Paradigm Shift: Moving from the Traditional Doctor’s Office to Team Based Care

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The presenters have nothing to disclose.
Health Care

Let’s talk about your experience....

Healthcare Costs Unsustainable

![Graph showing forecasts of national health care spending as a percent of GDP.](image)

Higher Healthcare Spending is NOT Associated with Better Quality

US Healthcare System
More specifically

- 73% of adults surveyed reported difficulty getting a prompt appointment, getting phone advice, or getting care nights/weekends without going to the ER.
  Public views on of US health system organization, Commonwealth Fund, 2008

- 50% of people with hypertension, 62% of people with high cholesterol, 63% of people with diabetes are poorly controlled.

2 Solutions have Emerged in the US

1) Reduce panel sizes. “Concierge” practices or “Boutique medicine”
   - Increases the cost of care
   - Impractical at a population level
   - Inherently unfair

2) Primary care providers “Share the Care”
   - Use less expensive staff to do non-MD work
   - Possible to scale up to the population level
   - Additional cost of new team members
One Trusted Primary Care Team

- Ensure patients and caregivers are involved in every step of the health care process
- Provide coordinated care
- Develop integrated care plans to support patients' health goals
- Provide care by telephone and e-mail if a face-to-face visit is not warranted
- Provide holistic care in the same location

The Shift

- **From I to We:**
  - From the lone doctor with “helpers” to the high-functioning team
  - From my patients to our patients
- **From He/She to They:**
  - From a sole focus on individual patients to a concern for the team’s entire panel
The Shift

- **From:** How can the physician (I) see today’s scheduled patients (he/she), do the non-face-to-face-visit tasks, and get home at reasonable hour?

- **To:** What can the team (We) do today to make the panel of patients (they) as healthy as possible, and get home at a reasonable hour?

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td><strong>Patient A</strong></td>
<td>Assist with Patient A</td>
<td><strong>Triage</strong></td>
<td><strong>Patient H</strong></td>
<td>Assist with Patient H</td>
</tr>
<tr>
<td>8:10</td>
<td><strong>Patient B</strong></td>
<td>Assist with Patient B</td>
<td></td>
<td><strong>Patient I</strong></td>
<td>Assist with Patient I</td>
</tr>
<tr>
<td>8:30</td>
<td><strong>Patient C</strong></td>
<td>Assist with Patient C</td>
<td></td>
<td><strong>Patient J</strong></td>
<td>Assist with Patient J</td>
</tr>
<tr>
<td>9:00</td>
<td><strong>Patient D</strong></td>
<td>Assist with Patient D</td>
<td></td>
<td><strong>Patient K</strong></td>
<td>Assist with Patient K</td>
</tr>
<tr>
<td>9:30</td>
<td><strong>Patient E</strong></td>
<td>Assist with Patient E</td>
<td></td>
<td><strong>Patient L</strong></td>
<td>Assist with Patient L</td>
</tr>
<tr>
<td>10:00</td>
<td><strong>Patient F</strong></td>
<td>Assist with Patient F</td>
<td></td>
<td><strong>Patient M</strong></td>
<td>Assist with Patient M</td>
</tr>
<tr>
<td>10:30</td>
<td><strong>Patient G</strong></td>
<td>Assist with Patient G</td>
<td></td>
<td><strong>Patient N</strong></td>
<td>Assist with Patient N</td>
</tr>
</tbody>
</table>

Traditional Template
### Evolving Template

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care Physician</th>
<th>Medical assistant 1</th>
<th>Team RN</th>
<th>Physician Assistant</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td></td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td></td>
<td>Acute Patients</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Coordinate with hospitalists and specialists</td>
<td>BP/DM coaching clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Huddle with RN, NP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Huddle with MD</td>
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</tr>
</tbody>
</table>

*30 patients are seen or contacted in the first 3 hours of the day*

### How We Take Care of our Patients

**NOW**

- **Panel management**
  "Panel manager" systematically reviews panels of patients to detect clinical quality performance gaps.

- **Phone visits**
  Health coaches give patients the knowledge, skills, and confidence to self-manage their chronic conditions.

- **E-mails**

- **Health coaches**

- **Longer visits**

- **Coordinate with team members**

- **Coordinate with specialists**

- **Nurse care managers**
  Nurse care managers coordinate health care for certain high-needs groups.

- **Group visit**
  15-minute visit
Customized

- Different patients have different needs
  - Some only need routine preventive services
  - Others need same-day acute care
  - Some have one or two chronic conditions
  - A small number have multiple illnesses and complex healthcare needs
  - Some have mental health/substance abuse needs
  - Others require palliative or end-of-life care
- Each sub-group of panel needs a different set of services by different team patients

OLD VS NEW

<table>
<thead>
<tr>
<th>OLD Interaction</th>
<th>NEW Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between individual provider and patient</td>
<td>Between patient and care team supported by clinical information and decision support</td>
</tr>
<tr>
<td>Face-to-face</td>
<td>Multiple modalities</td>
</tr>
<tr>
<td>Problem-initiated and focused</td>
<td>Based on care plan: “planned visit”</td>
</tr>
<tr>
<td>Topics are clinician’s concerns and treatment</td>
<td>Collaborative problem list, goals and plan</td>
</tr>
<tr>
<td>Ends with a prescription</td>
<td>Ends with a shared plan of care and follow-up</td>
</tr>
</tbody>
</table>