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Aus Ärzten werden Teamleader

Eine umfassende und patientenorientierte Hausarztmedizin braucht vermehrt Teamarbeit

Viele Aufgaben, die in einer Hausarztpraxis anfallen, setzen keine ärztliche Ausbildung voraus. Sie sollten deshalb an andere medizinische Fachkräfte delegiert werden. Die Ärztinnen und Ärzte überwachen die Umsetzung der angeordneten Massnahmen und steuern die Implementierung einer neuen, teambasierenden Betreuungsform. Ein Modell, das sowohl den Medizinern als auch den Patienten grosse Vorteile verspricht.



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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 find-

ings can be attributed primarily to the overburdened 15-minute clinician visit. Two solutions come to mind: Reduce the panel size to allow more time per patient – the concierge model – which would aggravate the impending shortage of primary care physicians. Or reorganise primary care into a team-based endeavor, offloading 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 analyse 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 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 organise 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 approach to meeting other patient needs would have to be determined.

One of the rationals 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 ten 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 prioritise the patient's agenda, adding group, telephone, and electronic encounters, and reorganising services with the aim of maximising 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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Literatur

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Abstract

Die Bedürfnisse der Patienten einer durchschnittlichen Hausarztpraxis sind vielfältig. Entsprechend aufwendig ist deren Erfüllung. Deshalb sollte die Betreuung der Patienten vermehrt in Teamarbeit erfolgen. Zu viele der alltäglichen Aufgaben werden noch immer von den Ärzten selbst anlässlich der regulären Sprechstunden übernommen. Damit fehlt ihnen häufig die Zeit, vertieft auf die Bedürfnisse der Patienten einzugehen oder die Pflege chronisch Kranker genügend zu überwachen. Das Delegieren verschiedener Aufgaben an ein Praxisteam bietet sich dabei als Lösung an.

In einem ersten Schritt wird die Patientenpopulation der Praxis genau analysiert. So lassen sich die Patienten in Gruppen einteilen, die von verschiedenen Fachkräften umsorgt werden können. Gesunde Patienten, welche die Praxis nur zur Krankheitsprävention aufsuchen, werden mehrheitlich von so genannten Panel Managern (speziell ausgebildete Praxisassistentinnen) betreut. Sie vereinbaren mit den Patienten nötige Arzttermine, informieren sie über normale Laborresultate und beantworten allgemeine Fragen rund um die Gesundheitsvorsorge. Patienten mit chronischen Leiden werden in Gruppen eingeteilt, welche eine ähnliche Pflege benötigen. Diese werden dann von Health Coaches betreut, die sich um die Patientenschulung, die Kontrolle klinischer Daten und die Medikamentenabgabe kümmern. Der Arzt widmet sich somit anlässlich der Sprechstunde fokussiert den individuellen Bedürfnissen seiner Patienten. Eine solche Umstrukturierung des Praxisalltags entlastet nicht nur die Ärzte, sondern ermöglicht auch eine umfassende und patientenorientierte Versorgung.

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Thomas S. Bodenheimer, Autor des vorgängigen Artikels, wird am 30. Oktober 2009 am 6. Schweizerischen Kongress für Gesundheitsökonomie und Gesundheitswissenschaften in Bern zum Thema «Integrierte Versorgung und Hausarztmedizin – ein Widerspruch?» referieren. Mehr Informationen zu dieser Tagung finden Sie unter www.sag-ase.ch/kongress.html.