
Oregon
Health
Authority

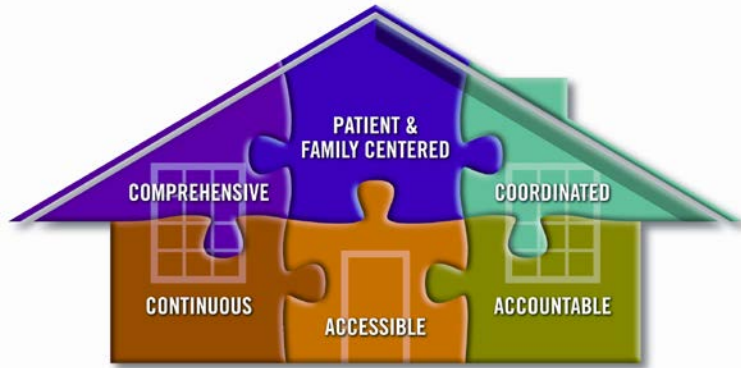
PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM



Patient-Centered Primary Care Home Program

- HB 2009 established the PCPCH Program:
 - Create access to patient-centered, high quality care and reduce costs by supporting practice transformation
 - In 2016 joined the Oregon Health Authority's Transformation Center
- Key PCPCH program functions:
 - PCPCH recognition and verification
 - Refinement and evaluation of the PCPCH standards
 - Technical assistance
 - Communication and provider engagement

PCPCH Core Attributes



ACCESS TO CARE

Be there when I need you.

ACCOUNTABILITY

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

COMPREHENSIVE WHOLE PERSON CARE

Provide or help me get the health care and services I need.

CONTINUITY

Be my partner over time in caring for my health.

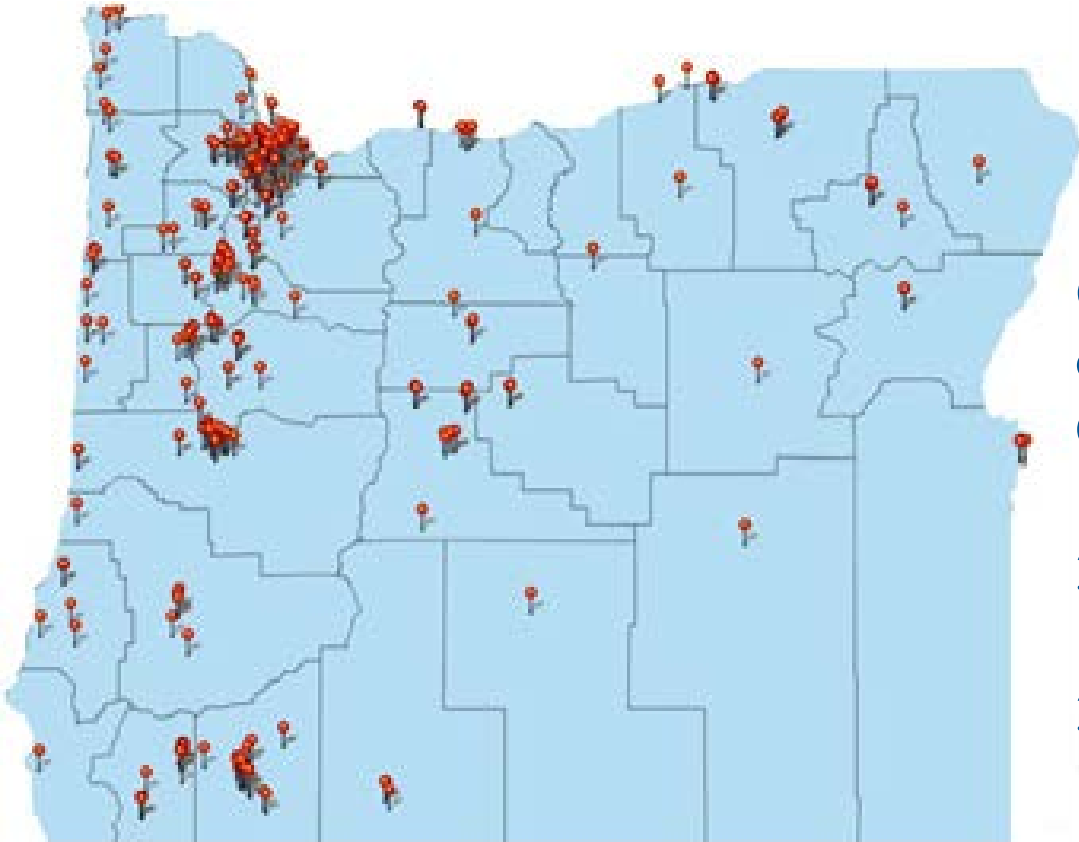
COORDINATION AND INTEGRATION

Help me navigate the health care system to get the care I need in a safe and timely way.

PERSON AND FAMILY CENTERED CARE

Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.

Where PCPCHs are located



618 PCPCHs, approximately $\frac{3}{4}$ of all primary care practices in Oregon

35 out of 36 counties

30 5-STAR designated clinics

PCPCH Site Visits - Key Learning

- **Variability and Patterns**

- Innovative processes
- Universal need for help/assistance
- Some have difficulty engaging front lines

- **Common barriers**

- **Inadequate financial resources, FFS reimbursement**
- Workforce/staff limitations
- Low adaptive reserve: feeling “alone”, “change fatigue”
- EHR

- **Characteristics of successful transformation**

- Motivation = innovation to provide best care possible to meet patient/community needs
- Collaborative “peer” learning and external support
- Multi-disciplinary staff engagement and integral involvement

Accountability

“Take responsibility for making sure we receive the best possible healthcare”

Clinic setting: Rural, hospital-owned, small (2 clinicians), family medicine

- **Problem:** Organization not effectively implementing PCPCH to reach the ground-level, recognized they were “check-boxing”
- **Actions:** Reset strategy
 - Engaged clinicians as a first step (address “pain points”), engaged operations people as second step, then implement.
 - Allowed process improvement specific to clinic population - clinic staff collectively identified areas to improve from menu of options.
 - Frontline staff trained in LEAN processes and integrally involved in implementation of changes
 - Multi-level, longitudinal QI structure to foster accountability, data review to understand if change = improvement
- **Outcomes:** Frontline staff empowered to make change and “make a difference”, staff “owns” improvement processes, proud of progress.

Comprehensive Whole Person Care

“Provide or help us get the health care information and services we need”

Clinic setting: Rural Health Center, medium-sized (3 clinical teams), family medicine

- **Problem:** Clinic population struggles with “determinants of health” issues, clinicians feel powerless to affect those problems.

- **Actions:** connect with community organizations, use team in innovative ways
 - Utilize RNs to focus on specific care areas of interest – e.g. RN focused on diabetes management/education, “wellness” groups, home visits for “pantry cleanout”
 - Behavioral Health Clinician and RN “run” MAT group visits
 - Patient advocate/navigator role – connects patients with concrete resources
 - Collaborate with community orgs to provide food, transportation resources

- **Outcomes:** Improved diabetes control, patients recognize clinic team “goes above and beyond”, helps patients “get on the right track for life”

PCPCH Impact

- Return on Investment
 - Every **\$1 increase** in primary care spending = **\$13 in savings**
 - PCPCH program implementation has resulted in **\$240 million in savings** to Oregon's health system between 2012 and 2014.
 - PCPCH-recognized 3 years lowers cost of care **\$28 PMPM** which is double the overall average for all PCPCH clinics
- Clinics Mature in the Model
 - Savings in specialty, emergency, and inpatient care costs more than doubled in 3rd year of PCPCH recognition compared to overall average
- The Whole is Greater Than the Sum
 - Cumulative effect of the PCPCH attributes has more impact on cost & utilization than the independent effects

Policy to Increase Investment in Primary Care – SB934

- Sets minimum benchmark for all payers (prominent commercial carriers, CCOs, PEBB/OEBB) to spend at least 12% of total medical expenditures on primary care.
 - if not meeting minimum, payers must submit plan to increase investment in primary care by at least 1% per year to reach 12% minimum threshold by 2023.
- Requires payers participating in Comprehensive Primary Care Plus (CPC+) to “offer similar payment methodologies” to all Oregon PCPCHs
- Multi-stakeholder Primary Care Payment Reform Collaborative to “advise and assist” implementation of Primary Care Transformation Initiative, and report annually on progress to the Oregon Health Policy Board and Legislature.

Primary Care Payment Reform

Collaborative Tasks/Goals

- Use value-based payment methods (**NOT** Fee-for-service) to:
 - Increase the investment in primary care;
 - Align primary care reimbursement by all purchasers of care;
 - Improve reimbursement methods, including through investing in the social determinants of health
- Increase investment in primary care without increasing costs to consumers or increasing total cost of health care
- Provide technical assistance to clinics and payers
- Aggregate payer data, align metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee
- Facilitate integration of primary care behavioral and physical health care

Thank you!

Questions?

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