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Population Health NEWS

Supporting Population Health Through Care Teams

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As the demand for proactive, comprehensive and high-quality primary care continues to increase, the healthcare industry has been exploring ways to expand the care team infrastructure to allow for improved capacity and collaboration within this changing environment. Expanded, patient-centered care teams further support opportunities for improved costs and outcomes, better management of care needs across the continuum and increased rates of patient and provider satisfaction.

In today's complex healthcare environment, thinking must extend beyond clinical care to include non-clinical factors that affect health and how those factors are integrated into providing the best patient care.

Historically, the core staff within a practice setting includes a provider—physician, doctor of osteopathic medicine, nurse practitioner, physician assistant—clinical support (registered nurse, licensed practical nurse, medical assistant); and clerical support (medical secretary, check-in/checkout staff and registration and billing administrators). Traditionally, a core staff team allows providers to treat patients once they have presented to a clinic.

This is largely a response to fee-for-service environments, in which providers generate revenue by the volume of services provided to patients and healthcare delivery systems have limited incentive to proactively manage and coordinate patient care. However, with a renewed focus on patient experience, quality and prevention of adverse health outcomes, the traditional staffing model is evolving into a care team centered on not only patients' needs but also on overall quality of care.

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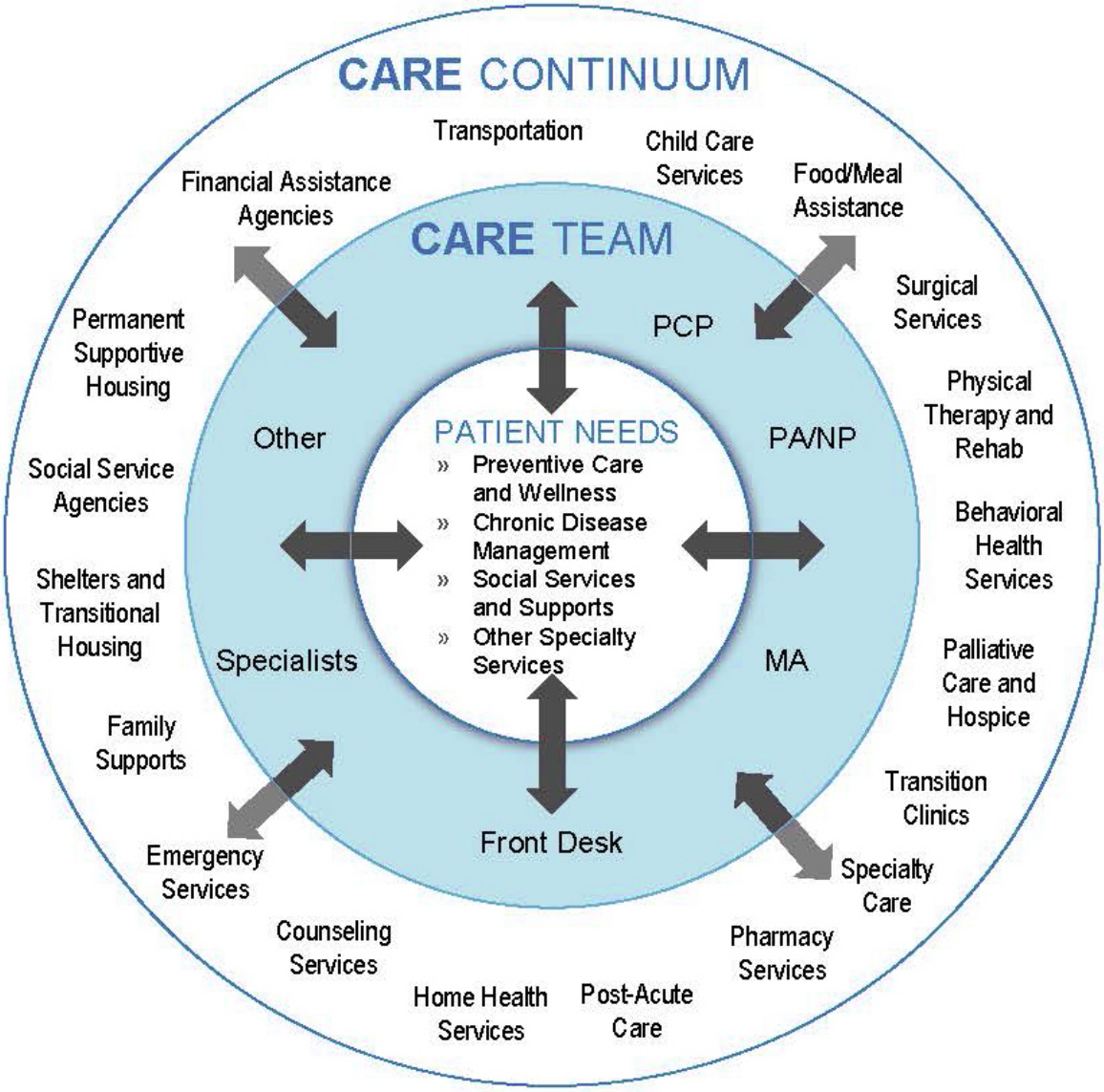
Today's care team focuses on the prevention, management and treatment of health conditions. It coordinates care for patients across a continuum and takes a holistic view of patients, including social determinants of health, mental health, nutrition and general well-being. As such, the care team has expanded to encompass traditional clinic staff as well as newer positions, such as health coaches, social workers, patient navigators and care managers.

Figure 1 — Expanded Care Team Model



Although care team models may vary slightly, all can be equally effective and impactful if designed correctly. To determine the optimal care team, a healthcare organization should consider three major factors:

- Needs of patients.
- Existing team roles and responsibilities.
- Costs and return on investment.

Needs of patients. The first step in developing a care team is to identify the needs of patients. Important considerations include demographics, clinical care needs (e.g., high prevalence of behavioral health issues) and social needs (e.g., lack of access to transportation or steady employment). A physician practice should assess the current patient population to develop a profile of patient needs. In tandem, it should examine clinical outcome measures to identify the greatest opportunity for improved care.

For example, if an assessment reveals a high prevalence of diabetic patients who do not receive regularly required testing, it may signal a need for care managers who can provide health education and remind patients about testing in order to improve outcomes.

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Existing team roles and responsibilities. Once a practice understands which new roles may be valuable, it should map out how additional staff members will operate within the existing care team structure. This can begin with optimizing the roles of existing staff members and ensuring that roles and responsibilities are clearly defined. A critical component of role optimization is to ensure that all individuals are working at the top of their licenses.

Clearly defining staff roles will allow a practice to assess any gaps in care that might exist. For example, if greater health education is identified as a need, a practice should decide whether existing staff can carry out any of those functions or if new staff is needed.

"Team-based care is defined by the National Academy of Medicine (formerly known as the Institute of Medicine) as "…the provision of health services to individuals, families and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

Costs and return on investment. Finally, in determining which staff members to hire and when, a practice should determine any associated expenses, including costs, to recruit, hire and retain staff. In addition, a practice should consider the potential return on investment for new staff. Given that government or commercial payers do not specifically reimburse many services provided by an expanded care team, practices should consider what additional revenue or savings opportunities could be generated through each role (see Table 1 below).

Table 1 — Care Team Financial Considerations

Staff	Role	Revenue/Savings Potential
RN Care Manager	» Provides patient education. » Ensures patient needs are matched with appropriate care. » Conducts transitions of care and care management functions. » Can perform traditional nursing roles.	» Additional nurse visits for established patients. » Ability to bill for chronic care management (CCM) and transitional care management (TCM) codes under Medicare.
Social Worker	» Manages social/environmental needs for patients that may be serving as a barrier to obtaining healthcare.	» Reduces lost revenue associated with no-show rates. » Improves adherence to care plans, leading to reduced readmissions or adverse health outcomes.
Pharmacist	» Provides medication management for patients on long-term medication. » Provides refills to patients (per physician protocols).	» Ability to bill for CCM and TCM codes under Medicare. » Increased pharmacy revenue (for practices with in-house pharmacies).
Care Coordinator (Nonclinical)	» Helps patients navigate their care. » Ensures appropriate health information is exchanged across settings. » Reminds patients of upcoming appointments, needed testing or other services.	» Reduction in readmissions (and readmission penalties). » Reduction in lost revenue associated with no-show rates. » Additional visits associated with preventive care and needed care for certain populations.

In addition to revenue considerations outlined in Table 1, practices can also negotiate alternative payment arrangements with payers, such as pay for performance or shared savings, that reward providers for better managing population health. These arrangements may offer greater revenue potential for enhanced services not available under fee-for-service arrangements.

For any practices considering a move toward greater population health, now is the time to consider a care team and resources available to support population health efforts. Planning now will better prepare practices for the future in an increasingly complex and demanding healthcare environment. In addition, carefully sequencing activities by assessing needs, optimizing existing team roles and thinking through cost implications will help practices avoid duplicated efforts and negative financial outcomes and result in a positive impact on patients, providers and a communities.

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