How States Will Solve the Healthcare Workforce Crisis: What to ask for from the Feds

Robert Phillips MD MSPH
The Robert Graham Center

Agenda

- Healthcare Reform about the Economy this time
- Primary Care seen as a solution
  - Lower costs, better population health
- Giving everyone insurance without sufficient access to primary care = EXPENSIVE
- Assuring Access to Primary Care
  - State examples
  - Workforce urgency
- What to ask for from the Feds

Why Health Reform Now?

THE WALL STREET JOURNAL.
WSJ.com

OPINION | MAY 15, 2009

Health Costs Are the Real Deficit Threat

That's why President Obama is making health-care reform a priority.

By PETER R. ORSZAG

"Over the long run, the deficit impact of every other fiscal policy variable is swamped by the impact of health-care costs."

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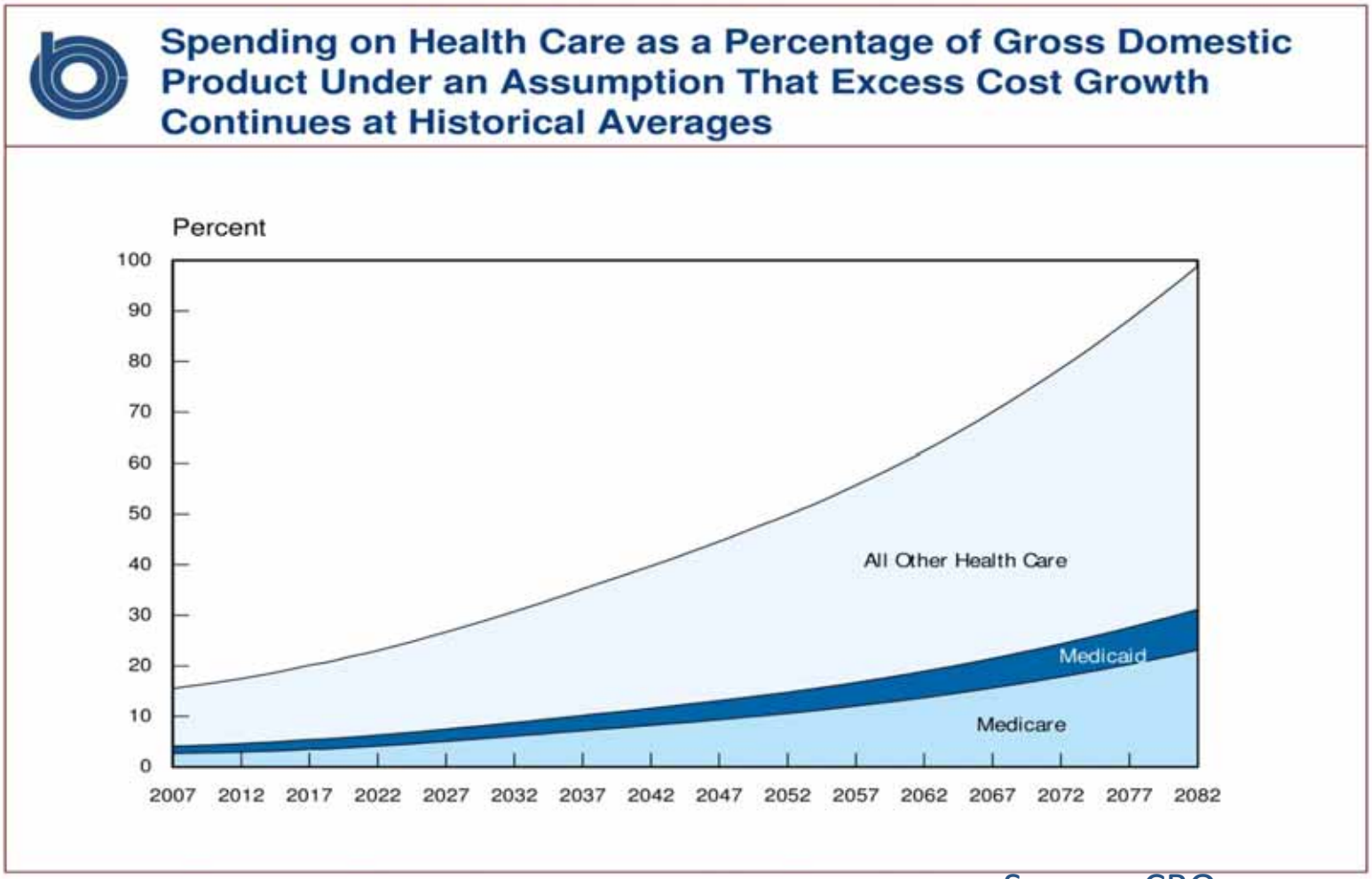
The Curve We're On



Source: CBO

Health Care Spending

- 16% of the US Economy ($2.3 trillion)

BUT

- From 2000 – 2005 healthcare devoured nearly 25% of our Economic Growth

- Now consumes 1/3rd of Federal and State Taxes

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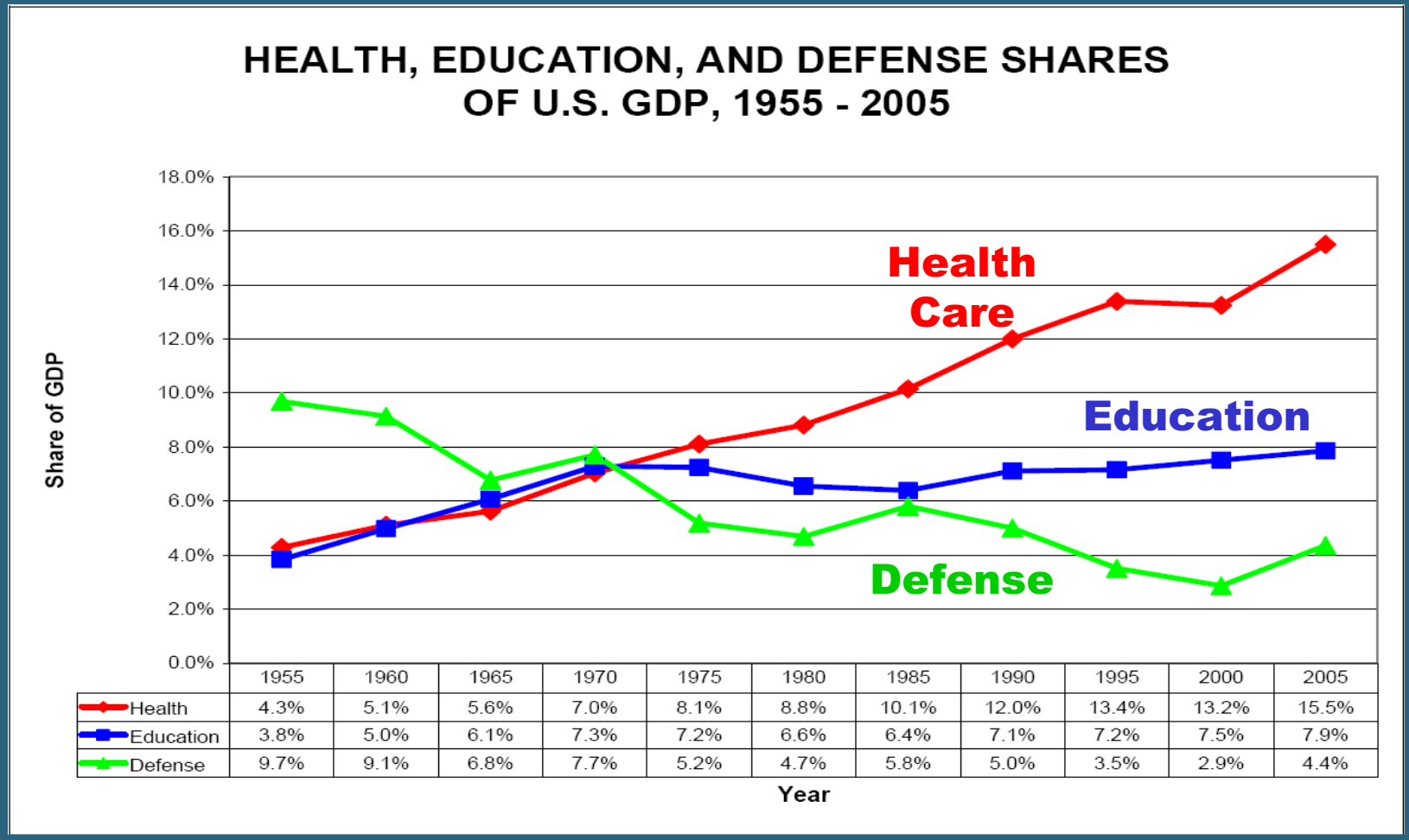
Will more spending on healthcare improve health?



	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
Health	4.3%	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.2%	15.5%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.9%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.4%

White House Strategy

- Keep Health Reform THE Priority

"We can't allow the cost of health care to continue strangling our economy."

President Obama April 14, 2009

"The cost of health care is crushing businesses and families"

Kathleen Sebelius, Secretary of HHS
May 5, 2009

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Turning back to Primary Care

"Meaningful, comprehensive reform must increase the value placed on primary care and redefine the role that primary care provides in our health system."

Sen. Max Baucus, chair
Senate Finance Committee

April, 2009

Turning back to Primary Care

"Primary Care that is squarely centered on each patient's individual needs is the only hope for fixing the broken US healthcare system,"

Paul Grundy, MD, IBM director of Healthcare, Technology and Strategic Planning.

Healthcare IT News by Richard Pizzi, Associate Editor 10/15/07

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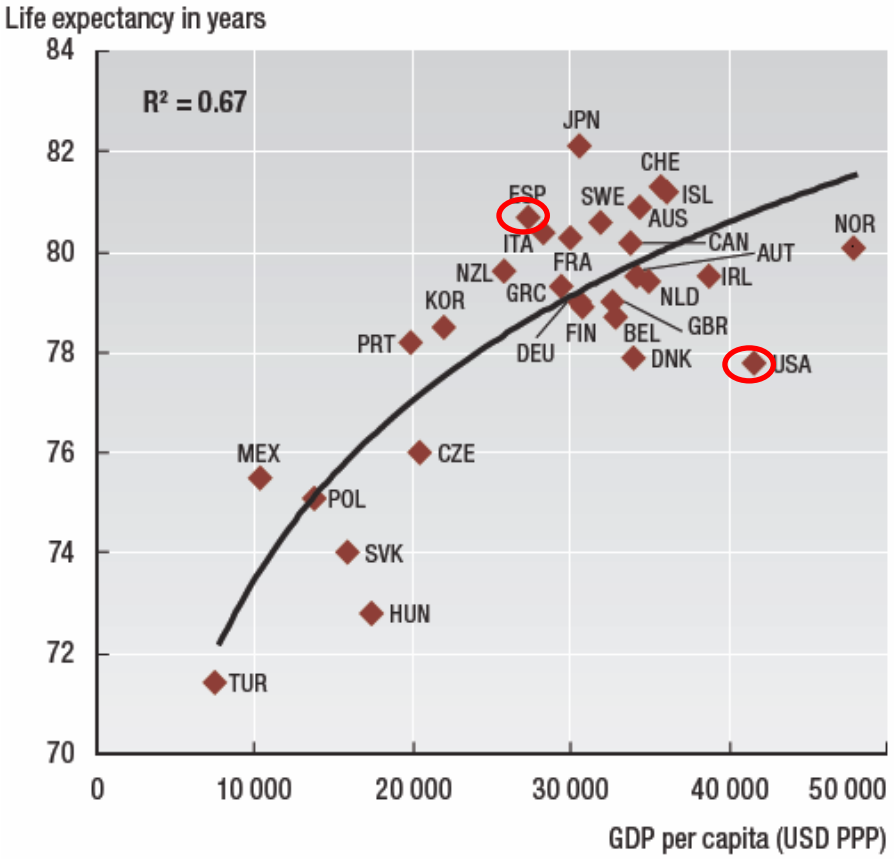
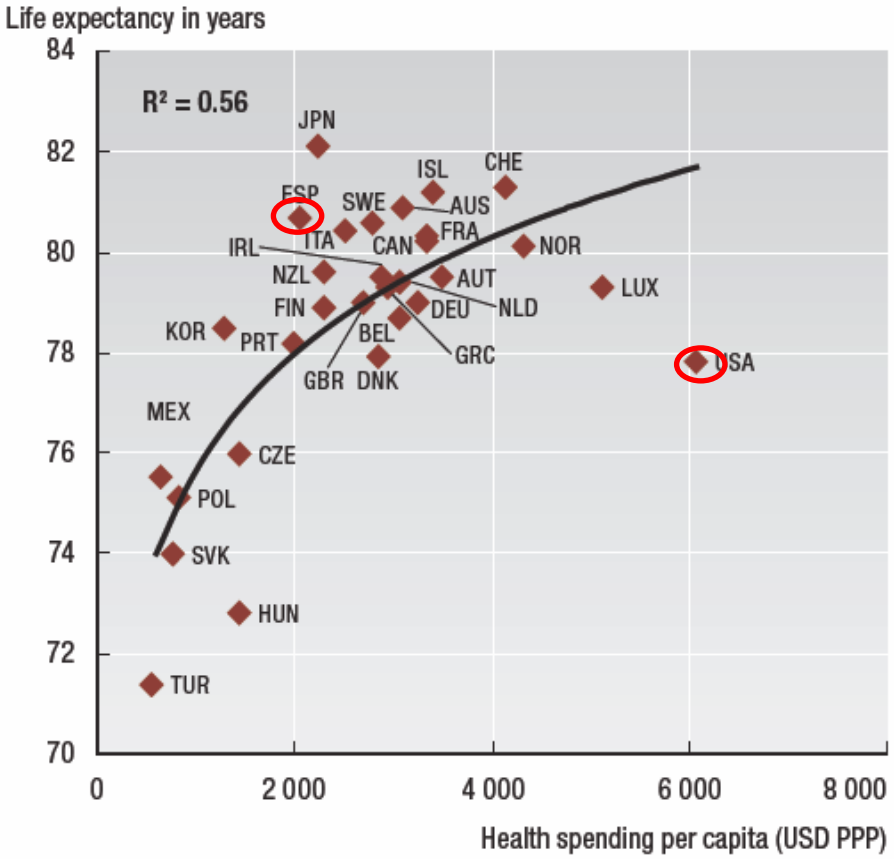
Life expectancy at birth and GDP per capita, 2005



Life expectancy at birth and health spending per capita, 2005



The Honorable Bernat Soria, MD PhD Health Minister of Spain

October 17, 2008 Patient Centered Primary Care Collaborative Summit, Washington, DC.

Spain's Conversion: A Guide for the US?

- National Health System ----1986
- 1986--First Primary Care Health Center
- 2006--13,000 PC Health Centers
  - 1 : 1,350 = PC:population
- 8.4% of GDP
- 4th among the 19 most developed countries
  Health Affairs (Health Affairs 27: 58-71 (2008);)
- 6th among 191 countries
  British Medical Journal (2001)

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Why Primary Care? Massachusetts

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Massachusetts Faces Costs of Big Health Care Plan

By KEVIN SACK
Published: March 15, 2009

BOSTON — Three years ago, Massachusetts enacted perhaps the boldest state health care experiment in American history, bringing near-universal coverage to the commonwealth with Paul Revere speed.

To make it happen, Democratic lawmakers and Gov. Mitt Romney, a Republican, made an expedient choice, deferring until another day any serious effort to control the state's runaway

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http://www.kff.org/uninsured/upload/7451_04_Data_Tables.pdf
2008 Massachusetts Health Insurance Survey

Need to build Primary Care Capacity Now

- So, with a higher per capita GDP, fewer uninsured and less rural-urban separation than Louisiana, Massachusetts struggles to guarantee comprehensive primary care access for its population—and to hold down costs

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Insuring Everyone

- Massachusetts cost model for the US
  - Cost of care for all people currently without a usual source of care

    $125 billion - $145 billion annually
- Enhanced Primary Care
  - If all states had Medicare spending of best 5 states: Save $70 billion annually
  - Give everyone cost outcomes of Community Health Centers: Save $450 billion annually

Assuring Access to Primary Care (beyond insurance)

- Improving the capacity and effectiveness of current primary care
- Resolving shortages and poor distribution
- Making sure Louisiana's physician pipeline is working for Louisiana

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Core Features of the Medical Home[1]

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety
- Enhanced Access
- Payment Reform

Improving capacity, effectiveness

- New care models---Patient Centered Medical Home
- Needs Facilitation for practices to transform
- Needs blended payment models
- Needs connections to community resources

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North Carolina

- Community Care of North Carolina
  - Practice and Community base care coordination
  - Blended payment model (Medicaid FFS + PMPM)
  - Even without full PCMH model saving $200-$300 million annually and able to pay Medicaid rates 95% of Medicare

http://www.communitycarenc.com/

Vermont Blueprint for Health

- Blueprint Integrated Pilot Program
  - Public-private (commercial insurers and Medicaid)
  - Enhanced payments to PCMH practices
  - Community Care Teams
    - Build out capacity of small practices by putting shared resources in the community
  - Community Activation and Prevention Teams
  - Health Information Technology information integration
  - Robust Evaluation

http://healthvermont.gov/blueprint.aspx

VERMONT Blueprint for Health

Smart choices. Powerful tools.

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    practice
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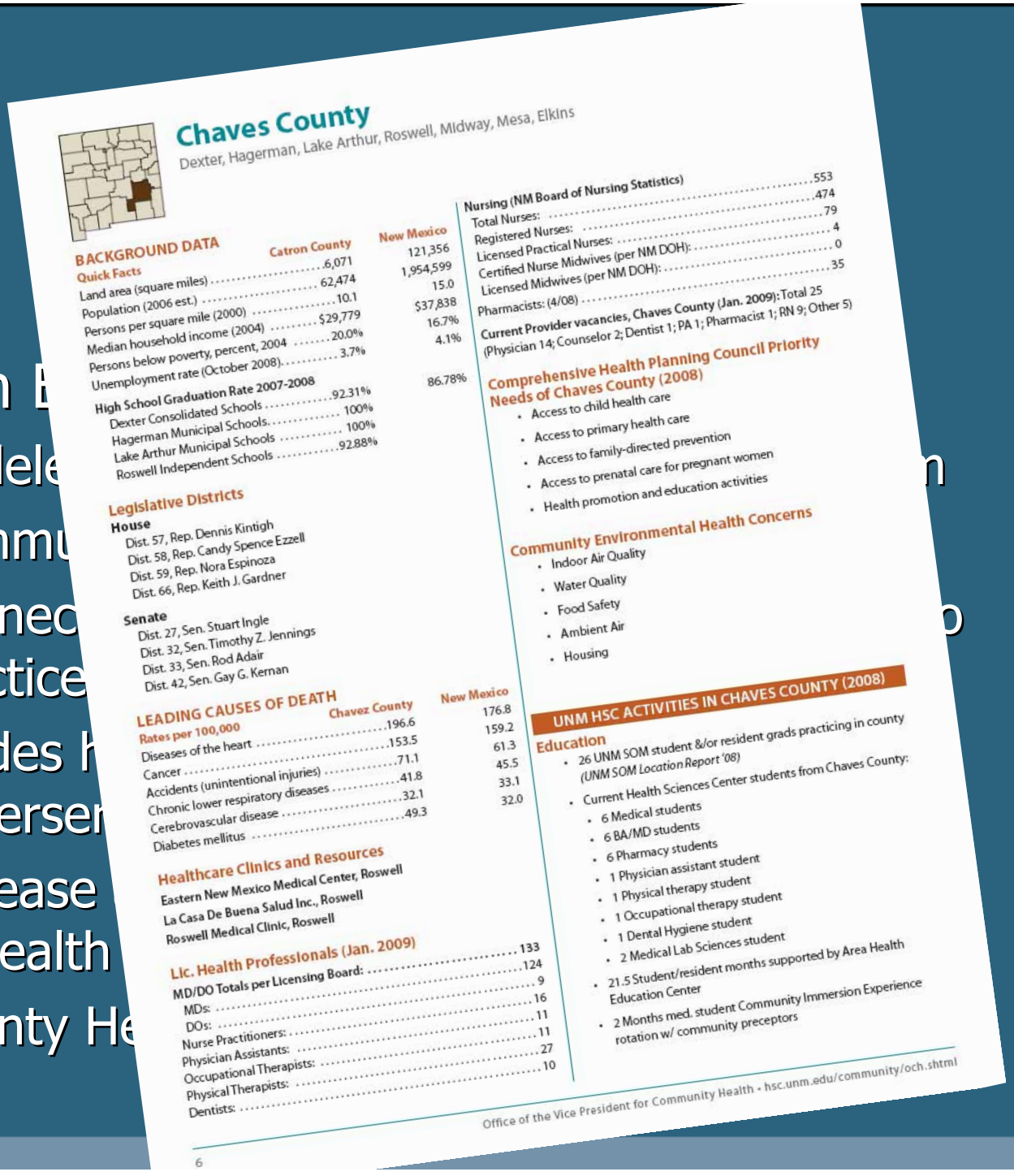

Chaves County

Dexter, Hagerman, Lake Arthur, Roswell, Midway, Mesa, Elkins

BACKGROUND DATA

Quick Facts	Chaves County	New Mexico
Land area (square miles)	6,071	121,356
Population (2006 est.)	62,474	1,954,599
Persons per square mile (2000)	10.1	15.0
Median household income (2004)	$29,779	$37,838
Persons below poverty, percent, 2004	20.0%	16.7%
Unemployment rate (October 2008)	3.7%	4.1%

High School Graduation Rate 2007-2008 86.78%

Dexter Consolidated Schools	92.31%
Hagerman Municipal Schools	100%
Lake Arthur Municipal Schools	100%
Roswell Independent Schools	92.88%

Legislative Districts

House

Dist. 57, Rep. Dennis Kintigh
Dist. 58, Rep. Candy Spence Ezzell
Dist. 59, Rep. Nora Espinoza
Dist. 66, Rep. Keith J. Gardner

Senate

Dist. 27, Sen. Stuart Ingle
Dist. 32, Sen. Timothy Z. Jennings
Dist. 33, Sen. Rod Adair
Dist. 42, Sen. Gay G. Kernan

LEADING CAUSES OF DEATH

Rates per 100,000	Chavez County	New Mexico
Diseases of the heart	196.6	176.8
Cancer	153.5	159.2
Accidents (unintentional injuries)	71.1	61.3
Chronic lower respiratory diseases	41.8	45.5
Cerebrovascular disease	32.1	33.1
Diabetes mellitus	49.3	32.0

Healthcare Clinics and Resources

Eastern New Mexico Medical Center, Roswell
La Casa De Buena Salud Inc., Roswell
Roswell Medical Clinic, Roswell

Lic. Health Professionals (Jan. 2009)

MD/DO Totals per Licensing Board:	133
MDs:	124
DOs:	9
Nurse Practitioners:	16
Physician Assistants:	11
Occupational Therapists:	11
Physical Therapists:	27
Dentists:	10

Nursing (NM Board of Nursing Statistics) 553

Total Nurses:	474
Registered Nurses:	79
Licensed Practical Nurses:	4
Certified Nurse Midwives (per NM DOH):	0
Licensed Midwives (per NM DOH):	35
Pharmacists: (4/08)	

Current Provider vacancies, Chaves County (Jan. 2009): Total 25 (Physician 14; Counselor 2; Dentist 1; PA 1; Pharmacist 1; RN 9; Other 5)

Comprehensive Health Planning Council Priority Needs of Chaves County (2008)

- Access to child health care
- Access to primary health care
- Access to family-directed prevention
- Access to prenatal care for pregnant women
- Health promotion and education activities

Community Environmental Health Concerns

- Indoor Air Quality
- Water Quality
- Food Safety
- Ambient Air
- Housing

UNM HSC ACTIVITIES IN CHAVES COUNTY (2008)

Education

- 26 UNM SOM student &/or resident grads practicing in county *(UNM SOM Location Report '08)*
- Current Health Sciences Center students from Chaves County:
  - 6 Medical students
  - 6 BA/MD students
  - 6 Pharmacy students
  - 1 Physician assistant student
  - 1 Physical therapy student
  - 1 Occupational therapy student
  - 1 Dental Hygiene student
  - 2 Medical Lab Sciences student
- 21.5 Student/resident months supported by Area Health Education Center
- 2 Months med. student Community Immersion Experience rotation w/ community preceptors

What lies ahead: Will there be a Primary Care Shortage?

- What's to come:
  - Substantial decline in US student interest
  - Increased reliance on international students
  - Increased interest in specialization and alternative careers
  - Increased opportunity to specialize
  - Contraction of primary care training programs
  - Majority of PAs now subspecialize; NPs?
- Current physician expansion effort not promoting primary care

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Is it a Primary Care Shortage?

- Problems:
  - Distribution
    - Still concentrated in desirable areas
    - Relative shortage in underserved and rural areas
    - True for physicians, NPs and Pas
  - Scope
    - Primary care physicians performing non-primary care tasks to remain solvent

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But We're producing more medical students and expanding residency programs?

- Medical Schools expanding, building—increase output 28% by 2012 (AAMC)
- Residency expansion (despite cap)
  - Allopathic grew 8% 23,443–25,171
  - Osteopathic grew 14.8% 2849
  - Now nearly 28,000 positions

National Residency Match Program data, 1997-2008. Available at http://www.aafp.org/online/en/home/residents/match.html
Watson DK, Nichols KJ. Medical Education Summits: Building a Solid Foundation for the Future of the Osteopathic Medical Profession. J Am Osteopath Assoc. 2008; 108(3): 110 - 115.

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Primary care losing ground: GME

- Between 2002 and 2006
  - Residency positions grew +7.9%
  - Subspecialty positions grew +24.7%
    - (33% between 2001 and 2008)
  - Primary care positions grew +2.3%
  - Family Medicine positions fell -2.8%
    - **However…the estimated number of graduates going on to practice primary care fell 15%** (from 28.1% to 23.8%)

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

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Erosion of Primary Care Training Capacity

- Since 1996 training cap was put in place, primary care positions in the annual Match have fallen by
  - 57% for primary care internal medicine
  - 34% for primary care pediatric positions
  - 18% for family medicine

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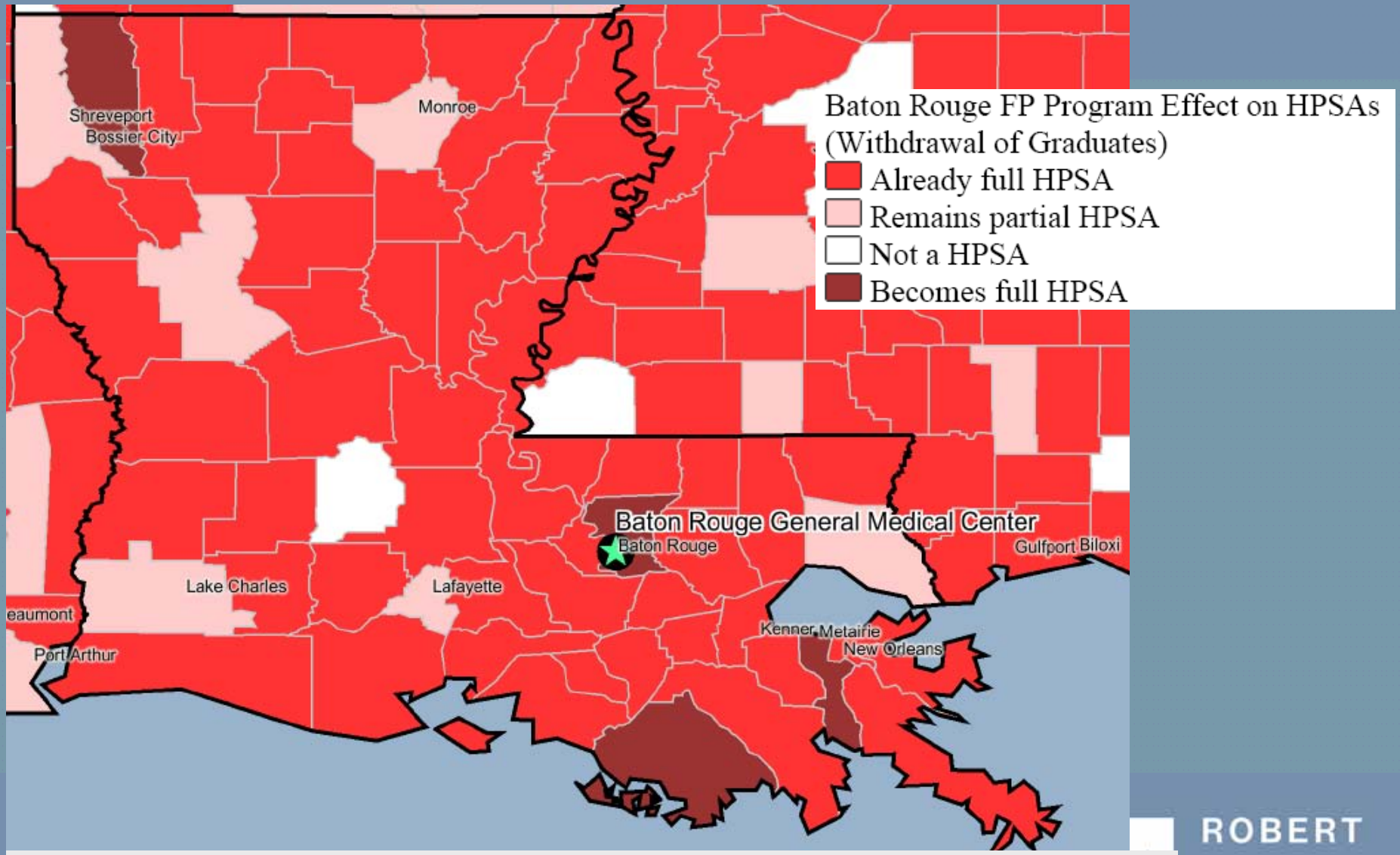

Baton Rouge Family Medicine Training Program--CLOSED

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Residency expansion

- Growth of specialty/subspecialty spots is bleeding primary care
- PC grads could fall to 17% of residency grads in next 5+ years
- COGME: Hospital incentives all wrong, bending GME to their financial needs

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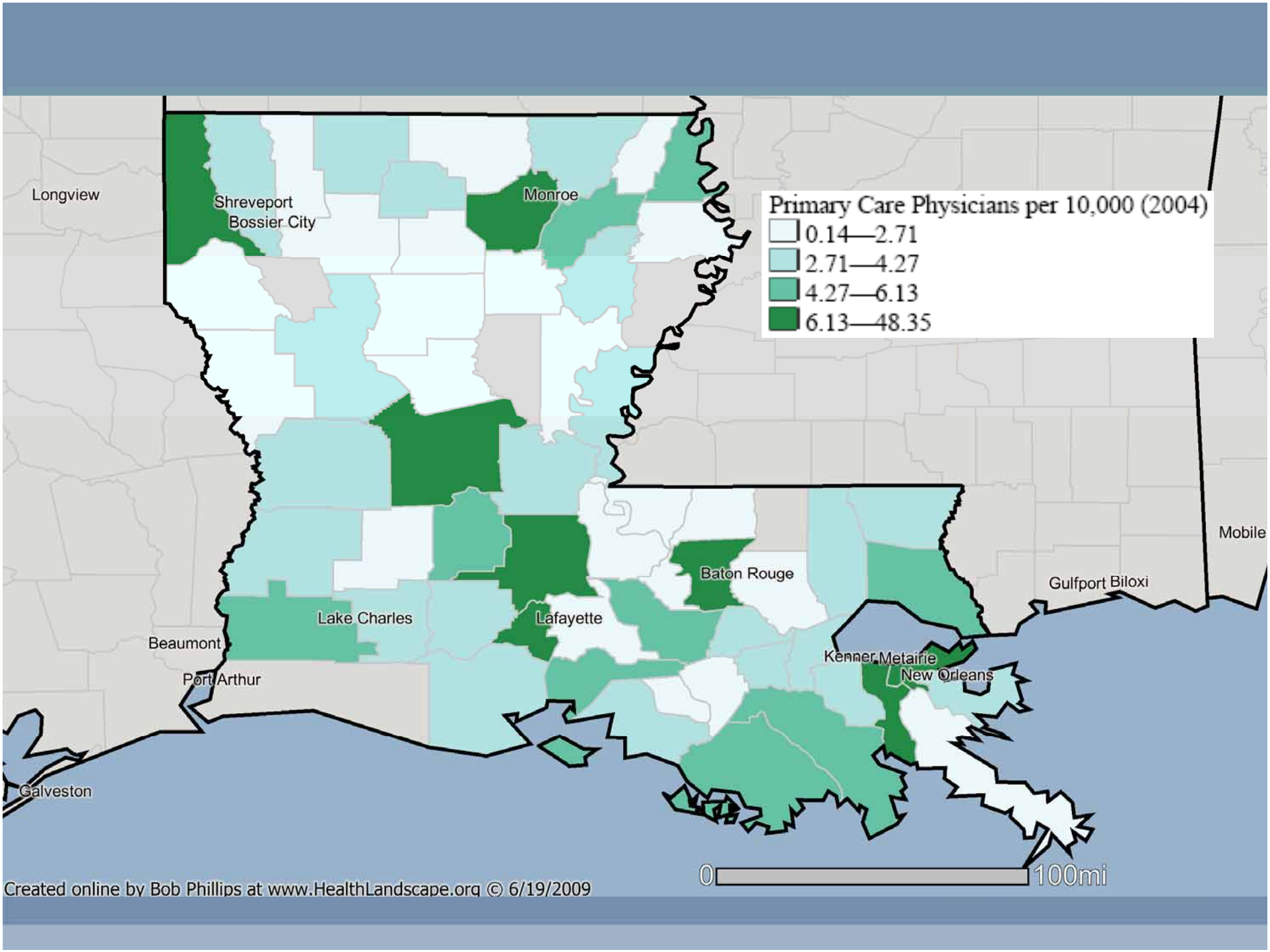
Primary Care Physicians per 10,000 (2004)
0.14—2.71
2.71—4.27
4.27—6.13
6.13—48.35
Longview
Shreveport
Bossier City
Monroe
Baton Rouge
Lake Charles
Lafayette
Beaumont
Port Arthur
Galveston
Kenner
Metairie
New Orleans
Gulfport Biloxi
Mobile
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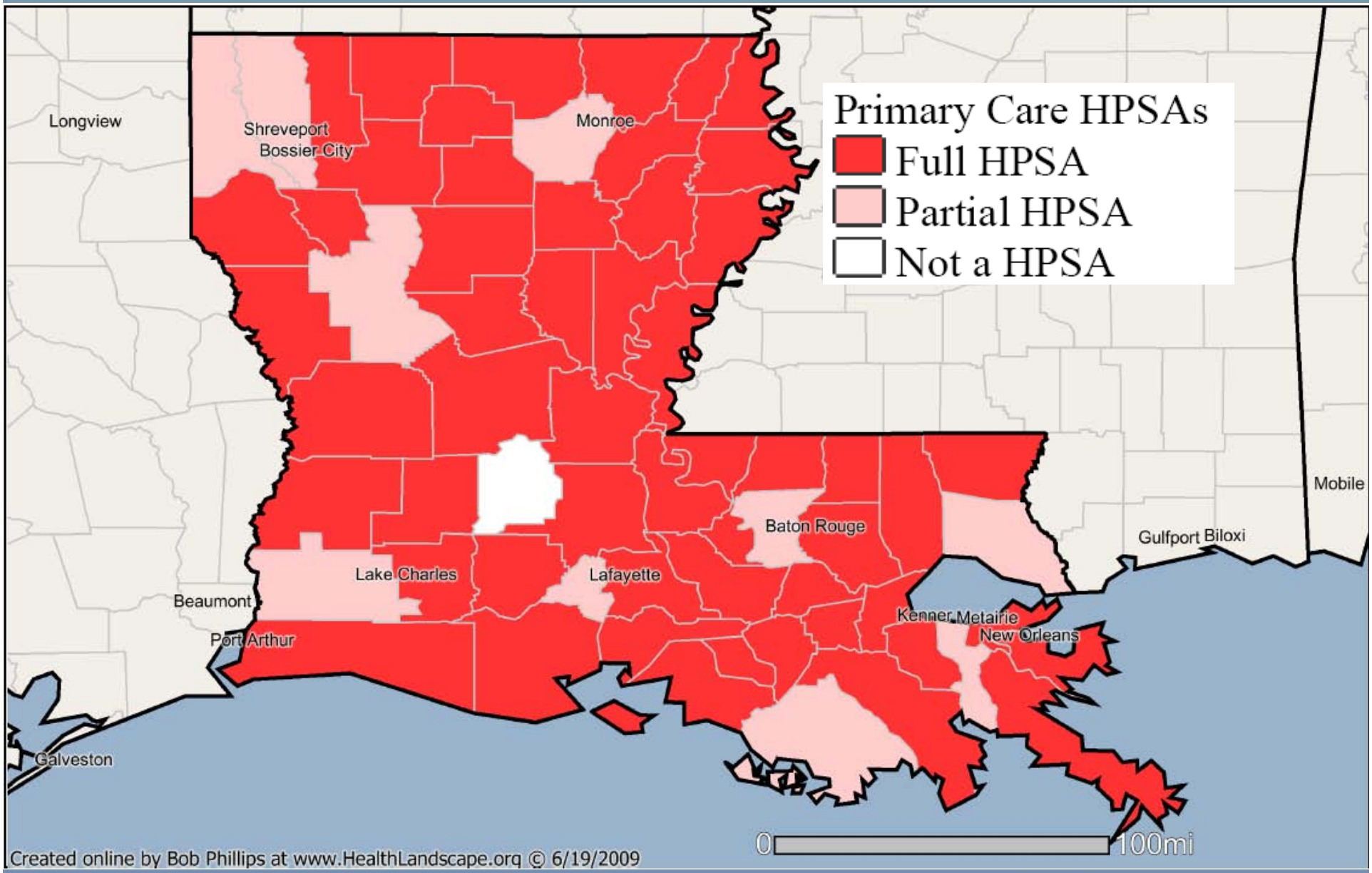
Created online by Bob Phillips at www.HealthLandscape.org © 6/19/2009


Primary Care HPSAs
Full HPSA
Partial HPSA
Not a HPSA
Longview
Shreveport
Bossier City
Monroe
Baton Rouge
Gulfport Biloxi
Mobile
Lake Charles
Lafayette
Beaumont
Port Arthur
Kenner Metairie
New Orleans
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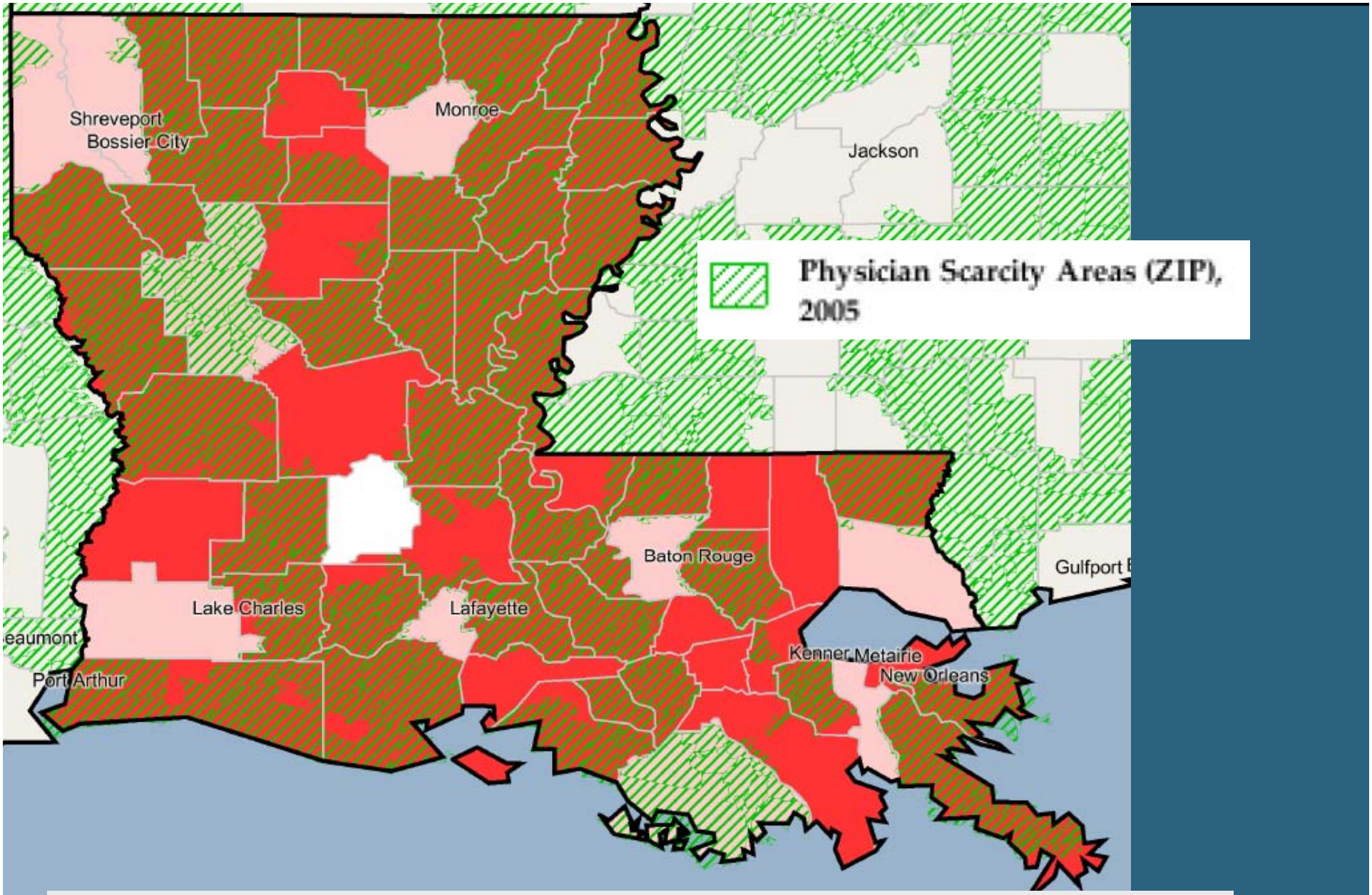
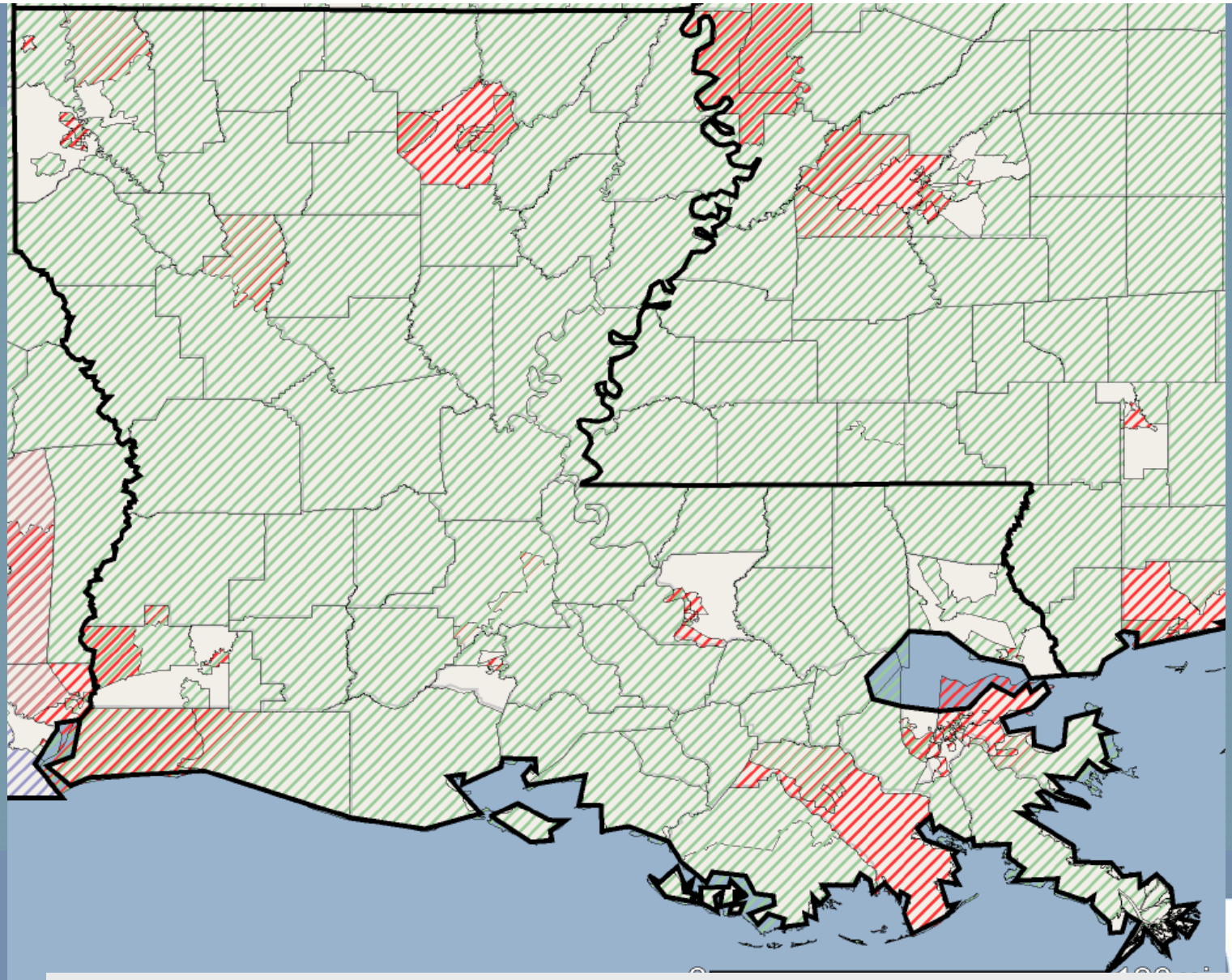


Poor Medicare Access



Shortage and Underservice

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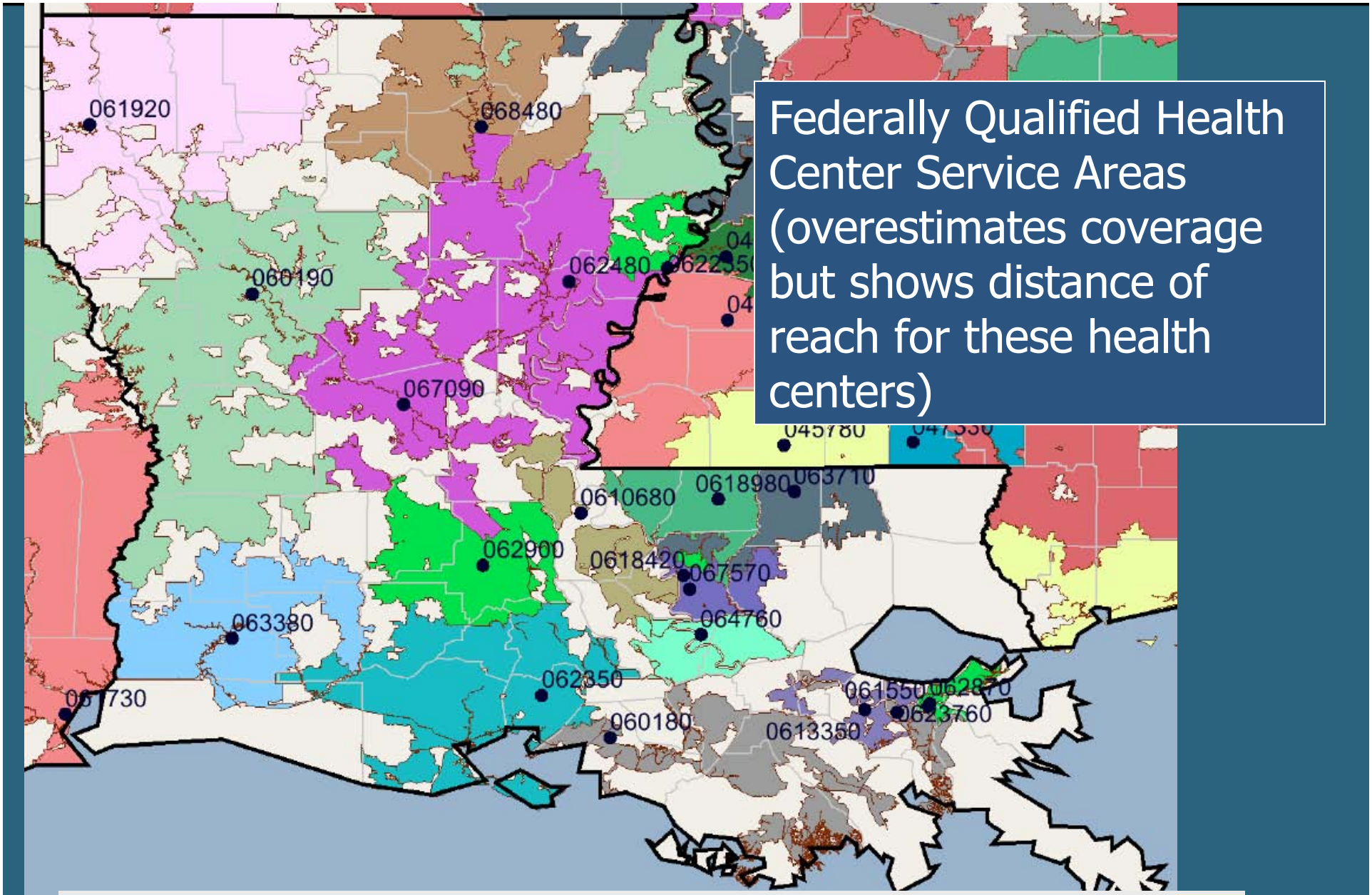

Federally Qualified Health Center Service Areas (overestimates coverage but shows distance of reach for these health centers)

Safety Net Coverage & Holes

Dr. Ricketts' Study of New Orleans Physicians after Katrina/Rita

Analysis Results

- **4,249 in AMA file matched with 4,436 LA BME file (98%)**
  - **171 not in practice, 9 deceased**
  - **1,771 indicated new practice location**
    - 481 to neighboring parish
    - 366 to other Louisiana location
    - 924 to other state
      - Texas 152
      - Florida 81
      - California 60
      - Mississippi 55
      - Georgia 54

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Ricketts' analysis

Conclusions

- Close to 50% of physicians experienced dislocation of practice
  - Younger and primary care physicians LESS likely to move
- Dispersion was to adjacent, populous, or familiar states
- Some evidence of disproportionate impact on African American physicians

Lasting effects?

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Louisiana Healthcare Workforce

- You have your work cut out for you
- Do your medical schools and residency demonstrate commitment to help?
- How do you redirect the pipeline?

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graham-center.org

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Past research

- student-related factors
- curriculum factors
- institutional factors
- debt
- Market factors

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What we found

- Debt had a curious effect
  - No debt -- less likely PC, rural, underserved
  - Middle debt (up to $150k) – more likely
  - High debt -- likelihood declines

- HOWEVER: Students who trade debt for service (NHSC) are 2-7 x more likely to choose study outcomes—and remain for 6-10 years beyond their obligation

(scholarships and loan repayment work!)

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What we found

- Income gap growth– cuts likelihood of choosing Primary Care in half

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Market doesn't absolve Schools

- Rural birth – 2.4 x rural practice
  1.8 x Family medicine
- Public Medical School
  1.8 x FM and Rural
- Interest in Serving Underserved
  3 x an FQHC
  4 x Rural Health Center
- Inner City, Rural and Primary Care Clerkships and Electives Matter

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Factors Affecting Medical Student and Resident Career Choices. Graham Center 2009. Funded by the Josiah Macy Jr. Foundation

Recommendations (relevant to Louisiana)

- More debt f
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- New Medical schools: public and rural

What to ask of Feds (now)

- Consider a Medicare Waiver similar to UTAH for Graduate Medical Education payments
  - Preserve current GME positions
  - Flexibility with specialty and location of training
  - COGME and Senator Bingaman both support Louisiana's retention of GME cap

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What to ask of Feds (now)

- Medicare Demonstration project for GME
  - Does redirecting GME payments to community based settings produce more primary care physicians, physicians willing to locate in (Medicare) shortage areas, physicians who serve Medicare patients?
  - Does it reduce Medicare costs?

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Congress

- Plan to have a bill by August recess
- Writing much of it now – June
- Senate: Health Education Labor Pensions, Senate Finance
- House: Energy & Commerce, Ways & Means, House Education & Labor
- Elephant: Budget Neutrality

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Items of Interest

- Primary Care Payment
- Primary Care Workforce
  - National Workforce Commission
  - State Grants
- Residency training expansion
  - Purports to help primary care
- Primary Care Extension Program
- Community Health Team grants

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What to ask of the Feds (in current legislative proposals)

- Medical school -support (then use!)
  - Proposed Faculty Loan Repayment increase
  - Proposed Disadvantaged Student scholarships increase
  - Sustained growth of National Health Service Corps support
  - Increased funding for Title VII

In draft Senate HELP Committee bill

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What to ask of the Feds (in current legislative proposals)

- State Healthcare Workforce Development Grants--Comprehensive Planning and workforce strategy development ($150m)
- Primary Care Extension Service ($120m)
  - Competitive grants to states
  - People in counties to help practices technical assistance with move to Medical Home; connect to communities and universities
  - Orient and involve teaching hospitals to communities (like New Mexico's HERO program)

What to ask of the Feds (in current legislative proposals)

- Grants to support a community health team to support a medical home model
  - Grants to states to accomplish what is underway in Vermont, West Virginia
  - Community based interdisciplinary teams that help small practices deliver medical home services, help transitions in care, help connect to public health