Perspectives

Six health care trends that will reshape the patient-provider dynamic

Joshua M. Liao\textsuperscript{a,*}, Ezekiel J. Emanuel\textsuperscript{a,b}, Amol S. Navathe\textsuperscript{a,b,c}

\textsuperscript{a} Division of General Internal Medicine, The University of Pennsylvania School of Medicine, United States
\textsuperscript{b} Department of Medical Ethics & Health Policy, The University of Pennsylvania, United States
\textsuperscript{c} Philadelphia VA Medical Center, United States

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ABSTRACT

Six trends – movement towards value-based payment, rapid adoption of digital health technology, care delivery in non-traditional settings, development of individualized clinical guidelines, increased transparency, and growing cultural awareness about the harms of medical overuse – are driving the US health care system towards a future defined by quality- and patient-centric care. Health care organizations are responding to these changes by implementing provider and workforce changes, pursuing stronger payer-provider integration, and accelerating the use of digital technology and data. While these efforts can also improve the clinical relationship and create positive system redesign among health care organizations, they require alignment between organizational and physician incentives that can inadvertently harm the dynamic between patients and providers. Organizations can utilize several strategies to preserve the patient-physician relationship and advance the positive benefits of new organizational strategies while guarding against unintended consequences.

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1. Introduction

Despite its focus on reducing health care spending, ongoing health care reform is not simply managed care reimagined. Managed care during the 1990s successfully reduced costs but lacked patient-centeredness and a data-informed quality focus. As care became cheaper, many voiced concerns about negative effects on the quality of care and the patient-physician relationship.\textsuperscript{1}

In contrast, six trends have emerged from ongoing pursuit of the “triple aim” – improved care experiences and quality, along with lower costs\textsuperscript{2} – to drive the US health care system towards a future defined by quality- and patient-centric care (Table 1). First, a growing number of programs have transitioned reimbursement from fee-for-service towards value-based payment (VBP), which may soon represent the majority of health spending.\textsuperscript{3} Ultimately, this paradigm shift will produce new clinical dynamics and decisions centered on how and when medical services contribute to patients’ overall health. Second, providers are capitalizing on the recent convergence of technological advances and provisions in national health reform\textsuperscript{4} by rapidly adopting digital health technology. With more ubiquitous patient access to electronic devices than ever before, digital platforms are revolutionizing how patients and provider organizations share information and interact.

Three additional trends are also poised to affect the patient-provider dynamic: decentralized care delivery in non-medical settings (e.g., retail clinics and home),\textsuperscript{5} clinical guidelines that promote increasingly individualized care,\textsuperscript{6} and increased transparency about health care quality and costs aimed at enhancing physician behavior and patient choice.\textsuperscript{7} Finally, these shifts are reinforced by cultural recognition among providers that, without adjustments in clinical decision making, excessive care and overuse can cause patients harm.\textsuperscript{8}

Albeit with fits and starts, these trends – each of which can increase the patient-centeredness of the clinical experience – will ultimately contribute to constructive system redesign. In particular, they will encourage new approaches centered on provider and workforce changes, payer-provider integration, and increased use of digital technology and data. However, because these organizational strategies produce new institutional incentives that leaders must align with those facing individual physicians,\textsuperscript{9} and may also fundamentally alter how patients interact with provider organizations, these trends can also produce organizational strategies that negatively affect the clinical relationship.

Physicians and organizational leaders alike must be mindful of these potentially negative impacts. In reshaping the clinical dynamic to increase value, organizational change must not...
inadvertently compromise providers’ professional duties or conflict with their focus on patient well-being.

2. The impact of organizational strategies on the clinical relationship

2.1. Provider and workforce changes

Many organizations are accelerating efforts to incorporate non-physician practitioners, restructure clinical teams with longitudinal patient navigators, and increase patient access through extended hours and care sites that co-locate primary care physicians and specialists.

Thoughtful use of these strategies can be beneficial to the patient-physician relationship. For physicians, it can allow more time with patients focused on clinical needs rather than administrative requirements, and promote “top of license” distribution of clinical and administrative tasks. For patients, it can decrease wait times while reducing lapses in care processes, such as screening tests, chronic disease management, and communication.

Unfortunately, workforce and facility redesign can also potentially strain the patient-physician relationship. Some physicians may experience lower job satisfaction due to greater managerial responsibilities or depersonalized care. Patients who interact with multiple team members may become confused about who is directing their care and perceive barriers in accessing their physicians.

2.2. Payer-provider integration

Institutions are pursuing greater alignment with payers through joint networks, incentive programs, and operating agreements that combine delivery and payment infrastructure, with many positive impacts on patient care.

Data from payers can help physicians prioritize patients in greatest need, thereby increasing efficiency and reducing disparities. Familiarity between generalist and specialist physicians can create more appropriate and informed referrals between physicians and enhance continuity for patients. Linking compensation to provider and patient outcomes can be effective in decreasing low-value care and particularly valuable in situations of high patient cost-sharing (e.g., high deductible, high premium plans).

However, payer-provider integration also presents potential harms. Limiting care within networks may be perceived by some patients and/or doctors as inappropriate gatekeeping that prevents them from being able to choose the best or preferred providers. This may produce particularly challenging and distressing interactions for physicians and patients who seek care “out-of-network” for complex or rare conditions (e.g., rare cancer).

Tying compensation to provider performance or patient outcomes can also produce ethical tensions in the patient-physician dynamic. Providers may feel incentivized to “treat to the numbers” rather than patients, or avoid high-cost and challenging patients altogether. Others may resent patients who need services that cause financial losses. In turn, patients may fear that providers could sacrifice quality and patient preference by choosing cheaper therapies, less competent specialists, or skimping on care altogether.

2.3. Digital technology and data

Adoption of new technologies, such as secure emails and biometric monitoring, is increasingly used for patient communication, remote care and data sharing. Institutions have also leveraged digital information to reduce inappropriate performance variability among providers while supporting efforts in predictive analytics, personalized “precision” medicine, and evidence-based referrals.

Digital platforms can also strain the patient-physician relationship. Certain types of communication are not appropriate for digital platforms, and these interactions should be evaluated against patient and provider dissatisfaction about reducing face-to-face encounters. Patients also should not perceive monitoring as invasive or data sharing as breaches of privacy. In turn, providers must be able to efficiently manage and interpret additional data streams because the failure to do could create both frustration for physicians and unmet expectations for patients. Most importantly, technology cannot distract from the holistic behavioral and social engagement strategies required for chronic disease management, lest organizations “hit the mark but miss the point”.

3. Strategies for promoting positive patient-physician relationships

3.1. Provider and workforce changes

Medical schools, residency programs, and health systems should prepare trainees and mid-career providers for a value-based future by training them in managerial and performance improvement skills. Equipped physicians will be more likely to experience satisfaction and positive effects of redesign—more effective communication with staff, more efficient distribution of administrative tasks, and care focused on the whole patient.

Provider training should be mirrored by commitments to implement more patient-centered care delivery and management processes. Operational redesign has focused largely on production efficiency (e.g., Lean, Six Sigma), which while beneficial, does not always balance clinical benefits and harms.

Organizations should supplement these techniques with a focus on patient needs and desires, committing resources to understand patient experience beyond process measures, such as preferred methods and frequency of contact. By consistently assessing these preferences, providers can individualize patient interactions using blends of physician and non-physician providers for various clinical situations.

3.2. Payer-provider integration

As patient advocates, physicians should extend transparency to their patients. Ensuring that patients hear information about costs and quality from their doctors, rather than outside parties, can frame conversations within honesty and trust.

Because payment is often mixed—blending capitation, FFS,
and VBP—and subject to change in the transition away from volume-based payment, it is difficult for patients to understand the incentives facing their providers. Organizations can use dedicated ethics committees to provide clarity and mitigate real or perceived conflicting incentives.15 By evaluating policies, care patterns, and individual cases, they can intervene when physicians do not appear to act as patient agents.

Provider groups can also minimize conflicts by developing or adapting decision aids for patients.16 Patients will better understand value and quality through shared decision-making and information about “patient pathways”: likely trajectories and outcomes for others with similar conditions. Insight into probable, not just general, risks and benefits can enable informed, individualized choices.

Finally, integration with payers provides health care organizations with the opportunity to experiment with and evaluate quality metrics. Potential strategies include identifying measures with added clinical relevance (e.g., composite metrics that account for co-morbidities and patient reported outcomes) and avoiding those that can cause outsized harm to the clinical relationship (e.g., metrics intended to limit specialist referrals).

### 3.3. Digital technology and data

Specific patients and clinical scenarios require different degrees of digital technology. Organizations should begin by identifying situations, such as mental illness, sexual health, and new cancer diagnosis that may be challenging or inappropriate for digital interaction.

Beyond these, strategies that focus on patient preferences can determine the best approaches in different situations. Some patients may be more or less open than others to digital monitoring and communication overall; others may desire them only for specific health conditions. Implementing technologies based on patient preferences, as some have begun to do,17 can make digital platforms beneficial without triggering privacy concerns, feeling invasive, or decreasing face-to-face clinical time.

Organizations should also embed technology within larger health information technology disease management infrastructure. Multidisciplinary interventions are more effective than remote monitoring alone in some situations,18 highlighting the need to develop human capital and modified workflows alongside technology. Such changes will also assist physicians with the challenging task of managing growing streams of digital data.

### 4. Conclusion

As six trends drive health care transformation, provider organizations will respond by implementing provider and workforce changes, pursuing integration with payers, and increasing the use of digital technology and data. By fundamentally changing how patients and provider organizations interact, the resulting responses can create exert both positive and negative effects on the patient-provider dynamic. However, because medicine is a fundamentally human endeavor predicated on trust and collaboration between patients and their care teams, organizations can utilize several strategies to protect these relationships from unintended consequences.

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### References


### Conflict of interest disclosure statement

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