HSG | CLINICAL PRACTICE TRANSFORMATION:
FUNDAMENTAL PHILOSOPHIES

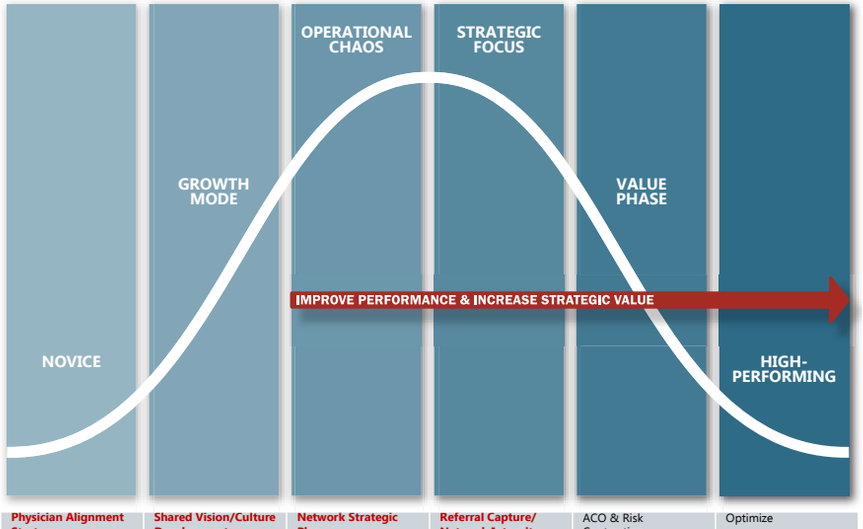
CREATING A TEAM-BASED APPROACH TO PATIENT CARE DELIVERY

Clinical Practice Transformation: Fundamental Philosophies

Care Transformation and *Clinical Practice Transformation* are terms that are swirling around the healthcare industry. **Many individuals we encounter are not sure exactly what they mean, how to pursue them, or how they are linked to other popular phrases such as "population health management."** Some of the confusion arises because we seek short phrases – or preferably a single word – that succinctly explain or quickly encapsulate the concept. However, like population health management, these terms are not readily described in a succinct fashion, as the concepts are multifaceted and fraught with layers of complexity that vary by location and individual circumstances.

Care Transformation generally refers to the global transition from volume-based to value-based care delivery. Clinical Practice Transformation generally refers to care transformation applied at the practice level. Several formal initiatives exist that are designed to better define and catalyze the clinical practice transformation process, including the CMS TCPi (Transforming Clinical Practice Initiative) and CPC+ (Comprehensive Primary Care Plus) programs. Each of these initiatives include training and support networks for program participants.

Most organizations cannot focus on addressing clinical practice redesign until a supportive management infrastructure is in place, physician leadership is engaged and part of the decision-making process, and business operations are under control. Hence, successful clinical transformation generally cannot be undertaken and realized until organizations progress on the network growth phases curve.



Physician Alignment Strategy	**Shared Vision/Culture Development**	**Network Strategic Plan**	**Referral Capture/ Network Integrity**	ACO & Risk Contracting	Optimize
Physician/Provider Manpower Plan	Management Infrastructure	**Network Performance Improvement**	Practice Transformation	Bundle Payments	
Interim Management	Acquisition and FMVs	Physician Engagement in Financial Improvement	**QI Plan/MACRA**	QI Across Care Continuum	
Executive Search	**Physician Leadership Development**	Aligned Physician Compensation	Direct Contracting	HEIP	

[A supplemental HSG whitepaper details the maturation phases employed physician networks progress through en route to the penultimate phase of a high-performing organization – HSG Physician Network Growth Phases: Accelerating the Performance of Your Network.]

The following sections explore each of these fundamental and overlapping concepts:

The path toward clinical practice transformation might be best approached by understanding and addressing some of its key underlying philosophies, which include:

1. Shifting from provider-centric to patient-centric care delivery
2. Shifting from care delivered by individual physicians to care delivered by a team of professionals (team-based care)
3. Shifting from a primary focus on face-to-face, office-based encounters to a focus on managing and coordinating a patient's health across the continuum of the patient's world, including the patient's home environment and social determinants of health.

1. Shifting from Provider-Centric to Patient-Centric Care Delivery

Many physicians roll their eyes when they hear "patient-centered care" and insist that they have always considered what is best for the patient when providing care. This assertion is often quickly followed by the question "After all, isn't that what patient-centered care is all about?" - a question meant to be rhetorical in nature. That thought is almost immediately linked to the feeling that formal programs like Patient Centered Medical Homes (PCMH) only add layers of regulations and external requirements to their practices which makes physicians' lives more complicated, detracts from good patient care, and merely results in a piece of paper that is just for show. These individuals feel that getting a certificate does not contribute to improving actual patient care and outcomes. Let's address each of these assertions in turn.

The concept that physicians have always considered what is best for the patient when providing care pertains to the clinical decision-making process and is true for most. However, even this consideration is what physicians and APPs (Advanced Practice Professionals) have considered to be in the patient's best interests – a rather paternalistic approach – and have not always truly considered the patients' and caregivers' perspectives. The development of the patient's plan of care has traditionally been a one-sided approach centered on the physician delivering the care. Physicians often did not ask for input, nor did they effectively determine what might be realistic and practical for the patients (and their caregivers).

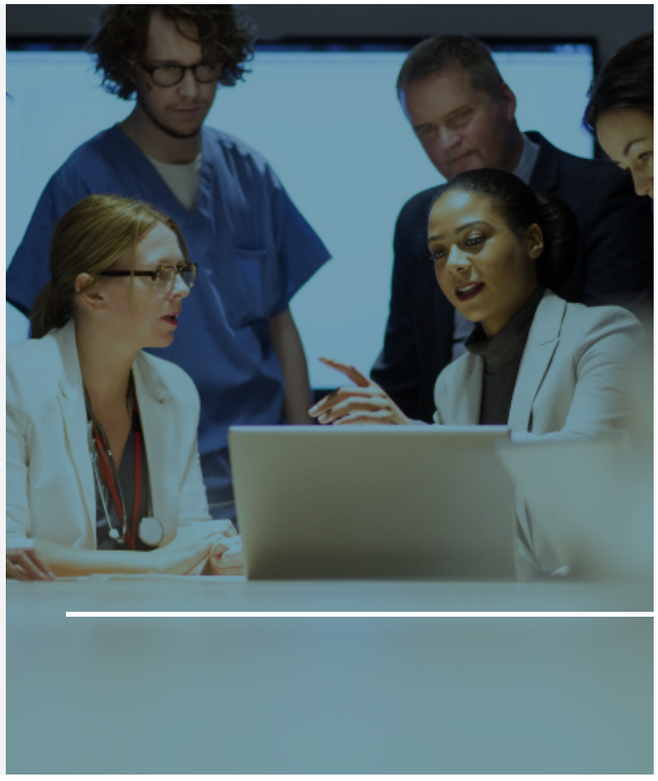
The care planning basically consisted of (1) here is what you need to do, (2) go ahead and do it, and (3) we will schedule a follow-up visit to see how you did. Of course, physicians included referrals to help with care (i.e., a clinical nutritionist, specialty consultant, or educational resources), but the onus for "compliance" rested squarely on the patient. Success or failure to "comply" was then referred to in terms of the degree to which the patient complied with their plan. Physicians developed and communicated the plan but it was up to the patient (and the patient's caregivers) to comply.

The new patient-centered, clinical decision-making paradigm retains the traditional ethical standards of do what is best for the patient and "first, do no harm" but incorporates the patient and caregivers in care plan development. The difference is determining what aspects of the ideal clinical plan the patient and caregivers are willing and able to accomplish. This shift also limits the number of interventions that are undertaken in the defined time interval, the degree or number of behavioral modifications targeted to be made, and the resources required or available to do so. The process will take more time and may involve more resources, but it will predictably be more effective since it is a realistic approach that more effectively garners patient and caregiver ownership and engagement.

The patient-centered paradigm shift also involves more than the clinical decision-making process. It requires a holistic review of the practice's clinical and business operations. Most of these processes have traditionally been provider-centric; focused on processes like the hours of operation and interactions and expectations required for the practice to be successful. True, the practice absolutely needs to be successful and sustainable. **However, how the practice accomplishes and measures that success might need to change to be more patient-centric, in order to ensure sustainability. We will present some specific opportunities in subsequent sections.**

Admittedly, a formal patient-centered care delivery model program – such as NCQA's PCMH, Patient Centered Specialty Practice (PCSP) for practices other than primary care, and Patient Centered Connected Care (PCCC) for urgent care centers, rehab, and other providers might not be a be-all-end-all solution, but it does provide a standardized framework upon which to build and has an established track record for success. And when done well, it should not add to provider difficulty, but should create an environment in which staff and providers flourish.

Those that insist that just getting a certificate will not contribute to improving actual patient care and outcomes are correct if the only thing the practice does is complete the requirements without actually transforming care delivery. This is difficult to do, but not impossible. The practice needs to commit to actual change – not just layering more requirements on how business is currently conducted. Practices that commit to real change and persevere with the changes realize the published benefits to the patient and the practice, such as improved clinical outcomes, better engaged (and happier) patients, lower costs, and increased staff satisfaction.[1] In addition, formal recognition (certification) also demonstrates to others what the practice aspires to, attests to, and has achieved – making the practice an outstanding organization with which to partner or refer.



To further explore the shift from a **provider-centric approach to patient care** to a **patient-centric approach**, let's look at some specific examples:

PATIENT ACCESS

Traditional access to a physician practice has been a provider-centric process. Office hours have centered on the hours the physician (and the staff) desired to work modified by other parameters the office needed to work around, such as hospital or nursing home rounds, organized meetings, etc. Patient access to the practice was limited to the posted business hours and the patient had to figure out how to arrange that. After-hours access occurred primarily through an answering service (often with return calls from a covering physician) and urgent issues were referred to the local emergency room.

Shifting to a more patient-centric approach does not mean that the individual physician needs to be physically available in an open office 24 hours a day, 7 days a week. It does mean that the practice needs to determine how to creatively maximize availability to meet the needs of the patient population served – and widely communicate the access mechanisms so patients know how to access practice resources when needed. Assessing patient access to services is the key element, while ensuring that patients are actively supported and not routinely left to their own devices. What elements should be considered in this new paradigm?

Normal business hours might need to be revisited based on patient need. A fixed 9 a.m. to 3 p.m. schedule in a pediatric practice (whether primary care or subspecialty care) directly conflicts with that patient population's primary duties and functions (i.e., school or pre-school) – not to mention the parents' work schedule and other logistics. Creative scheduling might include a bimodal emphasis of 7 a.m. to 10 a.m. and 2 p.m. to 6 p.m. appointment scheduling with indirect patient care (calls, emails, referring provider/ consultant, insurer contacts) between the major appointment blocks. Alternatively, overlapping provider and support staff scheduling, rather than identical time scheduling might permit enhanced access without increased personnel work hours (e.g., 7 a.m. to 4 p.m. and 9 a.m. to 6 p.m.). Similar conflicts arise in other practice settings, such as family medicine and internal medicine – if not with the patient's schedule, then potentially with a caregiver's schedule.

Normal business hour scheduling must also address same-day access – whether primary care or subspecialty care, whether on a scheduled basis or a "walk-in" basis, and whether physician-based or APRN/PA-based. In the offset schedule example above, same-day access could be targeted to the 7 to 9 a.m., 11 a.m. to 1 p.m., and 4 to 6 p.m. time frames for instance. These collective considerations resurrect the concept of "open access" scheduling – which fits this new paradigm very nicely.

The open access scheduling concept and its transition exceeds the scope of this paper; it won't be explored here.

Beyond the appointment schedule itself, how patients access the appointment schedule is also a consideration in the new paradigm. Restricting appointment schedule access to direct calls during normal business hours is unduly restrictive and rapidly becoming an even greater patient dissatisfier. Relinquishing total control and openly sharing access to appointment schedules has been a difficult issue for both providers and office staff and must be addressed in a patient-centric environment. Allowing access to schedules by other offices on the same EMR platform is a start, (e.g., for referrals between primary care and other specialty practices or to schedule hospital follow-ups from Emergency Departments and inpatient units) even if only to defined appointment types. Offering appointment access on the EMR's patient portal is another, which permits patient self-scheduling when convenient for them.

Providing after-hours access to the practice can be a conundrum that must balance quality of life, cost, and patient need. Offering onsite after-hours care can be costly and inefficient for individual small practices. Different options should be considered using resources inside and outside of the practice in a cost-effective manner. One option is to develop a consortium of practices offering rotating after-hours care and achieving greater practical efficiencies, as long as the consortium can withstand potential variations in care philosophy and potential "patient loss" between the practices. Another after-hours option is "contracting" with a local urgent care clinic or retail clinic to provide directed, even scheduled, after-hours access for practice patients (i.e., the patients are directed to that option via website, answering machine, patient communications, etc.) in exchange for returning the patient to the practice for follow-up care (and perhaps the option of electronically scheduling the follow-up appointment prior to patient departure or having standardized access time, such as 7:30 a.m. any morning Monday through Friday) and sending documentation of the encounter within one to two business days (unless electronically connected). A third option is contracting with a virtual visit organization or a nurse advice hotline for first level intervention followed by defining one of the above secondary level interventions.

Finally, the expanded world of telehealth is increasingly popular with patients, especially young adults, but still faces resistance by many providers. Asynchronous patient access to the practice through a secure EMR patient portal addresses many of the HIPAA and other logistical concerns and permits patient access to secure messaging (and patient scheduling) if the practice opens those options. Face-to-face Skype encounters can also be an option. Virtual connectivity can avoid bottlenecks and hassles for both patients and office staff members but creates issues with "control" of schedule, time management (answering messages) and revenue generation and productivity credit for non-face-to-face encounters, though telehealth reimbursement options are continually increasing. Introducing the various elements of tele-health can be a challenge and requires striking a favorable balance between patient engagement, practice reimbursement, and provider well-being to prevent overload.

PLAN OF CARE DEVELOPMENT

As previously mentioned, creating the patient's plan of care has traditionally been dictated by the physician, without significant input from the patient or the patient's caregiver. The physician arrived at a diagnosis, conveyed it to the patient (maybe with some standard patient education material to read or auxiliary referral), and outlined the course of action with the expected follow-up time frame. The patient was then expected to comply with the plan and follow-up accordingly, often with no contact from the office in between scheduled visits. The plan of care was conveyed pretty much as "This is what you need to do. Go home, follow the plan, and tell me how you did when I see you at your next visit."

This traditional plan development did not incorporate input from the patient about what he or she might be able or willing to do. It did not address barriers that might impact compliance. It's conveyance often did not test whether the patient fully grasped or understood the diagnosis and plan– except to check for the proverbial head nod (often without necessarily checking for an accompanying deer in the headlights facial expression). While this characterization might be a little stark, historically, it is not far from reality.

We acknowledge that patients only remember about 65% of what was said during an encounter by the time they reach check out desk and recall only about 35% of the information by the following day. This is precisely why we are encouraged to provide written instructions and patient education materials. It is also a reason to involve caregivers, or other trusted individuals, during the patient's visits. Concerns of HIPAA issues have unnecessarily hindered this inclusion as all that is required is the patient's verbal consent – we just need to ask (barring a reason not to include significant others during the encounter).

The physician (or APP)…

- Outlines the ideal clinical plan of care
- Ensures the patient (and/or caregiver) understands the plan of care options ("repeat back" process works well)
- Determines what the patient can do or is willing to do (identifying significant barriers)
- Adjusts the plan of care accordingly (focusing on several high-priority items rather than a laundry list of many)
- Provides a written plan augmented by pertinent patient education materials (language and culture appropriate)
- Determines a follow-up time frame consistent with patient (and/or caregiver) realities
- Offers contact from the practice to check on progress, answer questions that might arise, and address unforeseen barriers that have arisen or are anticipated to arise.

Developing and conveying the plan of care may also involve the assigned medical assistant or care manager so that they can be a patient advocate, have firsthand knowledge of the encounter, and better assist with plan development, execution, and follow-up.

PLAN OF CARE EXECUTION

Traditionally, the patient was pretty much on his or her own from the time he or she left the office until the next follow-up appointment, unless the patient reached out to the practice in the interim. If the patient did not schedule a follow-up appointment, the practice might never realize that the patient did not return as requested or expected.

Patient-centric execution of the plan of care might contain the following elements to assist the patient in the process:

A designated member of the practice (e.g., care manager or medical assistant depending on the individual patient).

- Accompanies the patient and caregiver to the check-out area to be sure that all elements of the plan of care are covered; or conducts the checkout in the exam room prior to patient departure, including scheduling a follow-up appointment that is convenient.
- Incorporates patient-friendly options such as remotely connecting monitoring devices with an automated interface to the office record (e.g., blood pressure or blood sugar monitoring) instead of requiring patient maintained logs.
- Follow up with patient one to three days after the visit to review the plan, answer questions, and ascertain any unforeseen barriers.
- Proactively follows up with the patient if the patient is not heard from as planned – e.g., daily weights for CHF.
- Follow up further (weekly if appropriate) for status reports and further assistance as appropriate.
- Preps the chart for the follow-up appointment in advance of the appointment day, with further patient contact for critical or missing items.

Plan of care execution may also involve components beyond the office walls, such as conducting home assessments, connecting with other agencies or, community and social support networks, or addressing socioeconomic issues and barriers.

Adopting a patient-centric focus often means a complete paradigm shift for many practices' approach to patient access and care delivery – all the while keeping the patients' best interests in mind.

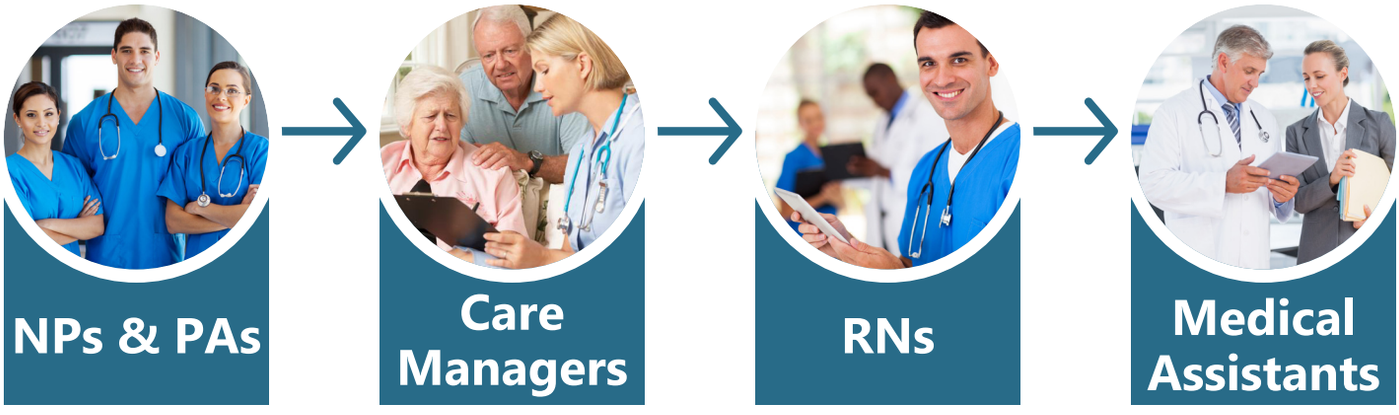
2. Introducing Team-Based Care - Shifting from Care Delivered by Individual Physicians to Care Delivered by a Team of Healthcare Professionals

When presented with the growing demands associated with quality reporting (ACOs, Quality Payment Program or QPP – aka MACRA), EMR utilization, and facets of clinical practice transformation, many physicians state, "there is no way that I can do all of that." That is actually the point of clinical practice transformation – changing the traditional "physician doing it all" approach to care delivery and adopting a team-based approach. This is an approach in which all team members have a role and are utilized at the top of their license and capabilities (which should be cultivated and grown). Embracing, progressively implementing, and fully-executing the new paradigm can be liberating. Clinging to the traditional model will lead to increased feelings of dismay, hopelessness, helplessness, and burn-out.

WHAT MIGHT THE TEAM-BASED APPROACH TO CARE DELIVERY LOOK LIKE?

Transitioning to team-based care seems like a fine idea, but what exactly does it mean and what does it look like? A good starting point is defining team member roles and anticipated outcomes. Assign each team member individual and group functions that maximize their license and capabilities, and then train them to do those and other advanced functions through role-specific competencies.

Team members and potential roles:



- **Provide direct patient care, including:**
  - Same-day access
  - Preventive care and wellness services
  - Stable, chronic conditions
- **Assist with care management activities**
- **Educate individual patients and groups**
- **Conduct group visits**

- **Initiate care management program encompassing:**
  - Transitional Care Management (TCM)
  - High-Risk Care Management
  - Chronic Care Management (CCM)
  - Rising Risk Care Management
- **Patient Navigation Initiate care management program encompassing:**
  - Transitional Care Management (TCM)
  - High-Risk Care Management
  - Chronic Care Management (CCM)
  - Rising Risk Care Management
  - Patient Navigation
  - Social Determinants of Health

- **Conduct Medicare preventive service visits**
  - Initial Preventive Physical Examination (IPPE – or more commonly referred to as the Welcome to Medicare visit)
  - Annual Wellness Visits (AWV)
- **Assist with patient navigation**
- **Train and supervise medical assistants**
- **Coordinate and supervise clinical operations, including triage, prescription refill requests**
- **Expand the practice's scope of services to include the RN skill set (ie immunizations, parenteral injections, etc.)**
- **Conduct or assist with patient education and group visit functions**
- **Assist with results review and telephone consultations**
- **Assist with determining and intervening in social determinants of health**
- **Patient triage (telephone)**

- **Perform the pre-visit screens/reviews**
- **Conduct the rooming-in process**
- **Be present for the provider-patient encounter**
- **Perform the post-visit follow-up**
- **Results and referral tracking program**

Then, utilize the newly-forming team to alter the approach to traditional office visits by working in phases before, during, and after the visit.

BEFORE THE DAY OF THE SCHEDULED VISIT

A pre-visit review is conducted one to two days before a patient's scheduled appointment. These are performed by the medical assistants, or involved care manager, and consist of the following elements:

- **Identify preventive and early detection screening opportunities**
- **Identify follow-up items from last encounter and determine status/results**
    - Follow-up on any outstanding/unaccounted for items
        - Referral management
        - Lab/imaging management
- **Identify unplanned encounters (e.g., ER reports) since last visit**
- **If reviewing a "new" patient, ensure intake materials are available – whether through hard copy completion on arrival for appointment or through a portal-driven process**

Appointment reminders can be built into this process – either office-based or automated.

ON THE DAY OF THE SCHEDULED VISIT

- **Assign medical assistants to patients/exam rooms – ideally aligned with patients whose records they screened the previous day. This type of assignment will often increase staffing levels, but will produce great dividends in patient engagement and provider fulfillment.**
- **Huddle team members with the provider(s) prior to the start of the schedule to review patients, plans, roles and desired outcomes.**
    - These should ideally only last about 15 minutes and can be conducted prior to each half-day schedule to be more efficient.
- **The medical assistant rooms the patient (with caregiver if patient permits) and ascertains and documents the following information:**
    - Chief complaint (reason for visit)
    - Ascertains if the patient has pressing concerns other than the stated reason for the visit
    - Verifies allergies/sensitivities and adverse reactions
    - Verifies Medication List (that patient is taking along with OTCs)
    - Performs vital signs
    - Determines status of social/behavioral issues
        - Tobacco use
        - Alcohol use
        - Appropriate screenings per office protocol – e.g., alcohol screen, depression screen, etc.
    - Confirms identified interim encounters – e.g., consultant, ED, hospital, or other care
    - Discusses and orders (via standing order protocol) recommended preventive and early detection screenings identified in pre-visit process with patient concurrence
    - Distributes patient education opportunities identified during pre-visit review or huddle
        - EHR generated
        - Practice specific
- **A care management interaction can be interposed if warranted**
- **Prior to provider entering the exam room, medical assistant informs of any additional or unforeseen patient concerns**
- **Provider's face-to-face encounter occurs**
    - Consider presence of caregiver/family (with permission)
        - Provides second set of ears
        - Potentially promotes greater understanding and compliance opportunities
    - Consider presence of medical assistant or care manager
        - Acts as additional patient advocate during the visit
        - Assists with medical record documentation of visit taking cues from provider (e.g., throat looks normal, no swollen glands, lungs are clear, etc.)
        - Affords first-hand knowledge of interaction to permit
            - Direct patient education and test of understanding after appointment
            - Entry of desired patient orders (except for prescription entry)
            - Follow-up contact with patient in one to three business days to address progress, questions, or barriers
- **Post visit follow-up as noted above**

Although clearly not a new concept,[2,3] team-based care and utilizing staff at the top of their capabilities affords great opportunities for practice efficiency, staff fulfillment, and provider well-being.

How Can I Afford All Of This?

Operating margins are tight. Additional staff costs money. How do you pay for this? A good question with several potential answers.

1

Some of the additional staff can perform functions that directly generate patient care revenue. The case for NPs and PAs is clear purely from the direct care, patient access perspective. Adding an RN to the practice can pay for itself in a short time. Shifting (or initiating) two or three Medicare AWVs per day to an RN generally pays for the RN's compensation and benefits. The remaining work day can be dedicated to performing additional AWVs, other roles listed above, or a combination thereof.

Care manager costs can be offset by pursuing Transitional Care Management (TCM) and Chronic Care Management (CCM) claim submissions. Each of these reimbursement codes has significant requirements but tool kits are available to assist compliance and calculators are available to determine cost/benefit ratios. Initiate a care management program by first focusing on TCM, which also more closely aligns with local hospital efforts and should result in synergistic patient and system benefits, and maybe even cost sharing opportunities.

2

Some of the additional staff can perform functions that free direct care providers for other revenue-generating purposes. For instance, if a direct care provider is conducting AWVs, shifting these to an RN continues the revenue stream but frees up a direct care provider for other visit types, which commonly generate higher reimbursement rates and are more professionally rewarding.

3

Partnering with other groups or organizations may permit cost sharing for shared resources, particularly for shared care management resources.

4

Pursuing payer contracts that provide care management resources for the practice or that pay a per-member, per-month (PMPM) component can allow incorporation of additional care delivery resources – including CMS programs like CPC+.

How Can I Afford All Of This? *(continued)*

5

CCM functionality can be outsourced to companies who perform the full array of CCM functions and charge a percentage of the CCM revenue generated by the practice, meaning the patient receives the CCM benefit and the practice receives additional revenue but does not incur overhead expenses.

6

Recent data indicate that "practices with more support staff per FTE physician not only report having higher levels of revenue, but also have increased productivity… across all specialties…"[4] (when used at the top of their capabilities in the type of framework described) and that "practices with a higher non-physician provider (NPP) to physician ratio (0.41 or more NPPs per full-time equivalent [FTE] physician) earn more in revenue after operating cost than practices with fewer NPPs (0.20 or fewer NPPs per FTE physician) regardless of specialty."[4]

While some of these transformation efforts are not inexpensive, resourceful pursuit of options and creative utilization patterns can mitigate, or even completely offset, **the associated incremental cost leading to financial success rather than ruin.**

3. Shifting from Face-to-Face, Office-Based Encounters to Managing and Coordinating a Patient's Health

Shifting focus consists of several components. The first shift comes at the traditional visit with an emphasis on the patient in the office to deal with the immediate aspect of the patient's care and existence.

The office visit focused primarily on the chief complaint(s) and/or pertinent diagnosis(es), how well the patient complied with the current/previous plan of care (when applicable), and the new/revised/continuing plan of care. As previously alluded, the patient bore the burden for compliance and checked in for status updates during further office visits. The shift to the new paradigm not only requires involving the patient and caregiver in plan of care design, but also involves greater consideration for, and involvement in, the "out-of-office experience."

The "out of office experience" requires a deeper level of investigation and exploration of the patient's social and socioeconomic circumstances to identify barriers to care and ways to mitigate them. Investigation may involve team members other than the direct care providers (like care managers), but the direct care providers must actively contribute to identifying potential issues, coordinating with team members, and assisting with follow-up actions.

The "out-of-office experience" also involves a closer relationship, or developing a relationship, with community-based agencies, organizations, and other groups that can offer patients support and intervention. Allies include the network of social service agencies, local churches, and other social groups pertinent to the patient. Many of these groups desire and welcome practice interaction to benefit the patient. These groups can have a profound impact on patient outlook, engagement, and action.

Another aspect of the "out-of-office experience" introduces proactive, ongoing contact with the patient between office visits. This process was alluded to in previous sections and assumes various forms, such as routine follow-up by the medical assistant one to three business days after an office encounter to clarify the plan of care, answer questions that arose since the visit, or discover unforeseen barriers to plan fulfillment. Other forms of this process include active, ongoing care management for higher risk patients or CCM follow through, or proactively tracking patient follow-through with ordered interventions and follow-up appointments.

EMBRACE TECHNOLOGY

A second shift from doing business solely through the traditional office visit was also alluded to earlier and involves progressive use of non-face-to-face encounter options. These include various aspects of telehealth, such as asynchronous interactions via secure email communications and text messaging and synchronous virtual visits via telephone or Skype. These options could be perceived as perilous in a pure fee-for-service environment, since the fee-for-service environment only reliably reimburses face-to-face encounters (in spite of progressive reimbursement of tele-health initiatives). However, reaching out to patients in this non-traditional fashion affords an opportunity to expand the practice's active patient population, and generate additional traditional fee-for-service visits.

These patient-centric interactions recognize patient conveniences and preferences while maintaining and advancing high-quality care. Employing these options becomes progressively important in value-based care initiatives and is crucial when functioning in a capitated reimbursement environment. Developing proficiency in these options establishes a favorable reputation in the community, attracts patients for whom these interactions are preferred – solidifying the practice's patient base – and prepares for contracts with increasing financial risk sharing. Pursuing these options requires analysis of the impact on revenues, including exploration and anticipation of expanding reimbursement opportunities, either through direct payment for the virtual encounters or through indirect payment via PMPM mechanisms.

PROACTIVE CARE

A third shift from doing business solely through the traditional office visit involves adopting proactive interactions with patients. The traditional office visit model relies on the patient initiating contact with the office, either to schedule a visit, seek advice, or request a specific service (like prescription refills or referrals).

This approach defines the practice's "active patients." Those patients who no longer contact the office become "inactive" and ultimately may be culled from the practice roster. Proactive patient contact in this context consists of two primary facets: reaching out to patients who fail to follow-up as requested and reaching out to patients who are "well," i.e., do not have chronic conditions that lead to regular contact with the practice.

Ongoing contact with patients between office visits, as advocated above, should minimize the number of patients who "fall through the cracks" by failing to follow-up as requested. Proactively contacting patients to remind them of planned follow-up care and when they fail to follow-up as scheduled, further closes the loop and portrays sincere concern for individual patient well-being.

This approach requires a system capability to determine when patients are due for follow-up or when they fail to follow through as planned. A robust referral tracking and lab/imaging tracking system are available in many EMRs and are strenuously advocated in PCMH and PCSP standards to help with these interventions.

Proactively scheduling follow-up appointments at the time of the original encounter or transition can also help. However, an adjunctive system may need to be implemented to ensure comprehensive follow through in all pertinent areas – especially those that arise during non-face-to-face interactions. Successfully implementing and executing such a system establishes the reputation of functioning in a caring environment, and reaps additional financial rewards as patients reliably follow through with recommended care.

Proactively reaching out to patients that do not have chronic conditions is a foundational population health management feature. Proactive contact with these "less active" patients allows the practice to actively partner in their health, encourages currency with recommended preventive and early detection screening interventions, and stimulates patients to be more fully engaged in their health.

A simultaneous shift in office offerings (such as health and wellness programs spearheaded by NPs, PAs, and RNs) provides even more concrete reasons to reach out to these individuals. The patient, the practice, and the entire health system reap dividends from these types of initiatives.

Success in the evolving value-based care environment *requires practices to concentrate on more than scheduled face-to-face patient interactions to not only survive, but to thrive.*

CONCLUSION

Clinical practice transformation can be confusing, disruptive, and expensive.[5] Breaking the process into digestible portions and developing a well-defined, well-planned, progressive approach to the transformative process makes it realistically achievable over time. Though every individual situation and circumstance is unique, common threads exist. Successful tactics include

- Tackling low-hanging fruit first to build confidence and to lay the groundwork for more complicated undertakings.
- Pursuing PCMH or PCSP recognition programs can provide a well-established, proven framework around which constructive change can be built.
- Adding staff members that make providers more efficient and/or directly generate additional practice revenue can offset associated incremental expenses and decrease the risk of burn out. Obtaining outside assistance can help catalyze the process, provide objective input, and unload a significant portion of the process from an already overly-burdened practice.
- Let us know how we can help by contacting a member of the HSG Leadership Team below.

GETTING STARTED

HSG works with health systems across the country to build high-performing networks. We want to help your network evolve through the Physician Network Growth Phases and develop the competencies it needs to thrive.

Please feel free to reach out to us to schedule a discussion about a performance improvement initiative for your network.

Terrence R. McWilliams
MD, FAAFP
HSG Chief Clinical Consultant

(502) 614-4292
tmcwilliams@HSGadvisors.com

References:

1. References regarding PCMH benefits available upon request.

2. P. Anderson, M. Halley, A New Approach to Making Your Doctor-Nurse Team More Productive. Family Practice Management, 15(7):35-40; Jul-Aug 2008.

3. N. Kuehl, Team-Based Care Leads to Financial Success. AAFP News, February 17, 2009. http://www.aafp.org/news/pcmh/20090217anderson-q-a.html

4. "Analysis of U.S. medical groups finds adoption of non-physician providers and support staff among factors driving more profitable and productive groups", MGMA Press Release, July 2017. http://www.mgma.com/about/mgma-press-room/press-releases/2017/analysis-of-us-medical-groups-finds-driving-factors-of-profitability-and-productivity

5. J. Belliveau, 63% Capitation Needed to Sustain Primary Care Transformation. RevCycle Intelligence, September 6, 2017.

Resources:

TCPi

"The Transforming Clinical Practice initiative (TCPI) is a four-year (September 2015-2019) technical assistance program designed to help clinicians expand their quality improvement capacity, engage in greater peer-to-peer learning, and utilize health data to determine gaps and target intervention needs."1

Transforming Clinical Practice Initiative. Centers for Medicare and Medicaid Services.
https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

Transforming Clinical Practice Initiative (TCPI). American Academy of Family Physicians.
http://www.aafp.org/practice-management/transformation/tcpi.html

PCMH, PCSP, PCCC

NCQA Patient-Centered Medical Neighborhood
http://www.ncqa.org/Programs/Recognition.aspx

HSG

HSGadvisors.com
502.814.1180
info@HSGadvisors.com