

What the Federal Government Should Do to Revitalize the Primary Care Infrastructure in the US

Graham Center Forum

Kevin Grumbach, MD

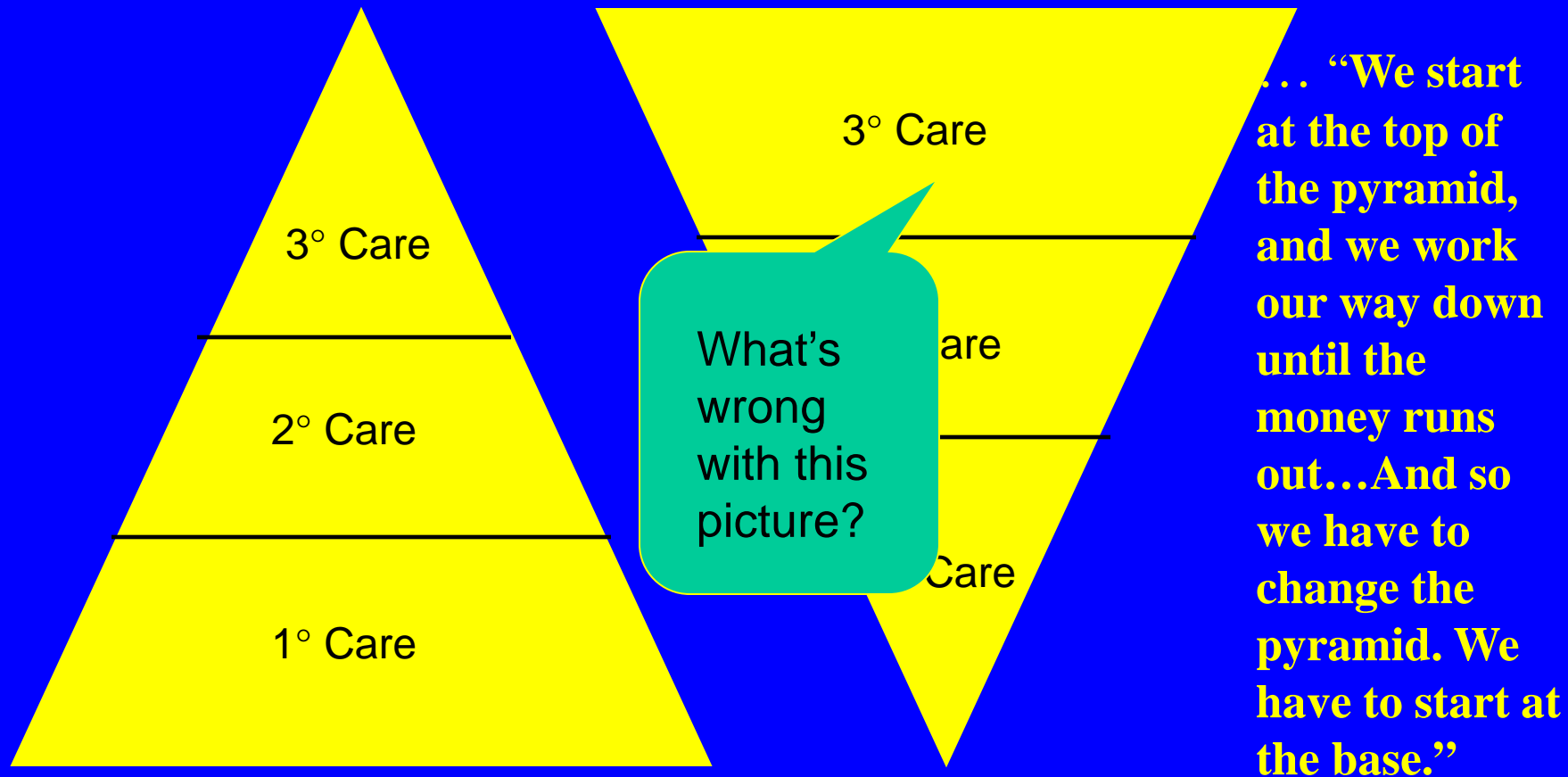
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University of California, San Francisco

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**Senator Daschle, Senate HELP Ct Confirmation Hearing
Jan 8, 2008: “Every country starts at the base of the
pyramid with primary care, and they work their way up
until the money runs out.”**



Considerable research evidence indicates that health systems and regions with a strong foundation of primary care have:

- Better population health outcomes
- Better quality of care
- More preventive care
- Lower costs
- More equitable care and mitigation of health disparities

The Crumbling Primary Care Infrastructure

- Plummeting numbers of new physicians entering primary care
- Primary care shortages throughout US
- Growing problems of access to primary care and “medical homelessness”



The New York Times

April 5, 2008

In Massachusetts, Universal Coverage Strains Care

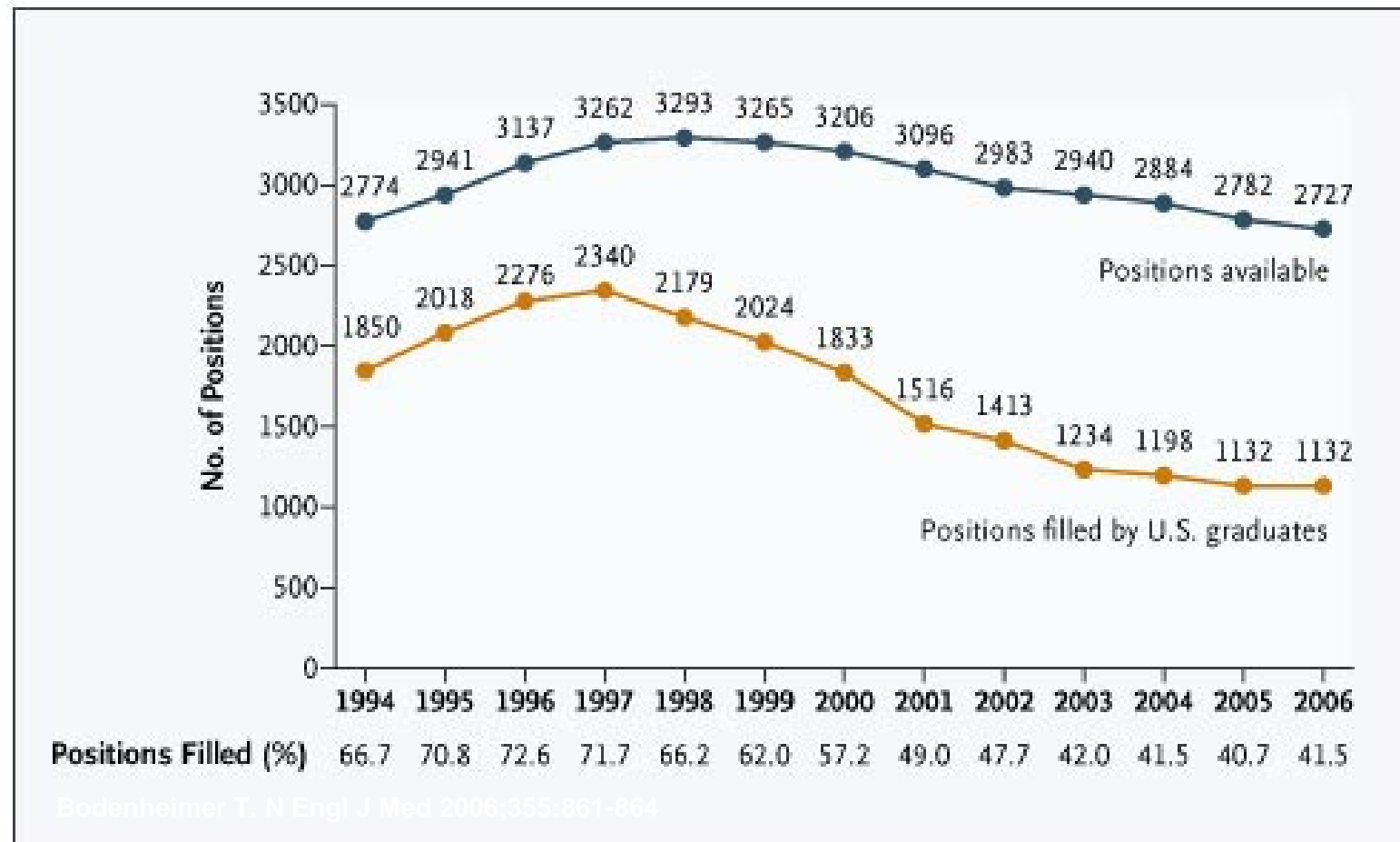


Dr. Katherine J. Atkinson of Amherst, Mass., has a waiting list for her family practice; she has added 50 patients since November.

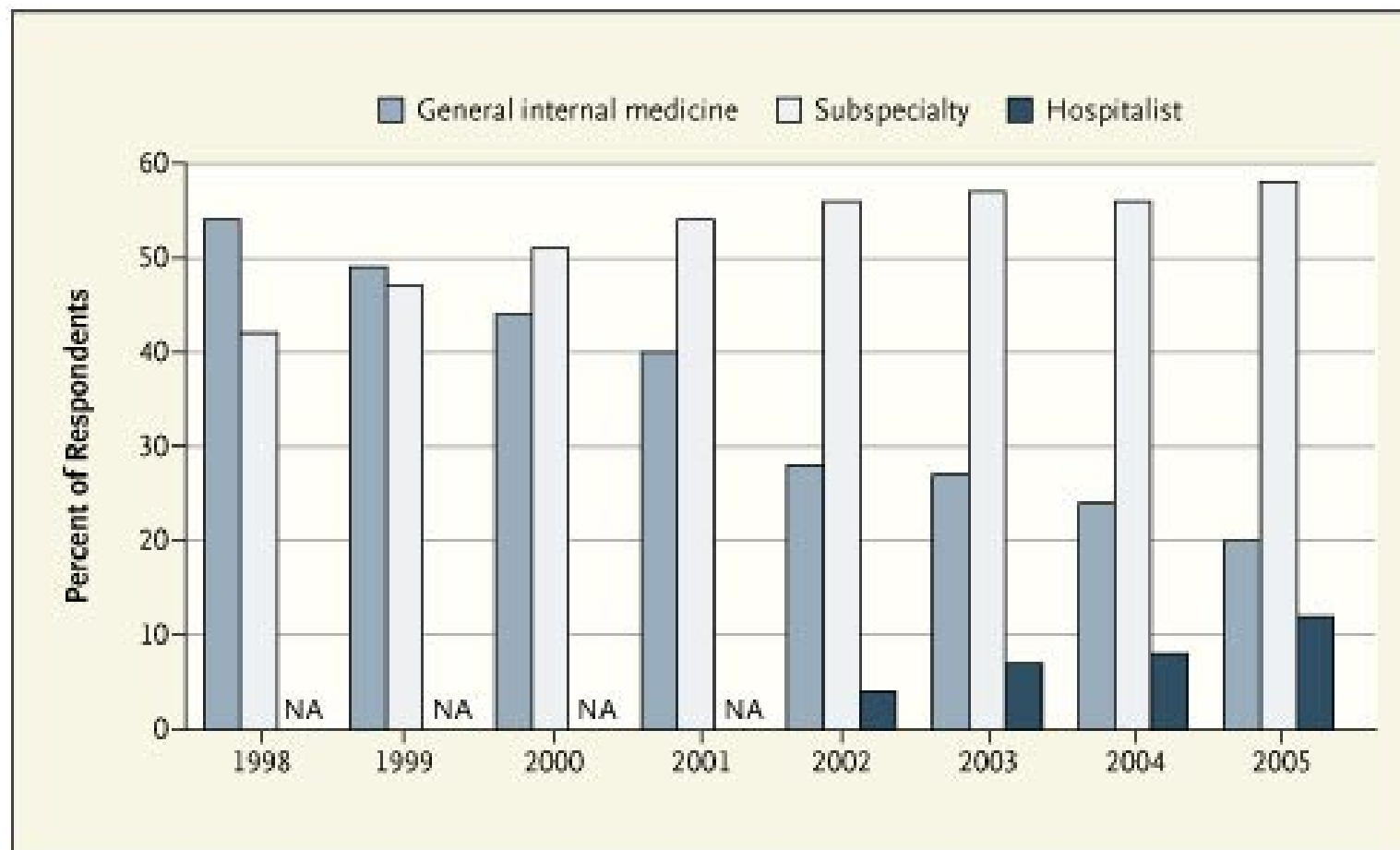


>750 vacancies for PCPs at Community Health Centers (2004)

Family Medicine Residency Positions and Number Filled by U.S. Medical School Graduates



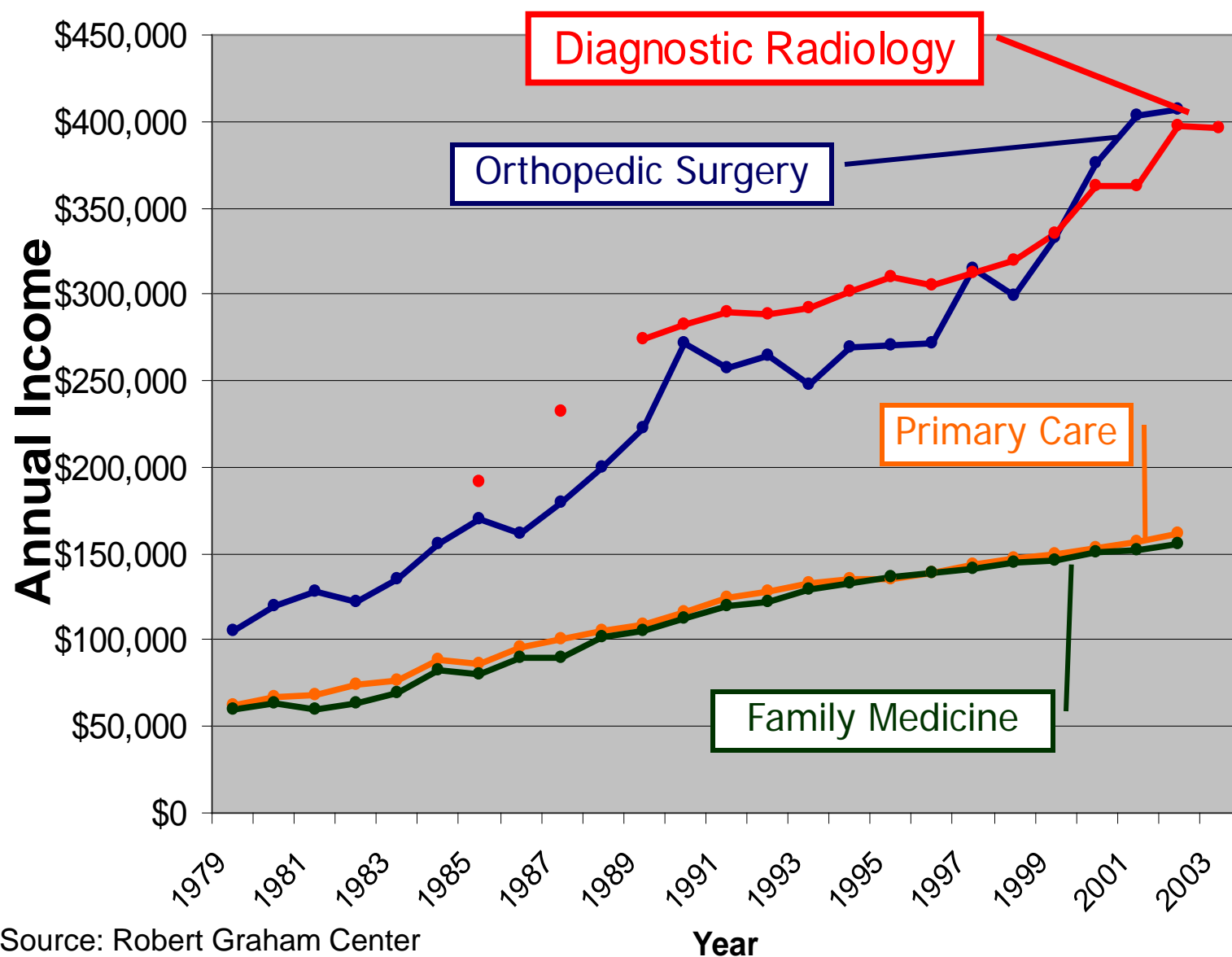
Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



Why Not Primary Care?

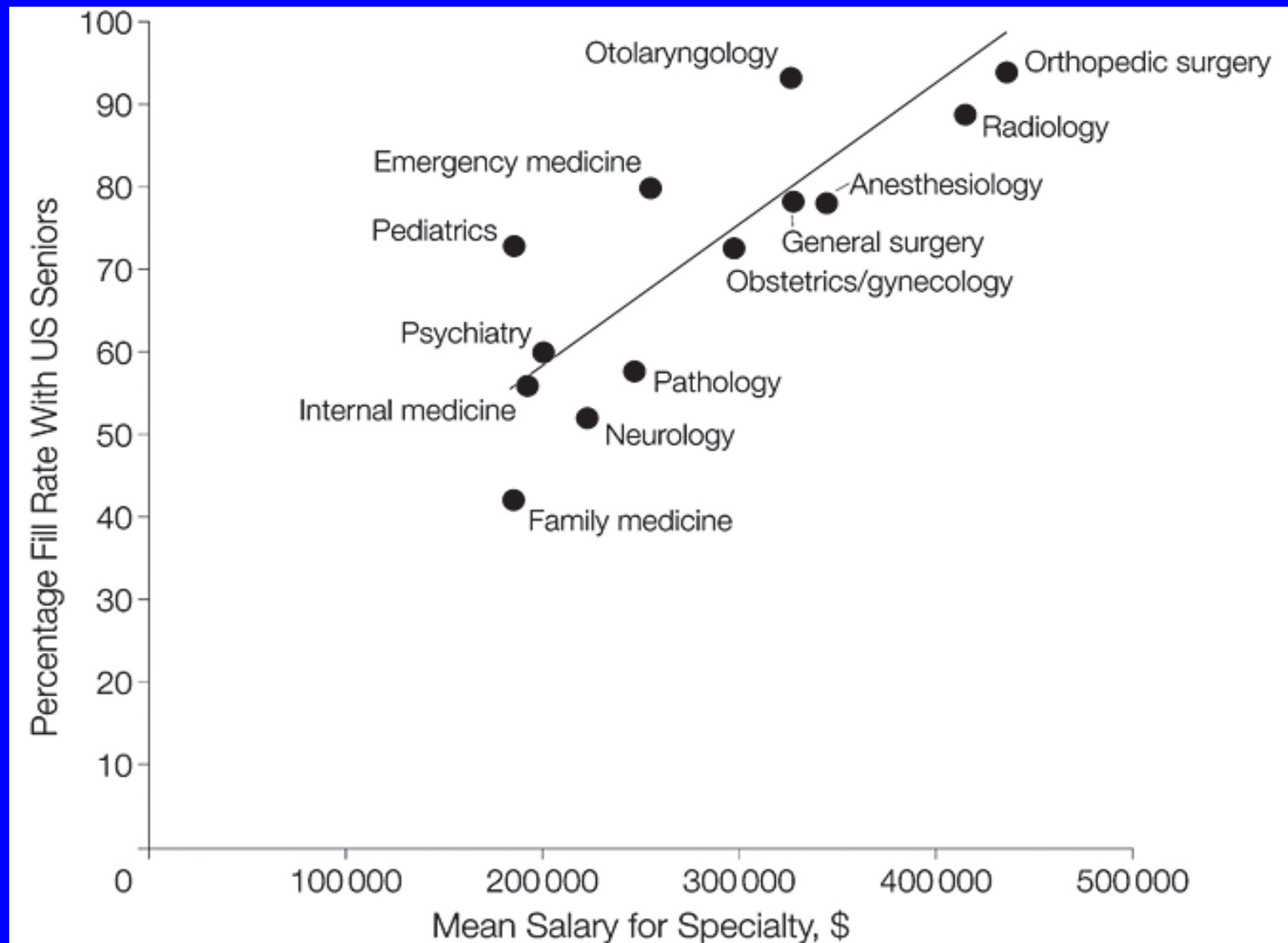
- Pre-medical School Factors
 - Underlying personality disposition, career aspirations
- Educational Environment
- Practice Environment
 - Compensation
 - Worklife Satisfaction and Joy

The Widening Physician Payment Gap

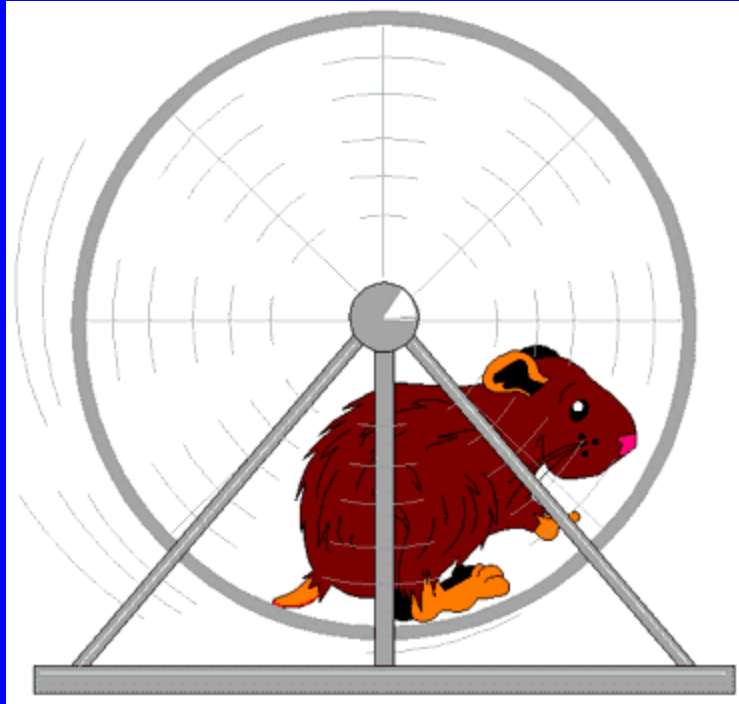


Source: Robert Graham Center

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



PCP Burn Out



“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stay still.”

Morrison and Smith,
BMJ, 20001

The New Math of the 15 Minute Primary Care Visit

- A primary care physician with a panel of 2500 average patients would spend:
 - 7.4 hours per day to deliver all recommended preventive care [Yarnall et al. Am J Public Health 2003;93:635]
 - 10.6 hours per day to deliver all recommended chronic care services [Ostbye et al. Annals of Fam Med 2005;3:209]

Problems in Clinical Performance

- 27% of patients with HTN adequately controlled
- 54% of diabetics have Hgb A1c > 7.0
- 14% of patients with CHD have LDL levels in targeted range
- Half of smokers counseled about smoking cessation by their physician

A 20th Century Model of Primary Care Will Not Meet the Demands of 21st Century Health Care



A Comprehensive Federal Initiative to Revitalize Primary Care

- Physician payment reform
- Infrastructure investment and facilitating practice redesign
- Training pipeline
- Research

Payment Reform: Medicare

- Revalue fee for service payments
 - MedPAC June 2008: “primary care services—which rely heavily on cognitive activities such as patient evaluation and management (E&M)—are undervalued.”
 - MedPAC recommendation: 5-10% increase for primary care, budget neutral
 - Grumbach recommendation: 20% increase

Payment Reform: Medicare

- Medical Home Care Coordination Payment
 - MedPAC June 2008: “Medical home initiatives encourage improved care coordination and have the potential to add value to the Medicare program through efficiency and quality gains.”
 - MedPAC recommendation: scale up TRHCA “demonstration” to larger “pilot” program
 - Grumbach recommendation: just do it



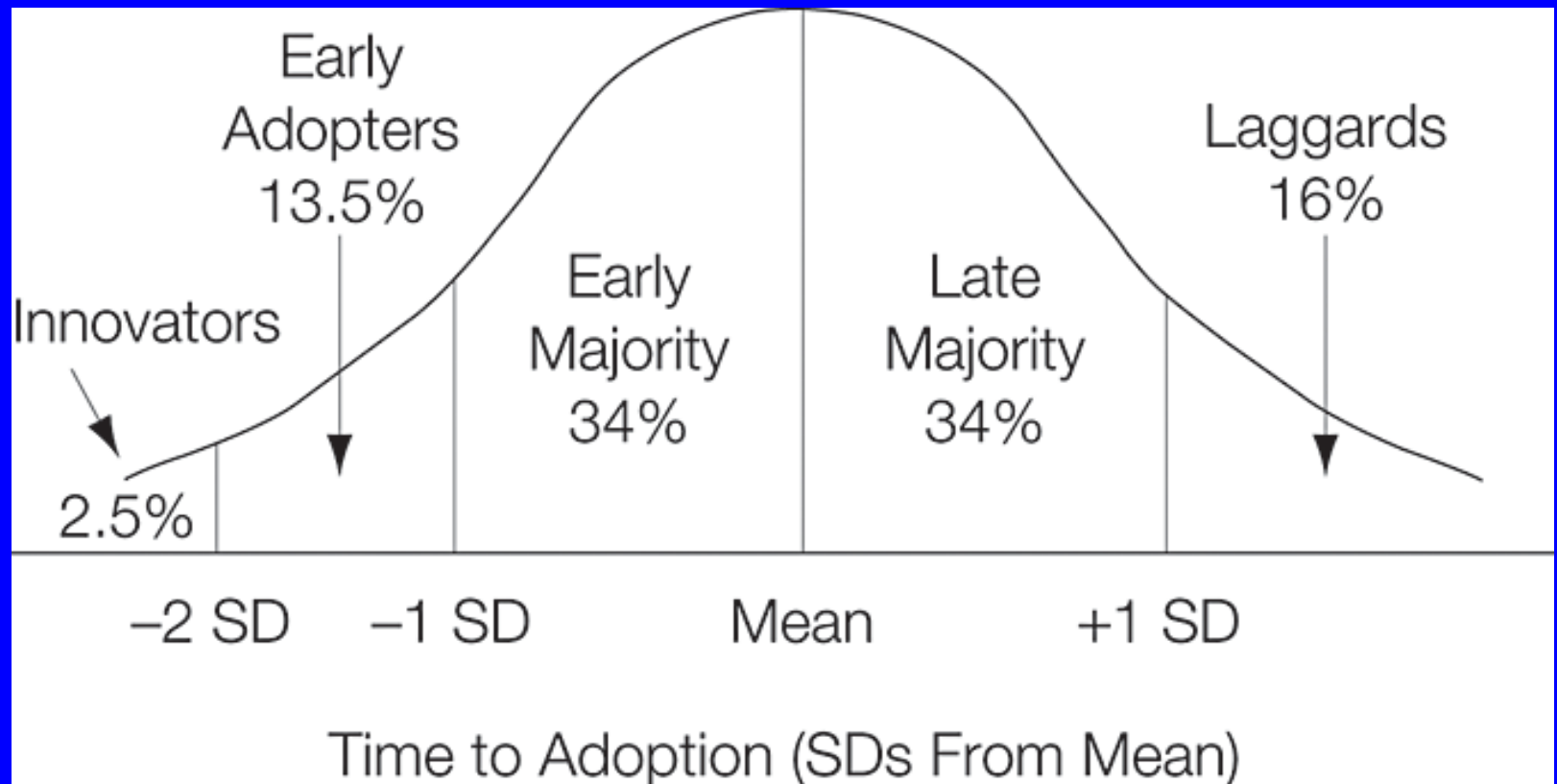
Payment Reform: Medicare

- Split the SGR (Sustainable Growth Rate)
 - CHAMP Act (HR 3162) passed by House 2007
 - 6 separate groups of expenditure targets:
 1. primary care and preventive services;
 2. other E&M services;
 3. imaging services and diagnostic tests (other than clinical diagnostic laboratory tests);
 4. major procedures;
 5. anesthesia services; and
 6. minor procedures/other physician services.

Practice Infrastructure: HIT

- Invest in hardware & software in ambulatory care settings, not just hospitals
- Interoperability
- Make sure new computers with nice EMRs don't sit there unused or underused

Adopter Categorization on the Basis of Innovativeness



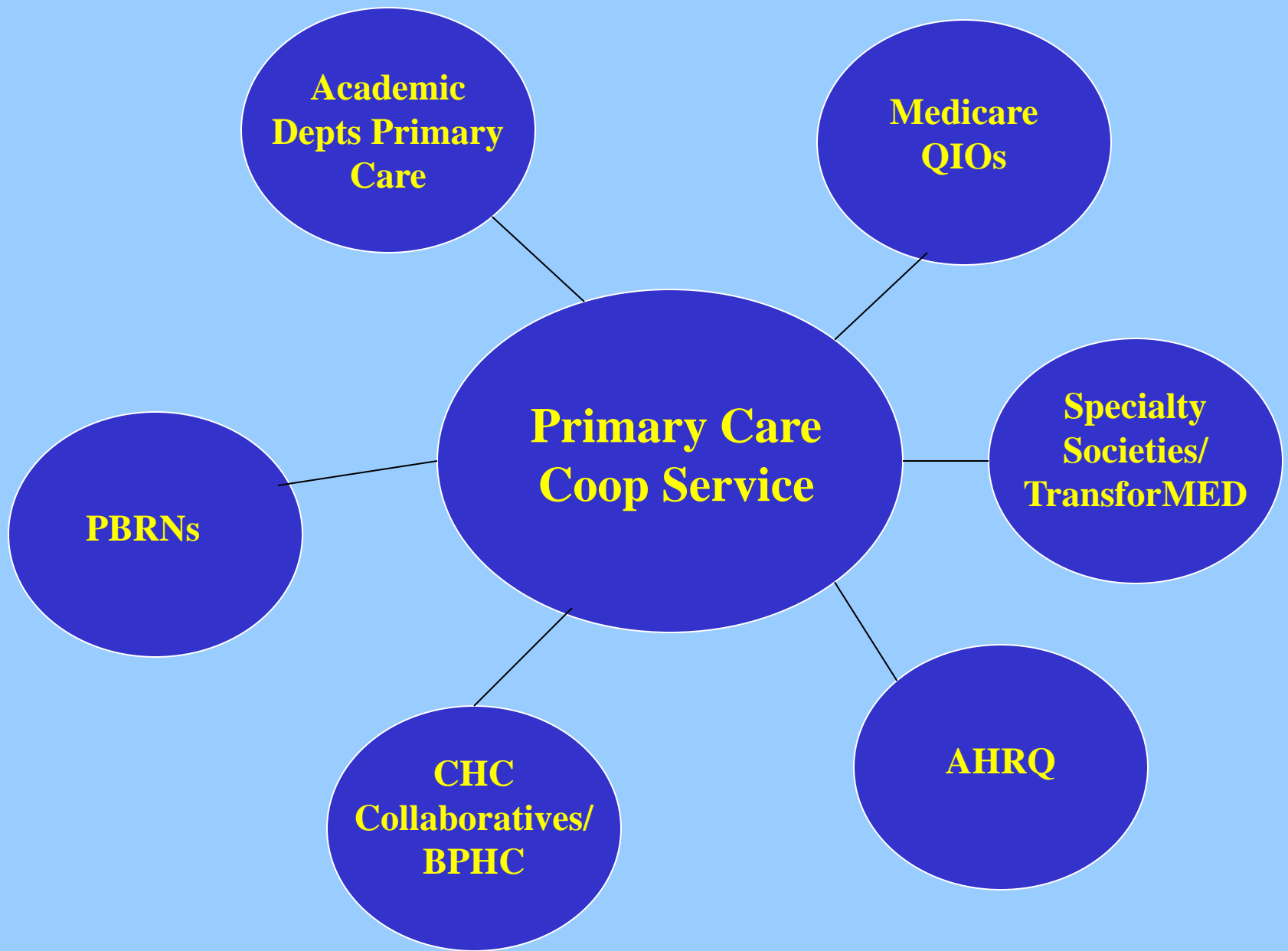
Rogers EM. *Diffusion of Innovations*. New York, NY: Free Press

Rogers's Best Practice Model for Diffusion of Innovation: USDA Agriculture Extension Cooperative Service

- Partnership between USDA, land grant universities, farmers
- Berwick: “one of the most successful innovation-spread programs ever seen in this country”
- Community engaged research, practice based research networks, learning communities, implementation and dissemination science

From Family Farmers to Family Doctors: Creating a Primary Care Cooperative Extension Service

- Technical assistance in implementation of chronic care models, advanced access scheduling, group medical visits, other innovative models of care
- Technical assistance in the application of EMRs for creating patient registries, tracking care processes, creating reminder prompts, patient portals, etc.
- Staff training for team-based practices
- Promoting learning communities to facilitate sharing of best practices and problem solving strategies
- Dissemination of research evidence on quality of care and practice improvement
- Facilitation of patient advisory councils



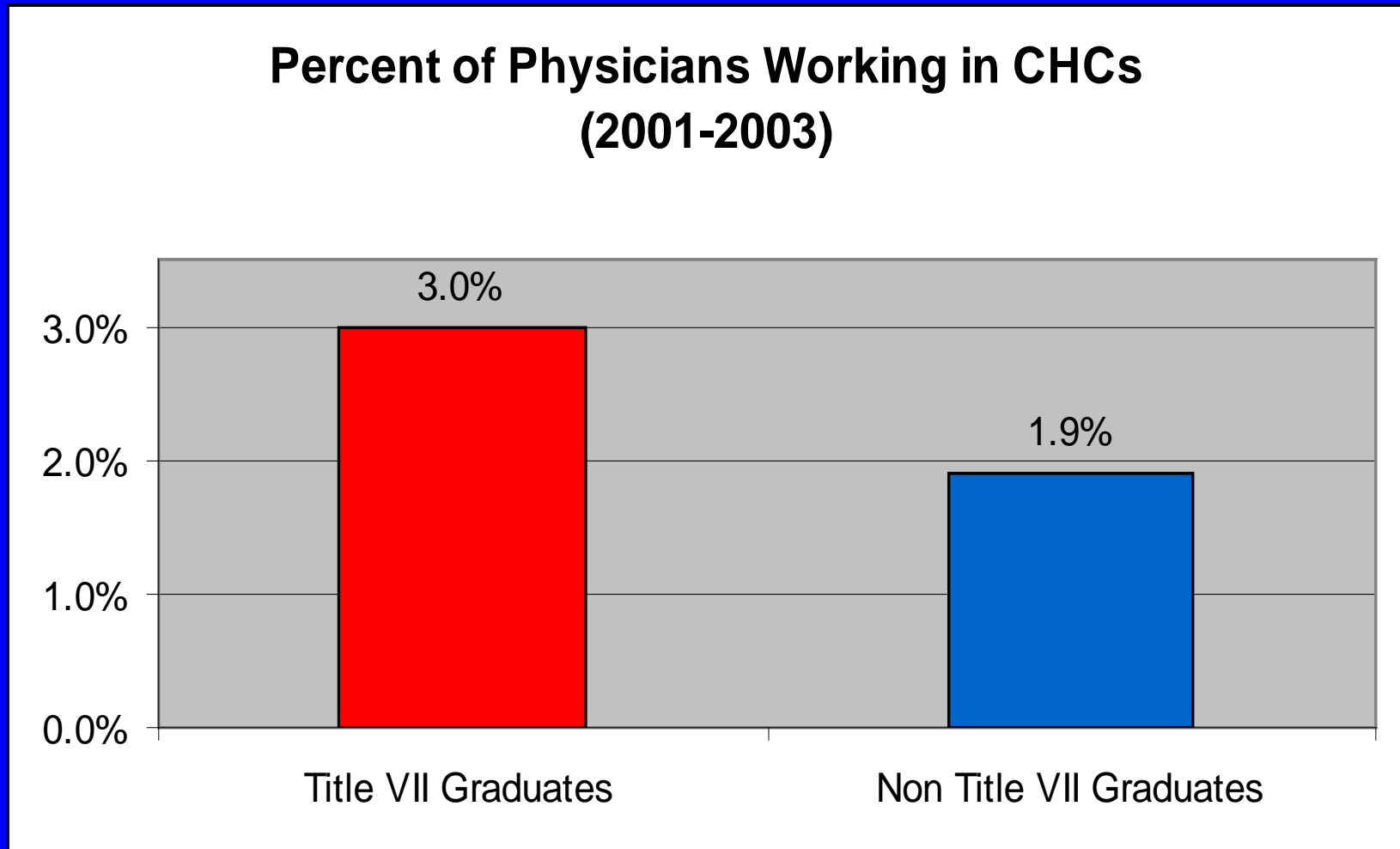
Key Federal Medical Education Programs:

- Title VII of the Public Health Service Act, Health Resources and Services Administration (HRSA)
 - Section 747 funds grants to educational institutions for training of primary care physicians, physician assistants, and dentists (~\$50M 2008)
 - Nursing (RN, NP) training funded through Title VIII
- Medicare Graduate Medical Education Payments
 - Pays hospitals for residency training (\$8.8B in 2007)
- National Health Service Corps
 - Scholarship and loan repayment programs in return for practice obligation in underserved area (~\$155M 2007)

Research Evidence That Title VII Section 747 Programs Are Effective

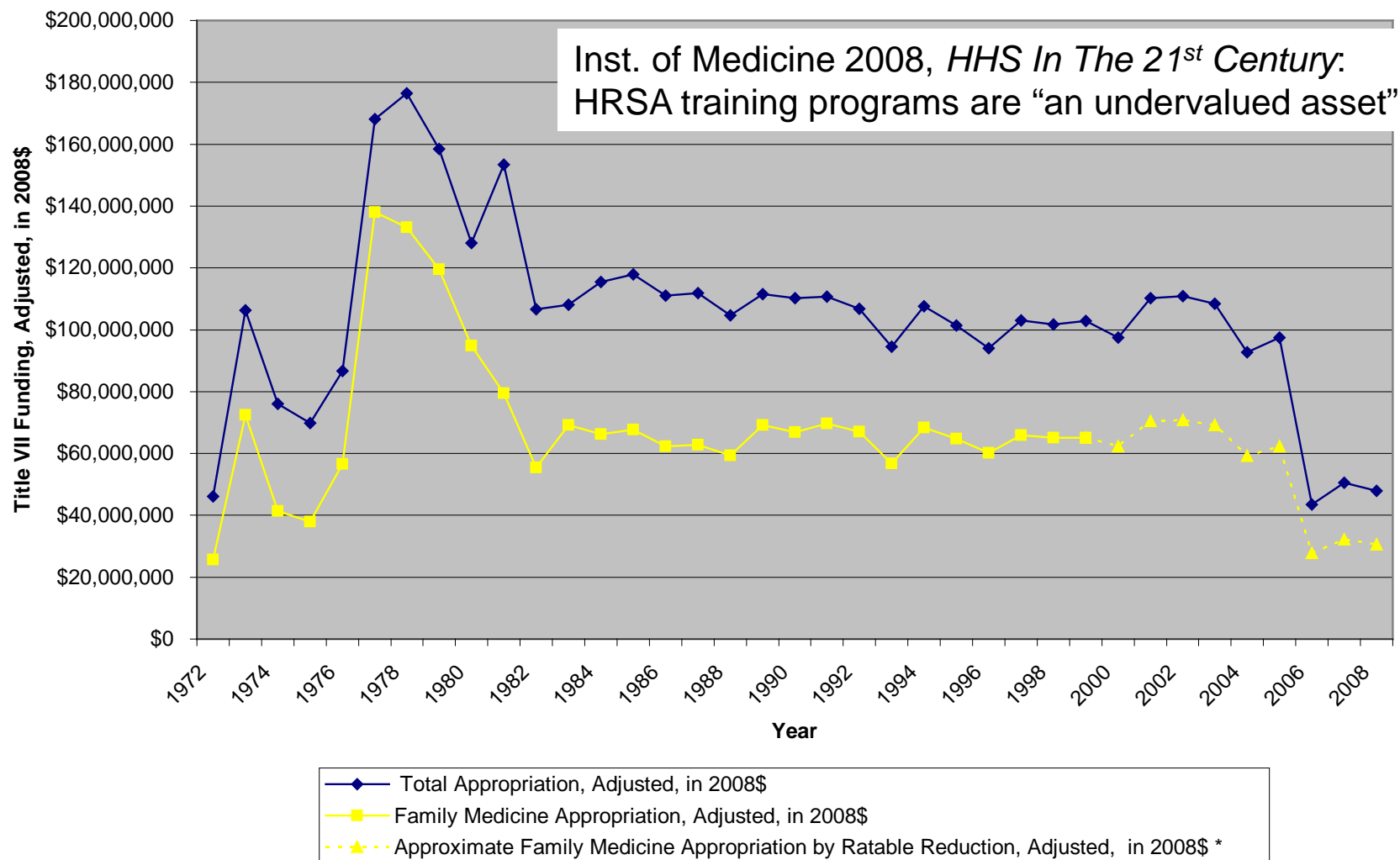
- Physicians who trained at medical schools and residency programs that received Title VII 747 funding are:
 - More likely to enter primary care
 - More likely to work in shortage areas
 - 58% more likely to practice at a Community Health Center
 - 24% more likely to join the National Health Service Corps

Percent of US Medical School Graduates Working at a Community Health Center According to Whether School Was Title VII Grant Funded



Source: D Rittenhouse et al, Ann Fam Med, 2008

Title VII Section 747 Funding Appropriations (in constant 2008 dollars)



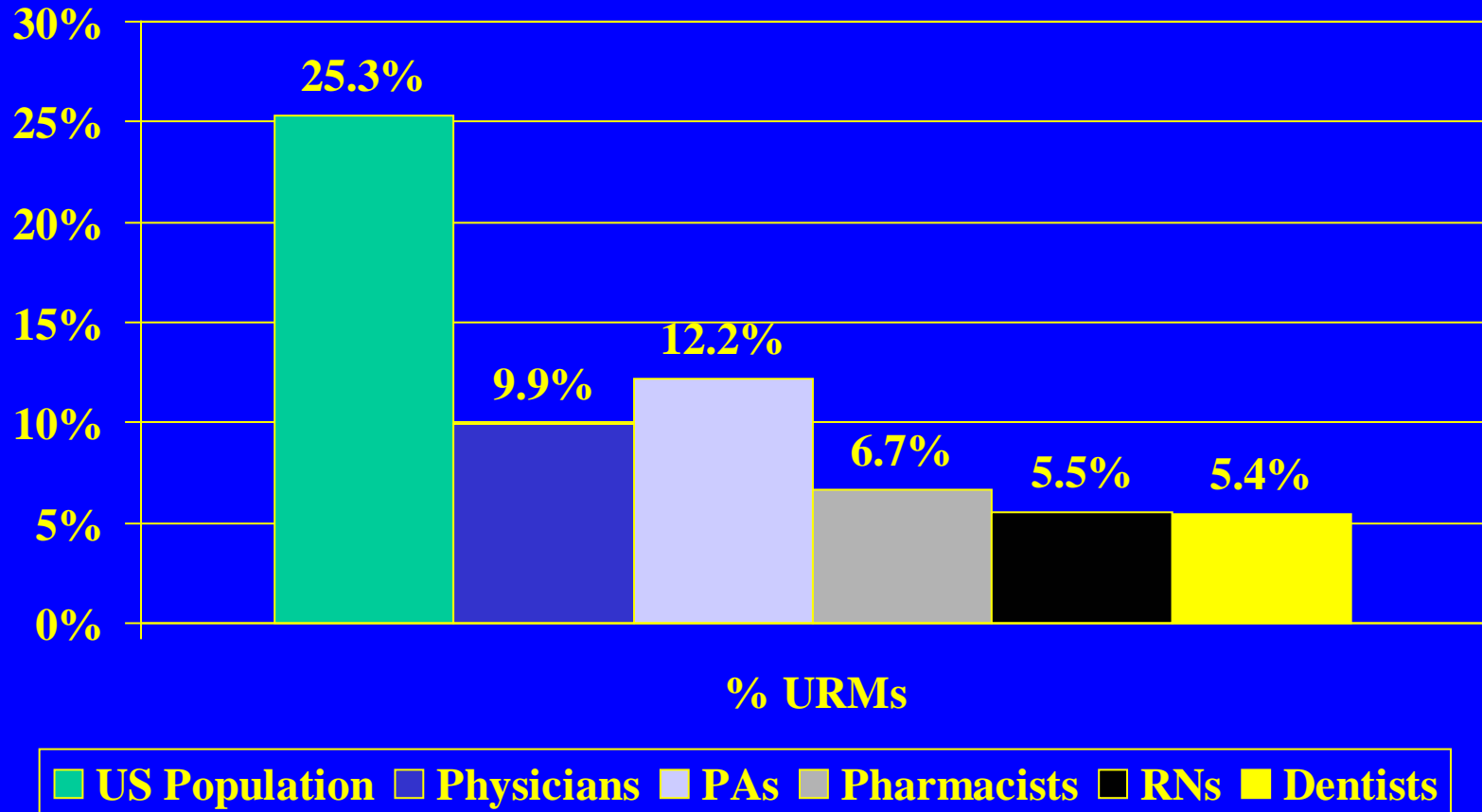
Recommendations of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry, 6th Report to Congress, 2006

- “the Title VII, section 747 grant program requires reauthorization and an appropriation at a minimum level of \$215 million”
- Reauthorization bills introduced in 110th Congress:
 - S 3708, HR 7302

Other HRSA Title VII Programs Focus on Diversity

- Widening gap between racial and ethnic composition of US population and physicians and other health professionals
- Implications for access and quality of care

Underrepresented Minorities* (URMs) as % of US Population and Selected Health Professions



*African Americans, Latinos, American Indians

Title VII Health Professions Programs to Support Minority and Disadvantaged Student Entry into Medicine and Other Health Professions

Program	FY 2005 (\$million)	FY 2006 (\$million)	% Change
Health Careers Opportunity Program (HCOP)	\$35.6	\$4.0	-88.9%
Centers of Excellence (COE)	\$33.6	\$11.9	-64.7%

Recommendations of the Council on Graduate
Medical Education, 19th Report to Congress:
*Enhancing Flexibility in Graduate Medical
Education* (2007)

1. Align GME with future needs
2. Broaden the definition of “training venue”
3. Remove regulatory barriers limiting flexible GME training programs and venues
4. Make accountability for the public’s health the driving force for GME

Medicare Payment Advisory Commission

Report to Congress, 2008

- Medicare GME “payments are provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with what Medicare’s goals are”
- “policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them.”
- “medical education subsidies could also be used to help pay student loans for clinicians committed to primary care specialties.”

Incentivizing Primary Care Through the National Health Service Corps

- 6000 sites seeking NHSC placements in 2008
- In 2008:
 - 950 applicants for 76 NHSC scholarship awards
 - 2713 applicants for 867 NHSC loan repayment awards
- Good evidence that NHSC participants tend to remain in practice in underserved areas, even if not at initial service site
- Legislative proposals under consideration:
 - Fund at least a doubling of NHSC scholarships and loan repayment positions (from current \$155M to >\$300M)

Research

- In an era of “personalized medicine,” how about an NIH institute focused on the whole person and not just individual organs and diseases?
 - NIH Institute on Primary Care
- Strengthen “T2” translational science in community engaged research (CTSAs)
- Increase AHRQ funding for primary care research, esp implementation/dissemination science
- Find a permanent adoptive home for the orphan of workforce research

Conclusions

- Whether a pyramid is more stable standing on its base or on its top has a known answer informed by the laws of Newtonian physics.
- Primary care is important and essential
- Stimulus and health reform bills provide an opportunity for Federal Government to play a decisive role to begin rebuilding the primary care infrastructure
- Need comprehensive package of interventions; no single measure will suffice
- Time to right the health care pyramid

