HEALTH POLICY

A 2020 Vision of Patient-Centered Primary Care

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Patient-centered care has received new prominence with its inclusion by the Institute of Medicine as 1 of the 6 aims of quality. Seven attributes of patient-centered primary care are proposed here to improve this dimension of care: access to care, patient engagement in care, information systems, care coordination, integrated and comprehensive team care, patient-centered care surveys, and publicly available information. The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care finds that one fourth of primary care physicians currently incorporate these various patient-centered attributes in their practices. To bring about marked improvement will require a new system of primary care payment that blends monthly patient panel fees with traditional fee-for-service payment, and new incentives for patient-centered care performance. A major effort to test this concept, develop a business case, provide technical assistance and training, and diffuse best practices is needed to transform American health care.

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Patient-centered primary care is beginning to take root. The Institute of Medicine (IOM) includes patient-centered care as 1 of 6 domains of quality.[1] Yet, the IOM also notes that a chasm exists between the kind of care that patients receive and the kind of care they should have, and calls for fundamental change in the system of care. It further argues that these changes would both be better for patients and make the provision of care more satisfying for clinicians.

A VISION FOR PATIENT-CENTERED PRIMARY CARE PRACTICE

The authors have already advanced a "2020 vision" for American health care.[2] It includes automatic and affordable health insurance for all, access to care, patient-centered care, information-driven care that is based on scientific evidence and supported by clinical information systems, and commitment to quality improvement and betterment of health outcomes by everyone in the health care sector. Patient-centered care is a key component of a health system that ensures that all patients have access to the kind of care that works for them.

Research by the Picker Institute has delineated 8 dimensions of patient-centered care, including: 1) respect for the patient's values, preferences, and expressed needs; 2) information and education; 3) access to care; 4) emotional support to relieve fear and anxiety; 5) involvement of family and friends; 6) continuity and secure transition between health care settings; 7) physical comfort; and 8) coordination of care.[3] Although these dimensions were originally applied to hospital-based care, they could apply equally to care in the ambulatory setting.

In 1998, attendees at a conference in Salzburg, Austria, developed a self-described utopian vision for a patient-centered health care system.[4] In this ideal world, the clinician-patient relationship is enhanced by "computer-based guidance and communications systems"; medical records are internet-based and available everywhere; and patients regularly complete surveys on their experiences, which are then fed back to clinicians in "real time" so they can improve care. In addition, patients and their clinicians form a contract about quality of care that sets out individual and joint goals appropriate for the patient and her/his condition(s); performance is then measured against those goals and aggregated for both clinicians and patients. Another attribute of this system is that community leaders work with clinicians to integrate community resources with clinical care. Finally, patient advocates are represented in the health care legislative, regulatory, and financing processes.

Berwick[5] has popularized the slogan adopted by the Salzburg group, "Nothing about me without me." Quality is often defined as providing the right care in the right way at the right time, but a patient-centered vision would define quality as providing the care that the patient needs in the manner the patient desires at the time the patient desires. Because both patients and physicians desire good health outcomes, sometimes these 2 definitions are identical. Economists have talked about the physician as patient's agent—providing the care the patient would want if the patient had the information that the physician has. But increasingly, patients wish for direct access to that information, the ability to be active partners in their care, and the opportunity to share in treatment decisions.[6,7]

Making significant strides toward a health system that is more responsive to patients' preferences, needs, and values will require substantially more attention to learning about those preferences from the patient's perspective. One place to start is learning more about how patients view the care they receive from their primary care clinicians, how well that care is addressing their concerns, and what changes in practice would be most effective in achieving patient-centered primary care. Currently, however, only 36% of primary care physicians systematically receive patient survey data that would provide valuable feedback.[8] A major initiative focused on patient-centered primary care research, outreach, and intervention would help make the IOM recommendations a reality.

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ATTRIBUTES OF PATIENT-CENTERED PRIMARY CARE PRACTICES

While there is considerable consensus about the definition of patient-centered care and a vision for what it would look like, much less is known about what kinds of primary care practice attributes or patient services are most likely to yield experiences valued highly by patients. To stimulate research and further discussion, we propose that a patient-centered primary care practice would have most of the following characteristics:

1. *Superb access to care*: ease of making an appointment; ability of patients to select the day and time of their appointment themselves; timely appointments; short waiting time in office; timely response to e-mails and telephone calls; efficient use of physician and patient time; e-mail and telephone visits when they are an appropriate substitute for in-person care; electronic prescription refills; and an off-hours service that makes primary care readily accessible on nights, weekends, and holidays.
2. *Patient engagement in care*: option for patients to be informed and engaged partners in their care, including a recasting of clinician roles as advisers, with patients or designated surrogates for incapacitated patients serving as the locus of decision making (when desired by patients); information for patients on condition/treatment options/treatment plan; clear delineation of roles and responsibilities for patients, caretakers, and clinicians; patient reminders/alerts for routine preventive care or when special follow-up is necessary (e.g., abnormal test results, or changes needed in dosage of a medication); patient access to their medical records and their ability to add or clarify information in the record; assistance with self-care; assistance with behavior change; patient education; and anticipatory guidance and counseling for parents on child health and development issues.
3. *Clinical information systems that support high-quality care, practice-based learning, and quality improvement*: registries; monitoring adherence; ease of access to laboratory and diagnostic test results; physician and patient reminders/alerts; decision support for physicians and patients; information on recommended treatment plans; and longitudinal charts on risk factors/use of services/outcomes.
4. *Care coordination*: coordination of specialist care, including systems that monitor whether recommended referrals take place; prompt feedback of specialist consultation reports to primary care physicians and patients; information about the availability and quality of specialty services and community resources; systems to prevent errors that occur when multiple physicians or sites are involved in care; posthospital follow-up and support; tracking of tests, test results, procedures, and the filling of prescriptions to monitor patient adherence to mutually agreed-upon diagnostic and treatment plans; and communication among health care providers who care for a patient but do so in different geographic locations or at different times.
5. *Integrated, comprehensive care and smooth information transfer across a fixed or virtual team of providers*: including physicians, advanced practice nurses, nurses, and others, as needed (e.g., social workers, nutritionists, health educators, exercise physiologists, and behavioral health specialists), and elimination of duplication of information and testing.
6. *Ongoing, routine patient feedback to a practice*: using, for example, low-cost, internet-based, patient-centered care surveys, leading to targeted plans for practice improvement. Such surveys following a patient encounter or episode of care could be used by the physician or practice to understand what went right or wrong from the perspective of the patient and suggest opportunities for improvement. An engaged patient is more likely to be compliant, to understand his or her condition, and thus more likely to have a better quality of life and satisfaction with the health care system.[9]
7. *Publicly available information on practices*: information by which a patient could choose a physician or a practice most likely to meet the patient's needs, and physician directories meeting National Committee for Quality Assurance (NCQA)-recommended standards (e.g., information about credentials, office locations, hours of practice, age, gender, race, quality of care, patient experiences with clinician, and peer assessment of practices).[10]

Certainly, these concepts are not revolutionary, but consistent with recommendations by experts and primary care professional organizations over the last 25 years. Twenty-five years ago, Malcolm L. Peterson, on behalf of the American College of Physicians, ascribed 4 unique attributes to primary care: accessible, comprehensive, coordinated, and continuous.[11] This has been elaborated slightly over time, but still remains at the heart of professional recommendations. For example, the IOM defines primary care as: "the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[12] Starfield advanced the measurement of primary care by setting forth 4 structural elements of the health services system (accessibility, range of services, eligible population, and continuity) and 2 process features (utilization of services by the population and recognition of problems by health service practitioners).[13] More recently, Showstack et al.[14] set out 7 core principles to guide the renaissance of primary care: health care organized to serve the needs of patients; the delivery of the highest quality care as documented by measurable outcomes; information and information systems; redesign of health care systems; redesign of the health care financing system to support excellent primary care practice; revitalization of primary care education; and the continual improvement of primary care. Safran[15] in particular has called for creating sustained clinician-patient partnerships and providing care that is oriented to the whole person. She has stressed the importance of teams, primary care as a contract with patients, and integration of care.

The Society of General Internal Medicine Task Force on the Domain of General Internal Medicine stressed teams, information systems, and financial incentives to improve quality and efficiency in the provision of comprehensive, ongoing care.[16] The Future of Family Medicine Project Leadership Committee developed similar themes, calling for a new model of practice that provides patients with a medical home and an expected basket of services, including a patient-centered team approach, elimination of barriers to access, advanced information systems including an electronic health record, redesigned, more functional offices, a focus on quality and

outcomes, and enhanced practice finance.[17] The American Academy of Pediatrics was an early leader in calling for the medical home concept.[18,19]

PIE IN THE SKY OR WAVE OF THE FUTURE?

To many primary care physicians pressed for time and financially strapped by inadequate payment systems, this list of patient-centered care practice attributes may seem overwhelming. However, nearly all primary care practices already incorporate some of these attributes into their practices, and about one fifth of primary care practices incorporate the majority of them (A.M. Audet, unpublished data, 2004). The authors have separately analyzed The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care, a nationally representative survey of direct patient-care physicians.[8] Some indication of the ease and feasibility of incorporating these attributes may be obtained by examining the relative frequency with which they now occur.

Three fourths of primary care physicians now make same-day appointments available. Seventy percent of primary care physicians receive timely feedback from specialty referrals. The great majority support making medical records available to patients and support team-based care. About half have patient reminder systems (although only one fifth are automated systems). Two in 5 primary care physicians can create disease registries of patients with ease.[8]

Some practices occur less frequently even though they are relatively inexpensive. For example, only 16% of primary care physicians communicate with patients by e-mail.[8] This may have more to do with a "cultural barrier" of sharing information and providing transparency to patients even though patients would value the information and flexibility.

The 2 most expensive innovations in medical practice occur relatively infrequently. Only about one fourth are currently using electronic medical records, and slightly more than one third obtain patient survey feedback.[8] While precise cost estimates are not available, each is likely to cost primary care physicians tens of thousands of dollars with current technology, although future developments may markedly lower these costs.

Finally, the attributes of patient-centered care set forth here represent a set of discrete practical steps that all primary care physicians can take to improve their responsiveness to patients' preferences. Some of the attributes are relatively inexpensive and could be readily incorporated into practice with demonstrable benefits to quality of care. Primary care practices could effectively incorporate many of the elements of patient-centered care such as online communication, same-day appointments, and team-based care.[20,21] Waiting times for appointments can be drastically reduced, as can turn-around times within the physician's office.[22,23] Shared decision making between patients and physicians can be facilitated using interactive techniques.[24] Promoting patient access to medical records yields the potential for modest benefits, such as enhancing doctor-patient communication, with minimal risks for patient worry, confusion, or anxiety.[25] Conducting patient surveys and acting on patient feedback should improve care. Survey tools exist and have been shown to be valid and reliable for assessment of patient experiences, both with adult and pediatric physicians and groups.[26,27] Some of these actions may make more efficient use of physician time, or permit the physician to spend office time on higher value services.[28] Others, however, may increase physician time or time of other office personnel and may require revamping payment methods to provide the necessary resources (addressed below).

LESSONS FROM ABROAD

Many of the attributes of patient-centered primary care practices already exist in Denmark.[29] Each Danish primary care physician has an enrolled patient population of about 1,500. Danish primary care experts stress the importance of this list of enrolled patients. Both physicians and patients feel that their contract with each other entails rights and responsibilities on both parties that lead to much better care. The payment system since the late 1990s has been a blend of primary care per patient panel fee and fee-for-service. Primary care physicians are paid a monthly fee for each enrollee, which accounts for about one third of gross income, and two thirds of income is derived from a government-negotiated fee schedule for individual services. Practices ensure the ability to handle same-day appointments and walk-ins. They have had electronic prescribing systems connected to local pharmacies since the late 1990s. An "off-hours" service includes a telephone service manned by physicians with access to the patient's health registry information. Off-hours physicians are paid for telephone visits, and can either deal with the problem by phone, fill a prescription electronically, or request that the patient come in to see a physician in the off-hours clinic. E-mails are sent to the primary care physician of record about care provided on the off-hours service or medications prescribed electronically, and the off-hours physicians call the primary care physician to hand over the patient the next day when there is an urgent health matter.

Another interesting development is the United Kingdom's (UK) recently implemented general practitioner (GP) contract. It provides bonuses of up to 30% of GP income for reaching quality targets.[30] The point system rewards not only clinical performance measures of quality but also conducting patient surveys and acting on patient feedback to improve care. Pay-for-performance incentive programs are growing in number in the U.S. but are still relatively few, with rewards that are relatively small and geared primarily to technical aspects of care rather than patient-centered attributes.[31] Ensuring that pay for performance systems include patient experiences with care would reward practices that render patient-centered care.

GETTING TO PATIENT-CENTERED PRACTICE: WHAT IS NEEDED?

Primary care physicians are feeling under siege, overworked, and underpaid.[32–34] So it is important to provide solutions that are realistic and do not create a new layer of problems. First, financial issues must be addressed head-on, and physicians must be given easy access to resources and tools that they can implement easily in their practice. The UK had the advantage of setting new expectations for primary care physicians at the same time it increased resources to finance health care—through a tax increase enacted specifically to improve access in the National Health Service. In the U.S., it may be necessary to achieve offsetting savings, either in specialty care or in

reduced use of hospital and emergency room care to finance improved primary care.

One way to begin would be to ensure that all Americans—whether insured by public programs or private insurance, or uninsured—have a "medical home." Indeed, patient-centered care ought to begin in the medical home. Adoption of a Danish-style medical home would have many advantages, including improved continuity of care and a clear set of rights and responsibilities for both physicians and patients.

To support the development of medical homes within primary care practices, there would need to be new incentives for primary care physicians. A new system of payment for primary care could include both a medical home monthly fee to encourage better physician-patient communication and coordination of care, combined with the current fee-for-service payment system. The medical home fee component would need to be sufficient to cover the cost of nonreimbursable services such as information technology and other practice systems to ensure patient-centered care, such as patient surveys and patient reminder systems. A model for this could be the blended per-patient fee and fee-for-service system in use in Denmark.[29] In the U.S., Newhouse has advocated a blended payment system both as a way of adjusting for the greater health care needs of sicker enrollees and as a way of balancing incentives for overuse and underuse.[35] Medicare is currently considering pay for performance for physician services and could be a leader by paying a monthly panel fee as well as rewards for performance on patient-reported experiences with care. Demonstrations to test the concept would be an important first step.

Adding the UK's GP incentive payments for reaching quality targets to this payment system would be an interesting innovation. Paying for performance would focus primary care practices on the importance of measuring and improving quality of care, including conducting patient surveys of patient experiences with care. In the UK system, major "points" are awarded simply for conducting such surveys, informing a supervising physician if there is one (for example, head of a primary care trust), and indicating that they have taken steps to address the concerns. For example, if patients complain that it takes too long to get an appointment, physicians could indicate that they have instituted a system of same-day appointments. Experience with this new reward and reporting system should be followed closely.

In the U.S., patient-centered care practices could be paid a fixed monthly fee for a package of services such as e-mail visits, reminders, access to electronic medical records, and demonstrating easy access to care when needed by the patient. These payments would offset the additional personnel, physician time, information technology, and office system costs that would be required to deliver these services.

Demonstrations would be necessary to test the concept, and a business case could be developed with appropriate costing of the enhanced services. Research would also be needed to document the impact of this patient-centered model of primary care—its impact on quality of ambulatory care, offsetting savings from reduced specialty care, emergency room use, and hospital utilization and, importantly, patient satisfaction and clinical outcomes. Obviously, unless it is demonstrated that there are offsetting savings, this model will not be adopted widely.

There are potentially other primary care payment models that could stimulate better experiences for patients and more satisfied physicians. For example, Allan Goroll, a primary care physician at Massachusetts General Hospital, and his colleagues have been considering the possibility of substituting a monthly retainer payment for all fee-for-service compensation. Such a proposal would need an evaluation similar to the blended payment proposal (A. Gorroll, personal communication, 2004). It differs from boutique medicine in that the retainer replaces fee-for-service compensation, would apply to all patients (not a 2-tiered service), is likely to be considerably lower than "boutique" fees, and could be covered by insurance.[36]

There is also an important role for organizations in providing training and technical assistance to primary care practices on methods of improving quality of care. Tools—whether shared decision-making videos or information technology systems that give patients access to their electronic medical records—and information on their effectiveness should be developed with public or private support.[37] Generation of comparative databases across practices over time would help identify best practices and provide benchmarks against which practices could assess their progress. Care provided in the outpatient, hospital, and nursing home settings also needs to be redesigned. Models of team work are needed that can be efficiently implemented in these various settings and that are easily adaptable to the specific features and flow of patient care. Physicians and other health care professionals will need to be trained to work in such teams whose central member is the patient. Ultimately, patient-centeredness should not only be considered as a priority, but as a precondition of our health care system.

It will undoubtedly take a sustained effort to transform American health care to achieve this vision. It requires champions—primary care leaders and leaders among employers, insurers, and politicians. But with appropriate leadership and policy changes, especially with regard to payment for primary care in private and public insurance plans, all Americans could receive primary care that is truly patient-centered.

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