New Models of Primary Care Workforce and Financing

Executive Summary

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Prepared for:
Agency for Healthcare Research and Quality
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5600 Fishers Lane
Rockville, MD 20857
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Contract No. HHSA290-2010-00004I
Prism Order No. HHSA29032009T
Task Order 9

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AHRQ Publication No. 16(17)-0046-9-EF
October 2016

This report is based on research conducted by Abt Associates in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA, under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract Nos. 290-2010-00004-I/ 290-32009-T). The findings and conclusions in this document are those of the authors, who are responsible for its contents; the findings and conclusions do not necessarily represent the views of AHRQ. Therefore, no statement in this report should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

Suggested citation: New Models of Primary Care Workforce and Financing Executive Summary. (Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA, under Contract No.290-2010-00004-I/ 290-32009-T.) AHRQ Publication No. 16(17)-0046-9-EF. Rockville, MD: Agency for Healthcare Research and Quality; October 2016.

Executive Summary

As the U.S. health care system seeks to reconfigure primary care to meet the needs of an aging and more complex population, environmental factors such as the advent of team care and the patient-centered medical home movement, value-based payment mechanisms, and the anticipated shortage of primary care physicians variously exert pressure on practices to redefine the key functions of primary care and experiment with changes to their workforce to deliver them. Innovative practices are experimenting with new ways to coordinate care, integrate behavioral health services, and effectively manage and support people dealing with chronic health conditions, and some are beginning to address the social determinants of health. Variation across the country in size of practice, urban/rural location, and availability of trained personnel results in staffing models that respond to local context. To inform the development of effective, new models of workforce configuration to meet the growing need for primary care, the Agency for Healthcare Research and Quality (AHRQ) commissioned eight case examples of exemplar primary care practices to explore the delivery of comprehensive, high-quality primary care. These case examples of vanguard practices help us to understand how seminal components of care are delivered, document what tasks are accomplished and by whom, and collect information for cost analyses. By selecting exemplar sites that vary by practice size and location, team composition, and financing structure, the site visit data suggest nascent team models through comparisons across sites.

Site visit aims:

- Describe innovations in care delivery and staffing patterns to substantiate hypothetical primary care workforce models.
- Collect data necessary to conduct workforce modeling, panel size, and cost estimates analyses.
- Document the stories of sites that have transformed their workforce to achieve improvements in quality or comprehensiveness of care delivery.

Overview of Case Example Methods

Exemplary sites were nominated based on the recommendations of a technical expert workgroup, the literature on primary care quality, and data and leaders from national and regional quality improvement initiatives. The nominees were assessed on the essential functions of comprehensive, high-quality primary care defined by the white paper (link here). Those chosen for site visits were frequently exemplary in several key functions, but the goal was to explore deeply the staffing and processes in sites that were innovative leaders in at least one key function.

Name of Site	Location	Type of Practice	Population	Exemplar Functions
Stanford Coordinated Care	Palo Alto, California	Small practice managing the most complex patients for the Stanford University Health Plan	Multiple, complex chronic conditions	Patient engagement Intensive care coordination by MAs Enhanced, patient-centered risk assessment Scribing Home visits

Name of Site	Location	Type of Practice	Population	Exemplar Functions
The Health Center	Rural Vermont	Small Federally Qualified Health Center	Rural, underserved	Medication management Telehealth Partnerships to extend team-based care Colocation/integration of dental and primary care
Fairview Health System	Edina, Minnesota	Integrated health system	Typical urban	Medication therapy management
Foresight Family Practice	Grand Junction, Colorado	Small, independent practice	Rural, small town	Patient-centered risk stratification Patient engagement Integrated behavioral health Community health worker
WellMed	San Antonio, Texas	Integrated health system	Medicare Advantage seniors	Community nursing program Palliative care team Home visits Community partnerships supporting wellness Scribing
Henry Ford Health System	Detroit, Michigan	Integrated health system, hospital affiliated	Urban, high social need	Centralized care management and palliative care MA health coaches Community health workers Integrated behavioral health Care transitions program
Cherokee Health System	Knoxville, Tennessee	Combined Federally Qualified Health Center and mental health center	Rural, high social need	Integrated behavioral health Telehealth visits Community health workers
Wesley Health and Wellness Center (Methodist Healthcare Ministries)	San Antonio, Texas	Private clinic affiliated with an integrated health care system	Urban and rural uninsured	Care integration Partnerships addressing social determinants of health Outreach through community health workers and community health nurses Specialist partnerships

Sites were located across the Nation in rural, suburban, and urban settings and ranged from a small, two-provider practice to very large integrated health care system clinics. Visits focused on documenting excellence in diverse components of high-quality care delivery, diverse settings of care, and the medical and social needs of the populations served. Major areas of focus were: care for complex patients and those with multiple chronic conditions, behavioral health integration with primary care, medication therapy management, community partnerships to provide care, and care coordination. Sites visited included large, integrated care systems delivering care tailored for seniors; practices tailored for populations with high social as well as medical needs; a small clinic focused on care for patients with complex, chronic conditions; and small, independent practices and community health centers delivering quality care in rural, small town environments.

Site visitors gathered data through interviews with clinicians and staff on primary care teams, observation of meetings and care delivery processes, and data collection forms for staffing and costs. These data were analyzed and summarized in the case example reports that follow. Key findings from the site visits practices are:

Key Finding 1: Enhanced Role of the Medical Assistant

The medical assistant, or MA, role is dramatically expanded to include many "patient-facing" activities beyond rooming patients and taking vital signs. In exemplar practices, MAs typically perform many preventive screenings and services; conduct health coaching, care coordination, and health education functions; and, with the use of standing orders, perform some clinical tasks. Some serve as scribes documenting care during the physician visit.

Cutting-edge innovation: Functioning in the care coordinator role, MAs follow up on their own assigned panels of patients and present cases in weekly team case review. (See Stanford Case Example Report)

Key Finding 2: Integrated Behavioral Health Services

Behavioral health practitioners, usually social workers or clinical psychologists, are integral members of the primary care team in most of the case example sites. Although they carry out some traditional independent counseling visits, most describe flexible and open scheduling, allowing for frequent, brief, supportive interactions with patients. Exemplary teams recognize mental and behavioral health interventions as central to comprehensive primary care.

Cutting-edge innovation: Very brief "just in time" interventions that may last only 5 minutes, in conjunction with primary care visits, allow many more patient "touches" each day. (See Cherokee, Foresight and Henry Ford Case Example Reports)

Key Finding 3: Medication Management

Onsite pharmacists and pharmacy technicians coach patients in taking their medications appropriately and troubleshoot medication adherence problems with patients. In remote areas, onsite automated dispensing units fill medication prescriptions in clinic. Pharmacists support appropriate prescribing by physicians through readily available consultative services.

Cutting-edge innovation: Through the use of collaborative practice agreements, pharmacists independently initiate, modify, or discontinue the use of medications for many conditions. (See Fairview, Cherokee and The Health Center Case Example Reports)

Key Finding 4: Defined Nursing Roles

In exemplary teams, registered nurses' (RNs) clinical skills are most often dedicated to clinical care management, including medication management. "Team" RNs provide clinical management of routine chronic illness patients through independent visits and provide telephone followup. Case management RNs provide these services for a caseload of patients with complex clinical issues, or those who are transitioning across care settings. Frequently, they function interdependently with social workers and community health workers to manage the care for people with complex conditions. Centralized care management in large, integrated systems is consistently linked to primary care practices by a specific care manager partnered with each practice.

Cutting-edge innovation: With the use of protocols, RNs titrate medications for patients with chronic conditions. (See Stanford case example)

Key Finding 5: Community Health Workers

Community health workers (CHWs) often take traditional "promotora," or health promoter, roles in the community, conducting outreach at community events and making home visits and assessments. As community navigators, CHWs connect patients with neighborhood resources and a variety of health services as well as phone-based or Web-based information sources. In one program, women with at-risk pregnancies received intensive interventions such as home visits and monitoring and strengthened social support. Some sites are developing a model with onsite CHWs as part of the primary care team. CHWs implement interventions with high-risk patients to explore a patient's needs, develop a more comprehensive and robust care plan, and assist with the RN case manager load as appropriate. For patients with diabetes in a pilot program, the CHWs help with health behavior change and goal setting by providing outreach through phone calls.

Cutting-edge innovation: Community health workers operate as advocates for healthy communities, generating partnerships with other organizations to build resources to meet patient needs. (See Cherokee and Methodist case examples)

Key Finding 6: Risk Stratification and Population Management

Most practices in the case example use an algorithm to stratify patients by severity of illness and likelihood of hospital or emergency room admission. Some use additional assessments for psychosocial factors that signal the need for a higher level of intervention. Visit workflow and tasking is adapted to incorporate more intensive intervention that addresses these needs.

Cutting-edge innovation: Practices use screening tools such as the Adverse Childhood Events Survey to assist in determining appropriate interventions when patients don't respond to evidence-based care. (See Stanford and Foresight case examples)

Key Finding 7: Care Coordination

Care coordination is often a set of disseminated roles covered by various team members. Clinical care management, referral management, and linking patients with community resources require different skill sets that may be covered by staff with appropriate training to optimize care delivery. Nurse care managers typically coordinate care for complex patients, especially through transitions from one care setting to another, such as from the hospital to home and a return to the primary care provider. Referral management can be done effectively by administrative or lay staff who are adept at referral management systems and followup. CHWs and social workers may be the most familiar with community resource linkages. Communication and effective teamwork among these team members creates an environment in which each role is optimally staffed and patients experience seamless coordination of care.

Key Finding 8: Home visits

Home visits are employed by several case example sites, most frequently for assessment and support of patients by community health workers, but also by medical teams for care of the severely ill. Through home visits by community health worker programs, patients at risk for specific health-related issues receive intensive monitoring, for example elderly patients at risk for falls or patients with substance use disorders or high social need receive strengthened social support. For patients with multiple chronic conditions, the elderly, or those receiving palliative care, home visits by clinical teams assess needs for services and provide additional support to optimize patient care at home and avoid the need for hospitalization. In some States, emergency medical technicians (EMTs) are working with health systems to conduct home visits.

Key Finding 9: Telehealth

Video telehealth visits and consultations are being used extensively to provide care to patients in remote areas and for consultation or shared visits to provide specialty care. Patients receive pharmacist interventions for medication education and counseling, specialty visits by hard-to-find specialties such as psychiatry, and even to deliver primary care to remote locations.

Cutting-edge innovation: To improve access to primary care in rural areas, an urban primary care physician partners with a local RN performing "hands-on" assessments and screenings in view of the physician through the telehealth connection, then diagnoses and treats patients. (See Cherokee and Wesley Case Example Reports)

Key Finding 10: Scribing

Scribing, or entering visit data and notes into the medical record by someone other than the provider, is a role taken up by MAs or lay persons, or sometimes medical students. Case example sites utilize this function to allow the provider to spend more time interacting directly with the patient, or to support providers for whom EHR data entry is challenging. Scribing is a way for medical students or non-clinical staff to spend time with patients and learn about clinical care that helps them become better trained. Experienced scribes are able to use computer and Internet skills to place orders for screening or care, or to arrange for medication delivery.

AHRQ Pub. No. 16(17)-0046-9-EF
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