Primary Care Practice Redesign: Critical Milestones and Key Learnings

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Agenda

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- Background
- Principle and Goals
  - Empowering Practice Team and Patients
  - The Four-Stage Office Visit
  - Strategic Redistribution of Work
  - Producing a High-Functioning Primary Care Practice
- Attributes
  - Access and Continuity
  - Patient and Family Engagement
  - Provider Alignment
  - Care Management
  - Population Health Management
- Practice Assessment: Data and Interviews
  - Practice Operations
  - Productivity
  - Practice Performance
- Implementing Team-based Care
  - AMA STEPS Forward Guide to Implementation
  - Early wins
  - Lessons learned

Background

- **The US is currently facing a critical shortage of primary care physicians**
  - Aging baby boomers requiring more medical care
  - Expanded insurance coverage under the Affordable Care Act bringing more patients into the market
  - Projected retirement of nearly 1/3 of the physician workforce within the next decade
  - Fewer physicians choosing careers in primary care

- **Physician-led team-based care engages all members of staff in direct patient care**
  - Affords providers (physicians, NPs, PAs) the time they need to listen, think deeply and develop trusting relationships with patients
  - Allows the primary care practice to absorb more volume, increasing opportunities to generate revenue and provide high-quality care
  - Creates more capacity through enhanced efficiency
    - Providers can increase the numbers of patients they see, as well as increase panel size

Background (continued)

- Implementing team-based primary care leads to long-term financial sustainability for the practice and positions the practice for success under value-based payment models
  - A Rhode Island study showed that a 23% increase in primary care spending was associated with an 18% reduction in total healthcare spending (2007-2011)
  - A 2016 study of Oregon's Patient Centered Primary Care Home program found every $1 increase in primary care expenditures resulted in $13 savings in other healthcare services, including specialty, emergency room, and inpatient care
  - A 2012 Commonwealth Fund analysis projected that a 10 percent increase in payment for primary care services would yield more than a six-fold annual return in lower Medicare costs for other services, mostly in specialty, inpatient, and post-acute care

Background: Financing

- Public and private payers are investing in enhanced primary care models through multiple efforts
  - Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) and original Comprehensive Primary Care (CPC) initiatives
    - Multidisciplinary model supported by CMS that aims to strengthen primary care by delivering patient-centered, population-based care
    - Regionally-based, multi-payer payment reform and care delivery transformation initiative that gives practices additional financial resources and flexibility to improve quality of care while reducing unnecessary services to patients
  - CareFirst BlueCross BlueShield's Patient-Centered Medical Home (PCMH) Program
  - Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP)
  - Anthem's Enhanced Personal Health Care Program (EPHC)
  - AAFP Proposal to CMS for Advanced Primary Care Advanced Payment Model (APC-APM) to incentivize high quality care while reducing administrative reporting burdens
- Care delivery redesign ensures practices have the infrastructure to deliver better care, resulting in a healthier population

A Call To Action

Loss of relationship between PCP and patient, driven by EHR requirements and acquisition of practices by larger organizations requiring ROI on PCP practices

- Has led to professional isolation with decreased PCP satisfaction and fulfillment, higher patient turnover and poor health outcomes
- Limited efficiency in a traditional practice model with provider performing tasks that could easily be delegated
  - Time not spent with patients and generating income for the practice contributes to financial instability of primary care practice

CORE PRINCIPLES AND GOALS

Practice Redesign Overview

- High-functioning primary care practice whereby providers, support staff and patients work together to improve the health and well-being of a panel or population of patients while reducing reliance on sick or episodic care
    - Co-locating provider, RN, LPN, and MA in a single “flow station” where patient requests are directly addressed in real time through verbal messaging and desktop management
    - Implementing innovations in workflow to enhance experience of primary care for patients, providers and support staff by:
        - Embracing a proactive model of care, with pre-visit planning and use of daily huddles
        - Support staff empowered to administer immunizations, update routine healthcare maintenance, schedule/order lab and radiology testing, and initiate discussions regarding Advance Care Planning (Advance Directives, Home Health and Palliative Care, etc.) per established protocols
        - Facilitating use of standing orders and expanded protocols for panel management
        - Using shared collaborative documentation, non-physician order entry, and streamlined prescription management

Redesign Overview (continued)

- Patient service representative (front office staff) maintaining ability to schedule patients directly and immediately
  - Protect 30% of appointment slots for open access (same-day)
  - Communicate directly with care team “flow station”
  - Be included in daily huddles and weekly team meetings
- Practice redesign does not always require investment in more staff
  - Changes in workflows and redistribution of work occur within the construct of the established team
  - Start with the end in mind and include team in the redesign process
  - Give team the required tools and empower them to solve problems together in real time

Redistribution of Work

- Empowering practice team and patients to reflect a strategic redistribution of work among all team members
    - Innovative practice style allows for development of a high-functioning primary care practice team
    - Each individual performs at the highest level of his or her qualifications
    - Provider is typically the only person in the office who can generate revenue
        - Spending time entering data into the EHR or filling out forms that do not require his or her expertise equals time not spent seeing patients and generating income for the practice
    - Provider and clinical assistants (RNs, LPNs, MAs) share responsibilities
        - Gathering data
        - Using protocols and standardized templates
        - Updating patient's medical, surgical, social, and family histories
        - Reviewing approaching health maintenance due
        - Updating patient's medication list and upcoming refills

Redesigned Physical Space

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- Office space redesign to accommodate team-based workflow
    - Each team (provider, MA, LPN, RN) co-located in flow station during patient care sessions
    - Elbow-to-elbow approach to addressing needs of patients and families in real time
        - Requests for prescription refills, referrals and same-day appointments handled together by team, with provider input "batched" by team in between patient visits
        - Nimble approach allows for making changes rapidly throughout the day
        - Feedback exchanged regularly with team, patients, families
    - Use of standardized protocols
        - Chronic disease management (labs due, immunizations, phone calls to check in)
        - Medication refills
        - Disease-specific protocols for medication management by team in between office visits (i.e., hypertension)

The Role of Medical Assistants and Nurses

- Team-based care does not involve charting by traditional "medical scribes"
  - More accurately seen as a "co-visit" with nurses and MAs managing preventive care and updating chronic illness management
    - The use of checklists for preventive care and protocols for chronic care management enhances the level of services provided at the visit
  - Assistants begin to explore patient concerns and document in EHR using templates developed by the care teams
    - Provider oversight ensures careful documentation of clinical decision-making and accurate order entry
    - All entries into the medical record must be properly authenticated by credentialed providers
    - Notations made by providers ensure that documentation has been carefully reviewed and accuracy confirmed
  - Redesigned workflows encourage staff to broaden learning and experience and meaningfully contribute to direct patient care
    - Expanded capacity compared to traditional practice models

Office Visit Breakdown

- Office visits divided into four stages

Stage 1: Medical Assistant/Nurse gathers data

- Documents patient's concerns and uses templates to record additional details through questioning
- Updates medical, surgical, family and social histories
- Reviews health maintenance updates due and orders testing, such as screening colonoscopies and mammograms, per protocol
- Administers and documents routine vaccinations due, per protocol
- Highlights medications due for refill
- Gives patient information about Advance Care Planning
  - Naming a healthcare proxy
  - Completing an advance directive
  - Providing information about palliative care, if appropriate

Office Visit Breakdown (continued)

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- Office visits

Stage 2: Physical examination and synthesis of data	**Stage 3:** Medical decision-making
• Provider and MA/Nurse enter room together • MA/Nurse remains in exam room during the visit, sitting at the computer and serving as a scribe for the physician • Provider verifies the accuracy of the information gathered by the assistant, asks more directed questions of the patient, and performs the physical exam • Assistant documents and enters data immediately into EHR	• Provider and patient formulate diagnoses and treatment plans together • Assistant records all diagnoses for the visit and enters any orders that require provider's approval • Assistant may also update problem list, HCC codes, and flow sheets with provider assistance • Patient is invited to ask questions while provider and assistant help to ensure patient understands the results of the visit

Office Visit Breakdown (continued)

- Office visits

Stage 4: Patient education and plan-of-care implementation

- Provider leaves the exam room to review and sign all documentation and orders for the encounter
- Assistant remains in room with patient
  - Confirms understanding of all instructions
  - Provides prescription and referral information
  - Delivers patient education
  - Carries out physician orders such as medication administration, wound care, ear lavage, or other in-office procedures, as directed
  - Schedules follow-up visits
- Provider then moves to the next patient with whom another clinical assistant has performed Stage 1 of the visit and the process repeats

ATTRIBUTES

Access and Continuity

- A shift in paradigm: “The Patient will see you now.”
- Improved patient access opening up capacity for new patient visits
  - Physician-led team-based practice model engaging greater number of staff members in direct patient care
- Increasing convenience for patients by providing access through multiple channels
  - In-office education, written materials, self-monitoring tools and educational links
  - Establishing “non-visit” options for patient engagement, such as secure texting, email, portals, apps and virtual visits
  - Group visits and open access capabilities
- Patients empowered to be part of the care team
  - Patients who feel like they have an entire team surrounding them with support will be more engaged and have better health outcomes
  - Sense of accountability when patients are engaged in managing their own care

Patient and Family Engagement

- Patients empowered to be part of the care team
- Engage patients and families in decision-making around all aspects of care
  - Patients who feel like they have an entire team surrounding them with support will be more engaged and have better health outcomes
  - Sense of accountability when patients are engaged in managing their own care
- Integrate culturally-competent self-management support
  - Guided by patient complexity, demographics, and socioeconomic factors
  - Minnesota Complexity Assessment Method
    - Leverages evaluation of social determinants of health to determine type and level of support required when implementing plan of care

Provider Alignment

- Create interdependent relationships with primary care providers
  - Contractual: through employment and management agreements
  - Functional: with shared EHRs and joint development of standardized practice protocols
  - Governance: by inclusion at Board and Executive Leadership levels and in planning committees
- Promote physician leadership development and protected non-clinical time
- Focus on physician engagement to reduce burnout
  - Maximize provider-patient time
  - Embrace team-based culture to improve practice revenue, productivity, quality of care, patient safety, and patient satisfaction

Care Management

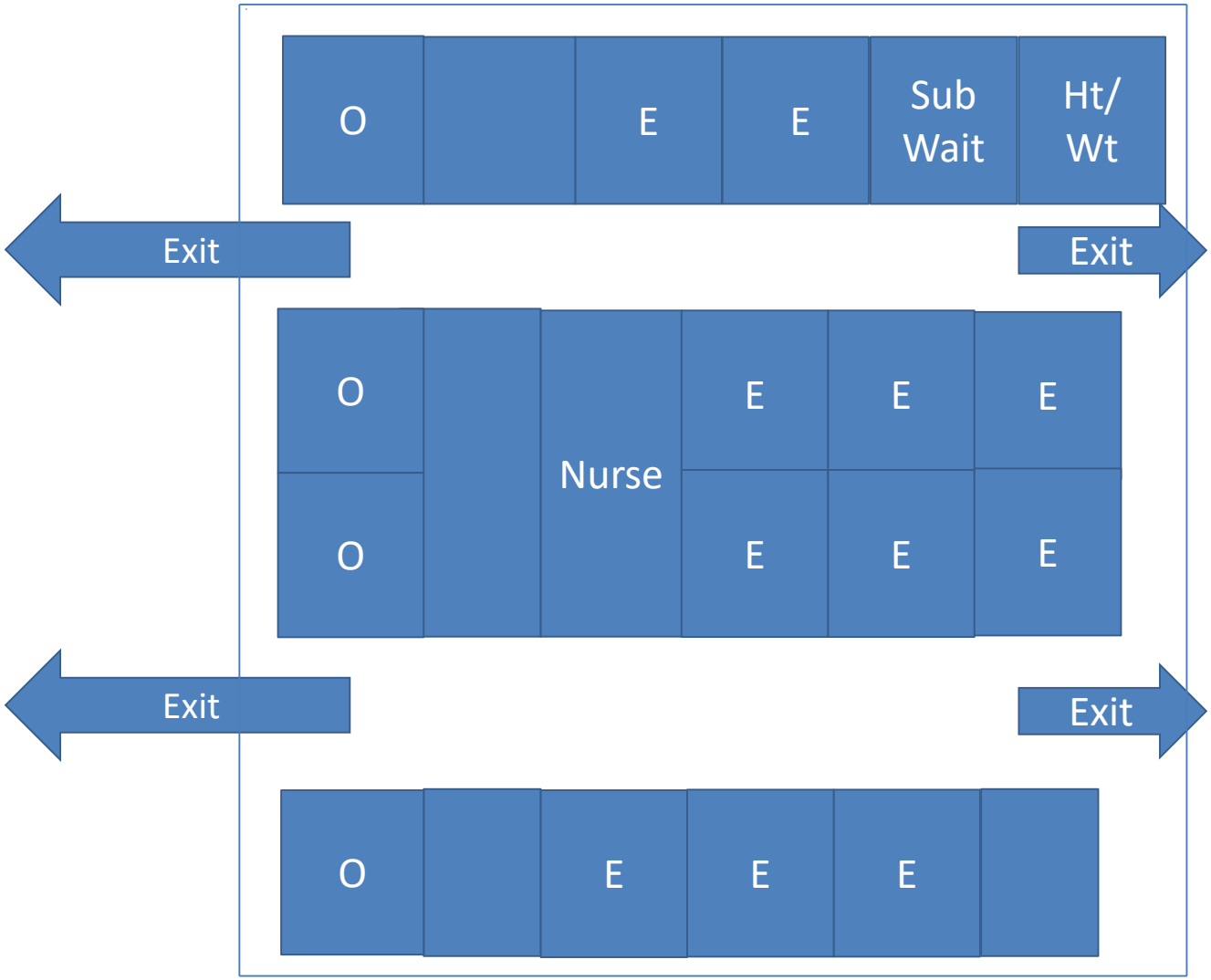
- Empanel and risk-stratify entire practice population
- Implement processes and procedures to reach out proactively to rising-and high-risk patients
  - Target recent hospital discharges, ED visits, and missed appointments
    - Each team (provider, MA, RN) co-located in flow station during patient care sessions
    - Use of standardized protocols to support patients with high needs
      - Chronic disease management (medication reconciliation, labs due, immunizations, phone calls to check in)
      - Medication refills
      - Disease-specific protocols for care management by team in between office visits

Population Health Management

Patient care continuity	• Patients see their own providers
Patient convenience	• Patient care when and where patient requires it • "The *patient* will see you now."
Care management	• Applying additional resources to high and rising risk patient populations to improve health outcomes while reducing cost and utilization
Care coordination with team-based approach	• Working closely with other healthcare providers to coordinate and manage care transitions, referrals, and information exchange

ASSESSMENT OF CURRENT STATE

Clinic Design: Diagram of Present State



Clinic Design (continued)

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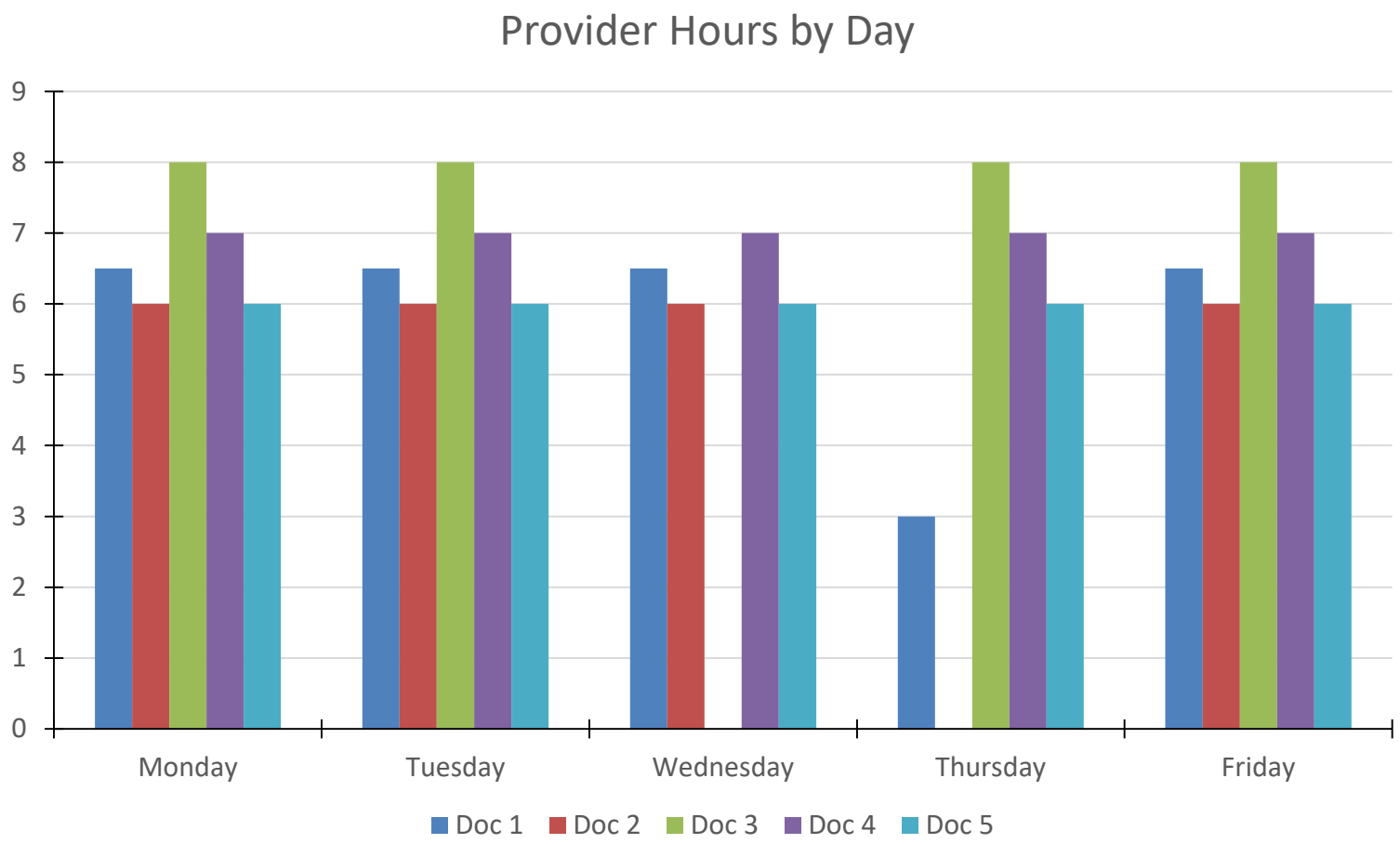
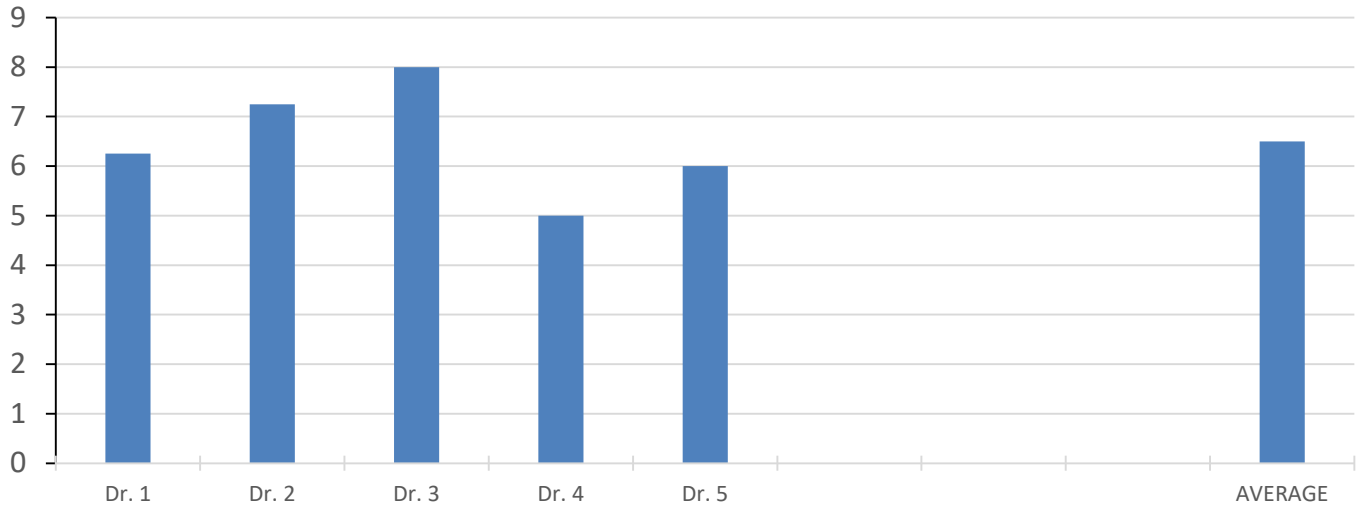
- **Providers and staff working in different parts of the medical office hinders communication**
- **Physician offices isolate physicians from the team and reinforce hierarchy**
- **Separate working stations occupy expensive space that might be better used for direct clinical care**
- **Patients move through work areas where protected health information is stored and patient care is being discussed**
- **Patients may leave the office without follow-up appointments, referrals, and post-visit instructions due to unclear flow paths**

Clinic Capacity



Clinic Volume

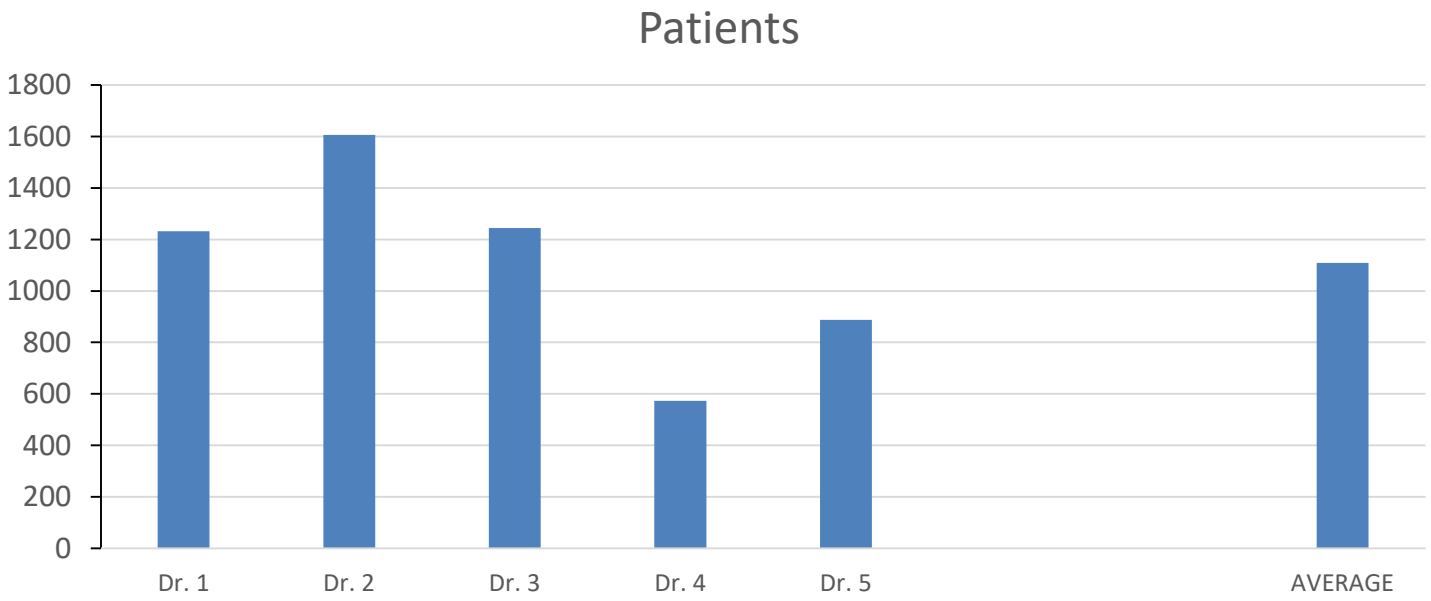
- Average Numbers of Patients Seen per Half-day Clinic Session



- Sample Family Medicine Clinic averages 6.5 patient visits per half-day session
  - National averages from MGMA data: 12 patients per session
  - Modest changes to appointment templates and a redistribution of clinical workflow will allow for increased visit capacity

Clinic Volume: Patient Panel Size

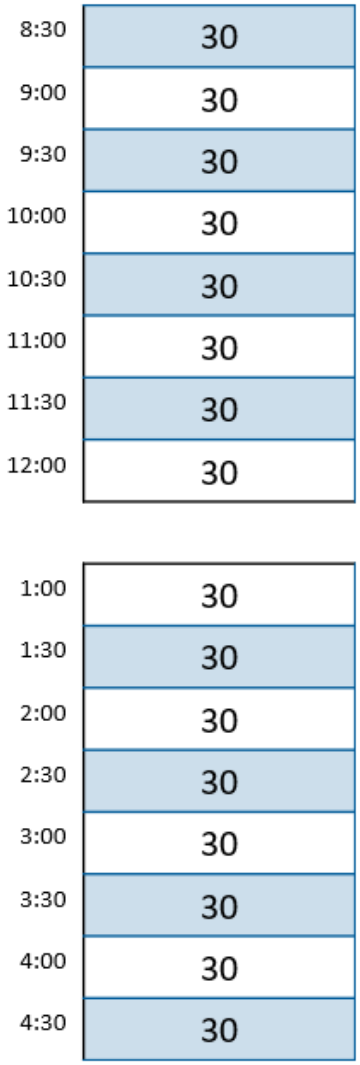
- Panel Size by Provider:



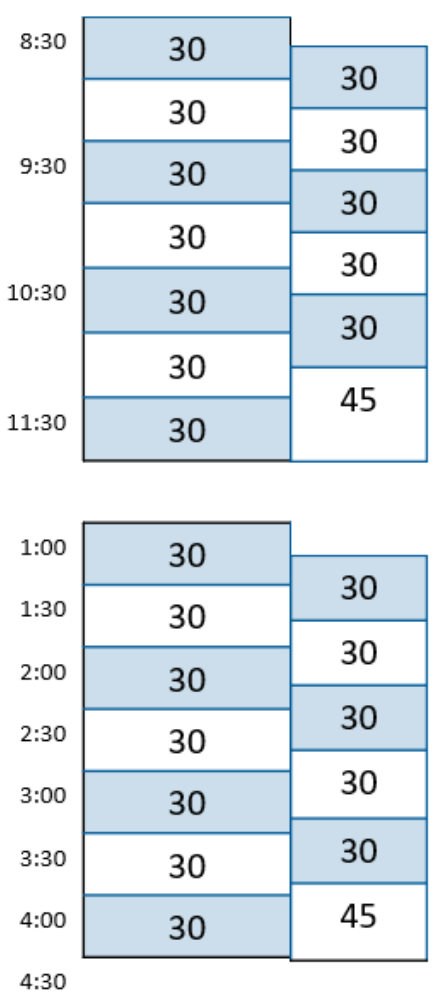
- Average panel size at Sample Clinic practices is 1108 patients
  - National average panel size is approximately 1900
  - Team-based care allows for increases in panel sizes due to enhanced efficiency in a team-based approach

Clinic Capacity

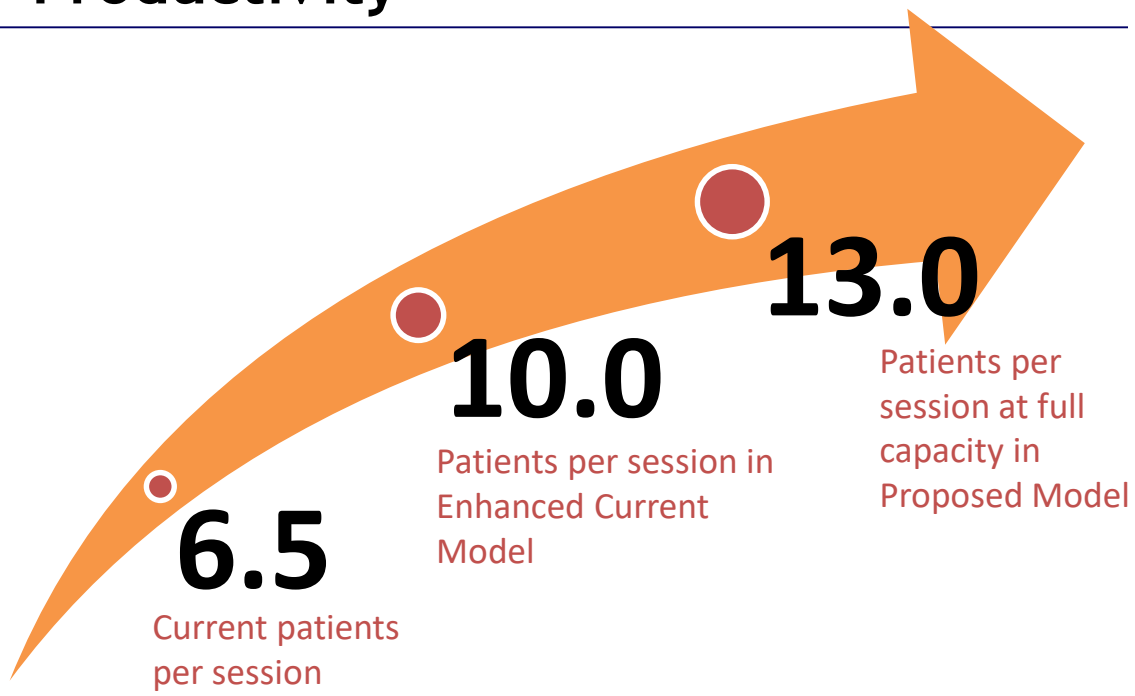
Current Model



Proposed Model



Provider Productivity



- Implementing team-based model of care allows for enhanced productivity
  - Opens up more time slots for patient visits
  - Allows for expansion of patient panel sizes
  - Doubling access for patients through use of shared documentation and delegation of routine tasks
- Use of protocols and standardized templates engages all members of team in direct patient care
  - Gathering data for patient interactions and quality data input
  - Chronic disease management (labs due, immunizations, phone calls)
  - Enhances clinic efficiency, improves continuity of care, helps achieve higher quality scores, enhances success in ACO/MIPS/APM/P4P models, and leads to better clinical outcomes

Financial Performance: Payer Mix

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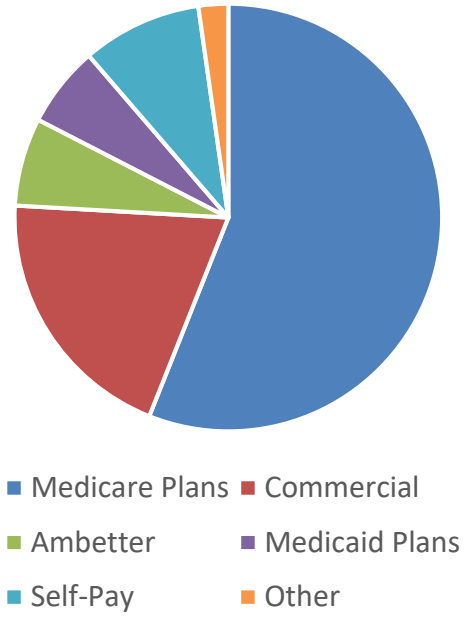
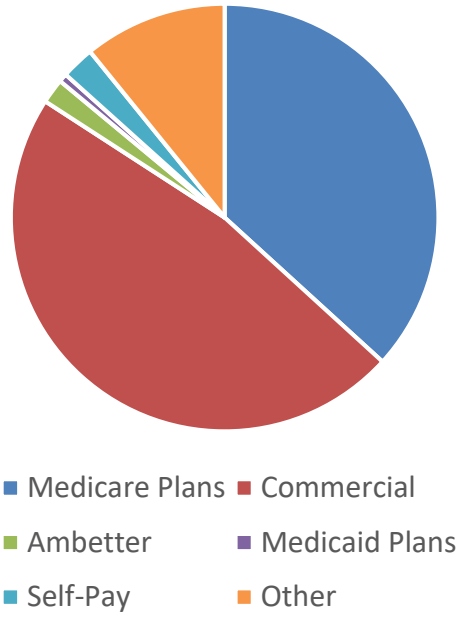
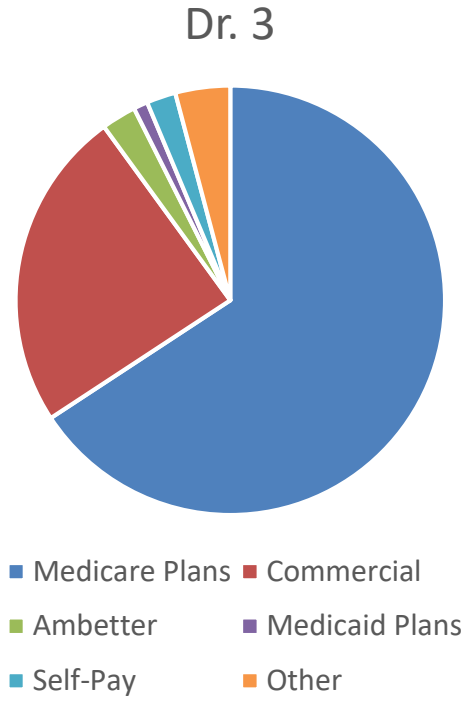
Dr. 1



Dr. 2



Dr. 3



Financial Performance: Payer Mix

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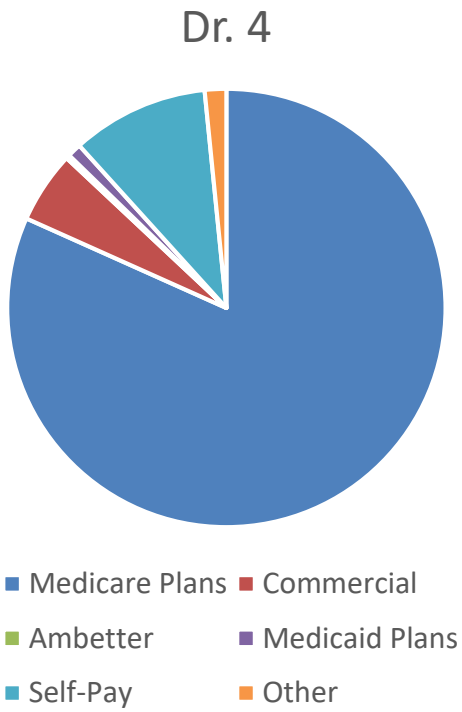

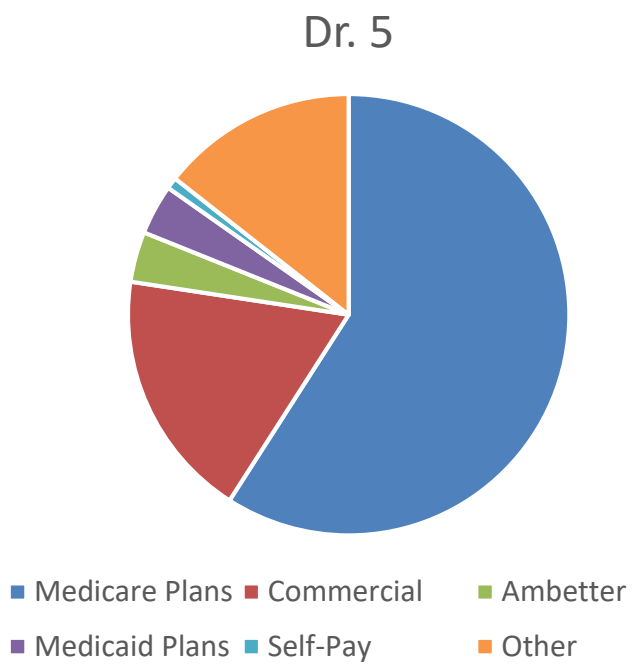

Financial Performance: E/M Visit Analysis

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E&M Code 99213 and 99214 Analysis*							
Provider	E&M Codes	Doc 1		Doc 2		Doc 3	
		Current	Proposed	Current	Proposed	Current	Proposed
E&M Code Mix	99213	55%	30%	48%	30%	70%	30%
	99214	45%	70%	52%	70%	30%	70%
E&M Average Reimbursment	99213	$ 74.70	$ 74.70	$ 69.48	$ 69.48	$ 70.48	$ 70.48
	99214	$ 103.59	$ 103.59	$ 101.83	$ 101.83	$ 100.74	$ 100.74
E&M Visits	99213	1,531	835	2,049	1,272	2,199	947
	99214	1,252	1,948	2,191	2,968	958	2,210
E&M Total Reimbursement	99213	$ 114,361	$ 62,364	$ 142,367	$ 88,380	$ 154,978	$ 66,748
	99214	$ 129,692	$ 201,800	$ 223,110	$ 302,233	$ 96,513	$ 222,635
Total Reimbursement		$ 244,053	**$ 264,164**	$ 365,478	**$ 390,613**	$ 251,491	**$ 289,383**
Benefit			**$ 20,111**		**$ 25,135**		**$ 37,892**

*Based on Historical Data 10/1/2016-9/30/2017

- Shift to team-based care model allows for more comprehensive visits
- Annual patient service revenues significantly increased with team documentation of moderately complex visits
- Additional documentation required is minimal and will not be part of physician's workflow, but rather completed as shared documentation at the team level
- Note that increased investments in primary care have been shown to reduce overall spending on health care*

*Source: Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare payment policy. March 2016.

Financial Performance: Visit Volume Analysis

Volume Analysis with 10% Increase*				
Provider	Doc 1		Doc 2	
	Current	Proposed	Current	Proposed
Average Reimbursment	$ 97.74	$ 97.74	$ 107.89	$ 107.89
Visits	1,823	2,005	1,032	1,135
Total Reimbursement	$ 178,185	**$ 196,003**	$ 111,341	**$ 122,475**
Benefit		**$ 17,818**		**$ 11,134**

*All procedures are included in analysis

- Comprehensive Care already coding higher level E/M visits
- Opportunity to leverage team-based care model to increase volume of visits by 10% through shared documentation and use of standardized clinical protocols

Quality: Wellness Panel Metrics

Measure	Score Range
Cervical Cancer Screening	61%
Tobacco Use Screening and Cessation Intervention	94%
Breast Cancer Screening	81%
Adult Pneumonia Vaccination	80%
Colorectal Cancer Screening	66%
Childhood Immunization Status	38%
Adolescent Immunization Status	71%

- The use of standardized protocols and patient data flow sheets improves clinical outcomes and patient engagement for diabetes
- Leverage Population Health Nurses and RN Care Managers around assessing and helping to complete care gaps aids in improving rates of screening and immunizations for patients

Quality: Diabetes Metrics

Measure	Score Range
Foot Exam	76%
HbA1c < 8	77%
HbA1c < 9	81%
HbA1c Testing	94%
Blood Pressure Control	78%
Lipid Profile	90%
LDL Control	61%
Nephropathy Screening	92%
Eye Exam	47%

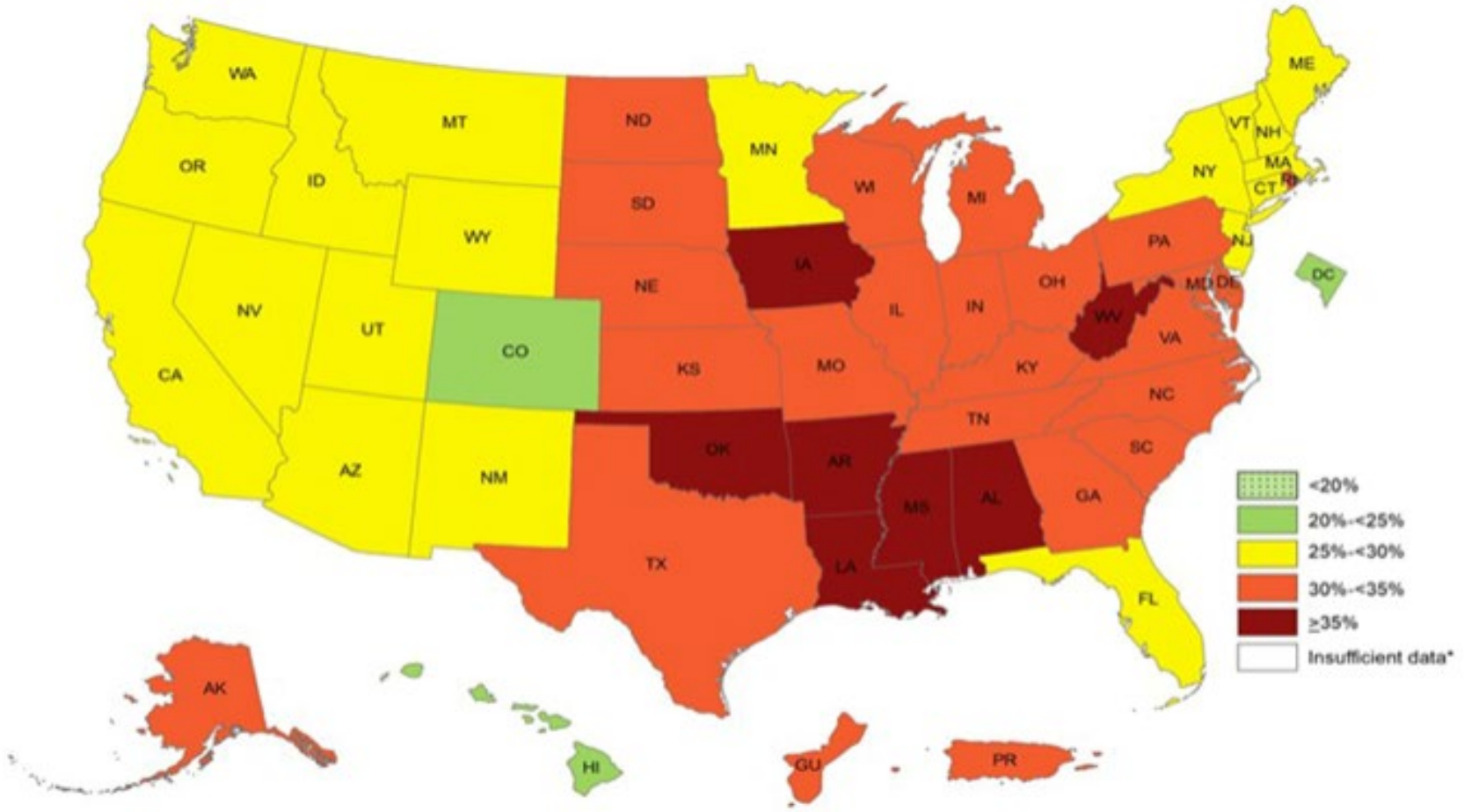
- Generally a very positive trend since beginning of 2018 for all!
- Teams with higher scores can share some best practices with the group?
- Let's pause to brainstorm around eye exams: current workflow vs. other resources we can leverage to improve rates of screening for diabetic retinopathy

Patient Experience Survey Results: CG CAHPS

Measure	Top Box Scores
Access to Care 3 Month	80.8% - 93.8%
Appointment as soon as needed	91.9% - 100%
Phone calls answered same day (during office hours)	59.5 % - 86.7%
Phone calls answered same day (after hours)	60.0% - 100%
Talk about diet and eating	58.1% - 70.7%
Talk about exercise and activity	67.0% - 78.2%

- Top box scores for Access are outstanding
  - Reported same-day appointments and walk-in access available at many locations
- Reported volume of calls up to 500/day per practice
  - Logging calls helps to determine most common reasons for high volume of phone requests
  - Reported that routine medications refilled for 3 months only
    - Best practices utilize a streamlined approach with a 90-day prescription supply and 3 refills
    - Using a synchronized renewal process improves patient adherence to therapy regimens and eliminates hours of unnecessary work that distract physicians and staff from more valuable clinical activities
- Health promotion and education about diet and exercise is a gap that is particularly significant for this population with a high incidence of diabetes and hypertension

Incidence of Obesity: Regional Variations



Prevalence of self-reported obesity among U.S. adults by state and territory.

CDC

CDC: September 12, 2018

Huddles and Pre-visit Planning

- Reported inconsistent use of pre-visit planning and daily huddles
  - Pre-visit planning involves gathering data and identifying gaps in care
  - Helps practice team to care for the whole patient
    - Improves delivery of timely preventive care
      - Health maintenance screenings
      - Counseling: smoking cessation, advance care planning
      - Immunization administration
      - Care management updates
      - Identification of patients eligible for Annual Wellness Visits
      - HCC capture opportunities for the ACO
- Huddles prepare the team for the day's schedule and improve efficiency
    - Include only key participants
      - Nurses, medical assistants, receptionist, and physician
    - Limit the huddle to seven minutes or less
      - Having everyone standing during the meeting will help keep it short and focused
    - Have an agenda
      - Identify any potential bottlenecks in the schedule in order to proactively address them
- Involving everyone in the game plan for the day improves office efficiency and enhances staff satisfaction

IMPLEMENTING TEAM-BASED CARE

Step One: Engage the Change Teams

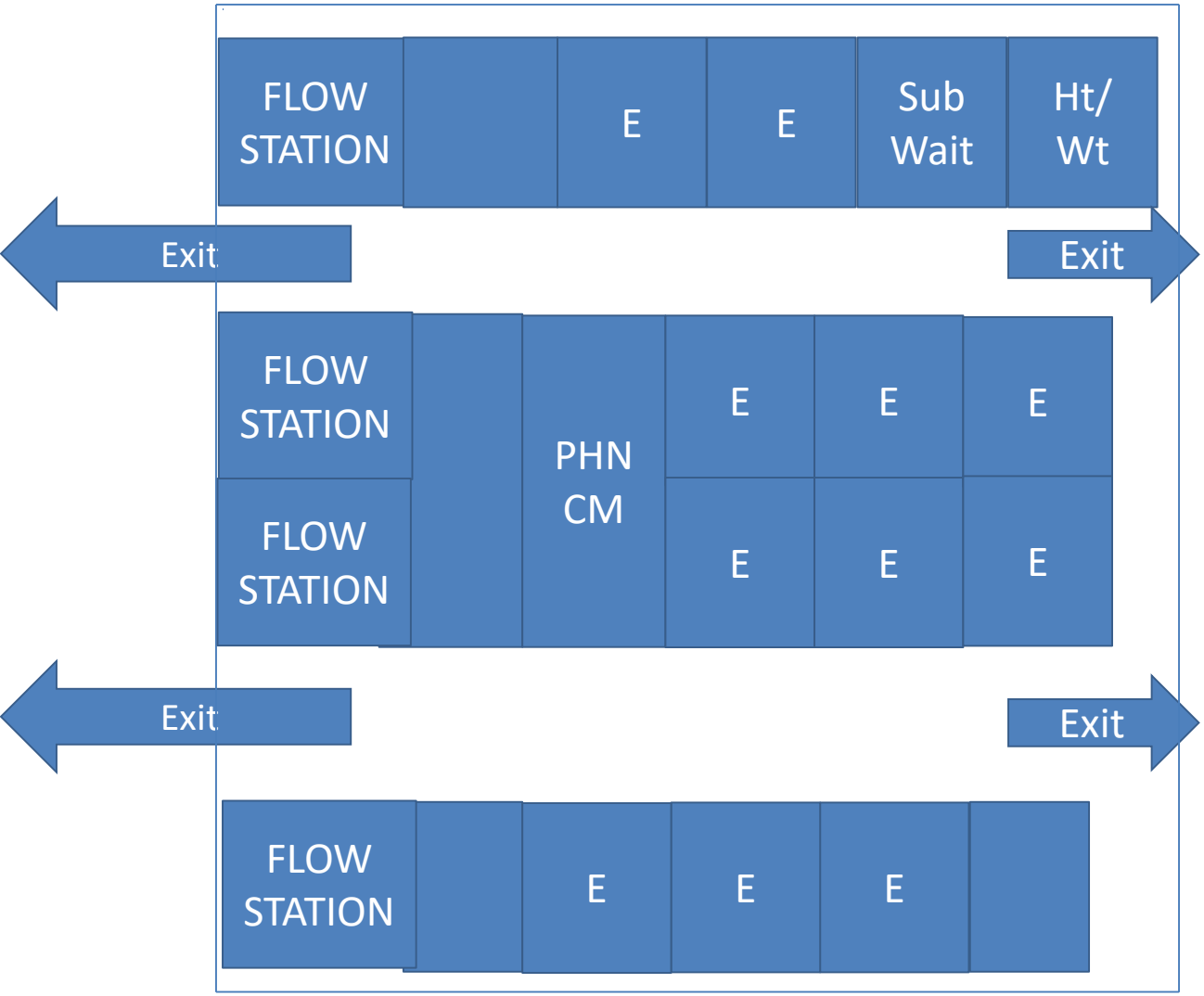
Group 1
Doc 1
2 LPNs/MAs
Receptionist
Population Health Nurse
Nurse Care Manager

Group 2
Doc 2
2 LPNs/MAs
Receptionist
Population Health Nurse
Nurse Care Manager

Group 3
Doc 3
2 LPNs/MAs
Receptionist
Population Health Nurse
Nurse Care Manager

A multidisciplinary approach that includes clinic staff, providers, and administrative leadership is crucial to empowering the process.

Step Three: Choreograph Workflows to Reflect the New Model of Care



- Co-locate provider and staff in a single "flow station" where patient requests are directly addressed in real time through verbal messaging and desktop management
- Remain open to new opportunities for new collaboration and processes
- Keep in mind potential for next iteration, "future state design"

Step Four: Increase Communication Among the Team, Practice, and Patients

- Co-location of team encourages real-time communication and development of team culture
  - Create temporary flow stations
    - Group 1: Dr. 1 and 2 Intrepid LPN/MAs
    - Group 2: Dr. 2 and 2 Brave LPNs/MAs
    - Group 3: Dr. 3 and 2 Innovative LPNs/MAs
  - Team remains together in flow station during patient care sessions

- Make sure to keep the practice, including patients, informed of the pilot team's work
  - Solicit regular feedback from leadership, practice, patients, families

Step Five: Use a Gradual Approach To Implement the Model

Stay nimble, be patient	Change is hard! Breathe. Share. Laugh.
Understand that change takes time, and every day will not be perfect	Staff and providers will need extra time to understand documentation preferences and challenges from each others' perspectives
	Working closely during implementation is necessary to successfully implement team-based care
Embrace mistakes as opportunities to learn and grow	"Success is stumbling from failure to failure with no loss of enthusiasm." -Sir Winston Churchill
	"Pain is temporary. Quitting lasts forever." - Lance Armstrong
Encourage 360-degree feedback from all stakeholders	Include medical assistants, nurses, providers, patient service representatives
	Be sure to reach out to patients and families for constructive criticism and ideas for improvement
Weekly team meetings provide an opportunity to discuss pitfalls and new ideas for improvement	"What is the rock in your shoe?"
	"If you had a magic wand…"

Step Six: Optimize the Care Model

- Co-location helps teams communicate with greater frequency and ease
  - Questions can be answered right away so that tasks are completed more quickly and efficiently
  - Work is more easily divided among team members who can easily visualize what others are accomplishing
- Desktop management
  - Fewer messages in EHR with pre-visit planning and needs of patients and families anticipated and addressed at time of visit
  - Better care coordination with 4th stage of office visit when assistant remains in room with patient arranging follow-up appointments, scheduling screening tests, answering questions, addressing patient education, and ensuring prescriptions are sent to pharmacy
- Team-based care involves patient, family, and staff in direct patient care
  - Team is viewed as extension of provider
  - More support surrounding patients and families results in stronger patient engagement and accountability
    - Patient health outcomes improve
- Empowering the care team helps them to build their skillset over time, responding to patient questions with confidence and improving staff satisfaction

Early Wins

- **Engaging all members of staff at equal level allows for unimpeded flow of ideas and creative solutions**
  - Patient Service Representative not part of team-based care at first due to recent restructuring of clinic operations and desire not to rock the boat at front desk
  - PSR asked to join pre-visit planning sessions
  - Offered to reach out to next day's patients to have lab work drawn prior to appointment, making it possible to have results to review at time of appointment
  - Developed a protocol for tracking and recording diabetic eye exam results; increased rates of screening for diabetic retinopathy from 21%-42% in first 30 days
  - At another site, PSR took on universal PHQ-9 screening at check-in and scanned result to visit note
- **Engaging patients in team-based care implementation yields real-time results**
  - Patients thrilled with extra one-on-one attention with doctor in the exam room
  - Frequent positive comments to front desk staff when leaving the clinic after appointment "How nice to have a whole TEAM!"
  - "Made our patients really happy even with the delays during implementation period, they were very grateful. Understood this was a new process but thrilled to get in to see doc same day. More efficient process."
  - More patients requested EHR Portal access after team-based visit
  - Team is viewed as extension of provider

Early Wins (continued)

- **Having IT involved from the outset enhances team's ability to work collaboratively**
  - Universal access to standardized views of population health dashboards means we enter data once and entire team can access it going forward
  - Assistance with simplifying workflows in the EHR makes us more efficient
    - Helpful to have another set of eyes on the process
  - Identified and removed steps in process that were not contributing meaningfully to our goals (and in one case shifted attention to new step that better reflected work being done with depression screening)
- **Physician focus is on Assessment and Plan now, more time freed up to allow for critical thinking and problem-solving**
- **Staff delighted at increased interaction with patients and families**
  - Chance to get to know people better and learn more in general while applying clinical skills and training in top-of-license patterns
- **RN Care Manager attended pre-visit planning session and created a system for notification in the EHR so she could meet with high-risk patients at end of office visit to establish relationship and develop rapport as part of the team**
  - Developed a plan for a patient with COPD who had frequent ED visits so that patient could contact her before going to the ED

Early Wins (continued)

- **Incorporated Advance Care Planning into rooming process**
  - Created a standard dialogue for introducing tools into Stage One of the office visit
  - Used tools already available in the office but not yet in use because staff lacked training in order to be comfortable discussing with patients
    - Conversation Starter Kits, Hello Kits, 5 Wishes
- **Started weekly team meetings**
  - Place to talk about how things are going, make adjustments, continue to build the team
  - Include others in our meetings to learn what they are passionate about doing for our patients and what suggestions they have for new processes
  - Learn more about each person's special interests and talents so we can capitalize on those
  - We do not all have to be experts in everything! Value of collective intelligence

Lessons Learned

- ✓ **Overall sense of feeling overwhelmed and unprepared eased by increased focus on preparation and simulation before team-based care implementation onsite**
  - Engage and educate teams who are planning to participate well in advance of onsite visit
  - Include all staff in planning meetings
  - Training for Nurse/MA staff on interviewing patients and documenting in record should take place prior to implementation of model in clinic
  - Identify key support people to have on hand, especially for Phase One
- ✓ **Scale way back on number of visits for first day to one patient every 60 minutes**
  - Increase to every 30 minutes morning of second day and begin to stagger patients in schedule with each Nurse/MA working out of one room, on day two
- ✓ **Entire team needs to have access to same views in record, from templates to quality dashboards**
  - Helps to create a standardized approach to care
  - Reduces confusion and frustration when communicating with team
- ✓ **Communicate early and often**
  - Pause frequently for feedback and ensure entire team participates
  - Schedule de-brief sessions at end of each day and at end of implementation

Lessons Learned (continued)

- ✓ **Food is a good mediator and stress-reducer**
  - Healthy snacks and drinks lighten the mood
  - Having lunch together during implementation keeps team together and talking through the transition
  - Questions can be answered right away and course corrections made if we stick together
- ✓ **Any clinic protocols should be available prior to implementation to facilitate customization of team-based approach and adaptation of processes during time onsite**
  - Identify what is standard vs. what is customized
- ✓ **Explore examples of standardized clinical protocols for implementation prior to Phase 2 of onsite implementation**
  - Million Hearts, Diabetes, Hypertension, Controlled Substance Monitoring
- ✓ **Providers are the team leaders and set the tone for the the entire team and workflow for the day**
  - Use telephone interviews to uncover and address concerns and resistance prior to onsite implementation
  - Set expectations for successful implementation and positive ROI for our work
- ✓ **Consider opportunities to strengthen team-based efforts through culture work**
  - Tools such as Human Synergistics can be helpful in overcoming barriers to practice redesign

Lessons learned (continued)

- ✓ **Review and update Nurse/MA job descriptions to reflect additional duties, including managing direct patient care by protocol and with physician's input, and documenting additional information in record**
- ✓ **Recruit, orient, and hire people who are interested in trying new things, not afraid of failure**
  - Hire for Attitude>Aptitude (80/20)
  - Set the stage for exponential growth by training adequate number of teams to mentor others and scale model in the organization
- ✓ **Engage teams to provide input around new facility design using team-based care principles**

REFERENCES

Resources

- Sinsky CA, et al. In search of joy in practice: a report of 23 high-functioning primary care practices. Ann Fam Med 2013;11(3):272-278.
- STEPS Forward: Implementing Team-Based Care. AMA Toolkit, Practice Improvement Strategies, 2017.
- Hopkins K, et al. Team-based care: saving time and improving efficiency. Fam Pract Manag. 2014;21(6):23-29.
- Basu S, et al. High levels of capitation payments needed to shift primary care toward proactive team and nonvisit care. HealthAffairs 2017;36(9):1599-1605.
- Dale SB, et al. Two-year costs and quality in the Comprehensive Primary Care Initiative. N Engl J Med. 2016;374(24):2435-2356.
- Herl KA. Taking aim at the high cost of provider turnover. Today's Practice 2017.
- Stovall GJ, et al. Investing in retention pays dividends. Grp Pract J; September 2011.
- CPC+ website. Innovation.CMS.gov/initiatives/comprehensiveprimarycareplus 2017.
- Million Hearts initiative to save 1 million lives in 5 years https://millionhearts.hhs.gov

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