



*Strategies to Achieve Alignment, Collaboration, and Synergy
Across Delivery and Financing Systems*

**The Comprehensive Care, Community, and Culture
Program**

*Research In Progress Webinar
Wednesday, May 22, 2019
12:00-1:00 pm ET/9:00-10:00am PT*

Agenda

Welcome:

Anna Hoover, PhD
Systems for Action
College of Public Health University of Kentucky

Presenter:

David Melzer, MD, PhD
Director of Center for Health and the Social Sciences
University of Chicago

Commentary:

Walter Kindred
President South Shore Cultural Center Advisory Board
C4P Patient & Community Advisory Board Member

Q&A:

Moderated by Dr. Anna Hoover



Presenter



David Meltzer, MD, PhD

Director of Center for Health and the Social
Sciences

University of Chicago



Commentator



Walter Kindred

President South Shore Cultural Center Advisory Board

C4P Patient & Community Advisory Board Member



Effects of the Comprehensive Care, Community and Culture Program (C4P) on Patient Activation and Hospital Admissions in Medicare Patients at Increased Risk of Hospitalization: Findings of a Randomized Trial

David Meltzer MD, PhD, Harold Pollack PhD, Emily Perish MPP,
Andrea Flores MPP, John Cursio PhD

for the CCP/C4P Research Group

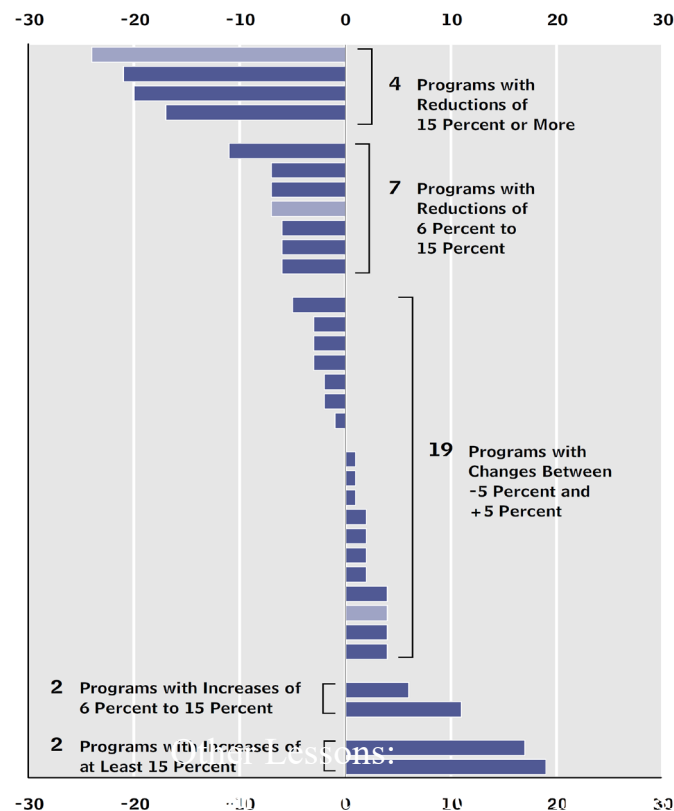
May 22, 2019

Background

- As US seeks to control health care costs and improve outcomes, improving care for patients at increased risk of hospitalization is critical
 - A small fraction of patients account for a large fraction health care spending
 - Hospitalization-related costs are a large fraction of these costs
 - Improving coordination of inpatient and outpatient care a key opportunity
 - Socioeconomically patients may be at increased risk of care coordination problems
- Payment models increasingly aligning incentives for improvement
 - Readmissions penalties
 - ACOs and shared savings
 - Capitation
- Solutions not easy

Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment (CBO, January 2012)

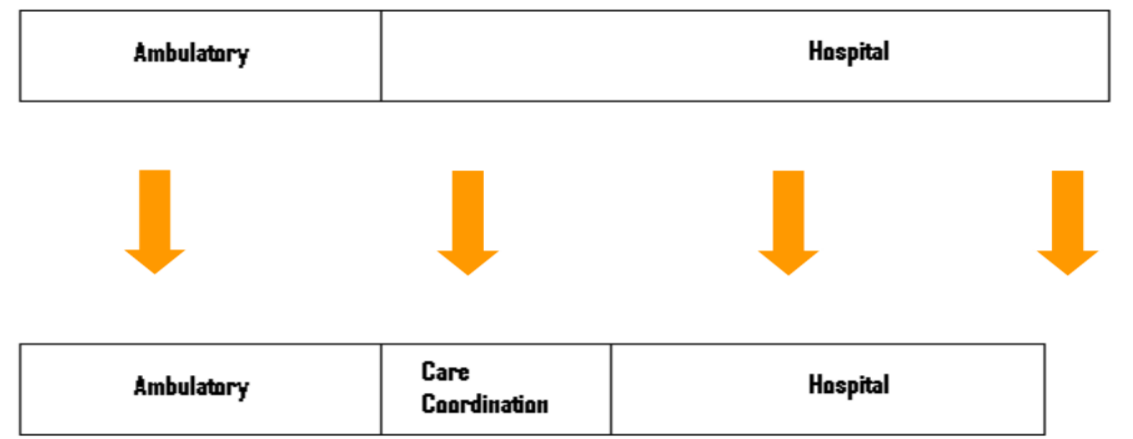
(Percentage change in hospital admissions)



Source: Congressional Budget Office.

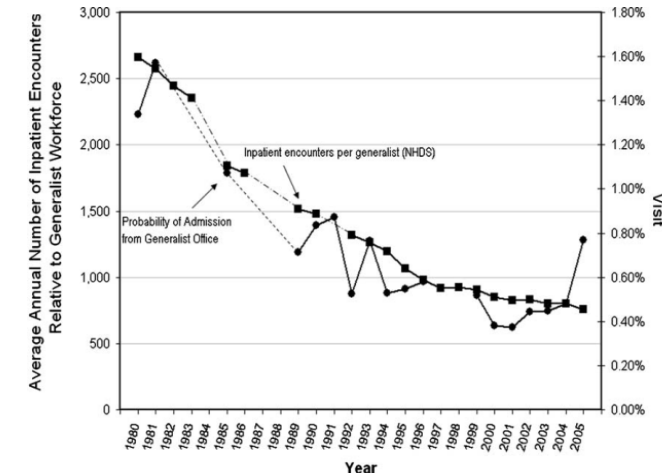
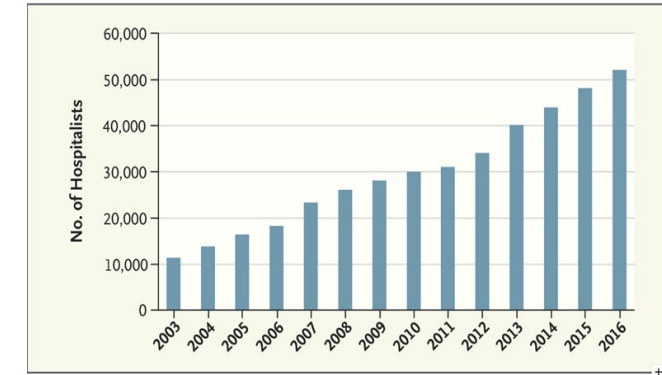
Note: Bars with lighter shading represent programs with fewer than 400 enrollees. The estimates for those programs are less precise than the estimates for the other programs.

Design Feature	Number of Programs	Average Effects (Percent)		Change in Regular Medicare Spending Needed to Offset Programs' Fees ^b (Percent)
		Hospital Admissions	Regular Medicare Spending ^a	
Program Fees Put at Risk				
Yes	18	0	-1	-11
No	16	-2	1	-13
Substantial Direct Interaction Between Care Managers and Physicians				
Yes	7	-7	-6	-13
No	27	0	0	-11
Interaction Between Care Managers and Patients ^c				
By telephone and in person	8	-7	-3	-13
Primarily by telephone	23	1	0	-11
All Programs	34	-1	0	-11



Hospitalists

- Change from traditional model of primary care physicians (PCPs) who care for patients in and out of the hospital
 - Hoped to improve care, lower costs
 - Advantages: Inpatient expertise, presence
 - Disadvantages: Discontinuities, loss of Dr-Pt Relationship
 - Net Effect: Modest
- Why did hospitalists grow?
 - Belief improve hospital care
 - Needs of primary care
 - Declining hospital vs. ambulatory volumes discourage traditional PCP
 - Declining hospital use with shift from hospitalization to ambulatory care
 - Increased ambulatory use with growth of preventive care
 - Organization of physicians into groups facilitated specialization



NOTE: Dotted lines indicate missing years of data

Ambulatory Economics Theory of Hospitalist Growth

(Meltzer, Chung, NBER Working Paper, 2010)

- Compare time costs of two models:
 - Traditional model:
 - Internist time to see patients in hospital, clinic, transport
 - Hospitalist/PCP model
 - Hospitalist time to see patient in hospital, communicate with PCP
 - PCP time to see patient in clinic, communicate with hospitalist
 - Cost of PCP/Hospitalist vs. traditional model driven by per capita communication costs relative to transport costs for a traditional internist

$$\Delta Cost_{PCP/Hospitalist \text{ vs. Traditional}} = 2\pi t_C - t_T \frac{(t_A + \pi t_H)}{(T_I - t_T)} = 2\pi t_C - \frac{t_T}{N_{IA}}$$

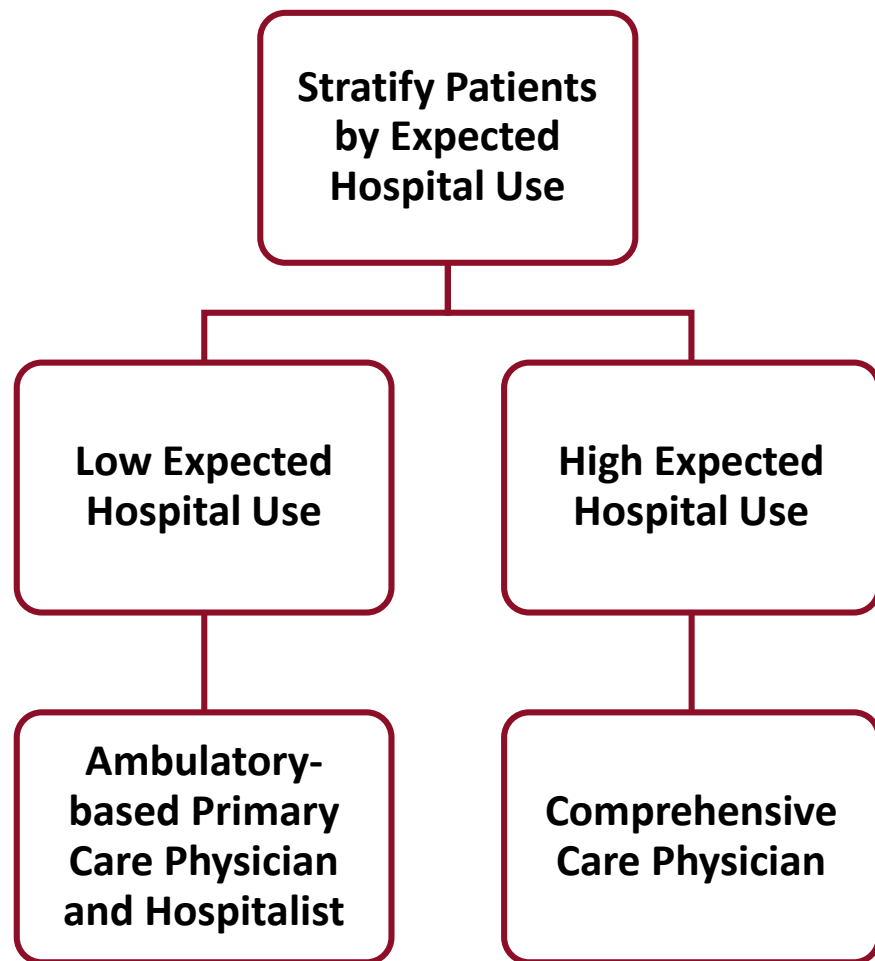
- Cost of PCP/Hospitalist Model vs. Traditional Model falls when:
 - Admissions (π) fall relative to ambulatory visits
 - Communication costs (t_C) decline
 - Transport costs (t_T) rise
 - Physician work hours (T_I) decline
- Confirm with data on PCP use of hospitalists from Community Tracking Study



What is the Value of the Doctor-Patient Relationship for the Hospital Setting? And for Whom does it Matter?

- Rich literature on the value of the doctor-patient relationship
 - Trust, interpersonal relationship, communication btw. doctor/patient, knowledge of the patient
 - Patients value seeing their own doctor in the hospital
 - But willingness to pay is not so high
 - Observational studies show lower costs, better outcomes with continuity of care
 - Care by PCP for > 10 years: 15% lower Medicare costs (Weiss et al AJPH 1996)
 - Lung CA patients cared for by own doctor in terminal hospitalization have 25% lower (OR=0.74, $p<0.01$) odds ICU use (Sharma et al, Annals, 2009)
 - One experimental study
 - Wasson et al (JAMA, 1984) randomized 776 complex VA patients to see same physician vs. different physician in each primary care visit. Continuous care group:
 - 49% lower emergent hospitalizations (20% vs. 39%, $p<0.002$)
 - 38% lower hospital days (6.6 vs. 9.1, $p<0.02$)
 - 74% lower ICU days (0.4 vs. 1.4, $p<0.01$)
- Discontinuity harmful/costly, esp. for complex, frequently hospitalized patients
- Better coordination of in/outpatient care may improve outcomes, but can we do it w/o offsetting any savings?

CCP Approach to General Medical Care



• Advantages?

- Most frequently hospitalized patients get own doctor in both settings. Continuity:
 - Is valued by patients
 - Decreases unneeded testing/treatment, errors
 - Lowers doctor costs (travel, history taking)
- All hospitalized patients get doctors with significant hospital experience and presence
 - Physicians can be specialists
- Patient choice restored
- CCP model can work for physician
- Patient-centered medical home / bundling / readmission penalties
- Smaller primary care base can fill hospital

• Challenges?

- Are enough patients willing to switch?
- Will doctors let patients switch?
- Will doctors do this job?
- Can it be economically viable?

CMMI Study

- Began in 2012 with funding from the Center for Medicare and Medicaid Innovation (CMMI)
 - Established CCP Program at University of Chicago Medicine, which provides general medical care to socioeconomically vulnerable population on Chicago's South Side
 - From November 2012 to June 2016, randomly assigned 2,000 Medicare and dual-eligible patients at increased risk of hospitalization to CCP or to 'standard care' by different physicians in and out of the hospital
 - If patients in standard care did not have a PCP or wanted a new PCP, we offered help to find one
- Primary Aims: To determine whether providing Medicare patients at increased risk of hospitalization with access to care from a CCP compared to standard care by different physicians in and out of the hospital affects patient outcomes over 1 year, including
 1. Patient experience with health care (satisfaction with provider)
 2. Health outcomes (self-rated general health status and mental health status)
 3. Resource utilization (patient-reported hospitalization rate, Medicare claims)

Key CMMI Design Elements

Lessons from Literature/Theory	Program Element
Focus on patients at increased risk of hospitalization	Patients expected to spend >10 days in hospital in next year; up to 40% of general medicine days, annual Medicare costs \$50,000- \$100,000 per year; diverse recruitment sources, including resident clinics
Maximize Direct Interaction with CCP/PCH	Panel size: 200. AM on wards. Midday buffer. PM in clinic.
Build Interdisciplinary Team	5 CCPs = 1000 patients. Organize CCP, RN, LPN, LCSW, clinic coordinator around common patient medical and psychosocial needs
Minimize costs (esp. coordination costs)	Small, well-connected teams, provider continuity, daily multidisciplinary rounds
Focus on care transitions	Post-discharge calls, Health IT
Financial incentives	Prepare for shared savings (randomized internal controls)
Sustainable roles and training for care team	Support the team members (group to spread weekend coverage, night coverage, psychosocial support, relevant clinical training (e.g., communication, palliative care), academic development, recognition).
Rapid cycle innovation	Frequent, data-driven meetings that seek to engage relevant leaders
Rigorous evaluation	2,000 person RCT, Triple Aim (Better Care Better Health, Lower Costs), survey and Medicare claims data, external and internal evaluators

Data Collection and Analysis

- Patient reported data from in person baseline survey prior to randomization and quarterly surveys by phone of patients in CCP and standard care arms
 - Patient demographics
 - Patient-reported outcomes:
 - Physician ratings (Hospital and Consumer Assessment of Health Plans rating (1 (worst possible) to 10 (best possible))
 - Self-rated general health status and mental health status (1 (poor) – 5(excellent))
 - Self-reported number of hospitalization in past quarter
- Analysis
 - Comparison of baseline demographics and health status measures
 - Longitudinal mixed effect models with logit for physician ratings (best possible) and health status variables (excellent or very good) and zero-inflated Poisson model for number of hospitalizations
 - Random intercepts to account for repeated measures within subjects
 - Covariates: gender, age categories (50-64,65-74,75-84,85+), dual-eligible status, Hispanic, number of hospitalizations at baseline
 - Pattern-mixture models (Little, JASA 1993) to address missing data and deaths
 - ~89% 1-year follow-up rate (91% CCP, 87% SC), 12.5% 1-year mortality rate

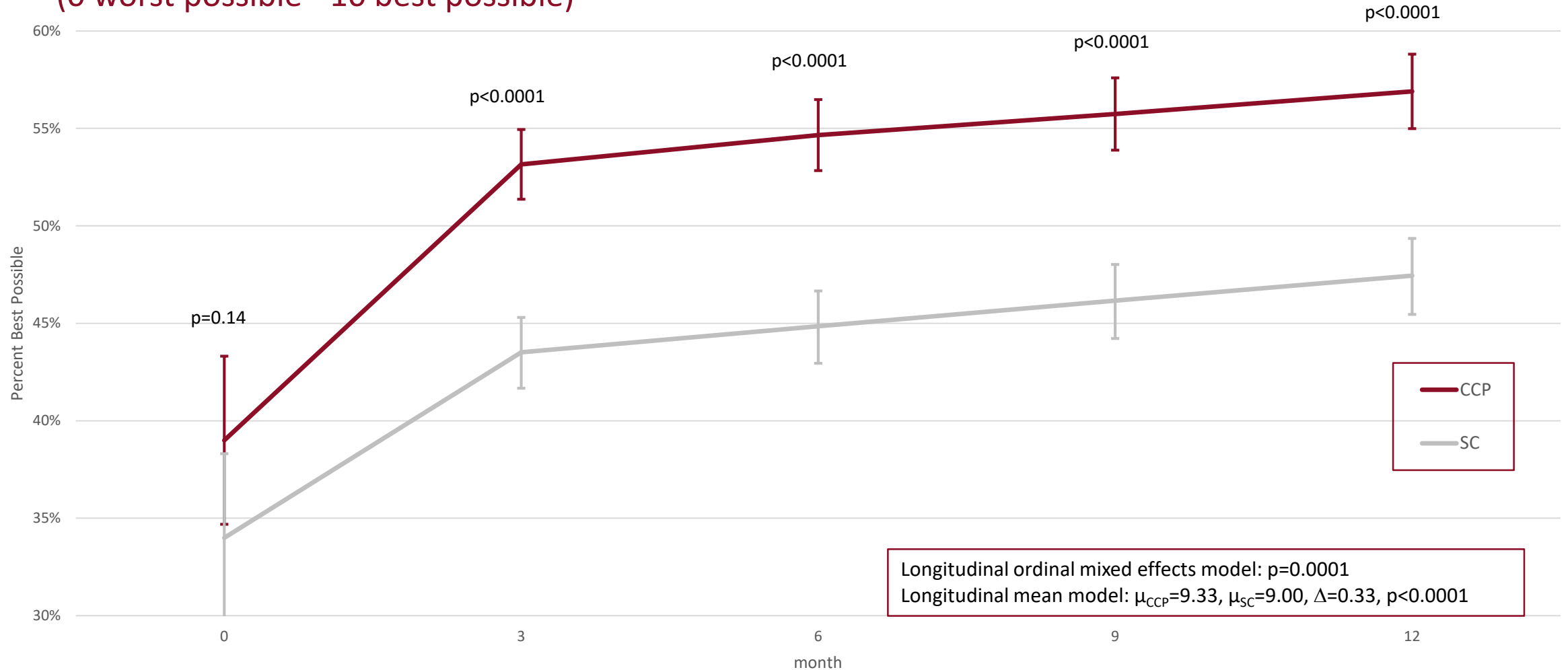
CCP Subjects

Characteristic	CCP N=996	SC N=996	P-value
Female, %	62	62	0.58
Dual, %	46	43	0.14
Black, %	88	86	0.14
White, %	6.9	7.6	0.55
Hispanic, %	3.7	3.8	0.91
Age in years, mean (SD)	63 (16)	64 (16)	0.33
Age groups %			
<50	22	21	0.55
50-64	25	24	0.64
65-74	30	30	0.71
75-84	17	17	1.00
85+	7.2	8.6	0.25

Characteristic	CCP N=996	SC N=996	P-value
Health Outcomes			
Provider rank, best possible, %	39	34	0.14
General health, excellent + very good, %	11	14	0.14
Mental health, excellent + very good, %	39	36	0.12
Hospitalizations in previous 12 months, %:			0.51
0	0.4	0.3	
1	33	33	
2 or 3	27	28	
4 or 5	6.7	7	
5 < times <= 10	4.4	3.5	
10 < times	28	27	
Missing	0.7	1.6	
Average per quarter (minimum est.)	1.13	1.10	

Physician Rating

(0 worst possible - 10 best possible)



CCP	478
SC	481

602

544

517

494

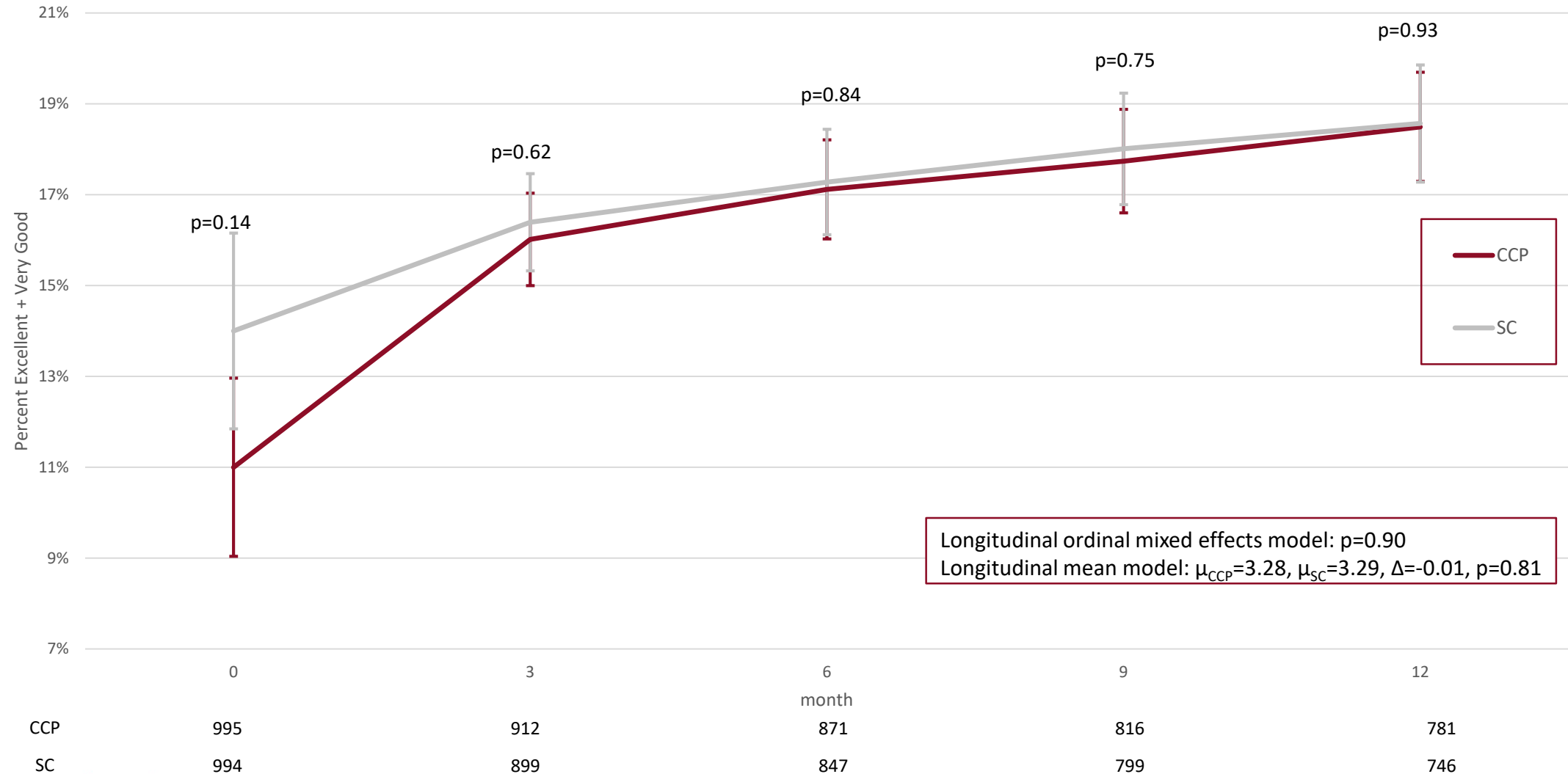
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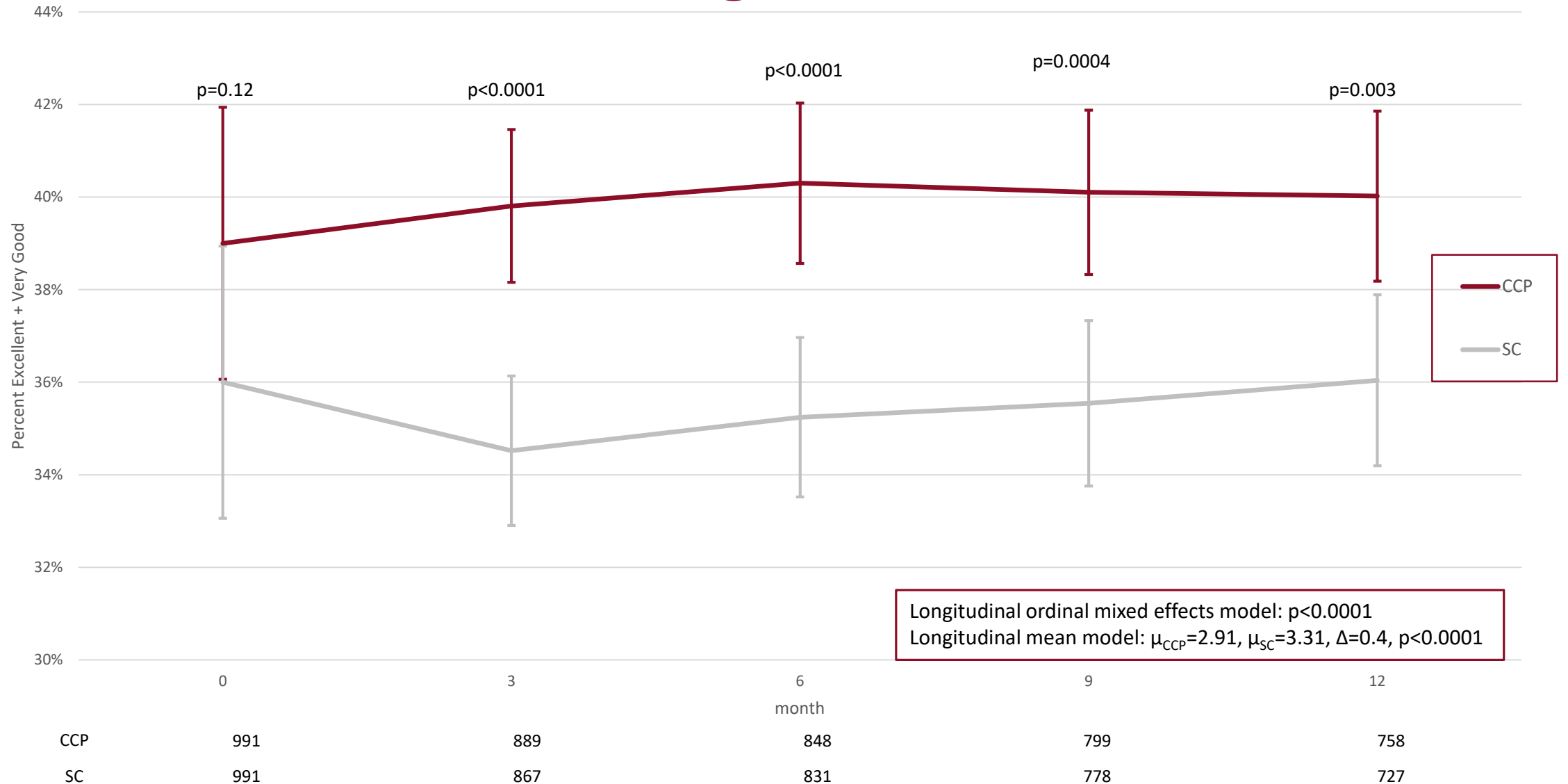
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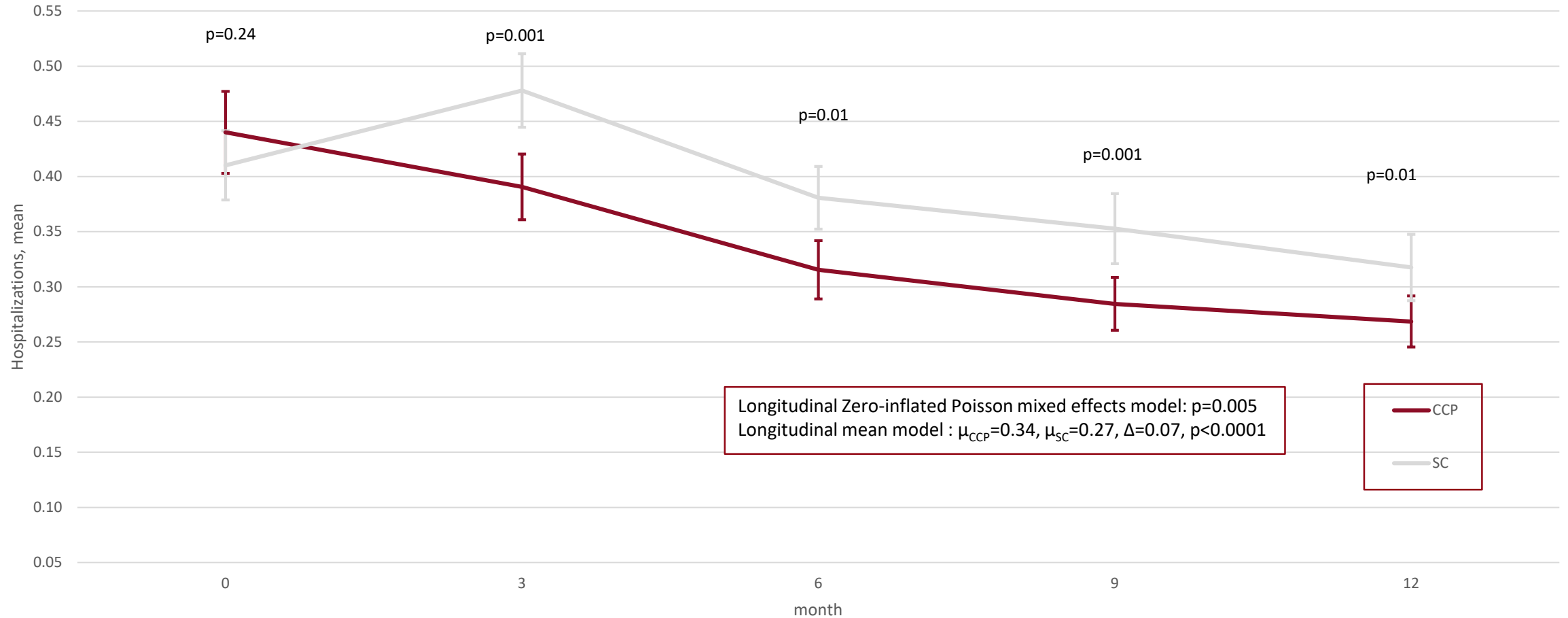
General Health Rating



Mental Health Rating



Follow-up Hospitalizations



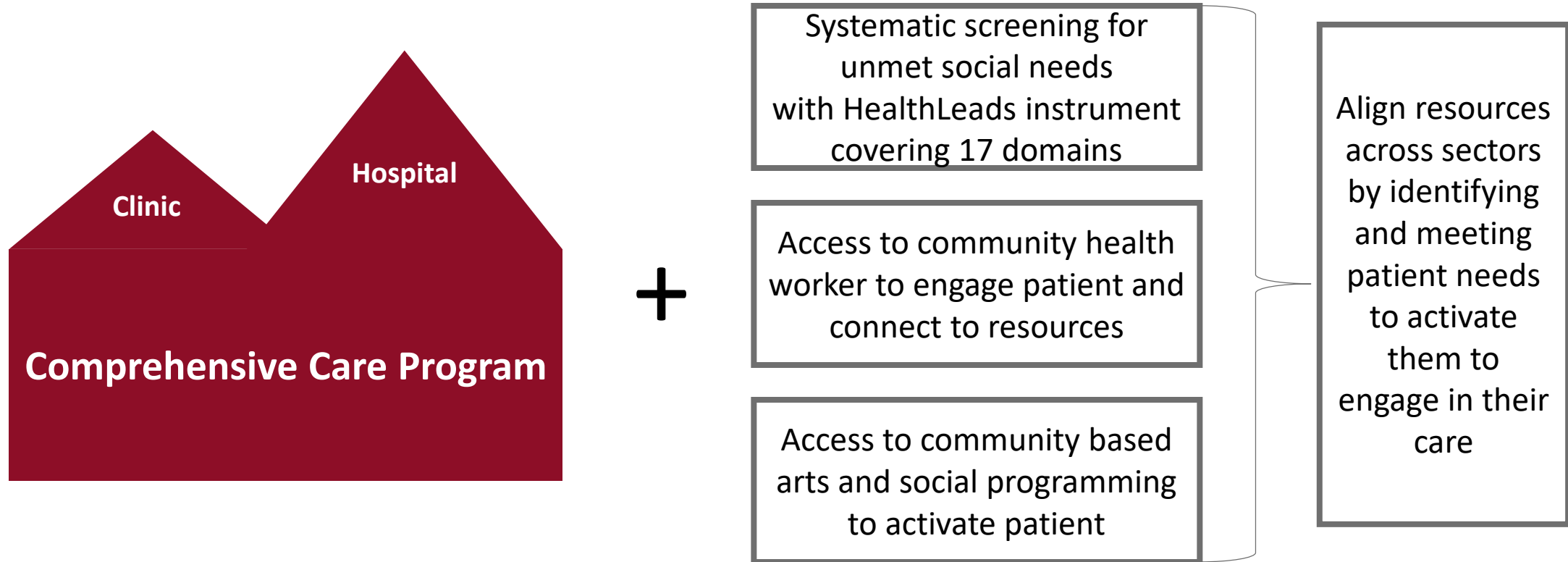
CCP Study Conclusions and Limitations

- It was possible to implement a CCP program at UCM
 - Positive patient outcomes, acceptable volumes for clinicians, acceptable ROI for hospital
- CCP care improved patient experience and at least maintained patient outcomes while reducing hospitalization by ~20% up to 1 year
 - Number needed to treat = enroll 4 patients to prevent 1 hospitalization over 1 year
 - Prevented about 250 hospitalizations in 1000 patients over year
 - Implies ~ \$4,000 lower hospital cost/patient/year if avg. cost of hospitalization ~\$15,000
 - Program savings of \$4 million/year substantially greater than program costs
- Limitations
 - Self-reported outcomes may be biased by patients and less than complete follow-up
 - Medicare claims data not yet available to assess hospitalization and costs
 - Dual eligibles more likely to drop out due to Illinois Medicare-Medicaid Alignment initiative, especially healthier ones
 - New CCP program, one hospital, limited set of doctors, socioeconomically disadvantaged population

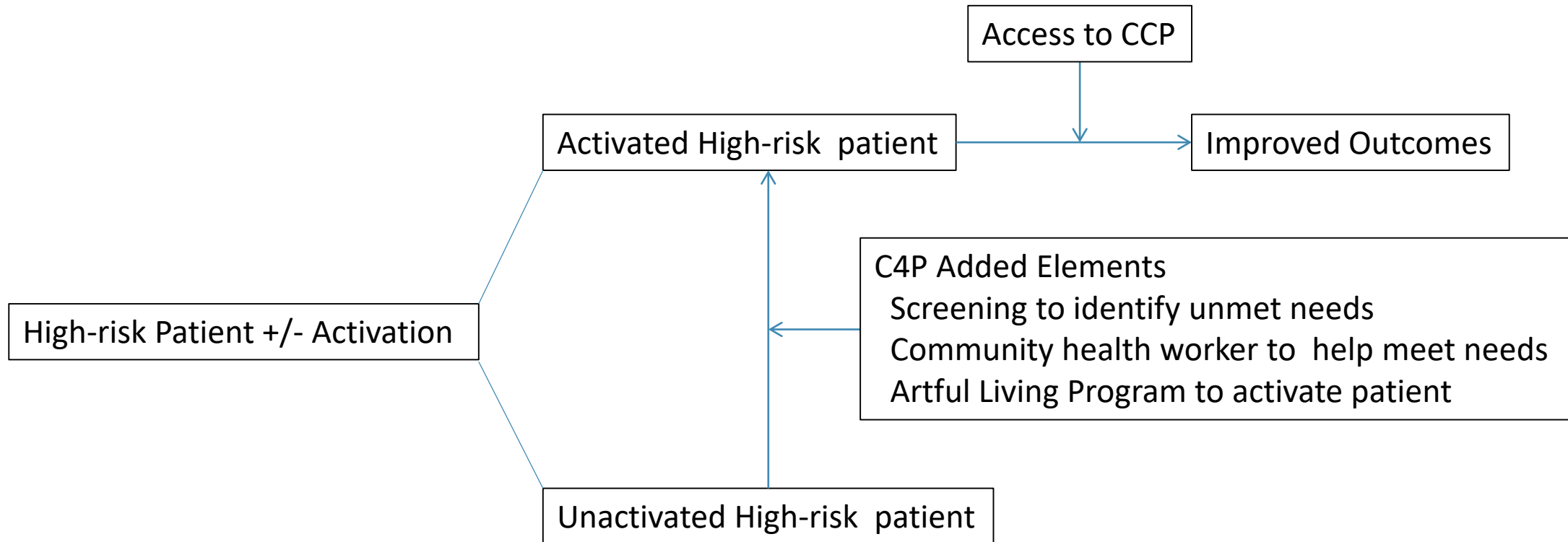
Needs for Improved Engagement

- ~30% patients randomized to CCP not engage despite efforts to reach engage them
 - No appointments
 - Make but not keep appointments
 - Other forms of low engagement add to this
- All forms of engagement create opportunity to benefit patients, lower costs
 - Frequently admitted, average costs ~\$75-100K/year
- Why do they not engage?
 - Diverse demographics
 - Young/old, well/sick
 - Low income, little social support, history of low engagement
 - Qualitative interviews
 - *“If I had transportation, I wouldn’t have a problem getting up... I don’t know if it’s just depression or what but a lot of times, I just don’t want to be bothered. It’s been like that a lot.”*

Comprehensive Care, Community & Culture Program (C4P)



C4P Conceptual Model



CCP Study

- Began in 2016 with funding from RWJF
 - Established C4P Program at University of Chicago Medicine
 - From August 2016 to February 2019, randomly assigned 526 Medicare and dual-eligible patients at increased risk of hospitalization to C4P vs. CCP Standard Care (SC) (different physicians in/out of hospital, help to find new PCP if desired)
- Primary Aims:
 - 1) Gain experience operating C4P
 - Operational experience
 - Insight into patterns of unmet social needs and implications for program design
 - 2) Pilot assessment of whether providing Medicare patients at increased risk of hospitalization access to C4P vs. CCP vs. SC affects patient outcomes over 1 year, including:
 - Patient Activation (Patient Activation Measure (PAM))
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Aim 1: Operational Lessons

- Iterative development of program elements critical
 - Recruitment and training of team (CHW, social workers)
 - Development of team roles/responsibilities, workflows, tools, resources
 - Engagement with patients in program important for intervention refinement
 - Iterative experimentation
 - Refinement of program dependent on recruitment
 - Critical mass of patients important; some patients especially engaged/impactful
 - “Standard care” not static; pressure for care coordination model as standard care in ACO
- Engagement possible
 - 30% of patients in C4P >3 months engaged in arts/social programming
 - Many regulars, not necessarily more socially engaged otherwise, health/psychosocial barriers to engagement important
 - 68% of C4P patients engage with CHW, SW
- Unmet social need data highly informative

Original Health Leads Assessment for Unmet Needs

(A Lot, Some A Little, No, DK, Refuse)

1. Food
2. Housing
3. Money to pay for basic needs, like utilities, coats and shoes, other household needs
4. Employment, education or job training
5. Help applying for public benefits, like food stamps or disability
6. Child care or activities for children you care for
7. Issues with school for children you care for
8. Legal assistance
9. Health insurance or dental insurance for you or your family
10. Transportation
11. Personal safety
12. Mental health or substance abuse treatment
13. Budgeting or financial planning
14. Companionship or social support
15. Engaging in activities you enjoy
16. Healthy eating and physical activity
17. Spiritual or religious support (added to original 16 Health Leads items)

Distribution of Unmet Needs at Baseline

# of Unmet Needs	# of Respondents	Cumulative % Respondents	Cumulative % Unmet Needs
0	159	32%	0%
1	90	49%	6%
2	50	59%	13%
3	50	69%	24%
4	33	76%	33%
5	27	81%	43%
6	29	87%	55%
7	12	89%	61%
8	12	92%	68%
9	10	94%	75%
10	14	96%	85%
11	9	98%	92%
12	3	99%	94%
13	3	99%	97%
14	1	100%	98%
15	2	100%	100%

59% respondents have only 0-2 unmet needs, accounting for only 13% of unmet needs

other 41% of respondents account for 87% of unmet needs

24% have 5+ needs, accounting for 67% of unmet needs

Latent Class Analysis of Unmet Social Needs

Class 1: Many basic social needs

Class 2: Healthy living/social engagement needs

Class 3: Health insurance/financial needs

Class 4: Child-related needs

Class 5: Few unmet needs

Class and % Participants in Class (n=456)	1 (8%)	2 (14%)	3 (21%)	4 (3%)	5 (53%)
Food	68%	21%	34%	20%	0%
Housing	65%	14%	23%	27%	5%
Money	92%	26%	57%	60%	1%
Employment or Training	41%	15%	16%	40%	5%
Health Insurance	68%	39%	64%	53%	13%
Applying for Public Benefits	68%	21%	41%	40%	2%
Child Care or Activities	11%	0%	1%	80%	0%
Children School Issues	5%	0%	0%	93%	0%
Legal	57%	23%	24%	73%	1%
Transportation	92%	30%	50%	60%	5%
Personal Safety	62%	12%	10%	27%	2%
Treatment for Mental Health or Substance Abuse	35%	15%	5%	0%	2%
Budgeting	68%	20%	6%	7%	2%
Companionship	84%	45%	7%	13%	1%
Engaging in Enjoyable Activities	92%	100%	8%	20%	4%
Healthy Eating / Physical Activities	100%	85%	25%	40%	8%

CCP Study

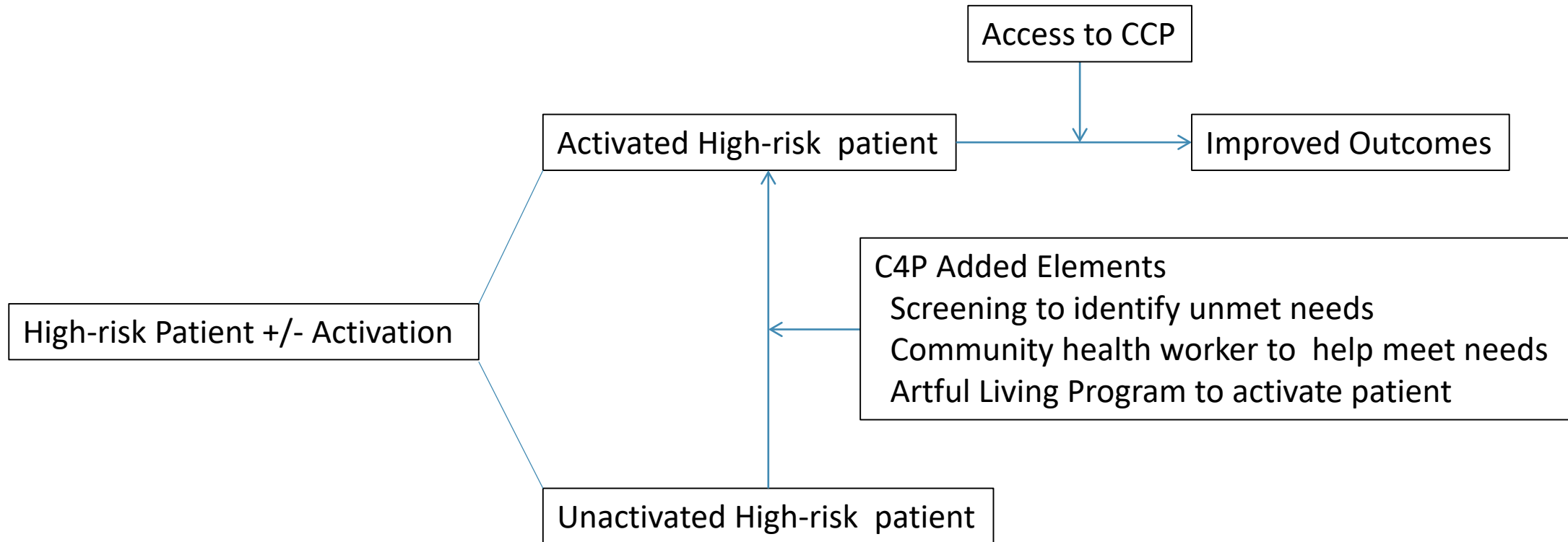
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C4P Subjects

Characteristic	SC N=172	CCP N=180	C4P N=182	P-value
Female, %	60	64	58	0.56
Dual, %	42	54	44	0.05
Black, %	87	88	86	0.65
White, %	11	9	9	0.65
Hispanic, %	2	3	4	0.48
Age in years, mean (SD)	62 (15)	62 (14)	60 (15)	0.29
Age groups %				0.79
<50	22	19	27	
50-64	30	31	28	
65-74	29	31	28	
75-84	14	16	13	
85+	6	3	5	

Characteristic	SC N=172	CCP N=180	C4P N=182	P-value
Health Outcomes				
PAM, highest, %	41	42	43	0.78
PAM, continuous, mean (SD)	71 (17)	72 (19)	71 (18)	0.05
Hospitalizations in previous 12 months, %:				0.56
0	25	18	22	
1	36	36	34	
2 or 3	22	24	27	
4 or 5	9	12	11	
5 < times <= 10	5	6	1	
10 < times	1	1	2	
Missing	2	3	3	
Average per quarter	0.85	0.99	0.74	

C4P Conceptual Model



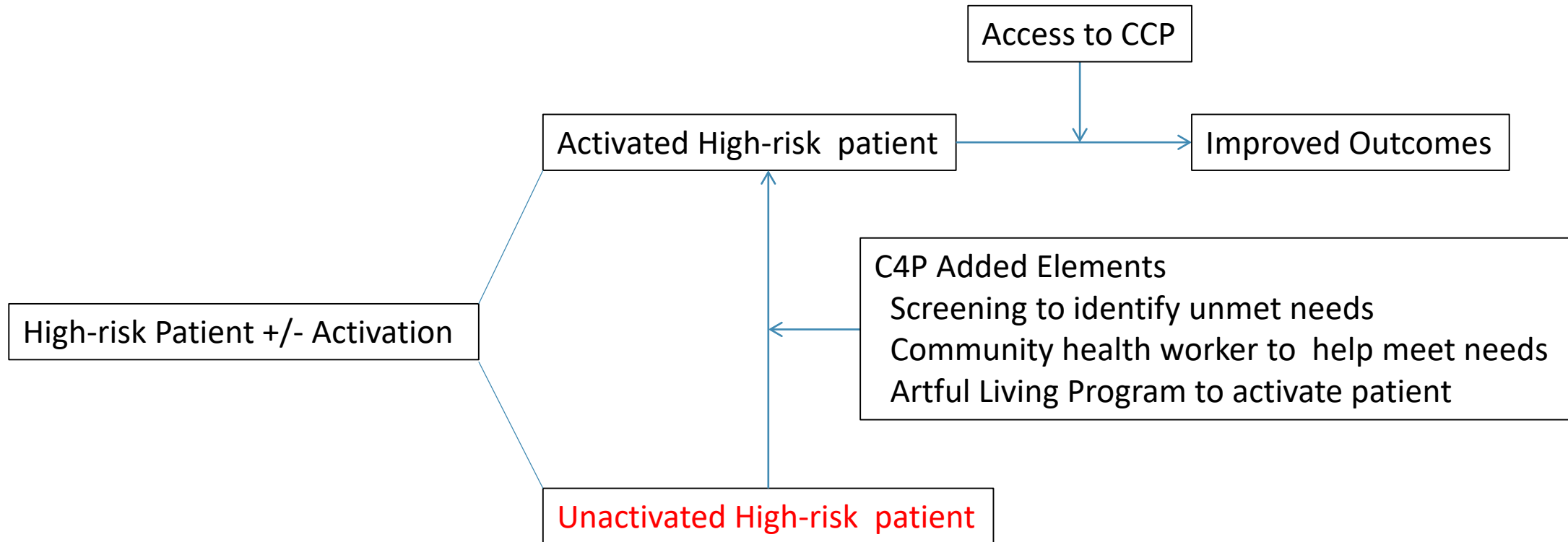
Preliminary Results by Study Arm

Outcome	Measure	Comparison to SC				C4P versus CCP		Favors C4P?
		CCP	p-value	C4P	p-value	difference	p-value	
Hospitalization rate	event rate ratio	1.114	0.52	0.730	0.16	0.638	0.04	yes
PAM (highest)	odds ratio	1.674	0.22	1.978	0.10	1.181	0.67	yes
PAM continuous	mean	3.475	0.16	4.953	0.04	1.478	0.52	yes

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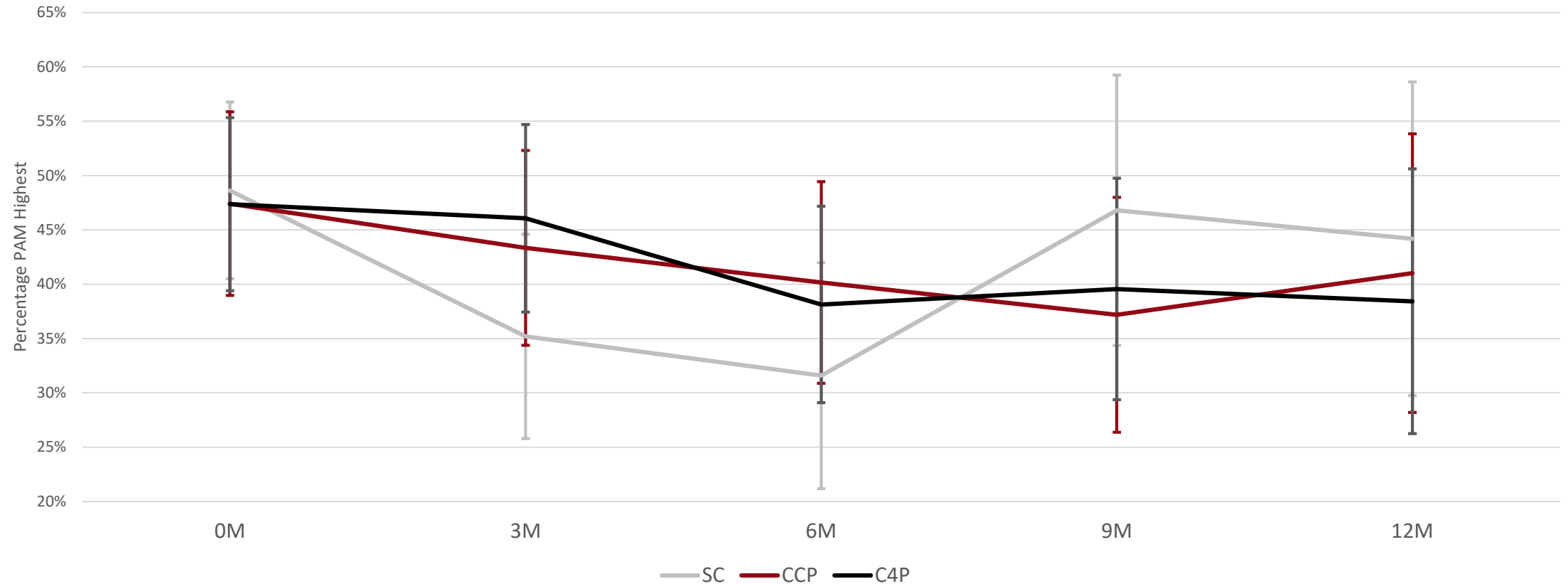
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		CCP	p-value	C4P	p-value	difference	p-value	
Hospitalization rate	event rate ratio	1.114	0.52	0.730	0.16	0.638	0.04	yes
High baseline hospitalization	event rate ratio	0.879	0.67	0.558	0.07	0.634	0.14	yes
Low baseline hospitalization	event rate ratio	1.329	0.31	0.830	0.52	0.624	0.09	yes
High baseline PAM	event rate ratio	1.021	0.95	0.968	0.92	0.948	0.88	yes
Low baseline PAM	event rate ratio	1.042	0.90	0.679	0.24	0.652	0.19	yes
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Patient Activation Measures

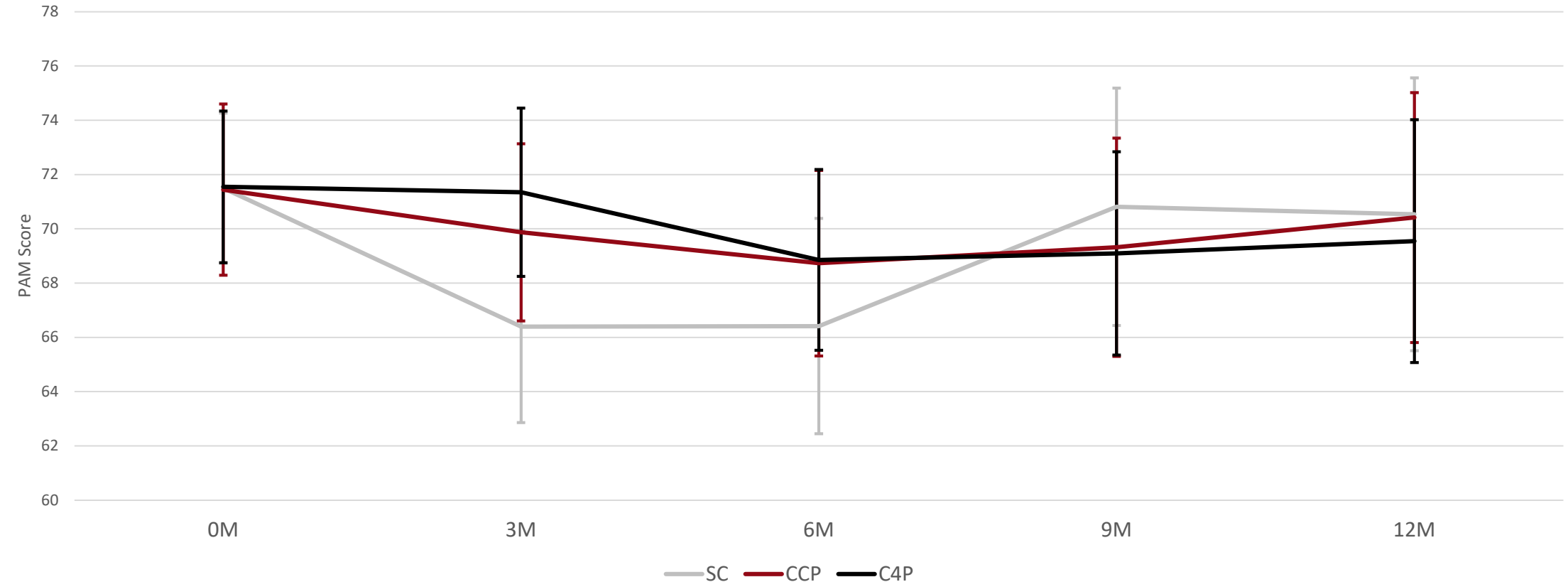
PAM Highest



SC	172	172	148	124	100
CCP	177	177	166	143	115
C4P	177	177	157	138	103

Patient Activation Measures

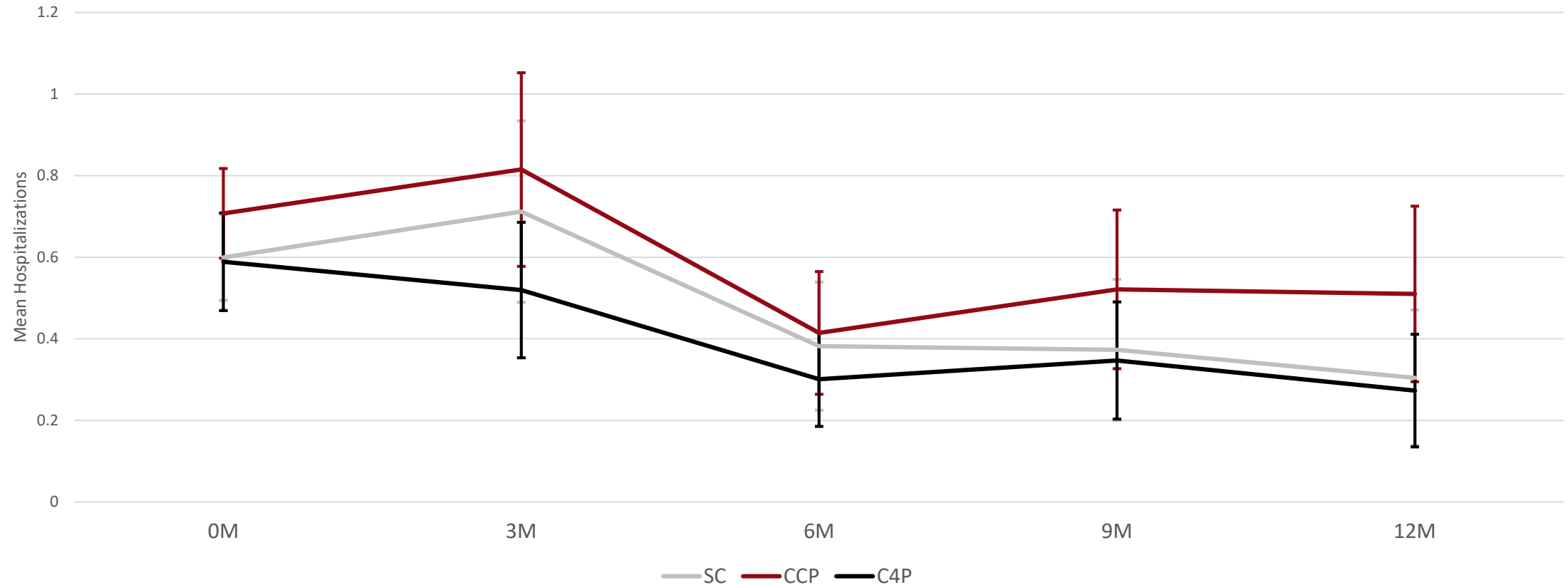
Continuous Measure



SC	172	172	148	124	100
CCP	172	177	166	143	115
C4P	177	177	157	138	103

Follow-up Hospitalizations

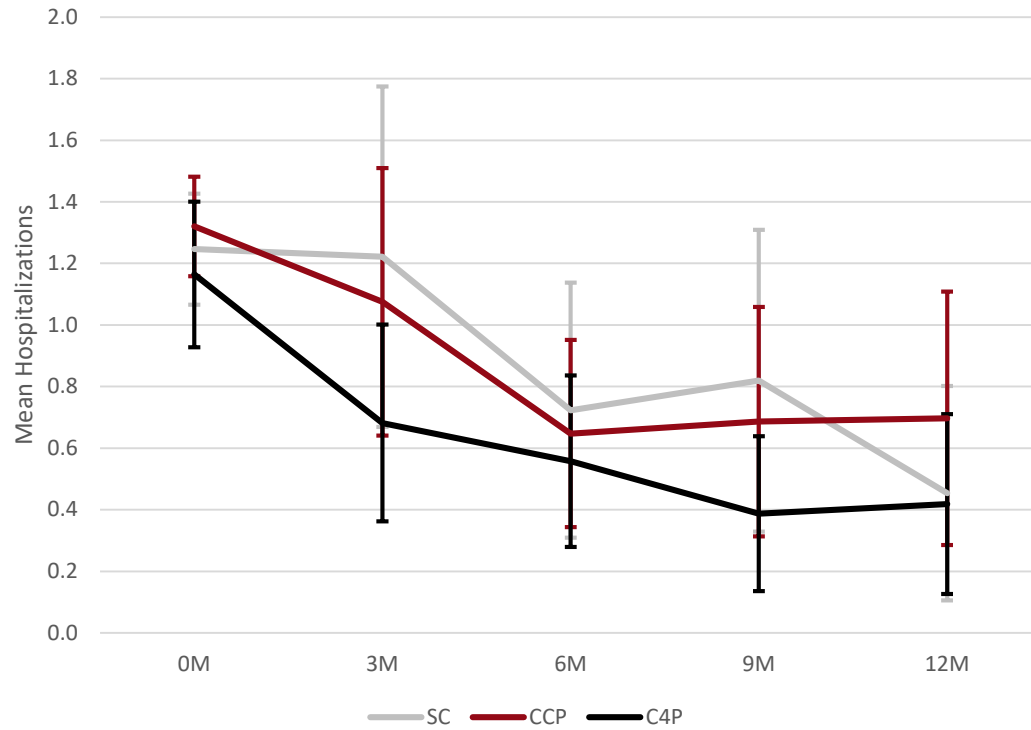
Overall



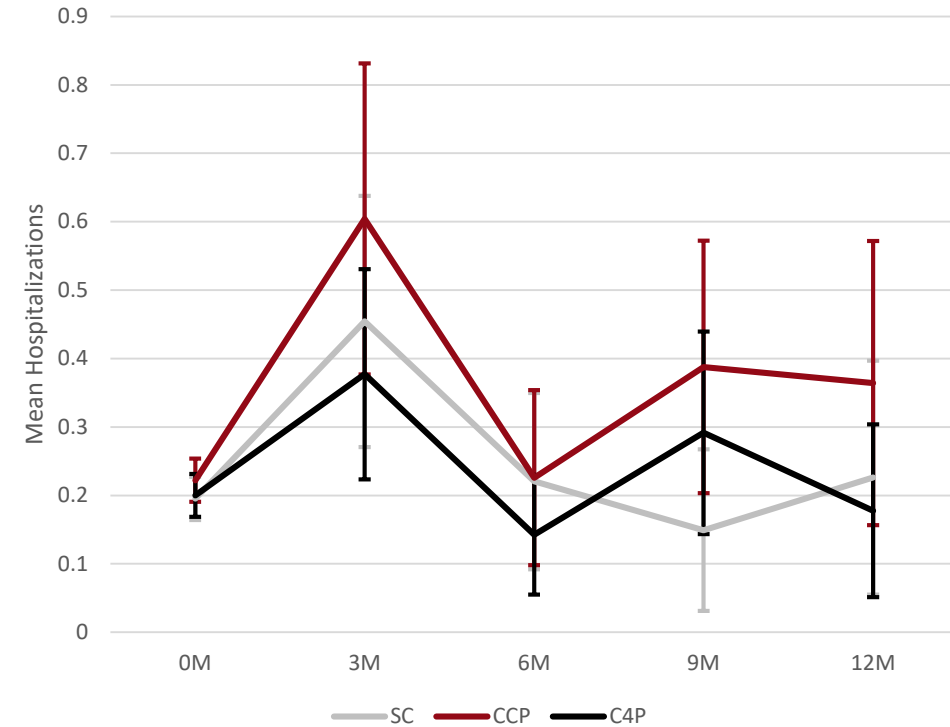
SC	172	172	148	124	100
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C4P	177	177	157	138	103

Follow-up Hospitalizations

Figure for C4P vs SC stratified by hospitalization at baseline level (High (left), Low (right))



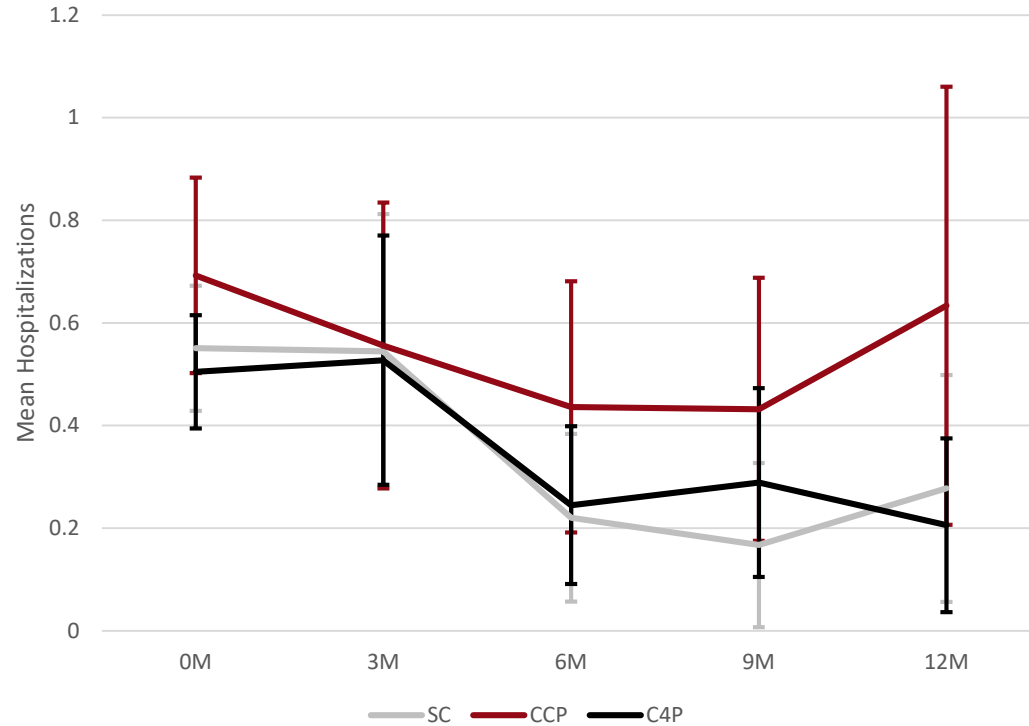
SC	65	65	56	46	39
CCP	76	76	68	58	41
C4P	71	71	65	60	44



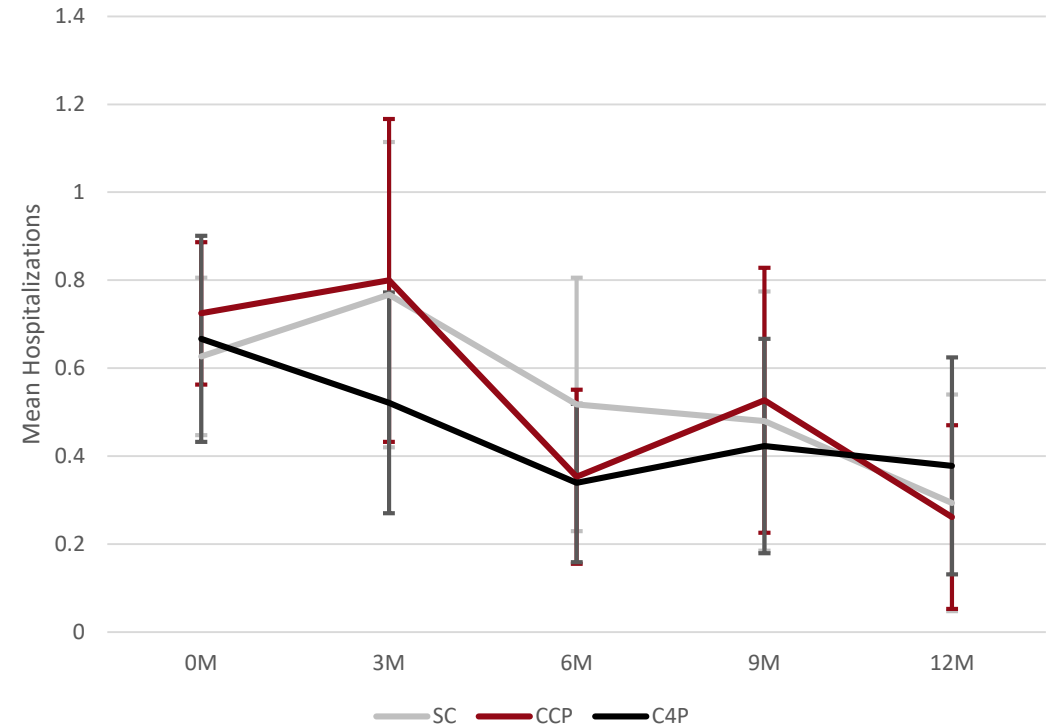
SC	107	107	92	78	61
CCP	104	101	89	80	62
C4P	106	106	101	83	71

Follow-up Hospitalizations

Figure for C4P vs SC stratified by PAM activation at baseline level (low (left), high (right))



SC	70	70	67	54	46
CCP	64	64	57	51	36
C4P	72	72	67	57	46



SC	76	76	63	52	42
CCP	71	71	67	61	44
C4P	80	80	76	69	55

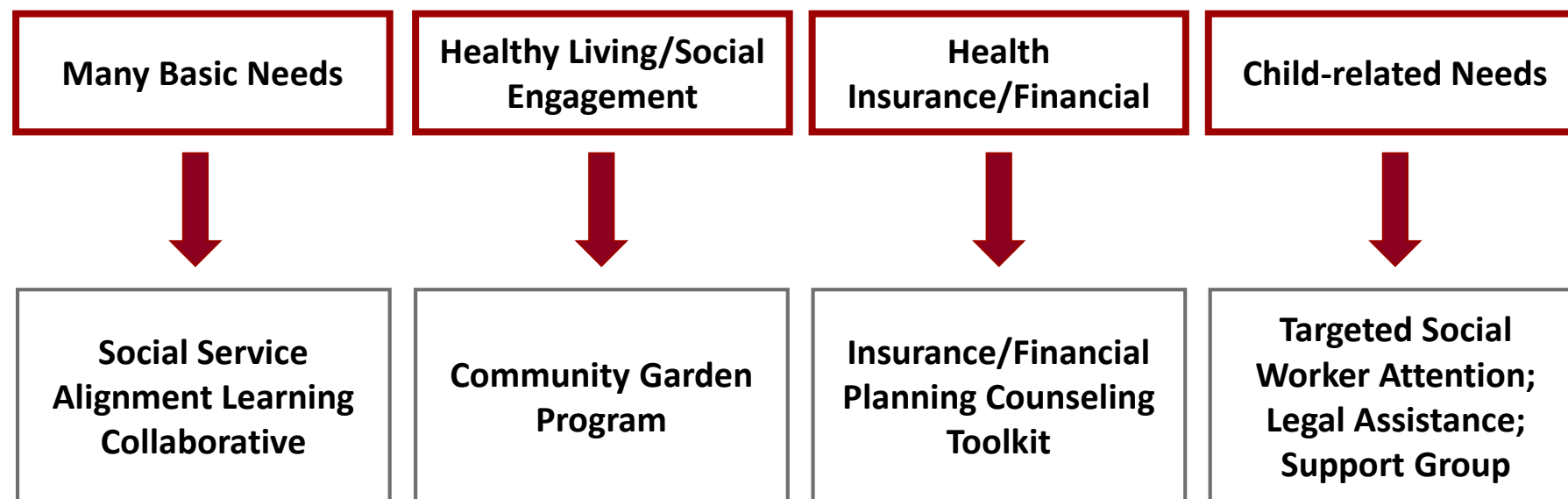
Conclusions/Limitations

- C4P operations iteratively improve, successful in engaging patients
- Even in small pilot, evidence of reduced hospitalization, increased activation with C4P vs. CCP, SC
 - More sample size needed
 - Claims data needed
 - Caution about excess survey burden, esp. for SC (trim survey almost 50%)
- Larger benefits of C4P vs. CCP in patients less activated at baseline
- Comparable benefits of C4P vs. CCP in patient with high or low baseline hospitalizations
 - Consider potential benefits of C4P in lower risk populations

Next Steps

- Complete analysis of CCP/C4P at UCM
 - CCP: Longer follow up (Donaghue), Costs, Duals/Non-Duals, hospitalization risk, qualitative assessment of Dr.-Patient relationship in CCP, EOL care
 - C4P: complete analysis of unmet social needs data, including over time, and analysis of outcomes data
- Phase 2 RWJ Study
 - C4P vs. CCP vs. CC RCT (1000/arm eventually)
 - Reduced survey burden
 - C4P tailored to clusters of unmet needs

Addressing Clusters of Unmet Social Needs through C4P



Note: Mental health and substance use issues pervade these clusters of needs

- Expand behavioral health services (inpatient/outpatient continuity)

Social Service Alignment Learning Collaborative



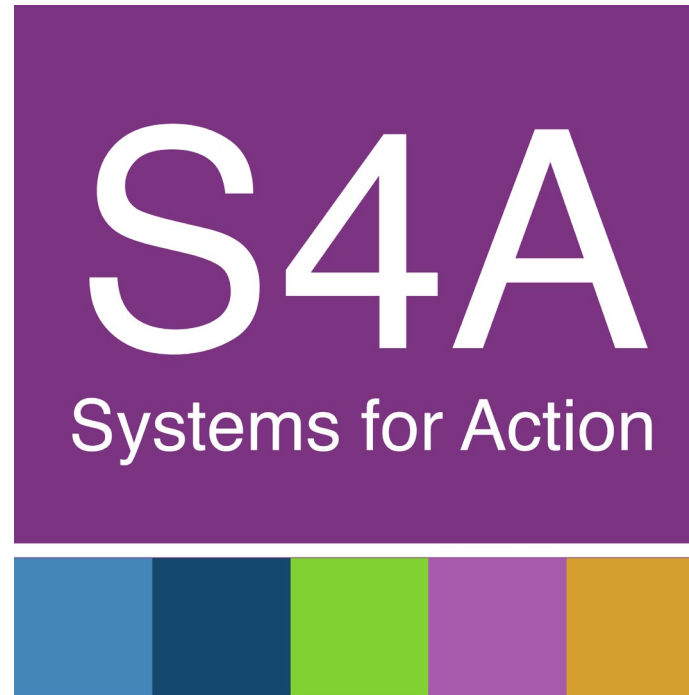
CCP/C4P Dissemination Efforts

- UCM
 - Migrating from fee for service to MSSP and other value based contracts
 - Expanding CCP/C4P to affiliated Ingalls Community Hospital
- Outside UCM
 - Vanderbilt, Kaiser Mid-Atlantic Region, National University Singapore implementing CCP or similar programs
 - CMS TCPI-funded Learning Collaborative through Great Lakes Practice Transformation Network
 - CMS reviewing Physician Focused Payment Model
 - Hope to engage other institutions (UK NHS, BCBS) interested in implementing and perhaps studying CCP/C4P

Thank You!

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Questions?



www.systemsforaction.org

Upcoming Webinars

- **June 26, 2019, 12 p.m., ET**
Systems for Action Individual Research Project
[Testing a Shared Decision-Making Model for Health and Social Service Delivery in East Harlem](#)
Carl Letamendi, PhD, MBA, and Rachel Dannefer, MPH, MIA, New York City Department of Health and Mental Hygiene
- **June 12, 2019, 12 p.m., ET**
Systems for Action Individual Research Project
[Testing a Shared Decision-Making Model for Health and Social Service Delivery in East Harlem](#)
Carl Letamendi, PhD, MBA, and Rachel Dannefer, MPH, MIA, New York City Department of Health and Mental Hygiene

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and

