Reinventing Primary Care: Embracing Change, Preserving Relationships

Richard L. Kravitz, MD, MSPH[1] *and Mitchell D. Feldman, MD, MPhil*[2]

[1]Division of General Medicine, University of California Davis, Sacramento, CA, USA; [2]Division of General Internal Medicine, University of California, San Francisco, San Francisco, CA, USA.

J Gen Intern Med
DOI: 10.1007/s11606-017-3994-1

Patients and doctors have reason to be dissatisfied with the US health care system. It is expensive. It is unreliable. It is unfair. And it can be alienating, both to those who receive care and those who provide it. If you are an average American, your chance of receiving recommended immunizations and cancer screenings is less than 75% (that's a "C" in most high schools).[1] If you have an acute upper respiratory tract infection, there's a good chance you'll be over-treated with antibiotics.[2] If you develop a serious symptom like syncope or hematuria and you are uninsured, you are unlikely to see a physician, at least not until things get worse.[3] If you are burdened with multiple chronic conditions (and assuming you have health insurance), you will probably see multiple specialists, each providing excellent evidence-based care for their disease of interest, but often oblivious to the effects of their ministrations on your overall health and life.

There is a prescription for what ails us, but it doesn't come in a bottle. It's called primary care. As defined by the pioneering work of Barbara Starfield, primary care is "first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system."[4] High-quality primary care has been associated with improved population health, lower costs, and greater equity.[5] Despite this evidence, primary care has been consistently under-resourced, accounting for just 6% to 8% of US health care expenditures (https://www.uhc.com/content/dam/uhcdotcom/en/ValueBasedCare/PDFs/UNH-Primary-Care-Report-Advancing-Primary-Care-Delivery.pdf). Newer payment models introduced under the Affordable Care Act raised expectations, but even those modest gains appear threatened under the new administration in Washington. It is unrealistic to anticipate a significant influx of resources into primary care anytime soon.

Thus, at least in the short term, physicians, patients, and policymakers interested in supporting a more comprehensive, dynamic, and thriving primary care sector in the United States cannot depend wholly on the federal government. Fortunately, there is still much that can be done. We need to look to new models that deliver a better care experience, achieve better population health outcomes, and control costs. In short, we need to reinvent primary care.

In this issue of *JGIM*, we are pleased to feature six articles, supported by a special grant from the California Health Care Foundation, that review the current landscape of primary care innovation; stimulate thinking on new directions for primary care; and begin to construct an agenda for energetic reform. In the first article, Ellner and Phillips[6] provide a roadmap for primary care reinvention. They emphasize four principles: reforming payment, supporting relationships, building teams, and enlarging the scope of primary care practice. The principles are inextricably linked in ways both obvious and subtle. For example, primary care physicians (PCP) cannot possibly aspire to more comprehensive practice without the support of teams and a payment model that supports investment in personnel and infrastructure to support quality.

In the next piece, Shrank discusses how new primary care delivery models, harnessed to changing consumer expectations, can lead to more patient-centered care.[7] However, he cautions that such models will require both information technology interoperability (so PCPs can remain informed about treatment their patients have received in retail and employer-based clinics) and payment reform (so PCPs are fairly compensated for the time it takes to coordinate care across settings).

Care delivery models that work for the average health care consumer (educated and relatively affluent) may not fit the needs of more vulnerable groups, particularly those whose health conditions or social circumstances conspire to create high health care needs. The article by Hochman and Asch[8] addresses two divergent approaches to caring more effectively for vulnerable, high-need, high-cost populations. Specialized clinics, outfitted to address the medical and social needs of these complex patients, seem particularly effective, even if not practical in many settings. In contrast, "complex case management programs" are readily integrated into existing primary care practices, but evidence for their effectiveness is scant. The most successful case management models use care coordinators who develop close personal relationships with both patients and PCPs.

The confluence of medical and mental health problems complicates the job of the PCP. The complications are not simply additive; physical health problems are a drag on

Published online: 27 February 2017

psychological well-being, while mental health problems can intrude on adherence and "will to function." In the fourth Symposium article, Kroenke and Unutzer[9] review the body of evidence supporting collaborative care models for improving quality of mental health services delivery in primary care. These models emphasize the population perspective; use standardized measures (such as the PHQ-9 for depression); employ a "treat to target" approach; support care by teams of PCPs, nurses or lay coordinators, and mental health specialists; and make liberal use of brief psychological therapies.

Medicine has been slow to embrace innovations in information technology (IT) that are routine in other industries, and primary care is no exception. The paper by Young and Nesbitt[10] offers hope that technology can extend the reach and enhance the effectiveness of PCPs as they strive to manage the health care needs of a defined population. Wisely applied, IT can capture data from bodily sensors to aid clinical decision making; ensure the safety of frail elderly through home monitoring; and help patients tap into robust social support structures through e-communities. No less important, IT may serve to strengthen links between PCPs and subspecialists, allowing PCPs to safely expand their scope of practice under supervision. Such collaboration may serve as a counterweight to current trends, in which patients often are swept out of primary care into the subspecialty sector, a trend that contributes to a decline of PCP skills and demoralization.

Primary care stands little chance of reinvention if there are insufficient primary care physicians available. The primary care workforce pipeline is thus of critical importance. In the final essay in this Symposium, Cassel and Wilkes[11] focus on one aspect of the pipeline problem: developing and nurturing student interest in primary care during medical school. Their prescription is based on the theory that students need to train in environments where the practice of primary care aligns with the principles of primary care. They argue that medical schools closely affiliated with integrated health delivery systems may be in the best position to deliver on this aspiration. They also emphasize the importance of health delivery science as the basic science foundational to primary care practice and leadership.

There is an unexpected common thread in these six articles: the importance of preserving and supporting human relationships. Yes, patients want convenience, but they also want a trusting, longitudinal relationship with a competent, caring PCP who is committed to their well-being. Other relationships are also vital, including those involving office staff, subspecialists, mental health consultants, and complex care management teams. We think systems that support and nurture these human relationships will thrive; those that ignore them will ultimately falter. As these six articles underscore, reinventing primary care is not for the faint of heart. However, it is essential if we are to have a health care system that is accessible, equitable, improves patient outcomes, and provides value for money.

Corresponding Author: *Richard L. Kravitz, MD, MSPH; Division of General MedicineUniversity of California Davis, Sacramento, CA, USA (e-mail: rlkravitz@ucdavis.edu).*

Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. **Schuster MA, McGlynn EA, Brook RH.** How good is the quality of health care in the United States? Milbank Q. 2005;83:843–895. doi:10.1111/j.1468-0009.2005.00403.x.
2. **Fleming-Dutra KE, Hersh AL, Shapiro DJ, Bartoces M, Enns EA, File TM, Finkelstein JA, Gerber JS, Hyun DY, Linder JA, Lynfield R, Margolis DJ, May LS, Merenstein D, Metlay JP, Newland JG, Piccirillo JF, Roberts RM, Sanchez GV, Suda KJ, Thomas A, Woo TM, Zetts RM, Hicks LA.** Prevalence of inappropriate antibiotic prescriptions among US ambulatory care visits, 2010–2011. JAMA. 2016;315(17):1864–1873. doi:10.1001/jama.2016.4151.
3. **Baker DW, Shapiro MF, Schur CL.** Health insurance and access to care for symptomatic conditions. Arch Intern Med. 2000;160(9):1269–1274. doi:10.1001/archinte.160.9.1269.
4. **Starfield B, Shi L, Macinko J.** Contribution of primary care to health systems and health. Milbank Q. 2005;83:457–502. doi:10.1111/j.1468-0009.2005.00409.x.
5. **Franks P, Fiscella K.** Primary care physicians and specialists as personal physicians: health care expenditures and mortality experience. J Fam Pract. 1998;47:103–4.
6. **Ellner AL, Phillips RS.** The coming primary care revolution. J Gen Intern Med. doi: 10.1007/s11606-016-3944-3.
7. **Shrank WH.** Primary care practice transformation and the rise of consumerism. J Gen Intern Med. doi: 10.1007/s11606-016-3946-1.
8. **Hochman M, Asch SA.** Disruptive models in primary care: caring for high needs, high cost populations. J Gen Intern Med. doi: 10.1007/s11606-016-3945-2.
9. **Kroenke K, Unutzer J.** Closing the false divide: sustainable approaches to integrating mental health services into primary care. J Gen Intern Med. doi: 10.1007/s11606-016-3967-9.
10. **Young HM, Nesbitt TS.** Increasing the capacity of primary care through enabling technology. J Gen Intern Med. doi: 10.1007/s11606-016-3952-3.
11. **Cassel C, Wilkes M.** Location, location, location: where we teach primary care makes all the difference. J Gen Intern Med. doi: 10.1007/s11606-016-3966-x.