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Changing medical relationships after the ACA: Transforming perspectives for population health



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ABSTRACT

American health care has undergone significant organizational change in recent decades. But what is the state of core medical relationships in the wake of these changes? Throughout ACA-era health care reform, the doctor–patient relationship was targeted as a particularly important focus for improving communication and health outcomes. Recent developments however have shifted the focus from individual-level outcomes to the wellbeing of populations. This, we argue, requires a fundamental rethinking of health care reform as an opportunity to renegotiate relationships. For example, the move to population medicine requires that the very concept of a patient be resituated and the scope of relevant relationships expanded. Medical relationships in this era of health care are likely to include partnerships between various types of clinicians and the communities in which patients reside, as well as a host of new actors, from social workers and navigators to scribes and community health workers. To address the upstream determinants of population health, providers must be increasingly willing and trained to collaborate with community stakeholders to address both medical and non-medical issues. These community-based partnerships are critical to providing health care that is both relevant and appropriate for addressing problems, and sustainable. Approaching health care reform, and the focus on population health, as a fundamental reworking of relationships provides scholars with a sharper theoretical lens for understanding 21st century American health care.

Introduction

As a response to ongoing initiatives to improve American health outcomes, reduce costs, and address health disparities, many scholars have analyzed the relationships that develop in medicine – particularly between practitioners and patients. As the most recent wave of health care reform has taken its course, marked most importantly by the passage of the Affordable Care Act (ACA) in 2010, these discussions have often centered on the fate of the traditional doctor–patient relationship. These critiques have arisen in response to what is widely assumed to be the besieged nature of this particular relationship (Senger, 2013; Fallowfield, Guarneri, Akif Ozturk, May, & Jenkins, 2014; Singer, 2014).

More recently, this scholarly focus on the relationship between practitioners and patients has expanded to include the emerging actors of an increasingly interprofessional medical workforce, such as nurse practitioners, physician assistants, behavioral health specialists, and scribes. From the perspective of medical relationships, this expanded approach to medicine has required a range of strategic considerations

not only to develop optimal ways for collaboration, but to overcome competitive and territorial professional dispositions (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Gittel, Godfrey, & Thistlewaite, 2013). Yet, even this expanded scholarly focus barely captures changes afoot in medical relationships in an era increasingly focused on populations and the social determinants of health, particularly in the wake of the ACA (Starr, 2013; Stoto, 2013). Beyond the clinical actors who are central to the establishment of new forms of interprofessional and team-based medical care lay a fundamentally different cast of key characters, from social workers and navigators to community health workers, and hospital-school liaisons to name a few. Many scholars have noted the increased importance of those actors that we broadly define as practitioners (Browne, Darnell, Savage, & Brown, 2015; Cosgrove et al., 2014; Rosenthal et al., 2010). In this paper, however, we use the word “practitioner” in a way that captures our argument about new medical relationships, beyond the traditional sense in which the word has been used as synonymous with “clinician.” This expanded view of who constitutes a medical “practitioner” is central to a new way of thinking about medical relationships them-

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selves.

Accordingly, we argue that a theoretical shift is necessary. Specifically, we underscore the importance of framing health care reform as an opening for a fundamental reworking of medical relationships that transcend the traditional scope of medicine, beginning with the ability of various non-medical components of communities to bring about change on the local level. Specifically, we suggest that understanding contemporary health care as concerned with cultivating these new relationships is a critical step for addressing health on the population level.

New and changing medical relationships

As we have noted, most discussions about medical relationships have focused on the important relationship between doctors and patients. In the past, these discussions tended to center on modes of communication. In the 1950s, for example, *Szasz and Hollender (1956)* discussed the potential for the emergence of new models of doctor–patient communication that could be effective depending on the type of illness and model of care. An acute illness such as an infection or injury could be treated primarily, if somewhat mechanically, with medical expertise and limited input from patients. Here, the biomedical model, driven by standardized assessments and best-practice guidelines, emphasizes a fixed logic or structure of patient care that limited the amount of patient involvement in the medical relationship.

Chronic illnesses, however, require the cultivation of new relationships that transcend those of the biomedical model. Chronic medical care is often dynamic and long-term (*Wagner et al., 2001*). Patients, therefore, must be consulted and work collaboratively with providers to establish a plan of care that is both rooted in evidence as well as in line with patient preference, that is, guided by the goals patients set for themselves. Developed out of a chronic illness model, the tradition of patient-centered care thereby creates opportunities for patient-provider collaborations, fortified by a strong commitment to open and bidirectional communication (*Berwick, 2009; Pelzang, 2010*).

Some scholars have argued that the traditional biomedical model is insufficient for the treatment of chronic illness, especially because it does not foster the kind of relationships that are required to both prevent and manage these conditions (*Longino & Murphy, 1995; Mirzaei et al., 2013*). Discussions recently have focused on alternative approaches that rely on care coordination among providers and settings, such as primary and specialty practices, ambulatory care, and long-term facilities (*Burns & Pauly, 2002*). The proliferation of particular roles within health care systems is not only a matter of complexity; these roles produce qualitatively different modes of interaction formalized in new relationships.

In many ways, however, the focus on chronic illness merely expanded – instead of rethought – the biomedical model. For example, including patients in each phase of treatment does not guarantee that their input will be taken seriously, just as open communication does not necessarily change power dynamics. Ultimately, the treatment of chronic illness focuses on treating individual patients after the onset of illness and according to a traditional medical model (*Halfon et al., 2014*). Although the prevention of chronic disease has become popular through practices such as health promotion and expanding access to primary care, these practices often assume a biomedical paradigm that emphasizes individual-level behavior and outcomes rather than population-level concepts, such as community well-being. For this reason, the move to population health in medicine increasingly requires a substantive adjustment in relationships as well as systems that are responsive to and reflect these new relationships.

Pre-ACA policy developments

Although the ACA facilitates the formation of new relationships for purposes of promoting population health, several aspects of the law

have the potential, as well, to facilitate a rethinking of how doctors, patients, and communities interact in relation to these structural changes. Before turning to the ACA in detail, however, it is important to note that the current wave of health care reform was preceded by several important policy developments. During the 1960s. There is a space here that should be deleted.s, for example, as part of President Johnson's "War on Poverty," community health centers were envisioned as a viable modality of treatment. The Economic Opportunity Act of 1964 provided the initial impetus for this strategy (*Lefkowitz, 2007*). Later legislation consolidated and focused these programs (*Bailey & Duquette, 2014*). Local resources were combined with Federal dollars to combat poverty by providing primary health services to underserved areas. Neighborhood clinics were thus established in low income urban and rural communities (*Geiger, 2005*). The general idea was that these centers would have impact on multiple levels. For example, jobs would be created, along with training local persons, while the health of poor communities was improved (*Geiger, 2003*). Moreover, the services offered would be low-cost and sustainable, due to local involvement in planning and implementing these interventions. Key to this approach is that health should be viewed holistically. Familial, environmental, and employment factors, for example, were introduced as important determinants of health. Additionally, patients should participate actively in their treatment. Community health centers, in this sense, should be governed by local boards that include patients. As a result of these changes, services would be culturally appropriate and situationally relevant, thereby improving community life. Prevention and education, likewise, would be elevated in importance. This shift in orientation can be viewed as part of the social movements that emerged during the 1960s. The hope was that average persons would participate more fully in vital institutions, including health care, and as a result would agitate for further equity (*Geiger, 1993*). Although funding waned for health care operating on the community level in the 1980s, the fundamental goal was that social and health disparities would be reduced, as institutions become more democratic.

Common to both the community health center movement and the ACA is an emphasis on activating communities to prevent illness and promote wellbeing. Population medicine, as a result, is thought to intervene before the onset of preventable diseases in order to address fundamental causes (*Phelan, Link, & Tehranifar, 2010*).

Changing medical relationships under the ACA

The ACA introduced various incentives for moving to this population-based approach, financial and otherwise, providing significant opportunities for health care practitioners to engage community perspectives in this new era of medicine. One reason why relationships are changing is that patients themselves are being redefined within the context of population medicine. This is true for several reasons.

One major cause of the impact patients are having (and will continue to have) on these transformations stems from the fact that the ACA has dramatically increased the number of access points to the American health system, especially through expanded Medicaid eligibility for those states that have opted to accept federal funds, and through the establishment of a new health care marketplace for those who are not eligible for Medicaid and lack access to employer sponsored health care (*Rosenbaum, 2011; Obama, 2016*). Even as expanded access through the ACA has solved one critical problem, it has put pressure on existing relations – especially doctor–patient relations – by raising questions about the capacity for existing practices to meet the needs of the some-odd 13 million Americans who now have health insurance who previously did not (*Hall & Lord, 2014; Kaiser Family Foundation, 2016*). This decrease in uninsured ranks, and attendant influx of new patients, is also putting pressure on the various moving parts of the American health care system to innovate, particularly through the introduction of team based care and new

forms of interprofessional cooperation, comprised of traditional medical providers as well as new team members. New team members, such as navigators, are in fact necessary precisely because the ACA establishes new relationships between insurance providers and patients, many of whom are unfamiliar with basic concepts such as deductibles, premiums, open enrollment periods, and other technical insurance terms. At the same time, especially in the area of the expanded Medicaid population, the ability of existing medical relationships and systems to meet the needs of these new patients is, in many ways, a test of the ACA's promise to transform medicine, not only through increased access, but in quality and cost as well.

For these reasons, patients who are entering the system for the first time are a test case for working with, as well as a driver in the formation of new relationships that are forming as a function of health care reform. Because non-medical, upstream determinants are increasingly being considered as key factors driving health disparities and outcomes, new collaborative strategies must address not only the health of individual patients but also the neighborhoods they inhabit (Leong & Roberts, 2013). Examples of interventions on this level include working with civic associations to provide safe and affordable housing, deploying medical professionals to schools to provide health education, partnering with churches or other community organizations to develop a stable source of healthy food, and collaborations with community members to conduct health needs assessments and understand local problems. In communities, as well, potential corporate partners – especially in the fast growing retail medicine sector – will undoubtedly play a role (Pollack, Gidengil, & Mehrotra, 2010). Accordingly, physicians and other providers are being asked to rethink the medical relationships necessary to improving population health. This maneuver, however, will require critical reflection on the meaning of medicine as well as the meaning of community.

Yet, though increased access might be a key driver, the developments we have described also create new financial dynamics that are having a dramatic effect on the formation of new medical relationships. Specifically, under new Alternative Payment Models – Accountable Care Organizations, practices that utilize episode-based payment systems, and Patient Centered Medical Homes, among others (DeVore & Champion, 2011) – medical practices and systems are assuming higher levels of risk for patient care in exchange for financial rewards. This, in turn, is fundamentally changing the actuarial context in which patients are situated (Wynne & Horowitz, 2016). In other words, the fact of increased access and the rise of Alternative Payment Models is fundamentally altering patient relationships to medicine in the areas of quality and cost as well, since new models incentivize, cajole, and even force practices to innovate and become more efficient (Shih, Chen, & Nallamotheu, 2015; Greenwald, Bassano, Wiggins, & Froimson, 2016). Beyond practice management, however, such developments also incentivize investments in population health insofar as they have the potential not only to reduce health disparities, but to do so in a way that promotes population-level wellness while encouraging institutions to reduce costs and increase efficiencies (Laverack, 2006; Lantz, Lichtenstein, & Pollack, 2007; Frerichs, Hassmiller Lich, Dave, & Corbie-Smith, 2016). The bond developed between patients – seen increasingly as members of communities – and practitioners, accordingly, must be viewed in a new way.

Contextualizing medical relationships

In this paradigm, practitioners are thought to engage not only individuals, but persons embedded in larger contexts, or “life-worlds” (Kleinman, 1988). Rather than only developing relationships with individual patients, health care providers should recognize the importance of the social context and begin to engage and develop relationships with communities. The transition to population health therefore challenges practitioners to become sensitive to how problems are defined by community members, along with the solutions that are

deemed practical. An approach to care that is driven solely by physiological or individual-level concerns, and is not open to social or environmental factors or the potential for both illness and health to be interpreted in various ways, does not have much utility in this period of change.

Of course this does not mean that practitioners will stop working directly with individuals, either as patients, clients, or otherwise. Rather, this shift requires acknowledging that individuals have always been socially situated, even if the traditional medical model has focused primarily on physiology and individual behaviors. After all, communities are comprised of individuals. Therefore, expanding the focus to communities does not undermine the important relationships between practitioners and patients, but introduces the significance of the social context for understanding illness and developing successful interventions to address health on the population level.

Some practitioners have responded to these developments by turning to narrative-based medicine and listening carefully to the stories patients are telling and, consequently, to the life-worlds that are revealed (Charon, 2006). These methodological adjustments reflect the extent to which medical care is increasingly concerned with integrating patient perspectives. The result is that approaches aimed at improving well-being must become open to the everyday lives of persons and increasingly directed by this information instead of relying on formulaic models or standardized care. The integration of local knowledge into interventions (Fals Borda, 1988; Murphy, Franz, & Callahan, 2015) is a critical component of appropriate, effective, and sustainable medical care. Preventing chronic illnesses and improving health outcomes in communities is not possible without understanding how problems are defined and what interventions are deemed relevant by local residents.

Although scholars have emphasized the need for a transformation in health care systems, the calls to emphasize patients as embedded within communities has at times been met with resistance (Wilson, 2000; Meza & Passerman, 2011). Instead, much of the literature on doctor–patient relationships continues to focus on how practitioners can communicate with patients in order to understand them better, but fails to rethink the idea of a patient itself, or to reflect the evolving goals of medicine. Increasingly common is for practitioners to emphasize collaborating with patients and empathizing with their experiences (Hojat, 2007). This approach, however, retains the atomistic view of patients precisely where the challenges of contemporary population health require that providers do more than change their feelings and styles of interpersonal communication. Indeed, practitioners working toward the goals of population health must be willing to change through their interactions with patients, just as patients must learn to relate to medical institutions in new ways as well. In particular, listening closely to patient or community perspectives will be important not only to form bonds, but to understand more fully the context of illness. In this sense, the focus on developing strong doctor–patient relationships conceals the potential for practitioners to engage actively both individuals and local communities to improve population health.

Beyond resisting changes to the doctor–patient relationship (Mechanic, 1996; Potter & McKinlay, 2005), practitioners might play a role in promoting an expansion of relationships. Particularly important is a relational model in which practitioners enmesh themselves in a community in order to understand locally defined problems. The result is that these local definitions guide medical care and influence the work of practitioners, rather than merely the complaints of individual patients. Although collaborative relationships and the growth of the “third sector” have been emphasized in non-U.S. contexts (Giddens, 1998; Evers & Laville, 2004), there is a current push in the U.S. to develop ties between health care and community organizations. Community-based health planners have been active in developing interventions that address community health concerns and prepare local residents to participate in health care planning (Minkler & Wallerstein, 2008). In the field of clinical psychology, many practi-

tioners have rejected the standard clinical focus that excludes the social context of illness. These observations were critical in the development of the discipline of community psychology (Nelson & Prilleltensky, 2010).

Despite this emphasis on understanding patients insofar as they are part of larger communities, these new relationships have not been integrated into the theoretical portrayal of medical relationships or the everyday practice of American medicine. Although the ACA nudges toward, but does not bring medicine fully in line with population health care, there are important steps made in this direction (Williams, McClellan, & Rivlin, 2010). We argue that several interrelated post-ACA openings could help scholars and practitioners alike rethink medical relationships in a way that accords with the theoretical shift we have described, moving the focus from individual patients to community wellbeing and activation.

Strategies to capitalize on ACA investments in population health

Community health needs assessments

The ACA standardized a process for regular communication between health care institutions, local agencies, and the communities they serve. In particular, hospitals and health systems are now required to complete Community Health Needs Assessments (CHNAs) every three years as well as develop an implementation plan to address identified and prioritized needs (Evashwick, 2013; Rosenbaum, 2015). These reports additionally must be produced with “input from people who represent the broad interest of the community served by the hospital facility” (IRS, 2011). Although the IRS guidelines leave open to hospitals how to define the boundaries of the community served and how to include stakeholders in the assessment process, they reflect the hope that medical providers, and even acute care institutions, should direct part of their attention to the community level where important partnerships might be formed to prevent illness and improve wellbeing. Of particular interest is that CHNAs offer an opportunity for hospitals and health systems to acknowledge and address the increasingly important non-medical determinants of health and illness. Preliminary evidence suggests that hospitals are increasingly devoting resources and staff to population health efforts, such as supporting crime prevention programs, housing initiatives, and developing community gardens to improve well-being (Burke et al., 2014; Hogg, Mays, & Mamari, 2015). Although the extent to which non-medical factors have been or will be a focus of CHNAs remains largely unknown, these assessments standardize requirements to report on community needs and the formal steps taken to improve poor health outcomes. Most important, through CHNAs and changes in financing, the ACA expands the responsibility of hospitals and providers to include the wellbeing of communities and establishes mechanisms for communities to play an elevated role in promoting wellness.

One important way that communities may become strengthened through CHNAs, we argue, is by encouraging partnerships for studying and impacting change in communities. For example, preliminary findings from two of the authors’ ongoing interviews with various hospital administrators, personnel, and research consultants involved with the first round of post-ACA CHNAs in Appalachian, Ohio suggest that hospitals and health systems have begun partnering with each other, as well as local health departments, community agencies, and local residents to complete collaborative reports and conceptualize projects to address health disparities. In fact, IRS guidelines are continually evolving in response to input from hospitals and recent adjustments encourage such collaboration on CHNAs to make reports more efficient and comprehensive (IRS, 2011). Although these new requirements do not guarantee that health systems will want to (or are able to) engage non-medical determinants of health and develop community partnerships, the ACA marks progress toward improving

population health by acknowledging the relationships that are and will continue to be formed between health care providers and the communities they serve.

Health Advisory Committees

If communities are going to become important partners in population health and play a pivotal role in new medical relationships, what type of capacity must be developed? An increasingly common approach in community-health interventions is to establish formal organizations – comprised of local residents – to facilitate communication with local officials and health care providers, and organize regular meetings with community members to assess problems and the success of existing programs (Newman et al., 2011). Although health care institutions often facilitate the development of local health boards, this maneuver does not guarantee that local knowledge about health and illness are sufficiently integrated into health care planning, or that community members actually control interventions. To be sure, some health care planners communicate with health committees solely to solicit sufficient buy-in to support current practices or future projects. Community initiatives undertaken as a marketing venture, as opposed to genuine community benefit, require fundamentally different kinds of relationships. Here the language of “advisory boards” may suggest that these committees are often consulted in lieu of playing a more hands on role in organizing health care.

Community-based activists, on the other hand, envision these local health committees as being truly community-based. This means that community members decide who is elected to the committee and what its focus will be. The health committee is charged with understanding and organizing various community perspectives and communicating them to government officials, health care practitioners, and other planners. In some areas, committee members also oversee a process of community training so that research methodology and health care skills can remain local (Orfaly et al., 2005). For example, increased support for community health workers in the ACA provides an important role for health committees to play in engaging community members in collaborative relationships around the organization of health care (Shaw, Heisler, & Davis, 2014). The goal is for community members to be able to not only provide input, but participate significantly in research or development projects. Although the nascent literature on health advisory boards emphasizes this potential, it also makes clear that most of these bodies meet monthly, suggesting that many advisory boards are not yet fully active in partnering to address community health (Newman et al., 2011). These health committees, however, offer an opportunity for health care practitioners to engage a local community, get to know residents and associated problems, and collaborate in developing solutions.

More generally, the goals of population health promotion and illness prevention require a more sustained approach to community organizing. For example, in one recent project in Grenada, in which several authors of this article participated, community members were trained to conduct a community needs assessment, communicate with the national health ministry, and work as lay community health workers (Murphy, Franz, & Callaghan, 2016). The particular skills gained during the training allowed workers to train other residents, thereby ensuring that this knowledge-base remains in the community (Rosenthal et al., 2010). Many different examples of “train-the-trainer” programs can be found in the academic literature (Orfaly et al., 2005); the key point is to ensure that local health committees successfully conduct research on community problems, participate in devising solutions, and evaluate the success of interventions (Wangalwa et al., 2012). The cultivation of such relationships is the foundation of community-driven health.

The health committee therefore represents an opportunity to organize these perspectives and communicate findings regularly to health care professionals, city planners, and other stakeholders. The

key to accomplishing this change is ensuring that health committees are identified by traditional providers as supplying an important connection to a community and guiding future health care initiatives. Although there are renewed opportunities after the ACA to integrate the community into health interventions, relationships with community organizations must be understood as fundamental to providing quality medical care. Future medical providers may be trained, for example, to participate in health advisory board meetings, collaborate on CHNAs, or interface with lay community health workers. These programs would aim to transform how practitioners conceptualize the relationship between medical provider and a range of partners in pursuit of improved health.

Medical education

Medical education has a critical role to play in socializing new doctors into a health care environment in which practitioners must direct their practice not only to the treatment of individuals, but the promotion of community ownership over and the sustainability of health care initiatives. Providers must therefore be trained with these types of orientations and alliances in mind, both in clinics and communities. Moreover, a link has been established between training students in closer contact with communities and the likelihood that students will remain in those communities to practice, particularly in primary care (Brokaw, 2009). This model will need to be extended as future workforce needs require not only physicians practicing in medically-underserved areas, but who are trained to work as part of teams, comprised not only of nurse practitioners and physician assistants, but social workers and a host of experts in non-medical areas, such as education, housing, and crime. This will require socializing medical students and other clinicians from an early point to see their role as medical experts as related to and in service of an enlarged view of what drives outcomes, moving modes of understanding as well as work that has traditionally not been associated with clinical practice to the foreground of their concern. Those who offer care should envision future population health interventions to be fundamentally intertwined with local communities, to see their patients as members of communities as well as individuals. They must see the cultivation of these relationships as central to their responsibility as clinicians. To do this effectively, however, they must be trained to engage and understand the relationships that now characterize American health care.

Although many practitioners have been trained with community health concerns in mind, we are advocating a more decisive turn, with deep consequences for the future of medical education. True investment in population health requires that medical students and physicians in their continuing education efforts strive to develop long-term relationships with communities that promote sustainable health practices. Post-ACA, more medical schools now encourage students to rotate through Community Health Centers or deploy community health teams in mobile health units (Knight et al., 2010). The ACA encourages this development as part of its promotion of primary care by funding a Teaching Health Center Graduate Medical Education program that provides funding to community health centers establishing new primary care residency programs (Chen, Chen, & Mullan, 2012). Just as inpatient services are increasingly being redirected to ambulatory and outpatient services, so too must medical education – especially those institutions with a strong primary care focus – be redirected. Students are better served training in institutional structures that are currently emerging, even if this process is ongoing, instead of requiring retraining in residency and future practice. More than a movement of medical education to new contexts, however, training in communities should emphasize relationship building and connectivity that will, in turn, fundamentally alter what it means to be a physician or other clinician.

While training physicians in increasingly community-oriented set-

tings is a pedagogically sound development, in many ways it is also, more simply, a response to material changes in health systems themselves. Accordingly, training students in this way is responsible pedagogy from a workforce and career development perspective. Here too, the ACA is playing a role. For example, as part of an overarching goal to move certain services – especially long-term care services – into the community, the ACA established the Home and Community-Based Services State Plan Option, which provides funds with which state Medicaid programs can enhance their capacities to provide quality home and community-based services for certain groups of patients. The ACA also made resources available for establishing pilot programs for demonstrating the effectiveness of innovative models. The Community First Choice program makes federal funds available for states developing community-based services and supports to enable individuals with disabilities to remain rooted in their communities (Medicaid, n.d.). Finally, as just one important example of the kind of institutional contexts in which new physicians will find themselves working – and rethinking the relationships that drive population health – the Community-Based Care Transitions Program aims to cultivate relationships between hospitals and community-based organizations to facilitate new coordination efforts as patients transition from inpatient to outpatient care (Kocher & Adashi, 2011).

The possibilities of these new relationships are vast, but also require an intentional focus on community asset building. For example, providers training to work in collaboration with health committees might create opportunities for developing relationships with community organizations and understanding local perspectives and values. Beginning during medical school, health care practitioners could learn to facilitate meetings with health advisory boards and emphasize the significance of the information gained through these partnerships. Additionally, medical students could participate in training community members to conduct basic medical assessments in order to understand and communicate local needs. Training in research methodology could also help local residents gather information about their community and associated needs and assets, and present these findings to funders to garner support for interventions. The possible scenarios for collaboration are many. But a true turn toward the cultivation of new relationships requires a definition of medical care that not only emphasizes relationship building in a population health context, but curricula that situate students in communities such that relationships on the community level inform their entire understanding of the practice of medicine.

These developments should be viewed as opportunities for medical educators whose students could lead the way to truly community-based health care. In a way, the new relationships we are describing are an implicit part of the focus on team-based care and collaboration, culminating in the undergraduate and graduate medical education emphases on interprofessional education, construed in a manner that is consistent with the tenets of population health (Greer, Clay, Blue, Evans, & Garr, 2014). The transition to the Alternative Payment Models described above has inspired changes in medical curricula that depict providers as partnering to offer holistic and coherent care (Henschen et al., 2013; Bodenheimer, Grumbach, & Berenson, 2009). In this sense, medical training has been sensitive to important policy changes and the relationships developed between providers in the coordination of medical care. The move to the community is the next logical step in this process, though likely the most difficult considering its scope and significance for changing power relations within medicine.

Some medical schools have already taken important steps in this direction. For example, the United Community Clinics at the University of Pennsylvania brings together a range of practitioners, including dental, nursing, and social work students in a unified, dynamic interprofessional space in which medical and social services are offered seamlessly to patients at the First African Presbyterian Church in the East Parkside community of West Philadelphia (United Community

Clinic). Similar interprofessional spaces are arising around the US (Lie, Forest, Walsh, Banzali, & Lohenry, 2016), in Canada (Holmqvist, Courtney, Meili, & Dick, 2012; Pammatt, Landry, Weidmann, & Jorgenson, 2015), and beyond North America (Buckley, Vu, & Remedios, 2014). This movement accords with the World Health Organization's (WHO) 2010 "Framework for action on interprofessional education & collaborative practice" (World Health Organization, 2010). As WHO recognizes, such programs hold great promise for ensuring that future practitioners view interprofessional, collaborative work broadly and as central to their goals of promoting healthy societies.

While these kind of institutions are becoming increasingly common, however, they have not yet been mainstreamed into medical and other health professions programs. Although all medical schools identify relationship building and communication, including cultural competency, as important, these topics mostly remain embedded in the 'hidden curriculum', which encompasses socialization and value-building beyond skills and knowledge (Mahood, 2011), instead of being part of a mandatory and formally assessed curricular focus. A critical part of meeting not only the quantitative challenges of contemporary medical workforce needs, but a physician workforce capable of working within changing health care systems tasked with engaging health on the population and community level, will require finding a more appropriate balance between clinical skills and the socio-cultural aspects of medicine that have important influence on health outcomes, especially when addressing the needs of the most vulnerable and marginalized populations (Betancourt, Green, Carrillo, & Park, 2005). Mainstreaming programs such as the ones we have described, we argue, will be essential to adapting medical education to emerging medical relationships.

Conclusion

Recent changes in the organization of health care are occurring at least partly in response to the increasing priority of addressing the health of populations. In this article we have focused on the relationships that this reorganization continues to bring about. Health care institutions ignore communities at the risk of providing increasingly expensive and inappropriate care. This suggests that institutions have good reason to adjust their everyday practices to acknowledge these changing relationships and, indeed, actively work to foster and care for them. The doctor–patient relationship must be rethought, or at least properly contextualized within the broader field of community-based health care. On a larger scale, the scope of medicine itself must be broadened, altered, and, in the case of community-based health care, relocated.

The ultimate goal is not only a new image of how doctors relate to patients, but a richer understanding of who patients are, including what sustains as well as ails them. Accompanying the move to population health, therefore, is a different set of medical relationships. Although various opportunities – from joining community stakeholders in planning local programs to training local health workers – are possible depending on the context and problem at issue, the point is that providers will be increasingly asked to identify and engage community partners in the pursuit of improved health outcomes. Accordingly, if the goal is to focus increasingly on preventing illness and promoting well-being in populations, doctors and other providers cannot afford to emphasize solely developing rapport with individuals at the expense of communities. Instead, an important goal should be to not only understand the particular locale in which patients reside, but to establish connections with it. These contexts and connections can inform health care interventions that will be taken seriously and adopted by local residents. Forming bonds with patients remains important, but must be accompanied by an awareness of the situated nature of individuals. Establishing a dialogue with the communities in which patients reside, therefore, will reveal an emerging and in many

ways new logic to health beliefs and behaviors and inform possibilities for successful partnerships. The task facing the medical establishment is to acknowledge the ongoing transition to population medicine, capitalize on ACA support for the cultivation of new relationships, and successfully develop the new community partnerships required for improved health outcomes.

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