Leveraging Health IT to Risk Adjust Patients

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Mercy Regional Medical Center, Centura Health

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Speaker Introduction

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Clinical Performance Coordinator
Centura Health Physician Group; Colorado
Coordinator for Comprehensive Primary Care Initiative
Mercy Family Medicine; Durango, Colorado

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VP Mercy Medical Group
Mercy Regional Medical Center
Centura Health Physician Group
Durango, Colorado
Conflict of Interest

Tamra Lavengood, RN, BSN, MSN
Will McConnell, PhD, MBA, MS

Have no real or apparent conflicts of interest to report
Agenda

• The Beginning
  – What was the Comprehensive Primary Care (CPC) Initiative?
  – Why did Mercy Family Medicine choose to participate?
  – The CPC movement grows to CPC+, largest initiative ever in history of CMS

• Key elements learned from CPC
  • Empanelment
  • Risk stratification
  • Care Management
  • Behavioral Healthcare Management
  • Care Coordination Emergency Department and Hospital Follow-up
  • Health Information Technology: Crucial Builds Needed for Success

• Outcomes and Lessons Learned
Learning Objectives

• Assess organizational dynamics to successfully transfer to an alternative payment model

• Leverage EHR clinical data and behavioral health data to successfully empanel and risk adjust patients

• Develop standardized care mechanisms for meeting performance thresholds for chronic disease patients
An Introduction of How Benefits Were Realized for the Value of Health IT

**Satisfaction:** Provide comprehensive primary care: improves outcomes; better for the patient; better for the clinical staff

**Treatment/Clinical:** Target comprehensive care on the sickest patients, focus on the top 20% for the best return on investment

**Electronic Secure Data:** Attach all patients to a primary care provider; risk stratify; use data to drive improvement for clinical quality measures

**Savings:** Decrease emergency visits and hospital visits (utilization) and realize cost avoidance
What Was the Comprehensive Primary Care Initiative?

Four-year multi-payer initiative designed to strengthen primary care 
**October 2012 through December 2016**

Population-based care management fees and shared savings opportunities to support the provision of a core set of five “Comprehensive” primary care functions

- Risk Stratified Care Management
- Access and Continuity
- Planned Care for Chronic Conditions and Preventive Care
- Patient and Caregiver Engagement
- Coordination of Care Across the Medical Neighborhood

https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative
Comprehensive Primary Care Pilot

- Demographics: - 474 practice sites
  - 2,200 practitioners
  - 2.7 million active patients
  - 38 public and private payers
  - 335,000 Medicare beneficiaries
- Purpose: - Improve care
  - Better health for populations
  - Lower costs
  - Inform future Medicare and Medicaid policy

https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative
Comprehensive Primary Care Pilot

Payment Model

- Participating primary care practices receive two forms of financial support on behalf of their fee-for-service (FFS) Medicare beneficiaries:
  - A monthly non-visit based care management fee per member
  - The opportunity to share in any net savings

CPC was a pilot to prove if building the infrastructure within Primary Care via additional revenue, would it make a difference: better health, better outcomes, lower costs. It made a difference and CMS is on board with Primary Care Reform.
Why Did Mercy Family Medicine Choose to Participate?

• Value-based purchasing was getting a lot of attention
  – We needed to identify viable payment models and prepare for the future
• Alignment with PCMH requirements
• Huge potential within CPC, for additional revenue to build infrastructure within clinic
• Great group of clinicians and staff
• Timing was right
Barriers to Get the Comprehensive Primary Care Initiative Started

• One more thing to do
  – Do we have the bandwidth?
• Moving into uncertain territory with CPC
• A lot of additional reporting and process work would be needed
• No real quantifiable risk stratification tools in the beginning
• Practice was recently acquired
Comprehensive Primary Care Initiative: Our Journey

Clinics were given 9 milestones to complete

CMS selected key elements that aligned with Patient Centered Medical Home elements

Milestone 2:
• Empanelment
• Risk Stratification
• Care Management
• Behavioral Health Integration
Empanelment

• End of 2012 = 79%
• End of 2016 = 99.9%
• Four Cut Method (1)
• Provider Panels

(1) Panel Size: How Many Patients Can One doctor Have?, Mark Murray, MD, MPA, Mike Davies, MD, Barbara Boushon, RN, Fam Pract Manag. 2007 Apr; 14(4):44-51
Risk Stratification

Risk Stratification

• All 500 clinics asked to develop their own risk stratification methodology

• Mercy Family Medicine reviewed tools from:
  – California Quality Collaborative
  – AAFP Risk Stratification Tool
  – Telluride Medical Center in Colorado (another CPC practice)
Identifying and Managing High Risk Populations at Centura Health

Developed our own Mercy Adult Risk Stratification Tool (MARST) and the Mercy Pediatric Risk Stratification Tool (MPRST)

Critical to have not only **Objective** elements but **Subjective** elements as well
HIT Needed for Risk Stratification

Using the system we had our risk stratification elements flow exactly like our EHR
## MERCY ADULT RISK STRATIFICATION TOOL

### 19 YEARS AND OLDER

1/28/15 | © 2015 Centura Health Corporation

| Risk Level: Evaluated By: Evaluation Date: Last Evaluation Date: | Provider: |
|---|---|---|---|
| Patient Name: | | | |
| DOB: | | | |
| Risk Stratification Level: Score | Age: | | |

### CARE PLANNING

<table>
<thead>
<tr>
<th>Score</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>EXTREMELY HIGH</th>
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<table>
<thead>
<tr>
<th>1</th>
<th>AGE</th>
<th>19 years - 55 years</th>
<th>56 years to 74 years</th>
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<td>2</td>
<td>HOSPITALIZATIONS (last 12 months)</td>
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<td>3</td>
<td>ER VISITS (last 12 months)</td>
<td>0 TO 1</td>
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<td>4</td>
<td>ALL OFFICE VISITS (last 12 months) (Exclude OB visits)</td>
<td>1 to 2</td>
<td>3 to 6</td>
<td>7 OR MORE</td>
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<tr>
<td>5</td>
<td>CURRENT PRESCRIPTION MEDICATIONS (Including Oxygen)</td>
<td>0-2 medications</td>
<td>3-5 medications</td>
<td>6 OR MORE</td>
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</table>

### LANGUAGE/HEALTH LITERACY

<table>
<thead>
<tr>
<th></th>
<th>Primary language: English</th>
<th>Carries out plan of care well</th>
<th>Demonstrates understanding of health care needs</th>
<th>Independently seeks health information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limited English: verbal skills</td>
<td>Hearing impaired</td>
<td>Carries out some of the plan of care</td>
<td>Requires some reinforcement</td>
</tr>
<tr>
<td></td>
<td>Requires interpreter for all practice interactions</td>
<td>Not able to carry out plan of care without continued reinforcement</td>
<td>Requires more routine reinforcement and education</td>
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</table>

### CHRONIC DISEASE

(Does not include mental health diagnosis)

<table>
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<tr>
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<th>1-3 chronic diseases diagnosed</th>
<th>4 or more chronic disease diagnoses</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1-15 years tobacco use history</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BMI &lt; 25</td>
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<td></td>
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</table>

### CHRONIC DISEASE QUALIFIER

| | N/A | 1 or more chronic disease diagnoses uncontrolled | 1 or more chronic disease diagnoses, severely uncontrolled |

### MENTAL & BEHAVIORAL HEALTH

(includes but not limited to: Dementias, Substance Abuse, Autistic Disorders, Eating Disorders, Developmental Delays)

<table>
<thead>
<tr>
<th></th>
<th>No Mental Health diagnoses</th>
<th>1-2 Mental Health diagnoses</th>
<th>3 or more mental health diagnoses</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Routine follow up with provider and or mental health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-2 Significant life stressors (Divorce, Death, Job Loss, Moving, etc.)</td>
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<td></td>
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</table>

### MENTAL & BEHAVIORAL HEALTH QUALIFIER

| | N/A | 1 or more Mental Health diagnoses uncontrolled | 1 or more Mental Health diagnoses severely uncontrolled |

### SOCIAL DETERMINATION & SELF MANAGEMENT

<table>
<thead>
<tr>
<th></th>
<th>Steady income</th>
<th>Independent</th>
<th>Stable residency</th>
<th>Family or other support</th>
<th>Adequate medical insurance</th>
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<tr>
<td></td>
<td>receives some support to meet social needs</td>
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<td>Lives alone needs some assistance with ADLs</td>
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<td></td>
<td></td>
<td>Lives in a Nursing Home or Assisted Living</td>
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<tr>
<td></td>
<td>Homebound</td>
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<td>Homebound</td>
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<tr>
<td></td>
<td>Homeless</td>
<td></td>
<td></td>
<td></td>
<td>Homeless</td>
</tr>
<tr>
<td></td>
<td>Unsafe home environment</td>
<td></td>
<td></td>
<td></td>
<td>Unsafe home environment</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td></td>
<td>Lack of financial or family support that impacts care</td>
<td></td>
<td></td>
<td></td>
<td>Lack of financial or family support that impacts care</td>
</tr>
<tr>
<td></td>
<td>Transportation barrier</td>
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<td>Transportation barrier</td>
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<tr>
<td></td>
<td>No medical insurance</td>
<td></td>
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<td></td>
<td>No medical insurance</td>
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### COMMENTS

COMPLEX CARE COORDINATOR REFERRAL (Please Circle)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>

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Please use blank slide if more space is required for charts, graphs, etc.

To remove background graphics, right click on selected slide, choose “Format Background” and check “Hide background graphics”.

Remember to delete this slide, if not needed.
# Mercy Pediatric Risk Stratification Tool

## Risk Stratification Level: Score

<table>
<thead>
<tr>
<th>Risk Level:</th>
<th>Score</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Extremely High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk 1: 0-1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk 2: 2-3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk 3: 4-6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk 4: 7-9</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Risk 5: 10-13</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Risk 6: 14-18</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CARE PLANNING

### Score

#### Age
- 3 years to 18 years
- Birth to 35 months
- Premature (<36wks) - 12 months

#### Hospitalizations (last 12 months)
- 0 to 1
- 2
- 3 or more

#### ER Visits (last 12 months)
- 0 to 1
- 2
- 3 or more

#### All Office Visits (last 12 months)
- Birth to 23 months: 4-5 visits
- 2 years to 18 years: 1-2 visits
- Birth to 23 months: 2-3 or 6-7 visits
- 2 years to 18 years: 3-4 visits
- Birth to 23 months: 1 visit or >8 visits
- 2 years to 18 years: >5 visits

#### Current Prescription Medications
- No Medications
- 1-2 medications
- 3 or more
- Oxygen Use

### Family/Caregiver

#### Language/Health Literacy
- Primary language: English
- Carries out plan of care well
- Demonstrates understanding of health care needs
- Independently seeks health information
- Limited English; verbal skills
- Hearing impaired
- Carries out some of the plan of care
- Requires some reinforcement
- Requires interpreter for all practice interactions
- Not able to carry out plan of care without continued reinforcement
- Requires routine reinforcement and education

### Chronic Disease
- No chronic disease
- Non-smoker/no secondhand smoke
- Growth Chart >25th percentile
- 1 chronic diseases diagnosis
- Exposure to secondhand smoke
- Growth Chart >25th percentile
- 2 or more chronic disease diagnoses
- Tobacco use
- Growth Chart >25th percentile

### Chronic Disease Qualifier
- N/A
- 1 or more chronic disease diagnoses uncontrolled
- 2 or more chronic disease diagnoses
- 3 or more significant life stressors (divorced parents, young parents <20, single parent, unemployment)
- 1 or more Mental Health diagnoses uncontrolled
- 2 or more mental health diagnoses
- 3 or more significant life stressors (divorced parents, young parents <20, single parent, unemployment)

### Mental & Behavioral Health Qualifier
- N/A
- 1 or more Mental Health diagnoses uncontrolled
- 2 or more Mental Health diagnoses
- 3 or more significant life stressors (divorced parents, young parents <20, single parent, unemployment)
- Homeless
- Unsafe home environment
- Unemployed
- Lack of financial or family support that impacts care
- Transportation barrier
- No medical insurance
- Foster Care

### Social Determination & Self Management
- Steady income
- Stable residence
- Adequate medical insurance
- Meets basic ADL’s
- Receives some support to meet social needs
- Some medical insurance
- Meets some of basic ADL’s
- Homeless
- Unsafe home environment
- Unemployed
- Lack of financial or family support that impacts care
- Transportation barrier
- No medical insurance
- Foster Care

## Comments:

### Complex Care Coordinator Referral

<table>
<thead>
<tr>
<th>(Please Circle)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

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Risk Stratification in CPC Practices

Comprehensive Primary Care practices risk stratify their patients by:

- Clinical intuition: 71%
- Practice developed clinical algorithm: 61%
- Published clinical algorithm: 40%
- Claims: 24%
- EHR methodology: 19%

Practices were able to select more than one method.
***Attention EHR Venders***

Create a methodology to risk stratify patients using objective data elements, BUT then have an end user capability for subjective, intuitive judgement.
### Mercy Adult Risk Stratification Tool

**MFM Adult Risk Stratification Tool (19 years and older)**

<table>
<thead>
<tr>
<th>Current Prescription Medications</th>
<th>0-2 medications</th>
<th>3-5 medications</th>
<th>6 or more medications</th>
</tr>
</thead>
</table>

#### Language/Health Literacy (expand for details)

0 = Primary Language is English, Carries out plan of care well, Demonstrates understanding of health care needs, Independently seeks health information.

1 = Limited English; verbal skills, Hearing impaired, Carries out some of the plan of care, Requires some reinforcement.

2 = Requires interpreter for all practice interactions, Not able to carry out plan of care without continued reinforcement, Requires routine reinforcement and education.

<table>
<thead>
<tr>
<th>Language/Health Literacy Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
</table>

#### Mental & Behavioral Health (expand for details)

Includes but not limited to: Dementias, Substance Abuse, Autistic Disorders, Eating Disorders, Developmental Delays

0 = No mental health diagnoses, Long term stability demonstrated with medication.

1 = One to two mental health diagnoses, Routine follow up with provider and/or mental health provider, One to two significant life stressors (divorce, death, job loss, moving, etc.).

2 = Three or more mental health diagnoses, Three or more significant life stressors (divorce, death, job loss, moving, etc.).

<table>
<thead>
<tr>
<th>Mental &amp; Behavioral Health Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
</table>
Mercy Adult Risk Stratification Tool

Have risk stratified over 15,000 patients

- 1.1% Highest risk – Level 6
- 20.4% High risk – Level 5 (6.5%) and Level 4 (13.9%)
- 25.3% Medium risk – Level 3
- 26.5% Low risk – Level 2
- 26.7% Low risk – Level 1
Says "80 percent of the health care dollars are spent by 20 percent of the population."
— Alan Bates on Tuesday, February 14th, 2012 in a floor speech.

Does 20% of the population really use 80% of health care dollars?

By Ian K. Kullgren on Thursday, February 23rd, 2012 at 4:02 p.m.
Figure 1. Concentration of health care expenditures, U.S. civilian noninstitutionalized population, 2012

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey (HC-155), 2012
Care Management for High Risk Patients (Person Focused)

- Care Management (person/disease centered) of patients in the highest risk quartile:
  For the Mercy Risk Tool Level 6 (1.1% with Mercy Risk Tool)

- Care Management (person/disease centered) of patients with rapidly rising risk and likely to benefit from active, ongoing, intensive care management
  For the Mercy Risk Tool Level 5’s and Level 4’s (20.4% with Mercy Risk Tool)

- Integration of behavioral health care management strategies for patients in higher risk cohorts
## Risk Stratified Care Management

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Reassessment interval</th>
<th>Care Management action steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Annually</td>
<td>Primary prevention: Care management that is aimed toward keeping the patient educated about his/her health and preventing illness by incorporating preventative screenings/immunizations</td>
</tr>
<tr>
<td>3</td>
<td>Every 6 months</td>
<td>Secondary Prevention: Care management that is aimed toward keeping the patient’s diseases in control; providing them with educational and service opportunities that will maintain or improve their disease state</td>
</tr>
<tr>
<td>4-5</td>
<td>Every 3 months</td>
<td>Tertiary Prevention: Care management that provides intensive education, referral to other resources for the patient’s/family’s wellbeing</td>
</tr>
<tr>
<td>6</td>
<td>Monthly</td>
<td>Complex Care Management: Care management of patients with multiple co-morbidities, multiple medications, frequent ER visits and hospitalizations</td>
</tr>
</tbody>
</table>
Get Ready for the Change – Do We Have All of the Required Elements?

Begins with Comprehensive Primary Care Delivery

- Qualified, competent Primary Care Providers
- Empaneled patients with care teams
- Risk Stratification of patients in real time using subjective as well as objective elements
- Integration of Behavioral Health Care Management
Behavioral Health Integration

• Behavioral Health care is needed for the majority of level 6 patients

• In house Licensed Clinical Social Worker
  – Warm handoffs
  – Scheduled patients
  – Evaluation tools: PHQ9
    • Tracking depression screening
Care Coordination (System focused)

Care Coordination across the Medical Neighborhood

– Emergency Department discharges
– Hospital discharges
<table>
<thead>
<tr>
<th>Month</th>
<th>Emergency Discharges</th>
<th>Inpatient Discharges</th>
<th>Emergency Discharges</th>
<th>Inpatient Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Discharged</td>
<td>Number Contacted in 7 Days</td>
<td>Percent Contacted in 7 Days</td>
<td>Number Discharged</td>
</tr>
<tr>
<td>January</td>
<td>151</td>
<td>151</td>
<td>100.0%</td>
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<tr>
<td>February</td>
<td>156</td>
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<tr>
<td>March</td>
<td>137</td>
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<td>49</td>
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<td>April</td>
<td>164</td>
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<td>46</td>
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<td>May</td>
<td>159</td>
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<td>54</td>
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<td>June</td>
<td>121</td>
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<td>July</td>
<td>160</td>
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<td>50</td>
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<td>August</td>
<td>152</td>
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<td>September</td>
<td>176</td>
<td>174</td>
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<td>39</td>
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<td>October</td>
<td>175</td>
<td>174</td>
<td>99.4%</td>
<td>42</td>
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<td>November</td>
<td>168</td>
<td>168</td>
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<td>39</td>
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<td>December</td>
<td>100</td>
<td>99</td>
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<tr>
<td>TOTAL</td>
<td>1819</td>
<td>1815</td>
<td>99.8%</td>
<td>546</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Emergency Discharge Average Time to Contact (in days) by Location by Month</th>
<th>Inpatient Discharge Average Time to Contact (in days) by Location by Month</th>
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<tr>
<td>TOTAL</td>
<td>1.63</td>
<td>1.99</td>
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</table>
Mercy Family Medicine’s Care Model
HIT Critical Builds with Ability to Track

- Empanel all patients to a primary care provider
- Risk Stratify all patients with objective and subjective information
- Longitudinal Care Plans
- Episodic Care Plans
- ED and Hospital interoperability with clinics
- Clinical Quality Measures; codes built for tracking
- Vendor collaboration with clinics!!
Medicare Expenses Per Patient Per Month All Attributed Patients

https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative
Hospital admissions, ED Visits, 30 day Re-Admissions for all attributed Medicare Patients

https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Current Four-Quarter Average Rates, Q12 to Q15 (Q15 estimate)</th>
<th>Previous Four-Quarter Average Rates, Q11 to Q14 (actual)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median Value Among CPC Practices in Your Region</td>
<td>Median Value Among CPC Practices in Your Region</td>
</tr>
<tr>
<td></td>
<td>Practices with a Patient Risk Profile Similar to Yours</td>
<td>Practices with a Patient Risk Profile Similar to Yours</td>
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<tr>
<td></td>
<td>All Practices</td>
<td>All Practices</td>
</tr>
<tr>
<td>Hospital Admissions (per 1,000 patients per year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of Hospital Admissions for Any Cause</td>
<td>180 LO</td>
<td>184 LO</td>
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<td>260</td>
<td>257</td>
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<td></td>
<td>207</td>
<td>213</td>
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<tr>
<td>Rate of Hospital Admissions for ACSCs</td>
<td>26 LO</td>
<td>25 LO</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>ED Visits (per 1,000 patients per year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of Total ED Visits</td>
<td>634</td>
<td>656</td>
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<td></td>
<td>706</td>
<td>692</td>
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<td>552</td>
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<tr>
<td>Rate of Outpatient ED Visits</td>
<td>520</td>
<td>642</td>
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<td></td>
<td>530</td>
<td>532</td>
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<td>406</td>
<td>415</td>
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<tr>
<td>Rate of ED Visits That Led to a Hospital Admission</td>
<td>113 LO</td>
<td>114 LO</td>
</tr>
<tr>
<td></td>
<td>173</td>
<td>171</td>
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<tr>
<td></td>
<td>137</td>
<td>136</td>
</tr>
<tr>
<td>Unplanned Readmissions (per 1,000 hospital discharges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of 30-Day Unplanned Hospital Readmissions*</td>
<td>(based on 118 average hospital discharges)</td>
<td>(based on 117 average hospital discharges)</td>
</tr>
<tr>
<td></td>
<td>(based on 32 average hospital discharges)</td>
<td>(based on 24 average hospital discharges)</td>
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<tr>
<td></td>
<td>69 LO</td>
<td>76 LO</td>
</tr>
<tr>
<td></td>
<td>123</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>109</td>
<td>101</td>
</tr>
</tbody>
</table>
CPC Great Idea!

• Successes:
  – Care Management for high-risk patients identified through risk stratification in real time using objective and subjective-intuitive elements, able to isolate the top 1% of our patient population
  – Care Management and Behavioral Health Care Management for high-risk patients led to reduced ED visits; Hospitalizations for any cause; and for Hospitalizations due to Ambulatory Care Sensitive Conditions (ACSC)
  – Care Coordination in the clinic setting providing communication between the inpatient and outpatient settings for ED and hospital discharges enabling follow up at 97.5% within 1.8 day for ED visits and 96.7% within 8hrs for hospital discharges
Successes Continued... (Q15)

Data is not risk adjusted so the comparison is with clinics that have a similar risk profile

- Decreased Per Member Per Month (PMPM) expenses for Medicare population of $617; 7th lowest in Colorado region of 75 practices of which $716 is the median and high $1,284. Mercy Family Medicine (MFM) has over 3000 attributed Medicare patients. MFM had a cost avoidance of Medicare expenditures by $297,000 per month compared to the Colorado region average. That equals $3,564,000 of cost avoidance for our 3000 Medicare patients annually.

- Decreased ED utilization from 656 to 634 (not risk adjusted) per 1000 Medicare patients. Average in Colorado region is 706 for clinics with a similar risk profile. MFM reduced Medicare expenditures by $140,400 compared to the Colorado region average.*

*based on Mercy Regional Medical Center average of $650/ED visit)
Successes Continued... (Q15)

Information is not risk adjusted so comparisons are with clinics with a similar risk profile to Mercy

- Decreased hospital admissions for any cause from 196 (Q1) to **180** (Q15) patients per 1000 Medicare patients, an 8% decrease. Average for Colorado region is 260 patients and had a 7% decrease throughout the initiative. Mercy Family Medicine reduced Medicare expenditures by $6,240,000 annually compared to the Colorado region average. *

- Decreased hospital admissions for Ambulatory Care Sensitive Conditions (ACSC) from 33 (Q1) to **26** (Q15) per 1000 Medicare patients, a 21% decrease. Average for Colorado region is 54 and had a 9% decrease throughout the initiative. Mercy Family Medicine reduced Medicare expenditures by $2,184,000 annually compared to the Colorado region average. *

- Decreased 30 day re-admit from 101(Q1) to **69** (Q15) per 1000 Medicare patients, a 31% decrease. Average for state of Colorado is 123 re-admits per 1000, and had a 3% decrease throughout the initiative. Mercy Family Medicine reduced Medicare expenditures by $4,212,000 annually compared to the Colorado region average. *

*based on Mercy Regional Medical Center average of $26,000/hospital visit)
Variables

- This is a picture looking at where MFM was in Q1 and where MFM is in Q15 (3.5 years). There were some quarters that we were lower and some quarters that we were higher. This reflects the beginning of MFMs CPC journey, October 2012, though June 2016.

- MFM also grew from 1117 Medicare patients to 3171, an 184% increase. The Colorado region clinic's average grew from 446 to 657 Medicare patients, a 47% increase.

- There are differences in demographics across the 75 Colorado Primary Care clinics: age; race/ethnicity (MFM has more Native American, less African American); HCC scores (MFM has more high risk patients); dual eligible (MFM has more patients also on Medicaid).
What’s Next?? CPC+
Largest initiative in the history of CMS.

- CPC+ is an advanced primary care medical home model.
- Building on lessons learned from the Comprehensive Primary Care (CPC) initiative
  - Care Management of high risk patients
  - Behavioral Health Care Management of high risk patients
  - Care Coordination with transitions of care from the ED and Hospital
  - Data driving improvement: Clinical Quality Measures; Cost; and Utilization
  - Offering alternative payment models which pay clinics up-front to build the infrastructure for comprehensive primary care with multi-payer involvement
  - 5 Year Model: Round 1 beginning January 1, 2017; Round 2 beginning January 1, 2018 for 10 new regions
14 CPC+ Regions Selected

Arkansas: Statewide
Colorado: Statewide
Hawaii: Statewide
Kansas and Missouri: Greater Kansas City Region
Michigan: Statewide
Montana: Statewide
New Jersey: Statewide
New York: North Hudson-Capital Region
Ohio: Statewide and Northern Kentucky Region
Oklahoma: Statewide
Oregon: Statewide
Pennsylvania: Greater Philadelphia Region
Rhode Island: Statewide
Tennessee: Statewide

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus/
A Summary of How Benefits Were Realized for the Value of Health IT

**Satisfaction**: Reduced hospitalizations, ED visits, re-admissions rewarding for patients and clinical staff

**Treatment/Clinical**: Identified high risk population to target resources, top 20%

**Electronic Secure Data**: Empanelment 99%; risk stratification >85%; data driving improvement for 9 Clinical Quality Measures

**Savings**: Decreased overall per-member-per-month expenditures and millions in cost avoidance for MFM’s 3000+ Medicare patients
Leave You With a Story:

How Care Management and Care Coordination saved a life……
Questions

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