Tom Bodenheimer

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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds, who are shaping the health care of the future. This week, Mark and Margaret speak with Dr. Tom Bodenheimer, Co-Director of the Center for Excellence in Primary Care, and Professor Emeritus of Family and Community Medicine at UC, San Francisco. He's a renowned expert on transforming primary care, which is seriously under-funded in the U.S. health care system. He calls for more resources, better deployment of health care teams and health coaching for better overall outcomes.

Lori Robertson also checks in, the Managing Editor of FactCheck.org, who looks at misstatements spoken about health policy in the public domain, separating the fake from the facts, and we end with a bright idea that's improving health and well-being in everyday lives. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to Podcast. You can also hear us by asking Alexa to play the program Conversations on Health Care.

Now, stay tuned for our interview with Dr. Tom Bodenheimer on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Tom Bodenheimer, Co-Director of the Center for Excellence in Primary Care, and Professor Emeritus of Family and Community Medicine at the University of California, San Francisco. He's a general internist who spent 32 years in primary practice in San Francisco's Mission District, before turning his focus to researching ways to improve primary care. Dr. Bodenheimer has written and co-authored hundreds of published papers and several books on health and health policy, including understanding health policy and improving primary care. He earned his Master's of Public Health from UC Berkeley, his medical degree from Harvard and did his residency in internal medicine at UC San Francisco School of Medicine. Dr. Bodenheimer, welcome back to Conversations on Health Care.

Dr. Tom Bodenheimer: I'm delighted to be here.

Mark Masselli: Tom, we are so happy that you're with us today. You're just -- you're one of our heroes. You're also very humble about the work that you've done. You've really become nationally known for your work on team-based care. I know our audience would

love to hear about the work that you're doing at the Center for Primary Care Excellence. We had the opportunity to have you here for a couple of days and heard you talk about the struggle that's happening in primary care, but also the hopes and aspirations that people like you had been writing about, have been preaching. As you said in your own words, you've been a messenger. I'm wondering if you could just share a little bit about that work and your thoughts on primary care?

Dr. Tom Bodenheimer: Center for Excellence in Primary Care, we do both research and practice improvement. One area that we've been very interested in is, we feel like many people, especially doctors, I must say, their relationship with patients is one of, "I want you to do what I tell you to do, and if you don't do it, you're non compliant." Sadly, that's still very much alive. Well today, it impacts not only primary care, but all of medicine. I think the thing that I've been most interested in doing is what we call health coaching. You'll find out what people are willing and able to do, and then work with them and make a collaborative plan on how they can improve their healthy behaviors. We never tell them that they're not doing what we want them to do, because it's about what they want to do. Ultimately, it's their choice. We've done randomized controlled trials on health coaching and people who get this health coaching have better diabetic control and hypertensive control than people that don't get health coaching.

We also do, what we call, practice coaching. Health coaching is working with patients, practice coaching is working with practices, and they're kind of similar. Like, you can't tell a medical practice you have to do this to get better. You have to see what they're willing and able to do. About seven or eight years ago, a couple of us from the Center for Excellence in Primary Care started visiting, what we call, bright spot practices, practices that are really good. We went to about 25 different practices around the country. We kind of took those observations of these practices, and created a model, which we call, The Ten Building Blocks of High Performing Primary Care. The sort of the basic building blocks is; number one, if you don't have good leadership, nothing good is going to happen. Number two is data-driven improvement, you have to have data, and you have to use it to improve. The data just -- can't just sit there in the computer, you've got to use it. The next one is empanelment, making sure that every patient is linked to a primary care provider. The fourth one is team-based care. The rest of the building blocks are like access, continuity of care, care coordination. We ask practices to assess how they're doing on the different building blocks, and

that kind of tells us what they need to work on. We have a four-day training to train leaders and practices on the different building blocks and how they can use them to try to improve their practices.

Margaret Flinter: Well, Tom, I think one of the inputs into all this work was a project that we had a chance to work on together this leap project, learning from effective ambulatory practices or exemplary ambulatory practices from the Boston suburbs to the heartland, all over the country, really tried to look in real time in real life, what were they doing that was different? I wonder if you want to just call out a couple of practices with a concrete example of how those building blocks ended up manifested?

Dr. Tom Bodenheimer: Yeah. One I can think of is West County Health Center in Sebastopol, California, which is in Sonoma County, just a little bit north of the Bay Area. This practice had incredible teams. There was one clinician, which would either be a nurse practitioner or a physician. There is a nurse on every team. There's a medical assistant on every team. There's a front desk person, like a receptionist on every team. The teams were stable. In other words, we made -- the teams always work together. Patients, who are patients of that team, always see that team, and the team only sees the patients that are on their panel. The team can really see, what's happening to their whole panel of patients? What percent of their patients are in good control for their diabetes? What percent of their patients have their cancer screenings done up to date? Then, people who don't have those things, the medical assistant and the front desk person can contact them and try to bring them in to do those things that are -- that we call care gaps that are not taken care of. The teams in that practice were really inspirational. The nurses would often go out to people's homes, and they could interact electronically with the clinician on the team, especially, frail, elderly people, you learn so much in the home that you cannot learn when they come into the clinic. The home visits were a key part of that. Having so many nurses in the practice really allowed the practice to do many more things than practices with fewer RNs. Another one was Asian Health Services in Oakland, where they had patient navigators who spoke, I think something like six or seven different Asian languages for all of the different Asian languages in the community around the health center. Great stuff.

Mark Masselli: Well, that's great. For people who might be tuning in now, and they're hearing us talk about coaches and teams, they might

be thinking you're talking about baseball. Teams are very important, and every member of the team has an important role. Teams just don't happen, because you call them teams. It requires some ingredients to make every member of the team operate at the top of their license. Can you talk about some of those core qualities that people need to do? I assume no different than a good baseball team, they're out there practicing. What are some of the core qualities that they may want to do a gut check to see if they have?

Dr. Tom Bodenheimer: We think of teams as sort of -- in three sort of components of teams. What's really important is that they have a stable structure. The same people always work together, the patients always come to their team. That's a big problem in primary care, because you have people who are part-time, and especially, in practices where they're residents who are learning to be physicians, and they come into these practices and they feel uncomfortable, because they're just starting. If they have a team that's always there for them, and they know the people on the team, they feel comfortable. Then there's team culture. There are many ways to measure team culture. It's basically, how do people get along with each other and how people work with each other. We've created a very simple sort of seven questions scale about team culture. It's very simple things and many practices. Questions like, I feel like we're all in it together. Simple stuff, but some teams score very low on team culture. The culture is not good, things don't go well.

Then the final thing is what we call share the care. Share the care is, how many of the functions that primary care needs to do are done by the physician on the team or by the nurse on the team or by the medical assistant on a team or by the behaviorist, and so forth. First we asked people, we give 10 particular things that all primary care practice need to do, like, colorectal cancer screening, or helping people with diabetes with their behavior change, or answering the phone in such a way that people can get a good appointment. We asked people to fill out who's actually doing that function. Ten years ago, it was like the physician, the physician, the physician was doing everything. Then we asked them, "How would you like the team to work?" Everyone was like, "Well, we would like the pharmacist to do a lot of stuff. We'd like the nurse to do a lot of stuff." The medical assistant to make sure that everyone has all of their cancer screenings, all their immunizations, but that's their responsibility. Over time, what we found is, the way that is happening now is that more functions are distributed compared with 10 years ago, when it was all the

physicians doing everything. We are making some progress in team-based care. We need to make much more progress. There are barriers to other people taking on these functions. For example, in fee for service situations, nurses and pharmacists pretty much can't get paid, so they're an expense. That's a barrier. There are regulatory barriers. Little by little, I think a lot of practices are trying to redistribute the care among the team.

Margaret Flinter: Well, another area that you have long paid attention to and lamented the slow progress is trying to devote more of the spend to primary care. How would you reallocate the spend, so that primary care actually got the resources that it needed, as of course, most of the high performing countries around the world already do?

Dr. Tom Bodenheimer: I mean, the other thing countries in Europe do is, they spend a lot more in other social services. It actually turns out. If you spend more on education than on health care, you'll have better health care. In terms of the social determinants of health and the whole community world in which health care lives, we -- probably we should be spending more money on other social services. It turns out that in the United States, 5% to 7% of that goes to primary care as opposed to other countries, like in Europe, the sort of an average is like 12% goes to primary care. If you increase the percent of the health care dollar going to primary care in the United States from like 5% to 12%, that's like, billions and billions of dollars that would go to primary care, which would allow us to do many of the things that we're asked to do. We used to just take care of the patient who's in front of us right now. Now, we're asked to take care of populations, and make sure that those populations are as healthy as possible. Having more money is not the only thing we need to do, because we also need to reorganize our teams and make sure people have access and make sure that people have continuity of care, but more money would really allow us to do a lot more than we're doing now. To me, primary care physicians and nurse practitioners and physician assistance, who have these panels of like 2,000, 2,500 patients, they're really heroes that really doing this work, which is almost undoable at the number of patients that they have to see. I think primary care practitioners who are working day-in and day-out are really the heroes of our healthcare system.

Mark Masselli: That's great. We're speaking today with Dr. Tom Bodenheimer, Co-Director of the Center for Excellence in Primary Care at the University of California, San Francisco, and Professor Emeritus

of Family and Community Medicine. Tom, you were talking about managing populations and that requires access to a lot of data. I think we've seen oftentimes, Margaret, here that we're not only a healthcare organization, but we're an IT company in many ways, because data is so important, and you've really been a champion of the use of data in thinking about how you coach, how you manage teams in the like, talk to us and to the clinicians who are listening about best practices in leveraging data and most importantly, how it can help improve patient outcomes.

Dr. Tom Bodenheimer: Let's just take a particular issue, like say, let's take colorectal cancer screening, which we know reduces the rate and increases the longevity of people who are going to get colon cancer. It's a very, very important thing that all primary care practices should pay attention to, and try to work as much as possible that all of their patients over the age of 50, get regular colorectal cancer screening. If you have a good IT system as you do, you can measure that for all your patients and you can see how you're doing over time. Then you also have to drill it down, not just to your whole organization, but to each team, so you can compare how different teams are doing. How do you use the data for improvement? Well, you talk about it in the team, "Okay, our colorectal cancer screening rate is only 45%. Our goal is 80%." One organization that does data better than any other is University of North Carolina Family Medicine Residency Clinic in Chapel Hill. They have data on all these things. They drill the data down to the teams. They drill the data down to each provider. All the data is on the walls. Everyone knows what everyone else's data is. It's all transparent. The other thing is, they want to make sure that all of their patients are offered to get colorectal cancer screening. Each team has a whiteboard up right above where the team is working, and the whiteboard says, "Today, there are six patients coming in who are overdue for colorectal cancer screening. So, make sure the medical assistants who do this, make sure that you really work with those six patients." Then at the end of the day they say, "We got five out of the six." It's really taking the data, and like, making it very patient specific to use, not only to improve the work of a team and of the clinicians in general, but to really make sure that every single patient has all of these things that they should do to keep healthy.

Mark Masselli: That's great.

Margaret Flinter: I've always thought of you as somebody who found tremendous joy and satisfaction in practice as a physician. Yet,

you said yourself that you reached a point where you were burned out, and we hear this all over the country, it's gone from being talked about as burnout to moral injury. Basically, comes when people are emptied out of their ability to continue working compassionately and at their full robust ability. When you left practice, one of your commitments was to really try and improve primary care for the sake of the patients and the people who care for them. Share your thoughts on burnout with us.

Dr. Tom Bodenheimer: Back when I was practicing -- I left practice in 2002, the word burnout didn't exist. When I think back, I can think about days when I really felt burned out, but it's not every day, it goes up and down. The best way to measure is to use the Maslach Burnout Inventory, and that's basically saying, so there's a bunch of statements like I feel completely exhausted every day, once a week, once a month. It really looks at how common it is. There are two parts of burnout that are quite separate. One is the exhaustion part and the other is what's called cynicism. Exhaustion is just too much work and there is too much work in primary care. That's a big thing. It's not easy to figure out how to reduce that work. One of the reasons why we want to spread things across the team is to reduce the work of the clinicians who are getting burned out without increasing the burnout of the other team members.

The other part of it, though, is really much more pernicious and that is people who can't stand the work that they're doing, part of it is, I hate my work. What's happened partly as a result of electronic medical records is that physicians are spending about half of their time dealing with electronic medical record documentation, which is 150 inbox messages you get every day in addition to seeing the patients face to face. If we can get rid of all that documentation and desk work, we will -- number one, reduce the amount of work and reduce the work that people hate. There are ways to analyze what these different inbox messages are and try to figure out which ones can be reduced. In terms of the documentation, there are different things that people have tried, people try scribes for doing the documentation in the electronic medical records. There is a team based structure, in which you have two medical assistants per clinician, in which one of the things that the medical assistant do is reduce the documentation burden on physicians. This is something we really need to work on. Every practice has to measure the burnout and try to figure out what to do about it.

Mark Masselli: I want to pick up on Margaret's statement about joy. You also

found as a Peace Corps physician is somebody who's worked in the Mission District been concerned about immigrants. Advocacy is very important in addition to practice, right? Talk about the joy that you get and the responsibility that you have to be engaged in the larger conversation?

Dr. Tom Bodenheimer: Yeah. I mean, burnout is sort of one end of the spectrum and joy is the other end, and we try to move toward the joy end of the spectrum as best we can. To me, most of the joy in practice that I remember comes from having long-term relationships with patients. Increasing the amount of time that people have making these relationships with patients brings more joy. Teaching brings joy, and teaching in healthcare is very much experiential. It's like teaching right there, than and there. It's not like sitting in a classroom, teaching people seeing patients. I just love teaching the UCSF medical students that would come. We had these first year students who would come, they didn't know anything. I had this one student, she was fluent Spanish speaker, and many of our patients were Spanish speaking as I was. I said, "Well, why don't you go and see this patient?" She went to see the patient. She was very wonderful, very empathetic, to come out, to talk about with the patient. Then when the end of the interview, the patient says, "Could I see her now? Could she be [PH 00:19:12] my primary care doctor?" Those things bring joy.

Margaret Flinter: Well, that's a great ending. We've been speaking today with Dr. Tom Bodenheimer, the Co-Director of the Center for Excellence in Primary Care, and Professor of Family and Community Medicine at the University of California, San Francisco. You can learn more about his groundbreaking work, go to profiles.ucsf.edu/thomas.bodenheimer or follow the work of the Center for Excellence in Primary Care on Twitter @ucsfcepc. Tom, thank you so much for your enormous contribution to the advancement of high quality care for all of the education and training of medical students and residents and other students of the health professions over the years, and for being a guest with us here on Conversations on Health Care.

Dr. Tom Bodenheimer: I'll thank you for all that you're doing. You're wonderful organization.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a

nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: The Census Bureau in September released its report on health insurance coverage in the United States in 2018, finding that the rate and number of the uninsured increased from 2017 to 2018, the first time it has found a yearly increase since the Affordable Care Act was enacted in 2010. In 2018, 8.5% of people were uninsured for the entire year. That's up from 7.9% in 2017 and it's an increase of about 1.9 million people. Most Americans with insurance get their coverage from private health insurance companies. 67.3% of people have private coverage with most getting that coverage through their employment. Those with Medicaid coverage dropped 0.7% points from 2017 to 2018 and the percentage of children without insurance went up by 0.6%. The Census Bureau also released information on income and poverty, finding that the median household income in 2018, $63,179, wasn't statistically different from 2017. That comes after increases in the median household income for the three years prior. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. One in five Americans will suffer a diagnosable mental health condition in a given year, and most often don't seek treatment. Seeing a rise in mobile apps aimed at behavioral health entering the marketplace, University of Washington researcher, Dror Ben-Zeev thought a comparative effective analysis study would be a good idea.

Dror Ben-Zeev: With the objective of having a head to head comparison between a mobile health intervention for people with serious mental illness called FOCUS and more traditional clinic-based group intervention. The study really gets at some of the core differences between mobile health and clinic-based care.

Mark Masselli: More than 90% of the mobile app group engaged in the online

program, which was a series of text messages, offering coping strategies and self monitoring of symptoms, along with weekly colons with a behavioral health clinician.

Dror Ben-Zeev: The second thing we wanted to see is after people complete care, are they satisfied with both intervention. Probably the most important piece of the study are the clinical outcomes. 90% of the individuals who were randomized into the mobile health arm actually went on to meet a mobile health specialist to describe the app to them and train them how to use it and use the intervention app, that's assigned to them at least once. Whereas in the clinic-based arm, we saw that only 58% of the participants assigned to that clinic-based intervention ever made it in for a single session.

Mark Masselli: Both groups of patients saw roughly equal results from their completed treatment, but the mobile group was more likely to engage in therapy.

Dror Ben-Zeev: The very existence of a group can be quite helpful, but for others, the interaction is anxiety provoking. When it comes to the clinical outcomes, in both intervention arms, people improved both in terms of reduction in their symptoms and the distress associated with symptoms.

Mark Masselli: A targeted mobile app aimed at facilitating access to clinical care for those experiencing serious mental illness symptoms, improving access to intervention for behavioral health needs. Now, that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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