

Oregon's Patient-Centered Primary Care Homes and Delivery System Transformation

December 2012

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

Oregon's Goals for PCPCH

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

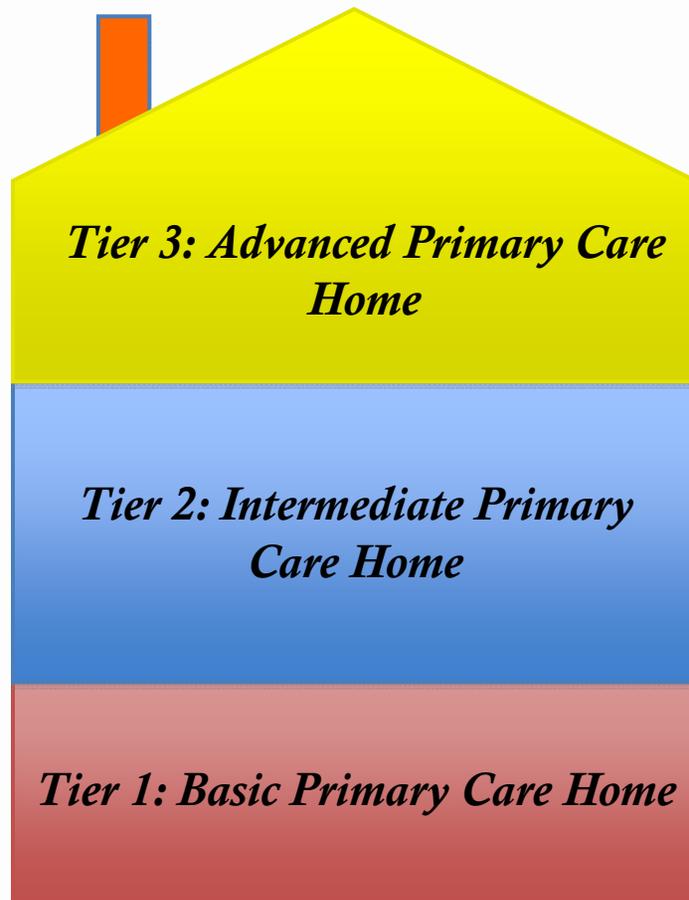
- All OHA covered lives (almost 900, 000) receive care through a Patient-Centered Primary Care Home
 - Includes Medicaid, public employees, Oregon educators, Oregon high-risk pool, Family Health Insurance Assistance Program, and Healthy Kids
- Spread to private payers and Qualified Health Plans via the Exchange
- 75% of Oregonians have access to quality care through a PCPCH by 2015

Oregon's Primary Care Home Key Attributes: Patient and Family Centered

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

- **Access to Care** – *“Be there when we need you”*
- **Accountability** – *“Take responsibility for us to receive 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”*

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

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

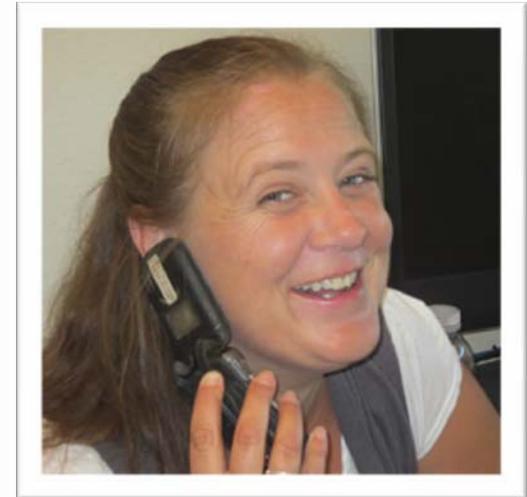
Tier 1: 30-60 pts & 10 must-pass
Tier 2: 65-125 pts & 10 must-pass
Tier 3: 130+ & 10 must-pass

Oregon's Early Success

Over 330 recognized primary care homes as of December 12, 2012

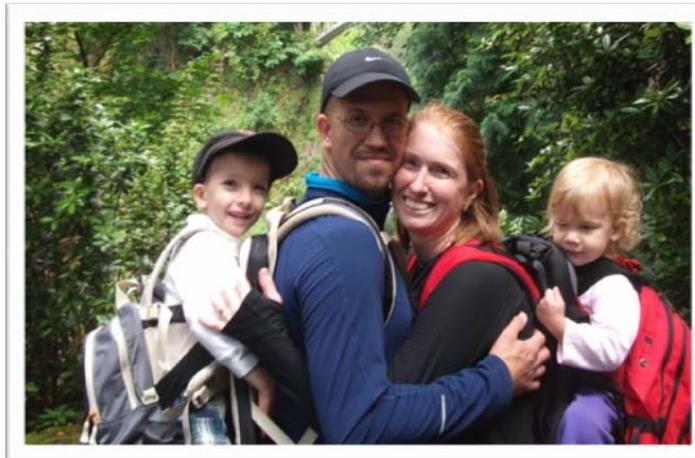


"The team working with my doctor knows about me. This saves me a lot of time."-- Bryant Campbell
(Providence Medical Group – North Portland Family and Community Medicine)



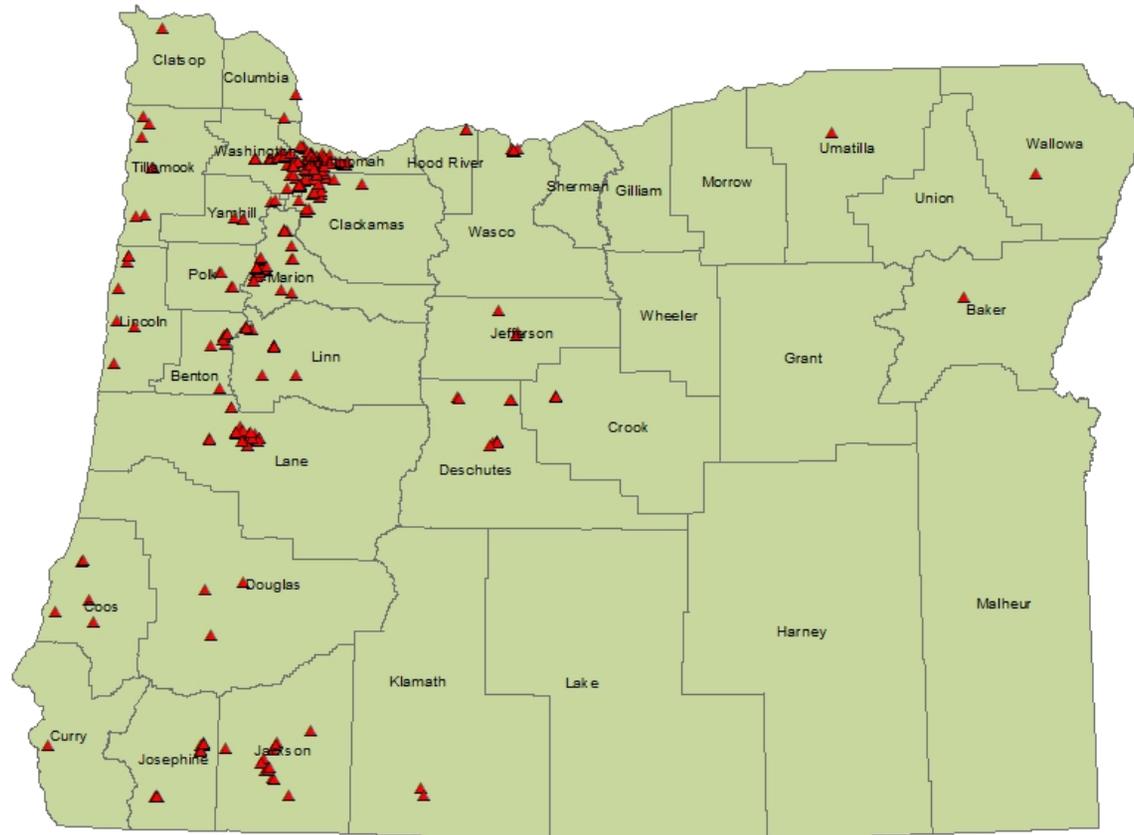
"My health seems better. I have more energy. I just feel happier when I wake up each morning. I feel good about my health." – Michelle Lee (Community Health Center in White City)

"If you're not in a patient-centered primary care home and this is available to you – grab on to it. The care has been fantastic." – Cristy Slawson
(Metropolitan Pediatrics in Gresham)



Primary Care Patient Centered Homes in Oregon

(Total of 323 sites as of 11/30/2012)



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Current Incentive Payments to Oregon PCPCHs and Primary Care

“ACA-Qualified” Medicaid Payments

- Health Home Enhanced Payments from 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 by Medicare & 5 local payers including OHA Medicaid FFS

Commercial Health Plan Enhanced Payments and Incentives -

- One example is PEBB Providence Choice providers and PEBB benefits favor PCPCHs by reducing co-pays.

Other Temporary Primary Care payments - (unrelated to PCPCH)

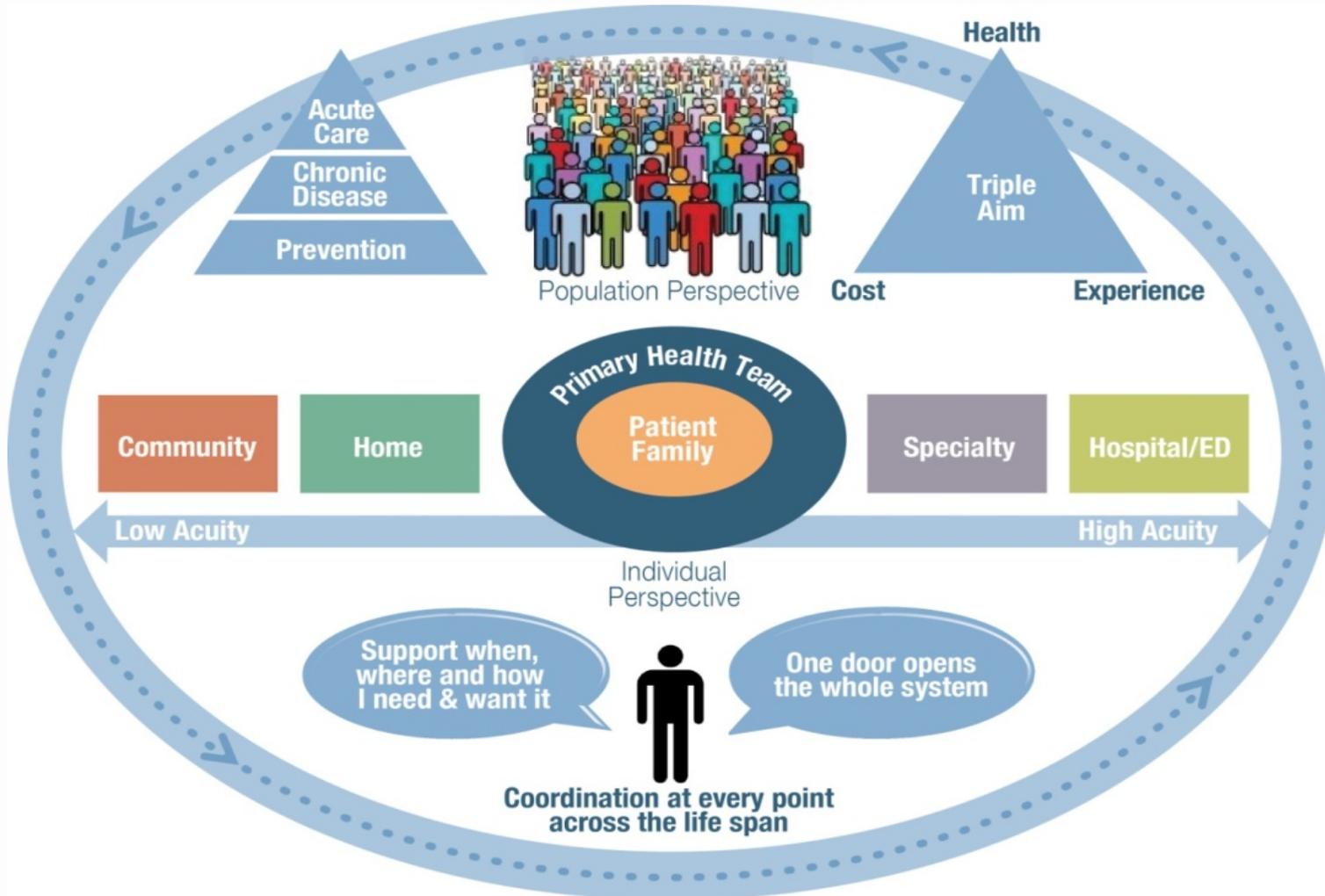
- Medicare’s Primary Care Incentive Payment (PCIP) program (2011-2015) for certain primary care providers
- ACA directs an increase for primary care physician reimbursement for two years (2013 & 2014) for providers serving Medicaid patients, matching Medicare rates.

Primary Care Homes are Integral to Oregon's Coordinated Care Model

- Key elements that will allow Coordinated Care Organizations to transform the delivery system
 - Local control
 - Coordination
 - Global budgets and shared savings
 - Metrics/Performance measures tied to payment
 - Integration of behavioral, physical & community health
 - Reducing health equities

AND Patient-Centered Primary Care Homes

Coordinated Care and Patient-Centered Primary Care Home Teams



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

Examples of CCO's role in PCPCH implementation in their network

- Support/technical assistance to not-yet recognized clinics, and link them to other resources available in the state
- Assess PCPCH Tier status and TA needs across network and foster progress to “climb” the PCPCH model (i.e. Tier 1→3)
- Monitor patients’ access to their PCPCH via focus groups, surveys, outreach, **and** share this information in a timely/actionable manner with frontline PCPCH providers
- Engage frontline providers in PCPCHs via in-person interviews, focus groups, surveys, and key stakeholder interviews about PCPCH capacity, patient access, and resource needs
- Initiate action plans to engage non-contracted PCPCHs that accept Medicaid patients in the CCOs geographic area of care

Examples of Innovative Payment/Financing to Support and Sustain Practice Transformation

- Initiate Tier-Based enhanced care coordination incentive payments
One example: \$2, \$4, \$6 PMPM plus additional PMPM for managing “more complex” patients (similar to ACA qualified payments).
- Specific investments in PCPCH implementation and/or *frontline* PCPCH infrastructure/staffing such as:
 - Employ or support RNs, Clinical Pharmacists, others based at PCPCHs for care coordination, complex chronic disease and medication management, patient education, and other clinical services
 - Support continuous quality and process improvement leaders on site
- Additional financial incentives based on performance on quality outcomes and/or inclusion into shared savings across network
- Capitated or other comprehensive, non-RVU based payment arrangements based on performance

Examples of CCO's role in engaging patients in PCPCH care

- Action plan to help members understand what Patient-Centered Primary Care is (how it benefits them, what quality and service they can expect) and connects them to local primary care homes.
 - PCPCH patient brochures available online: [English](#) & [Spanish](#). Russian and Chinese coming soon
- Identify patients getting care in urgent care/ER who do not have PCP, connect them to local PCPCHs with adequate access/capacity
- Include PCPCH patients in CCO Patient Advisory Council
- Align with PCPCHs to engage, educate, and empower patients and families to improve their health through integrated community health education and resource coordination efforts

Examples of Overall PCPCH Facilitation and Engagement

- Daily ER admission/discharge info from all CCO contracted hospitals/urgent cares sent via secure email to patients' PCPCH.
- Connect current or planned hospital transition care coordinators with PCPs to facilitate and communicate about transitions of care.
- Facilitating and enhancing specialty care, long-term care facilities, etc communication and care coordination with PCPCH
- Ensure use across the network of HIPPA-compliant secure email
- Encourage and enhance use of technology to improve information exchange such as EHR cross-talk ability and/or shared EHR alerts
- Enhancing resources, communication, and coordination of care for PCPCHs identifying significant patient needs in housing, transportation, food, school, etc

Example of CCO's role in assisting workforce allocation and assessment

- Identify a strategy or tool to assess workforce needs
- Initiate and coordinate partnerships/co-location with PCPCHs and other health professionals such as Community Health Workers, Peer Counselors, Behavioral Health specialists, etc to focus on complex patients/high-utilizers and how best to address their needs
- Enhancing PCPCH connections and resources available for complicated mental health management – such as psychiatry consultation to PCPs - and for patients needing dental health care.
- Connect with Oregon's [Primary Care Office](#) for some options to consider, such as National Health Service Corp, HRSA Health Professional Shortage Areas, Medically Underserved Areas/Populations, and assistance on workforce retention

Examples of CCO's Information Sharing with PCPCHs

- Notification of transitions of care (ER, Long-term care facilities, etc)
- Providing regular/actionable overall CCO/PCPCH patient cost and utilization data to the PCPCHs.
- Providing regular specialty cost/utilization and outcomes data to PCPCHs – encourage high value referral patterns and best outcomes
- Coordinating with PCPCHs to identify members who are not accessing recommended care (i.e. sending reminders for preventive care or recommended chronic disease care)
- Partnering with the PCPCHs to develop actionable, practice-level reports regarding recommended preventive/chronic care measures, identifying barriers to improvement, and collaborative plans to overcome identified barriers

Some Resources to Aid CCOs and PCPCHs

- Oregon's Patient-Centered Primary Care Home Program website has a variety of resources, including a list of recognized clinics and steps to become recognized: www.PrimaryCareHome.oregon.gov
- Oregon's State Innovation Plan has detailed information, including literature references as to the effectiveness of the PCPCH model: <http://www.oregon.gov/oha/OHPB/healthreform/docs/or-health-care-innovation-plan.pdf>
- A couple national resources are:
 - Patient-Centered Primary Care Collaborative: <http://www.pcpcc.net/>
 - [American College of Physicians white paper](#) for specialty/PCPCH interface strategies

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 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

PCPC Institute Goals



- Assist practices in becoming recognized as primary care homes and increasing their tier levels – promoting continuous quality improvement
- Provide a “front door” for TA and quality improvement – a trusted source offering something to benefit every type of practice/provider
- Become an ongoing mechanism to support primary care practice transformation and quality improvement in Oregon

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 – diverse stakeholders
- Curriculum developed using local and national content expertise
- Initial Learning Collaborative – 20-25 clinics selected
- Practice facilitation or “coaching” services
- A comprehensive, interactive learning system website
- Online learning modules and monthly webinars – Begin in January
- 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

PCPC Institute Rapid Start-Up Timeline



September - November 2012
Hire Program Director; Establish Oversight Panel; Mini-RFP and select TA providers; Recruit practices for Learning Collaborative; Logo & materials creation; Provider communications

January – October 2013
Learning Collaborative; Monthly webinars*; TA Expert Network; Train-the-trainer; Strategic planning



First monthly webinar about developing and implementing care plans
January 8, 2013 from 8-9:00am - Registration is open now

Curriculum Areas for Patient-Centered Primary Care Institute	
Learning Area	Brief Description
Leadership	<ul style="list-style-type: none"> • Strategies and skills for leading primary care transformation including creating the vision, aligning with organizational strategic goals • Building will and effective execution • Change management • Managing revenue streams
Quality Improvement	<ul style="list-style-type: none"> • QI strategies (Model of Improvement, Lean) • Selection and use of measures • Working within existing data systems to produce valid, reliable, actionable reports, and use of registry systems. • Optimizing use of health information technology
Team Based Care	<ul style="list-style-type: none"> • Building the team and clarifying team roles • Clinical best practices proactive management of the schedule (scrubbing and huddling), etc.
Behavioral Health Integration	<ul style="list-style-type: none"> • Strategies for integration and care collaboration
Access	<ul style="list-style-type: none"> • Empanelment, panel management, continuity • Advanced access scheduling processes • After hours coverage
Patient and Family Engagement	<ul style="list-style-type: none"> • Effectively engaging patients and families in organizational activities and quality improvement activities. • Patient-centered communication
Care Management	<ul style="list-style-type: none"> • Chronic disease management • Self management support • Preventive services • Medication management • Complex case management
Care Coordination and Integration	<ul style="list-style-type: none"> • Referral and Specialty Care coordination • Transitions of care • Health information exchange

Questions?

Plan	Transformation Contact
Cascade Health Alliance, LLC (CCC) May stay FCHP	Tracey Robichaud
Eastern Oregon Community Care Organization (ODS)	Tracey Robichaud
FamilyCare Coordinated Care Organization	Keri Mintun
Western Oregon Advanced Health LLC (DOCS)	Lisa Welch
Columbia Pacific Coordinated Care Organization, LLC (CareOregon & Gohbi)	Tracey Robichaud
HealthShare of Oregon (CareOregon, Providence, Tuality, Kaiser)	Keri Mintun
PrimaryHealth of Josephine County, LLC (CareOregon(OHMS))	Lisa Welch

Plan	Transformation Contact
Jackson Care Connect (CareOregon)	Lisa Welch
Yamhill County Care Organization (CareOregon)	Rosanne Harksen
InterCommunity Health Network Coordinated Care Organization	Rosanne Harksen
Trillium Community Health Plan, Inc. (LIPA)	Rosanne Harksen
AllCare Health Plan (MRIPA)	Bevin Hansell
Willamette Valley Community Health, LLC (MPCHP)	Rosanne Harksen
Umpqua Health Alliance, (DCIPA)	Bevin Hansell
PacificSource Community Solution, Inc	Tracey Robichaud

Visit: www.PrimaryCareHome.oregon.gov
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PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

Oregon
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Authority