THE GOVERNANCE INSTITUTE
A SERVICE OF nrc HEALTH
November 2019
System Focus

Creating a Primary Care Model for the 21st Century

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Key Board Takeaways

The primary care model must change to optimize clinical outcomes and reduce costs. Health system boards should:

- Replace the traditional physician-centered primary care model with a physician-led model with licensed practical and registered nurses providing services both as clinicians and as qualified clinical scribes under physician-generated protocols.
- Encourage and oversee the creation of value-based contracts that require robust risk and severity adjustment to succeed and to produce desired clinical and business outcomes.

The primary care model of the 20th century was made up of family physicians, general internists, general pediatricians, and OB/GYNs seeing relatively stable and healthy individuals on an ongoing basis to provide both screening and incremental care. The generic history and physical was largely discredited 30 years ago and so primary care physicians performed 20–30 focused evaluations a day in their offices and addressed patients' priority concerns in a time-sensitive manner. Most primary care physicians were forced to seek employment towards the end of the 20th century due to climbing overhead costs and declining reimbursement. Hospitals and health systems felt obligated to both employ these physicians to maintain access for patients and to potentially purchase their practices at fair market value in order to secure "feeder referrals." Unfortunately, many organizations lost a great deal of this investment due to the same falling reimbursements and climbing costs, and today many consultancies advise utilizing this model as necessary to feed the more profitable elective procedure and ancillary (e.g., laboratory, X-rays, CT scans, etc.) downstream revenue stream. It is argued that the typical $130,000 loss per primary practice per year will be offset by the high-margin revenue stream and that this is the necessary "cost of doing business."

This traditional model is no longer necessary nor relevant today and many forward-thinking physicians have created a far more progressive approach that utilizes the following three major innovations.

1. Utilize the Right Person for the Right Job

Homer Warner, M.D., the father of medical informatics at Intermountain Healthcare and the University of Utah once famously stated, "Physicians should never do what a nurse practitioner can do. A nurse practitioner should never do what a nurse can do. A nurse should never do what a technologist can do. A technologist should never do what a clerical specialist can do."

Over the past several decades, healthcare has evolved from an "intuitive" to an "empirical" to a "precision" model, meaning that standardized rules (such as clinical protocols, algorithms, and standards) can now be utilized to achieve an optimized outcome. Thus, whereas physicians should oversee the creation of standardized approaches to clinical conditions, it is no longer necessary for a physician to perform the day-to-day work.

Many primary care practices now utilize registered and licensed practical nurses (RNs and LPNs) to perform wellness evaluations and primary care services, utilizing clinical protocols developed by physicians and overseen by physicians and advanced practice professionals (e.g., advanced practice nurses and physician assistants). It makes no sense

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for a physician, a $300/hour professional, to perform a one- to two-hour wellness exam that pays approximately $126 under Medicare Part B when a licensed practical nurse, a $30/hour professional, could do so under appropriate supervision in a far more cost-effective manner.

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2. Utilize Qualified Clinical Scribes

Physicians often have limited knowledge of revenue cycle issues such as documentation, coding, billing, and collections and thus, inadvertently leave a great deal of money on the table. With the growing complexity of clinical documentation codes such as ICD-10 (which has over 79,500 new codes), it is imperative to utilize a professional that has complete knowledge of relevant clinical codes within any specific clinical area. Enter the clinical scribe, an RN or LPN with knowledge of specific clinical areas who becomes a certified coder, capable of translating the clinical work to appropriate documentation elements that can fairly and accurately capture the true acuity and complexity of patients being seen and treated.

According to clinical documentation improvement (CDI) auditors, the average healthcare system leaves approximately 35–40 percent of potential revenues on the table due to a failure to document and code relevant co-morbidities. In other words, when a patient presents with a given problem (e.g., diabetes), the clinician generally documents issues pursuant to the diabetes but fails to document other co-morbidities such as peripheral neuropathy, peripheral vascular disease, or chronic renal vascular disease, which adds significant complexity to a case.

A qualified clinical scribe is an integral member of the healthcare team who is present at the point of service to best guide the team to ensure a more comprehensive approach to both the treatment and document of clinical episodes of care.

3. Risk and Severity Adjust All Patients and Patient Encounters

Under value-based payments, increased risk and severity adjustment is directly associated with higher reimbursement. Conversely, failure to risk and severity adjust will lead to failing reimbursement models in an increasingly pay-for-value world. Thus, it is essential in every clinical setting to utilize risk and severity adjustment and to contract for risk and severity adjusted payments in order to realize optimum reimbursement at a time of falling payments.

Since 2004, Medicare, the largest healthcare payer, has utilized 79 hierarchical condition categories (HCCs) to risk and severity adjust its Medicare Part B (payment to physicians and ambulatory-based settings), Medicare Advantage (commercial carriers that provide coverage for Medicare beneficiaries), and Medicare-based alternative payment models (APMs) such as risk shared savings programs (accountable care organizations that lower the cost of care while meeting key performance metrics), bundled payments (a single payment for an episode of care such as a knee replacement), and advanced primary care (primary care models that meet key performance indicator targets for a portfolio of chronic diseases such as hypertension or diabetes).

Thus, failure to document the true granularity and specificity of each and every patient encounter makes it impossible to participate successfully in any of the value-based payment models. Only primary care practices that can work directly with payers (both public and private) willing to incentivize negotiated key performance indicators (KPIs) can hope to make a significant profit in the 21st century.

The Governing Board's Role

The governing board has an essential role in the transformation of its primary care services by ensuring that:

- Both management and physicians understand the imperative for this change.
- Physicians are supported in new executive roles in which they can be paid for delivering clinical and business outcomes to groups of "covered lives" and not compensated in a traditional wRVU productivity model.
- Practices standardize evidence-based approaches to all major clinical entities, particularly those that are higher risk and higher cost.
- There is a robust recruitment and training process for APNs, PAs, RNs, and LPNs willing and able to deliver primary care services under the oversight and supervision of physicians.

- RNs/LPNs are trained in both a clinical delivery and scribe model to effectively risk and severity adjust patients whom they treat.

Conclusion

The good news is that governing boards that are willing to lead the new primary care practices able to utilize lower-cost personnel utilizing physician-generated protocols and work with qualified clinical scribes to document and produce targeted outcomes based upon robust risk and severity adjustment will not only make handsome margins but will provide superior clinical outcomes at a fraction of the cost.

The traditional primary care model must be replaced in order to succeed in this century and governing boards will provide essential leadership to ensure that their health systems can deliver the kind of outcomes that their communities deserve.

The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc., for contributing this article. He can be reached at jburroughs@burroughshealthcare.com or (603) 733-8156.