

CAN PRIMARY CARE BE SAVED?

Redesigning primary care for quality, sustainability,
and meaning

Priscilla Wang, MD MPH
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 Mass General Brigham

Disclosures



I do not have any financial conflicts of interest to disclosure

The views and opinions expressed are those of myself and do not necessarily reflect the views or positions of entities with which I have affiliations

Key Points



Primary care is in crisis

The solutions to this crisis are not simply to improve efficiency, supply, or financing

We need to rethink the actual work of primary care – for quality, sustainability, and meaning

Primary Care in the US: Current State



Primary care is in crisis in the United States and globally



The
Commonwealth
Fund

 **Hospital News**

CANADA



Human Resources for Health

“Countries of the European region now appear to be on the cusp of a multi-layered, slow-burning primary care crisis” (2023)

Stressed Out and Burned Out: The Global Primary Care Crisis

Findings from the 2022 International Health Policy Survey of Primary Care Physicians

We need an all-hands-on-deck approach to solve the primary care crisis

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EDITORIAL

Open Access

The layered crisis of the primary care medical workforce in the European region: what evidence do we need to identify causes and solutions?



Giuliano Russo^{1*}, Julian Perelman², Tomas Zapata³ and Milena Šantrić-Miličević⁴



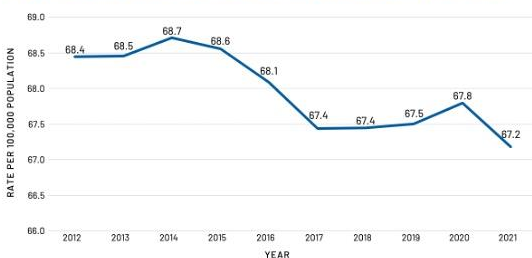
1. Primary care access is rapidly worsening (inadequate pipeline, worsening burnout accelerating departures)



THE HEALTH OF US PRIMARY CARE: 2024 SCORECARD REPORT

No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change)

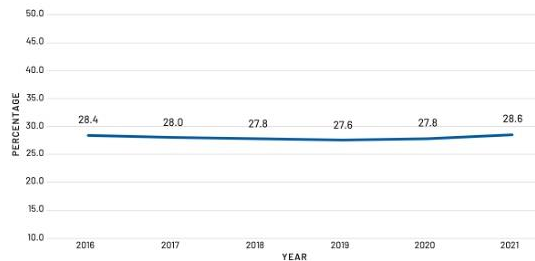
Figure 2. The Number of Primary Care Physicians per Capita Is Falling (2012–2021)



Data Source: Analyses of American Medical Association Masterfile (2012–2021), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2012–2021), and the American Community Survey 7 Five-Year Summary Files (2012–2021).

Notes: Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

Figure 4. The Share of All Clinicians (Physicians, NPs, and PAs) Working in Primary Care Remains Stagnant (2018–2021)



Data Source: Analyses of Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data, National Plan and Provider Enumeration System data, and Centers for Medicare and Medicaid Services Physician and Other Practitioners data, 2018–2021.

Notes: Primary care specialties included family medicine, general practice, internal medicine, geriatrics, pediatrics, and osteopathy. Estimates of nurse practitioners and physician assistants working in primary care were derived and are included in this figure. (See Appendix for detailed methodology.)



1. Primary care access is rapidly worsening (inadequate pipeline, worsening burnout accelerating departures)



At least **1 in 3** Primary care physicians (PCPs) under the age of 55 in all surveyed countries reported burnout



51% Of internal medicine and family medicine physicians reported burnout in the AMA's 2023 Physician Survey (top 2nd and 4th highest rates among all specialties)



45% Of US PCPs over the age of 55 surveyed planned to leave primary care within the next 3 years

Ref: "Stressed Out and Burned Out: The Global Primary Care Crisis", Commonwealth Fund (2022); AMA 2023 Organizational Biopsy



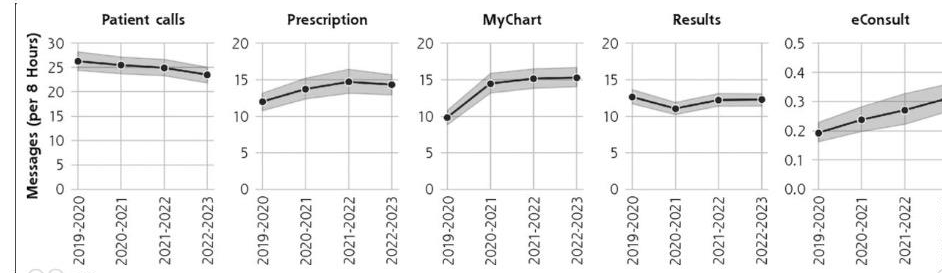
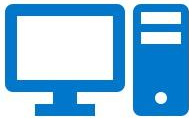
2. The work of primary care has become more complex and difficult, especially since the COVID-19 pandemic



More than half of primary care physicians in all countries said their workload has increased since the pandemic began.

Percentage of primary care physicians who said their workload “increased somewhat” or “increased a lot” compared to before COVID-19

The volume of electronic messages received by PCPs and time spent in the electronic health record (EHR) have increased since the pandemic, and remain increased

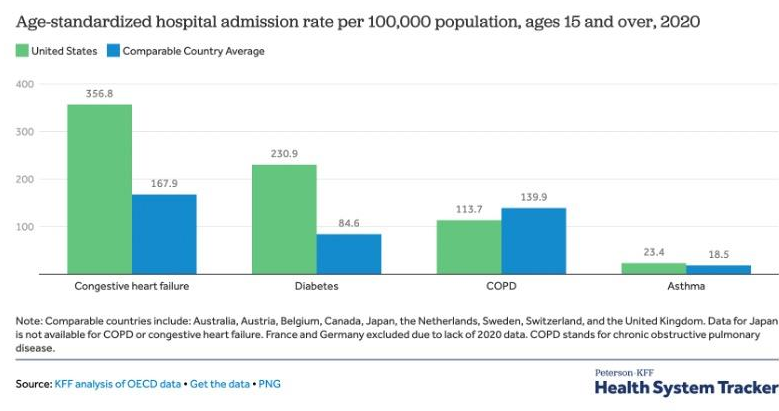
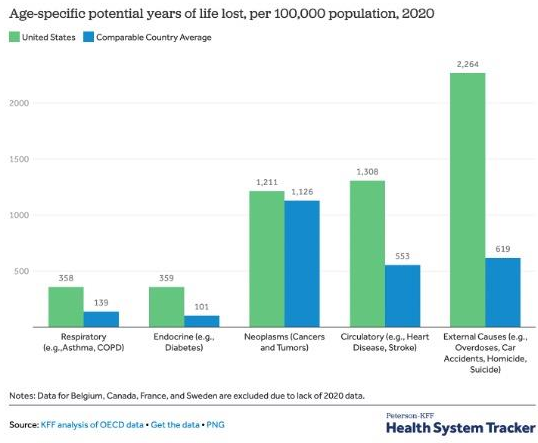


Ref: “Stressed Out and Burned Out: The Global Primary Care Crisis”, Commonwealth Fund (2022); Arndt et al, “More Tethered to the EHR: EHR Workload Trends Among Academic Primary Care Physicians, 2019-2023”

3. Primary care patients in the U.S. continue to experience poor health outcomes and health inequities



The United States has higher premature death rates and years of life lost, and higher readmissions for common conditions compared to other comparable countries



Ref: Wager et al, "How does the quality of the United States health system compare to other countries?", Kaiser Family Foundation, 2024



The background is a detailed technical drawing of a steam turbine engine, showing various components like turbines, condensers, and pumps. The drawing is in white lines on a dark blue background. A semi-transparent blue rectangle is overlaid in the center, containing the text. The drawing includes labels such as 'Zugflügelstahl', 'Abflügelstahl', 'Turbine 13', 'Turbine 12', 'Turbine 11', 'Kondensator', '401 W', '475 W', and '275 L W'. Dimensions like '3,86', '6,98', '1,67', '3,30', '6,30', '2,46', '3,59', '6,30', '2,46', '3,30', '1,67', '6,81', '3,89', '7,70', and '13,0' are also present. The text 'Addressing the US primary care crisis' is written in a bold, dark blue font within the blue rectangle.

Addressing the US primary care crisis

The solutions to the primary care crisis are not just simply to increase supply, improve financing, or implement technology



Simply increasing the **VOLUME** of providers (even via NPs and PAs) may help **ACCESS** but does not address the challenge of the **WORK** of primary care



Increasing **FUNDING** for primary care will help with creating new models of primary care, but needs to be paired with fundamental redesign



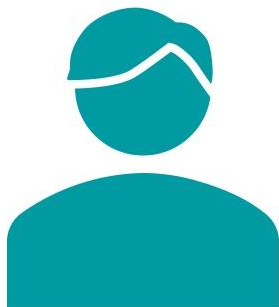
Implementing **TECHNOLOGY** has promise – but technology – when poorly implemented – can be a big part of the problem! (See EHRs...)

We need to rethink the actual WORK of primary care – what it takes for quality, sustainability, and meaning



What is needed for “quality care” depends on the unique patient – we need to map continuums of care

A tale of two patients:



“Lenny”

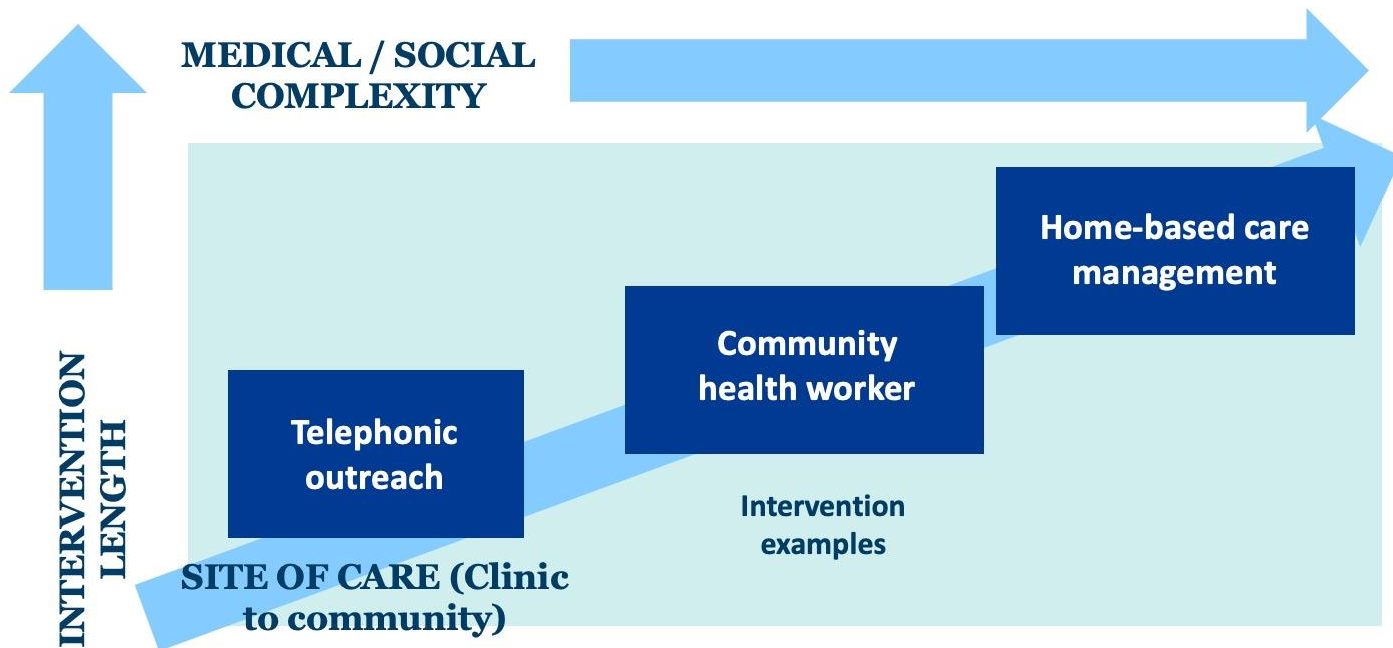
✓ 75 year old Black man with aphasia, early dementia, severe vascular disease, heart failure, social isolation



“Nancy”

✓ 24 year old Asian woman (domestic violence survivor), unhoused, food insecurity, anxiety

1. We need to fundamentally rethink *what* care we need to provide *to whom* and *by whom* – map the continuum



Wang et al, "Reframing Value-Based Care Management," *JAMA Health Forum*, 2023



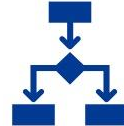
2. Define the baseline of care that needs to be provided to all and standardize and automate what is possible



Standard EHR
order sets



Result letter
templates



Clinical
algorithms



Defined
responses



CLINICAL CARE

Decreasing cognitive load by standardizing routine management for common chronic conditions



SOCIAL DRIVERS OF HEALTH

Screening without response causes moral injury – predefine a baseline for response, and indications for more support

3. Map and identify gaps, and define your team-based model based on needs – “pre-solve”



Design care from a patient—centered approach (what needs are not being met?) – and then identify the right roles for response (beyond PCPs)

CARE CONTINUUM CASE STUDY

The Mass General Brigham iCMP (Integrated Care Management Program) was created in 2012 to support high-risk, high-cost vulnerable patients

28,000+

Patients served

\$101

Savings/member/month

8%

Lower hospitalization rate



Care coordinators based in primary care offices



Multidisciplinary teams led by care coordinator



Care plans created with the patient, PCP & coordinator



4. Determine opportunities for financial sustainability by maximizing reimbursement and aligning with value-based care contracts

Identify all reimbursable services



Nursing visits in office

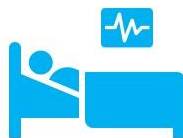


Pharmacist clinical management



CHW / care management

Align with value-based care contracts



Decreasing admissions

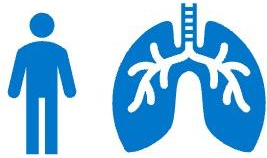


Hitting quality metrics



Funding models to allow innovation

5. The cure shouldn't be worse than the disease: we need to preserve the heart and humanity of primary care as well



Individuals / patients are not simply a collection of organ systems or body parts – and their care shouldn't be treated as such either



Physicians / providers are not just widgets in a system that are interchangeable – relationships take time to build

Let's actively design primary care systems to not only solve for problems, but to promote and protect what's necessary to be human and what brings joy in work

Summary



Beyond cost and access, let's redesign primary care around patient quality, sustainability, and meaning: **take-away points**



1. Map the continuum (complexity, site of care, length of need): what care, to whom, by whom



2. Define baselines of care & standardize & automate what is possible



3. Identify gaps on your continuum map, & define your team-based model to solve for needs



4. Support financial sustainability by identifying unique reimbursement options & aligning with VBC



5. Actively work to promote what makes primary care meaningful, joyful & dignified for all parties



Thank you!



Priscilla Wang, MD MPH

pgwang@mgb.org