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Primary Care: Its Pokemon Moment

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ABSTRACT

Primary care in the United States is undergoing bursts of evolution in response to health system stresses, changing demographics, and expansion of risk and value-based reimbursement structures. The impact of primary care remains substantive and associated with improved population health. However, the spectrum of services, the nature of the physicians involved and new ways of including the patient in her, or his own care suggests that a new definition of primary care be considered, and patient expectations be heeded and understood. Evolutionary bursts yield new traits and in primary care, they are spawning new care models with significant implications for general internal medicine, internal medicine/pediatrics trained individuals and medicine subspecialties given the focus of these models on Medicare Advantage. Ultimately, changes in reimbursement and creative incentives will be two factors among many that will solidify the next stage of primary care in the United States.

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INTRODUCTION

For the last two decades, the plight of primary care in the United States has been a topic of great interest.[1,2] There has been a great deal of energy and examination around 1) increased need, 2) disincentives founded in a focus on productivity and misaligned reimbursement models, 3) changing work requirements from electronic health records to prior authorization, 4) the migration to employed models, 5) the rise of advanced practice professionals (APPs), and most recently, 6) physician burnout.

Several questions arise in thinking about these topics:

1) Is there a contemporary relevant definition of primary care given the changing nature of healthcare?
2) What makes primary care so attractive and necessary in US healthcare today?
3) What about primary care has made it so resilient?
4) Has there been change in the state of primary care?
5) Can we address and promote primary care in the US in a different way looking forward?

The worldwide phenomenon of Pokemon has as one of its core features, the burst-like evolution of its characters as they attain new powers. It may feel contrarian and yet, evidence suggests that primary care in the US is having a burst of evolution today unlike any in the recent past.

DEFINING PRIMARY CARE TODAY

Various definitions of primary care have been circulated over time. They have incorporated descriptions of care, the activities involved, care settings, and other domains to

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round out the idea of primary, as in first care, and primary care as in principal care. These include:

1) "Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with patients and advise and treat a range of health-related issues. They may also coordinate a patient's care with specialists."[3]
2) A complex, multifocal explanation of primary care from the American Academy of Family Practice encompasses the Institute of Medicine's (IOM) definition: "the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[4,5]
3) The National Rural Health Association defined primary care as "Comprehensive health services at the point at which people enter the health care system that includes diagnosis, prevention, treatment and management." [6]

While primary care historically has been the domain of family medicine, general internal medicine, and general pediatrics, it is clear that in healthcare today, it can include obstetrician gynecologists, and other specialists who address the totality of patient needs, eg, transplant specialists for transplant recipients. Thus, while the IOM definition is foundational, 27 years on, it may be appropriate to amend it to

Providing access as needed in-person or via technology to coordinated care and services that address the majority and severity of a patient's healthcare needs with shared decision-making based in patient preference and evidence-based care supporting by an ongoing patient-physician and patient-practice relationship, and a way of accessing the patient's family and community, if possible, to support care needs.

This definition acknowledges that care can now be addressed via technology. It still prioritizes access, relationships, and shared decision-making. It also recognizes that a critical element is understanding how to support care needs. This is not insignificant and is the premise upon which care coordination resources have been developed.

CLINICAL SIGNIFICANCE

- Primary care positively impacts health outcomes and population health maybe more than any other aspect of healthcare delivery.
- New care models are creating different foci within primary care.
- These models accentuate prevention, address high-risk, high-need patients, and attempt to manage and monitor the care continuum differently.
- Many of these models focus on Medicare beneficiaries.

THE ATTRACTIVENESS OF PRIMARY CARE

For generations of Americans, the "doctor" image was the general practitioner. From Arthur Hertzler's **The Horse and Buggy Doctor**[7] to Life magazine's photo essay "Country Doctor" showing Dr. Ernest Ceriani,[8] to Norman Rockwell magazine covers, Americans saw the general practitioner as the person who addressed all of their healthcare needs. The focus on specialties during World War II[9] sparked a trend of medical specialty growth that continued with the expansion of the National Institutes of Health, the Department of Veterans Affairs research programs, and the introduction of Medicare in 1965. The last provided a source of funding for graduate medical education,[10] which ignited growth in "medical specialism".[11]

As specialty care grew, there was recognition that more generalists were in practice, and they performed different work than specialists. This, in turn, shaped primary care as the first access point for long-term, person-centered care, a place for comprehensive care for healthcare needs, and coordination of care for problems that required more than a generalist.[12]

Researchers have examined the relationship between primary care physician number and health. There is an association between greater primary care physician density and improved health outcomes, increased lifespan, and lower mortality.[13] Studies have also demonstrated that individuals with increased access to primary care were healthier compared to similar populations lacking such access.[14]

PRIMARY CARE RESILIENCY

Primary care has been the healthcare system's first answer to address a host of fundamental considerations: access, quality, prevention, screening and detection, early management of healthcare problems, and decreasing unnecessary care.

Doing this work requires people, information, and efficiency. Despite workforce shortages, there are still a large number of primary care physicians in the United States. In the AAMC 2022 Physician Specialty Data Report, specialties with the largest number of active physicians were internal medicine (120,342), family medicine (118.641), and pediatrics (60,305).[15] That does not mean that this number is sufficient for the future. Studies have projected a shortage of 17,800-48,000 primary care physicians by 2034[16,17] in the United States.

Importantly, primary care has been the site of preventive care for most individuals in the US.[18] This has been very successful. Cancer mortality has consistently decreased

since 1991 due to a variety of factors. There has been earlier recognition of potential malignancies,[19] a direct effect of the screening and detection that happens in primary care practice. Moreover, models suggest that the implementation of the US Preventive Services Task Force (USPTF) recommendations saved 12.2-16.2 million life-years in the US population.[20] Primary care clinicians are the most important group of clinicians activating these recommendations.

Finally, with recognition of escalating healthcare costs, it is notable that more primary care access is associated with decreased cost of care.[21] It is paradoxically striking therefore that the overall proportion of healthcare spending in the US attributable to primary care has fallen from 6.5% of total healthcare expenditures earlier in this century to 5.4% by 2016.[22]

PRIMARY CARE EVOLVING

Interestingly, this change in work has exposed the ongoing evolution and re-design happening in primary care today.[23] Multi-morbid individuals with significant debilitation require more intensive and frequent follow-up than healthy individuals who may only have one chronic condition. The care plan for a recently hospitalized or recently discharged patient from a post-acute facility is different than an urgent care issue. We are developing more refined clinician roles in newer care models with different teams to serve populations with variable needs (Table 1): urgent primary care, intensive primary care, chronic condition expertise, virtualists, hospitalists and SNFists, women's health, street medicine, and traditional longitudinal primary care.

Historically, we have thought of these as physician roles and often overlapping in the same person. Not every physician or APP is equally skilled across these tasks. So, primary care has started to conceive of them as separate and different roles and inform their practice with risk stratification to identify patients who may need added healthcare focus with the support of other team members—pharmacists, APPs as team clinicians or team leaders, licensed clinical social workers for psychosocial care, and even emergency medical technicians to deliver care in homes or in the community.[27]

Other bursts of evolution include reviving the ambulatory intensive care unit [28] to address high-risk, high-need patients. A parallel approach has been the genesis of multidisciplinary teams with physicians, APPs, and other healthcare professionals, e.g., a pharmacist, physical therapist, care manager, potentially a social worker, and a dietitian to manage a group of patients emphasizing prevention, health, and psychosocial care. The metrics and workflows are invariably different with this approach. This model has been grown by CVS Oak Street Health, among others.

The aforementioned efforts are only beginning to reflect the diversity and evolution of work in primary care. With the combination of technology and knowledge, it will be possible to complement the primary care team skills with motivational interviewing, coaching, improved access to social services for patients, streamlined clinical documentation and workflow review and optimization for physicians and APPs to achieve a better user experience with the electronic health record.

CONSIDERATIONS

The work in primary care has changed over time as have the patients. The historical symptom- and complaint-based approach to primary care has expanded. Starfield grouped primary care [29] into five domains: integrated care, comprehensive care, coordinated care, continuous care, and accessible care. Each has distinct characteristics though they are frequently interwoven clinically. Tasks are embedded in each domain to ensure that preventive, diagnostic, and

Table 1 Evolving Specialization Within Primary Care

Urgent Primary Care	Addressing immediate and often straightforward health concerns.
Intensive Primary Care	High-risk, high-needs individuals with multimorbidity (adult- and children-centered based on training) and a smaller patient load per clinician, caring for these patients, in clinics or in the home, updating models such as those created by CareMore [24] and accelerated by organizations like ChenMed.[25]
Chronic Condition Expertise	Primary care as the frontline for chronic condition management—clinicians who are expert at managing complications across co-mingled disease processes, e.g. cardiac-kidney-metabolic syndrome.[26] VillageMedical has activated its care model for patients in this way.
Virtualists	Clinicians exceptional at handling care over virtual care platforms.
Women's Health	Expertise addressing women's health issues especially in locations with decreased obstetrics and gynecology density.
Acute and Post-Acute care Hospitalists and Skilled Nursing Facility focused clinicians (SNFists)	Caring across the continuum for common clinical scenarios and facilitating transitions of care to and from different care settings.
Street Medicine	Clinician-led teams that address primary care issues and provide roaming care for individuals who lack permanent residence.
Traditional Longitudinal Primary Care	Across adult and/or pediatric populations.

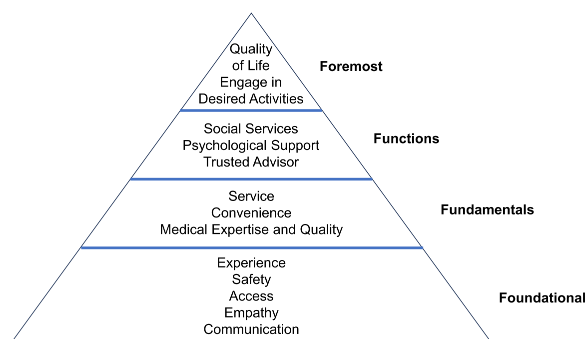

Figure 1 Patient expectations of their primary care relationship.

therapeutic services are provided appropriately, patient education and health-related counseling are timely, and minor procedural work occurs without complications.[30]

This care platform now lives in a healthcare ecosystem with more patients and more individuals with chronic conditions and related complications. The subset of these individuals who are younger are at greater risk for medical problems such as obesity and associated complications. A growing subset of the population is also aging. Twenty-five percent of the US population will be over 60 years of age by 2030 and nineteen percent greater than age 65.[31] These patients represent different challenges than their younger counterparts.

Plus, patients want ever more from their interactions with their primary care physicians and APPs. This can be categorized in four levels (Figure 1). The elements in the patient-oriented pyramid move from foundational, basic expectations of every encounter in healthcare, to more complex and necessary elements as one moves up the pyramid, culminating in the most individualized elements—the objectives that patients want to fulfill on an ongoing basis. This is one of the ripest areas for opportunity and transformation in care models.

The implications of these changes in primary care are significant for general internal medicine, internal medicine/pediatrics trained individuals and medicine subspecialties. The emphasis on Medicare Advantage with so many of the new entities entering the primary care space aligns with the expertise of general internal medicine. The recognition that many organizations expanding their primary care efforts are also looking at how to engage in care across the entire government and commercial payor realm means that individual clinicians will benefit from being able to care for adults and children. Finally, the management of multiple chronic conditions, many of which are truly integrated in their disease presentation, e.g., cardiac-kidney-metabolic syndrome,[26] emphasizes the benefits of integrating care with medicine subspecialists in a manner that is coordinated. There is no other area of medicine that is so well positioned to encompass the change in primary care and help it evolve with more clarity and effectiveness.

REIMBURSEMENT

Pham and Greiner outlined several questions in 2019 [32] about primary care compensation that are still relevant today:

- Should there be reimbursement plus payments for other aspects of care infrastructure?
- Should capitated payments be split between primary care versus non-primary care services?
- Should primary care spending include all team members?
- Should primary care spending align with the physician or the service?

It is nearly impossible today to sustain a primary care practice solely on practice revenue. The evolution of new payment models from the Centers for Medicare and Medicaid Services, Medicare Advantage, and even some Medicaid managed care plans may mitigate some of this austerity. However, aside from modest care coordination fees, there is minimal support for the costs associated with capabilities needed to drive performance in risk including information technology, additional team members, and care management. The reality is that the encounter in the clinic reigns and care outside of that visit is much more difficult to accomplish even though inter-visit management is probably essential for better patient management.

The value proposition of technology-enabled primary care-focused aggregators is that they support the build out of capabilities to manage risk better. This presumably leads to less payment outside of the group for services as the patients are managed more intently in the practice setting. The alternative is to join a larger group or a health system and practice in that environment. Those organizations often have different approaches to incentive payments and sub-capitation models that parse reimbursement revenue for all clinicians who are involved in patient care. This supports the continuum and the quality of care that patients desire.

NEAR-TERM FUTURE

The pressures on primary care from workforce to work are evident. The true work and joy are in the patient relationship and delivering clinical excellence not in risk adjustment documentation, assessment, and rapid prioritization because a fifteen-minute visit is nearly completed. Furthermore, the use of artificial intelligence (AI) whether ambient to make documentation easier, or generative to reduce workflow challenges, or predictive to inform potential interventions for patients, will further shape primary care practice.[33] These tools should be thought of in the same way as Meaningful Use with payments for support and implementation.

We should broaden loan repayment programs to recruit and retain practitioners in primary care. We can create more shared jobs to reduce physician churn and burnout. We can also be more creative with compensation including quasi-delegation for physicians to receive a larger per patient per month payment in any CMS reimbursement

structure, further education for the appropriate use of the new G2211 and G2212 codes and risk-adjusted reimbursement for documentation of social determinants whether in fee-for-service or value-based care structures.

Still, we should recognize that this area of medicine is quietly having bursts of evolution. It is defining micro-primary care specialty areas. It is the driving force for new reimbursement structures. And it is the frontline for wrestling with changes in the macro-environment that are affecting patients, from heat waves to accelerated use of GLP-1 agonists. Primary care is doing more than just getting by and it will be different again soon, maybe with a few more powers than it had before.

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