

Where Does Comprehensive Primary Care Plus (CPC+) Lead Primary Care? Lessons Learned in Ohio and Northern Kentucky

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ABSTRACT

The Ohio and Northern Kentucky (OH/NKY) region of the five-year federal Comprehensive Primary Care Plus (CPC+) project included 560 primary care practices, supported by 11 payers, offering an opportunity to comprehensively assess outcomes associated with this multipayer primary care payment reform initiative. This analysis of the first three years (2017–2019) shows significant improvements in emergency department and hospital use across the population of approximately 1 million attributed lives. Medicare and Medicaid achieved greater gains than the commercial insurers, as these populations generally have more opportunity for improvement due to higher disease burden and access issues, respectively. Standardization of claims data aggregation, measure alignment, and consistency of goals are important if multipayer primary care transformation is to be expanded and sustainable. Anecdotal evidence suggests that these approaches support and rejuvenate the participating primary care practices.

INTRODUCTION

The Health Collaborative (THC) is a health information exchange with a 21-year history as a neutral advocate for data transparency and innovation to transform health care in the Ohio and Northern Kentucky (OH/NKY) region. THC was granted two complementary roles for OH/NKY in Comprehensive Primary Care Plus (CPC+), a regionally based multipayer initiative run by the Center for Medicare and Medicaid Innovation designed to improve primary care access, quality, and efficiency. For the five-year duration of the project, which ended December 31, 2021, THC oversaw (1) the learning/diffusion work for more than 560 participating practices, and (2) aggregation of the claims data from the 11 participating payers. Fulfilling both of these roles gave THC the unique opportunity and volume of data to understand and integrate the findings from these two activities.

Data aggregated from all payers provides both the practices and the program a comprehensive view of the results rather than just the narrow sliver of a practice's performance provided by any individual payer. For example, when examining aggregated data from the CPC Classic population (the predecessor to CPC+) in OH/NKY in 2018,¹ Medicare fee-for-service outcomes showed marginal improvement in cost and utilization, but the THC's all-payer data showed a more robust performance. In addition, we observed significant differences among different payer types studied.

Using the THC multipayer claims database, we examined the first three years of CPC+ data from the region. We looked at 16 cost and utilization metrics from 11 different payers that provide claims data for Medicaid, Medicare (including Medicare Advantage), and commercially insured populations. These results can be presented in both risk-adjusted and unadjusted data, and high performers can be identified by payer, provider system, and individual provider practice.

METHODOLOGY

Design

The purpose of this retrospective study was to gain insight into the progress of the CPC+ initiative in the OH/NKY region, 1 of 18 regions to have been selected by the Center for Medicare and Medicaid Innovation (CMMI) to offer population-based management fees and shared savings opportunities to primary care practices to improve the efficiency and efficacy of health care delivery. The OH/NKY initiative spanned Medicare, Medicaid, and commercial insurance plans that agreed to support about 560 participating primary care practices representing more than 2,800 regional providers.

This report examines health care utilization measures for inpatient and outpatient services for patients attributed to providers in the OH/NKY CPC+ region. Paid claims results were collected from CPC+ participating payers with dates of service from January 1, 2017, through December 31, 2019.

Approach

A quantitative and descriptive design using a linear trend analysis approach was used to evaluate the status and changes in the studied variables over time. Analysis was conducted on 16 cost and utilization measures using aggregated payer claims data for the identified practices during the reporting periods. Measure results were not adjusted for patient risk levels or acuity. Improvement was evaluated by comparing 12-month measurement periods ending December 31, 2017, and December 31, 2019. For trendlines, each measurement period represents a rolling 12 months of aggregated claims results for each measure. Statistical significance of trendlines was identified using a p-value of less than 0.05.

Sampling Method

For consideration in this study, participating practices were required to have continuous membership in the CPC+ program from January 1, 2017, through December 31, 2019; 535 practices met the criteria. Each patient was attributed by the participating payers to a single primary care provider in the CPC+ program. Payers included Aetna, Anthem, Aultcare, Buckeye, CareSource, the Centers for Medicare and Medicaid Services, Medical Mutual, Molina, Paramount, SummaCare, and United Healthcare. All patients attributed by the participating payers to these 535 practices were included in the study. The average number of patients included in this cohort over the three-year evaluation period was 1,000,215.

Data Collection Method

Claims data was submitted by participating payers in the CPC+ project to THC's multipayer claims database. Results were aggregated and included all participating payers. A minimum of 90 days of claims runout after the end of the measurement period occurred before the final measure calculations.

Data Analysis Method

A linear trend analysis was used to evaluate how the studied measures changed over the course of the three-year evaluation period. If $r^2 \geq 0.60$ and $p \leq 0.05$ in any of the regressions, then the trend was regarded as statistically meaningful.

KEY FINDINGS

In our preliminary review of aggregated data for the OH/NKY region, we independently analyzed the 16 cost and utilization measures on a quarterly basis over the first three years (2017-2019). We found significant improvement in emergency department (ED) visit rates and hospital admissions, including avoidable hospital admissions (prevention quality indicator [PQI] 90) over the first three years of the CPC+ project (See Table 1). (We will present our analysis of 2020 data, which was affected by the COVID-19 pandemic, in a forthcoming companion blog post.)

Table 1. Emergency Department Visits, Inpatient Discharges, and Avoidable Hospital Admissions Declined for Practices in the OH/NKY CPC+ Region

Average membership included in results from measurement year 2017 to 2019: 1,000,215 members.

Measure	% Change in Rate per 1,000
Outpatient ED visits (EDV)	-7.5
Inpatient discharges (IPU)	-6.5
Avoidable admissions (PQI 90)	-12.3

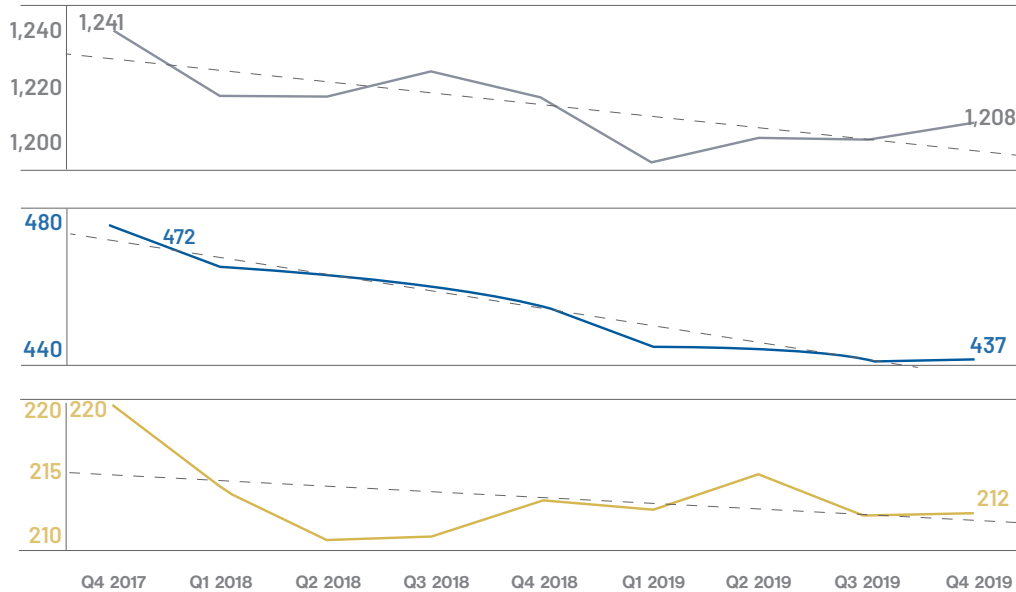
ED Visit Rates Decreased as PCP Visit Rates Increased

Over the course of the first three years (2017-2019) of the CPC+ project, outpatient ED visits for all payers gradually declined by 7.5% (Table 1). The reductions were more evident in Medicare and Medicaid populations, which historically have high ED use rates. By the end of 2019, we observed statistically significant reductions in outpatient ED visits for Medicare and Medicaid, with drops of 8.7% and 2.7%, respectively. We saw a 3.7% reduction in ED visits for commercially insured patients, but it was not statistically significant primarily due to a lower volume of observations. These changes for the Medicare and Medicaid populations did not begin until well into the second year of the program. (See Figure 1.)

Figure 1. ED Visits Dropped Significantly for Medicare and Medicaid Patients

ED visits per 1,000 patients from 2017 to 2019

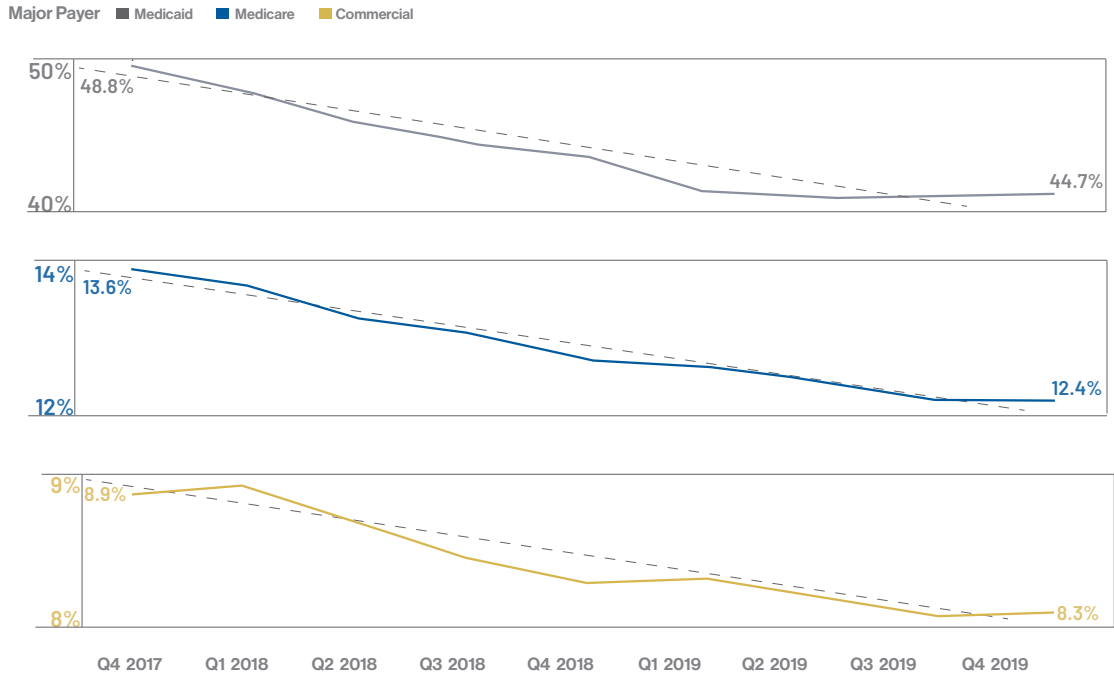
Major Payer ■ Medicaid ■ Medicare ■ Commercial



Note: Each measurement period represents a rolling 12-months. Results compiled using paid claims with minimum of 90 days of runout.

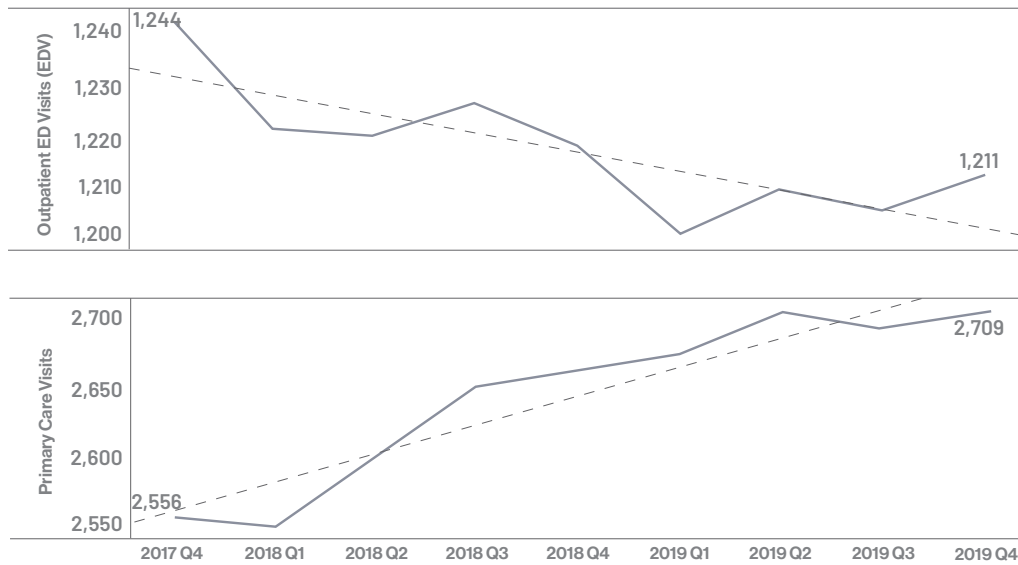
At the same time, we saw increases in primary care practice (PCP) visits, which are reflected in the ED/PCP ratios. (See Figure 2.) In Medicaid, the 5.9% increase in PCP visits was twice as large as the decrease in ED visits of 2.7%. (See Figure 3.) In the commercially insured population, the increase in PCP visits of 3.3% was almost equal to the 3.7% decrease in ED visits. These ratios suggest that practices were successful not only in decreasing utilization of the emergency department but also in redirecting patient care to more appropriate care resources, offering the opportunity to engage the patient proactively in areas of disease prevention and wellness. Interestingly, Medicare saw an increase in PCP visits of only 1.0% compared to an 8.7% reduction in ED visits. (See Figure 4.) This may reflect the well-known phenomenon of high PCP utilization by the elderly. The average range for PCP visit rate for Medicare beneficiaries over the three-year period was about 3,500 per 1,000 patients per year, while for commercially insured and Medicaid beneficiaries it was 2,500 per 1,000.

Figure 2. ED-to-PCP Visit Ratio Across Payers Suggest Practices Successfully Redirected Care



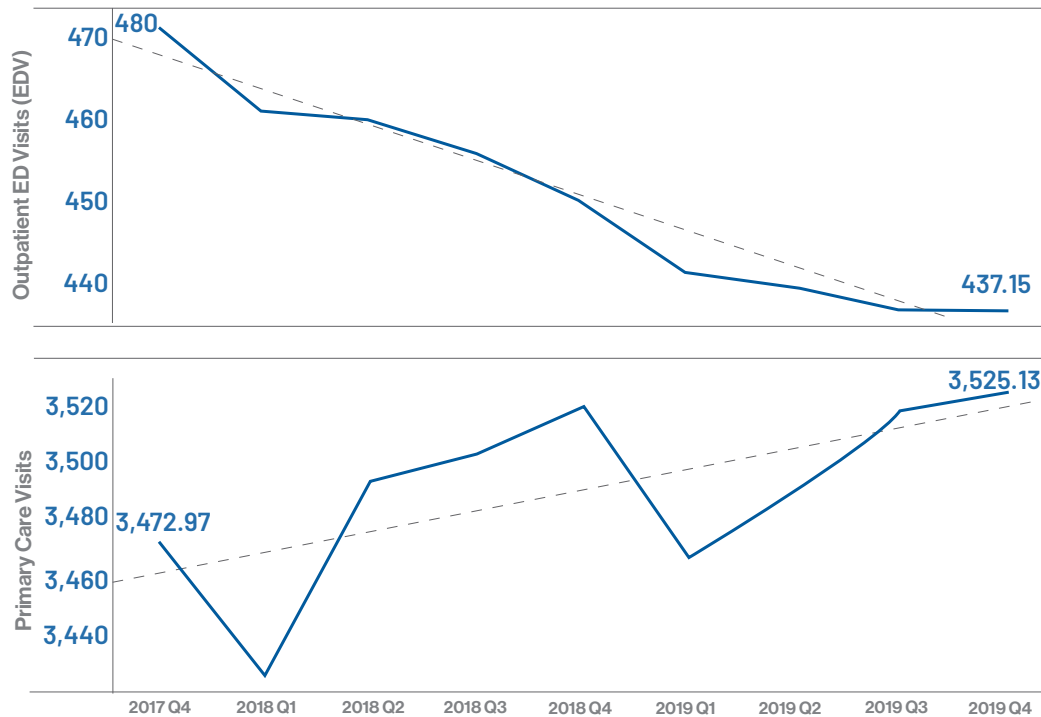
Note: Each measurement period represents a rolling 12-months. Results compiled using paid claims with minimum of 90 days of runout. Ratio of ED Visits to PCP Visits calculated as the total number of ED Visits / total number of PCP visits in the same measurement period.

Figure 3. The Increases in PCP Visits in Medicaid Were Twice as Large as the ED Visit Drop



Note: Each measurement period represents a rolling 12-months. Results compiled using paid claims with minimum of 90 days of runout.

Figure 4. Medicare Visits to the ED Were Reduced While PCP Visits Remained Relatively Flat



Note: Each measurement period represents a rolling 12-months. Results compiled using paid claims with minimum of 90 days of runout.

Hospital Admissions Dropped

There was also a statistically significant 6.5% decrease in total acute hospital admissions across payers from 2017 to 2019. Medicare admissions dropped by 5.1%, commercially insured admissions by 5.2%, and Medicaid admissions by 0.35%. Among the Medicare population, there was a statistically significant reduction of 6.7% in avoidable hospital admissions (PQI 90). This population has a higher prevalence of chronic disease and greater opportunity for reduction in these types of admissions. The Medicaid population demonstrated a 5.1% reduction in avoidable hospital admissions, which did not achieve statistical significance, and the commercial population showed no change. It should be noted that the total number of observed PQI admissions for the commercially insured was quite small (three admissions per 1,000 covered lives).

LESSONS FROM PRACTICE EXPERIENCE

We interviewed several of the primary care practices that had demonstrated positive results to better understand how CPC+ may have helped them improve their care. In this section we highlight two practices that stood out for their change management best practices. They also offer small practice vs. large system perspectives. The approach to comprehensive primary care varies considerably depending on the size and resources of the practice. Small, independent practices often capitalize on their ability to adapt to change quickly but struggle

with data and care management resources. Practices in large health systems, by contrast, have difficulty implementing change because of administrative hierarchy, but have access to greater resources such as data analytics and support staff.

Small Independent Practice: Little Flower Family Practice

Little Flower Family Practice is a small family practice in Canton, Ohio, with three providers (one physician and two nurse practitioners) and approximately 2,300 patients. Little Flower reduced outpatient ED utilization by approximately 30% and demonstrated continuous improvement throughout the CPC+ project.

Little Flower attributes much of its success to four key areas:

1. *Data accessibility and transparency.* Finding ways to make data actionable in the delivery of care was critical. For example, real-time notification from the local hospital about ED visits enabled the practice to manage patient follow-up in a timely fashion. Making practice-level and provider-level data readily accessible to the team in an easy-to-understand scorecard promoted an honest and open culture of improvement. While encouraging healthy competition among the three providers, the providers were also inspired to examine practice-level data and discuss how to share the load and help the whole population as a team.
2. *Change management.* The practice team leveraged their past change management experience to make permanent workflow improvements, improve access, and provide patient education. For example, modifying practice protocols allowed staff to give antibiotic injections, which streamlined care, increased availability in physician schedules, and reduced patient use of the ED. In addition, they conducted a “Call Us First” campaign and instructed their answering service to call the practice’s on-call doctor before sending their patients to the ED. The practice would see a patient three days in a row, if necessary, to avoid a preventable hospital admission.
3. *Close relationships with patients and community partners.* The providers learned that to comprehensively provide care, they needed to reach beyond the walls of their office. In a targeted effort to improve A1c and blood pressure measures, the practice partnered with the county and local hospital in a Fresh Produce Program, where they gave patients a \$30 monthly voucher and held cooking demonstrations. At the end of the six-month program, the practice observed improved A1c levels among participants. Other approaches that foster close relationship with patients include conducting universal screening for health-related social needs at all annual wellness visits and working closely with a social worker and pharmacist to better meet patients’ needs.

Integrating behavioral health providers into the practice remained a challenge due to limited supply and high demand for behavioral health professionals. Still, the providers routinely addressed mental health issues, conducted follow-up visits, and prescribed/monitored medications for depression. Providers performed “warm handoff” referrals to two community behavioral health providers (a psychiatrist and a psychologist) when mental health needs were beyond their scope. The primary care practice followed up on referral outcomes and shared treatment plans with behavioral health personnel.

4. *A culture of quality improvement.* The practice cites its experience as a patient-centered medical home (PCMH) prior to CPC+ as giving it a head start in creating a culture of quality improvement. As the practice manager said, “We’ve been doing this a long time, so the staff were ready for it. I love change, so the staff is used to that.” She added that small, independent practices are more able to adapt to rapid cycles of change.

A common tactical scenario in the practice for introducing a new approach might start by refocusing all staff on the mission—“everyone is there to take care of people”—and engaging a lead physician to discuss the goals; moving the discussion to a small group of clinicians and key staff; and finally, bringing the change back to all staff for discussion and feedback. Building buy-in and trust, sharing bonuses across all members, and allowing time for staff to give feedback creates an environment of staff sustainability with low turnover.

The practice dedicates one day per year to a retreat day, where key concepts of advanced (comprehensive) primary care, quality improvement, and team development are reviewed. Their excellent team-based care has resulted in high patient satisfaction and patient trust in the care team.

System-Affiliated Large Group Practice: ProMedica

The Toledo-based health system ProMedica achieved excellent results in ED and hospital visits, with three of their practices reducing utilization in both by more than 10%. According to system director of case management Kelli Chovanec and her team, ProMedica found that adopting a systemwide philosophy was important. Their philosophy states: “Prevention is best achieved through the fundamental integration of preemptive measures as a core tenet of primary care. The preventative aims should extend beyond disease management and avoiding complications caused by existing conditions, to include protective measures as a central component of health care delivery systems.”

Three key components have helped ProMedica succeed:

1. *Care management model.* ProMedica uses a care management model that supports horizontal leadership, continuity of care, and seamless transitions of care. These attributes have resulted in consistent positive trends of total expenditures per patient, emergency room utilization, and hospitalizations for the high-risk individuals within the primary care population. Over the first four years of CPC+, the practice has quadrupled the number of unique patients under care management.

The health system employs a sophisticated risk stratification model and leverages predictive analytics to ensure that the nurse care management resources are directed toward the high-risk patients in the population. Experienced nurse care managers are embedded in practices, engaging patients with an emphasis on self-management and the adoption of health-promoting behaviors. ProMedica practices use advanced-screening assessments to identify the social needs that can result in self-management concerns.

2. *Improving access.* ProMedica practices have recognized that avoidable ED visits are symptomatic of barriers to care. Over the past several years, the group has extended resources to promote and maximize convenient care access points such as same-day sick call availability, after-hours services, telemedicine, patient portals, and urgent care. They have posted “Know Where to Go” flyers and signage throughout practice and ED settings, as well as a dedicated website, to educate patients on proper care sites.
3. *Care coordination.* The practices of ProMedica have dedicated care coordination teams that support primary care with a comprehensive ED transitions patient outreach program. These teams perform outreach to patients discharged from their ED facilities to assess current symptom status, provide self-management support, coordinate safe handoffs across the care continuum, address social needs, and aid in understanding and identifying barriers to receiving care in the most appropriate setting. The practices also conduct proactive scheduling for preventive and chronic condition visits and outreach that connects unestablished patients with a primary care provider.

DISCUSSION

Much has been written about the need to provide tools and infrastructure to primary care practices so that truly comprehensive care can be provided in a sustainable way. Our observations echo the recent literature.^{2,3} These studies emphasize that sufficient time, specifically three to five years, is needed before measurable outcome improvement is seen. In the OH/NKY region, we are just beginning to see statistically significant improvements after three years. Many participating practices were so-called early adopters and were involved in change management prior to CPC+. However, they were only able to fully implement change after the CPC+ payers provided a non-fee-for-service payment that could be applied to robust care management, data infrastructure, and patient outreach initiatives. This reality underscores the need for an ongoing, multiyear strategy that will continue and expand value-based payment.

Although we won't have the final CPC+ claims data ready for analysis until mid-2022, these three-year early results suggest that this alternative payment model will demonstrate improved outcomes. The percentages of improvement in ED visits are significant and may translate to real savings through better care. It is also important to note that different populations had different results, and that the underlying reasons for ED utilization may be different for the Medicaid population than the Medicare population. Access and convenience are the larger issues for the former, while severity of underlying illness usually drives the need for an ED visit in the latter. Other issues such as plan design and relative health may affect commercial ED utilization among people in commercial plans.

Having data available to practices that differentiate among these populations has proved useful in providing practices with insights into root causes of different behaviors. For example, some practices have seen an increase in PCP visits as ED visits have decreased. When tracked at the patient level, these patterns have been traced back to specific interventions and education. Conversely, as seen in the Medicare population, increasing ED utilization in

the face of steady PCP utilization can sometimes be an early warning of a patient's worsening disease process and warrant more aggressive intervention by disease care managers.

The reduction in total acute hospital admissions across payers of 6.5% was encouraging. In addition, we saw no significant increase in total cost for the three-year period despite the usual annual inflation seen by payers across all three payer types. The results for avoidable hospital admissions were more mixed. Based on frequency of occurrence, the Medicare data are more reliable, and highly statistically significant improvement was observed. However, more time will be required to see if this holds up. Also, a majority of those admitted within this category had two diagnoses: congestive heart failure and chronic obstructive pulmonary disease. Patients admitted for these conditions eventually move to an end stage of their disease, so their admissions are less influenced by care management. This measure will therefore require additional analysis.

Encouraging are the stories from the practices of how CPC+ provided new energy and gratification for how the care is making a difference in their patients' lives. This change has occurred not only within the practices but also across specialties, social services, and pharmacies, and others that interact with the practices. Critically, we have heard from many of the physicians in these practices that fewer are entertaining early retirement. Moreover, CPC+ has apparently increased the participating practices' confidence in the new model to the degree that a significant number of CPC+ practices are participating in Primary Care First, a new risk-bearing federal payment model, and Direct Contracting, a set of voluntary payment options for Medicare.

In the OH/NKY region, it became evident early on that for multipayer initiatives such as CPC+ to succeed, standardized claims data, measurements, and goals were necessary. Managing data feeds from 11 different payers would otherwise be impossible for all but the largest and most sophisticated systems. Such standardization required consistent leadership from CMMI and implementation by a neutral regional health improvement collaborative such as THC. Much work remains, including making the claims data timelier and integrating it with clinical data from the electronic medical record to continually decrease the burden on practices. Incorporating social risk factors into the clinical data will also be important, as a good outcome goes beyond tending to clinical needs.

CONCLUSION

Where does this bring us and how do we build on this experience? Here are the four key components that innovative primary care practices require.

Value-Based Payment

As the field of medicine progresses to a pay-for-value model, payers and employers are developing multiple approaches. All would benefit from a comprehensive view of a practice's performance that only an aggregated claims database can provide. Otherwise, practices are left with only their slice of claims data on which to base decisions about partnerships, areas of improvement, and more. As the practices' scenarios presented in this report demonstrate,

the integration of data, care management, and office processes are all critical to successful outcomes.

Actionable and Timely Data

The practices need clinical, utilization, and cost data in a timely way to advance the care they deliver. As highlighted in our practice stories, there is also a need to supplement the data with some measurement of social needs. Understanding patients' ability to afford their medications, their access to health services, and their degree of engagement are all necessary to successfully deliver care. In addition, practices need assistance in the interpretation and application of these data to properly understand their performance in this new alternative payment world. In CPC+, the practice facilitators in our region who worked closely with practices to implement the process changes played this vital role. THC also provided data coaches, who assisted the practice facilitators and the practices with interpretation of their data.

An "On-Ramp" for Primary Care Practices That Have Yet to Engage in This Approach

Federal primary care models like PCMH, the Merit-based Incentive Payment System, and CPC have touched only a minority of the primary care practices in the United States. A strategy for introducing the comprehensive primary care model needs to be led at the national level with support from all health plans. The approach needs to be standardized and straightforward if we are to replace fee-for-service payments. As practices become more sophisticated, they can advance into models that reward risk taking, like CMMI's new Primary Care First, where the practice can be required to pay back some of the payments received in advance if it fails to meet certain benchmarks. However, to expect a practice that is new to this approach to assume risk is not realistic. This strategy will need to include organizations experienced in providing the facilitation and coaching necessary to succeed in these models.

Primary Care as Patient Advocate

As the physicians who participated in CPC+ in the OH/NKY region often commented, this initiative restored their faith and confidence in their ability to deliver the care for which they were trained. It has also provided tangible ways in which they and their colleagues can be more independent in their patient advocacy, regardless of the health system, group, or plan with or for whom they work. When practices are consistently rewarded for good patient outcomes, it gives them the flexibility to address their patients' needs in the best way they know how.

GLOSSARY

Acute hospital admissions – When patients’ severity of illness and intensity of service can only be addressed in an inpatient setting.

Alternative payment model—A payment approach that offers incentives to providers to provide high-quality and cost-efficient care.

Avoidable hospital admission—Admission to a hospital for certain acute illnesses or worsening chronic conditions that might not have required hospitalization had these conditions been successfully managed in an outpatient setting.

Care management—A team-based, patient-centered way to assist and support patients in managing medical conditions effectively.

CPC Classic—A four-year multipayer initiative launched by the Centers for Medicare and Medicaid Services in 2012, which laid the foundation for CPC+. Although practices were not required to participate in CPC Classic prior to CPC+, those practices that did participate showed greater improvement in CPC+ than those that did not.

CPC+—A five-year advanced primary care medical home model launched in 2017 that integrated lessons learned during CPC Classic, including progression of care delivery redesign, performance-based incentives, health information technology, and claims data sharing with practices.

Direct contracting—Payment model options aimed at reducing expenditures and improving quality of care under the fee-for-service payment model.

Fee-for-service—A payment method in which health care providers are paid for each service performed.

Independent practice—A primary care practice not owned and operated by a hospital or health care system.

OH/NKY—The Ohio and Northern Kentucky region, which includes Adams, Brown, Butler, Champaign, Clark, Clermont, Clinton, Greene, Hamilton, Highland, Miami, Montgomery Preble, and Warren Counties in Ohio as well as Boone, Campbell, Grant, and Kenton Counties in Kentucky.

Patient-centered medical home (PCMH)—A health care model of care that can be adopted by physicians’ practices that aims to improve health care by transforming how primary care is organized and delivered. A PCMH offers accessible, safe, high-quality comprehensive, patient-centered, coordinated care.

Predictive analytics—Using data to predict trends. In health care, this often means using health care data garnered through clinical integration and claims reports to identify at-risk patients.

Primary Care First –A CMMI demonstration of an alternative payment model that aims to improve quality and patient experience, as well as reducing health care expenditures, by increasing access to advanced primary care services.

PQI—Prevention quality indicator established by the Agency for Healthcare Research and Quality (AHRQ) that identifies hospital admissions that might have been avoided through access to outpatient care.

PQI 90 –Hospital admissions for one of the following conditions: diabetes with short- and/or long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.

Risk-adjusted—A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

Risk stratification—A process for categorizing patients based on their health status and other factors affecting health.

Team-based care—The provision of health services to individuals, families, and/or their communities by at least two health care providers who work collaboratively with patients and their caregivers to the extent preferred by each patient to accomplish shared goals within and across health care settings to achieve coordinated, high-quality care.

NOTES

- ¹ Shonk RF, Sessums LL. The Comprehensive Primary Care initiative: another side of the story. *Health Affairs Blog*. December 2, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20181130.132681/full/>. Accessed December 21, 2021.
- ² Crook HL, Saunders R, Roiland R, et al. A decade of value-based payment: lessons learned and implications for the Center for Medicare and Medicaid Innovation, part 1. *Health Affairs Blog*. June 9, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20210607.656313/full/>. Accessed December 21, 2021.
- ³ Gonzalez-Smith J, Crook H, Singletary E, et. al. *How to Better Support Small Physician-led Accountable Care Organizations: Recent Program Updates, Challenges, and Policy Implications*. Durham, NC: Duke Margolis Center for Health Policy; 2020. <https://healthpolicy.duke.edu/sites/default/files/2020-07/How%20to%20Better%20Support%20Small%20Physician-Led%20ACOs.pdf>. Accessed January 9, 2022.

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