MEDAXIOM
AN ACC COMPANY

High Performing Work Teams

Enhancing patient outcomes & professional well being

Joel Sauer, Executive VP Consulting

Presented to:

Indiana CHAPTER

Joel Sauer, MBA
Executive Vice President
jsauer@medaxiom.com
(260) 245-1015

Experience

- Former physician group & hospital system physician enterprise CEO
- Author of annual comp & production survey
- Depth in strategy, governance & leadership, provider compensation, co-management, physician/hospital integration models
- Consultant for 9 years

Disclosures

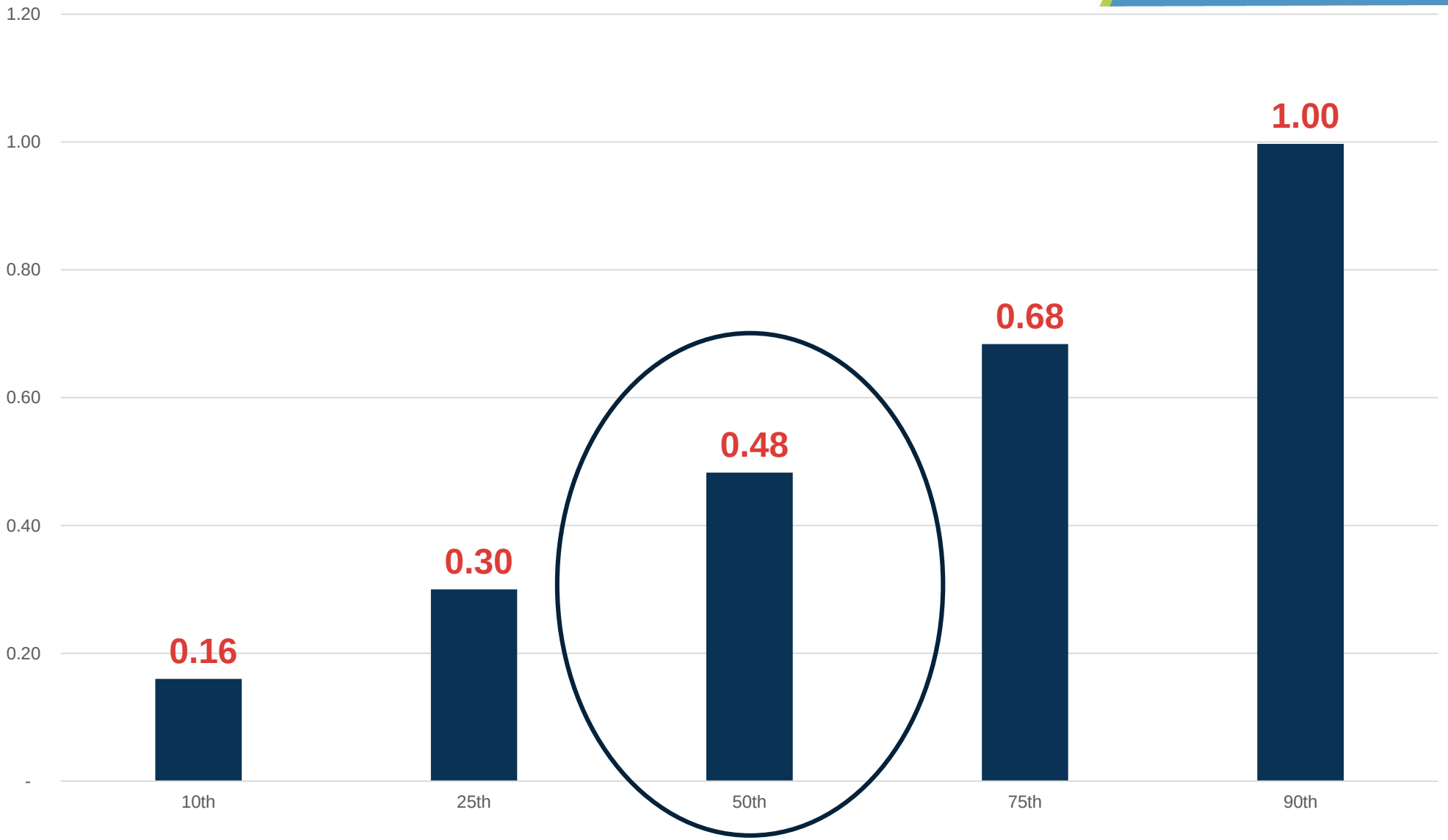
- None
  - Other than being a consultant!

Live Content Slide

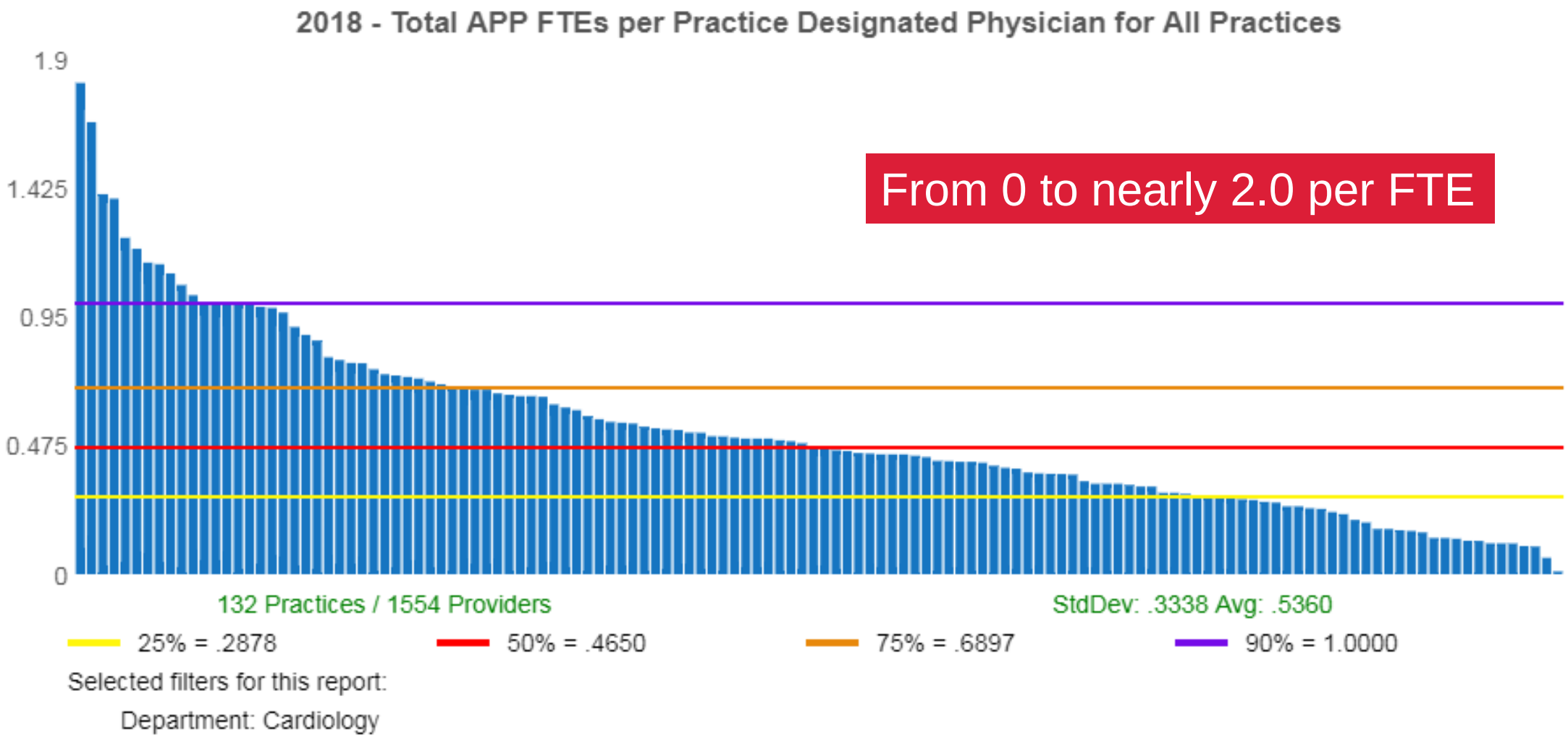
When playing as a slideshow, this slide will display live content

Poll: How many APPs does your practice have per physician FTE?

APP FTEs per Cardiologist



No ‘best practice’ yet in cardiology



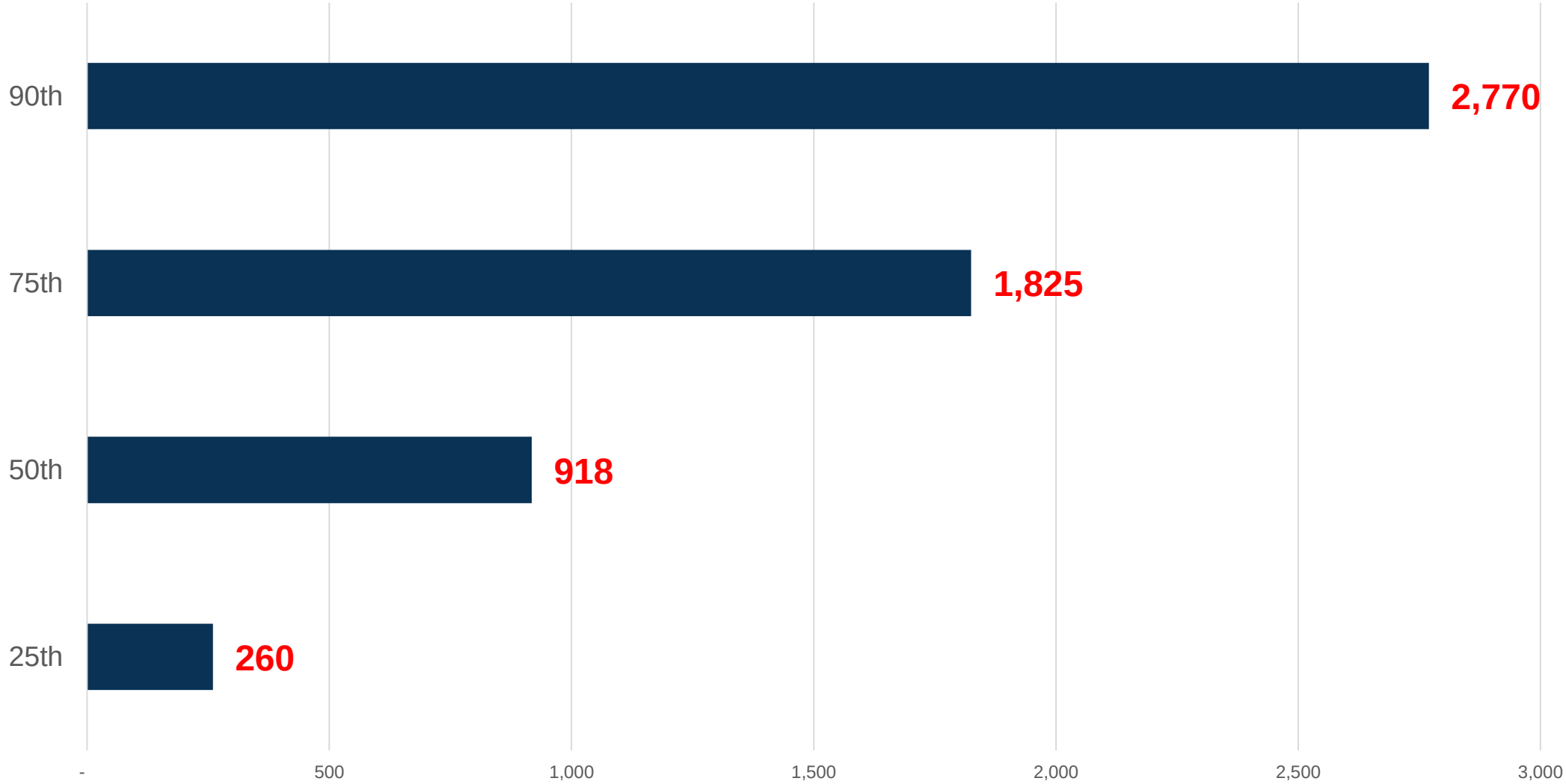
Live Content Slide

When playing as a slideshow, this slide will display live content

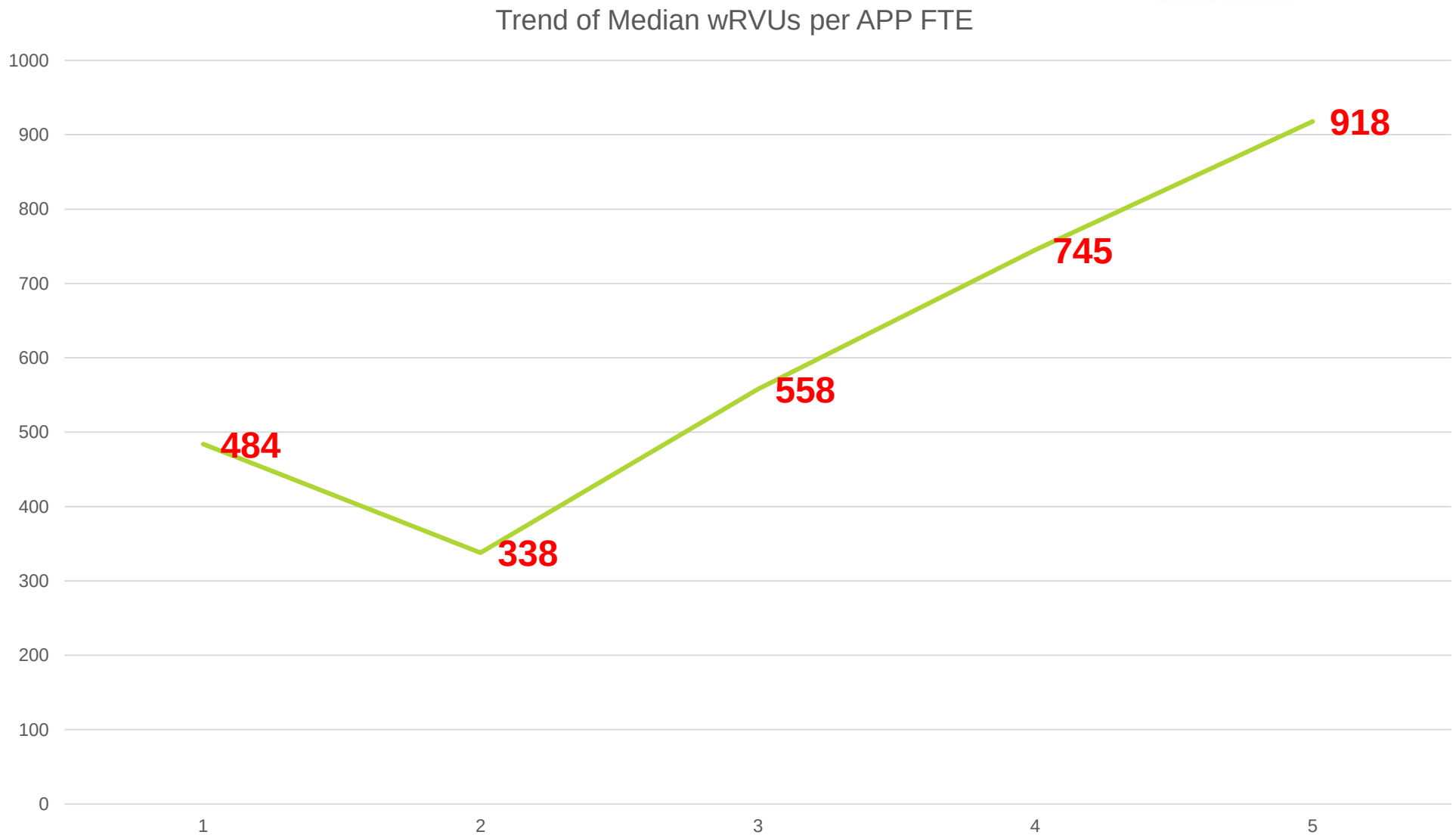
Poll: How many annual wRVUs (on average) do your APPs personally perform?

wRVU Production per FTE

Figure 9: wRVU Production per FTE APP



Making Progress!



Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What is a reasonable annual expectation for total APP wRVUs?

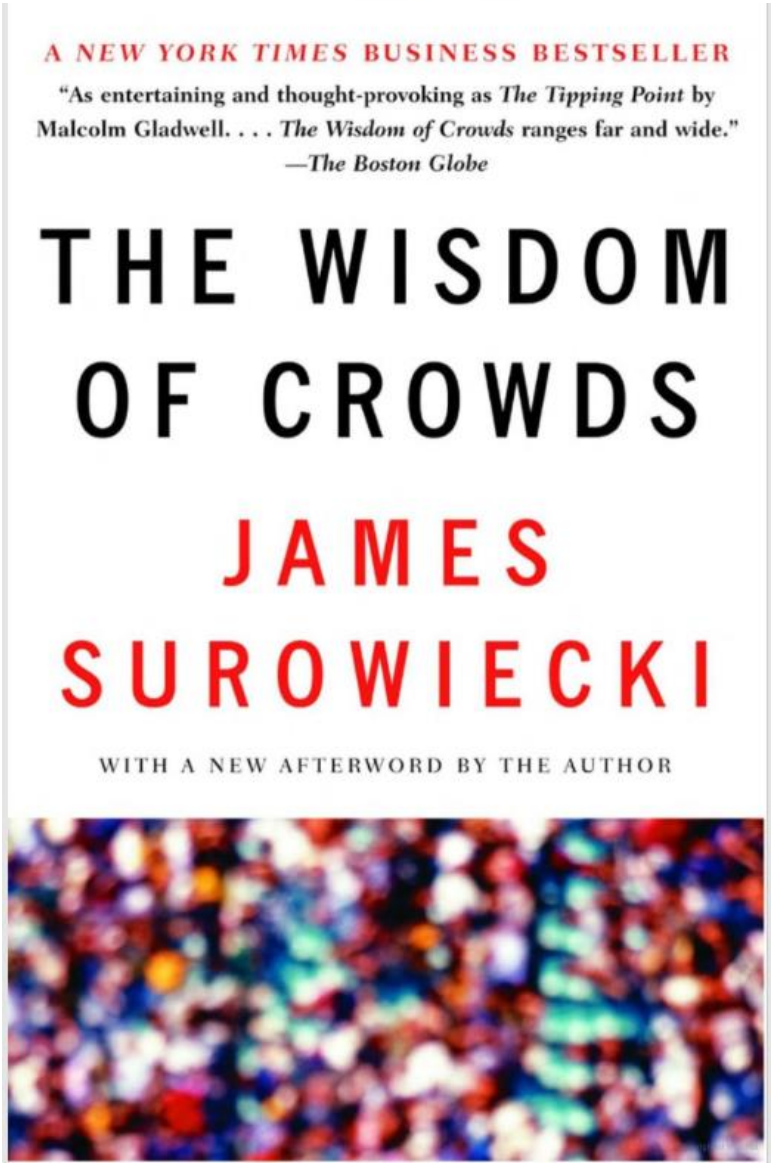
Live Content Slide

When playing as a slideshow, this slide will display live content

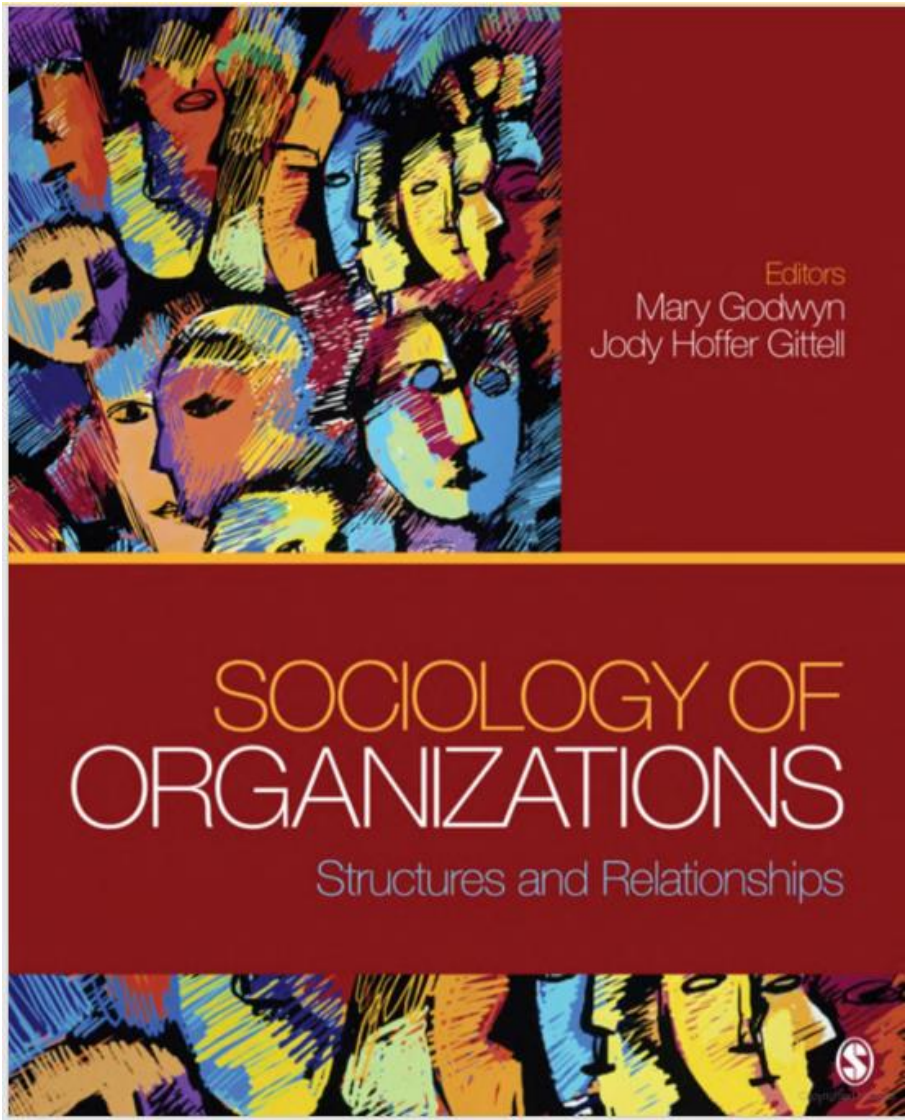
Poll: In my group, our cardiovascular work team is:

Why the Many Are Smarter Than the Few and How Collective Wisdom Shapes Business, Economies, Societies and Nations

… and healthcare!



"[Individuals in healthcare] are contexts in which autonomy works against learning"

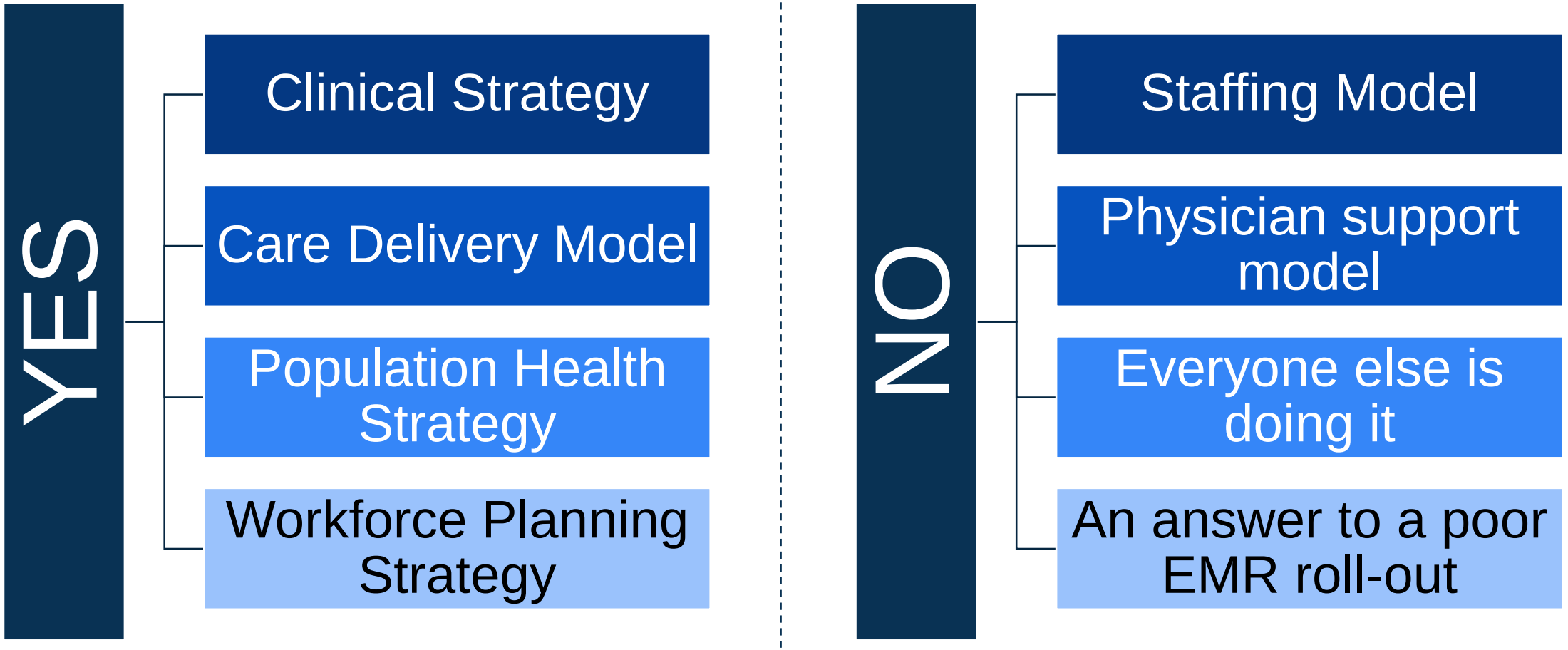


What is a Care Team?

A clinical care team for a given patient consists of the ***health professionals***—physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals—with the training and skills needed to provide ***high-quality, coordinated care*** specific to the ***patient's clinical needs*** and circumstances.

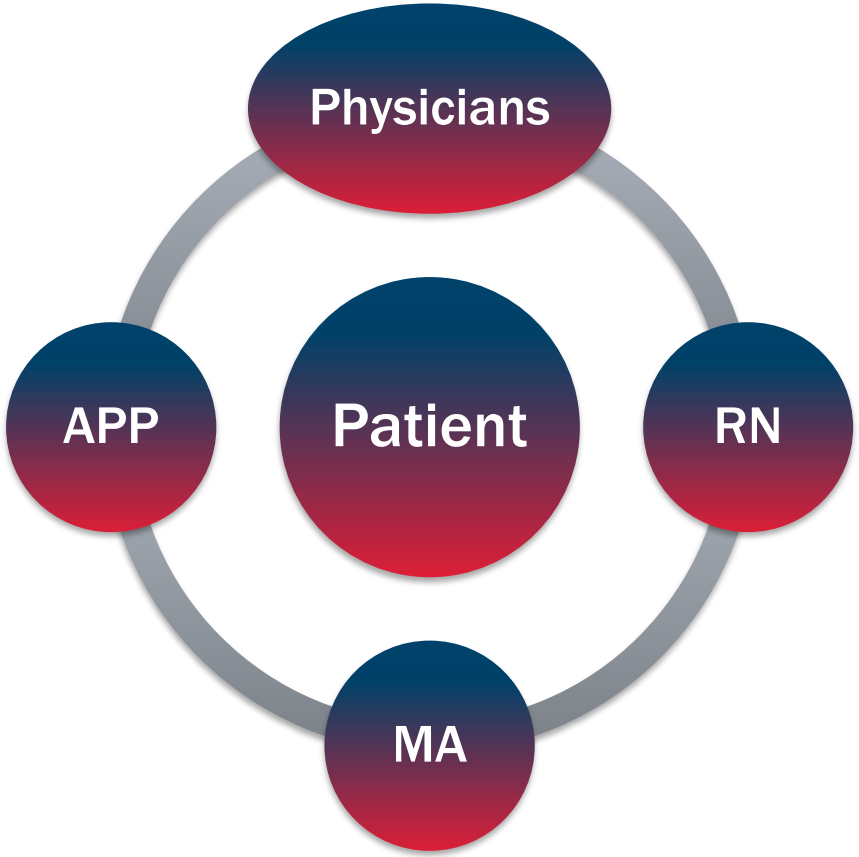
Source: "Principles Supporting Dynamic Clinical Care Team: An American College of Physician Position Paper" Nov 3, 2013, Doherty, Crowley

Team Based Care

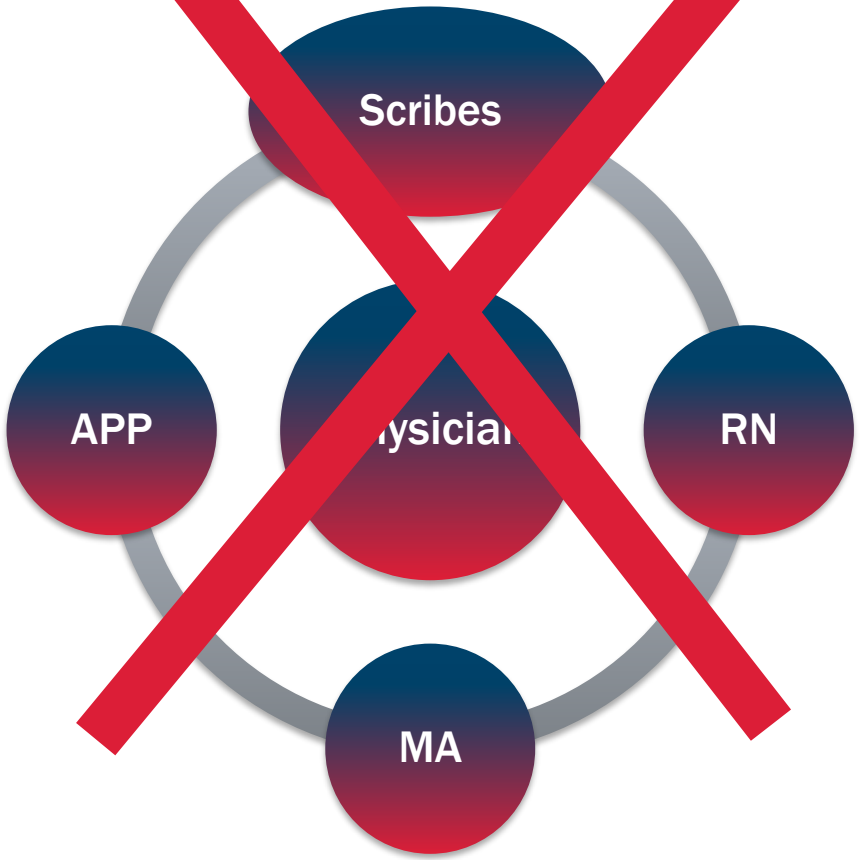


Care team strategy

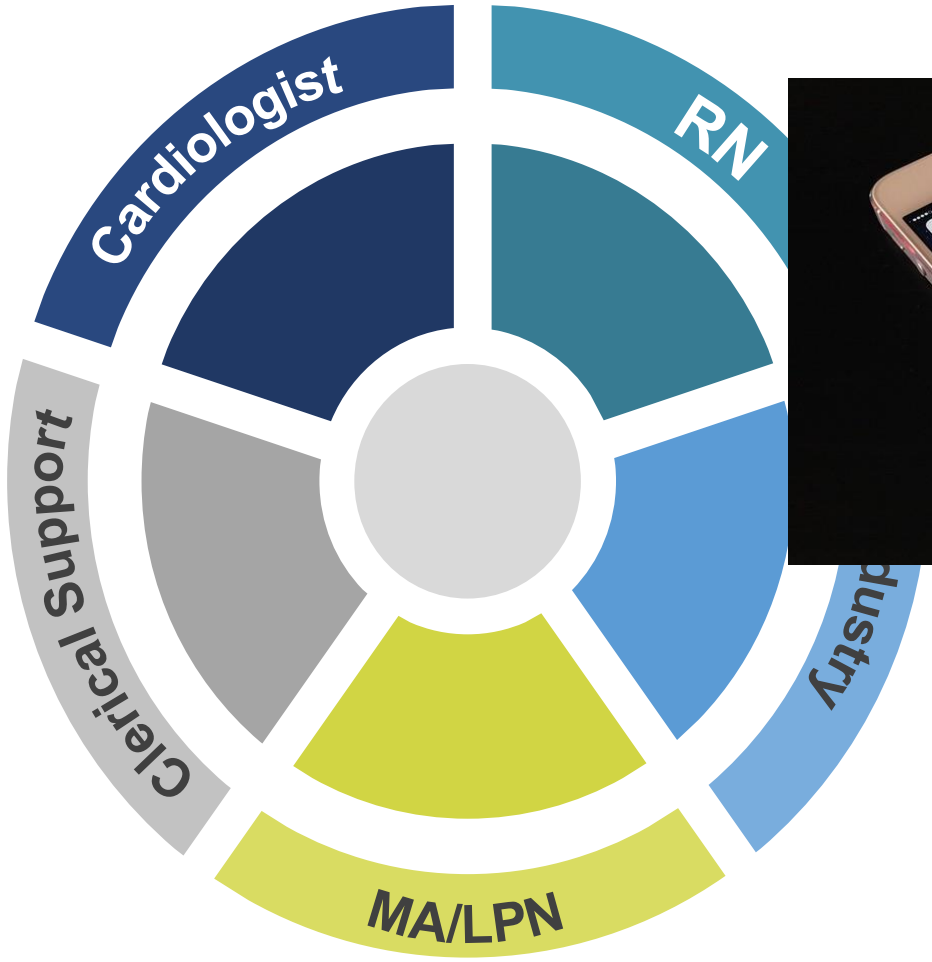
Panel Support



Physician Support

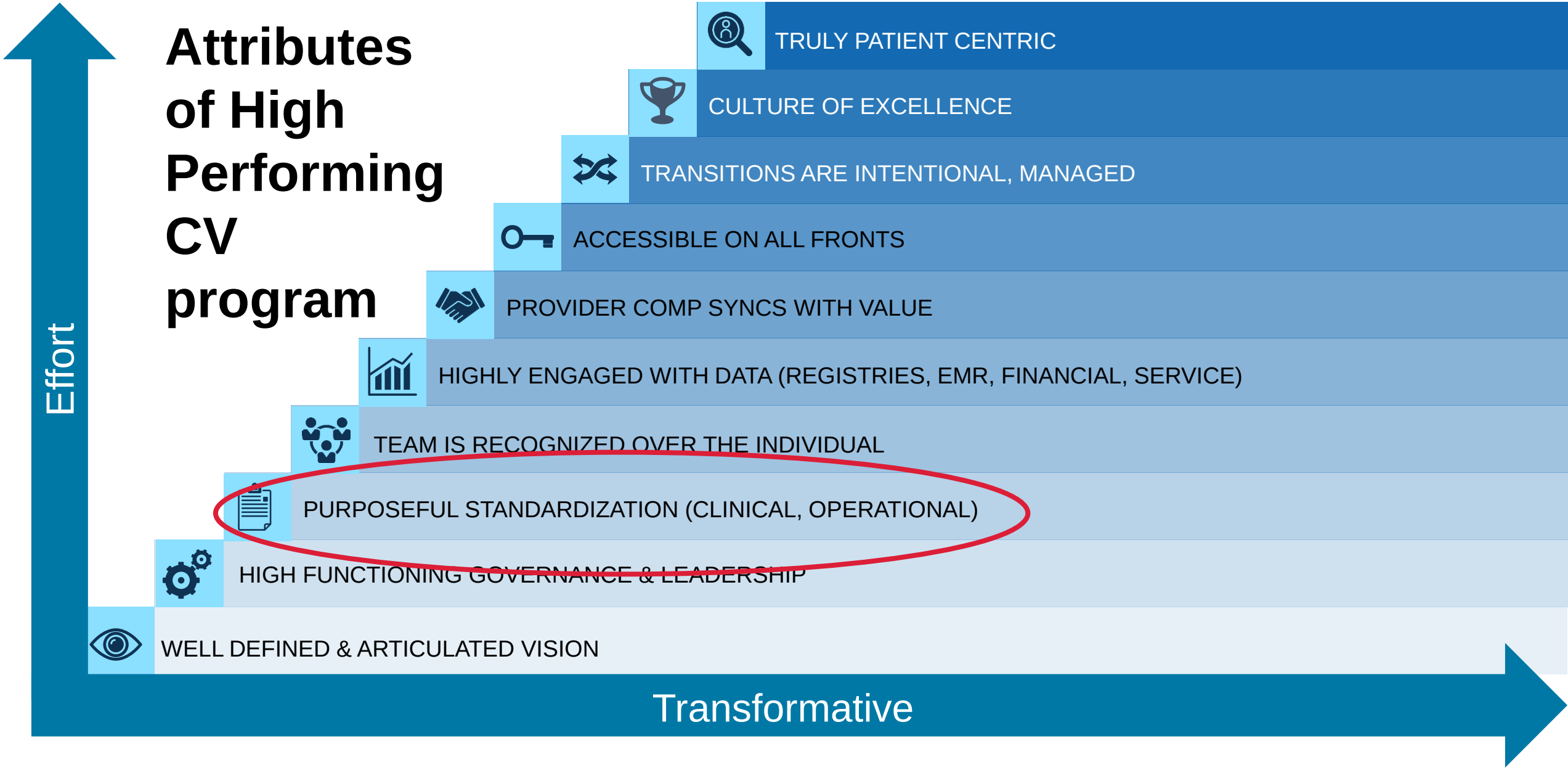


Who's on your team?



Ancillary
Hospital Care Manager
Pharmacist
Educator/Coach
Social Worker
Behavioral Specialist
OP Nurse Navigator
Clinical Quality Specialists
Clinical Informatics
Performance Improvement Specialists

Attributes of High Performing CV program



It starts with the physicians!

Managing Chaos

?? !! ?? !!
$%#@!

Cardiology Scheduling / Rooming Algorithm

Team Roles and Responsibilities Objectives

Defined, top of license roles and responsibilities for each team member

Minimal variation between teams to allow for cross coverage and standardization

Competency assurance

Safe atmosphere for escalation, feedback

Care Team Member Descriptions

Be intentional

Team Member	Licensed Y/N	Ideal Scope	Education Level	BLS
Scheduler/MOS	N	Patient clerical intake Managing Schedules Prior Authorization Registration/Check-out	Variable	Yes – if direct patient contact
CSA-Clinical Support Associate	Certified per MU2	Patient clinical intake, clinical chart abstraction, Office Visit Provider support EKG, Monitor placement	6-week technical program to 1-year diploma	Yes
LPN – Licensed Practical Nurse	Y	All that CSA performs plus patient communication, lab triage, patient triage, Patient education	1-2 year license program, Associates	Yes
RN – Registered Nurse	Y	Patient triage, Team nursing with careplan facilitation, medication management /surveillance per protocol, Patient Education	2 or 4 year degree (Magnet institution – 4-yr degree)	Yes – ACLS an option
APP – NP or PA	Yes and Certified **See State specific guidelines**	Direct patient care – E/M, Care team/clinic oversight, Nursing support, Patient results review, follow-up	Graduate degree	BLS/ACLS
Pharmacist	Yes	Patient medication reconciliation, Patient education, Medication clinic support/oversight	BS or Pharm D	BLS

Example- Ambulatory Standard Patie ming Process

Be intentional
Group level not MD

Office Visit Procedures for MA

Greet and intake patient

- Call from reception
- Take weight
- Open Patient Record
- Record vitals
- Take EKG
- Confirm pharmacy
- Enter visit type and chief complaint
- Reconcile meds
- Record allergies

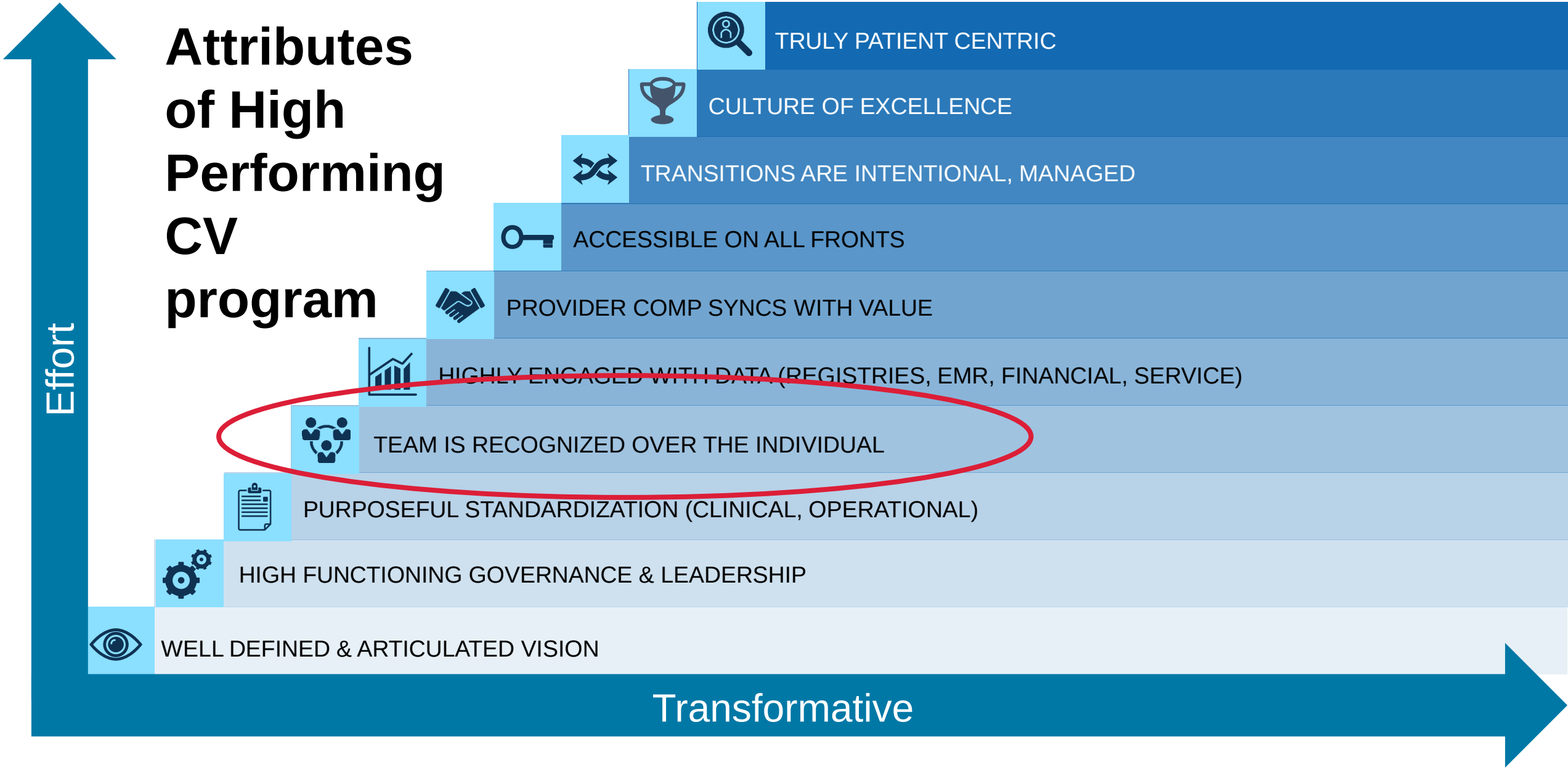
Record information

- Open Patient Record
- Complete MU data
- Record vitals
- Take EKG – charge capture
- Confirm pharmacy
- Enter visit type and chief complaint
- Reconcile meds
- Record allergies

Begin clinical data collection

- Verify risk factors
- Verify family Hx
- Verify social Hx
- Verify past procedures
- Record ROS
- Update room number for tracking

Attributes of High Performing CV program



Strategic and Aligned Team Based Care Structure

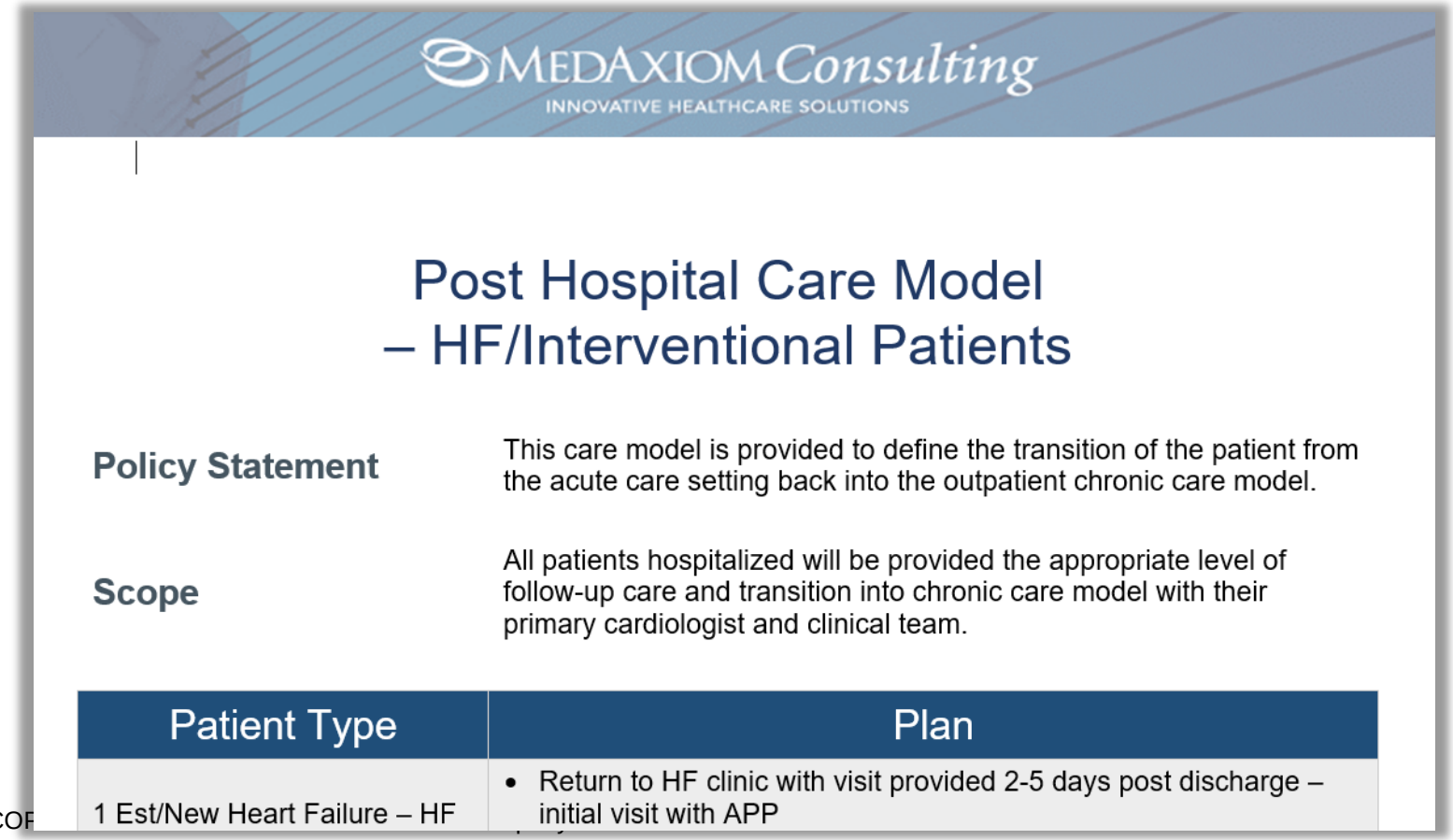
Make the big feel smaller (pods)	Defined groups
• 2-3 physicians • 1-2 APPs • 2 MAs • 1 RN	• Specialty (CHF, Int, EP) • Previous relationships • Geography, facility

Team Based Care Ambulatory

Care pathway development/Adoption	Objective
• Patient panel management • Post-hospital or Post-procedure follow-up • Specialty needs	• Predictable care pathways and intervals that allow for appropriate staffing and coverage • Purposeful Standardization

Physician leadership needs to develop & adopt, then physicians need to ADHERE

Care pathway example



MEDAXIOM Consulting
INNOVATIVE HEALTHCARE SOLUTIONS

Post Hospital Care Model – HF/Interventional Patients

Policy Statement

This care model is provided to define the transition of the patient from the acute care setting back into the outpatient chronic care model.

Scope

All patients hospitalized will be provided the appropriate level of follow-up care and transition into chronic care model with their primary cardiologist and clinical team.

Patient Type	Plan
1 Est/New Heart Failure – HF	• Return to HF clinic with visit provided 2-5 days post discharge – initial visit with APP

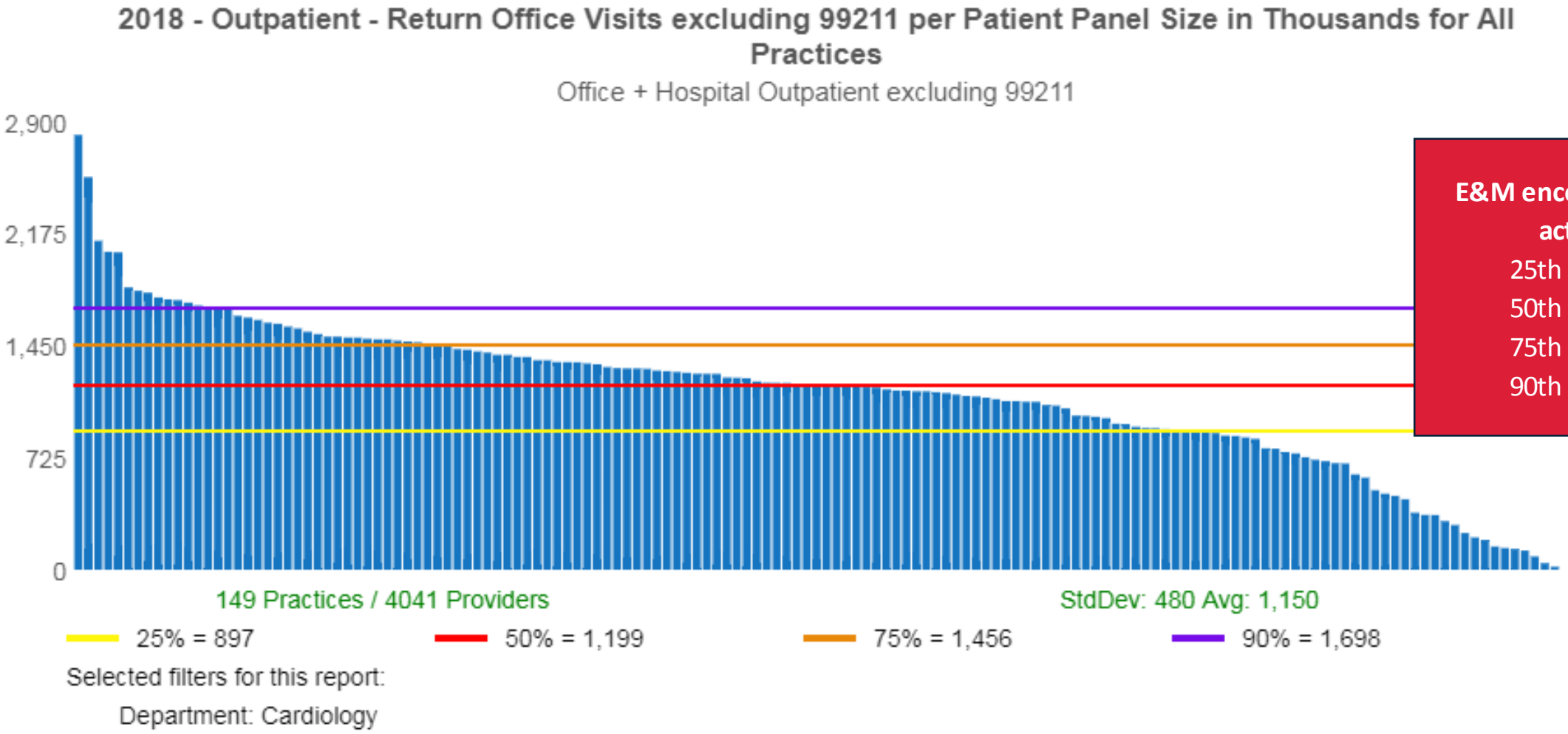
Develop protocols/ care plans based on patient population – then plan for them.

Patient Care Plan – Population Based - Example

Patient Type	Office Visit Model
Chronic Stable CAD	Pt seen q 6 months alternating between prim… …d ACP
Chronic Stable Valve Disease – low risk	Pt seen q 6 months alternating between pri… Patient receives echo prior to the visit with Cardiologist
Chronic Stable Valve Disease – high risk	Pt seen q 6 months more frequently by Cardiol…
Chronic Stable Arrhythmias	Pt seen q 6 months alternating between primary cardiol… echo prior to the visit with Cardiologist
Multiple Risk factor prevention patient/CAD equivalent patient (DM,PVD)	Pt seen q 6 months alternating between primary cardiologist and ACP –
Chronic Stable PVD	Pt seen q 6 months alternating between primary cardiologist and ACP – Patient rec… vascular studies prior to the visit with Cardiologist
Chronic Disease patient with change in condition – stabilized – Initial visit with primary cardiologist or ACP within 48-72 hours	Follow-up visit 3 months with either Primary Cardiologist or ACP depending on who was last to see the patient – If remains stable then return to q 6 month disease management model
New Patient Referral	Cardiologist
Primary Cardiologist Ordered diagnostic procedure post- visit – (TEE,R/L Heart Cath) -	Pt seen <1 month with Primary Cardiologist unless plan is well defined when test being ordered.
Post Hospital established Heart Failure	Pt seen 2-5 days post hospitalization with ACP – next visit at 6 weeks with primary cardiologist – medication titration q 2 weeks if applicable
Post Hospital new Heart Failure	Pt seen 2-5 days post hospitalization with ACP – next visit at 4 weeks with primary cardiologist – medication titration q 2 weeks if applicable

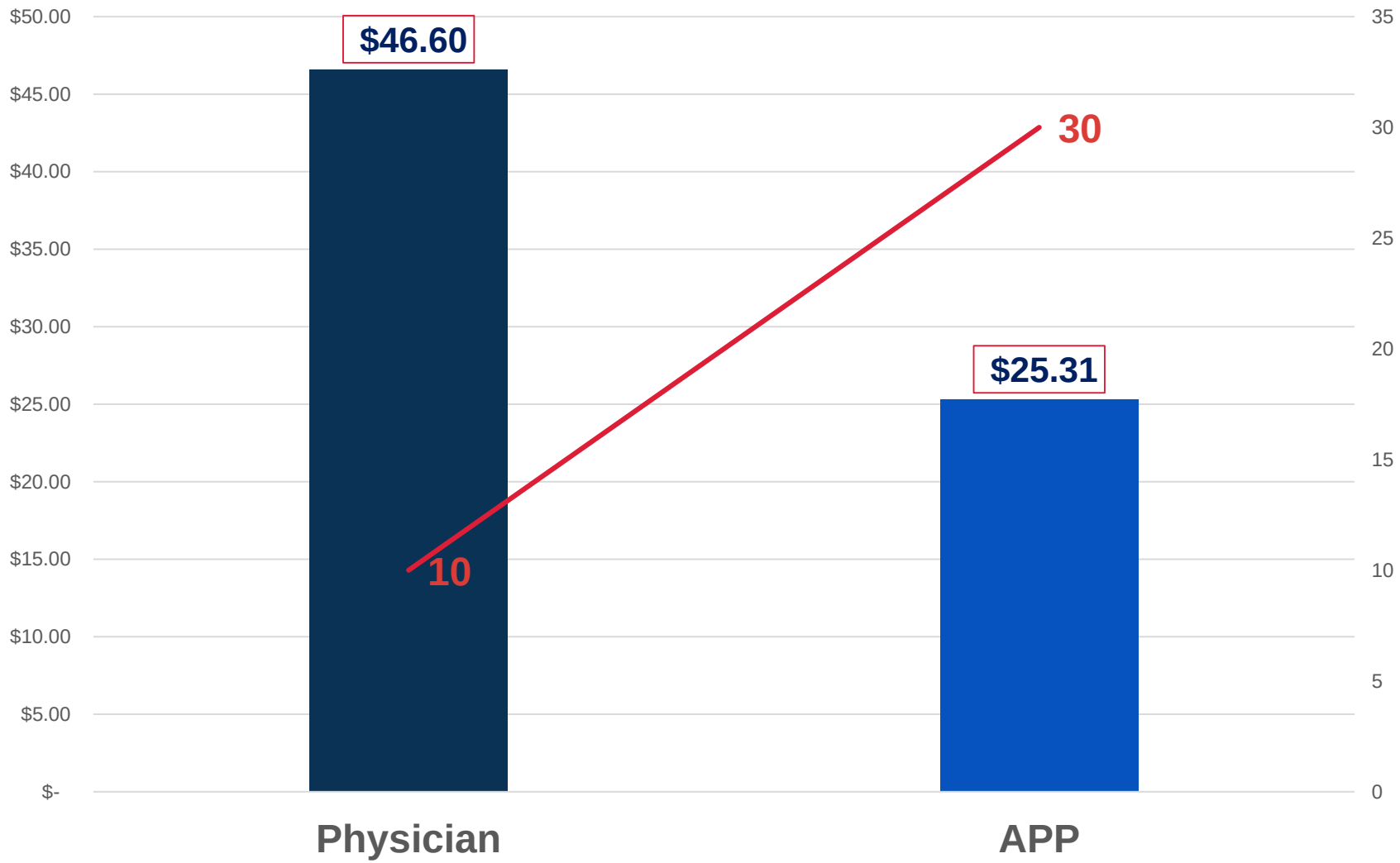
Be intentional
Group level not MD

Some variability expected, but . . .



E&M encounters per active patient	
25th	0.9
50th	1.2
75th	1.5
90th	1.7

Provider cost of a 99213



APP Schedule 20/30 20 Min. Annual Established Stable pt/30 Min Hospital F/U			
MORNING		AFTERNOON	
Patient Type	Time	Patient Type	Time
Established Visit (EST)	8:00	Established Visit (EST)	1:00
Established Visit (EST)	8:20	Established Visit (EST)	1:20
Established Visit (EST)	8:40	Established Visit (EST)	1:40
Established Visit (EST)	9:00	Established Visit (EST)	2:00
Established Visit (EST)	9:20	Established Visit (EST)	2:20
Established Visit (EST)	9:40	Established Visit (EST)	2:40
Established Visit (EST)	10:00	Established Visit (EST)	3:00
Established Visit (EST)	10:20	Established Visit (EST)	3:20
Post Hospital Follow-up	10:40	Established Visit (EST)	3:40
Post Hospital Follow-up	11:10	Urgent or Post Hospital Follow-Up	4:00
Post Hospital Follow-up	11:40	Urgent or Post Hospital Follow-Up	4:30
Patient Follow Up, Telephone, Tasking & Lunch			
22 Appointments Per Day			

Panel Support Model for APP Production & Financial Performance

Assumptions	
Work weeks per year	46
Days per week	5
Encounters per day	15

Peer Experienced E&M Coding Mix	
99213	45%
99214	50%
99215	5%

CPT Code	Billable Visits per Year	*Professional Non-Facility Payment Amount	APP Modifer	APP Prof Non-Facility Payment Amount	Total Professional E&M Revenue	wRVUs
99213	1,553	$ 70.63	85%	$ 60.04	$ 93,205	1,280
99214	1,725	$ 104.47	85%	$ 88.80	$ 153,179	2,199
99215	173	$ 141.30	85%	$ 120.11	$ 20,718	309
Totals	**3,450**				**$ 267,102**	**3,789**

Team Based Care: Increasing Physician Capacity for New Patients

	Encounters	Professional Non-Facility Payment	Total Revenue	wRVUs
99204	700	166.86	$ 116,802	1,701
99205	300	209.75	$ 62,925	729
Total	**1,000**		**$ 179,727**	**2,430**

Patient Panel Support

Special Considerations

Hospital Discharges

- 30-40 minute slots
- Access available within 3-5 days

Pre-Operative Evaluations

- 20-30 minute slots
- Protocol Driven
- Access available within 1-2 weeks

Urgent Needs

- Ideally the physician is available
- 30-40 minutes slots
- Access available within 1-2 days if not same day

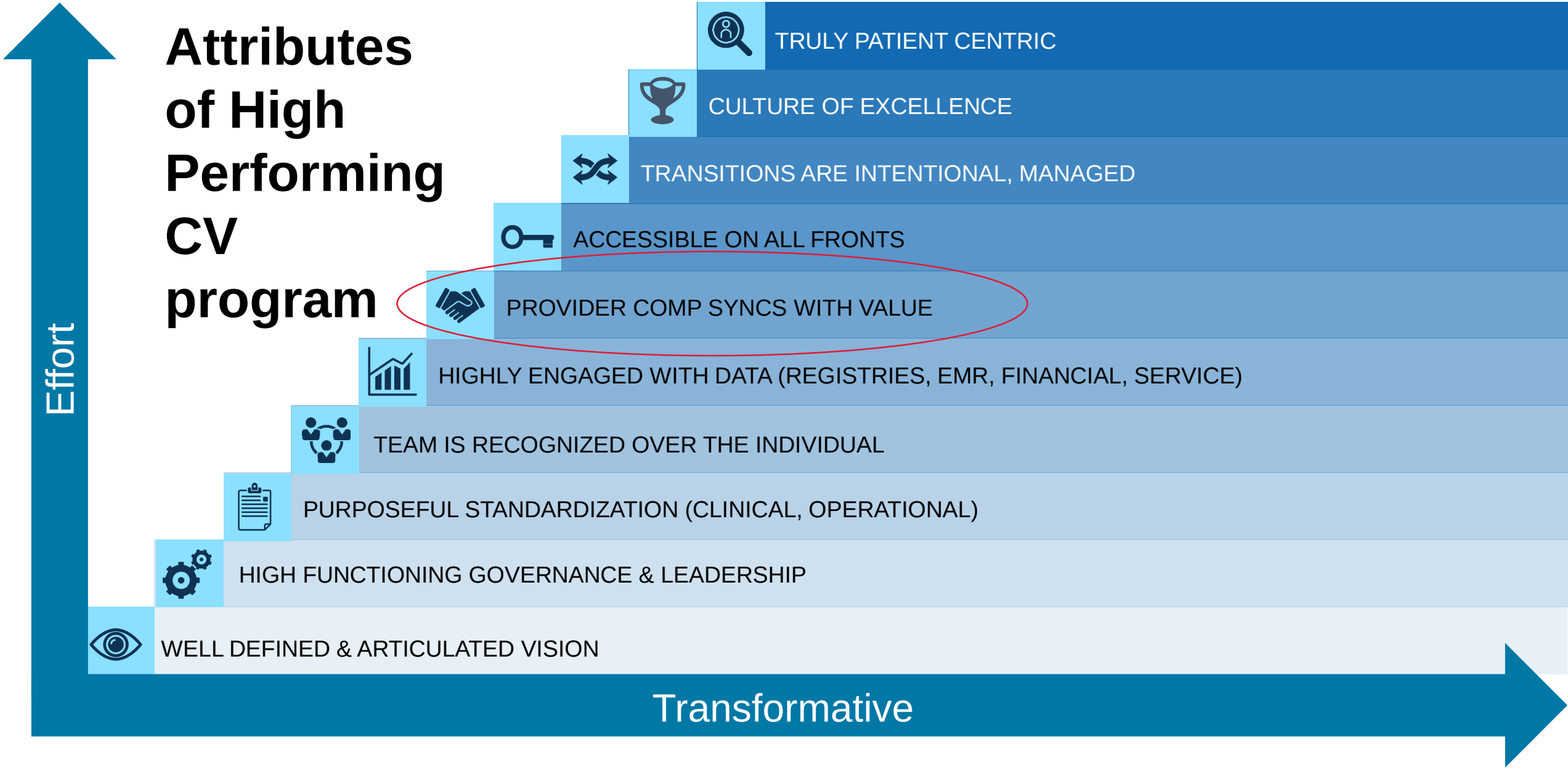
Hospital Rounding Support

Responsibilities

- *Admissions – H/P, Orders
- *Consults – H/P, Orders
- *Rounding Support – Daily Notes, Critical Care Time**
- Floor Calls – routine needs, peri-procedural, symptom-changes, condition changes
- Procedural Prep – H/Ps, Orders, Education
- *Procedures – Lines, Device Interrogations, VAD Interrogations,
- *Discharges
- Discharge Summaries

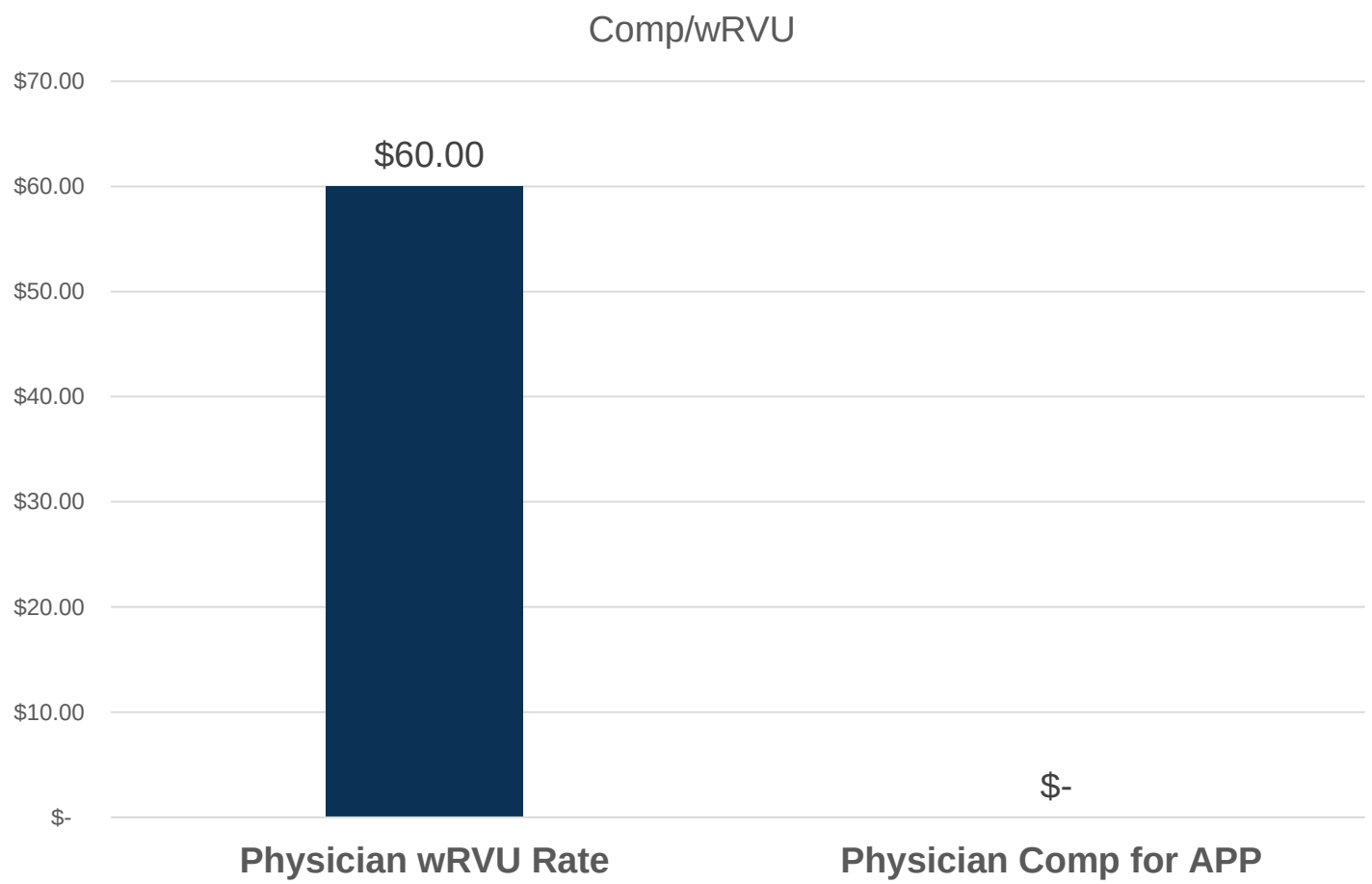
***reimbursable responsibilities**

Attributes of High Performing CV program

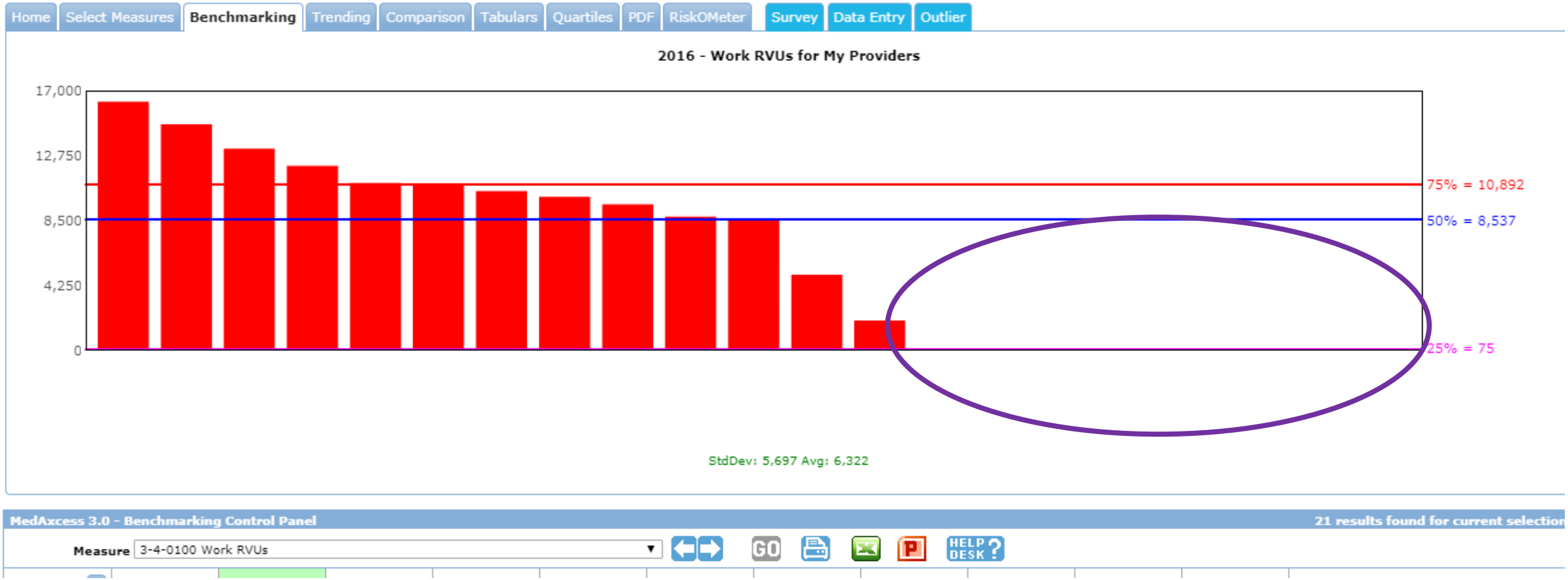


1977 Pontiac Astre

What we regularly see

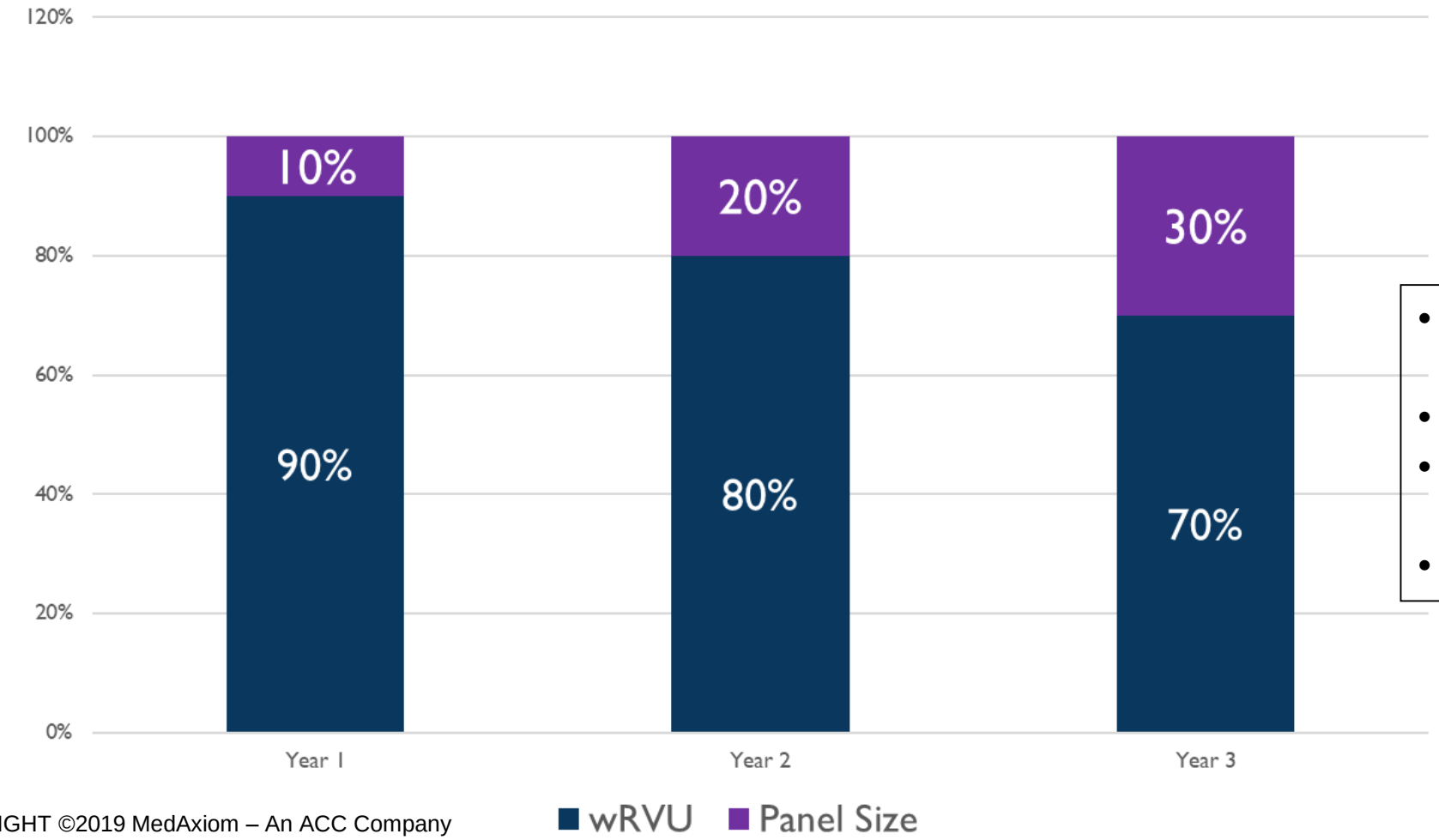


APPs generating inconsequential wRVUs



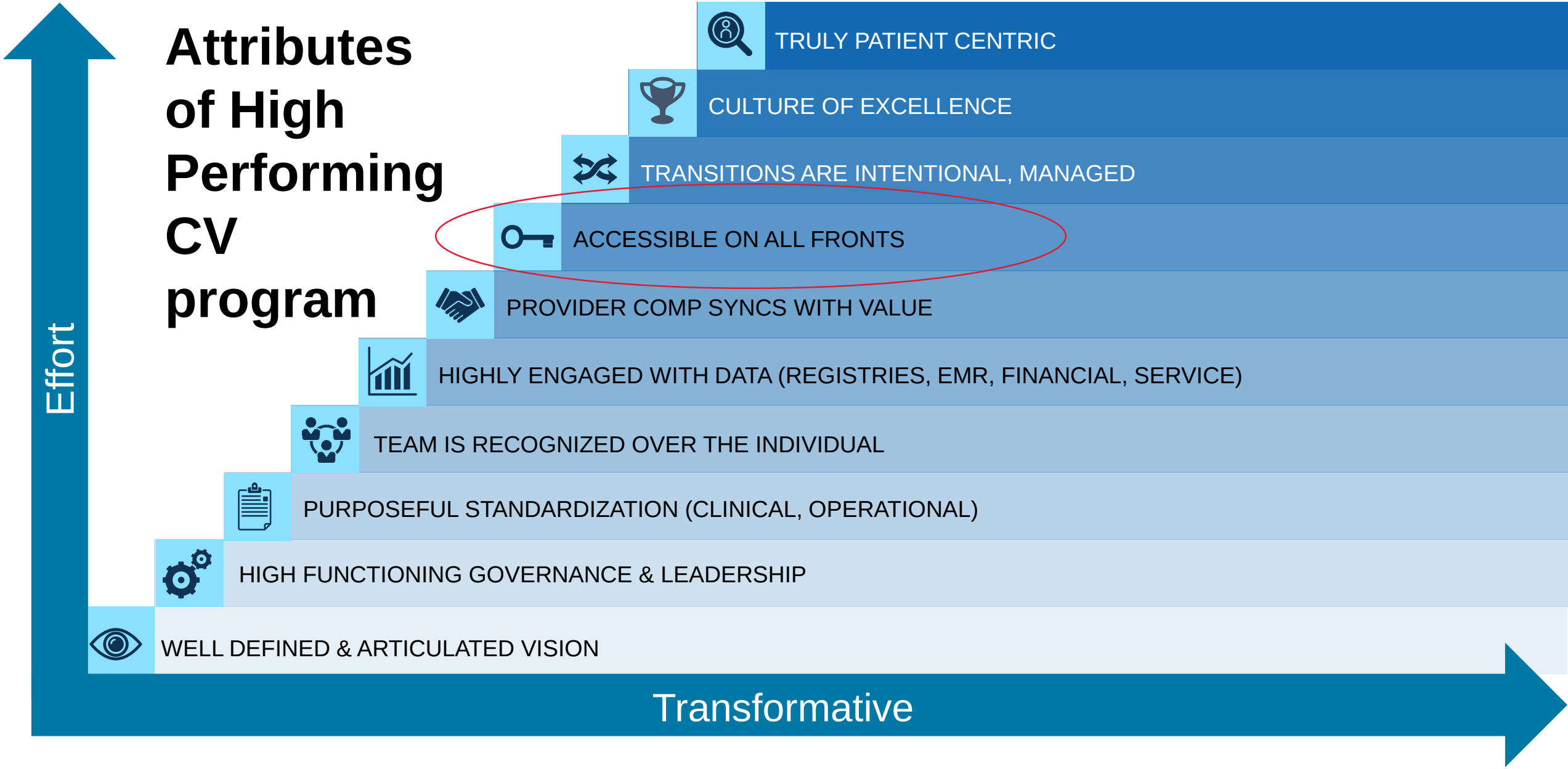
Alternative production measures

Panel size



- Emphasizes new patients, population growth
- Moves to a population focus
- Agnostic to provider (APP vs physician)
- Rewards "team" not individual

Attributes of High Performing CV program



New Patient Access

Industry Standard

- 5 business days

Market differentiator

- 2 business days
- Disease specific programs (AF, Chest Pain Pathway)
- Urgent care clinic

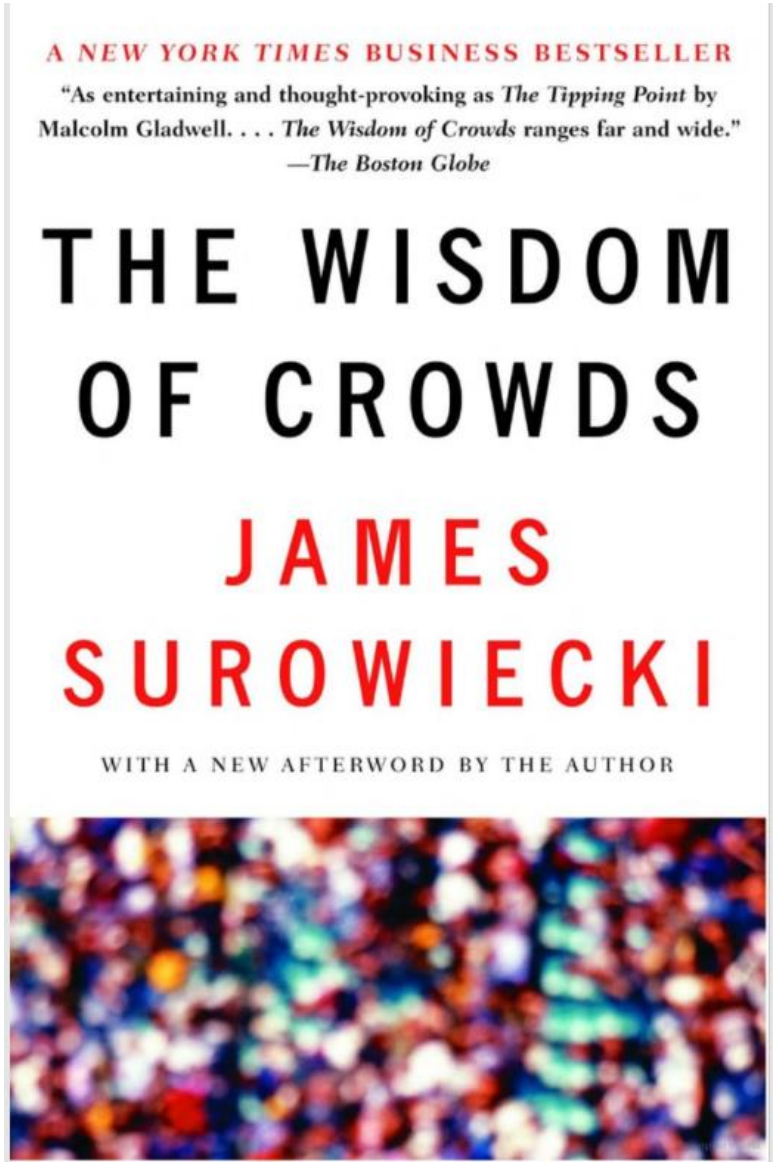
MEDAXIOM
AN ACC COMPANY

Standardize clinical processes + Manage adherence + Strive for "top of licensure" + Work in pods (not for everyone) + Never surprise your patients + Have a well defined AND followed escalation policy + Regular and forever review & training

"Best practices for Care Teams"

Why the Many Are Smarter Than the Few and How Collective Wisdom Shapes Business, Economies, Societies and Nations

… and healthcare!



Q&A

Joel Sauer, MBA
Executive - VP Consulting
jsauer@medaxiom.com
(260) 245-1015