The building blocks of high-performing primary care

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Center for Excellence in Primary Care, UCSF
Optimal healthcare system design
Our healthcare system
Adult primary care crisis

- Plummeting numbers of new practitioners entering primary care
- Declining access to primary care
- Practitioner burn-out
- Unsatisfactory quality
- The primary care medical home is falling off the cliff
Residency Match, 2010
% of graduating US medical students choosing specialties

2010 NRMP Main Residency Match data
Adult Care: Projected Generalist Supply vs Pop Growth+Aging

Gap: 40,000

Colwill et al., Health Affairs, 2008:w232-241
NP/PAs to the rescue?

• New graduates each year
  – Nurse practitioners: 8000
  – Physician assistants: 4500

• % going into primary care
  – NPs: 65%
  – PAs: 32%

• Adding new GIM, FamMed, NPs, and PAs entering primary care each year, the primary care practitioner to population ratio will fall by 9% from 2005 to 2020.

Colwill et al, Health Affairs Web Exclusive, April 29, 2008; Bodenheimer et al, Health Affairs 2009;28:64.
Why do we need to transform primary care?

- **Stressful worklife**
- **Survey of 422 general internists and family physicians 2001-2005**
  - 48%: work pace is chaotic
  - 78%: little control over the work
  - 27%: definitely burning out
  - 30%: likely to leave the practice within 2 years

Why do we need to transform primary care?

- 73% of adults surveyed reported difficulty getting a prompt appointment, getting phone advice, or getting care nights/weekends without going to the ER.
  
  Public views on of US health system organization, Commonwealth Fund, 2008

- 50% of people with hypertension, 80% of people with high cholesterol, 43% of people with diabetes are poorly controlled.

Why do we need to transform primary care?

• 23 seconds: Average time before patients were interrupted when making initial statement of their problem to their primary care physician.
  Marvel et al. JAMA 1999;281:283

• 50% of patients leave the office visit without understanding what their physician said.
  Schillinger et al. Arch Intern Med 2003;163:83
The problem: panel sizes too large for primary care physicians to manage alone

- A primary care physician with an panel of 2500 average patients will spend 7.4 hours per day doing recommended preventive care.

- A primary care physician with an panel of 2500 average patients will spend 10.6 hours per day doing recommended chronic care.

Average panel size in the US is 2300 patients
Primary care provisions of the Affordable Care Act (ACA)

• 2011: 10% increase in primary care Medicare fees
• 2013/4: Medicaid primary care fees must be equal to Medicare fees; federal government pays, not states
• 2010: HHS will reduce specialty payment and increase primary care payment for Medicare
• 2011: Medical home pilots tested by CMS innovation center
• CMS innovation center will test payment reforms
Transforming practice
Group Health Factoria Clinic

- Panel size reduced from 2300 to 1800
- Visit length increased from 20 - 30 minutes
- 1/3 face-to-face, 1/3 phone, 1/3 email
- Physician burnout dropped from 25% - 14%
- Burnout in control clinics grew from 28% - 35%
- Quality measures improved
- Patient experience measures improved
- $1 million investment recovered in one year by reduced ED visits and hospital admissions
- After 21 months, savings of $10.30 pmpm compared to control clinics

Reid et al. Health Affairs May 2010
Building blocks of high-performing primary care

1. Shared mission (vision) and concrete goals
2. Data driven improvement
3. Empanelment and panel size management
4. Team-based care
5. Population-based management
6. Continuity of care
7. Prompt access to care
8. Template of the future: escape from 15-minute visit
9. Coordination of care
10. Conscious and trained leadership
Empanelment and panel size management

- Empanelment = linking patients with a primary care clinician/team

- Advantages:
  - Patient and clinician/team know each other
  - Allows clinic to measure continuity of care (does patient always see his/her clinician/team?)
  - Allows calculation of panel size
  - Provides denominator for quality measures

- Proper panel size crucial for providing access

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Elements of team-based care

• Culture shift

• Stable teamlets

• Colocation

• Defined workflows and roles – workflow mapping

• Training, skills checks, and cross training

• Ground rules

• Communication – healthy huddles, terrific team meetings and minute-to-minute talk

• Standing orders/protocols
Culture shift: I to We, individual care to population care

- Instead of: “what can I do to maximize the care of the 30 patients on my schedule today?”

<table>
<thead>
<tr>
<th>Monday</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00AM</td>
<td>Ms. Ngo</td>
</tr>
<tr>
<td>8:15AM</td>
<td>Mr. Barnes</td>
</tr>
<tr>
<td>8:30AM</td>
<td>Ms. Reilly</td>
</tr>
<tr>
<td>8:45AM</td>
<td>Mr. Padilla</td>
</tr>
</tbody>
</table>

- The future: “what can we do to maximize the care of the 1500 patients in our panel?”
Stable teamlets

1 team, 3 teamlets

RN, social worker, pharmacist, health educator, nutritionist, care manager, panel manager
Co-location: Clinica Family Health Services
Ground rules

• Team members treat each other with respect
• When someone makes a mistake, he/she is given helpful feedback on how to improve
• Everyone is expected at AM huddles on time
• Team meetings have an agenda, facilitator, note taker
• MDs should not dominate meetings; everyone should be active participants in meetings
• Are decisions made by by consensus, by leader, by vote?
• What are the consequences of tardiness, excessive absences?
• What is the mechanism to resolve conflicts?
Standing orders for RNs or MAs to do diabetes refills without involving the clinician

<table>
<thead>
<tr>
<th>Appointment last 6 months</th>
<th>HbA1c = 7.5 or below</th>
<th>Normal creatinine and potassium in last 6 months</th>
<th>How to refill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>3 month supply + 1 refill</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes or No</td>
<td>No</td>
<td>1 month supply + order labs, give appt, no refill</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>1 month supply + give appt, no refill</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>3 month supply + give appt, no refill</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Yes or No</td>
<td>1 month supply + give appt, no refill</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant</th>
<th>Nurse</th>
<th>Nurse Practioner</th>
<th>Medical assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Patient A</td>
<td>Assist with Patient A</td>
<td>Triage</td>
<td>Patient H</td>
<td>Assist with Patient H</td>
</tr>
<tr>
<td>8:15</td>
<td>Patient B</td>
<td>Assist with Patient B</td>
<td>Injections</td>
<td>Patient I</td>
<td>Assist with Patient I</td>
</tr>
<tr>
<td>8:30</td>
<td>Patient C</td>
<td>Assist with Patient C</td>
<td>Wounds</td>
<td>Patient J</td>
<td>Assist with Patient J</td>
</tr>
<tr>
<td>8:45</td>
<td>Patient D</td>
<td>Assist with Patient D</td>
<td>A bit of time left for patient education</td>
<td>Patient K</td>
<td>Assist with Patient K</td>
</tr>
<tr>
<td>9:00</td>
<td>Patient E</td>
<td>Assist with Patient E</td>
<td></td>
<td>Patient L</td>
<td>Assist with Patient L</td>
</tr>
<tr>
<td>9:15</td>
<td>Patient F</td>
<td>Assist with Patient F</td>
<td></td>
<td>Patient M</td>
<td>Assist with Patient M</td>
</tr>
<tr>
<td>9:30</td>
<td>Patient G</td>
<td>Assist with Patient G</td>
<td></td>
<td>Patient N</td>
<td>Assist with Patient N</td>
</tr>
</tbody>
</table>
### Template of the Pasture

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td>RN Care Management</td>
<td>Acute Patients</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Coordinate with hospitalists and specialists</td>
<td>BP coaching clinic</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Huddle with RN, NP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Huddle with MD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 30 patients are seen or contacted in the first 3 hours of the day
The road to high performance

- Report forthcoming by California HealthCare Foundation on the building blocks of high performing primary care with many details
- Safety Net Medical Home Initiative has excellent implementation guides [www.qhmedicalhome.org/safety-net/publications.cfm](http://www.qhmedicalhome.org/safety-net/publications.cfm)
- Make site visits to high-performing clinics (Clinic Ole in Napa and Sebastopol Community Health Center may be the best in the Bay Area)
- TBodenheimer@fcm.ucsf.edu
- The road is long and hard; together we can do it