COMMENTARY

The Impending Collapse of Primary Care: When is Someone Going to Notice?

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For 2 years, the Larry A. Green Center conducted weekly to monthly surveys among a national sample of primary medical care practices on how they were faring during the on-going COVID-19 pandemic in the United States. As both a family physician and as one of the analysts of these surveys and the thousands of detailed comments accompanying them, I witnessed a courageous, professional, and deeply distressing saga. The most recent surveys hint at an impending collapse of primary medical care as we have known it. This Commentary reflects what I heard, from remarkable efforts to rapidly implement virtual care platforms and reach out to vulnerable patients in the face of workforce losses and inadequate assistance including lack of personal protective equipment to a sense of betrayal when vaccines finally arrived but primary medical care was, too often, left out of the distribution efforts. The last surveys highlighted a loss of primary care workforce and the potential collapse of relationship-centered primary medical care. One of the respondents asks, "When is someone going to notice?"

Three areas for change are recommended. Build a larger, more diverse primary medical care workforce. Emphasize capitation as a foundation for payment reform in primary medical care. Establish primary health care extension services that focus on supporting practices and in helping them integrate with public health and their communities. Listening to each other, let us rise together with our patients and be noticed. (J Am Board Fam Med 2022;00:000–000.)

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If only someone had noticed, it did not have to be this way. As a family physician, researcher, and educator, I am witness to a harrowing, heroic, and deeply disturbing unfolding saga. The recent November through March polling of primary medical care clinicians by the Larry A. Green Center suggests the mathematics of impending collapse for primary medical care.[1] I serve as an analyst on that team. The Green Center has been conducting weekly to monthly surveys of 500 to 1500 family medicine, general pediatrics, and general internal medicine clinicians' practices, both independent and system-owned, since March 2020 when COVID-19 began its first surge in the United States (see note below for more details on sampling). All these data, including the demographics of the sample, are regularly posted on their website and that of the Primary Care Collaborative and occasionally referenced in the national press.[2,3] I encourage readers to review the executive summaries. The Green Center website also posts all identified media reports related to these surveys.

For 2 years, I tracked the survey responses and, more significantly, read the thousands of comments from our colleagues describing their situation. The number and length of the comments were astounding and atypical for survey research; the respondents' experiences and their emotional impacts overrode the usual inertia. This commentary comes from my listening heart and seeks to channel their voices, their courage and professionalism, and their moral despair and

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sense of betrayal. The commentary ends with a few suggestions on priorities for cocreating a different future.

Before the COVID-19 pandemic, primary medical care was already in serious trouble.[4] Despite overwhelming evidence of the importance of primary care to the nation's health, a recent National Academy of Science, Engineering, and Medicine (NASEM) report notes: "this foundation remain[ed] weak and under-resourced."[5] (p. 3). Nonetheless, when COVID-19 washed over the country in March 2020, primary care clinicians responded rapidly and heroically. They quickly launched virtual care platforms, helped in hospitals and emergency rooms, and reached out to meet their patients' myriad physical, social, and emotional health needs. They did so even as they lost staff, put themselves and their families at risk, and suffered significant revenue loss due to a payment system based on face-to-face piecemeal productivity and documentation.[2,3]

And yet they received inadequate assistance. During the first 5 months of the pandemic, more than half of primary care clinician respondents and their staff lacked access to essential supplies, such as masks, basic elements of personal protective equipment (PPE) and testing resources. What they received were frequent denials of virtual care billing, delayed and inadequate payments, furloughs, layoffs, staffing shortages, extended hours, and an occasional thank you. Yet as their patients were first to point out,[6] their primary care clinicians were there for them. As professionals and the front line of neighborhood health care, they kept showing up, doing the extra, acting on their professional commitment to patients and communities.

For over a year, the Green Center reported high levels of stress among clinicians and staff, mental exhaustion at all-time highs, business failures, impending closures of practices, the lack of staff and PPE. The more vulnerable, such as independent practices, lacked PPE for over a year.[2,3] This information was met mostly with silence from legislatures and back pages in the media. Not many, other than patients, seemed to notice.

Vaccines arrived. For a moment, this glimmer of hope allowed for relief from practice strain and support could be imagined on the horizon. But primary care practices, where a large percentage of patient visits take place in the context of trusting relationships,[7] were rarely included in pandemic planning or vaccine distribution. The place that patients most value for vaccine information and shared decision making received few vaccines.[8] Reality again sank in. Little help was coming. Surges came and went and were on us again with the appearance of the Omicron variant in December.

While primary care practices kept rising to meet their patients' needs, our survey results told of steadily growing weariness and exhaustion. With the last surveys of 2021 and early 2022,[1] the mathematics of impending collapse came into view. One could now imagine the disappearance of relational primary medical care. We saw:

- Open staff positions doubled over the previous ten months.
- In more than half of practices, awareness of clinicians planning to quit or take early retirement doubled.
- One out of 5 practicing clinicians expects to quit in less than three years.
- Closing of practices and lack of options for practice expansion means growing demand from patients for primary care. Too often, that demand was now unmet.
- Payment delays and denials have risen in a quarter of practices.
- Because of the demands on their time, nearly a third of clinicians have reduced their involvement in educating the future healthcare workforce.

Paradoxically, the number of clinicians reporting severe stress is gradually declining. This may partially represent the absence of those already out of practice or those too burdened to respond to the surveys as well as those learning and developing operational adaptations to the logistic stressors. It may also suggest that fatigue and exasperation are being "normalized," the numbing phase of the burnout spiral.[9] This often happens before you just give up. In the "Comments" section of the surveys, the clinicians painfully search for a listener. The voice of professional vocation, the "calling" that has long inspired those who chose primary medical care, is harder to hear. Instead, they ask, "When is someone going to notice?"

Primary medical care shares the loss of workforce and high rates of severe stress, moral distress, and burnout during the on-going COVID-19 pandemic with many other hospital specialties, nursing staff, and support staff. These latter have been visibly reported in the media and research literature and attracted the attention of policy makers and

health system leaders.[10,11] Primary medical care gets lost within that larger collective. When is someone going to notice that when a public health crisis arrived, the attention and resources mostly went to the secondary and tertiary sources of care, the hospitals and pharmacies, and not to the front-line primary care practices where sustained relationships and trust are developed?

A particular kind of relational primary medical care is disappearing. Its demise may well mean the continued loss of trust in in our health care institutions. Being cared for by a "brand" is not the same as the presence of your personal clinician and/or health care team. When you get sick or confront a frightening health-related situation, how many of you long for being able to see someone you know and trust and who knows you and will assure you receive the best information and care and stay with you through that process? Have you noticed how hard that is to find? It is almost gone.[12]

This loss does not have to happen. Change is still possible. But time is running out. Three areas for focused attention, if addressed, could make a tremendous difference, and allow us to rebuild a relational and generalist primary medical care after the pandemic. Those areas include a larger, more diverse workforce, more appropriate and stable payment, and greater support for practices and for linkages with public health and community organizations.

1. Build a larger, more diverse primary medical care workforce. The United States needs enough generalist primary care clinicians so that everyone has a trusted, personal, usual source of care, one place to go for information, testing, vaccines, and for care from those you know and who know you. This workforce should reflect the diversity of our country. Policy considerations will likely need to include graduate medical education payment reform and addressing debt repayment for those going into primary care practice. In addition, policies that promote and incentivize a medical school applicant pool of students from working- and lower-class backgrounds and minorities, especially African American, Native American, and Hispanic ethnicity would help address the current lack of diversity.

2. Emphasize capitation as foundation for payment reform in primary medical care. Paying for the care of practice populations and neighborhoods, and not paying per "widget," maintains financial viability throughout challenges like the COVID-19 pandemic.[13] It promotes innovation[14] and facilitates reaching out to patients at difficult times. Practices could respond to emergencies without fear of closing and retain their ability to pay staff. Some of the hybrid payment models advocated by the National Academy of Science, Engineering, and Medicine represent useful first steps.[5]

3. Establish primary health care extension services. Imagine if every state and large urban area had a viable extension service, like our agricultural extension services, connected to every primary medical care practice and public health service in the country.[15] Extension services would support practices; keep tabs on issues of concern; serve as distribution centers for PPE, testing, vaccines, and staff support; and facilitate linkages between public health, community organizations, and primary medical care.

Our health care policies, often with good intentions, have, nonetheless, systematically ensured none of this happens.[4] As a result, the long-term decline in high value primary medical care likely worsens, and the United States may soon be without a trusted and reliable relational generalist frontline for health care. Meanwhile, we on the forgotten frontlines can witness each other with compassion and in solidarity. Let us rise together with our patients. Maybe now, someone will notice.

Thank you!

Note: The surveys were distributed weekly-monthly through multiple national, state, and local primary care organizations and PBRNs (practice-based research networks). Because it was a snowball sampling strategy, the denominator and thus, response rates, are unknown, but all the samples were representative of the different primary care specialties and national regions and were a mix of small-to-large practices and of independent, system-owned, and community health centers. The surveys were mostly completed by clinicians at the practices, but some were also completed by staff members.

Thanks to all the family physicians and other primary care clinicians and their staff who keep rising to the call.

To see this article online, please go to: http://jabfm.org/content/35/6/000.full.

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