

Coastal leaders describe challenges of designing the primary care practice of the future

Goal is to be patient-focused, data-driven and service-centered

BY MARY KORR
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PROVIDENCE – **G. ALAN KUROSE, MD, MBA**, president and CEO of Coastal Medical, recently described the growth and transformation of the designated Accountable Care Organization (ACO) over recent years to the Executive Masters in Healthcare Leadership program at the Brown School of Public Health.

Dr. Kurose, who began his career in a small internal medicine practice, gave a snapshot of Coastal: It is physician-owned and governed, with 88 doctors, 25 NPs/PAs in 19 clinical offices and has an active patient roster of 120,000.

The primary-care driven organization has operated on a Patient Centered Medical Home (PCMH) model since 2009, and is recognized as a National Committee for Quality Assurance (NCQA) Level 3 PCMH. “When we say call us first we really mean it. The front desk person is not a hockey goalie,” Dr. Kurose said in describing Coastal’s drive to be patient-centered.

Patient access has increased with Coastal365 adult clinics for urgent primary care visits, which are open

weeknights until 9 p.m., and during the day on weekends and holidays.

“But if you are going to provide access 365 days a year, it is going to cost money,” Dr. Kurose said. “Physicians are working on Sundays and holidays; it takes 20 more nurse care providers and six fulltime pharmacists. The care gets better and better, and we are learning what the costs are.”

He continued, “You are actually trying to change the behavior of physicians and patients. This notion of managing population health, of making the health of a population your goal, is not something that we were trained to do. This was not the perspective we came to this work with. You’ve got to keep measuring and changing performance. And you need the business model to support this. To save you need to spend.”

Meryl Moss, Coastal COO, said this required a “massive redesign to create the new primary care practice of the future.” After seeking input from the entire Coastal cadre of employees, the shift away from autonomous offices began.



Dr. G. Alan Kurose spoke on designing the primary care practice of the future to the Executive Masters in Healthcare Leadership program at the Brown School of Public Health.

Some activities, such as prior authorizations, documentation and prescription ordering have been centralized.

“Every office has a leadership team redesigning something about their practices. We are experimenting with about 18 pilot programs at present,” she said.

Quality measures/shared savings

Dr. Kurose said Coastal reports on 72 quality measures across five shared-savings contracts, so it takes a lot of infrastructure and technology to support this. The organization has sought out incentive programs to defray some costs. In 2012, Coastal participated in a Medical Shared Savings Plan (MSSP) pilot program with the Centers for Medicare and Medicaid Services (CMS).



Coastal COO Meryl Moss describes aspects of employee engagement to attendees, who included diverse professionals from the medical community.

PHOTOS BY MARY KORR

CMS provided Coastal with \$2.4 million over two years to fund the group's investment in staff and information technology to track and benchmark outcomes for 10,000 Medicare patients.

An MSSP is based on total cost of care. CMS determines "benchmark" costs with a weighted average of the prior three years, adjusted for population risk scores and national cost trends. If the cost savings are greater than a minimum savings ratio, the cost saving share is up to 50%. A quality score determines how much you earn.

Coastal was one of 29 of the 114 ACOs in the pilot program that generated savings; it reduced the total cost of care for the 10,000 patients in its Medicare ACO by 5.5% from July 2012 to June 2013.

The CMS Benchmark was \$87 million. "We generated savings of \$4.6 million, with the largest cost reductions in inpatient hospital and skilled nursing facilities (SNF)," Dr. Kurose said. "We received \$2.3 million from CMS but it was actually used to deliver this care."

He attributed the drivers of cost savings to:

- Hospitalizations down 21%
- ER visits down 7%
- ER visits leading to admissions down 21%
- Readmissions down 18%
- SNF costs down 42%

Technology/Data

Data analytics is an important tool used in achieving cost savings and better health outcomes for patients, Dr. Kurose said. "More and more, physicians and our medical providers are focusing on identifying and reaching out to their patients through, among other tools, data analysis, "because otherwise we might not hear from them. They are at home living their lives but we know their diabetes or hypertension is not being managed as well as it could be."

One of the most recent innovations is "claims-based analytics," he said. Coastal gets raw claims files from its third-party payer partners and runs it through a software management system and Coastal's electronic medical records system to generate a 'gaps-in-care' report; for example: Has the patient had a mammogram? A physician can look at what the patient reported and if it was paid for.

Physicians can also drill down into patient panels to view pharmacy records, or global inpatient, outpatient costs the patient has accrued over the year anywhere.

It also has the capacity of predictive modeling. For example, a physician can

try and determine all the patients with the greatest risk of hospital admission within 30 days. This Johns Hopkins' modeling software is built into the eClinicalWorks electronic health records Coastal uses.

Dr. Kurose said Coastal's experience is not readily translatable to the three-physician office he practiced in at the beginning of his career as a primary care internist.

"This group process, data collection, statistical analysis and contracting, those things are not immediately accessible to small practices. They would have to find some way to aggregate to conduct this business." ❖



Dr. Kurose showed the components of an ACO in this slide.