

Oregon's Support for Strong Primary Care



www.facebook.com/pcpcc



www.twitter.com/pcpcc

Patient-Centered
Primary Care
COLLABORATIVE

Welcome and Announcements

- Welcome – [Ann Greiner](#), PCPCC President & CEO
- Upcoming Webinar - February 27, 2018 at 3:00pm EST
 - **Topic:** [Overcoming Challenges to Ideal Primary Care](#)
 - **Registration:** Visit the Events Calendar on PCPCC Website:
www.pcpcc.org/calendar
- Interested in joining the PCPCC?
 - Please email Allison Gross (agross@pcpcc.org) or visit www.pcpcc.org/executive-membership
- Questions during the webinar?
 - Please use the chat box



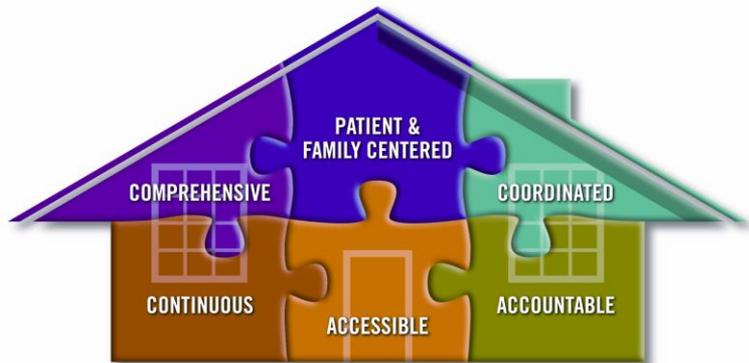
PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM



Evan Saulino MD, PhD
Clinical Advisor, Oregon PCPCH Program
Evan.Saulino@state.or.us

Patient-Centered Primary Care Home (PCPCH) Program

- Oregon House Bill 2009 established the PCPCH Program
 - Create access to patient-centered, high quality care and reduce costs by supporting practice transformation
 - In 2016 **the program became part of** the Oregon Health Authority's (OHA) Transformation Center
- Oregon Health Policy Board Goals (2010)
 - All OHA covered lives receive care through a PCPCH by 2015
 - 75% of all Oregonians have access to quality care through a PCPCH by 2015
 - Align primary care transformation efforts by spreading the model to payers outside the OHA
- 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

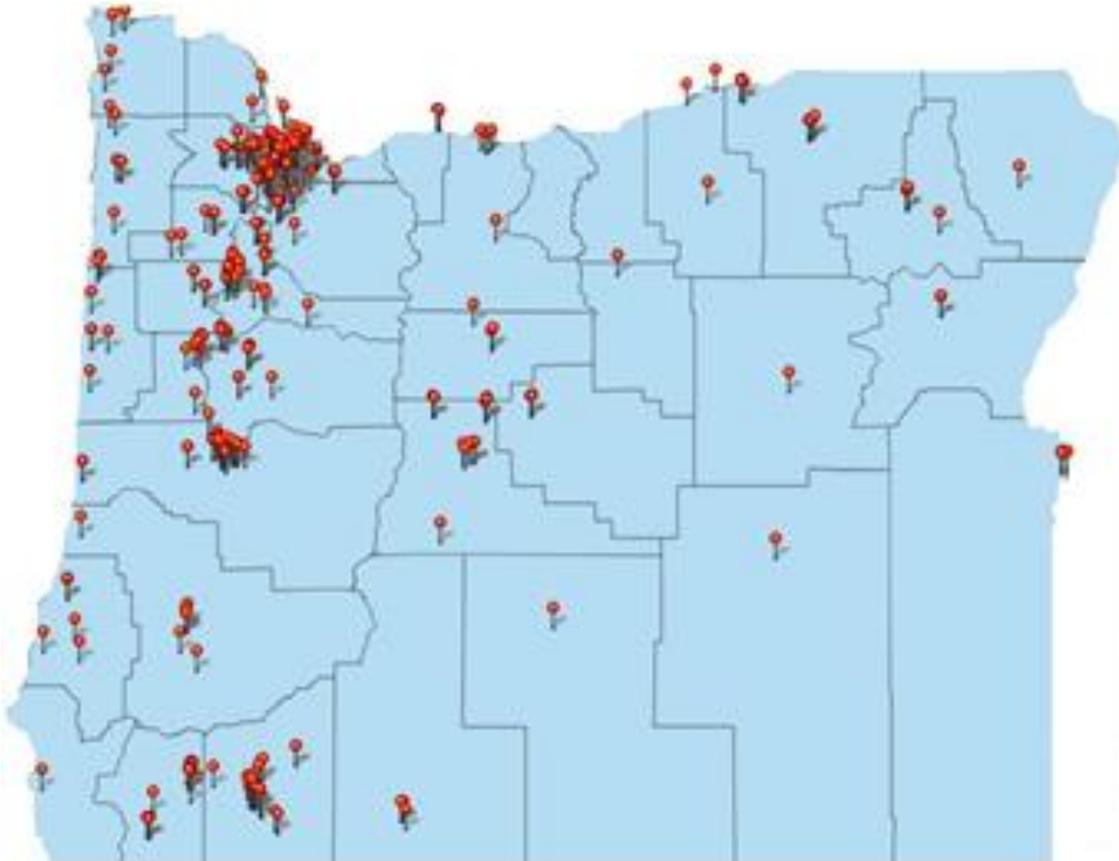
Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.

2017 PCPCH Recognition Criteria

- Multi-disciplinary Standards Advisory Committee guides the definition of the PCPCH clinical model of care.
- Six core attributes, each with specific standards and measures
- Eleven “must pass” measures all clinics must meet
- Five tiers of recognition based on which measures a clinic meets – the comprehensiveness of their care model. 5 STAR is the highest level of recognition.



Where PCPCHs Are Located



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

35 out of 36 counties

39 5-STAR designated
clinics

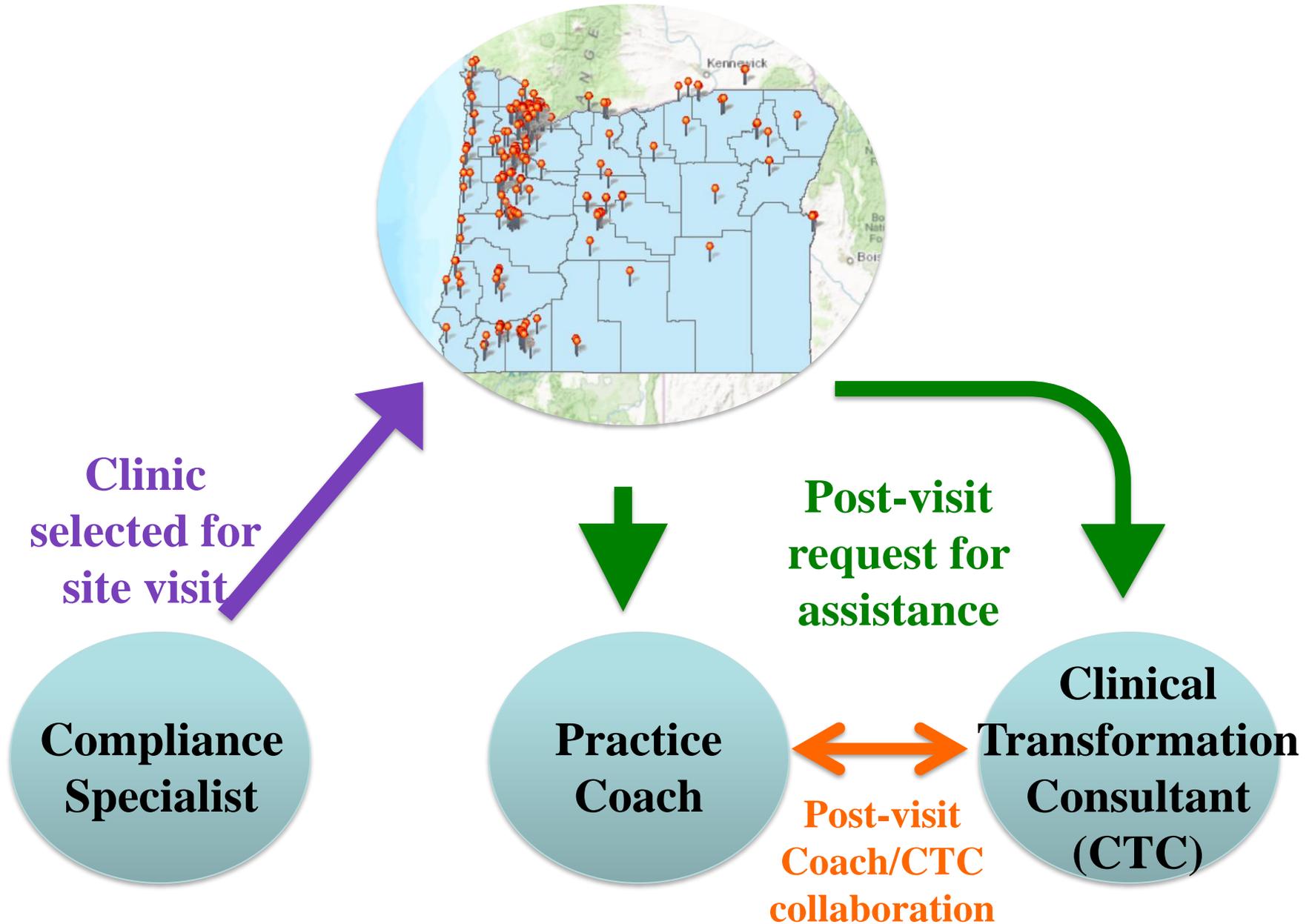
Verification Site Visits

- PCPCH Program conducted more than 200 site visits since 2012
- Team includes a Compliance Specialist, Practice Coach and Clinical Transformation Consultant
- During a site visit the team:
 - **Verifies** that the clinic practice and patient experience in the practice accurately reflects the measures attested to
 - **Assesses** the care delivery and team transformation process to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH
 - **Collaborates** to identify areas of improvement and to connect clinics with colleagues and technical assistance

Verification Site Visits - Key Learning

- **Variability and Patterns**
 - Innovative processes everywhere
 - Universal need for help/assistance
 - Some have difficulty engaging front lines
- **Common barriers**
 - Inadequate financial resources, fee-for-service reimbursement
 - Workforce/staff limitations
 - Low adaptive reserve: feeling “alone,” “change fatigue”
 - Electronic Health Record (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

PCPCH Site Visit Team Structure & Communication





Oregon's Patient-Centered Primary Care Institute

- Founded In 2012 through a public-private partnership between the Oregon Health Authority, the Oregon Health Care Quality Corporation and the Northwest Health Foundation.
- Connects Oregon practices in all stages of primary care home transformation to a broad array of technical assistance
 - Webinars on core practice transformation topics open to all, recorded and available online
 - [Online Learning Modules](#) plus searchable library of tools, training modules, videos, and best practices also available online at www.pcpci.org
 - Technical Assistance Professionals discussion forum
- Create opportunities for quality improvement professionals and other transformation leaders to share with one another and leverage resources

Innovation Is Not a Great Idea, It's a Great Process



Charlotte Navarre, RN Clinician, Annamarie Proctor, Team Lead Zoila Espana, Care Coordinator/Team Lead, Evan Saulino, MD, PhD

Read more here >>>

[Addressing Common Team Challenges –Strategies and Stories](#)

Transformation in Practice Webinar Series

- Hosted by the OHA Transformation Center to provide in-depth technical assistance on Patient-Centered Primary Care Home (PCPCH) model measures
 - Clinical Quality Improvement ([recording here](#))
 - Risk Stratification, Complex Care Coordination and Care Plans ([recording here](#))
 - Referral tracking, provider continuity, after hours access and written documents ([recording here](#))
- PCPCH program staff shares best practices they have learned from visiting PCPCHs across the state
- Features clinics that have successfully implemented some of the most commonly misunderstood PCPCH measures

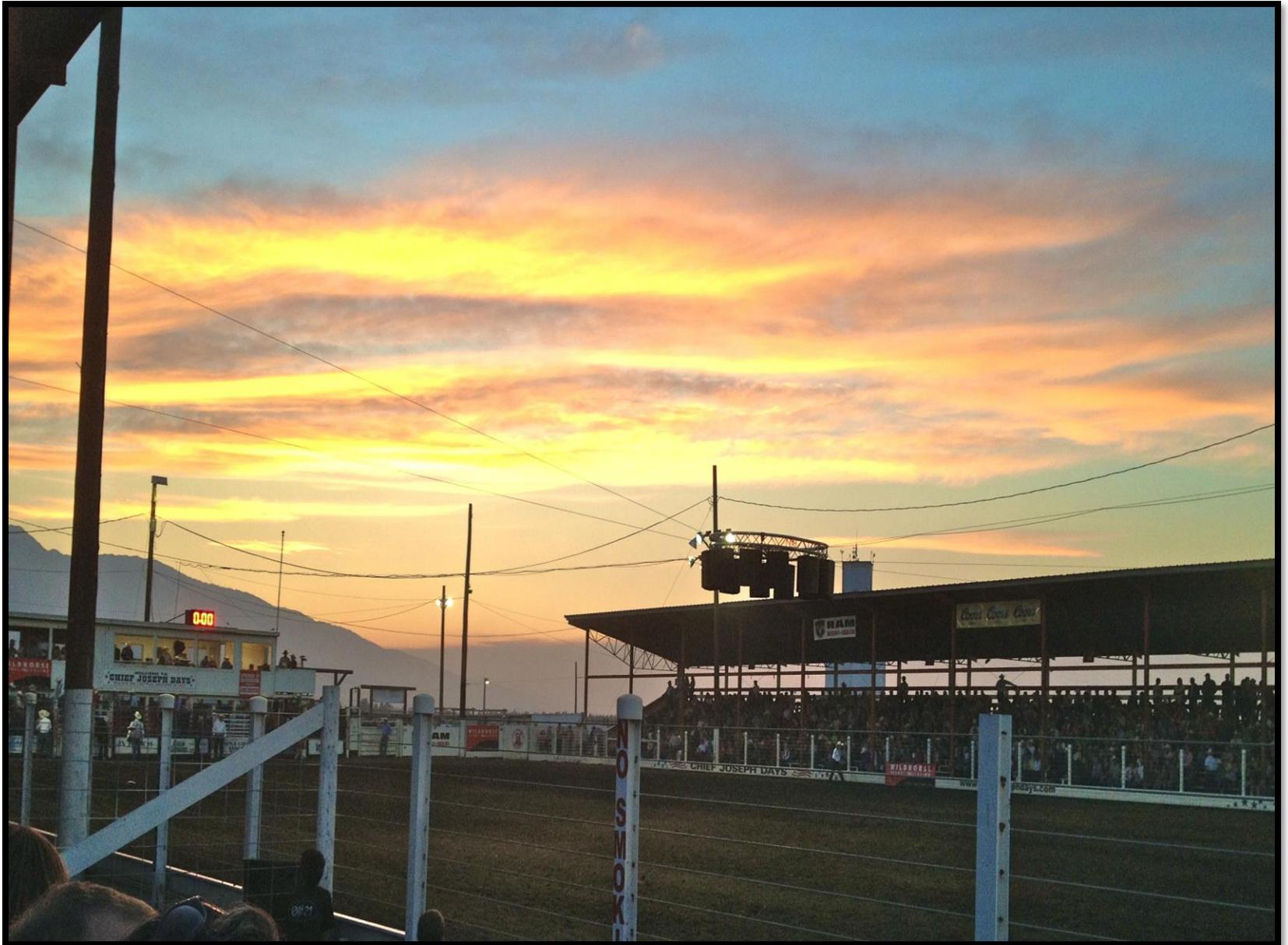
Springfield Family Physicians



Jane Conley, Practice Manager
janec@springfieldfamilyphysicians.com

PCPCH Program Implementation Report

- 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 any independent effects of the attributes



Wallowa County

Policy to Increase and Align Investment in Primary Care - Oregon Senate Bill 231 (2015)

Primary Care Spending in Oregon report

- Measures primary care spending across Oregon population – report annually to Legislature ([read the 2017 report](#))
 - Prominent carriers (commercial/Medicare Advantage)
 - Medicaid Coordinated Care Organizations (CCOs)
 - Public Employees/Teachers (PEBB/OEBB)
- Includes claims-based and non-claims-based expenditures

Primary Care Payment Reform Collaborative

- Comprised of payers, providers, patients, policy makers, self-insured companies, and other key stakeholders
- Developed and presented recommendations to the Oregon Health Policy Board in December, 2016
- Required to convene through 2027

Policy to Increase and Align Investment in Primary Care - Oregon Senate Bill 934 (2017)

- Sets minimum threshold for all payers (commercial carriers, CCOs, PEBB/OEBB) to spend at least 12% of total medical expenditures on primary care.
 - Payers not meeting the target 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
- Primary Care Payment Reform Collaborative to “advise and assist” implementation of Primary Care Transformation Initiative, report annually on progress to the Oregon Health Policy Board and Legislature.

Primary Care Payment Reform Initiative

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 by purchasers of care

To achieve the implementation of this Initiative, the Collaborative will support the:

- Use of value-based payment methods (not fee-for-service)
- Provision of technical assistance to clinics and payers in implementing the initiative
- Aggregation of data across payers and providers;
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee
- Facilitation of the integration of primary care behavioral and physical health care

Thank You!
Questions and Discussion?



Wheeler County

www.PrimaryCareHome.Oregon.gov

PCPCH@state.or.us

PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

Oregon
Health
Authority

Questions?

Patient-Centered
Primary Care
COLLABORATIVE