Generalism & Primary Care: An Old Idea in a New Era

GWU Milken Institute School of Public Health

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Policy Studies in Family Medicine and Primary Care

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

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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."

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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."

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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

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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

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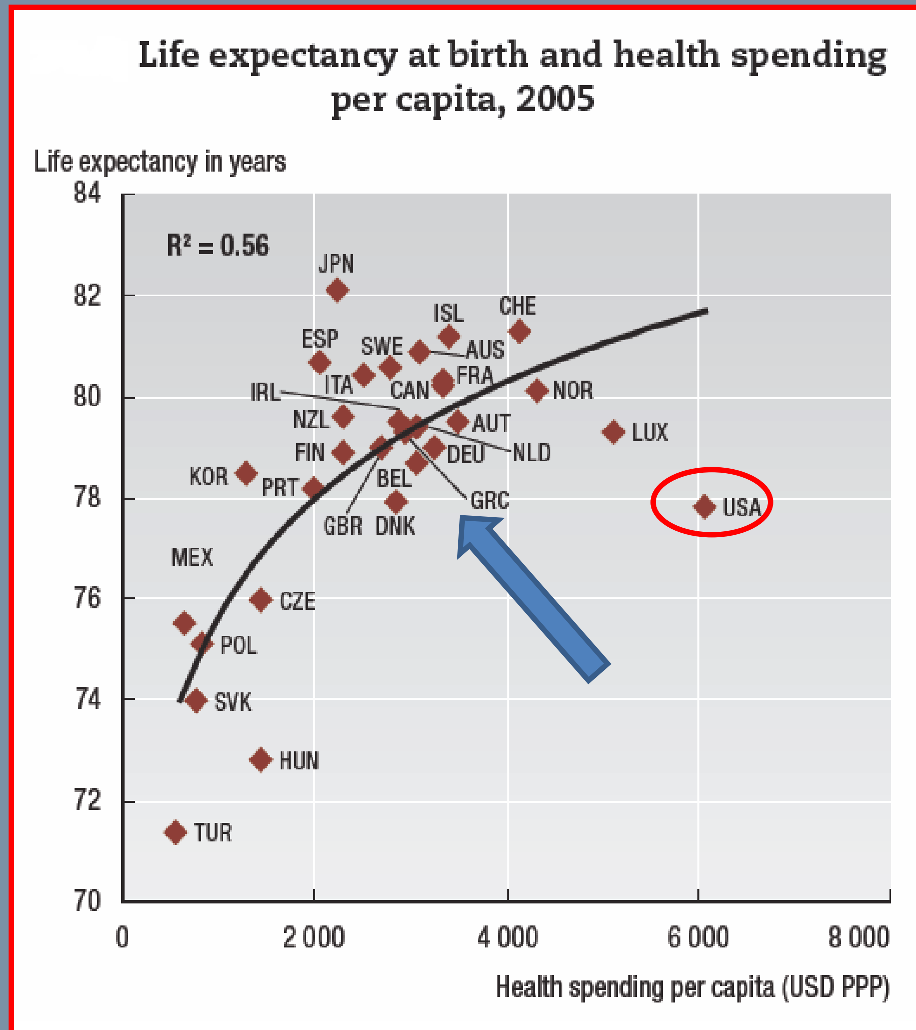
Three Challenges of Generalism

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.

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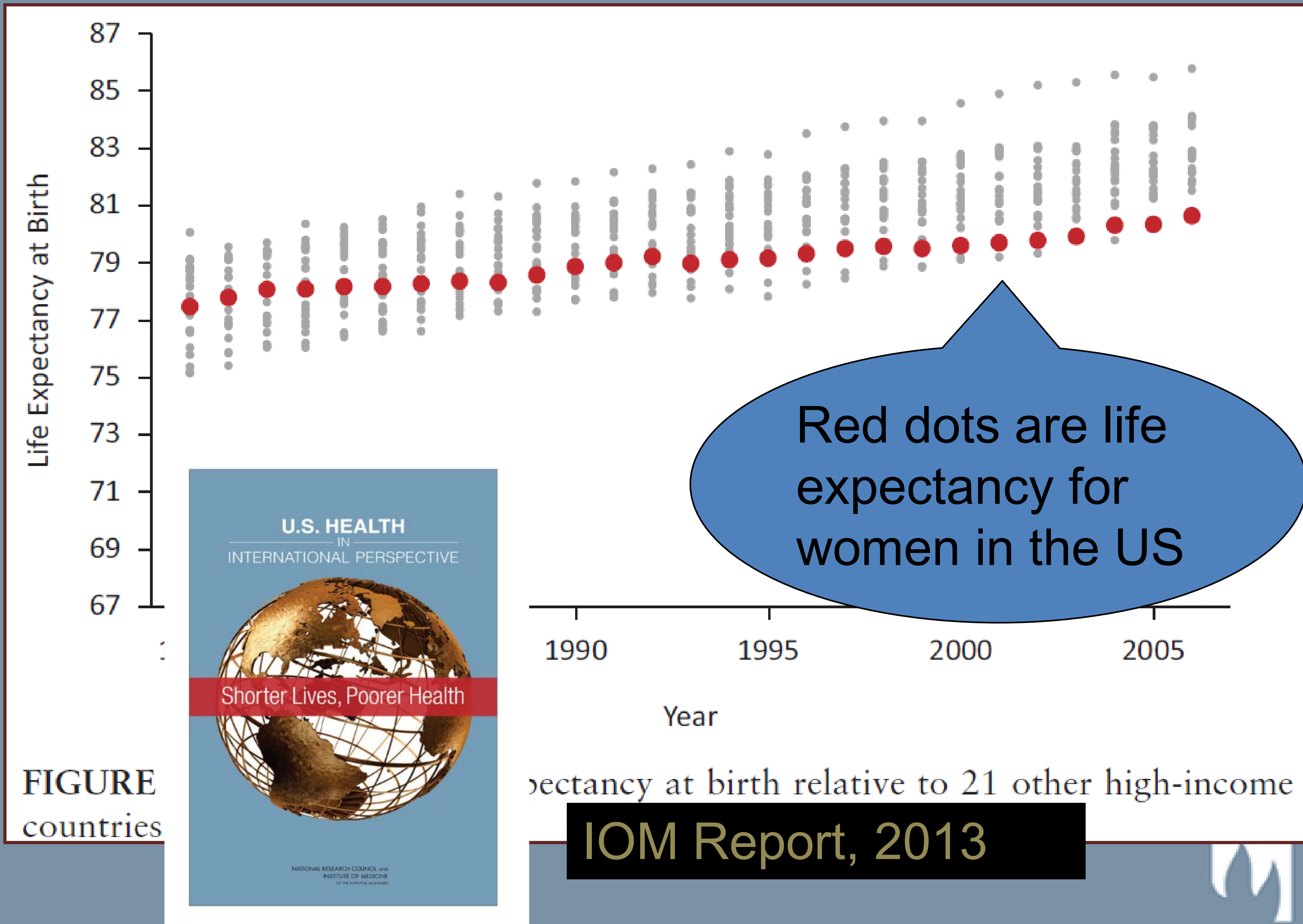
Race to the Bottom



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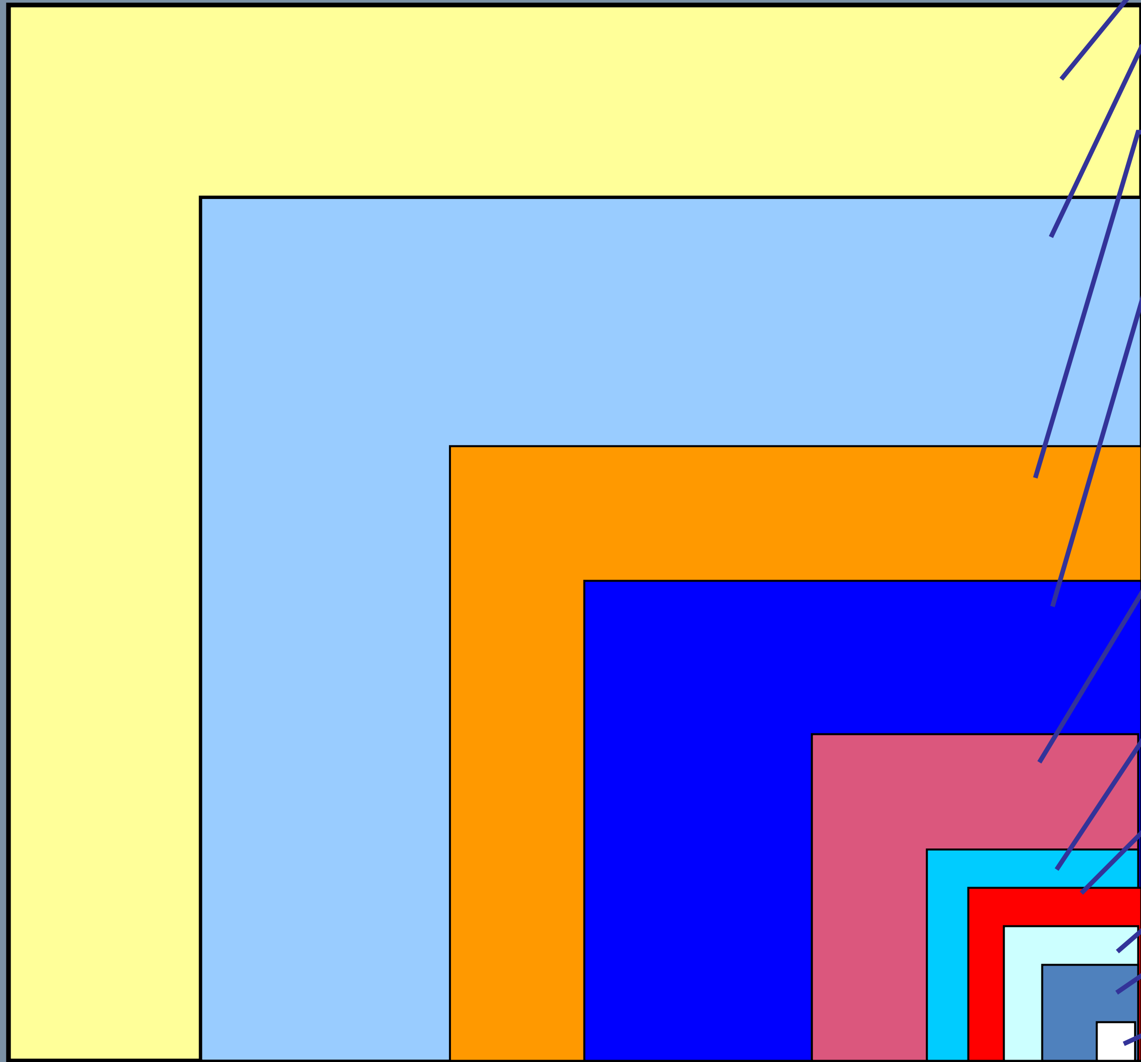
In an average month:



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

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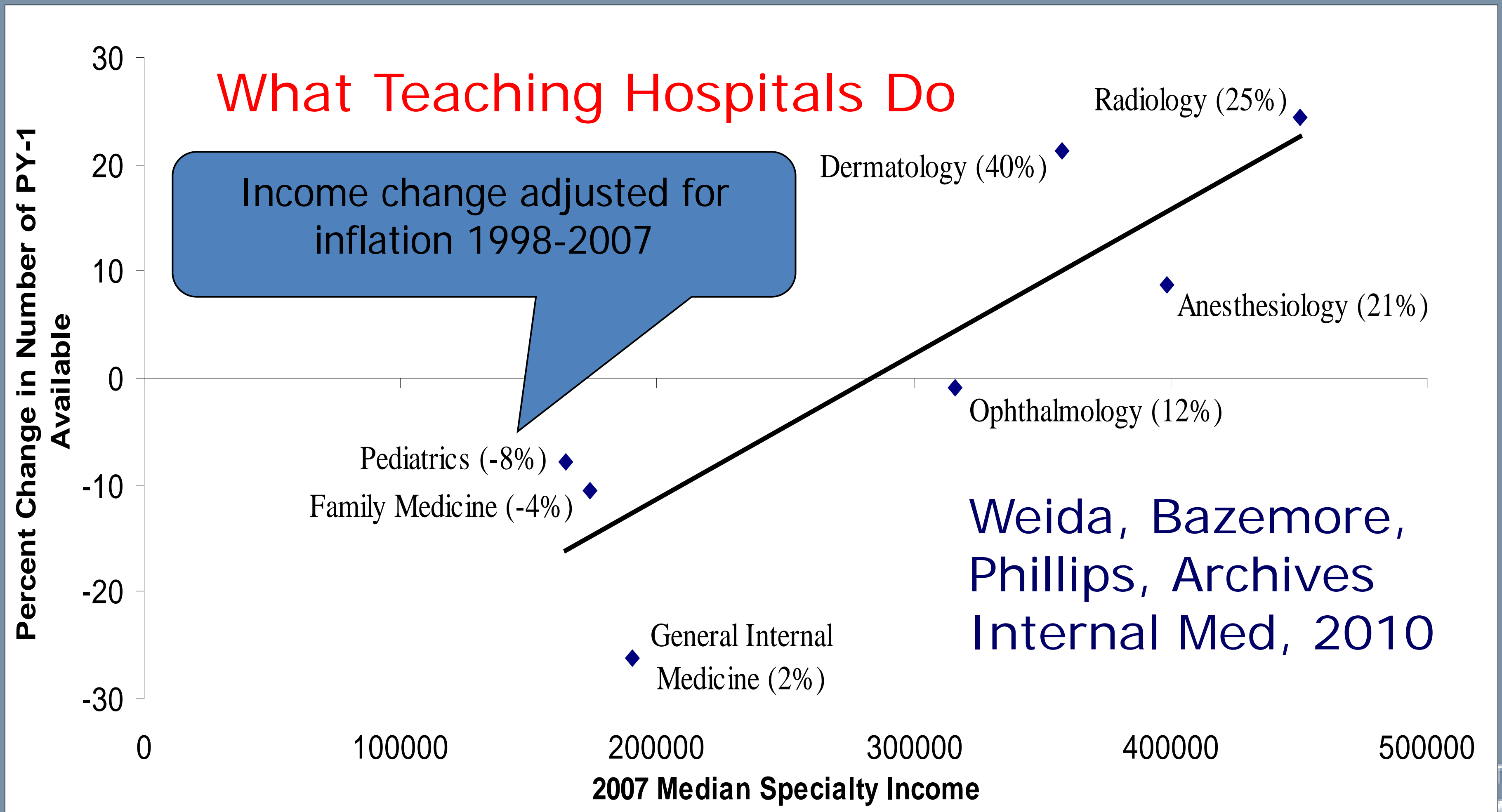
GME bending to Hospitals needs



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Primary Care Physician Production

Overall GME Primary Care Production	**25.2%**
Primary Care Physician Workforce*	32%
COGME Primary Care Workforce Recommendation*	40%

* COGME 20th Report

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Trends in Health Care Providers

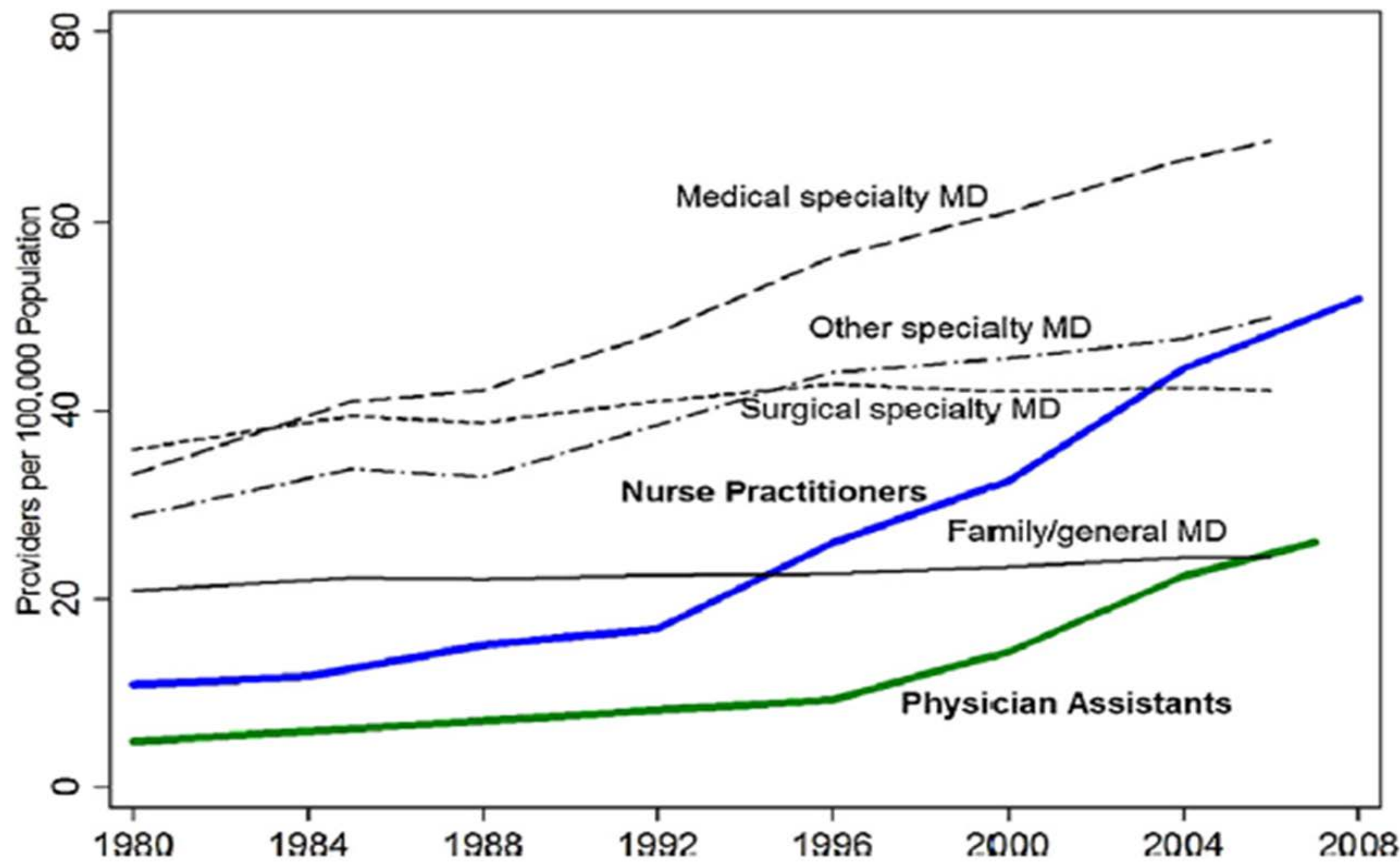

Fig. 1. Aggregate trends in health care providers, 1980–2008.
Source: Health Resources and Service Administration Area Resource File, National Survey Sample of Registered Nurses, American Academy of Physician Assistants.

Rural Physician Production

- **GME Rural Production: 4.8%**
  - Rural Physician Workforce: 11.4%
  - Rural U.S. Population: 19.2%

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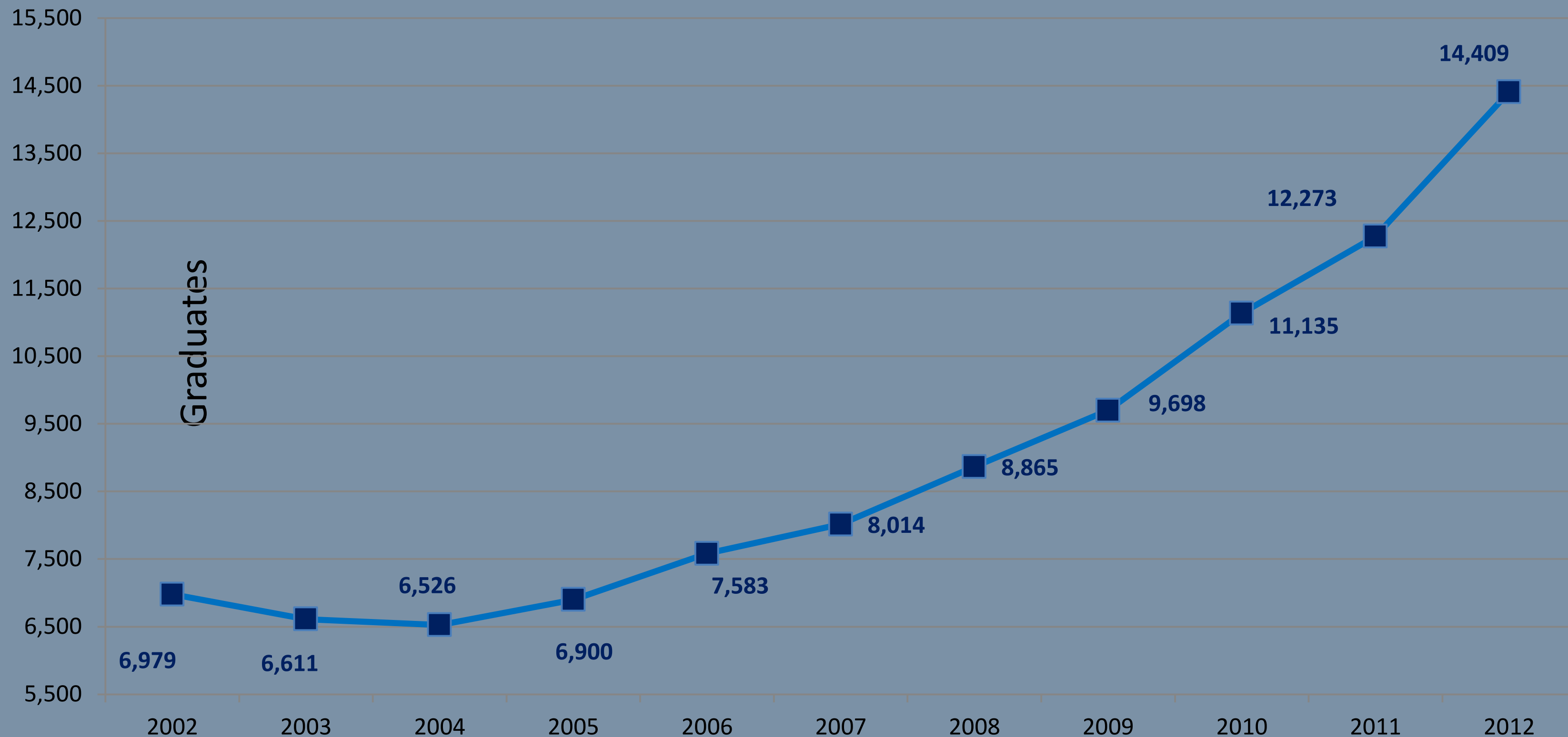
Growth in NP Graduates, 2002-2012



Source: American Association of Colleges of Nursing Annual Surveys; Prepared by HRSA/NCHWA

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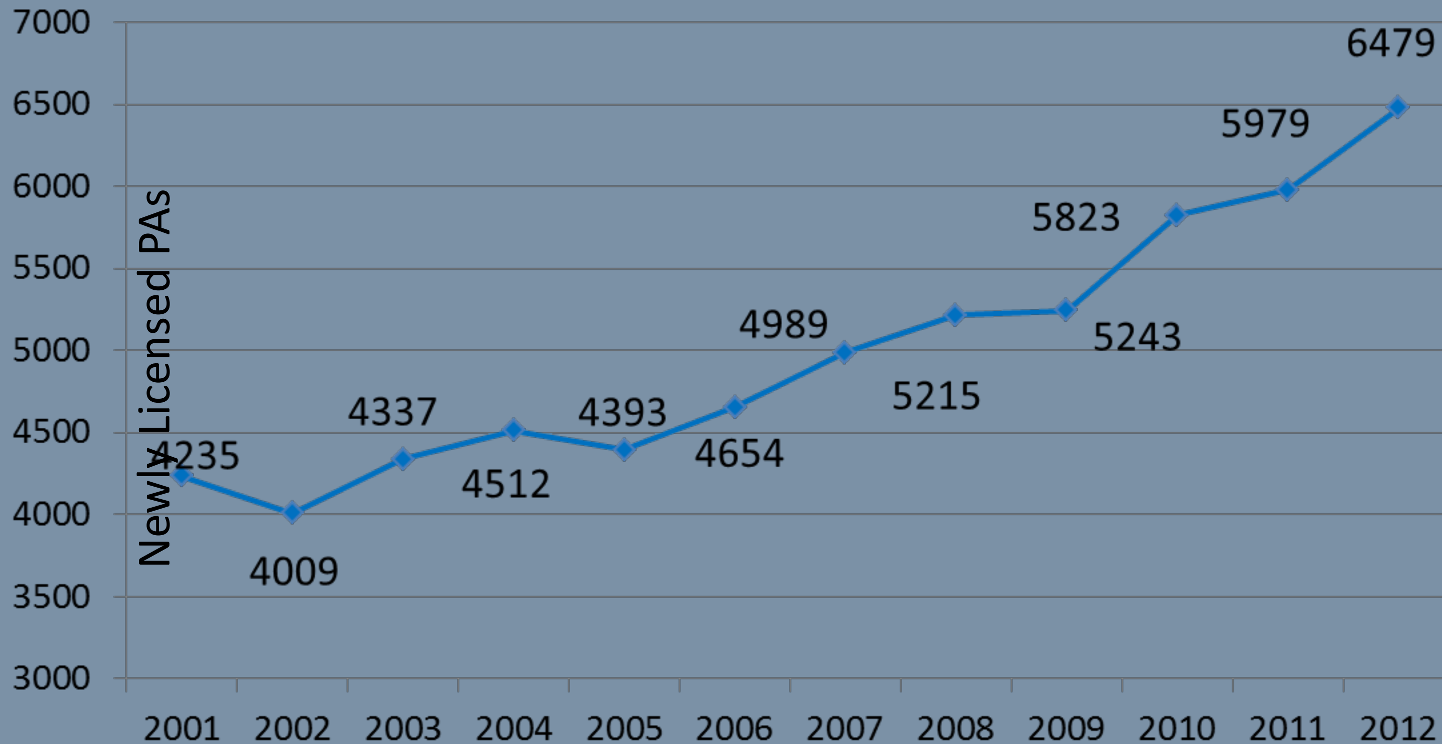
Newly Certified PAs, 2001 - 2012



Source: National Commission on Certification of Physician Assistants "Certified Physician Assistant Population Trends "; 2012 data from personal communication with NCCPA January 16, 2013

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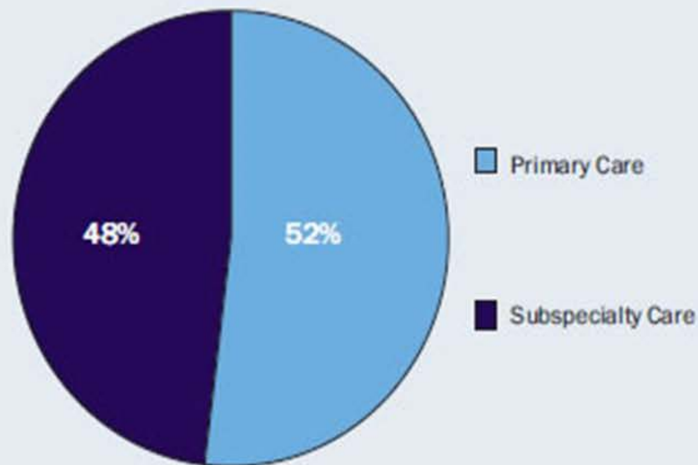
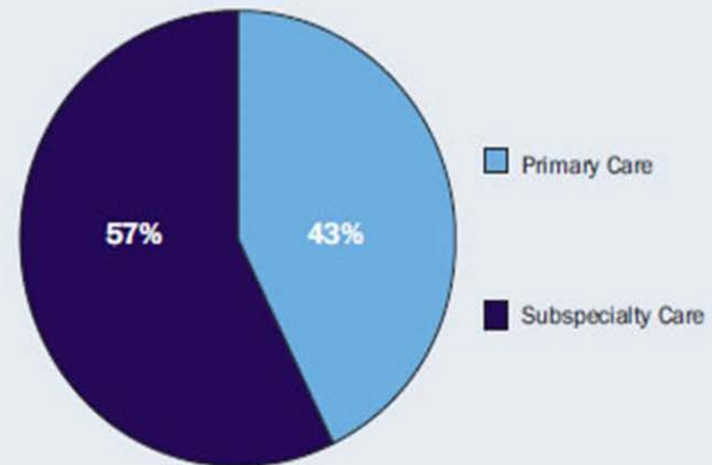
NP and PA Primary Care





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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!*

Altschuler, Margolis, Bodenheimer and Grumbach; "Estimating a Reasonable Patient Panel Size for Primary Care Physicians with Team Based Delegation", Annals of Family Medicine, Sept/Oct 2012

GME Accounta

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 ...ker interest in creating accountability ... The purpose of this study ... and test candidate GME ... related to physician

National Provider Identifier file, Medicare claims, and National Health Service Corps, measuring the number and percentage of graduates from 2006 to 2008 practicing in high-need specialties and underserved areas aggregated by their U.S. GME program.

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 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, in... hospitalists. Mean genera... retention was 38.4%. O... of graduates practiced i... 198 institutions produ... physicians, and 283 i... produced no Federa... Center or Rural He... physicians.

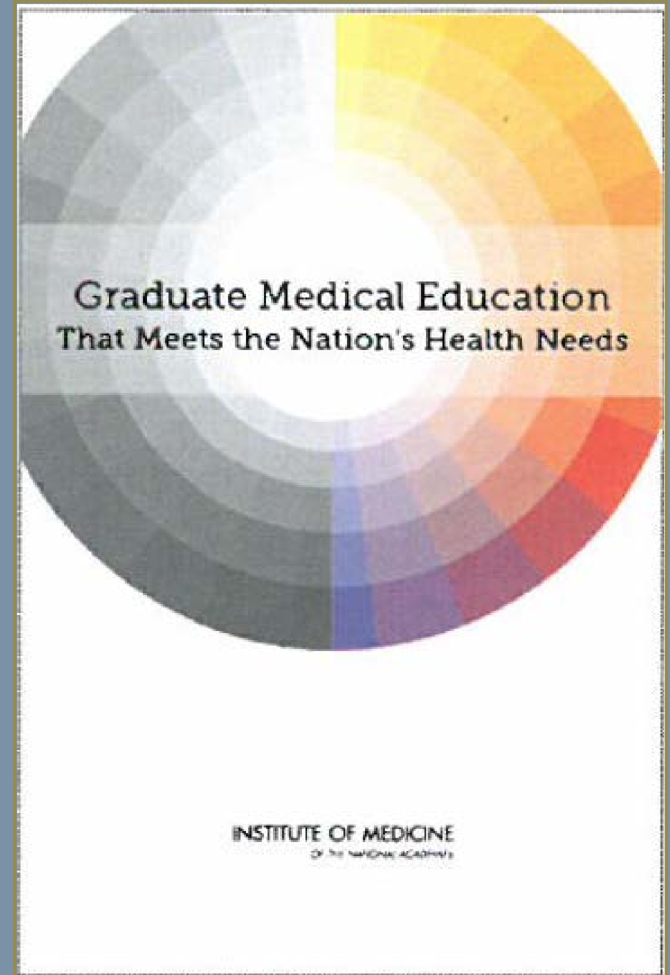
Conclusions

GME outcom... most institut... Specialty a... significan... educato... period o... GME ...

...lopment through ... and other federal ... workforce is ... health care

GME Opportunities

- Build on IOM GME Report
- Enhance the THC GME program
- Create more opportunities with VA models
- State based innovations



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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

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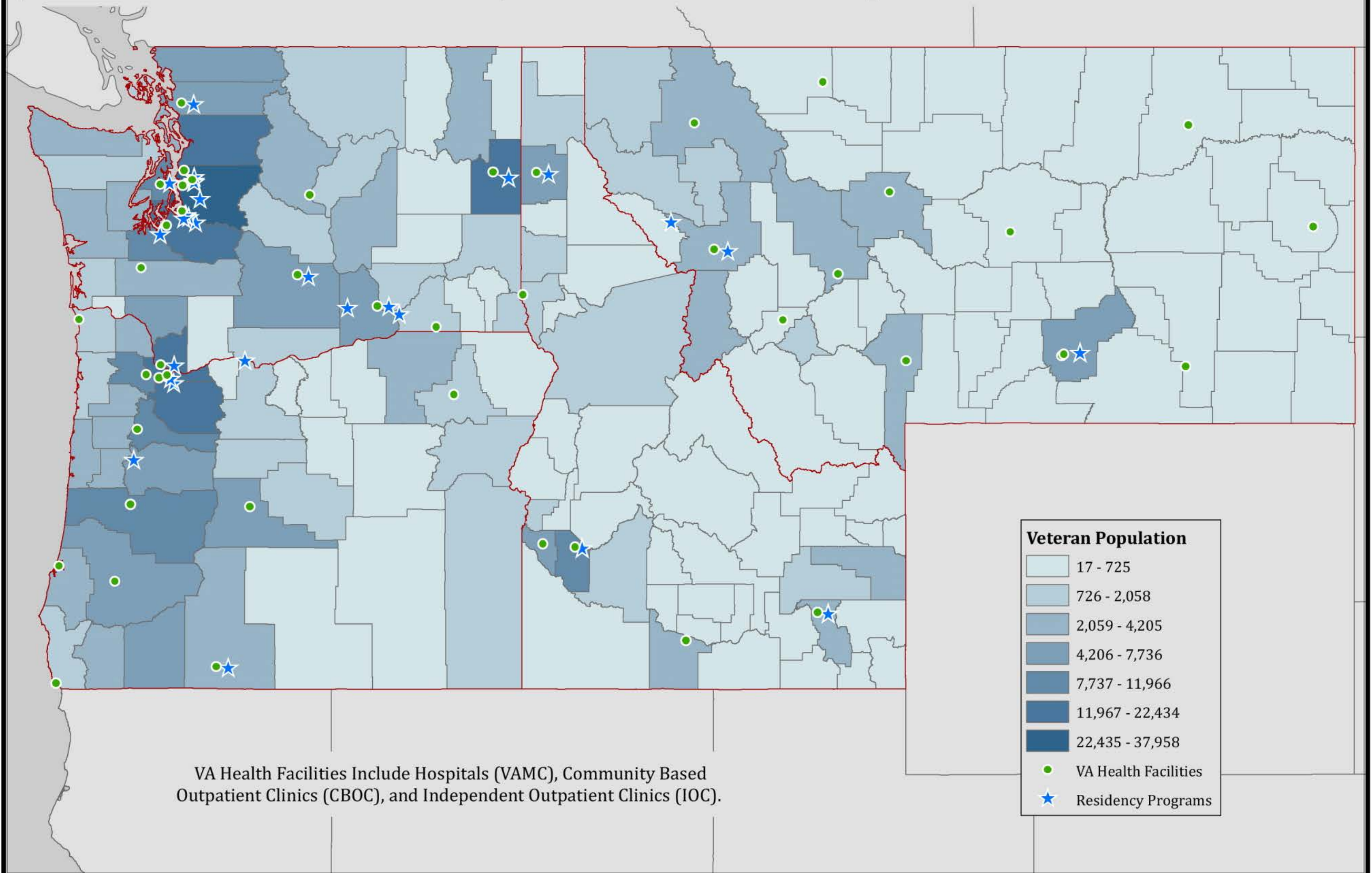
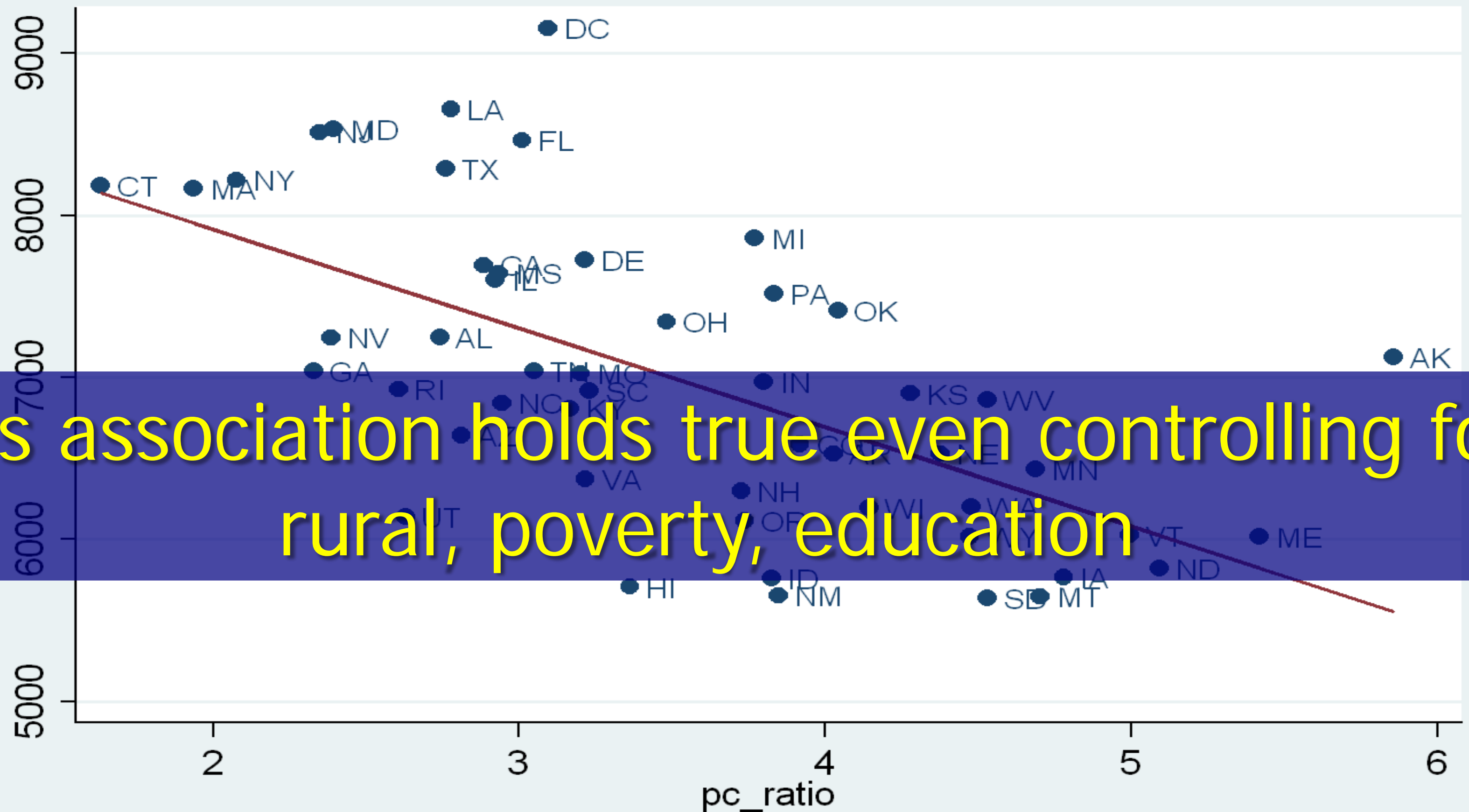

VA Health Facilities and Family Medicine Residency Programs in Relation to Projected Veteran Populations in 2020
Veteran Population
17 - 725
726 - 2,058
2,059 - 4,205
4,206 - 7,736
7,737 - 11,966
11,967 - 22,434
22,435 - 37,958
VA Health Facilities
Residency Programs
VA Health Facilities Include Hospitals (VAMC), Community Based Outpatient Clinics (CBOC), and Independent Outpatient Clinics (IOC).

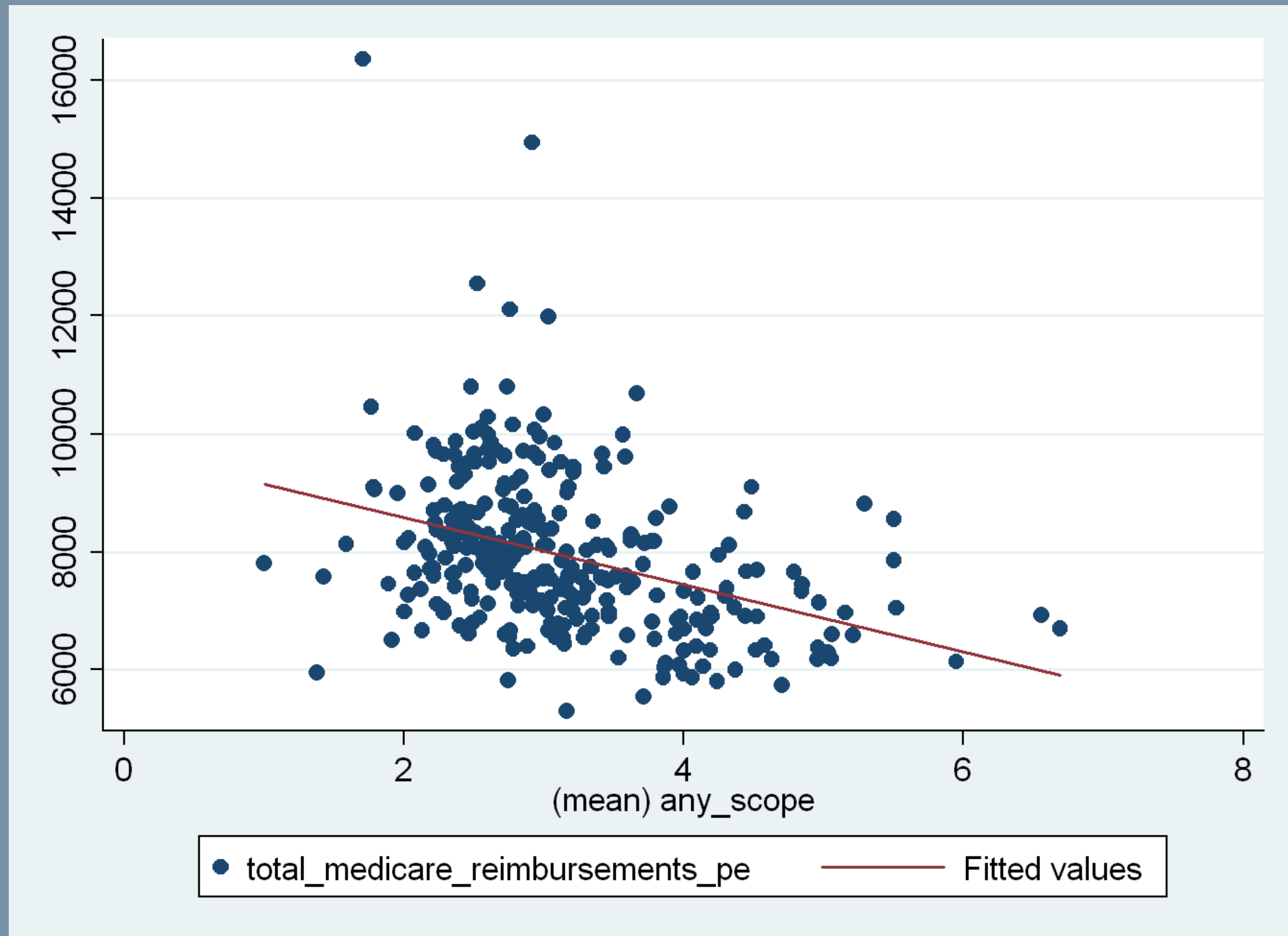
Greater numbers of pc physicians per capita is associated with lower cost care



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

Physicians per 10,000 and spending, 2006

Comprehensive Care Less Expensive



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Training Matters: Where

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.

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Training Matters: What

Unadjusted	Practice HRR Average Spending Per Beneficiary (Physician costs)		
Training HRR Average Spending Per Beneficiary		Low	Average	High
	Low	**$6,751**	$7,009	$7,846
	Average	$6,332	**$7,760**	$8,589
	High	$8,043	$8,299	**$9,398**

Adjusted	**Practice HRR Average Spending Per Beneficiary (Physician costs)**			
Training HRR Average Spending Per Beneficiary		Low	Average	High
	Low	**$6,918**	$7,215	$7,470
	Average	$6,715	**$7,664**	$8,213
	High	$7,904	$7,974	**$8,451**

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Scope is Shrinking

...n Child Health J (2013) 17:1576–1581
...10.1007/s10995-012-1159-8

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

Published online: 14 October 2012
© Springer Science+Business Media New Y...

Abstract Family physicians ... care for a disproportion... underserved communiti... trends in maternity ... the characterist... the ...nity c...

POLICY BRIEF

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

Stephen Petterson, PhD, Andrew W. Bazemore, MD, MPH, Robert L. Phillips, MD, MSPH, Imam M. Xierali, PhD, Jason ... Larry A. Green, MD, and James C. Puffer, MD

Family physicians' scope of work is exceptionally bro... for Medicare bonus payment specified in the he... able Care Act) used a narrow definition of ... centives to delivering comprehensi...

Recognizing the val... the Patient P... a 10% ...

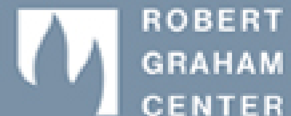
...higher like- ...y physi- ...viding ...eep

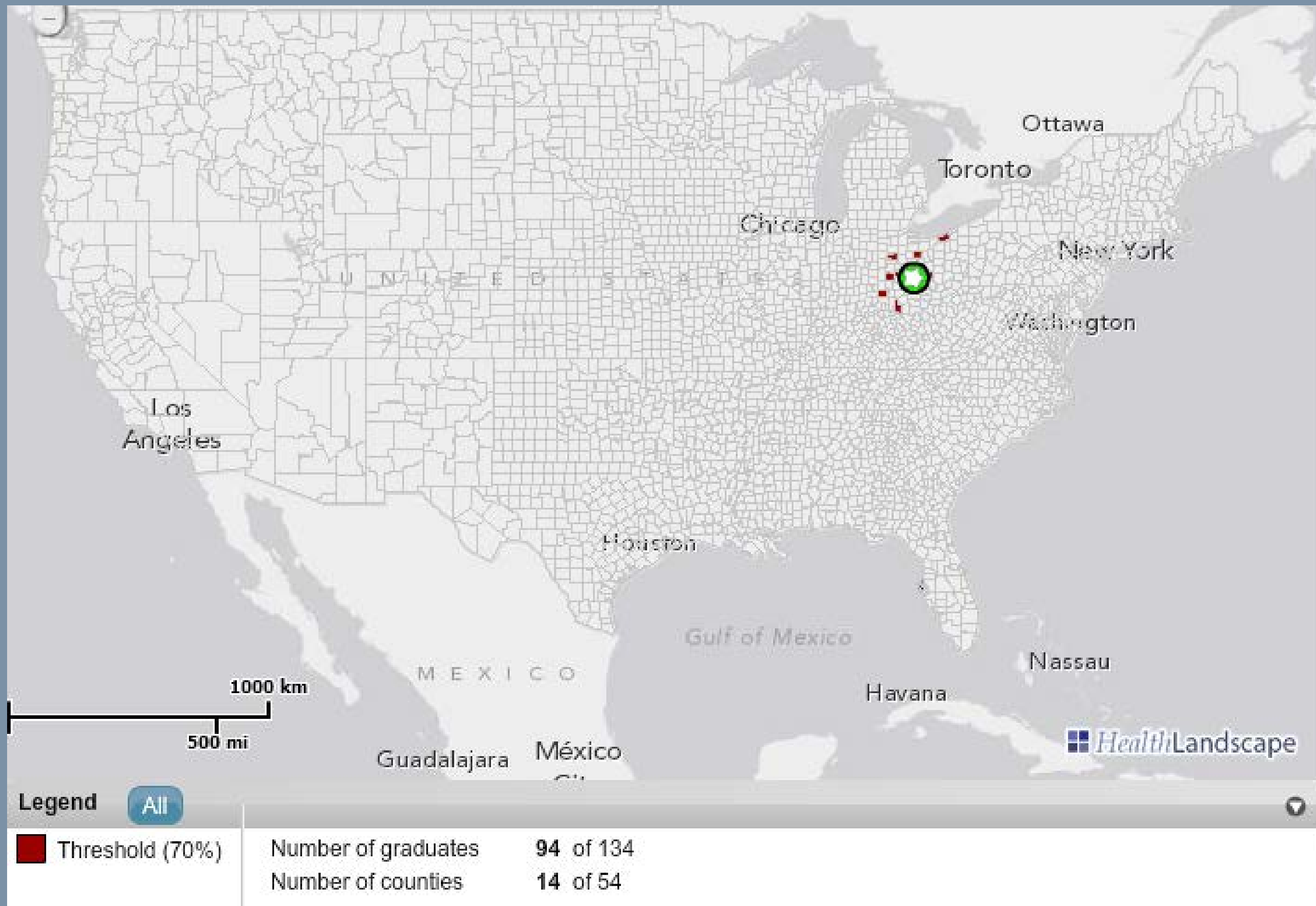
Training Matters: Who

Legend — All

Threshold (70%)		
	Number of graduates	**68** of 97
	Number of counties	**30** of 59

MetroHealth Family Medicine Residency





Mount Carmel Family Medicine Residency

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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!”

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“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?!

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Effective Practice Solutions

In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD[1]
Rachel Willard-Grace, MPH[2]
Andrew M. Schutzbank, MD[3,4]
Thomas A. Sinsky, MD[1]
David Margolius, MD[2]
Thomas Bodenheimer, MD[2]

[1]Medical Associates Clinic and Health Plans, Dubuque, Iowa

[2]Center for Excellence in Primary Care, University of California, San Francisco, California

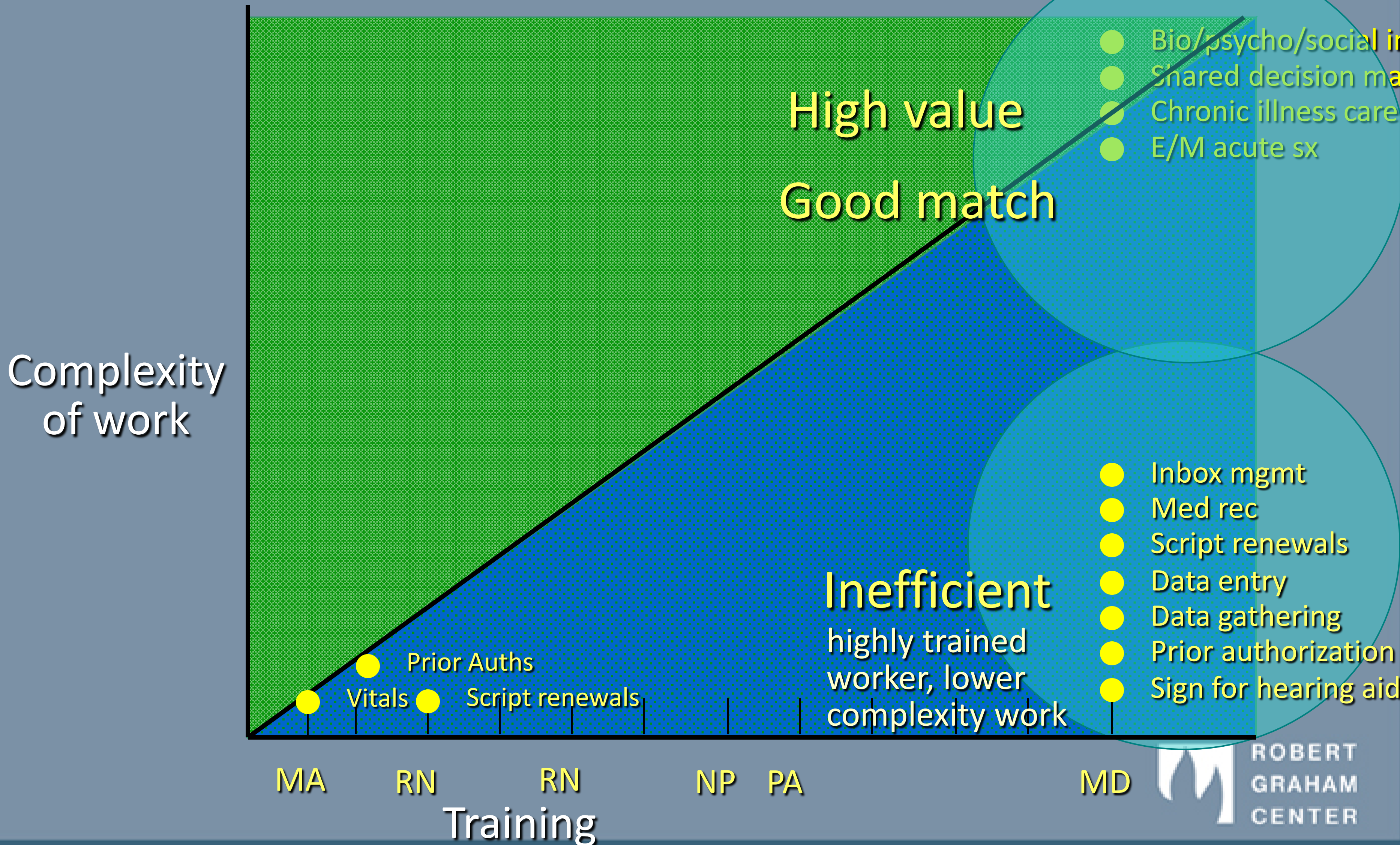
[3]Beth Israel Deaconess Medical Center, Boston, Massachusetts

[4]Iora Health, Cambridge, Massachusetts

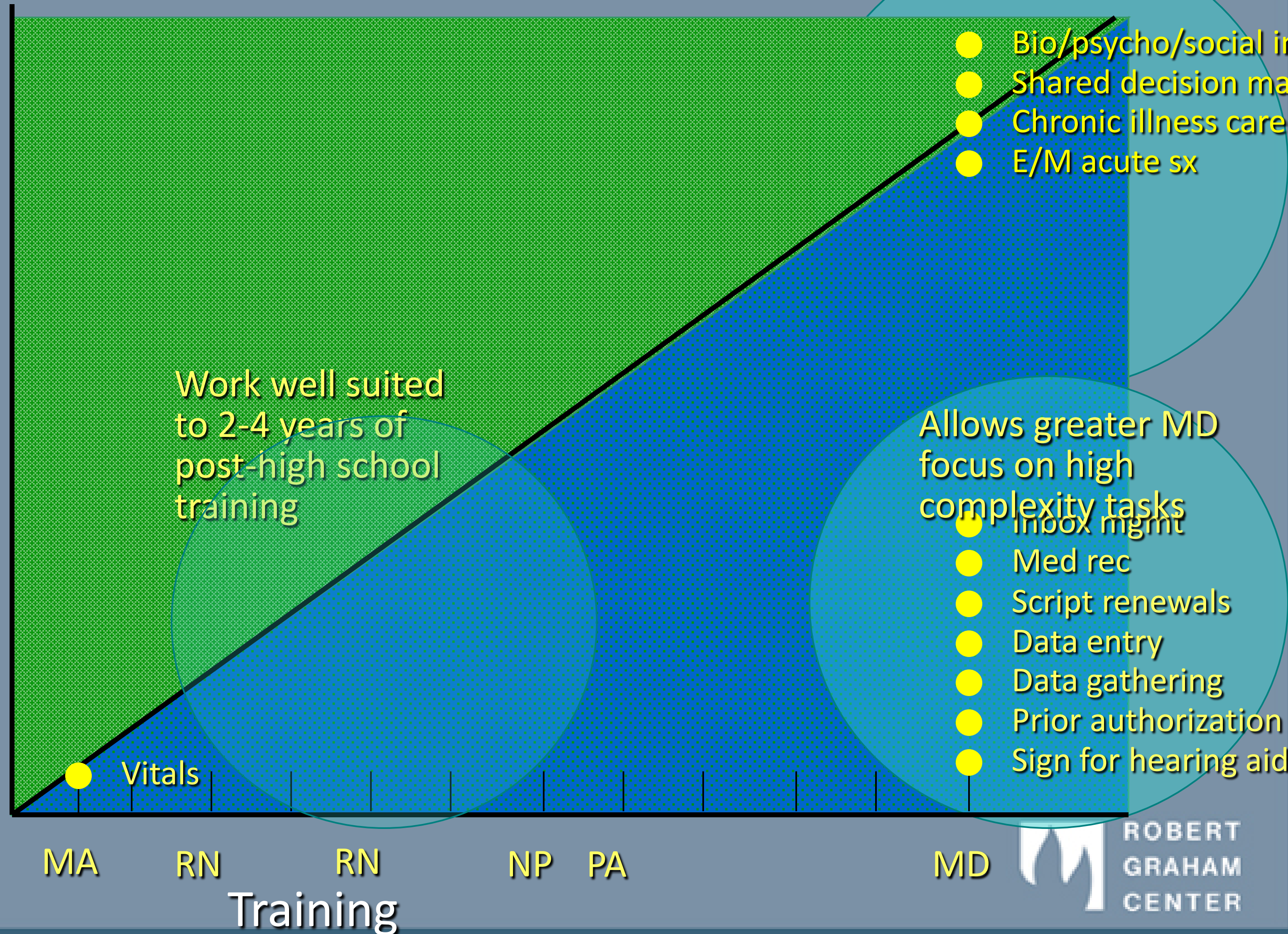
ABSTRACT

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 rooming 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

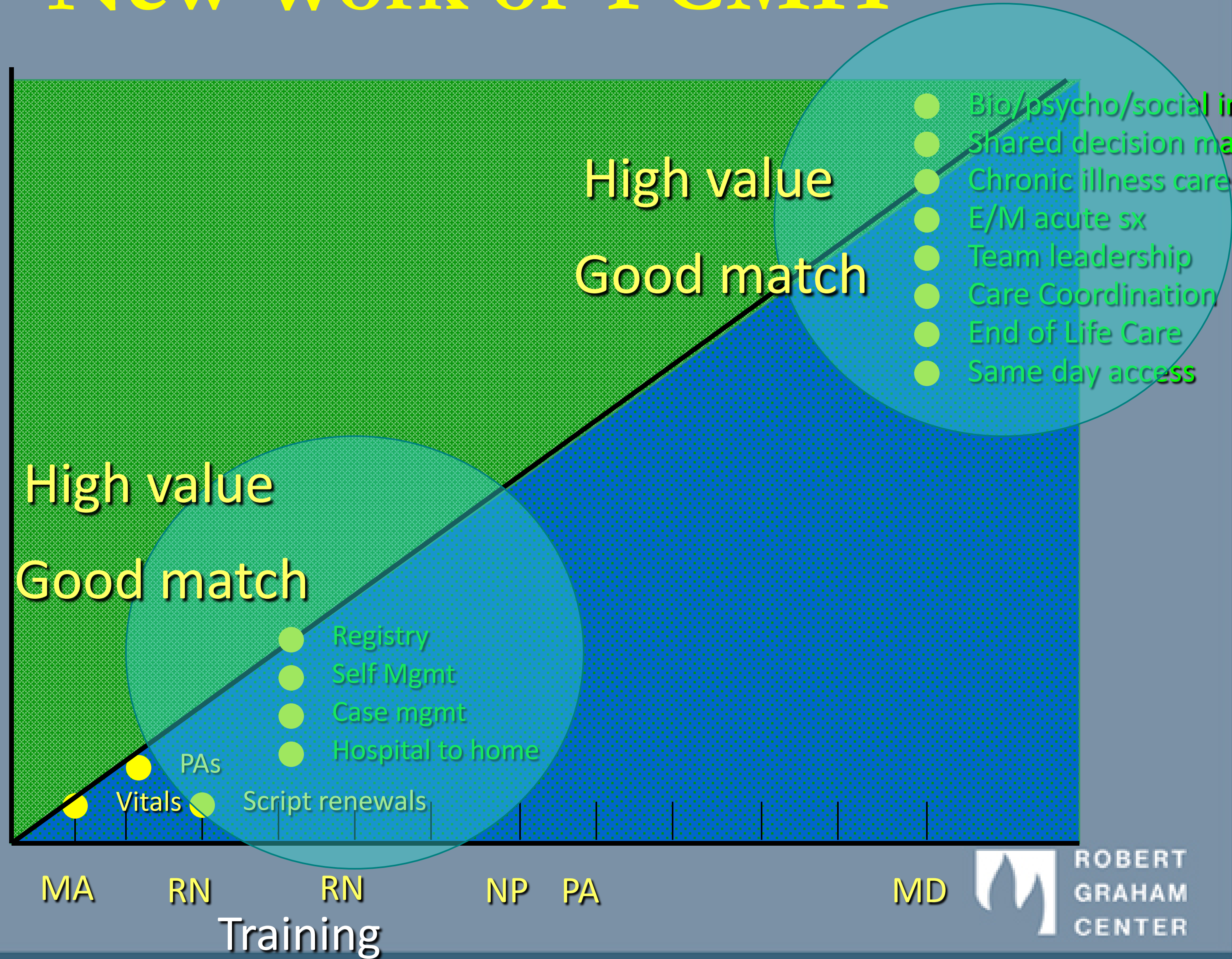


Matching Work to Worker

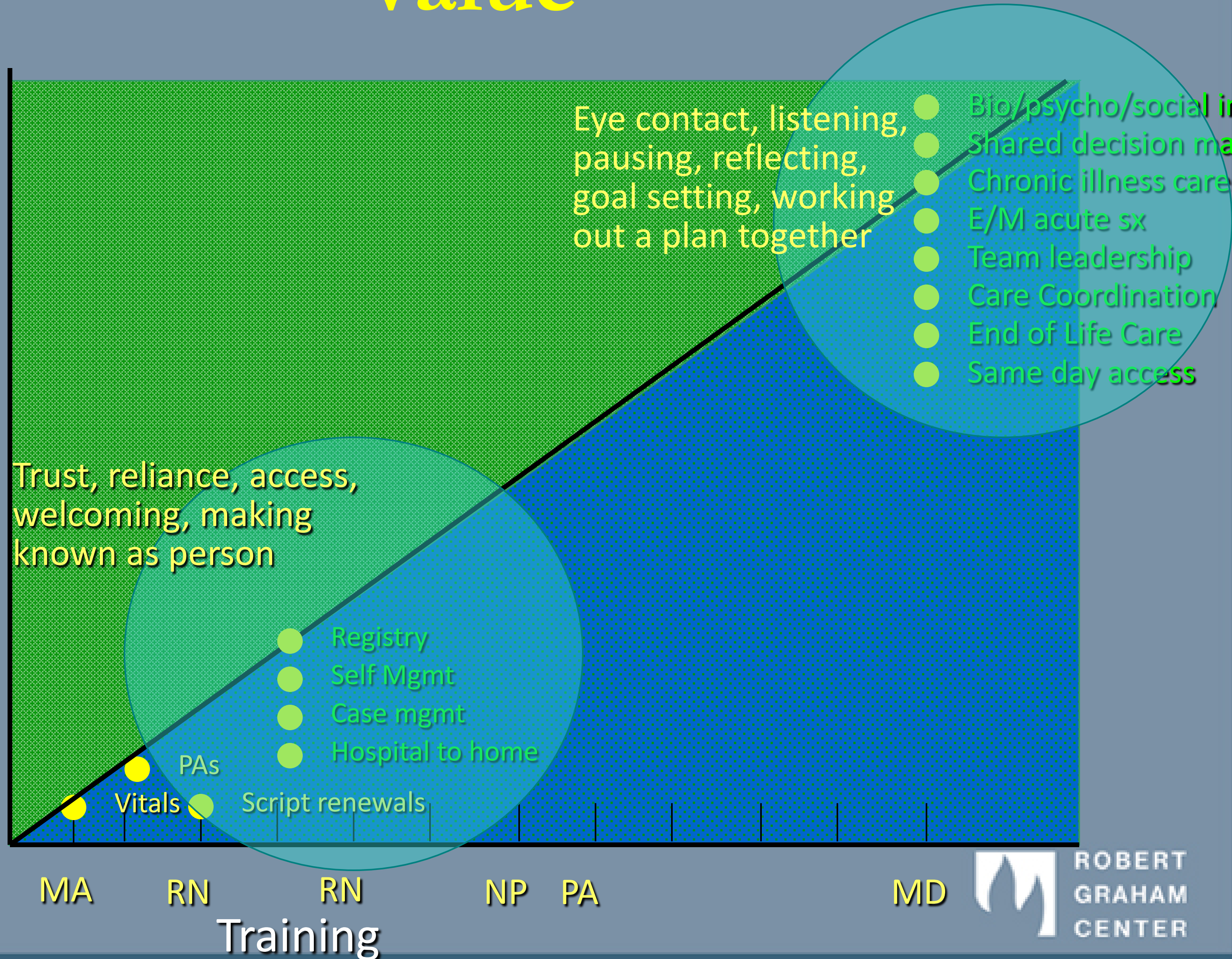


New Work of PCMH

Complexity of work



Value



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

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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

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"A dream you dream alone is only a dream. A dream you dream together is reality."

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THANK YOU!

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Policy Studies in Family Medicine and Primary Care