Staffing for Success in Value-Based Care
A Guide for a Fast-Changing Healthcare System
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ABSTRACT
Healthcare organizations have long aligned their staffing models with the nation’s fee-for-service reimbursement system, which bases payment on the volume of services provided. But over the last several years, the healthcare system’s rapid move toward value-based care has clearly shown that existing staffing strategies must also evolve to meet the demands of new care delivery models.

Staffing models will need to take into account emerging skill sets and capabilities, including care coordination, patient engagement, population health management, team-based care and use of analytics. Making those adjustments won’t be easy, particularly in an increasingly challenging reimbursement environment. However, by leveraging available technology to automate processes, enhance data capabilities and enable providers and staff to focus on improving patient care, healthcare organizations can greatly ease the transition.

Frost & Sullivan and Phreesia created this white paper to give healthcare organizations a better understanding of current trends in value-based care and the staffing models that are best equipped for a rapidly changing healthcare ecosystem. This paper will review the staffing and operational strategies currently being undertaken by several high-performing healthcare organizations in various stages of the transition to value. Finally, this white paper will provide a practical, step-by-step framework of recommended roles, duties and best practices that can help position medical groups for success.

I do not believe it would be possible to effectively deploy and operate care teams without innovative new technology.

– Rob Lloyd, COO, Revere Health

THE MOVEMENT TO VALUE-BASED CARE: TODAY AND TOMORROW
While pay-for-performance programs have been around for a long time, the Affordable Care Act (ACA) greatly accelerated the U.S. healthcare system’s shift from a traditional fee-for-service model based on volume to one that rewards better outcomes and lower costs. For instance, the federal government went from paying $0 through alternative payment models in 2013 to making 20% of Medicare payments in at-risk arrangements by 2015. That same year, The U.S. Department of Health and Human Services set aggressive goals of tying 30% of Medicare payments to performance in alternate payment models, such as ACOs, by the end of 2016—a target it met 11 months early—and 50% by the end of 2018. ¹

There are now more than 800 accountable care organizations across federal and commercial insurance programs, including more than 470 Medicare ACOs. ² The Medicare Shared Savings Program (MSSP), for instance, was established by the ACA to make it easier for providers to coordinate care and reduce costs for patients.

Thousands of practices have also been accredited as patient-centered medical homes, and many organizations are participating in bundled payments and other performance-based arrangements. And approximately 715,000 physicians stand to see their payments change under the first year of the Medicare Access and CHIP Reauthorization Act of 2016 (MACRA).

Although the new Administration has introduced considerable uncertainty about the ACA’s future and specific policy timelines, Congress’ anticipated efforts to defund or amend portions of the ACA will likely center around restructuring Medicaid expansion and redefining how insurance is provided, but are still expected to have far less impact on the larger movement

¹. “HHS reaches goal of tying 30 percent of Medicare payments to value ahead of schedule” March 3, 2016
https://www.advisory.com/daily-briefing/2016/03/04/obama-administration-reaches-2016-value-based-payments-goal

². “Accountable Care Organizations in 2016: Private and Public-Sector Growth and Dispersion” Health Affairs Blog April 21, 2016
to value-based care. Industry experts contend that the overall move to value is widely viewed as the only way to address ballooning costs and improve health outcomes.\(^3\) This view was evident in the bipartisan support of MACRA—392-37 in the House and 92-8 in the Senate—which repealed the sustainable growth rate in favor of a permanent doc fix that incentivized performance.

The value-based care initiatives established by the ACA are based on the Triple Aim, which was first introduced by Dr. Donald Berwick and his colleagues at the Institute for Healthcare Improvement.\(^4\) Simply stated, the value of a healthcare system can be measured by its ability to deliver better quality outcomes and improve the overall health of the population it serves. When this optimal level of quality care outcomes and improved population health is achieved, the costs of care are reduced.

Figure 1 – Achieving the Triple Aim

![Image of Figure 1 – Achieving the Triple Aim]

Source: Frost & Sullivan

**MEETING THE VALUE-BASED CHALLENGE**

Healthcare staffing models are rapidly transforming in response to the goals and demands of value-based care. Team-based care strategies that emphasize care coordination, near real-time access to electronic patient information and patient engagement are emerging as the goalposts for success.

For some organizations, that will mean adding new roles while others may manage the transition—at least in the beginning—by training their existing staff on new skills sets. For instance, some organizations currently use medical assistants as scribes to maximize the time physicians can spend on direct patient care, while others leverage nurse practitioners and other extenders to treat lower-risk patients.

"We have to align with what patients want. The patient comes first." — Dr. Lewis Kohl, CMIO and Senior Medical Director, CareMount Medical

What is clear is that the emerging care team model requires a long list of new duties and skill sets, including identifying and targeting at-risk patient populations, coordinating care across settings, measuring quality, analyzing cost and utilization, addressing social determinants of health, and managing huge amounts of patient data. To meet these and other pressing needs, healthcare organizations must commit far more staff time. Technology plays an integral role by helping to stratify patient populations, facilitating patient communication, and automating administrative tasks to allow existing staff to engage patients and address gaps in care.

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3. “Value-based care will persist” NEJM Catalyst Nov. 15, 2016
   http://catalyst.nejm.org/value-based-care-will-persist/

We could not be successful without making changes to our staff. It's a strategic priority.
– Melissa Linder, Director of Care Management & Quality, The Iowa Clinic

Care team structures and roles vary from one organization to another, but what follows are some of the most common roles and descriptions that have emerged for managing the demands of value-based care:

Physician extenders, such as nurse practitioners and physician assistants, play a key role in team-based care by allowing physicians to practice at the top of their license and focus on the sickest patients. NPs and PAs can exponentially expand care team capabilities and increase patients’ access to care.

Nurse navigators are a vital component of value-based staffing. Usually registered nurses, these navigators manage care for complex, at-risk patients, as well as encourage patient self-management. Navigators usually have first-hand knowledge of patient-centric technology and are well-trained in the use of analytics.

Care managers are very similar to — and in many organizations interchangeable with — nurse navigators.

In some provider groups, care managers have a case management background but have a background in social work or some other field other than nursing.

Care coordinators are usually medical assistants or licensed practical nurses who are tasked with helping to manage care for high-risk patients with chronic diseases. These coordinators ideally have received training in population health and patient communication and are familiar with the organization’s quality targets.

Transition coaches are specifically tasked with managing transitions of care, such as from the hospital to home or from hospital to skilled nursing facility, to prevent readmissions. These coaches coordinate with other providers, communicate with patients and collaborate with community organizations. While many larger healthcare systems have dedicated transition coaches, most medical practices likely assign these tasks to an existing staff member or provider.

Population health analytics managers provide reports on targeted patient populations, monitor progress on quality and cost targets and present data in a usable, actionable form. As is the case with transition coaches, smaller provider organizations may not have a dedicated person who owns these tasks, although the investment in a dedicated analytics person will likely pay off.
Patient outreach/staff member is usually a non-clinical role that involves reaching out to patients to address missing tests or appointments, providing follow-up, and relaying instructions. Many organizations leverage technology to automate tasks related to patient intake, allowing front-desk staff to conduct patient outreach.

Revere Health manages more than 400,000 covered lives and has nearly 1 million patient visits annually, supported by approximately 1,600 employees. Transitioning to value and succeeding in accountable care required significant changes to Revere Health’s staffing model, Lloyd said.

“We now use what we call a care team model,” he said. “Our RNs are referred to as care team leaders and they work with our care coordinators and physician extenders, such as nurse practitioners and physician assistants to coordinate our care much more effectively. With proper use of care teams, modifying patient behavior is becoming more of a reality.”

Because Revere Health is physician-owned, its physicians make decisions about when and how to augment their staff since their decisions affect their net margin, Lloyd explained.

The move to a coordinated, team-based model of care was supported by Revere Health’s use of technology. For instance, the group automated its patient intake process, thereby freeing up more staff time to focus on care coordination, patient engagement and other tasks that improve outcomes.

“I don’t believe it would be possible to effectively deploy and operate care teams without innovative technology,” Lloyd said.

**Key Takeaways:**

- Team-based models of care that include a range of different providers and staff allow physicians to practice at the top of their license and focus on high-risk, complex patients
- Technology can free up staff time to help coordinate care
- Giving physicians the authority to modify and adapt staffing can accelerate change

### LESSONS FROM THE FIELD: STAFFING STRATEGIES IN ACTION

In order to gain deeper insights into the most effective ways to optimize staff for value-based care, it helps to look to high-performing healthcare organizations that are on the forefront of the transition. Frost & Sullivan analysts interviewed leaders from the following organizations to find out how they were thinking about staffing as they move to value, what roles and duties they have put in place, the technology they are using to support those changes, and the results they are seeing from their efforts.

#### Revere Health

Revere Health, a large multi-specialty physician group headquarterd in Provo, Utah, is well on its journey to value-based care. Rob Lloyd, Revere Health’s Chief Operating Officer (COO) characterizes the group as a mature ACO—Revere was the first Medicare-accredited ACO in Utah—and “an active value-based system.”

#### Iowa Clinic, P.C.

For the Iowa Clinic, P.C. the largest multi-specialty group in central Iowa, risk-based contracts and aggressive performance targets are nothing new. The group, which includes more than 200 providers and averages roughly 200,000 unique patient visits each year,
recently participated in an accountable care organization through the Medicare Shared Savings Program (MSSP), as well as Medicaid managed care agreements and value-based arrangements with its commercial payers, such as Wellmark Blue Cross and Blue Shield. In fact, 75% of the Iowa Clinic’s privately insured patients are covered under some form of value-based contracts, according to Melissa Linder, the group’s Director of Care Management and Quality.

Staying on top of the myriad quality metrics in those programs is a challenge, Linder stated. “Our goal is always to meet those measures. If we don’t, we don’t get shared savings and we know we’re not reaching our quality targets.”

Linder credits The Iowa Clinic, P.C.’s success in value-based care to its care management program, which the organization created specifically to improve outcomes and meet the demands of performance-based models of care. Care managers are embedded in each location, work with providers to develop a continuum of care, and ensure there are no gaps in service.

Before launching the care management program in 2015, The Iowa Clinic, P.C.’s leaders commenced a task force of physicians to determine what skill sets care managers should possess and what their goals and objectives should be. They conducted a six-month pilot comparing two possible scenarios: one with care managers based outside the clinics and another one with a care manager located in each clinic as part of the staff.

“Both approaches were successful,” said Linder, “but the embedded care managers were much more successful. They had a rapport with the physicians and staff, and worked as part of the team.

“Care managers stay on top of quality targets and costs, honing in on areas like preventable readmissions, patient education and gaps in care,” said Beth McGinnis, The Iowa Clinic, P.C.’s Chief Information and Revenue Cycle Officer. The percentage of patients who are deemed high-risk—such as those with diabetes, congestive heart failure and chronic obstructive pulmonary disease—varies by specialty. In internal medicine, for instance, 15% of patients are supported by a care manager while that percentage is 5-10% for family medicine.

The group has also added an assistant Chief Quality Officer and additional analytics staff and plans to incorporate social workers to improve end-of-life care. “We could not be successful without making changes to our staff,” Linder said. It’s a strategic priority.”

The Iowa Clinic, P.C. has also leveraged technology to make those staffing changes possible, whether through improved data analytics, patient engagement solutions or tools that help alleviate administrative burden.

For instance, because The Iowa Clinic, P.C. automates many front-office tasks, staff can help reach out to patients to address gaps in care, including necessary tests and visits.

Key Takeaways:
- Embedded care managers are more likely to develop strong relationships and become part of the team
- Keeping quality metrics at the top of the priority list and tasking someone with continually monitoring progress is necessary to meet targets
- Access to data—and the experts who can work with it—is critical to manage outcomes and provide patient-centered care

CareMount

CareMount Medical, the largest independent, multi-specialty practice in New York State, is still early in its transition to value but has made preparing for the shift an organization-wide priority. The group, which includes 425 physicians and 3,000 employees caring for more than 500,000 patients, is participating in value-based programs with performance measures—CareMount Medical was among the first group of ACOs in the Medical Shared Savings Program—but is not yet involved in full capitation, said Dr. Lewis Kohl, CareMount’s Chief Medical Information Officer and Senior Medical Director.

“We have done very well in fee-for-service and we feel like we’ll do well in a value-based world,” Kohl said. “The scary part is the transition.”

To smooth that transition, CareMount is building a technology infrastructure and changing staffing structures.
to meet the demands of value. The organization now has a team of care managers tasked with identifying high-risk patients and ensuring they get the appropriate care. CareMount Medical has also added data analysts to enhance the organization’s existing population health management capabilities.

According to Kohl, it’s clear that team-based care that leverages nurse practitioners, physician assistants, care managers and other professionals is best-suited to keep patients healthy and performance targets. The question is, however, what mix of those team members is the ideal care model?

“One physician and one staff member might work for a certain pool of patients with the right analytics at their fingertips,” said Kohl, “but for a practice that is bursting at the seams, they might need three nurse practitioners and a physician who sees only the sickest patients. A lot depends on where you are, how busy you are, and how sick your patients are. I don’t think there’s an absolute hard and fast model yet.

CareMount Medical is also thinking about ways to use social workers, as well as partner with community organizations to address issues like housing, access to food and transportation. “Insurance makes it very difficult to add these roles now, but we realize our patients need these services,” he explained. “Patients really benefit from seeing social workers and we will be adding them to our care teams in the future.”

In fact, CareMount Medical is exploring a range of potential staffing strategies. In the future, groups may even consider using paramedics to do home visits.

Kohl says that what is clear is that success will depend on the availability of good data.

“You simply can’t make this transition without the data,” he said. “I think the most impactful thing will be to continue to strengthen our population health management capabilities simply because it will give us the capability to understand what we need to do. The people in that department will be evaluating whether an arrangement is working for us, how we will be paid and whether we’re meeting targets — it’s essential.”

Key Takeaways:

• The right care team mix will likely depend on a range of factors, including location and how sick your patients are
• Social workers, nutritionists and other professionals are key members of a care team, even if reimbursement for their services is a challenge
• Success in value-based care is impossible without access to good data

Providence Health Center

When Providence Health Alliance began making the move to a more coordinated, patient-centric model, one priority rose to the top, according to Alan Tindell, Vice President - Physician Operations. “We knew we needed to address physician burnout and make sure our physicians were included in the process,” he said. “In the past — specifically with our EHR implementation — we did not take into account our physicians’ issues and their workload as we began to plan. This time around, we took that into consideration and engaged physicians at every step.”

Providence includes a 267-bed acute-care hospital and 21 clinics — including 8 primary-care locations — in the Waco, Texas area. It’s also part of Ascension Healthcare, the largest non-profit healthcare system in the country.

Providence Health Alliance’s staffing model is evolving, and they recently piloted a team-based care program aimed at making sure everyone operates to the top of their license or certification, allowing physicians to focus on the most complex, high-risk cases.

“In this model, we’ve given each of our physicians two assistants — either medical assistants or licensed vocational nurses,” Tindell said. “They serve as both a nurse and scribe. They go in the room and do initial work-up and they stay in room acting as a scribe during the encounter. At the end, those LVNs or MAs complete the education and guide the patient through rest of the process.”
The result is a more efficient workflow that gives physicians fewer administrative tasks and more face time with patients. During the pilot, patient satisfaction scores went up and physician satisfaction scores are “through the roof,” he said. “We even had one physician who is a year from retirement tell us that he plans to practice for at least another five years.”

Providence has expanded the pilot to another 11 physicians with eventual plans to implement the program throughout the organization.

Providence also created a nurse navigator role tasked with using population health analytics to identify high-risk patients and help coordinate their care. Physicians and staff responded well to the addition of nurse navigators, Tindell said, especially because they were included in the planning process.

“We began to see the formation of a true team effort between our staff and our nurse navigators,” he explained. “Physicians and nurses liked seeing the navigators address issues and life challenges that had been impacting patient’s overall health. Patients’ problems were being solved rather than just referred for consultation.”

To go even further at addressing social determinants of health, Providence Health Alliance plans to add social workers to the care team architecture in order to improve the network’s ability to prevent costly emergency room visits, especially among patients in rural areas.

None of these changes would be possible without technology, Tindell said. “In the future, we’d like to leverage technology even further to reduce the number of staff answering phones and doing other clerical work and transfer those FTEs to patient-touch roles.”

Key Takeaways:

- Involve physicians in planning new staffing models and ensure their concerns and workload are taken into account
- Use non-physician care team members to do tasks like data entry, coordination and patient education, giving physicians as much face time with patients as possible
- Leverage technology to automate administrative tasks freeing up staff to focus on patient-centric duties
CONCLUSION

As the healthcare system moves forward on the journey to value in spite of policy uncertainties, provider organizations are implementing the key staffing changes that will help them make care better, more cost-effective and more patient-centered.

Making large-scale changes to existing staffing models can be overwhelming, but this paper aims to highlight the work of forward-thinking organizations that have added roles and skill sets to meet the demands of new models of care.

As Lewis Kohl of CareMount Medical said, “We have to align with what patients want. The patient comes first.” Effective, team-based care models that leverage technology hold real promise for transforming care delivery and achieving the goals of the Triple Aim.

Figure 4 – Summary of Staffing Strategy Steps to Position Medical Groups for Success in Value-Based Care

01 Define and analyze your patient population (High Utilizers)

02 Establish how you will better coordinate care (Choose a care team model)

03 Transition your organization through education and one-on-one sessions (Teach value-based care imperatives and quality metrics)

04 Work to provide care coordination for high utilizers and drive improved quality outcomes

05 Align quality outcomes with value-based performance metrics to minimize risk and achieve shared savings

Source: Frost & Sullivan

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