Central Ohio Primary Care (COPC) Spotlight on Innovation

BY BETTER MEDICARE ALLIANCE
MARCH 2017

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CENTRAL OHIO℠ PRIMARY CARE

Central Ohio Primary Care (COPC) provides a model of high-value patient care through population health and care coordination strategies enabled by Medicare Advantage. Through Medicare Advantage, COPC has been able to work with plans to improve health outcomes and achieve greater value for the health care dollar.

COPC effectively utilizes six key strategies to provide early intervention and patient-centered care:

1. The coordinated use of a comprehensive electronic health record.
2. Utilizing value-based contracts to invest in infrastructure design.
3. Effective risk stratification to prioritize resources to the highest risk and costliest patients.
4. Leveraging physicians to facilitate efficient care in the hospital setting to reduce lengths of stay.
5. Managing transitions of care to identify gaps to reduce hospitalizations.
6. Making house calls to improve patients' experience and use the home as a site of care.

The COPC Journey Toward Population Health

COPC's journey toward population health started in 1996 when 33 physicians from 11 practices merged. The decision was driven by need for new physicians who work exclusively in the hospital, called hospitalists, common medical records, professional administration, and the development of ancillary services. Currently, COPC is the largest physician-owned primary care medical group in the United States with over 300 physicians in 57 locations throughout central Ohio. To this day, independent primary care and teamwork are the cornerstones of the COPC mission which is "to provide the highest quality of primary health care to patients while maintaining the highest ethical principles."

In 2010, COPC made the decision to transform primary care practices into Patient-Centered Medical Homes (PCMH). The model, certified by the National Committee for Quality Assurance (NCQA), emphasizes communication and care coordination. In 2014, COPC partnered with plans to expand investments in transforming primary care through the Medicare Advantage framework. The flexible nature of the Medicare Advantage framework provided COPC with the resources and information to invest in innovative care coordination programs. Out of the 350,000 patients COPC cares for, 21,000 patients are in Medicare Advantage.

COPC's successful population health and care coordination strategies would not be possible in the Traditional Fee-for-Service (FFS) Medicare program. The PCMH model and Medicare Advantage together have led to more effective care teams, meaningful use of electronic medical records, and increased access to primary care. COPC care teams now use a comprehensive medical record to monitor care, determine procedures for patient outreach and support a team approach to patient care. As a result, patients receive better care and have easier access to physicians due to open scheduling for daily emergency slots and urgent care facilities operated by COPC to provide care on evenings and weekends.

PCMH and Medicare Advantage provided the building blocks that enable population health and care coordination strategies to improve outcomes for patients and lower costs. In the future, COPC plans on expanding partnerships through the Medicare Advantage framework by taking on downside risk, adapting new plan benefit designs, and expanding their integrated care network through skilled nursing, end of life, and 24/7 care to continue the population health journey.

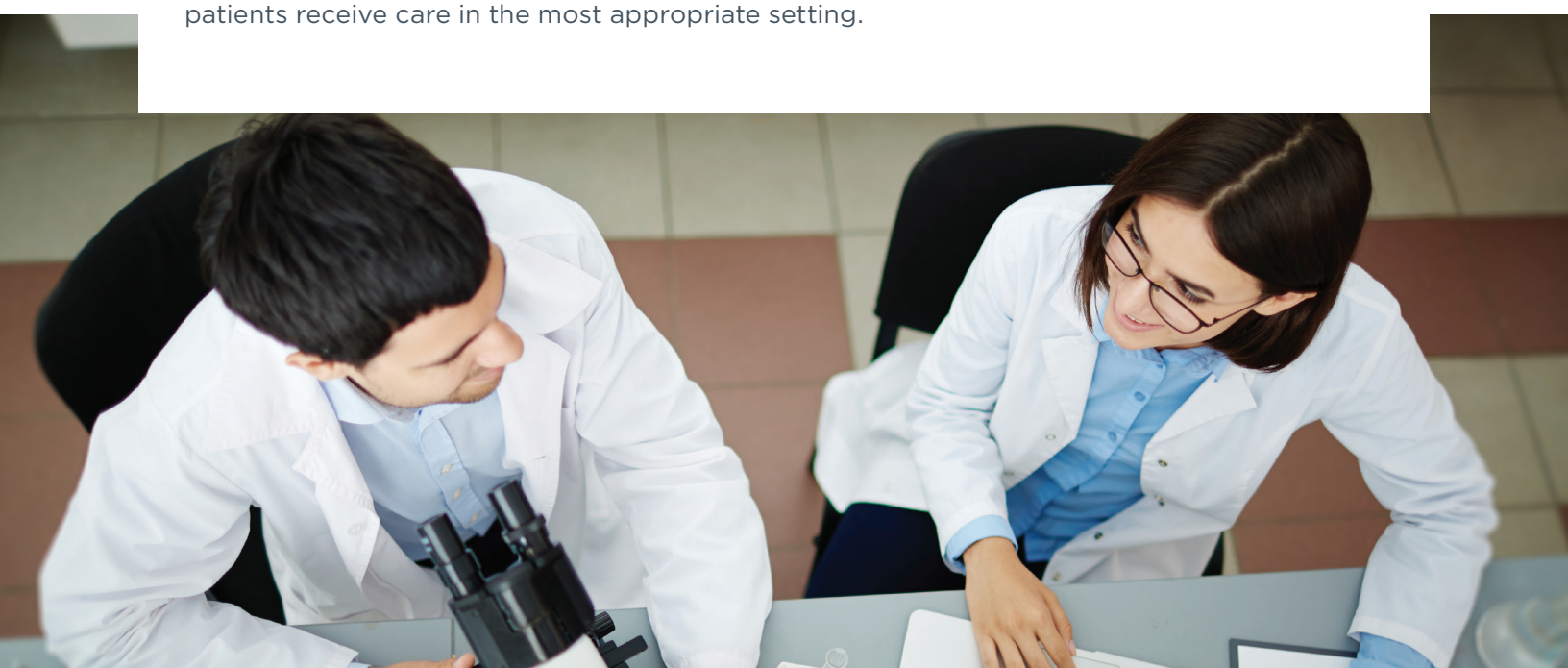
Essential Building Blocks of Population Health

COPC's population health initiatives are based on shared data between plans and providers used to identify at-risk patients. COPC population health building blocks include a comprehensive electronic health record for each patient, shared savings incentives through Medicare Advantage, and a focus on care coordination and early intervention for at-risk patients. Population health initiatives have improved patients' access to preventive services, lowered hospital admissions and readmission rates, and enabled patients to stay at home. COPC identifies risk by determining the 5% of patients that cost 45-50% of the health care dollar and the 20-25% of patients who may be in the top 5%. Patient populations are stratified into beneficiaries who require more robust care management, chronic care management, and patients who don't need or want higher levels of care.

1. COORDINATED USE OF A COMPREHENSIVE ELECTRONIC HEALTH RECORD AND CALL CENTER TO IMPROVE PATIENT CARE

COPC practitioners across settings use a common electronic medical record. The electronic environment has changed the way physicians practice as well as the interaction between plans and providers: COPC works in collaboration with Medicare Advantage plans to collect complete data in one record to ensure accurate risk adjustment captures the health status of each patient; the data is used by clinicians to facilitate the best care for the highest-risk patients; and accurate risk adjustment is critical to ensure providers receive the necessary resources to attend to each patient's needs.

COPC offers high complexity lab services, disease management programs, radiology and cardiac testing, among other services, providing a robust care network to patients that enables care to be captured in one record. The care network extends into four local hospitals through COPC-employed hospitalists. This model of care is designed to utilize a team of professionals who work with patients to improve access and standardize quality care, with administrative support from a central business office. COPC is setting up a 24/7 call center staffed by nurses who have access to patient's medical records to direct patients to the appropriate care setting. Innovative programs like the call center are designed to ensure that patients receive care in the most appropriate setting.



COPC partners with Medicare Advantage plans including Aetna, a health care benefits company that serves nearly 47 million consumers with resources and information to make decisions about their health. COPC and Aetna work together through value-based contracts that set a capitated (per patient per month) payment. Aetna also provides resources above and beyond the capitated payment to invest in infrastructure to deliver better care to patients. These resources enable COPC to invest in programs like hospitalist services, transition nursing, and home visiting. The investment comes with lower overall costs and improved health outcomes for patients. Through the partnership with Aetna, COPC has saved more than $2 million on 6,000 patients by implementing innovative care coordination programs.

2. LEVERAGING VALUE-BASED CONTRACTING TO INVEST IN INFRASTRUCTURE DESIGNED TO IMPROVE PATIENT CARE

All COPC Medicare Advantage contracts have shared savings arrangements that enable the provider to receive a portion of savings from cost-effective, quality programs. Dr. Bill Wulf, CEO and one of the founders of COPC, believes shared savings rewards physicians for interventions that improve health. For example, better care for chronic conditions like diabetes, and improved screening for conditions like colon cancer or breast cancer, creates value for the patient and the practice. Wulf has argued that purchasers of health care, including employers and patients, must demand value from the health care system.

Beyond providing COPC with additional resources, Aetna provides support to build on COPC's administrative capacity. For example, Aetna hosted a 7-hour workshop at COPC to support the implementation of process improvements to save time and reduce inefficiencies in practices.

3. RISK STRATIFICATION USED TO PRIORITIZE RESOURCES ON THE HIGHEST RISK AND COSTLIEST PATIENTS

COPC care coordination strategies target the 5% of high-risk patients who result in up to 50% of expenses. Care coordination teams consist of a primary care physician, a nurse, and a social worker. A patient is deemed high risk based on a physician referral, certain chronic conditions, or a hospitalization. A care coordination team meets with a patient in the physician's office or in their home to address both the medical and social needs of the patient. A patient who is high-risk is seen in the home within 48 hours of hospital discharge.

This new program prevented roughly 400 admissions in a population of 10,000 Medicare Advantage patients in its first year, out of the 1,000 patients who were enrolled in the care coordination program.

Care coordination services are also focused on a "rising" risk population. COPC identifies the top 20% of high-risk patients and provides interventions that target their condition. High-risk conditions include out of control Diabetes, Chronic Obstructive Pulmonary Disease, and Asthma. At-risk patients are identified and assigned to an office-based medical assistant who reaches out to the patient to obtain updates and provide support. These patients can also be referred to COPC condition-specific education classes.

Utilization of Patient-Centered Care Coordination Strategies

Medicare Advantage plans enable COPC to coordinate patients' treatment effectively because of the capitated payment system that provides up-front resources for care coordination. COPC uses these resources to implement value-based delivery models and patient-centered primary care. Filling gaps of care for beneficiaries through hospital interventions, effectively managing transitions of care, and care in the home improves patient outcomes. These programs have a beneficial spill-over effect on the ways COPC cares for their FFS Medicare beneficiaries.

4. LEVERAGING PHYSICIANS TO FACILITATE EFFICIENT CARE IN THE HOSPITAL SETTING TO REDUCE LENGTH OF STAY

COPC has continued to expand the use of hospitalists to facilitate the most efficient care for patients. The average hospital stay cost roughly $10,000, and Dr. Wulf estimates that about one out of four patients could be cared for in a less-costly setting. COPC hospitalists have access to the outpatient record, so all information on primary care, specialists, and hospital records are readily available to address a patient's medical needs. The 70 COPC hospitalists are shareholders and integrated into the care team.

COPC hospitalists caring for admitted patients noticed an increase in observation stays. Observation stays can occur when a patient doesn't meet admission criteria, but the doctor is concerned about sending the patient home. To ensure care is provided in the most appropriate setting for patients, COPC started a pilot program with Medicare Advantage plans to embed a physician and nurse in a local ER. COPC found ER doctors were putting patients in observation in part due to concerns about necessary follow-up care. A COPC ER intervention team was put in place to facilitate appropriate and timely follow-up care. As a result of the pilot program, many patients did not remain in the hospital, and 400 observation stays were prevented with an estimated $1.2 million saved. The program paid for itself in 6-months.

5. MANAGEMENT OF TRANSITIONS OF CARE TO REDUCE HOSPITALIZATIONS

Ensuring a patient remains in contact with a primary care physician across sites of care is one of many challenges for providers. Additionally, post-hospitalization care is critical to avoid re-admissions. To address this challenge, COPC utilizes nurses who visit patients in the hospital and coordinate their transitions of care. These transition of care nurses manage patients' move from the hospital to another facility or to home care. COPC has 14 transition of care nurses in the busiest area hospitals. The nurse makes telephone contact with the patient within 48 hours of discharge, reconciles medications, answers questions about follow-up care, and facilitates upcoming appointments. Throughout the patient's transition, the nurse communicates with the primary care physician. As a result of this program, COPC's 30-day remittance rate for Medicare Advantage patients is below 7% (the national average is 19% for Medicare beneficiaries).

FIGURE 1

12 MONTHS AT 3 HOSPITALS ALL MEDICARE		
		PERCENT READMITTED
TOTAL DISCHARGED	3954	7.1%
KEPT PCP APPOINTMENT	3682	5.7%
MISSED PCP APPOINTMENT	272	25.7%

12 MONTHS AT 3 HOSPITALS ALL MEDICARE ADVANTAGE		
		PERCENT READMITTED
TOTAL DISCHARGED	1094	4.4%
KEPT PCP APPOINTMENT	1016	3.5%
MISSED PCP APPOINTMENT	78	16.6%

COPC also identifies gaps in care by employing five registered nurses who use claims data from plans and electronic health records to help patients manage their chronic conditions. The nurses review medical charts to ensure patients receive services such as timely mammograms, colon screenings, and immunizations. The nurses, also known as quality nurses, look for gaps in care based on metrics from both the Healthcare Effectiveness Data and Information Set (HEDIS) and Stars quality measures. The nurses work with physicians to ensure health records indicate needed follow-up care for patients.

Timely care is a critical element of ensuring patients receive necessary preventive and follow-up care. COPC operates three urgent care facilities for their patients so they remain in network even when care is required outside of normal business hours.

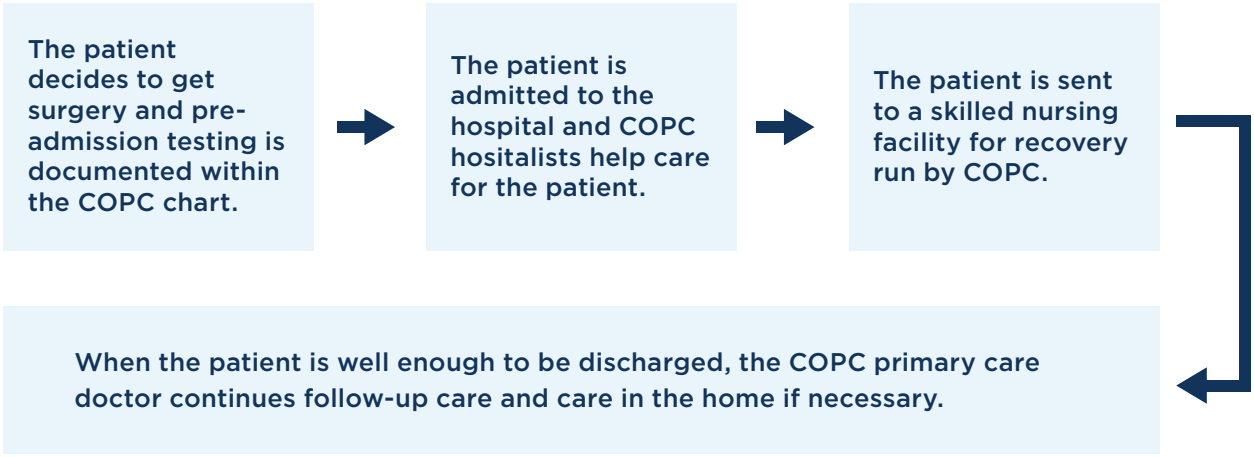
6. MAKING HOUSE CALLS TO IMPROVE THE PATIENT EXPERIENCE AND KEEP SENIORS AT HOME

COPC also cares for patients at home with two physicians dedicated to making house calls to the most vulnerable patients. The physicians have on average two visits per day, which facilitates effective care to patients in crisis. The goal is to keep patients out of the hospital through preventive, palliative, or hospice care in the home and improve patients' experience and satisfaction. Since FFS Medicare payment is per service, this program is more feasible in Medicare Advantage. The visiting physician program prevented 70 hospital admissions in the first 12 months of the program, creating savings of more than $700,000.

Keeping seniors in their own homes is a priority, which is why COPC has partnered with National Church Residences, the nation's largest nonprofit provider of affordable senior housing. The goal is to provide 24/7 home medical care for seniors in crisis. National Church Residences service coordinators track the health of seniors under their care and work with COPC to address health concerns and avoid unnecessary hospital visits or premature moves to higher levels of care.

FIGURE 2

COPC Care Coordination Team Touch Points from a Patient Perspective



Conclusion

Through the Medicare Advantage framework, COPC adds value to care for their patients by implementing six key population health and care coordination strategies:

1. The coordinated use of a comprehensive electronic health record.
2. Utilizing value-based contracts to invest in infrastructure design.
3. Effective risk stratification to prioritize resources to the highest risk and costliest patients.
4. Leveraging physicians to facilitate efficient care in the hospital setting to reduce lengths of stay.
5. Managing transitions of care to identify gaps to reduce hospitalizations.
6. Making house calls to improve patients' experience and use the home as a site of care.

COPC is a model of how to effectively work within the Medicare Advantage program to improve health outcomes and achieve greater value for the health care dollar. COPC will continue to partner with Medicare Advantage plans, take on more financial risk, and become active participants in the development of plan design. COPC is a strong example of how the flexibility provided by the Medicare Advantage model fosters a greater ability to align incentives to get the right care to the right patients at the right time.

Medicare Advantage has enabled COPC to implement care coordination strategies through the full spectrum of health care settings. COPC has reduced hospital readmissions through transitional nursing care, visiting physicians, use of hospitalists, and quality nurses. The programs have been so successful that COPC CEO Dr. Wulf said,

"If our CFO came to me tomorrow and said we have to stop one of these programs, I don't know which one we would stop."

Thank you to the organizations who contributed to this Spotlight on Innovation:

CENTRAL OHIO PRIMARY CARE

Central Ohio Primary Care is the largest physician-owned primary care medical group in the United States. We have over 325 providers and 55 practice locations throughout central Ohio. COPC was established in 1996 when a group of 33 physicians chose to focus more on the quality of patient care they were providing and less on the administrative paperwork. The result was the creation of an administrative support team that gave doctors more freedom to do what they do best - practice medicine. COPC has full-service laboratory, complete radiology services, cardiac testing, and hospitalist services. We have first-rate health management programs, including two physical therapy centers, an innovative diabetes management program, and an asthma disease management program. We have two SameDay Centers and a Pediatric Support Center that support our practice's urgent care needs seven days a week.

AETNA

Aetna is one of the nation's leading diversified health care benefits companies, serving an estimated 46.7 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. Aetna's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored

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