

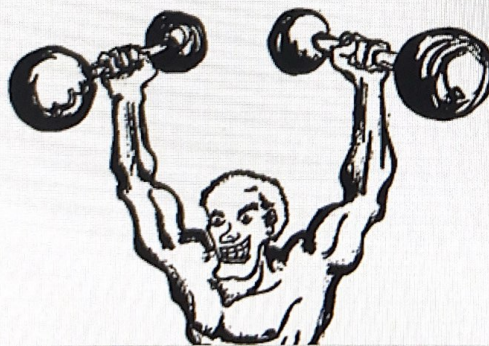
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CHAPTER 7

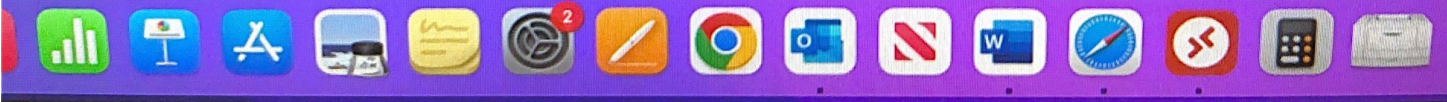
Outpatient and Primary Care Services

LEARNING OBJECTIVES

- Understand the meanings of outpatient, ambulatory, and primary care.
- Explore the main principles behind patient-centered medical homes and community-based primary care.
- Identify the reasons for the dramatic growth in outpatient services.
- Survey the various types of outpatient settings and services.
- Describe the role of complementary and alternative medicine in health care.
- Describe primary care delivery in other countries.
- Assess the impact of the Affordable Care Act on primary care.



270 of 663





▶ Introduction

The terms “outpatient” and “ambulatory” have often been used interchangeably. Historically, outpatient care has been independent from services provided in health care institutions. In earlier days, physicians saw patients in their clinics, and most physicians also made home visits to treat patients within the limitations of medical science prevalent in those days. Institutions for inpatient care, such as hospitals and nursing homes, developed later. With advances in medical science, the locus of health care delivery coalesced around the institutional setting of community hospitals. As the range of services that could be provided on an outpatient basis continued to expand, hospitals gradually became the dominant players in providing the vast majority of outpatient care, with the exception of basic diagnostic care provided in physicians’ offices (Barr and Breindel, 2004). Hospitals were better equipped to provide outpatient services because they had the resources necessary to capitalize on technological innovation. For example, hospital laboratories and diagnostic units were better equipped to perform most tests and diagnostic procedures than independent providers. In comparison, independent providers faced greater capital constraints and competitive pressures in the health care marketplace.

Later, health care delivery increasingly grew beyond expensive acute care hospitals to various alternative outpatient settings. Although basic primary care has traditionally been the foundation of outpatient services, some intensive procedures are also increasingly being performed on an outpatient basis. Additionally,





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Later, health care delivery increasingly grew beyond expensive acute care hospitals to various alternative outpatient settings. Although basic primary care has traditionally been the foundation of outpatient services, some intensive procedures are also increasingly being performed on an outpatient basis. Additionally, consumer demand has fueled the growth of complementary and alternative medicine.

Today, a large variety of outpatient services are available in the United States, yet many Americans do not have adequate access to health care because of maldistribution or shortages of providers and services. Hospital emergency care and community health centers constitute the main safety net for primary care services, particularly for uninsured individuals. Delivery of outpatient care by public agencies has been limited in scope and detached from the dominant private system of health services delivery. State and local government agencies sponsor limited outpatient services such as child immunizations, maternal and infant care, health screenings in public schools, monitoring of certain contagious diseases (e.g., tuberculosis), family planning, and prevention of sexually transmitted diseases. The Affordable Care Act includes provisions to address some of the issues of access for poor and vulnerable populations.



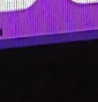
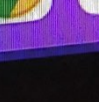
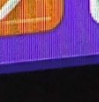
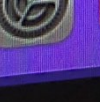
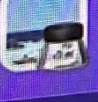


▶ What Is Outpatient Care?

Outpatient services do not require an overnight inpatient stay in an institution of health care delivery, such as a hospital or long-term care facility. Many hospitals, in addition to admitting patients for overnight or longer stays, have emergency departments (EDs) and other outpatient service centers, such as outpatient surgery, rehabilitation, and specialized clinics.

Outpatient services are also referred to as **ambulatory care**. Strictly speaking, ambulatory care constitutes diagnostic and therapeutic services and treatments provided to the "walking" (ambulatory) patient. Hence, in a restricted sense, the term "ambulatory care" refers to care rendered to patients who come to physicians' offices, hospital outpatient departments, and health centers to receive care. This term is also used synonymously with "community medicine" (Wilson and Neuhauser, 1985) because the geographic location of ambulatory services is intended to serve the surrounding community, providing convenience and easy accessibility to health care services for the members of that community.

However, patients do not always walk or drive their personal vehicles to the service centers to receive ambulatory care. For example, in a hospital ED, patients may arrive by land or air ambulance. EDs, in most cases, are equipped to provide secondary and tertiary care services rather than primary care. In other instances, such as with mobile diagnostic units and home health care, services are transported to the patient, instead of the patient coming to receive the services. Hence, the term





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Go to Next section



The Scope of Outpatient⁺ Services

Since the 1980s, extraordinary growth has occurred in the volume and variety of outpatient services, and new settings have emerged for delivering outpatient services. **TABLE 7-1** provides some examples. Hospital-based medical systems and integrated delivery organizations now offer a range of health care services that include a variety of outpatient services. In some areas, the growth of non-hospital-based ambulatory services has intensified the competition between hospitals and community-based providers over patients seeking outpatient care. Examples of such competitors in the outpatient services market include home health care, freestanding clinics for routine and urgent care, retail clinics, outpatient rehabilitation, and freestanding imaging centers. Other services, such as dental care and optometric services, remain independent of other types of health care services. Financing is the main reason for their independent nature: Medical insurance plans are generally separate from dental and vision care plans. Philosophical and technical differences account for other variations. Chiropractic care, for instance, is generally covered by most health plans but remains isolated from the mainstream practice of medicine. Complementary and alternative therapies as well as self-care are not covered by insurance, yet the products and services in these categories continue to experience remarkable growth.

TABLE 7-1 Owners, Providers, and Settings for Ambulatory Care Services

Part	Present
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TABLE 7-1 Owners, Providers, and Settings for Ambulatory Care Services

Past	Present
Owners/Providers	
▪ Independent physician practitioners ▪ Hospitals ▪ Community health agencies ▪ Home health agencies	▪ Independent physician practitioners ▪ Hospitals ▪ Community health agencies ▪ Managed care organizations ▪ Insurance companies ▪ Corporate employers ▪ Group practices ▪ National physician chains ▪ Home health companies ▪ National diversified health care companies
Service Settings	
▪ Hospital outpatient departments ▪ Physicians' offices ▪ Outpatient surgery centers ▪ Hospital emergency departments ▪ Home health agencies ▪ Neighborhood health centers	▪ Physicians' offices ▪ Walk-in clinics/urgent care centers ▪ Retail clinics ▪ Outpatient surgery centers ▪ Chemotherapy and radiation therapy centers ▪ Dialysis centers ▪ Community health centers ▪ Diagnostic imaging centers ▪ Mobile imaging centers ▪ Fitness/wellness centers ▪ Occupational health centers ▪ Psychiatric outpatient centers ▪ Rehabilitation centers ▪ Sports medicine clinics ▪ Hand injury rehabilitation clinics

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departments

- Physicians' offices
- Outpatient surgery centers
- Hospital emergency departments
- Home health agencies
- Neighborhood health centers

- Walk-in clinics/urgent care centers
- Retail clinics
- Outpatient surgery centers
- Chemotherapy and radiation therapy centers
- Dialysis centers
- Community health centers
- Diagnostic imaging centers
- Mobile imaging centers
- Fitness/wellness centers
- Occupational health centers
- Psychiatric outpatient centers
- Rehabilitation centers
- Sports medicine clinics
- Hand injury rehabilitation clinics
- Women's health clinics
- Wound care centers

Data from Barr, K. W., and C. L. Breindel. 2004. Ambulatory care. In: *Health care administration: Planning, implementing, and managing organized delivery systems*. L. F. Wolper, ed. 4th ed. Burlington, MA: Jones & Bartlett Learning. pp. 507-546.

Primary care is the foundation of ambulatory health services, but not all ambulatory care is primary care. For example, hospital ED services are not intended to be primary in nature. Conversely, services other than primary care have now become an integral part of outpatient services. Thanks to the technological advances in medicine, many advanced treatments are now provided in ambulatory care settings. Examples include conditions requiring urgent treatment, outpatient surgery, renal dialysis, and chemotherapy.

272 of 663

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▶ Primary Care

Primary care plays a central role in a health care delivery system. Other essential levels of care include secondary and tertiary care (distinct from the primary, secondary, and tertiary prevention discussed in the *Beliefs, Values, and Health* chapter). Compared to primary care, secondary and tertiary care services are more complex and specialized.

Primary care is distinguished from secondary and tertiary care according to its duration, frequency, and level of intensity.

Secondary care is usually short term, involving sporadic consultation from a specialist to provide expert opinion and surgical or other advanced interventions that primary care physicians (PCPs) are not equipped to perform. It includes hospitalization, routine surgery, specialty consultation, and rehabilitation.

Tertiary care is the most complex level of care, which is provided for relatively uncommon conditions. Typically, tertiary care is institution based, highly specialized, and technology driven. Much of tertiary care is rendered in large teaching hospitals, such as university hospitals. Examples include trauma care, burn treatment, neonatal intensive care, tissue transplants, and open heart surgery. In some instances, tertiary treatment may be extended, and the tertiary care physician may assume long-term responsibility for the bulk of the patient's care.

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It has been estimated that 75% to 85% of people in the general population require only primary care services in a given year, 10% to 12% require referrals to short-term secondary care services, and 5% to 10% use tertiary care specialists (Starfield, 1994). These proportions vary in populations with special health care needs.

Definitions of primary care often focus on the type or level of services, such as prevention, diagnostic and therapeutic services, health education and counseling, and minor surgery. Although primary care specifically emphasizes these services, many specialists also provide the same spectrum of services. For example, the practice of most ophthalmologists has a large element of prevention, as well as diagnosis, treatment, follow-up, and minor surgery. Similarly, most cardiologists are engaged in health education and counseling. Hence, primary care should be more appropriately viewed as an approach to providing health care rather than as a set of specific services (Starfield, 1994).

World Health Organization Definition

Traditionally, primary care has been the cornerstone of ambulatory care services. The World Health Organization (WHO, 1978) describes **primary health care** as follows:

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made

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274

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of both the country's health system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.¹

Three elements in this definition are particularly noteworthy for an understanding of primary care: point of entry, coordination of care, and essential care.

Point of Entry

Primary care is the point of entry into the health services system in which health care delivery is organized around primary care (Starfield, 1992). Primary care is the first contact a patient makes with the health care delivery system. This first contact feature is closely associated with the "gatekeeper" role of the primary care practitioner. Gatekeeping implies that patients do not visit specialists and are not admitted to a hospital without first being referred by their PCPs. The interposition of primary care protects patients from undergoing unnecessary procedures and overtreatment (Franks et al., 1992).

The United Kingdom's National Health Service (NHS) is an

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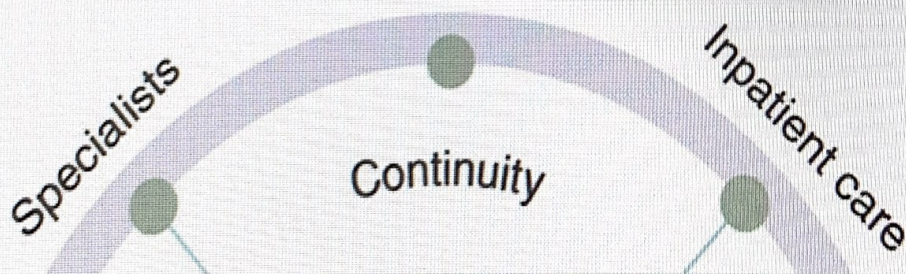
The United Kingdom's National Health Service (NHS) is an example of a health care delivery system founded on the principles of gatekeeping. In the NHS, primary care is the single portal of entry to secondary care and acts as a filter so that 90% of care is provided outside hospitals in ambulatory care settings (Orton, 1994). General practitioners (GPs) are primary care gatekeepers in the U.K. system. In the United States, under certain managed care, such as most Kaiser Health Plans, patients initiate care with their PCPs and obtain authorization when specialized services are needed.

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Coordination of Care

One of the main functions of primary care is to coordinate the delivery of health services between the patient and the myriad of delivery components of the system. Hence, in addition to providing basic services, primary care professionals serve as patient advisors and advocates. Coordination of an individual's total health care needs is meant to ensure continuity and comprehensiveness. These desirable goals of primary care are best achieved when the patient and the provider have formed a close mutual relationship over time. Primary care can be regarded as the hub of the health care delivery system wheel. The various components of the health care delivery system are located around the rim of this wheel, and the spokes signify the coordination of continuous and comprehensive care (FIGURE 7-1).



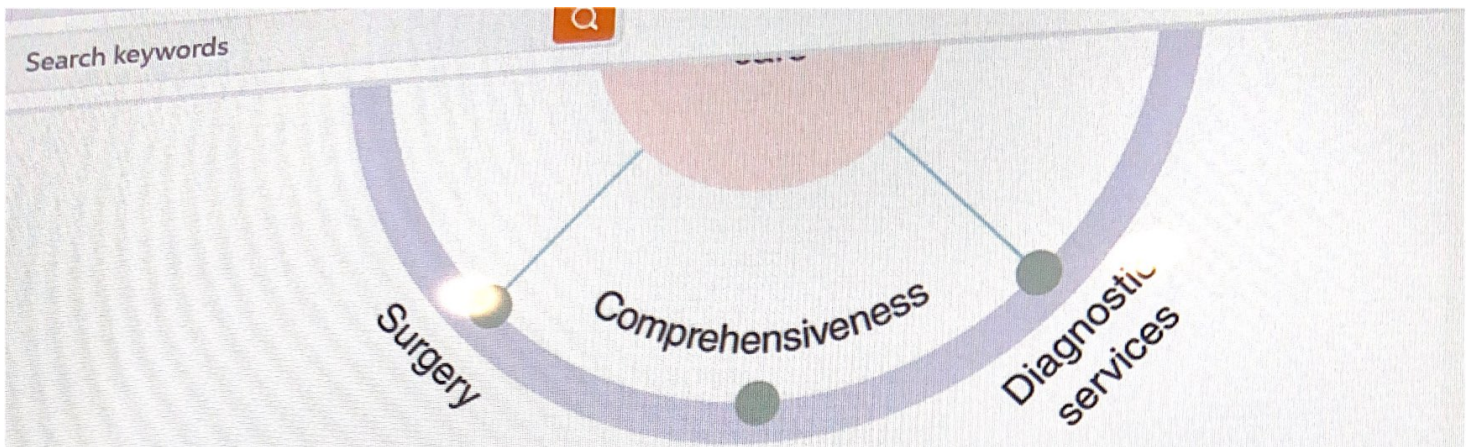


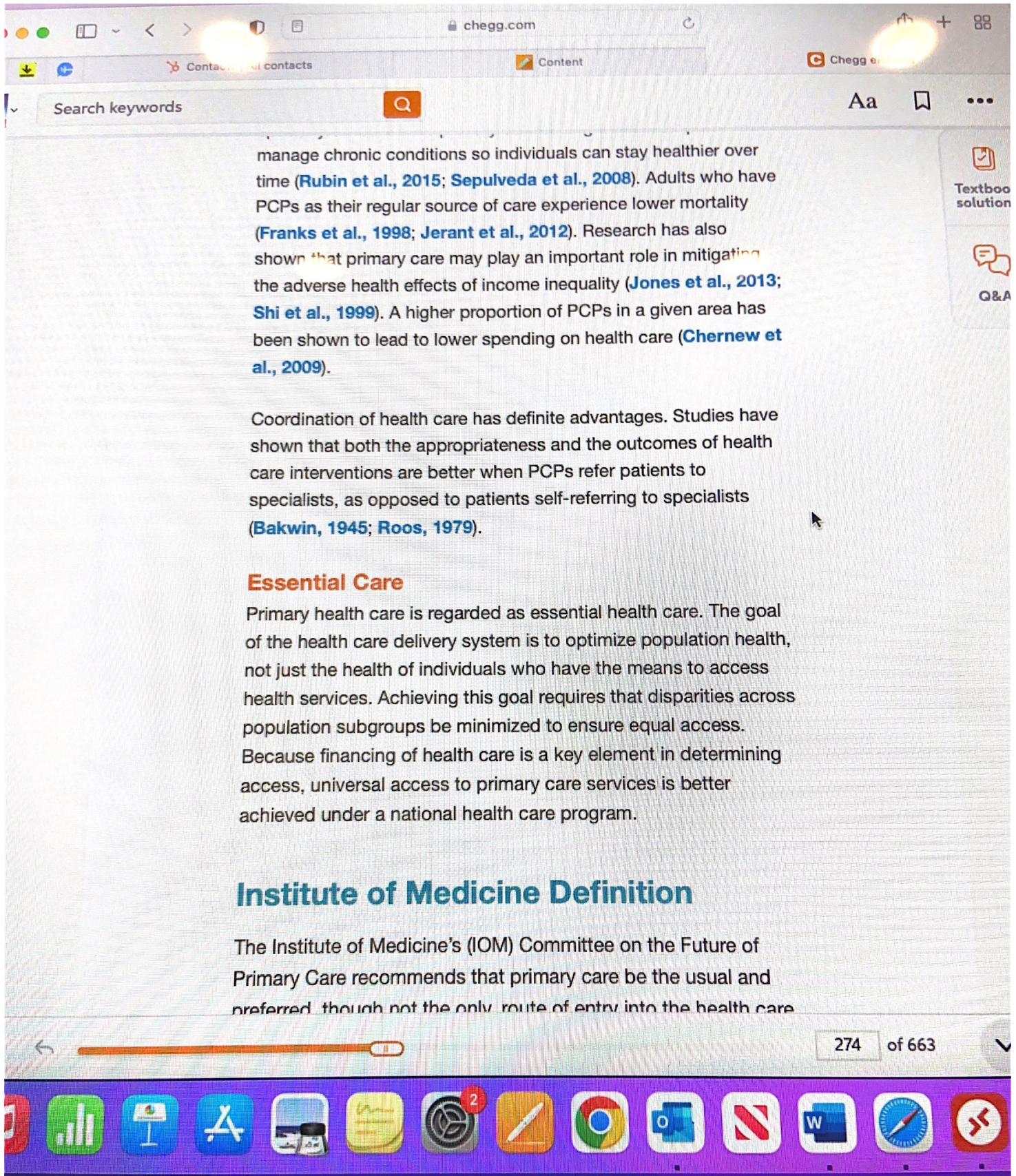
FIGURE 7-1 The coordination role of primary care in health care delivery.

275

Countries whose health systems are oriented more toward primary care achieve better health levels, higher satisfaction with health services among their citizens, and lower expenditures for the overall delivery of health care (Starfield, 1994, 1998). Even in the United States, better health outcomes are achieved in states with higher ratios of PCPs and better availability of primary care (Shi, 1994; Shi and Starfield, 2000, 2001; Shi et al., 2002). Higher ratios of family and general physicians in the population are associated with lower hospitalization rates for conditions that can be successfully treated with good primary care (Chang et al., 2011; Parchman and Culler, 1994). Having a regular source of primary care also leads to fewer ED visits and inappropriate specialty consults. The primary care setting is the ideal place to manage chronic conditions so individuals can stay healthier over time (Rubin et al., 2015; Sepulveda et al., 2008). Adults who have PCPs as their regular source of care experience lower mortality (Franks et al., 1998; Jerant et al., 2012). Research has also shown that primary care may play an important role in mitigating the adverse health effects of income inequality (Jones et al., 2013).

274 of 663





manage chronic conditions so individuals can stay healthier over time (Rubin et al., 2015; Sepulveda et al., 2008). Adults who have PCPs as their regular source of care experience lower mortality (Franks et al., 1998; Jerant et al., 2012). Research has also shown that primary care may play an important role in mitigating the adverse health effects of income inequality (Jones et al., 2013; Shi et al., 1999). A higher proportion of PCPs in a given area has been shown to lead to lower spending on health care (Chernew et al., 2009).

Coordination of health care has definite advantages. Studies have shown that both the appropriateness and the outcomes of health care interventions are better when PCPs refer patients to specialists, as opposed to patients self-referring to specialists (Bakwin, 1945; Roos, 1979).

Essential Care

Primary health care is regarded as essential health care. The goal of the health care delivery system is to optimize population health, not just the health of individuals who have the means to access health services. Achieving this goal requires that disparities across population subgroups be minimized to ensure equal access. Because financing of health care is a key element in determining access, universal access to primary care services is better achieved under a national health care program.

Institute of Medicine Definition

The Institute of Medicine's (IOM) Committee on the Future of Primary Care recommends that primary care be the usual and preferred, though not the only, route of entry into the health care

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The Institute of Medicine's (IOM) Committee on the Future of Primary Care recommends that primary care be the usual and preferred, though not the only, route of entry into the health care system. To emphasize this point, the IOM has defined primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Vanselow et al., 1995, p. 192).

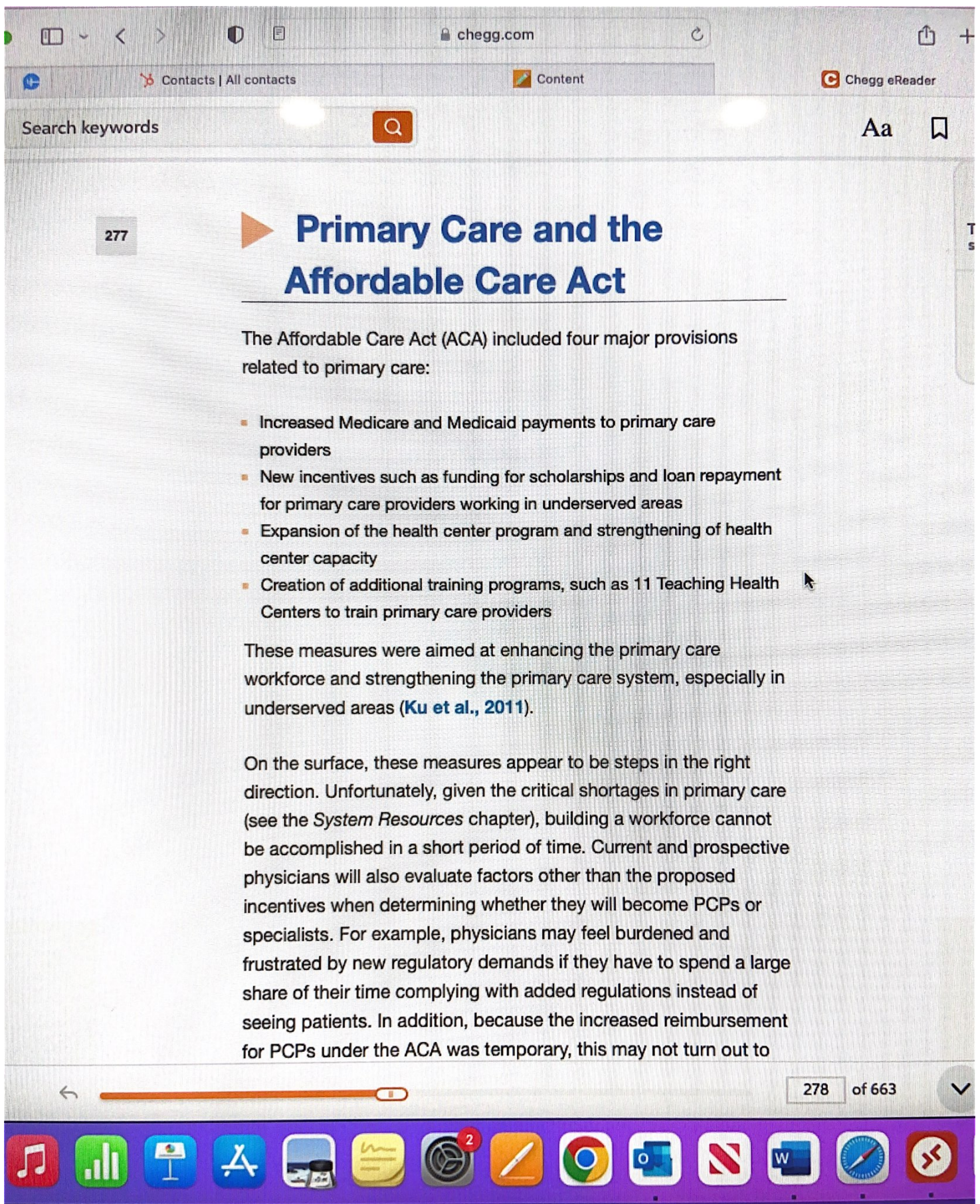
The term "integrated" in this definition embodies the concepts of comprehensive, coordinated, and continuous services that provide a seamless process of care. Primary care is *comprehensive* because it addresses any health problem at any given stage of a patient's life cycle. *Coordination* ensures the provision of a combination of health services to best meet the patient's needs. *Continuity* refers to care administered over time by a single provider or a team of health care professionals.

The IOM definition also emphasizes accessibility and accountability as key characteristics of primary care. *Accessibility* refers to the ease with which a patient can initiate an interaction with a clinician for any health problem. It includes efforts to eliminate barriers, such as those posed by geography, financing, culture, race, and language. Both clinicians and patients have **accountability**. The clinical system is accountable for providing quality care, producing patient satisfaction, using resources efficiently, and behaving in an ethical manner. Patients are responsible for their own health to the extent that they can influence it, as well for judicious use of resources when they need health care. The partnership between a patient and a clinician is based on mutual trust, respect, and responsibility.

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Various countries have established policies that hold primary care practices accountable for managing chronic conditions and meeting clinical standards. These policies tend to include financial incentives and primary care practice redesign, with an emphasis on information technology (IT) and use of interdisciplinary teams to support effective, safe, patient-centered, coordinated, and efficient care.

The IOM definition of primary care recognizes that primary care clinicians must consider the influence of the family on a patient's health status and be aware of the patient's living conditions, family dynamics, and cultural background. In addition, exemplary primary care requires an understanding of and a responsibility for the community's health (**Vanselow et al., 1995**).



277

▶ Primary Care and the Affordable Care Act

The Affordable Care Act (ACA) included four major provisions related to primary care:

- Increased Medicare and Medicaid payments to primary care providers
- New incentives such as funding for scholarships and loan repayment for primary care providers working in underserved areas
- Expansion of the health center program and strengthening of health center capacity
- Creation of additional training programs, such as 11 Teaching Health Centers to train primary care providers

These measures were aimed at enhancing the primary care workforce and strengthening the primary care system, especially in underserved areas (Ku et al., 2011).

On the surface, these measures appear to be steps in the right direction. Unfortunately, given the critical shortages in primary care (see the *System Resources* chapter), building a workforce cannot be accomplished in a short period of time. Current and prospective physicians will also evaluate factors other than the proposed incentives when determining whether they will become PCPs or specialists. For example, physicians may feel burdened and frustrated by new regulatory demands if they have to spend a large share of their time complying with added regulations instead of seeing patients. In addition, because the increased reimbursement for PCPs under the ACA was temporary, this may not turn out to

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As a result of the ACA, the primary care system in the United States is expected to experience an influx of newly insured patients. However, if PCPs become overburdened, many of the goals of primary care may remain unrealized for a large segment of the U.S. population.

The ACA also eliminated out-of-pocket costs for preventive services such as immunizations, certain cancer screenings, contraception, reproductive counseling, obesity screening, and behavioral assessments for children. This coverage is guaranteed for more than 137 million Americans, including 55 million women. Approximately 39 million Medicare beneficiaries have received preventive services such as cancer screenings, bone-mass measurements, annual physical examinations, and smoking cessation assistance due to the elimination of out-of-pocket costs for this care.

On another front, the ACA allocated \$1.5 billion to National Health Service Corps, a training program, which for decades has offered scholarships and loan forgiveness to young primary care clinicians who volunteer to practice in underserved areas. As of September

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New Directions in Primary Care

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Patient-Centered Medical Homes

The term "medical home" was first coined in 1967 to describe the team-oriented approaches developed for special-needs children whose health care needs require constant coordination. A **medical home** consists of an interdisciplinary team of physicians and allied health professionals who partner with patients and their families, taking responsibility for ongoing patient care using a team approach, technology, and evidence-based protocols to deliver and coordinate care. PCPs serve as advocates for patients to help them access services across the wide variety of health care services, ensuring that the patient's values, wishes, and directives are honored (Caudill et al., 2011).

The patient-centered medical home (PCMH) has emerged as a promising solution to address the significant fragmentation, poor quality, and high costs that afflict the U.S. health care system. With regard to PCMH and service utilization, evaluations of appropriate care have typically focused on greater use of preventive services, immunizations, and well-care visits, whereas evaluations of inappropriate use of services have examined outcomes such as ED visits, rates of hospitalization for preventable ambulatory conditions, and use of high-cost or inefficient procedures. Findings from these evaluations provide considerable support for the value of PCMHs, as they promote appropriate care and reduce inappropriate care (Christensen et al., 2013; Ferrante et al., 2015).

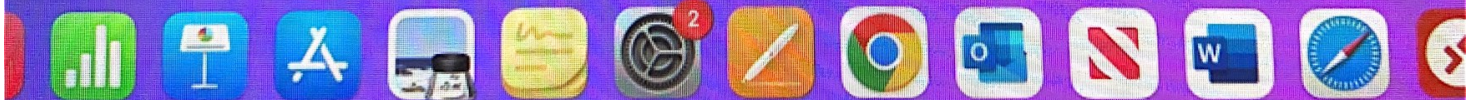




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In terms of the impact of a PCMH on the patient's experience and quality of care, studies suggest that both adult patients and parents of pediatric patients who go to a PCMH-designated primary care practice are satisfied with the care that they and their children receive and likely to perceive these health care interactions as positive experiences ([Christensen et al., 2013](#); [Rosenthal et al., 2015](#)); however, evidence for the associations between PCMH and some other quality indicators remains mixed ([Christensen et al., 2013](#); [Rosenthal et al., 2015](#); [Stevens et al., 2010](#)). Likewise, findings regarding PCMH and health care costs are inconsistent ([Christensen et al., 2013](#); [Gao et al., 2016](#); [Gilfillan et al., 2010](#); [Reid et al., 2009](#)).

In terms of the impact of PCMHs and clinical outcomes, several studies have demonstrated a positive impact of PCMHs on clinical measures at the practice level ([Gao et al., 2016](#); [Shi et al., 2015](#); [Shi et al., 2016](#)), but insufficient evidence is available to determine the effect of PCMH implementation at the patient level. More rigorous evaluations and standardization of key outcomes are





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concept and to assess the viability of implementation (Quinn et al., 2007).

A number of tools are used to assess important aspects of the PCMH. For example, the National Committee for Quality Assurance's (NCQA) Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH) tool is a practice self-report measure that has become the de facto standard used to judge “medical homeness.” It assesses nine standards: access and communication, patient tracking and registries, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. The three-level scoring system implicitly acknowledges that, for most practices, meeting these reporting standards will be a staged process (NCQA, 2008).

Unlike the NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC) conducts mandatory site visits to all applicants for its PCMH recognition program. AAAHC's recognition program involves the largest number of survey items by far (238 items), and AAAHC is unique in that it allows applicants to apply for either “accreditation” (which involves obtaining the base AAAHC accreditation in addition to meeting AAAHC's medical home standards) or a less burdensome option called “certification” (which does not require the base AAAHC accreditation). The AAAHC's Medical Home tool measures a practice's performance in regard to patient rights and responsibilities; organizational governance and administration; the patient-care team relationship; comprehensiveness, continuity, and accessibility of care; clinical records and health information; and quality of care (AAAHC, 2009).



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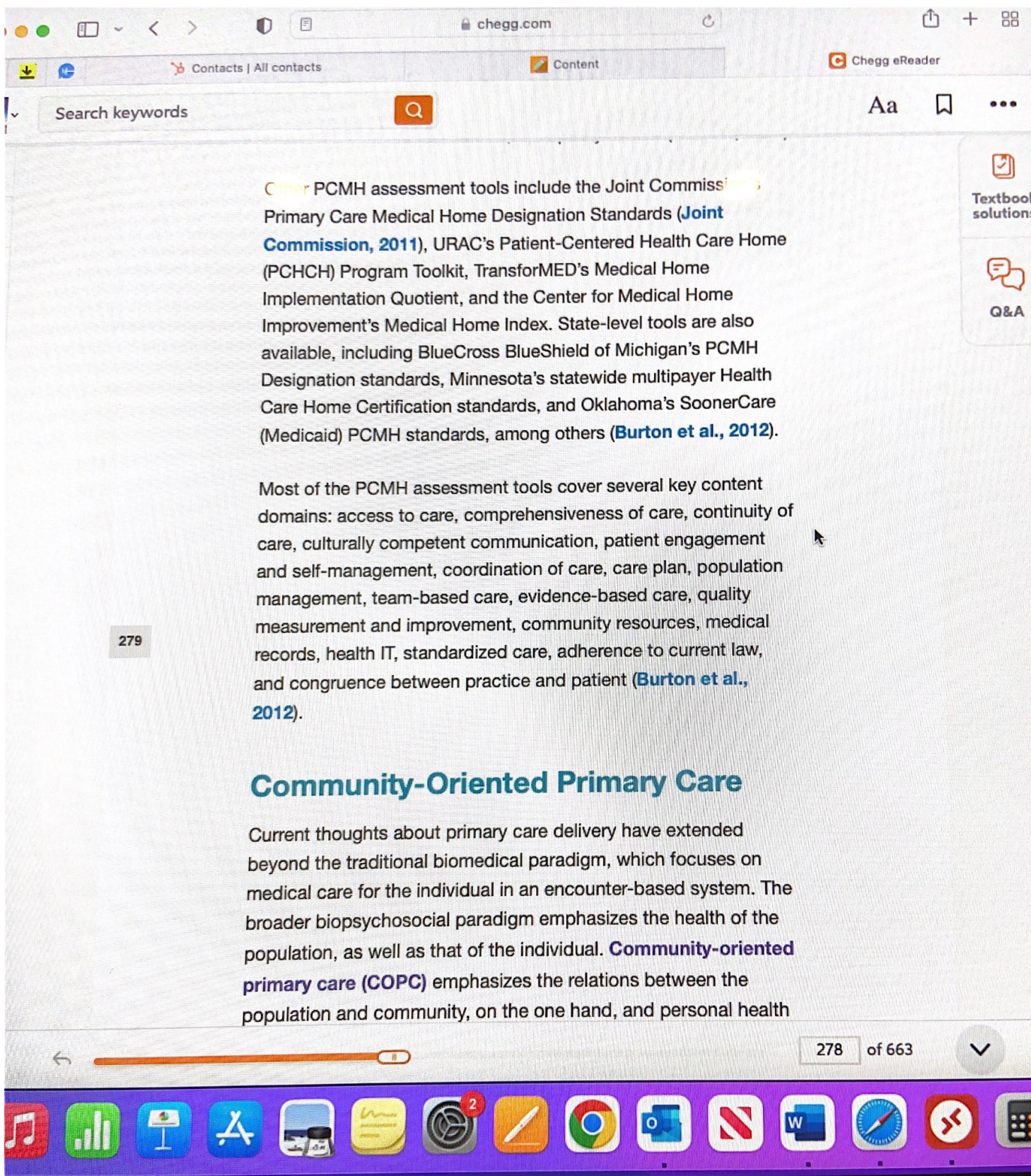


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278 of 663





Other PCMH assessment tools include the Joint Commission's Primary Care Medical Home Designation Standards ([Joint Commission, 2011](#)), URAC's Patient-Centered Health Care Home (PCHCH) Program Toolkit, TransforMED's Medical Home Implementation Quotient, and the Center for Medical Home Improvement's Medical Home Index. State-level tools are also available, including BlueCross BlueShield of Michigan's PCMH Designation standards, Minnesota's statewide multipayer Health Care Home Certification standards, and Oklahoma's SoonerCare (Medicaid) PCMH standards, among others ([Burton et al., 2012](#)).

Most of the PCMH assessment tools cover several key content domains: access to care, comprehensiveness of care, continuity of care, culturally competent communication, patient engagement and self-management, coordination of care, care plan, population management, team-based care, evidence-based care, quality measurement and improvement, community resources, medical records, health IT, standardized care, adherence to current law, and congruence between practice and patient ([Burton et al., 2012](#)).

Community-Oriented Primary Care

Current thoughts about primary care delivery have extended beyond the traditional biomedical paradigm, which focuses on medical care for the individual in an encounter-based system. The broader biopsychosocial paradigm emphasizes the health of the population, as well as that of the individual. **Community-oriented primary care (COPC)** emphasizes the relations between the population and community, on the one hand, and personal health

broader biopsychosocial paradigm emphasizes the health of the population, as well as that of the individual. **Community-oriented primary care (COPC)** emphasizes the relations between the population and community, on the one hand, and personal health care, on the other hand ([van Weel et al., 2008](#)). COPC incorporates the elements of good primary care delivery and adds a population-based approach to identifying and addressing community health problems. The main challenge has been bringing together individual health needs in the larger context of community health needs.

COPC incorporates the ideals espoused by both WHO and IOM in the delivery of primary care. The 1978 International Conference on Primary Health Care (held at Alma-Ata in the former Soviet Union, under the auspices of WHO) declared a philosophical vision of an affordable community-based primary health care system ([WHO, 1978](#)). More recently, WHO ([2010](#)) has offered some additional guidelines that encompass five key elements: (1) reducing exclusion and social disparities in health through universal coverage reforms, (2) organizing health services around people's needs and expectations, (3) integrating health into all sectors, (4) pursuing collaborative models of policy dialogue, and (5) increasing stakeholder participation. IOM ([2012](#)) has endorsed COPC as a dynamic, interdisciplinary model that integrates primary care and public health creating significant improvements in primary care delivery.

The application and adoption of COPC principles in actual practice, however, has not materialized in the United States. One fundamental problem is a lack of consensus on what a "community" is or should be. Assuming that consensus on the definition of a community can be reached, technological advances

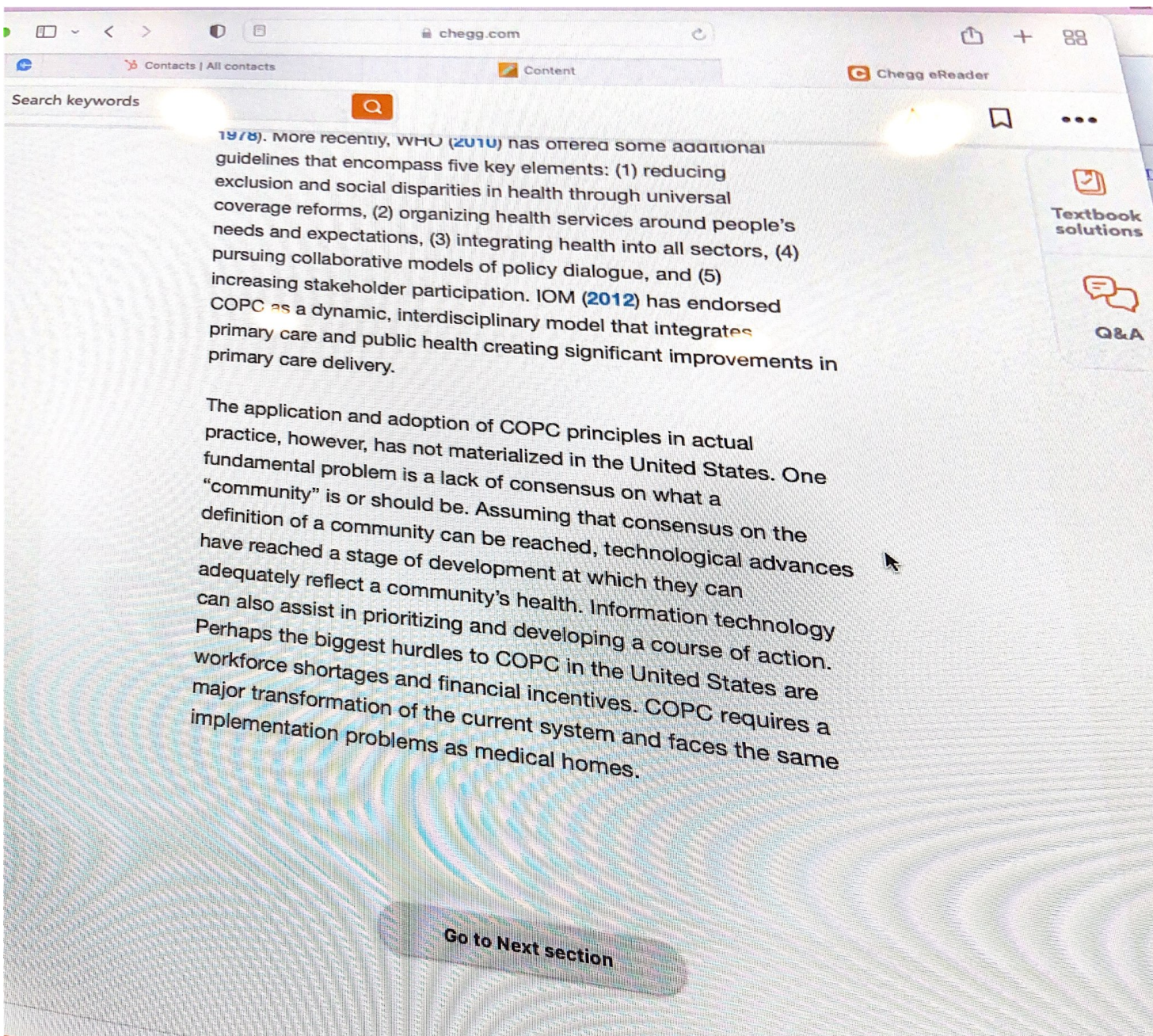


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1978). More recently, WHO (2010) has offered some additional guidelines that encompass five key elements: (1) reducing exclusion and social disparities in health through universal coverage reforms, (2) organizing health services around people's needs and expectations, (3) integrating health into all sectors, (4) pursuing collaborative models of policy dialogue, and (5) increasing stakeholder participation. IOM (2012) has endorsed COPC as a dynamic, interdisciplinary model that integrates primary care and public health creating significant improvements in primary care delivery.

The application and adoption of COPC principles in actual practice, however, has not materialized in the United States. One fundamental problem is a lack of consensus on what a "community" is or should be. Assuming that consensus on the definition of a community can be reached, technological advances have reached a stage of development at which they can adequately reflect a community's health. Information technology can also assist in prioritizing and developing a course of action. Perhaps the biggest hurdles to COPC in the United States are workforce shortages and financial incentives. COPC requires a major transformation of the current system and faces the same implementation problems as medical homes.

Go to Next section