Patient Centered Primary Care Home 2017
A Rural Heath Perspective

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Objectives

• Provide overview of PCPCH Model
• Review changes to 2017 PCPCH Model
• Share innovations from rural practices in Eastern Oregon
• Conversation: Explore challenges and share other innovations in the field
Core Attributes of a Primary Care Home

Oregon’s PCPCH model is defined by six core attributes, each with specific standards and measures.
Overview: PCPCH Saturation

• 629 clinics recognized as of 2016
  – 83% of CCO practices
  – 61% increase since 2012

• PCPCH clinics have higher mean scores than non-PCPCH clinics for:
  – Diabetes care
  – appropriate use of antibiotics for children with pharyngitis
  – well-child visits for children (3-6 yrs.)
  – preventive care (e.g. Chlamydia screening)

Source: Q-Corp Statewide Report on Health Care Quality 2015
Overview: PCPCH and CCOs

- **PCPCH enrollment is CCO Incentive Measure**
  - No Benchmark has been set for this measure
- **Goal**: To have 100% OHP members enrolled in Tier 3 PCPCH¹
- **CCOs report the number of members assigned to providers in PCPCH practices on a quarterly basis**
- **CCOs can also report to OHA:**
  - Number of health care teams or clinics meeting PCPCH standards
  - Number of primary care practitioners accepting members in a PCPCH by tier

¹ PCPCH Enrollment Measure Basic Information document revised Nov 2015
Overview: Site Visits

• PCPCH recognized clinics will receive a site visit at least once every five years

• Site Visit Process (~3 hrs. total)
  – 45 minute interval interviews with care teams/providers on clinic workflow
  – Chart review/PCPCH documentation review

• Patient focus groups (6-8 patients; 45 minutes)

• Consultant time (45 minutes)
  – Provider/staff leadership meeting with Clinical Transformation Consultant (CTC)

After the Site Visit:

– Clinic can receive assistance from PCPCH Program up to 6 months

– Practice Coach assistance with clarifying measures, reviewing improvement plans, providing tools and resources, and connecting the clinic with other (similar) PCPCH practices in Oregon

– CTC is also available to share ideas, learning, and provide peer-to-peer assistance
“Times, they are a-changin…”
–Bob Dylan

Changes to PCPCH Model beginning January 2017

- 12 standards have been revised
- Formerly “optional” measure will become a “Must-Pass” totaling 11 “Must-Pass” measures
- A new Tier structure: Move from 3 Tiers to 5 Tiers
- New technical specifications are available online now: www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf
- Revised online application system will be available January 2017
Changes in the Tiers

• To encourage continued primary care practice improvement and address the feedback from stakeholders, the revised PCPCH model has been expanded from three Tiers to five Tiers.

• The additional tiers segment the current Tier 3 PCPCHs to better distinguish clinic capability without causing any PCPCH to “drop a tier.”

• The highest tier in the revised model – 5 STAR - aligns with the current 3 STAR designation that was introduced in February 2015 to recognize clinics on the forefront of transformation.
## Tiering Changes

<table>
<thead>
<tr>
<th>Tier</th>
<th>Thresholds</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>30 - 60 points</td>
<td>+ All must-pass standards</td>
</tr>
<tr>
<td>Tier 2</td>
<td>65-125 points</td>
<td>+ All must-pass standards</td>
</tr>
<tr>
<td>Tier 3</td>
<td>130 – 250 points</td>
<td>+ All must-pass standards</td>
</tr>
<tr>
<td>Tier 4</td>
<td>255 -390 points</td>
<td>+ All must-pass standards</td>
</tr>
<tr>
<td>5 STAR</td>
<td>255 – 380 points</td>
<td>+ All must-pass standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ Meet 11 out of 13 specified measures</td>
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<tr>
<td></td>
<td></td>
<td>+ All measures are verified with site visit</td>
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</tbody>
</table>
PCPCH Core Attribute 1: Access to Care

- 1.C.0 and 1.C.1 combine to become a single Must-Pass: Continuous access to clinical advice by phone and documented encounters (become 1.C.0)

- 1.E.3 Meaningful Use measure pertaining to provision of copy to patients of their health information: Change in weight of point value from 15 points to 5 points (becomes 1.E.1)

- 1.F.1 Tracking time to completion for prescription refills: Change in weight of point value from 5 points to 10 points (becomes 1.F.2)
Rural Innovation 1.C.0: The Eastern Oregon Call Share Collaborative

- Collaborative includes small (1 to 2 providers), rural practices to share after-hours access to meet Must Pass measure 1.C.0
- Uses third-party vendor FoneMed which provides the following:
  - Nurse triage 24/7
  - Offers medical advice
  - Documents encounters and fax to each clinic by next business day

**FoneMed Cost Breakdown:**
- Ave of **$5200** per clinic per year (**$433** per month per clinic)
- Flat set up fee of **$395** with minimum billing of **$395** per month up to 17 calls
- Overage cost is **$22.50/call** (average call volume 6.25-12.5/month for clinic size of 2500 active patients)

**Co-op Cost Breakdown using FoneMed:**
- Current cost reduction of 52% (average of **$2600** per clinic per year)
- Local administration for billing and overage allocation (0.4% administrative cost)
- Reduced set-up fee charge (from **$395** to **$100**)
PCPCH Core Attribute 2: Accountability

• Adjustment of 2.A.2, which now reads: PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (10 points)
PCPCH Core Attribute 3: Comprehensive Whole-Person Care

• 3.A.1 PCPCH routinely offers or coordinates appropriate preventive services based on best available evidence: now includes a requirement for identifying areas for improvement.
• Standard 3.C – “stackable measures”
  – Revised 3.C.0 (Must Pass): change to “and” instead of “or”; add “...local referral resources and processes”
  – Revised 3.C.2: Emphasizes robust cooperative referral and co-management and/or co-location.
  – Revised 3.C.3: formerly emphasized co-location of specialty mental health, substance abuse, or developmental providers. Revised to place greater emphasis on, and specifications for: functional integration, population-based care, and same-day consultation.
PCPCH Core Attribute 3: Comprehensive Whole-Person Care

• Standard 3.E: Preventive service reminders.
  – Old 3.E.3 (Meaningful Use measure) reduced in point value from 15 points to 5 points (becomes 3.E.1)
  – Revised 3.E.2 emphasizes thoughtful, data-driven generation of lists that are then used for proactive outreach to patients missing evidence-based recommended preventive services.
  – Revised 3.E.3 – like 3.E.2, but with tracking to monitor completion of recommended preventive services.
Rural Innovation 3.C: Behavioral Health Integration

- Eastern Oregon CCO incentivizes primary care innovation for behavioral health integration
  - Greater Oregon Behavioral Health, Inc. provides additional $2PMPM to primary care for integration
  - Transformation Grants focus on behavioral health integration into primary care
    - New Directions Northwest (serves Baker County)
    - Yakima Valley Farm Workers (serves Umatilla County)
PCPCH Core Attribute 4: Continuity

- 4.G.3 Medication reconciliation: changes from a Meaningful Use measure to requiring a more comprehensive, robust medication management strategy. Meaningful Use process is incorporated into 4.G.1 (5 point measure)
PCPCH Core Attribute 5: Coordination and Integration

• 5.A.1a and 5.A.1b Pertaining to population data management: combine into one measure to become 5.A.1.

• 5.A.2 New measure: requires PCPCH to demonstrate ability to risk-stratify patient population according to health risks based on health needs or behavior.

• 5.C.1 Changes from assigning individual responsibility for care coordination to: more broadly requiring that PCPCH have defined roles among the care team members for care coordination overall.
Rural Innovation 5.C: Community Health Workers

- Community Health Workers/Personal Health Navigators are being integrated in primary care to provide:
  - Outreach and Mobilization
  - Community and Cultural Liaising
  - Case Management, Care Coordination and System Navigation
  - Health Promotion and Coaching

- EOCCO partnered with Oregon State University for online CHW training program

- CHW’s can bill for services to EOCCO enrolled members

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3 EOCCO CHW policy guidelines at www.eocco.com
PCPCH Core Attribute 6: Person and Family-Centered Care

- 6.C.1 Patient survey which was formerly optional becomes 6.C.0, Must-Pass.

- 6.C.2 Now requires a patient survey every two years instead of annually, and utilization of the survey data within the practice.

- 6.C.3 Also changes patient survey frequency from annually to every two years, and utilization of the survey data within the practice.
How are you being supported?

• CCO Support
  – Financial
  – Coordination with Community Advisory Council

• Technical Support
  – Webinars
  – In-person Learning Collaboratives
  – Conferences

• Other?