

ACO Accelerated Development Learning Sessions

Minneapolis, MN
June 20-22, 2011

Clinician Learning Module *Organizing and Delivering Care*



June 21, 2011
3:30–4:45 p.m.

Module 4A: Primary Care and Specialist Services

Richard J. Baron, MD, MACP

Group Director, Seamless Care Models

Innovations Center, CMS

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After attending this session, the participant should be able to-

- Describe supply and demand curves for primary care physician capacity
- Discuss the relationship between medical costs and other economic indices
- Describe the relationships between per capita distribution of physicians and cost/quality
- Review the characteristics of the uninsured
- Describe the key elements of the Patient Centered Medical Home
- Explain examples of higher investments in primary care yielding lower cost, higher quality

Greenhouse Internists, PC, Philadelphia, PA



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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”
 - 4.2% plan Family Practice
 - Total complement of US MD graduates: **6.7%**
- 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

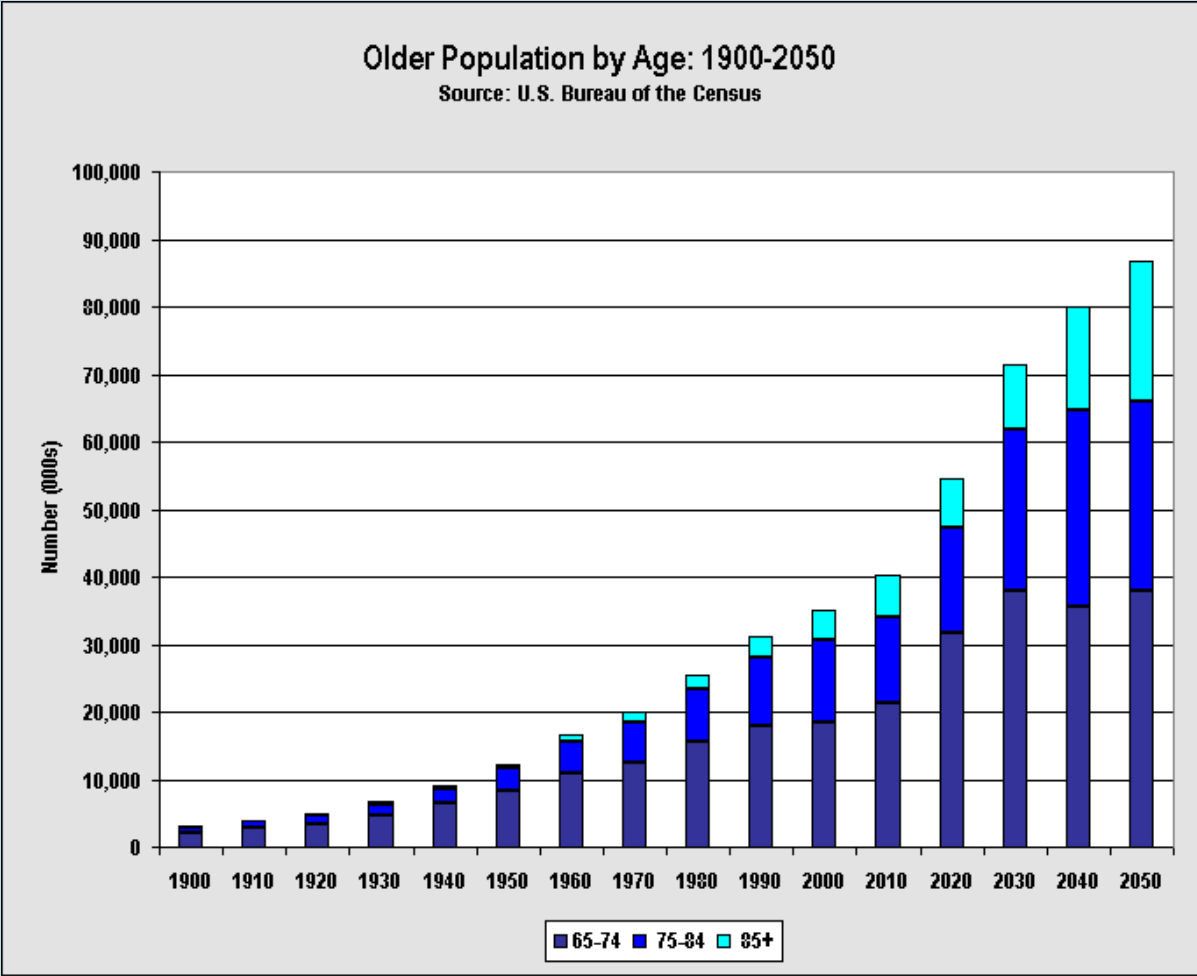
Happening at a Time When Needs Are Going Up

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

GIM Predictions

- 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

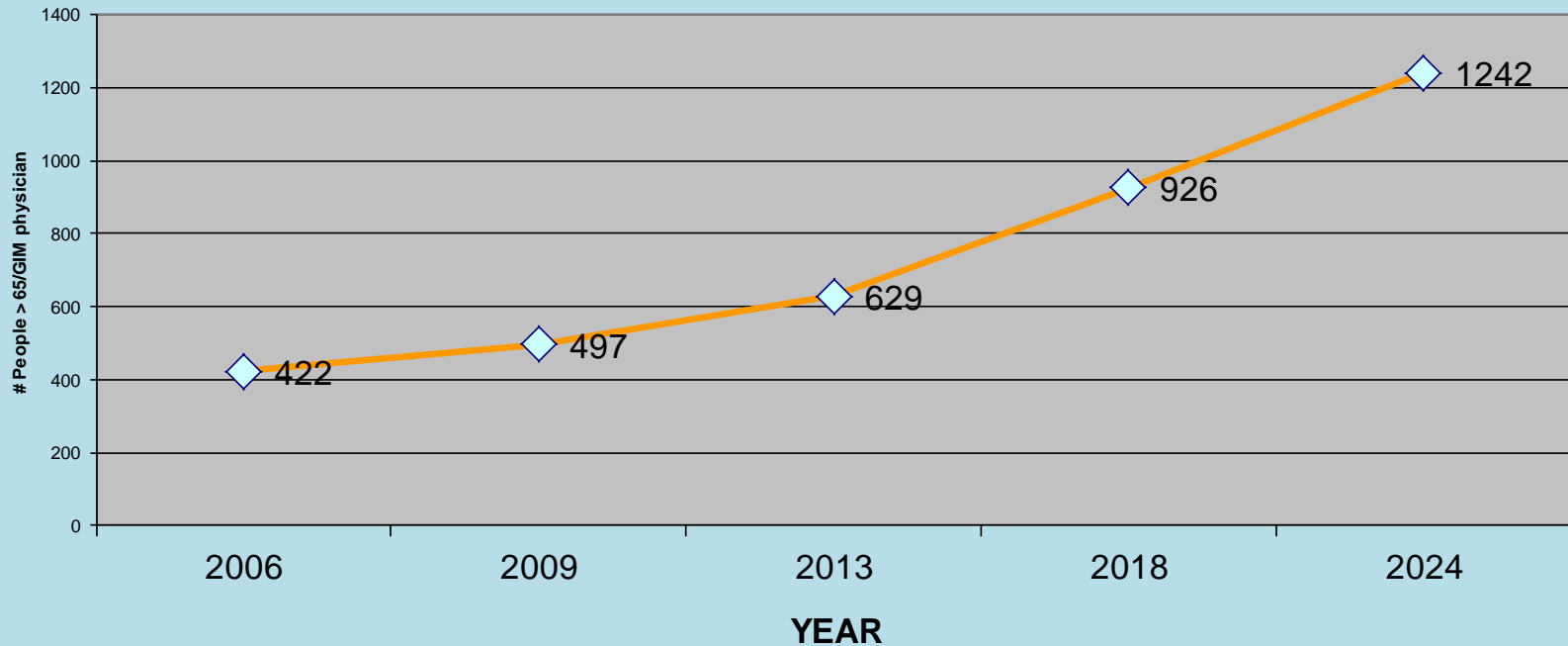
When the Population Is Aging



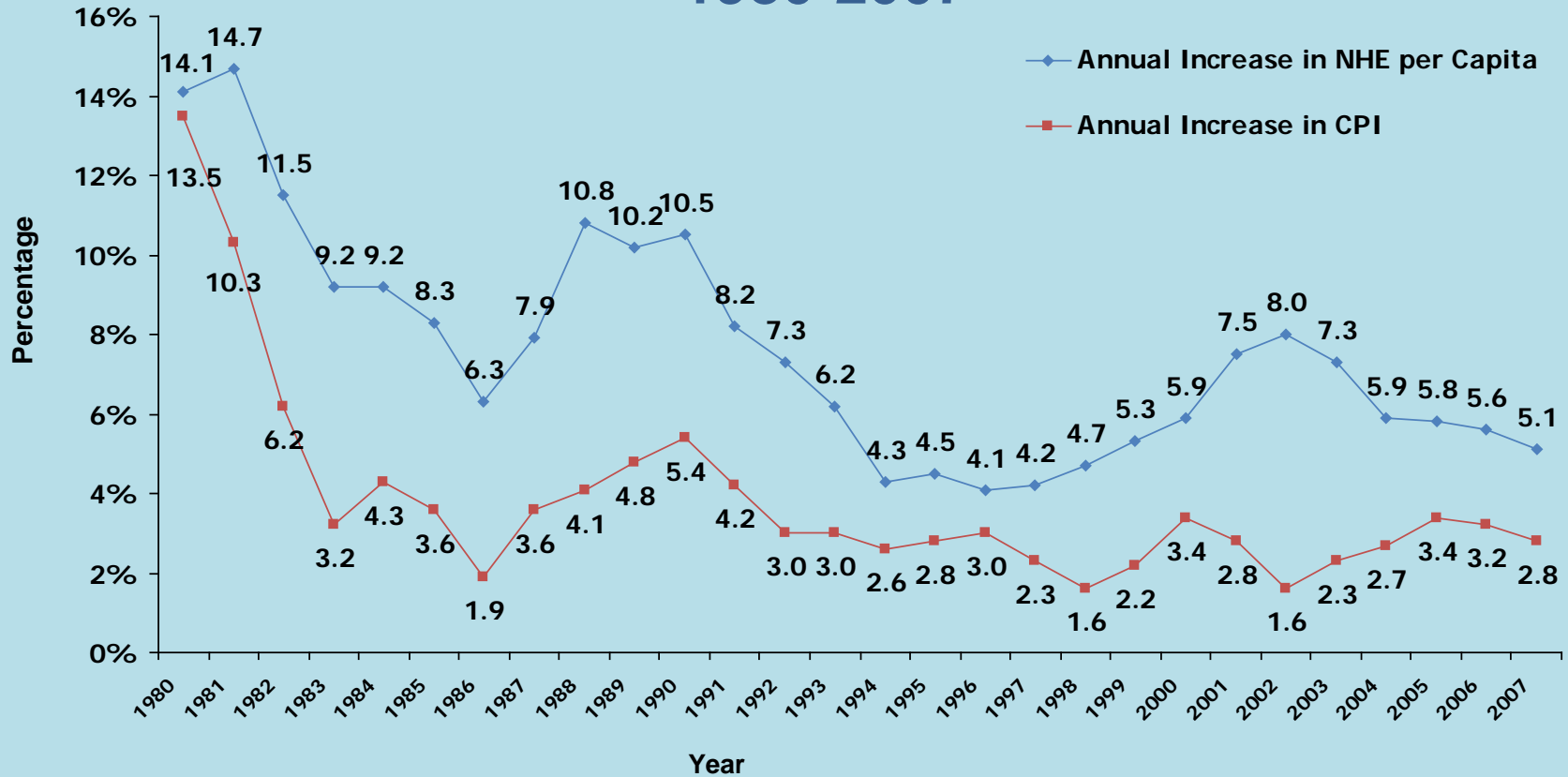
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Which results in increased patient load per remaining generalist

Number of people >65/GIM physician 2006-2024



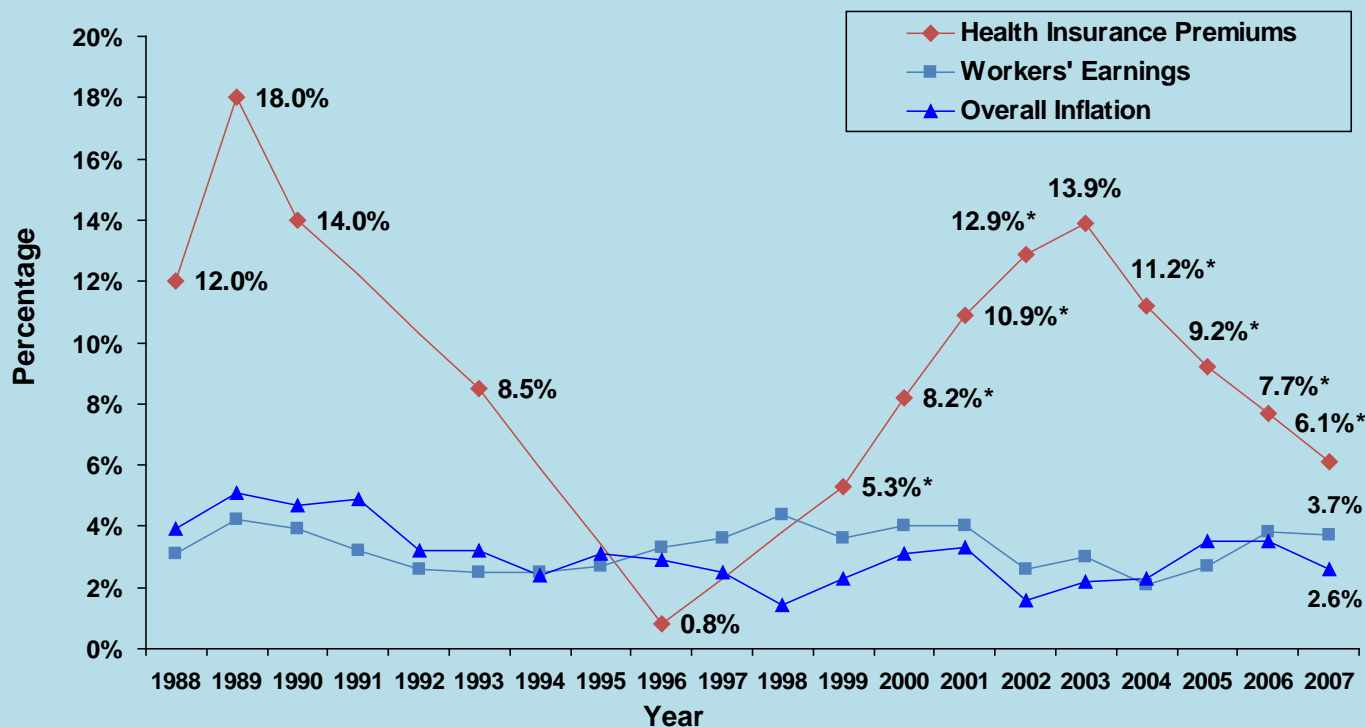
Percent Annual Increase in National Health Expenditures (NHE) per Capita vs. Increase in Consumer Price Index (CPI), 1980-2007



Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2007; file nhegdp07.zip), and CPI data from Bureau of Labor Statistics at <ftp://ftp.bls.gov/pub/special.requests/cpi/cpi.ai.txt> (All Urban Consumers, All Items, 1982-1984=100, Not Seasonally Adjusted, U.S. city average).

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



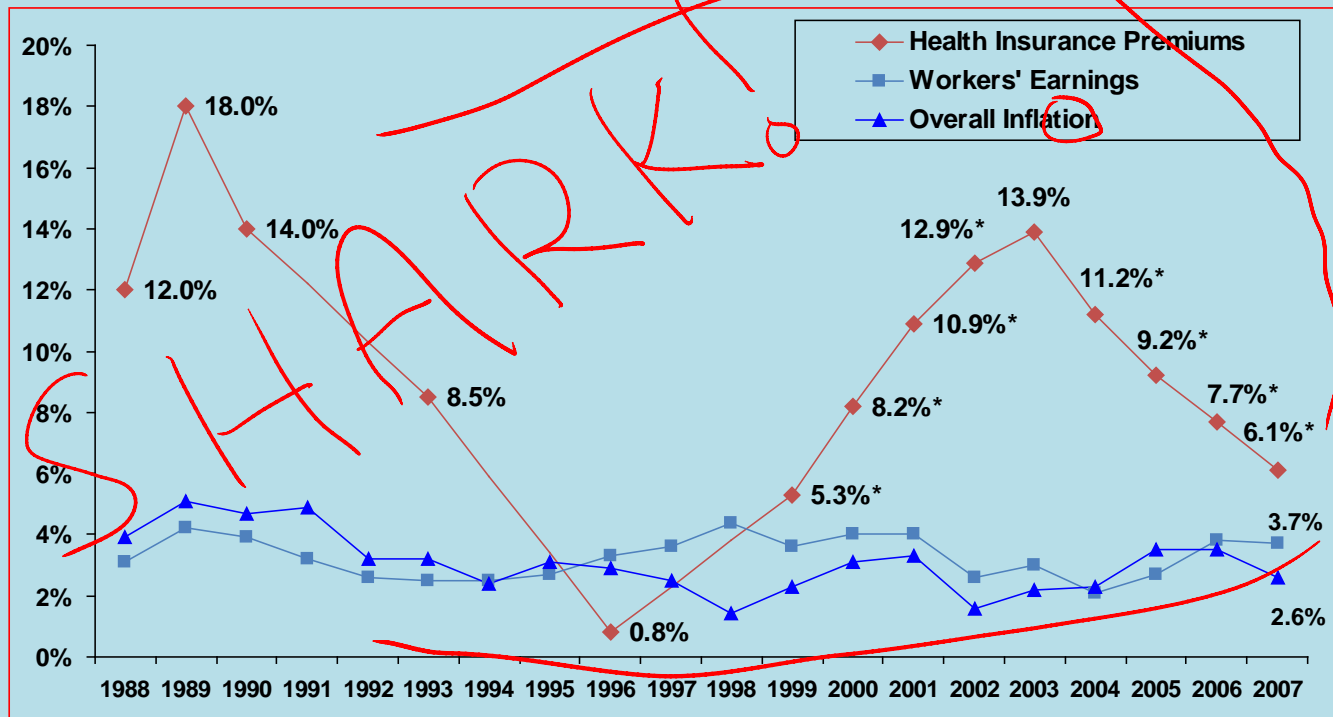
*Estimate is statistically different from estimate for the previous year shown ($p < .05$). No statistical tests are conducted for years prior to 1999.

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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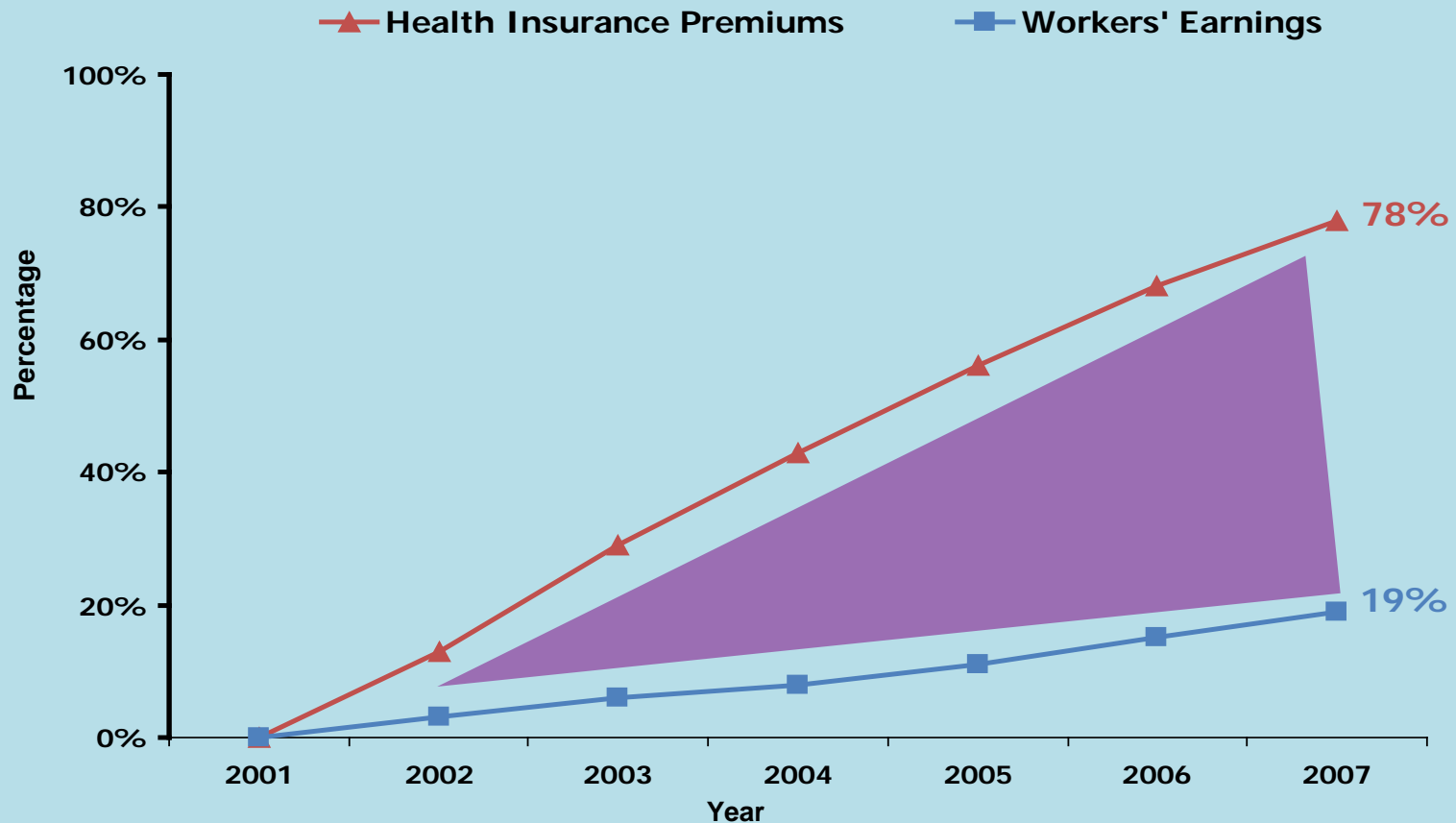
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("Shark" courtesy of Arnie Milstein)

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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).



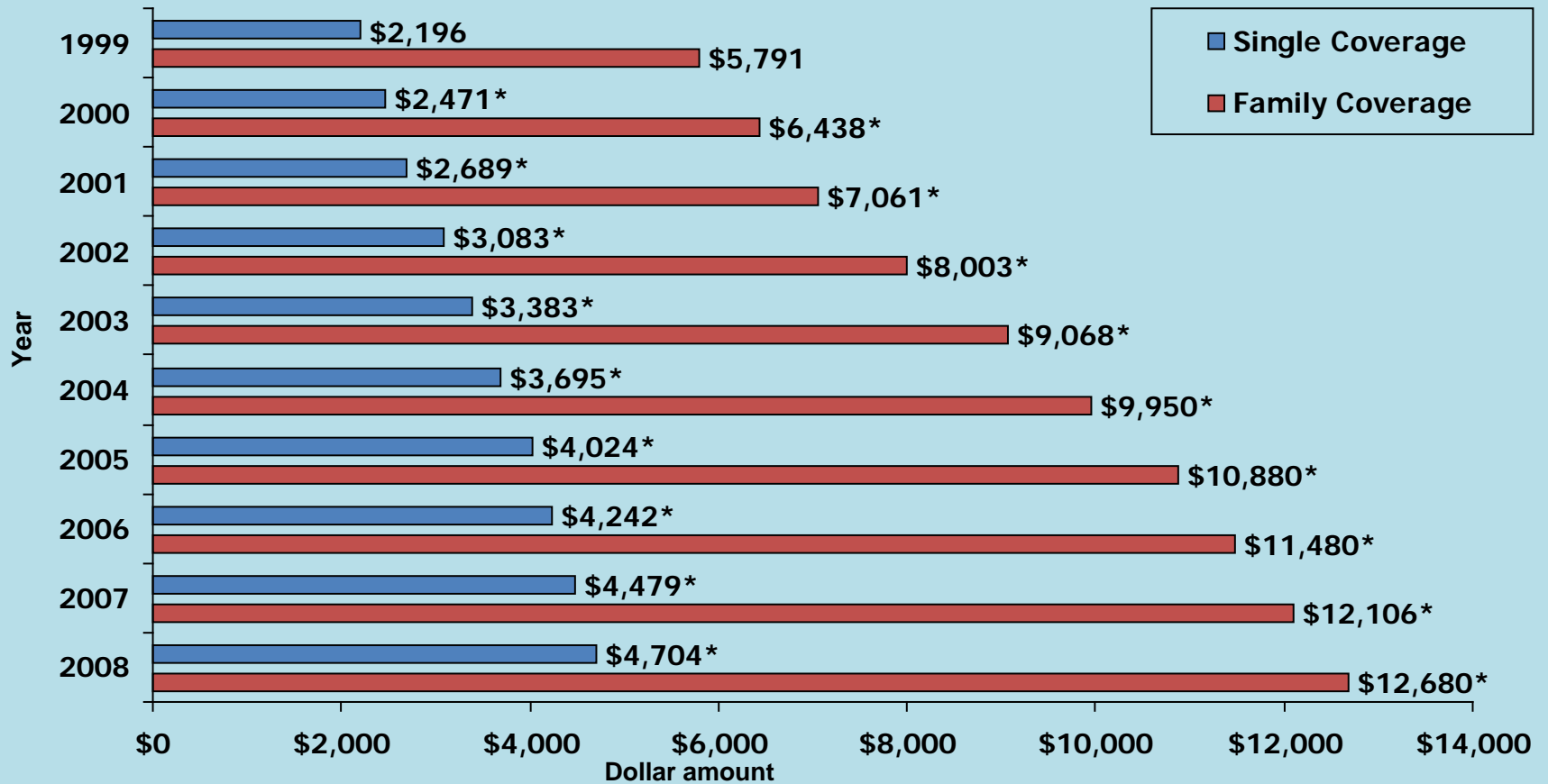
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The Growth Rate of Per Capita Health Care Costs

- “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

Average Annual Premiums for Single and Family Coverage, 1999-2008



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

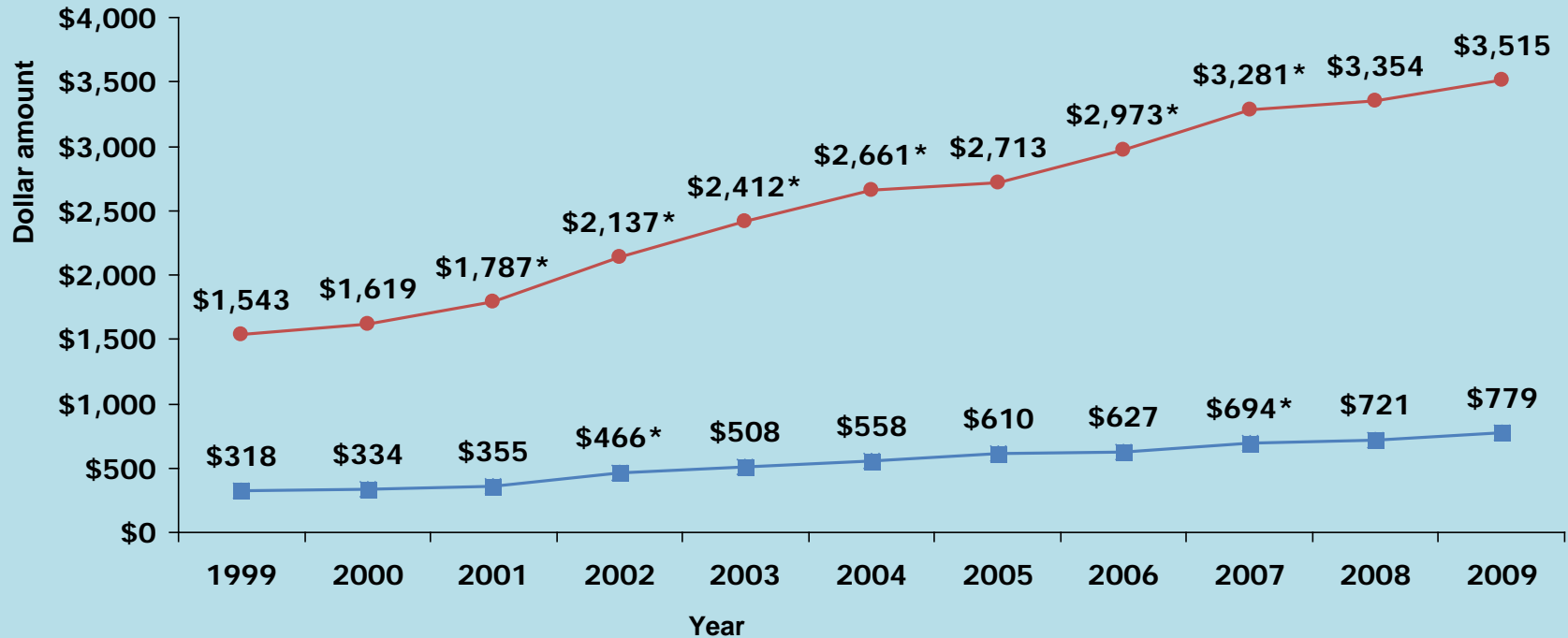
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.

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Shifting Who Pays for Care

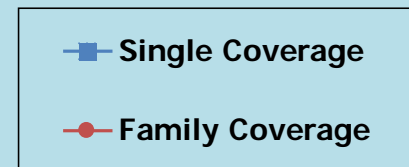
- So we shift who pays for care . . .

Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999-2009

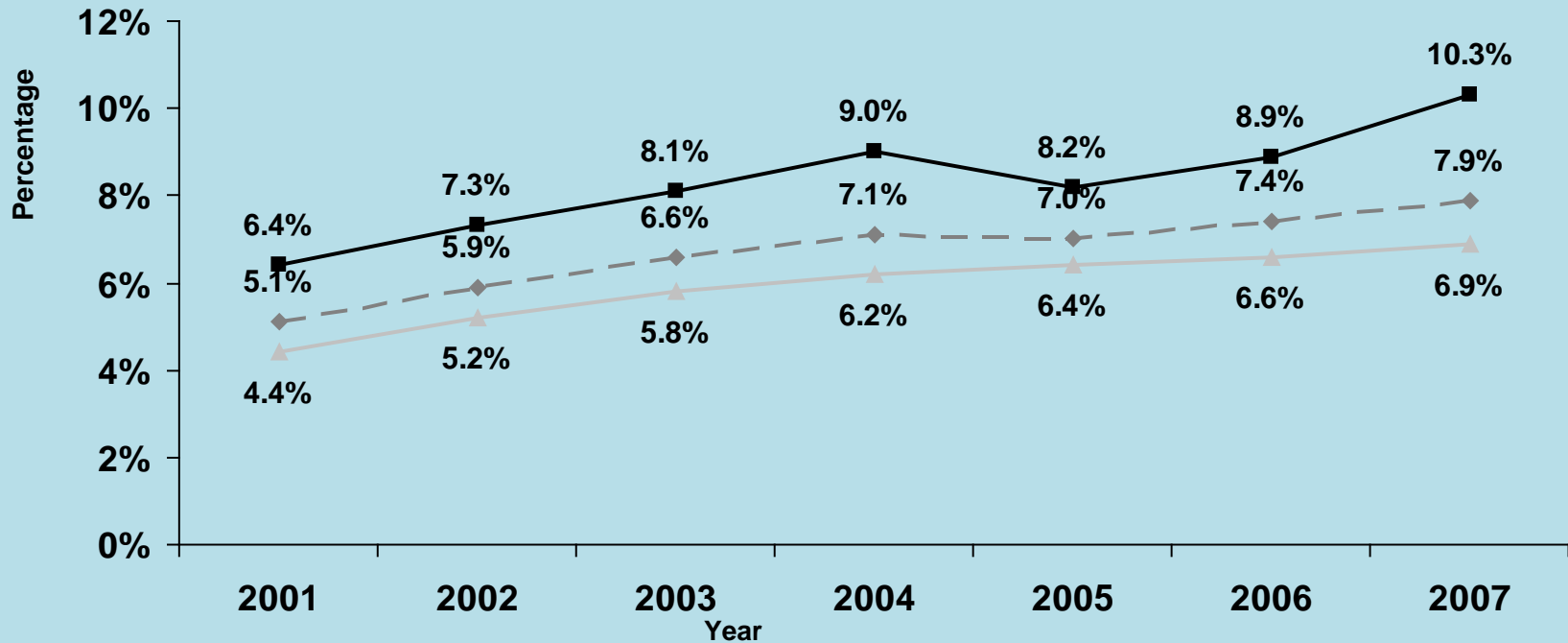


*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.



Average Family Premium Contribution by Firm Size as Percent of Income at 200% FPL, 2001-2007



Note: 200% FPL was \$35,300 for a family of four in 2001. It is \$41,300 for a family of four in 2007.

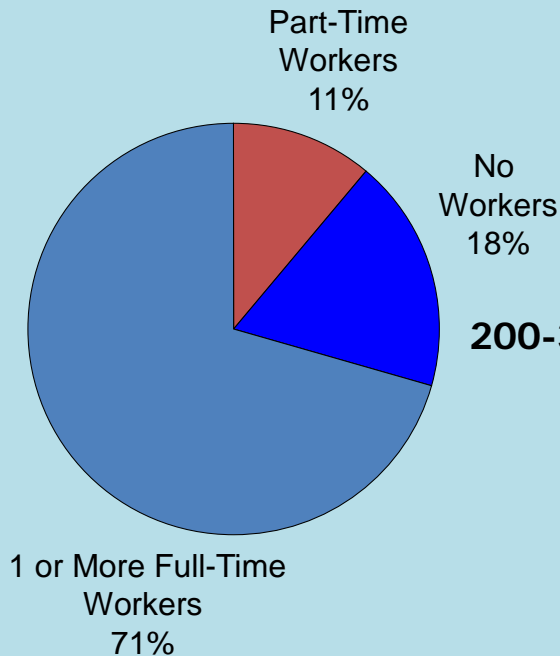
Source: Kaiser calculations based on worker contributions to employer-sponsored health insurance premiums from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007 and Federal Poverty Guidelines from <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>



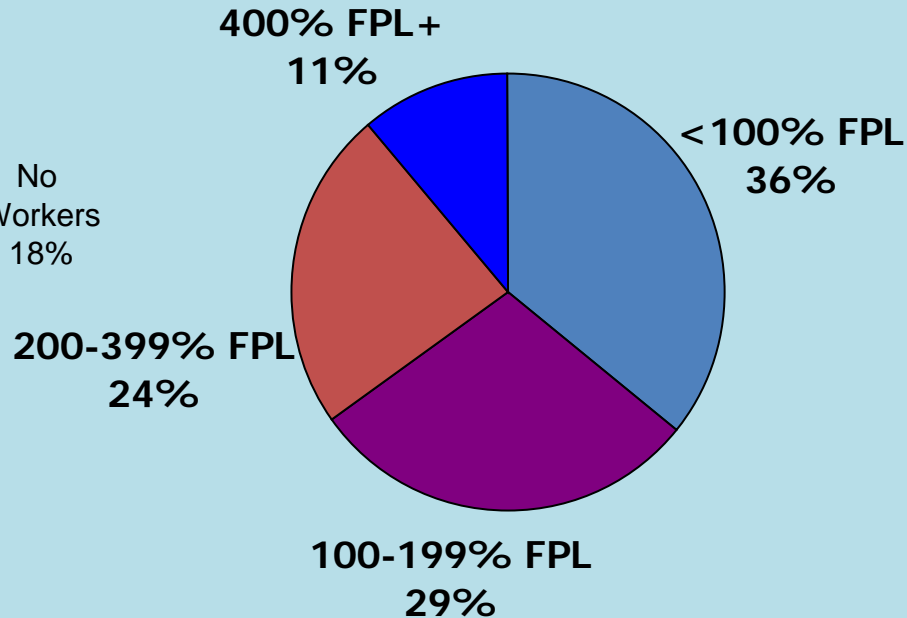
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Characteristics of the Uninsured, 2006

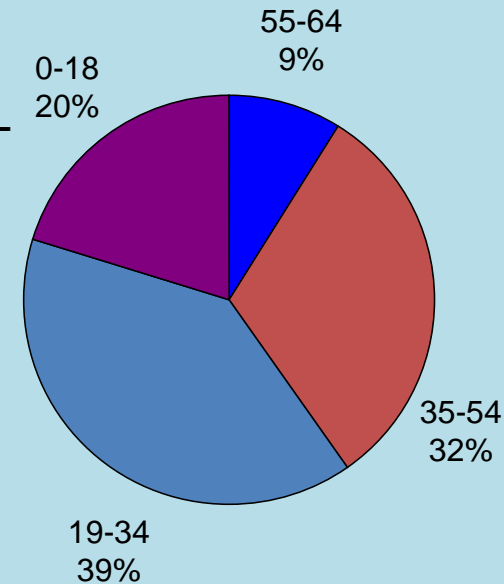
Family Work Status



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
- Personal/national wealth
- Increased use of services
- Duplication/uncoordinated care

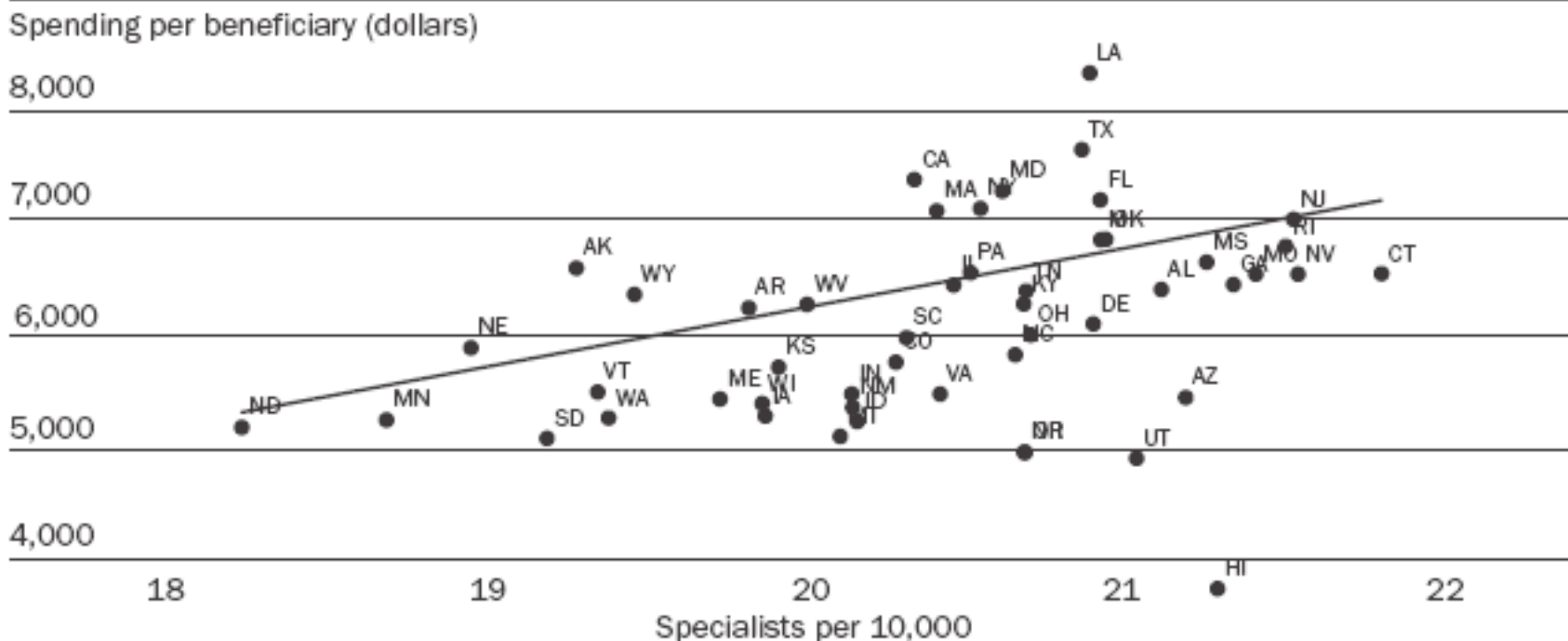
And how many of these issues do you think primary care could have an impact on?

- *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



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

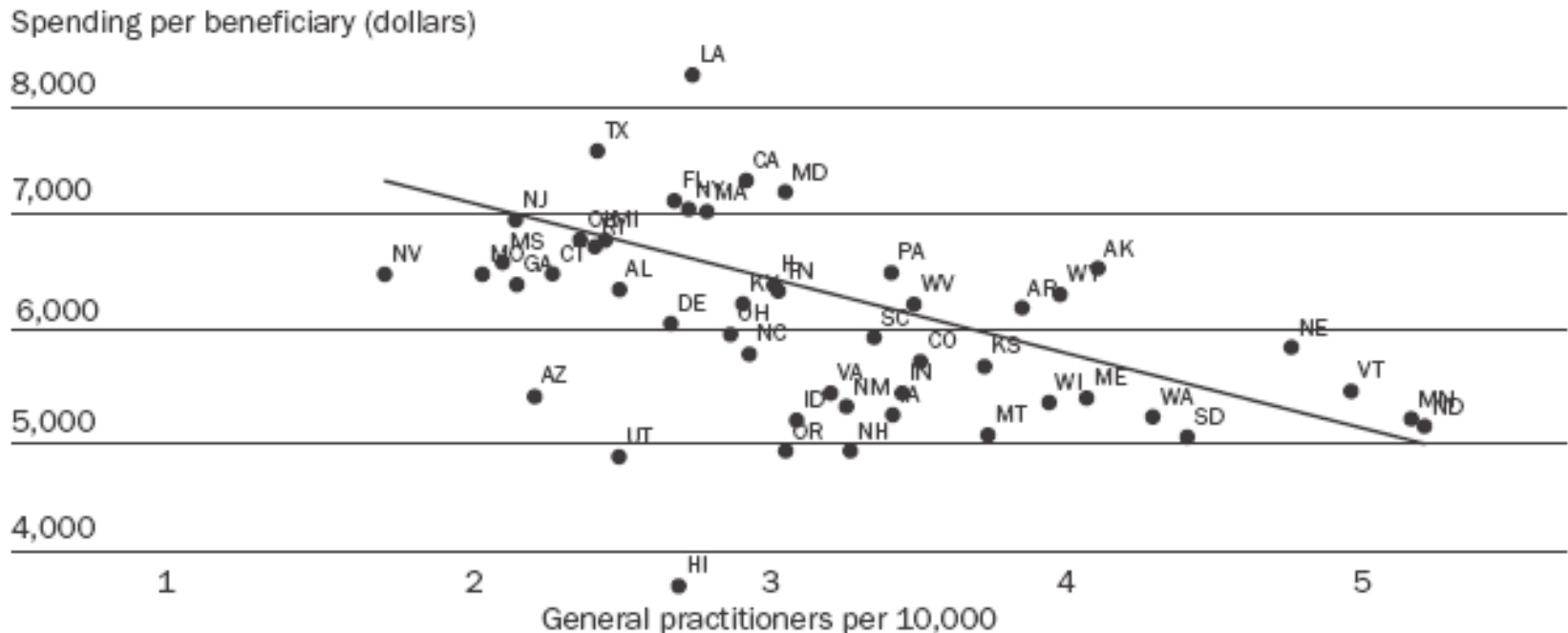
NOTE: Total physicians held constant.

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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

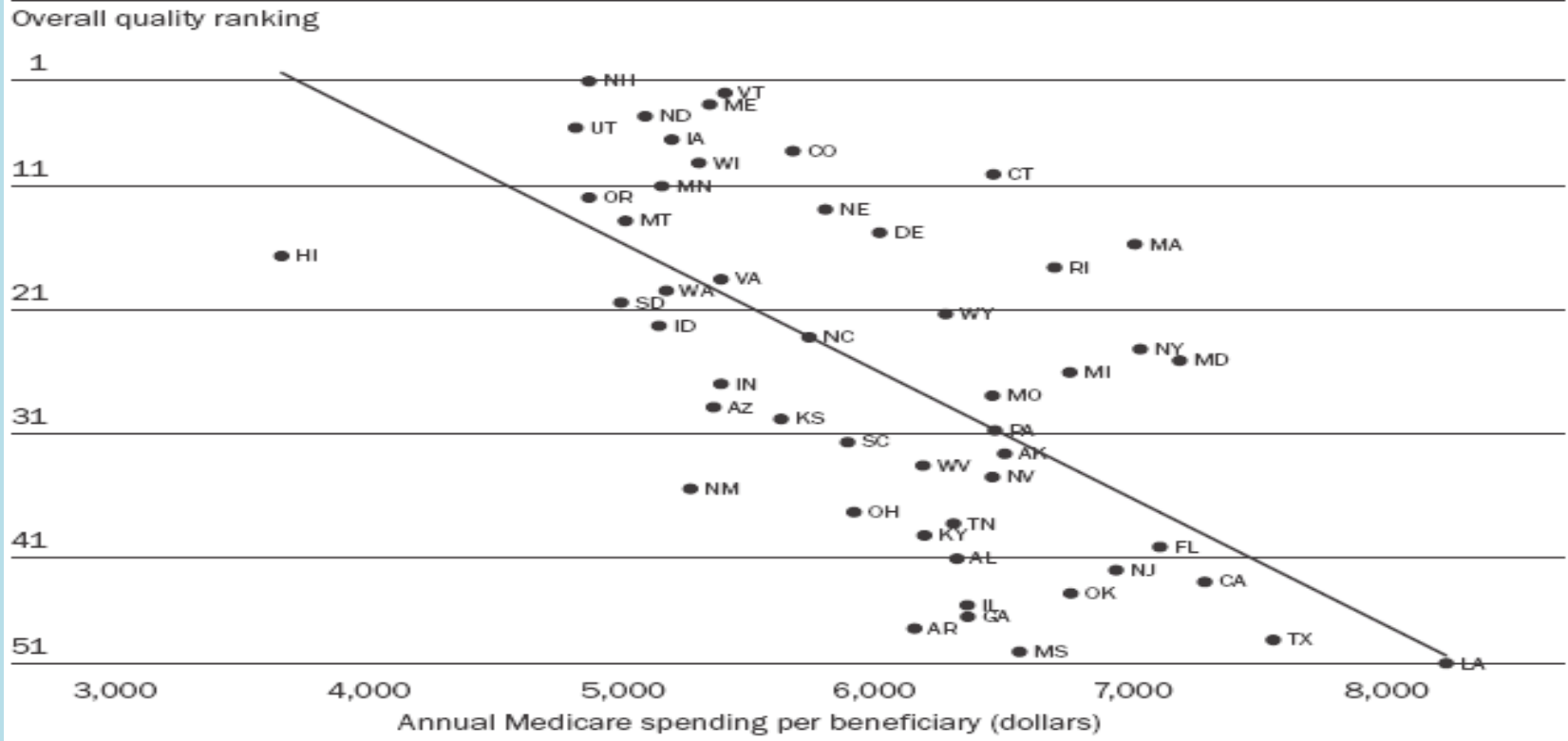


SOURCES: Medicare claims data; and Area Resource File, 2003.

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



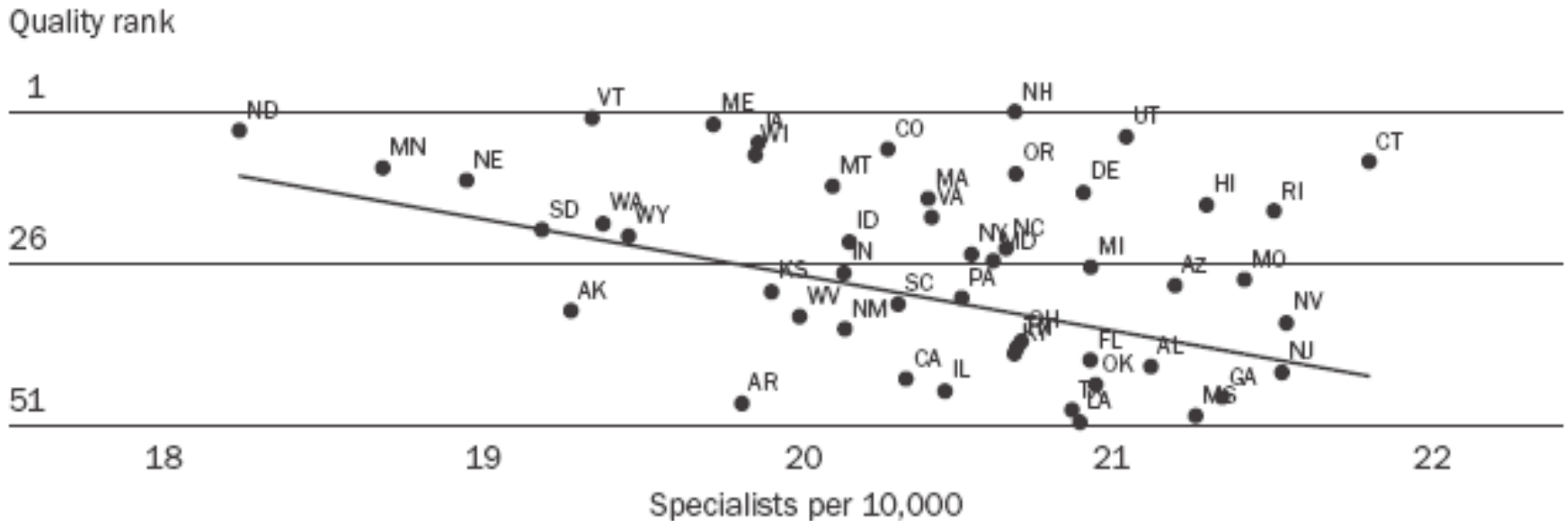
SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

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



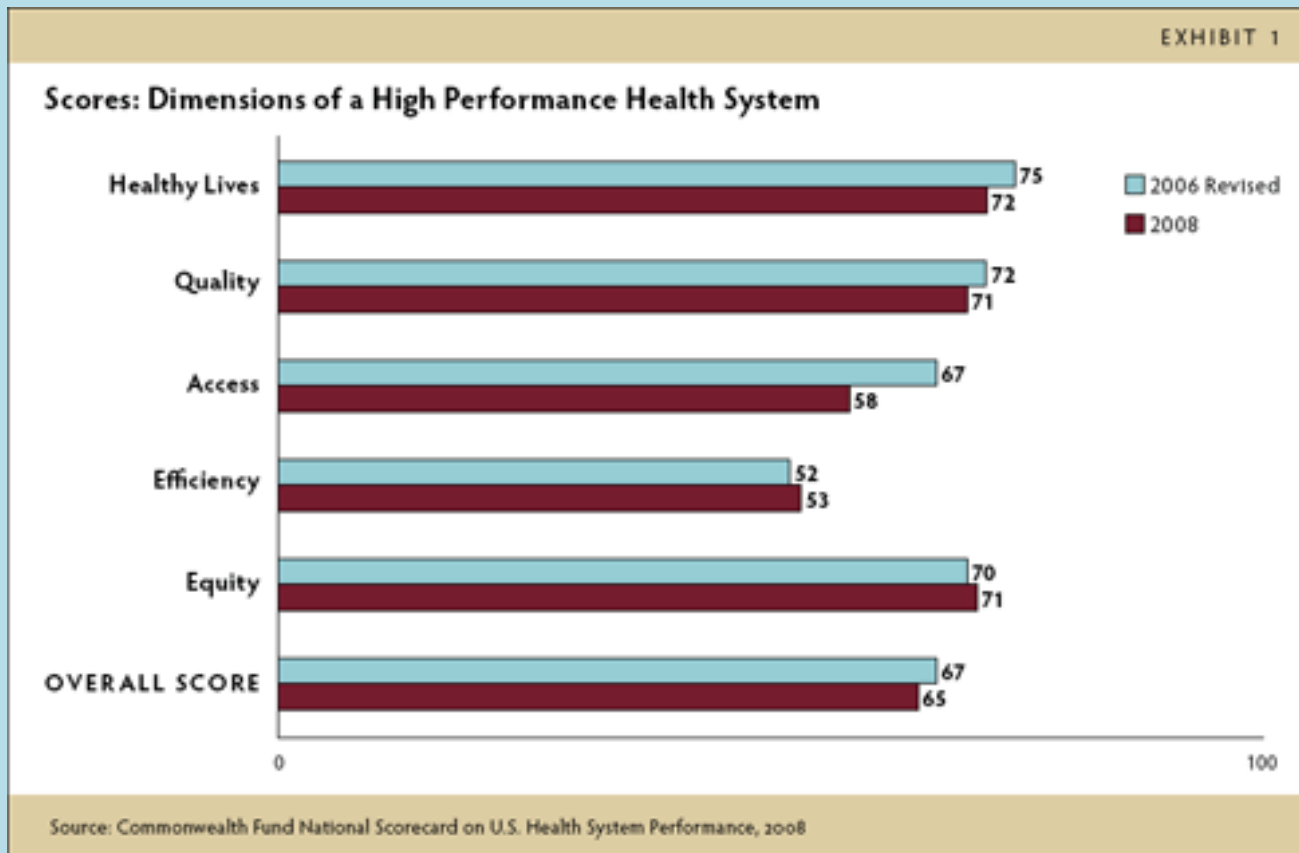
SOURCES: Medicare claims data; and Area Resource File, 2003.

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

US Health System

- Commonwealth Fund Data confirm comparatively poor performance of US Health System

Scores: Dimensions of a High Performance Health System



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

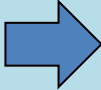
Milstein: Ambulatory Intensive Caring Unit, a “Super-Model” of Primary Care

- 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

PCMH at Group Health*

- Decreased panel size (2327  1800)
- Added staff: PAs, RNs, MAs, pharm
- Promoted e-mail, Web portal
- Pre-visit planning, patient outreach
- Daily huddles
- Added cost: \$16 PPPY

*Reid RJ et al. The Group Health medical home: higher patient satisfaction and less burnout for doctors. Health Affairs 2010;29(5): 835-43.

Impact

- Improved patient satisfaction/self-management
- Decreased burnout in staff/docs
- Improved quality (acute, chronic/preventive care)
- 29% fewer ER visits
- No change in total hosp, but 11% fewer admits for ASCs
- Overall, no impact on total costs

Other Pieces of the Evidence Base

- **Care Management, Transitions:** several, most not statistically significant
 - Steele et al.: 7-9% savings
 - Boulton et al.: Guided Care, 11% savings
 - GRACE trial.: 23% savings
 - Multiple others: significant improvements in quality, patient experience; *no measurable impact on total cost*
- **Access**
 - Actuarial data on difference in costs for common problems (e.g., “acute bronchitis” managed by Pulmonary Specialist costs 532% of PCP cost)
 - Reductions in ER utilization, hospital admissions—no reliable data on achievement of total cost reduction

High Leverage Changes

- Identify—and proactively care manage—high-risk patients
- Continuity/availability to participate in care decisions that occur “off-site” and “off hours”
- Integration of mental health
- Shared decision making
- All supported by comprehensive HIT adoption
 - Registry functionality
 - Proactive panel management
 - Enable/support team-based 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

But We Need Reorganized Practices Because the Work of Primary Care Has Changed

<i>Type of service</i>	<i>Number per physician per day</i>
Office visit	18.1
Telephone call	23.7
Rx refill	12.1
E-mail message	16.8
Laboratory report	19.5
Imaging report	11.1
Consultation report	13.9

Baron RJ. What's keeping us so busy in primary care?
A snapshot from one practice. *New Engl Journal of Med*, April 29, 2010.

How Might ACOs Support This?

- Different “internal bookkeeping” for primary care
 - If all you do is replicate FFS internally, you will miss opportunities
- Explicitly negotiated and supported care models
 - Define the capacity you believe is necessary
 - Likely need to “redirect” resources to assure this capacity
- Create accountability framework for primary care
 - Performance metrics that include quality and resources
- Incentive structures send powerful signals

Module 4A: Primary Care and Specialist Services

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Group Director, Seamless Care Models
Innovations Center, CMS

Richard.Baron@cms.hhs.gov

(410) 786-8626