Oregon Health Authority Patient-Centered Primary Care Home Program

May 2013

Presentation Objectives

- Provide a brief background on Oregon's Patient-Centered Primary Care Home Program and vision for practice transformation
- Outline goals and strategies for spreading access to primary care homes across the OHA and Oregon
- Understand linkages between PCPCH Program and larger health system transformation/Coordinated Care Organizations
- Explain payment reform objectives and current payment incentives available to recognized primary care homes
- Identify technical assistance and resources available for primary care clinics throughout Oregon

Patient-Centered Primary Care Home Program

HB 2009 established the PCPCH Program:

Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

Key PCPCH Program Functions:

- PCPCH recognition and verification
- Refinement and evaluation of the PCPCH Standards over time
- Communication and provider outreach
- Coordination across OHA divisions, CCO development and health reform initiatives
- Restructure primary care payment to align with the PCPCH framework
- Technical assistance development

Primary Care Home Standards Advisory Committee

Original Committee:

- 15 members, 6 ex-officio content experts; Multiple stakeholders (patients, providers, plans, employers, health authority, public health)
- 7 public meetings Nov 2009 - Jan 2010
- Reviewed past work in Oregon, other state, federal and private efforts across the country
- Produced three principle products: PCPCH Core Attributes and Standards, PCPCH Measures, Guiding Principles for Implementation
- Reconvened second group in Fall 2010 with focus on pediatric and adolescent populations

Ongoing Updates & Revisions to the Model:

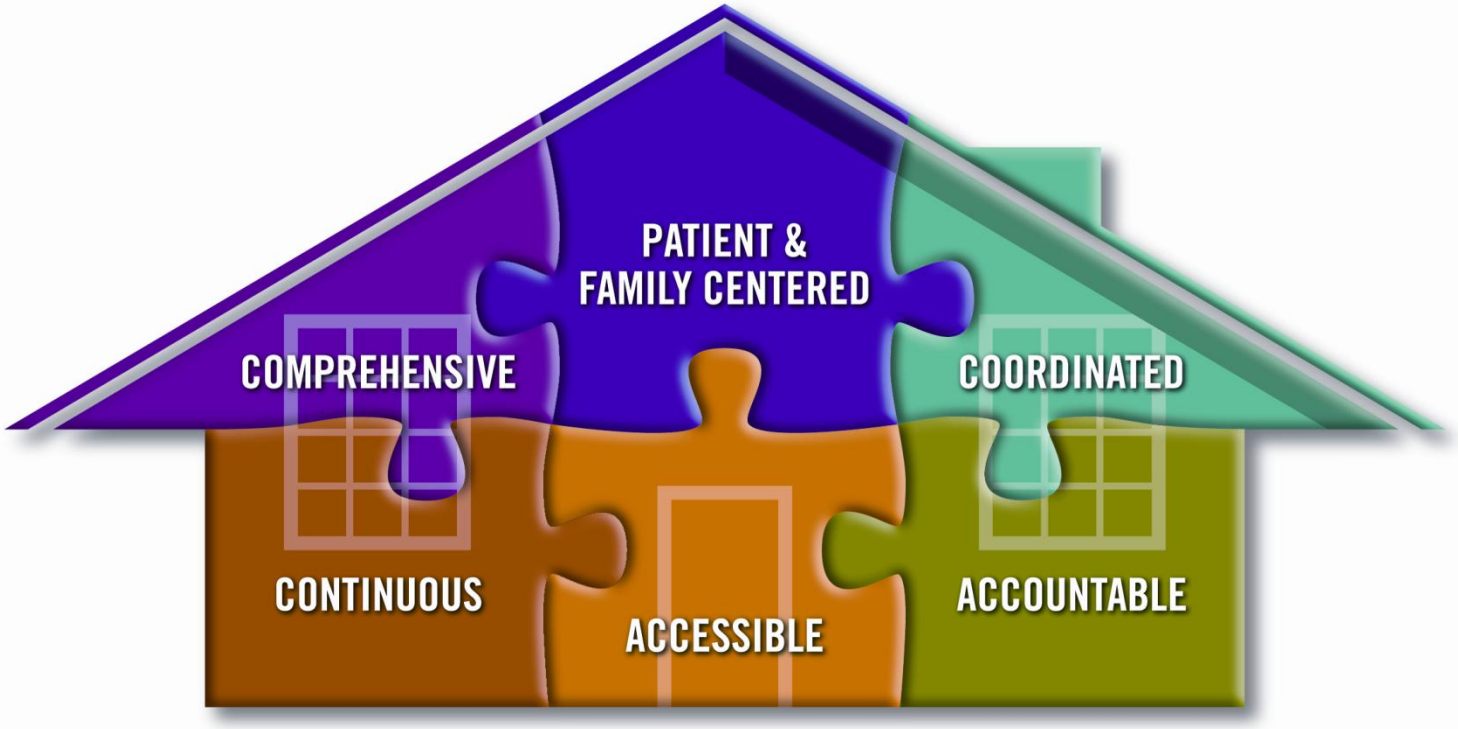
- Reconvened in Fall 2012 to refine the model. New criteria will launch October 1, 2013.

Oregon's Primary Care Home Key Attributes

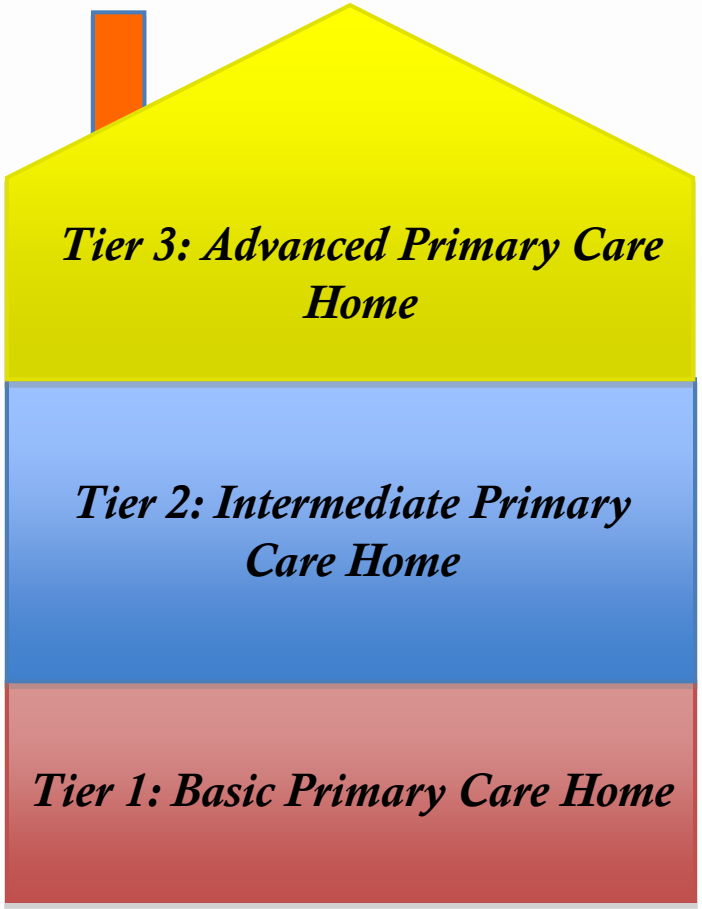
Oregon's PCPCH Model is defined by six core attributes, each with specific standards and measures:

- **Access to Care** – *"Health care team, be there when we need you"*
- **Accountability** – *"Take responsibility to provide us with the best possible health care"*
- **Comprehensive Whole Person Care** – *"Provide/help us get the health care and information we need"*
- **Continuity** – *"Be our partner over time in caring for us"*
- **Coordination and Integration** – *"Help us navigate the system to get the care we need safely and timely manner"*
- **Person and Family Centered Care** – *"Recognize we are the most important part of the care team, and we our responsible for our overall health and wellness"*

Core Attributes of a Primary Care Home



Different Levels of Primary Care "Home-ness"



- Proactive patient and population management
- Accountable for quality, utilization and cost of care outcomes

- Demonstrates performance improvement
- Additional structure and process improvements

- Foundational structures and processes

Primary Care Home Measures *(Access to Care Example)*

ACCESS TO CARE – *Be there when we need you*

- In-Person Access

  Appointment Access Measures

  Tier 1 – Practice surveys a sample of its population on satisfaction with in-person access to care.

  Tier 2 – Practice surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools and reports on results on the access to care domain.

  Tier 3 – Practice surveys a sample of its population using one of the CAHPS survey tools, reports results on the access to care domain, and demonstrates improvement with patient satisfaction in access to care.

- Telephone and Electronic Access
- Administrative Access

What Types of Services Do Primary Care Homes Provide?

All primary care homes must meet the 10 must-pass Standards & meet a points threshold

Must-Pass Examples

PCPCH Provides:

- Continuous telephone access to clinical advice
- In-person or telephonic interpretation to communicate with patients & families in their language of choice

Also

Attest to a menu of other PCPCH Standards that are worth different amount of points, depending on how advanced they are.

Examples of PCPCH Standards Scoring

- 15 pt example: Co-located, integrated mental health services
- 10 pt example: Identifies and coordinates care of patients with complex care needs
- 5 pt example: Offers in-person access to care outside of 8am-5pm hours

PCPCH Tier Scoring

Tier 1: 30-60 pts &10 must-pass

Tier 2: 65-125 pts &10 must-pass

Tier 3: 130+ &10 must-pass

Oregon Health Policy Board Subcommittee Recommendation on PCPCHs

Move forward decisively to transform the primary care delivery system.

- Adopt the PCPCH standards and proposed structure for aligning payment to the tiers as the model for primary care home redesign in Oregon.
- Sponsor development of the measurement, reporting, and feedback infrastructure necessary to implement the standards as a basis for payment.
- Assist primary care practices to develop the capacity to measure and report in accordance with the standards.
- Restructure primary care payment to align with the PCPCH standards framework.

Oregon's Goals for PCPCH

Based on the Oregon Health Policy Board's Action Plan:

- All OHA covered lives (almost 900, 000) receive care through a Patient-Centered Primary Care Home
  - Includes Medicaid, public employees, Oregon educators, Oregon high-risk pool, Family Health Insurance Assistance Program, and Healthy Kids

- 75% of Oregonians have access to quality care through a PCPCH by 2015

- Spread to private payers and Qualified Health Plans via the Exchange

OHA PCPCH Recognition

- OHA developed a centralized, web-based process for data reporting and recognition of PCPCHs
- Application includes:
  - Attestation to meeting individual PCPCH Standards
  - Health care quality data reporting
- Began accepting applications October 2011

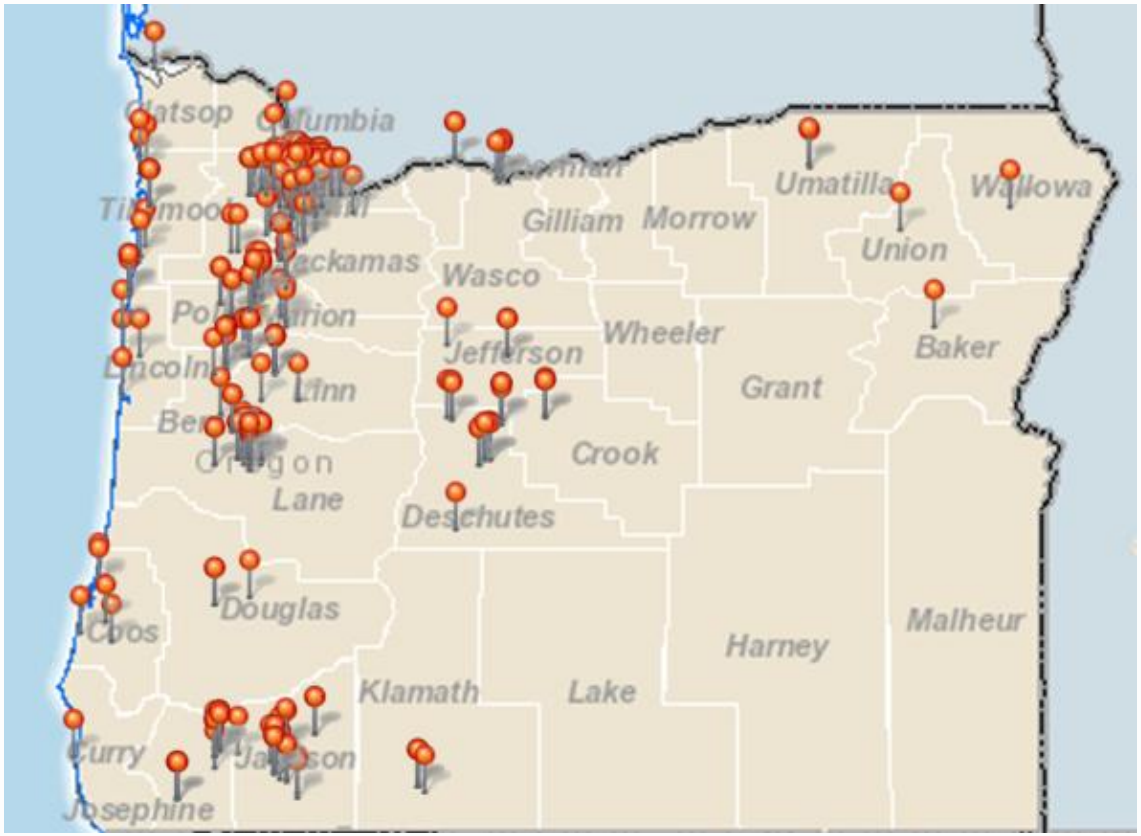
Resources available online on the Become Recognized page:

- Implementation Guide
- Technical Assistance and Reporting Guidelines
- Self-Assessment Form
- Online application system linked to quality data

Verification Site Visits

- Launched in September 2012
- Conducted more than 20 site visits to-date
- Goals:
  - **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to on their PCPCH recognition application. Additionally, for clinics participating in the Medicaid PCPCH payments, verifying evidence of required documentation, care planning, and service performance for "ACA-qualified" patients.
  - **Assessment** of the care delivery and team transformation process to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH.
  - **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the Patient-Centered Primary Care Institute

Patient-Centered Primary Care Home in Oregon as of April 2013 (>370 recognized)



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What about Patient-Centered Primary Care Homes and Coordinated Care Organizations?

Coordinated Care Organizations

Replace today's MCO/MHO/DCO system

Local health entities that deliver health care and coverage for people eligible for Medicaid (the Oregon Health Plan).

- ✓ Local control
- ✓ One point of accountability
- ✓ Global (single) budget – *fixed rate of growth*
- ✓ Expected health outcomes
- ✓ Health Equity
- ✓ Integrate physical and behavioral health
- ✓ Community health workers
- ✓ Focus on prevention
- ✓ Reduced administrative overhead
- ✓ Electronic health records
- ✓ **Patient-Centered Primary Care Homes***

*CCOs required to include recognized clinics in their networks of care to the maximum extent feasible

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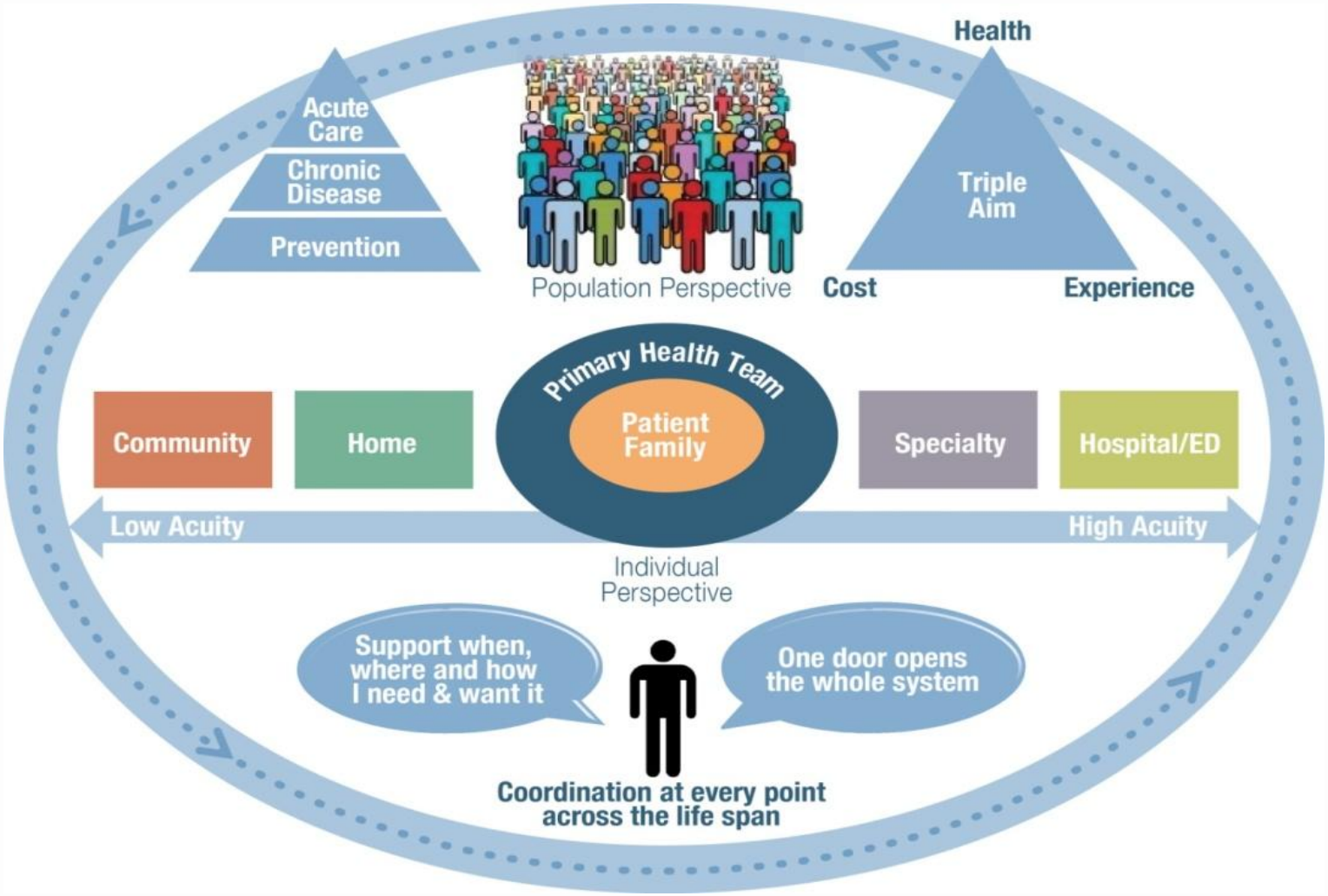
Coordinated Care and Patient-Centered Primary Care Home Teams



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Key Components Expected in Transformation Plans on PCPCH

- Understanding the extent of PCPCH implementation in the CCO's network
- Innovative payment/financing to support practice transformation and sustain PCPCHs
- CCO's plans to assist PCPCH patient engagement
- Overall PCPCH facilitation/engagement
- Workforce allocation and assessment
- Information sharing with PCPCHs

PCPCH Supplemental Payment Options

Current Incentive Payments to Oregon PCPCHs

Commercial Health Plan Enhanced Payments and Incentives -

- Aetna paying PMPM, based on tier of PCPCH or NCQA recognition
- PEBB Statewide plan, administered by Providence, provides an age-adjusted PMPM for tiers 2 & 3, and consumer incentives by reduced cost sharing for PEBB Statewide members seeking care at PCPCHs

"ACA-Qualified" Medicaid Payments

- Health Home enhanced payments from Section 2703 of the Affordable Care Act (ACA) for Medicaid members with certain chronic conditions being cared for by a PCPCH – continues through September 2013

Comprehensive Primary Care Initiative (CPCI) -

- Almost 70 clinics selected to be paid an enhanced payment for four years by Medicare & 5 local payers including OHA Medicaid FFS

PCPCH Technical Assistance and Resources

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Technical Assistance Resources

Visit PrimaryCareHome.oregon.gov

- ✓ Implementation Guide and Technical Assistance and Reporting Guidelines
- ✓ Payment Incentives Webpage
- ✓ Supplemental Payment Options Packet
- ✓ PCPCH Program Rules
- ✓ On-site verification process
- ✓ Regional forums, presentations
- ✓ Webinars
- ✓ Patient-Centered Primary Care Institute

Technical Assistance & Learning Collaborative Efforts Underway

- The OHA, in partnership with the Oregon Health Care Quality Corporation, and North West Health Foundation launched the **Patient-Centered Primary Care Institute** in September 2012 to support primary care practice transformation in Oregon.

- A broad array of resources are available and being developed, including the first PCPCH Learning Collaborative.

- TA website launched at www.pcpci.org
  - Additional tools and resources added frequently

Patient-Centered Primary Care Institute Objectives

- **Promote knowledge sharing** through a comprehensive website with easy access to tools, resources, online learning, best practice information and networking opportunities

- **Facilitate collaborative learning** using a network of technical assistance providers who provide face-to-face learning and practice facilitation to selected practices

- **Build capacity** for ongoing quality improvement by offering opportunities for technical assistance providers to collaborate and deploy resources collectively through networking and train-the-trainer programs

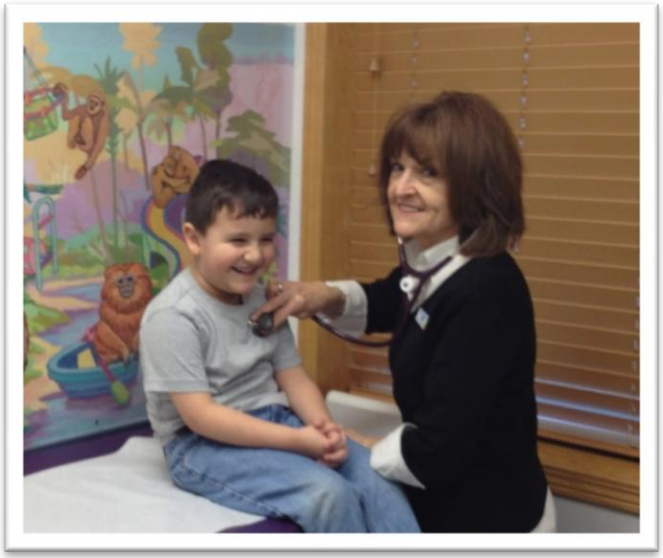
- **Create alignment** by coordinating efforts with other practice transformation initiatives in Oregon to leverage resources, maximize benefits for practices, and accelerate transformation. Alignment is **critical.**

PCPC Institute Key Strategies

- Assessment of needs – surveys, key stakeholder interviews
- Institute's Expert Oversight Panel – steering committee of diverse stakeholders
- Curriculum developed using local and national content expertise
- Initial Learning Collaborative – 25 clinics selected in December
- Practice facilitation or "coaching" services
- A comprehensive, interactive learning system website
- Online learning modules and monthly webinars
- Quality improvement training via a train-the-trainer model
- Convening TA organizations/providers, strategically re-deploying resources over time as needed
- Developing sustainable business plan

Success Stories and Continued Partnership

Visit the News & Stories page to read about how primary care homes fulfill a vision for better health, better care, and lower costs for all Oregonians



Visit: www.PrimaryCareHome.oregon.gov
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