Benchmarking Medical Home Staff Models

*Learning from The Advisory Board’s Medical Home Project*

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Road Map for Discussion

I  Defining the Scope of PCMH Staffing

II  Setting Support Staff Benchmarks

III  Quantifying Role Transformation
The Advisory Board’s Medical Home Project

*Transforming the Economics and Operations of Primary Care*

**A Working Group for Innovators**
- HCAB’s platform for supporting established medical home pioneering organizations as well as “fast followers” looking to learn best practices in medical home
- Over 300 organizations participating

**Illuminating Answers as They Emerge**
Participants receive priority access to new research publications, tools, expert responses to technical questions, and peer networking.

**2011 Focus Areas**
- Funding strategy
- Benchmark-driven staffing and operations design
- Staff training and change management

**Invitation to Participate**
- Participation in the Medical Home Project is open to all Health Care Advisory Board members at no additional cost.
- For more information, please e-mail Amanda Berra at BerraA@advisory.com
- Or visit [www.advisory.com/hcab/medicalhome](http://www.advisory.com/hcab/medicalhome)
The PCMH: Poster Model for Health Care Reform

The Medical Home Model

- Primary Care Practice
- Comprehensive Care
- Patient Engagement
- Enhanced Access
- Coordinated Care
- Team of Providers
- Disease Registry

Something to Believe In

“Patient-centered medical homes are considered by many to be among the most promising approaches to delivering higher-quality, cost-effective primary care, especially for people with chronic health conditions.”

Health Policy Brief: Patient-Centered Medical Homes
Health Affairs/Robert Wood Johnson Foundation
Physician Alone Cannot Achieve New Primary Care Goals

Not Enough Time in Physician’s Day to Provide Comprehensive, Coordinated Care

<table>
<thead>
<tr>
<th>Medical Home Goals:</th>
<th>Comprehensive Chronic and Preventive Care</th>
<th>Patient Engagement</th>
<th>Enhanced Access</th>
<th>Coordinated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Disease registry data entry, maintenance, monitoring</td>
<td>• Time-intensive patient education</td>
<td>• Same-day scheduling</td>
<td>• Increased communication with other providers and specialists</td>
</tr>
<tr>
<td></td>
<td>• Increased patient outreach, phone contact</td>
<td>• Motivational interviewing</td>
<td>• Expanded evening, weekend office hours</td>
<td>• More thorough documentation</td>
</tr>
<tr>
<td></td>
<td>• Increased results reporting</td>
<td>• Self-management follow-up</td>
<td>• Increased patient phone, e-mail access</td>
<td>• Increased patient follow-up</td>
</tr>
</tbody>
</table>

PCP Time Required per Day to Meet Clinical Guidelines for 2,500 Patient Panel

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Needs</td>
<td>3.7 hours</td>
</tr>
<tr>
<td>Chronic Needs</td>
<td>10.6 hours</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>7.4 hours</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21.7 hours</strong></td>
</tr>
</tbody>
</table>

Source: Yarnall K et al., “Family Physicians as Team Leaders: ‘Time’ to Share Care,” Preventing Chronic Disease, April 2009, 6:2; Health Care Advisory Board interviews and analysis.
A Wide Spectrum of Staffing Approaches

### Equipping Practices with Additional Staff, IT

- NP
- RN
- 0.5 FTE Nutritionist
- 0.5 FTE Social Worker
- EMR
- Data Manager

### Leveraging Existing, Available Resources

- Leveraging Existing Practice Staff
- Using Open Source Disease Registry

### Case in Brief: Capital District Physicians’ Health Plan, Inc.

- Physician-founded, governed health plan based in Albany, New York
- Piloting medical home in three practices using risk-adjusted capitated payment model with bonus for entire patient panel
- Practices adding additional staff, IT capabilities to meet comprehensive requirements of model

### Case in Brief: Integrated Health Partners

- 180-physician PHO in Battle Creek, Michigan; owned 50% by Battle Creek Health System and 50% by Calhoun County Physicians
- Launched “Pathways to Health” initiative based on Wagner’s Chronic Care Model in 2006
- Practices leveraging existing staff, free disease registry from other medical home pilots

One Model: Health Coaches Spearhead PCMH Functions

Health coach works collaboratively with physicians, staff, and other professionals to coordinate care across the continuum.

- **Manages Disease Registry**
  - Enters data, identifies and follows up with patients not meeting clinical goals

- **Conducts Pre-visit Chart Reviews**
  - Ensures maximal preparedness for patient visit, proper use of team members during visit

- **Provides Patient Education**
  - Uses education, action planning, motivational interviewing to support behavioral changes

- **Coordinates Care Team**
  - Works with PCPs and staff to meet medical home goals

- **Coordinates Care Across Continuum**
  - Connects patients with specialists, ensures that records and care plan are updated

- **Supports Quality Improvement**
  - Assists in creation of physician and clinic level quality performance reports

- **Facilitates Group Visits**
  - With physician or mid-level provider, schedules and leads group visits, educates patients

**Case in Brief: Mercy Clinics, Inc.**

- 150-physician group, 70% primary care physicians, employed by Mercy Medical Center in Des Moines, Iowa
- 27 health coaches support medical home operations, spearhead patient engagement, facilitate care coordination and manage disease registry

Source: Health Care Advisory Board interviews and analysis.
Leveraging RN as Most Flexible Provider for Health Coach

Benefits of Using RN as Health Coach

- Qualified to perform most functions related to care management alone
- Able to bill for some care management services, strengthening practice finances
- Has direct access to physicians, valued by PCPs as integral member of care team
- Works across all providers in practice to redesign care processes, improve quality

Prioritizing Health Coach Flexibility

“We have chosen to use mainly registered nurses as health coaches. RNs are the ultimate utility player in a primary care practice—they can do everything from patient self-management and goal setting to lower-level visits, and their clinical expertise and experience is really valued by our physicians.”

Kelly Taylor, RN, MSN
Director of Quality Improvement, Mercy Clinics, Inc.
Health Coaches Have a Demonstrated ROI

Finding the Business Case for Health Coach FTEs at Mercy Clinics

Estimated Percentage of Care\(^1\) Being Delivered to Patients

- 55%
- 95%

Profitable Care

Components of Health Coach Business Case

- Increased Office Visit Revenue
- Increased Lab Revenue
- Increased Clinician Productivity
- Shared Medical Appointments
- Pay-for-Performance Capture


\(^1\) Chronic and preventive care.
Coaches Support Higher-Level Billing, P4P

Evaluation and Management Levels of Services for Diabetes Patients

*Mercy North Clinic (10 Physicians, 1.6 FTE Health Coaches)*

<table>
<thead>
<tr>
<th>99213</th>
<th>99214</th>
</tr>
</thead>
<tbody>
<tr>
<td>56%</td>
<td>24%</td>
</tr>
<tr>
<td>35%</td>
<td>74%</td>
</tr>
</tbody>
</table>

13% increase in visit revenue from upcoding alone

Primary Care Physicians Receiving Pay-for-Performance Bonus

2007

- 99%

85 out of 86 primary care physicians earned over $1 million in P4P

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1. Assumes patient panel size of 2,200; 10% of patients are diabetic, average of three office visits per year per diabetes patient.
2. Low-complexity office visit.
3. Moderate-complexity office visit.

A Nearly 4:1 Return on Care Team Investment

Revenue and Expenses at Mercy North Clinic, 2006
10 Physicians, 1.6 FTE Health Coaches

- Increased Diabetes Care, Testing: $122 K
- Pay-for-Performance Bonuses: $114 K
- Saved Physician, Nurse Time: $15 K
- Health Coach Staffing Costs: ($73 K)
- Increased Microalbumin Cost: ($10 K)
- Increased HbA1c Cost: ($5 K)
- Net Contribution: $163 K

Revenue attributed to health coaches, does not include increases from focus on hypertension patients or increased referrals to additional preventive testing.

Clinic makes small profit on three out of four in-office diabetic tests.

To help assess the financial ROI from adding a health coach to your PCP practice(s), please see the Medical Home Health Coach Practice Impact Calculator available at www.advisory.com/hcab/medicalhome

**Range of Health Coach License Levels Currently In Use**

*Health Coach Role Can Be Designed to Fit a Variety of Provider Levels*

<table>
<thead>
<tr>
<th>Highest License Level</th>
<th>Nurse Practitioner</th>
<th>Registered Nurse</th>
<th>Licensed Practical Nurse</th>
<th>Medical Assistant</th>
<th>Community Health Worker</th>
<th>Non-clinical Staff</th>
</tr>
</thead>
</table>

**Mercy Clinics, Inc.**
- Employed practice in Des Moines, Iowa
- Most health coaches are RNs, aiming toward a 1:1 coach-to-physician ratio
- Significant practice profits achieved under fee-for-service

**Kaiser Permanente Northern California**
- KP practices in Richmond, California
- MAs work with PCPs managing panels of chronic patients
- Saw large improvement in heart attack, stroke rates

**Harvard Vanguard**
- Multispecialty practice based in Boston, Massachusetts
- NPs see chronic patients visits and make follow-up calls
- Visits include medication management, patient education

**Clinica Campesina**
- FQHC\(^1\) based in Denver, Colorado
- Care teams composed of MD or NP/PA, LPN, and MA
- LPNs coordinate the team, conduct patient education, oversee disease registry, and make follow-up calls

**Carondelet Health Network**
- Four-hospital system in Tucson, Arizona
- System leases diabetes team, including RN and CDE, to practices
- Community health worker coordinates patient contact with team

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1. Federally Qualified Health Center.

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Multiple Options for Building Physician Support Team

Additional Staff Not Always Practice-Based

- **Diffused Across Existing Staff**
  - All existing in-office staff change current work duties to support medical home process changes, services.
  - Need for more efficient care processes and workflow so medical home efforts do not mean additional work on top of “regular” job duties.

- **Dedicated Staff Member**
  - Centralize majority of medical home services in single office staff member, usually an RN.
  - Transitioning current staff member to this role often speeds process of practice transformation, but prior position will need to be backfilled.

- **Outsourced Resource**
  - Referring, accessing care team support functions from a system or network level entity instead of providing services within practice walls.
  - Examples from health system include chronic disease centers of excellence, case management, centralized scheduling.

Source: Innovations Center interviews and analysis.
System-Level Resources Can Extend Primary Care Team

**Scaling Resources Across Multiple Practices**

<table>
<thead>
<tr>
<th>Expansion of Primary Care Team</th>
<th>Clinicians to Consider Involving Medical Home Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources Needed</strong></td>
<td><strong>Core Team Inside Practice</strong></td>
</tr>
<tr>
<td></td>
<td>- Physician</td>
</tr>
<tr>
<td></td>
<td>- Mid-level provider</td>
</tr>
<tr>
<td></td>
<td>- RN/LVN</td>
</tr>
<tr>
<td></td>
<td>- MA</td>
</tr>
<tr>
<td><strong>Available at System Level</strong></td>
<td><strong>Medical Specialists</strong></td>
</tr>
<tr>
<td></td>
<td>- Certified Diabetes Educator</td>
</tr>
<tr>
<td></td>
<td>- Dietitian</td>
</tr>
<tr>
<td></td>
<td>- Pharmacist</td>
</tr>
<tr>
<td></td>
<td>- Behavioral Health Specialist</td>
</tr>
<tr>
<td></td>
<td>- Geriatrician</td>
</tr>
<tr>
<td></td>
<td>- Ophthalmologist</td>
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<tr>
<td></td>
<td>- Cardiologist</td>
</tr>
<tr>
<td></td>
<td>- Pulmonologist</td>
</tr>
<tr>
<td></td>
<td>- Podiatrist</td>
</tr>
</tbody>
</table>

**Health System Entities to Consider Involving in Medical Home Practices**

- Outpatient Diabetes Center
- Outpatient Heart Failure Center
- Wellness Center
- Discharge Coordination Service
- Home Health Agency

Source: Health Care Advisory Board interviews and analysis.
Multiple Different Functional Configurations Possible

End-state PCMH Model Likely to Differ Across Sites

Potential Functional Owners in Any Given PCMH Site

<table>
<thead>
<tr>
<th>PCMH Function</th>
<th>Care Team Leadership</th>
<th>IT Platform</th>
<th>Care Plan Monitoring</th>
<th>Care Coord.</th>
<th>Health Coaching</th>
<th>PCMH assessment metric selection</th>
<th>Consumer/Employer Branding</th>
</tr>
</thead>
</table>

Practice Site  Integrated Health System  IPA/MSO  Health Plan
No Single “Right Answer” Model

Some Variables in the PCMH Operational Equation

- Support Staff
- Panel size
- IT systems
- Visit length
- Visit volume

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Defining New Boundaries for PCP Panel Size

Multi-Pronged Primary Care Access Expansion Strategy at Aurora Health Care

**Patient Panel Size per PCP**

- **Current**
  - 2,500 Patients
  - Retail Clinics
    - Network of 10 AuroraQuickCare retail clinics
  - Expanded Hours
    - Saturday and evening access at all Aurora employed PCP practices
  - Urgent Care Centers
    - Network of 18 Aurora urgent care centers
    - E-visits
      - E-visits being piloted at an Aurora employed PCP practice, with plans to expand

- **Potential Target**
  - 10,000 Patients

**Case in Brief: Aurora Health Care**

- Fifteen-hospital system based in Milwaukee, Wisconsin, with network of over 700 employed primary care physicians
- Has made a range of primary care network investments over the past decade, including expanded clinic hours, urgent care clinics, and retail clinics E-visits
- Currently piloting the medical home model, e-visits, and patient portals

Source: Health Care Advisory Board interviews and analysis.
At a Minimum, “Someplace to Start”

The Primary Care/Medical Home Benchmarking Initiative

Phases in the Benchmarking Process

- Survey Design
- Data Collection /Analysis
- Reporting

Researchers worked with medical home pioneers to determine key data points

Panel size webconference, executive summary, and organization-specific reports in the works

Primary Care/Benchmarking Initiative Still Open

- Submit your site-level benchmarks on staffing models, payer mix, patient access, IT implementation, and other key aspects of primary care transformation
- All participants will receive customized reports comparing their results to others in the project
- Survey page link can be found at www.advisory.com/hcab/medicalhome
Road Map for Discussion

I  Project Overview

II  Setting Staff Benchmarks

III Strategic Considerations
A First Look at Survey Respondents

The Primary Care/Medical Home Benchmarking Initiative

Survey Respondents
As of February 28, 2011

101 Primary care and PCMH sites
59% Self-identified PCMH
64% Owned by hospitals

Self-Identified Medical Homes

35% Accredited by NCQA or a health plan
57% Hospital-owned
6 Mean physician FTEs
6 Median age (months)

Many PCMHs not accredited
Two Real-World Examples

Case in Brief: Oceanside Family Practice
- 7-physician group in an urban market
- "Virtual private practice" model with physicians paid on a revenue-less-expenses basis
- Largely FFS payment environment with some P4P
- 4.5 years into medical home transformation

Case in Brief: Dr. Adrian Percer
- Solo practitioner in a suburban market
- Independent practice
- Local health plan provides substantial funding and incentives for medical homes
- 1 year into medical home transformation

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Today’s Staff-Model Data Points

**Clinical Support Staff Per Physician**
- NPs
- RNs
- PAs
- LPNs/LVN
- MAs

**Potential Drivers of Variation**
- More mature medical homes
- Smaller vs. larger panel sizes
- Smaller vs. bigger practices
- Greater vs. lesser IT access
- Advanced practitioners with own patient panels
- Owned vs. independent practices
- Practices receiving payer help

**Who Does the Majority of These Tasks?**
- Pre-visit planning
- Patient Self-Management
- Group visit facilitation
- Working with hospitals around IP stays/discharges
- Working with referrals to specialists
- Population management data
- Well-patient check-ups
- Non-Emergent acute visits (ex: sore throat)
- After-hours/weekend visits
- Triaging patient questions and requests
Half of Medical Homes Added New FTEs

Since Becoming a Medical Home, How Many FTEs have been Added Specifically to Support the Practice’s Transformation?

Added FTEs to Support Transformation

<table>
<thead>
<tr>
<th>All Medical Homes</th>
<th>N=33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added FTEs</td>
<td>52%</td>
</tr>
<tr>
<td>Did not add FTEs</td>
<td>48%</td>
</tr>
</tbody>
</table>

Number of FTEs Added

Among Medical Homes that Added FTEs

<table>
<thead>
<tr>
<th>N=33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean: 1.5 FTEs added</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>0.5</td>
</tr>
</tbody>
</table>

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PCMH Staffing Slightly More Robust Overall

Compared to Non-Medical Home Primary Care Sites

Clinical Staff FTEs Per Physician FTE

Non-Medical Home n=23-26; Medical Home n= 36-41

- NPs per Physician (FTEs)
- PAs per Physician (FTEs)
- RNs per Physician (FTEs)
- LPNs/LVNs per Physician (FTEs)
- MAs per Physician (FTEs)
- Total clinical support staff per physician (FTEs)

Non-PCMH Primary Care
PCMH

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A Closer Look: Team Model at Oceanside and Percer

Case Study Practice Staffing More Robust Than Average for PCMH

Total Clinical Support Staff FTEs Per Physician FTE

<table>
<thead>
<tr>
<th></th>
<th>Oceanside</th>
<th>Percer</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPs per Physician (FTEs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>PAs per Physician (FTEs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>RNs per Physician (FTEs)</td>
<td>.6</td>
<td>1</td>
</tr>
<tr>
<td>LPNs/LVN per Physician (FTEs)</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>MAs per Physician (FTEs)</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Total Clinical Support</td>
<td>3.6</td>
<td>5.5</td>
</tr>
</tbody>
</table>

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Total Clinical Support Staff

**Total Clinical Support Staff Per Physician**

*Medical Homes*

n=59

- 25th P: 1.7
- 50th P: 2
- 75th P: 2.5

Mean: 2.8 clinical support FTEs per Physician

**Case Study Comparators**

- 3.6 Oceanside
- 5.5 Percer
Smaller vs. Bigger Practices

Economies of Scale Likely at Work

Mean Clinical Staff FTEs per Physician, By Practice Size (Number of Physicians at site)

Medical Homes
n=35

- 0 to 2.99 FTE physicians: 3.4
- 3.0 to 5.77 FTE physicians: 2.6
- ≥ 5.71 FTE physicians: 2.0
Lesser vs. Greater IT access

Increasing Staff Efficiency Through IT

Mean Clinical Staff FTEs Per Physician, By Robustness of Info Source Utilization

*Medical Homes*

n=35

Sources: Electronic Disease Registry, EMR, Claims Data, External Quality Info, RHIO/HIE
Hospital-Owned vs. Independent Medical Homes

Parent Orgs Contributing Support (Not Always in Subsidy Form)

**Contractual Relationship with Hospital**

- Medical Homes
  - Independent: 43%
  - Hospital-owned: 57%

**Mean Clinical Staff FTEs per Physician by Whether PCMH is Independent vs. Owned**

- Medical Homes
  - Independent: 2.38
  - Owned: 3.04

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Road Map for Discussion

I  Project Overview

II  Setting Support Staff Benchmarks

III  Quantifying Role Transformation
Elevating Practice Staff to Top-of-License Care

Training and New Job Descriptions Push Nurses, MAs to Top-of-License Practice at Kaiser

Before
- PCP
  - Assesses and treats both simple and complex patients
  - Provides all patient education
  - Oversees RNs, LPNs, MAs
- RN
  - Tied up with incoming patient call triage
- MA
  - Room patient, perform basic administrative tasks
- LPN
  - Assesses and treats simple patients
  - Oversees LPNs and MAs

Staff Retraining Program
For PCPs
- Educated about RN, LPN scope of practice
For RNs
- Retrained to practice at top of license
- Engaged to mentor LPNs
- Reassured that elevated LPNs will not displace RNs
For LPNs
- Trained for three-week in nursing clinical skills
- Given new job description, clear new responsibilities

After
- PCP
  - Uses care plan to assess and treat complex patients, oversees LPNs and MAs
- RN
  - Uses care plan to assess and treat simple patients, educates and coaches chronic patients
- LPN
  - Rooms patient, maintains disease registry, performs basic administrative tasks
- MA
  - Provides all patient education

Source: Health Care Advisory Board interviews and analysis.
How Are Job Descriptions Changing in the PCMH?

Who Mostly Does...

- Pre-visit planning
- Patient Self-Management Support
- Group visit facilitation
- Working with hospitals around IP stays/discharges
- Working with referrals to specialists
- Population management data entry
- Population management data analysis
- Well Patient check-ups
- Non-Emergent acute visits (ex: sore throat)
- After-hours/weekend visits
- Triaging patient questions and requests
Some Evidence of Site-wide Service Mix Shift

Medical Home-Related Functions Performed at Site

Non-medical home n = 33 medical home n = 48

<table>
<thead>
<tr>
<th>Function</th>
<th>Non-PCMH Primary Care sites</th>
<th>PCMH sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-visit planning</td>
<td>67</td>
<td>84</td>
</tr>
<tr>
<td>Self-mgmt support</td>
<td>68</td>
<td>95</td>
</tr>
<tr>
<td>Group visits</td>
<td>24</td>
<td>43</td>
</tr>
<tr>
<td>Hosp. coord.</td>
<td>83</td>
<td>91</td>
</tr>
<tr>
<td>Referral coord.</td>
<td>100</td>
<td>93</td>
</tr>
<tr>
<td>PM data entry</td>
<td>64</td>
<td>98</td>
</tr>
<tr>
<td>PM data analysis</td>
<td>68</td>
<td>98</td>
</tr>
<tr>
<td>After-hours and weekend visits</td>
<td>73</td>
<td>66</td>
</tr>
</tbody>
</table>
Physicians Offloading Certain Key Functions

*PCMH Physicians Owning These Tasks Less Often*

**Sites Reporting Physicians as Task Owners, by Task**

Among Sites Offering Service

*Non-Medical Home n=23-26; Medical Home n= 36-41*

<table>
<thead>
<tr>
<th></th>
<th>Plan visits</th>
<th>Support Pt self mgmt</th>
<th>Hosp Coord</th>
<th>Referral Coord</th>
<th>Data entry</th>
<th>Data analysis</th>
<th>Sore Throats</th>
<th>Triage ?s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non PCMH</td>
<td>8%</td>
<td>27%</td>
<td>50%</td>
<td>12%</td>
<td>9%</td>
<td>15%</td>
<td>73%</td>
<td>8%</td>
</tr>
<tr>
<td>PCMH</td>
<td>5%</td>
<td>18%</td>
<td>24%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>68%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Who Does Pre-Visit Planning?

Primary Owner of Pre-Visit Planning by Clinical Credential (% of sites)

Non-medical home n = 13, medical home n= 37

- MD: Non-PCMH Primary Care, PCMH
- NP: Non-PCMH Primary Care, PCMH
- PA: Non-PCMH Primary Care, PCMH
- RN: Non-PCMH Primary Care, PCMH
- LPN/LVN: Non-PCMH Primary Care, PCMH
- MA: Non-PCMH Primary Care, PCMH
- No Clinical Cred: Non-PCMH Primary Care, PCMH
- Off-site service: Non-PCMH Primary Care, PCMH

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Who Primarily Does the Self-Management Support?

Primary Owner of Patient Self-Management Support by Clinical Credential (% of sites)

Non-medical home n = 13, medical home n= 37

<table>
<thead>
<tr>
<th>Clinical Credential</th>
<th>Non-PCMH Primary Care sites</th>
<th>PCMH sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>NP</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>PA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RN</td>
<td>47</td>
<td>26</td>
</tr>
<tr>
<td>LPN OR LVN</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>MA</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>No clinical credential</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Off-site service</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

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Who Works with Hospitals?

Primary Owner of Coordinating Around Hospitals Stays by Clinical Credential (% of sites)

Non-medical home n = 20, medical home n= 38

- **MD**: 50
- **NP**: 24
- **PA**: 0
- **RN**: 15
- **LPN OR LVN**: 29
- **MA**: 0
- **Non-clinical credential**: 20
- **Off-site service**: 34

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## Take-Aways From the Data So Far

<table>
<thead>
<tr>
<th>Preliminary Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ PCMHs are altering staff model</td>
</tr>
<tr>
<td>✓ Greater IT, scale seem to help streamline team staffing profiles</td>
</tr>
<tr>
<td>✓ Our profiled sites tend to be more robustly staffed than average</td>
</tr>
<tr>
<td>✓ PCMHs are altering site functions</td>
</tr>
</tbody>
</table>
Next Steps

The Primary Care/Medical Home Benchmarking Initiative

Phases in the Benchmarking Process

Today’s presentation of “first findings”

Survey Design > Data Collection /Analysis > Reporting

Researchers worked with medical home pioneers to determine key data points

Panel size webconference, organization-specific reports, and additional analysis in the works

Primary Care/Benchmarking Initiative Still Open

• Submit your site-level benchmarks on staffing models, payer mix, patient access, IT implementation, and other key aspects of primary care transformation
• All participants will receive customized reports comparing their results to others in the project
• Survey page link can be found at www.advisory.com/hcab/medicalhome
• Questions?: Email Amanda Berra at berraa@advisory.com
How The Advisory Board Can Serve

**Bringing Best Practice Insight and ACO Strategy to Industry Partners**

<table>
<thead>
<tr>
<th>Medical home operations, strategy, best practices, toolkits, and workshops</th>
<th>ACO and medical home consulting, implementation, and management services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now sharing with executive teams at 2,700+ hospitals, health systems, independent physician practices, and health plans</td>
<td>Serving hundreds of provider organizations in areas such as CI program development, medical home design/launch, practice management, and payer contracting</td>
</tr>
<tr>
<td>Leadership development and training for physicians, nurses and staff</td>
<td>Real-time network performance analytics for medical home and ACO management</td>
</tr>
<tr>
<td>Working with our partners at Mercy Clinics in Des Moines, IA in delivering health coach training and medical home operational change</td>
<td>Installed base of 300+ health system clients on platform for physician performance management, disease registry and cross-continuum analytics</td>
</tr>
</tbody>
</table>

For more information, please contact ProgramInquiries@advisory.com

Source: Division of Health Care Finance and Policy, “Health Care Indicators in Massachusetts.” November 2009.