Evidence About Your Value (and the return on investment)

FMCC 2011

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Director

Objectives

- Who and How much
  - New health care workforce estimates
  - Patients and Primary Care
- We make a difference
- More = Less
  - Why market forces are destroying primary care
- More = Less
  - Federal workforce policy
  - Who's accountable?

Early Credits—The Graham Center Team

- I work with some really smart, creative and cool people
- This talk is about their work and their ideas
- Bridget Teevan Kim Epperson
- Dr. Andrew Bazemore Dr. Steve Petterson
- Dr. Imam Xierali (nearly) Dr. Meiying Han
- Dr. Jennifer Rankin Sean Finnegan
- Adam Schertz Dr. Laura Makaroff
- >120 Larry A. Green Visiting Scholars

Who and How Much?

"I'm with you fellars"

Specialty	2010 unadjusted	Overcount Adjusted	PC Multiplier	PC Adjusted
Family Docs	92,902	89,066	0.95	84,613
GPs	12,245	9,870	1.00	9,857
Internists	100,047	95,533	0.80	76,697
Pediatrics	52,720	50,258	0.95	47,745
Geriatrics	3,685	3,575	0.95	3,396
Total	261,599	248,302		222,308

Adjusted for retirements, deaths (JAMA)

Adjusted for hospitalists, etc

Work supported by HRSA/ORHP and AHRQ

Primary Care NPs and PAs

	Total	Number in Primary Care	Percent Primary Care
PAs	70,383	30,402	43%
NPs	106,073	55,625	52%

AAPA puts this figure closer to 24,000 or 34%

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

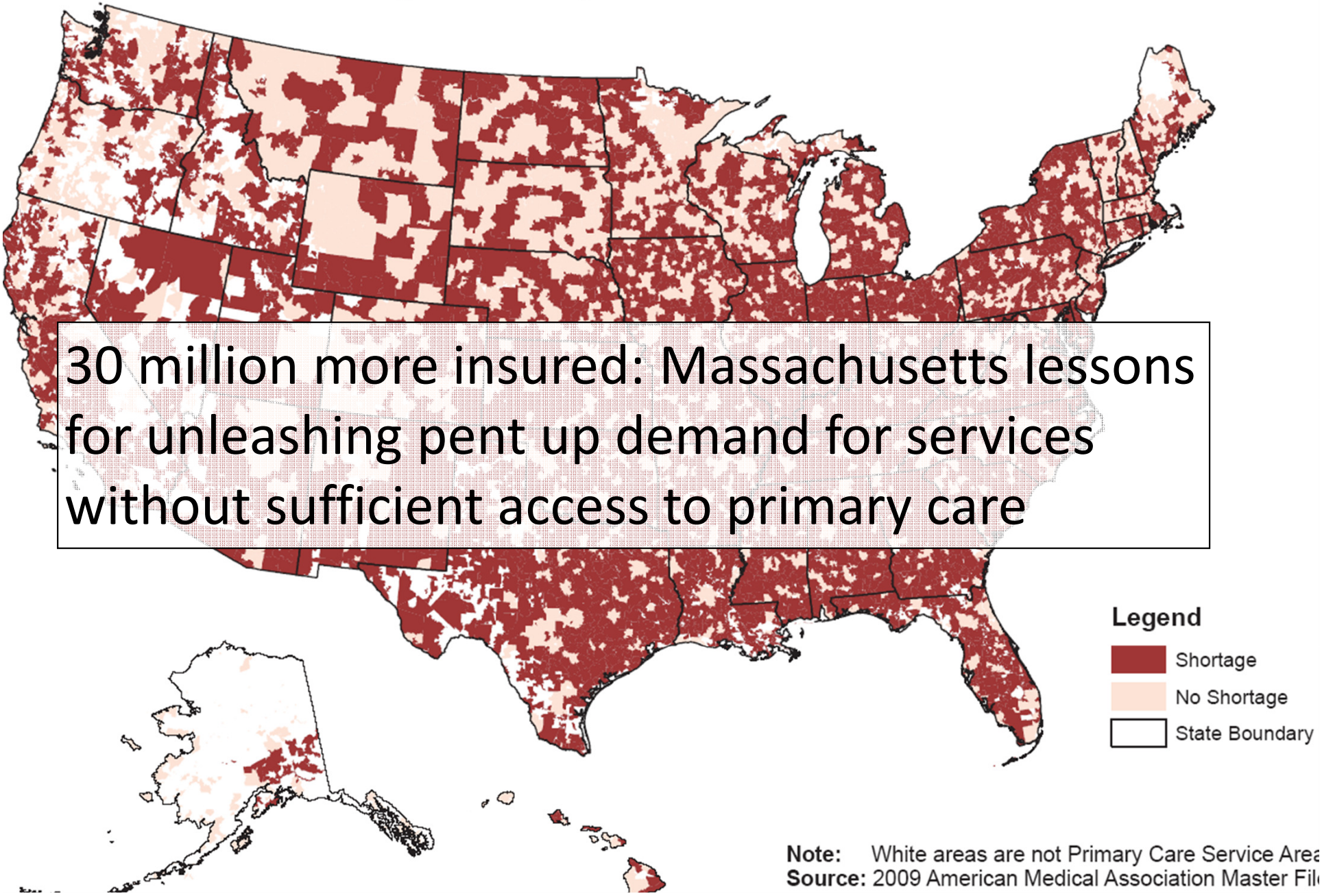
In a Tight Spot

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

PCP:population range = 500:1 – 5000:1

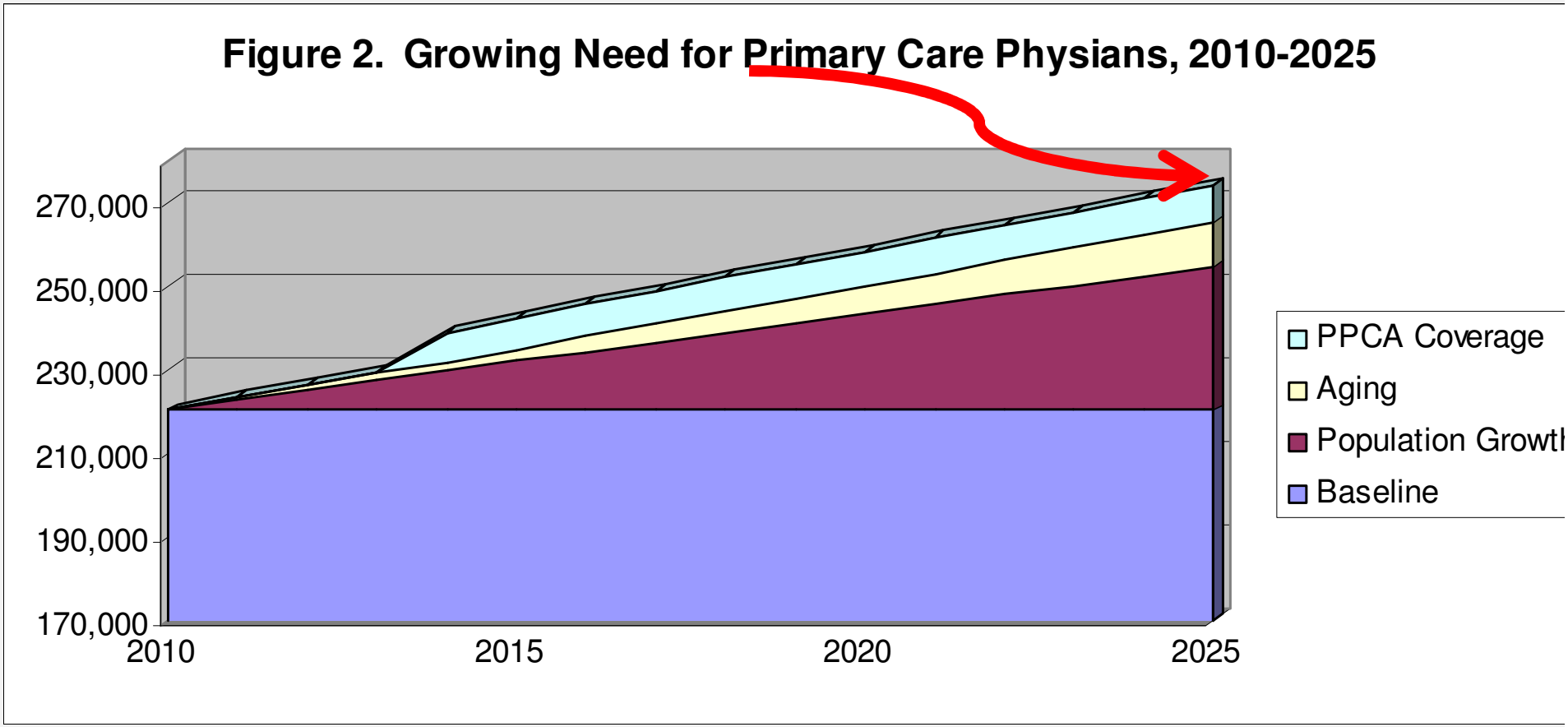
our current, glaring problem is distribution

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

Can we meet rising demand?



Contracted by AHRQ, negotiated with HRSA and ASPE—projections led by Dr. Winston Liaw and Dr. Steven Petterson

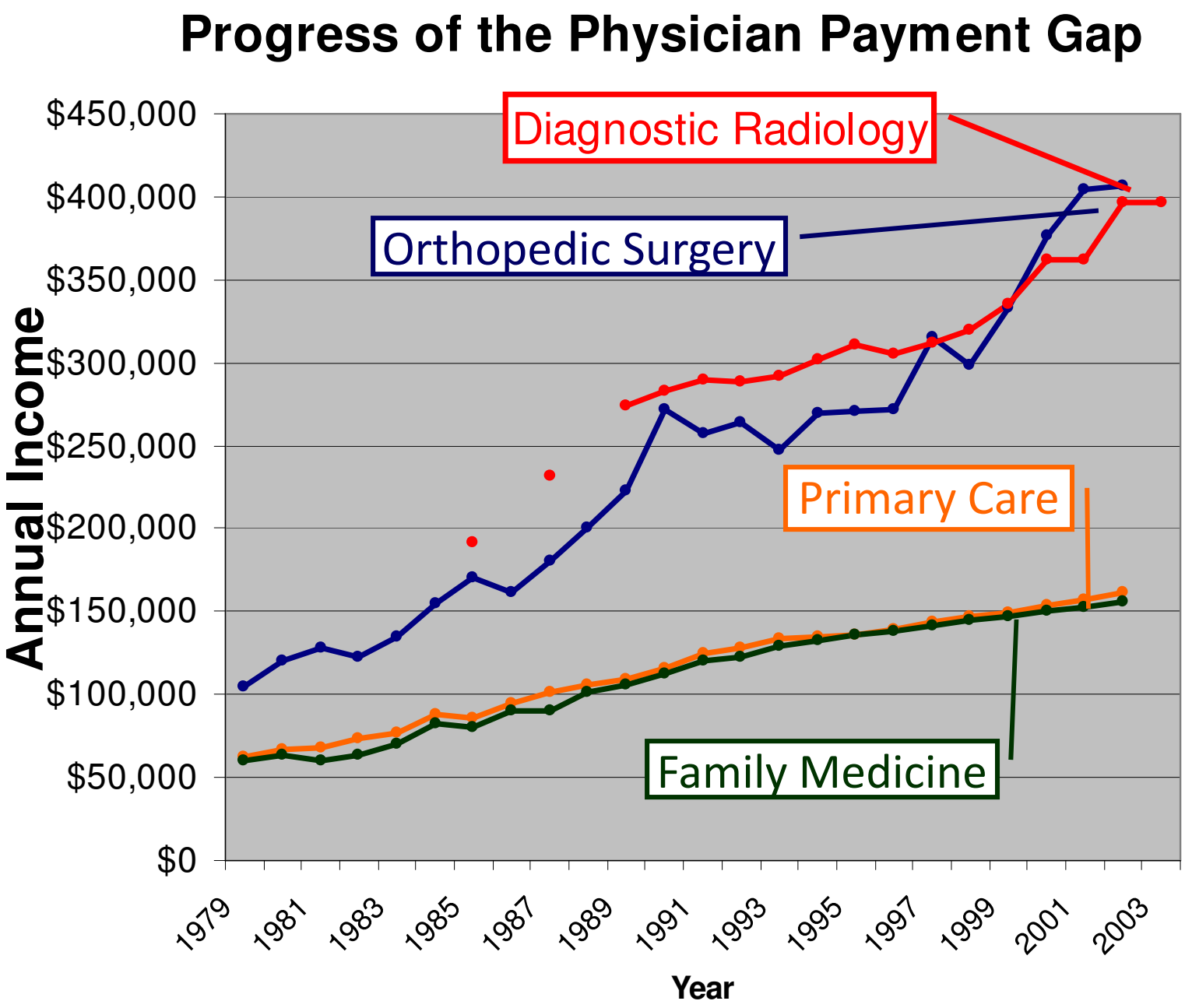
How Much?

- In 2008, 62% of the 1.1 billion ambulatory care visits were made to primary care delivery sites (53% if you exclude OB/Gyn)

- Family Medicine was nearly 25% of this (not bad for a workforce that is about 13% of total)

NCHS Data Brief Number 47, October 2010 Visits to Primary Care Delivery Sites: United States, 2008

More = Less

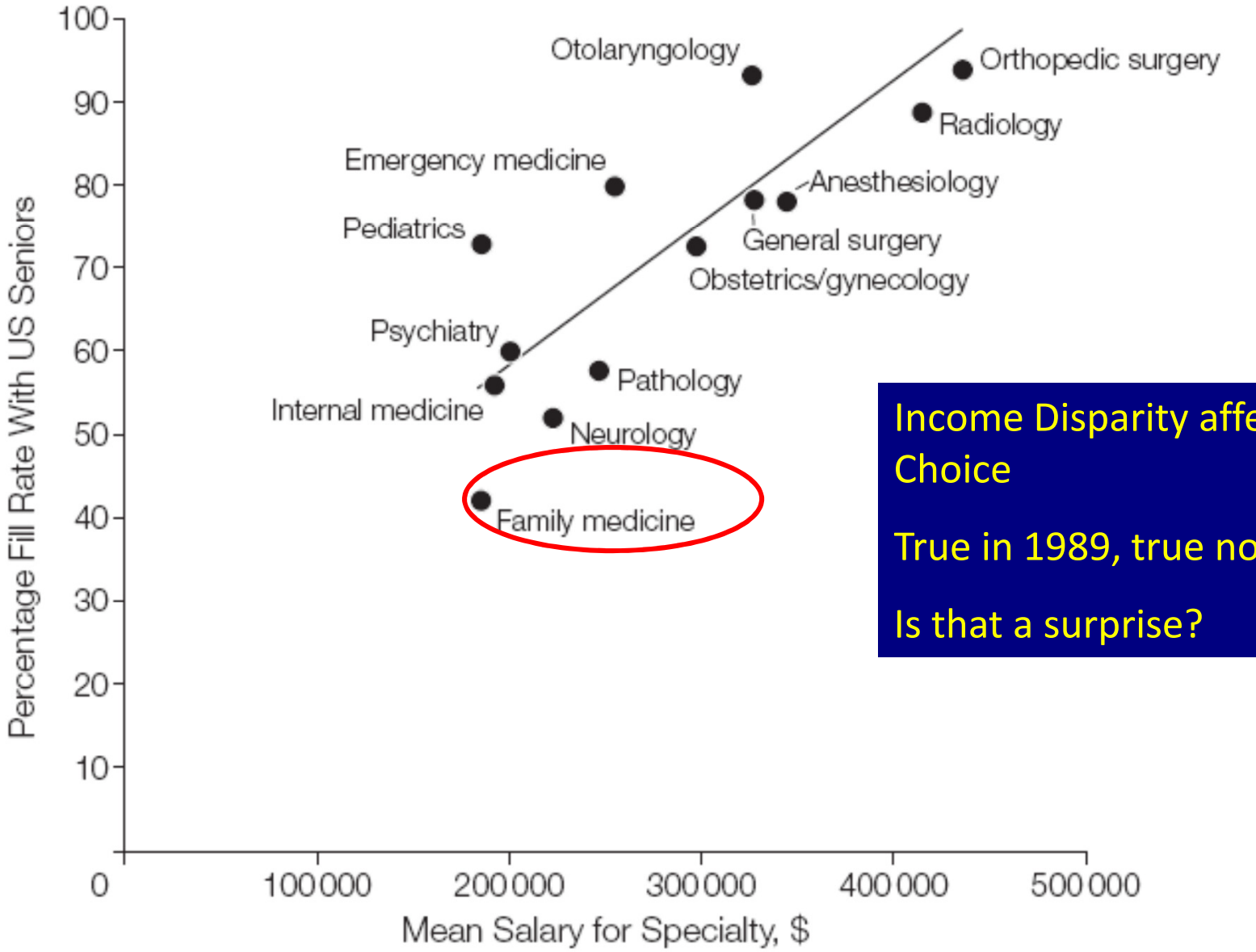

Progress of the Physician Payment Gap
Diagnostic Radiology
Orthopedic Surgery
Primary Care
Family Medicine
Annual Income
$450,000
$400,000
$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
1979
1981
1983
1985
1987
1989
1991
1993
1995
1997
1999
2001
2003
Year

Student Interest

• General Internal Medicine	2.0%
• Med/Peds	2.7%
• Family Medicine	4.9%
• General Pediatrics	11.7%
• Total:	21.3%

K. E. Hauer et al. Choices Regarding Internal Medicine Factors Associated With Medical Students' Career *JAMA*. 2008;300(10):1154-1164

Figure. Percentage of Positions Filled With US Seniors vs Mean Overall Income By Specialty

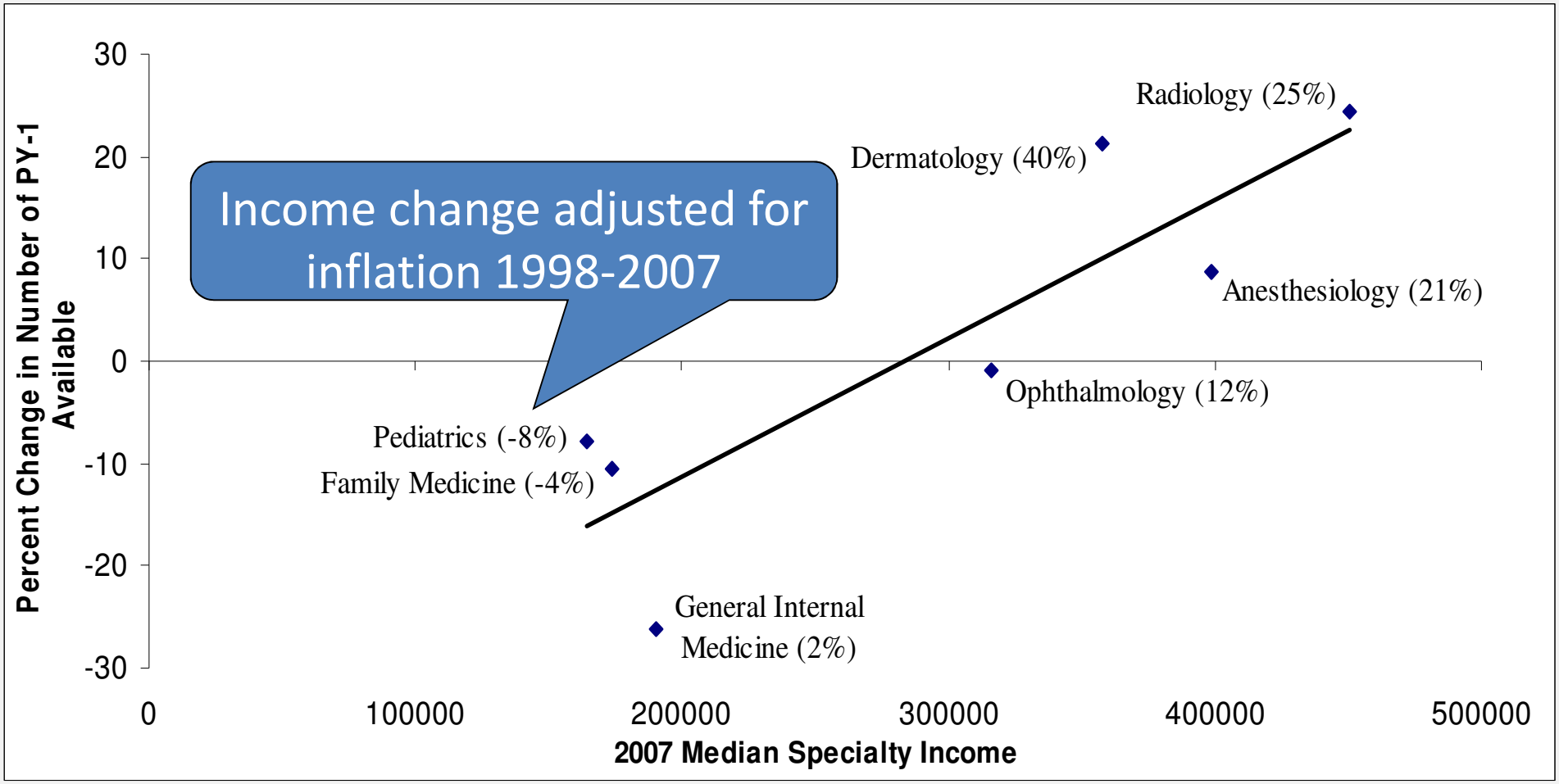


Income Disparity affects Choice

True in 1989, true now

Is that a surprise?

Specialty Income & GME expansion



Ultimate career plans for PGY-3 residents enrolled in IM programs in the United States, 2003-2009

	Career plan (%)			
Year	General internal medicine	Hospitalist	Subspecialty	Other/ Undecided/ Missing
2003	27	7	57	9
2009	21	10	65	5

Source: ITE Exam Survey; Courtesy ACP

Internal Medicine contribution to Primary Care

- The approximate number entering ambulatory practice in 2009 was:
  - *21% of 7152 = 1,502 general internists*

- Bylsma (2010) and Lipner (2006):
  - MOC studies at 10 years show 17-21% attrition of general internists

↓ to ≈ *1,200 (17%)*

Less: Primary care can’t replace itself

- Now down to about 22% primary care production by graduate medical education
- Current workforce 32% (and falling)
- MORE (gap in relative income) = LESS

The New York Times

"He takes the time with me. He knows my family. He talks about fishing, and that makes me comfortable. He lives around the corner from my daughter. He grew up and came right back and did his practice around everybody he knows. He's just special."

Mary Pat Dorsey, 64

DOCTORS INC.

Family Physician Can't Give Away Solo Practice

Brendan Smialowski for The N

Dr. Ronald Sroka examines a patient, Joseph Walsh, at his family medical practice.

By GARDINER HARRIS
Published: April 22, 2011

Dr. Ronald Sroka
Crofton, MD
Past President, Maryland State Medical Association

To summarize

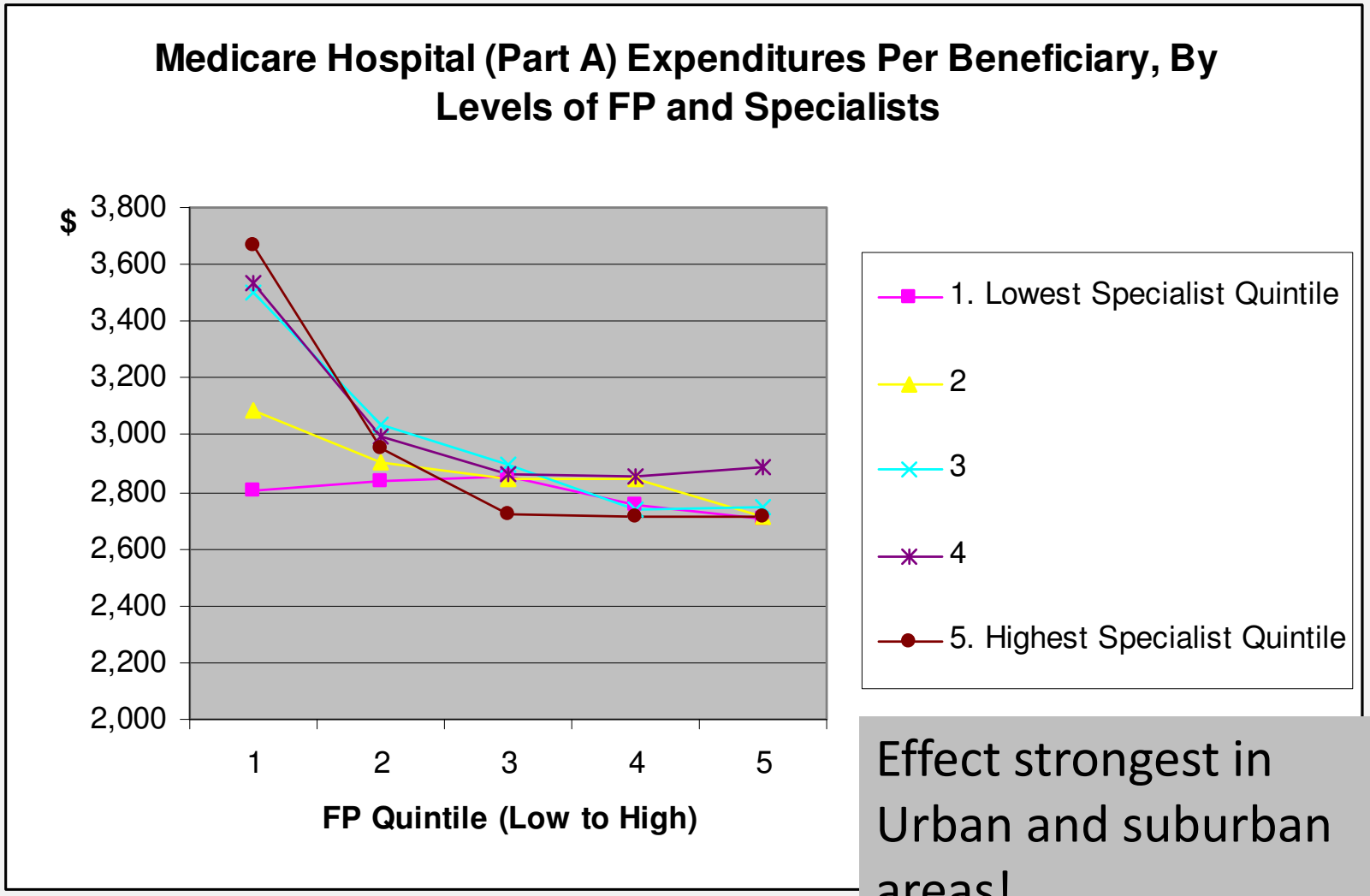
- Currently: physician distribution problem
  - About to be compounded by newly insured
- Need ~50,000 more physicians by 2025
  - Newly insured contribute less than 20% to need
  - But, distribution incentives too weak
- Primary care is not replacing itself so that shortage will become dominant
- Need to fix the physician income gap (and lack of investment in practice redesign)

More = Less

Associated Value

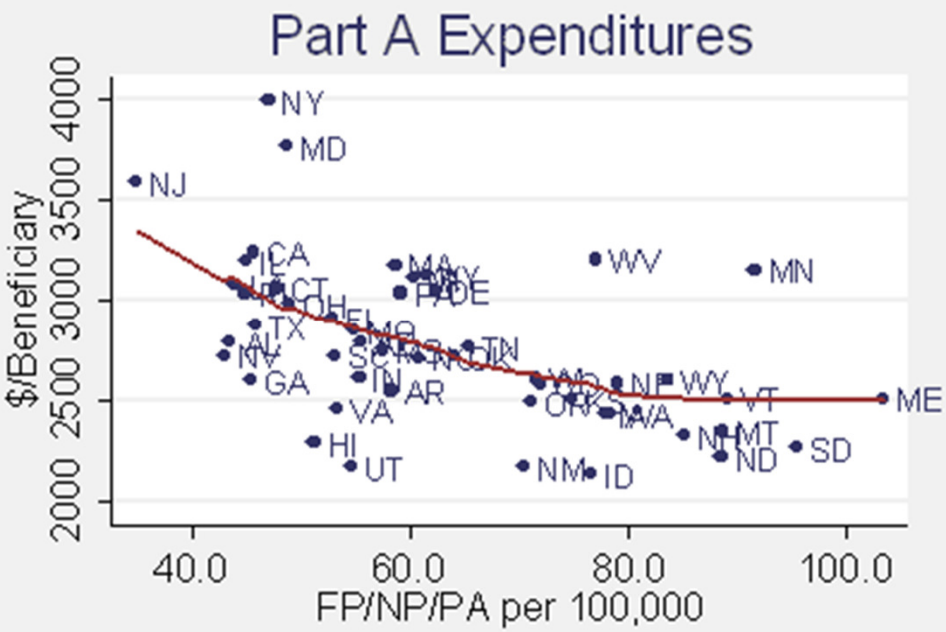
- Adding one FP per 1,000 population, or 100 per 100,000 reduces readmission odds for:
  - Pneumonia 7%
  - Heart Attack 5%
  - Congestive Heart Failure 8%
- 46 FPs per 100,000 population = -$81 million per year
- 100/100,000 population = -$579 million per year (83% of PPACA target)

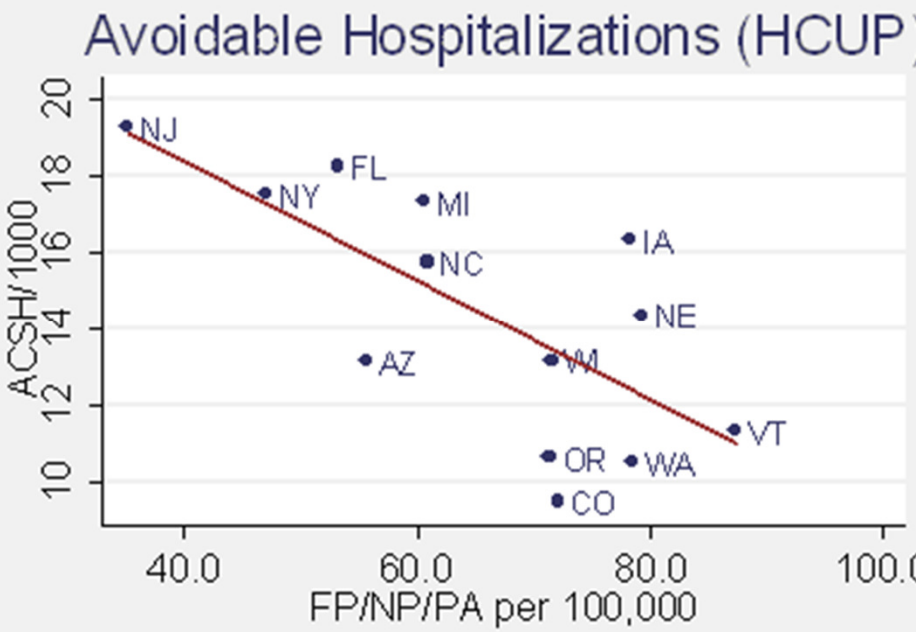
More = Less



Effect strongest in Urban and suburban areas!

What ratio matters?





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

Difficulty demonstrating for General Internal Medicine

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.

Evidence: Medical Home, Accountable Care

- UC San Francisco and Patient Centered Primary Care Collaborative updated their evidence November, 2010

  Kevin Grumbach (UCSF) Paul Grundy (IBM)

UCSF/PCPCC fact sheet

- Integrated Health System PCMH/ACO experiments
  - 7%+ reduction in total costs

Primary Care = 4-6% of Total cost (Gorroll, Pham)
More robust primary care in ACO = -7+%
The cost of the investment (and more) is covered!

Special issue
Journal of Ambulatory Care Management

- January 2011, included 1st of 4 papers about WellMed, Inc.

Is WellMed the future?

- Primary Care-based ACO (No hospital)
- Lower hospital utilization--but main hospital partner has margins 2-3 x that of traditional Medicare (costs lowered more than revenue, similar to Geisinger)
- Mortality rate 50% lower; Bed days 60% 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

To summarize

- Growing evidence of its importance to cost and quality—especially Family Medicine
- MORE (FM, bigger teams, smaller panels) = LESS (costs)
- Basis of the demonstrations with measurable, beneficial outcomes
- Growing coalition of business, payors making our case

More = Less

They are singing our song

- Payment
  - Primary Care Incentive Payment
  - Medicaid-Medicare parity (for a while)
- Distribution
  - Expanded National Health Service Corps, CHCs
  - Revising shortage & underservice designation
- Pipeline
  - HRSA investing $250 million in primary care expansion
  - Relaxed rules on outpatient training, preceptors
  - Teaching Health Centers
  - COGME and MedPac weigh in on payment and GME funding reform
  - GME Accountability

What we still need

- Payment
  - Increase Primary Care spending to 10-12% of total
  - Primary Care Incentive Payment—Not big enough
- Distribution
  - Change the purpose of the Geographic Practice Cost Index (part of SGR)
  - Increase HPSA bonus payments or expand loan forgiveness
- Pipeline
  - GME Accountability

Primary Care Incentive Payments

- Graham Center was able to show that the criteria for "Primary Care" were too narrow
  - Most rural family physicians were not eligible
- Able to demonstrate that broader scope of practice associated with LOWER Medicare costs
  - CMS changed rule, making ~25,000 more FPs eligible ($50-100 million)
- Now working with AAFP Govt Relations to make the case for increasing size of incentive

Evidence for Primary Care Payment

- Need to make sure incentives support broad-scope Family medicine
- Need to make sure incentive is large enough to change behavior and practice
- Large enough may mean moving Primary care from 4-6% to 10-12% of total spending (we need a target)
- Evidence building that the ROI is high (MORE funding for primary care means LESS overall cost)

Distribution

- GPCI could reduce Medicare payments as much as 10% (negating HPSA bonus)
- Needs to focus on goal of improving physician distribution and Medicare access, NOT accounting or regional practice cost differences--- otherwise goals are conflicting
- Also need more visible, tangible bonus or loan repayment to get them where they are needed (and quickly)

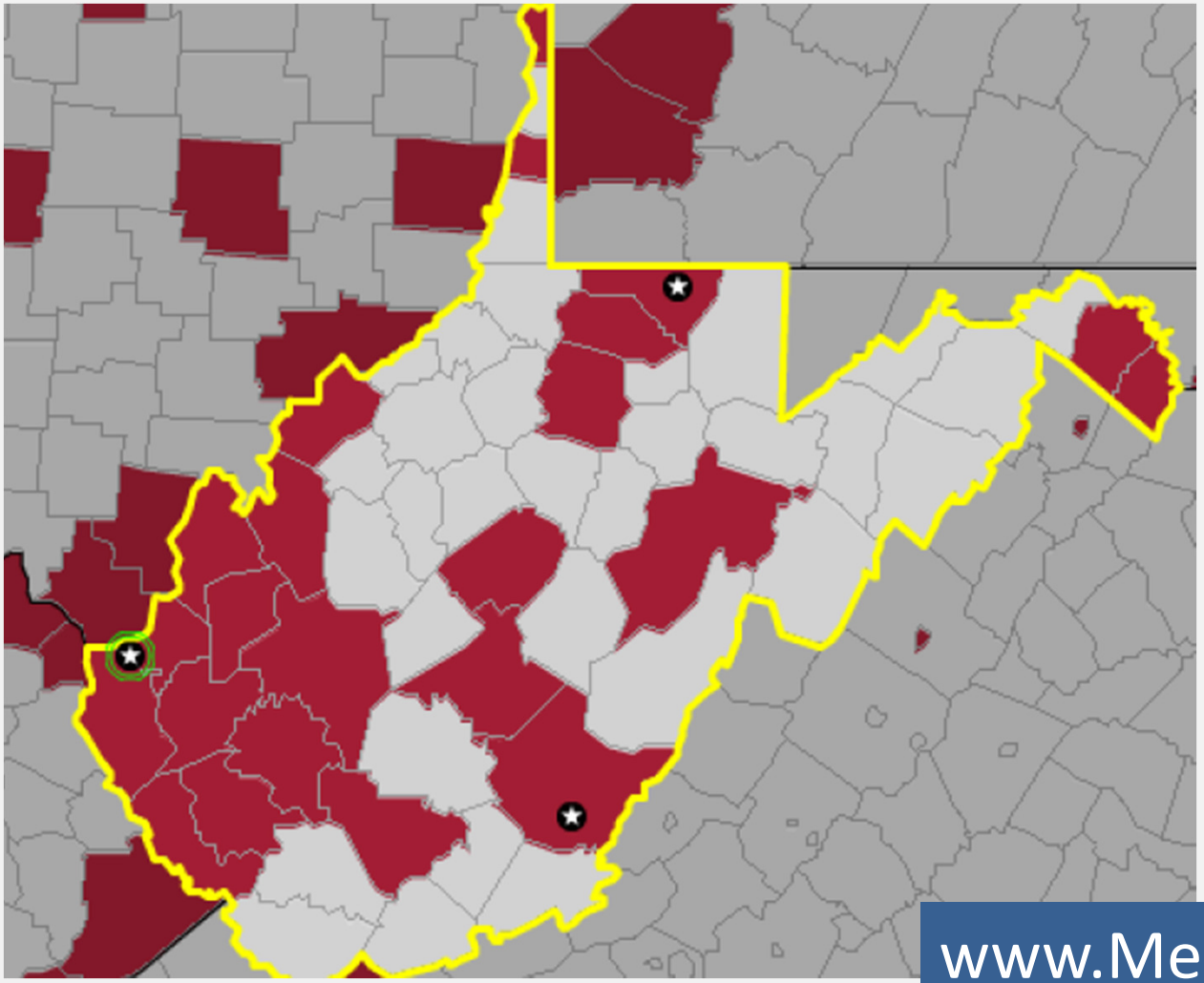
What we still need

- Payment
- Distribution
- Pipeline
  - GME Accountability

Education Accountability

- Dr. Petterson (RGC) worked with Fitz Mullan to do the Medical School Social Accountability study
  - Macy Foundation funds Med School Mapper
- MedPac says GME "unnaccountable" 1989, 2010
- ACA assigned development of accountability measures to COGME
- Data from Graham Center helped AAFP and "family" defeat GME expansion bill—presented at AAMC and just published Academic Medicine
- Macy Foundation funds RGC/GWU GME Social Accountability Study

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

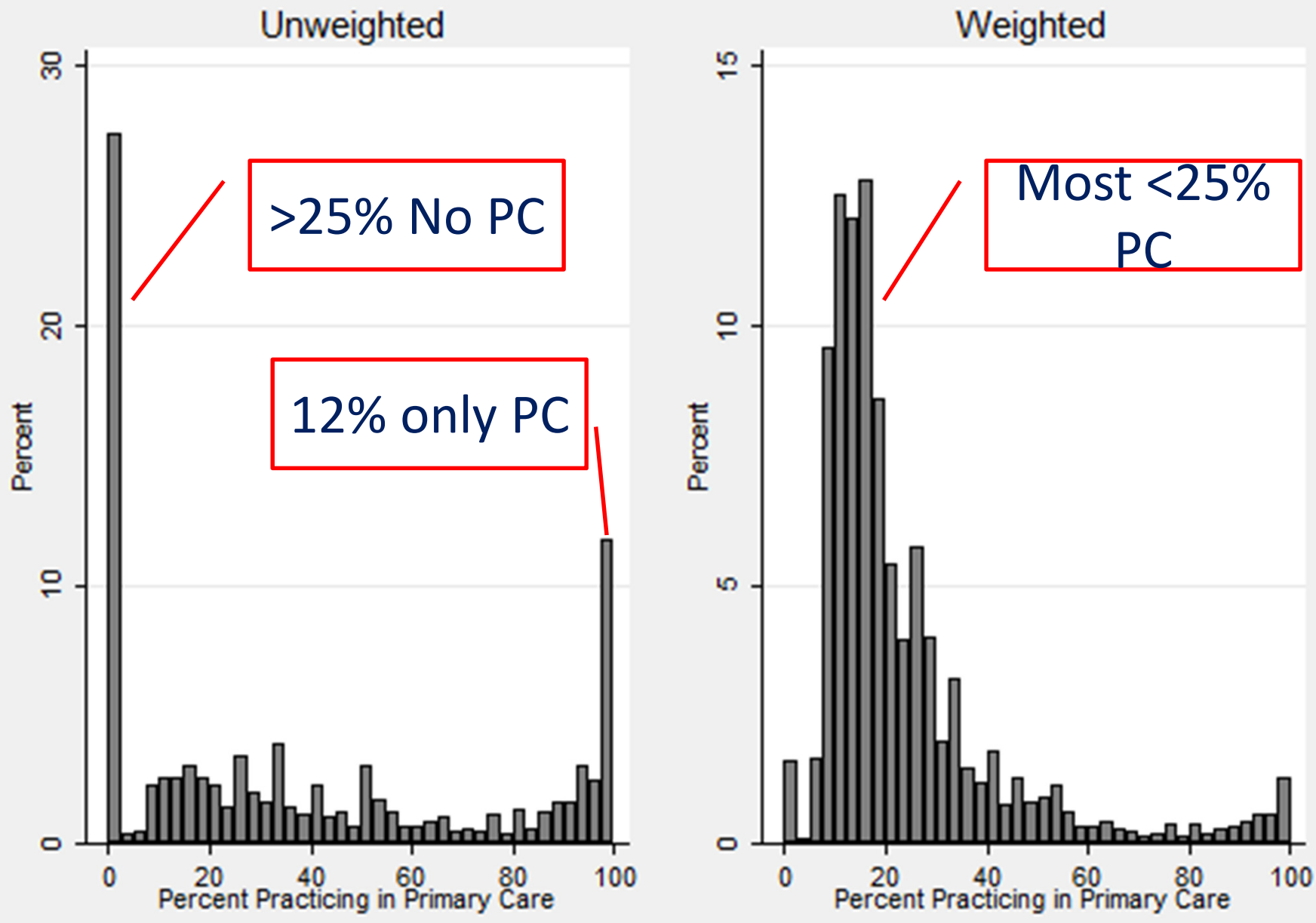
Resident Physician Shortage Reduction Act of 2009

- Introduced in both the U.S. House and Senate during health reform
- 15% increase in Medicare-funded GME
  - 15,000 positions
  - ~$1.5 billion annually
- Criteria:
  - Hospital 10 or more positions above GME Cap
  - at least 25% of its full-time equivalent residents in primary care and general surgery

Accountable legislation

- By 2009, nearly 10% growth above GME Cap, 85-90% of these were subspecialty or geared for fellowships
- 2005-7: 116,004 physicians completed first residency
  - 54,245 (46.8%) were in primary care and general surgery
  - And 586 of 683 training institutions met the 25% threshold
- 2-4 years later, only 25.8% were still in primary care or general surgery
  - 135 institutions lost eligibility
- A 35% threshold eliminated 314 institutions that train 81% of residents

Family Medicine said “NO”


Unweighted
Weighted
>25% No PC
12% only PC
Most <25% PC
Percent
Percent Practicing in Primary Care
0
10
20
30
5
15
0
20
40
60
80
100

Summary

- MORE (incentives, payment, scope) = LESS (cost)
- MORE (focus on distribution) = LESS (variation in access and quality)
- MORE (accountability) = LESS (production of a workforce we don't need)
- MORE (Graham Center research and tool building) = LESS (sketchy evidence for pushback)