Ganguli and colleagues explored national trends in receipt of preventive services among older adults with multiple comorbidities enrolled in Medicare based upon having a usual care clinician (UCP). Previous research has linked having a UCP with improved health outcomes and high-value care, as well as improved mortality with greater primary care physician supply. What is unknown is whether having a specialist vs a primary care clinician (PCP) as a UCP is associated with differences in preventive services, including the relevant topic today during the COVID-19 pandemic regarding uptake of routine vaccinations in the older adult population.

Using the Medicare Current Beneficiary Survey (MCBS), an administrative claims-linked survey database, Ganguli and colleagues found that the proportion of older adults enrolled in Medicare with a UCP declined a small amount between 2010 and 2016 and remained quite high at 94.2% and 91.0%, respectively. Additionally, the authors found essentially no shift in the proportion of Medicare enrollees having their UCP as PCP as opposed to a specialist clinician. In the adjusted analyses of Medicare enrollees with a UCP, a specialist clinician compared with a PCP as a UCP was not associated with differences in receipt of preventive services other than receiving the annual influenza vaccine.

The more sobering results of this study are found in Table 3. Although a small percentage of included Medicare enrollees were without a UCP, these adults had lower incomes and more frequently self-reported as having Black or Hispanic race or ethnicity. Adults without a UCP saw significant declines in routine evidence-based preventive services, with an abysmal uptake in vaccinations for seasonal influenza, pneumonia, and shingles. Similarly, while the majority of included Medicare enrollees had a UCP, adults without a PCP were vulnerable to missing important evidence-based services that typically fall into the purview of PCPs, most notably immunizations. The findings are also disappointing because the time under study included the passage and adoption of the Patient Protection and Affordable Care Act.

Although Ganguli and colleagues found an association between having a UCP and uptake in preventive services, we are left without an answer as to why this association exists, or why a minority of Medicare beneficiaries do not have a UCP. Events of recent years provide at least some insight into both uptake of vaccination and barriers to primary care.

As the COVID-19 pandemic has persisted largely due to undervaccination, US adults cite health care professionals as an important source of information when considering getting vaccinated. While administration of vaccines at community pharmacies, rather than physician offices, has increased substantially for Medicare beneficiaries, the physician-patient relationship may be a key component driving vaccine uptake. Why adults do not have a PCP is unclear, and likely is reflected in individual and system-based changes. Increased cost-shifting to individuals through greater out-of-pocket costs has been associated with lower PCP utilization, while closure of health care facilities in socially vulnerable rural and urban areas has further limited access to populations with already restricted options. Regardless, there are situations when factors outside the control of patients and health care professionals result in an inability to provide preventive services, which was witnessed in the last year as COVID-19 radically reshaped health care delivery.

For better or for worse, the substantial increase in the use of telemedicine during the COVID-19 pandemic has been a natural experiment in health care delivery in the US. Its impact on preventive services among Medicare beneficiaries is illuminating. The beginning of the COVID-19 pandemic shut
down “business as usual” in health care and led to a substantial decrease in office-based primary care visits with a concomitant increase in telemedicine. Although there remain disparities in access to primary care, even with expanded access with telemedicine, the addition of multiple modes of connecting with patients can improve the patient-clinician relationship. Concomitantly, Medicare beneficiaries who are socially disadvantaged have lower rates of COVID-19 vaccination. Expanding the availability of primary care may help build trust with adults disenfranchised from the health care system, and thus improve uptake of preventive services.

It is unlikely that a usual care clinician alone can solve issues of undertreatment and inequity if older adults do not have access to and resources necessary for acute, chronic, and preventive care. Qualitative research is needed to understand why those with Medicare do not have a UCP, as data abstracted through insurance-based claims are unlikely to provide insight into how we can best improve health care delivery and access for this population. Once barriers to care are better understood, prospective and ideally randomized clinical trial data will be necessary to determine how well suited a health care model is to improve access to timely care, such as COVID-19 vaccines to vulnerable populations.

ARTICLE INFORMATION
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