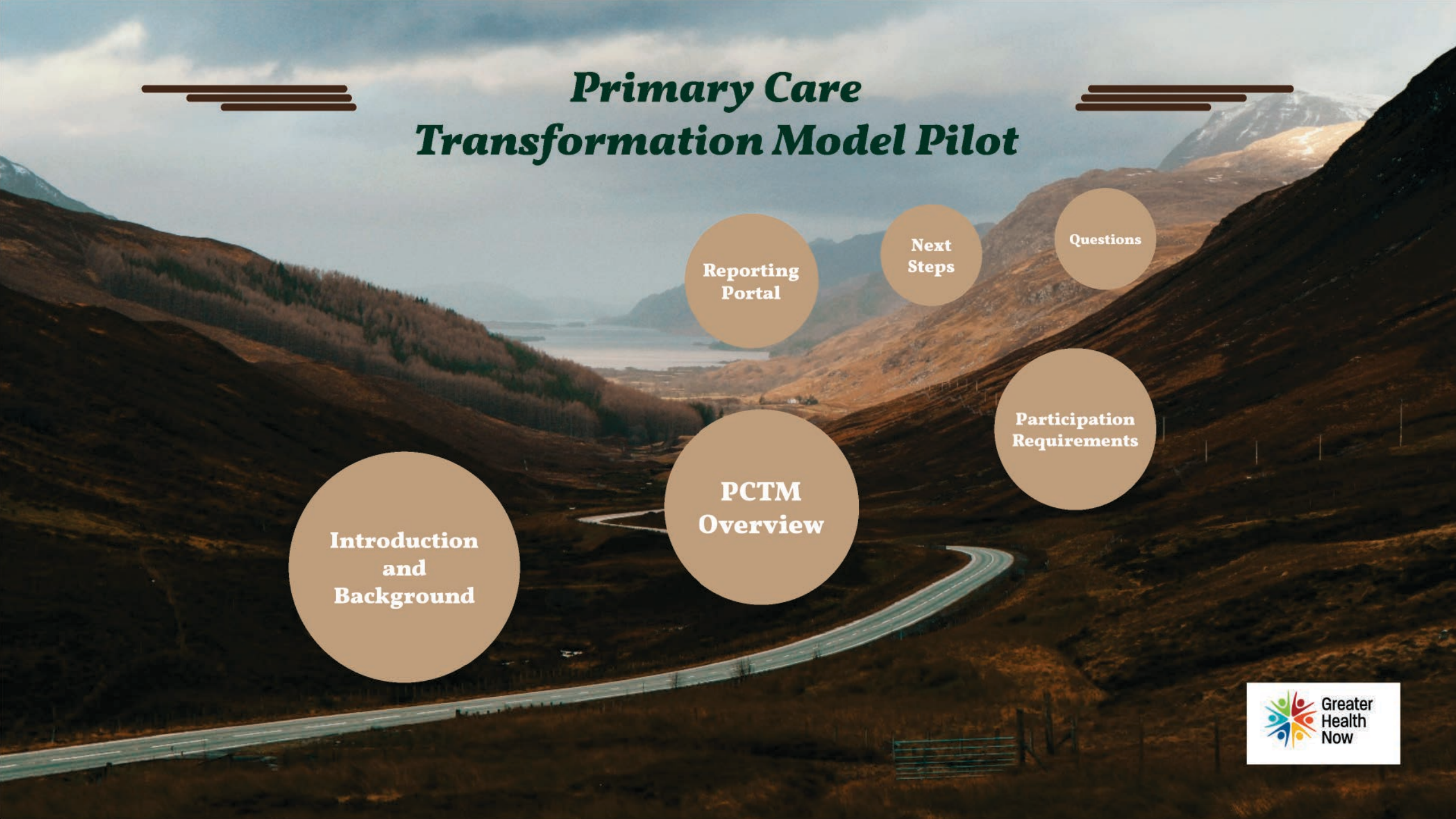

Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

Introduction, Background, and Goals

Introduction

Background

Goals

Introduction

Laurel Avila, MBA, BSN, RN
PCMH CCE

Introduction, Background, and Goals

Introduction

Background

Goals

Background

Greater Health Now is piloting the Primary Care Transformation Model (PCTM).

PCTM was created by the WA State Health Care Authority in collaboration with the state's payers and primary care provider community.

Introduction, Background, and Goals

Introduction

Background

Goals

Goals

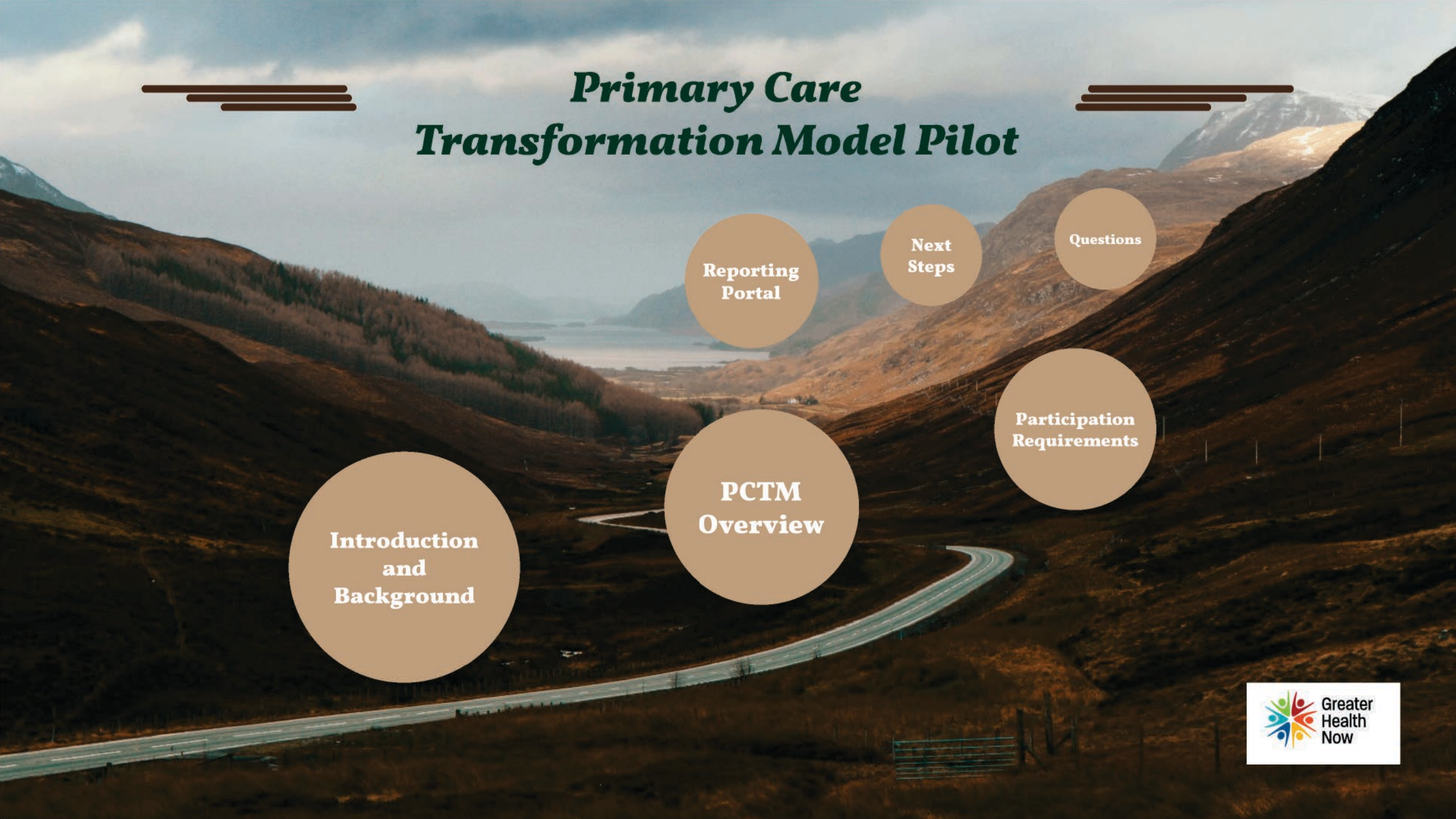
- Succeed in alternative payment models
- Enhance team-based care for patients
- Develop a care coordination strategy leveraging partnerships with community-based organizations
- Position clinics to acheive PCMH recogition

Introduction, Background, and Goals

Introduction

Background

Goals


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

PCTM Overview

10 Accountabilities

3 Levels of Achievment


10
Accountabilities
1
2
3
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6
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10

Whole Person Care

Practice is accountable for providing or ensuring access to a full range of primary care services to attributed patients

- minor illnesses and injuries
- chronic disease management
- preventive services
- office based procedures and diagnostic tests
- low complexity behavioral health interventions


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Accountabilities
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A Team for Every Patient

Attributed patients are assigned to primary care team (empaneled) for evaluation, treatment, and ongoing management. The primary care team may or may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team.

- empanelment
- huddles, chart prep
- established workflows


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Accountabilities
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Resource Allocation Strategy

Practice has and uses a documented strategy to prioritize resource use across all empaneled patients. The strategy includes addressing medical need, behavioral health diagnosis, and health-related social needs.

- risk stratification tool
- care management
- follow-up on hospital admission and ER visit


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Accountabilities
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Behavioral Health Integration

Washington State Integrated Care Assessment for Primary Care Settings is used to evaluate competency.

- Screening, referral to care, and follow-up
- Evidence-based care
- Use of psychiatric medications
- Information exchange among providers


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Accountabilities
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Patient Support

Ensure patient goals, preferences, and needs are integrated into care and patients have access to self-management tools.

- patient surveys and focus groups
- patient feedback incorporated into quality improvement strategy
- decision aids and self management support


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Accountabilities
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Care Coordination Strategy

Practice coordinates care to minimize gaps in care, ensure patients are connected to referred resources, and ensure general continuity of resources.

- individualized clinical summaries for referrals
- medication reconciliation after referred care visit
- community resource referrals
- care plans for patients
- care compacts with specialty providers


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Accountabilities
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Expanded Access

Practice offers same day appointments for routine and urgent needs, evening and weekend hours, 24/7 clinical advice,telephonic access, and community IT innovations. Access is provided for both physical and behavioral health.

- appointment availability
- same day appointments for urgent needs
- evening/weekend hours
- expanded access for physical and behavioral health


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Accountabilities
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Culturally Attuned Care

Practice provides culturally supportive care in location, language, and demographic composition.

- real-time interpretation for top 3 languages
- consideration for patient demographics as part of quality improvement
- culturally appropriate care
- partner with culturally attuned community-based organization


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Accountabilities
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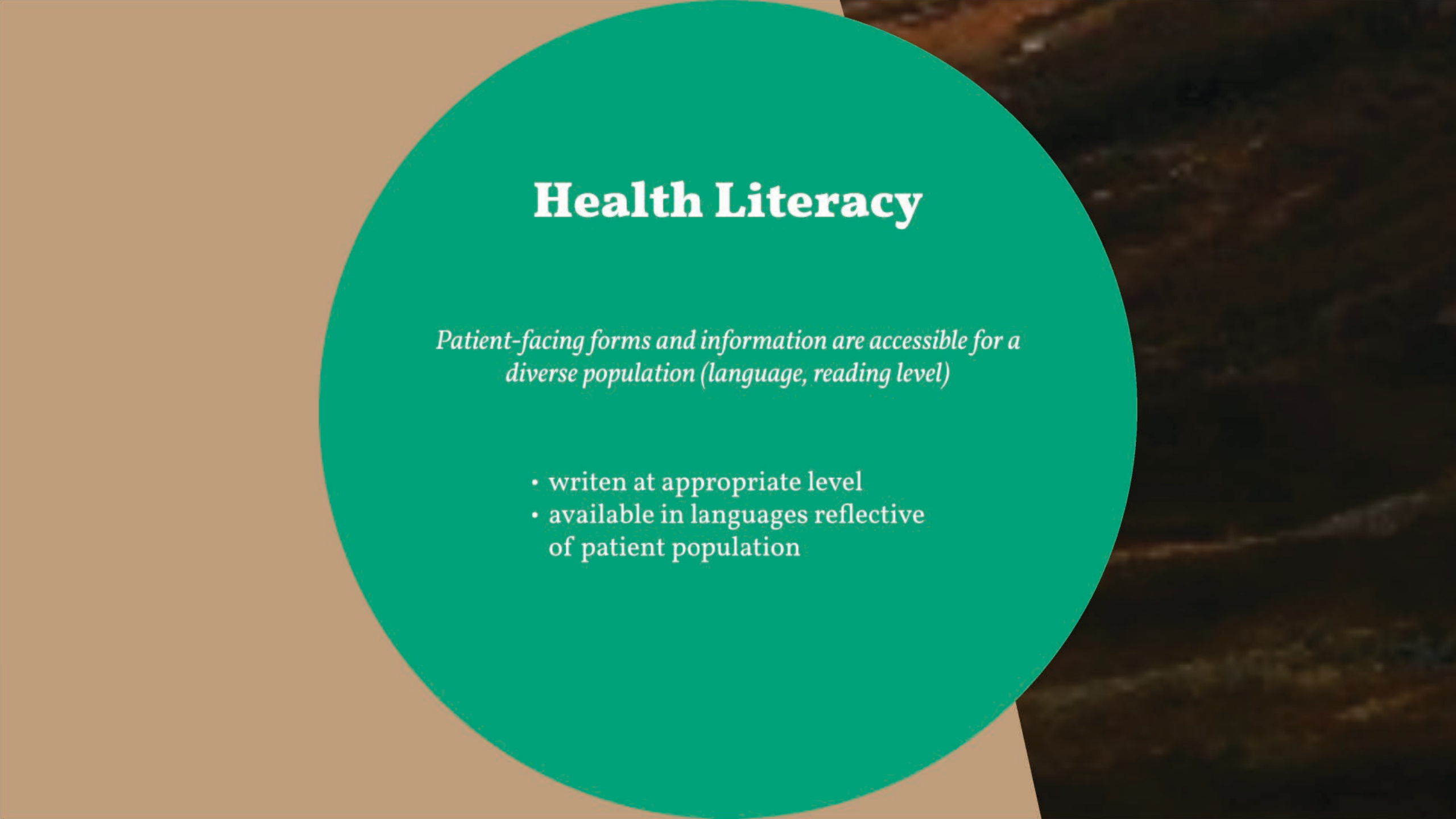
Health Literacy

Patient-facing forms and information are accessible for a diverse population (language, reading level)

- writen at appropriate level
- available in languages reflective of patient population

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Accountabilities
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Data Informed Performance Management

Practice builds capacity to query and use data to support clinical processes, population health, and business decisions that result in improved quality and financial performance.

- able to electronically send and receive data regarding attribution, care coordination, and performance to and from plans
- incorporates data into improving workflows
- has identified a process improvement model
- measure and track physical and behavioral health outcomes


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Accountabilities
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PCTM Overview

10 Accountabilities

3 Levels of Achievment

3 Levels of Achievement

Level 1
Meets minumum participation standards & working toward transformation

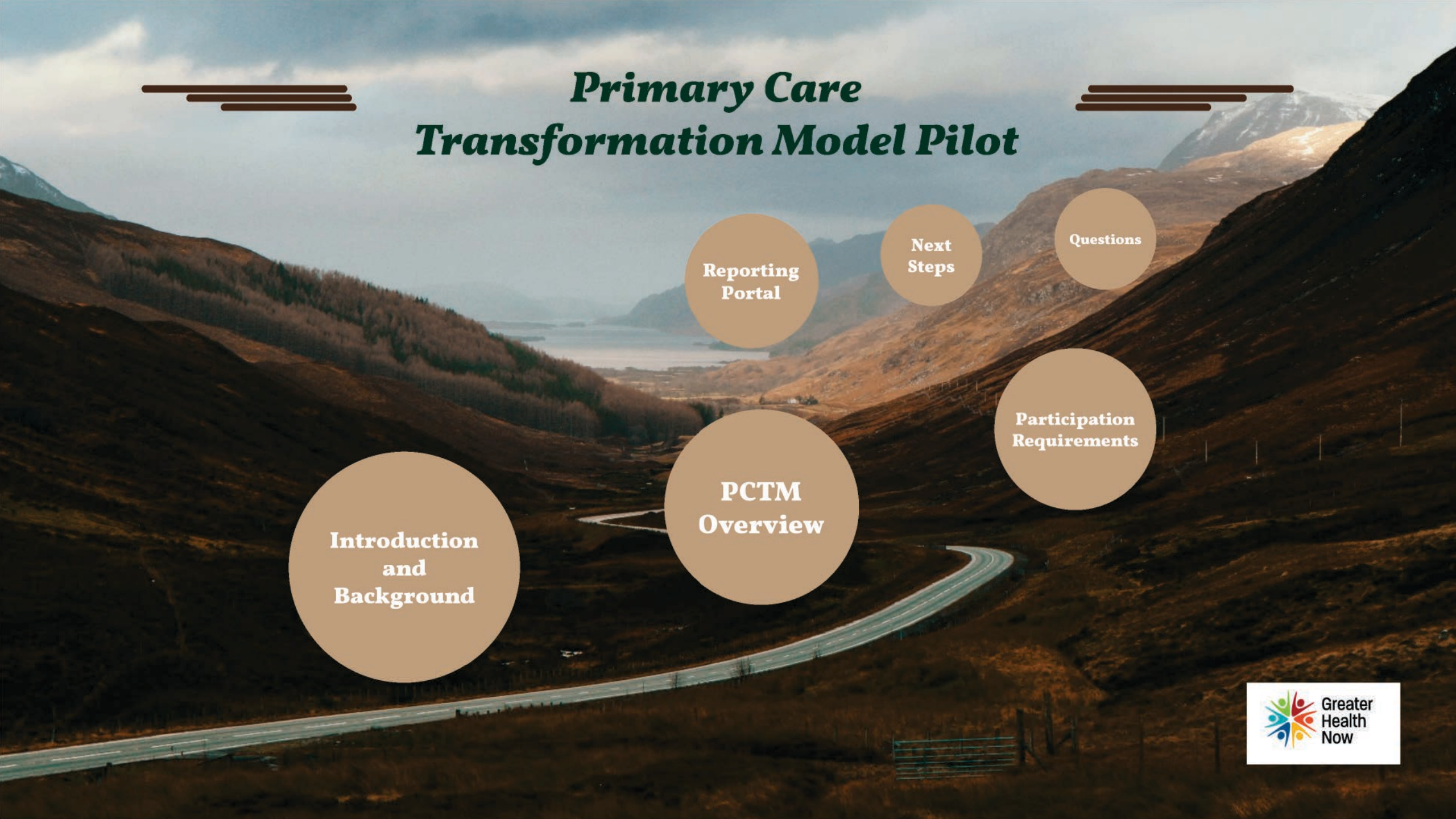
Level 2
Making Progress toward transformation

Level 3
Implementing model with fidelity

PCTM Overview

10 Accountabilities

3 Levels of Achievment


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

Participation Requirements

- Complete quarterly reporting
- Actively participate in monthly webinars (2 per quarter required)
- Meet with Laurel monthly

Incentive Allocation

Reporting Schedule

Incentive Allocation

Incentive Allocation	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Bonus	Total
Complete Quarterly Reporting						
Meet with PCMH Subject Matter Expert 3 times per quarter						
Participate in 2 Shared Learning Webinars (minimally)						
Complete 3 Requirements Listed Above	$20,000	$20,000	$20,000	$20,000		$80,000
Bonus: Movement from PCTM Level 1 to Level 2					$10,000	$10,000
Bonus: Movement from PCTM Level 2 to Level 3					$10,000	$10,000
Bonus: Formal Agreements with 3 or more Community Based Organizations					$10,000	$10,000
Maximum Available Incentive Allocation	$20,000	$20,000	$20,000	$20,000		$110,000

Participation Requirements

- Complete quarterly reporting
- Actively participate in monthly webinars (2 per quarter required)
- Meet with Laurel monthly

Incentive Allocation

Reporting Schedule

Reporting Schedule

Reporting Schedule	Dates	Reporting Due	Payment Due
First Quarter	1/1-3/31/24	4/26/2024	5/31/2024
Second Quarter	4/1-6/30/24	7/26/2024	8/30/2024
Third Quarter	7/1-9/30/24	10/26/2024	11/29/2024
Fourth Quarter	10/1-12/31/24	1/31/2025	2/28/2025

Participation Requirements

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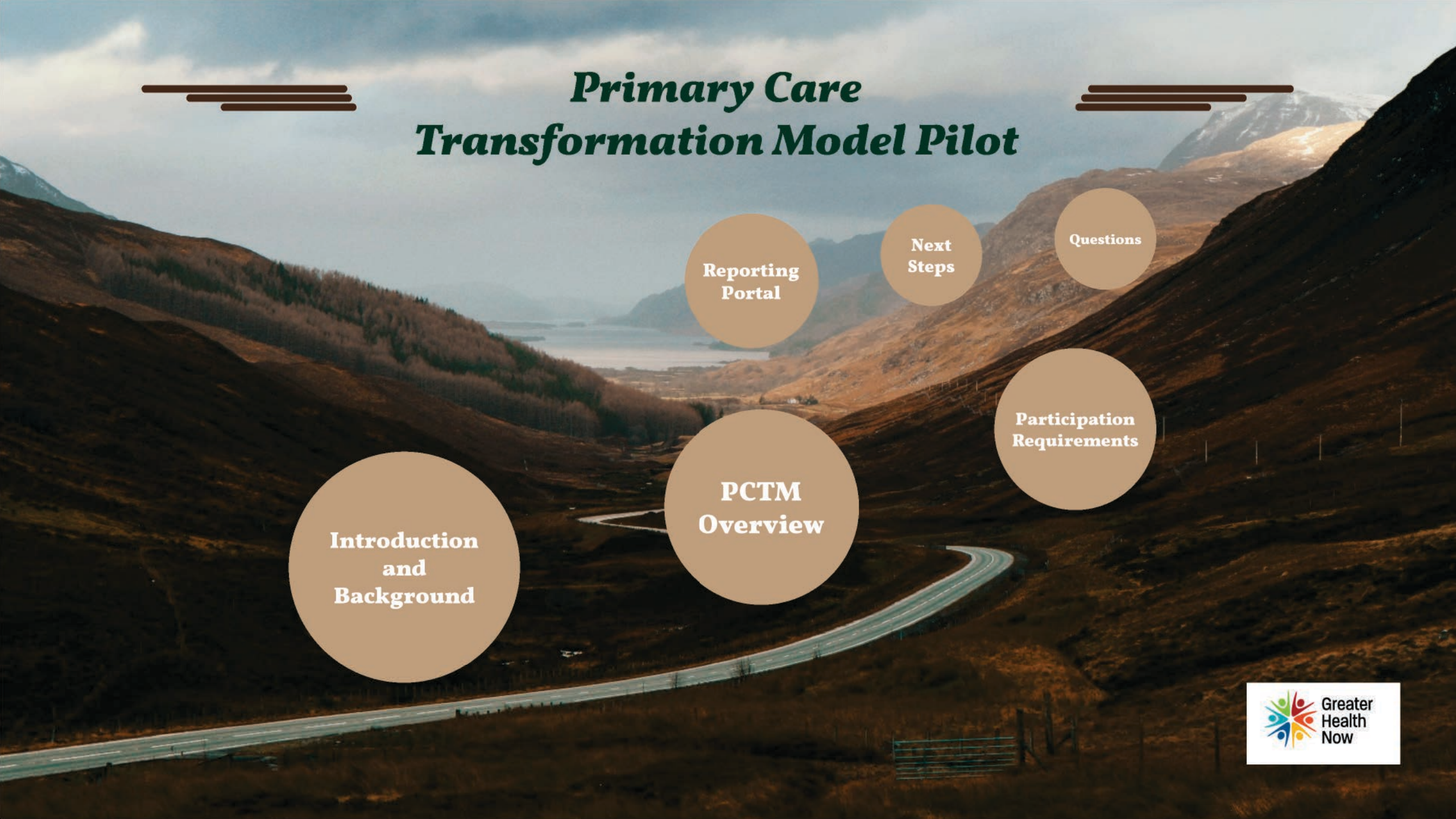
Incentive Allocation

Reporting Schedule


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

Reporting Portal

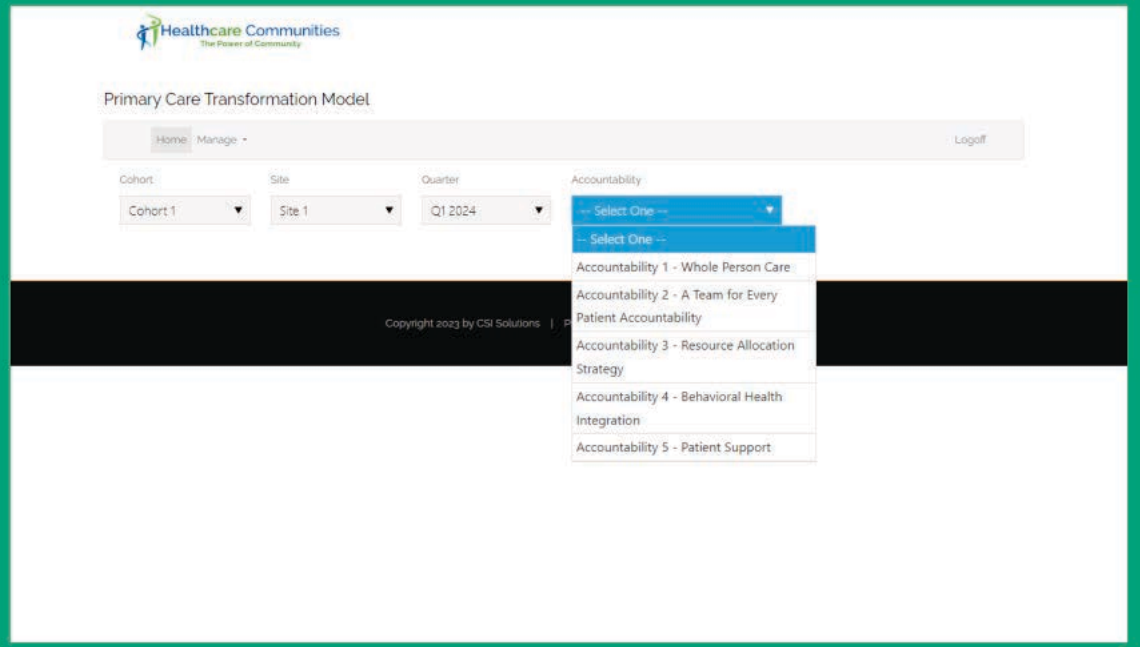
We will be using a reporting portal for demonstrating competency in the 10 areas of accountability.

Portal

Data Reports

Other

Reporting Portal



Reporting Portal

We will be using a reporting portal for demonstrating competency in the 10 areas of accountability.

Portal

Data Reports

Other

Data Reports Required

3.1.c.
number of hospitalization notifications
number of patients scheduled for follow up after hospitalization
3.2.c.
Number of ED visit notifications
number of patients scheduled for follow up after ED visit
3.3b.
number of patients identified in need of care management, care coordination, closure in gaps in care
number of patients that received care
6.1.c.
number of patients identified for medication reconciliation after engagement with other care providers
number of medication reconciliation conducted

Reporting Portal

We will be using a reporting portal for demonstrating competency in the 10 areas of accountability.

Portal

Data Reports

Other

Other Types of Competency Demonstration

- Provide a narrative explanation
- Upload a document or workflow diagram
- Upload a screenshot from your EMR with patient information redacted
- Share screen during scheduled visit with Laurel

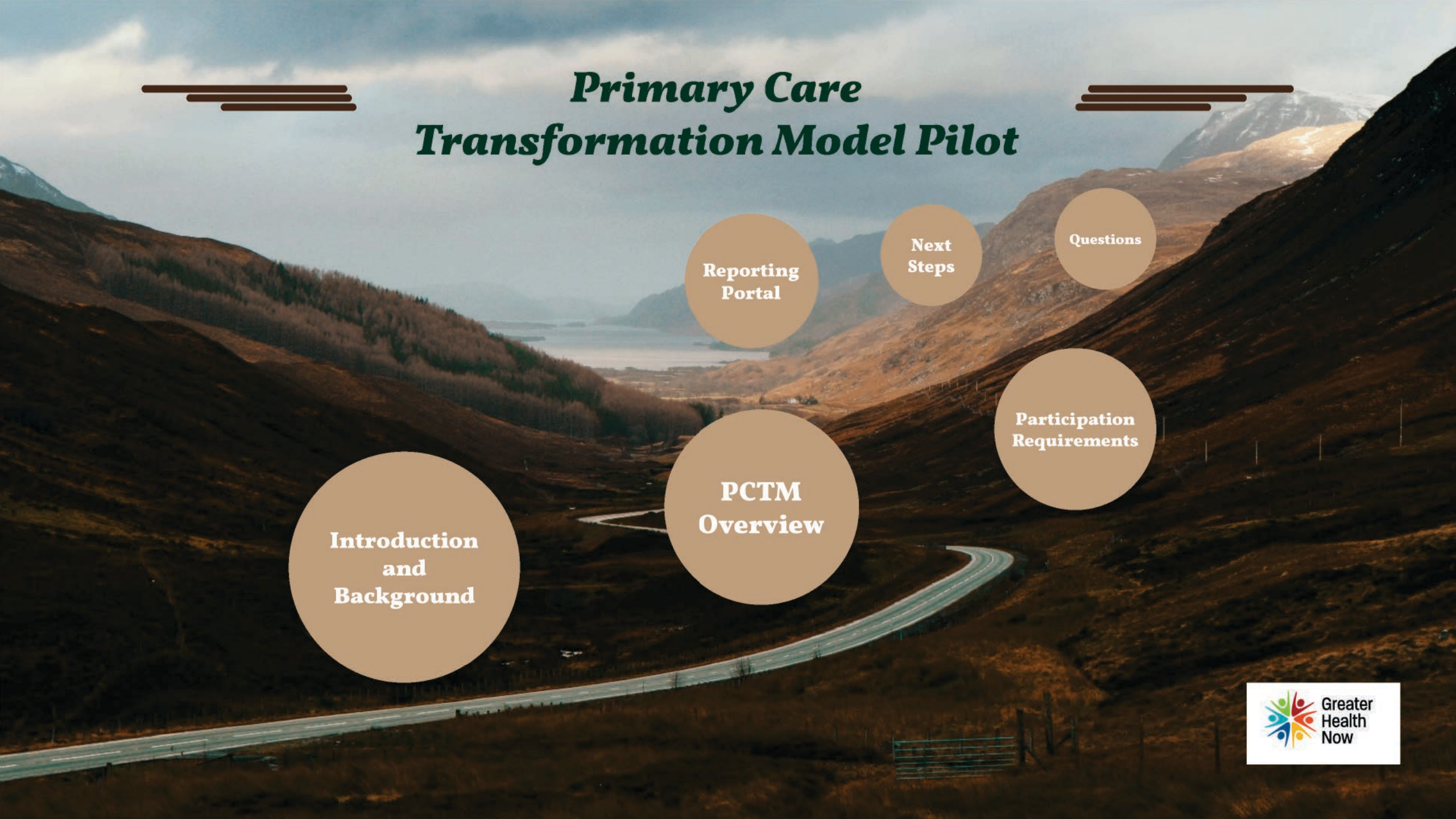
Reporting Portal

We will be using a reporting portal for demonstrating competency in the 10 areas of accountability.

Portal

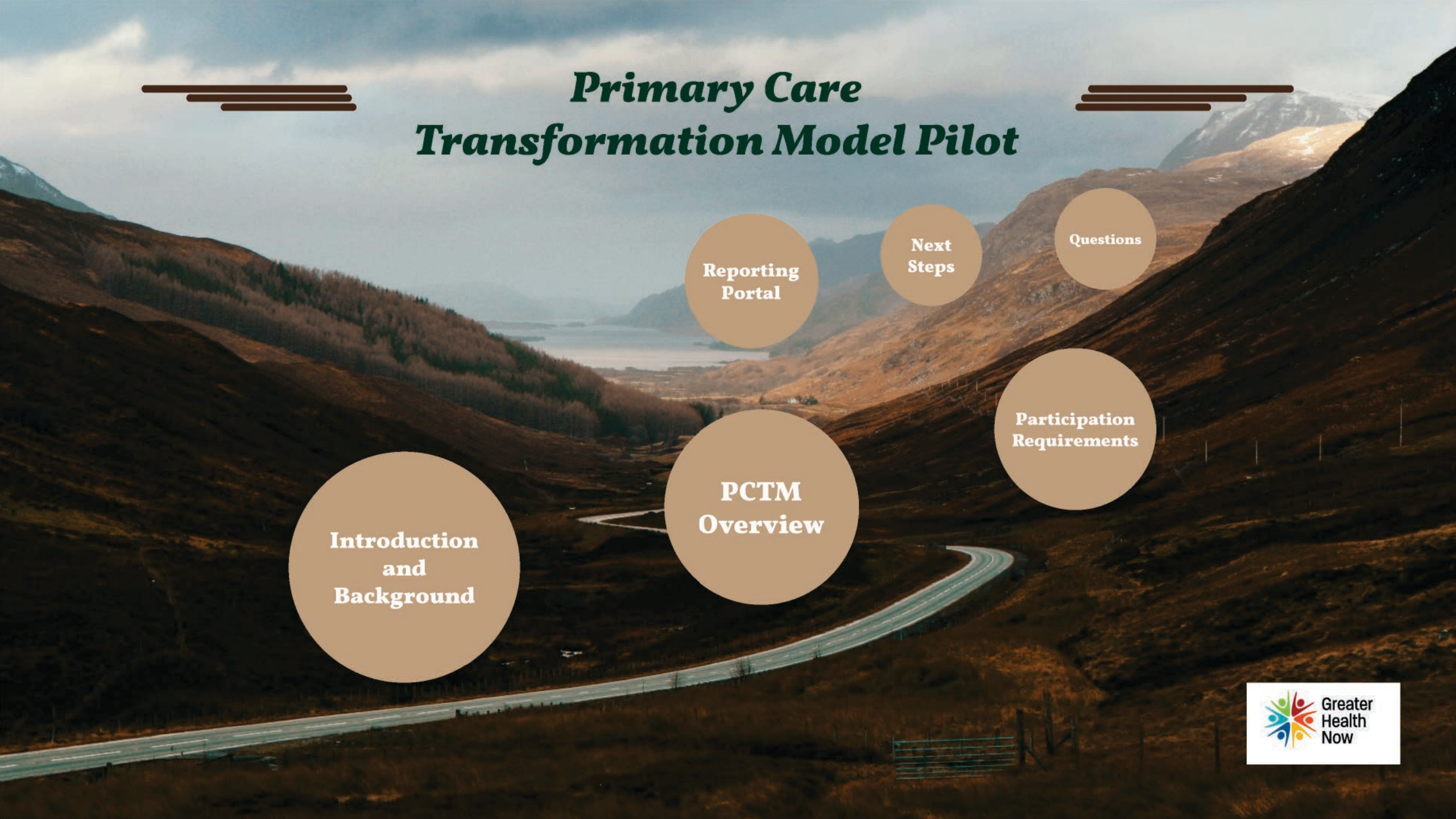
Data Reports

Other


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

Next Steps

- Submit Interest in Participation Form Online by **10/13/23**
- Contract Package will be distibuted mid-October to 10 clinic participants
- Completed contracts due mid-November
- Arrange meetings with Laurel for **12/2023 and beyond**
- Begin PCTM Pilot **1/1/24**


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now

Questions

Contact Information

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Contact Information

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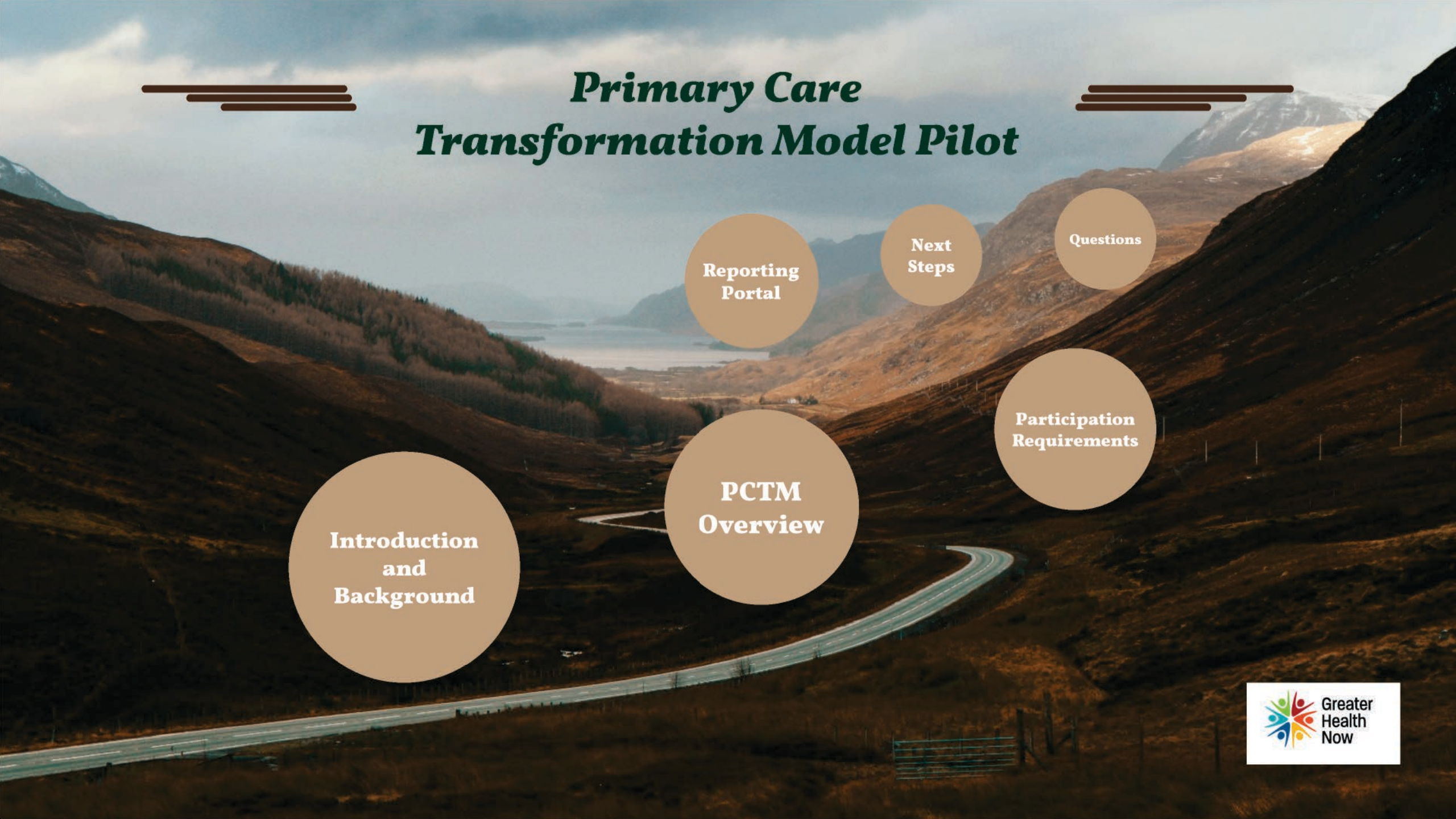
cell (509) 947-5210

Questions

Contact Information


Primary Care
Transformation Model Pilot
Introduction and Background
PCTM Overview
Reporting Portal
Next Steps
Questions
Participation Requirements
Greater Health Now