Relationships Matter
How Usual is Usual Source of (Primary) Care?
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Dear Colleagues,

At the heart of many innovations in primary care is cultivating a stronger relationship between individuals and the primary care clinicians who care for them. The evidence base is clear that *Relationships Matter* and where they exist, patients are healthier, care is more equitable, and costs are curbed.

Unfortunately, not everyone seeking to establish such relationships finds it easy to do so. There are long wait times to get into practices and to get care, lack of after-hours and weekend appointments, jobs that do not provide sick leave, and financial barriers, to name a few impediments.

Increasingly, practices are enhancing access and communication via portals and telehealth but demand for primary care is outstripping supply, or what is available is not meeting patient needs. Retail pharmacies and urgent care offer access and convenience to primary care services, filling gaps. At least one survey showed that those seeking services in such settings would prefer an ongoing relationship with a clinician or a care team, but more research is needed.

The National Academies of Science Engineering and Medicine (NASEM) report defines primary care as a common good, recommending that all individuals have a usual source of care, and laying out strategies for public and private payers to support such relationships.

The Primary Care Collaborative’s 2022 Evidence Report shows declines in usual source of care across all ages, races/ethnicities, and insurance types since 2000, with a slight upturn in 2020. The report also shows more pronounced declines over the last five years for younger adults (18-34), those over 65, and individuals who have dual coverage (Medicare/Medicaid). Non-Hispanic Black and Hispanic Americans have lower usual source of care rates than their White counterparts, even after controlling for other factors.

There is no easy fix to re-establishing and strengthening these essential bonds between individuals, communities, and primary care – the fragility of which likely affected our nation’s resiliency when the pandemic hit and led to poorer outcomes. Solving this problem will take changes to payment and benefit design, new investment in primary care and workforce policies, and creative care delivery solutions that leverage technology and data.

We must re-double our efforts, learning from Federally Qualified Health Centers (FQHCs) and primary care innovators who are in underserved communities with very low usual source of care and are reversing declines.

The heart of primary care is stressed; it urgently needs our collective commitment to reverse course so we can achieve Better Health for all communities.

Kind regards,

Ann Greiner
President and CEO
Primary Care Collaborative
Executive Summary

THE CONTEXT

Research confirms the benefits to individuals of having a usual source of care (USC) — as a person or place that you can turn to with a health issue or concern — and generally considered primary care.

This robust evidence base documents better population health outcomes, more equitable care, and lower cost of care across all demographic groups who have an ongoing relationship with primary care.\(^1,2\) An ongoing relationship — often considered the “secret sauce of primary care” — can enable clinicians to better know and understand their patients’ needs and preferences, to build trust and rapport, and may result in higher patient satisfaction.\(^3,4\)

There are recent externalities that may be influencing USC trends, including:

- The continued implementation of the Affordable Care Act (ACA), which expanded coverage for the commercially insured and Medicaid — conceivably enhancing demand for USC.

- A rapid rise in employers offering high-deductible health plans, which can pose a financial barrier to people getting primary care services beyond screenings, perhaps decreasing the uptake of USC.

- A maldistribution of primary care, with growing shortages in under-resourced urban and rural communities, undermining the supply of primary care and contributing to individuals’ inability to find and retain primary care.

- The rise of alternative sources of primary care services — including urgent, retail, and digital — that affect where individuals are getting care and may substitute for a USC.

- The negative effects of the pandemic on the primary care platform — with estimated losses in 2020 of $15 Billion — resulting in early retirements and career changes.\(^5\) Simultaneously, patient demand for primary care increased.
TRENDS IN USUAL SOURCE OF CARE (USC)

Despite some factors that may enhance USC, the 2022 Primary Care Collaborative (PCC) Evidence Report shows that the percentage of Americans with an ongoing primary care relationship has been declining, falling 10% between 2000-2019, from 84% to 74%. In 2020, there was a slight uptick in USC to 75%, potentially attributable to the pandemic. It is not known if this will be a one-time increase or a change in trend.

FIGURE 1

Percent of U.S. Population with a USC

Data Source: Analyses of Medical Expenditure Panel Survey, 2000-2020.

Notes: HAVEUS42 and LOCATN42 were combined to construct a two-category USC measure. No USC includes respondents not having a USC and those who reported emergency department as the USC. Adjusted for gender, female, education, race-ethnicity, region, insurance coverage, and income.

Much of the data reported in the PCC’s 2022 Evidence Report is from the Agency for Healthcare Research and Quality’s (AHRQ) 2000-2020 Medical Expenditure Panel Survey. Other data sources include the 2019 Behavioral Health Risk Factor Surveillance System and the 2019 National Health Interview Survey.

There has been a shift in where individuals seek their USC, with those who define a person as their USC declining and those who report a facility as their USC increasing. Due to a change in the way that the question was asked, however, the survey does not allow for comparisons over time. In addition, it is not clear if people might identify a team providing care as a facility or a person within a facility.
The PCC report shows that states vary considerably in USC, with data from 2020 demonstrating a spread of 27%. The states with high rates — up to 84% — are in the upper Northeast and pockets of the Midwest. The lower rate states — as low as 57% — are concentrated in the Southeast and Southwest, particularly non-Medicaid expansion states, and include Alaska, Nevada, and Wyoming.

Insurance type matters, with those on Medicare and both Medicare/Medicaid having the highest rates of USC, followed by those with Medicaid and those with commercial insurance. Except for the uninsured, these trends are likely related to health, given that patients with more medical conditions are more likely to have a regular clinician. For the uninsured, it is not necessarily fewer health conditions, but instead the lack of insurance coverage and costs that are barriers to having a USC.
There is also a more recent, concerning trend in USC in two, disparate age cohorts. There was an increase in younger people, age 18 – 34, having no USC, from 38% in 2014 to 46% in 2019, an 8%-point swing. For those over 65, between 2014 – 2019 there was a 60% increase in the percentage of those without a USC: from 5.9% to 9.7%.

The younger population may favor the access and convenience that the growing prevalence of retail, urgent, and telehealth outside of an established relationship provide, not wanting to wait days, weeks, or months for an appointment. This cohort may also consult the internet for advice and answers. How much of this care-seeking pattern will remain in place as this cohort ages is an important future research question. On the upper end of the age span, the increase in no USC is surprising, given that more seniors are in Medicare Advantage plans, which typically have a higher rate of USC than traditional Medicare.

As with all demographic groups, there has been a decline in USC rates for non-Hispanic Black and Hispanic individuals, but both groups were starting from lower levels than White Americans.

More specifically, in 2019:

- Hispanic individuals had a 66% higher rate of no USC (34.3%), compared to their White counterparts (20.7%)
- Non-Hispanic Black individuals had a 37% higher rate of no USC (28.4%), compared to their White counterparts (20.7%)

Source: Analyses of Medical Expenditure Panel Survey, 2015 and 2020. Full results in Appendix Table 4.
When holding all other demographic variables constant — including age, insurance type, poverty, region, and income — the odds of having a USC is still lower for Non-Hispanic Black and Hispanic populations. The location of where populations receive their care also varies, with Black and Hispanic populations more likely to receive care in the Emergency Department or in a facility than from a person.

Taken together, these differences across racial/ethnic groups are concerning and may be contributing to ongoing and persistent health inequities, inequities that were made worse during the pandemic.

**POTENTIAL SOLUTIONS**

In recent years, primary care has been leveraging technology and teams to provide more ready access to primary care and to strengthen an ongoing patient-clinician relationship. These innovations include implementing patient portals to enhance bi-directional communication, offering telehealth and telephonic visits, and building out teams to provide more points of contact to primary care.

To date, these innovations to enhance the value proposition for primary care have not been sufficient to overcome structural barriers. Policies that could make a difference include:

1. **Change How and How Much We Pay Primary Care**

Both public and commercial payers should be investing more in primary care and paying through a hybrid payment model — predominantly capitated with some fee-for-service — as called for by the 2021 NASEM report. Despite robust conversations about value-based payment in primary care and in other parts of the health system, the dominant way primary care is paid remains fee for service. Investment, calculated as the percentage of primary care spend as a percentage of total cost of care, is a dismal 5-7 cents on the dollar.

Paying more and differently can support primary care building out teams to provide more access and more comprehensive services, support longer visits for patients who need more attention, promulgate creative ways of delivering care not tied to a visit, and attract and retain clinicians in primary care. Primary care teams, where all members are working to bring their talents and expertise, may be able to provide care that is more timely, individualized, and able to meet an array of patient needs.
2. Incentivize Selection and Remove Financial Barriers to Primary Care

With nearly half of those with commercial insurance (46%) in PPO plans that do not require primary care to gain access to specialist services, employers need to take steps to make it easy and worthwhile for employees to select and retain a USC. Some employers have provided financial incentives for employees to select a primary care practice and/or to get wellness visits, while others assign a primary care clinician. Covered California, for example, has coupled such policies with consumer education about the benefits of a regular source of care, no co-pays or deductibles for annual primary care wellness visits, and primary care visits that are generally not subject to a deductible.

A justified critique of assigning a patient to a practice, more prevalent in Medicaid plans and on some ACA exchanges, is that this kind of plan matchmaking may engender patient distrust and clinician backlash. There are approaches to mitigate these effects, including allowing the patient to change primary care practices at any time and leveraging demographic data to make sure there is geographic, racial/ethnic, and language concordance between a patient and their clinician.

Another challenge is the percentage of commercially insured individuals in high-deductible health plans (HDHPs) — hovering around 30% in recent years — that may provide a financial barrier to primary care services beyond routine screenings. Employers with an appreciation for primary care have established on-site or near-site primary care clinics for their employees to get care outside of the HDHP or have entered direct contracting arrangements to provide primary care services. More recently, a policy change was made that will enable HDHPs paired with Health Savings Accounts to cover the provision of chronic care services on a pre-deductible basis, which could have a favorable future effect.

Throughout the report, quotes from real patients have been used to highlight findings from the data. These narratives were collected by and used with the permission of Patients for Primary Care (P4PC). P4PC formed in 2022 to center the voices of patients in the movement to revitalize primary care. P4PC is a national network of community members telling our stories to help raise awareness of the need for greater investment in primary care to ensure healthier futures for our communities. P4PC partners with the Primary Care Collaborative and other organizations in educational and advocacy efforts. We invite community members to join our movement for high-quality primary care for all! Visit us at www.P4PC.org to watch videos of our stories, share your own story, and join our network of primary care patient activists.
3. Workforce Policies to Attract, Retain, and Diversify Primary Care

In addition to policies that support team-based care, there needs to be more effective approaches to diversifying the workforce so that it better matches patient race/ethnicity and to attract more students to select the specialty of primary care and practice in underserved areas.

Unfortunately, the U.S. has made almost no progress over four decades in the representation of non-Hispanic Black and Hispanic students in medical school.\textsuperscript{13} Most analysts agree that pathway programs that focus on recruiting racial/ethnic minorities into the health professions earlier in the education pipeline have the best track record and should be the focus.\textsuperscript{14}

To attract students to select primary care and address primary care workforce maldistribution, federal and state loan forgiveness programs focused on primary care clinicians practicing in rural and underserved areas\textsuperscript{15} could be made more generous, particularly\textsuperscript{16} as there is an average differential in earnings between primary care and subspecialists of approximately $100,000 a year.\textsuperscript{17}

And finally, efforts to train primary care clinicians in teams in community settings where people “work and live,” as recommended by the NASEM report, should be expanded. The evidence suggests that residents who train in rural and underserved settings, such as community health centers (CHCs), are much more likely to practice in such settings.\textsuperscript{18,19} One analysis found that if academic health centers were held to the same rate as CHCs for training physicians, Medicare could save $1.28 Billion. These savings could be used to train additional primary care clinicians to serve in rural and underserved areas.\textsuperscript{20}

One of the things that really worries me about primary care is burnout and short staffing and how hard they’re working and how much they’re giving, but yet they’re losing staff. They’re losing front office staff and nursing staff and [face an] inability to recruit good providers. In a [rural] community like ours, if there’s not good primary care, we simply don’t have access. We can’t go down the road to get it. And so I want my primary care office to be vibrant. I want it to be fully staffed. I want it to be well funded. And I don’t want to have to worry about them quitting and giving up because this is an unsustainable position.

Maret is a third-generation farmer and former educator living in eastern Colorado. Her family’s primary care clinician for many years was a nurse practitioner working at a rural clinic operated by a large health system.
About the Primary Care Collaborative

Founded in 2006, the Primary Care Collaborative (PCC) is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations, the PCC’s mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and achieve the “Quadruple Aim”: better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

www.thePCC.org

About the American Academy of Family Physicians (AAFP)

Robert Graham Center

The AAFP's Robert Graham Center aims to improve individual and population healthcare delivery through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels. The information and opinions contained in research from the AAFP's Robert Graham Center do not necessarily reflect the views or policies of the American Academy of Family Physicians.

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