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Perspective Roundtable: Redesigning Primary Care

Introduction

DR. THOMAS LEE: Welcome to a Perspective Roundtable from the *New England Journal of Medicine*. I'm Dr. Tom Lee, network president for Partners Healthcare System and an associate editor of the *New England Journal of Medicine*. I'm also a primary care physician. But you don't need to be a primary care physician to know that there is a crisis in primary care today. You can just look, as we do, in our newspapers and see the headlines today, and see the shortage of primary care physicians and the difficulty that patients are having getting access to good care.

For primary care physicians, however, the perspective is one where there is too much to do — too many patients, too many demands, too much information flowing through, too little time to do a good job. These problems are exacerbated today by a compensation system in which there are many other options that pay considerably better. And the compensation system does not necessarily reward you for doing what matters most.

How did we get there, and how can we fix this? We're going to try to discuss this topic today with four leading thinkers on health policy in general and primary care in particular. My colleagues, Tom Bodenheimer from the Center for Excellence in Primary Care at the University of California, San Francisco. My colleagues from Harvard Medical School, Allan Goroll and Kate Treadway, and Barbara Starfield from the Bloomberg School of Public Health at Johns Hopkins. Welcome, and thank you for joining.

Pipeline and Problems

Now, I want to start by recalling how medicine was when we came out of school. Going back to the late '70s, the role models for my colleagues and friends were generalists. They were physicians who would go to the bedside with their patients and they would see them in the office, see them at all hours. They seemed to know everything. And they would do whatever it took to comfort their patients and help them. What went wrong? Why aren't these folks the role models today?

DR. KATHARINE TREADWAY: It's interesting — there's a lot of conflicting reasons that residents and particularly medical students don't choose to go into primary care. A lot of residents say to me, "You have to know too much." Seeing the subspecialist who has the super-precise knowledge of that specialty seems to be something that they can understand and feel that they could become expert in that area. So they are afraid of the sort of enormity of the breadth of primary care.

In addition, they watch primary care doctors who are very stressed and who are at the bottom of the reimbursement scale. They come out of medical school with enormous debt. So they turn away from what many started out in medical school thinking they were going to do to something that seems more manageable to them.

And I think the last thing is because hours are so fragmented and their care is so fragmented in their training — and, as an aside, I would say I don't want to see residents have to work the 120 hours that we all worked. But on the other hand, what's been sacrificed is a sense of continuity and of responsibility for a patient that robs them of discovering how fulfilling it is to see a patient go through an episode of acute illness and walk in well to your office. And what happens when you have that experience.

DR. THOMAS LEE: Well, you know, as I listen to you, I mean I hear three factors that, frankly, I'm going to ask you to rank order and tell me which you think are most important in trying to address as we try to bring along a generation of physicians to take good care of patients. Okay, one of those factors, of course, is money. A second factor is prestige. And then a third area is the controllable lifestyle, where controllable also means that you actually feel like you can do a good job.

DR. KATHARINE TREADWAY: I've never gone home feeling I've done everything that I needed to do. But it's certainly gotten much worse. And just to give you an example, about maybe 6 years ago, I got a letter from a subspecialist, an oncologist, about my patient with breast cancer that was now 10 years old and inactive. And at the bottom of his note it said, "This visit took 30 minutes."

When I saw my 70-year-old patient, not only did I talk to her about her breast cancer, but we went through her neuropathic pain, her osteoarthritis, her hypertension, her hyperlipidemia, her grief over the recent loss of her husband, a complete physical exam including a Pap smear, arranging all of her labs, making sure I had done her prescriptions and arranged her screening colonoscopy. And he was reimbursed at a higher rate than I was.

Now, there is, I think, among primary care doctors a tremendous amount of distress over the inequity of that situation and the fact that we are increasingly time-compressed to do a great number of things. And I think that — so I would say the feeling that you are really in a state of being constantly overwhelmed, combined with feeling that you are very underpaid.

DR. THOMAS BODENHEIMER: It's the worklife problem that is my number one. It sounds like it is everyone's number one. The worklife problem is, it's the tyranny of the 15-minute visit. If you come in to your practice in the morning and you see that you have 12 to 15 15-minute visits in the morning and another 12 to 15 15-minute visits in the afternoon, and you know you can't do it all in 15 minutes — I mean it's been shown that just to do chronic and preventive care for a panel of 2300 patients, which is the average panel size in the United States, just to do chronic and preventive care would take 18 hours a day to do it right.

The 15-minute visit is not possible to do chronic, preventive, acute care, plus building relationships with patients, plus care coordination, all the things we have to do. We have to change that.

DR. THOMAS LEE: So, what happens if we don't fix these problems? What if the supply of primary care physicians get worse, access just gets worse? Give me a scenario. Barbara, what do you think will happen?

DR. BARBARA STARFIELD: We can predict, I think, with relatively great certainty, what's going to happen. And it's going to be increasing relative declines in health of the American population. Around mid-century we were pretty much at the top. And with each decade we have fallen further and further behind. So that now the United States falls somewhere between 25th and 35th in the world in terms of pretty much any health indicator you want to look at.

And we know now from various types of evidence that the more and the better primary care you have, the better are the health indicators in the area or in the country. In this country, states with higher primary-care-physician-to-population ratios have overall better health, however you measure the health. And the impact on costs is equally striking. The more primary care we give relative to specialty care, the lower the costs.

New Delivery Models

DR. THOMAS LEE: So we have a cost imperative and we have a quality imperative to fix this issue. So let's turn to that. There has to be a better way. Now, Tom, you've been describing some new models. What is that better way?

DR. THOMAS BODENHEIMER: There are people who are beginning to develop what I would call the primary care practice of the future. And it's very different than the primary care practice of the past. So, number one, when a primary care physician walks into the office, it's not saying, "Okay. I have 30 15-minute visits that I have to accomplish before I can go home tonight." The primary care physician will walk into the office and say, "With my team, I am going to spend my day trying to make my panel of patients as healthy as possible."

That might be a visit, a traditional visit. It might be working with people on e-mail, on the phone, on group visits. It might be having a panel manager who says, "This is the panel of patients, these are the people who are overdue for mammograms, for Pap smears, for immunizations. These are the people on my panel with diabetes, whose hemoglobin A1c's are too high or who haven't had a hemoglobin A1c in the past year. We are going to contact these people. We are going to bring them in for the lab tests they need. And if they are out of control with regard to their chronic disease, they're going to meet with a nurse who has a physician-written protocol as to how to increase their medications to get their sugars back under control."

So we're going to look at the whole panel of patients and try and make that panel healthy, not just concentrate on the 15-minute visit. I think that the primary care physician of the future should probably see about 10 patients a day, should spend real time with those patients. Those should be patients that are complicated, that really need a physician to take care of them.

DR. THOMAS LEE: I listen to you and I think, "What a wonderful world it would be." Is this an abstraction? Is this a pipe dream? Is it happening? Is anyone doing this and doing it successfully?

DR. THOMAS BODENHEIMER: Some of the large, integrated systems are beginning to do it. So take Health Partners in Minneapolis. They have a whole system, which they call the pre-visit, the visit, the post-visit, and the between-visit care. In the pre-visit, a medical assistant makes sure that everyone's chronic and preventive care tasks are taken care of. And does medication reconciliation to make sure that the patients' medications are being taken as the physician or the nurse practitioner has ordered. And the visit, it's a traditional physician visit.

But then the post-visit would be making sure the patient understood what happened in the visit. We know that 50% of patients leave an office visit without knowing what happened in the visit. So, having a medical assistant or, in our case, a health coach making sure the patient understood what happened in the visit, working with them on behavior change, and then phone calls between the visits to make sure, "Were you able to get the medications that you were prescribed? Did you have any problem with the copays? Did you have any problem with the formularies? Do you still remember how to take the medications? Are you taking the medications? If not, why not, and what can we do to try to take care of that problem?"

DR. THOMAS LEE: What will it take in terms of the payment structure and the organization of medicine for these models to reach their potential?

DR. ALLAN GOROLL: Well, some of the systems that do the kinds of things that Tom is talking about actually redeploy their resources. They have an internal rule for what gets paid for and how it gets paid for and who gets what. So what they're doing is they are working within, right now, a distorted payment system. But they take those dollars and then they reallocate them in an intelligent and nondistorting way.

DR. BARBARA STARFIELD: In the last 25 years, we have learned so much about what primary care is that it's almost a crime not to put it to good use. We know what the principles of primary care are. And it is almost certainly the case that there are many ways, or at least several ways, that you can accomplish these principles.

Now, there are basically four organizational principles. One is you have to define your population. You have to know who you are responsible for. And the people have to know that they have a place to go. That's the defined population. That's one organizational feature. The second one is that that place has to be comprehensive. It has to provide a broad range of services. You can't be sending patients to this doctor, this doctor, this doctor. And it's probably why family physicians on the whole, looking at it from a population person point of view, do better than any other kind of primary care physicians, because they are more comprehensive. They do a broader range of services.

Okay. The third thing is some mechanism of continuity. You have to have some way to transfer information. You know, there're lots of ways you could do that. Electronic medical records is probably a very good one. But it's not the only way. And the fourth thing is accessible.

Okay. Four organizational features that you have to have in order to have good primary care. And the team may help doing one or more of those. But it's not that you have a team. It is that you're trying to accomplish a certain function and sometimes a team helps a lot.

And these principles of organization then translate into the two essential features, which we, basically, in our quality systems don't focus on at all. What's the patient's problem? And has the problem improved?

Building Teams

DR. THOMAS LEE: We know the whole health care system has to change, including the reimbursement structure, to get to some kind of relationship where we pursue these principles. But what do physicians have to do?

DR. KATHARINE TREADWAY: I think that what a medical team accomplishes is it offloads the things that are not, that are very important, the preventive screening, etc. But it then, by offloading that, allows you to once again focus on what is the patient's agenda. And I think, obviously, there are dangers to the idea of a medical team. I mean, if the doctor is actually never seeing anyone but just sort of saying to the nurse practitioner, "Do this," or the medical assistant, "Do this," that's not going to be rewarding for anybody. But I think taking away from the physician those tasks which are easily accomplished and which also, for most patients who don't have a huge emotional agenda going on with them, would allow us to have more time with our patients, to be aware of what they're worried about and to do the things that I think most primary care doctors do, which is to show up at a patient's bed when they've had their mastectomy, just to say hi. That, or to call a patient — "I know you just got your first dose of chemo. How did it go today?"

DR. THOMAS LEE: Well, I wonder if it is more than just offloading work. I wonder if — I wonder if there is something more to being a good team member. I think that a lot of our colleagues have difficulty working in teams, even if you surround them with teams. They have trouble delegating, even if you give them people to delegate to. Is this something — do you see this as a problem? And if it is a problem, what's the answer? Do we wait for the generation who feels that way to retire?

DR. THOMAS BODENHEIMER: Well, you know, teams are difficult. If you look at the research on teams, there's a lot of dysfunctional — there are a lot of dysfunctional teams around. And one thing is, if you have a team of six or eight people, and they all sort of have to know what's happening, there's a huge amount of communication needed to make sure that everyone knows what's happening with a particular patient. That takes a lot of time, it takes lot of energy.

Also, if you have a team of six or eight people, probably one of the people's going to be difficult to deal with. Just statistically, it's more likely with a large team. We've been working with small teams, a team of two. We call it a teamlet. It's a small team, part of the bigger team. And it's really a throwback to the old days when you had a solo doc, primary care doc, who was in an office with his nurse. It's always "his," of course, nurse. It was always "his"

back then. And they worked together like for 30 years. And the physician really knew what the nurse was good at. They worked together. There were only two people, so the communication was relatively easy. And the patients had trust in both of them. We're trying to reestablish that kind of teamlet idea, because it makes much easier the team concept. Now, you may need to have a larger team around that little teamlet sort of focus. But teams, if we don't change the panel size, I think we need teams. And I don't think we can reduce the panel size if we have an increasing shortage of primary care physicians. The panel size is going to go up.

Payment Reform

DR. THOMAS LEE: The ideal of focusing on the people who have diseases, not just the diseases that people have — we all know that ideal. And I think that our sense is the payment system here does not necessarily reward that. And I want to go to the payment system next. But do you think — I mean, which comes first, the chicken or the egg? Is it in the water and in the culture, in the educational values? And then the payment system may just reinforce that? Or is it the other way around, the payment system's where it begins and that's why it's in the water?

DR. BARBARA STARFIELD: Unfortunately, it's the chicken and the egg cycle. It doesn't start in any one place. But the challenges are much different now than they were then, because now we do have these increasing morbidity burdens that aren't this disease or this disease — but it's the whole constellation of diseases. And fortunately, we're really in a good position now to measure morbidity burden that's not disease-by-disease care. We have systems that can say, you know, this subpopulation has got a greater morbidity burden than this population — and it's not because they have more heart disease and they have more rheumatic fever — you know, that kind of thing.

And that is what we should be doing. We should be giving rewards, giving incentives, giving payment to physicians for dealing with the burden of problems they have to deal with. It's not a big trick. We have the tools to do it.

DR. THOMAS BODENHEIMER: The whole chicken-and-egg thing also relates to how we're going to solve our problem. For a long time, primary care physicians have been angry at insurers for not paying them enough, for all sorts of problems. It's time to stop that. The primary care practices and the insurers have to get together. And there has to be a compact in which the insurer will say, "If you do a better job, we'll pay you more." And the primary care practices have to say, "We promise to do a better job. But we need to get more payment and different payment."

DR. THOMAS LEE: Well, let's talk about that compact. Define "doing a better job." What is the deliverable that we should be ready to go forward with?

DR. THOMAS BODENHEIMER: Number one, as Barbara said, a primary care practice needs to know who its patients are and needs to be responsible for those patients, and the patients need to know where their home is. Number two, there has to be prompt access. If people have a problem today, they should be able to get their problem taken care of today. And there has to be night call and weekend call, so that people don't constantly go to the emergency department when they don't need to go to the emergency department. So access is absolutely critical.

And then we have to make sure that our quality is good, that all the preventive and the chronic care needs and the, as Barbara was saying, the problem that the patients comes to you with is solved.

DR. THOMAS LEE: All right, so we have an idea of what we want as patients and what we would like to provide. How should we get paid for it? Allan, you've thought a lot, you've made specific proposals. Do you want to give your platform?

DR. ALLAN GOROLL: Well, I think we need to pay for the things that we want. Right now we pay for things in another way. And the things that we pay for are procedures. And the unit of payment for primary care doctors and those who don't do procedures was the visit.

We have to come back, take responsibility for this, and redesign the system so it works for society and it works for patients and it works for the profession.

So I think the essential thing is let's stop paying for volume of visits, and let's pay for desired outcomes. And those outcomes can be in three areas, maybe four. The first area would be patient access and patient-centeredness, if we want to use that term. That is, how friendly is the care for patients? How accessible is it? How personalized is it? Etc.

The second area would be in quality of care — and not process. As has been pointed out by people, pay for performance is very often pay for process. And the problem is, is that the link, as you know as an expert in this area, between process and outcome is sometimes a leap of faith rather than an evidence-based event. So we want to pay for outcomes. And the kinds of outcomes medically that we're talking about are those outcomes that either are proxies for ultimate outcomes, like the hemoglobin A1c or a certain level of blood pressure control. Or, as Barbara alluded to, even functional status of the patient is a very important outcome. And the third area is in cost-effectiveness or cost and quality.

So what we envision is, let's pay people enough to have the resources to do the job right. We look at the payment to the organization, be it a team, an individual, or a larger organization that's going to give us the deliverables.

Number two, let's give them a huge incentive to do the right thing, meaning let's give them a bonus. Let's take a large part of their payment, maybe a quarter, and let's give them a bonus on top of the adequate payment to just get started, and give them a payment bonus for doing the right thing. And that is not putting in 16 extra catheters and 14 extra stents, but making sure that their patients' cardiovascular health is now the best it can possibly be.

Now, what that sounds like is capitation. And we had this notion of a comprehensive payment for comprehensive care. That was a 1980s concept. But it got distorted. And it got distorted in two ways. One, it was not risk-adjusted. And secondly, the only bottom line was the ultimate bottom line of cost, did you save money? And it had another flaw. The number of dollars that was given in capitation very often was nothing more than the number of dollars in the old payment system given as a lump sum, which were too few, in order to do the job right.

DR. THOMAS LEE: What's your take, Kate?

DR. KATHARINE TREADWAY: I, just as an individual provider, thinking about how I would like to be paid, I would like to be — probably half of my salary to be a sort of, in exactly that model where I am paid for the number of patients I have, their age, and how complex they are. Just as a lump sum having nothing to do with whether I ever see them. One of the issues is we get paid for visits, and yet the job of primary care doctor is enormously taken up timewise by paperwork, completing records, doing prior authorizations, answering phone calls, talking to people, e-mailing people. So that I would say, since I've been in practice a long time and I have an elderly, sick population, that for every hour of face-to-face time, I have another hour, at least, of time that I spend that's unreimbursed. So, if I'm there for 13 hours, I'm getting paid for about 6 of the hours I'm spending. So I do think that there should be a, you know, a substantial sort of lump of, "This is what you're being paid to manage these people."

I do think that visits could be paid. I think one of the major issues for primary care doctors around the RVU system is it's designed for specialty care and single problems. There is nothing in the RVU system that allows you to take into account the fact that you've just seen somebody with congestive heart failure, hypertension, hyperlipidemia, coronary disease, renal insufficiency, and diabetes. That is a far more complex set of problems.

I also — I think pay for performance with outcomes is very important, with the following caveat. And this is — I think there has to always be a little wiggle room, because I think all of us who have taken care of complex medical patients who, for example, have hemoglobin A1c's in the nines, is not necessarily because you're not trying. It is because there are social, psychosocial issues that lead this patient to "I'm not taking my 60 units of NPH this morning."

DR. BARBARA STARFIELD: We somehow have to encourage medical institutions, training institutions, to pay for the training of primary care physicians. Right now, we're spending about 70 times more on the production of specialists than we are on the production of primary care physicians. That absolutely has to change. We are not going to change anything unless we change the ethos of medical education. And that, I think, is maybe even my top thing, because that's going to change the prestige, that's going to change the financing, it's going to change everything. We've just got to get onto something that can be done like that, if we had the political will.

Revolution or Evolution?

DR. THOMAS LEE: Listening to you and the other comments, I was thinking of three different alternatives for what might happen with payment. There's status quo. The fee-for-service system, by and large, where with increasing cost pressures, I think, inevitably leading to payments that are increasingly inadequate for meeting practices' expenses.

Elsewhere in the spectrum, there's sort of revolution and evolution. You know, revolution would be like a big, drastic change in payment policies that — rolling out the model that you described, that would be revolutionary.

And I would say the vast majority of practices would not be ready to handle it. And then is there something in between — an evolution that may not happen as fast as people would like, but it won't be as disruptive to care as a sudden, dramatic change in the way you pay for people?

DR. THOMAS BODENHEIMER: Actually, there're a lot of proposals that are evolutionary. So the Medicare Physician Payment Advisory Commission, they think that, number one, primary care physicians should just get more payment for each visit than they're getting now. Plus there should be some kind of care-coordination fee per patient for all the time we spend in between visits coordinating with the rest of the health care system, plus some kind of pay-for-performance system. That's what I think I'd call the evolutionary system.

I think it might help to pay primary care more, but I don't think it gets away from the fundamental visit-based problems, so I don't think it's adequate. But I think it's more likely what's going to happen.

DR. ALLAN GOROLL: I would have revolution but in evolutionary fashion. Number one, strategy one, we fix the current primary care infrastructure cadre by giving them an incentive. If you will reorganize your practice in whatever way makes sense to get at the Starfield goals, then we will now — and this would be a new kind of social contract — we will now pay you in the revolutionary manner.

And if you don't change, guess what? You can get RBRVS, visit-based, maybe with a few survival mechanisms tossed in to keep the lights on. And you'll just muddle along. And that's the way it will happen. So that you would then, in essence, come up the capability scale. And when you reach a certain level, you would then be accredited for payment under the new system. So that's a way of melding the evolution and revolution.

Now, one comment about that, Barbara's right — if we don't change the medical education system in the United States, we are not going to be able to meet the need. So what I would say here is that, to the students coming in, is that it's very important that the revolution of the system be in place — because as a student choosing a career, that is now an option for how to do things. And if that option is there, if we actually know that we have a viable alternative like coming up, training appropriately, learning about how to do teams and information technology and working effectively, that's what we can aspire to.

DR. BARBARA STARFIELD: The revolution is medical education. And we do have to change the incentives in medical education. I mean, I think we could dwell on this a moment, but I won't, but that's a revolution we have to have quickly. The semi-revolution is the payment reform. And the evolution is to start thinking about how we change our own practices so that we're responding to patients' needs — not needs as we see them, but the needs as people present them.

DR. THOMAS BODENHEIMER: We have to reform payment, because right now what we are trying to do is a lot of practices are trying to change, sort of one practice at a time. Well, there are hundreds of thousands of primary care practices in this country. To change them one at a time is going to take forever. Real payment reform will really encourage and dictate that a lot of practices are going to change quickly.

However, the “plus” is that the practices need assistance in becoming really good primary care practices. So part of the payment reform has to be that there have to be some kind of, I’d call them practice-improvement teams or practice-improvement consultation to go to the practices and help them to make the changes they need. And there are people who are very good at doing that, but I think those practice-improvement teams should have patients on them, because otherwise we could go wrong.

DR. THOMAS LEE: Well, I want to thank all the panelists. It’s been an interesting discussion, and, actually, one thought that ran through my mind, listening to all the changes that you’re calling for and the references to evolution is, next year is the 200th birthday of Charles Darwin. And one of his comments on evolution was that the species that survive are not the strongest and they’re not the most intelligent, but they’re the ones that have the ability to change. And clearly the changes that you’re calling for are important. We’ll see how nimble our health care system is. We wouldn’t bet on it being extremely nimble, but I think we will change, because I think we have no choice. And I think that these insights will be useful to the readers and the viewers. Thank you very much.