Optimizing the Workforce: The Intersection of Healthcare Reform, Delivery Innovation, and Training

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A Note on Physician Supply and Adequacy

AAMC projects a shortage by 2030:

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Subspecialties</th>
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<td>7,500 – 43,100</td>
<td>33,500 - 61,800</td>
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2017 AAMC Physician Workforce Projections
~5-12% of all U.S. physicians
Clinically Active Physicians per 100,000 Residents by Hospital Referral Region

Source: Dartmouth Atlas
Why consider physician supply?

Major reason: access to care

Only *one* of *many* factors influencing access to care (insurance status, SES, language, etc)

Access is a local phenomenon: aggregate supply not especially instructive
Relationship between primary care supply and the percent of Medicare beneficiaries having at least one ambulatory visit to a primary care clinician.
Theoretical relationship between primary care supply and the percent of patients having at least one ambulatory visit to a primary care clinician.
Actual relationship between primary care supply and the percent of Medicare beneficiaries having at least one ambulatory visit to a primary care clinician

% with at least one ambulatory visit to a primary care physician (2003-07)

Primary care physicians per 100,000 residents (2006)

$R^2 = 0.07$
Must maintain humility in workforce projections and research

“No number of graduates would solve the most violent shortcomings of the current health care crisis, and... an offer of salvation to this crisis based on a quantity of graduates would be spurious and at later times would rise to haunt or spite its advocates.”

Letter from medical school deans Dr. Cheves Smythe and Dr. Walter Rice to the AAMC Executive Council, Dec 1968

Endorsed by AAMC Exec Council
Health Care Reform: possible workforce implications

30M newly insured?

- Utilization
- Physician demand

Bend the cost curve?

- Efficiency
- Cost sharing
- Physician demand
Health Care Reform: possible workforce implications

30M newly insured?  
Utilization  
Physician demand

Bend the cost curve?  
Efficiency  
Cost sharing  
Physician demand

Efficient, effective use of physicians
How to deal with a potential physician shortage

- Train more
- Lose fewer
- Find someone else
- Waste less

Shipman, Sinsky, *Health Affairs*, 2013
A Typical Day in Primary Care Clinic, circa 2008

- 18 patient visits
- 24 phone calls
- 12 Rx refills
- 17 e-mail messages
- 20 lab reports
- 11 imaging reports
- 14 consultation reports

Baron, *NEJM*, 2008
Is the day just full, or wasteful?

• 40-45% of a physician’s day in the office is spent outside direct patient care

• Clerical duties: 50% of a physician’s time during a patient visit is spent on clerical work

• Administrative tasks: 30-60 minutes per day on insurance and billing questions

• Inefficient technology: the simple has become burdensome (60 minutes/ day on non-value added clicking, scrolling, signing on, etc)

In Shipman, Sinsky, Health Affairs, 2013; additional sources available on request
“I spend 30 minutes before clinic on inbox work and making phone calls...I have a working lunch for charting and inbox work; otherwise I am unable to keep up. I spend another hour at the end of the day completing charts and working on my inbox... I...might spend another 30-60 minutes that night, clearing out my inbox to prepare for the next day. Work on the weekends and days off is generally limited to 1-2 hours to clear out the inbox for the next work day.”

-Group Health primary care physician

Reid, et al, JGIM, 2012
Workforce retention: Physician Resiliency and Burn-out

54% of physicians burned out
40% screen positive for depression
6.4% with suicidal ideation in past 12 months

Impact on learners?

Clinical training exposure of all kinds influences professional decisions and actions.
Volume to value: changing reimbursements are driving clinical transformation

Efficiency

Quality

Implications for the workforce?
Waste less:

If half of all physicians saved 30 minutes a day of 'waste' and spent that time with one additional patient per day, 15-20 million more physician visits could take place each year.
Examples of innovations that can improve clinician efficiency:

- Team-based care, delegation
- Workflow redesign
- Harnessing technology

Implications and opportunities for training?
How to deal with a potential physician shortage

Train more

Find someone else

‘Train BETTER’ – a catalyst for care transformation and workforce optimization

Lose fewer

Waste less
But how? Observations from 23 Teaching Practices Across the US

23 primary care family medicine, internal medicine, and pediatric residency practices
Data was collected using a structured site visit guide and semi-structured interviews with clinic leadership and staff. Site visit reports were coded and analyzed independently through an iterative process. The research team collaborated to identify themes.
Applying a Building Blocks Framework with a Teaching Mission Base

From Tom Bodenheimer, UCSF
Results: Stages of progress

**Traditional teaching clinics:** Have not implemented the fundamental features of that Building Block

**Early Redesign clinics:** Making efforts to redesign towards the Building Block

**Transforming clinics:** Great strides towards implementing the Building Block
Impact on learners?

Clinical training exposure of all kinds influences professional decisions and actions
Clinic First: 6 Actions to Transform Primary Care Residency Training

1. Consistent resident schedules to prioritize continuity and reduce inpatient/outpatient tension
2. Develop small core of clinic faculty
3. Create operationally excellent practices
4. Build stable clinic teams
5. Increase resident clinic time to enhance learning and access
6. Engage residents as co-leaders of transformation
High-Functioning Primary Care Residency Clinics
Building Blocks for Providing Excellent Care and Training

A Framework for “Training Better” in Primary Care

aamc.org/buildingblocksreport
Inefficiency across the workforce continuum
Inefficiency across the workforce continuum

Referral volumes from PCP to subspecialists have doubled in past decade

Poor communication, coordination

Fragmentation
Impact on learners?

Clinical training exposure of all kinds influences professional decisions and actions
Inefficiency across the workforce continuum

Team-based care models can drive efficiency in delivering care
Inefficiency across the workforce continuum

Opportunity to promote more efficient care at the interface of primary care and specialty care
Innovations that

- Reduce fragmentation
- Enhance primary care comprehensiveness
- Right size referral rates
- Improve access to specialty care

www.aamc.org/primaryspecialtycare
AAMC’s Project CORE: Coordinating Optimal Referral Experiences

By improving care delivery at the primary care – specialty care interface, the CORE model will:

• Improve **specialty access**
• Enhance **primary care comprehensiveness**
• Reduce **unwarranted variation** in referral thresholds
• Improve **communication and coordination** between primary care and specialists
• Improve **quality** and **convenience** for patients
• Control **costs of care**
Project CORE

Coordinating Optimal Referral Experiences

• CMMI Health Care Innovation Award to implement across 15+ specialties at 5 AMCs

• Improving communication/coordination between PCPs and specialists

• Leveraging the EMR through condition-specific eConsults and enhanced referrals

• Preliminary results show: more timely access to specialty input, reduced referrals, reduced costs of care for populations served, high PCP, specialist and patient satisfaction
Project CORE at 18 AMCs

CMMI Collaborative
- Dartmouth-Hitchcock
- University of Iowa
- UC San Diego
- University of Virginia
- University of Wisconsin

CORE2 Collaborative
- ECU Physicians
- Greenville Health System
- Ohio State University
- University of Michigan
- University of Washington
- Vidant Health
- Wake Forest

CORE3 Collaborative
- Medical College of Wisconsin
- MetroHealth
- Penn State University
- University of Colorado
- University of Utah
- Yale University
Residents using eConsults in the CORE collaborative

Source: data from one participating AMC in CMMI collaborative, Q5 (Sept. 2015) through Q11 (July 2017)
In Conclusion

Focusing on aggregate physician supply may not be the most productive way to optimize the workforce.

Exposing trainees at all levels to compelling models of delivering effective care can powerfully impact career decisions.

Reducing “waste” in the physician’s day enables greater opportunity to care for patients, with likely further payoff in workforce retention and future workforce interest.

Engaging trainees in care transformation efforts is vital.
Discussion & Questions

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