Generalism & Primary Care: An Old Idea in a New Era
GWU Milken Institute School of Public Health

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Today’s Highlights

G. Gayle Stephens: A social mission
Spotlights on our “system”, ecology, and training
A report from across the pond: Generalism
Value added by comprehensive care
Training matters!
Align practice patterns with complexity
Investing in primary care
Social Roots of Family Medicine

“...we developed as a movement of social reform, rather than a discipline of science and technology.”

“We were committed to serving the underserved with “1st Class Medicine” and to seek the value of health beyond mere relief of pain.”
G. Gayle Stevens: 1928 - 2014

- Family Medicine as Counterculture, 1978
- The Intellectual Basis of Family Practice, 1978, 1989
- Personal medicine…”never passé, although we must continue to learn what it means and how to do it.”
Guiding Patients Through Complexity: Modern Medical Generalism

• A Report of an independent commission for the Royal College of General Practitioners and the Health Foundation, Oct 2011
Generalism: The Concept

• True generalism in medicine is one of the hardest things to do well.

(Turns out Family Medicine IS rocket science!)
The Generalist’s Value

• At its root, generalism is a way of thinking and acting as a health professional
• The generalist sees health and ill-health in the context of the whole person’s wider life
• Young doctors need to decide what interests them: the science of disease or the way disease affects people
Three Challenges of Generalism

1. Increasing Complexity
2. Public Expectation
3. Sustainability—Squeezed to the max?
Billions More for Less

The Honorable Bernat Soria, MD PhD Health Minister of Spain
October 17, 2008 Patient Centered Primary Care Collaborative Summit, Washington, DC.
Race to the Bottom

Red dots are life expectancy for women in the US

IOM Report, 2013
In an average month:

- Of 1000 people
- 800 have symptoms
- 327 consider seeking medical care
- 217 visit physician’s office
- 113 visit primary care
- 65 visit CAM provider
- 21 visit hospital clinic
- 14 home health
- 13 visit emergency dept.
- 8 hospitalized
- <1 to academic health center hospital

The Ecology of Medical Care
GME bending to Hospitals needs

What Teaching Hospitals Do

Income change adjusted for inflation 1998-2007

- Anesthesiology (21%)
- Dermatology (40%)
- Radiology (25%)
- Ophthalmology (12%)
- Family Medicine (-4%)
- Pediatrics (-8%)
- General Internal Medicine (2%)

2007 Median Specialty Income

Weida, Bazemore, Phillips, Archives Internal Med, 2010
Primary Care Physician Production

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Overall GME Primary Care Production</td>
<td>25.2%</td>
</tr>
<tr>
<td>Primary Care Physician Workforce*</td>
<td>32%</td>
</tr>
<tr>
<td>COGME Primary Care Workforce Recommendation*</td>
<td>40%</td>
</tr>
</tbody>
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* COGME 20th Report
Trends in Health Care Providers

Fig. 1. Aggregate trends in health care providers, 1980–2008.
Source: Health Resources and Service Administration Area Resource File, National Survey Sample of Registered Nurses, American Academy of Physician Assistants.
Rural Physician Production

• GME Rural Production: 4.8%
  – Rural Physician Workforce: 11.4%
  – Rural U.S. Population: 19.2%
Growth in NP Graduates, 2002-2012

Source: American Association of Colleges of Nursing Annual Surveys; Prepared by HRSA/NCHWA
Newly Certified PAs, 2001 - 2012

Source: National Commission on Certification of Physician Assistants
“Certified Physician Assistant Population Trends”; 2012 data from personal communication with NCCPA January 16, 2013
NP and PA Primary Care

Nurse practitioners by specialty

- Primary Care: 48%
- Subspecialty Care: 52%

Physician assistants by specialty

- Primary Care: 57%
- Subspecialty Care: 43%
Non-Physician Clinicians in Primary Care

Impact of alternative staffing for PCMHs:

• **If no delegation:**
  • 1 physician for 983 patients = 315,000 PC physicians; *Then significant shortage!*

• **If significant delegation:**
  • 1 physician for 1,947 pts = 159,000 PC physicians; *Then significant surplus!*

GME Accountability

Toward Graduate Medical Education (GME)
Accountability: Measuring the Outcomes of
GME Institutions
Candice Chen, MD, MPH, Stephen Petterson, PhD, Robert L. Phillips, MD, MSPH,
Fitzhugh Mullan, MD, Andrew Bazemore, MD, MPH, and Sarah D. O’Donnell, MPH

Abstract

Purpose
Graduate medical education (GME) plays a key role in the U.S. health care
workforce, defining its overall size and specialty distribution and influencing
physician practice locations. Medicare provides nearly $10 billion annually to
support GME and faces growing policy interest in creating accountability
and transparency. The purpose of this study was to identify and test candidate GME
outcome measures related to physician retention in primary care, including
hospitalists. Mean general and subspecialty retention was 38.4%. Over
half of graduates practiced in 198 institutions produced no physicians, and 283
produced no Federally Qualified Health Center or Rural Health physicians.

Results
Average overall primary care production rate was 25.2% for the
study period, although this is an overestimate because hospitalists could
not be excluded. Of 759 sponsoring primary institutions, 158 produced no primary
care graduates, and 184 produced more than 80%. An average of 37.9%
of internal medicine residents were retained in primary care, including
hospitalists.

Conclusions
GME outcomes vary across specialties, institutions, and regions.
Specialty and practice site significantly affect GME outcome measures in the
period examined. The GME system needs significant reforms to improve
outcomes and retention of primary care physicians.
GME Opportunities

• Build on IOM GME Report
• Enhance the THC GME program
• Create more opportunities with VA models
• State based innovations
Model GME: Teaching Health Centers

• ACA: $230 M over five years to fund community based ambulatory sponsoring institutions
• Currently 60 programs in 24 states support about 550 FTEs
• Strong uptake by family medicine residencies—some new, mostly expansion
• Osteopathic programs enrolled early
• Parallel missions to VA goals of improving access to primary care
VA Innovations in Care and Education

• Transformation of primary care delivery through team approach: PACTs/EMR
• Centers of Excellence in Primary Care Education
• Mental health expansion in response to need
• Increased number and distribution of Community Based Out-Patient Clinics (CBOCs)
VACAA offers GME Training Opportunity

• Authorizes up to 1,500 new GME positions over five years
• Priority for positions and programs in primary care, mental health and as Secretary determines appropriate
• Outcome of enhanced residency training in veterans’ care → care for veterans in practice
VA Health Facilities and Family Medicine Residency Programs in Relation to Projected Veteran Populations in 2020

VA Health Facilities Include Hospitals (VAMC), Community Based Outpatient Clinics (CBOC), and Independent Outpatient Clinics (IOC).
Greater numbers of pc physicians per capita is associated with lower cost care

This association holds true even controlling for rural, poverty, education

Physicians per 10,000 and spending, 2006
Comprehensive Care Less Expensive
Do Residents Who Train in Safety Net Settings Return for Practice?

Robert L. Phillips, MD, MSPH, Stephen Petterson, PhD, and Andrew Bazemore, MD, MPH

Abstract

Purpose
To examine the relationship between training during residency in a federally qualified health center (FQHC), rural health clinic (RHCs), or critical access hospital (CAH) and subsequent practice in these settings.

Method
The authors identified residents who trained in safety net settings from 2001 to 2005 and in 2009 using 100% Medicare Part B claims files for FQHCs, RHCs, and CAHs and 2011 American Medical Association Masterfile residency start and end date histories. They used 2009 Medicare claims data to determine the relationship between this training and subsequent practice in safety net settings.

Results
The authors identified 662 residents who had a Medicare claim filed in their name by an RHC, 975 by an FQHC, and 1,793 by a CAH from 2001 to 2005 and in 2009. By 2009, that number of residents per year had declined for RHCs and FQHCs but increased substantially for CAHs. The percentage of physicians practicing in a safety net setting in 2009 who had trained in a similar setting from 2001 to 2005 was 38.1% (205/538) for RHCs, 31.2% (219/703) for FQHCs, and 52.6% (72/137) for CAHs.

Conclusions
Using Medicare claims data, the authors identified residents who trained in safety net settings and demonstrated that many went on to practice in these settings. They recommend that graduate medical education policy support or expand training in these settings to meet the surge in health care demand that will occur with the enactment of the Affordable Care Act insurance provision in 2014.
## Training Matters: What

### Unadjusted

<table>
<thead>
<tr>
<th>Training HRR Average Spending Per Beneficiary</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
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<tbody>
<tr>
<td>Low</td>
<td>$6,751</td>
<td>$7,009</td>
<td>$7,846</td>
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<tr>
<td>Average</td>
<td>$6,332</td>
<td>$7,760</td>
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<tr>
<td>High</td>
<td>$8,043</td>
<td>$8,299</td>
<td>$9,398</td>
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### Adjusted

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</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>$6,918</td>
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<td>$7,470</td>
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<tr>
<td>Average</td>
<td>$6,715</td>
<td>$7,664</td>
<td>$8,213</td>
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<tr>
<td>High</td>
<td>$7,904</td>
<td>$7,974</td>
<td>$8,451</td>
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Family Physicians in the Maternity Care Workforce: Factors Influencing Declining Trends

Sebastian T. Tong · Laura A. Makaroff · Imam M. Xierali · James C. Puffer · Warren P. Newton · Andrew W. Bazemore

Policy Brief

Rewarding Family Medicine While Penalizing Comprehensiveness? Primary Care Payment Incentives and Health Reform: the Patient Protection and Affordable Care Act (PPACA)

Stephen Pettersen, PhD, Andrew W. Bazemore, MD, MPH, Imam M. Xierali, PhD, Jason A. Eberhart, MD, Larry A. Green, MD, MPH, and James C. Puffer, MD

Family physicians’ scope of work is exceptionally broad, underscoring a disparity between current patterns in maternity care and underserved communities. The characteristic of the Patient Protection and Affordable Care Act (PPACA) used a narrow definition of “primary care provider” for Medicare bonus payment, thus depriving specialists of care incentives to deliver comprehensiveness.
Training Matters: Who

MetroHealth Family Medicine Residency
Mount Carmel Family Medicine Residency
Practice Matters

• Comprehensiveness of care, including integrated accessible models

• Effective practice solutions including high value roles for clinicians and all team members

• Investment in primary care infrastructure
Taking Our Temperature!

- The value of the personal physician
- The U.S. health system expense
- Our nation’s health is declining
- Most patients need general care
- Physician training missing the mark
- Some parameters associated with lower costs
- Primary care is effective and efficient
What Was I thinking?

• Pervasive burnout of primary care physicians
• Technology: Electronic health records are associated with decreased measures of physician well being
• Student thought bubble: “If I can’t have great career, I can get better paid!”
“The Hamster Wheel”

- Increase algorithms, screening, reporting
- See more patients!
- Oh! What about the community?
- And population and public health!
- Don’t forget behavioral and mental issues.
- You can’t see me today, Doc?!
In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD
Rachel Willard-Grace, MPH
Andrew M. Schutzbanks, MD
Thomas A. Sinsky, MD
David Margolis, MD
Thomas Bodenheimer, MD

1Medical Associates Clinic and Health Plans, Dubuque, Iowa
2Center for Excellence in Primary Care, University of California, San Francisco, California
3Beth Israel Deaconess Medical Center, Boston, Massachusetts
4Iora Health, Cambridge, Massachusetts

ABSTRACT

We highlight primary care innovations gathered from high-functioning primary care practices, innovations we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded roaming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.
Current Work Distribution in PC

Complexity of work

High value
Good match

Inefficient
highly trained worker, lower complexity work

MA    RN    RN    NP    PA    MD
Training

Vitals Prior Auths Script renewals

Inbox mgmt Med rec

Script renewals Data entry

Data gathering Prior authorization

Sign for hearing aid
Matching Work to Worker

Complexity of work

Work well suited to 2-4 years of post-high school training

Allows greater MD focus on high complexity tasks

- Vitals
- MA
- RN
- RN
- NP
- PA
- MD

- Bio/psycho/social in
- Shared decision ma
- Chronic illness care
- E/M acute sx
- Inbox mgmt
- Med rec
- Script renewals
- Data entry
- Data gathering
- Prior authorization
- Sign for hearing aid
New Work of PCMH

Complexity of work

High value

Good match

High value

Good match

MA  RN  RN  NP  PA  MD

Training

Bio/psycho/social in
Shared decision ma
Chronic illness care
E/M acute sx
Team leadership
Care Coordination
End of Life Care
Same day access

Vitals
Script renewals
PAs
Registry
Self Mgmt
Case mgmt
Hospital to home
Value

Complexity of work

Trust, reliance, access, welcoming, making known as person

Eye contact, listening, pausing, reflecting, goal setting, working out a plan together

Bio/psycho/social in
Shared decision making
Chronic illness care
E/M acute sx
Team leadership
Care Coordination
End of Life Care
Same day access

MA  RN  RN  NP  PA  MD

Training

Vitals
PAs
Registry
Self Mgmt
Case mgmt
Hospital to home
Script renewals
Investing in Primary Care

• Primary care is ~5% of national health spend
• Outcomes of systems where spend increases:
  – State of Rhode Island → 15 fold ROI
  – Commonwealth Fund → 6 fold ROI
  – State of Illinois → 33% spend reduction
Emerging Leadership for Change

- Recognition of need for change built on social responsibility
- Align investments with population needs
  - Train the right workforce
  - Train with right skills
- Support in generalism and primary care on system and practice levels
- Invest in primary care
“A dream you dream alone is only a dream. A dream you dream together is reality.”
THANK YOU!

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