The Status and Stresses of Primary Care Practice in 2012 and the ORPRN Response

Lyle J. Fagnan, MD

This edition’s column by Paul McGinnis, the director for community health, quality and practice development, highlights the changing landscape of practice in rural Oregon and ORPRN’s emphasis on engaging communities as well as practices to improve community health. The stresses of primary care practice include the increasing complexity of care, an anemic workforce pipeline, decreasing support for independent practices, and the challenges of meeting the health reform goals of becoming a Patient Centered Primary Care Home (PCPCH) and participating in Coordinated Care Organizations (CCOs). Here is my perspective on the primary care landscape in 2012.

**Increasing complexity of care— the 18 hour problem**

The primary care physician with a panel of 2500 patients will spend 7.4 hours per day doing indicated preventive care (Yarnell, 2003) and 10.6 hours per day providing recommended chronic illness care (Ostbye, 2005). The typical adult primary care clinician coordinates care for their panel of Medicare patients with 229 other physicians in 117 different practices. In a given year Medicare beneficiaries see seven different physicians in four separate practices. (Pham 2009).

**The Workforce Pipeline**

Rural areas have 21% of the population and 10% of the physicians. ORPRN practices struggle to recruit new physicians. The current U.S. primary care physician workforce is in serious decline because of decreased production, accelerated attrition, and contraction of effort. The projection for filling the pipeline does not look promising. Even with the addition of newly graduated general internal medicine physicians, family medicine physicians, family nurse practitioners, and physician assistants the primary care practitioner-to-population ratio will fall by 9% from 2005 to 2020. There will be a shortage of 40,000 adult primary care clinicians by 2020. In 1960, 50% of U.S. physicians were in primary care. By 1978, this had fallen to 36% and remained stable until 2002. By 2008 primary care physicians made up 32% of the physician workforce. For the past 5 years, the U.S. medical student interest in primary care has ranged from 14% to 20%.

**Burnout on the Columbia River**

The case for primary care practice redesign and practice transformation is clear as the primary care backbone of the U.S. health system is on the verge of collapse. A well-known expert in primary care redesign notes that without a multidisciplinary team, consistent quality chronic care is difficult and without payment reform such teams are impossible. (Bodenheimer, 2009) Several years ago a community internal medicine physician in the Columbia Gorge told me, “LJ, I cannot continue to care for diabetic patients the way I do now. It is wearing me out.” Indeed, he retired two years later.

The decline of the independent physician-owned practice

ORPRN member survey data from 2005 found 58% of our practices were physician-owned. Five years later that number declined to 37%. Health systems are having an increasing footprint in rural Oregon, buying up independent practices. This trend is consistent with the national picture for physicians.

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Is the transition from physician-owned practices to health system-owned practices a good thing? As ownership encounters this "Tug of War," I am not sure if patients and communities will win. How does the health system model affect a clinician’s commitment to the practice? I admit to a fair amount of bias, having spent much of my family medicine career in private practice. On the other hand, ORPRN works with health systems that are providing significant resources to improve the quality of care provided by their affiliated practices.

ORPRN is responding to the new primary care landscape by developing a capacity for practice and community health transformation with our projects. ORPRN is involved in several projects creating a medical home. We recently joined the Oregon Pediatric Improvement Partnership to extend a Medicaid-sponsored program to provide a learning community about being a PCPCH for children. These practices include Siskiyou Pediatrics, St. Luke’s Eastern Oregon Medical Associates, and Winding Waters Clinic. ORPRN has provided rural connections with the Qualis/Commonwealth funded Safety Net Medical Homes Initiative (SNMHI) program, recruiting two well-established physician-directed practices from Eastern Oregon to participate in this five-year practice transformation project. ORPRN works closely with leadership from CareOregon and the Oregon Primary Care Association (OPCA) on the SNMHI program.

Little is known about how practice transformation will unfold in rural settings. We are beginning to understand the role that communities play in change as the social determinants of health are best addressed at the community-level. An ORPRN project is studying the linkages between primary care and community resources to identify and manage obesity. The integration of mental health and primary care will be influenced by community priorities and capacity. ORPRN is involved in a multi-state collaborative led by New Mexico to use community health workers to transform practices and develop community health connections.

To learn more about practice transformation in rural settings, ORPRN has invited experts in primary care and community health to share their perspectives at a meeting in May. Charlie Alfero, a community organizer from rural New Mexico, will present his work in the use of community health workers to bend the quality and cost curve in frontier settings. Kristen Dillon, a family physician from Hood River, will share about a community-wide medical home project, “Busytown.” Sharon Vail, the Executive Director of a community-formed non-profit organization, Rimrock Alliance, will describe how Prineville is able to take charge and influence the approach to health care transformation in their community. Look for a summary of this important meeting on our new website in June. Using lessons from our community practices and partners, ORPRN will be a key rural facilitator to implement the Oregon standards of care to improve the “Triple Aim” outcomes of a healthy population, quality care and reasonable costs.

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**The Primary Care Physician Tug of War**

### The Independent Physician-Owned Practice
- The physician is connected with patients and families
- High value placed on touching
- Family physician practice ownership—nimble, more compact
- The practice creates the vision
- Caring for patients is my profession
- A measure of success is how your patients feel about you
- Providing comprehensive care at times of birth, hospitalizations, loss, and death
- The staff in my practice is my other family

### The Health System-Owned Practice
- The depersonalization of the family physician
- High value placed on technology
- Part of the larger system and have to petition (make the case) for change
- Health System ownership, vision and direction.
- Caring for patients is my job
- A measure of success is meeting my clinical quality measures
- Practicing at the top of my license, focusing on complex patients
- The staff come and go and they are someone else’s responsibility
Welcome new health care providers

Patricia L. Dannen, PA-C, has joined Chehalem Medical Clinic in Newberg. Patricia was born and raised in Eugene and attended the University of Oregon and Oregon Health & Sciences University. She lives part-time in Pacific City and part-time in Portland. She enjoys music, traveling, snowboarding, hiking, fishing and bike riding. Prior to coming to Chehalem Medica Clinic, she worked as a Primary Care provider in Lincoln City for 7 years. She loves her profession, and enjoys helping people get well, feel better and be healthier.

Welcome Heather Farmer, PA, to The Rinehart Clinic in Wheeler. Heather received her Masters from Midwestern University in Arizona. After being a student with Dr. Rinehart, she returned with her husband and baby son to live and work in North Tillamook County. A native of Vancouver, Washington, she enjoys hiking, kayaking, backpacking and cooking.

The Rinehart Clinic in Wheeler is pleased to introduce Jacqueline Novet, LCSW. Funded by Ford Family Foundation, she will provide patient navigation assistance, and develop support systems and resources to ensure that patients receive the highest quality of care. Jacqueline was born and raised in southern California. She received her Masters in Social Work from Portland State University. Jacqueline has additional training in digital storytelling, narrative medicine, and has worked in clinical, residential and community settings with adults with severe mental illness. She developed and taught a course in narrative photography and, in connection with the Trauma Healing Project, produced a series of storytelling workshops for adults with disabilities, recent immigrants, and adjudicated youth. She enjoys food, writing, reading, drawing, family history and flat-water kayaking.

Kristy Hertz, MA, came to Bayshore Family Medicine in October after many years working in assisted living, most recently at Lincoln City Rehabilitation Center. She is rapidly growing in her new position and enjoys interacting with families and patients across all age groups.

Jessica Wilson, MA, joined Bayshore Family Medicine in December and has quickly advanced in her position as medical assistant to Myra Thompson, PhD, NP. Jessica has worked at both the Rinehart Clinic and Tillamook Medical Group. She hopes to pursue an advanced degree in the near future.

Please also welcome the following, which will be highlighted in our next newsletter:

- Holly Agnor, PA, to Urgent Care Clinic in Hermiston
- Linda Harries, PA, to Pendleton Family Medicine
Busytown keeps Hood River health professionals focused locally

by Nancy Rollins

Kristen Dillon, MD, a physician at Columbia Gorge Family Medicine in Hood River since 2001, is excited to talk about Busytown. Better Health for Busytown was created by a group of Hood River health professionals who asked one another “What can we do locally?” after attending an accountable care organization (ACO) conference in Arizona. The ACO model is a Medicare option for physicians, hospitals, and other providers to share in cost-savings through the “triple aims” of reducing costs, improving quality, and enhancing patient health. Dr. Dillon initiated a meeting in Hood River with representatives from the area’s primary care clinics, specialty clinics, a public mental health agency, the public health department, a hospice organization, and the hospital. She has been working with the Busytown group for over a year now, and reports that she is “struck by the really good intentions of all of us in healthcare in Hood River County. It is timely right now with the big changes afoot in healthcare . . . We can't keep doing what we've been doing. Healthcare (in America) is now receptive to creativity and doing things differently.” Busytown's aim is to make a difference in their community.

Reducing hospital readmissions is a high priority nationally, but not as relevant for Hood River, where Providence Hood River Memorial Hospital's readmission rate is in the lowest quartile in Oregon. With an aim to work for the good of the community and do something that was in everyone's best interest, the group came up with a plan to clarify the health ecology of Hood River County and follow up with an intervention aimed to fill the gaps in health care. A one-year grant from Pacific Source Health Plans provided funding for the group's research project. Studying population data, the primary care workforce, resident relocation, ER encounters, and other pertinent data has informed Busytown of where there are gaps in Hood River’s healthcare system. With that knowledge, Busytown will create a community-wide system to better serve the area’s uninsured population. Says Dr. Dillon, “The idea is to fairly share the burden” by simplifying the logistics of determining eligibility and by setting a co-pay amount for clinics. A hub will be established for determining patient eligibility, grown from a collaboration between Hood River County Health Department, La Clinica del Carino Community Family Health, and Providence Memorial Hood River Hospital, organizations already experienced and set up to do so. Clinics would agree to see a set number of eligible patients a week at the same co-pay rate, thus distributing the responsibility equally.

With the first project underway, Busytown continues to look forward to future goals. In coming months they will create a mission statement and decide whether to incorporate as a Community Health Collaborative. “Our overall mission is to create a health care center in the community.” says Dr. Dillon. “The hospital medical staff structure is important but can no longer encompass the relationships that we need in place to coordinate care across the whole community.” Busytown’s “reason for being in Hood River County” is that there is no one person in charge of the big picture. “We want to overcome that fragmentation so that we can be more strategic about identifying our community's needs.”

Columbia Gorge Family Medicine recently moved to its new building on 1750 12th Street. Most of the clinicians at the clinic work 3.5 days a week and all take calls, hospital work, and OB. They share a philosophy of balancing work with family life, and stay involved “beyond our walls” says Dr. Dillon. She has always worked three days a week and views herself as having two jobs: her clinic work and her community work.

After looking at many rural communities across the United States, Dr. Dillon and her husband, Paul, chose
Hood River as their home. They and their two daughters are committed members of the Mid-Columbia Unitarian Universalist Fellowship where Dr. Dillon has served as a past president and religious education coordinator. Fluent in Spanish, Dr. Dillon and her family spent six months living in a small city in Ecuador in 2009.

Dr. Dillon received her medical degree from University of California San Francisco Medical School and completed her residency in 2000 at Fort Collins Family Medicine where she served as Chief Resident in her last year. Prior to attending medical school, Dr. Dillon attended Dartmouth College in New Hampshire and stayed in New England for two more years to teach high school and serve on a volunteer ambulance squad before deciding to go to medical school.

When asked if she had any advice to offer to rural clinicians in Oregon, Dr. Dillon said “I think it is imperative for rural clinicians to reinvent how they do things. Our communities depend on us for a huge portion of their health care, and we need to be present in a way that’s sustainable and viable. A lot of rural Oregonians need cared for, and we can’t serve them if we keep doing things in the same way.”

Hood River’s economy is based on agriculture, recreation and tourism, with recent growth in high-tech industries. Hood River doctors refer people out of the county for specialty care, and coordination of care is sometimes a challenge. The Latino population has continued to grow and is now at almost 30%. Hood River has one of the highest rates in Oregon of uninsured patients (22%).

Robbie Law, MD, is recognized

Robbie Law, MD, Chair of the ORPRN Steering Committee, was recognized by Don Berwick, MD, co-founder of the Institute of Healthcare Improvement (IHI), at the annual HI meeting in Orlando, Florida on December 7th, 2011. Dr. Berwick served as the administrator of the federal Centers for Medicare and Medicaid Services until November 2011. In accepting the Picker Award for Excellence, Dr. Berwick reported on his visit to Lower Umpqua Hospital in Reedsport, Oregon. Here is what he had to say about Dr. Law: "At a meeting there, one of the doctors spoke up – Dr. Robert Law – and he captivated me. Dr. Law, I learned, was the Oregon Academy of Family Practice’s “Family Physician of the Year” in 1999. And two sentences into his remarks at the meeting, I could see why. He spoke from his heart. He said how deeply he cared about his community, his patients, and his professionalism. He told why he felt lucky to be serving, and how willing he was to try out new ways to meet needs, even while resources get tighter. He said how offended he was by waste in the health care system – even in Reedsport – and how hard he wanted to work to make sure that every single thing done to, for, and with patients and families would actually help them – on their terms, not his. And – most importantly – he asked for help – for a context of policy, payment, and information that, simply put, would help him get his work done with pride and joy. 'If things don’t change soon,' he told me last week, 'I am not sure how we can keep going.'"

Robbie Law, MD, was also recognized by being selected to serve on the Editorial Advisory Board of the Annals of Family Medicine. Congratulations, Robbie!

Send us your new email address.

We try to keep our database up-to-date, but if you have changed your email address in the past year, please let us know. Send your new contact information to: ORPRN@ohsu.edu.
ORPRN’s mission has not changed since its creation in 2002. It is to improve the health of rural Oregonians by conducting and promoting research in partnership with communities and practices. We still feel this is a relevant and meaningful mission, but our strategies to achieve it over time are changing. Why? Because the primary care practice landscape has changed. The question to ask is; how can ORPRN remain relevant to our members?

Just as many of our practices became RHC certified the thrust for Patient Centered Primary Care Home began to emerge. This change allowed ORPRN to engage with practices in portions of the PCPCH model through various studies. These studies included the Medical Office Survey on Patient Safety, Shared Decision Making, Nurse-based Care Management, and Clinic/Community Linkages to Manage Obesity. These and other studies helped our practices learn about the internal practice transformation process and test their adaptive and economic reserves. During the last couple of years, two specific PCPCH process studies worked directly with clinics to facilitate transformation. Several clinics have already achieved PCPCH recognition from the Oregon Health Authority. ORPRN staff have assisted in these process changes.

In the meantime, several of our independently-owned physician member practices have joined with health systems or been merged under their local hospital. As such, the decision making process has added another layer to navigate before participating in research. How does ORPRN utilize the lessons learned in these practices to facilitate the transition to new systems and evaluate the impact of these transitions on the quality of care and staff satisfaction?

Now, rural communities are faced with the advent of Coordinated Care Organizations (CCOs) and Accountable Care Organizations (ACOs). These new payment methods push the decision making further away from the individual practice and involve broader levels of participation including health systems, hospitals, mental health and other health service providers. For CCOs and ACOs to achieve desired financial savings, clinics and hospitals must work with community groups to emphasize prevention and management of chronic disease.

One of the ways ORPRN can maintain relevance is by emphasizing the health of rural Oregonians (from the mission above) and working with entire communities including hospitals, practices and rural people to simultaneously address acute care needs as well as the social determinants of health.

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Growth in Eastern Oregon and the Gorge

The staff at Winding Waters, PC will be moving early this summer to their new medical office space on Medical Parkway located next to Wallowa Memorial Hospital in Enterprise, Oregon. The new building will have 11 exam rooms and was designed with clinician co-located office pods to reflect the mission of their practice to be a patient centered medical home.

Columbia Gorge Family Medicine’s new building has expanded parking, an outside play area for children, wifi and charging stations. Lab services are available on-site. Space is shared with Cascade Orthopedics.

St. Luke’s Eastern Oregon Medical Associates is expanding their practice to include eight more exam rooms and a new conference room. They will be co-located with behavioral/mental health services and a new dental practice. The clinic will provide specialty services such as oncology, radiology, cardiology, pulmonology, urology, an infusion clinic and echocardiography. Construction is anticipated to be completed early this summer.

Columbia River Community Health Services in Boardman is planning to move to their new facility in May, 2012. The new 15,000 square foot clinic will include 10 exam rooms and two procedure rooms.
From David Evans, MD

“In April I will be leaving Madras Medical Group and the community of Oregon family physicians to accept a new challenge of teaching students and residents at the University of Washington. A substantial part of my new job will be maintaining and advancing pre-doc rural training programs. It has been a pleasure to work with ORPRN in a number of capacities over the last few years. My practice in Madras was enhanced by interactions with ORPRN staff and projects. Thank you to all for your support.”

Join us in thanking David Evans for his contributions to ORPRN and primary care in Oregon.

Community Education Enhancement and Development (CREED) Symposium

The Community Health Improvement & Research Project (CHIRP) began in fall of 2011. In October, community partners came to OHSU for a morning of “Bench to Bedside” meetings with OHSU experts, and an afternoon with academic researchers and CTSA experts to discuss best practices for community/academic partnerships. The goal of the CHIRP program is to expand a successful community development model (CHIP) to include research training for both community partners and academic

ORPRN has partnered with four community health improvement partnerships (CHIPS): Crook County CHIP, Jefferson County Mountain View CHIP, East Linn County CHIP, and Lincoln County CHIP. To find out more, visit the website at http://www.ohsu.edu/xd/outreach/oregon-rural-health/hospitals/chip/chirp-research-program.cfm.

New webpage and ShareCenter

Look for ShareCenter to debut on April 12 at the OAFP and ORPRN Annual Spring CME Weekend. Members will view a demonstration and be invited to create their profiles. ShareCenter is an online tool for communication, sharing of resources, and discussing topics of interest. Members will be able to learn about ORPRN clinics and studies, share documents, communicate with one another, and join discussion groups. ORPRN’s new website will be launched at the same time. It will have a new look and feel and will highlight the work clinics are doing in their communities.” We are excited about our new sites and look forward to your feedback and suggestions.