Coordinating Care: A Major (Unreimbursed) Task of Primary Care

For several decades, first-contact care, continuity of care, comprehensive care, and coordinated care have been core attributes of primary care (1). Of these features, perhaps the most problem-ridden is the task of coordinating the care of patients among multiple entities beyond the primary care practice, that is, specialists, ancillary services, pharmacies, hospitals, and home care agencies. Studies demonstrate that referrals from primary care physicians to specialists often lack sufficient (or any) flow of information in either direction (2, 3). In this era of hospitalists, primary care physicians are often uninformed about what took place during their patients' hospital stay (4).

Care coordination is particularly important for Medicare beneficiaries because they see many different physicians. In 2003, 33% of Medicare beneficiaries visited more than 6 physicians, and 26% of beneficiaries with a diagnosis of coronary heart disease, congestive heart failure, or diabetes visited 10 or more physicians (5).

Most definitions of "coordination of care" focus on information exchange among care providers to ensure that they all act toward a common goal (6). This focus is too narrow. Coordination also takes place between providers and patients and families. In this realm, performance is also far from stellar. In 1 study, physicians did not provide clear recommendations 47% of the time, which led patients to misunderstand the advice (7). Up to 33% of physicians do not consistently notify patients of abnormal diagnostic test results (8). Eighteen percent of patients report that they received conflicting advice from different physicians, probably because their physicians had failed to communicate with one another (9).

The article by Farber and colleagues (10) in this issue provides a partial explanation for these care coordination failures. The authors asked 16 geriatricians and 226 patients in an ambulatory setting to record the number of minutes the physicians spent doing several types of clinical interactions. Because the time spent on each activity was recorded by the physician rather than by a separate observer, inaccuracies are likely to have occurred; however, the results are striking: The physicians spent a considerable amount of time providing care that took place between face-to-face visits to the physician rather than within the visit.

For every 30 minutes of intravisit time, the average geriatrician spent 6.7 minutes doing between-visit activities. Eighteen percent of the average physician's clinical work was between-visit work. Most fee-for-service payment systems reimburse only time spent during visits. Thus, almost one fifth of the geriatrician's work was done without pay. Three quarters of the between-visit interactions were related to coordinating care with patients, families, and other medical professionals. Had the geriatricians coordinated care perfectly, the unpaid between-visit time might have been greater. What is not reimbursed is less likely to be done well. Moreover, care coordination takes a great deal of time. Farber and colleagues found that physicians spent 47 minutes per morning or afternoon clinical session coordinating care. Lack of physician time and lack of payment are 2 likely explanations for inadequate care coordination.

What was the content of the between-visit interactions? Could physicians have delegated this work to nonprofessional staff? Sixty-five percent of the contacts involved new symptoms, such as a fall, pain, or dysuria; discussions with other professionals; family counseling; or managing chronic problems. These items are clearly physician-level duties. In comparison, 30% of between-visit interactions involved calling in prescription refills to the pharmacy, scheduling appointments with a specialist, or transmitting routine orders to a home care agency, which are administrative tasks that office staff could perform.

Could these activities have been conducted as reimbursed patient visits rather than unpaid between-visit care? In all likelihood, the answer is no. Seventy-seven percent of the interactions were by telephone, and 8% were electronic. Larson (11) pointed out that coordinating care for elderly patients through the many services provided by the health care system is enormously complex because of the increasing number and variety of treatment sites that elderly patients visit. The proportion of time that an elderly patient spends in the primary care office is tiny. Only through non–face-to-face interactions, mainly by using telephone or electronic methods, can primary care physicians integrate what happens at multiple sites and at patients' homes.

Does this study of geriatricians, whose patients have the greatest needs for care coordination, apply to other primary care practitioners? A study of 11 family physicians from 8 practices in Ohio, Tennessee, and California investigated this question, using trained medical student observers. They found that 23% of the workday was spent doing between-visit work. Care coordination comprised more than half of the between-visit work and occupied 13% of the workday (12). These findings strongly suggest that Farber and colleagues' findings for geriatricians are generally applicable to adult primary care.

Patients expect that their primary care physician will coordinate their care throughout the health system. For primary care to assume this responsibility, 2 things must happen: Everyone needs to have a medical home (usually a primary care practice) (13), and payers need to reimburse primary care physicians for care coordination work.

What is a medical home? In early 2007, the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association released a joint statement characterizing the patient-centered medical home (14). Under

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the medical home concept, patients enroll in a practice and join the panel of a physician within that practice. Patients know who is responsible for their care and physicians know which patients they are responsible for. One responsibility is to coordinate care with the rest of the health system. The medical home is not equivalent to a gatekeeper system, but if patients see a specialist without a referral, they must inform their medical home so that the practice can coordinate their care with the specialist.

Currently, empanelling patients in a medical home is far from universal. Thirty-four percent of Medicare beneficiaries do not have a clearly designated primary care medical home, in the sense of having a specified primary care physician. Among Medicare beneficiaries with a regular primary care physician, only 31% of visits involve that physician. Thirty-three percent of beneficiaries change primary care physicians from 1 year to the next (15).

Organizations that have proposed the medical home envision that payers would reimburse between-visit time spent coordinating care. They have proposed 2 payment methods. One functions within the fee-for-service payment system but adds a care coordination fee (13). The American College of Physicians and 34 other health care organizations support pending federal legislation, entitled the Geriatric Assessment and Chronic Care Coordination Act, which would pay a care coordination fee. Other support for this concept comes from the Patient-Centered Primary Care Collaborative, a coalition founded by large employers and national primary care associations. It calls for a monthly risk-adjusted care coordination payment for physician work outside of the face-to-face visit.

The other payment reform proposal places designated primary care medical homes outside the fee-for-service system and substitutes a comprehensive per-patient monthly payment (16), with bonuses for implementing an electronic health record and delivering high-quality performance. By adjusting the payment to take account of the patient's state of health, the physician would receive a larger comprehensive payment for patients who need extensive care coordination.

If physicians are to improve their care coordination performance, they need time to do the work and must be paid for the work. Farber and colleagues' findings reinforce the compelling case that the time to reform the system of paying primary care physicians is now.

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