The Unfinished Story of Family Medicine Transformation

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1998 was a year of great change. How we communicate, bank, arrange travel, and shop were being transformed by the new Internet browsers that rose just 3 years earlier. Tom Friedman referred to 1995 as the beginning of the third phase of human civilization, the information age.¹ In 1998, the Institute of Medicine (IOM) convened the Committee on the Quality of Healthcare in America. The charge to the committee was to vision a 21st century health care system where the gap between the care most Americans received and what was available would be closed. What the committee found was not a gap, but a chasm, and a report was released in 2001 to cross that chasm by transforming how health care is delivered.²

Building on the IOM report, leaders in family medicine convened and released a Future of Family Medicine Report in 2004.³ To meet the quality needs of the public, the process of delivering family medicine needed to change from brief episodic office visits on paper records to a continuous process of care using advanced information systems. Family medicine took the lead for all of primary care to bring about this transformation. Fewer medical school graduates were choosing to enter primary care, making the need for transformation an imperative.⁴

In 2007, the primary care organizations came together and released the principles for the patient-centered medical home (PCMH).⁵ PCMH practices would offer continuous access to care through a team of caregivers all working to the level of their license. Care coordination outside of office visits became the hallmark of a PCMH practice. Multiple organizations are offering certification in PCMH practice and this is becoming the new standard for primary care.

With the passage of the Affordable Care Act in 2010, many more Americans will have health insurance and access to care. The efficiencies of PCMH practice include greater teamwork, not relying on the physician to do everything, and non-visit communication and care focused on delivering care to populations. Health systems are forming out of the cottage industry of independent private practice and are being called upon to be accountable for the health of the population being served. Accountable care organizations (ACOs) are being challenged by financial incentives to follow the Triple Aim: improved health to populations, an improved experience of receiving care, and a reduction of wasteful health care spending.⁶

In his timely article in this issue of Family Medicine, Macaran Baird, MD, MS, calls upon us not to be complacent with all that has been accomplished in the last 10–15 years.⁷ PCMH practices are not the end of the transformation, but the beginning, and they need to become a new way of operating a practice, not a geographic location. Family medicine should continue to lead all of primary care into a process of improving the health of populations, a complex task with multiple facets that must be addressed.

Pioneers in primary care have taught us much about how to make a difference in population health. Health is not just about receiving medical care, and the social determinants of health must be addressed to make a difference. Jeffrey Brenner in Camden, NJ, has mobilized effective teams to bring health to some of the most challenging populations, including care to very high cost patients known as “hot

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spotters.” Dr Baird has been among a group of leaders working to being mental health providers into primary care in a collaborative model that is gaining traction because it works to keep patients out of emergency rooms and hospitals, the standard for reducing wasteful health care spending.9

Innovations in primary care can be found at the Patient-Centered Primary Care Collaborative (www.pcpcc.org) and at the Center for Excellence in Primary Care, led by Thomas Bodenheimer, MD, and Kevin Grumbach, MD.10 The complexity of advanced information systems, especially electronic health records and current coding practices, requires much greater teamwork and a changed role for the physician to be more efficient and effective.11,12

Nothing really changes until the financial incentives are in place. Internet-based enterprises, such as Google, Cisco, and Oracle, succeeded and became among the world’s largest businesses by finding a path to financial success. If primary care continues to be paid on a visit-based productivity formula, that is what will dominate. Financial incentives for population health, and delivering care without visits, are growing and must continue to be supported to drive transformation. Financial disincentives for wasteful health care spending are working well in hospitals. For primary care, using Internet communication and care offers great efficiency in reducing the need for expensive office visits for minor problems and ongoing communication about chronic illness care and preventive services. Prepayment for care coordination and rewards for successful performance will help drive this change.

Leaders in family medicine are convening again to provide a 2.0 version to the Future of Family Medicine effort. Let’s hope they heed the words of Dr Baird and not be complacent with the gains that have been made with PCMH so far. The transformation called for in the IOM report back in 2001 is still far from being realized, an unfinished story. Family medicine is still vulnerable to becoming an anachronism if it does not embrace the information age with Internet-based applications for communication and care. Primary care services can be provided by many different people in many different places, such as at Wal-Mart and the local pharmacy. Activated patients will increasingly be able to arrange their own care and even assemble their own medical homes. Through transformation, family medicine may remain the go-to resource for providing health through relationship-centered care.

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References