Primary Care in the Age of Reform—Not a Time for Complacency

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BACKGROUND AND OBJECTIVES: Improving opportunities for primary care are evident in the evolving health care marketplace. Yet a secure and meaningfully scaled role in the future for family medicine and primary care is not assured. Family medicine can help lead the primary care movement now—from both clinical and policy perspectives—by energetically embracing newly emerging care options rather than becoming complacent or defensive. Avoiding complacency means: (1) improving assessment and intervention for social and health system complexity (our complex patients), (2) regarding primary care as a way of operating, not as a geographical place—even with the name medical home in place, (3) coordinating with dedicated mobile teams for our most complex and costly patients, and (4) improving leadership competence at a level required for transformation, not just maintenance. (Fam Med 2014;46(1):7-10.)

In 2014, we see continued hope for significantly improved opportunities for primary care in the evolving health care marketplace. Yet we still have a long way to go to secure a highly functional and meaningfully scaled role in the future for family medicine and primary care in the context of local and regional environments. Family medicine can help lead the primary care movement now—from both clinical and policy perspectives—by energetically embracing newly emerging care options rather than becoming complacent or defensive. Avoiding complacency means: (1) improving assessment and intervention for social and health system complexity (our complex patients), (2) regarding primary care as a way of operating, not as a geographical place—even with the name medical home in place, (3) coordinating with dedicated mobile teams for our most complex and costly patients, and (4) improving leadership competence at a level required for transformation, not just maintenance.

Avoiding Complacency

Having established standards and successful implementation of functional patient-centered medical homes (called health care homes in Minnesota), we in primary care may feel happy about our new place closer to the center of importance in the evolving health care systems. We are proud of these accomplishments and look forward to our emerging opportunities.

The risk is that we may be seduced into being complacent regarding the value of the health care home and its relative “security” as a central organizing feature of a new health care system as we strive to move past the legacy of the “non-system.” The emerging opportunity is to integrate our own primary care services or health care homes with a rapidly expanding set of emerging care options not necessarily part of the health care home, such as retail clinics and mobile clinical teams for complex patients. Such options are now blossoming with the promise to become efficient and focused ways to improve patients’ health and experience while reducing overall costs—the Triple Aim. If primary care is to adapt constructively to these emerging care options, it must learn to quickly reach beyond primary care offices into the patient’s world at home and in the community via well-connected and well-coordinated care linked effectively to retail clinics, mobile teams, telephonic care, and hospital and specialty care. At the same time, we must continue to implement the key elements of the health care home and make those aspects work well through improved efficiency, better teamwork, better leadership, and improved processes that lead to improved outcomes.

These four precautions are offered to prevent complacency in the face of primary care successes and encouraging opportunities.

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(1) Improve assessment and intervention for social and health system complexity.
Many of the issues that inhibit positive outcomes for underserved and disadvantaged patients and families fall into the general category of social determinants of health—the conditions in which people are born, grow, live, work, and age, including the health system. Beyond these non-health care social factors associated with health, for many patients some barriers to positive outcomes relate to the complexity of the health care system itself—poor communication among providers, lack of a shared care plan, poor hand-offs during transitions from inpatient to other facilities or to home, and incompatible electronic records, to name a few common issues. Taken together, social and health system complexity are impediments to health and are interferences with care. Incorporation of concepts and methods for managing patient complexity are emerging and described elsewhere.

It is no surprise that within our health care home enterprises, many are fully committed to the continued integration of behavioral health (including addiction risk reduction). The perceived need for such integration is growing, and we are welcoming this shift locally and nationally. This must continue to expand to meet patients’ needs effectively. Many clinicians consider behavioral health co-morbidities or behavioral health factors part of the larger picture of “complexity.”

Some have observed that in the United States we have over-defined many patient complaints and dilemmas as mental health diagnoses, thus medicalizing dilemmas that are more directly linked to personal distress and social or community themes. This has led to many articles in the professional and popular press regarding over-use and appropriate use of psychotropic medication in primary care and psychiatry. By more accurately defining these social and community sources of distress and impediments to health and health care, the community and health systems can offer more adaptive and very different “non-medical” options for assistance, which are potentially more effective and less costly.

To be adaptive to reality, all care systems must find ways to identify sources of complexity—whether social, care system, or behavioral health—and deal with them successfully by creating action steps. With time, health systems will test which social, community, and care system interventions are most appropriate to achieving the Triple Aim.

(2) Regard primary care as a way of operating, not as a geographical place.
Primary care practices must avoid sitting in their clinics celebrating their successes in establishing efficient and patient-friendly health care homes. We run the risk of becoming the modern medical equivalent of the ineffective, passive, structurally fixed French defense against attack during the early phases of World War II, called the Maginot Line. The Maginot Line was a fixed, linear defense system hundreds of kilometers long that committed a huge proportion of a nation’s primary defense to a stationary, highly defended, immobile structure that attacking forces simply avoided by running mechanized armor around the fixed line and by flying a skilled air force easily over the line. The net result for France in World War II was a quick loss of their major defensive resources that ultimately sped their surrender to the hostile force.

Although other parts of the health care system are not necessarily hostile to primary care, it is clear that all must move ahead together with whatever improves health and reaches the Triple Aim. This means considering primary care and health care home as a philosophy and operating principle rather than a place to sit down and get comfortable should trends toward greater emphasis on primary care and health care home continue. Primary care is owed no loyalty or protection from the need to adapt rapidly and work well with emerging options for care. In our current medical era, using the health care home as a fixed, immobile approach to serving the patient’s needs on the way to achieving the Triple Aim would put all primary care at risk of becoming less relevant and to miss the contemporary opportunities in front of us. Primary care must also be mobile, adaptive, and ready to connect with others with options for reaching patients in need.

(3) Incorporate or coordinate with “hot spotters” and other mobile providers.
Mobile means able to meet patients or sub-populations of patients where they are, not necessarily through appointments in the medical home. A small clinical team defined at the level of each patient or sub-population to meet particular needs is sometimes called a clinical microsystem, and these can be quite mobile rather than embedded in primary care clinics.

Many markets in the United States are similar to that in the Midwest in which small entrepreneurial practices are asked by either insurance plans or larger health systems to focus their attention on a relatively small number of highly complex patients who are doing very poorly in the current health care environment. Often physician, nurse, pharmacist, and social work teams are assigned 100–150 patients, given ready access to whatever resources they think they need, a portable medical record usually housed in a laptop, and recommendations to be effective and aggressive in meeting the patients’ needs. These teams are burgeoning in the Midwest and probably in other areas of the US health care system.

Such mobile teams do not rely on a fixed health care home. They create a health care home environment around the patient in need. These small teams are built to adapt if the patient needs to shift the focus.
of care in the direction of social services or social support, improved understanding of the complex medical regimen, and/or integrating behavioral health or addiction services directly in the patient’s life. With the patient’s and family’s permission, those non-medical services as well as innovative medical services are gathered and made available quickly to the family and patient. Smaller and larger systems are finding these “hot spotter teams” highly effective, cost efficient, and highly satisfying to patients and families.22,23

Such hot-spotter teams will address the needs of the top 1%–5% of complex patients. However, as they expand and become more and more efficient, opportunities for direct application of services to the patient can also expand to a wider share of the market or additional sub-populations. Reinforcing this trend is the fact that hospitals are penalized for readmissions, cost overruns, and patient dissatisfaction at the same time that pressures mount to track and reduce the total cost of care—part of the Triple Aim. These pressures create momentum to shift more resources and talent to reach patients effectively wherever they can be helped most efficiently, often at home.

Highly coordinated health care homes can facilitate reductions in hospital readmissions, use of emergency rooms, and can house numerous efforts to integrate behavioral health care, as well as improve the patient’s experience at a lower cost. But doing so will require active integration with hospital services and a variety of expanding outpatient services, telephonic services, and mobile teams.

(4) Improve leadership competence. Most primary care leaders agree that business models must change and are creating new business options with variable degrees of success across the United States. Primary care contracts and methods of payment are gradually reaching beyond the normal fee for service model into innovative alternatives to pay for care management, to pay rewards for quality outcomes, and to create risk-bearing or gain-sharing contracts that offer greater rewards for reaching the Triple Aim. To accomplish these goals, it is essential that primary care create and expand educational opportunities in innovative leadership models to ensure that all participants on our primary health care team understand the larger issues, think at levels beyond the immediate clinical task to make that task relevant to the larger purposes, and communicate effectively and respectfully about our various roles for the expanding team. No longer is it sufficient for clinics and their leaders to be expert in designing and maintaining clinical systems. They also must be skilled and engaged in transforming practice and helping everyone adjust to changes in their professional identity, whatever the work is, who they do it with, and what counts as a good result. This takes leadership competency, usually at a level not previously recognized in primary care.24,25

Conclusions At this time in history it is important to take pride in what we have accomplished in primary care and at the same time maintain enough tension and dissatisfaction with our approaches so we accept and make use of emerging options for care that will help us achieve the Triple Aim. With the emergence of a rapidly evolving and increasingly sophisticated ambulatory outreach sector of the health care environment, including retail clinics and mobile teams, the rather fixed geographic nature of health care home runs the risk of being circumvented or bypassed. One risk to primary care is that insurance systems and large delivery systems will not see the health care home as capable of handling the higher level of complexity that many patients represent. Resources will be directed toward those who can reach the more expensive and more likely to be failing patients while a shrinking ratio of routine care could be delivered through the health care home. Over time many of those routine services could be increasingly managed by telephonic services, home measurement of routine labs, and by asynchronous Internet interactions or in retail clinics. Potentially fewer patient problems will require face-to-face visits in ambulatory offices or health care homes.

Primary care can adapt to the emerging opportunities, integrate our services with advanced mobile health care teams, and integrate the information gained to deliver efficient and more satisfying care still anchored in health care homes. A health care home can connect with retail clinics, pharmacies, and schools for common problems, hot-spotter teams for the few highly complex and costly patients, and can connect with the other community resources without becoming a Magnin Line of bricks and mortar that quickly becomes obsolete. Instead, primary care can link effectively to new mobile or other options for care designed to reach patients or sub-populations where they are. This can serve the Triple Aim in a manner that is practical, humane, and effective—and truly integrated with specialty care in the context of family and community and the many health and care options open to them.

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