

Provider Perspectives on the Transition to Value-Based Care: A Hierarchical Condition Categories (HCC) Coding Case Study

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Background

The transition to value-based care (VBC) is accelerating. University of Iowa Health Care is very early in this journey and recognizes the need to prepare for the transition to VBC. One tool is hierarchical condition categories (HCC) coding, which allows healthcare systems and payers to evaluate patient acuity, as well as predicted costs.

Objective

The objective of this project is to understand provider perspectives of a best practice alert (BPA) in UI Health's electronic health record (EHR) paired with pre-review by certified risk adjustment coders (RACs).

Methods

Implementation of an HCC BPA paired with pre-review by certified RACs was examined using ethnographic methods. To date, the ethnographer has attended and recorded notes at 38 meetings; observed and interviewed 5 primary care providers (3 family and 2 general internal medicine) about how they incorporate the HCC BPA into their clinical workflow; and observed the rollout of the HCC BPA paired with RACs at 2 family medicine clinics, which included observations and interviews with 4 providers. In total, 33 patient visits were observed, including pre-chart review, charting during visit (by provider or medical assistant in team-based clinics), and post-visit documentation and billing. A survey question was administered to the providers and coders each week for seven weeks after the initial rollout. All fieldnotes were analyzed for thematic content and recommendations. Descriptive statistics were completed for the surveys.

Results

During ethnographic site visits, the majority of providers expressed skepticism regarding the value of the HCC BPA. Providers reported HCCs did not add to patient care or distracted from the patient's reason for scheduling the visit. Many of the HCCs in the BPAs were considered not relevant to the patient and trying to determine why the HCC was recommended took too much additional time. Providers were mixed on the addition of RAC comments to the BPA. Some saw it as evidence UI Health was trying to make HCC coding easier for providers, while others saw it as a waste of resources. Survey responses to closed-ended questions also were mixed. Of the seven comments provided in the open-ended responses only one related to RAC comments and it was negative.

Discussion

Providers are still practicing in a fee-for-service environment with an emphasis on volume and RVUs. This is in tension with tools such as HCC coding, which are focused on benchmarking patient acuity at a population health level. This likely contributes to the providers skepticism of the usefulness of such tools. In addition, the HCC tool in the EHR appears to need further refinement to cull relevant information from the vast amount of data available for each patient.

Conclusion

UI Health is in a challenging transition with its heavy reliance on fee-for-service and a physician compensation model that reinforces volume over value. Data tools such as HCC coding algorithms in EHRs will need to improve to convince providers of their utility, but will be critical in the transition to caring for population health with quality and value.