Accessing WV health care – Are we preparing for the changing mega-trends?

At a recent medical meeting, the CEO of a large medical institution in a WV community of 100,000 stated that 75% of the citizens did not have a primary care physician. Although suspect of the accuracy of the number, if not correct today it soon could be. Are we planning for such a change?

Thirty years ago I questioned a county planning board as to why they planned to close (for low enrollment) an elementary school they had built a few years earlier since several large family housing developments were under construction, and more pending, in close proximity to the school. The response was that they needed to plan for what was, not what was going to be. As regards rural health care, it often seems we are planning for what is and what we want things to be, not what they are likely to be.

I applaud the enormous efforts of many WV individuals and institutions to recruit more primary care physicians, improve the effectiveness and efficiency of current medical practices through automation, telemedicine and "team" approaches, and foster communication and continuity among all health care entities. I am also aware of the ever increasing compliance barriers, bureaucratic requirements and declining reimbursements being thrust upon medical practitioners by government and private payers. An aging physician population, shortages in available medical residency position, and a possible increase in service demand because of expanded ACA economic access add to the challenge.

We must continue to grapple with this situation in the immediate future. But, implementation of the ACA and other factors will result in major additional health system mega -shifts we must be prepared to address if we have are going to provide timely, quality care to rural West Virginians.

Some of our rural community hospitals will close and, largely for economic factors alone, result in each community's loss of many primary care - and a few specialty - physicians. The November 13, 2014 USA Today notes that since 2010, 43 rural hospitals with 1,500 beds have closed and the trend has increased from 3 in 2010 to 13 in 2013. This trend is largely attributed to ACA requirements. The impact of such a closure is minor for suburban areas but major for mountainous, isolated communities.

Another ACA related trend is the escalating expansion of commercial clinics – freestanding or in retail stores – largely staffed with nurse practitioners – providing care for both acute and chronic conditions. Many such "entry" clinics have worked out partnerships with health plans and medical institutions, e.g., Kaiser-Target, Cleveland Clinic-CVS, Sutter Health – Rite Aid, OSU Wexner – Kroger's. Models are varied as to the scope of services and financing arrangement, for example, fee for service, cash, but most stress the convenience and cost-savings compared with traditional primary physician care. They can provide many – but not all – the services of a physician primary care practice.

As I noted in a recent article, it is quite possible that a primary care visit at such "cash" clinics could cost about $40 dollars. A November 20, 2014 article in Health Leaders Media notes there were about 1,000 such clinics in drug and grocery stores four years ago, 1,500 last year, 1,800 this year, with 2,600 projected for 2016. A November 12, 2014 article by Robin L. Rose, Vice President of Strategic Initiatives, Health System, Inc pegs the current number at 1,600 in 39 states. He notes visits run from $25 - $125.

He provides a detailed overview of the huge economic stature, revenues and patient load of the big five (Wal-mart, Walgreens, CVS, Kroger's and Target), as well as their marketing and promotional strategies.

West Virginia also has about twenty-five federally sponsored community health centers (CHCS) and several free clinics. In some CHCs the "entry" level of clinical care offered is not considerably different than that provided by retail clinics. However, the CHC model includes an allotment for "ancillary care overhead" that results in significantly higher per visit costs. Before the ACA, most such care was provided on a sliding scale or for free based upon family income and other factors. For the previously un/underinsured, near poor - now with subsidized ACA insurance - out of pocket costs (deductibles/co-pays) for non-preventive care could actually increase at such clinics, enticing patient to use retail clinics.

Approaching the issue from a patients' perspective, individuals of modest means covered by a basic ACA bronze plan have low premiums but a deductible of over $5,000. Many employers are also offering such plans. The high deductible discourages individuals from seeking care from either a primary care physician or community health center versus a retail clinic. Since they already receive a direct federal subsidy, it is possible CHCs could afford to "indirectly" pass this subsidy onto the ACA insured by ignoring the requirement to collect applicable deductible and co-pays. The political, legal and operational consequences of a CHC providing such an indirect insurance subsidy are not clear but, if allowed or ignored by federal officials, it would place rural private physician practices at an even greater economic disadvantage.

The bottom line is that, unless we develop new models, the great majority of rural primary care will be more limited in scope and sophistication as compared to that provided by full service primary care physician practices. There will be more referrals to specialists, diagnostic tests ordered and emergency room use with major cost implications. Of even more concern, especially because of the shortage of some specialists and the continual lack of EHR interoperability, receipt of timely, appropriate care, continuity of care and, ultimately, quality could suffer greatly.

We need to be planning to develop organizational, reimbursement and business models that encourage partnerships and integration between these developing "entry" clinics, backup primary care physician practices and specialty care that are attractive and sustainable to all players and obviate the concerns noted.

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