Lean in Healthcare: Collaborative Care

Overview:

- Physician practice (4 providers + care teams), part of larger primary care delivery system (9 practices, 76 providers)
- Physician practice taking *care* of chronic disease patients to a new level
- Financial: increased RVU/visit by 32%
- Quality outcomes: collaboration care model outperformed traditional care model in 9 of 10 key measures (LDL, A1C, BP, screenings, etc.)
- Patient satisfaction: top 2 in system for 8 years running
- Staff/Provider satisfaction: #1 in system (2009-2013)

Collaborative Care

Today's physicians' practices have many priorities to balance such as: disease management, quality of care, patient satisfaction, staff satisfaction, provider satisfaction and financial performance.

In one of our client's practices all of these features and attributes of care are being practiced and demonstrated, under a model for patient care called collaborative care.

Background: In the collaborative care model, the primary attribute is the true practice of *collaboration*. Collaboration of *care* amongst the provider, specialty RN and patient and coordination of care across specialists, primary care, hospitals and other services. Patients are nominated into the program and sign a compact agreeing to work with their care team to jointly achieve the goal of improving both health and lifestyle. Patients nominated are typically the *most* chronic of patients with 49% having multiple comorbidities. The practice provides both traditional models of care (FFS + population health) as well as *collaborative care* (specialty RN, provider, patient) and makes clear determinations where the collaborative care model will provide the most *value* (outcomes, satisfaction, medical expense) to the patient, provider and health system.

Care model: Collaborative care represents a fundamentally different approach to working with our (primarily) chronic disease patients. Instead of the traditional population health RN working from *lists*, making phone calls and *hoping* to influence patients, the role of a *specialty RN* has been configured and *standard work* has been defined for the activities/actions key to achieving the desired results (clinical, financial and personal return on investment).

The role of the specialty RN is configured to manage, coordinate and collaborate on the care of patients. Patient outreach, telemed, chart review, lab test review, coordination/communication with specialists, etc. are planned and expected. Where needed, social services, food pantry, transportation, etc. are coordinated. Most importantly the patient is at the center of the care provided with focus on improving or maintaining health as the objective.

The specialty RN's role is not limited to outreach and phone calls. The specialty RN is also the initial care provider for patient visits, performing 65+% of the patient *visit* prior to the physician engaging in the exam.

Key Points: Collaborative Care

- Patients nominated into Collaborative care program
- Specialty RN used to outreach, clinical oversight, patient communication and patient visit
- Clinical huddle used to transfer key information from specialty RN to provider.
- Provider must have confidence in specialty RN activities

Results:

- Specialty RN elevates traditional 99213 (2.34 RVU) visit to 99214 (2.76 RVU) and 99215 (3.67 RVU) visits
- Physician time for *chronic* patients reduced from 30-45 min/patient to 15 min/patient (increased Capacity/Access)
- Clinical outcomes for patients in *collaborative care* outperformed traditional care in 9 of 10 categories

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Care model (continued):

It is in this shift toward team based care that the provider's role shifts from (believing that they must perform) 100% of the patient visit to understanding that it is more important that they perform 100% of the right part of the patient visit.
This same approach is used as the *process* by which key decisions are made to support each of the clinical skills within the practice operating at the *top of their licensure* (PSR's, MA's, RN's, LPN's, NP's, MD's).

Financial Impact: The actions (practice processes) above directly and indirectly impact the primary care financial model. The keys to financial viability lie with three primary elements:

- RVU/visit: In the collaborative care model, the specialty RN (in following their standard work), earn extra *points* for medical records review, review of labs/tests, provide medical guidance … etc. These points enable a traditional '99213' office visits to be coded as 99214 and 99215 visits. When properly documented and supported in the medical record, these additional codes are both clinically and financially appropriate.

- Increased visits/capacity: When executed and communicated properly, the pre visit, between visit and clinical huddle activity translates into a more complete medical profile of patients for the provider (prior to entering the exam room). When coordinated properly with scheduling, room assignments, specialty RN and provider, the traditional 30-45 minute *chronic care* visits (for the provider) can now be effectively completed in 15-20 minutes. The net effect being more *capacity* per provider and a subsequent increase in *access* for each provider.

- Shared risk: A derivative of improved quality should also be a net reduction in hospital costs, ED visits, severity of conditions and need for specialty services. For the collaborative care practice, these elements were reinforced with health plan data associated with overall medical expense, in-patient costs, and ED visits. In a region where the CMS adjusted rates averaged 22% higher than average, the practice (overall) had total lower medical expenses (-17%), ED costs (-28%) and in-patient costs (-21%) than the region.

- For this 9 practice medical group, the pilot practice represented only 3.8% of the total patient population, however accounted for 11% of the total *shared risk revenue* ($217k)

Does the math work?
Using a $70,000 salary for a specialty RN and RN 'capacity' of 8 collaborative care patients per day per specialty RN, the increase in traditional FFS revenues (increased capacity + increased RVU/visit) provided a net +$51, 459, *before* shared risk revenues were included ($217k)

Patient, staff and provider satisfaction:
Across the 9 practice medical group, this practice for the past 7 years, has consistently ranked in the top 2 of all practices for overall patient satisfaction, and #1 in both staff satisfaction and provider satisfaction (2009-2012). In an era where it is far too common for primary care physicians to work until 7, 8, 9pm, collaborative care has enabled a 5-6pm work day to become the norm.

Summary:
The role of collaborative care as a key component in support of primary care and achieving the clinical objectives desired in a Patient Centered Medical Home (PCMH) are evident. Collaborative care in itself does *not* address all the needs of a community, however does address the specific needs for those who are often the most demanding patients within a patient panel. When coupled with an integrated practice level PCMH strategy, collaborative care both supports and reinforces the practice processes key to effective clinical, financial and interpersonal management of all patient panels.

Visit	Visit Time	RVU	Revenue @ $37/RVU	Total Rev/provider hr	Comments
Traditional Care Model	30 min	2.9 RVU 20% - 2.71 80% - 3.66	$107.30	$214.60	Minimal/no pre visit work. 95% of patient care completed by provider. Emphasis on having *minimal* clinical staff to support Provider
Collaborative Care	15 min	3.28 RVU 40% - 2.71 60% 3.66	$121.36	$485.44	Pre visit work completed by Pop Health/ Specialty RN. Clinical huddle completed by Provider-RN. RN has appropriate time for clinical analysis, records review, patient education… etc to optimize visit (and coding)

Additional revenue/hr due to Collaborative Care	= $270.84
RN Salary	= $70,000
Target 8 chronic visits/day (2 Provider hrs)	= $541.68 ($270.84/hr x 2 hrs)
# days required to break even	= 129 days (26 weeks)
Incremental $ @45 weeks (19 weeks x $541.68/day x 5 days)	= $51,459.60

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