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## Community-Oriented Primary Care


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# Community-Oriented Primary Care

Community-oriented primary care (COPC) is an approach to tackling the health problems of a defined community that departs from traditional primary care practice to incorporate population-based and epidemiological data. In essence, it "marries" the best of primary care with the best of public health so that the primary care practitioner takes responsibility for the care of an identified community. Rather than waiting for the patient to come to the physician, the physician (or practice) brings care to the patient. Through COPC, a rational, organized effort is made to have a measurable impact on the health problems of a particular group. In this age of managed care, the COPC approach may provide innovative ways to effectively improve the health of the patients enrolled in a certain HMO.

COPC is not a new concept. Will Pickles, an English GP, who served as the Medical Officer in a rural area, was one of the first in the modern era to practice using the COPC model. He carefully logged the name, date, village, and diagnosis of all the infectious diseases he encountered. In conjunction with a team that included a photographer, clergy, school teachers, and others, he painstakingly chronicled the events that occurred in his district. As a result, he gathered a community "history," performed a "physical exam," and carried out "tests" that led to specific community diagnoses including showing the relationship between chicken pox and shingles, the incubation period of Hepatitis A, and the infectious etiology of pleurodynia.

The term 'COPC' was coined by Sidney Kark, whose work in South Africa and Israel has helped popularize this model. In the United States, Fitzhugh Mullan, MD, and Paul Nutting, MD, have served to bring the COPC model to our attention. For some years, the principles of COPC have been embodied in publicly funded health programs such as neighborhood community health centers and the Indian Health Service. More recently, the private sector, especially HMOs, have recognized COPC as a way to achieve both economic and health goals.

There are three components essential to the COPC model: (1) a primary care practice/program; (2) a defined population; and (3) a process to address the health problems of a community. The primary care practice/program must meet basic requirements of primary care including accessibility, comprehensiveness, accountability, etc.

The community is the target population, that is, the group for which one practice has taken responsibility. At times, the community is clearly recognizable as is the case of a geographic community. In other instances, the community is less well defined, for example, the individuals enrolled in a health plan or a school population.

Communities share some common social, cultural, economic and political systems. Finally, the COPC process is an important component in the model. It is described as four steps which do not necessarily need to occur sequentially. They are (1) defining and characterizing the community; (2) identifying and prioritizing community health problems; (3) developing and implementing community specific and approved emphasis programs; and (4) monitoring the impact of interventions.

Several obstacles exist that have prevented COPC from moving more into the mainstream. These include: (1) the difficulty of defining the community where there

may be overlapping, complex boundaries; (2) limited resources directed to COPC activities; (3) limited data systems; and (4) lack of quantitative techniques feasible for use in primary care settings.

Despite these problems, COPC can be integrated into practice in an incremental way. The staging criteria for COPC functions are presented in Table 1. Simply identifying the current stage of a practice and moving to the next level can be an effective and feasible prospect.

In summary, COPC can be an effective and appropriate model to better manage target communities, especially with regard to prevention. It offers a strategy to market prevention, to maximize resources of a given practice and provide an intellectual base for a primary care practice to go beyond the individual and the disease. As the COPC model emerges in various health care settings, it will be important to assess its impact in modifying risk factors for preventable disease, addressing previously recognizable health problems, developing cost effective strategies, and addressing the maldistribution of health services.

| **TABLE 1** | **STAGING CRITERIA FOR COPC FUNCTIONS** |
|---|---|
| Stage 0 | No effort has been made to define or characterize a community beyond the active uses of the practice. |
| Stage I | There is no enumeration of the people who constitute the community. The community is characterized by extrapolation from large-area census data. |
| Stage II | There is no enumeration of the community, but it is characterized through the use of secondary data that correspond closely to the community for which the practice has accepted responsibility. |
| Stage III | The community can be characterized through the use of a data base that includes all members of the community and contains information to describe its demography and socioeconomic status. (Often such a data system is constructed over time from the active users of services but approximates the community closely, that is, at or above 90 per cent coverage of the community.) |
| State IV | Systematic efforts are made to assure a current and complete enumeration of all individuals in the community, including pertinent demographic and socioeconomic data. For each person, information exists that facilitates targeted outreach - address, telephone number, etc. |

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