Feeling right at home

Small-town physicians group puts medical-home concept into practice

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Common wisdom would say that significant innovations in healthcare delivery typically get their start in big cities or at major academic medical centers.

Likewise, Selmer, Tenn., with a population of about 4,600 might be an unlikely place to find a medical practice at the leading edge of an integrated-care concept that could transform the industry. Two hours east of Memphis, almost three hours southwest of Nashville, and just north of the Mississippi border, it's where Buford Pusser, immortalized in the "Walking Tall" movies, served as county sheriff in the 1960s. Now it's the home of the Prime Care Medical Center, a physician practice that's pushing the electronic health-record envelope and seeking to achieve designation as a patient-centered medical home even before the state standards for such a designation have been established. It's a process the practice has spent the past couple of years pursuing.

Prime Care is headed by physician James King, board chairman of the American Academy of Family Physicians and its immediate past president. He's leading by example, attempting to show his primary-care colleagues the advantages that medical homes provide both to patients and to a fragmented medical system. He's also leading by adopting the approach long before the economic incentives to practice this way are in place.

"It's not financially advantageous to do so yet," King says of the process his practice is going through to meet the medical home standards of the National Committee for Quality Assurance. "We will probably seek designation next year so we'll be ahead of the curve and be designated before (insurance) products show up."

Pediatricians are credited with developing the medical-home concept. And, last year, the American Academy of Pediatrics teamed up with the American College of Physicians, American Academy of Family Physicians and American Osteopathic Association to develop medical-home principles. These involve patients having a personal physician who leads an integrated team of healthcare professionals providing coordinated acute, chronic, preventive and end-of-life care facilitated by information technology tools and based on a foundation of safety and quality improvement (Nov. 12, 2007, p. 6).

Practice elements needed to achieve the NCQA medical-home designation include: enhanced patient-physician access and communication; tracking of

patient conditions, tests and referrals; care coordination management, disease registries; electronic prescribing; and mechanisms for performance reporting and improvement. Currently, the NCQA recognizes only six practices in Maine, Maryland, New York and Pennsylvania as fulfilling the requirements of a patient-centered medical home.

‘More difficult than it may appear’

“A lot of these things we already do—that’s just the way the practice works,” says Prime Care office manager Amanda Shelton. “You have to document everything, because—if the insurance company asks ‘Why did you do something?’—you have to be able to tell them why.”

Although the concept is basic, Prime Care physician Tim Linder says it’s not easy to meet the NCQA requirements.

“Half the primary-care docs would say, ‘I’m a medical home,’ but they’re not a good medical home,” Linder says.

Along with 31 other Blues plans, Blue Cross and Blue Shield of Tennessee is working on some medical-home pilot projects both on its own and in collaboration with the Robert Wood Johnson Foundation and the Memphis Business Group on Health.

“We have made it known we’re trying to establish a different way of delivering healthcare, and the patient-centered medical home can certainly be a part of that and would not be a bad place to start,” says Ken Patric, vice president and chief medical officer of the Tennessee Blues. “The concept is a simple one, but the operationalizing of it may be more difficult than it may appear.”

Tennessee Blues is getting started this month on its independent pilot with Cooksville (Tenn.) Primary Care Associates, a two-physician practice, says Senior Project Manager Kevin Raynor.

Raynor says for October and November, the practice will be paid a $5 per member per month care-management fee but, starting in December, the fee will go toward only those Blues members who have been recruited into the medical-home program. He adds that the Blues will also reimburse doctors $30 for e-mail and telephone consultations, though the parameters for what constitutes a consult haven’t been firmly established.

Targets are also being established for asthma, cardiac care, diabetes and hypertension outcomes; if those are met, Raynor says bonuses will be paid out sometime in early 2010.

There aren’t many data yet proving the benefits of the medical home, but a report in the September-October edition of the journal Health Affairs indicated that the

concept helped reduce hospital admissions by 20% and cut medical costs by 7% for Pennsylvania's Geisinger Health System in 2007.

In addition to his belief that medical homes can transform healthcare delivery and benefit patients, King's practice has a direct financial stake. "It's 40% of what we do for our patients, but there's no reimbursement formula for that," he says of the care-coordination services his practice provides.

Prime Care has 39 employees, including seven doctors, three nurse practitioners, three nurses, six billing clerks, six who staff the front desk, four administrative staffers and three referral clerks—including Elsie Suggs, a mild-mannered woman whose job description includes arguing with insurance companies.

"I may be on the phone for an hour at a time with insurance companies," Suggs says. "That's time my doctors are paying me for, but they're not getting any reimbursement."

Although insurers don't pay Prime Care for the work Suggs performs—at least not yet—Linder says "Elsie is worth her weight in gold."

Suggs' work involves tasks she says "doctors shouldn't need to be bothered with," such as coordinating outpatient tests, arranging for home healthcare and specialist referrals, making sure patients get test results and see the specialists that are in their health plans' networks, making sure the other providers have the medical data they need, and that Prime Care physicians get reports back from these other providers.

"If I wasn't here, the patients would end up with huge bills," Suggs explains. "There'd probably be a lot of nonpayments."

King, who estimates that 25% to 30% of Prime Care patients see a subspecialist on a regular basis, looks at Suggs' work as a public service. "We do everyone else's paperwork," he says.

Angst among specialists

Suggs' job also requires diplomatic skills in dealing with other specialists. King says about 10% to 15% of Prime Care's patients live in Mississippi or get prescriptions filled across the border, and this can sometimes cause some bumps in the patient's treatment. But Suggs says physician attitudes toward privacy regulations under the Health Insurance Portability and Accountability Act of 1996, not the law itself, lead to these problems.

"Some specialists won't send their reports back to us—even if we referred our patients to them," Suggs says. "It has nothing to do with state lines; it's the individual doctor's interpretation of HIPAA."

Other times, it's not their attitude about HIPAA but their attitude in general that causes problems. "Some specialists say they don't want the primary-care physician's notes," Suggs says. "They say, 'No thank you; it's a waste of our fax paper.' "

Linder says that this attitude is still common and ends up costing the healthcare system money. There are times he will have test results sent to specialists, he says, and then discover the specialists ordered the same tests anyway.

"People have to be dragged kicking and screaming to work together," Linder says.

There's also some wariness of the medical-home concept among specialists, because of the fear that if primary care gets more money, specialists will get less.

"Everyone realizes the pie can't get much larger," King says, noting how the nation spends about 16% of its gross domestic product on healthcare, a $2.3 trillion healthcare bill. "If we pay primary care more, it will have to come from somewhere. We see the money coming (from) savings from having fewer hospitalizations and emergency room visits, and, as EHRs get tied together, duplication of services will be less."

Both King and Patric say that the primary-care reimbursement for medical-home services shouldn't result in less compensation for specialists, but both add that—if medical homes work as well in practice as they do in theory—improved healthcare outcomes will lower the demand for specialists while increasing demand for primary-care physicians, and a balance will be achieved that results in fewer specialists being paid about the same rate they are making now.

"If people are healthier and don't need as many procedures, then there will be less need for specialists," Patric says.

Patric adds that it's just not a matter of the healthcare industry waiting for insurance companies to flip a switch and reimburse for care coordination and other medical-home services.

"When a physician sees a patient with a Blue Cross card, they think it's monolithic and that everyone has the same coverage," Patric explains. "We administer some 300 different plans, usually for large companies, and those companies decide what the benefits will be."

Patric says he knows of one large company that has been promoting the medical-home concept, but its support coincides with a desire to abandon its disease-management program.

In June, the industry group America's Health Insurance Plans issued a set of principles for patient-centered medical homes that included the use of pilot testing before moving forward with "reformed payment models," linking payment to measurable improvements, and using health IT to "facilitate evidence-based integrated care." A written statement released by the AHIP board calls the medical home "a promising concept that would replace episodic care with a sustained relationship between patient and physician."

The AHIP board adds that payment should "reflect the level of management required for the population served," and should also encourage "measurable improvements in clinical quality, access and satisfaction."

Though care coordination is a large part of the concept, King says there's more to achieving NCQA medical-home designation than just that. Enhanced access is a major component and, to achieve that end, Prime Care instituted "open-access scheduling" two years ago. "If you call today, you will be seen today," King says.

As a result of keeping about half his appointment slots open, King says he may show up for work with only 15 patients scheduled to visit but wind up seeing 35 before the day is through.

"It fluctuates, but not terribly bad," King says. "Also, this is an agricultural area. So, if it's wet, farmers want to get in before it's dry."

Although there are no convenient-care clinics operating inside Selmer retail businesses yet, King says he believes Prime Care had to "compete with the concept," and says the idea behind open-access scheduling is to improve patient satisfaction and, so far at least, it's having that effect. He admits, however, that part of the reason is because patient expectations have fallen so low. "They're so used to being put off," King says.

Open access isn't unconditional, however. King says patients give up the right to choose the doctor they want to see and, instead, see the physician who has a schedule opening. They also give up their right to "by the ways."

"You can't come in for a sore throat and say, 'By the way, I need my cholesterol checked,' " he says.

Another component of the medical home is enhanced communication. Part of that is being addressed by Beverly Dickey, who—in describing her role at Prime Care—says "I'm the nurse who became the IT person."

In addition to preparing for testing to begin electronic prescribing, which will replace Prime Care's computerized fax method, Dickey is working on developing a Web site application that will provide patients with results of their laboratory

tests over a secure e-mail. Patients would have access to the same secure e-mail system to send questions about those tests to nurses.

Among the taller stacks of paper neatly arranged on Dickey's desk is a work-in-progress project that, when finished, will serve as a guide to the other Prime Care doctors to make sure they're implementing the medical-home components correctly.

"I'm putting a manual together on how this process works and to make sure the patient protocols are met," Dickey says. This includes the creation of population registries that help chart the progress of patients with diabetes, hypertension and other chronic conditions. Such written standards are part of the NCQA's requirements for a medical-home designation.**A little extra attention**
"The end result is that our chronic patients are getting greater quality of care," Dickey says. "Patients are impressed and feel like they're getting a little extra attention, and it opens the doctors' schedules to treat more acute things."

Currently, however, the EHR system Prime Care uses—an older version of the GE Healthcare's Centricity Electronic Medical Record—lacks the ability to automatically populate patient registries, so the data need to be entered manually, something both Dickey and King hope will be corrected when they upgrade their EHR system, which is both universal and mobile for every member of the clinical staff.

"Every nurse, every physician has a tablet" computer, King says. "We're wireless, so I can take it in the room with me."

Putting the patient at ease is important, says King, who doesn't wear the traditional white coat in the exam room, and he makes sure others in the practice get the message. He tells of how he had to instruct one of the Prime Care doctors not to stand at the exam-room counter with his back to patients as he worked on the computer.

Although King works with the computer between him and the patient, he makes sure to make eye contact while in the exam room. He also keeps the bedside-manner banter going while all the time entering data or making quick jabs at his computer screen with the stylus.

While seeing one patient, a middle-aged gentleman with chronic allergies, King notes how the man continues to use him as his doctor despite the fact that he moved two hours away.

"He likes me—or he feels sorry for me," King says.

"He tries to help," the man replies. "Most of the time, he does."

During the next appointment, while King catches up on a woman's recent medical history, the patient, complaining of foot pain, tells King, "All I have to do is start walking, lose some weight and stop growing old."

"The alternative to growing old is not a good one," King replies, as he makes a diagnosis of plantar fasciitis and—instead of writing a prescription—he prints out some information on the condition, including some suggested exercises that should relieve the pain.

King says that Prime Care started moving away from paper medical records about five years ago, when it started looking to upgrade its accounting software and decided it was a good time to go paperless on the clinical side as well. Despite Prime Care's somewhat remote location, he says the IT companies he notified sent sales representatives to his office.

"The problem is there are so many of them," King recalls. "You don't know who will be around two years from now."

That's one reason why he chose GE's product, because he thought the company has staying power, but he adds that the AAFP doesn't favor one IT vendor over another.

Dickey says the original plan was to go live with the EHR one doctor at a time, but then it was decided that they would "jump in all at once," and King says there was a definite loss in productivity at first as people learned how to use the system, but now no one would ever go back.

In the beginning, King says he'd come into the office two hours early every day to enter into the new EHR the data he thought he'd need from his patients' old paper records, but the need to do this diminished within a few months.

The move also allowed him to decrease his staff by 2½ full-time-equivalent employees as they didn't need clerks to pull and refile patient records. Another move was that the person who used to transcribe physician dictation, Jackie Tull, now does document scanning. In addition to gleaning needed information and charts from the old paper records, she scans the records delivered or faxed from other physicians.

"This is from just one patient," Tull says pointing to a three-inch stack of paper.

King says not all paper records need to be scanned, and because data can't be manipulated or aggregated, it's not all that useful to scan in some charts. With these, he says just typing in something like "Dr. Smith's records on file" will suffice.

Also, as the need for storage space goes down, King is turning the paper record shelves into a library with the staff bringing books they'd like to share. In addition to sharing reading materials, the staff often shares lunch together with prepared meals brought in from local restaurants, both of which combine for building a team and family atmosphere.

"It works pretty well," Linder says. "Though maybe it would be better if we didn't have it, because I'd eat less and wouldn't have to exercise more."**The team spirit**
Linder says the team spirit gets noticed by the medical students assigned to the practice.

"We have fun," he says. "There's a joke at the med school that we turn radiologists into family medicine docs."

The Prime Care team started in 1985 with three doctors, and Linder joined as the fourth about 11 years ago, but his relationship with King goes back much further.

He says that King was the best man at his wedding and they attended medical school together at the University of Tennessee College of Medicine, Memphis, and they did their residency at the University of Tennessee Family Medicine Residency program at 551-bed Jackson-Madison County General Hospital in Jackson.

"He's a thinker and a doer; he's not a sitter," Linder says of King. "Going to school, our mantra was, 'Let's just get it done.' "

Like King, Linder is also active in the AAFP and serves as a delegate from Tennessee. But, instead of seeking a national post in the organization, Linder ran for a seat in the Tennessee Senate, but he finished third among three Republicans seeking to fill a seat vacated by a retiring long-time Democratic incumbent.

Linder credits King with Prime Care's clinical and economical success.

"He actually knows how to run a business, which is something less than 5% of doctors know how to do," Linder says.

King agrees with the comment somewhat, noting that the work Prime Care is doing to become a medical home doesn't necessarily put them at a competitive advantage in growing a patient base, but he thinks the efficiency it builds into the practice will pay off in the long run.

"Most primary-care physicians have enough work," he says. "The difficulty is making the business work at that level."