Leveraging CPC+ for Practice Transformation

Financial Growth Models

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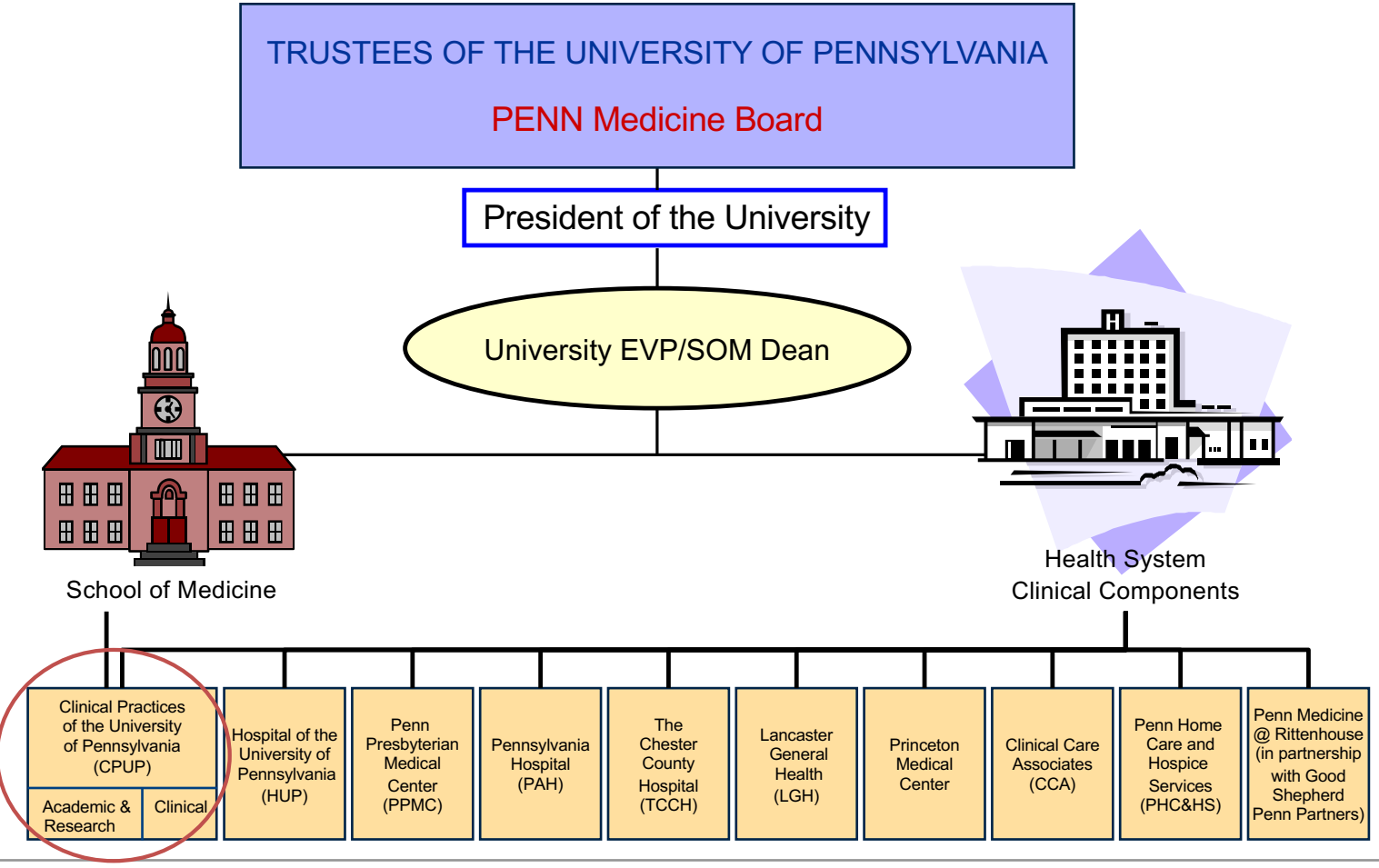
Penn Medicine

Penn Medicine Overview



We are Academic Medicine

Patient Care

Medical Education

Biomedical Research

Community Service

Traditional Academic Medical Center Missions

$8.2B Revenues 135,000 inpatients 5.4 M outpatients 40,000 employees	2,000+ faculty 800+ medical students 1,100+ residents	~$770M Research Funding	Community-based services and charity care

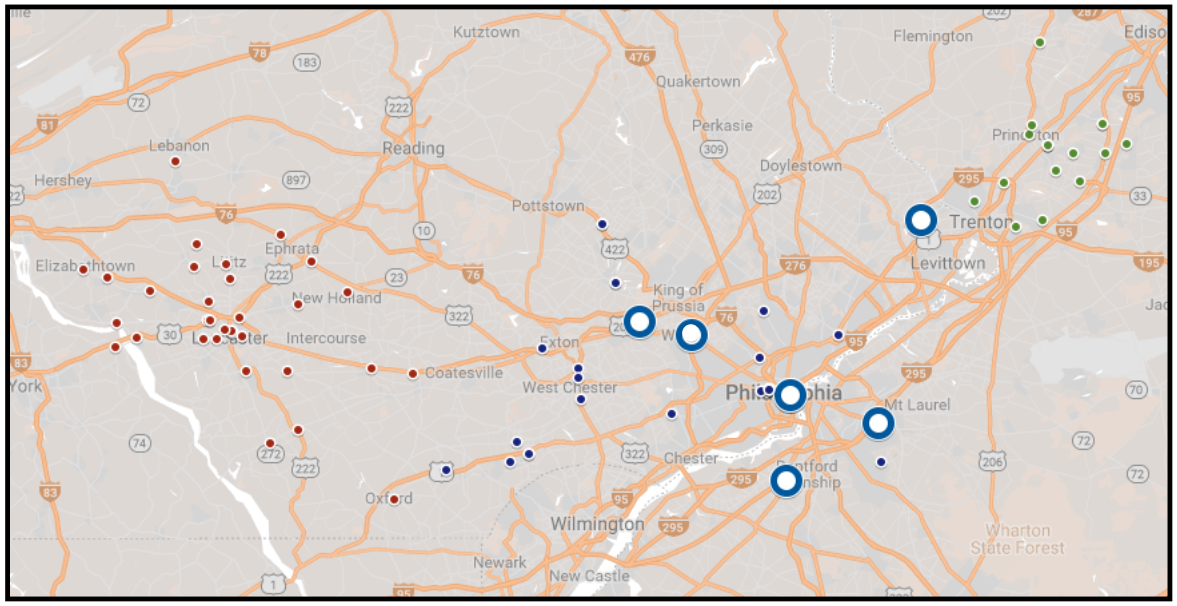
Penn Primary Care Footprint

88
Primary Care Practices

Approx.
310 Physician FTEs
110 APP FTEs

Approx.
559,068
Active Patients

Approx. 1.2M
Patient Visits



CPUP DGIM
CPUP Family Medicine
CPUP Geriatrics
Penn Primary Care
LGHP Primary Care
Princeton Health Primary Care

Primary Care Service Line Entities

CCA
CPUP
LGHP
Princeton
Practice of the Future

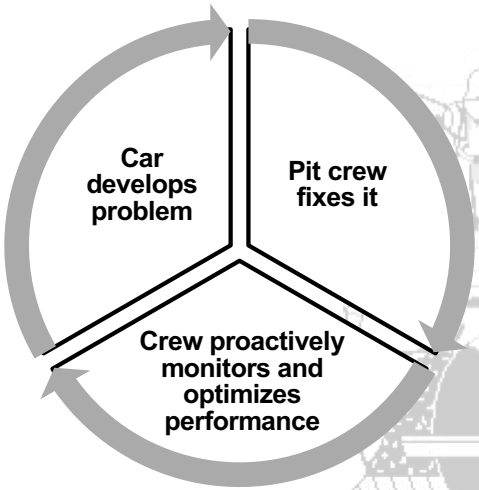
Transformation of Primary Care

Traditional Primary Care

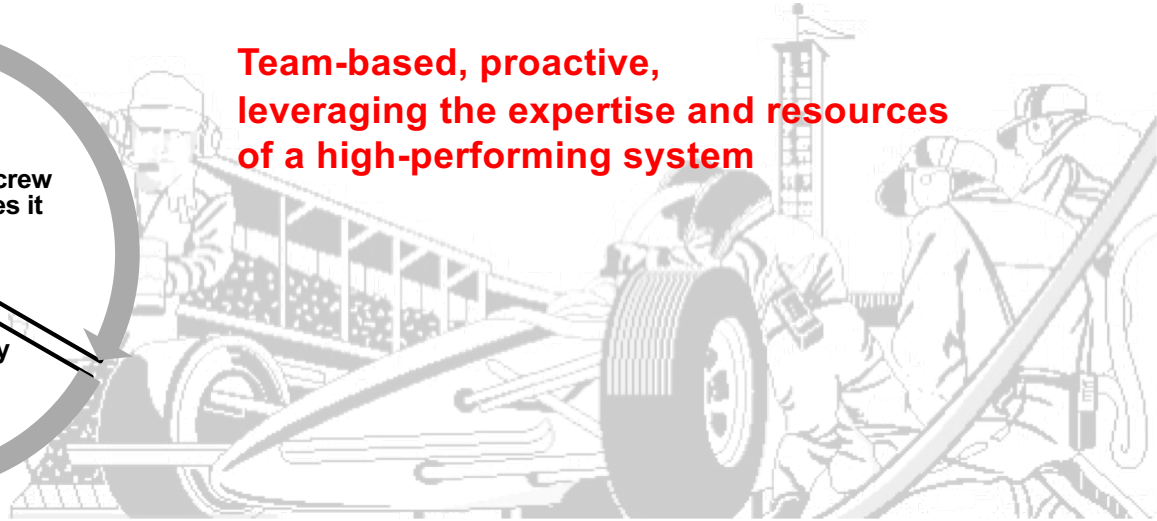
Car breaks down → Local mechanic fixes the problem → See mechanic again when your next problem arises

Reactionary, fixing issues as they arise.

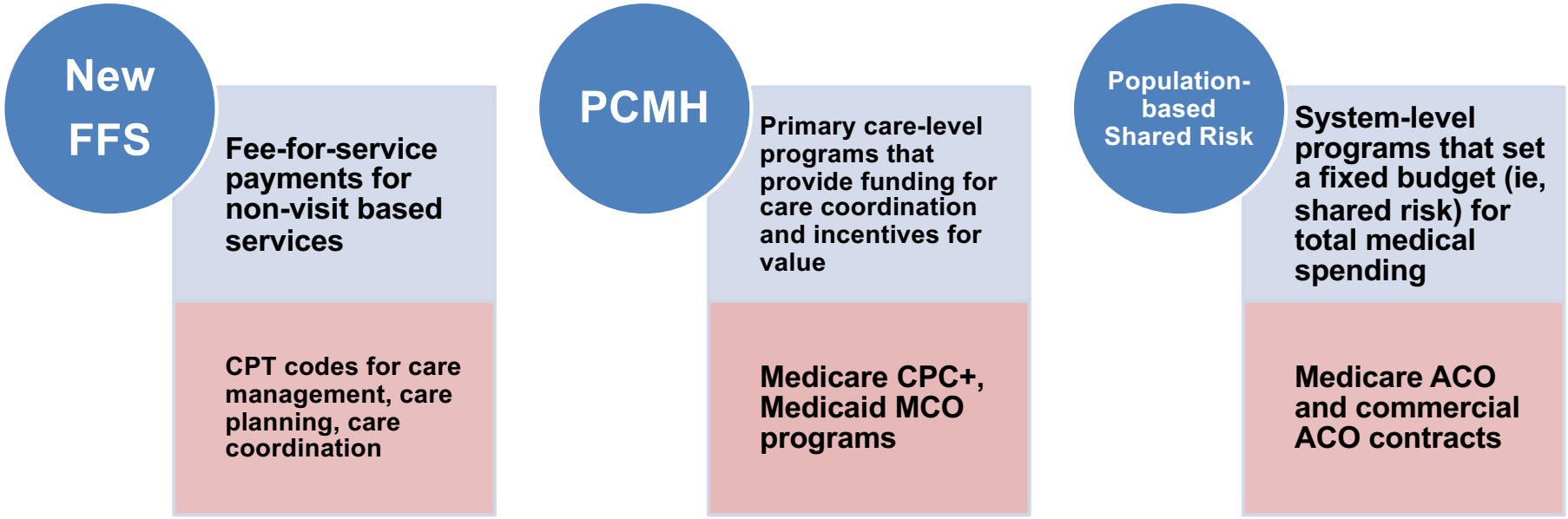
Advanced Primary Care



Team-based, proactive, leveraging the expertise and resources of a high-performing system



New payment programs support a new care delivery model



Comprehensive Primary Care (CPC+) Background

- **CPC+ is Medicare's advanced primary care medical home model that seeks to:**
  - Improve the quality of care patients receive
  - Improve patients' health
  - Spend health care dollars more wisely

- **To achieve this, the program focuses on key Comprehensive Primary Care Functions:**
  - Access and Continuity
  - Care Management
  - Comprehensiveness and Coordination
  - Patient and Caregiver Engagement
  - Planned Care and Population Health

CPC+ By the Numbers

5
Years
Beginning January 2017, progress monitored quarterly

2
Program Tracks
Based on practices' readiness for transformation

Up to 2,500
Practices Per Track
Dependent upon interest and eligibility

Financial Support for Practice Transformation

- **Care Management Fees paid based on attributed beneficiaries and support is tiered based on beneficiaries HCC score**
- **Performance Based Incentive targets several quality, utilization and patient experience metrics (CG-CAHPS) and is reconciled six months after the performance year**
- **Track 2 practices have a portion of their historical Medicare FFS revenue converted to capitated revenue that is paid quarterly and any patient visits are reimbursed at a reduced % of the Medicare Fee Schedule**

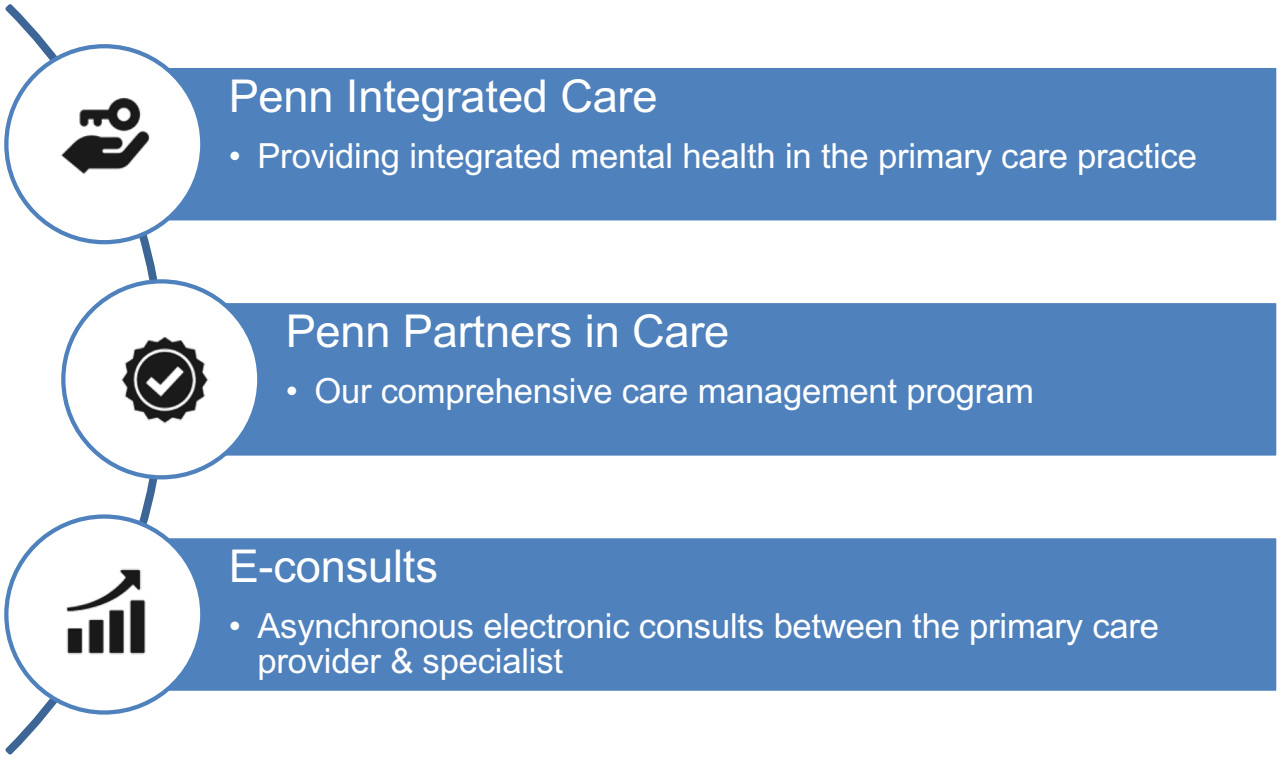
Payment Innovation Supports Practice Transformation

Medicare FFS Financial Support for CPC+ Practices

	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard FFS
	Paid prospectively on a quarterly basis	Paid prospectively on an annual basis; must meet quality and utilization metrics to keep incentive payment	Regular Medicare FFS claims payment
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)
	Paid prospectively on a quarterly basis	Paid prospectively on an annual basis; must meet quality and utilization metrics to keep incentive payment	CPCP paid prospectively on a quarterly basis; Medicare FFS claim is submitted normally but paid at reduced rate

Key Initiatives Supporting Advanced Primary Care

- **Wraparound services that are providing needed support to patients and reducing the burden on our family medicine & other primary care providers:**




PENN MEDICINE
Penn Integrated Care (PIC)

Penn Integrated Care Core Components

PIC IN PENN PRIMARY CARE

Implemented the collaborative care model in eight Penn Medicine primary care practices in January 2018. Expansion planned for 2020.

PENN CHART BUILD & REGISTRY

Penn Chart navigator for PIC built in-house and deployed for documentation, collaboration, and billing. Population health monitoring via a registry.

STAFFING

Five licensed clinical social workers embedded in the practices as Mental Health Providers (MHP). Consulting psychiatrists from the Department of Psychiatry.

SCREENING AND MEASUREMENT

Validated symptom measurement tools integrated into Penn Chart for systematic use. Health system depression screening used for patient identification.

RESOURCE CENTER

Telephonic resource center provides comprehensive, evidence-based assessment, triage, risk stratification and referral. Utilizes decision support software (BHL).

COLLABORATION

Weekly panel review sessions with psychiatrists and MHPs. Doc-to-doc consultation between PCPs and psychiatrists via e-consult for complex issues.

Care patient received from their practice

MENTAL HEALTH PROVIDER

Carry 80 patients at a time for 2-6 months, and use a population health, registry-based approach.

BRIEF INTERVENTIONS

Behavioral activation, motivational interviewing, problem-solving therapy, brief CBT, and substance use care, among others.

URGENT WARM HAND OFF

PCPs facilitate warm hand offs to the MHPs for patients in acute distress or with a safety concern.

CONSULTATION AND COLLABORATION

MHPs collaborate with PCPs on a daily basis and have weekly meetings with consulting psychiatrists to review their panel and cases.

Utilizing CPT Codes to bill for Integrated Mental Health

99492
$171.24

First 70 minutes in the first calendar month for CoCM.

70 minutes

99493
$136.65

First 60 minutes in any subsequent calendar month for CoCM

60 minutes

99494
$70.54

Each additional 30 minutes in a calendar month for CoCM

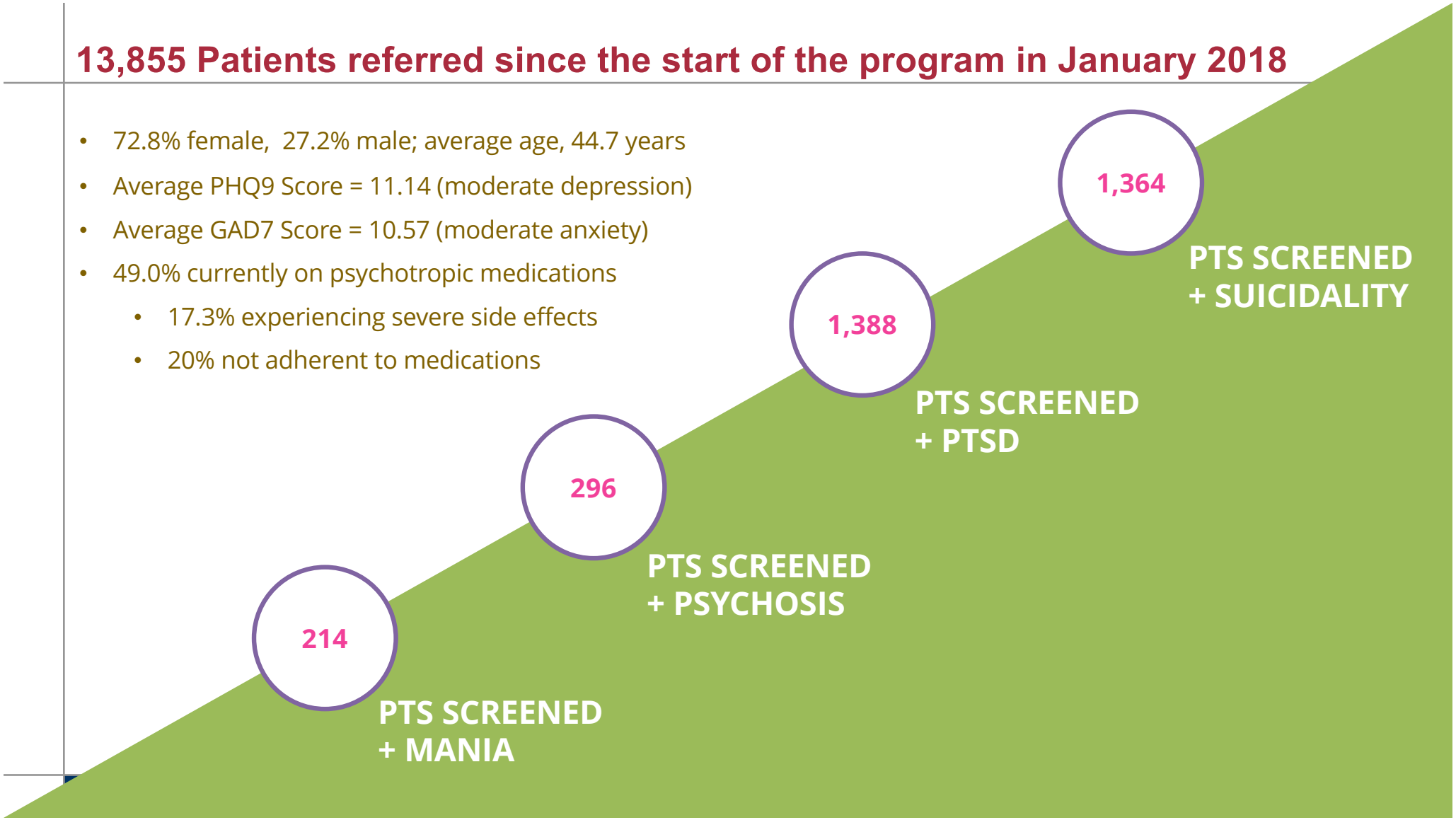
30 minutes

SERVICE COMPONENTS OF TIME-BASED FEE-FOR-SERVICE CODES:

- Initial assessment with validated rating scale(s)
- Care planning by the team, jointly with the patient; treatment may include pharmacotherapy, psychotherapy, or other treatments
- Proactive, systematic follow-up using validated rating scales and a registry; may provide brief evidence-based psychosocial interventions
- Weekly case review with psychiatric consultant

13,855 Patients referred since the start of the program in January 2018

- 72.8% female, 27.2% male; average age, 44.7 years
- Average PHQ9 Score = 11.14 (moderate depression)
- Average GAD7 Score = 10.57 (moderate anxiety)
- 49.0% currently on psychotropic medications
  - 17.3% experiencing severe side effects
  - 20% not adherent to medications



Care options for patients screened through Penn Integrated Care

PIC IN PRIMARY CARE (40%)

MHP embedded in the practice, in consultation with a psychiatrist and supervised by the PCP, provides brief, evidence-based interventions.

SUBSTANCE USE DISORDER CARE

Providers and resources that focus on substance use treatment, including acute care and intensive outpatient programs.

SPECIALTY MENTAL HEALTH CARE (60%)

Psychiatrist, psychologist, and/or other licensed mental health clinician provides longer term interventions for severe mental health conditions.

SELF-DIRECTED CARE

Resource Center follows patient for two months and refers to a higher level of care if patient's symptoms worsen. Self-directed resources provided.

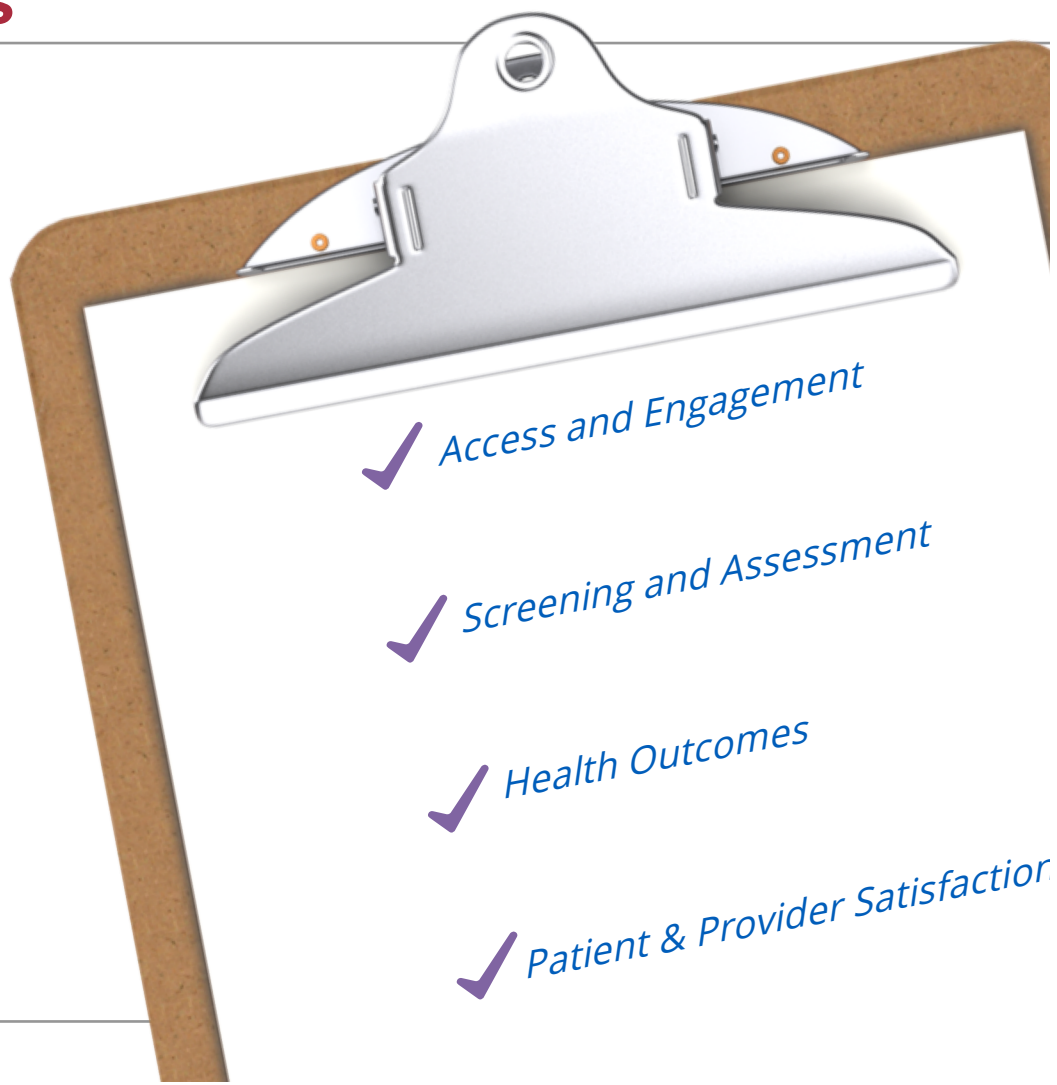
Program Evaluations Metrics

- Access
  - Number of referrals to PIC
  - Number of patients assessed
  - Disposition of assessed patients
- Engagement
  - # of patients in an episode
  - Duration of episode; # of encounters per episode
  - # of psychiatrist reviews per episode; # of MBC per episode
- Screening and Assessment
  - CMS2v6: Screening for depression and follow-up plan
  - CMS160v6: Depression utilization of PHQ-9 Tool
- Health Outcomes
  - % change in and remission of MH symptoms
  - % change and control of A1C and BP
- Patient and provider satisfaction
- Cost of care; acute care utilization; ROI

PROCESS

OUTCOMES

VALUE



PIC successful in reducing depression & anxiety

Jan 2018-Dec 2018: patients treated in the primary care practices by an mental health provider.

42%	33%	37%	40%
reduction in PHQ9 scores	depression remission	reduction in GAD7 scores	anxiety remission

Jan 2019-Nov 2019: patients treated in the primary care practices by an mental health provider.

48%	46%	49%	46%
reduction in PHQ9 scores	depression remission	reduction in GAD7 scores	anxiety remission

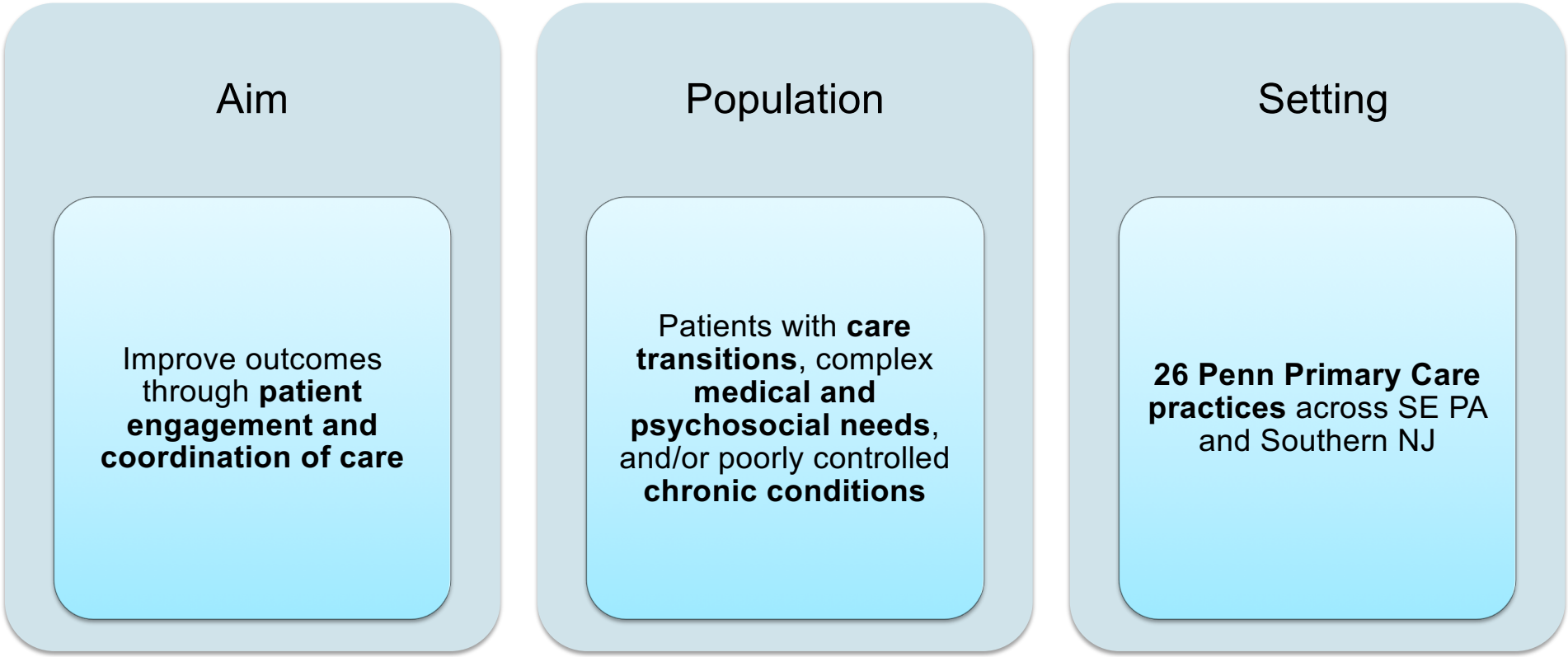
QUESTION FOR PARTICIPANTS

What has been your experience implementing integrated mental health?

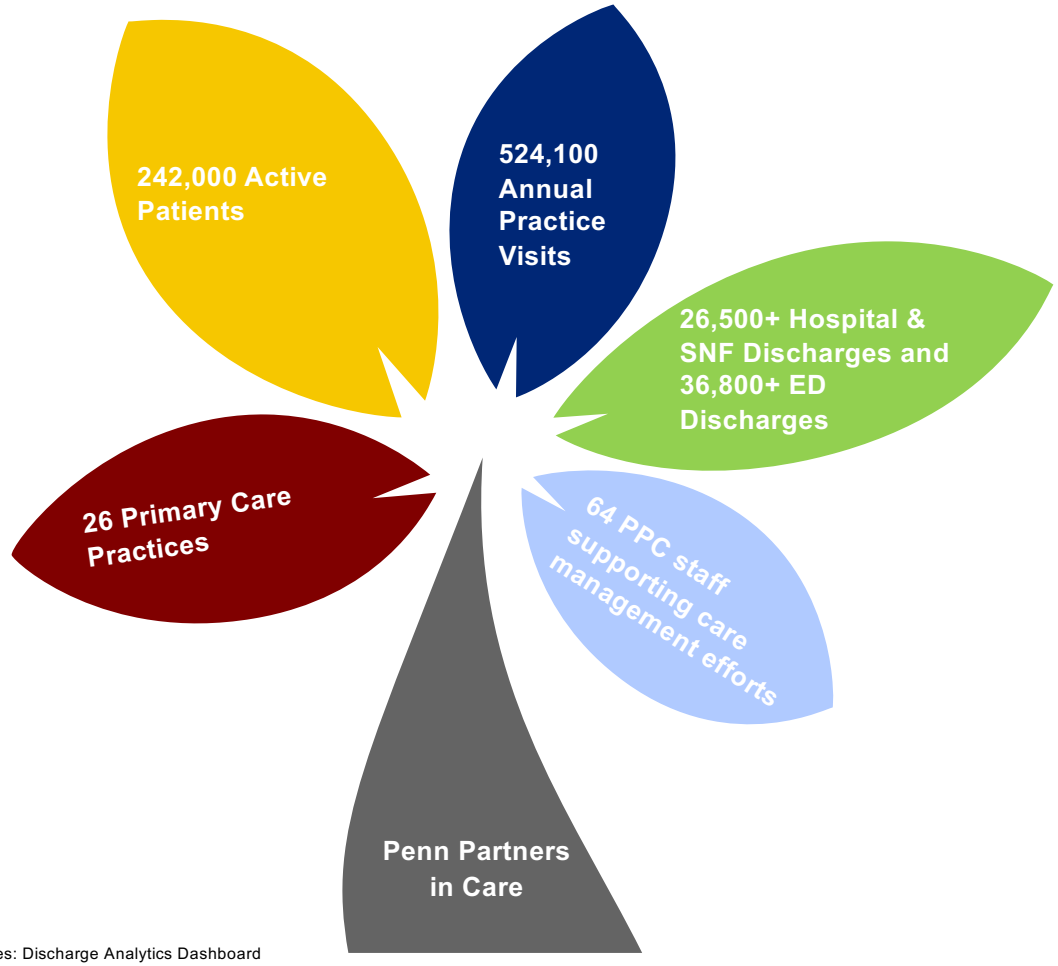
PENN PARTNERS IN CARE

PPC is foundational to Advanced Primary Care

Penn Partners in Care (PPC) is a comprehensive care management program funded through CPC+ & Medicaid "PCMH" Program care management fees.



Penn Partners in Care: Supporting Patients & Care Teams



Providers
153 Physician and APP cFTEs

Patients
All empaneled patients at the practice including 30,000 patients enrolled in Medicare/CPC+

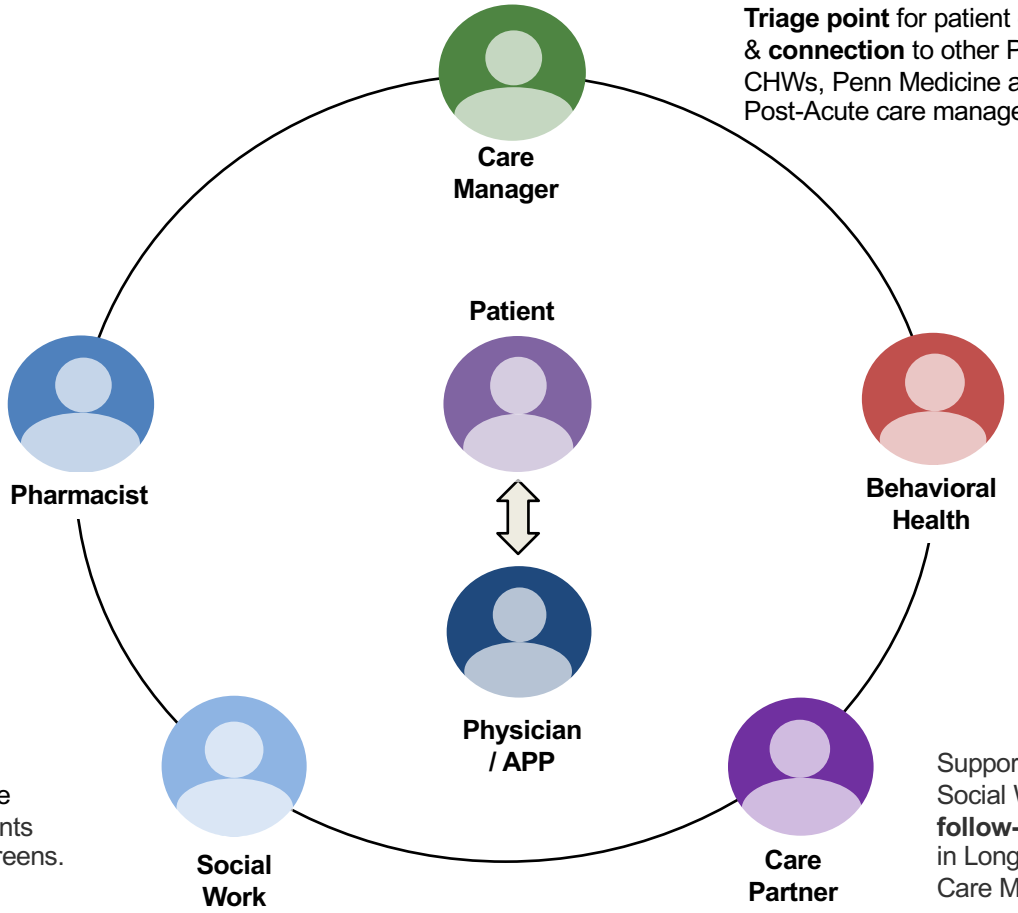
Practice Visits
Practices participating in Penn Partners in Care program had 524,110 annual visits from their empaneled patients in FY19

Discharge Volume
PPC Staff provide episodic care management services to ED and Hospital Discharges and target high-risk patients for Longitudinal Care Management

Penn Partners in Care
Multidisciplinary team consisting of nurse care managers, social work, pharmacists, community health workers, and care partners supporting patients discharged from the ED or Hospital and will actively manage 7,250+ high risk patients

Notes:
Sources: Discharge Analytics Dashboard

Penn Partners in Care (PPC) Team



Triage point for patient entry to PPC & **connection** to other Penn services: CHWs, Penn Medicine at Home & Post-Acute care managers.

Ambulatory comprehensive **medication management** by pharmacists to address adherence, drug-drug interactions and access challenges.

Provides **behavioral health support** for patients with depression, anxiety, & substance abuse. **Triages** patients to higher level of mental health services as needed.

Identifies & initiates resources to overcome social barriers for patients with positive SDOH screens.

Support Care Managers and Social Workers with **pro-active follow-up for patients** enrolled in Longitudinal and Episodic Care Management.

Key Program Performance Indicators

Improve patient health outcomes

- 30-day readmissions
- ED visits and hospitalizations
- Diabetes control (eCQM)
- Blood pressure control (eCQM)

Core Process Measures

- Post-hospital assessments completed within 2 business days of discharge
- Post-hospital office visits for at-risk patients
- Post-ED assessments completed within 7 business days of discharge
- Post-acute contact with hospital care teams
- HbA1c completed annually for diabetic patients
- Blood pressure monitoring completed annually for patients with hypertension

Operational Measures

- Number of new patient enrollments per month
- Total number of managed patients per month
- Care Management revenue from payers
- Program cost PMPM

QUESTION FOR PARTICIPANTS

What has been your experience implementing care management?

Penn | E-CONSULTS

E-consults can address the following challenges

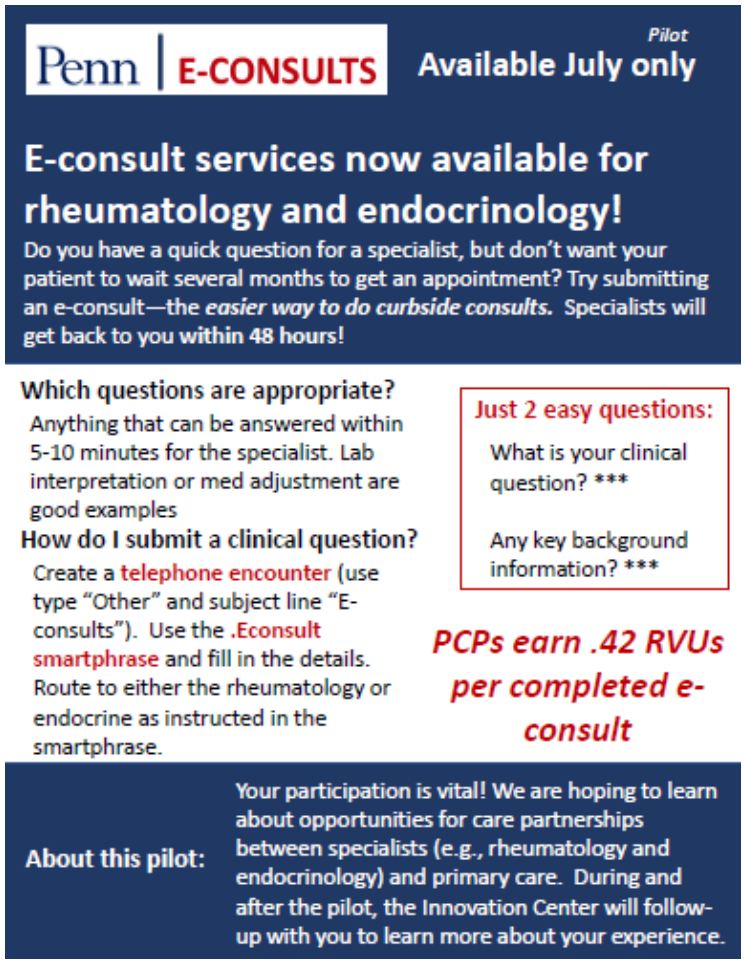
Primary Care

- **PCPs** want the best, timely treatment for their patients, but **struggle to get quick specialist input when necessary**
- **Current methods** of obtaining specialist input **are suboptimal** (e.g., curb-side consults, referrals, favors requested to specialist friends)
- **PCPs** have strong, established relationships with their patients, and **would prefer to manage more of their patients' care,** while also saving their patients' time

Specialties

- **Access is a challenge.** Wait times can be six months or more, delaying treatment for sick patients.
- Specialists are spending significant time **caring for patients that could be managed in primary care** (with a little bit of specialist support)
- At time of specialist NPV, **referral reasons can be unclear** with insufficient work-up

First Phase: 1-month, telephone encounter enabled E-consult pilot



Penn | E-CONSULTS

Pilot
Available July only

E-consult services now available for rheumatology and endocrinology!

Do you have a quick question for a specialist, but don't want your patient to wait several months to get an appointment? Try submitting an e-consult—the ***easier way to do curbside consults.*** Specialists will get back to you **within 48 hours!**

Which questions are appropriate?

Anything that can be answered within 5-10 minutes for the specialist. Lab interpretation or med adjustment are good examples

How do I submit a clinical question?

Create a telephone encounter (use type "Other" and subject line "E-consults"). Use the .Econsult smartphrase and fill in the details. Route to either the rheumatology or endocrine as instructed in the smartphrase.

Just 2 easy questions:

What is your clinical question? ***

Any key background information? ***

PCPs earn .42 RVUs per completed e-consult

About this pilot: Your participation is vital! We are hoping to learn about opportunities for care partnerships between specialists (e.g., rheumatology and endocrinology) and primary care. During and after the pilot, the Innovation Center will follow-up with you to learn more about your experience.

Key questions

1. Can e-consults facilitate better patient management in primary care?
2. Do e-consults help prevent visits to specialists and increase capacity in a strained system?
3. How much time do e-consults require from providers?
4. In which cases are e-consults most helpful?
5. What are barriers and facilitators that help make e-consults a successful model?

During the pilot we observed many additional benefits to all stakeholders

PCP

NPS= 93

- Improved timeliness and quality of treatment plan for their patient
- Provided educational value for future patients
- Enabled a “sense of community”
- Enhanced PCP-patient relationship

Specialist

NPS= 100

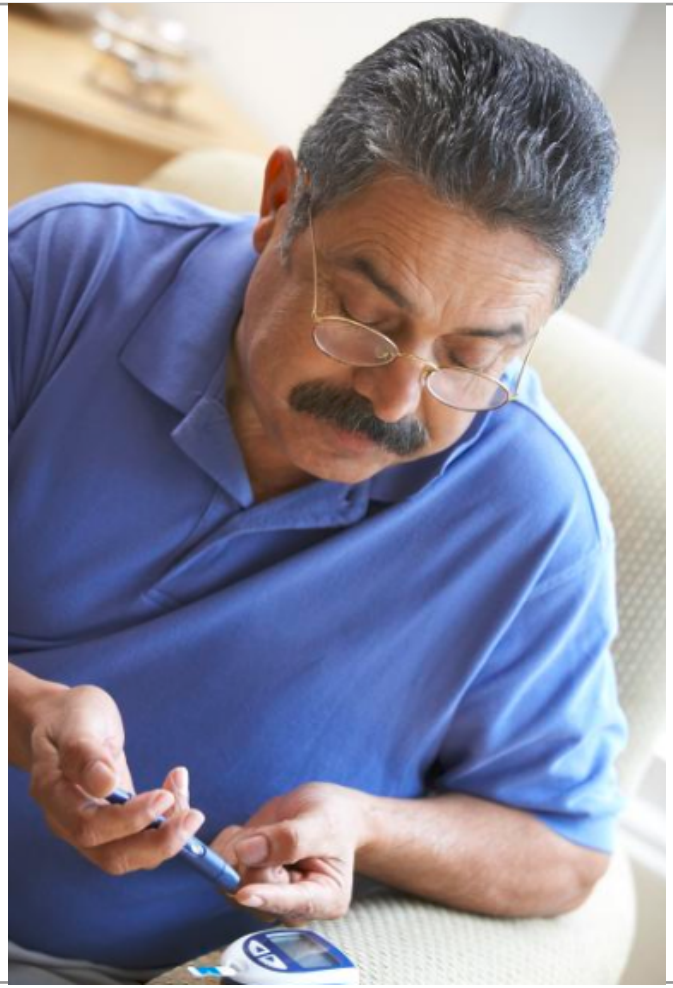
- Improved clarity of clinical questions
- Provided an opportunity to teach and feel that your input is valued
- Increased in-person time spent on the sickest, most appropriate patients with better work-up

Patient

NPS= 100

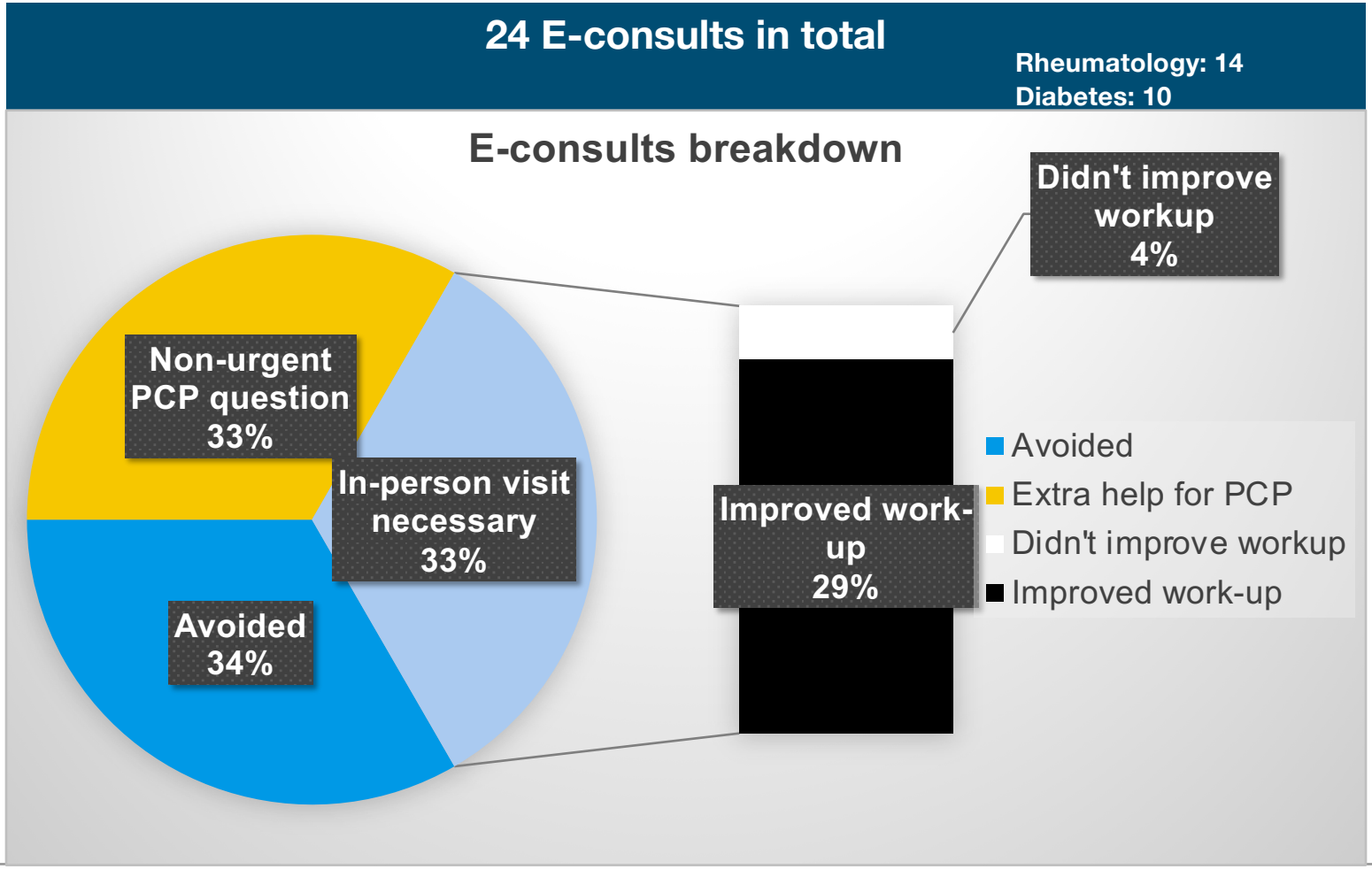
- Improved continuity of care with a trusted provider
- Valued improved treatment plan from specialist input
- Fast, easy access, to high-quality treatment plan
- Felt connected to Penn Network

E-consults checked all the boxes



- Improved timeliness and quality of primary care
- Specialist input without seeing a specialist
- Educational value for PCP and teaching value for specialist
- Enabled “sense of community”

34% of total e-consults avoided a specialist visit



A more detailed snapshot…

Improve patient health outcomes by reducing time to diagnosis and treatment

- E-consult turn around time is **27 hours compared to 3-6 months for an NPV**
- **86% of patients who needed to be seen had improved work-up**. With appropriate advanced work-up, target patients can be **prioritized for faster treatment**

Maximize top-of-license healthcare

- **80% of PCPs changed their course of action** based on specialist input
- **14 min specialist time spent** on "non-target" patients
- **Net time-savings of 14% for specialists**

Establish a sustainable long-term business model

- E-consults are **currently unreimbursed**
- Rheum only: If scaled, would require an **estimated 480 hours per year of specialist time** BUT **could free up an additional 67 NPV slots** for high-value, "target patients"

E-Consults Next Steps

- **First Epic Health System in United States to develop a workflow to bill Medicare for E-consults**
  - Results: Sometimes it's not good to be first!
    - Workflow clunky and not intuitive for physicians
    - Physicians tended to utilize old methods (Phone calls, chart messages)
    - Eligible population was incredibly small (Medicare patients (not medicare advantage) who need a new diabetes e-consult)

- **Phase 3**
  - Utilize formal Epic build and offer E-consults in a non-billing pilot to 10 primary care practices and three specialties (Endocrinology, Rheumatology and Cardiology)

QUESTION FOR PARTICIPANTS

What has been your experience implementing e-consults?