Putting the Patient at the Center of Primary Care

BY MARGARET FLINTER '80
SENIOR VICE PRESIDENT AND CLINICAL DIRECTOR, COMMUNITY HEALTH CENTER, INC., MIDDLETOWN, CONNECTICUT

We are in the midst of transforming primary care in the United States—and not a moment too soon. This "we" is an expansive one, extending beyond the traditional primary care providers of nurse practitioners, physician assistants, nurse midwives, and physicians to include everyone on the team who delivers care, organizes it, pays for it, and perhaps most importantly, engages as the patient.

The wave of change accelerates every day, perhaps because, as Winston Churchill famously said, "You can count on the Americans to do the right thing after they have tried everything else." In this first decade of the 21st century, what we have tried has led us to 40 million uninsured, a shortage of primary care providers, ugly health disparities based on race and income, an America where nearly half of all of us live with a chronic disease that is often unmanaged, and a payment system in which volume trumps value.

Why then, am I so hopeful?

Because across the country, in large systems and small practices, caring people have been driving the revitalization of primary care practice to focus on the person and a continuous relationship, caring for patients with all but the most unusual conditions, integrating and coordinating care, and attending to prevention. For those of us practicing in community health centers, where 20 million Americans receive their care, primary care has always extended one step further. In community-oriented primary care, the relationship goes beyond the individual to embrace the health of the neighborhood in which patients live and the center is situated. But now this focus goes beyond community health centers, or the VA, or a few well-known groups like the Mayo or Geisinger Clinics.

A wave of transformation is sweeping across primary care, driven by primary care providers. We have a new name for a new practice paradigm: the patient-centered medical home (PCMH). Whether you like the name or not (and many don't), it has emerged as an organizing vehicle to describe high-performance health care in which the patient is at the center of care and focus, all the time. A PCMH might be in a health center, a nurse-managed clinic, a large group practice, or a solo nurse practitioner's or physician's office.

Regardless, to be recognized as a PCMH, a practice must consistently achieve these standards. Every patient has a personal relationship with a primary care clinician. Patients can access care at a time and, increasingly, in a manner convenient to them. This may include electronic access. Care is delivered by a team, with each member playing a specific role to ensure that care is planned and organized for each patient. Care is integrated across settings, sometimes physically, such as with co-location of behavioral health in primary care, including home, hospital, specialists, and others in the "health care neighborhood." Patient education and self-management are fundamentals, not add-ons. Primary care teams help patients navigate a complex health system when needed. Technology is used to support all of the above, not just through an electronic health record, but through the exchange of information between settings, and for communication between patients, providers, and teams.

This is the primary care that I and my fellow YSN alumni have always aspired to over the years, and I dare say, often have succeeded in delivering. But now we have a set of practice tools, from advanced access scheduling to the chronic care model, and technology tools from electronic records to patient portals and continuous quality data. We have a growing national consensus that this model isn't just for special populations in community health centers, but it is fundamental to revitalizing primary care, satisfying patients, and achieving the triple aim of improving quality, increasing safety, and controlling costs.

What primary care is not is simple. It requires extensive training, not only to the clinical complexities of care, but also to this model of high-performance care in settings where that model is lived. I came to YSN in 1978 because then-dean Donna Diers had written that the mission of the Yale School of Nursing was to radically change the U.S. health care system. At the Community Health Center, Inc., and in similar settings across the country, we are doing just that. We are passionate about training the next generation of health care providers, who will take this work even further, and welcome our current and future cadres of YSN students, postgraduate residents, and ultimately, members of our primary care team. I invite our current and future YSN colleagues to join us in transforming primary care—not a moment too soon.