FAMILY HOME Timothy Buckley, D.O., takes care of the entire Campagna family at his medical-home practice in Higganum, Conn. From left: Colton, 3, Jody, 37, Collin, 5, and Matthew, 39.

GETTING HEALTH CARE RIGHT FIRST IN A SERIES

A doctor's office that's all about you

More than 25,000 doctors commit to patient-centered care

REMEMBER WHEN bankers kept, well, banker's hours, and you couldn't cash a check after 4 p.m. or on weekends? Banks finally woke up to their customers' needs for convenient hours. Today customer-focused service is making itself felt in some of America's medical offices.

In these reorganized practices, evening and weekend hours are only part of the difference. When you visit your doctor you won't feel you're getting the bum's rush before you have a chance to get your questions answered. If you've had a blood test or a CT scan, you won't have to call the office half a dozen times chasing down the results. And if you leave the hospital with an incomprehensible "discharge plan," someone from your doctor's office will help you arrange your follow-up care.

If you're already getting this type of service, you may be part of a "patient-centered medical home," the fastest-growing innovation in medical care. More than 10 percent of primary care practitioners—about 27,000 U.S. doctors in 5,560 offices—are now recognized as "patient centered medical homes" by the main accrediting group, the National Committee for Quality Assurance. Many thousands more are transforming their practices under other umbrellas. And major national insurers, such as Aetna and Wellpoint, are paying qualified practices an extra few dollars per patient per month to defray the additional costs involved in the switch.

The idea of patient-centered medical homes has been germinating for years among primary care practitioners. The

How to find a medical home

You may already be in a medical home and not know it because not all practices use the term with their patients. Expanded hours, same-day appointments for acute illnesses, use of nurses or care managers to coordinate your care for chronic diseases, requests for your feedback about care, and online access to your medical records are good signs that a primary care practice is functioning as a medical home.

If you're interested in finding a medical-home practice, start with your health plan's provider directory, which may have a special designation for such practices. You can also find an NCQA-recognized practice near you at *recognition.ncqa.org*.

PHOTO: CARRIE PROPHETT

Affordable Care Act gave them a boost by funding pilot programs to strengthen and reform primary care; the most ambitious pilot is paying 500 practices in eight states to turn themselves into medical homes for more than 300,000 Medicare beneficiaries. If any of those pilots, funded by the new Center for Medicare and Medicaid Innovation, turn out to effectively improve care and lower cost, Medicare and Medicaid can roll them out nationwide without additional congressional approval.

This report on medical homes is the first in a series about the reforms afoot in how you will receive your medical care in the months and years ahead. The series is funded in part by a grant from Atlantic Philanthropies.

A way to cut costs

Health care spending, long a cause of fiscal hand-wringing, is now a looming emergency. Within the next three years more than 25 million Americans are expected to sign up for health insurance (or pay a fine) as the Affordable Care Act rolls out. And tens of millions of Americans born during the baby boom are heading into their medically expensive sunset years. With more people, and more older people, needing care, it's becoming obvious that a health care system that produces below-average national health and costs 50 to 60 percent more than the systems of the most free-spending industrialized nations is unsustainable.

Other countries have solved the problem of costs by fiat. The prices that health care providers can collect for their services are established by the government (in Canada, France, Japan, and the United Kingdom) or national cartels of insurers (in Germany). For many political and historical reasons, that hasn't happened in the U.S., with the exceptions of Medicare and Medicaid.

Instead of national price controls, the U.S. is laying its bet on reforming the way health care is delivered and paid for. In the case of medical homes, in addition to the usual per-service fees for office visits and procedures, primary care doctors receive a little extra to defray the costs of setting up and running patient-centered care and may also share in any resulting savings if they succeed in keeping patients healthier and in less need of expensive care.

It will be years before we know whether these reforms really do save money and reduce deaths and disability from chronic illnesses. Meanwhile, it's important that you know how these changes will affect what happens to you in the doctor's office or during a hospital stay.

Doctors will be judged on how well their patients fare.

Who's in charge here?

One of the major ideas for saving money is to put someone firmly in charge so that patients aren't getting duplicative or contradictory treatments from a legion of specialists and so that doctors aren't overlooking important inexpensive preventive measures that can save misery and money in the long run. The person in charge will usually be a primary care doctor: a family physician, general internist, or pediatrician.

If this reminds you of the hopes for HMOs in the reforms of the 1990s, well, in some ways it is back to the future. But the lesson of the '90s has been registered: The new role for the primary care physician is not a "gatekeeper" preventing you from seeing a specialist but a facilitator of all your care who will be judged (and eventually paid) on how well you do rather than how many tests and procedures you get or don't get.

Turning a conventional doctor's office into a patient-centered office involves substantial reengineering to make delivering care less time-consuming and more organized for everyone involved. For a start, the 9-to-4 medical practice is going the way of banker's hours. "One thing patients want is more access," says Christine Bechtel, who works with the National Partnership for Women and Families and has extensively studied patients' perspectives on medical homes. If we want consumers to avoid using the emergency rooms for non-emergencies, she says, they need to have off-hour alternatives. Jody Campagna, 37, a homemaker from East Haddam, Conn., says that "most of the time I don't have a problem getting in" for a same-day visit to her medical-home practitioner, Timothy J. Buckley, D.O., in nearby Higganum when her chronic sinus infections, or her sons' frequent ear infections, kick up.

Other hallmarks of a medical home are efficient teamwork, "smart" medical records, and motivating patients to do their part to stay as healthy as possible.

The care team is ready

In old-style medical practices that are organized around the physician, patients may be stuck half-naked in a paper gown in the examining room while the doctor and staff gather essential information or wait for the results of a blood test.

But in patient-centered practices, like Bon Secours Medical Group in suburban Richmond, Va., the process has been reengineered, according to Andrew Rose,

How France does it

To put our country's health costs in context, it's useful to compare them with those of France, which is generally acknowledged as having one of the world's best health care systems. The French government sets the prices that health care providers can charge. France spends 11.6 percent of its gross domestic product on health care, while the U.S. spends 17.6 percent. Here are some details.

SPENDING & COVERAGE (2010)	FRANCE	U.S.
Total health spending per capita	$3,974	$8,233
Government health spending per capita	$3,061	$3,967
% uninsured	0%	15.7%
HEALTH OUTCOMES (2010)		
Life expectancy at birth (2011)	81.3 yr.	78.7 yr.
Infant mortality per 1,000 births	3.6	6.1
COSTS PER EPISODE (2012)		
Doctor's office visit	$30	$95
Hospital day	$853	$4,287
Angioplasty	$7,564	$28,182
Appendectomy	$4,463	$13,851
Childbirth delivery (normal)	$3,541	$9,775
Hip replacement	$10,927	$40,364
Heart bypass	$22,844	$73,420
TESTS (2012)		
Abdominal CT scan	$183	$630
Angiogram	$264	$914
MRI	$363	$1,121
NAME-BRAND DRUGS (30-day prescription, 2012)		
Cymbalta	$47	$176
Lipitor	$48	$124
Nexium	$30	$202

Sources: Organisation for Economic Co-operation and Development and International Federation of Health Plans.

TEAM EFFORT Rosemary Salomone with William Warning, M.D., at his medical-home practice in suburban Philadelphia. Others from left: Cathie Gorzalski, practice manager; Julian Salomone, husband and caregiver; and Barry Jacobs, Psy.D., a geriatric psychologist.

M.D., a family physician in one of its practice locations. First thing in the morning, the care team of doctors, nurses, and medical assistants "do a daily huddle where we look at our schedule for the day and identify any particular needs the patients who are coming in may have," he says. If a patient needs blood or urine tests, the nurses and assistants will take care of those before the doctor even enters the exam room.

"For instance, our nurses ask our diabetics 11 questions and put the answers into the computer," Rose says. "When I go in, I can concentrate on the answers that indicate a problem."

For patients with serious medical needs, more members, such as specialty physicians, case managers, and therapists, may be assigned to the care team, and appointments are organized so that the patient can see everyone in one visit. And the whole team meets with the patient, and with the family, as needed.

Rosemarie Salomone, 75, of Clifton Heights, Pa., had become very forgetful about taking her medications and had shed an alarming amount of weight. The family consulted a new physician, William Warning, M.D., who practices in a medical home with Crozer-Keystone, a primary care practice network in suburban Philadelphia.

"We were able to assess her whole medical situation," Warning says. The diagnosis was Alzheimer's disease. "We brought in a behavioralist and a geriatric physician to do multigenerational counseling and coordinate her care," Warning says. "They are embedded in our practice."

"It's like one-stop shopping," says Salomone's daughter, Michele Schumacher. "You don't have to go through the whole history again and again. At one point we had me, my mom, my dad, my sister, my brother, the psychologist, the geriatric doctor, and Dr. Warning all in the same room," she recalls. "We got the answers to all our questions right on the spot." The family also got the phone number of an Alzheimer's support group, which they have found very helpful.

Smart medical records

Today "the average full-time primary care practitioner might take care of 2,000 people," notes Christopher Campanile, M.D., who practices in a medical home at Coastal Hillside Family Medicine in Pawtucket, R.I. He believes you cannot do this work right without electronic medical records. They prompt the doctor to deploy needed tests, enable doctors to see a patient's history at a glance, and help avoid unwelcome drug interactions.

For years U.S. doctors lagged behind the rest of the developed world in computerizing their medical records, but that changed dramatically in 2009 when the federal stimulus bill brought forth more than $19 billion in funds to help practices go digital. The percentage of doctor's offices with electronic medical records shot up from 42 percent in 2008 to 72 percent in 2012. There have been complaints that doctors are asking questions needed more "for the record" than relevant to the particular patient visit and paying more attention to entering data into the computer rather than looking patients in the eye. It's hoped that professionals will become more facile as they adjust to the systems. Meanwhile, patient-centered care is benefiting in many ways:

Electronic systems send reminders for follow-up care.

Prevention and checkup reminders. "We don't wait for you to remember it's time for a screening mammogram," says Christine Sinsky, M.D., who practices in a medical home at Medical Associates in Dubuque, Iowa. "We'll reach out to you."

Many physician practices have for decades tried to prompt patients to get needed tests and checkups, but the effort is vastly simplified by the use of electronic medical records. In the suburban Philadelphia medical home, Warning recalls that before the advent of electronic records, "If we told a diabetic patient to come back in a month so we could check their blood pressure, we didn't have a robust tracking mechanism for knowing if they didn't come in." But today the records can automatically flag patients who need to be checked.

Easier communication with patients. Of course patients still have to be willing to participate in their own care. Witness Robert Eley, 58, who has diabetes and says he "would basically ignore" all those checkup reminders the Bon Secours medical home had been sending until he had a heart attack last March. A couple of angioplasties and a hospital stay later, he was ready to play ball. Now he checks his blood sugar three times a day and e-mails the results every evening to his primary care physician, Andrew Rose, M.D., through the practice's electronic patient portal. "He tells me whether to adjust the units of insulin I'm taking, whether they look good, what's the reason for a spike," Eley says. "I've lost 20 pounds and I'm trying to get more exercise in."

Under the old system, Rose says, that

PHOTO: DAVE MOSER

wouldn't have been possible. "You'd tell patients to call in their numbers every week. The nurse would write it down, and it would sit on my desk for a week," he says. "Now, it's in my e-mail inbox. It's made life so much easier."

Now that Eley will actually keep his appointments for those checkups, he'll be able to look up his lab results at the online patient portal as well, Rose says.

Managing care transitions. At a minimum, all providers within a health system are generally able to access patient records. In some cases, practices may be able to communicate with local hospitals, either directly or through the intermediary of an insurance company.

"In our practice, everything's electronically connected, so we know when a patient goes into the hospital," Rose says. "When a patient gets discharged, our nurse navigators get in touch within 24 hours. We eliminate any confusion about medicine changes or discharge instructions, and prevent readmission."

The system still has an important gap. The goal of true "interoperability," in which all providers anywhere can see a patient's record, remains more a dream than a reality. For example, a doctor isn't likely to receive electronic notice for patients seen in an out-of-town emergency room.

Giving doctors feedback. Pro Health Physicians, a primary care practice with about 340 providers scattered around Connecticut, uses its electronic records to prepare monthly report cards letting each practice know where it stands on various quality measures.

Timothy J. Buckley, D.O., in Pro Health's Higganum location, says the first report showed that his office was prescribing too many costly name-brand drugs and not enough affordable, and equally good, generics. Today his office's generic prescribing rate is better than the average Pro Health practice's.

"Doctors are smart and have egos," Buckley says. "And when you hand me a report that says I'm below average, you can bet I'm going to work harder."

Coordinating care. Garry Pape, a 66-year-old retired factory worker from Rickardsville, Iowa, ruefully describes himself as "one of the 5 percent of people who use 95 percent of the insurance money." A Vietnam veteran, Pape has a host of medical conditions, including, most recently, recurrent lung cancer.

His primary doctor, Christine Sinsky, has sent him to specialists aplenty to take care of his catalog of ills but never loses the thread of his treatment.

Patients are encouraged to make needed lifestyle changes.

"We don't leave anything to chance," she says. "We make the appointments for patients to see the cardiologist, rheumatologist, or pulmonologist. They leave with the appointment card in hand, not just a recommendation."

Since most of the specialists are part of Sinsky's large medical practice, she says, "if I make a change in Garry's medications, the oncologist will see it at the next visit and be working off an accurate list."

Pape keenly appreciates what Sinsky and her colleagues do in part because for four years, when his employer dropped Sinsky's practice from its health plan, he had to switch to another doctor. "I didn't get any of the follow-ups," he says. As soon as he retired and went on Medicare, he went back to Sinsky.

Patient involvement

"Approximately 70 percent of all medical costs are from bad patient behavior," says Robert Fortini, a nurse practitioner and vice president of clinical operations for Virginia's Bon Secours group. "People aren't exercising, they're not eating right, they're not getting their labs done or taking their meds," says Fortini, who feels it's the practice's job to help get people motivated. It has already hired a pharmacologist and nutritionist, and soon will be adding social workers.

"At some of our practices we schedule asthma or diabetes days," he says. "On a diabetes day, people can come in and go to different stations to receive aspects of care." They might see a pharmacist, a podiatrist, an eye doctor, and a nutritionist.

But ultimately patients with chronic illnesses must participate in their own wellness, and medical homes are trying to make that happen.

Connie Susa, 67, of Warwick, R.I., received a diagnosis of type 2 diabetes more than a decade ago. The executive director of a support and advocacy network for people with disabilities, she knew the key to controlling her disease was in her own hands. But she was frustrated because her doctor at the time didn't "consider me a partner in my health care," she says, and didn't communicate essential information. So she switched to Coastal Hillside Family Medicine, where a mainstay of her diabetes management is a monthly support group that the practice sponsors.

"The people are very different, but we encourage one another in our efforts to manage our symptoms and break through denial and self-justifications," Susa says. "The group keeps me going."

Doctor's office: Then and now

MEDICAL NEED	THAT WAS THEN	THIS IS NOW (or coming soon)
Appointments	"We can fit you in in three days."	Same-day attention for acute illness.
Sick or injured at an inconvenient hour	Go to urgent-care center or emergency room to see someone who does not know your history.	Clear arrangement for after-hours care. Your medical history available electronically.
Prescription renewal	Call office and wait for doctor to call you back.	Nurse handles immediately.
Preventive care	Remember to make appointments for checkups, screenings, vaccines.	Electronic record tracks preventive measures and reminds you and professionals.
Test results	Play phone tag with the doctor.	Available at online portal.
Follow-up care	Up to you to make timely appointments.	Office tracks and reminds you of needed follow-up.
Specialist appointments	Specialists and primary care doctors may not communicate.	Primary care physician coordinates with specialists.
Hospital release	Doctor has no idea you're in the hospital unless you initiate contact.	Knows when you are hospitalized and takes initiative to follow up.