

priority on trying to do a good job and having a sane life than on making a higher income. The message they're sending is that more money will not be enough to revitalize primary care.

Revitalization will take something more like reinvention, and it will demand creativity and flexibility from all parties — including primary care physicians themselves. These physicians need to learn to work in teams and adjust to the notion that much of primary care can be delivered by nonphysician team members, some of whom are located in nontraditional settings, such as limited-service clinics in retail stores.

In this collection of articles, Starfield describes some of the major policy issues that must be addressed as the U.S. health care system develops a stronger primary care focus, and Roland suggests that there are some features of primary care in the United Kingdom that might warrant adaptation. As we test new concepts in the years ahead, primary care will undoubtedly change dramatically. But if we are successful and wise, these changes should allow key aspects of being a primary care physician to remain the same.

Primary care doctors should once again feel a deep sense of satisfaction when they leave their offices or patients' homes after helping people through difficult times. They should be able to leave work thinking not of their income, or of unanswered phone calls, or of test results that they might have overlooked. They should go home thinking, "This is what I was meant to do."

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Sustaining Relationships

Katharine Treadway, M.D.

"A growing chorus of discontent suggests that the once-revered doctor-patient relationship is on the rocks."

New York Times, July 29, 2008

With its combination of care for acute, undiagnosed illness and complex, multisystem disease, as well as the provision of extensive preventive care, all in the setting of a long relationship built on mutual trust and knowledge, primary care has long been a deeply rewarding profession. But in recent years, this once-extraordinary specialty has seen its ranks diminish as doctors struggle with an increasing amount of paperwork, the explosion of therapeutic options, and a dramatic expansion in preventive care responsibilities. Care is

increasingly fragmented, leaving patients angry and doctors frustrated. The time demands have exploded, which has eroded everyone's ability to develop the personal, long-term relationships that are a great source of satisfaction for providers and comfort for patients. Such relationships can be instrumental in providing effective and efficient care.



My 12-year relationship with one patient and her family had a profound effect on care at the end of her life. When I met Mrs. C, she told me, "I am

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Transforming Practice

Thomas Bodenheimer, M.D.

Overstressed by large patient panels, many primary care practices are performing below par. In one study, patients explaining their problem to a physician were interrupted after an average of 23 seconds. Fifty percent of patients leave office visits not understanding what the physician has told them. It would take a primary care physician 18 hours per day to provide all recommended preventive and chronic care services to a typical patient panel. As a result, only half of evidence-based care is actually provided.¹ These disturbing findings can be attributed primarily to the overburdened 15-minute clinician visit.

Two solutions come to mind: Re-

duce the panel size to allow more time per patient — the concierge model — which would aggravate the impending shortage of primary care physicians. Or reorganize primary care into a team-based endeavor, off-loading many functions from the 15-minute visit — a solution requiring fundamental payment reform that uncouples reimbursement from the clinician visit and creates incentives for team building.

The latter approach involves a fundamental paradigm shift: rather than spending all day in traditional patient visits, primary care physicians must analyze their patient panel and manage it so as to keep all patients as healthy as possible. To do so, practices need a registry (database) that gives them access to their patients' diagnoses, key clinical data (e.g., blood pressures and cholesterol levels), and

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reminders of studies or services that are overdue. A panel manager (perhaps a retrained medical assistant) must systematically and repeatedly review the registry and use physician-created standing orders to ensure that all tasks related to preventive and chronic care (subject to patient preference) are performed. Such panel management has the potential to improve care as well as reduce the burden on the 15-minute visit.²

Practices would stratify their panel according to patients' needs and organize services accordingly. Patients needing acute care must be able to get care on the day they request it — through same-day scheduling systems,³ urgent-care clinics, nurse advice lines, or e-mail or the Web. Healthy patients needing preventive care could be served largely by panel managers, who would order preventive services, send patients normal test results, and arrange clinician visits, telephone calls, or e-mail encounters for patients who need or want a discussion of abnormal results or other issues.

Patients with one or two chronic conditions could be cared for by a team whose nonclinician members — under physician supervision — led planned visits, ideally for groups of patients, focused on patient education and lifestyle change, clinical data tracking, and medication intensification. Health coaches (registered nurses supervising trained medical assistants or community health workers) could provide much of this care.⁴ The 15-minute visit could then be devoted to patient-generated agenda items.

Patients with complex health care needs (multiple diagnoses, polypharmacy, high utilization and cost)

— including patients requiring palliative or end-of-life care — should consume a major portion of physicians' time. Reliance on nurse care managers could improve the quality of care, reduce costs, and assist physicians in these patients' care.⁵ Patients with mental health or substance abuse problems would be



cared for by behavioral health professionals under physician supervision. The most efficient approaches to meeting other patient needs would have to be determined.

One of the rationales for this approach is that physicians perform many tasks that do not require a medical degree and could thus be delegated to other team members. To build the requisite teams, small practices could aggregate to share team members. Physicians would become team leaders with a dramatically different daily schedule — having at most 10 visits per day and spending time consulting with team members, handling physician-level telephone and electronic encounters, and ordering medication changes, which would be carried out by health coaches, who would contact patients, explain the changes, listen to patients' concerns, and follow up on adherence. Patients could receive electronic or telephonic consultation as medically appropriate, which would reduce the demand for visits.

Would such a change in approach

enhance the continuity of care and the building of trusting relationships that are so central to primary care — and that are endangered by today's rushed 15-minute visits and part-time clinician schedules? If the team approach is clearly explained to patients, if patients are offered continuity with the team, and if team members provide patient-centered, high-quality care, it is likely — though not yet proven — that patients will transfer their trust in the physician to a trust in the team. Most patients will probably agree that a balance should be struck between their needs and the work-life realities of overburdened primary care physicians.

By offloading tasks from the 15-minute visit in order to prioritize the patient's agenda, adding group, telephone, and electronic encounters, and reorganizing services with the aim of maximizing the health of a practice's entire patient population, innovative primary care practices could lead primary care out of crisis into an era of renewal.

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