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# UPDATING PRIMARY CARE

An emerging economic model seeks to improve care and compensation

BY DAVID ALLEN

That primary care practice in the United States must change is not news to anyone. Indeed, a number of changes are already occurring. It is too early to tell exactly what primary care eventually will look like, but the early signs are already evident.

The reasons change must happen are numerous:

- The **shortage of primary care physicians** is becoming more acute. A 2006 Department of Health and Human Services study concluded that the United States is currently short more than 50,000 primary care physicians and that this shortage will steadily worsen for the foreseeable future. A 2008 US News & World Report article stated that 29 percent of people covered by Medicare report having trouble finding a primary care physician willing to see them – up from 24 percent in 2006.
- An **aging population**—and the retirement of aging primary care physicians—exacerbates the shortage. Older people need primary care physician services more often.
- Poor **primary care physician compensation** is causing too few medical school graduates to choose a primary care specialty. When the average medical school graduate carries \$140,000 of debt, the \$150,000 national average take-home pay of a primary care physician does not sound very attractive in comparison to specialties like radiology, ophthalmology, anesthesiology and dermatology, which offer reasonable lifestyles and average pay more than twice that of a primary care physician.
- **Wasteful health care utilization** is driving up costs unnecessarily. Some studies suggest that almost half of all emergency room visits could have been better handled by a primary care physician—and that the most common reason people use the ER instead of a doctor’s office is that an appointment wasn’t available.
- A **medical model** focused on episodic treatment instead of wellness, prevention, and disease management does not result in optimal health care. People who are overweight and/or depressed and/or hypertensive

and/or abusing tobacco/alcohol/drugs and/or a slew of other health risk factors are (a) unlikely to get much more than a stern reprimand from their primary care physician and (b) much more likely to get sick and incur high health care costs at some time in the future.

- Frustration with poor **patient service** is increasing dissatisfaction with how primary care services are delivered. Calling well in advance for appointments is becoming an antiquated concept in a culture that increasingly expects instant gratification. Taking a half-day to travel to the doctor's office, fill out paperwork, sit in a crowded reception area, wait in an exam room, spend only 10 or 15 minutes with the physician, wait again to give a urine sample or blood sample, return to the front desk to schedule further visits for tests or follow-up, receive a cryptic phone call or note a week later to "explain" test results, and then get a bill some months later (with perhaps multiple phone calls to get insurance paid and the balance settled) fits *nobody's* definition of good service.
- Poor **continuity of care** undermines quality and the physician-patient relationship. A recent *New England Journal of Medicine* study concluded that, in an average year, the typical Medicare recipient sees two primary care physicians and five specialists.
- People increasingly desire **information and empowerment**, especially to understand chronic health conditions. Primary care offices are great at diagnosing and prescribing treatment, but notoriously poor at educating or counseling patients on how to best manage their health.

The responses of physicians, patients, and payers to the above factors are both situational and fundamental. Situational responses are actions taken in an effort to escape the adversity and dysfunction, such as:

- Patients are choosing **alternative care** from non-physicians who are often delivering non-evidenced-based treatment. A 1998 *Journal of the American Medical Association* study estimated that use of therapies such as herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy had increased from 33.8 percent of the population in 1990 to 42.1 percent in 1997. There is strong evidence to suggest that use of alternative medicine is continuing to grow.
- Primary care physicians are being **consolidated into larger practices** and their incomes are being subsidized by specialist or inpatient services. Evidence for this can be seen in the Twin Cities, where independent primary care group practice is rapidly disappearing.

- Primary care physicians are choosing to **opt out** of the “hamster care” that characterizes the mainstream primary care practice. Some are recognizing that rural practices offer much higher income potential when the primary care physician can do more procedures, practice obstetrics, and efficiently manage hospitalized patients. Some who remain in urban areas are simply focusing on better compensated specialty services such as cosmetics, or are “unplugging” from the dysfunctional third-party payer systems and providing concierge care. And some are taking positions that offer reasonable balances of compensation and lifestyle, such as working as hospitalists or emergency physicians, or working for corporations like insurance companies.

## LIGHTENING THE LOAD

Yet it is the fundamental response that will ultimately fix the problems of primary care. A May 28, 2008, column in the Boston Globe, written by Joseph B. Martin, MD, former dean of the Harvard Medical School, describes how to fix the problem: “...most important, new models of healthcare delivery must be developed – with a new focus on team work, where, for example, doctors, nurses, pharmacists, and social workers form efficient groupings to consider patient-centered care. Teamwork and new ways of delegating treatment will take the load off of the hard-pressed primary care physician.” The approach Dr. Martin is describing holds the promise of improving the quality and service associated with primary care, as well as elevating the compensation and professional satisfaction of primary care physicians.

There are two keys to this new model: support staff and technology. New support staff will include physician extenders, care coordinators, health educators, and referral coordinators. The use of physician extenders is well underway already. Convenience-care outlets typically use nurse practitioners to staff “clinics” in retail settings. Many physician practices employ nurse practitioners or physician assistants to do routine health visits or urgent care.

The use of “care coordinators” is likely to grow substantially in the coming years. Care coordinators help patients manage and monitor their chronic conditions. Much of the impetus for care coordination is coming from third-party payers recognizing that they have been mistaken in moving disease management away from physicians to separate disease management organizations; external disease management has fragmented care and exacerbated the problems of primary care. In Minnesota, examples of the shift to having primary care take back responsibility for disease management include the DIAMOND Project (more on this later) and the recent state legislation that will compensate primary care physicians extra for being a “medical home” for MinnesotaCare patients.

If care coordination gains traction and demonstrates the ability to improve quality, prevent the development of higher acuity disease, expand the patient capacity of primary care physicians, increase primary care physician compensation, and lower costs by avoiding expensive treatment for more advanced diseases, then it is likely that the use of health educators and referral coordinators will become more common. For example, payers are beginning to recognize that an obese person in his 20s has health care costs about 10 percent higher than average and an obese person in his 50s has health costs about 20 percent higher. It is not hard to imagine payers wanting primary care physicians to offer health education services (e.g., addressing diet and exercise) in order to help people shed unwanted pounds. Similarly, for patients with low back pain—a common condition that leads to significant office visit and diagnostic costs—a referral coordinator with a well-designed protocol for evaluating and treating low back pain could have a substantial cost-benefit advantage.

In addition to staff, primary care physicians will need new technologic capabilities to effectively coordinate and manage their team of caregivers. Features of this technology will include electronic health records, telemetrics (allowing patients' clinical metrics to be transmitted regularly to the EHR), and patient communication and information platforms (educating patients and facilitating communication).

## IMPLEMENTING A NEW APPROACH TO PRIMARY CARE

Minnesota's DIAMOND (Depression Improvement Across Minnesota—Offering a New Direction) project illustrates both the challenges of implementing this new model of primary care and how staff and technology can work together to improve primary care physician professional satisfaction and compensation. The DIAMOND project is an initiative to pay primary care physicians a care management fee for coordinating the care of patients diagnosed with depression. While some feel that this approach may result in an overreliance on pharmaceuticals and an underuse of talk therapy for depression management, many feel that this approach has the potential to vastly increase the number of people receiving treatment for depression.

For each patient with a depression diagnosis, the DIAMOND project anticipates the primary care physician will be paid a care coordination fee of as much as \$50 per month. Thus, assuming the total compensation and overhead associated with employing a care coordinator is \$8,000 per month, 200 patients at \$40 each would cover costs. Coordinating care for 300 patients would result in a profit of \$4,000 per month, presumably to the benefit of the supervising primary care physician's compensation.

Are these reasonable assumptions? Estimates that perhaps 20 percent of the population suffers from depression at some point during their lives would indicate that there are many patients who would benefit from treatment. Yet, even in the busiest of practices, it will take some time to build the care coordinator's patient load; this is a distinct advantage for larger clinical practices. And it is hard to imagine one care coordinator

monitoring the progress of 300 people unless there is very good technology for patients going online and regularly self-reporting their status. The DIAMOND project illustrates that there is a good potential for care coordination to be a lucrative addition to primary care capabilities, but it will require careful management and implementation.

This approach could expand across many diagnoses and conditions. In each, the business model will have to be developed, but (at least theoretically) it has the potential to be an additional profit center for the primary care physicians. It doesn't seem too much a stretch to imagine a primary care physician of the future practicing in a group setting with a half-dozen or more disease management teams. The promise of this approach is that it would improve the quality of care, increase primary care physician compensation and, just possibly, allow primary care physicians to make better use of their skills by focusing on diagnosis and the most complex problems.

It is clear that primary care is going to have to change in order to remain viable as a specialty and serve the needs of our communities. This emerging economic model offers the potential to improve care while also improving the compensation of primary care physicians.

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