How do we get to the primary care of the future?

ADOPTING A TEAM CARE APPROACH

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“Why we need team-based care”

- **Primary care pillars and principles**
- **The practice of the future (PCMH)**
- **Moving toward team care models**

Pillars of primary care

- **Barbara Starfield's 4 pillars of primary care**
  - **Continuity of care**
  - **First contact care [requires Access]**
  - **Comprehensive care**
  - **Coordination of care**

Modern additions

- **Additional principles**
  - **Concern for entire population of patients**
  - **Measurement to drive quality improvement**
  - **Patient-centered care**
    - Patient self-management support
- **Model components**
  - **Team-based care**
  - **Meaningful use of EHR, linked to rest of medical neighborhood**
  - **Payment incentivizes the above attributes**

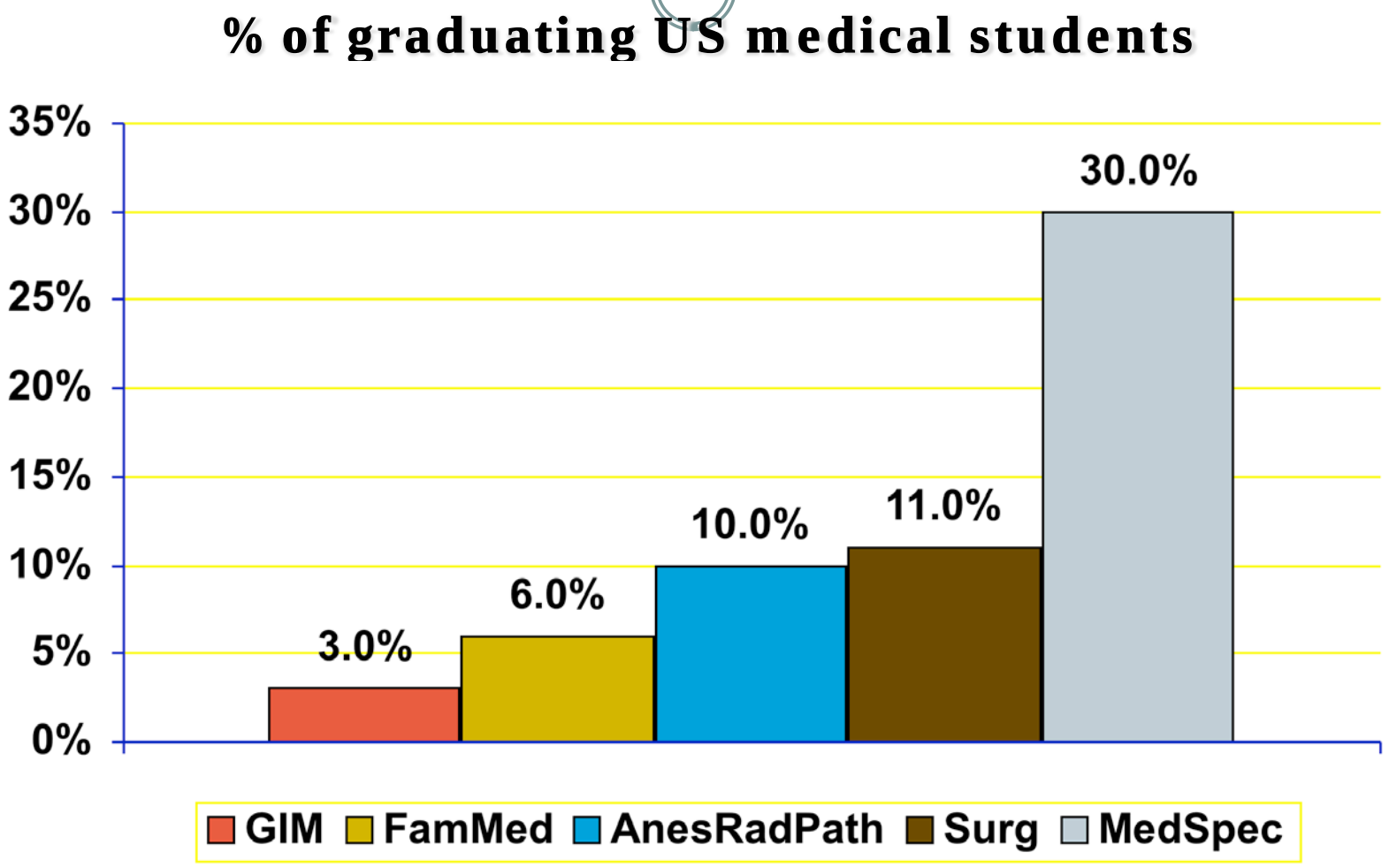
Equity

- How do we do we build this model for the entire US population, despite a growing demand and lessening supply of providers?

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

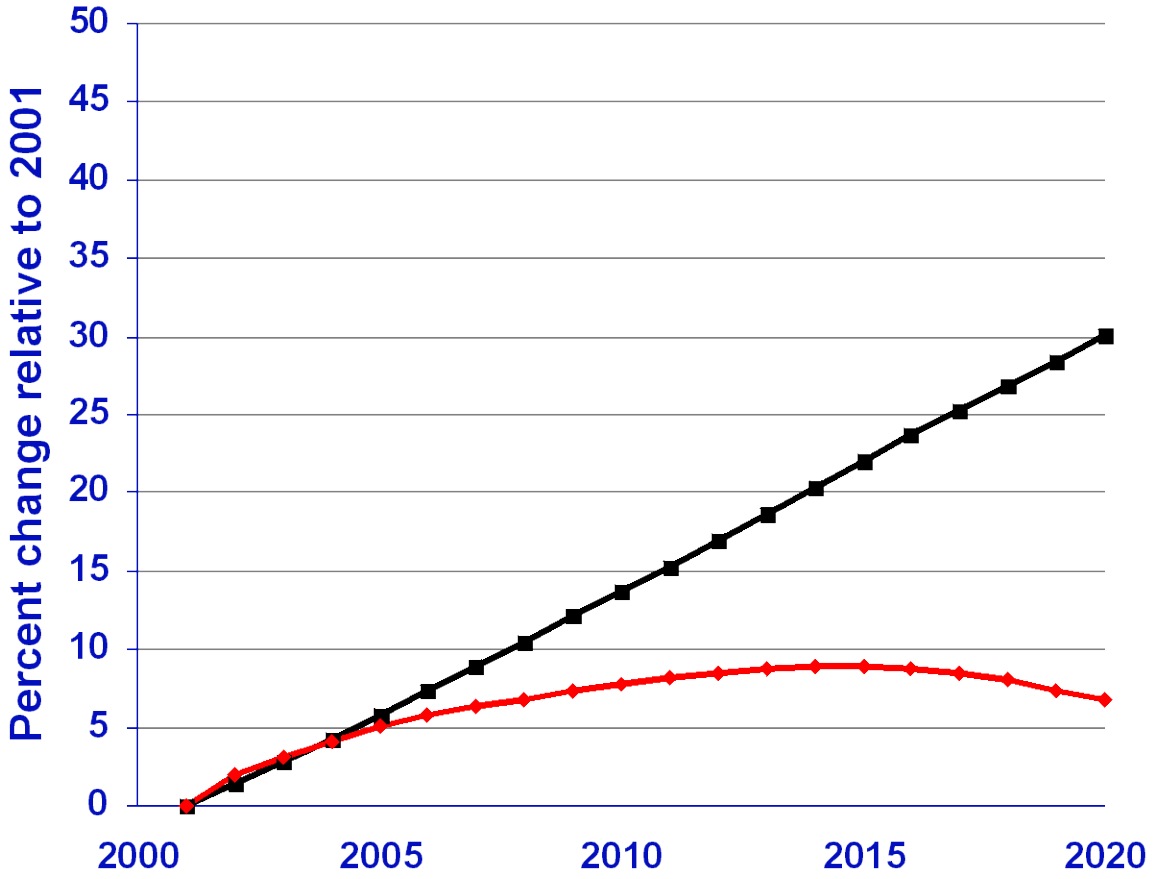


Stressful worklife

- 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

Adult Care: Projected Generalist Supply vs Pop Growth+Aging



Demand:adult pop'n growth/aging

Supply, Family Med, Gen'l Internal Med

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

Workload of US adult primary care

- **Primary care physician with 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]**

- **Primary care physician with 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 US: 2300**

The dilemma

- The shortage will get worse
- Panel sizes will go up
- This will reduce access, reduce quality, and increase clinician dissatisfaction
- As clinician dissatisfaction increases, fewer MDs/NPs/PAs will enter primary care

The Patient-Centered Medical Home (PCMH) can make the care experience better for practitioners, staff, and patients.

Neighborhood context

- Payment reform: change from fee-for-service
- Accountable Care Organizations
- Coordinated neighborhoods that value a strong primary care base

Fundamentals of the PCMH

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 over time 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 et al, J Gerontology 2010;65:421

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
- Your goal:
  - 100%? 85%?
  - Doing better than you're doing now

Continuity and access

- Continuity and access can be in conflict
- Clinic culture:
  - What does the front desk offer patients when they call to be seen?
- Each clinic must create its own culture: is continuity a primary goal or not?

Continuity, access and panel size

- We have large panel sizes
  - Shortage of PCPs
  - Financial stability
- The larger the panel size= less access
- To achieve continuity and access with large panel sizes, we must have teams
- Teams are a necessity now

Continuity and teams

- Continuity is redefined as continuity with a team rather than with a clinician
- Stable teams
- Small teams (teamlets)

Primary Care Teams

Teams:

a group of diverse clinicians who participate in, and communicate with each other regularly about the care of a defined group (panel) of patients.

Teamwork?

The Frantic Bubble

- How Teams Work– Or Don't– In Primary Care: A Field Study on Internal Medicine Practices
  - Chesluk and Holmboe. Health Affairs May 2010. Reinventing Primary Care issue.

Re-building Primary Care Teams

- Attitudes toward re-distributing the work
- Attitude #1:
  - Offload tasks from the clinicians to RNs/MAs
  - Will create resentment in the team: This isn't my job description, I already have too much to do
- Attitude #2:
  - Entire team is responsible for health of our panel
  - Different people on the team will have different responsibilities
  - Re-distributing work is not delegating tasks from clinicians to other team members; it is sharing responsibilities

Tasks vs. Responsibilities

- **Delegating tasks**
  - Do this EKG.
  - Check that patient's blood sugar
  - Call the pharmacy to refill the metformin

- **Re-distributing responsibilities**
  - **Panel management.** The MA is responsible for working the registry to make sure that all patients in the panel receive their chronic and preventive care services on time
  - **Health coaching.** RN or MA responsible to assist patients with chronic conditions to gain the knowledge, skills, and confidence to self-manage their condition

Team roles

Panel management

Health coaching

Practice of the future

- Clinicians (MD/NP/PA) no longer see all the patients for all their problems
- Depending on people's problems, the appropriate team member addresses the problem
- Many routine preventive and chronic care issues can be handled by RNs, LVNs, MAs
- This creates time for clinicians to spend adequate time with complex patients

The patient-centered medical home requires a culture shift

- **Present:**
  - the doctor (sometimes NP or PA) assumes all the responsibility, makes the decisions, and orders others to perform tasks
- **Future:**
  - Entire team assumes responsibility for a panel of patients
  - Team members share the responsibility to make that panel of patients as healthy as possible
  - Tasks are linked to a sense of responsibility and purpose

Culture shift: I to We

- **From:** How can the clinician (I) see today's scheduled patients, do the non-face-to-face-visit tasks, and get home at reasonable hour?

Monday	Patients
8:00AM	Sr. Rojas
8:15AM	Ms. Johnson
8:30AM	Mr. Anderson
8:45AM	Sra. Garcia

- **To:** What can the team (We) do today to make the panel of patients as healthy as possible, and get home at a reasonable hour?

Creating teams

- **Well-functioning large teams are difficult**
  - **Lots of energy and time taken up with multiple team members having to communicate information and coordinate tasks with each other**
  - **If one person on the team is not cooperative, the entire team can fail**
  - **"The best team size is a team of one." Dr. Harold Wise, *Making Health Teams Work*, 1974**
- **Smaller teams are easier**
  - **Divide the practice into small teams with each team responsible for a panel of patients**
  - **Create 2-person teamlets (MD/RN, NP/LVN, MD/MA)**
  - **4-person teamlets are a new experiment**
  - **VA: 4 person teamlets (MD/NP, RN, LVN, clerk) responsible for 1200 patient panel**

Creating teams and teamlets

- Common goals
- Implementing systems to achieve the goals
- Clear division of labor
- Training
- Communication
- Ground rules

Creating teams and teamlets

Ground rules

- How are team meetings run (facilitator, time keeper, note taker)
- How are meeting minutes written up and distributed?
- Are decisions by consensus, by leader, by vote?
- How to deal with tardiness, excessive absences?
- Conflict resolution

Monograph on primary care teams

- Bodenheimer T. *Building Teams in Primary Care*, Parts 1 and 2. California HealthCare Foundation, 2007. Available at www.chcf.org, put "teams" into the search box

NCQA Patient Centered Medical Home Element 1G: The Practice Team

The care team manages patient care in the following ways:

1. Defines roles for all team members including clinical and non-clinical practice staff.
2. Has regular team meetings and a communication process (e.g. daily huddle, email or instant messaging, messages in chart)
3. Uses standing orders for medication refills, tests, routine preventive services
4. Care team are assigned and trained to coordinate care (tests, referrals, community based services)
5. Care team assigned and trained to support patient/family in self-management, self efficacy and behavior change (e.g. weight reduction, smoking cessation, stress reduction)
6. Care team assigned and trained to manage populations of patients
7. Care team assigned and trained in communication skills with vulnerable populations
8. Care team involved in performance evaluation and improvement

Preventive services: old way

- Mammogram for 55-year-old healthy woman
- Old way:
  - Clinician gets reminder that mammo is due
  - At next visit, clinician orders mammo
  - Clinician gets result, (sometimes) notifies patient

Preventive services: new way

- MA in role as panel manager checks registry every month
- If due for mammo, MA sends mammo order to patient by mail or e-mail
- Result comes to MA
- If normal, MA notifies patient
- If abnormal MA notifies clinician and appointment made
- For most patients, clinician is not involved
- Similar for FOBT, pneumovax, flu shots

Chronic care: hypertension: old way

- Clinician sees today's blood pressure
- Clinician refills meds or changes meds
- Clinician makes f/u appointment
- Often blood pressures are not adequately controlled

Chronic care: hypertension new way

- LVN/MA in role as panel manager checks registry q month
- Patients with abnormal BP contacted to come for LVN or RN visit
- LVN or RN in health coach role does education on HBP and meds, med-rec, med adherence/lifestyle discussion
- Patient is taught home BP monitoring
- If BP elevated and patient is med adherent, RN intensifies meds by standing orders
- If questions, quick clinician consult
- LVN or RN in health coach role f/u by phone or e-mail if patient does home BP monitoring or by return visit
- Clinician barely involved
- Processes, outcomes, patient involvement improved by panel management and health coaching

Chronic pain: old way

- Clinician negotiates pain contract with patient
- Patient comes every month to get refill
- If clinician is not available on the day that refill is needed
  - In disorganized systems, big mess
  - In organized systems, another clinician writes the refill

Chronic pain: new way

- Clinician negotiates pain contract with patient
- Clinician and LVN/MA or RN discuss with patient how med refills will work
- Regular LVN or RN refill visits are scheduled
- At refill visit LVN or RN assesses pain, may do tox screen
  - If pain stable, LVN or RN asks clinician for secure rx
  - If pain not stable, brief clinician consult
- LVN/RN does patient education on alternatives to narcotics

Patients with complex healthcare needs: old way

- Clinician sees the patient every month for 30 minutes
- Often the visit plus care coordination takes longer than 30 minutes and clinician
  - Doesn't provide the best care, or
  - Is running behind because the patient took an hour, or
  - Both

Patients with complex healthcare needs: new way

- Initial hour meeting with patient/family with care team (MD, RN, SW, behaviorist and/or pharmacist)
- Clinician, not worrying about preventive services or non-complex chronic care, has time
- Care plan made with team and patient/family
- RN care manager responsible for implementing and assessing care plan, teaching about meds, red flags
- RN does phone, home-visit f/u, care coordination, consults with MD or other team members as needed
- Regular MD /team visits
- **This will not work unless the other changes are made to free up MD for complex patients**

Team-based care responsibilities

- Panel management
- Health coaching for self management support and navigation
- Medication reconciliation and titration management
- Complex care management
- Mental health and behavioral health integration
- Management of simple problems
- Lab follow up

Redesign necessities for team care

- Staffing and training
- Electronic tools
- Workflows and algorithms
- Communication methods
- Risk stratification of patients
- Visit types

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Template of the past

Time	Primary care physician	Medical assistant	Nurse	Nurse Practioner	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	Huddle				
8:10-8:30	E-visits and phone visits	Panel manage-ment	RN Care manage-ment	Acute patients	
8:30-9:00					
9:00-9:30	Complex patient				
9:30-10:00	Huddle with RN, NP	Blood pressure coaching clinic	Huddle with MD		Panel manage-ment
10:00-10:30	Coordinate with hospitalists and specialists		Care manage-ment	E-visits and phone visits	
10:30-11:00	Complex patient				

About 30 patients contacted/seen in 3 hours

TEAMS can transform and revitalize primary care.

- Care for large panels while improving quality and access
- Engage staff in meaningful work, sharing responsibility for the health of a panel of patients
- Allow clinician to lead a team rather than individually see one patient after another