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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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The Role of Primary Care in Health Care Reform

By *Kenneth Goldblum, MD*

Few discussions on health care reform fail to mention the importance of primary care and, indeed, primary care plays such a critical role in health care delivery that any successful health care reform effort will necessarily depend on a strong primary care foundation. At the present time, that foundation is not solid enough to fulfill its role. It will need significant reinforcement if reform is to succeed.¹

For a patient experiencing a new problem, primary care is generally the first contact with the health care system. Comprehensive in nature and centered on the whole person rather than a specific disease process or organ system, primary care coordinates care given by different providers in different settings. It is continuous over time and, as such, is forward looking and prevention based.

Although health care reform is multifaceted, with different orientations depending on the context, a majority of its goals target lowered costs, improved quality and safety, better access to care, and more patient-centeredness. By its very nature, primary care supports these goals; for example, studies of geographical variation in costs in this country have shown that areas with more primary care have lower costs. On a macro scale, this is supported

by data showing that countries with a higher percentage of primary care doctors also have lower costs. Outpatient quality improvement efforts have focused on primary care initiatives with specialist programs lagging behind. Moreover, newer care delivery models such as the Patient-Centered Medical Home (PCMH) are designed in part to improve both access and patient-centeredness.

Despite the concordance between the nature of primary care and the goals of reform, primary care is ill equipped to fulfill its potential foundational role. Consider the following:

- At a mere 5% of total health expenditures, primary care is woefully underfunded. It is trapped in a fee-for-service payment methodology that reimburses visits and does not support the goals of reform.
- Primary care is fragmented, with evidence revealing that in 1 year the average Medicare patient sees 2 primary care doctors and 5 specialists working in 4 different locations.²
- Primary care is increasingly isolated as fewer and fewer primary care physicians practice in the hospital setting.

- Primary care is time challenged, with one study documenting that it would take 7.4 hours per day to provide all recommended preventive care and another revealing that it would take 10.6 hours per day to provide all recommended chronic care.³

Despite recent efforts, including those contained in the Affordable Care Act, primary care doctors remain in short supply. Market forces likely will exacerbate this problem.

Three initiatives currently under way or close to starting have the potential to help improve the situation for primary care. The first of these is the PCMH, a care delivery model innovation that seeks to improve the core primary care functions of access, comprehensiveness, coordination, and quality improvement. Although it does deliver results in these areas, the data are not as robust with regard to cost reduction. The extent to which PCMH is truly able to drive change depends primarily on payers supporting the concept. In the absence of strong data on cost reduction, such payer support remains in question.

The second initiative currently affecting primary care is payment for meaningful use (MU) of electronic

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medical records (EMR). Legislated through the American Recovery and Reinvestment Act in 2009, final criteria for the first stage of MU were recently established, and the first wave of practices is now in the certifying process. Anecdotal evidence suggests that the criteria will represent a difficult stretch for many physician practices and therefore may not be a significant driver of change. On the positive side, the 2011 standards for National Committee for Quality Assurance PCMH certification include many of the same elements that are necessary for MU certification, so a practice that certifies as a meaningful user of EMR will be well on its way to PCMH certification as well.

The last initiative, one that begins soon, is the Medicare Shared Savings Program. Preliminary rules were published in March of 2011, and the final rules are still pending at the time of this writing. While the term Accountable Care Organization (ACO) is used in other contexts, here it refers to a business structure of providers of traditional Medicare services who will contract with the Centers for Medicare and Medicaid Services to engage in a shared savings program. The sharing of savings is first predicated on the organization's achievement of acceptable performance levels on specific quality measures. The preliminary rules describe 65 such measures, many of which are outpatient, primary care-based measures. Five of the measures are MU measures, and there is a requirement that 50% of the ACO's

primary care doctors be certified as meaningful users of EMR by the ACO's second year.

Because ACOs will be held liable for losses incurred under the Shared Savings Program, they also must be risk-bearing entities with sufficient capital – a resource not typically associated with primary care physicians. Given that participation in the ACO is entirely at the discretion of the primary care doctor, this initiative does have the potential to better fund primary care if the practitioners are able to leverage this with a strategically aligned capital partner.⁴

Although these 3 initiatives have different origins and different goals, they tie together and support each other. As noted, practices that can certify as meaningful users of EMR are well on the way to PCMH certification, and MU certification is critical for ACO participation. PCMH certification, in turn, goes a long way toward meeting the proposed ACO quality measures. Only the ACO is a true payment methodology reform but, to the extent that the PCMH is embedded in the ACO and driving its quality, the ACO may provide the PCMH with financial support. Many themes of reform – from cost reduction to quality improvement to better patient-centeredness – run through all 3 of these initiatives.

Although each of these initiatives has the potential to improve the plight of primary care, a true bolstering of the

foundational role of primary care (and thereby a true support of the delivery system as a whole) will depend on new payment mechanisms that support the goals of reform. To accomplish this will require fundamental reform that uncouples reimbursement from the individual visit and creates incentives for team building.⁵

A reimbursement system that pays for visits will continue to produce visits without necessarily improving access, comprehensiveness, safety, or quality of care. Conversely, a reimbursement system that rewards the goals of reform has the potential to address the challenges of primary care and, hence, improve the delivery system as a whole.

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