
An NJAFP White Paper

Perspectives on Cost Effective Delivery of Health Care and Family Medicine

Reducing Health Care Costs through Focus on Family Medicine

Family Physicians have always been the representative of the patient – the patient’s advocate. This has never been truer than in the current health care delivery system where the family physician is on the front line working on behalf of their patients to have insurers approve their medical recommendations for treatment. Family physicians – providing quality health care through the Patient Centered Medical Home - are trained to emphasize health promotion and disease prevention, thereby avoiding more costly hospital care, and are uniquely qualified to provide appropriate, cost-effective care to a diversified patient population.

Methods and Principles of Cost Effectiveness

The NJAFP believes that the following principles are basic to cost effectiveness in health care:

- **QUALITY AMBULATORY CARE:** Major efforts must be made by the state to promote and emphasize quality ambulatory care provided by those best trained to provide such care -- family physicians through the Patient Centered Medical Home. This education should begin at our state’s medical school and continue through the administration of our state programs.

- **INCENTIVES FOR ELECTRONIC MEDICAL RECORDS:** EMR’s proven cost’s savings are seen through improved billing systems, increased outcomes for patients, reduced medical errors, enhanced documentation, increase screening and preventative care, reduce complications (including drug errors), and encourage better health habits and self-management of medical conditions. The success of EMR begins with its implementation at the primary care physician’s office setting – where coordination of patient care from birth to end-of-life truly occurs. With the upfront cost of implementing EMR in family physicians’ practices reaching upwards of \$50,000 per physician, current data indicates that rates of adoption in small practices continue to lag. New Jersey’s primary care physicians are unlikely to jump into the investment without significant state or federal financial assistance, including but not limited to tax incentives, financing assistance, and restructured insurance payments for physicians who purchase, implement or improve EHR systems.

- **PAY FOR PERFORMANCE IN STATE PROGRAMS:** Pay for Performance (P4P) programs engage the patient and encourage significant leaps in the cost effective and quality care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care. State programs, including Medicaid, can easily incorporate P4P to provide incentives and higher reimbursement for office process improvements and improved outcomes of patient care. A model P4P for Medicaid or other state programs is the Bridges to Excellence coalition (www.bridgestoexcellence.org), which is a non-profit group working on P4P programs with the Centers for Medicare and Medicaid Services.

- **QUALITY CONTROL YIELDS COST SAVINGS:** The state can partner with family physicians to stress quality control in the system, rather than cost containment, as the primary goal of state regulation. This change will yield greater long-term savings and address chronic systemic problems in the delivery of health care in the state. EMR is the obvious first step.
- **DEDUCTIBLES AND CO-PAYS:** Word of caution: the continued trend toward consumer driven health plans, the use of health insurance deductibles and co-payments are also useful tools in emphasizing cost containment but these should not be prohibitive in achieving access to quality health care.
- **INSURANCE PLANS - HEALTH PROMOTION AND DISEASE PREVENTION:** Health promotion and disease prevention must receive primary emphasis on all health care plans with payment to physicians providing such medical care being equal to or greater than that provided for acute medical care.
- **AUDIT AND CONSOLIDATE STATE PROGRAMS:** State health care programs should be screened and audited for cost effectiveness with input from participating health care providers and beneficiaries of these services. Where possible, state programs that buy prescription drugs should be consolidated and increased use of generic drugs implemented in state programs except where it is not the recommendation of the patient's family physician.
- **HEALTH EDUCATION AND PHYSICAL FITNESS:** Health education and physical fitness should be primary curricular items in our entire educational system from elementary through secondary schools. Healthy life-styles for adults should include continued health education, disease prevention and physical exercise.
- **INCENTIVES FOR PATIENTS AND PHYSICIANS:** There should be incentives provided to both physicians and patients to maximize value in health care: highest quality at lowest costs.
- **INCREASE COST AWARENESS IN MEDICAL TRAINING:** Medical education should emphasize cost awareness and cost effectiveness at all levels of education -- undergraduate, graduate and continuing medical education programs.
- **PATIENT EDUCATION ON COST EFFECTIVE MEDICAL CARE:** Patients must be educated regarding the necessity of their involvement in cost-effective medical care. This can be achieved through informational programs sponsored by employers or insurance plans emphasizing personal responsibility for healthy life-styles and cost-effective medical care.
- **PUBLIC EDUCATION PROGRAMS:** The state should not overlook public education programs as a means to address affordability and rising health care costs. A successful public campaign would emphasize the positive effects of exercise, nutrition and highway safety, and the detriments of drug and substance abuse, obesity and smoking.