



Envisioning a New Health Care System for America

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BACKGROUND AND OBJECTIVES: Between August 2013 and April 2014, eight family medicine organizations convened to develop a strategic plan and communication strategy for how our discipline might partner with patients and communities to build a new foundation for American health care. An outline of this initiative, Family Medicine for America's Health (FMAHealth), was formally announced to the public in October 2014. The purpose of this paper and the five papers to follow is to describe the guiding principles of FMAHealth in greater detail. FMAHealth is taking place at a pivotal point in the history of American health care, when the deficiencies of our overly expensive, underperforming health care delivery system are becoming more apparent than ever. By forming strategic partnerships to implement this initiative, family medicine seeks to define a new approach to health system leadership, care delivery, education, and research. This will require substantial reorientation of existing priorities and reimbursement systems, which are focused on delivering services, instead of on improving health. Family medicine is committed to engaging and empowering patients, their families and communities, and other health care professionals to establish a more equitable, effective, and efficient delivery system—a system in which health is the primary design element and the “Triple Aim” is the guiding principle.

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identified population for whom to provide care, a commitment to equitable care for its members, and the existence of an entity or organization that would serve as an “integrator.” The integrator accepts responsibility for all three aims for that population, and its role includes five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration.

Serious flaws in our nation's delivery system have constrained our ability to achieve the Triple Aim for years. Further, the Affordable Care Act, with a major focus on increasing health insurance coverage, has made these flaws more obvious. Extensive evidence regarding the impact of socioeconomic and environmental factors on health outcomes suggests that traditional health care delivery systems, centered on physicians and hospitals, are inadequate to achieve patient engagement, behavior change, community activism, and social change required for better health.^{4,5} However, community

The United States spends more than 17% of its gross domestic product on health care, but health outcomes are worse than any other industrialized country, the majority of which spend less than half as much as we do.^{1,2} Given that US health care is not coordinated, comprehensive, or integrated, an opportunity exists to redesign the way health care is provided to better meet the needs of patients, their families, and communities. A new vision is required if we have any chance in the next decade of

achieving the “Triple Aim:” improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations.

In their 2008 *Health Affairs* article introducing the “Triple Aim” concept, Berwick, Nolan, and Whittington argued that achieving all three goals was critical to resolving major problems within the US health care system.³ In outlining the essential elements necessary to achieve the Triple Aim, they described the necessity of defining an

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groups are often disempowered and lack sufficient expertise to redesign care. Because the specialty of family medicine is deeply rooted in the communities we serve; is based on trusting, long-term relationships between physicians and patients; and now represents the largest and most widely distributed primary care specialty geographically, the field is well positioned to help fill this gap. We can play a significant role in shaping health care system transformation. Partnering with patients and communities, along with like-minded collaborators in other specialties and health care professions, we can lead major changes necessary to achieve an integrated system designed to promote health. The time for family medicine to heed this call for action is now.

To meet this urgent challenge, eight family medicine organizations convened over a period of 9 months (August 2013–April 2014) to develop a strategic plan and communication strategy for how we might partner with patients and communities to build a new foundation for our delivery system. Thus, the Health Is Primary: Family Medicine for America's Health (FMAHealth) initiative was born. The details of this ambitious initiative have been described elsewhere.⁶ In developing this plan, the leadership of these organizations focused on several key issues:

- The US health care system is fragmented, depersonalized, costly, and ineffective.^{7,8}
- A health system with primary care as its foundation delivers better outcomes at lower cost.^{9,10}
- Patients, families, and communities must be empowered to drive change at the local, regional, and national levels.
- Integration of interprofessional teams, mental health, and population health into the patient-centered medical home (PCMH) is essential to achieve the primary goal of promoting health.^{11,12}
- The development of enlightened payment models and appropriate infrastructure is necessary for family

physicians and other primary care providers to fully realize their potential.¹³

- New technology, a robust research program to study new approaches to health care, and a well-trained workforce are essential for these efforts to be successful.

Using these guideposts, FMA Health was created to harness advances in health information technology (HIT), the power of patient engagement, primary care workforce and educational redesign, and anticipated payment reform to achieve high value, quality care at reasonable cost. In this paper, we describe the vision behind this initiative, the strategic coalitions and redesign of the primary care delivery system that must be developed to achieve this vision, and the leadership that must be undertaken by the specialty of family medicine to guarantee the success of this initiative.

The Vision

Patients must be at the center of any new model of care and must be fully engaged in creating it. The broad-based transformation necessary to achieve the Triple Aim in American health care cannot be about professional self-interest or physician-determined priorities. Thus, we seek to create a common vision for the health of the American public by engaging those who provide and receive health care. To empower individuals in this way, our approach to leadership must extend well beyond professional boundaries into communities themselves. We desire to create the integrative function necessary for achieving the Triple Aim.³ Our vision is to transform the health of our country, not just its medical care.

A Coalition to Create Patient-Centered Care

A critical force that guided the creation of the specialty of family medicine more than 45 years ago was the longing of the public for a relationship with a personal physician that would partner with them in guiding

their health.¹⁴ Stephens appropriately summarized what would become the central tenet for the specialty by declaring:

If the centerpiece of surgery is the operation and cutting is its method; if the centerpiece of radiology is the image and looking is its method; the centerpiece of family practice is the durable clinical relationship and listening is its method. Whatever we can do to preserve and enhance this exchange is good.¹⁵

This concept guides the training of family physicians, and it remains a powerful force that welds the therapeutic relationship between an individual patient and family physician. Accordingly, it seems logical that family physicians take responsibility for forging a new relationship with patients, families, and communities that uses everything we have learned about promoting better health and empowers them to insist on health care built to serve their needs rather than health system priorities. While family physicians can and should assume leadership in forging these new relationships, they cannot accomplish this alone. Strategic partnerships with other primary care providers (including nurse practitioners and physician assistants), mental health professionals, public health providers, and other health care professionals are necessary to facilitate transformative change.

Central to the notion of focusing on patient-centered care is the understanding that individual patients are a reflection of the communities in which they live, and by better understanding and harnessing the unique relationships among patients, families, communities, and those professionals dedicated to promoting health, we can work together to achieve better care and better health.¹⁶ This is not a new concept; it was delineated in the Report of the National Commission on Community Health Services titled "Health Is a Community Affair"—better known as the Folsom Report—almost 50

years ago and evolved into the concept of community-oriented primary care (COPC) 20 years later.^{17,18}

However, these historic reports and concepts did not fully elucidate the power of strategic partnerships among family physicians, patients, and their communities, nor how mobilizing our collective strengths might help us achieve the integrated health care system envisioned by both Folsom and COPC. We can no longer tolerate the siloed existence of medicine, public health, and mental health;¹⁹ by integrating these functions into a newly designed health care paradigm, we can provide care that is more comprehensive and targeted to the needs of patients, appropriately placed within the context of the families and communities in which they live. This concept has been underlined by recent work by the Institute of Medicine and many others that focuses on the need for integration of care of individuals, families, communities, and populations.²⁰

Integral to achieving this vision are high-performing interprofessional teams in the PCMH. While Folsom advocated for a personal physician who would serve as the central integration point for each patient's medical services, the ever-growing complexity of comprehensive care makes this challenging. For example, it would take a primary care physician 18 hours per day to implement all currently recommended preventive and chronic care services for the average patient panel, let alone care for acute issues.²¹ To enhance care and more effectively improve health, we envision teams of patients, family caregivers, pharmacists, physician assistants, nurse practitioners, nurses, community health workers, and social workers who partner with family physicians and other primary care providers to deliver highly personalized and effective care. Utilizing community resources to augment their management plans, these teams will always engage and empower the patient as the central focus of their efforts. Further, these

care teams must be closely integrated with systems and providers that deliver specialty and hospital care to ensure patients receive such care wherever they are in the system.

Elements of a New Delivery Model

A fundamental conclusion of the Future of Family Medicine project a decade ago was that we needed a new practice model for family medicine and primary care.²² Our country now demands a new strategy to engage local communities and patients. In addition to building practices to serve patients, we need to build community care systems in partnership with patients.

Frustrated with the politicization of health care and impatient for meaningful change, some parts of the health care industry are attempting to institute reform and are working diligently to transform health care on the local level. But these efforts have often been misdirected and ineffective and have met with outright resistance from other sectors of the system. Purchasers, payers, and patients, frustrated with inefficient, expensive, and low quality care as well as the glacial pace of meaningful change, are demanding greater value.²³ The opportunity to connect with these partners as a way to finally bring about transformative change has never been greater, and FMAHealth will provide a roadmap and an opportunity for doing so.⁶

The characteristics of family physicians who would lead these new delivery models were enumerated in the role definition exercise that launched the deliberations leading to the creation of FMAHealth.²⁴ These characteristics included the following:

- Family physicians are personal doctors for people of all ages and health conditions.
- They are a reliable first contact for health concerns and directly address most health care needs.
- Through enduring partnerships, family physicians help patients prevent, understand, and manage

illness, navigate the health system, and set health goals.

- Family physicians and their staff adapt their care to the unique needs of their patients and communities.

- They use data to monitor and manage their patient population and use best scientific evidence to prioritize services most likely to benefit health.

- They are ideal leaders of health care systems and partners for public health.

The integration of primary care, public health, and mental health is an essential element of the proposed new delivery model, and new communication models and HIT will play a key role in bringing these systems together.²⁵ An excellent example of the potential power of HIT to impact care is the use of data analytics by the Special Care Center in Atlantic City to identify high utilizers of care and provide community-based care that has improved patient outcomes and lowered emergency department visits.²⁶ Community mapping utilizing the Uniform Data System (UDS) mapper is yet another example of how geospatial information can be used to influence care.²⁷

Almost 70% of family physicians had adopted electronic health records (EHRs) by 2011, and this most likely surpassed 80% recently.²⁸ However, the full potential of the EHR to impact care delivery at the practice level has yet to be fully realized. These systems lack interoperability, have no standardized format for collecting and storing data, and have little utility in formatting data in a way that can be used by physicians to monitor and improve the quality of care they deliver. The American Board of Family Medicine (ABFM) has embarked recently on an effort to accept and extract data from its board-certified diplomates.²⁵ These data will be reformatted to help family physicians monitor and improve the quality of care that they deliver. The data will feed into a clinical data registry that will be used for

better understanding the care provided by family physicians and developing quality measures that are meaningful for the specialty and actionable by the clinician. Creatively repurposing the EHR to provide this information is essential for system redesign. The integration of clinical data and community data will also contribute to the delivery of meaningful patient-centered and community-oriented primary care.

The advent of smart phone adoption has revolutionized the way in which the American public goes about its business. It will also change the way that patients interact with their family physicians. Health applications will allow patients to undergo diagnostic testing at much lower cost without traveling to a medical facility or clinical laboratory, and this information can be instantly downloaded into the patient's EHR.²⁹ This personal technology will also be used to monitor therapy, assist with modifying patient behavior, and provide access to personal health information. It will serve as an important multiplier of the power of patient engagement and will further enhance the delivery of patient-centered care in this proposed new model.

Payment Reform

Essential to any change that focuses on primary care as a critical design feature is comprehensive reform to support a truly patient-centered model of care.³⁰ The high costs and inefficiency of the traditional fee for service model are self-evident.³¹ Early signs of movement in a new direction are encouraging, and the chronic care management fees that will soon be initiated by the Center for Medicare and Medicaid Services are steps in the right direction.³² However, rapid movement toward global payment paradigms will further strengthen the opportunity for primary care to lead health system transformation.

Although the primary care community has demonstrated that it will not be deterred by the slowness of payment reform in providing patient and community-centered care,

limits to what can be accomplished unilaterally clearly exist. The importance of linking practice transformation to payment reform to accelerate progress became strikingly apparent during the early efforts after the Future of Family Medicine initiative a decade ago, and we cannot allow transformation efforts to be impeded by antiquated and misaligned payment models again. Patient-centered transformations in primary care that will lead to better quality and improved health must be supported by appropriate payment reform.³⁰

The PCMH and direct primary care models are examples of early transformative practice changes tied to payment reform that are improving the quality of care provided to patient communities.^{33,34} Community-based health care delivery has shown promise in improving health.³⁵ Increased funding for public health and mental health is equally important, as both have been shown to significantly improve population health outcomes.³⁶

Ramifications for the Discipline of Family Medicine

The transformed health care system envisioned by FMAHealth will require the creation of a health workforce that will best serve the needs of communities and the patients and families that live within them. This will necessitate rethinking the way in which we educate and train health care professionals.³⁷ We cannot equip the next generation with the knowledge, attitudes, and skills needed for the provision of transformed health care without proper resources and innovative training environments.³⁸ Family medicine must advocate for more funding for training, especially in community environments, in addition to traditional academic health centers. If we are serious about reducing health disparities and modifying social determinants of health, we must create the tools to measure a community's vital signs—those specific social determinants that influence the achievement of health.³⁹ We will also need to place students

and trainees in local environments where they will learn to recognize these community vital signs, work with interprofessional teams, identify local resources, and understand patients within the context of the communities within which they live to promote health and provide optimal health care.

Equally important is providing the proper mentors to guide students and trainees within these environments. This will require expanding the training and experience of existing faculty that enables them to teach the necessary skills required of learners in order for them to fully succeed in diverse community environments.^{40,41} An appropriate start has been accomplished with the Primary Care Faculty Development Initiative funded by the Health Resource Services Administration (HRSA), the Josiah Macy Jr. Foundation, and the respective Foundations of the American Boards of Family Medicine, Internal Medicine, and Pediatrics. However, the initial pilot funded by these resources needs to be aggressively scaled to impact all primary care training programs.

Leadership

A new vision of collaborative leadership is needed if we are to be successful in integrating functions within the current health care system so that we might achieve health for all. As Berwick, Nolan, and Whittington noted with respect to achieving the Triple Aim:³

The remaining barriers are not technical; they are political. The superiority of the possible end state is no longer scientifically debatable. The pain of the transition state—the disruption of institutions, forms, habits, beliefs, and income streams in the status quo—is what denies us, so far, the enormous gains on components of the Triple Aim that integrated care could offer.

Assertive and imaginative leadership is needed to overcome these barriers. Traditional models of

health care leadership, dominated by physicians, hospitals, and insurance companies and focused on disease-centered care, are poorly suited for this purpose. The new requirements of leaders in health care today are tilting toward a call to service, community engagement, collaborative relationship building, and tough negotiation for what is necessary to execute the personal doctoring and comprehensive care needs of individual patients, families, communities, and populations. FMAHealth has defined strategic priorities around practice redesign,³⁰ payment reform,³⁰ workforce education and development,³⁸ technology,²⁵ research,⁴² and engagement¹⁶ with the goal of achieving the Triple Aim for the American people. Family medicine aspires to collaborate broadly and to provide the leadership needed to achieve these goals.

FMAHealth will aggressively pursue a leadership strategy aimed at developing the “communities of solution” envisioned by the Folsom Report¹⁷ with key underlying principles of:

- **Locality.** De-fragmenting our health care system will require that all of those who interface with current systems share a common vision for health and accept responsibility for leadership roles in local towns, schools, practices, academic medical centers, medical schools, and residency programs to create the conditions for change necessary to support this vision. Though this is a national initiative, it will clearly require sensitivity and adaptation to local contexts and conditions.

- **Broad Engagement.** Family physicians practice in every community in America and traditionally have integrated their practices to meet community needs. Family Medicine for America’s Health will develop and engage leaders from multiple constituencies within and across these communities and will commit the nation’s family physicians to catalyzing this process to achieve the triple aim in partnership with patients, families, and communities.

- **Multiple Leadership Styles.** Multiple leadership styles need to be cultivated through which broad coalitions described above can be formed, nurtured, and catalyzed to integrate current systems and create new ones.

- **Change Management.** Key to leadership development for communities of solution will be the training of all current and future leaders with skill sets to create conditions for change, to manage the change process adeptly, and to remain nimble in the face of change.

FMAHealth has outlined a transformative, broad-based leadership strategy involving all who engage with a common vision for the health of our nation and empowering individuals to develop and exercise leadership to realize this common vision. Though this vision will continue to evolve and be refined, the necessary leadership to guarantee success will be based on the above principles and will be communicated broadly as part of the initiative’s communication strategy. This strategic plan will be used by multiple national professional and advocacy organizations involved in FMAHealth to promote leadership training at local, regional, and national levels. An “FMAHealth Communities of Solution roadmap” will be created to track leadership development and the execution needed to carry out the vision. If successfully implemented, this leadership strategy will create the conditions for change necessary to reverse the current direction of American health care toward improving America’s health.

Conclusions

Rapid changes in multiple aspects of our health care and health education systems need to occur if we are to achieve improved health for America in the next decade. Family physicians are committed to engaging and empowering patients, their families and communities, and health care professionals to establish a new delivery system in which health is the primary design element and

the Triple Aim is the guiding principle. This new health care system will capitalize on the unique contributions that patients, communities, and professionals bring to create local “communities of solution” that will uniquely address the needs of their populations to achieve better health for America.

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