

Bright spots

... in primary care

Team-based care in BellinHealth, Green Bay, Wisconsin

Tom Bodenheimer MD and Sara Syer MS, PA-C,
April 2016

We spent a full day talking with leaders and shadowing care teams at the BellinHealth Ashwaubenon Family Medicine Center.

BellinHealth is a not-for-profit integrated provider organization serving Northeastern Wisconsin and Michigan's Upper Peninsula. Bellin's leadership is impressive and dedicated. Bellin's population tends to be white working class and elderly patients with significant rates of chronic illness. Starting in 2014, Bellin initiated team-based care, with family physician James Jerzak the initial team-based care champion. As of April 2016, 27 clinicians – 16 physicians and 11 advanced practice clinicians at 6 sites – have gone live using the standardized processes of team-based care.

Each team includes 2 clinicians (physicians or advanced practice clinicians -- NPs or PAs), 4 care team coordinators, and 1 RN. Two care team coordinators (CTCs) almost always work with the same clinician; all 3 know their patients and the

Site profile

Name: BellinHealth

Location: Green Bay, Wisconsin

Type of practice: Not-for-profit integrated provider organization includes 2 hospitals, 32 primary care sites, 12 specialty practices, 4 retail clinics, 125 employer-based clinics, and a learning and innovation center

Payment model: Mostly fee-for-service with some risk contracts, including a Medicare ACO contract

Electronic Health Record: EPIC

Take away messages

- Bellin is instituting a team model that groups two assistants (MA, LPN, or LVN) per provider.
- Assistants receive extensive training on using the electronic health record and conducting population management. During the patient visit, one assistant "takes care of the computer" while the provider focuses attention on the patient.
- Bellin is closely tracking the business case for this team model. Increased productivity and more comprehensive visits are expected to cover the costs of the additional personnel.

patients know them. CTCs are LPNs or MAs who receive extensive on-the-job training for their new role.

We asked, What is the main function of the care team coordinator? The answer was: to re-establish the clinician-patient relationship which has been fractured by the advent of the EMR. We observed that during patient visits, the EMR was unobtrusively sitting at the corner of the room, no longer interfering with the clinician-patient relationship. The CTC entered information in the EMR and handled all the documentation and order entry. It was clear that a strong team-patient relationship existed; the patients we observed showed great trust in the CTCs.

We were able to observe 3 clinicians and 3 CTCs caring for 5 patients. Each team works in a co-located space so that clinicians and CTCs are constantly talking with one another. At 8 AM sharp, each clinician and 2 CTCs huddled for 5 minutes to discuss the day's schedule.

The following are excerpts from 3 patient-team visits.

Ms. G is empaneled to Dr. Jerzak, Jami and Sarah (CTCs always working with Dr. Jerzak).

Jami had talked with Ms. G on the phone and knew that Ms. G had lost her father yesterday. Sarah spent about 10 minutes on the pre-visit with Ms. G, taking the history and entering it into EPIC, doing medication reconciliation, entering prescription refills needed, making sure the agenda for the visit was clear, checking vital signs, and discussing care gaps (in this case Ms. G was overdue for mammogram and colorectal cancer screening). Jami arranged for the mammogram and discussed colorectal screening options.

When Dr. Jerzak came in, Jami summarized the situation and Dr. Jerzak spent some time talking about her father. Dr. Jerzak asked questions about some musculoskeletal symptoms that Ms. G had described to Jami. Jami added the new information to the history she had entered into the EMR. The physical exam template is a list of normal findings, and when Dr. Jerzak did the PE, Jami edited the template for abnormal findings. Ms. G's lab had been done the day before and Dr. Jerzak discussed it with Ms. G. Dr. Jerzak discussed the musculoskeletal symptoms and offered physical therapy referral. He then spent a few more minutes giving Ms. G choices about her borderline-elevated blood pressure and discussing other aspects of Ms. G's life, and left Jami to finish the visit. During the visit, Jami was entering diagnosis codes into the EMR, pending new orders for lab, imaging, referrals, and medication changes, and putting in the billing codes.

In the post-visit, Jami, who knew that Ms. G did not want colonoscopy, taught Ms. G how to do colorectal cancer screening with a Fit test. She arranged the physical therapy referral, first asking what dates and times would be convenient. She checked about Ms. G's physical activity goals and briefly went over the after visit summary with Ms. G. Jami made an appointment for a follow-up visit in 6 months, including a lab draw the day prior to the appointment. She did a PHQ9 and warm hand-off to the behaviorist -- who supports several teams -- to talk to Ms. G about her father's death. Jami invited Ms. G to contact her or Dr. Jerzak through MyChart (patient portal) and concluded the visit.

The entire visit took about 30 minutes, with Dr. Jerzak's portion about 15 minutes. Even though several issues were on the agenda, the visit did not seem rushed, and plenty of time was spent on family and social talk. After the visit, before seeing the next patient, Dr. Jerzak spent 3 minutes going over Jami's notes, making a few additions and edits to Jami's present illness, co-signing the orders and meds pending by Jami, and closing the chart before seeing the next patient.

Mr. L. is empaneled to Dr. Jerzak, Jami and Sarah

He is a 52 year old working-class man with obesity, pre-diabetes, knee pain, acute poison ivy rash, and a tobacco use. He recently gained 6 pounds. In the pre-visit, the care team coordinator, Sarah, arranged for Mr. L to see the social worker after the visit to discuss a job issue. Sarah took much of the history, entered it into EPIC, did med rec and checked for care gaps on cancer screening, diabetic labs, and other routine services. She did routine med refills. Mr. L said that he walked 4 miles a day before his knee problem, which Sara applauded. She discussed his eating habits briefly. When Dr. Jerzak entered, Sarah slipped him a tiny note: Mr. L is using opioid pain medications from another physician.

In the visit, Sarah edited her present illness as Dr. Jerzak elicited new information. She brought up colorectal cancer screening, which Mr. L had declined. Dr. Jerzak convinced him to do a colonoscopy by saying that Vince Lombardi, the iconic Green Bay Packer coach who died of colon cancer, might be coaching today if he had done a colonoscopy. Sarah pulled up Mr. L's knee x-ray report and Dr. Jerzak went over it with Mr. L and together they made a care plan. Sarah, very fast and competent on entering data in EPIC, entered physical findings, billing codes, labs and med orders almost before Dr. Jerzak asked her to, showing how comfortable the Dr. Jerzak-Jami-Sarah team are with one another. As in the previous visit, substantial time was spent with Dr. Jerzak asking about Mr. L's life in addition to discussions about the poison ivy, knee pain, pre-diabetes, opioid use and tobacco use. It didn't seem rushed.

After Dr. J left, Sarah printed out the after visit summary and went over it with Mr. L, highlighting important items. For a somewhat complicated instruction – how to use the steroid cream for the poison ivy rash -- she explained it carefully. She found out where and when Mr. L wanted to do the colonoscopy and researched where this service is available in Mr. L's town and covered by his insurance. She discussed his weight and smoking, and ordered labs for the morning of the next primary care visit (most results available in 1 hour) in 2 months. She asked Mr. L to fill out a patient survey asking how the visit went.

Ms. W, empaneled to nurse practitioner (NP)

Ms. W is a 60 year old woman, former smoker, with an acute exacerbation of COPD; this was an acute visit rather than a multi-problem chronic care visit. The care team coordinator had done a short intake visit, obtaining a history, doing vital signs and asking about second-hand smoke exposure. When the nurse practitioner entered, the CTC began documenting the visit, entered the nurse practitioner's physical exam findings and refills for a long-acting bronchodilator inhaler and short-acting bronchodilator in the EMR. The NP offered the patient a steroid burst but Ms. W preferred not. After the NP left the room, the CTC printed out and reviewed the after visit summary in the room. Ms. W also had a billing question about a previous visit and was referred to the billing department. Both the NP and CTC had rapport with Ms. W and the computer was not evident in the NP-patient relationship.

The 3 components of team-based care

1. Redesign of the office visit

- Pre-Visit: Before the provider enters the room, the Care Team Coordinator, (CTC), a role filled by a medical assistant or licensed practical nurse, performs expanded rooming functions including: agenda setting and preliminary documentation, refill management, and care gap closure using standing orders.
- Visit: The CTC hands off the patient to the clinician for the conventional "visit", and then while the clinician directly engages with the patient with no EMR distraction, the CTC, who stays in the room, continues documenting and pending orders for consults, x-rays, referrals, or new prescriptions.
- Post-visit: After the clinician leaves the room, the CTC puts the plan in

motion by finishing pending the orders, setting up the next appointment and pre-visit labs, reviewing details of the after visit summary with the patient, along with health coaching and goal setting. Meanwhile, the clinician will go out to the colocation space, review and edit the documentation, and co sign the orders and meds pending by the CTC. Charts are usually closed before going into the next room with the second CTC. There is no need to carry the details of one patient in one's mind while moving to the next. There is no need to take work home at night, since it is finished by the end of the day, thanks to the involvement of the team.

2. In-basket management

Task delegation of inbox messages can save an hour or more of physician time per day. Test results that come to the inbox are usually handled by the same CTC who saw the patient, extending continuity. If normal, the CTC contacts the patient. If abnormal, the clinician and the CTC discuss abnormal results, and when necessary involve the RN. Co-location of nurse, MA and physician makes in-basket management efficient, eliminating the limitations of electronic communication.

3. Population health management

Extended care team members such as case managers, diabetic educators, clinical pharmacists and RN care coordinators work closely with the core team of MA, nurse, and physician, to optimize management and improve outcomes for each panel of patients, with an emphasis on high risk or complex patients.

Training care team coordinators

Dr. Jerzak trained Jami, the first CTC, with on-the-job training without a training curriculum; they figured it out as it happened. A curriculum (training plan) was developed and Jami and other experienced CTCs became the trainers of clinicians and new CTCs. The experienced CTC's did training during half-days when their clinician was out of the office. In the training, clinicians and CTCs learn what happens in the pre-visit, visit, post-visit, documentation issues, and in-basket work. Teams do role plays, 3 days of observation and feedback, and a dress rehearsal walk-through before a team is ready to go live. Schedules are blocked for reduced visits during the first go-live week. In general, there is a 16 week program for training teams, which includes such things as change management, team culture, population health basics, goal setting, motivational interviewing, and documentation

basics. The week before go-live there is an intensive 3 day session training on EPIC, where teams work together to determine preferred templates and learn many aspects of electronic health record work. There is also mentoring in the first weeks of go-live in order to make sure all processes are performed correctly. Bellin understands that diluting the rigor of the training could lead to poorly performing teams. Bellin has also developed an 8-week training process for CTCs that are hired into existing teams.

Hiring CTCs

Bellin has found that it makes little difference if a CTC has a MA or LPN background. What is important is attitude and ability to learn. 70-80% of people can perform the CTC function; a few will be great, most good. Spotting people who are not enthusiastic about the new role is important; they would not work out as CTCs. More CTCs are needed than two per FTE clinician to cover for vacations and absences and to help with training.

The extended care team

Practices initiating team-based care need to decide on sequencing -- which team functions to develop first and which later. Bellin has focused on the core team (which some practices call the teamlet) of one clinician and two care team coordinators. Some work has been done on the RN role and the extended care team role, but these are less developed than the core team roles.

RNs will be transitioning from full-time performing triage and in-basket management toward chronic care management. This transition has started with RNs scheduled for some Medicare wellness visits, with CTCs taking on some triage and in-basket responsibilities to clear time for RN chronic care management. This work is at an earlier stage than core team development.

The extended care team, supporting 3 or 4 core teams, includes social worker, behaviorist, pharmacist, and RNCC (RN care coordinators for complex patients with high rates of ED and in-patient utilization). Because Bellin has 10,000 ACO (Next Generation Medicare Accountable Care Organization) patients for whom it receives shared savings revenue if the patients' costs are below a benchmark cost level plus high quality, the RNCCs focus on improving the care and reducing the costs of high-utilizing patients. The entire extended care team is available to assist the RNCCs with high-utilizing patients, and extended care teams meet regularly to discuss their complex patients.

The business case

Expenses to implement team-based care include additional staff (expanding from 1 to 2 support staff per FTE clinician), training time which reduces productivity, and facility changes to allow co-location of teams. Assuming that most revenues are fee-for-service, paying for these improvements requires clinicians seeing 1 – 2 additional visits per day and billing more 99214 codes which generate more revenue than 99213 visits. The 99214 codes are justified by 1) the longer team-care visits address more diagnoses, and 2) the CTCs provide more rigorous documentation. Bellin has found that some clinicians have generated more than enough additional revenue to pay for the CTCs on their team, but that not all clinicians have done so. Bellin is analyzing coding and productivity patterns of each clinician in order to focus feedback and training where it is needed. Bellin's leadership understands that for team-based care to be spread to all primary care clinicians and to be permanently sustainable, all clinicians need to generate sufficient additional revenue to pay for their team. In addition, a 10% increase in panel size per clinician would reduce system expenses by requiring fewer clinicians per patient population. Bellin has no interest in creating a team-based care model that loses money and is thereby short-lived.

Concluding thoughts

We have visited many primary care practices and have shadowed many care teams. This was the most impressive team-based-care model we have seen, and the model has been carefully implemented. Bellin's team-based care addresses all four of the quadruple aim elements: population health, patient experience, costs of care, and clinician/staff experience. These elements are being tracked and thus far are improving under team-based care. A key lesson is that to address the entire quadruple aim, it is necessary to have 2 clinical assistants (in Bellin's case, care team coordinators) per FTE clinician. In addition, Bellin understands that if there is no business case for the team-based care model, it will not survive over time.