

# **Fixing the Crisis in Primary Care: Insights and Innovations**

**Tom Bodenheimer MD**

**Department of Family and Community Medicine**

**University of California at San Francisco**

# Agenda

- 1) **Why is primary care in crisis?**
- 2) **Macrosystem reform: fixing primary care payment**
- 3) **Microsystem reform: fixing primary care practice**

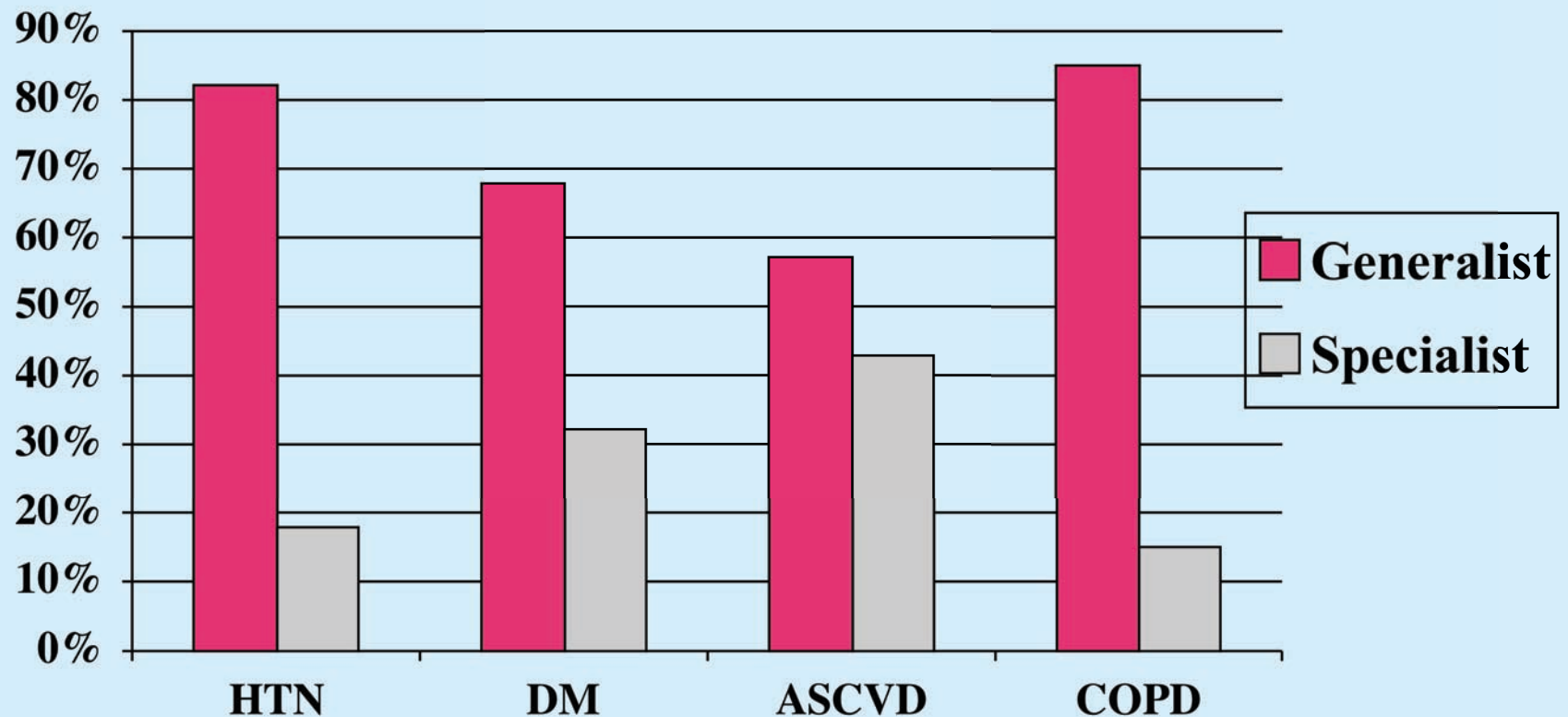
# How are we doing?

- ◆ **Half of discharged CHF patients are readmitted within 90 days [Ni et al. Arch Int Med 1998;158:1231]**
- ◆ **Less than half of eligible atrial fibrillation patients receive warfarin [Samsa et al. Arch Int Med 2000;160:967]**
- ◆ **Only 21% of physicians provide smoking cessation counseling and only 15% of smokers are offered assistance to quit [Unrod et al. JGIM 2007;22:478]**

# How are we doing?

- ◆ **66% of people with hypertension are inadequately treated** [JNC 7, JAMA 2003;289:2560.]
- ◆ **63% of people with diabetes have HbA1c levels greater than 7.0%** [Saydah et al. JAMA 2004;291:335]
- ◆ **62% of people with elevated LDL-cholesterol have not reached lipid goals** [Afonso et al. Am J Man Care 2006;12:589]

# Percentage of Office Visits According to Physician Specialty, By Primary Dx



Source: L Green, Analysis of 1996 Natl Amb Med Care Survey

**Who is falling down  
on the job?**



# Who is falling down on the job?

- Is it a doctor problem?
- **Sometimes**
- A patient problem?
- **Sometimes**
- A system problem?
- **Always**

# Tyranny of the urgent



# **Tyranny of the urgent**

- **Primary care clinicians have too many issues to deal with in the average 15 minute visit**
- **Acute problems crowd out time for routine management of chronic illness and preventive care**

**Wagner et al. Milbank Quarterly 1996;74:511.**

# The hamster syndrome

**“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still...The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among doctors.”**

**Morrison and Smith, BMJ 2000;321:1541.**

# Hamster Care



**Funny things doctors write in their charts  
when they are working like hamsters:**

**“She is numb from  
her toes down.”**

**“Patient has two  
teenage children,  
but no other  
abnormalities.”**

**“While in ER, she  
was examined,  
X-rated and sent  
home.”**

# The reality of the 15-minute visit

- **A study of 264 visits to PCPs using audiotapes: patients making an initial statement of their problem were interrupted by the physician after an average of 23 seconds. In 25% of visits the physician never asked the patient for his/her concerns at all [Marvel et al. JAMA 1999;281:283]**
- **In a study of 1000 physician visits, the patient did not participate in decisions 91% of the time [Braddock et al. JAMA 1999;282:2313]**
- **42% of primary care physicians report not having adequate time with their patients [Center for Studying Health System Change national physician survey]**

## **Primary care is broken: the 50% rule**

- **Asking patients to repeat back what the physician told them, half get it wrong [Schillinger et al. Arch Intern Med 2003;163:83]**
- **Asking patients: “Describe how you take this medication” -- 50% don’t understand how to take it and take it differently than prescribed [Schillinger et al. Medication mis-communication, in Advances in Patient Safety (AHRQ, 2005)]**
- **50% of patients leave the physician office visit without understanding what the physician said [Roter and Hall. Ann Rev Public Health 1989;10:163]**

# Poor coordination of care

- **Coordination of care**
  - **US academic medical center, adult referrals**
    - **68% of referrals -- specialists reported they had received no information from PCP**
    - **25% of the time specialty consultation reports had not reached PCP 4 weeks after specialty visit**
    - **Lack of time important contributor to poor referral process**

**Gandhi et al. JGIM 2000;15:626**

# Poor coordination of care

- **Coordination of care**
  - **Information transfer between hospital-based and primary care physician**
    - **PCP involved in discussions about discharge plan: 3% of the time**
    - **PCP notified that patient had been discharged: 17-20% of the time**
    - **PCP never received discharge summary: 25% of the time**
    - **Discharge summary did not include lab reports: 38% of the time**
    - **Discharge summary did not include discharge meds: 21% of the time**
    - **PCP cared for post-hospital patient before receiving discharge summary: 66% of the time**

Kripalani et al. JAMA 2007;297:831



# Primary care can't do it

- 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]

## **The pathology of primary care: the 15-minute visit**

- **Physicians cannot be expected to provide all acute, chronic and preventive care in the 15-minute visit**
- **The rushed 15-minute visit may be largely responsible for**
  - **Doctors interrupting patients**
  - **Poor information giving**
  - **Rare collaborative decision making**

# Why is primary care broken?

- Reimbursement is low compared to specialist reimbursement
- As a result
  - US medical students are not choosing primary care careers
  - To keep financially solvent, primary care practices need overly large patient panels
    - Large panels create the hamster syndrome which adds to medical student avoidance of primary care
    - Large panels mean that primary care physicians cannot do all the acute, chronic and preventive care that society expects

Bodenheimer, NEJM 2006;355:861

# Dwindling Numbers

	<b># US grads entering family medicine residency</b>
<b>1997</b>	<b>2340</b>
<b>2005</b>	<b>1132</b>

# Dwindling Numbers

- **1998: 54% of internal medicine residents chose primary care internal medicine**
- **2005: 20% enter primary care, the rest choose subspecialist or hospitalist careers**

**Bodenheimer, NEJM 2006;355:861**

## Median compensation, 1995-2004, MGMA data In thousands of dollars, before taxes

	1995	2004	10-yr increase
<b>All primary care</b>	<b>133</b>	<b>162</b>	<b>21%</b>
<b>Family practice</b>	<b>129</b>	<b>156</b>	<b>21%</b>
<b>Internal medicine</b>	<b>139</b>	<b>169</b>	<b>21%</b>
<b>All specialists</b>	<b>216</b>	<b>297</b>	<b>38%</b>
<b>Invasive cardiology</b>	<b>337</b>	<b>428</b>	<b>27%</b>
<b>Noninvasive cardiology</b>	<b>239</b>	<b>352</b>	<b>47%</b>
<b>Dermatology</b>	<b>177</b>	<b>309</b>	<b>75%</b>
<b>Gastroenterology</b>	<b>210</b>	<b>369</b>	<b>76%</b>
<b>Heme/Oncology</b>	<b>189</b>	<b>350</b>	<b>86%</b>
<b>Orthopedics</b>	<b>302</b>	<b>397</b>	<b>31%</b>
<b>Radiology</b>	<b>248</b>	<b>407</b>	<b>64%</b>
<b>Surgery, general</b>	<b>217</b>	<b>283</b>	<b>30%</b>

# Definition of specialists

- Physicians who know more and more about less and less
- Until they know everything about nothing

## Primary care docs

- Know less and less about more and more
- Until they know nothing about everything

# **The primary care-specialty income gap**

- **The income gap is not just an issue of money; it is an issue of whether we will have a primary care foundation to our health system**

**Dorsey et al. JAMA 2003;290:1173, Whitcomb and Cohen NEJM 2004;351:710. Bodenheimer NEJM 2006;355:861.**

# The Vision of the Primary Care Home



# The reality of the primary care home



# Fixing primary care

- **Macrosystem reform**
  - Health plans and Medicare need to
    - Invest in primary care
    - Change how primary care is paid
- **Microsystem reform**
  - Primary care practices must step up to the plate and make improvements (the “medical home”)

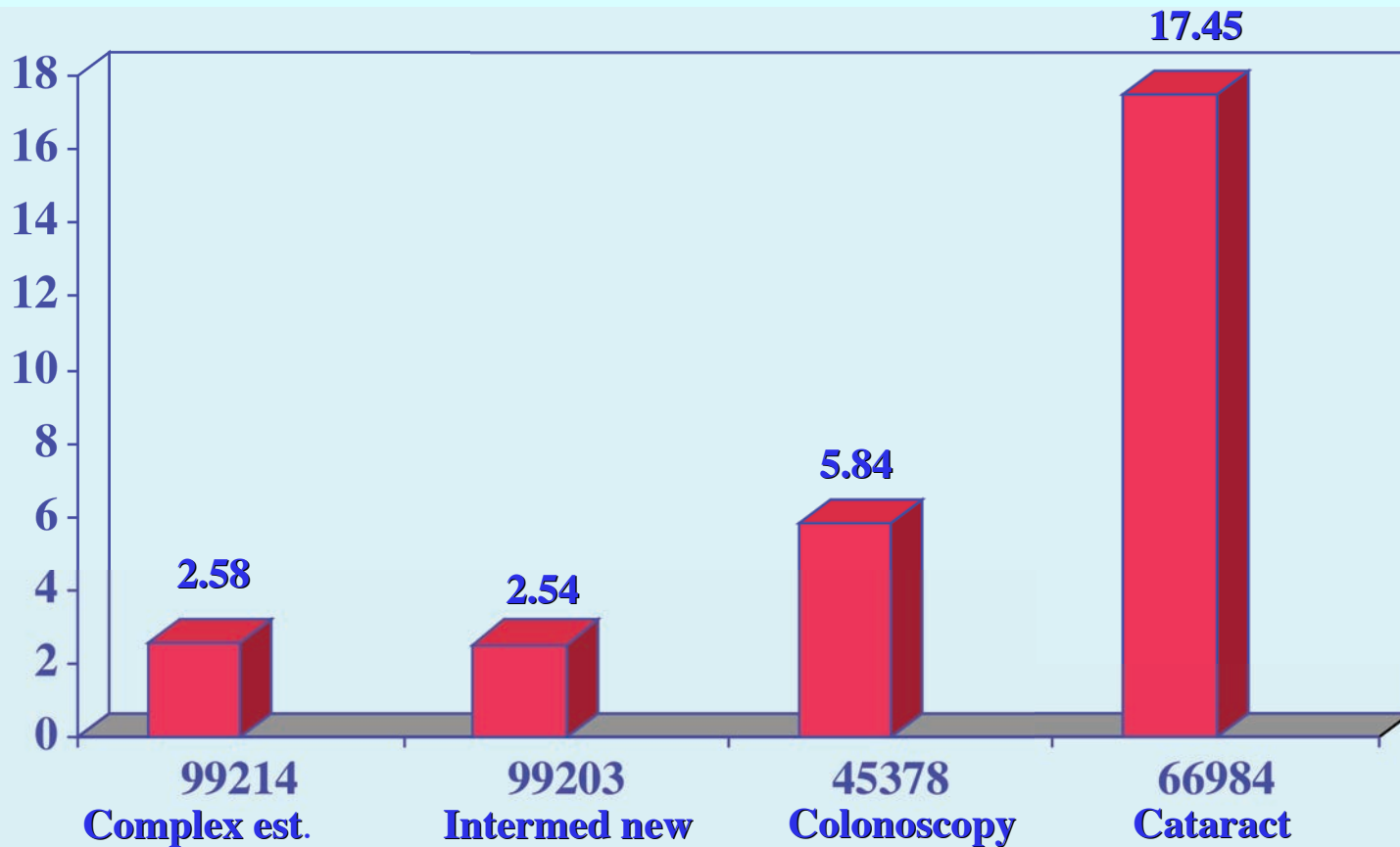
# **Macrosystem (payment) reform**

- **Fee-for-service reforms**
  - Reform RBRVS system to give value to cognitive services
  - Reform the Medicare SGR system which penalizes primary care
  - Equalize private insurer conversion factors
  - Add payments for phone and e-visits, care coordination, EMR adoption
  - Reward low-cost Medicare regions
- **Eliminating fee-for-service**

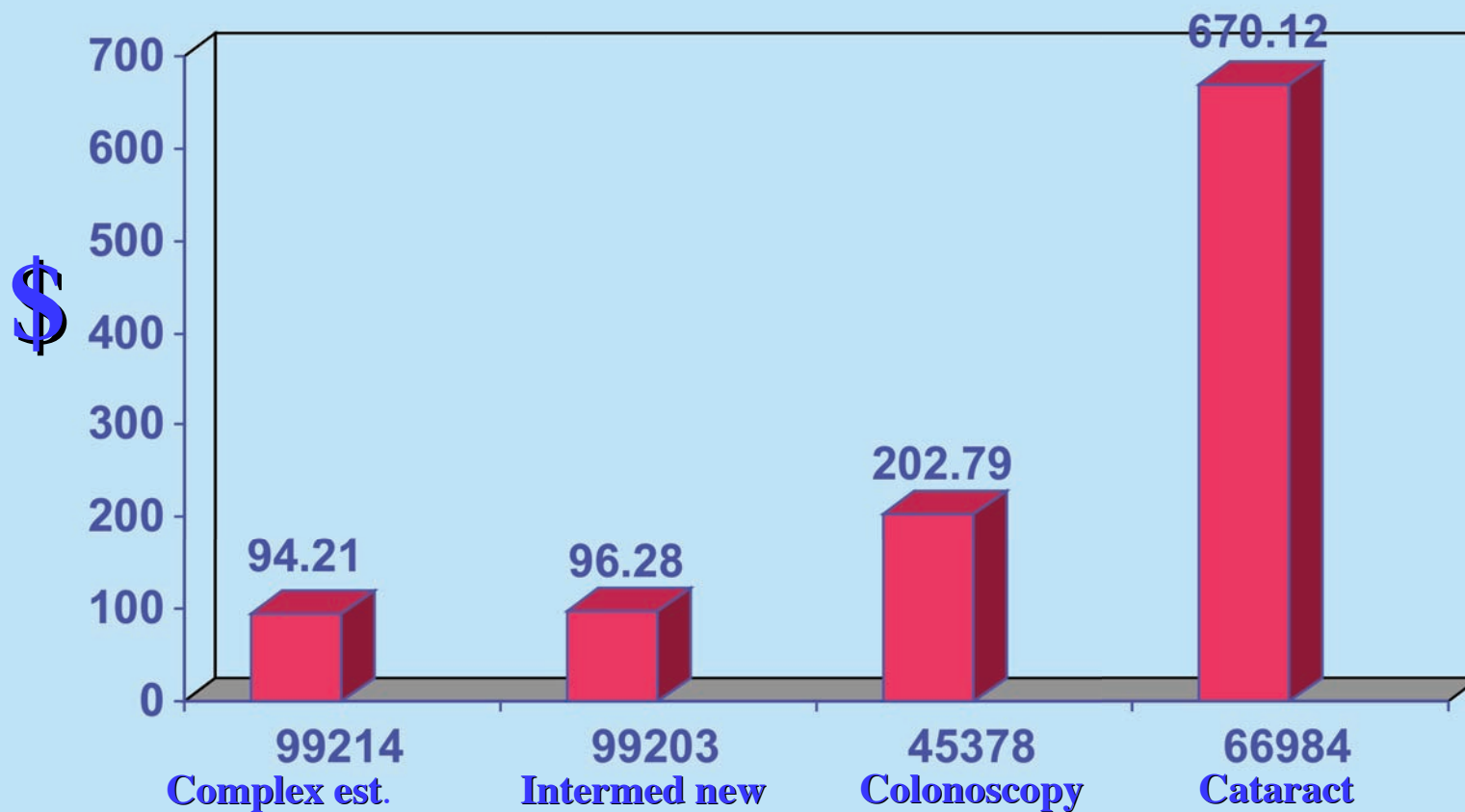
## **Reform RBRVS system to give value to cognitive services**

- **Medicare and most private insurers use the RBRVS system**
- **Each service is assigned a relative value unit (RVU)**
- **The fee is the RVU x conversion factor**
- **Congress sets the Medicare CF; private insurers set their own CFs**

# 2007 RVUs for 30 minutes physician time



# 2007 Medicare payment for 30 minutes physician time



Assumes GPCI approximately 1.0; CF 37.9

# **Reform RBRVS system to give value to cognitive services**

- **Medicare mandates that RVUs be updated every 5 years**
- **CMS has delegated the update process to the Relative Value Scale Update Committee (RUC)**
- **The RUC is a committee of the AMA**
- **It recommends RVU changes to CMS, which must approve them**

## How RVUs are updated (the “RUC”)

- The RUC has 29 members, most named by specialty societies, including primary care specialties
- Even though PCPs provide about half of all Medicare visits, primary care has only 14% of the seats on the RUC
- Specialty societies request changes in RVU values
- The 86% of RUC members who are not primary care tend to vote together on RVU updates
- In the 2000 update process, cognitive codes were not discussed at all. Procedure and imaging codes went up and office codes remained the same
- In 2005-6, office visits did receive an increase  
Bodenheimer et al. Annals of Internal Medicine 2007;146:301.

# **Reform RBRVS system to give value to cognitive services**

- **Reforming RBRVS would take a major effort to restructure the RUC or for CMS to stop contracting with the RUC for RVU updates**
- **It would create an unwelcome fight between primary care and specialists**
- **But it may be necessary**

# Reform the Medicare SGR

- **SGR = Sustainable Growth Rate**
- **Total dollars Medicare pays physicians each year (about \$90 billion in 2006) is based on SGR formula**
- **SGR limits total Medicare physician payment increases each year, based on # Medicare beneficiaries, physician practice expense rise, increase in gross domestic product**
- **If total Medicare physician payments exceed SGR target, conversion factor is reduced the following year**
- **Example: If SGR allows Medicare physician payment to rise by 5% in 2006, but Medicare physician payment rose 10% in 2006 due to volume growth, then the conversion factor (physician fees) goes down by 5% in 2007**

# Reform the Medicare SGR

- Past few years, Medicare physician payment has exceeded the SGR; Congress has bailed out the physicians and has not reduced the CF
- 86% of SGR overage is due to imaging and procedural payment growth. Specialists are responsible for physician payment exceeding SGR, but all doctors -- primary care and specialty -- are penalized
- Medicare primary care payment is low in part because specialist payment is so high. Zero sum game

# Reform the Medicare SGR

- Split the SGR into 2 buckets: cognitive services vs. procedural/ imaging services
- CF for cognitive will rise because these services don't exceed SGR targets
- CF for procedural/imaging will go down because these services do exceed SGR targets
- Increased CF for cognitive services will help primary care a great deal

# **Equalize specialty and primary care private insurance payments**

- **For Medicare, the conversion factor is the same for all services (37.9 in 2007)**
- **Payment = RVU x conversion factor**
- **Big difference!! For many private insurers, the conversion factor varies**
- **Specialists usually enjoy conversion factors higher than primary care conversion factors**

## **Equalize specialty and primary care private insurance payments**

- **CF for specialists are higher because specialists have organized into market-dominant single-specialty groups; their market power forces insurers to pay high CFs**
- **To equalize this, primary care needs to organize in markets -- not easy due to FTC and lack of resources to organize**

## **Add payments for phone and e-visits, EMR, registries, care coordination, care managers, health coaches**

- **This is an area of intense discussion and some action**
- **It could improve primary care payment substantially**
- **15-20% of general internist's time is spent on care coordination between visits, most unpaid**
- **However, any payment system based on fee-for-service primarily rewards quantity, not quality**

## **Reward low-cost Medicare regions**

- **We all know about Miami (high-cost, low-quality) vs. Minneapolis (low-cost, high-quality)**
- **Why not reduce Miami conversion factor and increase Minneapolis conversion factor to reduce total Medicare per capita Miami expenditure and increase Minneapolis**

## **Reward low-cost Medicare regions**

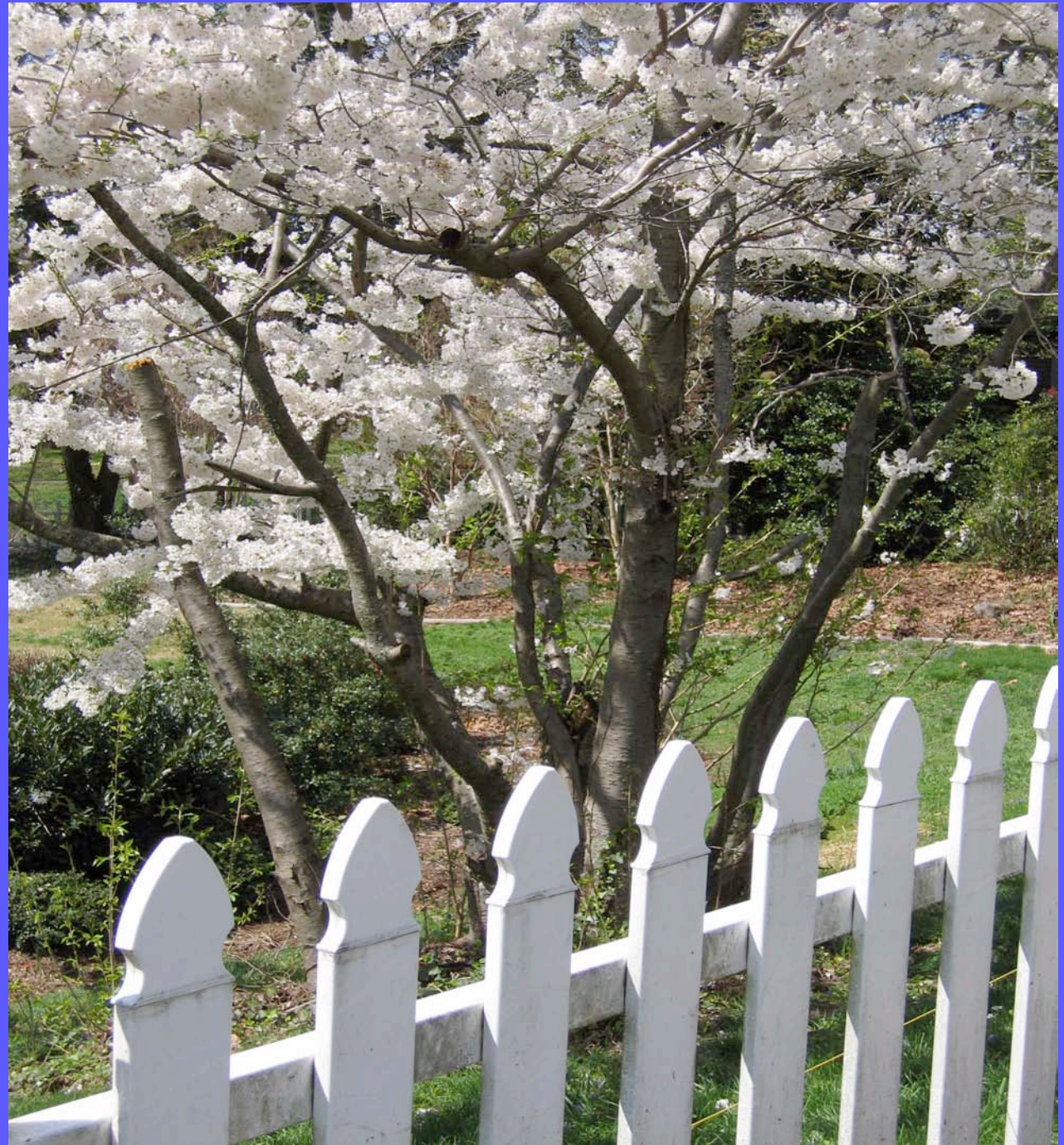
- **May not help primary care (hurt it in Miami, help it in Minneapolis)**
- **Politically dead meat -- Florida 4th largest state has too many electoral votes. No president would sign it**

# **Eliminate fee-for-service payment for primary care**

- **Goroll, Schoenbaum et al. proposal to change primary care financing (JGIM 2007;22:410)**
  - **Eliminate fee-for-service; initiate comprehensive risk-adjusted payment per patient plus P4P**
  - **The payment provides higher PCP income, but more importantly is used to support a strong primary care team and a computerized office**
  - **To deserve such financing, primary care practices must meet certain requirement**

**Ending fee-  
for-service**

**It's beautiful**



# **Microsystem reform**

- **If we are asking Medicare and private insurers to invest in primary care through improved payment**
- **We need to step up to the plate and show that we deserve this investment**
- **To deserve the comprehensive payment of Goroll/Schoenbaum, we need to make major changes in primary care organization**
- **Macrosystem and microsystem reform closely intertwined**

# Change in practice: Stratifying the patient population

- People who need same-day acute care
- Healthy people who need preventive care
- Women who need pregnancy and infant care
- ✓ People with a chronic condition
- ✓ People with complex healthcare needs
  - People with mental health/substance use issues
  - People who need care at the end of life
- Primary care practices must build different models for these different strata of their panels
- All patients cannot be funneled into the 15-minute visit

# **Stepping up to the plate for patients with chronic conditions and patients with complex healthcare needs**

- **Innovations**
  - **Panel management model**
  - **Care management model**
  - **Coaching model**
- **Goals of innovations**
  - **Improve patient experience**
  - **Improve processes and outcomes**
  - **Make worklife more reasonable for physicians**

# **The panel management model**

- **Cannot work without a registry**
- **Registries only work if someone works them**
- **A team member needs to be designated to work the registry**
- **Panel manager**
  - **Identifies patients who need services done, orders them, and contacts them**
  - **Identifies patients in poor control, tries to bring them in for planned visits**
  - **Works with clinicians to intensify medications quickly**
- **Panel managers need coaching skills**

# The care management model

- Panel management: for patients with preventive needs and less complex chronic illness
- Less effective for patients with complex healthcare needs
- RN care management model is more effective, with intensive nursing individualized to each patient
- Care managers are not in disease management companies; they are in primary care practices
- If small practices, they are in medical groups/IPAs
- 4 studies: care management improves care and reduce costs for patients with complex healthcare needs
- It offloads a lot of work from physicians

Dorr et al, Disease Management 2006;9:1; Sylvia, Boult et al. Disease Management 2008;11:29; Naylor et al, JAGS 2004;52:675; Coleman et al. Arch Intern Med 2006;166:1822

# **Why we need care management: cost containment**

- **2/3 of Medicare costs are attributable to 20% of Medicare beneficiaries with 5 or more chronic conditions -- patients with complex healthcare needs**
- **5% of beneficiaries incur 48% of Medicare costs**
- **The average Medicare patient with complex healthcare needs sees 14 outpatient physicians, has 37 physician visits, and 49 prescriptions per year, and even with all these out-patient services is hospitalized 100 times more frequently than patients in better health**  
**Wolff, Boult. Ann Intern Med 2005;143:439**

# The coaching model

- **Coaching vs. rescuing**
- **Coaching for post-hospital discharge patients (Caretransitions.org)**
- **Coaching for primary care patients with chronic conditions and risk factors (Teamlet Model)**



# Coaching at SFGH Family Health Center: The “teamlet” model

- Medical assistants and community health workers are trained to become health coaches. If RN is available to become health coach, all the better
- Coaches work closely with clinicians
- This new subunit is called the “**teamlet**”
- Called teamlet because
  - It is part but not all of the team
  - It is small
- Plan is to combine coach with panel manager

## **Remember the 15-minute visit?**

- **Physicians interrupt patients**
- **50% of patients leave the visit without knowing what took place**
- **91% of the time no shared decision making**
- **It is impossible to provide acute, chronic, preventive and care coordination services in the 15 minute visit**

# **Teamlet coaching addresses the basic pathology of primary care: the 15-minute visit**

- **In the teamlet concept, the 15-minute visit is extended to**
  - **Pre-visit by health coach**
  - **Visit by physician (perhaps with health coach)**
  - **Post-visit by health coach**
  - **Between-visit by health coach**
- **HealthPartners model**

# Pre-visit by health coach

- ✓ Orders health maintenance/chronic disease services that are due (based on physician-written protocols). This can also be done separate from the visit by the panel manager.
- ✓ Medication reconciliation (often takes clinician 5 minutes to figure out which meds patient is actually taking, plus meds from another physician or healer)

# Clinician visit

- Health coach may or may not participates in visit
- Health coach can fill out forms, do computer entry, set up for procedures, get things not in the room
- Utah model with Epic EMR, medical assistant acts as scribe at the computer; clinician focuses on the patient.
- Physicians see an extra patient or 2 per day to pay for extra MAs and get home earlier and are far more satisfied.

## **Post- visit by Health Coach**

- **Makes sure patients understand clinician's advice (50% don't know what happened in the visit):  
“closing the loop”**
- **Makes sure patient agrees with decisions made in visit (patients don't participate in decisions 91% of the time)**
- **Does behavior-change goal setting/action plans**
- **Helps patients navigate system**
- **Teaches disease-specific skills**
- **Sees if patient has any issues/concerns; health coach listens**
- **Clinician may “pop in” if coach has questions**



## **Between-visit by Health coach**

- **Coach calls patients between visits; did they get new meds, understand meds, taking meds, side effects, behavior-change action plans, problems**
- **Every medication change should have f/u phone call after 3-4 days**
- **For patients to call their clinician is often difficult; they can call the coach if there is a problem, providing between-visit easy access**
- **Coach checks with clinician if needed**

# **Coaching, care management, and panel management**

- **Combining coaching, care management, and panel management**
  - **For patients with less complex preventive and chronic care needs -- panel manager to make sure all recommended services are done in a timely fashion**
  - **For patients with one or two poorly controlled chronic conditions -- coaching in teamlet model**
  - **For patients with complex healthcare needs -- RN care manager with coach extenders**

# Are panel management and teamlet coaching feasible?

- Needs serious re-configuration of primary care workforce
- Example: pods with panel size 5-6,000
  - 1 physician, 2 PA/NPs -- the clinicians
  - For each clinician, 3 MA/coaches
  - 1 RN care manager backs up coaches and does more intensive planned visits, patient education, and polypharmacy management
  - 1 coach also functions as panel manager
  - Depends on size of practice and nature of the patients
- Requires change in how primary care is paid
- It is possible (but challenging) to begin with existing workforce: training and re-thinking personnel roles

# Can this model work with current payment system?

- Parts of the model might be compatible with productivity-based payment
  - Neighborhood Healthcare in San Diego has two MAs per physician: pays for them with more productivity
  - Utah model similar
  - North Carolina -- Medicaid pays RN care managers
  - Maine Medical Center pays for RN care managers for many small practices
- To roll out the entire model (panel management plus coaching plus care management) needs change in payment system

**These models  
are a work in progress**

**Comments are desired and  
appreciated**

**[TBodenheimer@fcm.ucsf.edu](mailto:TBodenheimer@fcm.ucsf.edu)**