Primary care practices will be continually challenged to drive clinical transformation and care coordination across the continuum as more and more systems evolve to care for patient populations. This transition will have a major impact on practices and require significant cultural and operational shifts away from the status quo.

A basic premise of effective population health is the need to expand one’s reach to a large population and manage care effectively across the continuum. To accomplish this successfully, it is important to not only consider the number of primary care physicians within a practice but also the composition and size of a physician’s panel. Under this new paradigm, considering physician numbers alone is not sufficient. Practices must also examine the ease of physician access and the access experience that the practice, the physician, and the care team at large create. Understanding each physician’s panel and the unique patients who comprise the panel is key to success in this evolving healthcare environment.

Reinventing the primary care practice requires going beyond the status quo and asks us to consider how care is delivered, to whom, and where.

High-Touch, Low-Touch

Physicians will need support to build individualized care teams that bolster their distinctive patient populations and allow them to effectively manage large patient populations. It is increasingly important to consider the types of patients treated and the resources required to maintain their health, whether it is high-touch (frequent visits, routine follow-up calls, care management support services) or low-touch (self-help, email, e-visits).

A one-size-fits-all approach to care limits effectiveness as we evolve and disruptive innovators enter the marketplace.

Understanding each physician’s panel is key to success in this evolving healthcare environment.

Practices must evaluate panel sizes as a first step in building individualized care teams to support specific patient needs. Each physician panel’s disease burden can be assessed based on condition-specific criteria and risk factors as well as nonclinical factors such as socioeconomic indicators and healthcare literacy. This includes compiling risk factors and condition-specific information from the electronic health record (EHR), claims data, active disease registries, or other in-place data-warehousing solutions.

Additional resources, such as howsyourhealth.org, are available to help practices stratify patient panels based on nonclinical elements, including patient-identified care needs and concerns, patient health perceptions, and geospatial mapping tools such as PatientAccess, an application developed by GeoHealth, Inc., that maps geographic relationships between physicians and patients.

Tools such as these reveal patient needs and agendas that the office may miss. They also benefit by identifying groups of patients with similarly reported conditions and build on existing disease registries. Identifying the unique characteristics of each physician panel within the practice and the practice as a whole...
establishes a well-defined baseline for deploying staffing resources most effectively.

**Team Roles**

Once the panel is evaluated, the practice can start to identify the type of care team required to support the population of patients at hand and specific roles and responsibilities of each team member. For example, if a physician has a high volume of chronic care patients, a high-touch, high-contact delivery model with care managers and health coaches could be evaluated to continuously engage patients in their care. For panels with high commercial, healthy populations, increased use of advanced practice clinicians to provide easy, convenient access would be appropriate, as would deployment of clinical educators and nutritional counselors for panels with high incidences of diabetes. In locations in which transportation or illiteracy are challenges, community resources could be engaged or the use of home visits evaluated as a means to deliver needed care.

When we consider a care team structure, we often tend to think of teams in silos supporting only one physician or pod of physicians. Some team members, such as medical assistants, may be assigned to a particular care team or pod while other members may support multiple care teams, depending on the incidence of disease and the need for that particular skill set in managing the population. For example, a physician with a high rate of patients with diabetes will need more support in that area, including diabetes educators, nutritionists, etc., than a practice with few diabetic patients. By stratifying the patient panel and understanding its unique population needs, practices can move beyond the one-size-fits-all model and effectively manage limited staffing resources while improving population health.

**Virtual Access**

To drive clinical transformation, providing a best-in-class experience that connects patients when and how they desire care is increasingly essential. Incorporating access touchpoint modalities such as virtual visits, online chat features, self-help patient portals, email communication, and call centers in a cohesive fashion across practices builds brand loyalty and increases the “stickiness” quotient. Same-day access availability is essential to ensure patient appointments are offered on the day patients call so they are not inclined to go elsewhere. Offering expanded hours and/or developing relationships with urgent care centers avoid expensive and potentially unnecessary visits to the emergency department.

Optimizing the patient portal is essential to engaging and interacting with patients. Interactive email, scheduling, and registration capabilities optimize the patient portal. Patients should be allowed to complete health histories and make copayments online prior to their appointment to avoid costly delays in the office. The patient portal should be the go-to site for patients, including links to reputable Internet sites, reminders for preventative and other follow-up care, as well as the ability to connect with physicians or care team via secure email. According to a study published by *Medical Care* in May 2014, “Use of the refill function through an online patient portal is associated with improved adherence to statins in an integrated health system.”

Furthermore, for patients who want or need phone access to an individual, creating a phone application provides patients with a ready source to answer immediate health concerns so they don’t have to go outside the practice’s sphere of influence. For example, the application can link to a branded call center that provides immediate response to health questions and concerns. These centers can easily address patient concerns, or they can refer the patient to the most appropriate care site, depending on the problem to be resolved. Patients need to play an active role in their care in this new healthcare environment, and providers must provide increased access modalities and education to engage patients in these new accountability expectations.

**Data Analysis**

Finally, to lead the market and create brand differentiation and value, primary care practices must actively demonstrate performance-to-quality and cost measures. Tracking, analyzing, synthesizing, and reporting meaningful data at the provider level are critical to competing in the population health environment; this requires sophisticated population health management infrastructure and informatics across the network. Integrated technology and automated dashboards to track and report on quality performance measures will be critical to maximize pay-for-performance dollars. Such technologies gather and analyze clinical data on physician and practice use rates to assess if standard care protocols and best practices are being followed. Practices should monitor the incidence of tests and procedures to ensure they are performed only when necessary, thereby eliminating wasted care by testing wisely and implementing best practices across the network.

The EHR provides one source of data, but the
ability to aggregate data with payers, data warehouses, and other emerging technologies such as geographical information systems (GISs) allows for understanding specific geographic trends and patterns in care delivery and wellness as well as supporting holistic care delivery. The public health and epidemiology arenas have used GIS for decades, but its recent application to population health, incorporating where we live, work, and interact with our overall health status and well-being, is of most interest today. GIS is a tool that helps us understand the impact of our environment on health status. Healthcare decision-making and clinical practice have not traditionally included the use of spatial data; including this type of data has strong advantages.

Ethan M. Berke, M.D., associate professor of community and family medicine at the Dartmouth Institute for Health Policy and Clinical Practice, considers the benefits that can be achieved by integrating GIS into clinical practice: “GIS technology, spatial analysis, … location of clinical services, and information from our patients about their perceived environment can be integrated to better understand the context in which people live healthy or unhealthy lives. Place becomes a vital sign—as important as a blood pressure, pulse, or pain score in providing optimal primary and secondary care to our patients.”

Furthermore, Christopher L. Simpson and Laurie L. Novak in a 2013 American Medical Informatics Association (AMIA) study discuss the impact of place on the walkability score. The study “revealed that members of lower income communities were more likely to report high crime rates as a barrier to physical activity,” and “as this is one of the specified activities recommended for many chronically ill patients, healthcare providers alerted to the low walkability score in a specific patient’s neighborhood can take steps to assist the patient in identifying alternatives for getting exercise.” GIS is a powerful tool in population health management that is a real benefit when integrated with other data sources and appropriately incorporated into

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the care team’s overall care plan.

Practice transformation and reinvention go beyond the status quo and require us to think differently about how we deliver care, in addition to where and by what means that care is delivered. They also make us think about the types of data we look at and how we use them. As practices evolve, we must think about providing care in an entirely new manner that crosses the continuum, takes into account individual health status, creates a best-in-class patient experience, enhances patient access and care coordination, and supports exceptional value. These tenets lay the foundation among providers, employers, payers, and patients and are key success criteria for all practices, regardless of size.

References

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