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After COVID-19: How To Rejuvenate Primary Care For The Future

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Primary care practices, for years changing at a snail's pace, have undergone a revolution in a few short weeks. Up to now, primary care has been driven by the face-to-face medical visit, which has today been rendered obsolete and harmful by the social and economic upheaval of the coronavirus pandemic. The number of distance visits—

specifically defined as e-visits, phone visits, and video visits—has exploded, leading to a breathtaking change in primary care. But will we return to our old ways once the pandemic has played itself out?

This blog post considers: Why should distance visits become the new normal for primary care? What are the barriers? And which policies could help overcome those barriers?

We believe a positive outcome from the devastation of the virus could be the rejuvenation of primary care.

Primary Care Should Permanently Increase Distance Visits

Primary care is in trouble. A Merritt Hawkins "secret shopper" survey found that primary care wait times grew by 30 percent from 2014 to 2017. With poor primary care access, patients are going elsewhere. Acute primary care visits per capita dropped by 30 percent from 2002 to 2015 while urgent care, retail clinic, and emergency department visits increased.

For clinicians, primary care is no longer "do-able." According to Kimberly S. Hawblitzel Yarnall and colleagues, it would take 21.7 hours per day to care for a standard patient panel of 2,500. Family medicine burnout rates exceed 50 percent, leading to clinicians reducing their hours, thus further restricting patient access. Direct observation of 57 physicians found that 27 percent of their average day was spent face to face with patients; 49 percent was consumed in electronic health record and administrative work. To make matters worse, primary care in the US receives only 6–8 percent of health care expenditures compared with an average of 12 percent in other developed nations.

Ending the hegemony of the face-to-face visit and rebalancing the appointment template toward 50 percent distance visits are likely to improve patient access while reducing work and burnout.

Studies are mixed but suggest that e-visits and phone visits reduce the number of face-to-face visits and take less time for clinicians and staff. When the Kaiser Permanente system in Hawaii massively changed its primary care model in 2004—with e-visits and phone visits increasing sixfold and eightfold, respectively—office visits decreased 26.2 percent.

Multiple studies demonstrate that these visits can provide high-quality care for a large number of medical conditions. To list only a few examples, most diabetes and hypertension can be followed through e-visits with home monitoring. Common musculoskeletal problems can be diagnosed and treated via video-visit observation. For

years, the Veterans Health Administration has cared for seriously ill people at home through video technology. Boston's Medically Home has created a virtual hospital at home for high-acuity patients, with monitoring equipment allowing distant clinicians to check pulse, blood pressure, respiratory rate, and EKG; listen to heart and lungs; assess patients' neurological status; assist with mental health problems; reduce social isolation; and reduce hospital admissions.

Distance visits rescue patients from losing time at work or school, from arranging transportation and parking, and from crowded waiting rooms. Surveys find that 60 percent to 80 percent of patients, including the elderly and those using community health centers, appreciate phone and video visits. One survey found that 63 percent of patients and 59 percent of clinicians reported no difference in quality between office visits and video visits, with 53 percent of clinicians stating that video visits were more efficient.

As urgent care and retail clinic visits climb, primary care practices struggle to preserve continuity of care. Offering prompt access to patients' primary care clinician via phone or video can enhance both continuity and access, avoiding urgent care and retail clinic encounters. Moreover, millions of phone and video visits are offered by private companies such as Teladoc, unlinked with patients' primary care. These visits undermine the longitudinal therapeutic relationship, spawn additional face-to-face visits, and increase costs. These fragmented encounters can be avoided when primary care permanently ramps up distance visit capacity.

Barriers To Overcome

Payment

For years prior to COVID-19, most e-encounters and phone visits were not reimbursed. As the pandemic spread in early 2020 and Americans stayed home, clinics across the country lost millions in revenue because they were financially reliant on face-to-face visits.

Effective March 6, 2020, Medicare expanded its coverage, reimbursing distance visits at the same rate as face-to-face visits, although documentation continues to be burdensome. Also in March 2020, several state Medicaid programs initiated distance care payment. Private insurers have stepped up, in some cases waiving copayments. The coronavirus is helping to solve the payment problem with major expansions of telehealth payment. However, according to the Medicare Telemedicine Health Care Provider Fact Sheet, these policies are programmed to expire when the emergency is over.

Organization

The typical practice has an appointment template mandating face-to-face visits every 15–20 minutes throughout the day. Prompt attention to e-messages is a low priority, and many patient-initiated phone calls are hurriedly answered at lunch or after work. In fact, the percentage of primary care practices offering phone visits declined from 2008 to 2015. Years of improvement efforts have shown that re-engineering primary care workflows is a big challenge, but now the virus is by necessity changing these workflows.

Key Policies Could Help Overcome The Barriers

Global Budgeting

To facilitate distance visits in primary care, fee-for-service reimbursement with its time-consuming documentation is not appropriate. Distance visits are common at globally budgeted systems such as Kaiser Permanente where the system receives a fixed payment per patient regardless of the number of services performed, and clinicians are paid salary plus quality incentives. A silver lining from the pandemic could be the exit of fee-for-service and adoption of global budgeting for primary care. Practices and clinics could repurpose money and personnel used for billing toward patient care. Burnout would likely decrease.

Investing In Primary Care

Until fee-for-service ends, the virus-related efforts of Medicare, Medicaid, and private insurance to reimburse distance visits are necessary but not sufficient. Primary care practices need to step up to the plate to create a new balance between face-to-face and phone/video visits—perhaps 50/50. Remember the HITECH Act of 2009 that incentivized medical practices to adopt electronic medical records? Practices had to painfully reinvent themselves to implement the legislation's requirements. Similarly, to rebalance visit types, practices will need time, commitment, and an infusion of funds. Let us not forget that primary care receives a scant 6–8 percent of all health care spending. To qualify for funds, practices would have to retool themselves: put their technology in order, create appointment templates that are doable for clinicians, agree on clinical protocols to ensure quality and appropriateness, and educate and collaborate with patients.

Rethinking HIPAA

HIPAA rules for distance visits, softened during the pandemic, should be permanently relaxed. For example, encryption of e-visits could be waived for patients who agree.

Promoting Continuity Of Care

Continuity of care with a personal clinician should be a requirement for practices receiving financial assistance for distance care retooling. As much as possible, patients should only interact with their personal clinician, the clinician's team, or specialists/ancillary providers referred by their clinician.

A Research Agenda

Observational research including time-motion studies of primary care practices could learn the extent to which phone and video visits reduce the need for face-to-face visits, whether they cost less, take less time, add capacity to see more patients, and improve access. Research could also measure clinician, staff, and patient acceptance of these visits and whether a rebalancing of visit types reduces burnout.

Conclusion

The coronavirus pandemic is a plague upon humanity. Yet, in small ways, crisis brings forth opportunity. If any positive consequence of the virus is possible, it might be the transformation of primary care for the sake of its patients, clinicians, and staff.

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