CASE STUDY

If You Build It

Primary care transformation at Corewell Health

Corewell Health is the recipient of the 2024 AMGA Acclaim Award. As part of the Acclaim Award application process, healthcare organizations are asked to submit narratives describing major systemwide initiatives that exemplify the goals of the award. One of the narratives from Corewell Health's application is summarized below.

Corewell Health embarked on a transformative journey toward value-based care, beginning with a comprehensive reevaluation of primary care. This ambitious shift was designed to maximize value by achieving superior health outcomes at reduced costs. Key strategies included segmenting patient populations based on specific health needs, creating integrated interdisciplinary teams, employing diverse care delivery methods, incorporating robust data integration, and embedding specialty care within primary care. Additionally, provider compensation was realigned to reflect value-based outcomes. This strategic overhaul was driven by a commitment to achieving the Quadruple Aim and advancing the crucial goal of health equity.

Primary Care Redesign

Following the engagement of the organization in risk arrangements with payer partners, Corewell Health looked to primary care to usher in new models of care that would better serve the goals of the system and its patients. In total, the organization is responsible

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for more than 357,000 patients with risk-based contracts, 290,000 of whom are empaneled to Corewell Health West's 250+ primary care providers (PCPs) across 65 primary care practices. The engagement in risk contracts finally aligned the goals of the organization with those of patients, and a number of key performance indicators (KPIs) were selected to target the services that would most influence success in the contracts: emergency department utilization (EDk), inpatient admissions (ADk), and Per Member Per Month costs (PMPM). Successful targeting of these KPIs required the development of a strategy inclusive of the financial, clinical, operational, technical, and experiential elements of care delivery.

Strategy

It was acknowledged early on that incremental improvements or modifications at the individual clinic level would not accomplish the degree of change required to achieve Corewell's vision. The entire department needed to be reimagined to implement the guiding principles that would inform the design of key processes and achieve the performance requirements for sustainability. These principles included:

- **Population segmentation** based on severity of conditions for a tailored approach to care for unique patient cohorts, typically grouping patients into Healthy, Rising Risk, High Risk, and Medically Complex and Frail categories.
- The creation of **integrated, interdisciplinary teams** developed around each patient cohort customized to the specific needs, conditions, and severity of those conditions with top-of-license care provided by allied health clinicians.
- **Physicians' time and effort aligned with their unique expertise**, such that PCPs spend most of their time managing and creating plans of care for medically and diagnostically complex patients, rather than on sick visits for healthy or medically stable patients.
- **Care delivered through multiple modalities**, such as virtual care, asynchronous care, in-person physician office visits, home visits, or other remote patient monitoring (RPM).
- **Integrated data and information** to measure outcomes that matter to patients, quality KPIs, and costs of care for each patient subgroup.
- **Aligning provider compensation and incentives** with value-based outcomes and shifting away from volume of reimbursable services.
- **Integration of specialty care in primary care**, through which primary and specialty care providers function as members of a joint team organized around meeting the needs of patients.

In service of these principles, Corewell Health adopted a care model that created medical centers offering team-based care that was tailored for at-risk populations that are historically underserved, at-risk due to social determinants of health (SDoH) factors, or had other identified needs and care preferences. Identified populations requiring special consideration included the following:

- Urban Medicaid patients with higher prevalence of behavioral health and substance use disorders
- Older adults with multiple comorbidities at high risk of ED use and inpatient admissions
- Patients in rural communities that have higher rates of chronic disease and historically have underutilized healthcare services due to access problems
- Younger, healthy patients who have an interest in wellness but who tend to underutilize healthcare due to lack of interest or engagement, creating downstream risk

The result was the creation of multiple primary care practices that catered to these populations:

- **Community Medicine Clinic (CMC)**, which serves the urban, SDoH need-intensive population
- **Advanced Primary Care clinic (APC)**, for complex geriatric patients
- **Rural Rising Risk clinics (RRR)**, which serve patients in rural areas with higher incidence of social and structural barriers
- **Virtual Primary Care practice (VPC)**, for younger, healthier patients focused on prevention and wellness
- **Rising Risk clinics (RR)** to serve geographically diverse patients with higher incidences of chronic disease

AMGA Acclaim Award

AMGA's Acclaim Award honors healthcare delivery organizations that are bringing their organization closer to the ideal medical group and health system by measurably improving patient experience of care; improving health of populations with a focus on quality outcomes; reducing the per-capita cost of healthcare; and emphasizing workplace wellness.

AMGA's prestigious Acclaim Award highlights the continued research and investigation toward finding the finest models of medical management, coordination of care delivery, and a systemic approach to improving the patient and provider experience.

***For more information about the Acclaim Award, visit* amga.org/acclaim.**

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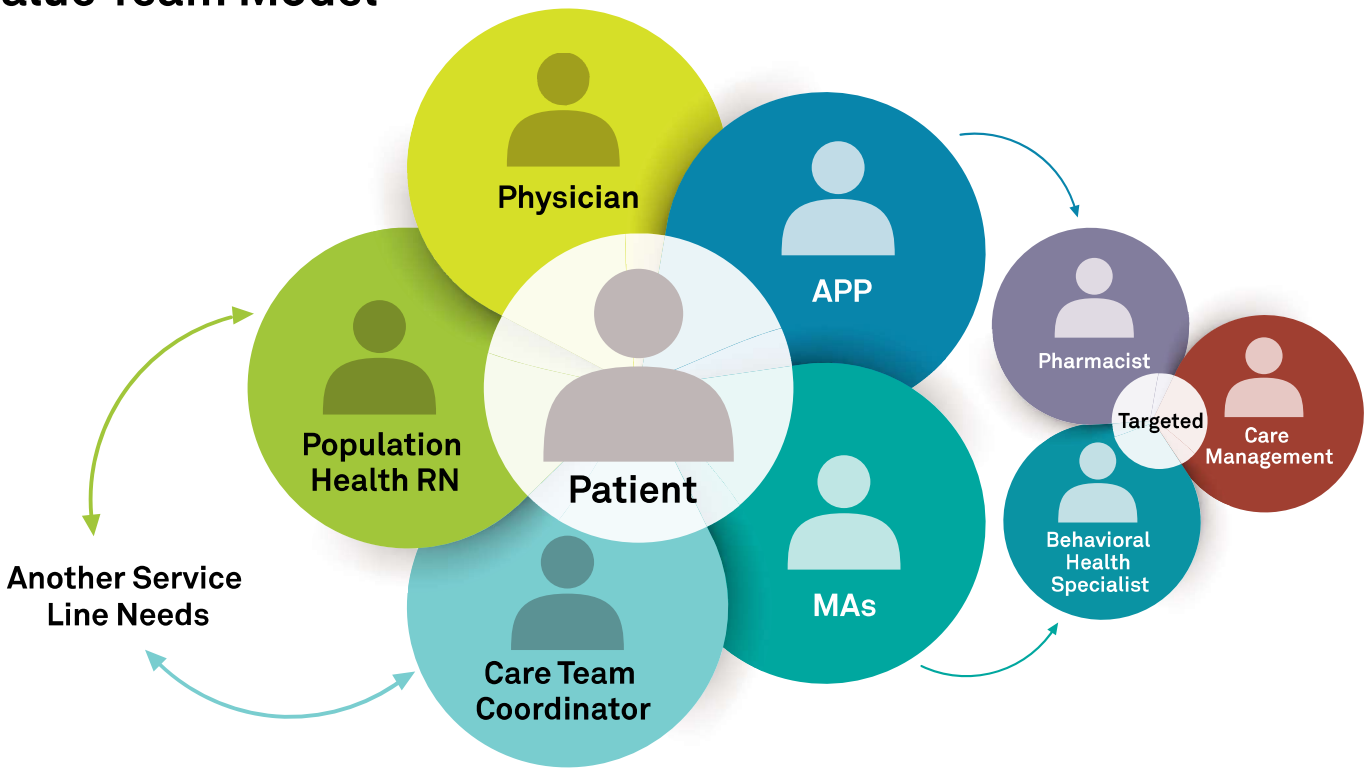
Figure 1
Value Team Model



The care team model was designed to leverage existing system resources but also included the creation of new roles, such as the Population Health RN and Medical Assistant (MA) Coach. In addition to these roles dedicated to panel management, value teams were equipped with embedded care managers, pharmacists, and behavioral health specialists who provide services to those at higher risk of adverse outcomes or who have complex care needs (Figure 1).

These clinics also developed additional tactics that were specific to their patient populations and based on their individual needs. For example, the APC clinics offer transportation services and home visits for patients with transportation barriers, while CMC embedded a physical therapist to help patients who suffer from chronic pain. The RRR clinics developed walk-in telehealth sites to improve access, while the RR clinics embedded specialty services lines such as endocrinology and diabetes education in their clinics to assist with chronic disease management.

This team model facilitated top-of-license practice for clinicians, allowing physicians to leverage the clinical expertise of others while still being able to keep patient care "in-house." It also allowed for the diversion of relatively healthy patients to advanced practice providers (APPs) and allied health staff so that the physicians can dedicate their time to those most in need of complex care. Optimal team function and communication is facilitated by daily huddle times that are spent discussing patients, as well as shared electronic medical record navigators and modules. Department process improvement meetings are also held weekly to ensure the opportunity to address clinical and operational issues and iterate locally.

Results

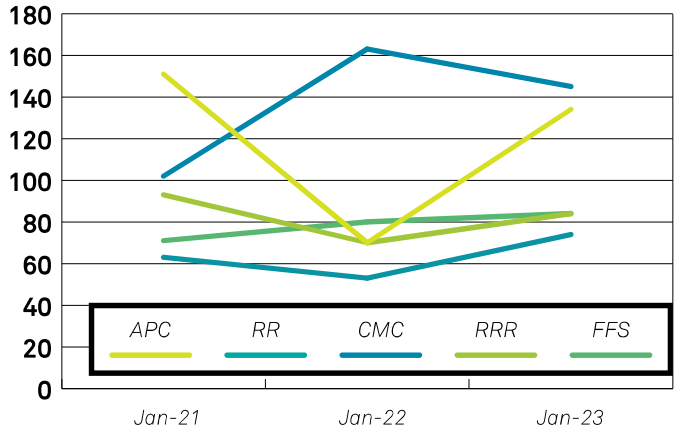
Given the operational, clinical, and technical overhaul that this redesign required, the first two years of work were largely concerned with team building, role definition, patient recruitment and reassignment, logistical factors, workflow design, and change management. Different approaches and tactics were required for those clinics that previously existed as fee for service (FFS) (e.g., Rising Risk, Rural Rising Risk) vs. those that were newly formed (e.g., APC, VPC). Therefore, it has taken some time for the dust to settle and the clinics to become fully operational as intended. However, despite the time required to become established, the clinics have shown remarkable improvement in both clinical outcomes and the meeting of operational targets.

Key Performance Indicators

Multiple operational and clinical KPIs were established and monitored to measure the success of the clinics' impact on

Figure 2

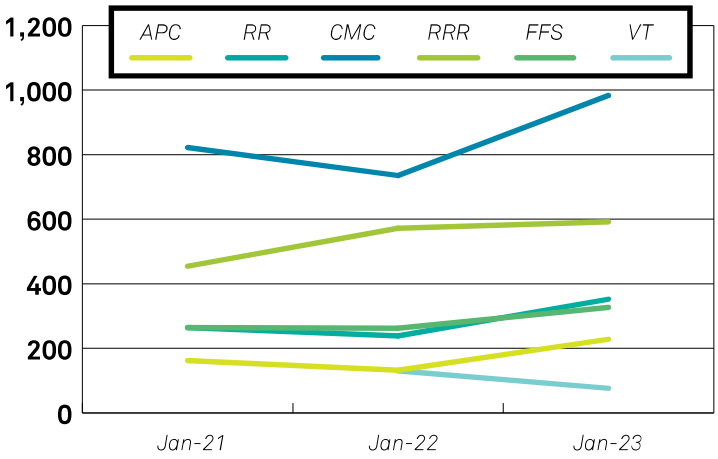
Inpatient Admissions per Thousand (ADk)



APC – Advanced Primary Care, RR – Rising Risk; CMC – Community Medicine Clinic; RRR – Rural Rising Risk; FFS – Fee for Service

Figure 3

Emergency Department Visits per Thousand (EDk)



APC – Advanced Primary care, RR – Rising Risk; CMC – Community Medicine Clinic; RRR – Rural Rising Risk; FFS – Fee for Service

2024 Acclaim Award

Michigan-based Corewell Health has been named AMGA's 2024 Acclaim Award recipient. The Acclaim Award honors healthcare delivery organizations bringing their organization closer to the ideal medical group and health system as they move toward value-based care. For their accomplishments, Baylor Scott & White Medical Group and St. Elizabeth Physicians were also named Acclaim Award honorees.

Corewell Health was recognized for the following initiatives:

- **Creating a future in which health is simple, affordable, equitable, and exceptional through Safe & Affirming training for team members and the establishment of a navigation hub for LGBTQIA+ patients.**
- **Implementing Advanced Primary Care (APC), a delivery model specifically tailored for geriatric patients to better meet the needs of a high-risk, high-cost population.**
- **Developing a transitional care model program (Bridging Older Adults) specifically for frail geriatric patients, using a hands-on approach to ensure this population is well supported through episodes of acute illness.**
- **Recognizing the influence of quality of each human interaction between patient and care team member on overall experience by utilizing Press-Ganey surveys to measure patient satisfaction.**
- **Creating the Office of Physician and APP Fulfillment (OPAF), focusing on reducing provider burden without sacrificing quality or patient satisfaction.**

The 2024 Acclaim Award finalists were:

- **Houston Methodist Physician Organization**
- **The Permanente Medical Group**
- **Sanford Health**
- **Summit Health-VillageMD**
- **UW Medicine Primary Care & Population Health**
- **Vancouver Clinic**
- **WellSpan Health**

***For information about applying for the 2025 Acclaim Award, visit* amga.org/acclaim.**

the financial goals related to established risk contracts and clinical effectiveness. While some KPIs such as emergency and inpatient utilization were variable across sites, several metrics showed strong improvement, both from baseline and when compared with FFS practices. The value clinics collectively performed better in EDk (412.06 vs. 422.9) and ADk (75.15 vs. 87.04) (Figures 2 and 3). Total medical PMPM cost was modestly higher for value clinics ($533.10 vs. $482.75); however, this was not unexpected given the resource-intensive approach that was taken in caring for these patients and the delayed ROI associated with increased prevention and management-focused care (Table 1).

Leading clinical indicators of A1c and hypertension (HTN) control were also tracked to assess the clinical impact of the care model and resources provided. Percentages of patients meeting A1c target (<9%) at value sites currently range

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Table 1

Operational KPIs by Site

	PMPM			MLR			HCC gap (avg.)		
Site	Baseline	Current	% Change	Baseline	Current	% Change	Baseline	Current	% Change
APC	1,033.94	1,223.55	18.30%	84.7	88	3.90%	0.045	0.102	126.70%
CMC	536.60	546.45	1.80%	86.7	94.2	8.65%	0.195	0.142	-27.20%
RR	785.27	516.42	-34.20%	84.8	88.2	4.01%	0.233	0.294	26.20%
RRR	504.50	502.84	0.00%	94.5	92.8	-1.80%	0.23	0.308	33.91%
FFS Primary Care	506.42	555.33	9.70%	90.2	92.8	2.90%	0.174	0.214	23%

APC – Advanced Primary care, RR – Rising Risk; CMC – Community Medicine Clinic; RRR – Rural Rising Risk; FFS – Fee for Service; MLR - Medical Loss Ratio; HCC - Hierarchical Condition Categories

between 67% and 88%, and 66% and 80% for those with HTN (Figures 4 and 5). Across the board, this represents an almost 9% increase from the previous year. Eight out of nine value clinics exceeded the 90th percentile for Centers for Medicare & Medicaid Services Metrics that Matter, controlling high blood pressure, while seven clinics achieved this mark for hemoglobin A1c control for 2023. When compared to other primary care practices within the organization and associated accountable care organization, the value clinics performed better in all categories apart from breast cancer screening (difference of <1%). This level of performance was achieved despite the higher-risk patients who are cared for within these clinics.

The Human Factor

While the above metrics hint at the initiative's ability to impact financial and physical health of patients, they do not fully speak to the Quadruple Aim in its entirety, specifically the human factor. Throughout this process of culture and delivery model change, the patient experience and provider wellness were also top of mind, as Corewell Health didn't aim only to improve costs and clinical outcomes, but also the way patients interacted with healthcare and the sustainability of the workforce.

All patients, including value clinic patients, participate in systemwide Press-Ganey experience surveys to provide feedback on the clinics and their providers. Despite the significant change management that occurred during this time, all value sites remained within 1.5% of the rest of primary care practices, with several sites exceeding the benchmark top box rating in both "Likelihood to Recommend" (LTR) and "Provider Communication," in comparison to their FFS-clinic counterparts (Figure 6). Additionally, the provider well-being scores of clinicians at value sites were compared to those of providers at FFS clinics. Both physicians and APPs at value sites reported lower rates of high distress than their FFS counterparts during a time period characterized by systemwide change fatigue and staffing shortages (Figure 7). The additional support in patient care provided by the allied health team as well as the maturing team culture and community as a means of moral support in the workplace are thought to be contributing factors to the overall improved morale.

Lessons Learned and What's Next

There were innumerable lessons learned at the individual, department, and system level throughout this endeavor, and learnings are ongoing. Ensuring reporting related to program data and analytics at the start of an initiative was vital to conducting ongoing evaluation and refinement.

Starting with looking at each specific population and their unique barriers during the care model design versus trying to make the population fit a prespecified care model was also necessary to be effective in solving the problems impacting health outcomes. Creating a robust educational plan to help clinicians, providers, and staff understand the "why" behind the redesign was also imperative to the success of the change management efforts. Lastly, establishing a culture of accountability and support was crucial to the success of individual clinics.

A weekly "iHub" meeting of leaders from all the value transformation sites

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Figure 4

Value Clinic – A1c Controlled vs. Uncontrolled

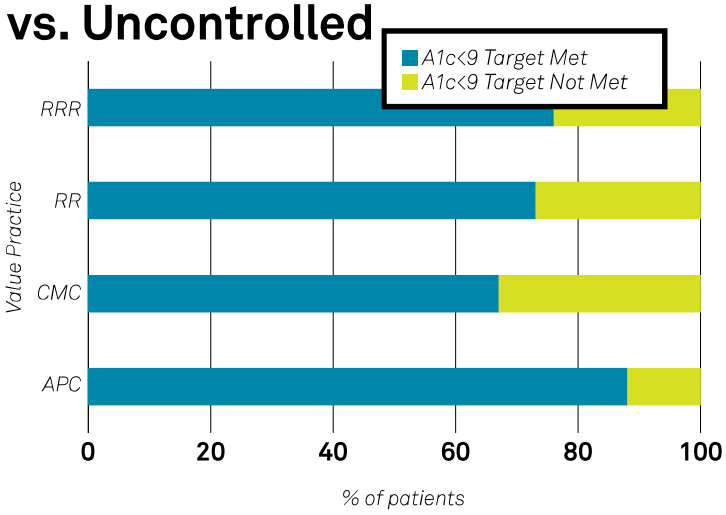

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Figure 5

Value Clinics – HTN Controlled vs. Uncontrolled

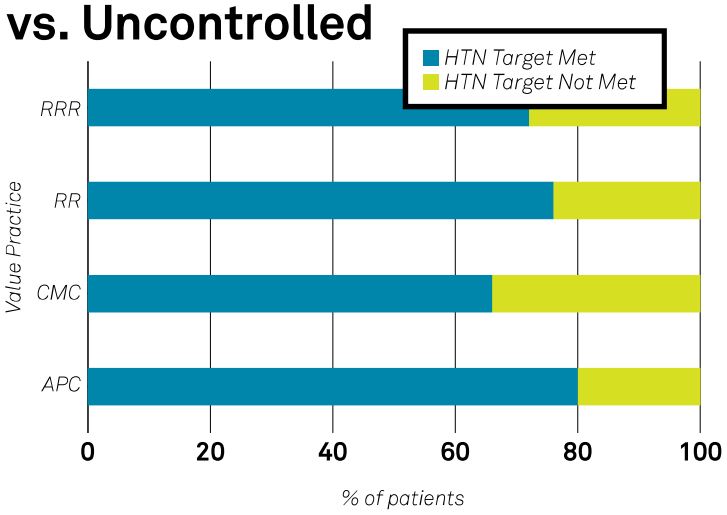

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Figure 6

Patient Experience Survey Results – Value Clinics vs. Comparison Cohort

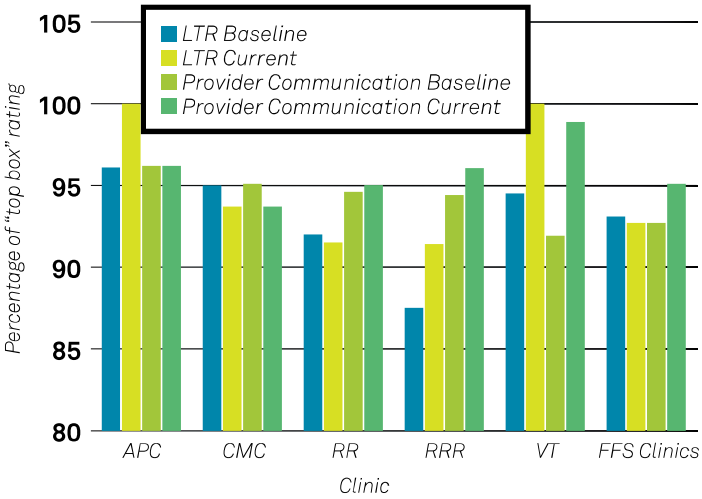

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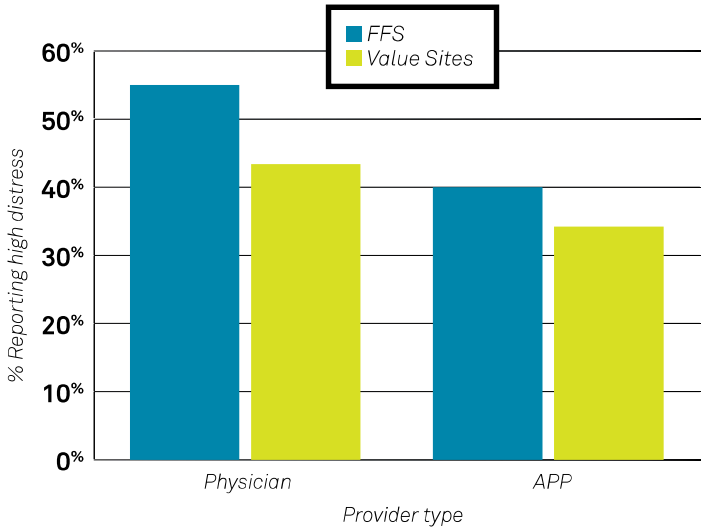
Figure 7

Provider Well-Being Index Scores



and primary care leadership provided the opportunity for frequent KPI report outs, barrier removal, collective brainstorming, and the chance to share in each other's successes. This has helped to build stamina, maintain momentum, and demonstrate commitment in an era of constant change and the next best thing. Going forward, the organization is in the process of scaling the value team model to an additional five sites slated to transition to value-based care within the coming months. GPJ

Adapted from the 2024 AMGA Acclaim Award application for Corewell Health.