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Ohio's Patient-Centered Medical Home Care Delivery and Payment Model

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Comprehensive Primary Care Learning Session
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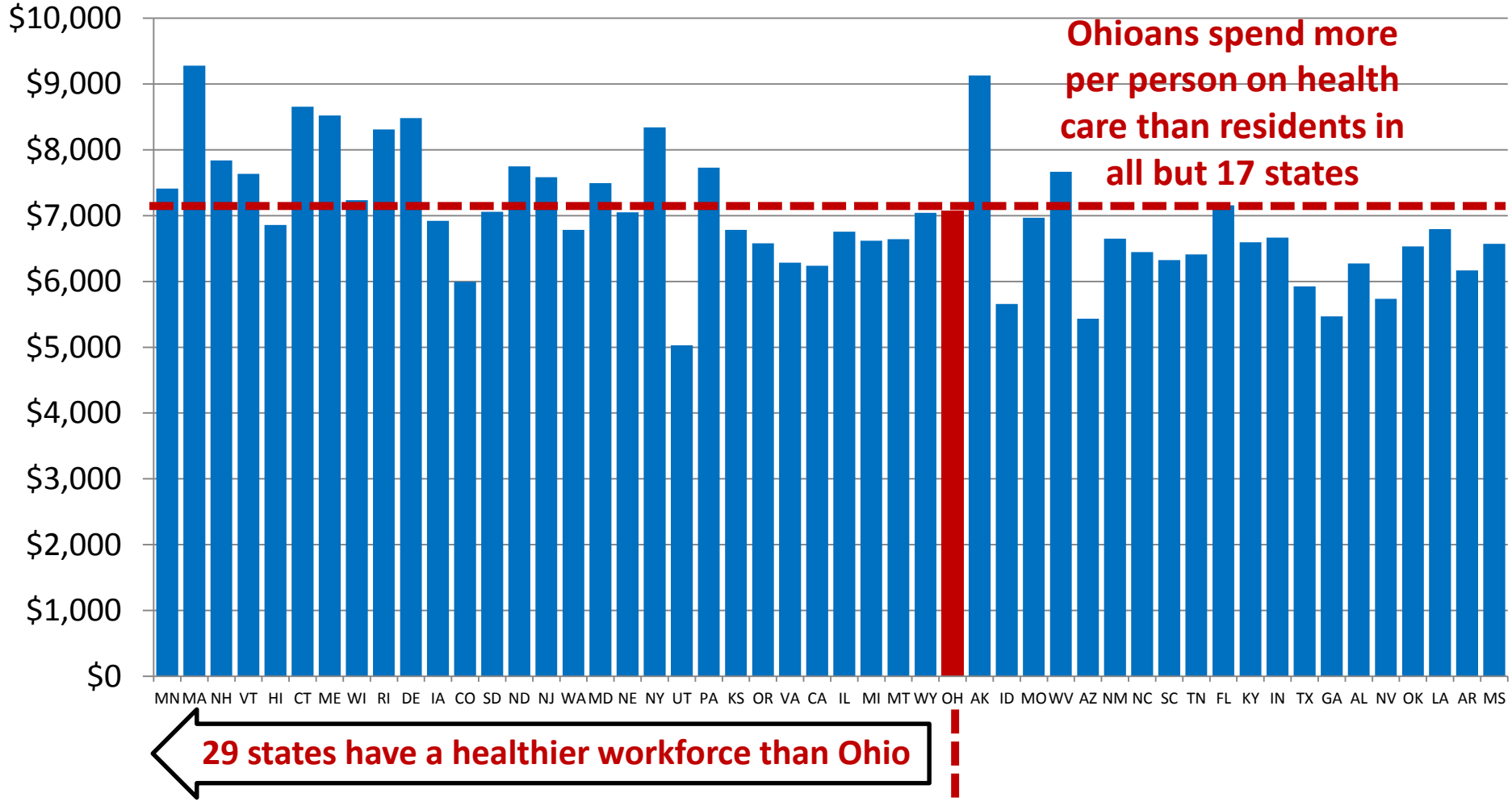
Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

In 2013, Ohio won a federal innovation grant to adopt two payment models that reward higher-quality, value-based care

Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
2014	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi)	▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
2015	▪ Collaborate with payers on design decisions and prepare a roll-out strategy	▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
2016	▪ Model rolled out to at least two major markets	▪ 20 episodes defined and launched across payers, including behavioral health
2017-2018	▪ Model rolled out to all markets ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers, including behavioral health

updated August 27, 2015

Ohio's vision for PCMH is to promote high-quality, individualized, continuous and comprehensive care

- **Patient Outreach:** Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship
- **Patient Experience:** Offer consistent, individualized experiences to each member depending on their needs
- **Patient Engagement:** Have a strategy in place that effectively raises patients' health literacy, activation, and ability to self-manage
- **Potential Community Connectivity Activities:** Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)
- **Behavioral Health Collaboration:** Integrate behavioral health specialists into a patients' full care
- **Provider Interaction:** Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient

- **Access:** Offer a menu of options to engage withpatients (e.g., extended hours to tele-access to home visits)
- **Assessment, Diagnosis, Care Plan:** Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans
- **Care Management:** Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments
- **Provider Operating Model:** Practice has flexibility to adapt resourcing and delivery model (e.g. extenders, practicing at top of license) to meet the needs of specific patient segments
- **Transparency:** Consistently review performance data across a practice, including with patients, to monitor and reinforcement improvements in quality and experience

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Vision for Ohio's primary care delivery model (1/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Patient outreach	▪ **Reactive**, presentation-based prioritization	▪ **Proactive**, targeting patients with **chronic conditions and existing PCP**/ team **relationship**	▪ **Proactive**, targeting patients with **chronic conditions but no clear PCP relationship**[1], and prioritizing **patients at-risk** of developing a chronic condition	▪ **Proactive, with broader focus on all patients** including healthy individuals
Access	▪ Offer **limited access** beyond office/ regular hours	▪ Expand channels for **direct patient PCMH interaction for at-risk patients** with an existing PCP/ team relationship through phone/ email/ text consultation ▪ Provide **24/7 access** to PCMH-linked resources for at-risk patients with an existing PCP/team relationship	▪ Provide appropriately resourced **same-day appointments** ▪ Ensure appropriate site of visit **for at-risk** patients (e.g., home, safe/ convenient locations in the community) ▪ Offer a **menu of communication options** (e.g., encrypted texts, email) to all patients for ongoing care management ▪ Provide **full accessibility for patients with disabilities** (e.g., exam tables for patients in wheel chairs)	▪ Offer **remote clinical consultation** for broader set of members, where appropriate and only if practice has capability to share medical records with and receive medical records from tele-health provider ▪ Increase time spent in locations that represent **key points of aggregation** for the community (e.g., churches, schools), meeting patients' needs in the most appropriate setting
Assessment, diagnosis, treatment plan	▪ Diagnose and develop treatment plan **for presenting condition**, with emphasis on pharmaceutical treatment	▪ Identify and document **full set of needs** for at-risk patients with an existing PCP/ team relationship (e.g., barriers to access health care and to medical compliance) ▪ Develop evidence-based care plans with **recognition of physical and BH needs** (e.g., medications), customized based on benefits considerations ▪ Identify and close **gaps in preventive care** for at-risk patients with an existing PCP/ team relationship	▪ Systematically incorporate patient **socio-economic status and ethnic-based differences** into treatment (e.g., automatic screening flags for relevant groups) ▪ Assess gaps in both primary and secondary preventive care across the broader patient panel and **prioritize member outreach** accordingly ▪ Include **BH needs** (e.g., psycho-social treatment) into care plan through regular communication with BH provider ▪ Identify and incorporate **improvements to care planning process**	▪ Agree on **shared agenda with patients to best meet their acute and preventive needs** with a multi-generational lens and leveraging the result of predictive modeling, where appropriate ▪ **Collaborate meaningfully with other key community-based partners** (e.g., schools, churches) for input into a treatment plan and share relevant information on an ongoing basis with patient consent where appropriate

Vision for Ohio's primary care delivery model (2/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Care management	▪ **Most patients lack connection to a care manager** while others are subject to many, overlapping care coordination efforts	▪ **Foster communication between care managers** for patients ▪ Identify who, within the practice, is in charge of care management activities for at-risk patients	▪ **Coordinate between care managers** to ensure clarity over which manager has lead responsibility when and reduce duplications of outreach to patients ▪ Establish **initial links with community-based partners** for at-risk patients	▪ **Patient identifies preferred care manager**, who leads relationship with patient and coordinates with other managers and providers ▪ **Collaborate meaningfully with other key community-based partners** (e.g., schools, churches) to exchange information with patient consent where appropriate
Provider operating model	▪ Primarily focus on managing **patient flow/ volume**	▪ Improve **operational efficiency** through process redesign and standardization, harnessing improvement tools (e.g., standardized use of clinical practice guidelines)	▪ Optimize staff mix (e.g., extenders, community health worker, cultural diversity), redesign processes and leverage technology, where appropriate, to maximize practice's operational efficiency (e.g., practice at top of license)	▪ Practice has **flexibility to adapt resourcing and delivery model** to meet the needs of specific patient segments as appropriate
Transparency	▪ **Review performance data irregularly**, if at all, to identify and pursue opportunities for improvement	▪ **Bi-directionally exchange performance data** with payers using a standard format and with a high degree of timeliness that can lead to improvements in treatment ▪ **Consistently review performance data** within the practice to monitor quality and prioritize outreach efforts ▪ Leverage standard process to ensure that data leads to **identification of opportunities and changes to practice patterns,** working with payers where appropriate ▪ Share **priorities from patient survey** with members and staff (e.g., post findings in the office)	▪ **Discuss performance data with other providers**, sharing learnings, receiving "second opinion" on challenging cases and advice on opportunities for improvement ▪ **Share relevant performance data with public health agencies** ▪ Implement changes based on **priorities resulting from patient satisfaction survey**	▪ **Share relevant performance data with members and communities** through website and in-office communication (e.g., information about wait times)

Vision for Ohio's primary care delivery model (3/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Provider interaction	▪ Select specialists for referrals based on **prior experience** ▪ Do not consistently leverage all available resources during **transitions in care**	▪ Proactively reach out to patients **after an ED visit/ hospitalization** ▪ **Track and follow-up** on specialist referrals and diagnostic testing ▪ Information is shared bi-directionally between PCP and specialist	▪ Select specialists for referrals also based on **likely connectivity** with member ▪ Select **specialists** for referrals based on **risk-adjusted data on outcomes and cost**, potentially leveraging data from episodes of care ▪ Proactively reach out to patients **before and after any planned transition in care**	▪ **Match type of care with member needs**, as jointly identified by member and provider (e.g., regular in-person interactions with multi-disciplinary team only when needed) ▪ **Proactively manage urgent needs, to the extent possible** (e.g., **reach out to the ED** to anticipate arrival of patients that have sought care from the practice first, to accelerate provision of care and ensure that it is targeted) ▪ Ensure **access and integration** to all capabilities needed (e.g., clinical pharmacy)
Behavioral health collabora-tion	▪ Do not consider undiagnosed BH cases a priority	▪ Integrate presenting behavioral health needs **into care plans** ▪ **Refer BH cases** to appropriate providers ▪ Collaborate 'at a distance' with BH providers for most at-risk patients	▪ Focus on diagnosing and addressing **undiagnosed BH needs** ▪ **Track and follow-up** on BH referrals and ensure ongoing communication with BH specialist – onsite where possible ▪ Provide **more coordinated care between primary and BH** providers (e.g., same-day scheduling, co-location, system integration)	▪ **Integrate behavioral specialists** in the practice, where scale justifies it ▪ **Fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care** ▪ **Build competencies** to directly provide select BH services on site, when scale justifies it ▪ Collaborate with **community-based resources** to manage BH needs
Potential community connec-tivity activities	▪ Have **limited community connectivity** outside of office, or relationships with social services	▪ **Inform patients of social services and community-based prevention programs** that can improve social determinants of health (e.g., provide list of helpful resources, including local health districts)	▪ Facilitate connectivity to **social services and community-based prevention programs** by identifying targeted list of relevant services geographically accessible to the member, covered by member benefits, and with available capacity (e.g., Community Health Nursing, employment, recreational centers, nutrition and health coaching, tobacco cessation, parenting education, removal of asthma triggers, services to support tax return filings, transportation)	▪ **Actively connect members** to broader set of social services and community-based prevention programs (e.g., scheduling appointments and addressing barriers like transportation to ensure appointment happens) ▪ **Ensure ongoing bi-directional communication with social services and community-based prevention programs** (e.g., follow up on referrals to ensure that the member used the service, incorporate insights into care plan, provide support during transitions in care) ▪ **Collaborate meaningfully** (e.g., through formal financial partnerships) with partners based on achievement of health outcomes ▪ **Actively engage in advocacy and collaborations** to improve basic living conditions and opportunities for healthy behaviors[1]

1 E.g., encourage children to walk to school as part of a coordinated Safe Routes to School initiative

Vision for Ohio's primary care delivery model (4/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Patient engagement[1]	▪ Have standard fliers and **educational material available in the office**	▪ Assess patient's **level of health literacy, engagement, and self-management** and have a defined plan to provide appropriate materials and improve over time ▪ Ask patients how they wish to be engaged (e.g., email, phone calls, language), consistent with the resources and infrastructure the practice currently has ▪ Offer **"patient navigator"** support to at-risk patients, to help them find and access healthcare resources	▪ Adopt means that practice did not previously provide to engage with patients and meet patient's preferences (e.g., text messaging) ▪ Use individualized techniques to **activate patients** (e.g. motivational language) ▪ Leverage tools such as remote monitoring devices **to promote patient activation and self-management** ▪ Provide **targeted educational** resources (e.g., online video/guides, printed materials) to all members	▪ **Consistently measure improvement in patient activation and health literacy**, increasing share of patients at appropriate level to achieve optimal care outcomes ▪ **Actively engage with patients to motivate appropriate degree of self-management** ▪ **Connect** at-risk members with other members with similar needs, to help create an additional support system for members and families
Patient experience[2]	▪ **Do not explicitly focus** on patient experience	▪ **Prioritize continuity of relationship** with provider and team for patient ▪ Regularly **solicit and incorporate targeted feedback** from patients into overall patient experience (e.g., quarterly survey)	▪ Achieve greater **cultural competence** through training, awareness, and access to appropriate services (e.g., translation) ▪ Regularly solicit and incorporate the **feedback of patients into individual care**	▪ Offer **consistent, individualized experiences to each member** depending on their needs (based on age, gender, ethnicity, socio-economic situation) ▪ **Integrate patients into the practice management team** to provide feedback on overall patient experience ▪ Participate in **online patient rating sites** (if relevant to practice population)

1 Promoting individual activation, health literacy, and self-management
2 Quality of patient's interaction with providers in and out of the traditional office setting

How would practices access PCMH payments?

- There is **one PCMH model in which all practices participate**, no matter how close to an ideal PCMH they are today. The program is designed to encourage practices to improve how they deliver care to their patients over time
- Practices **have two decisions to make**:
    1. Enrolling
    2. If the practice is below a pre-defined size threshold, whether to pool (partner) with other providers for access to shared savings
- All practices **could have access to two non-financial benefits upon joining**:
    1. Recognized as a state-designated PCMH, which can help attract new members
    2. Access to data and reporting that will provide the actionable, timely information that practices need to make better decisions about outreach, care and referral decisions
- All practices **could have the opportunity to access two payment streams:**
    1. New clinical activities payments to compensate practices for activities that improve care and are currently under-compensated
    2. Outcomes-based payment for achieving total cost of care savings and meeting pre-determined quality targets
    - Some practices also may be eligible for one-time practice transformation payments to help them successfully begin the transition to a PCMH

What are the requirements to access PCMH payment streams?

Requirements and Measures		Enrollment and Practice Transformation	New clinical activities	Outcome-based payment
Capability	▪ Commitment	✓		
	▪ Planning	✓		
	▪ Tools	✓		
	▪ Personnel	✓		
	▪ Standard Processes	✓	✓	✓
Activity	▪ Activities		✓	
Performance	▪ Efficiency		✓	
	▪ Clinical Quality		✓	✓
	▪ Patient Satisfaction		✓	✓
	▪ Total Cost of Care			✓

What health plans are partnering with the state to align PCMH requirements and payment incentives?

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

Designing Ohio's PCMH model requires input on many decisions

Care delivery model	A. Target patients and scope B. Target sources of value C. Care delivery improvements	Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.
Payment model	D. Technical requirements for PCMH E. Attribution/assignment F. PCMH activities G. Quality/efficiency/total cost H. Payment streams/incentives I. Risk adjustment	Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time
Infrastructure	J. Provider infrastructure K. Payer infrastructure L. State system infrastructure	Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery
Scale-up and practice performance improvement	M. Scale-up target N. Practice transformation support O. Patient engagement P. Workforce/human capital Q. Legal/regulatory environment R. Network/contracting S. ASO contracting/participation T. Performance transparency U. Ongoing PCMH support V. Evidence/pathways/research W. Multi-payer collaboration X. Stakeholder engagement	Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact

SOURCE: Ohio PCMH Charter for Payers (October 2013)

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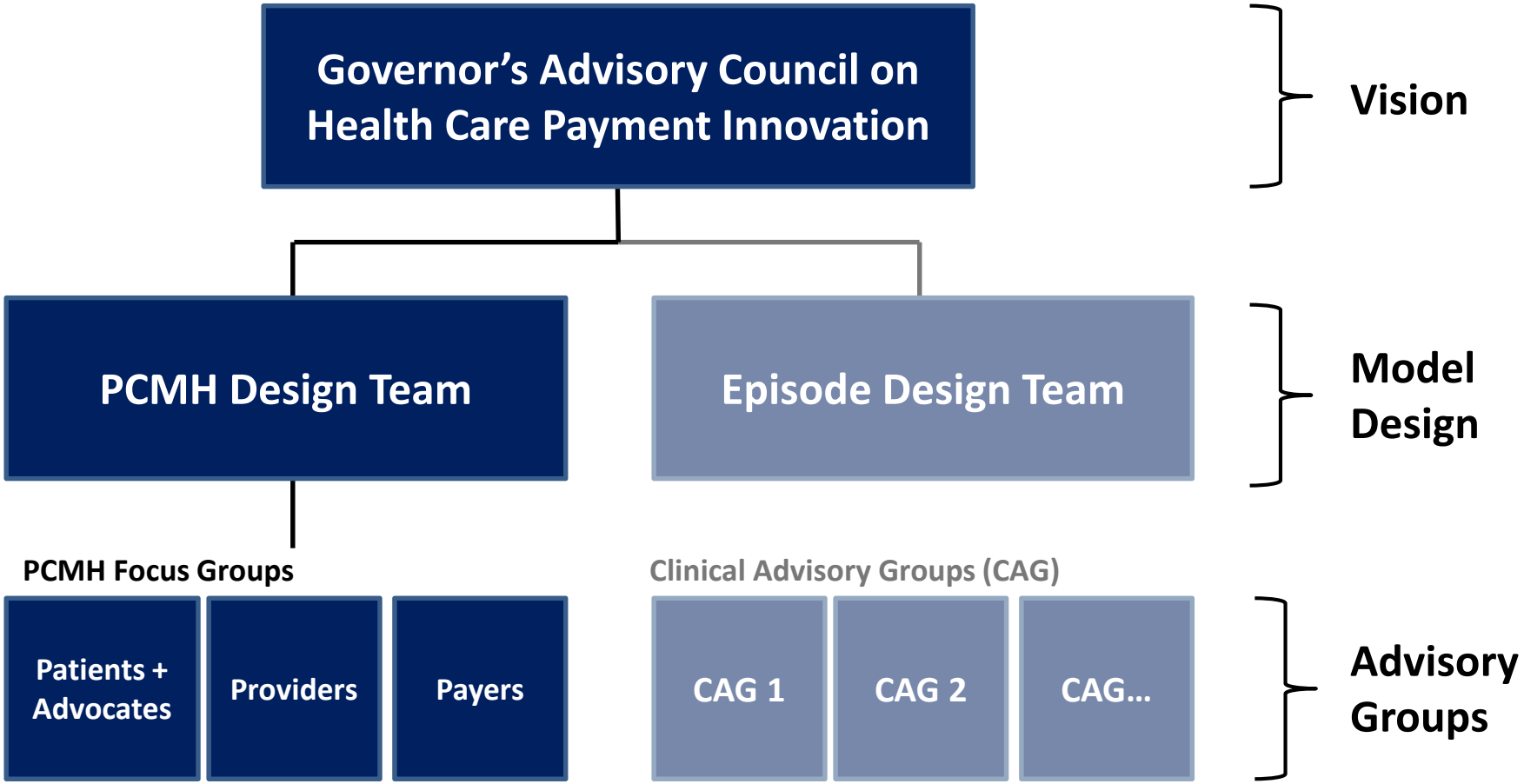
Ohio's payment innovation design team structure is on track to deliver PCMH model design decisions by the end of 2015



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Ohio Medicaid is surveying practices on readiness for PCMH in preparation to roll out the model in 2016

What is the purpose?

- Get **input on key PCMH model design decisions**
- Understand what practices are already doing today, key resources needed to successfully transform to a PCMH, identify regional/other differences

Who is eligible?

- **Primary care and specialists anticipated to be a part of the PCMH model** will be invited to participate[1]
- One **office manager and clinician** from each practice will take the survey (separate questions) and will each receive a $25 Visa gift card for participating

How do I take the survey?

- **Online: http://bitly.com/MedicaidPCMHSurvey**
- **Expected to take 20-25 minutes to complete**
- An email with the link will be shared to emails on file with Medicaid MITS portal and State Medical Board. OPCPCC, RHICs, associations, and individuals also welcome to share the link

1 All practices which accept Medicaid must provide Practice NPI and Medicaid Group ID (purpose is to reduce amount of demographic questions asked in order to get aggregated, state-level data)

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Want to learn more?

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Ohio's PCMH Model:

- **Overview Presentations**
- **Charter for Payers**
- **PCMH Examples**
- **State Innovation Model Test Grant Detail**