



Patient-Centered Primary Care Home Program Update

January 2019

Happy New Year!

As the Patient-Centered Primary Care Home Program celebrates the end of its 9th year, we'd like to extend a big thank you to our community of over 650 practices committed to the vision of a health system that is accessible, accountable to its community, comprehensive, continuous, coordinated, and patient-centered. We hope that you will continue to leverage this program in improving the health of Oregonians and meeting your own goals for excellence!



2018 milestones...

- 24 practices were newly recognized as PCPCHs
- 178 practices renewed their PCPCH recognition
- 53 practices moved to a higher tier of recognition
- 21 practices were recognized as 5 STAR PCPCHs

PCPCH Spotlight: Samaritan Coastal Clinic

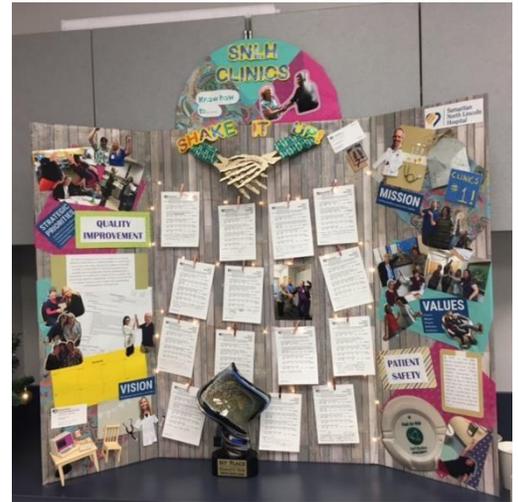
The Samaritan Coastal Clinic in Lincoln City has been working hard to change their culture to one of continuous process improvement, leveraging [Plan-Do-Study-Act \(PDSA\)](#) cycles as a regular strategy for testing changes. In July of 2018, they implemented [morning huddles](#) to improve communication and ensure that different types of staff are on the same page each morning. Staff became increasingly engaged, suggesting ways to improve patient care and/or the patient experience on a daily basis. With attendance now consistently high, the clinic is planning its next series of PDSA cycles to add daily huddle boards or [daily management boards](#). These boards will include current quality improvement work, an area to suggest quality improvement projects, quality metrics, the patient experience, staff shout-outs, and whatever else the team determines is important to them. The boards will also serve as a communication tool for daily workflow issues. "Staff is really excited because the goal is to cascade issues we cannot resolve ourselves up the chain of command daily. Unresolved issues will stay on the boards until they are addressed and everyone will know [the status of any given area] at a glance. The goal is to continue to empower staff and ensure everyone is easily able to assess where we are by checking the huddle boards."

Lisa Castle, a clinic administrator and one of the main drivers of continuous quality improvement at Samaritan Coast Clinic, notes that staff enthusiasm "has been truly inspiring. Staff are now ... suggesting ways to save money and/or new improvement projects which they want to work on as a team such as Par levels for ordering medications and supplies." One recent PDSA cycle involving their patient restroom alarm system had an employee pretend to be a patient in need. The test revealed that some boxes that had been placed on the countertop garbled the alarm which made it difficult for

staff to identify where the voice was coming from or what was being said – slowing their response time. The clinic is now taking measures to ensure the alarm box does not get blocked again.

“Our goal has been to challenge everyone to think outside the box, challenge the status quo (just because we have always done something a certain way does not mean it is necessarily the best way), to find joy in our work and to work towards making things better for both our patients and our caregivers through continuous quality improvement while working as a team-team patient” - Lisa Castle.

Extra Guidance: Achieving Standard 5.F. in a Pediatric Clinic



Pediatric practices applying for PCPCH first-time recognition and renewal alike often face confusion when navigating the must-pass Standard 5.F.0 – “PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.”

It is a fortunate thing that hospice and palliative care are rare needs among most pediatric populations. PCPCHs must, however, be prepared should the need ever arise. In the occasion that a pediatric patient can benefit from these services, they deserve the same level of access and coordination as an older patient. While we do not necessarily expect a pediatric practice to offer these services onsite, it is important that PCPCHs have a defined process to coordinate hospice and palliative care and counseling for any such cases. This usually includes a list of hospice or palliative care providers that patients would be referred to and a plan to communicate with said providers to the extent that the patient and/or their family is not left to try to arrange these services alone. We can all agree that our children deserve our preparedness in this regard!

New in Research: Patient-Centered Medical Homes and Diabetes

A 2018 cross-sectional study of over 1,250 primary care patients took a deep-dive look at which components of the Patient-Centered Medical Home Model contribute to patient adherence to diabetes management plans among individuals with type II diabetes. Results indicated that patients’ perceptions regarding access to their doctor (PCPCH Attribute 1: “Access to Care”) and their doctor’s knowledge of their medical history (PCPCH Attributes 4 & 5: “Continuity” & “Coordination and Integration”) are important factors in motivating patients to take an active role in their health and healthcare:

“Results of the study suggest that patients value their doctor’s comprehensive knowledge of their medical history; perhaps allowing patients to feel more confident and hence, trusting that their doctor is competent in delivering the best care based on their medical history and overall needs. Physicians/providers comprehensive knowledge of their patients’ health issues and life circumstances may lead to a more personalized care plan that meets the needs of the patient and takes into consideration their current level of self-management skills and resources available to them. Organizational access was also found to be an important factor in patient activation. Study results indicate that patients value the ability to quickly receive care and/or appointments.”

Full Research Publication: Bilello, L., Hall, A., Harman, J., Scuderi, C., Shah, N., Mills, J., & Samuels, S. (January 2018). Key attributes of patient centered medical homes associated with patient activation of diabetes patients. BMC Family Practice: <https://doi.org/10.1186/s12875-017-0704-3>

Coming Up: Events and Trainings

Integrated Behavioral Health Billing: Practice Perspectives

February 6, 2019 from 12:00 – 1:00 pm PST

Integrated behavioral health is part of many programs and models for robust primary care, including Comprehensive Primary Care Plus (CPC+), the Oregon Patient-Centered Primary Care Home (PCPCH) program, national medical home models and more. Many practices struggle to financially sustain these integrated models. HealthInsight has joined members of the Integrated Primary Care Leadership Collaborative to host a webinar to learn from professionals working in different integrated behavioral health settings who have adopted successful strategies for sustaining these integrated models.

Join this webinar to hear from panelists representing a rural clinic, a large health system, a network of FQHCs, and a community mental health clinic about how they have implemented billing and other approaches for integrated behavioral health, and their reasons for implementing certain aspects over others. This webinar is applicable for operational and billing staff, administrators and leadership, behavioral health clinicians, and anyone in Oregon who wants to better understand billing for behavioral health services.

Register now: <https://healthinsight.zoom.us/webinar/register/495a821fa9e4f5f434538d7d4481ef37>
www.healthinsight.org

Improving follow-up to developmental screening: best practices for primary care providers

The OHA Transformation Center is offering technical assistance to CCOs and their contracted primary care providers on increasing rates of developmental screening (CCO incentive metric) and effective follow-up (referrals and connection to supportive services for children when indicated by developmental screening results). This webinar is presented by the Oregon Pediatric Improvement Partnership.

Register to watch the recording here: <https://attendee.gotowebinar.com/register/8084440010377322242>

Handouts

- [General medical decision tree](#)
- [Shared decision-making tool \(parent education sheet\)](#)
- [Scripting - 36-hour phone follow-up](#)
- [Oregon early childhood diagnostic crosswalk](#)
- [Tools compendium](#) (additional tools and examples of tools tailored for specific communities)

Participants must watch the recording by January 31, 2019 to claim CME (FREE to participants):

- Accreditation: The School of Medicine, Oregon Health & Science University, is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
- Credit: Oregon Health & Science University School of Medicine designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Patient-centered counseling trainings (with CMEs)

Registration is open for patient-centered counseling trainings across the state. CMEs are available at no cost to participants.

Who: Oregon clinicians, clinic staff and traditional health workers serving Oregon Health Plan members who want to learn and practice patient-centered counseling skills to support patients' health goals.

What: Dana Sturtevant, MS, RD, will lead a full-day, CME-accredited training focused on learning and practicing patient-centered counseling skills. The session will focus on increasing your confidence and skills to facilitate conversations with patients about sensitive topics. Examples will draw from effective contraceptive use and sexual health, tobacco use, controlling high blood pressure and other CCO metric-related topics. Evidence-based health communication models will include motivational interviewing, the FRAMES model and Five A's for tobacco cessation counseling.

When: The one-day training will be held at locations throughout the state from February through April. Each training will be 9 a.m.-4:30 p.m. Spaces still available for McMinnville, Bend, La Grande, and Hermiston.

Register here: <https://patient-centered-counseling-trainings.eventbrite.com>

Event webpage: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Patient-Centered-Counseling.aspx>

If the location you'd like to attend is full, you can join the waitlist here: <https://www.surveymonkey.com/r/9RZYTVB>

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.