



**Mayor's Task Force on Improving  
Access to Primary Care in Boston**

**Final Report**

**July 31, 2008**

## **Acknowledgments**

This document is the embodiment of Mayor Thomas M. Menino's vision, leadership, and staunch commitment to improving primary care access in Boston.

Paula Johnson, M.D., chair of the Boston Public Health Commission board, took the mayor's charge and skillfully shepherded the process through its conclusion. BPHC Board members Hortensia Amaro, Ruth Ellen Fitch, and Celia Wcislo provided invaluable guidance.

This report is the culmination of the efforts of many, including members of the Task Force and Working Groups, Commission board members, and BPHC staff. The working groups were co-chaired by Bruce Auerbach, MD, Larry Culpepper, MD, Thomas Lee, MD, Robert Mandel, MD, Bill Walczak, and Ellen Zane.

The first draft of the report was authored by Jeffrey Levin-Scherz, MD. BPHC staff who contributed to the process by staffing the working groups and editing the report were Maia BrodyField, Nicole Charon-Schmidt, Barbara Ferrer, Pam Jones, Maurice Myrie, Ian Newton, Nancy Norman, MD, Debra Paul, and Gerry Thomas.

Special thanks to Judy Steinberg, MD, MPH for her contributions.

## **Introduction**

Primary care access has been shown to improve quality of care and health outcomes, reduce inequities, and lower overall cost of care. Nonetheless, primary care is in crisis throughout the United States. Lower overall pay and demanding work requirements for primary care physicians, including general internists, family physicians and pediatricians, have led to difficulty filling residency positions, and the “pipeline” of physicians completing training in primary care is dangerously low. The American College of Physicians published an article warning of “the impending collapse of primary care,” and family medicine residencies fill only half of their positions with United States graduates. There is an acute shortage of nurse practitioners and physician assistants in primary care, and nursing and many ancillary care providers are also in short supply. The state’s landmark health care reform law added an additional 360,000 adults to the ranks of the insured, which is expected to further strain the supply of providers.

In February 2008, Mayor Thomas M. Menino, along with Dr. Paula Johnson, Chair of the Boston Public Health Commission Board, convened the Mayor’s Task Force on Improving Access to Primary Care in Boston to evaluate the current state of care in Boston, examine challenges and make recommendations about how to improve primary care access for Boston residents. Recommendations have been developed by three working groups: health systems, workforce and finance. The Task Force included members from the provider, employer, health plan, academic, consumer and government sectors. We are grateful for their valuable contributions.

Included in this report are recommendations and suggested next steps to improve access to primary care in the city of Boston. Although the Task Force was charged with improving access, its recommendations also recognize the importance of quality and cost.

The recommendations in this report are intended to complement the efforts of the Executive Office of Health and Human Services in examining primary care access, as well as several pieces of pending state legislation. Furthermore, we recognize the need to collaborate with national efforts that address the impact of federal antitrust laws, the role of Medicare as the payment trend setter and major funder of Graduate Medical Education, and the importance of loan forgiveness programs administered through the National Health Service Corps.

## **Executive Summary**

Though Boston is home to some of the nation's outstanding academic medical institutions, in the years ahead many Boston residents may find themselves losing access to essential primary care. Massachusetts health care reform has increased the number of insured residents, but health care costs will rise and quality will suffer if there are not enough primary care providers. This report offers recommendations intended to improve access to quality primary care and improve health outcomes.

The Mayor's Task Force on Improving Access to Primary Care in Boston has identified five priority recommendations to improve primary care access for residents. For each recommendation we review the underlying problem, lay out action steps, explain how the recommendation will improve primary care access, and discuss necessary resources, timeframes and the potential role of city government. Additional recommendations developed by working groups are listed in the Appendix and can be adopted as part of a broad agenda to improve access to quality primary care services.

### **PRIORITY RECOMMENDATIONS**

- 1. Advance uniformity and alignment of performance measures, payment methodologies and payment incentives.**
- 2. Support expanding the roles of non-physician health professionals.**
- 3. Promote financial incentives to recruit and retain a robust and diverse primary care workforce in Boston.**
- 4. Reduce the burden of chronic disease in Boston residents by improving access to nutritious food, increasing opportunities for physical activity and reducing exposure to environmental hazards, particularly in communities of color and low-income communities.**
- 5. Establish an ongoing primary care task force to monitor progress and prioritize opportunities to improve access to primary care.**

## **Recommendation One:**

### **Advance uniformity and alignment of performance measures, payment methodologies and payment incentives**

#### Underlying Problem

Many health plan “pay for performance” measures focus on the activities of primary care physicians, and health plans include varying measures and targets in their contracting conditions. Although care coordination is an essential component of primary care, numerous activities necessary for coordination are uncompensated. Fee schedules favor procedures rather than the evaluation and care management predominantly delivered by primary care clinicians. Further, each health plan differs on criteria for determining what procedures to cover, the claims and appeals process, and fees. As a result, though primary care practices may have 4 or more FTEs supporting each physician many of these staff are working on reimbursement issues, not supporting patient care.

#### Action Steps

1. The Boston Public Health Commission (BPHC) should review the various payment methodologies, including pay for performance measures, from health plans that contract with the City of Boston, highlighting substantive differences that create workflow difficulties in primary care practices.
2. The BPHC should engage the Massachusetts Medical Society and other parties to collect examples of prior authorization and other health plan administrative procedures that do not add value for patients, along with examples of medical home or comprehensive care models that enhance patient care.
3. Health plans should identify ways to streamline claiming processes to reduce administrative waste.
4. The City should evaluate the possibility of including criteria in the bidding process that would require health plans to remove unnecessary administrative barriers and improve alignment of performance incentives and payment methodologies.

#### How This Will Improve Primary Care Access

Identifying payment methodologies which advance the concept of a medical home will improve care for patients while also streamlining the administrative process for clinicians. Freed from the burdens of duplicative and conflicting administrative processes, primary care practices will be able to increase resources to care delivery. Practices will also have much clearer expectations for how performance and outcomes-based incentives can be aligned across the medical sector. Ultimately, this will have the added effect of improving job satisfaction and improving retention of primary care providers by eliminating non-essential clinical work requirements.

## Examples

Across the country there are new payment models being piloted and implemented. Bridges to Excellence, a *medical home payment initiative*, has been implemented by many states and employers. The program gives primary care physicians \$125 per patient per year for providing certified medical homes. Prometheus Payment, Inc., with support from Robert Wood Johnson and the Commonwealth Fund, advocates system reform through a new model of *evidence-based care rates* (ECR). ECR covers all care given in a set period of time. Prometheus is using “expert opinion” to build the rates from the ground up based on appropriate evidence-informed services. There are also plans that are using *blended payment models*. The North Carolina Community Care Program is using a blended payment with their 750,000 Medicaid members. Approximately 3,000 physicians in 15 networks statewide participate. Payment is 95% of Medicare rates and providers receive \$3 per member per month (PMPM) for case management and a \$2.50 PMPM for care and disease management. Tufts Cigna’s prospective payment model pays a fee for service and providers receive a monthly care management payment and performance bonus for quality and reducing costs.

In addition, the state of Maryland is considering expanding its hospital-based all-payer system to providers in out-patient settings. Many international financing systems models exist, but are premised on universal government sponsored health insurance.

## Resources Required

This recommendation will require project management at the BPHC, as well as collaboration with various outside organizations including the Massachusetts Medical Society and local health plans. Further, this recommendation requires the engagement of the Health Benefits and Insurance Department, which procures health insurance on behalf of the City of Boston.

## Timeframe

The City of Boston negotiates its contracts with health plans in early fall for the following fiscal year. Therefore, efforts to inventory opportunities for change would have to begin immediately so that they could be used in establishing the bidding requirements and selection criteria for 2010 or 2011 health insurance coverage.

## Role of the City Of Boston

The City of Boston, with 18,000 employees, has leverage as a major health insurance purchaser. In this initiative, the City can also play an important role as an advocate and a convener.

## **Recommendation Two:**

### **Support expanding the roles of non-physician health professionals**

#### Underlying Problem

Few new graduates of internal medicine training programs intend to practice general internal medicine. Over the past decade, family medicine training programs have also suffered a substantial decline in enrollment. Virtually all estimates suggest that there will not be enough primary care physicians to take care of our aging population. While strategies that increase the number of primary care physicians are essential, the projected shortfall of physicians is serious enough to warrant an expansion in the roles, responsibilities and training of physician assistants (PAs) and nurse practitioners (NPs). Efforts are needed that will also make it attractive for PAs and NPs to practice primary care within the city. This is not possible without modifying rules and regulations that limit their scope of practice, even if they have appropriate training. As these professions are also experiencing workforce shortages, more effort should go into recruiting.

Historically, various professional societies have objected to expanding the scope of practice for clinicians outside of their membership. The primary care shortage should be seen as an opportunity for professional societies (both medicine and nursing) to collaborate in identifying ways of enhancing access and capacity by changing the scope of practice of non-physician primary care providers while continuing to ensure the highest quality of care.

#### Action Steps

1. Increase current capacity at Physician Assistant training programs (Northeastern University) and Nurse Practitioner training programs (Boston College, Northeastern University, Simmons College, University of Massachusetts Boston); this will require creative solutions that address the shortage of qualified instructors in these programs.
2. Expand pipeline programs with local high schools that are designed to increase the racial and ethnic diversity of the healthcare workforce.
3. Expand training opportunities for other clinicians who support the provision of primary care, including more training of current medical assistants to become Licensed Professional Nurses.
4. Support legislation that allows for expanded scope of practice for non-physicians, elimination of regulations that restrict the scope of practice for medical assistants, and insurance reimbursement for care provided by licensed non-physicians. In addition, the BPHC should work with the Massachusetts Department of Public Health and other state agencies to identify changes that can be made within existing law.
5. Convene health care providers to share best practices in implementing “team care” that supports the expansion of non-physician roles.

### How This Will Improve Primary Care Access

Physician Assistants and Nurse Practitioners should play a larger role in primary care delivery. Allowing expanded scope of practice for non-physicians with appropriate training will increase primary care capacity.

### Examples

With the use of nurse practitioners, Urban Medical Group is able to provide home and institutional care for many more severely ill and elderly Boston residents than it otherwise could. Harvard Vanguard offers its medical assistants tuition support and on-site classes toward becoming an LPN through a partnership with a community college.

### Resources Required

This initiative will require project management within the BPHC. To achieve full success, the City will also need to engage the State Boards of Registration in Medicine, Nursing and Pharmacy and the colleges and universities providing training for health professionals.

### Timeframe

It is likely that some changes can be made within primary care practices immediately, as these will not require any change in regulation or legislation. Increases in PA and NP training will take a number of years to have an impact, and regulatory or legislative effort will require a long lead time.

### Role of the City Of Boston

The City can play a positive role through advocacy and by convening representatives of educational and health care institutions.

### **Recommendation Three:**

### **Promote financial incentives to recruit and retain a robust and diverse primary care workforce in Boston**

#### Underlying Problem

Too few health professionals across the country are choosing disciplines in primary care, general internal medicine, family medicine or pediatrics. Research shows clinicians of color are more likely than their White counterparts to stay in primary care and serve vulnerable populations, and that Blacks and Latinos have better health outcomes when clinicians share their ethnic background. Achieving a diverse workforce is critical to access and quality of care. The reasons for the shortage of primary care providers and the limited diversity within primary care are numerous and interconnected. While carrying the same debt, primary care clinicians receive substantially lower pay and recognition than other disciplines. They often work long hours and shoulder heavy responsibilities. Nurse practitioners and physician assistants face similar issues, and are also in short supply. Finally, steep housing prices and the high cost of living make it difficult for primary care clinicians with significant debt to live in the Boston area.

Given the current shortage of primary care clinicians, various hospital systems are offering signing bonuses and enhanced payments. While this is often an effective recruitment strategy for hospitals, it has made it harder for safety net providers such as community health centers to recruit clinicians. This in turn has made it difficult to expand clinic hours, resulting in a continued reliance by patients on emergency room services in the evenings and on weekends.

#### Action Steps

1. The BPHC should convene Boston safety net and other providers to identify opportunities to offer recruitment and retention incentives for primary care clinicians, particularly those who treat the most vulnerable populations.
2. Request the assistance of philanthropic partners in supporting incentive programs that can help make primary care practice in community health centers attractive for those professionals with substantial student loan debt.
3. Encourage community agencies involved in creating mixed-income housing to identify opportunities that include health care professionals in these plans.
4. Provider organizations should consider housing aid (such as forgivable loans or guaranteed housing at affordable rates) when they are making their recruitment plans.
5. Support legislation and voluntary efforts to increase loan forgiveness programs for primary care health care clinicians, including physicians, nurse practitioners, and physician assistants.

### How This Will Improve Primary Care Access

Financial incentives to recruit and retain primary care clinicians will lead to improved access through increased capacity.

### Example

Together, the state primary care loan forgiveness program and the Bank of America loan forgiveness program, both of which began in 2007, have been instrumental in hiring or retaining 64 primary care physicians and nurse practitioners over the past 15 months. The Massachusetts League of Community Health Centers administers both of these programs.

### Resources Required

The BPHC will provide project management to convene provider and philanthropic organizations to identify financial incentives that can improve recruitment and retention.

### Timeframe

The BPHC can convene providers to develop an inventory of potential financial incentives over 90 days. Many provider organizations could initiate new programs in their next fiscal year.

### Role of the City Of Boston

The City can convene provider and philanthropic organizations to develop strategies for ensuring the availability of an adequate number of primary care clinicians in the most underserved Boston communities.

## **Recommendation Four:**

**Reduce the burden of chronic disease in Boston residents by improving access to nutritious food, increasing opportunities for physical activity and reducing exposure to environmental hazards, particularly in communities of color and low-income communities.**

### Underlying Problem

Chronic disease care accounts for 30-40% of primary care visits and 75% of overall health care costs in the US. Tobacco use, poor nutrition and lack of physical activity are the contributing causes of chronic disease. Asthma and other chronic respiratory conditions are exacerbated by many preventable environmental factors. Locally and nationally, we are facing a chronic disease epidemic, driven by increasing obesity rates. In Boston, an estimated 46% of Boston Public School students are at an unhealthy weight; among adults, 52% are overweight or obese. There are significant racial and health disparities among risk factors and prevalence of chronic disease, with 66% Black Bostonians considered overweight/obese and both Blacks and Latinos suffering from diabetes at rates more than double that of Whites. Ultimately, building support for healthier lifestyles can complement efforts to improve primary care access by improving health status and decreasing mortality.

### Action Steps

1. Business, schools, public and community-based organizations, and elected officials should work together to establish a compact to support efforts that establish Boston as a national model for promoting resident health and well-being. Many elements of this partnership are already in place, including efforts to make the city more amenable to bicycle transportation and pedestrian traffic, as well as efforts to increase access to healthy and affordable foods.
2. Identify and promulgate health regulations in the areas of nutrition, tobacco, environmental hazards, and others that promote good health and prevent disease (such as the transfat ban).
3. Amend or adopt City ordinances that can improve population health (such as restricting tobacco sales).
4. Implement policies or programs city-wide that can improve and/or protect the health of the City's employees (such as the Take the Stairs campaign).
5. The BRA and city planner should coordinate the various City department programs and policies that impact the walkability, bikability, and availability of recreational and park spaces, ensuring that these issues are given high priority in development, public works, and transportation projects.
6. The BPHC should track efforts to improve population health across the city and include this information in its annual Health of Boston report.

## How This Will Improve Primary Care Access

Healthier residents require fewer primary care visits, thus reducing demand on existing primary care capacity.

## Examples

The Mayor and the BPHC Board have been very active in advocacy and implementation of regulations that affect the “built environment” and social determinants of health. The Mayor’s advocacy for bike trails and the recent prohibition of trans fats in restaurants are two such examples.

The BPHC’s NeighborWalk program has engaged more than 1700 residents annually in neighborhood walking groups. These groups have provided opportunities for people to safely engage in physical activity with their neighbors, colleagues, friends and families. The BPHC partnered with Project Bread and the Boston Public Schools to pilot the Healthy Meals Initiative. The pilot features a professional chef cooking in two schools and educating cafeteria managers about healthier ways to prepare and present breakfast and lunch options that are both nutritious and delicious.

## Resources Required

Implementation will require project management and analytical support for tracking and developing annual reports. This effort will require collaboration of multiple municipal agencies, including the Environment Department, the Boston Public Schools, and the Transportation Department. Various components of this initiative include capital improvements that will require substantial resources.

## Timeframe

Nutritional and wellness programs can be designed and implemented 90-180 days after funding is secured and projects are approved. Exercise promotion that requires “built environment” investments will take 2-10 years to fully put into place.

## Role of the City Of Boston

The City of Boston can help reduce risk factors for residents through concerted efforts in schools and municipal workplaces – as well as through capital infrastructure investments that make it easier for city residents (and those who work in the city) to adopt and maintain healthy lifestyles. The Mayor can also advocate for improved infrastructure investments that support healthy lifestyles throughout the state.

## **Recommendation Five:**

### **Establish an ongoing primary care task force to monitor progress and prioritize opportunities to improve access to primary care**

#### Underlying Problem

This Task Force has identified a number of recommendations which can be carried out in Boston in the short and long term. At the same time, there is a great deal of effort being made at the state and federal level to improve access to primary care. There will be a need to monitor progress on the recommendations as well as coordinate with concurrent governmental, legislative, and private sector activities.

#### Action Steps

1. The Mayor should appoint a Task Force to Improve Primary Care Access with the following charges:
  - Monitor progress on the initiatives in this report.
  - Present regular reports to the Mayor describing efforts to improve primary care access.
  - Develop a database of primary care providers (physicians, nurse practitioners, and physician assistants) within the city, including discipline, specialty, race, ethnicity, gender, linguistic capacity, and clinical full-time-equivalency. This database would be used to measure capacity and identify gaps in service.
  - Collaborate with academic institutions to track the entry, completion and career path of medical, nurse practitioner and physician assistant students. Data collected should include number of students, race, ethnicity and gender demographics to assess success at meeting workforce capacity and diversity goals.
  - Encourage community health centers, hospital based ambulatory primary care practices, and private primary care practices to report on efforts they are making to improve the efficiency and effectiveness of their practices. This information will be collated and shared with all participants.
  - Develop a centralized system for consumers and residents to report difficulties obtaining primary care and advocate for redress.
  - Identify funding opportunities for hiring operations management engineers to offer consultation to participating practices.
  - Establish a Mayoral Prize for innovations to improve access and quality of primary care. This will encourage advances in primary care and promote dissemination of innovation across the community.
  - Make recommendations about how health information technology and other innovations can be used to improve primary care access, especially to the medically underserved community.

- Collaborate with health plans, purchasers, and primary care providers to explore new payment methods that would increase pay rates for primary care clinicians and provide 'quality incentives' through patient-centeredness and care coordination.
2. The Task Force should work closely with ongoing statewide and federal efforts to improve primary care access.
  3. The Task Force should be made up of representatives from consumer, provider, payer, academic and government sectors.

### Example

In 2004, Mayor Thomas M. Menino convened the Mayor's Task Force to Eliminate Racial and Ethnic Disparities in Health. Members were leaders from multiple sectors – business, community coalitions, health centers, higher education, hospitals, and insurance – and were charged with developing a comprehensive blueprint to eliminate racial and ethnic health disparities. The blueprint's recommendations and accompanying reports not only contributed to major changes in Boston's healthcare institutions but in the manner we talk about health inequity and the social determinants of health. The recommendations continue to be implemented through the work of the BPHC Disparities Project.

### How This Will Improve Primary Care Access

The Task Force will help identify and disseminate information about effective strategies that can be implemented to improve access to quality primary care for Boston residents.

### Resources Required

The BPHC will provide project management and staff support for this Task Force. An effective task force will also need a dedicated chairperson and committed task force members, along with assistance from staff at various institutions with data collection, research, and data base development activities.

### Timeframe

This Task Force could meet 60 days after it is appointed.

### Role of the City Of Boston

The Mayor would convene this Task Force. The Task Force efforts, including a Mayoral Prize, are likely to play an important role in promoting innovation.

## **Appendices**

- A. Working Group Membership
- B. Principles from Working Groups
- C. Full list of Working Group Recommendations
- D. Bibliography

## **Appendix A: Working Group Membership**

### **HealthCare Systems**

- Mr. John Auerbach, Massachusetts Department of Public Health
- Ms. Ashley Barrington, Massachusetts League of Community Health Centers
- Ms. Jennifer Bennet, The Family Van
- Mr. John Droney, Caritas Physician Network
- Mr. William Halpin Jr., South Boston Community Health Center
- Dr. James Heffernan, Beth Israel Deaconess Medical Center
- Ms. Sally Iles, Massachusetts General Hospital
- Ms. Deb Joelson, Tufts Medical Center
- Dr. Rich Kalish, Boston Medical Center HealthNET, Boston University School of Medicine
- Dr. Barbara Kelley, Northeastern University School of Nursing
- Dr. Raj Krishnamurthy, Boston Medical Center
- **Dr. Thomas Lee, Partners Community Healthcare, Inc.**
- Dr. Jeff Levin-Scherz, Harvard School of Public Health
- Ms. Adela Margules, Bowdoin Street Health Center/BIDMC
- Dr. Paul Mendis, Neighborhood Health Plan
- Dr. Meyechia Minter-Jordan, Dimock Community Health Center
- Mr. Christopher O'Connor, Caritas St. Elizabeth's Medical Center
- Dr. Dan O'Leary, Caritas Carney Hospital
- Dr. Zeev Neuwirth, Harvard Vanguard Medical Associates
- Ms. Joan Pernice, Massachusetts League of Community Health Centers
- Dr. Mark Schuster, Children's Hospital Boston
- Dr. Namita Seth Mohta, Brigham & Women's Hospital
- **Mr. Bill Walczak, Codman Square Health Center**
- Ms. Lisa Whittemore, Brigham & Women's Hospital

### **Workforce Development**

- **Dr. Bruce Auerbach, Massachusetts Medical Society**
- Ms. Leslie Bailey, Massachusetts League of Community Health Centers
- Ms. Kate Bilsborrow, Massachusetts Association of Health Plans
- Ms. Linda Cragin, Massachusetts AHEC Network
- **Dr. Larry Culpepper, Boston University School of Medicine**
- Dr. Peter Davidson, Boston Medical Center
- Ms. Julia Dyck, Massachusetts Department of Public Health
- Ms. Susan Edgman-Levitan, Stoeckle Center for Primary Care Innovation
- Ms. Ediss Gandelman, Beth Israel Deaconess Medical Center
- Ms. Kristin Garcia, Greater Boston Interfaith Organization
- Dr. Robert Master, Commonwealth Care Alliance
- Dr. Margaret McAllister, UMass Boston, College of Nursing and Health Sciences
- Dr. Angela Nannini, Northeastern University School of Nursing
- Dr. Angelleen Peters-Lewis, Brigham & Women's Hospital
- Dr. Joyce Pulcini, Boston College School of Nursing

- Dr. Leslie Schwab, Harvard Vanguard
- Dr. Theodore Sectish, Children's Hospital Boston
- Ms. Paulette Shaw Querner, Harbor Health Services
- Dr. Pat Tabloski, Boston College School of Nursing
- Dr. Marion E. Winfrey, UMass Boston, College of Nursing and Health Sciences
- Ms. Harriet Tolpin, Partners Healthcare
- Ms. Lisa Vinikoor, Greater Boston Interfaith Organization

### **Financing**

- Dr. Marylou Buyse, Massachusetts Association of Health Plans
- Dr. Peggy Chou, Boston Medical Center
- Ms. Kim Damokosh, Tufts Medical Center
- Ms. Patricia Edraos, Massachusetts League of Community Health Centers
- Ms. Deborah Enos, Neighborhood Health Plan
- Dr. David Fairchild, Tufts Medical Center
- Ms. Ruth Ellen Fitch, Dimock Community Health Center, BPHC Board Member
- Ms. Diane Gilworth, Beth Israel Deaconess Medical Center
- Dr. Peter Greenspan, Massachusetts General Hospital
- Ms. Ellen Haffer, Massachusetts League of Community Health Centers
- Ms. Christie Hager, Massachusetts House Speaker's Office
- Ms. Jean Haynes, BMC HealthNet Plan
- **Dr. Robert Mandel, Blue Cross Blue Shield**
- Ms. Patricia McMullin, Beth Israel Deaconess Medical Center
- Dr. Susan Jo Roberts, Northeastern School of Nursing
- Ms. Karen Quigley, Community Catalyst
- Dr. Judith Steinberg, Harvard School of Public Health student ('08)
- Ms. Jessica Taubner, Joint Committee on Health Care Financing
- Dr. Greg Young, Children's Hospital
- Mr. Eugene C. Wallace, Harvard Vanguard Medical Associates & Atrius Health Foundation
- Ms. Celia Wcislo, 1199SEIU United Healthcare Workers East & Mass Connector Board, BPHC Board Member
- **Mrs. Ellen Zane, Tufts Medical Center**

Names in **bold** indicate co-chairs.

## Appendix B: Working Group Principles

### **Mission**

To develop and promote policies and practices that increase the availability (supply) of primary care providers, promote greater equity in health, achieve better health outcomes (*or prevent unnecessary illness and death*) and lower (*or control*) costs.

### **Goals:**

- Adequate supply of well-trained primary care providers (meet HP2010 provider/patient ratio)
- Every person/individual has a regular source of care (further refine patient-centered medical home, advanced medical home, medical home, etc) (HP2010)
- 100% health insurance coverage for all residents (HP2010)
- Eliminate racial and ethnic disparities in health access and health outcomes (HP2010)
- Support efforts to increase workforce diversity

Combined, the three work groups drafted a total of 21 separate principles. These principles were used by each group to guide the development and/or prioritization of recommendations. While there was little redundancy or repetitiveness there were common categories that provided a means to logically group them—Access, Quality, and Cost.

### **Access**

- Primary care should be recognized and promoted as a specialty with a body of expertise specific to it.
- The primary care workforce should reflect the diversity (racial/ethnic/linguistic) of the populations to be served.
- Retaining the existing supply of primary care clinicians should be a priority, along with recruitment.
- Workforce development strategies should be tailored to be responsive to demographics, geography, practice settings, and political and economic environments.
- Models and strategies should embrace and promote entry and re-entry and shorten the pipeline.
- Recommendations about the primary care workforce should be inclusive of all qualified providers, i.e. physicians, nurse practitioners, and physician assistants; the term “provider” should encompass all of these groups.
- Primary care, like all medical care, should be focused on the individual patient and his/her needs. This patient-centeredness requires access to culturally competent care, good communication between patient and provider, evidence-based care delivery and care coordination. Payment methodologies should be tailored to foster these key characteristics of excellence.
- A comprehensive, patient-centered standard of care that is delivered by a multi-disciplinary team should apply across all health care settings and for all

individuals, across the life span, regardless of ability to pay, or whether they have public or private insurance and as such, payment methods should provide consistent incentives across these payer types.

### **Quality**

- Recommendations about the primary care workforce should promote the full and effective utilization of all members of the primary care team.
- Recommendations should recognize the importance of addressing professional and lifestyles challenges.
- Safe – avoiding injuries to patients from the care that is intended to help them.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- Effective – providing services based on scientific knowledge to all who benefit, and refraining from providing services to those not likely to benefit.
- Patient-Centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

### **Cost**

- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy. (STEEEP)
- The payment system should provide incentives for primary care to focus on the management of patients with chronic diseases as well as the prevention of disease and disease progression.
- Payment should support a comprehensive view of primary care encouraging the management of physical and behavioral health conditions and the psychosocial components of both.
- The payment system should recognize that primary care services are best delivered by a multidisciplinary team<sup>1</sup>. Team members and size should be customized based on the patient's needs. Payment should reward effective teams that communicate and coordinate care.
- Primary care practices should have systems in place to support an excellent standard of care. These may include electronic medical records, clinical decision support, patient registries, etc. Payment should reflect the need to use these types of tools to achieve expected outcomes and the payment system should reward achieving desired outcomes.
- Payment system reform and compensation should reflect the value added and critical role primary care can play in increasing quality, equity<sup>2</sup> and

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<sup>1</sup> Multidisciplinary teams may include nurses, social workers, nutritionists, alternative or complimentary care providers, etc.

<sup>2</sup> Equity also includes reducing racial and ethnic health disparities

affordability of care, as seen in primary care based health care systems internationally.

- Primary Care payment reform should support changes in practice patterns that will reduce the rising rate of growth in medical costs over time, not increase them.
- Purchasers, payers, providers and patients have a shared responsibility in improving health care quality, outcomes, affordability and equity. Incentives should be aligned across each of these health care system participants. Primary care payment methodologies should reflect aligned incentives.
- Payment reform should support changes in systems and payment to improve transparency in quality and pricing.

## **Appendix C : Full List of Working Group Recommendations**

### **Training and Education**

1. Expand role of non-physicians by working with Boston health educational institutions to identify training capacity, enrollment, and challenges in training non-physicians for roles in primary care.
2. Link health care delivery systems with schools to expose students to opportunities in primary care fields.

### **Organizational Structure**

1. Establish on-going primary care task force to monitor progress and prioritize opportunities to improve access to primary care.
2. Create primary care workforce registry and use information to set targets for increasing capacity and diversity.
3. Create venues to share best practices in improving ambulatory care.
4. Document non-value added work to inform health plan requirements.
5. Encourage “team approach” in primary care setting, including increased utilization of non-physicians for health care delivery.
6. Improve coordination with non-traditional sites of care by creating a working group (with representatives from Boston Public Schools, BPHC, mobile clinics, college clinics and community based organizations that employ community health workers) to make structural and functional recommendations about aligning services.
7. Use incentives to promote use of e-technology for improving communication between providers and patients.
8. Address lifestyle and professional concerns that affect retention and recruitment by replicating existing “job doability” pilot programs.

### **Finance/Reimbursement**

1. Add a monthly payment for care coordination to the current Fee for Service (FFS) system.
2. Establish uniform payment methodologies across payers.
3. Pilot payment models that support integrated care.
4. Require primary care physician designation for all patients enrolled in a health insurance plan.
5. Create innovative financial incentives to keep primary care clinicians in Boston (such as expanded loan forgiveness programs and housing subsidies).
6. Pilot model programs that receive reimbursement (through insurance) for non-traditional members of primary care team (patient navigators, case-managers and community health workers).
7. Provide financial incentives to primary care providers who use e-technologies to enhance communication with their patients.

### Legislative/Regulatory

1. Support advocacy that increases pay rates for primary care clinicians.
2. Support legislation that recognizes NP and PA scope of practices as primary care providers.
3. Support identification and elimination of regulations that restrict moving medical tasks to the most appropriate professional.
4. Identify possible board of health regulations and city ordinances that support healthy lifestyles, access to nutritious foods (including school breakfasts and lunches), and reduce exposures to environmental hazards.
5. Advocate for licensing boards and/or other agencies to conduct a workflow analysis that can inform recommendations for addressing obstacles and expediting the licensure process.

## **Appendix D: Bibliography**

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