Underlying Challenges in Primary Care

This really needs to be a discussion about primary care, primary prevention. As a group we have shied away from this, because it is difficult to study, measure, and implement. As a group of practitioners are spread thin, our success is measured in bullet points, minutes, and gold performance stars attached proudly to our names in the figurative classroom of adulthood. None the less our underlying mission remains the same, the same mission probably contemplated by all of us at some level from the first college application letters, the first “doctor” concepts that entered our minds, and perhaps the collective need of the society we live in. Commonly it is pointed out that one often cannot see the forest for the trees, but in primary care we often fail to see the people from the A1Cs. Even saying this conjures a generic holistic hippie dippie reaction from many; we have 20 minute appointments and patients taking 20 different medications how can I realistically “see the person, change the person”? But the bottom line is that if we don’t understand how to better coach people to elicit a beneficial response then we aren’t “doing our jobs”, or rather fulfilling our purpose, from a purely strategic standpoint.

The most difficult topic, perhaps both from a practice standpoint as well as a research standpoint is the matter of obesity & sedentary lifestyle and the inextricable link with metabolic syndrome. This is, after all, what primary care has always been essentially charged with dealing with as a de facto matter of course. If we don’t address it, who will? Nearly all of our most common and expensive diseases are the direct result of poor diet and sluggish lifestyle yet the topic remains taboo in a sense. Practically speaking it is muddled in the medical community amongst physiologists as well as medical practitioners, and the public perspective is amorphous. There is no real insight into this matter of self improvement beyond the glitzy one liners seen on late night television during boisterous advert attempts to sell any number of products designed to do as such. Not only is the shared public standard of obesity and what it means for health a controversial topic in the social scene, but the mere matter of bringing up the subject at a medical visit risks an immediate doctor/NP/PA patient disconnect resulting in a shattering of the therapeutic bond and poor patient satisfaction scores. The underlying instinct seems to be an awareness of the problem, and the causal link seems to be accepted, at least subconsciously, yet standardization of strategies (and strategies that work) are simply non-existent. Add to this regional and cultural differences and it is no wonder that no meaningful change has been realized. Even focusing on one simple aspect of a downstream marker of success or failure in a patient already subjected to years of metabolic havoc, an A1C, is a matter of much research and strategizing, but in a way it is extricated from the whole and only through this process of symbolism and externalization are we able to start talking about fruits and vegetables. We talk about an A1C in a type 2 diabetic, but we are really talking about a complex symbol of regimen adherence, lifestyle choices including food intake, non-exercise activity thermogenics (NEAT), exercise habits, genetics, and a number of other co-factors. Of course, I could have just said “heart disease”, but that would be too easy.

The next subject that needs focus may as well be a unicorn; i.e. the internal locus of control. I originally wanted to bring up smoking cessation, but the mere utterance of that was practically a travesty. It is such an ubiquitous topic, deceivingly complex, but when considered in whole it

really comes down to the issue of self control, motivation, and execution. The same principle, if better understood, would likely share applicability in the formation of strategies and normalization in the mind of practitioners and the public for obesity management, habit deformation, and general lifestyle change components. Again, in primary care, these upstream points are where we should be trying to stem the tide. Training methods have been studied by many different institutions throughout human history, but their methods and results generally have not been applied to coaching lifestyle management. Unfortunately focused research into human behavior is often focused on sports team wins, militarization efforts, special forces training, and other realms outside of one's personal health and well being on an individual level and all the way down to a person's daily habits and routine. Either we don't know enough or we aren't approaching the problem honestly, or both.

The last topic I would like to discuss would be the workflow and set-up of the medical practice. We have a current set up that is largely designed to optimize compatibility with payors; visits seem to be tailored to budgets and to insurance company reimbursement protocols. However, the workflow does not appear to have been adequately studied from a workflow engineering perspective. When you build a factory the processes and outputs are all carefully examined and tailored so that the input creates an ideal output. And we do that, to some degree, in that we make the most with what we have but no one really knows if things were done very differently if outcomes might scale proportionally different, and would they be considerably better? Medicine has taken on characteristics of a service & hospitality industry, but lest we forget it is also a discipline, a profession, and we have a purpose beyond satisfaction scores. Are many incremental changes ideal for some health concerns and other more pivotal shifts needed at certain types of problem solving visits? The truth is we don't know, and if we don't know then we may never reach our full potential within the context of our current visit system or even in a conceptual system not currently in existence where patient visits might look different than they do now. Perhaps the antithesis of research into comprehensive workflow reinvention is the rise of research focusing on pattern identification in EMR database sets, which is useful but limited in scope and can only direct one's gaze the subpar performers and suggest what direction needs exploring, but that type of data mining provides no guidance on how to go about doing so beyond the basic supposition of the reader.

An additional topic that is related, but is perhaps not allowed for in the schedule would be the interconnected concept of regimen adherence. That of course has a lot to do with time constraints, but also with practitioner patient mismatches in terms of readiness to change, the desired degree of change, and other personality traits that are currently essentially left to chance. Why isn't there a more effective tool at matching up practitioners and patients both in terms of practice style but also in terms of assessing a patient's willingness and capacity to change? Some tools exist, but they are certainly not the norm, and perhaps they should be.

There are a million other specific practice questions, but from a daily basis these are the common threads that I observe as most prevalent in underlying thematic structure.