



Oregon
Health
Authority

PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM



The Oregon Health Authority
Patient-Centered Primary Care Home Program

2014 -2015 Annual Report

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Table of Contents

Executive Summary	1
Health Care Transformation in Oregon	5
PCPCH Model of Primary Care Delivery	7
PCPCH Model Development	7
PCPCH Core Attributes	8
PCPCH Eligibility	9
10 Must Pass Measures	9
Tier Structure	11
Point Values	12
PCPCH Program Functions	13
Practice Recognition	13
PCPCH Standards Refinement	13
Technical Assistance and Resource Development	14
PCPCH Program Technical Assistance	14
Patient-Centered Primary Care Institute	14
Communication and Provider Engagement	17
Aligning Payment with Quality	17
Verification of Standards and Measures	20
On-site Verification Visits	20
PCPCH Site Visit Team	20
PCPCH Characteristics	22
Size	22
Organization Structure	22
Geography	23
Clinic Type	24
Program Evaluation	25
Clinical Quality Measures	25
PCPCH Survey	26
Cost and Efficiency	28
PCPCH Model Implementation Study	31
Attribute Scoring Methodology	32
Site Visit Evaluation	33
Patient Reported Outcomes	34
Ongoing Program Evaluation	35
Looking Ahead	36
Goals for 2015	36
3 STAR Designation	36
PCPCH Program Implementation Challenges	37
Stories from the Field: PCPCH Profiles from across Oregon	39
Oregon Health & Sciences University Family Medicine at Richmond	39

Winding Waters Clinic	40
Randall Children’s Clinic - Emanuel	41
Harney District Hospital Family Care	42
Springfield Family Physicians	43
Appendices	45
Appendix A: PCPCH Program Timeline	45
Appendix B: List of PCPCH Standards and Measures	46
Appendix C: PCPCH Standards Advisory Committee Members	52
Appendix D: Most Common and Least Common Attested to Measures	54

Executive Summary

Patient-Centered Primary Care Homes are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. At the heart, this model of care promotes collaborative, whole person relationships between the primary care home, community and the patients and families served. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness, and managing chronic conditions.

Patient-Centered Primary Care Home Program Overview

The [Patient-Centered Primary Care Home](#) (PCPCH) Program was created by the Oregon Legislature through passage of House Bill 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon’s vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon’s version of the “medical home” which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

The PCPCH Program identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes. In 2010, the [Oregon Health Policy Board](#), which serves as the policy-making and oversight body for the [Oregon Health Authority](#) (OHA), set three goals for the PCPCH program:

1. all OHA covered lives will receive care through a PCPCH;
2. 75% of all Oregonians have access to a PCPCH by 2015; and
3. align primary care transformation efforts by spreading the model to payers outside of the OHA.

This report is a comprehensive description of the PCPCH Program in Oregon chronicling the PCPCH model development, program operations, PCPCH characteristics, program evaluation and future direction of the program.

PCPCH Model of Care

Following the passage of HB 2009, the PCPCH Program convened a Standards Advisory Committee (committee) of Oregon stakeholders including patients, clinicians, health plans and payers to assist the OHA in developing the PCPCH model of care. The committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs.

The six core attributes are as follows:

- **Accessible** – Care is available when patients need it.

- **Accountable** - Practices take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive** - Patients get the care, information and services they need to stay healthy.
- **Continuous** - Providers know their patients and work with them to improve their health over time.
- **Coordinated** - Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- **Patient and Family Centered** - Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. All PCPCHS must meet 10 "Must Pass" measures that reflect the most essential elements of the PCPCH model.

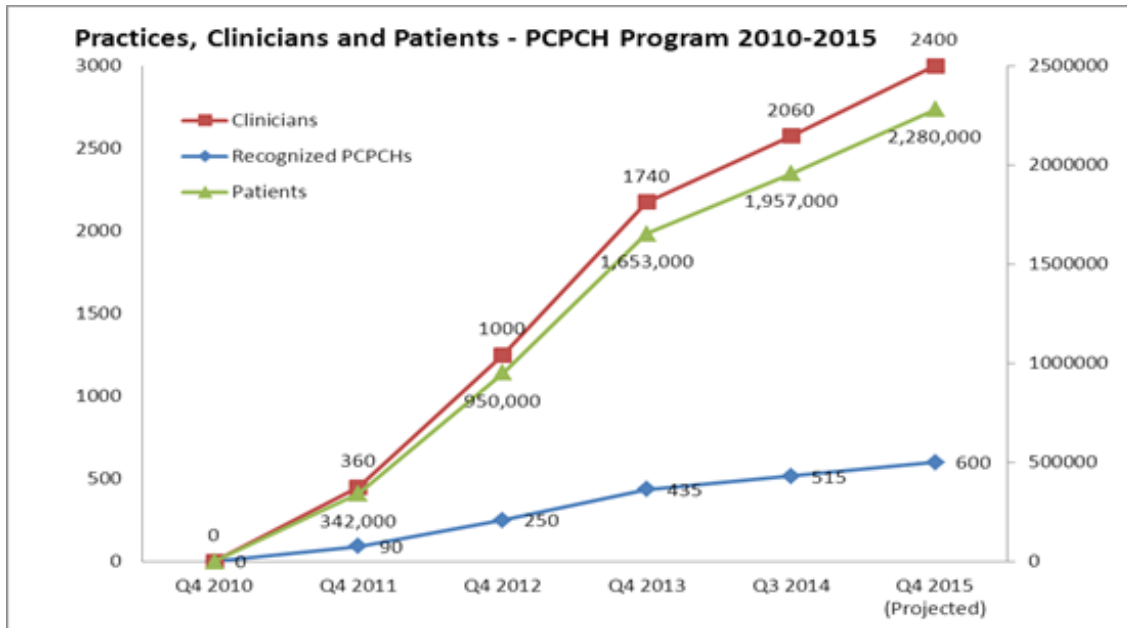
There are three levels, or tiers, of PCPCH recognition a clinic can achieve depending on what measures of the model they have attested to implementing. With the exception of the 10 "Must Pass" measures, each measure is assigned a point value. The total points accumulated by a clinic on their application determine their overall tier level of PCPCH recognition.

The committee reconvened in 2012 and 2013 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation. In 2015 the committee will convene again to develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.

PCPCH Program Achievements

Operations

- By the end of 2014, there were 538 recognized PCPCHs, representing over 50% of all eligible clinics in Oregon and serving approximately 2 million Oregonians, over half the state's population. More than 95% of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status. The following graph illustrates the current and projected growth of PCPCHs, providers, and patients in Oregon.



(**Based on estimation of a median of 4 clinicians and a median of 3,800 patients per PCPCH.)

- The percentage of [Coordinated Care Organization](#) (CCO) members (Medicaid) receiving health care from a recognized PCPCH has increased from 51.8% in 2012 to 80.4% in 2014. The increase in enrollment of CCO members in a PCPCH has been especially dramatic in Eastern Oregon where enrollment has increased from just 3.7% to 68.6%, over the same time period.¹
- In 2012 PCPCH Program staff began conducting on-site visits to verify the clinic practice and patient experience in the practice accurately reflects the measures a clinic attested to on their PCPCH application. By the end of 2014, a total of 75 visits had been completed in 23 out of 36 counties in Oregon.
- In 2013 OHA and the [Oregon Health Leadership Council](#) (OHLC) convened a series of meetings that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon. Representatives from participating organizations agreed to shared goals, objectives and key actions that support aligning payment with quality by signing a [Multi-payer Strategy to Support Primary Care Homes](#).

Program Evaluation

- Oregon implemented the PCPCH Program as part of the state’s strategy to achieve the Triple Aim of improving the individual experience of care, improving population health

¹ Oregon Health Authority. (2015). Oregon’s Health System Transformation: 2014 Mid-Year Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

management and decreasing the cost of care. A 2013 survey of PCPCH recognized clinics found that:

- 85% of practices feel that PCPCH model implementation is helping them improve the individual experience of care, and
 - 82% report progress towards improving population health management.²
- A recent study examined the change in health care service utilization and costs over time in PCPCHs compared to non-PCPCH clinics. The study found a significant increase in preventive procedures and a significant reduction in specialty office visit use and cost in the PCPCH group.³
 - 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.⁴

Technical Assistance

- Practice Enhancement Specialists and Clinical Transformation Consultants (providers) working with the program are available to help PCPCH clinic staff identify needs, barriers, and areas of improvement, as well as connect them with resources to assist in their primary care transformation journey.
- Through our partnership with [Oregon Health Care Quality Corporation](#), the [Patient-Centered Primary Care Institute](#) (PCPCI) is advancing practice transformation state-wide through technical assistance opportunities and resources. In 2014 PCPCI hosted 15 webinars for over 600 participants, and worked with 24 clinics in a series of Learning Collaboratives focused on primary care home model implementation.

² Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

³ Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

⁴ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

Health Care System Transformation in Oregon

For more than two decades the State of Oregon has been on the forefront of health system transformation, and a national leader in promoting and fostering innovation rather than relying on traditional approaches to address healthcare delivery system challenges. Oregon's broad transformation goals align with the Triple Aim of healthcare reform, as originally defined by the Institute for Healthcare Improvement (IHI)⁵: better health, better care and lower costs for all Oregonians.

The [Patient-Centered Primary Care Home \(PCPCH\) Program](#) was established by the Oregon Legislature through passage of [House Bill 2009](#) as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon's vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon's version of the "medical home" which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted as the basis for this transformation.

Key elements of the [Coordinated Care Model](#) include:

- [Best practices to manage and coordinate care](#)
- [Shared responsibility for health](#)
- [Performance is measured](#)
- [Paying for outcomes and health](#)
- [Transparency and clear information](#)
- [Maintain costs at a sustainable rate of growth](#)

The CCM has been implemented in Oregon through [Coordinated Care Organizations](#) (CCOs). CCOs are community-based organizations that include all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are responsible for the health outcomes of the population they serve, and emphasize primary care, disease prevention and helping people manage chronic conditions. This focus helps reduce unnecessary emergency room visits and gives Oregonians the support they need to be healthy. CCOs have the flexibility to institute their own payment and delivery reforms that achieve the best possible outcomes for their members.

⁵ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

As a component of this model, CCOs are required to use recognized PCPCHs for primary care delivery to the greatest extent possible in their networks. Approximately 80% of CCO members receive their primary care through a recognized PCPCH.⁶ The goal is that 100% of CCO members are enrolled in a Tier 3 PCPCH.⁷

Oregon is committed to spreading the CCM to a broader market by aligning coordinated care model principles across payers and implementing organization alignment around those principles. As a first step toward spreading the model, the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) have adopted many components of the CCM, including use of PCPCHs, within their health benefit plans. Further, the Oregon Health Authority (OHA), PEBB and OEBB created the [Coordinated Care Model Alignment Workgroup](#). The workgroup began convening in 2014 and is tasked with developing a timeline and work plan to spread the CCM, developing common contract terms for interested purchasers, developing a process for organizational alignment and shared learning among purchasers to foster broad implementation, and supporting system wide measure and metric alignment. This work will continue through 2016.

⁶ Oregon Health Authority. (2014). *Patient-centered primary care home enrollment*. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/measure-patient-centered.aspx>

⁷ Oregon Health Authority. (2014). *2015 CCO Incentive Measure Benchmarks*. Retrieved from <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

PCPCH Model of Primary Care Delivery

PCPCH Model Development

Following the passage of HB 2009, the OHA convened the PCPCH Standards Advisory Committee (committee), a diverse group of Oregon stakeholders including patients, clinicians, and health plans, to advise OHA on the PCPCH model of care.

The committee was tasked with the following:

- Define of core attributes of the PCPCH to promote a reasonable level of consistency of services provided by patient-centered primary care homes
- Develop a process to identify PCPCH's that meet the core attributes defined by OHA
- Define uniform quality measures for PCPCH's that build from nationally accepted measures and allow for standard measurement of PCPCH performance
- Define uniform quality measures for acute care hospital and ambulatory services that align with the PCPCH quality measures.
- Create policies that encourage the retention of and the growth in the numbers of, primary care providers.

Over the course of seven meetings between October 2009 and January 2010 the committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs. The six core attributes are Accessibility to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family Centered Care. Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. The committee reconvened in 2012 to discuss pediatric aspects of care, and in 2013 to refine the PCPCH model.

Recently behavioral and mental health care providers have expressed interest in adopting the PCPCH model of care delivery. In 2015 the committee will reconvene to discuss improving primary care and behavioral and mental health integration within the PCPCH model. Please refer to Appendix A for the PCPCH Program Timeline.

The PCPCH model framework is intended as a tool for the OHA, policymakers and other Oregon stakeholders to assess the degree to which primary care clinics are functioning as patient-centered primary care homes and promote widespread adoption of the model. A list of all PCPCH standards and measures is in Appendix B.

PCPCH Core Attributes

The PCPCH core attributes are articulated in patient-centered language to communicate the benefits of the model of care to the general public.

Core Attribute 1: Access to Care (Accessible)

Patient-Centered language: “Be there when we need you.”

Intent: Care is available when patients need it.

Core Attribute 2: Accountability (Accountable)

Patient-Centered language: “Take responsibility for making sure we receive the best possible health care.”

Intent: Practices take responsibility for the population and community they serve and provide quality, evidence-based care.

Core Attribute 3: Comprehensive Whole Person Care (Comprehensive)

Patient-Centered language: “Provide or help us get the health care, information, and services we need.”

Intent: Patients get the care, information and services they need to stay healthy.



Core Attribute 4: Continuous (Continuity)

Patient-Centered language: “Be our partner over time in caring for us.”

Intent: Providers know their patients and work with them to improve their health over time.

Core Attribute 5: Coordination and Integration (Coordinated)

Patient-Centered Language: “Help us navigate the health care system to get the care we need in a safe and timely way.”

Intent: Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.

Core Attribute #6: Person & Family Centered Care (Patient & Family Centered)

Patient-Centered Language: “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”

Intent: Individuals and families are the most important part of a patient’s health care. Care should draw on a patient’s strengths to set goals and communication should be culturally competent and understandable for all.

PCPCH Eligibility

Any health care practice that provides comprehensive primary care and meets the core attributes can become a recognized as a PCPCH. Recognized PCPCH clinics include physical health providers, behavioral, addictions and mental health care providers, solo practitioners, group practices, community mental health centers, tribal clinics, rural health clinics, federally qualified health centers, and school-based health centers.

10 Must Pass Measures

All practices must meet 10 “Must Pass” measures to be recognized as a PCPCH. These 10 measures reflect the most essential elements of the patient-centered primary care home model.

Access to Care: Telephone and Electronic Access

Explanation: PCPCH provides continuous access to clinical advice by telephone

Intent: Access to clinical advice outside of in-person office visits is an important primary care home function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that PCPCH patients, caregivers, and families can obtain clinical advice via telephone from a live person at all times.

Accountability: Performance and Clinical Quality

Explanation: PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.

Intent: Measuring and improving on clinical quality is a foundational element of primary care homes. The intent of this measure is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate.

Comprehensive Whole-Person Care: Medical Services

Explanation: 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.

Intent: Acute and chronic medical care for common problems is a core component of primary health care. The intent of this standard is to ensure that primary care homes are routinely providing access to both acute and chronic medical care for all of their patients.

Comprehensive Whole-Person Care: Mental Health, Substance Abuse, & Developmental Services

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

Intent: Assessment and appropriate intervention for mental health, substance use and developmental, behavioral or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, or developmental conditions is strongly associated with improved health outcomes in these populations. The intent of this standard is to ensure that primary care homes are routinely assessing their patients for these issues, and providing appropriate treatment, referral and care coordination for these conditions.

Continuity: Personal Clinician Assigned

Explanation: PCPCH reports the percentage of active patients assigned to a personal clinician or team.

Intent: Interpersonal continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes are able to monitor and measure whether patients are assigned to a personal clinician or health care team. Primary care homes should seek to promote patients' relationships with their personal clinician and health care team.

Continuity: Personal Clinician Continuity

Explanation: PCPCH reports the percent of patient visits with assigned clinician or team.

Intent: Continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes can measure and improve patients' continuity with an assigned personal clinician or health care team.

Continuity: Organization of Clinical Information

Explanation: 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.

Intent: Primary care homes must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as patients move throughout the health care system. Maintaining a health record with up-to-date information is an essential prerequisite to managing safe transitions of care between health care providers.

Continuity: Specialized Care Setting Transitions

Explanation: PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

Intent: Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. Primary care homes should take responsibility for facilitating appropriate transitions of care by developing working relationships with their usual providers of hospital care. PCPCHs that have clinicians providing their own hospital care do not need to have a written agreement in place.

Coordination and Integration: End of Life Planning

Explanation: PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

Intent: Arranging for culturally appropriate end-of-life and palliative care is an important aspect of care coordination for patients, caregivers, and families. This standard is intended to ensure that primary care homes engage their patients, caregivers, and families in end of life discussions, routinely assess patients need and eligibility for hospice or palliative care when appropriate, and refer patients for these services or coordinate services within the clinic.

Person and Family Centered Care: Language/Cultural Interpretation

Explanation: 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.

Intent: Cultural and linguistic proficiency is a core component of person and family-centered care. The intent of this measure is to ensure that primary care homes communicate with patients, caregivers, and families in their language of choice using trained medical interpreters.

Tier Structure

There are three levels, or tiers, of PCPCH recognition a clinic can achieve depending on what measures of the model they have attested to implementing. With the exception of the 10 "Must Pass" measures, each measure is assigned a point value. Must Pass and 5 point measures focus on foundational PCPCH elements that should be achievable by most clinics in Oregon with significant effort, but without significant financial outlay. Measures worth 10 or 15 points reflect intermediate and advanced functions. The total points accumulated by a clinic on their application determine their overall tier level of PCPCH recognition.

Tier 3

- 130+ points and all must pass standards
- 88% of PCPCHs are Tier 3

Tier 2

- 65-125 points and all must pass standards
- 11% of PCPCHs are Tier 2

Tier 1

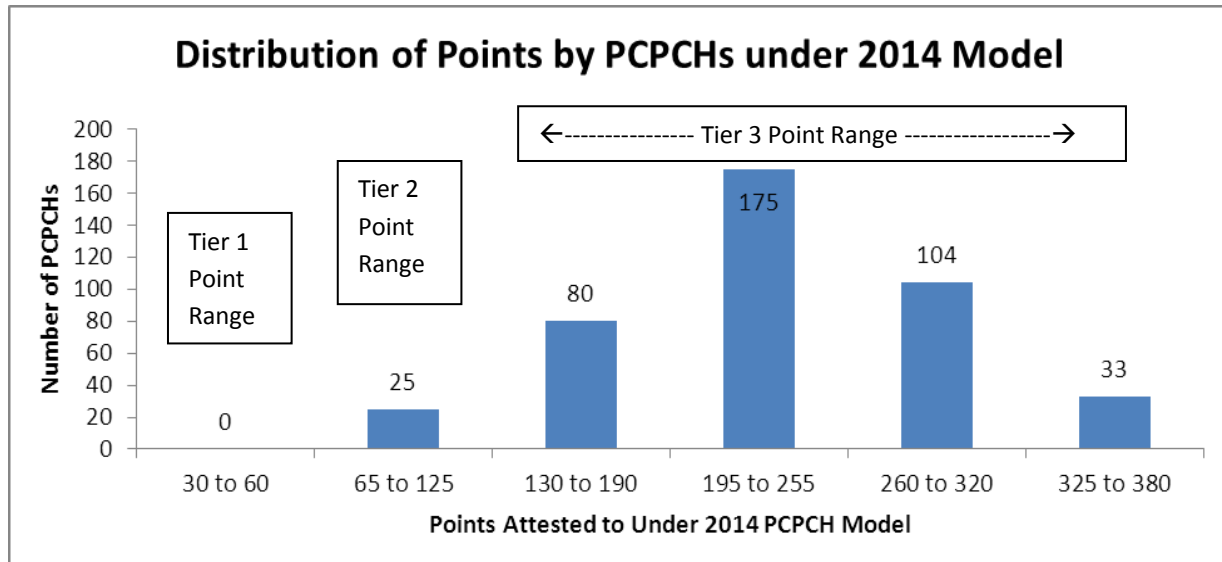
- 30-60 points and all must pass standards
- 1% of PCPCHs are Tier 1

In February 2015, the PCPCH Program launched the 3 STAR Designation for clinics that have implemented advanced PCPCH model measures. This designation was developed to recognize clinics that are on the forefront of transformation.

Within the PCPCH model clinics can implement measures that are tailored to best serve the needs of their patient population and their practice transformation goals. The most and least common measures PCPCHs have attested to implementing are listed in Appendix D.

Point Values

There is variation in the total points a clinic can accumulate in the PCPCH model. Practices must attest to a minimum 30 points to become recognized as Tier 1 PCPCH. Under the 2014 PCPCH model the lowest number of points attested to by a practice is 65, with a maximum number of 380 points possible. The figure below illustrates the distribution of points earned by practices under the 2014 PCPCH model.



PCPCH Program Functions

In 2010, the [Oregon Health Policy Board](#), which serves as the policy-making and oversight body for the OHA, set three goals for the PCPCH program: 1) all OHA covered lives will receive care through a PCPCH, 2) by 2015 75% of all Oregonians have access to a PCPCH, 3) and align primary care transformation efforts by spreading the model to payers outside of the OHA. The PCPCH Program functions support the achievement of these goals.

Practice Recognition

PCPCH recognition is a voluntary attestation process, and practices are charged no fees to participate. Prior to applying for recognition practices are encouraged to review [The Patient-Centered Primary Care Home 2014 Recognition Criteria Technical Assistance and Reporting Guide](#) which contains details about the program and specifications for the PCPCH standards. It is also recommended practices complete the [Self-Assessment Tool](#) to determine which standards their clinic can attest to before completing the online application.

Recognized practices must submit a renewal application every two years if they want to maintain their PCPCH recognition status. In addition, practices are permitted to reapply once every six months if they have implemented additional PCPCH measures that result in an increased tier level or overall total points score.

The PCPCH Program began accepting applications from practices in September 2011, and by 2012 there were 90 recognized PCPCHs in Oregon. To date, there nearly 550 recognized PCPCHs in Oregon. Please refer to Appendix A for the PCPCH Program Timeline.

For more information about the PCPCH recognition process, visit www.PrimaryCareHome.oregon.gov.

PCPCH Standards Refinement

The PCPCH Standards Advisory Committee (committee) provides the OHA with policy and technical expertise for the PCPCH model of care. The committee convenes periodically to review PCPCH implementation progress and to advise on refining the model to further guide primary care delivery transformation. The intention of this work is incrementally adapt the PCPCH model to the changing health care needs of Oregonians, align the model with the best evidence where it was available, and to improve the effectiveness of the standards and measures overall.

For more information about the committee, please see www.oregon.gov/oha/pcpch/Pages/committee.aspx. A list of past committee members can be found in Appendix C.

Technical Assistance and Resource Development

PCPCH Program Technical Assistance

The PCPCH Program provides technical assistance to providers and practice staff as they navigate primary care transformation around the primary care home model.

There are two Practice Enhancement Specialists (PES) on the PCPCH Program staff to provide guidance and general practice coaching to clinics implementing the PCPCH model. PCPCH Program staff are available to assist clinics with their attestation and provide guidance during the application process as well.

PCPCHs also receive support and assistance through the verification site visit process. The purpose of the site visit is to verify that the clinic practice and patient experience in the practice accurately reflects the standards and measures the clinic attested to on their PCPCH application. During and after a site visit, PCPCH Program PES help clinic staff identify needs, barriers, and areas of improvement, as well as connect them with resources to assist in their primary care transformation journey. Resources are tailored to a clinic's specific needs; some examples include practice management tools, printed materials, or connecting clinic staff with others who have successfully implemented the PCPCH model. For more information see the Verification of Standards and Measures section of this report.

Patient-Centered Primary Care Institute

In 2012 the Oregon Health Authority developed a public-private partnership with the [Oregon Health Care Quality Corporation](#) and the [Northwest Health Foundation](#) and founded the [Patient-Centered Primary Care Institute \(PCPCI\)](#). The Institute partners with technical assistance organizations and content experts to support PCPCHs in their transformation efforts.

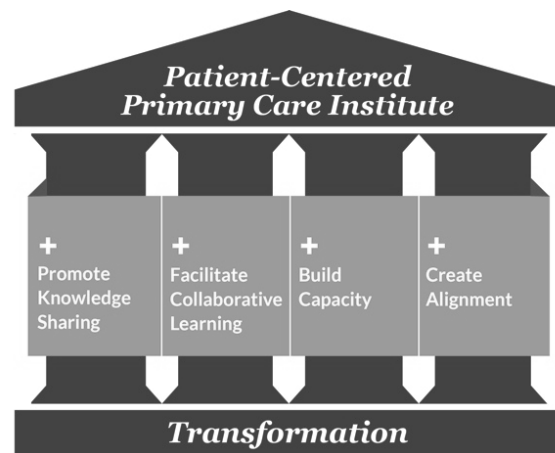


The mission of the PCPCI is built on four foundational pillars of practice change:

- 1. Promote Knowledge Sharing** through PCPCI's website that serves as a hub of information, announcements, news, and resources.
- 2. Facilitate Collaborative Learning** by partnering practices with technical assistance experts who lead face-to-face learning sessions, offer at-the-elbow coaching, and provide a space for practice participants to receive and offer peer-to-peer support. In the past two years, PCPCI has provided in-person training opportunities and practice coaching to more than 80 primary care practices in Oregon.

3. Build Capacity by offering avenues for transformation champions to collaborate, deploy resources collectively and improve the overall quality of the information and services available to primary care practices.

4. Create Alignment across efforts to improve primary care by identifying synergies, gaps, duplications and challenges, and connecting people to one another.



Patient-Centered Primary Care Institute Activities

Webinars

In 2014 the PCPCI hosted 15 webinars with nearly 600 attendees. Past webinar topics include:

- Engage, Collect, Partner: How to Use Patient Experience of Care Surveys in Your Practice
- Empanelment: What Do You Do After Every Patient Has an Assigned Care Team?
- Brief Intervention Skills for Primary Care Clinicians and Behavioral Health Consultants in the Primary Care Behavioral Health (PCBH) Model
- Coming Out of the Shadows: Addressing Substance Use in Primary Care
- National Health Service Corps and Other Programs - Tools to Support Providers and Expand Oregon's Health Care Workforce
- Patient-Centered Primary Care Home Program Overview
- PCPCH Site Visits: What to Expect
- Scrubbing and Huddling
- Strategies for Rural, Small Independent Practices
- Enhancing Adolescent Well-Visits
- Collaborating for Health: Motivational Interviewing in Primary Care
- Trauma-Informed Care in Primary Care Settings
- Clinician Wellness: Building Resiliency in the Primary Care Home Team

Learning Collaborative

Currently, 24 practices are participating in a series of Learning collaboratives, each one facilitated by technical assistance (TA) partners across the state. The practices are receiving in-person training, technical assistance and practice coaching to support adoption of the PCPCH model.

Each Collaborative TA partner works with six practices around foundational elements of practice transformation, such as quality improvement, and integrates these elements around a specific aspect of the primary care medical home:

- **Improving Patient Experience of Care (2 learning sessions)** includes the implementation of a patient experience of care survey, patient engagement methods, and design of quality improvement projects in a way that addresses multiple PCPCH standards. This Collaborative includes fielding of the Clinician and Group CAHPS PCMH survey.
- **Improving Access through PCPCH** focuses on understanding a practice's supply and demand and how to move to an "open access" scheduling model. This Collaborative is tailored to support the practices particular access needs around absorbing many new patients, creating more same-day capacity, reducing backlog, and utilizing all team members in non-face-to-face visits. This Collaborative also provides an opportunity for practices to designate a "practice coach in training," which can be ideal for multi-site practices interested in sharing learnings across sites.
- **The Patient-Centered Communication Skills, Behaviors and Attitudes** collaborative has worked on embedding the spirit of patient-centered communication in a practice's organizational culture, identifying ways to measure patient-centeredness, mastery of basic patient-centered office skills, cultural agility, health literacy and self-management support.

Past Learning Collaborative goals include:

- Increasing screenings and vaccination rates among targeted populations;
- Enhancing care for patients with certain conditions, including building registries, proactively managing patients and activating reminders for patients who are due for check-ups;
- Improving patient access to care by offering same day appointments, and decreasing deferred acute care and emergency visits;
- Decreasing nurse triage time to increase nurse availability to provide proactive care management;
- Ensuring that 75% of patients discharged from the hospital have a care coordination phone call, medication reconciliation, and allergy reconciliation; ensure those patients are offered an appointment with their physician in seven days; and
- Receiving real-time reports and discharge summaries from local hospitals when clinic patients go to the emergency department or are admitted.

Practice Facilitation

Along with the current Learning Collaboratives, 15 practices that participated in the 2013 Learning Collaborative are continuing to collaborate with the PCPCI and utilize practice facilitation support from technical assistance (TA) partners across the state around planning and implementing PCPCH and quality improvement (QI) related efforts. The practices receive coaching and support through email, phone and in-person visits from an assigned practice coach. These practices have agreed to set at least two quality or process improvement goals and report progress towards these goals.

Communication and Provider Engagement

The PCPCH Program supports and engages health care providers and staff during their practice's primary care transformation through various communication methods. PCPCH Program staff answer questions, provide guidance, and communicate regularly with providers and other stakeholders through email at PCPCH@state.or.us and by telephone. In 2014 the program launched a monthly email newsletter featuring updates, links to relevant national and state research, technical assistance resources, and other useful information for health care providers and their staff. The newsletter is distributed to over 2,500 subscribers to the [PCPCH Program listserv](#). Any individual interested in primary care transformation in Oregon can subscribe to the newsletter.

The PCPCH Program website www.PrimaryCareHome.Oregon.gov was revised with expanded content on the site visit verification process, technical assistance, evaluation reports, and profiles of recognized PCPCHs. The website serves as a primary source of information for stakeholders and includes tailored content for patients, providers, policy makers, health plans, and the general public. In addition, a PCPCH Facebook page was created for those interested in engaging through social media.

In 2014 PCPCH Program staff began conducting outreach to the more than 400 practices in Oregon that are not currently recognized as a PCPCH. Seventy-six practices were recognized as PCPCH for the first time, and more than 30 practices whose PCPCH recognition had lapsed became re-recognized during the past year.

Aligning Payment with Quality

The OHA is working with public and commercial payers across Oregon to pursue innovative payment methods that move us toward a health care system that rewards quality, patient-centered care. This work supports the PCPCH Program goal of spreading the PCPCH model to payers outside of the OHA.

Multi-payer Strategy to Support Primary Care Homes

From July to September 2013 OHA and the [Oregon Health Leadership Council](#) (OHLC) convened a series of meetings that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon. Representatives from participating organizations agreed to shared goals, objectives and key actions that support aligning payment with quality by signing a [Multi-payer Strategy to Support Primary Care Homes](#). Key joint actions agreed to in this strategy include:

- All Oregon payers will use a common definition of primary care home based on OHA's PCPCH Program;

- Payers will provide variable payments, or other payment models, to those primary care practices in their network participating in OHA's PCPCH Program, based on each practice's PCPCH points total and their progress toward achieving outcomes which lead to the Triple Aim. The structure, qualifications, and amount of these payments will be the responsibility of each payer to determine or negotiate with practices in their network; and
- OHA's PCPCH Program will build in practice accountability for progress toward transformation. They will work with payers and practices to identify and agree on a common set of meaningful outcome metrics, consistent with those already in place for Oregon providers, as well as reporting formats and administrative processes that simplify the administrative burden on practices.

Public Employees' Benefit Board

The [Public Employee's Benefit Board](#) (PEBB) provides an age-adjusted, per-member-per-month incentive payments to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan administered by [Providence Health & Services](#). In addition, PEBB members in the PEBB Statewide plan have lower cost share for primary care services when they access care through a recognized primary care home—from 10 to 15 percent. The Providence Choice Plan within PEBB also emphasizes use of this model through requiring members to seek care through primary care homes.

Coordinated Care Organizations

Several Coordinated Care Organizations (CCOs) offer incentive payments for recognized PCPCHs. Incentive payment amounts and structure vary by CCO. Two examples include [Eastern Oregon Coordinated Care Organization](#) (EOCCO) and [Willamette Valley Community Health](#) (WVCH). EOCCO provides recognized PCPCHs a per-member-per-month (PMPM) payment based on Tier level. EOCCO also encourages continued transformation by offering incentive payments to clinics that implement improvements that enable them to move up to the next tier level in the PCPCH model. WVCH provides incentives payments for PCPCH recognition to over 85% of the primary care practices in their network. Visit the OHA [Transformation Center](#) for more information about CCOs.

Aetna

Aetna's Patient Centered Medical Home (PCMH) recognition program offers per-member-per-month payment incentives using the PCPCH tiers, and is available to physician practices in Oregon that meet certain criteria: Directly contracted with Aetna; Received recognition by the NCQA or by the State of Oregon Patient-Centered Primary Care Home program as a PCPCH; Have 10 or more attributed Aetna members; and be reimbursed at 100% of the Aetna Market Fee Schedule (AMFS).

Comprehensive Primary Care Initiative

Oregon is one of seven markets selected to participate in a four year, multi-payer federal initiative to strengthen primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers. Nearly 70 Oregon primary care practices were selected to participate and each is required to be recognized as a PCPCH and to achieve certain Centers for Medicare and Medicaid Services (CMS) milestones over the four years. Enhanced payments to the selected practices began in November 2012 from CMS and five Oregon payers including Regence Blue Cross, Providence Health Plan, CareOregon, Tuality and the OHA (Medicaid FFS).

Verification of Standards and Measures

On-Site Verification Visits

PCPCH recognition is based on a self-attestation model with a relatively low administrative burden for clinics. This approach has likely contributed to robust participation in the program; greater than 50% of primary care clinics in Oregon are recognized as a PCPCH.

The fidelity of a self-attestation model relies on a strong verification procedure. Therefore, PCPCH Program staff conduct on-site visits to recognized primary care homes across the state. The purpose of the on-site verification visit is threefold:

1. **Verification** that the clinic practice and patient experience accurately reflects the standards and measures attested to when the clinic was recognized as a PCPCH;
2. **Assessment** of the care delivery and team transformation process in the clinic to understand how the intent of the patient-centered model of care is integrated into the services the primary care home provides; and
3. **Collaboration** to identify clinic needs, barriers to implementation and areas of improvement needed to help practices successfully implement PCPCH standards. The site visit team helps practices establish improvement plans, and connects practices with technical assistance through resources including the Patient-Centered Primary Care Institute.

The PCPCH Program staff began conducting site visits in 2012. By the end of 2014, 75 on-site verification visits had been completed in 23 of out 36 counties in Oregon. Approximately 15% of recognized PCPCHs have had a site visit at their clinic.

PCPCH Site Visit Team

There are two PCPCH site visit teams conducting on-site verification visits at clinics across the state. Each team is comprised of a Compliance Specialist, a Practice Enhancement Specialist, and a Clinical Transformation Consultant. Team members have extensive experience in practice transformation and implementation of primary care home standards.

Compliance Specialist

The Compliance Specialist (CS) is the primary contact for the clinic before the site visit, and assists the clinics with scheduling and preparing for the site visit. The role of the CS is to review documentation to verify the clinic is meeting the standards attested to in its PCPCH application. During the site visit the CS interviews front office staff, quality improvement teams and clinic leadership. The CS also conducts a chart review with a clinician or other clinic staff member.

Practice Enhancement Specialist

The role of the Practice Enhancement Specialists (PES) is to observe and verify the functionality of attested to PCPCH standards during the site visit, and provide technical assistance to the clinic. The PES disseminates tools and strategies for clinical transformation to the PCPCH and serves as a practice coach for up to six months following the site visit.

Clinical Transformation Consultant

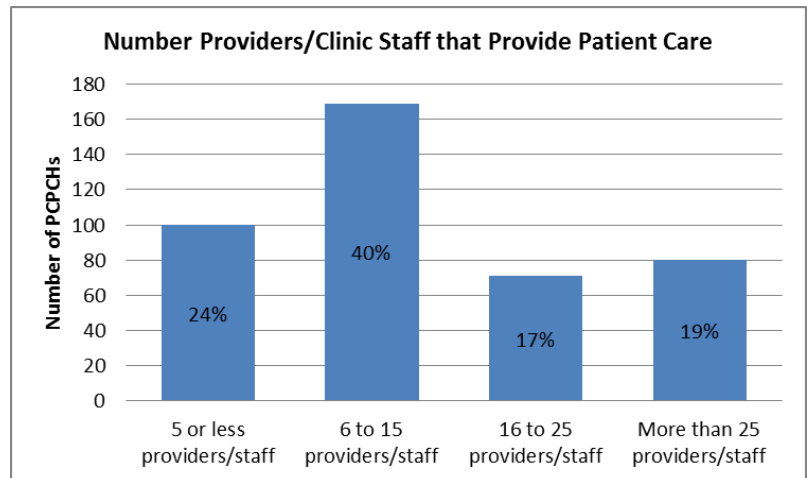
The Clinical Transformation Consultant (CTC) is a provider with extensive experience in practice transformation and the primary care home model. The CTC provides a clinical and quality improvement based perspective on PCPCH transformation. Having a CTC participate in the on-site verification visit provides clinicians the opportunity to learn from a peer how to overcome barriers and foster progress in transforming their practices. The CTC is available to assist the clinic for up to six months following the site visit.

PCPCH Characteristics

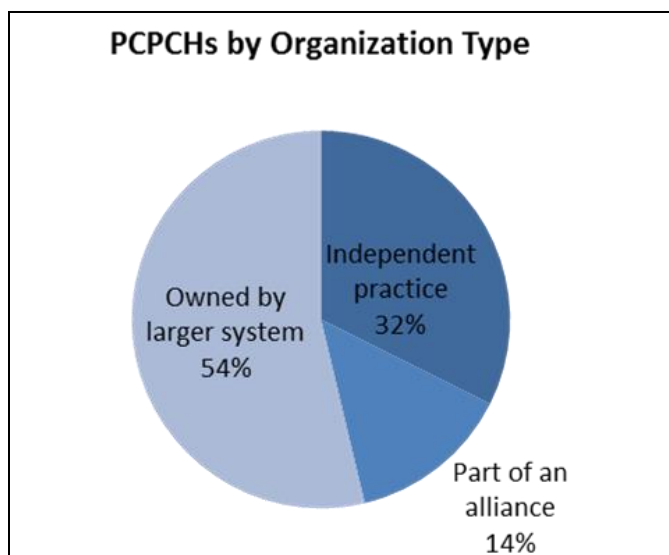
By the end of 2014, 538 practices were recognized PCPCHs across the state. Approximately 15% of PCPCHs became recognized by OHA for the first time in 2014. PCPCHs are diverse and vary by size, organizational structure, geography, and clinic type.

Size

Recognized PCPCHs range in size from practices with only one provider to practices with over 200 providers and clinical staff. The average number of providers and clinical staff in a PCPCH is 19, and 24% of PCPCHs have 5 or less providers or staff that provides direct patient care.⁸



Organizational Structure



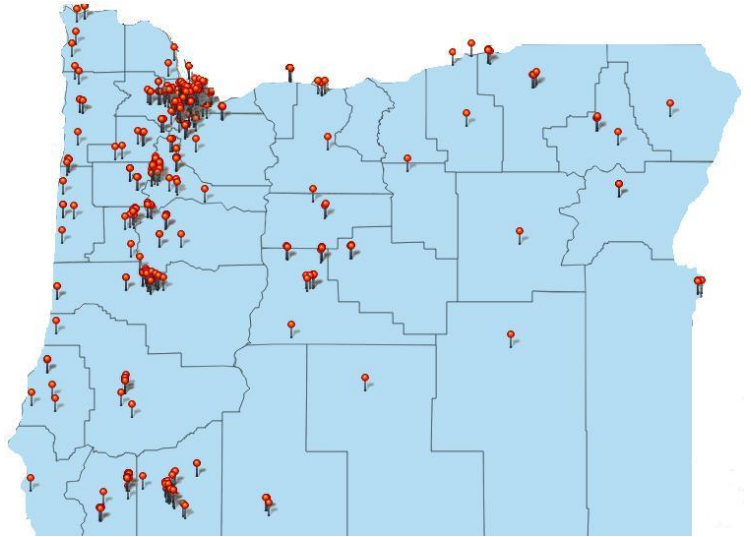
Approximately one-third of PCPCHs identify as being independent and unaffiliated with any other practice or larger organization and more than half identify as being owned by a larger system that governs the practice. 14% identify as having independent governance but are part of an alliance such as an Independent Practice Association (IPA) for shared group purchasing or other economies of scale.⁹

Geography

⁸ PCPCH application data self-reported by practices

⁹ PCPCH application data self-reported by practices

Currently PCPCHs are located in 34 of Oregon's 36 counties; the goal is to have PCPCHs in all counties by the end of 2015. The spread of PCPCHs across the state has had significant impact on primary care delivery. The percentage of CCO members receiving health care from a recognized PCPCH has increased from 51.8% in 2012 to 80.4% in 2014. The increase in enrollment has been especially dramatic in Eastern Oregon where it increased from just 3.7% of CCO members enrolled in a PCPCH to 68.6% of CCO members enrolled in a PCPCH.¹⁰



The geographic distribution of PCPCHs is as follows:

- **35% Rural PCPCHs:** Communities 10 miles from a population center of a population of at least 40,000 people
- **26% Urban Small PCPCHs:** Urbanized areas with population between 40,000-100,000 people
- **18% Urban Medium PCPCHs:** Urbanized areas with population between 100,000-200,000 people
- **21% Urban Large PCPCHs:** Urbanized areas with population greater than 200,000 people¹¹

¹⁰ Oregon Health Authority. (2015). Oregon's Health System Transformation: 2014 Mid-Year Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

¹¹ Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

Clinic Type

The PCPCH Program recognizes a variety of clinic types including family medicine, pediatric-focused, internal medicine, Community Health Centers (CHC), Federally Qualified Health Centers (FQHC), School-Based Health Centers (SBHC) and clinics focused on naturopathic care. The table below lists PCPCHs by clinic type.¹²

PCPCHs by Clinic Type	# of PCPCHs	% of PCPCHs
Family Medicine	284	68%
Pediatric and/or Adolescent Clinic	108	26%
Internal Medicine	105	25%
Federally Qualified Health Center	67	16%
Women's Health Clinic	44	11%
Community Health Center	43	10%
Rural Health Center (designated)	28	7%
Behavioral/Mental Health Clinic with integrated primary care	30	7%
School Based Health Center	21	5%
Residency Training Clinic	21	5%
Solo Private Practice	17	4%
Other	12	3%
Native American or Indian Health Clinic	4	1%
Naturopathic Clinic	3	1%
Military or Veteran's Administration Clinic	0	0%
Note: Will not total 100% because clinics can select more than 1 clinic type		

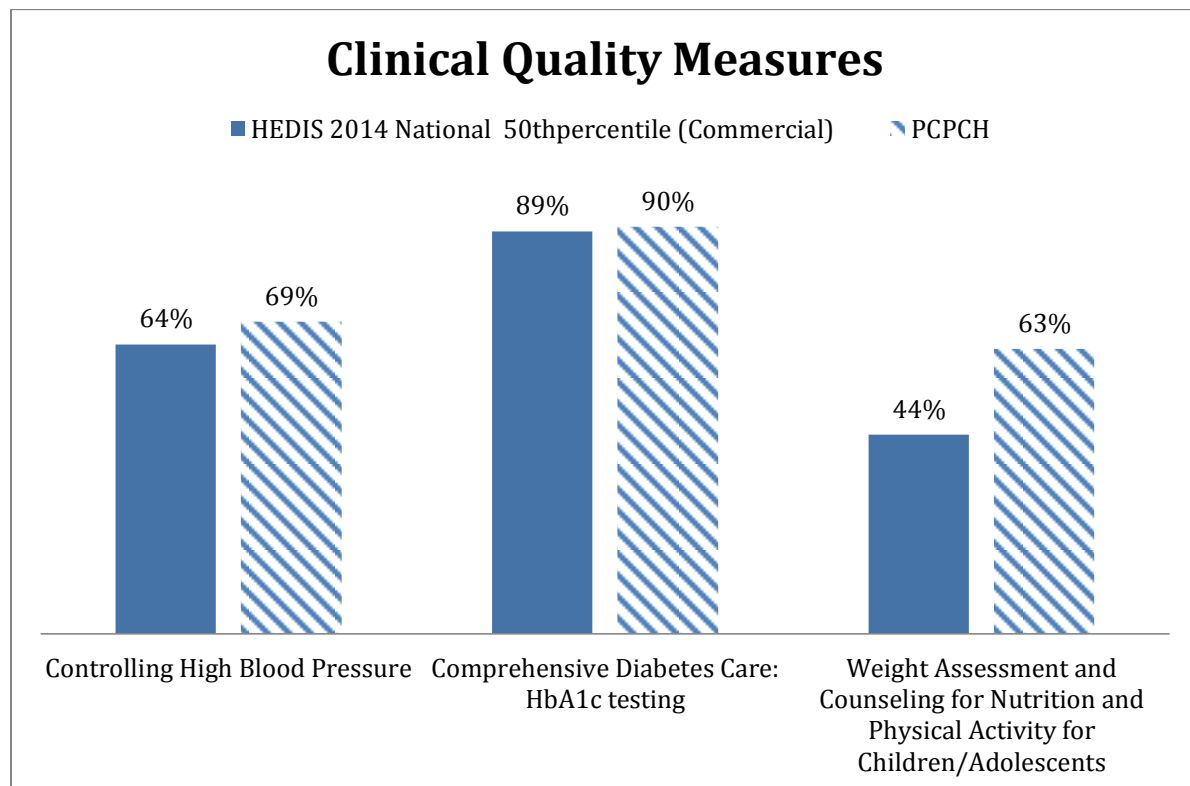
¹² PCPCH application data self-reported by practices

Program Evaluation

The PCPCH Program conducts evaluations to assess the effectiveness of the program. A variety of program components have been evaluated to provide a comprehensive analysis. Both PCPCH Program staff and contracted health services researchers have completed evaluations. Results are used to identify areas of development and improvement of the program's implementation of the PCPCH model.

Clinical Quality Measures

A measure in the PCPCH model requires practices to track at least one quality metric from a menu of PCPCH quality metrics listed in the [2014 PCPCH Recognition Criteria Technical Specifications and Reporting Guide](#) (TA Guide). Practices implementing more advanced measures of the PCPCH model report their clinic's performance on a tracked quality metric to the PCPCH Program and meet benchmarks set for that metric. The self-reported PCPCH performance on select tracked quality metrics is shown below. Compared to national [HEDIS](#) thresholds, PCPCHs performed better on average on several clinical quality measures.



The PCPCH data are self-reported on the PCPCH recognition application for Standard 2.A – Performance and Clinical Quality. Region 10 includes Alaska, Oregon, Idaho and Washington.

In 2013 the Oregon Health Care Quality Corporation (Q-Corp) published the Statewide Report on Healthcare Quality.¹³ This report found recognized PCPCHs achieved significantly higher scores than non-recognized clinics on several measures of care. The measures are listed in the table below.

Measure	Mean PCPCH Clinic Score (n)	Mean Non-PCPCH Clinic Score (n)	Percent Difference	p-value
Chlamydia Screening	42.9% (175)	38.7% (130)	+10.9	0.011
Diabetes Eye Exam	62.4% (210)	59.9% (199)	+4.2	0.030
Diabetes Kidney Disease Monitoring	80.4% (210)	76.5 (199)	+5.1	<0.001
Appropriate Use of Antibiotics for Children with Sore Throats	83.4% (58)	75.0% (47)	+11.2	0.030
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.3% (148)	55.3% (152)	+14.5%	<0.001

Oregon Health Care Quality Corporation. (2013). *Information for a Healthy Oregon: Statewide Report on Health Care Quality*.

PCPCH Survey

The PCPCH Program contracted with [Portland State University](#) to conduct a survey of staff and providers at PCPCHs.¹⁴ The online survey was distributed in August 2012 to the 205 PCPCHs and to an additional 368 PCPCHs in May 2013. The surveys collected information to supplement what clinics reported on their PCPCH application. Respondents were asked about practice size, geographic distribution, populations served, services provided, and organizational structure. The survey also asked questions based on the six core attributes of the PCPCH model as principles of the Triple Aim. Data collected from the survey were self-reported. In 2014 the

¹³ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://q-corp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

¹⁴ Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

PCPCH application system was revised to include questions about clinic characteristics for future data analysis.

Survey Findings by Core Attribute

- **Access to Care** – Nearly all practices administer a patient satisfaction survey (94%) but less than two-thirds share the results with their staff, patients or governing board. The majority of practices track access measures such as the third next available appointment and percent of no-show appointments. Almost all practices offer same-day appointments and allocate certain number of appointment slots per day for same-day appointments for patients.
- **Accountability** – 90% of practices have a quality improvement team. Of those practices, 96% use clinical quality data to systematically improve their practice and provide feedback to providers about clinical quality measures. Less than 15% of practices reported sharing their performance data with patients.
- **Comprehensive Whole Person Care** – Approximately two-thirds of practices report that primary care and behavioral health providers generally work together within their practice.
- **Continuity** – Over half of practices are notified when one of their patients is admitted or discharged from their usual hospital providers. Smaller practices reported they were less likely to be notified when their patients were admitted to or discharged from the hospital.
- **Coordination and Integration** – Nearly all practices use an Electronic Health Record (EHR) and have a system in place to track certain diagnoses, risk factors, and conditions that are clinically important to their patient population.
- **Person and Family Centered Care** – A majority of practices offer formal training programs to staff to improve their skills in cultural competence and patient communication.

Additional Findings

- **Achieving the Triple Aim**
 - 85% of practices report that PCPCH implementation is helping them to achieve the aim of improving the individual experience of care.
 - 82% report progress towards improving population health management.
 - Less than half reported that the implementation of the model helped them decrease the cost of care.
- **Additional Services**
 - Over 80% of practices reported adding at least one service during implementation of the PCPCH model. For example, services such as adding a care management team, sending reminders for preventive services, or implementing a process for tracking patients admitted or discharged from hospital.
- **Influencing the Decision to Become a PCPCH**

- The two most important factors for practices in influencing their decision to become a PCPCH were the opportunity to improve patient care and eligibility for enhanced payment.
- Improved marketability and encouragement from Coordinated Care Organizations (CCOs) or other payers were not identified as key factors to this decision.
- **Barriers**
 - Cost and lack of resources were the most commonly identified barriers to PCPCH implementation. Other barriers reported by respondents included:
 - Staffing and training
 - Limited time
 - Administrative burden and reporting requirements
- **Technical Assistance**
 - 49% of respondents in the first survey and 32% of respondents in the second survey indicated that they currently participate in some formal education, training or technical assistance focused on building knowledge and skills related to implementing the PCPCH standards.
 - More than 50% of providers surveyed identified a need for additional training on the following topics:
 - Patient and family engagement and communication
 - Behavioral health integration
 - Complex care management
 - Comprehensive care planning
 - Care coordination

Cost and Efficiency

There is an increasing amount of evidence supporting the benefits of patient-centered medical homes including better patient experience,¹⁵ prevention and disease management,¹⁶ lower costs from reduced emergency department visits and hospital admissions and decreased provider burnout.¹⁷

Building on this evidence, [Portland State University](#) conducted research for the PCPCH Program that evaluated cost and efficiency.¹⁸ The evaluation assessed the effects of PCPCH designation on the service utilization patterns and expenditures among early adopters of the PCPCH model in Oregon.

¹⁵ Kern LM et al. (2013). Patient experience over time in patient-centered medical homes. *American Journal of Managed Care*, 19,5. P. 403-10.

¹⁶ Ferrante, JM, et al. (2010). Principles of the Patient-Centered Medical Home and Preventive Services Delivery. *Annals of Family Medicine*, 8,2. p.108–116.

¹⁷ Reid, RJ, et al. (2010). The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. *Health Affairs*, 29. p. 5835-843

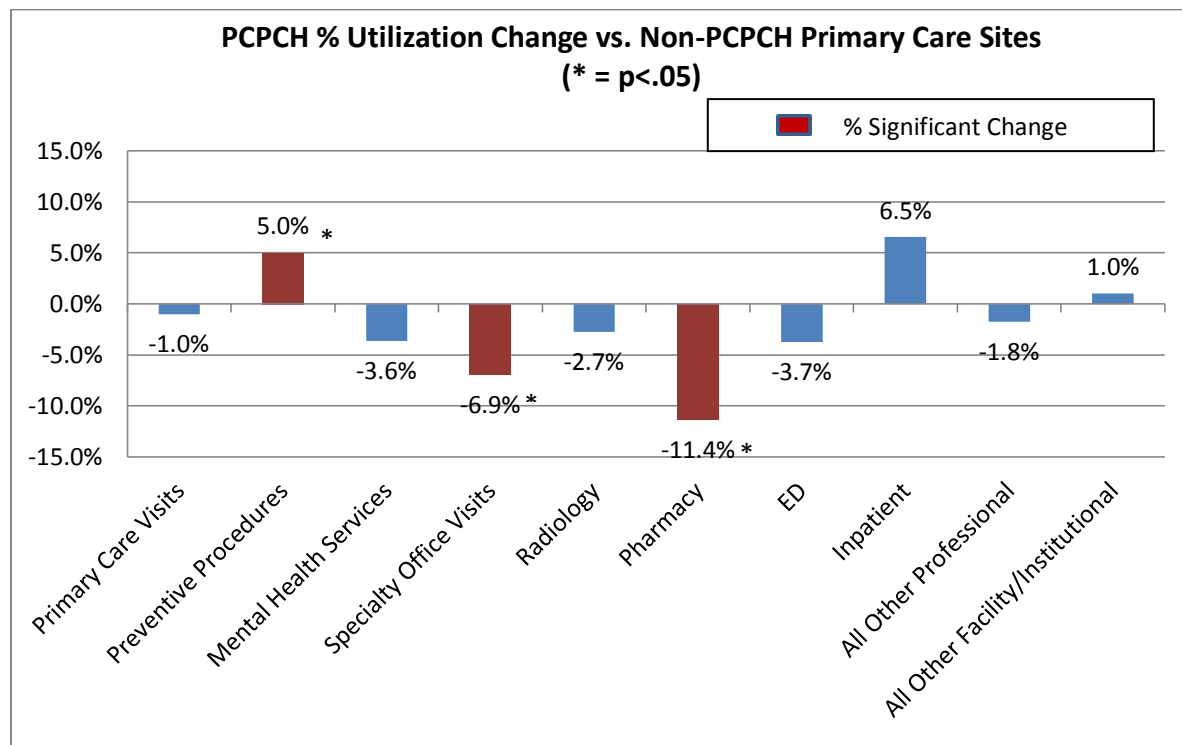
¹⁸ Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

The intent of this evaluation was to identify whether service use patterns and expenditures changed for patients served in PCPCHs compared to non-PCPCH practices. Using [Oregon's All-Payers-All Claims](#) (APAC) database, researchers calculated change in utilization and expenditures among patients receiving primary care at the clinic level during two time periods: October 2010 through September 2011 (pre-PCPCH recognition) and January 2012 through December 2012 (post-PCPCH recognition). These changes in PCPCHs were compared to changes in non-PCPCHs in the same time period. The difference in these pre-post changes is the estimated net effect of PCPCH designation on patient utilization and expenditure.

The findings indicate that preventive care procedures increased and specialty care visits decreased in PCPCH practices compared to non-PCPCH practices. These findings are consistent with the expectations of the PCPCH model that PCPCHs should emphasize primary care utilization over specialty care when appropriate.

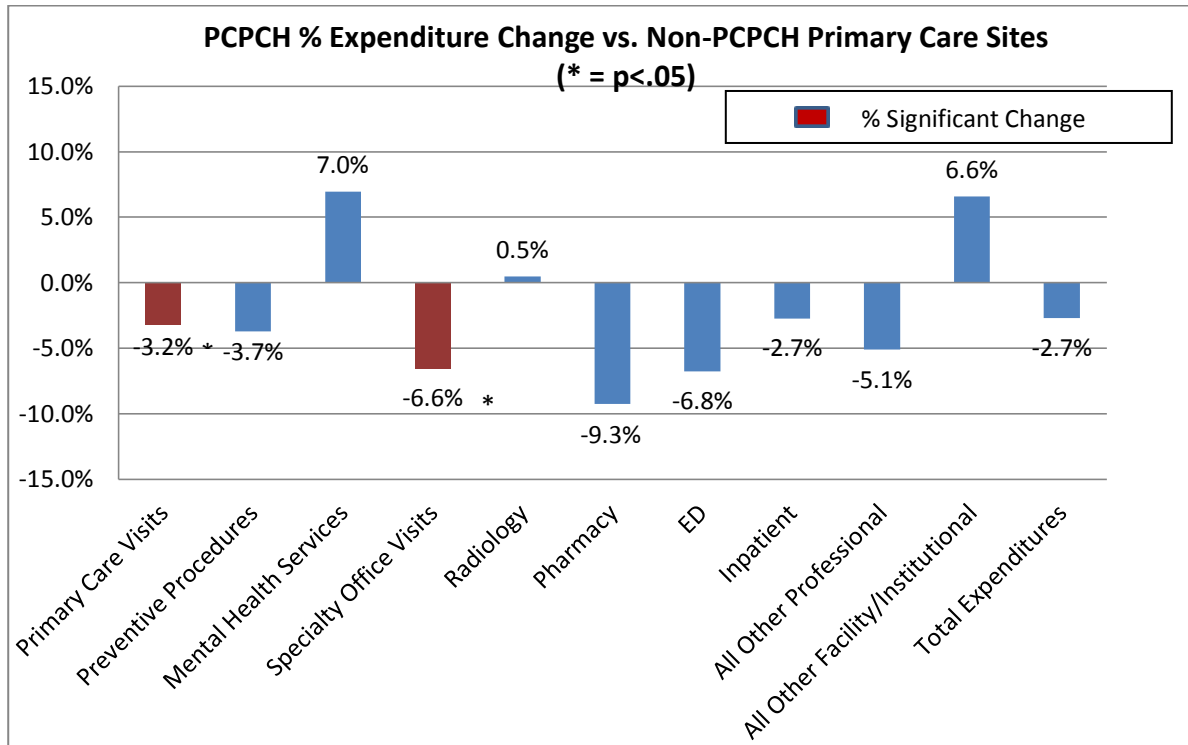
Utilization

In the first year following PCPCH recognition, PCPCHs had a statistically significant net increase in preventive procedures (5% increase) and statistically significant net reductions in specialty visits (6.9% decrease) compared to non-PCPCH practices. Pharmacy claims significantly decreased by 11.4% in PCPCH practices relative to non-PCPCH practices.



Expenditures

After the first year of being recognized as a PCPCH, primary care visit expenditures decreased significantly by 3.2% compared to non-PCPCH practices. Specialty office visit expenditures decreased significantly by 6.6% compared to non-PCPCH practices. Other important outcomes, such as reduced ED and inpatient use or reduced overall expenditures, while generally trending in the expected direction were not statistically significant. It is important to note that these are promising findings given the short time frame.



PCPCH Model Implementation Study

In May and June of 2013, researchers at Portland State University conducted 23 in-depth interviews with key stakeholders. The goal was to determine the factors that facilitated or impeded the development and implementation of the PCPCH model. After the interviews, members of the research team reviewed the responses to identify key themes among the participants interviewed.¹⁹

Summary of Key Findings: PCPCH Model Implementation Study

1. Support for the program among policymakers and health system leaders was influenced by exposure to a successful Patient-Centered Medical Home (PCMH) program in a neighboring state, while health service providers' support was based largely on perception of the model as the "right thing to do." Both groups expressed belief in the benefits attributed primary care home model.
2. The PCPCH Program has received broad support, but its complexity and uncertainty regarding future modifications may present challenges to maintaining commitment to the shared vision of the PCPCH model and ongoing support for the Program.
3. Implementation of CCOs and other health system transformation efforts were seen as being integrally related to, and supportive of, the PCPCH model. However, in some respects they were also viewed as competition for resources and attention, suggesting the need for greater alignment of PCPCH with other transformation initiatives.
4. Strong leadership within OHA and the commitment of Program staff were complemented by external leadership among key community-based organizations.
5. Many individuals noted positive experiences serving on committees, task forces, and work groups, and several respondents indicated that including more participants would provide additional perspectives that could be useful for future Program improvements.
6. Communication with community stakeholders was critical to the successful development and implementation of the PCPCH Program, and will be equally important for its sustainability.
7. The range of concerns expressed by interviewees suggests the need for ongoing strategic planning to ensure the sustainability of the PCPCH Program and model of care.

¹⁹ Rissi, J.J. & Baker, R. (2014). Report on the Results of the 2012-2013 Qualitative Patient-Centered Primary Care Home Evaluation. Portland State University. Submitted to the Oregon Health Authority.

Findings from these interviews have influenced PCPCH Program operations. For example, staff are developing a strategic plan to improve communication of program goals to stakeholders. Aligning the PCPCH model with other areas of health transformation in the state such as the expansion of the Coordinated Care Model and Behavioral Health Integration is also a key area of focus for the program.

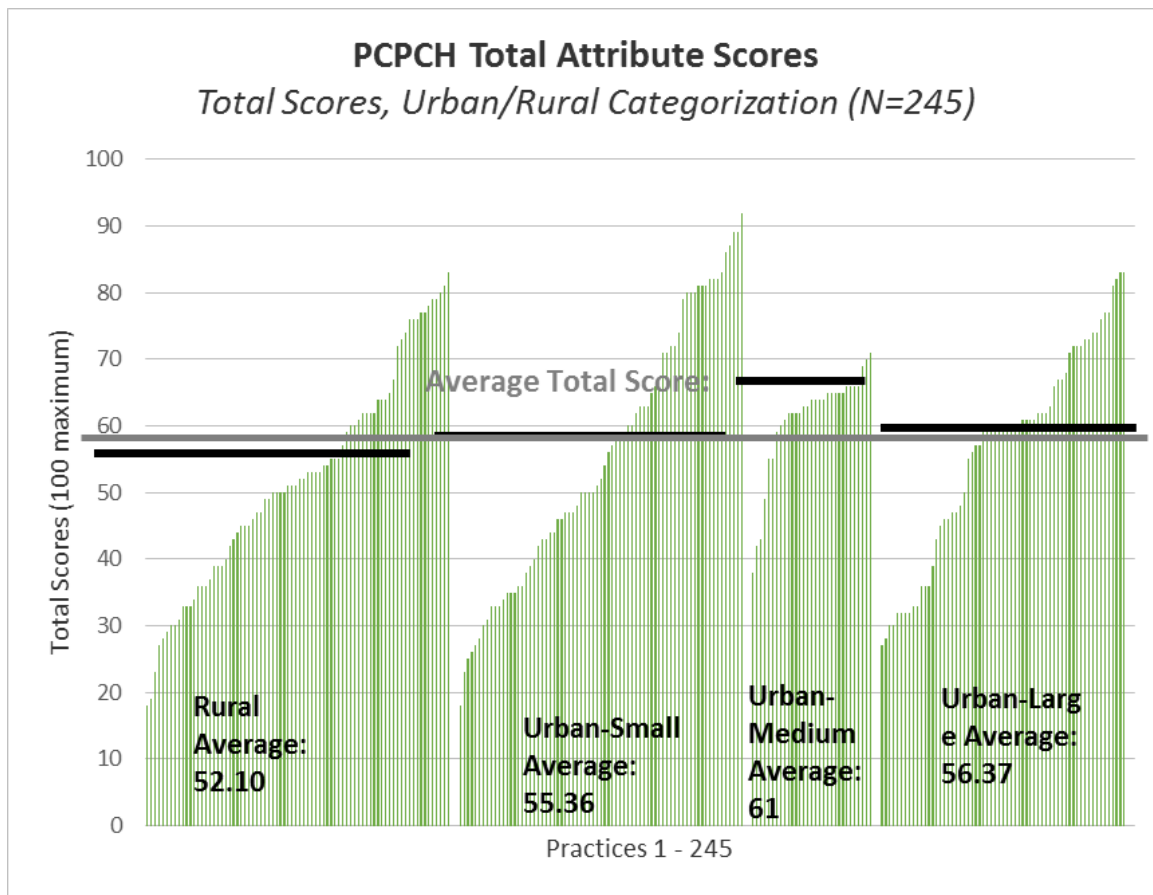
Attribute Scoring Methodology

In order to synthesize data collected from the PCPCH application and the supplemental survey sent to all recognized practices, researchers at Portland State University developed an attribute scoring methodology.²⁰ Using this method each practice was assigned a single score (1 to 100) comprised of their responses on the application and supplemental survey. This score allows the program to more easily compare recognized PCPCH practices using all available data.

Summary of Key Findings: Attribute Scoring Methodology

1. The average total attribute score across all recognized practices was 55.29 out of 100.
2. The data indicate that geographic location of the practice (rural, urban small, urban medium, urban large) was not a substantial factor in the average attribute score of a practice.
3. The data indicate that the organizational structure of the practice (whether the practice was independent, part of an alliance or owned by a larger system) was not a substantial factor in the average attribute score of a practice.
4. Performance on Attribute 2 (Accountability) of the PCPCH model was consistently low across all categories compared to the other 5 attributes of the model.

²⁰ Gelmon, S. B. Sandburg, B., & Bally, R. (2014). Implementation of Oregon's PCPCH Program: Results of Attribute Scoring. Portland State University. Submitted to the Oregon Health Authority.



Site Visit Report Evaluation

In the fall of 2014, the PCPCH Program contracted with the [Providence Health & Services Center for Outcomes Research and Education](#) (CORE) to analyze qualitative reports completed during the PCPCH site visit process.²¹ Below is a summary of their findings from the site visit reports:

Site Visit Findings by Core Attribute

- **Access to Care** – Practices struggled with the tracking of data and metrics such as patient satisfaction with access to care, after-hours access and tracking clinical advice received over the telephone.
- **Accountability** – Half of the practices were engaging in a quality improvement effort to directly help increase the clinic’s ability to be responsive to patient’s needs. However,

²¹ Center for Outcomes Research and Education, Providence Health & Services. (2014). Oregon’s Patient-Centered Primary Care Home Program Common Standards and Best Practices: Results from a 2013 Narrative Evaluation. Submitted to Oregon Health Authority.

only one quarter of practices were using the Plan-Do-Study-Act model or similar Quality Improvement process.

- **Comprehensive Whole Person Care** - More than half of the practices reported using a pre-visit planning process that included “scrubbing and huddling” where providers and staff meet to discuss the needs of patients prior to scheduled appointment times. Over half of the practices had a co-located referral provider either located physically on-site or virtually available.
- **Continuity** – Findings indicated many practices are able to share information in real-time with external providers and nearly half of practices reported successful two-way communication with outside providers.
- **Coordination and Integration** – Many practices have room for improvement in care management, especially in proactive care, and care plans for patients with complex needs. There was also room for improvement in approximately half of practices to better track referrals, tests and results.
- **Person and Family Centered Care** – Patient engagement activities was one area identified in the findings for improvement. These activities include shared decision making, patient advisory councils, and encouraging patients to be more proactive in managing their health. All sites administered a patient care survey such as CAHPS although only 6% met the CAHPS benchmarks for experience of care domains. Only 20% of practices reported sharing these results with staff members.

Patient Reported Outcomes

The PCPCH Program contracted with the [Providence Health & Services Center for Outcomes Research and Education](#) (CORE) to conduct an evaluation of the PCPCH initiative on patient-reported outcomes. CORE used a set of existing survey data — the Oregon Health Study, a longitudinal study of low-income Oregonians — to assess access, quality, and health outcomes over time. The intent was to compare the change in key outcomes over time between groups to determine whether patients who had received care in a PCPCH did better over time than patients whose primary care occurred in a traditional setting. Below is a summary of their findings:

- **Access and Utilization** – In general, there was little evidence to suggest the PCPCH model affected access, utilization, or preventive screenings and behaviors. PCPCH and non-PCPCH patients saw very similar rates of improvement in most of these measures over time
- **Quality of Care** – In the quality measures, PCPCH patients were more likely to receive assistance for food, transportation, and housing when they needed it — a key indicator of whole person care that is a core part of the PCPCH model. However, they were also less likely to report that their care seemed well coordinated
- **Health** - There was some indication the PCPCH model is impacting patient health outcomes. All patients reported better overall health at follow-up than at baseline, but PCPCH patients saw more improvement than non-PCPCH patients. The result was only

marginally significant ($p < .10$), but may be an early indication that the PCPCH model holds promise for helping improve patient health.

Ongoing Program Evaluation

As the PCPCH model of care delivery evolves there is a need for continued evaluation of the PCPCH Program. Upcoming evaluation efforts will focus on advanced primary care transformation and examining in greater detail a subset of high-performing PCPCH practices. Evaluation work will include:

- Examining patterns of utilization and expenditures amongst PCPCH practices with a focus on the high-performing sites;
- Assessing the usefulness of the attribution scoring methodology in evaluating PCPCH performance; and
- Identifying the organizational conditions and process improvement activities that are necessary to achieve performance improvement.

Looking Ahead

PCPCH Program Goals 2015

The PCPCH Program has contributed greatly to furthering Oregon's health care transformation initiative to provide better care, better health and lower costs to all Oregonians. Looking ahead the program has set ambitious goals for 2015, including:

- 600 practices recognized as PCPCHs at the end of the year
- Recognized PCPCHs in all 36 counties in Oregon
- Conduct at least 100 on-site verification site visits across the state
- Outreach to never before recognized practices
- Continued outreach to recognized PCPCHs to keep them engaged in transformation and the PCPCH model
- Convene the Standards Advisory Committee to refine PCPCH model
- Continue with program evaluation to assess if the PCPCH model is helping practices to reach the Triple Aim
- Develop a PCPCH Program strategic plan for 2015-2017

3 STAR Designation

In February 2015 the PCPCH Program launched the 3 STAR Designation. Currently almost 90% of practices are recognized at the highest level of the PCPCH model - Tier 3. Among the practices recognized as a Tier 3, there is tremendous variation in the measures practices attest to, the interpretation of the standards, and how the standards are implemented. The 3 STAR designation allows the PCPCH Program to distinguish practices that have implemented truly transformative processes into their workflow using the PCPCH model framework and recommended best practices. The 3 STAR designation acknowledges clinics that are trailblazers in practice transformation. Practices must meet the criteria below to be considered for 3 STAR designation.

3 STAR Designation Criteria

- Recognized as Tier 3 PCPCH under the 2014 PCPCH Standards
- Attest to a total of 255 points or higher on the PCPCH application
- Receive a site visit to verify the practice is meeting all PCPCH standards attested to.
- Meet 11 or more of the 13 specified measures below:
 - 1.B.1: After Hours Access
 - 2.D.3: Quality Improvement
 - 3.C.2: Referral Process with Mental Health, Substance Abuse or Developmental Providers

- 3.C.3: Co-Location with Specialty Mental Health, Substance Abuse or Developmental Providers
- 4.B.3: Personal Clinician Continuity
- 5.C.1: Responsibility for Care Coordination
- 5.C.2: Coordination of Care
- 5.C.3: Individualized Care Plan
- 5.E.1: Referral Tracking For Specialty Care
- 5.E.2: Coordination with Specialty Care
- 5.E.3: Cooperation with Community Service Providers
- 6.A.1: Language/Cultural Interpretation
- 6.C.2 or 6.C.3: Experience of Care

A complete list of PCPCH standards and measures is in Appendix B.

Program Implementation Challenges

The PCPCH Program is an integral component of broader health care transformation efforts in Oregon. As with any complex initiative, implementation has not been without challenges. Limited patient perspective, staffing capacity, and payment support to PCPCHs are three current challenges for PCPCH Program implementation.

Limited Patient Perspective

The PCPCH Program recognizes health care clinics for their commitment to patient-centered primary care; however program staff has limited direct interaction with patients. Currently program staff only solicits patient feedback during on-site verification visits and relies primarily on PCPCH providers and staff to relay their patients' perspective about the effectiveness of the PCPCH model to OHA. The limited engagement with patients makes incorporating their perspective in the PCPCH model challenging. In the future, the PCPCH Program plans to create more opportunities to engage with patients about the PCPCH model.

Staffing Capacity

The PCPCH Program does not currently have the staffing capacity to conduct on-site verification visits to the nearly 550 recognized PCPCHs. The goal of the program is that each recognized PCPCH will have a site visit once every three years. However, with the pace of primary care transformation this may not be sufficient to truly capture and verify how recognized PCPCHs have implemented the model.

Payment Support to PCPCHs

Through its health system transformation efforts, Oregon is counting on primary care providers to change care delivery but payment incentives are not changing at the same pace to adequately support the adoption of new care models. There are numerous pilot projects occurring across the state, but pilot project parameters and payer participation vary widely.

This leaves some providers under-supported and others trying to juggle different initiatives and incentives across payers.

A bill that aims to ensure that sufficient resources are allocated to Oregon's primary care system is under consideration in the 2015 legislature. [Senate Bill 231](#) would require commercial insurers and coordinated care organizations to report the percentage of their total medical expenditures that are directed to primary care. The OHA would be responsible for reporting results to the legislature during the February 2016 legislative session. In addition, the OHA would be required to convene a learning collaborative with the purpose of sharing best practices on primary care alternative payment methodologies and initiative alignment.

Stories from the Field: PCPCH Profiles from across Oregon

Oregon Health & Sciences University Family Medicine at Richmond Portland, Oregon

Recognized PCPCHs are committed to delivering primary care that is centered on the patient and their family. In practice, this means acknowledging patients as an important member of the care team, delivering care that is respectful of cultural backgrounds, and empowering patients to be responsible for their overall health and wellness. This core attribute of the PCPCH model is best demonstrated by [Oregon Health & Sciences University \(OHSU\) Family Medicine at Richmond](#), a Tier 3 PCPCH located in Portland, Oregon.

At OHSU Family Medicine at Richmond a Patient Advisory Council advises the clinic on new processes and systems. The council was created several years ago and is



comprised of patients who have been nominated for membership by their care team or express interest in joining the council. Patient Advisory Council members meet every other month to provide feedback to the clinic about topics such as workflow processes, new service lines and improvements to patient experience of care. **Incorporating the Patient Advisory Committee's recommendations into clinic operations improves how care is delivered to patients from the patient's perspective.**

Some members of the Patient Advisory Committee also serve on OHSU Family Medicine at Richmond Health Literacy Committee. This committee is comprised of clinic staff who review all new and revised materials developed for patients, such as brochures, forms, and standard letters. Materials that are easy for patients to understand improve health literacy and have been shown to reduce health disparities. **"Patients are a great voice and work right alongside us as if they were staff,"** states Erin Kirk, Clinic Quality Manager.

Winding Waters Clinic Enterprise, Oregon

[Winding Waters Clinic](#) has provided care to Wallowa County residents for 55 years. Winding Waters was incorporated by two physicians at a time when the local hospital emergency department, hospital in-patients and clinic patients were all taken care of by the same physicians. The patient was the focus for those pioneer physicians over 50 years ago and remains the primary purpose of Winding Waters Clinic today.

Winding Waters Clinic has been a Tier 3 PCPCH since 2011. **The PCHCH model has provided the framework for Winding Waters to achieve transformation to a medical home,** including providing 24 hour access to a physician via phone, implementing expanded hours, installation of an HER, establishing a Patient Advisory Council, moving into new office space physically designed around team-based care, creating a Care Coordination Team, implementing a Chronic Pain Management program, hiring of an RN Care Manager, and integrating Behavioral Health services into their clinic



Care Coordination Team at WWC

Winding Waters Clinic seeks out community partnership opportunities to continue its transformation work, allowing the clinic to positively impact the health of their community. Dr. Elizabeth Powers explains, “The impact of our clinic is no longer defined by or limited by the walls of our office building.” Community partners are co-located within their clinic space, and staff actively go out into the community to create opportunities for learning and health improvement. For example Winding Waters Clinic has partnered with a local social services agency (Building Healthy Families) to improve early literacy levels by participating in the national Reach Out and Read program. **The clinic also created a lending library in their waiting room for both children and adults.** Providers assess the literacy level of their patients using the “Newest Vital Sign” and check literacy of patient handouts using the [Patient Education Materials Assessment Tool](#) form.

Every day, Winding Waters Clinic staff see their efforts improving the lives of patients. “The care coordination team keeps a cookie jar full of stories, each of which illustrates how they have really made a difference in the life of one of our patients,” Dr. Powers states.

Randall Children’s Clinic–Emanuel Portland, Oregon

The [Randall Children’s Clinic – Emanuel](#) is a pediatric primary care practice located in Portland and is affiliated with Legacy Health Systems. The practice is one of the first clinics in Oregon to be recognized as Patient-Centered Primary Care Home, and has maintained a Tier 3 status since 2011.



As the Randall Children’s Clinic - Emanuel embarked on its journey to become a PCPCH one goal was to improve access to care for their patients. Jeanene James, Medical Home Project Manager explains, **“We knew that patients were not satisfied with the way their health care was being managed.** Our access to available

appointments was often weeks, if not months, out and patients were not receiving continuity care from the same provider. Families were enduring long wait times when calling the clinic and delays in receiving return calls from their care team.” To improve access for their patients the clinic expanded its hours and designated 3 days a week just for walk-in appointments for sick visits. Walk-in appointments are available Wednesday and Monday evenings, and Saturday mornings.

“With the changes we have made we are proud to say that when a patient calls to schedule a routine care exam we are usually only a few days to one week out. We are now able to tell patients of our walk in hours for those same-day sick calls and also have been able to build our schedules to hold 9 same-day appointments per provider each day. These additions have been greatly appreciated by our families and staff,” James states enthusiastically.

Legacy Health Systems conducts patient satisfaction surveys, and the results for Randall Children’s Clinic – Emanuel are at an all-time high. Clinic staff attributes these high marks to the changes that have been implemented to improve access and families feeling better about the proactive care their child is receiving.

Randall Children’s Clinic – Emanuel has come a long way since beginning its primary care transformation journey 2011, and it hasn’t always been easy. James explains, **“During this time we have had several setbacks which include staff and physician turnover, but we have always continued to keep our patients and their families a priority.”**

Harney District Hospital Family Care Burns, Oregon

[Harney District Hospital Family Care](#) began their transformation journey in 2013 after participating in a Patient-Centered Primary Care Home (PCPCH) Learning Collaborative hosted by the [Patient-Centered Primary Care Institute](#) (PCPCI). During the collaborative clinic staff realized they were doing many of the core attributes of the PCPCH model already, and used the tools they learned to improve their processes to deliver better care and coordination of services to their patients. The clinic has been a Tier 3 PCPCH since fall 2013.

Harney District Hospital Family Care is located in rural Burns, Oregon which has a population of approximately 3,000 residents. This can make coordinating care a challenge that requires creative solutions. Clinic Manager Stacie Rothwell explains, “We strive to help try to keep our patients local so they do not have to travel the 280 round trip to the next town for care. We are on target to provide over 1,500 specialty visits this year through our local clinic in collaboration with many specialists from Bend. **If we are able to identify a healthcare need that is going unmet, we strive to explore the options and feasibility of bringing it local.**” The practice is currently in the midst of enhancing their Mental Health Integration by adding Tele Psychiatry this spring, and recruiting of a full time social worker and therapist to enhance their integrated care model.

The addition of a Care Manager to the team has made a notable improvement to the quality of care provided to patients. Rothwell says, “Our Care Manager assists patients in many ways from helping them with managing chronic conditions, coordinating care, assisting with transitions in care, and providing patient and family education.”

A Patient’s Story

One clinic success story revolves around a 79 year old male patient. He is a single Basque gentleman who knows very limited English and is unable to read or write. He lives alone and enjoys taking care of his home and yard. In January 2014 his health began to rapidly decline and he experienced four major hospitalizations within a five month period.

In May 2014 our Care Manager met with this patient and his caregiver, a family friend. Medications were reviewed and barriers to care addressed. Education was provided on congestive heart failure and how to monitor his weight daily and increase the amount of medication if needed. Weekly home visits to check his weight, monitor medications and general well-being took place.

Six months later, his weight is stable, he feels well, his strength is back and he is once again back out visiting friends and taking care of his yard and home. If he has a problem with anything, he knows to seek out our Care Manager so she can help find solutions before his health begins to decline.

Springfield Family Physicians Springfield, Oregon

[Springfield Family Physicians](#) is a private practice serving individuals and families in the communities of Springfield, Eugene, and the surrounding areas. The practice was one of the first clinics in Oregon to be recognized as a Patient-Centered Primary Care Home (PCPCH), and they have maintained their Tier 3 recognition since 2011.

Continuity of care is one of the six key attributes of the PCPCH model. **From a patient's perspective Continuity is best described in this way: "Be our partner over time in caring for us."** Similar to most recognized PCPCHs, patients at Springfield Family Physicians are assigned a primary care provider (PCP) and the practice has clear communication strategies in place when a patient is unable to see his or her PCP. **What distinguishes Springfield Family Physicians is that their vision for continuity revolves around integrating mental and behavioral health services into the practice.**

A Patient's Story

We have a longstanding patient who lives with diabetes and schizophrenia, and has little support from family. **She has never been able to be convinced to regularly check her blood sugar levels at home or engage in self-care for her diabetes.** Her A1C was 12.8. Our RN care manager, BH Care manager and Community Support Specialist accepted the challenge of working intensely with her to gain her trust, help her understand her illness and begin to make positive changes.

At first, this involved daily home visits from the RN or BH therapist. After a few weeks, the patient allowed the Community Support Specialist to take her shopping for groceries, and together they prepared a week's worth of healthy meals. This was repeated several times until the patient could do it herself. Overtime, the daily home visits turned into daily telephone calls and occasional home visits. **The patient now checks her CBG each day, faithfully records the numbers, self-injects insulin, logs everything she eats and drinks, walks daily, calls the support team to report her numbers or ask questions, and actively engages with the healthcare team.** Her most recent A1c had fallen to about 9.0. She spent the holidays with her grown children, and we are hopeful that family support will improve as her confidence in caring for herself improves.

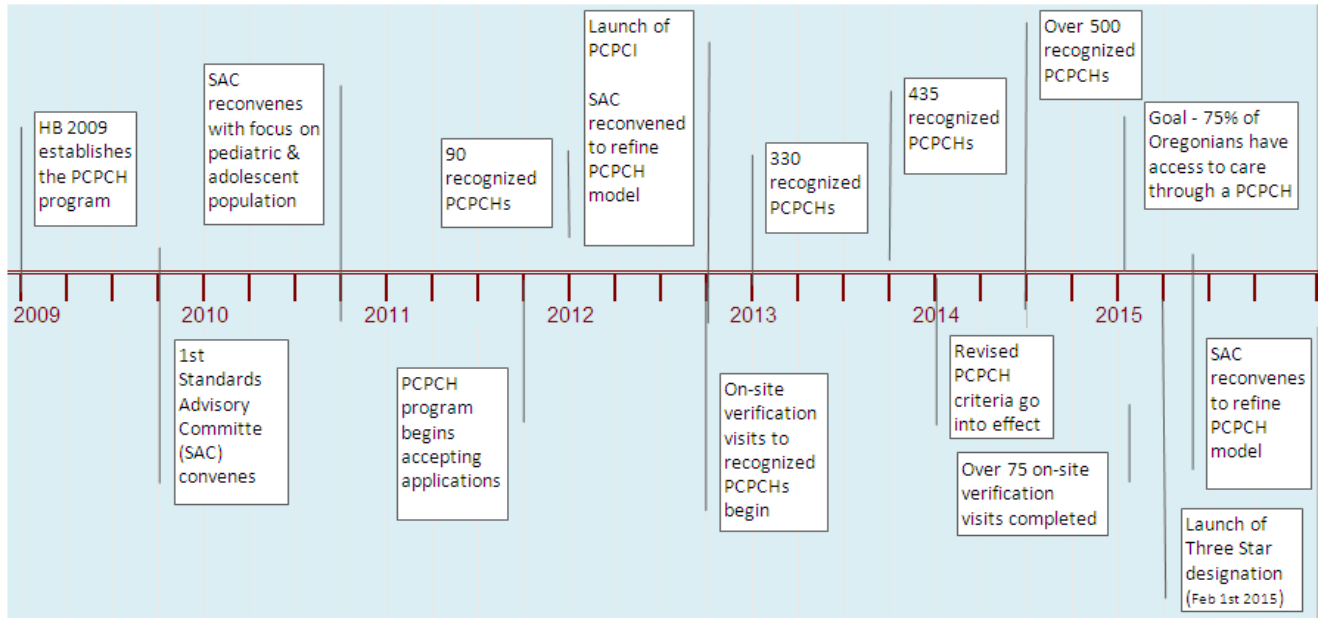
Before Springfield Family Physicians began their transformation journey the practice was struggling to meet the behavioral health needs of their patients. In 2012 they partnered with a local behavioral health organization to embed a part-time behavioral health therapist within their practice, and began experimenting with "warm hand offs" and "treatment to target" therapies. "The value of this onsite resource and the benefit to our patients was quickly realized," stated Jane Conley from Springfield Family Physicians, "and it wasn't long before the need required two fulltime therapists."

Patients noted the improved to care at Springfield Family Physicians too. A recent patient told Conley, **“Of course I like coming to this office for my behavioral therapy, because this is where I already feel safe.”** The rate of patients attending their behavioral health appointments has markedly improved since they began integrating behavioral health services into their practice, and Conley said the providers greatly appreciate having this resource readily available when a patient is in their office.

Appendices

Appendix A: PCPCH Program Timeline

PCPCH Program Timeline (2009-2015)



Appendix B: List of PCPCH Standards and Measures

2014 PCPCH Standards		
PCPCH CORE ATTRIBUTE	Must Pass?	Points Available
PCPCH Standard		
PCPCH Measures		
CORE ATTRIBUTE 1: ACCESS TO CARE - <i>“Health care team, be there when we need you.”</i>		
Standard 1.A) In-Person Access		
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	No	5
1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care.	No	10
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	No	15
Standard 1.B) After Hours Access		
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	No	5
Standard 1.C) Telephone and Electronic Access		
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Yes	0
1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient’s medical record.	No	5
Standard 1.D) Same-Day Access		
1.D.1 PCPCH provides same-day appointments.	No	5
Standard 1.E) Electronic Access		
1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.	No	15
Standard 1.F) Prescription Refills		
1.F.1 PCPCH tracks the time to completion for prescription refills.	No	5
CORE ATTRIBUTE 2: ACCOUNTABILITY - <i>“Take responsibility for making sure we receive the best possible health care.”</i>		
Standard 2.A) Performance & Clinical Quality		

2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Yes	0
2.A.2 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	No	10
2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	No	15
Standard 2.B) Public Reporting		
2.B.1 PCPCH participates in a public reporting program for performance indicators.	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	No	10
Standard 2.C) Patient and Family Involvement in Quality Improvement		
2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities.	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	No	15
Standard 2.D) Quality Improvement		
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	No	15
Standard 2.E) Ambulatory Sensitive Utilization		
2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	No	5
2.E.2 - PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization.	No	10

2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - "Provide or help us get the health care, information, and services we need."		
Standard 3.A) Preventive Services		
3.A.1 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	No	15
Standard 3.B) Medical Services		
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.	Yes	0
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)		
3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.	Yes	0
3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.	No	10
3.C.3 PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention		
3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	No	5
Standard 3.E) Preventive Services Reminders		
3.E.1 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services.	No	5
3.E.2 PCPCH tracks the number of unique patients who were sent appropriate reminders.	No	10
3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.	No	15

CORE ATTRIBUTE 4: CONTINUITY - *“Be our partner over time in caring for us.”*

Standard 4.A) Personal Clinician Assigned

4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	No	15

Standard 4.B) Personal Clinician Continuity

4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	No	15

Standard 4.C) Organization of Clinical Information

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.	Yes	0
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Standard 4.D) Clinical Information Exchange

4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	No	15
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Standard 4.E) Specialized Care Setting Transitions

4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Yes	0
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Standard 4.F) Planning for Continuity

4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	No	5
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Standard 4.G) Medication Reconciliation

4.G.1 Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation.	No	5
4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled.	No	10
4.G.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of care.	No	15

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *“Help us navigate the health care system to get the care we need in a safe and timely way.”*

Standard 5.A) Population Data Management (check all that apply)		
5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.	No	5
5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	No	5
Standard 5.B) Electronic Health Record		
5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be “meaningful users” of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	No	15
Standard 5.C) Complex Care Coordination (check all that apply)		
5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	No	10
5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.	No	15
Standard 5.D) Test & Result Tracking		
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)		
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	No	5
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.	No	15
Standard 5.F) End of Life Planning		
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.	Yes	0

5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	No	5
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - "Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."		
Standard 6.A) Language / Cultural Interpretation		
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.	Yes	0
6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.	No	5
Standard 6.B) Education & Self-Management Support		
6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	No	10
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	No	15
Standard 6.C) Experience of Care		
6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	No	5
6.C.2 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.	No	10
6.C.3 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities		
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	No	5

Appendix C: PCPCH Standards Advisory Committee Members

2012 Standards Advisory Committee Members

Chair

Susan Kirchoff, RN Multnomah County Health Department

Co-Chair

Glenn Rodriguez, MD Oregon Academy of Family Physicians Director, Providence Milwaukie Hospital Family Practice Residency Program

Committee Members:

Carrie Baldwin-Sayre ND, Vice President of the Oregon Association of Naturopathic Physicians

Patty Black, Peace Health Medical Group Patient Advisory Council

Kat Chinn NP, Nurse Practitioners of Oregon

Tatiana Dierwechter MSW, Benton County Health Department

David Dorr MD, MS OHSU Medical Informatics Internal Medicine

Sherrie Ford, Columbia County Health Department

L J Fagnan MD, Oregon Practice Based Research Network

Laurie Francis, MPH Oregon Primary Care Association

R J Gillespie MD, Oregon Pediatric Improvement Partnership

Arthur Jaffe MD, President, Oregon Pediatric Society

Chuck Kilo MD, Chief Medical Officer OHSU Founder Greenfield Health

Susan King RN, Executive Director Oregon Nurses Association

Helen Kurre, PharmD, MBA, Providence, Director of Medical Practice Integration

Carla McKelvey MD, IPP of OMA, Pediatrician

Janet Meyer MBA CEO- Tri-County Medicaid Collaborative Tuality Healthcare

Meg Portwood NP, Nurse Practitioners of Oregon

Mike Shirtcliff DMD, CEO- Advantage Dental

Mindy Stadtlander MPH, CareOregon

Rachel Solotaroff MD, Medical Director- Central City Concern

Megan Veihman PharmD, Richmond Family Health Center

Rick Wopat MD, Good Samaritan Clinic

Kathy Savicki, Mid-Valley Behavioral Care Network

Dana Hargunani MD, Child Health Director, Oregon Health Authority

Joe Hromco PhD, Director of Clinical Operations Life Works NW

2010 Standards Advisory Committee Members

Chair

J. Bart McMullan, Jr., MD, Health Leadership Task Force

Vice-Chair

Mitchell Anderson, Benton County Health Department

Members

James Beggs, MD, Cascade Comprehensive Care

Karen Erne, PHR, MA, Blount International

Craig Hostetler, MHA, Oregon Primary Care Association

Arthur Jaffe, MD, Oregon Health and Sciences University

Susan King, RN, Oregon Nurses Association

Carolyn Kohn, Community Advocate

David Labby, MD, CareOregon

Robert Law, MD, Dunes Family Health Care

Mary Minniti, CPHQ, Peace Health Medical Group

Melinda Muller, MD, FACP, Legacy Health

Glenn Rodriguez, MD, Oregon Academy of Family Physicians

Carole Romm, MPA, RN, Central City Concern

Tom Syltebo, MD, Kaiser Permanente Northwest Region

Ex-Officio Members

David Dorr, MD, MS, Oregon Health and Sciences University

Chuck Kilo, MD, MPH, GreenField Health

David Pollack, MD, Oregon Health and Sciences University

John Saultz, MD, Oregon Health and Sciences University

Barney Speight, Oregon Health Authority

Jane-Ellen Weidanz, Oregon Health Authority

2010 Pediatric Standards Advisory Committee

Co-Chairs

David Labby, MD, Medical Director, CareOregon

Susan King, RN, Executive Director, Oregon Nurses Association

Members

Frances Biagioli, MD, Oregon Health and Science University, Department of Family Medicine

Arthur Jaffe, MD, President, Oregon Pediatric Society, Oregon Health and Science University

Robert Dannenhoffer, MD, Pediatrician, Past President, Oregon Medical Association

Kelli Kennedy, RN, Legacy Health Systems

RJ Gillespie, MD, MHPE, Medical Director, Oregon Pediatric Improvement Partnership

Liz McElhinny, RN, Children's Health Alliance

Regan Gray, Policy Director, Children First for Oregon

Bonnie Reagan, MD, Family Physician

Warren Griffin, MD, Mid-Valley IPA

Kathy Savicki, Mid-Valley Behavioral Care Network

Marilyn Hartzell, M. Ed, Director, Oregon Center for Children and Youth with Special Healthcare Needs, Oregon Health and Science University
Tom Sincic, NP, School Based Health Care Network
Weston Heringer, Jr., DMD, ODS Community Health, Inc
Kelly Volkmann, Benton County Health Department
Craig Hostetler, MHA, Executive Director, Oregon Primary Care Association
Kara Williams, M. Ed, Education Specialist, Oregon Department of Education
Ex-Officio Member Colleen Reuland, MS, Research Associate, Children and Adolescent Health Measurement Initiative

Appendix D: Most Common and Least Common Attested To Measures

Standards attested to by 90% or more of PCPHs include:

- 1.C.1 – When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient’s medical record
- 1.D.1 – PCPCH provides same day appointments
- 3.D.1 – PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risks or developmental promotion behaviors
- 5.1.A – PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient populations

Standards attested to by 10% or less of PCPCHS include:

- 2.C.1 – PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year
- 2.C.3 – Patient, caregiver and family-defined family advisors are integrated into the PCPCH and function in peer support or in training roles
- 4.G.2 – PCPCH tracks the percentage of patients whose medication regimen is reconciled
- 6.C.3 – PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communications, coordination of care and practice staff helpfulness