Pay for Relationship: A Novel Solution to the Primary Care Crisis

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More than a decade after the publication of the Joint Principles of the Patient-Centered Medical Home (PCMH), primary care remains in crisis. Peer-reviewed studies of the medical home suggest underwhelming impact: a positive but negligible effect on cost, little to no real change in quality, and mixed results around utilization. Meanwhile, in the trenches, half of primary care physicians have at least one symptom of burnout. And, at least as measured by office visits, primary care has started to shrink.

Those of us who were there at the start of the PCMH movement had no doubt we would achieve triple aim results: significantly improve population health and patients' experience of care, all while lowering costs. A large body of evidence from the 1980s and '90s had been amassed proving that primary care prevents illness, delays death, enhances equity in care delivery, and lowers costs. Evidence that, a recent study showed, continued to hold up in 2005 and 2015.

So what went wrong?

In 1992, Barbara Starfield described primary care as consisting of the four Cs: first Contact, Coordination, Comprehensiveness, and Continuity.

Medical homes and accountable care organizations have chosen to focus the majority of their energy and resources into building concrete versions of the first three of these concepts. First Contact became access, Coordination became care management, and Comprehensives became population management.

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It is my hypothesis that the patient-centered medical home (PCMH) / accountable care organization (ACO) movement committed resources to access, care management, and population health but took continuity — the trusting relationship — for granted (Figure 1). In an environment where a higher percentage of total health care spending failed to flow to primary care, the inevitable result is a slow strangulation of trusting relationships by the time needed to deliver coordinated care and population health, and the disruption to continuity that new forms of access allow. The damage to trusting patient–primary care relationships has resulted in burned out primary care physicians (PCPs), and the failure of many medical homes and accountable care organizations to significantly lower costs and improve outcomes. Any solution to the current state of primary care must assign value to the trusting relationship to balance the value assigned to the other three Cs.

A Look at the Four Pillars of Primary Care

Used to be called	Current Terminology	Definition and Comments
First Contact	Access	After googling and calling your mother, primary care is the first way a patient contacts healthcare
Comprehensive	Population Health Integrated Behavioral Health Social Determinants of Health	Primary care should provide all recommended primary and preventive care
Coordinated	High Risk Care Management Transitions in Care Referral/test tracking	When primary care can't provide all care, they should coordinate the care the patient receives outside the practice
Continuous	Trusting relationship	Patient-centered relationships over time

Source: The author

Figure 1 Click To Enlarge.

If one believes the customer of health care should be the patient and not the insurer, the fact that trusting relationships is something most patients want should be in and of itself a strong enough reason to assign it an economic value. Likewise, much of primary care burnout comes from the moral injury created by the disconnect between why we became PCP's and the realities of our day-to-day work. The relationship with the patient is what attracted us to primary care. Medical trainees are smart enough to know it doesn't make economic sense to go into primary care. Separate them too much from the relationship with the patient, and they will find callings outside of primary care. In the absence of a workforce, primary care will inevitably continue to shrink, resulting in further increases in health care costs and worsening of patient outcomes.

Sadly, these two arguments are probably not enough to support an emphasis on the fourth C and a commitment to Pay for Relationship. While we know that primary care improves health and lowers costs, can we say the same for trusting relationships? Phrased another way: Which of the four Cs — first contact, coordination, comprehensive, or continuity — matters the most? Are they separable? Are they synergistic?

Studies do not yet exist and are likely too complex to undertake, but four insights in the literature are instructive:

1. An analysis of the Medicare Coordinated Care Demonstration Programs showed that a key differentiator between successful and unsuccessful programs was whether the nurse care coordinator had frequent in-person meetings with the patient, and occasional in-person meetings with the PCP.
2. Retail clinics, by design, are a natural experiment in separating accessibility from comprehensiveness, coordination, and continuity. The best study of these practices suggests that all they do is increase utilization and spending.
3. A significant body of evidence shows that continuity of care is associated with greater patient satisfaction, improved health promotion, increased adherence to medication, reduced hospital use, and lower mortality rates.
4. A recent study by D.M. Levine, et al., demonstrated that patients who reported experiencing *all four* Cs of primary care received significantly more high-value care and a better health care experience overall.

As mentioned above, primary care was achieving triple aim results in the 1980s and 1990s. Before electronic health records (EHRs), PCMHs, and ACOs, accessible, comprehensive, and coordinated care wasn't paid for; it happened either by chance or because it was important to the patient or the PCP. The trusting relationship wasn't paid for either. Yet relationships grew because it was important to most PCPs and most patients. And because most visits were face-to-face, the social niceties that require some chitchat before addressing the patient's problems helped facilitate that trust. Evidence suggests that trust naturally develops after years of "thoroughly evaluating problems, understanding a patient's individual experience, compassion, empathy, advocacy, reliability and dependability, communicating clearly and completely, continuity of care, building a partnership, giving time in the consultation, providing appropriate and effective treatment, and being honest and respectful to the patient."

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I would argue that trusting relationships are foundational to the four Cs. Having exceptional information technology does little to impact outcomes if the patient doesn't trust us enough to respond to a population health outreach. There is no point in being accessible if the patient feels

bad about bothering us when they feel sick. And how can we expect patients to make lifestyle changes if we don't know them as an individual and can frame the change in way that matters to them.

Developing Pay For Relationship

There are, undoubtedly, risks to assigning a financial value to something as intrinsically motivated as the primary care–patient relationship. What we should *and can* pay for is care that *enables* relationships.

At the very least, all changes to health care delivery and reimbursement should require a "relationship impact statement" — does it build relationships, and if not, how can any damage to the relationship be mitigated. All new EHR clicks should require the removal of an equal number of clicks elsewhere. Any new screening questionnaire must replace an older less useful piece of work, or its completion should be paid for to help fund a larger primary care team.

Thinking bigger, it is interesting to imagine a health care payment system built around the patient– primary care relationship. There are several design principles to consider for such a system.

A MODEST PROPOSAL FOR PAY FOR RELATIONSHIPS

Several elements are necessary to fully create, support, and sustain a primary care model that is driven by a patient-provider relationship built on trust:

- EHRs include software that tracks all primary care team members, automatically billing to reflect the work.
- All patients designate a single primary care clinician, whether a physician, physician assistant, or nurse practitioner.
- All PCPs identify a core team of nurse practitioners, physician assistants, medical assistants, nurses, social workers, psychologists, nutritionists, pharmacists, and community health workers. They also identify primary care teams with which they share coverage.
- The Centers for Medicare & Medicaid (CMS) assigns a dollar-per-minute amount for interactions between members of the patient's team and primary care team, resulting in a

net inflow of revenue into primary care.

- No cost sharing or copays are required for communication between the patient and primary care.
- CMS adjusts reimbursement based on the cost of delivering and the relationship benefit of care, dependent on:
  - the profession of the care team member involved in the interaction
  - whether the PCP team, a covering team, or an unrelated team is providing care
  - the interaction takes place face-to-face in the patient's home, face-to-face in a hospital, face-to-face in the primary care office, by video, by phone, by asynchronous electronic communication (such as email or Web-based tools)
  - the day of the week and time of the interaction

Some may be concerned about paying the cost of the increased number of primary care touches that logically will result from eliminating copayments. This cost will be balanced by the movement of care from emergency rooms and specialists to primary care, which evidence shows will result in lower costs and higher quality. Replacing the current "stick" system of higher copays for emergency room and specialist care to a "carrot" system of copay-free primary care will also mitigate the tendency of patients to avoid medically important services when faced with a high copayment.

PAYMENT FOR ALL MEMBERS OF THE PRIMARY CARE TEAM

Interaction with the patient's core primary care team should be reimbursed more than interactions with a covering team, and the covering team should be reimbursed more than interactions with a team outside of the practice, including retail clinics. It is more work for a system to connect the patient with someone they know rather than the first available person. When a retail clinic sees a patient, they only address the problem the patient complains of. When I see the patient, I address not only that problem, but all their medical issues, and all overdue preventive and chronic care. Admittedly, there is a trade-off for the patient between convenience and continuity; I can never guarantee the specific date and time a patient wants. If you believe in

the value created by the trusting patient–primary care relationship, then it makes sense to incentivize opportunities to maintain that relationship.

Here are some other continuity considerations:

> Care outside of the usual 8-5 weekday hours costs more to deliver but is convenient and keeps patients out of the emergency department. It should be paid for at a higher rate.
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> Home visits flatten the interaction with the patient and their family, and are incredible relationship-building opportunities. They are very expensive for the primary care team to do, given the fixed overhead of an office and the travel time. They should be paid for at a higher rate.
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> Hospitalists are here to stay. Yet many patients feel abandoned by the PCP they trust during one of the most vulnerable periods of their care. PCP visits to the hospital should be paid for even when the patient is being cared for by a hospitalist.

PAYMENT REDESIGN FOR PRIMARY CARE

New revenue must flow into primary care. Primary care payment redesign cannot be about rearranging deck chairs on the Titanic. Only 5.6% of total health care spending goes to primary care in the U.S. (versus 14% in other developed countries). Recent work suggests that for Medicare patients, it may be as low as 2.12%. If resources are fixed, incentivizing relationships can only result in damage to accessibility, comprehensiveness, and/or coordination.

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It is absurd to compare the cost of this proposal to the status quo. The primary care status quo is unstable. The profession is shrinking. Without some intervention, we are moving to a system where primary care will be a luxury for the richest who can pay cash for it; the poorest, since there will always be doctors committed to the needs of the underserved; and those who are lucky enough to work for an employer who is willing to make the investment to build their own primary care outside the current reimbursement system. Everyone else we be left to navigate health care on their own, with the resulting poorer outcomes and higher costs.

PAYMENT FOR TIME

Time is by far the best proxy for relationships — and the most doable. It is absurd to believe anyone can create a documentation and coding system that can measure how much trust was created in an encounter. Even if possible, such a system would clearly be burdensome for the PCP, thus failing the "relationship impact" test.

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There are two major concerns about billing based on time. Traditionally, it's been fairly easy to inflate time actually spent with the patient. Today's EHRs already know when providers are working and who's in the room with a patient. That data could then automatically be aggregated for billing, saving time during the visit and eliminating guesswork, inaccuracy, and keeping clinicians from billing two patients simultaneously (outside of shared medical appointments). Having the EHR bill for time automatically would also save the new non-MD primary care team members the irritation and waste of having to learn to use a new coding system.

The second concern is that some of the time spent with the patient will be spent discussing the patient's kids, the physician's kids, the patient's dog, or the physician's dog. The key point of this paper is to say, "that's not just ok, it's what we are hoping for." Chitchat provides valuable information to the clinician about the patient's lifestyle, stressors, and what will motivate them to make changes. More important, it's during the chitchat that the trusting relationship is born, when the patient has an opportunity to know the PCP as a human being and to decide whether they are deserving of their trust.

(Primary care work that has no direct relationship benefit — such as procedures, work that does not directly involve the patient, or basic data collection and processing — should be paid with a flat fee, to encourage doing the work as efficiently as possible.)

Shortcomings Of Current Systems

In theory, reimbursement models in place today, whether volume- or value-based, have elements that should support the trusting relationship between the patient and the primary care provider. Clearly, the status quo is not working.

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FEE-FOR-SERVICE

It is interesting to note that the average office visit in the United States is getting longer, even though patients perceive it to be getting shorter. Obviously, office visits are a great opportunity to build relationships. Unfortunately, that relationship-building time continues to be squeezed.

Some of this reflects poorly designed EHRs, and time that must be spent on the new work of population management and care coordination. But starting in 1995, visits have also had to fulfill the rules of evaluation and management coding. The coded level (typically 99213 or 99214 for PCP visits), and hence the reimbursement, usually comes down to how many review-of-systems questions were asked and how many parts of the patient's body were examined. This made E&M coding an exercise in reimbursement for documenting negative findings, needless exams or patient questionnaires, or pasting in a review-of-systems only distantly related to what took place during the visit — none of which has anything to do with building trusting relationships.

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Interestingly, CMS has recently committed to addressing the waste of E&M coding, allowing time to be used as the basis of evaluation and management coding starting in 2021.

CAPITATION AND ACCOUNTABLE CARE

Capitation is clearly a form of pay-for-relationship, given that all revenue travels with the individual patient. Ideally, a small reimbursement multiplier would be added for each year a patient continues with their PCP, creating an incentive to keep the relationship healthy. In fact, capitation should directly incent trusting relationships, while P4R as proposed above incents only processes that, hopefully, result in trusting relationships.

Yet, capitation continues to shrink, and Accountable Care Organizations have had mixed results. Small numbers of patients can create large swings in total patient cost of care and dicey ethical issues. Modelling has shown an independent practice moving from fee-for-service to capitation doesn't break even until 63% of its revenue is capitated, a transition unlikely to happen fast enough for the practice to financially survive. Even small health care systems lack financial resources to hire the team to provide population management and care coordination in hopes they meet goals and receive ACO payments years in the future.

Medicare has tried to address many of these issues with the Primary Care First model. It will be interesting to see how many PCPs sign up for the model, and whether they use the monthly payment to build teams and grow relationships, or to increase the PCP's income. I am concerned the model is not designed to move nearly enough of health care spending to primary care for a practice to successfully provide all four Cs of primary care.

The design principles of P4R eliminate the upfront cost to the practice or system of hiring the team to provide the four Cs of primary care needed to be successful in capitation and ACOs. It also ensures new money flowing to primary care is spent in a way that will benefit patients.

Lastly, more physicians are now employed than independent: 57% of family practitioners and 47% of general internists are employed, and with 70% of physicians under age 40 choosing to be employed, that number will keep growing. As Bruce E. Landon recently pointed out, most accountable care organizations continue to budget and pay physicians based on the existing fee-for-service system. Most capitated systems are not going to do the hard work of developing their own methodology to compensate PCPs and redistribute revenue within their system. So even if the majority of care is going to be provided by capitated systems, there still needs to be a fee-for-service payment system that incents trusting relationships.

CONCIERGE CARE

It is interesting to note that concierge care is a reimbursement system in which the trusting relationship is directly paid for, in this case by the patient. It is probably the only way an independent physician can provide four-Cs primary care without the conflicts that come from being employed by a large health care system.

However, like many of my colleagues, while I understand concierge care is a solution for PCPs and their patients who can afford it, I find any answer to the primary care crisis that doesn't meet the needs of all Americans, rich or poor, unacceptable.

You Get What You Pay For

A decade ago we promised the ***transformation*** of primary care. Primary care redesign has been more work and taken more time than the word transformation implied. In retrospect, a better word choice would have been ***evolution***. Evolution is a wonderfully elegant idea, only requiring two things: variation and selective pressure. The amount of variation in primary care, especially as it relates to access, comprehensiveness and coordination, in the last decade is inspiring.

> *PCPs want trusting relationships. So do patients. It's time to create a health care system where that trusting relationship is valued."*

The ugly truth is that selective pressure in health care is money: how insurance pays and how a health care system divides up that payment. The health care system we end up with will be determined by that selective pressure. If we pay for high tech, we will get high tech. If we pay for hospitalizations and drugs, we will get hospitalizations and drugs.

I want the health care system I work in, and the health care system I am a patient in, to be accessible. I want that system to make sure all my medical and psychological needs are met in a comprehensive, coordinated way. I also want it to be one that I trust, that trusts me, and that knows me as an individual human being. The trusting patient-centered relationship over time has created too much health, eliminated too many disparities, saved society too much money, brought me so much joy as a primary care clinician, and hopefully so much joy for my patients, to be allowed to slowly wither and die.

My dad told me you get what you pay for. PCPs want trusting relationships. So do patients. It's time to create a health care system where that trusting relationship is valued.

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