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## **The Patient-Centered Medical Home and Nephrology**

The Patient-Centered Medical Home is a concept endorsed enthusiastically by patients and supported by Primary Care Physicians (PCPs). It has intrigued providers, payers, and the federal government with its promise of savings through reduced emergency room visits and duplication of tests. Some societies have come out against it. Others, such as the American College of Physicians (ACP), have made it a major agenda item, and invested countless hours in presenting the concept to other societies to convince them to join ACP in their endorsement of a new model of coordinated care.

### **Background**

The idea was presented to the American Society of Nephrology (ASN) at its Board of Advisors meeting in November 2007. It was discussed at various committee and advisory group meetings before being assigned to the ASN Public Policy Board (PPB). The policy board formed a task force and asked the chair, Thomas D. DuBose, Jr., MD, to formulate the Society's response and position on the PCMH. The members of the task force are: Mary (Tessie) T. Behrens, MD, Arnold S. Berns, MD, FASN, Connie L. Davis, MD, Thomas H. Hostetter, MD, Paul E. Klotman, Stuart L. Linas, MD and Lynda Szczech, MD, FASN.

### **Process**

The approach taken by the task force was multi-pronged. The group first spoke by conference call and created four case scenarios to illustrate how the PCMH might manifest itself in a nephrologist's office – and what concerns and questions might arise with implementation. (Attachment 1) The case scenarios covered a patient with Stage 3 chronic kidney disease (CKD), a patient referred to a nephrologist for an initial evaluation of CKD, a patient with end-stage renal disease (ESRD), and a patient with an uncommon but complex disorder.

The task force then presented these cases to a representative from ACP, who answered their questions and provided background information. Dr. DuBose joined the ACP Council of Subspecialty Societies PCMH Workgroup, and Senior Policy Coordinator Susan Owens participated in meetings and conference calls held by the Patient-Centered Primary Care Collaborative. Along with Paul Smedberg, ASN Director of Policy and Public Affairs, Ms. Owens met with representatives from other subspecialty societies, such as the American Society of Hematology, the American College of Rheumatology, and the American Gastroenterological Society, to investigate what their approach was to the concept - and if they planned to endorse or reject it.

### **Position**

If a physician chooses to serve as patient's "medical home," he or she receives a bonus for coordinating all of the patient's care, from diet to mental health to preventative measures. The physician would be required to be available to the patient 24/7 via email or phone. The consensus of the task force is that nephrologists usually would not want to serve as the "medical home," except perhaps in cases of ESRD patients on dialysis or

transplant recipients, given their unique medical regimen. It would be easiest for practices with an already established infrastructure and technological resources, but could be a financial burden for smaller practices.

However, even if a nephrologist chooses not to serve as the medical home, he or she still has an obligation to ensure that the PCP is treating CKD patients appropriately and that referrals happen in a timely fashion.

### **Recommendation**

The ASN PCMH Task Force recommends that the Society endorse the concept of the PCMH, but with the caveat that nephrologists must be involved in the creation and outline of the PCMH to ensure that kidney disease patients continue to receive the same quality of care. ACP stressed that the idea of a PCMH is still evolving, and that ASN can participate now to form the concept around the Society's priorities.

Therefore, the task force recommends that ASN should:

- 1) Help define quality guidelines to help gauge the success of a PCP as the medical home for patients with CKD. This could include the treatment of anemia, Vitamin D, blood pressure, and bone disease.
- 2) Define chronic care paths within the PCMH.
- 3) Provide input in the development of "a la carte" codes for things such as email consultations.

The task force also cautions against one element of the Centers for Medicare & Medicaid Services (CMS) demonstration project, scheduled to begin in January 2009. Within this demo, CMS intends to share the savings from the PCMH with the physician

who serves as the medical home. The task force feels that this sets up a perverse financial incentive to restrict consultations that could be in conflict with the quality of care provided.