

Transformation Plan Element #2

Patient-Centered Primary Care Home

Transformation Plan Guidance and Technical Assistance

Oregon Health Authority's technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

Overview

Critical to the success and sustainability of CCO transformation is a foundation of high-performing primary care, including the Patient-Centered Primary Care Home (PCPCH) model. To meet Oregon's PCPCH Standards, primary care homes depend on cooperative and community-based work to achieve continuous quality improvement for the population they serve. CCOs need to develop a plan and milestones demonstrating their support to develop and spread Patient-centered Primary Care Homes (PCPCH) across their provider network. The CCOs are critical partners with the primary care homes in achieving access, engagement, and quality benchmarks towards the highest tier of the Standards and to transform care across the CCO.

Background

At the core of Oregon's Coordinate Care Model is a model of primary care that has received attention in Oregon and across the country for its potential to advance the Triple Aim goals of health reform: a healthy population, extraordinary patient care, and reasonable costs. Primary care homes achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs and a patient and family centered approach to all aspects of care. Note that this is a recommendation for an incentive measure for the quality pool, and is reflective of the value that is being placed on promoting the PCPCH model in Oregon.

In 2009 and 2010, Oregon developed its comprehensive standards for Patient-Centered Primary Care Homes. The initial public stakeholder group reviewed the various approaches to a medical home including the National Committee for Quality Assurance (NCQA) standards that were becoming widely adopted, but felt the NCQA standards did not go far enough to encourage improved health outcomes. Designed from the perspective of the patient and family, the following are six key attributes of a primary care home that are at the core of the Oregon standards and are key to the expected outcomes:

- **Access to Care:** "Health care team, be there when we need you."
- **Accountability:** "Take responsibility for making sure we receive the best possible health care."
- **Comprehensive, Whole-Person Care:** "Provide or help us get the health care, information, and services we need."
- **Continuity:** "Be our partner over time in caring for us."

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- **Coordination and Integration:** “Help us navigate the health care system to get the care we need in a safe and timely way.”
- **Person and Family-Centered Care:** “Recognize that we are the most important part of the care team—and that we are ultimately responsible for our overall health and wellness.”

The OHA’s PCPCH program for practice recognition, technical support, and performance improvement started in October of 2011, with more than 300 primary care practices recognized to date – more than 60% as Tier 3, the highest level of attainment in Oregon’s system. As delivery system transformation is supported by the evolution of payment methods from fee-for-service models, a crucial component will be the innovation and supports necessary for a primary care practice to transform to a team-based, patient-focused model of care that works closely with its community. Implementing a strong primary care system through a network of recognized PCPCH providers is a requirement of CCOs. Oregon’s goals for furthering development and adoption of PCPCHs are:

- 75% of Oregonians have access to a recognized primary care home by the end of 2015, with most of these achieving Tier 3.
- Increasing the spread of the PCPCH model to other OHA-covered populations such as PEBB and OEBB, as well as Medicare and commercial carriers for non-OHA populations by end of 2013.

Figure 1 below illustrates how Oregon’s Coordinated Care Model will be achieved with PCPCH at the core across all populations. Under Oregon’s Coordinated Care Model, patients and families are at the center, and physical, behavioral and other types of care and services are integrated and provided in a community setting to the greatest extent possible. The system emphasizes prevention, chronic disease management, health outcomes and health equity. The benefits expected from these care improvements are many.

For example:

- The integration of physical, behavioral and other types of care will result in improved care coordination, reducing unwarranted or duplicative care and reducing medical errors;
- This will also result in administrative alignment, which will reduce administrative costs;
- Better prevention, care in community settings, and stronger coordination and case management will begin to reduce hospitalization and emergency room use and achieve improved outcomes; and
- Increased financial flexibility will enable communities to prioritize their own needs and encourage the use of the most cost effective care.

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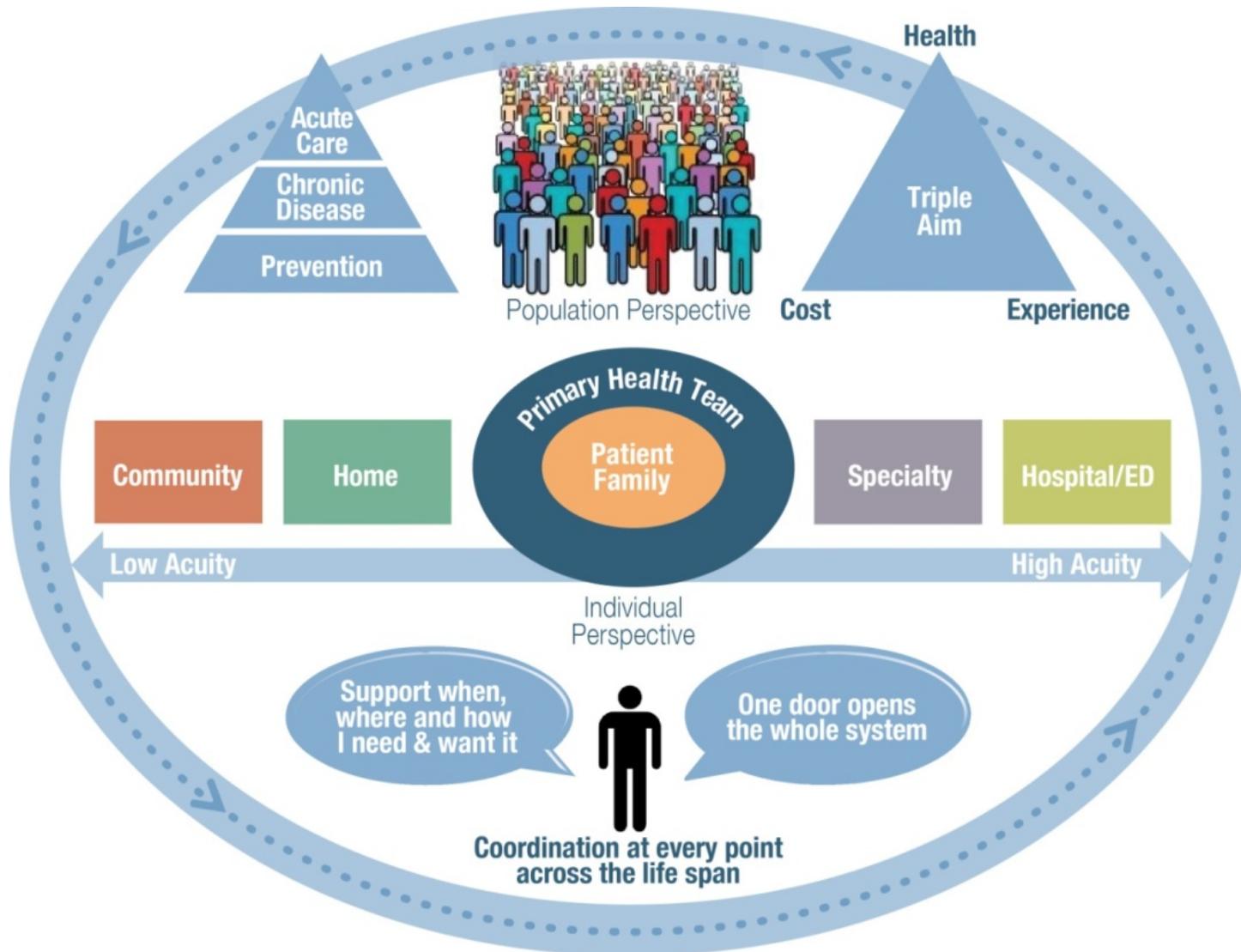


Figure 1 - Primary Care Home at the Core of Oregon's Coordinated Care Model

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Background from RFA request: Appendix A

A.3.1. Oregon's Patient-Centered Primary Care Homes Model of Care

A.3.1.a. Describe Applicant's plan to support the provider network through the provision of:

- Technical assistance
- Tools for coordination
- Management of Provider concerns
- Relevant Member data
- Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families

A.3.1.b. Describe Applicant's plan for engaging Members in achieving this transformation.

Integral to transformation is the Patient-Centered Primary Care Home, as currently defined by Oregon's statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

A.3.1.c. Demonstrate how the Applicant will use PCPCH capacity to achieve the goals of Health System Transformation, including:

- How the Applicant will partner with and/or implement a network of PCPCHs as defined by Oregon's standards to the maximum extent feasible, as required by ORS 414.655, including but not limited to the following:
 - Assurances that the Applicant will enroll a significant percentage of Members in PCPCHs certified as tier 1 or higher according to Oregon's standards; and
 - A concrete plan for increasing the number of enrollees that will be served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and
 - A concrete plan for tier 1 PCPCHs to move toward tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.
- How the Applicant will require two-way communication and coordination between the PCPCH and its other contracting health and services

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providers, including hospitals, in a timely manner for comprehensive care management.

A.3.1.d. Describe how the Applicant's PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services.

A.3.1.e. Describe how the Applicant will encourage the use of federally qualified health centers, rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

Other models of patient-centered primary health care

A.3.2.a. If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

A.3.2.b. Describe how the Applicant's use of this model will achieve the goals of Health System Transformation.

A.3.2.c. Describe how the Applicant will require two-way communication and coordination between its patient-centered primary health care providers and other contracting health and services providers in a timely manner for comprehensive care management.

A.3.2.d. Describe how the Applicant's patient centered primary health care delivery system will coordinate with PCPCH providers and services with DHS Medicaid-funded LTC providers and services.

References/Resources

- Oregon's Patient-Centered Primary Care Home Program website has a variety of resources and is available at www.PrimaryCareHome.oregon.gov
- Oregon's State Innovation Plan has detailed information, including literature references as to the effectiveness of the PCPCH model and is available at: <http://www.oregon.gov/oha/OHPB/healthreform/docs/or-heath-care-innovation-plan.pdf>

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- The OHA, in partnership with the Oregon Health Care Quality Corporation, and Northwest 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 will be available over the coming year, including the first PCPCH Learning Collaborative. Initial information is available on the [Resources page](#) at www.PrimaryCareHome.oregon.gov with a full website coming in mid-December 2012 at www.PCPCI.org
- Additional national resources are available at the Patient-Centered Primary Care Collaborative: <http://www.pcpcc.net/>

Components: Cooperative partnerships across the CCO network with PCPCHs as well as community-based work on continuous quality improvement for the population served are critical to the success and sustainability of both the CCO and the PCPCH. In order to incentivize this philosophy of improved access, quality, and outcomes we recommend the following components to assess the CCO Transformation Plan with respect to this cornerstone of their success – PCPCHs.

1. Understanding PCPCH implementation in the CCO Network
 2. Innovative Payment/Financing
 3. PCPCH Patient Engagement
 4. General PCPCH facilitation/engagement
 5. Workforce allocation and assessment
 6. Information Sharing with PCPCHs
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1. Understanding PCPCH implementation in the CCO Network

OHA Expectations

Demonstrate that the CCO plans to monitor and address the extent of spread of the PCPCH model in their CCO network.

Demonstrate that the CCO will be monitoring the access for their membership to PCPCH and the members' satisfaction with the network's adequacy of PCPCHs

Measurement Methodology

- The CCO details its plan on addressing how it will assess members' PCPCH access across their provider network
- The CCO's plan will also describes how the CCO will assist and improve access through provider-specific engagement, and those efforts are outlined

Baseline

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- The CCO will assess current access by its members to PCPCHs contracted in CCO network, identified by recognized Tier status.

Transformative Activity

- Describe the actions the CCO plans to address how it will improve PCPCH access across their provider network, including provider-specific engagement

Improvement Metric

- The CCO will set a benchmark of achievement on increasing access to PCPCH it will be striving towards that includes over what time period in which it will be achieved.
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2. PCPCH Patient Engagement

OHA Expectations

Demonstrate that CCO has plans on enrolling a significant percentage of its members in PCPCHs certified as Tier 1 or higher according to Oregon's standards

Measurement Methodology

- The CCO develops a clear strategy and plan with milestones on how the CCO will coordinate communication with patients and between patients and the PCPCH.

Baseline

- Describe the number of enrollees currently receiving care in a PCPCH certified as Tier 1 or higher according to Oregon's Standards.

Transformative Activity

- Describe the role the CCO will be playing in engaging or educating members about PCPCHs, and its plan to achieve improvement towards the benchmark

Improvement Metric

- Describe how the CCO will measure its improvement in the number of enrollees currently receiving care in a PCPCH certified as Tier 1 or higher according to Oregon's Standards towards the goal of having 100% of members having access to a recognized PCPCH within 5 years, with the majority of these PCPCHs being Tier 3 (Incentive pool metric)
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3. Innovative Payment/Financing

OHA Expectations

Demonstrate that the CCO is implementing consistent alternative payment methodologies that align payment with health outcomes **and** begin to consider how the CCO might demonstrate *dedicated* support for PCPCH Tier-based transformation. See the Alternative Payment guidance for further information. .

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Measurement Methodology

- The CCO details a concrete plan of how it intends to increase its use of alternative payments that incentivize the PCPCH model

Baseline

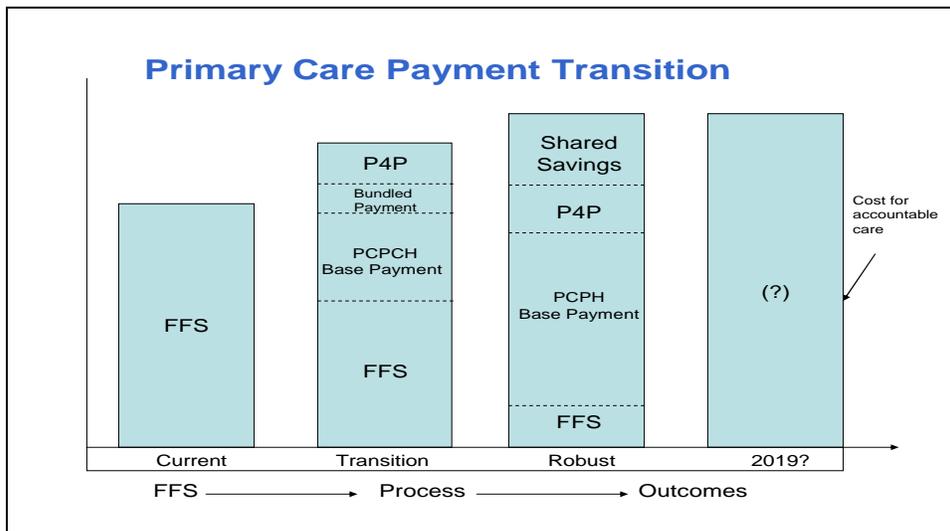
- The CCO will describe the current support of primary care/PCPCHs in their network which could include the following:
 - Percentage of funds spend on primary care/PCPCHs
 - The type and the number of PCPCHs in their network receiving alternative payment to incentivize the PCPCH model.

Transformative Activity

- Describe the actions the CCO intends to undertake for alternative payments. Examples of what could be proposed and initiated across the PCPCHs in their network:
 - Tier-Based enhanced payments for CCO population in the PCPCH – \$2, \$4, \$6 PMPM plus additional PMPM for managing “more complex” patients (similar to ACA qualified payments) including timeline for implementation.
 - Specific investments in PCPCH implementation and/or *frontline* PCPCH infrastructure/staffing.
 - Financial incentives built around PCPCH Quality outcomes
 - Specified inclusion of contracted PCPCHs in “shared savings” budgeting
 - Comprehensive non-RVU based payment structures for PCPCHs built around population management/outcomes.

One example of the transformation of primary care payments was proposed by the Oregon Health Policy Board’s Incentives and Outcomes committee’s work:

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Improvement Metric

The CCO would describe how it will monitor and assess improvement in increasing incentive payments or support of the PCPCHs in their network and the impact.

4. General PCPCH facilitation/engagement

OHA Expectations

Demonstrate that the CCO plans to foster and be innovative in the communication and information flow between CCO-contracted entities and PCPCHs.

Demonstrate that the CCO is assisting the PCPCHs linking with community resources.

Demonstrate the CCO is furthering behavioral health integration in partnership with their primary care network of PCPCHs. See the guidance on integration for further information.

Demonstrate that the CCO plans to spread the PCPCH model and community learning about care transformation.

Measurement Methodology

The CCO details the methods they will use to foster communication and information flow between CCO-contracted entities and PCPCHs. This would address the following questions:

- How do they plan to assist and ensure that hospitals contracted with CCOs are coordinating with PCPCHs via daily ER/hospital patient updates?
- How do they plan to assist and ensure that specialty clinics in the CCO's network are providing communication/data sharing/access between them and the contracted PCPCHs clinics?

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- Will they be doing similar efforts with other facilities in the CCO's network, such as ambulatory surgical centers, other outpatient settings?
- Will they be assisting on any needed communication and information flow between PCPCHs and nursing homes/assisted living, other settings or providers (i.e. EMS, etc)?

The CCO details how it plans to assist linkages with PCPCHs and community resources, including:

- What are CCO plans to facilitate coordination/referral/tracking between PCPCHs and community resources (housing, transportation, food, school, etc)?
- What will be the CCO's role in facilitating coordination with community/public health resources and the PCPCHs in their network in order to assist the PCPCHs efforts to improve overall health of the members?

CCO details how it furthers behavioral health integration in partnership with PCPCHs, to address how the CCO plans to facilitate PCPCH/Mental and Behavioral Health co-location and collaborative care planning/record sharing, and referrals from PCPCHs?

CCO describes its plans to spread the PCPCH model and community learning about care transformation, including addressing the following areas:

- Does the CCO plan to participate in or facilitate PCPCH participation in the statewide Patient Centered Primary Care Institute and/or regional collaborative to support PCPCH transformation?
- What are the CCOs facilitating interaction/learning between PCPCHs across their network? How?
- What TA will the CCO be providing/funding to foster PCPCH transformation, if any, in addition to statewide or regional efforts?

Baseline

- The CCO will describe current efforts to foster communication with the PCPCHs with the following entities across its provider network including:
 - hospitals and specialists
 - behavioral health providers and resources
 - other contracted entities used by PCPCH members, such as LTC and assisted living settings as well as linkages with social service and community health in the CCO's area.
- The CCO will describe current efforts by the CCO to spread the PCPCH model and community learnings about care coordination, including existing learning collaborative, other efforts.

Transformative Activity

Describe the actions that will be taken to improve from its current efforts in these areas as described in the measurement methodology

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Improvement Metric

- The CCO will describe how it will assess improvement in fostering communication with the PCPCH and other providers and entities in its network
 - The CCO will describe how it will assess its success and efforts in spreading the PCPCH model across its network
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5. Workforce allocation and assessment

OHA Expectations

Demonstrate that the CCO will engage in linking PCPCHs and Community Health Workers or other non-traditional Health Care Worker efforts

Demonstrate that the CCO is planning on assisting and ensuring an adequate workforce to support the primary care teams in the PCPCH

Measurement Methodology:

For the PCPCHs and Community Health Workers efforts:

- The CCO clearly define the role of the “Community Health Worker” particularly with respect to how they interact/work with PCPCHs and addresses the following questions:
 - Will Community Health Workers be physically based at PCPCHs?
 - Will they coordinate ER/hospital communication/transitions with PCPCHs? How?
 - Will the CCO/CHW coordinate action plans on a patient and population level with PCPCHs? How? Who decides what role the CHW plays on a daily basis – the CCO? The PCPCH?

For assisting and ensuring adequate workforce to support:

- The CCO will describe its methodology for a workforce needs assessment
- The CCO will describe its plans to reallocate, train, or recruit the workforce needs identified specifically in PCPCHs to support team-based care.

Baseline:

- Describe the CCOs current use of non-traditional health care workers, if any and how they are/will be linking with PCPCHS.
- Describe current primary care workforce needs in supporting the primary care teams in PCPCHs in their provider network

Transformation Activity:

- Describe the actions that will be taken to improve linkages with non-traditional health care worker efforts
- Describe the actions that will be taken to assess and support adequate workforce to support the primary care teams in PCPCHs in the CCO network.

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Improvement Metric

- Describe how the CCO will know that PCPCHs are linking with Community Health Workers or other non-traditional Health Care Worker efforts
- Describe how the CCO will know that there is adequate assistance to PCPCHs to ensure an adequate workforce support

6. Information Sharing with PCPCHs

OHA Expectations

Demonstrate that the CCO is planning on providing utilization and other needed data on members to their network PCPCHs in order to better assist the PCPCH with care coordination.

Measurement Methodology

- The CCO details out its methods of assessing the utilization and data needs of the PCPCHs for enhancing care coordination, and its ongoing monitoring strategy to continuously improve that exchange of actionable information.

Baseline

- Current Percentage of PCPCHs in a CCO Network receiving key utilization and other data currently on the members using that PCPCH.

Transformative Activity

- The CCO will describe its actions on how information will be shared with the CCO's PCPCH providers regularly to assist in panel management and care coordination efforts. This should address:
 - ED visits and hospitalizations admissions and discharges
 - Recent specialty evaluations, recent labs and other tests
 - Data on healthcare costs and overall utilization of services of PCPCHs' members.

Improvement Metric

- Describe how the CCO will monitor improvement in PCPCHs receiving key utilization and other data on the members using that PCPCH, and sets milestones towards all PCPCHs able to use data to improve care coordination and also be informed of cost and quality performance.