Family Medicine Updates

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GRAHAM CENTER ARTICLE AND KATRINA FORUM

Graham Center Article Blasts US Health Care System

A recent article from the Academy's Robert Graham Center in Washington, DC, blasts "dysfunctional financing schemes" that prevent adequate funding of US primary care. The article also presents possibilities for building "a stable and robust health system built on primary care."

Robert Phillips, Jr, MD, MSPH, director of the Graham Center, wrote the article, "Primary Care in the United States: Problems and Possibilities," published in the December 10, 2005 issue of the *British Medical Journal*.

The US health care system, says Phillips, "operates as a marketplace darling, consuming nearly 16% of the overall economy and nearly 25% of its overall growth. Its role as a reliable economic engine produces amazing technology and pharmaceutical development, but it also yields uninsurance and underinsurance, poor population health compared with other developed countries, and unethical disparities in both health and health care." He adds, "For all the United State's fiscal largesse, there is relative underinvestment in primary care."

Medicare has long undervalued primary care; the program "often cuts its annual payments to cope with overspending on procedures in secondary and tertiary care," Phillips says. He advises separating funding for primary care from that allocated for secondary and tertiary care. Applying the Medicare sustainable growth rate formula separately for services covered by evaluation and management codes (mainly for primary care) and for services covered by other codes (mostly procedural and for secondary and tertiary care) may accomplish nearly the same thing, Phillips suggests. Such a separation would preserve access to the most important primary care functions even when Medicare funds are cut, because spending targets have been exceeded (mainly because of procedural costs).

Phillips underscores the difficulties the 3 primary care specialties are having in transforming their care according to new models and in attracting new doctors. The work, settings, and compensation of general internists and pediatricians are more similar to those of family physicians than to those of subspecialist internists or pediatricians, he says. "The political and clinical integration of these specialties could unify more than a third of all US doctors and create a force for change."

Phillips concludes, "By some measures of sufficiency, the primary care workforce in the United States has never been more capable of caring for people. Is it just in time to witness its demise, or just in time to retool and transform its clinical models and role in the health care system? The problems and possibilities may be coming into adequate alignment to permit a previously unthinkable period of experimentation." He calls for experiments in "how primary care is financed, how it may be protected from financial cannibalism by secondary and tertiary care, how it is organized, and how it is taught."

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Katrina Forum Looks at Revamping Medical Infrastructure

As they look at rebuilding the Gulf Coast after Hurricane Katrina, policy makers would do well to finish the storm's destruction of the medical infrastructure in the area, said Karen DeSalvo, MD, MPH, chief of general internal medicine and geriatrics at Tulane University School of Medicine in New Orleans, at a recent forum cosponsored by AAFP's Robert Graham Center.

Rather than attempting to recreate the old system, DeSalvo described a new health care system based on AAFP's Future of Family Medicine report. Policy makers, she said, should build a health care system that focuses on primary care as its foundation. "Never before have we had the chance to build a health care system from scratch," she said during the December 20, 2005 Washington, DC forum "After Katrina: Healthcare Infrastructure in the Gulf."

"We should promote primary care as the centerpiece of a new health care system (in Gulf Coast states)," DeSalvo said. "The data are very strong that primary care drives the system. It is more efficient (and) has better outcomes and fewer health disparities."

The forum drew 48 congressional and HHS staff members, news reporters and others, who heard presentations by family physician J. Edward Hill, MD, of Tupelo, Miss., president of the AMA; David C. Kibbe, MD, director of the Academy's Center for Health

Information Technology; and Linda Magno, director of the Medicare Demonstrations Program Guide.

Hurricane Katrina wrecked the medical infrastructure along the Gulf Coast, according to Hill. Some 6,000 physician practices were affected, 4,500 of which were in 3 Louisiana parishes, he said. The average practice loss was $363,000 after insurance coverage.

DeSalvo called for a health care system that mirrors the model of care espoused in the Future of Family Medicine report. New Orleans' pre-Katrina health system was the antithesis of that model, she said, adding that the FFM model will best serve patients, conserve resources and improve outcomes.

"Patients in the system experienced fragmented care delivered in clinics located inconveniently downtown and open during hours convenient to the physicians and trainees," she said of that pre-Katrina health care. "Other care in the city was generally provider-centric, not supported by interoperable information technology or by health policies that financially supported primary care."

Worse, the system perpetuated itself by training physicians who expected to work in a subspecialty-focused, hospital-based, provider-centered practice. "In reengineering the health system of New Orleans, planners propose to shift the paradigm away from this … model," DeSalvo said. "Our ultimate vision for the post-Katrina health system is one in which every citizen has a 'medical home' that provides high-value care that is responsive to their needs and perspectives."

Planners want a network of primary care practices that would be housed in community centers and that also would offer exercise facilities, child care and Internet access for patients, said DeSalvo. These health care clinics would offer group visits for chronic conditions, open-access scheduling, multidisciplinary teams and electronic health records. The clinics also would train residents and medical students "so that they are exposed to a patient-centric model of primary care," she said.

One clinic—the Covenant House—already is implementing the tenets of the planners' vision. The facility provides socioeconomic, recreational and health care services for residents from the surrounding neighborhood. Plans call for a multidisciplinary team that includes a social worker and counselor and a training program to expose students and residents to patient-centric care, said DeSalvo.

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MAINTENANCE OF CERTIFICATION FOR FAMILY PHYSICIANS

In addition to its regular 7-year recertification process, in 2004 the American Board of Family Medicine (ABFM) began the implementation of its Maintenance of Certification for Family Physicians (MC-FP). The roll out of MC-FP was designed to gradually transition all Diplomates into this new program by 2010 by entering all physicians who certify or recertify into this new program in the year after they successfully pass the examination. The first group that entered MC-FP in 2004 was comprised of those physicians who certified or recertified in 2003; the last group to come in to the program in 2010 will be those who certify or recertify in 2009.

The ABFM has recently modified the program to include more options and greater flexibility for Diplomates. The most important new enhancement is the opportunity for Diplomates to extend their certification period from 7 to 10 years by regularly completing MC-FP requirements in a timely fashion.

About the Program

MC-FP is a mechanism that provides the ABFM with the means of continuously assessing Diplomates. Every specialty board that belongs to the American Board of Medical Specialties (ABMS) has agreed to a generic structure with which each of its individual programs must comply. This structure consists of 4 elements designed to assess 4 important physician characteristics: professionalism (Part I), self-assessment and lifelong learning (Part II), cognitive expertise (Part III), and performance in practice (Part IV). While these elements are similar to and consistent with the ABFM's long-standing, existing recertification program, MC-FP stresses the importance of ongoing participation in activities which evaluate each of these between recertification examinations—a requirement that ABFM believes encourages clinical excellence and benefits both physicians and their patients.

Extending a Certificate from 7 to 10 Years

As mentioned, one of the important new enhancements is the option to extend a recently earned 7-year certificate by 3 years, effectively creating a 10-year certification period. Under the original MC-FP program that