

Prescription: PCP

The key to health care reform? Empowering your primary care physician, one nonprofit says

By Anthony Lane

A woman with abdominal pain walks into an emergency room.

No, it's not a joke, but a recipe for some serious health care spending. Start with a CAT scan, which could run \$6,000. Blood tests, administrative costs and other expenses might add hundreds more.

individual practices create a "patient-centered medical home," in the lingo of policy wonks.

"The reality is that a family doctor, or an internal medicine doctor, can handle most of what comes in the door," Sharp says.

same tests). It also changes the way participating doctors are compensated. Instead of just collecting fees for services rendered, these doctors will get a per-patient care management fee and will get some compensation based on their performance managing chronic conditions like diabetes and depression.

In many ways, the Sharps' office in Woodland Park already functioned as a medical home before the pilot program started in the spring. The doctors cap the number of patients they see at around 1,900, so those who are sick can always get an appointment quickly. (Sorry, there's a waiting list for newcomers.)

effective primary care practices: eliminate barriers to access, encourage relationships, emphasize comprehensive care and coordinate patients' care.

You might think he'd be a proponent of patient-centered medical homes, but Moore sees a problem with them. He says that since pay-for-performance plans often base compensation on the way doctors manage specific diseases, medical homes can encourage doctors to neglect overall health in the interest of lowering, for instance, a diabetic patient's blood-sugar measurements.

"There are unintended consequences," he says, adding that incentives should

How it works

A "patient centered medical home" may be the latest awkward phrase to enter the health care vernacular, but it's actually an idea with some traction — Medicaid, the federal program for low-income families, has embraced it, and several pilot programs in different states are trying it out with private insurers.

Through March in Colorado, about 150,000 children on Medicaid or the

state's Child Health Plan Plus coverage were signed on with a doctor offering the medical home approach. The government pays these doctors extra for seeing patients when they are well, and it also connects them with social services and other providers so they can address needs of families that might be struggling because of lost jobs or housing. The overarching goal is to improve general health and reduce hospitalizations.

The Colorado Department of Health Care Policy and Financing reports that the program saves an average of \$215 a year for each child, with savings jumping to more than \$1,100 each year for children with chronic medical conditions. At a minimum, this amounts to tens of millions of dollars.

Applying the same idea to adults covered by private insurance companies would require a "culture change" in how doctors organize their practices and receive reimbursement from insurers, says Marjie Harbrecht, director of the Colorado Clinical Guidelines Collaborative, the nonprofit overseeing the pilot program. It's daunting, she says, but necessary: "We've got to get back to a primary care base."

The pilot program encourages doctors to focus on relationships with patients, improved access to care and coordination of patients' treatment (preventing different specialists from running the

And all this, for one of Dr. Greg Sharp's patients, might have failed to show the real problem: The woman, who had her gallbladder removed years ago, was uncomfortable because a sphincter on a tube leading to the missing organ was freaking out.

"Because I knew the patient, because I knew her history, we basically figured out it was not an emergency," says Sharp, a family physician who recently treated the woman at his office in Woodland Park. After a short visit, costing maybe \$65, he wrote her a prescription.

She was better the next day.

"That's what it means to have a doctor who knows you," says Sharp, who runs Ideal Family Healthcare with his wife, Heather Sharp. "You save money while finding out what is wrong."

In this era of Health Maintenance Organizations, primary care physicians have often been scorned as gatekeepers, people limiting access to more expensive care provided by specialists. But many health care reform advocates now believe efficient, effective primary care is essential to reining in the nation's out-of-control health care spending.

Ideal Family, along with 16 other offices on Colorado's Front Range, is participating in a national pilot project aimed at doing just that: tweaking the health care payment system and helping



Dr. Greg Sharp likes to keep up with his younger patients.



Greg and Heather Sharp stay accessible, even after hours, by cell phone.

Patients have the doctors' cell phone number, so they can call, even in the middle of the night, to determine whether they should go to an emergency room or wait for an office visit in the morning.

Greg Sharp says the pilot program coaches doctors and staff to ramp up their technology (something he and his wife were already doing). He's pleased that it provides some reimbursement for the time he spends e-mailing patients or coordinating their care.

"The medical home wants to defragment care, so it's not, 'The left hand doesn't know what the right is doing,'" he says. He laughs as he continues, invoking the 1980s sitcom *Cheers*: "The medical home is that one place where everyone knows your name."

Incentive plans

Gordon Moore, a Seattle physician, is a pioneer in developing primary care "micropractices." He lists four aspects of

instead be built around the four aspects of effective practices.

Harbrecht says she's spoken to Moore and says she "totally agree[s]" with the gist of his argument. But she thinks disease management can be part of the overall incentive structure; the challenge, she says, is finding the right combination of incentives to promote overall health in a way that can still be measured.

While the program is running over the next two years, Harbrecht explains, the goal is for each of the 17 pilot sites to show improvements in treatment quality, some reduction in costs and an increase in patient satisfaction. The data then could be used to motivate more changes.

Along the way, she's hopeful the model will continue spreading to other practices.

"The bottom line," she says, "is that we cannot continue with the status quo."

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