CPCI: Stepping into the future of population health delivery with empowered primary care

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Learning Objectives

- Understand the history and current status of health transformation under the Comprehensive Primary Care Initiative relative to this region
- Articulate the need for transformation and the main drivers of the quadruple aim
- Discuss the complex interdisciplinary approach needed for this transformation
- Explore the data sources, analytics and functions needed from IT resources for CPCI transformation

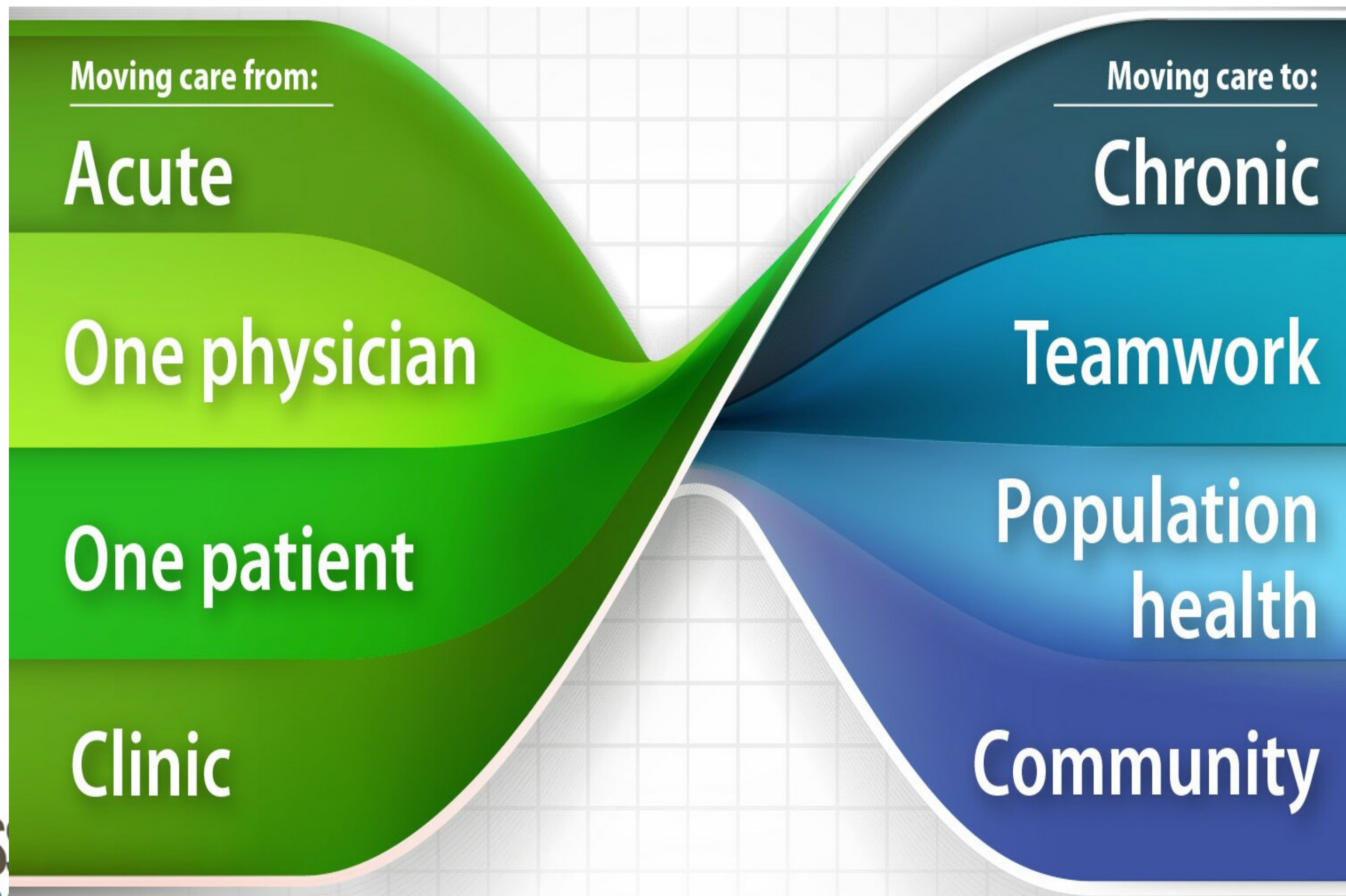
Patient care Transformation

Could a greater miracle take place than for us to look through each other's eyes for an instant?

- -- Henry David Thoreau

Is this important?

Transformation of Primary Care



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Why transform? Quadruple Aim

Better Outcomes for Patients/Populations

Lower Cost for Healthcare at a Higher Quality

Better Patient Experience

Reduction of Provider Burnout

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What is CPCi?

- **Definition**

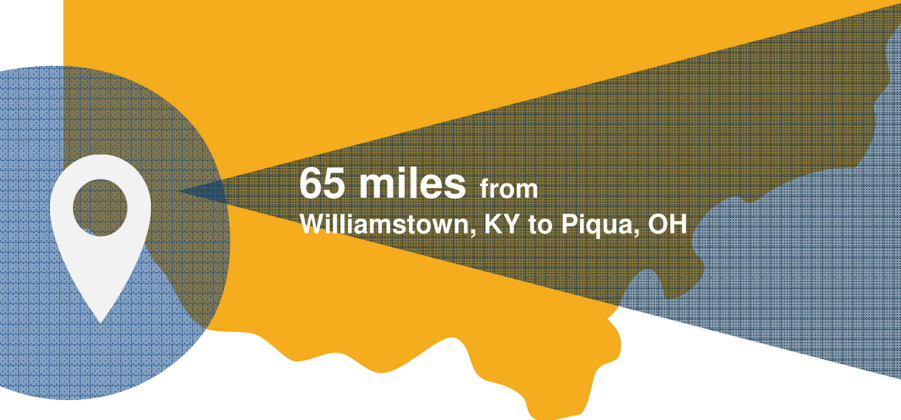
A four-year pilot program, incorporating both public and private payers, to transform the delivery and reimbursement of primary care by placing emphasis on comprehensive primary care and care coordination/management.

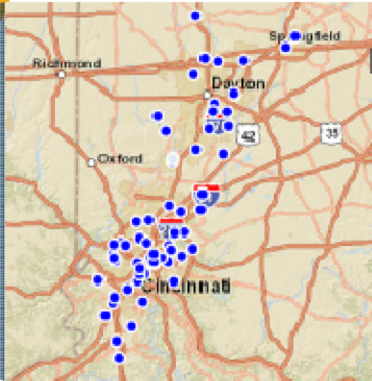
Cincinnati/Dayton/N. Kentucky Pilot

❖ 9 payors ❖ 68,200 lives ❖16 TCHP primary care practices

1	MOB 334	9	MOB 440
2	Delamerced	10	Madeira
3	Hyde Park Family Medicine	11	Norwood Family Medicine
4	Walnut Internal Medicine	12	Rookwood Internal Medicine
5	Redbank Internal Medicine	13	Westside Internal Medicine
6	Delhi Internal Medicine	14	Mason
7	Forest Hills	15	Hyde Park Internal Medicine
8	Compton	16	Norwood Internal Medicine

CPC – Our region

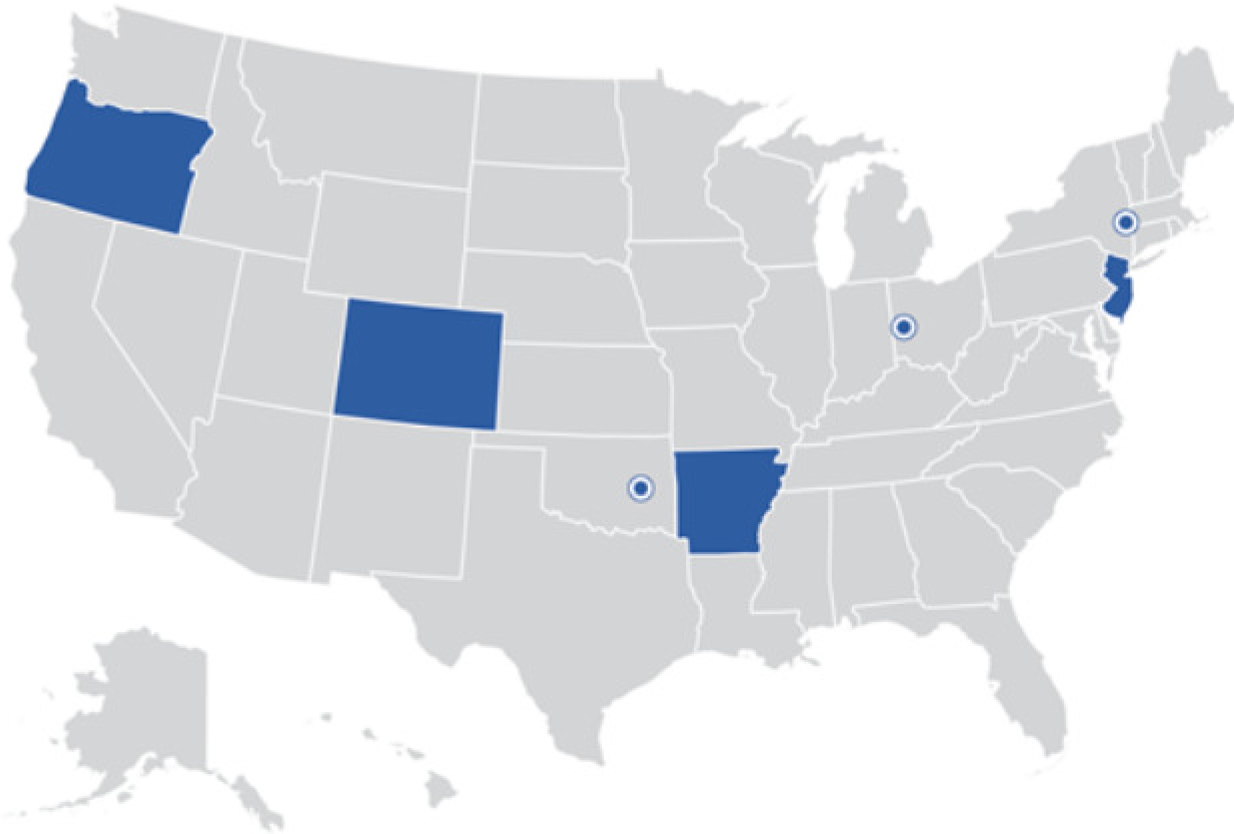




- **75** practices and **261** providers
- **Multi- payer:** 9 health plans + Medicare
- **300,000** estimated commercial, Medicaid and Medicare enrollees

CPCi Markets

The Participating Practices



Source: Centers for Medicare & Medicaid Services

There are 500 primary care practices participating in the CPC initiative. (List | Map)
This represents 2,144 providers serving an estimated 313,000 Medicare beneficiaries.

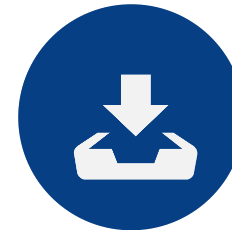
Components of CPC

PCMH/Team Care

Milestone process measures, CQM's and teams

Payment Reform

Payment Reform to align payment to outcomes



Data Collection/ Analytics and Reporting

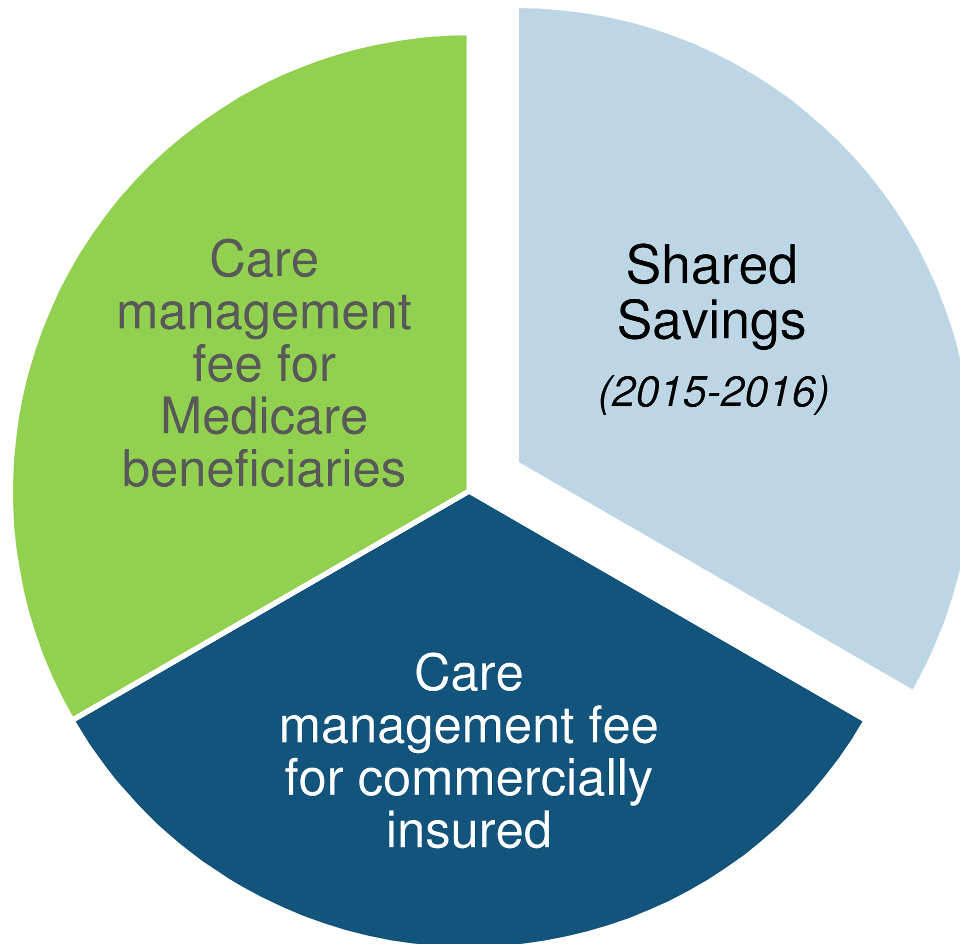
Identifying data, building reports and creating accurate analytics and dashboards

Defining Team-Based Care

- Patients come first
- Every person in the office has responsibility for taking care of patients
- As a team, we all take care of patients, even if they never cross our threshold
- Patient care happens beyond our office walls

- Added RN Care Managers and Care Coordinators

CPC Payment Model



Aligned Measures List

Survey-based Quality Measures

Domain	NQF Number	Measure Title	Measure Steward	Rationale for Inclusion
Patient/Caregiver Experience	0005	CG-CAHPS: Getting Timely Care, Appointments, and Information; How Well Your Doctors Communicate; Patients' Rating of Doctor; Access to Specialists; Health Promotion and Education; Shared Decision Making	AHRQ	**CMS CPC Measure**
Patient/Caregiver Experience	0006	CAHPS: Health Status/Functional Status	AHRQ	**CMS CPC Measure**

Claims-based Quality Measures

Domain	NQF Number	Measure Title	Measure Steward	Rationale for Inclusion
Care Coordination	1768	All-Cause Unplanned Readmission	NCQA	**CMS CPC Measure**
Care Coordination	N/A	Ambulatory Sensitive Conditions Admissions: Overall Composite (AHRQ Prevention Quality Indicator PQI #90)	AHRQ	**CMS CPC Measure**
Care Coordination	0275	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator PQI #5)	AHRQ	**CMS CPC Measure**
Care Coordination	0277	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator PQI #8)	AHRQ	**CMS CPC Measure**
Clinical Process/ Effectiveness	0058, 0052, N/A	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Imaging for Low Back Pain, and/or Imaging for Non-complicated Headache	HEDIS	**Choosing Wisely**

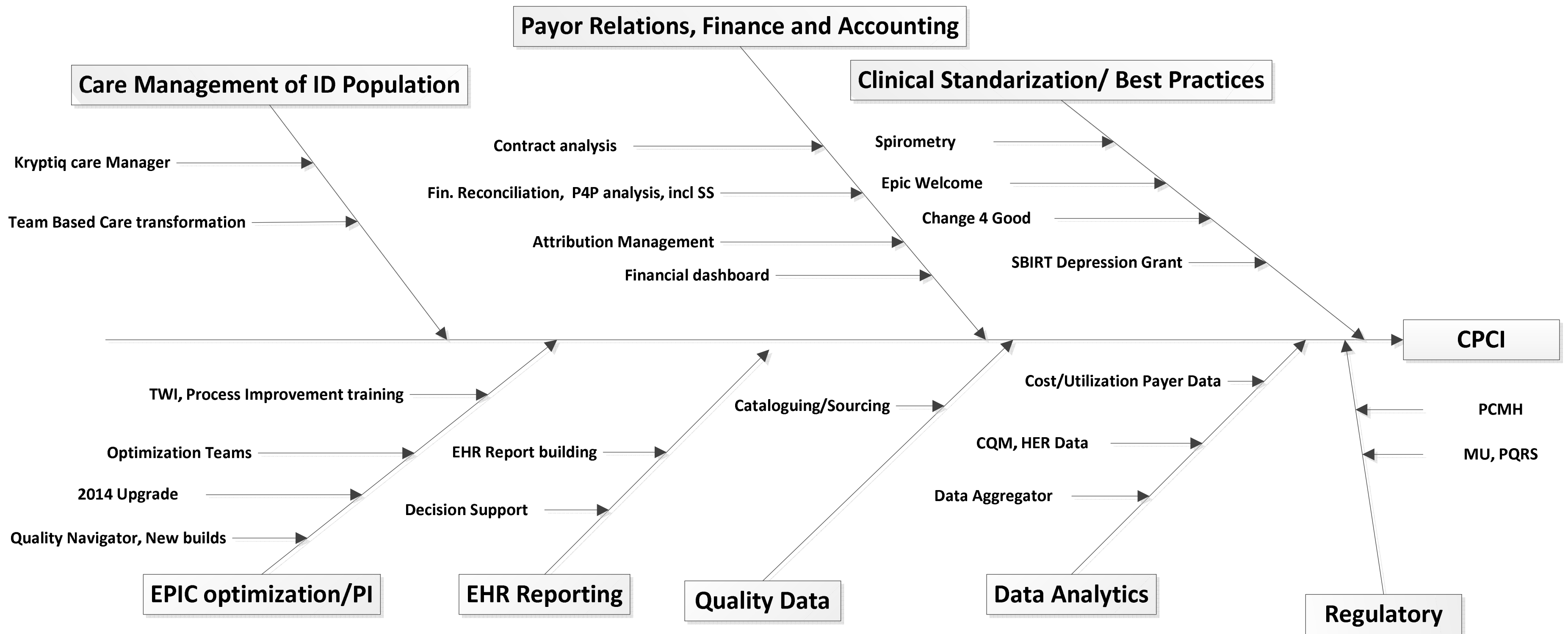
Aligned Measures List

EHR-based Quality Measures

Domain	NQF Number	Measure Title
Clinical Process/ Effectiveness	0018	**Controlling High Blood Pressure**
Population/ Public Health	0028	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
Clinical Process/ Effectiveness	N/A	**Breast Cancer Screening**
Clinical Process/ Effectiveness	0034	**Colorectal Cancer Screening**
Population/ Public Health	0041	**Preventive Care and Screening: Influenza Immunization**
Clinical Process/ Effectiveness	0043	**Pneumonia Vaccination Status for Older Adults**
Clinical Process/ Effectiveness	0059	**Diabetes: Hemoglobin A1c Poor Control**
Clinical Process/ Effectiveness	0064	**Diabetes: Low Density Lipoprotein (LDL) Management**
Clinical Process/ Effectiveness	0075	**Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control**
Clinical Process/ Effectiveness	0083	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)**
Patient Safety	0101	**Falls: Screening for Future Fall Risk**
Population/ Public Health	0418	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**
Patient Safety	0419	**Documentation of Current Medications in the Medical Record**

*Practices Report 9 of 13

Projects Building CPCI Success



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Early Results

CPC Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

Project Timeline: 2013-2016

THE HEALTH COLLABORATIVE
Technology Powered by HealthBridge

Regional Data Transparency + Engaged Physicians = National Leaders in Primary Care Transformation

220,000 Beneficiaries | 250 Providers | 9 Health Plans

Key Functions

- Patient Experience
- 24/7 Access to Medical Record
- Shared Decision Making
- Clinical Quality Improvement
- Care Management

Population Health

- **84,000** Patients Received Care Management
- **42,000** Discussed Smoking Cessation Treatment Options
- **8,700** Discussed Advance Care Plan Options

Evidence-Based Care

Medicare Outcomes to Date

Outcome	Change
Overall Hospital Admissions	-8%
Primary Care Treatable Admissions	-10%
Readmissions	-3%
Overall Expenditures	-3.4%

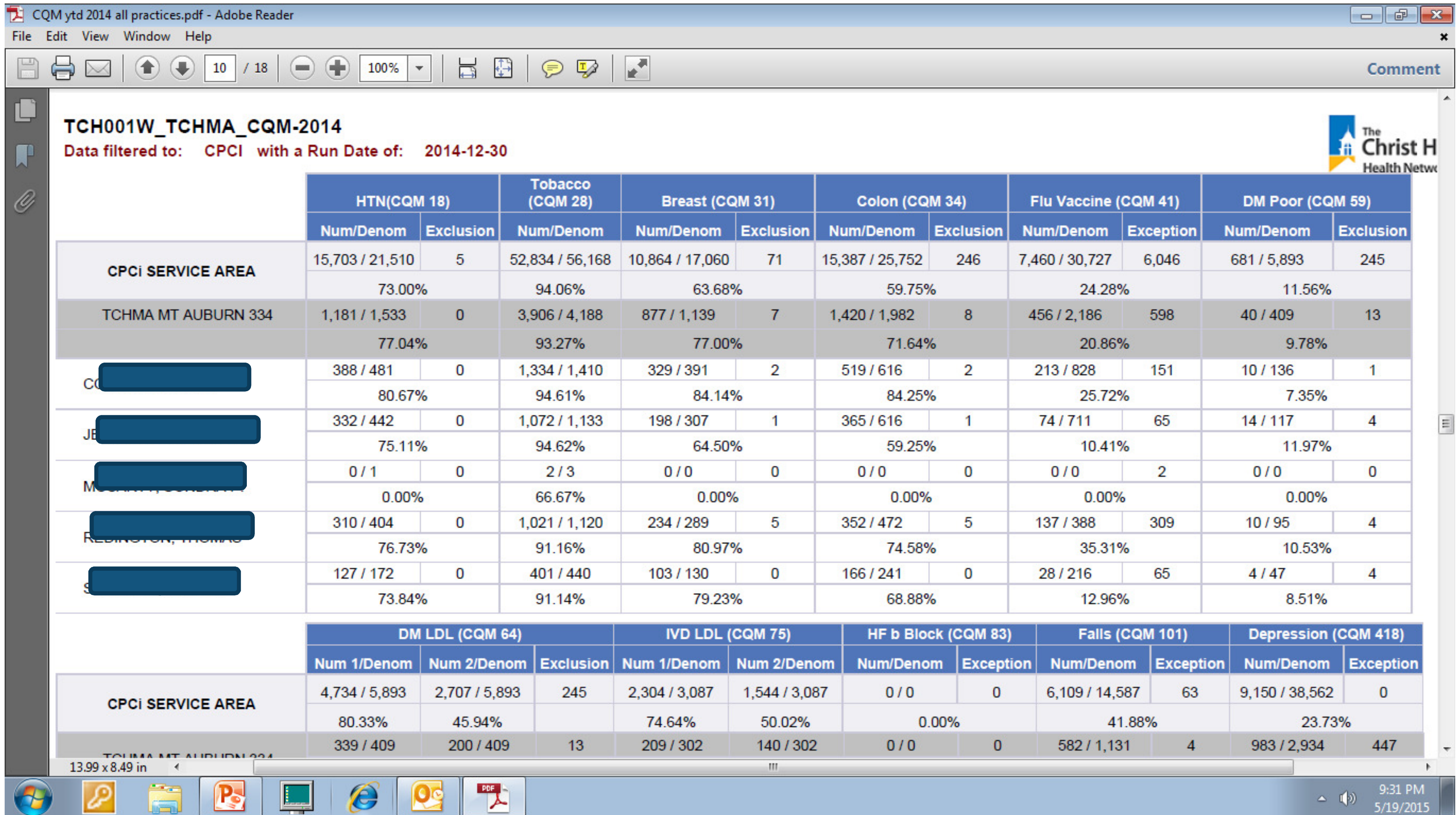
Data-Driven Improvement

The Christ Hospital™ Health Network

Proactive Data

- CQM’s
- Kyrptiq POC and Registry

Clinical Quality Measures



CQM ytd 2014 all practices.pdf - Adobe Reader

TCH001W_TCHMA_CQM-2014

Data filtered to: CPCI with a Run Date of: 2014-12-30

The Christ Hospital Health Network

	HTN(CQM 18)		Tobacco (CQM 28)	Breast (CQM 31)		Colon (CQM 34)		Flu Vaccine (CQM 41)		DM Poor (CQM 59)	
	Num/Denom	Exclusion	Num/Denom	Num/Denom	Exclusion	Num/Denom	Exclusion	Num/Denom	Exception	Num/Denom	Exclusion
CPCi SERVICE AREA	15,703 / 21,510	5	52,834 / 56,168	10,864 / 17,060	71	15,387 / 25,752	246	7,460 / 30,727	6,046	681 / 5,893	245
	73.00%		94.06%	63.68%		59.75%		24.28%		11.56%	
TCHMA MT AUBURN 334	1,181 / 1,533	0	3,906 / 4,188	877 / 1,139	7	1,420 / 1,982	8	456 / 2,186	598	40 / 409	13
	77.04%		93.27%	77.00%		71.64%		20.86%		9.78%	
CO	388 / 481	0	1,334 / 1,410	329 / 391	2	519 / 616	2	213 / 828	151	10 / 136	1
	80.67%		94.61%	84.14%		84.25%		25.72%		7.35%	
JE	332 / 442	0	1,072 / 1,133	198 / 307	1	365 / 616	1	74 / 711	65	14 / 117	4
	75.11%		94.62%	64.50%		59.25%		10.41%		11.97%	
M	0 / 1	0	2 / 3	0 / 0	0	0 / 0	0	0 / 0	2	0 / 0	0
	0.00%		66.67%	0.00%		0.00%		0.00%		0.00%	
R	310 / 404	0	1,021 / 1,120	234 / 289	5	352 / 472	5	137 / 388	309	10 / 95	4
	76.73%		91.16%	80.97%		74.58%		35.31%		10.53%	
S	127 / 172	0	401 / 440	103 / 130	0	166 / 241	0	28 / 216	65	4 / 47	4
	73.84%		91.14%	79.23%		68.88%		12.96%		8.51%	

	DM LDL (CQM 64)			IVD LDL (CQM 75)		HF b Block (CQM 83)		Falls (CQM 101)		Depression (CQM 418)	
	Num 1/Denom	Num 2/Denom	Exclusion	Num 1/Denom	Num 2/Denom	Num/Denom	Exception	Num/Denom	Exception	Num/Denom	Exception
CPCi SERVICE AREA	4,734 / 5,893	2,707 / 5,893	245	2,304 / 3,087	1,544 / 3,087	0 / 0	0	6,109 / 14,587	63	9,150 / 38,562	0
	80.33%	45.94%		74.64%	50.02%	0.00%		41.88%		23.73%	
TCHMA MT AUBURN 334	339 / 409	200 / 409	13	209 / 302	140 / 302	0 / 0	0	582 / 1,131	4	983 / 2,934	447

9:31 PM 5/19/2015

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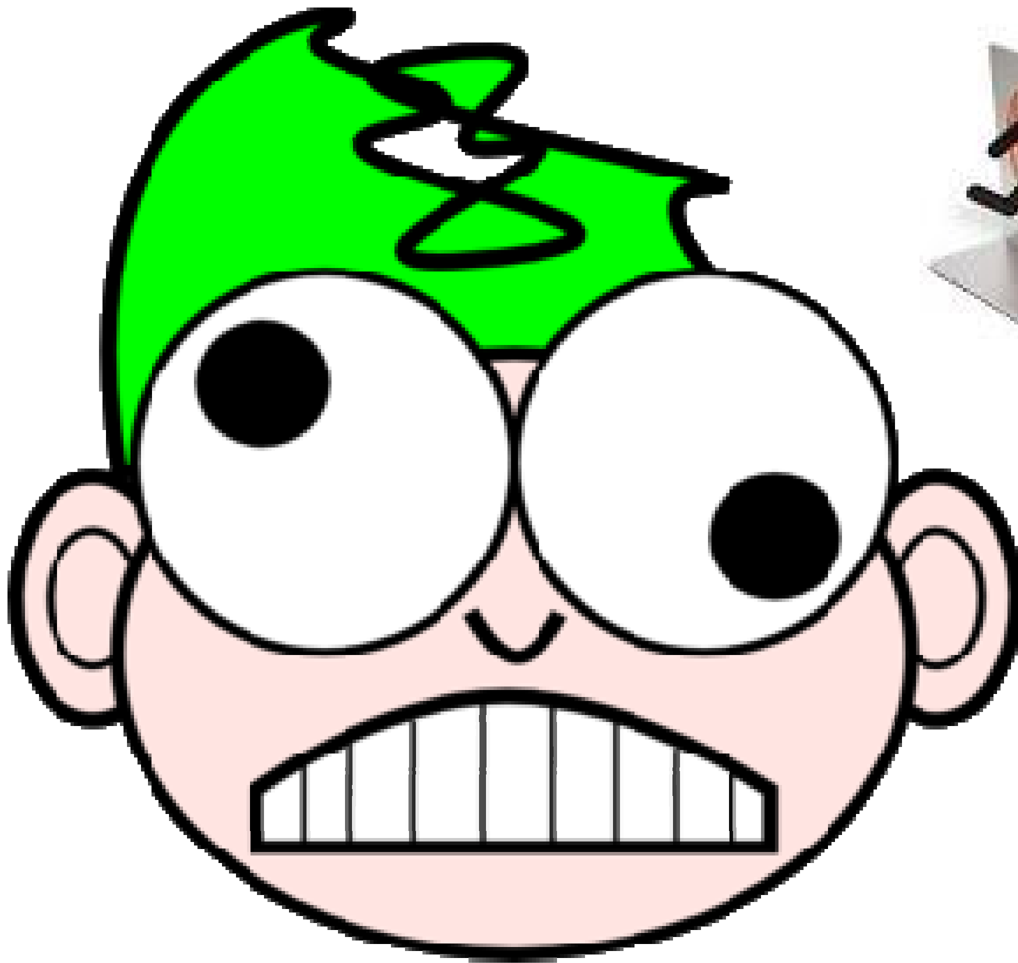
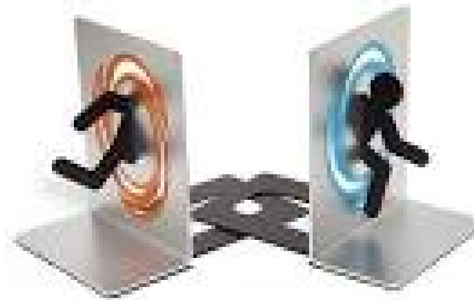
CMS Portal Quarterly submissions

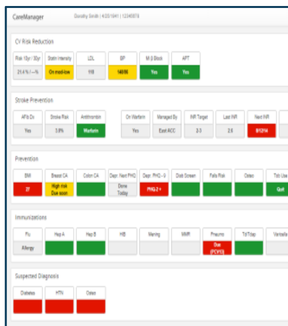


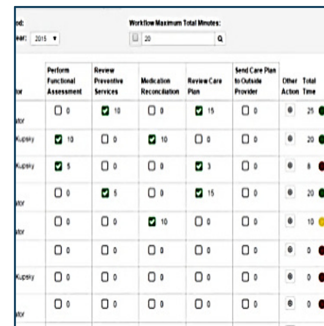


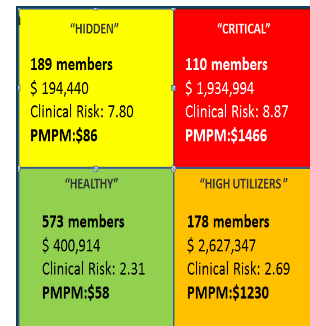
Milestones

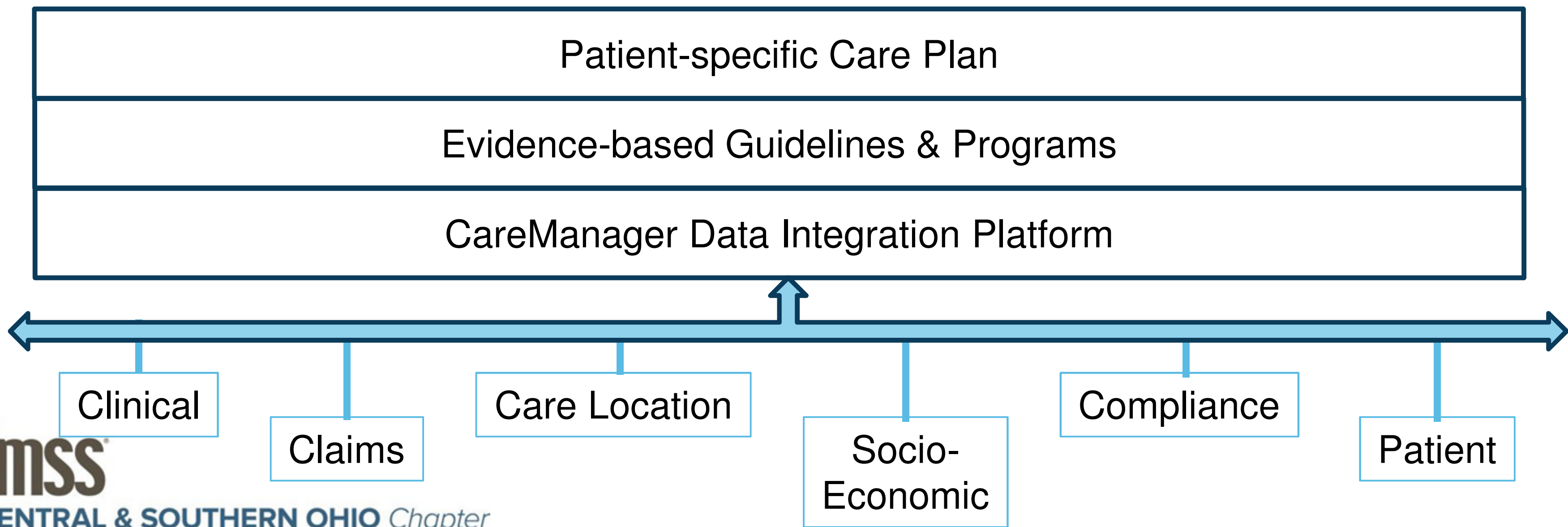
ENLI COMPREHENSIVE POPULATION HEALTH SUITE

Provider Engagement (POC)	Patient Engagement (Care Plan)	Care Management (CWM)	Risk Management (Analytics)	Performance Management (Registry)









Data Driven Proactive Care

- At Point of Care
- Data pulled from EHR

CareManager — Dorothy Smith | 4/25/1941 | 12345678 — Update chart data. — Select Patient

CV Risk Reduction (Memo | View Plan)

Risk 10yr / 30yr	Statin Intensity	LDL	BP	MI β Block	APT
21.4 % / —%	On mod-low	118	148/86	Yes	Yes

Stroke Prevention (Memo | View Plan)

AFib Dx	Stroke Risk	Antithrombin	On Warfarin	Managed By	INR Target	Last INR	Next INR	TTR
Yes	3.0%	Warfarin	Yes	East ACC	2-3	2.6	8/12/14	75%

Prevention (Memo 1 | View Plan)

BMI	Breast CA	Colon CA	Depr. Next PHQ	Depr. PHQ - 9	Diab Screen	Falls Risk	Osteo	Tob Use
27	High risk Due soon		Done Today	PHQ-2 +				Quit

Immunizations (Memo | View Plan)

Flu	Hep A	Hep B	HIB	Mening	MMR	Pneumo	Td/Tdap	Varicella	Zoster
Allergy						Due (PCV13)			

Suspected Diagnosis (Memo | View Plan)

Diabetes	HTN	Osteo

Data Driven Proactive Care

- Population Level

Kryptiq CareManager™ | Change Cluster

- CV Risk Reduction
  - Treatment
  - Services Due
- Diabetes
- Prevention
- Stroke Prevention
- Patient Control Panel
- Admin

Cardiovascular Risk Reduction / Treatment — Provider: Harry Winston - JZ

Select Filter | New | Edit | Clear Filter

Cardiovascular Risk Reduction / Treatment

Patient	Age	Risk 10yr[1]/30yr[2]	Statin Intensity[3]	LDL	A1c	BP	MI & block	APT[4]	Tob Use	BMI	Last Appt
ABEITA, JAMES	67	ASCVD	On high	99	Due	165/100		Yes	Due	33	
ALEXANDER, ELMER	34	DM, age<40 --/?			7.7	Due			Quit	Due	2/25/2014
ALLAIN, FREEDA	51	ASCVD	On high	92	7.7	135/77			Quit	Due	2/23/2015
ALLSON, HARRIET	68	?				Due			Due	Due	
ALTAMIRANO, MARK	37	--/?				Due			Due	27	
ALTMAN, CLARA	24	--/?		105		139/81			Due	20	2/20/2015
ALVAREZ, ELMO	19	DM, age<40		106	Due	Due			Due	Due	
AMBACH, NEAL	23	--/?				Due			Due	Due	7/7/2014
ANDREWS, BAILEY	20	--/?				Due			Current	Due	2/16/2015
ANGER, NEAL	33	LDL>190	No statin	193		139/81			Due	Due	2/16/2015
APPENZELLER, LENA	22	--/?				Due			Due	Due	7/7/2014
ARBAUGH, LEN	48	27.1%/--	No statin	110		170/115			Current	Due	7/7/2014
ARMSTRONG, STEPHANIE	22	--/?				Due			Due	12	2/11/2015
ARNOLD, ARIANNA	52	?				Due		Warfarin	Due	Due	2/15/2015
ASTORGA, ANASTASIA	47	?				Due			Due	Due	
AUSTIN, GRACIE	79	LDL>190	On high	195		Due			Due	30	
AVERY, GREG	74	ASCVD	No statin	101	Due	149/79		Yes	Quit	Due	2/21/2015
BADENOV, BORIS	77	?	No statin	115	Due	163/90		DT Inhib, APT	Due	39	
BANKS, MINERVA	20	--/?				Due			Due	Due	

Central & Southern Ohio Chapter

Data Driven Proactive Care

- Coordination Of Care

Central Worklist Manager™

Jim Coppa | Log Out

- Reminders
- Workflow
- Patients
- Programs
- Admin

Program: Chronic Care Management

Find Patient: Name or DOB (mm/dd/yyyy)

My Patients Only

Workflow Time Period: Month: 12 Year: 2014

Workflow Maximum Total Minutes: 20

Patient	DOB (age)	Program	Coordinator	Perform Functional Assessment	Review preventive services	Perform Medication Reconciliation	Update Care Plan	Send care plan to outside providers	Other Action	Total Time
Jeff Abbey	5/26/1970 (45)	Chronic Care Management	☆ Steve Kupsky	☐ 0	☐ 0	☐ 0	☐ 0	☐ 0		0
Lucille Andersen	9/22/1929 (86)	Chronic Care Management	☆ Team	☐ 0	☐ 0	☐ 0	☐ 0	☐ 0		0
Shari15 Anderson15	3/1/1961 (54)	Chronic Care Management	★ Jim Coppa	☐ 0	☐ 0	☐ 0	☐ 0	☐ 0		0
Bob Butcher	6/1/1965 (50)	Chronic Care Management	☆ Team	☑ 3	☑ 10	☑ 10	☐ 0	☐ 0		23
Michelle Deeds	2/16/1926 (89)	Chronic Care Management	★ Jim Coppa	☑ 15	☐ 0	☑ 5	☐ 0	☐ 0		20
Crimson Dillard	3/24/1977 (38)	Chronic Care Management	☆ Team	☑ 10	☐ 0	☑ 15	☐ 0	☐ 0		25
Micky Dodds	2/16/1926 (89)	Chronic Care Management	★ Jim Coppa	☑ 9	☑ 10	☐ 0	☐ 0	☐ 0		19
Betty Ferry	11/24/1944 (71)	Chronic Care Management	☆ Steve Kupsky	☑ 10	☑ 15	☐ 0	☐ 0	☐ 0		25
Sally Jill	11/23/1994 (21)	Chronic Care Management	☆ Kryptiq Administrator	☐ 0	☑ 15	☐ 0	☐ 0	☐ 0		15
George June	11/23/1994 (21)	Chronic Care Management	☆ Steve Kupsky	☑ 10	☐ 0	☐ 0	☐ 0	☐ 0		10

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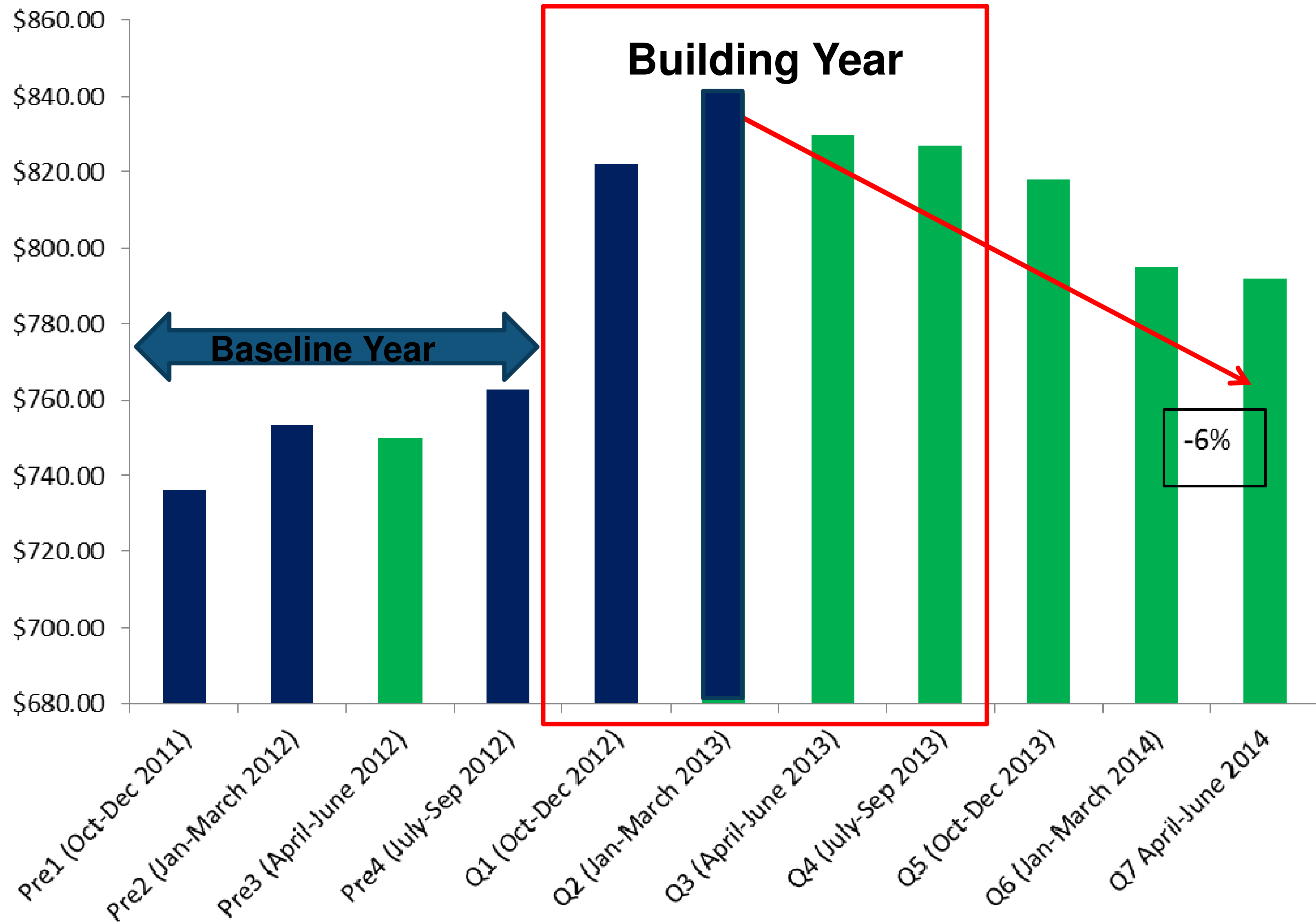
Reactive Data

- Claims Data
- Patient satisfaction Data

Overall and Consistent Change

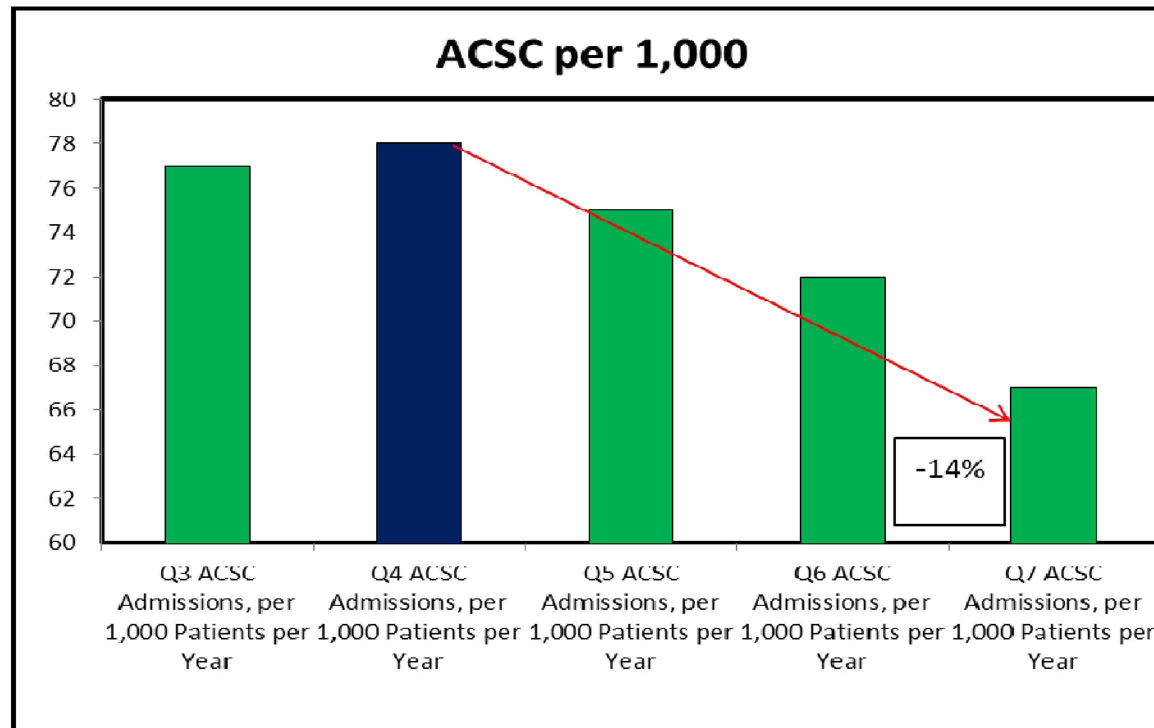
Q5-Q8, October 2013-September 2014

Practice Name	Expenditure Change	Total ED Visit Change	ACSC Admisssion Change	30 Day Readmission Change	Admission Change
TCHMA MOB 334	$73	-22	-41	-12	-14
TCHMA OH0117	$63	48	3	57	21
TCHMA, OH0119	$1	-81	3	76	-42
TCHMA Red Bank IM	$56	-52	20	35	12
TCHMA, OH0129	$37	-17	-23	-2	0
TCHMA Forest Hills	-$102	-14	-20	-28	-52
TCHMA Compton	-$85	4	20	-16	-51
TCHMA MOB 440	-$147	37	-21	33	-93
TCHMA Madeira	-$74	-106	-22	-11	-44
TCHMA Norwood FM	$65	97	-7	46	15
TCHMA Rookwood IM	-$186	-3	26	-26	-48
TCHMA Westside IM	-$13	6	-4	-1	-21
TCHMA Mason	-$13	-7	11	-19	-21
TCHMA Hyde Park	$7	-18	-13	3	-21
TCHMA Norwood IM	-$98	2	-6	-4	-51



Unadjusted Quarterly Expenditure Changes
Building Year
Baseline Year
-6%
$860.00
$840.00
$820.00
$800.00
$780.00
$760.00
$740.00
$720.00
$700.00
$680.00
Pre1 (Oct-Dec 2011)
Pre2 (Jan-March 2012)
Pre3 (April-June 2012)
Pre4 (July-Sep 2012)
Q1 (Oct-Dec 2012)
Q2 (Jan-March 2013)
Q3 (April-June 2013)
Q4 (July-Sep 2013)
Q5 (Oct-Dec 2013)
Q6 (Jan-March 2014)
Q7 April-June 2014

Ambulatory Care Sensitive Conditions
Our region



Historical & Current Fee-For-Service
Value-Based Payment & Population Health Management

Culture eats Strategy for Lunch...

Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

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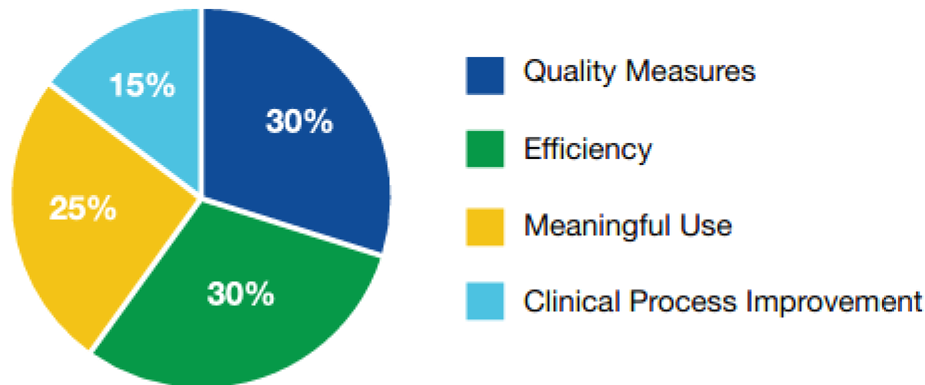
Federal Program: MIPS

2019 MIPS Program %* Weight



* Percentages reflect MIPS program weights for provider grading purposes.

Reimbursement Implications

Year	Penalty Cap	Value-Based Bonus Opportunity (subject to scaling factor)
2019	-4%	Up to +12%
2020	-5%	Up to +15%
2021	-7%	Up to +21%
2022	-9%	Up to +27%

Discussion