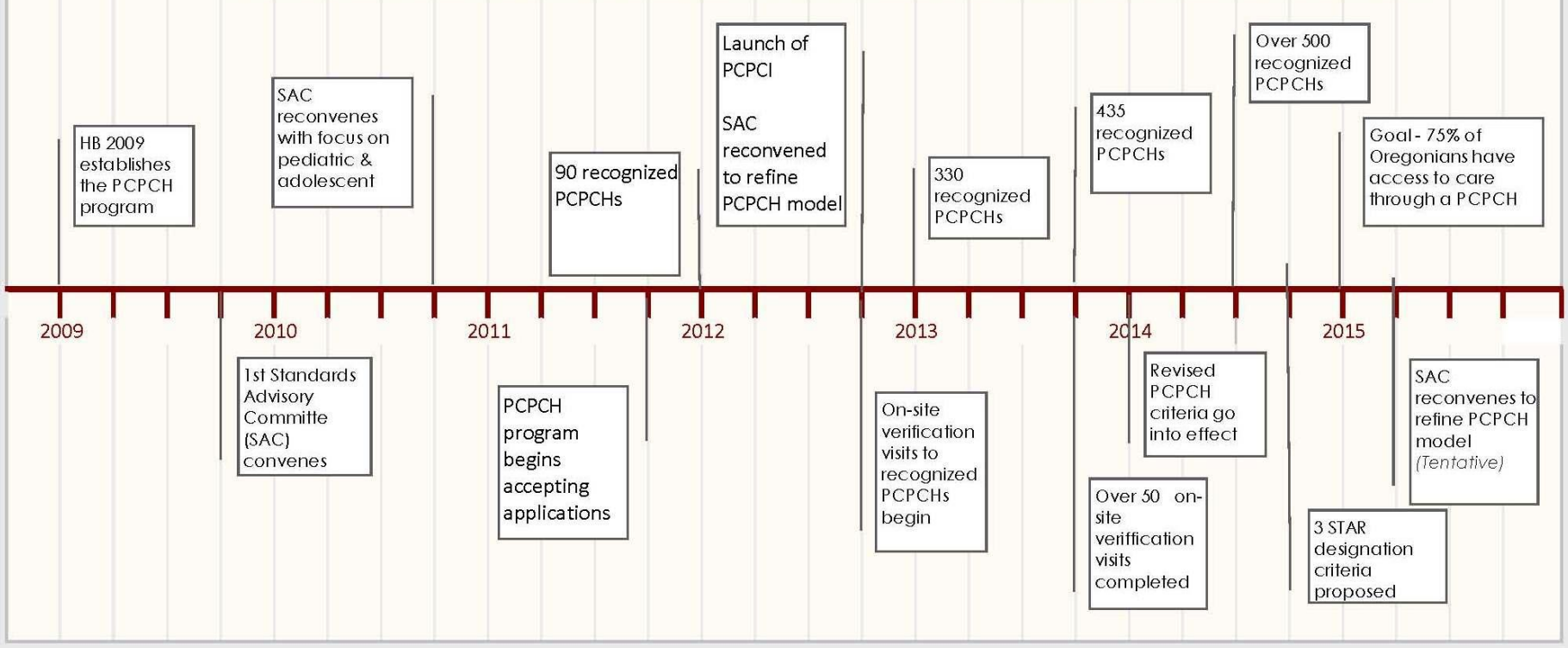
Oregon Health Authority

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

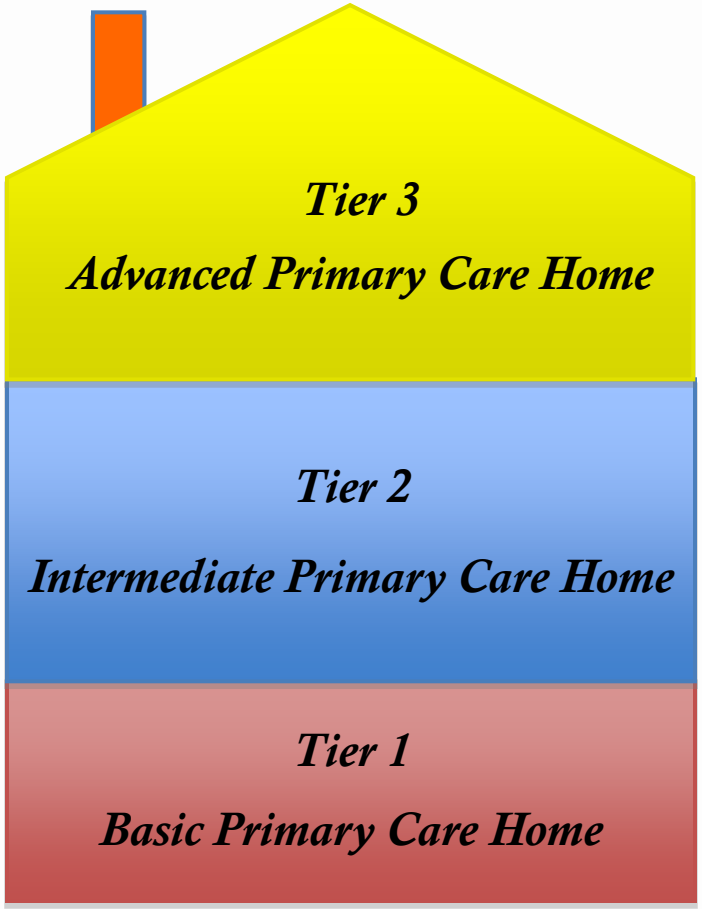
Patient-Centered Primary Care Home Program

- **House Bill (HB) 2009 established the PCPCH Program:**
  - *Create access to patient-centered, high quality care and reduce costs by supporting practice transformation*
- **Key PCPCH program functions:**
  - Recognition and verification
  - Refinement and evaluation of the PCPCH standards over time
  - Technical assistance development
  - Communication and provider engagement
- **Goals of PCPCH program:**
  - All OHA covered lives receive care through a PCPCH
  - 75% of all Oregonians have access to a PCPCH by 2015
  - Align primary care transformation efforts by spreading the model to payers outside the OHA

PATIENT CENTERED PRIMARY CARE HOME PROGRAM



Different Levels of Primary Care "Home-ness"

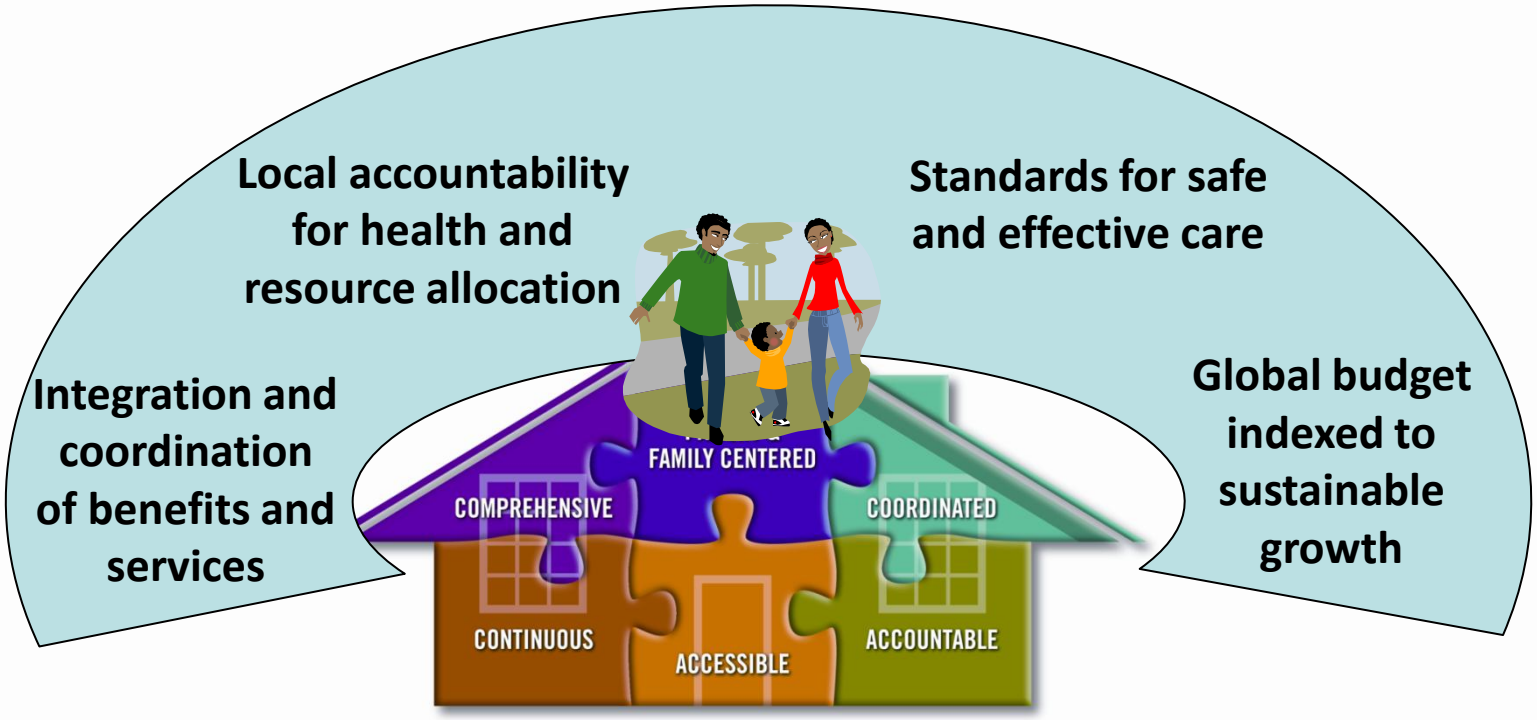


- Proactive patient and population management
- Accountable for quality and utilization
- 130 + points and all 10 must-pass criteria

- Demonstrates performance improvement
- Additional structure and process improvements
- 65 - 125 points and all 10 must-pass criteria

- Foundational structures and processes
- 30 – 60 points and all 10 must-pass criteria

COORDINATED CARE ORGANIZATION



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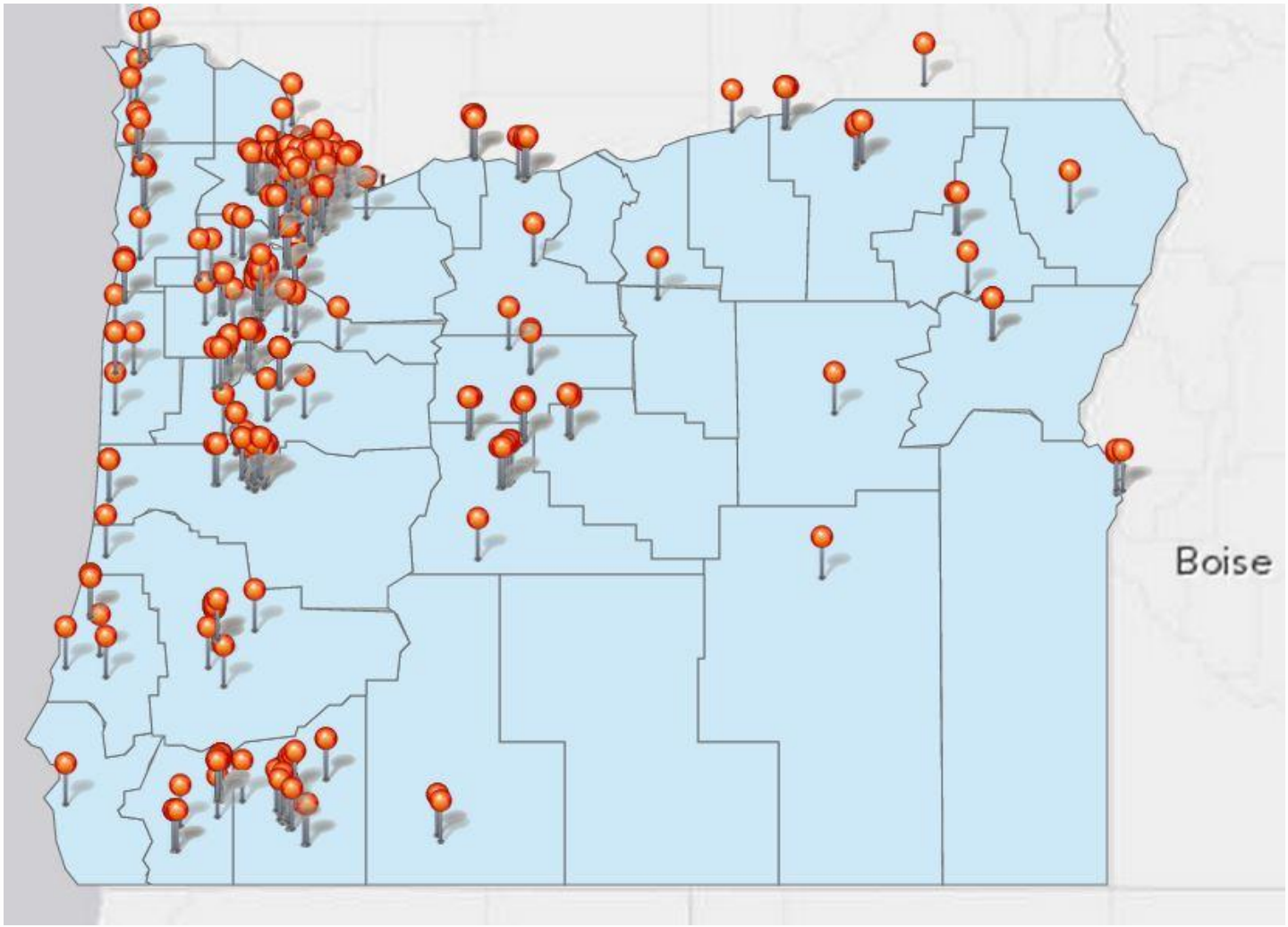
Where are PCPCHs?



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What do PCPCHs look like?

Columbia River Community Health Services
Boardman, OR

- **Staffing**
  - Average # providers = 5.1 (1-39 FTE)
  - Average # other clinical staff = 9.4 (0-70 FTE)
  - Average # annual visits = 14,539 (229-134,000)
- **Services**
  - Majority serve adult and pediatric populations
  - Majority provide obstetrics care
  - < 20% offer CAM
- **Ownership**
  - Nearly half owned by a larger system
  - 40% independent and unaffiliated
  - About 10% independent but in alliances
- **Implementation**
  - Over 80% (N=252) of survey respondents needed to add new services in order to implement the model

What have we learned?

- Improving health outcomes in the following areas:
  - Increase the quality of care (85%)
  - PCPCH clinics had higher mean scores than non-PCPCH clinics for*:
    - diabetes eye exams
    - kidney disease
    - monitoring in diabetics
    - appropriate use of antibiotics for children with pharyngitis
    - well-child visits for children (3-6 yrs.)
- Clinics reported improvement of access and experience of care in the following areas:
  - access to services (75%)
  - individual experience of care (85%)
  - improve population health management (82%)

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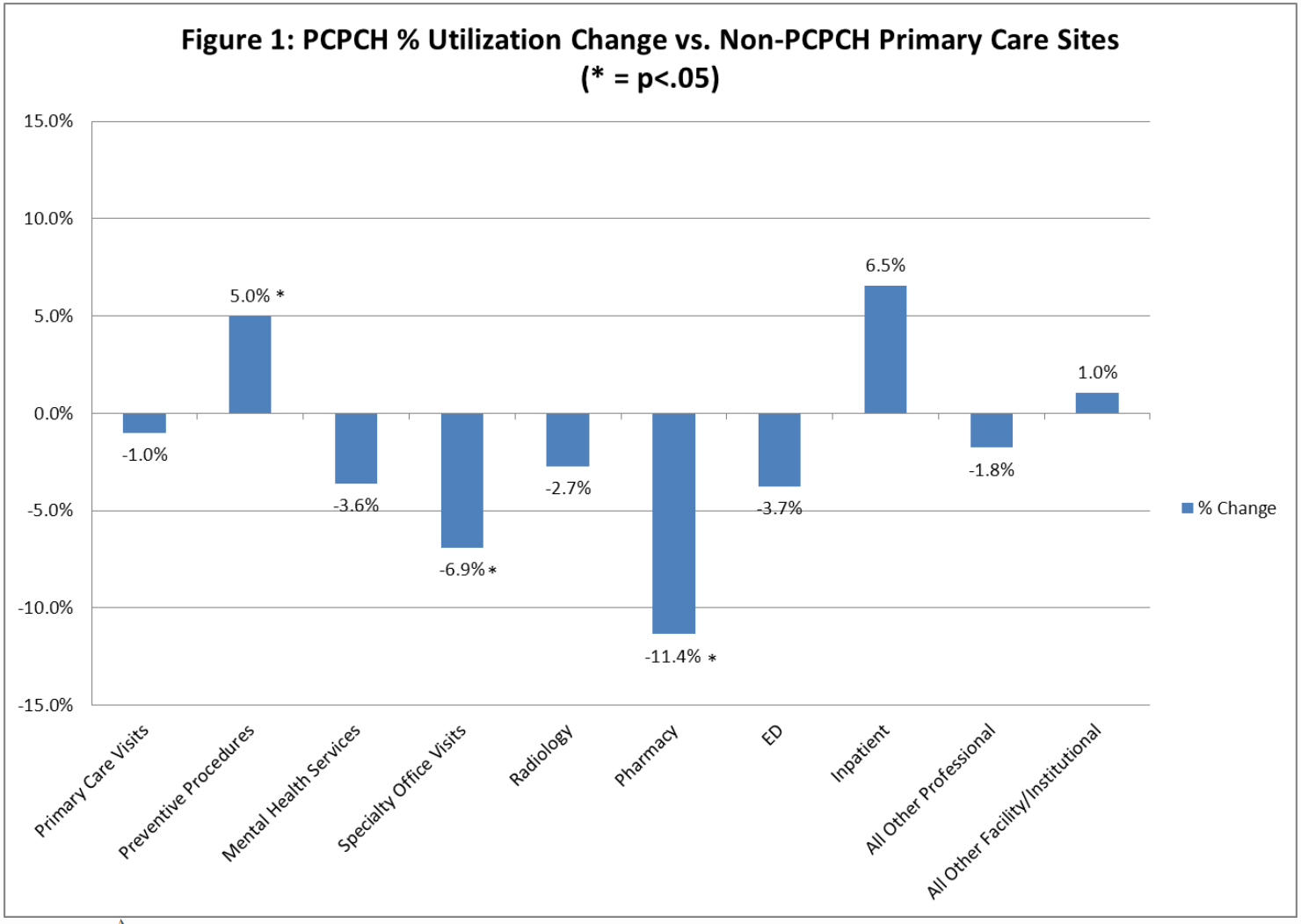
**Information for a Healthy Oregon.* The Quality Corporation, August 2013

Impact on Utilization



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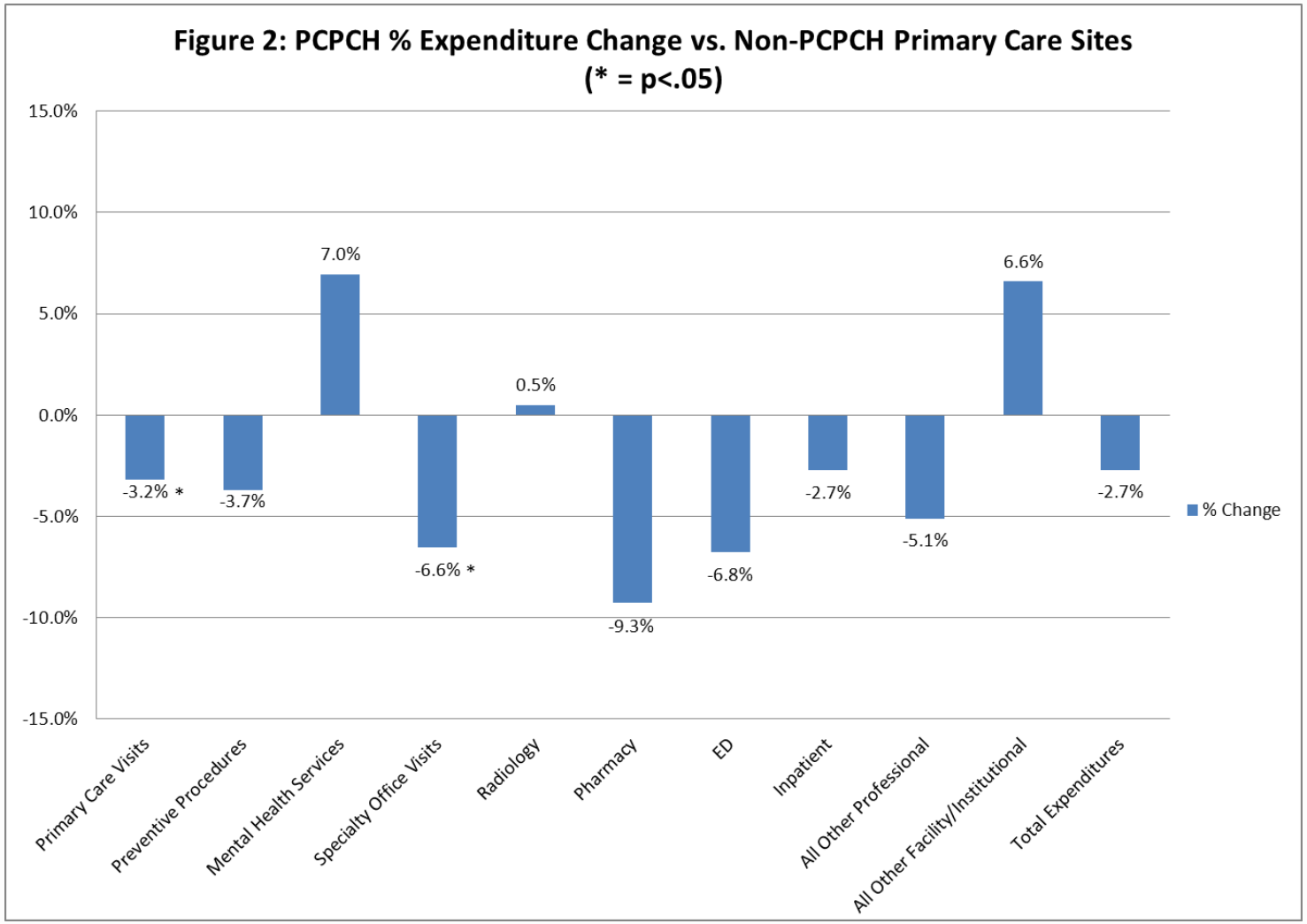
Impact on Expenditures



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Current Incentive Payments to Oregon PCPCHs and Primary Care

Commercial Health Plan Enhanced Payments and Incentives

- Public Employees Benefits Board (PEBB)
- Aetna's Patient Centered Medical Home (PCMH) recognition program
  - Per-member-per-month payment incentives using the PCPCH tiers, directly contracted with Aetna. Contact Denise Casner at Aetna at 503-937-0621.
- Coordinated Care Organizations (CCO)
  - May offer incentive payments for recognized primary care homes. Check with your CCO representative to inquire about alternative payment methods that may be available.
- Multi-Payer Agreement*
  - Signed by representatives from several organizations last year. Check with the payers you work with to inquire about what is available.

* Available at http://www.oregon.gov/oha/pcpch/Pages/payment-incentives.aspx

The Heart of the PCPCH Program: A Patient's Story

- Deschutes Rim Health Clinic in Maupin, OR
- Guided by White River Health District Board of Directors
  - Tax based plus
  - Option Tax Levy
- Serves >1000 patients in Wasco County
- Tier 2 PCPCH
- Sharon DeHart PA-C, member of Central Oregon IPA and Columbia Gorge CCO

Deschutes Rim: Our Philosophy of Care

- Deschutes Rim Health Clinic strives to provide the rural communities of South Wasco County with high quality medical care for our friends, neighbors, and visitors.
- Mission: to provide high-quality, comprehensive, primary healthcare and outstanding service to all in our community regardless of their financial circumstances.

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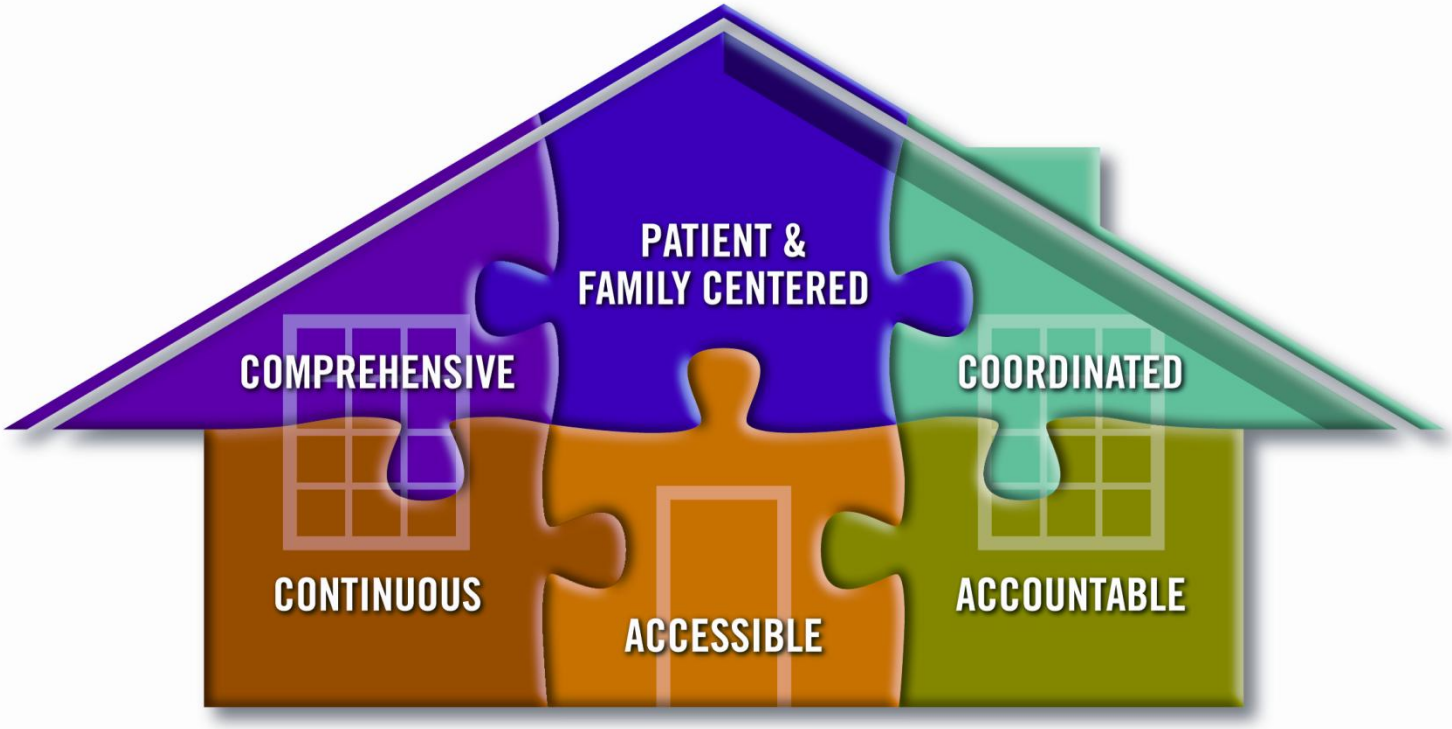
From patients to primary care, the Patient Centered Primary Care Home (PCPCH) Attributes



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ACCESS TO CARE

"Health care team, be there when we need you"

- Provide access to in-person care at least 4 hours weekly outside traditional business hours
- Provide continuous access to clinical advice by telephone
- Provide same day appointments.
- Provide access to health information

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ACCOUNTABILITY

"Take responsibility for making sure we receive the best possible health care"

- Involve patients, caregivers, and patient-defined families as advisors
- Uses performance data to identify opportunities for improvement

COMPREHENSIVE WHOLE PERSON CARE

"Provide or help us get the health care, information, and services we need."

- Offers and/or coordinates preventive services
- Sends reminders about preventive services due/overdue
- Provides screening strategy for mental health, substance use or developmental conditions and provides on-site assistance or referrals

CONTINUITY

"Be our partner over time in caring for us."

- Opportunity to build a relationship over time with primary care provider and/or care team
- Maintains and updates a health record for each patient
- Shares communication with outside organizations in real time
- Communication with hospital providers about patient care

COORDINATION AND INTEGRATION

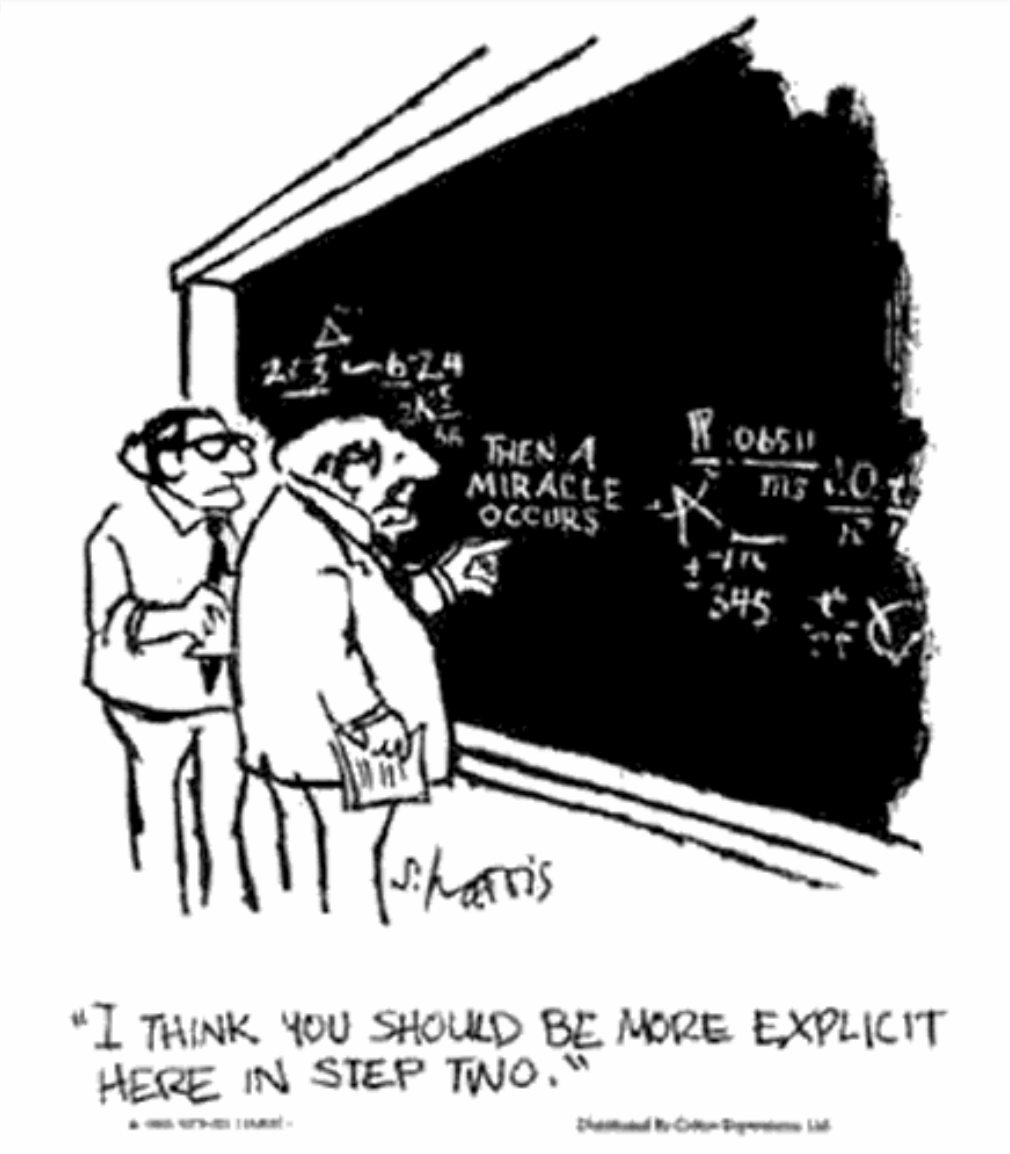
"Help us navigate the health care system to get the care we need in a safe and timely way."

- Coordinate care for patients
  - Including sub-population of patients
  - Designated care coordinator/care manager
- Ability to use electronic health record in a meaningful way
- Ensures that the patients wishes are documented and being met, when the time comes
- Ability to track tests, results and referrals to consulting specialty providers
  - Timely confidential notification to patients and families

PERSON AND FAMILY CENTERED CARE

"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."

- Process for identifying educational resources for:
  - Patient education
  - Self management support
- Provides knowledge and helps coordinates community resources for patients and/or family


THEN A MIRACLE OCCURS
"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Don’t wait for a miracle, we are here to help! Resources and Technical Assistance

- www.pcpci.org
  - Updated self-assessment tool: are you ready to pursue PCPCH recognition?
  - Topic specific webinars
  - Downloadable tools
- www.pcpci.org/online-modules
  - Online learning modules
- www.PrimaryCareHome.oregon.gov or PCPCH@state.or.us
  - Knowledgeable with integrating workflow for PCPCH measures
  - Dedicated staff to assist with application process