

Each quarter, all participating practices within the Comprehensive Primary Care (CPC) initiative report their progress on the nine CPC Milestones (the transformative work of the CPC practices) through the CPC Web Application. This edition of Fast Facts summarizes practice reports from July 2014 for the second quarter of 2014, which spanned the period from April through June 2014. When possible, we compare data from December 2013 and June 2014. These figures are self-reported and do not represent an evaluation of this work or CPC itself.

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I. CPC Practice Statistics

Table 1. CPC Practice Statistics as of July 2014*								
	AR	CO	NJ	NY	OH/KY	OK	OR	All CPC
Practices	63	73	67	74	75	64	67	482
Providers	248	432	272	359	293	258	626	2,347
Active Patients	381,124	454,533	300,405	310,113	462,531	299,030	504,433	2,712,169
Median Number of Panels per Practice	2	4	3	3	3	3	6	3

*The most current count of practices, providers, and active patients can be found on the [CPC website](#).

II. Care Management for High-Risk Patients (Milestone 2)

Risk-stratified care management – focusing on patients with the greatest need and potential for preventable harm – is at the heart of the Comprehensive Primary Care (CPC) initiative. CPC practices are asked to empanel patients to a provider or care team, assign each patient a risk status, and provide care management resources to those patients identified as most likely to benefit from those services.

- Care Management Staffing.** Prior to the implementation of CPC, practices reported an average of 1.35 full-time equivalent (FTE) employees per practice in a care management (CM) role, with a total of 667 FTEs across all 493 practices.¹ By the end of CPC's first program year, CPC practices reported an average of 2.50 FTEs allocated to care management services, increasing the total number of FTEs across all CPC practices to 1235. During this period, 436 practices increased the number of FTEs allocated to care management, 284 of which had no FTEs devoted to care management before this initiative began (Fig. 1). By the end of 2013, 568 more FTEs were providing care management services in CPC practices than before the initiative began. In particular, the 284 practices that had allocated no FTEs to care management services prior to CPC reported 394 FTEs for care management at the end of 2013. Care management was performed largely by registered nurses (RNs) and designated care managers, who provided 45% and 17% of care management services in CPC, respectively.²

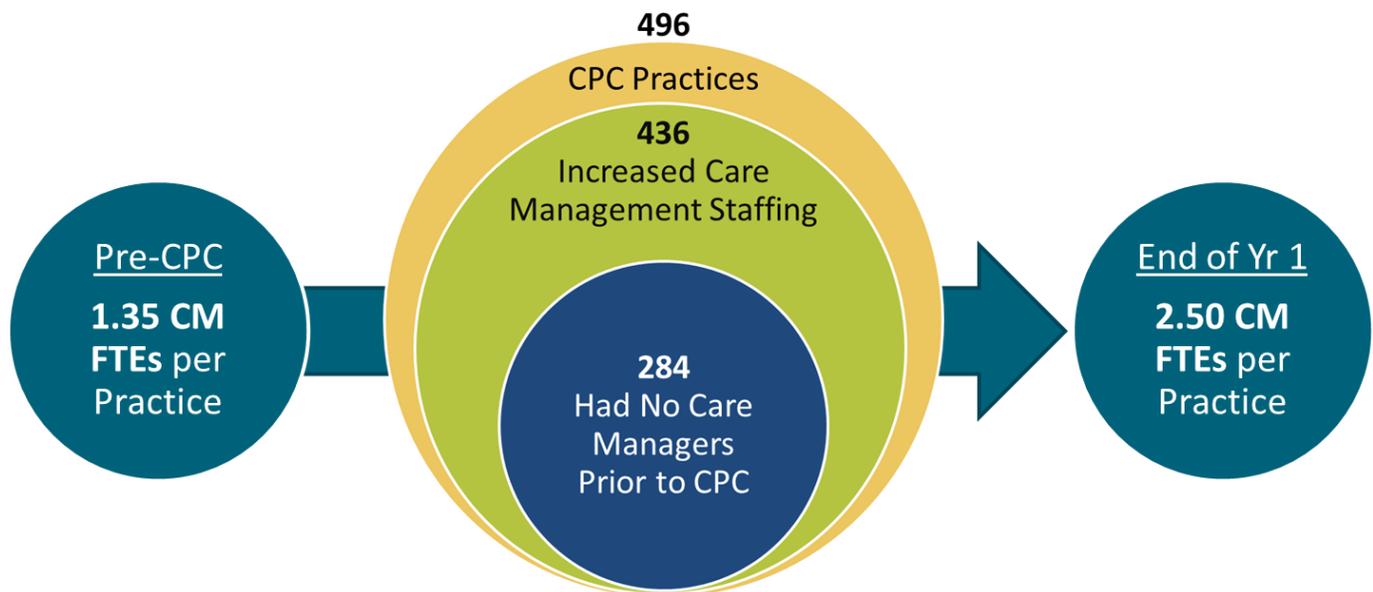


Figure 1. Care Management Staffing in CPC Practices Prior to CPC Start vs. End of CPC Year 1³

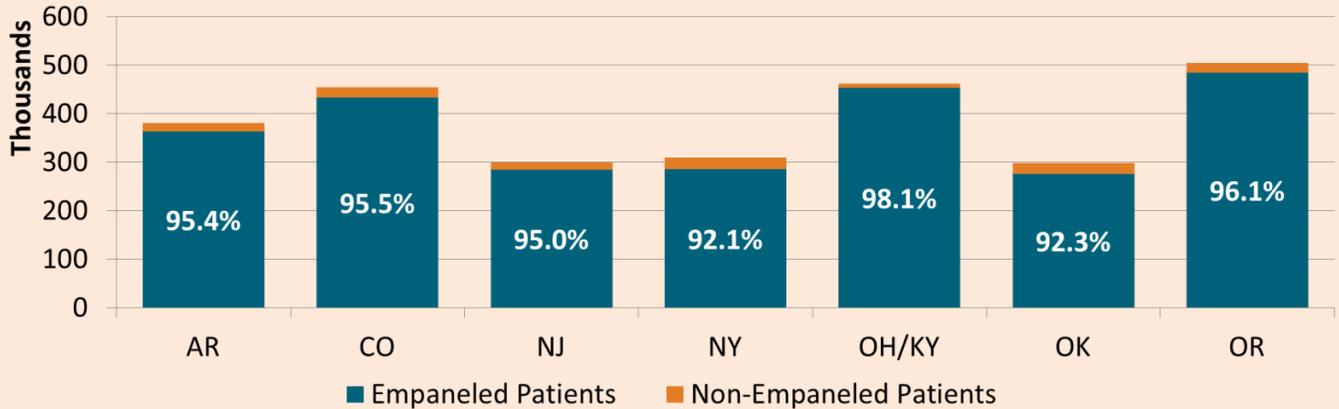
¹ In December, practices reported both the approximate number of FTEs “currently” allocated to care management services, and the approximate number of FTEs that had been allocated to care management services prior to the start of CPC.

² Determined by the proportion of full-time employees (FTEs) in a care management role. Although practices quantified the staff who provide care management, they did so without a universal definition of what training or skillset a care manager should have. Consequently, a wide variety of professionals provide care management in this initiative, including physicians, social workers, medical assistants, nurses, and others.

³ There were 496 CPC practices at the end of CPC Year 1 (2013).

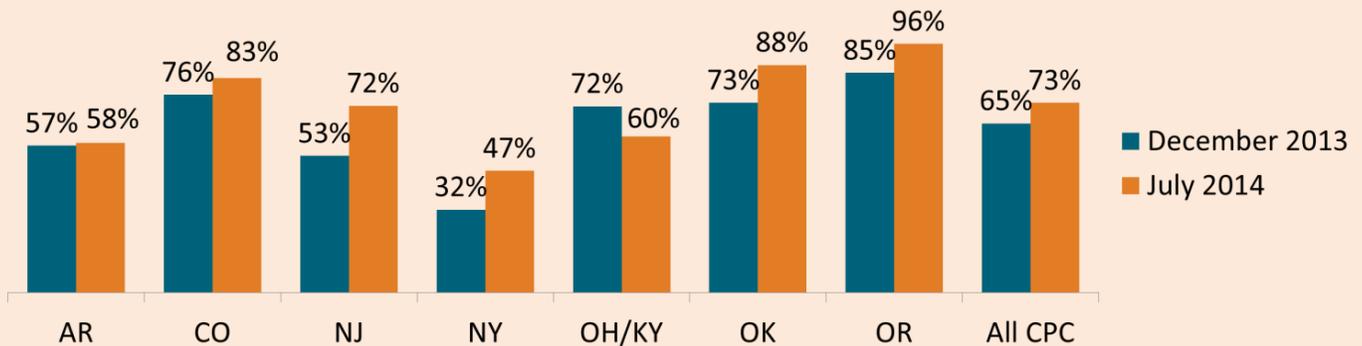
- Empanelment.** 95.2%, or 2,582,911, of all of the patients cared for at CPC practices were empaneled to a provider or care team as of July 2014 (Fig. 2). This represents an increase of over 250,000 empaneled patients since December 2013, when 91.7% of all active patients were empaneled.

Figure 2. Percent of Active Patients Empaneled to a Provider or Care Team, July 2014



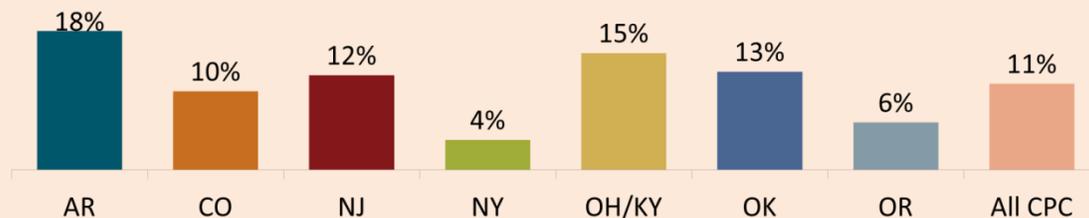
- Risk Stratification.** The percent of active patients assigned a risk status has increased from 65% in December 2013 to 73% in July 2014 (Fig. 3). Across CPC, 20% of risk-stratified patients were assigned to one of the top two risk tiers as of July 2014.

Figure 3. Percent of Active Patients Assigned a Risk Status, December 2013 vs. July 2014



- Care Management.** As of July 2014, 298,036 patients were receiving care management services.

Figure 4. Percent of Active Patients Receiving Care Management Services, July 2014



Advanced Primary Care Strategies

In 2014, CPC practices are asked to implement one of three advanced primary care strategies. 167 practices elected Behavioral Health Integration (BHI), 273 elected Self-Management Support (SMS), and 80 elected comprehensive Medication Management and Review (MM) (Fig. 5). 30 practices selected two, rather just one, strategy, and two practices elected to implement all three strategies.

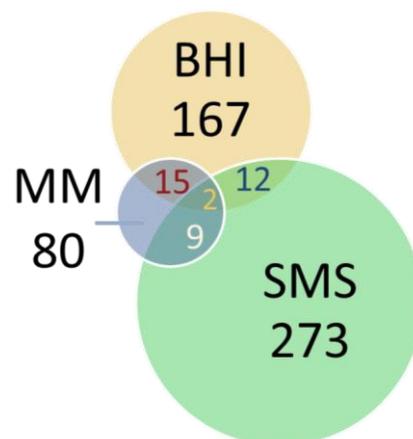
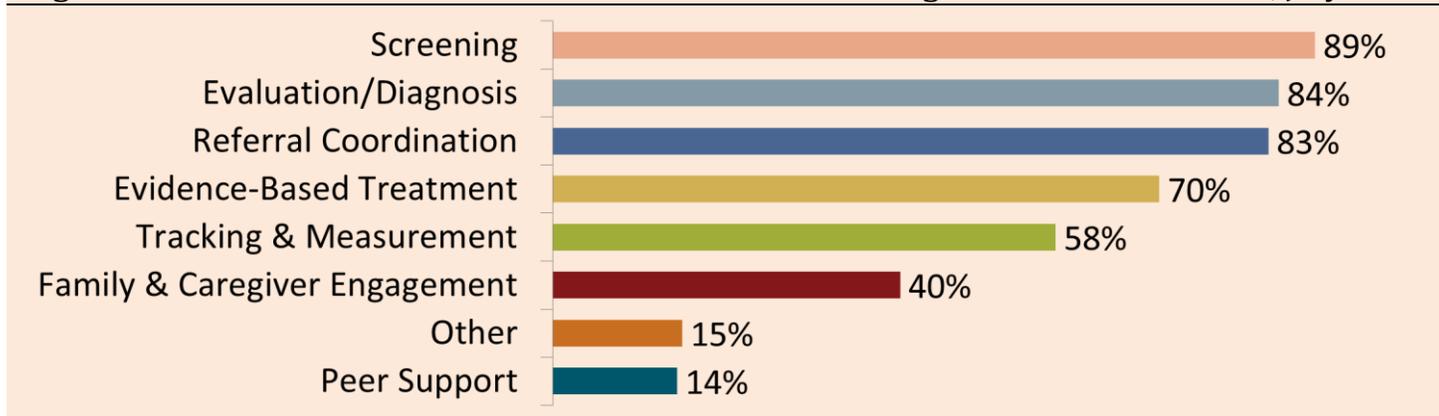


Figure 5. Number of Practices That Selected Each Advanced Primary Care Strategy for 2014

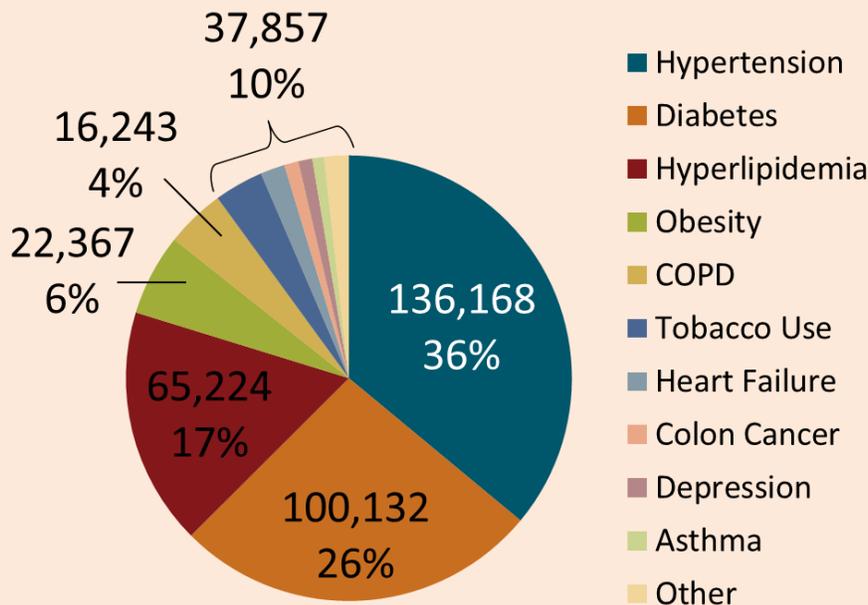
- Behavioral Health Integration.** 167 CPC practices are integrating behavioral health services into their practices in 2014. These practices offer a variety of services, most commonly screening, evaluation/diagnosis, and referral coordination (Fig. 6). Behavioral health services are most often provided by physicians, behavioral health specialists, and physician assistants. Though not required by the CPC initiative, 65.3% of practices employ behavioral health specialists.

Figure 6. Prevalence of Services Offered at Practices That Integrate Behavioral Health, July 2014



- Self-Management Support.** 273 CPC practices chose to provide self-management support to their patients in 2014. Over three-quarters (79%) of the 377,991 patients that received self-management support between April and June 2014 suffered from hypertension (36%), diabetes (26%), or hyperlipidemia (17%) (Fig. 7).

Figure 7. Number of Patients that Received Self-Management Support, by Condition, as a Proportion of All Patients That Received Self-Management Support between April and June 2014



“Other” conditions include IVD, CAD, Fall Risk, Chronic Anticoagulation, CKD, Prostate Cancer, Chronic Disease, ER Visits/Hospitalizations, Breast Cancer, Metabolic Syndrome, and Alzheimer’s Disease.

Figure 8. Prevalence of Strategies Used at Practices That Provide Self-Management Support, July 2014

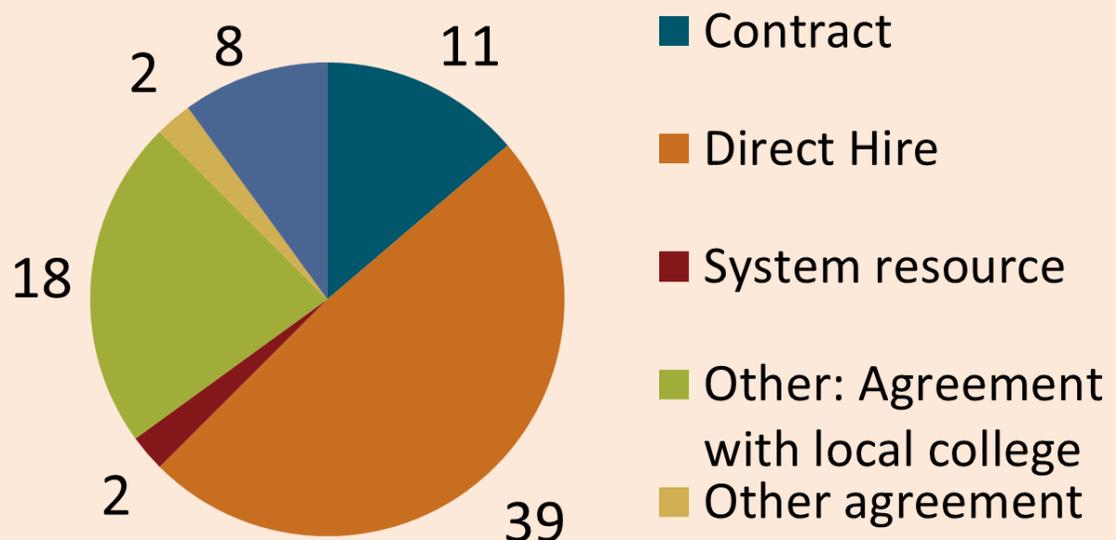


- Medication Management & Review.** 80 CPC practices chose to provide comprehensive medication management and review services. All practices that elected this strategy offer medication reconciliation, while most coordinate medications across care transitions between settings and providers, and regularly assess medication regimens (Fig. 9). Most of these practices have hired pharmacists directly or utilize their services through agreements with local colleges of pharmacy (Fig. 10). Pharmacists at these practices engage with patient care in a variety of ways, most frequently by providing medication review, follow-up or coincident referrals, pre-appointment consults, specified medication management appointments, and e-consultations. The average practice engages a pharmacist for 18 hours a week.

Figure 9. Prevalence of Services Offered by Practices that Provide Medication Management and Review, July 2014



Figure 10. Number of Practices that Engage Pharmacists as Part of the Care Team, by Method, July 2014

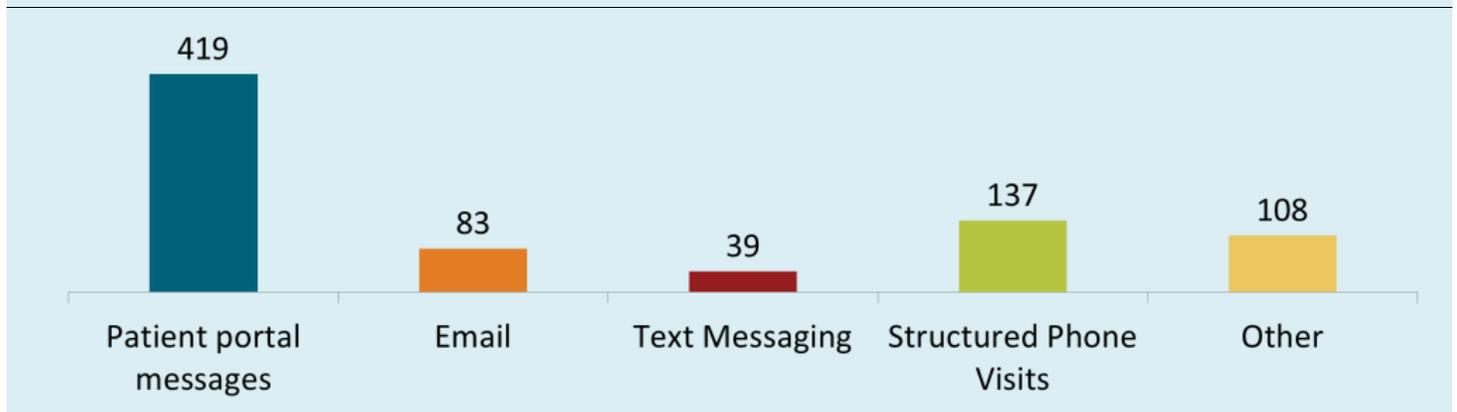


III. Access and Continuity (Milestone 3)

In 2014, CPC practices are asked to offer 24/7 access to a care team practitioner who has real-time access to the electronic medical record, and to enhance access by implementing at least one asynchronous form of communication (e.g. patient portal, email, text messaging) and make a commitment for a timely response.

- Enhanced Access.** Aligned with the goals of the CPC initiative, 99% of CPC practices offer patients 24/7 access to a care team practitioner who has real-time access to their electronic medical record. Practices offer this access through a wide variety of means, most commonly through patient portals and the ability to reach providers by telephone (Fig. 11).

Figure 11. Number of CPC Practices Offering Modes of Enhanced Access, July 2014



IV. Improve Patient Experience (Milestone 4)

As part of CPC’s overall goal to improve patient experience of care, CPC practices either conduct office-based patient surveys or convene regular patient-family advisory councils (PFACs) in order to guide improvements in the system of care and create an active culture of improvement. 359 practices administer regular office-based patient surveys, 206 convene PFACs, and 79 reported using both methods in 2014 (Fig. 12).

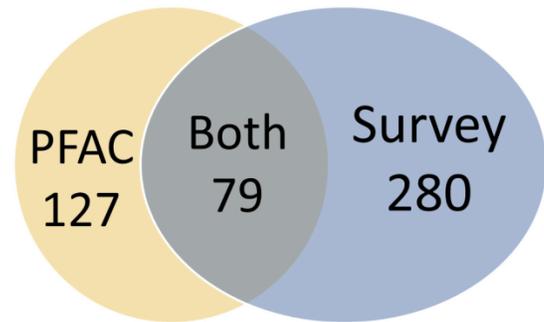
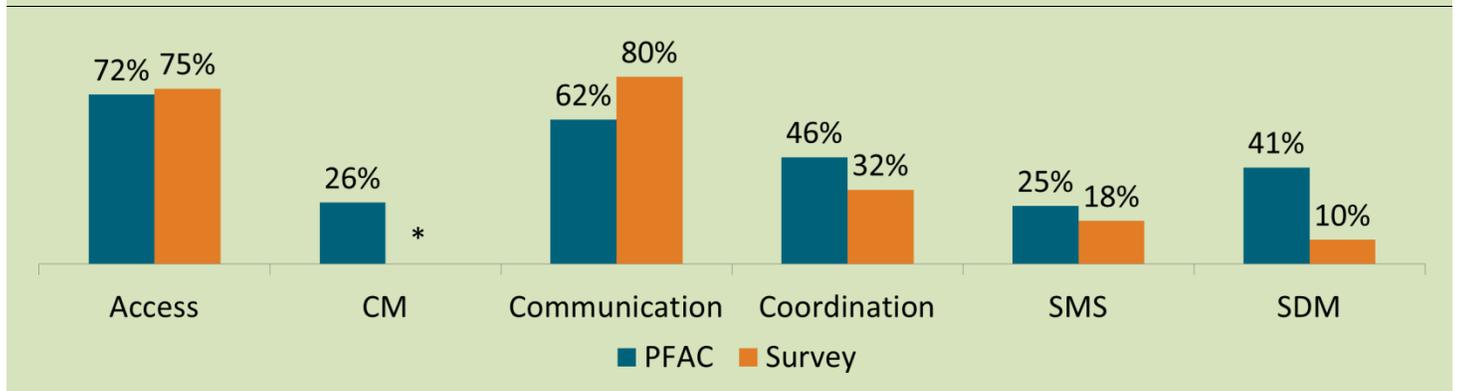


Figure 12. Patient Experience Improvement Approaches Selected by CPC Practices

- Patient-Family Advisory Councils (PFACs).** The average PFAC is composed of approximately eight patients or family members and four practice staff members. The majority of PFACs have established charter or mission statements. Within the 206 practices that implemented PFACs, 180 PFACs met between April and June 2014. Action plans from these PFACs have emphasized two common themes: improving front desk processes or patient access (e.g., reducing wait times, extending hours, or developing visit slots for walk-ins) and improving communication and engagement with patients (e.g., improving patient portals, written instructions, and information accessibility).

Figure 13. Area of Improvement or Focus Selected for a PFAC or Survey, by Percentage of Practices that Selected It, July 2014*

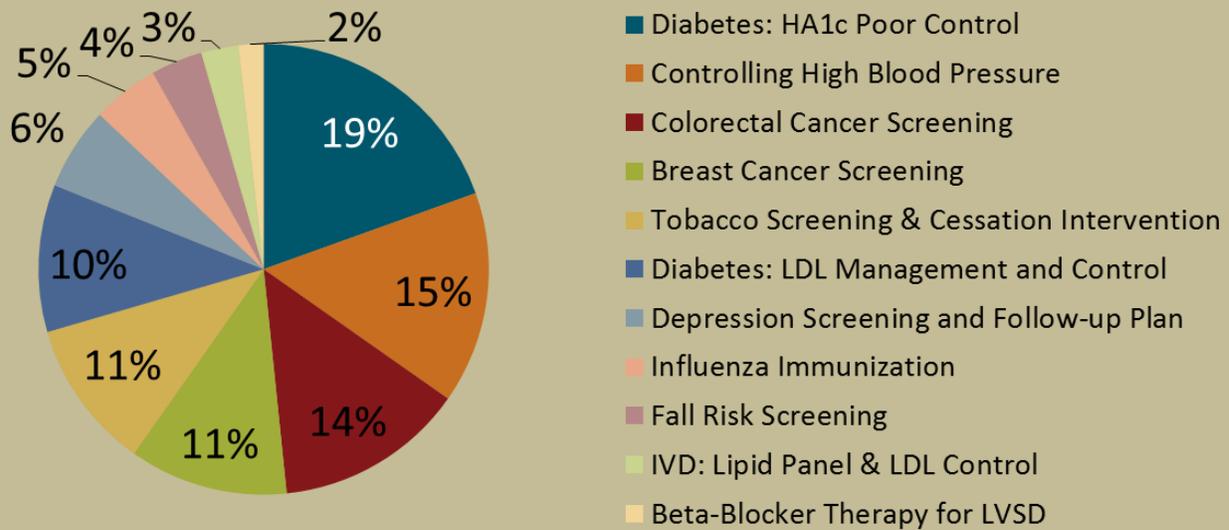


*Note: Practices administering office-based surveys were not given the option to select risk-stratified care management as a targeted area of improvement. The numerator of the given proportion is the total number of practices that selected this area of focus or improvement; the denominator is the total number of practices that elected to convene a PFAC or administer a survey. Abbreviations: CM = Care Management; PFAC = Patient-Family Advisory Council; SMS = Self-Management Support; SDM = Shared Decision-Making.

V. Use of Data to Guide Improvement (Milestone 5)

Continuous data-driven improvement and the optimal use of health information technology are two primary drivers of the change that practices pursue in CPC. In pursuit of these goals, CPC practices are asked to report nine clinical quality measures (CQMs) to CMS at the practice-site level from a list of eleven measures. They are also asked to select three of these measures on which to focus their quality improvement activities, generating panel-specific reports on these measures on at least a quarterly basis.

Figure 14. Clinical Quality Measures on Which CPC Providers Focused Their Quality Improvement Activities, by Percent of Practices that Selected Each Measure, July 2014



- Quality Improvement Focus.** Practices most commonly choose to focus their quality improvement efforts on diabetes-related CQMs: 19% of practices focus on hemoglobin A1c control and 10% focus on LDL management and control for diabetes patients (Fig. 14). Most practices review clinical quality measures (CQMs) on a monthly or quarterly basis. A variety of staff generate these reports and make them available, most often dedicated data analysts, clinic managers, and physicians, and sometimes nurses and medical assistants.

VI. Care Coordination (Milestone 6)

In 2014, CPC practices are asked to implement two of three care coordination strategies: (1) track the percent of patients with visits at target emergency departments (EDs) who received a follow-up phone call within one week of discharge; (2) contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours of discharge; or (3) enact care compacts or collaborative agreements with at least two groups of high-volume specialists in different specialties to improve transitions of care.

- Follow-up Contact.** Every CPC practice tracks follow-up with patients discharged from either targeted EDs *or* hospitals, and 413 practices have committed to follow up with patients discharged from *both* targeted EDs *and* hospitals (Fig. 15). While practices that focused on EDs are simply asked to track the percent of patients who receive post-discharge follow-up within one week, practices that focus on hospitals are asked to target a 75% post-discharge follow-up rate within 72 hours or two business days. Overall, practices across all CPC regions have achieved this follow-up rate goal, as the median CPC practice followed-up with 80% of its patients discharged from both target EDs and hospitals between April and June 2014 (Fig. 16).

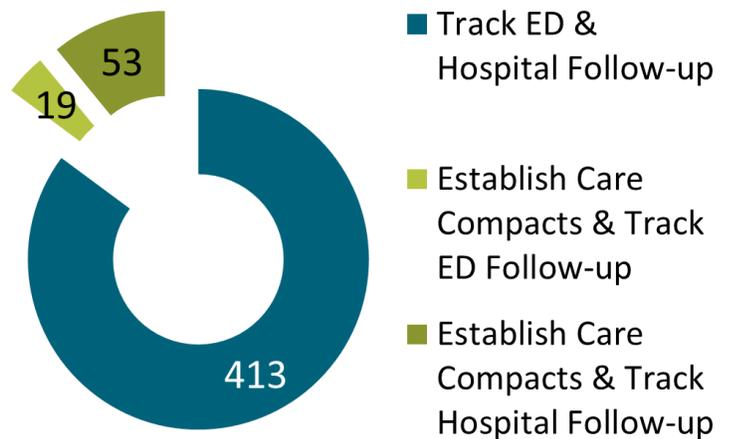
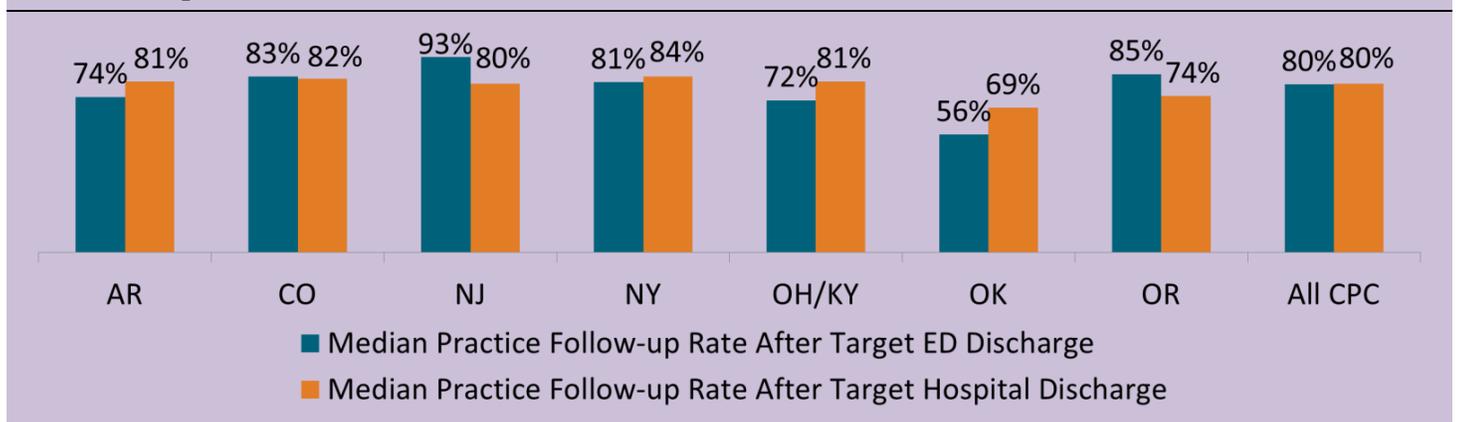


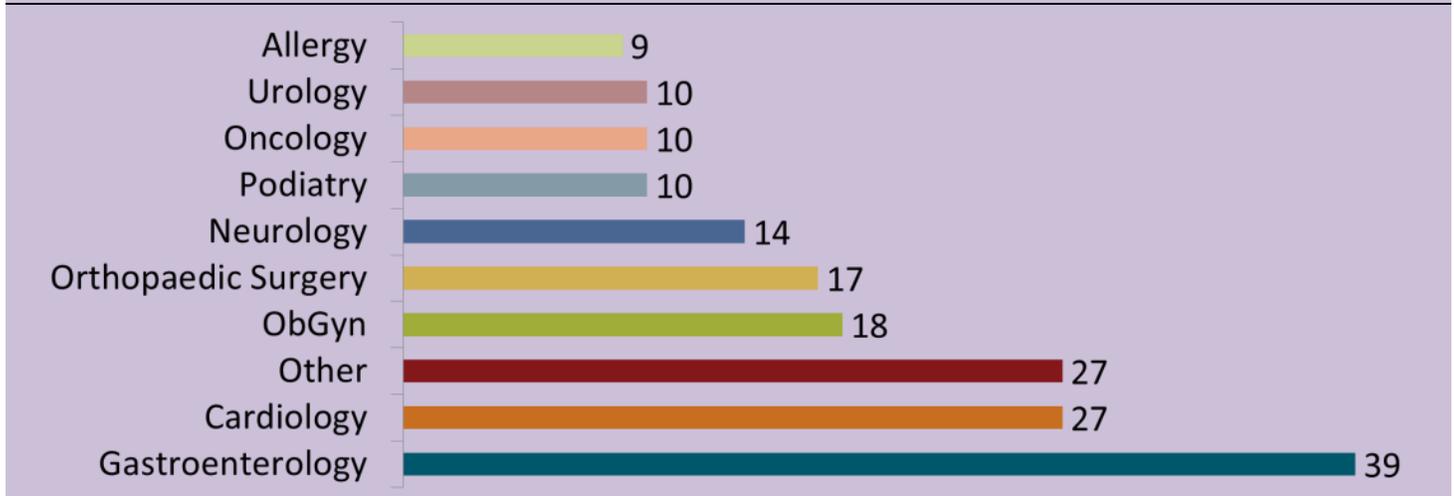
Figure 15. Combinations of Care Coordination Strategies Chosen by CPC Practices in 2014.

Figure 16. Median Practice Follow-up Rates Following Target ED and Hospital Discharge Between April and June 2014.



- Care Compacts.** 72 CPC practices chose to enact care compacts or collaborative agreements with at least two high-volume specialists to improve care coordination and care transitions for their patient population in 2014 (Fig. 15). All of these practices also track post-discharge follow-ups from either EDs or hospitals. CPC practices have enacted care compacts with a variety of specialists, most commonly gastroenterologists and cardiologists, as shown in Figure 17.

Figure 17. Top 10 Most Popular Specialties With Which CPC Practices Signed Care Compacts*, July 2014



*The next-most prevalent "Other" specialties with which CPC practices have enacted care compacts are dermatology (9), pulmonology (8), rheumatology (8), ophthalmology (7), psychiatry (5), radiology (4), endocrinology (4), and nephrology (3).

VII. Shared Decision-Making (Milestone 7)

CPC practices strive to engage patients and families in decision-making in all aspects of care. To this end, in 2014, CPC practices are asked to implement shared decision-making tools or aids for at least two health conditions, decisions, or tests.

- Decision Aids.** In 2014 CPC practices were asked to use at least three decision aids to support shared decision-making between providers and patients in preference-sensitive care. Cancer screening was the most commonly addressed preference-sensitive condition, and most decision aids were acquired from Health Decision Points, the Mayo Clinic, or the CDC (Table 2; Fig. 18).

Table 2. Most Common Preference-Sensitive Conditions, Decisions, or Tests Addressed by Decision Aids, July 2014

Preference-Sensitive Condition, Decision, or Test	# of Practices Utilizing Decision Aids
Colon cancer screening	187
PSA for prostate cancer screening	148
Tobacco cessation	130
Medications in diabetes	103
Breast cancer screening	58
Back pain management and imaging	58
Antibiotic overuse for upper respiratory infection	57
Care preferences over the life continuum	55
Management of anxiety or depression	49
Statin/aspirin use	42
Other*	255

*Conditions selected by at least 10 practices include osteoporosis (34), management of heart failure (28), anticoagulation in atrial fibrillation (19), hypertension (16), lung cancer screening (16), management of heart failure (15), high cholesterol (14), knee osteoarthritis (13), COPD (10), management of asthma (10), and management of chronic pain (10). Fewer than 10 practices selected at least one of 25 other conditions.

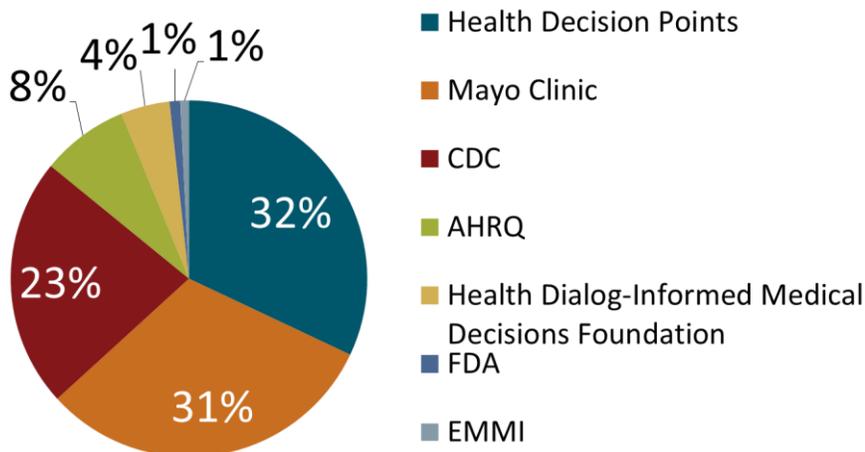


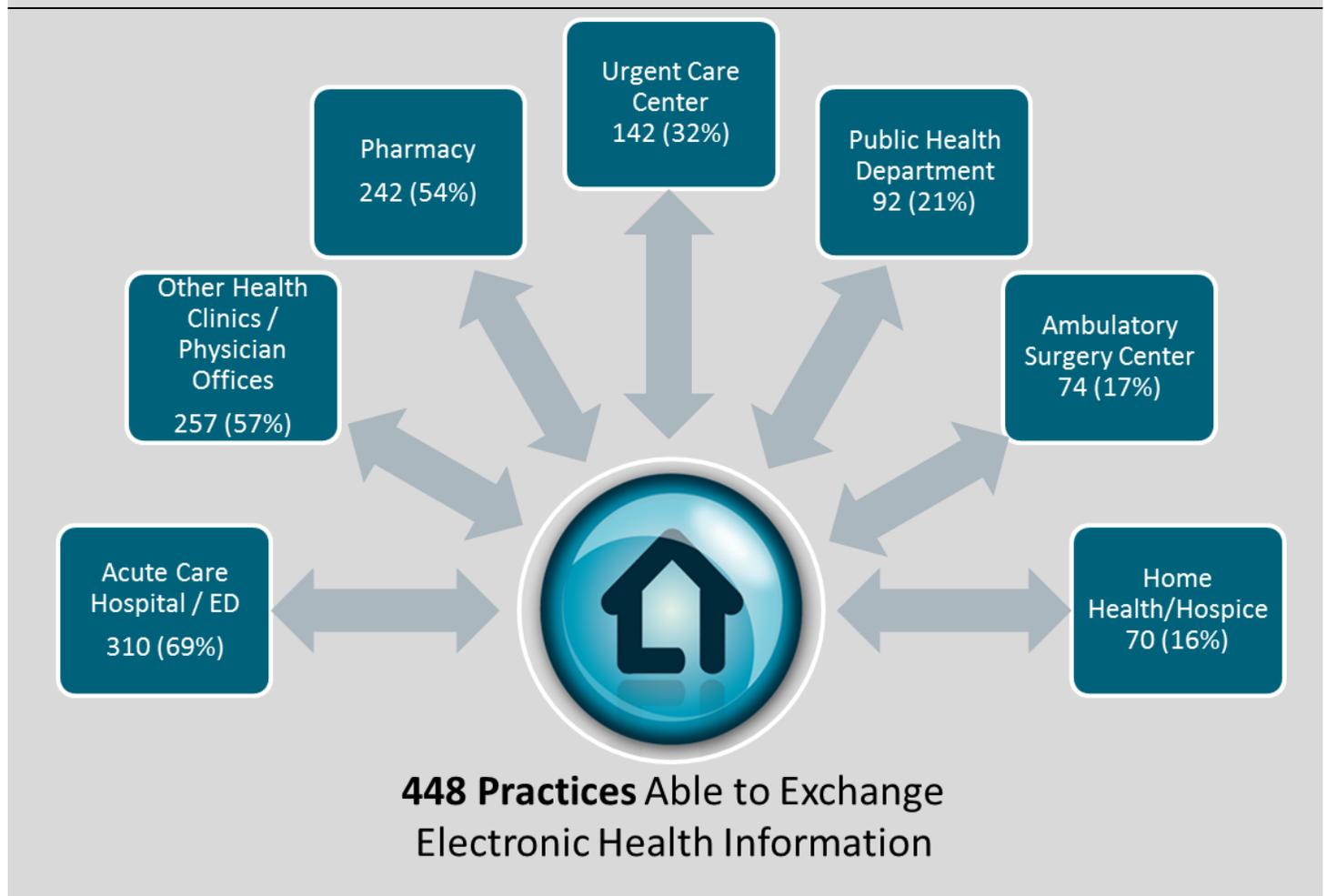
Figure 18: Source of Decision Aids Used

VIII. Health Information Technology (Milestone 9)

In 2014, CPC practices were asked to attest that all of the eligible professionals in their practice were Meaningful Users of health information technology, and to upgrade their EHR technology to the 2014 edition ONC Certification standard.

- **2014 ONC Certification.** 405 CPC practices (84%) were using a 2014 edition ONC-certified EHR at the end of June 2014.
- **Health Information Exchange.** 448 CPC practices (93%) were able to exchange electronic health information with at least one care setting at the end of June 2014 (Fig. 19). Over half of these practices were able to exchange electronic health information with acute care hospitals or emergency departments, physician offices or other health clinics, and pharmacies.

Figure 19. Number of Practices Able to Exchange Electronic Health Information With Specific Care Settings (As a Percent of All Practices Able to Exchange Electronic Health Information With At Least One Care Setting), July 2014*



*Not shown: Skilled Nursing Facility (49 practices; 11%); Specialty Hospital (48 practices; 11%); Rehabilitation Hospital (45 practices; 10%); Other Long-Term Care Facilities (22 practices; 5%).