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Health Systems and Primary Care: Time to Catalyze Change

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Health systems across the United States have done a good job of getting larger, but generally do a poor job integrating clinical care. As a result, little progress has been made at achieving the highly touted "Quadruple Aim" of healthcare: higher quality and better population health, lower costs, a more patient-centered focus, and better practitioner well-being.

There is an extensive body of literature attesting to the importance of primary care as a driver and linchpin of these important societal goals and a high-functioning, integrated healthcare system. Now that community health systems have become a leading employer of primary care practitioners (PCPs) in the United States, they own significant responsibility for making primary care successful.

The Current Primary Care Landscape

Most health systems do not acquire primary care physicians and their practices to facilitate a transformation of care. Rather, they do so to feed patients to specialists who perform revenue-generating activity for health system hospitals. This was true in the 20th century's managed care decades when hospitals bought primary care practices to capture "covered lives" and approve specialty referrals and hospitalizations. When the managed care model waned, many hospitals divested themselves of their owned primary care practices and doctors. In more recent years, hospitals again began to aggressively employ primary care doctors as competition between health systems grew and the need to feed patients to a growing cadre of employed specialists and high-cost service lines has become critical to financial stability.

While a majority of the nation's primary care doctors are now employed, this has not generally improved their personal or professional circumstances. Levels of burnout

are at historic highs, PCPs are amongst the most poorly compensated doctors and the most burdened by educational debt, their measures of engagement are distressingly poor in many health systems, and recruitment of new practitioners to primary care specialties is—not surprisingly—a struggle. The country's experience with the COVID-19 pandemic has not only highlighted the inadequacy of our public health infrastructure, but also the fragility of our primary care matrix and its poor integration with community-based agents of population health. Primary care is chronically under-resourced, accounting for 35 percent of the nation's healthcare visits but receiving only 5 percent of healthcare expenditures. While health systems struggle to recruit PCPs (relying more and more on non-physicians to carry the primary care workload), it has been observed that the country's health system has a crumbling foundation

➜ Key Board Takeaways

- To promote a high level of integration and achieve the Quadruple Aim, start by transforming the organization's historic approach to primary care practitioners.
- Work with management to move primary care practitioners off of productivity compensation models and engage these clinicians in substantial redesign of workflows and care delivery.
- Encourage modest increases in financial resources to support primary care. This can promote significant improvements in morale and the energy and initiative that primary care clinicians devote to creating a truly integrated health system enterprise. Only a fraction of financial resources in most health systems currently supports primary care.
- Push for more interprofessional, integrated, team-based care led by primary care physicians. Healthcare in America is characterized by delivery systems that are highly siloed and typically deliver fragmented, poorly coordinated care.
- Urge management to provide the time and resources primary care practitioners need to work with community groups and build collaborative initiatives to improve health. Population health is on the radar scope of most health system boards in 2021. Building bridges with community organizations is often best done by primary care practitioners who are trained to be attentive to the social, psychological, and the physical needs of patients.

where "…visits to primary care clinicians are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative healthcare fields."[1]

Transforming Healthcare through Primary Care

Given this background, the National Academies of Sciences, Engineering, and Medicine (NASEM) recently issued the findings of its Committee on Implementing High-Quality Primary Care.[2] Since there is well-established evidence supporting claims that properly deployed primary care can transform healthcare in positive ways, the NASEM gave its committee the specific charge to develop an implementation plan to carry out recommendations promulgated by previous Institute of Medicine consensus groups.[3]

The NASEM committee notes that, **"High-quality primary care is the provision of whole-person, integrated, accessible, and equitable healthcare by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."** This is not primary care as it is found in most health systems today. While a few health systems have facilitated the certification of their primary care practices as "patient-centered medical homes," most put an emphasis on throughput and provide compensation based on productivity algorithms. The primary care doctors in these systems are constantly told they don't generate revenue to cover their salaries, are harangued to increase patient volumes, and are overwhelmed by poorly designed electronic health records whose completion devours inordinate amounts of their professional and personal time. When well-intentioned health system leaders suggest that their employed PCPs do more to facilitate the Quadruple Aim, this message falls on the deaf ears of practitioners too exhausted and burdened to contribute to secondary goals vocalized, but not prioritized by health systems. In many health systems, primary care offices act, explicitly or implicitly, as urgent care centers designed to capture patients for referral to hospital specialists and services.

In its recent report, the NASEM consensus committee makes the following observation:

1 National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, 2021.
2 *Ibid.*
3 For example, see the 1996 IOM report, *Primary Care: America's Health in a New Era*, which made extensive recommendations for reforming and strengthening primary care, most of which were never carried out.

Many health systems providing primary care services through employed or contracted models have accepted global capitated payments but continue to operate and compensate primary care on an FFS model, blunting the effects of models intended to strengthen primary care. Health systems in these arrangements should honor the intentions of payers and evidence of superior performance, seeing that new payment models allocate sufficient management authority and resources to the practice of primary care.

Facilitating Change: The Board's Role

What can health system boards do to facilitate stronger primary care in their delivery networks and in the communities they serve?

As health systems enter into more risk-bearing contracts with population-based health and cost accountabilities, boards should push management teams to deploy greater financial resources to their employed or contracted primary care teams. For example:

- Ask how management is providing adequate incentives for PCPs to engage in and lead interprofessional, integrated, team-based care.
- Review physician compensation plans to see how they can support PCPs in fostering partnerships with community-based organizations.
- Explore the institution of loan repayment plans specifically designed for PCPs (carefully crafted, of course, to comply with fraud and abuse regulations). Because primary care doctors are compensated at lower amounts than specialists, the burden of educational debt falls more heavily on their personal lives.

Health system boards can also work with primary care physician leaders to understand how current productivity compensation models can be significantly modified so that instead of driving an "urgent care" high throughput model, they instead drive the vision of primary care described by the NASEM report referenced above.

The board and management should not just hand down edicts and hope that primary care doctors respond as they anticipate. Primary care practitioners need to be engaged in wide-ranging discussion regarding how to redesign care delivery in the health system to achieve the Quadruple Aim. These discussions should not simply occur at a management level where ideas so often go into the "black hole" of traditional care. Unless it is clear the board wants to entertain truly transformational changes, traditional incentives doom change and most primary doctors have long ago

learned to have low expectations from their health systems. This in turn undermines engagement, retention, and recruitment.

Where the health system has a large employed multi-specialty collection of practitioners, it should strive to ensure that all patients with a health system specialty attending are also assigned to a primary care practitioner. The latter can then serve to coordinate the patient's care throughout the system and drive team care that is truly integrated. But health systems cannot just assign this task to PCPs and expect transformative results without working with these doctors to redesign their daily workflows, reorder priorities, and reallocate resources.

Today, an increasingly voiced critique of health systems is that their growth in size drives up healthcare costs but does not generally result in superior care for individuals or populations. If governing boards want their health systems to be effective engines of transformation in healthcare, commitment to a substantive redesign of primary care is a good place to start.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. *He can be reached at tsagin@saginhealthcare.com.*