insurance with a new non-insurance health care paradigm. Although we don't yet have the downstream data to know how we are impacting the cost of care, pilot projects with insurers offer the best method to collect and analyze that data. We are currently completing negotiations with both national and regional health insurance organizations to start these pilots.

Conservative estimates of potential savings can be gleaned from a primary care medical home project completed in 2008 showing 11% reductions in overall costs in a North Carolina Medicaid program utilizing primary care medical homes. This project did not include 7 day access to care or any of the other innovations that Qliance is now offering. We hope to reduce downstream costs by 20-40% by simply doing primary care well and by giving our providers the time and tools to get that job done. We also intend to make primary care a desirable ambition for coming generations of medical students and residents, thus averting the demise of primary care in this country.

Qliance and other Direct Primary Care Practices in 21 States are banding together to encourage the Congress to add innovative Insurance/Direct Practice hybrids to the insurance exchanges being mandated by these bills. This would allow all of us to continue working for our patients without forcing those patients to buy their primary care twice – once from their insurance company and again from us.

That is how we plan to save medical care:

- By no longer working for insurance companies and by instead working for our patients directly
- By being capitated by our own patients to produce the care that we are proud of and that they want and can afford
- By eliminating profit on items and services sold as ancillaries in our office to avoid incenting over or under utilization
- By being open 7 days a week and by having hours that serve the needs of our patients
- By doing what we can do in the primary care world so that our patients don't need to end up in hospitals, emergency rooms, and specialists' offices unless there is no good alternative
- By coordinating and communicating with the rest of the medical care world so that our patients have unified, safe, and sensible care
- By collaborating with like-minded health care systems and insurers to create a uniquely American solution to the problem of health care in this country

In this way we hope to provide high quality, low cost, high access, truly human health care that might actually become the envy of the rest of the world some day. Perhaps Winston Churchill was right.

Garrison Bliss, MD is Chief Medical Officer of Qliance Medical Management Inc. and President of Qliance Medical Group of Washington PC, Seattle, WA. He can be reached at 206-913-4700 and by email at qliance@qliance.com.

Prescription for Pennsylvania...continued

To determine how to best meet the challenges posed, the governor created the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission (Chronic Care Commission) to work with the Governor's Office of Health Care Reform (GOHCR) to develop a strategic plan for transforming how chronic care is provided and paid for across the Commonwealth. The 44 members of the commission, composed of some of the thought leaders on health care in Pennsylvania, reviewed Pennsylvania data and national best practices that were proven to improve health outcomes while reducing cost.

In the strategic plan they presented to the Governor and legislative leaders in February 2008, they recommended that primary care practices be engaged to transform how they treat chronically ill patients through a series of regional learning collaboratives that incorporate both the Chronic Care Model developed by Dr. Ed Wagner at the MacColl Institute for Healthcare Innovation and the Patient-Centered Medical Home model developed by the Patient-Centered Primary Care Collaborative. Recommendations to include payment reform were also in the plan.

continued on page 5