

Preserving Primary Care Robustness Despite Increasing Health System Integration

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Small and solo family medicine practices remain a vital part of the health care landscape, but many are joining larger health systems or choosing employment.^{1,2} While most graduating family medicine residents feel prepared for and want a broad scope of practice, most are choosing employment, and many cannot find positions that let them exercise their full training.³ These findings about increasing migration of primary care physicians to larger health systems and hospital employment, are concerning as they may reduce ability of primary care to deliver the functions associated with better outcomes seen in small, physician-owned practices.⁴ Primary care physicians delivering greater comprehensiveness of care are associated with lower costs for Medicare beneficiaries.⁵ Primary care is more comprehensive in rural practices and in areas with more family physicians. At the other end of the spectrum, another recent study found that hospital-based practices provided more low value care than community-based practices, and hospital-owned community-based practices made more specialty referrals than physician-owned community-based practices.⁶ As family physicians increasingly work in hospital-led health systems where the primary goal is often directed at increasing efficiency and throughput rather than scope or effectiveness, there is reasonable concern that family medicine may not be poised to deliver its most desirable functions at the very time the health system is pivoting to value-based care.⁷ Working in such vertically integrated systems could purposefully enable primary care to become more robust and effective, but

instead it is often incentivized to shore up a pipeline of patients to more lucrative services.

Health system integration should not be confused with team-based care. There is growing evidence that family medicine teams, done well, can increase practice scope, support better primary care, and improve outcomes.⁸ If the members of the team are allowed to work to the top of their training, offload unnecessary work from other team members, and avoid duplicative work, it can improve outcomes and enhance joy in practice.⁹ While fee-for-service payments often force physicians, nurse practitioners and physician assistants into highly overlapping roles, capitated, population-based, and blended payment models allow them to increase role differentiation and broaden the skills and scope of the team.¹⁰ Adding behavioral health providers, social workers, care coordinators, community health workers, scribes, and pharmacists can further enhance outcomes and reduce unnecessary care. If, as Sinsky and Bodenheimer suggest, these team members can also offload work from physicians, doctors can spend more time with patients, perform more procedures they would otherwise refer, and even return to caring for patients in the hospital.⁹ Preliminary analysis of the 2016 American Board of Family Medicine Graduate Survey (all diplomates 3 years out of training) suggests that broad scope of practice may be protective against burnout. So teams that support broad scope with all team members contributing meaningfully to

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patient care may be good for patients and clinicians. There are also mature models for small practices that may not be able to afford to add team members to their own practices, but can share community-based social workers, care managers, and behavioral health providers to support broader scope and improve outcomes.^{11,12}

One risk to reduction in family medicine scope are employers that don't understand or respect the power of primary care to improve outcomes and lower costs. There are good examples of physician-led Accountable Care Organizations (ACOs) and Medicare Advantage plans that offer better support to primary care and enjoy better outcomes.¹³⁻¹⁵ However, many hospitals and ACOs are still hedging their bets about value-based payments, have sizeable investments in subspecialty infrastructure to feed, have cultural biases, or all the above. This often translates into thinking primary care is a simple service that should efficiently push patients to higher cost services rather than provide the real value.^{7,16} These are sizeable barriers to the type of conversion needed to avoid erosion of what primary care contributes toward the goals of the Triple Aim for health care. This problem is compounded by the fact that many primary care physicians are trained in hospitals where they are "imprinted" with behaviors, including scope, that make them high cost physicians regardless of where they end up practicing for many years.^{17,18} Convincing hospitals and health systems to invest in or otherwise support robust primary care functions could, therefore, prevent the loss of primary care value as they employ physicians, and create a legacy of high-functioning primary care from their training programs.

Another concerning reason that family medicine continues down this path is, frankly, acceptance of a path of least resistance. Many of our elder statesmen "go along to get along." Whether it is lifestyle choices or burnout, it is tempting to trade scope reduction for stable salary and hours. Likewise, family medicine leaders may find it easier to give in to the systemic pressures to pull their faculty or staff out of obstetrics and inpatient care. Unfortunately, these choices lead to the "foil" definition of family medicine produced at the launch of Family Medicine for America's Health.¹⁹ These choices lead to a collective, cultural forgetting of the specialty's origins, which turns out to be what the health system writ large most need from it now. The founding generation of family

physicians took major personal risks to build the field in which we now work. Now is not the time to choose short term convenience.

Whatever emerges from the turmoil around health reform, the Quality Payment Program and other value-based payment models are likely here to stay. Hopefully, this policy focus on reducing costs and improving health and health care will continue to enhance the role of robust and comprehensive primary care. The Family Medicine for America's Health effort cautioned up front that "Making primary care more robust is a major cognitive shift, and ... [A] change of this magnitude will be threatening and difficult for many." That caution was as much about primary care as health systems. The ABFM is working to support this shift and shore up the role of the specialty to improve patient and population health.²⁰

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