

# **Assuring an Adequate Primary Care Workforce and Transforming Primary Care**

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Abundant research evidence indicates that health systems and regions with a strong foundation of primary care have:

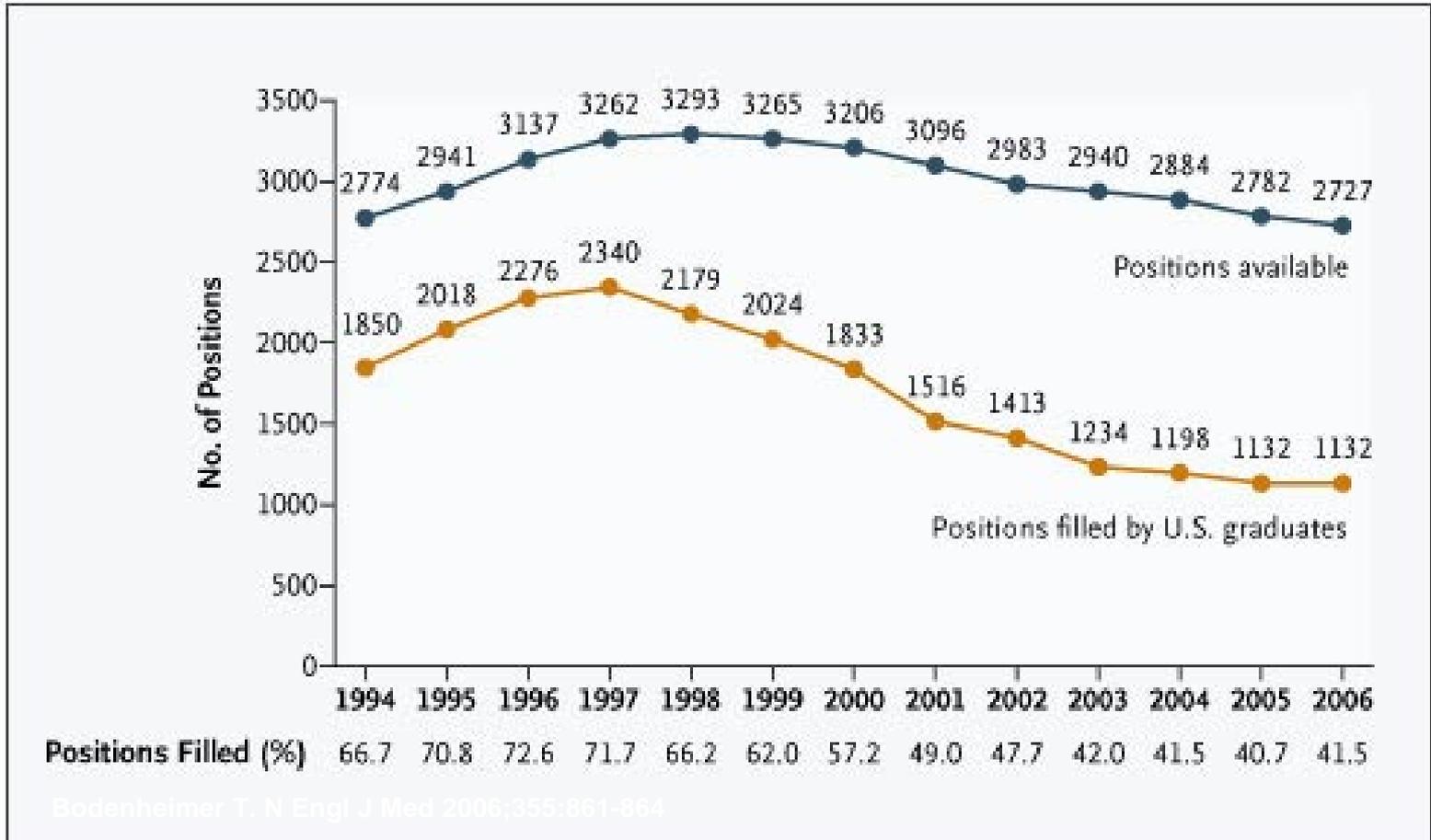
- Better population health outcomes
- Better quality of care
- More preventive care
- Lower costs
- More equitable care and mitigation of health disparities

# But the Primary Care Workforce Foundation in the US is Crumbling

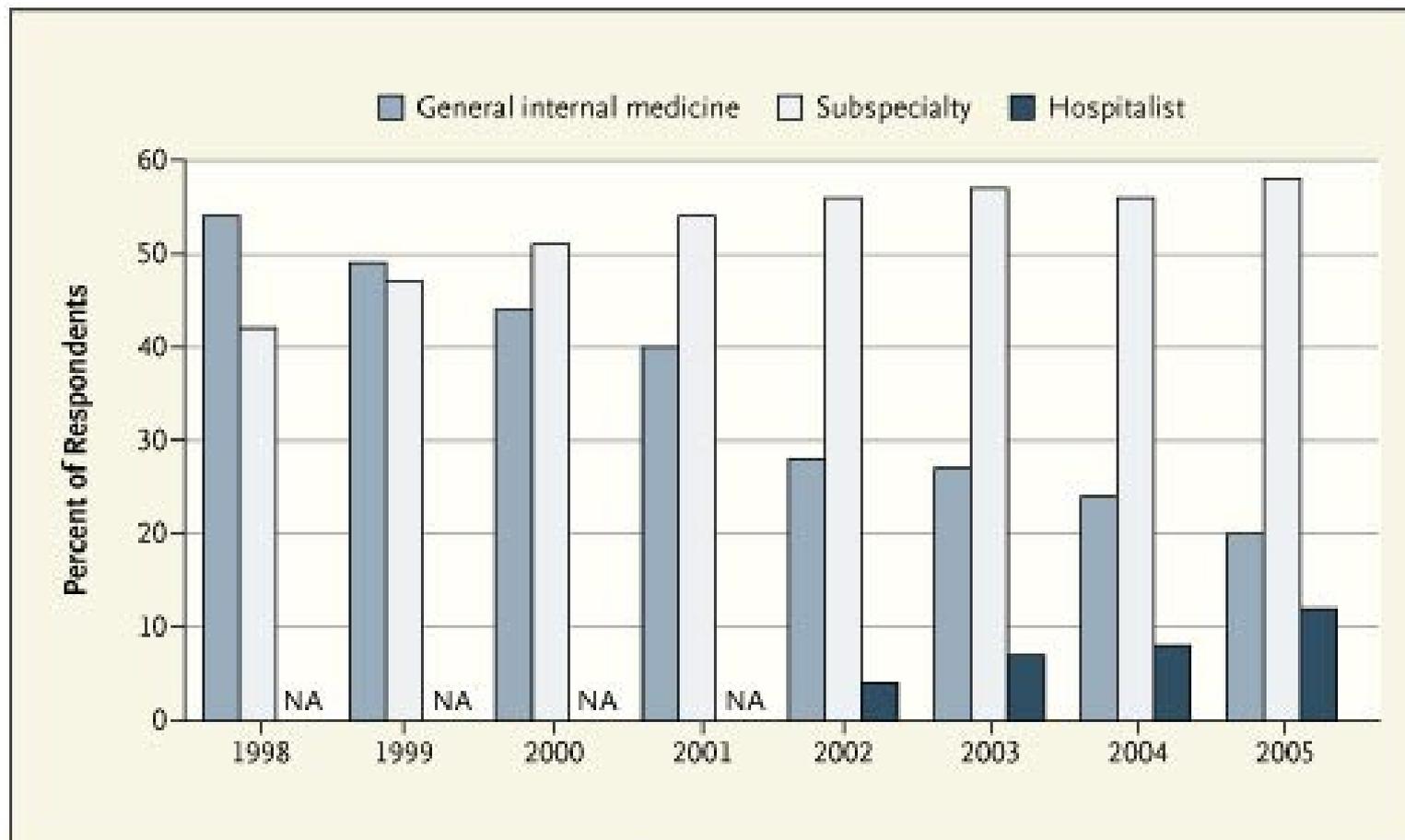
- Plummeting numbers of new physicians entering primary care
- Primary care shortages throughout US
- Growing problems of access to primary care and “medical homelessness”



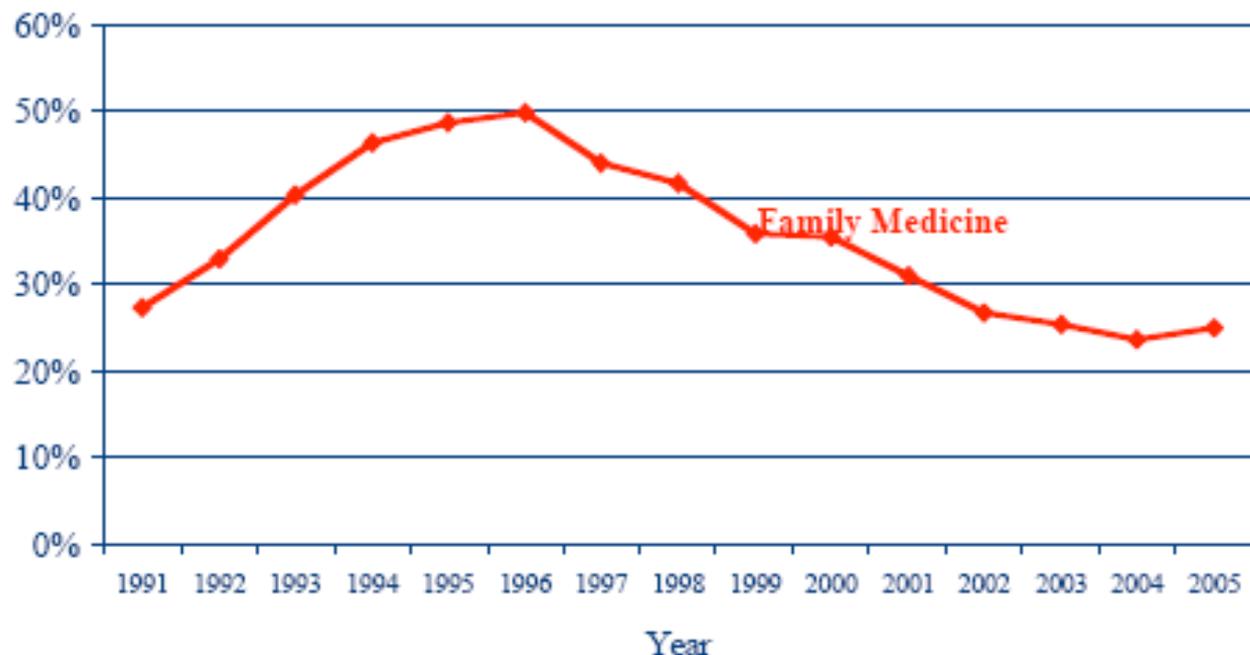
# Family Medicine Residency Positions and Number Filled by U.S. Medical School Graduates



# Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



*Percent of New PAs Entering Family Medicine Parallels the Rise and Fall of MDs Going into Family Practice 1991-2005*



\*PAs graduating in year immediately preceding the census reference year are considered New Graduates.

Sources: AAPA Membership Census Survey, 1991-1995; AAPA Physician Assistant Census Survey, 1996-2005.

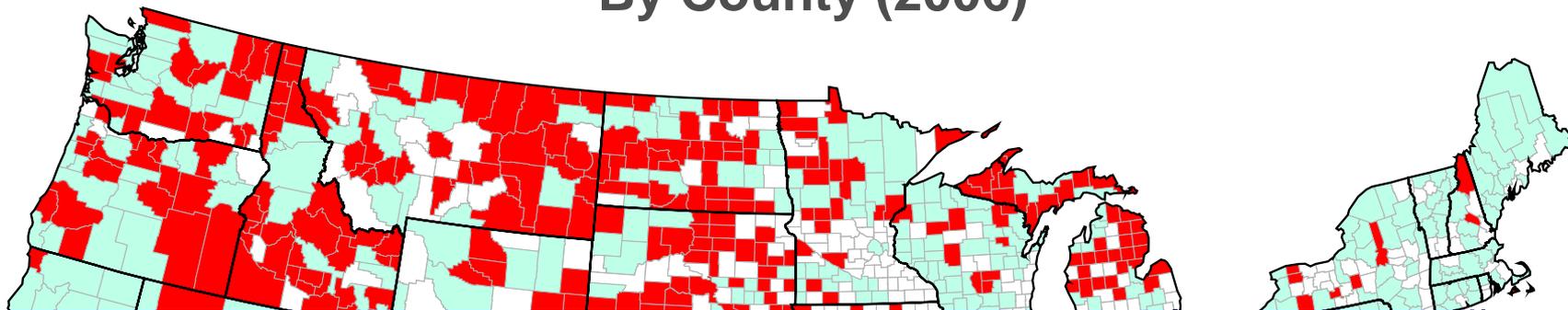


# **In Massachusetts, Universal Coverage Strains Care**

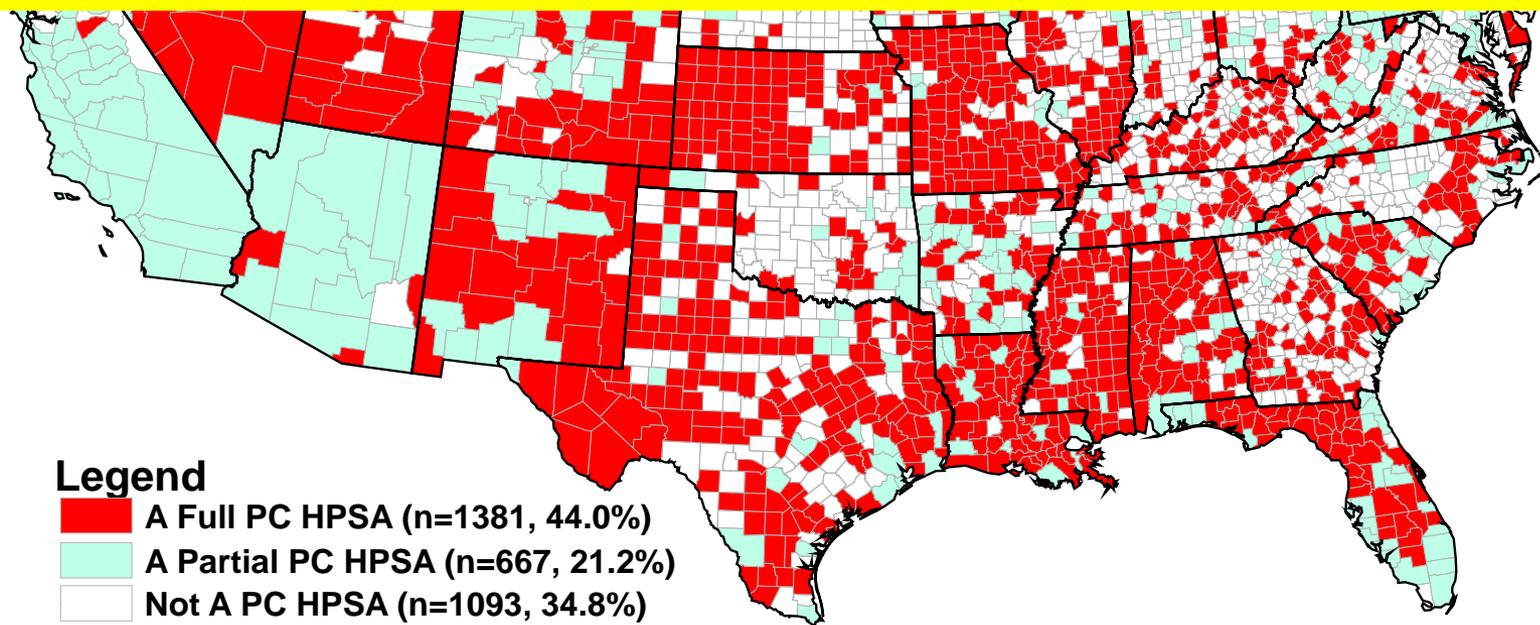


**Dr. Katherine J. Atkinson of Amherst, Mass., has a waiting list for her family practice; she has added 50 patients since November.**

# US Primary Care Health Professional Shortage Areas By County (2006)



>750 vacancies for PCPs at Community Health Centers (2004)



## Legend

-  A Full PC HPSA (n=1381, 44.0%)
-  A Partial PC HPSA (n=667, 21.2%)
-  Not A PC HPSA (n=1093, 34.8%)

Data Source: HRSA (08/03/2006)

Prepared by The Robert Graham Center

# Why Not Primary Care?

- Predisposing Factors
  - Underlying personality disposition, career aspirations
- Educational Environment
- Practice Environment
  - Compensation
  - Worklife Satisfaction

# Feedback to UCSF Students About Their Interest in Family Medicine

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*“Why would you want to be a family doctor?  
They’re basically glorified triage nurses.”*

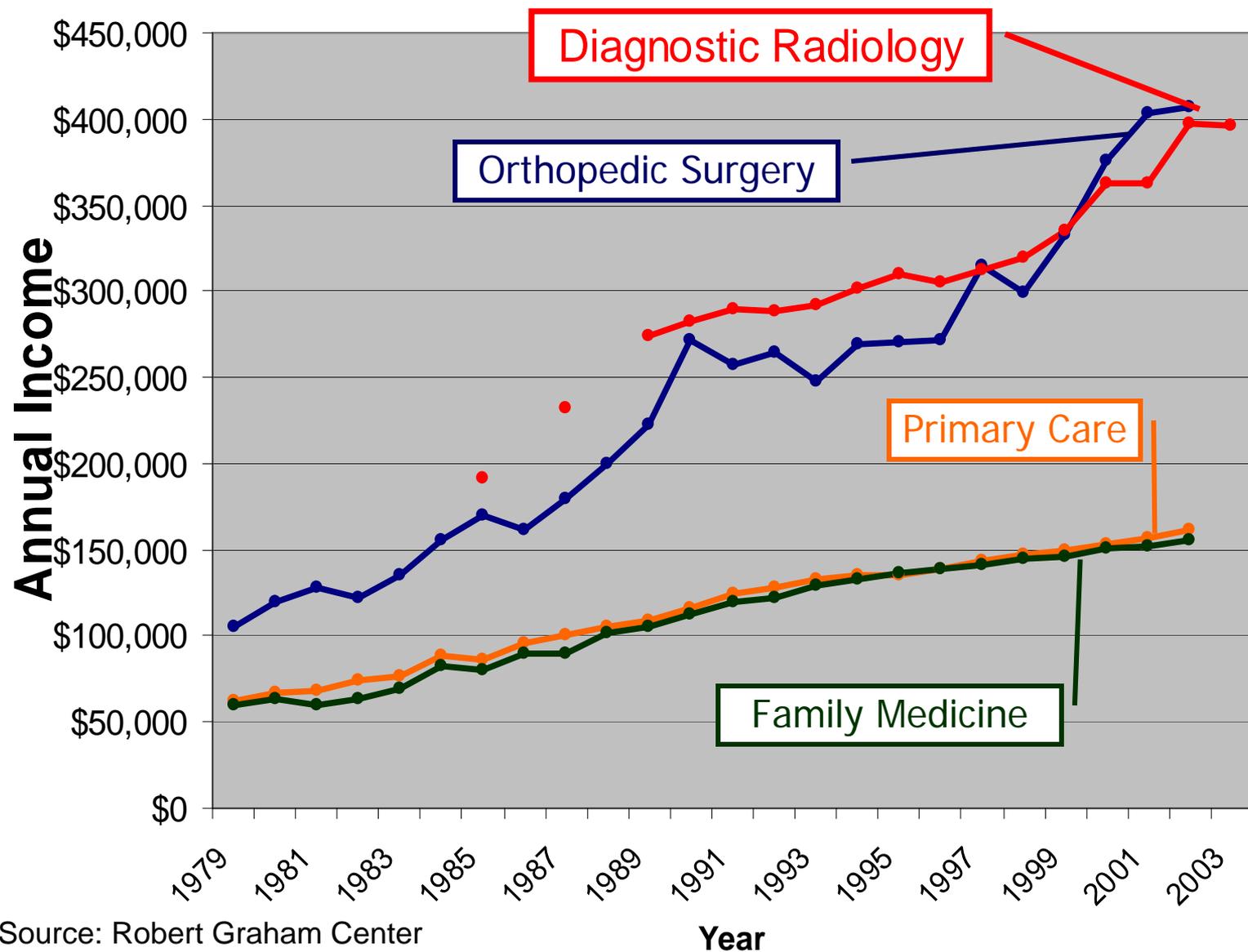
*“But you’re too intelligent for family  
practice!”*

*“Family practice is an evil plot by Congress!”*

Source: Fam Med, 1995

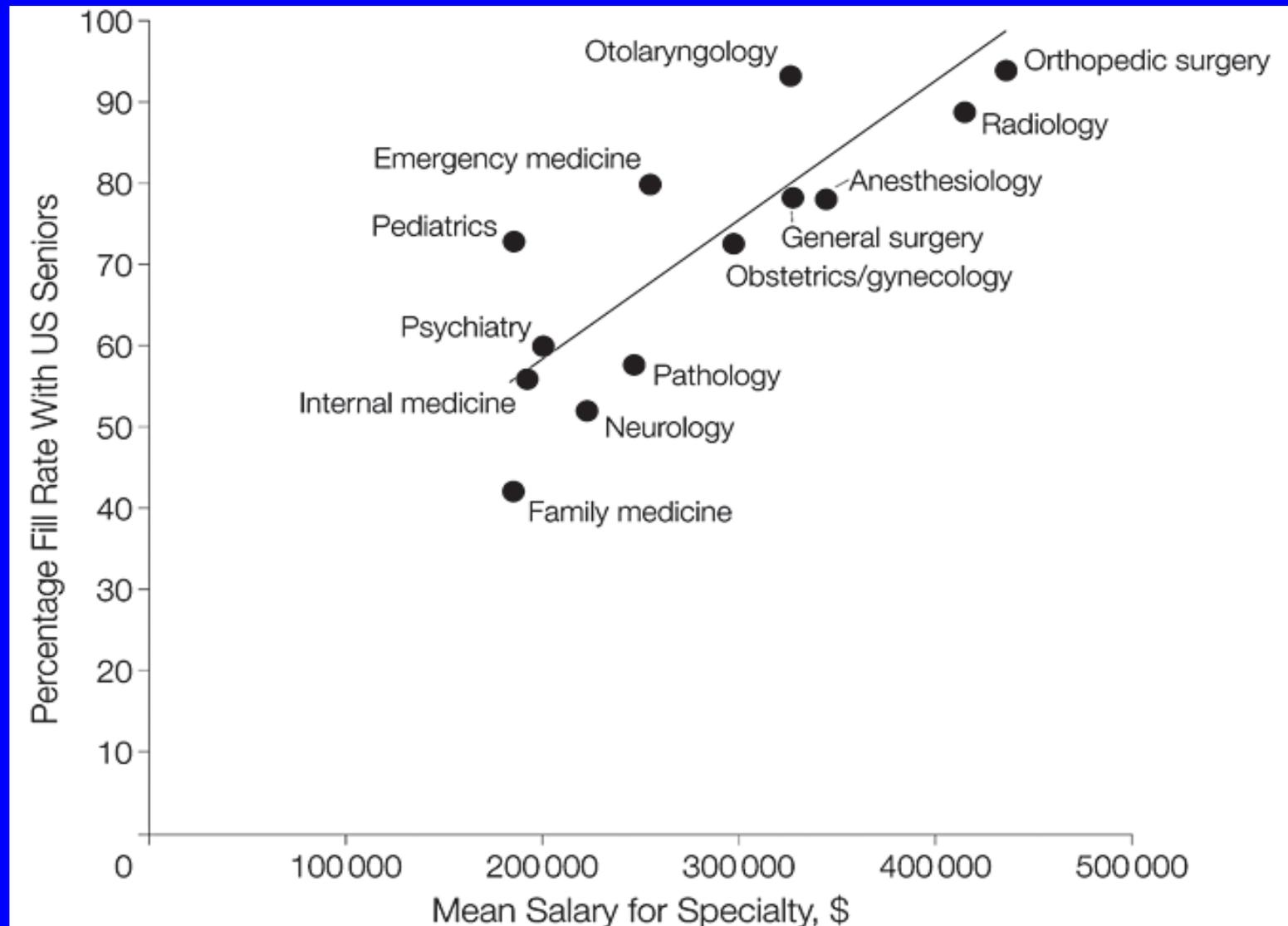


# The Widening Physician Payment Gap

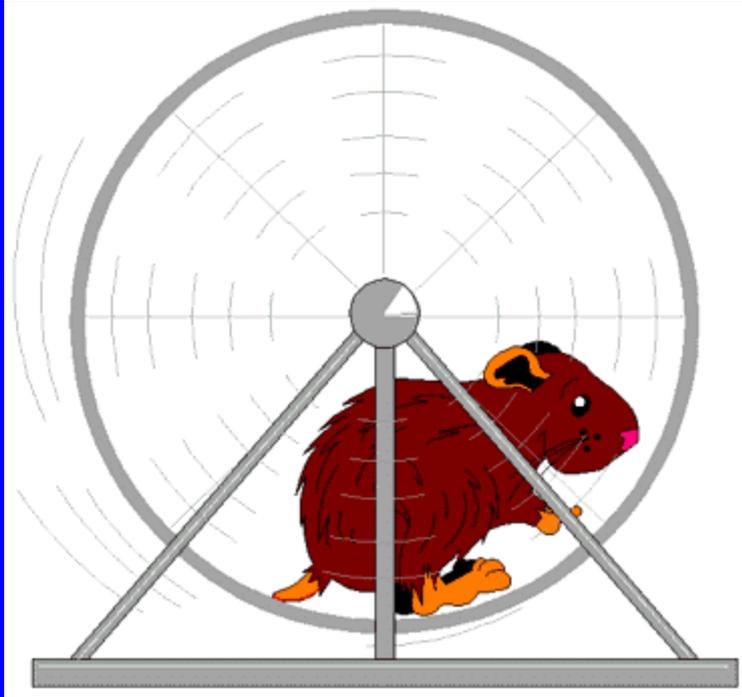


Source: Robert Graham Center

# Percentage of Positions Filled With US Seniors vs Mean Overall Income By Specialty



# PCP Burn Out



**“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stay still.”**

**Morrison and Smith,  
BMJ, 20001**

# 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 [Yarnall et al. Am J Public Health 2003;93:635]
  - 10.6 hours per day to deliver all recommended chronic care services [Ostbye et al. Annals of Fam Med 2005;3:209]

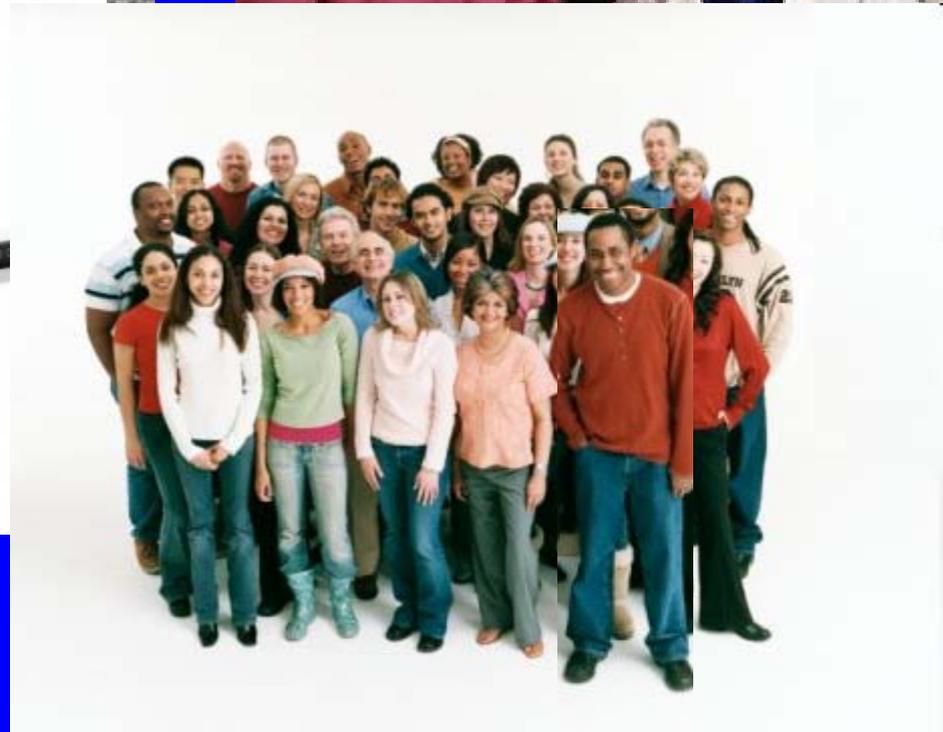
# A Comprehensive Strategy is Required to Revitalize Primary Care and Rebuild the Primary Care Workforce

- “Push” factors
  - Medical school admissions policies
  - Medical education orientation
- “Pull” factors
  - Financial incentives
    - Physician payment reform
    - Loan repayment and scholarships
  - Transforming primary care practices into high-performing, joyful workplaces

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



- Rittenhouse & Shortell: 4 Cornerstones of the PCMH
- Primary Care
- Patient-Centered
- New Model Practice
- Payment Reform
  - Needs to be coordinated, multi-payer approach



# Group Health Cooperative of Puget Sound Primary Care Redesign Pilot

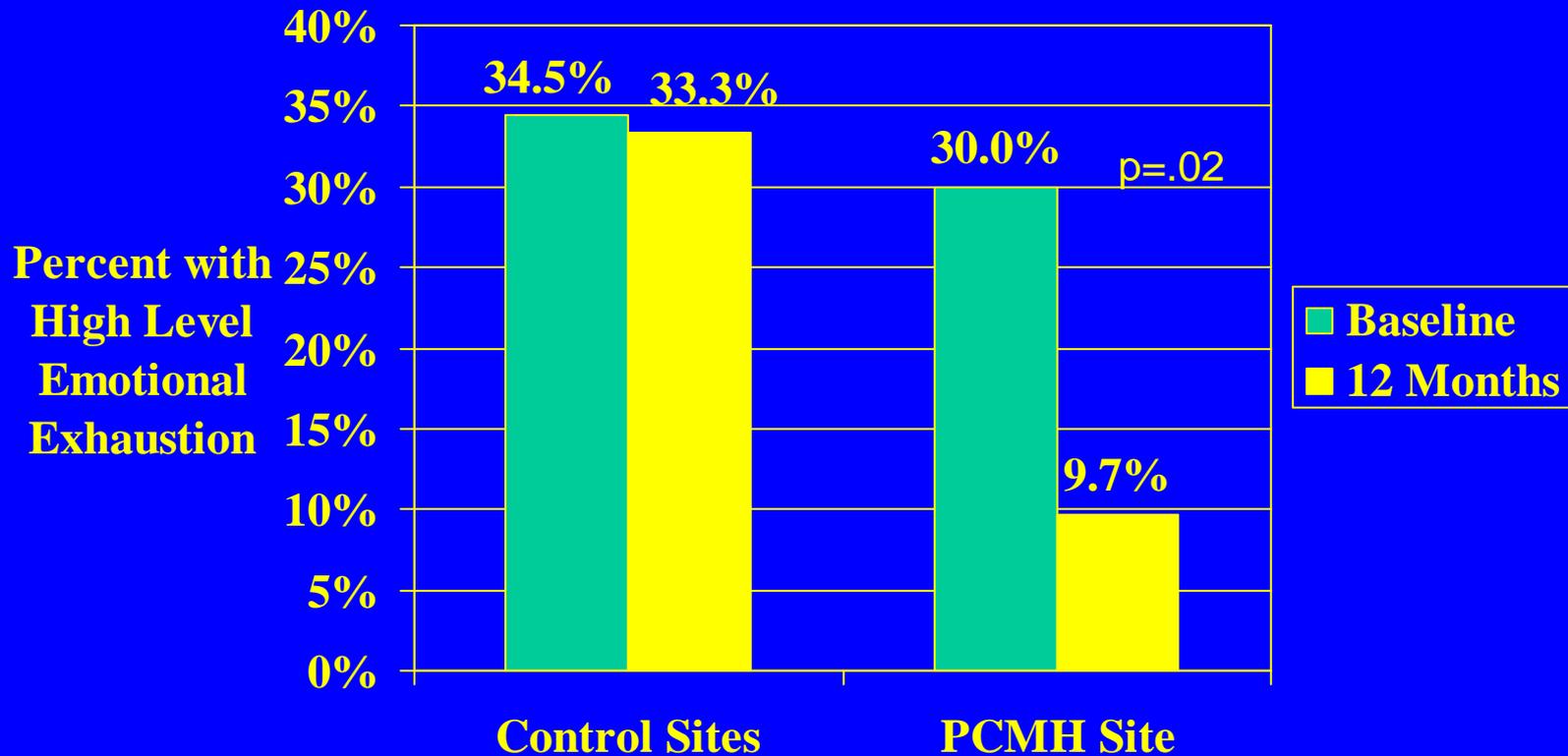
- Patient Centered Medical Home model piloted at one site in 2007
  - Avg PCP panel size reduced from 2327 to 1800
  - Longer face-to-face visits and scheduled time for phone and email encounters
  - Increased team staffing and teamwork
  - HIT
  - Panel management

# Group Health PCMH Pilot: Controlled Evaluation 12 Month Outcomes

- Improved continuity of care
- Better patient experiences (6 of 7 measures)
- Better composite quality of care score
- Reductions in ED visits and Ambulatory Care Sensitive Hospitalizations
- No difference in total costs

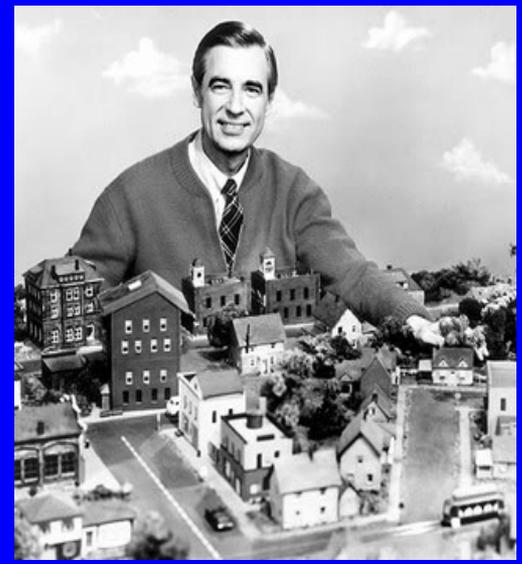
Source: R Reid et al. Am J Managed Care 2009;15:e71

# Group Health PCMH Pilot: Effect on Clinic Staff



# From Medical Homes to Medical Neighborhoods

- High performing primary care necessary but not sufficient
- Concept of “Accountable Care Organizations”
  - True integrated delivery systems (Kaiser, Henry Ford, VA)
  - Virtual organizations

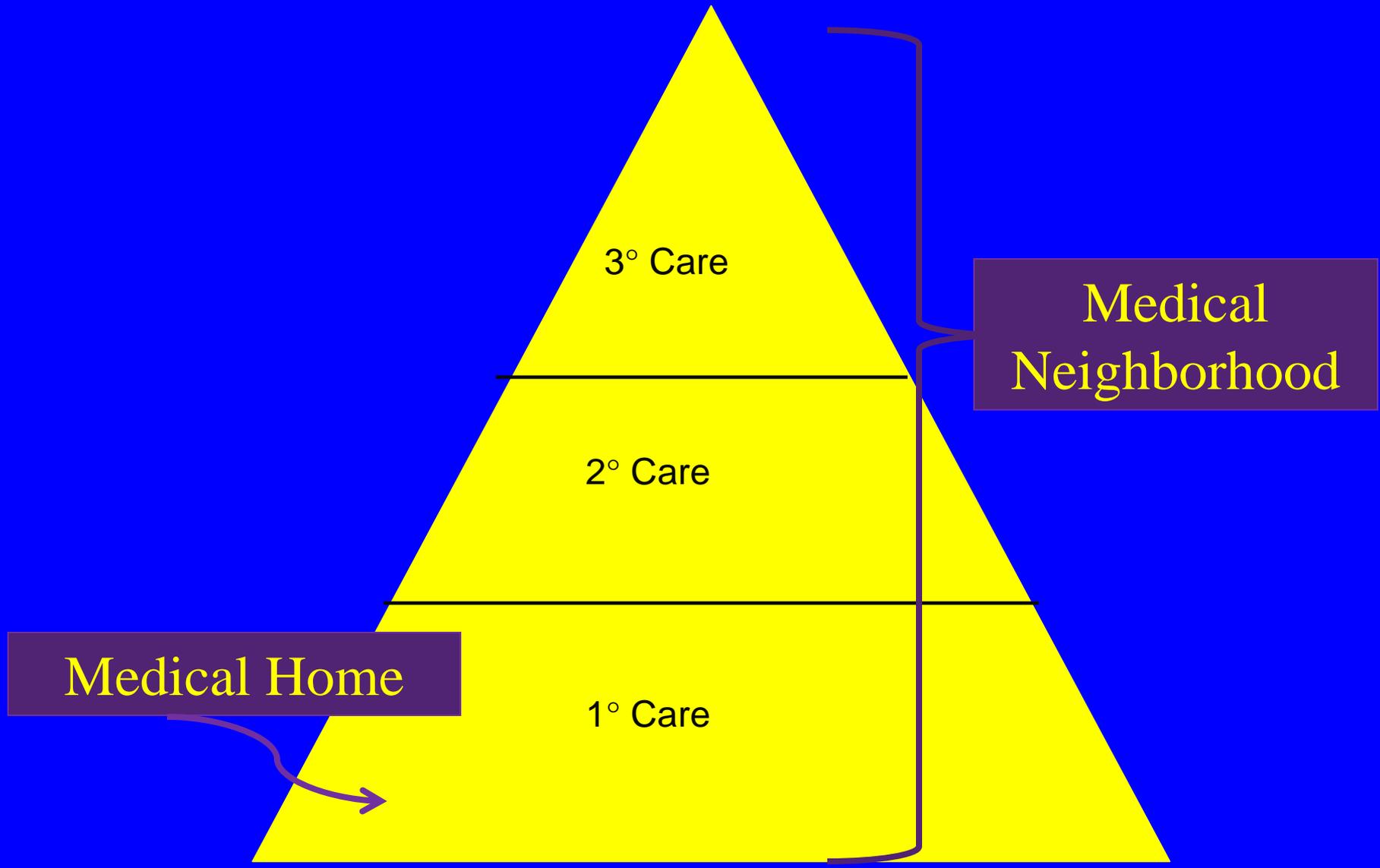


The NEW ENGLAND JOURNAL of MEDICINE

Perspective  
DECEMBER 10, 2009

**Primary Care and Accountable Care — Two Essential Elements of Delivery-System Reform**

Diane R. Rittenhouse, M.D., M.P.H., Stephen M. Shortell, Ph.D., M.P.H., M.B.A., and Elliott S. Fisher, M.D., M.P.H.



3° Care

Medical  
Neighborhood

2° Care

Medical Home

1° Care

# The Concept of **Integrated Care**

- Ann Beal, Aetna Foundation:
  - “Integrated health care starts with good primary care and refers to the delivery of comprehensive health care services that are well coordinated with good communication among providers; includes informed and involved patients; and leads to high-quality, cost-effective care. At the center of integrated health care delivery is a high-performing primary care provider who can serve as a medical home for patients.”

**Transforming the Delivery of  
Primary Care  
is a Workforce Policy**