

Can Health Care Reform Resuscitate Primary Care in the United States?

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**ASTHO-NCSL Webinar
Health Reform and Workforce Shortages**

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Goals and Objectives

- 1. Briefly describe the benefits of primary care.**
- 2. Summarize trends affecting the primary care workforce.**
- 3. Examine how legislation and policies influence primary care workforce trends.**
- 4. Engage in discussion with the panelists and audience on how to ensure a bright future for the primary care workforce.**

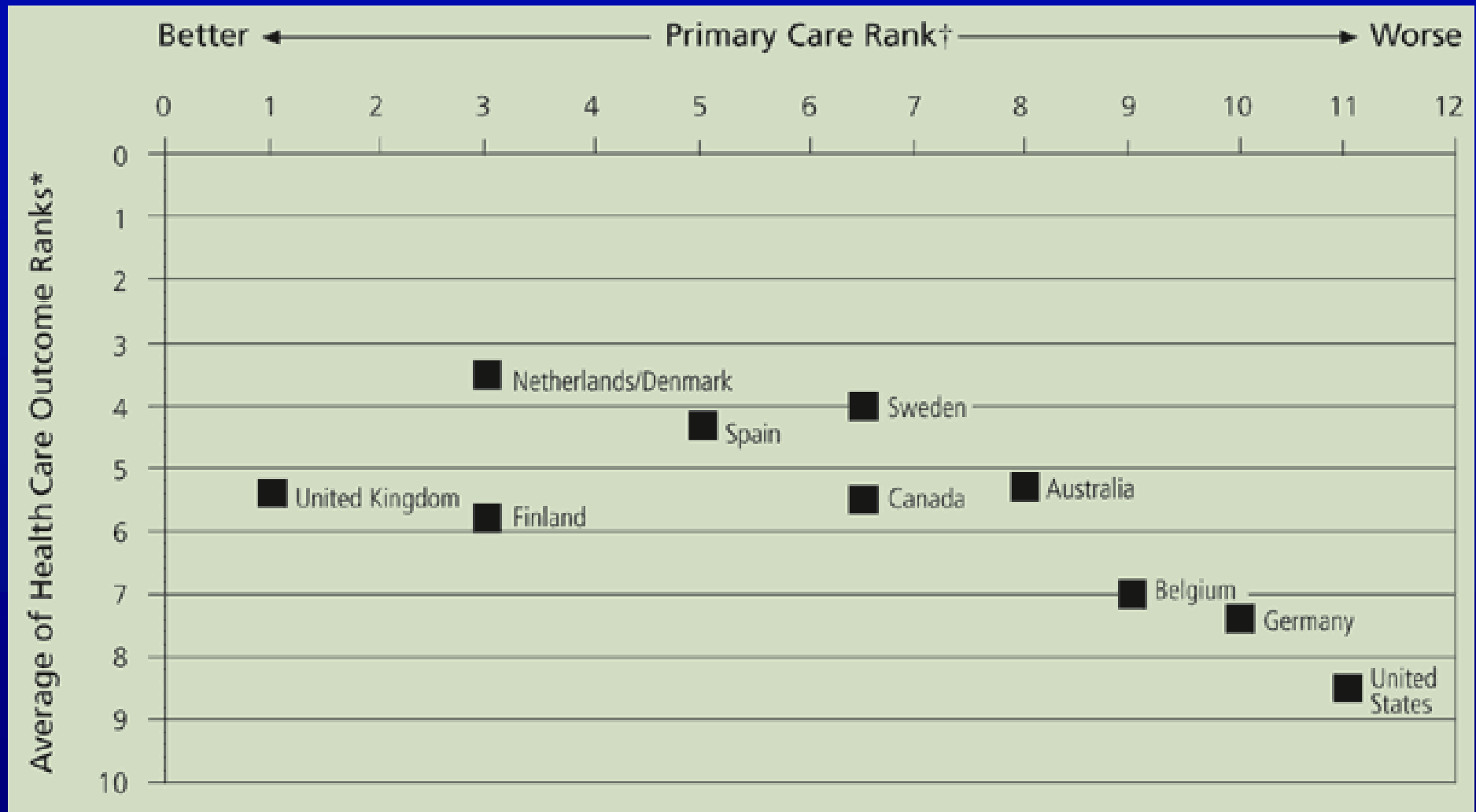
Part 1. The Benefits of Primary Care

Primary care-based health care delivery results in:

- More preventive care
- Better quality of care
- More equitable care
- Better population health outcomes, including lower mortality
- Lower costs

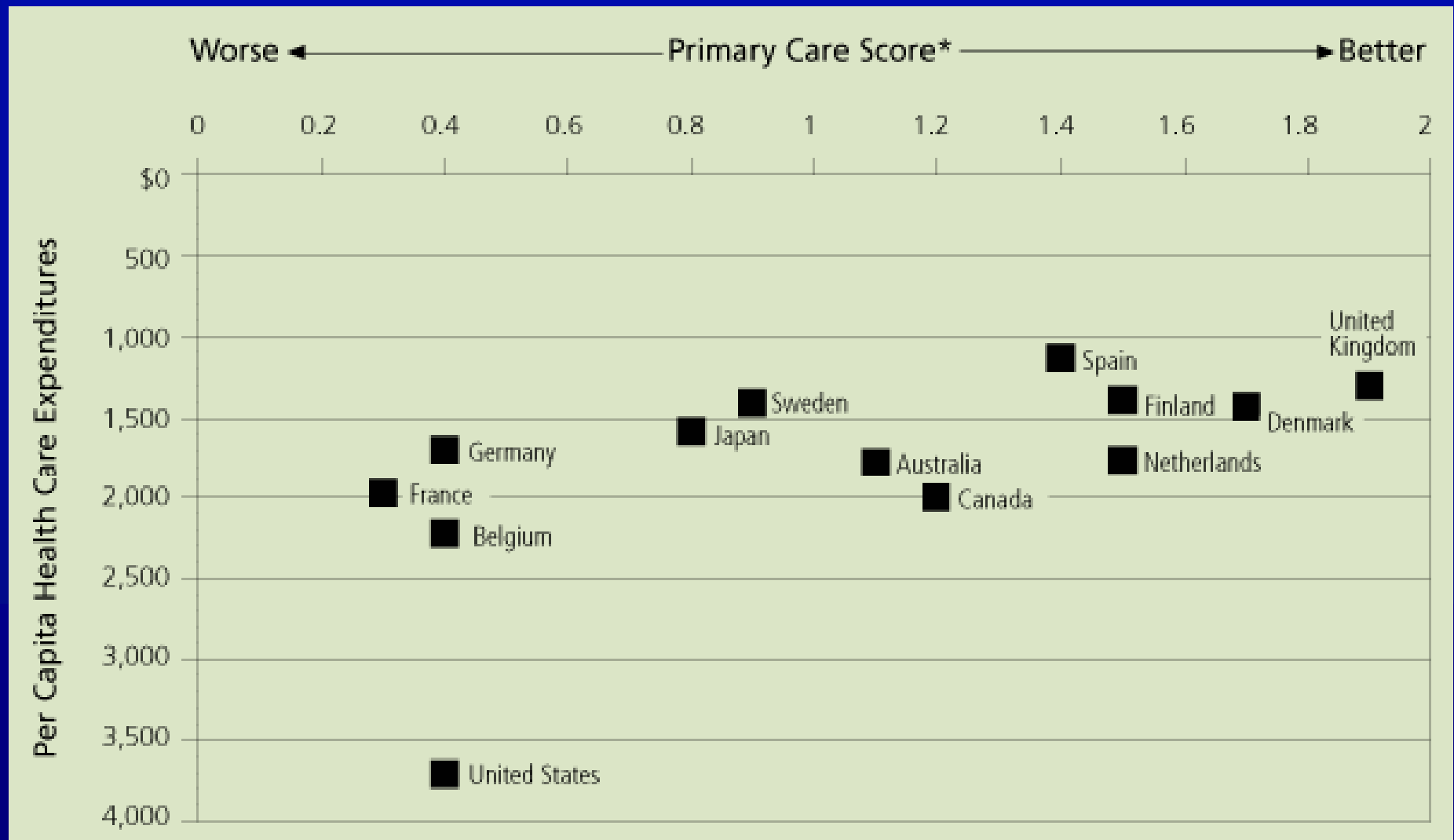
Starfield, B., L. Shi, and J. Macinko. 2005. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly* 83(3): 457-502.

Primary care and health care-sensitive outcomes



Starfield B, Simpson L. 1993. Primary care as part of U.S. health services reform. *JAMA*; 269:3136-9.

Primary care and health care expenditures



Starfield B, Simpson L. 1993. Primary care as part of U.S. health services reform. JAMA; 269:3136-9.

Part 2. Trends in the Primary Care Workforce

Primary care plays a critical role in health care delivery, particularly in rural and inner city locations.

But primary care faces:

- **Low overall supply**
- **Uneven distribution**

Trends in the Primary Care Workforce

Issues

- The number of U.S. health care students choosing primary care careers has declined precipitously.
- Factors discouraging recruitment and retention:
 - Low compensation
 - Rising malpractice premiums
 - Professional isolation (in many settings)
 - Limited time off (in many settings)
 - Difficulty finding jobs for spouses (in rural settings)

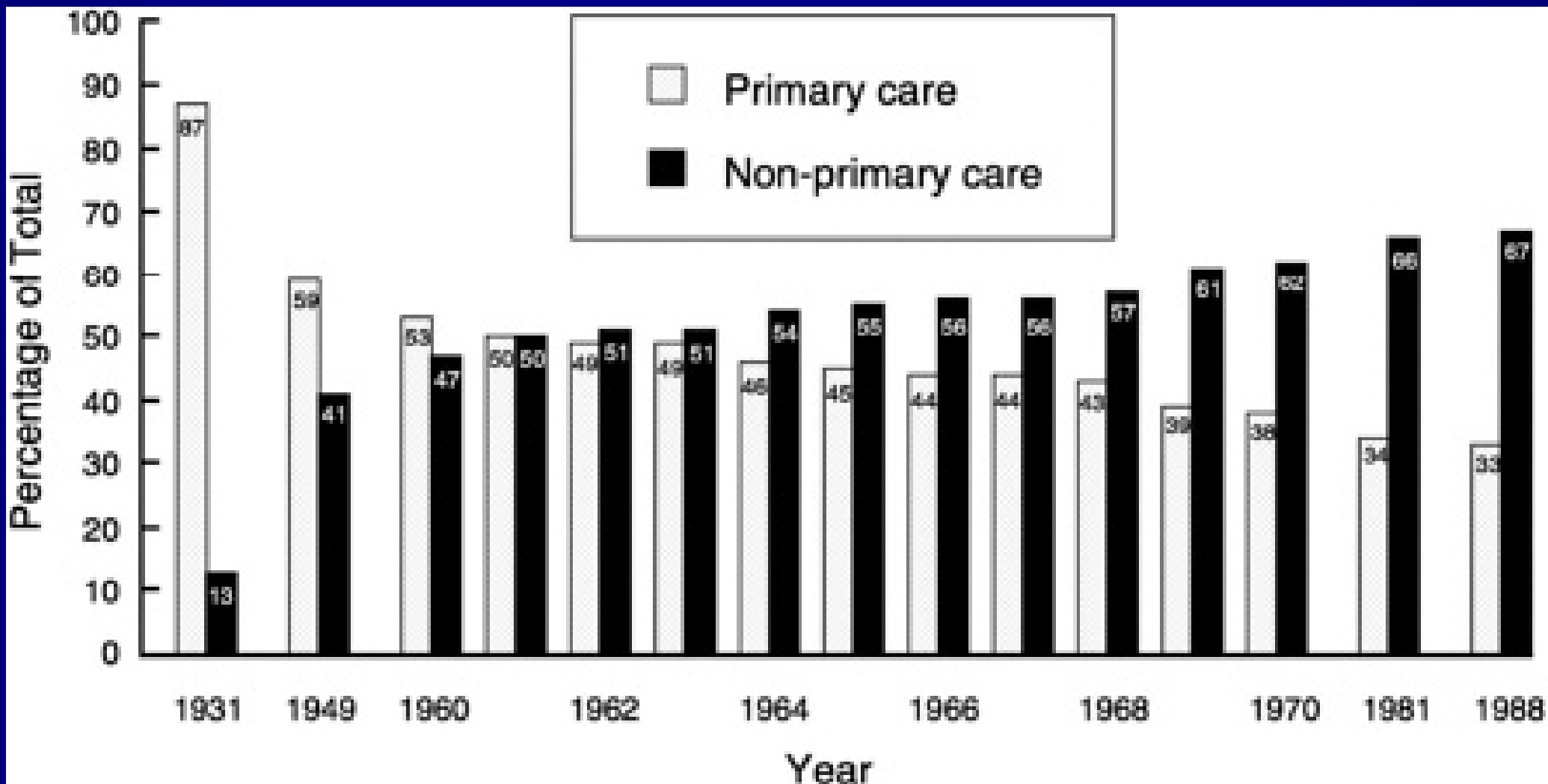
Trends in the Primary Care Workforce

The decline of primary care in the U.S.

- Despite the benefits of having a strong system of primary care, new physicians are increasingly choosing specialties over primary care.
- Primary care shortages persist throughout US, particularly in rural and inner city locations.
- Evidence of growing problems of access to primary care.

Trends in the Primary Care Workforce

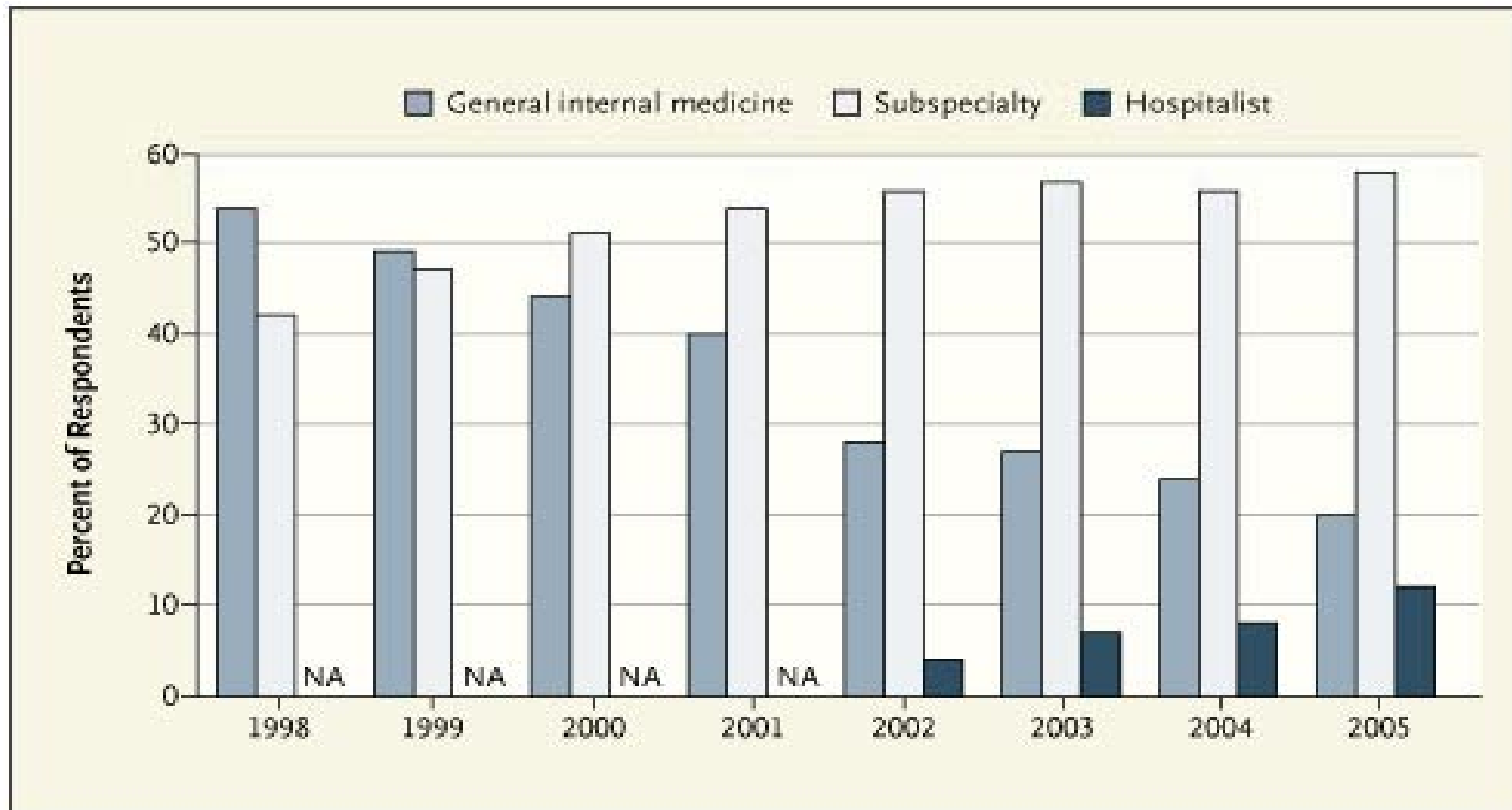
New physicians entering specialties



Institute of Medicine (IOM). 1994. *Changing the Health Care System: Models from Here and Abroad*.

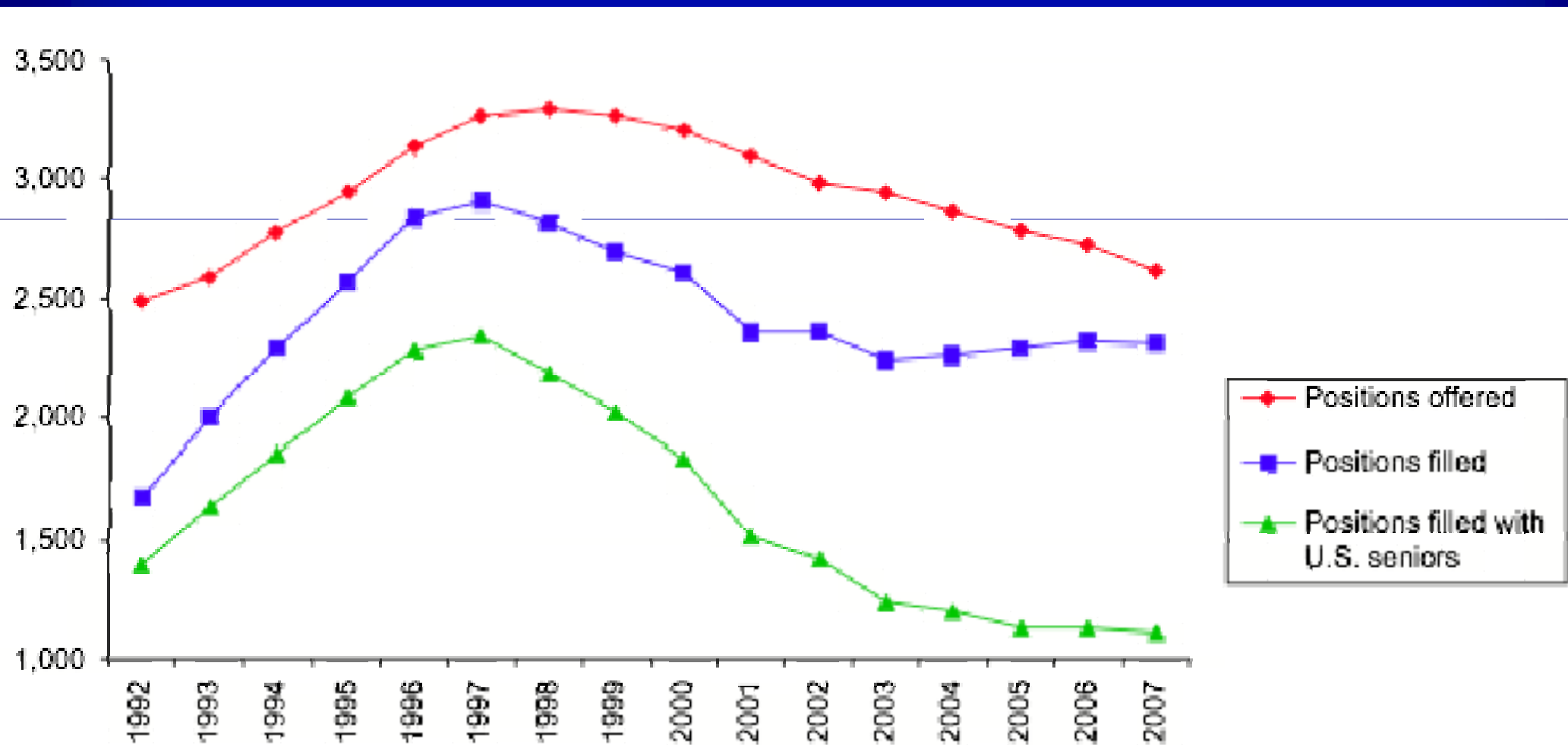
Trends in the Primary Care Workforce

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



Trends in the Primary Care Workforce

Declines in the Family Medicine Match



Adapted from: Bodenheimer T. 2006. N Engl J Med;355:861-864.

Trends in the Primary Care Workforce

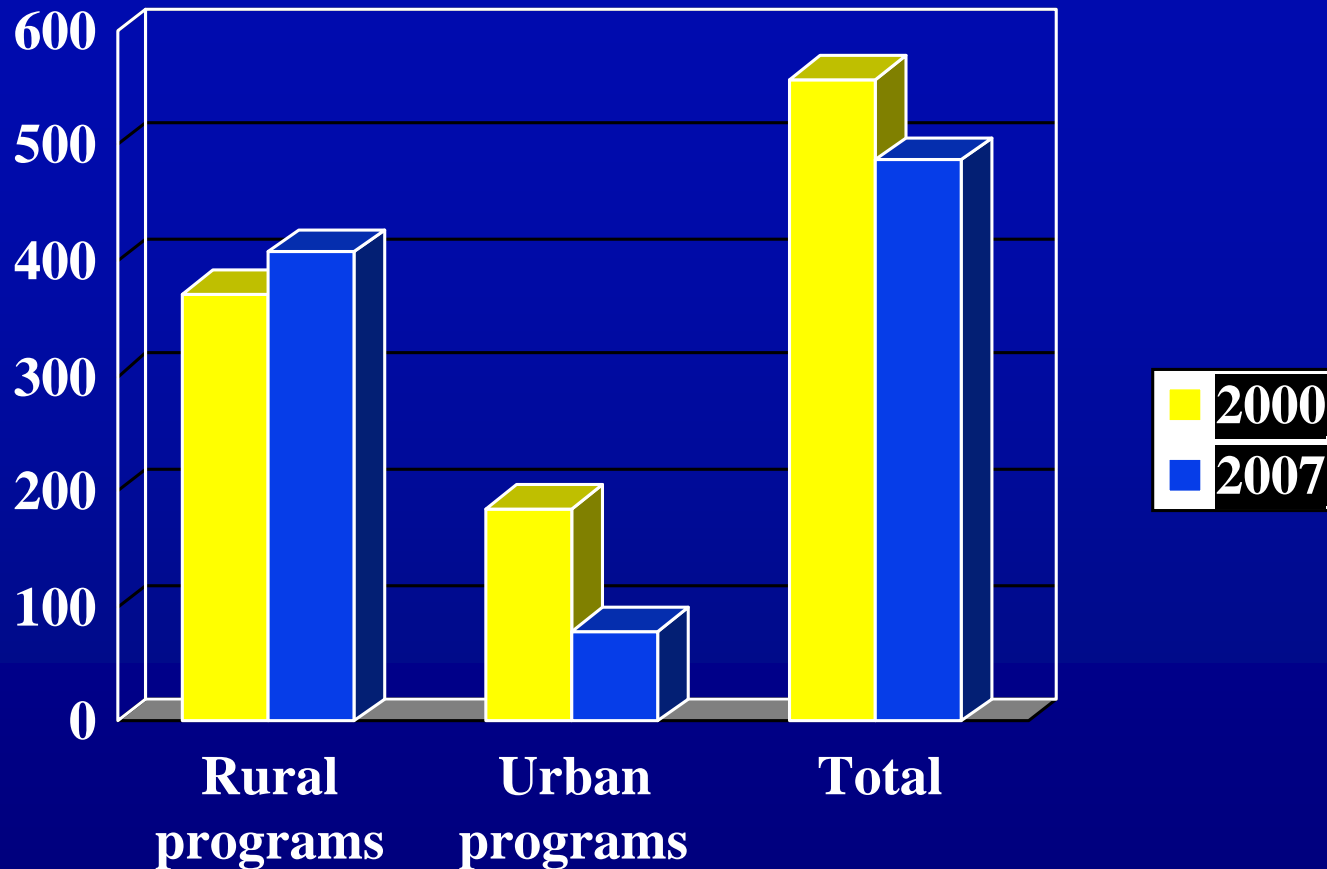
Changes in Rural Training Opportunities

- Within primary care, family physicians constitute the largest proportion of the rural and inner city primary care physician workforce.
- The availability of family medicine residency training opportunities in rural, inner city, and health center locations provides a critical mechanism for supply in the highest need areas.
- Yet training opportunities in rural and inner city ambulatory locations are under threat.

Chen FM, et al. Policy brief: the availability of family medicine residency training in rural locations of the United States. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, June, 2009.

Trends in the Primary Care Workforce

Change in Rural Training FTEs

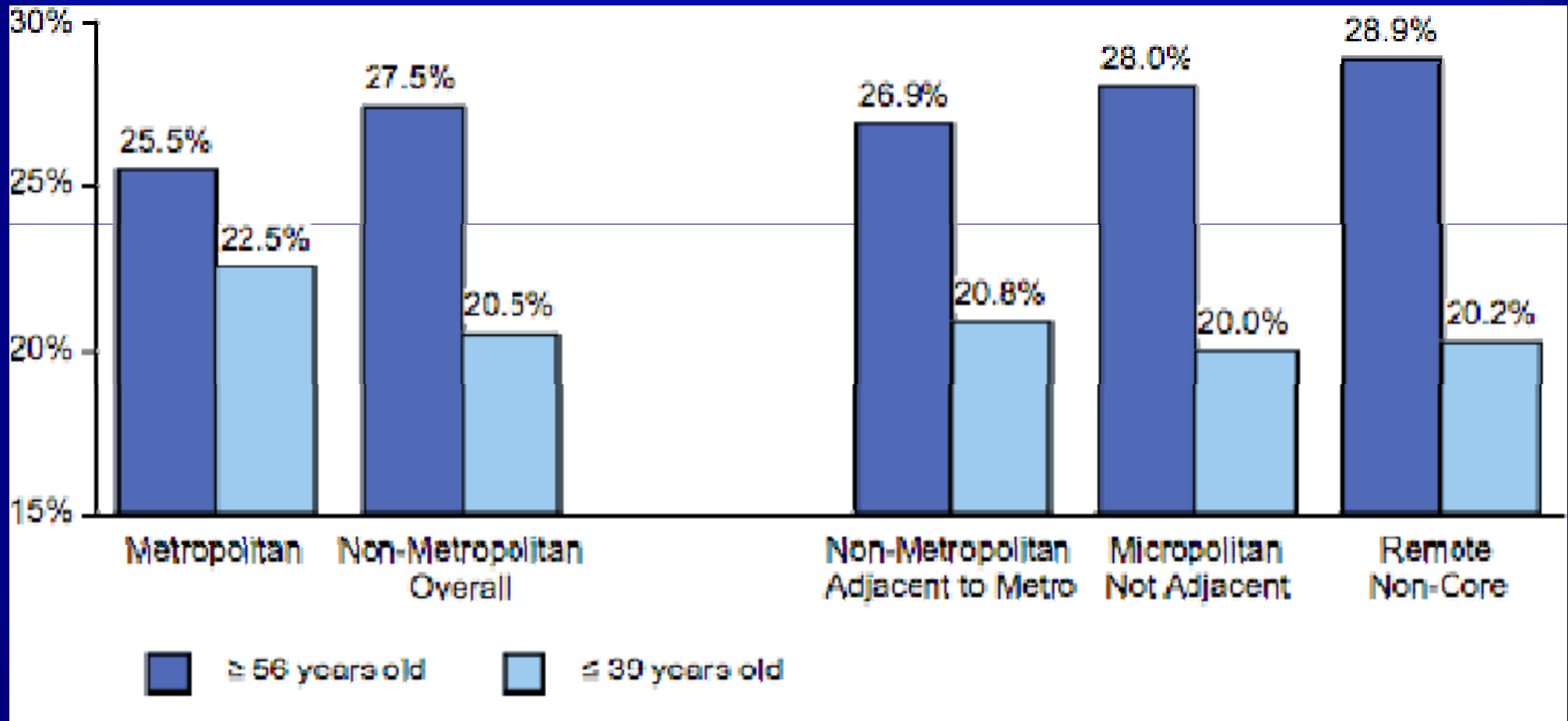


Chen FM, et al. Policy brief: the availability of family medicine residency training in rural locations of the United States. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, June, 2009.

Trends in the Primary Care Workforce

The “Graying” of Primary Care Physicians

Near-Retirement Age Primary Care Physicians



Doescher MP, et al. Policy brief: the aging of the primary care physician workforce: are rural locations vulnerable? Seattle, WA: WWAMI Rural Health Research Center, University of Washington; June, 2009.

Trends in the Primary Care Workforce

Increasing Reliance on DOs and IMGs

Evidence

- In 2005, osteopathic physicians comprised 7.8% of the primary care physician workforce and 4.9% of all physicians.
- Osteopathic medical schools are expanding.
- In 2005, international medical graduates comprised 25.4% of the primary care workforce and 22.2% of all physicians.
- Over the past three years, the majority of family medicine residency slots have been filled by IMGs and DOs.

Fordyce MA, et al.; 2005 physician supply and distribution in rural areas of the United States. Final Report #116. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; Nov 2007.

Trends in the Primary Care Workforce

Increasing Reliance on NPs and PAs

Evidence

- 34% of the primary care workforce in Wyoming.
- 46% of the direct clinical care providers at rural CHCs.
- Yet the question of whether PAs and NPs will continue choosing primary care careers has not been answered.

Skillman SM, et al. Wyoming primary care gaps and policy options. Final Report #122. Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington; Dec 2008.

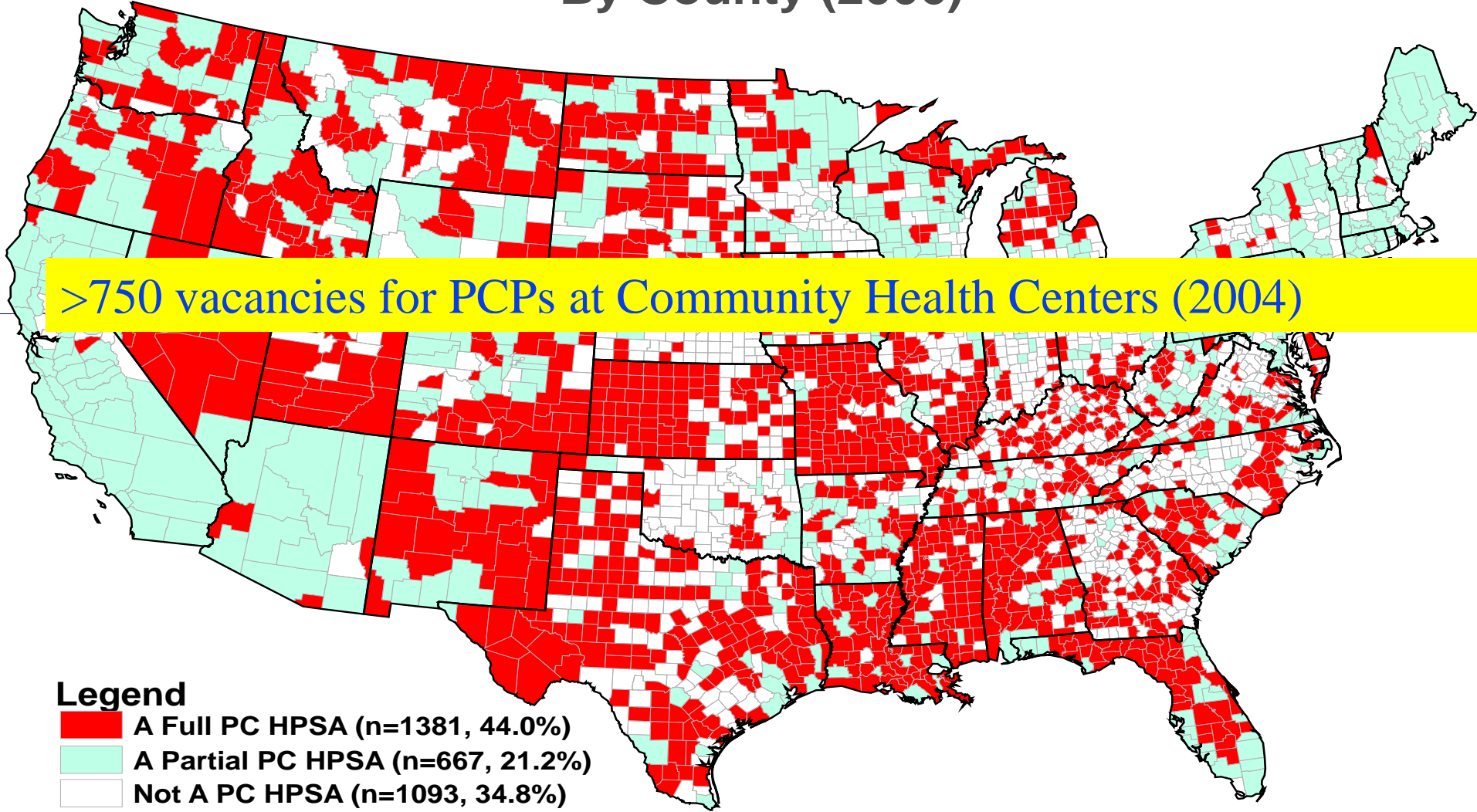
Trends in the Primary Care Workforce Community and Migrant Health Centers

Evidence

- In 2004, CHCs had high proportions of unfilled positions
 - roughly one third of CHCs spent over 7 months recruiting a family physician.

Rosenblatt RA, et al. Shortages of medical personnel at community health centers: implications for planned expansion. JAMA. Mar 1 2006;295(9):1042-1049.

US Primary Care Health Professional Shortage Areas By County (2006)



Data Source: HRSA (08/03/2006)

Prepared by The Robert Graham Center

Trends in the Primary Care Workforce

Decline of Primary Care in the U.S.

- Estimates suggest that increased insurance uptake under health care reform would increase the workload of existing primary care physicians by roughly 30% between now and 2025.
- By the same period, the supply of primary care physicians will rise by only 7%.
- This would lead to a shortfall of 35,000 to 44,000 primary care physicians who treat adults.
- Overall population growth and a growing elderly population are driving the projected shortfall.

**Source: Spyros Andreopoulos. Doctor shortage imperils Obama's health care reform
San Francisco Chronicle, Sunday, December 21, 2008**

Part 3: The Primary Care Pipeline

Factors that Influence Supply

1. Factors before health professions school matriculation
2. Educational environment:
3. Practice environment
 1. Compensation and debt burden
 2. Work/life satisfaction: long working hours; the complexity of dealing with chronically ill patients; paperwork

The Challenge: Most training is in the Academic Health Centers...



**...but we need folks who choose
to work here...**



...and here.



The Primary Care Pipeline

Factors before medical school matriculation

We do not do a good job of producing our own primary care workforce.

E.g., rural physicians are 3x more likely than their urban counterparts to come from a rural background and there may be an inner city parallel.

But many rural and urban educational systems are inadequate to the task of producing health care professionals.

The Primary Care Pipeline

Factors before medical school matriculation

We need to improve K-12 education. One of the most effective “health care reform” policies might be to systematically improve educational quality in rural and inner city communities.

Rural and inner city school districts and states must ensure that students have adequate preparation to gain admission to and perform well in health professions schools.

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Factors during health professions training

Admissions

Schools can have a major impact on the number of primary care providers by admitting students with an early interest in primary care and those who grew up in rural and inner city locations.

In other words, schools can be effective not only as passive conduits to careers, but also as settings which reinforce the aspirations of students who will later become primary care providers.

The Primary Care Pipeline

Factors during medical school and residency

Admissions

Location of upbringing

Plan to become primary care provider (earlier the better)

Size and type of undergraduate college

Objective, unbiased admissions process, including unbiased interviews

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The Role of States

Admissions

States have an obligation to meet the health care needs of their residents.

So, state-supported medical schools could take an active role in designing the admissions process to best meet those needs.

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Factors during medical school and residency

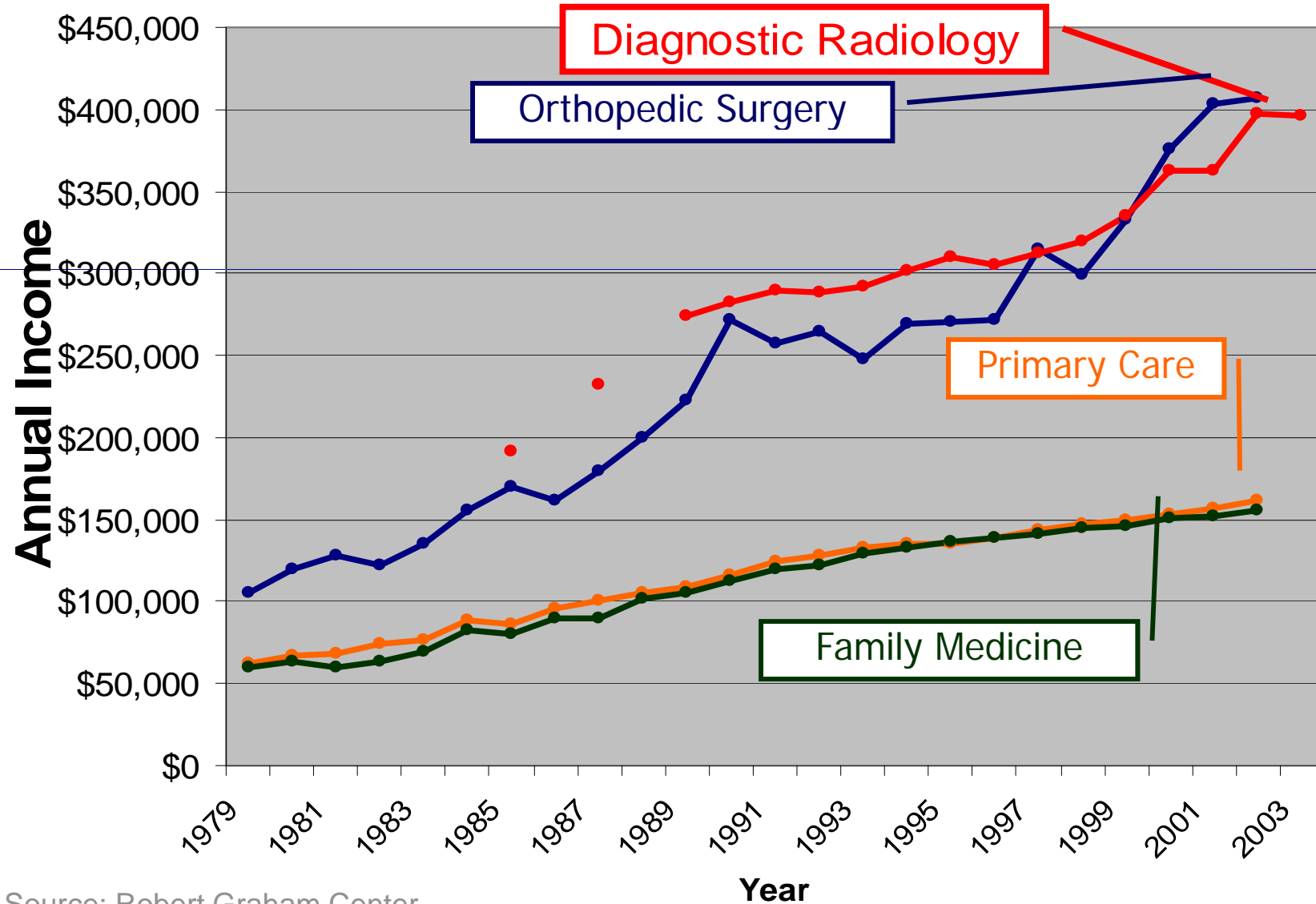
Curricula

Intensive long-term relevant integrated clinical curriculum

- Multiple primary care courses and rotations
 - For physicians, residency program which reinforces primary care values, and provides relevant skills for ambulatory rural and inner city settings
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- **Other Factors**
 - Manageable student debt (<\$150,000 for physicians)
 - Strong psychosocial support for students
 - Institutional values and commitment

Factors affecting the practice environment

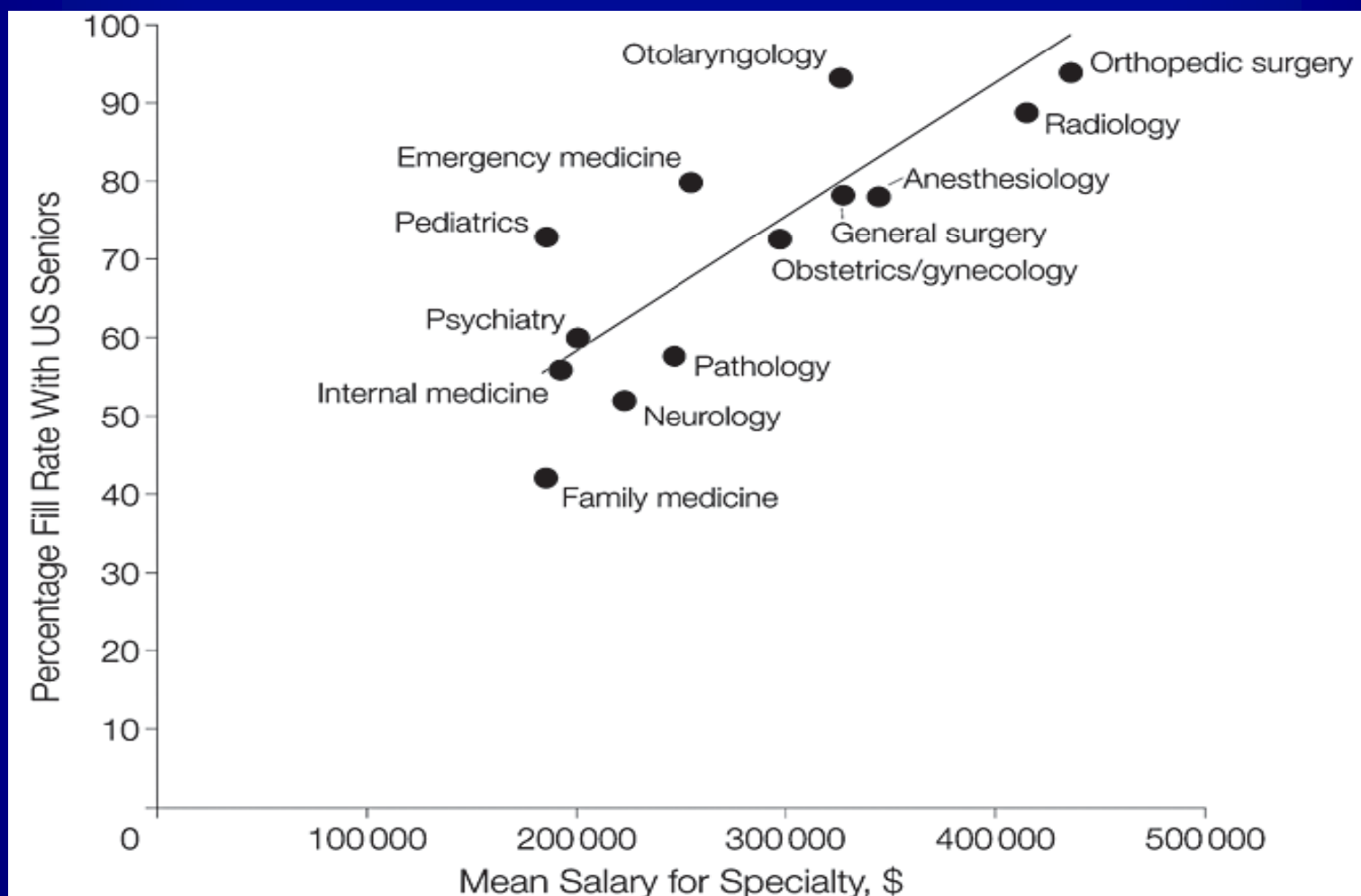
The Widening Physician Payment Gap



Source: Robert Graham Center

The Primary Care Pipeline

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



Ebell, M. H. JAMA 2008;300:1131-1132.

The Primary Care Pipeline

Factors affecting the practice environment

Lifestyle

A primary care physician with a panel of 2500 average patients would spend:

7.4 hours per day to deliver all recommended preventive care.

10.6 hours per day to deliver all recommended chronic care services.

Yarnall et al. Am J Public Health 2003;93:635.
Ostbye et al. Annals of Fam Med 2005;3:209.

The Primary Care Pipeline

Policies affect primary care career choices

- Provider payment
- Training pipeline
- Infrastructure investment and practice redesign

The Primary Care Pipeline Payment

Fee for service payment

- 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.
- Many primary care experts, such as the AAFP, recommending: 20+% increase.

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Payment: Medicare

Sustainable Growth Rate (SGR)

Congress created the SGR formula to control Medicare spending by setting yearly targets for total Medicare physician expenditures.

Each year, if total physician expenditures exceed a target, the SGR mandates Congress to reduce the conversion factor to bring MCR physician spending back into line.

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Payment: Medicare

Sustainable Growth Rate (SGR)

Currently 6 separate groups of expenditure targets lumped into a single CF:

Evaluation and management (E&M)

1. primary care and preventive services
2. other E&M services

Non-evaluation and management (non-E&M)

1. imaging services and diagnostic tests (other than clinical diagnostic laboratory tests)
2. major procedures
3. anesthesia services
4. minor procedures/other physician services

Having 2 separate SGR pools, one for E&M and the other for non-E&M services could strengthen financing for primary care and other non-procedural disciplines.

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Funding for Medical Education Programs

- Title VII and VIII 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)

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Research on Title VII Section 747 Programs

- Research shows that 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

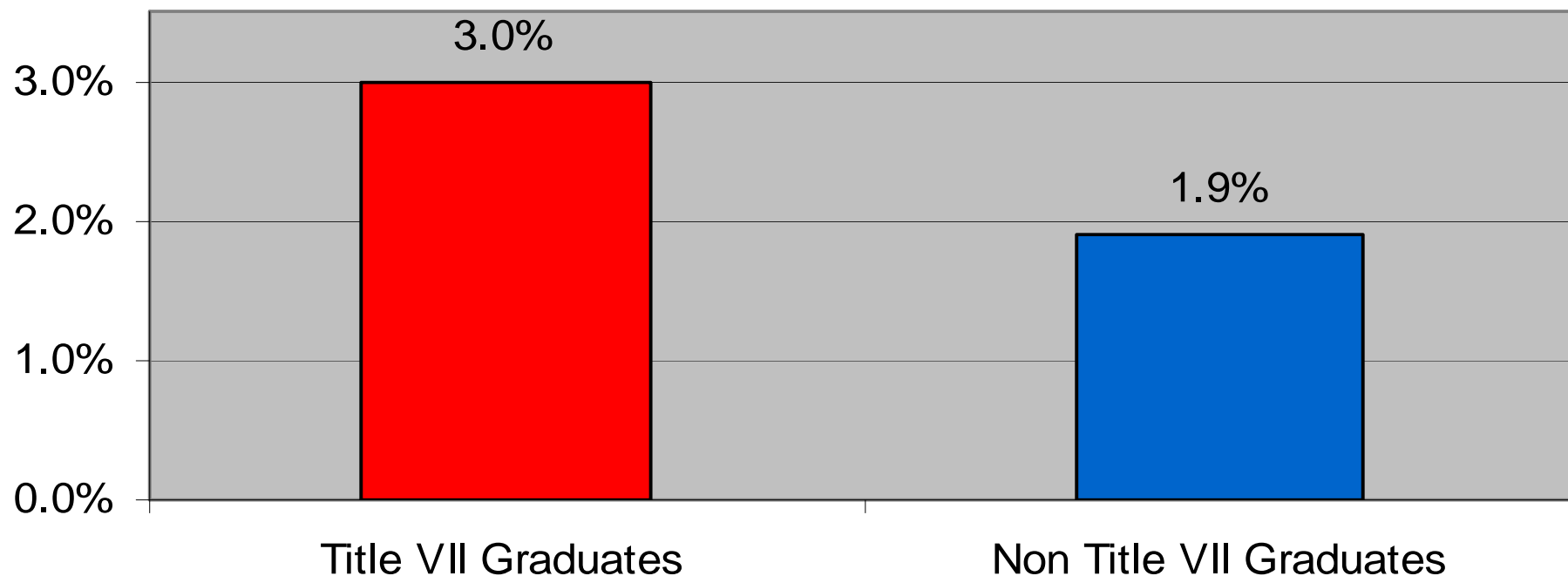
Source: D Rittenhouse et al. Ann Fam Med 2008;6(5):397-405.

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Research on Title VII Section 747 Programs

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

Percent of Physicians Working in CHCs
(2001-2003)

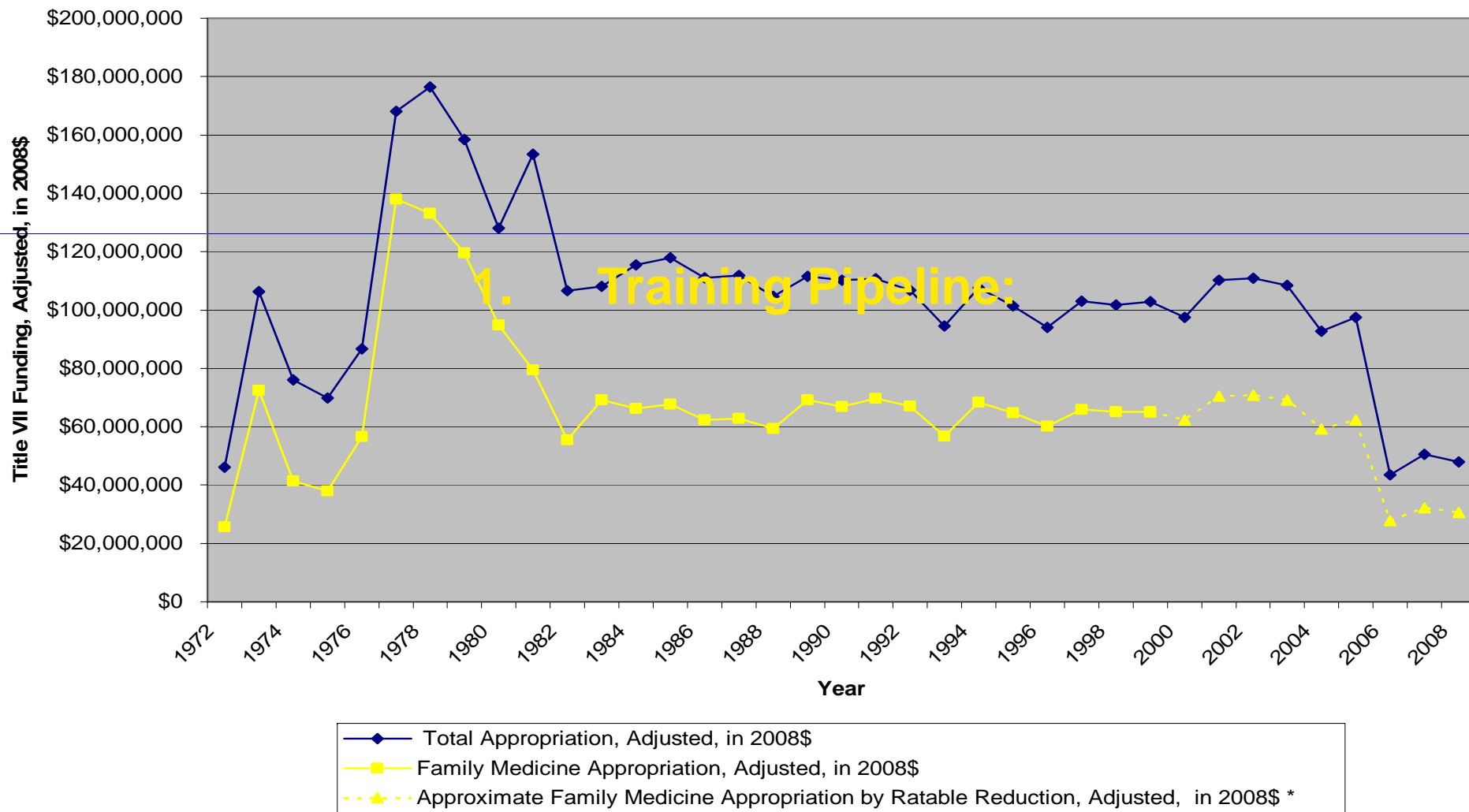


Source: D Rittenhouse et al, Ann Fam Med, 2008

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Title VII Section 747 funding appropriations (in 2008 dollars)

Title VII Funding Over Time, Adjusted for Inflation



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Title VII Section 747 programs

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.”

- AAFP recommended an increase in the fiscal year 2008 appropriation bill provide at least \$300 million for Title VII, including \$92 million for the Section 747, the primary care medicine and dentistry cluster (which would restore the program to its fiscal year 2003 level).
- ARRA: Secretary Sebelius recently announced that \$48 million of the \$200 million in ARRA funds for Title VII and VIII would be applied to support the the primary care medicine and dentistry cluster.
- \$264 million is in the Obama 2010 budget for Title VII of which 56 million is budgeted for the primary care medicine and dentistry cluster.

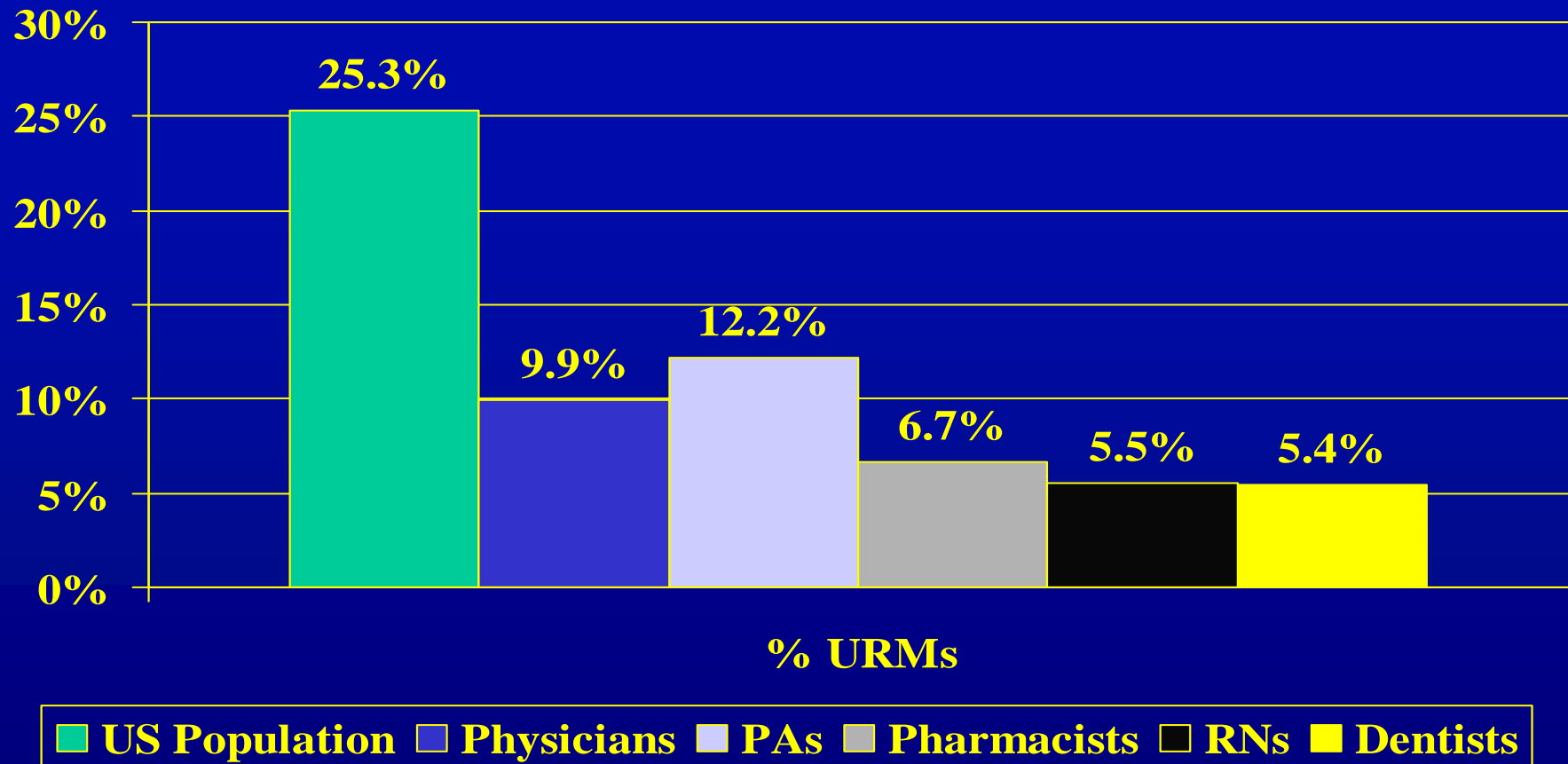
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Programs focusing on diversity

- Widening gap between racial and ethnic composition of US population and physicians and other health professionals.
- Communities are increasingly diversifying.
- Implications for access and quality of care in rural and inner city locations are not well understood.

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Underrepresented minorities* as % of US population and selected health professions



*African Americans, Latinos, American Indians

The Primary Care Pipeline Diversity

Program	FY 2005 (\$million)	FY 2006 (\$million)	2009 ARRA*/ 2009 Omnibus	Proposed FY 2010 (\$million)
Health Careers Opportunity Program (HCOP)	\$35.6	\$4.0	TBD/ \$19.0	\$22.0
Centers of Excellence (COE)	\$33.6	\$11.9	TBD/ \$21.0	\$25.0

* On July 28, 2009, Secretary Sebelius announced that \$10.2 million of the remaining ARRA funds would be applied to increasing the diversity of the health professions workforce.

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The Role of the States

One of the main ways that states support health professionals is by providing general revenue appropriations for (mostly undergraduate) medical, dental, nursing and allied health education.

In 2004-2005, medical school revenues from state and local government general funds totaled more than \$4 billion.

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Residency Education

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.”

The Primary Care Pipeline

Recommendations of COGME 19th Report to Congress: *Enhancing Flexibility in Graduate Medical Education (2007)*

Align Medicare GME with future needs

Broaden the definition of “training venue”

Remove regulatory barriers limiting flexible
GME training programs and venues

Make accountability for the public’s health the
driving force for Medicare GME

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The Role of the States in GME

Medicaid GME

- State Medicaid programs are not obligated to pay for GME, but since its inception, some states have used Medicaid revenues to pay for a portion of GME.
- State support for GME may include:
 - * Operating subsidies to teaching hospitals and clinics
 - * Direct support of clinical education programs
 - * Medicaid reimbursement to hospitals for teaching cost

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The Role of the States: GME

- Most states also appropriate funds directly for residencies in primary care, especially family medicine.
- Legislators in many states say support for residency training is one solution to the health care access problems many rural residents and indigent populations face.
- Also, studies have found that state support is important to many nurse practitioner and physician assistant training programs.

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Proposed Medicare GME legislation: S.973 (Nelson) and H.R.2251 (Crowley)

Include provisions for “protecting” primary care and general surgery

“The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions.”

These bills, however, would allow growth in the capacity for subspecialty training.

Both versions also would rely on having more international medical graduates from developing countries to fill the expansion in training slots.

The Primary Care Pipeline

Post-Training Pipeline: Initial Practice Location

- 6000 sites seeking NHSC placements in 2008:
 - 950 applicants for 76 NHSC scholarship awards
 - 2,713 applicants for 867 NHSC loan repayment awards .
- 2009 ARRA: Initial \$300 million; Obama 2010 budget: \$169 million.
- On July 28, 2009, Secretary Sebelius announced that of the \$200 million remaining in ARRA, \$80.2 million would be applied for scholarships, loans, and loan repayment awards to students, health professionals, and faculty. Of those funds, \$39 million would be targeted to nurses and nurse faculty, \$40 million to disadvantaged students in a wide range of health professions, and \$1.2 million to health professions faculty from disadvantaged backgrounds.

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Post-Training Pipeline: The Role of the States

- Beginning in the 1980s, many states began to require that recipients of state-level health professions scholarship and loan programs (in nursing, dentistry and some allied health fields) repay that assistance by practicing in a medically underserved area of the state for a set period of time.
- The effectiveness of these initiatives in terms of improving recruitment and retention of health professionals in these settings is not known.

The Primary Care Pipeline

Post Training: Practice support

Health Information Technology

- Invest in hardware & software in ambulatory care settings and hospitals.
- Support Interoperability
- Make sure new computers with EMRs are actually used.

The Primary Care Pipeline

Post Training: Practice support

Networks/Care Coordination

- Emergency Care
- Specialist Care
- “Lifestyle” support: e.g., after hours call coverage, shared practice arrangements, etc.

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Post Training: Practice support

Patient-Centered Medical Home

E.g., Medicare 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 “demonstration” to larger “pilot” program.
- Some states are funding medical home pilot projects.

Part 4

Conclusions and Discussion

- Primary care should serve as the foundation of the patient care workforce.
- The example of primary care training was used to illustrate how local, state and federal policies could be crafted to support provider payment, the training pipeline, and the practice environment in rural locations.
- Now, let's hear from you: how we can ensure a bright future for the primary care workforce?