REFLECTION

Joe's Story: How a Capitated Payment Model Lets Me Be the Physician I Want to Be

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ABSTRACT

For many years I cared for Joe, following him through diagnoses of strokes, end-stage renal disease, and metastatic prostate cancer. Gaining his trust, coordinating his care across specialist visits and hospitalizations, and helping him and his family clarify goals of care took an investment of time and relationship-building. I was able to spend this time with Joe, and all of my medically complex patients, because I had taken a job in a Program of All-Inclusive Care for the Elderly (PACE), a fully capitated model of care. With care organized around the patient instead of the visit, this payment model transformed my work life. As I reflect on the care that I provided for Joe over the years, I consider how health care organization and finance can either help or hinder our ability to provide patient-centered, coordinated, continuous care for our patients. Evolving payment models can help make space for family physicians to provide the robust primary care we are trained to deliver.

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One afternoon when I was in clinic, I received a call from the ICU of a local hospital. The hospitalist caring for a patient of mine, I'll call him Joe, had begun to discuss comfort care at the end of life. Joe asked her to call me from the bedside to participate in the conversation, because, as he told her, "I know Dr Denham will tell me the truth." He had been through so much in the last few months—a diagnosis of metastatic prostate cancer, a fall with a pathologic hip fracture, a hospitalization to repair the fracture that was complicated by a heart attack and internal bleeding. When I came to the bedside, we talked about his final transition and the overwhelming challenges his body was going through.

This is the story of an intense connection I was able to make with a patient I cared deeply about. But it is also a story about how structures of care, the ways we organize and pay for health care, have an impact on whether family doctors can be the kind of physicians we want to be, delivering the personal, coordinated, continuous care that exemplifies family medicine at its best.

Joe's Story

When I first met Joe, he had accumulated health challenges that were beyond his 59 years. He had endured a stroke and a heart attack, he had chronic hepatitis C, he had diabetic neuropathy and chronic kidney disease. Over the 9 years that I cared for him, I accompanied Joe through many additional health challenges—2 more strokes, progression to dialysis, and the diagnosis of prostate cancer. Joe had a warmth and charm that made it easy to connect with him. During our frequent clinic visits, and later when I would make home visits to his apartment, I would hear about his love for his granddaughter, who he only ever referred to as "Baby Girl," his closeness with his sister, the many young people in the community he mentored.

But also, Joe could be difficult. He would argue and challenge me. He was often not adherent to the recommendations I made, sometimes taking too many of his medications, sometimes too few. When I spoke with specialists who helped care for him, they would often say something like, "I actually really like him," spoken with a kind of surprise that revealed both how charmed they were by him but also how difficult he could be.

Joe did not have a lot of trust in the health care system, and in the first few years I took care of him I had to work to earn his trust. His access to health care

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had been intermittent and uneven. I could see that structural factors contributed to his disproportionate morbidity, from the segregated schools in small town North Carolina that left him with limited ability to read, to the inequitable drug policies that resulted in years of his life tied up in the prison system. I recall one day in clinic when his anger welled over because he felt that I was not addressing his leg pain. He told me about all the times that he had felt belittled or ignored by doctors. We pursued further diagnostic testing and determined that his pain originated from arterial disease. A referral to a vascular surgeon and restoration of blood flow to his leg relieved his pain and allowed his wounds to heal.

Over the years, my relationship with Joe and his family deepened. I remember the hour and a half family meeting with him, a social worker, his many siblings, and his pastor, to talk about whether to start dialysis. We discussed not only the medical implications but also the spiritual, making space for his pastor's voice to explore how starting dialysis might not be giving up on God's ability to heal him, but rather allowing his medical team to care for him using the tools that God provided.

I advocated for Joe as he moved through a fragmented and uncoordinated system. I spoke with the nephrologists to make sure they knew about the painful cramping that he was having during dialysis sessions. They were able to alter his dialysis regimen to increase his comfort. I spoke with the vascular surgeons and cardiologists about the bleeding complications that he had experienced with antiplatelet therapy, so that they could adjust their interventions accordingly. By sharing details of his medical history and what I knew about his values and priorities, I could help him avoid interventions that might cause more harm than benefit in the context of his frailty and comorbidities.

How an Alternative Payment Model Facilitated Joe's Care

Caring for complex patients like Joe is hard and time-consuming work. How was I able to show up each time he was in the hospital, make a personal connection with each medical specialist, make time for long family meetings to talk about goals of care? I was doing this not just for Joe but for each of the medically complex patients I had the privilege to care for.

As family physicians, many of us are caught on the treadmill of the 15-minute visit. The fee-for-service model distorts care in ways that do not serve us or our patients, encouraging more services, regardless of whether we are improving health or quality of life. There are low incentives for coordination of care, for avoiding duplication of services, for providing efficient care. For practices to be financially viable, physicians must see more and more patients in a day, with shorter and shorter visits, because the unit of care is the visit, not the health or well-being of the patient.

About a decade ago, I made a career change that stepped completely outside of fee-for-service reimbursement. I took a job with a Program of All-Inclusive Care for the Elderly, or PACE, a team-based, fully capitated model of care for older patients with complex multimorbidity. Medicare and Medicaid provide a fixed, risk-adjusted payment per patient per month that covers all aspects of patients' care, from primary and specialty care to hospitalizations and nursing home care.

This capitated payment model transformed my work life. With care organized around the patient instead of the visit, I could structure care in a way that best served the patient, whether with an hour-long visit, a home visit, a telephone call, or a visit with another member of the interdisciplinary team. When I worked in a fee-for-service practice it sometimes felt overwhelming to deal with all the needs of medically complex patients. I was more likely to refer to subspecialists or to send patients in crisis to the emergency department instead of working them into my schedule. In my current practice, I have time to deal with the full complexity of my patients' care myself and to be closely involved in coordinating care across settings. The PACE model allowed me to explore Joe's medical and psychosocial needs, to clarify his goals of care, to collaborate with specialists and interdisciplinary team members in a way that fully supported him. I could do the same for many other patients like him, in a way that would have felt impossible in a fee-for-service model.

The Larger Context of Alternative Payment Models

Because the health care financing system in the United States has resulted in high cost but has not delivered on quality, payers are moving away from fee-for-service toward value-based payment, rewarding value and quality of care rather than just doing more stuff. Although much about our transition to alternative payment models is a grand experiment, with limited data on whether new models improve cost or patient outcomes,[1-3] there is an emerging literature on outcomes in capitated payment settings. Program evaluations of PACE have shown lower hospitalizations, emergency department visits, and rates of institutional long-term care placements, with comparable mortality and cost.[4,5] Promising outcomes have been seen with larger health care systems.[6]

Value-based payment is a step in the right direction. Physicians should be held accountable for quality and value. But most of us practice in a value-based payment system that is built upon a fee-for-service architecture.[7] We are still paid by the visit and therefore still have pressures to see as many patients as possible, but we have quality reporting layered on top of those visits, further squeezing our time with patients. For value-based payment to work for both patients and physicians, it needs to be structured to give primary care physicians the time and space to work to the highest scope of our training and deliver high-quality, cost-effective, coordinated care. Capitation is a model that moves us in that direction. When a substantial portion of primary care physicians' payments are fully capitated, those physicians have the latitude to reorganize care in more substantial ways in order to better serve the needs of their patients.[8]

The End of Joe's Story

When Joe went to the hospital for a fall and pathologic hip fracture, he got sucked up into a web of subspecialists, each of whom had expertise in their corner of Joe's health, but none of whom could truly address the big picture of his care. The cardiologists were focused on his coronary artery disease, the gastroenterologists on his gastrointestinal bleeds, the orthopedists on his hip fracture, none of them fully appreciating his limited life expectancy. I was able to be a point of continuity in his care, to help the hospital team make decisions that made sense and were consistent with his wishes. When he told me that the only thing he wanted before being able to let go was to see "Baby Girl," his teenage granddaughter, I worked with the ICU staff to make an exception to their visitation policy so that she could come to the bedside. He lived a few more weeks after discharge from the hospital. I continued to attend to his care, visiting frequently with him to ensure that he was comfortable and could focus on having quality time with his family.

Over the years that I cared for Joe, it was deeply rewarding to get a glimpse into his full human complexity and to use my clinical skills to the best of my ability to help him live his final years on his own terms. The relationship I established with Joe as his primary care physician laid the groundwork for me to advocate for his needs, closely coordinate his care, and help him and his care team navigate the complex decisions that his situation required. Caring for Joe in the context of a payment model that organized care around his needs allowed me to establish that relationship and to be the kind of primary care physician I wanted to be.

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Key words: health care finance; physician-patient relationship; geriatrics

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