Practice Transformation in the Primary Care Space

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BACKGROUND AND PURPOSE

HCA Physician Services Group (PSG) has more than 1,200 ambulatory locations with more than 11.9 million patient encounters occurring annually. The ability to provide **high-quality and coordinated care** has inherent complexities in an organization of this size. Our journey towards a care coordination model started in the fall of 2013 with an internally developed tool, CareVantage. CareVantage was focused on identifying patients that had care gaps in the following four areas: **Hypertension management (based on Framingham Heart Study), Diabetes and A1C controls, Colorectal cancer screening, and Mammography screening**.

In late 2016, we identified the need to expand our care coordination efforts as we partnered with two Accountable Care Organizations (ACOs), joined 30 practices with Comprehensive Primary Care (CPC+), and managed numerous other payer quality initiatives.

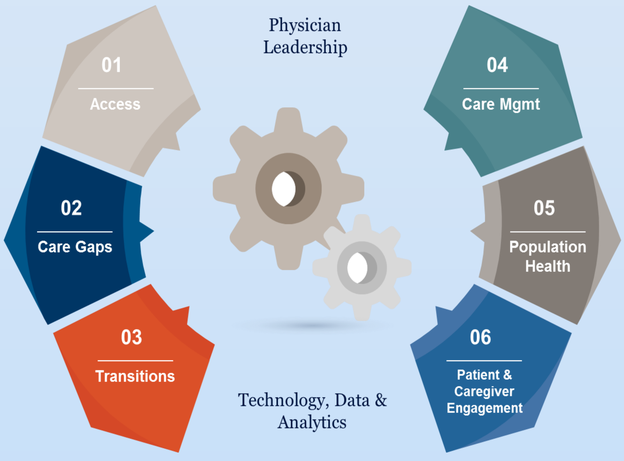
Over the past two years we have **expanded** our **care coordination** efforts and increased the focus on **transitions of care, closure of care gaps, and management of high risk patients** that need additional support to meet their health goals.

PSG CURRENT STATUS FOR CARE COORDINATION

PSG has implemented a care coordination model in a subset of locations across the enterprise based on market dynamics. There are **nine geographic regions** that have current care coordination activities. These include aligned ACOs, CPC+ participating practices, and various commercial and Medicare Advantage (MA) contracts. These markets constitute approximately **710,000 attributed lives**.

PSG's care coordination activities are being provided through our **primary care practices with the intent to provide a medical home to support holistic care of the patient**. PSG's care coordination model is purposely built to be **payer agnostic**. Our model is **physician led, coordinator supported, and wellness-focused**. It provides disease/condition support, transitions of care, and is based on research and evidence from current literature as well as practical experience.

PSG CARE COORDINATION MODEL



PAYER CLIMATE

CMS laid the foundation for a transition from fee for service to value-based purchasing reimbursement with **MACRA (previously Meaningful Use and Physician Quality Reporting System) and Transitional Care Management (TCM)**. These programs pay or penalize based on quality metrics instead of patient volumes. MACRA outlines **pay-for-performance** focus on quality outcomes and claim-based metrics in the form of Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models such as ACOs and CPC+. Research points to the **lack of integration and presence of silos as barriers for coordinated patient care, care transitions, and improved quality outcomes**.[2] This is further compounded by the lack of a team-based approach and care coordination complexity based on the fragmentation of care frequently seen in an ambulatory setting. As is frequently the case when CMS implements a new payer model or program, commercial payers are now following suit and implementing quality programs in their payer contracts similar to MACRA.

PSG PAYER-CARE COORDINATION DRIVERS

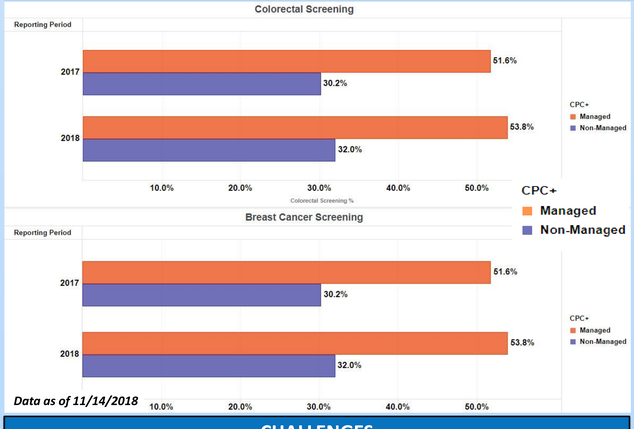
RESULTS

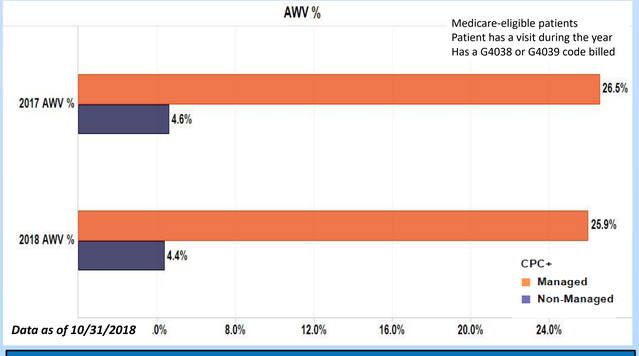
As part of developing a care coordination model, one of the early questions that arises is **how to measure value**? We continue to explore how to demonstrate the intrinsic and extrinsic value of care coordination – from a patient outcome perspective as well as from an operational and financial perspective.

In 2018, our team focused on improving care gap closures based on established clinical quality metrics as part of the CMS MACRA program. The following four metrics were our main areas of focus: **breast cancer screening, colorectal cancer screening, influenza immunization, and diabetes hemoglobin A1C (HBA1C) control**. Reviewing pre- and post-care coordination efforts, **we demonstrated improvement in each metric** comparing non-care coordinated practices with practices that have active care coordination.

In addition, with our **focus on transitions of care** to ensure our patients are effectively supported after hospitalization, one of our care coordination teams was able to accurately demonstrate that **greater than 80% of their discharged hospitalized patients met the transitional care management goals** (follow up in two days and patient appointment within 14 days of discharge). From a patient care perspective, **this supports the appropriate continuity of care to decrease inappropriate readmissions**.

IMPROVEMENT IN COLORECTAL & BREAST CANCER SCREENING AND ANNUAL WELLNESS VISITS (AWVs)





CHALLENGES

1. **Limited staff experience** performing care coordination in the primary care ambulatory setting. Hospital staffing models are not transferrable.
2. **Variable and competing payer requirements** make it challenging to develop a standardized care coordination model that is based on consistent goals.
3. Demonstrating the **cost versus benefit** of care coordination efforts.
4. Identifying **appropriate staffing ratios** for care coordinator to patient.
5. **Ambulatory electronic medical record limitations** including population health tools that are effective at documenting, sharing, and reporting information.
6. Preponderance of **behavioral health and social needs** that are often costly to address and have limited resource availability.

CONCLUSIONS

There are few who would argue that care coordination is not the right thing to do for patients. The care provided in the ambulatory setting can be fragmented, abrupt, and at times confusing to patients – especially for patients that are transitioning from an acute episode or inpatient stay back to their home and self-care management and recovery. Thus, we feel it is our duty as an organization to continue to refine and grow our care coordination program and share our success in support of patients everywhere. The success of care coordination across our enterprise and others is paramount to **creating a patient centric model of care that brings value to patients, providers, and payers**.

NEXT STEPS

PSG will continue to build on the care coordination model that has been established over the past two years. A top focus in 2019 will be the **creation of a comprehensive care coordination value and performance dashboard** that is inclusive of all program elements. This will allow us to better measure and focus our work on the areas of most opportunity as well as shift staff alignment where there is greatest need. Metrics that are being considered for this scorecard are the following: **Percentage of annual wellness visits; Inpatient readmission rates; Transitional Care Management (TCM) billing; Percentage of high risk patients (based on HCC scores) managed by care coordinators; and Overall patient satisfaction scores**.

Additional opportunities we will address in the coming year are working with our **Ambulatory EHR vendor to enhance functionality** for improved population health capabilities in the medical record. And working with key stakeholders to produce **education aimed at improving provider documentation and coding** in order to more accurately capture the clinical picture and HCC scores of our patient population.

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DISCLOSURE

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