Family Medicine Updates

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NEW MODELS OF CARE IN FAMILY MEDICINE

The report of the Future of Family Medicine Task Force 6, published as an online supplement to the *Annals* and available at http://www.annfammed.org/content/vol2/suppl_3/, makes a bold call for a national demonstration project to implement the elements of the New Model of family medicine. This national project is to be based on the implementation of 10 disparate practice innovations, ranging from open-access scheduling to chronic disease management systems, electronic health records, and outcomes analysis. In addition, a multimethod evaluation of the business and medical performance of the New Model is to be conducted. While a few academic programs may wish to be part of the formal testing of the new model, there is a major role for all academic units, from departments to residency programs and practice networks, to implement and test parts of the New Model as they are able. Because we do not know which parts of the proposed model will actually work, or how the various pieces might best fit together, there is an important role for every part of the "family" of family medicine to help in putting the recommendations to the test, and to report on the outcomes.

Some components of the New Model, such as open access, are already available. Indeed, open-access scheduling is calculated, according to the report of Task Force 6, to increase the average family physician's compensation by more than $9,000 per year. This is one experiment that may self-fund. Similarly, online appointment scheduling, already available in many settings, is estimated to increase average physician compensation by more than $5,000 per year. If these estimates are even close to correct, then there is little standing in the way of widespread adoption, even in the absence of a nationwide demonstration project. Further testing of these innovations, in different settings and with different mixes of patients, are needed to determine whether the estimates are correct and to establish the critical variables in achieving such savings.

A number of the recommendations will be harder to implement. Electronic health records are estimated to be among the most useful changes, with a net increase in compensation estimated at more than $15,000 per physician. While plausible, demonstration of such savings in a variety of practice sites will be reassuring. In particular, testing in academic settings, which are often linked to or based in hospital facilities, may be more difficult because of the need to integrate inpatient and outpatient records. On the other hand, the potential savings from such integration are greater. Only testing in a variety of settings will establish the cost and efficacy of electronic health records.

Similarly, group visits, which are estimated to be the second most positive change, are found less often because of payer reluctance to reimburse for their cost. Additional testing and reporting of situations in which group visits are cost-effective, and in which they are not, will help convince insurance companies and other physicians of their value.

Some of the recommendations may occur in ways other than those envisioned in the report. Chronic disease management, for instance, may be more effectively implemented across populations larger than those cared for within individual practices, at least in suburban and urban settings. Tests of different strategies for disease management are another area ready for study.

The Future of Family Medicine project is one of the greatest challenges and opportunities facing academic family medicine units. The project provides a path to move academic units beyond being primarily training sites for students and residents, to being places that not only improve the delivery of care and outcomes for patients, but also teach these better ways of care to our learners. For academic units, the report of Task Force 6 provides a list of potential changes that could improve our practices. While some will wish to participate as part of a larger controlled experiment, there is nothing that prohibits each practice from engaging in experiments on its own, and there is every reason for doing so. We have much to thank the authors of the report, who have provided a list of potential changes and an analysis of potential benefits. Now it is our turn to act.

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