New Models of Primary Care Workforce and Financing

Case Example 4

Foresight Family Physicians

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Case Example #4: Foresight Family Physicians

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Introduction

The Agency for Healthcare Research and Quality (AHRQ) contracted with Abt Associates and its partners, the MacColl Center for Health Care Innovation and Bailit Health Purchasing, to conduct research on innovative ways to configure primary care workforce teams that can deliver fully comprehensive, high-quality care to the U.S. population. The purpose of the research is to offer models of primary care teams and the associated costs for consideration and discussion by policymakers and providers in the field of health services delivery. To explore existing innovative workforce configurations, AHRQ and the Abt project team conducted a literature review, explored extant data sources, convened a Technical Expert Workgroup of national experts in primary care workforce, and conducted site visits to primary care practices with innovative workforce configurations.

The case example report which follows provides an in-depth look at the workforce configuration of Foresight Family Physicians, an independent family practice delivering high-quality, comprehensive medical care (located at 2503 Foresight Cir., Grand Junction, CO 81505). Team members visited the site on August 26, 2015. The data discussed below were collected on or prior to the visit and reflect calendar year 2014.

Why Foresight Family Physicians?

Foresight Family Physicians (Foresight) is a small, independent practice between two large integrated systems in Grand Junction, Colorado, a town of just under 60,000 on the west slope of the Rocky Mountains. Foresight was chosen as an exemplar of a small practice involved in several State and national quality improvement (QI) initiatives such as the Comprehensive Primary Care Initiative, a Centers for Medicare & Medicaid Services multipayer program to improve primary care. Foresight aspires to be the premier primary care practice in its area. It has a strong team structure with well-developed roles and tasks. Foresight practices ongoing QI and invites patient and family input through a Patient and Family Advisory Committee (PFAC).

Overview of the Practice

Foresight is a long-established practice that serves the local population of Grand Junction and the surrounding rural area. The physicians, Drs. J. Dale Ott and Gregory C. Reicks are both doctors of osteopathy. The local economy is dominated by ranching and energy enterprises, which generate a disproportionate number of worksite injuries. For this reason, the practice is a licensed occupational health site. It has a large number of industry clients and serves employees of these clients who have workers' compensation claims. These patients make up 10–12 percent of Foresight's patients but are not included in physician panels, and Foresight physicians are not their primary care providers.

Foresight is currently involved in the Comprehensive Primary Care Initiative, and its culture of team care and quality have developed through a series of collaboratives and QI initiatives. During the site visit, the atmosphere in the practice seemed upbeat, active, and open.

Patient Population Description and Practice Panel Size

Empaneled to the practice are 4800 patients. In 2014, the number of patient visits was 4138.

Until recently, the practice's patient population was typical for the area. Since Medicaid expansion, however, Foresight has taken on a number of new Medicaid patients; they say they now probably have a higher percentage of Medicaid patients than the average practice in their location of Mesa County. For example, the practice enrolled 622 newly insured Medicaid patients in 2015, as part of serving the community. The greatest challenge to expanding the panel has not been the time required for face-to-face interaction and documentation, but the time to review laboratory results and consult notes and other paperwork; this work cannot be delegated.

Foresight has found that many of the newly insured have multiple untreated health needs, both physical and mental. Even relatively young adults, aged 20–50, have multiple needs, so the practice has been overwhelmed with collecting their intake data and baseline laboratory tests. This situation has forced Foresight to think about how to manage their populations and panels and use their team effectively to move nonclinical activities away from providers.

In 2014, 85 percent of patients seen at Foresight were Caucasian; 78 percent of non-Caucasian patients were Hispanic. In addition, 13 percent of patients were high-intensity patients with multiple or complex chronic conditions; 23 percent were covered by Medicaid and 31 percent by Medicare. About 36 percent of patients had commercial insurance and 10 percent were uninsured; 49.8 percent were men and 50.2 percent were women.

Age Range	Percentage of Foresight's 2014 Patient Panel
0-18 years	12
19-64 years	68
65+ years	21

Patients are empaneled only to physicians (DOs) at Foresight, though nurse practitioners (NPs) and physician assistants (PAs) provide independent patient visits. Any patient with a visit in the last 3 years is considered an active patient, excluding the occupational health patients, since Foresight physicians are not their primary care providers. Provider panel sizes are determined by physician preference and capacity. The approximately 4800 patients are not distributed equally between the two providers, but are defined by each provider's historic practice and preference, with one provider approaching 3000 patients. Dr. Reicks has more Medicaid and newly insured patients; Dr. Utt has more geriatric patients. The practice is still adjusting for optimal panel size for each physician.

> "Being the premier practice in the area is a strategy. We see it as sustainable. We can bring new patients in because of our reputation. We'll always be fee-for-service, so financial stability will always be about volume. We are always thinking about how to manage a bigger panel size to increase the revenue. Our strategy is to market ourselves to payers—we get better outcomes and are worth better payments."
> – Dr. Reicks

Model of Care

Foresight strives to be an exemplary patient-centered medical home (PCMH) through participation in QI collaboratives and other quality initiatives. The practice uses extensive data collection and workflow mapping for QI, engages the PFAC to improve responsiveness to patient concerns, and employs a practice-generated risk-stratification algorithm (see Appendix) that aims to give patients optimally tailored, cost-effective care. The practice has expanded the members of the core team for each provider panel and enhanced the roles and tasks of team members.

Patient-Centered Care

> "My framework for practice is positive psychology, not so much mental illness. This is a paradigm shift for the practice. I have done some correction with patients who say, 'I'm bipolar,' Now I say, 'you are much more than that, tell me what else is going on with you.' We are hoping to share a perspective of everyone's humanity, shift the culture of how people are viewed."
> – Integrated health specialist

The practice strives for whole-person care and uses PFAC meetings to respond to questions from the practice about changes in care delivery under consideration. The PFAC has provided feedback on the patient portal, appropriate emergency room use, and use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® survey, among other issues. The PFAC is co-led by the front desk lead and a patient advisor.

The clinic is working on engaging patients in their care. It is creating its own decision aids and implementing the Patient Activation Measure (PAM) to improve tailoring of care and enhance intervention effectiveness.

Workforce Configuration

Exhibit 1. Foresight Family Physicians team FTEs and roles

FTE	Clinical Staff Workforce Category/Role	Comments
2	DO	
1	NP	Not empaneled, works with physician.
1	PA	Not empaneled, works with physician.
1.25	Care Manager	PA working as care manager/health coach and RN.
1	Social Worker	Master's-level social worker working as a behavioral health clinician.
4	MA	
1	Occupational Health Manager	Licensed for drug screens, pre-employment testing, hearing function; on QI team managing data reports, doing workflow mapping and as scribe for all meetings.

.25	Clinical Psychologist	Covers longer behavioral health interventions.
FTE	Business Operations Support Workforce Category/Role	Comments
1	Clinic Manager	
.05	Scanner, Administrative Support	
.2	Administrative Support	Fills in when front desk lead does QI work.
N/A	Information Technology Staff	Performed by Dr. Reicks.
1	Patient Accounting Staff, Billing	
FTE	Front Office Support Workforce Category/Role	Comments
3	Medical Receptionist	Lead creates daily schedules and exception reports, prepares decision aids and screening tools for specific patients.
1	Administrative Assistant	
	DO=doctor of osteopathy; NP=nurse practitioner; PA=physician assistant; RN=registered nurse; MA=medical assistant; QI=quality improvement; N/A=not applicable	

The practice is divided into two core teams. Each consists of a physician, an NP or PA, two medical assistants (MAs), a care manager (also referred to as a health coach), and a behavioral health provider that the practice calls an integrated health specialist (IHS). The core teams are not run identically. For instance, one team uses the morning-huddle model of visit preparation, and the other chooses not to huddle. One physician prefers co-visits with care managers, the other consecutive visits. However, team roles are similar, and both teams are supported by an extended team of front desk, QI, and business staff. The core teams work separately, with each physician having a dedicated front desk, MA, and care manager. Each physician also has an NP or PA, which the practice has incorporated into the teams in the past few years. The two physicians, the NP, and PA see approximately 30 patients per day. The NP and PA are not empaneled, but the practice makes great effort to have patients see their established provider, and over time, the NP and PA have established relationships with some patients. Historically, the NP and PA helped increase access for same-day/walk-in patients, so some patients have seen both the NP or PA and their assigned physician. Because the practice would like to ensure that patients see their established provider, the clinic is now assigning the NP and PA each to a single team.

The front desk staff participates in patient check-in, runs registry reports, tracks and distributes the six shared decision aids currently in use, and distributes assessments such as the Patient Health Questionnaire (PHQ)-9. Each front desk person is assigned to a provider, with one staff member for each physician and one for the NP and PA. Part of the work of the front desk staff is assuring that patients see their assigned provider whenever possible. The staff makes and prints a list of gaps in care for patients with visits the next day, makes reminder calls to patients, and ensures followup appointments are scheduled. The staff members perform first-level triage and forward calls to providers or their MAs. They enroll patients and activate them to use the patient portal. The front desk lead is on the QI team, and with a patient, co-chairs the PFAC.

MA activities are rooming and visit preparation, checking patient vital signs, verifying chief complaints, updating medical records and changes in history, helping with procedures, doing preventive screenings, and some behavior change support. MAs schedule other appointments and arrange referrals following a protocol, order durable medical equipment, and give vaccinations and injections. Team care has changed the role of the MA at Foresight, where much of the followup is now done by the care manager. A floating MA who works 1–2 days per week helps with followup calls and referrals.

The goal of this practice is the integration of whole-person care. Care managers, the IHS and an onsite community health worker (CHW) have independent visits with patients as needed. These staff members review the schedule and book time to see patients who are high risk, or are brought in by providers for point-of-care service (see QI section for risk segmentation). Care managers work with 150–200 patients with complex clinical issues. They see patients before, during, and/or after the physician visit, and initiate phone outreach to patients. Dr. Reicks described the benefit of the care manager as a "closer" for complex patients who checks with the patient at the end of the visit to ensure that all chronic conditions and multiple medications are fully addressed. The goal of care managers is to help patients be better informed and feel confident about self-management activities. The practice is learning that each physician could use a full-time care manager.

The IHS works with patients on becoming more engaged in their own health. The providers have different preferences for seeing patients before, after, or concurrent with the IHS. The practice now administers the PAM to help determine which patients need additional intervention. The IHS also sees patients with high PHQ-9 scores, or patients who are homeless or mentally ill. The IHS sometimes sees patients for 30-minute visits at the patient's request, although the clinic aims for no more than one of these visits per day. Many IHS "touches" with patients are 5–10 minute interactions with brief interventions that may happen in the exam room rather than a more formal office visit. However, patients in crisis are scheduled for an office visit. The IHS also handles care transitions for patients leaving inpatient psychiatric care or detox facilities. The offices of the IHS, care manager, and CHW are close together to facilitate interaction.

Care Coordination

Care coordination is a disseminated function, with less clinically complex referral management by MAs, complex care management by care managers, and some behavioral health-related referrals and transitions handled by the IHS. The CHW also functions as a coordinator for some social needs.

Community Health Workers

The CHW is an employee of Mindspring, a local mental health clinic, but is a full member of the Foresight team. The CHW helps patients with substance abuse and mental illness or dual diagnosis, mostly in community settings rather than in office visits. This team member sees approximately 40 patients, with the frequency and length of service depending on need, and provides many types of assistance with social support needs. At meetings at Foresight, the CHW

reviews patient lists, focusing on high utilizers. The CHW also attends Mindspring meetings for oversight.

Workflow

The foundation of workflow at Foresight is using process mapping to increase efficiency and teamwork. Each new quality goal is operationalized into activities that are mapped into the workflow, assigning roles and noting key interdependencies. A meeting that occurred during the site visit addressed workflow mapping for implementing the PAM and determining workflow for assuring statin use by patients with diabetes and cardiovascular disease. Foresight has developed a stratification algorithm for identifying risk levels for their entire patient panel and workflow activities that ensure appropriate care levels for each patient by risk level (see QI section for risk stratification description and Appendix for risk stratification tool).

> "We aim for standard work. We have a common goal—the process maps—but we allow for individual differences."
> – Dr. Reicks

The Foresight patient care load is approximately 30 people a day for each provider. The Foresight front desk participates in visit preparation, assessment, and prevention efforts. The role of the MAs is streamlining patient interaction, rooming patients, and charting. However, one MA per provider is insufficient for pre-authorization, medication refills, talking to patients about care gaps and screenings, and using the decision aids in patient rooms. Therefore, Foresight is testing a two-MA model with a floating MA 1–2 days a week.

Team members review daily schedules to assign patients to staff according to risk level. Providers document issues that were easily addressed during the visit, and use voice recognition software for more complex documentation at the end of each session. Care managers and the IHS see patients in co-visits or independent visits before or after the provider visit, and perform the "closer" role, which was described as reviewing the visit and assuring patient understanding of the care plan and self-management activities.

Exhibit 2. Foresight Family Physicians team tasks and roles

Tasks	Roles Included
Pre-visit planning, chart scrubbing	Front desk staff identify gaps in care and print lists. MAs preview schedules for physicals or chronic care. IHS reviews schedule for behavioral care needs. Care manager reviews notes, may call patient about care planning or to ask to bring in medications.
Checking patients in	Front desk staff greets patients, checks patients in, and alerts the appropriate MA to room the patient.
Rooming the patient	MAs typically room the patient, but other staff assist as needed.
Ordering lab tests and collecting vital signs	MAs, DOs, PAs, NPs, and care managers do these tasks.
Delivery of routine preventive services	MAs deliver preventive services with care managers; physicians and NP/PA deliver more complex preventive services as needed.

Tasks	Roles Included
Medication reconciliation or management	Front desk staff documents changes in medication lists for patients to sign. MAs and RN/PA care managers check medications. All providers manage medications.
Reviewing and reconciling problem list	MAs, physicians, and NP/PA, and care managers perform this task.
Patient navigation	Care managers and the IHS assist with organizing care of patients across settings. Front desk staff helps with referral followup.
Self-management goal setting and action planning	IHS and care managers do primary goalsetting and action planning.
Patient telephone/email followup	Front desk staff and MAs typically follow up with patients except for clinically complex issues, which are handled by care managers.
Injections and venipuncture	MAs handle all vaccines and injectables.
Triaging phone calls and emails	Front desk staff performs these tasks.
Care and transition management of high-risk patients	Care managers work with high-risk patients, IHS manages detox and mental health transitions.
Referral management	Followup on labs or specialist visits are handled by the front desk staff. Care managers, IHS and CHW track and follow up on patient referrals for their patients.
Independent visits by non-providers (RN, MA, health coach)	Care managers and IHS conduct independent visits, but may also see patients when they are visiting a provider. CHW sees patients in community settings.

MA=medical assistant; DO=medical doctor; PA=physician assistant; NP=nurse practitioner; IHS=integrated health specialist; CHW=community health worker; RN=registered nurse

Team Building and Training

Building and sustaining teams is a clear priority at Foresight, although the transition to team care has created some tensions. A care manager attributed the effectiveness of their teams to:

- Clear vision, communicated through monthly meetings and emails.
- Team structures as good as Fortune 100 companies.
- Good meetings with clear agendas, run by a facilitator and a recorder that enable consistent communication. Meetings that allow for interaction and honest feedback. Meetings that end with reading kudos to acknowledge good teamwork from a box for feedback from patients and staff.
- Team members who have a clear understanding of different roles and responsibilities.
- Care teams of providers and MAs that sit next to each other. Care managers and IHS also sit together so they can consult and share resources.

- Financial rewards that are the best in the region, with midyear bonuses to recognize good work.

A blog post by the IHS about the importance of the front desk in primary care contains the quote:

> "I am sure they make a difference. It's important that we are a healing place for people with unsatisfactory experiences in health care."
> – Nurse care manager

The teams are supported by regular formal meetings as follows:

- Monthly office meeting for all staff. Office is closed 12:00–1:30, and lunch is provided.
- Monthly high-risk team meetings to review lists of high-risk patients (e.g., who were in the hospital or emergency room [ER]) with discussion on how to work with these patients.
- Bimonthly QI meetings.
- Bimonthly care manager meetings.
- Weekly huddles of 5–10 min for front desk and for MAs to discuss 1–2 topics relevant to their role. Topics (e.g., correct documentation) usually come from providers.

Foresight also has many informal meetings and communications such as informal huddles for the two care managers and the IHS or quick communications between MAs and providers or among care managers who are collocated.

> "One of the biggest transformations at Foresight is the understanding that everyone needs to be involved to make things work. That has really only happened in the last year—wasn't the case previously. The huddles have helped a bunch—allow everyone to have input."
> – Clinic manager

The transition to team care that has expanded the types of clinical providers has changed the role of MAs, in some cases narrowing the responsibilities by reassigning some clinical tasks to care managers.

> "MAs can be challenged, trying to do what their provider wants but also do these other things that are required."
> – Care Manager

The team is still becoming comfortable with the new roles and responsibilities, as evidenced in meetings with all MAs to talk about procedures, improving individuals' skills, and problem solving. The lead MA is responsible for training all MAs, primarily through shadowing.

The clinic surveyed all staff about their understanding of medical home measures and concepts. At each all-staff meeting they review the meaning of a few measures. This procedure has helped the practice see that some staff did not understand the meaning of medical home or, for instance, the role of the IHS. The practice now includes these concepts in new staff orientation, including acronyms and their definitions.

Foresight introduced a practice monitor who asked staff about their understanding of team-based care using the Medical Home Practice Monitor. The practice has now discussed findings at three or four team meetings and is working to clarify roles in specific challenging situations. The practice is learning how to keep the entire team informed about what they are learning from implementing team-based care.

> "Patients open up to different people at the practice, the ones who they feel comfortable with, so at team meetings, various team members will contribute valuable knowledge about patients that helps everyone. For example, the community health worker who drives patients to appointments knows a lot about people's lives."
> – Clinic manager

Access, Comprehensiveness, and Quality

Access

The Foresight clinic is committed to expanding access to care. Currently, scheduling of nonurgent appointments is approximately 30 days out, but urgent patients are seen the same day. The clinic schedule contains same-day appointment blocks, and double booking is permitted for urgent care. Since the clinic had 622 new Medicaid patients in 2015, they are overwhelmed, especially because all new patients must have a risk stratification test and be integrated into guideline-driven care.

Foresight has expanded access for patients in the following ways:

- The practice has extended hours: NP and PA work 10–hour days to keep the practice open longer.
- The practice has Saturday hours, usually 8:00 to 1:00 or 2:00, with coverage rotating among all four providers.
- Physicians take their own calls.
- A patient portal is available and use is increasing. After slow initial uptake, the practice incentivized use with gift cards, increasing use to almost 40 percent.
- The practice is exploring ways to provide non-face-to-face encounters such as phone or secured email care, but has not found a way to bill for it. The practice recognizes the need for a resource for non-visit care, especially for less complex patients, but doesn't have provider capacity. It is considering an RN for triage and phone followup.

Comprehensiveness

Because Grand Junction is relatively isolated, equally far from Denver and Salt Lake City, the medical community works together to care for its patients to avoid referral to the larger cities, interviewees said. They said that care compacts with specialists ease care coordination and continuity of care and assure comprehensive care for the population. The practice has eliminated some onsite services such as imaging, colonoscopy, phlebotomy, and lab services.

Community Linkages

Foresight has a new relationship with the Mindspring local mental health center. Because of Medicaid expansion, organizations like Mindspring are beginning to share patients more with primary care. The Foresight care managers and IHS have developed relationships with Mindspring staff.

The CHW is paid by Mindspring but works exclusively with Foresight patients, for example "hotspotting" patients with high utilization of ER services instead of practice visits. The CHW provides transportation and home visits and works with Mindspring to get mental health care for patients who need it. The CHW is part of and is a resource for both Foresight care teams and comes to team meetings on high-risk patients. The practice is considering writing several case studies of high-utilizing patients whose care was changed by working with the CHW.

Physical therapy is available from physical therapists who rent space in the building from Foresight.

Quality

Foresight Family Practice is a data-rich organization and their data drives QI. This is a legacy from the many QI initiatives in which they have participated over the past decade. Under the Comprehensive Primary Care Initiative, Foresight created a dashboard of specific measures for PCMH transformation, including Meaningful Use of health information technology. Rocky Mountain Health Plan provides practice transformation coaching and a learning collaborative environment for QI, as well as enhanced payment for meeting some PCMH standards.

The practice stratifies patients by level of complexity and risk with a goal of offering optimal care and meeting quality standards, sometimes including shared savings for the practice. Foresight is refining their risk-stratification algorithm after finding that some patients require more or fewer resources than the tool predicted, and high-risk lists from insurers did not predict utilization well. The practice is considering addressing social needs as predictors for the influx of new Medicaid patients with many unmet care needs. It is also reviewing reports on high utilizers, for example, using the Adverse Childhood Events Survey to identify reasons for high service use and to inform changes in care.

The clinic participates in a pain management videoconference group with Project Echo (a distance learning and collaborative program) in which a group of multidisciplinary consultants review cases presented by geographically remote providers. Dr. Reicks has presented cases and says that he found the group input to be useful. For example, he learned how to work with patients who are chronic opioid users, incorporating elements of pain psychology and trauma-informed care. The clinic now reaches out locally to behavioral health providers to see if they use the same strategies.

The QI meeting during the site visit included discussions about following up on approximately 800 patients who have completed the PAM, setting goals for hypertension screening, and

checking coding to assure documentation of risks for nephropathy and retinopathy for morbidly obese patients is correct and results in accurate risk scores. Attendees also reviewed charts on ER/inpatient use and readmission and costs that showed shared savings from insurers. In several cases, per-member-per-month costs were significantly lower than the rest of the county. The practice attributes these shared savings to QI and enhanced care.

Foresight is actively pursuing PCMH recognition for its new standards and is considering an eClinicalWorks module that automatically collects PCMH measures. The clinic is trying to be the premier practice in the county and feels that recognition attracts payers and increases the likelihood of participation in the Comprehensive Primary Care Initiative and other programs. They have applied for the Million Hearts Initiative.

The QI meeting was an interactive group discussion. Team members listened to each other and developed processes designed to work for all involved. Suggestions about what would and would not work came from all team members, who agreed to a plan-do-check-act cycle.

> "We want to be known as the best primary care practice in our community, so we need data to show we have different outcomes in many areas. In the past few years, we have increased registry use, providing more data. Then, once we have data, we ask, 'how can we improve?' We are always thinking ahead regarding measurement."
> – Dr. Reicks

The QI team comprises both physicians, the practice manager, the front desk lead, the occupational health manager, and the IHS. The occupational health manager is the registry manager, runs data reports and develops workflow maps, and takes notes for QI and team meetings. The lead physician, Dr. Reicks, has IT skills, and programs new queries and data collection fields into the electronic health record (EHR). The QI team showed immense enthusiasm for their work. They described transforming the practice over time and said they take satisfaction from looking at a problem and solving it together.

> "Our team works well because we have different points of view—some are big picture, some are point and shoot, but all views contribute to the discussion."
> – Dr. Reicks

The QI team found that changing many procedures at once is stressful for their personnel. To make changes, they now start small, working out the change with one provider and one team before implementing it practicewide. At one meeting each month, they include an MA to gain perspective from that role. The team found that, because individuals and teams tend to have their own agendas, they must emphasize that QI changes are for the entire practice and benefit all patients.

Implications for Primary Care Staffing Models

Foresight shows that independent small practices might improve quality and maintain profitability by optimizing care for specific populations using care management and integrated behavioral health. NPs and PAs, even when not empaneled, contribute to efficient and sustainable care. Mental health providers may help a practice lower costs by addressing core issues for patients and contributing to better outcomes. Measurement and data are foundations of QI, but empowering care teams to use data to change care patterns is equally important.

At Foresight, standard work and well-defined staff roles support sustainability, even with minor variations in implementation. Well-integrated EHR and quality-reporting systems are central to system-wide improvement. The data specialist role is important, bridging data management and practice change.

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