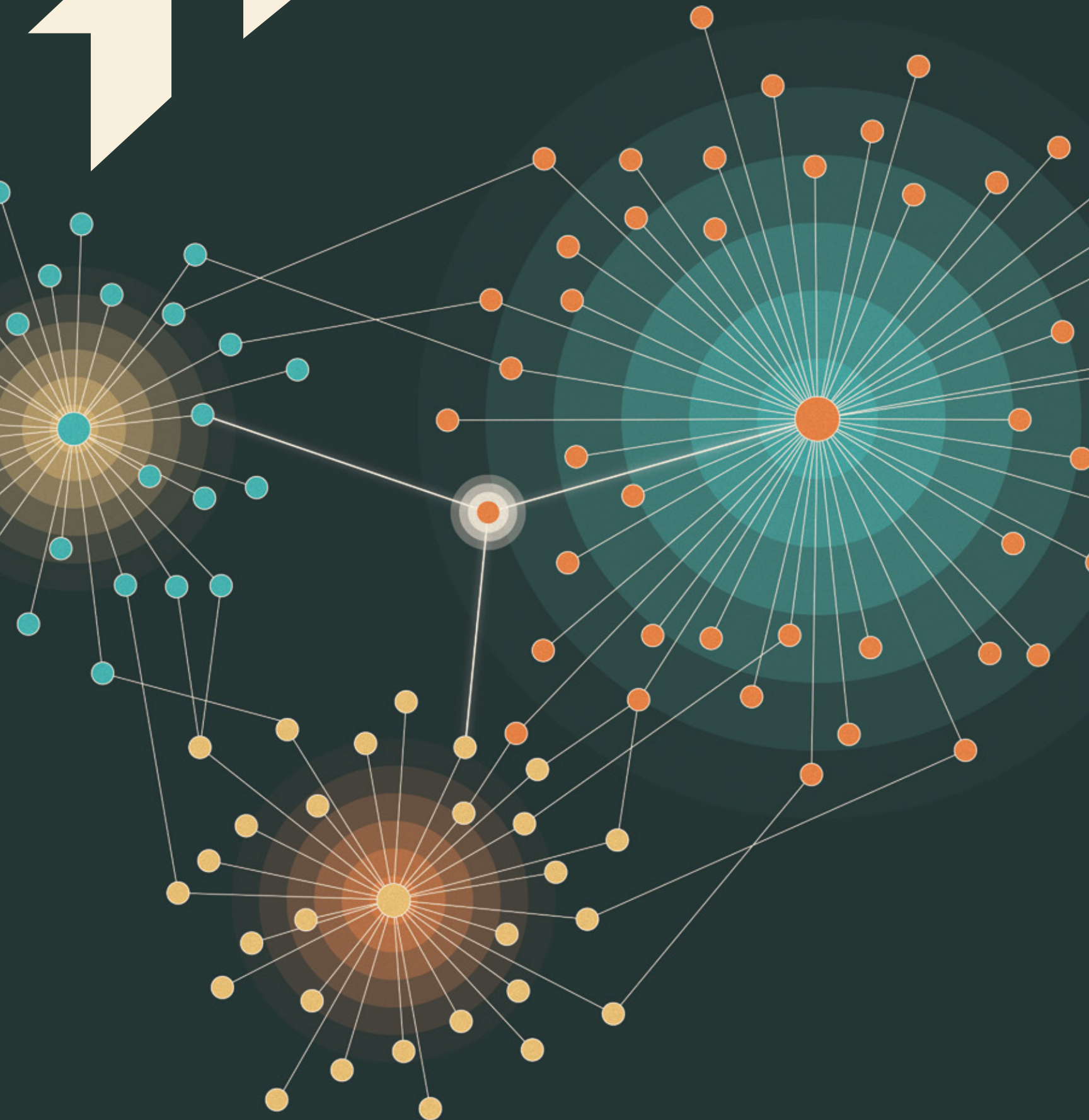




PRECIPICE





INTRODUCTION

Welcome to Precipice, a publication from the University of Colorado Department of Family Medicine. Precipice is designed to address hard problems in family medicine and primary care as we strive to help our patients and neighbors become healthier, and as we listen to the conversations at our national meetings and in our literature.

ABOVE
Frank deGruy, MD,
MSFM, Woodward
Chisholm Professor
and Chair
University of Colorado
Department of Family
Medicine

THIS FOURTH ISSUE OF PRECIPICE DISCUSSES ...



Welcome to the fourth issue of Precipice, a magazine devoted to raising difficult problems facing family medicine and primary care today. We will discuss these problems in salons at our national meetings and elsewhere. This issue looks to the future, to some of the wrenching changes we must negotiate if we are to achieve our full potential as effective agents of health. I will back up to get a run at this by beginning at our beginning and underscoring several critical inflection points in the history of our discipline; we can thereby get a clearer sense of where we're headed and what it will take to fully realize ourselves. This issue of Precipice also contains excerpts from interviews with three leaders in our field who are in some measure creating this future. I believe you will find their remarks instructive, and I hope you find their shared vision inspiring.

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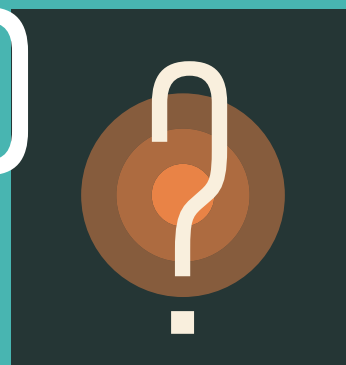
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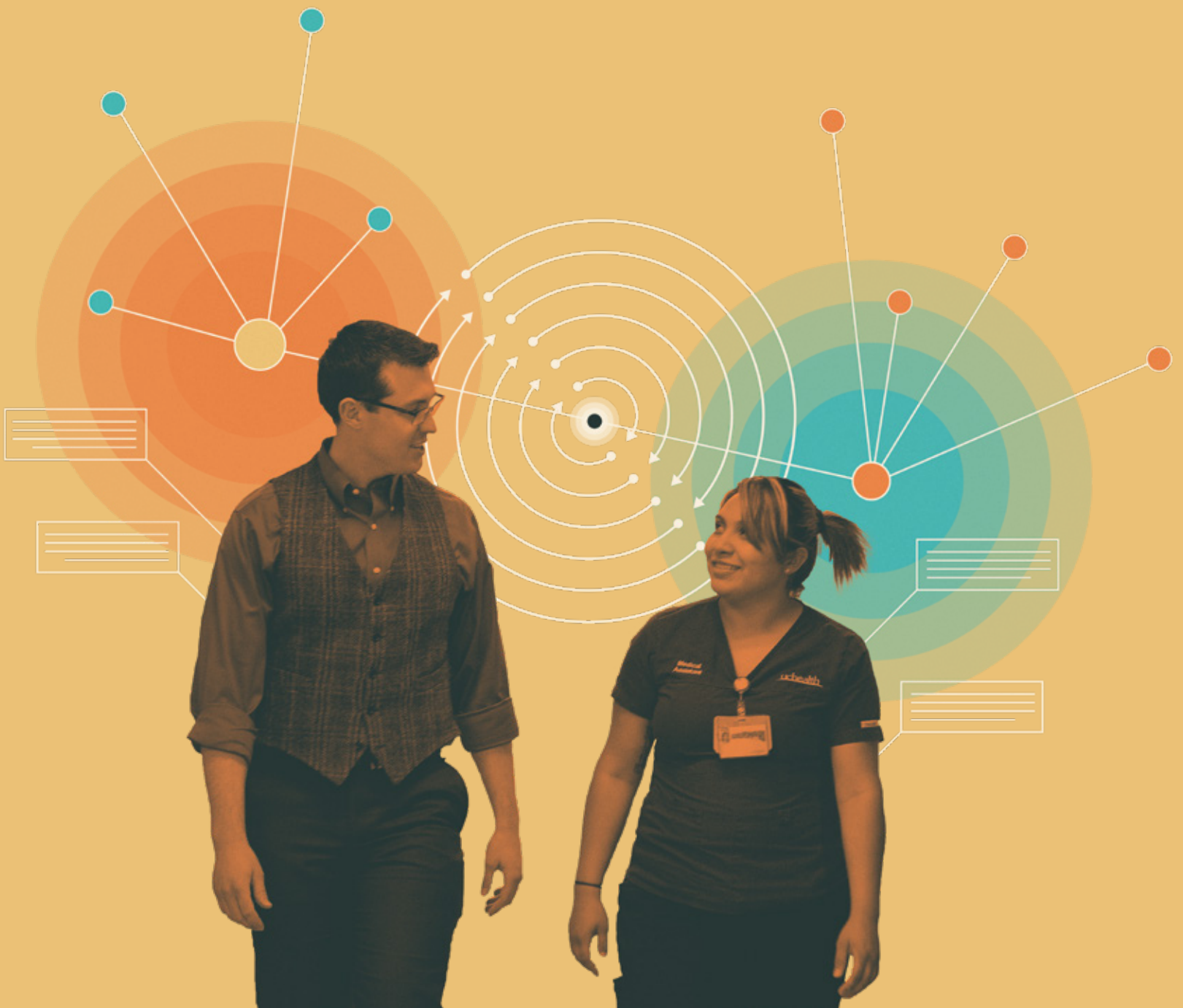
PICTURED
Maurice Wood, MD
Founding President
of the North American
Primary Care Research
Group, Professor
Emeritus, Medical
College of Virginia

THE PROBLEMS WE ADDRESS



In the beginning of family medicine as a discipline, we defined the world of family practice, as it was then called, by the problems that people brought into our waiting rooms. We designed our residency training curriculum straight off that list, and it turns out that it takes about three years to train a physician to diagnose and manage about 85% of these problems. The remaining 15% can be addressed by consultation or referral to a specialist. Thus, the length and content of our first residency programs were set, with heavy emphasis on mastering clinical problems. During this foundational phase, practicing clinicians and residency training programs made great strides in advancing our capacity to gain, maintain, and measure competence at managing that long list of clinical problems.

FROM PROBLEMS TO PRACTICE



By the 1990s, we had enough evidence to say confidently what features of primary care produced better health and less expensive, yet higher quality, and more rewarding care. The Institute of Medicine codified these features into a definition of primary care in 1994, essentially asserting, “If you do these things, primary care works.” Here’s the definition:



Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

This has held up to close scrutiny for the last quarter century, as the evidence that these features confer value has only become more compelling.

Today we are still wedded to a long list of problems that we must know how to manage, but it has become obvious that most of what we are dealing with in primary care are chronic diseases: COPD, chronic heart disease, arthritis, diabetes, depression, and so on—diseases that generally begin asymptotically and require attention before they become symptomatic. If we wait for someone with diabetes to become symptomatic enough or scared enough to suffer the inconvenience of a clinic visit before we begin taking care of them, we waited too long. Their symptoms at that point will come from complications that we might have prevented but may now be irreversible. So, we tumbled to the fact that the challenge before us is greater than just the problems we are competent to diagnose and treat; it’s how we practice.

About 25 years ago, this led to a revolution in primary care as we incorporated chronic disease management programs into the fabric of our practice. We developed disease registries, guideline-based management, measurement-based outcomes, care managers who reached out and called patients at home, and proactive interventions. We also moved to team-based care, which reoriented the practice of primary care. Because nearly every patient had behavioral problems, and because referring patients out to behavioral consultants wasn’t an option (patients resist), a core member of the

primary care team very quickly became the behavioral clinician. As a result, our care and our lives got better. We became more capable of “addressing a large majority of personal health care needs.” We were providing more comprehensive, more expert primary care, and we are still in the midst of this evolution today.

But a funny thing happened when we put psychologists on chronic disease management teams in primary care to take care of, let’s say, depression. They couldn’t just stick to depression, even if that’s why we hired them. People who have one chronic disease almost always have several chronic diseases. For instance, depression is often enmeshed within a tangle of mental diagnoses, psychological symptoms, worries, stressors, and unhealthy behaviors. The average 55-year-old primary care patient has six active chronic problems on his/her problem list, and they’re mixed up together, interacting with each other, waxing and waning in severity and salience. When chronic disease management programs flourished about 15 years ago, health plans, hospitals, and third parties offered (and sometimes pushed) these programs for primary care patients with diabetes, asthma, rheumatoid arthritis, depression, and all the other chronic diseases. And then our poor patient, who had several of those things going on at the same time, became overwhelmed when those protocols started tripping over each other. Care became fragmented and chaotic. We eventually figured out that we cannot win health one disease at a time. We needed another kind of transformation.

FROM PRACTICE TO PATIENTS



It turns out that each individual patient needs a personal, custom-made care plan that contains all of her health problems, concerns, previous experiences, desired outcomes, and so on. This health plan makes use of guidelines for managing all of the diagnoses this person might have, but we just can't mindlessly adhere to these guidelines. They take too long to follow, they sometimes contradict each other, they add up to too much intervention, and they need sequencing and adjustment. In fact, they sometimes must be ignored. This burgeoning pile of guidelines needs shaping into a larger, coherent personal care plan.

Thus, the fundamental therapeutic gesture in primary care has become the creation of a personal care plan for the whole person. We pay attention to evidence-based guidelines; but we bend, stretch, delay, and ignore them and otherwise shape them in the context of everything else that's going on. We do this until we and the patient have a plan that makes sense, that she can do, that adds up to the most benefit and least harm. We became person-centered instead of disease-oriented. The work of primary care is now a fundamentally creative act. It's shaping and managing a personal care plan that is different for every patient—even those with the same problems. These plans change from one month or one year to the next, and their development and maintenance are led by patients who we know by name.

In 1984 Don Ransom wrote an essay entitled *The Patient Is Not a Dirty Window*. The idea is not to wipe away the messy, idiosyncratic, personal factors so you can see the disease inside the person; the idea is that the person, and not their diseases, is the subject of our attention and efforts. And when that happens, we discover how painfully difficult and profoundly rewarding personal doctoring really is. We see that there is healing power in personal relationships – that it is usually more therapeutic for a patient to be known and understood than to get the right medication for his or her chronic disease. We come to understand that a personal relationship is the most potent therapeutic agent in a primary care clinician's armamentarium.

Now, back to that behavioral clinician I left hanging a few paragraphs back. Psychiatrists and psychologists generally aren't trained in the ways I just described.

They are ill-equipped to work inside a primary care clinic, where it's noisy and chaotic and fast-paced, where plans change all the time, where people need each other right now, and where interruptability is a virtue. That means it's hard to find a behavioral clinician who operates like the primary care clinician I just described. But once we do, then we've got the nidus of a team. Those two, plus a care manager, and we can do some serious good and have a seriously rewarding practice. But where do we find them? Well, we train them.

Our residency programs are no longer for training family physicians, they are for training the primary care workforce.

And these behavioral health clinicians don't look very much like the therapists who sit in a quiet office with the potted plant and the soft music, for 50 minutes of every hour, one patient after another. They're running the rapids with their clinic partners, paddling as hard as they can; dealing with a child who is acting out, but calling out that his mother is depressed; and this next patient is here for a cognitive behavioral therapy session, but her migraines have flared, so the behavioral health consultant pulls the primary care provider into the room for a quick consultation and changes the agenda of the visit, and then makes sure she gets immunized while she's there; and then gets pulled into the next room for a warm handoff with a patient who came in for a urinary tract infection but is having panic attacks; and on and on like that all day. It turns out that our primary training responsibility is to train all the members of the primary care team together because we need teams, and this is how you build them.

FROM PATIENTS TO FAMILIES AND COMMUNITIES



Okay, this brings us up to today. For what, exactly, does this prepare us? Imagine we have advanced primary care practices with well-functioning teams as we do in some places and as we will everywhere soon. Now, further imagine that we begin to see coming up over the horizon evidence that most of the variance in health, in mortality, is located in the family and the community. In fact, this evidence is already emerging for us all to see. Health is won and lost much more in the community than in the clinic. As good as we have become at clinical medicine, at its best it accounts for only 10% of the variance in people's health. The social determinants of health account for four times that much: people's health behaviors, whether they have a job, whether they live in a dangerous neighborhood, if they live in a food desert.

So what does this mean to practice in the context of family and community—to take into account the social determinants of health? We can't fully know yet. But surely we can see that it means we should continue breaking down our clinic walls to do our work out in the community. We will need to go into households and neighborhoods, schools and workplaces, prisons, courthouses, firehouses—under bridges, on the margins and within the froth of everyday life—everywhere people play and shop and make laws and do all the things big and small that truly determine their health.

Most importantly, we will need to go into these places and strike up new partnerships. If we have anything to offer, we'll have to figure out how to build trust and real relationships with people who are paid differently than we are, who do different things for health than we do, who define health differently, and who don't see us as the center of the universe.

Thus we arrive at our next and perhaps most difficult evolution. We went from clinical problem mastery, to chronic disease management, to comprehensive whole-person-centered care.

Now we must figure out how to truly practice in the context of family and community.

This will be community-based primary care, where the definition and structure and function of primary care teams will undergo another radical transformation, and where we will have to learn another set of collaborative practices. What we will have to offer will only be a part, and usually not the central part, of the mix of resources and partnerships that collectively constitute a patient's and a community's personal health plan. Just as today's advanced primary care practices have learned to respond to health care needs adaptively, our community partnerships will require us to be even more flexible, more adaptable.

KURT STANGE ON FINDING OUR PLACE IN THE COMMUNITY



PICTURED
Kurt Stange, MD, PhD
Director, Center for Community Health Integration
Research & Development for Community Health &
Integrated, Personalized Care
Case Western Reserve University, Cleveland

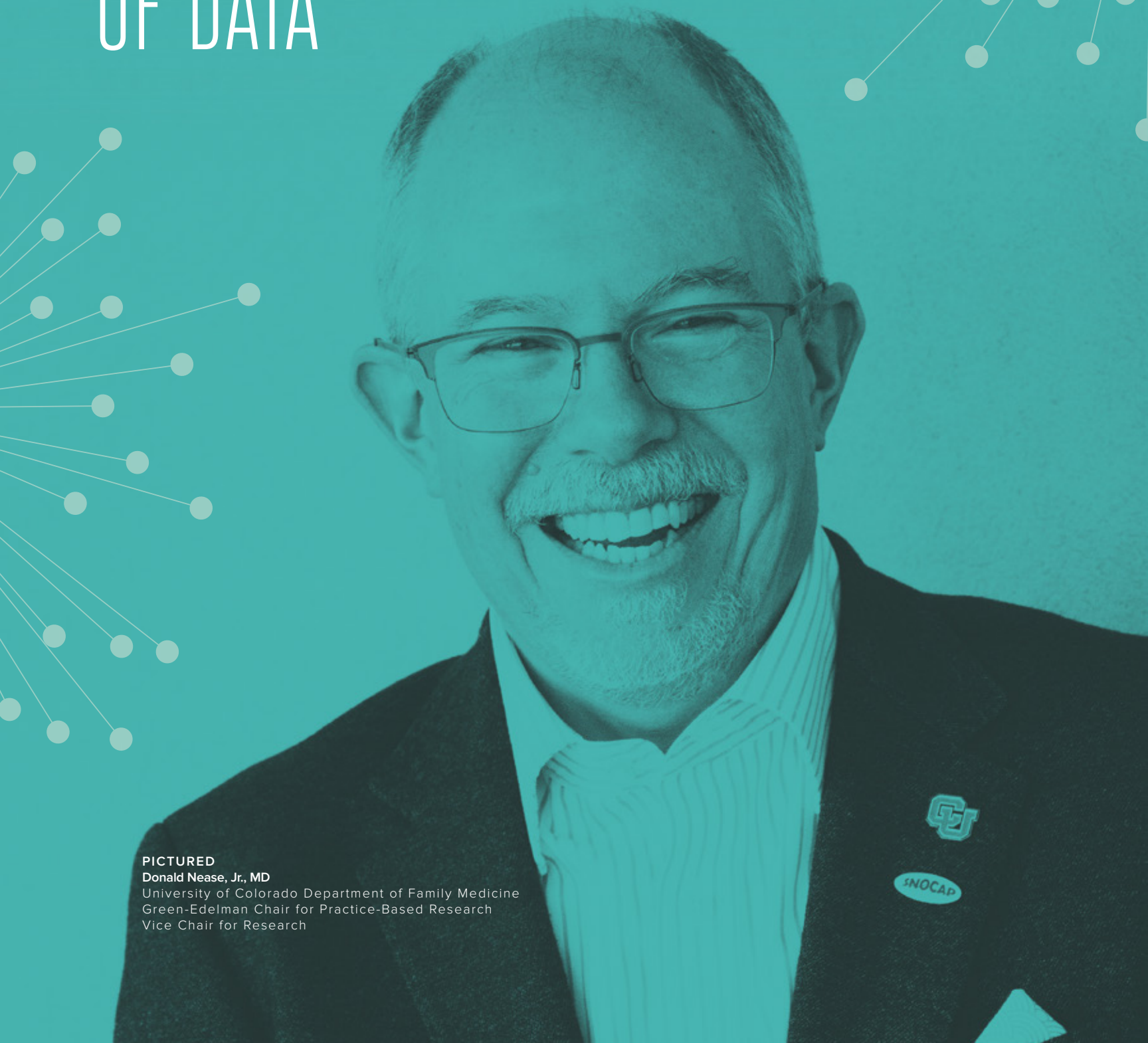
Kurt Stange has been organizing and convening partners across communities and thinking about some of the preconditions, purposes, and possibilities for population health, community partnerships, and context-sensitive healthcare for decades. We spoke with Kurt about how we might prepare and position ourselves for these new relationships, and here is some of what he had to say:

Early on this kind of practice was done informally, and the measurement of its value was either not done or was done informally as well. That worked okay on a small scale when practices were more in the community, but now we're trying to scale it up to populations using bigger health systems, calling for more rigor and more formal evaluation. It has a feel of reinventing something that used to be there. For example, some of us had family charts that were lost when we went to electronic health records.

“

We need to realize that this takes a long time, and has to start small or at least local. We need to put our egos aside. We are a vital part of what needs to happen, but we are not the whole thing—we're not talking about health care, but health. There's a bottomless need for credit and control, and we should just remove ourselves from that as a motivation. We should not come in with 'Here's what we are going to do,' but 'Here's what we have to offer.' We need to start by hammering out local solutions. We need long, local narratives that are built up by lots of local voices. We can scale from that. So far that kind of leadership in our organizations is in short supply.

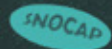
DON NEASE ON THE POWER (AND LIMITATIONS) OF DATA



PICTURED

Donald Nease, Jr., MD

University of Colorado Department of Family Medicine
Green-Edelman Chair for Practice-Based Research
Vice Chair for Research

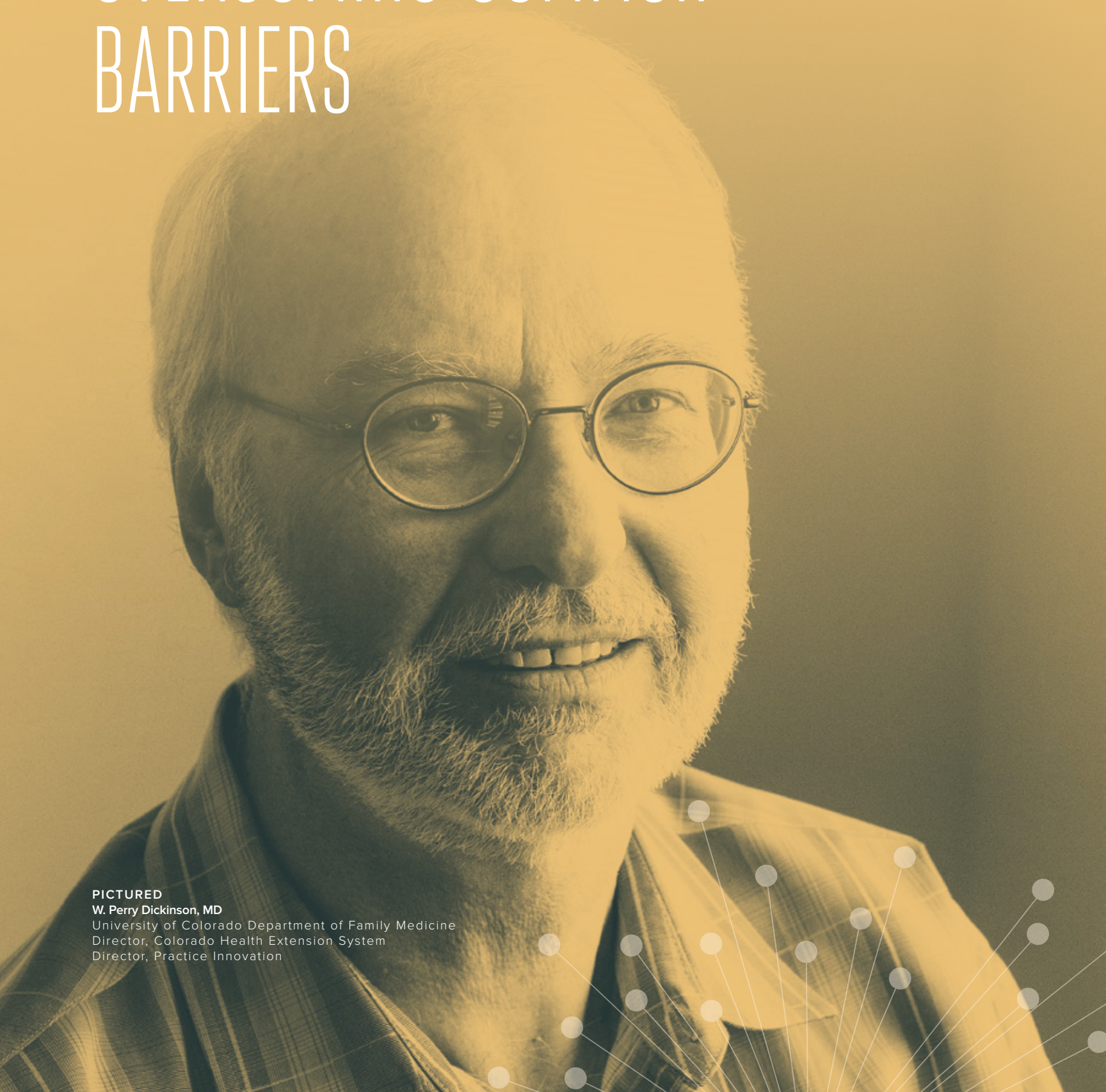


Don Nease is working on ways to connect these new community partners with one another so that health information can be exchanged effectively and responsibly. He sees this as a technical problem but even more as a sociocultural problem. He says:

We need to discover new ways of knowing our communities and of mapping community health organizations, and agencies, and agents. There are people out there helping, and we need to find them and partner with them. We need to build networks that include us. There are definitely new methods and techniques that are in use in other sectors that we can bend to our purposes—things like blockchain technology and social network analysis. Let's rethink the primacy of generalizability in favor of letting contexts drive local solutions. We will definitely need to enter into these partnerships, because it's not ours—we don't own the keys to community health. Big data can help, but it leads to blind alleys if it is stripped of context. We are likely to see the emergence of community specialists of some sort as a new kind of health partner.



PERRY DICKINSON ON OVERCOMING COMMON BARRIERS



PICTURED
W. Perry Dickinson, MD
University of Colorado Department of Family Medicine
Director, Colorado Health Extension System
Director, Practice Innovation

Perry Dickinson has been working in communities for a couple of decades, using large grants, demonstration projects, and cooperative agreements to facilitate the integration and transformation of primary care practices, and embed them more deeply into communities. Here's Perry:

As the concept of advanced patient-centered health homes evolves, it becomes naturally more concerned and involved with population health. Community engagement naturally broadens the definition of team. It's almost a two-stage process: first practices address more clinical problems, say by including behavioral problems into their sphere of responsibility, then they are more able to take on population health problems, and make the difficult partnerships with community organizations. These are difficult partnerships. Even though we have good, sustainable community health projects in action in Colorado, the cultural barriers are huge. Clinics and community agencies don't necessarily share a common language, common definitions of health, conventions of information exchange, or even basic interventions. And there is often actual resentment over budgets. Healthcare budgets are so large, and in some eyes, so wasteful, that there might be serious disagreements about how to share the burden of cost of partnerships. These partnerships often require bridging great differences. We have seen great benefit from workers called community connectors—people who are tasked with bridging silos in the health landscape.



WHAT DOES ALL THIS ADD UP TO?

1

As important as this “last great transformation” is, we must remember that it is neither the last transformation, nor the only issue that deserves our attention. Our fate as a discipline embedded in an ever-changing complex health care system is to continually change ourselves—in ways that we already can see will improve us and in ways that we cannot possibly see yet.

2

Look again at the 1994 IOM definition of primary care cited on page 5. All of those characteristics of primary care still need our attention. Just because we’re thinking here about practicing in the context of family and community, does not mean that we are done working on better care for patients with diabetes or asthma or any of the common diseases that afflict our patients. We have hardly solved the problem of access to high-quality primary care. Entire careers still need to be spent on augmenting our comprehensiveness, or understanding and using the therapeutic value of personal knowledge of patients, or dealing with problems over time. There is no end to our work on improving the health of our patients and their families and communities. It’s just that today our focus is on practicing in the context of family and community—this is just one of many important challenges facing us in our quest to help people become healthier.

3

This is hard work, and it takes a long time. Best to start small, armed with a wide lens for contextual factors. Small, modest starts are within our grasp. It is yet unknown how to take these local successes to scale.

4

We really must put our egos aside. We will not necessarily be at the center of these efforts. This is likely to be a painful and protracted transformation for us.

5

There are formidable technical problems to overcome, such as safe and appropriate information exchange, and new fields will emerge in response to some of these large problems.

6

The sociocultural problems might be even more formidable, and will require that we take on such fundamental health issues as definitions, priorities, approaches, financing, and leadership.

7

There are emerging roles, such as community connectors, that will need further development but show enormous promise in facilitating the formation of community partnerships.

QUESTIONS TO HASH OUT IN A SALON



How will we know if we have produced a primary care-community partnership that results in improved health? What new measures do we need? What new methods do we need? In other words, how do we research primary care-community partnerships and community-based health efforts?



In what ways will primary care clinicians need to change their roles and competencies to do this community-based work? What will the new family physician look like if we fully realize the vision of “practicing in the context of family and community?”



How do we train the workforce for this? Are our present-day residencies up to this task? Are there new roles we need to develop? Are there new settings we need?

ABOUT THIS PUBLICATION

This publication was prepared by members of the University of Colorado Department of Family Medicine with design, layout, and production help from Relish Studio and original illustrations by Brad Todd, and photographs by Lisa Martinez and Jeff Navarro. Copyright CU Department of Family Medicine. The content herein may be used by anyone who cares to use it for the furtherance of health, the improvement of healthcare, or the development of your own programs. It was prepared to inspire and instruct us to become more effective health professionals.

CONTACT US

inquiry@precipiceonline.org

FIND US ONLINE

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SALONS 2018

NAPCRG

November 9-13, 2018
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ADFM

February 13-16, 2019
Houston, TX

STFM

April 27-May 1, 2019
Toronto, Ontario

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ILLUSTRATIONS
Brad Todd

PHOTOGRAPHY
Lisa Martinez, Jeff Navarro

DESIGN + LAYOUT
Relish Studio