Oregon Health Authority

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POLICY AND ANALYTICS
Transformation Center

PCPCH Program Overview

- Established in 2009 by the Oregon Legislature
- Standards are developed and refined by a volunteer multi-stakeholder Standards Advisory Committee.
  - Next Committee will meet in fall 2019.
- Six core attributes, each with specific standards and measures.
- Eleven "must pass" measures all clinics must meet.
- Five levels or tiers of recognition based on which measures a clinic meets, and how many points are awarded.
  - 5 STAR is the highest level of recognition.

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

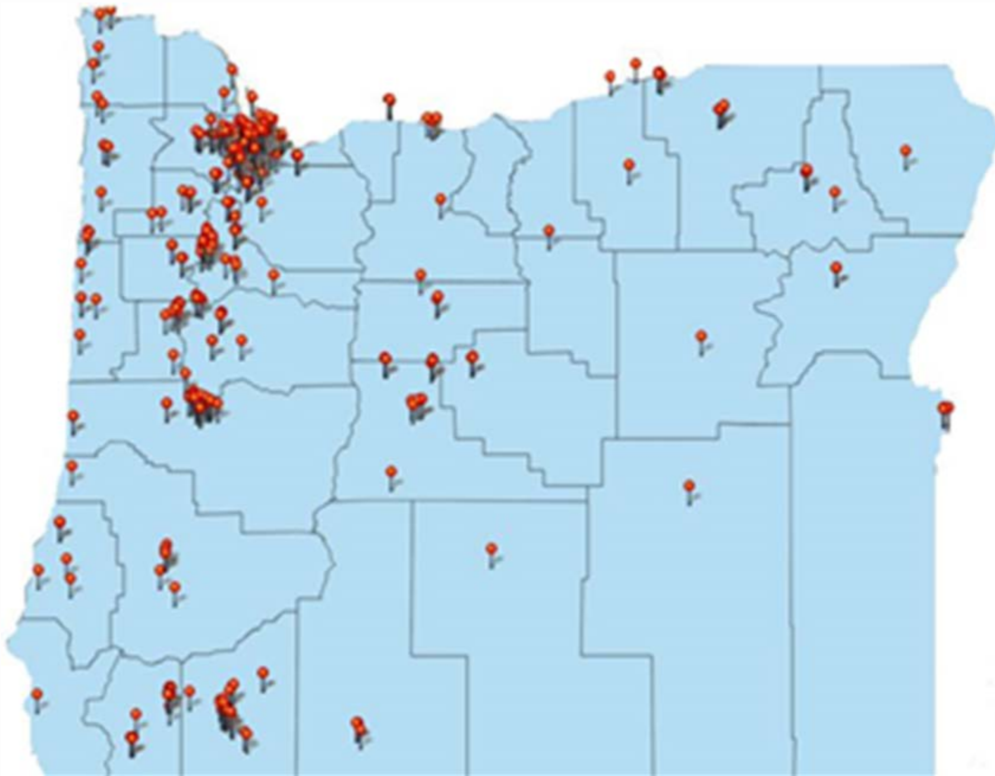
COMPREHENSIVE WHOLE PERSON CARE
Provide or help me get the health care and services I need

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



- 650 PCPCH clinics throughout 35 of the 36 counties.
- 50 5 STAR clinics
- Approximately ¾ of all Oregonians get their care at a PCPCH!

PCPCH program 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.
- Site visits ensure the integrity of the PCPCH program and the attestation model.
- By participating in the program, your clinic agrees to an on-site visit when selected. Each clinic will receive a site visit at least once every five years.

PCPCH site visit team

Role	Description
Compliance Specialist (CS3)	• schedules and coordinates visit, reviews charts and documents, technical assessment measures
Practice Enhancement Specialist (PES)	• conducts staff and patient/caregiver interviews, evaluates practical application of PCPCH program standards, provides technical assistance and practice coaching post-site visit
Clinical Transformation Consultant (CTC)	• Family Medicine or Pediatric provider from a high functioning PCPCH, who provides peer perspective and networking *(when available)*

5 STAR designation

Attest to 255-380 Points

All Must Pass measures

11 of 13 5 STAR measures

Site visit from PCPCH Program

Thirteen 5 STAR measures

- 1.B.1- After Hours Access.
- 2.D.3- Quality Improvement.
- 3.C.2- Referral Process or Co-location with Mental health, Substance abuse, or Developmental providers.
- 3.C.3- Integrated behavioral health services.
- 4.B.3- Personal Clinician Continuity.
- 5.C.1- Responsibility for Care Coordination.
- 5.C.2- Coordination of Care.
- 5.C.3- Individualized Care Plans.
- 5.E.1- Referral tracking for Specialty Care.
- 5.E.2- Coordination with Specialty Care.
- 5.E.3- Cooperation with Community Service Providers.
- 6.A.1- Language/Cultural Interpretation.
- 6.C.2 or 6.C.3- Experience of Care.

Clinic Stories: An innovative approach to PCPCH in rural communities

Mountain View Medical Center- Forest Grove

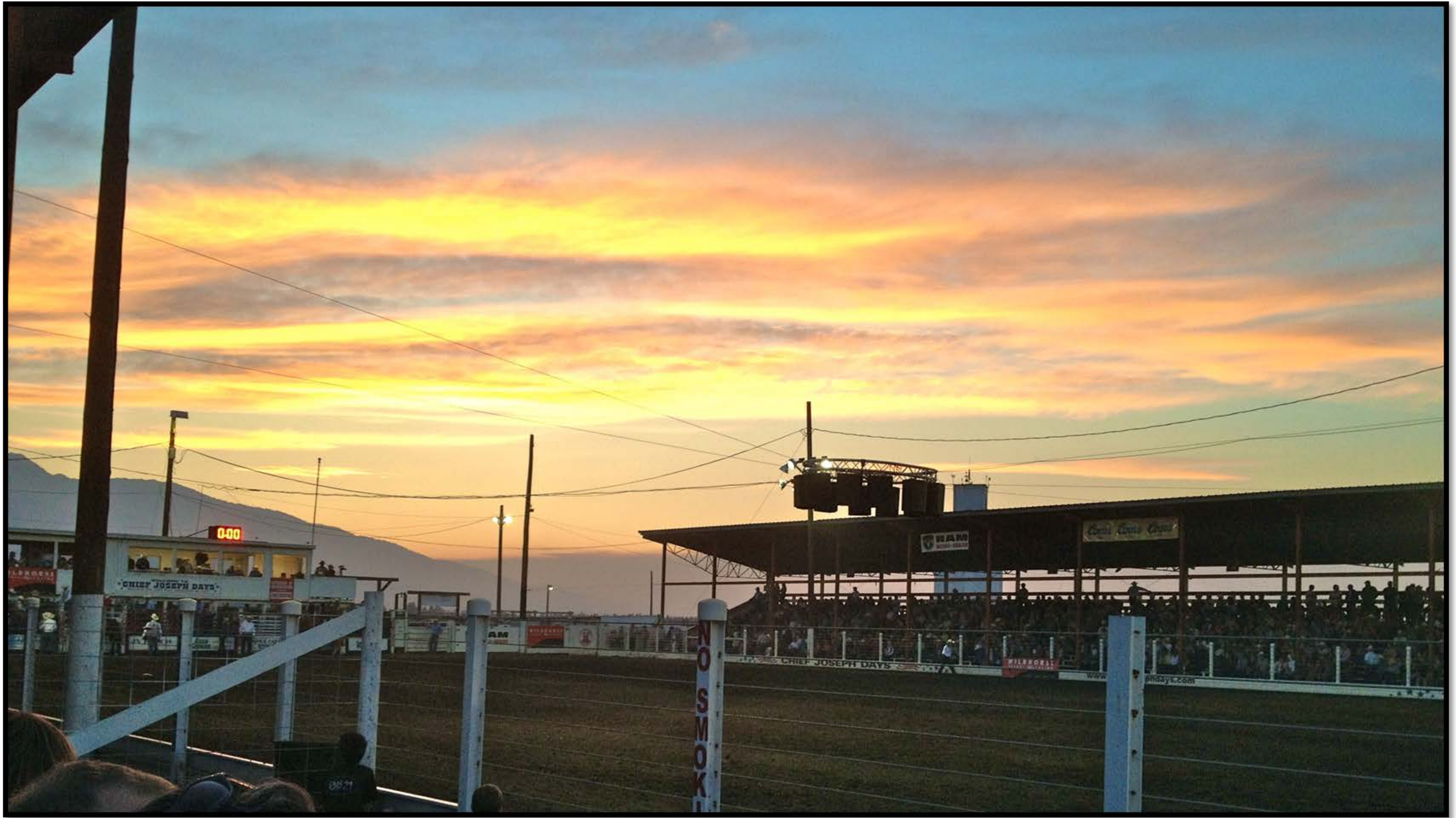
Breast Cancer/Mammogram Screening

Central Oregon Pediatric Associates- Redmond

Community Resource Outreach

Rogue Community Health- White City

Priority Partners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CHIEF JOSEPH DAYS
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Policy to Increase & Align Investment in Primary Care Oregon Senate Bill 934 (2017)

- Sets minimum threshold for all payers to spend at least 12% of total medical expenditures on primary care

- Primary Care Payment Reform Collaborative to advise and assist the Oregon Health Authority, report annually to legislature on progress towards goals

- Requires payers participating in national Comprehensive Primary Care Plus (CPC+) initiatives to "offer similar payment methodologies" to all Oregon PCPCHs*

*Rural Health Centers/Federally Qualified Health Centers/pediatric practices were explicitly excluded from CPC+

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Primary Care Transformation Initiative

Per SB 934 the Initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care)
- Improve reimbursement methods, including by investing in the social determinants of health
- Align primary care reimbursement across all purchasers of care

The Collaborative will support:

- Use of value-based payment methods (not fee-for-service)
- Provision of technical assistance
- Aggregation of data across payers and providers
- Alignment of performance metrics
- Integration of primary care behavioral and physical health care

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Thank you!

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For more information

Patient-Centered Primary Care Home Program

www.primarycare.Oregon.gov

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Primary Care Payment Reform Collaborative

https://www.oregon.gov/oha/HPA/CSI-TC/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx