Building and training health care teams

Tom Bodenheimer MD

Center for Excellence in Primary Care

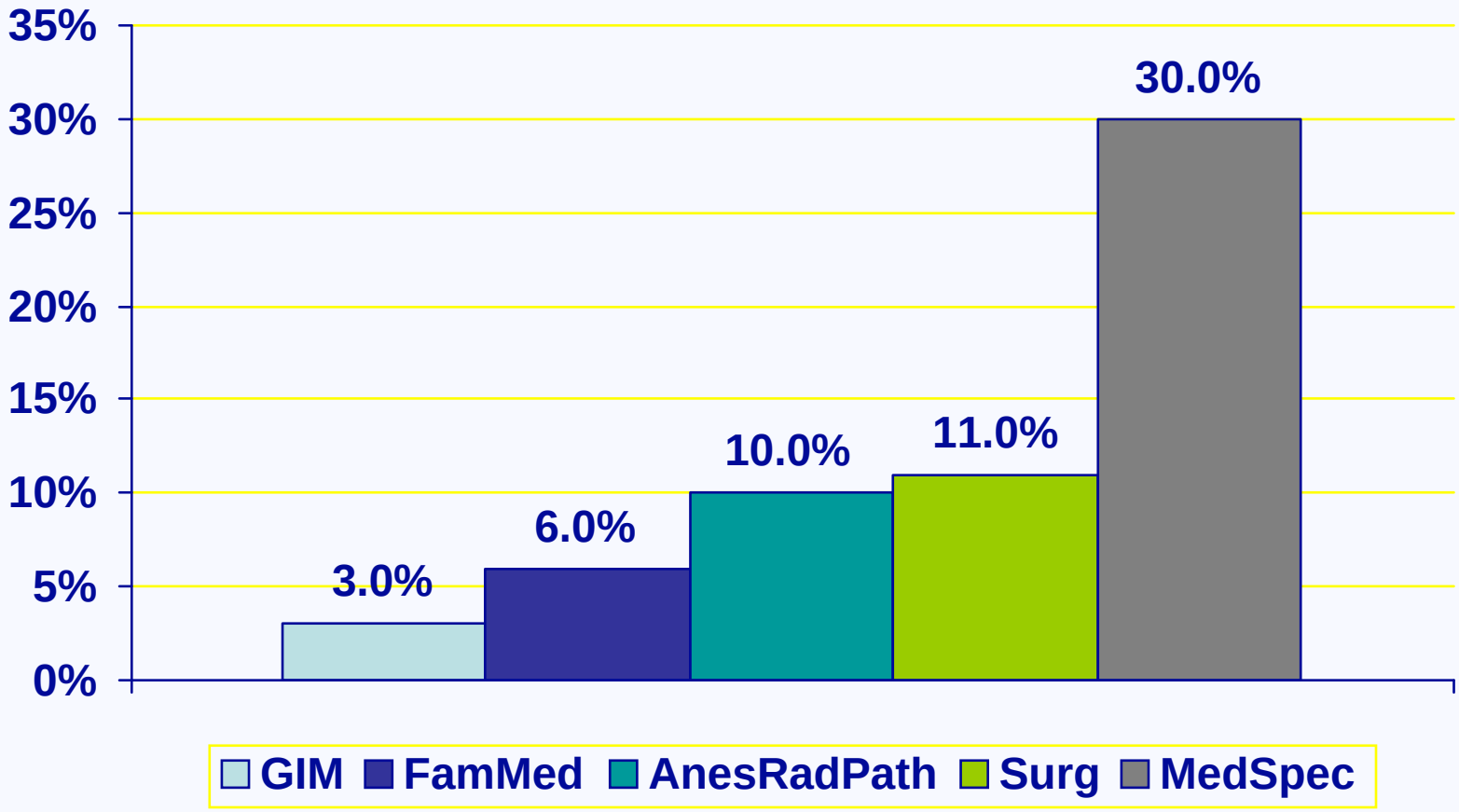
Department of Family and Community Medicine, UCSF

Agenda

- Why we need teams: the primary care crisis
- The practice of the future (PCMH)
- Moving toward team care

Residency Match, 2010

% of graduating US medical students choosing specialties



Adult primary care crisis

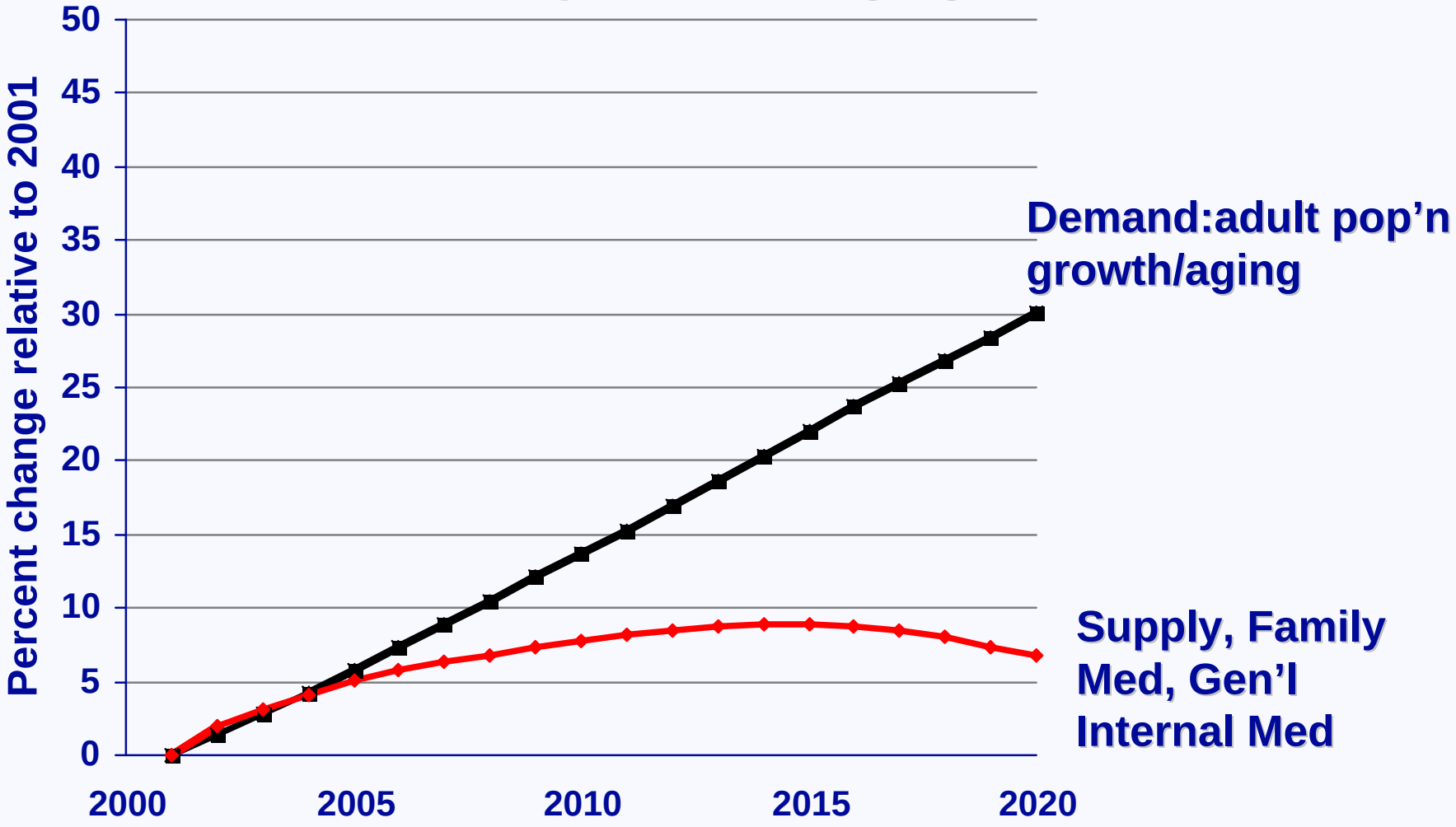
- American College of Physicians (2006)
  - "primary care, the backbone of the nation's health care system, is at grave risk of collapse."

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



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.

Workload of US adult primary care

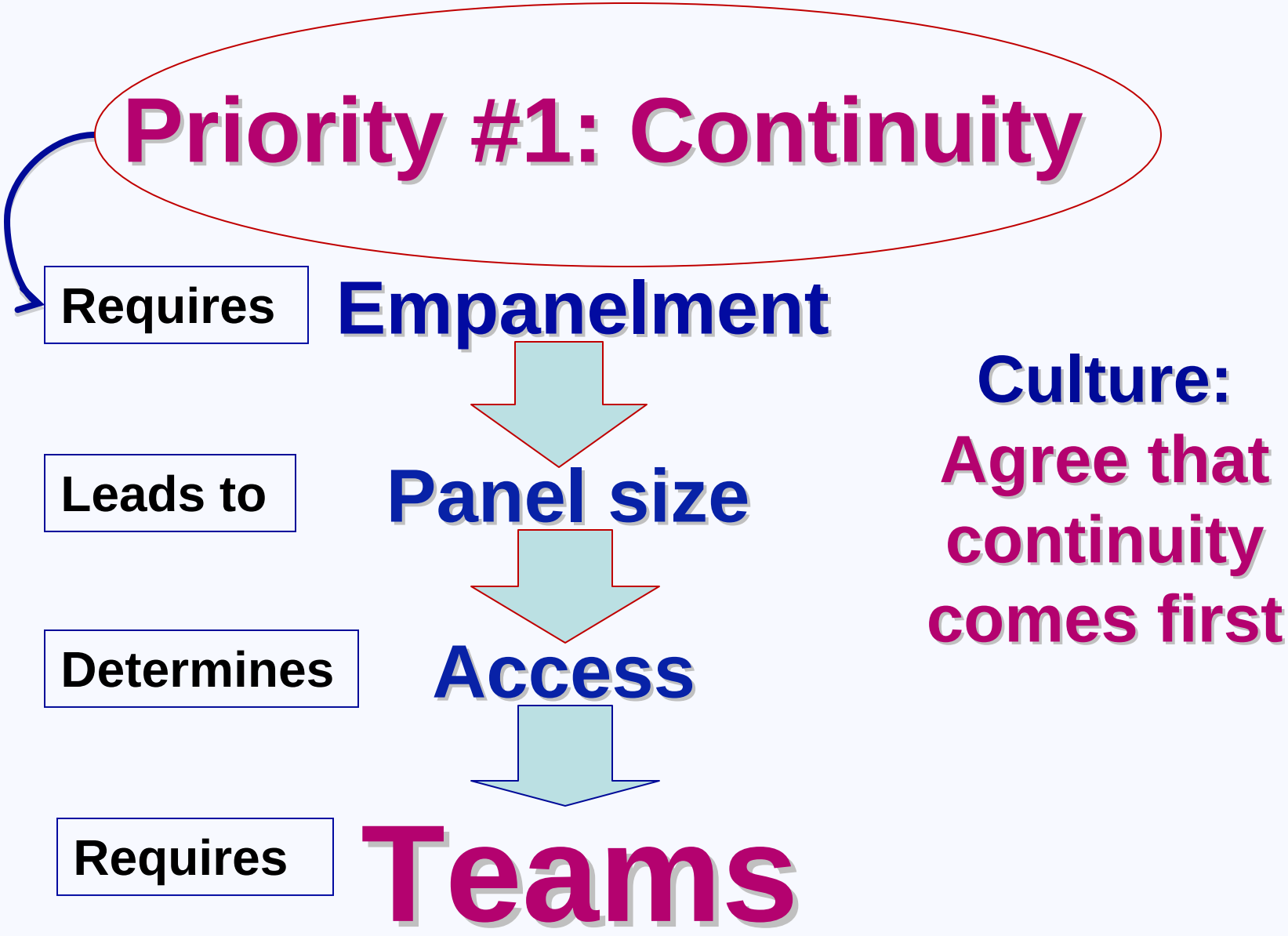
- **Primary care physician with panel of 2500 average patients will spend 7.4 hours per day doing recommended *preventive care* [Yarnall et al. Am J Public Health 2003;93:635]**
- **Primary care physician with panel of 2500 average patients will spend 10.6 hours per day doing recommended *chronic care* [Ostbye et al. Annals of Fam Med 2005;3:209]**

- **Average panel size in US: 2300**

The dilemma

- The shortage will get worse
- It will hit some geographic areas faster than others
- When it hits, panel sizes will go up as there are less clinicians per patient
- This will reduce access, reduce quality, and increase clinician dissatisfaction
- As clinician dissatisfaction increases, fewer MDs/NPs/PAs will enter primary care
- A death spiral could develop

Fundamentals of the PCMH



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
  - Better physician satisfaction

    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

Continuity, access and panel size

- **The larger the panel size, the lower the access, the harder to achieve both continuity and access**
- **At least 50% of what clinicians do could easily 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]
- **If they are trained and if they have time**
- **Teams add capacity, thereby improving access**

Share the care with the team: examples

- Physical therapists are responsible for patients with back pain, and refer to physician if red flags
- Pharmacists are responsible for patients with hypertension including titrating meds with standing orders
- RNs are responsible for all diabetes care except initiating new medications
- LVNs are responsible for prevention panel management, making sure all patients who need cancer screening receive it

Continuity and teams

- Continuity could be redefined as continuity with a team rather than with a clinician
- The same people need to work together all the time; then patients know who is their team
- Teams should be small, so that continuity is not continuity with 8 people, but with 2 or 3 people (teamlets)

Sharing the care

- Models of re-distributing the work
- Model #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
- Model #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

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?**

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

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

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

- MA in role as panel manager checks registry q month
- Patients with abnormal BP contacted to come for RN visit
- 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
- 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 trained MA discuss with patient how med refills will work
- Each week clinician writes the prescriptions, keeps them in safe place
- Regular MA refill visits are scheduled
- At refill visit MA assesses pain, may do tox screen
  - If pain stable, MA gives rx to patient
  - If pain not stable, brief clinician consult
- MA does patient education on alternatives to narcotics

Informing patients of lab results

- **Old way:**
  - **Clinician does it. 7% of abnormal lab results and majority of normal results are never told to patient [Casalino, Arch Int Med 2009;169:1123; Elder, Fam Med 2010;42:327)**
- **New way:**
  - **RN is trained to separate lab results into normal, slightly abnormal, and very abnormal**
  - **Patients asked how they want to get lab results**
  - **Clinicians asked if they want to see normal results**
  - **Receptionist notifies patients of all normal results**
  - **Clinicians view abnormals and inform patients by phone, e-mail or visit depending on patient preference and medical appropriateness**

Teams can reverse the *death spiral*

- **The worklife of the clinician as clinical leader of the team can be more satisfying than seeing one patient after another**
- **If team members feel a responsibility for the health of the panel of patients rather than being given one task after another, work is more satisfying**
- **If the primary care shortage hits hard, a well-functioning team could care for a larger panel without reduction in access or quality**

Tbodenheimer@fcm.ucsf.edu