Physician Insights:

Traditional office visits are not sufficient for managing complex, polychronic patients.

The traditional care model is not effective in addressing the needs of the highest risk, chronically ill patients. Many primary care physicians (PCPs) know that they cannot appropriately address the needs for these patients in a 15-minute office visit. These providers could benefit from a partner with a unique care model to help effectively manage this patient population.

This report provides physician insight to important questions, such as:

- What are the top pain points when treating this population?
- What services could be most helpful from a provider partner?
- What is the value of in-home observation?

Research Methodology

To gain insights regarding caring for complex, chronically ill patients, we conducted qualitative in-depth interviews with PCPs from a variety of geographies, practice sizes, and reimbursement structures from October to December 2018. During one-hour telephonic interviews, participants were asked to respond to questions regarding their practice structure, caring for complex patients, and their collaboration preferences.

INTERVIEWEE PRACTICE AND REIMBURSEMENT STRUCTURE

ONGOING GAPS IN CARE[1]

76%

of physician practices do not **use nurses or case managers to monitor and manage care for patients with chronic conditions outside of the office**

94%

of doctors said they do not **make home visits**

61%

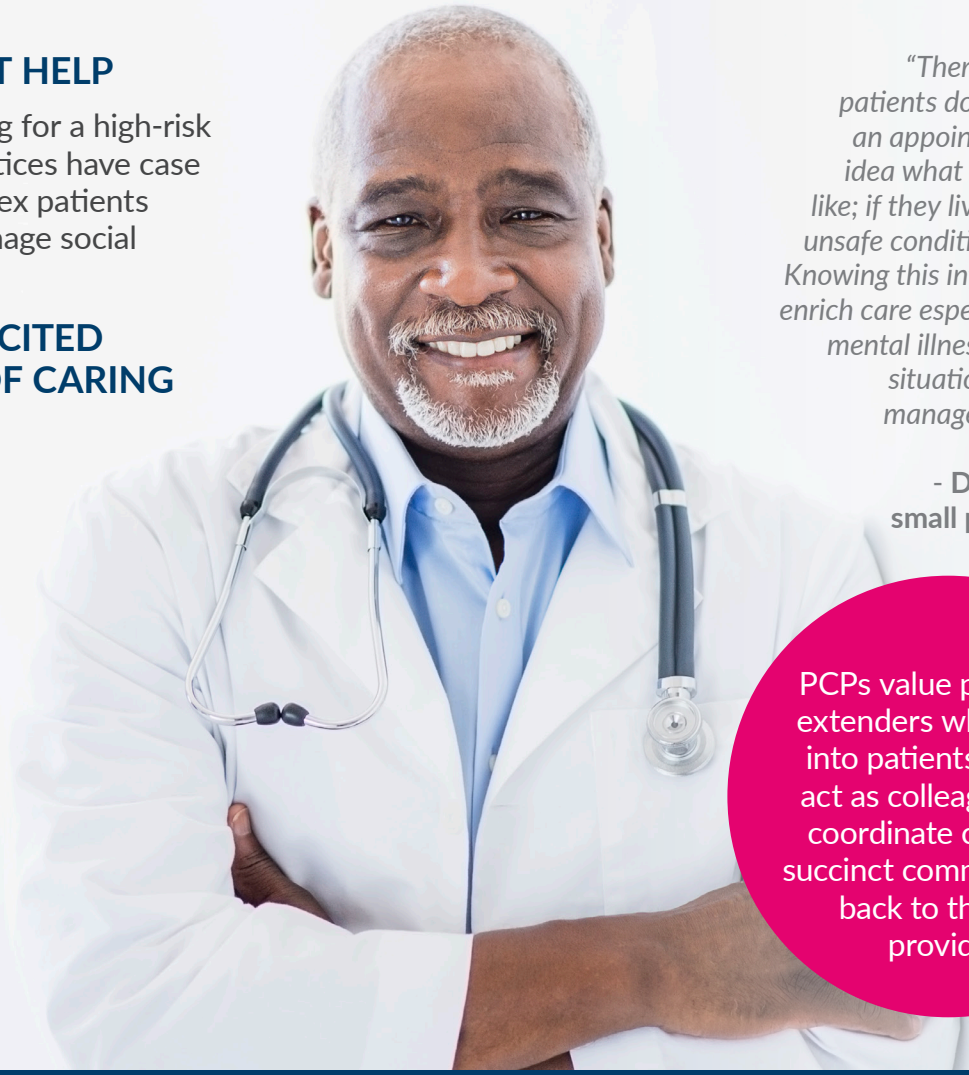
of physician practices do not **have after-hours care arrangements**

WHERE PHYSICIANS NEED THE MOST HELP

The level of support a PCP has to assist in caring for a high-risk population varies by practice. Some larger practices have case managers and social workers assigned to complex patients (primarily telephonic support) to help PCPs manage social determinants of health.

SOCIAL DETERMINANTS OF HEALTH CITED AS THE MOST CHALLENGING PART OF CARING FOR THIS POPULATION

- **Financial situation (affordability of medication, co-pays, etc.)**
- **Access to care (transportation)**
- **Living situation (reside alone, with smoker, etc.)**
- **Health literacy (Rx labels, discharge instructions)**
- **Support system**



"There are things that patients don't reveal during an appointment. I have no idea what their home life is like; if they live with a smoker, unsafe conditions/fall risk, etc. Knowing this information would enrich care especially those with mental illness, hard financial situations, or who can't manage co-morbidities"

- David, physician, small private practice

PCPs value physician-extenders who can go into patients' homes, act as colleagues, and coordinate care with succinct communication back to the lead provider.

TOP PAIN POINTS

88%

stated they need more time with patients

75%

reported a negative impact when appointments run over

75%

stated facilitating care coordination added significant amount of work

THE VALUE OF IN-HOME PATIENT OBSERVATION

Supplemental, high-level care, within a patient's home, including after-hours clinical support, is relevant for PCPs who want deeper insights for their complex patients and feel that traditional services are having little impact on patients' day-to-day needs. Identifying negative life events or social determinants of health sooner and spending more time outside of the office educating patients on their diseases can impact care plans and slow down the progression of diseases.

PCP'S TOP VALUED SERVICES

78%
Nurse Practitioner On-Call

75%
More Time with Patients Outside of Office

63%
Social Services Support

"The current health care system doesn't fit patients with multiple chronic illnesses. The best care for them goes beyond dispensing medications and ordering tests. Many of these patients have trouble coming to the clinic and are bouncing back and forth from the hospital/acute settings. Front line primary care doctors generally are not equipped to care for these patients in a meaningful, impactful, patient-centered way."

- Peter, physician, large medical group

To learn about our partnership programs for health plans that complement their provider networks to improve the quality and cost of care for high-risk, chronically ill members, email us at info@VivelyHealth.com to arrange a meeting.

1. Osborn, Robin, Donald Moulds, Eric C. Schneider, Michelle M. Doty, David Squires and Dana O. Sarnak. Primary Care Physicians In Ten Countries Report Challenges-Caring For Patients With Complex Health Needs, Health Affairs, Vol. 34, No. 12, December 2015. (https://www.healthaff airs.org/doi/abs/10.1377/hlthaff .2015.1018?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&)

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