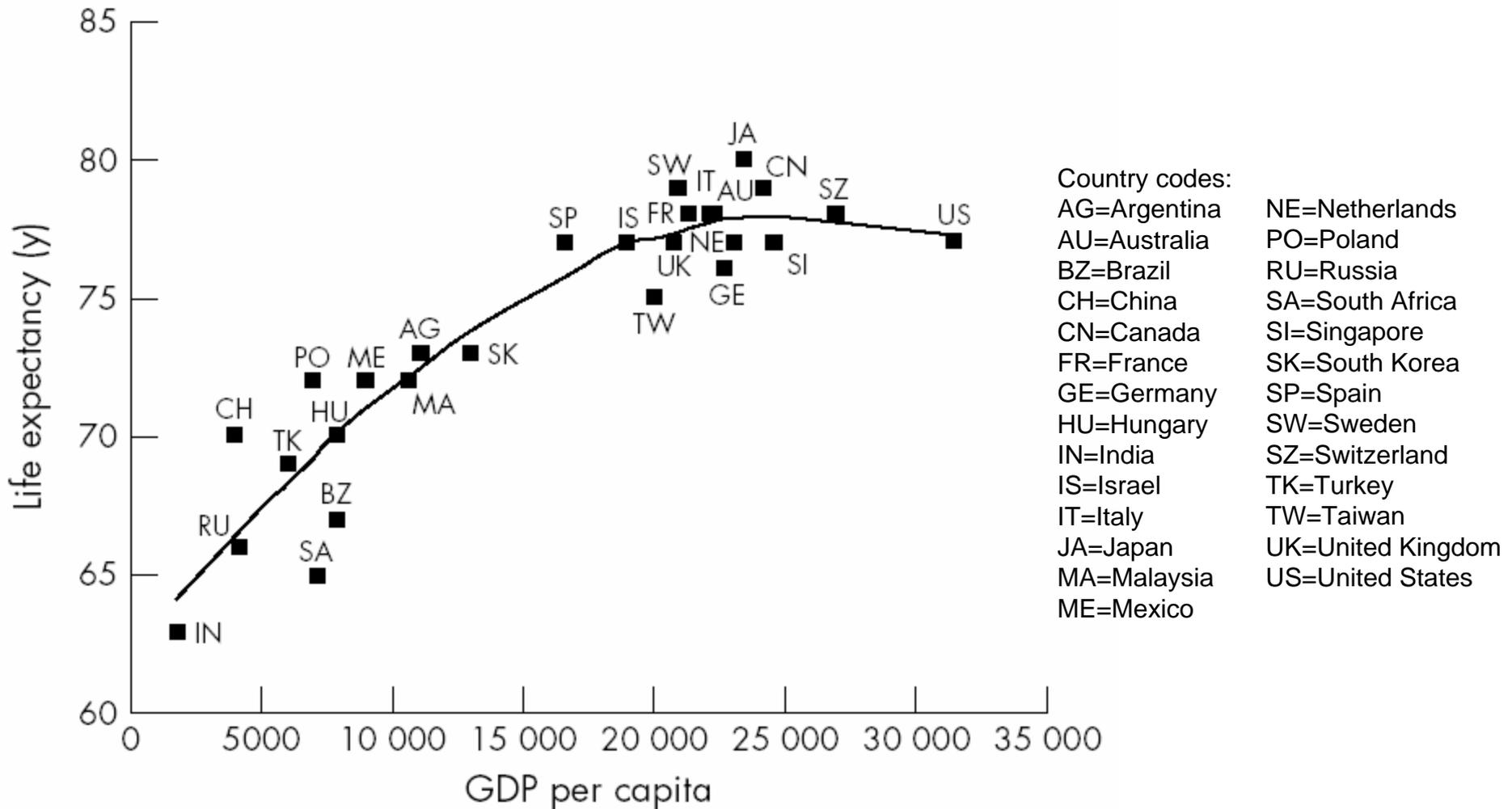


The Medical Home and Retail Clinics: Complementary Care or Conceptual Clash?

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Life Expectancy Compared with GDP per Capita for Selected Countries



Why Is Primary Care Important?

Better health outcomes

Lower costs

Greater equity in health

Primary Care

First Contact	<ul style="list-style-type: none">• Accessibility• Use by people for each new problem
Longitudinal	<ul style="list-style-type: none">• Relationship between a facility and its population• Use by people over time regardless of the type of problem; person-focused character of provider/patient relationship
Comprehensive	<ul style="list-style-type: none">• Broad range of services• Recognition of situations where services are needed
Coordination	<ul style="list-style-type: none">• Mechanism for achieving continuity• Recognition of problems that require follow-up

Good Primary Care Requires

- Health system **POLICIES** conducive to primary care practice
- Health services delivery that achieves the important **FUNCTIONS** of primary care

Key factors in achieving an effective health system in both developing and industrialized countries are:

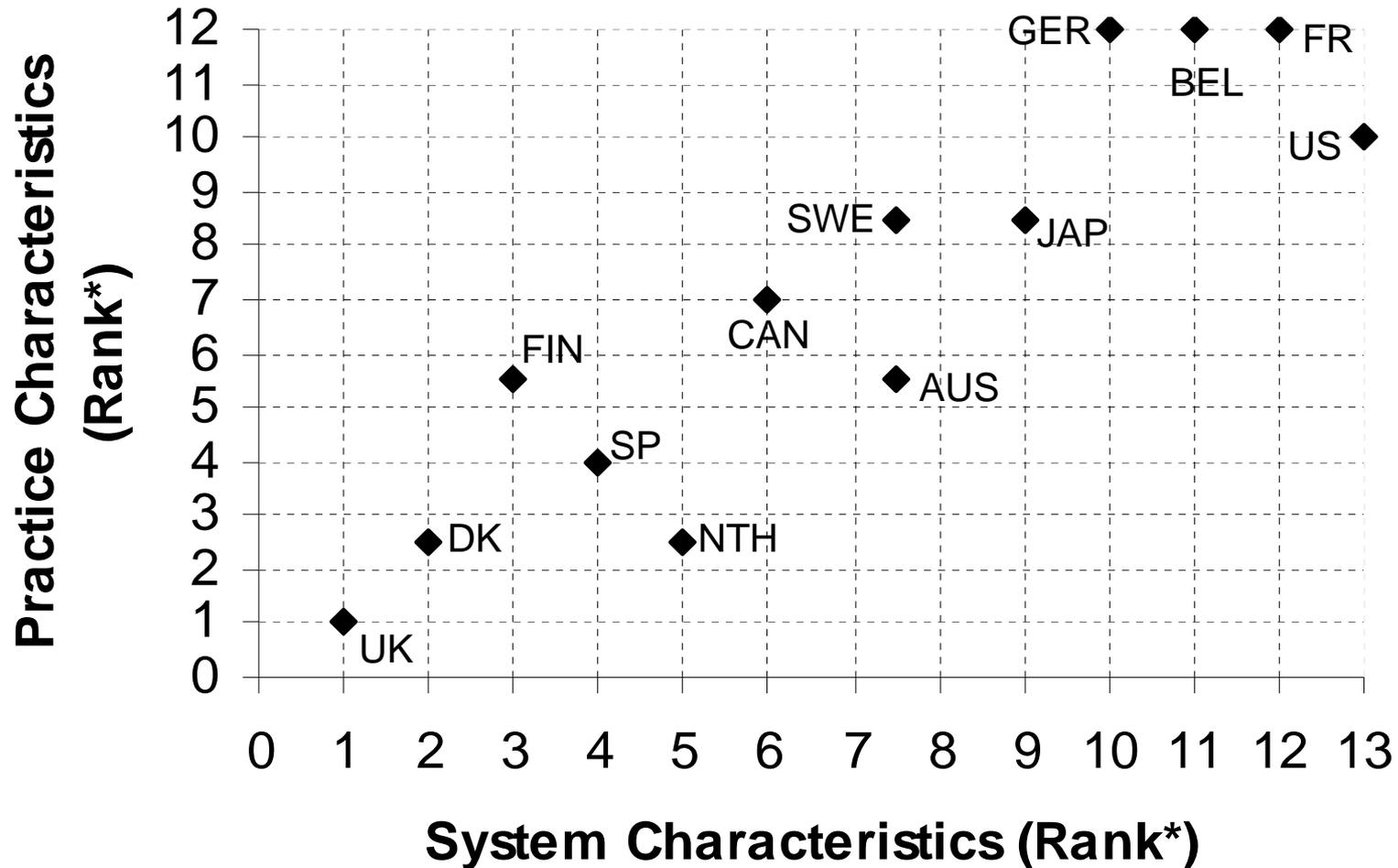
- Universal financial coverage, under governmental control or regulation
- Efforts to distribute resources equitably (according to degree of need)
- No or low co-payments
- Comprehensiveness of services
- Skilled delivery attendants
- Immunization coverage

At the clinical level,

- The critical structural features are Accessibility, mechanisms of Continuity/Information Systems, and the Range of Services available in primary care.
- The critical process features are Problem Recognition on the part of practitioners (both for initial problems and for reassessment), and Utilization of primary care services, both over time and for new problems as they arise.

Together, these features achieve the evidence-based **FUNCTIONS** of primary care: first contact, person-focused (not disease-focused) care over time, comprehensiveness, and coordination.

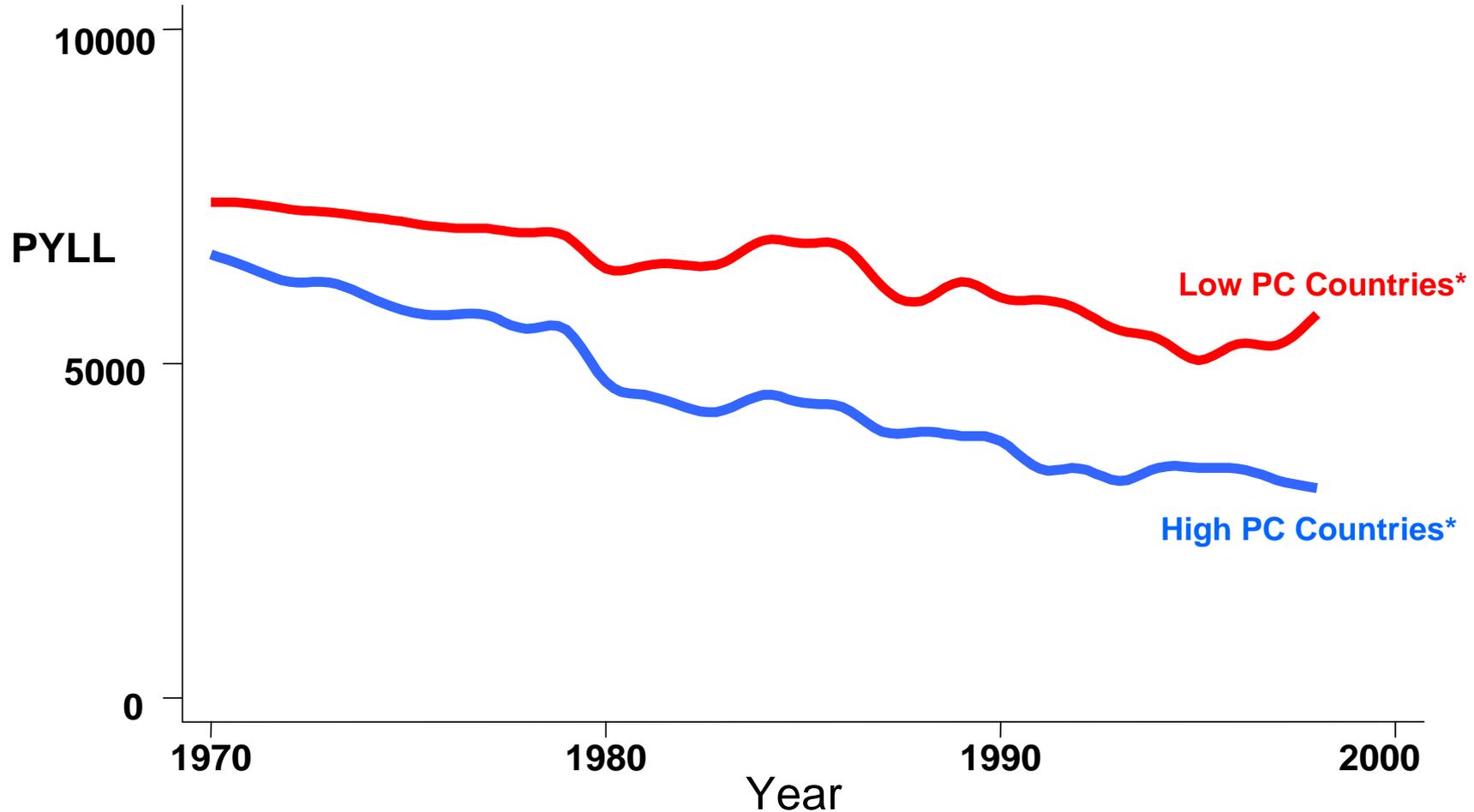
System (PHC) and Practice (PC) Characteristics Facilitating Primary Care, Early-Mid 1990s



*Best level of health indicator is ranked 1; worst is ranked 13;
thus, lower average ranks indicate better performance.

Based on data in Starfield & Shi, Health Policy 2002; 60:201-18.

Primary Care Strength and Premature Mortality in 18 OECD Countries



*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. $R^2(\text{within})=0.77$.

Many other studies done WITHIN countries, both industrial and developing, show that areas with better primary care have better health outcomes, including total mortality rates, heart disease mortality rates, and infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer, and melanoma. The opposite is the case for higher specialist supply, which is associated with worse outcomes.

In 35 US analyses dealing with differences between types of areas (7) and 5 rates of mortality (total, heart, cancer, stroke, infant), the greater the primary care physician supply, the lower the mortality for 28. The higher the specialist ratio, the higher the mortality in 25.

Above a certain level of specialist supply, the more specialists per population, the worse the outcomes.

We know that

1. Inappropriate referrals to specialists lead to greater frequency of tests and more false positive results than appropriate referrals to specialists.
2. Inappropriate referrals to specialists lead to poorer outcomes than appropriate referrals.
3. The socially advantaged have higher rates of visits to specialists than the socially disadvantaged.
4. The more the training of MDs, the more the referrals.

A MAJOR ROLE OF PRIMARY CARE IS TO ASSURE THAT SPECIALTY CARE IS MORE APPROPRIATE AND, THEREFORE, MORE EFFECTIVE.

Use of Specialists in the US

- Referral rates from primary care to specialty care in the US are HIGH.
- At least one-third and as many as three-fourths of visits to specialists are for routine follow-up.
- Percentage of people seen by a specialist in a year is high.

Resource Use, Controlling for Morbidity Burden*

- More DIFFERENT specialists seen: higher total costs, medical costs, diagnostic tests and interventions, and types of medication
- More DIFFERENT generalists seen: higher total costs, medical costs, diagnostic tests and interventions
- More generalists seen (LESS CONTINUITY): more DIFFERENT specialists seen. The effect is independent of the number of generalist visits.

*Using the Johns Hopkins Adjusted Clinical Groups (ACGs)

Source: Starfield et al, Ambulatory specialist use by patients in US health plans: correlates and consequences. Submitted 2008.

Comprehensiveness is a critical feature of primary care because it is responsible for avoiding referrals for common needs in the population and hence for saving unnecessary expenditures.

Comprehensiveness is measured by the availability in primary care of a wide range of services to meet common needs, and by demonstrating that care is, indeed, provided for a broad range of problems and needs.

In New Zealand, Australia, and the US, an average of 1.4 problems (excluding visits for prevention) were managed in each visit. However, primary care physicians in the US managed a narrower range: 46 problems accounted for 75% of problems managed in primary care, as compared with 52 in Australia and 57 in New Zealand.

Comprehensiveness in Primary Care

Wart removal	IUD insertion IUD removal Pap smear
Suturing lacerations	Tympanocentesis
Removal of cysts	Vision screening
Joint aspiration/injection Foreign body removal (ear, nose) Setting of simple fractures Sprained ankle splint	Age-appropriate surveillance Family planning Immunizations Smoking counseling
Remove ingrowing toenail	Hearing screening
Behavior/MH counseling	Home visits as needed
Electrocardiography	Nutrition counseling
Examination for dental status	OTHERS?

Family Physicians, General Internists, and Pediatricians

A nationally representative study showed that adults and children with a family physician (rather than a general internist, pediatrician, or sub-specialist) as their regular source of care had lower annual cost of care, made fewer visits, had 25% fewer prescriptions, and reported less difficulty in accessing care, even after controlling for case-mix, demographic characteristics (age, gender, income, race, region, and self-reported health status).

Joint Principles of the Patient-centered Medical Home

- Personal physician: ongoing relationship for first contact, continuous, comprehensive care
- Physician directed medical practice
- Whole person oriented
- Coordinated and/or integrated care
- Quality and safety
- Enhanced access
- Added value payment

The Proposed PC/MH (Patient-centered Medical Home)

- Electronic health record
- Patient-centered (poorly conceptualized)

Question: DO THESE “ENHANCEMENTS”
IMPROVE PRIMARY CARE?

This requires evaluation.

Any evaluation of enhancements to clinical primary care must consider the extent to which they better achieve the evidence-based primary care functions:

- First contact for new needs/problems
- Person (*not* disease) focused care (enhanced recognition of people's health problems)
- Breadth of services
- Coordination (enhanced problems/needs recognition over time)

Tensions in the Medical Home Community

Team leader?

Disease orientation?

Chronic Care Model?

Primary care characteristics as the main criteria?

Comprehensiveness?

Relationship with retail clinics?

Consistent with population-oriented primary care?

(What is the “population”?)

Is a Focus on Chronic Disease Compatible with the Patient- Centered Medical Home?

In Pennsylvania, the Governor's Office of Health Care Reform convened several health plans and physician societies in the southeastern part of the state to "institute a PCMH approach to manage the care of chronically ill patients".

To what extent is this approach consistent with the principles of population-oriented primary care and the patient-centered medical home? Who is left out?

Retail Clinics: Regressive Anachronism or Disruptive Innovation?

- Major source of savings is lower salaries for providers (nurse practitioners and physician assistants)
- Acute illness and immunizations constitute 90% of visits
- **Less** likely to be located in socially-compromised areas
- Are geared to providing access, NOT primary care
- **Might** be useful when instituted in an integrated health system

The Role of States in Improving Primary Care: The Example of North Carolina

Starting in 1988 with a demonstration project of the PCCM program in a small rural area, the physician/state collaborative program now covers 750,000 people on Medicaid (one-fourth of the state's population) and saves at least \$161 million (\$200 per person), mostly from reduced emergency department and outpatient visits and lower medication costs.

Key features are a personal physician, a network of community-based "case-managers," and collaborative quality-improvement activities.

There is no such thing as a “primary care service.” There are only primary care functions and “specialty care” functions. We know what the primary care functions are; they are evidence-based. Payment should be based on their achievement over a period of time. Any payment system that rewards specific services will distort the main purpose of medical care: to deal with health problems effectively, efficiently, and equitably.

Is it possible to evaluate primary care?

YES, but the TOOLS must address the evidence-based functions of primary care. Particularly missing from proposed evaluations is **COMPREHENSIVENESS** of care.

What States Can Do

1. Advocate for policies conducive to primary care practice at the federal level: support for primary care training and practice; eliminate disparities in clinical earnings in primary care and secondary care; greater incentives for more equitable distribution of providers
2. Support financial incentives for primary care training by medical academia (medical school and residency)
3. (Continue to) support financial incentives for loan repayment and practice in primary care
4. Provide bonuses for “medical home” practices that achieve the functions of primary care, **ESPECIALLY COMPREHENSIVENESS** of care, including
 - providing a wide range of types of services
 - low case-mix adjusted referral rates
5. Insist that evaluations address primary care functions