Achieving the Quadruple Aim in Primary Care: Challenges and Opportunities

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Objectives

1. Understand current challenges in primary care and professional burnout
2. Understand a framework for high performing primary care, the Ten Building Blocks, and their relationship to the Quadruple Aim
3. Understand some potential opportunities to achieve the 4th aim

By the end of the session, attendees should:
What happened to primary care?
“The gulf is widening and the trajectory for many primary care physicians is entirely unsustainable for a host of reasons.”

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.

The gulf is widening and the trajectory for many primary care physicians is entirely unsustainable for a host of reasons. Here are the top 3 that I see:

1. The current system of primary care does not work.
2. The culture of primary care is antiquated.
3. The incentives for primary care are skewed.

Adult Care: Projected Generalist Physician Supply vs. Demand

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

Sources:
1. Colwell et al., Health Affairs, 2008:w232
3. Bodenheimer et al., Health Affairs 2009:28:64
Results of Large Panels

- **Poor access** for patients
- **Inconsistent quality**
- **Lack of time** to build relationships with patients
- **Clinician burnout**

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:
Why Are We So Burned Out?

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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physicians</th>
<th>U.S. Workers</th>
</tr>
</thead>
<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>
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<tr>
<td>- Once a month</td>
<td>12.7%</td>
<td>15.6%</td>
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<tr>
<td>- A few times a month</td>
<td>15.5%</td>
<td>17.7%</td>
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<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>
</tr>
<tr>
<td><strong>Depersonalization</strong></td>
<td></td>
<td></td>
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<tr>
<td>- Never</td>
<td>32.7%</td>
<td>39.4%</td>
</tr>
<tr>
<td>- A few times a year</td>
<td>24.9%</td>
<td>23.9%</td>
</tr>
<tr>
<td>- Once a month</td>
<td>11.0%</td>
<td>10.1%</td>
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<tr>
<td>- A few times a month</td>
<td>11.4%</td>
<td>10.9%</td>
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<tr>
<td>- Once a week</td>
<td>6.6%</td>
<td>5.1%</td>
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<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>
</tr>
<tr>
<td><strong>Burnout</strong></td>
<td>17.5%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>


Standards, Incentives & Standards

Joint Comm
AAAHC
NCQA
URAC
MU

State standards
Organizational standards
Evidence-based standards
Payer standards
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.”

“Funny, I thought the hour-long wait was the stress test.”

“The doctor will see you now—I can’t promise that he’ll talk to you, but he’ll see you.”
Some not so happy patients...

https://youtu.be/6udKmE84Qs

Source: AHRQ, Improving Primary Care Practice - http://www.ahrq.gov/professionals/prevention-chronic-care/improve/
Our Goals Have Evolved

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.”

Sources:
Reclaiming Primary Care


"WE CANNOT SOLVE OUR PROBLEMS WITH THE SAME THINKING WE USED WHEN WE CREATED THEM"
Your poll will show here

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2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help or Open poll in your web browser

23 high-performing practices

Thinking Differently: 
10 Building Blocks of 
High-Performing Primary Care


Ten Steps to Prevent Physician Burnout

1. Make clinician satisfaction and wellbeing quality indicators.
2. Incorporate mindfulness and teamwork into practice.
3. Decrease stress from electronic health records.
4. Allocate needed resources to primary care clinics to reduce healthcare disparities.
5. Hire physician floats to cover predictable life events.
6. Promote physician control of the work environment.
7. Maintain manageable primary care practice sizes and enhanced staffing ratios.
8. Preserve physician "career fit" with protected time for meaningful activities.
10. Make self-care a part of medical professionalism.

Sources:
Evidence Based Ideas for Reducing Burnout

BUILDING SDH CAPACITY
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

An additional dimension: SDH

- Primary care providers (PCPs), particularly those working in safety net settings, face the demands of providing medical care while simultaneously addressing social determinants of health (SDH).

Sources:
My patient JR

- 46 year old undocumented Mexican man with chronic seizure disorder on multiple seizure medications. Patient is illiterate and lives with elderly, Spanish-speaking parents. Presented for titration of seizure medications due to suboptimal levels. At visit, informed me that he and his parents were recently evicted from apartment, given 3 days notice. Squatting with sister (and her 4 kids) in a 2 bedroom apartment.

My Patient JR, Continued

My goals for the visit

- Manage the seizure meds
- Check levels
- Ensure seizure free-periods

JR’s goals for the visit

- Get housing assistance
- Find emergency and long-term housing solutions
- Inform clinic not to send mail
It got worse...

Patient evicted because landlord found higher paying tenant; eviction also illegal

Housing worker - needs minimum of $3300 per month to find 2 bedroom apartment in SF

Patient and parents unemployed, no income

SF affordable housing wait list minimum of 5 years – patient given list of places to call (illiterate, no phone)

“Doctor’s note” not likely to influence housing options

In the safety net, the “treatment” is....

Remember JR

- Housing
- Food
- Legal support
- Transportation
- Language and literacy
- Clothing
- Financial support
SDH and Primary Care

Leading causes of workplace stress for safety net clinicians in US were insufficient resources for patients and within the health center.

Few resources exist to address SDH systematically and comprehensively in underserved settings.

Dimensions of burnout may be pronounced for PCPs working with vulnerable populations, organizational resources are low; emotional and material needs of patients are high.

Sources:

Study Design & Methods

• To understand relationships between clinician perceptions of capacity to address SDH and clinician burnout
• Web and paper-based survey, October 2014–February 2015
• Approx 500 primary care clinicians (physicians, physician residents, nurse practitioners, and physician assistants)
• 10 county, 6 university, and 3 VA administered health centers in San Francisco
A Conceptual Model for Clinician Perceptions of Capacity

SDH CONCEPTUAL MODEL

Conceptual Model for Clinician Perceptions of Capacity to Address Patients' Social Needs
Olayiwola et al. Adapted from Roelens et al BMC Public Health 2006
SDH Scale

Addressing social needs: This section is designed to understand your ability to address the social needs of your patients. Social needs include housing security and habitability; food security; financial assistance and employment benefits; transportation; childcare; utility assistance; and legal services.

a. I am comfortable asking about patients’ social needs (e.g., housing, food, childcare) as part of their primary care.

b. It is as important to address patients’ social needs as it is to address their medical needs in primary care.

c. I have the skills to address the social needs of patients through connecting them with resources, dedicated staff, or tools.

d. My clinic has the resources, such as dedicated staff, community programs, resources or tools to address patients’ social needs.

Outcomes
- Maslach Burnout Inventory:
  - Professional Efficacy
  - Emotional Exhaustion
  - Cynicism

Results: SDH Scale Questions

<table>
<thead>
<tr>
<th>Clinician perceptions of capacity to address patients’ social needs</th>
<th></th>
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<tbody>
<tr>
<td>Belief that addressing social needs is an important role for primary care</td>
<td>9.26 (1.20)</td>
</tr>
<tr>
<td>Comfortable asking about social needs</td>
<td>8.67 (1.56)</td>
</tr>
<tr>
<td>Skills in addressing social needs</td>
<td>6.92 (2.26)</td>
</tr>
<tr>
<td>Clinic resources available to address social needs</td>
<td>6.52 (2.68)</td>
</tr>
</tbody>
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* Response options ranged from 1= Strongly disagree to 10=Strongly agree
Source: Olayiwola et al, Unpublished data

* Correlations suggest related yet conceptually distinct dimensions of perception
* Low to moderate correlations
Additional Analysis

<table>
<thead>
<tr>
<th>Univariate Analysis</th>
<th>Multivariate Analysis</th>
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<tbody>
<tr>
<td>• Each of the 4 SDH items was significantly associated with:</td>
<td></td>
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<tr>
<td>– Lower reported levels of exhaustion and cynicism</td>
<td></td>
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<tr>
<td>– Higher levels of professional efficacy</td>
<td></td>
</tr>
<tr>
<td>• PCP perception of clinic capacity and resources to address SDH was the only one of the four SDH items to remain a significant predictor of burnout scores</td>
<td></td>
</tr>
</tbody>
</table>

Source: Olayiwola et al, Unpublished data

Key Conclusions

• #1: PCP perceptions of greater clinic capacity to address SDH are significantly associated with lower burnout on all 3 measures
• #2: Above is not mitigated by individual clinician beliefs, confidence and skills in addressing SDH
• #3: PCPs with more direct patient care-associations between perceived clinic capacity and burnout heightened
ADDRESSING STAFFING RATIOS

VA PACT Study 2014

Study Design

- Web-based, cross-sectional survey of 4500+ primary care personnel from 588 VA clinics participating in PACT
- Team ratios approx 3:1: Nurse Care manager, admin clerk, clinical associate
- Dependent variable- burnout
- Independent variables - measures of team-based care:
  - Team functioning
  - Time spent in huddles
  - Team staffing
  - Delegation of clinical responsibilities
  - Working to top of competency
  - Collective self-efficacy

Findings

- 39% of staff reported burnout (PCPs, nurses, clinical associates, clerks)
- Lower burnout associated with: participatory decision-making, fully staffed PACT (even after adjusting for clinic workload and proportion of PCP panels over capacity)
- Higher burnout associated with: PACT team assignment, working “below” license, stressful, fast working environment
- Not just about assigning teams, but getting team composition and staffing right

Staffing Ratios

Considerations

Consider value added for increased intensity of service

Other human resources costly but can increase production

Higher clinician:non-clinician ratios decrease burnout and improve efficiency


Estimates of Staffing Infrastructure

- Analytical model developed:
  - Targeted interviews with administrators of PCMH practices through convenience sampling
  - Literature reviews
  - Staffing implications of Joint Principles of PCMH
  - Analysis of current staffing estimates from MGMA
  - Staffing compensation by geographic location
- Staff with specific expertise needed to carry out PCMH functions
- New functionalities needed for fully operational PCMH
- Incremental staffing estimates:
  - Receptionists
  - Nurse care managers, NPs
  - Non-clinical pharmacists
  - Social workers
  - Nutritionists
  - Health coach MAs
  - Clinical Data Specialists

59% Increase

Current: 2.68 FTE:1 physician
Insufficient to meet PCMH standards

Ideal: 4.25 FTE:1 physician
Incremental cost $4.68 pmpm

TEAM CULTURE AND TEAM ROLES

Building Block 4: Team-Based Care
Building Block 4: Team-Based Care

Why does team-based care matter?

- Align roles to meet population needs
- Non-clinician team-members contribute to continuous healing relationship
- Build capacity to make timely access possible
- Foundation for the Template of the future

Teamwork...

“'Yes, I work well with others – just not with these others.’"
Reframing the Discourse Since the Threats Have Not Changed

Historical Approach: Demand-Supply Gap

New Approach: Demand-Capacity Gap

Team Roles

New Models

9 Elements of High Performing Team Care

- Stable team structure
- Colocation
- Culture shift: Share the Care
- Defined roles with training and skills checks
- Standing orders/protocols
- Defined workflows and mapping
- Staffing ratios adequate to facilitate new roles
- Ground rules
- Communication: meetings, huddles, daily flow

Source: Ghorob and Bodenheimer. Building Teams in Primary Care: A Practical Guide. 2015. Fam Syst Health
Team-Based Care: Stable Teamlets

Patient panel
Clinician + MA teamlet
Other team members: nurse, behavioral health professional, social worker, pharmacist, complex care manager, health coach, panel managers

1 team, 3 teamlets

Study Design & Methods

Setting: 19 San Francisco primary care safety net clinics
Data collection: Annual PCP & staff survey (2012–2014)
Survey measures:

- Maslach Burnout Inventory (MBI) 16-item General Survey
- One-item measure of team structure
- One-item measure of PCP satisfaction with team model
- Seven-item measure of team culture developed by study team
- 12-item measure of panel management capability

Data analysis: T-tests, chi square, GEE modeling to account for clustering at clinic level
Results: Provider satisfaction

Provider satisfaction with team model, by team model
(n=235 PCPs)

Teamlet (n=42) (works with same clinical assistant)
Satisfied, 79%
Neutral, 12%
Not satisfied, 10%

Team (n=161) (works with group of clinical assistants)
Satisfied, 40%
Neutral, 26%
Not satisfied, 34%

No teams (n=22) (works with different clinical assistant)
Satisfied, 9%
Neutral, 32%
Not satisfied, 59%


Results: Panel management capability

% PCPs confident that panel management can and will be done, by team model (n=207-222 providers)

Immunizations (p<.01)
Teamlet (n=39-40) 63%
Team (n=149-161) 37%
No team (n=19-21) 29%

Cancer screenings (p<.05)
Teamlet (n=39-40) 49%
Team (n=149-161) 26%
No team (n=19-21) 26%

Diabetes care (p=.06)
Teamlet (n=39-40) 44%
Team (n=149-161) 26%
No team (n=19-21) 21%

Interaction between team structure and team culture on clinician burnout

Among clinicians reporting low team culture, team structure appeared to have little impact on burnout. Among clinicians reporting high team culture, stable teamlets were associated with lower burnout (p = .002). 231 clinicians from SFDPH and UCSF primary care practices, Maslach Burnout scale.


Key Findings

- Teamlets associated with greater **PCP satisfaction**
- Teamlets associated with higher **PCP confidence**
  that staff can take on new roles (like panel management)
- **Greater team culture** associated with lower emotional exhaustion and cynicism
- Tighter team structure was **associated with lower PCP exhaustion** when team culture was also high
- **Greater panel management capability** associated with lower cynicism when team culture was low
Closing the Demand-Capacity Gap: Share the Care

Clinicians

Non-clinician team members

Patients

Technology

Group visits
Alternative scheduling

Peer health coaches
Self care

MAs as panel managers
Health coaches
Scribes
Nurses
 Pharmacists
Behavioral health
Standing orders

Telehealth
eReferrals
Phone visits
eVisits

Source: Bodenheimer and Smith, *Health Affairs*. 2013; 32:1881-86

Share the Care™:
Culture Shift From “I” to “We”

All team members know their patients

Redefining roles of the care team

Empowered to share responsibility for their panel

Success stories are about all team members

Pay-for-performance and recognition systems reward the team
Team-Based Care, the 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.


Adult Primary Care: Capacity vs. Demand

Sharing the care adds capacity
Patient self-care reduces demand

Thinking Differently
Teams Are Like Chess

Not enough to just have the chess pieces....

Must know what every piece does AND how to play together

PCMH and PCMN offer patient-centric solutions to delivering health care

Advanced primary care systems should focus on well being of staff- both through measurement and strategy

Building Blocks offer a useful framework to achieve PCMH quality and move towards Quadruple Aim

Primary care transformation can be attained, measured and spread
Thank You!

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