Achieving the Quadruple Aim: Practice Transformation, Provider Satisfaction and the Future of Primary Care

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University of California, San Francisco, San Francisco General Hospital
AACHC and WCN Region IX Leadership Conference
San Diego, CA – June 2015
Objectives

- Understand the literature of burnout in primary care
- Understand the core fundamentals of the “Quadruple Aim” in healthcare and various standards of Primary Care excellence
- Understand strategies to achieve the 4th aim and what the future of primary care could look like
My Recent Journal: The Day I Had
“There are close to a quarter million primary care physicians in the U.S., more than any other individual specialty, and about half the total number of all specialists combined. Yet, somehow, primary care seems to lack the power and social influence necessary to chart its own professional course.”
Adult Care: Projected Generalist Physician Supply vs. Demand

Shortage of 40,000 by 2020
Shortage of 52,000 by 2025

Sources:
1. Colwill et al., Health Affairs, 2008:w232
“Maybe there will be some primary care doctors available on this planet!”
Who is Really Winning?

“On the other side are patients who are equally frustrated by providers who demand adherence to antiquated (often analog) processes around scheduling and redundant bureaucracies while the ubiquitous smartphone moves everyone further and further into a mobile and connected reality.”
What is Primary Care?

Primary care is the cornerstone of health care that is effective and efficient and meets the needs of patients, families, and communities. Our primary care system currently has significant—and perhaps unprecedented—opportunities to emphasize quality improvement (QI) and practice redesign in ways that could fundamentally improve health care in the United States.

Source:
AHRQ, Improving Primary Care Practice
Doc McStuffins—6 year old Disney character who “fixes” toys and provides personal care to them
Why We Went into Primary Care
What We Found
The Medical Neighborhood

Community Organizations

- Community Centers
- Public Health
- Schools
- Employers
- Faith-Based Organizations

Patient-Centered Medical Home

Connected via Health IT

Home Health
Hospital
Pharmacy
Mental Health
Diagnostics
Skilled Nursing Facility
Specialty & Subspecialty

Source:
Patient-Centered Primary Care Collaborative
TeamSTEPPS®

Teamwork & the Primary Care Team

The Primary Care Team has all these obstacles to effective care:

- Conflict
- Lack of Coordination
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity
- Miscommunication
- Hierarchy
- Lack of information sharing

Team Strategies & Tools to Enhance Performance & Patient Safety

Source:
Team STEPPS® - AHRQ and DoD
Workload of a PCP

The average primary care physician:

- Manages a panel of 2300 patients
- Interacts with at least 229 other physicians in 117 practices
- Would spend 21.7 hours a day completing evidence based preventive, acute and chronic care for their panel

Sources:
Hamster Syndrome

Source:
"I'm sorry, the doctor no longer makes diagnoses."
The Dilemma

Panel size too large for average PCP to manage

Can't reduce panel size due to worsening shortage of adult primary care clinicians

Shortage = larger panels, poorer access for patients, poorer quality, more PCP burnout, higher health care costs

More PCP burnout means fewer medical students will be attracted to primary care

Unless we think differently
PCPs in the Safety Net are also faced with:

- Complex patients—medically and psychosocially
- Poorly coordinated care
- Social determinants of health
- Low literacy and limited English proficiency
- Racial/ethnic minorities, vulnerable populations

Sources:
### Table: Burnout Index: Comparing Physicians & U.S. Workers

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physicians</th>
<th>U.S. Workers</th>
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<tbody>
<tr>
<td><strong>Emotional exhaustion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Never</td>
<td>12.7%</td>
<td>11.8%</td>
</tr>
<tr>
<td>- A few times a year</td>
<td>26.5%</td>
<td>30.9%</td>
</tr>
<tr>
<td>- ≤Once a month</td>
<td>12.7%</td>
<td>15.6%</td>
</tr>
<tr>
<td>- A few times a month</td>
<td>15.5%</td>
<td>17.7%</td>
</tr>
<tr>
<td>- Once a week</td>
<td>9.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>- A few times a week</td>
<td>13.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>- Every day</td>
<td>8.7%</td>
<td>5.6%</td>
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<tr>
<td><strong>Depersonalization</strong></td>
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<tr>
<td>- Never</td>
<td>32.7%</td>
<td>39.4%</td>
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<td>- A few times a year</td>
<td>24.9%</td>
<td>23.9%</td>
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<td>- ≤Once a month</td>
<td>11.0%</td>
<td>10.1%</td>
</tr>
<tr>
<td>- A few times a month</td>
<td>11.4%</td>
<td>10.9%</td>
</tr>
<tr>
<td>- Once a week</td>
<td>6.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>- A few times a week</td>
<td>8.8%</td>
<td>5.9%</td>
</tr>
<tr>
<td>- Every day</td>
<td>4.0%</td>
<td>3.9%</td>
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<tr>
<td><strong>Burned out</strong></td>
<td>37.5%</td>
<td>27.6%</td>
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</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physicians</th>
<th>U.S. Workers</th>
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</thead>
<tbody>
<tr>
<td><strong>Depression and suicidal ideation</strong></td>
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<td>- Screen positive for depression</td>
<td>40.4%</td>
<td>41.4%</td>
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<tr>
<td>- Suicidal ideation in the past 12 months</td>
<td>6.9%</td>
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</table>

**Satisfaction with work-life balance (Work schedule leaves me enough time for my personal or family life)**

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>U.S. Workers</th>
</tr>
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<tbody>
<tr>
<td>- Strongly agree</td>
<td>14.2%</td>
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<tr>
<td>- Agree</td>
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<td>- Neutral</td>
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<td>19.7%</td>
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<tr>
<td>- Disagree</td>
<td>26.2%</td>
<td>17.6%</td>
</tr>
<tr>
<td>- Strongly disagree</td>
<td>13.9%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

High Levels of Burnout

What Percentage of Physicians Are “Burned Out?”

Source:
Graphic © Medscape Physician Lifestyle Report 2013
Why Are We So Burned Out?

Source:
Graphic © Medscape Physician Lifestyle Report 2013

What Are the Causes of Burnout?

- Too many bureaucratic tasks
- Spending too many hours at work
- Present and future impact of Affordable Care Act
- Feeling like just a cog in the wheel
- Income not high enough
- Lack of professional fulfillment
- "Inability to provide patients with quality care they need"
- Too many difficult patients
- Increasing computerization of practice
- Difficult colleagues or staff
- Compassion fatigue
- Difficult employer

1 = Not at all important
7 = Extremely important
Burnout Matters!

Figure 1

Quality-of-Life Continuum as it Relates to Professional Behavior

- Distress
  - Focus on self
  - Reduced empathy
  - Reduced compassion
  - Medical errors
  - Poor communication
  - Less satisfaction with work
  - Depression
  - Substance abuse

- Well-being
  - Focus on patient
  - Empathy
  - Compassion
  - High-quality of care
  - Enhanced communication
  - Greater satisfaction with work

Source:
The Perfect Storm
Patient-Centered Care

- Team-Based Healthcare Delivery
- Population Health
- Patient-Centered Care
- Refocused Medical Training
- Patient & Physician Feedback
- Decision Support Tools
- Advanced IT Systems
- Access to Care
Standards, Incentives & Standards

State standards

Joint Comm

AAAHC

NCQA

URAC

MU

Payer standards

Evidence-based standards

Organizational standards
"It's bad news - your illness isn't on our performance targets."
In This Context, a New Paradigm was Needed…

Triple Aim

Source:
Physician burnout is an escalating problem receiving little attention from health care leaders. Burnout is a long-term stress reaction which includes emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment. Physician burnout rates range from 30-65% across medical specialties, with the highest rates experienced by those at the front line of care, including emergency medicine and general internal medicine. Recruitment of medical students into general internal medicine is worryingly low, as health care reforms necessitate greater reliance on primary care. Burnout poses problems for both health care organizations and patients. While burned-out physicians attempt to maintain quality of care at their own expense, work conditions that result in burnout are associated with poorer care quality.1 Burned-out doctors are more likely to leave their practice, thus reducing access to care. Turnover sacrifices continuity, and replacement costs are at least $230,000 per primary care physician. Satisfied role models could make a difference in this steady drain on primary care, but it is getting harder to find them. The situation may be no better for hospitalists physicians, for whom burnout is also common.2 Women physicians in national surveys have a 60% higher burnout rate than that seen in men, yet the workplace remains largely indifferent as gender as a predictor of burnout. And despite known work condition challenges that contribute to burnout in ethics serving minority patients, few if any changes have occurred to improve this situation. Finally, models to prevent physician burnout are not well documented.

We offer suggestions for addressing these challenges. The first that burnout is a long-term stress reaction that may take time to measure and intervene. To combat burnout, organizations need to identify stress in its earlier stages (Fig. 1), and choose programs to prevent burnout before it occurs. Following this quality improvement (QI) model for organizational self-care can produce a sustainable workplace for clinicians, with high quality and accessible care for patients (see Table 1).

We attempt to address and their relationships with quality care. Preceding these metrics are predictors (e.g., work control, time pressure, pace of work [chaos] and values alignment between clinicians and leadership) are significant (e.g., physician satisfaction, attrition). In short, these tools are used in QI models, allowing for interventions to address poor clinician outcomes and drive a decline in burnout rates. One mechanism to accomplish this is to train clinical wellness committees such as Stanford University led by Dr. Bryan Bell within the Permanente Medical Group. Permanente directed by Dr. Betty Kung, metrics are crafted with divisional units across all disciplines. Attention to health care costs and efforts to minimize stress hold great potential for reducing burnout.

1. Incorporate mindfulness and teamwork and practicing clinicians. Mindfulness, stress reduction, is a means for internally directed stressors, Teamwork, the Patient-Centered Medical Home (PCMH) critically important for burnout prevention and support of burned-out clinicians. We attempt to address physician burnout is a long-term stress reaction that may take time to measure and intervene. To combat burnout, organizations need to identify stress in its earlier stages (Fig. 1), and choose programs to prevent burnout before it occurs. Following this quality improvement (QI) model for organizational self-care can produce a sustainable workplace for clinicians, with high quality and accessible care for patients (see Table 1).

**INSTITUTIONAL METRICS**

1. Ensure that metrics for institutional success include physician satisfaction and well-being. Any system that does not measure, monitor, and optimize clinician well-being and sustainability is at risk. We suggest measuring the following metrics predictors (e.g., work control, time pressure, pace of work [chaos] and values alignment between clinicians and leadership) are significant (e.g., physician satisfaction, attrition). In short, these tools are used in QI models, allowing for interventions to address poor clinician outcomes and drive a decline in burnout rates. One mechanism to accomplish this is to train clinical wellness committees such as Stanford University led by Dr. Bryan Bell within the Permanente Medical Group. Permanente directed by Dr. Betty Kung, metrics are crafted with divisional units across all disciplines. Attention to health care costs and efforts to minimize stress hold great potential for reducing burnout.

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3. **Enhancing Meaning in Work**

A Prescription for Preventing Burnout and Promoting Patient-Centered Care

By D. Smith, MD

Enhancing meaning in work is a prescription for preventing burnout and promoting patient-centered care. A meta-analysis of 18 studies involving physicians found that interventions aimed at enhancing meaning in work significantly reduced burnout and improved patient outcomes. These interventions include educational programs, mentoring, and opportunities for professional growth and development. For instance, one study found that doctors who receive training in mindfulness and stress reduction techniques report lower levels of burnout and improved patient satisfaction. Another study showed that when doctors are given more autonomy in decision-making, they experience less burnout and report higher levels of job satisfaction. In conclusion, enhancing meaning in work is crucial for preventing burnout and promoting patient-centered care.
# Table 1. Ten Steps to Prevent Physician Burnout

<table>
<thead>
<tr>
<th>Institutional Metrics</th>
<th>Work Conditions</th>
<th>Career Development</th>
<th>Self-Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Make clinician satisfaction and wellbeing quality indicators.</td>
<td><strong>4</strong> Allocate needed resources to primary care clinics to reduce healthcare disparities.</td>
<td><strong>8</strong> Preserve physician “career fit” with protected time for meaningful activities.</td>
<td><strong>10</strong> Make self-care a part of medical professionalism.</td>
</tr>
<tr>
<td><strong>2</strong> Incorporate mindfulness and teamwork into practice.</td>
<td><strong>5</strong> Hire physician floats to cover predictable life events.</td>
<td><strong>9</strong> Promote part-time careers and job sharing.</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> Decrease stress from electronic health records.</td>
<td><strong>6</strong> Promote physician control of the work environment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>7</strong> Maintain manageable primary care practice sizes and enhanced staffing ratios.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sources:**
And Still…

A Newer Paradigm is Necessary…

To Keep the Workforce
Our Goals Have Evolved

Triple Aim

Quadruple Aim

Sources:
From Triple Aim to Quadruple Aim

In visiting primary care practices around the country, the authors have repeatedly heard statements such as, “We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims.”

REFLECTION

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD
Christine Sinsky, MD

*Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California
*Medical Associates Clinic and Health Plan, Dubuque, Iowa
*American Medical Association, Chicago, Illinois

ABSTRACT

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus impedes the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.


INTRODUCTION

Since Don Berwick and colleagues introduced the Triple Aim into the health care lexicon, this concept has spread to all corners of the health care system. The Triple Aim is an approach to optimizing health system performance, proposing that health care institutions simultaneously pursue 3 dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.1 The primary Triple Aim goal is to improve the health of the population, with 2 secondary goals—improving patient experience and reducing costs—contributing to the achievement of the primary goal.

In visiting primary care practices around the country, the authors have repeatedly heard statements such as, “We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims.” These sentiments made us
10 Building Blocks of High Performing Primary Care

Sources:
Some Inspiration...

"WE CANNOT SOLVE OUR PROBLEMS WITH THE SAME THINKING WE USED WHEN WE CREATED THEM"
Think Differently!
My son Darius at 7 years old

https://youtu.be/ub8Tsrj4gy0
My daughter Nissi at 4 yrs old

https://youtu.be/-A6jRVgbnxo
Thinking Differently—Quadruple Aim and the Building Block Crosswalk

Implement team documentation: associated with greater physician and staff satisfaction, improved revenues, and the capacity of the team to manage a larger panel of patients while going home earlier.

Use pre-visit planning and pre-appointment laboratory testing: reduces time wasted on the review and follow-up of laboratory results.

Expand roles allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching under physician-written standing orders.

Standardize and synchronize workflows for prescription refills: can save physicians 5 hours per week while providing better care.

Co-locate teams: increases efficiency and can save 30 minutes of physician time per day.

Brief Case Study: My Experience

CHC Locations in Connecticut
Community Health Center, Inc.

Patients who consider CHC their health care home: 130,000
Health care visits: 410,000 per year

CHC Inc. Profile:
- Founding Year: 1972
- Primary Care Hubs: 13
- No. of Service Locations: 218
- Licensed SBHC locations: 24
- Organization Staff: 600+

Innovations
- Integrated primary care disciplines
- Fully integrated EHR
- Patient portal and HIE
- Extensive school-based care system
- “Wherever You Are” Health Care
- Level 3 PCMH-NCQA
- Joint Commission PCMH
- Centering Pregnancy model
- Residency training for new nurse practitioners and post doc psychologists
Challenges

- Multiple Sites (isolation)
- Provider Turnover
- Practice Transformation
- Specialty Access
- Patient Frustration
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<tr>
<td></td>
<td>7. Maintain manageable primary care practice sizes and enhanced staffing ratios.</td>
<td></td>
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</tbody>
</table>

**Sources:**
## Missed Opportunities Dashboard

![Community Health Center, Inc. Logo](image)

### Huddle Alert Summary

Data as of: 1/2/2013 1:49:16 PM

<table>
<thead>
<tr>
<th>PCP</th>
<th>Total of Missed Oppt</th>
<th>A1C testing</th>
<th>Breast cancer screening</th>
<th>Colorectal cancer screening</th>
<th>Cervical cancer screening Beta</th>
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<td>Jones MD, Robert</td>
<td>7</td>
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[Show Graphs]
Sustained Reduction in Missed Cancer Screening Opportunities

Missed Opportunities: Agency-Wide

- A1C testing
- Breast cancer screening
- Depression screening
- Colorectal cancer screening

UCSF Center for Excellence in Primary Care
Additional Strategies

- Accredited non-hospital, non-academic internal CME program
- Optimizing physician time through Share the Care
- Provider-specific questions on employee satisfaction
- Scholarly and quality improvement opportunities
- Mentoring and pipeline with medical and nursing students, residents
Provider Turnover

PCP Vacancies by Year

- 2009: 50%
- 2010: 50%
- 2011: 40%
- 2012: 30%
- 2013: 10%
- 2014: 20%
Driving Change: Charting our Future
"CONGRATULATIONS MRS JONES! IT'S A NOKIA!"
10 Building Blocks of High Performing Primary Care

Sources:
Template of the Future

Achieving the Quadruple Aim

Achieving the Triple Aim

Traditional in-person 15 minute primary care visit
# Template of the Present

<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>Triage</td>
<td><strong>Patient H</strong></td>
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<tr>
<td>8:15</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>
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<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>
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<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>
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<tr>
<td>9:15</td>
<td><strong>Patient E</strong></td>
<td>Assist with Patient E</td>
<td></td>
<td><strong>Patient L</strong></td>
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<td>9:30</td>
<td><strong>Patient F</strong></td>
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<td><strong>Patient M</strong></td>
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<td><strong>Patient G</strong></td>
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<td><strong>Patient N</strong></td>
<td>Assist with Patient N</td>
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### Template of the Future

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
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<th>Nurse Practitioner</th>
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<tr>
<td>8:00</td>
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<tr>
<td>8:10</td>
<td><strong>E-visits and phone visits</strong></td>
<td><strong>Panel management</strong></td>
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<td><strong>RN Care management</strong></td>
<td><strong>Acute Patients</strong></td>
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<td><strong>Panel manage-ment</strong></td>
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<tr>
<td>9:00</td>
<td><strong>Complex patient</strong></td>
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<tr>
<td>9:30</td>
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</tr>
<tr>
<td>10:00</td>
<td><strong>Coordinate with hospitalists and specialists</strong></td>
<td><strong>BP coaching clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td><strong>Huddle with RN, NP</strong></td>
<td><strong>Huddle with MD</strong></td>
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</tbody>
</table>

**Huddle**

30 patients are seen or contacted in the first 3 hours of the day
## Template of the Future

<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>
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</thead>
<tbody>
<tr>
<td>8:00–8:10</td>
<td></td>
<td></td>
<td>Huddle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10–8:30</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td>RN Care management</td>
<td></td>
<td>Acute patients</td>
</tr>
<tr>
<td>8:30–9:00</td>
<td>Complex patient</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9:00–9:30</td>
<td>Huddle with RN, NP</td>
<td>Blood pressure coaching clinic</td>
<td>Huddle with MD</td>
<td>Panel management</td>
<td></td>
</tr>
<tr>
<td>9:30–10:00</td>
<td>Coordinate with hospitalists and specialists</td>
<td>Care management</td>
<td>E-visits and phone visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00–10:30</td>
<td>Complex patient</td>
<td></td>
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<td></td>
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</table>

About 30 patients contacted/seen in 3 hours
# Real Life Example from Iora Health

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>9AM</td>
<td>Huddle</td>
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<td>Huddle</td>
<td>Huddle</td>
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<td>Huddle</td>
<td>Huddle</td>
</tr>
<tr>
<td>10AM</td>
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<td>Hold Time Slot</td>
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<td>Hold Time Slot</td>
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<tr>
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</tr>
<tr>
<td>12PM</td>
<td>📞 Michelle</td>
<td>David</td>
<td></td>
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<td>David</td>
<td>Hold Time Slot</td>
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</tr>
<tr>
<td>1PM</td>
<td>Gary</td>
<td>Michael</td>
<td></td>
<td>Michael</td>
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<td>Hold Time Slot</td>
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<tr>
<td>2PM</td>
<td>Movari</td>
<td>Zahn</td>
<td>Nicholas</td>
<td>Zahn</td>
<td>Nicholas</td>
<td>Movari</td>
<td>📞 Larry</td>
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<tr>
<td>3PM</td>
<td>Jenny</td>
<td>📞 George</td>
<td>📞 Hold Time Slot</td>
<td>George</td>
<td>Jenny</td>
<td>📞 Martin</td>
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<tr>
<td>4PM</td>
<td>Gina</td>
<td>Paul</td>
<td>Daniel</td>
<td>Daniel</td>
<td>Gina</td>
<td>Daniel</td>
<td></td>
</tr>
</tbody>
</table>
Think Differently!

RED GREEN BLACK
BLUE BROWN YELLOW
BLACK BLUE GREEN
RED PURPLE
RED ORANGE GREEN
BLUE PINK
YELLOW ORANGE
My Future Journal:
The Day I Want to Have
Thank You!

Contact:
Nwando.Olayiwola@ucsf.edu
Twitter: @DrNwando
(415) 206-2970 (O)