Advancing the Medical Home: State Models and Methods

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

Minnesota's Health Care Home Initiative
Development of Standards

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History of Medical Home in Minnesota

- Mid 90's – MCSHCN (Minnesota's Title V agency) commitment to Medical Home
- 2003 – Medical Home Learning Collaborative – MCHB funded
- 2005 – Minnesota Medical Association – Healthy Minnesota endorses Medical Home
- 2007- First "medical home" legislation- Provider Directed Care Coordination for patients with complex illness in the Medicaid FFS population (Primary Care Coordination)
- 2007- Governor's Healthcare Transformation Taskforce and Legislature's Health Care Access Commission both endorse Medical home
- 2008- Health Care reform legislations requires "health care homes" for all Medicaid/ SCHIP/ state employees/ privately insured

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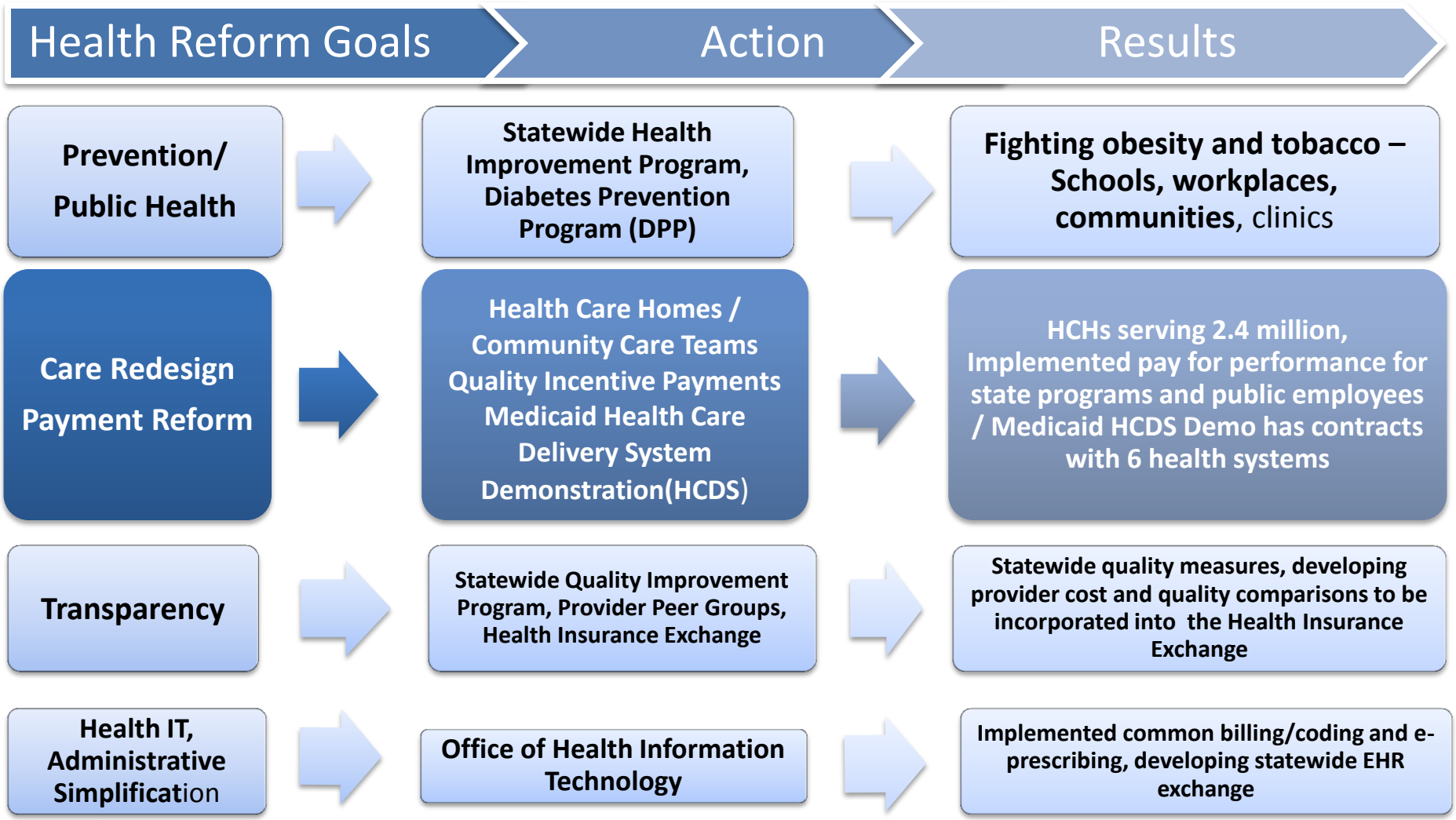
MN Health Reform



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HCH Legislation: Standards developed by the Commissioners must meet the following criteria:

- Use of primary care
- Focus on high-quality, efficient, and effective health care services
- Provide consistent, ongoing contact with a personal clinician or team of clinical professionals
- Ensure appropriate comprehensive care plans for their patients with complex or chronic conditions
- Encourage patient-centered care
- Measure quality, resource use, cost of care, and patient experience;
- Use scientifically based health care, patient decision-making aids
- Use health information technology and systematic follow-up, including the use of patient registries

Assumptions for HCH Rules

- Community stakeholders work is reflected in rules and patients have roles in design at all levels
- Encourage providers to create patient-centered health care homes.
- Allow for innovation and flexibility and are operationally feasible
- Emphasize primary care services that seem feasible to personal clinicians who provide primary care
- Shall not seem excessively burdensome
- Support transforming practices to meet IHI “triple aim” outcomes, improving health, patient experience, cost control.
- Focus on outcomes that support certification processes over time

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HCH Development Process

- Collaboratively organized in state government between the Departments of Health and Human Services with emphasis on public-private collaboration with broad stakeholder input.
- A combination of grant contracts and state organized processes
- Integration with all of the other parts of the Health Care Reform legislation with HCH models
- Learning from and building on local and national experiences Flexibility within the parameters of the legislation creating opportunity to test different models
- Meaningful measures that focus on desired outcomes more than process
- Refinement of model over time

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Program Development; Foundational Components

- A capacity Assessment
- Outcomes recommendation
- Patient/Family/consumer council

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Program Development; Program Components

- Certification criteria
- Certification and recertification process
- Payment methodology
- Learning collaborative
- Outcome measurement

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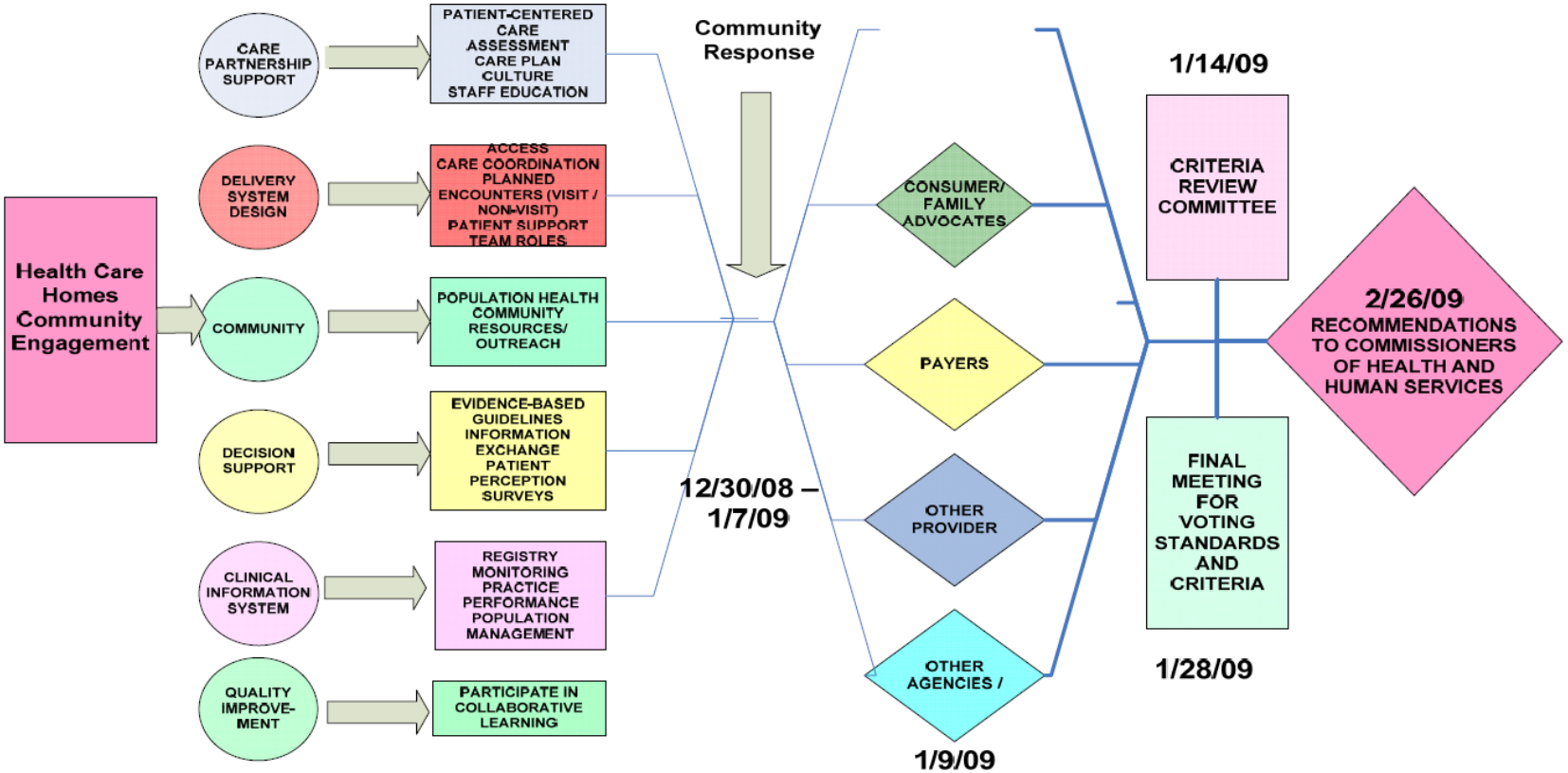
Community Engagement Process

Figure 1: Community Engagement Process



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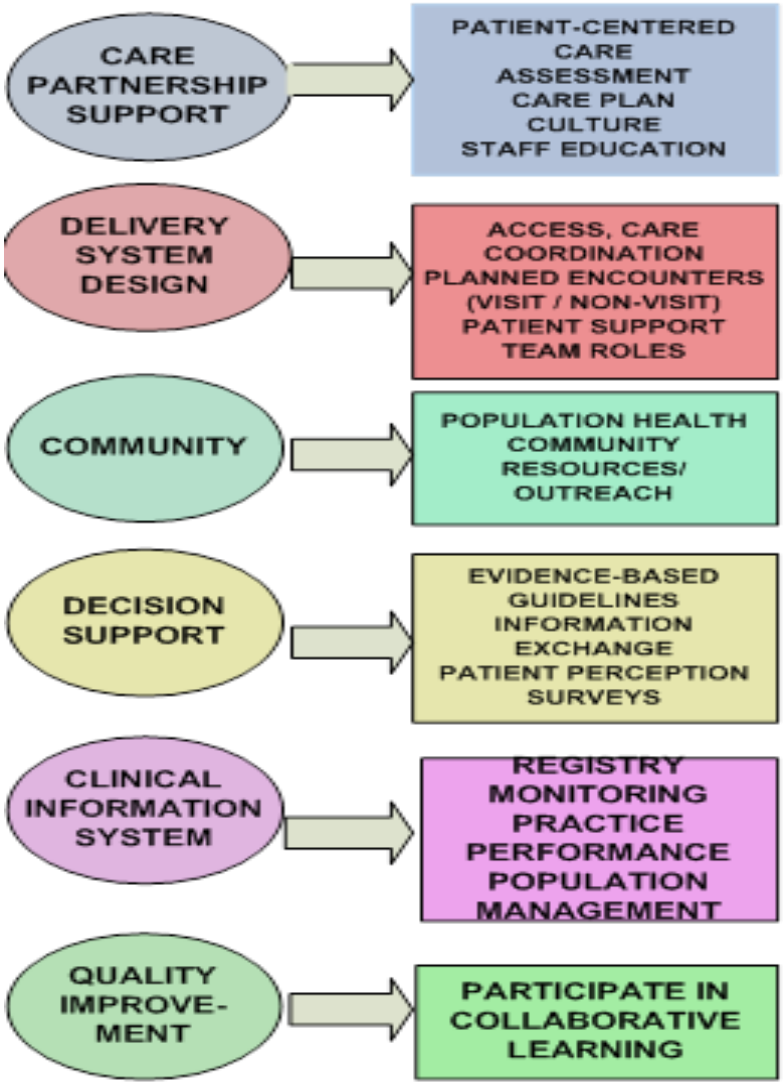
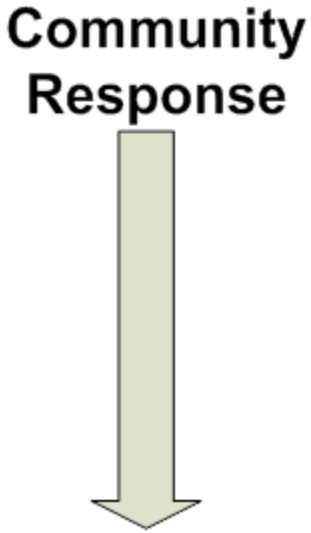
HCH: Criteria Process Domain Work Group



- **12/18/08**
- **Outcomes drive the process.**
- **Review existing CMS, NCQA, PCC standards.**
- **Identify draft standards for each care domain.**
- **Begin process for design of measures / functions,**

HCH: Criteria Process, Community Response



12/29/08 – 1/7/09

- Internet survey tool
- Draft standards from 12/18/09 work.
- Rank with consumer friendly criteria
- Written for public opinion / feedback on draft standards. Not a scientific survey
- Statewide distribution for public feedback

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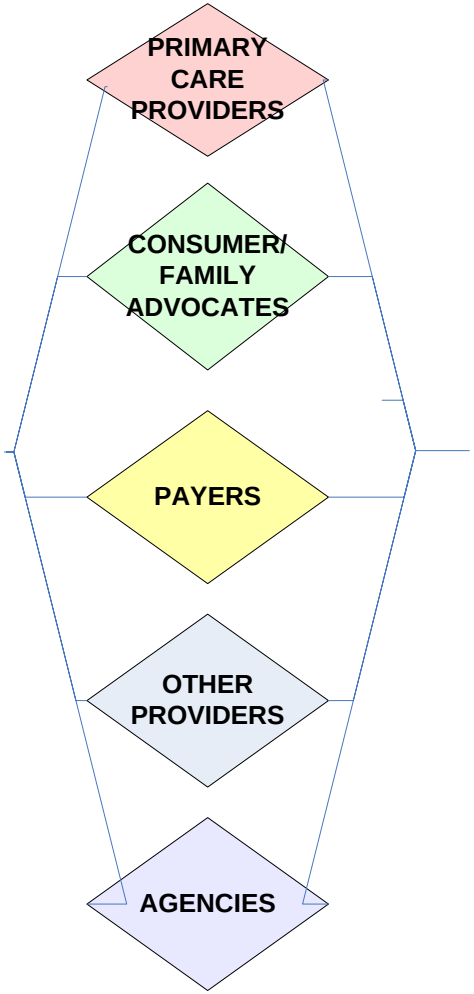
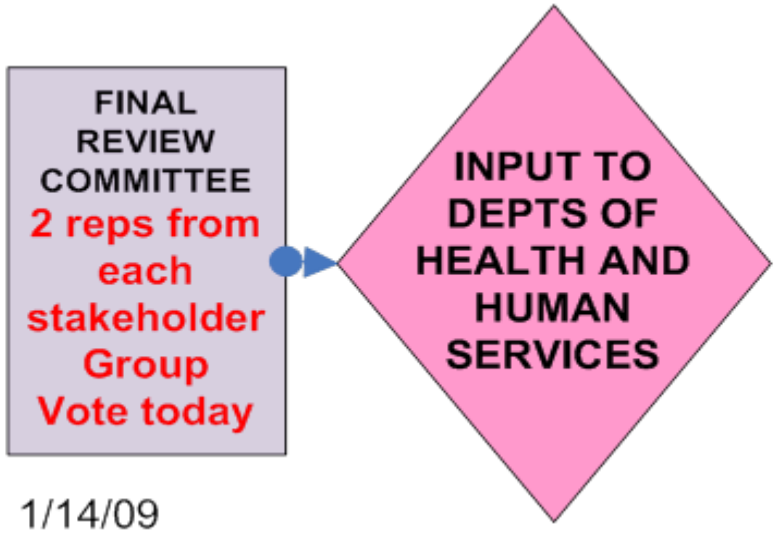
HCH: Criteria Process Stakeholder Workgroup



- **1/9/09**
- **Stakeholders review standards, measures / functions.**
- **Prioritize work**
- **Identify barriers**
- **Develop recommendations**

HCH: Criteria Process
Final Workgroup Review



1/14/09, 8 a.m. – 12N
Final review & prioritization of standards.
Implementation discussion
Can this criteria be verified?
Is it essential for transformation?
Recommendations to Commissioners of Health and Human Services in late January 2009

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Thank you!

- For more information visit the Minnesota Department of Health, Health Care Home website at:

http://www.health.state.mn.us/healthreform/homes/index.html

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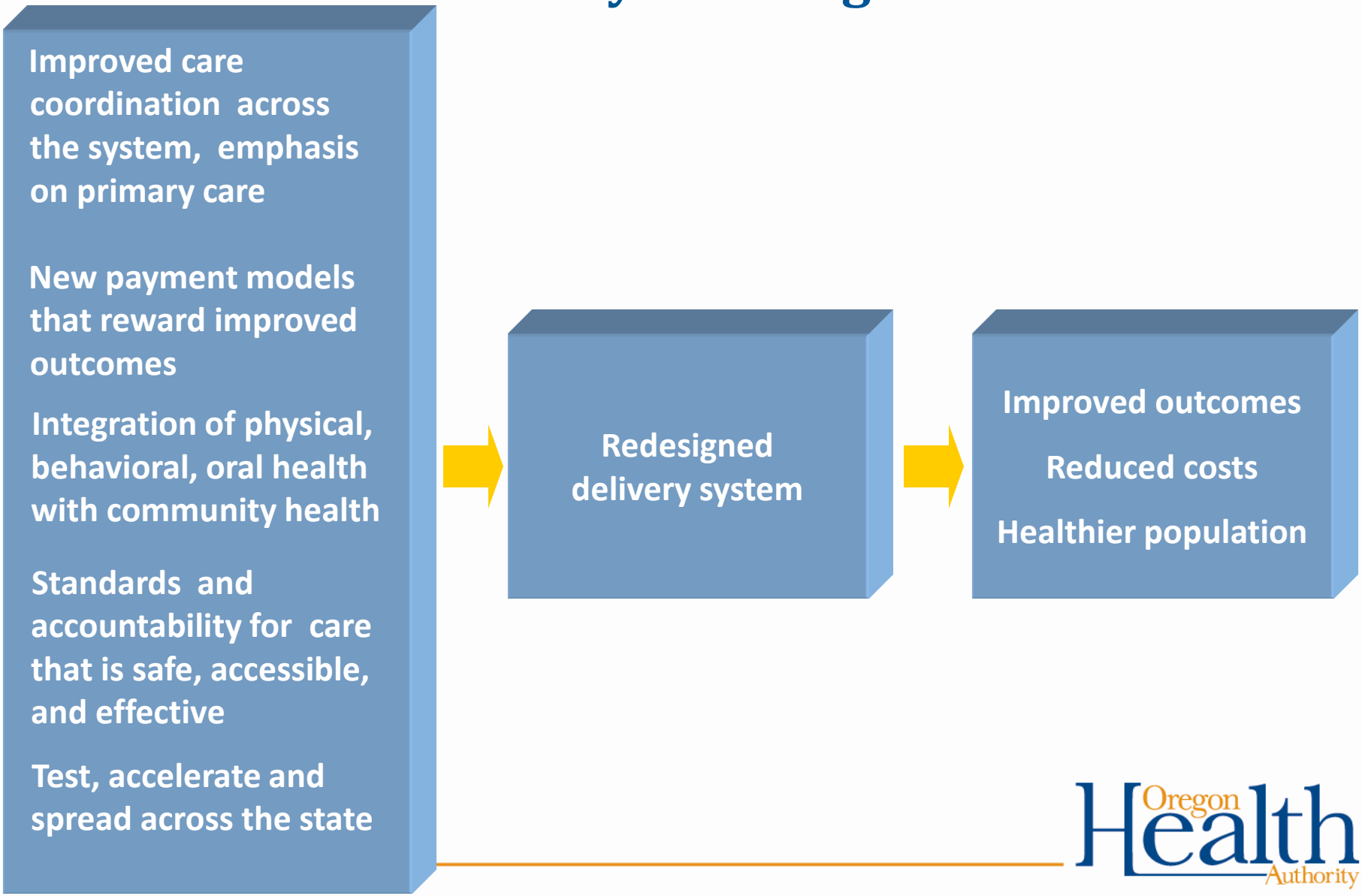
Oregon's Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Collaborative
Annual Fall Conference
November 2014

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

Oregon Health Authority

Theory of Change



Oregon Health Authority

Launching Oregon's Coordinated Care Model in Medicaid

- Built on 1994's Oregon Health Plan that covers 640,000 Oregonians today
- HB 2009 set the stage for Oregon's broad health care reform, including proceeding with a health insurance exchange, the PCPCH program, and delivery system transformation
- Senate Bill 1580, as a follow up to 2011's HB 3650-Health Care Transformation directed the State to launch Coordinated Care Organizations (CCOs)
- Strong bi-partisan support
- A year of public input – more than 75 public meetings or tribal consultations

Oregon Context: Health System Transformation

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PATIENT CENTERED PRIMARY CARE HOME

Oregon Health Authority

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

PCPCH Program shall:

- Define core attributes of the patient-centered primary care home to promote a reasonable level of consistency of services provided by primary care homes in the state
- Establish a simple and uniform process to identify primary care homes that meet the core attributes
- Develop uniform quality measures that allow for standard measurement
- Establish a learning collaborative
- Have an advisory committee to assist in carrying out these functions

Standards Advisory Committee

- 15 multi-stakeholder members
- 7 public meetings Nov 2009 - Jan 2010

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."

COORDINATION AND INTEGRATION

"Help us navigate the health care system to get the care we need in a safe and timely way."

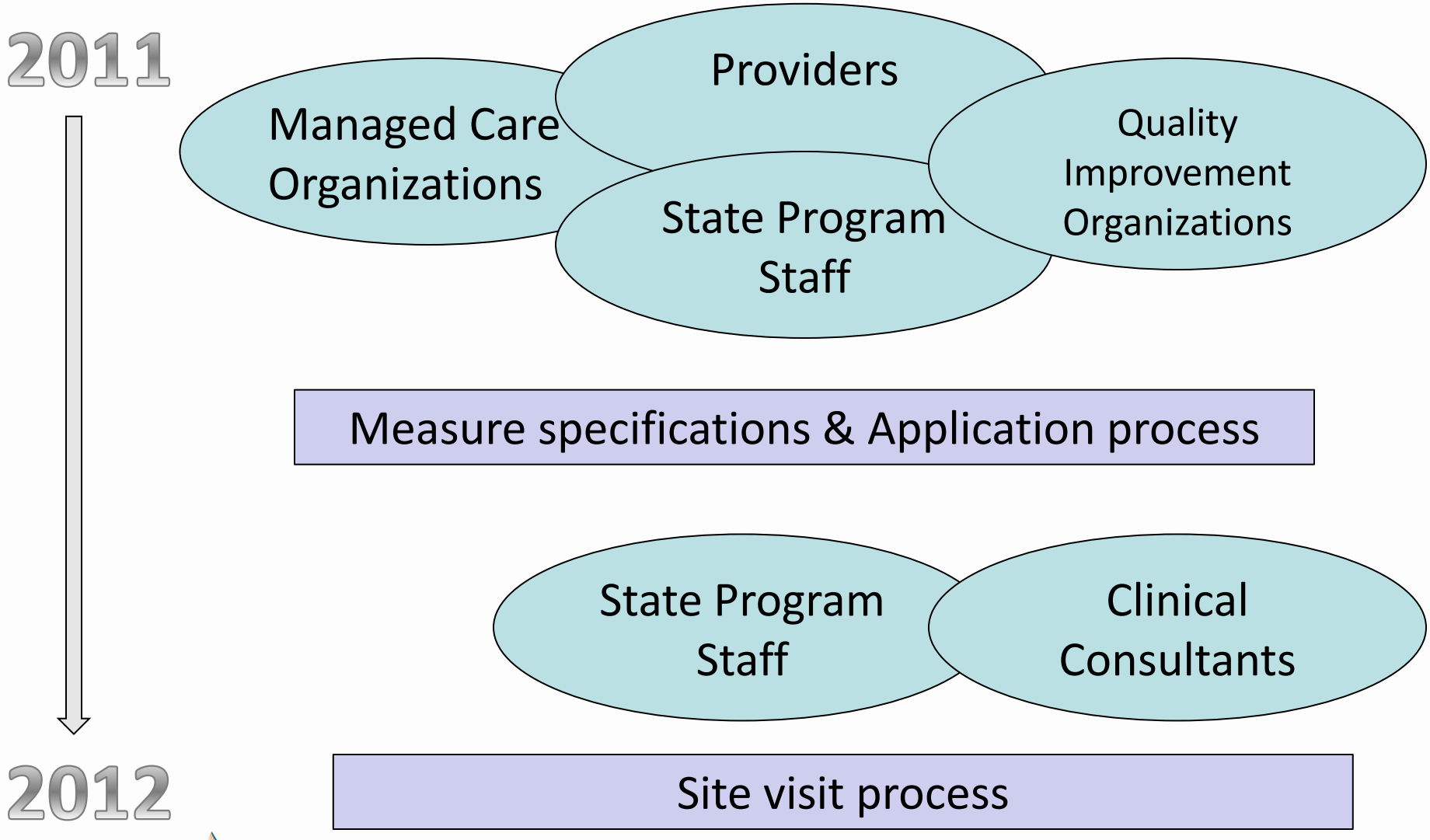
PERSON AND FAMILY CENTERED CARE

"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."

Standards Advisory Committee

- Pediatric Advisory Committee
  - 23 multi-stakeholder members
  - Brought in additional expertise in pediatrics
  - 5 public meetings Aug - Nov 2010
  - Reviewed model to ensure that unique needs of children and adolescents were met
- 2014 Standards Development
  - 23 multi-stakeholder members
  - 5 public meetings Aug - Oct 2012
  - Refined model based on evidence and alignment with other initiatives

Program Development and Launch



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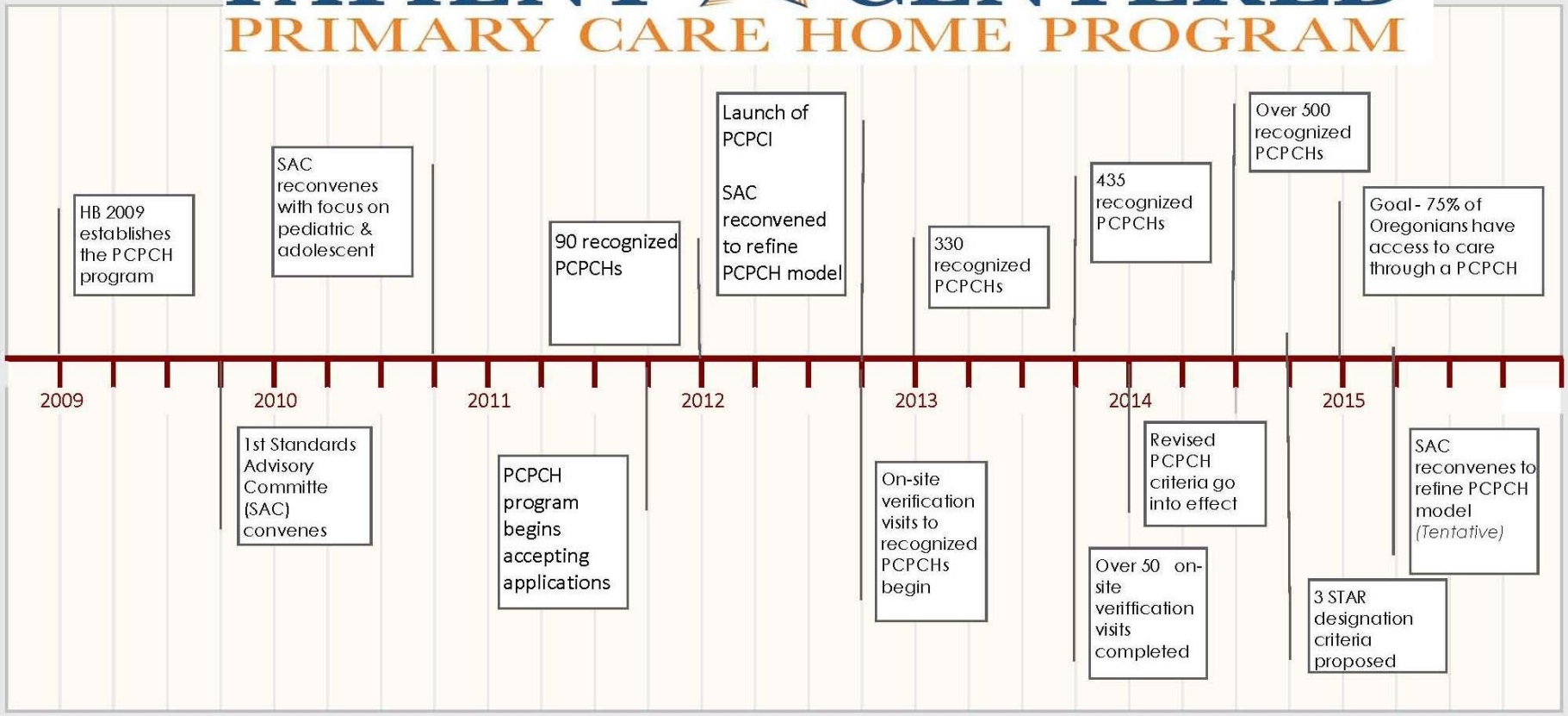


Payment Incentives for Primary Care Homes

Commercial Health Plan Enhanced Payments and Incentives -

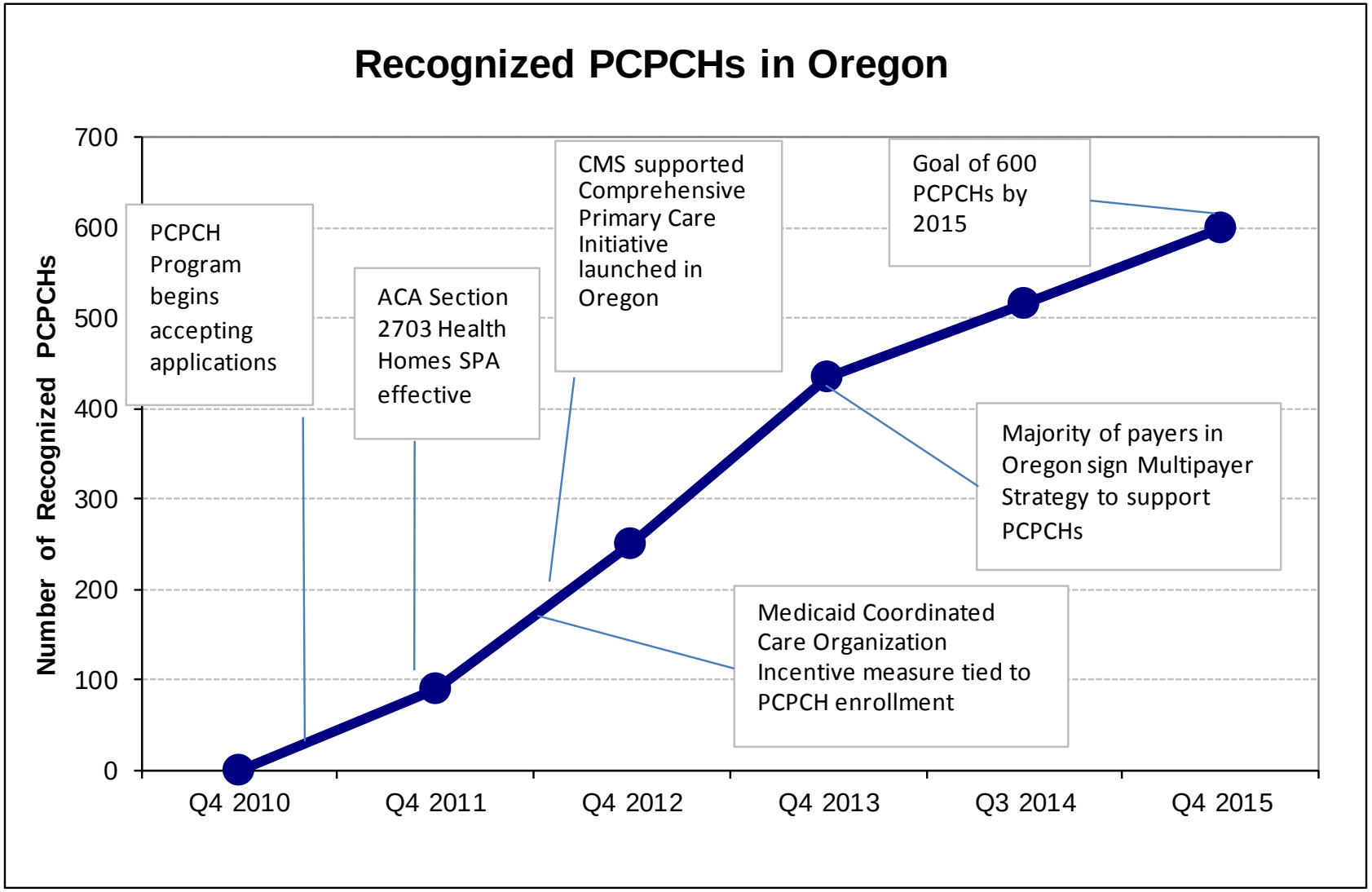
- PEBB Providence Choice age-adjusted PMPM for tiers 2 & 3, and consumer incentives though reduced cost-sharing
- Aetna PCPCH incentive payment program
- Voluntary multi-payer agreement

Comprehensive Primary Care Initiative (CPCI) -

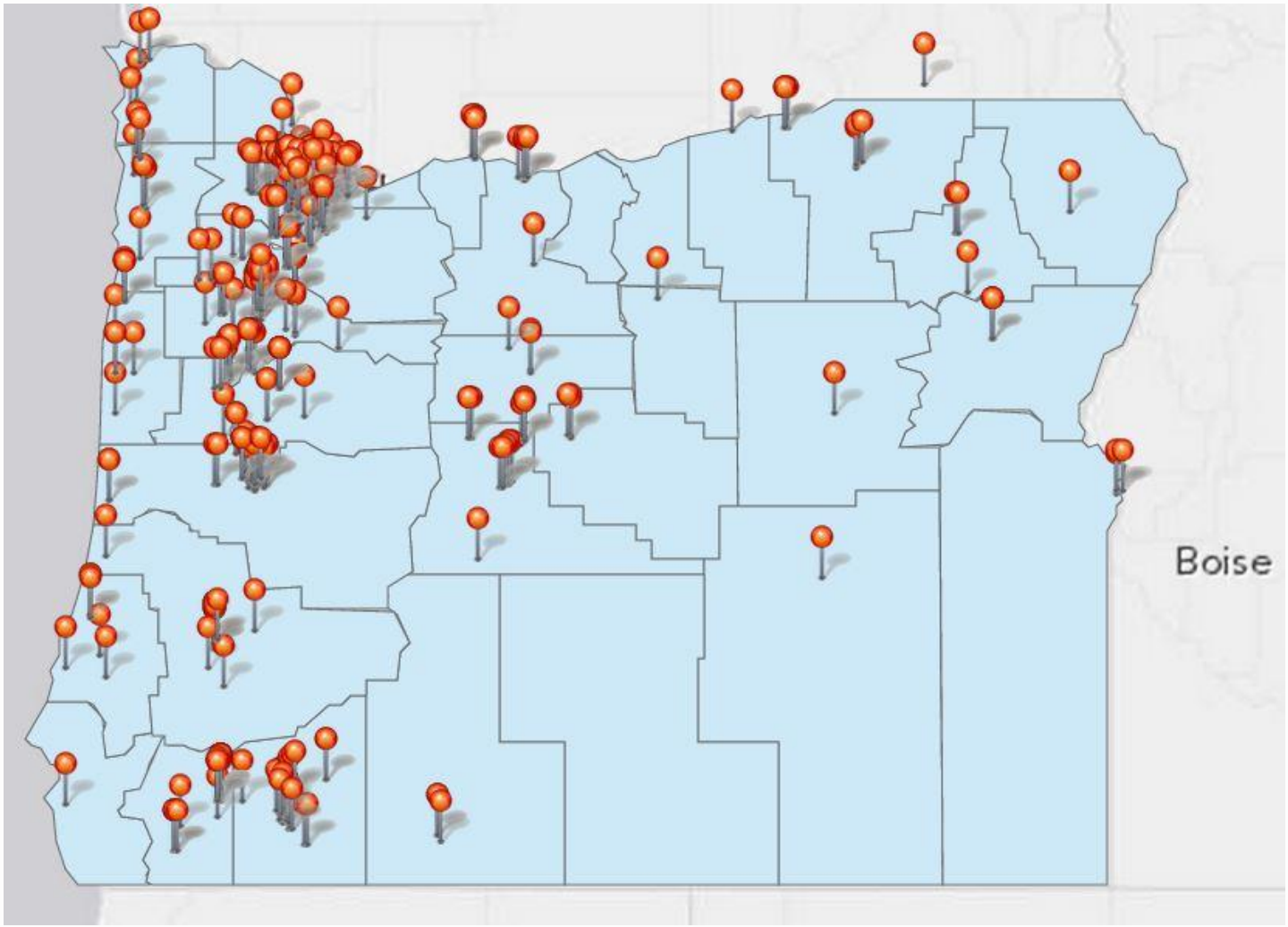
- 67 primary care homes selected to be paid an enhanced payment by Medicare & 5 local payers including OHA Medicaid FFS

Medicaid-Covered Lives -

- CCOs - Varying incentives for PCPCH recognition provided through Medicaid Coordinated Care Organizations
- ACA Section 2703 Payments for "ACA Qualified" – 8 quarter opportunity through the ACA, ended September 30, 2013


Recognized PCPCHs in Oregon
Number of Recognized PCPCHs
700
600
500
400
300
200
100
0
Q4 2010
Q4 2011
Q4 2012
Q4 2013
Q3 2014
Q4 2015
PCPCH Program begins accepting applications
ACA Section 2703 Health Homes SPA effective
CMS supported Comprehensive Primary Care Initiative launched in Oregon
Goal of 600 PCPCHs by 2015
Majority of payers in Oregon sign Multipayer Strategy to support PCPCHs
Medicaid Coordinated Care Organization Incentive measure tied to PCPCH enrollment

Where are PCPCHs?



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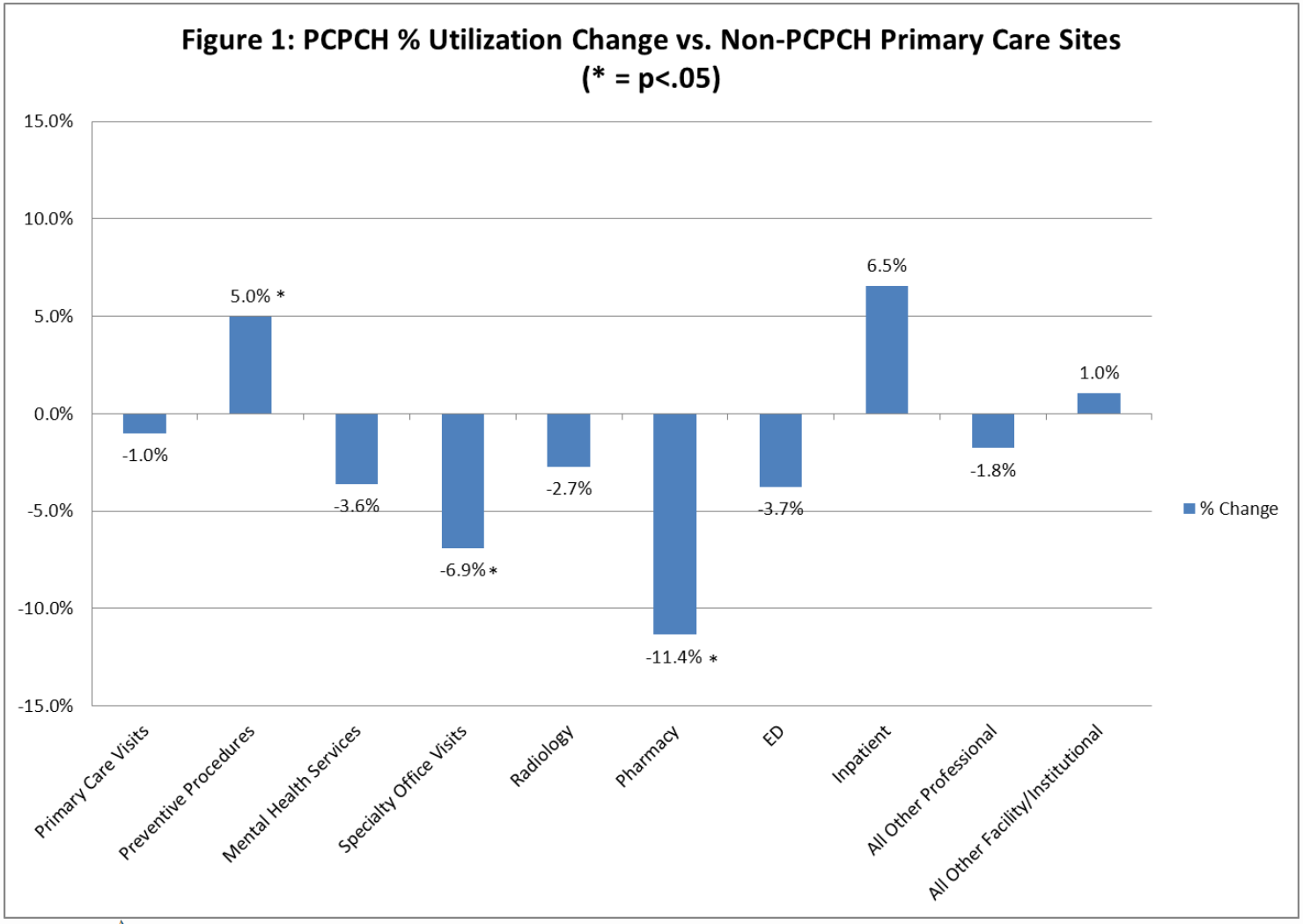
What do PCPCHs look like?

- Staffing and services
  - Average # providers = 5.1 (1-39 FTE)
  - Majority serve adult and pediatric populations
  - < 20% offer CAM
- Ownership
  - Nearly half owned by a larger system
  - 40% independent and unaffiliated
  - About 10% independent but in alliances
- Implementation
  - Over 80% (N=252) of survey respondents needed to add new services in order to implement the model

Achieving the triple aim

- 85% of those surveyed believe the PCPCH model is helping them improve the individual experience of care
- 85% feel the model is helping their practice increase the quality of care
- 82% report the model is helping them improve population health management
- 75% feel the model is helping their practice increase access to services
- PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years (*Information for a Healthy Oregon.* The Quality Corporation, August 2013.)

Impact on Utilization



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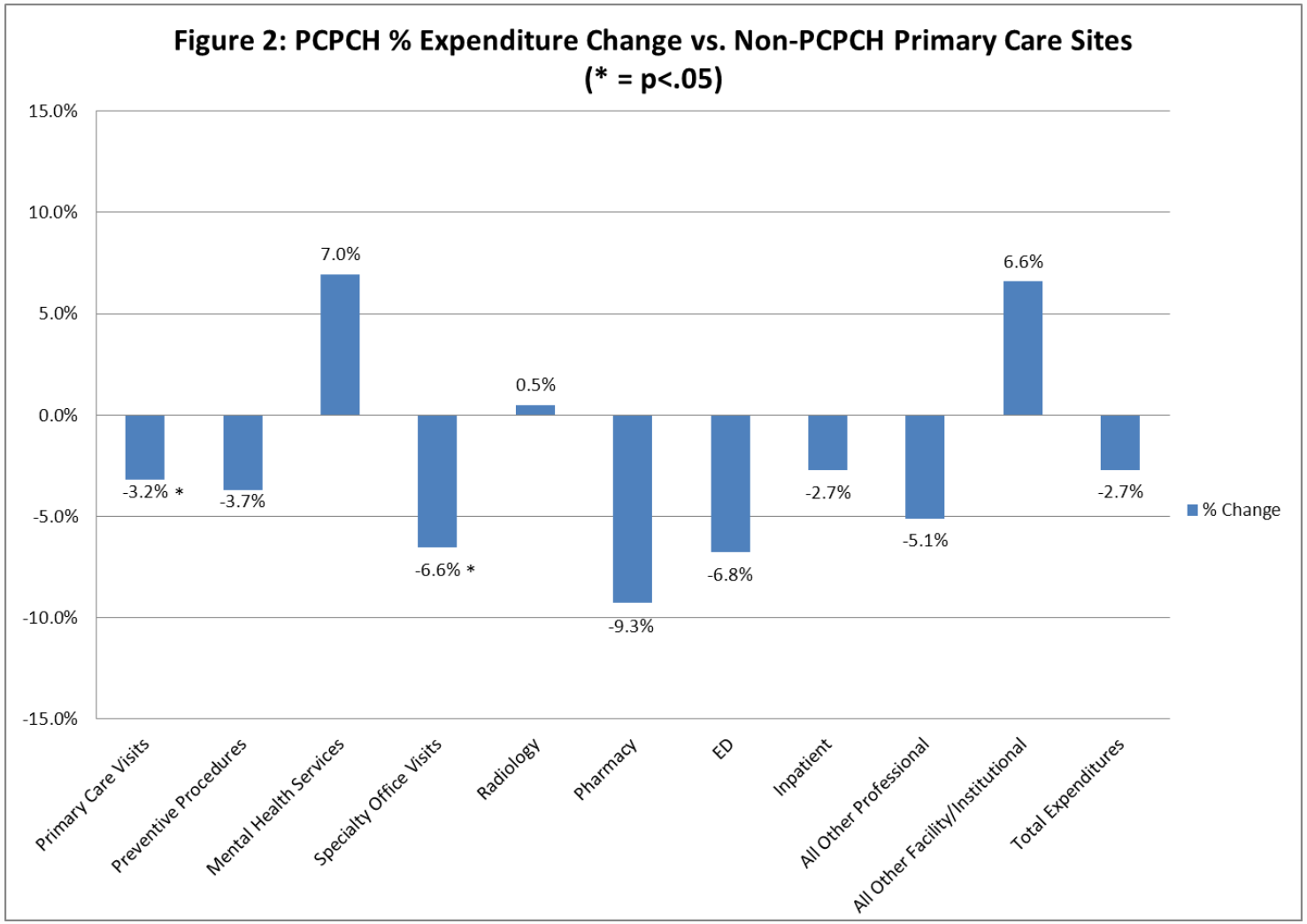
Impact on Expenditures



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Key Lessons

Requirements for success:

- Collaborate through public discussion and dialogue
- Technical assistance
  - Patient-Centered Primary Care Institute (www.pcpci.org)
  - Transformation Center (http://transformationcenter.org)
- Resources
  - Human and financial
- Ensure operational capabilities are in place
- Keep it simple!

Considerations:

- Using an “engagement model” approach
- Using a broader, population or standards-based approach
- Balancing provider accountability with administrative burden
- Partner with other payers for sustainability

Questions?

Contact us at: PCPCH@state.or.us

www.PrimaryCareHome.oregon.gov

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