



*Advising the Congress on Medicare issues*

# Team-based primary care

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# Motivation

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- 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

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- 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

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- 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

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- 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

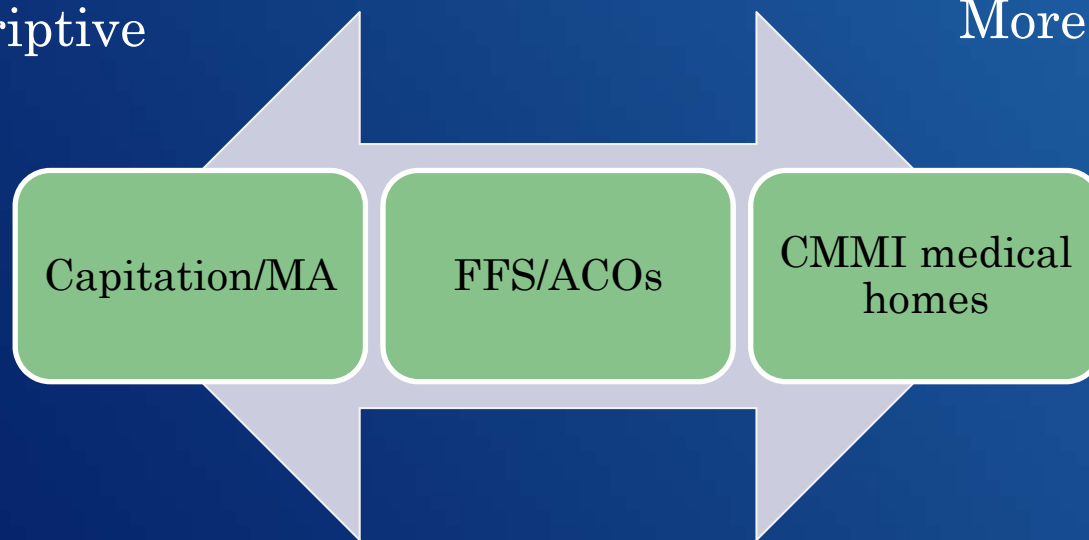
# Team-based primary care in the context of payment reform

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Does the payment system prescribe how clinicians organize themselves?

Less prescriptive

More prescriptive



# Medical home model: Description

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- 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

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- 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

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

# NORC interviews of team-based practices

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

# Findings from interviews

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- 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

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- 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

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- “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

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- 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