ACAP
Association for Community Affiliated Plans

How Safety Net Health Plans are Transforming Primary Care: Case Studies from the Field

The intense health care reform debate of the last two years generated considerable discussions about the deficiencies in how medical care is delivered in the United States. Far too often, the health care system focuses on the roles of various medical care providers instead of on the individual patients who really matter. Recognizing the flaws in such a misdirected and fragmented approach, policy makers and the health care community are increasingly calling for a patient-centered model of care, one that emphasizes the role of primary care and gives patients a "medical home," to use the common, now oft-repeated phrase.

The Association for Community Affiliated Plans (ACAP), a national association of safety net health plans, strongly supports the concept of patient-centered care. The Association and its members are focused on "primary care transformation" – an approach that encompasses the broad idea of a "patient-centered medical home" model, but is not as limited and can include other ways of improving primary care as well.

The goal of transforming primary care is to improve access to medical services, provide coordination, and increase patient satisfaction. It thereby improves the quality of care patients receive and, and most importantly, their health. The focus remains on what the patient needs, reducing errors, giving a higher priority to preventive services, and improving the coordination and integration of care. An additional benefit of this approach is the potential to reduce costs.

From the recent conversation about what is needed to fix our health care system, one might think that the concept of primary care transformation, or a "medical home," is new. But the concept's essential elements have been a cornerstone of managed care organizations since their inception. These elements include:

- **Consistent access** to primary care, regardless of time of day or night.
- **Patient-centered care coordination** at the primary care provider level that effectively addresses chronic conditions and the unique needs of Medicaid members.
- **Emphasis on quality and safety**, including use of information technology.
- **Patient engagement**, so patients become active partners in improving their health status and better adhere to treatment regimes.
- **Improved communication and education**, between providers and patients, to address issues such as health literacy, cultural sensitivities, and language barriers.
- **Alignment of incentives for providers**, such as using pay-for-performance and other tactics.
- **Team-based care**, which encourages a multi-disciplinary approach to care.

The driving principles for transforming primary care are not unique and reflect the work of other organizations. They mirror, for example, the Joint Principles of Patient-Centered Medical Home adopted in 2007 by the leading primary care physician associations[1], and the standards used by the National Committee for Quality Assurance (NCQA) to certify physician practices as medical homes[2].

ACAP represents 51 not-for-profit safety net health plans in 25 states serving over seven million people. Most of these plans employ some or all of the elements outlined above. They are working to transform primary care in a way that is flexible, scalable, and accountable. For example, health plans adjust to meet the needs of community by hiring and moving staff from the plan to practice sites more easily than small providers can hire new and specialized staff. And health plans hire practitioners – a team of nutritionists, for example – to work with numerous provider sites, which is far more efficient than each of the provider sites hiring its own nutritionist.

With interest in transforming primary care growing and gaining more widespread support, ACAP prepared this paper to show how health plans are already incorporating elements of this model into the way they operate. To do so, ACAP took a close look at seven Medicaid-focused health plans – serving communities coast to coast – to provide examples for each of the elements that are essential to transforming primary care. Those health plans are:

- **Neighborhood Health Plan of Rhode Island** has worked closely with the community health centers to transform how primary care is provided.
- **CareOregon** has worked closely with their primary care providers to develop a model to transform primary care through patient-centered collaboration.
- **Contra Costa Health Plan**, in California, is working to assist smaller practices by providing community-based, patient-centered case management in the practitioner's office.
- **Network Health,** operating statewide in Massachusetts, has developed an enhanced patient-centered care management program to help transform site-based care management for high-risk patients.
- **Amerihealth Mercy**, operating in 15 counties in Pennsylvania, is part of a state medical home collaboration that is focused on chronic care and includes pay-for-participation and pay-for-performance components.
- **CareSource**, in Ohio, has developed a medical home model that includes sharing of electronic health data with all providers who are interacting with the plan member and incentive-based reimbursement to reward patient engagement and performance.
- **Monroe Plan for Medical Care** of New York is focused on transforming practices by helping primary care physicians obtain NCQA physician recognition for excellence in diabetes care.

Techniques similar to those outlined in this paper can be replicated by other plans, and ACAP is encouraging its members, and the broader health care community, to consider how they can adapt and adopt them. Transforming primary care provides significant benefits to patients and throughout the health care system. As this paper demonstrates, Medicaid-focused health plans are already spearheading this transformation, remaining on the leading edge of a national movement.

Access

Consistent and improved ***access*** to care which goes beyond coverage issues is a fundamental element. Access to care can be improved by health plans and providers in a variety of ways, from reducing wait times to providing services for the patient at alternative locations.

- **Neighborhood Health Plan of RI (NHPRI)** worked jointly with Rhode Island's Community Health Centers to develop the Advanced Medical Home by utilizing their Primary Care Infrastructure (PCI) program. The PCI program consists of five domains, which include 15 different services, and are designed to improve or encourage multi-disciplinary care, broad systems of access, patient self-management, information technology infrastructure, and performance measurement. NHPRI provides contract incentives to the providers to encourage these services. One domain, *Broad Systems of Access,* provides incentives for appointment systems that promote and provide same day access, 24/7 informed telephonic care, provider use of remote entry electronic medical records, extended weekday hours, and weekend hours.

- **CareOregon** implemented the Primary Care Renewal project to encourage practices to strengthen primary care by providing comprehensive, coordinated care. Initially, five practice sites were offered grants to participate in the project with the expectation that they would implement several core elements, one of which is improved access. This element has shown to be effective, with one clinic primarily serving homeless patients reducing the average wait time for an appointment from 17 days to 3 days. The practice was able to increase staff as a result of the grant from CareOregon and dedicate resources to address the wait time.[3]

Patient-Centered Care Coordination

Another important element of primary care transformation is improved ***patient-centered care coordination*** at the primary care provider level that effectively addresses health and psychosocial issues, such as chronic conditions and the unique needs of Medicaid members.

- **ContraCosta Health Plan (CCHP)** has five Case Management programs: 1) The Complex Case Management Program, for clients that have difficulty adhering to a treatment plan; 2)The SelectCare Special Needs program (SNP) Medicare managed care program for dually-eligible members, 3) The Healthcare Coverage Initiative (HCCI) Risk Assessment, for the County's medically indigent/uninsured population, 4) The Good Health Check-Up Program, for addressing inconsistent pediatric well visits, and 5) Comprehensive Perinatal Services Program (CPSP), to ensure comprehensive perinatal care. CCHP's Case Management programs include a strong social component in which they work with members to coordinate appointments and address barriers to obtaining services, such as coordination with/referral to community resources for food, housing, transportation, socialization, financial counseling and mental health services. In addition, the Comprehensive Perinatal Services Program has a full-time Medical Social Worker, who provides services based on the member's choice, either telephonically or in person at a location specified by the member.

- **Network Health** offers customized and coordinated care plans to a diverse membership (i.e., members with chronic and critical conditions and acute episodes of illness) through its long-standing integrated model, which includes medical, behavioral health, social, and wellness care management. The model ensures continuity of care by fulfilling member needs along the

continuum of care, and is supported by a clinical team of nurses, behavioral health care clinicians, and licensed social workers. The plan uses face-to-face outreach and engagement efforts to reach members who are hospitalized or in the community and often difficult to reach. In addition, the plan recognizes that engagement with primary care physicians is a critical part of the program, and therefore communicates with them regularly.

Quality & Safety

The ***quality and safety*** element includes working with the practice to improve and support health information technology (HIT) as well as ensuring practices meet specific certification or standards.

Quality

- **AmeriHealth Mercy** is participating in the Pennsylvania medical home demonstration "Chronic Care Management, Reimbursement and Cost Reduction Commission", which blends The Patient Centered Medical Home model with The Chronic Care model. The pilots currently focus on adult diabetics and a smaller group of pediatric practices participate with a focus on asthma. Requirements of the practices to participate include attending "learning collaborative" meetings which are intended to provide the practices with learning sessions in best practices, medical homes, etc. The practice must also work with an IPIP (Improving Performance in Practice) coach to transform the practice, utilize a patient registry to track patients and report the data for evaluation. Additionally, practices must achieve Level 1 NCQA Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH) Recognition within 12 months, including emphasis on using non-physician staff, team approaches and encouraging patient self-management.

- **CareOregon** has a formal learning center set up at their headquarters to promote an ongoing learning collaborative. It serves as a location where participating practices come for learning sessions which include best practices and process improvement sessions. Practice leaders conduct sessions based on proven learning methods and share performance data based on the tiered incentives for providers. The learning center has gained substantial popularity among providers, with attendance exceeding 100 people on some days.[4]

HIT

- **CareSource's** Member Profile is an example of how access to members' health history can improve quality outcomes. The information is pulled from claims data from across the state. The data is compressed into a usable format for the physician to readily access, thereby, improving the quality of care provided. The system provides more efficient care by avoiding duplicate services, medical errors, and can identify when services are utilized for specific diagnoses. The system is updated on a near- real-time basis, and the medication history is updated daily, helping providers determine whether patients are compliant with prescription drugs.

- **Network Health,** in partnership with Commonwealth Care Alliance, created and now utilizes a common database for the initial roll-out of its Network Health Alliance program — a program that provides members with complex health needs access to an integrated clinical team of nurse practitioners, community health workers, and social workers. The common database includes

claims and EMR data allowing for real time alerts of gaps in care, as well as authorization data to assist in active-site and community-based care management.

Patient Engagement

Another important concept of Primary Care Transformation is ***patient engagement***, which encourages members to become active partners in improving health status and have better adherence to treatment regimes.

- **Network Health** has a long-standing health coaching program, focusing on self-management of chronic diseases, including behavior modification and goal setting. The plan distributes extensive educational materials, many focused on shared decision making. With the creation of Network Health Alliance and its extensive use of community health workers, the plan further expanded its efforts to engage members with the most complex health needs in their homes and communities, and connect them with their PCP and an extended care team.

- **Neighborhood Health Plan of RI's** PCI program, as discussed above, also focuses on patient education and motivational interviewing in the *Patient Self Management* domain. An in-center teaching curriculum provides patients with individual teaching and written instructional materials for patients with diabetes, cardiovascular, and pulmonary chronic diseases. Families of patients are considered as well. Motivational training is offered, which engages family members and caregivers in care planning and a written plan is provided to patients and family for patients with chronic illness.

- **CareSource** of Ohio has implemented a unique reimbursement scheme to reward patient engagement by the health care home. In addition to their normal reimbursement, a health care home office site can receive additional payments designed to encourage engagement. These per member per month payments are based on meeting certain thresholds for activities such as implementation of engagement agreements with patients, use of the automated member profile at each visit and follow-up contacts within 3 days of a sick visit.

Improved Provider/Patient Communication and Education

Improving provider and patient ***communication/education*** that addresses issues such as health literacy, cultural sensitivities, and language barriers is also an essential element of primary care transformation.

- **Contra Costa Health Plan** provides Case Management programs to promote standards of care through increased coordination of services, decreased fragmentation of care, efficient utilization of resources and patient/family involvement and satisfaction. The plan adopted an innovative publication tool to print the majority of health education tip sheets that are shared with members. The tool provides colorful graphics to provide explanation of diseases, procedures, and prevention tools. Contra Costa Health Plan also recognizes how critical language barriers can prevent patient access to care, and provides timely access to interpretation services. In addition, Contra Costa Health Plan also recruits staff that can provide immediate interpretation to its members and offers trainings in promoting bicultural awareness to its staff and providers.

- **Monroe Plan for Medical Care** was the lead agency in creating the Rochester Regional Quality Improvement Initiative (RQI) for Diabetes Care, with funding from The Robert Wood Johnson Foundation. The Rochester RQI initiative has been providing ongoing consulting services, helping physicians and their practices to evaluate and improve processes for managing diabetic patients according to specific care guidelines. Collaborative meetings were held regularly between representatives of the participating practices to share successes and strategies for care improvement – such as how to increase the number of foot exams or how to better document care. A new regional registry of diabetic patients also was established as part of the initiative. As a result of their participating in the RQI, 37 physicians have been recognized by the National Committee for Quality Assurance (NCQA) for their efforts to improve the quality of care for patients with diabetes.

Alignment of Incentives

There are a variety of options for ***aligning incentives,*** such as rewarding high quality care provided in a cost efficient manner as well as recognition for case management services and group visits.

- **CareOregon** offers an innovative solution for providing incentives. Additional reimbursement is based on three tiers with specific weightings and formulas. Tier one - *Payment for capacity to do work* - encourages the practices to continue participation in the collaborative project and focus on population health management. Tier two- *Payment for improvement* - tracks specific measures which gauge how practices improve on metrics for preventive care, diabetes, hypertension, and continuity of care. Tier three – *Payment for outcomes* - rewards those who meet 90 percent of the metrics in tier two. In addition, reducing ED visits and "ambulatory-sensitive inpatient admissions" are also evaluated for incentives.[4]

- **AmeriHealth Mercy,** along with other members of the multi-payor collaborative, provides incentives to the practices in the medical home demonstration project. Enhancements to the current contractual payments are provided to assist with the cost of incremental staff and technology costs. Payments are based on the specific NCQA PCC-PCMH Recognition Level the practice has achieved.

- **CareSource** of Ohio provides performance-based reimbursement to health care homes, in addition to the reimbursement discussed above to reward patient engagement. The semi-annual reimbursement rewards performance on select HEDIS outcome and process measures including access of care and well child visits, effectiveness of care measures that address preventive, acute and chronic care services, and reducing avoidable emergency room use.

Team-Based Care Approach

A ***team***, or a multidisciplinary approach, to providing primary care should include physician and non-physician personnel, as well as the health plan, to manage all of a patient's needs.

- A core element of participating in **CareOregon's** Primary Care Renewal Project is a commitment from providers to implement specific elements of a medical home, one of which is team-based care. Each team consists of four individuals, including a clinician, a medical assistant, a care

manager, and a behaviorist, who care for a specific panel of patients. Teams coordinate efforts and utilize each encounter to provide efficient care. They evaluate the patient's medical record to determine if patient is up to date on preventive services and medications and actively provide these services when needed. An additional set of codes and blended capitation rates are used to ensure payment for these services.[4]

- The **Network Health** Alliance model specifically incorporates an expanded care team consisting of nurse practitioners, community health workers, and social workers in collaboration with the patient's PCP and primary care site. This expanded care team provides a comprehensive home-based assessment of the patient and develops an integrated care plan. Concentrating on the most unengaged high-risk patients, this integrated model plays a key role in the successful transformation to a sustainable patient-centered medical home (PCMH).

Challenges

Primary care transformation is an evolving process. The health plans continue to improve their programs; however, as with all innovations, challenges should be expected. Discussions with Safety Net Health Plan representatives demonstrate that several challenges lay ahead in moving the concept of Primary Care Transformation forward.

- HIT- Health plans and practice sites developing and implementing EMRs must consider how to receive optimal utilities from EMRs once they are installed to drive population outcomes.
- Sustainability- Transforming primary care is an evolving process and efforts should be made to continue refining the process based on best practices. Safety Net Health Plans and other stakeholders must consider how to ensure Primary Care Transformation models are both effective and sustainable.
- Adaptable- The primary care transformation model should apply to new populations as well as current programs. The transformation process should be adjusted based on needs of the population.
- Return on investment – Health plans may encounter difficulty determining cost effectiveness data and how to quantify.
- Provider capacity – While assessing the current state of provider ability to participate in medical home pilots, the following considerations were determined:
    - Change perception of responsibility – there exists a common perception that a patient's responsibility is undermined if a practice assumes an outreach role.
    - Limited use of existing EMR tools - practices are not using the entire range of capabilities provided by the EMR.
    - There is an overestimation of capabilities for medical homes as compared to the NCQA standards.

Next Generation

Population Health - Population-based approaches should be considered an integral aspect of the health care delivery model. **CareOregon** has embraced this approach by shifting their view as an organization

to one that takes responsibility for the population's health.[5] For example, one clinic participating in the Primary Care Renewal project looked at the population to determine high ED users and was able to work individually with members to determine the reason for the excessive ED use. They were able to give these patients extra attention, which in turn provided an effective cost-control, saving CareOregon $1 million per year by redirecting these patients to their medical home rather than the ED.[1]

Community-Based Programming - In the initial phases of implementing Primary Care Transformation, it is important to have a broad understanding of the community. **Children's Mercy Family Health Partners,** in Kansas and Missouri, has performed interview sessions with a range of providers from single practitioners to FQHCs prior to implementing their medical home pilot in an effort to determine compatibility and commitment to the pilot. In addition to the medical home core staff, Children's Mercy Family Health Partners included other health plan staff, such as provider relations representatives and health improvement managers in their assessments. They found that most providers have a good acceptance of the pilot; however, the interviews identified a need for the health plan to fill in the gaps to create a successful medical home pilot. **Children's Mercy Family Health Partners** has worked with the provider community to determine the challenges ahead of time and were able to proactively work to address the issues.

In addition to initial implementation, continuous feedback should also be supported. In discussions with the Safety Net Health Plans, most plans stated they have an interactive relationship with their providers to ensure continuous, productive dialogue regarding each respective program.

Finally, community connections must be explored to further enhance primary care transformation, which will help to recognize the need for a different framework that works within a community, such as connecting with faith based organizations.

Conclusion

Safety Net Health Plans have long been engaged in primary care transformation elements across the country. When discussing transformation of primary care on a federal level, we want to be sure that the role of Safety Net Health Plans is considered, so that they can continue to play a critical role in transforming primary care to best meet the needs of vulnerable members they serve.

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[1] *Joint Principles of the Patient-Centered Medical Home*, March 2007
http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf

[2] *Physician Practice Connections® - Patient-Centered Medical Home™* , NCQA, March 2010,
http://ncqa.org/tabid/631/Default.aspx

[3] Davis, J. (2009). Portland Monthly Magazine. *January 2009*

[4] *Clinics Adopting Plan-Supported Medical Home Model Enhance Access, Improve Quality, and Reduce Admissions Among Medicaid Managed Care Enrollees,* AHRQ Health Care Innovations Exchange,
http://www.innovations.ahrq.gov/content.aspx?id=2584&tab=1 (Sept. 9, 2009).

[5] *Pursuing the Triple Aim: CareOregon,* Institute for Healthcare Improvement, http://www.ihi.org/NR/rdonlyres/2643EDBF-032F-470C-8D9C-AB0B598B491F/0/IHITripleAimCareOregonCaseStudyDec08.pdf (July 29, 2009).

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