Facing the Crisis of Adult Primary Care

July 27, 2010

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Agenda

• The adult primary care practitioner crisis
• Declining access to primary care
• Confronting the adult primary care crisis
The adult primary care crisis

• 1/3 of U.S. physicians practice primary care, compared with 50% in most developed nations

• 2007 survey of fourth-year students, 7% planned careers in adult primary care. Hauer et al, *JAMA* 2008;300:1154

• Reasons for lack of interest in primary care careers:
  – PCPs earn on average 54% of what specialists earn, and most medical students graduate with >$120,000 in debt
  – The work life of the PCP is stressful
  – Medical students experience dysfunctional primary care and the medical school culture is hostile to primary care
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

Primary Care Physicians to Population Ratio 1980-2008 (Physicians per 100,000 persons)
Adult Care: Projected Generalist Supply vs. Population Growth + Aging

Shortage 2025: 35-44,000

Demand: adult pop’n growth/aging

Supply, Family Med, General Internal Med

Colwill et al., Health Affairs, 2008:w232-241
NP/PAs to the rescue?

- NP graduates have fallen from 8,200 in 1998 to 5,900 in 2005. 65% of NPs go into primary care.
- PA graduate numbers stable at 4,200 for several years. 32% of PAs practice in primary care.
- About half of NP/PAs are in primary care: increasingly choosing specialist offices, EDs, inpatient settings.
- Even with NP/PAs entering primary care, the primary care practitioner to population ratio will fall by 9% from 2005 to 2020.

Underrepresented Minorities* (URMs) as % of U.S. Population and Selected Health Professions

Medical students from underrepresented minorities are much more likely to choose primary care.

*African-Americans, Latinos, American Indians
Access to adult primary care

- 2008: 28% of Medicare patients without PCP had difficulty finding new PCP
- 17% increase from 2006
- Medicare patients having difficulty finding new specialist decreased from 18% in 2006 to 11% in 2008.

MedPAC. Report to Congress, March 2009
Access to adult primary care

• 22% of Medicare patients and 31% of patients with private insurance had unwanted delay obtaining appointment for routine care in 2008. MedPAC. Report to Congress, March 2009

• 73% of adults with PCP had trouble contacting the physician by phone, obtaining care after hours, or experiencing timely office visits. Closing the Divide. Commonwealth Fund, 2007
Geographic distribution

• Primary care physician:population ratio
  – Urban: 100/100,000 population
  – Rural: 46/100,000 population

• Rural areas
  – 21% of the U.S. population
  – 10% of physicians

• 65 million people live in primary care health profession shortage areas
2008 Primary Care Health Professional Shortage Areas By County

Legend
- A Full PC HPSA (n=1776, 55%)
- A Partial PC HPSA (n=637, 20%)
- Not a PC HPSA (n=806, 25%)

Data Source:
1. American Medical Association Masterfile, July 2008
2. HRSA Geospatial Warehouse, Aug. 15, 2008

Prepared by The Robert Graham Center
Access to adult primary care

- 46% of Californians going to ED said the problem could have been handled in primary care, but they were unable to access PCP. California HealthCare Foundation, Oct 2006.

- Medicaid patients of primary care practices with more than 12 evening hours per week utilized the ED 20% less than those cared for in practices with no evening hours. Lowe et al. Medical Care 2005;43:792-800
70% of adult PCPs take no Medicaid patients or limit the number

<table>
<thead>
<tr>
<th>Category</th>
<th>2006</th>
<th>2009</th>
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<tr>
<td>Massachusetts internists accepting any new patients</td>
<td>69%</td>
<td>44%</td>
</tr>
<tr>
<td>Massachusetts family physicians accepting any new patients</td>
<td>75%</td>
<td>60%</td>
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<tr>
<td>Texas family physicians accepting new Medicare patients</td>
<td>63%</td>
<td>51%</td>
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<tr>
<td>Texas family physicians accepting new Medicaid patients</td>
<td>41%</td>
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<tr>
<td>Vermont internists accepting new Medicare patients</td>
<td>70%</td>
<td>58%</td>
</tr>
<tr>
<td>Vermont internists accepting new Medicaid patients</td>
<td>62%</td>
<td>42%</td>
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Access to adult primary care
Massachusetts after coverage expansion

• 2009 average wait time to see new PCP: 44 days (over 6 weeks), up from 33 days in 2006.
• 2009 survey: 52% of Massachusetts residents reported going to ED for themselves or their family in past year.
• Physician dissatisfaction:
  – Family medicine: 45%
  – General internal medicine: 55%

Mass Medical Society Physician Workforce Study, 2009
Workload of U.S. adult primary care

- A PCP with a panel of 2500 average patients will spend 7.4 hours per day doing recommended preventive care. Yarnall et al. *Am J Public Health* 2003;93:635

- A PCP with a panel of 2500 average patients will spend 10.6 hours per day doing recommended chronic care Ostbye et al. *Annals of Fam Med* 2005;3:209

- Average panel size in U.S.: 2300

- Average panel size in Veterans Admin.: 1200

- Average panel size in community clinics: 1200
Workload of U.S. adult primary care

- Survey of 422 general internists and family physicians (2001-2005):
  - 48%: work pace is chaotic
  - 78%: little control over the work
  - 27%: definitely burning out
  - 30%: likely to leave the practice within two years

Unsustainable work life: The 15-minute visit syndrome

• 50% of patients leave the PCP office visit without understanding what the physician said. Roter and Hall. *Ann Rev Public Health* 1989;10:163; Schillinger et al. *Arch Intern Med* 2003;163:83

• Patients making an initial statement of their problem are interrupted by the PCP after an average of 23 seconds. Marvel et al. *JAMA* 1999;281:283

• Patients do not participate in decisions 91% of the time in primary care. Braddock et al. *JAMA* 1999;282:2313
The dilemma

• Panel size too large for lone PCP to manage.

• We can’t reduce panel size due to worsening shortage of PCPs.

• Shortage = larger panels, poorer access, more PCP burnout.
Solution: Health care reform and primary care

- Increased Title VII funding for primary care residencies
- Increased National Health Service Corps funding
- Primary care extension program: practice coaches to help primary care practices become PCMHs
- 10% increase in Medicare payments to primary care 2011-2016
- Medicaid to pay primary care same rates as Medicare 2013-2014
- Innovation center to stimulate PCMH pilots and payment reform for primary care
Solution: National policy options

- **Money:** drastic reduction in PCP-specialty income gap
  - RBRVS reform
  - SGR reform
  - Payment reform
  - Debt relief

- **Practice transformation to reduce PCP stress**

- **Medical education reform**
  - Culture
  - Curriculum
  - Primary care experience
  - Medicare GME reform

Solution: Practice of the future

- 8 - 10 PCP face-to-face visits per day. Reduces burnout.
- Serious investment in team-building.
- About 100 patients “touched” each day: email, phone, outreach for chronic/ preventive care, group visits, visits with other team members.
- Minority of encounters physician face-to-face visits.
- Patients not requiring PCP expertise see other team members.
- RN care management for high-cost patients with complex health care needs.

Margolius and Bodenheimer, *Health Affairs*, May 2010
Solution: Payment reform

• Fee-for-service add-ons
  – Additional payment for non-visit-based care coordination, pay for performance
  – Fees for non-practitioner services (pay RNs, pharmacists, health coaches, panel managers)

• Get rid of fee-for-service
  – Globally budget primary care practices via risk-adjusted capitation
  – Extra payments for preventive services, extended hours, high-quality and patient experience
  – Reward primary care for reducing ED visits, hospitalizations, total health care costs
Will we succeed in reversing the adult primary care shortage?

- *Not for a long time, if ever*
- The only hope is for payers (Medicare, Medicaid, commercial) to partner with primary care practices to reform payment and transform the practices
  - Pay RN care managers, pharmacists, health coaches, panel managers, and other non-practitioner personnel for their work
  - Pay for phone visits and e-visits needed to reduce demand for face-to-face visits
SoonerCare
Health Management Program

Mike Herndon, D.O.
Medical Director, Health Care Management
SoonerCare Health Management Program

- Existing Health Management Program, mandated by OK legislature in 2006 – Dual-Armed Approach
  - Nurse Case Management – Focuses on high-risk patients – self-management
  - Practice Facilitation (PF) – Focuses on practice improvement

- Reducing Disparities at the Practice Site (RDPS) developed through partnership with existing contractor, Iowa Foundation for Medical Care (IFMC)
  - 8 PFs statewide
  - No grant funds used to pay PF salaries. 60+% of grant funds go toward RDPS provider incentives
Goals of Practice Facilitation

- Redesign care delivery process for patients with chronic conditions by:
  - Focusing on quality of care
  - Focusing on office efficiency
Practice Selection for RDPS

- Predictive Modeling Software - MEDai

- Practice criteria for RDPS:
  - 500 Medicaid members on panel
  - 30 or > Diabetics
  - 15 or > Minorities
  - Not previously facilitated
How to get in the door?

- OHCA program coordinator calls to set up “the pitch”

- Face-to-face pitch is conducted with provider and clinic staff, OHCA program coordinator and IFMC PF manager
  - Discuss goals of PF services, incentives, emphasize free service

- Acceptance – select start date, do introduction with PF, get PF agreements signed
So what do PFs do?

- Team development
- Workflow redesign
- Involve all clinic staff, practicing at the top of their license (e.g., standing orders)
- Registry
  - Deployment
  - Establish use within office workflow
  - Maintenance
- Develop resource library, educational materials
- PDSA cycles – education, facilitation, self-assessment
- Stage One – 5 to 6 weeks, full-time (4 days per week); weekly follow-up X 1 month, taper frequency to support sustainability
- Stage Two – 2 to 3 weeks
How exactly do they do it?

- **Week 1**
  - Full assessment (self-assessment, process mapping, workflow, pain points)
  - Identify prevalence of chronic disease and associated cost drivers (e.g., claims data, chart reviews, performance management system, and MEDai)
  - Data findings presentation

- **Week 2**
  - Basic use of CareMeasures registry (or approved substitute), including data entry and Patient Care Summary (outstanding care opportunities) utilization:
    - Processes for identifying patients, gaps and methods to close gaps
    - Process for Patient Care Summary utilization, including who will print if practice plans to print/standing orders
    - Additional functionalities
    - Identify processes for data entry (data, demographics, clinical information, whose task will it be), Patient Care Summary printing and report follow up (PF will assist in initial data entry)
How exactly do they do it?
(continued)

- **Week 3**
  - Focus on specific strategies to improve provider/patient interactions:
    - Standing orders (discussion, policy creation, implementation)
    - Further develop team roles
    - Utilization of patient education resource library
    - Schedule appropriate follow-up visit
    - No show/no call reduction strategies
  - Establish and begin distribution of written educational materials, including disease-specific materials

- **Week 4**
  - Begin assessment of care management processes (educational plan, self-management tools, community resources, tracking) and provide some introductory care management tools
How exactly do they do it?

-continued-

■ **Weeks 1 through 4**
  ■ Team development / job descriptions
  ■ Policy and procedure development
  ■ Staff education
    ■ Disease-specific best practices
    ■ Practice redesign principles (self-mapping, QA/QI principles, PDSA, performance monitoring)
  ■ Maintain weekly one-to-one meetings with PCP including monitoring of:
    ■ Satisfaction
    ■ Support
    ■ Provider input regarding PI processes
What are the successes?

- Engaged all 10 selected practices
- 50% of practices have embraced registry and actively utilize it
- High degree of receptivity and no negative feedback regarding PF
- Cost savings: HMP independent evaluation of 62 practices (2/1/08-6/30/09)
  - $2.8 million aggregate savings when using Trend Line Method
- Improvement of 16.5% on disease management quality measures in all HMP-facilitated practices
- Positive, cooperative relationship with IFMC
What were Oklahoma’s obstacles?

- Practice staff turnover
- Weakness of provider buy-in and leadership
- Registry data entry too time-consuming
- Practice provider and staff capabilities – education, computer literacy
- Unwillingness to change – content “not broke, why fix it?”
- Competing initiatives – REC, PCMH, PQRI, PRN, Medical Association
- Lack of contract flexibility to make modifications
- NCMs disconnected from providers/practice
- Program staff turnover
Lessons learned?

- Provider leadership and buy-in are critical
- No two practices are alike; there is no mold
- Practices with electronic medical records are more complex to facilitate
- Leave contract language broad – allow for design flexibility
- Need for collaboration with other payors/initiatives
- Foster support within & from own agency; stay visible; PF services touch many other areas (PCMH, compliance audits, etc.)
- Practices are largely overwhelmed
“If we had it to do all over again...”

- Develop and utilize practice “application process” for selection strategy

- Develop dual roles of a practice-level facilitator and a practice-level NCM

- Write contract to allow program modification for integration with other initiatives – PCMH, REC, etc...
Vermont Models for Improving Medicaid Primary Care

Center for Health Care Strategies Webinar

July 27, 2010

Susan Besio, Ph.D., Commissioner

Department of Vermont Health Access (Medicaid)

Vermont Health Care Reform
Vermont PCP Context

- Relatively good distribution of Primary Care Providers (PCPs) statewide
  - 800 PCPs in 300 practices in 13 Hospital Service Areas
  - 77% of practices have 1 - 5 PCPs
  - 18% of practices have 6 -10 PCPs
  - 5% of practices have 11+ PCPs

- Three major health plan carriers + Medicaid + Medicare

- Most PCPs participate in all plans

- History of working together
Vermont Medicaid Strategies to Support Primary Care

- Medicaid Chronic Care Initiative
- Blueprint Integrated Medical Home Pilots
- Health IT
- Medicaid Rate Support
Medicaid Chronic Care Initiative

- Targeted at individuals with 1+ of 11 chronic conditions
  - Referrals from PCPs, ERs, state human service departments, predictive modeling
  - Individuals with high risk levels are prioritized

- Statewide Community-based teams of state employed RN’s and Social Workers (1-5 staff in each of 8 regions; 18 total)
  - Direct patient, primary care provider and ER contact

- Contract with APS Healthcare for those w/ less intense needs
  - Telephonic Support
    - Disease Management Coordinators: Data gathering and member education
    - RN Health Coaches
    - Social Worker
  - RN Health Coaches in 2 regions
Medicaid Community Care Team

Services:

• Develop relationships with emergency room staff
• Facilitate access to medical home
• Develop individualized holistic plans of care
• Optimize adherence rates to chronic disease treatment, health maintenance and screening
• Coordinate medical services, including behavioral health and substance abuse resources
• Arrange transportation to doctor’s offices if necessary
• Attend doctor’s office visits with patients as needed
• Provide health coaching and education
• Support and encouragement to make lifestyle changes
• Assistance with accessing community resources (housing, food and fuel assistance, etc…)
Medicaid CCI: Provider Benefits

- Supports the Providers’ Plan of Care for their patients
- Provides members with education and encouragement to self-manage their chronic conditions
- Reduces inappropriate use of the Emergency Room; reduces hospital admissions
- Gives PCP information on why patients use Emergency Room, prescription fills, etc.
- Provides members with support upon discharge from the hospital and link back to PCP
- Improves access to care by providing direct contact with RN Health Coaches and Care Coordinators
- Decreases no-show rates (due to higher patient engagement, transportation to appointments)
Blueprint Integrated Medical Home Pilots

- **Multidisciplinary care support teams (CHT Teams)**
  - Local Support & population management
  - Support general health maintenance of target population as well as care for chronic conditions

- **Financial reform (incl. Medicaid & 3 major commercial insurers)**
  - Payment to practices based on NCQA PCMH score
    - Conducted by UVM
  - Shared costs for Community Health Teams
  - State subsidizing Medicare portion

- **Health Information Technology**
  - Web-based clinical tracking system (DocSite)
  - Visit planners & population reports
  - Electronic prescribing
  - Updated EMRs to match program goals and clinical measures in DocSite
  - Health information exchange network

- **Community Activation & Prevention**
  - Prevention specialist as part of CHT
  - Community profiles & risk assessments
Team supports active caseload of 5,000 patients and oversees a total of 20,000 target population

Team composition varies by community (Formal Team)

Team coordinates with already existing community resources (Functional Team)

Team members move as individuals across practice sites

Are linked via an health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry

Designed to be flexible and scalable

Costs: $350,000 per 5-FTE team (equal shares by 5 payers)
Act 128 of 2010

- Blueprint Expansion

  - Moves the Blueprint to DVHA (Organizational Integration with Medicaid, Health Care Reform, HIT Responsibility)

  - Expands the Blueprint for Health to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013 to primary care practices statewide whose owners wish to participate

  - No later than January 1, 2011, health insurers and hospitals will be required to participate in the Blueprint for Health as a condition of doing business in this state. Doctors and other health care professionals are encouraged to participate
Blueprint: Provider Benefits

- All of the CCI Provider benefits on Slide 6, plus …
- Provides patient registry tool for panel management of key clinical indicators
- Provides EHR-like clinical management tool if don’t have EHR
- Provides support for clinical practice change (peer support, training, direct work with office staff)
- Provides direct access to Community Health Team and their specialists (e.g., nutrition, behavioral health)
- Brings Prevention Specialists into primary care setting
Vermont Medicaid PCP Payments

- Enhanced Payment ($150) for working with Medicaid Community Care Team
  - Paid at Case Closure (met all goals, transferred to APS, lost, opted out)

- Have protected Evaluation and Management Codes at 100% of 2006 Medicare levels since 2006
  - 87.8 of current Medicare rate

- Pay $5.00 pmpm to be PCP of record for a Medicaid enrollee ($5.3 million annually)

- Plus Blueprint Payments for NCQA Scores and support for Community Health Teams
HIT & HIE

- In 2005, VT authorized and funded a single statewide Regional Health Information Organization (RHIO):
  - VITL (Vermont Information Technology Leaders), a public/private partnership, 501(c)3
  - Developed 1st statewide HIE Plan, including standards based architecture for statewide HIE
  - Medication History Pilot Project in Emergency Rooms

- 2007 HCR legislation: $1 m multi-payer investment in EHR adoption and deployment in small practice primary care

- 2008: Health IT Fund - 0.2% fee on paid medical claims for 7 years
  - Electronic Health Records for primary care practices
  - Development of State-wide Health Information Exchange Infrastructure

- 2009: Moved HIT responsibility to DVHA Division for Health Care Reform
  - Integrates HIT and Medicaid
Federal HIT/HIE Policy, Oversight, & Standards - Office of the National Coordinator

State HIT/HIE Policy, Oversight, & Standards – OVHA/HCR

State Government & Public Health

Vermont Health Care Providers & Institutions

Health Information Exchange (HIE) “Cloud”

for interchange of health records, demographic data, image files, clinical messaging, & other digitized health information

Statewide HIE Operated by VITL

- Tertiary and Community Hospitals
- Primary Care & Specialty Providers
- Federally Qualified Health Centers & Rural Health Clinics
- Free Clinics
- Mental Health/BH/SA Providers
- Long Term Care Providers
- Home Health & Hospice Providers
- Community Human Service Agencies (Family Centers, Area Agencies on Aging, etc.)

Individual Vermonters: connectivity to EHR Portals, Personal Health Records (PHR), Health 2.0 applications and Ix Services

Public Health surveillance, registries, & other public health functions

Medicaid health programs case management functionality and connectivity

Other Medicaid & AHS case management functionality and connectivity

Other state agency & dept. case management functionality and connectivity

Law Enforcement, Corrections, & Court System

VERMONT
For More Information

- Medicaid Chronic Care Initiative
  
  dvha.vermont.gov/for-consumers/vermont-chronic-care-initiative-vcci

- Blueprint For Health
  
  healthvermont.gov/blueprint.aspx