



Overview of the Patient-Centered Primary Care Home Program

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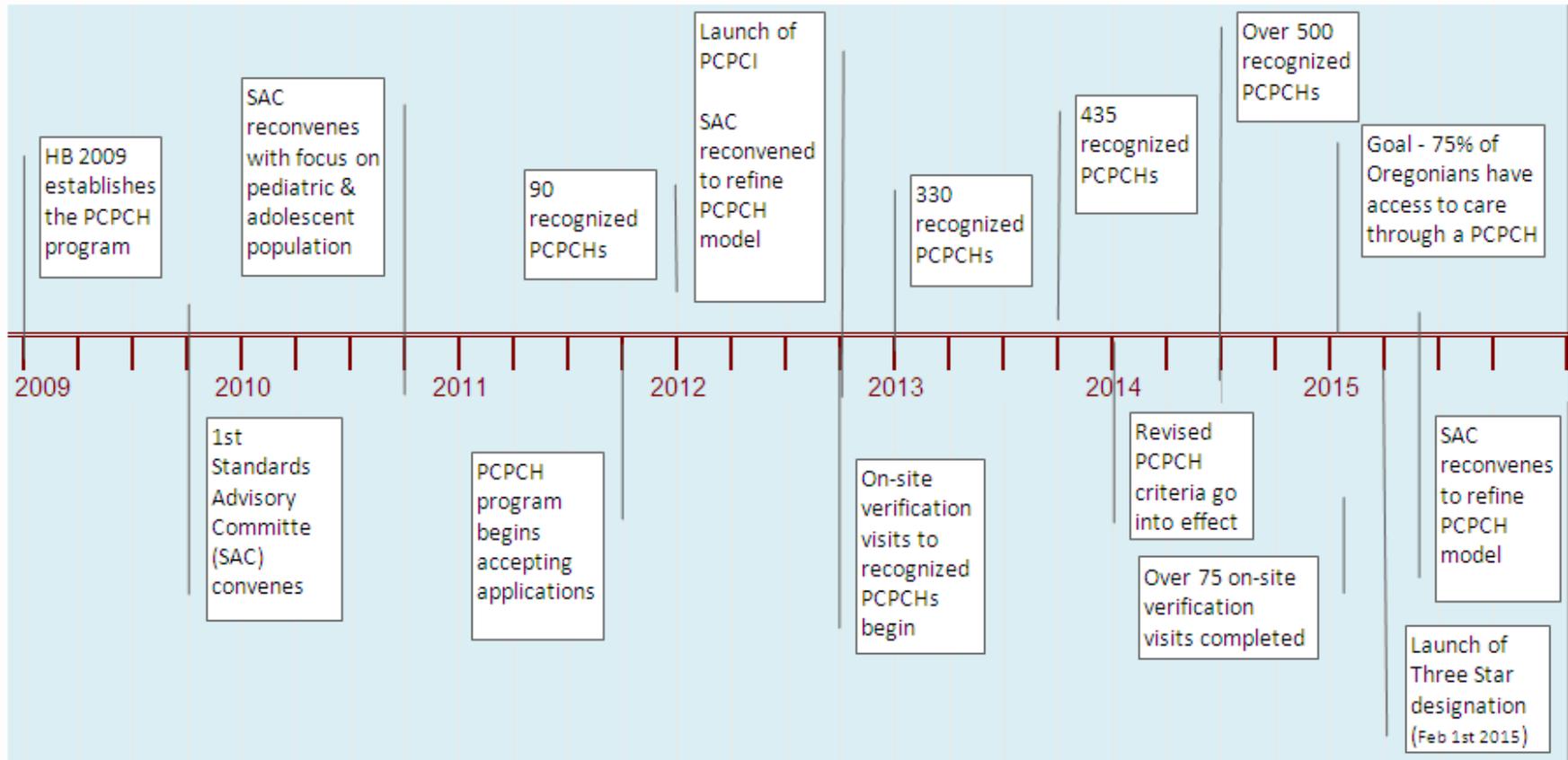
PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

Oregon
Health
Authority

Patient-Centered Primary Care Home Program

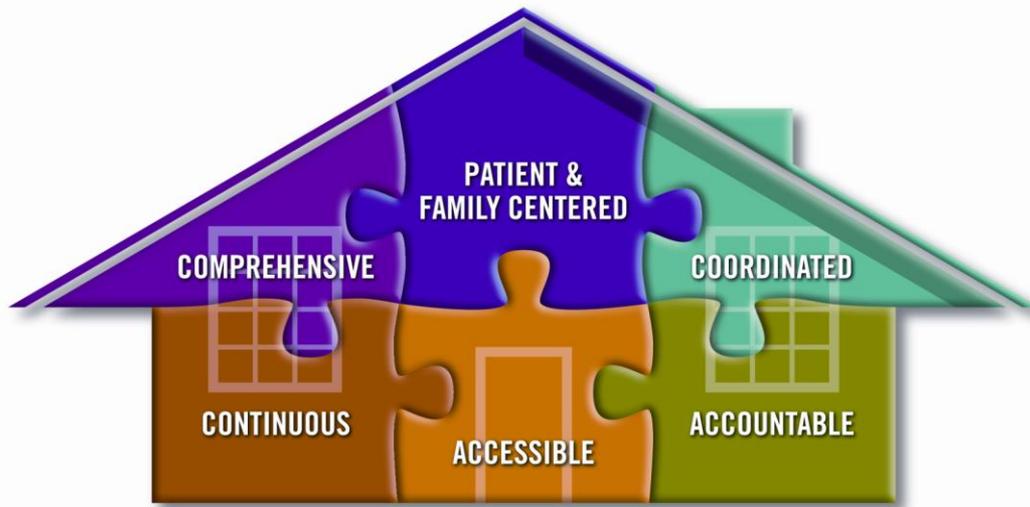
- HB 2009 established the PCPCH Program:
 - Create access to patient-centered, high quality care and reduce costs by supporting practice transformation
- Key PCPCH program functions:
 - PCPCH recognition and verification
 - Refinement and evaluation of the PCPCH standards
 - Technical assistance development
 - Communication and provider engagement
- Goals:
 - All OHA covered lives receive care through a PCPCH
 - 75% of all Oregonians have access to a PCPCH by 2015
 - Align primary care transformation efforts by spreading the model to payers outside the OHA

PCPCH Program Timeline



Oregon's Primary Care Home Model

- The PCPCH model is defined by six core attributes, each with specific standards and measures.
- There are 10 “must pass” measures all clinics must meet.
- Clinics can achieve three different Tiers of recognition depending on the criteria they meet.



Core Attribute 1: ACCESS TO CARE

“Health care team, be there when we need you”

Must Pass Measure Intent:

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

- Patients, caregivers and families get clinical advice from a live person at all times
- Decreases emergency and urgent care utilization

Example:

Business and After hours calls answered by:

- Live person and referred to a clinician (or care team) for clinical advice
- On-call provider or nurse
- Nurse triage live answering service (forwarded to on call clinician or nurse as appropriate)

Core Attribute 2: ACCOUNTABILITY

“Take responsibility for making sure we receive the best possible health care”

Must Pass Measure Intent:

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

- Demonstrate capacity to monitor clinical quality data to improve clinic performance and quality improvement

Example:*

- Colon Cancer Screening (NQF0034)
- Diabetes Care: HbA1c testing (NQF0057)
- Diabetes Care: HbA1c control (NQF0575)
- Adolescent well-care
- Developmental screening for 0-3 yrs. (NQF1399)

*Examples based on alignment with CCO Incentives Measures: www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Core Attribute 3: COMPREHENSIVE WHOLE PERSON CARE

“Provide or help us get the health care, information, and services we need.”

Must Pass Measure Intent:

3.B.0 - The PCPCH routinely offers the following:

- Acute care
- Management of chronic conditions and coordination of care
- Office-based procedures
- Diagnostic tests
- Patient education and Self Management Support

Must Pass Measure Intent:

3.C.0 - The PCPCH has a screening strategy for mental health, substance abuse and developmental conditions with documentation for on-site and local referral resources:

- Associated with improved health outcomes
- Core component of whole person primary health care

Core Attribute 4: CONTINUITY

“Be our partner over time in caring for us.”

Must Pass Measure Intent:

4.A.0 - PCPCH reports the % of active patients assigned to PCP/team

4.B.0 - PCPCH reports the % of patient visits with assigned PCP/team

- Promote patients' relationship with PCP/team
- Shared responsibility and communication

Example:

- Integration of team-based care
 - Allows team approach for comprehensive, continuous patient care
 - Allows for provider coverage
 - Allows for enhanced communication and coordination of patient care
- Empanelment
 - Appropriate work distribution
 - Understand supply/demand

Core Attribute 4: CONTINUITY

“Be our partner over time in caring for us.”

Must Pass Measure Intent:

4.C.0 - PCPCH maintains and updates a health record for each patient

- Need up-to-date records that are comprehensive
- Essential for safe transition of care between clinicians and facilities

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

- Appropriate care transition is important for patient safety
- PCPCH facilitates relationship and communication for hospital care

Example:

Written agreement with usual providers of hospital care that includes:

- Process for requesting admission
- Process for communication at time of admission, discharge and follow-up
- Performance expectations at time of admission, discharge and follow-up
- Process for record sharing

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.”

Must Pass Measure Intent:

5.F.0 - PCPCH has a process to offer or coordinate hospice and palliative care and counseling

- Responsibility of PCPCH to coordinate end of life care
- Ensures that the patients wishes are documented and being met, when the time comes

Example:

- Care coordination around:
 - Palliative care discussions with patient and family
 - Coordination of services
- Group visits for POLST discussion and end of life planning
- Documentation in EHR for end of life care resources

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.”

Must Pass Measure Intent:

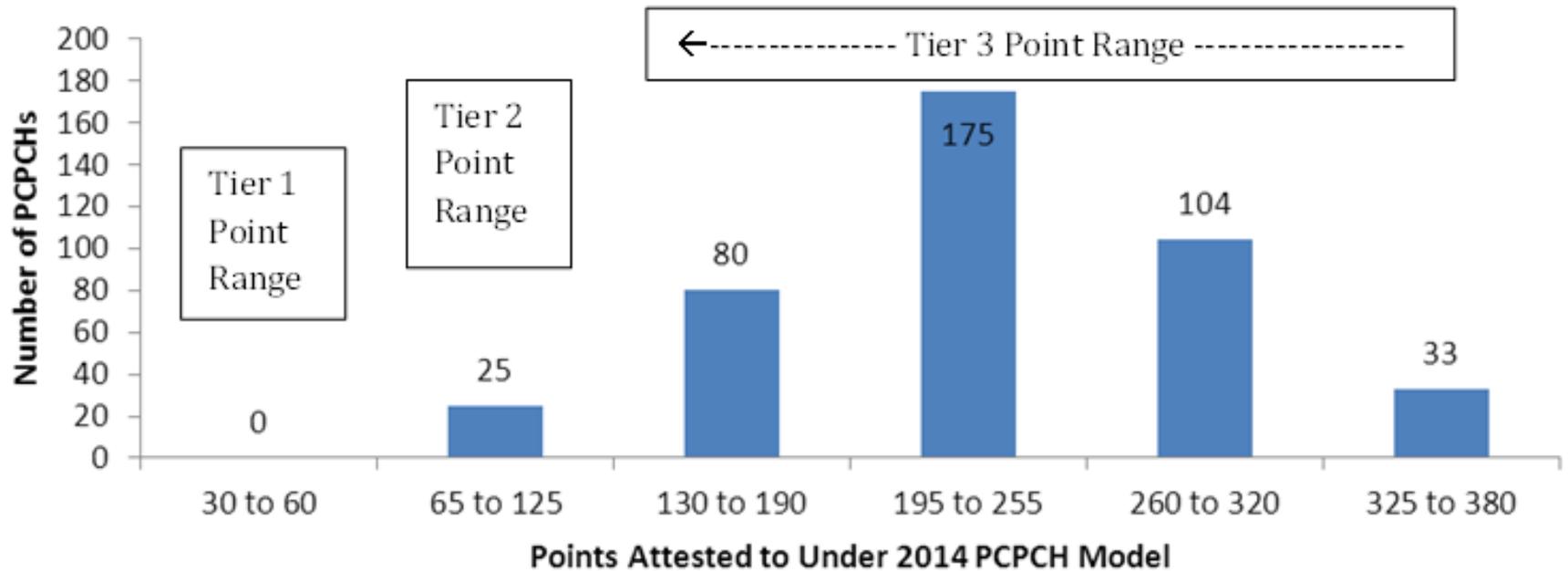
6.A.0 - PCPCH offers language interpretation services, either by:

- Providers who speak a patient and family’s language at time of service
- In-person interpreters
- Telephonic trained interpreters

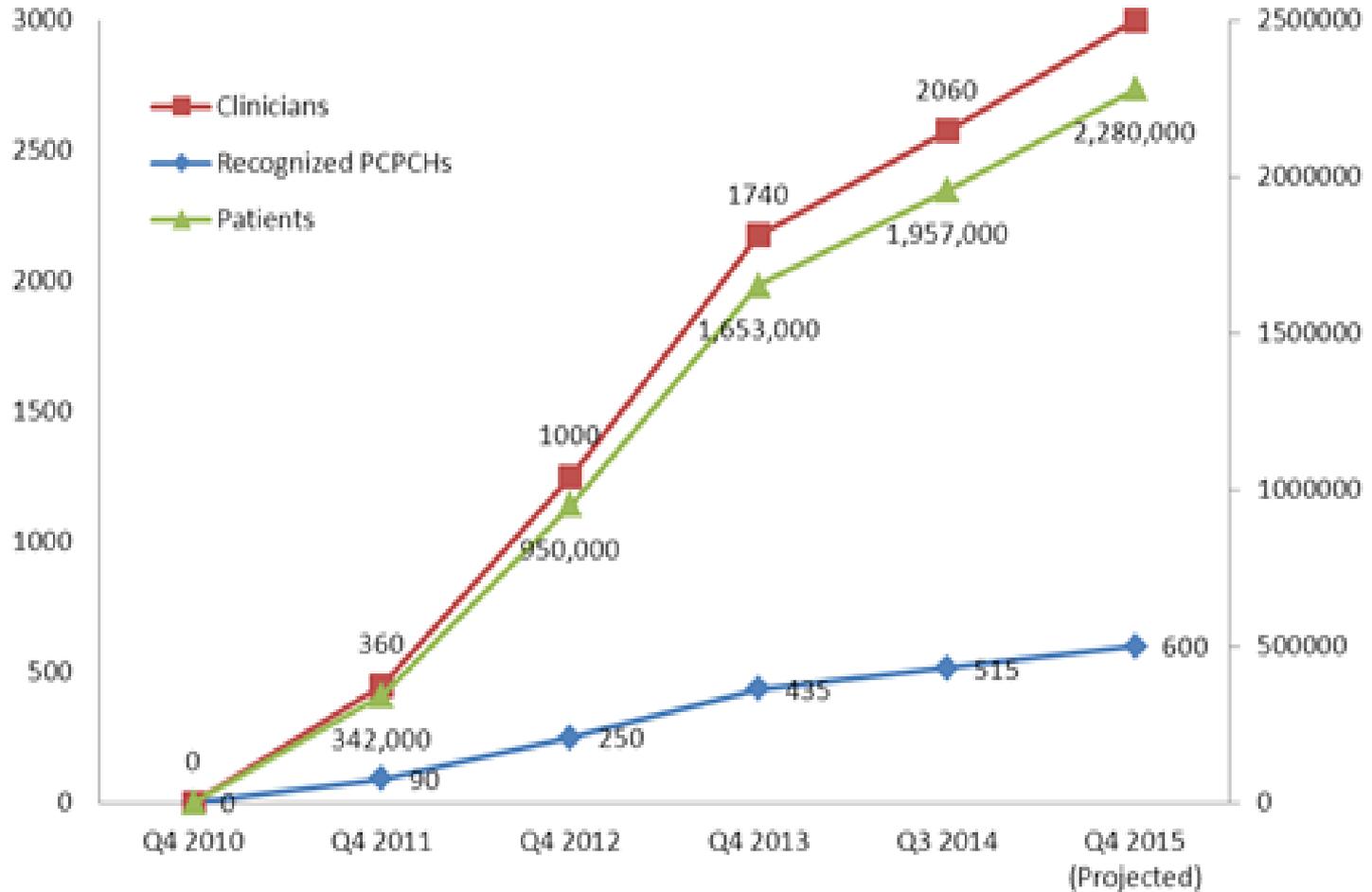
Example:

- Update hiring policies to include certified bilingual personnel
- Contract with interpretive service
- Use EHR to document patient language preference
- Offer translated written materials

Distribution of Points by PCPCHs under 2014 Model



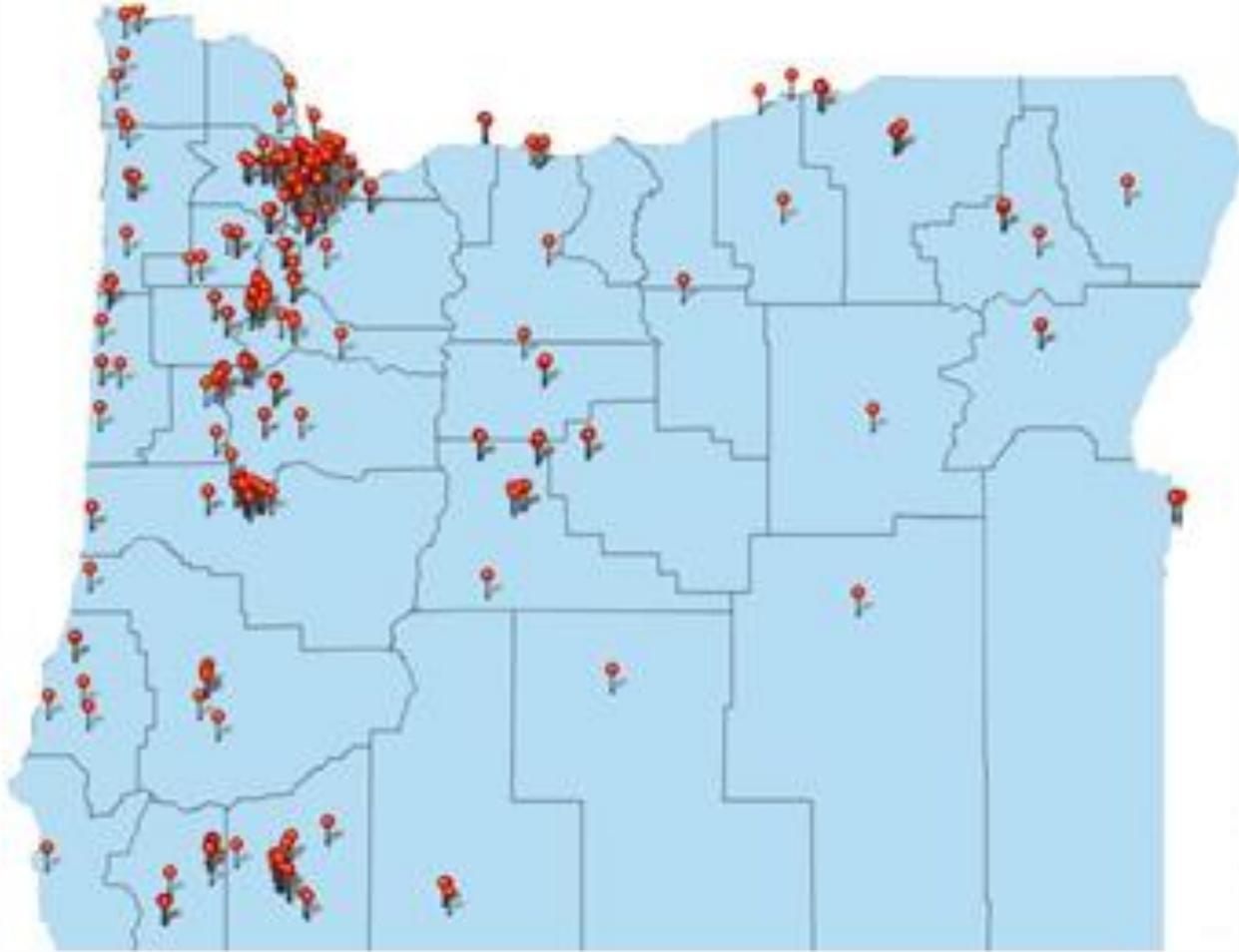
Practices, Clinicians and Patients - PCPCH Program 2010-2015



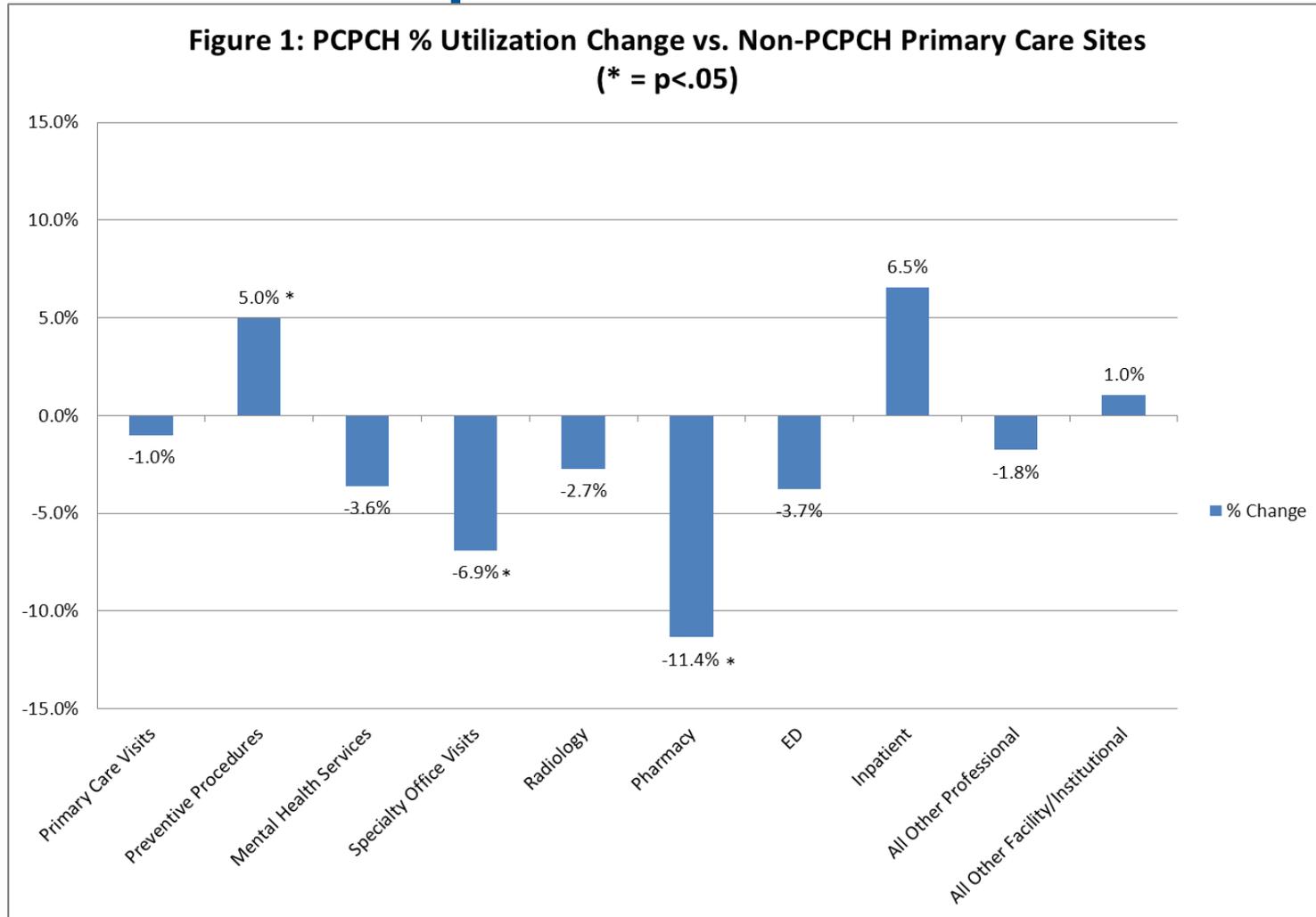
What do PCPCHs look like?

- **Staffing**
 - Average # providers = 5.1 (1-39 FTE)
 - Average # other clinical staff = 9.4 (0-70 FTE)
 - Average # annual visits = 14,539 (229-134,000)
- **Services**
 - Majority serve adult and pediatric populations
 - Majority provide obstetrics care
 - < 20% offer CAM
- **Ownership**
 - Nearly half owned by a larger system
 - 40% independent and unaffiliated
 - About 10% independent but in alliances
- **Implementation**
 - Over 80% (N=252) of survey respondents needed to add new services in order to implement the model

Where are PCPCHs?

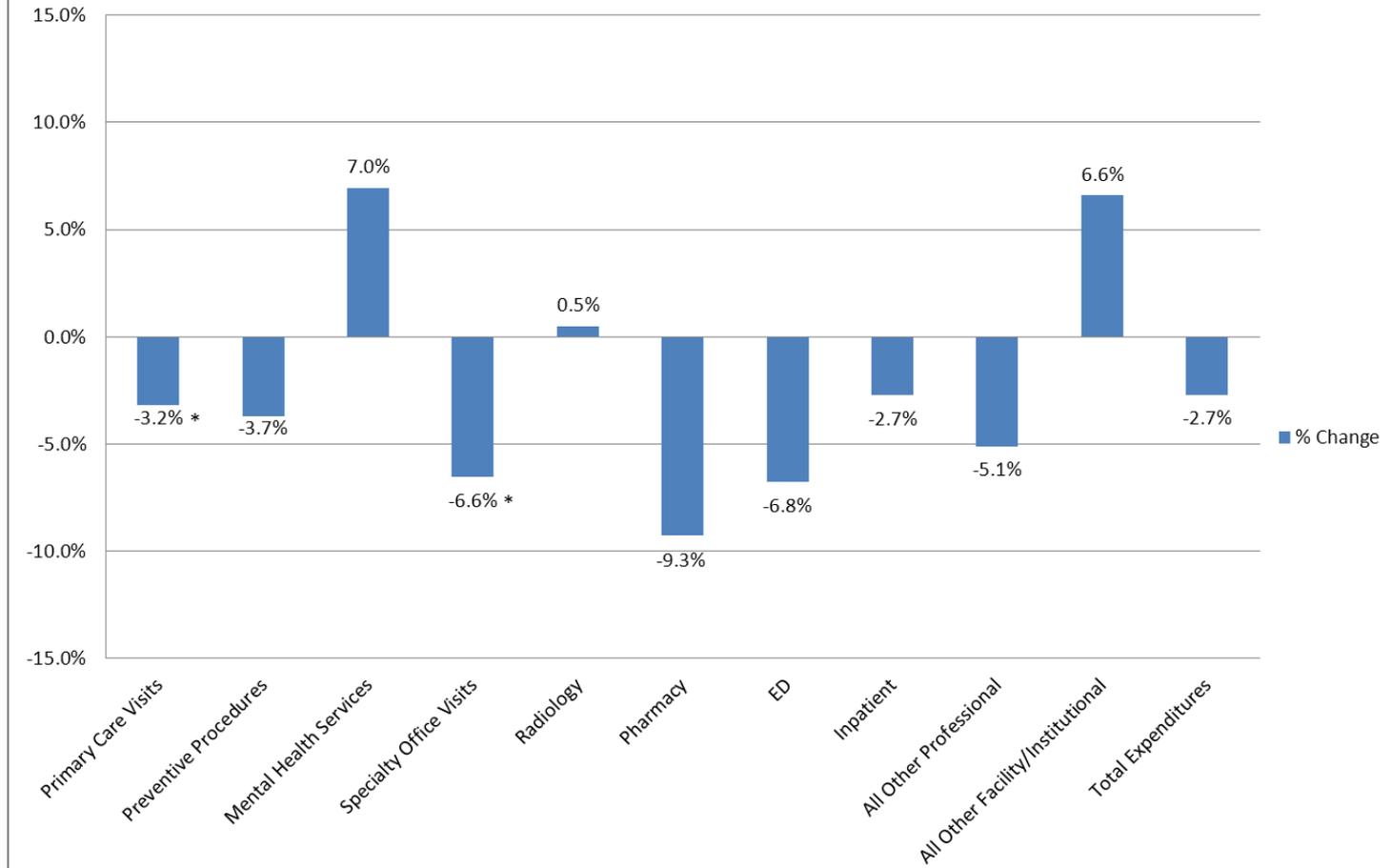


Impact on Utilization



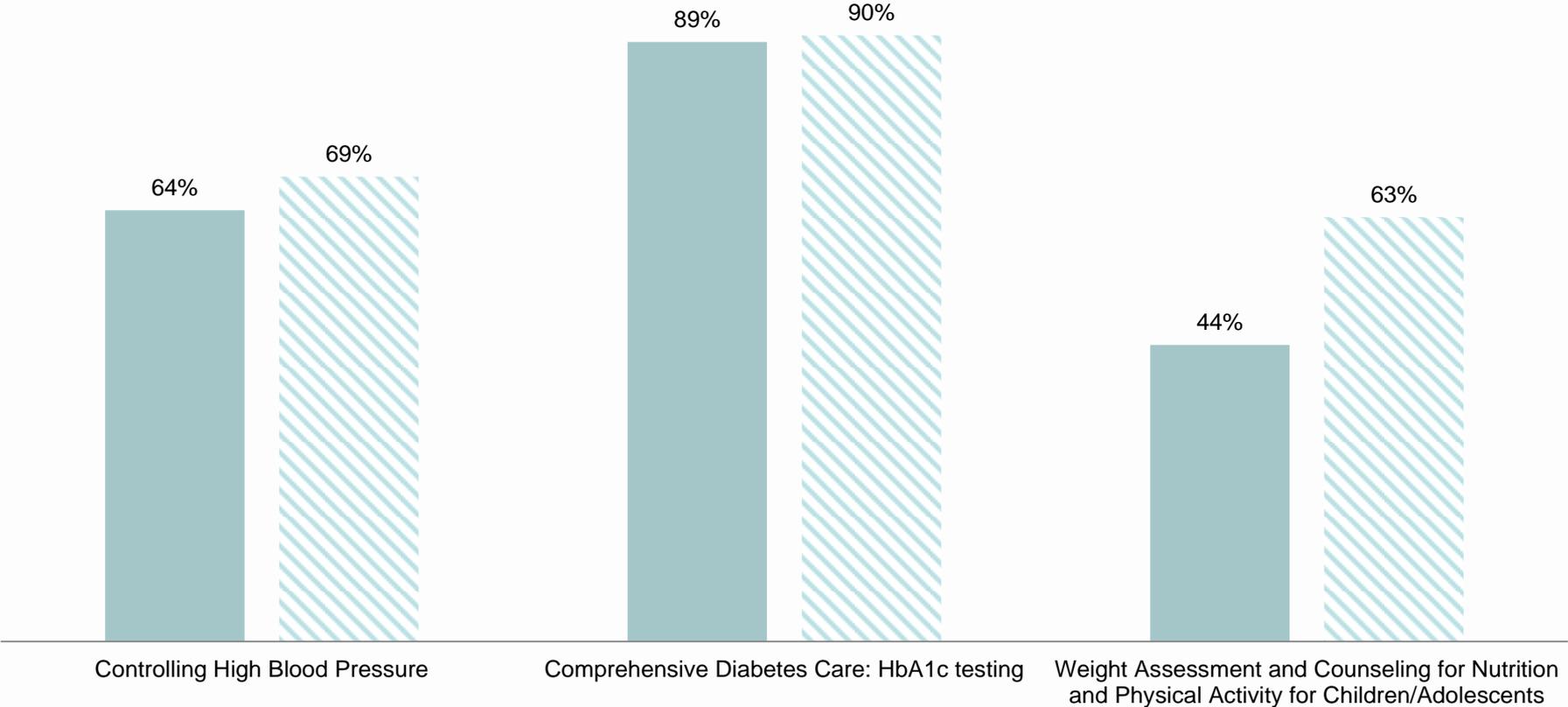
Impact on Expenditures

Figure 2: PCPCH % Expenditure Change vs. Non-PCPCH Primary Care Sites
(* = p<.05)



Clinical Quality Measures

■ HEDIS 2014 National 50thpercentile (Commercial) ▨ PCPCH



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 3 rd , 4 th , 5 th and 6 th 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.*

Provider Perceptions

Improving outcomes

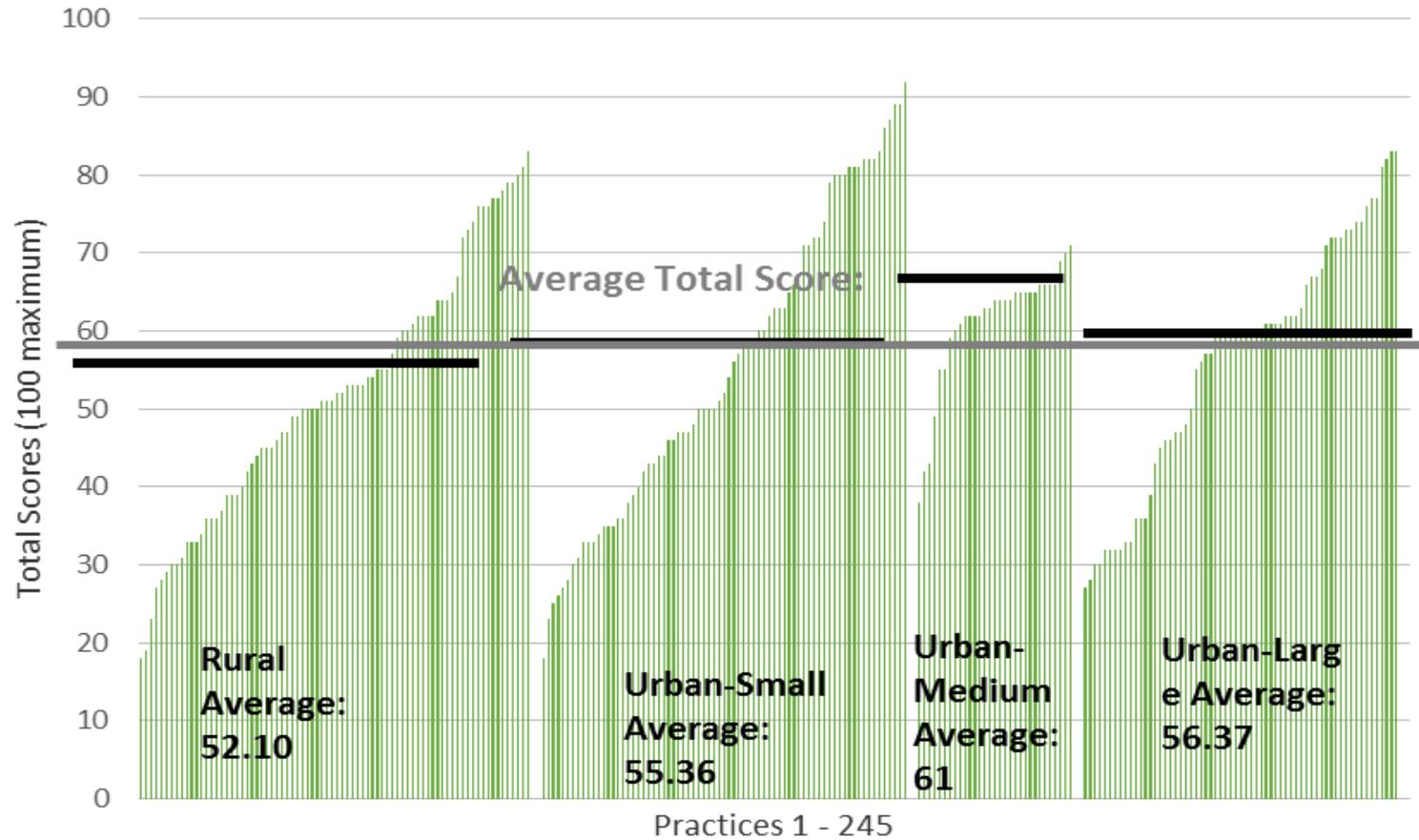
- 85% feel the model is helping their practice increase the quality of care

Improving access and experience of care

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

PCPCH Total Attribute Scores

Total Scores, Urban/Rural Categorization (N=245)



Most Common and Least Common Attested To Measures

Standards Attested to by 90% or more of PCPCHs 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

Most Common and Least Common Attested To Measures

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

Verification Site Visits

- Launched in September 2012
- Conducted more than 80 site visits to-date
- Goals:
 - Verification
 - Assessment
 - Collaboration
- All recognized practices will be visited within five years
- Site visit teams:
 - Compliance specialist
 - Practice Enhancement Specialist
 - Clinical Transformation Consultant
- Before the visit:
 - Site visit team will conduct a pre-visit call
 - Clinics have about 5-6 weeks to prepare for site visit
- After the visit:
 - 90 days to draft an improvement plan (if needed)
 - OHA provides TA for all clinics and coordinates with other TA sources

Recent Key Activities

- Focus on technical assistance
 - Patient-Centered Primary Care Institute
 - Site visits: clinical champion/practice coach team approach
- 3 STAR designation
 - Winding Waters Clinic in Enterprise was awarded the 1st 3 STAR designation in the state in June 2015.
- Payment Reform
 - 2013 Multi-payer agreement
 - SB 231

Legislative Updates from the 2015 Session

- SB 231
 - Passed both the Oregon Senate and the House, currently in Committee
 - Directs prominent carriers in the state as well as PEBB and OEBC to report the proportion of their expenses allocated to primary care by the end of 2015.
 - OHA will work with the Department of Consumer and Business Services to develop criteria and processes for the collection and reporting of these data.
 - OHA will convene a primary care payment reform collaborative to develop and share best practices around reimbursement and investments in primary care that support and facilitate health care innovations and improvements.

Legislative Updates from the 2015 Session

- SB 832
 - Passed in the Oregon Senate, currently in House Committee
 - Requires the OHA to develop standards for achieving the integration of behavioral health services and physical health services in PCPCHs and behavioral health homes
 - Defines behavioral health home as a mental health disorder or substance use disorder treatment organization that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.
 - Defines integrated health care and behavioral health clinician
 - Allows providers in PCPCHs and behavioral health homes to use billing code applicable to the behavioral health and physical health services that are provided.

What's Next for PCPCH Program

- Continued focus on technical assistance
- Program Evaluation
 - Case study of 30 exemplary PCPCHs
- 2014 Annual Report
- PCPCH Standards Advisory Committee
 - Meeting from June – November 2015 to review the model
 - Focus on behavioral health & primary care integration

Thank you!

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