REEVALUATING
THE VALUE OF PRIMARY CARE
USING DESIGN THINKING

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Primary Care in the United States is at a **critical crossroads**.
The health care system is shifting from **Fee for Service** to **Total Cost of Care**
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- paid for sick care
- paid for health
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- paid for sick care measured on volumes
- paid for health measured on outcomes and patient experience
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- paid for sick care paid for health
- measured on volumes measured on outcomes and patient experience
- difficult to bill for non-physician services embraces team models
Moving from a system that was never designed to one that is more thoughtful presents us with a unique opportunity.
The new system must:

attract and retain patients
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provide high value care
The new system must:

- attract and retain patients
- provide high value care
- have highly satisfying services
The new system must:
- attract and retain patients
- provide high value care
- have highly satisfying services
- better meet consumer needs
We must design to optimize:
coordinated care
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coordinated care

management of populations
We must design to optimize:

coordinated care
management of populations
management of chronic conditions
This shift is not simple.
We can’t just keep things as they are.
28% of patients could list their medications
37% could state the purpose of their medication
14% could state common side effects
42% could state their diagnosis
50% of all prescriptions went unfilled
50% of filled prescriptions were taken improperly
REASONS FOR NOT SEEKING CARE

Cost
Insurance
Too Busy
Not sure what to do
Of every 5 patients seen in the clinic today:

1 needs to see a provider

1 could be served with non-visit care

3 could be served by a care team
The current healthcare system is in the business of **doing things to patients.**

(in fact, it overtly rewards providers for this)
The health care system cannot respond to the needs of the patient without **talking to them first**.
Consumers define health not as the absence of disease but as the ability to function in their daily lives.
Consumers are looking for services that **support their health** rather than systems that rid them of disease.
We developed a system that helped patients get **what they needed**, when they needed it, how they wanted it.
CONVEYOR BELT CARE

WRAP AROUND CARE
Sharing care responsibilities across the team means:

- Increasing nurse-only visits
- Improving the integration of allied staff members providing specialized services.
- Daily communication and coordination of patient care across the team.
- Increasing non-visit care options.
How is this Different from Previous Care Team Models?

We are not simply emphasizing physician efficiency and maximizing individual physician productivity.

The Optimized Care Team:

- Establishes how each member of the team can add the most value to direct patient care.
- Emphasizes the delegation of care across disciplines.
- Diversifies the relationships patient's have with their clinic.
- Diversifies the access points patients have with their clinic.
7 weeks of experimentation
1300 patients seen
“I’d rather come in for one very thorough 45min appointment where I see the whole team, than come back 3 times in 3 months.”

“Seeing the pharmacist was great. I pick up the meds for the family and I got to ask questions I otherwise would have forgotten.”

“I liked that everyone seemed to know about me.”
Did your care providers know your story and reason for visit?

- no
- somewhat
- yes

Visit Satisfaction Comparison

- less satisfactory
- the same
- more satisfactory
Capacity Gained
Actual Recorded vs. Potential

Utilization of Integrated Team
- 143 Actual Recorded
- 305 Potential

Nurse Visits
- 80 Actual Recorded
- 132 Potential

Non-Visit Care
- 70 Actual Recorded
- 147 Potential
It worked.
It worked.
Everyone agreed it was better.
It worked.
Everyone agreed it was better.
So why isn’t it operationalized?
Culture
Physician Attitudes
Culture
Physician Attitudes
Allied Health Staff Confidence
Culture
Tools
Culture
Tools
Compensation
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