Team-Based Primary Care for the C-suite:
Promote Financial Sustainability, Reduce Total Cost of Care, Achieve Shared Savings

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Introducing Today's Speakers

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.

Polling Question #1

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

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

The Case for Primary Care Investment

- 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
- Care delivery redesign helps to ensure practices have the infrastructure to deliver better care, resulting in a healthier population and a sustainable financial practice model

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

An Unsustainable Path: Shifting Payment Models

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to

blow up fee for service…

That's one of our prime goals—is to get rid of fee for service."

Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler, 11/29/18

CMS: “Keep patients healthy, out of hospital!”

New primary care payment models announced by CMMI April 22, 2019

- Pay providers for outcomes rather than procedures
- Incentivize days at home as well as quality of care
- Free doctors to focus on the patients in front of them
- Reduce regulatory and administrative burdens

HHS Secretary Alex Azar says, “The new primary care experiment will transform the U.S. health system.”

- Most sweeping attempt to date to change primary care

Primary Care First Payment Structure: A Conceptual Overview

- Risk-adjusted, population-based payment PBPM
- Flat primary care visit fee per face-to-face encounter
- Performance-based incentive payments based on acute hospital utilization alone
  - -10% payment adjustment if Quality Gateway not exceeded
  - Up to 50% positive payment adjustment determined by comparing performance to three different benchmarks:
    - National adjustment
    - Cohort adjustment
    - Continuous improvement adjustment

Source: CMS/CMMI Primary Care First Informational Webcast, April 30, 2019

An Unsustainable Path: Margins

Medicare Margins

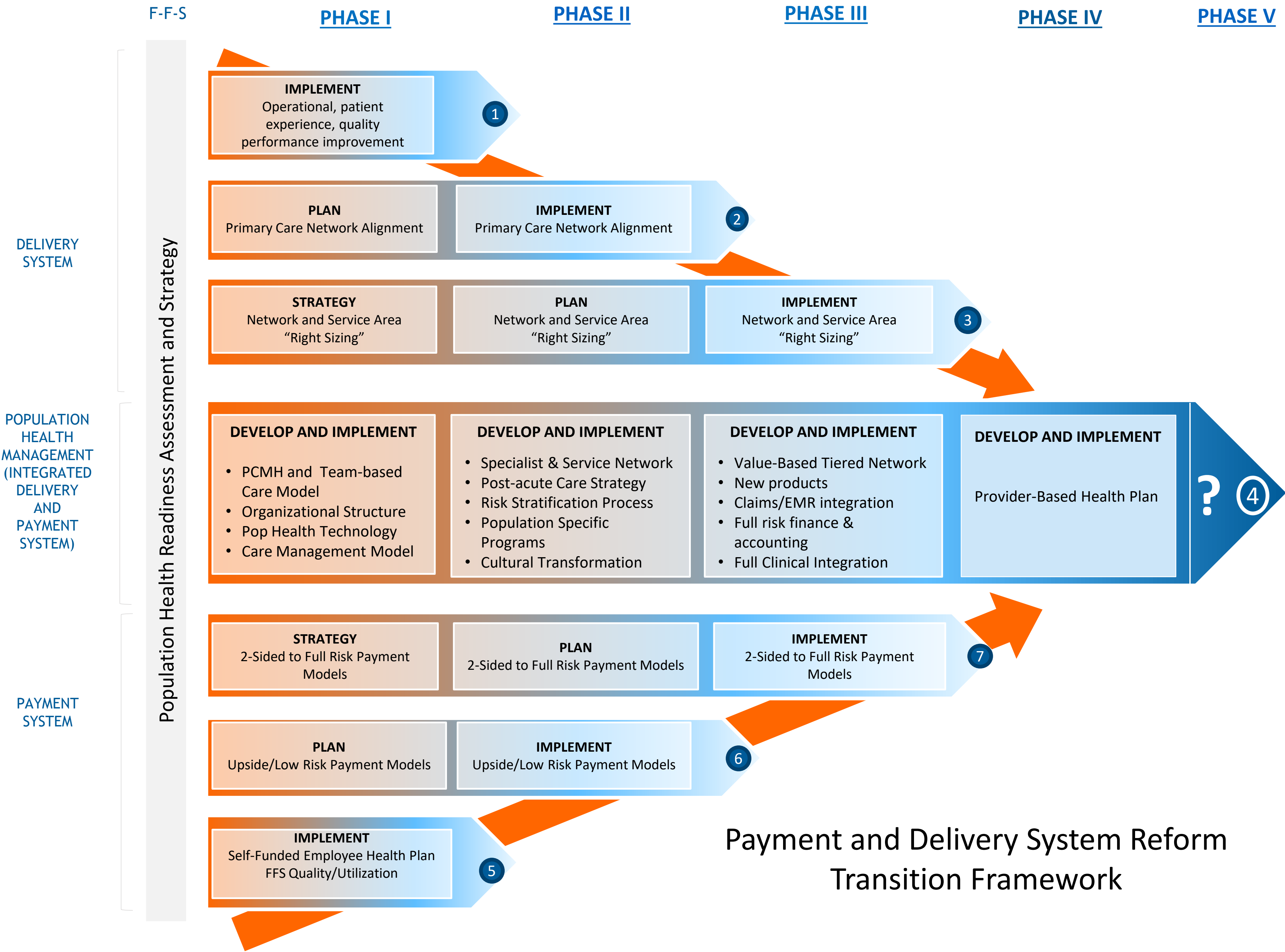
2.0%
0.0%
-2.0%
-4.0%
-6.0%
-8.0%
-10.0%
-12.0%

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 P 2019 P

All (exc. CAHs) NFP FP All Projected

Source: MedPac Report to Congress, March 15, 2019

- Hospital margins are under assault
- Many health systems struggle with provider burnout, recruitment, retention and engagement
- Provider practices may pose financial sustainability challenges that in many instances appear intractable
- Addressing these issues without alienating the medical staff is essential



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?

- Team-based primary care involves restructuring 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 American Academy of Family Physicians and American Medical Association

Benefits of Team-Based Care Model

- ✓ Reduces total cost of care for organization
- ✓ Helps reduce readmissions penalties
- ✓ Helps achieve shared savings and incentive payments
- ✓ Reduces sources of conflict when engaging primary care practices around improving performance
  - Engages providers and staff around workflows, quality of care and patient satisfaction
  - Financial and operational gains realized without becoming source of conflict
- ✓ Promotes long-term financial sustainability of primary care practices

Benefits of Team-Based Care Model (continued)

- ✓ Reduces physician turnover and burnout
- ✓ Enhances patient engagement and promotes better clinical outcomes
- ✓ Returns joy to practice of medicine by enhancing collaboration and empowering entire team
- ✓ Increases practice panel size and visit capacity
- ✓ Improves overall performance in value-based payment models

Polling Question #2

- Have any of your primary care practices implemented team-based care (and, if they have, are the teams co-located?)
  - We have not implemented a team-based care model.
  - We have team-based care but teams are not co-located.
  - We have team-based care and the teams are co-located.

Four Core Principles of Team-Based Care

Co-location of provider and clinical team in a single "flow station"

Increase communication and collaboration

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

- Identify and address gaps in care

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

- Identify same-day appointment slots

Leveraging the **4-stage office visit**

Maximize efficiency of the team

Polling Question #3:

- Do your MAs/nurses remain in the exam room to document in real-time, during provider visit?
  - Always
  - Most of the time
  - Occasionally
  - Never

The Role of Medical Assistants and Nurses

- Team-based care does not involve charting by traditional "medical scribes"
- A "co-visit" with nurses and MAs managing preventive care and updating chronic illness management
- Assistants explore patient concerns and document in EHR using templates developed by care teams
- Redesigned workflows encourage staff to broaden learning and meaningfully contribute to direct patient care

Four-Stage Office Visit

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

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

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

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

Polling Question #4

- Are your primary care practices experiencing any capacity or appointment access challenges?
  - Few or no access problems
  - Moderate access problems
  - Significant access problems

Example: Patient Visit Capacity Improvement

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

Team-based Care Leverage

Visit Capacity

Potential Slots - 63% Capacity Increase, 26

Potential Slots - 31% Capacity Increase, 21

Current Slots - Base, 16

*Based on a recent client's data
*Note: Model requires use of two exam rooms

RECAP: Benefits of Team-Based Care Model

- Significant increases in productivity with changes in workflow & redistribution of work within established clinical teams
- Supports long-term financial sustainability 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
- Ensures practices have infrastructure to deliver better care, resulting in 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 practice of medicine
  - Achieving the Quadruple Aim
- Establishes strong foundation for success under value-based payment models

The Stroudwater Approach

- Clinician-led consulting team
- Scalable, train-the-trainer model
  - Pilot practice Physicians and staff become the team-based care champions for future practice implementations
- Refined, hands-on coaching during onsite implementation
- Close collaboration with client to customize model
- Proven results

Stroudwater Clients: Team-Based Care Implementation Early Successes

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% in 3 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 Successes

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

Stroudwater Clients: Team-Based Care Implementation Early Successes

- **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

Testimonials: The Patient Experience

Overall improved patient engagement w/ team-based care implementation across multiple practices. Patients reported enjoying increased face-to-face time with 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."

Testimonials: Provider & Staff Experience

- Nursing staff member stated "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."
- Front desk staff member shared "I love the huddle; it works!"
- One physician commented that 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. There's a reason for that, but there are also fixes. This is one of those fixes."

Resources

- CMS Press Release. HHS News: HHS to deliver value-based transformation in primary care: The CMS Primary Cares Initiative to Empower Patients to Drive Better Value and Results. April 22, 2019.
- 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

Q & A/Open Discussion

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