

EDITORIAL

Primary Care: The Good, The Bad, and the Truly Ugly

This year will mark the 35th anniversary of my graduation from the University of Rochester School of Medicine and Dentistry in Rochester, NY. The occasion fills me with ambivalence. On the one hand, I take great pride, of course, in this important accomplishment and all of the training and work that has followed. On the other hand, I am troubled by the current state of my chosen clinical specialty, namely primary care—general internal medicine. What I see is the good, the bad and the truly ugly!

I gave up inpatient hospital-based care nearly eight years ago, after assuming the deanship of our College of Population Health, but I still see patients in our faculty general internal medicine ambulatory practice. Of course I'm not as busy as my full-time clinical partners, but I like to think that I can still make a difference in the lives of certain patients. In fact, at 60 years of age, I'm among the oldest full-time, campus-based primary care general internists on the faculty at Jefferson.

Some of the good that I see is the "change being driven by delivery system reforms emanating from Washington, including the meaningful use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; numerous sections of the 2010 Patient Protection and Affordable Care Act (ACA), and key portions of the Medicare Access and CHIP Reauthorization Act (MACRA), signed into law in April 2015."¹ Taken together, HITECH, ACA, and MACRA have completely changed the face of primary care – in my view, for the better.

The ACA, in particular, is completely transforming primary care with major investments in enhanced reimbursement for primary care community health center

expansion and partnership with multiple payers for the transformation of clinical practice, driven largely by the creation of patient-centered medical homes (PCMHs). These new entities "offer the possibility of refining the structure of transformation." They highlight "up-front supplemental payments for care management, as well as shared savings financial incentives as two key elements of more successful PCMH interventions."² In addition, federal funding has been augmented by state governments, private payers, and non-profit and philanthropic organizations.²

Finally, primary care doctors are learning to "apply the right resource in the right setting to care for patients." For example, "fee-for-service medicine typically utilizes physicians to care for patients regardless of their need. But in a risk managed environment, physicians provide the most value when they work at the top of their license, while lower level contributors, such as nurse practitioners, physician assistants, social workers, pharmacists, and even health coaches, can take on some of the tasks typically assumed by doctors."³ It appears that we are making good progress toward a complete restructuring of what it means to be in primary care practice in 2016.

While this transformation to a PCMH structure is underway, the "bad" is the murky evidence that we are actually on the right road! According to Chokshi and others, "the Agency for Healthcare, Research, and Quality synthesis report of 14 grants to study primary care transformation revealed few overarching pearls. Instead, the success of transformation depended on context. External recognition as a PCMH-certified practice alone was seldom sufficient as a marker of meaningful transformation, from

the patient's perspective."⁴ It appears to me that we are losing sight of the ultimate goal, which is an improvement in the individual patient's experience and clinical outcome. We are burdened by too many measures and a mindset focused on "checking the box" to receive a marginal increase in reimbursement. Experts like Millenson and Berenson¹ call into question the entire movement toward patient-centered care. They, too, bemoan the growing list of measures and support my contention about the weak evidentiary basis pointing us in the correct direction.

However, the truly "ugly" is another matter. In the 35 years since my graduation, the core content of both undergraduate and graduate medical education has changed only modestly. Yes, at the GME level, duty hours propel house officers from the building at set times, and yes, modern-day interns and residents hardly ever spend the night in the hospital, but the fundamentals are unchanged.

Specifically, in a world characterized by public reporting of outcomes, we still devote modest resources to educating the next generation of physicians about their most important responsibility, namely, providing safe care to patients. The modern house officer learns little about the system basis of care, and is exposed only tangentially to the core tenets of performance improvement.⁵ Most UME programs are still structured as two years of memorization in the classroom, with outmoded teaching technology and two years of an apprenticeship in various parts of the inpatient setting. Little exposure is given to leadership training, improvements in teaching, and related lifetime skills that will be necessary for an effective primary care practitioner far into the 21st century.

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Nonetheless, I have a good deal of hope for the future of primary care. For example, I am very impressed by our primary care colleagues working with new delivery models, such as IORA Health, a Massachusetts-based startup company with more than \$48 million in investor backing, which is “breathing life into the way consumers can connect to their healthcare team.”⁴ We’ve had the privilege of hosting IORA’s founding CEO, Dr. Rushika Fernandopulle, at the College of Population Health. I’m also impressed by the work of ChenMed, based in Florida and other parts of the Southeast. “Their model includes having longer and more frequent

patient visits, providing free transportation to patients, and placing an emphasis on cultivating a physician culture around relationship building and the desire to be accountable for outcomes.”² Finally, I am enthusiastic about the future of primary care, as I believe that “new care models, including virtual visits, retail clinics, and urgent care centers, and technology-enabled specialist consults will force a rethinking of what constitutes primary care. Longitudinal patient relationships and a disease prevention-oriented mindset must remain at the core of primary care practice. Quality metrics, which primary care doctors generally find unsatisfactory, must be

streamlined around that core.”² I want to remain a vital part of the ongoing discussion about which quality metrics makes sense to primary care doctors as the future belongs to those physicians who are participating in this transformation. Just imagine what the next 35 years of primary care practice might look like for our younger colleagues!

David B. Nash, MD, MBA

Dean

Jefferson College of Population Health

David.Nash@jefferson.edu

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