Commentary

Community-oriented Primary Care: An Examination of the US Experience

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Abstract: Community-oriented primary care (COPC) represents a specific variation on the general primary care model. Seven case studies from vastly different health care settings were examined and this report describes the diversity of expression of the principles of COPC observed. The results suggest that COPC is not limited to publicly funded programs, but can find expression in the private sector as well. The organization of financing and the lack of feasible quantitative tools hinder the full development of the model. (*Am J Public Health* 1986; 76:279–281.)

Introduction

For over 20 years, community-oriented primary care (COPC) has provided the philosophical basis for health programs for underserved populations.[1-8] However, a concise operational model and systematic appraisal of the obstacles and opportunities for full expression of the model have not been developed. A recent study from the Institute of Medicine examined seven case studies including practices and programs that demonstrate elements of the COPC model which have evolved in different health care environments of the United States.[6,7]

Application of Model to Seven Case Studies

The seven case studies were selected from over 100 potential sites to represent the diversity of health care settings within the US. Among the sites, there was considerable variation in the primary care program, the type of community addressed, and the mechanisms of financing as summarized in Table 1.

Operational Model

COPC consists of three elements: a practice or service program actively engaged in primary care, a defined community for which the practice has accepted responsibility for health care, and a process by which the practice, with the participation of the community, identifies, and addresses the major health problems of the community. The process, in turn, consists of four functional steps:

- defining and characterizing the community
- identifying the community health problems
- modifying the health care program
- monitoring the effectiveness of program modifications

For each function scales were constructed to describe levels of development of the component activities. Stage IV activities represent the full expression of the principles of COPC and thus would be characteristic of the ideal COPC practice or program. The intermediate stages describe activities which are at successive levels of development, based in part on the data from the case studies. Table 2 summarizes the staging criteria for each of the functions.

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Defining and Characterizing the Community

All study sites had explicitly defined the population for which the program has accepted responsibility, and could describe the characteristics and number of individuals in the denominator population. Five of the sites could enumerate all members of their community (a criterion for stages III and IV for this function).

Identification of Community Health Problems

All the study sites were at stage III for the activities of this function and had conducted one or more population-based assessments of the community's health needs. Along with formal quantitative studies, nearly all of the sites also relied on subjective impressions (stage I) and extrapolation from secondary data (stage II) to identify community health problems. However, a focused study often served to identify the correlates of the problem and to provide information needed to target program modifications on the individuals or groups at highest risk.

Modification of the Health Care Program

Nearly all of the study sites addressed health problems with modifications in both the primary care and community health programs, and were at stage III for this function. Financial constraints limited the extent of modification in most study sites, and these frequently were financed with external grant money rather than from the existing revenue base.

Monitoring the Impact of Program Modifications

The principals at the study sites generally acknowledged the importance of this function, but noted the difficulty in routine evaluations, citing the lack of resources, specific skills, and feasible evaluation techniques as major impediments.

Lessons Learned

These results suggest that the fundamental principles of COPC can be expressed in a variety of health care settings, although COPC generally has been associated with publicly funded programs. Nonetheless, the financing arrangements, as expected, offer serious impediments to full development of the model. While not an absolute impediment, fee-for-service practice offers little financial flexibility for undertaking COPC activities. Lack of quantitative techniques that are feasible in the busy clinical setting also are a problem.

Some of the obstacles can be overcome by achieving a critical mass through collaboration with other programs in the

TABLE 1—Characteristics of the Seven Study Sites Demonstrating Elements of the Community-oriented Primary Care Model

Study Sites	Location	Approximate Size of Community Served	Years in Operation	Type of Ownership	Predominant Source(s) of Revenue	Number and Type of Physicians	Annual Number of Visits
Checkerboard Area Health System	Cuba, NM (80 mi. from Albuquerque) Rural	14,000	13	Private, not for profit	Public grants, contracts, and fee for service	4 family physicians	34,000 (1982)
Crow Hill Family Medicine Center	Bailey, CO (50 mi. from Denver) Rural	7,280	6	Private, for profit	Fee for service	2 family physicians	9,000 (1983)
East Boston Neighborhood Health Center	Boston, MA Urban	32,000	13	Private, not for profit	Public grants, contracts, and fee for service	23 primary care specialists	118,000 (1982)
Kaiser-Permanente Medical Care Program of Oregon	Portland, OR Urban and Suburban	255,103	40	Private, not for profit	Prepaid capitation	250 mixed primary care specialists	1,084,000
Montefiore Family Health Center	Bronx, NY Urban	105,000	3	Private, not for profit	Public grants, contract, and fee for service	6 family physicians	28,000 (1982)
Sells Service Unit (Indian Health Service, USPHS)	Sells, AZ (60 mi. from Tucson) Rural	14,050	28	Federal funds	Recurring federal budget	7 primary care specialists	42,373 (1982)
Tarboro-Edgecombe Health Services System	Edgecombe County, NC Rural	55,000	14	Mixed, public and private, for-profit and not for profit	Public grants, contracts, and fee for service	18 mixed primary care specialists	90,000 (1983)

community. In several study sites, this was achieved through an informal network of several practices or programs that operate in the same community and collaborate in the COPC functions while maintaining independence in their primary care delivery programs. The local health department could act as the focal point for COPC activities, by carrying out the quantitative functions and coordinating the primary care provider organizations and the community health organizations in programs which are indicated.

Community participation is a central feature of COPC, although the case studies suggest that COPC activities are driven by the practitioners rather than by the community. Each study site had one or more physicians with an unusual commitment to COPC, and this appears to be relatively more important to the success of COPC than community involvement per se.

Community-oriented primary care is a compelling notion and the fully developed model holds considerable promise for a system of primary care that is more responsive to the health and health care needs of defined communities. However, COPC is not the prevailing mode of practice in the US and the extent to which COPC can achieve a margin of improved health status at a reasonable margin of cost remains untested. Nevertheless, the potential of COPC to balance the competing demands of cost containment and the quality of care argue for a systematic examination of its marginal costs and impacts.

TABLE 2—Summary of Criteria for Stages of Development of COPC Functions

	Functions			
Stages of Development	Defining and Characterizing the Community	Identifying Community Health Problems	Modifying the Health Care Program	Monitoring the Effectiveness of Program Modifications
Stage I	Based on subjective impressions of the practitioners and/or consumers	Based on subjective impressions	Based on national or organization-wide initiatives	Based on subjective impressions
Stage II	Characterized by extrapolation from secondary data sources	Extrapolation from secondary data	In response to special resources that become available	Extrapolation from secondary data
Stage III	Enumerated and characterized by ad hoc data base specific to the community	Use of data sets specific to the community	Tailored to identified needs of the community	Use of data sets specific to the community
State IV	Enumerated and characterized from a current and complete data base of the community	Routine mechanisms identify and set priorities among a range of problems	Targeted on specific high-risk individuals and groups	Specific to program objectives and differential impact among risk groups

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Expanded Nurse Training Program Includes Home Health Care

The Boston University School of Nursing has received a grant from the U.S. Department of Health and Human Services to expand its graduate program in Community Health Nursing to provide study tracks in Nursing Administration in Home Health Care Services *and* Clinical Specialization in Home Health Care Services.

Students choosing Clinical Specialization may elect one of the following specialty areas: Care of Children and Their Families; Care of Adults and Their Families; Care of Older Adults and Their Families; and Care of The Dying and Their Families.

This three-year grant is offered in collaboration with the following graduate programs: Nursing Administration; Parent–Child; Medical Surgical; Rehabilitation; and Gerontological Nursing. Both full and part-time study is available. For further information, contact Bianca Chambers, Project Director, Boston University School of Nursing, 635 Commonwealth Avenue, Boston, MA 02215; tel: (617) 353-4067.