OREGON RURAL HEALTH CONFERENCE

PRIMARY CARE MEDICAL HOME

SEPTEMBER 22, 2011

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Pressure for Change

- Health care cost increases are not sustainable
- Reformed health system needs as its foundation:
  - Primary care
  - Prevention
  - Wellness

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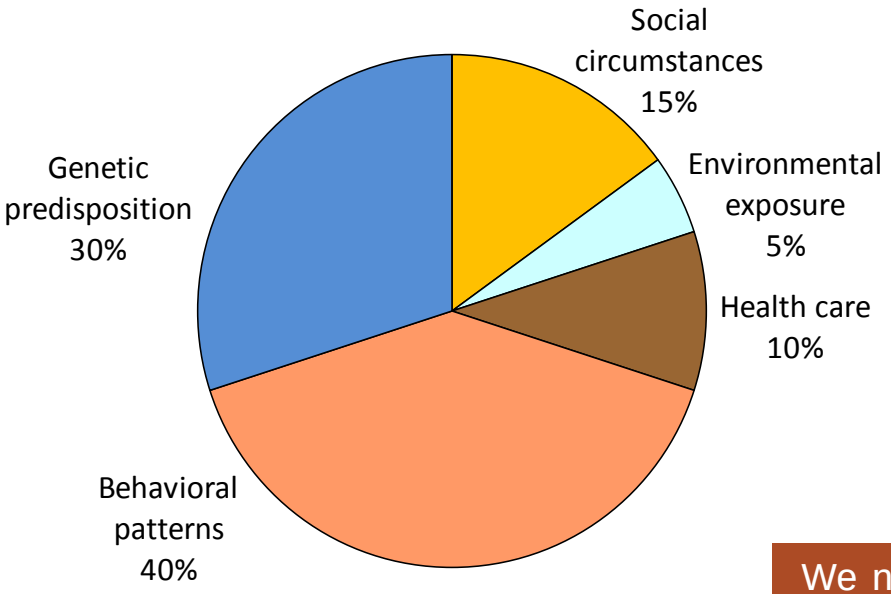
Pressure for Change (cont'd)

Determinants of Health and Their Contribution to Premature Death



We need to be in the business of **changing behavior** -- not delivering isolated services.

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Why the Primary Care Home in Oregon?

- Issues with current primary care model
- Our stakeholders wanted something better
  - Patients
  - Payers
  - Providers & support staff
- Recruitment getting harder
- Pay for Performance and transparency coming

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What is a Primary Care Home?

- Flexible, based on population need
  - Patient-centered experience
  - Quality & safety
  - Team-based care
  - Enhanced access
  - Coordination of care
  - Behavioral health integration

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What is a Primary Care Home (cont'd)?

- PCH Visual

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National Health Care Reform

- Expanding access to safety net
- Reducing the number of uninsured
- Payment focused on cost and quality
- Focus on wellness

What type of delivery model will prepare us for this new world?

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Challenges, Barriers and Competing Priorities

Environment:

- Payment focused on old model
- Workforce not trained for model
- HRSA productivity requirements
- Current economic environment & need to focus on access

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Challenges, Barriers and Competing Priorities (cont'd)

Clinic level:

- Capturing data
- Spreading leadership and buy-in throughout the clinic
- Finding resources
- Allowing time to build external relationships

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Key Issues for Payment Reform

- Ensure that quality data - and payment - account for psycho-social factors
- Support home for entire patient population, not just chronic conditions
- Minimize clinics' administrative burden and cost
- Tailor payment to reward movement on indicators
- Allow *time* for appropriate work
- Pay for work that improves health outcomes
- Fund learning collaboratives

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Exciting Developments

- Policy alignment and opportunity
  - APM – RHCs/FQHCs
  - PCPCH payment
  - CCO/ACO
  - Patient-centered focus
- Results from Oregon PCH initiative
- Opportunity to connect neighborhood

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Keep Your Eye on the Ball: Metrics That Will be Important to Improve

- SNMHI metrics (quality and access):
  - Percent of appointments per month where patients see a provider on their own care team
  - Average number of days until third next available appointment
  - Percent of diabetic patients with:
    - HbA1c test within last six months
    - HbA1c test in last six months with <8 as result
    - LDL < 100 in last 12 months
  - Percent of patients 18 yrs+:
    - With hypertension with BP<140/90
    - Screened for depression in last 12 months
  - Percent of female patients 21 – 64 yrs old with pap test within three years
- Total cost
    - ER utilization
    - Hospital admissions
- PCPCH metrics

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Thank You!

Contact Information

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