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## FEATURED ARTICLE

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### ***Primary Care Incomes: Not Much Relief in Sight***

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Primary care incomes are well below the incomes of many specialties, and the gap between primary care and specialty incomes is widening. This primary care-specialty income gap is one of the major reasons why fewer US medical graduates are choosing primary care careers. Narrowing the gap is an important step toward re-invigorating the primary care workforce.

On June 21, 2006, the Centers for Medicare and Medicaid Services (CMS) announced that the Medicare program is moving to narrow the gap, trumpeting what sounded like a 37% increase in the 99213 office visit code – the most common item on the Medicare fee schedule used by primary care physicians.

Unfortunately, the 37% increase is grossly misleading. The actual increase in the average primary care physician's charges for Medicare patients from 2006 to 2007 is only 5%.

#### Summary of the income statistics

According to annual surveys by the Medical Group Management Association (MGMA), median physician income for all primary care increased by 9.9% from 2000-2004, compared with a 15.8% increase for all specialties. During those years median family practice income grew 7.5% to \$156,000 while median invasive cardiology income grew 16.9% to \$428,000, median hematology/oncology income increased by 35.6% to \$350,000 and median diagnostic radiology income jumped by 36.2% to \$407,000.

The Center for Studying Health System Change confirmed the widening of the primary care-specialty income gap in a 2006 report: from 1995 to 2003, inflation-adjusted income decreased by 7.1 percent for all physicians and by 10.2 percent for primary care physicians.

#### Why is an apparent 37% increase actually 5%?

The Medicare fee for a particular service is calculated as the Relative Value Unit (RVU) of the service multiplied by the Medicare conversion factor which is set each year by Congress. RVU values were set by the Resource Based Relative Value Scale system adopted by Medicare in 1992 and copied in whole or in part by many private insurers. RBRVS favors procedures and imaging studies over primary care office visits; for example, a colonoscopy, which takes about as long to perform as a primary care visit for a complex patient, has an RVU value about three times that of the office visit.

Medicare outsourced to an American Medical Association committee, the RVU Update Committee (RUC) the task of updating RVU values every 5 years. In 2000, the RUC, dominated by specialists, increased

many procedure and imaging codes while making no change in office visit codes. In 2005, the primary care societies for family medicine and internal medicine made a strong case that the RUC needed to recommend major increases in office visit RVUs. Under pressure from some public agencies for its composition heavily favoring specialists, the RUC did propose office visit RVU increases, which were accepted by the Medicare program.

However, the 37% increase for the 99213 office visit announced by Medicare failed to explain that this 37% increase only affected half of the RVU determination. Already, 37% falls to 18.5%. Moreover, Medicare is slated to reduce its conversion factor, which means that an increase in RVU value is balanced by a reduction in conversion factor, making the actual fee lower than the 18.5%. A few other technical factors enter into the equation. Lo and behold, both family physicians and general internists will see about 5% -- not 37% -- more money from Medicare in 2007.

Anyone who wants to read the 605-page details can find them on the CMS website: enter CMS-1512-PN on the search box on the upper right. Table 54 provides the accurate information. As one observer put it, "The headlines giveth, the small print taketh away. "

Is it not time for the nation to make a substantial investment in primary care?

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## ABSTRACTS

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### MDs in Areas with More Resources Have Lower Satisfaction

California Healthline May 31, 2006

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Original article citation:

Sirovich BE, MD, Gottlieb DJ, Welch HG, Fisher ES. **Regional Variations in Health Care Intensity and Physician Perceptions of Quality of Care.** *Annals of Internal Medicine.* 2006 May. 144(9): 641-649.

Primary care doctors who work in areas with the most medical resources -- including specialists, hospital beds and diagnostic equipment -- say they are less satisfied with the quality of care they provide than doctors in areas with fewer resources, according to a study published in the May issue of *Annals of Internal Medicine*, the Chicago Tribune reports.

Dartmouth Medical School researchers conducted a nationwide survey of 6,000 physicians who treat Medicare patients. Medicare spending was 58% higher in areas with the most resources compared with areas with the fewest. The study finds that 50% of physicians in high-intensity health care areas said they were able to obtain elective hospital admissions for their patients, compared with 64% of physicians in low-intensity areas.

Doctors in high-intensity areas were less likely to say they obtained adequate hospital stays for patients, strong specialist referrals or high-quality diagnostic imaging services. The study also finds that physicians in high-intensity areas are less likely to report satisfaction with their careers.

Elliott Fischer, the study's senior author, said, "To the surprise of many, (these) doctors ... perceive the quality of care to be worse on almost every dimension that we looked at. Doctors are less satisfied, and they perceive the resources to be scarcer, even when they have more."

Brenda Sirovich, the study's lead author, said the increased demand for resources in high-intensity health care areas creates a situation "where demand feeds supply, feeds demand, feeds supply in sort of a never-ending cycle."

Lawrence Casalino, professor of health studies at the University of Chicago, said, "The implications (of the study) are important; it's not that we need to pour more money into the system, and it's not that we need more hospital beds and more specialists."

Earlier Dartmouth studies found that more expensive health care and more services do not improve patient outcomes, and researchers estimated that 30% of Medicare spending is used for unnecessary care (Kotulak, *Chicago Tribune*, 5/30).

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## **Average Physician Salary Down**

California Healthline June 22, 2006

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The average inflation-adjusted salary for U.S. physicians decreased by 7% between 1995 and 2003, according to a study scheduled for release on Thursday by the Center for Studying Health System Change, the *New York Times* reports. For the study, researchers examined telephone surveys of 6,600 physicians in 2004 and 2005, as well as previous surveys conducted by HSC.

According to the study, primary care physicians experienced a 10% decrease in salary between 1995 and 2003, the largest decrease reported. Primary care physicians in 2003 reported an average salary of \$146,405 after malpractice insurance and other costs but before taxes, and surgeons who specialize in areas such as orthopedics reported an average salary of \$271,652, the study finds.

In addition, the study finds that Medicare reimbursements to physicians increased by 13% between 1995 and 2003 -- compared with a general inflation rate of 21% -- and that reimbursements from private health insurers increased by less than 13%.

Cecil Wilson, chair of the board of the American Medical Association, said that the study "confirms what they already know from their own practices: payments are not keeping up with inflation" (Abelson, *New York Times*, 6/22).

### Implications

According to the *Cleveland Plain Dealer*, the study indicates that the "salary trend probably is discouraging doctors from doing charity work and may be driving doctors away from primary care" (Spector, *Cleveland Plain Dealer*, 6/22).

Rick Kellerman, president-elect of the American Academy of Family Physicians, said, "What it is going to come down to is problems with access" to primary care physicians.

The study also indicates that physicians have begun to "order more revenue-generating diagnostic test procedures" to address decreased salaries, the *Times* reports.

Paul Ginsburg, president of HSC and a health care economist, said, "Physicians have responded to the stagnant fees by producing more visits as well as more procedures" (*New York Times*, 6/22).

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## **Creating a High-Performing Clinical Team Delivering top-notch care requires more than individual skill and motivation**

Moore LG. Creating a High-Performing Clinical Team Delivering top-notch care requires more than individual skill and motivation. *Fam Pract Manag.* 2006 Mar;13(3):38-40.

(This is an edited version; you can read the full article at <http://www.aafp.org/fpm/20060300/38crea.html#a#a>.)

- Working as a team helps practices improve the quality of care they provide.
- By collecting feedback from your patients, you will learn what your practice does well and what needs improvement.
- Regular meetings give your team a designated time to discuss goals and processes.
- A checklist for patient visits can clarify ambiguity in team members' roles and prevent repetition in your workflow.
- Identify the tools your team needs to accomplish your goals, and then put them in place; it will expedite the implementation of your ideas.
- Creating simple processes will keep your practice operating smoothly and efficiently.

## Forming your game plan

This article explores the behaviors of highly functional clinical teams. This insight comes from personal experience in practice, from work as faculty in various improvement collaboratives with the Institute for Healthcare Improvement and from the developing research into why certain clinical teams excel. The findings suggest that successful teams employ the following steps:

**Collect feedback on performance.** I am in solo practice with one nurse, Judy Zettek, RN, and we have an excellent working relationship. We communicate well and often, and I used to think this was all that was necessary to achieve our desired results. However, once we started to regularly gather data on our patients' experiences with the practice, we found unexpected gaps between what we had assumed and what was actually transpiring.

Patients with chronic conditions reported excellent experiences regarding access, efficiency and continuity, but they reported surprisingly low scores on the quality of information they received on their conditions. At the same time, an insurer's chart review found deficiencies in documentation of HIPAA authorizations, health care proxy discussions and adult immunizations.

We now have several ways of obtaining feedback from patients. First, we ask them informally to tell us what they think about how our office works. Second, we ask those who participate in our group visits to offer us feedback, similar to how a focus group would operate. Finally, we formally collect specific data by surveying patients through the Web site <http://www.howsyourhealth.org>.

**Conduct regular meetings.** Our next step was to meet regularly to discuss goals and processes. We had discussed these in an ad hoc manner, but phone calls and patient arrivals often brought our conversations to an abrupt end, and over time we found that our improvement efforts didn't always move ahead as quickly as we would have liked.

Judy determined that we needed a scheduled, uninterrupted meeting to address these issues properly. She started scheduling an hour every few weeks for us to discuss our goals and what we were doing to improve..

**Clarify goals and roles.** Ambiguity in roles is not unusual in medical practices. Sometimes we work on tasks that should be handled by someone else.

Even a practice the size of ours can suffer from ambiguity. To help us avoid errors of omission or rework, Judy and I created a checklist to clarify who does what. During the course of each patient visit, we check off the following tasks as we perform them:

- Verified insurance,
- Collected co-pay,
- Obtained HIPAA signature,
- Took vital signs,
- Asked about smoking status and readiness to quit,
- Reconciled medications,
- Documented health care proxy discussion,
- Performed Pap/mammogram,
- Updated immunizations,
- Reviewed changes to personal or family history of GI cancer or polyps,
- Referred patient to [howsyourhealth.org](http://www.howsyourhealth.org).

**Act on ideas.** When we decide to change the way we work, we do it right then. It's more effective to test a new tool or approach that same day than to plan a grandiose implementation over the course of several meetings. (For more information on rapid cycle improvement, see <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.)

Immediately following the meeting where we developed the checklist, we created a mock-up on paper and tried it with the very next patient. We quickly realized that we could use the visit template function in our electronic health record, which would make it easier to incorporate age- and gender-specific information.

**Keep it simple.** Your processes must be easy to understand. Because our checklist is part of the note for the visit, when Judy and I have a handoff in the process, we can see exactly what is happening, pick up where the other left off and follow through to completion.

**Everyone's a winner.** A high-performing clinical team is achievable in any practice. It takes a group of individuals working closely to serve patients and a willingness to follow the steps outlined in this article. Teams that implement these behaviors are likely to achieve better health outcomes with less effort than teams that do not. Our team has achieved a very high score for team satisfaction as well as patient satisfaction with the care we deliver. By setting clear goals, defining roles, holding regular meetings, having the right tools to do our work and ensuring transparency and simplicity in the work itself, you can do the same.

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### **Match: Internal medicine still lukewarm draw for grads: Lifestyle, income and mentoring concerns remain the chief reasons for the strong appeal of subspecialties**

From the May ACP *Observer*, copyright © 2006 by the American College of Physicians.

*(This is an edited version; you can read the full article at <http://www.acponline.org/journals/news/may06/match.htm>)*

Given ... lifestyle concerns and the fact that primary care physicians typically earn less than sub-specialists, it's no surprise that students continue to shy away from primary care. Even though the results of this year's National Resident Matching Program (NRMP) show a net increase of 19 U.S. students choosing primary care residencies, it's still nowhere near the high of 3,234 eight years ago—and internal medicine is still trying to figure out how to reverse the trend. At stake, the College has pointed out in a series of position papers and press conferences, is the continued viability of the nation's system of primary health care.

#### **Primary care numbers**

One bright spot in this year's Match was the fact that family medicine ended a five-year decline in its fill rate. While the number of family medicine positions was cut by 50 this year to 2,711, 85% of those were filled (41.4% by U.S. seniors), up from 82.4% last year. The fill rate for medicine-pediatrics also bumped up from 87.2% last year to 91.5% in 2006.

"It's encouraging that for the first time in many years, family medicine did not decline," said Lee R. Berkowitz, FACP, president of the Association of Program Directors in Internal Medicine (APDIM). "It suggests that people are getting more interested in these primary care disciplines."

Internal medicine saw a net gain of 19 U.S. seniors selecting residencies in either categorical internal medicine, primary care internal medicine or medicine-pediatrics, compared with a gain of 18 last year. Almost 98% of the 4,735 available slots in categorical internal medicine were filled, up from the 94% of slots filled in 2002.

However, those gains are relative. For one, the number of internal medicine residencies filled by U.S. seniors has declined from 2,930 in 1998, or 62.4% of total slots, to 2,668 or 56.3% this year, leaving almost half of internal medicine slots to be filled by non-U.S. graduates. And according to annual in-training surveys of residents, the percentage of graduating internal medicine residents planning careers in general medicine has fallen from 54% in 1998 to 20% in 2005.

"The results show that the number of students going into internal medicine is remaining stable compared with last year, but it's dropped sharply from its peak," said Steven E. Weinberger, FACP, the College's Senior Vice President for Medical Education and Publishing. "When taken in conjunction with the data from the resident surveys showing a continuing drop in the percentage of residents ultimately choosing a career in general internal medicine, we are still quite concerned."

### Top three roadblocks

Graduating seniors say they and their peers are still gravitating to subspecialties and specialties outside of internal medicine because of three factors:

- **Lifestyle.** The common thread running through many students' choices is the controllable working hours offered by fields such as anesthesiology and radiology. Those have emerged as popular choices in recent years, said Susan A. Kline, FACP, NRMP's chair and executive vice dean and vice provost of New York Medical College in Valhalla, N.Y. At the college this year, Dr. Kline noted, 20 of the 188 seniors matched to anesthesiology and 19 to radiology. That compares to two students matching in anesthesiology and 12 to radiology just five years ago.

That trend was borne out in the 2005 graduation questionnaire from the Association of American Medical Colleges (AAMC). When asked which factors had the biggest impact on their career choice, 71% of medical students said lifestyle had a moderate to strong influence. (See "[Factors affecting seniors' career choice.](#)")

- **Income.** That same survey found 49% of respondents saying that salary expectations likewise exerted a moderate to strong influence.

"Primary care has gained the reputation that it isn't the most lucrative field to go into and many students are worried about paying back debt," said Kerry Donegan, ACP Student Member, a senior at Mount Sinai School of Medicine in New York who matched in internal medicine at New York Presbyterian Hospital/Weill Cornell Medical Center. "General internal medicine requires long-term care of chronic disease—and much of primary care's expertise is not recognized or reimbursed with the financial rewards enjoyed by other specialties."

- **Role models.** Other physicians' experiences also factor into students' decisions. In the AAMC survey, 74% of seniors said that role models or mentors had a moderate to strong influence on which field they chose—more than lifestyle or income.

Ms. Donegan, who is immediate past Chair of ACP's Council of Student Members, said that working with enthusiastic residents during medical school was a big factor in her decision to choose internal medicine. She noted, however, that many of her classmates were influenced by the problems they perceived in primary care.

"It is often difficult to change patients' habits, particularly those affected by diseases with modifiable risk factors like diabetes and hypertension," she said. With the inherent rewards of good patient care overshadowed by administrative hassles, she added, "primary care seems like more of a struggle compared to high-tech subspecialties like ophthalmology."

"We need to see doctors who are happy with the path they've chosen, who look forward to seeing their patients on a daily basis," agreed Ms. Dunnigan, who is immediate past Vice Chair of the Council of Student Members. "Having positive role models is the biggest factor in encouraging medical students to become internists."

### Reversing the trend

Experts warn that the flat interest in primary care has far-reaching implications for the aging U.S. population. Within five years, the first wave of 76 million baby boomers will become eligible for Medicare, while the population of people over age 85—those most in need of chronic care—is expected to rise by 50% this decade.

"We have to really define what the workforce needs are for general internal medicine and make it clear that a shortage both now and in the future will really pose significant difficulties for patients," Dr. Weinberger said. To that end, the College is working with other internal medicine groups to bring about sweeping changes.

An ACP position paper posted last month on the *Annals of Internal Medicine* Web Site maps out sweeping redesign options for training programs to make internal medicine residencies more attractive to students. The College also continues to strongly advocate for changing both how physicians are paid and how chronic care gets delivered.

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