Patient Centered Primary Care Home

Achieving 5 STAR Status

Community Health Centers of Benton and Linn Counties

July 2018

Community Health Centers of Benton & Linn Counties

Outline for today

Organizational Readiness

Quality, Data Tracking, Reports

Patient Engagement

Site Focus

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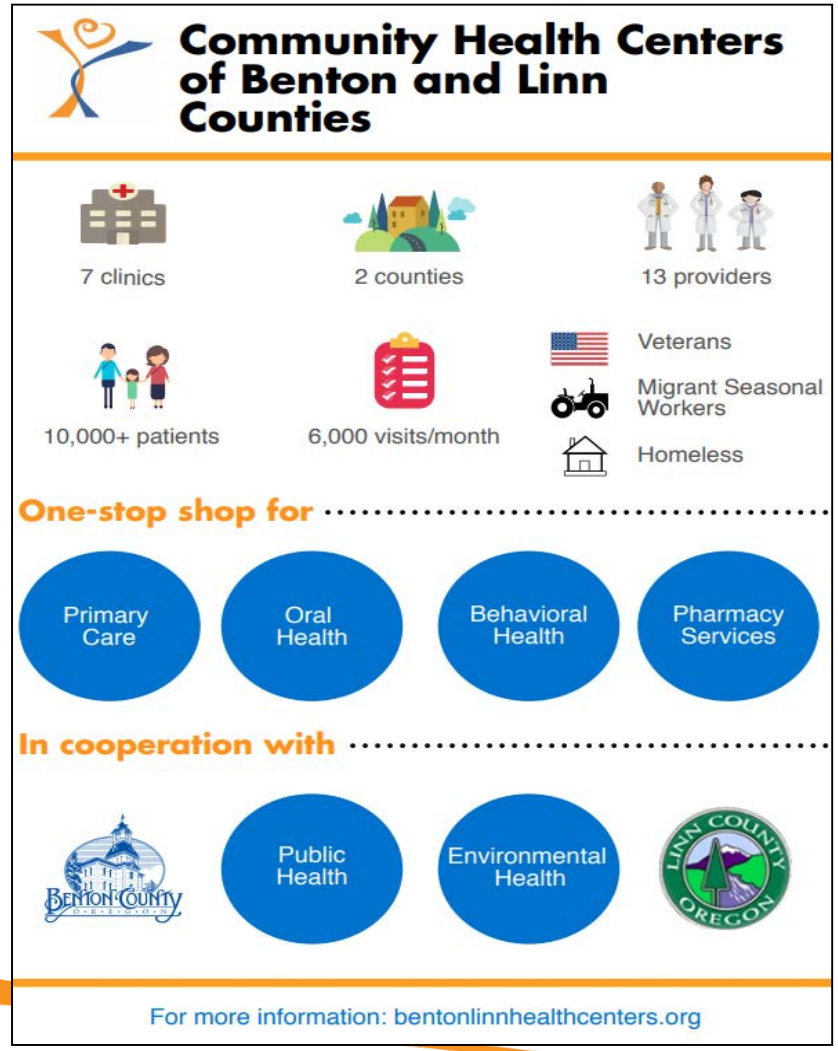
Who we are:



FQHC (Public entity funded 2004)

6 Primary Care clinics

Corvallis (2), Alsea, Monroe, Lebanon, Sweet Home

Additional Services

- Family Planning
- School-based Health Centers (2)
- Pharmacy
- Behavioral Health
- Oral Health Services

Target populations

- Latino/Hispanic
- Veterans & Seniors
- Complex health needs

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Organizational Readiness

Health Center Director: Sherlyn Dahl

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Expand care team

Core Team

- Providers
- Medical Assistants
- Schedulers

Additional Members

- Panel Manager
- RN Care Coordinator
- Behaviorist
- Clinical Navigator
- Clinical Pharmacist

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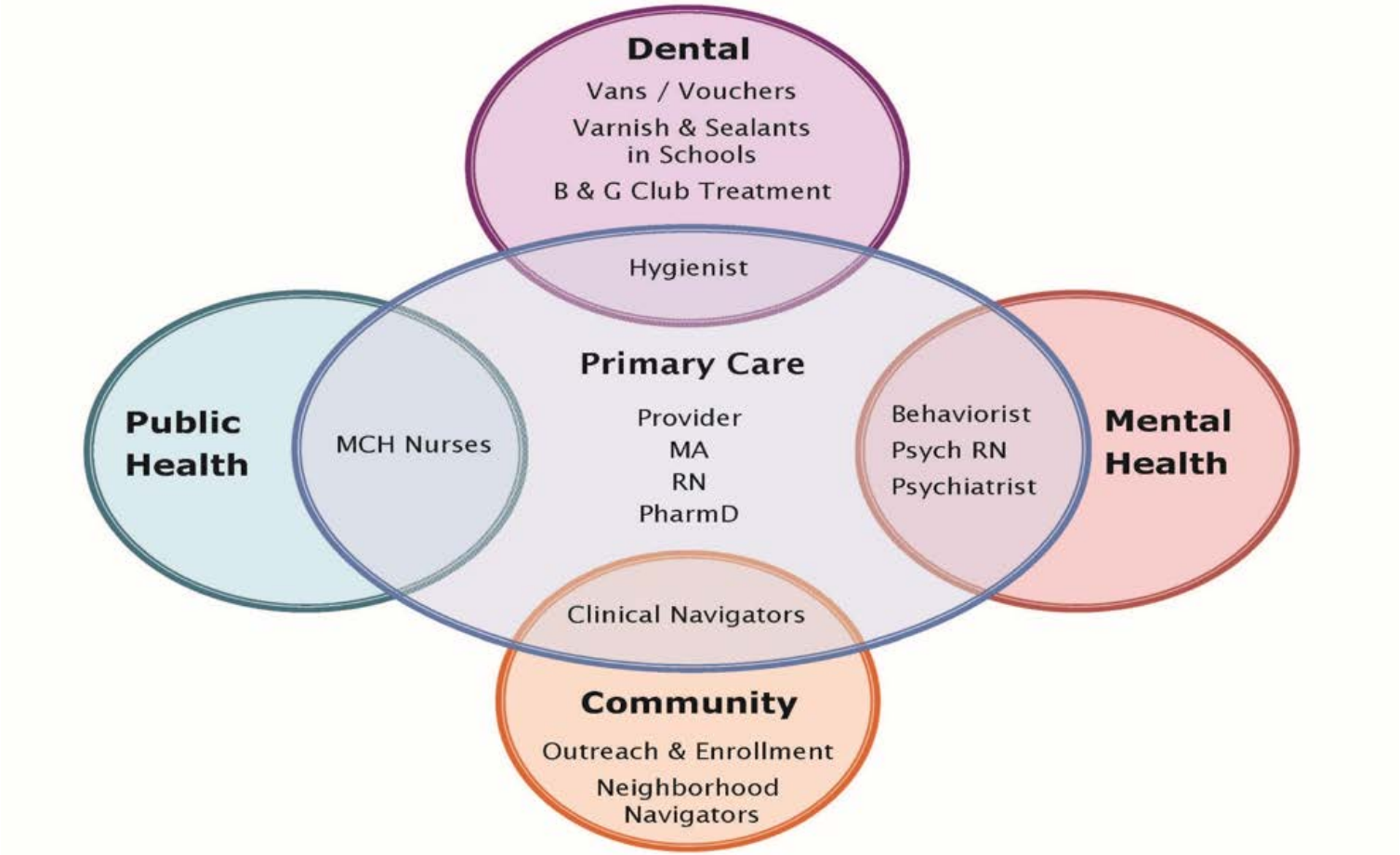
Care team infrastructure



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Patient-focused access

Expanded evening hours

Alternative methods for access

- Promote MyChart for communication & accessing results
- Use Care Team members for care coordination, follow-up, and alternative visits

Follow-up after ED & hospitalization

- Designated appointments after discharge
- Messaging regarding calling PCP first

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Invest in infrastructure

Data & Reporting

- Documenting results & reporting trends is critical
- Added staff to develop & generate reports

Quality Improvement

- Developed QI tools
- Added QI Coordinator
- Strengthened staff engagement in QI

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Impact of APM participation

Detached payment from a provider visit/schedule

Increased reliance on team

- Added FTE to fully staff teams

Supported exploring alternative methods for access such as;

- Team member visits
- Use of Navigators
- Group visits

Created financial ‘predictability’ with PMPM

Financial resources for innovation

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Quality Improvement
Data Tracking & Reports

Data Analyst: Kathy Simonson

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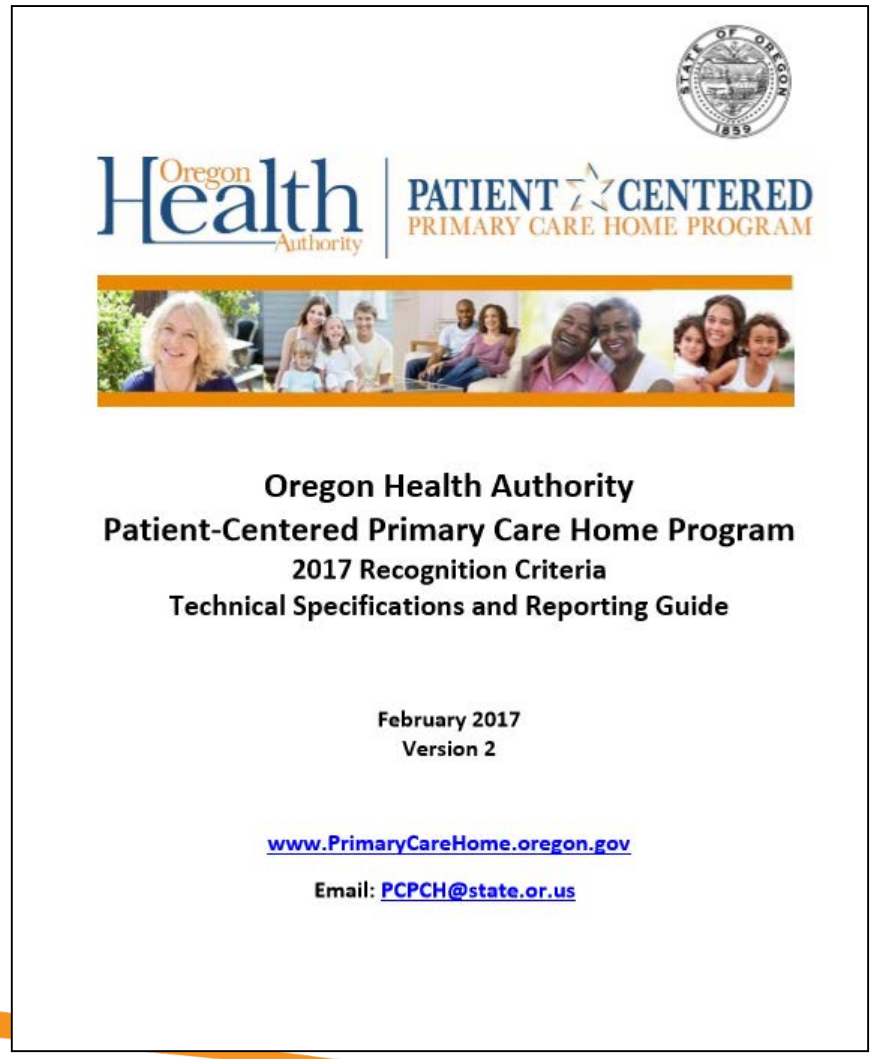
Technical Assistance Guide



Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

Oregon Health Authority
Patient-Centered Primary Care Home Program
2017 Recognition Criteria
Technical Specifications and Reporting Guide

February 2017
Version 2

www.PrimaryCareHome.oregon.gov

Email: PCPCH@state.or.us

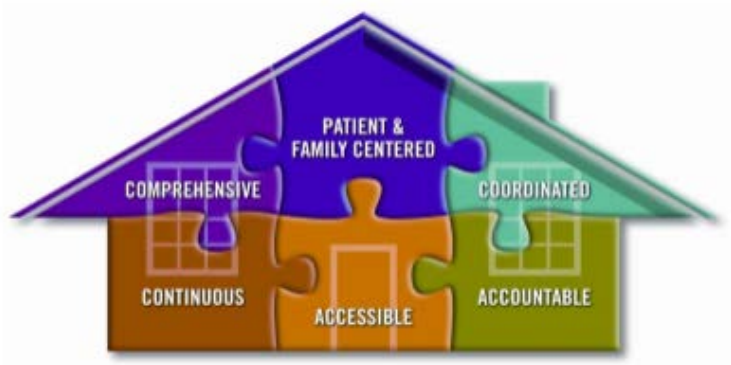
5 STAR Designation

Tier 5 in the PCPCH model is a unique designation called 5 STAR. This designation distinguishes exemplary clinics that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices.

5 STAR designated practices must meet the following criteria:

- Be recognized as a PCPCH Tier 4 under the 2017 PCPCH Standards
- Attest to 255 points or more on the clinic's most recently submitted PCPCH application
- Meet 11 or more of the 13 specified measured listed in the table on page 10.
- Receive a site visit to verify they are meeting all PCPCH standards attested to. The designation will not be awarded on attestation only.

The Core Attributes of Primary Care Homes



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Standards

1. Access to care
2. Accountability
3. Comprehensive whole person care
4. Continuity
5. Coordination and Integration
6. Person and Family Centered Care

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Tiers and Measures

There are 33 measures

Each assigned a point value which is used to determine PCPCH Tier Level

Tier Level	Point Range	Additional Required Criteria
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65 - 125 points	+ All must-pass standards
Tier 3	130 - 250 points	+ All must-pass standards
Tier 4	255 - 380 points	+ All must-pass standards
5 STAR (Tier 5)	255 - 380 points	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

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Tier determination

11 Must-Pass criteria required for PCPCH recognition

The 11 Must-Pass Criteria for PCPCH Recognition

STANDARD	MEASURE
1.C Telephone and Electronic Access	1.C.0 - PCPCH provides continuous access to clinical advice by telephone.
2.A Performance & Clinical Quality	2.A.0 - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
3.B Medical Services	3.B.0 - PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support.
3.C Behavioral Health Services	3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources.
4.A Personal Clinician Assignment	4.A.0- PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)
4.B Personal Clinician Continuity	4.B.0 - PCPCH reports the percent of patient visits with assigned clinician or team. (D)
4.C Organization of Clinical Information	4.C.0 - PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.
4.E Specialized Care Setting Transitions	4.E.0 - PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
5.F End of Life Planning	5.F.0 - PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
6.ALanguage/Cultural Interpretation	6.A.0 - PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice
6.C Experience of Care	6.C.0 - PCPCH surveys a sample of its patients and families at least every two years on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.

(D) – Data submission required with application.

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5 STAR

11 of 13 specified measures required to meet 5 STAR (Tier 5) status

5 STAR Designation Criteria Measures

1.B.1 After Hours Access	PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
2.D.3 Quality Improvement	PCPCH has a documented clinic-wide improvement strategy with performance goals derived from patient, family, caregiver and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.
3.C.2 Referral Process or Co-location with Mental Health, Substance Abuse or Developmental Providers	PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers
3.C.3 Integrated behavioral health services	PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.
4.B.3 Personal Clinician Continuity	PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team (80%).
5.C.1 Responsibility for Care Coordination	PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients,-and tells each patient or family the name of the team member responsible for coordinating his or her care.
5.C.2 Coordination of Care	PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
5.C.3 Individualized Care Plan	PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.
5.E.1Referral Tracking For Specialty Care	PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.
5.E.2 Coordination with Specialty Care	PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).
5.E.3 Cooperation with Community Service Providers	PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.
6.A.1 Language/Cultural Interpretation	PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.
6.C.2 or 6.C.3 Experience of Care	6.C.2 -PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process. 6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process, and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.

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Documentation

Each clinic must attest for PCPCH separately

*Not at organization level

Documentation supporting the score for each measure must be specific, per site

- Report
- Chart review
- Sample survey

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Quality Improvement process

To become a PCPCH, may require:

- New processes
- Staff training
- New reporting
- Quality Improvement

Particularly to reach 5 STAR (Tier 5) status

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Patient Engagement

Patient Engagement & Communications
Coordinator: Christine Mosbaugh

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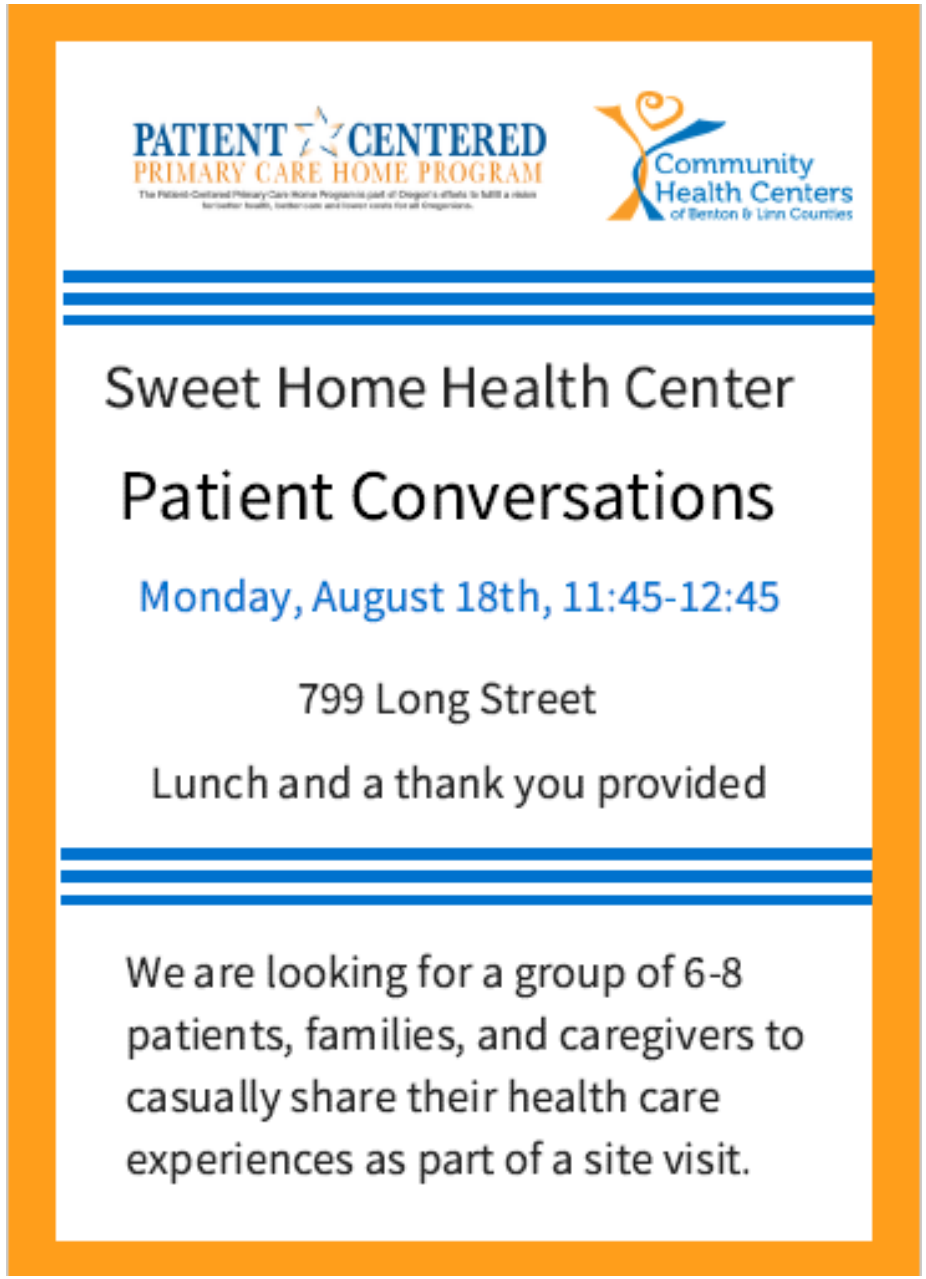
Recruitment

6-8 patients, caregivers

Representative of patient population

Able to speak about their experiences



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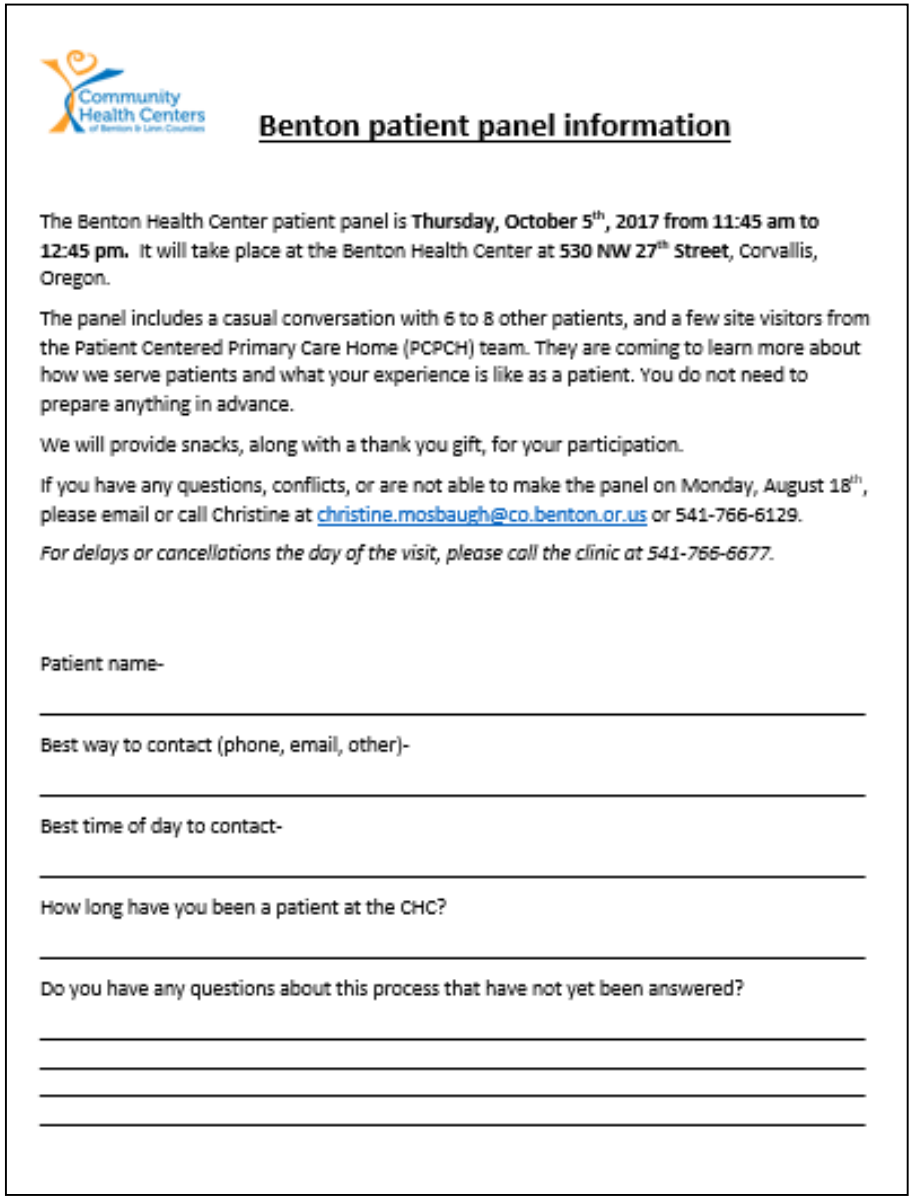
Clinic staff role

Varied by location

- Health Navigator
- Medical Assistant
- Client Services Representatives

Shared responsibility



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Benton patient panel information

The Benton Health Center patient panel is **Thursday, October 5th, 2017 from 11:45 am to 12:45 pm.** It will take place at the Benton Health Center at **530 NW 27th Street**, Corvallis, Oregon.

The panel includes a casual conversation with 6 to 8 other patients, and a few site visitors from the Patient Centered Primary Care Home (PCPCH) team. They are coming to learn more about how we serve patients and what your experience is like as a patient. You do not need to prepare anything in advance.

We will provide snacks, along with a thank you gift, for your participation.

If you have any questions, conflicts, or are not able to make the panel on Monday, August 18th, please email or call Christine at christine.mosbaugh@co.benton.or.us or 541-766-6129.

For delays or cancellations the day of the visit, please call the clinic at 541-766-6677.

Patient name-

Best way to contact (phone, email, other)-

Best time of day to contact-

How long have you been a patient at the CHC?

Do you have any questions about this process that have not yet been answered?

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Site Visitor Conversations

PCPCH site visitor facilitated

- 45 minutes
- No staff present

Experience of care (similar to CAHPS)

- Access
- Continuity
- Whole-person care
- Communication
- Coordination

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End of day debrief

Transparent

Preliminary feedback

Know level

Wait for follow-up

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Report back to clinic

"The staff treat us like people, not just another number."

"They don't judge me and my family, they just care for me."

"The best care I have received in my life has been here."

"The clinic is understanding- even billing conversations are compassionate here."

"They are always making referrals as there are limitations to small clinics. They've got that process dialed in."

"They help me understand my disease."

"He goes above and beyond for his patients. Out of all the patients he sees, he makes me feel so special."

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Site reports

Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

Site Visit Report

Organization	Community Health Centers of Benton & Linn Counties
Practice Site	Monroe
Site Visit Date	September 26th, 2017
Site Visitors	Amber Anderson Loralee Trocio

Report Contents:
Overview and Site Visit Summary
Verification Summary Sheet
Attestation Verification Details
Patient Interview Summary

Access to care: ***"Health care team, be there when we need you"***

Accountability: "***Take responsibility for making sure we receive the best possible health care"***

Comprehensive whole person care: "***Provide or help us get the health care, information, and services we need"***

Continuity: "***Be our partner over time in caring for us"***

Coordination and Integration: "***Help us navigate the health care system to get the care we need in a safe and timely way"***

Person and Family Centered Care: "***Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness"***

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Site Focus

Site Manager: Carol Oldshield

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Primary Care Homes

“Patient-centered primary care is care that is relationship-based with an orientation toward the whole person, and that includes partnering with patients and their families to understand and respect each patient's unique needs, culture, values, and preferences.

Care that is patient-centered also supports patients in learning to manage, organize, and participate in their own care at the level the patient chooses."

— Agency for Healthcare Research and Quality (AHRQ)

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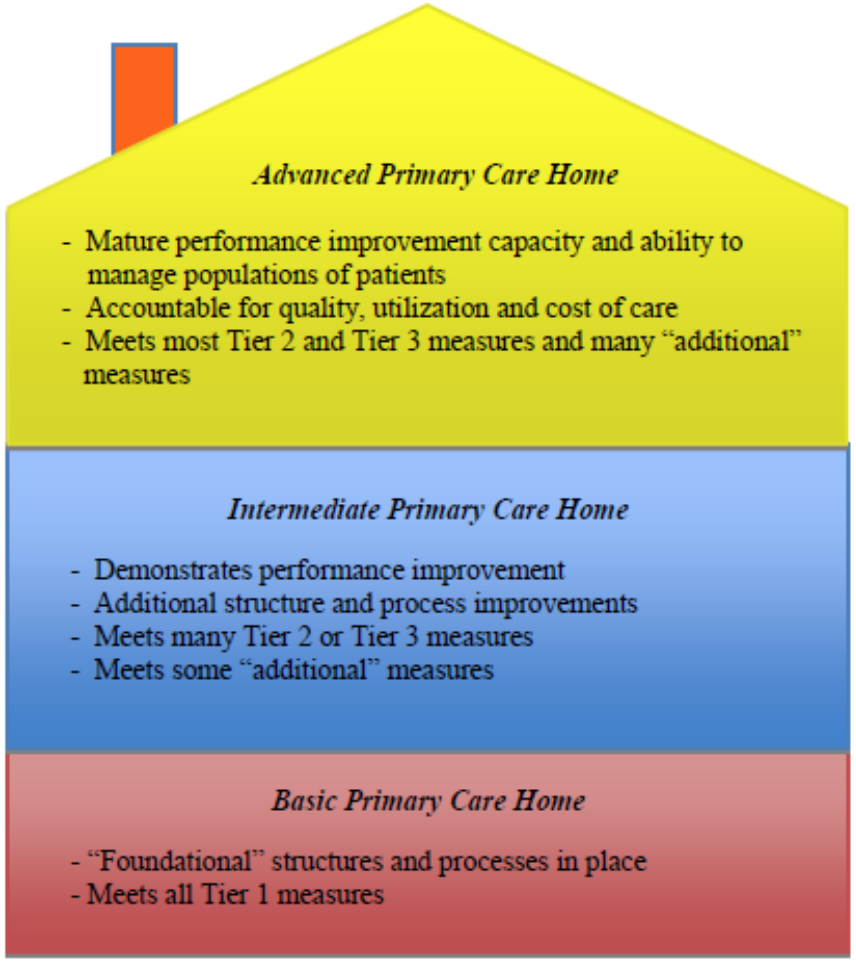
Standards

Comprehensive
Patient and Family Centered
Coordinated
Continuous
Accessible
Accountable

Figure 3: Functional Capacity of Basic, Intermediate and Advanced Primary Care Homes



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Site manager responsibilities

- Monitor provider templates for same day access
- Review Panel Manager reports
- Quality metrics spreadsheets
- Track your team's ongoing QI projects (PDSA documentation)
- After hours phone message/ service

Preparing for the site visit

- Create notebooks using PCPCH guidelines
- Create a site visit agenda
- Prepare your team for site visit
- Invite patients to meet with PCPCH program staff
- Snacks/beverages for patient panel

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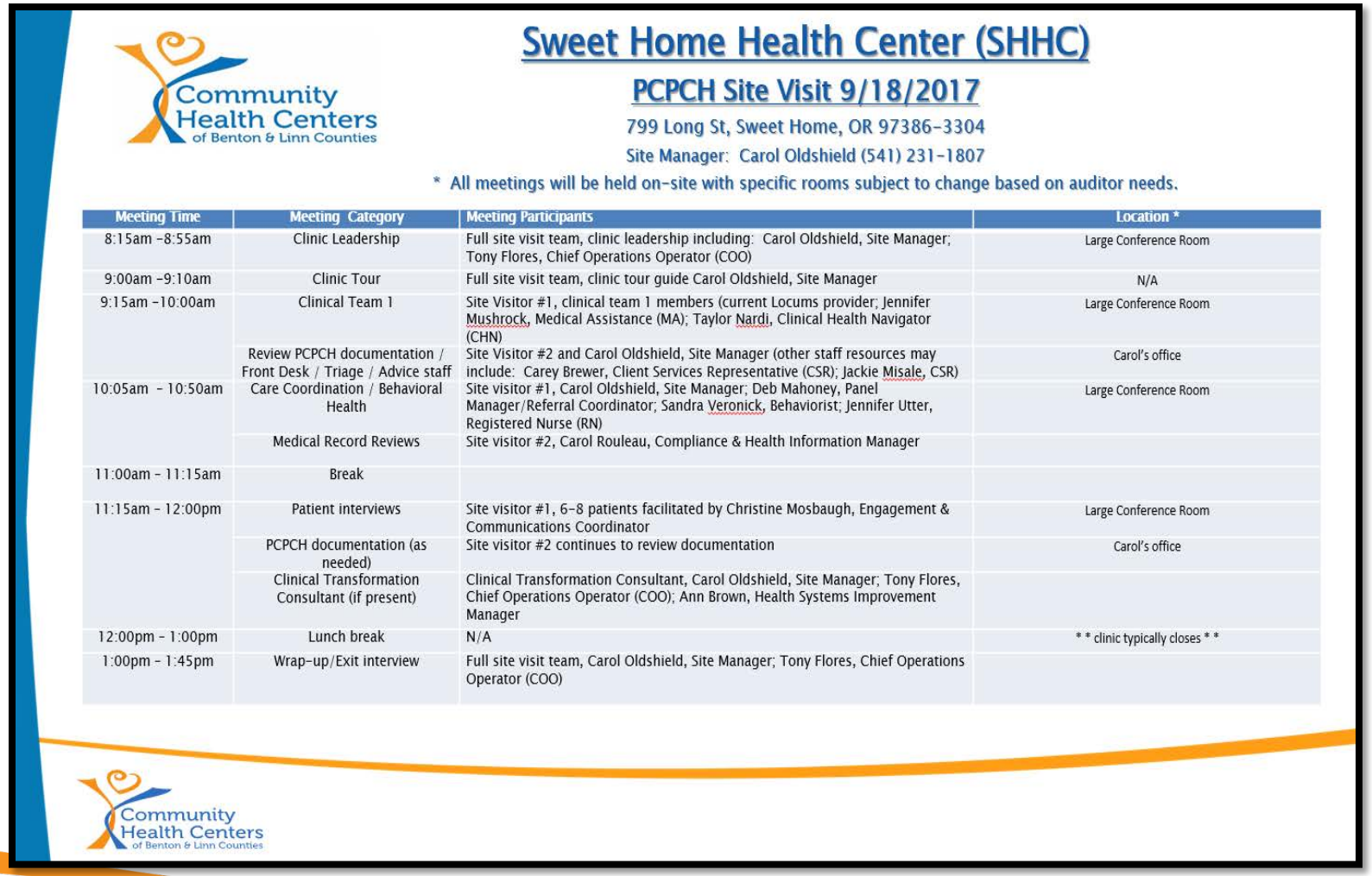
Site visit schedule



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Sweet Home Health Center (SHHC)

PCPCH Site Visit 9/18/2017

799 Long St, Sweet Home, OR 97386-3304

Site Manager: Carol Oldshield (541) 231-1807

* All meetings will be held on-site with specific rooms subject to change based on auditor needs.

Meeting Time	Meeting Category	Meeting Participants	Location *
8:15am -8:55am	Clinic Leadership	Full site visit team, clinic leadership including: Carol Oldshield, Site Manager; Tony Flores, Chief Operations Operator (COO)	Large Conference Room
9:00am -9:10am	Clinic Tour	Full site visit team, clinic tour guide Carol Oldshield, Site Manager	N/A
9:15am -10:00am	Clinical Team 1	Site Visitor #1, clinical team 1 members (current Locums provider; Jennifer Mushrock, Medical Assistance (MA); Taylor Nardi, Clinical Health Navigator (CHN)	Large Conference Room
	Review PCPCH documentation / Front Desk / Triage / Advice staff	Site Visitor #2 and Carol Oldshield, Site Manager (other staff resources may include: Carey Brewer, Client Services Representative (CSR); Jackie Misale, CSR)	Carol's office
10:05am - 10:50am	Care Coordination / Behavioral Health	Site visitor #1, Carol Oldshield, Site Manager; Deb Mahoney, Panel Manager/Referral Coordinator; Sandra Veronick, Behaviorist; Jennifer Utter, Registered Nurse (RN)	Large Conference Room
	Medical Record Reviews	Site visitor #2, Carol Rouleau, Compliance & Health Information Manager	
11:00am - 11:15am	Break		
11:15am - 12:00pm	Patient interviews	Site visitor #1, 6-8 patients facilitated by Christine Mosbaugh, Engagement & Communications Coordinator	Large Conference Room
	PCPCH documentation (as needed)	Site visitor #2 continues to review documentation	Carol's office
	Clinical Transformation Consultant (if present)	Clinical Transformation Consultant, Carol Oldshield, Site Manager; Tony Flores, Chief Operations Operator (COO); Ann Brown, Health Systems Improvement Manager	
12:00pm - 1:00pm	Lunch break	N/A	* * clinic typically closes * *
1:00pm - 1:45pm	Wrap-up/Exit interview	Full site visit team, Carol Oldshield, Site Manager; Tony Flores, Chief Operations Operator (COO)	

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It takes a village

- Health Information Manager- compliance
- Business analyst- data site specialist
- Quality Improvement manager
- RN Care Coordinator
- Provider
- Medical Assistant
- Health Navigator/ Community Health Worker
- Site Manager
- Engagement and Communications Coordinator
- Deputy Director of Clinical Operations

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A tale of two clinics

5 STAR/Tier 5 clinic

- Strong cohesive team consistent providers
- Excellent knowledge of patients
- Good documentation
- On site pharmacist
- Strong patient engagement
- Home visits

Tier 3 clinic

- No regular provider (using locums) for more than 1 year
- Staff has knowledge of patients, locum providers do not
- Poor, vague and varied documentation
- No on-site pharmacist
- Very little patient engagement

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Results…

Five STAR Status

- East Linn
- Monroe*
- Lincoln*
- Benton

*First 5 STAR School Based Health Centers in Oregon

Tier 3 Status**

- Sweet Home
- Alsea

**An opportunity to become Tier 4 and reapply for Five STAR Status in 6-12 months

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians.

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What questions do you have for us?

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