Team-Based Care Offers a New World of Value

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In a world of value, accountable care, and shared savings, the overarching goal is to increase delivery of quality, affordable health care. Examples of cost-saving measures include appropriate triage of nonemergent patients away from the emergency department—instead directing patients to a primary care provider with extended office hours—and care coordination of chronically ill patients through condition-focused programs. Health systems and provider groups are rewarded for prevention with care coordination incentives that are absent from the fee-for-service model. To achieve care coordination, interdisciplinary teams are emerging with new categories of health care workers, including population health managers and care coordinators.

With team-based care, incentives will reward not what we do for patients, but instead how well we coordinate care through transitions like hospitalization or surgery. Preventing negative outcomes for patients with chronic diseases like diabetes or hypertension will take longer to realize, but the adage is true: "An ounce of prevention is worth a pound of cure."

Medicare population growth is significant and will leave many older patients facing access issues. Between 2012 and 2050, the United States will experience considerable growth in its older population. By 2050, one-fifth of the total US population will be 65 years or older, up from 12% in 2000 and 8% in 1950 [1]. The aging of the baby boomers is largely responsible for this increase in the older adult population, as baby boomers began turning 65 years old in 2011.

Nationwide, hospitals and health systems are also expanding health care delivery teams by using more physician assistants (PAs) and nurse practitioners (NPs), and there is a greater emphasis on team-based, interdisciplinary care. Increasing the capacity of the health system to meet the growing numbers of patients seeking care is critical. In the team-based care model, all team members can participate in delivery of health services by working at the top of their licensure and skill set. For example, PAs and NPs can be empaneled, offering primary care delivery services; nurses can conduct complex care management and patient education programs; front desk staff can call patients as needed to close evidence-based care quality gaps; medical assistants can provide medication review, goal setting, patient education, and electronic health record scribing; and pharmacists can support complex medication reconciliation and comprehensive medication management programs [2].

Implementing interdisciplinary care teams is critical to transforming a practice into a patient-centered medical home (PCMH). Leveraging the entire care team, including families and community partners, allows the PCMH to design efficient outreach processes that support patient health goals. Because of the challenges of building effective infrastructure and amassing appropriate resources, value-based accountable care programs develop more quickly in larger physician groups and hospital systems. Thus, newer federal incentives such as the Practice Transformation Network initiative encourage and incentivize resource allocation to smaller, rural providers [3]. In 2015, the Centers for Medicare & Medicaid Services awarded $685 million to 39 national and regional collaborative health care transformation networks and their supporting organizations to provide technical assistance that will give more than 140,000 clinicians and their practices resources designed to support value-based practice transformation.

Leveraging a team approach to care will allow physicians and other clinical members of the team to focus on diagnosis and treatment while nonclinical personnel address administrative tasks. There is mounting evidence that many care coordination activities are more effectively executed by nonphysician members of the care team. A single primary care provider would need more than 18 hours per day to provide all of the evidence-based preventive and chronic illness care required for an average panel of patients [4]. Other evidence shows that most providers spend 13% of their day on care coordination activities and only 50% of their day using their medical knowledge to treat patients [5].

As hospitals and health care systems continue to improve the quality of and access to patient care, team-based care is becoming more the norm. Organized medicine is catching on to not only the value for patients but also the return on investment when team-based care is used to improve patient health, wellness, and clinical outcomes. NCMJ

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