HHS Public Access

Author manuscript

Ann Intern Med. Author manuscript; available in PMC 2023 February 01.

Published in final edited form as:

Ann Intern Med. 2022 August ; 175(8): 1179–1180. doi:10.7326/M21-4509.

Small Solutions for Primary Care are Part of a Larger Problem

Derjung Mimi Tarn, MD, PhD[1], **Neil S. Wenger, MD, PhD**[2], **Kurt C. Stange, MD, PhD**[3]

[1]Department of Family Medicine, David Geffen School of Medicine at UCLA, University of California, Los Angeles, Los Angeles, CA

[2]Division of General Internal Medicine / Health Services Research, Department of Medicine, David Geffen School of Medicine at UCLA, University of California, Los Angeles, Los Angeles, CA

[3]Center for Community Health Integration and Departments of Family Medicine & Community Health, Population & Quantitative Health Sciences, Oncology, and Sociology, Case Western Reserve University, Cleveland, OH

Over the last four decades, many efforts have sought to improve the delivery of primary care.[1] Each practice improvement initiative has promise, and sometimes scientific evidence of efficacy, to improve care for the single disease or process targeted. Yet implementation of initiatives requires time, training, possible practice redesign, and growing administrative burden.[2] Initiatives also may require extensive patient education to manage or reframe expectations. These efforts may yield additional payment, but often they are not commensurate with the administrative burden required to garner the remuneration.[2] At a time when patients require whole person care to improve their overall health and wellbeing,[3] efforts to improve the quality of narrow processes in the primary care setting may instead lead to fragmentation of care and clinician burnout.[4] We believe that truly patient-centered, integrated, whole person care in the primary care setting would comprehensively address patient concerns during any given office visit, whether those concerns include chronic disease management, acute issues, and/or preventive healthcare.

Our ongoing work on a National Institute on Aging-funded study to help practices implement Medicare Annual Wellness Visits provides a vantage point into this conundrum, of well-intentioned efforts to improve specific aspects of care instead reducing primary care's ability to serve as a force for integration.[5] The Annual Wellness Visit exemplifies a piecemeal initiative focused on specific components of care that fails to meet patient expectations of comprehensive care. Our insights come from our aggregate experiences caring for primary care patients and performing public health research, and from interviews with patients.

Widely touted and promoted, the Medicare Annual Wellness Visit provides an opportunity to promote patient wellness and increase use of important preventive healthcare services.[6] This outpatient office visit is a free-to-the-patient visit that Medicare offers as a yearly benefit. The premise is that it offers clinicians dedicated time to devote to screening and prevention

Corresponding author: Derjung Mimi Tarn, MD, PhD, David Geffen School of Medicine at UCLA, Department of Family Medicine, 10880 Wilshire Blvd., Suite 1800, Los Angeles, CA 90024, (310) 794-8242, Fax: (310) 794-6097, dtarn@mednet.ucla.edu.

activities. Practices and clinicians benefit because they receive payment for the visit and for additional screening and counseling services performed. The visit does not include a physical examination, which theoretically leaves clinicians with more time to focus on other activities.

A challenge for these visits, as with any change to usual practice, is the effort required to increase their utilization, as exemplified by low uptake of the visits.[7] Annual Wellness Visit requirements, like many well-intentioned efforts to improve primary care, risks fragmenting care rather than supporting its vitally-needed role as a force for integration. Clinicians must separately bill for included counseling services such as advance care planning, and for any acute or chronic issues addressed. Practices frequently need to implement new workflows to identify and schedule patients for Annual Wellness Visits and need training on visit procedures, Medicare documentation requirements, and billing strategies to ensure complete reimbursement. These efforts are time consuming and cumbersome for all parties involved.

As part of our study, we interviewed Medicare patients from community-based practices regarding a recent Annual Wellness Visit. These interviews reinforced how confusing and difficult the structure of Annual Wellness Visits can be for patients. Patients often believed the purpose of the Annual Wellness Visit was for their “annual physical” or “yearly med check.” A few thought the purpose was to assess acute complaints or manage chronic medical issues. Overwhelmingly, all patients felt that Annual Wellness Visits should include a physical examination, and all but one wanted laboratory testing. One patient shared the common view that the yearly visit should “take some blood tests, check everything – your heart, your lungs, see if there are any spots on your body.”

Overall, most patients failed to understand that a physical examination, chronic disease management, and attention to acute concerns were not part of the Annual Wellness Visit. Practices reinforced these beliefs by creatively adapting the visits to address these additional issues, often billing separately for these services. This inclusive approach helped to integrate care and make it more convenient and accessible. However, patients who expected the Annual Wellness Visit to include comprehensive care were sometimes confused and vexed by the separate billing that seems to fly in the face of the “free” framing of the visit.

Taking a step back, the experience of patients and practices is helpful in raising the policy gaze from the parts (discrete practice improvement initiatives) to the whole (care of whole people and support of the integrative function of primary care[4]). The Annual Wellness Visit is just one of many examples of well-intentioned piecemeal mechanisms designed to enhance a narrow aspect of patient care and promote certain services.[4] Yet similar to other initiatives, the Annual Wellness Visit adds to the administrative burden on clinicians and practices and fails to meet patient expectations for care. Furthermore, a culture change is required for full implementation of these visits – for practices, clinicians, and patients. A cumulative unintended consequence of implementing one process at a time to improve primary care is to overwhelm practices, confuse patients, and fragment care.[2,5] Thus, while providing small solutions for discrete problems, these initiatives contribute to a larger problem.

The recent National Academies of Sciences Engineering and Medicine's report on Implementing High Quality Primary Care calls primary care a "common good."[8] As healthcare becomes increasingly specialized, primary care is a much-needed resource for integrated care. Patients want integration – they want whole-person care.[9] Whole-person care is less available now due to the multitude of discrete initiatives that fragment delivery processes, as well as the current payment system, which pays clinicians based on discrete services provided. What primary care needs more than anything now is support that promotes integration of care.[4] Payment reform, in the form of hybrid payment models that provide base support for practices to invest in supporting the care of whole people and populations, is an important part of the solution.[8] The fragmentation, administrative burden and moral injury of trying to improve care one-initiative-at-a-time has reached a tipping point[2,10] that could soon spell the end of primary care. Supporting primary care's role as a force for integration is crucial to meeting the needs of patients and effective health care systems.

Acknowledgements

We are grateful to the patients and practices participating in the "Medicare Annual Wellness Visit Practice Redesign Toolkit: A Tailored Intervention to Improve Preventive Health Service Use" study, supported by the National Institutes on Aging grant R61AG068946. Dr. Stange's time also is supported by a grant from the University Suburban Practice Foundation for the Wisdom of Practice Initiative, and by a Distinguished Scholar Fellowship from the American Board of Family Medicine Foundation. We also thank Wilson Pace, MD, Natalia Loskutova, MD, PhD, the DARTNet Institute, and the American Academy of Family Physicians National Research Network for their insights and contributions.

References

1. Miller WL. The story of general practice and primary medical care transformation in the United States since 1981. Commissioned paper for the NASEM Consensus Report: Implementing high-quality primary care rebuilding the foundation of health care. 2021:1–60. https://www.nap.edu/resource/25983/The%20Story%20of%20General%20Practice%20and%20Primary%20Medical%20Transformation%20in%20the%20United%20States%20Since%201981.pdf. Accessed May 20, 2021.
2. Bujold E. The Impending Death of the Patient-Centered Medical Home. JAMA internal medicine. 2017;177(11):1559–1560. [PubMed: 28973064]
3. Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. Health Aff (Millwood). 2010;29(8):1489–1495. [PubMed: 20679652]
4. Heath I, Rubinstein A, Stange KC, van Driel ML. Quality in primary health care: a multidimensional approach to complexity. BMJ. 2009;338:b1242. [PubMed: 19342404]
5. Casalino LP. The unintended consequences of measuring quality on the quality of medical care. N Engl J Med. 1999;341(15):1147–1150. [PubMed: 10511617]
6. Colburn JL, Nothelle S. The Medicare Annual Wellness Visit. Clin Geriatr Med. 2018;34(1):1–10. [PubMed: 29129209]
7. Practices Caring For The Underserved Are Less Likely To Adopt Medicare's Annual Wellness Visit. Health Aff (Millwood). 2018;37(2):283–291. [PubMed: 29401035]
8. National Academies of Sciences, Engineering and Medicine. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press; 2021.
9. Lynch J. A whole person approach to wellbeing : building sense of safety. In: London ; New York: Routledge, Taylor & Francis Group,; 2021.
10. Grumbach K, Bodenheimer T, Cohen D, Phillips RL, Stange KC, Westfall JM. Revitalizing the U.S. Primary Care Infrastructure. N Engl J Med. 2021;385(13):1156–1158. [PubMed: 34432974]