

# Standards and Measures for Patient Centered Primary Care Homes

*Recommendations from the*  
Office for Oregon Health Policy and Research (OHPR)

Patient Centered Primary Care Home  
Standards Advisory Committee

# Why Primary Care Homes?

## *Goals of the Oregon Health Fund Board & HB 2009*

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

*“Right care at the right time and in the right place”*

# How is a Primary Care Home Different?

## *Status Quo Care*

- Access options limited
- Fragmented episodic care
- Uncoordinated
- Multiple providers/locations
- Rewards for volume
- Responsive to needs of providers

## *Primary Care Home*

- Access options meet patient needs
- Continuous relationships
- Coordinated across the system
- One-stop shopping
- Rewards for quality and value
- Responsive to needs of patients and families

# Improving “Triple Aim” Outcomes

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graph TD; Title[Improving Triple Aim Outcomes] --> A[A Healthy Population]; Title --> B[Extraordinary Patient Care]; Title --> C[Reasonable Costs];
```

## A Healthy Population

- Care is focused on wellness, prevention and chronic disease management
- Clinics actively evaluate the needs of the population they serve and improve their care

## Extraordinary Patient Care

- Patients have personal, continuous relationships in patient-centered clinics
- Services people want and need are easily available
- Patients' health information is available to them and their clinicians when it is needed
- Individual wishes about end-of-life care are known and followed

## Reasonable Costs

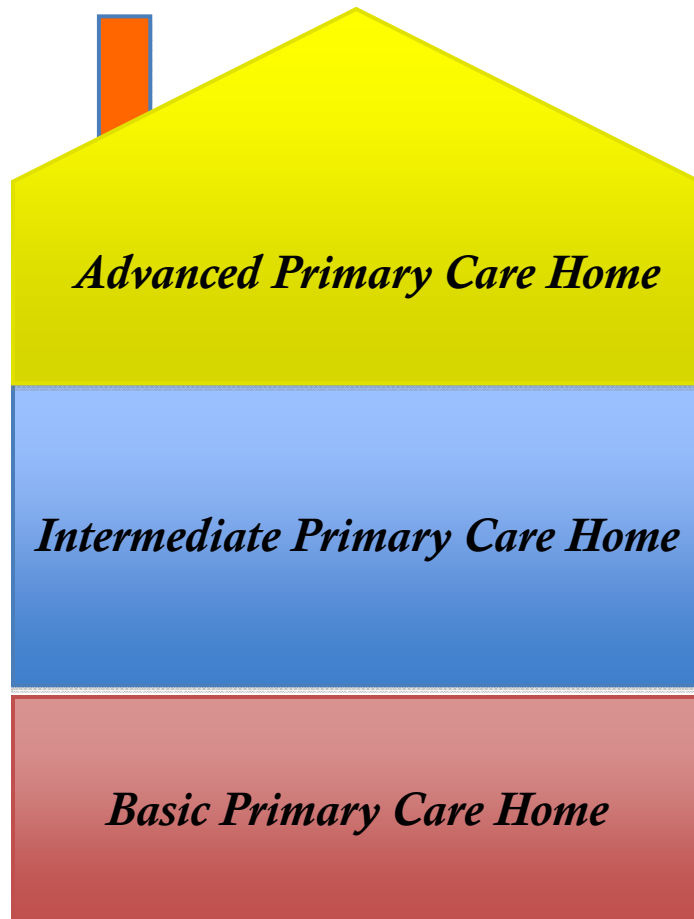
- Care is coordinated, reducing duplication and medical errors
- Chronic diseases are managed or prevented, reducing utilization of expensive acute services

# What will it take to transform into a Primary Care Home?

- Status quo primary care?
- Commitment to practice transformation?
- Significant systems and process changes in place?
- Systems and process changes + proven performance improvement capacity?
- Fully functional primary care home, ready to accept accountability for health and financial outcomes.



# Different Levels of Primary Care “Home-ness”



- Proactive patient and population management
- Accountable for quality, utilization and cost of care outcomes

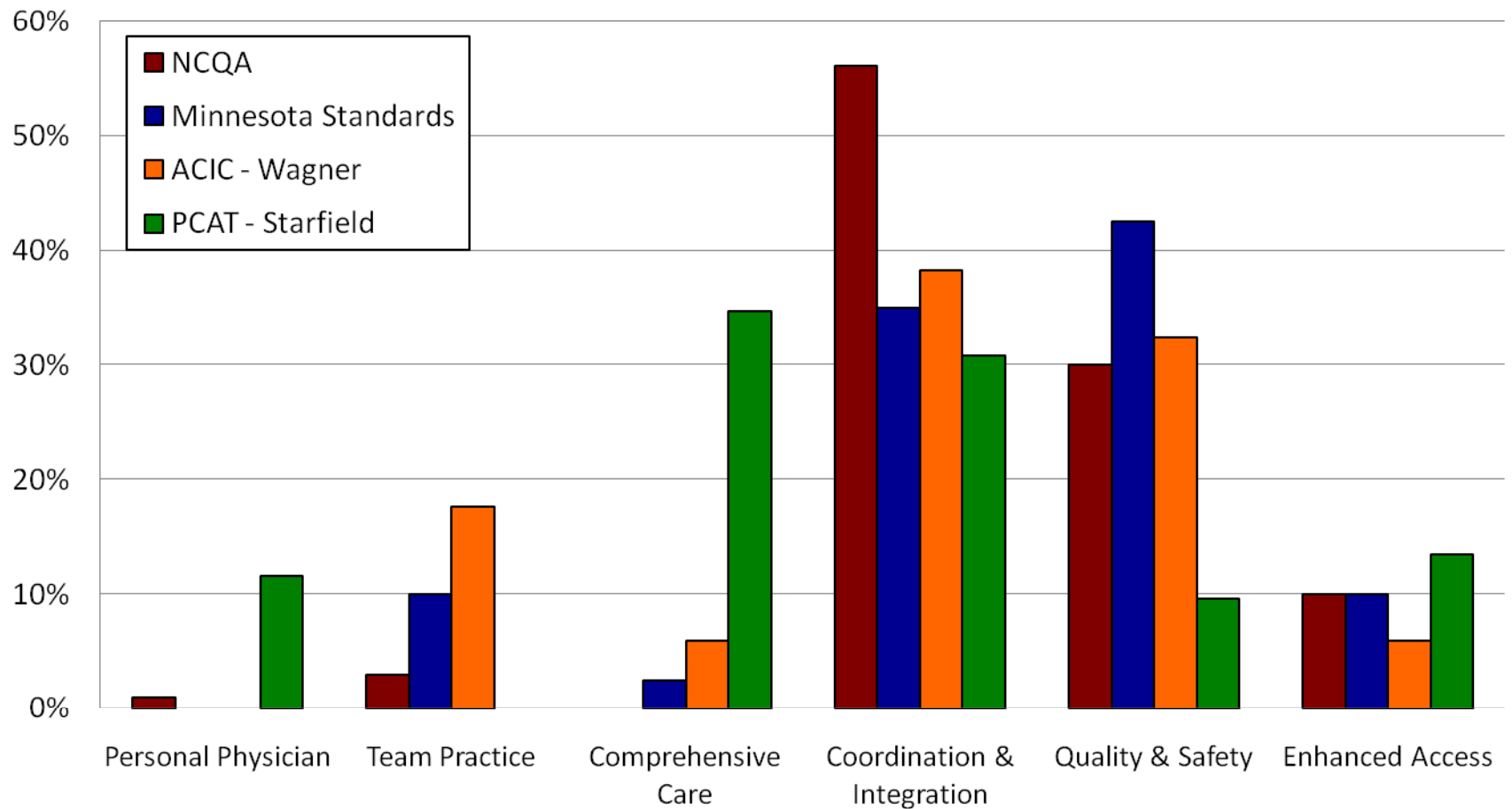
- Demonstrates performance improvement
- Additional structure and process improvements

- Foundational structures and processes

# Primary Care Home Standards Advisory Committee

- 15 members, 6 ex-officio content experts
- Multiple stakeholders (patients, providers, plans, employers, health authority, public health)
- 7 public meetings Nov 2009 - Jan 2010
- Reviewed past work in Oregon, other state, federal and private efforts across the country
- Three principle products
  - PCPCH Core Attributes and Standards
  - PCPCH Measures
  - Guiding Principles for Implementation

# “Medical Home” Measurement Tools Across the Nation



# Oregon's Primary Care Home Core Attributes

*What does it mean to a Patient / Person?*

**ACCESS TO CARE**

*Be there when I need you.*

**ACCOUNTABILITY**

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

**COMPREHENSIVE  
WHOLE PERSON  
CARE**

*Provide or help me get the health care and services I need.*

# Oregon's Primary Care Home Core Attributes (2)

*What does it mean to a Patient / Person?*

## **CONTINUITY**

*Be my partner over time in caring for my health.*

## **COORDINATION AND INTEGRATION**

*Help me navigate the health care system to get the care I need in a safe and timely way.*

## **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.*

# Primary Care Home Standards

## *“Access to Care” Standard*

ACCESS TO CARE – *Be there when I need you*

### Standards

- In-Person Access
- Telephone and Electronic Access
- Administrative Access

# Primary Care Home Measures

## *(Access to Care Example)*

### ACCESS TO CARE – *Be there when I need you*

#### ➤ In-Person Access

##### Appointment Access Measures

Tier 1 – Clinic tracks and reports access to appointments.

Tier 2 – Clinic demonstrates improvement in access to appointments.

Tier 3 – Clinic meets a benchmark for appointment access.  
*(e.g. 80% of the clinic's patients report they are able to get an appointment when they need one).*

#### ➤ Telephone and Electronic Access

#### ➤ Administrative Access

# Primary Care Home Standards

## *“Coordination and Integration” Standard*

### COORDINATION AND INTEGRATION

*Help me navigate the health care system to get the care I need in a safe and timely way.*

#### Standards

- Data Management
- Care Coordination
- Care Planning

# Primary Care Home Measures

## *(Care Planning Example)*

COORDINATION AND INTEGRATION - *Help me navigate...*

- Data Management
- Care Coordination
- Care Planning

### Care Planning Measures

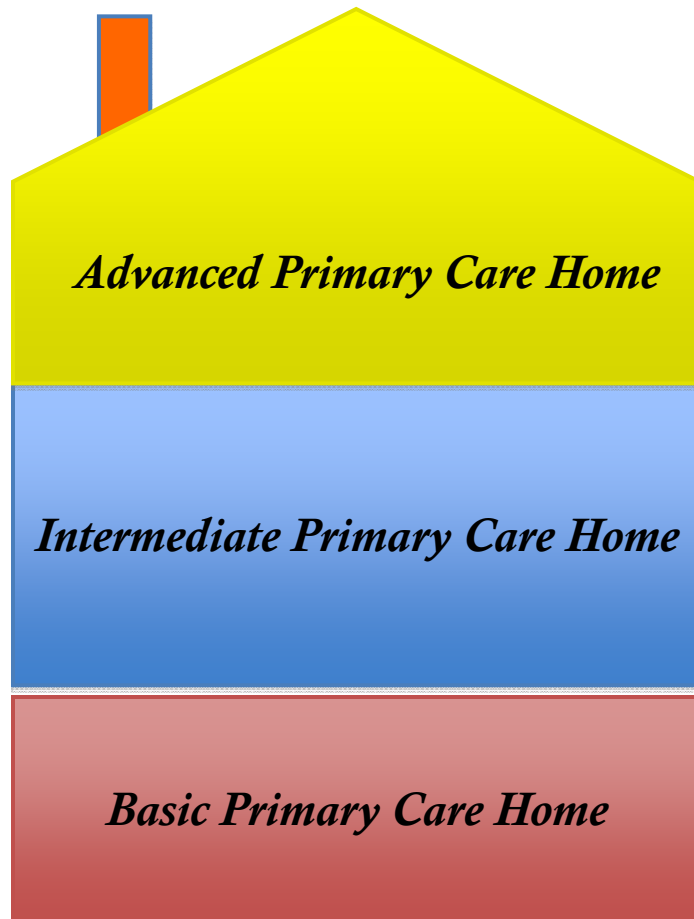
Tier 1 – Clinic can provide all patients with a written care summary.

Tier 2 – Clinic identifies high risk individuals and provides them with a written care plan.

Tier 3 – Clinic improves the % of high risk individuals who have a written care plan that has been reviewed and updated in the past year.

# Using the Measures to Recognize Performance

## *Flexible, Additive Approach*



- Accountable for quality, utilization and cost of care outcomes
- Meets most Tier 2 and Tier 3 measures and many “additional” measures

- Meets many Tier 2 or Tier 3 measures
- Meets some “additional” measures

- Foundational structures and processes
- Meets all Tier 1 measure

# Advisory Committee's Guiding Principles for the Standards

- Payment Reform
  - ✓ Value the work of primary care, not just physician visits
  - ✓ Adequately support new systems and staffing
  - ✓ Risk adjustment of payment by patient complexity
  - ✓ Reward high functioning primary care homes
- Driving Delivery System Change
  - ✓ Gradual improvements in care for all clinics serving all patient populations regardless of payer

# Advisory Committee's Guiding Principles for the Standards

- Measurement
  - ✓ Consistent, predictable, centralized and transparent process for measurement
- Encouraging Continuous Improvement
  - ✓ Measures should evolve over time
  - ✓ Learning collaboratives and workforce development to support transformation
- Aligning Incentives Across the Health Care System
  - ✓ Integrate with other initiatives (quality, HIT)
  - ✓ Requirements for hospitals, specialists to communicate with the PCPCH and participate in care coordination

# Next Steps for the Health Authority

**HB 2009**– OHA “shall develop” strategies to encourage covered OHA populations (OHP, Public Employees, OMIP) to receive care in Primary Care Homes

- Next Steps... payment models and pilots

- Health Policy Board Committee on Incentives and Outcomes
  - Subcommittee on Payment Reform
- Health Leadership Task Force Multi-payer Pilot
  - Partnership to include OHA lives?
- Other strategies to ensure adequate Medicaid lives in pilots?

# For More Information

Full Standards report will be available at:

<http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/PCPCHStandardsAdvisoryCommittee.shtml>

Oregon Health Authority & Policy Board

<http://www.oregon.gov/OHA/index.shtml>

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