NATIONAL HEALTH POLICY FORUM

Transforming Primary Care:
Implications for Practice Design and Workforce

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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Richard Baron, MD
President and Chief Executive Officer
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Don Klitgaard, MD
Medical Director
Myrtue Medical Clinic

Steven Wartman, MD
President
Association of Academic Health Centers

FRIDAY, OCTOBER 15, 2010

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(*Across from the Dirksen Senate Office Building*)

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The demand for health services in the United States is growing steadily as a result of population growth, aging, and the increasing prevalence of chronic disease. Additionally, the expansion of health insurance coverage to 32 million people under the Patient Protection and Affordable Care Act (PPACA) will place new demands on the U.S. health care workforce. In parts of the United States, especially rural and low-income communities, patient access and the supply of primary care providers were already perceived as concerns before the enactment of the PPACA.[1] These circumstances have prompted questions about whether the health care workforce will be adequate to meet future demand for services. However, to make that assessment it is necessary to take into account not only increases in demand but also how the delivery of services may change.

Deficiencies in the quality and efficiency of the U.S. health care system have prompted interest in changing the way care is organized, delivered, and financed. While some of this interest has translated into policy initiatives, there has also been an evolution in how care is delivered by individual physician practices and other organizations. The delivery of primary care services in particular has been the focus of many of these changes, which could have far-reaching implications for workforce needs. In some integrated health plans, community health centers, and innovative physician practices, for example, physicians may concentrate their efforts on patients whose care requires the breadth and depth of their training. Advanced practice nurses, physician assistants, medical assistants, and other nonphysicians may be able to provide routine services for patients whose needs are not acute or complex enough to require a physician's attention.[2] Use of information technology (IT) has further widened the scope of such practice innovations and holds the promise of involving patients more effectively in the management of their own health. These practice innovations can relieve access pressures and reduce costs. But fee-for-service payment incentives, interprofessional tensions, state practice laws, and the costs of health IT have inhibited their adoption.

PRIMARY CARE AND ITS DISCONTENTS

In practice, the term primary care denotes a loosely related array of services that may be organized in a wide variety of ways. The field encompasses preventive services and routine care as well as complex diagnostic and referral services and the management of chronic illnesses. How care is actually delivered may also vary, even within

a single practice, depending on individual patient needs and patient and provider preferences. Primary care physicians may be trained in several different medical specialties, including family practice, general internal medicine, and geriatrics. As noted above, services may also be delivered by nurses, physician assistants, medical assistants, and others, as well as by physicians. A large proportion of primary care visits occur in small physician practices, however, which typically have only limited resources for health IT and assistive personnel.

Traditional patterns of care revolve around face-to-face encounters between physicians and patients for even the most routine services. Overreliance on physician-delivered care can aggravate the twin problems of long waiting times and short visits. This production-line practice model also exhausts physicians and underuses their skills, which in turn reduces the appeal of primary care specialties to medical students, exacerbates provider shortages, and frustrates efforts to increase the primary care workforce.

Various alternative practice models have been developed in a limited number of integrated delivery systems and innovative medical groups and clinics. Medicare, Medicaid, and private payers also have experimented with payment innovations that would support alternatives, such as care-management fees, bundled payment, and variations on the "medical home" concept. Further experimentation is encouraged in the PPACA. The core concept in most of these models is the provision of care by a team of health care professionals, usually led by a physician or physician group but sometimes taking the form of nurse-managed clinics.

The mission of the team is not simply to address the needs of individual patients who come to the practice for services, but to take responsibility for the health of a population that the practice serves over time. That population would include relatively healthy people who need only infrequent routine or preventive services, others experiencing episodes of illness or injury that require short-term attention, and the chronically ill, who have single or multiple conditions that require complex diagnostic and referral services and ongoing coordination of care. Team-based care is designed around a recognition that the patient panel of a primary care practice is stratified by the severity and complexity of patient needs and that these varied levels of need can be met most efficiently and effectively by the coordinated efforts of a team that includes professionals with a variety of skills.[3] Depending on a patient's needs, that efficient and effective care may require only one or selected members of the team. Seven

years of medical training may not be needed to write a prescription for a routine urinary tract infection for an otherwise healthy adult, for example.

Physicians describe the drivers of practice change partly in terms of the problems created by a payment system that is not aligned with their everyday realities. For example, a five-member physician practice in Philadelphia with a 9,000-patient panel used its new electronic health record system to analyze the amount of "nonvisit" work the doctors did for which they did not receive direct reimbursement. On average, members of the practice handled more than 18 phone calls a day, 16 e-mails, 12 prescription refills, 19 laboratory reports, 11 imaging reports, and 13 consultation reports. Ongoing practice reorganization efforts have involved hiring a nurse to do "information triage," adjusting internal compensation so that physicians are paid for phone calls and e-mails, expanding the duties of medical assistants, and hiring a health educator to work with chronic patients on improving their management of their conditions.[4]

Another example comes from the Group Health Cooperative in Seattle, a large, integrated delivery system that in 2006 began a single-clinic experiment with enhanced staffing after encountering problems with physician burnout and declines in quality. The clinic added a physician to its staff in order to decrease each physician's caseload from 2,300 to 1,800 each. The clinic also added to its complement of medical assistants, licensed practical nurses, physician assistants, and nurse practitioners, in a team that also included a clinical pharmacist. E-mail and interactive IT were also used to provide patients with new self-management tools. The added staff relieved physicians of many routine duties, reducing the number and increasing the duration of daily patient encounters. Enhanced communications resulted in a reduction in office visits, and health improvements resulted in fewer hospitalizations among the clinic's patients, which helped offset the costs of increased staffing. Emergency room visits by the clinic's patients were 29 percent lower than at comparable Group Health clinics that were not included in the experiment, and net per-patient costs averaged $10.30 less per month after nearly two years.[5]

MANY OBSTACLES TO CHANGE

As a long-established integrated delivery system, Group Health had the resources of a large organization at its disposal, as well as a long history of collaborative staff organization. Other providers

are likely to have greater difficulties changing their practice models. Fee-for-service payment is often cited as the biggest barrier, because it rewards a high volume of physician billings and frequently does not pay for care provided by nonphysicians or for time spent on electronic communications, patient education, care coordination, and other ingredients of team-based care. Public and private payers have expressed interest in payment innovations, but new payment models that could be implemented on a broad scale have not yet emerged.[6] Interprofessional friction and state scope-of-practice laws have in some cases been a barrier to practice change. Physicians and patients who have a lifelong familiarity with the traditional model of physician-centered care may be disturbed by alternative approaches that make greater use of nurse practitioners or physician assistants during patient visits. As is the case with the introduction of electronic health records, the implementation of new practice models is likely to be disruptive in the short run and to make unpredictable demands on a practice's personnel and resources.

Transforming primary care will also entail major challenges for the education and training of the health care workforce.[7] The PPACA includes enhanced support for the training of primary care doctors, nurses, physician assistants, and others. But nursing schools and physician assistant programs have had substantial difficulties recruiting faculty and securing training sites. Greater potential income for subspecialists will continue to draw aspiring professionals away from primary care. Another important challenge will be implementing interprofessional training programs that will prepare physicians and other health professionals to work effectively together.[8]

SESSION

This Forum session will look at the evolving practice of primary care and the practice transformation that many physicians are trying to bring about. It will consider innovations already in progress, their promise, and the barriers to going further without system-wide redesign. Implications of practice redesign for health professions training will also be explored. **David Margolius**, a student at the Alpert Medical School at Brown University, has done research and consulting on improving primary care practice. He will provide an overview of the basic elements of practice transformation. **Richard Baron, MD,** president and chief executive officer of Greenhouse Internists in Philadelphia, will describe the steps his practice has taken to improve the quality and efficiency of the care it provides

and the lessons of this experience. **Don Klitgaard, MD,** medical director of the Myrtue Medical Center in Harlan, Iowa, will describe the efforts of a rural family practice to adopt electronic health records and team-based care, improve clinical processes, and develop wellness programs for its patients. **Steven Wartman, MD,** president of the Association of Academic Health Centers, will discuss the implications of new models of primary care practice for the education and training of physicians and other health professionals.

KEY QUESTIONS

- What are models for the delivery of primary care that promote efficiency and make optimal use of the skills and training of the full array of clinicians, including physicians, nurse practitioners, physician assistants, and others? What changes are already occurring?
- How can a critical mass of primary care physicians be motivated to change practice models in the direction of more efficient, team-based care?
- What will enable smaller practices to make such changes? Are there achievable, intermediate steps for them to take on the path to team care? Capitation payments have made such changes possible for some larger organizations. What payment changes could help smaller practices achieve similar results?
- How do we assess and ensure the adequacy of our capacity to train sufficient numbers of nurse practitioners, physician assistants, and other health professionals? What changes might help produce an optimal future workforce in terms of numbers and mix of professionals, skills, and capacity to practice according to these new models of care?
- How can educational institutions best introduce appropriate interprofessional training?

ENDNOTES

1. Thomas Bodenheimer and Hongmai Pham, "Primary Care: Current Problems And Proposed Solutions," *Health Affairs,* 29, no. 5 (May 2010): pp. 799–805.

2. Robert J. Reid *et al.*, "The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers," *Health Affairs,* 29, no. 5 (May 2010): pp. 835–843. See also Barbara J. Culliton and Sue Russell, Eds., "Who Will Provide Primary Care and How Will They Be Trained," proceedings of a conference sponsored by J.H. Macy Foundation, April 2010; available at www.josiahmacyfoundation.org/documents/JMF_PrimaryCare_Monograph.pdf.

3. David Margolius and Thomas Bodenheimer, "Transforming Primary Care: From Past Practice To The Practice Of The Future," *Health Affairs*, 29, no. 5 (May 2010): pp. 779–784.

4. Richard Baron, "What's Keeping Us So Busy in Primary Care: A Snapshot from One Practice," *New England Journal of Medicine*, 362, no. 17 (April 29, 2010): pp. 1632–1635.

5. Reid *et al*., "Group Health."

6. Robert Berenson and Eugene Rich, "How to Buy a Medical Home? Policy Options and Practical Questions," *Journal of General Internal Medicine*, 25, no. 6 (June 2010): 619–624.

7. Culliton and Russell, "Who Will Provide?"

8. Brian Schuetz, Erin Mann and Wendy Everett, "Educating Health Professionals Collaboratively For Team-Based Primary Care," *Health Affairs*, 29, no. 8 (August 2010): pp. 1476–1480.