

Reforming Primary Care: A Comprehensive Strategy From the American College of Physicians

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Introduction

According to the American College of Physicians (ACP), the healthcare system in this country is threatened with an ominous future. Without prompt and significant changes in the way that healthcare is organized, financed, and taught in this country, the "collapse" of primary care is imminent. What will remain in its place is an increasingly fragmented jumble of poorly coordinated subspecialized services, even higher costs for even lower quality of care, reduced access, rising inefficiency, and more patient dissatisfaction.

They have a point. Current government and private reimbursement programs are built on a system of episodic treatment for acute illness. There is little support for chronic care management, cross-disciplinary care coordination, or even many preventive services. However, approximately 45% of Americans are living with a chronic condition, and half of these have multiple chronic conditions.^[1] For the Medicare program, 83% of beneficiaries have 1 or more chronic conditions and 23% have 5 or more.^[2] Within 6 years, the first wave of 76 million baby boomers will become eligible for Medicare. The number of adults aged 65 and older is expected to grow 54% between 2000 and 2020, and those over 85 will grow by 50% between 2000 and 2010.^[3] In 2000, physicians spent about 32% of their clinical time taking care of older adults; by 2020 they are expected to spend closer to 40%.^[4] It is anticipated that the demand for general internists will increase by 38% between 2000 and 2020.^[4] However, will there be an adequate supply of well-trained primary care physicians to meet this increasing demand produced by a changing American demographic and a much needed shift from acute to chronic care? Probably not.

In 2005, only 13% of first-year internal medicine residents planned to pursue careers in primary care. Among third-year residents, only 20% planned to practice general internal medicine, a drop from 54% only 7 years earlier.^[5] Primary care track internal medicine residency enrollment declined by 46% from 1999 to 2004.^[6] Also, according to a survey among internists who were board-certified in the early 1990s, 21% of those practicing primary care left practice entirely, compared with only 5% of subspecialty internists.^[7]

This dramatic decrease in the primary care workforce is offset by an increase in the number of most other subspecialties. Why not rely more heavily on these competent physicians to perform the tasks that have been traditionally assigned to generalists? The ACP flatly rejects this approach, arguing that it would inevitably lead to poorer quality, higher costs, reduced access to needed services, and worsening patient satisfaction. They point out that states with more primary care physicians per capita have better health outcomes, including reduced mortality from cancer, heart disease, and stroke.^[8,9] Areas with more specialists have higher per capita Medicare spending,^[10] and an increase in the number of primary care physicians is associated with a higher quality of care and lower costs among Medicare beneficiaries.^[11] Hospitalization rates and expenditures are higher for ambulatory care-sensitive conditions in areas with limited access to primary care,^[12] and studies have consistently shown that the vast majority of Americans prefer to have a long-term relationship with a single primary care provider.^[13]

One solution to the pending shortages in primary care internists is to rely more heavily on other

generalists, most notably family physicians, who are similarly trained to comprehensively care for adults, and all other patient populations. Even though the ACP largely, and understandably, sidesteps this issue, its feasibility is questionable because all primary care disciplines (internal medicine, family medicine, pediatrics, and obstetrics/gynecology) are struggling with the same undersupply problems.

The ACP is "profoundly concerned" about the looming collapse of primary care, and believes that it has the authority, credentials, and responsibility to publicize the crises and propose solutions. The ACP is the nation's largest medical specialty society representing 119,000 medical students and internists who take care of more Medicare patients than any other physician specialty. In a series of 3 position papers presented at their 2006 Annual Session in Philadelphia, Pennsylvania, the ACP laid out a detailed proposal that is intended to save primary care and meet the increasingly complex healthcare needs of a rapidly aging population. The proposals include:

- Creating a new national workforce for internal medicine;
- Reducing student debt and redesigning training for internal medicine; and
- Reforming the dysfunctional healthcare payment and delivery system.

The policies contained therein build on the concept of an "advanced medical home" that the ACP proposed in a paper that was released earlier this year. All of the position papers are available for review at the [ACP Web site](#).

Creating a National Workforce for Internal Medicine

Governments of countries with a single-payer system have the leverage to centrally control their healthcare workforce. The United States, without a single funding source, has no comprehensive way to manipulate the training, supply, and distribution of healthcare workers. For example, the number and types of healthcare professionals being trained bear little relation to national healthcare requirements. Instead, they are largely determined by the availability of training programs, the number of applicants to these programs, and the inpatient service needs of academic medical centers, an especially poor indicator of ambulatory care resource requirements. According to the ACP, only a national healthcare workforce policy can adequately address the gaping discrepancy between the healthcare needs of an aging population and the professionals who are available to deliver this care. Any such workforce policy should include a number of key features.

A Comprehensive Plan to Attract Medical Students and Residents Into Office-Based, Primary Care Careers

This could be accomplished by changing the reimbursement policies that currently undervalue primary care services, providing relief from high levels of student debt and offering exposure of medical students and residents to contended role models who are delivering high-quality care in well-functioning, primary care practices.

Recognition and Support of the Critical Role Played by Subspecialists, Hospitalists, and Geriatricians

When it comes to prevalent chronic conditions, such as hypertension and diabetes, the evidence suggests that primary care physicians can deliver the same quality of care as specialists, often

with fewer resources. Nevertheless, high-quality care for complex conditions depends on a partnership between generalists and specialists. In some cases the specialist, most notably the geriatrician, may be in the best position to provide both primary and specialized care for elderly patients who are beset with multiple, problematic conditions.

An Increase in the Number of General Internists Trained to Practice Patient-Centered Medicine According to the Chronic Care Model

The current system is almost completely based on episodic, illness-oriented care, which emphasizes the resolution of acute symptoms over the long-term care of patients. This approach needs to be replaced by a new system that is built on patient-centered, physician-directed longitudinal care focused on preventive and coordinated services. This will require an up-front investment in training and information technology designed to enhance practice quality, accessibility, and efficiency. The widespread adoption of the ACP's *advanced medical home* model (see below) would predictably attract more physicians into primary care if they were fairly compensated for their increased efforts at care coordination, continuity, and quality improvement.

Collaborative Teams That Value the Essential Contributions of Nurse Practitioners and Physician Assistants

The ACP supports the expanded roles of nurses, nurse practitioners (NPs), and physician assistants (PAs) in the management of noncomplex cases. However, they should not be viewed as a substitute for the comprehensive care provided by physicians who possess the training and experience to handle the complexities of chronic disease management. On the other hand, primary care physicians cannot be expected to successfully provide the highest quality care alone, and should work as leading members of a team that includes nurses, PAs, social workers, ancillary personnel, subspecialists, and case managers when necessary.

Judicious Use of International Medical Graduates to Meet the Needs of a Changing American Demographic

Most international medical graduates (IMGs) choose internal medicine over other specialties, and many rural and underserved communities rely on them to provide otherwise unavailable services. In a national healthcare workforce policy, the annual number of IMGs who are admitted to US residency programs could be adjusted up or down to compensate for shortages or surpluses of domestic physicians. The ACP cautions that IMGs should not be relied on as the only means to address the chronic shortage of primary care physicians in the United States.

Reducing Student Debt and Redesigning Training for Internal Medicine

Reducing Student Debt

A variety of factors contribute to the precipitous decline in medical student and resident interest in primary care. At the end of the day, though, it comes down to economics. Over 80% of graduating medical students are in debt. The median debt burden is now over \$100,000 for graduates of public medical schools and \$135,000 for private school graduates. About 5% of medical students can expect to carry a total debt of \$200,000 or more. Unsurprisingly (yet most disturbingly), students whose debt exceeds \$150,000 are less likely to select a primary care residency.^[14] To attract increasing numbers of medical students and residents into primary care, it will be necessary to do 1 of 2 things: Provide considerable debt relief or substantially increase

generalists' income (or some combination of both).

The ACP proposes several options to reduce the burden of debt:

- Expand existing federal loan repayment programs that encourage careers in primary care;
- Create new loan repayment and forgiveness programs with the same goal; and
- Defer educational loan repayment to ease the financial burden on indebted graduates. (Increasing the income of primary care physicians will be taken up later.)

Redesigning Training for Internal Medicine

In addition to addressing student debt, the ACP believes that substantial changes in undergraduate and graduate training programs could serve to entice students into primary care careers. At the undergraduate level, students must be given as much time as possible to explore all career options that encompass internal medicine so that they can make an informed choice well before their final year. It is essential that ambulatory training occur in patient-centered, service-oriented practices that are staffed by enthusiastic role models -- faculty *and* residents -- who are upbeat about their careers in internal medicine. Students should become familiar early on with the systems that are necessary to produce high-quality, safe, and efficient care, and then see those same systems in action in well-functioning practice environments.

At the graduate level, the ACP makes the following recommendations for redesigning internal medicine training.

First, the 3-year residency model should be maintained, but include 2 years of "core" training and 1 year of customized experiences tailored to residents' specific career goals. Future hospitalists, for example, would spend their final year largely in an inpatient environment, whereas future ambulatory care specialists would spend most of their time serving outpatients.

Second, the educational needs of residents must come first. Institutions need to realize that the primary purpose of any residency training program is the education of its residents, not the service needs of the institution.

Third, equal (or near equal) emphasis should be placed on inpatient *and* outpatient training. Despite the shift to ambulatory care, internal medicine training is still largely based in the hospital. When residents do see outpatients, they tend to view them as a distraction from their "real" responsibilities in the hospital. Moreover, many hospital-based ambulatory care facilities are dysfunctional teaching clinics that serve to frustrate rather than inspire residents who work there. To address this issue, residents should have longitudinal ambulatory care experiences in efficiently run community practices as part of a block schedule that is entirely devoted to outpatient care.

Fourth, team-based care, as previously discussed, should be incorporated into residency training. In addition to nonphysician health professionals, the teams ought to include other trainees and even faculty. This approach is particularly attractive because it can provide staffing flexibility.

Fifth, residency programs should develop and support a core faculty who are given sufficient

time, financial remuneration, and institutional recognition for teaching. These expert clinical educators should not only be skilled practitioners, but competent instructors, evaluators, mentors, and role models. In addition, they should have some training in system-based care.

Sixth, both faculty and trainees should conduct themselves according to the highest levels of professionalism, and should constantly model this behavior in their interactions with patients, medical students, and colleagues.

Reform of the Dysfunctional Healthcare Payment and Delivery System

According to the ACP, inadequate and counterproductive payment and delivery systems are the primary forces accelerating the collapse of primary care. To drive home this point, they identify several Medicare policies that are antithetic to a thriving primary care system:

- Undervaluing clinical evaluation and management services predominately provided by primary care physicians while overvaluing more technical services and procedures provided by specialists;
- Offering no payment for services that are necessary to the provision of patient-focused, longitudinal, and coordinated care;
- Using an annual fee update formula (ie, the sustainable growth rate) that has a disproportionately adverse impact on primary care physicians; and
- Providing incentives for volume of service rather than the quality or efficiency of care.

In a highly detailed 12-point treatise, the ACP proposes a series of "modest" changes to the Medicare physician payment and delivery system that could reverse the slide toward primary care's demise. They focus on Medicare because it is the largest purchaser of healthcare in the country and serves as the standard for health plan policies in the private sector. Here is a synopsis of their recommendations, which they divide into 4 sections.

Ensuring Accurate Valuation of Physician Services

Misvalued services result in overuse of unnecessary and potentially harmful services and may encourage the insufficient use of necessary and beneficial services. The inappropriate valuation of clinical evaluation and management (E/M) services, which are the bread and butter of primary care, is driving physicians away from the field. The yearly compensation for primary care specialists (ie, family medicine, general pediatrics, and general internal medicine) is 40% lower than most other specialist physicians.^[15] The E/M services provided by primary care physicians typically require a time-consuming, cognitive process consisting of a face-to-face meeting with the patient, history and physical exam, diagnostic deliberations, patient counseling, and coordination of follow-up services. This is in contrast to the time-limited, technical procedures that are commonly provided by other specialists. The current Medicare payment system significantly undervalues E/M services, which disproportionately affect primary care physicians. Among other proposals to address this issue, the ACP takes the position that the Center for Medicare and Medicaid Services (CMS) should increase the relative value units assigned to E/M services and develop a better process for identifying misvalued relative value units in the future.

Providing Separate Medicare Payments for Services That Facilitate Accessible and

Coordinated Care

Currently, Medicare only pays physicians for services provided during face-to-face encounters with patients. It does not reimburse for the use of telephone, email, or related technologies to care for patients. Encouraging physicians to communicate with their patients beyond the confines of their offices enhances practice accessibility, convenience, and efficiency. Physicians can respond remotely to nonurgent questions and reserve time-intensive office visits for those patients who are in most need of direct care. Medicare also does not provide reimbursement for care coordination across treatment settings, which are necessary to ensure the provision of well-integrated, longitudinal, and comprehensive services. Finally, Medicare does not offer incentives for physicians to use health information technology (HIT) in their practices. HIT, which is especially relevant to primary care because it supports activities that are essential to evidence-based practice and coordination of services, and includes electronic health records, patient registries, lab and consultant follow-up, patient self-managements tools, point-of-care decision support, and assessment of physician compliance with quality and treatment guidelines. The ACP takes the position that CMS should provide reimbursement for activities that facilitate timely communication, care coordination, and improved quality through HIT adoption and implementation.

Adding a Quality Component to the Medicare Payment System

Medicare contributes to the healthcare quality deficit in this country by providing reimbursement for procedures and other services regardless of their contribution to quality care. A thoughtfully conceived and implemented pay-for-performance (P4P) system would not only improve quality, but financially reward practices that invest the resources that are necessary to provide quality care and report on their performance. Any P4P systems should (1) recognize the level of work and commitment to quality, which will differ among physicians and across specialties; (2) rely on valid quality measures and reliable reporting mechanisms; (3) value HIT for its ability to assist in measuring quality and reporting on progress; and (4) provide positive rewards, not negative penalties, for demonstrable quality improvement. The ACP takes the position that CMS should provide financial incentives for physicians to participate in continuous quality improvement programs.

Replacing the Sustainable Growth Rate Formula and Introducing Alternative Payment and Delivery Models

The current Medicare payment system is based on the sustainable growth rate (SGR) payment formula. Congress implemented this formula in order to contain the considerable increase in the volume of Medicare-reimbursed services that are provided by physicians. Since its implementation in 2000, this payment system has been unable to control service volume and has led to mandated cuts in physician payments since 2002, which Congress has negated in all years except 2002. Primary care physicians are preferentially harmed by SGR mandated cuts and inadequate updates because of their relatively low reimbursement, low practice margins and fixed costs, and little or no ability to offset cuts by increasing volume. Congress is interested in replacing the ineffective SGR methodology. The ACP takes the position that any alternative payment and service delivery system should provide support for primary care physicians to do what they do best: Provide efficient care coordination of patients with multiple chronic conditions. The new methodology should provide P4P incentives for quality measurement and reporting, allow physicians to share in systemwide savings, and accommodate investments in HIT to support cost-efficient, quality improvement.

The Advanced Medical Home

The forgoing recommendations all rest on a comprehensive care model that the ACP proposes as a solution to the growing litany of intractable problems conspiring to doom the US healthcare system. The advanced medical home is a highly structured, patient-centered model of care anchored by a competent team of health professionals who are committed to the active, coordinated involvement of well-informed patients. The team is led by a physician who specializes in the management of complex, chronic conditions. This model is nothing new. Similar models have been proposed by pediatric and family medicine organizations. The ACP builds on this model by placing it in the context of a redesigned reimbursement system that supports primary care.

Physicians adopting the advanced medical home structure would engage in the following key practices:

- Use evidenced-based medicine and decision support tools at the point of care;
- Organize care according to the Chronic Care Model,^[16] adapting its core functions for both acute and chronic care;
- Encourage patients to engage in self-management and provide them with the resources and support that they need to be successful;
- Provide enhanced and convenient access by supplementing face-to-face visits with the use of telephone, email, and other communication technologies;
- Identify and measure key quality indicators to demonstrate continuous quality improvement;
- Implement the use of HIT to support patient education, patient care planning, coordination of care, and monitoring of performance; and
- Participate in programs that provide feedback and guidance on overall practice quality.

Unlike disease management programs, the care and coordination of services in the advanced medical home are performed by the patient's physician and his or her healthcare team, rather than a case manager who is in charge, but may only occasionally (if ever) consult the physician.

Except in integrated group practices that are largely funded through prepayments (ie, concierge practices), the current reimbursement system in the United States does not support the infrastructure that is necessary to implement, let alone maintain, this model of care. There are no financial incentives for practices to move from away from the volume-based, episodic, fee-for-service payment system currently in place. The ACP is working on developing a revised payment model that would support the advanced home model, a necessary step if it is to be widely adopted. Their detailed positions on reforming the dysfunctional payment and delivery system can be viewed as a significant step in that direction.

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