AMA/CME ARTICLE

Primary Care Practice in a Managed Care Environment: Changes and Challenges

Kenneth R. Epstein, MD, FACP

This activity is designed for physicians, medical directors, and healthcare policy makers.

GOAL

To understand how the clinical function of the primary care physician differs between a fee-for-service and a managed care practice environment.

OBJECTIVES

1. Understand some of the factors affecting physician choice of specialty or primary care careers.
2. Understand the advantages and disadvantages of primary care physicians controlling referrals and testing.
3. Understand the role of quality measurement in a managed care practice setting.
4. Understand the role of data management systems for patient management in a managed care practice setting.

As managed care becomes an integral part of the healthcare system in the United States, the role of the primary care physician is rapidly changing. No shortage of publications assess the financial impact, both real and potential, of these changes but few focus on their clinical implications. In this article, I review some of the ways in which the growth of managed care is changing the clinical practices of primary care physicians—those who are on the "front lines." Although problems or difficulties clearly exist with certain plans or systems of care, this article reviews the role of the primary care physician in an "idealized" managed care setting.

From the Division of Internal Medicine, Department of Medicine, Jefferson Medical College, Thomas Jefferson University, Philadelphia, PA.

Address correspondence to: Kenneth R. Epstein, MD, FACP, Associate Director, Division of Internal Medicine, Jefferson Medical College, Thomas Jefferson University, 125 South 9th Street, Suite 502, Philadelphia, PA 19107

Importance of Primary Care in the Healthcare System

The trend toward specialization in medicine began with the end of World War II[1] and was supported by changes in medical school curricula in the 1950s. In 1940, 76% of physicians in the United States were considered general practitioners and 24% were specialists. By 1960, 55% of all physicians were specialists, a number that increased to 69% by 1966.[1] In *The Social Transformation of American Medicine*, Paul Starr argues convincingly that the increasing number of physicians choosing to specialize was primarily due to economic and social pressures rather than the increasing body of scientific knowledge, as many physicians maintain. He raises an interesting question—if primary care physicians had been paid more than subspecialists in the 1950s and 1960s, would as many physicians have chosen to specialize? In the 1990s, despite a continually growing body of medical knowledge, economic forces are leading an increasing number of medical trainees to choose primary care careers.[2] Even so, some analysts believe there will be a relative shortage of generalists and a surplus of specialists for at least 25 more years.[3] To make up this shortfall, the Pew Health Professions Commission has recommended that 50% of all graduate medical education training programs focus on primary care disciplines by the year 2000.[4]

With the growth of managed care, primary care physicians are playing an increasingly pivotal role in the healthcare system. They decide on appropriate diagnostic and treatment plans, which may or may not include diagnostic testing or referral to a specialist. In this "gatekeeper" role, the primary care physician can decrease the likelihood of patients referring themselves to specialists.

Controlling Referrals and Testing

Requiring a patient to see a primary care physician first, rather than a specialist, allows the patient's concerns to be evaluated in the context of his or her medical and prior utilization history. Primary care physicians can integrate the influence of psychosocial factors into the diagnostic evaluation, since the patient may be better known to them than to a specialist. This system also allows for more rational use of resources. The primary care physician can view the patient's symptoms in light of previous laboratory and radiologic tests, reducing the need for repeated testing. For instance, a rheumatologist would most likely order serologic testing and roentgenograms as part of the initial evaluation for a patient with arthralgias and a swollen knee. If this patient was seen by his or her primary care physician, the medical history would be readily available. The physician might note that serologic testing was negative 6 months ago, when the patient had identical symptoms, and that prior x-ray films of the knee revealed advanced osteoarthritis. Therefore, unnecessary testing with its attendant expense could be avoided, and the clinical care of the patient might potentially be improved. Another example are patients who refer themselves to a cardiologist for chest pain, unaware that previous evaluations have revealed significant gastroesophageal reflux disease.

Yet having primary care physicians act as gatekeepers can create an unnecessary burden for patients who clearly require the services of a specialist. For example, a diabetic patient experiencing visual changes cannot visit an ophthalmologist without first obtaining a referral from the primary care physician. Another example is a patient with a fractured bone, who would be better served by seeing an orthopedist first, if the primary care physician does not do casting. Another concern is the risk of misdiagnosis by the primary care physician, which might be less likely if a specialist was consulted first. Kirsner and Federman[5] note that misdiagnosis and incorrect treatment of skin lesions by primary care physicians may cost more than referral to a dermatologist.

Convincing patients of the sincerity of the primary care physician's decision not to conduct a diagnostic test or refer to a specialist is a significant problem. Although the decision may have been made for purely clinical reasons, the physician must reassure patients that their care was not limited for financial reasons. Physicians must explain the rationale behind their clinical decisions and clearly document these reasons in the patient's medical record. Disagreements on referral to specialists between primary care physicians and patients have been the basis of several malpractice cases brought in managed care settings.

Emphasizing Prevention, Not Treatment

Since primary care physicians in managed care settings often receive capitated payments, they benefit financially by keeping patients healthy. From a clinical and ethical perspective, physicians have always sought to maintain patients' health, but traditional fee-for-service insurance does not promote preventive care. In contrast, a capitated payment system encourages preventive health services. Many managed care plans pay for exercise programs, nutritional counseling, and smoking cessation efforts. Managed care organizations also promote patient education.

Defining Quality of Care

Many primary care physicians find it difficult to accept that quality of care is externally defined by managed care administrators. Some managed care companies use published, nationally accepted standards of care, while others define their own. For practitioners accustomed to using their own clinical knowledge and judgment to define the quality of healthcare they are providing, this can be difficult to accept. Many physicians also are troubled by the use of utilization statistics as part of the definition of quality care.

Physicians are most receptive to being judged according to nationally accepted standards, such as the National Institutes of Health Consensus Report[6] or the Agency for Health Care Policy and Research Practice Guidelines.[7] They are less accepting of internal standards created by managed care companies. They also may disagree when quality of care is defined based on comparisons with their peers. Defining standards of care based on utilization of resources also is a new and controversial concept for many physicians.

A growing number of managed care companies are using patient satisfaction as a measure of quality of care. Although some physicians may argue with this criterion for quality, it is increasingly accepted as a valid and important aspect of quality, particularly in the office setting.[8] Physicians may not necessarily consider the many factors that affect patient satisfaction, such as the availability of a physician by telephone for an urgent concern or waiting time to obtain an appointment. Patients' perceptions of these and other aspects of an office practice may be measured by the managed care company.

Primary care physicians may be unaccustomed to measuring several aspects of quality. For example,

managed care companies may determine compliance with standards by auditing patient records in the physician's office. Some physicians may be uncomfortable allowing persons outside their practice to have access to patient charts. Others, especially solo practitioners, may use methods of charting at odds with the managed care company's preferred methods of documentation.

Measures of quality of care also are used to determine financial compensation. In this area, managed care organizations may take a "carrot" or "stick" approach. With the "carrot" approach, a physician's monthly capitation payment is based on performance of certain quality measures, such as complying with preventive standards or completing continuing medical education credits. With the "stick" approach, a percentage of the physician's compensation is withheld until the quality measures or utilization standards are met.

Comparing one's quality of care against external standards or the care provided by one's peers can be a valuable exercise. Although most physicians believe they are practicing good quality care, traditionally no basis of comparison has existed. Having a busy and growing practice often is accepted as proof of the quality of care provided. However, some physicians may have busy practices even though they provide low quality care. Feedback from the managed care company on the quality of their care may help these physicians improve their practice. Physicians who meet or exceed the managed care company's standards may feel gratified and be motivated to continue practicing good quality care.

Need for Data Management Systems

With the growth of managed care, physicians are finding that data management systems are becoming a necessity for tracking patient numbers, utilization, and compliance with standards of care. Analysis of data from computerized systems is replacing chart audits as a means of measuring quality.

For the solo primary care physician, creating a data management system can be difficult and prohibitively expensive. These practitioners may be forced to rely on the results of the managed care company's data system as a means of obtaining data on their practice. Physicians in larger group practices may benefit by developing their own internal data system. They can then obtain information on their own practice and proactively monitor certain outcomes or utilization measures. For example, physicians in a group practice could analyze referral patterns to determine which consultants they use most frequently. The physicians can then decide whether they could improve the process of obtaining these consultations, whether they are receiving prompt and helpful information from the consultants, and whether the degree of utilization of the consultants is appropriate.

The Only Constant Is Change

The healthcare system is rapidly changing, and no one can fully anticipate the future result of these changes. However, most analysts agree that managed healthcare is here to stay. In some metropolitan areas, more than 50% of the population is enrolled in a managed care plan.[2] By the year 2000, two thirds of the US population will be covered by managed care.[3] Both Medicare and Medicaid are being converted to managed care systems in many parts of the country. As a result of these changes, primary care physicians are being forced to change their practice methods, which may have worked well in a fee-for-service environment but are no longer efficient or effective under managed care. Although much has been made of physician dissatisfaction with managed care arrangements, when surveyed, most physicians express overall satisfaction with their professional careers and degree of autonomy under managed care.[9,10]

The only certainty in medical practice is that it will continue to change. All physicians, but particularly those in primary care, must anticipate and stay ahead of changes in the healthcare system, rather than merely responding to changes after they occur.

··· REFERENCES ···

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CME QUESTIONS: TEST # 029608

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Instructions

After reading the article, "Primary Care Practice in a Managed Care Environment: Changes and Challenges," select the best answer to each of the following questions. In order to receive 1 CME credit, at least 7 of the 10 answers must be correct. Estimated time for this activity is 1 hour. CME credits are distributed on a yearly basis.

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1. Medical trainees are most likely to become specialists rather than generalists because of:
a) financial incentives
b) ever-increasing body of medical knowledge
c) changes in job market
d) social pressures
e) a, c, and d only

2. Managed care plans emphasize which type of care?
a) acute care of ill patients
b) management of chronic illnesses
c) referral to specialists
d) management of hospitalized patients
e) preventive services

3. Approximately when did the percentage of specialists surpass that of generalists in the United States?
a) 1930
b) 1940
c) 1950
d) 1960
e) 1970

4. Managed care organizations determine a physician's quality of care by assessing all of the following except:
a) compliance with preventive standards
b) number of years in practice
c) utilization of resources
d) patient satisfaction
e) compliance with National Institute of Health Consensus Panel recommendations

5. Patient satisfaction can be measured by which of the following aspects of office practice?
a) physician's technical skill
b) waiting time for appointments
c) telephone triage policy
d) physician's ability to explain treatment options
e) all of the above

6. Physicians who create their own data management system realize all of the following benefits except:
a) less expensive
b) more readily available data
c) ability to monitor one's own utilization of resources
d) ability to track referrals to consultants
e) ability to monitor one's own outcomes

7. What percentage of the U.S. population are expected to be enrolled in managed care plans by the year 2000?
a) 20%
b) 33%
c) 50%
d) 67%
e) 85%

(CME QUESTIONS CONTINUED ON PAGE 1126)

AMA/CME TEST FORM
AJMC Test #029608

Primary Care Practice in a Managed Care Environment: Changes and Challenges

Application for 1 Credit Hour of AMA Category I

(Test valid through September 15, 1997. No credit will be given after this date.)

Please circle your answers:

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3.	**a**	**b**	**c**	**d**	**e**
4.	**a**	**b**	**c**	**d**	**e**
5.	**a**	**b**	**c**	**d**	**e**
6.	**a**	**b**	**c**	**d**	**e**
7.	**a**	**b**	**c**	**d**	**e**
8.	**a**	**b**	**c**	**d**	**e**
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10.	**a**	**b**	**c**	**d**	**e**

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CME QUESTIONS: TEST #029608

(continued from page 1122)

8. What percentage of physicians were specialists in the United States in 1940?

a) 12%
b) 24%
c) 47%
d) 61%
e) 75%

Use the following list to answer questions 9 and 10:

1. Greater knowledge of the disease process
2. Greater knowledge of past evaluations and tests
3. Greater knowledge of psychosocial issues
4. Decreased burden to patients when specialty referral is necessary

9. What are the advantages of seeing a primary care provider first?

a) 1 and 4
b) 1 and 2
c) 2 and 3
d) 3 and 4
e) 2 and 4

10. What are the advantages of seeing a specialist first?

a) 1 and 4
b) 1 and 2
c) 2 and 3
d) 3 and 4
e) 2 and 4

PROGRAM EVALUATION

Albert Einstein College of Medicine & Montefiore Medical Center would like to have your opinion. Please fill out the questionnaire below, tear off along the dotted line, and mail along with your AMA/CME test form. We thank you for your evaluation, which is most helpful.

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____ excellent ____ good ____ fair ____ poor

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