Primary Care: Too Important to Fail

The U.S. primary care system is struggling. Increasing demands and expectations, coupled with diminishing economic margins, have created a challenging work environment. Analysts warn of increasing attrition in the current workforce and diminishing recruitment of new physicians to primary care (1).

As the new Obama administration arrives in Washington, policy prescriptions for health care reform are being dispensed from every side. Many of them emphasize the importance of revitalizing the nation’s primary care system. As a foundational element of the health care system, primary care is needed to improve quality, increase access, and contain costs (2). These are the principal goals of health care reform.

A key to the sustainability of primary care will be payment reform coupled with innovative quality measures and value-based purchasing. Although challenging, payment reform seems possible within the larger context of national health care reform, particularly because Congress must act on Medicare physician reimbursement this year. Payment reform alone, however critical, won’t revitalize primary care. Payment reform is a maintenance medication and primary care is in need of an immediate rescue. The U.S. primary care system needs a stimulus package that, such as plans for an economic stimulus package, focuses on infrastructure.

As the article by Pham and colleagues (3) in this issue suggests, a primary care infrastructure investment must address the substantial challenges of care coordination in primary care. By using a survey of more than 2000 primary care physicians who participated in the Community Tracking Study, the authors calculated the number of other physicians and practices that a primary care physician’s Medicare patients visit over the course of a year. Their sobering conclusion was that a typical primary care clinician must coordinate the care for their Medicare patients with 229 other physicians working in 117 different practices. Although rural physicians work with slightly fewer peers, those in smaller practices and those treating more patients with chronic illnesses work with even more. Although most practicing clinicians already know that coordination is a big challenge, Pham and colleagues’ article does a good job of quantifying and detailing the size of the problem. Given the conservative study design choices that the research team made—they do not include primary care physicians’ coordination with nonphysician therapists, educators, psychologists, and community partners, and do not include the vital care coordination with patients and their families—the true scope of the issue is even larger. Although previous work by this team and others (4) has demonstrated that Medicare beneficiaries often are cared for by multiple physicians in multiple practices, the article provides valuable insight into the scope of the care-coordination challenge from the perspective of the primary care physician.

The functions of primary care, including care coordination, cannot be accomplished by the lone physician, no matter how dedicated. Primary care teams are a central tenet of the patient-centered medical home, a comprehensive model for delivering primary care. As primary care practices are redesigned to take advantage of the complementary skills of a variety of team members, care coordinators will take their place as indispensable members of the team. Current medical home demonstration projects across the country are experimenting with divided payment models that incorporate per-patient per-month capitated fees to enable practices to make investments in nonphysician team members. A substantial hurdle facing these projects is the costs of transforming the typical small primary care practice into a medical home. Even if payments are robust enough to support the ongoing expenses of a primary care team, they are unlikely to cover the substantial 1-time costs of redesigning workflow, reconfiguring offices, recruiting and training new staff, and retraining the current workforce. If the potential of the medical home is confirmed, our nation must be prepared to make an investment to support the transformation of primary care practice.

Once we begin to examine how to assist primary care practices in transforming into fully functioning medical homes, we find that few small- or medium-sized practices (more than 75% of primary care practices in 2006 employed 5 or fewer physicians [5]) have any infrastructure to support quality improvement. Small primary care practices are unable to support full-time quality improvement officers, chief information officers, social workers, health educators, mental health professionals, and care coordinators. A community could support this enterprise. Therefore, a community-based health care extension service may play an important enabling role in the transformation and sustainability of primary care. The functions of these community-based and -managed teams would be to:

1. Provide small, local primary care practices with the services of care managers, social workers, health educators, and other professionals.

2. Serve as connectors linking local primary care practices to existing community resources, such as social services, mental health services, and public health resources and programs. A community-based health care extension service would be more effective if its mission included mobilizing, organizing, and coordinating the local on-the-ground public resources, such as agencies on aging, substance abuse services, and family services, and connecting them with primary care practices and patients.

3. Provide primary care practices with quality improvement technical assistance, including practice redesign, assistance with the adoption of health information technology, and information on local best practices and national evidence-based practices and guidelines.

4. Partner with academic centers and primary care practice–based research networks to coordinate practical...
clinical trials to answer practice-informed research questions.

The model of shared community-based, practice-controlled resources already exists in North Carolina. The Community Care of North Carolina initiative has demonstrated success as measured by improved quality of care, cost savings, physician satisfaction, and scalability (6, 7).

Primary care health information technology infrastructure investments could also produce dividends in the form of improvements in quality, safety, and better care coordination. Pham and colleagues correctly note that the electronic exchange of health information between physicians is currently limited. However, electronic health information exchange, electronic health records, personal health records, and asynchronous electronic communications all offer potentially efficient and effective ways to ensure that the right information is available to the right people at the right time to improve the coordination of care in the United States. Because currently available health information technology, even if more widely adopted, would not fully achieve our goals for quality, we must aggressively invest in next-generation systems and tools and plan for their deployment.

We would be wrong to spend time debating which needs to come first: payment reform, attention to workforce, building an infrastructure for primary care, or a focus on care coordination. Each of these activities is critical and contributes to success of the others. By the same token, we cannot build a reformed health care system on an endangered primary care enterprise. We must invest now. Primary care is too important to fail.

David S. Meyers, MD
Carolyn M. Clancy, MD
Agency for Healthcare Research and Quality
Rockville, MD 20850

Disclaimer: The opinions expressed here are those of the authors and do not reflect the views of the Agency for Healthcare Research and Quality.

Potential Financial Conflicts of Interest: None disclosed.

Requests for Single Reprints: David S. Meyers, MD, Agency for Healthcare Research and Quality, John M. Eisenberg Building, 540 Gaither Road, Rockville, MD 20850; e-mail, david.meyers@ahrq.hhs.gov.

Current author addresses are available at www.annals.org.


References
Current Author Addresses: Drs. Meyers and Clancy: Agency for Healthcare Research and Quality, John M. Eisenberg Building, 540 Gaither Road, Rockville, MD 20850.