



Advising the Congress on Medicare issues

Team-based primary care

Kate Bloniarz and Katelyn Smalley

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Motivation

- Importance of primary care
 - Ensuring adequate access is critical to delivery system reform
 - Concern that fee schedule undervalues primary care relative to other services
- Poor coordination in traditional FFS Medicare
 - Fragmentation of care
 - Poor communication between providers and across time
 - Little explicit payment
- Complexity of primary care in an elderly population
 - Many chronic and acute conditions
 - Confounding psychosocial issues

Motivation, continued

- What is Medicare's role in supporting team-based primary care?
- Related work to date
 - Primary care services and payment, federally-qualified health centers, care coordination models, services provided by advanced-practice nurses and physician assistants
- Context for per-beneficiary payment discussion

Outline of today's presentation

- Medicare's payment rules
- Medical home model
- Other team-based primary care models
- Results from structured interviews with physician- and nurse practitioner-led teams
- Conclusion

Medicare's FFS payment for services delivered by clinician teams

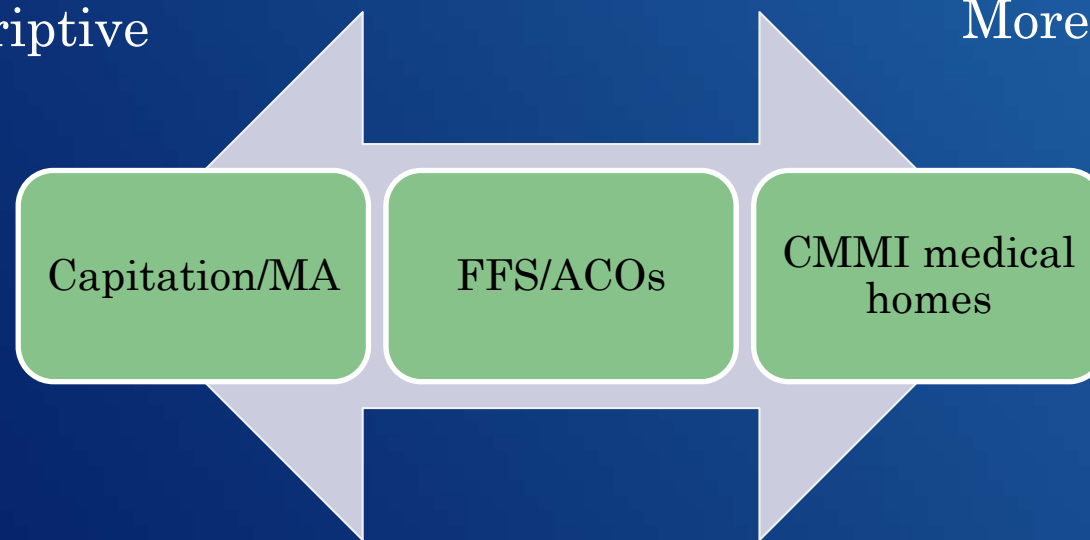
- Services generally defined by provider categories
 - Physician services, nurse practitioner services
 - May be limited by state law
- Nearly all services require a face-to-face visit
- Incident-to provision covers services delivered by staff under direct supervision of a physician, nurse practitioner or physician assistant

Team-based primary care in the context of payment reform

Does the payment system prescribe how clinicians organize themselves?

Less prescriptive

More prescriptive



Medical home model: Description

- Requirements
 - Team-based care (including a designated primary care provider and identifying a team structure and communication process)
 - Enhanced access
 - Coordination of care
 - Comprehensive care
 - Systems-based approaches to quality and safety
 - Strategies for partnering with patients
- NCQA just released new requirements, including more explicit team roles and responsibilities

Medical home model: Effect on quality and cost is mixed

- A few studies find reductions in hospital spending or other services, but others find no difference
- Results more significant in integrated delivery systems
- Example: Pennsylvania chronic care initiative
 - For the whole population, no significant differences in spending or utilization, scant differences in quality measures
 - For subgroup of high-cost patients, some evidence that spending was lower
- Targeting high spending patients, providing feedback to providers and risk-based payments may make a difference, but difficult to do

Other models of team-based care

- Veterans Health Administration
- FQHCs
- Nurse-managed health clinics

NORC interviews of team-based practices

- 5 physician-led teams
- 5 nurse-led teams
- 9 different states

Findings from interviews

- Teams vary in how they organize themselves
- Team structure and processes range from very hierarchical to very informal
- Medical assistants seem crucial to all the teams we spoke with, regardless of structure
- Administrative duties are reassigned from clinician team leader to office manager

Findings from interviews, continued

- Communication is key, but meetings must be targeted and short
- Electronic health record sometimes used to assign tasks and manage flow of the visit
- Providers anticipate gains in quality, but cite other reasons for organizing in teams
- Variation in team structure and function did not seem to be correlated with clinical background of team leaders

Summary of findings

- “Team models” in practice look very different across settings
- It often takes significant effort and resources (both personnel and financial) to adopt a team-based model
- Non-clinician staff play a very important role in team functioning
- VHA experience illustrates difficulty in applying a uniform model across a large delivery system

Conclusion

- In team-based primary care there is high variability with respect to structure, staffing and activities
- Regulatory structure that the Medicare program might consider is hard to envision
- Medicare's face-to-face requirement may be an impediment
- One potential solution could be per-beneficiary payment for primary care