Resilience Strategies for Team Care

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Upon completion of this educational activity, participants will be able to:

1. Explain why teams are important in primary care practice
2. Understand the concept of a stable team
3. Apply the concept of “share the care” in their practice
4. View practitioner engagement from the perspective of patients
Resilience: the ability to recover from or adjust easily to misfortune or change
Overview

Learning from bright spots

Primary care practitioner workforce review

Teams in primary care
Learn from the bright spots

Bright spots are practices or teams that work very well, achieving the quadruple aim
- Improved patient experience
- Better population health
- Lower costs
- Better clinician and staff experience

In primary care there are bright spots and dark corners

For health care, Utah is one of the bright spots in the country
Learn from the bright spots

Intermountain Healthcare has bright spot primary care teams, and less developed teams that can learn from the bright spot teams.

Potential clinics: Not yet team-based care
Adoption clinics: At least 2 years of developing team-based care
Routinized clinics: Teams for over 6 years; teams are the standard way these clinics function

Reiss-Brennan B, J Primary Care and Community Health 2014;5(1):55-60

Reiss-Brennan, B. et.al. Association of Integrated Team-Based Care with Healthcare Quality, Utilization and Cost. JAMA 2016: In Print
Learning from 23 bright-spot practices

Bodenheimer et al, Ann Fam Med 2014:12:166
Sinsky et al, Ann Fam Med 2013:11:272
From these 23 bright-spot practices, we observed several common features.

The 10 Building Blocks of High-Performing Primary Care:
Overview

Learn from the bright spots

Primary care practitioner workforce review

Teams in primary care
Projected primary care physician supply vs. demand

- 8000 new primary care physicians (PCPs) enter the workforce each year.
- By 2020, 8500 will retire each year.
- Shortage of 17,000 by 2025
- Utah: shortage of 1100 by 2030 (46% of current PCP workforce)

Demand: pop’ n growth/aging, diabetes/obesity, ACA

Supply: family docs, general internal medicine docs

Colwill et al., Health Affairs, 2008:w232
Which statement is correct?

The primary care physician/population ratio will increase by 2025

The number of new primary care physician entrants into the workforce will exceed the number of retirements

There will be a primary care physician shortage of 17,000 by 2025

Utah will not have a primary care physician shortage
Geographic distribution of primary care physicians

**USA:** Urban areas have 84 primary care physicians per 100,000 population

**USA:** Rural areas have 68 primary care physicians per 100,000 population

27 of Utah’s 29 counties are Primary Care Health Professions Shortage Areas

Utah ranks 42nd out of 50 states in primary care physicians per population
NP/PAs to the rescue?

New graduates each year (2014)
- Nurse practitioners: 18,000
- Physician assistants: 7,500

% going into primary care
- NPs: 50%
- PAs: 32%

Even with many new NPs/PAs, the primary care practitioner to population ratio will fall by 8% from 2010 to 2025.
Growth in primary care physician graduates, 2005 - 2015
Growth in Nurse Practitioner Graduates*
2001 - 2014

Graduates

7,261 6,979 6,526 6,900 7,583 8,865 9,698 11,135 12,273 14,310 16,031 18,484

Growth from 2013 to 2014: 15.3%
Physician Assistant Pipeline Growth
Newly Certified PAs, 2001 - 2014

Growth from 2013 to 2014: 14.7%
## Primary care practitioner (PCP) USA workforce

<table>
<thead>
<tr>
<th></th>
<th># in 2010</th>
<th>% of PCPs 2010</th>
<th># in 2025</th>
<th>% of PCPs 2025</th>
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</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>210,000</td>
<td>71%</td>
<td>216,000</td>
<td>60%</td>
</tr>
<tr>
<td>NPs</td>
<td>56,000</td>
<td>19%</td>
<td>103,000</td>
<td>29%</td>
</tr>
<tr>
<td>PAs</td>
<td>30,000</td>
<td>10%</td>
<td>42,000</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>296,000</td>
<td>100%</td>
<td>361,000</td>
<td>100%</td>
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Auerbach et al, Health Affairs 2013;32:1933
% of primary care practitioners working in rural areas, US 2010

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<table>
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<tbody>
<tr>
<td>NPs</td>
<td>28%</td>
</tr>
<tr>
<td>PAs</td>
<td>25%</td>
</tr>
<tr>
<td>Physicians</td>
<td>14%</td>
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</tbody>
</table>

Primary care PAs and NPs are more likely than primary care physicians to care for populations in rural areas.
Which statement is correct?

- Utah will have enough primary care practitioners by 2025 because of the excellent U of U physician assistant program
- The proportion of primary care practitioners who are physicians is dropping
- Utah has one of the highest primary care physician to population ratios in the US
- Physicians are as likely as NPs/PAs to work in rural areas
Primary care practitioner workforce projections: take-home points

The primary care practitioner (physicians, NPs, and PAs) to population ratio is slowly falling.

Physicians will make up a smaller and smaller proportion of primary care practitioners.

In the US, nurse practitioners are the most rapidly growing group of primary care practitioners.

In Utah, PAs are the most rapidly growing.

Compared with physicians, a much larger proportion of NPs and PAs work in rural areas.

NPs and PAs are the future for primary care in the US and Utah.
PAs and NPs rescuing our healthcare system from the primary care physician shortage is an example of the system’s resilience.

Life is not about how fast you run or how high you climb but how well you bounce. ~Vivian Komori
Overview

- Learn from the bright spots
- Primary care practitioner workforce review
- Teams in primary care
The 10 Building Blocks of High-Performing Primary Care
Bodenheimer et al, Ann Fam Med 2014:12:166

Teams

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future
Teams are difficult. Why bother?

If we want to succeed as a team, we need to put aside our own selfish, individual interests and start doing things my way.

- Do your patients feel comfortable receiving care from a team?
- Do any team members independently care for patients without clinician involvement?
- Has the team improved any quality measures over what a lone clinician could achieve?
- Does the team reduce the work of clinicians?
- Does the team add capacity to see more patients without causing clinicians more work?

If the answers are all No, the team is not worth having.
What do patients want from physicians?


**Competence**
- I want my physician to have the knowledge needed to help me

**Empathy**
- I want my physician to care about me

**Familiarity**
- I want to know my physician; I want my physician to know me

**Continuity**
- I want to see my personal physician when I need help

It doesn’t have to be a physician. It could be a NP, PA, RN, behaviorist, pharmacist, physical therapist, or medical assistant.
The 9 elements of high-performing teams

<table>
<thead>
<tr>
<th>Stable team structure</th>
<th>Co-location</th>
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<tbody>
<tr>
<td>Culture shift: share the care</td>
<td>Defined roles with training and skills checks</td>
</tr>
<tr>
<td>Standing orders</td>
<td>Defined workflows</td>
</tr>
<tr>
<td>Staffing ratios adequate to allow new roles</td>
<td>Ground rules</td>
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<tr>
<td>Communication: team meetings, huddles, minute-to-minute interactions</td>
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Stable team structure: teamlets

1 team, 3 teamlets

- Patient panel
  - Clinician + MA teamlet
  - RN, behavioral health professional, social worker, pharmacist, complex care manager
BellinHealth 3-person teamlet structure

Supporting 3 or 4 teamlets is an extended care team including RN, social worker, pharmacist, behaviorist, complex care manager
Patients know and trust their clinician and care team coordinators. Even when patients have misfortune, the trusted team helps them recover or adjust.

Clinician burnout is greatly lessened because care team coordinators do all documentation and charts are completed 10 minutes after each visit (recovering from the misfortune and change of the EMR).

Care team coordinators have a great deal of responsibility for their patients, which makes their work interesting and fun (recovery from being dissatisfied with their jobs).

The team-based care helps the entire system by improving clinical outcomes and increasing revenues.

This model supports resilience for patients, clinicians, all team members and the entire system.

Resilience: the ability to recover from or adjust easily to misfortune or change.
Definition: stable teams/teamlets

1. The same people always work together

2. Patients empaneled to a teamlet are always cared for by that teamlet

3. The teamlet is responsible for the health of its patient panel and only sees patients on its panel
Why should teams be stable?

1. Patients: “I want to know the people caring for me” and “I want the people caring for me to know me”

2. Clinicians working with the same MA every day tend to have lower levels of burnout than clinicians working with different people on different days [Willard-Grace et al, J Am Board Fam Med 2014;27:229].

3. Research shows that patients prefer small practices. A stable team/teamlet divides a large, impersonal practice into small, comfortable units that feel like small practices [Rubin et al, JAMA 1993;270:835].
• Which statement is correct?

• Teams are important because they are part of the PCMH
• Teams make more work for physicians
• Patients want team members to know them and they want to know their team members
• 2-person teamlets are better than 3 person teamlets because they are smaller
Share the care is a culture shift

- From “I” -- clinician makes all decisions and non-clinician staff helps the clinician
- To “We” -- the entire team shares responsibility for the health of their patient panel

Sharing the care is not delegating tasks to non-clinician team members; it is reallocating responsibilities

Will all clinicians agree to share the care? Will all RNs, LPNs, MAs want to assume new responsibilities?

- Of course not

Start with the bright spots -- enthusiastic clinicians and team members.

- Standing orders are needed to empower team members to share the care
Why do we build teams that share the care?

- To improve access for patients by adding capacity
- To reduce provider burnout by having all team members contribute to the care of patients empaneled to their team
- To improve quality beyond what a provider alone can achieve
- To create a comfortable small practice environment for patients
- To engage everyone in the practice to contribute to patient care in a meaningful way
Let’s start with access to care for patients

Good patient access requires demand = capacity

Many (not all) practices have a demand-capacity gap

Demand for 1 practitioner = panel size x visits/patient/year

For the average US practice, that is 2000 x 3 = 6000 visits per year

Capacity for 1 practitioner is visits per day x days per year

If a practitioner works 200 days/year and sees 20 patients/day, capacity = 4000

6000 - 4000 = demand/capacity gap = 2000

How do we close that gap?
Demand, capacity, and access: closing the gap

Have practitioners work more days per year, from 200 to 250

Now, capacity is 250 days x 20 visits per day = 5000. Demand capacity gap is 6000 – 5000 = 1000

Then have practitioners see more patients per day, from 20 to 24

Now, capacity is 250 x 24 = 6000

Demand-capacity gap is 0. You solved the problem
Physician burnout is associated with poor patient experience and reduced patient adherence to treatment plans.

Survey of 422 general internists and family physicians:
- 27%: definitely burning out
- 30%: likely to leave the practice within 2 years


NP and PA burnout little studied, but probably similar.

You reduced your demand-capacity gap to 0, but your practitioners all quit so now you have no capacity.

Not a resilience strategy.
# Closing the demand-capacity gap: share the care

<table>
<thead>
<tr>
<th>Practitioners (MD, NP, PA)</th>
<th>Non-practitioner licensed personnel</th>
<th>Non-licensed personnel</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>Pharmacists</td>
<td>Physical therapists</td>
<td>Behaviorists</td>
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<tr>
<td>MAs as panel managers</td>
<td>MAs as health coaches</td>
<td>MAs as scribes</td>
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<tr>
<td>Peer health coaches</td>
<td>Self care</td>
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Closing the demand-capacity gap by adding capacity through non-practitioner professionals

Assume panel of 2000, creating 6000 visits/year

- 1000 visits by patients with diabetes
- 1000 visits by patients with hypertension
- 1000 visits for uncomplicated low-back, knee, shoulder pain

Assume RNs, pharmacists, PTs can independently care for 2/3 of these visits (no practitioner needed)

- Total non-practitioner visits = 2000

Each practitioner provides 4000 rather than 6000 visits/year

Demand-capacity gap closes (6000 total visits), and burnout drops because practitioners have fewer visits per day
Mental health personnel in teams

- Patients with depression cared for by Intermountain Health routinized (bright spot) mental health integration (MHI) primary care teams
  - Fewer emergency department visits
  - Better quality outcomes
  - Greater satisfaction
- Bright spot teams did not increase costs to the health system
Some evidence for re-allocating responsibilities

RN: RCT of patients with diabetes and elevated BP. Patients with RN management (including initiating meds and titrating doses) 3 times more likely to reach BP goal (p = .003) than physician management [Denver et al, Diabetes Care 2003;26:2256]

Pharmacists: RCT of pharmacist management of hypertension (including medications) compared with usual care. At 18 months, 72% BP control for pharmacist care vs. 57% in usual care group (p= .003) [Margolis et al, JAMA 2013;310:46]
Some evidence for re-allocating responsibilities

Patients with uncomplicated musculoskeletal injuries who directly access physical therapists without seeing a physician have better functional outcomes, greater satisfaction, and lower health care costs. [Ojha et al, Physical Therapy 2014;94:14; Overman et al, Phys Ther 1988;68:199].

Primary care behaviorists working as depression care managers in primary care improve depression outcomes compared with physician-only care and can reduce physician visits [Unutzer and Park, Primary Care 2012;39:415].
Social workers for high-risk, high-cost patients

- CareOregon’s program for high-risk, high-cost patients is called The Health Resilience Program
- Teams embedded in primary care practices are led by Health Resilience Specialists, many of whom are social workers
- Most programs for high-risk patients are led by RNs and/or social workers
Sharing the care with non-licensed personnel: panel management

- Preventive care: immunizations, cancer screening (cervical, breast, colorectal)
- Chronic care: e.g. diabetes: all lab tests are done in a timely fashion

Medical assistants identify patients on their teamlet’s panel overdue for routine services and arrange for those services to be performed.

Physician-written standing orders are needed to empower the medical assistants.

Quality of preventive services improves [Chen and Bodenheimer, Arch Intern Med 2011;171:1558]

An estimated 50% of all preventive care activities could be performed by medical assistants [Altschuler et al, Ann Fam Med 2012;10:396-400]
Sharing the care with non-licensed personnel: health coaching

Health coaching: assisting patients develop the knowledge, skills and confidence to become informed, active participants in their care [Ghorob, Family Practice Management, May/June 2013]

In RCT, patients with MA health coaches had significant drop in A1c and LDL-cholesterol compared with controls [Willard-Grace et al, Ann Fam Med 2015;13:130]

Estimated 25-30% of chronic care activities could be performed by MA health coaches [Altschuler et al, Annals of Family Medicine 2012;10:396]
Sharing the care with non-licensed personnel: scribes

UCLA internal medicine, Reuben et al, JAMA Int Med 2014;174:1190

Study of 2 scribes ("physician partners"), one LVN, one college educated

75 minutes of physician time saved in each 4-hour clinic session

79% of patients satisfied

Patients more likely to report that physician spent enough time with them

Purpose of the scribes: To re-establish the physician-patient relationship that has been fractured by the EMR
Hey doc, I’m here too

I really like my doctor of over 10 years, but rarely get to talk with him face to face; as I’m talking, he is typing. Annoys the hell out of me.
Audience response slide

- Pick the best answer

- Nurses, pharmacists and behaviorists can increase capacity to see more patients, often independent of physicians

- Medical assistants, in a 3-person teamlet, could perform panel management, health coaching, and scribing, like Bellin Health’s care team coordinators

- Standing orders are needed to empower team members to share the care

- All of the above
Share the care with patients: peer health coaches

Patients trained as peer health coaches or peer educators can add capacity to primary care

In a RCT, we trained 30 low-income diabetic patients with diabetes to be peer coaches for other low-income patients with diabetes. The peer coaches achieved better glycemic control than similar patients without coaches [Thom et al, Ann Fam Med 2013;11:137-144]
Training peer health coaches
Teams that function beyond the primary care office

Primary care and public health are the most underfunded sectors of US health care

Peers/CHWs/patient navigators working in the primary care practice or in the community have the potential to bridge the primary care/public health divide

Two examples of how primary care teams can engage the community and address the social determinants of health
Delta Health Center, Mound Bayou, Mississippi

One of the two first community health centers in the US, 1965

Led by Dr. Jack Geiger, one of the public health giants of our time

Local banks denied mortgages to African-Americans; health center demanded the banks hire African-Americans and engage in fair mortgage practices in return for getting the health center’s banking business. It worked.

The health center hired community residents, assisted them with college prep and scholarships; some of whom became MDs and public health workers

The health center created an agricultural coop to create jobs and grow healthy vegetables

Community Health Teams (CHTs) funded by Medicare, Medicaid, private plans

Outside of primary care practices but work closely with primary care

Each CHT led by RN, includes social workers, CHWs, public health specialists

No co-payments, no prior authorizations, no billing for CHT services

CHTs provide
- Population management using statewide registry
- Counseling and referral for mental health care
- Substance abuse treatment support
- Condition-specific wellness education
- Support at home for frail elderly
- Health coaching for chronic conditions

Has reduced hospital admits and ED visits
The primary care practitioner to population ratio is falling

NPs and PAs are essential primary care practitioners of the future

Practitioners alone cannot meet the population’s need for care

Sharing the care with a well-trained team, empowered with standing orders, can add substantial capacity without worsening practitioner burnout

Teams can extend care into the community and the medical neighborhood

**Resilience:** the ability to recover from or adjust easily to misfortune or change. High-performing teams can build resilience for patients, practitioners, all team members, and the entire organization.
Great Primary Care Is a Beautiful Thing