Benchmarking Medical Home Staff Models

Learning from The Advisory Board's Medical Home Project

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THE 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

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The Advisory Board's Medical Home Project

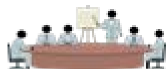
Transforming the Economics and Operations of Primary Care

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.



Implementation and Operational Support

Innovator Spotlight Series

Tools and calculators

	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

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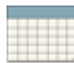
The PCMH: Poster Model for Health Care Reform

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 Johns on Foundation

"Health Policy Brief: Patient-Centered Medical Homes" Health Affairs/Robert Wood Johnson Foundation, Sept. 14, 2010

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Physician Alone Cannot Achieve New Primary Care Goals

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

Medical Home Goals:	**Comprehensive Chronic and Preventive Care**	**Patient Engagement**	**Enhanced Access**	**Coordinated Care**
New Time-Consuming Tasks:	• Disease registry data entry, maintenance, monitoring • Increased patient outreach, phone contact • Increased results reporting	• Time-intensive patient education • Motivational interviewing • Self-management follow-up • Group visits	• Same-day scheduling • Expanded evening, weekend office hours • Increased patient phone, e-mail access	• Increased communication with other providers and specialists • More thorough documentation • Increased patient follow-up

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

Acute Needs	3.7 hours
Chronic Needs	10.6 hours
Preventive Services	7.4 hours
Total	**21.7 hours**

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.

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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

Source: Porter S, "N.Y. Initiative Couples Payment Reform and Practice Reform," AAFP News Now, American Academy of Family Physicians, June 6, 2008; Goroll A et al., "Fundamental Payment Reform for Adult Primary Care," *Journal of General Internal Medicine,* 22: 410-415; Health Care Advisory Board interviews and analysis.

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One Model: Health Coaches Spearhead PCMH Functions

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

Health Coach

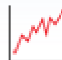
Coordinates Care Team
Works with PCPs and staff to meet medical home goals

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 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.

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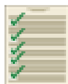
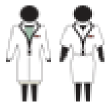
Leveraging RN as Most Flexible Provider for Health Coach

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.

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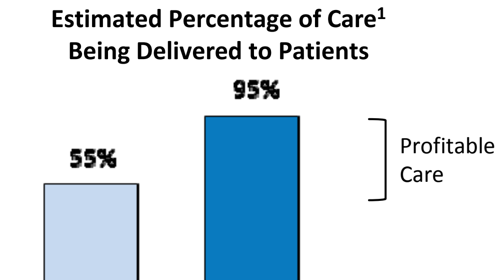
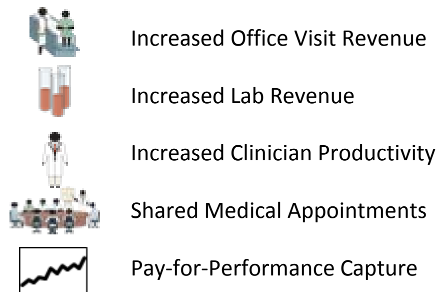
Health Coaches Have a Demonstrated ROI

Finding the Business Case for Health Coach FTEs at Mercy Clinics

Estimated Percentage of Care[1] Being Delivered to Patients



Components of Health Coach Business Case



1 Chronic and preventive care.

Source: Swieskowski D, "Improving Chronic Care: Health Coaches & the Business Case," available at http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/improvigchronic_care_presentation.pdf, accessed August 31, 2009; Health Care Advisory Board interviews and analysis.

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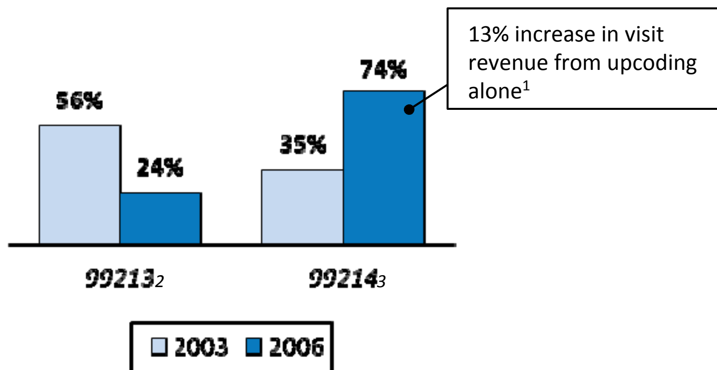
Coaches Support Higher-Level Billing, P4P

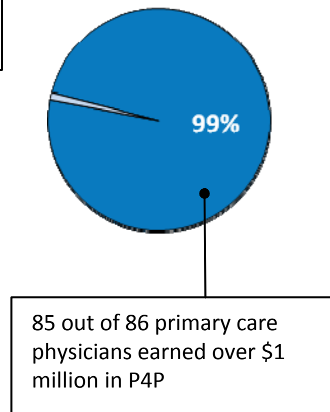
Evaluation and Management Levels of Services for Diabetes Patients

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



Primary Care Physicians Receiving Pay-for-Performance Bonus

2007



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.

Source: Swieskowski D, "Improving Chronic Care: Health Coaches & the Business Case," available at http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/improvigchronic_care_presentation.pdf, accessed August 31, 2009; Health Care Advisory Board interviews and analysis.

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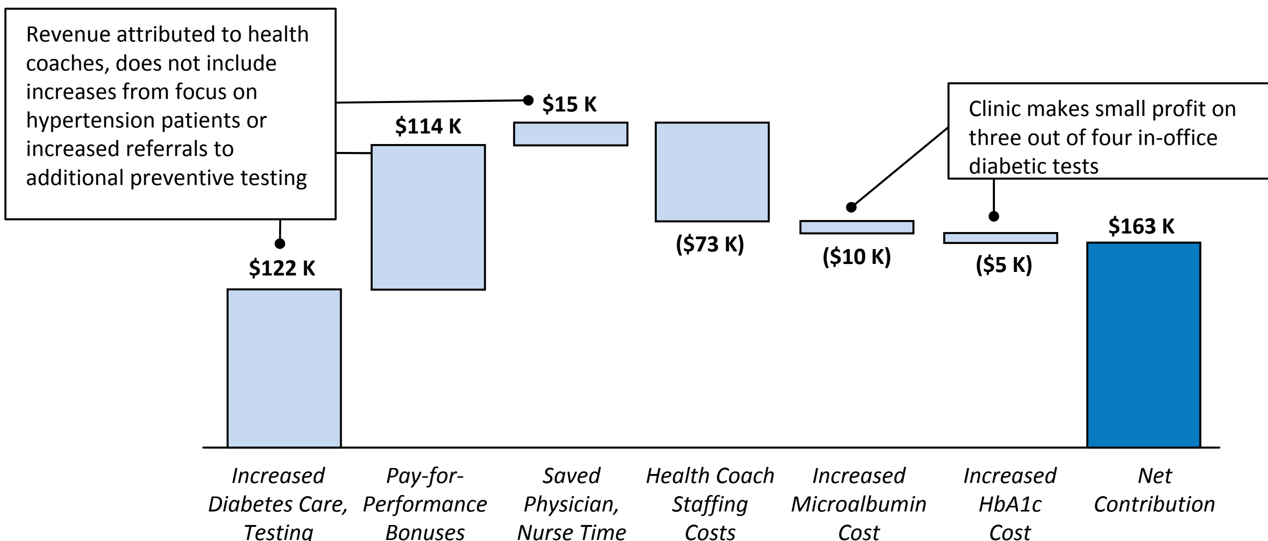
A Nearly 4:1 Return on Care Team Investment



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

Source: "Mercy Clinics: The Medical Home," *Group Practice Journal*, April 2008; Health Care Advisory Board interviews and analysis.

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Range of Health Coach License Levels Currently In Use

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

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

Highest License Level	**Nurse Practitioner**	**Registered Nurse**	**Licensed Practical Nurse**	**Medical Assistant**	**Community Health Worker**	***Non-clinical Staff***

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

1 Federally Qualified Health Center.

Source: Bodenheimer T, "Building Teams in Primary Care: 15 Case Studies," California HealthCare Foundation, July 2007, available at http://www.chcf.org/publications, accessed October 25, 2010; Health Care Advisory Board interviews and analysis.

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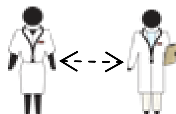
Multiple Options for Building Physician Support Team

Additional Staff Not Always Practice-Based

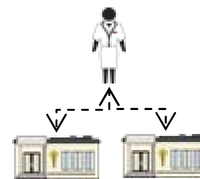
Diffused Across Existing Staff

- 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

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Source: Innovations Center interviews and analysis.

System-Level Resources Can Extend Primary Care Team

Scaling Resources Across Multiple Practices

Clinicians to Consider Involving Medical Home Practices

Resources Needed (vertical axis) — *Expansion of Primary Care Team* (horizontal axis)

Core Team Inside Practice
- Physician
- Mid-level provider
- RN/LVN
- MA

Available at System Level
- Certified Diabetes Educator
- Dietitian
- Pharmacist
- Behavioral Health Specialist

Medical Specialists
- Geriatrician
- Ophthalmologist
- Cardiologist
- Pulmonologist
- Podiatrist

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

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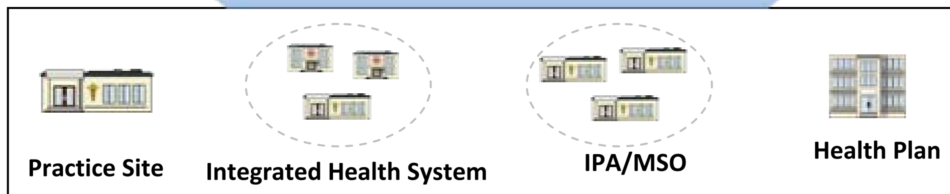
Source: Health Care Advisory Board interviews and analysis.

Many Different Functional Configurations Possible

End-state PCMH Model Likely to Differ Across Sites

Potential Functional Owners in Any Given PCMH Site



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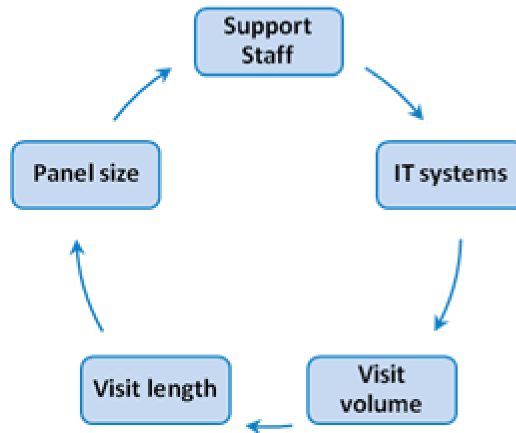
No Single "Right Answer" Model

Some Variables in the PCMH Operational Equation



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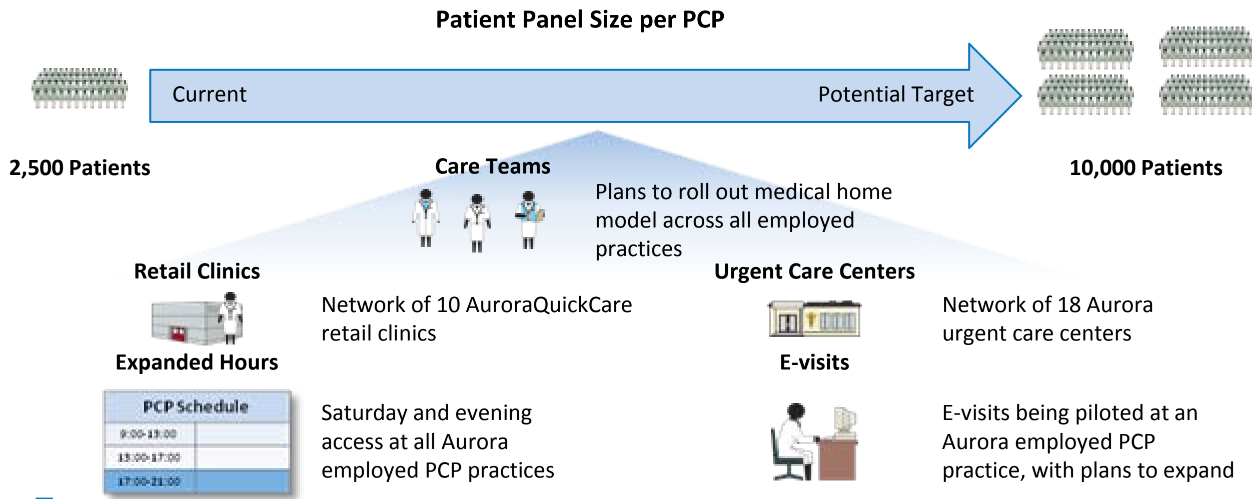
Defining New Boundaries for PCP Panel Size

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



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

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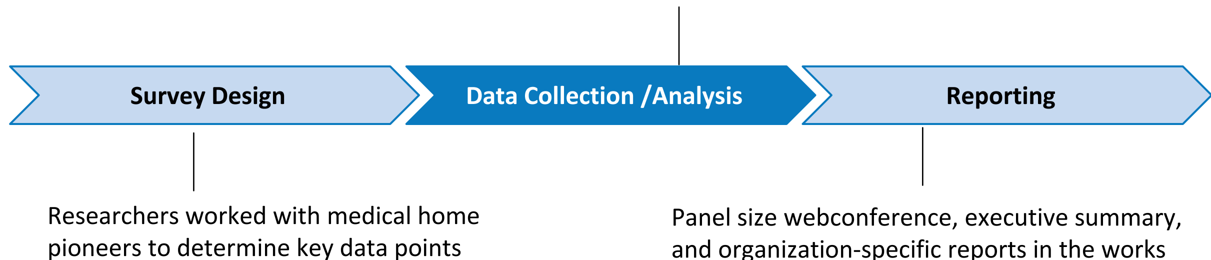
Source: Health Care Advisory Board interviews and analysis.

At a Minimum, "Someplace to Start"

The Primary Care/Medical Home Benchmarking Initiative



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**

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Road Map for Discussion

I Project Overview

II Setting Staff Benchmarks

III Strategic Considerations

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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

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Two Real-World Examples

Case in Brief: Oceanside Family Practice[1]

- 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[1]

- 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

1 Pseudonym

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Today's Staff-Model Data Points

Clinical Support Staff Per Physician

- NPs
- RNs
- PAs
- LPNs/LVNs
- MAs
- Total clinical support staff per physician

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

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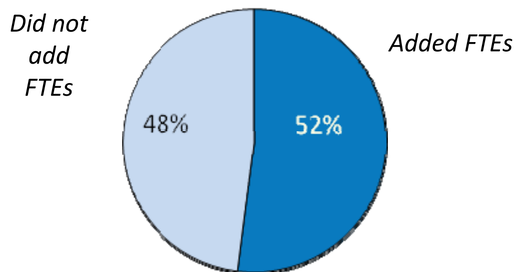
Half of Medical Homes Added New FTEs

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

Added FTEs to Support Transformation

All Medical Homes

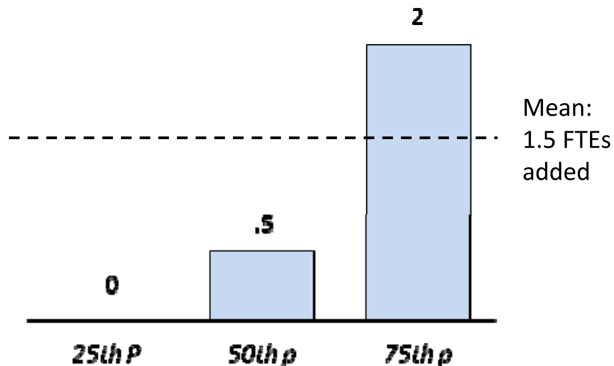
N=33



Number of FTEs Added

Among Medical Homes that Added FTEs

N=33



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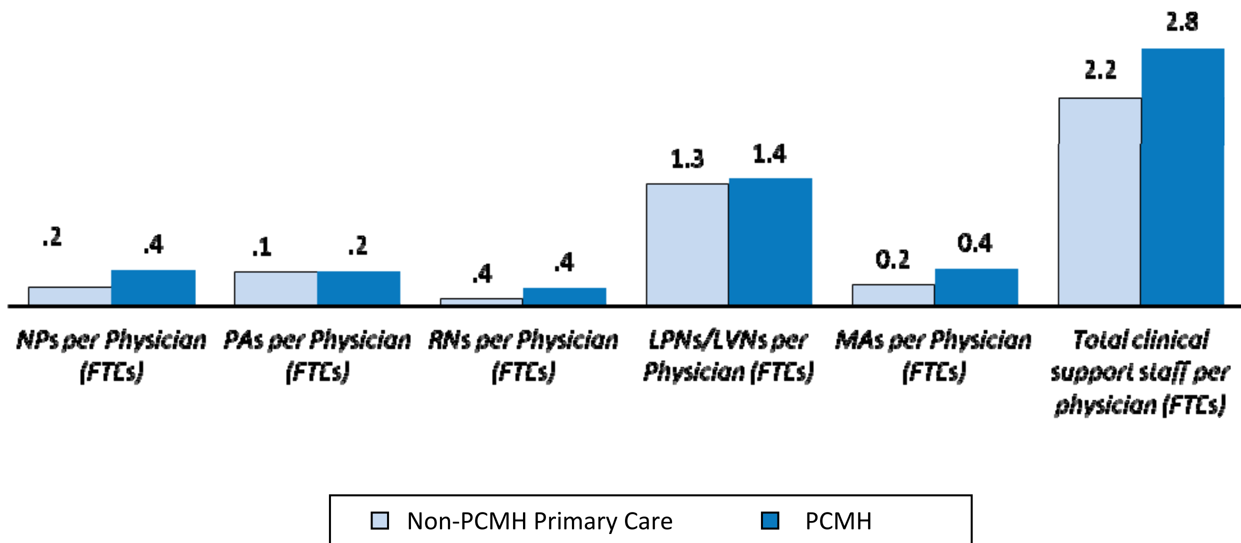
PCMH Staffing Slightly More Robust Overall

Compared to Non-Medical Home Primary Care Sites



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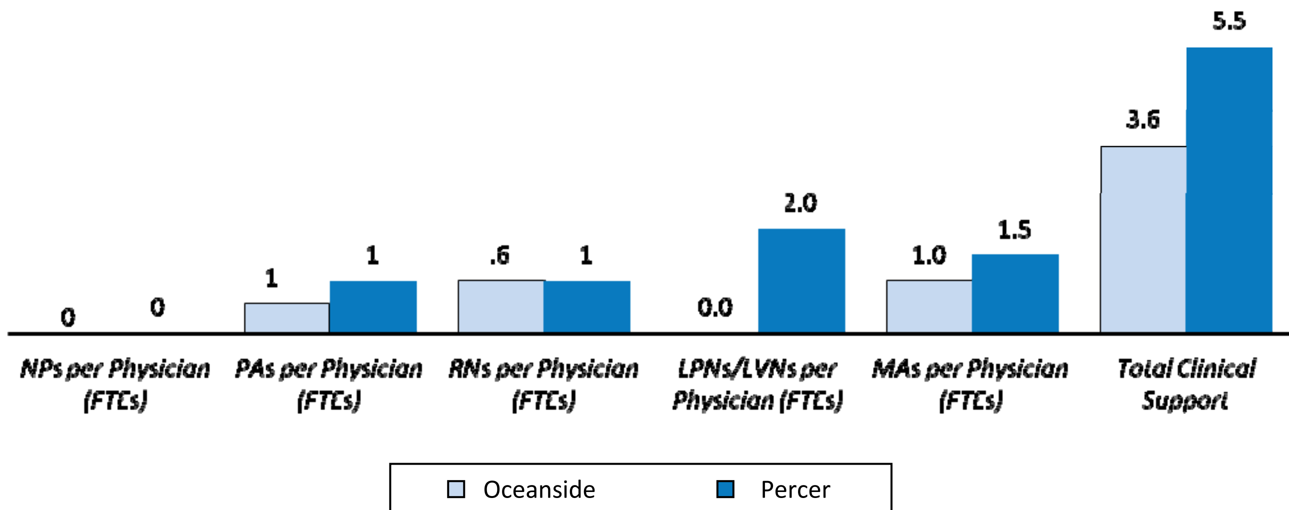
A Closer Look: Team Model at Oceanside and Percer

Case Study Practice Staffing More Robust Than Average for PCMH



1 Pseudonym

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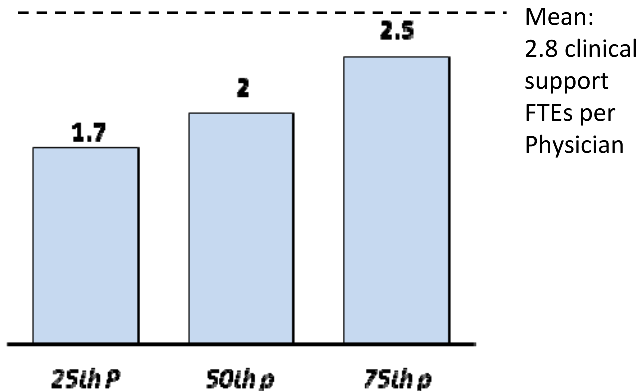
Total Clinical Support Staff

Total Clinical Support Staff Per Physician

Medical Homes

n=59



Mean:
2.8 clinical support FTEs per Physician

Case Study Comparators

3.6 Oceanside

5.5 Percer

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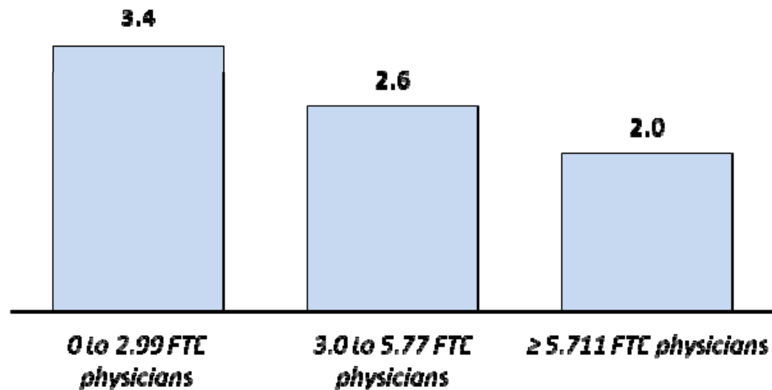
Smaller vs. Bigger Practices

Economies of Scale Likely at Work

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

Medical Homes

n=35



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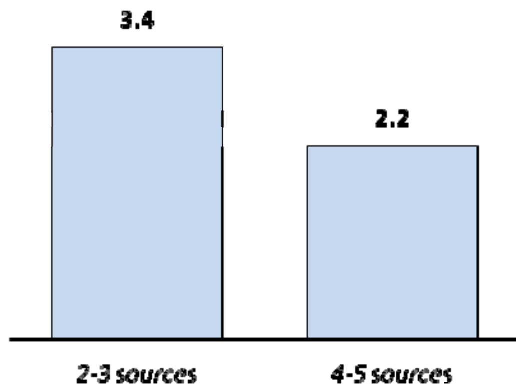
Lesser vs. Greater IT access

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

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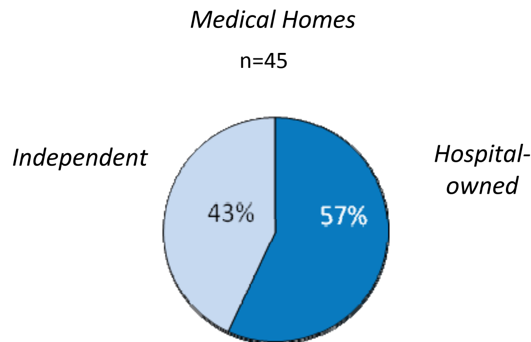
Hospital-Owned vs. Independent Medical Homes

Parent Orgs Contributing Support (Not Always in Subsidy Form)

Contractual Relationship with Hospital

Medical Homes

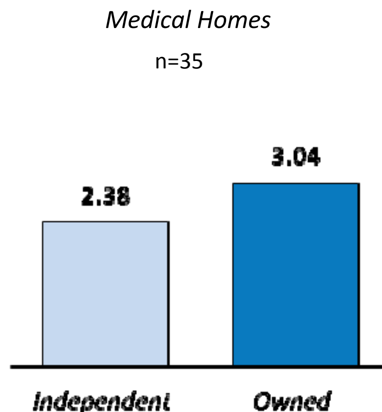
n=45



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

Medical Homes

n=35



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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 **LPN**

- Room patient, perform basic administrative tasks

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

Develops medical care plan for simple and complex patients which lower-level staff can carry out and monitor

RN

Uses care plan to assess and treat complex patients, oversees LPNs and MAs

LPN

Uses care plan to assess and treat simple patients, educates and coaches chronic patients

MA

Rooms patient, maintains disease registry, performs basic administrative tasks

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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

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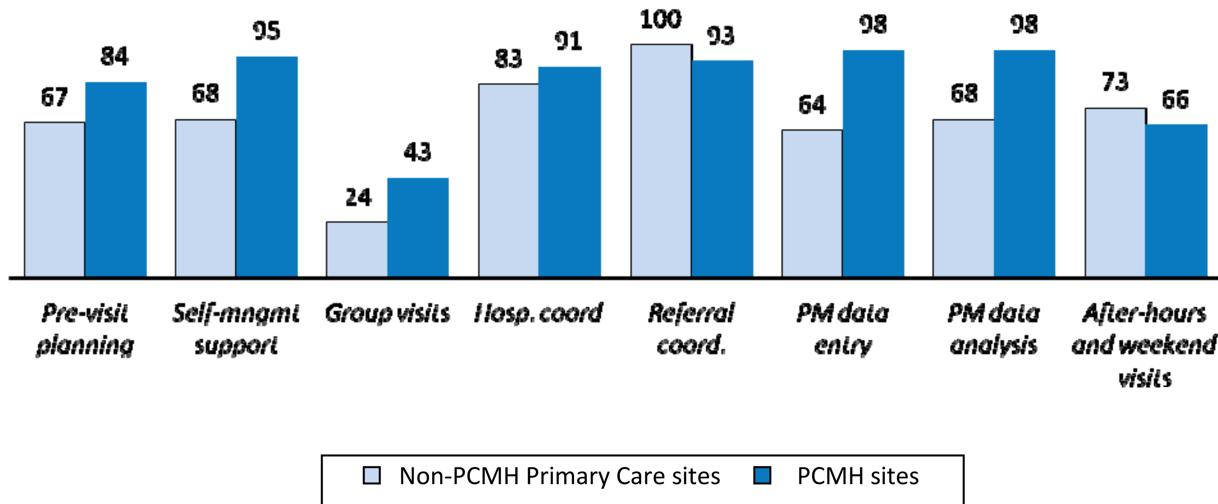
Some Evidence of Site-wide Service Mix Shift

Medical Home-Related Functions Performed at Site

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



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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

	Plan visits	Support Pt self mgmt	Hosp Coord	Referral Coord	Data entry	Data analysis	Sore Throats	Triage ?s
Non PCMH	8%	27%	50%	12%	9%	15%	73%	8%
PCMH	5%	18%	24%	5%	3%	3%	68%	3%

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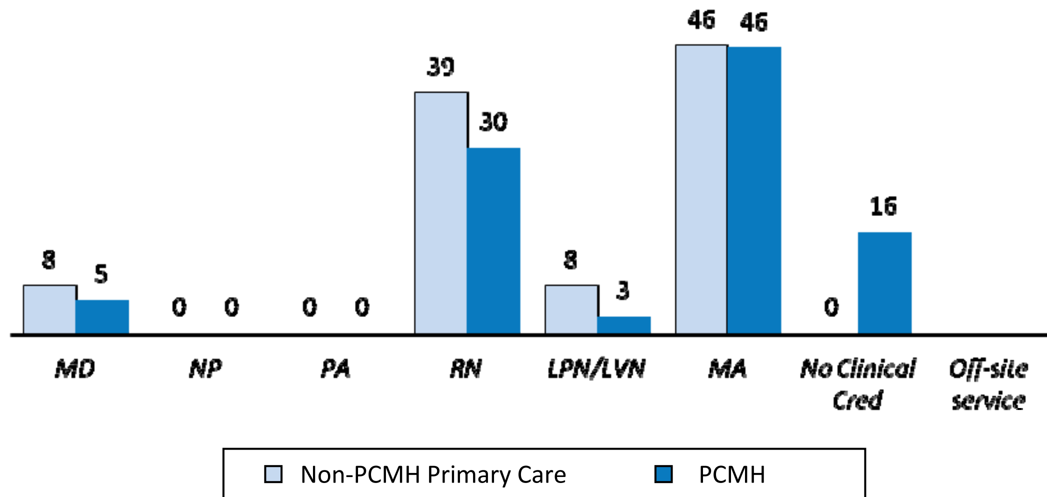
Who Does Pre-Visit Planning?



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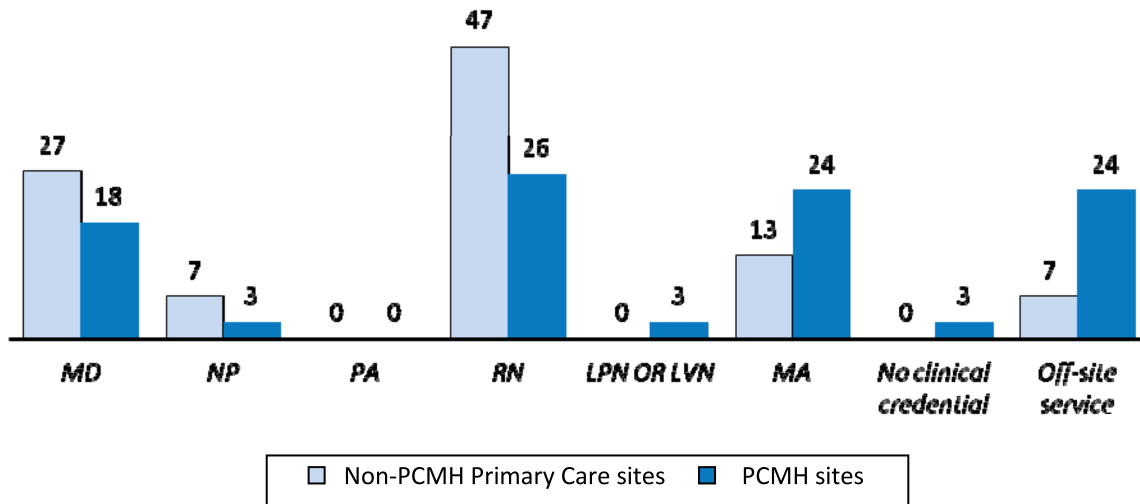
Who Primarily Does the Self-Management Support?

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

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



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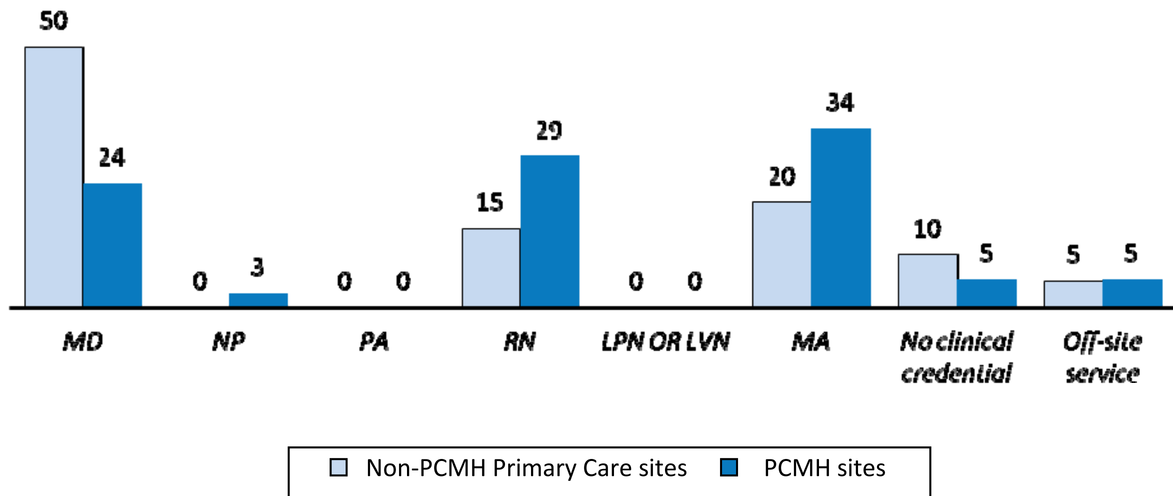
Who Works with Hospitals?

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

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



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Take-Aways From the Data So Far

	Preliminary Conclusions
✔	PCMHs are altering staff model
✔	Greater IT, scale seem to help streamline team staffing profiles
✔	Our profiled sites tend to be more robustly staffed than average
✔	PCMHs are altering site functions

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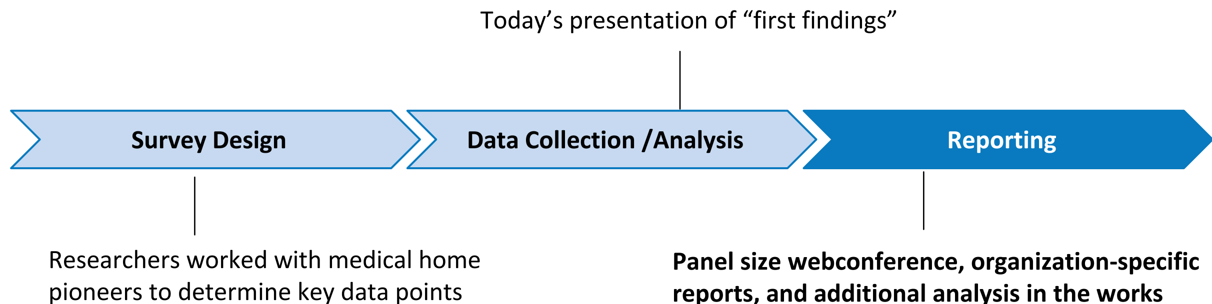
Next Steps

The Primary Care/Medical Home Benchmarking Initiative



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

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For more information, please contact ProgramInquiries@advisory.com

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

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