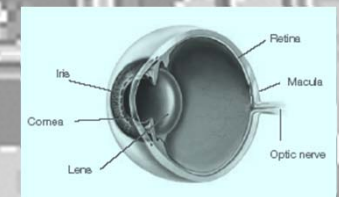
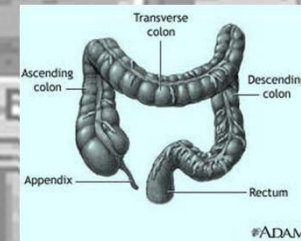
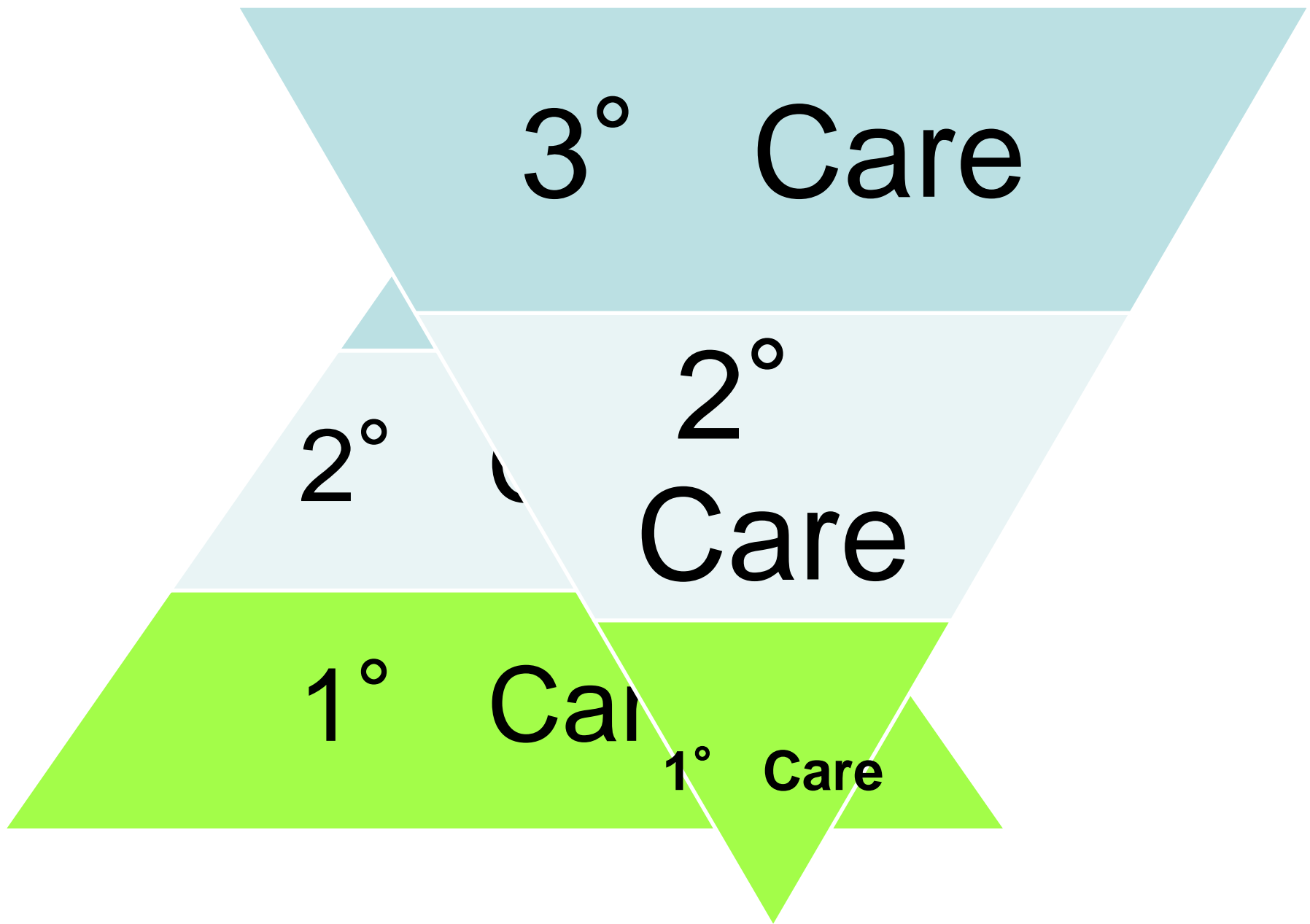


The building blocks of high-performing primary care

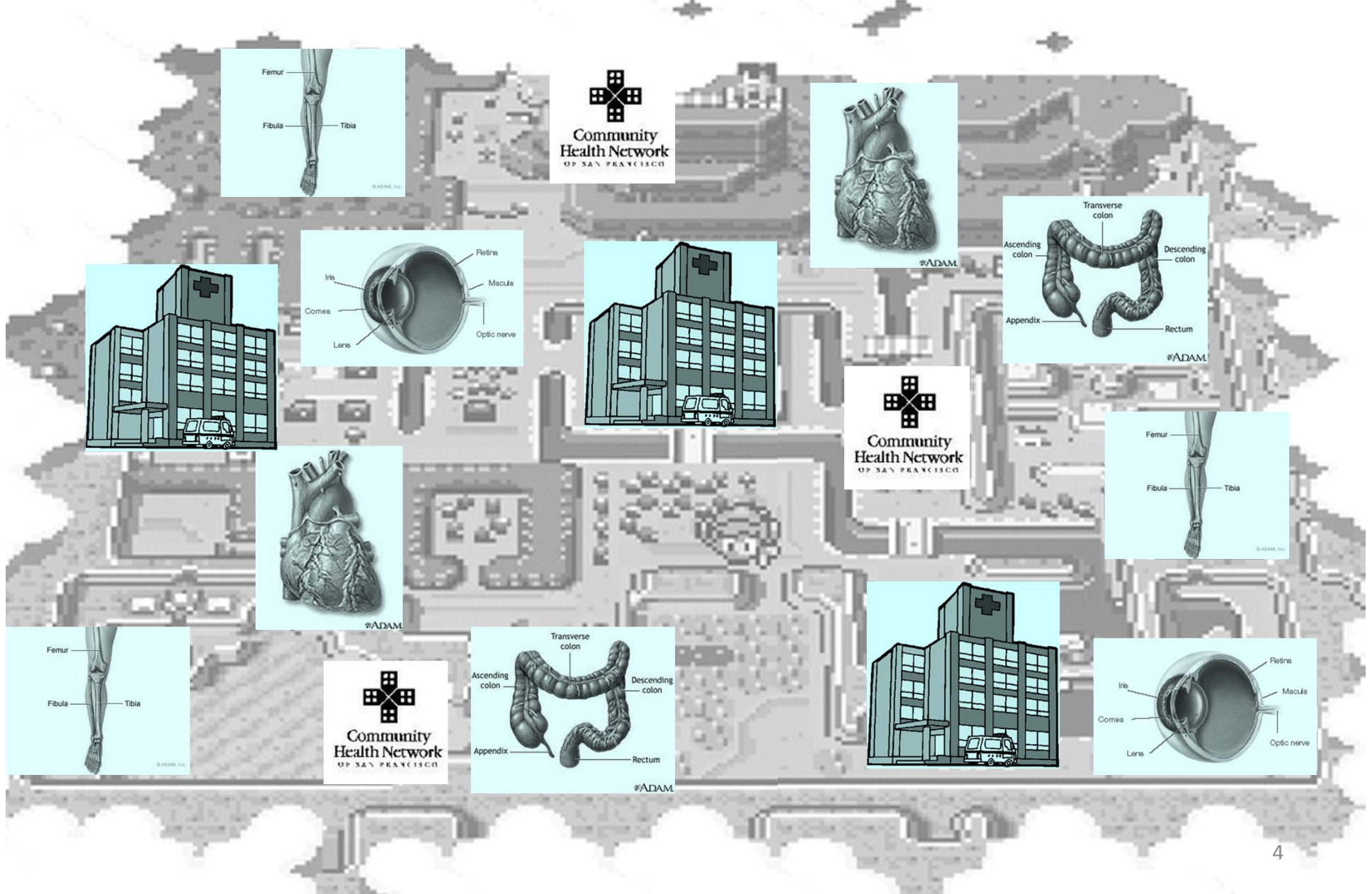
Tom Bodenheimer MD
Center for Excellence in
Primary Care, UCSF

Optimal healthcare system design





Our healthcare system



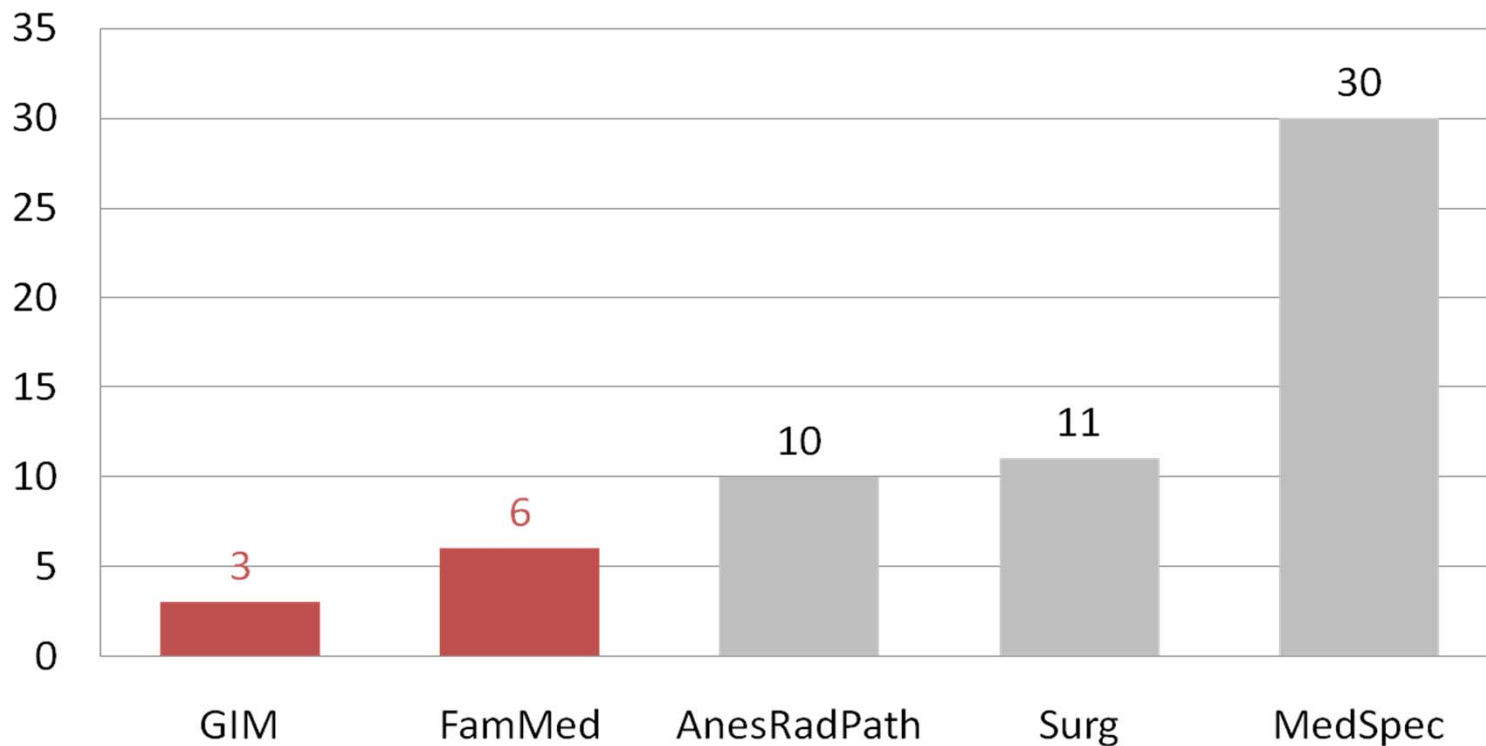
Adult primary care crisis

- 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



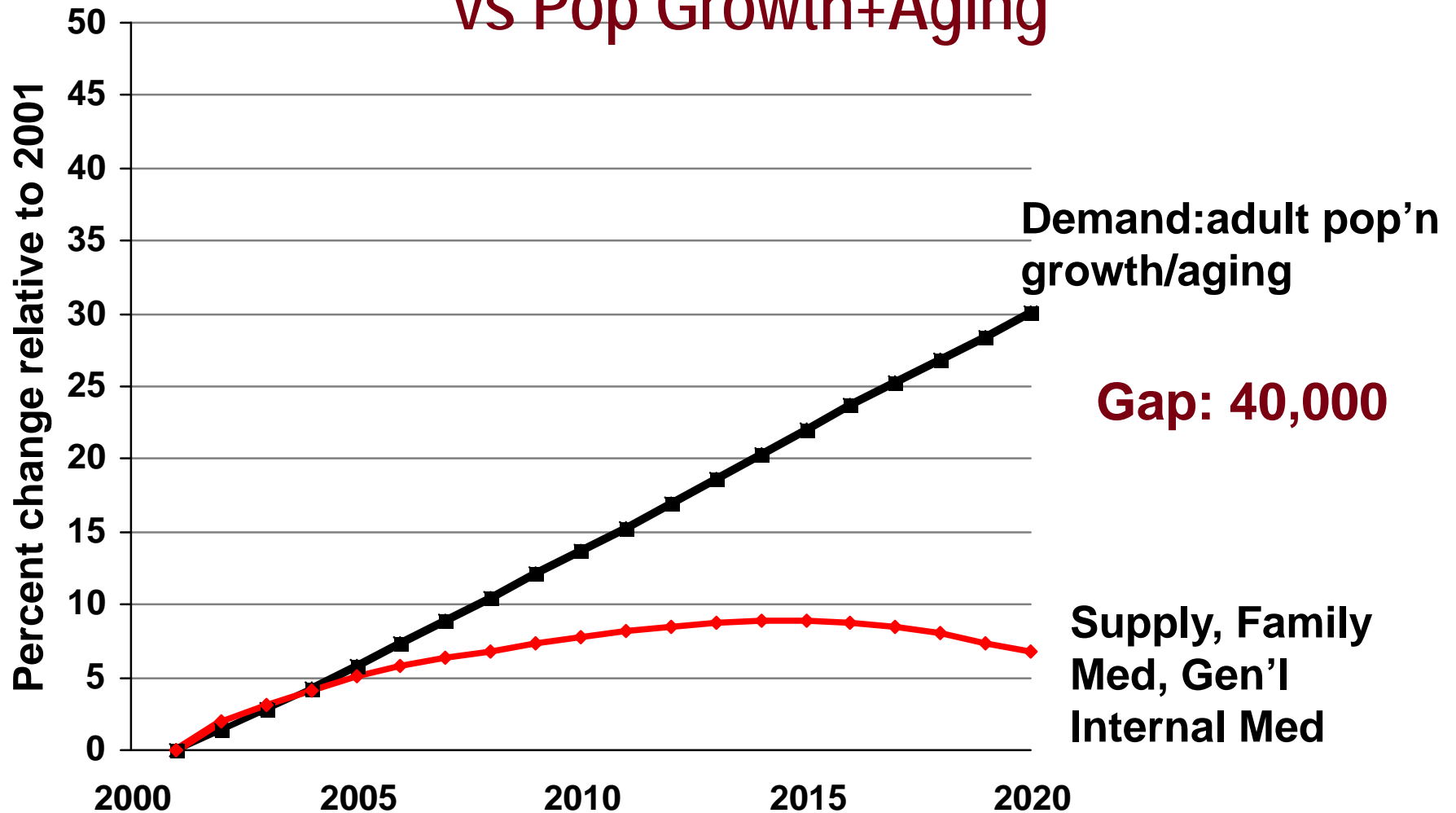
Residency Match, 2010

% of graduating US medical students
choosing specialties



2010 NRMP Main Residency Match data

Adult Care: Projected Generalist Supply vs Pop Growth+Aging



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

Linzer et al. *Annals of Internal Medicine* 2009;151:28-36

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.

Egan et al. JAMA 2010; 303(20):2043-2050, Ford, Internat'l J Cardiol 2010;140:226, Cheung et al. Am J Med 2009;122:443

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.

Yarnall et al. Am J Public Health 2003;93:635

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

Ostbye et al. Annals of Fam Med 2005;3:209

Average panel size in the US is 2300 patients

Alexander et al. J Gen Intern Med 2005; 20:1079-83.

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. Am J Managed Care 2009;15(9):e71-87.

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
- **Empanelment Guide** www.qhmedicalhome.org/safety-net/Empanelment.cfm

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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

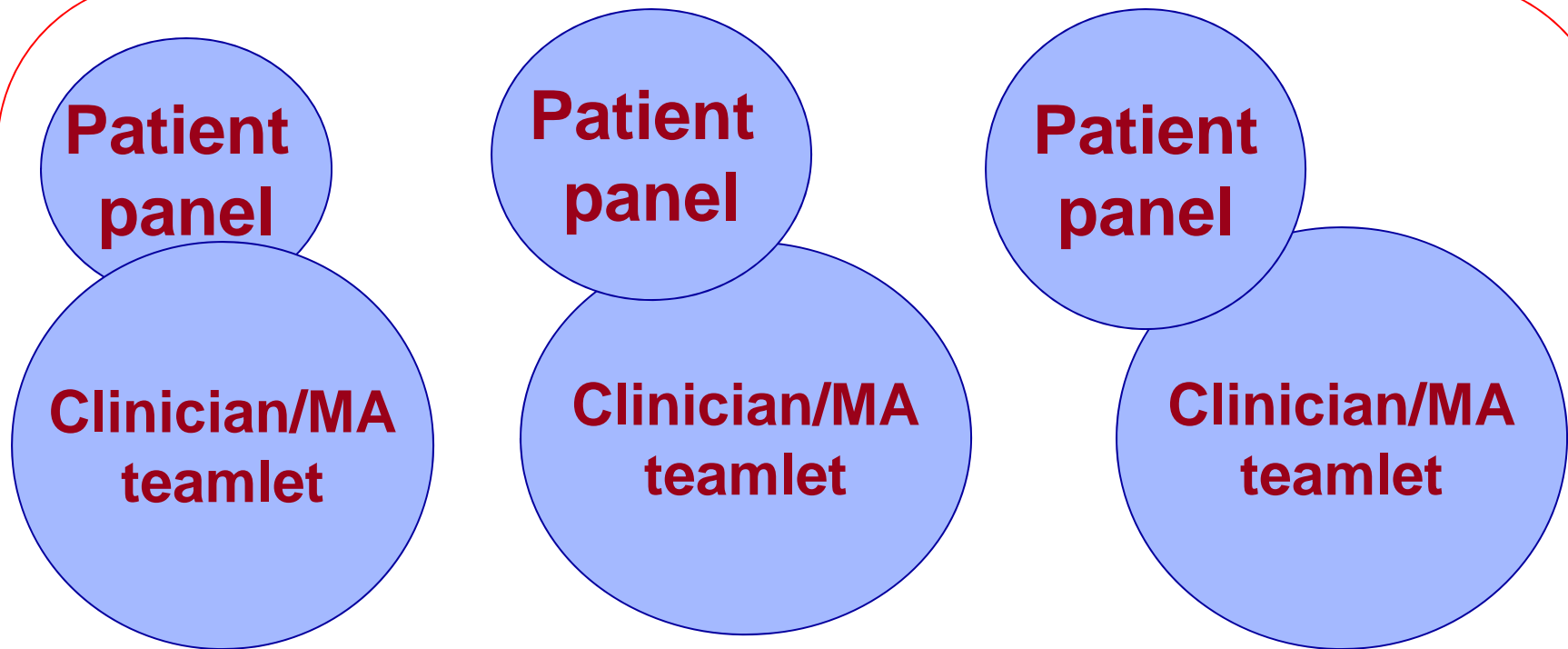
- Instead of: “what can **I** do to maximize the care of the 30 patients on my schedule today?”

Monday	Patients
8:00AM	Ms. Ngo
8:15AM	Mr. Barnes
8:30AM	Ms. Reilly
8:45AM	Mr. Padilla

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



Stable teamlets



**RN, social worker, pharmacist, health educator,
nutritionist, care manager, panel manager**

1 team, 3 teamlets

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

Appointment last 6 months	HbA1c = 7.5 or below	Normal creatinine and potassium in last 6 months	How to refill
Yes	Yes	Yes	3 month supply + 1 refill
Yes	Yes or No	No	1 month supply + order labs, give appt, no refill
Yes	No	Yes	1 month supply + give appt, no refill
No	Yes	Yes	3 month supply + give appt, no refill
No	No	Yes or No	1 month supply + give appt, no refill

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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 Pasture

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

•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
- 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