Creating a Care Team

A value-based approach to cardiovascular health care.

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The concept of creating a care team to deliver high-quality, cost-effective cardiovascular care has been gaining ground over the last few years. It comes as no surprise, considering the growing patient population, an increase in incidence/prevalence of most cardiovascular-based diseases, a continued shortage of physicians, and evolving reimbursement models. The industry is quickly changing, with a radical shift from receiving reimbursement for each service provided to a reimbursement model that takes into account services rendered, quality outcomes, and costs. Add to that the reality of the increased requirements for documentation, patient complexity, and challenging patient coordination, and it is easy to see why traditional models are struggling.

The care team approach can provide a great solution to these challenges. According to a recent American College of Physicians position paper, "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."[1]

As we embark on the future, we are seeing a need to shift to a value-based model in which quality and costs are taken into account, a strong partnership exists between the hospital and the practice, health care is centered more around the patient, and the need for complex care coordination and multidisciplinary visits is addressed. The team-based care model can provide success at several different levels: improved care coordination, care integration, and efficiency for the patients. For the health care professionals who are on the team, there will be an increase in professional satisfaction, a shift from a focus on acute care services to a focus on prevention, and an ability for the professionals to focus on areas of expertise and work at the top of their licensure and training. Finally, for the health care system, a care team approach will provide a more efficient care delivery model, maximize resources and facilities, and should facilitate continuous quality.

TEAM CONSIDERATIONS

Developing care teams does not simply mean adding more staff, but rather a very deliberate utilization of the appropriate staff organized into a team functioning at the top of licensure to meet the specific objectives or care needs of the patient population they are serving. In creating the care team, there are several questions that need to be asked. First, is your care team patient or physician centered? This question is related to the purpose of the team: is it to create a multidisciplinary approach to patient care or to offload the physician? The answer can be "yes" to both and ultimately means utilizing all to the top of licensure, but in a symbiotic way in which the sum of all is more valuable than any individual.

The second question is, what is the objective of the care team? For cardiovascular services, there are several areas in which a team-based approach can be very valuable. Team-based care for patient panel support can extend a physician to be able to manage a larger number of patients, and it can offer more immediate access for urgent issues and support in between visits. A team to navigate and support the patient through critical transition periods between hospital and home or procedure and home is of tremendous value. Chronic disease management for heart failure (HF) or atrial fibrillation is also a great way to utilize a team. These patient populations require higher levels of resources at different points in their progression, and a multidisciplinary approach can be key in successful and timely management. Finally, special populations such as cardio-oncology, hypertrophic cardiomyopathy, and structural heart disease are other areas that have been managed well with this approach.

PATIENT PANEL SUPPORT

The concept of patient panel management has been a common model in primary care for many years. In reality, cardiovascular specialists have also been managing panels of patients as related to secondary prevention and chronic disease management. Most cardiologists have anywhere from 1,200 to 2,000 patients whom they see on a fairly regular basis for these reasons.

(MedAxiom MedAxcess, unpublished data, 2015). The majority of these patients are seen for ongoing medical management with a care plan already in place. This is a great opportunity to develop a team-based care approach with an advanced practice provider (APP) providing services at every other visit. This model will free up the physician to either manage a larger number of patients or assume other responsibilities, such as increased procedure time or interpretation of diagnostic testing. The addition of APPs to the physician team will allow for significant growth in the program without expanding more expensive physician resources.

The objectives of this care team approach include an ability to increase patient throughput for routine care, increase patient panel size per physician, enhance physician utilization, and provide support for other members of the care team. However, it is important, however, to develop a deliberate plan for patient care so that all members of the team are aware of their roles and responsibilities (Table 1). A recent analysis of the American College of Cardiology's PINNACLE Registry data from 2012 that compared quality measures between the traditional model and a team-based model for patient panel support found that the quality of the team-based model was as good in all measures and slightly better in two measures. This indicates that quality can be ensured if the APP receives appropriate training and support.[2] A typical schedule can easily support 15 to 20 patients per clinic day, including time for in-basket management and follow-up (Table 2).

However, there are additional considerations in this model. The APP can be utilized for posthospital follow-up visits that typically require fairly open access with appointments needed within 3 to 5 days. The APP can also provide pre- and postprocedural support with history/physical examinations and postprocedure follow-up appointments. Finally, urgent needs are always a priority, and the addition of an APP to the team will either free up the physician to be more available, or the APP can be a resource utilized for this purpose. When utilized appropriately, the APP can be an excellent, cost-effective addition to a program's provider team in managing routine follow-up care.

WAYS THAT APPs CAN PROVIDE SUPPORT

- Admissions*: history/physical examination, orders
- Consults*: history/physical examination, orders
- Rounding support*: daily notes, critical care time
- Floor calls: routine needs, periprocedural, symptom changes, condition changes
- Procedural prep: history/physical examination, orders, education
- Procedures*: lines, device interrogations, ventricular assist device interrogations
- Discharges*
- Discharge summaries

*Reimbursable activities.

TABLE 1. SAMPLE CARE PLANS

Patient Type	Cardiologist	APP	Therapy/ Management	Diagnostics
Stable CAD	Every other year	Every other year	Secondary prevention with risk factor modification and symptom surveillance	_
AMI postdischarge	6 weeks	3–5 days	Medication reconciliation, patient education, ensure stability, medication titration	_
Post-PCI (planned)	6 months for routine medication review and symptom evaluation	1–2 weeks for medication review, patient education, and follow-up	Review antiplatelet therapy, anti-ischemic regimen, and risk factor control	Baseline ECG post-PCI

Abbreviations: AMI, acute myocardial infarction; APP, advanced practice provider; CAD, coronary artery disease; ECG, electrocardiogram; PCI, percutaneous coronary intervention.

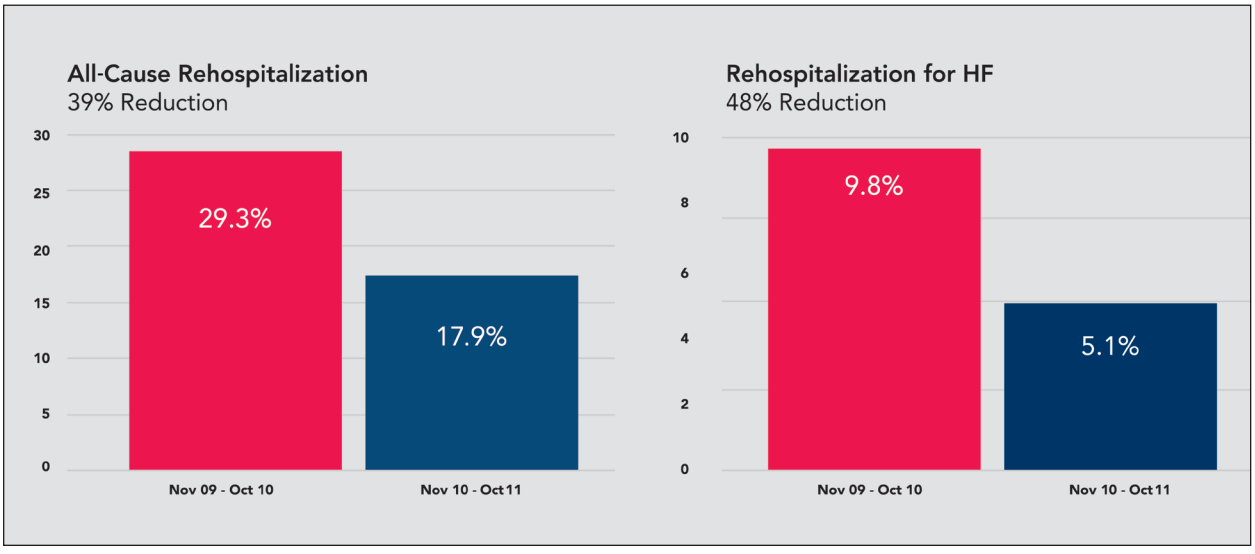
TABLE 2. SAMPLE APP SCHEDULE*

Morning		Afternoon	
Patient Type	Time	Patient Type	Time
Established visit	8:00	Established visit	1:00
Established visit	8:20	Established visit	1:20
Established visit	8:40	Established visit	1:40
Urgent clinic	9:00	Urgent clinic	2:00
Urgent clinic	9:30	Urgent clinic	2:30
Posthospital follow-up/CHF	10:00	Urgent or posthospital follow-up/CHF	3:00
Posthospital follow-up/CHF	10:30	Urgent or posthospital follow-up/CHF	3:30
Posthospital follow-up/CHF	11:00		
Posthospital follow-up/CHF	11:30		
Patient follow-up, patient questions, and results review, lunch		Patient follow-up, patient questions, and results review	
16 total appointments per day			

Abbreviations: APP, advanced practice provider; CHF, congestive heart failure.
*This schedule includes both 20-minute annual visits for established, stable patients and 30-minute hospital follow-ups and visits with CHF patients.

HOSPITAL SUPPORT

A team-based model can really stretch the physician coverage in the hospital setting. The addition of an APP to the provider team can increase patient throughput with benefits that include a decrease in patient length of stay due to the ability for earlier discharge and enhanced facilitation of care. Physician resources can be reallocated to procedural care or imaging interpretations. With documentation so important for appropriate reimbursement, teaching the APPs the details required and utilizing their support for split-shared visits will typically improve charge capture through more detailed documentation. This holds true for quality initiatives as well. For responsibilities such as core measures, managing quality data capture, and improved outcomes, the team-based approach can add another layer of assurance for these responsibilities.



Courtesy of MedAxiom/Spectrum Health.

Figure 1. Utilizing APPs to reduce rehospitalization. Some programs have developed care plans that include rounding by an APP to better evaluate and manage the cardiovascular disease processes; one such program saw a drop in their readmissions.

KEYS TO SUCCESS FOR A TEAM-BASED CARE APPROACH

- A culture that engages physicians to participate and collaborate—physician leadership is integral
- Utilization of evidence-based scientific guidelines as the basis for clinical protocols/pathways
- Adopt best practices as standard work, train teams to create expertise, and establish metrics for performance management
- Develop a team based on needed skill sets where all members work to the top of their licensure

In a busy interventional service, the APP can provide support in multiple ways. The addition of an APP to the interventional rounding team can free up the physician to spend part or most of the day in the lab while facilitation of discharges, rounds, and new consults are being addressed by the APP. Reasonable volumes for this model are typically 15 to 25 patients per day on the service managed by an all-day APP and an interventionist spending most of the day in the lab.

TRANSITIONAL CARE

With readmission reduction being a major initiative, the utilization of a team-based approach with an APP can have a major impact. Five of the seven top readmission patient populations are cardiovascular related, with HF and acute myocardial infarction readmissions being tied to government-level incentive programs in which a reduction in reimbursement can occur if the readmissions rates are too high. A program in the southeast United States noted that the average cost per patient decreased from $21,743 with usual care to $5,767 with the transition clinic program at 30 days, and there was an even larger cost savings at 1 year of $105,018 with traditional care to $51,343 with clinic care.[3] The program started with a 1-hour visit at 3 to 4 days after discharge with follow-up, tailored from there.

An APP with specific clinic slots and/or clinic days assigned to early hospital follow-up visits can have a major impact on the readmission rates. Traditional physician models rarely have the adequate access required for these effective early follow-up appointments, and holding a physician schedule open can be a costly waste of resources if the slots go unused. The utilization of an APP-staffed clinic is both cost-effective and clinically effective.

A second area within transitional care is the management of patients who are discharged to subacute rehab or skilled nursing facilities. Many hospital programs that evaluate their readmissions are finding that a number of the readmissions were originally dispositioned to a facility. The facility care is often meant for functional rehab, and at times, the disease process that provoked the original hospitalization can go unchecked. Some programs have developed care plans for these patients that include rounding by an APP to better evaluate and manage the cardiovascular disease processes. One such program took this approach for their HF patients and observed a decrease of 39% for all-cause readmissions and 48% for HF-related readmissions (MedAxiom Data/Cardiovascular Transitions Program, Spectrum Health, unpublished data, 2011) (Figure 1).

SUMMARY

With the rapid and dramatic changes in the health care industry, the increase in patient volumes, and the growing challenges of care coordination, a team-based approach is proving to be a viable and effective solution. A team-based approach for cardiovascular patient populations provides support to allow the increase in patient panel sizes, manage chronic diseases that require higher levels of resources, and develop specific programming around special populations. Building an appropriate team-based culture, utilizing team members to the top of their licensure, and developing guideline-driven standard work are all keys to success. The investment required will pay off in improved patient care and more satisfied patients and team members, all of which are priceless. ■

1. Doherty RB, Crowley RA; Health and Public Policy Committee of the American College of Physicians. Principles supporting dynamic clinical care teams: an American College of Physicians position paper. Ann Intern Med. 2013;159:620-626.
2. Virani SS, Maddox TM, Chan PS, et al. Provider type and quality of outpatient cardiovascular disease care: insights from the NCDR PINNACLE registry. J Am Coll Cardiol. 2015;66:1803-1812.
3. Welch T, Bilchick K, Reigle N. Cost analysis of heart failure readmission intervention program. J Am Coll Cardiol. 2016;67(13_S):1293.

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