Primary Care Workforce

A WHITE PAPER of the 2012 Primary Care Workforce Summit

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Executive Summary

High-quality healthcare at an affordable price is the gold standard Wisconsin must strive to attain, despite the myriad of complex issues that make this goal so elusive. The combination of care and value is what families, seniors, taxpayers and employers all need and deserve. The evidence is clear that primary health care medicine provided by teams of professionals—the Patient-Centered Medical Home (PCMH) model—delivers improved outcomes and cost-effective care, otherwise known as the Triple Aim: better health, improved patient satisfaction and lower costs.

How do we strengthen the overburdened primary care workforce, given the challenges? This question led to the formation of the Wisconsin Primary Care Workforce Summit, consisting of leaders from medicine, nursing, and pharmacy, as well as organizations representing hospitals, Wisconsin's two medical schools and other healthcare organizations. All of these professionals came together, committed to developing practical solutions and working to implement them. Eleven months of planning and review of current data occurred before dozens of Summit participants met to deliberate over how best to proceed and what exactly to recommend.

Ultimately, this collaboration developed recommendations that fall under three main categories of need for action and incentives:

1. Create, promote and sustain team-based patient-centered primary care. Transitioning to the Patient-Centered Medical Home (PCMH) model requires a whole new way of providing care and doing business. It involves completely redesigned practices, new healthcare professionals on the team, different ways to collect information, and transformed compensation policies for primary care professionals. This can be accomplished by creating a Wisconsin team care model, based on what has already proven to be successful in pilot projects now occurring in many other states. To encourage its development, insurance payments would be tied to the overall health of the populations being served, recognizing the value of prevention and rewarding primary care's ability to control costs. For these teams to succeed, the Summit recommends ongoing efforts to educate the local community and all healthcare professionals about primary care's important role in achieving more efficient and effective healthcare.

2. Align reimbursement, payments and compensation to recognize primary care's value relative to improved outcomes, more satisfied patients, and lower costs. The Summit recommends creating a new, state-level office charged with helping practices transition from the fee-for-service model to a team-based approach. Payments and reimbursements would be tied to both patient outcomes and satisfaction. Rather than a system that rewards the number of procedures performed, or the number of patients processed, as is true with the relative value unit (RVU) payment model now commonly used, the revised payment system rewards the whole medical team for its ability to maintain population health.

3. Align training and recruitment to meet the demand for patient-centered primary care teams. To increase the workforce population, the Summit proposes increasing the number of primary care residency training programs. More specifically, the leaders recommend direct funding to locate

programs in underserved rural and urban communities where access to care is lowest. This strategy will encourage those primary care professionals to stay in the community.

In addition, the Summit recommends targeting loan repayment and other incentives to medical students who have demonstrated an interest in practicing primary care in a shortage area. Lower tuition, more generous scholarships, tax credits and loan repayments options will help solidify the healthcare professional student's interest and commitment to primary care. Loan forgiveness strategies, funded by employers, government and health insurance, also will be important.

The training of team members must be modernized through increased emphasis on inter-professional education. Members of the primary care team (nurses, physicians, physician assistants, pharmacists and behavioral health clinicians) train together so they learn to work cooperatively and collaboratively from the outset of their professional experience.

An effectively trained and properly reimbursed team-care model results in a healthier population with decreased per patient health costs. But to get there, significant obstacles must be overcome.

Current Challenges

Increasing Demand

Healthcare's thorniest challenge is to provide excellent patient care in a cost-effective manner. This becomes even more complicated as the population ages and our healthcare system struggles to accommodate an influx of new patients who are entering the system. For example, the Affordable Care Act requires everybody to have health insurance by 2014[1]. At that time, tens of thousands of patients in Wisconsin will enroll in the federally mandated health exchanges. Consequently, Wisconsin's Medicaid and private insurance rolls may increase substantially according to the state's Legislative Fiscal Bureau[2].

Like the rest of the population, professionals providing primary care are aging and will be part of a wave of retirements certain to affect healthcare over the coming decades. More complex problems associated with the elderly require more care and more time. But who will provide that care? The primary care workforce may further contract as current healthcare clinicians reach their 60s, reducing their working hours before taking full retirement.

Hospital ERs already see too many patients who aren't suffering from an emergency, yet the sick go there because they are not established with a primary care clinician. The ER option is not only extraordinarily expensive, but it is *not* an environment equipped to manage chronic health conditions, such as asthma, high blood pressure and diabetes, all of which require continuity and coordination of care. Nevertheless, the ER is where more patients will go if there are no other perceived alternatives. A primary care medical home for all aims to rectify this inefficiency in care delivery.

> When people need care and have the insurance to cover it, where will they gain access when our healthcare system is overwhelmed by the extra patients?

Even professionals committed to practicing in a primary care environment face a variety of financial disincentives ingrained in our healthcare system. Doctors are paid by the procedure instead of whether the person gets better or stays well. This leads to more unnecessary tests and greater expense. For example, doctors aren't paid if patients *don't* get the flu, but they are paid when patients get sick and end up at the clinic. There is no financial incentive to encourage patients to get a flu shot, for example, in order to prevent illness in the first place. The same could be said about tracking cholesterol levels, behavioral issues like smoking, alcohol use and dietary habits, as well as taking generic medicines, which are less costly and usually as effective as brand drugs.

Lack of access to effective primary care has led to an explosion of health care spending in the U.S., making the healthcare industry a major player in the American economy with massive per-person expenditures. "According to one of a series of exhaustive studies done by the McKinsey & Co. consulting firm, we spend more on health care than the next 10 biggest spenders combined: Japan, Germany, France, China, U.K., Italy, Canada, Brazil, Spain and Australia," writes Steven Brill, in *TIME* magazine's March 2013 special report, an issue completely devoted to examining health costs[3]. For that massive investment, American patients usually suffer worse outcomes than their foreign counterparts. Infant mortality is higher and we live shorter lives than residents of these other industrialized countries, all of which do more for less with their healthcare budgets.

Other professions carefully navigate a series of complex tasks, by employing somebody whose job it is to make sure things are getting done on schedule and in the right order. This is known as project management. If it works for the construction industry, information technology, aviation and scores of other service industries, why wouldn't patient population management also be applied to our healthcare system?

Shortage Now

Future trends may be challenging, but the shortage already exists, primarily in rural and lower-income urban areas. Family doctors, for example, have plenty of job opportunities available right now and more positions are sure to become available. There are currently 147 open family medicine positions that are unfilled in Wisconsin, according to the Wisconsin Academy of Family Physicians. But the problem is distribution. Family physicians, as well as family nurse practitioners and physician assistants, are drawn to higher income urban and suburban practice settings.

The primary care workforce shortage projections vary according to the survey model used, but we do know how many primary care professionals are needed today in these shortage areas. For example, Milwaukee's inner city alone needs 57 primary care physicians, according to a February 2013 report from the Wisconsin Primary Care office at Wisconsin's Department of Health Services[4].

"Wisconsin has 137 federally designated Primary Care Health Professional Shortage Areas (HPSA) in rural areas and in central city areas, and designated Medically Underserved Populations in Milwaukee, Madison, Beloit, Green Bay, Kenosha, Racine, and Wausau," states a November 2012 Issue Brief from the University of Wisconsin Population Health Institute[5].

Patients living in these shortage areas are almost twice as likely to be hospitalized. Such high-level care can be prevented when patients have regular access to care, according to a 1999 report from the *Archives of*

Family Medicine[6]. By the time such patients are hospitalized, they are usually in a fragile condition and the costs associated with taking care of them explode exponentially.

We have long heard about the need for more family doctors. However, the shortage extends to all primary care professions, including internists, pediatricians, physician assistants, nurse practitioners and pharmacists.

Student Interest

If there is such great demand for primary care services, why aren't more students pursuing this opportunity?

"Although the overall number of medical students—including U.S. seniors—who choose family medicine is up, medical schools are expanding enrollment at an even faster pace, and new medical schools have opened," says Jeff Cain, MD, President of the American Academy of Family Physicians. "So, the reality is that the percentage of U.S. seniors choosing family medicine has decreased."[7] In other words, the recent nationwide expansion of medical school enrollment is not producing a proportional expansion in the number of students choosing primary care careers.

We are not seeing increased student interest at the very time these new professionals are needed most. One important reason for this predicament may lie in perceptions. Perhaps the most common one is that primary care is so broad and challenging that it's nearly impossible to grasp all of the content to be a truly competent care giver.

Perhaps even more prominent is the belief that primary care is less prestigious compared to other medical specialties, a view which is validated from a financial standpoint when one considers the compensation disparity between primary care specialists and their subspecialist colleagues.

"Over a 35-to-40-year career, the difference in income results in a $3.5 million gap, on average, between the 'return on investment' for primary care physicians and that for subspecialists," reports a 2009 *New England Journal of Medicine* article[8]. Similar financial disparities confront nursing, pharmacy and other primary care healthcare professions. The more "specialized" the training, the higher the salaries. And this phenomenon is directly tied to the current payment system in healthcare.

The fee-for-service payment system was initially designed for specialist services but eventually morphed into primary care, as well, even though it was never envisioned to cover cognitive, nonprocedural healthcare services. A new compensation model must be developed in order to narrow the income gap, improve access to care and attract the best and brightest to the primary medical home patients want and need.

Starting out

Another practical problem involves the structure and location of clinical education programs. Most new primary care professionals establish their practices where they completed their advanced training. Since shortage areas are rarely sites for such training programs, these shortage areas don't have the opportunity to draw from this pool of new talent. Wisconsin's challenge is to encourage primary care professionals to

practice in the locations that need the help. But just having greater numbers of these care givers may not necessarily mean they will gravitate to the communities that need them the most.

In the case of physician assistants (PA), new graduates who want to practice in a rural community may not find any positions available because the clinics will not accept inexperienced PAs. What may occur is that the newly minted PA will find a job in a sub-specialty area within a hospital and may never find his or her way back to the practice of primary care in an underserved area.

Solutions

How often can any one person working independently provide what is necessary to get a complex job done? And what could be more complex than managing the health of a population of human beings? Imagine a health care system where a coordinated team is assigned to every patient. A family doctor, internist, nurse practitioner or physician assistant might take on the role of managing a particular patient's care while another team member will lead the planning of care for the population that the practice serves. Healthcare hierarchy would not determine this leader's role on the team as much as his or her ability to best manage the needed task.

For this model of team care to thrive, a variety of incentives must be established to create, promote and sustain team care, which pertains to compensation models, payments, recruitment strategies and training programs. The healthcare system not only needs more primary care medical professionals to meet the patient demand, but it needs to do a much better job of assigning the right people to the right places so they are most likely to remain practicing in those communities.

1. Create, promote and sustain team-based primary care.

The Summit leaders recommend a gradual, but full transformation of healthcare practices in Wisconsin, leading to payment systems that reward better health, better healthcare and lower cost. In fact, such demonstration practices already exist in nearly half the states. The idea is to create a Wisconsin model based on the best practices of primary care and then present this to insurers for funding consideration.

This model would include payments to the Patient-Centered Medical Home based on the complexity of the cases and how well they are managed, including preventive care that is essential to having a healthier population. Therefore, "pay for performance" would be based on patient outcomes associated with the efforts of the whole team rather than today's system that rewards each procedure and service performed. This would involve taking a new approach to the task at hand, meaning the goal is not just to put out the fires but to make sure smoke alarms have batteries, the electrical codes are up to date and that chimneys are cleaned and inspected annually.

The team would be compensated for keeping the patients receiving their care healthy and not just for responding to their illnesses. The yard stick used to measure these efforts may include rates of flu shots, appropriate frequency of routine health maintenance exams,

Which families are not up to date on immunizations? Did last week's patients have their blood drawn as directed? How many had their prescriptions filled and who still needs their medicine?

cholesterol screening, smoking cessation efforts, improvement in hospitalization rates, and so on.

One of the team members takes on the lead role, making sure a particular patient is properly followed and progressing through the prescribed treatment plan. In some cases, that will be a nurse practitioner, in others, a family doctor, physician assistant, pharmacist or other member best able to manage that patient's care. If perhaps the nurse practitioner has treated this person over many years and is familiar with his medical history, he or she might be best positioned to follow this patient's care and make sure the right steps are followed to assure his best chance for optimal health.

This arrangement frees up physicians to care for a larger group of patients. When the team system functions optimally, physicians are able to do that because they are sharing work appropriately with the other professionals on the team.

Yes, this will require an additional investment to establish these teams, but the evidence shows that this is money well spent.

> For example, Capital Health Plan in Tallahassee, Florida, has demonstrated that adequate primary care coverage relieves pressure on the ER. By more than tripling the number of primary care visits, emergency department cases dropped by 37% from 2003-2011, according to a new report from the Patient-Centered Primary Care Collaborative. Not surprisingly, Capital Health Plan's claims costs tumbled by 18% during that time.[9]

To facilitate these practice changes, the Summit leaders suggest creating a new position housed in the Governor's office or independent, charged with helping healthcare groups, payers and employers transition from fee-for-service models to team-based care and a blended payment system. This would be similar to the Director of Practice Transformation position that functions as part of the Governor's office in the state of Ohio.

For a team-based healthcare system to thrive, the entire community must be part of the solution. That means campaigns must begin to educate the public about the value of enhancing primary care through the implementation of the Patient-Centered Medical Home model. Integrated efforts in schools, professional organizations and community groups should promote interest in the primary care health professions.

Part of the answer to making primary care a more desirable career choice is to make it less burdensome for everybody involved. The electronic medical records system is a case in point. Currently, the system is laden with inefficiencies for primary care and is one of the nagging issues that makes the practice less desirable and more challenging than it has to be. The Summit recommends practices have an appropriate team member responsible for patient data entry to free up the physicians and other members on the team to spend more time treating patients and reviewing or editing critical data.

The recommendations include efforts to heighten the prestige associated with providing primary care by acknowledging and promoting the fact that the medical home concept is an essential, evidenced-based way to achieve better health, boost patient satisfaction rates and lower costs.

2. Align reimbursement, payments and compensation to recognize primary care's value, relative to improved outcomes, more satisfied patients, and lower costs.

The inefficiencies and counterproductive financial incentives of the current healthcare system's fee-for-service model must be phased out in favor of incentives to provide high-quality care that promotes prevention and results in a healthier population. The blended payment model will still pay for certain procedures, but other payments will go to the medical team based on services they provide that benefit the health of the overall patient population.

The evidence shows that primary care is best positioned to care for the population while keeping costs under control. Advance practice nurses, physician assistants, pediatricians and other primary care professionals do so by making sure only those who need the services of cardiologists, orthopedic surgeons, emergency room physicians, and other sub-specialists are the patients who end up in those sub-specialists' offices and operating rooms.

The Primary Care Workforce Summit has identified specific areas of concentration that will lead to the optimal healthcare environment described thus far. The solutions lie in making *teams* the key component in a patient's care. But this will not happen until the compensation system offers financial incentives for prevention and cost control that specifically rewards this practice model. An exciting transformation is beginning to happen as major healthcare systems support demonstration projects that focus on team-based care. Already these models are delivering better patient outcomes for less cost. The Comprehensive Primary Care Initiative (CPCI) undertaken by the Center for Medicare and Medicaid Innovation has created the blueprint for how practices need to transform and how payment needs to be changed to support a patient-centered approach to care. Seven sites around the country are currently participating with 60+ physician practices in each site with blended payment for a minimum of 60% of the patients seen by the practice.[10]

"WellPoint predicts that its new Patient-Centered Medical Home program could reduce its projected medical costs in 2015 by up to 20 percent based on an analysis of its current medical home pilot projects," according to the report from the Patient-Centered Primary Care Collaborative.[11]

3. Align training and recruitment to meet the need for primary care teams.

To work effectively in teams, professional schools will need to integrate and modernize their training so various health professionals can learn to *work together* as well as *learn together* in the same classrooms and outpatient settings. This is the concept of inter-professional education. The Summit leaders feel strongly that students must see what they've learned in the classroom play out successfully in a clinical setting, as well. Health professionals need to be trained in these environments so they can see that they actually do work and can understand how they fit into this model. This team training will need to occur both for new professionals entering the field and for those already in practice.

Also essential to the creation of teams are incentives, some of which will require policy changes, in order to attract more of the best students to primary care. This can be accomplished through a series of incentives, looking strategically at which students are most likely to practice primary care in a shortage area and providing various forms of financial support to them. Wisconsin residents

are the first priority because they are most likely to practice here after graduation. Incentives may include lower tuition, scholarships, tax credits and loan repayments to help cement student interest in, and commitment to, primary care. Loan forgiveness strategies would be important as well, and could be funded by employers, government and health insurers.

This integrated training should occur within the communities that are especially in need of primary care services, and the training must explore and teach the skills necessary for a successful team-based care model. And when possible, it must invite patients, families and the larger community to participate and support this form of education.

An infusion of funding toward expanding and creating new training programs in these shortage areas is essential to achieving the goal. The Summit recommends the expansion of current residencies in all primary care disciplines, as this is the most effective short-term strategy for increasing the workforce.

The Teaching Health Center Graduate Medical Education (THCGME) program, a five-year federal project begun in 2011, is an excellent example of this strategy. These are community-based outpatient centers that participate in primary care residency programs. "Physicians trained in (community) health centers are more than three times as likely to work in a health center and more than twice as likely to work in an underserved area than those not trained at health centers," according to the U.S. Department Health and Human Services.[12]

In addition, the Summit recommends that funding for graduate medical education must support all primary care professionals, including programs for advanced practice nurses, pharmacists and physician assistants. For instance, new physician assistant graduates interested in a rural practice would be more likely to continue treating patients following their training if there were expanded rural internship programs.

Sustaining such a system not only means having a sufficient number of professionals on the team, but doing a better job of determining who will be most likely to thrive in such an environment. Even if the goal of attracting more professional interest in primary care succeeds, that doesn't guarantee that enough workers will flow to the shortage areas. Greater attention must be paid to helping families of health care professionals assimilate into these communities.

When more graduates respond to these incentives, there will need to be a larger pool of clinical instructors as well. The Summit therefore recommends putting statewide incentives in place to help increase the capacity of practice sites to provide clinical training opportunities for students and increase the pool of community-based physicians, nurses and physician assistants who will take on the responsibility for supervising and mentoring trainees.

To implement these ideas and recommendations, state and federal lawmakers would need to get behind the policy changes necessary. Although money for Medicare-funded residency programs has been frozen since 1997, Medicare still pays most of the cost of medical residencies. That means as Congress works to streamline and reduce costs in Medicare and Medicaid, it must also funnel more money to residency training so there are more slots for primary care graduates.

Summary

Team-based primary care, the Patient-Centered Medical Home, is the major answer to Wisconsin's primary healthcare challenges, although no one system can magically erase all of the issues confronting the healthcare system. Nevertheless, under this model, patients are more likely to get the appropriate care they need at a lower cost, and be more satisfied with the experience.

Wisconsin's funding system must transition from one that pays for volume to one that pays for results. More primary care professionals—physician assistants, nurses, physicians and pharmacists—will use their skills to better manage patient care early in the treatment process and help patients navigate their way through a more coordinated system.

Wisconsin will have a fighting chance of delivering a sufficient number of primary care professionals to meet the growing demand for their skills only if:

- Incentives are put into place for students to pursue primary care careers;
- There is an expansion of inter-professional education and residencies that occur in shortage areas; and
- There are concentrated efforts to retain professionals already practicing in a primary care setting.

A healthcare system that rewards high quality and value, and creates incentives for the implementation of proven ways to maintain the population's health, will in turn be rewarded with a healthier population. When we create incentives to coordinate care and manage a disease, greater efficiency and better outcomes will result. Link prevention services to the payment system and fewer serious health conditions will evolve, resulting in happier patients, longer lives and less cost for individuals, insurance companies, employers, and taxpayers.

An engaged community, supportive lawmakers and a collaborative effort across healthcare professions will help create the momentum necessary to reach the day when every Wisconsin resident has a primary care home, managed by a *team* of healthcare professionals. Only then will Wisconsin have the best opportunity to serve our citizens in a manner that leads to optimal care at a lower cost.

Summit participants and other stakeholders will need to work together to prepare detailed recommendations for the action items outlined above.

Addendum

The process that led to the detailed discussions summarized in this white paper began with thirteen organizations representing healthcare professionals from across Wisconsin. They met over an 11-month period, working to plan and orchestrate the summit meeting and how they would work through solutions. These leaders formed an alliance to find common ground on which to develop answers to the primary care shortage Wisconsin faces.

Before the summit meeting convened in late November 2012, these stakeholders were asked to offer their vision for primary care delivery, the barriers to that vision and their recommendations for what can be done to overcome those barriers. To that end, they submitted dozens of papers and data summaries for consideration by the group. The discussions centered around five critical question areas: practice transformation, payment reform, education, recruitment, and legislative initiatives.

The summit participants were assigned to tables, each dedicated to one of these question areas. Each group discussed the merits of the recommended action items in their assigned critical question area. The table then identified 8-12 action items that they thought should be presented to the full group. The table leaders combined the input from the three tables assigned to their critical question area and presented the selected action items to the full audience for their input.

Organizations participating in the Summit:

- Wisconsin Academy of Family Physicians
- Wisconsin Chapter of the American College of Physicians
- Wisconsin Chapter of the American Academy of Pediatrics
- Wisconsin Nurses Association
- Wisconsin Academy of Physician Assistants
- Pharmacy Society of Wisconsin
- Wisconsin Primary Health Care Association
- Wisconsin Hospital Association
- Wisconsin Medical Society
- Partnership for Healthcare Payment Reform
- Medical College of Wisconsin
- University of Wisconsin School of Medicine & Public Health
- Wisconsin Area Health Education Center

For more information about the Summit and details about its recommendations, please visit http://www.wafp.org/summit.

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