A Pandemic-Inspired Transformation of Primary Care

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ABSTRACT

Lessons learned from the current COVID-19 pandemic can be harnessed to reengineer and restructure the current primary care paradigm with an eye toward advancing population health for years to come. During this pandemic, primary care in particular has again demonstrated its value to the healthcare system in the US and elsewhere through its agility to adapt to a broad range of healthcare settings. Guaranteeing the preservation, stabilization and growth of primary care practices and disciplines is paramount to ensure that this foundation of the healthcare system survives. Holding on to pre-pandemic paradigms will also significantly increase the risk of being unprepared for the next challenges to the healthcare system and to the health of the population.

On January 31, 2020, Health and Human Services Secretary Alex M. Azar II declared a Public Health Emergency for the entire US to aid the response of the healthcare community to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) pandemic. The first death attributable to SARS-CoV-2 infection was reported on February 6, 2020 and, at the time of this writing, the SARS-CoV-2 pandemic continues to foment morbidity and mortality on a scale previously unseen since the 1918 H1N1 influenza pandemic. Concurrently, the pandemic appears to have launched a radical transformation of the US healthcare system, including its primary care enterprise. How primary care is reimagined and reinvigorated by the pandemic is bound to reshape the US healthcare for generations to come. It is the objective of this commentary to advocate that the lessons learned from the pandemic be harnessed to reengineer and restructure the current paradigm with an eye toward advancing population health for years to come.

INTRODUCTION

Over the last decade, a re-energized version of primary care involving family medicine, primary care internal medicine and pediatrics, has emerged with a renewed focus on the health of individuals, communities, and populations. Viewed in this light, the importance of primary care in general to overcoming the pandemic cannot be overstated. Though intensive care units and emergency departments have rightfully assumed the limelight, primary care has quietly emerged as a critical resource during this global calamity. The pandemic has drastically increased the role of primary care as the first point of contact, just as it has amplified the critical role of intensive care units at the other end of the care spectrum. This crisis has made it clear that every American benefits from a robust primary care relationship, if for no other reason than to facilitate screening and triage of SARS-CoV-2-exposed symptomatic and asymptomatic patients. Those without primary care providers (PCP) are left to fend for themselves, replete with the need to secure SARS-CoV-2 testing absent an order by a PCP. In addition, PCPs have continued, albeit with some limitations, to provide preventive services as well as manage the burden of acute and chronic diseases.

PRIMARY CARE RESPONDS TO PANDEMIC

The agility of primary care and of PCPs has been repeatedly showcased during the SARS-CoV-2 pandemic. Indeed, PCPs stepped in at multiple healthcare junctures – be it in primary care clinics, outpatient respiratory clinics, or inpatient hospital wards. In so doing, PCPs have proven invaluable in a context wherein specialties have often been sidelined due to the narrower scope of their practice. Concurrently, long overdue modifications to primary care practices in terms of their care delivery models have been put in place at an unprecedented pace. Telehealth is a case in point. After decades of slow to moderate growth, telehealth has recently expanded at an exponential rate and by all accounts is here to stay. "Going Virtual" and telemedicine are the new buzzwords as primary care practices moved within days and weeks to shift the majority of their visits to virtual telephonic, video, text, and email media.[1] Viewed in hindsight, none of this is surprising. What should have been recognized earlier is the reality that many of the services afforded by PCPs do not require in-person interactions. Moreover, telemedicine has previously been proposed as a potential solution to the provision of healthcare in a public health emergency so as to "provide the right care at the right time in the right place."[2] Finally, greater reliance on telemedicine fits in well with the changing demographic landscape wherein younger generations prefer and expect rapid, convenient responsiveness to their needs and requests. One of the rate-limiting challenges

to the widespread adoption of telemedicine prior to the SARS-CoV-2 pandemic was the element of reimbursement. This stumbling block has since been temporarily rectified by the waiving of section 1135 of the Social Security Act by the Centers for Medicare & Medicaid Services.[3] Continued reliance on virtual medicine post-pandemic seems likely at this point; yet to be determined is the willingness of insurers to continue to cover this vital service.

UNDERFUNDED IN US

While the SARS-CoV-2 pandemic has reaffirmed the importance of primary care to the healthcare system, the foundation upon which it rests remains in peril from years of underfunding and neglect. A recent analysis points out that no more than 5-7% of healthcare dollars were being spent on primary care services in a given year. This level of investment compares poorly with the reality of member nations of the Organization for Economic Co-operation and Development, which spend approximately 14% of their healthcare resources on primary care services and appear to enjoy better healthcare outcomes than the US.[4] Financial issues have also jeopardized much of the US healthcare system. While healthcare systems are overwhelmed with SARS-CoV-2 patients, the Gross Domestic Product (GDP) of the US dropped a record 4.8% in the first quarter of 2020, with a significant drop in healthcare spending being a major cause.[5] Primary care practices are not immune to this drastic reduction in healthcare spending. In fact, in many primary care practices, the in-person visit volumes have dropped by as much as 80%, and are at risk of going out of business. The availability of primary care unequivocally reduces population level mortality,[6] improves health outcomes, and reduces emergency department visits, hospital admission, readmission rates and costs.[3,7,8] Sacrificing primary care now will create a tidal wave of future deleterious consequences including everything from untreated diabetes leading to heart disease, unscreened cancers leading to metastasis, undiagnosed depression leading to substance use and much more – lasting well beyond this global pandemic.

STRENGTHENING PRIMARY CARE NOW AND POST-PANDEMIC

There are both short- and long-term steps to strengthen primary care during this current pandemic and for healthcare's post-pandemic phase. Medicare's announcement of pay parity for telemedicine visits in April 2020 is a step in the right direction and should be moved from "temporary" to "permanent." The Small Business Administration's Paycheck Protection Program (PPP) and the ability of primary care practices to access funds from this program was another key intervention. In the long-term, however, re-examining how PCPs are paid for the care of patients will be critical. The current "fee-for-service" payment paradigm is showing itself to be unworkable during the pandemic. It bears repeating that just as the US is in the midst of the greatest healthcare crisis of the century, healthcare systems – from solo practitioners to the mega-systems – are in financial chaos. This is not happening in countries where universal health care is the rule or wherein value-based payments or capitation arrangements are the status quo. It is uncertain whether or not there exists the necessary political will to overhaul our system. Still, note must be made of renewed calls to move away from payment for episodic care towards global payments for the care of patient populations in a manner that is equitable and just.

Primary care has demonstrated time and time again its value to the healthcare system in the US and elsewhere. During this pandemic it has moved with agility to adapt to a broad range of healthcare settings, proving its worth yet again. To ensure that this foundation of the healthcare system survives, during this healthcare crisis and the likely crises to come, guaranteeing the preservation, stabilization, and growth of primary care practices and disciplines is paramount. Holding on to pre-pandemic paradigms will also significantly increase the risk of being unprepared for the next challenges to the healthcare system and to the health of the population. Finally, we must ask ourselves and our leaders, "If not now, when?" and avoid missing this opportunity for fundamental reform.

References

1. Etz R. COVID-Survey. https://www.green-center.org/covid-survey. Accessed May 8, 2020.
2. Hollander JE, Carr BG. Virtually Perfect? Telemedicine for COVID-19. N Engl J Med. 2020; 382:1679-1681. DOI: 10.1056/NEJMp2003539
3. Medicare Telemedicine Health Care Provider Fact Sheet. Mar 17, 2020. CMS.Gov. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Accessed May 8, 2020.
4. Jabbarpour Y, Greiner A, Jetty A, et al. Investing in Primary Care: A State-Level Analysis. July 19, 2019. https://www.milbank.org/publications/investing-in-primary-care-a-state-level-analysis/?gclid=EAIaIQobChMI45_Jm6Cd6QIVqdSzCh1h-1QjkEAAYASAAEgKkIPD_BwE. Accessed May 8, 2020.
5. Federation of American Hospitals. COVID-19 Alert: Dramatic GDP Reduction Reflects Unprecedented Financial Stress on U.S. Hospitals. https://www.fah.org/fah-ee2-uploads/website/documents/COVID-19_Alert-Dramatic_GDP_Reduction.pdf. Accessed May 8, 2020.
6. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015. JAMA Intern Med. 2019;179(4):506-514.
7. Chetty VK, Culpepper L, Phillips RL, et al. FPs Lower Hospital Readmission Rates and Costs. American Family Physician, May 1, 2011. Am Fam Physician. 2011;83(9):1054.
8. Starfield B, Shi L, Macinko J. Contributions of Primary Care to Health Systems and Health. Milbank Q. 2005;3:457-502.

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