# Primary Care during Covid-19

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## Short Communication

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## INTRODUCTION

Primary care practises are under a lot of stress as a result of the COVID-19 epidemic. The pandemic uncovered a number of flaws in the primary care infrastructure worldwide. In most of countries specially in the developing ones system is overburdened, with little to no surge capacity to cope with emergencies, a limited reach due to an overreliance on brick-and-mortar clinics, and a reactive rather than preventive mentality. Even before the outbreak, primary care providers were dealing with large patient panels and a labour scarcity. Primary care physicians are forced to prioritise acute treatment due to a lack of time to fulfil all of their patients' needs for acute, chronic, and preventive care; as a result, patients receive just half of the recommended chronic and preventive care treatments.

On top of that, shocking discrepancies in primary care access, quality, and affordability continue, particularly in rural and vulnerable regions where doctors are scarce. The extraordinary difficulty of COVID-19 has compounded these system weaknesses, which were already dangerous in normal circumstances [1,2].

Many primary care systems are moving to telemedicine, pre-visit planning, and centralised population health management as they reorganise on the fly to combat COVID-19. Telemedicine has proven to be crucial in providing care to patients who are sheltered at home while also reducing dangers to physicians.

In developing countries very rare and in developed one also a very small number of physicians used telemedicine before COVID-19; today, it is the favoured, if not dominant, mode of delivering treatment. Pre-visit planning tactics such as clinic schedule sweeping, patient pre-visit screening, and triaging visit priorities - long considered "nice-to-have" protocols — have been quickly and extensively accepted as "must-haves."

Systems that have been experimenting with centralising their population health services in order to improve treatment quality have accelerated their transitions in order to free up primary care physicians to deal with the influx of COVID-19 patients. These necessary rapid shifts in health systems across the country present an opportunity - a bright spot - to improve primary care [2].

### Telemedicine is currently evolving

When everything is said and done, the COVID-19 epidemic will be remembered as a turning moment for telemedicine, a time when it was no longer perceived as a niche service, but as a critical component of care delivery. The longer COVID-19 runs, more it will push the boundaries of what can be achieved through virtual visits in terms of breadth, depth, and thoroughness of care. What we need today is a telemedicine curriculum to be taught in residency programmes and medical schools.

Telemedicine, patient-generated data, and preventative care can all be integrated into a retooled primary care intake and care optimization process. Humans would power such an approach, which would be supplemented by artificial intelligence. The biggest impediments to telemedicine adoption were payer coverage and regulatory limitations until recently loosening of constraints on virtual care. Telemedicine, patient-generated data, and preventative care can all be integrated into a retooled primary care intake and care optimization process. Humans would power such an approach, which would be supplemented by artificial intelligence. The biggest impediments to telemedicine adoption were payer coverage and regulatory limitations until recently loosening of constraints on virtual care [2,3].

In the future, a fundamental driver of change will be the lack of payment for pre-visit plan and inter-visit care management activities. Patients have issues about data overload, technology/EHR interoperability, and workflow integration, while providers have worries about data overload, technology/EHR interoperability, and workflow integration. To realise this vision, health

organisations must be willing to invest in primary care teams, relax constraints around the use of patient-generated data, invest in workforce training, and move toward value-based compensation.

# REFERENCES

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