

Primary Care Model – Return to the Patient

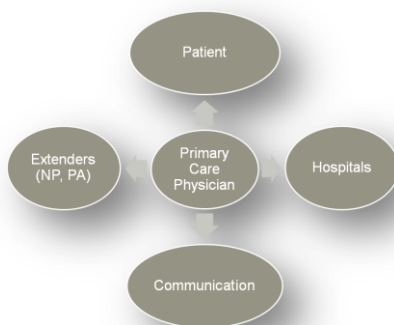
In coming years, crafting a strong primary care model will become a key determinant of hospital's success. Winning organizations will be those who understand that the pluralistic primary care model will incorporate more than physicians and focus on new models and ways of creating comprehensive care continuums for patients and the communities.

Shifting Focus

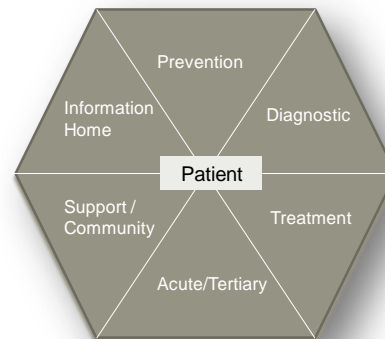
The shift away from primary care being defined by a family practice or internal medicine physicians will continue to accelerate. Growth of non-physician providers has already outpaced primary care physician growth and will continue to play a larger and larger role in the provision of care.¹ New models driven by the big retailers (e.g., *Minute Clinic*) and other non-traditional providers as well as clinical nurse specialists focused on chronic care management will continue to shape the public's attitudes about how care is delivered.

Historically the primary care physician was the center of the relationship, as the expert in charge of organizing and deploying assets and capabilities to deliver care. Future trends suggest that the patient will move to the center. Primary care will then be defined by the array of services accessed by the patient.

Historical Primary Care Relationship



Future Primary Care Relationship



Given the complexity of the care process and the limitations of knowledge transfer to the patients, there will remain a coordination and distribution role. Under the professional fee, work-RVU structure, primary care physicians are not incentivized to provide this coordination and distribution role, but rather to be an efficient component of the delivery process. Discussions of Medical Home and Accountable Care Organizations have suggested physicians (particularly primary care physicians) be compensated differently for a new role. However, we must ask whether this is an appropriate role for the independent physician or for that of a larger organization.

Who Will Lead the Future?

Primary care physicians, for decades, have been trained to diagnose, treat, and manage disease. To expect primary care physicians to take on a dramatically different role of coordinator for all the components from prevention to chronic care management using new, non-physician-centric models is unrealistic. As such, a larger organization must play a role in moving the patient to the center and coordinating/distributing primary care services.

¹ Physician assistants in clinical practice have grown 70% over the past 8 years from 43,000 in 2001 to 74,000 in 2008; American Academy of Physician Assistants

Hospitals with their experience coordinating and organizing complex multi-individual process and their connections to the local communities are the logical organization to organize primary care. However hospitals are not the only organizations positioned to do so. Additionally, hospitals are often fixed-asset-centric in their thinking and will likely struggle with the use of virtual and remote technologies to deliver care. As such, hospitals will face increasing competition for control over the primary care components of the continuum in the future from three other major groups:

- Physician groups
- Payers
- Large retail companies with history of service
- Employers

Physicians have the unique position of history on their side. Moreover, they have the closest personal connection with patients. Yet, they are disadvantaged by both training (diagnose, treat, monitor rather than coordinate and manage resources) and their physician-centric view of care delivery.

*The patient, not the physician will be
at the center of the future primary
care relationship*

Payers have the unique position of controlling most of the funds flow for care delivery. However, payers are reactive in nature and might be described as more of a marketing group rather than a management group. Their core competencies are in packaging goods and services and as such are a real contender for providing the coordination needed in primary care. Nevertheless, the cost control focus of the underwriter mentality will be difficult to overcome.

Retailers might leverage the unique connection and understanding of delivery services to customers. Moreover, there is no cultural barrier to standardization and evidenced-based management in the large retailer that are used to setting up stores in identical fashion throughout the country and monitoring their product success on a real-time basis. Moreover, they have shown that for the non-complex components of primary care, they can create a highly convenient, quality service. They will be limited in the complex areas as they are fundamentally geared towards repetitive rather than customized processes.

Employers (or employee groups such as unions) might leverage their proximity and payer position with patients. While they have an incentive to create a more efficient model if it reduces costs over time, they are fundamentally geared towards managing the output of the employees rather than the provision of services to the employees. It is more likely the employers will partner with one of the other four groups.

Implications

The changing reimbursement structures and market demands will cause dramatic changes in primary care over the next several years. While we expect hospitals and physicians to play a leadership role in defining the changes to primary care, there are other potential new players. Hospitals must be prepared for the coming changes and team appropriately with other non-traditional partners.



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