



Patient-Centered Primary Care Home Program Update

December 2019

Celebrating PCPCH successes in 2019



This has been a big year for the PCPCH program! Primary care practices of all shapes and sizes have been working hard to improve the accessibility and quality of their services with the aim of delivering truly patient-centered care. Below are just a few of the milestones that clinics across the state accomplished in 2019:

28 clinics became PCPCHs for the first time

62 PCPCHs increased their tier level

30 PCPCHs were awarded 5 STAR recognition for the first time

In addition to the tremendous efforts of our practices, the PCPCH program has visited over 90 clinics this year to uphold program standards, gather best practices, and offer clinic-level guidance and technical assistance on how to improve care (see “Extra guidance: PCPCH verification site visits”). The insights gathered at these visits and from additional stakeholders helped to inform discussions held by the Standards Advisory Committee, which had their final meeting this month and will soon release their official recommendations for the next iteration of the PCPCH model and standards (see “Wrapping up the Standard Advisory Committee meetings”).

Wrapping up the Standards Advisory Committee meetings

The 2019 PCPCH Standards Advisory Committee began meeting in July to discuss potential changes, additions, and improvements to the current standards and overall model.

The first committee convened nine years ago when the PCPCH program was first established by HB 2009 in order to develop the core attributes, standards, and measures of the PCPCH model of primary care delivery. The Oregon Health Authority periodically re-convenes the committee to review best practices, clarify existing measures, and refine the model based on lessons learned and current literature. Like previous committees, the [2019 committee](#) was made up of a diverse group of health system representatives including patient advocates, providers, hospitals, health plans, and coordinated care organizations (CCOs)—all committed to advancing health, improving health care, and lowering health care costs in Oregon.

In line with recent health system transformation efforts, this year's discussions included increased integration of value-based payments (VBPs), substance abuse disorder (SUD) treatment, social determinants of health, oral health, and health equity into the PCPCH model. Other new topics included clinic staff vitality and alternative visit types (see this month's PCPCH Spotlight).

The committee report, including their final recommendations, will be made available on the [PCPCH Standard Advisory Committee webpage](#) in the coming months. The program will continue to accept public commentary by email on the standards discussed or other aspects of the model through early 2020. We appreciate your feedback as we work to improve the Patient-Centered Primary Care Home model!

PCPCH Spotlight: MCMC Internal Medicine

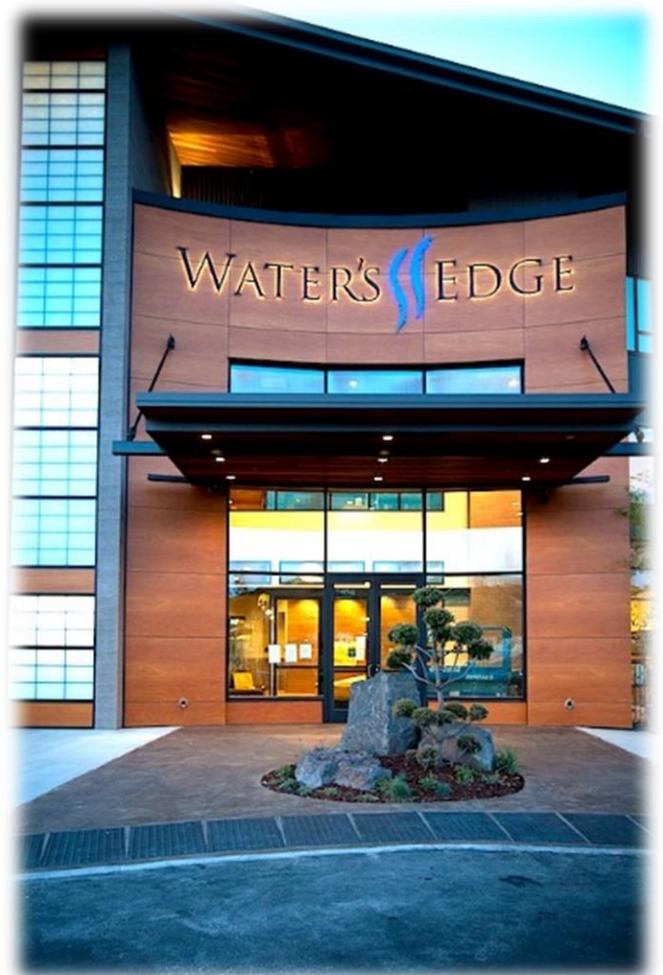
Making it to a doctor's appointment isn't always easy. Work schedules, mobility issues, health conditions, and transportation are some of the many barriers that patients face in accessing care via a traditional clinic visit. It is for this reason that **Mid-Columbia Medical Center's (MCMC) Internal Medicine Clinic at Water's Edge** has worked hard to develop alternative visit types to meet the health needs of their patients.

With a change-ready culture, MCMC Internal Medicine has a long and rich history of bringing healthcare directly to patients in The Gorge community. They provide an extensive menu of services from traditional in-office visits to alternative pathways of care including:

Traditional home visits completed by a provider in a patient's home. These visits can apply to either acute events that would cause leaving the home to be too much of a burden or can span a patient's long-term relationship with our office over many years.

Residential care of patients in local assisted living facilities and adult foster care programs. While many of these patients are able to come to Water's Edge for their care, for others leaving their home base is a burden. MCMC IM visits these patients directly in their facilities where they provide direct, on-site, primary care by multiple providers from the office. This is often done in concert with MCMC Home Health Services.

Post-acute care service line. When a patient is discharged from the MCMC IM hospital and must transition to a skilled nursing facility, their care is overseen by a skilled nurse practitioner and physician in the clinic. Together they are able to supervise patients' improvement and recovery after acute illness while providing daily face-to-face care coordination with their usual primary care provider. This allows patients to have the best possible transition of care and a "soft landing" up returning to their home.



Extra guidance: PCPCH verification site visits

In addition to submitting an online attestation every two years, all clinics wishing to become or remain PCPCHs are required to agree to a potential site visit. Since the PCPCH program is attestation-based, site visits are mandated by the Oregon Administrative Rule in order to uphold the PCPCH standards.

Site visits are managed by PCPCH site visit teams which include a Verification Specialist, Improvement Specialist, and a Clinical Transformation Consultant (provider) when available. During a site visit, the PCPCH site visit team reviews documents, interviews providers and other staff, and conducts a patient focus group with the overall aim being to:

1. Verify that the practice and patient experience in the practice accurately reflects the measures attested to
2. Assess care delivery and health care team processes to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH
3. Collaborate to identify areas of improvement and to connect clinics with resources, colleagues, and technical assistance

After the site visit, the site visit team provides the clinic with a comprehensive report and offers technical assistance for up to 6 months.

Clinics are selected on a yearly basis to receive these site visits. All clinics applying for 5 STAR recognition must receive a site visit before being recognized as such. The rest of the site visits in a given year are conducted with randomly selected clinics from various tier levels. PCPCH staff have visited more than 320 practices since 2012.

CCOs required to provide a Per-Member-Per-Month payment to all PCPCHs beginning in 2020

Earlier this fall the Oregon Health Authority (OHA) signed contracts with organizations that will serve as Coordinated Care Organizations (CCOs) for the Oregon Health Plan's nearly 1 million members for the next five years. In these contracts CCOs are required to provide a per-member-per-month (PMPM) payment to PCPCHs in their network based on tier level. A PMPM dollar amount is not specified, but it must be "sufficient enough to aid in the development of infrastructure and operations needed to maintain or advance PCPCH tier level." The PMPM payment amount must increase each year of the 5-year contract.



Oregon has a long history of health system transformation, including substantial efforts to move away from traditional fee-for-service health care payments to payments based on value that support positive health outcomes for Oregonians and cost savings. Movement toward value-based payment (VBP) is supported nationally, as it is broadly accepted that the status quo fee-for-service payment model promotes a fragmented health system unable to provide patient-centered, whole-person care.

Please check with your CCO representative for more information and to inquire about other value-based payments that may be available beginning in January 2020.

Technical Assistance Opportunities

TA for Health Information Technology: TA is available for both of the projects listed below in the form of one-on-one support, user group collaboration with a cohort of users on your EHR, and documentation. Enrollment is ongoing, from now through June 2020. Please contact Claire Ramey at rameycl@ohsu.edu to begin!

Health Information Exchange (QRDA III format): Technical assistance is now available to support quality reporting and health information exchange (HIE) utilization. The OHA Transformation Center and Office of Health Information Technology has partnered with the Care Management Plus team at Oregon Health & Science University. TA is available to clinics to support the generation of accurate clinical quality metric (CQM) reports in QRDA III (Quality Reporting Data Architecture Category Three) format and HIE utilization.

Clinical Quality Metrics Registry (QRDA I): The QRDA I Technical Assistance project is part of the Oregon Health Authority's (OHA) Clinical Quality Metrics Registry project. To ensure the CQMR receives the best possible data, OHA will transition the CCO incentive program reporting requirements to QRDA I format, a patient level reporting format. In partnership with OHSU, technical assistance is available.

TA for Alcohol & Opioid Management: Clinics are welcome to join one or both of the projects below to receive free technical assistance in addressing unhealthy alcohol and opioid use. Scope and duration will be modified to fit the needs of each enrolled clinic. See [flier](#) for more information. Questions? Contact Alissa Robbins at Alissa.Robbins@dhsosha.state.or.us.

ANTECEDENT: ANTECEDENT (pArtnerships To Enhance alCohol scrEening, treatment, and intervention) is a 3-year study, funded by AHRQ, to address *unhealthy alcohol use* in primary care. ANTECEDENT is aligned with the Oregon Health Authority (OHA) Coordinated Care Organization (CCO) incentive metric for Screening, Brief Intervention, and Referral to Treatment (SBIRT) for unhealthy alcohol and drug use.

PINPOINT: The PINPOINT (Pain and Opioid Management) Collaborative is a 3-year CDC-funded collaboration that focuses on the complex and changing nature of the opioid overdose epidemic and highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach. ORPRN will support clinics to address chronic pain management and opioid prescribing.

Questions?

We are here to help! Contact us at PCPCH@dhsosha.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.

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.