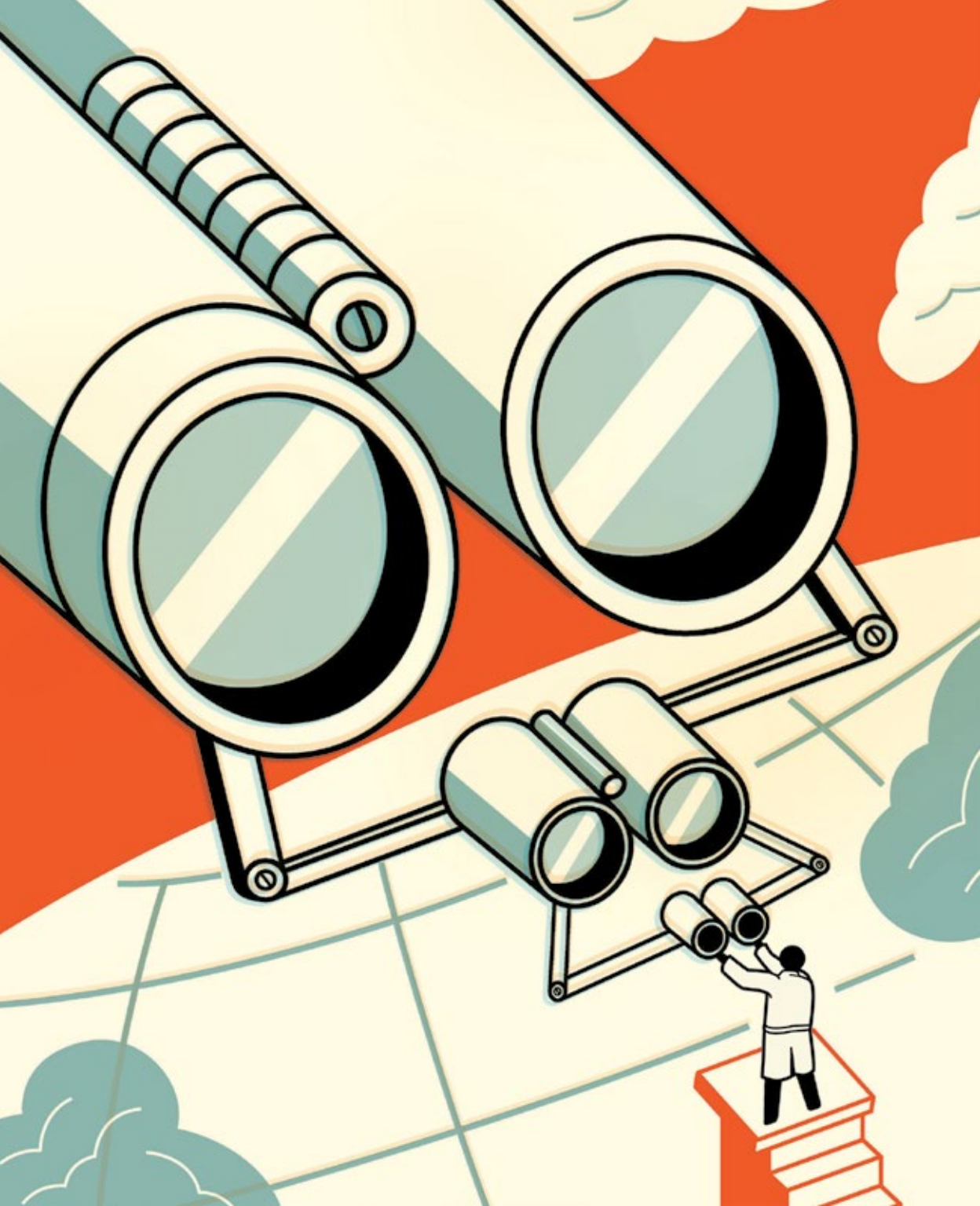

PRIMARY CARE RE-ENVISIONED

FIVE KEY CHANGES CRITICAL TO THE MASSIVE OVERHAUL WE NEED

The end of primary care as we've long known it is imminent.

The reason, simply, is that the traditional primary care model is ill-equipped to manage patient populations effectively in the new value-based care delivery paradigm. This is evident every time a specialist is paid more than a primary care physician or payment is denied for care coordination or preventive care. Disjointed efforts to align primary care providers and band-aid fixes to the existing primary care model will neither address underlying structural problems nor achieve urgently needed improvements in access, continuity of care, patient satisfaction, outcomes and cost-effectiveness.

Current realities demand a radically different care platform—one that is relational rather than transactional, personalized in its approach and focused on improving, not just maintaining, patients' health. Most importantly, primary care must be redirected to meet the needs of patients on their terms and timelines. (See Exhibit 1.)

While the patient-centered medical home (PCMH) model has made initial strides in this direction in recent years, it has fallen short in several ways. Operating costs are still too high, patient outcomes remain mixed and there is still too much emphasis on patients traveling to the medical home to receive care. A study led by the RAND Corporation, Harvard Medical School and the University of Pennsylvania found minimal improvements in hospital admissions, emergency department usage or the cost of care at 32 Pennsylvania PCMHs from June 2008 through May 2011.[i]

In contrast, the new primary care model, if successful, will be characterized by five key changes: (1) Primary care physicians must play a different role; (2) technological advances will fundamentally transform diagnosis and treatment; (3) patients will be more empowered and engaged than ever before; (4) panel sizes will be significantly larger, benefiting patients and providers alike; and (5) care must increasingly be provided at the patient's convenience.

1. The Evolving Role of the Primary Care Physician

Within this new construct, primary care physicians will continue to play a central role, but no longer as individual providers. Rather, they will function as leaders of coordinated health care teams providing 24/7 personalized care services to a select number of patients. The often-heard request to "call back during regular office hours" will become an artifact of the past; advances in remote biomedical monitoring and reporting will further transform the patient-provider relationship, in many instances precluding the need for in-person office visits. In fact, 30% to 40% of traditional primary care patient visits will no longer occur in a primary care setting, thus minimizing square-footage requirements and helping to optimize the balance between patient demand and physician supply.

The evolution of the primary care physician into care team leader is already evident in many parts of the country. However, the pace of change must accelerate. Compounding the

EXHIBIT 1: New technologies and care systems will enable a future primary care model that is relational rather than transactional.

ANATOMY OF A FUTURE PRIMARY CARE INTERACTION

	PATIENT	PROVIDER
PRE-ENCOUNTER	• See and share patient history/ health insurance electronically • Participate in patient monitoring (e.g., blood testing, vitals, etc.)	• Easily access patient records and insurance information electronically • Proactively monitor patients; get alerted when vitals fall outside normal range
SETTING APPOINTMENT	• Select appointment type, time and location via call-in or online registration	• Centralized, coordinated scheduling becomes more of the standard
ARRIVAL	• Check in via phone application or kiosk and then go straight to patient exam room	• Provider and care team alerted when patient arrives for visit
ENCOUNTER	• Visits are more "treatment" vs. "diagnostic" focused • 25% of time spent with physician and 75% of time spent with care team	• Treatment options provided reflect evidence-based protocols reviewed by provider in advance • Time spent mostly on patient intervention and required follow-up
CHECKOUT	• Future visits/follow-up monitoring scheduled or confirmed by care team • Any billing completed electronically or covered through value-based plan	• Patient record updated in real time • Follow-up instructions/resources/ videos emailed to patient
POST-ENCOUNTER	• Ability to communicate with care team remotely via phone, IM, email, text, etc.	• Post-visit follow-up sent electronically • Prescriptions shipped to house or pharmacy of choice

49.8% of primary care physicians describe their morale and outlook on the medical profession as negative.

urgency is the fact that health care systems and physicians today are caught between clashing reimbursement dynamics: They must continue to operate in an outmoded, volume-driven, fee-for-service world while taking steps to accommodate a growing emphasis on value and outcomes. Absent a full transition to the new model, care will remain fragmented, quality inconsistent and patient access further constrained. Provider morale also remains at risk: A survey by The Physicians Foundation found that 49.8% of primary care physicians describe their morale and outlook on the medical profession as negative.[ii]

Reinvented appropriately, however, the primary care role will take on heightened significance—a fact being recognized and reflected, at least to a modest extent, in ACA provisions that encourage primary care training and in the slow reversal in the last five years of a 30-year decline of interest in primary care among medical school graduates.[iii] Care teams will be informed by highly sophisticated evidence-based clinical protocols and will be characterized by clearly mapped workflows and open channels of communication throughout the care continuum.[iv] Technology applications will provide increased data, insights and decision-making support to health care teams. Advanced practitioners, such as nurse practitioners and physician assistants, will assume expanded clinical responsibilities and patient interactions as it becomes more common for them to diagnose ailments, write prescriptions and make referrals to specialists. And the primary care physician will serve as the care team CEO, with responsibility for keeping patients healthy; managing the care of the chronically ill; and addressing low acute, episodic conditions that arise.

2. The Transformative Impact of Technology

The new primary care model will be enabled and hastened largely by the exponential rate of advances in monitoring technologies, telemedicine, electronic records storage and artificial intelligence. These will have direct implications for wellness care, as well as for the diagnosis and treatment of many common conditions. Providers will be able to examine a patient remotely and obtain real-time data on a wide range of variables, such as blood pressure, body temperature, and glucose and oxygen levels, as well as diet, exercise goals and prescription compliance.

Approximately 20% of traditional primary care visits could be conducted virtually in the future ...

HealthSpot,[v] Higi,[vi] Soho Health[vii] and other companies have pioneered the design and installation of sophisticated health kiosks in retail pharmacies and supermarkets, as well as in public settings such as shopping malls and office building lobbies. Some units, such as those placed in select Rite Aid, CVS and Walmart stores, offer basic health screenings, symptom checks and wellness advice free of charge.[viii] HealthSpot's fee-based units enable individuals to interact with providers via high-definition videoconferencing and a suite of connected medical devices that stream biomedical data and store it in the cloud.[ix]

Remote patient monitoring (RPM) technologies are already reinventing care protocols in some markets. Mobile sensors automatically record patients' real-time clinical information for instantaneous transmission to clinicians, enabling rapid and potentially life-saving medical interventions across long distances. RPM technologies have proven especially well suited to helping care teams monitor and manage chronic disease in seniors and provide post-acute care.[x]

At Minnesota-based HealthPartners, a not-for-profit health system, certified nurse practitioners provide 24/7 diagnoses and prescriptions—and, when indicated, referral to a specialist—for a wide range of common conditions via the Virtuwell online clinic. Kurt Salmon's analysis of diagnostic codes offered at Virtuwell-type settings indicates that approximately 20% of traditional primary care visits could be conducted virtually in the future, allowing those basic-complexity patients to shift out of the higher-level care delivery platforms and make room for a larger panel size.

3. The Empowered and Engaged Patient

With expanded access to both their personal health care information and available treatment options, patients will be empowered to engage more actively in their care decisions than ever before. They will, in fact, be the stewards of their own information, which will be automatically updated and easily accessible.

As their engagement deepens, patients will also continue to take on more responsibility for the cost of their health care, giving them an incentive to shop for the best value and pushing health systems to compete on price. Patients will no longer automatically turn to a physician for routine services that can be provided by an advanced practitioner or

A patient panel of 2,500 may translate into an 18-hour day for an individual clinician.

through a health care app without needing a face-to-face interaction.

Physicians, meanwhile, will be forced to embrace evidence-based clinical protocols that result in better patient outcomes. This change will result in more personalized care and greater access for patients. And it will free primary care physicians to spend more time with patients with more complex needs.

4. The Expansion of the Patient Panel

More access and improved operational efficiencies will make it possible for care teams to double patient panel sizes, which currently average between 2,000 and 2,500.[xi] Admittedly, a chief complaint of primary care physicians operating in a fee-for-service environment is the financial pressure to spend less time per patient—and risk compromising care—in order to squeeze in more visits and hit productivity targets.

While productivity will remain a key metric, primary care must evolve toward a compensation model that not only includes relative value unit (RVU) metrics but also incorporates additional care-management targets, including outcomes, cost savings and patient satisfaction. One of the key advantages of RVU models is that they reflect the reality that some patient encounters require more time and complex care than others.[xii]

Given that a patient panel of 2,500 may translate into an 18-hour day for an individual clinician,[xiii] successfully expanding the panel to 5,000 or even 6,000 will require careful balancing of productivity goals and patient needs. If care teams are to achieve that benchmark, a large part of the care now provided directly by physicians must be handled by advanced practitioners, who will coordinate with other team members as required.

Of course, realistic panel sizes will depend on their makeup. Patients with high acuity levels and chronic or comorbid conditions will obviously require more time, care and resources than patients with less-challenging medical profiles. Panels will necessarily be sized accordingly.[xiv]

5. Patient Convenience Matters

In the past, primary care was delivered in a manner that suited the convenience of the physician. Now it must shift to suit the convenience of patients who, as telemedicine and other technology-enabled options make remote

care a reality, will refuse to spend an hour squeezed into a waiting room between the office hours of 9 a.m. and 5 p.m. Extended hours, even 24/7 access, will be expected, as will shifts in care delivery access points, as electronic access to health records and partnerships with local pharmacies and other emerging providers evolve.

In 1979, the Institute of Medicine defined primary care as "accessible, comprehensive, coordinated, continuous and accountable." That same standard applies today and will not change in the future. But the mechanisms and protocols of primary care—how, where, when and by whom it is delivered—will bear little resemblance to historic models.

In short, primary care must be re-envisioned —and sooner rather than later. Fixing it around the edges will take too long, yield scant benefits and fall woefully short of what providers and patients require. An essential but failing system, primary care is overdue for a massive overhaul. ❖

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