



## Patient-Centered Primary Care Home Program Update

May 2019

### PCPCH Spotlight: Providence Hood River Internal & Family Medicine Clinics

There is no better way to increase a clinic's ability to be responsive to the needs of its unique patients and families than directly involving them in their quality improvement efforts. Providence Hood River Internal & Family Medicine clinics have demonstrated what a difference this practice can make via their Patient & Family Advisory Council (PFAC)—a well-organized group made up of 10 advisors and 4 clinic champions that convene regularly to continuously improve clinic operations.



*Providence Hood River Internal & Family Medicine team appreciation lunch*

Meeting once every two months, Hood River's PFAC makes cooperation and an interactive environment the focus as members discuss progress on clinic improvement goals and propose new changes to improve communication, patient experience, and overall satisfaction. Meetings have even included walk-throughs of the clinics to gather advisor feedback on workspaces. Numerous improvements have been successfully proposed and implemented through these meetings including:

- **Wheel chair access in clinic** - Rearrangement of waiting space/chairs allowed for designated wheel chair access.
- **Clinic Magnets** - Magnets were created that included clinic hours, phone address and extended hours information; these are available to all patients at front desk.
- **External parking lot** - Parking lot was re-done and this made it possible to add an additional handicap accessible parking space as a PFAC Advisor mentioned there was only one.
- **Lab waiting area signage** - We added more signs, magazine rack and tried to "spice" up the dull look that some PFAC advisors were noticing.
- **No Fragrance Flyer & TV** - It was brought up that certain fragrances bring up peoples' allergies and therefore we added this "no fragrance" sign to our TV which plays at the waiting area.

- **New magazines** - We noticed that some of our magazines are outdated- we have a designated person who will rotate magazines in waiting area and exam rooms. We also obtain a few subscriptions to new magazine.
- **Coffee cart and garbage bin placement** - With the relocation of the coffee cart along with the garbage bin it allowed for a more “Open Space” feeling.

Additional areas covered include signage, consolidating flyers/patient info in patient rooms, check in times vs. arrival time, verbiage regarding certain initiatives and how to best reach patients, and bilingual resources (telephone tree and paper materials).

*“We stay very tightly focused during our meetings to the topic, who can assist with this, and then an action plan. We often revisit these topics in our Quality improvement Medical home meetings where more staff are involved to assist with completion. In addition, our recruitment for PFAC members is constant to ensure that we are getting an accurate picture of our patient population. We as Providence Caregivers continue to add extreme value and emphasis on ensuring that this group is successful and feel that the importance placed by staff show how committed and involved we are in the quality improvement arena.”*

### Extra Guidance: Standard 4.A. vs 4.B.

**Continuity of care** is a foundational attribute of the Patient-Centered Primary Care Home model as it has been associated with not only better patient experience, but improved health care outcomes. In lieu of this, all Patient-Centered Primary Care homes are expected to meet Standards 4.A. and 4.B. – “personal clinician assigned” and “personal clinician continuity”. While these are sometimes interchanged or misunderstood as the same calculation, these are two distinct standards each with their own intent and purpose.

**Standard 4.A.** concerns what proportion of a clinic’s patients are assigned to a personal clinician or team. The intent of this measure is to increase the number of patients that have a personal clinician or team whom they know is primarily responsible for their care. This knowledge can foster trust and a feeling of consistency among patients that can promote more open communication and engagement with care.

**Standard 4.B.** builds on this measure by determining what proportion of a clinician’s patients that visit the clinic actually receive care from their assigned clinician or team. The intent of this standard is to promote patients’ relationships with their health care provider or team and improve consistency.

While seemingly similar, clinics may have different proportions for these two standards that highlight opportunities for improvement. For instance, if 100% of a clinic’s patients are assigned to a personal clinician (Standard 4.A.) but only 30% actually receive care from their clinician when they come for a visit (Standard 4.B.), this may be indicative of an opportunity to improve scheduling or patient-assignment procedures to ensure that their patients are able to reap the benefits from continuity of care, if that is a priority. Conversely, we understand that some patients or clinics may prefer to prioritize seeing the first available provider depending on the medical issue at hand.

Further information on these two standards can be found on pages 61-67 of the [PCPCH Technical Assistance Guide](#). Questions can also be emailed to the PCPCH program at [PCPCH@state.or.us](mailto:PCPCH@state.or.us).

### National Diabetes Prevention Program: Oregon-specific resources

Effective January 1, 2019, the National Diabetes Prevention Program is a Medicaid and Medicare covered benefit in Oregon. Resources are compiled by OHA Public Health and hosted on the Transformation Center website for CCOs and primary care teams to support work to prevent diabetes at both the system and clinic levels. See program information and benefit coverage in Oregon, including billing guidance, training opportunities, implementation resources, and more: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Diabetes-Prevention-Program.aspx>.

## New in Research: Patient-centered care & health care disparities

A recent systematic review examined the empirical evidence on the impact of the Patient-Centered Medical Home model on health disparities among adults. Four studies were identified which provided preliminary evidence that the PCMH model can help to reduce or eliminate disparities in health care processes, access, outcomes, and patient experiences based on race/ethnicity, income, age, and gender.

Specifically, these studies found that medical homes reduced disparities between groups in:

- preventive care services such as screening
- access to care
- emergency department visits
- outcome measures such as glycosylated hemoglobin levels among patients with diabetes
- patient experience

Despite this preliminary evidence, the limited number of studies available in this topic highlights the need for more research. No studies were found, for instance, that demonstrated a reduction or elimination in health care quality measures related to structure. With this in mind, study authors generated the following recommendations for stakeholder roles in understanding and improving disparities:

<i>Table 3. PCMH Stakeholders and Their Role(s) in Understanding/Improving Disparities</i>	
<b>PCMH Stakeholder(s)</b>	<b>Potential PCMH-Disparities Opportunity</b>
Grant making organizations	Include disparities-centered outcomes in funding priorities and announcements, and provide support in technical assistance programming
Researchers/Scientists	Improve and implement constructs to better collect and analyze socio-demographic and socioeconomic data in methodology, program development and study design
Accrediting bodies	Consider opportunities to expand newer guidelines and standards to positively impact disparities and capture disparities-specific data
Policy makers	Develop and promote PCMH supportive legislation with demonstrable impact on vulnerable populations, including workforce, financial and practice-based reforms
Primary Care Practices	Utilize electronic or other systems and practice protocols to collect patient-specific socio-demographic and socioeconomic data and design PCMH interventions and programs to address identified disparities
Patients and patient advocacy groups	Engage in practice transformation efforts with primary care practices; encourage collection of comprehensive patient demographic factors; ensure that PCMH interventions/changes have meaningful impact on patients and communities

*“Although a limited number of studies met our inclusion criteria, the findings are a promising lead for multiple measures of clinical quality affected by the PCMH model. Given the significant investments being made at the federal, state and local level to redesign primary care delivery systems under the model, it is important for multiple stakeholders to align on common strategies for Patient-Centered Medical Homes to measure and achieve health equity.”*

**Full Research Publication:** Olayiwola, J., Sheth, S., Mleczo, V., Choi, A., & Sharma, A. (2017). "The Impact of the Patient-Centered Medical Home on Health Disparities in Adults: A Systematic Review of the Evidence," Journal of Health Disparities Research and Practice: Vol. 10 : Iss. 1 , Article 5. Available at <https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1466&context=jhdrp>

## Coming Up: Events and Trainings

### 2019 Oregon HPV Summit (Free)

**When:** Tuesday June 11, 2019

**Where:** City of Keizer Civic Center, 930 Chemawa Road NE, Keizer, Oregon

The 2019 Oregon HPV Summit is an opportunity for people who care about preventing cancer to gain insight on how to increase HPV vaccination rates in their communities and throughout Oregon. During the Summit, you will have a chance to meet local and national experts, have an opportunity to engage with others like you from all over Oregon and to participate in discussions and interactive breakout sessions. Session topics being considered include:

- How to talk to parents about HPV
- Best Practices for increasing HPV vaccination rates
- The most up-to-date data on HPV-cancer burden in Oregon and HPV vaccination rates
- Youth and HPV
- Oregon's 2019 HPV Vaccination Week
- HPV-cancer survivorship

Register by May 31<sup>st</sup> at <https://oregonhpvsummit2019.weebly.com/>

### Free, quick online tobacco cessation counseling training (with CME)

**What:** This short online course will improve your care team's ability to help patients quit tobacco. The course focuses on Brief Tobacco Intervention and Motivational Interviewing techniques.

**Who:** All members of the care team committed to supporting their patients to quit tobacco.

**When:** The course is self-paced and takes approximately 45 minutes. The course can be started, paused and resumed later as needed.

**CMEs:** This training has been reviewed and is accepted for up to 1.0 prescribed credit from the American Academy of Family Physicians (AAFP). For other licensing boards that may not pre-approve continuing education credits (for example, the Board of Licensed Professional Counselors and Therapists), please submit the certificate of participation to your accrediting body.

**Access the training:** <https://tcrc.rapidlearner.com/3462253711>

**Questions?** Please contact Anona Gund ([Anona.E.Gund@dhsosha.state.or.us](mailto:Anona.E.Gund@dhsosha.state.or.us) or 971-673-2832)

### Upcoming Postpartum Care Training Opportunities

**(May 16)** *Postpartum Care Online Learning Community Series: Jackson Care Connect's Starting Strong* - This session will highlight an incentive-based program for engaging women in perinatal care and resource navigation. [Details and registration](#)

**(June 6)** *Postpartum Care Online Learning Community Series: First Steps and Start Smart* - This session will highlight innovative programs from Columbia Pacific CCO and Trillium Community Health Plan for perinatal care coordination and case management. [Details and registration](#)

## 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@state.or.us](mailto: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](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.*