

21st-Century Primary Care New Physician Roles Need New Payment Models

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JAMA. 2008;299(13):1595-1597.

Primary care medicine is in search of redefinition. Prevalent payment modes have undermined traditional models and reduced workforce interest while some functions of primary care are emerging in new incarnations. Payers find physicians "too expensive" for basic primary care services, and young physicians find their earnings expectations greater than primary care careers can offer. Understanding these market forces could lead to better understanding of required physician expertise within the larger framework of primary care. A more explicit definition of that expertise could lead to more appropriate market valuation of physician services.

Fee-for-service reimbursement has undermined good primary care.¹ At a time when advances in understanding systems of care point to new models in which physicians' roles might be redefined to contribute more value to patients and to the delivery system, financing models have not yet caught up. Many of the most important aspects of primary care services, including care coordination and intervisit care, remain unsupported.² The fee-for-service payment model influences how society thinks about medical care,³ reducing it to visits or hospitalizations or procedures—the component "widgets" of fee-for-service economic production—and overshadowing a patient-centered, longitudinal, multidimensional practice that primary care physicians aspire to give and patients to receive.

The classic definitions of primary care included first-contact care, continuity of care, comprehensive care, and coordinated care.⁴ Commercial acute care-only ventures, often in partnership with large retail outlets, are appearing in shopping venues to meet conveniently the needs of individuals with acute, often minor, but time-sensitive concerns.⁵ Employers are beginning to reinstate workplace clinics, typically staffed by nurse practitioners or physician assistants, to care for employees' illness and minimize avoidable absence from work. Advanced practice nursing is taking a more prominent role in rural clinics and even in a few urban models.⁶ Although these models address first-contact care—arguably the least costly component of the Starfield model⁴—they may not do as well for the continuity of care, comprehensive care, and coordinated care components of the model.

For patients with multiple complex chronic illnesses, purchasers and payers are recognizing that someone needs to be accountable for effectively managing care. Increasing coordination of care in primary care is one strategy to reduce unnecessary and redundant services and help address the steep increase in the cost of medical care. Increased coordination of care may also reduce gaps in services, problems with care transitions, and both errors and quality shortcomings.⁷⁻⁸ Increasing costs have led to a drive for greater efficiency in health care, and payers are seeking ways to reward more efficient practitioners, making a strong case that 21st-century primary care must include responsibility for managing and organizing all aspects of a patient's medical journey. Although primary care physicians cannot be expected to do everything in such a model, they must have the skills to be accountable for a system that will provide this management function. For most small primary care practices, however, fee-for-service payment is inadequate to support teams and infrastructure, and the outcomes of good care coordination-fewer office visits, hospitalizations, and redundant diagnostic tests-will result in reduced practice revenue or uncompensated effort that saves money for someone else.

Therefore, it is not surprising that patients and purchasers of care discover that finding well-trained physicians in practices equipped to meet those more complex needs is difficult. Fewer trainees are selecting primary care specialties, and even those who do are not likely to be trained with needed management skills. The current reimbursement system has had an effect on training as well, resulting in the lack of a physician workforce able to function optimally in a comprehensive, care-coordinating role. Hospitals, particularly big community and teaching hospitals, do not hesitate to purchase a new imaging machine with revenue-generating prospects, but many hesitate to invest in electronic medical records (EMRs), integration of specialties, or other care coordination models that might have the perverse effect of reducing their own revenues.⁹

A cardiologist could not be trained without a fully equipped catheterization and electrophysiology laboratory, but many medical residents are trained without EMRs and care teams to support comprehensive care, thereby starting practice without the skills to use the tools they need to be successful. If physicians in primary care are expected or needed to "coordinate it all," it is important to think differently about the competencies required of them, weighting less heavily toward well-patient or acute care and more heavily toward complexity and continuity where the physician's extensive medical training is put to best use. Another important need is to focus on some neglected competencies.

All training programs accredited by the Accreditation Council for Graduate Medical Education and all 24 specialty certifying boards of the American Board of Medical Specialties have agreed to 6 core competencies by which trainees and practicing physicians are evaluated, including patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, and practice-based learning and improvement. Systems-based practice describes the skills of care coordination, teamwork, and information management that patients and purchasers alike are seeking. Systems-based practice and practice-based learning and improvement have been neglected areas of training, especially in primary care. Surgical residents must train in a well-functioning operating room and learn the roles of operating room teams and processes. All too often, however, primary care residents see outpatients in the least well-organized part of the hospital, and faculty are not skilled in teaching systems management and practice-based learning and improvement skills.¹⁰

The American Board of Internal Medicine is making progress in expanding the evaluation of competencies of primary care physicians to create and operate efficient, well-organized practices and to evaluate the relative contributions of individual physician expertise and high-performing systems. A few internal medicine residencies have been exempted from traditional training requirements if training programs can show evidence that residents have mastered these competencies.¹¹

The resurgence of patient and purchaser interest in primary care is leading to the support of some innovative practice models, largely outside the academic health centers. One is the patient-centered medical home, advanced by the American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Practice, and the American Osteopathic Association.¹² Demonstrations are under discussion with several major private payers. The Tax Relief and Health Care Act of 2006 instructs the Centers for Medicare & Medicaid Services to develop an 8-state demonstration of the medical home under Medicare. In all these models, the funding mechanism for enhanced primary care is projected to reduce overall use by the 10% to 20% of patients who use the most services. Such savings could fund practice infrastructure, including information systems and clinical team staff. However, it may be challenging for training centers or integrated delivery systems to innovate with these models because overall savings to a payer could represent net revenue loss to the delivery system. It will be important to fund pilot projects involving caring for high-need patients to have the highest likelihood of achieving savings.

Another model, the ambulatory intensive caring unit, is being tested with

the Hotel Employees and Restaurant Employees International Union in Las Vegas and Atlantic City. This model involves explicit tiering of access to care that makes extensive use of nonphysician clinicians and staff (fully linked to and integrated into the practice with health information technology) for health coaching, proactive outreach, and preventive screenings. The physicians are focused on managing the team and provide direct clinical care for the patients with the most complex illnesses, developing ways to keep these patients as healthy and functional as possible and reducing unnecessary interventions, complications, and hospitalizations. These models are being pilot-tested by health care purchasers who are already bearing the cost of "downstream utilization" and are willing to invest heavily and directly in enhanced primary care with the hope it will have a favorable effect on overall cost trends. Employers want to use physician expertise efficiently and effectively and place high value on systems management and complexity management capabilities.

A third model is concierge medicine, in which physicians receive a retainer in addition to their fee-for-service billing. The retainer can range anywhere from a few hundred dollars to several thousand dollars per year and allows physicians to have a smaller number of patients to whom they can devote more time as well as, possibly, to invest in interdisciplinary teams and EMR support.¹³ That some patients are willing to pay a surcharge in addition to high health insurance premiums is testimony to how difficult it is to find acceptable primary care.

Innovations in both delivery models and financing structures are clearly required because the existing market has not yet brought forth models to meet these needs under a fee-for-service system. The innovative models offer hope for improving the environment and effectiveness of primary care, but they must be intensively evaluated to understand what works, what does not work, and what is the optimum profile of physician contribution to success. Because successful primary care is likely to involve information technology and multidisciplinary teams, physician competencies in these areas will be of increasing importance.

Responding to the United States' urgent need for cost-effectiveness,¹⁴ physicians in primary care will need to restructure their work and customize their technology to ensure the work gets done as efficiently as possible, much of it by less expensive and less trained team members. Funding partners for pilot programs could be payers and governments who have articulated an interest in a more affordable, accessible health care system and who pay for the added costs of existing inefficiencies. The combined missions of research, education, and patient care could, in some

teaching institutions, focus on developing a delivery system that meets the 6 aims for quality better than the system in place now.¹⁵

As innovative efforts to create positive financial models for primary care emerge, there is one consistent trend—a realization that the physician's extensive training is a costly commodity that must be engaged in the most cost-effective manner possible. The "first contact" and "preventive/screening" components of the traditional primary care model may well be best managed by nonphysician professionals, but to ensure continuity and personalization, these services must be linked—through information availability and through effective teamwork—to ongoing comprehensive patient care models. Physicians must be trained to be effective partners in such teams, which will take many different forms.

As primary care evolves and develops new models, it will be critical to remain focused on the many ways fully elaborated models of primary care can and must contribute value to patients and the overall delivery system. In the current system, there is no lack of opportunities to add value. The challenge will be to develop and nurture them in an environment in which so many barriers have kept them from developing on their own.

AUTHOR INFORMATION