FROM THE EDITORS' DESK

Seismic Change and Micro-Innovation

Richard L. Kravitz, MD, MSPH

UC Davis Division of General Medicine, University of California Davis, Sacramento, CA, USA.

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As the September 2016 issue of *JGIM* rolls off the presses, the country will be preparing for what may be one of the most consequential presidential elections in history. What is at stake for health care in this election? On the Democratic side, Hillary Clinton's campaign has released detailed plans reflective of her deep involvement with Bill Clinton's health care reform efforts in the early 1990s. (If Bernie Sanders is the nominee, the conversation will be different.) The essence of the (Hillary) Clinton health plan is to preserve, refine, and enhance the Affordable Care Act of 2010. Her proposed alterations include a series of wonky measures that promise to increase access, control costs, or improve quality—all at the margin. For example, one provision would permit up to three “sick” visits per year free of out-of-pocket costs (deductibles and co-pays). Another would eliminate the ability of pharmaceutical companies to deduct the costs of direct-to-consumer advertising from taxable income and require FDA pre-clearance of such ads. A third would offer a tax credit to families whose out-of-pocket health care expenses exceed 5 % of their annual income. The Clinton plan also includes some vague references to insurance market reform, but it is unclear whether these modest initiatives will solve the problems highlighted by United Healthcare's recent exit from most of the 34 ObamaCare health exchanges where the large health insurer previously offered coverage.

If the Clinton plan is characteristically cautious, the Trump plan has been described as “a jumbled hodge-podge of old Republican ideas, randomly selected, that don't fit together” (New York Times, April 8, 2016). Mr. Trump favors the repeal of Obamacare, eliminating the individual mandate, reducing barriers to selling health insurance across state lines, and encouraging consumers to manage their own costs through health savings accounts and higher-deductible health plans. He has

publically declared a commitment to “take care of everybody,” while at the same time proposing that federal funding of Medicaid be channeled through block grants to the states, which would have the effect of ratcheting down already strained state Medicaid budgets.

Missing from both candidates' plans is a framework for strengthening primary care. Substantial evidence (albeit little from well-designed randomized controlled trials) supports the notion that strong primary care systems (emphasizing Starfield's four C's of first contact accessibility, continuity, comprehensiveness, and care coordination) are associated with better patient outcomes and lower costs. Today we are far from this ideal; instead, hamster medicine reigns, with many primary care practitioners suffocating under a mountain of paperwork, electronic charting, and quality metrics that have little to do with quality. In the long run, sustained improvement in health care will not be achieved without focused attention to primary care. Whoever the winner is in November, they need to know this.

In the meantime, the revitalization of primary care will occur slowly, fueled by micro-innovations developed in both academic and front-line practices. The need is great: as detailed by Linzer et al.¹ in this issue, among academic general internists who practice in ambulatory settings—precisely those responsible for teaching and inspiring primary care's future practitioners and leaders—more than two-thirds report a great deal of work-related stress, and two in five are “burned out.” The reasons are legion, but it cannot help that 70 % of the ambulatory practitioners surveyed reported inadequate time for clinical documentation, a problem that electronic health records (EHRs) have paradoxically made worse.

One possible solution to the EHR paradox is the use of trained “medical scribes” to assist with routine documentation. This idea, while attractive on its face, has undergone little formal evaluation. In the qualitative paper by Yan et al.,² physicians and patients in six health care systems described multiple benefits of involving scribes in ambulatory care, including greater efficiency and more physician–patient “face time.” However, some physicians experienced increased rather

than decreased stress, stemming from discomfort with yielding control over documentation to an untrusted “other.”

Another category of primary care micro-innovation involves shifting responsibility for tasks that do not require physician-level expertise to humanoid confederates. In the article by Rose et al.,³ patients identified as problem drinkers were encouraged through an interactive voice response (IVR) system to discuss drinking with their clinicians. Patients randomized to IVR were more likely to discuss alcohol with their provider, to bring up the topic themselves, and to receive a recommendation about alcohol use. Under this paradigm, a computer takes care of patient screening and activation. All the physician has to do is diagnose and treat.

Micro-innovations like these will not determine the fate of the republic. They will not even, by themselves, cure what ails primary care. But while we wait for the big fix, micro-innovations are important, and not just for

the health or economic benefits they deliver. Small movements in the right direction are also critical for morale. Let us hope the next president remembers that.

Corresponding Author: Richard L. Kravitz, MD, MSPH; UC Davis Division of General Medicine University of California Davis, 4150 V. Street, Suite 2400 PSSB, Sacramento, CA 95817, USA (e-mail: rkravitz@ucdavis.edu).

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