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?
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”

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

Adjusted for retirements, deaths (JAMA)

Adjusted for hospitalists, etc

Work supported by HRSA/ORHP and AHRQ
### Primary Care NPs and PAs

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Number in Primary Care</th>
<th>Percent Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAs</td>
<td>70,383</td>
<td>30,402</td>
<td>43%</td>
</tr>
<tr>
<td>NPs</td>
<td>106,073</td>
<td>55,625</td>
<td>52%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Primary Care Service Areas in shortage vs “surplus”</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physicians</td>
</tr>
<tr>
<td>Areas with <strong>shortage</strong></td>
<td>4,838</td>
</tr>
<tr>
<td># Needed</td>
<td>-34,479</td>
</tr>
<tr>
<td>Areas with <strong>“surpluses”</strong></td>
<td>1,668</td>
</tr>
<tr>
<td>#Excess Physicians/Providers</td>
<td>34,479</td>
</tr>
</tbody>
</table>

PCP: population range = 500:1 – 5000:1

our current, glaring problem is distribution
30 million more insured: Massachusetts lessons for unleashing pent up demand for services without sufficient access to primary care
Can we meet rising demand?

Figure 2. Growing Need for Primary Care Physicians, 2010-2025

Contracted by AHRQ, negotiated with HRSA and ASPE—
projections led by Dr. Winston Liaw and Dr. Steven Petterson
• 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)
More = Less
Progress of the Physician Payment Gap

Annual Income

Year


Diagnostic Radiology
Orthopedic Surgery
Primary Care
Family Medicine
<table>
<thead>
<tr>
<th>Student Interest</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Internal Medicine</td>
<td>2.0%</td>
</tr>
<tr>
<td>Med/Peds</td>
<td>2.7%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>4.9%</td>
</tr>
<tr>
<td>General Pediatrics</td>
<td>11.7%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>21.3%</strong></td>
</tr>
</tbody>
</table>

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

True in 1989, true now

Is that a surprise?
Specialty Income & GME expansion

Income change adjusted for inflation 1998-2007

- Anesthesiology (21%)
- Dermatology (40%)
- Radiology (25%)
- Ophthalmology (12%)
- Family Medicine (-4%)
- Pediatrics (-8%)
- General Internal Medicine (2%)

2007 Median Specialty Income

0 100000 200000 300000 400000 500000
## Ultimate career plans for PGY-3 residents enrolled in IM programs in the United States, 2003-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>General internal medicine</th>
<th>Hospitalist</th>
<th>Subspecialty</th>
<th>Other/Undecided/Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>27</td>
<td>7</td>
<td>57</td>
<td>9</td>
</tr>
<tr>
<td>2009</td>
<td>21</td>
<td>10</td>
<td>65</td>
<td>5</td>
</tr>
</tbody>
</table>

*Source: ITE Exam Survey; Courtesy ACP*
The approximate number entering ambulatory practice in 2009 was:

- 21% of 7152 = **1,502 general internists**


- 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
“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

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
• 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

Medicare Hospital (Part A) Expenditures Per Beneficiary, By Levels of FP and Specialists

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

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)
• 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!
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
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”
GME Accountability Measures

- Josiah Macy Jr. Foundation funded study
  - RGC/George Washington University
- Kicked off with a Qualitative, Key-Informants
  - Dr. Anjani Reddy, Sonia Lazreg, Rebecca Etz
- Quantitative Analysis just starting
  - Will be used to rank all teaching hospitals on several measures

- >25% No PC
- 12% only PC
- Most <25% PC
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)