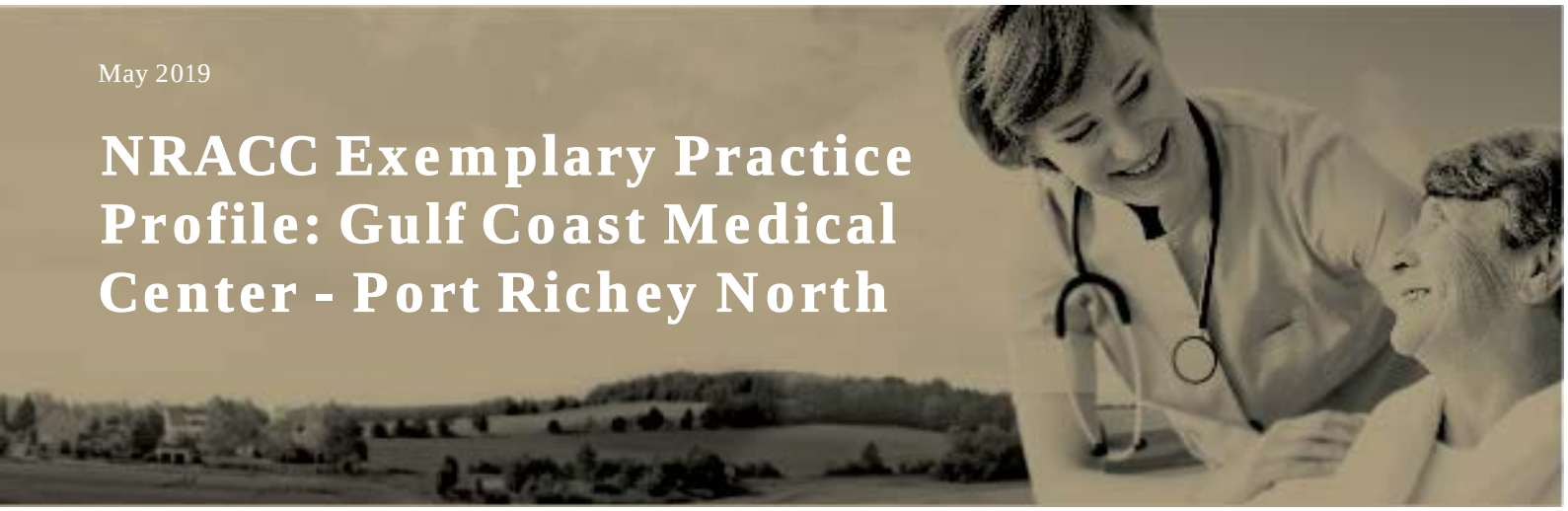
NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM
A 501(c)(3) ORGANIZATION

Gulf Coast Medical Center



May 2019

NRACC Exemplary Practice Profile: Gulf Coast Medical Center - Port Richey North

Gulf Coast Medical Center, a leading provider of outpatient services, was seeking assistance with Merit-based Incentive Payment System reporting when the practice joined the National Rural Accountable Care Consortium in August 2017 as a referral from the Centers for Medicare & Medicaid Services.

Ultimately, we took full advantage of NRACC coaching and technical support to make significant leaps in population health management, including a greater focus on prevention and wellness and ongoing support to patients to help reduce complications and emergencies related to chronic conditions.

About the Practice

Gulf Coast Medical Center is a privately-owned organization with five locations in Pasco and Hernando counties on the west coast of Florida. Our 26-member medical staff includes both internists and family practitioners as well as specialists in cardiology, podiatry, gastroenterology and pulmonology.

We provided care for more than 25,000 patients in 2017, including about 4,000 in Medicare. The most prevalent conditions across our patient population include diabetes, heart disease and chronic obstructive pulmonary disease.

We are a recognized Patient-Centered Medical Home and Joint Commission accredited. We also are closely involved in medical education and have more than 50 internal medicine residents rotating throughout our practices and participating on health care teams.
In 1982, a group of physicians led by Dr. Steven Strobbe opened the first walk-in medical clinic in New Port Richey in Pasco County. More than 22% of the nearly 540,000 residents of Pasco County are over the age of 65.

When we enrolled in the Transforming Clinical Practice Initiative, we sought MIPS assistance but were immediately interested in increasing Annual Wellness Visits, improving Chronic Care Management and engaging patients more effectively. Before joining TCPI we were unaware that help was available.

PASCO COUNTY HEALTH STATUS

Indicator	Year	County	State
Adults who are current smokers	2016	23.3%	15.5%
Adults who have ever been told they have a depressive disorder	2016	19.1%	14.2%
Coronary heart disease age-adjusted death rate (per 100,000 population)	2015-17	102.3	95.2
Colorectal cancer age-adjusted death rate (per 100,000 population)	2015-17	15.3	13.5
Diabetes age-adjusted hospitalization rate (per 100,000 population)	2015-17	2581.8	2344.5

Source: County Health Status Summary Profile - 2017

The Transformation Process

One-on-one monthly coaching calls with our quality improvement adviser were instrumental in creating our CCM program and helping us enroll more than 200 patients in the past year. Our goal was to enroll 10% of our Medicare patients in CCM by the end of 2018 (currently we are at 5%). The Plan-Do-Study-Act we worked through with the NRACC's support helped us develop a pathway and a process to make the CCM goal obtainable.

Although we are a Patient-Centered Medical Home and Joint Commission accredited, all of our AWVs were previously outsourced due to a lack of resources. The QIA coached us on the implementation of nurse-led AWVs. They also helped us complete NRACC's Return-on-Investment Tool to financially model this change and assisted with our development of a PDSA to implement the model. We began integrating the nurse-led AWV model in May 2018 and since bringing this service in-house we have conducted almost 600 AWVs (May-Oct). The goal was to complete 800 nurse-led AWVs by the end of 2018.

We have a unique health care challenge because of our location. We have a big influx of winter visitors over the age of 65 who live in our area about seven months a year. During this time, we are in constant contact with Medicare Administrative Contractors and other clinics across the United States to see if patients have had AWVs, enrolled in CCM, or have a primary care provider back home. To better serve this population, we work closely with clinicians across the country, utilizing secure messaging and deploying Collaborative Care Agreements to promote care continuity and to reduce duplicate services.

Our primary goal in joining TCPI was to achieve at least a neutral payment adjustment from MIPS. NRACC helped us by walking us through a MIPS checklist of the necessary steps to receive a positive adjustment. We focused on meeting the requirements for the quality measures, improvement activities, and advancing care information. With NRACC's guidance and MIPS assistance, we were able to utilize our electronic medical record (EClinicalWorks) to report as a group for performance year 2017 and achieve a score of 94. We are confident that PY 2018 will be even better.

We have been able to use NRACC's resources, such as the 24-hour, nurse-advice line and health coach training, to work on reducing hospitalizations and emergency room visits. We have also implemented the PDSA change model with support from our QIA and set strategic goals on increasing both AWV rates and CCM enrollment.

Providing Patient-Centered Care

We believe that patient engagement is an effective way to improve population health. Under NRACC's guidance, we have developed a quality improvement team as well as a supervisory team that collaborate on policies and procedures to support patient and family engagement. We have incorporated interpreter services for the deaf and made brochures available in Spanish. In addition, we have bilingual staff to assist. We use medication management through medication reconciliation and participate in the state's Prescription Drug Monitoring Program.

Since joining TCPI in 2017, our practice management team of three has attended every NRACC coaching call. The trio has worked diligently in the past year to better manage chronic conditions and to establish ongoing relationships with patients.

In the past year, we established an education and quality assurance department. The department has helped the practice understand and interpret data while ensuring all measures were reported accurately. After running the quality reports, our team would contact our NRACC QIA for coaching on how to improve quality. As we have a moderate number of patients with diabetes and heart disease, we wanted to focus on ways to better serve this population. Having more insight into our quality measures has been instrumental to accruing cost savings of nearly $250,000. We are currently exploring options for alternative payment models.

Improving Quality, Lowering Costs, Moving to APM

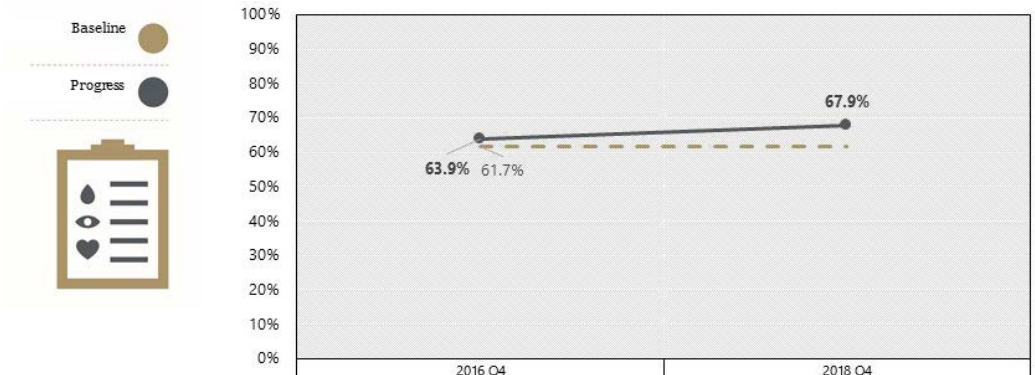
While we were performing well prior to enrolling with NRACC, we were a practice that needed assistance to go from good to great. Due to strong engagement and coaching, we were able to progress from Phase 1 to Phase 4 within TCPI.

Because of the AWVs, we are scheduling more preventive screenings and vaccinations. The percentage of patients being screened for colon cancer increased 32 points to 68.7%. Pneumonia vaccinations went up more than 60 percentage points. Depression screening increased 19 percentage points. Based on screening results, we come up with an effective treatment plan and follow-up.

We have also made gradual improvement in controlling high blood pressure in our patients. We created a standard operating procedure for monitoring high blood pressure.
Staff check the patients' blood pressure on multiple occasions throughout the visit as well as evaluate whether the patient is taking medication as directed. We started using a device to spot-check vital signs to help save time and see more patients.

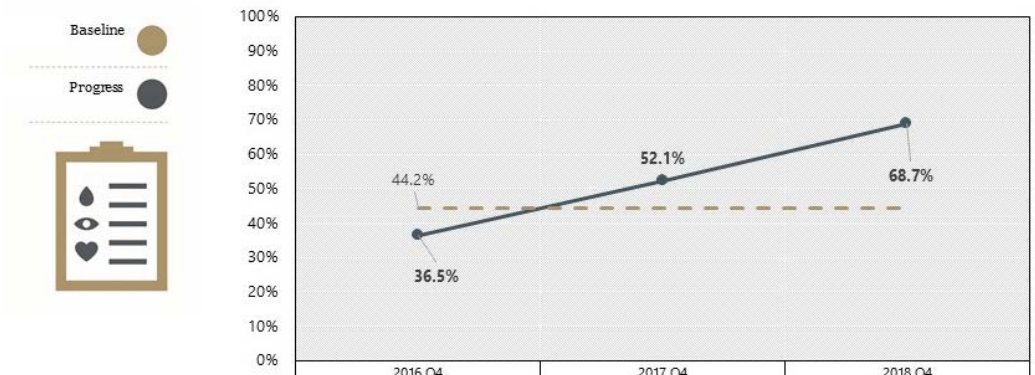
GULF COAST MEDICAL CENTER – PORT RICHEY NORTH

Improvement in controlling high blood pressure



	2016 Q4	2018 Q4
Numerator	2274	7623
Denominator	3560	11231
Rate	63.9%	67.9%
National average benchmark	61.7%	61.7%

Improvement in colorectal cancer screening



	2016 Q4	2017 Q4	2018 Q4
Numerator	2194	5450	7448
Denominator	6014	10457	10836
Rate	36.5%	52.1%	68.7%
National average benchmark	44.2%	44.2%	44.2%

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