A Reemerging Political Space for Linking Person and Community Through Primary Health Care

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Objectives. We sought to understand how national policy key informants perceive the value and changing role of primary care in the context of emerging political opportunities.

Methods. We conducted 13 semistructured interviews in May 2011 with leaders of federal agencies, think tanks, nonprofits, and quality standard–defining organizations with influence over health care reform policies and implementation. We recorded the interviews and used an editing and immersion–crystallization analysis approach to identify themes.

Results. We identified 4 themes: (1) affirmation of primary care as the foundation of a more effective health care system, (2) the patient-centered medical home as a transitional step to foster practice innovation and payment reform, (3) the urgent need for an increased focus on community and population health in primary care, and (4) the ongoing need for advocacy and research efforts to keep primary care on public and policy agendas.

Conclusions. Current efforts to reform primary care are only intermediate steps toward a system with a greater focus on community and population health. Transformed and policy-enabled primary care is an essential link between personalized care and population health. (*Am J Public Health.* 2012;102: S336–S341. doi:10.2105/AJPH.2011.300553)

Primary care, feared to be dying over the past decade in a fragmented US health care system,[1–4] has reemerged to the public and policymakers as a foundation of integrated, high-value health care.[5–13] It is no coincidence that this reemergence is paralleled by a growing awareness of the social,[14] environmental,[15] and community[16] determinants of health and the essential role of our beleaguered public health infrastructure in shaping them.[17]

However, despite their parallel ascent, the interdependence of primary care and public health[18–22] has not entirely been recognized. In the wake of landmark health care reform, it is important to understand the current policy landscape to imagine more fully the health care system of the future and the steps we must take as a nation to get there. Therefore, we interviewed national policy key informants to ascertain their understanding of the value of primary care and its changing role, and to obtain their guidance on the emerging political opportunities for primary care to become a stronger foundation for the US health care system.

METHODS

The research protocol was approved by the Case Western Reserve University institutional review board. We conducted 13 semistructured interviews in May 2011 with individuals in leadership positions in health-related Washington, DC–based federal agencies, think tanks, nonprofits, and quality standard–defining organizations. We selected organizations for their important roles in defining the implementation phase of recent health reform measures related to primary care and in defining the next set of national health care priorities. We selected individuals on the basis of their leadership positions in these organizations.

After constructing a sampling matrix to include a broad range of perspectives, we began contacting informants deemed to have a stake in or viewpoint on our study question. We used a snowball method to identify additional participants with diverse perspectives.[23] Individuals that were interviewed came from a variety of backgrounds. Six were primary care physicians, and the remaining came from backgrounds that included public health, economics, law, and the private health sector. Six interviewees were from federal agencies, 4 were from quality standard–defining organizations, 2 were from nonprofits, and 1 was from a health care think tank.

Interviews lasted from 45 to 60 minutes and were audio-recorded and transcribed. We conducted all interviews but 1 in person. Interviews began with broad questions[24] about why primary care has been a buzzword in recent health care reform efforts and what is valuable about primary care at the level of the individual, community, and population (Appendix, available as a supplement to the online version of this article at http://www.ajph.org). Subsequent questions explored barriers to primary care meeting its potential and what primary care of the future might look like. We also explored interviewees' personal experiences of primary care and their information needs as policymakers. For each question, follow-up probes drew out additional depth.[25]

The analysis team consisted of a medical student and 3 family physician–researchers—1 of whom has experience and was certified in general preventive medicine and public health, and 2 of whom have extensive experience in policy analysis. All of the physician–researchers have experience in conducting qualitative research. In a reflexivity exercise,[26] the team identified their shared belief in the importance of primary care, and asked a medical anthropologist with experience in primary care research to serve as an auditor of the process to challenge themes, identify unrecognized subject matter, and provide an additional analytic perspective.

All members of the analysis team read the transcripts and they used an immersion–crystallization[27] approach to identify key themes. Each member individually identified emergent themes. Different configurations of

the team discussed themes in meetings. The purpose of these discussions was to discover common themes and to identify text in the data that supported or refuted each theme. One member of the team (S. A. S.) used an editing[28] approach to pull out text relevant to each theme and to look further for confirming or refuting data. Subsequently, the anthropologist reviewed all transcripts and analyses, serving as an auditor to challenge and refine emerging themes and to identify confirming or disconfirming data.[29] In constructing final analyses, 2 members of the theme identified subthemes and selected quotations, and these were confirmed by the remainder of the team.

RESULTS

Four major themes emerged from the analysis: (1) an affirmation of the current relevance of the fundamental tenets of primary care as a foundation for the US health care system, (2) an understanding of the patient-centered medical home as a transitional step to foster innovation and payment reform that enable high-level primary care, (3) a call for an immediate focus on community-based solutions integrating primary care and public health, and (4) an urgent call for continued advocacy to push primary care beyond the edges of the national political radar into a place of increased priority (see the box on this page).

Primary Care as the Foundation of an Improved Health Care System

There was a strong recognition among key informants that primary care must be foundational to an improved health care system in the United States and that this now is known by policymakers. Primary care, however, must go beyond what it is now and has been in the past, and must transform alongside policy and culture to reflect renewed values related to community and population health and to apply broader health determinants to individual care.

Although numerous tenants of successful primary care were cited, informants emphasized that optimal primary care is patient-driven, is able to engage with the community and have an impact on community health, has the capacity to lower health care costs, can coordinate care for patients, can improve access to care, is based upon an ongoing relationship with the patient, emphasizes prevention, is team-based, and can identify or address the social determinants of health.

Those qualities most emphasized to be at the intersection of high-value primary care that addresses individual and population health were that it can coordinate care, remains person-centered, and is community-focused.

Accordingly, several participants emphasized the need to broaden understanding of the term "coordination" in primary care to include the coordination and leveraging of community opportunities and resources that can reduce barriers to care and have an impact on health outcomes directly. For example, several participants mentioned that it should be the responsibility of primary care to help patients obtain available resources such as childcare and transportation or to enable community solutions for well-being (such as building sidewalks). The role of primary care in coordination is to keep both the individual (person-centered) and the environment with which they are embedded (community-focused) at the center of care decisions.

Key Themes That Emerged in Interviews With National Policy Key Informants About the Value and Changing Role of Primary Care in the Context of Emerging Political Opportunities

Emergent Themes

1. Primary care is the foundation of an improved health care system.
2. The patient-centered medical home has started a necessary and radical shift.
3. Primary care is valuable when it can work at the intersection of individual, community, and population health.
4. Advocacy and research are urgently needed.

Necessary Radical Shift Started by Patient-Centered Medical Home

Key informants affirmed the patient-centered medical home (PCMH)[30] model of primary care as an important effort that has shifted primary care toward a more effective model of care and has shifted the national policy dialogue to reflect a renewed focus on primary care and its role in improving the health outcomes of the US population. However, they characterized the PCMH as only a preliminary step, calling it an "early start."

In terms of shifting the political awareness, a participant noted that "there is increasing awareness that primary care infrastructure is essential if we are going to see improvements in quality and cost effectiveness." They also saw the PCMH as a movement that is elevating primary care in a new way and is putting pressure on primary care "to be accountable to their patients."

Primary Care and Individual, Community, and Population Health

Participants emphasized the expanded role of primary care in improving community health and in integrating population-level, social, and environmental influences of health into individual patient care. Despite the fact that participants may have been working from varied definitions of these terms, it was clear that primary care is valuable when it is able to address additional influences of health beyond those typically addressed in a medical setting. Participants identified several components of primary care or the health care system that must continue to be prioritized to bolster primary care as a critical link between medicine and public health (see the box on the next page).

Maintaining the personal relationship. Participants affirmed that the personal relationship with the patient is still central to primary care—that it is impossible to fully take care of a patient without understanding his or her history and life context. In addition to this personalizing context, primary care also is seen as the health care system's opportunity to "step back and see the whole picture." As one participant put it, "The question is not, 'did you get the right tests?' but 'Did you actually get them, have transportation, have child care, etc.?'" These determinants and barriers to care

Primary Care Policy Priorities to Bolster Primary Care as a Critical Link Between Medicine and Public Health

Primary Care Policy Priorities
• Maintain the personal relationship in primary care.
• Clarify the distinct but related responsibilities of primary care and public health.
• Build and broaden the primary care team.
• Follow the lead of community health centers to engage communities.
• Leverage community resources more effectively.
• Use technology intentionally to reach shared goals.
• Equip the workforce with the appropriate skills.
• Link new expectations to payment.

must be addressed both within primary care and by supportive policy, participants noted, if primary care is to be equitably accessed and able to address the challenges of an "aging population with multiple chronic diseases." Through the personal relationship that is understood in the context of the health care system and community, primary care providers could be able to identify these types of barriers and more effectively address them.

Clarifying the responsibilities of primary care and public health. Although the view of primary care taking a larger role in addressing the social determinants of health was consistent across most interviews, a participant did question if this public health function was in fact the role of primary care. In addition, participants used the terms *community health* and *population health* somewhat interchangeably, suggesting some merging of what community health and population health mean in the context of shifting roles and responsibilities.

Among participants, the term *community health* appeared to refer broadly to the local population for which a single or several primary care teams or providers have the opportunity to interact with and care for over time. Participants seemed to use the term *population health* to refer to the health of the entire US population. This would be the scale at which federal policies are implemented or imagined.

Building the primary care team. Participants affirmed that *primary care* is not synonymous with *primary care physician.* Although the primary care physician is an important part of the primary care team, the primary care of the future, informants asserted, must allow all members of the health care team to "work to their capacity." New relationships must be formed for this to occur, and the relationships within the care team as well as between the team and community partners must reflect the values of an improved system of care that emphasizes prevention. For example, one participant said that primary care teams must be "less physician-centric" and that this cultural shift must be implemented at the medical education level, asserting the need to critically examine

> relationships that physicians have with other primary care providers and think more creatively about how we use other professions even outside of health care in the traditional sense. How do we incorporate that into a team, and how do we bring the patient and the community to be true stakeholders in the conversation?

Following the lead of community health centers. The role of federally qualified community health centers (CHCs) as a model of primary care that engages communities and integrates care more fully was emphasized in many interviews. Several participants discussed CHCs' incorporation of patients onto boards and how this not only can improve patient care by informing centers of community health needs, but also can foster local agency over health. The gap between CHCs' participatory governance and most primary care practices was articulated by a participant who stated, "We don't have those mechanisms in primary care. There isn't anything that requires us to really go out and get input. We do it but it's not with the same strength and magnitude." Another participant noted that there is a larger role for primary care in "civic engagement." In the context of much discussion of prevention, participants distinguished not only the role of primary care in community health but also the role of primary care of engaging a community in its own health.

Leveraging community resources for patient care. Informants suggested that it is time for primary care to help organize needed local resources to address determinants of health in the community (environmental, social, economic) with a participant stating,

> If you don't follow up on recommendations, you get blamed as being noncompliant. It is a very different mindset that needs to be really addressed. There are things that need to be done that may not be done by the doc.

Participants also emphasized that policy must help to define the infrastructure changes needed for this role to be achieved. Nearly every participant noted the barrier of cost to expanding or changing primary care as well as the need for policy and funding to incentivize new roles for primary care.

Using technology intentionally. Informants acknowledged that for primary care to take on a role in coordination of patient care with a renewed emphasis on community and public health, technology must be incorporated in a way that provides the needed data in ways that are useful on a personal and local level. With an ongoing national discussion of primary care as a way to reduce health care costs, informants saw technology as a critical opportunity for primary care to create systems of feedback between primary care and public health, to improve quality, to enhance learning, and to transform complicated care processes. As a participant noted, "We need a system of feedback loops in which physicians are not just learning about their patients but they are sharing information about the population."

Equipping the workforce with the right skills. It was clear from interviews that informants understood the expanding role of primary care, but they were careful to emphasize the role of workforce training to allow providers and team members to acquire the appropriate skills. For example, it was noted that

> Historically, physicians do not train to understand how systems work and there is actually little historically in medical and residency training that prepares physicians to work effectively in a system. And so, if you are thinking and

> talking about managing care for a patient, it is more and more important that physicians understand the care process and how other parts of the health care community [fit into it].

Emphasis was placed on not only the role of providers or primary care team members to take on new roles, but also on the health care education system to transform and to produce and train providers that have the skills to take on such roles. A participant even went so far as to say, "That's our biggest impediment right now: a real evolution in the medical education mindset."

Linking new expectations to payment. It was overwhelmingly understood by participants that new expectations for primary care must be linked to payment reform. As a participant noted,

> My feeling is that the economics needs to work for doctors; it's not about revenue maximization or profit maximization, it's around sufficiency. They have to be able to make enough to feed their family, pay practice cost, but it is not about the incremental dollar and the second home in Florida; it's about job satisfaction. . . . It's economic sufficiency, not maximization.

The tone of the interviews was that sufficient economic incentives for improved care must be in place for other efforts to be functional, not only for provider salaries but also to foster creativity and drive systemic change.

An Urgent Need for Advocacy and Research

Participants described the difficulty in shifting political and public understandings of the importance of primary care. They emphasized the need for advocacy to keep primary care in the national spotlight. They noted public misperceptions about the value of primary care to community health as a significant barrier. "I think that people don't understand what primary care is. I think that generalists have taken for granted that everyone knows what a generalist does," noted a participant. In addition, several participants even discussed at some depth the need for a sustained political movement and public champions.

DISCUSSION

The informants of this study reinforced and expanded beyond the fundamental tenets of primary care.[31–35] As defined more than a decade ago by the Institute of Medicine:

> 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.[36(p15)]

In an era of fragmentation[37–39] of the health care system, the Folsom commission pointed to primary care providers as galvanizers of "communities of solution," organic and locally grown ways of understanding and improving health and health services delivery sites.[40,41] Consistent with this, the informants of this study also articulated older concepts of community-oriented primary care,[42–46] wherein providers work with community partners to take responsibility for the health of a defined population by linking an epidemiologic understanding of a community with both medical and social interventions to improve the health of people and populations. This process involves engaging the community, evaluating its needs, and sharing control of how those needs are prioritized and addressed.

Recently, an extensive literature review undertaken by the Canadian Health Services identified challenges and themes around the need to more effectively integrate public health and primary care across contexts.[47] In addition, a recent study of how primary care is organized in 24 different countries with health care reforms showed a vision for primary care that is manifested in ways that are responsive to the local sociopolitical climate.[48] Thus, the US vision for expanded primary care and public health is part of a larger global movement that is evidenced by the World Health Organization's recent call to reenergize the grand vision of health for all[49–54] on the 30th anniversary of the Alma Ata declaration, which called for all nations to "protect and promote" the health of their peoples through primary health care.[32]

The informants of the current study similarly called not for revisiting old ideas, but for grounding in new ways of integrating health care and public health. These informants pointed toward a goal for community-oriented care that has rarely been realized in this country, an aspiration, in fact, that launched CHCs more than 40 years ago. Achieving that level of primary care delivery requires changes that go well beyond current reform efforts.

Informants identified the need to go beyond the provider- and disease-driven paradigm of health care to an approach that actually engages constituents and community resources in the promotion of the health of whole people and communities. In accordance with that, they identified the current ambitious work toward the PCMH[55–57] as only an intermediate step, a political expediency,[58] on a larger journey toward integrated primary care and public health. They pointed out the challenging political task ahead and the need for much greater advocacy for the all too uncommon, common good.

These study findings reflect both the insights and the potential biases of highly informed insiders in the nation's capital with considerable knowledge of health policy. As such, the informant pool may not reflect a popular dominant view, or the opinions of those with more shallow knowledge of primary care. Thought congruence among their thinking around the themes identified here may reflect saturation of ideas, or may be the result of too narrow a pool of informant experience and expertise.[29,59,60] Nevertheless, the concordance and relevance of these informants' insights for the current situation is more than striking. The themes that emerged offer us a concrete set of priorities from which to work.

The opportunities identified in these analyses are sharply focused reminders of a unique political moment that did not end with the passage of the Patient Protection and Affordable Care Act.[61] Study participants identified a way forward that is grounded in timeless concepts of integrated care delivery that includes public health and community stakeholder input, to be used in a formative way at a time when regulators are crafting the shape, funding, and direction of accountable care organizations[62–64] and the PCMH.[35,55,57,65–67] Absent such stakeholder input at the ground level, it is unlikely that we will see these disruptive innovations achieve their potential impact on the health and healing of people and population, of citizen and community.

The combination of fundamental values and new organization and collaboration identified in this study resonates with the concept of primary health care[12,68–70] that focuses

both on public health and on personal health care. This understanding within the federal government and policy advisors is evidenced by the focus of this combined *American Journal of Public Health®—American Journal of Preventive Medicine* special issue and by the focus of a new Institute of Medicine commission study on the integration of public health and primary care commissioned jointly by the Health Resources and Services Administration and the Centers for Disease Control and Prevention. This call for primary health care also reverberates with the triple aim of improved quality, controlled cost, and advanced population health.[71] The location of these informants inside the District of Columbia beltway is a source of hope at a time when primary care is incredibly malleable and providers across the country are busy innovating 1 practice at a time and across diverse systems and collaboratives.[11,30] It is up to us in the public health and health care communities to engage others in our communities to build a stronger movement that can create sustainable and creative solutions to achieve our shared vision. ■

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Contributors

This study was designed by S. A. Sweeney under the mentorship of K. C. Stange and with input from A. Bazemore and R. L. Phillips throughout the design process. Background research and all interviews were conducted by S. A. Sweeney in Washington, DC, with guidance from A. Bazemore and R. L. Phillips at the Robert Graham Center. Initial analysis was conducted by S. A. Sweeney and K. C. Stange. Secondary analysis included A. Bazemore and R. L. Phillips. Writing was largely conducted by S. A. Sweeney and K. C. Stange with several rounds of revisions by A. Bazemore and R. L. Phillips. R. S. Etz was brought in at the final stage of analysis to offer alternate themes or analyses and to provide validity.

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Human Participant Protection

This study has been approved by the Case Western Reserve University institutional review board.

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