



# Patient-Centered Primary Care Home Program Update

August 2019

## Growing evidence for Patient-Centered Medical Homes



A recent [Health Affairs blog post](#) reviewed the increasing amount of evidence of the benefits of the NCQA patient-centered medical home model due to characteristics such as:

**Focusing on prevention and chronic disease management:** The [American Journal of Managed Care \(2018\)](#) found that NCQA PCPCHs saved Medicaid \$214 per month for HIV patients with diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, or behavioral disorders by ensuring that these high-needs patients got the low-cost treatments they needed to prevent high-cost care.

**Incentivizing quality improvement:** The [Patient-Centered Primary Care Collaborative \(2018\)](#) reported that the Medicare Shared Savings Program accountable care organizations (ACOs) with more NCQA PCMHs—which had clear incentives to improve on cost and quality—had greater average savings and higher quality on health promotion, health status, prevention, and chronic disease management (including pneumococcal vaccinations, tobacco cessation, depression screening, and diabetic and coronary artery disease measures) than those with fewer or no PCPCHs.

In addition, the article examined the differences between these evaluations and earlier ones that did not find benefits to the PCMH model (such as the widely cited [2014 JAMA study](#)), noting that such studies assessed practices with no financial incentives or rewards for improvement. These studies were also conducted prior to updates to NCQA standards emphasizing pediatrics, health information technology, clinician-patient collaboration, behavioral health care integration, team-based care, high-need populations care management, and patient and family involvement—all of which are components of Oregon’s own PCPCH program. Further evidence of the positive impact of these PCPCH model features have been made available by the [National Committee for Quality Assurance](#).

## The importance of patient experience

With the many barriers that patients face in accessing high-quality care, it may come as a surprise that many Americans purposely avoid seeking medical care even when experiencing major health problems.

A [2015 qualitative study](#) examined the self-reported reasons that patients avoid medical care and found that, among traditional barriers such as cost and time constraints, over one-third of the 1,369 participants reported unfavorable evaluations of the process or outcomes of seeking care—the most frequent of which had to do with their perceptions and experiences with providers.

The most common negative perceptions included...

- Lack of follow-up from providers
- Difficulty communicating with providers
- The manner and language use by providers
- Not feeling listened to or cared about
- Concerns of not being taken seriously
- General mistrust
- Feeling that providers are too busy



The connection between patient experience and healthcare outcomes is well-established. According to the Agency for Healthcare Research and Quality, positive patient experiences have been associated with improved prevention, disease management, adherence to medical advice, self-management, quality of life, and health outcomes. It is for this reason that many of the PCPCH standards, including the must-pass Standard 6.C.0 encourage clinics to focus on improving the experience of their patients. The links below from the Patient-Centered Primary Care Institute are some of the many resources available for improving patients' experiences in healthcare.

- [Measuring and improving the patient experience of care](#)
- [How to use patient experience of care surveys in your practice](#)

## Helpful Resources for PCPCHs



### The Patient-Centered Primary Care Institute

The [Patient-Centered Primary Care Institute](#) is a great resource for current or future PCPCHs looking for further guidance on the PCPCH model. They provide useful information, tools, and resources including training modules for the 2017 PCPCH Standards, technical assistance, and guidance around specific measures.



## The Patient-Centered Primary Care Collaborative

The [Patient-Centered Primary Care Collaborative](#) is a nation-wide collaborative that works to promote policies and share best practices that support growth of high-performing primary care organizations. Their website includes free [PCPCC Webinars/Videos](#) on patient-centered services and practices.



## The Institute for Healthcare Improvement

The [Institute for Healthcare Improvement](#) is a nation-wide organization that provides frameworks, tools, resources, and training modules for healthcare providers wishing to improve their practices. Topics include Chronic Care Management, Complex & Social Needs, Health Equity, Person- and Family- Centered Care, Provider Burnout, etc.

## Coming Up: Events and Trainings

### CCO 2.0 Webinar

Join OHA on Thursday, August 22 from 12:00 p.m. – 1:00 p.m. PDT.

The Oregon Health Authority (OHA) will share its communications plan for members with changes to their CCO choices, the next steps in the CCO awards process, and what stakeholders and providers can do to support members during this transition.

Register at <https://register.gotowebinar.com/register/9167980141055966733>

Attendees can submit questions for the presenters during the registration process.

Questions? Contact Maria Vargas, Regional Outreach Coordinator at [Maria.Vargas@dhsoha.state.or.us](mailto:Maria.Vargas@dhsoha.state.or.us).

### Free Behavioral Health Integration Event

#### Innovative Care for Behavioral Health and Substance Use Disorders: Payment, Data and System Strategies

This one-day event will offer peer-to-peer learning on how CCOs, primary care practices and specialty behavioral health organizations are integrating behavioral health. Topics will include the benefit of integration in reducing emergency department use amongst those with mental illness, effective use of data, and substance use disorder strategies.

**When:** October 30, 2019, 8 a.m.–4 p.m.

**Where:** Salem Convention Center (tentative)

**Audience:** CCO behavioral health directors, CCO medical directors, primary care practices, CMHPs, behavioral health providers

**Registration:** <https://www.eventbrite.com/e/innovative-care-for-behavioral-health-and-substance-use-disorders-payment-data-and-system-strategies-tickets-66411513625>

**Contact:** Summer Boslaugh (summer.h.boslaugh@dhsola.state.or.us, 503-753-9688), Transformation Analyst, OHA Transformation Center.

## Webinar: Controlling high blood pressure (with no-cost CME)

The Transformation Center invites clinicians who serve Oregonians to a recorded free CME-accredited webinar focused on controlling high blood pressure. The webinar features Dr. Mark Backus, a Bend physician who was named a hypertension control champion by the Centers for Disease Control and Prevention Million Hearts® campaign.

**When:** Available on demand through September 20, 2019.

**Webinar registration (includes pre-test questions for CME):**

<https://attendee.gotowebinar.com/register/9066652441072643329>

**More details:** <https://www.oregon.gov/oha/HPA/CSI-TC/Documents/Controlling-High-Blood-Pressure-Webinar.pdf>

After this 1-hour presentation, participants will be able to:

- 1) Review CCO hypertension metric specifications
- 2) Explain the implications of the SPRINT blood pressure study and new American Heart Association guidelines
- 3) Illustrate the proper body position for taking blood pressure
- 4) Identify ways for providers to improve blood pressure control
- 5) Share strategies for clinics to improve blood pressure control
- 6) Describe how to identify patients who require referral or special testing for their hypertension

## Free online trauma-informed approach training modules

Trauma Informed Oregon has created four FREE self-directed online training modules on the foundations of a trauma informed approach. Each module includes a content video, an additional “Voices from the Community” video that highlights how trauma informed care is being implemented in a specific community, additional resources that you can read to further your learning, questions that can be used for personal reflection, and a content quiz followed by a certificate of completion. The four modules have a total run time of about 75 minutes and can be completed at your own pace.

- [Introduction to Trauma Informed Care Training Modules](#)
- [Module 1: What is Trauma Informed Care?](#) walks you through the principles that serve as the foundation for trauma informed care. This module takes approximately 30 minutes to complete.
- [Module 2: Why is Trauma Informed Care Important?](#) walks you through why trauma informed care should be incorporated into organizations and systems. This module takes approximately 15 minutes to complete.
- [Module 3: Trauma Specific, Trauma Sensitive, Trauma Informed](#) walks you through the basic differences between trauma specific services and trauma informed care. This module takes approximately 15 minutes to complete.
- [Module 4: A Brief Overview of NEAR Science](#) walks you through the collection of fields of study that include Neurobiology, Epigenetics, ACEs and Resilience. This module takes approximately 15 minutes to complete.

## Questions?

We are here to help! Contact us at [PCPCH@dhsoha.state.or.us](mailto:PCPCH@dhsoha.state.or.us).

## About the Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCH) are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. The PCPCH Program administers the application, recognition, and verification process for practices applying to become Patient-Centered Primary Care Homes. The program is also working with stakeholders across Oregon to support adoption of the primary care home model. For more information visit [www.PrimaryCareHome.oregon.gov](http://www.PrimaryCareHome.oregon.gov).

*The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for transformative, whole-person, and evidence-based care.*