



Primary Care **OUR FIRST LINE OF DEFENSE**

IMAGINE IF THE ONLY PLACE you could bring your child when she develops a fever or an ear infection, or needs a checkup or a refill for her asthma inhaler, was to a hospital emergency room. Or imagine you have multiple medical problems—diabetes, high blood pressure, and high cholesterol, say—yet don't have a regular doctor you can trust will make sure you're getting all the right care you need to keep them under control.

In other words, imagine how difficult it would be to get all the care you and your family need to stay healthy without a primary care provider.

Whether a family physician, an internist, a pediatrician, or a nurse practitioner, primary care providers are often the first contact we have with the health care system. Practicing in private offices, community health centers, and hospitals, they diagnose and treat common illnesses and spot minor health problems before they become serious ones. They offer preventive services such as flu shots, cancer screening, and counseling on diet and

smoking, and play an important role in helping to manage the care of patients with chronic health conditions.

When people don't have access to a regular primary care provider, they end up in emergency rooms more often, and they're admitted to hospitals more frequently. Without regular screening, a controllable condition like high cholesterol—which often can be kept in check with common drugs—can eventually lead to a life-threatening heart attack.

The evidence shows that good access to primary care can help us live longer, feel better, and avoid disability and long absences from work. In areas of the country where there are more primary care providers per person, death rates for cancer, heart disease, and stroke are lower and people are less likely to be hospitalized. Another big plus: health care costs are lower when people have a primary care provider overseeing their care and coordinating all the tests, procedures, and follow-up care.

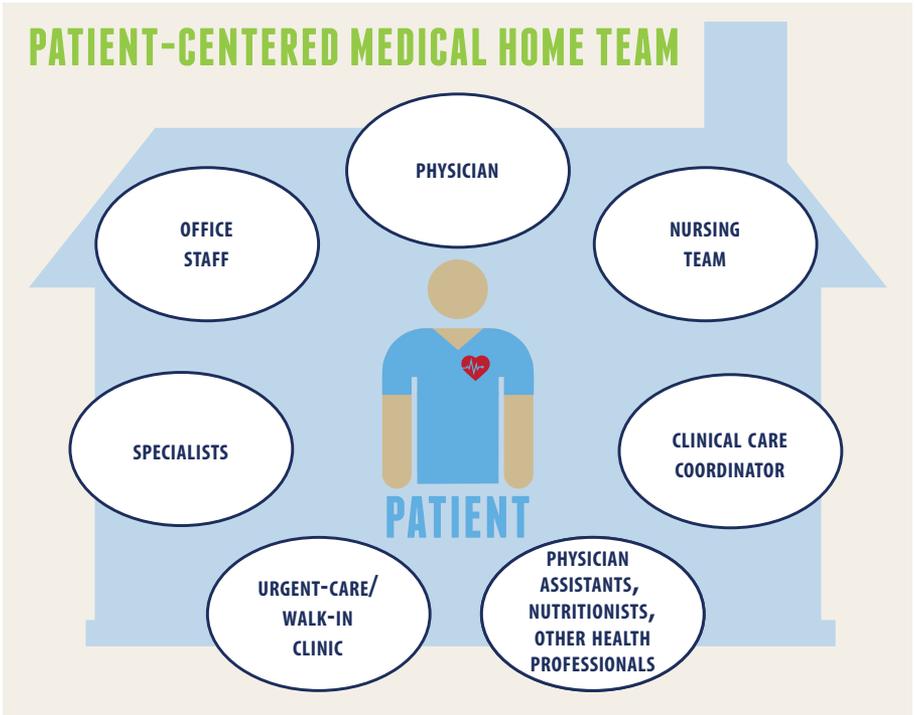
MEDICAL HOMES AND MEDICAL NEIGHBORHOODS

EASIER ACCESS TO PRIMARY CARE is a key to both improving the quality of health care overall and reining in our country's high medical costs. But making primary care more accessible is just the start. Primary care practices are increasingly becoming the hub of a new model of care known as the *patient-centered medical home*.

The basic mission of a medical home is to build a close partnership between clinicians and patients—to ensure that we aren't left alone to navigate an increasingly complex health care system, and that we receive the care most appropriate to our individual needs. This means:

- Including patients in decisions about which treatment approach is right for them.
- Enabling patients to see a doctor or other clinician after regular office hours, such as evenings and weekends.

PATIENT-CENTERED MEDICAL HOME TEAM



- Hiring nurses and care managers to follow up with patients after an office visit—to make sure they've gotten their medications and know how to take them, for example.
- Keeping track of when patients need to schedule appointments and when they need prescription refills, and monitoring them if they've been hospitalized.
- Acting as the point person for patients, particularly those with multiple health conditions who are receiving care from a number of health professionals.

All these activities are geared toward a single goal: ensuring that the patient always remains front and center.

To make the medical home the building block of the health care system, physician practices will need to invest in technologies such as

electronic health records (more on these below) and Web-based systems for scheduling and communicating with patients online. Clinicians and staff, meanwhile, will need to work together in teams to treat patients with multiple chronic conditions, who require an extra level of care. Changes are also needed in the way health insurers pay for care, so that providers are encouraged and rewarded for delivering a variety of patient services—from answering patients’ questions by email to coordinating with a patient’s other care providers—that lead to better long-term health and lower overall costs.

The Affordable Care Act—the health reform law popularly known as “Obamacare”—contains funding for expanded primary care and for existing medical home initiatives across the country that reach more than a million Medicare and Medicaid enrollees. Many private insurers are also experimenting with ways to reward health care providers for delivering comprehensive primary care.

For all, the goal is that medical homes will improve health outcomes and reduce the expense associated with a lack of coordination in patients’ care, frequent emergency room visits, avoidable hospitalizations, and the costly move to nursing home care.

To have the greatest impact, a medical home must be located at the center of a “medical neighborhood” inhabited by hospitals, specialty physicians, physical therapists, social workers, long-term care facilities, mental health professionals, and other service providers. It is the role of the primary care provider to coordinate care and make sure that patients don’t slip through the cracks—or receive tests or procedures they’ve already had. This is particularly a concern for patients who see multiple doctors.

ONE PATIENT, TWO VERY DIFFERENT OUTCOMES

TAKE, FOR EXAMPLE, the hypothetical case of Mr. W., an elderly man with diabetes who lives alone. Mr. W. has a primary care doctor but hasn’t seen her for close to a year—because of his faltering memory and a lack of

reliable transportation. During that time, he should have been taking several medications to control his blood sugar, cholesterol, and blood pressure. He was also supposed to be monitoring his glucose on a daily basis.

But Mr. W. doesn't always remember to take his pills—and, besides, the blood pressure drug makes his skin dry and itchy. He's also not sure how to read the glucose meter and, already overweight, he struggles to maintain a healthy diet. The result: Mr. W. is now living with poorly controlled

WHAT MEDICAL HOMES PROVIDE

BETTER QUALITY CARE

 Percent of adults with chronic diseases having **PROBLEMS WITH CARE COORDINATION**



FEWER HOSPITAL ADMISSIONS AND LOWERS COSTS

People with medical homes, who have **ACCESS TO 24/7 CARE**, experienced:



MORE SATISFIED WORKERS AND BETTER CARE FOR MINORITY PATIENTS

 Percent of staff reporting **HIGH EMOTIONAL EXHAUSTION** at 12 months



Medical homes **REDUCE RACIAL DISPARITIES** in accessing medical care:



3 OUT OF 4 whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it

Sources: C. Schoen et al., "New 2011 Survey of Patients with Complex Care Needs in 11 Countries Finds That Care Is Often Poorly Coordinated," *Health Affairs* Web First, Nov. 9, 2011; A. Beal et al., *Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from the Commonwealth Fund 2006 Health Care Quality Survey*, The Commonwealth Fund, June 2007; D. D. Maeng and J. Graham, "Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisinger's Medical Home Model," *American Journal of Managed Care*, March 2012 18(3):149–55; R. J. Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*, May 2010 29(5):835–43.

diabetes and progressive heart disease—a not uncommon outcome for someone in his situation. Eventually, he is rushed to the ER with a heart attack and hospitalized for a week afterward.

Typically it costs about \$12,000 a year to cover an adult with diabetes whose condition is stable. But if the condition is uncontrolled, as is the case with Mr. W., a diabetic person can rack up expenses averaging \$102,000 per year, with costs shouldered by a combination of the patient and his family, the insurance company, government programs like Medicare, and sometimes hospitals, if the patient is uninsured.¹

If, on the other hand, Mr. W. were enrolled in a patient-centered medical home, his story might be very different. First, a nurse care manager embedded in Mr. W.'s primary care practice stays in regular contact with him to find out if he is renewing his prescriptions, taking his medications, and monitoring his blood glucose level. Mr. W.'s electronic health record automatically alerts the practice when it's time for a checkup or blood test. When that happens, a nurse or social worker calls and helps arrange transportation to the doctor's office. A nurse care manager is always available—24/7—to help Mr. W. with his health needs, and talks regularly

IT HELPS TO HAVE CONNECTIONS

The Role of Information Technology

To support their stepped-up role in managing the care of patients, medical homes need to take advantage of the growing field of **health information technology**. The federal government now offers physicians financial incentives to adopt electronic health records and online systems for making appointments or ordering prescriptions.

With these systems in place, practices are better able to keep track of the health status of their patients and alert them when it is time for a screening, a prescription renewal, or an office visit. If a patient goes to see a specialist or is hospitalized, this information too is entered into the patient's electronic record. In this way, the medical home staff keeps up-to-date on all aspects of the patient's care. And most important, patients receive timely, appropriate care that meets their current needs.

with his primary care physician to coordinate the care and support they provide.

When Mr. W. has to see a cardiologist or other specialist, this too is set up by the medical home staff. Results of any tests are sent directly to his primary care provider and then integrated into his health record. With this kind of coordination, Mr. W.'s diabetes is much more likely to remain under control, because the system is designed to catch early signs of trouble. If, in fact, he does end up in the hospital, Mr. W.'s primary care team would help with his transition home, set up nursing or home care, help schedule follow-up appointments, and ensure that he knows how to manage his chronic conditions.

The Patient-Centered Primary Care Collaborative provides real-world examples of how medical homes can improve care while saving money. For example, Horizon Blue Cross Blue Shield of New Jersey has been able to cut emergency room use by 26 percent and hospital readmissions by 25 percent among its medical home enrollees. And HealthPartners in Minnesota reports 39 percent fewer ER visits, 40 percent fewer hospital readmissions, and a reduction in appointment wait times from 26 days to 1 day.³

INCENTIVES FOR CHANGE

FOR PATIENT-CENTERED MEDICAL HOMES to live up to their potential, many insurers will need to rethink how they pay for care. Today it's common for an internist or other primary care doctor to be paid a separate fee for each office visit, blood test, EKG, or other test or procedure. The problem with this kind of fee-for-service reimbursement system—which has prevailed for decades in the U.S.—is that it encourages doctors to order more tests than may be necessary and to perform more procedures, leading to

unnneeded treatments, or even harm to the patient. In doing so, it also drives costs skyward.

Doctors working within medical homes, however, are paid not for providing the most care, but for providing the *most appropriate* care. That includes spending extra time with patients to help them make informed decisions about their treatment, following up with them after they've left the hospital, and overseeing the care received from other providers. And it requires that insurers recognize the value of hiring community health workers or nurse case managers to make sure patients with chronic conditions like diabetes or heart disease take their medications, eat correctly and exercise, and join wellness programs.

The push to pay for quality, not quantity, is already happening in places around the country. In demonstration projects funded by the Centers for Medicaid and Medicare Services, health care providers in several states are receiving a single fee that covers all costs related to a particular patient or group of patients. Doctors share in the savings achieved when they provide excellent preventive care, communicate regularly with patients, and take other steps to keep patients out of the hospital and emergency room.

Some private insurers are also using the lure of incentives to motivate primary care practices to become medical homes. The BlueCross BlueShield Association reports that medical homes run by member companies now cover some 4 million patients in 39 states. They give participating physicians a 12 percent increase over the usual fees for services

IT'S A FACT

U.S. ADULTS WHO HAVE A PRIMARY CARE PHYSICIAN HAVE 33 PERCENT LOWER HEALTH CARE COSTS AND 19 PERCENT LOWER ODDS OF DYING THAN THOSE WHO SEE ONLY A SPECIALIST. AS A NATION, WE WOULD SAVE \$67 BILLION EACH YEAR IF EVERYBODY USED A PRIMARY CARE PROVIDER AS THEIR USUAL SOURCE OF CARE.

Sources: B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly*, Sept. 2005 83(3):457–502; and S. J. Spann, "Report on Financing the New Model of Family Medicine," *Annals of Family Medicine*, Dec. 2004 2(2 Suppl. 3):S1–S21.

and throw in an extra \$200 per patient if providers agree to manage the care of chronically ill enrollees over the long term. This involves working with patients to develop a personalized treatment plan and conducting regular follow-up through phone calls or office visits. It also means helping patients achieve positive lifestyle changes like quitting smoking or losing weight.

This year, nearly 60 percent of participating BlueCross BlueShield physicians earned incentive payments for lowering the total cost of care for their patient population.³

ACCOUNTABLE CARE ORGANIZATIONS

IN ADDITION TO ADOPTING health information technology like electronic health records, medical homes that are part of an *accountable care organization*, or ACO, can expand their capacity to provide comprehensive care to patients. An ACO is made up of providers, including primary care practices, hospitals, and pharmacies, that agree to share responsibility for the quality and cost of care delivered to a specific population of patients. Their goal is twofold: 1) to provide seamless care, where patients' needs are anticipated and met, and 2) to keep costs under control. Already there are Medicare ACOs, Medicaid ACOs, and private ACOs that manage the care of people living in a particular region.

Accountable care organizations are a new phenomenon, and it's still far too early to draw any conclusions about their impact on the health care system. But if they can deliver on their promise to improve patient outcomes, patient experiences, and health care costs, they could have a transformative effect on American health care.

MEETING THE DEMAND FOR CARE

BY NOW IT SHOULD BE CLEAR that primary care is integral to an effective, efficient health care system. Still, there are concerns that there will not be enough practitioners—doctors and nurses—to meet the growing demand

EXPANDING PRIMARY CARE ACCESS IN UNDERSERVED AREAS

For many low-income Americans **community health centers** are a critical source of health services, especially in areas where there aren't enough private physician practices. These clinics, which serve nearly 20 million people nationwide—many of them uninsured or covered by Medicaid—offer an array of primary and preventive health care, as well as supportive services such as patient education, language translation, and transportation. They are particularly well positioned to serve as the hub in the medical neighborhood.

Recognizing their importance to underserved communities, the federal government has invested heavily in health centers over the past decade. The Affordable Care Act provides an additional \$11 billion to health centers from 2011 to 2015 to help them meet the expected rise in demand for primary care once millions of uninsured people gain health coverage.

for services as the Affordable Care Act expands the number of Americans with insurance coverage. An estimated 65 million Americans now live in areas with a shortage of primary care providers, yet only one-third of U.S. physicians are practicing as primary care doctors.⁴ While the share of fourth-year medical students opting for a career in primary care has increased in the past two years, it's not enough to solve the problem.

The Affordable Care Act contains several initiatives to increase the primary care provider pool.⁵ Already some \$250 million has been earmarked for training a total of 1,700 physicians, nurse practitioners, and physician assistants to work in primary care settings. The health law also provides \$1.5 billion over five years to expand the National Health Service Corps, which repays educational loans and offers scholarships to primary care providers who choose to practice in “medically underserved” areas—those with a shortage of primary care physician practices. According to the U.S.

Department of Health and Human Services, today nearly 10,000 National Health Service Corps providers are delivering primary care to 10.4 million people.⁶

Though that increase is substantial, it will likely not be enough to meet the soaring demand for primary care.⁷ The answer, many experts believe, lies in changing the way patient care is delivered. By making greater use of electronic medical records and other information technologies, by relying more on nurse practitioners and other nonphysicians to provide services, and by having clinicians work together in teams, we can fill the primary care gap. And in doing so, we'll create a more a solid foundation for our nation's health care system.



NOTES

- ¹ IMS Institute for Healthcare Informatics, “[Understanding High-Cost Patients.](#)”
- ² [Patient-Centered Primary Care Collaborative](#) (accessed March 27, 2013).
- ³ V. S. Elliott, “[Physicians Collect Bonuses for Medical Home Participation,](#)” *American Medical News*, June 25, 2012.
- ⁴ *Health Affairs*, [Patient Centered Medical Homes](#), Health Policy Brief, Sept. 2010.
- ⁵ M. K. Abrams, R. Nuzum, S. Mika, and G. Lawlor, *Realizing Health Reform’s Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (New York: The Commonwealth Fund, Jan. 2011).
- ⁶ U.S. Department of Health and Human Services, “[National Health Service Corps Expands the Primary Care Workforce,](#)” news release, Feb. 6, 2013.
- ⁷ See, for example, L. V. Green S. Savin, and Y. Lu, “[Primary Care Physician Shortages Could Be Eliminated Through Use of Teams, Nonphysicians, and Electronic Communication,](#)” *Health Affairs*, Jan. 2013 32(1):11–19.

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