Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

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.

Patient-Centered Primary Care Home (PCPCH) Program

- Established in 2009 by the Oregon Legislature to create access to patient-centered, high-quality care and reduce costs by supporting practice transformation
- PCPCH model standards are developed and refined by a volunteer multi-stakeholder Standards Advisory Committee
- In 2016, PCPCH program joined OHA's Transformation Center
- Program functions include:
  - PCPCH recognition and verification
  - Refinement and evaluation of the PCPCH standards
  - Technical assistance delivery
  - Communication and provider engagement

Health system transformation

COORDINATED CARE ORGANIZATION

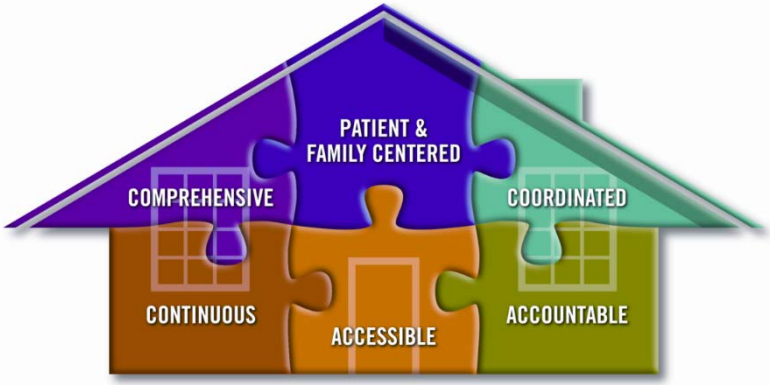
Local accountability for health and resource allocation

Standards for safe and effective care

Integration and coordination of benefits and services

Global budget indexed to sustainable growth

PATIENT CENTERED PRIMARY CARE HOME



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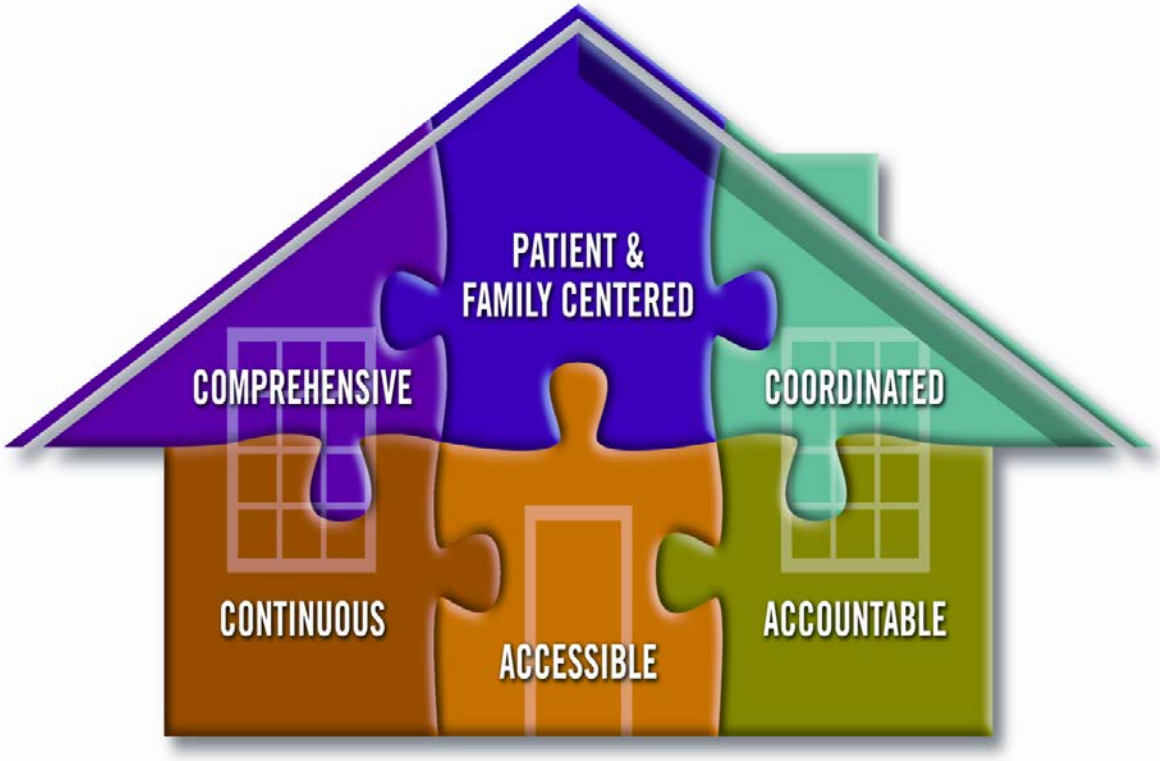
PCPCH model overview

- Six core attributes, each with specific standards and measures
- Eleven "must pass" measures all clinics must meet
- Five tiers of recognition based on which measures a clinic meets



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Six PCPCH core attributes

ACCESS TO CARE

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

ACCOUNTABILITY

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

COMPREHENSIVE WHOLE PERSON CARE

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

CONTINUITY

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

COORDINATION AND INTEGRATION

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

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."

Eleven PCPCH “must pass” measures

1.C.0 - PCPCH provides continuous access to clinical advice by telephone.

2.A.0 - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.

3.B.0 - PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support.

3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources.

4.A.0- PCPCH reports the percentage of active patients assigned to a personal clinician or team.

4.B.0 - PCPCH reports the percent of patient visits with assigned clinician or team.

4.C.0 - PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.

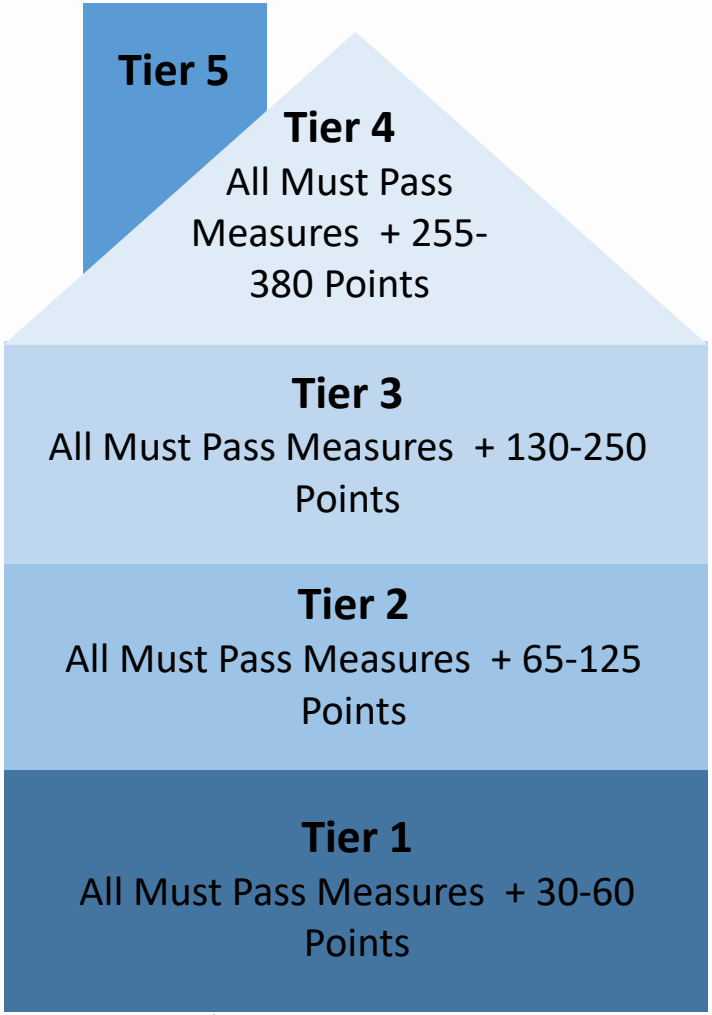
4.E.0 - PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

5.F.0 - PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

6.A.0 - PCPCH offers and/or uses either providers who speak a patient and family’s language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice

6.C.0 - PCPCH surveys a sample of its patients and families at least every two years on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.

Five PCPCH recognition tiers

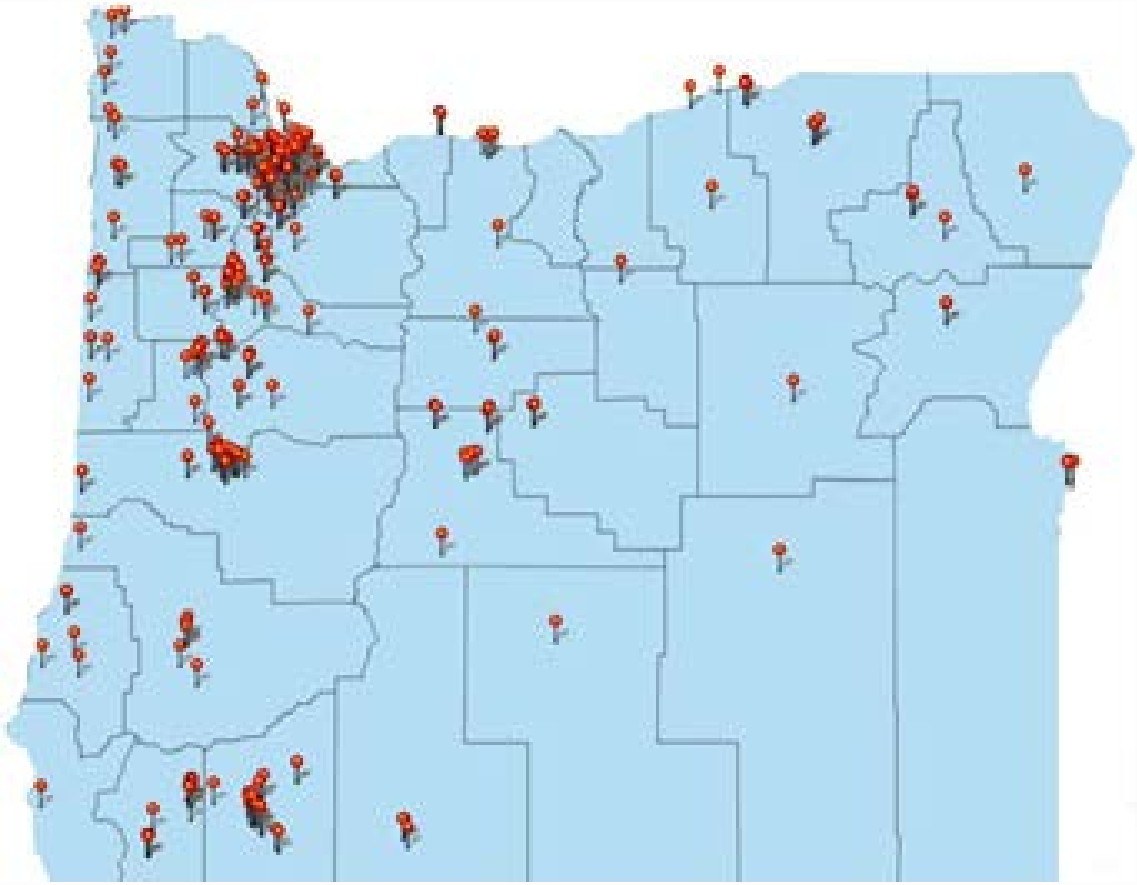


- 11 must pass measures (required)
- Each measure is worth 5 to15 points
- Tier level is determined by the number of points a clinic receives
- Tier 5 (5 STAR) has unique criteria
  - All must pass measures
  - 255 points or more
  - Meet 11 of 13 advanced measures
  - Verification site visit required

PCPCH verification site visits

- PCPCH recognition is attestation based and clinic participation is voluntary.
- PCPCH program staff conduct site visits to selected clinics to verify the measures attested to are being implemented.
  - Team includes a Practice Coach, Compliance Specialist and a Clinical Transformation Consultant (provider) when available.
- Site visits ensure the integrity of the PCPCH program and the attestation model.
- By participating in the program, a clinic agrees to an on-site visit when selected. Each clinic will receive a site visit at least once every five years, per Oregon Administrative Rules.

Where PCPCHs are located



- 652 PCPCH clinics throughout 35 of the 36 counties.
- 57 5 STAR clinics
- Approximately ¾ of all Oregonians get their care at a PCPCH!

Impact on the Triple Aim

Better Care

- 85% of clinics surveyed report that PCPCH implementation is helping them improve individual experience of care.

- The PCPCH model has helped clinics shift toward population-based strategies that can care for patients who share a diagnosis or demographic characteristics.

- Significantly lower rates for specialty office visits, radiology, and emergency department use were demonstrated by PCPCH patients as compared to those seeking care in non-recognized clinics.

Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys.

Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency.

Impact on the Triple Aim

Better Health

- 82% of clinics report that PCPCH implementation is helping them improve population health management.

- PCPCHs performed better than non-PCPCH clinics on the following clinical quality measures: diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years.

Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys

Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality.

Impact on the Triple Aim

Decreased Cost

- PCPCH program implementation has resulted in $240 million in savings to Oregon's health system between 2012 and 2014.

- For every $1 increase in primary care expenditures related to the PCPCH program, there is a $13 in savings in other services, such as specialty care, emergency department and inpatient care.

- For a clinic that has been a PCPCH for three years, the total cost of care per-member, per-month is lowered by $28. This is double the overall average savings of $14 per-member, per-month for a PCPCH in the first year of recognition.

Gelmon, S., Wallace, N., Sandberg, B., Petchel, S. & Bournis, N. (2016). Implementation of Oregon's PCPCH Program: Exemplary Practices & Program Findings

What's next for the PCPCH Program

- PCPCH Standards Advisory Committee to convene
  - Topics to address: oral health, social determinants of health, metrics, pain management, and others
  - July to December 2019

- Increase number of site visits and technical assistance support
  - Hope to double site-visit capacity – 2 teams to 4 teams
  - Technical assistance outside the context of a site visit

- Align with and support the work of the Primary Care Payment Reform Collaborative

What questions do you have?

For more information

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