How to Design the Cost-Effective Clinical Workforce
Hospitals can’t continue to rely on **outdated clinical network strategy**.

Hospitals and health systems have long relied on a common clinical network strategy: amass as many physicians as possible. Driven by fears of a looming physician shortage and the volume-based incentives of the fee-for-service payment system, hospitals focused on partnering with physicians to fuel growth.

But this strategy is based on three outdated assumptions:

- Physicians serve as patients’ health care agents. More physicians in our network means more patients.

- There’s a scarcity of physician talent. Physicians who aren’t with us are against us.

- We face a limited set of competitors. We compete with organizations that look like us, namely other hospitals and ambulatory care sites.

All three of these assumptions are faltering. In fact, patients are becoming active retail shoppers for both coverage and care; there may not be a physician shortage; and disruptive innovators are entering the market.
At the same time, hospitals' clinical network aspirations are evolving. The goal isn’t just to amass the most physicians in a market anymore—you want to build a cost-effective clinical network. The network of the future needs to have the right number of providers to match emerging patient demand. It needs to be more collaborative and accessible. And most important, it needs to reliably deliver high-quality, low-cost care to compete in the new value-based health care market.

So hospitals and health systems need a new clinical network strategy, designed to deliver three distinct products:

1. Acute Care Episodes
2. Population Health Management
3. On-Demand Patient Access

Read on to learn more about why the old assumptions guiding clinical network strategy no longer hold true—and to find out how leading organizations are deploying the clinical workforce of the future.
Physicians no longer serve as patients’ sole health care agents.

Historically, physicians have served as patients’ primary health care agents. Physicians retained exclusive access to clinical information and controlled referrals, making them indispensable when patients needed to make health care decisions. So to get more patients, hospitals needed to cater to their physicians.

But this dynamic is quickly changing. Patients still turn to their physicians for guidance, but they have to factor narrowing networks and rising deductibles into their care decisions, too. They also have access to more information and new tools—including thousands of mobile apps—offering unprecedented transparency into provider cost and quality, as well as insight into conditions and treatment options.

All roads to patients no longer run through physicians.
Respondents age 25 to 34 prefer fully active roles in care decision making.
The **physician shortage** is not a foregone conclusion.

In recent years, clinical network strategy has also been driven by fear of a looming physician shortage. Hospitals have focused on amassing more physicians than competitors, fueling a huge increase in hospital-physician partnership activity.

But shortage projections are based on outdated estimates of physician supply and demand. New care models and technologies are improving physician efficiency and increasing effective supply, while population health efforts and the retail insurance environment are reducing demand.

We modeled the future of physician demand and supply, examining a market with 100,000 patients and applying different care management scenarios. Under a move to either moderate or aggressive degrees of care management, physician demand drops dramatically.

And this isn’t just an academic exercise. Organizations with experience in population health management are already experiencing declines in physician demand, especially for certain specialists.
Impact of Population Health on Specialist Demand

Change in Percentage of Physicians Needed

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Shift from Loosely Managed Population to Moderately Managed Population</th>
<th>Shift from Loosely Managed Population to Well-Managed Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmologists</td>
<td>-22.3%</td>
<td>-44.5%</td>
</tr>
<tr>
<td>Non-invasive Cardiologists</td>
<td>-22.3%</td>
<td>-44.6%</td>
</tr>
<tr>
<td>Anesthesiologists</td>
<td>-17.3%</td>
<td>-34.5%</td>
</tr>
<tr>
<td>Diagnostic Radiologists</td>
<td>-20.7%</td>
<td>-41.4%</td>
</tr>
<tr>
<td>Dermatologists</td>
<td>-15.9%</td>
<td>-31.9%</td>
</tr>
</tbody>
</table>

Population Health Management Modeling Assumptions

- Model based on capitated population of 100,000 covered lives in Springfield, Missouri.
- Selected population is similar to the average population of 100,000 people in demographics (age, sex, race) and insurance (Medicare, Medicaid, commercial) characteristics.
- Model uses utilization rates per 1,000 as its care services benchmark, defined by Milliman, as encounters for professional fee claims; focus of analysis is restricted to physician claims (i.e., Part B claims) and does not include facility or drug claims.
- “Well-managed” refers to the highest degree of medical management, including substantial utilization review, preauthorization, and case management.
- “Moderately managed” refers to a moderate degree of medical management in the ways described above.
- “Loosely managed” refers to a nominal degree of medical management typified by non-HMO, large insurers, in the ways described above.
- The Medical Group Management Association (MGMA) physician productivity data used in the model are reported in encounters per physician per annum, segmented by specialty and performance quartile. For the purposes of this modeling, the median performance quartile was selected.
Hospitals face new competition from disruptive innovators.

Hospitals traditionally haven’t faced diverse competition, but that’s changing quickly. Walmart, Walgreens, and CVS are all investing in storefront delivery models. Technology firms are building new platforms to connect patients with providers, threatening to bypass established patient-provider relationships. And innovative providers are redesigning primary care models, setting a new standard for patient access and convenience.

These new competitors identify specific consumer needs, then develop and sell a solution. And their solutions generally don’t require hospitals’ high-cost infrastructure or physician-centric care models.
And these disruptors understand what patients want: access. We recently asked patients to rank the key drivers of how they select primary care providers, and on-demand access figured in 6 of the top 10.

The New Access Standard

- Consumer-centered hours
- Conveniently located
- Widespread availability
- On-demand services

Patients’ Loyalty Driven by Access

Choosing a PCP

- 67% Consumers listing convenience as top factor

Changing Providers

- 39% Consumers reporting they would likely or definitely switch doctors over consistently long wait times

Determining Where to Seek Care

- #1 Ranking of access as preferred primary care attribute among consumers¹
Hospitals need to develop a cost-effective clinical network.

At the same time that legacy network design assumptions are faltering, hospitals’ clinical network aspirations are evolving. The goal isn’t just to amass the most physicians in a market anymore, but to build a cost-effective clinical network that can compete in the new value-based market. Network design strategy is changing in four key ways:

» **First**, hospitals need to rightsize clinical networks to match emerging patient demand. For many organizations, this will mean developing a smaller, more purposefully designed clinical workforce.

» **Second**, hospitals need better labor cost efficiency. Or more simply put, you need lower provider input costs. You’ll need to think long and hard about what roles you need—and how to fill them.

» **Third**, hospitals need a more collaborative clinical workforce. In an outcomes-driven environment, you need providers who are comfortable with collaboration and cooperation.

» **And finally**, hospitals need to be ready to meet the new standard for patient access.
Today’s Challenge

Building the Cost-Effective Clinical Network

Key Attributes

Rightsized
• Sized to meet emerging market demands

Low-Cost
• Consistently delivers efficient, reliable acute care episodes

Coordinated
• Prioritizes care management to limit avoidable demand
• Ensures seamless transitions between sites of care

Accessible
• Supports patients in self-managing care
• Develops and disseminates tools to support patient engagement
The clinical network of the future must deliver three distinct products.

When deploying the clinical workforce of the future, you need to design for three distinct clinical products, each with a different provider staffing model.

Hospitals aren’t getting out of the acute care business, so the focus must shift to delivering acute care episodes in the most cost-effective way possible. Physicians are still central here, but acute care delivery will include more technology and team-based care models to improve efficiency and reliability.

Organizations are also moving toward population health management, but anyone going down this path knows that the investments mount quickly. The best population health managers organize their labor force to improve care for their patients and generate savings for the system—all at an affordable cost. This means creating a scalable population health workforce that combines physicians, advanced practitioners, medical assistants, community health workers, lay caregivers, and even patients.

Meanwhile, patients want on-demand access—and that’s new for many organizations. Virtual care platforms and convenient care sites can help meet this emerging need, relocating the front door of the delivery system away the traditional PCP office.
Designing for Three Clinical Products

- **SCALABLE PATIENT ACCESS**
  - Staff to ensure streamlined patient access to virtual and ambulatory care

- **COST-EFFECTIVE CARE MANAGEMENT**
  - Expand the primary care team to include underutilized practice staff, specialists, community caregivers

- **EFFICIENT ACUTE CARE**
  - Deploy technology and labor substitution to establish cost-effective acute-care enterprise

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- Percentage of Population Served
- Rightsized, High-Cost Capacity
- Network Capacity
- Ample, Low-Cost Capacity
Each clinical product requires different staff, responsibilities, care models, and investments. Even the physician role will vary for each model.

### The Clinical Workforce of the Future

<table>
<thead>
<tr>
<th>Clinical Product</th>
<th>Staff Input</th>
<th>Responsibilities</th>
<th>Production Model</th>
<th>Scalability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Episodes</td>
<td>Transition from siloed practice to team-based care</td>
<td>Practice at top-of-license across acute care settings</td>
<td>Channeled business to highest value physician; use of technology to maximize high-cost capacity</td>
<td>Investment in midlevel staff and technology</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Inclusion of a broad range of lower cost care team members</td>
<td>Deliver top-of-capability care across comprehensive care team</td>
<td>Collaborative, multi-disciplinary care model</td>
<td>Centralization of high-cost providers and infrastructure</td>
</tr>
<tr>
<td>On-Demand Patient Access</td>
<td>Shift away from physician-staffed model to a wide range of alternate providers such as APs, RNs, pharmacists, tech support</td>
<td>Offer accessible, affordable on-demand access; focus on customer experience</td>
<td>Meet market-based benchmarks for service, access, and affordability</td>
<td>Investment in new convenient care sites and virtual care platforms</td>
</tr>
</tbody>
</table>
Designing for Three Clinical Products

1. Acute Care Episodes
2. Population Health Management
3. On-Demand Patient Access
Build **internal referral markets** to channel volumes to the highest performing physicians.

To deliver efficient acute care, you need to change referral behavior so that referral decisions are based on clinical quality and cost rather than long-standing personal relationships.

For example, Nashville-based MissionPoint Health Partners ranks all physicians by quality and volume—and then publicizes the highest-performing physicians across the network. Referring physicians have no question which physicians within the network deserve their referrals.

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**Physician Performance Scores**  
*By Specialty, 2013*

<table>
<thead>
<tr>
<th>Quality</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image.png" alt="Graph" /></td>
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</table>

**Weight Score Formula**

- **40%** 30-Day Readmissions
- **24%** Mortality Rate
- **20%** Average Charges
- **16%** Complications of Case Rate

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**CASE IN BRIEF**

**MissionPoint Health Partners**

- Physician group based in Nashville, Tennessee
- Uses the Advisory Board’s Crimson Continuum of Care software tool to rank primary care physicians, specialists along volume, performance vectors
- Shares data with physician leadership to course correct when necessary
Meanwhile, Sharp Community Medical Group in San Diego is channeling referrals by establishing a two-tiered, performance-based physician network. The group places physicians in the preferred tier based on their quality and cost performance—plus their willingness to collaborate with other physicians. And the broader network provides geographic coverage, keeping the network competitive for large payer contracts.

**Role of Broader Network**
- Provides widespread geographic access
- Mitigates systemic capacity bottlenecks
- Ensures network sufficiency for contracts

**Attributes of Preferred Network**
- Determined by performance, demonstrated willingness to collaborate with colleagues
- Allocated significant IT, care coordination support from network
- Consolidated into price-competitive offerings for wholesale purchasers

**CASE IN BRIEF**
**Sharp Community Medical Group**
- Community physician group located in San Diego, California
- Segments a premium tier of physicians from broader group based on a series of performance metrics, demonstrated willingness to collaborate
- Preferred physicians receive enhanced practice investments from network, inclusion in select managed care and employer contracts
Centralize specialty services to match supply and demand.

Centralizing certain services allows networks to better match provider supply with patient demand.

At Permanente Medical Group, centralized scheduling helps maximize use of existing supply. When patients call to schedule an appointment, they’re offered a choice: wait to see their physician of choice or schedule with a physician from the pool more quickly. The pooled scheduling model ensures that the medical group offers all of its available capacity—and lets patients choose between quick access and seeing their preferred provider.

**Pooled Specialty Practice Model**

<table>
<thead>
<tr>
<th>Orthopedic patient</th>
<th>Protocol practice</th>
<th>Appointment with preferred orthopedist</th>
<th>Scheduling Outlook</th>
<th>Appointment with any physician from pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3 weeks until next available appointment</td>
<td>&lt;48 hours until next available appointment</td>
<td></td>
</tr>
</tbody>
</table>

**CASE IN BRIEF**

**The Permanente Medical Group**

- 8,000-provider physician-led medical group headquartered in California
- Pools specialists to offer patients a choice between waiting to see their first-choice physician and rapid access to another high-performing physician
- Reduces capacity bottlenecks through practice while achieving high satisfaction driven by patient preference for immediate access
But you can’t forget the demand side of the equation. When Partners HealthCare saw its dermatologists’ schedules getting clogged with low-acuity cases, they established a centralized pool of dermatologists to provide virtual skin consults for primary care practices. These consults fully addressed patient needs in nearly half of the cases, protecting live-appointment capacity for the most complex patients.

**Diverting Demand Without Sacrificing Quality**

- **50%**  
  Percentage of questions that can be answered immediately through virtual consult

- **30%**  
  Percentage of patients requiring an in-person follow-up after consult

- **90%**  
  Rate of satisfaction with digital care model among participating patients

**CASE IN BRIEF**

**Partners HealthCare Centers for Connected Health**

- Division of Partners HealthCare, an integrated health system in Boston, focusing on technology-enabled care delivery
- Developed “virtual visits” to triage low-acuity dermatology cases for primary care
- Diverts easily resolved volume, reduces avoidable demand for in-person dermatology
Develop virtual care capabilities to extend specialists’ reach.

Virtual care not only offers a huge opportunity to protect specialist capacity—it also provides an effective way to extend specialists’ reach.

For example, San Francisco-based Dignity Health developed a telemedicine network to provide remote consults to hospitals both within and outside of the Dignity system. The network is expanding its telemedicine offerings from traditional services such as ICU coverage and stroke care to new specialty areas, such as cardiology and nephrology. The model removes geographic constraint—Dignity physicians in San Francisco can easily treat patients across their markets without leaving their seats—allowing the system to expand clinical capacity without adding specialists.

<table>
<thead>
<tr>
<th>Today’s Internal Diagnostic Focus</th>
<th>Tomorrow’s Expanding Care Delivery Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Reach</td>
<td>Services provided in-system to dignity subsidiaries</td>
</tr>
<tr>
<td>Service Offering</td>
<td>Built for traditional diagnostic support <em>(tele-ICU, tele-psychiatry, tele-stroke)</em></td>
</tr>
</tbody>
</table>

**CASE IN BRIEF**

**Dignity Health Telemedicine Network**

- Health system-operated telemedicine network headquartered in San Francisco, California
- Uses employed and affiliated physicians to provide acute care telemedicine internally and to constrained markets outside the system
- Expanding across service lines to deliver cardiology, nephrology services at scale
Surgeons can also extend their reach through virtual technology. At UAB Medicine, new technology—a combination of Google Glass and virtual reality software—allows experienced surgeons to demonstrate clinical procedures with their hands in the digital surgical field, increasing the number of cases veteran surgeons can influence.

**Usage of Google Glass in Surgery**

**CASE IN BRIEF**

**UAB Medicine**
- Academic medical center located in Birmingham, Alabama
- Combined Goggle Glass and VIPAAR virtual reality technology to perform remotely assisted shoulder replacement surgery
- Enables veteran surgeons to advise through real-time videoconferencing, demonstrate technique within surgical field
Employ cost-effective clinician-substitution strategies.

Finally, hospitals and health systems need to radically rethink the labor cost efficiency of acute care. All too often, extraneous administrative tasks, unclear job descriptions, lack of automation, and limited focus on top-of-license care unnecessarily drive up labor costs during care episodes.

For most hospitals, the biggest immediate opportunity involves labor substitution, focusing on the question, “Who does what?” In many cases, the answer will be a lower-cost provider—as demonstrated by the University of New Mexico’s Project ECHO, which upskills PCPs so they can deliver specialty services. Not only is the specialty care provided by these PCPs more labor cost efficient, but the clinical quality is just as good as the care provided by specialists. Project ECHO is currently expanding the range of specialty services PCP are being trained to deliver.

CASE IN BRIEF

**Project ECHO**

- Program developed by the University of New Mexico (UNM) to extend care delivery to the underserved, primarily through a virtual care training platform
- Specialists train PCPs in managing a series of chronic and/or complex disease states
- Currently expanding the program to encompass wider range of services
HCV Treatment Outcomes
Cure Rates Among Genotype 1 HCV Patients

Expanding to a Range of Specialty Services

<table>
<thead>
<tr>
<th>Specialist</th>
<th>PCP</th>
<th>Advanced Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrinology</td>
<td></td>
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<td>Rheumatology</td>
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<tr>
<td>Infectious Disease</td>
<td></td>
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<tr>
<td>Women’s Health</td>
<td></td>
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<tr>
<td>Complex Care</td>
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</tbody>
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Upskilling Physicians
Making Full Use of the Primary Care Unit
But at the cutting edge of clinical substitution, technology-based solutions are replacing certain specialist roles altogether.

For example, Sedasys is an automated propofol infusion machine that allows physicians such as gastroenterologists to perform procedures on healthy patients without the direct supervision of an anesthesiologist or CRNA. The system provides sedation and monitors the patient throughout the surgery—plus offers cost savings between $400 and nearly $2,000 per case.

We modeled the potential labor cost savings, comparing the cost of employing an anesthesiologist and four CRNAs versus the cost of one anesthesiologist and six Sedasys machines. The technology-substitution scenario could save nearly half a million dollars.

**Sedasys Selectively Augments Role of Anesthesiologist, CRNA**

_Elevating Care Quality, Operational Efficiency_

[Diagram showing clinical evolution and operational efficiency with icons for automated propofol delivery, detailed recording capabilities, sustained patient monitoring, and perioperative workflow improvements.]
CASE IN BRIEF

**Sedasys**

- Division of Johnson and Johnson’s Ethicon business division; developed the first computer-assisted sedation system, providing minimal-to-moderate propofol sedation without anesthesiologist/CRNA oversight
- Targeted toward low-risk endoscopies, colonoscopies in healthy patients, with projected savings per case ranging from $450 to $1,850; potential applications to cardiac catheterization, cataract/ARMD procedures, interventional radiology

15M Projected size of current patient population eligible for sedation via Sedasys technology

1 Anesthesiologist + 4 CRNAs = $1M

1 Anesthesiologist + 4 Sedasys = <$500K
Deploy the **advanced medical home** as the foundation of your cost-effective population health strategy.

The first wave of medical homes played a major role in the transformation of primary care, shifting responsibilities from PCP-centered care teams to nurse-driven care, as well as introducing team huddles, health coaching, and proactive outreach to high-risk patients. All of these efforts helped stabilize primary care, getting many PCPs off an impossible fee-for-service treadmill and improving quality of care.

While the early medical homes made improvements over the baseline primary care practice model, they struggled to increase panel sizes and ended up increasing practice labor costs. The next phase of the medical home model focuses on increasing panel size and reducing practice costs.

How? First, you have to off-load all unnecessary tasks from the PCP, while creating more meaningful roles for the rest of the medical home care team.
PCPs should lead the care team, work with the most complex patients, and coordinate with specialists; their other patient care responsibilities must be distributed across the team. RNs and advanced practitioners should take on the higher-level work of diagnosis and treatment, while other PCMH practitioners will need to backfill roles formerly assumed by PCPs, nurses, and advanced practitioners. With appropriate training, medical assistants can take on chart prep, rooming, patient screening, and pre-visit support functions, as well as participate in care planning and oversee practice operations.

### Goals for the Advanced Medical Home

Building on the Critical Elements of the Traditional Medical Home

<table>
<thead>
<tr>
<th></th>
<th>Traditional Medical Home</th>
<th>Advanced Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Team</strong></td>
<td>PCP-centric ➔ RN-centric</td>
<td>RN ➔ MA, non-clinical staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Further prioritization of PCP time</td>
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<tr>
<td></td>
<td></td>
<td>to complex primary care cases</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Team huddle</td>
<td>Streamlined EMR workflows</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Health coaching</td>
<td>Reduced patient idle time</td>
</tr>
<tr>
<td></td>
<td>Proactive outreach</td>
<td>Improved access, virtual contact</td>
</tr>
<tr>
<td><strong>Model Goal</strong></td>
<td>Stabilize primary care</td>
<td>Increase capacity</td>
</tr>
<tr>
<td></td>
<td>Improve quality</td>
<td>Improve quality; decrease costs</td>
</tr>
</tbody>
</table>
Expand your definition of the primary care team.

But to provide truly effective primary care, you'll need to expand the care team well beyond the confines of the traditional practice care team alone.

Community-based practitioners and lay caregivers are a vastly underutilized resource in care management. Community paramedics, in particular, are a great solution for homebound patients lacking familial and social support; they can provide better, less expensive basic home care support and patient navigation than the practice-based care team. And practice staff can never replicate the attentiveness that a lay caregiver will provide to unwell loved ones—a level of engagement that can make the difference between success and failure in care management efforts.

Medical specialists have a role to play, as well, to prevent care fragmentation—especially when you consider that the average elderly patient sees five specialists a year. Some specialists, such as endocrinologists and cardiologists, already focus on care management and longitudinal care delivery, but there’s a much wider range of medical specialists who can and should be incorporated into the primary care network in a more formalized, coordinated, and cooperative way. It’s time to overcome the legacy PCP-specialist divide.
**Top-of-Capability Primary Care Team**

- **PCP**
- **RN/Advanced Practitioner**
- **MA**
- **Community Health Worker**

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**Care Team Extenders**

- **Community Practitioner**
  - Deploy community-based clinicians to deliver timely, inexpensive, culturally appropriate care

- **Lay Caregiver**
  - Empower patient family members with tools to leverage their established relationship and manage care effectively

- **Specialist**
  - Reduce care fragmentation by incorporating medical specialists into the primary care network
Implement a **multi-tiered** care management infrastructure.

To provide cost-effective care management at scale, hospitals and health systems must deploy clinical and non-clinical staff far beyond the PCP or specialist practice. The most effective population health managers have figured out which care management functions should be provided at the system level, which ones should be distributed across practices, and which are best offered at the practice level.

Centralized tasks typically include data and analytic support, clinical guideline development, and telephone-based care management.

Staff that provide some services in the practice but remain too expensive to devote to each one, such as pharmacists or behavioral health specialists, are often distributed across multiple primary care sites.

Staff members providing direct care management remain permanently located in the practice.

This is not a one-size-fits-all solution. Some health systems may find a need for regionalized pharmacy support, for example, while others might employ a full-time practice-based pharmacist.
### Key Questions

What non-primary care needs are prevalent among my patient population?

What in-practice care management roles can be easily scaled across multiple practices?

What care management functions do not need to be done in person?

<table>
<thead>
<tr>
<th>Systemized</th>
<th>Distributed</th>
<th>Practice-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical standards and guidelines</td>
<td></td>
<td></td>
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<tr>
<td>• Patient outreach to fill care gaps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Telephonic management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data analytics</td>
<td></td>
<td></td>
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<tr>
<td>• Risk stratification</td>
<td></td>
<td></td>
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<tr>
<td>• Portal management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Technical support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pharmacists</td>
<td>• Social workers</td>
<td></td>
</tr>
<tr>
<td>• Care coordinators</td>
<td>• Discharge planners</td>
<td></td>
</tr>
<tr>
<td>• Community-based practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other practice support staff based on population need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PCP</td>
<td>• RN/AP</td>
<td></td>
</tr>
<tr>
<td>• MA</td>
<td>• Longitudinal specialist</td>
<td></td>
</tr>
<tr>
<td>• Community health worker</td>
<td></td>
<td>• Community health worker</td>
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</tbody>
</table>
Choose your retail care strategy: find a partner or build it yourself.

Faced with disruptive innovators, providers have two major options to compete for retail clinic business: partner with someone who already knows how to do this well, or build it yourself.

Green Bay-based Bellin Health System’s FastCare program demonstrates the partnership route. Bellin establishes contracts between local retail providers and health system partners, then co-brands the clinics with the local health system’s name. Bellin also provides the marketing and business development platform.

Bellin’s clinics typically require only 24 months to breakeven—much faster than most other retail models we encountered in our research.

CASE IN BRIEF
Bellin Health System
• Integrated health care delivery system based in Green Bay, Wisconsin
• Facilitates development and operation of 35 retail clinics with 25 health systems
Bellin FastCare Franchises Successful Retail Model

Retailer leases space to Bellin

Bellin subleases space to Group X, builds out retail clinic, for monthly fee

Group X wants clinics, but has no experience running model or doing deals with retailers

Key Breakeven Benchmarks

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. charge per visit</td>
<td>$62</td>
</tr>
<tr>
<td>Avg. reimbursement per visit</td>
<td>$33</td>
</tr>
<tr>
<td>Visits per day</td>
<td>20</td>
</tr>
<tr>
<td>Staffing</td>
<td>2.3 NPs/PAs</td>
</tr>
<tr>
<td>Clinical and lab services provided</td>
<td>29</td>
</tr>
<tr>
<td>Hours per week</td>
<td>75–77</td>
</tr>
<tr>
<td>Time to breakeven</td>
<td>24 months</td>
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</tbody>
</table>
Meanwhile, Coastal Medical in Rhode Island developed a homegrown access strategy. The practice keeps one site open every day of the year, including weekends and holidays, and has branded the model through their “Coastal 365” campaign, linking the practice with year-round access to care.

**Coastal Medical Positions Year-Round Access as Quality Improvement Tool**

*Example: Patient Seeking Low-Acuity Care Outside of Traditional Office Hours*

**Typical Options**
- Patient must visit non-Coastal providers, resulting in possible unnecessary costs to system and loss of care coordination

**Coastal 365 Model**
- Open every day; on evenings, weekends, and holidays
- Staffed by Coastal Medical providers
- Improved quality and coordination of patient care, reduced overall cost of care

14% Reduction in ED visits in 2013 after implementing Coastal365 campaign

**CASE IN BRIEF**

**Coastal Medical**

- 85-physician independent practice based in Providence, Rhode Island
- Launched extensive “Coastal 365” campaign to promote year-round access as a unified brand identity among providers, employees, and patients
Invest in virtual care platforms to offer immediate access.

If there’s one thing you should do to compete on the patient access front, it’s develop a virtual care strategy.

Organizations tend to worry about up-front technology costs and physician resistance, but these misconceptions are gradually being overwhelmed by the sheer strategic importance of delivering virtual care. Done right, a successful virtual care strategy allows providers to compete on access while off-loading visits from PCPs to increase panel sizes. Virtual care also provides an inexpensive opportunity to extend your brand and perhaps even attract new patients to the health system.

Establish a Virtual Care Strategy
More Than Just Meeting Meaningful Use Requirements

**Virtual Care Misconceptions**
- “Virtual care is a cost sink; if I invest in the portal and related technologies, it won’t drive any revenue to my organization.”
- “The portal is just a vehicle for Meaningful Use dollars.”
- “My physicians will not get paid by practicing virtual medicine.”

**Virtual Care Realities**
- The portal is the centerpiece for meeting patient demands and effectively competing in your market
- Virtual care provides a ripe opportunity to enhance and extend your brand
- Investing in a portal and related technology allows your PCPs to off-load unnecessary visits, increase panel sizes
Use your virtual care platform to enable comprehensive care delivery.

Virtual care is far greater than just the patient portal alone. A successful virtual care strategy will accomplish three goals:

1. Automate administrative functions, such as appointment scheduling and billing

2. Streamline and simplify clinical transactions, such as sharing lab results and filling new prescriptions

3. Support virtual visits through messaging or live video

This commitment will pay off: virtual care utilization is expected to increase more than 200% in the next four years, with providers projected to see nearly $14B in revenue from virtual visits.
Expanding the Applications of Virtual Care
*From Administrative Transactions to Real-Time Care Delivery*

**Virtualize Care Delivery**
- Asynchronous, message-based visits
- Live, video-based visits

**Streamline Clinical Transactions**
- Deliver online education, shared decision-making tools
- Prescribe new medications
- Receive lab results

**Automate Administrative Functions**
- View medical records
- Schedule in-person appointments
- Refill existing prescriptions
- Pay bill

**Virtual Care Platform Function**

**A Fast-Emerging Market Segment**

$13.7B
Estimated revenue from virtual visits in 2018, up from $100M in 2013

220%
Projected increase in households using virtual care between 2013-2018
Conclusion

There’s **no one-size-fits-all solution** for primary care anymore.

Designing the clinical workforce to support acute care episodes, population health management, and on-demand patient access will result in the end of the traditional primary care practice model. The industry is moving toward a more customized, consumer-centric version of primary care, and the standard one-size-fits-all PCP office model won’t suffice anymore. Neither will the first iteration of the medical home, which makes only incremental improvements on the baseline PCP office model.

There isn’t a single primary care model that meets all the needs of the future. Instead, many organizations will deploy a tiered primary care model, with each level designed to meet the demands of a different segment of the patient population.
We’re approaching the end of the generalist PCP model.

As the tiered primary care model becomes more dominant, PCPs will no longer serve as generalists and instead take on new tailored roles and responsibilities. The generalist PCP model will soon be a thing of the past.

PCPs might specialize in particular chronic illnesses and become “super-PCPs,” or they may focus on the highest-risk, highest-cost patients and serve as complex care managers. Some PCPs will become care team supervisors who oversee the comprehensive care teams practicing in an advanced medical home. And still other PCPs will become concierge care providers supporting on-demand patient access.

Four Emerging PCP Identities

1. **Super-PCP**
   Physicians who develop expertise in longitudinal specialties and work to manage patients with the particular specialty condition

2. **Complex care manager**
   Physicians who are primarily responsible for managing the highest risk, highest cost patients—those with multiple complex chronic illnesses

3. **Care team director**
   Physicians who lead and oversee the diagnosis and treatment provided by nurses and advanced practitioners in the advanced medical home model

4. **Concierge care provider**
   Physicians who manage smaller patient panels and receive a retainer fee per patient
Brand loyalty is shifting from physicians to health systems.

We’re on the verge of a new type of patient-provider relationship—one that connects the patient directly with the health system.

The historical patient-physician relationship, the relationship that fueled the last decade’s acquisition of primary care physicians in order to capture market share, may soon cease to exist. Instead, health systems that prove they can deliver convenient, affordable, patient-centered care—regardless of which provider the patient sees or which site they visit—have an immense opportunity to build strong relationships with loyal patients.

**Former Patient Loyalty Paradigm**
*Patient-Physician Relationship Drove Broader System Loyalty*

PCP gatekeeper to broader health system

**New Patient Loyalty Paradigm**
*Patient Develops Direct Health System Brand Loyalty*

Convenient care experience drives loyalty to health system brand
Learn more

**Nine Insights CEOs Need to Know in 2014**
Discover the most important takeaways from our research on the emerging retail health insurance market, provider partnerships, and clinical network strategy.
[advisory.com/hcab/2014ceoinsights](http://advisory.com/hcab/2014ceoinsights)

**Health System Growth Strategy for the Value-Based Market**
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**The Consumer-Oriented Ambulatory Network**
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Sources

Milliman MedInsight, 2014.

Endnotes

1) Based on Advisory Board survey of consumers choosing where to receive care for the flu.
2) Virtual Interactive Presence in Augmented Reality.
3) Extension for Community Healthcare Outcomes.
4) Hepatitis C Virus.
5) As measured by sustained viral response (SVR); p<.01, difference in cure rates not significant.
6) Certified registered nurse anesthetist.