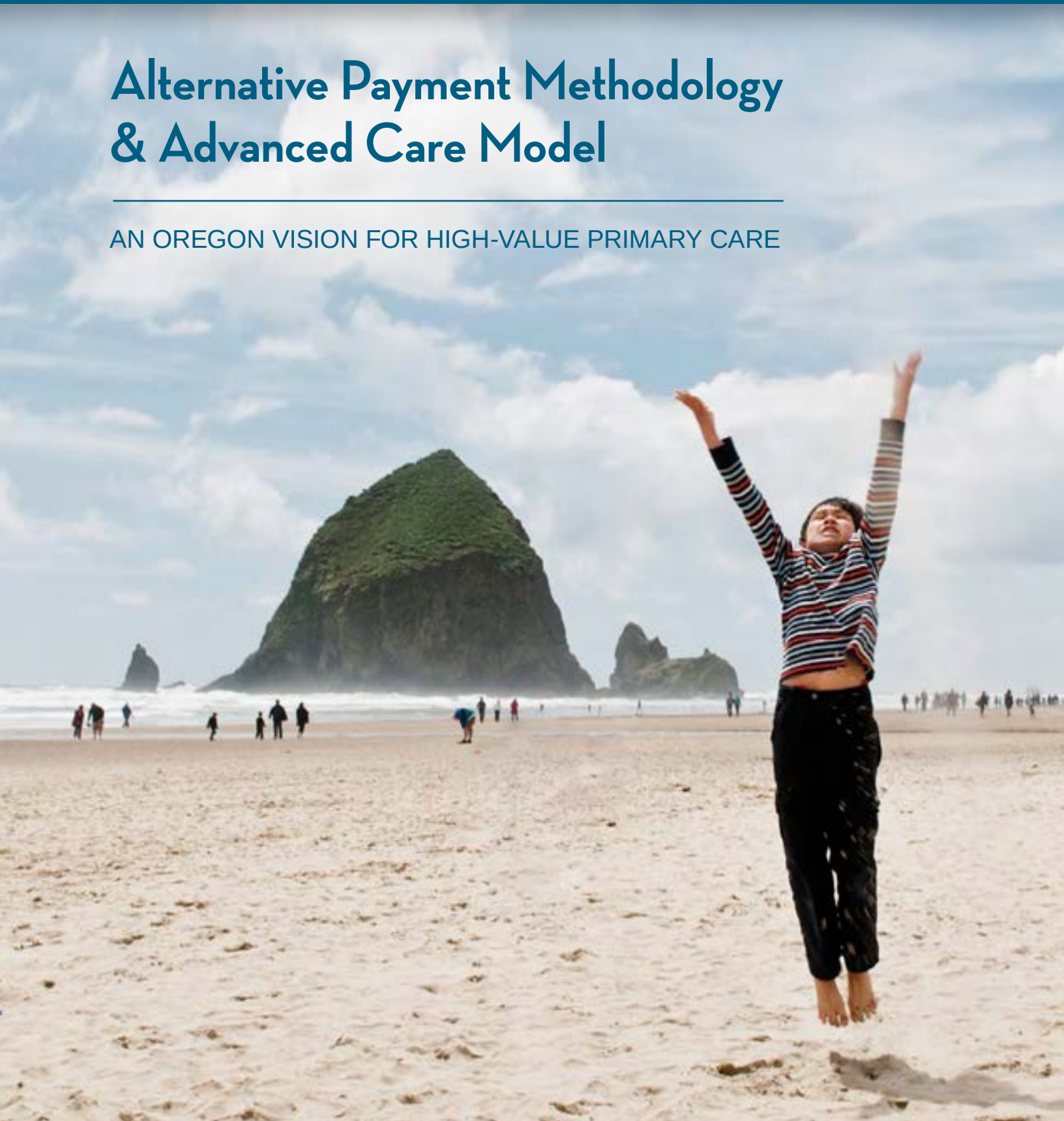
OPCA
Oregon Primary Care Association

Alternative Payment Methodology & Advanced Care Model

AN OREGON VISION FOR HIGH-VALUE PRIMARY CARE




OUR GOAL
is to align payment
with an efficient,
effective, emerging
care model that
lowers overall costs
while improving quality,
access, and health
equity for all.

OPCA serves a powerful network of community health centers.

OPCA's 32 community health center members are dedicated to caring for the health of people experiencing poverty and marginalization in Oregon. Together, health centers serve more than 430,000 Oregonians. By **joining together and sharing knowledge**, Oregon health centers are collectively improving primary care and advancing health equity in their communities.

In order to fulfill our mission of health equity for all, health centers in Oregon need the space not just to deliver healthcare, but to foster health in the communities they serve by tailoring their care and services to the **unique issues and circumstances of their patients**. They need the time to develop trusting relationships with patients and they need to be flexible in where, how, and what kind of care and services are provided.

OPCA and Oregon community health centers developed the **Alternative Payment Methodology and Advanced Care Model**, in partnership with the Oregon Health Authority, as a transformative model that puts our communities on the path to optimal health.

In the Alternative Payment Methodology and Advanced Care Model (APCM), the fee-for-service model is replaced by a capitated (per-patient, per-month) payment that community health centers can use to partner with patients to create a plan for supporting better health. The new payment methodology supports the expanded health center team to provide health and wellness services when and where the patient needs them, rather than limiting payment to traditional provider encounters.

Care teams can now spend the time to develop a fuller understanding of the patient's medical and life circumstances to jointly determine the appropriate priorities and care plan. This approach allows the care team to treat the whole person by paying attention to their overall wellness, as well as the underlying economic, environmental and social drivers of health and well-being.

APCM DELIVERS RESULTS[1]

15% ↑ colorectal cancer screening rates

21% ↑ depression screening with follow up

APCM health centers run over 40% of all 5 STAR Clinics — Oregon's highest level of Patient Centered Primary Care Home recognition.[2]

Creating a high-value health system.

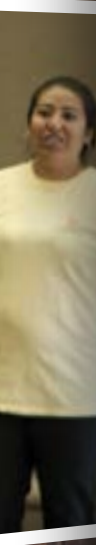
APCM is a key piece of the Oregon health center strategy for moving towards a more high-value health system. It is pretty easy to agree that a focus on quality of health outcomes would be an improvement on our current approach of focusing on the volume of services. APCM minimizes the incentive to focus on volume by replacing fee-for-service payment with the capitated model. The goal of APCM is to create a higher value approach for all stakeholders: patients, health center care teams and leadership, and health care payers.

90% of care teams expanded

Nearly 90% of the health centers reporting have been able to expand their care teams as a result of participating. [3]

Patient engagement increased

Documentation of patient engagement with the care team beyond traditional visits has more than tripled since 2013.[3]



How APCM improves health system value for patients

- Patients benefit from a flexible, holistic model of primary care that serves as a **hub for services** that promote health and well-being for the community.

  An **interdisciplinary team** of professionals works together within the primary care setting to address patients' **medical, dental, behavioral and social needs**. The primary care team is also connected through community partnerships to other organizations that are working to improve health.

  Care teams may include:
  - Community health workers
  - Clinical pharmacists
  - Nurse care managers
  - Behavioral health counselors
  - Dietitians
  - Physical therapists
  - Primary care providers
  - Other allied health professionals

- **Care is well-coordinated and integrated**, so that patients are not asked to share the same information repeatedly or offered duplicate services.

- **The primary care staff engage with patients to promote wellness** and good health — not just in response to illness.

- **Access to care and services is both convenient and flexible.** Patients interact with members of the care team in a variety of ways, according to patient preferences, including: primary care provider visits; phone or video-conference calls; messages through the electronic medical record; care team home visits; support or educational groups; text messages; and group medical visits.

  The care team proactively seeks to understand and respond to patients' circumstances and priorities.

- Patients experience **care that is respectful and collaborative**. Caregivers demonstrate empathy and compassion toward patients' experiences and perspectives.
  - Staff are trained in trauma-informed care, and understand that traumatic experiences may be shaping how patients respond to the health care system and their own health.
  - Patients benefit from proactive outreach from the care teams and are empowered as partners in health care decision-making.

Quality of health outcomes > Volume of billable services

How APCM improves value for health center teams and leaders

APCM envisions a future where care teams have more freedom to organize and optimize their work in a way that matches the needs and priorities of patients, and health centers are a **provider of choice** in their community due to the high quality care and patient experience they provide.

While changing models of practice is slow and challenging work, the predictability of the capitated payment methodology allows health center leaders to make **strategic investments** in their team, facility, and IT infrastructure in order to improve population health over time.

Teams have more members who can work to establish trusting, meaningful relationships with their patients and expand the scope of care beyond the medical domain.

Care team members have the flexibility to **go the extra step** in understanding and documenting social factors that affect patients' lives and health. Care teams are able to provide both i**n-house and community-based services** that respond to patients' most immediate social barriers, such as food insecurity, social isolation, and financial hardship. The health centers' investment in building a trauma-informed approach to care improves the experience of employees as well, who benefit from a **relationship-oriented system** that maintains sensitivity and respect for all stakeholders.

Care team members provide specialized skills and work together to provide a seamless experience of care.

APCM enables **each member of the team to contribute their expertise** to supporting patients. Nurses have more time for health education and care coordination, community health workers provide connections to social resources, primary care providers respond to medical issues, clinical pharmacists facilitate chronic disease management, and behavioral health clinicians provide support for patient needs relating to mental health and substance use disorders.

Health centers have more time and flexibility to coordinate the work of the team.

Without the same pressure to conduct traditionally billable visits, APCM allows teams to **collaborate in improving care**. Teams work together to test and implement new types of visit formats and team roles, develop new care coordination and population health management strategies, and work with patients on wellness and prevention-oriented care.

Data is an essential tool for care team collaboration.

APCM enables health centers to invest in **population health management infrastructure**, which allows teams to use data to better understand their patient population, utilization patterns, and opportunities for improvement. Health centers track and report the variety of ways that they are interacting with patients and families. Actionable, team-level data is used to plan care at the individual and population level, identify health disparities, and to design, test and implement improvement efforts.

How APCM improves value for payers

APCM envisions a future where payment is based on results, rather than volume. To achieve their goals of improving health and reducing the overall costs of providing health care, payers make investments to increase primary care capacity. Transformative investments in primary care support the delivery of cost-effective health promotion services that work to address the root causes of poor health.

- **In order for value-based payment models to be sustainable for safety net providers, payment methods need to account for the additional resources required to effectively support patients experiencing significant social challenges.** Without risk adjustment models to account for differences in the social drivers of health, value-based payment can reinforce disparities in health outcomes and discourage health systems from serving the most vulnerable patients.

- **APCM enables health centers to achieve financial stability in serving the state's most complex and marginalized populations. This approach adds value for payers by ensuring that their most vulnerable members have access to high quality primary care.**

- **APCM serves as a bridge to payment models where health centers share financial accountability with payers to deliver on high-priority results.**

Sharing financial accountability through value-based payment models is one of the key emergent methods for improving cost-effectiveness in the health system. Through APCM, payers are able to create incentives that encourage quality and introduce financial risk-sharing with providers. Built on a population health paradigm, providers are accountable to report on the cost, quality, access, and population health equity for the care and services they deliver and are moving towards tying payment to outcomes in these domains. Capitated payment methodologies give health centers the ability to build the infrastructure necessary to succeed in an environment of value-based pay.

With the appropriate data analytics, team-based care and patient engagement models in place, alternative payment methodologies give health centers the flexibility to be creative and innovative in working towards the target areas for improvement.

- **As part of a strategy to reduce high health care costs, community health centers and their community partners function effectively as a hub for ensuring appropriate utilization of the health system.**

The flexibility enabled by APCM supports health centers to develop and deepen community integration efforts that provide patients with effective and appropriate care and care coordination. These efforts bring down the total costs of health care by reducing unnecessary emergency department and inpatient utilization, which are among the most expensive types of health services.

State analysis of APCM showed $17 million in Medicaid costs avoided over first three years.[4]

OPCA
Oregon Primary Care Association

As a nonprofit membership association founded in 1984, OPCA's members include all of Oregon's community health centers, also known as federally qualified health centers (FQHCs), other safety net clinics, and those who support them.

We believe that all people, in Oregon and beyond, should have the chance to lead their healthiest lives and have access to equitable health care. Our mission: Lead the transformation of primary care to achieve health equity for all.

The end of our story is not yet written, as our transformation efforts continue to evolve. Please reach out if you have any questions about our APCM vision or experience.

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Notes
1. As reported by Oregon health centers, 2018.
2. Oregon Health Authority, 2017.
3. As reported by Oregon health centers, 2018.
4. Optumas Report commissioned by Oregon Health Authority, 2017