Multipayer Strategy to Support Primary Care Homes

November 5, 2013

Background

Strong, effective primary care health homes are foundational to transforming and sustaining high quality healthcare for Oregonians. Evidence shows that team-based primary care will lead to better outcomes and drive down costs. The more quickly Oregon can drive adoption of primary care health homes statewide, the more quickly we will drive achievement of the Triple Aim (improving care, improving health, and reducing cost).

Oregon's statewide primary care health home program is known as PCPCH (Patient Centered Primary Care Home). PCPCH is a tiered approach representing increasing levels of primary care home attributes for a given practice. A broad-based, multi-payer strategy is needed to support primary care homes statewide. Multi-payer support will ensure that practices are compensated for the work they are doing to provide coordinated care, and supported in achieving outcomes through a robust and shared primary care home approach.

The Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC) convened a series of meetings from July to September 2013 that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon, facilitated and supported by the Center for Evidence-based Policy. Through the process, the organizations listed below agreed to the shared goals, objectives and initial key actions listed in this document.

Goal

Mutual investment and commitment to accountable, sustainable, patient-centered primary care that results in achievement of the triple aim.

Objectives

1. Simple, straightforward, and explainable payment models
2. Payment policies will align
    - Metrics
    - Standards
    - Quality
    - Accountability audits
    - Other support
3. Meaningfully raise the bar in the delivery of quality care and outcomes for patients
4. Allow for innovation, continuous improvement and movement to the triple aim
5. Build on existing efforts and align with them where possible
6. Facilitate and/or further provider transformation

Actions

To reach the goals and objectives, payers agreed to the following initial joint actions:

1. All Oregon payers will use a common definition of primary care home based on OHA's PCPCH Program. (see attachment)
2. Payers will provide variable payments, or other payment models, to those primary care practices in their network participating in OHA's PCPCH program, based on each practice's PCPCH points total and their progress toward achieving outcomes which lead to the Triple Aim. Some payers may also require that practices meet specific thresholds or other conditions prior to qualifying for payments. The structure, qualifications, and amount of these payments will be the responsibility of each payer to determine or negotiate with practices in their network.
3. OHA's PCPCH program will build in practice accountability for progress toward transformation. They will work with payers and practices to identify and agree on a common set of meaningful outcome metrics, consistent with those already in place for Oregon providers, as well as reporting formats and administrative processes that simplify the administrative burden on practices.
4. The Oregon Health Authority, through its state health transformation efforts, has efforts underway to assist providers in achieving the standards of PCPCH, including the Transformation Center, site visits, and the Patient-Centered Primary Care Institute. Payers will work with providers, purchasers, and other stakeholders to identify meaningful ways for further collaboration in order to support the long-term sustainability of primary care homes. This group will specifically discuss efforts to engage self-insured employers in primary care home efforts.
5. Payers will convene to review the progress toward outcome metrics, and impact on total cost of care on at least an annual basis and determine whether adjustments need to be made to this payer collaboration or individual payer contributions based on the following:
    - Whether cost savings and other outcome measures expected from this effort are realized.
    - Whether practices are progressing according to the structure of the PCPCH program.
    - Whether there is a need to convert some practices (e.g. established and high achieving practices or underperforming practices) to a different kind of reimbursement model.
    - Whether new research reveals opportunities for improved practice transformation and cost containment.
    - Whether shared savings or other payment models provide opportunities for reinvestment.

    Payers will also work with providers to review implementation strategies.

6. Participating organizations agree that strong primary care homes are a necessary foundation for achieving the Triple Aim, and that the ability to adequately and sustainably invest in primary care will be the result of changes across the entire medical neighborhood. For this reason, participating organizations in this effort support OHA's commitment to convene broad payment reform discussions no later than January 31, 2014.

Participating Organizations Agreeing to these Goals, Objectives and Actions

John Wagner
Aetna

Pat Curran
CareOregon

Suzanne Dinsmore
Childhood Health Associates of Salem

John Sobeck
CIGNA

Paul Barner
First Choice Health

Christi Siedlecki
Grants Pass Clinic

Chris Ellertson
Health Net of Oregon

Janet Meyer
Health Share of Oregon

Bess Jacobo
Kaiser Permanente

Majd El-Azma
LifeWise Health Plan of Oregon

Shikha Gupta
Moda Health

Evan Saulino
Oregon Academy of Family Physicians

Robin Moody
OR Association of Hospitals and Health Systems

Bruce Goldberg
Oregon Health Authority

Don Antonucci
Oregon Health Leadership Council

Jo Bryson
Oregon Medical Association

Susan King
Oregon Nurses Association

Ken Carlson
Oregon Pediatric Society

Ken Provencher
PacificSource Health Plans

Dave Underriner
Providence Health & Services

Don Antonucci
Regence Blue Cross Blue Shield of Oregon

Chris Senz
Tuality Health Alliance

Valerie Gordon
Umpqua Health Alliance

Patient-Centered Primary Care Home 2014 Recognition Criteria
Quick Reference Guide

Oregon Health Authority
Last Updated August 19, 2013

This guide is intended to provide a brief overview of Oregon's Patient-Centered Primary Care Home (PCPCH) Program criteria for recognition that will be effective January 1, 2014. The technical specifications will be available mid-September 2013.

Please refer to the following definitions when using this document:

Unchanged: The measure was part of the 2011 criteria.
New: This optional measure was added to the 2014 criteria.
(D): Data submission required.

The scoring system for the 2014 PCPCH recognition criteria remains the same. There are 10 must-pass standards that every recognized clinic must meet. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. A clinic's overall tier of recognition is determined by the following:

Tier 1:	30 – 60 points and all 10 must-pass measures
Tier 2:	65 - 125 points and all 10 must-pass measures
Tier 3:	130 or more points and all 10 must-pass measures

Important Note:
Any clinic applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail, including what documentation the clinic must have to support their attestation. Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted.
The technical specifications for the 2014 criteria will be available mid-September 2013.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*			
Standard 1.A) In-Person Access			
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	Unchanged	No	5
1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care.	Unchanged	No	10
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	Unchanged	No	15
Standard 1.B) After Hours Access			
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	Unchanged	No	5
Standard 1.C) Telephone and Electronic Access			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Unchanged	Yes	0
1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient's medical record.	New	No	5
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	New	No	5
Standard 1.E) Electronic Access			
1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.	New	No	15
Standard 1.F) Prescription Refills			
1.F.1 PCPCH tracks the time to completion for prescription refills.	New	No	5
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*			
Standard 2.A) Performance & Clinical Quality			
2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Unchanged	Yes	0

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
2.A.2 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Unchanged	No	10
2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Unchanged	No	15
Standard 2.B) Public Reporting			
2.B.1 PCPCH participates in a public reporting program for performance indicators.	New	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	New	No	10
Standard 2.C) Patient and Family Involvement in Quality Improvement			
2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	New	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities.	New	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	New	No	15
Standard 2.D) Quality Improvement			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	New	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	New	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	New	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
Standard 2.E) Ambulatory Sensitive Utilization			
2.E.1 PCPCH obtains information necessary to track selected utilization measures most relevant to their overall or an at-risk patient population.	New	No	5
2.E.2 PCPCH reports to the OHA selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization. (D)	New	No	10
2.E.3 PCPCH reports to the OHA selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures. (D)	New	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*			
Standard 3.A) Preventive Services			
3.A.1 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	Unchanged[1]	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	New	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	New	No	15
Standard 3.B) Medical Services			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.	Unchanged	Yes	0
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)			
3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.	Unchanged	Yes	0

[1] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.	Unchanged[2]	No	10
3.C.3 PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.	Unchanged	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention			
3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	Unchanged	No	5
Standard 3.E) Preventive Services Reminders			
3.E.1 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services.	New	No	5
3.E.2 PCPCH tracks the number of unique patients who were sent appropriate reminders.	New	No	10
3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.	New	No	15
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*			
Standard 4.A) Personal Clinician Assigned			
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15
Standard 4.B) Personal Clinician Continuity			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	New	No	10

[2] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	15
Standard 4.C) Organization of Clinical Information			
4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.	Unchanged	Yes	0
Standard 4.D) Clinical Information Exchange			
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
Standard 4.E) Specialized Care Setting Transitions			
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Unchanged	Yes	0
Standard 4.F) Planning for Continuity			
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	New	No	5
Standard 4.G) Medication Reconciliation			
4.G.1 Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation.	New	No	5
4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled.	New	No	10
4.G.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of care.	New	No	15
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*			
Standard 5.A) Population Data Management (check all that apply)			
5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.	Unchanged	No	5

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	Unchanged	No	5
Standard 5.B) Electronic Health Record			
5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be "meaningful users" of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	Unchanged[3]	No	15
Standard 5.C) Complex Care Coordination (check all that apply)			
5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.	Unchanged	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	Unchanged	No	10
5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.	Unchanged[4]	No	15
Standard 5.D) Test & Result Tracking			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	Unchanged	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	Unchanged[5]	No	5

[3] The intent of this measure has not changed, but the language has been clarified.

[4] This measure was included in the 2011 criteria under Standard 5F; the intent has not changed, but language is clarified and reorganized under 2014 Standard 5.C.

[5] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).	Unchanged[6]	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.	Unchanged[7]	No	15
Standard 5.F) End of Life Planning			
5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.	Unchanged	Yes	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	New	No	5
CORE ATTRIBUTE 6: 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."*			
Standard 6.A) Language / Cultural Interpretation			
6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.	Unchanged	Yes	0
6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.	New	No	5
Standard 6.B) Education & Self-Management Support			
6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	Unchanged[8]	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	New	No	10

[6] This measure was included in the 2011 criteria as measure 5.E.1.b; the intent has not changed, but language is clarified and reorganized as measure 5.E.2.

[7] The intent of this measure has not changed, but the language has been clarified.

[8] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	New	No	15
Standard 6.C) Experience of Care			
6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	Unchanged	No	5
6.C.2 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.	Unchanged[9]	No	10
6.C.3 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.	Unchanged[10]	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, complaint, and grievance procedures; roles and responsibilities; and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	New	No	5

[9] The intent of this measure has not changed, but the language has been clarified.

[10] The intent of this measure has not changed, but the language has been clarified.