We Want To Hear From You!

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Patient-Centered Primary Care Institute

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Introduce Presenter

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Learning Objectives

• Gain a broad understanding of the PCPCH Program, including the core attributes, tier levels, 2014 standards for recognition and the verification site visit process

• Receive information on the more than 500 recognized PCPCHs in Oregon, including data about staffing, services provided, clinic ownership, and geography

• Review results from a 2013 survey of recognized PCPCH clinics on what Oregon providers think of the PCPCH model

• Understand the direction and priorities for the PCPCH Program in the future
Patient-Centered Primary Care Home Program

- HB 2009 established the PCPCH Program:
  - Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

- Key PCPCH program functions:
  - PCPCH recognition and verification
  - Refinement and evaluation of the PCPCH standards
  - Technical assistance development
  - Communication and provider engagement

- Goals:
  - All OHA covered lives receive care through a PCPCH
  - 75% of all Oregonians have access to a PCPCH by 2015
  - Align primary care transformation efforts by spreading the model to payers outside the OHA
Health System Transformation

**COORDINATED CARE ORGANIZATION**

- Local accountability for health and resource allocation
- Standards for safe and effective care
- Integration and coordination of benefits and services
- Global budget indexed to sustainable growth

**PATIENT CENTERED PRIMARY CARE HOME**

- Comprehensive
- Coordinated
- Accessible
- Accountable
- Patient & Family Centered
Core Attributes of a Primary Care Home

Oregon’s PCPCH model is defined by six core attributes, each with specific standards and measures.
Different Levels of Primary Care “Home-ness”

Tier 1
Basic Primary Care Home

Tier 2
Intermediate Primary Care Home

Tier 3
Advanced Primary Care Home

- Proactive patient and population management
- Accountable for quality and utilization
- 130 + points and all 10 must-pass criteria

- Demonstrates performance improvement
- Additional structure and process improvements
- 65 - 125 points and all 10 must-pass criteria

- Foundational structures and processes
- 30 – 60 points and all 10 must-pass criteria
# 10 Must-Pass Requirements

1.C.0 PCPCH provides continuous access to clinical advice by telephone.

2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.

3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.

3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)

4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)

4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.

4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

6.A.0 PCPCH offers and/or uses either providers who speak a patient and family’s language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.
Steps to Apply for PCPCH Recognition

1. Review 2014 Technical Assistance Guidelines

2. Complete a Self-Assessment Tool
   • Prepare for application and gather data
   • Strongly recommend preparing documentation binder

3. Apply
   • Submit your application using online system located on the “Become Recognized page at:
     www.PrimaryCareHome.oregon.gov
Verification Site Visits

• Launched in September 2012
• Conducted more than 50 site visits to-date
• Goals:
  • **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to on their PCPCH recognition application
  • **Assessment** of the care delivery and team transformation process to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH
  • **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with colleague and technical assistance through the [Patient-Centered Primary Care Institute](#)
Where are PCPCHs?
What do PCPCHs look like?

- **Staffing**
  - Average # providers = 5.1 (1-39 FTE)
  - Average # other clinical staff = 9.4 (0-70 FTE)
  - Average # annual visits = 14,539 (229-134,000)

- **Services**
  - Majority serve adult and pediatric populations
  - Majority provide obstetrics care
  - < 20% offer CAM

- **Ownership**
  - Nearly half owned by a larger system
  - 40% independent and unaffiliated
  - About 10% independent but in alliances

- **Implementation**
  - Over 80% (N=252) of survey respondents needed to add new services in order to implement the model
PCPCH Total Scores
Urban/Rural Categorization

Rural Average: 52.10
Urban-Small Average: 55.36
Urban-Medium Average: 61
Urban-Large Average: 56.37

Practices 1 - 245
PCPCH Total Scores
Number of FTE Primary Providers

0-2 FTE
Average: 53.16

3-5 FTE
Average: 60.22

6-9
Average: 59.22

10+ FTE
Average: 58.19
What have we learned?

• Improving outcomes
  • 85% feel the model is helping their practice increase the quality of care
  • PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years (Information for a Healthy Oregon. The Quality Corporation, August 2013)

• Improving access and experience of care
  • 75% feel the model is helping their practice increase access to services
  • 85% of those surveyed believe the PCPCH model is helping them improve the individual experience of care
  • 82% report the model is helping them improve population health management
Impact on Utilization

Figure 1: PCPCH % Utilization Change vs. Non-PCPCH Primary Care Sites
(* = p<.05)
Impact on Expenditures

Figure 2: PCPCH % Expenditure Change vs. Non-PCPCH Primary Care Sites
(* = p<.05)
What do practices still need?

• **Most commonly reported barriers:**
  • Cost and lack of resources
  • Staffing and training
  • Time
  • Administrative burden and reporting

• **Most requested areas for future assistance:**
  • Patient and family engagement and communication
  • Behavioral health integration
  • Care management/complex case management
  • Comprehensive care planning
  • Care coordination
  • Team-based care and empanelment
Where PCPCH Program Is Headed

• **Communication and Engagement**
  • Maintain relationships with engaged clinics
  • Engage unrecognized clinics
    • Approximately 400 – 500 unrecognized clinics in Oregon
    • Partnerships with other organization and stakeholders for identification and connection

• **Technical Assistance**
  • Expanded site visit process & technical assistance support
    • Two teams that include practice coach and clinical champion
    • Follow-up and assistance with setting/achieving goals

• **3Star Designation Launch**
Patient-Centered Primary Care Home
2014 Recognition Standards

Online Learning Modules
NOW AVAILABLE

WWW.PCPCI.ORG/ONLINE-MODULES

Who?
Recommended for:
Clinical Staff including providers, care coordinators, nursing staff, medical assistants, social workers, behavioral health consultants and pharmacists
Office Administrators responsible for overall practice function
Policymakers, Quality Improvement Professionals, Students and others wanting more information on Oregon’s Patient-Centered Primary Care Home (PCPCH) recognition program

What?
They cover:
The PCPCH model of care and how it drives health system changes that achieve the Triple Aim of health care reform
The foundational elements of primary care home practice transformation
The 6 Core Attributes of the PCPCH model and a detailed overview of each of the 33 standards for recognition

Why?
They are valuable as an:
Interactive, audio-visual companion to the PCPCH Technical Assistance Guide
Excellent orientation for clinics new to the PCPCH recognition program, or new clinical staff
Essential educational resource for clinics striving to improve patient care or advance their recognition status

*Information on CME and CE credit is available on our website: www.pcpci.org/online-modules

The Patient-Centered Primary Care Institute is a public-private partnership between the Oregon Health Authority (OHA) and the Oregon Health Care Quality Corporation (Q Corp).
The institute connects primary care practices to technical assistance providers and transformation resources and tools that help them achieve or advance their recognition as a primary care home.
Questions?
Resources

Patient-Centered Primary Care Home Program
www.PrimaryCareHome.oregon.gov
PCPCH@state.or.us

Patient-Centered Primary Care Institute
www.pcpci.org

Online Learning Modules
http://www.pcpci.org/online-modules

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