The Changing Face of Primary Care Medicine

By Tom Charland

In June 1952 my father opened North Scituate Pharmacy in the northwest part of Rhode Island. Next door was the primary care office of Robert F. Spencer, M.D., whose character resembled the beloved and kindly Marcus Welby, M.D. There was even a pass-through window between the drug store and doctor’s office so patients could get their prescriptions filled before leaving. It was a simpler way of doing things.

The independent pharmacy and the family doctor are rapidly becoming history. Large retail chains now rule the drug store market; large, hospital-employed medical groups now rule the primary care market. The large retail drug chains seem to be thriving. But when it comes to large primary care practices, both senior leadership and providers wonder where it’s all going. Burnout, demanding consumers, fewer medical school graduates, administrative burdens, complex productivity goals and new competitors are all adding up to make primary care’s long-term survival somewhat of a question mark.

Are things really that bad for traditional primary care medicine? Should we really believe those observers who say things are only going to get worse? We will explore this topic in some depth at our next ConvUrgentCare Strategy Symposium, January 23-25 in Scottsdale.

Despite all the problems and complications, for most large multispecialty practices things are going pretty well, at least at the bottom line. But at the same time, there is widespread acceptance that healthcare costs and insurance premiums continue to rise at unsustainable rates. Amid the policy debates is the fact that primary care plays a critical role. Yet on the surface it appears there is little progress toward getting at the source of the problem.

Accountable care organizations (ACOs), which are being forced upon medical groups, is a good illustration. Angst around a lack of progress toward cost savings could be felt at the October 6 meeting of the Medicare Payment Advisory Committee (MPAC), which oversees the three Medicare ACO program types (Pioneer ACOs, Medicare Shared Savings Program (MSSP), and Next Generation ACOs) covering 470 ACOs and nearly 9 million beneficiaries. The Pioneer ACOs are showing savings of less than 1 percent; the MSSP is losing money. But the key point coming out of the most recent meeting was that the hospital-based ACOs performed much worse than physician-based ACOs.

“The hospital-based systems tend to be very regimented,” said...
MPAC Commissioner William Hall, M.D., a geriatrician and professor of medicine at the University of Rochester School of Medicine in Rochester, NY. “They tend to look at healthcare providers much more as integers than to a system of care, and that they can be replaced by other providers. And I think it’s caused a certain amount of change in the physician culture.”

“We need to be going deeper to understand what are the real attributes that are determining the winners and the losers,” said another MPAC commissioner, Craig Samitt, M.D., who is executive vice president and chief clinical officer at Anthem Inc.

“We’ve been studying this within the Anthem ACO, and one of the things that we may find is it’s not just about the payment model. It’s about the capabilities within the practice, whether it’s leadership or data availability or technological solutions or care model designs.”

Zeev Neuwirth, M.D., recently named senior medical director of population health at Carolinas Healthcare System in Charlotte, has spent a number of years leading primary care and ambulatory medicine at this large integrated delivery network. He is at the center of the transition from volume to value. He is also one of the national thought leaders who has been identifying the challenges and potential solutions for healthcare executives and frontline physicians in large medical groups.

“In many respects things haven’t gotten bad enough to force the difficult changes needed to cross into the value-based landscape,” he says. “For the primary care providers at the front line of care it can seem more like climate change than imminent change, even in the face of the impending regulatory and payer mandates. We have hard working, smart, gifted and giving people. Physicians and their teams are focused on becoming more effective and efficient. But it’s a natural tendency to keep doing things the same way, and this is especially true in healthcare delivery. What are the immediate consequences that would drive such change? This in-between state is a bizarre place to be, and a difficult one to sustain. It’s challenging to build focused strategies and tactical foundations for the future when the immediate is so real and pressing.”

However, underneath the discussion and debate, and independent of the regulatory forces, there is an unquestionable shift taking place – some say a revolution – affecting primary care in two areas: one clearly visible and the other percolating under the radar.

Consumers Driving Change

The visible revolution takes the form of consumers having a lot more input and power over the way healthcare is delivered. The term “consumer-driven health care” has been around now for more than a decade. But it seems that only now are we feeling the implications of that movement. Hospital administrators, politicians, insurance executives, medical societies and government bureaucrats still call a lot of the shots, but more and more consumers are deciding what happens in healthcare, particularly at the low end of the acuity spectrum.

Some primary care physicians embrace this movement. Others resist it. Have you ever heard a primary care physician complain that urgent care and retail clinics are taking away “the easy stuff”? Or that those easy things break up their day in between more complex chronic care patients? Those complaints may be legitimate from a physician’s perspective, but they completely ignore the movement taking place that puts more power in consumers’ hands when making decisions about where to go for care.

Frankly, that provider/industry-centric thinking should have disappeared a decade ago. But the attitude persists, particularly among groups that represent the primary care constituency, including the American Medical Association, American Academy of Family Physicians and the American Academy of Pediatrics. But make no mistake, the consumer-driven market for primary care is moving on in large part without the medical establishment.

What is emerging is a primary care landscape breaking apart into specialized piece parts based on the specifics of a given patient’s circumstances. Think about television in the 1960s and 1970s. It was broadcast through three primary networks: CBS, NBC and ABC. Broadcast television ruled the TV world. But slowly it broke apart into smaller broadcast networks, cable TV providers, satellite providers, cable and satellite content networks, on-line and mobile device streaming.

In primary care, we see services breaking into a similar scheme of specialized or situational services: retail clinics, urgent care, high-intensity primary care,
low-intensity primary care on demand, telemedicine (real-time video), home visits (Uber docs) and eVisits (algorithmic on-line visits). The bottom line is that traditional primary care has lost a large percentage of visits to these situational, focused-factory-like providers.

“The traditional primary care medical group practice as we know it today will be gone in 10 years,” says Bruce Irwin, M.D., founder and CEO of American Family Care, one of the largest urgent care operators in the United States. “Most primary care doctors will be practicing in on-demand settings.”

That is a bold statement, one that we believe is accurate for about 50 percent of primary care visits. More on that later.

Dissecting the Primary Care Market

For a long time the CDC’s National Center for Health Statistics published the National Ambulatory Medical Care Survey. From the early 1990s until 2012 these surveys sliced and diced physician office visits in the United States. Unfortunately, federal budget cuts and a new change in philosophy on data liberation curtailed this work. But over the course of 1991 to 2007, these surveys showed amazing consistency in the number of office visits per year (3 per person per year) and the number of primary care visits per year (1 per person per year). From 2007 to 2012, however, there was a statistically significant drop of 70 million primary care visits, from 576 million visits to 506 million visits per year. Since these surveys are no longer published, we can’t go back and see if 2012 was an anomaly, or if there was something happening that would cause this drop.

But it just so happens that over this same period (2007-2012), we estimate there was an increase of 550 new retail clinics and 5,000 new urgent care clinics. A modest performing retail clinics averages about 8,000 visits per year; the same urgent care clinic averages about 12,000 visits per year. Add those up and the combined total of visits in 2012 from just those new clinics would be 65 million. In other words, we don’t think the 70 million drop in primary care visits was a coincidence. It was the start of the new face of primary care medicine.

Since 2012 there has been continued growth in the retail clinic sector (613 more clinics) and the urgent care sector (approximately 3,000 more clinics). We have also seen growth in work site clinics, telemedicine and eVisits.

The available market for acute episodic illnesses and injuries, which 15 years ago was the domain of traditional primary care, is not unlimited. In fact, it is significantly less than one visit per person for the urgent care scope of service, which includes injuries such as lacerations and broken bones. There’s an even smaller available market for the retail clinic scope of service.

A Perfect Storm

Primary care physicians are trying to survive a perfect storm of market changes. Patient pathologies are more complex with the aging and obese populations across the nation. New entrants are emerging, such as payers, encroaching on the healthcare delivery domain. Patient demographics are changing, such as the emergence of millennials who have no allegiance to a particular physician. Economic forces are shifting, but in unclear ways and at an erratic pace. New technologies are ready for prime time. And beneath all of this landscape, medical societies and physician academies appear blind to the inevitable change.

It is no wonder that primary care visits have become more concentrated around chronic disease management as acute episodic visits move to new competitors. That drives complaints from primary care providers that they are losing the easy visits to on-demand providers.

When looking at changing demographics, Dr. Irwin from American Family Care argues that as baby boomers age, the next generations have grown up with on-demand alternatives to getting medical care.

“Forty percent of millennials have chronic conditions,” he says. “They’ve grown to expect their care in an on-demand modality. If urgent care centers can deliver care today within a 58-minute door-to-door time, what’s the point of an appointment? And with new technology, that turnaround time is only going to shrink.”

As far as new entrants, perhaps the best example is Optum, the services arm of UnitedHealth Group. Optum has it all: big data, primary care brick and mortar, urgent care brick and mortar, employer relationships, telemedicine, and a variety of support services that make

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any medical group or clinic infrastructure more efficient. A good example of Optum entering a market is Connecticut. In December 2015, Optum acquired ProHealth Physicians, the leading primary care physician organization in that state. Several months later, Optum’s MedExpress urgent care subsidiary announced plans to open clinics for the first time in Connecticut, identifying seven initial cities. The combination of highly efficient primary care, supported by big data, and supplemented by urgent care and telemedicine represents the kind of disruption we expect to see in markets across the country.

It’s not like these developments have happened overnight. The growth of retail clinics, urgent care and telemedicine are more than a decade in the making. ACOs have been a topic with MPAC since 2006. So it doesn’t help that organizations that are supposed to represent and support the primary care constituency appear to be causing more harm than good. On one day the leaders of the AMA, AAFP and AAP issue a press release warning of huge shortages of primary care providers, and the next day they issue a press release bemoaning the fact that the Veterans Administration is using advanced practice providers for primary care.

These organizations should be listening to consumer demands, anticipating competitive disruption, looking at demand-side and supply-side data, and leading the change that enables primary care to thrive. But perhaps their most vocal members are still living in the past. The image of Marcus Welby, M.D. captured the love a community had for its family doctor and, in many ways, showed how family doctors were local celebrities. But celebrity doesn’t last forever.

“What’s sad is that there is an addictive quality to it,” says actor Giovanni Ribisi. “To believing your own hype; to allowing yourself to become validated by others and no longer by yourself. That’s the danger of celebrity.”

### Hope through Data Liberation

All of this might imply that traditional primary care is a lost cause or a dying breed. But competition is good. It’s what will wake up primary care leadership to new possibilities. We have found in recent years that rank-and-file physicians are much more open to supporting health system initiatives not only around on-demand care, but on the totality of how they practice, even if those efforts might create internal competition or disruption.

“I know it is going to create disruption, but I’m happy that we’re keeping it in the family,” said one pediatrician upon learning the details of a system-led urgent care initiative.

Many of the on-demand initiatives involve partnerships with independent urgent care operators such as Go Health, Premier and Four Winds, who are pivoting their business models toward management services and joint ventures. Other partnerships involve retailers like Walgreens and Rite Aid, who are increasingly working with health systems to operate retail clinics in their stores.

But perhaps the biggest reason for optimism is the ongoing restructuring of primary care practices themselves. Many large employed medical groups are taking a hard look at what constitutes primary care and how primary care providers can be far more strategic in how care is delivered, both within the primary care practice and downstream to specialists. This is the second revolution we referred to earlier, the one that moves forward under the radar.

In looking at his system’s large primary care service, Dr. Neuwirth at Carolinas HealthCare believes that the primary care delivery and approach to population healthcare ecosystem needs to be restructured.

“Given how other industries and other areas within healthcare delivery have achieved transformational effectiveness, efficiently and customer services, it seems to me that we need to figure out how to change primary care to be segmented based on our customers’ needs,” he says. “That is, segmented and focused on patient and population conditions, situations and needs.”

Neuwirth points out that the focused factory concept has been demonstrated to achieve better patient outcomes in a variety of settings within healthcare.

“It’s worked in complex chronic care, as well as in low-complexity acute episodic care,” he says. “The advent of hospitalists, ED physicians, extensivists, sports medicine physicians, and urgent care providers are just some of the examples of how this movement toward segmented focused care has been shaping itself. This type of focus allows for a more defined approach to day-to-day operations, improvements and innovation than the ‘one-size-fits-all’ approach.”
Neuwirth says it’s easier to create higher standards and measurements when you’re focused and clear on what your brand and value proposition are. “It’s also easier to be patient centered when you’re focused on a specific need or situation,” he says. “And from the provider side, I believe it will allow for more meaningful and sustainable work for primary care providers. The movement will elevate the value proposition of the primary care physician.”

Neuwirth speaks frequently on primary care redesign and will be one of our speakers at the next ConvUrgentCare Strategy Symposium in January.

As for influencing downstream care, primary care physicians may not realize yet how critical and how valuable their practices are about to become. The major force behind this realigned focus on primary care is the result of a shift by the Centers for Medicare and Medicaid Services (CMS) in the way it releases data, what is often referred to as the CMS data liberation movement. A few years ago CMS decided to get out of trying to micromanage how clinics should practice. Instead, it decided to release every detail on how every doctor practices medicine. The data is not in the form of surveys or samples; it is the entire CMS data set. The result is a movement, largely entrepreneurial driven, that slices and dices the data and boils it down to high-value versus low-value care, exposing a huge amount of waste in the U.S. healthcare system.

For example, low back pain can be treated with physical therapy or spine fusion surgery. The outcome is statistically the same but the cost difference is huge. So spine fusion surgery is considered low-value care; physical therapy is high-value care. Any orthopedic surgeon who makes a living on spine fusion surgery today will likely be having difficulty finding patients in five years.

The movement is going to change the landscape of how primary care providers and specialists work together. For example, those specialists who provide lots of high-value care but who are still under 100 percent fee-for-service arrangement will be rapidly moving away from fee-for-service because they can make more money through bundled or incentive payments. Primary care doctors who currently send patients to low-value providers will rapidly change their referral patterns.

“PCPs stand to make out like bandits,” says Josh Rosenthal, co-founder and chief strategy officer at RowdMap Inc, one of the firms playing in the data liberation movement. “If you are practicing high-value care today and you are in a fee-for-service arrangement, you’re financially upside down.”

Rosenthal says a third of the supply out there is low-value care and PCPs will be the gatekeepers for what goes to high-value specialists and what doesn’t go to low-value specialists.

“A lot of the specialists are really nervous about PCPs picking up a more significant role in the downstream options for patients,” says Rosenthal. “They have incentives to move care to high-value care and to do more high-intensity stuff themselves.”

Rosenthal also will be speaking at the ConvUrgentCare Strategy Symposium in January. He has arguably one of the best views of what primary care will look like (continued next page)
partnerships and joint ventures with large medical groups. If they don’t, they will be on the outside looking in as primary care models become more strategic and more sophisticated. Primary care practices will move as much as 50 percent of their low-intensity activity to on-demand access by using new technologies like mobile apps that enable patients to see wait times across multiple locations and get themselves into queue. In other words, there are no barriers to putting these apps into play at traditional primary care practices.

And although ACO activity is creating angst at MDPAC, there is room for optimism there as well. The release of this data will accelerate cost savings and make low-value specialists less attractive in the market place. Ultimately, many of these ACOs will figure out how to combine high-value care with convenience.

Fork in the Road

Primary care is clearly at a crossroads and most people we talk to say the point of departure is coming soon. On-demand characteristics are going to show up within the core of primary care practices over the next two years, driving perhaps as much as half of PCP office visits. Many of these practices will be reaching out via telemedicine, both to people’s homes and to area employers.

At the same time data analytics tools will become commonplace to primary care practices, putting primary care doctors back in the driver’s seat in making sure patients get the right care, at the right place, at the right time and at the right price. That would sure be a simpler way of doing things.

Tom Charland is founder and CEO of Merchant Medicine.

Register Now for the 9th Annual ConvUrgentCare Strategy Symposium

Hotel Valley Ho, Scottsdale, AZ, January 23-25, 2017

The 9th Annual ConvUrgentCare Strategy Symposium is set for January 23-25, 2017. This invitation-only thought leadership event geared to hospital system executives will be held at the beautifully renovated Hotel Valley Ho in Old Town Scottsdale, Arizona, one block from the art gallery district on Main Street.

The urgent care, retail clinic and employer services markets have always been competitive, but this year feels different. Disruption feels as though it is coming from multiple directions. The leaders of health systems and large medical groups will have to move aggressively in the short term to compete in this space or yield to new entrants. Our Symposium is built around ideas and strategy that help build competitive advantage for our attendees.

The symposium begins at 1 p.m. on Monday, January 23rd, enabling most attendees to fly in that morning. The meeting ends on Wednesday, January 25th, at noon. For an invitation, brochure, and discount code, email us at info@merchantmedicine.com