An Introduction to Team-Based Primary Care

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Introducing Today's Speakers

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Louise Bryde, MHA, BSN, RN, Principal

- Louise Bryde brings to the firm more than 35 years of experience in healthcare management and clinical operations. She has a proven record of accomplishment in developing and executing initiatives to enhance access and improve quality and cost-effectiveness of healthcare delivery in both the public and private sectors. At Stroudwater, she focuses on population health, strategic planning and operational improvement, and models of care, including Patient-Centered Medical Home and Team-Based Care initiatives.

Heidi Larson, MD, MBA, Sr. Consultant

- A family medicine physician with 25 years' clinical experience, Heidi is passionate about leveraging the power of relationships to build strong primary care networks. Whether independent or hospital-based, practices can use redesign techniques to create more capacity, improve profit margins, and prepare for success under value-based payment models. Before joining Stroudwater Associates, Heidi spent 15 years in solo practice in Portland, Maine, where she served as a liaison between independent physicians and the Maine Health Physicians Hospital Organization.

Agenda

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- Background
- Transition Framework
- Definition of Team-Based Care Model
- Core Principles of the Model
- Four-Stage Office Visit
- Benefits of the Model
- Implementing the Model- Early Results
- Patient Experience
- Provider and Staff Experience

First Polling Question

- Is your organization facing any of the following challenges?
- Answer Options for Question 1:
  - Limited primary care access and patient panel size capacity
  - Participation in risk-bearing payment models (ex. ACO, Medicare Advantage)
  - Poor financial performance of employed practices
  - Failure to achieve clinical quality goals and earn payer incentive bonuses
  - Poor patient satisfaction/experience scores

Background: Why Implement Team-Based Care?

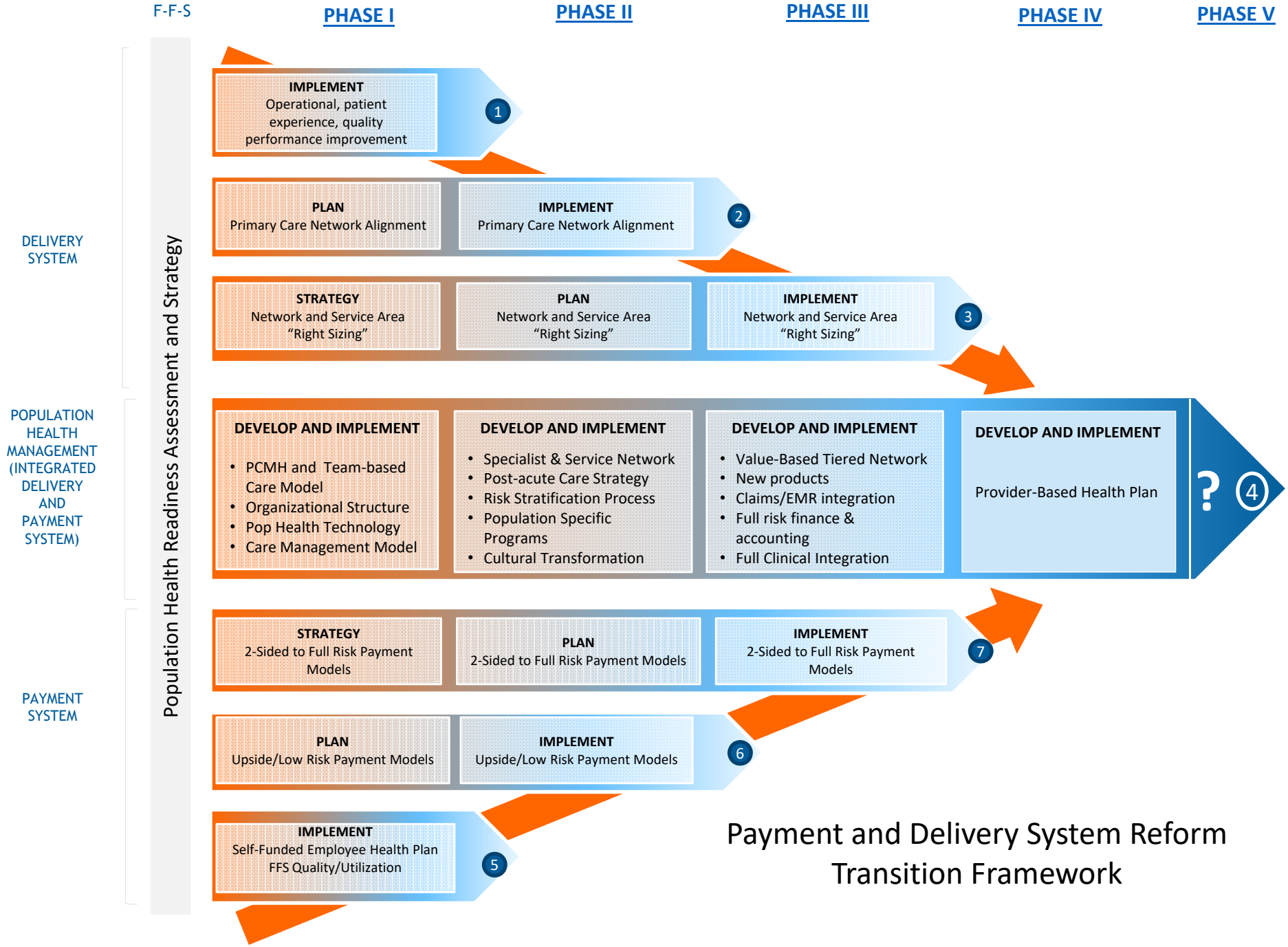
- **The US is currently facing a critical shortage of primary care physicians**
  - Aging baby boomers requiring more medical care
  - Expanded insurance coverage under the Affordable Care Act has brought more patients into the market
  - Projected retirement of nearly 1/3 of the physician workforce 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)

- Increasing total spend on primary care from current levels of 6% to 12% can yield up to a 15-fold return on investment
- Implementing team-based primary care supports 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
- Care delivery redesign helps to ensure practices have the infrastructure to deliver better care, resulting in a healthier population

Source: American Academy of Family Physicians, Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care, A Proposal to the Physician-Focused Payment Model Technical Advisory Committee From the American Academy Of Family Physicians, April 14, 2017


F-F-S
PHASE I
PHASE II
PHASE III
PHASE IV
PHASE V
DELIVERY SYSTEM
POPULATION HEALTH MANAGEMENT (INTEGRATED DELIVERY AND PAYMENT SYSTEM)
PAYMENT SYSTEM
Population Health Readiness Assessment and Strategy
IMPLEMENT
Operational, patient experience, quality performance improvement
1
PLAN
Primary Care Network Alignment
IMPLEMENT
Primary Care Network Alignment
2
STRATEGY
Network and Service Area "Right Sizing"
PLAN
Network and Service Area "Right Sizing"
IMPLEMENT
Network and Service Area "Right Sizing"
3
DEVELOP AND IMPLEMENT
• PCMH and Team-based Care Model
• Organizational Structure
• Pop Health Technology
• Care Management Model
DEVELOP AND IMPLEMENT
• Specialist & Service Network
• Post-acute Care Strategy
• Risk Stratification Process
• Population Specific Programs
• Cultural Transformation
DEVELOP AND IMPLEMENT
• Value-Based Tiered Network
• New products
• Claims/EMR integration
• Full risk finance & accounting
• Full Clinical Integration
DEVELOP AND IMPLEMENT
Provider-Based Health Plan
? 4
STRATEGY
2-Sided to Full Risk Payment Models
PLAN
2-Sided to Full Risk Payment Models
IMPLEMENT
2-Sided to Full Risk Payment Models
7
PLAN
Upside/Low Risk Payment Models
IMPLEMENT
Upside/Low Risk Payment Models
6
IMPLEMENT
Self-Funded Employee Health Plan FFS Quality/Utilization
5
Payment and Delivery System Reform Transition Framework

What Is Team-Based Primary Care?

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- Team-based primary care involves a restructuring of clinical workflows to allow for increased sharing of responsibilities across the entire team, enhancing practice efficiency while improving provider, patient, and staff engagement
  - Ideally, each physician/provider is supported by two clinical assistants (Medical Assistant, LPN, or RN) utilizing two exam rooms to maximize work flow efficiencies and teamwork
- Strong support for this model from the American Academy of Family Physicians and the American Medical Association

Second Polling Question

- Have any of your primary care practices implemented the team-based care model and, if they have, are the teams co-located?
- Answer Options for Question 2:
  - We have not implemented the team-based care model.
  - We have team-based care but the teams are not co-located.
  - We have team-based care and the teams are co-located.

Four Core Principles of Team-Based Care

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Co-location of Provider, RN, LPN, and MA in a single "flow station", increasing communication and collaboration, such as addressing patient requests directly in real time through verbal messaging and desktop management

Implementing innovations in workflow by embracing a proactive model of care, including **pre-visit planning**

- Support staff empowered to administer immunizations, schedule/order lab and radiology testing, and initiate discussions such as Advance Care Planning (ex. Advance Directives & Palliative Care) per established protocols
- Increased use of standing orders and expanded protocols for patient management
- Use of shared collaborative documentation, non-physician order entry, and streamlined prescription management

Consistently holding a 5-minute **daily morning huddle** with entire care team, including front desk staff

- Check-in with the team, learn of any staffing changes or concerns
- Identify potential bottlenecks or gaps in the schedule
- Identify 2-4 same-day appointment slots for acute visits

Leveraging the **4-stage office visit** to maximize efficiency of the team

Third Polling Question

- Do your MAs/Nurses remain in the exam room to document in real-time, during the Provider visit?
- Answer Options for Question 3:
  - Always
  - Most of the Time
  - Occasionally
  - Never

The Role of Medical Assistants and Nurses

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- 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

Four-Stage Office Visit

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Stage 1: Medical assistant/nurse gathers data including expanded patient history and medication review

Stage 2: Physician performs physical exam and synthesizes/verifies data. MA/nurse documents findings in real time during office visit

Stage 3: Physician carries out medical decision-making, formulates diagnoses, and develops plan

Stage 4: MA/nurse provides patient education and implements the plan

Office Visit Stage 1

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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/past 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 Stages 2 & 3

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•Stage 2: Physical examination and synthesis of data

- Provider and MA/Nurse enter room together
- MA/Nurse remains in exam room during the visit, sitting at the computer and documenting findings for the Provider in real-time
- Provider verifies the accuracy of the information gathered by the assistant, asks more directed questions of the patient, and performs the physical exam

Stage 3: Medical decision-making

- 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 Stage 4

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•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
  - Reviews/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 per established procedures
- Provider then moves to the next patient with whom another clinical assistant has performed Stage 1 of the visit and the process repeats

Fourth Polling Question

- Are your Primary Care Practices experiencing any capacity or appointment access challenges?
- Answer Options for Question 4:
  - Few or no access problems
  - Moderate access problems
  - Significant access problems

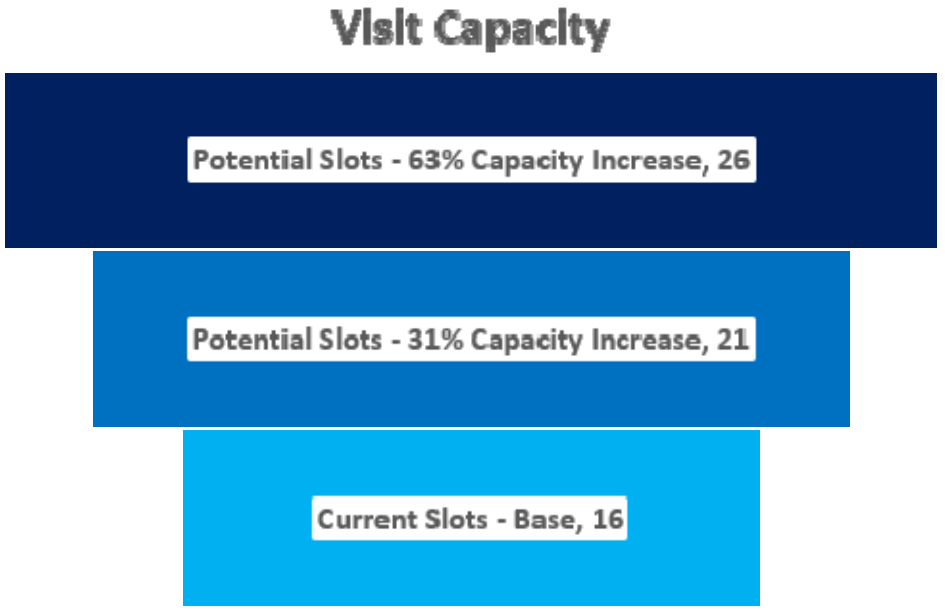
Benefits of the Team-Based Care Model

- Significant increases in productivity can take place with changes in workflow and redistribution of work within the constructs of established clinical teams
- Implementing team-based care also supports long-term financial sustainability for the practice through potential increases in practice revenue, optimized provider: patient time, and reduced opportunity costs due to reduced patient use of alternative sites of care such as the ED
- Reductions in clinical variation through use of standardized protocols may lower direct costs
- Care delivery redesign helps to ensure practices have the infrastructure to deliver better care, resulting in a healthier population and more engaged patients
  - Increased delivery of preventive care & services
  - Improved focus on chronic disease management with better clinical outcomes
- Increased collaboration restores joy to the practice of medicine
  - Achieving the Quadruple Aim
- Team-based care establishes a strong foundation for success under value-based payment models

Patient Visit Capacity Improvement

	Current Model	Proposed Model
8:30 AM	30	30
9:00 AM	30	30
9:30 AM	30	30
10:00 AM	30	30
10:30 AM	30	30
11:00 AM	30	30
11:30 AM	30	45
12:00 PM	30	
1:00 PM	30	30
1:30 PM	30	30
2:00 PM	30	30
2:30 PM	30	30
3:00 PM	30	30
3:30 PM	30	30
4:00 PM	30	45
4:30 PM	30	
Total Visits	**16**	**26**

Team-based Care Leverage



*Based on a recent client's data

*Note: Model requires use of two exam rooms

Stroudwater Clients: Team-Based Care Implementation Early Results

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An Internal Medicine practice in the Northeast achieved improved rates of preventive care services, increased visit capacity, and enhanced care management activities within the first six months, including:

- Implemented universal PHQ-9 screening for depression at patient check-in, increasing documentation of screening from baseline of 2% to 40% after three months
- Leveraged pre-visit planning and team morning huddles to increase patient same-day visit access and eliminate appointment wait lists, increasing visit volume from 90% of capacity to 124% of capacity in six months
- RN Care Manager attended pre-visit planning session and created a system for notification in the EHR so she could meet in-person with high-risk patients at end of office visit, strengthening patient relationships and rapport
  - Example: Developed plan for patient with COPD who had frequent ED visits, so patient could contact the care manager before going to ED

Stroudwater Clients: Team-Based Care Implementation Early Results (continued)

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- During implementation, a primary care practice in Nebraska developed a protocol for tracking and recording diabetic eye exam results, with increased rates of documented screening for diabetic retinopathy from 21% to 42% in the first 30 days of implementation
- A primary care practice in the Southeast significantly increased their tetanus vaccination rate within the first 30 days of implementation as a result of simple changes in workflows

Stroudwater Clients: Team-Based Care Implementation Early Results (continued)

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- **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

The Patient Experience

Overall improved patient engagement with team-based care implementation across multiple practices. Patients reported enjoying the increased face-to-face time with their physicians:

- "Really liked it. More personal."
- "I feel more taken care of."
- "Really loved having all the focus on ME"
- "If I don't hear everything the doctor says, I can call back and ask you about it."
- "It's like a family environment."
- Getting calls from patients who have heard they can come in prior to a visit for lab draw, so results will be available to review with the doctor
- More patients requested EHR Portal access after team-based visit
- Team is viewed as extension of Physician

Provider and Staff Experience

- One nurse said, “I feel more directly involved in patient care; I am actually using my nursing skills.” “You are listening to us now. That’s a big deal.”
  - The nurses and medical assistants who are learning now will become our team-based care champions for other practices who would like to move to this model in the future
- An office manager stated that we created a level playing field where every team member is empowered to speak up: “Use your whole team on the field!”” Trust your team.”
  - Front desk staff: “I love the huddle; it works!”
- Collectively, we embraced mistakes as opportunities, stayed nimble and talked to each other, “What is the rock in your shoe?”
- One physician commented that the new model had “changed her life”
- Another physician used to use vacation days to catch up on paperwork but still couldn’t complete everything: “We are seeing high rates of depression and burn-out in healthcare workers. There’s a reason for that, but there are also fixes. This is one of those fixes.”

Q & A/Open Discussion

Resources

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- 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

About Our Services

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