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Comprehensive Primary Care Plus (CPC+)

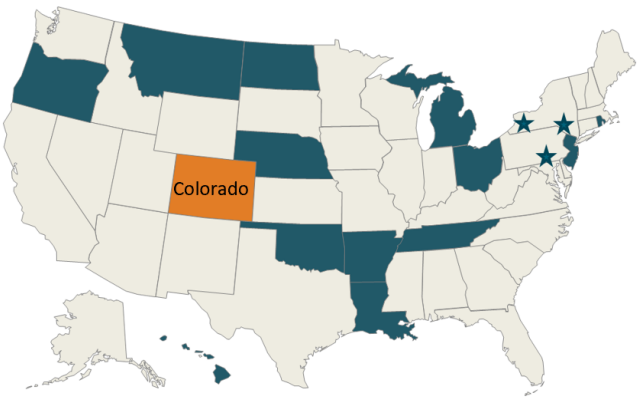
How HealthTeamWorks Helped Practices in Colorado Achieve Success in the Comprehensive Primary Care Plus Model

HealthTeamWorks was a crucial partner of the CPC+ Regional Learning Network and provided practice transformation and coaching support to over 200 independent and system practices in Colorado.

By guiding them to use data-driven methods, form effective care teams, and provide resources based on population needs, HealthTeamWorks supported practices to create a sustainable culture fostering effective population health management.

Practices learned to use meaningful data and develop practical quality tools and dashboards to improve their effectiveness and patient care. By implementing screening tools for Behavioral Health (BH) and Social Determinants of Health (SDoH) and strengthening collaboration with community partners, practices could better address patients' needs.

Colorado practices improved their measures of care delivery, outcomes, quality, and utilization, ultimately enhancing the quality, access, and efficiency of primary care.



CPC+ Regions: Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Louisiana, Michigan, Montana, Nebraska, North Dakota, Greater Buffalo Region of New York, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee.

About CPC+

Comprehensive Primary Care Plus (CPC+) was a national five-year advanced primary care test model introduced in 2017 by the Centers for Medicare and Medicaid Services (CMS). The CPC+ model focused on strategies to promote population health and chronic disease management techniques and encouraged coordinated patient-centered care. The model was designed to optimize performance by providing actionable data and effectively capturing and diffusing new knowledge among participating practices, payers (including CMS), and HIT vendors to fully engage them in achieving the CPC+ aims. Participating practices gradually shifted from a fee-for-service (FFS) approach to population-based payment model, with three payment elements offered to support and incentivize practices to better manage beneficiaries' health and provide a higher quality of care.

2,610 participating practices in 18 regions, including Colorado, were supported by 52 aligned payers. This gave practices additional financial resources and flexibility to make investments, improve the quality of care, and reduce the number of unnecessary services their patients received.

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Initial Challenges

Although many participating practices in Colorado had been part of the original Comprehensive Primary Care Initiative (CPCi) or other state-level practice transformation initiatives and had begun working on improving care delivery, most were still in the early stages of developing and implementing change. For several practices, the type of model of care promoted by CPC+ was entirely new.

Initial challenges Colorado practices faced in CPC+ included:

- *Patient Experience of Care* – Practices struggled to attain good scores on Patient Experience of Care (PEC). Many were not familiar with or not using the CAPHS survey to measure PEC. In the first year of CPC+, the Colorado region scored the lowest in this area.

- *Risk Stratification of High-Risk Patients and Care Management Services* – Practices faced challenges implementing a risk stratification process. They spent significant time creating risk stratification processes and redesigning workflows and algorithms (i.e., adding clinician input). Some struggled to understand the care management role and faced challenges implementing a process to identify patients that could benefit from longitudinal care management. Additionally, several practices described challenges with documenting care management encounters and care plans in the Electronic Health Records (EHR), given their current EHR capabilities.

- *Use of Data to Drive Quality Improvement* – Practices identified several challenges in using payers' feedback reports to guide quality improvement, including inconsistent access to patient-level data, reporting that represented small numbers of patients, and misalignment across payer reports in measurement methodologies and reported outcomes. Practices did not have processes to review and utilize their internal data sources and did not include different practice roles in their quality improvement teams. These factors contributed to challenges in making data-driven improvement a part of their culture.

- *Emergency Department and Hospital Utilization* – ED and hospital utilization were high at the start of CPC+. Most participating practices faced challenges in reducing inappropriate or avoidable utilization. Lack of patient education on appropriate use, limited access to primary care services, and poor chronic condition management were some of the factors that drove the high utilization.

"We are lucky to have been supported by HealthTeamWorks throughout our participation in the CPC+ model. The support that HealthTeamWorks has provided our practice has helped us grow and excel in the quality care we provide our patients."

Samuel Herbert, LMT
Program Coordinator, Regulatory Analyst (WCDH) & Quality Director Lead (EPHC)
Wray Hospital & Clinic

"With HealthTeamWorks by my side, I was able to become a true subject matter expert for my organization. The help I received was consistently above and beyond! I would recommend HealthTeamWorks to any large system or privately owned Primary Care Practice who wishes to transform the delivery of Primary Care and truly make a difference in the lives of their patients."

Caitlyn Hockenbury
Field Operations Program Manager
Boulder Community Health

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Results and Approach

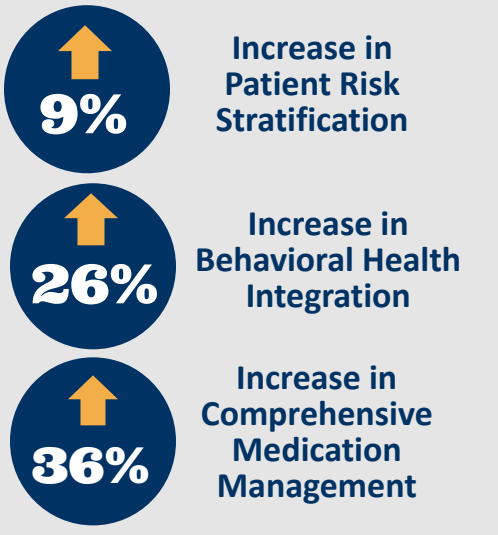
Facing these initial challenges, HealthTeamWorks supported Colorado's CPC+ practices change how they provided care, resulting in improved quality and a reduction in unnecessary service utilization and expenditures.

Here are some areas where the Colorado region made crucial improvements by the end of the CPC+ program.

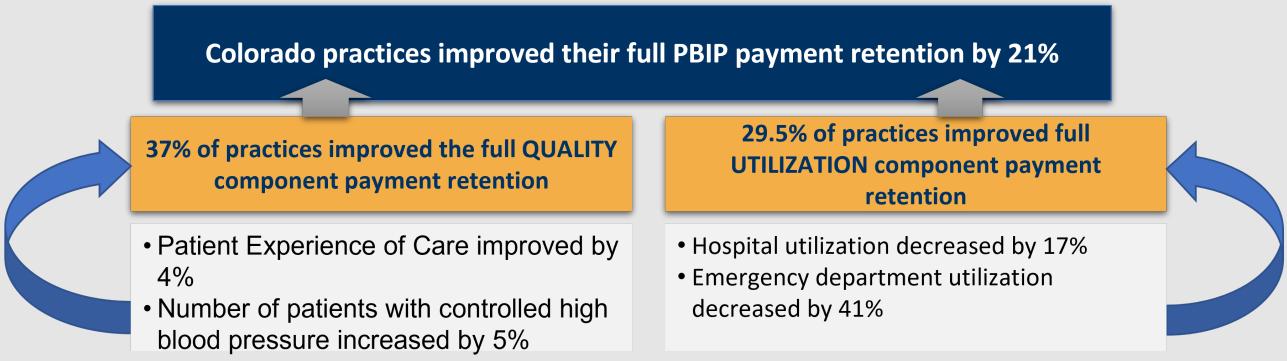
Performance Measures Improvement

One of the three payment elements in CPC+ was the Performance-Based Incentive Payment (PBIP), where practices were prospectively paid and retrospectively reconciled those payments based on how well they performed on **quality** and **utilization measures** driving the total cost of care. HealthTeamWorks' practice transformation team helped practices improve their performance measures and, as result, increase their PBIP payment retention.

Care Delivery and Outcome Measures Improvement



PBIP Retention Improvement



The HealthTeamWorks Approach in the CPC+ Model

- Enhanced partnerships with health information exchange (HIE) vendors and commercial payers to better support participating practices to achieve the triple aim.
- Planned and delivered in-person and virtual Learning Collaborative Sessions for all practice staff members.
- Facilitated in-person and virtual practice meetings to initiate and/or sustain practice transformation efforts at the system and practice level.
- Coached and guided practices to use internal and external data effectively to drive change and create a culture of quality improvement.
- Hosted cross-regional webinars and trainings covering Care Management, Advanced Care Planning, Use of Data, and the program-specific Data Feedback Tool.
- Coached practices to achieve alignment across different payment models such as SIM, TCPi, ACOs, and commercial payers.
- Connected practices regionally, cross-regionally, and with community programs to support and enhance Behavioral Health Integration and resources for identified patient needs related to Social Determinants of Health.

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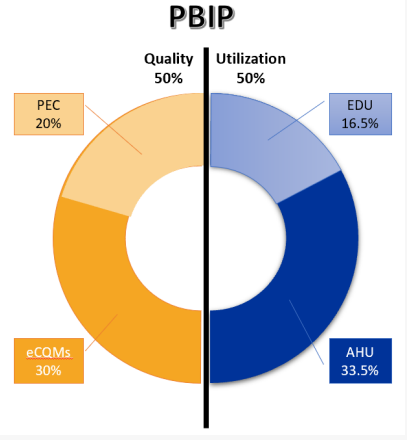
Practice Success Story
Summit Medial Clinic

After the conclusion of the first year of CPC+, Summit Medical Clinic received its 2017 Performance-Based Incentive Payment (PBIP) results showing an overall performance score of 73% based on the following Quality and Utilization measures:

- Patient Experience of Care (PEC)
- Electronic Clinical Quality Measures (eCQMs):
  - Controlling High Blood Pressure (CMS 165) and Diabetes
  - Hemoglobin A1c Poor Control > 9% (CMS122)
- Emergency Department Utilization (EDU)
- Acute Hospital Utilization (AHU)



CPC+'s PBIP incentive money was paid in advance and recouped based on performance. As a result of their 73% performance score, Summit Medical Clinic had to pay back 27% of that prospective payment.

Practice Overview

Summit Medical Clinic has participated in several state and federal practice transformation initiatives, including CPCi, SIM, and CPC+.

Number of Practitioners: 4

Number of Patients: 5,100

EHR: Allscripts

Geographic Area: Urban

Practice Approach: A comprehensive and patient-centered approach to internal medicine and nephrology help them deliver the highest quality care throughout each patient's treatment journey.

Solution

HealthTeamWorks' practice facilitator visited the practice monthly and supported staff with reviewing data and creating dashboards using different sources of information. This enabled them to identify high utilization measures as the primary source of their poor overall performance.

Reducing hospital and emergency department (ED) utilization became a priority. With the help of their HealthTeamWorks' practice facilitator, staff began to monitor different sources of data and engage in "Plan, Do, Study, Act" (PDSA) cycles aimed at improving performance.

Implemented quality improvement efforts included:

- Home Visits: Clinicians initiated home visits for high-risk patients and patients with high ED use.
- Patient Education Campaigns:
  - The practice implemented on-hold messages to educate patients about when to go to the ED and when to be seen by their primary care provider.
  - The practice gave out fridge magnets with phone numbers and practice hours of operation.
  - Patients were educated to use the patient portal to communicate with the practice.

Results

The implementation of detailed data compilation and review and the efforts to educate patients around appropriate ED and hospital use showed tremendous results. These quality improvement efforts resulted in a significant reduction in hospital and ED utilization.

The overall performance score showed an improvement of 20 percentage points, going from 73% to 93%. As a result, Summit Medical Clinic was able to retain more incentive money compared to the first year of the program and only had to pay back 7% of the prospective payment.

Performance Improvement

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The Colorado Alternative Payment Model (APM) Market

The APM options in Colorado continue to expand. This includes APM models such as Primary Care First (PCF), expansion of ACO options, Direct Contracting, and continued growth of Medicare Advantage options. On a parallel path, the state of Colorado continues to promote the transition from Fee-For-Service (FFS) models to APM models of payment as directed by legislative requirements and facilitated by the Colorado APM Alignment Initiative.

The Colorado APM Alignment Initiative focuses on developing a multi-payer statewide alternative payment model that moves payers away from fee-for-service payments to value-based payments. In addition, in December 2021, CMS announced that Colorado would be one of four states across the nation to participate in a State Transformation Collaborative (STC) initiative to expedite the implementation of APMs in partnership with Health Care Payment Learning and Action Network (HCPLAN) and drive higher quality and more equitable care. All efforts at the state and national level lend to a culture of promoting the APM as the prominent payment model in Colorado.

Learnings from previous transformation work with SIM, CPC, TCPi, and CPC+ show that healthcare transformation is not easy. But as reflected in the data from CPC+, these efforts do result in higher quality care and lower utilization under a payment model that can support the necessary infrastructure. Even after CPC+ concluded, Colorado physicians, providers, systems, and practices continued the journey to improve the quality of and increase revenue for primary care, and these learnings are critical to continue moving away from FFS and to value-based models of payment.

HealthTeamWorks is Here to Help

HealthTeamWorks is well-positioned to provide individualized practice and system support that includes quality improvement, utilization reduction, risk stratification improvement, care management optimization, performance improvement, organizational development, and the practice support needed to strengthen community and culturally responsive high-quality care. By partnering with practice and system teams, we:

- Customize Care Management training through data reviews, clinic workflow assessments, and team input.
- Optimize data review, including population health data, quality data, utilization data, and care team task data that supports quality improvement initiatives.
- Optimize EHR/Care Management for effective communication across the team and enhance patient engagement via patient-identified goals.
- Engage the team to address potential inequities and increase awareness of implicit biases and other obstacles that can impact patient compliance and efficiency of care via Allyship and Health Equity training and support.

Contact Us

To connect with HealthTeamWorks team, and to discuss how we can support, please contact us at:

solutions@healthteamworks.org

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www.healthteamworks.org