Case study

Changing culture, managing risk

Northwest Primary Care takes a proactive approach to value

As a physician-owned organization, Northwest Primary Care prides itself on its ability to deliver quality care to patients at every stage of life. The 26-provider family and internal medicine practice offers preventive healthcare, physical therapy, sleep studies, and other services, with eight locations in the Portland, Oregon, area.

NWPC became involved in value-based care through Medicare Advantage plans and value sharing contracts in the 1980s. The main motivation for the move toward value-based care was financial.

"If you manage patients well and you live within your medical budgets, you share financially in the upside," said NWPC Medical Group Administrator Michael Whitbeck.

The practice began to participate in contracts that would allow its providers to be rewarded financially for better managing patients and delivering improved clinical results. Since then, it has entered into more aggressive contracts, ranging from contracts that offer shared savings all the way to full capitation — and not just for primary care, but all professional services.

To meet clinical and financial targets, NWPC relies on a care team that is integrated through technology and manages patients using strategies that mitigate clinical risk.

Care coordination to minimize hospitalizations

Changing culture was an early challenge NWPC faced.

"Physicians have to get the idea that the way to maximize profitability is to keep patients healthy," Whitbeck said. "Give them what they need, when they need it, and where they need it and keep them out of the hospital. Once physicians started practicing that way, it changed the culture. Now with us, it's been the culture for decades."

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>
> — Jeanette Christopher, Director of IT, NWPC

While the practice initiated case management for early Medicare Advantage risk contracts, it has expanded those roles to accommodate today's value-based programs. It used Comprehensive Primary Care Initiative funds to set up care coordination and added infrastructure to post-care coordinators at clinic locations.

Once high-risk patients are identified through American Academy of Family Physicians (AAFP) guidelines, they are assigned a care coordinator, who reaches out to them at least monthly. One staff member is dedicated to patients who are high utilizers of healthcare services, which is defined by three emergency room (ER) trips in a 90-day period, or five in six months. And because of the role of social determinants in healthcare outcomes, the practice keeps social workers on staff, provides tools for self-management of COPD and pain, and partners with community resources in areas such as hospice, aging, and disability.

"A patient may have chronic conditions that are controlled, but they are isolated, live in low income housing, and have little financial support," Whitbeck said. "That may kick them higher on the

risk scale, even though their condition is controlled. If you don't have financial resources, family, or friends, the likelihood of you utilizing the ER is probably greater."

Once patients are hospitalized, the cost of care escalates sharply.

Managing risk in-house

To ensure maximum insight into patients' conditions and treatment, NWPC manages patients regardless of diagnosis. In a normal primary care environment, if a patient is diagnosed with chronic heart failure, chronic kidney disease, or cancer, that patient is referred to a specialist and subsequently managed by that specialist.

"In managed care you don't do that," Whitbeck said. "You manage the patient internally as much as possible. You only refer out to the specialist as needed and you get the patient back into primary care for their follow-up as quickly as possible. This is a real big culture change."

Optimized technology

All patient data — conditions, treatment plans, hospitalizations, specialist referrals, and social welfare needs — is logged, stored, and disseminated to the proper staff using Greenway's Intergy EHR and practice management software. As it does for all practices participating in value-based care, technology supports the practice's infrastructure.

To maximize the value of that infrastructure, NWPC's data analyst added an Open Database Connectivity (ODBC) back door to the Intergy database.

"This allowed him to pull the exact information we need and set it up to run each day," Whitbeck said. "The reports, alerts, and information on which the nurses and doctors will rely are right there, automatically, every morning."

When seeing patients, whether it's the first visit or after a hospital discharge, NWPC's providers also leverage Intergy's EHR care plans. These are at the forefront of the patient's chart, not buried in a document or deep within encounter notes. Providers can click on the care plan and know what the plan is and what the follow-up should be. The care plan is the refined result of all data the practice collects on the patient.

Intergy's patient portal also facilitates patient communication and follow-up. This system allows practitioners to communicate securely with patients and provide them information such as test results and reminders, while also allowing patients to make requests. The practice encourages patients to sign up for secure messaging via the portal. It's a "wonderful tool," Whitbeck said, that helps strengthen patients' engagement in their own health and wellbeing by providing a secure means of two-way communication that's available 24/7.

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