Patient-Centered Primary Care Home Program Update

September 2021

Approaching Standard 2.D with an eye for health equity

PCPCH Standard 2.D encourages primary care practices to use data to identify opportunities to improve the care they provide to their patients, and our PCPCHs have not disappointed! Clinics across Oregon have excelled in coming up with creative and impactful ways to improve the efficiency, experience, and impact of their services.

Several practices have even taken this a step further, taking the initiative to not only examine the experience of their overall patient population, but also the *differences in experience* among their patients based on their characteristics or demographics. In other words, PCPCHs are beginning to use data to not only improve their overall care, but improve the equity of the care they provide.

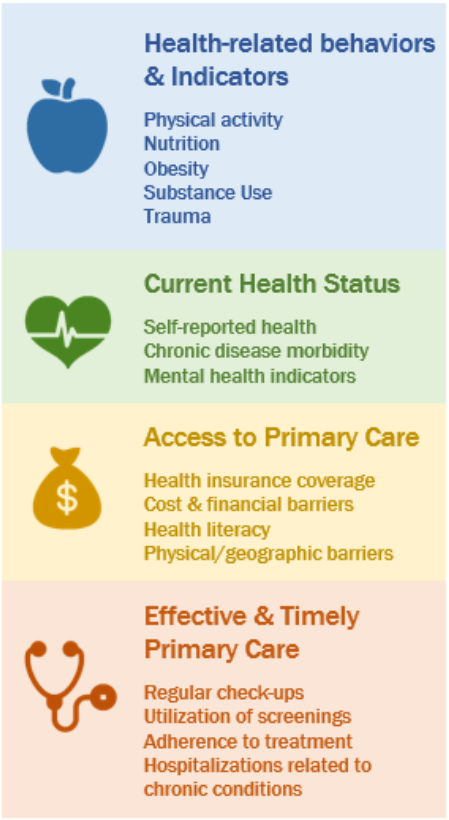
This type of improvement has become a focus for the Oregon Health Authority over the last couple years as COVID-19 highlighted many of the healthcare-related disparities that Oregonians have been experiencing. Primary care practices and providers interested in better understanding how to identify gaps in their services or improve the equity of their care have a variety of options for doing so. Below are some of the many ways that practices can use data to identify such opportunities:

Begin collecting demographic data on your patients such as their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. REALD is an example of such patient data collection, and templates/guides are available on OHA's REALD for Health Care Providers webpage. Most practices are currently required to collect such data from their patients during COVID-related encounters, but providers are encouraged to collect this information from their patients in general.

Stratify your clinic's performance data or quality measures by these types of patient characteristics to identify significant differences in one or more indicators of health, access, or timely, high-quality care (see the figure to the right for examples).

Use U.S. Census data, community needs assessments (such as those produced by your local CCO) or other local data sources to better ***understand the community in which your practice is located*** in order to identify your underserved groups. For example, are there sizable demographics in your

Examples of Possible Disparities Among Your Patients



community that rarely visit your practice? What sort of adjustments could you make to your services to improve access for these groups?

Collect insights from your targeted patients. Once you know which types of patients are having trouble accessing or experiencing the full benefit of your services, involve them in developing solutions. While there are a lot of great research and tools already available, your local community and patients may be experiencing unique barriers that aren't captured in national or state assessments.

The resources below provide additional strategies that PCPCHs can use to approach Standard 2.D in this way. And as always, we encourage you to use those that best meet the needs and capacity of your unique practice. We at the PCPCH Program have always been amazed by the types of solutions that our PCPCHs come up with, and we look forward to continuing to learn from you what it means to deliver high-quality primary care!

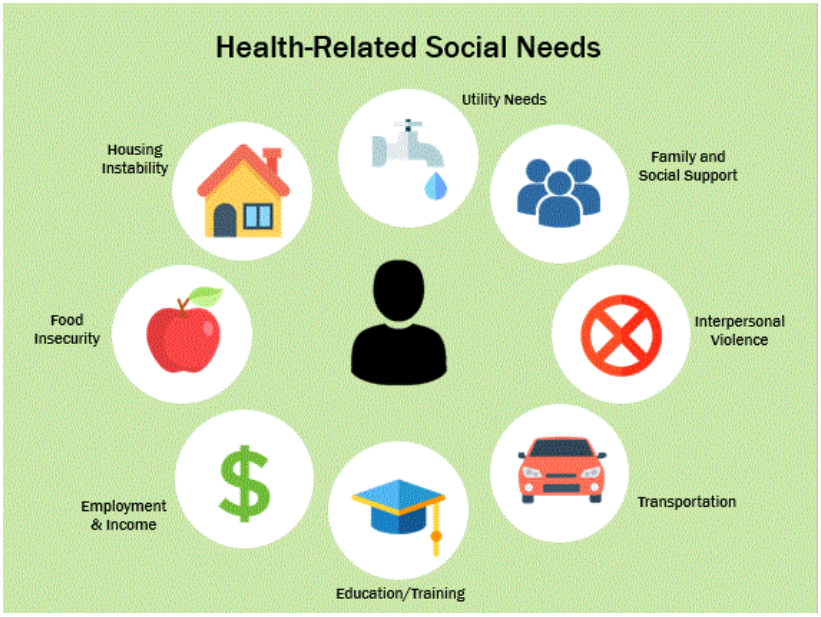
- Create the Data Infrastructure to Improve Health Equity (Institute for Healthcare Improvement)
- Telling a Story with Data to Improve Health Equity (American Hospital Association)

New PCPCH resource library

PCPCH Program staff are excited to announce a new resource library for primary care practices interested in learning more about how they can improve the equity of the care they provide. The searchable tool is located on our Resources and Technical Assistance webpage under the "Additional Resources" heading. It currently includes information on topics such as improving cultural competency, addressing social needs, understanding implicit bias in primary care, providing trauma-informed care, and more. Additional topics beyond health equity will be added in the future.

Understanding the new requirements around Standard 3.D

Like several other standards in the PCPCH model, **Standard 3.D - Comprehensive Health Assessment & Intervention** underwent some significant changes that went into effect in January of 2021. All practices applying or re-applying for PCPCH recognition after this point must be meeting the new specifications which are included in the 2020 Recognition Criteria Technical Specifications and Reporting Guide.



In the previous iteration of the model, Standard 3.D centered on assessing and intervening in health-related behaviors or risk factors such as substance use, diet, interpersonal violence, etc. While there is still some overlap, the standard has since been revised to focus on **Health-Related Social Needs (HRSN)** in particular. More information on what this means and what sorts of screenings and activities meet this standard can be found on pages 73-76 of the 2020 TA Guide. In addition, PCPCH staff have developed the following resources to help practices better understand the new specifications.

- Webinar on Standard 3.D
- Extra Guidance on Standard 3.D

Health IT announcements and events

The **Office of the National Coordinator for Health Information Technology (ONC)** is hosting the following opportunities over the next couple weeks:

2021 ONC Virtual Tech Forum - September 17th

The final day of ONC's Tech Forum is **September 17, 2021**. **Check out the detailed agenda and register today** for the all-virtual 2021 ONC Tech Forum. Hear industry perspectives about the progress being made in health IT over the past year and how we can continue to advance health technology to improve patient care, health equity, data exchange, and interoperability.

What Healthcare Providers Need to Know About Information Sharing & the Information Blocking Regulation - September 24th, 11am - 1pm

Got questions about information sharing under ONC's information blocking regulations? **Click here to register** for virtual office hours on **Friday, September 24** to ask ONC about the information blocking regulations in their 21st Century Cures Act final rule. ONC experts can explain how the rule supports secure, appropriate sharing of electronic health information and how information sharing leads to more affordable and equitable care and improved care quality.

Free health information exchange technical assistance for primary care clinics

Available through September 2021

OHA and the Care Management Plus team at OHSU have partnered to provide free technical assistance related to health information exchange and direct secure messaging. Answers to general questions can be provided as well as assistance with testing and validating new implementations, including work with EHR vendors to resolve challenges. Interested primary care clinics can contact Michelle Bobo at bobom@ohsu.edu.

Million Hearts Learning Lab (free CME)

November 17th, 12:00 - 12:45 pm

The **Million Hearts Learning Lab** is a bi-monthly learning series focused on cardiovascular disease prevention and management topics. The series is open to clinicians, quality improvement, and other interested staff across the country, but with a focus on community health centers. Clinicians may earn 1.0 CME credit per session through the American Medical Association's EdHub. **Click here to register** for the next session on November 17th which will focus on **"Intensifying Treatment to Achieve Blood Pressure Control."**

Questions?

We are here to help! Contact us at 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.

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