What a Pandemic Reveals about the Implementation of High Quality Primary Care

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Summary

Pandemics expose vulnerabilities and uncover possibilities.

The COVID-19 pandemic exposes vulnerabilities from:

- Reductionist, commodified misunderstanding of what is most valuable about primary care
- A fragmented system that venerates vertical over horizontal and whole systems integration
- Payment and administrative burden divorced from value.

The pandemic uncovers possibilities to:

- Understand and support primary care as a force for integration:
  - A first contact point of connection for being known as a whole person and community member
  - A vehicle for prioritizing, personalizing, providing and coordinating care
  - Part of a larger evolution toward commonality, sustainability, and equity
- Systematically generate generalist knowledge
- Re-purpose administrative overfunding toward primary health care and public health
  - Invest in infrastructure for integrated primary health care and public health
  - Implement technology in the context of relationships
  - Prospectively paying primary care to support relationships, capability, and flexibility
  - Implementing high value primary care as a commons for the collective good

The current moment is ripe with loosened connection to a fragmented and commodified health care system that is past its time. Long-term investment in primary health care will prepare us for ongoing and future pandemics, and add much-needed resilience, equity, and personal connectedness to a currently brittle, depersonalized, fragmented system.
Introduction

Pandemics expose vulnerabilities. They also bring to light what is possible if we allow ourselves to become unstuck.

We are living through a time of many pandemics: The slow burn of obesity,\textsuperscript{1-3} diabetes,\textsuperscript{4-7} and multimorbidity.\textsuperscript{8-10} The multigenerational momentum of the rich getting richer, and the poor getting poorer, as structures and deeply-ingrained individual and societal conditioning create inequitable opportunity.\textsuperscript{11-13} The torrid pace of COVID-19 and the repercussions of our ever-changing attempts to stem its surge.\textsuperscript{14-18} The cynically fanned flames of greed, anger and fear that — like selfless love\textsuperscript{19-22} — are even more contagious than coronavirus.

All these crises meet the pandemic criterion of occurring over a wide geographic area and affecting an exceptionally high proportion of the population. But we view them with very different senses of urgency. The degree to which we feel personally affected, or have gotten used to them — just as we have accommodated to such long-standing crises as climate change,\textsuperscript{23} classism,\textsuperscript{24} and racism,\textsuperscript{25-27} — creates very different senses of urgency. This chapter focuses on the COVID-19 pandemic as an urgent and crystallizing lens for revealing important and actionable truths about what is needed to implement high-quality primary care.

Thirty-two years ago, I finished patient care late on a Friday afternoon. Rushing toward the back hallway door, trying for once to be on time for dinner with my family, I was halted by the distant look on the face of the social worker who did behavioral counseling for our family practice.

I said, “Eileen, you’re standing there with a faraway look in your eyes.”

She replied, “I think I just figured out what I want to do with the rest of my life.”

A statement like that is as good a reason to be late for dinner as any patient urgency. I stopped and waited. She continued, “I’m going to work for people whose lives have been touched by cancer.”

I shuddered, “Why would you want to do that?”
“I spend most of my days trying to get people unstuck. They hold on so tightly to things that give them a small short-term sense of security. But in the long run, these attachments hold people back.” She paused and stared me against the wall, “People who just got a cancer diagnosis are unstuck from everything.”

It took Eileen Saffran more than a year to interactively refine her vision, fundraise, and implement it, but The Gathering Place now is a community for people whose lives have been touched by cancer.  

The cancer that is COVID-19, and our rupturing response, spreading through our society has many people and institutions unsettled, but also potentially unstuck. Living in a world that few of us ever imagined is allowing our imaginations to consider and action on possibilities that only months ago seemed fanciful. But the need for a sense of security, even one that ultimately holds us back, is strong, and the moment for change is fleeting. 

_Carpe diem. Respice ad futurum._ It is time to seize the day, with an eye on the future.

**Vulnerabilities exposed by the pandemic**

The pandemic reveals vulnerabilities to which we otherwise are inured during the illusion of stable times.

_Reductionist misunderstanding of what is most valuable about primary care_

Jessica grew up in a working class family but found that she and her husband each needed to work two jobs to keep their three children in shoes and backpacks and (later) cellphones. She became depressed and anxious after he died. She developed obesity, hypertension, type 2 diabetes, arthritis, and then chronic low back pain. For each problem, she got optimized evidence-based care from a different specialist (except for her obesity and sense of despair, which no one seemed to want to address). She struggled to pay for and take the nine medications prescribed by 5 non-communicating regular doctors and the occasional urgent care or emergency clinician. When pain finally made her lose her housekeeping job and her health
care insurance, she decided to invest $120/month for a family subscription to a direct primary
care doctor.

Jessica and her new doctor spent their first hour together looking behind the surface
symptoms and diagnoses. She later described feeling a growing sense of safety during that initial
and subsequent visits. Together, she and her primary care doctor began to unpack her health and
illness journey in the context of her life story, moving beyond treating her diseases and
symptoms at face value. The immediate result was reducing her medications from nine to four
— none were the first line treatment for any disease, but each provided some possible help
across her multiple problems. Over many in-person and remote visits for herself and her
children, Jessica and her doctor realized how grief and loneliness had changed her life. Based on
a suggestion by the doctor, she decided to join a volunteer group with her children.

At her next visit she was off her pain medication, and looked transformed, saying how
good she felt helping others and spending time with her children. Over the course of the next 6
months, she made friends and rediscovered her old passion for dancing. She connected with her
new friends, lost weight and gained fitness. Her blood pressure and diabetes improved, as did the pain. Her depression abated as meaning returned. In Jessica’s own words, she got her life back.

When “the COVID” started hitting her friends (colleagues and residents) at the group
home where she now worked, Jessica’s anxiety flared back. Information from her doctor
reduced the anxiety and helped keep her and her charges safer. But knowing she could call her
personal physician helped even more. Her sense of safety returned, and her doctor was surprised
and reassured by the order he saw in her home during telehealth encounters that felt like mini-
home-visits.

Our medico-industrial complex has made tremendous progress by dividing complicated
problems into their component parts.30-32 But, as Jessica’s story illustrates, complex health and
health care problems are not solved by optimizing their component parts.33-36 Solving complex
problems requires discernment across multiple levels, working with openness and humility,
focus[ing effort on the apparently most fruitful endeavor, observing, learning, refocusing,
connecting, integrating, iterating between the parts and the whole — in short, the generalist approach epitomized in high quality primary care that is set up to take time with people.37-40

At the start of the pandemic, the health system problems of fragmentation,35 inequity,13,41 and low value42 were hidden or lacked salience for many. But the pandemic reveals how chronic under-investment in health care as a relationship, and over-investment in healthcare as a commodity,43-48 cause illness through compromised ongoing health care,49 and by exacerbating inequities50,51 in social and environmental determinants of health that include unfair access to educational opportunity, living wage jobs, and safe and advantageous environments.52-55 Generalist knowledge and ways of knowing are needed now to iteratively prioritize attention and bring together different ways of knowing particulars to create an integrated whole.56,57 The fragmented, impersonal, often inaccessible response to the pandemic brings to light the need for primary care to contextualize acute, chronic, preventive and mental health care by knowing the person in their family and community context.58

The same predominant mental model that values narrow expertise over expansive wisdom59,60 has led to misunderstanding what is important about primary care.39,61,62 Yes – primary care provides the first line of evidence-based care of chronic illness63-70 — often multiple chronic illnesses68-71 — that are commonly seen in primary care,72 as well as preventive services,73 acute problems,74 mental health,75,76 and problems of living.75,77 But measuring and rewarding quality for each of these parts individually78 misses what is uniquely valuable about the whole of primary care and its relationships.61,62

Primary care, if executed correctly, is a source of integration within an otherwise fragmented system35 — finding one drug and a behavior change that works for three illnesses;37 using an acute concern as a teachable moment for an apparently intractable preventive health behavior change;79,80 addressing family issues during half of new patient visits and a quarter of visits by established patients;81 providing care for a family member other than the identified patient during 18% of visits;82 prioritizing and personalizing care based on evolving information for the 25 problems that come up during apparently simple diabetes follow up visits by patients from vulnerable populations.83
This craft of generalism has coherence, as evidenced by the single factor emerging from a factor analysis of 11 domains of care that primary care patients and their clinicians say are what matters about primary care. Yet, the complex interrelationships between these primary care mechanisms, and how they work together with each other and with other sectors to foster population health, equity, quality, and sustainability are not widely understood, even among those practicing and advocating for primary care.

Primary care is designed to prevent health crises by promoting health on an ongoing basis. And yet, our fragmented health care system structurally separates mental and physical health care, crams the most complex functions — integrating, personalizing and prioritizing care for whole people — into 10 minutes, whereas specialists caring for a single disease are allotted three times as much time. Current systems foster fragmentation and minimize the ability of primary care by considering it mostly a vehicle to manage already diagnosed diseases and feed hungry hospitals, rather than a means to scan the entirety of a person’s health needs, continually refine what is most useful, and promote healing, health and connection.

For integrated, personalized, accessible, sustainable and effective health care, being known as a person, not just as a disease or a consumer of a service line, matters. There are tremendous benefits to having a first connection with health care that knows the person and that does not pre-specify what the person must be, or have, to show up. Being known by a primary care clinician and practice — a place, person or team of first contact and a comprehensive frame and connection to other resources — is a precious and under-appreciated space in health care that is being squeezed out by commodified views and support and payment systems. Being known — as a person, a family, a member of a community — also is an important step toward fairness, and systems based on primary care exhibit less inequity between the advantaged and disadvantaged.

The COVID-19 pandemic brings to the fore the importance of health care as a relationship, not just a commodity. A COVID-era survey of primary care patients found that the vast majority valued being known, feeling connected, feeling safe to ask anything, being helped

* Accessibility, advocacy, community context, comprehensiveness, continuity, coordination, family context, goal-oriented care, health promotion, integration, and relationship.
to make sense of what’s going on. A recent study found dozens of ways to invest in relationship, even during remote telehealth visits — physical distancing with social connectedness.

Being known is not just a vital process of primary care. It is an outcome of healing relationships, along with hope and trust. Healing is fostered in primary care by: abiding (being accessible, being present for major health events, caring actions, commitment to not give up), appreciating power differences (partnering, educating, exhorting), and valuing (a non-judgmental stance, connecting, and presence through full attention, attending to the person’s illness as well as the disease, and by suffering with the patient). When primary care focuses first on the person, and then does whatever is most needed based on that, healing connections are forged. But the current organization and understanding of health care, exposed by the COVID-19 pandemic, is blind to these healing connections.

In a recent national survey, patients said:

I am very happy that my doctor has a personal relationship with me, knows about my life, my current issues (non-medical), and cares about how I am doing.

I greatly appreciated my doc proactively sending out an email to all his patients at the beginning and twice since letting us know the concerns with our specific chronic illness and what we need to do to protect ourselves. This has a lot to do with why I trust him so much.

I can call any time. That’s important. Especially during COVID.

I have a greater sense of well-being and safety by having a PCP.

During the COVID-19 pandemic, one physician contrasted his ongoing experience in seeing patients in the rural practice he started more than two decades ago, with his more recent experience in developing standalone telehealth services for a large integrated healthcare system.

He said, “I had one patient in my practice who got really sick with COVID-19. It was at the earliest stage of the pandemic locally. I know him well and ended up treating him entirely remotely. We did a virtual visit, and he had suggestive symptoms. But at that point, local testing was restricted only to inpatients and highly selected outpatients. He didn’t meet the criteria – he had mild symptoms and was less than 60 years old. We started a telephone contact system. My staff or I call patients on a regular basis that we are concerned about. We called this patient
daily. He worsened, and I sent him to the emergency department where he was admitted and eventually put onto a ventilator. His wife decompensated with stress and anxiety. I did virtual visits with her, doing brief counseling and adjusting her depression and anxiety medicines, treating her as the ‘hidden patient’ to her sick husband in the hospital. He recovered, and I’ve been following both of them as outpatients virtually. I haven’t seen either in the office since it started. Both are improved.”

This same physician described another patient he talked to in a one-off virtual visit that patients pay his system to provide with a rotating bank of clinicians. In this remote urgent care visit he saw a 16-year-old whose family had no relationship with a primary care clinician. He referred this patient to his system’s hotline to be considered for COVID-19 testing. The patient had multiple symptoms, but was not deemed to be high risk, and so not tested. But the physician noted that he lives with his elderly grandmother, and his mother has diabetes and hypertension. In the face of a shortage of testing, and a lack of follow-up, the doctor saw that the family needed ongoing monitoring. He had his practice add the family to their daily call list, and have shepherded them through the illness and risk.

A fragmented system that venerates vertical over horizontal and whole systems integration

A fragmented, each to their own health system diminishes everyone, even those who can buy care that is considered “the best.” But a crumbled part of a disintegrated whole is not the best. Buying the best commodity of health care, devoid of the contextualizing relationship of being known as a person and a member of a family and a community, often is dangerous and low value for the individual and for the collective of which the individual is a part.

In response, health systems try various schemes to foster integration.

Vertical integration organizes multiple levels of care, often along disease-based service lines, within one system. A prominent economist called “Vertical integration of health care delivery and financing — the most effective model for ‘owning the whole patient.’”

In contrast, horizontal integration organizes cross-sectoral collaboration to improve overall health of people and populations. Horizontal integration has another name — primary health care — and as defined by the World Health Organization, it involves comprehensive care;
addressing social, economic, and environmental health determinants; and empowering individuals, families, and communities.127

When a vaccine is ready for the new SARS-CoV-2 coronavirus, a command and control vertically integrated system may be the easiest way to deliver it to those who already are connected, just as the well-connected were the first to have access to COVID-19 testing and personal protective equipment early in the pandemic.128 But how will we reach those who are not well-connected? How will we bridge rural/urban, racial/ethnic/class and other divides, or reach the disadvantaged who will be further disadvantaged as yet another innovation appears not meant for them?50-52,54,55,129 How will we integrate behavioral health care, during a pandemic during which the mental health effects are at least an order of magnitude more common than the infectious disease effects?129-131

This is where horizontal integration — particularly primary health care116,132,133 that already has invested in relationships with individuals, families and communities — is needed. For pandemic response and for high value health systems, what is needed is a whole system approach in which vertical and horizontal integration develop in tune with each other.134,135 But unless we make a priority of conceptualizing and implementing a comprehensive integrated health care system, horizontal and bottom-up aspects will continue to get short shrift, resulting in fragmented care, unfair and ineffective allocation of resources, and a continued unnatural schism between caring for mind and body.96-99,136-138

The implementation of the 1978 Alma Ata declaration is instructive in how the desire for simple solutions and quick wins can thwart attempts at whole system approaches.139,140 Signed by 134 countries and 67 international organizations, the Alma Ata declaration presented a grand vision for primary health care as a central and universally accessible function of health systems — essential to social and economic development as well as to health. That vision was not achieved because its implementation focused on vertically-integrated approaches to narrowly-defined problems with short-term, measurable outcomes, and a reductionist mindset that required top-down organization.135,141-145 A renewed vision, established in Astana in October, 2018, espoused empowered communities, working across all sectors, to build sustainable primary health care.146,147 But implementation will require building a sense of the commons — resources accessible to all members of society held in common for the good of individuals and the
collective — that currently has been lacking in the US response to the pandemic, and in our societal approach to health and health care.

In contrast to the fragmented and divisive US response to COVID-19, Germany used an aggressive public health (testing and tracing) approach to identify positive cases and their contacts, and sent all positives to the general practices that make up 48% of the health care workforce. General practice physicians treated infected patients with an integrated approach based on knowing the person and their context, dramatically reduced hospitalizations and resulted in a lower death rate than the US. This is the beauty of whole system integration: horizontal integration at the appropriate level, and the ability to ramp up vertically-integrated programs with the contextualizing foundation of strong horizontal systems. In addition, the German response was framed as a call to solidarity, rather than as an opportunity to divide and conquer. Imagine how the COVID-19 pandemic might have unfolded differently if almost everyone know the answer to the question ‘Who is my primary doctor,’ and local, state, and national governments could reliably start executive orders with ‘Contact your primary physician about…’

Ironically, public health and primary care, despite their horizontally-integrative and whole systems ethos and missions, suffer from siloed organizational structures. Public health is organized in rigidly-administered categorical programs, and primary care professional and certifying organizations are separate and competing rather than collaborating on a common mission that includes but transcended their discipline-specific competitive interests. Further, as currently organized, public health and primary care lack common ground from which to work. Public health has under-funded but organized local, state, and national structures, whereas primary care has limited geographic infrastructure but has direct relationships with the people and communities they serve. The 2013 Institute of Medicine report Primary Care and Public Health – Exploring Integration to Improve Population Health identified opportunities that have not been met because of narrow, unconnected leadership and a reactive, shortage mentality. It is time for public and health care organizational leadership and ways of working together to focus on the larger good that people need from us.

The over-valuing of vertical over horizontal integration belies a reactive approach that waits until a crisis forces action — a time when possibilities are limited, costs are high, and the...
advantaged become more advantaged and the disadvantaged more disadvantaged.\textsuperscript{160-164} Rather than investing in relationships and other infrastructure for upstream preventive and early care on an ongoing basis, we spend on huge bailouts for hospitals doing the downstream disaster work,\textsuperscript{165} and smaller short-term stopgaps for primary care and public health during a crisis,\textsuperscript{166,167} after long-term under-investment in public health and integrated primary care has dampened their ability to respond to the pandemic.\textsuperscript{159,168}

Contrast the US response to the pandemic with that of South Korea and Hong Kong. Those countries paid attention to lessons learned from the SARS pandemic,\textsuperscript{169} and invested in health care systems that were ready to respond to new threats. During the COVID-19 pandemic, they engaged in aggressive public health case finding and quarantine and primary care triage, with only selective referral of the sickest cases to secondary and tertiary hospitals.\textsuperscript{170-173}

South Australia responded to the early pandemic with even greater integration of primary care and public health.,\textsuperscript{174} General practitioners, their professional organizations and Primary Health Networks worked alongside public health officials to rapidly ramp up testing, care for the large majority of patients remotely and at home, and only very selectively engage emergency departments and hospitals, thus saving resources and reducing community and health care worker spread. Three-quarters of all COVID-19 patients were cared for by GPs.\textsuperscript{174} Prior collaboration in respiratory infection work between South Australian Pathology and the Australian Sentinel Practices Research Network [ASPREN]\textsuperscript{175} facilitated rapid ramp-up of testing. This integrated, multilevel approach is how apparently intractable multifactorial problems are effectively addressed.\textsuperscript{78,128,176}

Being trapped in payment divorced from value

An instrumental result of over-valuing vertical over horizontal integration is under-investment in public health, and integrated primary care.\textsuperscript{76,159,168,177-179} Whereas countries with higher value health systems, as evidenced by better population health and equity at lower cost, spend a higher percentage of their budget on primary care, the US, with the highest per capita health care spending in the world\textsuperscript{180} spends less than 6\% of its health care budget on primary care.\textsuperscript{181} Within the US, and across all fifty states, recent research found an inverse association
between the percent of health care spending on primary care, and total hospitalizations, hospitalizations for ambulatory care sensitive conditions, and emergency department visits.\textsuperscript{181}

In addition, the US spends markedly more than other high-income countries on health care administrative costs of care — 8\% in the US compared to 1\% to 3\% in the other countries that spend substantially less on health care than the US.\textsuperscript{182} This waste provides an opportunity for reinvestment toward a greater good than greed.

Payment for primary care is addressed in detail elsewhere in this report. Recent reports highlight the brittleness of a system largely based on fee-for-service in its limited ability to respond to COVID-19,\textsuperscript{167} and the vulnerable state of primary care practice piecework financing.\textsuperscript{183,184}

According to a weekly national survey,\textsuperscript{119} in order to protect patients, staff, and to comply with stay-at-home orders, primary care practices stopped or greatly diminished in-person services while trying to dramatically ramp up remote services. Within three weeks of President Trump’s March 13, 2020 declaration of a national emergency, half of primary care practices reported a severe impact on their practices; 90\% were limiting chronic and acute care visits, and the large majority were switching to predominantly telehealth visits, despite a largely deficient infrastructure beyond basic telephone services.\textsuperscript{119}

By the second week in April, nearly half of practices were unsure if they had enough cash to keep their practices open, 42\% laid off or furloughed staff, and 85\% reported dramatic decreases in patient volume and corresponding income. Connected and concerned for their patients, they prioritized work that was largely unpaid, including triaging and referring potentially infected patients in the face of largely unavailable testing and personal protective equipment, calling patients at home for check-in and monitoring, and outreach to high-risk subgroups and individuals. By mid-April, 57\% identified less than half their work as reimbursable. They noted, and responded to high rates of COVID impact on patients’ physical, psychological and financial well-being, and on particular vulnerable subgroups.\textsuperscript{119}

By the end of April, 45\% of practices (like many other small businesses across the country) were unsure if they had enough cash to stay open for the next four weeks. By mid-May, 42\% had sought and received some relief from government or private sources, but 21\% found themselves ineligible for existing programs and without other options. Over 80\% indicated
payment based on volume, extensive documentation, and measure-driven incentive programs that were not favorable to practice resilience during the pandemic. Half felt that predictable payments in exchange for transparent reporting on a small set of meaningful measures was key to current and future practice sustainability.  

While grateful for growing opportunities to be paid for telehealth visits, and recognizing the potential utility of such visits even after the end of the pandemic, the disjointed disarray of hoops to jump through to possibly get paid for telehealth was yet another marker of the fragmentation of the US health care system. Telehealth payment also serves as an indicator of how every attempt to help primary care with different payment and organizational structures over the past several decades and accelerating in recent years, has come with a concomitant increase in administrative burden that has become stifling and a major source of burnout as energy and resources are spent on box ticking and trying to get paid. The degree of administrative burden has become intolerable, even for the most zealous practitioners of primary care reform.

In one example, reflected through the lens of the COVID-19 crisis, the adjacent table was put together by a local health care system to try to help its affiliated primary care clinicians get paid for their telehealth visits. As the footnotes indicate, payment for telehealth is full of exceptions and rules requiring careful administrative attention. This is one small example of the cacophony of things that primary care

<table>
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<td><strong>Telehealth - Audio Only/Telephone</strong></td>
<td><strong>Teleophonic 98966-98968 99441-99443</strong></td>
<td><strong>e-Visit 99421-99423</strong></td>
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Some self-insured employers may not cover these services.

Generally and unless otherwise noted the services covered are those approved for telehealth delivery by CMS and the ODM Emergency Rule and include but are not limited to Office Visits, Consults, Psychotherapy, some PT/OT/SP.

Services covered are same as those covered via Telehealth video excluding services not possible to deliver via Telephone such as PT/OT/SP therapy.

Insurance company 3 only covers 99202 thru 99215 when provided via Audio only / Telephone.

Insurance company 6 covers eVisit when service is related to a COVID19 diagnosis or exposure.

Medicare only

Cost share waived for telehealth only when service is related to COVID testing or treatment. Insurance company 3 – waived for COVID testing only.
clinicians do to get paid, sapping huge amounts of energy and attention from actual care of patients, and feeding a huge health insurance company and health care system bureaucracy of low-added-value administrivia. The alternative — doing what the patient needs without attention to their insurance — risks financial ruin. It is no wonder that physician burnout is being re-labelled as moral injury.\textsuperscript{192-194}

So many well-meaning changes in health care have explicitly tried to advance and even support primary care. But as the acronym soup of deprofessionalizing\textsuperscript{195} fractional initiatives have come and gone, each has left a residual of administrative burden and fragmentation that often outweighs the benefits — RBRVS,\textsuperscript{196-198} Managed Care,\textsuperscript{199-210} P4P,\textsuperscript{211-214} PCMH,\textsuperscript{215-217} ACOs,\textsuperscript{218-226} Meaningful Use,\textsuperscript{203,227-233} MACRA,\textsuperscript{234-237} CPC+,\textsuperscript{238-242} MIPS,\textsuperscript{234,236,243,244} etc. The cumulative burden is a now an intolerable load of low-value administrative churning that takes up an overwhelming amount of the attention, energy and resources of those on the frontlines trying to integrate and personalize care for whole people and families and communities. The overall effect is to diminish the higher-order integrating, personalizing, prioritizing functions of primary care that are so desperately needed by patients and by a fragmented, costly and too ineffective system, and to make untenable independent or small practice that could be a much-needed source of innovation and personalization of care.\textsuperscript{187,191,245} Similar well-intentioned but ultimately harmful attempts at centralized control and personal accountability have had similar effects on frontline workers in education\textsuperscript{246} and other fields.

Autonomy appears to be protective from burnout among primary care practice clinicians and staff,\textsuperscript{247-249} and yet, in the face of health system and payer restrictions, autonomy can be hard to find. The disempowerment of the frontline primary care workforce also has diminished its ability to nimbly innovate and to adapt to local patient needs as primary care becomes a feeder for hungry hospital-managed health care systems. Accountable Care Organizations, an attempt to raise the gaze of health care toward advancing the health of people and populations rather than filling the coffers through fee-for-service disease care, are primarily run by hospitals, since their scale and over-investment in techno-services gives them the capital to take on the necessary financial risk.\textsuperscript{226,250} However, the Accountable Care Organizations that show value are those independent primary care groups and physician groups, not run by hospitals.\textsuperscript{219,251} And it is the small and independent practices — those most grounded in their local communities and patient populations, that are most vulnerable during the pandemic.\textsuperscript{167,184} In the end, the price of
autonomy seems to have been set up as vulnerability to being snuffed out by administrative burden and the financial challenges of the pandemic.\textsuperscript{184,186} Reinvigorating professionalism as a belief system about the best way to organize health care that promises to place the community’s interest about the provider’s interest,\textsuperscript{86,195,252-260} is more likely to be fruitful than continued efforts to externalize the intrinsic motivations of healers.\textsuperscript{193,247,261,262}

**Possibilities revealed by the pandemic**

From the pandemic, we learn that many small changes across multiple levels of a system, together, can make a big difference.\textsuperscript{51,52,152,153,160,170,172,184,263-268} Where there is prior investment in flexible systems and in trustworthy relationships, there is capacity to rapidly and effectively respond to emerging challenges.\textsuperscript{132,152,156,170,171,263,266-270}

In a rapidly changing environment, the generalist organism is more adaptive than the specialist customized to a narrow ecological niche.\textsuperscript{29,271} But by not understanding and supporting the generalist, horizontally-integrating value of public health and primary care, we have boxed primary care practices into inflexible niches and narrowed scopes of activity,\textsuperscript{64,109,111,272-278} that diminish their adaptability and capability to flexibility innovate to meet local patient and community needs.\textsuperscript{46,279-283} Generalist care makes specialty care more effective, and vice versa.\textsuperscript{89,95,134,284-290} High quality primary care complements specialist expertise by starting with a focus on the whole (person, family, community, population) and then iteratively identifying and working on the most important part in that moment, while keeping the whole in view.\textsuperscript{33,291,292} That fundamental, essential integrating, personalizing, prioritizing role is not widely understood, and has largely been beaten out of the US health care system.\textsuperscript{61,260,293,294}

Implementing high quality deeply-understood primary care can help us deal with the fast and slow pandemics that are crippling our society, if we: 1) understand and support primary care as a force for integration, 2) systematically generate generalist knowledge, 3) re-purpose administrative overfunding toward primary health care and public health.
Understanding and supporting primary care as a force for integration

The pandemic exposes, in disheartening and deadly display, the fragmentation, depersonalization, and ineffectiveness of US health care. In contrast, properly understood, supported and implemented primary care is a force for integration amidst fragmentation. It is a point of connection to being known as a whole person rather than a commodity. It is a vehicle for prioritizing, personalizing, providing and coordinating care for people and populations. It is a vehicle for healing the false schism between mind-body and public-personal health. It is not just cheaper specialty care for each disease added together. It is based on the wisdom of the generalist approach. We must stop conceptualizing, measuring, and paying for primary care as the sum of its parts. Misunderstanding what is important about primary care is killing it, burning out the current workforces and deterring the much-needed next generation of innovators ready to re-invent core generalist principles in the information age. Misunderstanding primary care has shattered it into its most reductive disintegrated commodified parts, just when we most need it to be a force for integration within health care and society.

In properly understood and well-grounded, well-supported, well-implemented primary care—people are primary. Not disease. Not payment. Not management of bits and pieces. People and the knowledge gained through relationships that generate wisdom about how health is won and lost.

To avoid doing more harm than good, efforts to implement high quality primary care must begin with understanding, and then supporting what is valuable about generalism. Supporting time and development of relationships are a cornerstone. Re-empowering frontline clinicians and patients, and reducing administrative burden and fragmenting methods of measurement are essential.

This can be accomplished by focusing measurement, resources, and the clinical focus of generalism on what matters—on the higher-order integrating, personalizing, functions that are accomplished with time, and in the course of providing a broad range of care and coordinating care received elsewhere. This requires a sufficient primary care workforce, and organization of care and payment that supports the investment of time needed to develop the relationships that are the basis for much of the value of primary care.
One of the fundamental tenets of primary care is accessibility as a first contact\textsuperscript{58} with a powerful and dangerous system.\textsuperscript{315} For the patient, having that first contact happen with a focus on the whole person in their family and community context maximizes the options for promoting health, healing and meaning, and minimizes the possibilities for doing harm and causing waste. The pandemic reveals how far we are from understanding what matters about primary care.\textsuperscript{186,316} To be effective for people and populations, and to save a fragmented system from itself, primary care must be made accessible by having sufficient numbers, time with patients, support of their person-centered role, and a health care system that provides accessibility for everyone to relationship-centered care.\textsuperscript{58,105,161,317-320}

Systematically generating generalist knowledge

How did German GPs reduce hospitalizations and deaths from COVID-19 when there is no specific treatment?\textsuperscript{154,155,321-323} How does healing happen, as it so often does, outside of the realm of treatment of individual diseases?\textsuperscript{47,48,121,122,324,325} How can we explain the paradox of primary care, that despite apparently poorer care of individual diseases, systems based on primary care have healthier populations, less inequity, better quality of care, at a more sustainable cost?\textsuperscript{93,94} What are the mechanisms by which integrated, personalized, prioritized care of whole people lead to healing and health at the level of the individual, value at the level of the health care system, and health and equity at the level of the community and population?\textsuperscript{61,87,326,327}

Both basic and applied generalist research are needed, and there is no home for the generation of fundamental generalist knowledge in current research support mechanisms. Dividing up the generalist and primary care enterprises into their component parts for research does not yield understanding of the whole, and the reductionist, fragmented knowledge that results is harmful in fostering further misunderstanding of the whole of primary care and its potential to advance healing, health and equity.\textsuperscript{88,89,91,328-331}

One of the reasons that it is so difficult to understand high quality primary care and to implement it, is that scientific knowledge is dominated by reductionist framing and methods that systematically divorce the phenomena of health and health care from the contextual factors that primary care uses to integrate, personalize and prioritize care.\textsuperscript{56,57,71} A recent RAND report,
sponsored by the Agency for Health Care Research and Quality, makes the important distinction between health services and primary care research. Abbreviating primary care research as PCR, the report calls out “the lack of targeted funding for a lead agency to coordinate PCR.”

The report further notes:

- “A coordinating center for PCR is needed to adequately support research on core functions of primary care and coordinate and prioritize PCR across HHS.
- AHRQ is the only federal agency with the statutory authority to be the home for PCR, but is currently not funded to carry out PCR.”

The report goes on to suggest that the Department of Health and Human Services:

“Provide targeted funding to create a hub for federal PCR. Study participants emphasized that the most expeditious way to create a funded hub to support research on core PCR needs and adequately coordinate federal PCR efforts would be to provide targeted funding for this mission to AHRQ, which already has the statutory authorization for this role. Despite not having received targeted funding for this mission, the agency has been able to sponsor key studies on primary care systems and innovation to help fill this gap. In addition, it operates the National Center for Excellence in Primary Care Research that has expertise in disseminating evidence, practical tools, and other resources to improve primary care.”

The integrated use of quantitative and qualitative methods for generating primary care knowledge are well-known, as are the laboratories of practice-based research networks, but neither is systematically supported, and the current disease- and age-group organization of the NIH furthers the fragmentation. To complement the AHRQ role in health services research, a home for fundamental generalist research within NIH, such as an Institute for Generalist Knowledge, is vitally needed to generate knowledge on how health and healing emerges and can be generated for whole people, families and communities.

Also needed are training programs that develop investigators adept at the mixed methods needed for primary care research, and that are grounded in the real world of practice and community. Federal training mechanisms that allow a 50% commitment to research to allow continued grounding in practice, rather than the traditional 75% research commitment, could create the needed workforces. Models exist in the now defunct Robert Wood Johnson Foundation Generalist Physician Faculty Scholars Program (which could be extended to primary care investigators who are not physicians), and the American Cancer Society’s Cancer
Control Career Development Award for Primary Care Physicians, although the latter award’s focus on a single disease class limited the scope of such training.

Re-purpose administrative over-funding toward primary health care and public health

The pandemic highlights the incapacity and waste of the US health care system — that despite the world’s highest health care expenditure,345 we have been unable to provide an effective response to an acute health threat compared to countries that spend far less.17 The pandemic highlights the need for reinvestment of the unconscionable and ineffective bloating of administrative overhead in US health care.156,182,187,190 The post-pandemic era is likely to be unstuck for public and public/private options that, once they work their way through the political process, will invest in the shared need of all Americans for a strong public health and primary care infrastructure, and for supportive systems that reduce administrative burden on citizens and providers alike. Some principles and immediately actionable options are described below.

Invest in infrastructure for integrated primary health care and public health

There is growing recognition of the need to increase the horizontally-integrating connections between primary care, public health, behavioral and social services, and the communities they serve.76,98,138,159,178,299-301,346-351 This will require consistent investment in information and relationship infrastructure that is not driven by the latest crisis, but that recognizes that this investment is fundamental to the effectiveness, fairness, and sustainability of efforts to improve the health of the population.

The COVID-19 pandemic has made apparent the need to actualize the principles outlined in the 2013 Institute of Medicine report on integrating primary care and public health.159 These principles are: working toward a common goal of improving population health; involving the community in defining and addressing its needs; strong leadership that works to bridge disciplines, programs, and jurisdictions; a focus on sustainability; collaborative use of data and analysis. The report notes the permissive infrastructure (still in place) from the Affordable Care Act. Providing funding for provisions such as the authorization of the Primary Care Extension Program,352-354 and interoperable public health, social service, behavioral health and primary health care information systems are within reach and likely to have large long-term benefits to
combat the current fragmented systems. The response of South Australia in the pandemic is an example of what is possible with investment guided by a long-term vision.

Primary care is a vital part of the solution to our society’s problems of unfair and inadequate access to health, but it is only part of the solution. Primary care’s professional organizations need to go beyond the current tribalism to partner with each other, with their patients, and with other sectors affecting health and health care, if they are to make a difference. Scaling up the partnerships with community members and organizations that happens in well-grounded primary care practice could advance the needed focus on the whole person and on the needs of disadvantaged communities for which trusting and trustworthy connection is so strongly needed.

Informatics tailored to the generalist task is needed to support primary health care. Current systems have been built largely to support the cacophonous and fragmented payment system, and are divorced from public health, mental health, and social services systems that dwarf health care in their potential to improve the health and equity of the population. The CMS Accountable Health Communities initiative is a small fledgling step towards integrating the medical, social and environmental determinants of health, but it depends too heavily on the current fragmented, fragmenting systems and incentives.

In order to support horizontal integration and personalization of health care for people and populations it is vital to measure what matters. The recent National Academy of Medicine Vital Signs report and the Person-Centered Primary Care Measure, based on what patients, clinicians and payers say is important in health care, are excellent starts.

IMPLEMENTING TECHNOLOGY IN THE CONTEXT OF RELATIONSHIPS

In response to the natural experiment of the pandemic and the resulting stay-at-home orders, many primary care practices largely shut down their in-person operations and variably began telehealth. Types of visits and staffing continued to change rapidly, along with surprisingly rapid changes by governmental and private insurance payers.

For example, one community health center cancelled all patient visits beginning Tuesday, March 10, in advance of their state governor’s stay-at-home order. They furloughed three physicians, multiple nurse practitioners and midwives, and 40 staff members, shut down
operations and began building new workflows. On Monday, March 16, they began telephone or video telehealth visits, and within two weeks had resumed their prior weekly number of visits, adjusting for the furloughed clinicians. More than 90% of these visits were remote visits, with only a highly-selected 10% in-person — a dramatic change from the previous practice of nearly all visits happening in person. They recalled their furloughed staff and began conducting targeted outreach to individual patients known to be vulnerable because of their social, mental, or physical conditions, and also to patient populations at high risk because of chronic illnesses, refugee or minority status, or age. They are beginning additional patient-home monitoring interventions. Other clinics, however, have not been able to resume anything close to normal numbers of visits, and early studies are showing adverse effects on chronic illness and preventive care.

Clinicians at this practice estimate that with these new telehealth tools to make virtual home visits, and with interventions to supplement these tools to make them more accessible across the digital divide, that even after the pandemic, 20-70% of their visits will be remote, in order to best meet patient needs for accessibility. They worry about being paid for these visits and what administrative burden will be involved in that payment, and they are anxious for further research and system support to advance the beneficial and reduce the negative effects of telehealth on case and on equity of access.

The COVID-19 pandemic has unleashed innovation in telehealth and in payment. It is unlikely that this genie will be put back into the bottle, unless it becomes buried in burdensome payment structures. In order to avoid exacerbating care fragmentation and disparities, it is vital that this and other innovative technology, such as personal monitoring systems, are implemented in the context of personalizing, integrating relationships that value personal and collective narratives, and that they be paid for and made available to independent practices, which are a potential source of innovation, and to vulnerable individuals and communities for which they could be most helpful in improving the accessibility and quality of care.

In order to be effective, the decision on when to use these new remote technologies or to interact face-to-face needs to be liberated from decisions about onerous documentation for billing. That will allow electronic health records to focus on providing information to support
integrating, personalizing and prioritizing care based on knowing the person not just the science of what works on average, and the business of how to get paid for delivering commodities of care. Billing must be separated from documentation so that the electronic health record can become a clinical, behavioral, and population health information system and fully integrated into the multiple encounter modalities.\(^{408}\) In order to empower relationships between patients, clinicians and communities, the records systems must be in the bottom up control of the generalist healer-patient partnership and not a top-down implementing system.\(^{408}\) Systems can use their top-down power and information to support care personalization, prioritization, and integration; these functions can be effectively supported from the top, but their control from the top is profoundly disempowering to frontline workers, patients and communities whose engagement is vital.

COVID-19 has created a tipping point. Either we will convert these new platforms into better access, continuity, more tightly connected teamwork, richer relationships and connections OR they will be taken over by systems, marketing, tech industry, and algorithms creating a perfect storm of greed-driven fragmentation that finally destroys primary care, leading to loss of health, rising costs, worsening disparities, and rising aimless despair.

**PROSPECTIVELY PAYING PRIMARY CARE TO SUPPORT RELATIONSHIPS, CAPABILITY AND FLEXIBILITY**

One family physician with a Direct Primary Care practice noticed during the pandemic that, “While everyone else was spending incredible amounts of energy sorting out how to get paid for caring for patients in non-standard ways, we’ve been able to just focus on what to do to provide the best care for our patients.” Rather than billing insurance, patients at this practice pay \$41 per adult and \$21 per child per month as a subscription that pays for their primary medical care. This practice never closed during the pandemic, but shifted to doing a higher percentage of visits by phone, and they quickly launched a telehealth platform. They saw no change in revenue and had no need to furlough or lay off staff members. At a time of shortage, they were able to acquire a small number of COVID-19 testing supplies, and used them selectively based on how they would change particular patients’ medical care or life or work circumstance.

The practice team focused on how to keep the office and patients safe, and how to care for patients. Because of the large need for general information, and a large amount of misinformation in their community they started posting a twice a week newsletter for their
patients and the larger public, and then they provided individual responses to patients’ calls in response. In addition to providing care for acute illnesses and for patients’ anxiety and information needs, they pulled lists of patients with chronic care, preventive, and mental health needs, and worked to meet as many of these needs as possible remotely, while using their limited personal protective equipment to selectively see people in person. Patients were able to have help in managing the pandemic in the context of their own individual needs, while being known as individuals, and members of families and communities.

The COVID-19 pandemic provides a moment to nurture malnourished primary health care.\textsuperscript{167} Health systems that are more high value in population health, fairness and sustainable cost invest more than the US in primary care.\textsuperscript{409,410} The percent of US health care spending on primary care should be more than doubled, with a resulting increase in the effectiveness, connectedness and sustainability of the system.\textsuperscript{252,411} Payment mechanisms are needed that reduce administrative burden, support on-the-ground innovation, time and relationship development with individuals, families & communities, and that provide primary care with the autonomy to connect to competing specialty services. Grounding population health platforms in primary care, rather than in hospital care, is likely to increase their effectiveness and affordability, as has been shown in comparisons of hospital and physician-owned accountable care organizations.\textsuperscript{251}

Further, primary care needs to be paid differently. For many years, reformers have called for a blended payment structure\textsuperscript{412,413} that would support the higher level integrating, personalizing, prioritizing, abiding functions\textsuperscript{61} of primary care that fall between the cracks of fee-for-service commodity-focused payment, but that are vital for a high-functioning health system. There is growing consensus among the practice, policy and payer communities that it no longer makes sense to pay fee-for-service for primary care.\textsuperscript{167,177,412,414-421} Rather than paying piecemeal for each visit and procedure, and expecting primary care practices to piece together a cacophony of funding sources to integrate care for whole people, it makes much more sense to prospectively pay for primary care on a per-patient, per-month rate. Such an approach would stabilize vulnerable primary care finances, support local innovation to meet patient and community needs, and provide flexibility to fully address the needs of individual patients for an
integrated approach to caring for acute concerns, managing multiple chronic illnesses, and advancing prevention and mental health.422,423

IMPLEMENTING HIGH VALUE PRIMARY CARE AS A COMMONS FOR THE COLLECTIVE GOOD

When family practice was being rebirthed from the ashes of declining general practice, Gayle Stephens reminded the field of primary care to wear the cloak of humility that comes from recognizing that whatever ability we possess as generalists comes from being part of a larger whole.424 Generalism is about being a vital cog in the wheel of time evolving upstream toward wholeness.

Stephens reminded us that the generalist healer was rebirthed as part of a larger countercultural movement425 of which we were a vital part, but only a part. Perhaps the COVID-19 pandemic is revealing a larger still-emerging countercultural movement around fairness, inclusiveness, and commonality, of which primary care is a part, but only a part.426,427 Perhaps the civil rights wave of the 1960’s upon which family practice rode into existence, and the backlash24 and tsunamic foment of the current era’s recognition that Black Lives Matter370-373 and that unfair systems that disadvantage the working class of all races and ethnicities24 create a multigenerational moment for sea change.117

With the coronavirus pandemic as our forefront, and the backdrop of ongoing pandemics of racism,25-27 classism24,428 and fragmentation, we have the opportunity to make radical change for the better. The yearnings ebb and flow between returning to the false refuge of the old traps or venturing into the new path whose first steps are only dimly-seen, but whose direction is clear.

The new direction for implementing high value primary care is to be a commons for the collective good.125,148,378,429 A place, a relationship, a system, where differences can come together. Where the unclear big picture can be made purposeful at the scale of the inter-personal. Where fragmentation can be integrated. Where impersonal can be made personal. Where the ten thousand things can become one by focusing on the most helpful next step on the ground, while periodically raising the gaze toward the emerging whole.37,430-433

To become such a commons, primary care needs to be its generalist self. It needs to get over its tribal self. It needs to be a base and a bridge between medical and behavioral care, public and community health, and work humbly across the many sectors that influence health. It
needs to ask what it can give toward a larger good. Primary care deserves to be understood, implemented, and supported as a force for integration.
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