Breakout Session G :

PCMH Collaboration Across the State –
The Ohio Story

2014 PCPCC Annual Fall Conference
Nov. 13, 2014
Washington, DC

The Ohio Story

- Moderator – Ted Wymyslo MD

- Panel - Richard Shonk MD –Cincinnati Region
- Jeff Biehl – Columbus Region
- Randy Cebul MD – Cleveland Region
- Ted Wymyslo MD – The State Engagement

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Ohio – The Buckeye State

- Population - 11.57 million (7th largest population, 34th in size)
- Medicaid population - 2.34 million (20%)
- 7 medical schools
- Unemployment rate - 5.6% (seasonally adjusted)-(cf US-5.9%)
- State Health Ranking – 40 (2013)

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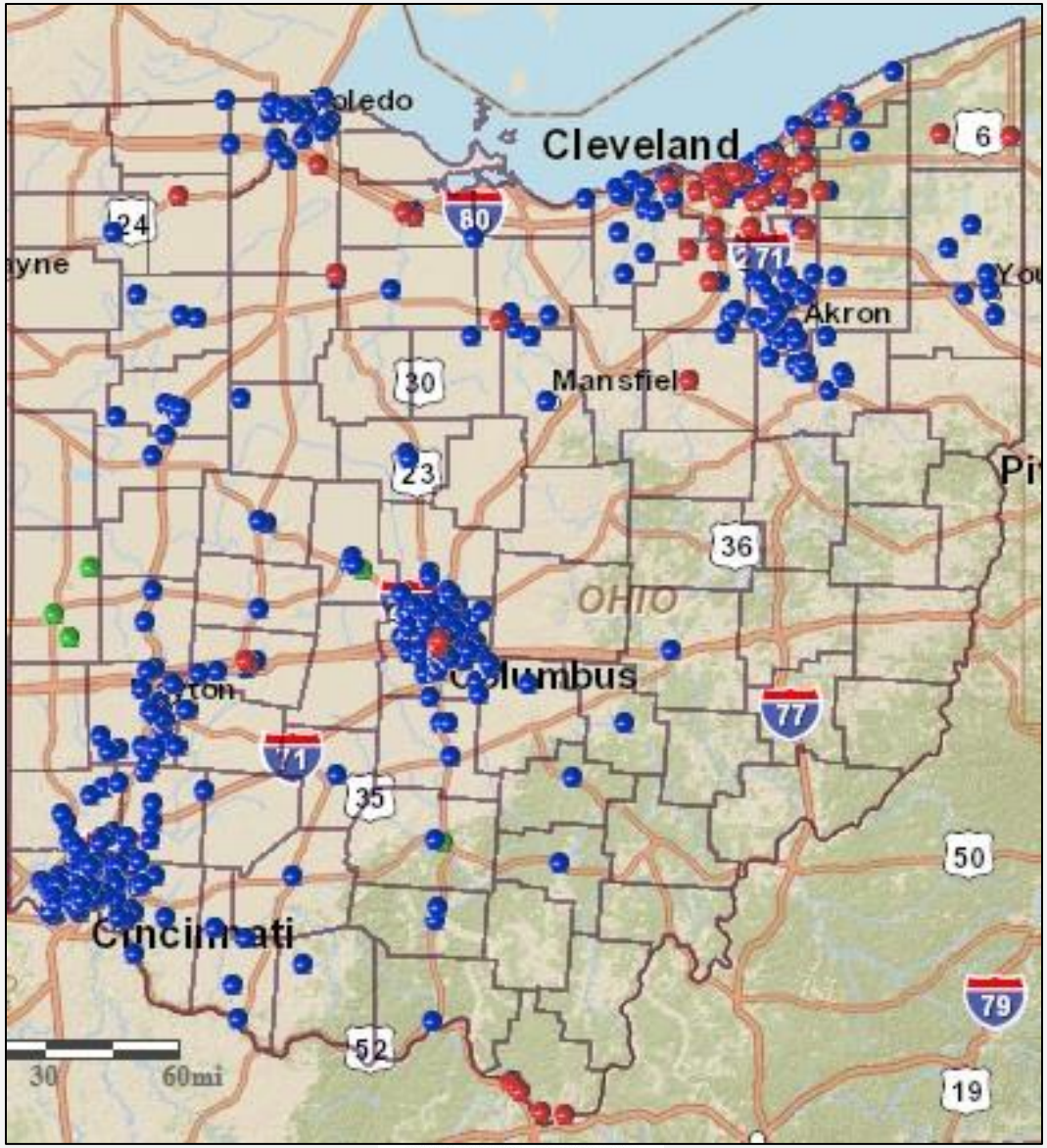
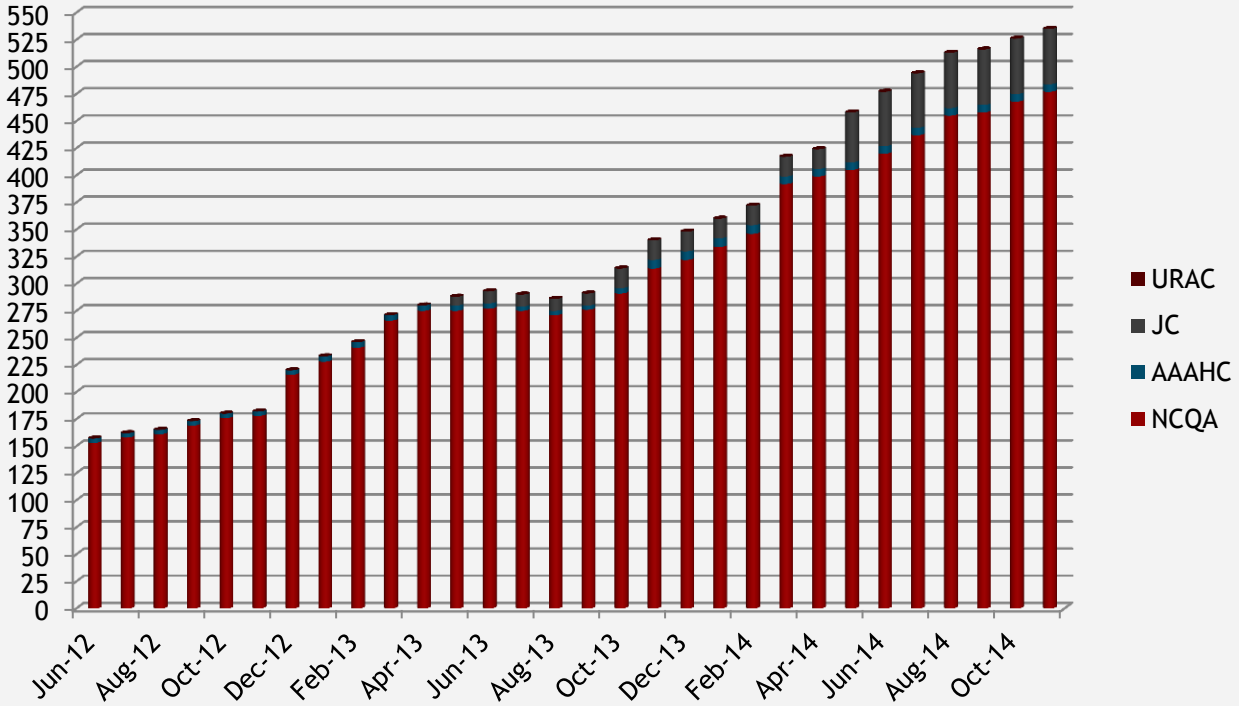
Ohio PCMH Map



Ohio PCMH Recognized Sites November, 2014



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Ohio PCMH Recognized Sites November, 2014

- NCQA - 477 sites
- TJC - 51 sites
- AAAHC - 7 sites

- TOTAL =535 sites

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November 2014

OPCPCC Initiative:

Synergy through Synchronization

Richard F. Shonk, MD, PhD

Chief Medical Officer

GREATER CINCINNATI HEALTH COUNCIL
THE HEALTH COLLABORATIVE
HEALTH BRIDGE

Cincinnati Regional Health Transformation

Better Care. Better Health. Lower Cost.

the Health Collaborative

where collaboration creates transformation

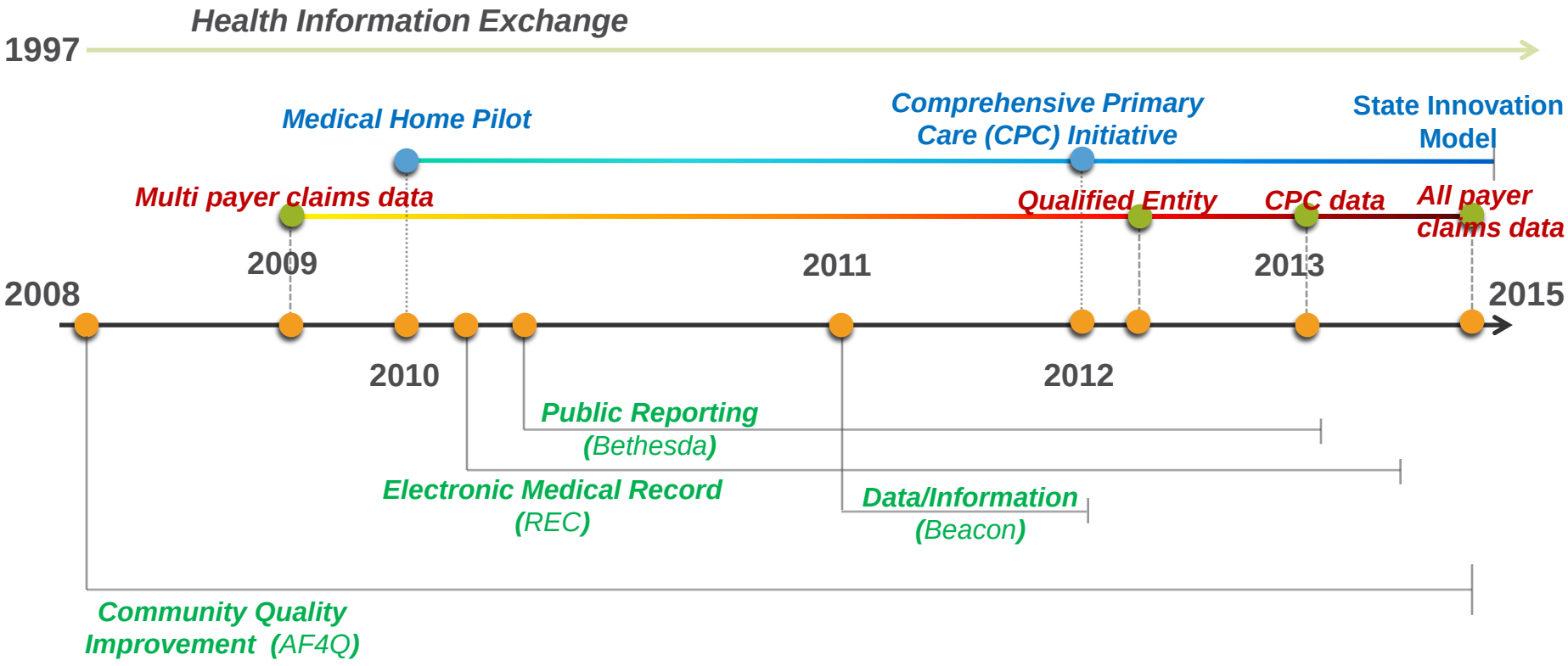
GREATER CINCINNATI HEALTH COUNCIL

Creating connections. Improving care.

HealthBridge

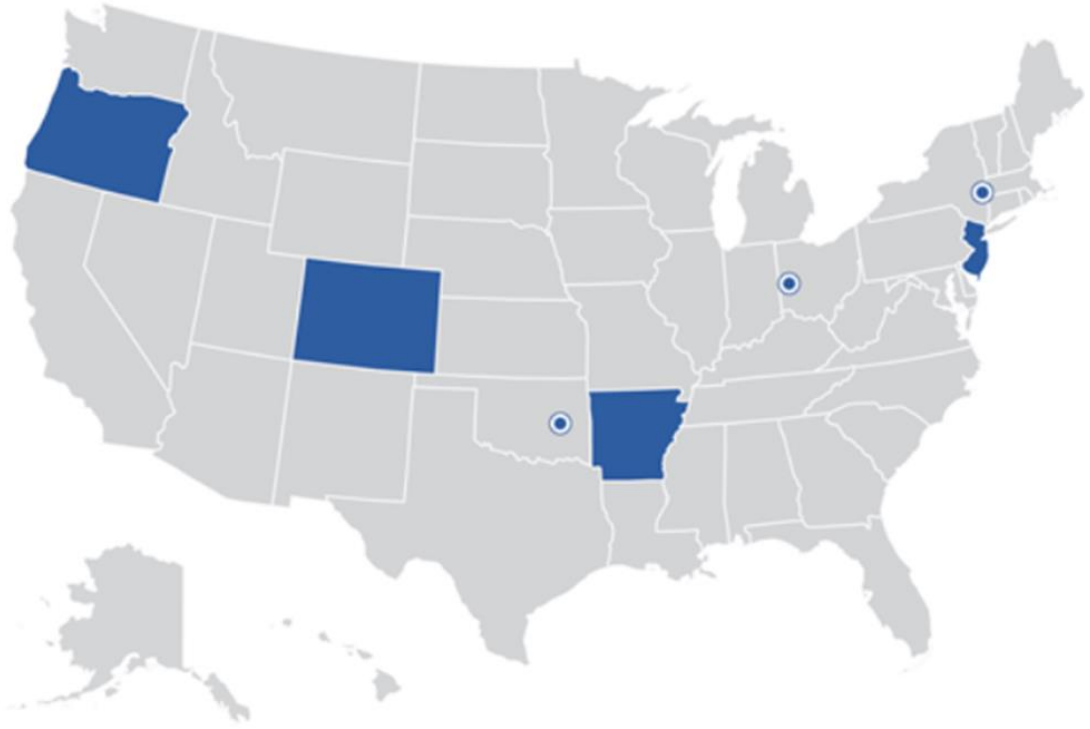
Better information. Better care. Better outcomes.

How we got here…
And where we are headed



CPCi Markets

The Participating Practices

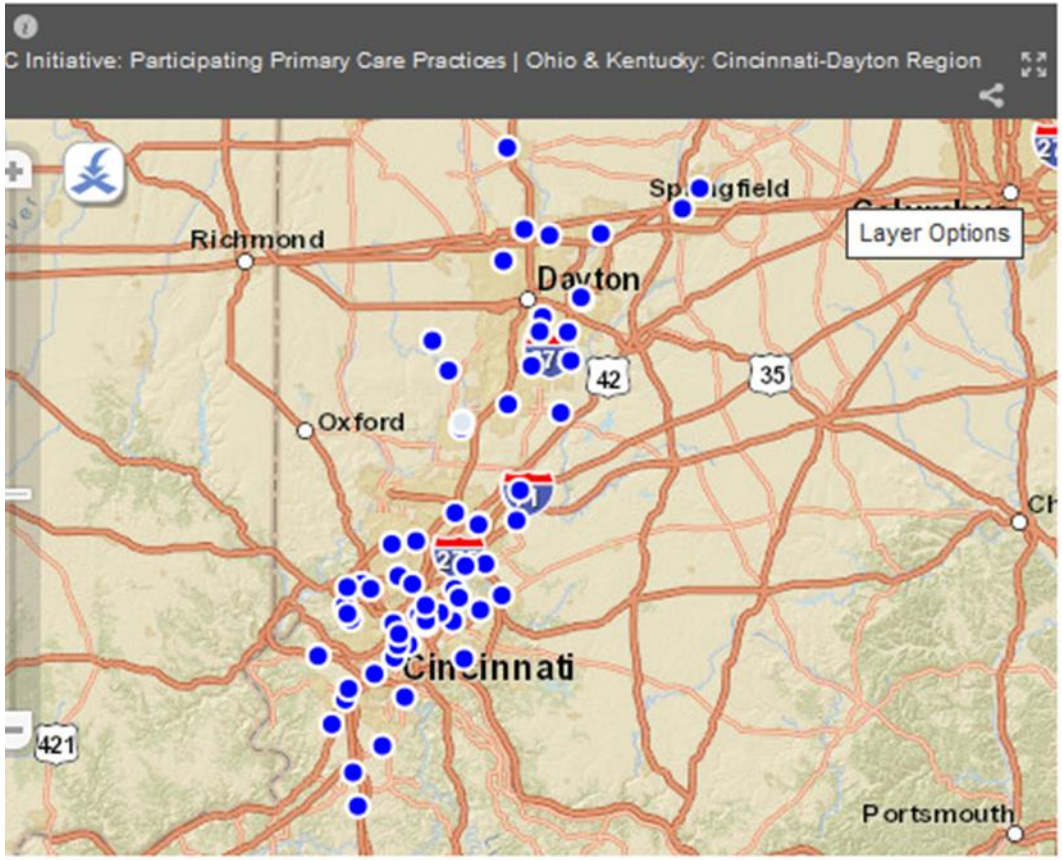


Source: Centers for Medicare & Medicaid Services

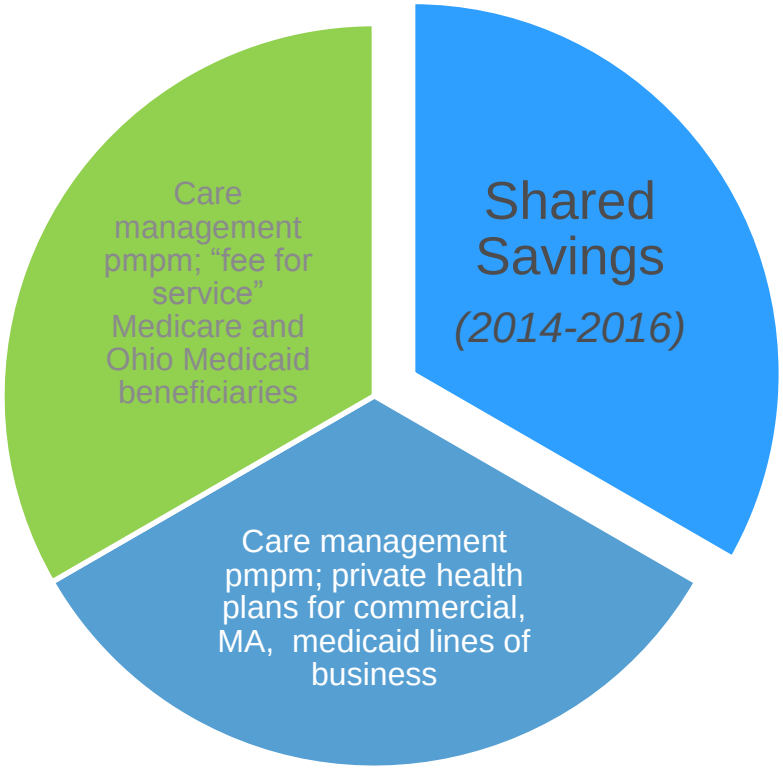
There are 500 primary care practices participating in the CPC initiative. (List | Map)
This represents 2,144 providers serving an estimated 313,000 Medicare beneficiaries.

Cincinnati/Dayton/Northern Kentucky Market

- 75 Practices
  - 1/3 Independent
  - 2/3 System
- 250 Physicians
- 220,000 lives
- 9 Payers
  - Aetna
  - Anthem
  - Caresource
  - Centene/Buckeye
  - CMS
  - Humana
  - Medical Mutual
  - Ohio Medicaid
  - UnitedHealthcare



Payment Model

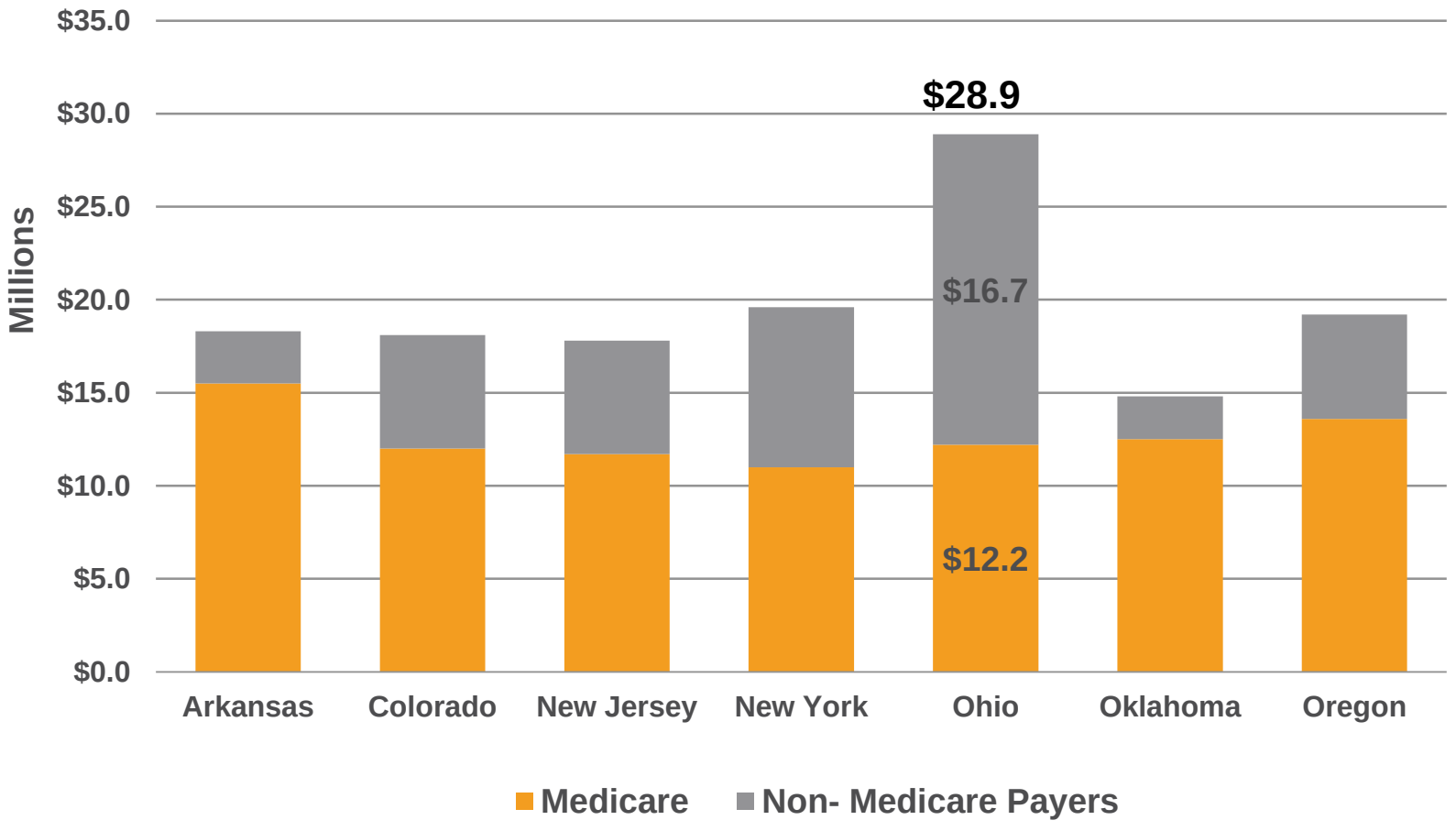


Fee for Service + PMPM + Shared Savings = Total Reimbursement

The CPC Investment

Care Management Payments to Practices

through 12/31/13



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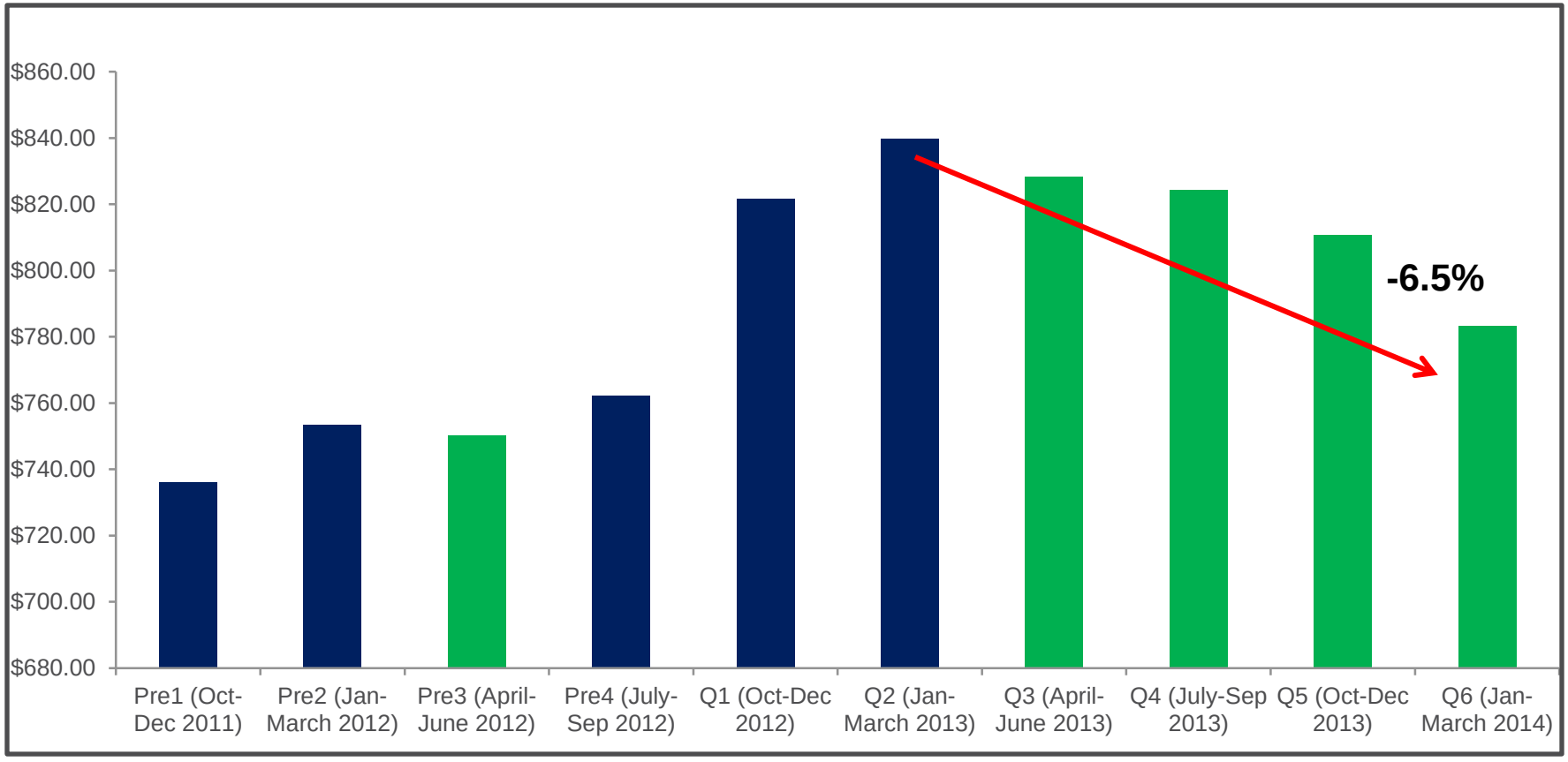
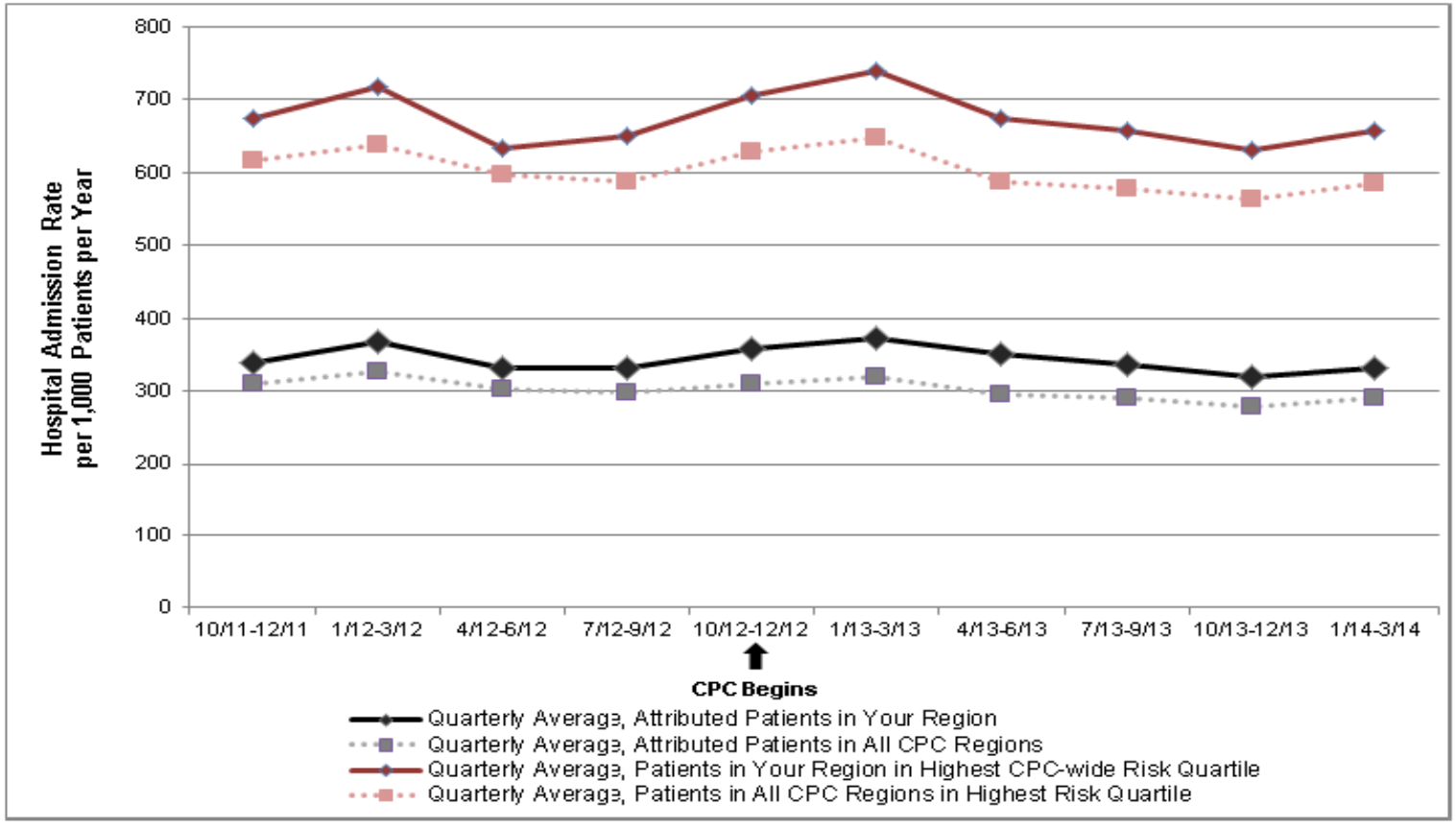
Early Results

Regional Quarterly Expenditures (PMPM) For **Medicare FFS**



Hospital Admissions
Medicare FFS Patients

Figure 5. Hospital Admissions for Any Cause: Quarterly Trends in Average Rates per 1,000 Medicare FFS Patients (unadjusted)

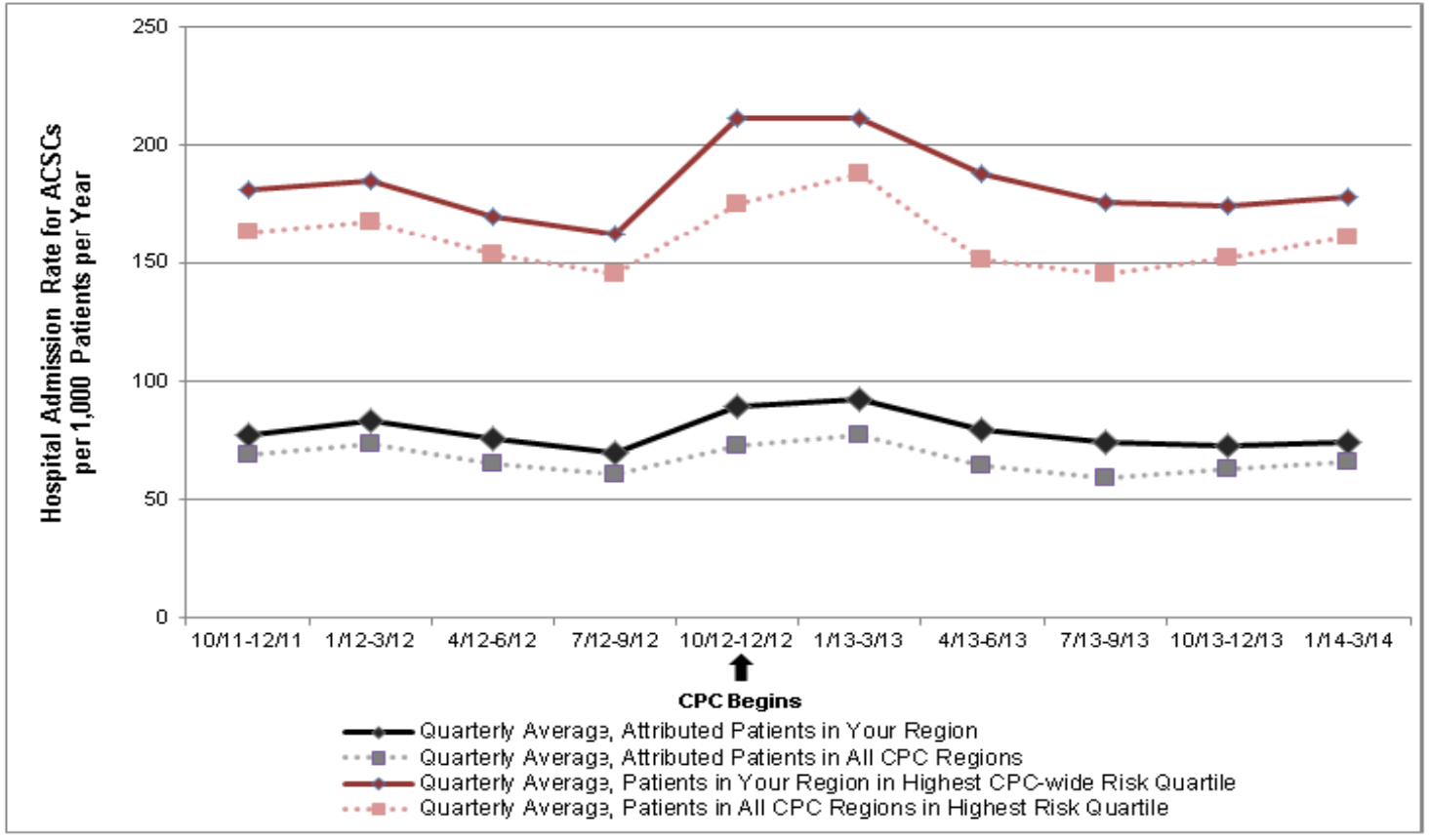


Source: Medicare claims data.

Notes: Data labels refer to averages among attributed patients in your region. Data are not risk-adjusted. For the most recent quarter, hospital admission rates represent preliminary estimates, adjusted for the lag in filing and processing Medicare claims.

Hospital Admissions for Ambulatory Care-Sensitive Conditions

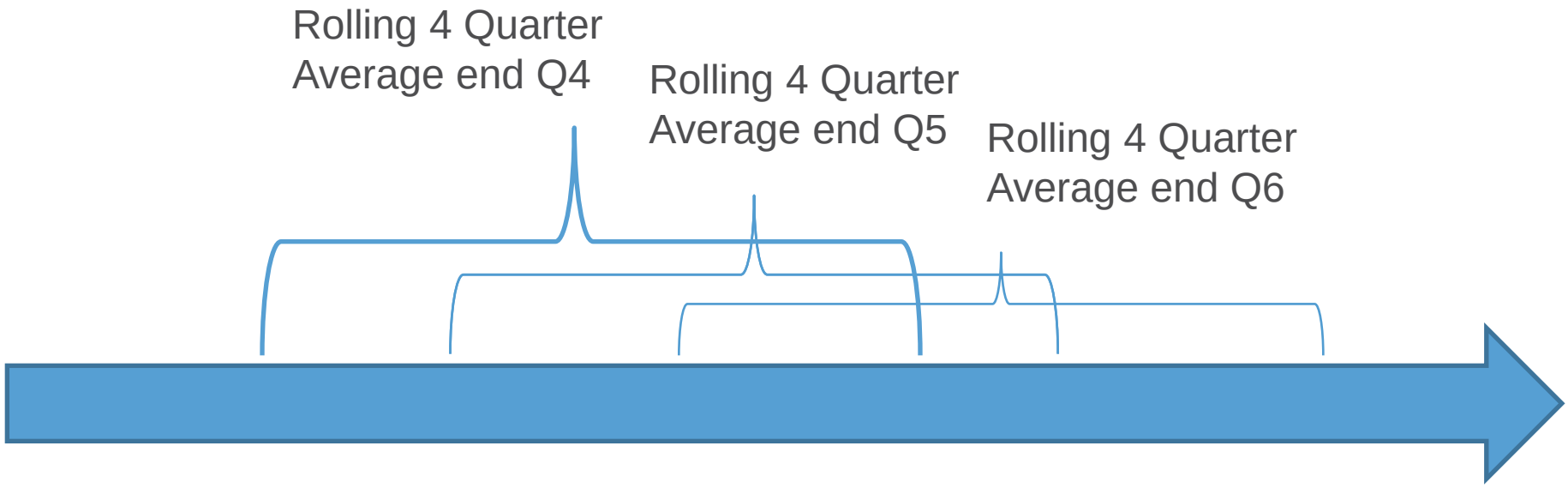
Figure 6. Hospital Admissions for Ambulatory Care-Sensitive Conditions (ACSCs): Trends in Average Rates per 1,000 Medicare FFS Patients (unadjusted)



Source: Medicare claims data.

Notes: Data labels refer to averages among attributed patients in your region. Data are not risk-adjusted. For the most recent quarter, hospital admission rates represent preliminary estimates, adjusted for the lag in filing and processing Medicare claims.

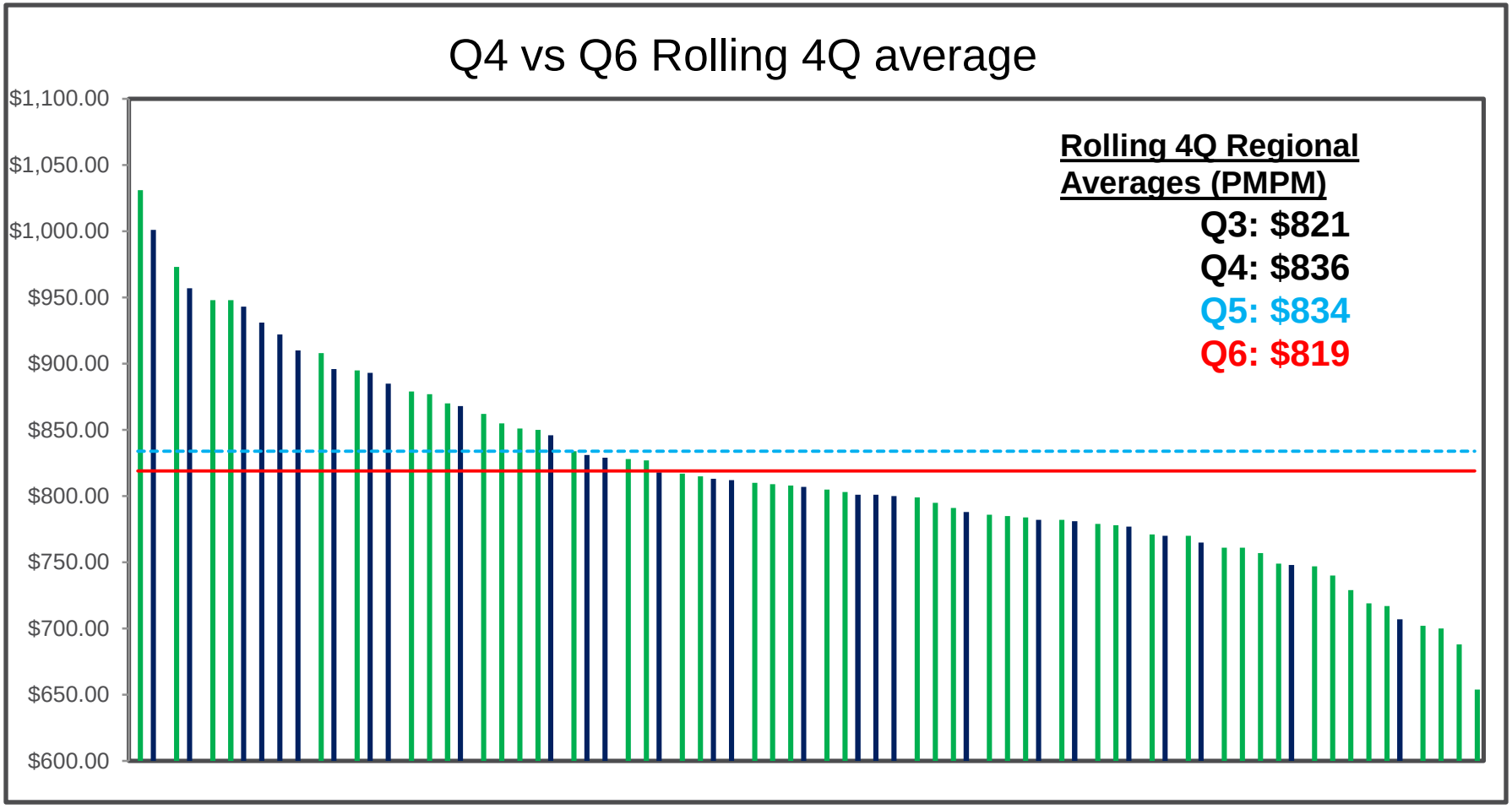
CPC Time Frames for Practice Reporting (Medicare FFS)



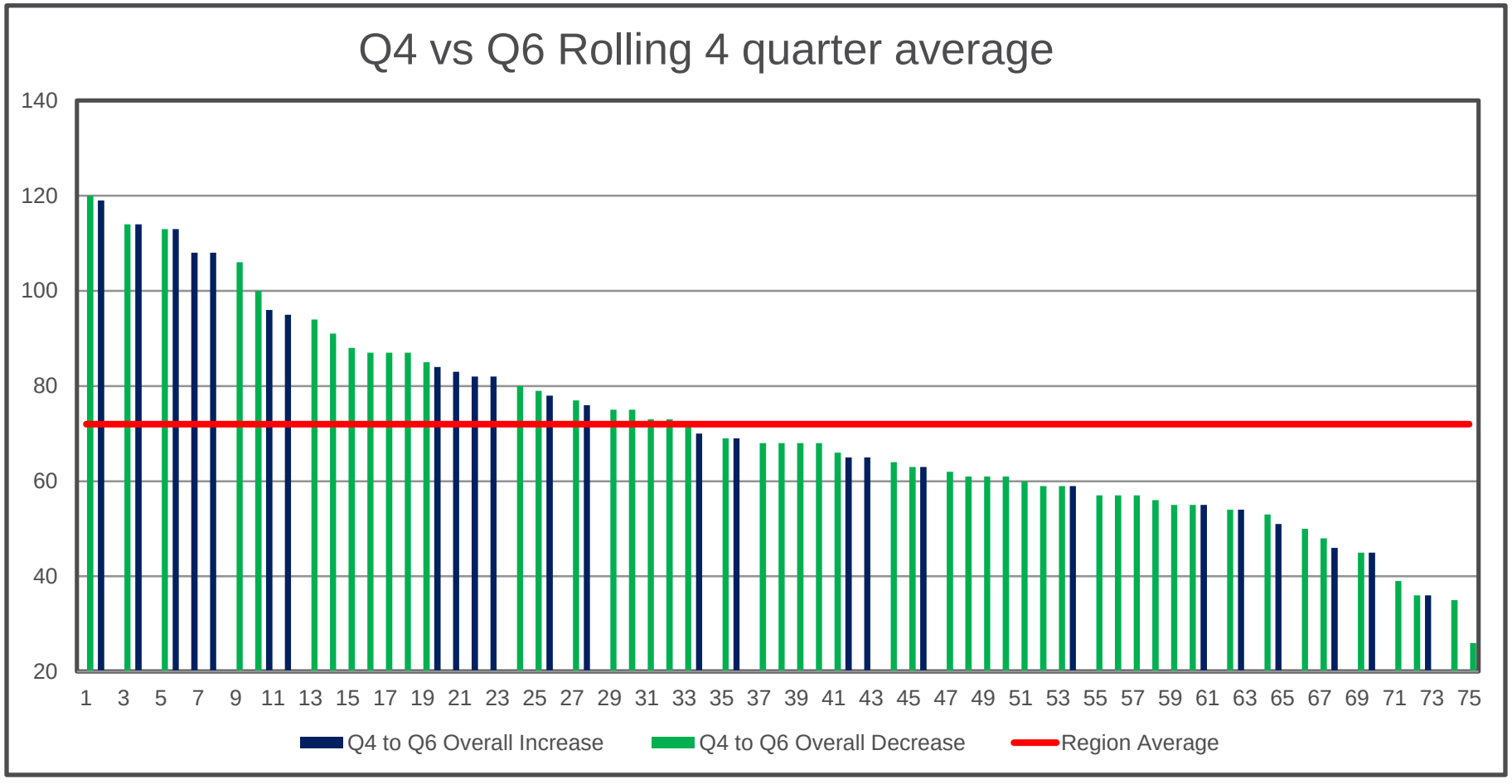
Pre-CPC	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
Jul- Sept 2012	Oct. – Dec. 2012	Jan.- March 2013	April- June 2013	July- Sept. 2013	Oct- Dec 2013	Jan. – March 2014

Total Cost of Care

Practice Level; Medicare FFS PMPM; Risk Adjusted

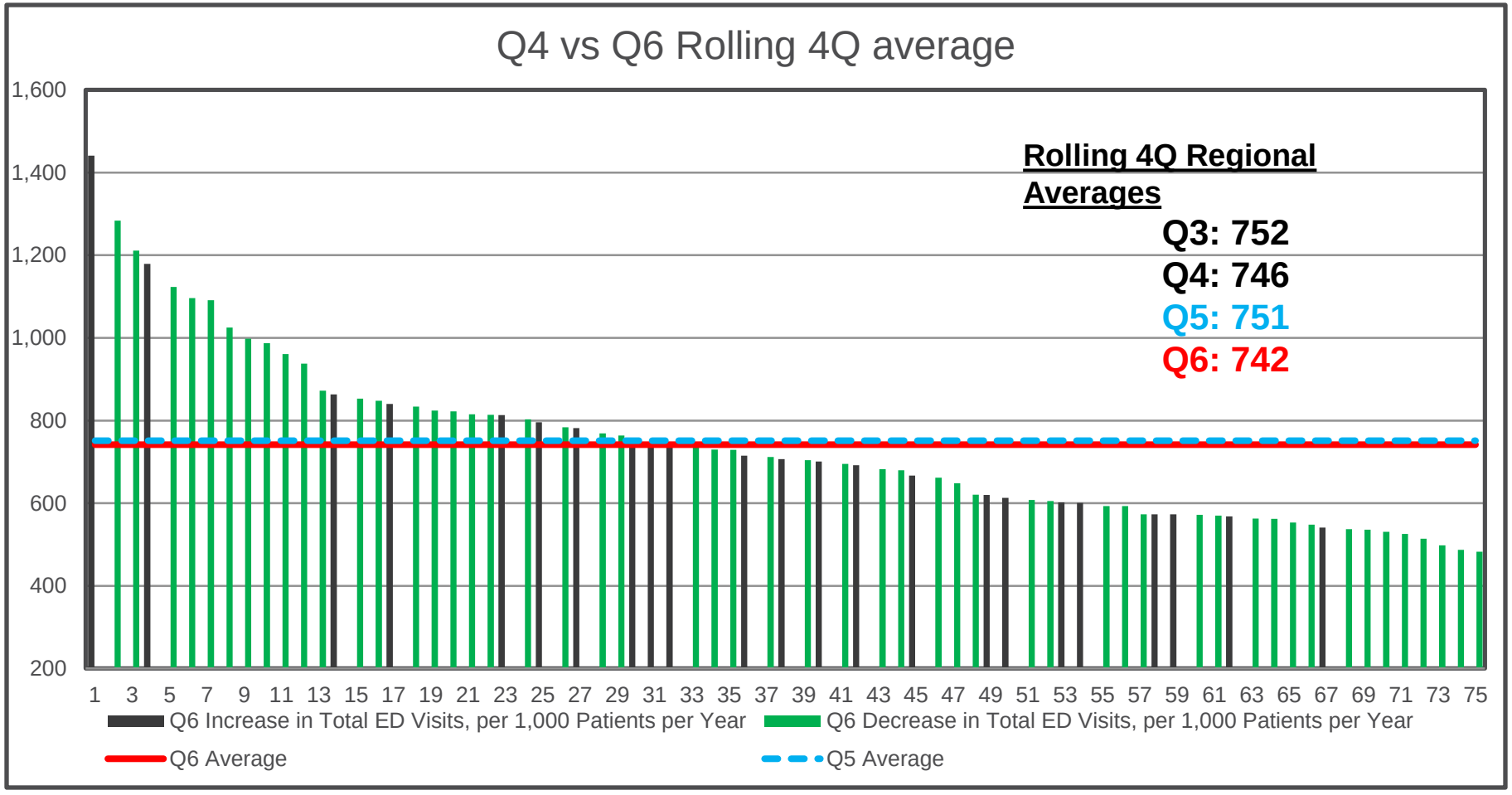


Ambulatory Care Sensitive Admissions per 1,000
(Medicare FFS; Not Risk Adjusted)



Average ED Visits/1000 By Practice

(Medicare FFS; Not Risk adjusted)



Lessons Learned

(All Infrastructure Related…)

- Electronic Health Record EHR
- Meaningful Use
- Critical Mass
- Health Information Exchanges
- Measurement of care delivery feedback loop
- Standardization of processes across payers
- Convening Support

Lessons Being Learned

(…And All Data Related)

- Robust Credible Comprehensive View; “n” Power
  - At The Practice Level
  - Pay for Value requires Measurement of Value
- Neutral “Source of Truth”
  - Benefits of Co-Ownership
- Attribution Tracking
- Practice Quality/Process Improvement
- Proof of Concept
- Outcome targets

Ohio | Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

Goal

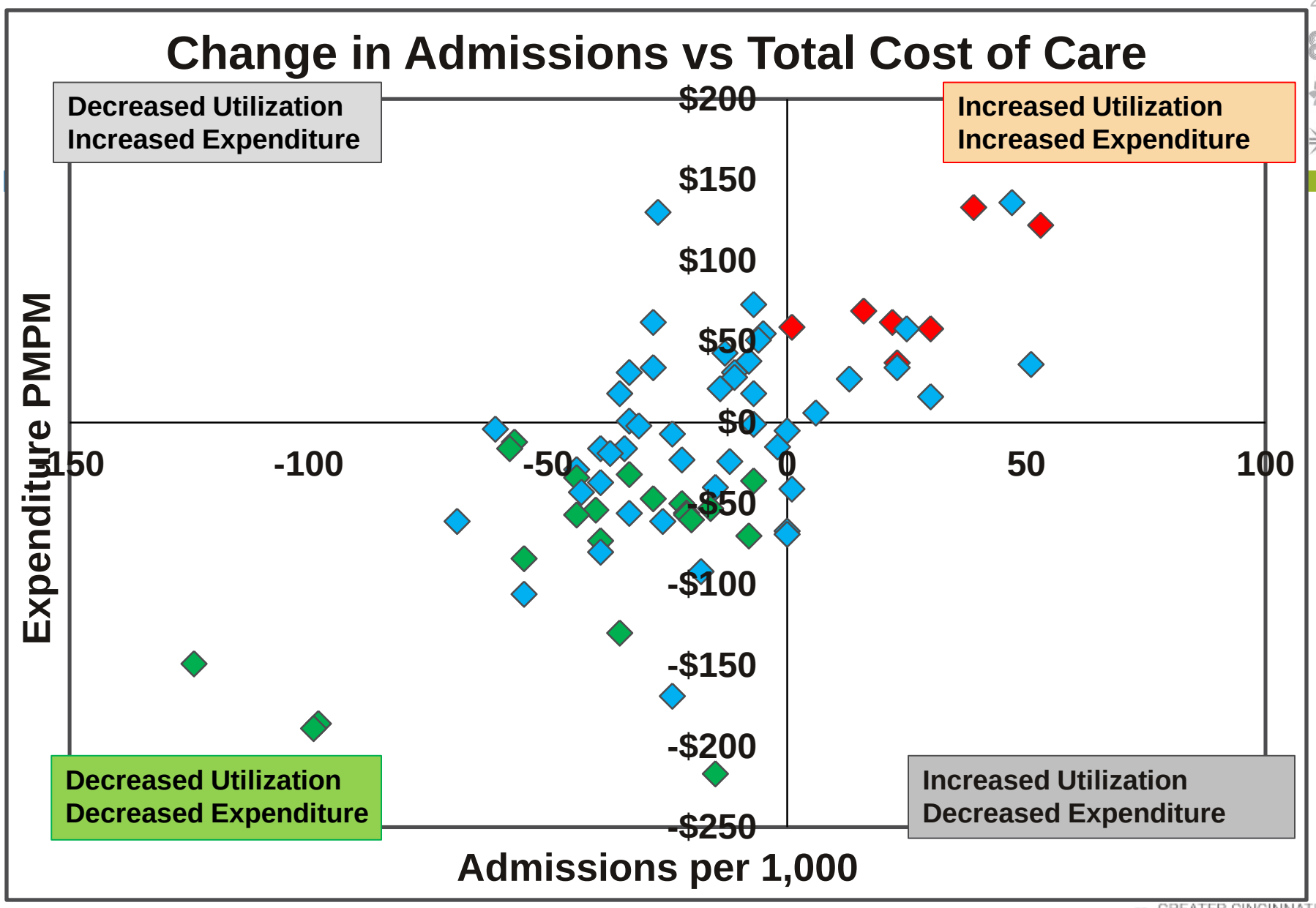
80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

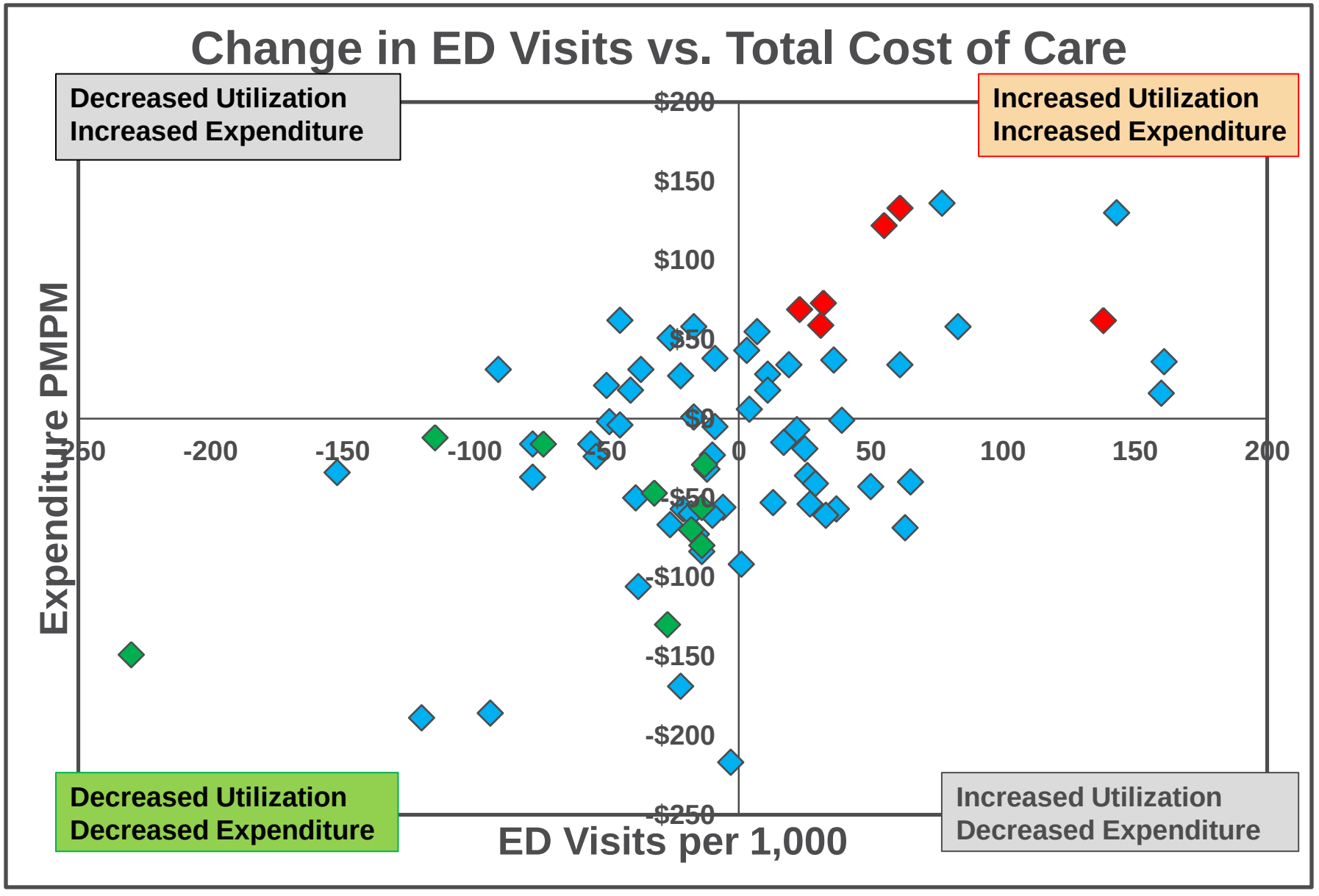
- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Appendix


Change in Admissions vs Total Cost of Care
Decreased Utilization
Increased Expenditure
Increased Utilization
Increased Expenditure
Decreased Utilization
Decreased Expenditure
Increased Utilization
Decreased Expenditure
$200
$150
$100
$50
$0
-$50
-$100
-$150
-$200
-$250
-150
-100
-50
0
50
100
Expenditure PMPM
Admissions per 1,000

Change in ED Visits vs. Total Cost of Care



PY 2013 Patient Experience Results

CAHPS	Region	All Regions
	Your Region's Median Score	All Region Median Score
CAHPS Overall Score	16.2	16.2

CAHPS	Region			All Regions		
	Never & Sometimes	Usually	Always	Never & Sometimes	Usually	Always
Getting timely Appointments, Care, and Information	13%	30%	57%	17%	29%	54%
How well providers communicate	4%	16%	80%	5%	17%	78%
Attention to Care from Other Providers	14%	14%	72%	16%	14%	70%
Shared decision making	17%	24%	59%	17%	23%	60%

CAHPS	Region		All Regions	
	No	Yes	No	Yes
Providers support patient in taking care of own health	56%	44%	55%	44%

CAHPS	Region			All Regions		
	1 - 6	7 – 8	9 – 10	1 - 6	7 – 8	9 – 10
Patient Rating of provider	5%	18%	76%	7%	22%	71%

Overview

November 2014

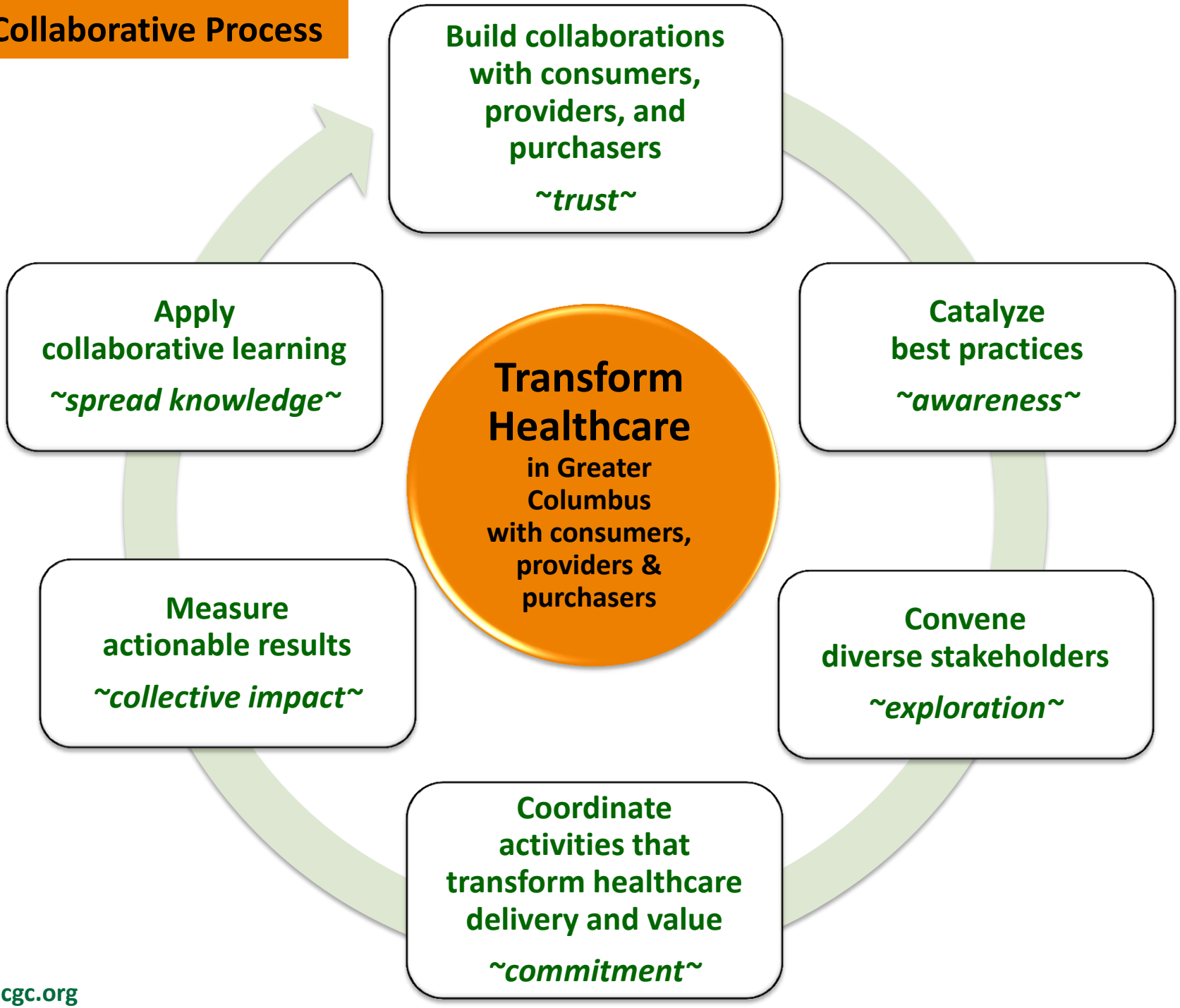
Healthcare Collaborative of Greater Columbus

The Healthcare Collaborative of Greater Columbus is a non-profit, public-private partnership. We serve as a catalyst, convener, and coordinator of healthcare transformation & learning in Greater Columbus.

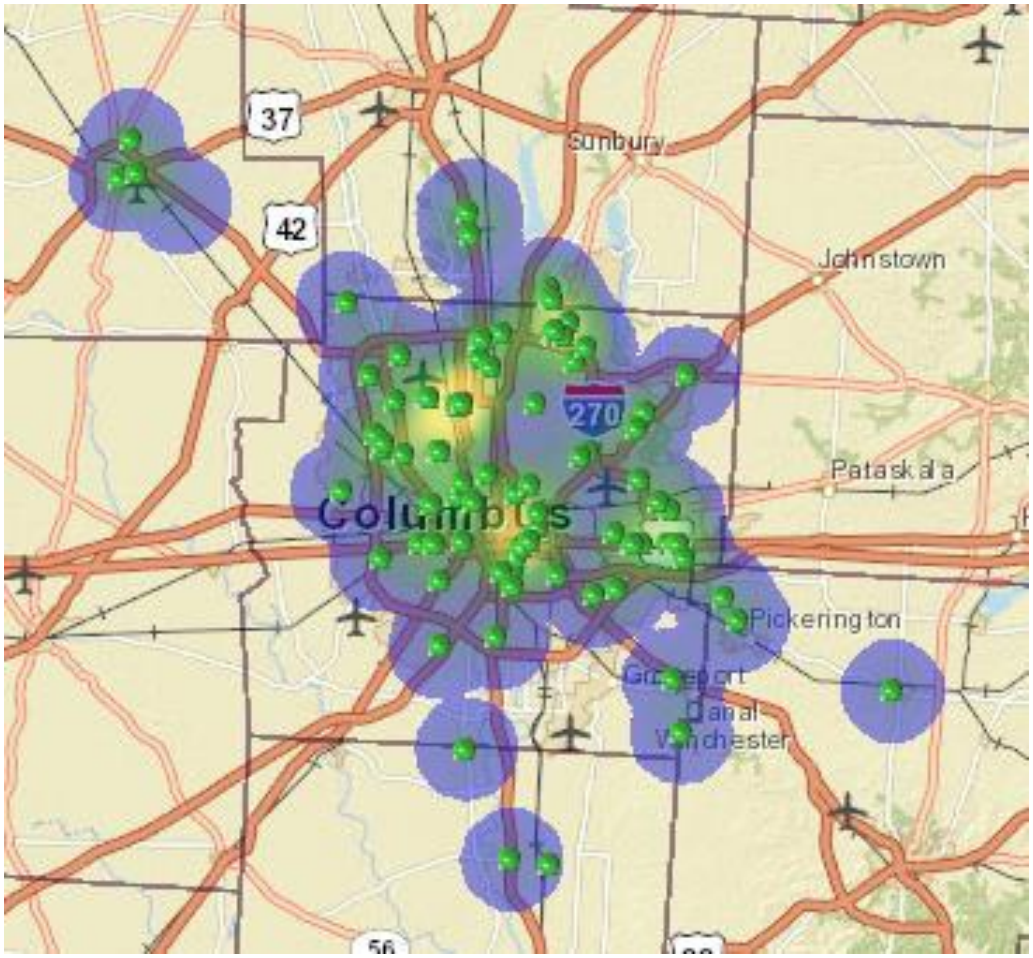
Our Collaborative Approach

- ✓ **The status of our healthcare situation is not acceptable in terms of its quality, safety, transparency, or cost.**
- ✓ **We strive for win-win solutions recognizing that change is required by all – consumers, providers, and purchasers.**
- ✓ **We believe the best solutions come from a collaborative approach – we seek no authority in our role as a catalyst/convener/coordinator**
- ✓ **We work together with our public-private partners to accelerate and scale innovation.**

Our Collaborative Process



PCMH Spread in Greater Columbus



- ✓ **2009 - PCMH pilot design**
- ✓ **2010 - started with 7 diverse practice sites**
- ✓ **2011-2013**

  PCMH transformation teams established in 4 hospital systems, largest FQHC and largest physician-owned group

  100+ diverse PCMHs
- ✓ **2014 and beyond…**

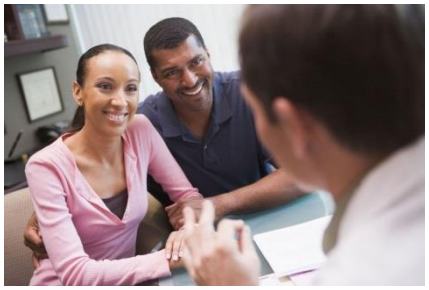
  PCMHs advancing population health management

  Value-based payments and benefit designs

2014-2106 Our Strategic Areas of Focus

SHARED RESPONSIBILITY

…improve engagement between consumers, providers, and purchasers



PATIENT-CENTERED PRIMARY CARE

…improve the value of primary care

HEALTHCARE TRANSPARENCY

…improve access to information as a foundation for transformation

COLLABORATIVE LEARNING

…improve the application of learning in Greater Columbus

Shortening the Path to Patient-Centered Care: Northeast Ohio

PCPCC 2014 Annual Fall Conference
Washington, DC
November 13,2014

Randall D. Cebul, MD
President, Better Health *Greater* Cleveland
rdc@case.edu

Better Health Greater Cleveland

Regional Health Improvement Collaboratives Supported by RWJF

Common Expectations

- Triple Aim: Improve care, health, and costs for persons with chronic conditions
- Focus on primary care
- >50% saturation of health care market
- Support Region-wide QI
- Publicly report achievement
- Support payment reform

Better Health Greater Cleveland

Better Health *Greater* Cleveland

- **Vision**

  To help make northeast Ohio a healthier place to live and a better place to do business.

- **Mission**

  To provide a safe space for health care competitors to collaborate

Provider and population health driven

EMR catalyzed

Shortening the Path to Patient-Centered Care: Where We Are, Where We're Going

Patient-centered and coordinated care
Paying for Value and Outcomes

Fragmented care
Paying for Volume of Services

Better Health Greater Cleveland

Better Health

PCP Sites

October 2014

80 Practices

Better Health Greater Cleveland

Practice Coaches Help with PCMH and Improvement

Linda
NCQA PCMH App
HIT

Bonnie
HIT
Workflow
NCQA PCMH App

Kristin
PHQ-9 Implementation
Depression Workflow

Rehan
HIT
Improving Metrics

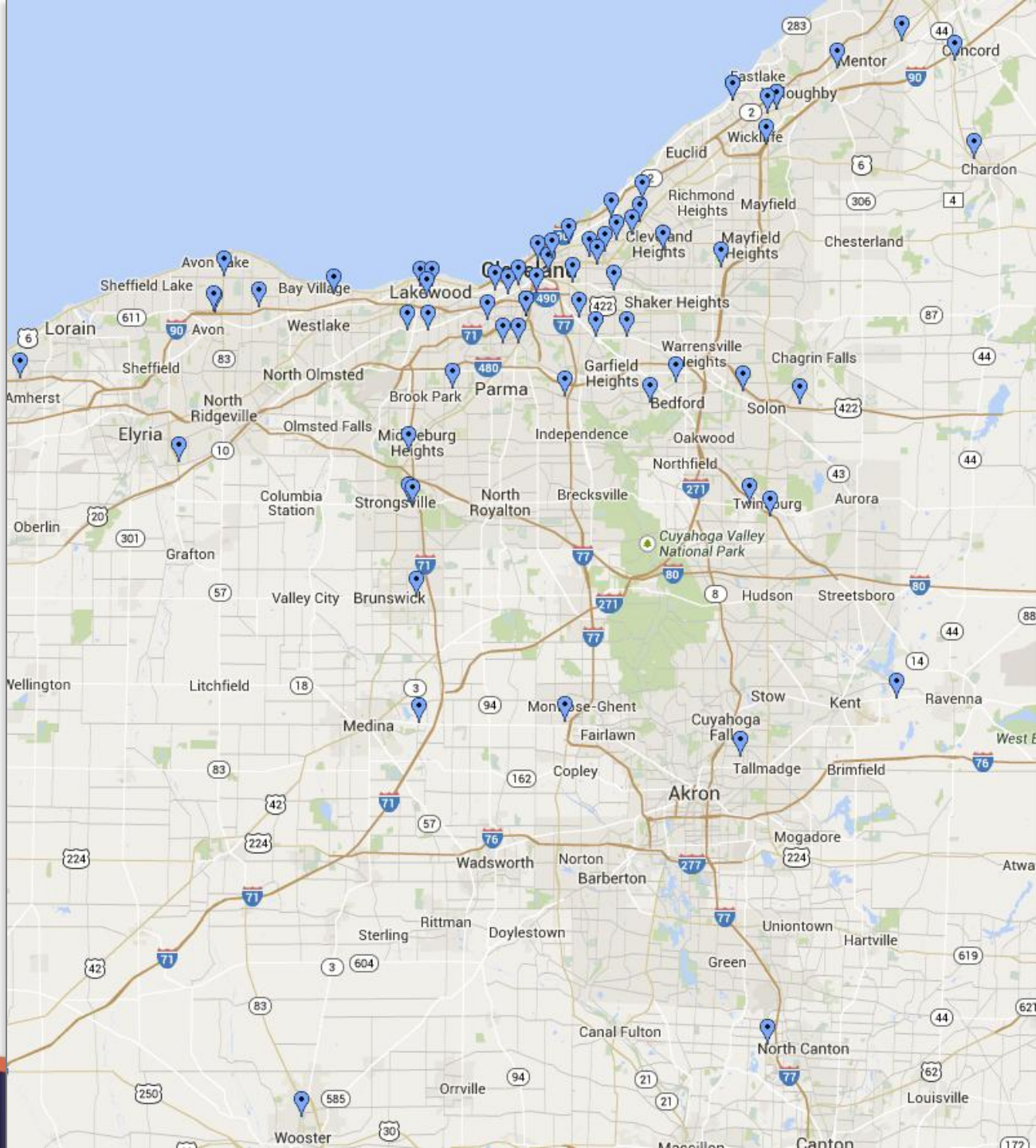
Aleece
CAHPS
CW
Re-Cert

Better Health

PCMH Sites

October 2014

68 Practices



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Competitors Collaborating

15th Learning Collaborative Summit
September 26, 2014

Better Health Greater Cleveland

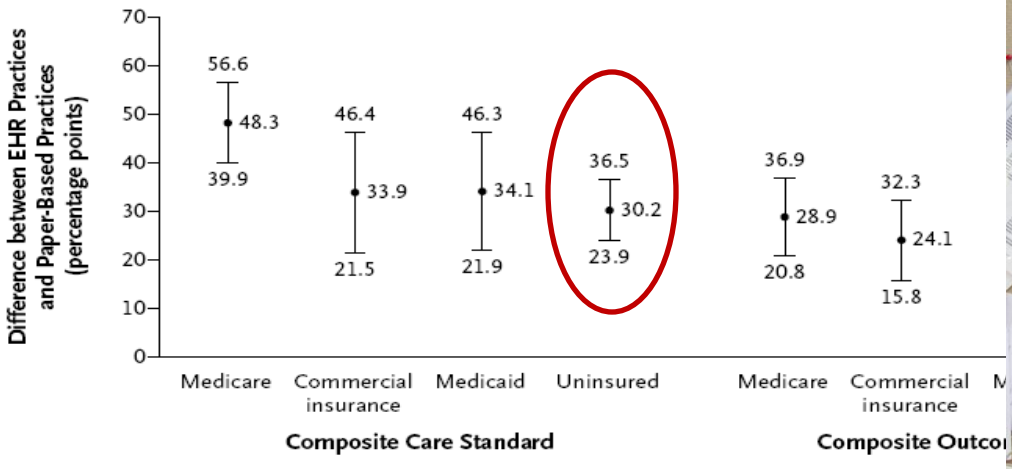
Helping others to use EMRs to measure and report care

We documented that EMRs help shorten the path (*better achievement, faster improvement*) and all patients benefit

SPECIAL ARTICLE

Electronic Health Records and Quality of Diabetes Care

Randall D. Cebul, M.D., Thomas E. Love, Ph.D., Anil K. Jain, M.D., and Christopher J. Hebert, M.D.



Dr. Mostashari, National Coordinator of HIT for DHHS visited to learn HOW

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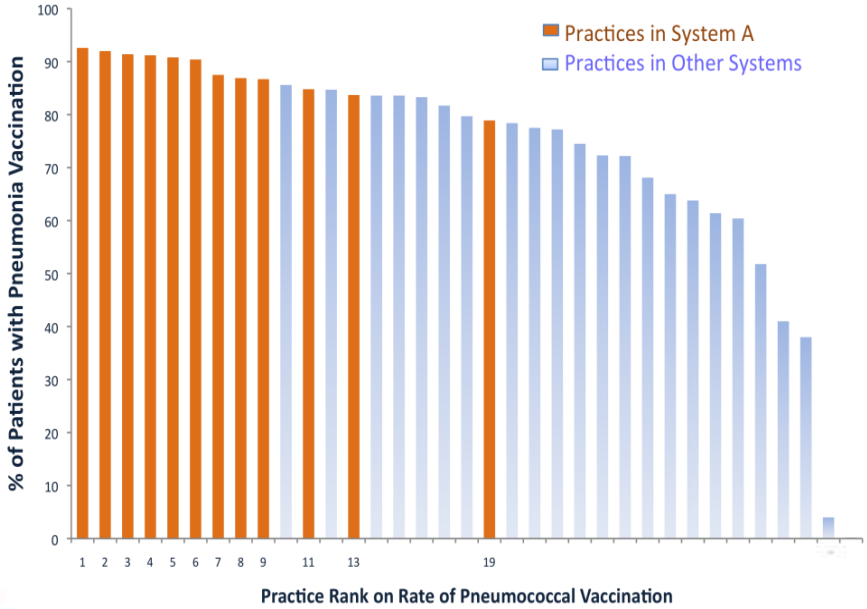
Using Data to Identify and Disseminate a Best Practice

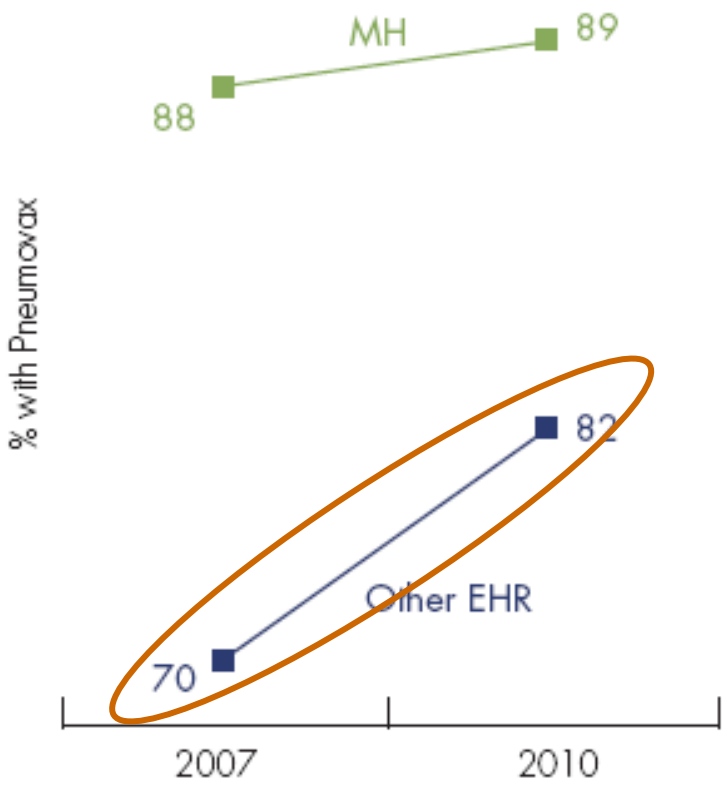
Vaccinations in Diabetes

2007 → 2010

2007

Who are those guys?
How did they do this?





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Engaging Employers and Insurers: Value-based Insurance Design Conference

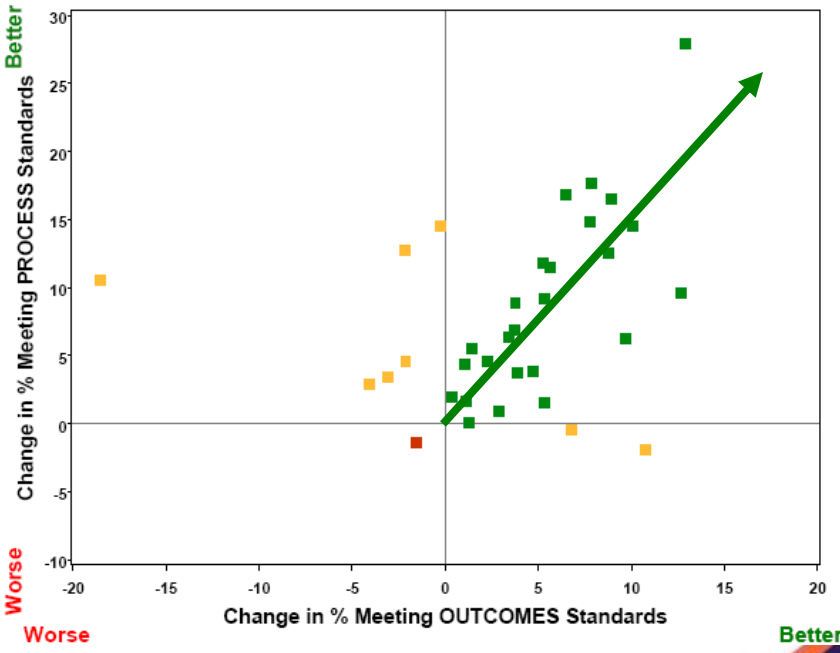
Mark Fendrick, MD, Director
Center for Value-based Insurance Design
University of Michigan

Rita Horwitz, RN, BSN
Director, Business Development

Better Health Greater Cleveland

Accountable Patient-Centered Care: Delivering better care and clinical outcomes

- Doubled practices committed to publicly reporting – 34 to 80.
- 5x more patients reported – from 26,000 to over 145,000
- All but one initial practice has improved on care or outcomes
- > 25,800 More patients w/HBP have good BP control and > 9,300 More diabetics have good lipid control
- 96% of our patients with Heart Failure are on appropriate Rx



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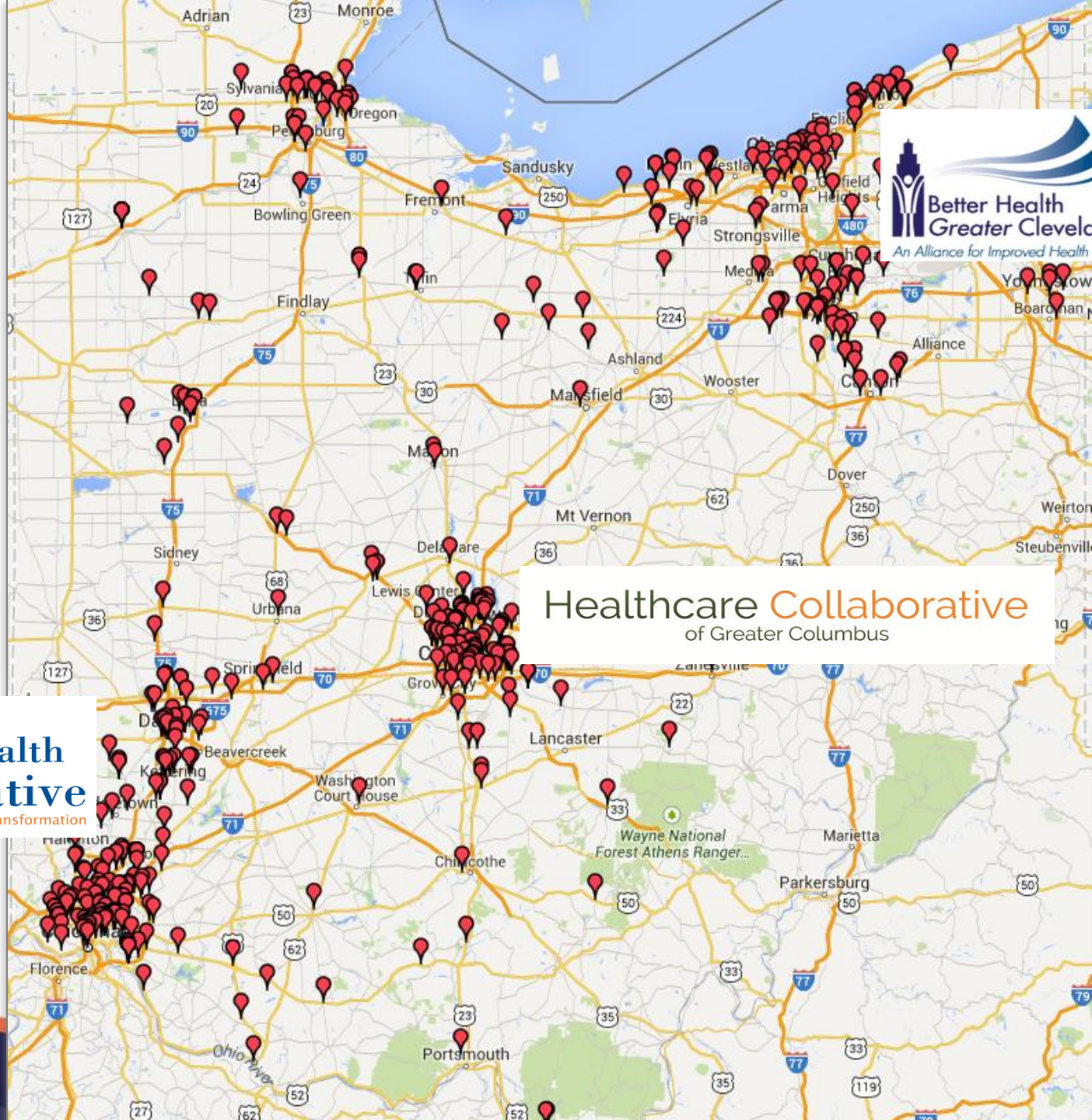
Ohio´s PCMH Sites October 2014

529 Practices



the Health Collaborative
where collaboration creates transformation

Better Health Greater Cleveland

Thank you

rdc@case.edu

www.betterhealthcleveland.org

Expansion of the PCMH Model in Ohio

- Organized PCMH Collaboratives in Cincinnati, Columbus, Cleveland
- Need identified in Toledo, Dayton, Akron/Canton and Southeast Ohio regions
- HB 198 drafted 2009-10
- HB 198 – Ohio PCMH Education Pilot Project signed into law June, 2010

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HB 198: Ohio Patient-Centered Medical Home Education Pilot Project

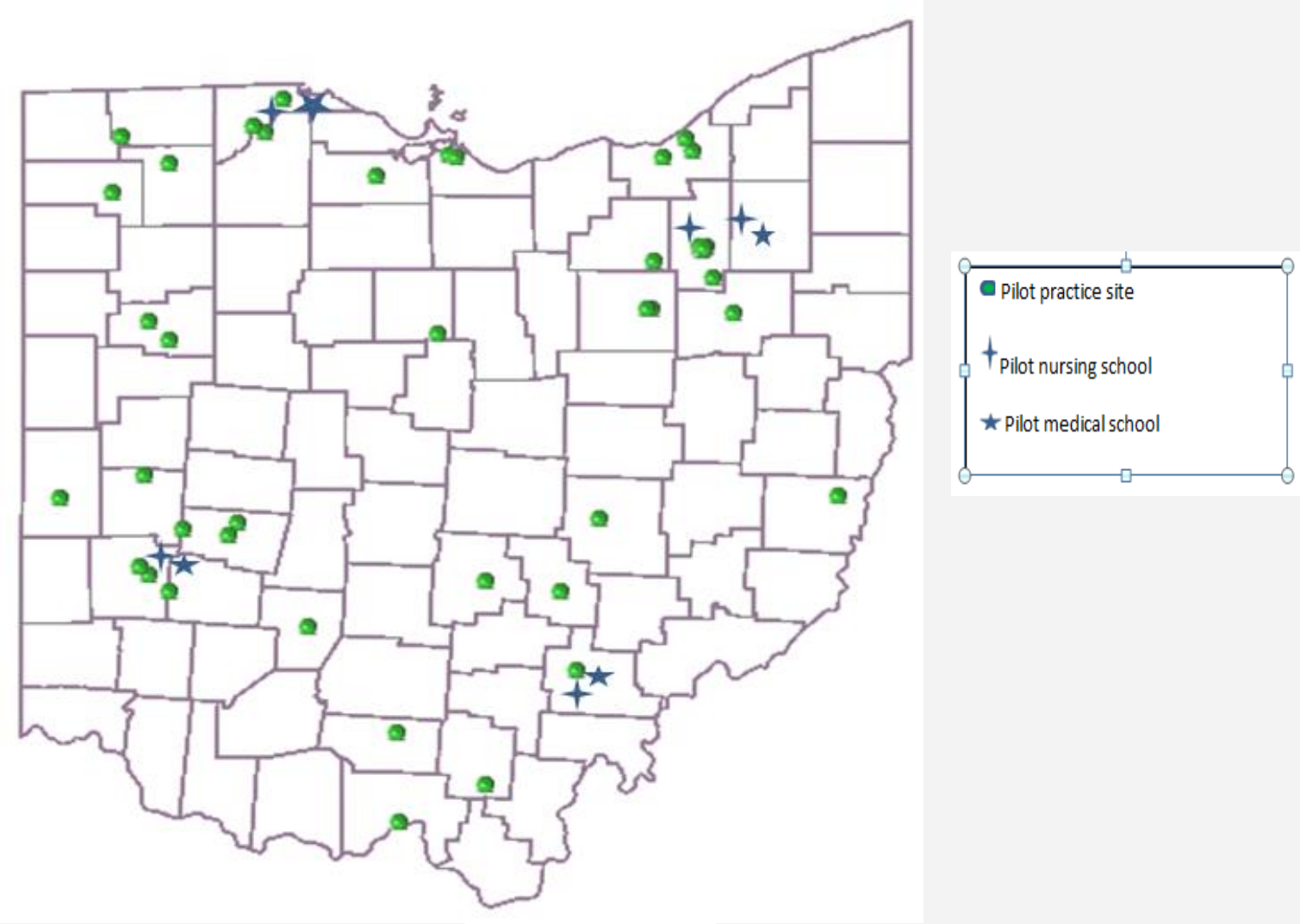
Learning Collaborative:

- **42** total practices
- **4** medical schools
- **5** nursing schools

Includes:

- Choose Ohio First Scholarships
- Reimbursement Reform
- Curriculum Reform

PCMH Pilot Site locations



PCMH Education Pilot Project

42 practice transformation (started with 51)

- Completed 2 year transformation process with TransforMED in June 2014
- Monthly group calls, webinars, practice calls
- Statewide learning Collaborative meetings
  - Saturday, April 13, 2013
  - Saturday, September 7, 2013
  - Saturday, April 6, 2014

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PCMH Education Pilot Project

Choose Ohio First Scholarships

- Board of Regents administers
  - 30 nursing students/yr. (divided amongst 5 graduate nursing programs)
  - 50 medical students/yr. (divided amongst 7 schools)
  - Must commit to working in Ohio in primary care for 3 years

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PCMH Education Pilot Project

Curriculum Reform

- Campuses receive $25,000 matching funds from Board of Regents
- Medical school meeting – July 11, 2013
- Nursing graduate program meeting – October 10, 2013
- Interdiscliplinary meeting – June 4, 2014

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State Leadership in Healthcare Reform

Jan, 2011	Gov. Kasich sworn in
Jan, 2011	Office of Health Transformation created – Greg Moody-Director
Feb, 2011	ODH Director Appointed – Ted Wymyslo MD Cabinet Level Position

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OPCPCC

Ohio Patient-Centered Primary Care Collaborative

- Coordinates communication among existing Ohio PCMH practices
- Facilitates statewide learning in collaborative PCMH practices in Ohio
- Facilitates new PCMH practice startup in Ohio
- Shapes policy in Ohio for statewide PCMH adoption

Facilitated by the Ohio Department of Health

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OPCPCC

Ohio Patient-Centered Primary Care Collaborative

5 Learning Centers:

- Patient Engagement
- HIT
- Metrics
- Payment Reform
- Communications and Education
- ? Interprofessional Education

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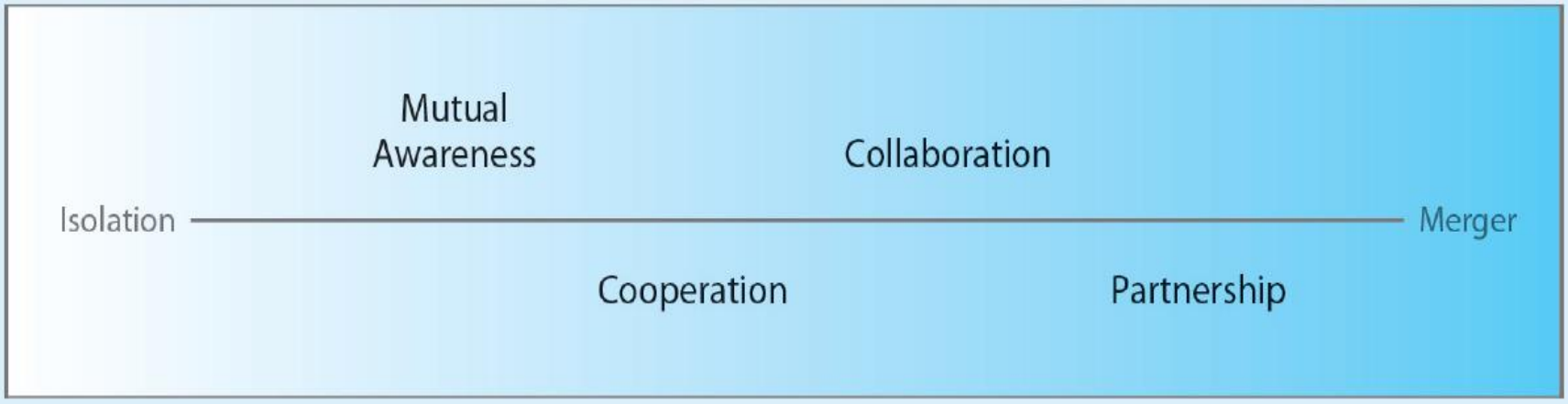
Priorities for Improved Health

TOTAL HEALTH

IOM—Integration of Public Health and Primary Care

Goal: Optimize population health.

IOM Continuum of Integration



Primary Care and Public Health Exploring Integration to Improve Population Health" Report Brief, http://www.iom.edu/~/media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health_Revised%20RB_FINAL.pdf

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Where We Are	Where We Need to be
Fragmentation	**vs. Coordination**
• Multiple separate providers	• Accountable medical home
• Provider-centered care	• Patient-centered care
• Reimbursement rewards volume	• Reimbursement rewards value
• Lack of comparison data	• Price and quality transparency
• Outdated information technology	• Electronic information exchange
• No accountability	• Performance measures
• Institutional bias	• Continuum of care
• Separate government systems	• Medicare/Medicaid/Exchanges
• Complicated categorical eligibility	• Streamlined income eligibility
• Rapid cost growth	• Sustainable growth over time

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SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

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Innovation Framework

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance the Governor Kasich's Medicaid modernization and cost containment priorities	*Share services to increase efficiency, right-size state and local service capacity, and streamline governance*	*Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement*
• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate programs for children • Share services across local jurisdictions • Recommend a permanent HHS governance structure	• Participate in Catalyst for Payment Reform • Support regional payment reform initiatives • Pay for value instead of volume (State Innovation Model Grant) – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

Governor's Advisory Council on Healthcare Payment Innovation

- Convened Jan 2013
- Providers, consumer advocates, purchasers and plans to coordinate multipayer healthcare payment innovation statewide
- CPR principles endorsed – Pay For Value

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Healthcare Initiatives in Ohio

- CMMI – CPCi kickoff – Cinci - 11/12
- CMMI - SIM Planning Grant - 2/13
- Medicaid Expansion in Ohio - 1/14
- CMMI – SIM Testing Grant - pending

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PCMH in Ohio

A Collaborative Approach to Health Transformation

- Regional Collaboratives – C/C/C
- State Initiatives- Legislature/ Governor's Office/Agencies
- Insurers
- Employers
- Consumer Advocates
- Providers/Professional Associations

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Thank You!

For additional information please visit the OACHC website at www.ohiochc.org

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