Comprehensive Primary Care (CPC) Initiative Overview

What is CPC? A 4-year collaboration between CMS and private/public payers aimed to improve primary care delivery to positively impact the Triple Aim (decreased expenditures, improved population health and improved patient experience of care). CPC identifies 5 primary care functions to drive practice transformation: 1) Access and continuity, 2) Planned care for chronic conditions and preventive care, 3) Risk-stratified care management, 4) Patient and caregiver engagement, and 5) Care Coordination across the medical neighborhood. Practices must meet 9 Milestones designed to increase capacity around the 5 functions and must submit quarterly progress data which is assessed and used for practice coaching. Milestone requirements are updated annually to continue building practices' progress. CPC is a practice-level intervention; practices receive non-visit based, monthly care management fees in addition to traditional payments to invest in redesigning and transforming care.

Nearly 500 practices across 7 different regions participate in CPC. In Oregon, there are currently 65 practices participating, with 704 providers serving 52,740 Medicare FFS patients and 544,036 total active patients. Including CMS, there are 6 payers in the market.

What changes have practices made?

- Implemented Risk-stratified Care Management focusing appropriate services based on patients' risk
- Hired & trained care managers, behavioral health providers, social workers, and pharmacists
- Offer 24hr access, asynchronous communication & track continuity of care
- Communication and HIE agreements to improve hospital and ED follow up
- Introduced 3 or more decision aids to help with shared decision making around preference-sensitive conditions
- Use patient-experience surveys and/or patient-family advisory councils (PFAC) to incorporate the patient voice
- Worked with practice coaches to expand Quality Improvement capabilities and data review
- Attained Meaningful Use Stage 1 and are at least working towards Stage 2 if not already meeting it for Eligible Providers
- Engaged with other practices and built a community of similar practices focusing on practice transformation

Starting in the second year, practices worked on Advanced Primary Care Strategies (APCSs) and implemented some of the following: Integrated behavioral health (BHI) capacities with services provided either in the practice or through care compacts/referral agreements with external providers, Increased development of self-management support (SMS) for patients, Integration of pharmacists into the care team to provide medication management (MM). 36 practices are working on BHI, 10 on SMS, 10 on MM, and 9 on a combination of APCSs

CPC Transformation Outcomes

- 112,572 patients receiving care management
- 86% Hospital follow-up within 2 days
- 84% ED follow-up within 1 week
- 65% of practices have a PFAC
- 7.4% **Decrease** in hospital admissions*
- 1.5% Increase in Outpatient ED visits*
- 3.8% **Decrease** in 30-day readmissions*
- 35% Improvement in PCMH-A scores (From 2012-2015)

What assistance do practices receive? Practices frequently highlight the need for technical assistance, particularly from organizations and people within the region who know the program, provide leadership, expertise and build relationships with practices to assist in their transformation efforts.

National Assistance		
Feedback Reports	Annual Meetings	Webinars
Cross-regional Rapid-Cycle Action Groups**	Centralized web-based communication platform (CPC Connect)	EHR Affinity Groups
Regional Assistance		**Regional Faculty Expertise in:**
Quarterly Phone Coaching	Intensive In-person Coaching/Site Visits	• Risk-Stratified Care Management • Health Information Technology • Behavioral Health Integration • Shared Decision Making • Quality Improvement • Self-Management Support • Patient Centered Medical Home
In-Person Learning Sessions (2/year)	Data/Feedback Report Walk-Thrus	
Virtual Learning Sessions (2/year)	Real-Time Program Support	
Alignment with other programs	Support in Forming Patient Family Advisory Councils	

*From 1 Year prior to CPC through June 2015

**Oregon Regional Faculty led a BHI action group and served as content experts on a Shared Decision Making Action Group

For additional questions, please contact David Dorr, MD, MS at dorrd@ohsu.edu

What do practices say?*

"There is so much work to be done with primary care… We are just getting started and would love to see CPC continued as it **gives us a framework and helps with goal setting**…It is some of the most challenging work in my long career but has changed the way we look at providing care."

"**It is all about the patient**, not about getting out of the office at 5pm and collecting a paycheck. **People are enjoying their jobs again**."

"We have PCMH QI meetings now and everyone gets involved. One doctor studied blood pressures on all our patients, and when he brought that data to the committee, the others said 'this is great! **I feel like a doctor again**!'"

"I hear my Care Coordinators spending an hour or more on the phone with patients who are **transitioning from a hospital discharge to home**…This is labor intensive work and without the CPCi or payer support, I am deeply concerned these positions may be cut…"

"The biggest change has been seeing the **physician leadership becoming more open to new ideas** (Shared decision making, screeners, tracking quality measures). More innovation in the practice and more willingness to think outside of the old established ways of providing services. They ask now, "What does the PFAC (Patient-Family Advisory Council) think of this?"

"Participation in CPC…has opened **a continuing dialogue focused on improving care for all of our patients**...Examples include risk stratification, panel management, target metrics, shared decision-making tools - the list goes on."

"Now we have **reportable goals** that everyone agrees to for the quarter, have identified at risk patients in an organized way and have structural resources we have not had in the past in the form of panel coordinators and additional nurse resources."

"PMPM…fees allowed the **addition of critical staff to [move] the patient centered care model forward**. We are now able to provide much needed support for behavioral health, case management, and clerical interactions with nursing homes..."

"We now have in place **expanded clinical teams** that include a pharmacist, case manager and behaviorist. These individuals have brought a great deal to the practice and [are] a tremendous asset…"

"It also took **data to show that the improvements put in place were working and reducing system costs**."

"Our entire [organization] wants to be CPCI, they are so jealous of [our participating clinic] and the **change that is being created**."

"What has been most helpful is that **learning activities** were offered in a variety of ways. The in-person activities enhanced networking while telephone and online activities provided much-needed flexibility."

*All but one are responses to a survey about CPC Expansion conducted in August 2015
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