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

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

Data-Driven Improvement

What is CPC?

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare is working with commercial and state health insurance plans to offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices selected to participate in this initiative are provided tools and resources to better coordinate primary care for their Medicare patients as well as the beneficiaries of participating commercial plans.

CPC In Our Region

- The Health Collaborative regularly convenes the participating stakeholders in the Cincinnati/Dayton/Northern Kentucky Market, while also providing support to the 75 participating primary care practices in the region.

Process Measures/Milestones

Milestone #1: Budget

Record actual CPC funding and expenditures from previous program year and complete annotated annual budget with anticipated revenue and spending for upcoming program year.

Milestone #2: Provide care management for high-risk patients

Empanel active patients to a provider/care team, stratify patients by risk status, and implement one or more of the following advanced primary care strategies: Behavioral Health Integration, Medication Management, and Self-Management Support for 3 high risk conditions.

Milestone #3: 24/7 Access to medical record and continuity

Expand access to medical record outside of office hours, implement an asynchronous form of communication, and measure visit continuity of patients with their empaneled provider.

Milestone #4: Assess and improve patient experience of care

Assess patient experience by conducting monthly practice-based surveys or convening a patient and family advisory council at least quarterly.

Milestone #5: Data-Driven Quality Improvement

Use EHR Clinical Quality Metric (CQM) data to perform continuous quality improvement on 3 such measures and use health plan data to identify and reduce a high cost area.

Milestone #6: Coordination Across the Medical Neighborhood

Implement two of the following: Track % of patients receiving a follow-up call within 1 week of an ED visit, Contact at least 75% of patients discharged from target hospital(s) within 2 business days or 72hrs.

Milestone #7: Shared Decision Making

Use at least 3 decision aids to support shared decision making for preference-sensitive conditions and track the amount of eligible patients receiving those decision aids.

Milestone #8: Participation in the Learning Collaborative

Fully engage and cooperate with Regional Learning Faculty, participate in webinars and attend all CPC Learning Sessions in their region.

Milestone #9: Health Information Technology

All eligible professionals must work toward attestation of Meaningful Use stages 1 and 2 in the timelines set by the EHR incentive program.

Comprehensive Primary Care Drivers

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5 Essential Elements

1 Sustainable Prospective Care Management Payments	▪ Investment up front – Infrastructure to convert a practice is costly ▪ Payment Models – *gradual* movement from FFS to value-based ▪ **Critical Mass** – over 50% of practice population covered by participating payers	▪ Multi-payer approach ▪ Transparent payment and practice compensation models are critical for physician engagement and payer comfort
2 Clinical and Claims Data Aggregation: The "Five C's"	▪ **C**onsistent; standard measures ▪ **C**ontiguous; tracked over time ▪ **C**omprehensive; a majority of practice's patient panel is included	▪ **C**redible; timely, accurate, and usable; e.g. identifying high risk patients/patterns ▪ **C**ost/Quality Balance; measuring to manage value
3 Avoiding Administrative Overload for Practices	**Aligned: Similar** ▪ Payment/financial model ▪ Attribution ▪ Risk adjustment ▪ Guidelines and goals	**Standardized: Same** ▪ Metrics ▪ Reports ▪ Communication Employers, Health Plans, and Government need to ***eliminate conflicting incentives*** for clinicians
4 Physician/Provider/ Practice Culture	▪ Create ***ownership*** mentality; empowerment vs employment ▪ Integrate into ***workflow***; if what we do distracts providers from patient care then we have failed	▪ ***Incentives*** and rewards have to be palpable ▪ Willingness to change from physician autonomy to ***team-based care*** ▪ ***Delegation*** – team members practicing at highest extent of licensure
5 Care Coordination and Care Management	▪ Identification of high risk patients for outreach and management. ▪ Stakeholder recognition that primary care practice must be the quarterback for ***all care management*** for ***all entities*** that touch their attributed patients.	***A Call to Action***: Recognition by educational and training programs that the availability of individuals competent in this role are at a premium today and will only grow as this approach to health care is expanded.

Comprehensive Primary Care Drivers

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5 *Important* Elements

Timely Access	▪ Patients need to connect easily to their Medical Home and their medical record via office, phone, email, virtual visits etc… ▪ Practices need to know when patients access other points of the health system.
Actionable Tools	▪ Practices need cost, quality and patient feedback views that permit them to manage the Triple Aim patient-by-patient and population-by-population. ▪ Information needs to be less than three clicks away in the EHR.
A Supportive Medical Neighborhood	▪ **Behavioral Health Integration:** co-management of common co-morbid mental health conditions; integration of behavioral components in self-management of chronic disease. ▪ **Specialist Care:** warm hand offs; quality and cost information about hospitals and other providers ▪ **Reliable Programs and Outreach Efforts** for the management of the patient's medical and *social* needs ▪ **Awareness of Population Health** efforts within the community and how they can be integrated for their patients
Electronic Health Record Capability Supported by Health Information Exchange (HIE)	▪ Real time communication within the Medical Neighborhood ▪ Real time communication by and with the patient ▪ Transform *health information exchange* into *health information knowledge*
Structured programs for budgeting and process improvement	▪ Payment upfront for value requires that a practice ***demonstrate credibly*** to payers that they can account for how value is generated and increased. ▪ Required process measures and their milestones need to be clear and aligned across payers.

Managing The Work of Relationships

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A Neutral Space

Patient Centered Consumer Advocacy	▪ Promote the consumer voice from the patient perspective ▪ Discern what access looks like when it is convenient ▪ Determine how information can be transmitted and made understandable
Clinical Practices	▪ Provide practices with needed cost, quality and patient feedback views that permit them to manage the Triple Aim patient-by-patient and population-by-population ▪ Keep a constant eye on the administrative burden and unintended consequences to clinical workflow ▪ Identify best practices, subject matter experts, learning networks
Health Plans and Employers	▪ Maintain alignment among payers regarding measurement, attribution and risk adjustment ▪ Avoid programs that undermine the pay for value incentive ▪ Maintain focus on clinical and cost outcomes ▪ Provide forum for aggregating data, analyzing trends and reporting results
Federal and State Government	▪ A forum to advocate for necessary Policy, Accountability, and Standardization ▪ Liaison with government as payer/employer to maintain alignment
Community Needs	▪ A forum for the community to address the health care system as a whole and not system-by-system ▪ Integrate Population Health initiatives into Comprehensive Primary Care approach