

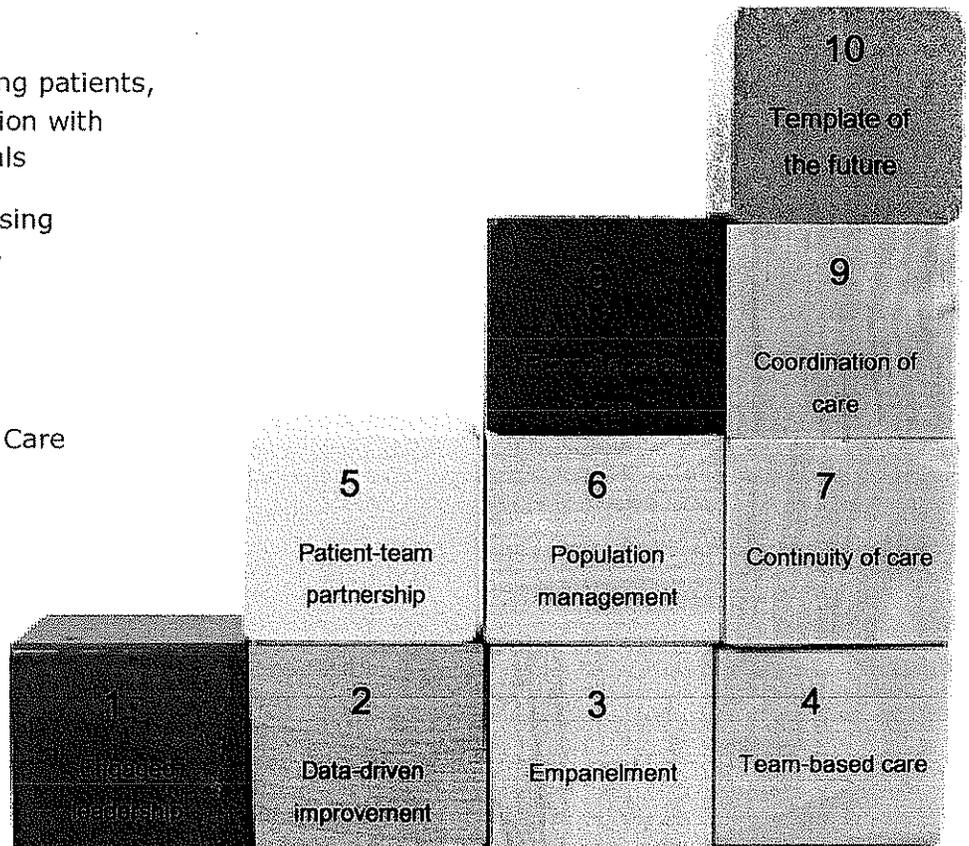
# Building Blocks of High-Performing Primary Care

## The Share-the-Care Model

Center for Excellence in Primary Care  
University of California, San Francisco

These building blocks were derived from site visits to high-performing primary care practices and clinics. The unanimity with which these principles are put into practice suggests that there is one basic model – with individual variation -- for primary care excellence.

- 1) Engaged leadership, including patients, creating a practice-wide vision with concrete objectives and goals
- 2) Data driven improvement using computer-based technology
- 3) Empanelment
- 4) Team-based care
  - a) Culture shift: Share the Care
  - b) Stable teamlets
  - c) Co-location
  - d) Staffing ratios adequate to facilitate new roles
  - e) Standing orders/ protocols
  - f) Defined workflows and workflow mapping



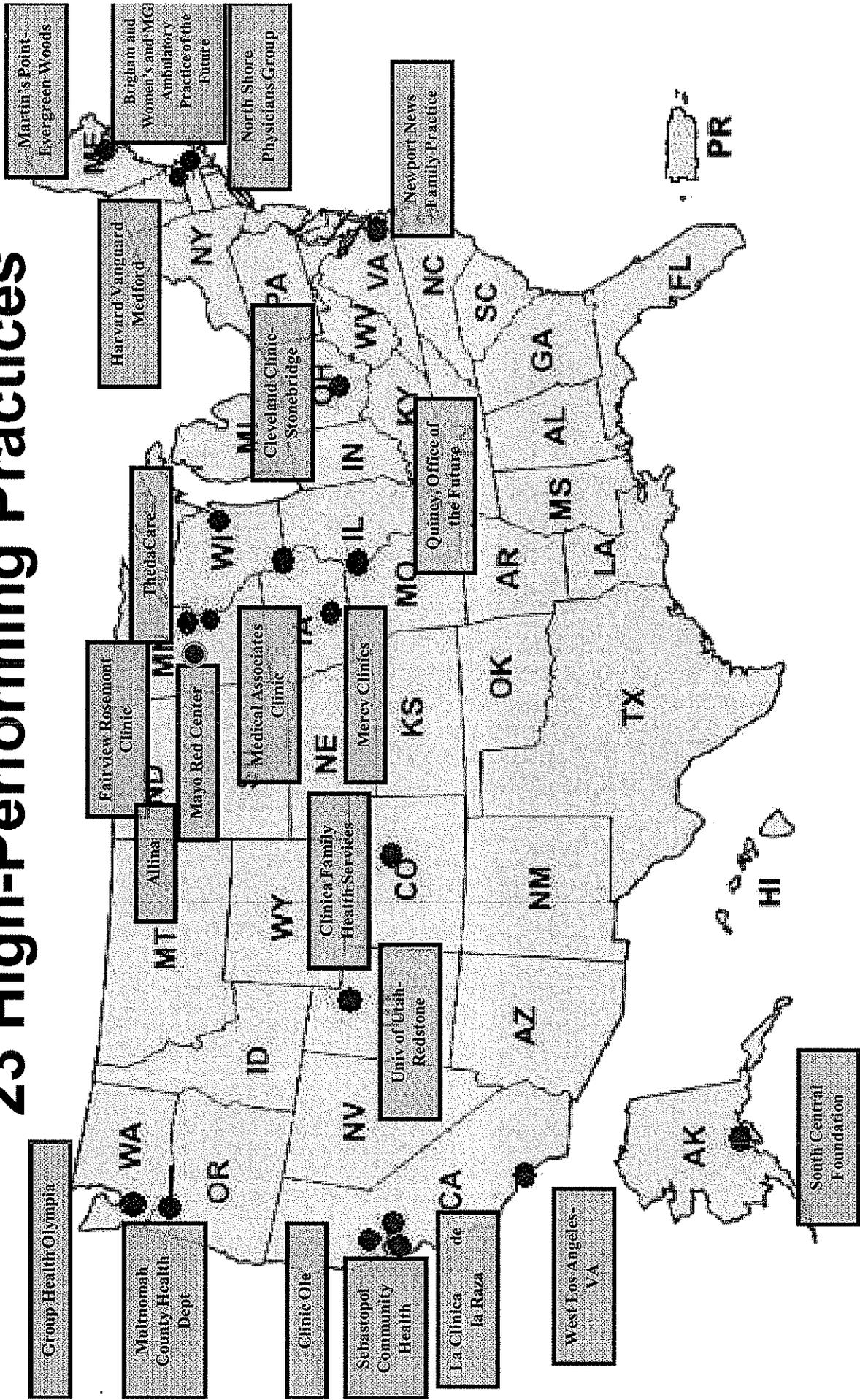
- g) Defined roles with training and skills checks to reinforce those roles
- h) Ground rules
- i) Communication: team meetings, huddles, and minute-to-minute interaction

- 5) Patient-team partnership
  - a) Evidence-based care
  - b) Health coaching
  - c) Informed, activated patients
  - d) Shared decision making

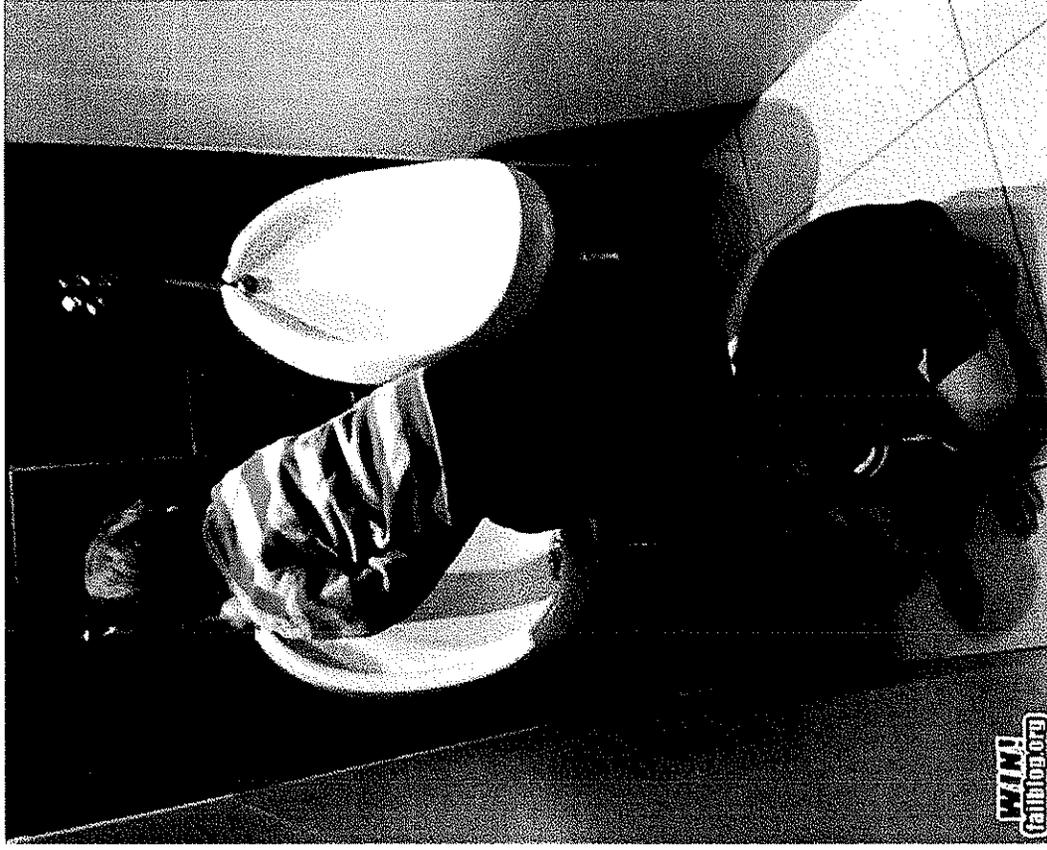
- 6) Population management
  - a) Panel management
  - b) Self-management support (health coaching)
  - c) Complex care management
- 7) Continuity of care
- 8) Prompt access to care
  - a) Weekday hours
  - b) Nights/weekends
  - c) Phone access
- 9) Coordination of care
  - a) Within the medical neighborhood
  - b) With community partners
  - c) With family and caregivers
- 10) Template of the future: escape from the 15-minute visit
  - a) E-visits
  - b) Phone visits
  - c) Group visits
  - d) Visits with nurses and other team members
  - e) Requires payment reform

For detailed descriptions of six of these building blocks, see the California Healthcare Foundation report, *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, April 2012 ([www.chcf.org](http://www.chcf.org))

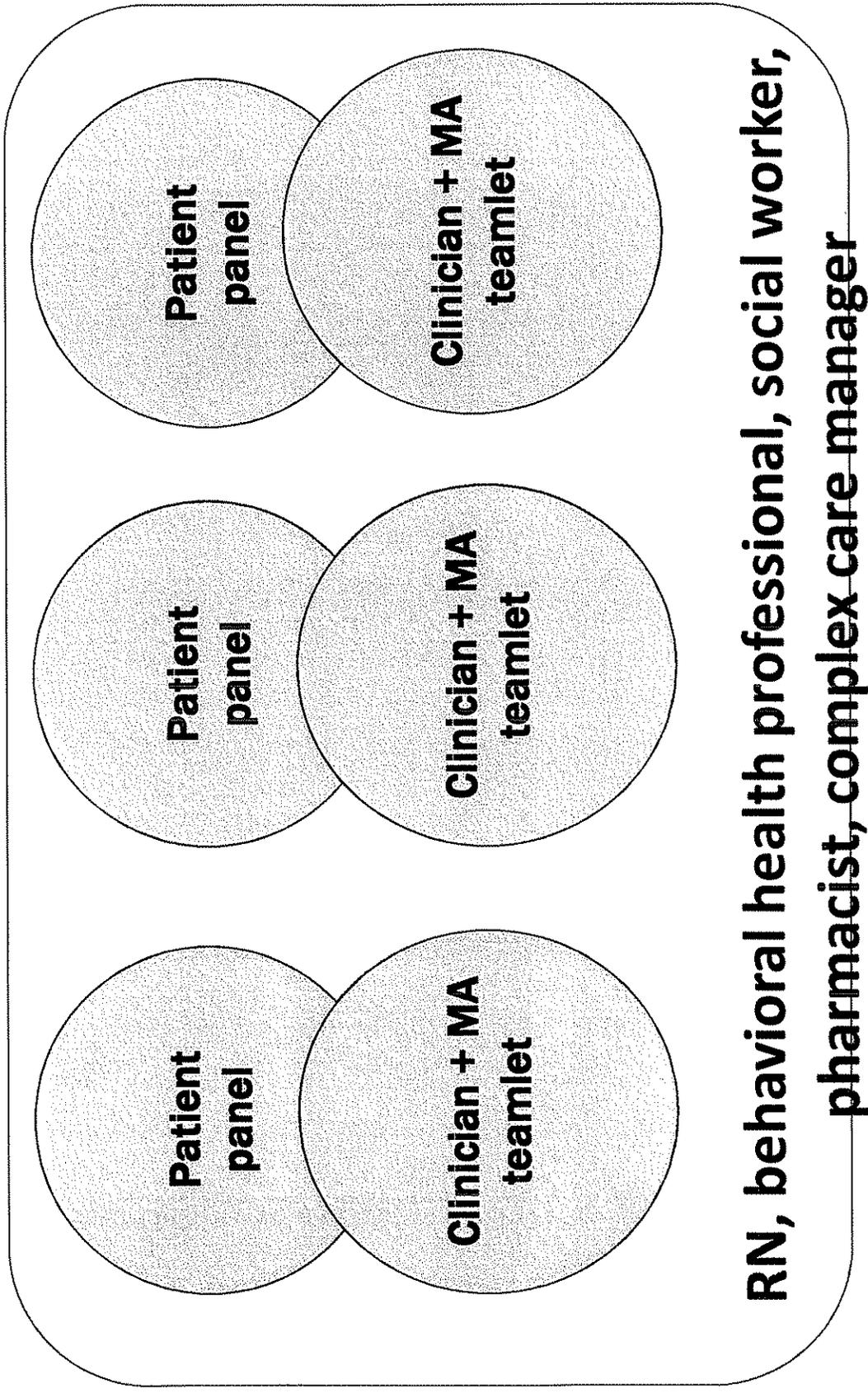
# 23 High-Performing Practices



# Why do we need teams?



# Team-based care: stable teamlets



1 team, 3 teamlets

# Share the care: who does it now?

Tasks	PCP	RN	LVN	Medical assistant	Pharmacist
Orders mammo grams for healthy women between 50 and 75 years old					
Refills high blood pressure medications for patients with well-controlled hypertension					
Performs diabetes foot exams					
Reviews lab tests to separate normals from abnormal					
Cares for patients with uncomplicated urinary tract infections					
Finds patients who are overdue for LDL and orders lipid panel					
Prescribes statins for patients with elevated LDL					
Does medication reconciliation					
Screens patients for depression using PHQ 2 and PHQ 9					
Follows up by phone with patients treated for depression					
<b>Totals</b>					

# Share the care: who should do it?

Tasks	PCP	RN	LVN	Medical assistant	Pharmacist
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## The components of high-performing teams in primary care

Tom Bodenheimer MD

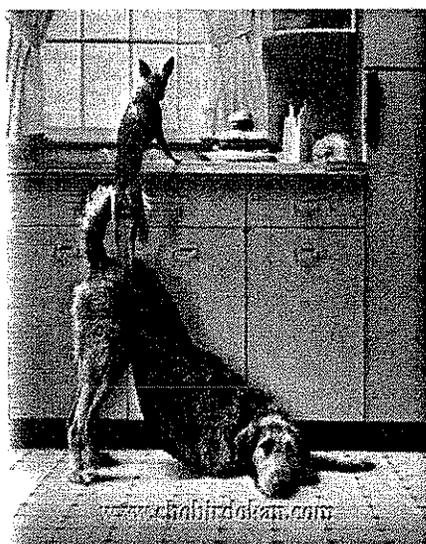
Amireh Ghorob MPH

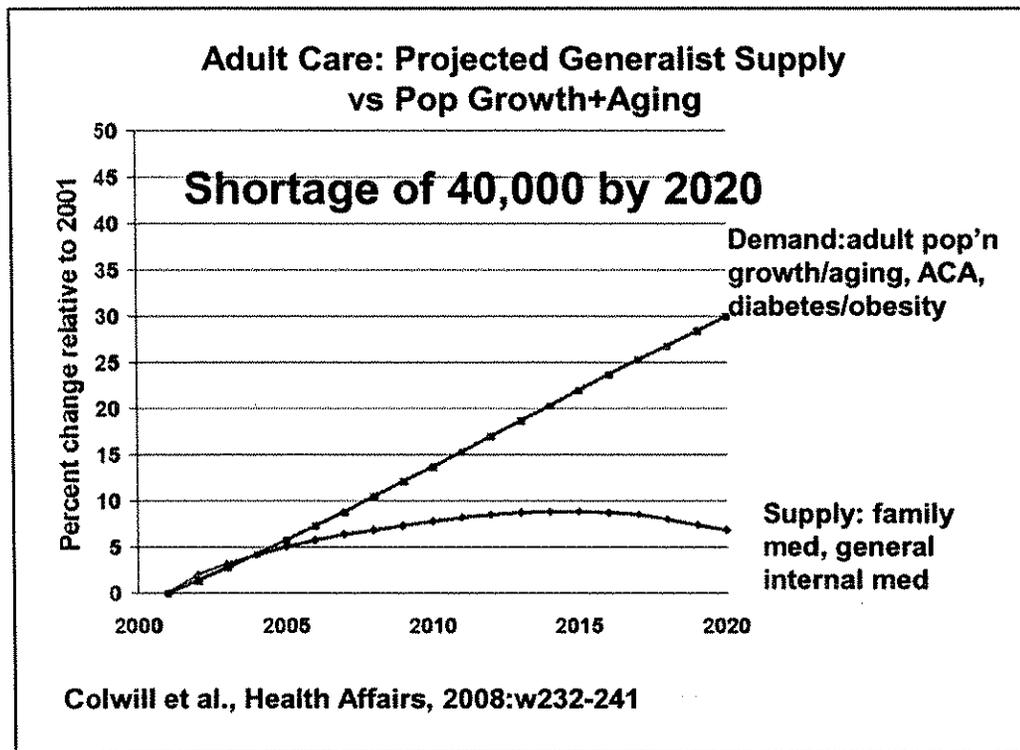
Rachel Willard MPH

Center for Excellence in Primary Care

UCSF Department of Family and Community Medicine

## Why do we need teams?





### 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 clinician 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.

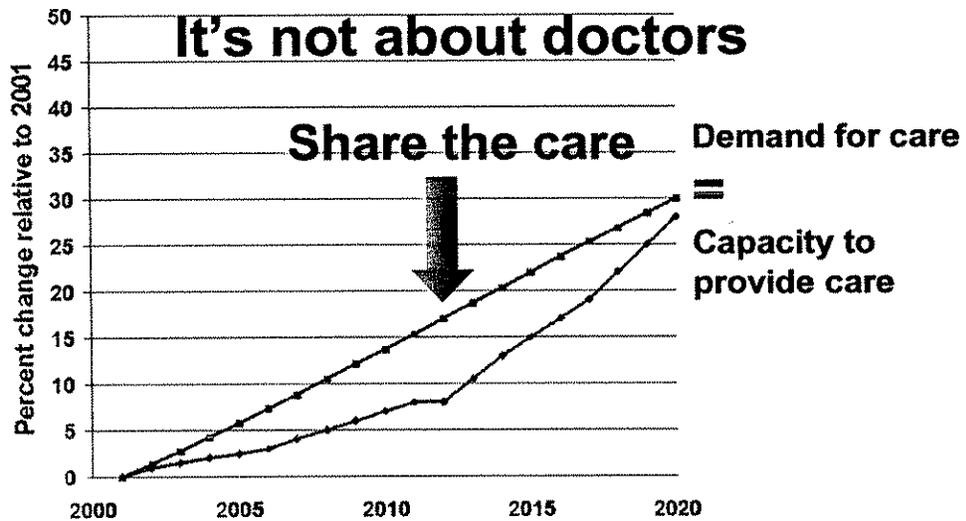
## Why do we need teams?

To increase capacity

We will never solve the adult primary care workforce crisis with MDs, NPs, PAs

We need other team members to share the care

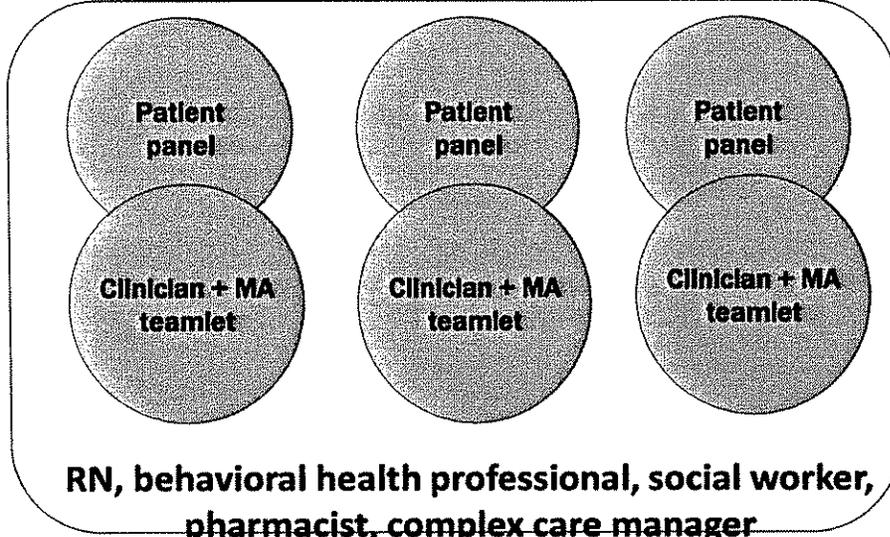
## Adult primary care: capacity vs. demand



Thinking differently



### Team-based care: stable teamlets

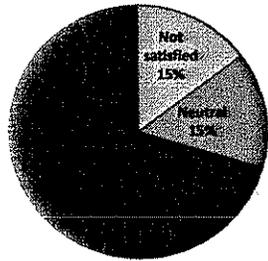


1 team, 3 teamlets

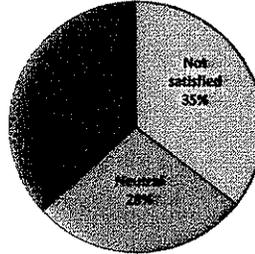
### Clinician Satisfaction with Teams

n=135

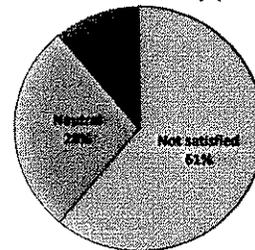
Teamlet (work with same MA) (n=27)



Team (work with group of MAs) (n=90)



No teams (work with different MAs) (n=18)



## Team-based care

- Culture shift: Share the Care
- Stable teamlets
- Co-location
- Standing orders/protocols
- Defined workflows and roles – workflow mapping
- Training, skills checks, and cross training
- Ground rules
- Communication – huddles, team meetings, and constant interaction

### Share the care: who does it now?

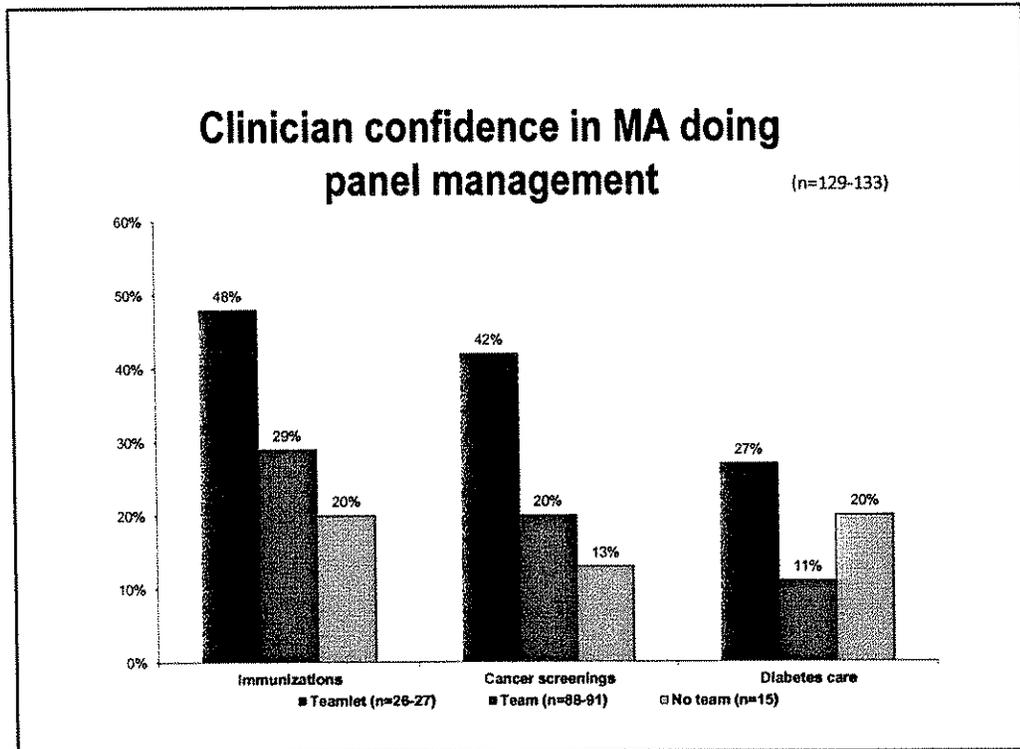
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### **Share the care through panel management**

- **MAs use registries to identify patients overdue for routine services and arrange those services**
  - **Preventive care: immunizations, cancer screening**
  - **Chronic care: e.g. diabetes, all lab tests done on time**
- **Standing orders needed to empower MAs**
- **Quality of preventive services improves [Chen and Bodenheimer, Arch Intern Med 2011;171:1558]**
- **About 50% of all preventive care could be done by MAs [Altschuler et al, Annals of Family Medicine 2012;10:396]**

### **Preventive services: new way**

- **MA (panel manager) checks registry every month**
- **If due for mammo, MA sends mammo order to patient**
- **Result to MA, if normal, MA notifies patient**
- **If abnormal, MA notifies clinician and app't made**
- **For most patients, clinician not involved**
- **For women 40-50 who want or need mammogram, clinician discussion**
- **Similar for colon cancer screening**
- **Requires standing orders**



## Share the care through health coaching

- **MAs trained as health coaches can assist patients with chronic conditions to learn about their disease, engage in healthier behaviors, and increase med adherence**  
 [Margolius et al, Annals of Family Medicine 2012;10:199; Ivey et al, Diab Spectrum 2012;25:93; Gensichen et al, Ann Intern Med 2009;151:369]
- **Estimated 25-30% of all chronic care activities could be shared with medical assistants**  
 [Altschuler et al, Annals of Family Medicine 2012;10:396]

### **Chronic care: hypertension: new way**

- MA (panel manager) checks registry every month
- Patients with high BP sees pharmacist, RN, or coach
- Coach does education, med adherence, lifestyle change
- Patient taught home BP monitoring
- If BP high, patient med adherent, RN/pharmacist intensifies meds
- Standing orders needed
- Health coach f/u by phone or e-mail
- Clinician barely involved
- **Blood pressure control improved with this innovation**  
[Margolius et al, Annals of Family Medicine 2012;10:199]

### **How can pharmacists improve primary care?**

- **Pharmacists care for patients with HBP and diabetes better than physicians**
  - Iowa family medicine program
  - Asheville project
  - Minnesota project
  - Everett Clinic in Washington State
  - Community Health Center, Inc. in Connecticut
  - Kaiser Permanente
    - Pharmacists do much hypertension treatment
    - 85% of KP patients have controlled BP, compared with 50% in US

Smith et al, Health Affairs 2010;29:906

### **How can pharmacists improve primary care?**

- **70% of primary care visits result in a Rx**
- **Adults with chronic conditions: 48% taking four or more medications**
- **33 - 50% of them adhere to their meds**
- **32% of adverse events leading to hospitalization are due to medications**
- **Pharmacists do better than physicians**
  - **Eliminating unnecessary prescriptions**
  - **Improving med adherence for appropriate prescriptions**

Smith et al, Health Affairs 2011;30:646

### **How can pharmacists improve primary care?**

- **Pharmacists as part of the care team are associated with**
  - **Better adherence**
  - **Fewer adverse effect**
  - **Reduced pharmacy costs**
  - **Reduced hospital and emergency department utilization, reducing overall health care costs**

Smith et al, Health Affairs 2011;30:646

### **How can pharmacists improve primary care?**

- **Connecticut community health centers**
- **Long visits with pharmacist with f/u visits**
- **Med education and med reconciliation**
- **Remove inappropriate meds, change dose**
- **Find lower cost substitutes**
- **Gave patients a clear med list**
- **Work with patients on adherence**
- **Quality improved, costs declined**

**Smith et al, Health Affairs 2011;30:646**

### **Take-home points**

- **Share the care means:**
  - **Non-clinicians assuming responsibility for care**
  - **Panel management**
  - **Health coaching**
- **It is challenging without payment reform**
  
- **Sharing the care adds capacity without needing more clinicians**

## Share the care: who should do it?

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