POSITION PAPER

Primary Care Practice Transformation in the Era of COVID-19 and Beyond: Key Principles for General Internal Medicine Practitioners

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As members of the Clinical Practice Committee (CPC) of the Society for General Internal Medicine (SGIM), we support practice innovation and transformation to achieve a more just system by which all people can achieve and maintain optimal health. The COVID-19 pandemic has tested the US healthcare delivery system and sharpened our national awareness of long-standing and ingrained system shortcomings. In the face of crisis, SGIM members innovated and energetically mobilized to focus on the immediate needs of our patients and communities. Reflecting on these experiences, we are called to consider what was learned from the pandemic that applies to the future of healthcare delivery. CPC members include leaders in primary care delivery, practice finance, quality of care, patient safety, hospital practice, and health policy. CPC members provide expertise in clinical practice, serving as primary care doctors, hospitalists, and patient advocates who understand the intensity of care needed for those with severe COVID-19 infections, the disproportionate impact of the pandemic on Black and Brown communities, the struggles created for those with poor access to care, and the physical and emotional impact it has placed on patients, families, and clinicians. In this consensus statement, we summarize lessons learned from the 2020-2021 pandemic and their broader implications for reform in healthcare delivery. We provide a platform for future work by identifying many interactive elements of healthcare delivery that must be simultaneously addressed in order to ensure that care is accessible, equitably provided, patient-centered, and cost-effective.

INTRODUCTION

The Society of General Internal Medicine (SGIM) consists of more than 3300 leading academic general internists dedicated to improving access to care for all populations, eliminating healthcare disparities, and enhancing medical education. SGIM envisions a just system of care in which all people can achieve optimal health. Our core values uphold delivery of high-value, evidence-based, person-centered, community-oriented healthcare. We aim to achieve these values through our commitment to population health outcomes and their social determinants; interdisciplinary collaboration and team-based care; and collegiality through joy in practice and support of diversity, equity, and inclusion.[1]

The COVID-19 pandemic exposed systemic deficiencies in our nation's health system, as existing resources proved inadequate in the face of the rapidly evolving pandemic. Long-standing unmet healthcare needs placed vulnerable patients in the highest risk categories for morbidity and mortality. As the SARS CoV-2 spread indiscriminately, existing inequities of access and care delivery posed dire consequences, especially to Black and Brown communities, and rural communities in America.[2] Ad hoc redesign became the norm as health professionals and enterprises faced challenges from the volatility, complexity, and ambiguity the pandemic brought to the healthcare environment.[3]

The pandemic has been transformative for the national healthcare system and for individual healthcare professionals. Our experiences call for a national effort to achieve a just and equitable healthcare delivery system through broad

innovation and healthcare reform strategies that substantially improve the health of our country. In addition to SARS CoV-2, there are silent pandemics of untreated and undertreated conditions such as hypertension, obesity, substance use disorders, and diabetes. As existing modes of healthcare delivery and access to care have been challenged, new and expanded modes of healthcare delivery have emerged that should become part of our collective future. Furthermore, systemic distrust of healthcare delivery based on long-standing institutional biases and legacy experiences within large sectors of our population call for immediate and effective correction.

With this report, members of SGIM's Clinical Practice Committee articulate 6 key principles that frame future efforts for improving and enhancing the delivery of general internal medicine (GIM) services to individuals and communities. The below principles summarize and coalesce the unique perspectives of GIM clinicians. They provide a framework for consensus and a platform for future work, related to enhancing GIM delivery post-pandemic across settings such as primary care, non-face-to-face care management, and transitions of care. While it is beyond the scope of this paper to provide specific action steps, we intend to highlight within these 6 principles a shared set of values and a platform for the necessary work needed to achieve a more just healthcare delivery system. Notably, these principles reiterate long-standing values of SGIM, currently intensified by the public health emergency (PHE) presented by COVID. Additionally, each principle provides insight and areas of focus by which SGIM members can provide innovative solutions, implement advocacy efforts, promote educational awareness, and cultivate a future GIM workforce.

ENVISIONING A JUST AND EQUITABLE SYSTEM OF CARE FOR ALL

Principle There should be equitable and easy access to essential quality primary care services for all people, regardless of race, ethnicity, gender, site of residence, or ability to pay.

GIM physicians stand witness to the consequences of unequal access to essential healthcare and the long-standing socioeconomic disparities experienced by minority groups.[4] Structural inequalities in healthcare delivery have historically resulted in differential treatment of people based on race, sex, gender identity, class, sexual orientation, stereotypes, and other identities that underpin implicit and explicit biases. As one example, studies have demonstrated that Black patients receive significantly lower amounts of appropriate pain management than their White counterparts, despite being hospitalized for identical injuries.[5] The term "structural violence" has been used to describe the ways in

which institutions perpetuate inequity through implicit and explicit bias. Medicine is not immune to this reality. Medical experimentation without consent, segregated medical care, and physician-initiated sterilization without consent provide ample evidence for bias, injustice, and disparate treatment.[6]

Minorities have higher prevalence of uninsurance, underinsurance, and less employer-based insurance; these social determinants are associated with less care and worse health outcomes.[7,8] *Equitable access to care and access to health insurance should not rely on employment status, income, gender, age, or race. These are social constructs that widen health disparities, which have been further exacerbated in extreme circumstances such as the COVID-19 pandemic.* Fewer physicians practice in minority and under-resourced communities, amplifying access problems; there is compelling evidence that diversifying the physician workforce is more likely to provide primary care for underserved poor and minority populations.[7–9] These issues, among others, have disproportionately impacted populations at high risk for severe infection, hospitalization, ICU admission, and death from COVID-19, particularly Black and Brown Americans, the elderly, those in rural America, and individuals with chronic illnesses.[2,10,11]

Expanding access must include moving healthcare and preventive services beyond the confines of brick and mortar institutions by employing community-based care, home visits, and widely available communication technologies. Additionally, diversifying and supporting multicultural exchanges within the workforce help ensure that physicians engage in effective GIM delivery among minority communities. As physicians, we must continually expand our multicultural capabilities, self-awareness of biases, and knowledge of social inequities.

Additionally, we have an obligation to address root causes for health disparities revealed by the pandemic, while also ensuring that future healthcare delivery redesign models do not widen gaps in healthcare access. To that end, we call for institutional and enterprise commitment to identify and correct practices leading to individual patient and/or community mistreatment. This includes complicity with inadequate and prejudicial healthcare provided in non-medical settings such as prison systems, border security, immigrant care, and deportation.

Given that racial and ethnic profiling leads to discrimination impacting the mental and physical health of all patients, particularly minority populations, persistence and advocacy is the only way forward. We are innovators for addressing the social determinants of health (SDoH) in communities; we recognize that the current status quo should be seen as untenable by anyone in healthcare. It is our given responsibility to improve the health and well-being of patients and communities, and to develop an inclusive narrative around public well-being and safety, based on sound evidence and patient-centered care.[2]

DELIVERING HIGH-VALUE PRIMARY CARE THROUGH APPROPRIATELY RESOURCED PRACTICE REDESIGN AND FINANCE

Principle Primary care must be supported as the essential hub of health systems serving adult patients; payment reform must support high-value primary care and provide resources that ensure health promotion, disease prevention, and continuous care of complex chronic conditions.

Primary care currently constitutes 6% of healthcare spending in the USA, compared with an average of 12% in other developed nations.[12] Evaluation and management (E/M) payments have not historically reflected the growing complexity of inputs, interactions, patient and caregiver education, and management decisions that occur in primary care visits, nor have E/M services adequately accounted for time spent by the health team before, during, and after such encounters. Undervaluation of cognitive work has contributed to revenue shortfalls and professional service maldistribution. The Resource-Based Relative Value Scale, the nation's convention for assigning prices to services for virtually all payment models, government and private, must be reworked to capture the full range of office and inpatient E/M services.[13,14]

Loss of revenue due to inability to schedule face-to-face visits under fee-for-service payment systems has threatened the viability of many facilities and practices, highlighting the need for innovative reimbursement structures that pay for access and quality for individuals over time. However, any move toward a capitated payment for continuous care must be based on mutual agreement between the primary care provider and the patient. Capitation payments must be adjusted to reflect patient circumstances that make delivery of care more challenging, so as to avoid "cherry picking" of patients and to ensure equal access for all. Similarly, we must continue to define patient risk, which extends far beyond current models based on dual eligibility and use of hierarchal condition codes.

Because the cost of health insurance is largely offset in the USA by employer-based plans, loss of jobs during the pandemic caused loss of insurance, increasing the need for charity care and Medicaid services through community health centers serving low-income patients. Yet many community health centers and academic medical centers (AMC) closed sites and/or furloughed staff due to financial challenges during the pandemic, further diminishing accessible care.[15] We advocate for expanded funding and support of community and teaching health centers that ensure access to care for all.

GIM physicians also seek transformation of healthcare delivery that provides safe care during pandemics and more broadly. GIM practitioners played a vital role in performing rapid-cycle assessments of delivery models, pivoting care delivery models to optimize patient safety, address health risk, and assess community need. Examples of innovation within the pandemic include (1) implementation of pre-visit planning calls to help patients and caregivers weigh risks and benefits of visiting clinics for in-person care, (2) creation of decision tools for determining the necessity of in-person versus telehealth visits at time of scheduling, and (3) a collaborative design and provision of e-consultative services and virtual consultations between primary care providers and specialty practices.[16] Such adaptability and innovation are essential to the future of healthcare delivery, regardless of the crisis level.

Additionally, the pandemic rapidly expanded options for providing care with new audio-visual technologies. We found that many audio-only patient interactions for chronic disease management carry the same work intensity as the highest levels of face-to-face care, particularly when coupled with home monitoring devices that allow practitioners to assess and manage conditions such as hypertension and diabetes.

Based on our pandemic experiences, we have noted that low-income and older populations especially benefit from telehealth services. Such telehealth services have shown to be substitutive, rather than additive, and have not been linked to increased expenses in Medicaid patient populations.[17] Consumer surveys from the bipartisan policy center show that telehealth appointments addressed patients' needs, while mitigating unnecessary trips to the emergency room and/or urgent care center.[18] Additionally, telehealth services have infrastructure needs that are comparable to in-person care, and payment should be determined accordingly. The resources and expenses of implementation include, but are not limited to, procurement of digital platforms that are HIPAA compliant; electronic medical record (EMR)–integrated solutions with multiparity video to support resident supervision; provision of devices such as webcams, headsets for providers, and peripheral devices for patients; workflow development; provider training; scheduling of staff to support needs that arise during the virtual encounter; patient support services (including language interpretive services and support for technical difficulties that arise); and program evaluation tools.[17]

In AMCs, synchronous electronically based care demands the same direct supervision of residents, medical students, and team members by attending physicians as in-person care. Because safety-net AMCs carried large proportions of telephone-only visits, we advocate that pay parity for this form of care must continue, in order to minimize health inequities.[19] While the pricing of these services is yet to be determined, any valuation that does not fully take into account the many resources required, or the medical complexity involved, will lead to utilization levels well below what is needed to close access gaps. Reimbursement policies implemented during the COVID pandemic for telemedicine and other innovative cognitive services should remain part of our new "hybrid" approach to healthcare delivery, providing

clinicians the ability to choose best platforms based on patient needs and preferences.[20,21]

To that end, we support (1) maintaining coverage and providing parity in payment for telephonic and video E/M services comparable to face-to-face encounters, (2) relaxing telehealth originating site and geographic eligibility requirements in order to enhance access to care within vulnerable communities, and (3) providing coverage for home monitoring devices and self-reporting of values, which can assist in remote management of chronic illnesses.

PROMOTING INTERDISCIPLINARY COLLABORATION, TEAM-BASED CARE, AND DIGITAL PLATFORMS TO ACHIEVE POPULATION HEALTH

Principle Support for robust population health tools, interdisciplinary collaboration, team-based care, and telehealth infrastructure in all primary care settings is essential for identification, tracking, and outreach of vulnerable patients with COVID-19, chronic conditions, social vulnerabilities, and those in need of preventive care.

Before the pandemic, it was projected that a primary care physician with a panel of 2500 patients would spend 7.4 h per day simply delivering all recommended preventive care and 10.6 h daily to deliver all recommended chronic care services.[22,23] We believe that team-based, multidisciplinary collaborations to coordinate patient-centered care delivery allow clinicians to rely on colleagues with expertise in community-based, public health–based, and other social services to provide comprehensive care while preventing clinician burnout. Payment structures and practice delivery models must therefore support the systems that allow physicians to build satisfying work relationships in which they share responsibility for health outcomes.[24] These systems, which include robust staff support, resources, and support for data analytics, are critical during COVID-19, when mental health issues, food insecurity, unemployment, and the need for appropriate shelter are intensified. Population health management tools vary by practice and include electronic medical records (EMRs), assessments of care gaps and health risk, and use of online patient portals for pre-screening patient needs. These tools should be optimized for identifying high-risk patients and/or those with care gaps. Importantly, telehealth modalities promoting virtual co-location of multidisciplinary teams in providing care coordination and co-management of patients with multiple complex medical and social needs may prove essential.

For communities, we endorse interdisciplinary collaboration that supports caring for populations who live in defined geographic areas whether or not they currently receive healthcare in that area. During the pandemic, robust care management teams, in collaboration with community health workers and public health programs, assisted with source control by incorporating contact tracing and health assessments, connecting patients and families to community resources and support services, and identifying those who would most benefit from in-person versus telemedicine services. Similar population health management systems should continue to be implemented to reduce readmissions of patients discharged with acute illnesses (such as heart failure exacerbation) by connecting patients and families to community partners and the supports needed to optimize their health behaviors, while also working with public health officials to consider the community infrastructure (e.g., access to food, recreational facilities) contributing to disease. Care management teams can also address effective transitions of care, management of uncontrolled chronic disease, provision of immunizations, education of patient groups, and identification of other preventive care gaps. Allotting time for effective and meaningful ongoing collaboration, sometimes on a daily basis, is important for pandemics but is also needed for routine health optimization.[25]

PROVIDING RESPONSIVE, PATIENT-CENTERED, AND COMMUNICATIVE HEALTHCARE

Principle We must provide healthcare and information based on a continuously evolving scientific base, in a complex and rapidly changing healthcare environment.

With the pandemic, we were confronted with contradictory information from not only news media sources and but also public agencies.[26] We believe that honesty is necessary in healthcare delivery. For example, it is important that clinicians, practices, and health systems are transparent about waits, prioritization, triage, and infection control. We must assure patients in times of uncertainty, while also setting appropriate expectations that messaging may change over time to reflect the evolution of our scientific understanding as additional data emerges.

The need to equip patients with the rapidly evolving scientific knowledge has set a precedent for future patient education. The provision of the same virtual and digital dissemination tools employed in social media should be leveraged for preventing and countering misinformation in digestible ways that patients can understand. In the future, we should repeatedly share new knowledge that may impact care using modalities that patients and communities understand.

This increased need for efficient communication, combined with patient access to both raw data and clinical notes, demands that confusing and sometimes disparaging medical terminology be eliminated. There must be a renewed commitment to improve communication using patient-centered language, and eliminate unneeded documentation that

interferes with the effective flow of information and burdens our fellow clinicians. We believe that GIM physicians should be involved in reversing mistrust of the health system through the development and the implementation of policies related to patient engagement at all levels of healthcare delivery, as well as advocating for transparency regarding how resources are collected and allocated. To the degree that patients have found telehealth and other innovative services to be helpful during the pandemic, for example, their voices should be valued as we deliberate the future of healthcare system redesign that serves the health of communities.

Finally, when crafting approaches to improve community health, it is important to consider both community risk and resilience so that GIM physicians, patients, and communities are fully empowered and equal collaborators. Risk factors are circumstances that increase the likelihood that people within the community will experience poor health and safety outcomes. Resilience is the ability to thrive despite the presence of risk. Limiting risk factors reduces threats to health and safety but does not necessarily achieve conditions that support good health.[1] Studies show that resilience factors can counteract the negative impact of risk factors, and that resilience factors on health and safety are interactive and cumulative.[27,28] To promote individual and community resilience, GIM members and other healthcare providers should be vigilant in advocating for and linking patients to appropriate behavioral health services. Similarly, the health system, policymakers, and the private sector should ensure adequate funding to support such activities during the current pandemic and beyond.[29]

PROVIDING SAFE, HIGH-QUALITY, AND EFFECTIVE EVIDENCE-BASED CARE

Principle We believe that all primary care practices should ensure that clinical decisions are evidence-based and implemented with robust safety measures to protect the vulnerable and eliminate disparities.

The rapidly changing clinical environment in the midst of the COVID-19 pandemic resulted in daily process changes in healthcare settings, making long-standing protocols obsolete. At the same time, we have a new appreciation for how rapidly plan-do-study-act cycles may occur, with processes often implemented at the start of a day, followed by virtual feedback loops and process changes within the same

week.[26] Quality and safety reporting using patient registries and care teams helped identify and prioritize patients with disease-related concerns, health maintenance needs, and other tracking measures at a time where face-to-face care was drastically reduced.[30]

We believe that medical care and practice design must be based on evidence from the best scientific studies and guidelines available. Our job as GIM physicians is to promote and effectively integrate research into practice and policy. To fulfill this commitment, we support partnership approaches involving practitioners and the research community. For patient care, we need practical interventions, awareness of cost-effectiveness, generalizable conclusions, and, importantly, *a commitment to reducing health disparities.*

To that end, future research should be conducted in diverse settings, with community-based participation. Research implemented in safety-net institutions serving vulnerable communities is especially important, considering that only 20% of the variation in health outcomes is related to care provided in the medical setting, while 80% of health is determined by outside factors, such as social and environmental influences.[31] For each dollar spent discovering new treatments, mere cents are devoted to learning how such interventions can be better implemented within communities.

Alternative research designs addressing critical SDoH—including rapid learning studies with focus group feedback and systematic studies combining environmental and community data—produced efficient, replicable, and relevant community solutions during the COVID-19 pandemic. These interventions demonstrated that such innovative methods are feasible, underscoring the value of clinical investigations with community collaboration in solving real-world problems.

As the next generation of scientists is being trained, there must be an intentional focus on achieving the Five Core Dissemination and Implementation Values of Implementation Science when conducting research. This includes (1) *implementing rigor and relevance studies in diverse, low-resource settings* that recognize the importance of alternative research designs to address important public health challenges (e.g., SDoH) facing our communities; (2) *achieving efficiency and speed by shifting to research designs that access existing and expanding data sets within the EMR*, thereby overcoming barriers to limited funding for large-scale, multisite randomized controlled trials; (3) *collaboration through community-based participatory research* that embraces and promotes community/clinical partnerships; (4) *improved capacity for alternative implementation research design methods* by training the next generation of scientists and key stakeholders (in settings such as primary care clinics, community hospitals, and community-based organizations) on such methods; and (5) *disseminating results to the cumulative knowledge of not only the medical community, but also the lay community*.[31] We believe that a thorough accounting

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[1] For example, the proliferation of fast food and junk food is a significant risk factor for poor nutrition, and steps to minimize the marketing and availability of such food are important aspects of an overall approach to good health. However, is equally important to ensure that safe, healthy, affordable, and culturally appropriate food is available in a community.

of the resources needed to fully address the impact of SDoH and medical comorbidities among the underserved will demonstrate the need for enhanced healthcare spending. We support "risk" and reported quality metrics among underserved and vulnerable patient populations that capture how such communities are under-resourced and impacted by SDoH.[31]

ENSURING A SATISFIED AND SOUND GIM PHYSICIAN WORKFORCE FOR THE FUTURE

Principles Physician well-being and satisfaction must be continually assessed and addressed as essential components of compassionate, high-quality care.

Worker protection for those who have endured furloughs, pay cuts, or unemployment due to COVID-19, or prolonged illness related to the pandemic, should be required by healthcare enterprises and included in future federal programs. Additionally, providers should not be placed in unsafe situations when caring for patients with transmissible life-threatening illnesses. "Hazard bonuses" to clinicians in high-risk fields for exposure should be considered; every effort should be made by health systems, the state, and federal governments, to ensure that proper personal protective equipment (PPE) can be manufactured, funded, and distributed to frontline providers.

We believe that funding must be allocated to abate anxieties so that the workforce can focus on the clinical needs of individual patients and communities in times of pandemics and comparable large-scale disasters.[32] Stress on the minority physician workforce during the pandemic was especially high, given the overwhelming need for care among minority communities whose health was affected by policies limiting their resources. A commitment going forward to a supportive and safe environment where such concerns can be expressed openly, safely, and with intention will be an important component of responsive leadership.[33]

At the organizational level, physician well-being can be achieved by (1) ensuring the psychological safety of clinicians through anonymous reporting mechanisms that allow them to advocate for themselves and their patients without fear of reprisal, and (2) sustaining and expanding existing well-being programs. We support a national epidemiologic tracking and intervention program to record and measure clinician well-being, and report on the outcomes of interventions.[34] Nationally, we believe that federal funding should be allocated to care for clinicians who experience physical and mental health effects of COVID-19 service.

Finally, more must be done to develop long-term, sustainable solutions to workforce diversity and to minimizing burnout. We endorse equitable pay and promotions criteria, a workforce culture that supports work-life balance, and curricula addressing how implicit bias and institutional culture impact faculty and resident experiences in the workplace. Importantly for achieving joy in practice, we support healthcare delivery involving a coalition of primary care providers, community partners, behavioral health teams, patients as key informants, and public health experts that work collaboratively in co-located, innovative, evidence-based ways to outline best practices for delivering quality care to those we care about most—our patients and communities.

CONCLUSION

Major disasters seriously disrupt essential routine healthcare delivery for people with chronic illnesses, leading to adverse clinical outcomes that exacerbate existing health disparities. As CPC and SGIM members who serve the day-to-day needs of patients, families, and communities have administrative duties and responsibilities, and remain committed to the development and implementation of policies and practices that are based on the best evidence available, we are committed to a better future for all patients and communities. With this report, we summarize insights based on our firsthand knowledge of the 2020–2021 COVID-19 pandemic, as they align with the mission and values of SGIM to form a more just and equitable healthcare system. Our work is intended to be a foundation for future innovation and advocacy by society members. We endorse a *shared commitment for change broadly defined* based on SGIM's long-standing commitment to expand access and address healthcare inequities. We invite our fellow GIM physicians to join together and complete the tasks needed to expand and improve the care we deliver to individual patients and communities.

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