Innovative health programs counter primary care shortage

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Nurse practitioner Donna Torrisi is the founder of the Family Practice and Counseling Network in Philadelphia, a network of nurse-managed health centers providing primary health services to public housing residents. Although much of her time is spent on administrative responsibilities, she still sees patients at least one day a week.

About 65 million Americans live in communities with a shortage of primary care doctors, physicians trained to meet the majority of patients' health care needs over the course of their lives.

How much more difficult will finding a primary care doctor become as a result of the recently passed health care reform legislation, which will extend coverage to an estimated 34 million currently uninsured Americans by 2019?

Massachusetts, which in 2006 passed a law that led to nearly universal coverage of its 6.6 million residents, might provide some clues.

'NOBLE FIELD': The challenges of primary care

In that state, fewer and fewer internists and family practice doctors are taking new patients, and wait times to see family practice doctors are lengthening, according to the Massachusetts Medical Society and the non-profit Massachusetts Health Quality Partners.

Even before Congress in March passed the landmark law designed to make health care more affordable and expand coverage, an aging population and doctors' increasing preference for higher-paying specialties set the stage for a primary care shortage. And what many believe to be an outdated reimbursement system — one that drives doctors to schedule office visits when a quick phone call or e-mail might do — doesn't help.

The shortage of primary care doctors could lead to longer waits not only for primary care, but also for specialty care as well as greater use of expensive emergency rooms for non-emergencies, researcher Walt Zywiak of Computer Sciences Corp., an international consulting company headquartered in Falls Church, Va., noted in a July report.

But some innovative programs provide a glimpse of what the future of primary care — a future in which a one-on-one visit at the doctor's office takes a back seat — could look like. They include:

• A Portland, Ore., practice where doctors provide more care via the phone or e-mail than face-to-face.

• A Massachusetts practice that offers "shared medical appointments" for six to 14 patients.

• A Philadelphia clinic in which nurse practitioners, who have earned master's or doctorate degrees and have trained in the diagnosis and management of health problems, provide primary care.

Better communication

GreenField Health, founded in Portland in 2001, gets its name from a *Harvard Business Review* article in the early 1970s, chief operating officer Steve Rallison says. If you could create a business from scratch, it said, you'd start with a green field.

GreenField Health has leveled the playing field as far as how its doctors — five internists, one family practitioner and one pediatrician — care for patients. "We're not going to be caught in the tyranny of the visit," Rallison says. "The pressure for most internists, family physicians, is they have to see lots of patients to generate revenue."

More often than not, GreenField's doctors answer questions and resolve problems, such as interpreting test results or adjusting medications, without seeing patients. Office visits make up only a quarter of their work effort, Rallison says, with phone calls 35% and secure messaging 40%. Doctors get to know patients with 90-minute initial visits. Annual visits are an hour, follow-ups a half-hour.

How can GreenField afford to do this, given that insurers usually don't pay doctors to talk on the phone or send e-mails? Patients pay an annual "retainer fee," from $350 to $650, depending on the patient's age, to cover what insurance doesn't.

Before joining the practice in 2002, internist Cynthia Ferrier had always been in a traditional fee-for-service — or fee-for-office visit — practice. She'd see 20 to 25 patients a day and usually would be late for every appointment except the first because they ran over the allotted time. Responding to patients' e-mails was out of the question. At GreenField, which doesn't have a waiting room, Ferrier sees eight to 10 patients a day. She answers phone calls and e-mails between appointments.

Colleagues at her old practice warned she'd be swamped with phone calls and e-mails. "You're going to get every worried crazy person out there," one told her. But that hasn't happened, she says. Because they know they can get a timely response, patients aren't bombarding her with questions.

Shelly Holly, 46, of Portland, says her $400 annual retainer fee is well worth it.

Holly, an environmental planner, liked her former doctor, but didn't like how long she had to wait for an appointment or how long she had to hang out in the waiting room.

When she heard about GreenField, "it just seemed to make sense. My time is valuable, too."

With her GreenField doctor, "if I have questions ... I just slip out my iPhone and type out an e-mail and e-mail it to him. Lo and behold, I might get an answer back in 20 minutes."

Help for doctors

GreenField Health may be a model of the practice of the future, but it's not typical today, Philadelphia internist Richard Baron says. Compared with many cities, he says, Portland is fairly affluent, so it's easier to attract patients who can pay a retainer fee.

"In our marketplace, and in most marketplaces in the U.S.," Baron says, "if you try to charge patients supplemental fees, you're on the edge of violating agreements with insurance companies." He echoes the call for reimbursement reform. Instead of paying primary care doctors per visit, he says, pay them a preset amount per patient per year, an approach called "capitation" that's used by HMOs.

Although some primary care doctors, worried about inadequate payments, regard capitation as a dirty word, Baron says it "can work just fine if it's based on an accurate understanding of the volume of services a group of patients is going to need."

Besides freeing doctors to provide care in the most efficient way, capitation would enable them to hire support staff, such as medical assistants, says Baron, chair last year of the American Board of Internal Medicine.

"We don't ask surgeons to stop in the middle of an operation and go find a scalpel. We arrange it so that there's a skilled team of people that are supported by the reimbursement system."

Baron and Thomas Bodenheimer at the University of California-San Francisco use a phrase that's kicked around a lot these days: "Work up to the top of your license." Translated: Doctors shouldn't waste their time on tasks that could be handled by someone with less training.

"Physicians do a huge amount of work that you do not need an M.D. to do," Bodenheimer says. "There's so much stuff that's routine, you could teach a high school student to do some of these things in a week."

But doctors usually don't hire someone to do that work, Bodenheimer says, because "you can't keep hiring people who don't get reimbursed." He says physicians might find that hiring medical assistants, who typically have one or two years of training after high school, increases efficiency and saves them money, although no one has studied that issue.

Harvard Vanguard Medical Associates, a non-profit multi-specialty group practice that cares for nearly a half-million people in eastern Massachusetts, may have hit upon a way to have its medical assistants — as well as nurses, social workers and dietitians — and pay for them, too.

Shared appointments

In 2008, Harvard Vanguard began offering "shared medical appointments," or SMAs. They're not classes, emphasizes internist Gretchen Gaida.

SMAs are scheduled for physicals, well-child checkups, chronic illness management and other types of primary care, as well as for specialty care. Six to 14 patients, who sign agreements to keep information about the others confidential, participate. SMAs last 1½ hours, but patients can leave when they feel their questions have been answered. Doctors take blood pressures and listen to hearts in front of the room but examine patients in a private room when necessary.

Physicians bill the same for patients seen in an SMA or individually. Considering doctors might schedule only four individual patient visits in 90 minutes, Gaida says, income from SMAs enables Harvard Vanguard to pay for the extra health professionals needed to run them smoothly.

Instead of thumbing through magazines in the waiting room, SMA patients meet in a conference room, where a "behaviorist," a nurse, social worker or psychologist who serves as a facilitator, writes down their questions for the doctor.

"The hardest part is getting patients to try it," says Gaida, who offers three SMAs for physicals each month in Chelmsford. But once they do, she says, 80% to 90% return for another.

Deborah Phillips, 57, of Billerica, Mass., is a convert. "I felt so comfortable, every time I go now that's what I do," says Phillips, who has diabetes. "You'll hear how someone else is handling the same problem that you have, only differently. I don't feel so alone out there."

Many in the health care field look to nurse practitioners and physician assistants, or PAs, to help fill the primary care gap. Both types of providers require graduate-level training.

"There is so much work that physicians do that they could be unburdened of," says Perri Morgan, director of PA research at Duke University.

Eugene Stead, then Duke's chair of medicine, founded the physician assistant profession in the 1960s to train former Vietnam medics to help fill a shortage of primary care doctors, Morgan says.

Today, PA classes are 70% to 80% women, she says, and, while the profession is growing, the proportion opting to practice in primary care has declined, while an increasing number are following physicians into specialties.

"We should just make more PAs," says Morgan, who wrote about the move away from primary care in May in the journal *Health Affairs*. "We can make PAs so much faster than doctors. There aren't going to be enough doctors anyway. And I'd like to see a larger proportion going into primary care."

Unlike nurse practitioners, PAs can't work independently of doctors anywhere, Morgan says. "PAs are committed to being dependent practitioners," she says. Still, some practice fairly autonomously, she says, and don't consult doctor supervisors every day.

In the past 18 months, many states have begun to re-examine laws governing what nurse practitioners can do, says nurse practitioner Mary Naylor, a University of Pennsylvania gerontology professor. Currently, Naylor says, the most restrictive states don't allow nurse practitioners to prescribe medication or practice without a doctor's supervision.

Nurse-managed centers

Donna Torrisi, a member of Penn's second graduating class of nurse practitioners in 1976, was instrumental in persuading Pennsylvania legislators to grant nurse practitioners prescribing authority and recognition as primary care providers. In 1992, she helped found the Family Practice and Counseling Network in Philadelphia, which she still directs.

Supported by the non-profit Resources for Human Development, the network of nurse-managed centers offers primary care for all ages, serving public housing residents, the poor and the uninsured.

This past fiscal year, Torrisi says, the network's three sites racked up 60,000 patient visits; this year, it expects 70,000. As a federally qualified health center, the network is reimbursed on the basis of its costs, not the number of patient visits.

On a sunny spring day in the network's sprawling, tastefully decorated North Philadelphia center, Torrisi, who sees patients one day a week, stopped to chat with patient Irene Pegram. Pegram, 76, clutched a paper bag of medication and worked on w ord puzzles while she waited for a ride home. A network patient for 16 years, she was diagnosed with diabetes five years ago. "Right now I'm coming in every week for the diabetes class," she says.

In the class, a nurse trained as a diabetic health educator sat at a table with eight patients. They played a board game that provided tips on managing their disease. Elsewhere at the center, a

social worker led a "Stress Less" class, which utilizes such stress-relievers as yoga and essential oils, while a recovering addict, hired 17 years ago, led a support group for people battling their own addictions.

While nurses rule at Torrisi's clinics, "you need everybody" to meet the need for primary care, she says. "You need the doctors. You need the physician assistants, you need the nurse practitioners."