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Transforming Primary Care

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As the employers of many primary care physicians, hospitals and health systems must decide whether to move toward a Patient-Centered Medical Home (PCMH) model of care or stick with traditional practice models. A PCMH can help with a crucial new task: reducing costs and meeting quality targets through better management of chronically ill patients. Interestingly, PCMHs can also help with another challenge: expanding primary care capacity.

Some PCMH practices are "box checkers" seeking accreditation to obtain additional payments from health plans. Others are really transforming how they deliver care in their practices.

IMPROVING CARE

Much of the time in today's primary care practice is spent treating patients with chronic conditions. Ideally, in tomorrow's practice (a very close tomorrow), chronically ill patients will receive more preventive services, including health counseling, education, and assessment of treatment compliance. As Willard and Bodenheimer point out, some aspects of all of these tasks can be handled by nurse practitioners, physician's assistants, licensed practical nurses, and even medical assistants, as long as those alternative providers[a]:

- Work in teams with each other and one or more primary care physicians
- Work within a strict framework of workflows and standing orders
- Are well-trained in knowing when to involve (other) clinical staff

Alternative providers have more time than physicians do to engage patients in managing their own health. For example, medical assistants can communicate the results of frequently repeated tests to chronic care patients, and can explore with patients the factors that could be contributing to abnormal results.

The primary care physician's preventive care workload also can be lightened by creating standard orders for vaccines, preventive care studies, etc.

Primary care teams can be supported by a shared support team, which may include care coordinators, panel managers (focused on monitoring data and identifying "exceptions" that require attention from another team member), social workers, pharmacists, nutritionists, and others appropriate to the practices. Some members of the support team may be in the same space as the primary care practice; some may rotate between offices; some may be available only by phone and email.

With these resources available, the role of the primary care physician will need to transform to that of team leader and manager. This change may be a reach; few primary care physicians have been trained in these new roles.

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For hospitals and health systems seeking to manage population health, it will be critical to not only provide and organize required support resources, but also to support primary care physicians as they transition to this leadership role. Identifying or recruiting a core of primary care physicians who have these skills and can serve as role models, mentors, and trainers to other primary care physicians could be a key investment in the success of PCMH strategies. And PCMH success may be central to clinical integration and population health strategies.

EXPANDING CAPACITY

Through the thoughtful involvement of a range of health professionals on a team, the physician time spent on each patient should decline. As a result, PCMHs can be an opportunity for hospitals and health systems to provide additional primary care capacity to meet the expected surge in demand for primary care.

Footnote:

a. Willard, R., and Bodenheimer, T., "The Building Blocks of High-Performing Primary Care: Lessons from the Field" California Healthcare Foundation, April 2012.

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