National Cancer Policy Forum:
Cost Considerations in Medical Practice

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The Ecology of Medical Care

- Half of all physician visits are to generalist clinicians
- Most visits for common, serious conditions are to primary care practices
- Primary care infrastructure consists of small, relatively independent practices

Green LA, Freyer GE Jr, et al NEJM 344(2001):2021-25

The Ecology of Primary Care Practices

- Typical practice consists of
  - 2-5 clinicians
  - Fewer than 3 non-clinician nursing and clerical staff for each clinician
- Most practices have a hierarchical management structure
  - Physician owners and office manager provide oversight

Stange KC et al, J of Fam Pract 46(1998):377-89

Primary Care Practices:
Culture and Financial Reality

"Climates permeated with stress and overwork"

- Most work on margins of financial viability
  - Little time for self-reflection
  - Little or no training in quality improvement and organizational management

Crabtree BF. Healthcare Manage Rev, Vol 281(2003):279-83

Grumbach K and Bodenheimer J. JAMA (2002):889-93

The Realities of Primary Care Practice

- Complexity is the norm
- Clinicians face a diverse set of problems and must constantly set priorities
- Few of these decisions impact reimbursement

Primary Care and CRC Screening: Assumptions
Assumption 1

Primary care clinicians virtually all recommend CRC screening

Assumption 2

Virtually no primary care clinicians are successfully screening all eligible, enrolled patients

Assumption 3

Despite a list of 5 screening options, referral for colonoscopy has become the predominant screening strategy with a stool-based testing strategy as a backup

Assumption 4

Primary Care Clinicians have two concerns about costs of CRC screening:

1. Can the patient afford the test?
2. Can the physician bill for the service?

Ubel PA et al. The influence of cost-effectiveness information in physicians' cancer screening recommendations. Social Science and Medicine 56(8):1727-36 2003 Apr.

Assumption 5

- Most insured patients can afford colonoscopy
- Clinicians perceive that they have no financial incentive to promote screening … and may have a financial disincentive
- Perceived payment for in-office digital rectal FOBT and in-office development are supporting these practices

Assumption 6

- PCC's do not isolate the cost of CRC screening, either in business models or in day to day decision-making
- Prevention, in general, is perceived as non – or, at best, partially reimburseable

Assumption 6: Corollary 1

- Few primary care clinicians can quantitate a specific cost associated with CRC screening in their practices
- But the additional time and staff associated with screening implementation are barriers

Assumption 6 – Corollary 2

- The greater complexity of CRC screening compared to other screening initiatives is an impediment to screening
- Screening with PSA, despite a less compelling evidence base, occurs at a remarkably high rate
  - Barriers are low

How do PCC's "absorb" the cost of time devoted to screening?

How do primary care offices change to improve practice performance?

No Single Model To Absorb These Costs

- PCC offices are complex, non-linear systems
- Organizational principles can be used to describe PCC settings
- Generally speaking, high performing practices share some key characteristics

Crabtree BF, et al. Primary Practice Organizations and Preventive Services Delivery: A Qualitative Analysis. J of Fam Pract 46(5):403-409 1998, May

Clinical Preventive Service Delivery In Primary Care

- Study of 18 family medicine offices
- Practices use individualized approaches
  - No one approach used successfully across all practices
- Preventive service delivery was identified as a priority
- Factors included competing demands, a physician champion, and economic concerns

Crabtree BF, et al. Annals of Fam Med 3(5):430-5, 2005

Characteristics of High Performing Practice

- Leadership
- A culture of improvement
- Greater staff involvement
- Higher investment in people
  - Greater investment in technology has not, yet, been demonstrated to promote prevention, including CRC screening

Orzano AJ, et al. Improving outcomes for high risk diabetes using information systems. J Am B of Fam Med 20(3) 295-51 2007 May-Jun

Improving Quality: Characteristics of High Performing Practices

- Involving staff in decision making
  - Higher staff retention
  - Higher productivity
  - Practice satisfaction
- Staff meetings do not correlate with improved participation and outcomes
- Soliciting staff feedback through every day discussions works better

Hung Y et al. Medical Care Vol.44 (10): 946-51 Oct 2006

Prescription For Health: RWJ Funded Pilot Programs To Improve Quality Care Delivery

- 17 PBRN's funded in round 1
- Lessons from prescription for health
  - Health behavior change resources are enthusiastically received by all
  - Patients prefer personal contact methods
  - Practice extenders require extensive training and careful case management and support

Prescription For Health: cont'd

- Lessons from prescription for health
  - Integrating tools requires practice change, use of a practice change model and specialized expertise
  - Even simple interventions require change and a change model

Ann of Fam Med 3 Suppl 2:512-19, 2005 Jul-Aug

Electronic Health Records Do Not Invariably Improve Care Quality

- Analysis of 50 practices in a practice improvement study
  - 37 practices not using an EMR were more likely to meet diabetes outcomes than 13 practices utilizing an EMR

Crosson JC, et al. Annals of Fam Med 5(3):209-15. 2007

The New Model of EMR Implementation

- Enterprise wide
  - Participation required
- Central management using business principles and extensive outsourcing
- Practice redesign must precede implementation

The New Model of EMR Implementation: Cost

- Cost of purchase and implementation of a 460-strong faculty practice plan-wide: $21,000,000
- BUT associated with rapid return on investment
  - Approximately $10,000 per physician
- Still unproven as a method to improve preventive care

A New Model To Enhance Prevention and Chronic Disease Management

- The Patient Centered Medical Home

The Physician Practice Connection: Patient-Centered Medical Home

Joint Principles of PPC-PCMH:

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated or integrated
- Quality and safety are hallmarks
- Enhanced access
- Payment recognizes value

www.NCQA.org

PPC-PCMH Content and Scoring

Standards:

1. Access and communication
2. Patient tracking and registry functions
3. Care management
4. Patient self-management support
5. Electronic prescribing
6. Test tracking
7. Referral tracking
8. Performance reporting and improvement
9. Advanced electronic communications

Multiple Initiatives To Fund Medical Homes

General Model

- Enhanced up-front payment for infrastructure
- Higher reimbursement for episodes of care (in some cases)
- Reimbursement linked to quality

Medical Home Reimbursement Model and CRC Screening

- Who is paying more?
  - Employers
  - Insurance companies
- Expectation of cost-saving
- BUT: Focus is greater on chronic disease management RATHER than cancer screening

Conclusions

- Primary care systems are complex
- Costs of CRC screening are infrequently considered explicitly
- Complexity of CRC screening contributes to cost
  - PCC's don't recognize a financial incentive to screen
- Investment in and support of human resources and leaders is more important than investment in technology
- New medical home models hold promise, but will demand changes in payment