Creating Ideal Primary Care

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June 30, 2010

What is Ideal Primary Care?

- Patients receive all the time they need and want for care with great service
- Patients receive the best care
- Physicians and staff enjoy their work and sustain high level professional satisfaction
- Medical errors are minimized
- Physicians are supported by a team and care for the right number of patients

What is a Patient-Centered Medical Home?

- A Patient-Centered Medical Home (PCMH) is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by *replacing episodic care* based on illnesses and patient complaints with *coordinated care* and a long-term healing relationship (NCQA).

Adapted from Joint Principles of the Patient-Centered Medical Home, March 2007. Available at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf.

The Time Problem – Current Primary Care

- Time Needed for Chronic Illness Care
- Time Needed for Preventive Care
- Time Needed for Acute Care
- Total face to face time for 2500 patients

- 10.6 hours a day for 2500 patients
- 7.4 hours a day
- 4.6 hours a day
- 22.6 hours/day

Ann Fam Med 2005;3:209

Am J Pub Health 2003;93:635

The Ticking Clock in the Doctor's Office

"Patients on routine visits to their primary doctors often have lots of questions but not enough time to get good answers."

Patients leave the office with an average of 3 unanswered questions

- *New York Times,* February 6, 2007

58 y/o female with obesity and diabetes comes in with symptoms of fatigue, insomnia and back pain. She has a 15 minute appointment

HEDIS diabetes measures for this patient:

- Percent with an annual retinal exam
- Percent with one of more glycohemoglobin tests
- Percent of those having glycohemoglobin tests showing a level of <7.5 % (goal 7.0%)
- Percent with an annual screening test for microalbuminuria
- Percent with two or more blood pressure checks per year
- Percent of those with one or more blood pressure checks having a systolic BP <135 (goal <<130/80)
- Percent with an annual lipid panel
- Percent of those with an annual lipid panel showing an LDL level <130 mg/dL (goal << 100)

Case con't

Other Diabetes Measures:

- Flu vaccine
- Pneumovax vaccine
- Dental visit
- Cardiac screening tests
- Lab monitoring for side effects of medications
- Annual foot exam

Case con't

Cancer screening needs:

- Colon- needs colonoscopy (or 3 other types of screening)
- Cervical- needs pap if last <1-3 years prior
- Breast- needs annual mammogram

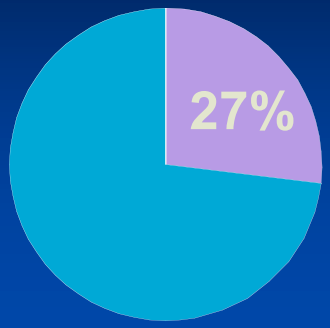
Osteoporosis screening and prevention

Depression screening and management

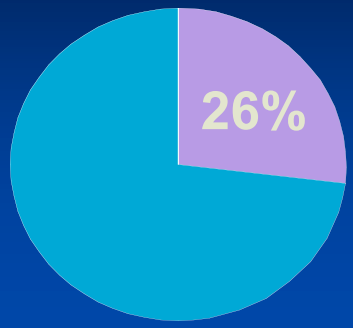
Case con't

General health issues:

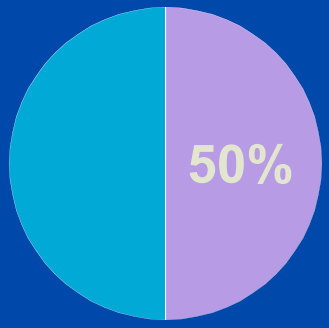
- Adult DTaP vaccine
- Weight management
- Advance directives
- Culturally-sensitive care
- Diabetic education and self management
- Tobacco screen
- Alcohol screen
- Domestic violence screen
- What about the fatigue, insomnia and back pain?



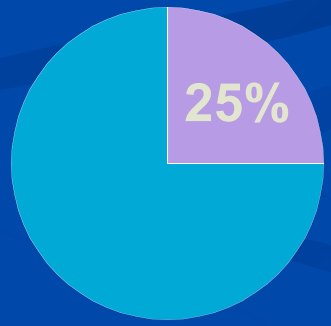
Only 27% of hypertension is adequately controlled.



Only 26% of people with diabetes have blood pressures well controlled.



50% of patients hospitalized with congestive heart failure (CHF) are readmitted within 90 days.



Only 25% of people with depression receive treatment.

Care Does Not Equal Visits

- Optimal care is based on deep, trustful relationships between practice and patients
- A great relationship demands that we go far beyond visits in delivering care to patients

An outmoded way of managing patients

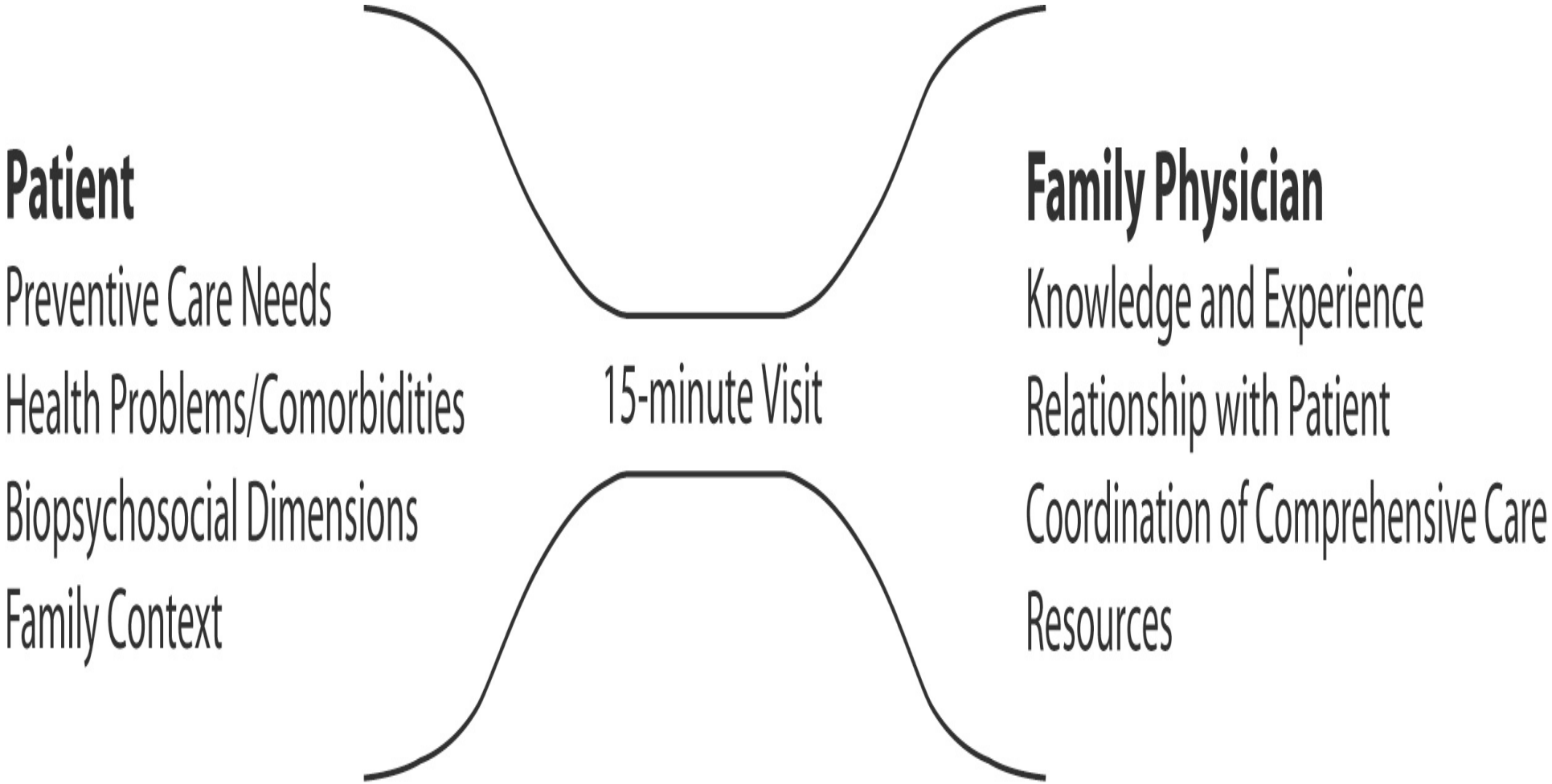
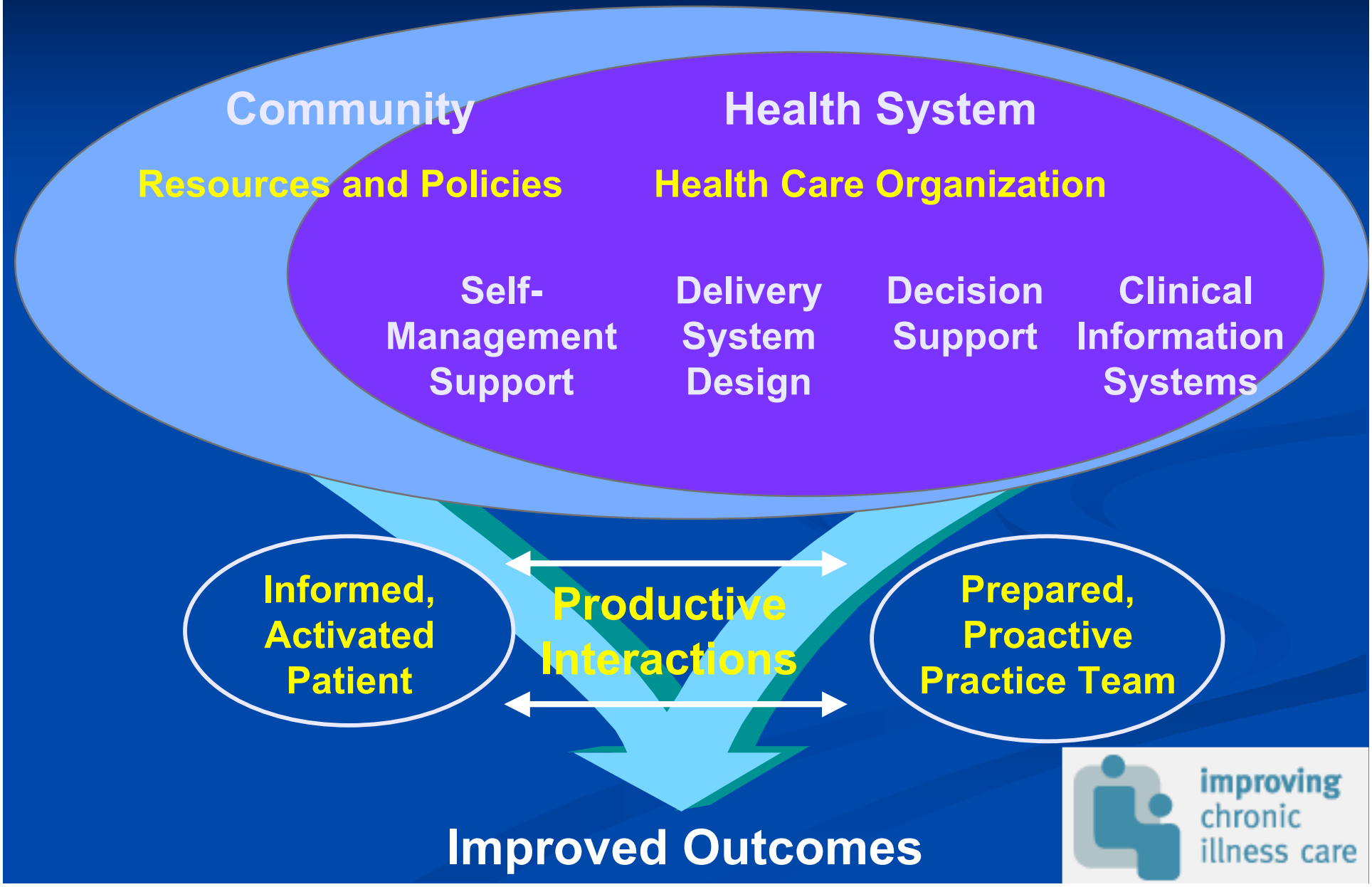


Figure 1. The Bottleneck of Brief Episodic Visits

Chronic Care Model

http://www.improvingchroniccare.org



Different Models of Idealized Primary Care

- Organized Team Model – Each PCP covers a large panel of patients (2000 or more) with one or more mid-level providers and others onsite such a care manager, care coordinators, pharmacist and others.
- Relationship Centered Model – Each PCP is a personalized care physician and has a smaller panel size (600-1200) with an activated medical assistant as care coordinator and a "neighborhood" of team members helping to coordinate care.

Organized Team Model

- Larger panel size per physician
- Everyone works to the limit of their license, dividing the services among the team
- Medical Home care coordination payment may be as low as $4 pmpm to pay for care coordinator
- Physician work schedule focuses on more complex patient

Relationship Centered Model

- Smaller panel size per physician
- Longer visits and fewer patients seen daily
- Activated medical assistant, often an LVN or RN, serves as a patient care coordinator in co-practice with the physician
- Medical Home care coordination payment larger, $30-50 pmpm, often paid by the patient as a "membership" to the physician (resembles concierge practice with online communication rather than cell phone)

HIT Functions for Ideal Primary Care

- Patient Registry – needed for proactive care and quality measurement
- eRx – needed for avoiding medication errors
- EHR – needed for organizing and accessing patient data
- Clinical Decision Support – needed for smart practice and avoiding medical errors
- Patient Portal – needed for continuous access for communication and care


Are You a Member of Eisenhower 365?

Eisenhower Primary Care 365 Origins

- 1998 - Idealized Design of Clinical Office Practice (IHI collaborative and annual conferences)
- 2001 - Crossing the Quality Chasm (IOM Report) Care is based on a continuous health relationship (and not on visits)
- 2001 – Launch of Greenfield Health Practice in Portland, OR by Chuck Kilo and others

Old Primary Care Schedule

- First patient at 8 am and 12 patients each half day session
- 24 patient visits
- 12 patient phone calls
- Done at 6:30 PM
- Patients served -- 36

Ideal Physician Schedule

- Begin online message at 8 am and communicate with 10-15 patients.
- First patient at 9 AM – 5-6 patients/session
- 10-12 patient visits – vary in length from brief to extended
- 6 patient phone calls (telephone visits)
- 30 patient e-visits and messages in 2 sessions lasting 30 min. each
- Done at 5:30 PM
- Patients served – 46-48

What is an Ideal Primary Care Panel Size?

- 2000 to 3000 numbers are historic and not based on any strategic analysis – origins from a time when people when to physicians only when they were sick - may work for organized team model
- Greenfield Health panel size 1000
- EPC 365 panel size 900 with more seniors
- Concierge medicine with cell phone access – 200 to 600

PCMH Hybrid Financial Model

- Payment for care coordination by a team outside of visits (and for improved access, smaller panel sizes, more time with the physician)
- EPC 365 - $595 annually for individuals, $555 for couples and household family, no fee for children 18 and under if parents join
- Regular billing for office visits
- 60% of income comes from the fee.
- Physician incomes of $225-250k with 10-12 visits/day (overhead cap of 60%)

The Major Redesign Elements of Ideal Primary Care

- Care becomes continuous rather than episodic based only on visits
- Care becomes proactive rather than reactive
- Patients become activated for greater self-management

We've Only Just Begun the Redesign of Primary Care

Thank you!

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