Paul Ambrose Spring Forum:
Primary Care Present and Future

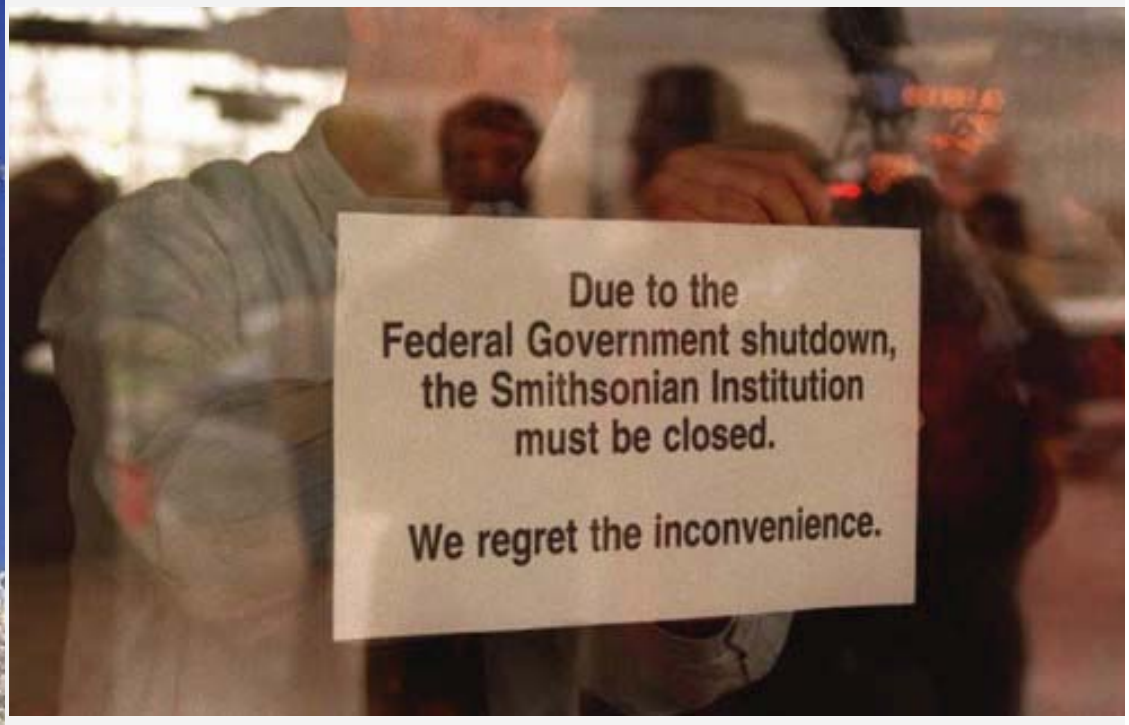
Robert L. Phillips, MD, MSPH

Director

The Robert Graham Center

- Placed in Washington, DC 11 years ago, AAFP
- To improve policy-making with better evidence about primary care, family medicine
- Editorial independence (only one)
- Small staff
  - 2 family physician researchers
  - Sociologist/statistician
  - Economist
  - 2 Geographer
  - 6 excellent research and support staff

Washington, DC



Present: Primary Care Physicians

	2008 3-Year Average	Overcount Adjusted	PC Multiplier	PC Adjusted
FM	85,345	79,453	0.95	79,453
GP	12,876	10,003	1	10,003
IM	92,485	85,224	0.8	68,179
PD	49,060	44,879	0.95	42,635
Total	239,766	219,559		200,270

Adjusted for retirements, deaths (JAMA)

Adjusted for hospitalists, etc

Work supported by ORHP/HRSA R04RH15123

NPs and PAs in Primary Care

Provider type	Total	Number in Primary Care	Percent Primary Care
Physician Assistants	62,771	27,214	43.4%
Nurse Practitioners	92,978	48,323	52.0%

If you co-locate NPs, PAs and apportion FTE by physician specialty ratio at site

(National Provider Identifier File 2009)

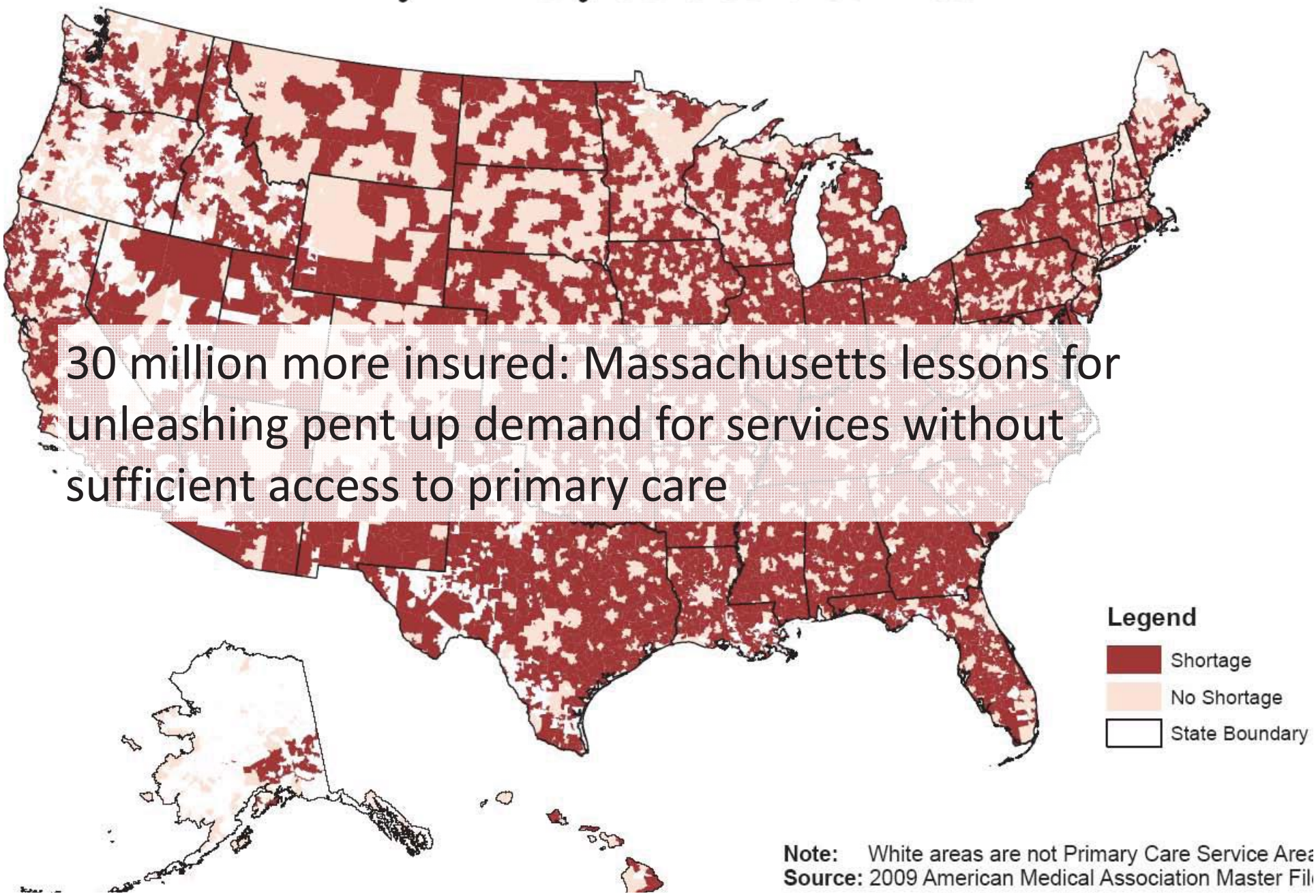
Enough? Depends

Average PCP:population ratio is about 1500:1

(range 500:1 – 5000:1)

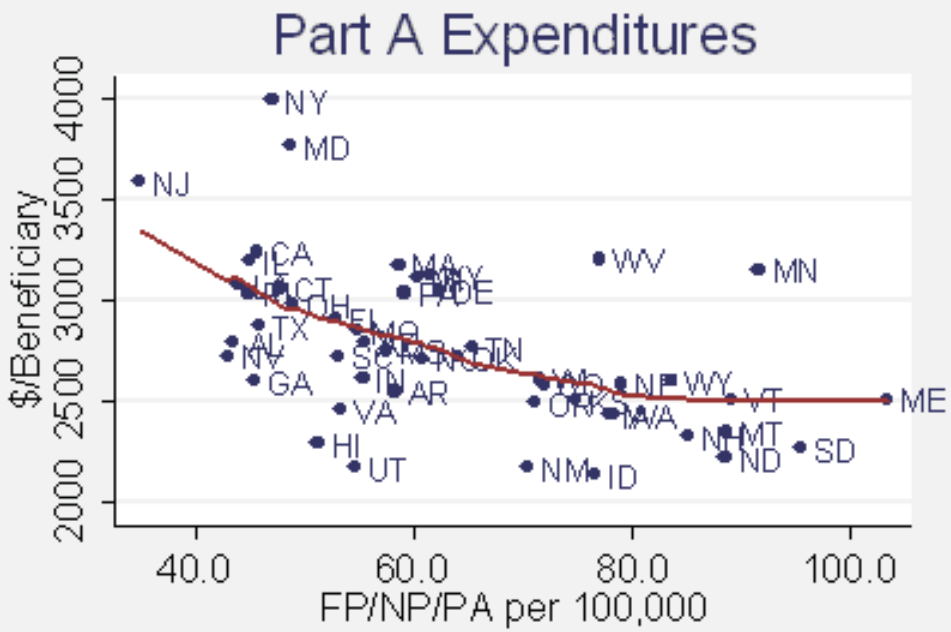
Primary Care Service Areas in shortage vs "surplus"	National Average	
	Physicians	Providers
	1500:1	1100:1
# with shortages	4,838	4,930
# Needed	-34,479	-54,372
# with "surpluses"	1,668	1,576
# Excess	34,479	54,372

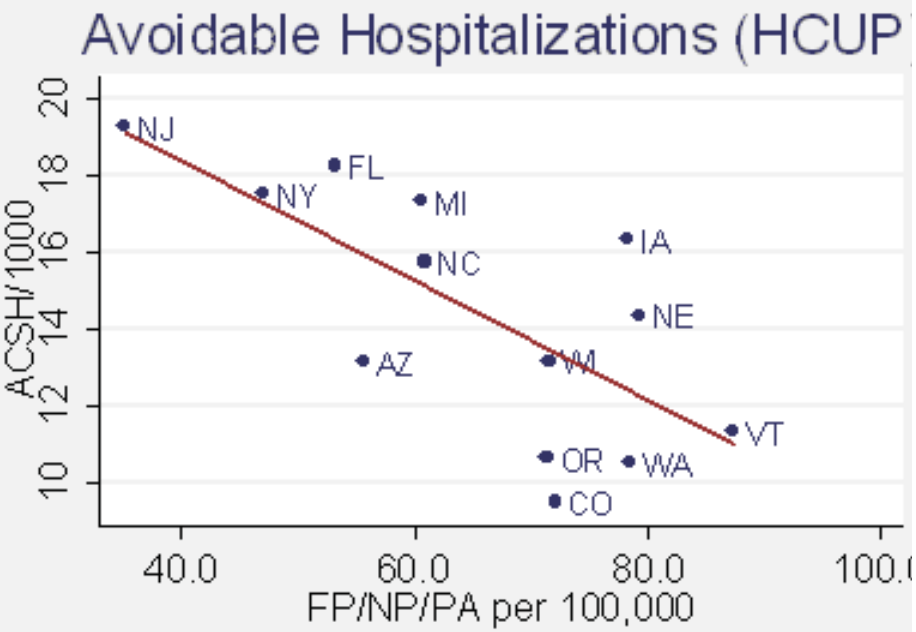
Primary Care Physician Shortage at 1500:1 Ratio By Primary Care Service Area



30 million more insured: Massachusetts lessons for unleashing pent up demand for services without sufficient access to primary care

What is the right ratio?





Between 1500:1 and 2000:1 (FP + NP+PA; 1000:1 with GIM) if costs and avoidable hospitalizations matter

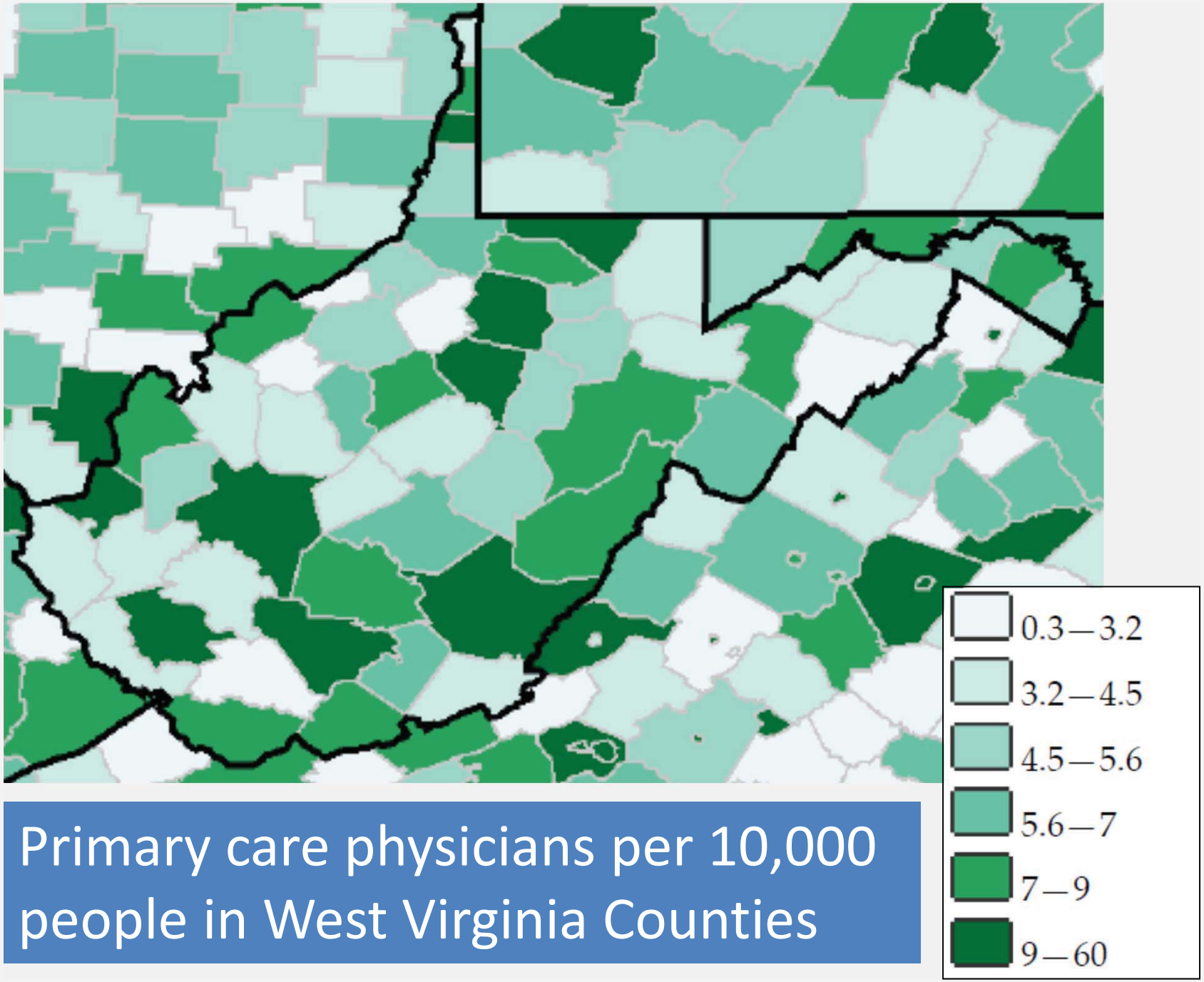
Difficulty demonstrating for General Internal Medicine

Present: Primary Care Not Replacing Itself

- Between 2002 and 2006
  - Residency positions grew +7.9%
  - Subspecialty positions grew +24.7%
    - (33% between 2001 and 2008)
  - **However…the estimated number of graduates going on to practice primary care <u>fell 15%</u>** (from 28.1% to 23.8%)

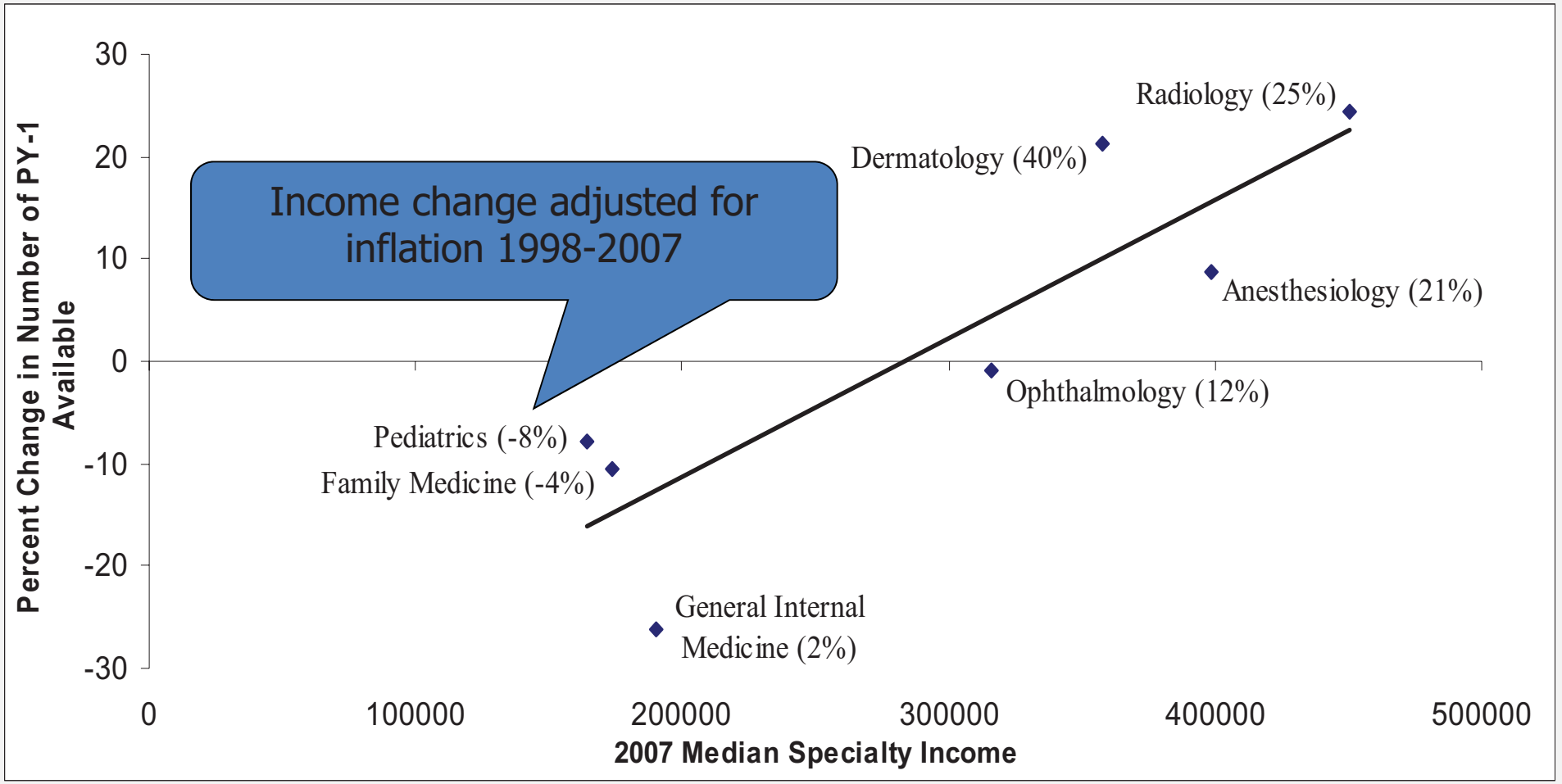
Now about 22%

E. Salsberg et al. US Residency Training Before and After the 1997 Balanced Budget Act. *JAMA.* 2008;300(10):1174-1180.

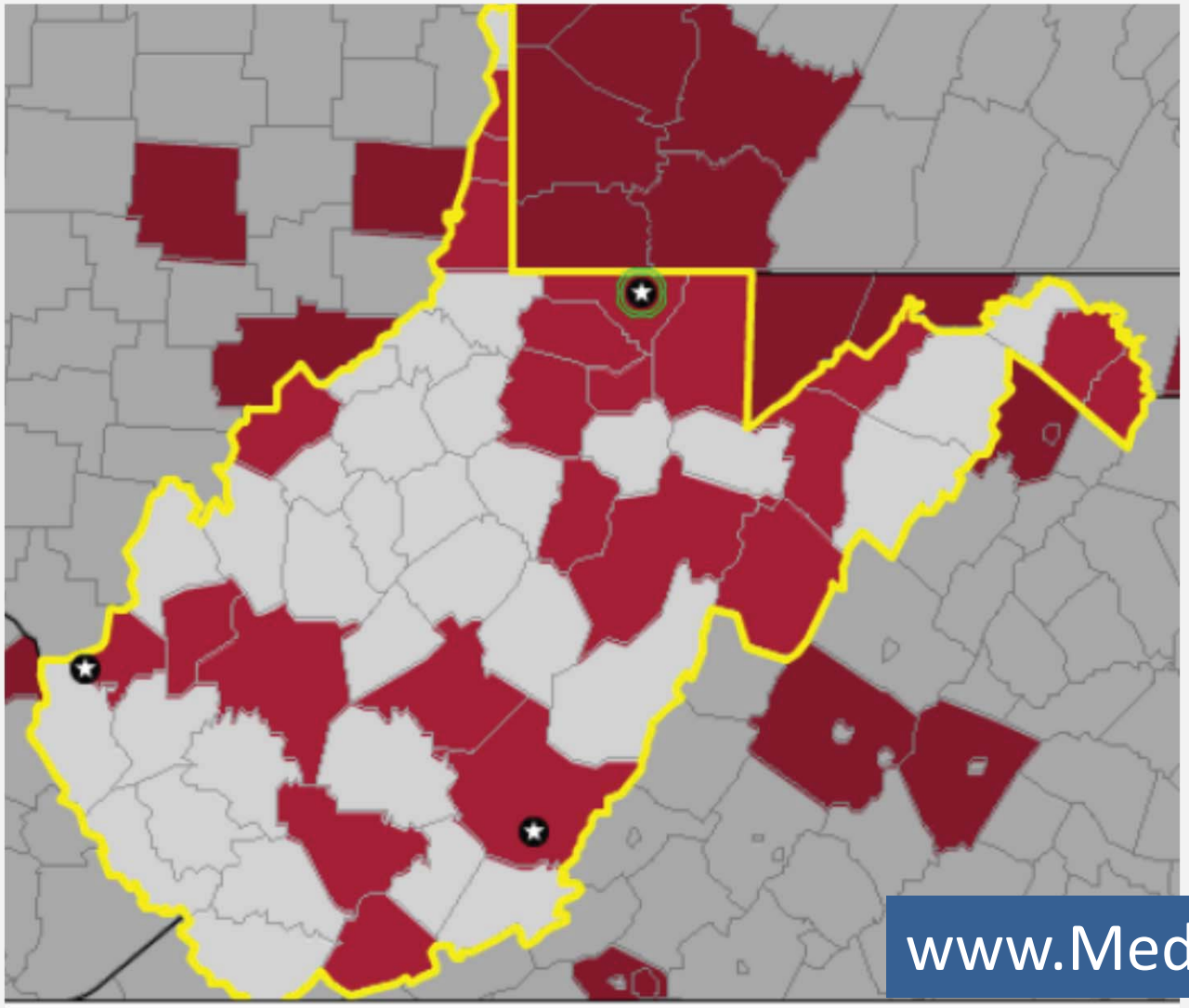


Primary care physicians per 10,000 people in West Virginia Counties

A Decade of GME Expansion



WVU Medical School

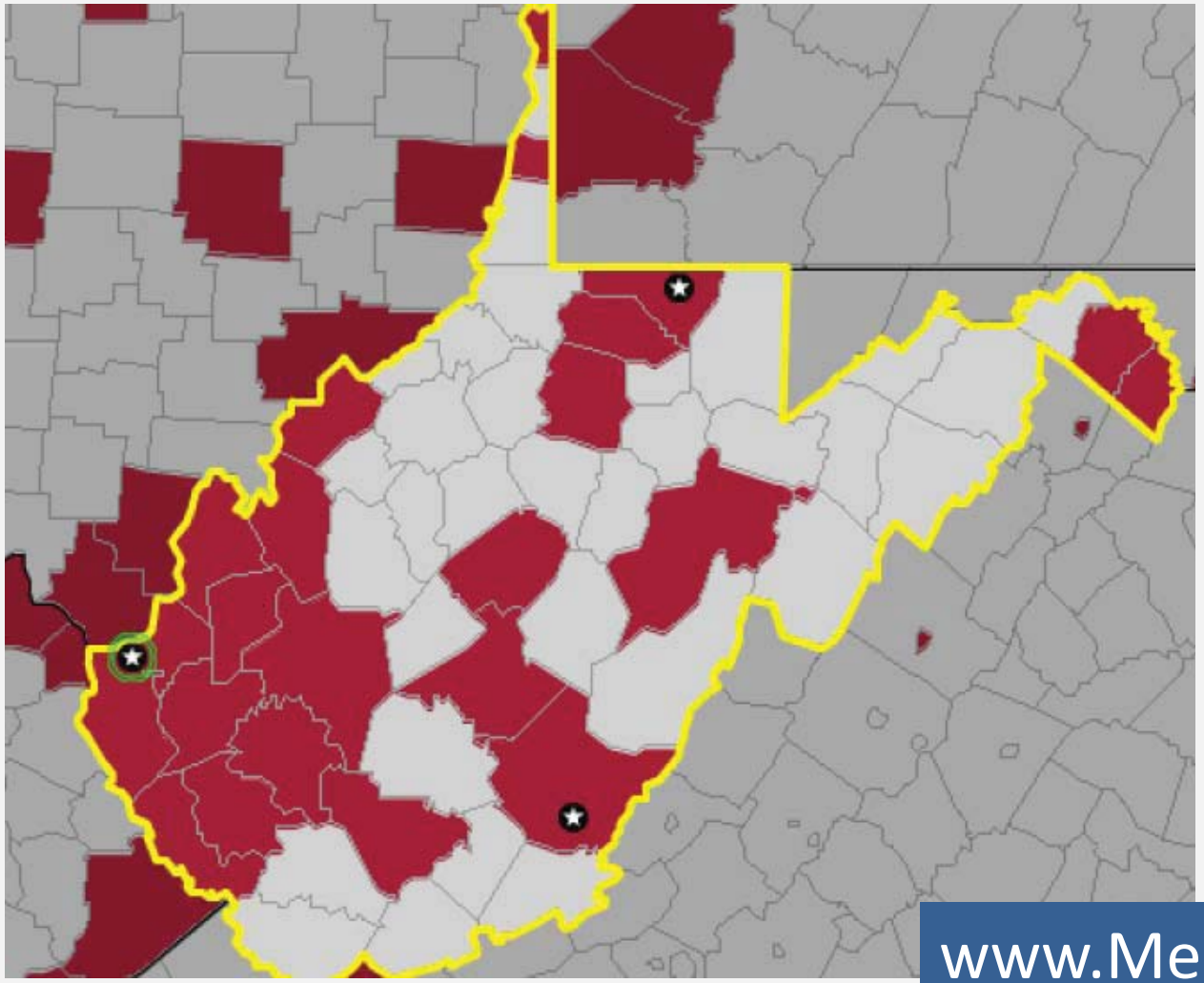


33.3% of grads stay in state

18%	Rural
45%	primary care
3%	General Surgery
19%	Family Medicine

www.MedSchoolMapper.org

Joan C. Edwards School of Medicine

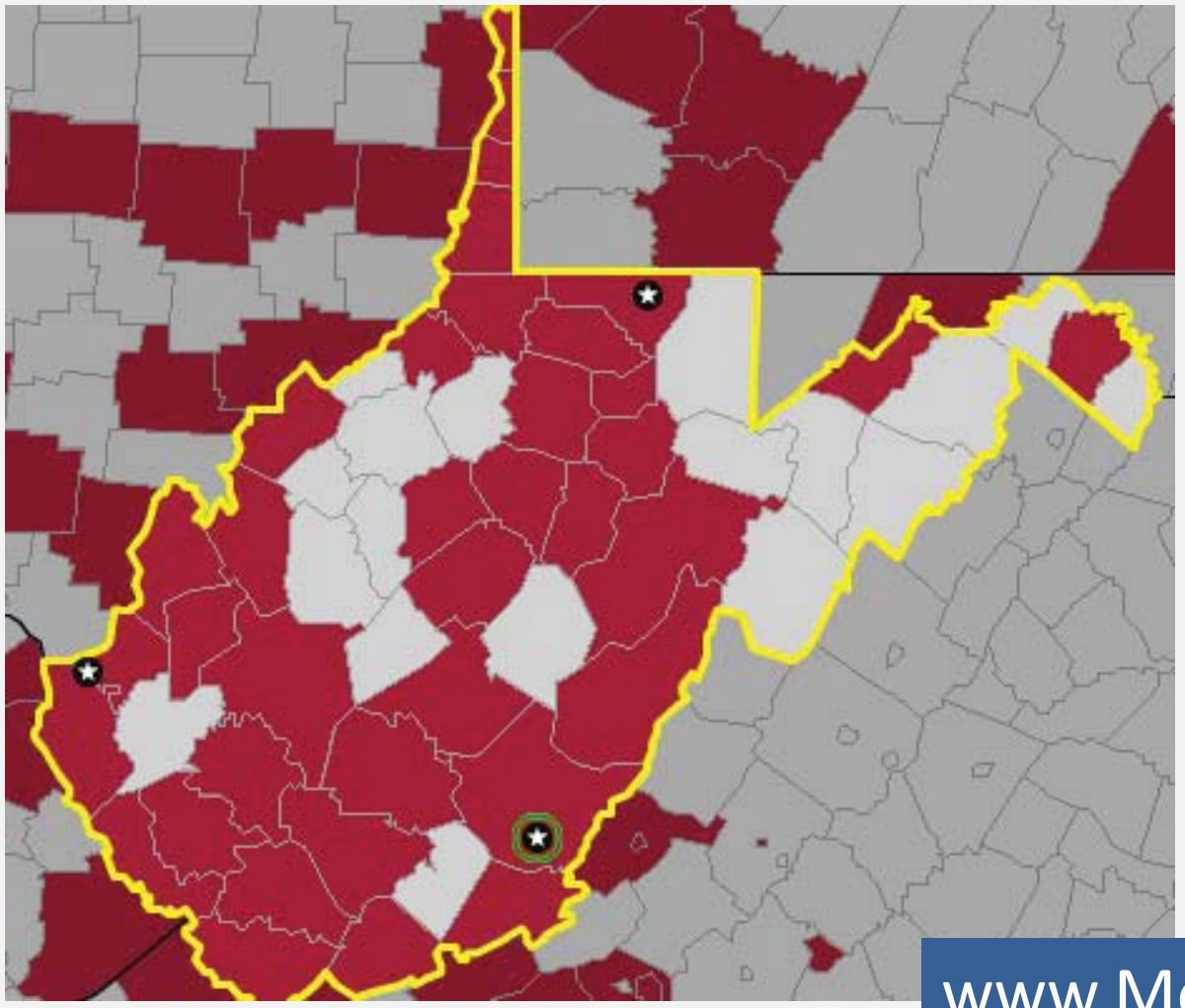


38.9% of grads stay in state

17%	Rural
47%	Primary care
3%	General Surgery
25%	Family Medicine

www.MedSchoolMapper.org

West Virginia School of Osteopathic Medicine



32% of grads stay in state

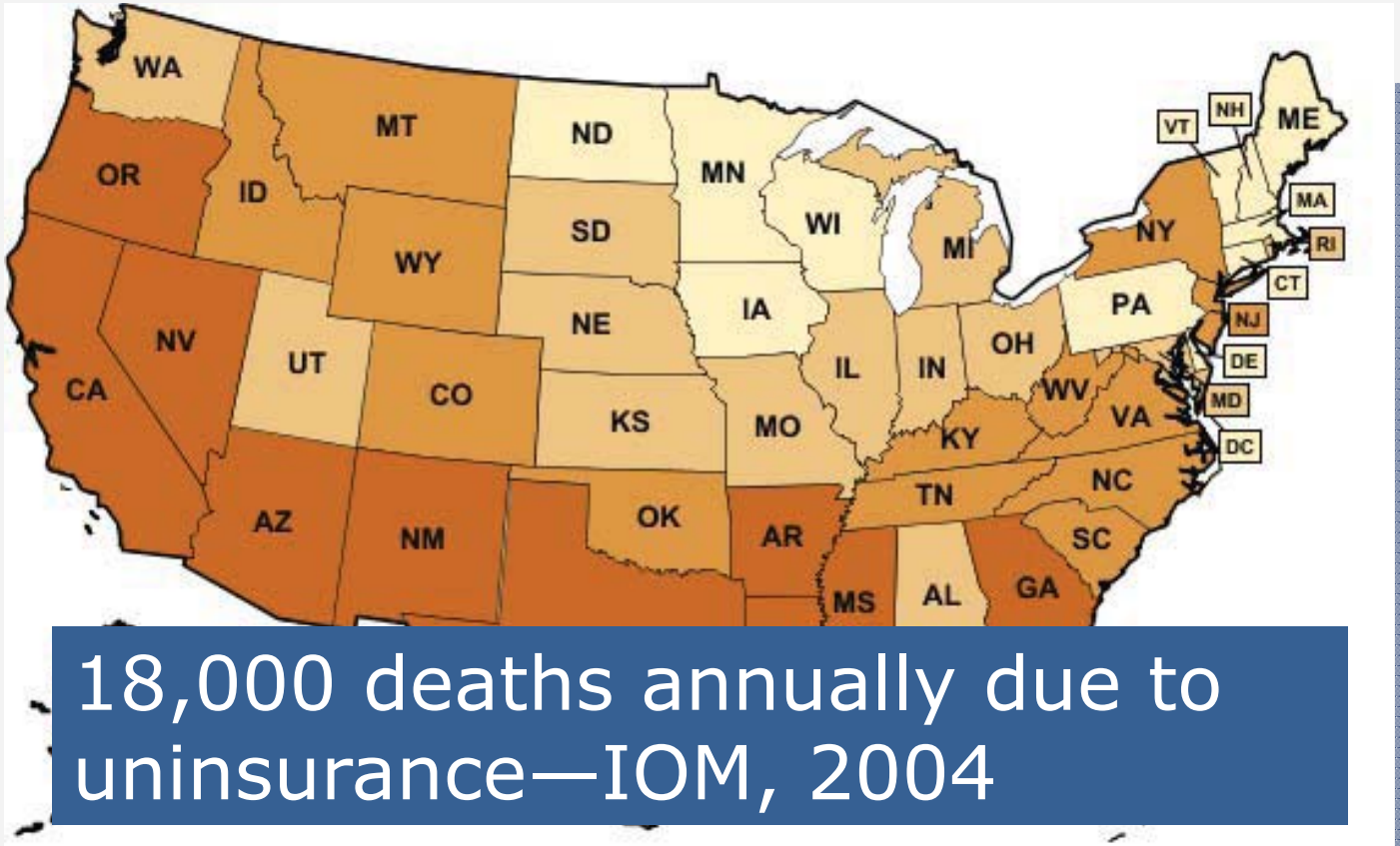
35%	Rural
55%	Primary care
2%	General Surgery
42%	Family Medicine

www.MedSchoolMapper.org

Future: The Patient Protection and Affordable Care Act

Affordable Care Act

- Will Insure more people ~ 30-32 million
- About half on Medicaid
- About half through “health insurance exchanges”
- Strong focus on primary care
  - Strongest on primary care access
  - Weakest on primary care payment gap



18,000 deaths annually due to uninsurance—IOM, 2004

5.4% - 11.1%

11.3% - 13.2%

13.6% - 16.2%

16.6% - 25.2%

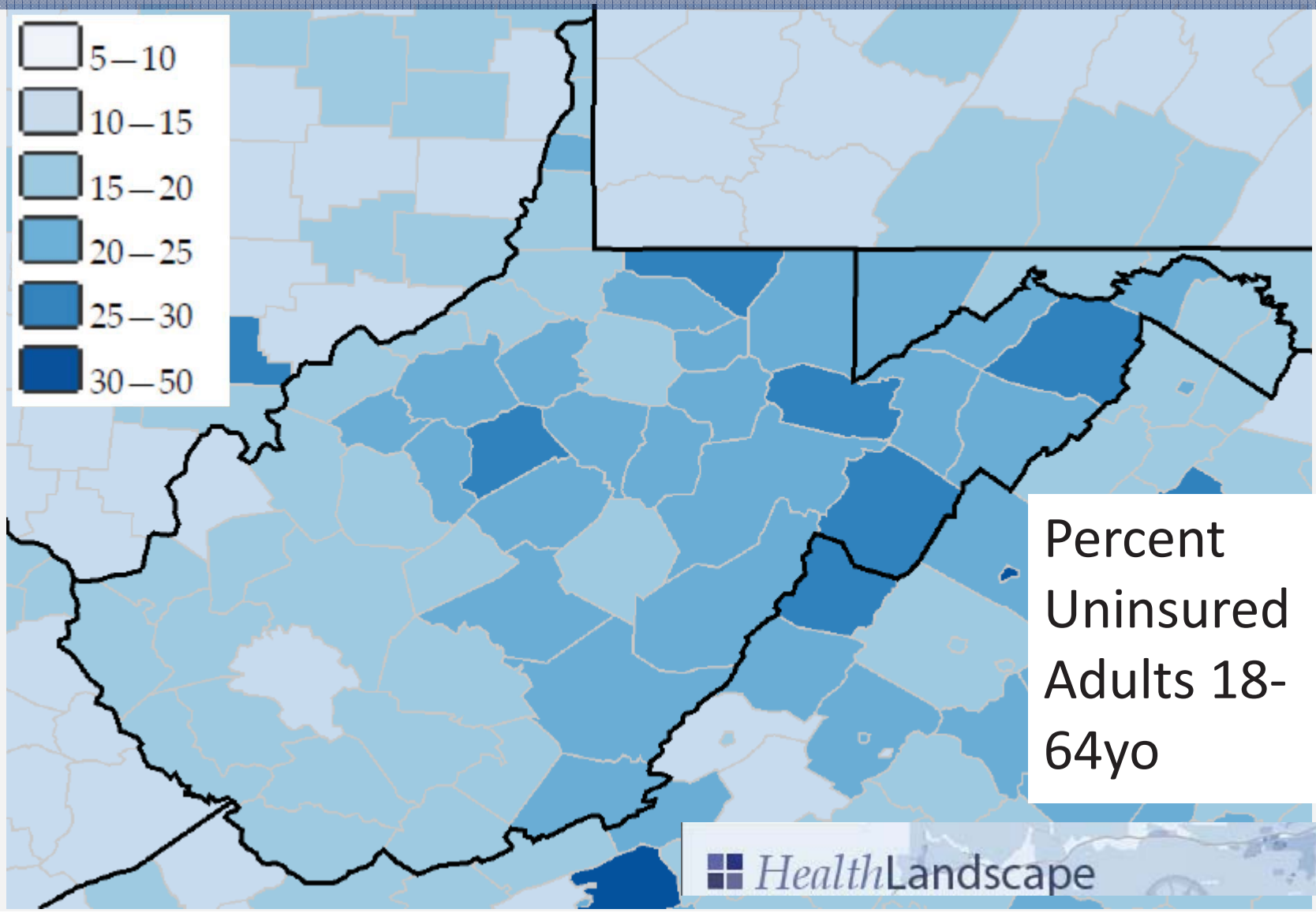
Health Insurance Coverage of the Total Population, states (2007-2008), U.S. (2008): Uninsured

THE HENRY J. KAISER FAMILY FOUNDATION statehealthfacts.org
Your source for state health data

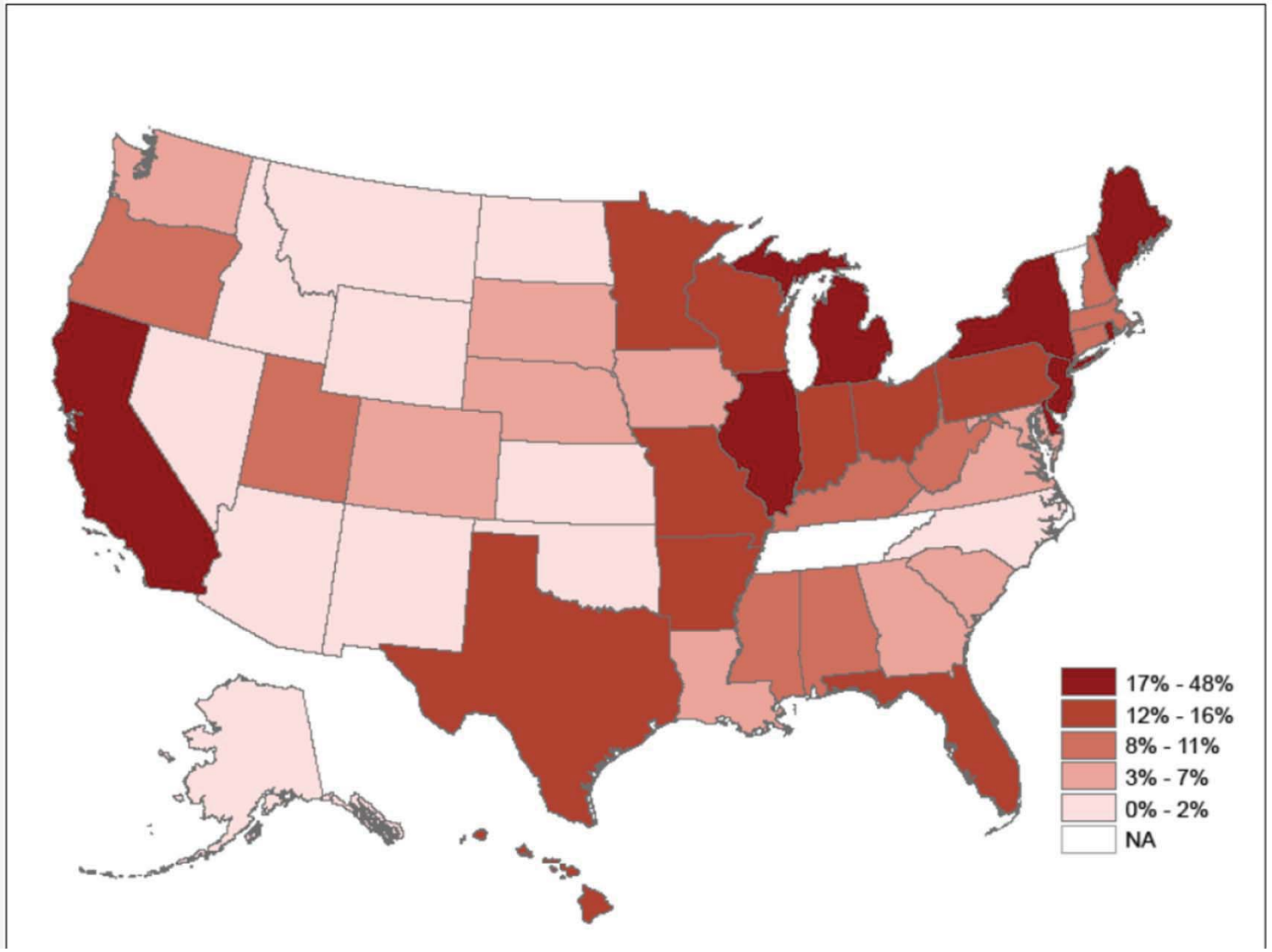
But 1 in 3 nonelderly people were uninsured sometime in the last year

87 million people

Uninsured in West Virginia (%)



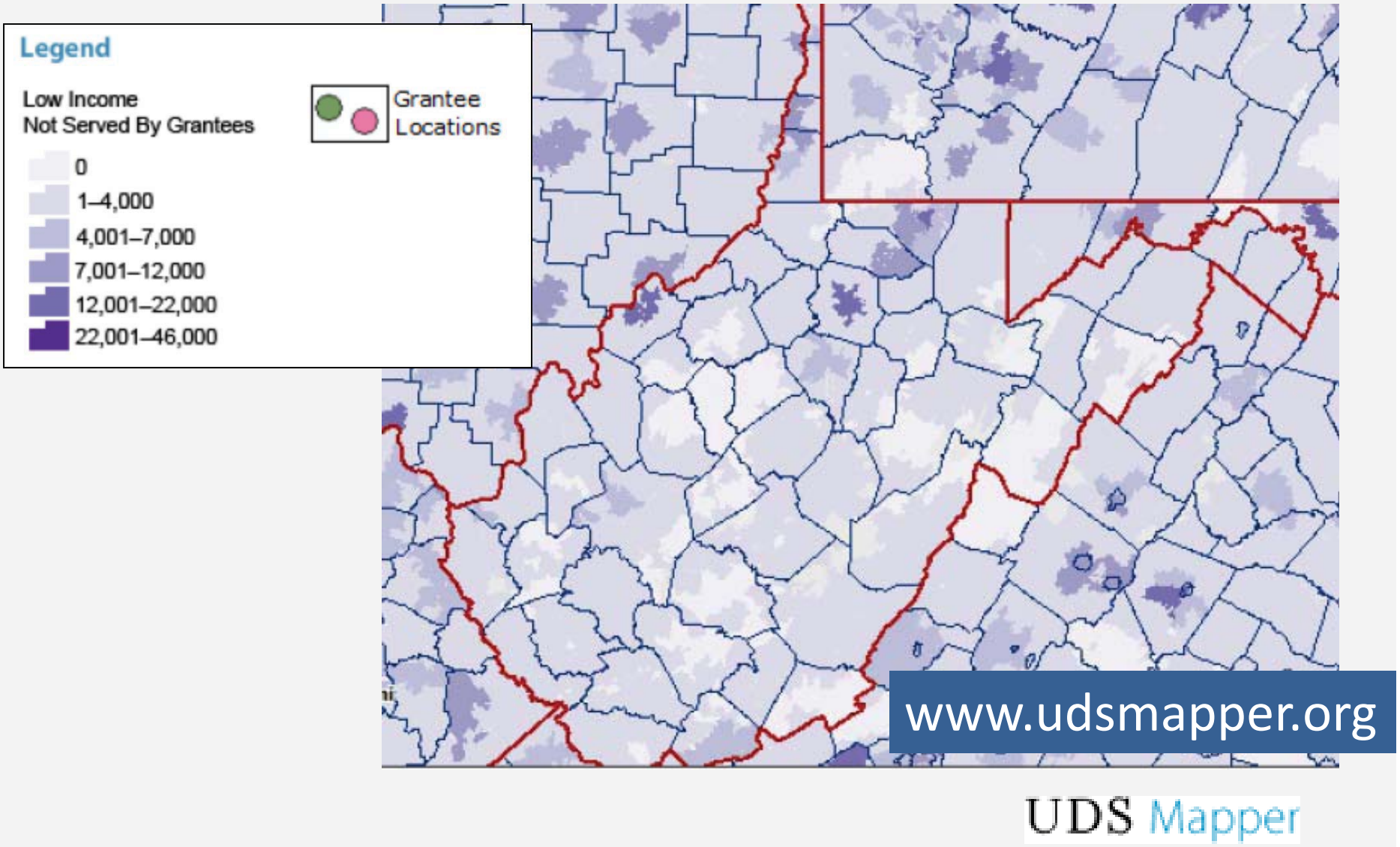
ACA:Federal Medicaid top-off 2014



ACA: Increase Access

- Double Capacity of Community Health Centers
  - Currently serve 19 million
  - Goal of 40 million by 2015
- Increase National Health Service Corps
  - More than doubles the investment
  - Loan repayment for service
  - Locates them in underserved areas

New Access Points for Newly Insured



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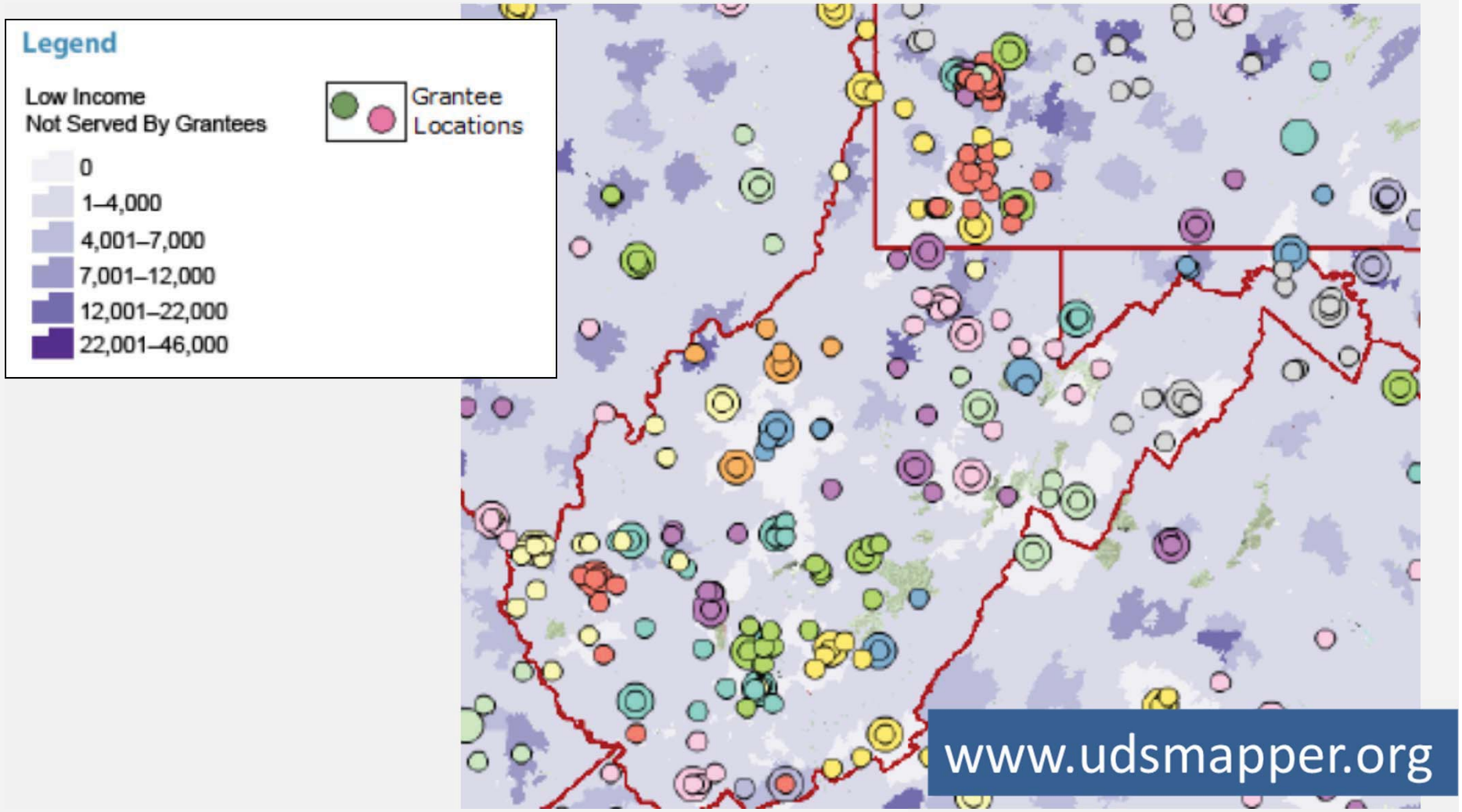


More PC Training Dollars

- ~$250 million to train more primary care physicians over 5 years
- 12 Teaching Health Centers—community health center training sites
- New regulations to allow funding of time in the outpatient setting
- Reallocation of ‘unused’ positions with strong preference for primary care

Medical Home & Accountable Care

- Expands authorization of demonstrations of Accountable Care Organizations and Patient Centered Medical Home
- Medicare's Innovation Center trying to learn quickly how to use regulatory authority to support purposeful transformation of practice

Accountable Care Organizations

- Accountable care organizations (ACOs) seek to have providers to think of themselves as a group with a common patient population, care delivery goals, and performance metrics, rather than as discrete entities
- financial incentives for broad cost containment and quality performance across multiple sites of care

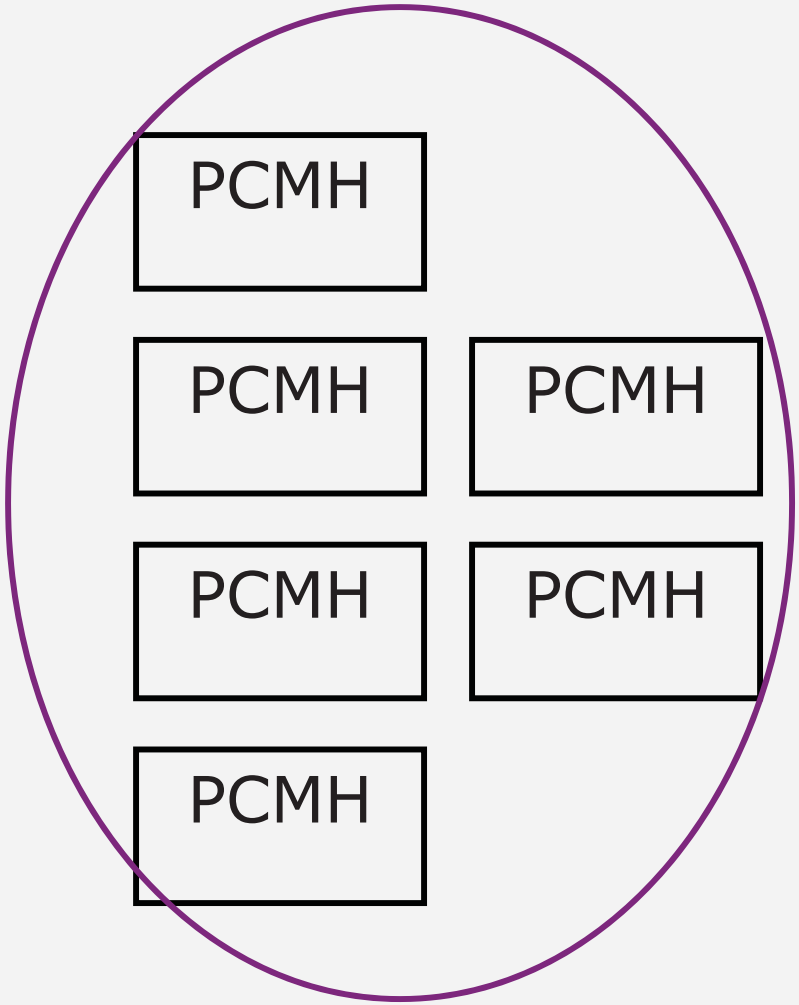
Marsha Gold. **Accountable Care Organizations: Will They Deliver?**
Mathematica Policy Research, inc. January, 2010

MedPAC on ACOs and Patient Centered Medical Homes

- An **ACO** is "a set of physicians and hospitals that accept joint responsibility for the quality of care and the cost of care received by the ACO's panel of patients"
- The **Patient Centered Medical Home** is a medical practice that
  - furnishes primary care, conducts care management, has formal quality improvement program, has 24-hour patient access, maintains advance directives, and has a written understanding with each beneficiary that it is the patient's medical home"
- **MedPAC regards medical homes as building blocks of effective ACOs**

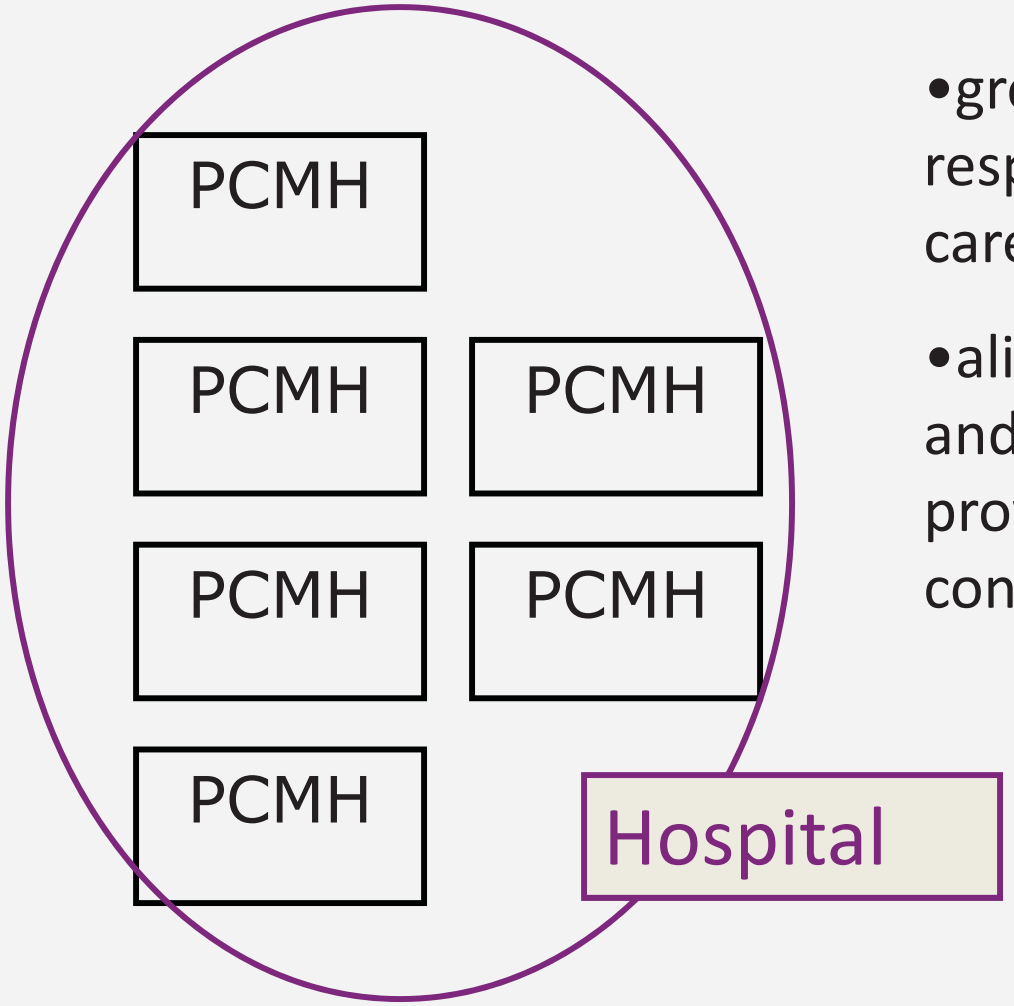
Medicare Payment Advisory Committee (MedPAC). *Accountable Care Organizations*. http://medpac.gov/chapters/Jun09_Ch02.pdf. July 10, 2009.

Accountable Care Organization



- group of providers responsible for the health care of a group of people
- alignment of incentives and accountability of providers across the continuum of care

Accountable Care Organization



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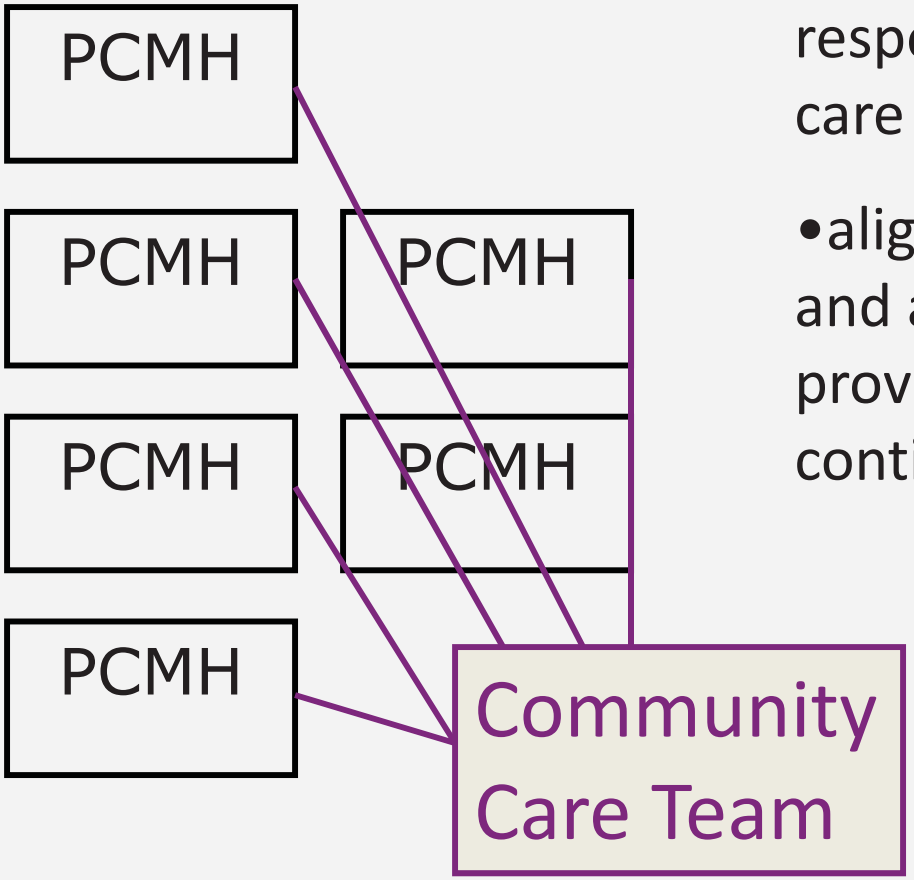


- group of providers responsible for the health care of a group of people
- alignment of incentives and accountability of providers across the continuum of care

UCSF/PCPCC fact sheet

- Integrated Health System PCMH/ACO experiments
  - 7%+ reduction in total costs (entire cost of primary care for Medicare!!)
  - 16%-24% reduction in hospital admissions
  - 30-40% reduction in emergency department
  - Geisinger, Group Health Cooperative,HealthPartners

  - Most of these in just 2-5 years!

UCSF/PCPCC fact sheet

- Insurance experiments
  - 30%+ reductions in hospitalizations, ER visits vs controls
  - Up to 50% reduction in cost growth vs controls
  - North Carolina Medicaid estimates saving nearly $1 billion in just 6 years

UCSF/PCPCC fact sheet

- Johns Hopkins Guided Care PCMH Model
  - 24% reduction in total hospital inpatient days,
  - 15% fewer ER visits
  - 37% decrease in skilled nursing facility days
  - Annual net savings of $75,000 per nurse care coordinator (Medicare)
- Genesee Health Plan (Michigan)
  - 50% decrease in emergency department visits
  - 15% fewer inpatient hospitalizations
- Erie County PCMH Model
  - Estimated savings of $1 million for every 1,000 enrollees

Case Study Of A Primary Care Accountable Care Organization

WellMed, Medical Management, Inc

Robert Phillips, MD, MSPH
Stephen Petterson, PhD
Maribel Cifuentes, RN
Svetlana Bronnikov, MS
Bridget Teevan, MS
David R. West, PhD

AHRQ Task Order: SNOCAP-USA (University of Colorado, Robert Graham Center) HHSA290200710008

Dr. David Lanier: Task Order Officer

Practice setting

- Lots of space
  - In primary care trend is downsizing footprint
  - Big community space for exercise classes, computer classes, nutrition/cooking classes
- Podiatry, Rheumatology, Dermatology rotate through (Now hiring Cardiology)
- Free orthopedic shoes fitted onsite

Teams With Defined Roles

- Med Assistants do most data entry
- Health Coaches
  - Call patients next day to reinforce care plan
  - Meet with patients (clinic, home, phone) to do behavior change, mental health, care plan
- Two Disease Mgmt programs for COPD, DM, CHF, CAD—A “complex care” team manages the most fragile, high cost patients intensely

Teams Continued…

- Inpatient
  - Their own case managers and hospitalists (their culture, their plan)
  - Interventions for specific conditions—national award for model Knee Replacement protocol
- Nursing home teams led by NPs

Teams Continued…

- Very low turnover compared to market
- Grow their own—able MAs trained and mentored into higher roles
- Starting an MA school
  - cut usual cost in half (more diversity)
  - Train to their model
- Two week orientation for new physicians + pairing with best clinicians for shadowing and mentoring

Utilization

	Texas Region Medicare	WellMed
	2006	2008
ER visit rates (%)	28.1	17.8
Hospitalization rates (%)	22.1	14.4
Re-hospitalization rates (30 days) (%)	19.9	13.9
Hospital Bed-Days/1000	2559	1002

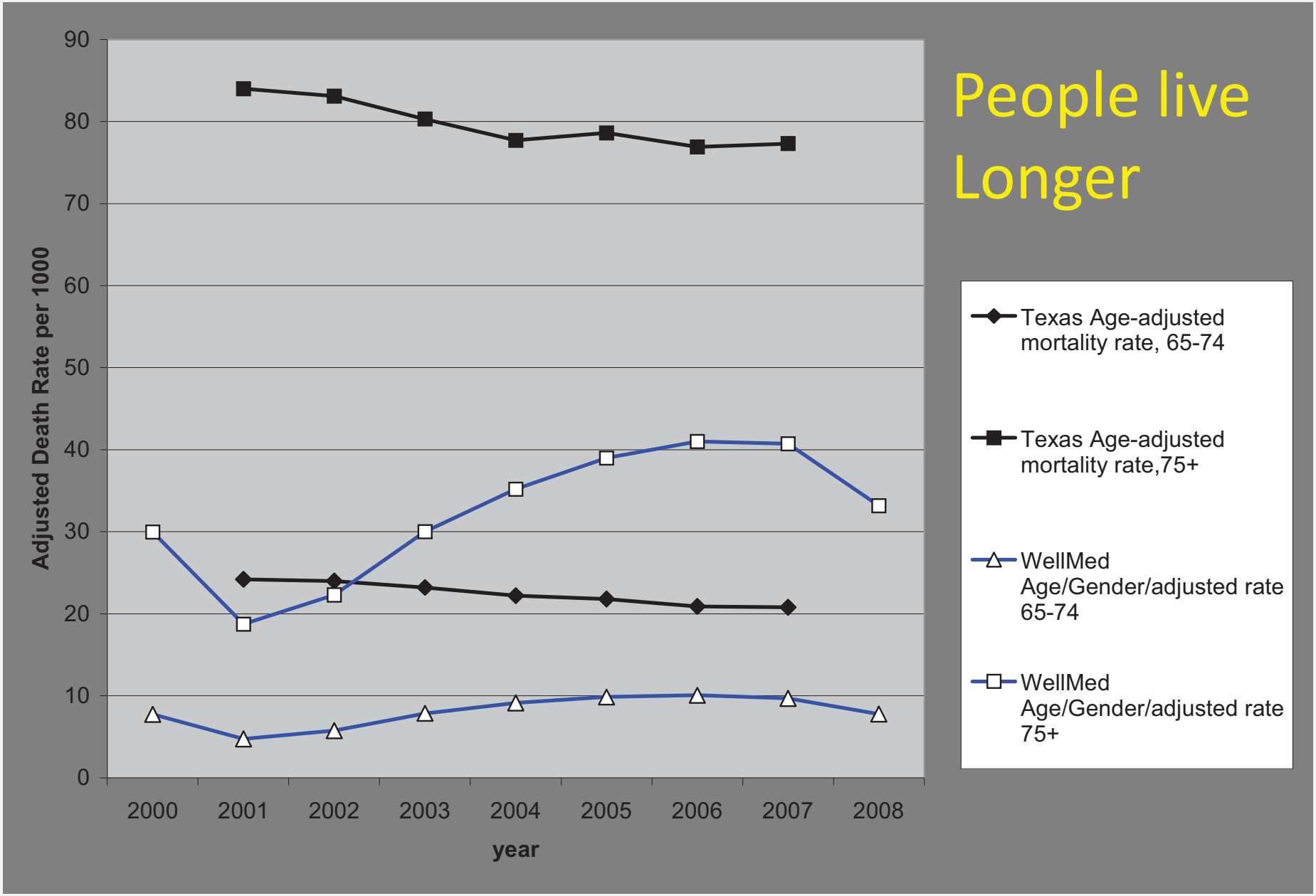
Just to be crystal clear

About 10% of total to primary care (30-40% more than straight Medicare)

60% reduction in bed days

Huge Return on Investment

People live Longer



Is WellMed the future?

- Lower hospital utilization--but hospital partner has margins 2-3 x that of traditional Medicare (costs lowered more than revenue, similar to Geisinger)
- Mortality rate 50% lower
- Improving preventive care with IT systems that monitor and manage patient population
- Average physician panel size < 500, backed by robust teams and disease management
- Up to 140% income bonus 2010 (100% financial, 40% quality) $260k-$550k for a primary care physician

Always in motion is the future…
Move forward cautiously we must
Yoda

Future: McDowell County