Comprehensive Primary Care Initiative in Residency Practices

Roger Garvin RPS Consultant, Program Director OHSU - Portland
William Gillanders RPS Consultant
Joyce Hollander-Rodriguez, Program Director OHSU-Cascades East

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Goals

After attending this session participants will:

- Understand the history of the CPC initiative
- Articulate challenges to team creation and think about local expanded team structure
- Consider ways Advanced Practice models can be used for resident education

Context

- Providence
  - Milwaukie FM – 9 residents, 5.15 FTE faculty, 23,000 annual patient visits
  - South East FM – 9 residents, 4.4 FTE faculty, 18,250 annual patient visits
  - St. Vincent Internal Medicine –
- OHSU
  - Gabriel Park – 12 residents, 12 providers, 35,000 patient visits
  - South Waterfront - 12 residents, 17 providers, 50,000 patient visits
- OHSU-Cascades East – rurally located in Klamath Falls
  - 24 residents, 15 providers, 28,000 annual visits

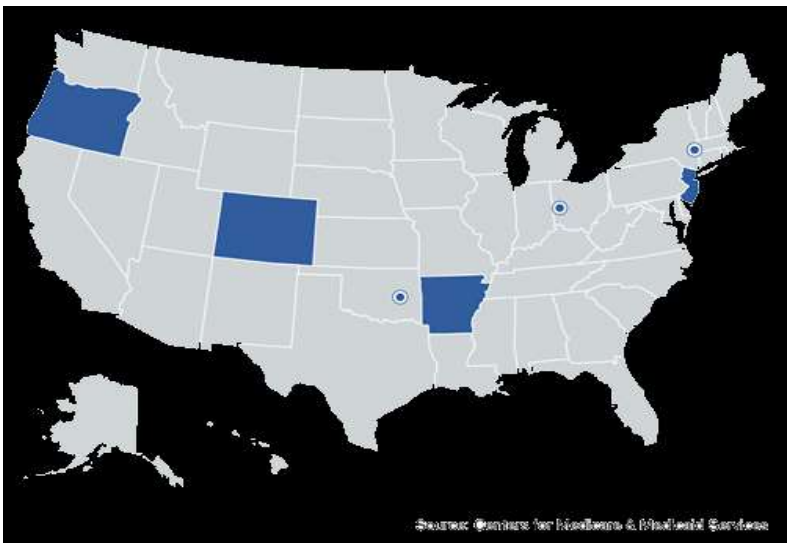
Key Terms

- Core Team
- Expanded Team
- Medical Neighborhood
- Risk Stratification - A formal estimate of the probability of a person's succumbing to a disease or benefiting from a treatment for that disease
- Risk Adjustment - actuarial tool used to predict health care costs based on the relative actuarial risk of enrollees
- Case Management
- Care Planning
- Pay for performance Quality Metrics
- Monetary Return to practices for decreased utilization

CPCI History

- In October 2012, the Center for Medicare & Medicaid Innovation launched the Comprehensive Primary Care (CPC) initiative to improve primary care delivery in seven regions across the United States chosen based on the extent of payer interest and geographic diversity.
- Oregon was one of these seven regions and had by far the most providers enrolled. Six residency practices
- CMMI selected 502 practices from about 1,000 applicants,
  - favored practices that were meaningful users of EHRs, had PCMH recognition, and were experienced in QI. CMS did not select practices based on their outcomes or other aspects of their functioning.

Seven CPC Regions Participating



CPCI – 5 Functions

CPC requires that practices meet annual Milestones that help them build the capability to deliver CPC's five key functions:

(1) access and continuity,

(2) planned chronic and preventive care,

(3) risk-stratified care management,

(4) patient and caregiver engagement

(5) coordination of care across the medical neighborhood

CPCI - Supports

To help participating practices function more effectively, CPC offers three main incentives:

- enhanced payment
- data feedback
- learning activities and technical assistance.

The substantial practice transformation involved in enhancing and integrating these five functions is expected to result in better performance measured against Triple Aim metrics (Better Quality, Higher Patient Satisfaction, Lower Cost effective care)

CPCI - Funding

- CMS and 31 other payers provided monthly care management fees in addition to FFS to invest in redesigning and transforming care
  - 19 percent of total [non-CPC] practice revenue, or about $70,045 per clinician, in CPC's first program year.
- Most practices met the required Milestones at the end of CPC's first year;
  - less than 10 percent were placed on corrective action plans (38 practices) or terminated from the initiative (4 practices).

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative

Where Did We Start?

- Practices – all are Level III Oregon Medical Homes
  - Providence: Epic EMR and robust Registries using Kryptiq data management software
  - OHSU Cascades East: capitation model with local CCO, but Epic EMR transition led to a setback in data management, monthly reporting
  - OHSU Portland: monthly reporting on key quality measures and patient registries from Epic

Where Did We Start?

- Teams
  - Providence: Early state of team practice and had some pharmacist and behavioral health support through Providence Medical Group
  - OHSU Cascades East: Early team practice, co-location of behavioral health without full integration, one advanced practice provider, nurses without full care management
  - OHSU Portland: integrated behavioral health, nurse care managers

What Did CPCI Bring To Our Practices?

- Funding (per year) – GP - $200k, SWF $340k.
  - Milwaukie $200k, SE $200k
  - Cascades East - $250 -$290K
- Data feedback – locally not more useful that what we were already gathering, but able to access national performance data for benchmarking and library of 'stories' regarding what other practices doing. Ongoing issues with data capture, reporting and integrity
- Learning activities and technical assistance
- A reason to do things we believed in but hadn't started yet
  - PFAC, shared decision-making tools, expanded clinical teams, behavioral health warm hand-offs

Process

- Team Creation
- Risk stratification
- Faculty engagement
- Resident engagement

Core Team and Extended Team

- Providence:
  - **Core Team**: Clinician/Mentor, Clinical Care Coordinator (MA), Physician Assistant, 2 Rooming MA, PGY1, PGY2, PGY3 and two or three Core Faculty.
  - Offices modified to accommodate geographic collocation of teams. Three teams in each office.
  - **Extended Team**: Added PsyD, Pharm D and Care Managers (Maternal and General) to each office. Obtained Community Outreach Worker through separate Care Oregon (Medicaid) grant.

Core Team and Extended Team

- OHSU Portland:
  - Core Team: 3-4 physicians, 3-4 residents, 1-2 PA, 1 NP, MAs, RN care manager
  - Extended Team: LCSW, consulting psychiatrist, Maternity care coordinator

Core Team and Extended Team

- OHSU Cascades East:
  - Core Team: 2-4 faculty, 6 residents,1 NP/PA, 1 RN care manager, 1-3 MAs, LPNs
  - Extended Team: 2 behaviorists, refill coordinator, referral coord, pt assistance, health navigators/NEMT (through CCO/hospital partnership)

Providence Outcomes

- Effects on the triple aim
  - Patient's experience – Press-Ganey and CAHPS = non-inferiority (started at high level)
  - Quality – Improved performance on preventive services and rehospitalization. Met all Quality Benchmarks
  - Utilization -- cost savings just about equal to increase revenues. No return of utilization money
  - Costs – first year decrease of 2% in monthly expenditures per beneficiary. For entire project.

OHSU Portland Outcomes

- Effects on the triple aim
  - Patient's experience – Qualitative feedback via nursing journal, improved Press-Ganey scores at one clinic. Stable at the other.
  - Quality – decrease in rehospitalization rates
  - Utilization -- increase hospitalization costs in most recent quarter
  - Costs –

OHSU Cascades East Outcomes

- Effects on the triple aim
  - Patient's experience –Patient-Family Advisory Council, CAHPS survey through NRC-Picker
  - Quality – high risk patients
  - Utilization – drop in all-cause and ACSC hospitalizations
  - Costs –
    - Primary care expenditures low
    - Total expenditures high related to hospital costs

Take Away Points for Residency Practices

- This form of funding will probably become more available under MACRA
- Both Core Teams and Expanded Teams need to be adapted to the practice.
  - Not just titles, but the quality of the actual people matters
  - Need to create functioning teams

- All team members need to be educators and enjoy working with new physicians
- Resident engagement in the process can add to their education, particularly through population-based improvement projects and team participation
- Capitation models may favor expanding residency faculty with 'clinician teachers' and advanced practice providers to help anchor clinical teams.
  - Create a model that allows the practice/team to function in a patient-focused way

Discussion

- In groups of 2-3 discuss what barriers you see to an Advanced Practice Model such as CPCI?

During the break…

- Discuss / think about how you might implement the information you just heard.
- Fill out a session evaluation.

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