Primary Care Renewal:

Toward Realigned Incentives

Safety Net Medical Home Initiative
Annual Conference
Boston – March 7-8, 2009

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CareOregon

Co Designed Payment Model – 1.0

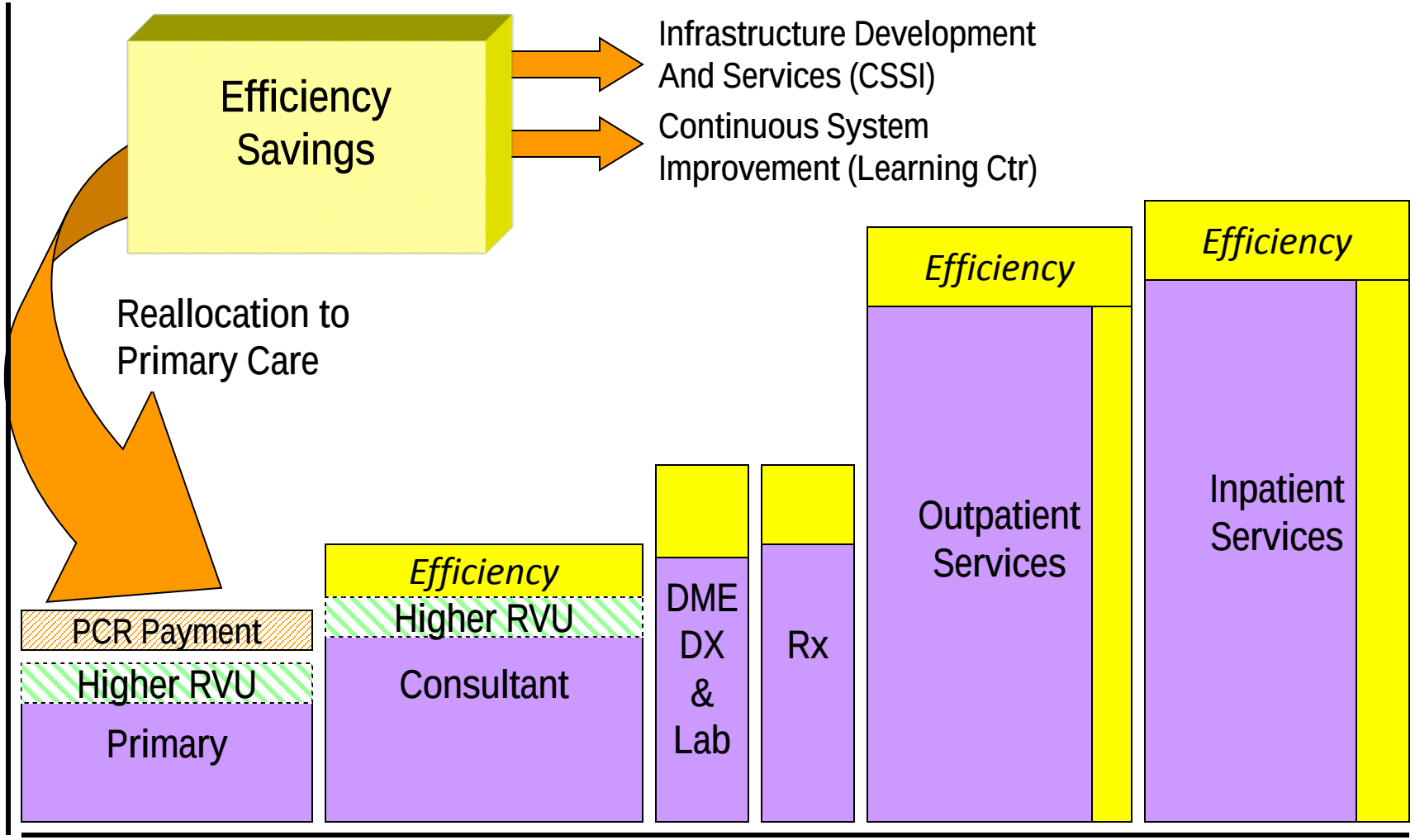
- **Initial Funding for Pilots starting in 2007**
  - **Based on existing Quality Improvement support program**
  - **Amount determined by number of assigned members**
  - **PCR Breakthrough Collaborative Model with agreed metrics and reporting from beginning**
- **Building the Capacity for Measurement is not trivial**
- **2009: Quarterly payments to PCR medical home clinics based on member assigned, risk adjustment**
  - **Risk adjustment based on State risk method**
  - **Designed to reflect increased work for increased acuity population**
- **Variable payment based on cumulative scoring:**
  - Tier 1: Pay for participation, reporting
  - Tier 2: Pay for improvement / at target
  - Tier 3: Pay for outcomes (ED, Hospital)
- **Initial clinical metrics: focus on Diabetes and HTN**
  - Early attempts for "3 next available," care management "touches"

Mean ACG-PM risk score -- 5/1/10	
	ADULT Medicaid
All other clinics	0.088
All PCR clinics	**0.103**

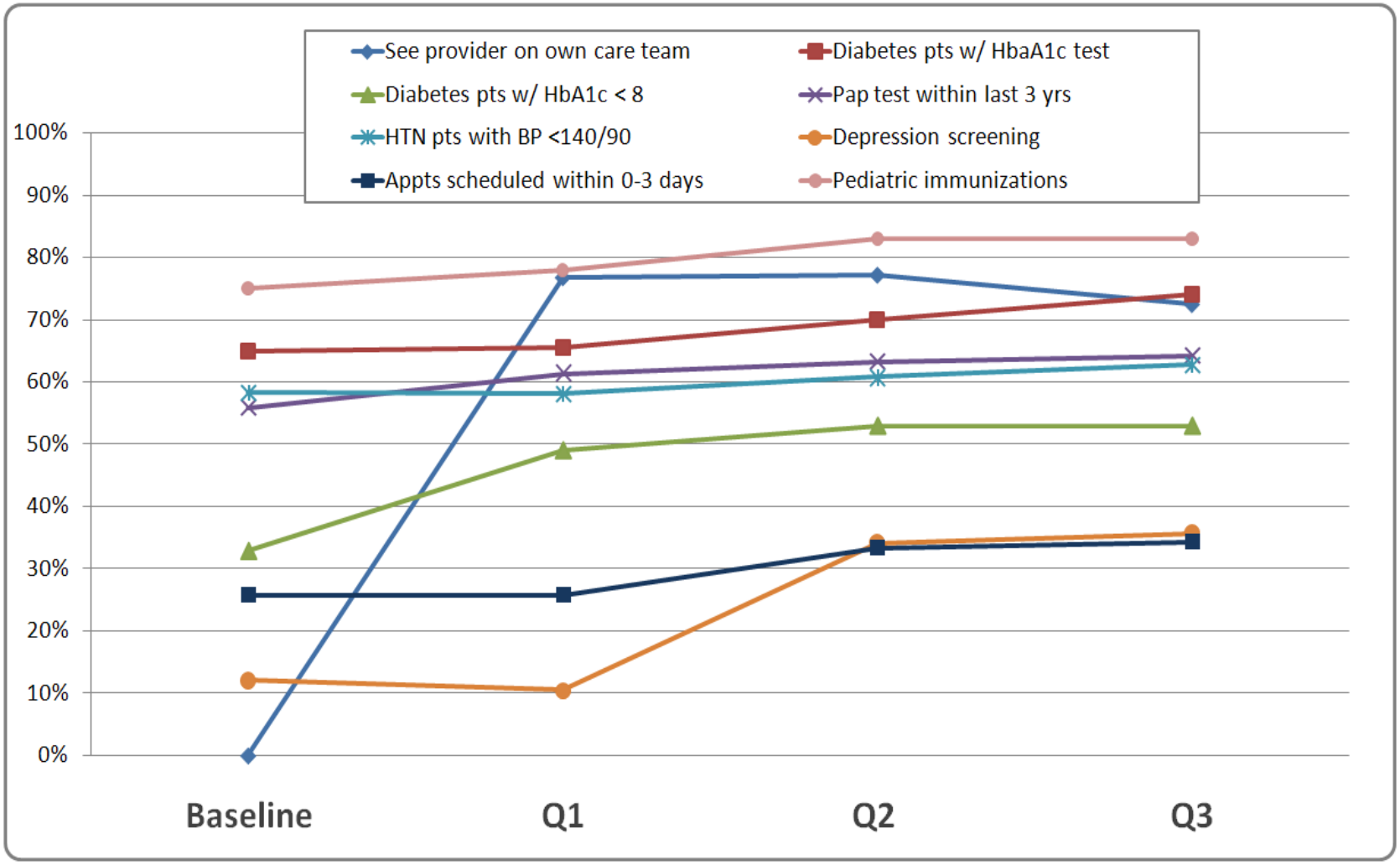
PCR "original" 6	
OHSU Richmond	0.128
Legacy Emanuel	0.122
Legacy Good Sam	0.156
MCHD Mid-County	0.087
VG Cornelius	0.071
Old Town	0.119

PCR "spread" clinics	
VG Beaverton	0.100
VG Hillsboro	0.084
MCHD North Ptld	0.097
MCHD Northeast	0.094
MCHD East County	0.090
MCHD Westside	0.129
MCHD La Clinica	0.068
MCHD HIV clinic	0.361
OHSU Scappoose	0.099

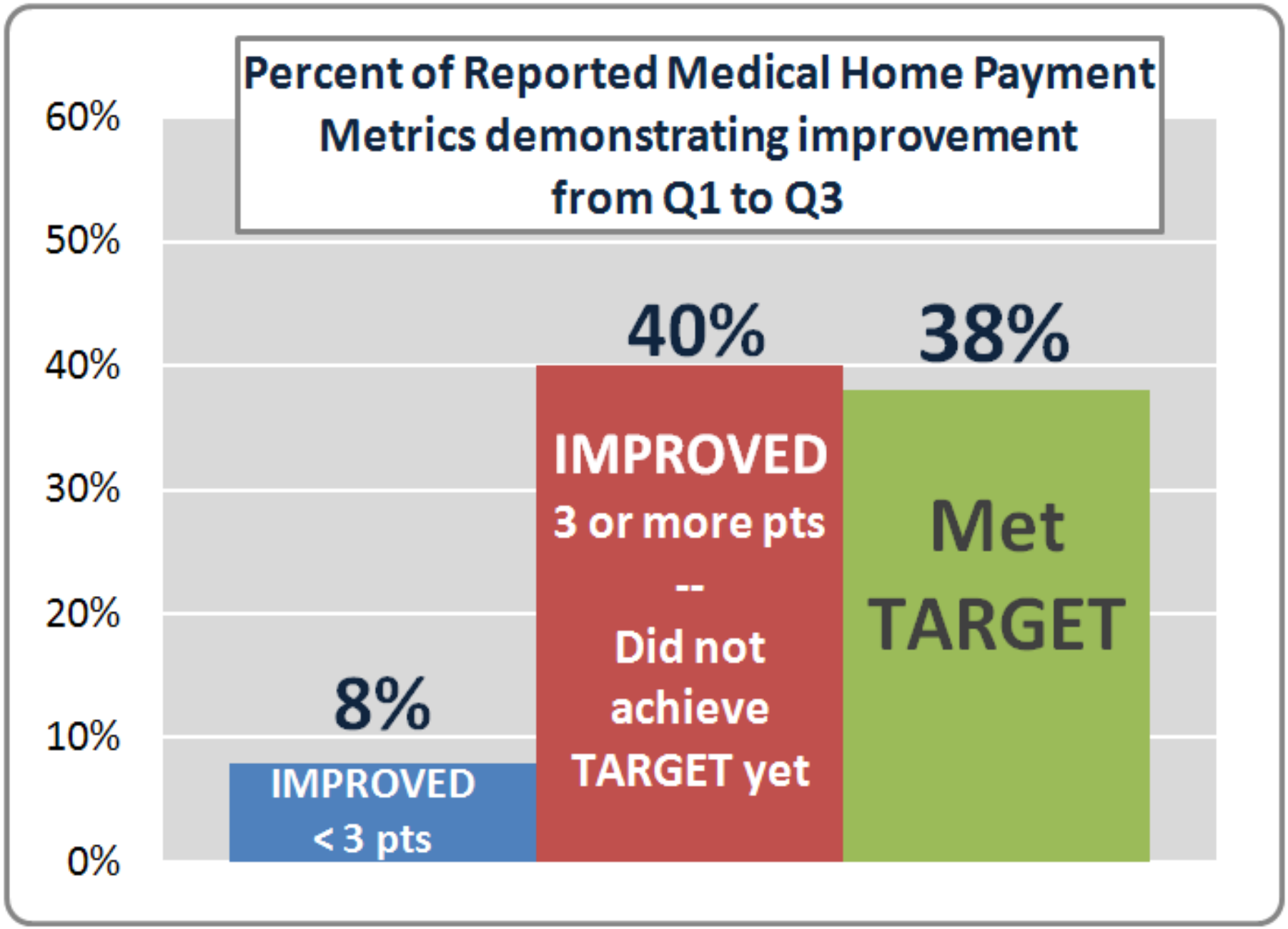
Efficiency Fuels High Functioning Sustainability



PCR Medical Home Payment Model Metrics: 2009 Pilot Year Results



Q4 2008 Jan –Mar 2009 Apr – Jun 2009 July – Sept 2009


Percent of Reported Medical Home Payment Metrics demonstrating improvement from Q1 to Q3
60%
50%
40%
30%
20%
10%
0%
8%
IMPROVED
< 3 pts
40%
IMPROVED
3 or more pts
--
Did not achieve TARGET yet
38%
Met TARGET

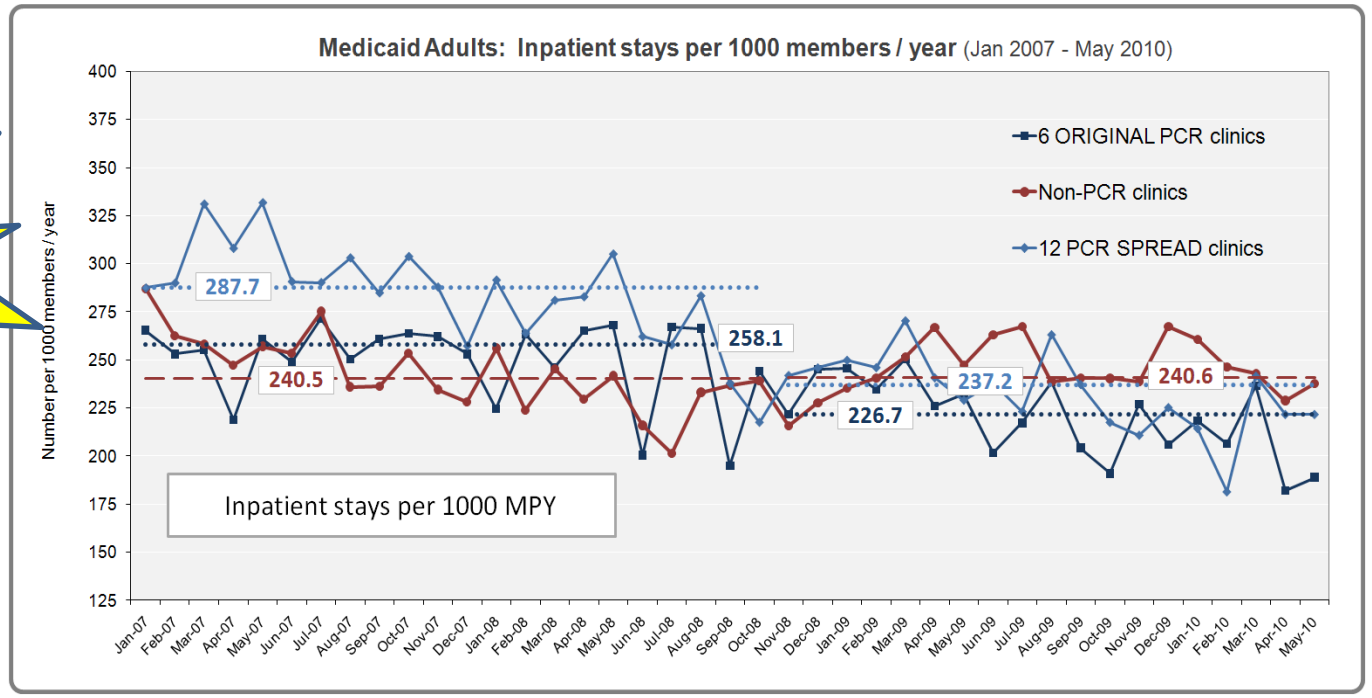
Co Designed Payment Model – 2.0

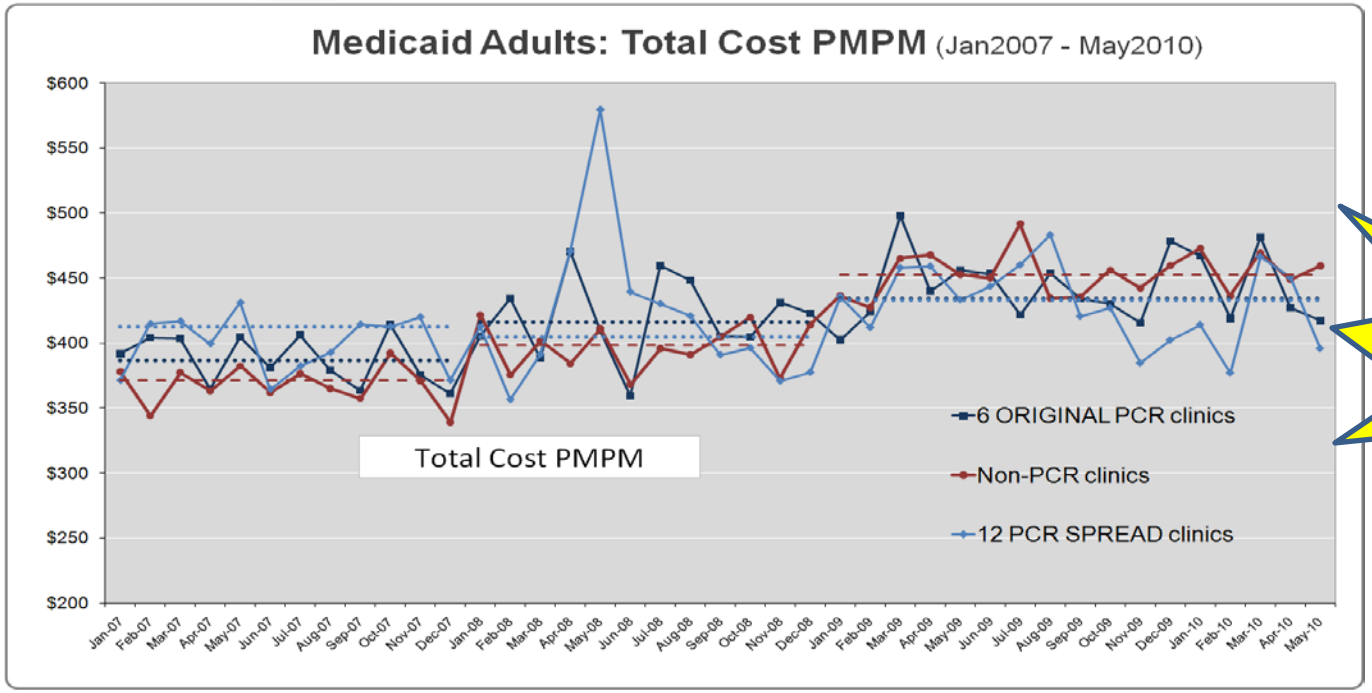
- **2010: Redesign with more accountability**
  - Entry Criteria: Teams, Panels, Reporting Systems established, Workplan (per qrt/ yr)
  - More quarterly metrics (required / optional): continuity, access, clinical, care management metrics with cumulative scoring vs Tiers.
  - Annual Improvement payments: patient satisfaction, utilization (decreased ED, Hosp)
- **Creation of Data and Reporting Workgroup**
  - What is an "active patient?"
  - Common data definitions (numerators/ demoninators)
  - Deciding what is "important"

- **Goal: Aligning Payment System with Learning and Improvement**

At 3 Years…

Decreased Inpatient!!!

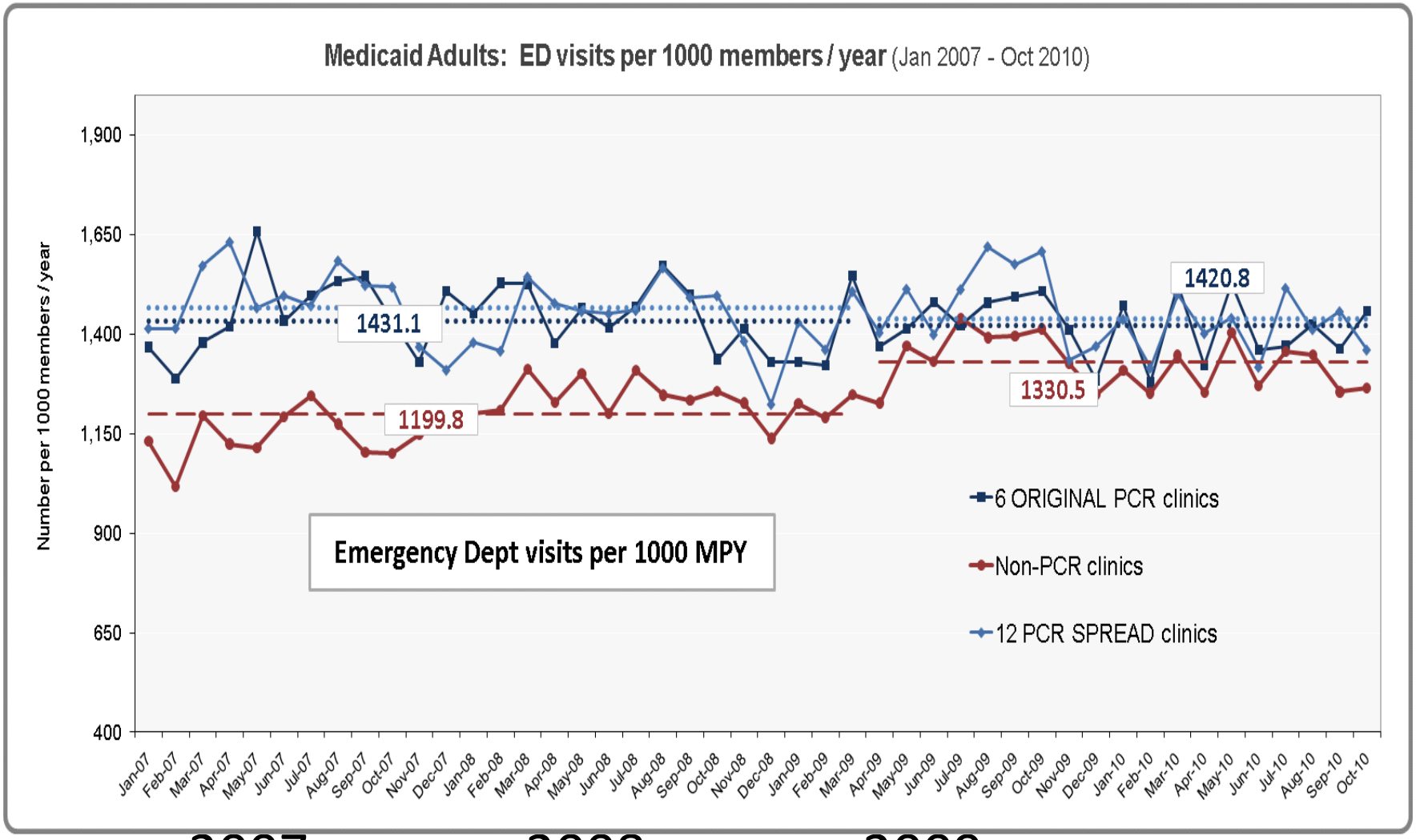




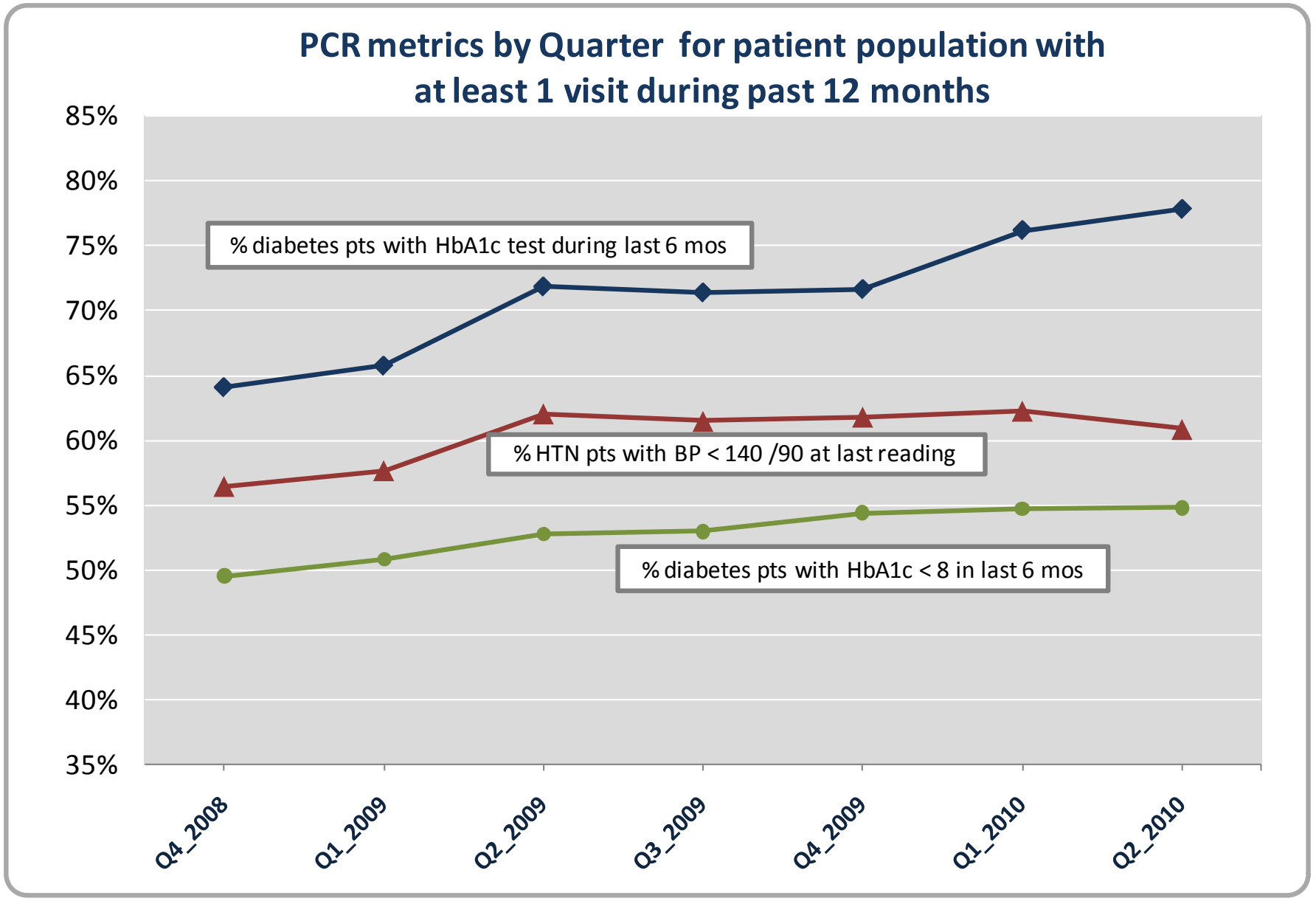
Decreased Cost!!!

Medicaid Adults : ED visit rates *Jan07 – Oct 2010*

"Original" 6 PCR Clinics vs. Spread vs. all other clinics



2007 2008 2009

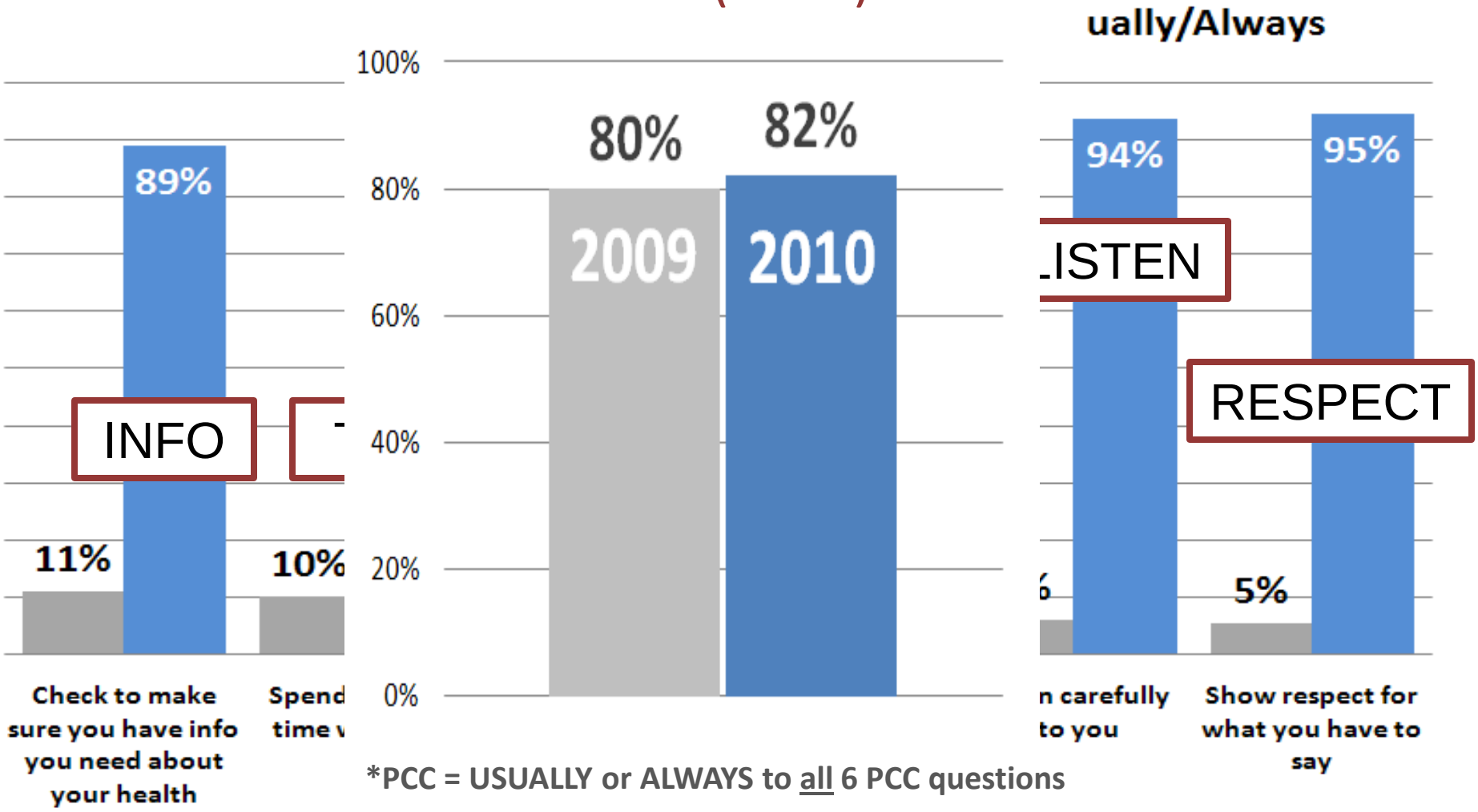

PCR metrics by Quarter for patient population with at least 1 visit during past 12 months
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
% diabetes pts with HbA1c test during last 6 mos
% HTN pts with BP < 140 /90 at last reading
% diabetes pts with HbA1c < 8 in last 6 mos
Q4_2008
Q1_2009
Q2_2009
Q3_2009
Q4_2009
Q1_2010
Q2_2010

6 Components of Patient Centered Care

In the last 6 mo

lth care team:

Patient Centered Care(PCC*)

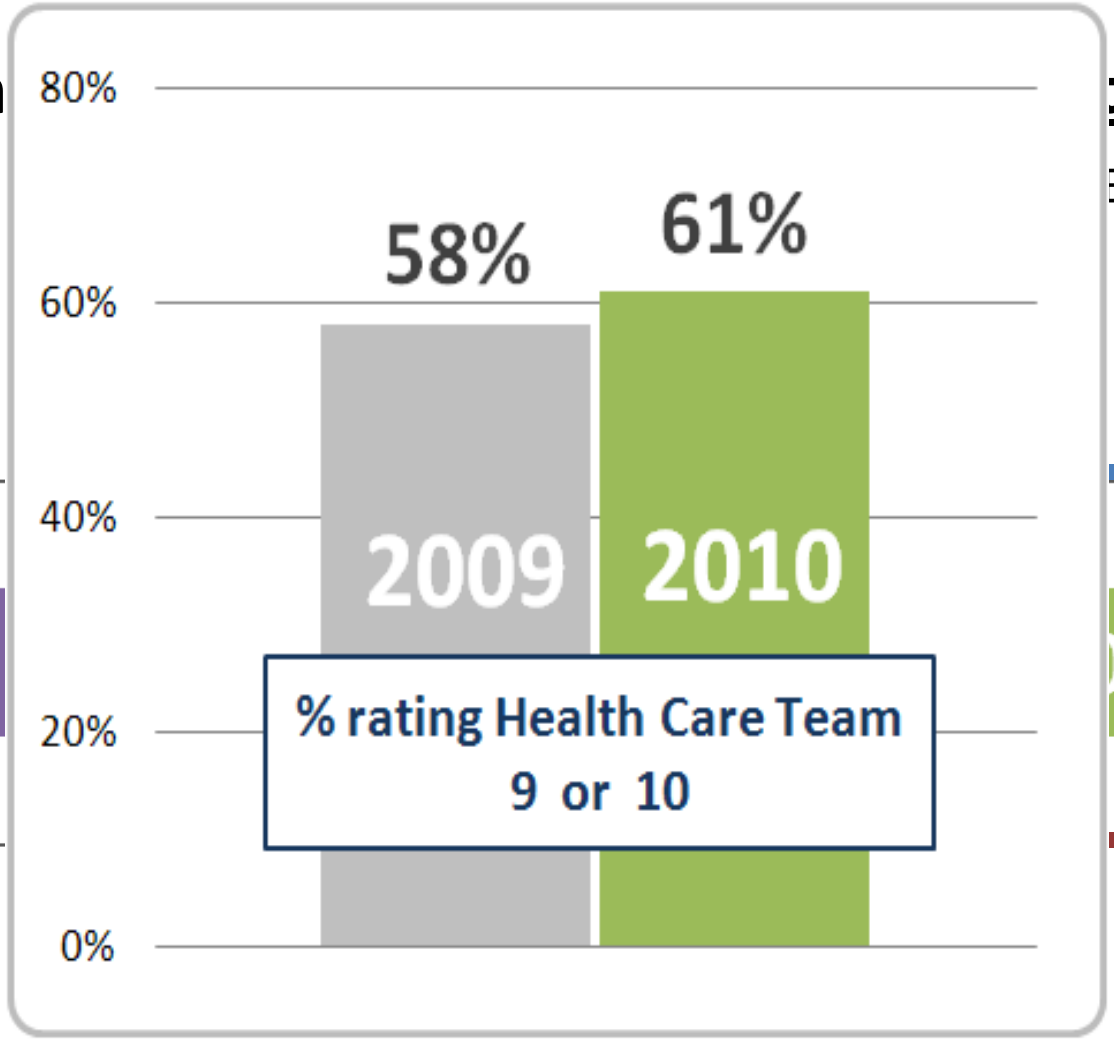


*PCC = USUALLY or ALWAYS to all 6 PCC questions

PCR Patient Experience of Care Survey

Global rating of care measure: 0-10 point rating scale

What num **team** in th **h care** BEST possible



7 pts or less

pts

N = 1,401;

Oregon Health Authority PCPCH Standards

What is the "payment system" for this?

- **Access to Care**: *Be there when I need you*
- **Accountability**: *Take responsibility for making sure I receive the best possible health care*
- **Comprehensive Whole Person Care**: *Provide or help me get the health care and services I need*
- **Continuity**: *Be my partner over time in caring for my health*
- **Coordination And Integration**: *Help me navigate the health care system to get the care I need in a safe and timely way*
- **Person and Family Centered Care**: *Recognize that I am the most important member of my care team – and that I am ultimately responsible for my overall health and wellness*

State of Oregon PCPCH Core Attributes