HEALTH CARE REFORM AND PRIMARY CARE:
Where Do We Stand and Where are We Going?
Robert B. Baron MD MS
Professor and Associate Dean
UCSF School of Medicine

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Health Care Reform and Primary Care
- The crises in US health care and primary care
- What is the Accountable Care Act and how does it affect us as providers and patients
- Why reform of primary care is an essential ingredient in health reform
- Primary care provisions in the health reform bill
- Potential practice changes that address the crises

I currently practice primary care
1. Yes
2. No
3. Sometimes
If yes, how large is your practice?
1. Solo
2. Small group (6 PCPs or less)
3. Larger group (7 or more PCPs)
4. Hospital-based outpatient clinic

What I like best about my primary care practice is:
1. Building ongoing relationships with patients
2. Serving as the “quarterback” in my patient’s care
3. Working as part of a great team
4. Continuing to learn by interacting with primary care colleagues and specialists
5. Seeing patients with a wide variety of important clinical issues
6. Making a good salary

What I like least about my primary care practice is:
1. Time pressures
2. Our new electronic health record
3. Difficult patients
4. Caring for patients with minor health issues
5. Inadequate financial compensation

Why Health Reform Now?
- Access is worsening
  - 49 million Americans lack health insurance
  - 38 million 10 years ago
- Health outcomes are inferior
  - USA: 31st life expectancy, 37th infant mortality
- Costs continue to escalate
  - 1993: $1 trillion, 2012: $3 trillion
  - National spending/ person
    - 1960: $1,066
    - 2007: $7,421
    - 2018: $13,100
US is an Outlier in Medical Spending

National Income and Medical Spending
(US Dollars, 2006)

Legend for Figures 1.1 through 1.4
1. Australia 10. Greece 19. Poland
4. Canada 13. Italy 22. Spain
7. Finland 16. South Korea 25. United Kingdom
9. Germany 18. New Zealand

Data source: OECD

US Life Expectancy is Poor Value

Medical Spending and Life Expectancy at Age 25

IOM Estimates of Excess Health Care Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>Costs ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary services</td>
<td>$210</td>
</tr>
<tr>
<td>Inefficient delivery</td>
<td>$130</td>
</tr>
<tr>
<td>Excess admin. costs</td>
<td>$190</td>
</tr>
<tr>
<td>Prices that are too high</td>
<td>$105</td>
</tr>
<tr>
<td>Missed prevention opps</td>
<td>$55</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$765 (30% of total U.S. expenditures)</strong></td>
</tr>
</tbody>
</table>

The Health Care Imperative, 2010

Patient Protection and Affordable Care Act (ACA)
March 23, 2010
Patient Protection and Affordable Care Act

- A study in what is possible (health politics): winners, losers, imperfections, omissions
- Not ideal health policy: which policies, structures, and financing lead to optimal clinical and economic health outcomes?

Patient Protection and Affordable Care Act (ACA)

First step: Expand access to health insurance
- Everyone has coverage
- Fairer insurance practices
- Expand coverage to 32 million by 2019

Second step: Improve quality of care
- Change the practice of medicine

Third step: Stabilize cost of health care
- Reduce waste and fraud
- Improve efficiency

The ACA is just the beginning of needed health reform

Expanding Access: A Three Part Formula

- Insurers must offer coverage to everyone, regardless of pre-existing conditions
- Subsidies to help people to afford coverage
- Everyone must have health insurance
  - Risk pool must include healthy people to keep premiums affordable
  - Only way to cover those with pre-existing conditions

The Individual Mandate

- All citizens, legal immigrants must have coverage
- Tax penalty if no coverage (by 2016)...higher of:
  - $695/person; up to 3 times for a family, or
  - 2.5% of household income
- Exemptions granted for
  - Undocumented persons
  - No coverage for less than 3 months
  - Lowest cost plan > 8% personal income
  - Financial hardship
  - Religious objection
**Initiatives to Improve Quality of Care**

- **PQRI: Physician Quality Reporting Initiative**
  - Medicare payments increased (up to 2%)
  - Data used for “Physician Compare” website (2013)
  - Facilitate the use of electronic health records
- **ACOs: Medicare Accountable Care Organizations**
  - Similar to PHOs (physician-hospital orgs); capitated
- **PCORI: Patient Centered Outcomes Research Institute**
  - Comparative Effectiveness Research
- **Tort reform**
  - $50 million over 5 years to evaluate liability reform

**Physician Payment Reform**

- **Medicare**
  - 10% PCP bonus if charges for office visits, SNF and home visits are >60% total Medicare payment
  - 10% Gen Surgeon bonus in shortage areas (2011-16)
  - Mental health services: 5% bonus
- **Medicaid**
  - PCPs paid Medicare rates for E/M visits, in 2013-14
- **Independent Medicare Advisory Board (IMAB) 2015**
  - Recommend payment cuts, but not services
- **Medicare Value Based Payment Modifier (2015)**
  - Adjustment to rates based on quality & cost performance

**Center For Medicare and Medicaid Innovation**

- Test innovative payment and delivery models for Medicare, Medicaid, CHIP while slowing growth in costs
- Examples:
  - Independence at Home demonstration
  - Community-based Care Transitions Program (Hospital partnerships with community-based organizations)
  - Medical homes (3 models)
  - Health Care Innovation Challenge
  - Accountable Care Organizations (ACO), Pioneer ACOs
  - Bundled payments
  - Comprehensive Primary Care Initiative

**Preventive Services**

- Specified preventive services must be covered with no cost-sharing (no out-of-pocket costs)
- Applies to private and public programs
  - (New) Private insurance policies 2010
  - Medicare, Medicaid 2011
  - State insurance exchanges 2014
- Improves coverage for preventive services in many individual and small group plans
Preventive Services

- Preventive services include:
  - USPSTF grade [A] or [B] recommendations
  - AAP Bright Futures recommendations for adolescents
  - CDC ACIP vaccination recommendations
  - Contraception

Health Care Reform Scorecard

Potential Winners

- Most of the uninsured
- Patients insured by individual and small group plans
- Women’s health services
- Children under 26 yrs old
- Primary care providers
- NPs, PAs, CNMs
- Insurance companies
- Pharma companies

Potential Losers

- Undocumented persons
- Women needing abortions
- Most specialists
- Medicare Advantage
- Poor in states that don’t expand Medicaid
- Poor in states without state exchange if federal exchanges can’t provide premium support

Bending the Cost Curve: Issues Not Addressed

- Reducing patient demand for unnecessary services
- Financial incentives in fee-for-service practice
- Inefficiencies in end-of-life care
- Duplication, inefficiency and waste
- Regional and geographic variations
- Insurance fraud
- Restrictions on health policy and payment based on comparative outcomes research

Senator Daschle, Senate HELP Ct Confirmation Hearing Jan 8, 2009: “Every country starts at the base of the pyramid with primary care, and they work their way up until the money runs out.”

…”We start at the top of the pyramid, and we work our way down until the money runs out...And so we have to change the pyramid. We have to start at the base.”
Randy MacDonald, Senior VP IBM
House Ways and Means Hearing April 29, 2009
- “I will start with the very last question asked by the committee--what is the single most important thing to fix in healthcare? Primary care. Strengthen primary care -- transform it and pay differently using a model like the Patient Centered Medical Home.”
- Congressman: “And the second issue?”
- “Well, if you don’t fix the first issue and do not have a foundation of powerful primary care then you can do nothing else. You have to fix primary care before you can even begin to address a second issue.”

Abundant 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

But the Primary Care Foundation in the US is Crumbling
- Plummets numbers of new physicians entering primary care and burnout among PCPs
- Growing problems of access to primary care and “medical homelessness”
- Dysfunctional systems that are not delivering the goods in primary care

Residency Match, 2012
% of graduating US medical students choosing specialties
**Why?**

Reasons for lack of interest in primary care careers

- PCPs earn on average 54% of what specialists earn; average med student debt $170,000

- Worklife of the PCP is stressful. Younger MDs care more about issues of work life balance

- Medical schools are often toxic to primary care “You are too smart for family medicine”

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**Stressful Worklife**

- Survey of 422 general internists and family physicians
  - 48%: work pace is chaotic
  - 78%: little control over the work
  - 27%: definitely burning out
  - 30%: likely to leave the practice within 2 years


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**Projected shortages of patient care physicians, 2008 to 2020**

Projections prepared by the Lewin Group for the AAMC
Shortages projected for both primary care and subspecialists

<table>
<thead>
<tr>
<th></th>
<th>Primary Care</th>
<th>Subspecialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>9,000</td>
<td>4,700</td>
</tr>
<tr>
<td>2015</td>
<td>29,800</td>
<td>33,100</td>
</tr>
<tr>
<td>2020</td>
<td>45,400</td>
<td>46,100</td>
</tr>
</tbody>
</table>

Source: AAMC Projections, 2010

Health Care Reform: likely workforce implications

32M newly insured?

- Utilization
- Physician demand

Bend the cost curve?

- Efficiency
- Cost sharing
- Physician demand

M.D. and D.O. growth since 2002 for current schools

- M.D.
- D.O.
The number of residents entering the ACGME pipeline grew 7% between 2002 and 2010

Source: ACGME

Unless GME Positions Grow, Someone Likely to be Squeezed Out

Projected Growth in MD and DO Entrants into GME

36,000 Currently Available Residency Positions

IMG GME Entrants

DO GME Entrants

MD GME Entrants

Rate of USMDs likely to become PCPs stabilizing?

Percent USMD PGY-1 Residents Likely to Become PCPs

Thirty years of USMD match rates into Family Medicine

Percent of US Medical School Seniors* Matching into Family Medicine

* Includes only those seniors who were matched

Source: GME Track (Paul Jolly)
Notes: Percent equals 1) number USMDs entering IM, FM, or Peds minus number entering IM Subspecialties or Peds Subspecialties that same year 2) divided by number of PGY1 entrants.
PA Growth

Newly Certified PAs, 2000 - 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Newly Certified PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>4,051</td>
</tr>
<tr>
<td>2000</td>
<td>4,235</td>
</tr>
<tr>
<td>2001</td>
<td>4,512</td>
</tr>
<tr>
<td>2002</td>
<td>4,654</td>
</tr>
<tr>
<td>2003</td>
<td>4,889</td>
</tr>
<tr>
<td>2004</td>
<td>5,215</td>
</tr>
<tr>
<td>2005</td>
<td>5,243</td>
</tr>
<tr>
<td>2006</td>
<td>5,823</td>
</tr>
<tr>
<td>2007</td>
<td>6,009</td>
</tr>
<tr>
<td>2008</td>
<td>4,098</td>
</tr>
<tr>
<td>2009</td>
<td>4,393</td>
</tr>
<tr>
<td>2010</td>
<td>4,654</td>
</tr>
<tr>
<td>2011</td>
<td>4,989</td>
</tr>
</tbody>
</table>

Source: National Commission on Certification of Physician Assistants
"Certified Physician Assistant Population Trends (PA-Cs)"

Growth in NP Graduates 2000 - 2011

Newly Licensed PAs

Counts include master’s and post-master’s NP and NP/CNS graduates, and Baccalaureate-to-DNP graduates.

Primary vs. Specialty Care

Distribution of Active Practitioners Across Primary Care and Specialty Care, 2010

<table>
<thead>
<tr>
<th>Role</th>
<th>Primary Care</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPs</td>
<td>52.0%</td>
<td>48.0%</td>
</tr>
<tr>
<td>PAs</td>
<td>43.4%</td>
<td>56.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>33.5%</td>
<td>66.5%</td>
</tr>
</tbody>
</table>


The Diagnosis

The fundamental pathology of primary care:

The 15-minute visit

In primary care, time just flies by
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
  - 10.6 hours per day to deliver all recommended chronic care services


The dilemma

- Panel size too large for average PCP to manage alone (2300 average in US)
- Can’t reduce panels due to worsening shortage of PCPs
- Shortage = larger panels, poorer access for patients, poorer quality, more PCP burnout
- More PCP burnout means fewer students attracted to primary care
- Doomsayers: it could become a primary care death spiral

But...

- Upsurge of energy within primary care practices and clinics all over the country
- Intelligence and dedication of many people working in primary care: nurses, clinicians, medical assistants, practice leaders

Transforming Practice Group Health Factoria Clinic

- Panel size reduced from 2300 to 1800
- Visit length increased from 20 - 30 minutes
- 1/3 face-to-face, 1/3 phone, 1/3 email
- Physician burnout dropped from 25% - 14%
- Burnout in control clinics grew from 28% - 35%
- Quality measures improved
- Patient experience measures improved
- $1 million investment recovered in one year by reduced ED visits and hospital admissions
- After 21 months, savings of $10.30 pmpm compared to control clinics

Reid et al. Am J Managed Care 2009
Reid et al. Health Affairs May 2010
Primary Care Progress I

- Providing improved diabetes, asthma, CHF, cholesterol, hypertension management
- Made possible by
  - Chronic Care Model
  - New culture of measurement

Primary Care Progress II

- Deep transformation of primary care
  - Continuity of care
  - Access
  - Empanelment
  - Proper panel size
  - Teams
  - Caring for populations in addition to individuals
- Patient-centered medical home

What Do We Mean By The Patient-Centered Medical Home?

4 Cornerstones of the PCMH
- Primary Care
- Patient-Centered
- New Model Practice
- Payment Reform

Vision of the primary care practice of the future

- Re-create -- with high clinical quality -- the solo practice GP/nurse teamlet in our far more complex system
- Teamlets similar to the GP/nurse responsible for a panel of patients. Patients trust the teamlet, teamlet knows the patients
- Most teamlets are clinician (MD, NP, PA) and medical assistant (MA)
**Priority #1: Continuity**

*Requires* Empanelment

*Leads to* Panel size

*Determines* Access

**Teams**

**Culture:** Agree that continuity comes first

- **Teamlet of the present**
  - Patient panel
  - Clinician
  - Tasks
  - MA

- **Teamlet of the future**
  - Patient panel
  - Clinician/MA teamlet

**Practice of the future:**
Primary care in an era of shortage

- PCPs: 8 - 10 face-to-face visits/day. Reduces burnout
- Serious investment in team building
- Team’s panel, not physician’s panel
- About 100 patients “touched” each day: e-mail, phone, group visits, visits with other team members
- Patients not requiring PCP expertise see other team members. PCPs needed for building relationships, diagnosis, complex management, transitions, training and mentoring team
- Physicians see new patients, introduce team
- Payment reform required

*Margolius and Bodenheimer, Health Affairs, 2010*
### Template of the Past

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary Care Physician</th>
<th>Medical Assistant</th>
<th>Nurse</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Patient A</td>
<td>Assist with Patient A</td>
<td>Triage Patient H</td>
<td>Assist with Patient H</td>
<td></td>
</tr>
<tr>
<td>8:15</td>
<td>Patient B</td>
<td>Assist with Patient B</td>
<td>Injections Patient I</td>
<td>Assist with Patient I</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Patient C</td>
<td>Assist with Patient C</td>
<td>Wounds Patient J</td>
<td>Assist with Patient J</td>
<td></td>
</tr>
<tr>
<td>8:45</td>
<td>Patient D</td>
<td>Assist with Patient D</td>
<td>A bit of time left for patient education Patient K</td>
<td>Assist with Patient K</td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Patient E</td>
<td>Assist with Patient E</td>
<td>Patient L</td>
<td>Assist with Patient L</td>
<td></td>
</tr>
<tr>
<td>9:15</td>
<td>Patient F</td>
<td>Assist with Patient F</td>
<td>Patient M</td>
<td>Assist with Patient M</td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Patient G</td>
<td>Assist with Patient G</td>
<td>Patient N</td>
<td>Assist with Patient N</td>
<td></td>
</tr>
</tbody>
</table>

### Template of the Future

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary Care Physician</th>
<th>Medical Assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:10</td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10-8:30</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td>RN Care management</td>
<td>Acute patients</td>
<td></td>
</tr>
<tr>
<td>8:30-9:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:30</td>
<td>Complex patient</td>
<td>Huddle with RN, NP</td>
<td>Blood pressure coaching clinic</td>
<td>Huddle with MD</td>
<td></td>
</tr>
<tr>
<td>9:30-10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Coordinate with hospitalists and specialists</td>
<td>Care management</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td></td>
</tr>
</tbody>
</table>

About 30 patients contacted/seen in 3 hours

### Primary Care Practice of the Future: Stratifying the Patient Population

Build different models for different patients. All patients cannot be funneled into 15-minute visit

- People who need same-day acute care (RN,NP,PA)
- Healthy people who need preventive care (panel managers, MAs)
- Women who need pregnancy and infant care (RN,NP,PA,MD)
- People with a chronic condition (health coaches)
- People with complex healthcare needs (MD, RN complex care manager)
- People with mental health/substance use issues (MD, behavioral health provider)
- People who need care at the end of life (MD, RN complex care manager)

### Practice of the Future: How to Start

- Start with 2 major innovations
  - Panel management
  - Complex care management
**Panel management**

- Patients needing routine preventive and chronic care
- Requires a registry
- Requires panel managers (often MAs) to comb registry for care gaps
- Panel managers identify patients with care gaps, contacts patients and orders services
  - Preventive: mammograms, FOBT, immunizations, etc.
  - Chronic: HbA1c, LDL cholesterol, diabetic eye exams, etc.
- Panel managers work with standing orders written by physicians

**Complex care management**

- Complex, high-cost patients need RN or RN/social worker to work with physician
- 5 studies: care management improves care
- 4/5 studies: care management reduces costs
- Reduces physician time with complex patients
- RN complex care manager could assist patients in several practices

Bodenheimer and Berry-Millett, Care Management of Patients with Complex Healthcare Needs, RWJF 2009.

**From Medical Homes to Medical Neighborhoods**

- High performing primary care necessary but not sufficient
- Concept of “Accountable Care Organizations”
  - True integrated delivery systems
  - Virtual organizations

**Conclusion**

- Health reform will be a major issue in our lifetimes
  - Tension: demand for care and ability to pay for it
- Poor health status is the U.S. is not correctable by better health care alone
- Be open in your thinking about reform
  - **Pessimist**: Better than no change, but the ACA makes a broken system available to more people
  - **Optimist**: Be part of the solution
Conclusion

- Be open in your thinking
- Based on the reality of American health politics, covering >95% of Americans is a good first step
  - Correctly puts prevention and primary care at the center of the American health care universe
  - If quality and cost containment is successful, the ACA will revolutionize U.S. health delivery
  - The first signed legislation since 1965 to evolve from a health care market to a health care system

Current Status of Primary Care

- Time pressures, poor compensation, little respect, little interest among students
- Modest increases in reimbursement, PCMH and “neighborhoods,” team based care, reduced panel size

Advocacy Opportunities

- Primary care workforce
  - NHSC/Loan repayment
  - Title VII programs
  - Teaching Health Center GME
  - Medicare GME/Children’s GME
- Payment policy
  - Prevention services
  - Care coordination
  - On-line services/telephone services
  - Extension of Medicare and Medicaid increases
  - Rebalance of Evaluation/Management codes