

Reinventing Primary Care

For primary care, change is in the air. It is not simply the evolution of time or even the winds of a political season; it is a deep, organic change growing out of the very foundations of our health care system. Change is coming to primary care and it is inevitable.

The change will be nothing short of a transformation. The patient relationship, the role of the primary care physician, reimbursement for primary care, and relationships with specialists and facilities – all will be substantially different in the coming years. This article describes why these changes will occur, speculates about key characteristics of the transformation, and suggests what primary care organizations should be doing now to prepare.

Primary care will transform because it must. The first force requiring change is that the supply of primary care physicians is insufficient to meet demand. People seeking the services of a primary care physician have a hard time finding one who will accept new patients, especially if their insurance coverage does not reimburse well. According to U.S. News & World Report, in 2007, 29% of people covered by Medicare reported trouble finding a primary care physician willing to accept them – up from 24% in 2006. A 2006 California HealthCare Foundation survey suggests that almost one-half of emergency room patients could have been cared for by a primary care physician and that difficulty getting a physician appointment was the most frequent excuse for using the ER instead. Projections by the U.S. Department of Health and Human Services suggest that the shortage of primary care physicians will get worse, not better, in the coming years (see Table 1).

Table 1: Primary Care Physician (PCP) Supply and Demand

	PCP Physician Supply	PCP Physician Demand	Shortage
2000	214,810	267,100	(52,290)
2005	228,660	281,800	(53,140)
2010	244,370	297,500	(53,130)
2015	259,910	316,300	(56,390)
2020	271,440	337,400	(65,960)

Source: “Physician Supply and Demand: Projections to 2020”; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions; October 2006.

Yet it is not simply a shortage of primary care physicians forcing change; it is a fundamental deficiency in the way primary care is provided. Service is often abominable in comparison to the service levels of other professions or, for that matter, most other industries. Appointments may not be available for weeks, locations are frequently inconvenient, parking is often a problem, and many find that the uncertainty of when their appointment will start and finish leads them to take a half day off for work for what may turn out to be a 15 minute appointment.

In addition to the service deficiencies associated with the current way primary care is delivered are quality deficiencies. For many primary care physicians, the pressure to produce RVU's (Relative Value Units) limits the time that can be spent with any individual patient. Patients with multiple or complex problems, patients who have trouble understanding, or patients needing education or guidance (in other words, most patients) get inadequate attention. Perhaps the most serious quality issue is the emphasis on dealing with the immediate problem at hand, at the expense of long-term issues like prevention and wellness; many physicians see their role as treating a disease or condition, rather than helping a patient avoid future problems.

Certainly, the finger of blame for the problems in primary care can be pointed in many directions. Primary care physicians are, to a large extent, prisoners of a system that gives them little opportunity to fix these problems. The prevalent procedural-based reimbursement structure leaves little alternative to primary care physicians but to endeavor to see high volumes of patients as quickly as possible. Additionally, the sizeable number of people without insurance or the ability to pay for care combined with the low reimbursement from government programs leads many physicians to avoid accepting new patients who don't have private insurance.

The fact is that no one is being well served by the current primary care situation. Physicians would undoubtedly be happier if they could spend more time with each patient, care for them more completely, and be better compensated as well. Patients generally like their physicians, but are deeply concerned about the costs of health care, access to services and service levels. Health plans recognize that they are an integral part of a system that is not cost-effective and does not deliver good quality or service. Employer sponsors of health plans are frustrated with rising costs and perceptions of poor value. The government is facing a crisis as the cost of programs like Medicare and Medicaid consume ever larger portions of our tax dollars. And all of us are concerned about how to care for people who don't have insurance or the means to pay for care.

Collectively, these are the conditions that will force primary care to transform. This transformation will come from two directions: first, from payors changing reimbursement and contracting methods, and second from physicians or health systems proactively changing their method of delivery.

Payors are starting to change the way they reimburse and contract with primary care providers. One large Minnesota health plan has initiated several pilot projects to compensate primary care physicians directly for doing "disease management" (engaging, educating and coaching patients on the management of chronic health conditions) – instead of relying on the more widespread practice of having an internal health plan department or separate organization perform this function. At least one large Twin Cities' employer is in negotiations with a primary care organization to open a work site clinic for the purpose of providing employees and dependents more accessible care. The Institute for Clinical Systems Improvement (ICSI), a collaboration between health plans and clinical groups, is currently promoting the DIAMOND project as an effort to pay primary care physicians a fixed monthly coordination fee for managing patients diagnosed with depression. At this writing, the Minnesota state legislature is in negotiations with the governor regarding legislation that would introduce per-patient

monthly care coordination fees, payable to primary care physicians, for MinnesotaCare insureds that enroll in a primary care “medical home”.

In the long run, it will probably be the actions of those who provide health care services who actually effect the greatest transformation. In addition to responding to the opportunities brought to them by the payor community, change is occurring within primary care. Academic medicine is promoting the medical home concept as a way to put the primary care physician with their patients at the center of all medical care. New ancillary primary care givers are entering the scene, such as the new doctoral level nurse practitioner. And new business models are also joining the party, with convenience care centers staffed by nurse practitioners sprouting up in pharmacies and other retail outlets across the country.

As this transformation occurs, here are some of the changes we believe primary care physicians will see:

- The **role of the primary care physician** will evolve to become the captain of a team of caregivers.
- The **physician-patient relationship** will be restored to a more permanent and holistic status as the **medical home** develops to become the dominant primary care treatment model.
- **Wellness, prevention and management of chronic health needs** will become as important to primary care physicians as providing episodic care.
- **Physician extenders** will provide much of the routine care to patients, sometimes at other locations such as work sites or retail outlets.
- **Care Coordinators** will play an important role in maintaining communications with patients and keeping them engaged in managing their health.
- **Care Tracks** staffed by ancillary personnel following protocols and supervised by primary care physicians (for individual patients) and specialists (for the overall protocol) will manage a myriad of health issues (e.g., diet and exercise, nicotine addiction, diabetes, depression, chemical dependency, asthma and allergies, spine care, pain management, and healthy heart care).
- **Home Visits** will be an important treatment option for many primary care teams and **telemedicine devices** will be used to monitor at-home patients’ health metrics.
- **Electronic Health Records** will become an essential tool for keeping the primary care physician informed and communicating information between team members and locations.
- **Reimbursement** will evolve as health plan sponsors partner with providers (e.g., to promote wellness or manage chronic disease), health plans move disease management back to primary care, and patients themselves increasingly pay out-of-pocket for what they perceive as superior value.
- **Compensation** of primary care physicians will increase as they transform from being cogs in a production machine to becoming lead caregivers for a panel of patients.

As more primary care is delivered in this way, a tipping point may be reached and all of health care could be affected. Emergency departments may operate at much lower volumes as primary care provides 24/7 access for urgent care. Certain specialty services and facilities may also see declines in volume as prevention has its effect and treatment becomes more conservative. Competition between primary care teams may become focused at a market niche level, such as by geography, age, gender, health

issues, language or ethnicity. Service levels may become an important competitive factor; appointments may not be required for many services and some care teams will compete by offering value-added benefits like transportation, exercise facilities or dietary programs.

Implementation of a significantly different form of primary care will not be easy for any health care organization. Full transformation will impact a wide cross-section of clinical, administrative, staffing, financial, facilities, marketing and informatics systems. The saving grace is that complete transformation is not something that can or should occur immediately. Transformation will be gradual, allowing systems a chance to evolve and, importantly, changes in the way primary care is reimbursed to keep pace. The essential task at this time for a primary care organization is to develop and begin implementing a plan that maps the critical path from the present to the future.

Primary care physicians who recognize the inevitability of this transformation and act first to embrace, plan and implement it will have a significant advantage in the marketplace. It will be difficult for physicians who fail to prepare to catch up later, as the first movers secure contracts and employ the available ancillary work force.

Change is always difficult and often unpleasant. The changes that will be occurring in primary care, however, are desperately needed. These changes will help address the shortage of primary care physicians by allowing an individual physician to oversee care for a larger population of patients. These changes will improve the quality, accessibility, service levels and value of primary care. Primary care physicians should embrace these changes not only for these reasons, but also because they should make being a primary care physician more fulfilling and rewarding.

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