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Perspectives Paper

Will new care delivery solve the primary care physician shortage?: A call for more rigorous evaluation

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ABSTRACT

Transformations in care delivery and payment models that make care more efficient are leading some to question whether there will really be a shortage of primary care physicians. While it is encouraging to see numerous federal and state policy levers in place to support greater accountability and coordination of care, it is too early to know whether these efforts will change current and future primary care physician workforce needs. More research is needed to inform whether efforts to reduce cost and improve quality of care and population health will help alleviate or further exacerbate expected primary care physician shortages.

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1. Introduction

Health care in the United States is undergoing major transformations in care delivery and payment models that are bringing us closer to the goals of the IHI “triple aim”¹ of improving both the patient experience of care and population health while simultaneously reducing cost. New payment models that reward value over volume such as Accountable Care Organizations (ACOs) and increased payments for practices recognized as Patient-Centered Medical Homes (PCMHs) are providing incentives for primary care practices to redesign care delivery, leading them to integrate novel team members and new technology to facilitate highly-coordinated, team-based care. While much of the innovation at the national level is spurred by the Affordable Care Act,^{2,3} states⁴ and even private insurance companies^{5,6} are also experimenting by paying more for care coordination in the hopes of reducing duplication of effort and avoidable hospitalizations and emergency room visits.

While there is a growing body of evidence that such transformations in care delivery and payment models hold significant potential for helping to advance the triple aim,^{7–10} there is very little empirical data available to assess what affect these changes will have on workforce needs. New models of primary care are increasingly incorporating team members such as nurse

practitioners (NPs), physician assistants (PAs), medical assistants (MAs), health coaches, care coordinators, and community health workers who facilitate task delegation and shared decision-making, thus potentially reducing the need for more physicians. Furthermore, advances in technology such as the adoption of electronic medical records (EMRs) and telemedicine facilitate a shift away from in-person office visits, which could also mitigate physician shortages. Thus, in an era of expected primary care physician shortages,^{11–14} these transformations in care delivery and payment models offer potential solutions for offsetting primary care shortages by incentivizing a more productive and efficient health care workforce.^{15–18} On the other hand, the fact that these new models rely upon a robust primary care workforce to provide increased level of services and attention to quality outcomes may mean that we will actually need more primary care physicians than has been projected. It is also possible that advances in technology will not reduce the need for physicians to the extent that has been hypothesized, and could actually drive up demand for services if physicians become more accessible to patients through shared records and alternative visits through video or email.

Given the heightened focus on ensuring we have an adequate primary care physician workforce, this paper first describes what is known about the workforce implications of new primary care models that incorporate team-based care, before going on to illuminate several additional factors which must be taken into account when considering the effect that the use of teams will have on primary care capacity. The paper then turns to the role

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that technology may play in easing physician shortages and raises some additional points to consider. It concludes by calling for policy makers, researchers and funding agencies to incorporate workforce implications into evaluations of the new models of care currently being tested. The evaluation plans that have been proposed thus far do not include an explicit focus on measuring and evaluating the impact these transformations have on provider capacity or demand for primary care services.^{19–21} Furthermore, patient panel size—a common metric used to discuss provider capacity—is fraught with ambiguity.²² Developing reliable metrics for evaluating primary care capacity and funding large scale workforce evaluations will be essential to help policy makers and health care providers identify and adopt the most efficient models of care and better inform understanding of the workforce needed to support the triple aim.

2. Teams offer potential for increasing primary care capacity

Numerous studies^{11–14} project primary care physician shortages; those that take into account both the aging population and the expansion of insurance coverage under the Affordable Care Act generally estimate shortages of 35,000–50,000 full-time-equivalent primary care physicians by 2025. However, as a recent report by the Bipartisan Policy Center and Deloitte Center for Health Solutions points out, current models do not adequately account for new delivery models or the role that other professionals are playing in care delivery.²³ In order to model the effects of care redesign on primary care capacity, researchers at the Columbia Business School and the University of Pennsylvania's Wharton School recently designed a theoretical model that shows increasing patient panels to 3400 as a result of open access scheduling, team-based approaches to care and increased use of electronic visits could potentially offset primary care physician shortages.¹⁶ This is a significant increase over the estimated 2300 patients per provider thought to be the average among primary care providers in the United States,²⁴ or the figure of 2500 patients per provider used in some projection estimates.¹⁶

A new study²⁵ examining innovative primary care practices also points to the potential of team-based care to lead to greater efficiencies, demonstrating the way some practices are streamlining visits to reduce physician time on clerical work and other tasks that can be delegated through enhanced protocols and standing orders. Having lab tests ordered prior to the visit and improving team functioning through co-location, team meetings, and workflow mapping were also cited as examples for improving efficiency. While this study did not focus on panel sizes, the researchers found these efforts to redesign primary care can increase job satisfaction and, in some cases, lead to increased capacity. Cleveland Clinic Strongsville, for example, was able to increase the number of patient visits per day from 21 to 28 by using RNs and MAs in expanded roles without hiring additional physicians. Beyond helping physicians make the most efficient use of their day, this research shows potential for new care models to reduce burn-out and thus increase workforce retention. Furthermore, if medical students are exposed to these professionally satisfying models of care during clerkships and residencies, the number electing to become primary care physicians could increase as well.

3. Several missing factors must be taken into account

Despite the potential offered by team-based care, several additional factors must be taken into account. The following three sections address the issues that should also be considered when

evaluating the effect of team-based care on primary care physician capacity.

3.1. Improved care coordination and disease management may require smaller patient-to-provider ratios

The theoretical model proposed by Green and her colleagues does not take into account changes in levels of service that often accompany a team-based approach to care, such as improved care coordination and disease management, medication reconciliation, greater attention to behavioral health and other specialist access, and an increased focus on patient education.^{26,27} Other analysts suggest much more modest panel sizes of 1400–1900 are needed in order to accommodate the increased level of services in a team-based approach to care, more in line with what is found in practice.²⁸ For example, Group Health Cooperative of Puget Sound reduced patient panel sizes from 2300 to 1800 in order to increase visit length and provide higher quality of care when they moved to a team-based model.²⁹

Another factor to consider is that not all panels are created equal. Panels with high percentages of chronic care patients are often smaller, as demonstrated by the Special Care Center in Atlantic City, founded by Rushika Fernandapulle.³⁰ The clinic, which focuses treatment on the casino workers who are sickest and thus most expensive to treat, has approximately 600 patients per MD for the two physicians in that practice, plus two NPs, eight health coaches, and one full-time social worker. The discrepancies between what is possible under theoretical models and what has been achieved in practices such as Group Health and the Special Care Center—both leaders in providing high quality care under innovative delivery models—point to the need for more systematic research to determine how panel size is changing as a result of innovations in payment models and care delivery. Accountable Care Organizations (ACOs), patient-centered medical homes (PCMHs), and other new delivery models feature a more intensive population-based approach to health along with increased care management efforts, which requires a robust primary care workforce.³¹ As we continue to collect data on how capacity changes under new models of care, it will be important to better understand the extent to which increased visit capacity translates to increased panel size versus improved access and continuity of care for existing patients.

3.2. Changes in the supply and scope of midlevel providers

As more practices come to rely upon team-based care, the number of NPs³² and PAs³³ in training is increasing rapidly. Recently, momentum for expanding the scope of practice for NPs has been growing in response to projected demand for primary care,³⁴ and some have argued that more states should follow the 16 that already allow NPs to practice completely independently of physician oversight so that they could step in to ease the shortage of primary care physicians. Meta-analyses of numerous pilots and research studies have found that the quality of care delivered by NPs specializing in primary care is at least as high as that of physicians,³⁵ and patients also exhibit high levels of satisfaction with NPs.³⁶ However, given the vast variation in states' scope-of-practice laws,³⁴ there is no guarantee that consensus will be reached across all 50 states which could limit the extent to which NPs will be able to take on a greater share of the primary care workload. Even if they are allowed to practice independently, it is worth noting that not all NPs choose to specialize in primary care. Recent estimates suggest that only a little over half of NPs currently practice in that field,³⁷ limiting the numbers who could be used to alleviate primary care physician shortages.

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