The Organization of Health Care: The Contrasting Role of Primary Care and Consulting Specialties

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(Fam Med 2012;44(7):516-8.)

Both health care education and the delivery of health care suffer from a great degree of fragmentation in the United States. Professional academic organizations and educational institutions have a responsibility to promote an effective and efficient continuum of medical education and to develop, test, and disseminate new models of health care delivery.

In a series of presidential columns, I will focus on elements important to improvement of the continuum of education and the practice of medicine. These elements will include the science of health care delivery and practice transformation, models of care coordination, interprofessional education, leadership development, and advocacy to improve the continuum of medical education. Fundamental to an effective educational system is the health care delivery system itself. This column will focus on the importance of clearly defined roles for physicians who are usual sources of comprehensive, longitudinal care (primary care physicians) and all other physicians (consulting specialty physicians).

Health care in the United States is more fragmented and disorganized than any other industrialized nation in the world. This has led to unexpectedly poor health care outcomes at very high cost. The preponderance of evidence suggests that the most effective systems of care place a relatively greater emphasis on primary care and have clearly defined philosophies and roles for primary care and consulting specialty care.

In the most effective, efficient, and equitable systems, primary care is provided in the context of community-based services that are easily accessible, that have low or no out-of-pocket cost to the patient, and that have close linkages with mental health and public health services. Such primary care operates on a biopsychosocial model of care and provides a population-based, usual source of comprehensive, longitudinal care. Consulting specialty services, on the other hand, provide secondary and tertiary health care, and focus on excellent treatment for specific diseases and catastrophic events. A well-developed system of care coordination, the personnel for which are housed in the primary care practices, provides a strong bond between the primary care practices and the consulting specialty practices. Optimal care coordination services have a well-developed registry function, high-level management of transitions of care, and population-based identification and care for high-risk, high-use, and high-vulnerability patients.

In a highly functional health care system, health care professionals work at the top of their degree (at the top of their license, at the full scope of practice), and there is minimal crossover and better coordination between primary care services and consulting specialty services. The current system in the United States stands in stark contrast to this model. A 2009 study from the Johns Hopkins Bloomberg School of Public Health found that more than 45% of ambulatory office-based visits to consulting specialty physicians in the United States could be handled as well or better in primary care settings. Experts in innovative design support the Bloomberg findings by calling for an appropriate and evidence-based decentralization of health care services, with technologies and office encounters moving to the appropriate level of care and location.
When visits and technologies are transferred progressively from specialty practices to primary care practices to consumers of health care, the predicted shortage of health care professionals quickly becomes manageable. Consulting specialists would have a patient panel that is more focused on complex, specialty-specific cases, instead of duplicating primary care services. Specialty practice would thus more accurately reflect specialized training. The heavier burden on primary care practices could be solved by better organization and care coordination and by an integrated approach by primary care physicians, physician assistants, mental health professionals, nurse practitioners, public health officials, and other health care professionals. Ultimately, patients themselves would be better equipped to take greater responsibility for their health. Organizations that embrace new technologies for innovation would realize the significant efficiencies necessary for this system change.

Primary Care
The basic concept for the primary care office is that it should be based in the community and should closely unite primary care medical practice with comprehensive mental health and public health services. Physical, organizational, functional, and financial alignment should occur for optimal function. The care coordination function should provide a direct link to other community services. High-functioning data management systems are needed to provide point-of-service decision-making capability, development of the registry function, and rapid feedback of organized information to the practice so that improvements routinely occur. Philosophically, the primary care practice must have significant interest in the health of the population for which it is responsible, the community in which it resides, and the families and individuals for whom it cares. There must be a broad understanding of the principles of preventive medicine, chronic medical conditions, and acute medical problems. Of crucial importance is evidence of the four essential functions of primary care: (1) first contact access, (2) coordinated, integrated care, (3) patient-focused care over time, and (4) comprehensive care. With respect to best outcomes and efficiency, the most important of these functions is comprehensiveness of care. A large number of office-based medical procedures should be provided. The primary care practice should provide general hospital and maternity care or be integrated tightly with a group of physicians who provide this care and espouse the principles of primary care.

Primary care practices must have enhanced systems of access for patients, which include the utilization of new technologies, social media, and virtual visits. Because such practices will assume responsibility for care of a population, they will need tools to track the health services of individual patients within a population. Consultation and referral guidelines should generate focused questions and assure consultation tracking, appropriate communication, and coordination of care.

A prototype of this type of practice is being developed at the family medicine centers at the Southern Illinois University. In Quincy, a progression of grants led to the development of community-oriented primary care and the development of interprofessional team care. This practice now provides comprehensive mental health services for children under the roof of the patient-centered medical home and an “office of the future” that focuses on top-of-the-license practice by all health care professionals and staff. The mental health services are provided by social workers, licensed counselors, resident and faculty physicians of the practice, and a community-based consulting child psychiatrist who is present 1 day a week. Physicians are provided scribes so that the physicians spend virtually all of their time in face-to-face contact with the patient and in clinical decision making. The staff members are given extra responsibility in registry implementation, medical records completion, and the provision of health education.

Consulting Specialists
Consulting specialty practices and hospital-based services should focus on the management of specific diseases and the provision of acute and catastrophic care at the secondary and tertiary level. This focus is vastly different than the population-based and community-based focus of the primary care practice. Consulting specialists, like other health care professionals, should provide services that are consistent with their highest level of training. Many initial services and follow-up encounters that now occur in consulting specialty practices will occur in primary care practices. Participation in care coordination for transitions of care will be important, and identification of high-risk, high-cost, highly vulnerable patients will be needed to provide them access to the care coordination system provided by the primary care practices and public health system.
Consulting specialists will need high-functioning data management systems so that information can be transferred rapidly to and from the primary care practices and other venues.

Advances in technology will provide the basis for electronic virtual consultations between primary care and consulting specialists. Virtual consultations occur when information from the primary care practice is provided to a consulting specialist, and the consulting physician uses the electronic information to generate a clinical recommendation. This recommendation may involve immediate examination of the patient, or it may involve recommendations for the primary care physician with specified parameters for follow-up. The virtual consultation will likely result in an increase in total consultations, more-focused consultations, fewer face-to-face consultations, more mutual education and learning experiences between primary care professionals and consulting specialists, and greater system flexibility and efficiency. The Mayo Clinic, through its self-insurance plan for employees and dependents, has had success with the virtual consultation system. When combined with new telemedicine technologies, the virtual consultation will be even more useful when geographic and transportation constraints exist.

Payment mechanisms for the primary care practices and for consulting specialty practices may take somewhat different forms. For primary care practices, there will be need for payment reform that incentivizes efficiency of care, coordination of care, and quality of care. A blended payment system with proper financial incentives will combine substantial prospective payments for care coordination and retrospective payments for fee-for-service and for quality of care. For consulting specialty services, there will need to be considerable payments both for fee-for-service and for quality indicators. Hospital systems and the consulting specialist physicians will need to partner to develop the most efficient and effective systems of secondary and tertiary care.

The primary care practice and the consulting specialty practice are two complementary but different types of care. They are linked by the bonds of coordination of care, which include management of registries, management of transition of care, and management of patients of the most complex nature. But the boundary between primary care and specialty practice in the United States is blurred and results in an expensive, relatively ineffective system of care that is not the optimal environment for learning for medical students, resident physicians, and other health care professionals. The tendency for greater emphasis on general competencies may actually further accentuate the blurred boundaries. The current rapid change in education and practice give family medicine educators great opportunity to influence the proper development of health care delivery systems of the future.

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References