

OREGON RURAL HEALTH CONFERENCE

PRIMARY CARE MEDICAL HOME

SEPTEMBER 22, 2011

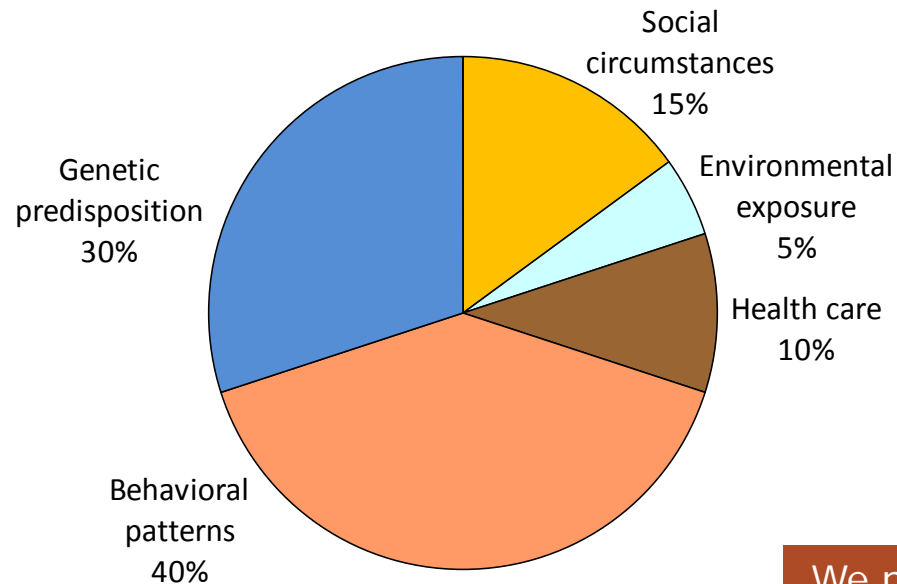
Pressure for Change

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



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.



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

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

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

- PCH Visual

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?





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

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



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

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





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

Thank You!

Contact Information

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