Welcome to

ASTHO’s Delivery and Payment Reform Technical Assistance Call Series

Primary Care and Public Health: Linking Public Health and Advanced Primary Care to Improve Outcomes

Presented by ASTHO and the Centers for Disease Control and Prevention
Institute of Medicine Report (released March 28, 2012)

http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx
Degrees of Integration: Public Health and Primary Care

Institute of Medicine, Primary Care and Public Health: Exploring Integration to Improve Population Health, March 2012
2014-2016
ASTHO
Supported
Primary Care
and Public
Health
Integration
Strategic Map

http://www.astho.org/pcphcollaborative
The National Committee for Quality Assurance (NCQA) is the leading organization recognizing three levels of advanced primary care practice, known as Patient-Centered Medical Homes (PCMHs).

**Key Facets of Patient-Centered Medical Homes**

- Enhanced Access After Hours & On-Line
- Long-term Patient & Provider Relationships
- Shared Decision Making
- Patient Engagement on Health & Healthcare
- Team-Based Care
- Better Quality & Experience of Care
- Lower Cost from Reduced Emergency Department & Hospital Use

The Future of Patient-Centered Medical Homes: Foundation for a Better Health Care System
CMS State Innovation Models (SIM) Initiative

Innovation Models

The Innovation Center develops new payment and service delivery models in accordance with the Affordable Care Act and previous legislation. Our Innovation Models are organized into seven categories:

- Comprehensive Primary Care Initiative
- FQHC Advanced Primary Care Practice Demonstration
- Frontier Extended Stay Clinic Demonstration
- Graduate Nurse Education Demonstration
- Independence at Home Demonstration
- Medicare Coordinated Care Demonstration
- Multi-Payer Advanced Primary Care Practice
- Transforming Clinical Practices Initiative

Results for “Primary Care Transformation”

Results 1-8 of 8

Primary Care Transformation

Comprehensive Primary Care Initiative

The Comprehensive Primary Care Initiative is a multi-payer initiative providing financial support to primary care practices in 7 markets.

Stage: Ongoing

FQHC Advanced Primary Care Practice Demonstration

The FQHC Advanced Primary Care Practice Demonstration is testing the efficiency of patient-centered medical homes among FQHCs.

Stage: Ongoing

Frontier Extended Stay Clinic Demonstration

The Frontier Extended Stay Clinic Demonstration is allowing remote clinics to treat patients for more extended periods, including overnight stays, that are entailed in routine physician visits.

Stage: No Longer Active

Graduate Nurse Education Demonstration

The Graduate Nurse Education Demonstration is supporting hospitals for the reasonable cost of providing clinical training to advanced practice registered nursing (APRN) training.

Stage: Ongoing

Independence at Home Demonstration

The Independence at Home Demonstration is supporting home-based primary care for Medicare beneficiaries with multiple chronic conditions.

Stage: Ongoing

Medicare Coordinated Care Demonstration

The Medicare Coordinated Care Demonstration is testing whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield patient outcomes without increasing program costs.

Stage: No Longer Active

Multi-Payer Advanced Primary Care Practice

In the Multi-Payer Advanced Primary Care Practice Demonstration, CMS is joining in multi-payer primary care initiatives that are currently being conducted within states.

Stage: Ongoing

Transforming Clinical Practices Initiative

A large-scale health transformation initiative to support clinician practices in sharing, adapting, and developing comprehensive quality improvement strategies.

Stage: Announced, Accepting Applications
Objectives of the call:

1. To increase understanding of advanced primary care models, including Patient-Centered Medical Homes (PCMHs).
2. To increase awareness of opportunities for public health and primary care collaboration to improve population health.
Dr. Ted Wymyslo
Chief Medical Officer, Ohio Association of Community Health Centers

Bonnie LaPlante
Health Care Home Capacity Building and Certification Supervisor, Minnesota Department of Health
Expansion of the PCMH Model in Ohio

- Organized PCMH Collaboratives in Cincinnati, Columbus, Cleveland
- Need identified in Toledo, Dayton, Akron/Canton and Southeast Ohio regions
- HB 198 drafted 2009-10
- HB 198 - Ohio PCMH Education Pilot Project signed into law June, 2010
Learning Collaborative:

- 42 total practices
- 4 medical schools
- 5 nursing schools

HB 198: Ohio Patient-Centered Medical Home Education Pilot Project

Includes:

- Choose Ohio First Scholarships
- 2 year Training in PCMH model
- Curriculum Reform
PCMH Pilot Site locations
# State Leadership in Healthcare Reform

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Jan, 2011</td>
<td>Gov. Kasich sworn in</td>
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<td>Jan, 2011</td>
<td>Office of Health Transformation created</td>
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<tr>
<td>Feb, 2011</td>
<td>ODH Director Appointed - Ted Wymyslo MD Cabinet Level Position</td>
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<tr>
<td>Fragmentation</td>
<td>vs.</td>
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<td>Multiple separate providers</td>
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<td>Provider-centered care</td>
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<td>Reimbursement rewards volume</td>
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<tr>
<td>Lack of comparison data</td>
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<td>Outdated information technology</td>
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<tr>
<td>No accountability</td>
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<tr>
<td>Institutional bias</td>
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<td>Separate government systems</td>
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<td>Complicated categorical eligibility</td>
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<td>Rapid cost growth</td>
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*Where We Are vs. Where We Need to be*

*SOURCE: Adapted from Melanie Bella, State Innovative Programs for Dual Eligibles, NASMD (November 2009)*
<table>
<thead>
<tr>
<th>Modernize Medicaid</th>
<th>Streamline Health and Human Services</th>
<th>Pay for Value</th>
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<tbody>
<tr>
<td><strong>Initiate in 2011</strong></td>
<td><strong>Initiate in 2012</strong></td>
<td><strong>Initiate in 2013</strong></td>
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<tr>
<td>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</td>
<td>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</td>
<td>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</td>
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- Extend Medicaid coverage to more low-income Ohioans
- Eliminate fraud and abuse
- Prioritize home and community services
- Reform nursing facility payment
- Enhance community DD services
- Integrate Medicare and Medicaid benefits
- Rebuild community behavioral health system capacity
- Create health homes for people with mental illness
- Restructure behavioral health system financing
- Improve Medicaid managed care plan performance

- Create the Office of Health Transformation (2011)
- Implement a new Medicaid claims payment system (2011)
- Create a unified Medicaid budget and accounting system (2013)
- Create a cabinet-level Medicaid Department (July 2013)
- Consolidate mental health and addiction services (July 2013)
- Simplify and replace Ohio’s 34-year-old eligibility system
- Coordinate programs for children
- Share services across local jurisdictions
- Recommend a permanent HHS governance structure

- Participate in Catalyst for Payment Reform
- Support regional payment reform initiatives
- Pay for value instead of volume (State Innovation Model Grant)
  - Provide access to medical homes for most Ohioans
  - Use episode-based payments for acute events
  - Coordinate health information infrastructure
  - Coordinate health sector workforce programs
  - Report and measure system performance
• Coordinates communication among existing Ohio PCMH practices
• Facilitates statewide learning in collaborative PCMH practices in Ohio
• Facilitates new PCMH practice startup in Ohio
• Shapes policy in Ohio for statewide PCMH adoption

Facilitated by the Ohio Department of Health
5 Learning Centers:

- Patient Engagement
- HIT
- Metrics
- Payment Reform
- Communications and Education
- Interprofessional Education
Priorities for Improved Health

- Expand Patient-Centered Medical Homes Across Ohio
  - Strengthen relationships with external stakeholders
  - Enrich work climate at ODH

- Curb Tobacco Use

- Decrease Infant Mortality

- Reduce Obesity
Governor’s Advisory Council on Healthcare Payment Innovation

- Convened Jan 2013
- Providers, consumer advocates, purchasers and plans to coordinate multipayer healthcare payment innovation statewide
- CPR principles endorsed - Pay For Value
Healthcare Events in Ohio

- HB-198 - 42 Practice Collaborative - 7/12
- CMS - APCP Demonstration - 20 FQHCs - 9/12
- CMMI - CPCi kickoff - Cinci, Ohio 11/12
- CMMI SIM Planning grant - 2/13
- Medicaid Expansion in Ohio - 1/14
- CMMI SIM Testing grant - 12/14
PCMH in Ohio
A Collaborative Approach to Health Transformation

- Regional Collaboratives - C/C/C
- State Initiatives- Legislature/ Governor’s Office/ Agencies
- Insurers
- Employers
- Consumer Advocates
- Providers/ Professional Associations
Ohio PCMH Recognized Sites
December, 2014

- NCQA - 486 sites
- TJC - 51 sites
- AAAHC - 7 sites

- TOTAL - 544 sites
Thank You!

For additional information please visit the OACHC website at www.ohiochc.org

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Minnesota’s Health Care Home Initiative

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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
## MN Health Reform

### Health Reform Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Results</th>
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<tr>
<td>Prevention/Public Health</td>
<td>Statewide Health Improvement Program, Diabetes Prevention Program (DPP)</td>
<td>Fighting obesity and tobacco – Schools, workplaces, communities, clinics</td>
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<td>Care Redesign Payment Reform</td>
<td>Health Care Homes / Community Care Teams Quality Incentive Payments Medicaid Health Care Delivery System Demonstration (HCDS)</td>
<td>HCHs serving 2.4 million, Implemented pay for performance for state programs and public employees / Medicaid HCDS Demo has contracts with 6 health systems</td>
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<tr>
<td>Transparency</td>
<td>Statewide Quality Improvement Program, Provider Peer Groups, Health Insurance Exchange</td>
<td>Statewide quality measures, developing provider cost and quality comparisons to be incorporated into the Health Insurance Exchange</td>
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<tr>
<td>Health IT, Administrative Simplification</td>
<td>Office of Health Information Technology</td>
<td>Implemented common billing/coding and e-prescribing, developing statewide EHR exchange</td>
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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.
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
Program Development; Foundational Components

• A capacity Assessment
• Outcomes recommendation
• Patient/Family/consumer council
Program Development;
Program Components

• Certification criteria
• Certification and recertification process
• Payment methodology
• Learning collaborative
• Outcome measurement
Community Engagement Process

Figure 1: Community Engagement Process
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
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
Current status and Program Evaluation

• 53% of Primary Clinics serving Minnesota are certified
• At the end of 2014 the Regional Nurse planners are capacity building with approximately 88 clinics
• The three year evaluation of the program demonstrated HCHs had better Colorectal screening, Asthma and Diabetes care and depression follow up
• Overall HCH enrollees demonstrated 9.2% less Medicaid expenditures than non-HCH enrollees
SIM Grant - Minnesota’s Accountable Health Model Vision

• Every patient receives coordinated, patient-centered primary care.
• Providers are held accountable for the care provided to Medicaid enrollees and other populations, based on quality, patient experience and cost performance measures.
• Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care; and
• Provider organizations effectively and sustainably partner with community organizations, engage consumers, and take responsibility for a population’s health through accountable Communities for Health that integrate Medicare care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

• [Website Link](http://www.health.state.mn.us/healthreform/sim)
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
If you have a question, you may type it into the chat box now or press 14 to have the operator unmute your line.
Thank you for joining us!

Please complete our webinar evaluation survey:
https://jfe.qualtrics.com/form/SV_8AevipygTzVNQcB

Visit ASTHO’s website for additional resources and access today’s presentation:
http://www.astho.org/Programs/Health-Systems-Transformation/Delivery-and-Payment-Reform-TA-Call-Series/

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