



Patient Centered Primary Care: Context and Transformation

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Learning Collaborative
Better Health *Greater* Cleveland
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Goals of this talk

- Review workforce trends in primary care and, specifically, general internal medicine
- Review GIM-specialty distribution issues from a “cost-quality” perspective
- Describe a new model of internist/GIM practice that addresses society’s needs
- Discuss specific issues related to transformation to a Patient Centered Medical Home
- Share our experience at Greenhouse internists

Status of “General” IM

- Dramatic decrease in those picking it
- 2007 data (Hauer and CDIM colleagues, JAMA 2008):
 - 23.2% of 4th year students plan IM
 - 24/1177 (that’s **2%** folks) plan “GIM”
- 10 years after initial cert (Lipner et al, ACP-ABIM data)
 - 98% with SS cert still in practice
 - **79% IM only** are still in practice



Happening at a time when needs are going up

- Population demographics
- Cost pressures
- Access problems
- Increased Uninsured

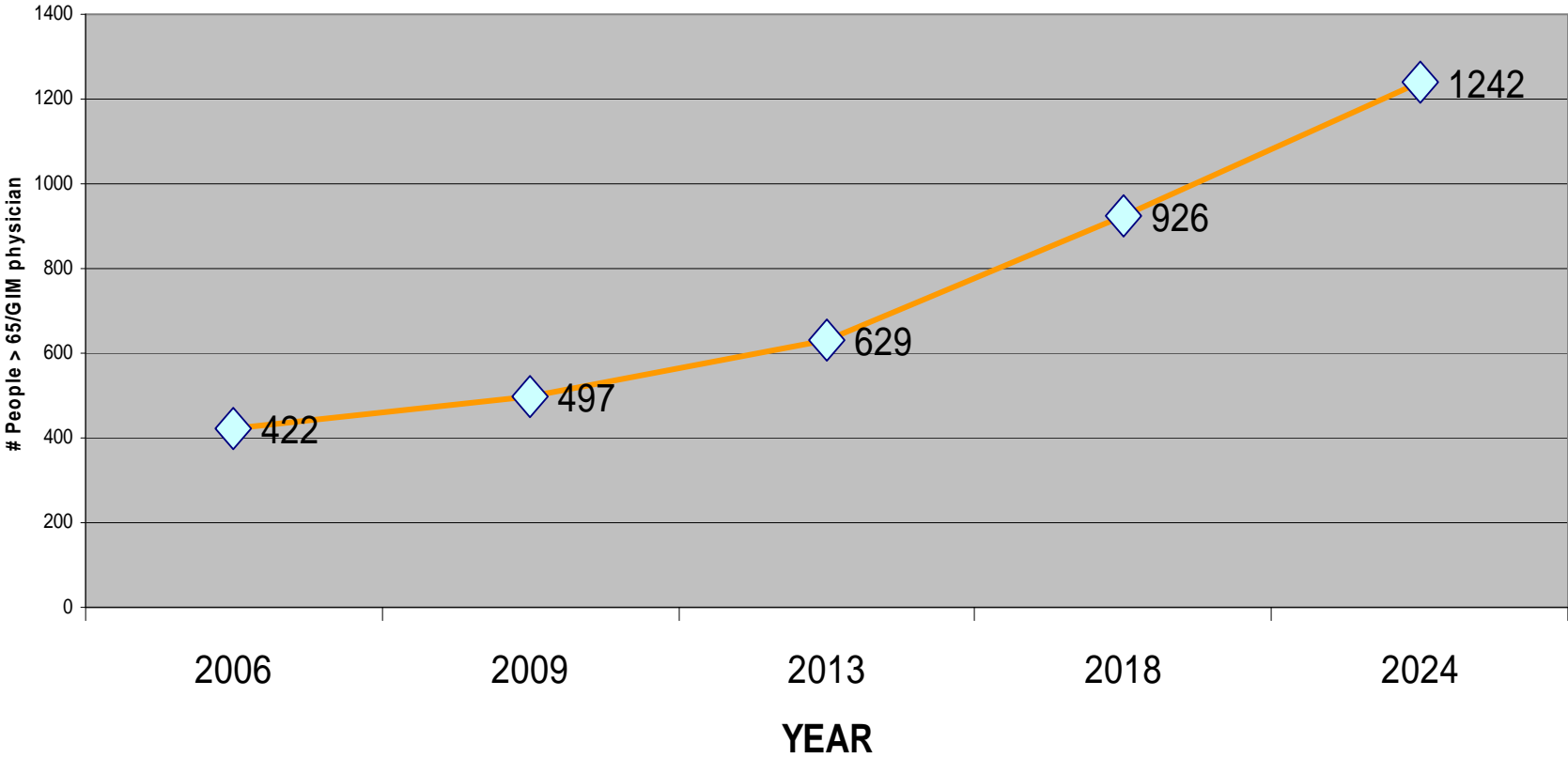


If we assume 90K GIM in 2006 and today's rate of GIM choice along with projected retirements and 21% leaving after 10 years, we have

- 60,000 by 2018
- And 50,000 by 2024

Which results in increased patient load per remaining generalist

Number of people >65/GIM physician 2006-2024

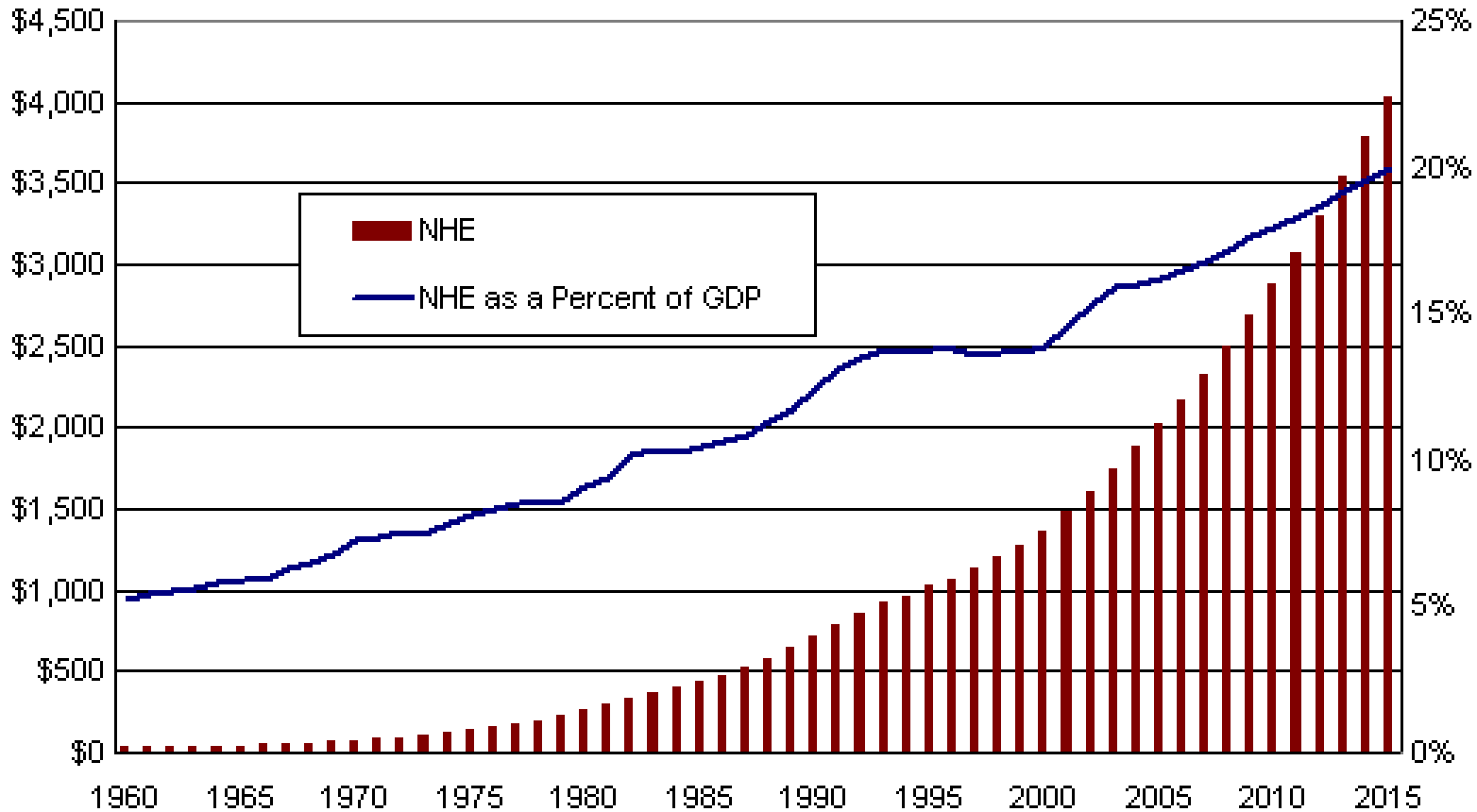




And we have enormous cost pressures

- Higher costs of health insurance
- Higher deductibles
- Fewer employers offering insurance
- More children without insurance
- Rising number of uninsured
- With health care costs going up faster than wages
- Even *before* \$700B bailout!

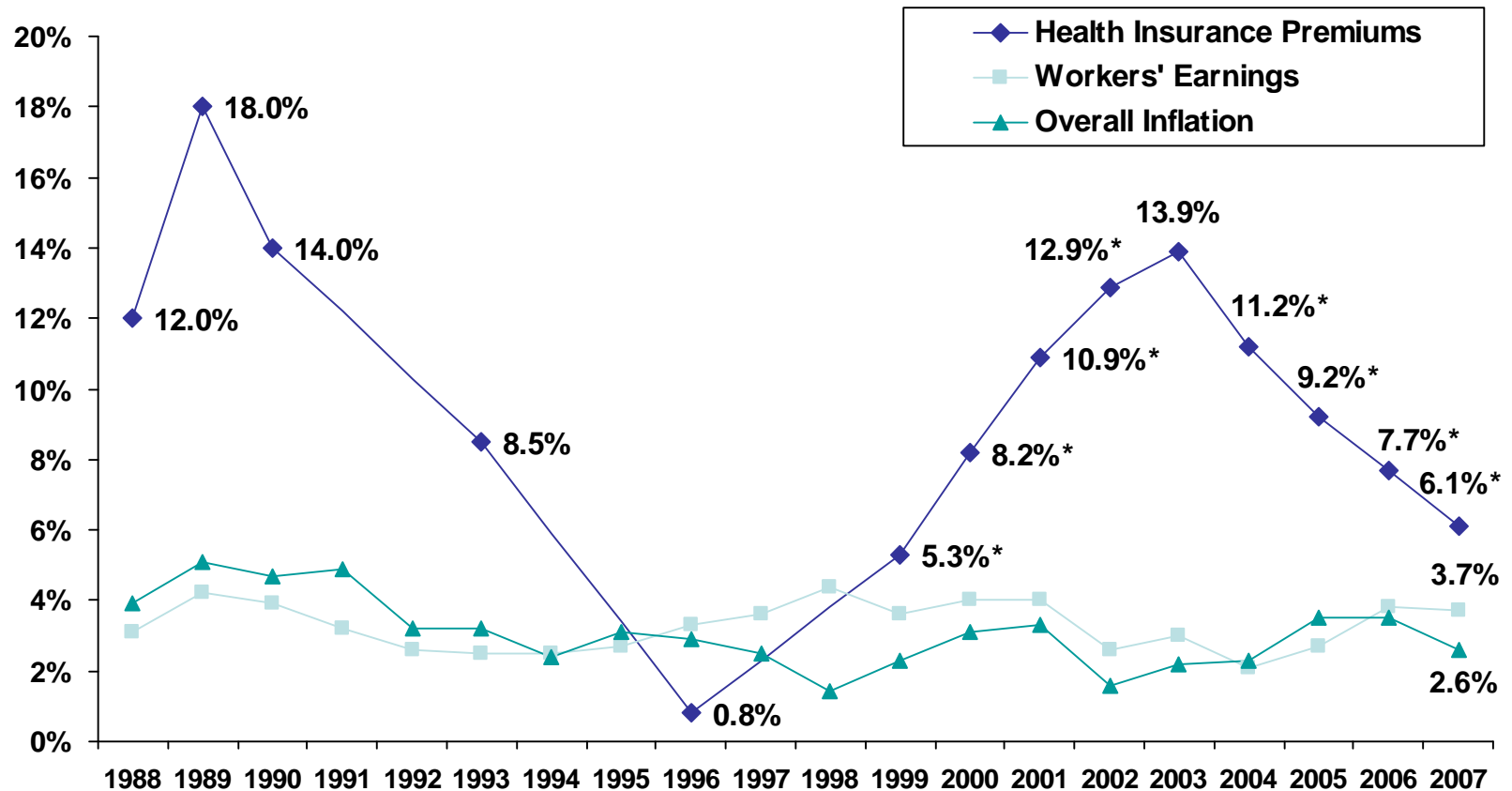
National health expenditures (aggregate) and share of GDP



Source: Employee Benefit Research Institute estimates from Centers for Medicare and Medicaid Services and U.S. Department of Commerce. (2005-2015 data are projected.)

Last Updated: April 1, 2006

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2007

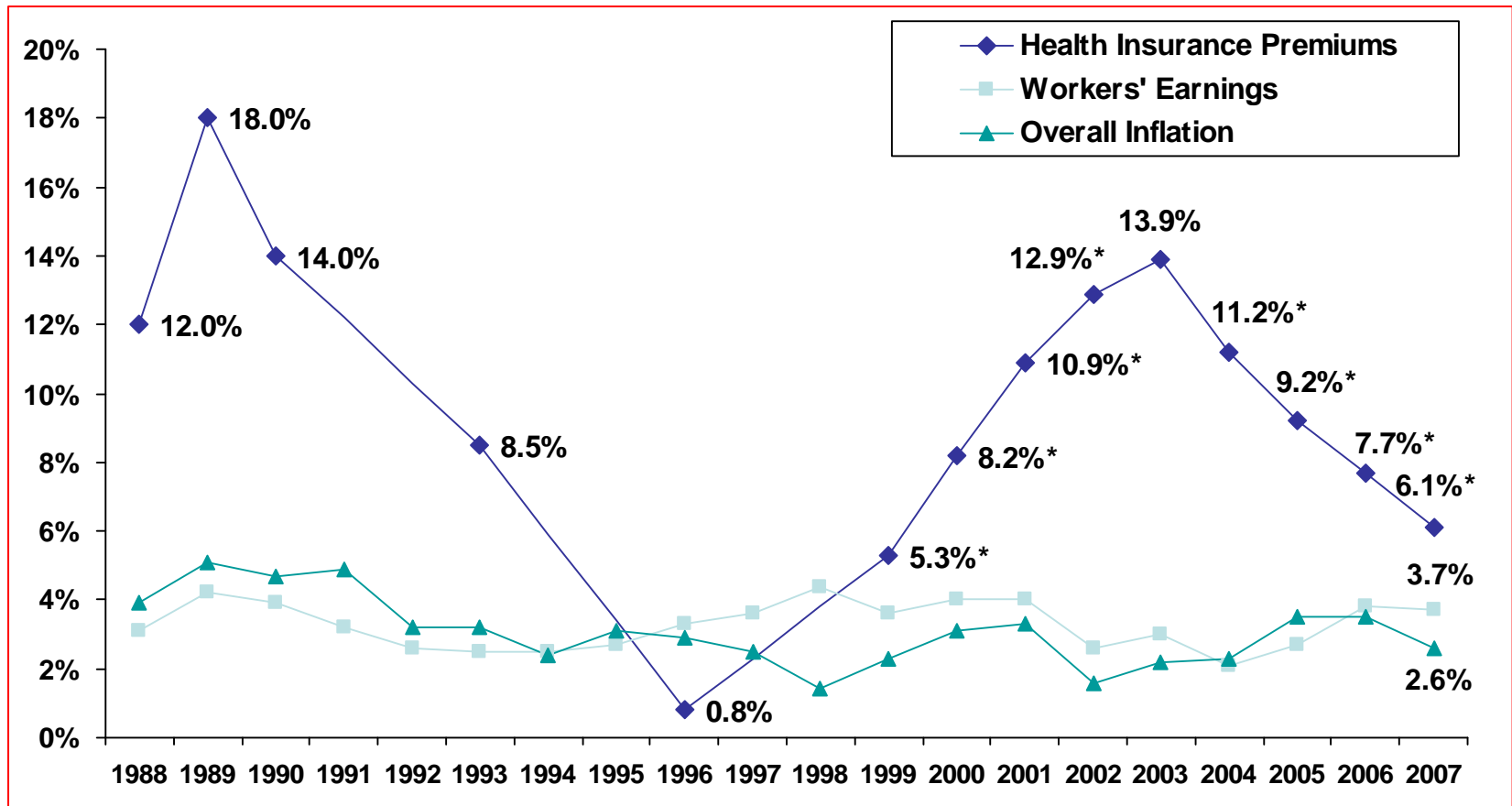


*Estimate is statistically different from estimate for the previous year shown ($p < .05$). No statistical tests are conducted for years prior to 1999.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. The average premium increase is weighted by covered workers.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007 (April to April).

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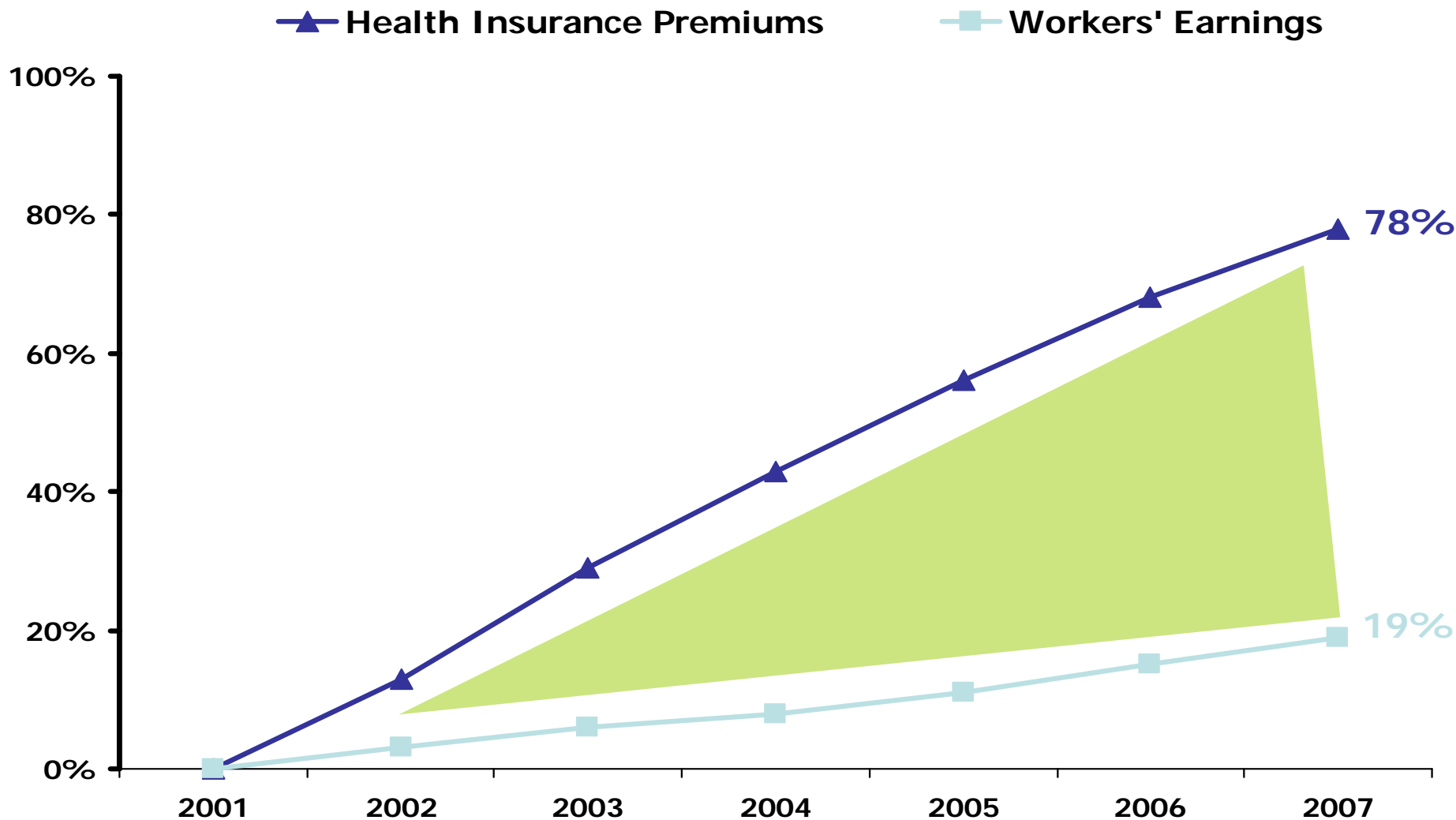
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("Shark" courtesy of Arnie Milstein)

Cumulative Changes in Health Insurance Premiums and Workers' Earnings, 2001-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007 (April to April).



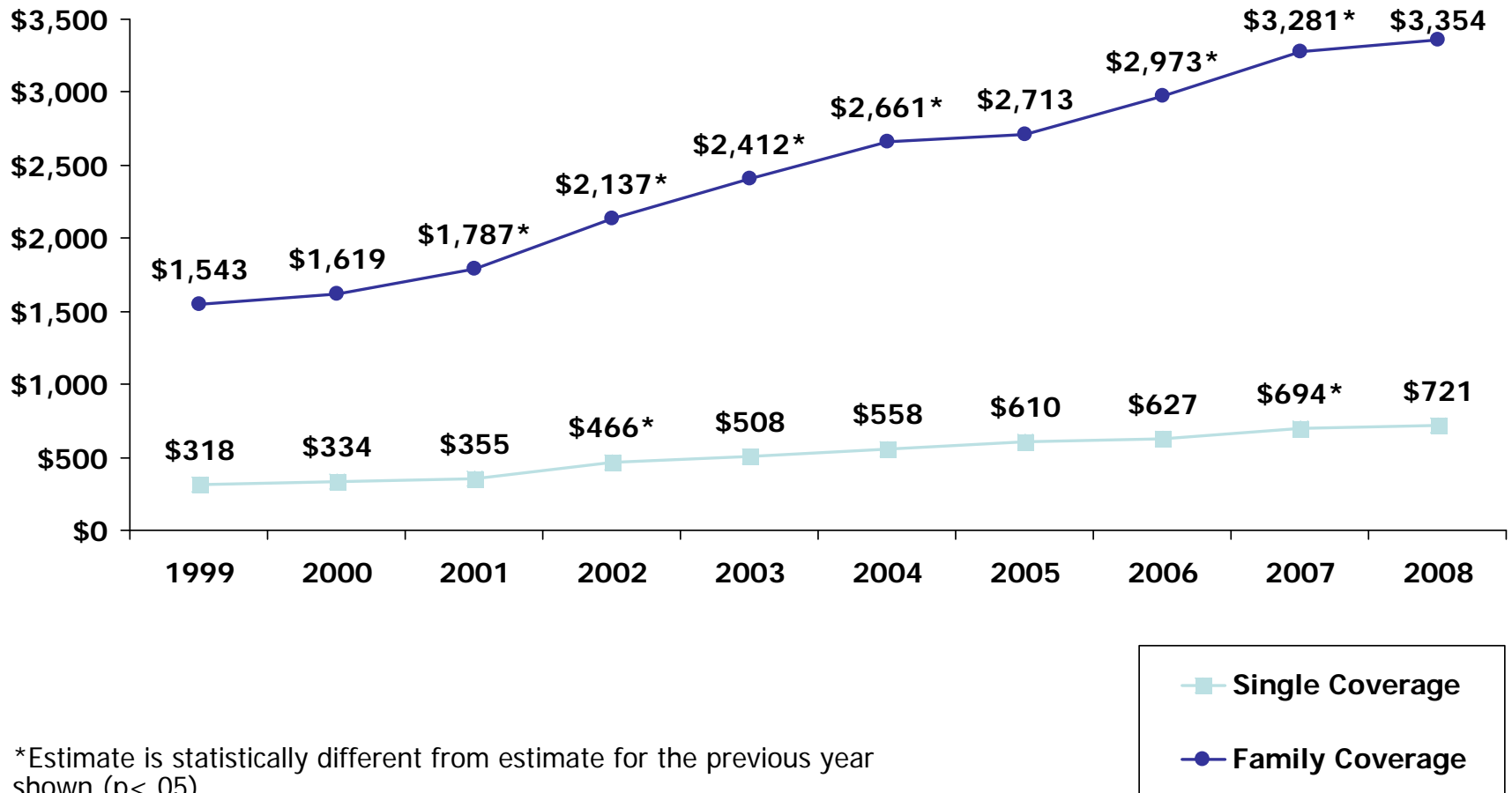
“The long term fiscal condition of the United States has been largely misdiagnosed. Despite all the attention paid to demographic challenges . . . Our country’s financial health will in fact be determined primarily by the growth rate of per capita health care costs.”

Orszag PR, Ellis P. The challenge of rising health care costs- A view from the CBO. NEJM 2007; 357: 1793-95



So we shift who pays for care . . .

Exhibit 3: Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999-2008



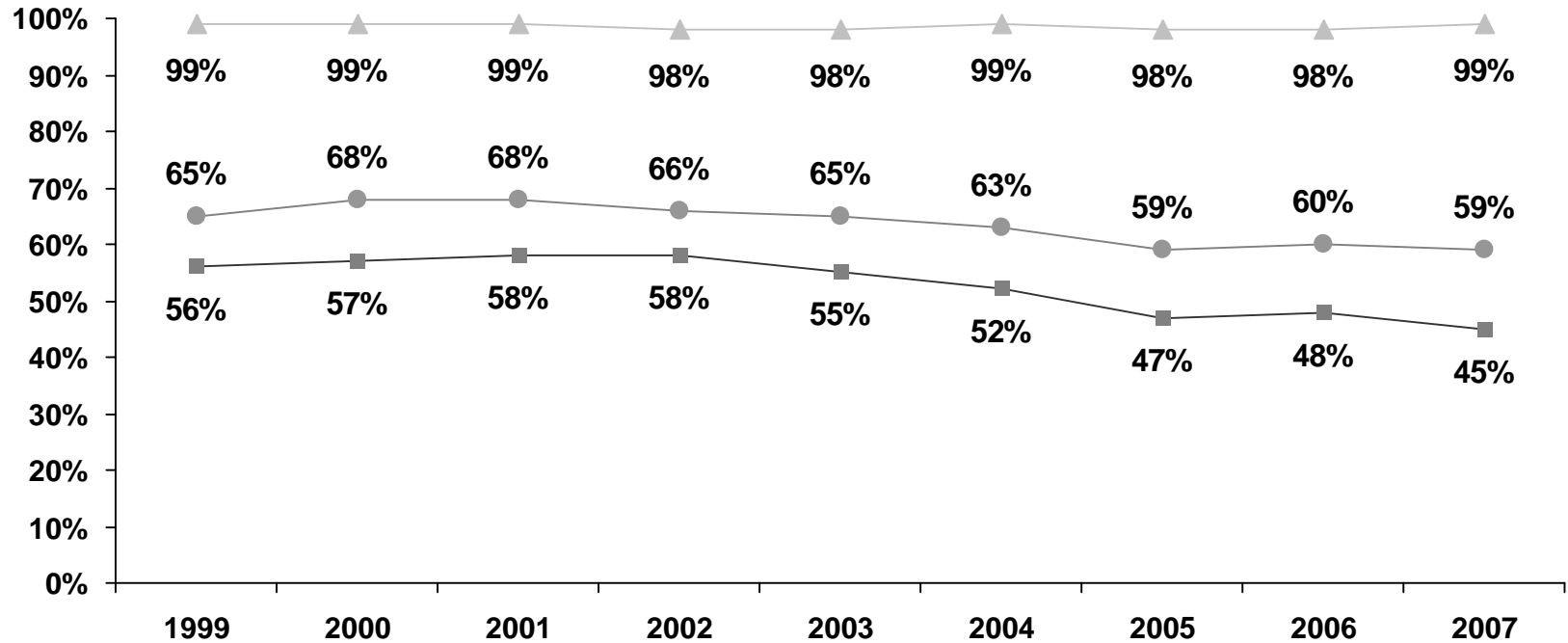
*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.



And employers, especially small ones,
stop offering insurance

Percentage of All Firms Offering Health Benefits, 1999-2007*



*Tests found no statistical differences from estimate for the previous year shown ($p < .05$).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

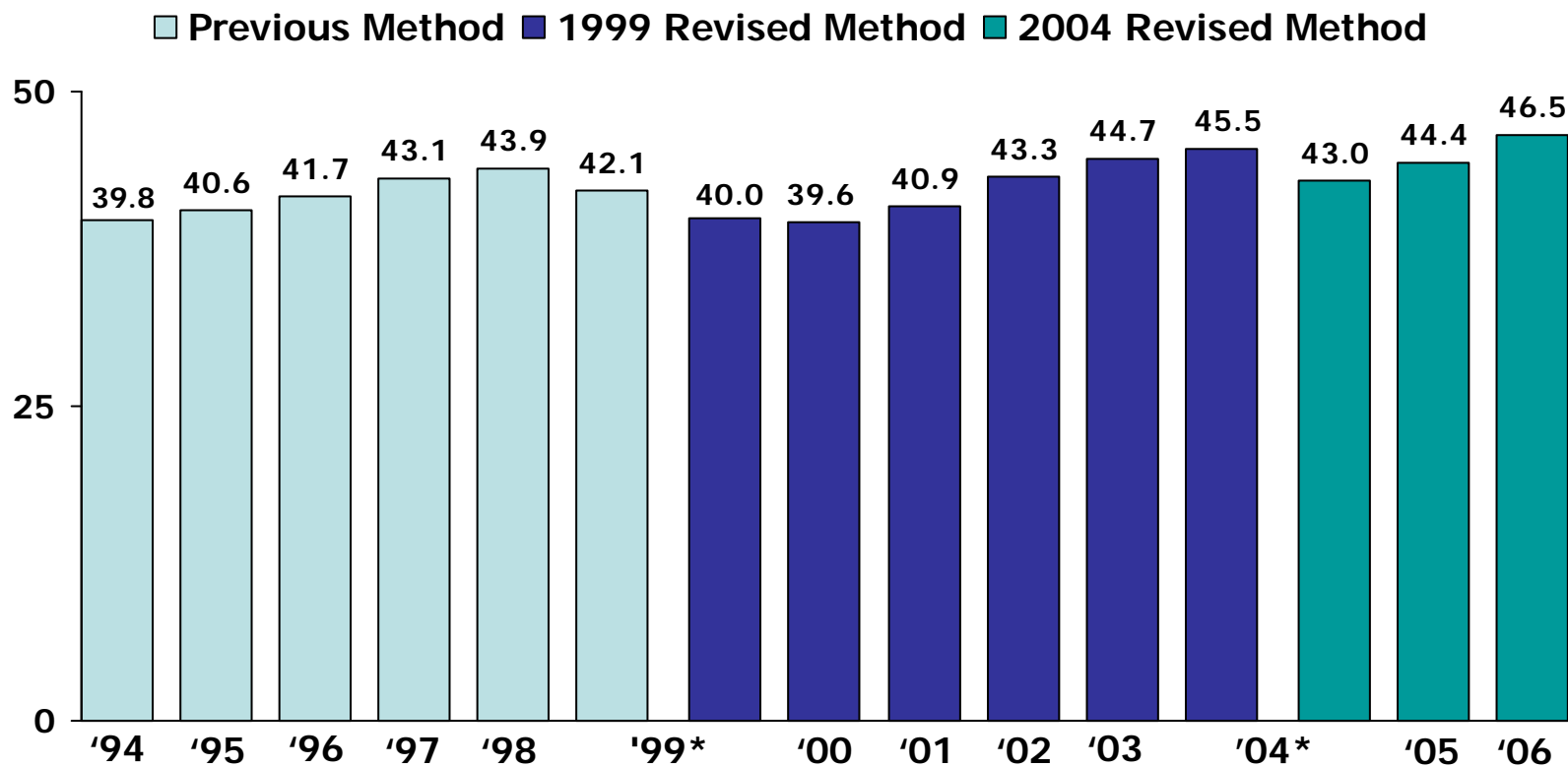


Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007.



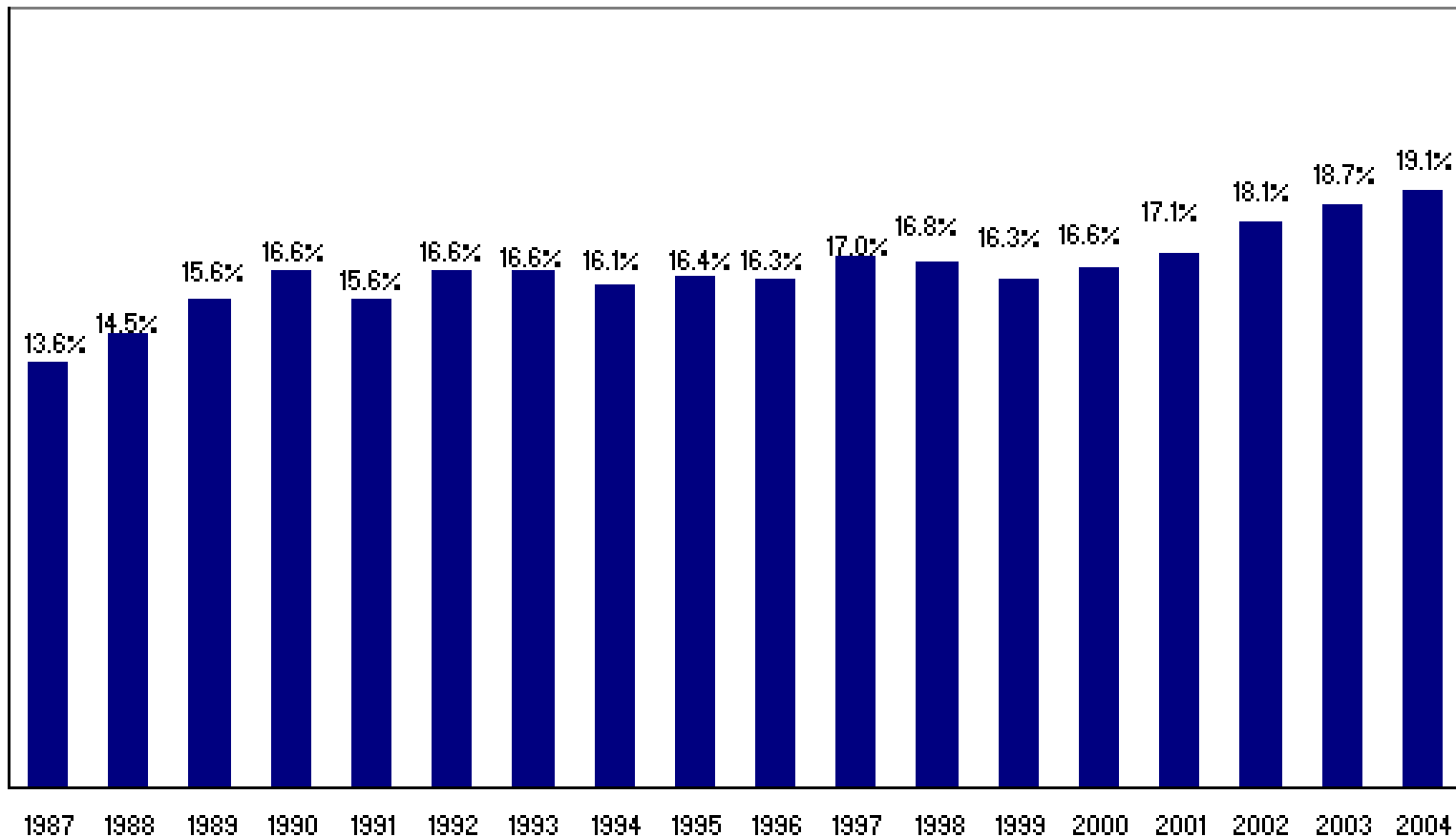
And the number of uninsured keeps
going up . . .

Number of Nonelderly Uninsured Americans, 1994 – 2006



* The Census Bureau periodically revises its CPS methods, which means data before and after the revision are not comparable. Comparison across years can be made between 1994 and 1999, 1999 through 2004, and 2004 through 2006.
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2007 CPS.

including those who work

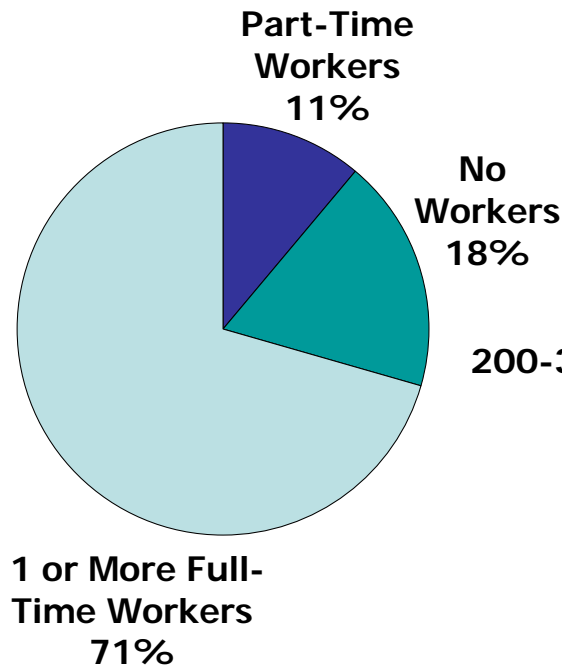


Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1988-2005 Supplements.

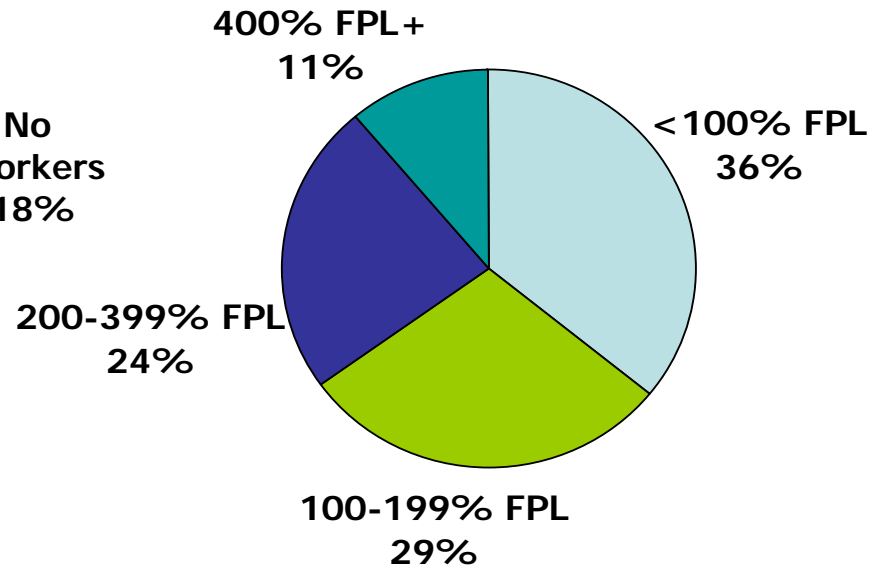
Last Updated: April 1, 2006

Characteristics of the Uninsured, 2006

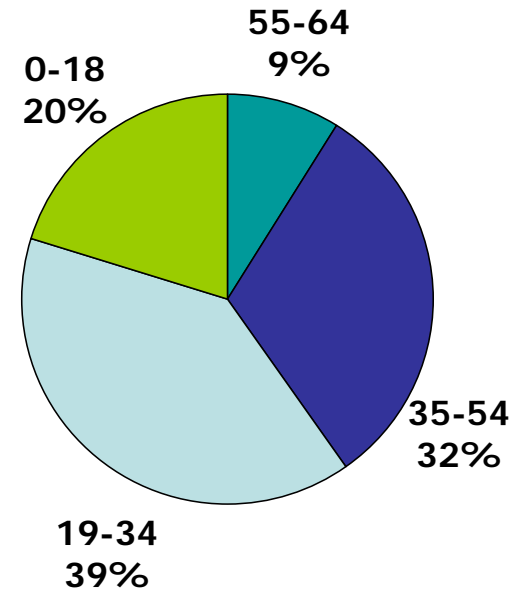
Family Work Status



Family Income



Age



Total = 46.5 million uninsured

The federal poverty level was \$20,614 for a family of four in 2006.
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2007 CPS.



What are the cost drivers?

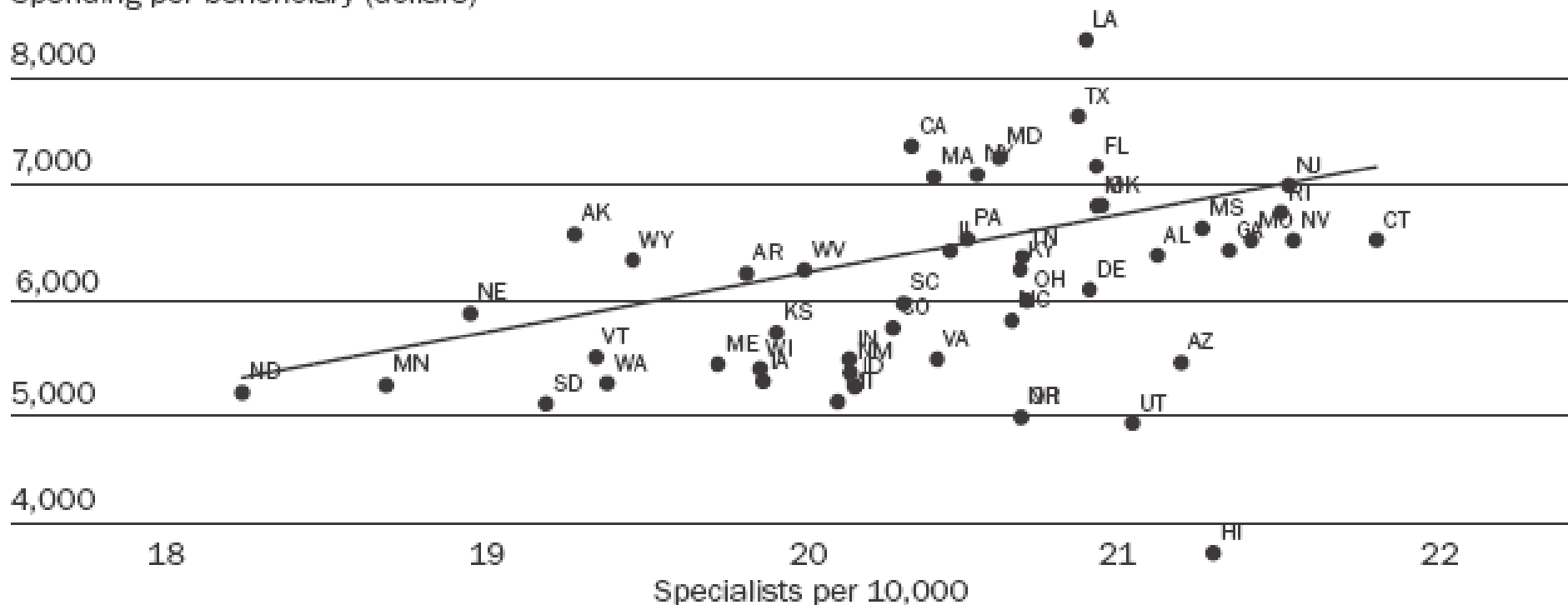
- Technology (e.g., X-ray to CT to MR)
- Pharmaceuticals
- Longevity
- Increased use of services
- *Primary care vs. specialty distribution*

More specialists mean higher spending

EXHIBIT 7

Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)



SOURCES: Medicare claims data; and Area Resource File, 2003.

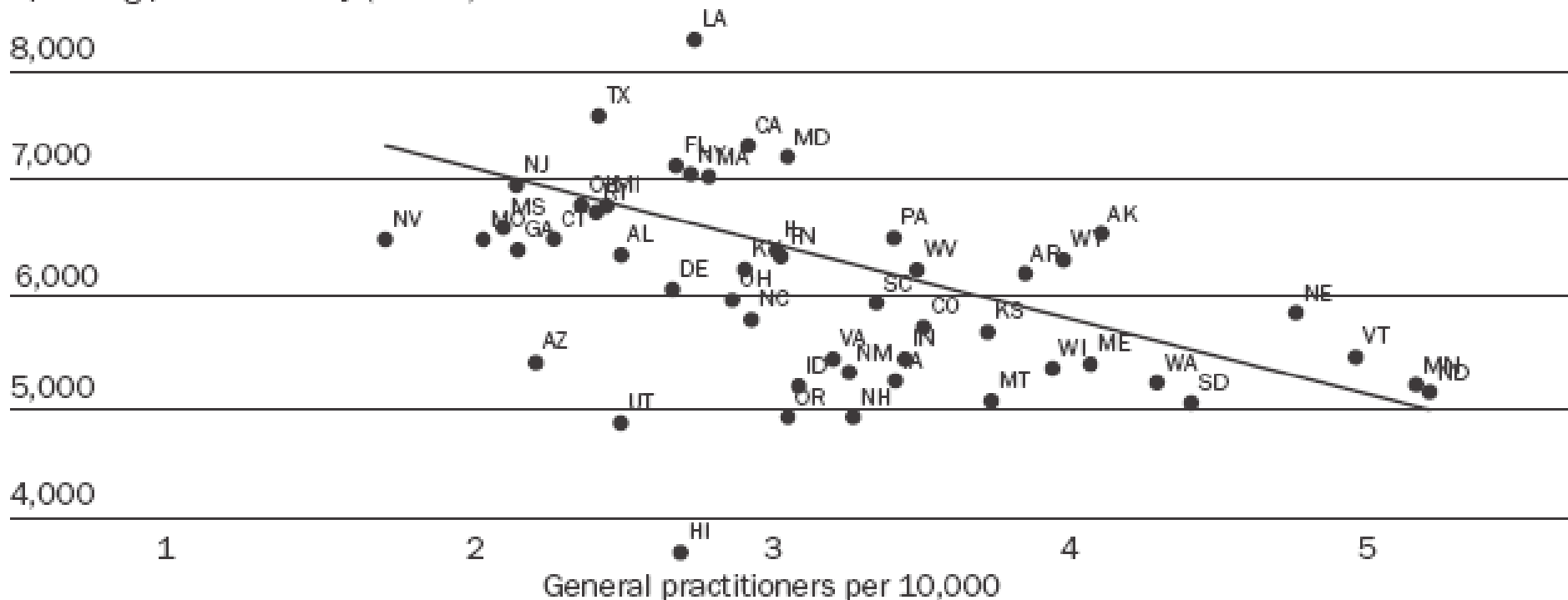
NOTE: Total physicians held constant.

While GPs are associated with less spending

EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)



SOURCES: Medicare claims data; and Area Resource File, 2003.

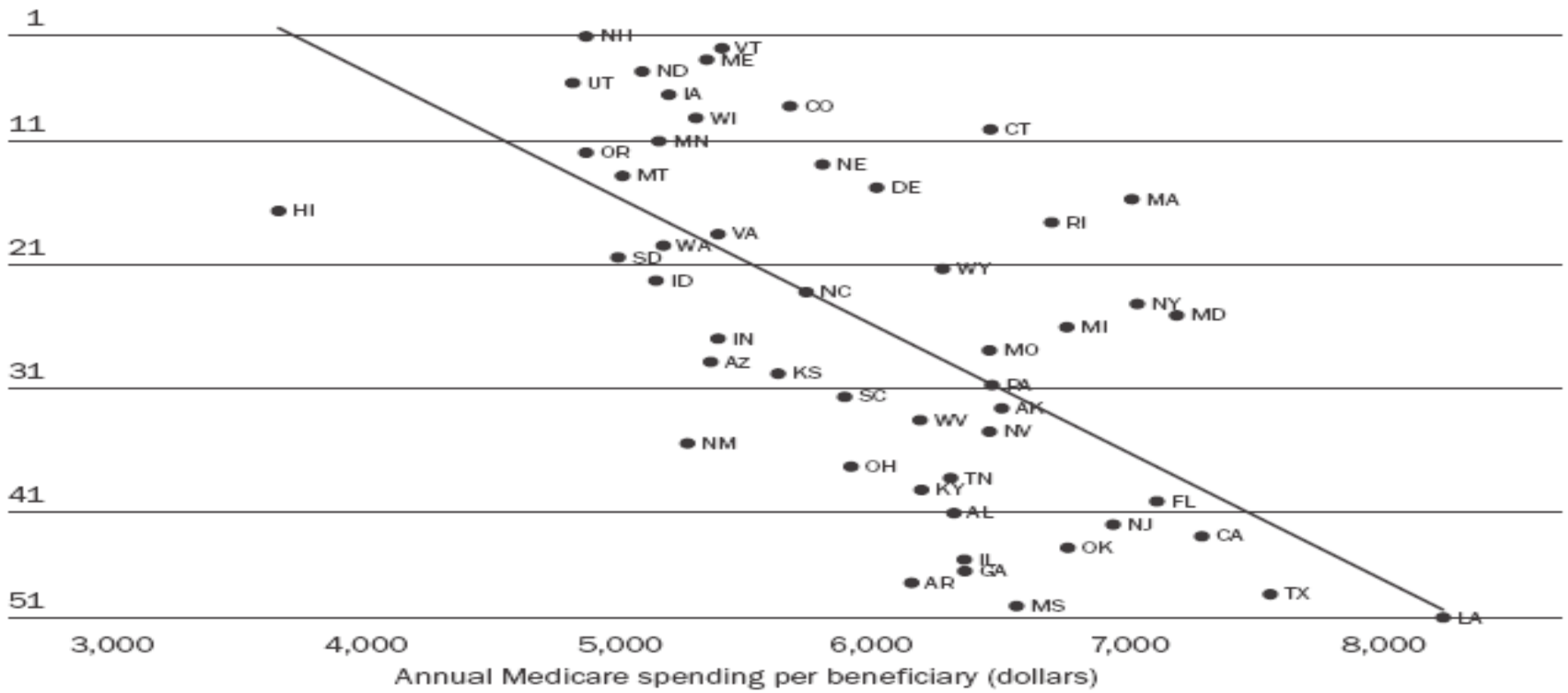
NOTE: Total physicians held constant.

As it turns out, cost is *inversely* related to quality

EXHIBIT 1

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

Overall quality ranking



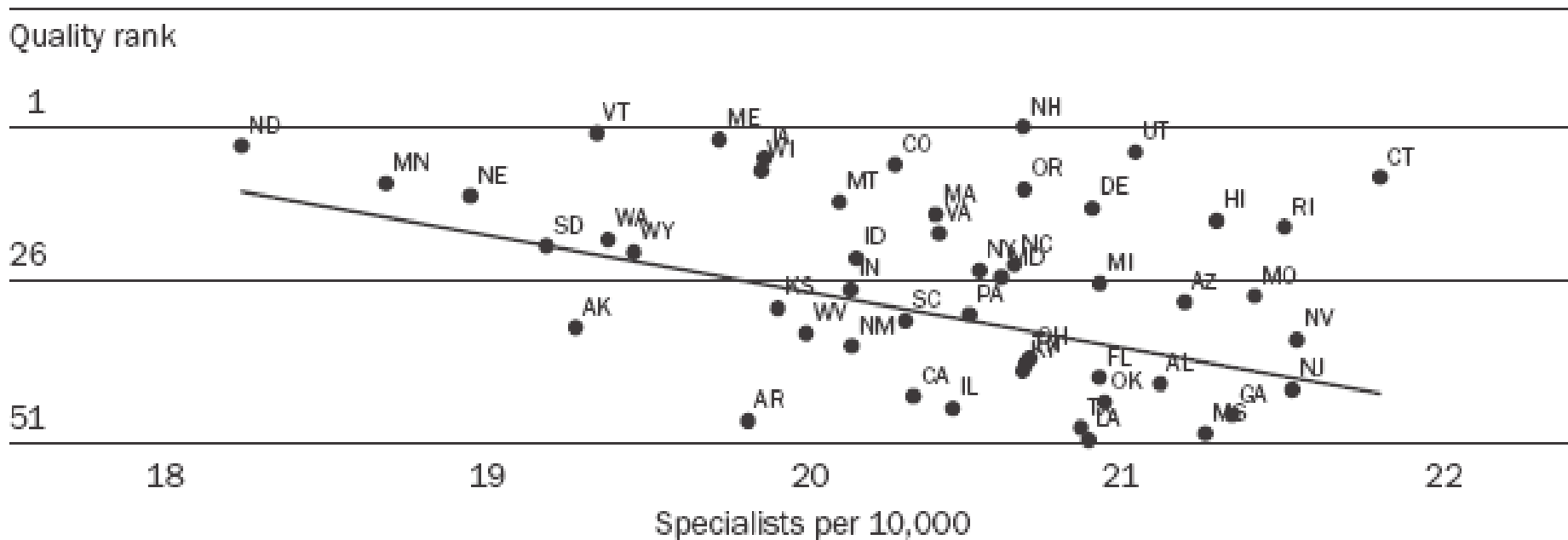
SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

NOTE: For quality ranking, smaller values equal higher quality.

And more specialists predict lower quality ranking

EXHIBIT 6

Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000



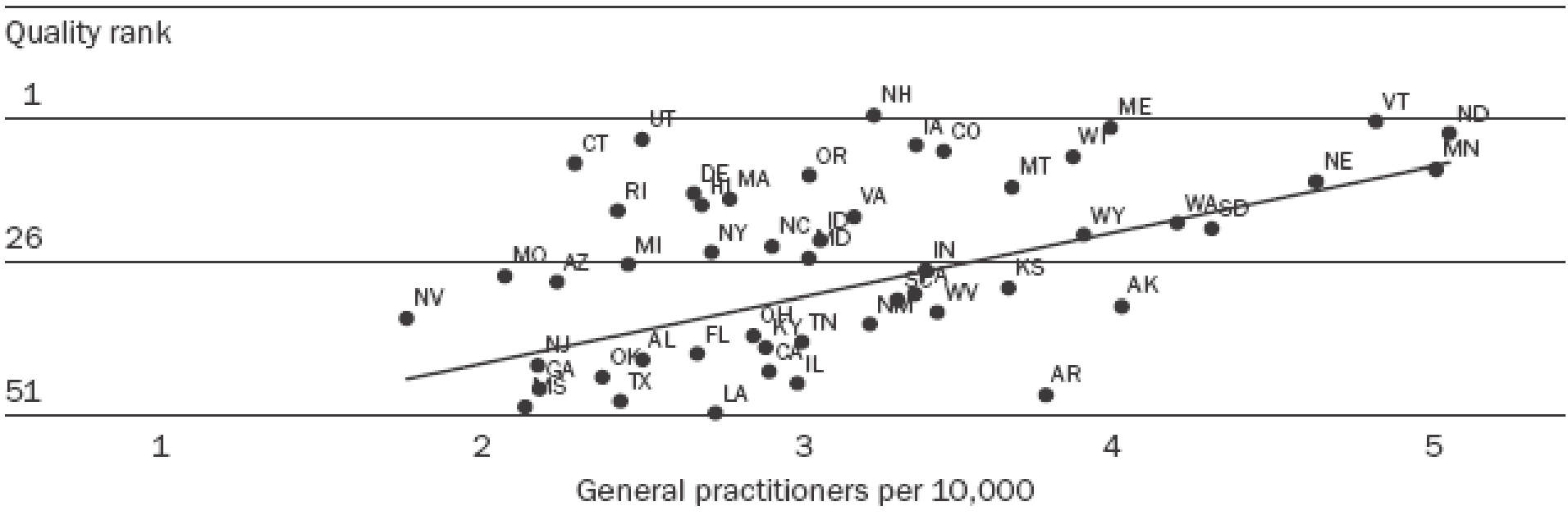
SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

While more GPs predict higher quality ranking

EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



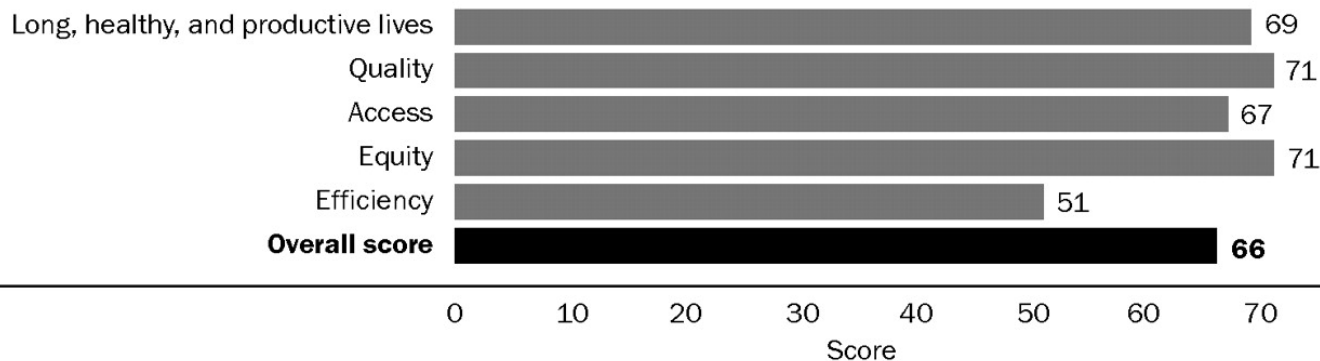
SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Commonwealth Data confirm high cost, low quality for US compared to other countries

EXHIBIT 7

Summary Of Scores: Dimensions Of A High-Performance Health Care System



SOURCE: Authors' calculations based on scores in Exhibits 1–6. Quality: average of (1) right care, (2) coordinated care, (3) safe care, and (4) patient-centered, timely care. Equity: average of income, insurance, black, and Hispanic.

Cathy Schoen, Karen Davis, Sabrina K.H. How, and Stephen C. Schoenbaum,
U.S. Health System Performance: A National Scorecard,
Health Affairs, Vol 25, Issue 6, w457-475w

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But what is it about primary care that leads to higher quality/lower cost?

- Is it the 8 minute visit?
- The failure to refer?
- The willingness to tolerate uncertainty and ***not*** to refer?
- Care coordination?
- Care management?
- Proactive, inter-visit care?
- Preventive care?



Patient Centered Medical Home: ACP, AAP, AAFM, AOA

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment



NCQA PPC PCMH tool criteria

- Access and communication
- Patient tracking and registry
- Care management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improvement
- Advanced electronic communication



Consumer “Principles for Patient- and Family- Centered Care”

- Interdisciplinary team, patient at center
- Coordinates care across settings and time
- Patient has ready access to care
- PCMH “knows” its patients
- Patients and clinicians are partners in making decisions
- Open communication supported
- Patients and caregivers supported in managing the patient’s health
- Environment of trust and respect
- Safe, timely, effective, efficient, equitable, patient centered and family focused

Milstein: Ambulatory Intensive Caring Unit, a “super-model” of primary care

- Targeted at most expensive 20% (who utilize 60% of next year’s resources)
- First floor
 - RN, CHW, pharmacist, dietitian under protocol
- Second floor
 - IT-enabled and streamlined NP and MD visits
- Third floor
 - Integration with first two, care directed to high performers

Aggregate financial impact

- A-ICU operating costs: \$1018 PMPY (\$644 *more than, or 2.7 times as much as* the “typical primary care clinic”)
- Overall projected *net* savings: **36.9%**
 - Base projection without A-ICU: \$6525 PMPY
 - With A-ICU, net of primary care cost increase: \$4118



High leverage changes

- Health information technology adoption
- Standardization
- Care coordination
- Team based care in primary care
- New payment models
 - Gorroll- “Comprehensive pay for comprehensive work”
 - More global, less –but still some- FFS



ABIM work on CCIM: New skills are required, *it's not just funding*

- Expert diagnostician and clinician
- Patient advocate
- Effective communicator
- Team leader and an effective teammate
- Systems manager
- Effective user of health information technology and health data
- Effective change agent
- Practitioner accountable for efficient, accessible care



Change management

- Where you are is not where you need to be
- No one likes change
- Thermodynamics
- Nickols model: How? What? Why?



Leading change

- Articulate a vision
- Communicate it effectively
- Inventory skills needed to get there
- Train folks who need it
- Measure progress toward goals
- Demand success, don't accept failure
- Anticipate resistance, hostility, opposition



Greenhouse experience EHR

- Disruptive and stressful
- Everyone hated going to work
- No one knew how to do their job
- Everyone blamed everybody else
- Most difficult thing we ever did
- But today, we use it to accomplish unimaginable things



Technology

- Project Mammogram
- In office communication activates teams
- Building “goal setting” into EHR for MAs to complete- maybe kiosk/patients
- Regular reporting
- Physician interaction
 - E.g., pain mgmt project

Staff

- MAs rooming protocol
 - Chief complaint, vital signs
 - Also: Med reconciliation, review “services due”, Living Wills, etc.
- Front desk telephone outreach
 - Future flag appointments, lost to f/u
- Health Educator
 - 50% “wholesale”, 50% “retail”



Physicians

- Recognition of email, phone calls as part of productivity metric
- Expectation of “team leadership in chronic disease management”
- Change in “full time” direct patient hours