



A BLUEPRINT FOR TEAM-BASED HEALTHCARE IN TENNESSEE

Coordinating the Delivery of Care
to Improve Quality and Reduce Costs



EXECUTIVE SUMMARY

Tennessee enjoys a vibrant healthcare business climate. The nation's largest healthcare organizations are headquartered around Nashville and there are respected academic and public hospital systems, technology companies and healthcare service providers in all three Grand Divisions of the state.

Still, Tennessee's public health consistently ranks near the bottom in national studies. The Commonwealth Fund placed Tennessee at number 40 overall in 2014, while the United Health Foundation listed Tennessee at number 45; this despite the fact that approximately one-third of the state's budget is spent on healthcare.

With all the variables affecting healthcare access, quality and cost, Tennesseans may be best served by reexamining the point of care, where physicians and other healthcare providers encourage prevention, provide counseling and administer treatment.

Operational silos on the provider side have for decades created inefficiencies, obstructed quality and driven up costs. Antiquated rules governing supervisory relationships between physicians and other healthcare professionals do not help.

As industry stakeholders are challenged to respond to changing market dynamics, there is a clear opportunity to evolve Tennessee's healthcare system by adopting a patient-centered, physician-led, team-based approach to healthcare delivery.



MARKET DYNAMICS

Collaboration between healthcare professionals may seem like a no-brainer from the outsider's perspective – including patients' – but the U.S. healthcare industry is traditionally slow to adapt to new concepts, even those that are conceptually and practically effective. It can take a slew of pressures to ignite change that truly impacts patient care and/or financial operations.

Fortunately for patients, those pressures exist and are already driving healthcare providers toward more efficient and effective team-based delivery.

PAYMENT REFORM

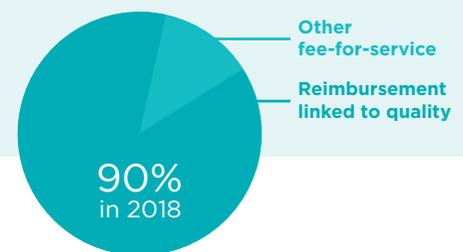
As government and commercial payers search for ways to trim their costs and deliver more value, a crop of alternative payment models has emerged that tie reimbursement to quality rather than quantity.

The State of Tennessee received a grant from CMS in 2013 to design a payment reform model and then a year later received \$65 million to implement the program. The State is moving forward with the Tennessee Health Care Innovation Initiative, which is designed to reduce the cost of healthcare and increase quality by moving from a pure fee-for-service model to a retrospective, value-based reimbursement system measuring providers' performance on specific episodes of care. Under the new model, providers are rewarded or penalized based on how well they perform compared to their peers. These financial risks and incentives should encourage Tennessee providers to work more closely with one another to achieve efficiency and quality targets.

Patients are adjusting to payment reform, too. Alternative payment models have for the past several years helped employers offset increasing insurance costs by shifting more of the financial burden to their covered employees. Higher out-of-pocket responsibility naturally compels patients to get more engaged in their own healthcare decisions, including where they receive care and how much it costs.

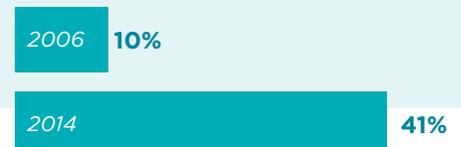


Nationally, the Centers for Medicare & Medicaid Services has committed to investing in alternative payment models such as Accountable Care Organizations, patient-centered medical homes, bundling payments for episodes of care, and more integrated care for beneficiaries. Its goal is to have 90 percent of Medicare fee-for-service payments in value-based purchasing models by 2018.



The Kaiser Family Foundation reports that an employee's contribution (premiums and out-of-pocket expenses) to his or her health plan now approaches \$5,000 per year, on average, and the percentage of insured working Americans with an annual deductible of at least \$1,000 increased to 41% in 2014, up from just 10% in 2006.

Americans with at least \$1,000 annual deductible:



\$9,000,000

CARE COORDINATION

Healthcare providers recognize that they must make some crucial adjustments to successfully navigate these new payment models, including becoming more integrated in the delivery of care.

The apex of higher quality and lower cost is not attainable without it.

Accountable Care Organizations were among the first efforts to create a coordinated network of payers and providers who share financial risk and reward based on patient outcomes. Participating payers and providers agree to a set of goals upfront for an episode of care and then work together to try to deliver the best care at the lowest possible cost. When they are successful, the patient has a better experience and better health outcome.

Technology also plays a key role in supporting better care coordination. While electronic health records, health information exchanges and other programs have not generated their intended interoperability, efforts remain afoot at the state, regional and national levels to leverage technology to improve information sharing. Most physicians concede that despite the additional administrative burden and significant financial investments associated with EHRs, digital patient records are a dramatic improvement over paper charts of old in terms of faster and more complete access to patient data and can help facilitate a team-based model.

More recently, patient-centered medical homes have emerged as a way to coordinate primary care services and emphasize communication between providers. The National Committee for Quality Assurance, a nonprofit organization widely recognized as a driving figure for healthcare quality improvement, reports that a medical home inspires quality care, cultivates more engaging patient relationships, and produces savings through expanded access and delivery options that match patient preferences with payer and provider capabilities.

PCMH initiatives grew 400% from 2009 to 2013 and continue to expand across the U.S. NCQA reports that private and public payer initiatives increased from 18 states in 2009 to 44 states during this same four-year period, and now cover nearly 21 million patients.

*MissionPoint Health Partners, Nashville-based Saint Thomas Health's ACO, said it saved **\$9 million** in its first year of operation and earned half of that back from CMS through the Medicare Shared Savings Program. The CMS program rewards eligible ACOs that demonstrate savings through better coordinating care. MissionPoint scored the **highest** of any Tennessee ACO on quality measures monitored by CMS, ranking at or above average compared to 220 national ACOs.*

*Tennessee Senator Lamar Alexander, the top Republican on the Senate Health Committee, has for years led a push in Congress to give healthcare providers more time to meet requirements of the Meaningful Use program, part of the \$35 billion HITECH Act passed in 2009. The American Medical Association **strongly agreed** with Sen. Alexander's calls for delays in 2015, saying the meaningful use program needs adjustments to achieve its goals of EHR usability and interoperability.*

\$310,000,000

Blue Cross Blue Shield of Michigan's patient-centered medical home project helped save \$310 million during its five years of existence, according to a University of Michigan study. The team-based model led by more than 3,000 physicians showed fewer hospital admissions, readmissions and emergency department visits, and more preventive services, enhanced chronic disease management and increased care coordination.

Tennessee aims to build on existing PCMH efforts in the private sector by creating a robust PCMH program as part of the Tennessee Health Care Innovation Initiative. The state's three TennCare Managed Care Organizations will participate in a statewide program to transform primary care, starting with approximately 12 practices and building up to a statewide aligned commercial and Medicaid PCMH program.



PATIENT ACCESS

There is already a shortage of primary care physicians in Tennessee, and the lack of integrated, coordinated care in our current system exacerbates access issues for Tennesseans. Patients who are not part of a health plan network that participates in an ACO or PCMH can have a difficult time matching up with primary care providers and specialists, especially in rural and other underserved parts of the state. Overutilization, such as redundant tests, is common. Worse, patients who experience barriers to access often prolong needed medical care until their condition deteriorates to the point of an emergency. This scenario costs everyone. Patients need support from all caregivers to ensure they get the care they need, when and where they need it, adhere to treatment plans and follow through with check-ups to achieve the best possible outcome and prevent other issues. Physicians need support from all caregivers in order to meet quality metrics in alternative payment model systems.



A growing population, aging demographics and a rising number of people with medical coverage under the Affordable Care Act mean demand for physician services is expected to quickly outpace supply. A report from the Robert Graham Center looking at 2010 primary care staffing levels in Tennessee found that the state needed to add 1,107 additional primary care physicians by 2030 just to maintain its current rates of primary care utilization. Further, only 15.8 percent of active Tennessee physicians in 2012 were younger than 40 while 26.5 percent were 60 or older (Association of American Medical Colleges).

2010



+ 1,107 primary care physicians



2030

CURRENT HEALTHCARE TEAM DYNAMICS

There are rules in Tennessee, as in every other state, setting parameters for how different healthcare providers should interact with one another in the delivery of patient care. On the surface, these rules protect patients and maintain some level of consistency across disparate provider relationships, geographic areas and medical practice environments.

Tennessee's rules stipulate that physicians, because of their education, training and experience, serve in a supervisory role for other practitioners, such as physician assistants (PAs) and advance practice registered nurses (APRN including nurse practitioners, certified nurse midwives, clinical nurse specialists and certified nurse anesthetists). These mid-level providers are licensed to provide a limited scope of medical services compared to a physician, but the shortage of primary care doctors, among other factors, has generated an increasing demand from patients who enjoy the convenience of having a PA or APRN attend to their uncomplicated medical needs. This phenomenon is illustrated by the proliferation in the last decade of in-pharmacy clinics staffed by mid-levels and offering a menu of uncomplicated health services.

Rules governing supervisory relationships between physicians, PAs and APRNs carry some nuances but are common in their fundamentals.

- Mid-levels who have earned and maintain licensure status from the appropriate board(s) can provide health services when acting under the supervision and direction of a supervising physician, if the services are within the scope of the mid-level's practice as dictated by law, described in a written agreement between the mid-level and supervising physician, and within the physician's usual scope of practice.
- Any physician who supervises a PA or APRN must possess a current Tennessee medical license (MD or DO), and demonstrate experience and/or expertise in the same area of medicine as the supervisee. Further, a PA or APRN should not provide services that are not also part of the supervising physician's practice. For example, if an APRN provides cosmetic laser services, then his/her supervising physician should also provide laser services.
- The authority of a PA or APRN to prescribe medications is set in a written formulary which describes the categories of drugs they may issue. Certain controlled drugs must either be specifically authorized in the formulary or specifically authorized by the supervising physician before issuance.
- Physicians are not limited in the number of providers they can supervise at any time. The medical board's policy just requires that it be "determined by the physician at the practice level, consistent with good medical practice."
- By the same token, PAs and APRNs may be supervised by multiple physicians in the same practice setting, such as hospital emergency departments where staff may be supervised by any one of many ER physicians, depending on who is on duty.
- The licensed physician must personally review a certain percentage of patient charts monitored or written by the supervisee within any given 30-day period.



CURRENT HEALTHCARE TEAM DYNAMICS (CON'T)

Very few provisions of the existing Tennessee regulatory climate limits or prohibits APRNs, PAs or any other healthcare providers from practicing to the full extent of their education and training.

But the one-size-fits-all requirements on physician supervision are broad and difficult to enforce. TMA has received anecdotal evidence, for example, of an ER physician supervising a family practice PA, and a psychiatrist supervising a family practice PA. These arrangements are unacceptable unless the supervising physician can demonstrate some competent level of training or experience in family medicine. If the relationship is not confluent by specialty or competency of services, then the supervising physician and mid-level should not engage in a supervisory relationship.

Aside from the obvious influence on quality of patient care, these relationships can also create liability issues for everyone involved. The prescribing of medications is a good example. Tennessee regulations state that any prescription issued by an APRN under supervision of a physician is considered that of the APRN, so the APRN has independent liability exposure if patients sue. Supervising physicians, however, might also be liable for medical errors by an APRN with whom they have a supervisory relationship.

Specific points within Tennessee's physician supervision guidelines are not necessarily out of whack and are actually very much applicable in many circumstances.

The notion, however, that a single set of regulations will work for every situation does not allow for the genuine collaboration needed within a healthcare delivery team.



Although Tennessee courts have yet to decide on the issue of a supervising physician's liability for an APRN, case law dealing with PAs may be indicative. These cases suggest that a physician may have indirect liability if the PA is the physician's employee or otherwise is considered the physician's agent. However, more recent case law suggests that a supervising physician may only be held liable for a PA's actions if the physician was aware of the PA's actions, such as if the physician read the patient's charts or was made aware of a medical situation by the PA. Both of the rulings in these cases could easily apply to a case regarding a physician's supervision of an APRN.

When the Tennessee Attorney General filed a false claims act lawsuit against a physician seeking funds for alleged illegal billings by his contract PA, TMA argued that state law does not require a supervising physician to oversee the billing aspect of the PA's practice; just the clinical aspect. In this particular case, the PA owned his own practice and submitted TennCare billings through a third party billing company. The supervising physician had no control over what bills were submitted. In September 2015, the trial judge ruled with TMA and the Tennessee Academy of Physician Assistants as a matter of law that a supervising physician is not responsible for the billing and coding practices of a PA that he/she supervises.

\$459,000,000,000

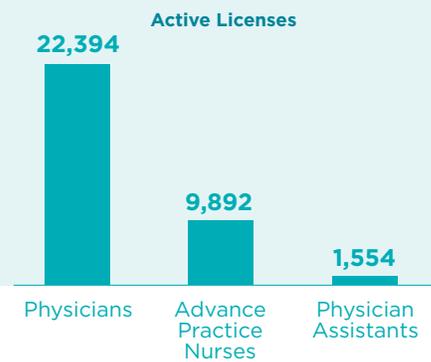
Our healthcare system needs fewer patients in the ER, not more. The American Hospital Association reports that since 2000, U.S. hospitals have given away more than \$459 billion in uncompensated care to their patients, including \$46.4 billion of uncompensated care in 2014.

CURRENT HEALTHCARE TEAM DYNAMICS (CON'T)

Tennessee's antiquated supervision rules were created in the late 1990s, long before the advent of modern healthcare delivery systems. For this reason, some providers - including physicians - may choose to overtly or inadvertently ignore them and practice without the appropriate interaction within the team setting. And when this happens, there is a direct and negative effect on patients.

- **Access** - Proponents of APRN independent practice argue that by separating from physician supervision altogether, they will be able to serve more patients and provide greater access to care. That may be plausible in theory, but in practical terms it would have unintended consequences. Without the education, training and experience in treating complex and serious medical conditions a relationship with a physician would bring to bear, there might not be a physician available for consultation and APRNs would be left to send patients to the nearest hospital emergency department for treatment.
- **Quality** - Allowing a healthcare professional to practice outside the scope of his or her medical training, without appropriate medical intervention or oversight, creates the potential for misdiagnosis and/or overutilization of services. Patients are simply more comfortable and confident having a physician either directly involved in their care, or leading the team, even for minor medical needs.
- **Safety** - There is general consensus within the medical community that different team members - from physicians to PAs to APRNs to other care providers - should be able to work to the fullest extent of their education and training. We compromise patient safety and quality, however, when we allow team members to perform outside their professional competence, without proper oversight through collaboration.

According to the Tennessee Department of Health, there were 22,394 total active physician licenses in Tennessee in 2013, compared to 9,892 advance practice nurses and just 1,554 physician assistants.



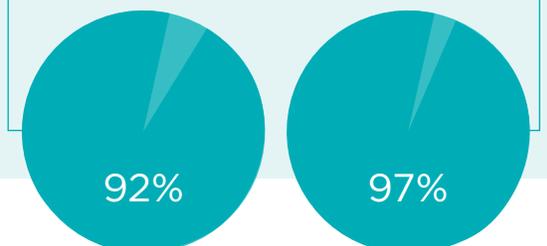
Medical errors are estimated to cause 100,000 deaths in the U.S. per year. Facilitating more effective teamwork should be part of concerted efforts to reduce diagnostic errors as healthcare delivery becomes more complex (Institute of Medicine).

Nurse practitioners in Tennessee prescribe more pain medications than any specialty, accounting for more than 20% of all supply, according to BlueCross BlueShield of Tennessee, the state's largest insurer. Nurses also consistently make up the vast majority of the Top 50 prescribers of Controlled Substances as reflected in the state's Controlled Substance Monitoring Database. These trends suggest that independent practice would do nothing to help combat the state's prescription drug abuse epidemic and, in fact, may well exacerbate the problem.



These trends have occurred with physician supervision required by state law. It would be unreasonable to believe that the problems would improve if APRNs had no oversight.

TMA found in a 2013 survey that **92%** of Tennesseans believe physicians should have primary responsibility for leading and coordinating their care, and **97%** of respondents felt that physicians and nurses need to work together in a coordinated manner to ensure that patients get the care they need.



VISION FOR THE FUTURE OF HEALTHCARE IN TENNESSEE

If Tennessee is to create more access to healthcare services, raise the overall quality of care to improve its consistently dismal public health status, and successfully rein in costs through new value-based payment models, then healthcare delivery must shift from a fragmented, inefficient system to one centered on collaboration.

Tennessee has an opportunity to lead other states with an innovative, team-based approach to healthcare delivery that involves a multidisciplinary group of healthcare professionals who communicate effectively, share information, participate in decisions about treatment plans and play unique and complementary roles in the delivery of patient care.



Physicians complete seven years or more of postgraduate education and more than 10,000 hours of clinical experience, many times that of any other healthcare professional.

1. IT MUST BE PATIENT-CENTERED.

The care team should work together, along with the patient and his or her family and any outside caregivers, to develop goals around patients' specific needs and perspectives. Acknowledging the patient's point of view upfront increases the likelihood that the patient complies with the treatment plan, is engaged in the process, and not only does not derail but actively contributes to the goal of the best possible outcome at the lowest possible cost.

2. IT MUST BE PHYSICIAN-LED

While some competencies may overlap among the various healthcare professionals on a team, physicians are undeniably the most qualified to direct overall patient care and should ultimately be accountable for the clinical care, quality improvement, and efficiency of care for each patient. They are the quarterbacks of the healthcare team.

3. IT MUST BE TEAM-BASED

Effective patient care teams have clearly defined responsibilities to maximize each team member's skills, education and training. Team members complement one another, subscribe to a common set of goals and work together to administer overall patient care.

HOW WE GET THERE

Collaborative healthcare delivery makes good sense on paper; the challenge lies in putting it into practice (pardon the pun). Following are some fundamental ways various stakeholders can make patient-centered, physician-led, team-based healthcare a reality in Tennessee.

LAWMAKERS AND REGULATORS

New public health policies or revisions to existing state law and rules should strengthen interprofessional relationships, not weaken them.

There are inherent problems in existing state rules, for instance, that require physicians to spend a minimum percentage of their time reviewing patient records though it may not be necessary in some practices. The rules should be updated to allow physicians to focus their review and involvement on cases that need specialized management versus routine care that is being handled fine by a mid-level under the patient's treatment plan.

Solution: The physician quarterback of the healthcare team should be required to review only complex charts, and be accessible to the PA, APRN and others on the team, as needed and determined by the team.

State law also currently requires the Board of Medical Examiners (BME) and the Board of Nursing to publish rules jointly defining the relationship requirements between an APRN and the APRN's supervising physician.

Solution: Doing away with the dual board approval would allow the BME to define what is complex and needs physician involvement. There should be no requirements for other, non-complex cases unless desired by the care team.

Current Tennessee regulations for supervisory relationships are based on a single protocol for all providers.

Solution: The relationship between a physician and PA or APRN should be one of collaboration and not supervision. Doing so gives each team member an opportunity to have input into a custom protocol that the team designs to best fit the team makeup, practice environment, specialty, experience level, patient mix and geographic area.



TMA introduced the Healthcare Improvement Act of 2015 to help pave the way for more team-based healthcare delivery in Tennessee, and will continue pushing the General Assembly to pass the bill in 2016.

PAYERS

Already the market is seeing health plans and payment models encourage care coordination. Aforementioned efforts like ACOs and PCMHs carry some level of support from government and commercial payers. Insurance companies wield a great deal of influence and can significantly impact the team-based movement by continuing to reward providers who demonstrate quality and efficiency through integrated care.

PROVIDERS

By collaborating with each other in a team setting, physicians and mid-level providers can give patients all the care they need, even if the physician cannot always be physically present. Not all areas of Tennessee allow for every single patient to have continuous access to a physician. And it is not always necessary.

The team should develop tailored treatment plans for each patient, drawing on the strengths of each team member to empower mid-levels and specialists to perform more proactive patient outreach to coordinate preventive care, screenings, follow up tests and other quality-generating efforts, while physicians can spend their time directing care on high-level, complex cases.

Consultation and communication between providers is imperative. Each team member should be clear in his or her role for the team to achieve optimal performance and avoid the unnecessary and costly duplication of services. At the same time, team members should be flexible and be able to adjust if circumstances warrant a change in the team responsibilities or treatment plan.

Effective communication and collaboration will naturally cultivate a culture of trust and respect whereby each member of the team is accountable, starting with the physician quarterback.

In a perfect world, integration extends beyond the healthcare professionals within a medical practice. Primary care physicians, APRNs and PAs should coordinate in the same manner with outside specialists, hospitals, rehabilitation facilities, and others in the referral network who in any way participate in the patient's care.



By 2017, it is expected that every major commercial health plan doing business in Tennessee will have an alternative payment reform component which includes quality measures.

The training and education of APRNs is appropriate for dealing with patients who need basic preventive care or treatment for straightforward illnesses and previously diagnosed chronic conditions. The APRN should be able to confer with his or her physician to determine exceptions within their practice.

CONCLUSION

In an era of outcomes-based payment models, in a region with incredibly poor public health ratings and high incidence of chronic disease, in a state where the top prescribers of Controlled Substances are mid-levels, we need more collaboration in healthcare, not less.

We need stronger interprofessional relationships based on principles of collaboration, integration and teamwork to reach common goals developed with and for each patient.

We need treatment plans that hold physicians accountable as the team leader, yet draw on each team member's complementary strengths to create an efficient and effective patient experience.

We need to recognize that collaborative relationships differ between practice settings, medical specialties and geographic areas and trust healthcare providers to develop appropriate supervisory protocols for uncomplicated healthcare scenarios.

We need lawmakers, regulators, payers and providers to collectively push Tennessee toward this new method of healthcare delivery that promises higher quality care at the lowest possible cost.

It's what Tennessee patients want. It's what Tennessee patients deserve.



SOURCES

- American Hospital Association: Uncompensated Hospital Care Cost Fact Sheet, 2015
- American Medical Association
- Association of American Medical Colleges: 2013 State Physician Workforce Data Book
- BlueCross BlueShield of Tennessee: Regional Advisory Panels Pain Management Variation Data, 2014
- Centers for Medicare & Medicaid Services: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume – January 2015
- Commonwealth Fund: Scorecard on State Health System Performance, 2014
- Health Services Research: Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs, 2014
- Institute of Medicine: Improving Diagnosis in Health Care, 2015
- Kaiser Family Foundation: 2014 Employer Health Benefits Survey
- MissionPoint Health Partners
- Nashville Post
- National Committee for Quality Assurance: Patient-Centered Medical Home Recognition
- Office of Sen. Lamar Alexander
- Robert Graham Center: Projecting Primary Care Physician Workforce (Tennessee)
- Tennessee Board of Medical Examiners
- Tennessee Department of Health workforce data, 2013
- Tennessee Health Care Innovation Initiative
- Tennessee Medical Association: statewide opinion polling, 2013
- Tennessee Medical Association internal research
- United Health Foundation: America's Health Rankings, 2014 Annual Report

