Oregon Health Authority

Presenter Introduction

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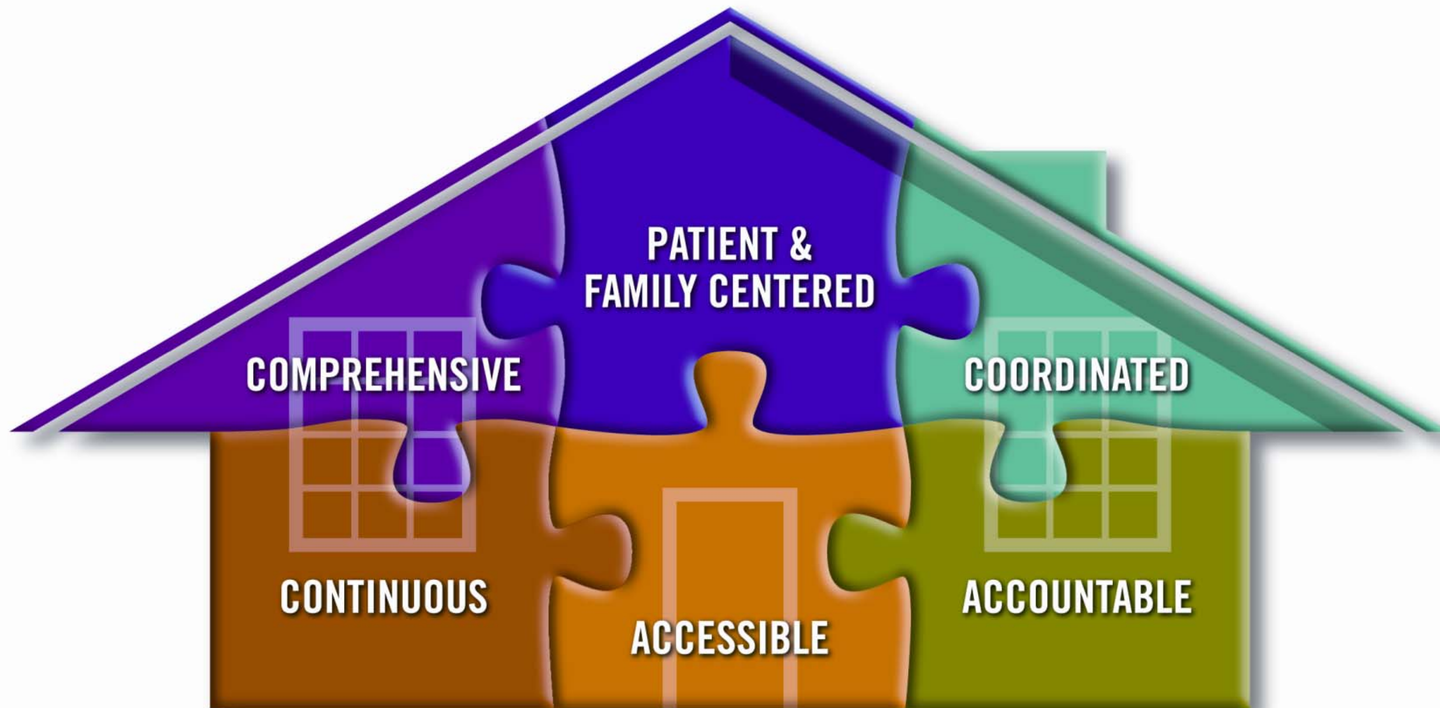
Core Attributes of a Primary Care Home

Oregon's PCPCH model is defined by six core attributes, each with specific standards and measures



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PCPCH Six 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."

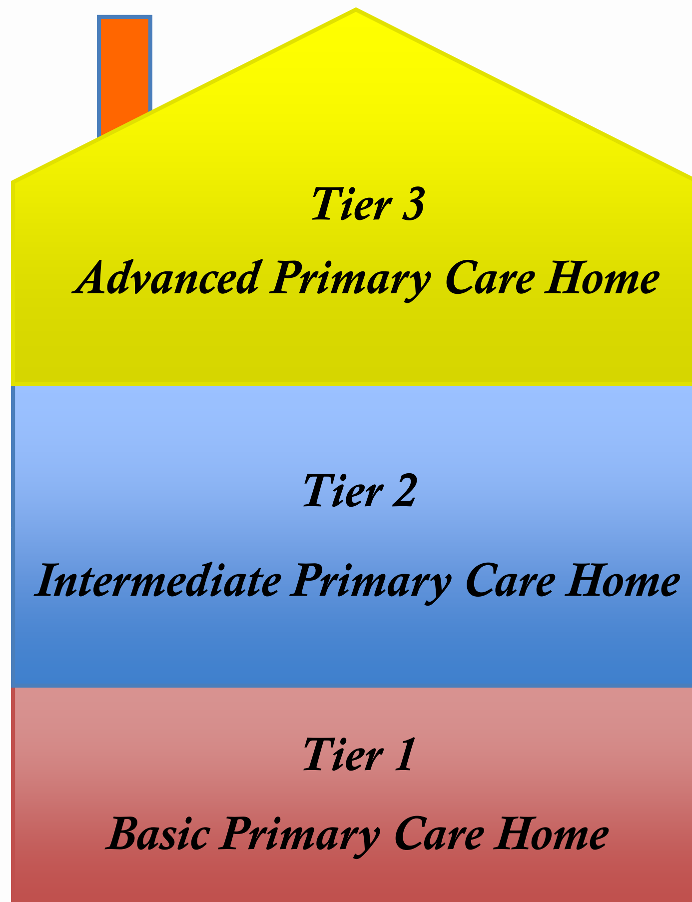
COORDINATION AND INTEGRATION

"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."

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

Where are PCPCHs?

Boise

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10 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; Patient education and self-management support.
3.C.0 PCPCH has a screening strategy for mental health, substance use, or 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. (D)
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)
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.O 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.

ACCESS TO CARE

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

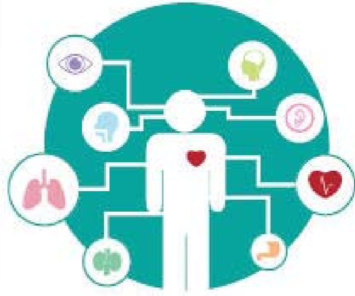
Must Pass Measure Intent:

1.C.0) The PCPCH provides continuous access to clinical advice by telephone:

- Patients, caregivers and families get clinical advice from a live person at all times
- Decreases emergency and urgent care utilization

Example:

- Business and After hours calls answered by:
  - Live person and referred to a clinician (or care team) for clinical advice
  - On-call provider or nurse
  - Nurse triage live answering service (forwarded to on call clinician or nurse as appropriate)



COMPREHENSIVE WHOLE PERSON CARE

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

Must Pass Measure Intent:

3.C.0) The PCPCH has a screening strategy for mental health, substance abuse and developmental conditions with documentation for on-site and local referral resources:

- Associated with improved health outcomes
- Core component of whole person primary health care

Example:

- Screening tools for adults/peds
  - ASQ, MCHAT
  - PHQ-2/PHQ-9
  - SBIRT, AUDIT, DAST
- Documentation (including screen shots) of assessment
  - Patient intake or history
- List of common MH/BH/SA referrals to community-based organizations

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CONTINUITY

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

Must Pass Measure Intent:

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

- Appropriate care transition is important for patient safety
- PCPCH facilitates relationship and communication for hospital care

Example:

- Written agreement with usual providers of hospital care that includes:
  - Process for requesting admission
  - Process for communication at time of admission, discharge and follow-up
  - Performance expectations at time of admission, discharge and follow-up
  - Process for record sharing

CONTINUITY

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

Must Pass Measure Intent:

4.A.0)PCPCH reports the % of active patients assigned to PCP/team

4.B.0) PCPCH reports the % of patient visits with assigned PCP/team

- Promote patients' relationship with PCP/team
- Shared responsibility and communication

Example:

- Integration of team-based care
  - Allows team approach for comprehensive, continuous patient care
  - Allows for provider coverage
  - Allows for enhanced communication and coordination of patient care
- Empanelment
  - Appropriate work distribution
  - Understand supply/demand

Application Process

- Review the “2014 Technical Assistance and Reporting Guidelines”
- Complete the Self-Assessment Tool
- Set up an account PCPCH@state.or.us
- Complete and submit the application

For more information, visit the “Become Recognized” page of the PCPCH Program website:

http://www.oregon.gov/oha/pcpch/Pages/become-recognized.aspx

Congratulations, your site has been selected for a site visit!

COME ON DOWN™

- The clinic will receive a letter via email explaining the visit
- Phone call with the site visit team (30 min)
  - Help you define the agenda and help plan the day
  - Describe what we'll need **prior** to the visit
  - Describe what we'll need **on the day of** the visit
  - Determine primary contacts at the clinic

The Purpose of the PCPCH Site Visit

- Verification
  - To protect the integrity of the program
- Assessment
  - To discover innovation and share best practices
- Collaboration
  - To provide “at the elbow” support

Who's Coming To Our Clinic? PCPCH Site Visit Team…

The PCPCH staff is divided into two site visit teams:

- Site Visitor
  - Reviews and verifies that you are meeting the standards
- Practice Enhancement Specialist-PES
  - Verifies the functionality of attested PCPCH standards
  - Assists with technical assistance and/or follow-up *after* site visit
- Clinical Transformation Consultant (physician)
  - Provides the clinical perspective of PCPCH transformation work
  - Assists with verification and functionality of clinic standards

What Will the Visit Look Like?

- Site visit team members will meet with different care providers
  - Short 45-50 minute interviews
- Chart review
  - 6-10 charts
- Patient focus group
  - 6-8 patients would be ideal
- Meet with clinic leadership to kick off and close out the day
- **The visit typically starts at 08:15 and we are done by 3:15**

What have we learned about PCPCHs?

- **Improving health outcomes**
  - 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.)
- **Improving access and experience of care**
  - access to services (75%)
  - individual experience of care (85%)
  - improve population health management (82%)

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

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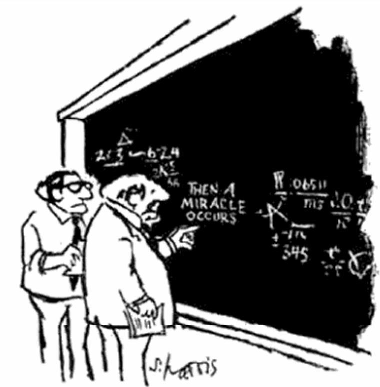
Benefits of PCPCH Participation

- Framework for improvement efforts
- Sharing of best practices
- Technical Assistance
- Networking

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 PCP measures
  - Dedicated staff to assist with application process



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Questions?