Physician-led health care teams with Bryan Batson, MD
[Podcast]

AMA Update covers a range of health care topics affecting the lives of physicians, residents, medical students and patients. From private practice and health system leaders to scientists and public health officials, hear from the experts in medicine on COVID-19, monkeypox, medical education, advocacy issues, burnout, vaccines and more.
Featured topic and speakers

In today’s AMA Update, Bryan Batson, MD, CEO of Hattiesburg Clinic, in Hattiesburg, Mississippi, shares details from a new study that demonstrates the value of physician-led, team-based care. AMA Chief Experience Officer Todd Unger hosts.

Read more about Hattiesburg Clinic's "Targeting Value-based Care with Physician-led Care Teams."

Learn how the AMA is #FightingForDocs and access resources from the AMA Recovery Plan for America’s Physicians.

Speaker

- Bryan Batson, MD, CEO, Hattiesburg Clinic

Transcript

Unger: Scope of practice is a really important issue and it's a key part of the AMA's recovery plan for America's physicians, and that's why I'm really excited today to talk with Dr. Bryan Batson, CEO of Hattiesburg Clinic in Hattiesburg, Mississippi, about a study that demonstrates the value of physician-led, team-based care. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Batson, it is a pleasure to have you with us today.

Dr. Batson: Thank you, Todd. It's great to be here.

Unger: Let's start off with a little bit of background about Hattiesburg Clinic. You've got a pretty incredible story that began with an analysis of cost data for your accountable care organization or ACO. So why don't you just start with a little bit of thinking behind your ACO structure. Any
background on that you want to provide the audience out there?

**Dr. Batson:** Yeah. Hattiesburg Clinic, we really began our value-based journey before we started this study in 2016. In 2011, we converted to the Epic EMR, and began gathering our quality data. But around that time is when we started reporting quality data to CMS as well through the PQRS or GPRO program.

And the ACO, we entered into a Medicare ACO contract in January of 2016. As you said, our organization is physician owned and physician-run, so we're an independent organization. So we have been invested in value-based health care for many years.

**Unger:** What prompted this analysis that we're going to talk about in more detail for your ACO? And what were you looking at specifically?

**Dr. Batson:** Well, as an organization that was really focused on improving value-based health care for our patients and our community, the Medicare ACO journey was integral to that. And one of the great benefits in being part of the Medicare ACO is that you are given the raw claims data and the total cost of care. So we were very curious to find out internally where our costs were going for our Medicare ACO patients. And out of curiosity more than anything else, we—one of the first things we wanted to do was try to look at who our highest cost providers were in our system.

**Unger:** So let's talk about what you found. And were you surprised by the findings?

**Dr. Batson:** Well, I'll say we were surprised in some of the stark differences that we saw. One of the first passes we took it the information, and when we were looking at our claims data and our cost data on our Medicare ACO patients was to look at our top 10 providers, if you will. So those physicians and/or APPs that were among the higher in the group for cost for our Medicare ACO patients.

And what we found was that eight of our top costliest providers, if you will, were APPs or advanced practice providers. Four of our top five costliest providers were advanced practice providers. In that top five, the one physician who was in that group was a physician who was specifically running a clinic for Medicare highly complex patients in the geriatric age group and those patients who had the highest complexities of care. So seeing her in that group was not a surprise. But what was a surprise was to see the other four in that group being all advanced practice providers.

**Unger:** Were you surprised by that?

**Dr. Batson:** I will say we were enlightened is probably a better term. Hattiesburg Clinic, we're in Mississippi, a state that has one of the lowest physician-to-patient ratios in the country. So Hattiesburg Clinic had been on a journey over the 10, 15 years prior to joining the Medicare ACO where we're expanding our care teams and did so knowingly with the addition of advanced practice providers to

Copyright 1995 - 2021 American Medical Association. All rights reserved.
And this was in the face of physician shortages and in a need to make sure that we were providing care to our patients that we were expanding the teams as quickly as we could. And over the course of that 15 years had significant growth. In around 2005, our organization had around 25 advanced practice providers but by the year 2020, we had over 180. So there was significant growth over the course of those 15 years in our care team makeup.

Unger: So when you dug in to the numbers, what else did you discover?

Dr. Batson: So this data set that we looked at, it was really looking in the mirror for us. It was really to say, as we are advancing in value-based health care delivery, how do we do it better? How do we refine our process? How do we refine our system in a way that we’re meeting the challenges of a value-based health care delivery?

So we had studied over 33,000 unique Medicare beneficiaries, and we really took a closer look at patients who are non-ESRD and non-nursing home patients. So the bulk of our patients of those 33,000 unique beneficiaries were not dialysis or nursing home patients. We began to take a deeper look at how is our quality, also our cost and utilization, and the patient experience.

And essentially what we did was to look at patients in two categories. One, those who had a physician as their PCP and those who had a non-physician or advanced practice provider, or a nurse practitioner or a PA. So we looked at the data across those big categories of quality, cost and utilization, and patient experience for physicians versus non-physicians.

Unger: And what ends up driving, let's say, the differences that you saw?

Dr. Batson: Well, I would say taking the first metric and quality, there were 10 quality metrics that we looked at of the Medicare ACO quality metrics. And of those 10, physician PCPs performed higher on nine of those 10. What I think was most stark in those findings was that there were double-digit differences in things like pneumococcal vaccination and influenza vaccination.

These are measures that we typically call process measures, that sometimes even a non-physician or non-APP can do with the help of a nurse or other rooming staff. So the significant difference in quality, especially in those two measures, was stark. That was really the quality metrics that we looked at.

Then on the cost side, we simply looked at per member per month costs for patients who had a physician as a PCP versus those who had an APP as a PCP. And the cost differences were also quite stark.

We broke that down a little bit further into looking at what was driving the cost differential between the two. And then, as I said, we looked at patient experience. But back on the cost, what we found was
that physicians who were the PCPs had, on average, about a $43 lower per member per month cost than those who had an APP as a PCP. And then we risk adjusting those. So to account for patient complexities and risk, we used HCC coding to risk adjust that, and the difference between physicians and APPS widened to nearly $120 PMPM.

**Unger:** And the factors that are underneath that on that cost side, so you looked at tests, referrals. Tell us more about that.

**Dr. Batson:** So certainly that was the next question, is what was driving that difference in cost? And there appeared to be a significant difference in the amount of tests being ordered per patient by APPs, the number of referrals to specialists by APPs. And then there was a higher ER utilization rate for patients who had an APP as their PCP. And those were fairly significant. So on average, APPs had about an 8% higher referral rate and they had about a 2% higher ER utilization rate than those patients who had a physician as their PCP.

**Unger:** So quality, cost, how about patient satisfaction?

**Dr. Batson:** Patient experience was another area that we looked into. And we had over 200,000 Press Ganey responses that we examined. And overall, patient experience was similar between physicians and non-physician PCPs, with physicians performing higher overall. But not a significant difference. Physicians were rated as a higher that overall rating of provider compared to our APP partners.

**Unger:** So this is a—it's big news. And you get this kind of data, what do you do with it? How do you make changes, then, to your care delivery model to reflect what you learned?

**Dr. Batson:** Well, first for us, I think it was really important and it remains true today, is we very much value our APP members of Hattiesburg Clinic. Our nurse practitioners and PAs have been integral to our journey. Up to 2020, when this study started, we really looked at this study in data from 2017 to 2019 with multiple thousands of patients. In that same three-year period, we saved Medicare—through the ACO, we saved Medicare over $23 million.

Our APPs in our organization were helpful in that. We were able to provide a lot of care to a lot of patients. We were ranked the number one ACO in the United States for quality for similarly positioned ACOs, patients—ACOs who started with Medicare the same year and we're in the same track as us.

So first and foremost, I think it's always important to point out the fact that we believe that the nurse practitioners and PAs in our organization are very important to our success. This study, if you will, this examination, this look in the mirror was how do we improve further upon it. So once we had this information, we felt it was time to redesign our care teams.
We took this information, had a lot of conversation internally about how do we repurpose our staff and our physicians. And beginning in January of 2021, we shifted to where primary care physicians were the only ones allowed to be the head of the team, if you will. So nurse practitioners and PAs were still part of our care teams but that patients were no longer to be—we're no longer allowed to be followed solely by a nurse practitioner or APP in the primary care setting. That was one step.

Another step was in the specialty world, that referrals in the specialty population needed to see a physician first. Again, our nurse practitioners and PAs are very instrumental in us being able to provide specialty care but we felt it was important that patients referred to specialists see a specialist physician first. And we had some ways that we could work with situations where the referring physician was okay with the patient seeing an APP or nurse practitioner or PA first. But by and large, the expectation is that the patients see a physician first when referred to a specialist.

Unger: Now Dr. Batson, I really appreciate the sensitivity that you're sharing about your staff and your care teams. And I think it's completely consistent with the messaging here at the AMA. We live in a team-based care world and what's really important here is that physician leadership part of that, what your data is showing. When you went to your staff and you talk to them about this, what was the reaction? How did you communicate that to make sure that those principles really came through loud and clear?

Dr. Batson: I think it was really with a focus on the patients. It is how do we provide the best care we can to the patients who are entrusting us with their care? When we approach it from that perspective, I think we can't go wrong if we're focusing on patients first.

We certainly are very fortunate to have a great physician staff and an APP staff, and it takes all of us to take good care of our patients. And that has been our driving principle from the very beginning. It is why we began examining our data back in 2012 to determine how do we do better. And I think that has been the driving principle from the beginning.

Unger: And how did the staff react?

Dr. Batson: There was—certainly everybody wants to understand the data better, and that's reasonable and expected. So a lot of this was educating ourselves on how do we do better, how do our physicians interact more meaningfully with our APPs and educate our patients on what team-based care looks like.

Team-based care is crucial. It is crucial, especially in a state like Mississippi, where we are underserved in many areas and we need to make sure we're leveraging everyone's skill set to the best of our ability. So education was a big piece of it. And then working our way through a year education process to our patients, that when we came to understand these truths about our value-based journey that we spent a year trying to educate our staff and our patients about this transition that was going to
take place in January of 2021.

**Unger:** Now it's interesting having heard the background on how you got into looking at the data. When you were doing this, did you have any sense that it was going to end up being used, really, beyond certainly Hattiesburg Clinic and have more national implications?

**Dr. Batson:** We didn't. I think there were certainly, as we started to understand it better and started to share our story with our state, the Mississippi State Medical Association, they certainly felt that it was a story that more people could learn from. This was a journey for us and it is still a journey. We're still learning and we're still refining. But we worked with the MSMA to make sure that we were helping share the story as best we could in the most appropriate fashion.

**Unger:** And you published that study called "Targeting Value-based Care with Physician-led Care Teams" in the Journal of the Mississippi State Medical Association. Are you are you seeing reactions from counterparts across the country?

**Dr. Batson:** Yes. We've had multiple organizations reach out to us asking how can they learn a little bit more about their own system and how can they refine it? It was quite simple. To be perfectly honest, it was really once you get the data from Medicare on your ACO population, how can you examine it in a way that helps you refine your process?

So we've had multiple organizations reach out to us. Naturally, there have been a lot of questions and some angst around some of the findings as well. But our purpose remains the same, is that we're going to continue to learn from our examination of ourselves and hopefully continue to improve on the way we deliver care.

**Unger:** I'm curious in particular about how a study like this gets communicated to a state legislator. We see issues around scope of practice. They do play out many times at state legislatures, and I think there are a lot of assumptions that get made around cost and coverage, state coverage that haven't necessarily been informed by data. So when you take a study like this, how's that played out in your own state?

**Dr. Batson:** We were very fortunate to have some legislators who sat down with us and looked at the data. I remember one legislator, we were looking at the Excel spreadsheets together and really digging down into the specifics. Not just the top layer and the headline, if you will, but really digging down into the data.

We were exceptionally fortunate to have legislators who are willing to sit down with us and understand the data and how we analyzed it, and really take a broader look at what this might tell. I think it helped, too, for the fact that we did this. This was local data in a health system in Mississippi, and our legislators were willing to take the time to understand what we learned, and what it was telling us and...
what we were doing in response to it.

**Unger:** Well, last question, and just a theme of our discussion today, you've been really clear that the findings that came out of this work don't undermine the important role that nurse practitioners and PAs play in care delivery and the health care team. Why is this so important to keep in mind, as other health systems look at what came out of the data and think about how it informs their own approach to physician-led care teams?

**Dr. Batson:** I think that has been—just like the first time that we were trying to digest this information ourselves internally, we had to understand the ramifications of it and we absolutely value our relationships with the nurse practitioners and PAs who work in our system. Likewise, the CRNAs and other APPs. That is crucial to this.

I think we need to be functioning as highly functioning teams and that requires multiple people on that team all working together. This has been an important piece of this for us and continues to be. And we hope that others will recognize that as well as they examine their information.

**Unger:** Dr. Batson, thanks so much for being here today. It's a pretty incredible story. I love situations where you gain so much insight from looking at the data and then you put that learning into action.

To learn more about the AMA's work on the scope of practice issues, you can check out the AMA's Recovery Plan for America's Physicians on the AMA website. We'll be back with another video and podcast soon. For all our videos and podcasts, check out ama-assn.org/podcasts. Thanks for joining us today and please take care.

---

**Disclaimer:** The viewpoints expressed in this podcast are those of the participants and/or do not necessarily reflect the views and policies of the AMA.