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Examining Models of Care and Reimbursement, Including Patient Management Fees, ACOs, and PCMHs: A Panel Discussion Published On line: April 11 2013

Moderator:

How does the new way diabetes is managed compare with the older way?

Dr James Holly of SETMA stated that the biggest change is that providers now have a concept of accountability and that there is a renewed sense of responsibility to improve healthcare and lower costs.

Dr Holly discussed quality metrics as a major determinant of medical care and compared quality metrics with a GPS system. A GPS system only works if you know where you are. “Can you imagine a GPS system that told you where Dallas was but wouldn’t tell you where you are and gave you no signposts along the way?” asked Dr Holly.

A medical treatment plan is the same: you cannot have a system in which you only know what the end goal is. Constant and continuous quality metrics are needed so that adjustments can be made as the treatment proceeds. Those metrics need to be universal so that the pharmacist, the doctor, the patient, and the provider can all look at the metrics to understand how the treatment is proceeding.

Dr Holly noted that if the patient knows where they are in the overall treatment plan, they will be more compliant and more involved in the treatment.

Dr Holly also stated that the patient-centered health model can change how clinicians perform. If the patient has a public forum to report on a clinician's or provider's performance, that performance will improve. These changes may be challenging for some populations to adjust to, but adjustment will occur over time.

Dr Keith Shealy of Mackey Family Practice agreed with what was said by Dr Holly, adding that an open system is good for competition. "Doctors are competitive, very competitive," said Dr Shealy. Doctors who are low on a public rating system will strive to do better, meaning better care for patients.

Dr Laura Long of BlueCross BlueShield, South Carolina, noted that traditionally, BlueCross BlueShield had a care management model in which coaches reached out to patients. During that period "We worked primarily with our members and we tried to coach them as best we could and we would periodically reach out to the physician but we weren't necessarily collaborating," said Dr Long, adding, "Historically, we were working in our traditional silos." That has changed.

Today, the patient-centered medical home model is more open. Dr Long added, "What we are doing in the patient-centered medical home is we are sharing information." Claims information is shared with clinicians and case managers. Case managers can access the electronic medical records and add electronic "sticky notes" that clinicians can see and use to adjust treatment if necessary.

Another important change is that in addition to paying physicians for traditional services, BlueCross BlueShield is also paying physicians for outcomes in 2 new ways. First, clinicians can get reimbursed for additional services, including pharmacy visits, education visits, and home visits.

Second, if clinicians are doing a better job at controlling certain clinical parameters (eg, blood pressure) they will get paid more. Such measures lead to fewer emergency department and hospital visits and therefore are cost-effective for the provider.

Dr Sam Ho from United Healthcare agreed with the other panelists on how significantly the healthcare system has changed in the last few years toward a more patient-centered system.

Dr Ho stated that the changes encompassed 5 levels:

1. Healthcare needs to be more patient centric instead of disease focused.
2. There needs to be a transformation of the records delivery system that allows all members of the team to be informed. For example, if a patient is in the emergency department and the primary care physician does not know that, the system is failing.

3. The payment system should be value based instead of volume based.
4. Transparency should be universal and encompass the consumers, the doctors, and the hospitals, and include data on how they are performing in relationship to standard guidelines.
5. The program should reward those who adhere to the treatment plan. If a patient is improving and adhering to the treatment, then premiums, copays, and out-of-pocket expenses should be reduced.

"He was angry, hostile, bitter, and mean."

Dr Holly provided an example of patient-centered healthcare from his own practice. "I saw a man in the hospital; he was a patient of one of my partners, a new patient. He was angry, hostile, bitter, and mean. The nurses said, 'You don't want to go in there,'" explained Dr Holly.

He took the time to talk with this man and he discovered that the patient had several problems: he couldn't afford his medications, he was going blind due to his uncontrolled diabetes, he was incapacitated and could not work, he could not afford the gas to see the doctor or attend diabetes educational programs, he could not afford the copays for the educational programs, and he could not afford to go see an ophthalmologist to save his eyes.

Dr Holly told the audience that he and his team used funds available for these patients and worked to get the patient gas cards, reduced copays, and an appointment with an ophthalmologist. As

Dr Holly noted, "In a patient-centered medical home, we have not done our job unless we can give patients access to care that we have prescribed." Dr Holly concluded the story by stating that he saw the patient 6 weeks later and "[the patient] had something I could not prescribe….He had hope, for the first time in years."

Moderator:

The emotional and social needs that often accompany a medical need have not always been addressed or covered by more conventional health insurers. How is your organization addressing those non-medical needs?

Dr Long noted that their organization recognizes that the social needs of a patient are often greater than the true medical needs and that social needs have a significant impact on medical care. Issues such as the person having financial or transportation problems, or other comorbidities, for example, depression, can have a major effect on treatment adherence.

Dr Long also said many providers have programs in place to help patients. However, those programs are not effective if implemented in isolation from the physician. "The thing that has me excited about patient-centered medical homes is that they are now being integrated with the physician," stated Dr Long.

Also, the physicians are being incentivized in this new model for better outcomes instead of for the volume of patients they see. That means that a physician will be rewarded for taking the time to address some of the behavioral, financial, or emotional issues that can impede treatment. In return, the patient is rewarded with better care. - See more at: http://www.ajmc.com/publications/evidence-based-diabetes-management/2013/2013-1-vol19-sp2/Examining-Models-of-Care-and-Reimbursement-Including-Patient-Management-Fees-ACOs-and-PCMHs-A-Panel-Discussion#sthash.N92ydHiI.dpuf

Dr Shealy stated that they screen all of their patients for mental and emotional issues. They are well aware that patients with depression cost more money, so an integrated behavioral health curriculum is part of their practice.

Moderator:

What about physicians who don't have their own private foundation? Who pays for that physician to develop a patient-centered model?

Dr Ho answered this question by admitting that it is a challenge. Developing a network of pharmacists, certified diabetes educators, social workers, nurse practitioners, and other providers can be done; however, much work is required. As more insurers and granting agencies accept the patient-centered approach to healthcare, such networks will likely become easier to establish.

Moderator:

Is the patient-centered home model the basis of the care within accountable care organizations (ACOs) or will something else evolve?

Dr Long said, "I see the patient-centered model as the foundation for accountable care organizations." According to Dr Long, the primary care physician is the basic provider of management services for patients with chronic conditions. From that foundation, specialists and other health professionals may be added; however, patients need to be able to return to their primary care physicians as the ACOs continue to expand and evolve.

Moderator:

Will the patient-centered model work better for preventing diabetes or treating it?

Dr Long answered that the model is best designed to prevent diabetes. Historically, the medical community treats patients after they get sick: it is a reactive model. The patient-centered model is proactive: it provides rewards when patients do not get sick.

Dr Long said doctors are aware of individuals in their patient populations who are at risk for a medical condition (diabetes, hypertension, etc) and they can develop algorithms and teaching programs for those patients before they get sick. Under the patient-centered model, doctors will be properly compensated for this care. “

We know that prediabetes is a huge problem, especially in South Carolina, where the diabetes rate is very high. The way you can address that problem is [that] you can screen your patients at high risk for prediabetes, you can put inplace weight management programs, you can be aggressive with metformin, etc. And you can get reimbursed for that,” said Dr Long.

One thing that the patient-centered model is well suited for is preventive care. At the core of the model are the patient and the primary care physician. If the model allows the physician to take their time before medical problems develop and the doctor is properly compensated, the patient is healthier and the provider has lower healthcare expenditures. Everyone wins.

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