Community-Oriented Primary Care

Researchable Questions for Family Practice

Paul A. Nutting, MD
Tucson, Arizona

Family medicine is a restless discipline. Typical of our adolescence, we fidget and explore, seeking options for our mature identity. This process is healthy, and like adolescence, it leads to growth and maturity. We should forgive ourselves for our idealism and our occasional tendency to reach for unrealistic goals. The vitality of our youth drives us to boldly explore new ideas, and in this tendency lies our best hope of forging a better form of primary care for the American people.

Over the last several years, discussions of community-based approaches to primary care have crept into the language of family medicine.[1–6] These approaches vary more in strategy than in philosophy; the commonality lies in expanding our vision from the stream of individual patients passing through our examining rooms to a concern for proactively and systematically dealing with the health needs of a larger community. Community-oriented primary care (COPC) is among the approaches described[7–10] and more recently debated in the pages of the Journal.[11–13] It is generally agreed that COPC consists of three components: a primary care practice or program, a defined target population, and a systematic process for identifying and addressing priority health problems of the target population.[7] The third component, the process, consists of four functional steps: defining and characterizing the target population, identifying high-priority health problems, developing and instituting modifications in practice patterns or program policies, and monitoring the impact of the intervention strategy.

The fundamental principles of COPC allow considerable latitude in the type of target population to which the process can be addressed, including an entire community, a population enrolled in a particular health plan, a workplace or school population, or all members of the household of the active patients of a practice.[6,14] Alternative definitions of the target population determine the specifics of the COPC approach used.

The article by Gold and Franks in this issue of the Journal[15] illustrates a classic approach to COPC. An entire community was defined as the target population, and a survey was conducted for screening blood pressures, knowledge of cardiovascular risk factors, and selected dietary practices. The intervention program consisted of a brief educational session on cardiovascular risk factors delivered at the time of the initial survey, and follow-up to assure that individuals with elevated blood pressures were not lost to care. Most individuals were referred to their identified source of care, and follow-up services on a sliding fee schedule were offered to those indicating financial barriers to follow-up. A comparison of before and after measures in a control community allowed the authors to demonstrate a positive impact of the intervention on blood pressure and knowledge of risk factors, albeit with little measured effect on risk behaviors.

The application of the principles of COPC to a range of practice settings offers a rich substrate for family practice research. First are questions of the economics of COPC. What are the fixed costs of the quantitative (and nonreimbursable) activities required to define and characterize the community, identify priority health problems, implement practice modifications, monitor impact, and further refine intervention strategies? Are additional revenues generated from the provision of additional health services to members of the target population? How does the margin of revenues generated compare with the costs of the COPC process? Does the cost (or profitability) of COPC vary depending on the type of intervention, such as attempts to find undiagnosed hypertension in the population, to prevent unwanted teenage pregnancies, or to provide smoking cessation services to those addicted to tobacco?

COPC is often challenged for the lack of evidence of an impact on the health of the target population. The same criticism could be levied, of course, against other ap-

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From the Indian Health Service, Tucson, Arizona. The views expressed are those of the author and do not reflect official policy of the Indian Health Service or of the US Public Health Service. Requests for reprints should be addressed to Paul A. Nutting, MD, Indian Health Service, 7900 SJ Stock Rd, Tucson, AZ 85746.

proaches to primary care or other forms of specialty care. Nonetheless, studies are needed to measure the impact of the COPC process relative to its costs to both the practice and society. How might positive health impacts within a target population be measured? How does impact vary by type of target population addressed and by characteristics of the primary care practice?

Both the costs and the impact of COPC will vary depending on the type of problem addressed and the intervention strategy employed. Will COPC prove of value in health promotion and disease prevention and in modifying individual behavioral risk factors? Can COPC effectively address a maldistribution of health services among the target population? Can the COPC process be effective in identifying and addressing previously unrecognized health problems in the community?

Often the COPC process is assumed to begin with a baseline study of the community, yet in many cases this first step may not be necessary, particularly when there are data available from public health sources as well as information available from community organizations and knowledgable individuals. Is the time and expense of an epidemiologic study justified in terms of the new information it provides about community problems, about priorities for intervention among problems, about the feasibility or projected impact of specific interventions? Are there easier and more economical ways of deriving the same information or coming to the same conclusions? Can a nominal group process discover the same information when the group consists of health professionals and members of the target population? Can analysis of the existing data on the target population or the larger community of which it is a part provide comparable information? How might combinations of approaches be fashioned for maximum information at minimal cost?

One should also be careful not to equate every community-based intervention with COPC. Too often an emphasis program is called COPC simply because it is based in the community or has grass-roots participation in planning and operation. COPC is a particular process by which appropriate interventions are generated and monitored; isolated from the process that generated and will continue to monitor and refine it, the intervention itself is not COPC. In promoting the research base of COPC, it is critically important to address research to the COPC process itself. How and why is a particular problem identified as a high-priority problem? What other problems might have been addressed in this community with equal or greater impact on the health of the community? How and why is a treatment strategy selected as opposed to a strategy of primary prevention? What might have been the impact of a similar level of resource directed toward other problems equally important in the community? Why might personal contact, rather than mass media, be selected as the central strategy? What are the marginal impacts of further refinements in the intervention strategy based on information obtained by monitoring the impact of the program?

Of the obstacles to COPC cited, the difficulty in defining a target population that does not overlap with neighboring practices poses the immediate and most vexing challenge. Defining the target population as all members of the households of active patients has been offered as an approach potentially suitable for virtually every family practice,[6,14] and recent studies have suggested that individuals are accessible among both the inactive patients[16] and the nonpatients.[14]

Addressing a practice population consisting of all members of the households of active patients also provides an opportunity for innovative intervention strategies that may be embedded within the natural dynamics of the family. Enlisting family members in outreach and employing a family-centered intervention is feasible and may reduce the need for formal outreach workers. Involving members of the family in the intervention is not a new concept to family physicians and may be particularly productive in effecting behavioral change, such as smoking cessation, diet modifications, and exercise, that may be more successfully initiated and maintained in the context of the family.[17]

As family medicine continues to explore strategies for improving its contribution to the health of individual communities, COPC deserves both our attention and best efforts. COPC offers a rich soil for further research by family physicians, and Marthe Gold and Peter Franks are to be commended for their important contribution to this end.

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