

Oregon Health Policy Board
Update on Patient Centered Primary Care Home Activities

I. Patient Centered Primary Care Home Overview

State Legislation: HB 2009 created a Patient Centered Primary Care Home (PCPCH) Program within the Office for Oregon Health Policy and Research (OHPR) and specified five key activities:

1. Define core attributes of the patient centered primary care home to promote a reasonable level of consistency of services provided by patient centered primary care homes;
2. Establish a simple and uniform process to identify patient centered primary care homes that meet the core attributes defined by OHPR;
3. Develop uniform quality measures for patient centered primary care homes that build from nationally accepted measures and allow for standard measurement of patient centered primary care home performance;
4. Develop uniform quality measures for acute care hospital and ambulatory services that align with the patient centered primary care home quality measures; and
5. Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.

HB 2009 also specified a number of other activities to be undertaken by OHPR and the Health Authority:

- OHPR to establish Learning Collaborative(s) – to promote the development of PCPCHs
- Oregon Health Authority – may provide reimbursement for PCPCHs under medical assistance
- Oregon Health Authority – shall develop uniform contracting standards to promote PCPCHs within public employee benefit programs and shall develop strategies to encourage public employees to receive care from PCPCHs

HB 3418 provided specific statutory guidance on the key functions of “Primary Care Homes” and requires the OHA to study the feasibility of payment reform for Primary Care Homes within Medicaid.

Federal Legislation: Various “medical home” demonstrations are contained in drafts of Federal health care reform legislation. In general, these proposals would support the work underway in Oregon. For example, by providing an enhanced match rate for “medical home” demonstrations within Medicaid and allowing Medicare to participate in multipayer demonstrations.

Intended Outcomes: Improve the primary care delivery system to achieve the “triple aim” of improved outcomes, improved patient experience of care and reduced per-capita costs over time.

The Oregon Health Fund Board (HFB) and its Delivery Systems Subcommittee identified the development of primary care homes as a key strategy for improving health care delivery in Oregon. The conceptual work and key goals of the HFB were incorporated into HB 2009 and HB 3418. Specifically, to:

- Improve individual and population health outcomes
- Reduce inappropriate utilization
- Reduce health system costs
- Strengthen primary care
- Encourage prevention and chronic disease management over acute, episodic care
- Stimulate delivery system change

II. Activities to Date and Anticipated Timeline

HB 2009 - The OHA director appointed a Standards Advisory Committee in late October 2009 to assist OHPR with policy development on the first three “key activities” contained in HB 2009 shown above. The committee has held five meetings to date, with its most recent meeting on 1/7/09. The committee aims to complete a draft set of Primary Care Home Standards by the end of January. These standards will form the basis for primary care payment reform efforts at the state level.

Anticipated Next Steps:

- Jan 2010 – complete draft Primary Care Home Standards
- Jan 2010 – Background research with DMAP and other entities within the Health Authority on approaches to applying the standards to payment.
- Spring 2010 – develop payment reform pilot projects options with both public and private sector stakeholders, working with the Board’s Health Systems Performance Committee and it’s payment reform subcommittee.
- June 2010 - report from DMAP due to Legislature on payment reform feasibility study parameters in OHP. **(From HB 3418)**
- Summer 2010 – develop strategies for learning collaborative or other mechanisms to support development of primary care health homes.

III. Dependencies

Parallel Work Efforts: Several other projects are ongoing in Oregon that will drive the development of primary care homes. Two notable projects are a Commonwealth Grant to support development of medical homes in safety net and rural clinics (partnership between CareOregon, the Oregon Primary Care Association, and the Oregon Rural Practice Information Network) and a multi-payer effort is in development by the Healthcare Leadership Taskforce. A number of individual insurers have also independently developed small pilot projects.

IV. Stakeholder Input Process

OHPR has worked with a wide variety of stakeholders across the state to recruit members for the Standards Advisory Committee and develop background information and proposals to bring before the committee. All meetings of the committee have been open to the public and a number of individuals have submitted public comment.

V. Key Decision Points for Board

Scope of initial pilots for the Oregon Health Authority

How best to include as many OHA-covered lives as possible in joint public-private payment reform pilots and initiate additional pilots?

Payment Structure

How best to structure payments, particularly if no new dollars?

How structure accountability for efficiencies and cost-savings – role of clinics versus plans

Timing of expanding to larger populations

Do outcomes support moving forward?

How soon?

VI. Staff Resources

Senior OHA staff: Jeanene Smith, Office for Oregon Health Policy and Research

Lead Staff: Rob Stenger, Policy Fellow, Office for Oregon Health Policy and Research

Patient Centered Primary Care Home Program - Standards Advisory Committee
Proposed Standards

The PCPCH Standards Advisory Committee has developed language to further delineate the core attributes of a Patient-Centered Primary Care Home. The framework developed by the committee contains six broad Core Attributes (Access to care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family Centered Care). Within each Core Attribute are a number of Standards, or focused areas that will contain specific measures or metrics.

ACCESS TO CARE – Be there when I need you.

- Make it easy for me to get care and advice when I need and want it for myself and my family members.
- Provide flexible, responsive options for me to get care in a timely way.

Standard: In-Person Access

- Make sure I can quickly and easily get an appointment with someone who knows me and my family.
- Ensure that office visits are well-organized and run on time.

Standard: Telephone and Electronic Access

- Make sure I know what to do if I need or want help when your office is closed.
- Provide multiple ways for me to easily get care or advice outside of office visits.

Standard: Administrative Access

- Respond to my requests for help with refills, paperwork, etc. in the most efficient way possible to meet my needs.

ACCOUNTABILITY – Take responsibility for making sure I receive the best possible health care.

Standard: Performance Improvement

- Work to improve the care and services you provide and ask me for feedback and ideas about what to improve.
- Publically report information about the safety, quality and cost of the care you provide.
- Show me what you are doing to ensure I will get the right care while avoiding unnecessary care.

Standard: Cost and Utilization

- Keep me informed about the relative costs, benefits and risks of the different options for my care so I can make informed decisions.
- Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve my quality of life.

COMPREHENSIVE WHOLE PERSON CARE – Provide or help me get the health care and services I need.

- Help me get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use.
- Help me understand my health risks and/or conditions and give me tools and support to manage my own care.

Standard: Scope of Services

- Provide most of the care I need for common problems at your clinic.

CONTINUITY – Be my partner over time in caring for my health.

- Let me choose my personal clinician.
- Know who I am and remember important information about my health history, needs and values.
- Help me make well-informed decisions about my health and health care.

Standard: Provider Continuity

- Make sure I can see or talk with my chosen personal clinician or team whenever I need to.
- When it is not possible for me to see a member of my primary care team, ensure that important information about my health history and values are available to those who will care for me.

Standard: Information Continuity

- Make sure that all health professionals caring for me have access to up-to-date and accurate information about my health history.
- Ensure that my personal health information is always protected and kept private.
- Make it easy for me to access my personal health information.

Standard: Geographic Continuity

- Stay involved in my care wherever I go within the health care system, and help me to coordinate my care across places and people.

COORDINATION AND INTEGRATION – Help me navigate the health care system to get the care I need in a safe and timely way.

- Make sure I understand what care or services I need to stay healthy and manage my medical and mental health problems and where to get them.
- Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions.

Standard: Registries and Data Management

- Follow my care closely and let me know when tests or checkups are needed.
- Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health.

Standard: Care Coordination

- When I need to go to other providers or places for care or services, help me coordinate and plan my care without delays and confusion.
- When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.
- Make sure I understand the reasons for sending me to a specialist or for a test, prepare me for what to expect and follow up with me afterwards to make sure I understand the results.

Standard: Care Planning

- Help me and my family set goals and plan for my care in a way that is understandable and meets my needs.
- Provide me with the information I need to care for my own illness and challenge me to actively care for myself.

PERSON AND FAMILY CENTERED CARE – Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.

- Listen to me and my family members or caregivers and promote experiences that enhance my independence and control over my health.
- Respect my culture and values and build a relationship with me that is responsive to my needs and preferences.

Standard: Communication

- Communicate in the language that my family members and I can understand.
- Explain things in ways that make it easy for my family members and I to understand and check to be sure we understand.
- Share information with me in an unbiased way.

Standard: Education and Self-Management Support

- Respect my capacity to learn and engage me and my family members as partners in managing my health.
- Help me know what I need to do to manage and maintain my health.
- Invite me to set goals for improving my health and support my efforts to change my behavior to improve my health and wellness.

Standard: Experience of Care

- Regularly ask my family and me about our care experience.
- Value our feedback and use this information to improve the way we work together.

**Office for Oregon Health Policy and Research
Patient Centered Primary Care Home - Standards Advisory Committee**

Chair

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

Vice-Chair

Mitchell Anderson
Health Director
Benton County Health Department
Corvallis, OR

Members

James Beggs, MD
Medical Director
Cascade Comprehensive Care
Klamath Falls, OR

Karen Erne, PHR, MA
Benefits Manager
Blount International
Portland, OR

Craig Hostetler, MHP
Executive Director
Oregon Primary Care Association
Portland, OR

Arthur Jaffe, MD
General Pediatrics
Oregon Health and Sciences University
Vice President, Oregon Pediatric Society
Portland, OR

Susan King, RN
Executive Director
Oregon Nurses Association
Tualatin, OR

Carolyn Kohn
Community Advocate
Grants Pass, OR

David Labby, MD
Medical Director
CareOregon
Portland, OR

Robert Law, MD
Physician
Dunes Family Health Care
Reedsport, OR

Mary Minniti, CPHQ
Quality Improvement Director
Peace Health Medical Group
Eugene, OR

Melinda Muller, MD, FACP
Senior Medical Director, Primary Care
Legacy Health
Portland, OR

Glenn Rodriguez, MD
President
Oregon Academy of Family Physicians
Portland, OR

Carole Romm, MPA, RN
Director, Community Partnerships & Strategic
Development
Central City Concern
Portland, OR

Tom Syltebo, MD
Clinical Quality Representative
Kaiser Permanente Northwest Region
Portland, OR

Ex-Officio Members

David Dorr, MD, MS
Assistant Professor, Medical Informatics
Oregon Health and Sciences University
Portland, OR

Chuck Kilo, MD, MPH
Medical Director
GreenField Health
Portland, OR

David Pollack, MD
Professor of Public Policy
Oregon Health and Sciences University
Portland, OR

John Saultz, MD
Chair, Department of Family Medicine
Oregon Health and Sciences University
Portland, OR

Barney Speight
Director of Healthcare Purchasing
Oregon Health Authority
Salem, OR

Jane-Ellen Weidanz
Governmental Affairs Manager
Addictions and Mental Health Division
Oregon Health Authority
Salem, OR

OHPR Staff

Jeanene Smith, MD, MPH, Administrator
Gretchen Morley, MPA, Health Policy Development Dir.
Robert Stenger, MD, Health Policy Fellow

Jeanene.Smith@state.or.us
Gretchen.Morley@state.or.us
Robert.Stenger@state.or.us