

# **Rethinking the model of primary care**

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# **Why should primary care be the foundation for any healthcare system?**

- a. Healthcare costs are higher in areas with more specialists and fewer primary care physicians**
- b. Increased primary care physician to population ratios are associated with reduced ambulatory sensitive hospital admissions**
- c. Persons who receive care in a primary care model have better preventive services than those who don't**
- d. All of the above**

**“Primary care, the backbone of the nation’s health care system, is at grave risk of collapse.”**

**American College of Physicians,**

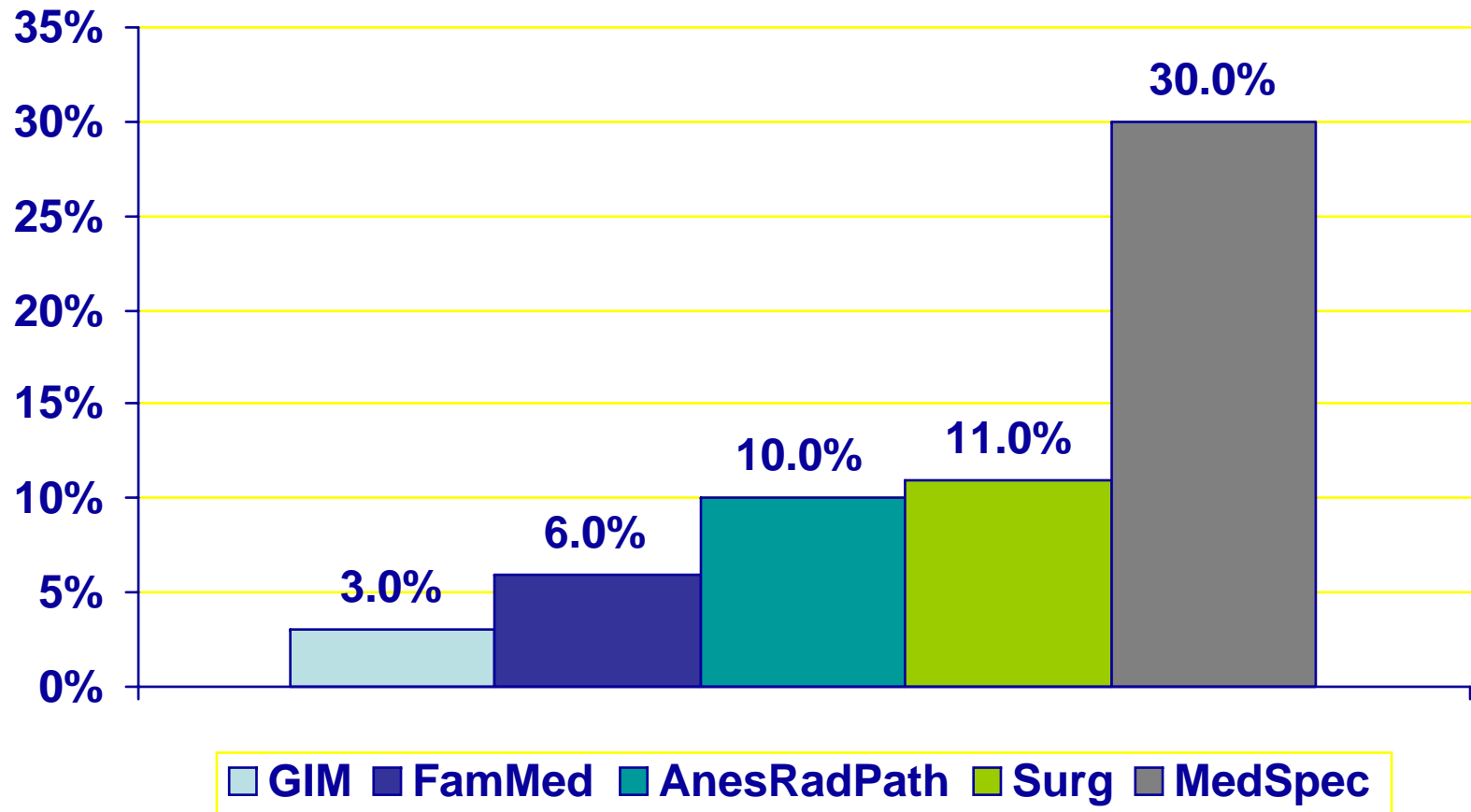
**2006**

- **Plummeting numbers of new physicians entering primary care**
- **Primary care shortages throughout US**
- **Growing problems of primary care access**
- **The primary care medical home is falling off the cliff**



# Residency Match, 2010

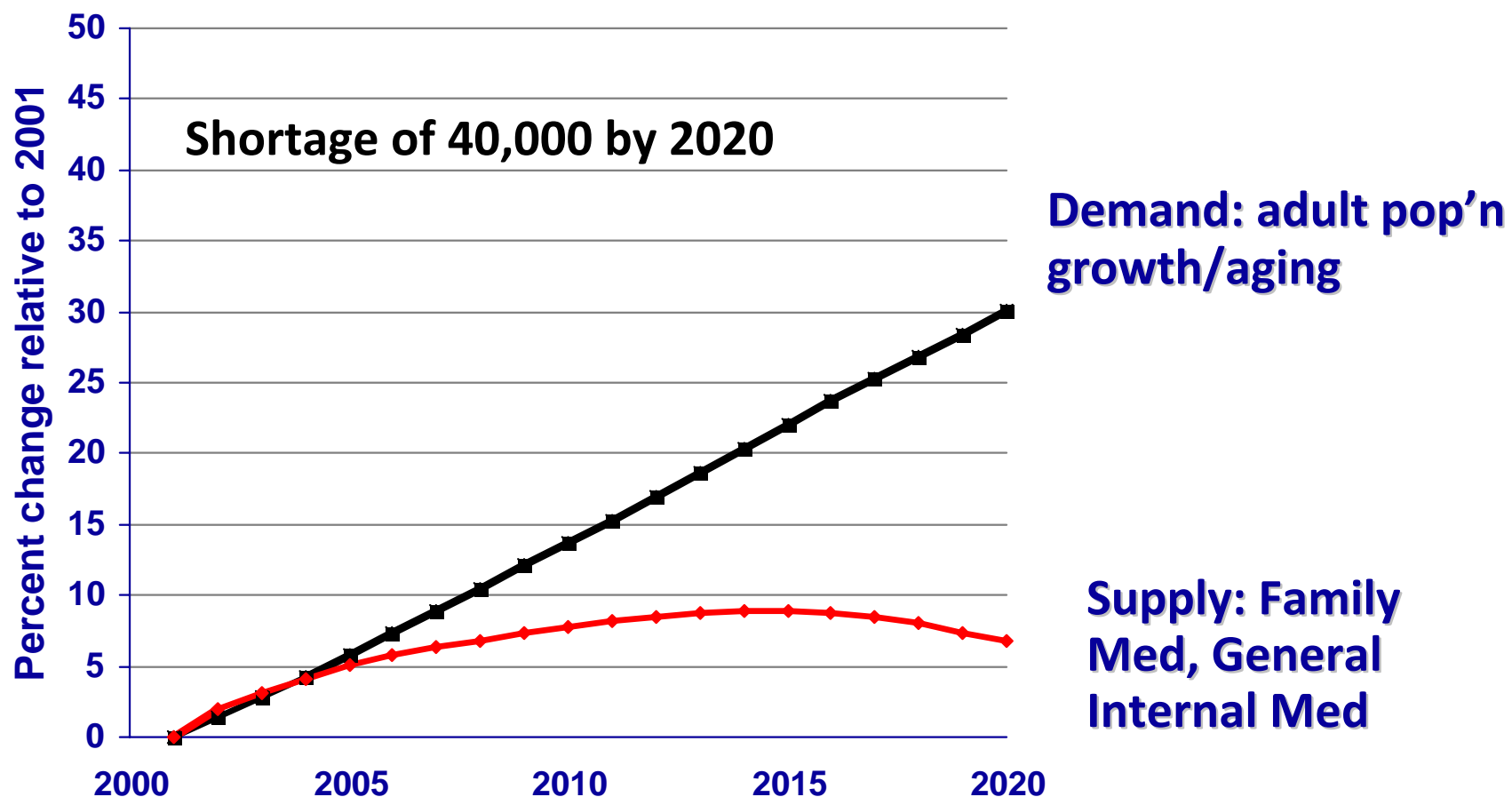
## % of graduating US medical students choosing specialties



# **What is the main reason why US medical students rarely choose adult primary care careers?**

- a. They want more money and choose fields like radiology**
- b. Medical school culture devalues primary care**
- c. Medical students are aware of the stressful hamster-like worklife of a primary care physician**
- d. The breadth of knowledge required in primary care frightens medical students**

# Adult Care: Projected Generalist Supply vs. Pop Growth+Aging



Colwill et al. Health Affairs, 2008:w232-241

## **Can nurse practitioners and physician assistants solve the primary care workforce shortage?**

- a. No. Not enough NPs/PAs are trained to fill the gap**
- b. Yes. The 12,500 NPs/PAs graduating each year can fill the gap**
- c. All graduating NPs enter primary care**
- d. All graduating PAs enter primary care**

# **Panel Size Too Large for Physician to Manage Alone**

- **Average primary care panel in US is 2,300**
- **A primary care physician with a panel of 2,500 average patients will spend 7.4 hours per day doing recommended preventive care**  
Yarnall et al. Am J Public Health 2003;93:635
- **A primary care physician with a panel of 2,500 average patients will spend 10.6 hours per day doing recommended chronic care**  
Ostbye et al. Annals of Fam Med 2005;3:209



## **Due to overly large panel sizes, primary care faces which problems?**

- a. 50% of patients leave the primary care visit without knowing what the physician said**
- b. The average family doctor interrupts patients after an average of 23 seconds**
- c. Only 9% of the time do patients participate in decisions about their care**
- d. All of the above**

## **Which national quality performance indicator is true?**

- a. 75% of patients with hypertension have good blood pressure control**
- b. 65% of patients with diabetes have good blood sugar control**
- c. Physicians provide 80% of recommended chronic and preventive care**
- d. All of the above**

# The Diagnosis

**The fundamental pathology of primary care:**

**The 15-minute visit**

**In primary care, time flies by**

**Fee-for-service rewards volume, not value**



# **First Primary Care Revolution**

- **Providing improved diabetes, asthma, congestive heart failure, cholesterol, hypertension management**
- **Made possible by**
  - **Chronic care model**
  - **Collaborative performance improvement**
  - **New culture of measurement**

# **Second Primary Care Revolution: Deep Transformation of Primary Care**

- **Building blocks of good primary care**
  - **Continuity of care**
  - **Empanelment**
  - **Proper panel size**
  - **Access**
  - **Teams**
  - **Healing populations in addition to individuals**
  - **Data-driven improvement**

# Second primary care revolution

## Priority #1: Continuity

Requires

**Empanelment**

Leads to

**Panel size**

Determines

**Access**

Requires

**Teams**

**Culture:**  
**Agree that  
continuity  
comes first**

# Start with continuity of care

- **Continuity of care is associated with**
  - Improved preventive care
  - Improved chronic care outcomes
  - Better physician-patient relationship
  - Reduced unnecessary hospitalizations
  - Reduced overall costs of care

Saultz and Lochner, Ann Fam Med 2005;3:159
- **Continuity is related to patient satisfaction** Adler et al, Fam Pract 2010;27:171
- **For older adults, continuity with a PCP is associated with reductions in mortality (adjusting for many other factors)** Wolinsky, J Gerontology 2010;65:421
- **Primary care physicians want continuity of care**

Stokes, Ann Fam Med 2005;3:353

## **Start with continuity of care**

- **To achieve and to measure continuity, patients must be **empaneled** to a clinician or team**
- **Measuring continuity:**
  - **% of a patient's visits that are visits to the patient's personal clinician**
  - or**
  - **% of a patient's visits that are visits to the patient's team**



# Continuity and access

- **“See your own, don’t make them wait”**
  - Mark Murray, founder of same-day access scheduling
- **Requires leadership intervention and weekly monitoring to succeed**
- **For access and continuity**
  - Clinicians work at least 50% time, 4 days/week
  - Clinicians have open slots each day
  - Clinicians required to squeeze in their patients, but not patients of other physicians
  - To sustain access permanently
    - Reduce demand
    - Increase capacity
    - Create team care

# Access

- **Reduce unnecessary demand**
  - **Continuity of care reduces demand**
  - **Longer visit intervals don't reduce quality**  
(Schechtman et al, Am J Med 2005;118:393-9)
  - **Patient portal with e-visits**
  - **Addressing high primary care users**
    - **Social visits: behaviorist**
    - **Have lean workflow for rx refills**
    - **Truly complex patients: RN care managers with a care plan for each patient**

# Access

- **Increase capacity**
  - No-shows drop with prompt access
  - Group visits increase capacity 30%
  - Panel management: MDs shouldn't be doing routine preventive and chronic care tasks
  - Diabetes, hypertension visits to RN or pharmacist, using standing orders
  - Back pain directly to PT; PT sends red flags to MD
  - Behavioral health visits
- **You cannot increase capacity without a team**

## **To build capacity:** **share the care with the team**

- **Physical therapists care for patients with back pain, refer to physician if red flags**
- **Pharmacists care for patients with hypertension including titrating meds with standing orders**
- **RNs care for all diabetes care except initiating new medications**
- **LVNs make sure all patients who need preventive cancer screening receive it**
- **At least 50% of what clinicians do could be done by someone else on the team [Yarnall et al. Am J Public Health 2003;93:635; Ostbye et al. Annals of Fam Med 2005;3:209]**

# **Continuity and teamlets**

- **Continuity is redefined as continuity with a teamlet rather than with a clinician**
- **The same people need to work together all the time; then patients know their teamlet and learn to trust the teamlet**
- **Teamlets are small, so that continuity is not continuity with 8 people, but with 2 people**

**Patient  
panel**

**Patient  
panel**

**Patient  
panel**

**Teamlet  
Clinician/MA**

**Teamlet  
Clinician/MA**

**Teamlet  
Clinician/MA**

**Receptionist, RN, social worker, pharmacist,  
health educator, behaviorist, health coach**

**1 team, 3 teamlets**

# Teamlet



# **Will Patients Accept Teams?**

- **Evidence suggests that teams can work for patients if:**
  - **The same people work together all the time so patients know their team**
  - **Teams are small (teamlets)**
  - **Teams are visible rather than invisible**
  - **The physician introduces the team to the patient**

**Rodriguez et al. Medical Care 2007;45:19;  
Rodriguez et al. JGIM 2007;22:787**



## 2-part paradigm shift: I to We, Individual care to population care

- Instead of: “what can **I** do to maximize the care of the 25 patients on my schedule today?”

Monday	Patients
8:00AM	Mr. Flores
8:15AM	Ms. Jones
8:30AM	Ms. Rogers
8:45AM	Mr. Johnson

- The future: “what can **we** (the team) do today to maximize the care of the 1500 patients in our panel?”



# **Practice of the future:**

## **Primary care in an era of shortage**

- **PCPs: 8 - 10 face-to-face visits/day. Reduces burnout**
- **Serious investment in team building**
- **Team's panel, not physician's panel**
- **About 100 patients “touched” each day: e-mail, phone, outreach for chronic/ preventive care, group visits, visits with other team members**
- **Patients not requiring PCP expertise see other team members. PCPs needed for diagnosis, complex management, transitions, training and mentoring team**
- **Payment reform required**

**Margolius and Bodenheimer, Health Affairs, May 2010**

# Template of the past

Time	Primary care physician	Medical assistant	Nurse	Nurse Practitioner	Medical assistant
8:00	Patient A	Assist with Patient A	Triage Injections Wounds  A bit of time left for patient education	Patient H	Assist with Patient H
8:15	Patient B	Assist with Patient B		Patient I	Assist with Patient I
8:30	Patient C	Assist with Patient C		Patient J	Assist with Patient J
8:45	Patient D	Assist with Patient D		Patient K	Assist with Patient K
9:00	Patient E	Assist with Patient E		Patient L	Assist with Patient L
9:15	Patient F	Assist with Patient F		Patient M	Assist with Patient M
9:30	Patient G	Assist with Patient G		Patient N	Assist with Patient N

# Template of the Future

Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00-8:10	<div>←</div> <div>Huddle</div> <div>→</div>				
8:10-8:30	E-visits and phone visits	Panel management	RN Care management	Acute patients	
8:30-9:00					
9:00-9:30	Complex patient		RN Care management	Acute patients	
9:30-10:00	Huddle with RN, NP	Blood pressure coaching clinic			
10:00-10:30	Coordinate with hospitalists and specialists		RN Care management	E-visits and phone visits	Panel management
10:30-11:00	Complex patient				

About 30 patients contacted/seen in 3 hours

## **Coordinating care: how are we doing?patient voices**

- **“I’ve basically kind of fixed up most of it myself. I think what it comes down to is who’s the coordinator? The coordinator seems to be me.”**
- **“Don’t leave it to them. Take your situation in your own hands. You have to take the situation into your own hands.”**

**Harrison and Verhoef. Health Serv Res 2002;37:1031**

# Coordinating care: how are we doing?

- **US academic medical center, adults**
  - **68% of referrals—specialists reported they had received no information from PCP**
  - **25% of the time specialty consultation reports had not reached PCP 4 weeks after specialty visit**

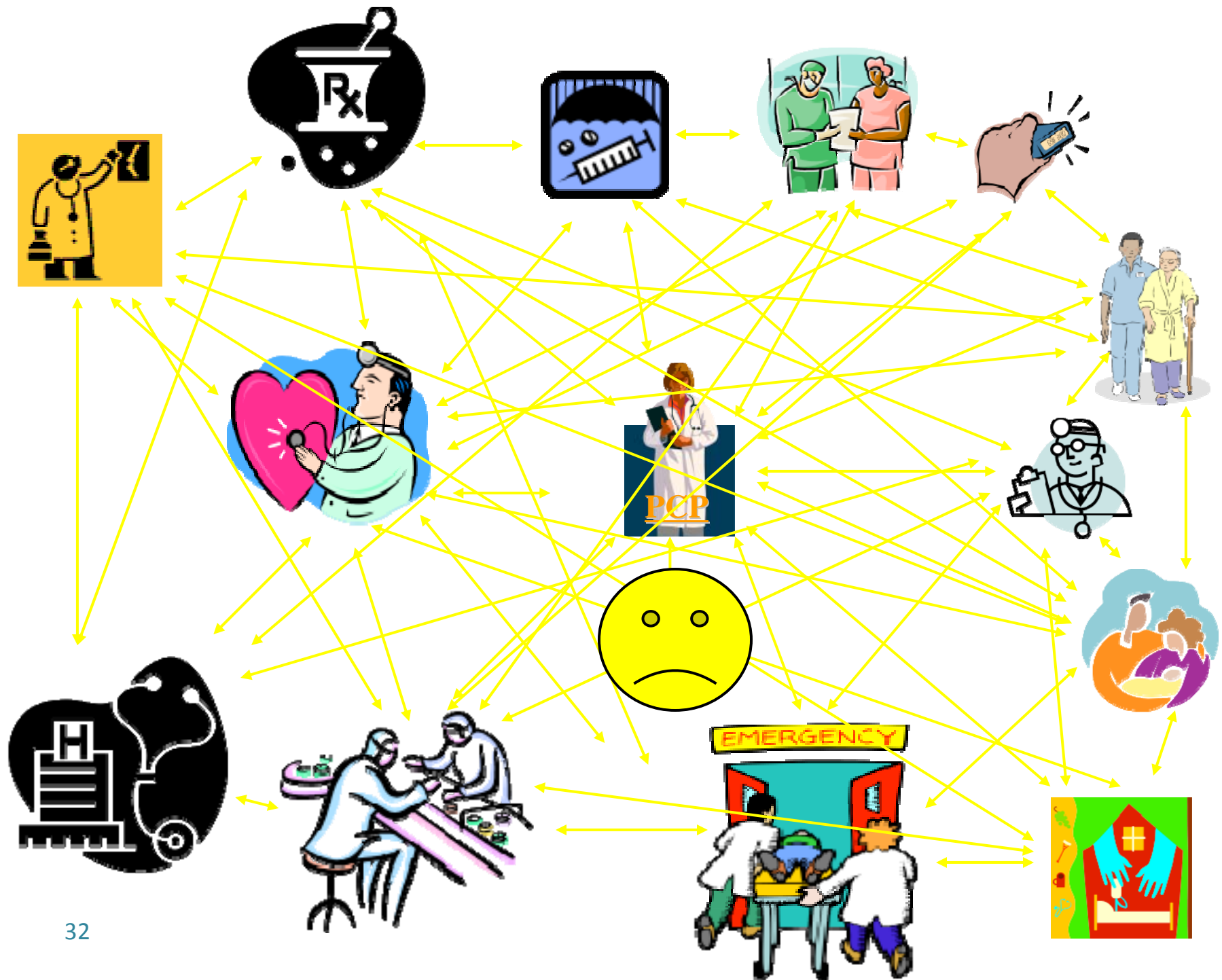
**Gandhi et al. JGIM 2000;15:626**



# Coordinating care: how are we doing?

- **Information transfer between hospital-based and primary care physician**
  - PCP involved in discharge plan: 3% of the time
  - PCP told patient is discharged: 17%–20% of the time
  - PCP never got discharge summary: 25% of the time
  - Discharge summary: no lab reports: 38% of the time
  - Discharge summary: no med list: 21% of the time
  - PCP cared for post-hospital patient before receiving discharge summary: 66% of the time

Kripalani et al. JAMA 2007;297:831





## **Improving care coordination**

- **Care coordination: a clinician function**
- **Primary care, specialty, hospital – all culprits in poor care coordination**
- **To fix the primary care part of the problem, provide time and payment for this crucial work**
- **In the practice of the future template, physician had 30 minutes on her template just for care coordination**

# **Payment Reform for Primary Care Transformation**

- **Primary care does not cost much (average 6% of total system costs), but primary care is needed to achieve reductions in hospital days, specialty visits, ED visits**
- **To reduce total healthcare costs**
  - **Invest in primary care**
  - **Make primary care assume some risk**

# Putting Primary Care at Risk

- If primary care practices do not assume any risk for their patients' total healthcare costs, they won't care about total costs
- Risk: capitation, shared savings, bonuses for reducing costs, penalties for failing to reduce costs
- First **invest** in primary care to give practices funds and tools needed to succeed at cost reduction
- Then, have primary care assume some risk so that there is an incentive to reduce total healthcare costs

