Central Ohio Primary Care and Patient Centered Care

History of COPC

- Formed in 1996: 33 physicians from 11 practices
- Hospitalist program
- Administrative services
- Ancillary services
- Contracting leverage
- Single record
- Quality

COPC Today

- Largest physician owned PCP group in the country
- 300 physicians in 57 locations
- 60 % Internal Medicine
  - 70 dedicated Hospitalists
  - 12 Endocrinologists
  - 8 Infectious Disease
  - 4 Physical Medicine
  - 1 Cardiologist
- 20% Pediatrics
- 20% Family Medicine

COPC Today (cont.)

- 2nd generation EHR. eClinicalWorks. Includes patient portal
- 350,000 active patients
- 44 level 3 NCQA certified PCMHs
- High complexity laboratory serving 385,000 patients in 2015. 1.3M lab tests
- Diabetes, Asthma, COPD and smoking cessation disease management programs
- High complexity Radiology and Cardiac testing
- Physical Therapy

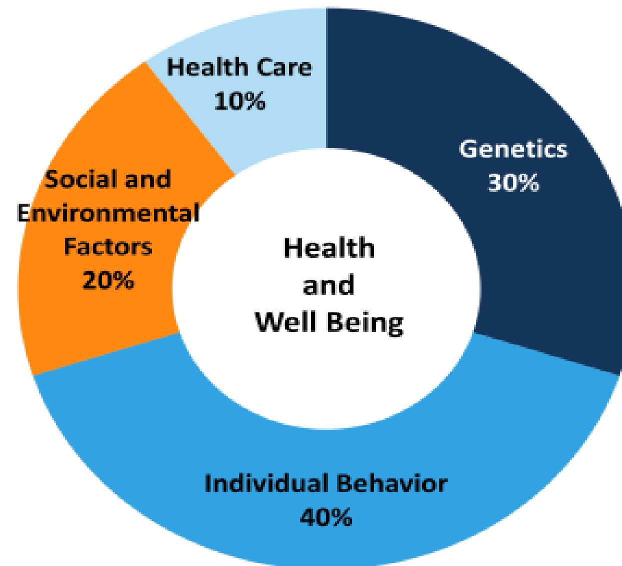
The Problem with Healthcare

- We can not sustain our cost trajectory
- We are not getting value defined as quality per dollar spent
- FFS is not patient centered care
- We are “killing” our Primary Care Physicians

Recognize our limitations

Figure 1

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

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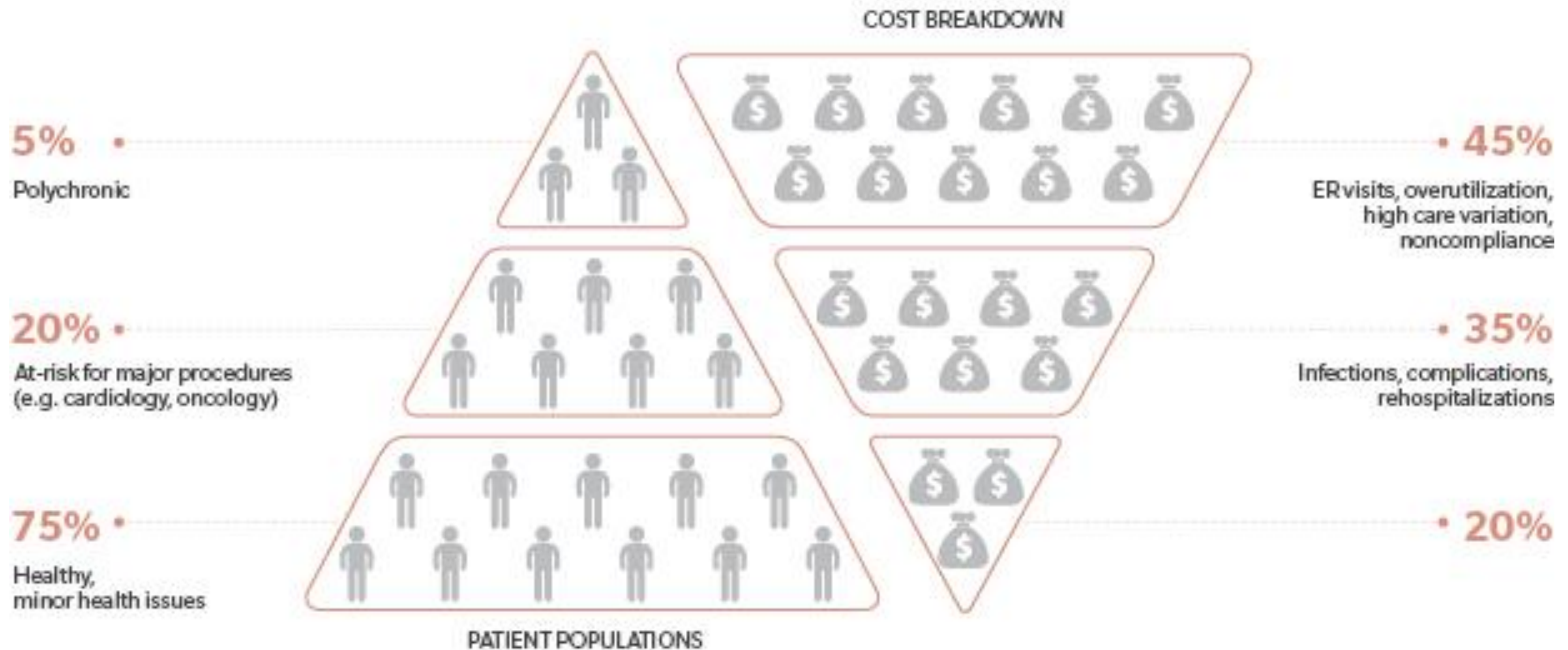
Which patients are in the greatest



COPC Patient Centered Care

- Began with PCMH program in 2011. Largely a commercial insurance initiative
- Expanded to a population health program in 2014 focused on high risk MA patients
- COPC chose not to be an ACO

2011 PCMH Initiative

- 2011-2014: 44 sites accredited by NCQA
- PCMH is team care with patient at the center of care. All site employees have a role in care
- Patients have a more active role
- Our Goals: 1) Improve access

  2) Standardize quality goals for

  chronic conditions

Improving Access

- Open PCP schedules for acute visits and hospital discharges
- COPC Same Day Centers opened
- **RESULT:** COPC ER/1000 is 30% below market

PCMH clinical goals

- Pediatric: Obesity
  ADHD
  Asthma

- Adult: Lipids
  High Blood Pressure
  Diabetes

COPC Education Programs

- Diabetes Education: >1000 patients/year

  < 10% diabetics poor control
- Asthma Education: Reduced pediatric ER 75%
- Smoking Cessation classes
- COPD education

2014 Population Health initiative

- Expanded in 2014 to address Medicare Advantage population of 20,000
- All MA contracts have shared savings
- Includes: Transition Nursing
  Visiting Physician
  Hospitalist expansion
  Quality Nurses
  Care Coordination Teams

Transition of Care Nursing

- 14 dedicated RN's
- Meet with each patient upon admission
- Manage discharge and follow up appointment
- Telephone contact at 48 hours

- **RESULT:** 30 day readmit rate for MA patients is below 7%with national avg. 19%

Visiting Physician

- Dedicated physicians for home visits
- Patients: Unable or unwilling to see physician

  Crisis patients
- 2 visits / day per physician
- Improved palliative and hospice care

- **RESULT:** 71 Medicare admissions prevented in 2 years for savings of $780,000

Hospitalist Services

- Expanded from two to four hospitals
- COPC is placing hospitalists at our expense

Quality Nurses

- 5 embedded RN's use plan claims data and EHR to close care gaps
  - Examples: mammography, colon Ca screen, immunizations
- Follow quality metrics for both HEDIS and Stars measures
- Message physicians with EHR

Care Coordination

- Identify patients in 5% highest risk recognized by hospitalization or physician referral
- RN/LSW to assess and meet clinical and social needs
- 1000 patients enrolled in 2015

- **RESULT:**

	2013	2014
COPC admits/1000	191	151

national avg. 284 (Ohio in 2012, 329/1000)

400 admissions prevented on 10,000 patients

Medical Neighborhood

- Address barriers to care and health
  - Financial
  - Transportation
  - Mental illness
  - Social support
  - Housing
  - Education

Rising Risk Population

Those in the 20% that are “next years” high risk patients

- Diabetes out of control
- COPD
- Asthma

ER Intervention

- Observation stays have increased
- Pilot program with 9 payers at local ER
- Physician and RN in ER
- Access to outpatient record and schedule

- **RESULT:** 400 observation stays prevented in 9 months. Estimated $1.2M savings

What are we learning?

- Incentives drive behavior for both patients and physicians
- Patient centered care creates value
- PCP burnout is real and a threat
- ER utilization remains too high
- Few employers are demanding value
- Skilled nursing is over utilized

2016 Initiatives

- Improved End of Life Care
- Skilled nursing facility initiative
- Admitting Officer of The Day for ER intervention
- Evening call center for patients

QUESTIONS?