



Patient-Centered Primary Care Home Program Update

February 2019

We're off the starting blocks for what will be a very exciting year for the Patient-Centered Primary Care Home Program! With new practices applying and over half of our 650 PCPCHs due to re-attest this quarter, our staff is ready to support our community of clinics during what will be a busy few months for everyone. This year we'll also be revising and expanding the official PCPCH standards/measures with the help of a PCPCH Standards Advisory Committee made up of leaders from our PCPCHs, health care organizations, and other community partners. See the "Become Involved" section of this update for more information on how you can join this committee and help shape the future of the program!

PCPCH Spotlight: St. Charles Family Care in Sisters

Though all practices recognized as PCPCHs must meet high standards for quality care, some go above and beyond in their level of dedication to the model. At St. Charles Family Care in Sisters, Oregon, staff have worked hard to empower their patients through facilitating trusting relationships with their care teams.

Having adopted a team-based care model, St. Charles Family Care assigns patients to teams that might include a behavioral health consultant, a community health educator, a nurse care coordinator, and a clinical pharmacist—all of whom collaborate with the provider on how best to improve their health and well-being. This allows issues to be addressed that fall outside of the typical spectrum of clinical care. As described by one of the clinic's behavioral health consultants: ***"We do a lot of problem solving. It's teamwork, working as a tribe and thinking outside the box and outside the clinic."***



Communication between patients and their care teams is frequent and staff take an active role in contacting patients after missed appointments or when something seems off. Further, St. Charles Family Care urges patients—as the most important members of their care teams—to take an active role in advocating for their health.

During a recent check-in, one patient with stage IV kidney disease felt comfortable communicating his fear of dialysis and asked the behavioral health consultant whether she might help him emotionally prepare via a visit to the dialysis center—a gesture that she met with understanding. *"I could have spoken to [him] about it, but it wouldn't have been as real," she said "[He] needed to see it with people [he] trusts."*

The results of this level of engagement are palpable. *"They're on my side," the patient said. "They're real people. They care [and] they listen."*

Extra Guidance: Meeting Standard 6.D.

Clarifying patient and family roles and responsibilities as part of a care team is an effective way to build long-lasting and trusting relationships—particularly when this information exchange occurs before or during an initial visit. Available evidence shows a strong association between information sharing and (1) patient empowerment, (2) self-management through better adherence to medications, (3) improved chronic disease control and (4) reduced costs of care.

In light of this, clinics interested in achieving 6.D.1 are required to provide a written document or other educational materials that meet the intent of this measure to patients and families at the onset of the care relationship. This document is not to be confused with the standard health history intake forms or notice of privacy practices. Rather, these materials (often a brochure or handout) must include:

1. PCPCH and patient/family rights
2. Complaint and grievance procedures
3. Roles and responsibilities

More information about this measure can be found on pages 104-105 of the [PCPCH Technical Assistance Guide](#). And as always, feel free to email PCPCH@dhsosha.state.or.us for clarification on this and other PCPCH measures.

New in Research: Supporting Medical Assistants in PCPCHs



A recent cross-case comparison study examined the shifts in Medical Assistant (MA) responsibilities among practices participating in patient-centered medical home transformation initiatives, including the attitudes of MAs towards this shift and barriers/facilitators to these role changes.

RESULTS:

Shift in roles: MA roles and responsibilities changed from a mostly reactive role (completing tasks dependent on physician orders during the patient visit and facilitating patient flow through the office) to a

more proactive one (conducting pre-visit planning, engaging in the overall care for patients, and assisting with population management).

Attitudes: MAs differed in their attitudes about increased responsibilities, with some welcoming the opportunity to take on expanded roles, others resenting their increased responsibilities, and some expressing insufficient understanding regarding why new tasks and procedures were being implemented.

Barriers to successful transition...	MAs felt supported when they...
<ol style="list-style-type: none"> 1) insufficient understanding of the PCMH concept 2) lack of time for added responsibilities 3) additional workload without additional compensation 4) disparate levels of medical knowledge and training 5) reluctance of clinicians to delegate tasks 6) uncertainty in making new workflow changes routine 7) staff turnover 8) change fatigue 	<ol style="list-style-type: none"> 1) understood how their responsibilities fit within broader PCMH practice transformation goals 2) received formal training in new tasks 3) had detailed protocols and standing orders 4) initiated role changes with small, achievable goals 5) had open communication with clinicians and practice leaders 6) received additional compensation or paths to career advancement

“Practice leaders need to be conscious of obstacles when they increase expectations of MAs, and they must be willing to invest time and resources into developing their MA workforce. An environment that allows open dialog with MAs and rewards and compensation that recognizes their increased efforts will help make expansion of MA roles occur more smoothly and efficiently.”

Full Research Publication: <https://www.jabfm.org/content/jabfp/31/2/226.full.pdf>

Jeanne M. Ferrante, Eric K. Shaw, Jennifer E. Bayly, Jenna Howard, M. Nell Quest, Elizabeth C. Clark and Connie Pascal. (March 2018). *Barriers and Facilitators to Expanding Roles of Medical Assistants in Patient-Centered Medical Homes (PCMHs)*. *Journal of the American Board of Family Medicine*: 31 (2) 226-235. DOI: <https://doi.org/10.3122/jabfm.2018.02.170341>

Become Involved:

Join our Standard Advisory Committee!

The Oregon Health Authority (OHA) is seeking nominations for the **2019 Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee**. This committee will provide OHA with policy and technical expertise on the PCPCH standards and measures for recognition. We are looking for motivated leaders who are committed to advancing health, improving health care and lowering health care costs in Oregon. Click **HERE** for more information about committee meetings and how to apply.

Applications are due on **February 22, 2019**.

Click **HERE** for more information about the Standards Advisory Committee.

“Transformation in Action” Newsletter

This newsletter provided by OHA’s Transformation Center includes stories about coordinated care organizations’ innovative work, highlights evidence-based best practices, and celebrates successes. To sign up, [subscribe to “OHA – Transformation in Action”](#) (under OHA Topics).

Coming Up: Events and Trainings

Webinar - Perinatal Depression Screening

February 21, 12-1 pm

The Oregon Pediatric Society is sponsoring a lunchtime webinar on peripartum mood disorders and postpartum depression screening. The webinar, led by pediatrician R.J. Gillespie, MD, MHPE, from The Children’s Clinic, will address:

- Importance of screening
- Enhancing provider understanding, utilization and implementation of standardized screening tools
- Educating providers in proper documentation, coding and billing of screening tools
- Building provider awareness of local community resources for evaluation and intervention

Register here: https://zoom.us/webinar/register/WN_1n5_5W9ORPGS2cemlycEDg

Whole Health in Populations Experiencing Mental Illness

The Oregon Rural Practice-based Research Network is inviting CCO-contracted clinicians, clinical staff and CCO staff to participate in a FREE 4-session webinar series on whole health for populations experiencing mental illness (MI). Sessions will focus on what clinicians and clinical teams can do to improve whole health for these populations, with the goal to reduce inappropriate ED utilization and hospital readmissions. Sessions will be delivered in a didactic format and include case examples from various parts of the state and interactive polling. All sessions will be delivered through the Zoom platform. Participants can log in from their office or home.

This 4-session cohort-based webinar series will include the following topics:

- Access to health care for populations experiencing mental illness
- Pain and pain management for those with mental illness
- Dental/oral health for MI populations, including examples of coordination/integration
- Sustaining clinician satisfaction when working with medically complex patients

Sessions will occur **April 10, April 24, May 8** and **May 22**

Register here - space is limited: <https://wholehealthinmipopulations.eventbrite.com>

See full details and schedule: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Whole-Health-MI-Populations-Webinars.pdf>

Innovation Café - Strategies for Addressing the Social Determinants of Health

The Oregon Health Authority Transformation Center is excited to announce the **2019 Innovation Café: Strategies for Addressing the Social Determinants of Health**. This FREE one-day event will engage health system leaders and key partners in peer-to-peer learning and networking to spread innovation, with the aim of addressing key social determinants of health. Best practices in health system innovation and collaboration with community-based organizations will be discussed through café-style project presentations and plenary sessions.

- **When:** June 5, 2019, 8 a.m.– 4 p.m.
- **Where:** Oregon Convention Center (tentative), Portland
- **Registration:** Registration will open in March. Please visit the Innovation Café website for additional information: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Innovation-Cafe.aspx>
- **Contact:** Reach out to Tom Cogswell at thomas.cogswell@state.or.us with any questions

Call for Project Presentations (Due March 22)

Much of the day will be spent in small-group table discussions, with informal 20–25 minute small-group table discussions with 15-25 participants. Presenters will share a short project overview using a one-page handout and will then facilitate a discussion with table participants (PowerPoint presentations not required). Project presentations should focus on linkages between the social determinants of health and health outcomes, health care costs, and/or partnerships with health organizations or health care providers. If you'd like to present a project, please make sure that it addresses either **housing, trauma, early learning/early childhood education, or food insecurity/diaper insecurity** and that it focuses on the Medicaid population.

Project presenters do not need to be employed by a health care organization and can submit a project on behalf of a non-health partner organization. Submissions of collaborative projects involving multiple organizations are encouraged. Please submit your brief project proposal at the following link: <https://www.surveymonkey.com/r/RVVJNZS>.

Questions?

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