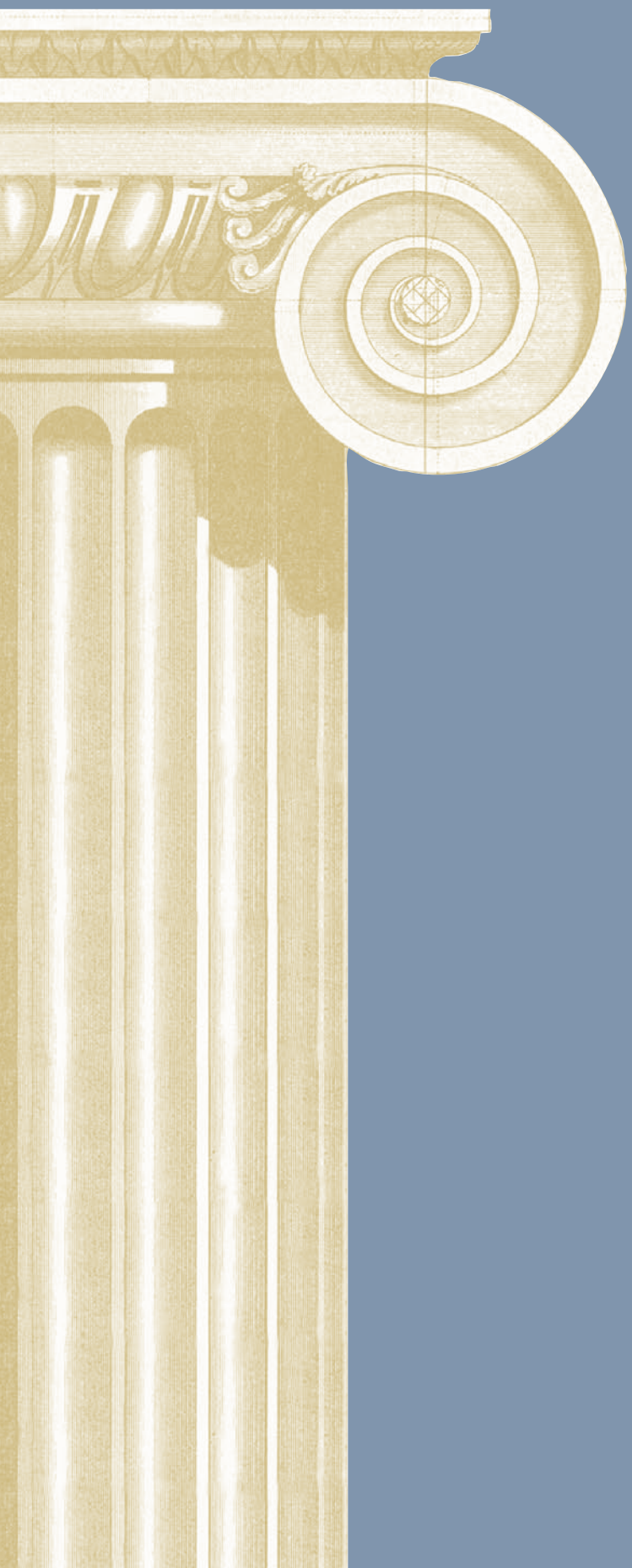

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policy brief

Primary Care in Pennsylvania: Defining the Problem and Identifying Potential State Policy Solutions

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FOREWORD

In September 2009, the Institute of Politics Health and Human Services Policy Committee sought to identify new policy issues on which to focus during the coming year. Ten important health and human service issues were narrowed down to two, one of which was primary care. Primarily, the committee expressed an interest in determining what state policymakers and the next administration could do to foster the development of primary care in Pennsylvania amid a nationwide shortage of providers. As a result, the following research paper was commissioned, with the intended audience being state policymakers, the next governor, and anyone else who has an interest in ensuring adequate provision of primary care in Pennsylvania in the coming years.

INTRODUCTION

The Center for American Progress calls the primary care workforce "the backbone of the health care system."[1] However, evidence indicates that our backbone is currently deteriorating, as analysts predict a significant shortage in primary care providers within the next 10–20 years. Federal legislation that will increase the insured population will only exacerbate and accelerate the problem.

As a result, it is essential that Pennsylvania determines how to deliver better primary care to its citizens before the situation becomes critical, as it already is in other states. Pennsylvania has several high-quality medical schools and has become a net exporter of doctors. The state will need to determine how to retain more of those physicians and at the same time encourage more of them to choose primary care as a specialty. It is illustrative that in the United States, there is one primary care physician for every three doctors; globally, the ratio is one to one.[2]

However, increasing the number of physicians will only partially address the shortage, especially given that in the time it takes to train new physicians from start to finish (12 years), the problem will already be in full force. In the past decade, new models of primary care have expanded rapidly, partly in an effort to do more with less and to fulfill needs where gaps in access to care occur. These models include federally qualified health care centers, retail clinics, accountable care organizations, and patient-centered medical homes, all of which will be addressed in this report.

Many of these models incorporate nonphysician staff members such as care managers, nurse practitioners, and physician assistants. If these models are used to address the primary care shortage, then the total number of these health care workers will need to increase along with the number of physicians.

Payment for services also remains an issue, as the income gap between primary care physicians and specialists continues to widen due to reimbursement rates that do not place value on much of the work that primary care physicians currently perform. Solutions that will be explored include increasing and adjusting the reimbursement rates; changing the payment system altogether (as in the patient-centered medical home model); and providing loan forgiveness to physicians who enter primary care, particularly in underserved areas.

The goal of this report is to help inform the policymakers in Pennsylvania as important decisions are made in the next few years in order to help them craft a comprehensive and coordinated state policy around the provision of primary care.

DEFINITION OF PRIMARY CARE

The American Academy of Family Physicians (AAFP) defines primary care as "care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin, organ system, or diagnosis." AAFP notes that while some primary care services are provided by nonphysician providers, who can include nurse practitioners and physician assistants, these individuals should be supervised or directed by primary care physicians. Ideally, according to the AAFP, nonphysician providers would form part of a care team headed by a primary care physician.

In Pennsylvania, under Act 113 of 1992, which requires the commonwealth's Department of Health to address the supply and distribution of primary care, primary care practitioners include family physicians, pediatricians, internists, obstetricians, general dentists, certified nurse-midwives, physician assistants, and certified registered nurse practitioners. Also, it is important to note that in some cases, mental health services are included in the definition of primary care, as evidence has shown that many such services are provided in the primary care setting.[3]

For the purposes of this report, the term "primary care" will encompass the type of care referenced in the AAFP definition, with specific attention paid to family and general physicians, internists, nurse practitioners, physician assistants, and other medical staff essential to alternative models of care.

WHY PRIMARY CARE?

In the summer of 2008, the Physicians Foundation surveyed 270,000 primary care physicians and more than 50,000 specialists on issues that included the provider shortage, administrative activities, reimbursement and finances, and physician morale. The foundation received more than 11,000 responses.

This survey was unique in that its goal was to obtain responses primarily from physicians in a traditional small-practice model as opposed to a newer system, like a patient-centered medical home. Below are some of the findings that help to frame the discussion of the problems surrounding primary care in the United States.

- Forty-nine percent of physicians reported a plan to reduce the number of patients they see or to stop practicing entirely within the next three years.
- Sixty percent would not recommend medicine as a career choice for students.
- If they had the opportunity to choose their careers over again, only 27.69 percent of primary care doctors would choose that field again. Of the remaining 72.31 percent, more than 26 percent would not choose to practice medicine, while more than 40 percent would choose a specialty other than primary care.
- Just a little less than 90 percent reported moderate to severe difficulty in recruiting additional physicians to their practice.

In addition:

- Ninety-four percent reported an increase in the amount of time they have had to spend on nonclinical paperwork.
- Sixty-five percent state that the reimbursement they receive from Medicaid does not cover the cost of care, and 36 percent also reported that Medicare reimbursements do not cover the cost of care. Of those responding, 33 percent no longer treat Medicaid patients, while 12 percent no longer treat patients with Medicare.
- 63.4 percent of physicians work more than 51 hours weekly; 38 percent work more than 61 hours weekly.
- Only 36.77 percent reported regularly having the time to communicate fully and appropriately with their patients.

The above factors indicate a decline in the interest in practicing primary care and in the working environment for primary care physicians, just as evidence is demonstrating primary care physicians' importance to our health care system. Locally, Lawrence John and Anthony Spinola, cochairs of the Allegheny County Medical Society's Primary Care Working Group, report that primary care-centered health care systems result in:

- Lower mortality rates,
- Less use of emergency departments,
- Better preventative care,
- Fewer medical tests,
- Higher patient satisfaction,
- Lower care-related costs, and
- Reduced health care disparities within a population.[4]

Meanwhile, they state that "the United States, compared to other developed countries, ranks lowest in primary care-based functions … but highest in health-care spending."[5]

More generally, all of these statistics indicate that the population will make fewer trips to the hospital and will be less costly to treat when illness does occur if primary care is sustained and even expanded in the United States. This can potentially be attributed to the unique relationship that primary care practitioners have with their patients and their focus on preventative medicine and monitoring chronic disease.

DEFINING THE PROBLEM

Statistics on Primary Care Physicians/ Other Professionals

In 2009, the Institute of Medicine reported that it would take an additional 16,261 physicians to meet the current need for care in underserved areas.[6] By 2025, Health Affairs predicts that there will be a shortage of 35,000–44,000 family physicians, based on guidelines from AAFP that suggest 42 family physicians per 100,000 people. This shortage is due to a number of factors, including the following:

- **An aging population:** The elderly (age 65 and older) seek health care from primary care providers more frequently than younger patients, and the percentage of elderly patients in the United States is projected to grow significantly in the coming decades.[7] Often, they have one or more chronic conditions, which require more time and effort to treat. This is especially a problem in Pennsylvania, which already has a high elderly population compared to other states.
- **An aging physician workforce:** A 2003 study conducted by the Pennsylvania Medical Society placed Pennsylvania 41st among states in the percentage of its physicians who were under 35. Also, the American College of Physicians indicates that general internists retire at a younger age than do physicians in other specialties.[8] However, the 2010 State of Medicine in Pennsylvania report from the society indicates that this issue may be more of a problem in certain areas of the state than in others.
- **A declining level of interest among current medical students in pursuing primary care as a career:** In the 2010 Match Summary and Analysis, AAFP reported a slight increase in the number of U.S. fourth-year medical students matched into family practice residencies, reversing a previous trend.[9] However, anecdotal evidence continues to indicate that many of the best and brightest students are discouraged by peers and sometimes professors from pursuing careers in family practice.

The shortage of primary health care providers is especially prevalent in rural areas. Because of geographic and economic reasons, many rural areas are considered underserved and have trouble with recruiting and retaining primary care physicians. As a result, they rely on incentives like the J-1 waiver program and loan repayment programs to fill provider needs.[10] Lack of residency opportunities in rural clinics also seems to exacerbate the physician shortage.[11] Meanwhile, efforts to recruit cost money and drive up the cost of health care in these locations.

Pennsylvania has, on average, more physicians per capita than most other states in the United States. However, this seems to be due to an above-average population of specialists and does not reflect a higher primary care physician population. The chart below demonstrates where Pennsylvania ranks compared to other states and territories in terms of the number of primary care physicians (PCPs). It is important to note that while numbers of physicians may appear to be high, the geographic distribution of these physicians is by no means equitable. In explaining its Physician Shortage Area Program, Jefferson Medical College highlights the problem with three salient facts:

- While 20 percent of the people in Pennsylvania live in a rural area, only 9 percent of physicians practice there.
- Almost one-half of the state's physicians practice in just three counties: Allegheny, Philadelphia, and Montgomery.
- The remaining 64 counties in Pennsylvania are home to three-quarters of the state's population.[12]

(See chart on page 6)

Physician Reimbursement

Payment rates set by insurance providers as well as Medicare and Medicaid reimbursement rates all affect the income earned by primary care practitioners. In many cases, these rates have not kept pace with the increasing costs of the technology and administration required in modern physicians' offices. In fact, physicians in the 2008 Physicians Foundation survey identified "declining reimbursement" as the most prominent issue facing patient care today.[13] Testimony from the U.S. Government Accountability Office report on primary care indicates that "resource-based payment systems like those of most payers today do not factor in health outcomes or quality metrics; as a consequence, payments for services and their value to the patient are misaligned."[14] Again, this is due to the fact that rates do not take into account many factors of primary care, including the time practitioners spend analyzing patient cases. Specifically and more importantly, the rates do not reflect the fact that this critical analysis performed by primary care physicians often results in better outcomes and healthier patients.

Locally, Highmark reported raising reimbursement rates for primary care services by 2–3 percent at the beginning of 2009. While most physicians feel that this is a positive step, it does not address the other part of the problem, which is that the services physicians are reimbursed for do not include tasks that currently take up a large portion of their day, like filling out paperwork and performing other administrative duties.

MCARE and Medical Malpractice Insurance in Pennsylvania

A primary cost driver for physicians in all states, including Pennsylvania, is the cost of medical malpractice insurance. In addition to any private insurance they purchase, physicians practicing in Pennsylvania are required to pay into the state's MCARE Fund, which is designed to cover any additional costs beyond what the physicians' primary insurance provider will cover in the event of a lawsuit. The creation of this fund in 2002 reportedly stemmed from a lack of affordable private malpractice insurance in Pennsylvania; the state wanted to ensure that physicians who could not get adequate coverage in the private sector would be covered by other means.

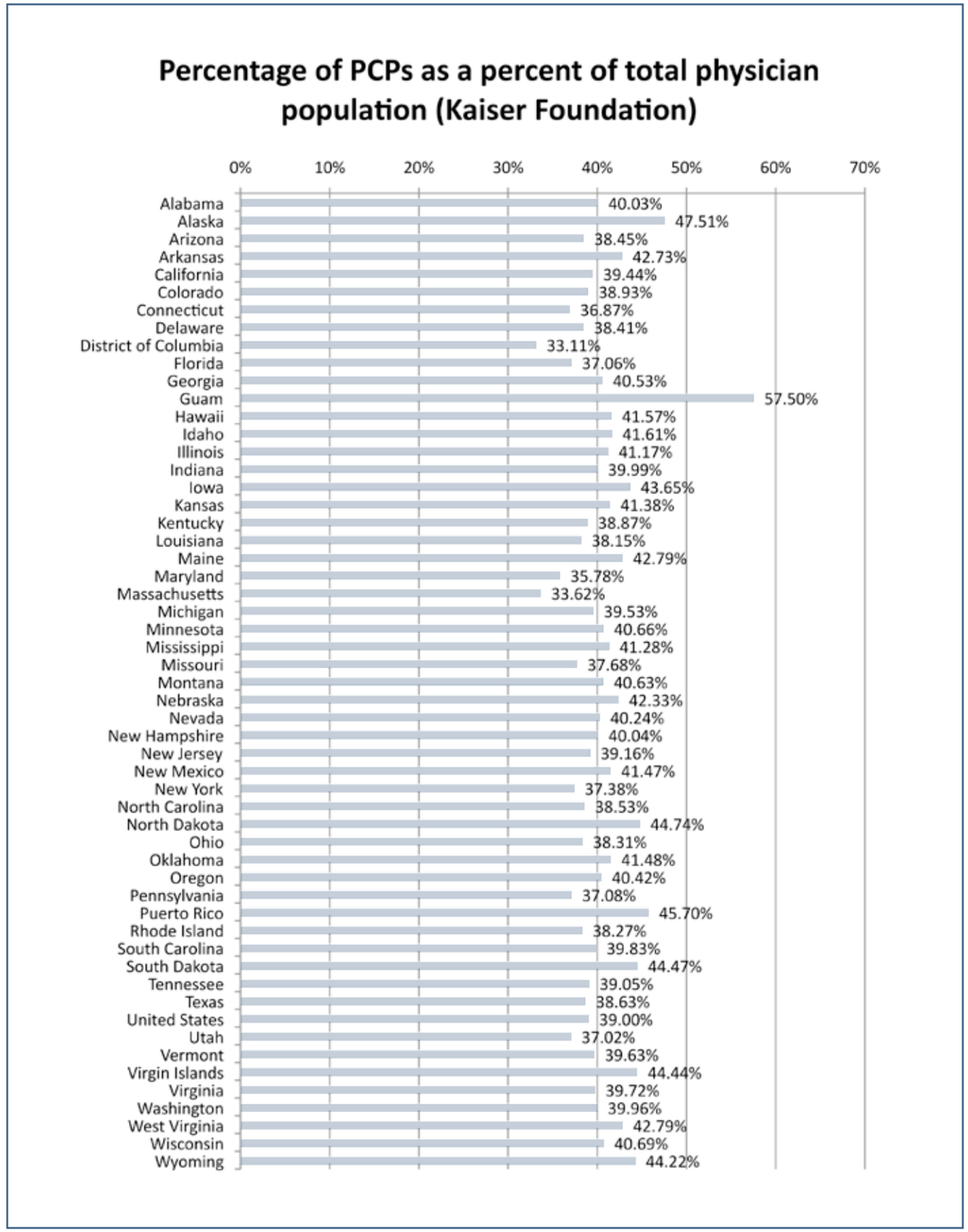
This is one area where it pays to be a primary care physician; MCARE fees for specialists were often twice as high, presumably due to the increased risk associated with being a specialist.

Cost of/Debt from Medical Education

Although medical school students often are faced with similar debt burdens upon graduating, their ability to repay that debt is significantly affected by the specialty they choose. For example, the Center for American Progress reported in 2009 that "the average medical student has $155,000 of debt upon graduation," while "the average annual income for family physicians is $173,000."[15] This can then be compared to the average incomes for radiologists ($391,000) and cardiologists ($419,000).[16] In fact, family practitioners rank among the lowest in terms of annual income for physicians, and although there is evidence to suggest that income is not the primary factor in students' choice of specialty, some correlation has been proven.

Loan forgiveness for physicians who enter primary care often has been cited as a way to help close the income gap between family practitioners and specialists. The Association of American Medical Colleges provides a list of 90 medical school scholarship and loan forgiveness programs sponsored nationally and in 41 states. It is important to note that many of these programs have a significant number of requirements attached to them. Although this type of program is perceived to be useful for recruitment, it has been less effective at assisting with retention, according to some rural health providers.[17]

The debt burden faced by students who choose to practice primary care is just one of several factors that may discourage graduates. Studies of medical students show that other factors



can play a role in their decisions to choose other specialties, including the administrative burdens on primary care doctors that are not included in current reimbursement models. Anecdotally, students also have reported being discouraged from pursuing a career in primary care by school administrators, professors, and even other students. Basim Khan reported in the *Los Angeles Times* that "a recent graduate was once told that she was 'too smart for primary care,' a remark that reflects an implicit expectation that the most successful students will specialize."[18] One study that compared students' specialty choices upon entering and exiting medical school found that only 30 percent of students who had shown an initial interest in primary care ended up choosing that pathway. Specialties showed interest retention rates that were significantly higher.

Pennsylvania has had a primary health care practitioner loan repayment program in place since 1993; it offers loan forgiveness to practitioners who serve for four or more years in a federally designated Health Professional Shortage Area. The program is funded through both state and federal appropriations. According to the 2007 Primary Health Care Practitioner Program Annual Report published by the Pennsylvania Department of Health, a majority (more than 79 percent) of loan forgiveness recipients have remained in Pennsylvania to practice. Over a 15-year period (from 1993 to 2007, inclusive), a total of 265 practitioners were able to take advantage of this program; 83 of them were family practice physicians.

Summary

Pennsylvania's physician workforce is aging and retiring, and not enough medical students are choosing to pursue careers in primary care. The financial and administrative burdens that today's primary care physicians face are part of the reason for the difficulty in attracting young physicians to this field. Although the state and federal governments have been aware of this problem for some time, government programs designed to address the problem have not made a significant impact. In response, Pennsylvania and the nation have seen a growth in primary care provided through nontraditional sources.

CURRENT METHODS OF MEETING PRIMARY CARE NEEDS

J-1 Waiver Use

According to Robert Steinbrook, the growth in the J-1 waiver program can be attributed to the decline in the number of U.S.-born medical school graduates pursuing careers in primary care.[19] This federal program permits foreign nationals who entered the United States to attend medical school to remain here after graduation to practice instead of returning home for two years before applying for a visa to return, as is customary. Each state may receive up to 30 waivers annually.

Conditions of the waiver for the physician include:

- Practicing in a federally designated medically underserved area,
- Practicing for 40 hours over at least four days each week, and
- Serving for at least three years.

Conditions of the waiver for the facility seeking to hire a physician include:

- Displaying that attempts were made to recruit a physician from the United States and
- Being willing to treat Medicare and Medicaid patients as well as the uninsured.

Similar to the loan forgiveness program, the J-1 waiver program is helpful in recruiting physicians but less so in retaining them, rural providers have found.[20]

Pennsylvania has attempted to address that by reviewing applications carefully and accepting those physicians who seem most likely to remain in their practice positions after the three years have passed.

In addition to recruiting international graduates of U.S. medical schools, the United States also is increasingly relying on foreign-trained physicians to fill workforce shortages. Some argue that there are ethical implications to this practice, as many of these physicians come from nations where trained medical professionals are in short supply and the need for care is great.

Nurse Practitioners

As the cost of medical care increases and fewer and fewer primary care physicians are available to fill positions, many practices are utilizing nurse practitioners (NPs) in different ways to help close the gap in the provision of care.

The American College of Physicians has found that NPs:

- Treat almost 600 million patients annually,
- Are likely to provide care to younger patients with acute (rather than chronic) conditions,
- Provide a significant proportion of care to vulnerable populations, and
- Help to improve access to care in rural areas.[21]

Physician groups have generally objected to some components of the expansion of duties for nurse practitioners, believing that because NPs do not receive the same education as physicians, they should not be permitted to take the place of physicians in many cases. However, these groups do support a number of reforms in the current system that will enable physicians and NPs to work together more easily and efficiently. For example, the American College of Physicians has made several

recommendations, including developing a method by which NPs and physicians can work in care teams and get reimbursed accordingly for their collaboration.[22] This is especially essential to the creation of care teams used in patient-centered medical homes.

As the demand and need for NPs grows, workforce concerns remain. One problem is the lack of educators available to train additional new NPs. Another potential concern is the recent policy of the American Academy of Nurse Practitioners to change all master's-level NP programs into doctoral programs by the year 2015. Not only could this exacerbate a shortage of teaching professionals, it also could lead to fewer students choosing an NP program as a result of the additional time commitment. Locally, Robert Morris University recently developed a Doctor of Nursing Practice degree, which is currently offered at its Moon Township location.

In 2007, Pennsylvania joined a number of other U.S. states in passing legislation (Act 48 of 2007) that significantly expanded the duties of NPs as long as they are acting within the scope of an agreement with a physician and any specialty licenses held by the NP. New duties include:

- Issuing orders for home and/or hospice care,
- Issuing orders for durable medical equipment,
- Making physical therapy and dietician referrals,
- Making respiratory and occupational therapy referrals,
- Giving TANF disability assessments, and
- Giving home-bound schooling assessments.

Health care systems that employ NPs still have the ability to regulate the scope of practice within their own systems. The legislation also requires MCARE coverage for NPs, even though they are not permitted to withdraw from the fund. Several additional bills that include provisions to expand allowable functions for NPs are currently pending in the Pennsylvania General Assembly.

Physician Assistants

Pennsylvania's State Board of Medicine has developed regulations in accordance with state law that outline the licensure and practice of physician assistants (PAs). Unlike nurse practitioners, PAs cannot practice medicine independently and cannot bill for services independently; they may only practice as an agent acting under the direction of a supervising physician. However, PAs are permitted to practice at a satellite location as long as direct communication with a supervising physician is possible at all times (either in person or through some form of telecommunication), the PA has a written agreement that delineates permitted duties, and the patients' records are reviewed by the physician within 10 days of treatment. PAs also are currently permitted to act on behalf of a physician in many respects and can order and administer drugs and therapeutic treatments, certify death (but not cause of death), and provide signatures on certain forms requiring the signature of a physician.

Because PAs train as generalists, they can switch specialties more easily throughout the course of their careers to take advantage of new opportunities or respond to workforce shortages, which makes them uniquely capable of filling primary care roles when such positions become available. In fact, one study found that 49 percent of all active PAs changed specialties at least once during their careers.[23] Somewhat disconcerting is the fact that, as with physicians, more PAs have been moving out of family practice than have been going in.[24] However, the authors of this study determined that PAs may be more responsive to some of the primary care incentives that are present in the new federal health care reform legislation.[25]

Summary

The current methods of addressing the shortage of primary care providers through the use of J-1 waiver physicians, nurse practitioners, and physician assistants will not be sufficient to meet future needs. It will become necessary for governments, health care systems, and health professionals to develop new or reinvent old models of delivery that improve the efficiency of health care in Pennsylvania. The next section examines various models that have demonstrated success in improving primary care.

MODELS OF DELIVERY OF PRIMARY CARE

A crisis exists in primary care on many levels. However, crisis can create opportunity. There is increasing evidence to support the proposition that policies developed to strengthen primary care both decrease health care costs and improve the quality of care. Several criteria can be used to measure the effectiveness of these policies:

1. Do they improve access to care?
2. Do they improve prevention and provide for early diagnosis of illness?
3. Do they reduce unnecessary testing, referrals, and medication?
4. Do they provide lower-cost treatment?
5. Do they reduce the number of preventable emergency room visits?
6. Do they provide for patient education, self-management, chronic disease, and support?

A number of models that organize the delivery of primary care have been developed to meet these criteria. Five of these models will be examined, and a preliminary analysis of their effectiveness will be provided. In general, there are two trends in the development of models of primary care delivery: one that focuses on the coordination of care and another that focuses primarily on single-visit acute care.

Single-visit Acute Care Models

The following are two examples of organizations primarily focused on single-visit acute care.

Retail Clinics

Retail clinics are generally for-profit organizations that typically are located in retail stores such as Target, CVS, Walgreens, Walmart, and grocery chains. They provide convenient medical care without an appointment and with short wait times. The professional personnel are primarily nurse practitioners or physician assistants. Retail clinics employed 3,000 nurse practitioners by the end of 2009, and the number is growing. By 2013, it is estimated that 6,500 NPs will be needed. Initially, clinic visits were mainly paid for by the patients; however, Medicare, Medicaid, and private insurers now are paying for the visits as well.

The first retail clinics opened in 2000. While they showed remarkable growth in the first few years, that growth has recently slowed. As of July 2009, there were approximately 1,107 clinics in operation in the United States. Also in the last few years, there have been a growing number of acute care organizations entering retail medicine via contractual arrangements with drug store and grocery chains.

Some have been critical of retail centers, believing that they increase fragmentation in the health care system, provide inferior care, and adversely impact the delivery of preventative care; however, a number of research studies tend to contradict some of the criticisms. In fact, research has shown that clinics serve a population that lacks access to regular primary care providers, and that they perform a limited number of procedures, including treating such things as sore throats and skin conditions, giving immunizations, pregnancy testing, and diabetes screening at a lower cost with equivalent quality to other settings.

Research did not support the claim that these clinics are improving care for the medically underserved.

In summary, retail clinics may exacerbate the already substantial problems of fragmented health care and poor coordination among health care providers. On the other hand, the clinics offer treatment for common illnesses at a lower cost with similar quality to other care settings. Because of the limitations on the treatment available at clinics, it is worth noting that they will not be able to serve as a replacement for a traditional primary care practice model. However, they can exist alongside other models to serve a portion of the patient population whose situation may not require the attention of a physician at that time. This can free up physicians to spend more time with patients who have chronic conditions or require more extensive diagnoses. This system will work, though, only if reimbursement rates change to account for the work that primary care physicians do with chronic care patients.

Because several acute care facilities provide services in retail settings, some retail clinics operate as part of a coordinated care system. The following case study of Heritage Valley ConvenientCare centers illustrates how retail centers can be integrated into a coordinated care network.

Case Study: Heritage Valley ConvenientCare

One-stop shopping seems to be a central theme of Walmart's business model, and its recent partnership with Heritage Valley Health System in Western Pennsylvania certainly enhances that reputation. Across the nation, Walmart has been partnering with nonprofit health systems like Heritage Valley to operate clinics within its stores; Heritage Valley is the first health system in the state to partner with Walmart for this purpose. John Luellen, who oversees the ConvenientCare system for Heritage Valley, recently provided the Institute of Politics with an opportunity to examine this model in depth.

With the first clinic opening in the fall of 2009, Heritage Valley now has four clinics located within Walmarts in Beaver, Butler, and Lawrence counties in Pennsylvania and one in East Liverpool, Ohio. Each site is staffed with a full-time nurse practitioner and a medical assistant, and the pricing, the services offered, and the general operations remain the same at all sites. Services provided at ConvenientCare locations are similar to those available at other retail clinics. Luellen stated that Walmart has a standard list of services that the company wants all of its nonprofit partners to provide. The prices also are comparable to what patients would see at other clinics. All insurances are accepted, and those without insurance are required to pay prior to receiving services. Services provided at ConvenientCare locations are similar to those available at other retail clinics. Luellen stated that Walmart has a standard list of services that the company wants all of its nonprofit health partners to provide. The prices also are comparable to what patients would see at other clinics. All insurances are accepted, and those without insurance are required to pay prior to receiving services.

What makes ConvenientCare unique among retail clinics in Western Pennsylvania?

Heritage Valley's ConvenientCare sites feature a number of characteristics that set them apart from other retail clinics in the area. The first is that they are operated by a nonprofit health system as opposed to a for-profit pharmacy or group. The only other nonprofit retail clinics in the state are operated

by Geisinger Health System in central and eastern Pennsylvania. Also, although ConvenientCare clinics are located within Walmarts, there is no formal relationship between the two organizations other than that of landlord and tenant. No data sharing goes on, and no referrals are made from the clinic to the Walmart pharmacy, although patients have the option to choose that pharmacy to fill their prescriptions.

Second, although ConvenientCare clinics are staffed by nurse practitioners like other clinics, 100 percent of the cases are reviewed by one of Heritage Valley's primary care physicians. Each retail location is associated with one or more practices within the Heritage Valley system, and all patients seen at the retail locations are considered patients of the affiliated practices. Billing for services continues to be at the reduced NP rate, despite the oversight from physicians.

What makes this level of oversight possible is the technology utilized at both the ConvenientCare clinics and throughout the system. A number of years ago, Heritage Valley issued Care Cards, which resemble the frequent shopper cards with unique bar codes that are used to track purchases at many retail stores. Instead of tracking purchases, Care Cards allow the health system to track patient visits electronically. Care Cards can be used by patients at any of the clinics, and they enable the staff to pull up patient information immediately. If the individual does not have a Care Card, his or her information is entered into Heritage Valley's electronic system during the visit to the clinic and maintained in the same manner as that of a patient who visits a traditional physician's office. As mentioned previously, the physicians associated with each clinic are responsible for reviewing all cases that come through the clinics and for remaining on call during the day in case the NP has a question about a patient or procedure. Other innovative technology devices in use at ConvenientCare clinics include handheld devices for practitioners that allow them to review patient information as the patient is registering or before the patient arrives in the exam room. Additionally, while not patient related, webcams recently were installed to relieve staff at the five locations of traveling what could be a considerable distance to meet with the other clinic practitioners, which Luellen indicated has greatly contributed to staff satisfaction.

Results

Eight months after the first ConvenientCare location opened, Luellen seemed pleased with the progress that the system had made thus far in gaining community and physician acceptance for the clinics. He stated that primary care physicians within Heritage Valley were, for the most part, pleased with the clinics. Physicians whose practices are affiliated with one of the locations were especially pleased, because they now have a place to which to refer their patients for after-hours care besides the emergency room. He noted that one doctor chose to stop scheduling same-day urgent care visits in his primary office, preferring instead to send those patients to one of the clinics in order to utilize the extra time to focus more on his chronic care patients. Doctors also seemed to like the policy that requires physician review of 100 percent of the casework handled at the clinic.

In terms of measurable outcomes, Luellen mentioned that visits to the clinics have grown steadily since their opening. While the Chippewa site was busy from the day that it opened, other locations have grown more slowly. It is still too early to do much analysis on the model, but Luellen noted that many Walmart employees have utilized the clinics for their basic vaccination and annual physical needs. Recently, Walmart contracted with Heritage Valley to do employee drug testing through the clinics as well.

Because of the limitations on the treatment available at the clinics, it is worth noting that they will not be able to serve as a replacement for a traditional primary care practice model. However, they can exist alongside other models to serve a portion of the patient population whose situation may not require the attention of a physician at that time.

Urgent Care Centers

Urgent care is the delivery of ambulatory care outside a hospital emergency department on a walk-in basis without a scheduled appointment. Urgent care centers offer services similar to those provided at retail clinics, but they also are capable of treating minor and moderate lacerations and offer X-ray facilities. These centers provide treatment for episodic care at a lower cost than hospital emergency rooms while still providing care that cannot be delayed until an appointment at a physician's office is available. A key difference between urgent care centers and retail clinics is in the scope of services; urgent care centers are able to offer a broader range of treatments.

There are approximately 9,000 urgent care centers in the United States, all of which offer extended hours on evenings and weekends. Centers are staffed by physicians with support of physician assistants, nurses, and other personnel. Providers include for-profit and nonprofit organizations as well as major health care delivery systems.

Coordination of Care Models

Besides the single-visit acute care system, the following are three examples that focus on models that are primarily interested in the long-term coordination of care.

Accountable Care Organizations

Accountable care organizations (ACOs) are flexible structures that "consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth."[26] They accomplish this by coordinating care for a defined group of patients with the goal of improving patient care, thereby lowering expenditures.

Examples of ACO structures include:

- Primary care physicians, specialists, and one hospital;
- All of the physicians in a geographic area whose patients are admitted to a particular hospital;
- Physicians practicing in groups;
- Networks of discrete physician practices;
- Partnerships or joint ventures between hospitals and physicians;
- Hospitals employing physicians; and
- Integrated health systems or community-based coalitions of providers.

In addition, ACOs may feature a variety of payment models. Evidence has not yet demonstrated that one structure is superior to the others. In fact, a key attribute of ACOs is that they are adaptable to local physicians and health systems, according to Elliott Fisher.[27] However, there is some agreement that size is an important component; in order to achieve cost savings, ACOs must serve at least 15,000 privately insured individuals or at least 5,000 Medicare beneficiaries.[28]

In the past decade, ACOs have been featured in Medicare demonstration projects across the country. The projects featured a variety of the organizational structures listed above, but the key component was the shared savings program, which allocated to providers a portion of what Medicare saved as a result of better health outcomes. Health Affairs notes that "in the third year of the demonstration, five [providers] had achieved sufficient reductions in spending growth to allow them to obtain more than $5 million in shared savings bonuses as their share of a total of more than $32 million in Medicare savings"; even so, additional evidence is needed to determine whether these models will be able to slow health care spending generally while continuing to improve patient outcomes.[29]

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) include all organizations receiving grants under section 330 of the federal Public Health Service Act. The act stipulates that FQHCs must serve an underserved population; offer a sliding scale payment system; provide comprehensive services, including dental and other preventative services; and have an ongoing quality assurance program. Additional services can be added where appropriate for the target population and can include behavioral health, mental health, or substance abuse services. In return, the act offers FQHCs enhanced reimbursement from Medicare and Medicaid and protection for providers from medical malpractice suits through the Federal Tort Claims Act.

The act supports a range of delivery systems, including community health centers, public health centers, outpatient services for Native Americans funded by the Indian Health Service, and organizations serving homeless and migrant populations.

History of Federal Government Support for FQHCs

1962	**Migrant Health Act:** Provided support for clinics serving migrant agricultural workers
1964	**Economic Opportunity Act:** Authorized and funded community health centers for the first time
1991–98	**Significant program expansion:** Increased funding from $1.1 billion to $2.2 billion and increased the number of centers from 750 to 1,200
2009	**American Recovery and Reinvestment Act (stimulus):** Provided grants totaling $1.5 billion to support construction/renovation/information technology upgrades and $500 million for service expansion
2010	**Patient Protection and Affordable Care Act (health care reform):** Authorized an additional $7 billion over the next five years
2011	**Federal budget:** Adds $290 million to increase access for the uninsured

The shortage of primary care personnel, including doctors, dentists, nurses, and community health workers, is a serious problem for FQHCs. The 2009 stimulus package attempted to address this shortage by providing $300 million to the National Health Service Corps, which offers health education scholarships and loan repayment programs for providers who work two to four years in health professional shortage areas, including in FQHCs.

FQHCs provide a comprehensive health care system for poor and underserved communities over a long period of time; they have proved to be efficient and effective at delivering care.

Patient-centered Medical Homes (PCMHs)

The medical home model's central principle is to provide comprehensive, coordinated care that is designed and centered around patient needs and long-term relationships with a primary-care professional team.

PCMHs have established a number of practices and procedures to better satisfy patient needs, including the following:

- Reimburse providers for time spent managing patient care
- Upgrade the health care information system through electronic records
- Engage leadership
  - o Provide visible and sustained leadership to lead overall culture change and specific quality improvement (QI) strategies to sustain and spread change
  - o Establish and support a QI team that meets regularly and guides improvement efforts
  - o Ensure that providers and other team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model
  - o Build the practice's values of creating a medical home for patients into staff hiring and training processes
  - o Adopt a QI strategy
  - o Choose a model for QI that is appropriate for the implementing organization
  - o Establish and monitor metrics to evaluate improvement efforts and outcomes and ensure that all staff members understand the metrics for success
  - o Obtain feedback from patients and families about their health care experiences and use it to guide QI efforts
  - o Involve patients, families, providers, and care team members in QI strategies
  - o Optimize use of health information technology to:
    - Schedule appointments
    - Define and understand the patient population and subpopulations
    - Define and track care of individual patients and subpopulations, including referrals and those with abnormal lab or imaging results
    - Provide patient-specific educational materials, individual care reminders, and patient summary data at time of visit
    - Enable feedback to team and allow for external reporting on processes of care and population outcomes
    - Improve communication between patients and care teams via Web-based interactive support, secure communications, and remote monitoring
- Empanelment (assigning patients to primary care providers within PCMHs)
  - o Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental, or additional services
  - o Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community and family need
  - o Understand practice supply and demand and balance patient load accordingly
- Shift to patient-centered interactions
  - o Respect patient and family values and expressed needs
  - o Encourage patients to expand their role in decision making, health-related behaviors, and self-management
  - o Communicate with patients in a culturally appropriate manner—i.e., in a language and at a level the patients understand
  - o Provide self-management support at every visit through goal setting and action planning
- Provide organized, evidence-based care
  - o Use planned care according to patient needs
  - o Use point-of-care reminders based on clinical guidelines
  - o Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit
- Utilize continuous, team-based healing relationships
  - o Establish and support care delivery teams
  - o Link patients to a provider and care team so that both patients and the provider/care team recognize each other as partners in care
  - o Ensure that patients are able to see their provider or care team whenever possible
  - o Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members
  - o Cross-train care team members to maximize flexibility and ensure that patient needs are met
- Enhance access
  - o Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits
  - o Provide scheduling options that are patient and family centered and accessible to all patients
  - o Help patients to obtain and understand health insurance coverage
- Coordinate care
  - o Link patients with community resources to facilitate referrals and respond to social service needs
  - o Provide care management services for high-risk patients
  - o Integrate behavioral health and specialty care into care delivery through colocation or referral protocols
  - o Track and support patients when they obtain services outside the practice
  - o Follow up with patients within a few days of an emergency room visit or hospital discharge
  - o Communicate test results and care plans to patients and families[30]

Several insurers are making changes to the way they pay primary care physicians, focusing on the medical home model. One example is CareFirst BlueCross BlueShield, an insurer operating in Maryland; Washington, D.C.; and northern Virginia.

CareFirst began a two-year demonstration project in January 2009. Under the project, 11 group practices, each with five to 13 primary care physicians, will create a medical home. They will receive an immediate 12 percent increase in payments for coordinating patient care, developing treatment plans, and choosing the most cost-effective specialists when referring patients. The primary care doctor will be reimbursed for spending up to one hour evaluating the patient's needs and developing a care plan. This is only one example of many payment changes that are possible through the medical home model. States also have become involved in supporting PCMHs; since 2005, at least 24 states have enacted legislation to develop medical home models as part of their health reform efforts.

Additionally, the medical home model has the support of a broad-based advocacy organization: the Patient-Centered Primary Care Collaborative. The collaborative was formed in 2006 to promote the medical home model. Its members consist of more than 160 organizations that represent more than 50 million employees/beneficiaries who engage in implementing the medical home model.

The U.S. Congress supported the medical home model through its passage of the Medical Home Demonstration Act of 2007. This act authorized and funded a number of medical home demonstrations that will be evaluated on their ability to provide high-quality care at a lower cost with active patient participation and satisfaction.

Summary: How Do Patient-centered Medical Homes and Other Models of Care Affect Primary Care?

The benefits to primary care of the models listed above are multifaceted. In numerous pilot programs across the country, the reorganization of care has improved patient health by allowing for greater access to quality primary care. They also have the added benefit of attracting more physicians to the field. The ways in which this is accomplished include the following**:**

- **Providing physicians with a better work environment:** In many PCMH projects, physicians have access to greater administrative support than they do in traditional private practices. For example, in its PCMH project, Geisinger Health System in central and northeastern Pennsylvania employs nurse care managers to assist physicians with managing patient caseloads, especially for those patients with chronic conditions.
- **Changing the way primary care physicians are paid:** By reimbursing physicians based on actual results or for the additional daily tasks that they do in relation to total patient care, these models offer primary care physicians financial benefits that they would not otherwise have under the traditional fee-for-service model.
- **Providing unique and alternative ways to utilize nurse practitioners and physician assistants:** By utilizing nurse practitioners and physician assistants, where appropriate, within team care approaches, these models can often provide primary care to more patients more efficiently than traditional practice models.

RECENT STATE INITIATIVES IN SUPPORT OF PRIMARY CARE

Given that the effects of the shortage of primary care providers have been felt nationwide, a number of states have developed innovative programs to address various aspects of the problem. While many are too new to provide concrete evidence of success, descriptions of some of the more promising are provided below.

Pennsylvania: PCMH Development

Pennsylvania is a national leader in supporting the development of medical homes. Through executive order, then Governor Edward G. Rendell established the Pennsylvania Chronic Care Management & Cost Reduction Commission in 2007. The commission adopted a strategic plan to manage chronic disease in Pennsylvania. Central to that strategy is the development of patient-centered medical homes.

The plan implemented in 2008 provided financial incentives, coaching, and faculty support in the development of medical homes. The state helped to develop 32 medical homes that represent 236 primary care physicians who serve more than 200,000 patients in the southeast part of Pennsylvania. Preliminary evaluations showed that all 32 practices demonstrated improved quality of care, reduced admission rates to hospitals, and lowered costs.

In 2009, the program expanded to include 783 primary care physicians and an additional 1 million patients. This expansion was supported through contributions from insurance companies totaling $30 million for the purpose of transferring practices to medical homes. PCMHs featured in the program were able to meet the standards for medical homes developed by the National Committee for Quality Assurance, an organization that many states look to for quality assurance standards and whose criteria can provide the basis for PCMH reimbursement.

The state has supported two other PCMH models that are in early stages of development. The Southwestern Pennsylvania model's goals are similar to those featured in the southeast program, emphasizing the role of nurse practitioners as care managers. When reimbursing health care professionals, the northeast model replicates the Geisinger Health System model, focusing on shared savings and outcome-based analysis rather than fee-for-service methods.

Besides medical homes, Pennsylvania has supported legislation and programs:

- That change the scope of practice laws to allow nurse practitioners, physician assistants, pharmacists, and dental assistants to practice at the full extent of their education and training and
- That develop a statewide health information exchange.

Other States

As mentioned previously, other states are experiencing similar problems in recruiting and retaining primary care physicians. Many have implemented initiatives that have affected primary care directly or indirectly. Pennsylvania may be able to learn from the results of some of these initiatives. Below are examples from three states.

Massachusetts

The Massachusetts health care reform effort has received a lot of national attention because of its relevance to the discussion of national reform. While most of the focus has been on the plan's coverage for the uninsured, the state also offers some important lessons in terms of access to primary care and addressing the needs of a sudden influx of individuals who may not have utilized the health care system previously.

Primary care physicians in Massachusetts make up a smaller percentage of the total physician population than they do in Pennsylvania (see chart on page 6), and at just a little more than 33 percent, they are well below the national average of 39 percent. In 2009, the Massachusetts Medical Society reported the highest number of primary care physicians' offices closed to new patients ever recorded. Additionally, one in five adults stated in 2008 that a doctor's office would not accept new patients at all or would not accept their type of coverage.[31] However, even with this barrier, access to health care improved, with 92.1 percent of the population reporting a usual source of care in 2008 compared to 86.4 percent of the population in 2006.[32]

One way that Massachusetts addressed the rising demand for health care following the legislation's passage was through increased use of community health centers. A March 2009 study found that community health centers experienced a surge in patients, especially among middle-aged and almost elderly adults who were at high risk for chronic conditions and who lived in traditionally medically underserved, low-income communities. The report indicated that these newly insured individuals perhaps had delayed seeking care until they had insurance.[33]

Massachusetts also has tried to address recruitment and retention issues, though many of the strategies it has adopted are similar to those already in existence in Pennsylvania. These include, for example, incentives for physicians to serve in health professional shortage areas or medically underserved areas, loan repayment for physicians willing to work at a community health center, and the J-1 waiver program.

Other components of Massachusetts health care reform that may be relevant to the simplification of practicing primary care in Pennsylvania include the statewide adoption of electronic medical records and uniform billing and coding for providers and insurers. The state is currently examining a new payment system that would eliminate the traditional fee-for-service model and incorporate providers into accountable care organizations, where one payment would be issued for all services provided to each individual patient.[34]

Vermont

The Vermont Blueprint for Health was passed in 2006 and represents a comprehensive reform of the state's health care system. While providing for the uninsured like the plan in Massachusetts, the Vermont plan stresses chronic care management as a means for controlling costs.[35] Components include patient health literacy, the adoption of best practices by physician groups, and municipal wellness programs. The model for the blueprint is based on PCMHs working in conjunction with community health teams. Three pilot programs serving a total of 60,000 patients are currently in operation.

One of the blueprint's goals is to enable the provision of "high-quality primary care, where providers have the financial support, staffing, and information technology to conduct more thorough assessments and follow-up."[36] In order to accomplish this, the health reform plan includes a pilot program to provide technical assistance to primary care physicians in purchasing electronic health record equipment in an attempt to create an integrated statewide electronic health information system.[37] Also, financial reform through cooperation with the state's insurance companies provides additional funding for primary care practices through a per person, per month payment based on the National Committee for Quality Assurance's Physician Practice Connections–Patient-Centered Medical Home score, where greater scores indicate greater quality of care for patients.[38] Vermont's Department of Banking, Insurance,

Securities and Health Care Administration is responsible for monitoring the reimbursement based on information submitted through a statewide data collection system known as VHCURES (Vermont Healthcare Claims Uniform Reporting and Evaluation System).

This year, Vermont hopes to expand the model to additional areas, but first it needs to ensure that enough primary care practices are prepared to operate as patient-centered medical homes.

Minnesota: Focus on Rural Medicine

Minnesota's efforts at recruiting and retaining primary care professionals, especially physicians, revolve around three key programs:

- Rural Physician Associate Program
- University of Minnesota Medical School Duluth
- Rural Physician Loan Forgiveness Program

The Rural Physician Associate Program places third-year medical students in a rural community center under the supervision of a family practice doctor for nine months. This gives the students the opportunity to form relationships with patients and to live in a rural setting, which they would not normally get to do in rotations.[39]

At the University of Minnesota Duluth (UMD), school administrators selectively admit students who show a proclivity toward careers in rural primary care. One feature of the school is the Family Medicine Preceptorship Program, which provides each first-year student with a preceptor, a family doctor who serves as a mentor. Given that role models play a large role in students' decisions to pursue family medicine, it is no wonder that UMD has the highest percentage of rural practitioners of any medical school in the country.[40]

The loan forgiveness program in Minnesota is currently serving 151 practitioners, 19 of whom are physicians. One medical student has indicated that this program has allowed her to have the freedom to practice in a rural area, and she plans to stay there for the rest of her career.[41] According to Minnesota 2020, "a 2007 evaluation of the program found that as many as 86 percent of physicians and 93 percent of nurses stayed at their sponsoring facility after their service obligation."[42]

FEDERAL GOVERNMENT

The federal government has developed a number of programs and laws to strengthen primary care over the next several years. This review will cover only the portion of the Patient Protection and Affordable Care Act of 2010 that relates directly to primary care. The following is a synopsis of the act's impact on primary care by year of implementation.

Portions of the Patient Protection and Affordable Care Act of 2010

2010	• Temporary high-risk pools will be created within states to help cover those who previously could not get individual insurance coverage due to preexisting conditions. • Coverage will be extended to dependent children up to age 26.
2011	• Medicare will provide 10 percent bonus payments to primary care physicians and general surgeons. • Medicare beneficiaries will be able to receive annual wellness visits with no copayment as well as personal prevention plans. • Private health insurance plans will be required to cover preventative health services with little or no cost to the patients. • Funding will be increased for national service corps and community health centers. • Section 747 of the Public Health Service Act will be reauthorized, providing funds for medical school and residency programs to increase the training of family physicians.

2012	• Physician payment reform will be implemented in Medicare to enhance primary care services and encourage doctors to form accountable care organizations.
2013	• National pilot programs will be established for Medicare payment bundling to encourage doctors, hospitals, and other care providers to better coordinate patient care. • Medicaid rates will be increased to the Medicare rate level. • Cost sharing (deductibles, copays, etc.) for preventative services will be eliminated for Medicaid patients.
2014	• Having health insurance becomes mandatory. • Each state must offer a qualified health benefit exchange offering a variety of insurance plans to individuals and small groups. • Medicaid will be expanded to cover everyone at or below 133 percent of the federal poverty level.
2015	• Medicare will create a physician payment program to reward quality of care rather than the volume of services.

POLICY OPTIONS: INCREASING THE PROVISION OF QUALITY PRIMARY CARE

Policy options for improving the provision of primary care in Pennsylvania center around the following:

- Loan forgiveness
- Simplification of practice administration
- Reimbursement rates
- Medical school primary care programs
- Residency opportunities

In addition, it is key that Pennsylvania poise itself to take advantage of the funding available for primary care initiatives through the federal health care reform legislation. These opportunities include funding for:

- Demonstration projects to address health professions' work force needs,
- Providing health homes for Medicaid enrollees with chronic conditions, and
- Continuing educational support for health professionals serving in underserved communities.

While states are generally able to apply directly for this funding, it is not necessary to do so; rather, the state government should ensure that the appropriate entities within Pennsylvania (schools, health centers, private or nonprofit organizations) are aware of the opportunity and have the technical assistance they need to apply and then to carry out the program or project once funding has been awarded as part of a coordinated effort to improve primary care.

Provide Loan Forgiveness

As noted previously, Pennsylvania currently offers a loan forgiveness program for physicians. This program could be expanded by funding additional loans, by offering different compensation packages to more physicians, or by allowing more health care providers to apply. Legislation that would accomplish this was introduced in the 2009–10 session by State Senator Ted Erickson. His bill, SB 527, would have provided a percentage of loan forgiveness for each year of service as a primary care physician in Pennsylvania, up to seven years and 100 percent forgiveness, and proposes an annual appropriation of $10 million to accomplish this. In addition, State Representative Josh Shapiro is considering introducing similar legislation.

Also, as noted in the section on the federal health care reform legislation, provisions have been made to expand the National Health Service Corps, which provides scholarships and loan repayment for physicians as well as dentists, nurse practitioners, physician assistants, and certified nurse-midwives.

Provide Funding for or Remove Barriers to Administrative Improvements

Research has demonstrated that administrative burdens for primary care physicians have increased significantly in recent years. Providing relief for these burdens is often costly and/or difficult to achieve without state regulation or intervention.

Integrating health information technology systems into family practices and clinics is one way to improve the provision of care, increase efficiency, and save practitioners time. Pennsylvania efforts include legislation (SB 700) that would provide loans to practices seeking to upgrade or install health information technology systems. According to the bill, acceptable loan uses under this bill include technology or telecommunications purchases, the purchase of studies or surveys to determine what system might be appropriate, training for physicians and staff in the use of technology, improving security for purposes of information exchange, and the purchase of clinical decision support systems. In order to ensure that these funds help those in areas of need, the legislation requires at least 50 percent of the funding to go to practices in counties of the fourth through eighth classes and that the practices accept all patients regardless of ability to pay. Senate Bill 700 is currently in the Pennsylvania Senate Public Health and Welfare Committee awaiting review.

Continued expansion of duties for nurse practitioners and/or physician assistants also has been suggested, and legislation related to this issue is introduced regularly at the state level. However, concerns from various advocacy groups about quality of care have stymied attempts to expand the duties of nurse practitioners and other nonphysician professionals in Pennsylvania beyond what was included in Act 48 of 2007.

Improve Medicaid, Medicare, and Insurance Reimbursement for Services Provided through Family Practice

One key component of improved reimbursement is ensuring that primary care physicians are reimbursed for the time they spend coordinating care. This is especially important for the continued success of the patient-centered medical home model, of which care coordination is an integral part. In the section on Vermont's Blueprint for Health, it was noted that the state government of Vermont was successfully able to negotiate with the state's insurance providers for reimbursement for primary care services not usually covered by insurance, including the cost of a care manager for each patient-centered medical home.

At the federal level, the Center for American Progress notes that "there is near universal agreement on Capitol Hill that we must increase reimbursement rates for services provided by primary care specialties" and that provisions to do so have been included in the health care reform legislation.[43] It is important, however, that in addition to increasing rates for physicians, rates for services provided by nurse practitioners and other types of medical professionals are addressed in order for them to contribute effectively to reducing the shortage.[44] Some insurers continue to restrict payments to nonphysician professionals who provide care that the insurers feel should only be provided by a physician.

Provide Incentives for the Development of Alternative Models and Methods of Payment

In a speech on the federal health care reform legislation, President Barack Obama highlighted two unique initiatives relating to alternative payment systems and models of care, one of which is located here in Pennsylvania at Geisinger Health System. Geisinger offers physicians a salary plus bonuses that are based on the quality of care that patients receive. According to *TIME* magazine, this has resulted in Geisinger's ability to successfully retain primary care physicians. Model components can include the following:[45]

- Pay for performance: Doctors receive payment based on patient health and quality of care as well as their ability to contain costs.
- Episode care: Payment is provided for an entire episode of care, like a major surgery, including recovery, rather than for different components of the procedure.
- Global care: Payment is provided to a team of health professionals who care for a patient for a specific period of time.

According to *TIME*, the above payment systems already exist in many forms across the country; AARP reports that the pay of 30 percent of the nation's primary care physicians features an incentive based on performance.[46] While some indicate that not all doctors would fit well into a Geisinger-type model, it remains an example of an innovative option for addressing reimbursement issues.

One way that governments could incentivize this behavior is by continuing to offer pilot programs through Medicare and Medicaid.

Encourage the Growth of Family Practice Programs at Pennsylvania's Medical Schools

A survey conducted in the fall of 2009 by the Association of American Medical Colleges found that almost 50 percent of schools that responded planned to develop and implement incentives to encourage students to pursue primary care, so it is clear that those in command at medical schools are at least aware of the problem and considering potential ways to address it. Any incentives that the state could develop to encourage this practice would be helpful, such as tying part of the state funding for medical schools to the presence of and efforts surrounding primary care programs.

Jefferson Medical College at Thomas Jefferson University in Philadelphia has an exemplary program in family medicine that has been in operation for several decades. Titled the Physician Shortage Area Program, it screens applicants for a rural background and an interest in practicing family medicine after graduation.

More generally, it may be helpful for state policymakers to work with Pennsylvania's medical schools to create incentives for the admission of Pennsylvania students. Students who have grown up in the state are more likely than out-of-state students to stay here to practice upon graduating and completing their residencies.

While difficult to influence from a state policy perspective, curriculum changes in family practice programs and residencies can have a positive impact on the decision to enter primary care. A study of the family practice residency program at Bellevue/New York University found that 87 percent of the survey respondents

entered and continue to practice as primary care physicians and 90 percent work with the underserved. One of the unique components of this program is the psychosocial block, a 10-week course that provides residents with the communication skills necessary to work with difficult patients and their families or individuals with substance abuse issues. According to the study, "the graduates consider psychosocial and patient-centered skills to be the most unique and durable contributions of the Bellevue/NYU PC Program to their clinical practices," and that the skills "distinguished them from other physicians by allowing them to effectively and compassionately care for patients whom their colleagues felt too uncomfortable or frustrated to care for."[47] Even more impressive is that the results, over different cohorts of residents, are robust over time. Also, the number of program graduates who feel "burnt out" is significantly less than the national average.

Expand In-state Residency Opportunities

According to the Center for American Progress, almost 40 primary care residency programs closed in the decade between 1995 and 2006 because they were underutilized. However, in recent years, enrollment generally at U.S. medical schools has increased. Additionally, a number of new medical schools have opened in response to demand. Unfortunately, this growth will not translate into additional doctors unless residency opportunities are expanded as well. One barrier to new residency slots is a federal law passed in 1997 that imposes a cap on Medicare funding for residencies through graduate medical education programs.[48] Because all such programs must be approved through a government entity, the Accreditation Council for Graduate Medical Education, there is little chance of an expansion of opportunities for graduates until this law is changed. Additionally, graduates of U.S. medical schools must compete for these spots with international graduates as well as those who attend osteopathic schools.

One suggestion offered has been to limit the amount of specialty residency slots available, which would by default increase demand for residencies in primary care. Another has been to redistribute residency positions that go unfilled to hospitals that agree to provide primary care training.[49] Third, the federal legislation may contain language that would make it easier to train residents in nonhospital and community care settings, thus increasing their likelihood of remaining in primary care as practicing physicians. Although much of this takes place at the federal level, the federal legislation may permit state involvement as well, possibly through additional stipends to medical schools or hospitals that offer residency programs in the desired settings.

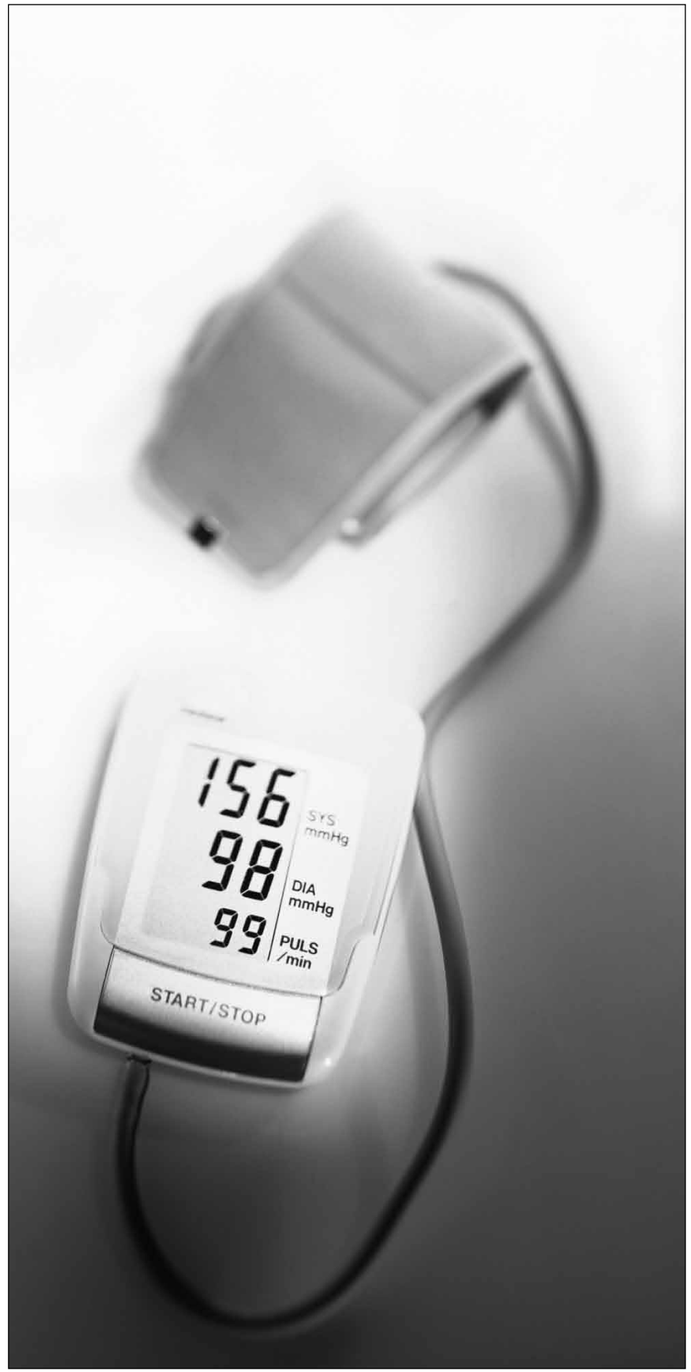
Federal Grant Opportunities for States[50]

Program	Funding	Details
Demonstration Projects to Address Health Workforce Needs	$85 million for each fiscal year from 2010 to 2014	Grants will go to six states that develop demonstration projects that would educate and train low-income individuals in health care professions, specifically personal or home care.
Planning Grants for State Provision of Health Homes for Medicaid Enrollees with Chronic Conditions	$25 million total, with matching requirements for states	States that participate in the new Medicaid option to provide health homes for enrollees with two or more chronic conditions are eligible to receive the grants; designated providers must offer a prescribed list of services and must include provisions for treating mental health and substance abuse issues along with the chronic conditions.
Continuing Educational Support for Health Professionals Serving in Underserved Communities	$5 million for fiscal years 2010-14 and any additional sum necessary to continue the program in subsequent years	Grants will go to states, local governments, nonprofit entities, or academic centers that enhance medical education, primarily for primary care, through distance learning, collaborative conferences, and continuing education.

Conclusion

The ability of access to quality primary care to lower health care costs and to improve patient health across populations and communities has been well documented. However, too few medical students are pursuing careers in primary care while the age and rate of retirement among current primary care physicians continue to increase. As a result, not enough Pennsylvanians have access to quality primary care. The passage of federal health care reform legislation that results in an increase in the insured population will only increase the number of professionals needed, as patients who previously relied on emergency rooms for care, or went without care entirely, will seek to develop a relationship with a primary care practitioner.

This report provides a brief overview of the problem and offers only some of its potential solutions. It is intended to bring awareness of this issue to Pennsylvania's elected officials and to encourage the development of comprehensive strategies and partnerships that take advantage of Pennsylvania's strengths, like its high-quality medical and nursing schools, as well as federal programs that offer competitive grants to states that have projects ready to go. It is only through quick and coordinated action that Pennsylvania will be able to meet the challenge of providing sufficient primary care in the years to come.



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REFERENCES

1. Ellen-Marie Whalen, "Expanding the Primary Care Workforce: An Essential Element of Health Care Reform," Center for American Progress, November 3, 2009, www.americanprogress.org/issues/2009/11/primary_care_shortage.html.
2. Jeffrey Kluger, "Is There a Better Way to Pay Doctors?" *TIME*, October 26, 2009, 36.
3. Frank deGruy III, "Mental Health Care in the Primary Care Setting," in *Primary Care: America's Health in a New Era*, eds. Molla S. Donaldson, Karl D. Yordy, Kathleen N. Lohr, and Nel A. Vanselow, (Washington, D.C.: National Academies Press, 1996), 285.
4. Lawrence R. John and Anthony Spinola, "Why Primary Care Matters," *Pittsburgh Post-Gazette*, August 24, 2008, G4.
5. John and Spinola, G1.
6. M. Renee Zerehi, "Solutions to the Challenges Facing Primary Care Medicine," (Philadelphia: American College of Physicians, 2009), 1.
7. Institute of Medicine, Retooling for an Aging America: Building the Health Care Workforce, (Washington, D.C.: National Academies Press, 2008), 39.
8. Zerehi, 22.
9. American Academy of Family Physicians, 2010 Match Summary and Analysis, www.aafp.org/online/en/home/residents/match/summary.html#Parsys68643.
10. Linda K. Kanzleiter, Myron R. Schwartz, and Hleziphi Naomie Nyanungo, *The Sustainability of Rural Community Health Service Providers*, Center for Rural Pennsylvania, January 2010, 15.
11. Kanzletier et al, 12.
12. Howard Rabinowitz, Jefferson Medical College Physician Shortage Area Program, www.jefferson.edu/psap.
13. The Physicians Foundation, *The Physicians' Perspective: Medical Practice in 2008*, October 2008, www.mendocinohre.org/rhic/200811/PF_Report_Final.pdf.
14. A. Bruce Steinwald, "Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services," (Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, presented on February 12, 2008), 18.
15. Whelan.
16. Ibid.
17. Kanzleiter et al, 15.
18. Basim Khan, "But Where Will the Primary-care Doctors Come From?" *Los Angeles Times*, November 5, 2009, articles.latimes.com/2009/nov/05/opinion/oe-khan5.
19. Robert Steinbrook, "Easing the Shortage in Adult Primary Care—Is It All about Money?" *New England Journal of Medicine*, 2009, 360(26): 2696-9.
20. Kanzleiter et al, 15.
21. Jack Ginsburg, Tia Taylor, and Michael S. Bar, *Nurse Practitioners in Primary Care*, American College of Physicians, January 29, 2009, 4.
22. Ginsburg et al, 2.
23. Roderick S. Hooker, James F. Cawley, and William Leinweber, "Career Flexibility of Physician Assistants and the Potential for More Primary Care," *Health Affairs* 2010; 29(5): 880.
24. Hooker et al, 885.
25. Hooker et al, 880.
26. Mark McClellan et al. "A National Stretegy to Put Accountable Care into Practice," *Health Affairs* 29, (5)(2010) 982.
27. Pittsburgh Regional Health Initiative, November 2009, *PRHI Executive Summary*, "The Next Big Thing: Accountable Care." www.prhi.org/docs/ACOFINAL_11-17-09.pdf.
28. Ibid.
29. McClellan et al., 984.
30. Ed Wagner, MD, MPH, and director, MacColl Institute for Healthcare Innovation (presenter at the Safety Net Medical Home Initiative Annual Regional Meeting, June 17, 2010).
31. Sharon K. Long and Paul B. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web exclusive, May 28, 2009, w582.
32. Long and Masi, w580.
33. Leighton Ku et al, *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, March 2009.
34. *Massachusetts Health Care Reform: Three Years Later*, Kaiser Commission on Medicaid and the Uninsured fact sheet, Henry J. Kaiser Family Foundation, September 2009, www.kff.org/uninsured/upload/7777-02.pdf.
35. *Vermont Health Care Reform Plan*, Kaiser Commission on Medicaid and the Uninsured fact sheet, Henry J. Kaiser Family Foundation, December 2007, www.kff.org/uninsured/upload/7723.pdf.
36. *Vermont Blueprint for Health 2009 Annual Report*, Vermont Department of Health, January 2010, 7.
37. *Vermont Health Care Reform Plan*.
38. *Vermont Blueprint for Health 2009 Annual Report*, 3.
39. Nina Slupphaug, "Minnesota Programs Serve as a Model for Recruiting Primary Care, Rural Doctors," Minnesota 2020, May 6, 2010, www.mn2020.org/index.asp?Type=B_BASIC&SEC=%7B9C473EC8-AFCB-4B04-8A35-CBCF9242FB6A%7D.
40. Slupphaug.
41. Slupphaug.
42. Slupphaug.
43. Whelan.
44. Whelan.
45. Kluger, 36.
46. Kluger, 36.
47. Mack Lipkin et al, "Two Decades of Title VII Support of a Primary Care Residency: Process and Outcomes," *Academic Medicine*, 83(11), 1068.
48. Tracy Hampton, "U.S. Medical School Enrollment Rising, but Residency Programs Too Limited," *JAMA, The Journal of the American Medical Association*, 2008; 299(24): 2846.
49. Whelan.
50. Adapted from "Summary of State Grant Opportunities in the Patient Protection and Affordable Care Act: H.R. 3590" prepared by Rachel Morgan, senior health policy specialist for the National Conference of State Legislatures, May 24, 2010.

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