From the Editor

How Should We Measure Success (or Failure) in Primary Care?

The care we deliver is a product not only of our knowledge but also of the systems we've put in place.

I'm a failure. Actually, you're a failure too. We're all failures! At least when it comes to metrics and performance, that's how it feels.

For some reason, this week has been metric-heavy. In modern medicine, every week is metric heavy, I guess, but this week was more so. Mammogram care gaps, access metrics, financial shared savings. All that stuff. All week long. And maybe I'm alone on this, but I've never gotten a performance report that says "100%! Good job! You get an A!" Never.

This got me thinking about how we measure success — or the converse, failure — in primary care. It's easier to measure these things in procedural-based specialties. Removal of the wrong limb during surgery is a glaring failure. Similarly, the language of inpatient safety reporting is riddled with terms like CLABSI (central-line associated blood stream infection), CAUTI (catheter-associated urinary tract infection), and other HACs (hospital acquired conditions) measured to determine inpatient safety.

We don't yet have similar "failure" language in primary care, but imagine the following: A patient with heart failure calls your office for a same-day appointment, but you have no open spots, and the patient ends up in the hospital for heart failure exacerbation. The care we deliver is not just a product of our medical knowledge; it's also a product of the systems we've put in place to use that knowledge. So was this a failure? A colleague of mine used to say, "Every hospital admission represents a failure of outpatient care." You can imagine how popular he was at the Department of Family Medicine meetings!

On the one hand, he's correct. Simply seeing high-risk patients more frequently has been shown to reduce admissions.[1] This is a systems issue. Build the system in your office to be more receptive to seeing the patients who need to be seen, when they need to be seen, and your quality of care will improve.

On the other side of that pancake, as my mom used to say, are all the variables we cannot control. A patient is more likely to have an inappropriate admission if they have even one of the following: renal failure, sensory deficit prior to admission, previous mobility impairment, hypoalbuminemia, diabetes mellitus, obesity, active smoking, cardiovascular disease, and on and on. That describes just about every one of my patients! Highly complex patients are more likely to be admitted, whether appropriately or inappropriately.[2] And these are just the medical issues. When we factor in social determinants of health, we see additional reasons for admission that are difficult to control.[3] And I haven't even touched on the pharmaceutical side of this equation, whether it's the cost of or access to medications,[4] limited clinical benefits,[5] or adverse effects.[6]

The point is that outpatient primary care is complex. Robert Eidus, MD, MBA, made a keen observation that primary care physicians are "relationship-based comprehensivists."[7] We take care of the whole complex patient, not just their catheter, not just their limb — the whole person, including variables we might only have a minimal impact on.

I'm trying to get to the spot where I don't view any score less than 100% as a failure. I think it's a common personality flaw among those of us who went into medicine. One way to get there is to focus on the change we can make, the mistakes we can avoid, and the illness we can prevent. Develop systems. Listen to your patients. Worry about those gaps that can be closed. By that definition, all of us in family medicine can be successful. FPM

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