Report Title: PCPCH Site Visit Report Evaluation

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Part IV - PCPCH Evaluation Report 2013
Executive Summary

The Oregon Patient Centered Primary Care Home (PCPCH) recognition is a "self-attestation" model with comparatively low administrative burden for clinics applying, compared to other industry "medical home" recognition standards, such as NCQA. This methodology has likely helped ensure extraordinary participation - over 400 clinics are recognized as Oregon PCPCHs less than 2 years into the life of the program. However, the fidelity of a "self-attestation" model relies upon a strong verification program.

On-site verification visits were designed with 3 stated goals to align with overall PCPCH program strategies:

1. **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to when the clinic was recognized as a PCPCH. Additionally, for those clinics that are participating in the Medicaid PCPCH payments for "ACA-qualified" patients, verifying that clinics have evidence of required documentation, care planning, and service performance for the "ACA-qualified" patients.
2. **Assessment** of the care delivery and team transformation process in the clinic to understand how integrated the qualities and intent of the PCPCH with regards to teamwork and service are in the practice.
3. **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the PCPCH Clinical Advisor and the statewide Patient-Centered Primary Care Institute to overcome improvement barriers.

Summary of Results

Implementation/Fidelity: A total of 36 PCPCH site visits were completed by the end of July, 2013. Eight (8) clinics received "improvement plans" because they had attested to meeting a "must pass" that could not be verified OR because there were enough PCPCH Standards/Measures that could not be verified to potentially cause them to drop a PCPCH Tier level.

Standard 4.E.0 – the "written agreement with hospital" focused on communication around hospital care transitions was the most common deficiency leading to an "improvement plan". The "improvement plan" outlines what the clinic needs to do to meet the measure within 90 days, and by July 31, 2013 four (4) clinics had met their "improvement plans" and implemented this "hospital agreement".

Overall, site visit tools/protocols were found to be sufficient to verify that clinics were meeting the intent of the standards/measures they attested to, but also were sufficient to uncover instances where clinics were not meeting standards/measures they attested to as well as instances where some clinics were actually meeting some standards/measures they did not attest to.

Quality/Cost and Efficiency: A significant number of clinics reported the PCPCH Standards/Measures provided a "framework for improvement" that they felt guided their improvement strategies. Most PCPCHs were able to demonstrate data improvements for quality measures. A majority of clinics had implemented specific access improvement efforts (ie expanded hours, "open access scheduling"). A majority of clinics had added new team roles (ie RN Care coordinator, Behavioral Health provider) and services within the last 2 years.

Site visit findings also demonstrated significant variability in robustness of implementation for various individual PCPCH Standards/Measures, as well as generally variable team-based care functionality. Although the 3 tier PCPCH structure often did reflect a true measure of robustness of the PCPCH model in practice, there was significant variability in performance capability for the individual PCPCH Standards/Measures in clinics even within a single tier level. The PCPCH Standards demonstrating significant variability included Standards 1A/6C – the "assessment of patient experience" standards, 2A – the "accountability" standard, 3A – the "preventive care" standard, 3C1 and 2 – the measures regarding mental/behavioral/substance abuse/developmental screening and co-management, and several of the Core Attribute 5 "care coordination" measures.

These findings reflect that PCPCH clinics can likely be separated into more than three tiers of capability under the current PCPCH Standards/Measures. The intent and robustness of the individual Standards/Measures could be altered, or TA strengthened to help achieve more robust implementation - as this variability in implementation of the model is likely to reflect in PCPCH cost, quality, and outcome effects overall.

Commonly identified areas of need for concrete technical assistance include:

- Mental/Behavioral Health integration
- Complex/routine care management and care planning
- Data management and utilization in the clinic
- Team-based care/team roles/cultivating a culture of improvement

Patient Experience: Patient interviews were routinely incorporated into the site visit day. Modified CAHPS patient experience questions with additional open-ended questions formed the backbone of the patient "focus group" interviews. Patients were often unfamiliar with the PCPCH concept, though they were overwhelmingly positive about their care and the concepts represented in the PCPCH model. Patients were solicited to identify areas for improvement, but approximately 1/3 of the time no areas for improvement were identified. This suggests that more robust facilitation or probing questions to better assess patient experience and prevent a tendency for patients to provide "positive" answers for Site Visitors may be important for future site visits. Patient participation was variable – from 2-8 patients at each site visit. Some clinics suggested the PCPCH program should provide "material recognition" of patient time and input to minimize patient burden and encourage participation.

Provider Experience: Clinics were provided an opportunity to offer feedback and suggestions about how to make the site visit process better during the site visit "wrap up" meeting, and via post-visit survey. By the end of July 2013, 26 surveys had been sent and 10 returned. 90% of responding clinics felt the information in the site visit reports was "helpful/good" (6) or "very helpful/great (3). Two-thirds of the respondents felt the OHA site visitors were "very courteous, knowledgeable, and professional". The turnaround time for site visit reports was noted to be slow. Some clinics complained it was a burden to remove clinicians from patient care for the site visit interview timeslots.

Other key findings regarding provider experience with the PCPCH model and program include:

1. Lack of resources (financial/staff/time) under current payment/reimbursement models was unanimously identified by clinics as a primary barrier to continued transformation and sustainability.
2. Difficulty with communication between sub-specialists/hospitals and the PCPCH and difficulty with EHR data management were recurrently identified as key barriers to improving patient care, coordination, and outcomes.
3. Clinics had significant difficulty understanding and implementing the required documentation, service, and reporting requirements for the Medicaid ACA-Qualified payment program for PCPCHs. TA was provided during site visits to aid the understanding and accurate implementation of documentation and processes necessary. The clinics that had submitted "ACA-qualified" lists for payment expressed concern about the timeliness and accuracy of payments.
4. Some clinics felt communication from the OHA regarding PCPCH, particularly in relation to other health reform efforts (CCOs, Medicaid payments for primary care), was insufficient and at times confusing.
5. Clinics felt the TA provided at the site visits was valuable to better understand the intent of various PCPCH Standards/Measures – particularly when the "Clinical Advisor" was included to provide a more thorough assessment, consultation, and connection to TA resources.
6. Desire for mentorship connections ("someone like us who has done this") and other specific TA needs was high. Most clinics did not feel they had adequate access to or knowledge of these resources. Some clinics requested TA be included in follow up plans after the site visits.

Summary of Key Recommendations

1. Expand site visit capacity to allow visits to each Oregon PCPCH every 3 years.
2. Take steps to complete site visit reports and send them to clinics in a more timely manner.
3. Implement strategies to use the insight gained at site visits as a springboard for improvement at those clinics.

4. Incorporate PCPCH-experienced clinicians as "consultants" at each site visit – to provide a robust assessment and "mentorship" collaboration with clinics, and foster meeting goals identified during site visits
5. Consider strategy modification for patient interview and assessment of patient experience - including materially valuing patient time and input, and incorporating a trained "peer" patient interviewer at each site visit.
6. Use all methods available to ensure sustainable financing of nascent PCPCH innovation by fostering administratively simple, sustainable levels of funding across the OHA and other payers to support provision of a robust PCPCH model of care for all Oregonians.

Part IV – Evaluation
PCPCH Site Visits Year One - 2013

Task: In conjunction with OHA, develop and implement PCPCH verification process. This process, to be conducted through on-site clinic visits, will address each of the six evaluation areas (A – F).

A. **Implementation of the PCPCH model**
B. **Fidelity to the PCPCH Model**
C. **Clinical Quality**
D. **Cost & Efficiency of Care**
E. **Patient Experience of Care**
F. **Provider & Staff Experience**

The Oregon PCPCH recognition is a "self-attestation" model with comparatively low administrative burden for clinics applying, compared to other industry "medical home" recognition, such as NCQA. This methodology has likely helped ensure extraordinary participation - over 400 clinics are recognized as Oregon PCPCHs less than 2 years into the life of the program. However, the fidelity of a "self-attestation" model relies upon a strong verification program.

In order help create a robust verification structure to assess the fidelity of the PCPCH model as implemented and practiced in recognized clinics, the PCPCH program contracted with a consultant "Clinical Advisor" through the Providence Center for Outcomes Research and Education (CORE). The responsibility of this role was also designed to evaluate the effects, implementation information, and experiences of the participants affected by the program at the frontline level, and to connect that information with the PCPCH program/OHA, payers, and to the development of TA resources to foster transformation along the PCPCH continuum.

Methods:

The first step to set up the verification process was to design a protocol, staff roles, tools, and follow-up/tracking structures to define the standard for a robust PCPCH site visit assessment. To provide a informed foundation for a successful PCPCH on-site evaluation process, in the Spring/Summer of 2012, a review of several state (MN, OK, CO) and private agency (NCQA, URAC, Accreditation Association for Ambulatory Health Care (AAAHC)) "medical home" recognition tools/standards and site visit structures/protocols was performed through document review and direct phone interview. Although the state of Minnesota follows a chronic disease-based "health home" model rather than a population-based model of care like Oregon's PCPCH Program, the Minnesota site visit structure was determined to be the most robust at assessing the six evaluation areas (A-F above) that we wanted to investigate for the Oregon PCPCH program. Thus, the Minnesota Health Home site visits served as a key foundation vf to help guide the initial design, tools, and protocols for Oregon's PCPCH site visits.

Unlike other states and most private entity recognition programs, rather than design a site visit that was for verification purposes only, the PCPCH program made a strategic decision to develop the site visit structure to align with broader overall program and OHA goals - to help clinics assess their barriers and needs for further transformation to improve care, and to provide them with assistance and tools to foster sustainable progress to transform and improve care.

In order to implement this unique multi-purpose on-site evaluation, the PCPCH Site Visits were designed with 3 stated goals:

4. **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to when the clinic was recognized as a PCPCH. Additionally, for those clinics that are participating in the Medicaid PCPCH payments for "ACA-qualified" patients, verifying that clinics have evidence of required documentation, care planning, and service performance for the "ACA-qualified" patients.
5. **Assessment** of the care delivery and team transformation process in the clinic to understand how integrated the qualities and intent of the PCPCH with regards to teamwork and service are in the practice.
6. **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the PCPCH Clinical Advisor and the statewide Patient-Centered Primary Care Institute to overcome improvement barriers.

Initial proposals for the PCPCH site visits included 3 clinic evaluation roles (two program staff plus a contracted clinician expert) plus a patient representative to directly assess patient experience at each site visit; however budget and staff constraints required implementation of a smaller, more focused site visit structure. In order to produce the best assessment given organizational/budget constraints, the site visits were implemented with at least two (sometimes 3) OHA PCPCH Site Visitors spending a full day at each clinic site talking with different staff to assess

through the interview process, direct observation, and document review how patient care is delivered throughout the clinic. Included in the interviews are:

- clinicians (MD/RN/FNP/PA) and other clinical staff (LPN/MA/etc.)
- front desk staff
- 4-6 patients
- clinic and organizational leadership
- behavioral/mental health and care coordination staff (if present)

Site visits are scheduled at least 30 days prior to the day of visit to allow clinics to plan and organize staffing for the visit, and the communication/scheduling process follows a protocol implemented and refined by the Program/Site Visitors/Clinical Advisor. OHA Site Visitors review data and documentation provided by the clinic prior to and during the site visits to verify the clinic is meeting PCPCH standards, and may request additional documentation if needed. The Site Visitors also review medical records in a chart-review process to demonstrate/corroborate that certain PCPCH standards for appropriate care, documentation, and coordination are occurring as attested to in the PCPCH application. This medical record review includes a clearly defined process developed in collaboration with DMAP staff, to review "ACA-Qualified" patient charts when the clinic has participated in the PCPCH Medicaid payment program.

Included at the end of each site visit is a "wrap up session" with clinic leadership to explain initial findings, expectations about follow up, and to answer clinic staff/leadership questions. The site visit reports detail, measure-by-measure attested to the by the clinic, how the site visitors verified the measure, or what was found that did NOT meet the intent of the standard/measure. In addition, each PCPCH Core Attribute section (Access, Accountability, etc.) contains an "Assessment and Recommendations" summary to provide constructive feedback on findings, suggestions of strategies and tools (including hyperlinks) for improvements the clinic could implement. A specific patient-interview summary section is included in the report. When each clinic receives their final PCPCPH site visit report, included in the email is an electronic survey link, soliciting their feedback on their pre-site visit, site visit, and post-site visit experiences and suggestions for improvement.

Site visit tools, scheduling/visit/post-visit protocols, and draft site visit training manual have been developed and are kept on the PCPCH file server.

The site visits were initiated in September, 2012 with a pilot group of 5 clinic visits to refine site visit materials and processes. These were performed by PCPCH Program staff and the PCPCH Clinical Advisor as the site visit team.

Two Site Visitors were hired in early December 2012, following a multi-step interview process in collaboration with the Division of Public Health. Their positions, HR reporting structure, and physical location is within the Division of Public Health.

In addition to on-site visit training, the new site visitors received approximately 25 hours of didactic training on the PCPCH model/background/requirements/ protocols/tools to date, plus ongoing content feedback during site visits, in person, and through electronic communication. The site visitors received approximately 6-8 hours of content training per week in addition to continued training during the site visits through December and January, 2013. The two OHA Site Visitors were doing independent site visits by late February/early March, 2013.

Summary of Key Findings

A. Implementation of the PCPCH model

In an effort to ensure the site visit process, materials, and overall assessments are relevant to the diverse types of PCPCH clinics in Oregon, the clinics visited have included urban, rural, small (1-3 clinician), large organization, independent, Federally Qualified Health Center, Pediatric, Internal Medicine, and Family Medicine practices. Included were practices with heavy "Medicaid" populations particularly those participating in the Medicaid "ACA-qualified" payment program, practices that mostly care for privately insured patients, and practices spread around the state geographically. On average 4-5 PCPCH site visits were scheduled per month from December-July 2013, and including the initial five pilot visits, a total of 36 PCPCH site visits were completed by the end of July, 2013.

Eight (8) clinics received "improvement plans" because they had attested to meeting a "must pass" that could not be verified OR because there were enough PCPCH Standards/Measures that could not be verified to potentially cause them to drop a PCPCH Tier level. Clinics have 90 days to meet their improvement plan. To do so they may have to implement processes, services, or other remedies to meet the "must pass" measures and/or align the practice capabilities with their recognized PCPCH Tier status.

Tools/protocols were found to be sufficient to verify that clinics were meeting the intent of the standards/measures they attested to, but also were sufficient to uncover instances where clinics were not meeting standards/measures they attested to *as well as* instances where some clinics were actually meeting some standards/measures they did not attest to.

Clinics were provided an opportunity to offer feedback and suggestions about how to make the site visit process better via post-visit survey. By the end of July 2013, 26 surveys had been sent and 10 received back. 90% of responding clinics felt the information in the site visit reports was "helpful/good" (6) or "very helpful/great (3). Two-thirds of the respondents felt the OHA site visitors were "very courteous, knowledgeable, and professional". Common themes we saw in the survey response comments included:

- the site visit and visitors were helpful and knowledgeable

- the scheduling process was difficult and somewhat confusing
- the timeliness of receiving the full site visit report was worse than expected.

Representative quotes:

> "The site visit needs to be slightly more adjustable to the scheduled providers' and medical assistants' already busy schedules."
> "We are all new at this, so it was great to have a non-threatening visit. We appreciated the cooperativeness of the content and flow."
> "We were told to expect our report within four weeks and it's been over twelve. There's nothing in the report that we didn't learn at the site visit."
> "More clarity/simplicity in the directions for preparation."
> "All four visitors were very knowledgeable of the PCPCH and other projects going on around the State and Nation, which helped us."

Staff limitations and the unique shared model of management between Public Health and the PCPCH Program offered some concrete strategies and expertise benefits, however it resulted in significant communication and logistical difficulties.

The variation of feedback from visit to visit was pronounced – some reporting the site visit was helpful and others reporting it felt like they were "criticized" or it was "audit-like". There was repeated feedback that including a clinician role on the site visit team to provide consultative information and concrete TA/resources was invaluable to clinics.

Clinics provided clear feedback that the site visit scheduling process and pre-visit communication/preparation was confusing or inadequate, particularly amongst the early on in the site visits following the pilot cohort. In February/March 2013, the PCPCH Program team revamped the pre-visit communication/scheduling/preparation strategy and tools to reflect the feedback received.

The timeliness of the clinics receiving the final reports was poor. The goal time period to complete the site visit reports was 3 weeks following the visit, however, in practice it ranged from 2 weeks to 3 months following the site visit. This timeline was affected by the rapid training, program (altered by administrative delays in hiring Site Visitors), and a learning curve for use of tools and narrative report writing. A busy schedule for Site Visitors that included pre-visit preparation and calls with clinics, document review, travel, and site visit follow up produced a further delay in clinics receiving their Site Visit reports.

B. Fidelity to the PCPCH Model

1. **Most PCPCH recognized clinics had their PCPCH Tier status verified.** The recognized PCPCH Tier status of 28 of 36 (78%) of the visited Tier 2 and 3 PCPCH clinics was verified. As of August 1, 2013, 8 clinics received

"improvement plans", and 4 of these clinics had satisfied their improvement plans, 1 clinic had closed. So, through the entire site visit process including post-visit follow up, the PCPCH program has thus far verified the Tier status at 32 of 35 (91%) of the visited clinics, with 3 "Improvement plans" pending.

2. **There is significant variability in robustness of implementation of various individual Standards/Measures.** Although the 3 Tier PCPCH structure often did reflect a true measure of robustness of implementation of the PCPCH model, there was significant variability in performance capability for the individual PCPCH Standards/Measures in clinics even within a single Tier level. Contributing to this was the significant positive relative weight on Tier rating for clinics that have industry-standard EHRs – despite their variable capability to use the EHR effectively. These findings reflect that PCPCH clinics can likely be separated into more than three tiers of capability under the current PCPCH specifications, and/or the intent and robustness of the individual Standards/Measures and technical assistance should be strengthened in subsequent iterations of the model to take this into account - as this variability with the model will likely reflect on PCPCH cost, quality, outcomes overall. See **Clinical Quality/Cost and Efficiency of Care** section for further detailed discussion.
3. **Understanding of PCPCH Standard/Measure intent was improved during the site visits,** particularly for those clinics where some standard/measure (s) could NOT be verified. This direct feedback was consistently provided during the day-end wrap-up sessions with clinic leadership and staff.
4. **The most common PCPCH standards/measures attested to by the clinics that were NOT verified at the site visit included:**
    - **"Must-pass" Standard 4.E.0 - "PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care."** Primary reasons the "hospital agreement" was not in place despite attestation:
        - Because the clinic thought they were part of a big system and physicians in clinic/hospital were employees, so an agreement to meet Standard 4.E.0 was not necessary. This reflects a misunderstanding of the intent and PCPCH technical guidelines for Standard 4.E.0 – which are focused on how clinicians should communicate at the time of, during, and at the end of a patient's time in a hospital to ensure the best coordination of care and flow of information during care transitions. Several organizations that have since worked with their clinics to meet improvement plans for this "must pass" standard, provided feedback such as, "discussing and implementing the agreement opened up interesting discussions about ideal communication we'd not had before".
        - Because the clinic had a template agreement but the hospital administration had not responded to the clinic attempts to initiate an agreement or had refused to complete an agreement with the clinic.

- **5.E.3 – "PCPCH tracks referrals and coordinates care where appropriate for community settings outside the PCPCH (such as dental, educational, social service, foster care, public health, or long term care settings)." (Tier 3 – 15 points)**

  Relatively few of the site-visited clinics attested to meeting this measure. However, several clinics that did attest to this measure where it could not be verified were not tracking referrals and/or not actively coordinating care beyond an initial referral. Most commonly the clinics had mistakenly understood the intent of the measure as either including medical referrals (ie specialty, PT/OT, DME), or that the measure did not require tracking or communication "loop closure" but only the initial referral to a community agency.

- **3.C.2 - "PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers." (Tier 2 – 10 points)**

  There was significant variability in how robustly this measure was met (see **Clinical Quality/Cost and Efficiency of Care**). Where it was attested to but could not be verified, clinics generally had one-way communication – such as sending a referral for mental health services or receiving a mental health consult note - but these clinics could not provide examples or evidence of co-management or two-way communication to meet the intent of the measure.

- **4.B – Personal Clinician Continuity Standard**
  Measures:
  - **4.B.0 PCPCH reports the percent of patient visits with assigned clinician/team. (Must Pass)**
  - **4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team. (Tier 3 – 15 points)**

  The most common difficulties in verifying this measure were due to clinics' misunderstanding of the standard intent and/or required data, data management barriers, and variable clinic staffing/organization. Some clinics did not recognize that this continuity measure requires a calculation of patient visits with their PCP (or team) over a defined period of time. Some were unable to reproduce their data, several times this was due to changes in EHRs. Some clinics did not include all providers or team members in their calculations. Some used "team" calculations, though functionally for patient care the clinic was not organized into teams. Once clinics understood the data requirements for this standard, and how team calculations should reflect clinic function from a patient perspective, clinics were given opportunities to recalculate their

numbers. There were several examples of clinics whose recalculated data no longer meet the 80% benchmark they'd attested to for Measure 4.B.3.

- **5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information. (Tier 1 – 5 points)**

  The barriers clinics demonstrated in meeting this measure often directly related to problems managing the EHR and/or producing reliable data reports from the EHR. Several clinics had EHRs with this capability, but the clinics were not actually using the capability in practice. However, it was also common for clinics to miss the importance of "proactive management" as necessary to meet the intent of this measure.

- **5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care. (Tier 1 – 5 points)**

  Where it could not be verified, commonly clinics attesting to this measure designated the physician as the default team member responsible for care coordination. There were several examples of clinics who'd planned to hire a care coordinator when attesting, who had not completed the hire, or where the person hired into that position had moved on by the time of the site visit. Wide latitude was provided to clinics using multiple team members for care coordination as long as there were some clearly identified mechanisms to inform patients of the team members' care coordination roles. Referrals and insurance "prior authorizations" for imaging were often managed by one specific clinic staff member, whereas other care coordination roles were often delegated to MAs, LPNs, or RNs.

- **5.F.2 PCPCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan that includes the following: self management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate). (Tier 2 – 10 points)**

  Clinics where this measure could not be verified usually provided examples of clinicians' "SOAP" note "Assessment and Plan" to demonstrate how they felt they were meeting the measure. This misunderstanding of measure intent and requirements provided frequent educational opportunities at site visits. In part because the PCPCH "ACA-qualified" Medicaid payment requirements include care plans for qualified patients, clinics were generally receptive to this education and reported improved understanding. However, staff time to develop care

plans, EHR architecture barriers, and functionality of care plans in practice were common problems/concerns reported by most clinics, even where this measure could be verified.

- **6.A.0 PCPCH documents the offer and/or use of either providers who speak a patient and family's language or time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. (Must Pass)**

  Clinics where this measure could not be verified felt they met this measure because they had access to a part time staff member who spoke one non-English language (Spanish), and reported they had few non-English-speaking patients.

C. **Clinical Quality**
   and
D. **Cost & Efficiency of Care**

As discussed in Section B.2 above, the PCPCH site visits revealed significant variability in clinic performance capability for the individual PCPCH Standards/Measures - even amongst clinics within a single Tier level. The details of these findings reflect at least five key contributors to PCPCH functionality:

1. Clinic staff and clinicians' understanding of the intent – the *"why"* – and the technical specification and clinic needs – the *"how"* – required for functional implementation of some PCPCH Standards/Measures. Because Oregon's PCPCH model implementation is less than 2 years old, this variability in "on the ground" clarity is not unusual for any policy; however this should be an important consideration in the subsequent development of communication and technical assistance strategies and resources for Oregon's primary care community.
2. Clinics that had:
   - participated in learning collaboratives or were active members of organizations with collaborative learning activities (ie ORPRN, OCHIN, CHA)
   - received significant "transformation" funding (ie. CareOregon Primary Care Renewal, Comprehensive Primary Care Initiative) , and/or less frequently, on-site PCPCH-related technical assistance
   - a strong leadership and teamwork culture that included "operations" and clinical engagement and alignment, and demonstrated leadership extension to multi-disciplinary staff

   were all clearly associated with more robust practice implementation for nearly every PCPCH Standard/Measure the clinics attested to. These three key catalysts for significant, sustainable transformation should be important considerations for PCPCH Program/OHA policy and TA planning going forward.

3. Clinics where administrative staff handled the PCPCH "project" and application nearly or completely independent from clinicians and front-line staff were much more likely to have standards that could not be verified and/or met PCPCH Standards/Measures in a ways that were generally less robust compared to clinics with stronger front-line/clinician input. This situation often was indicative of larger leadership culture and/or organizational deficits.
4. With some notable exceptions, although they generally attested at Tier 2 or 3, larger practices and system-affiliated clinics often experienced difficulty fostering change, empowering front-line innovation, and spreading care improvements despite their substantial management and resource capacity. While smaller practices and independent clinics could be more nimble at making initial change, and at times demonstrated IT and QI sophistication on par with or exceeding large organization colleagues, they more often lacked the financial resources and personnel necessary for sustained data/IT, QI, and care management.
5. The functionality of the "medical neighborhood" was a key factor in enabling or inhibiting PCPCH functionality. For example, where hospitals, specialists, the primary care community, and the larger health community worked collaboratively, enhanced transformational functionality of multiple PCPCH Standards/Measures was clearly demonstrated. At the same time, PCPCHs in more dysfunctional "medical neighborhoods" felt they had limited ability to affect or create structures to support more effective and robust implementation of PCPCH Standards they may be meeting, but recognized were limited in functionality – examples of included Standards 3.C.2, 4.E.0., and several of the Core Attribute 5 standards.

Given the site visit findings and that this variability implementing the PCPCH model will likely reflect on PCPCH cost, quality, outcomes overall, PCPCH clinics could be separated into more than three tiers of capability under PCPCH specifications. Other policy and operations actions that will help reduce variability are to:

- provide clinics with enhanced technical assistance and collaborative opportunities
- develop specific strategies to share "best practices"
- improve communication regarding the intent of individual PCPCH Standards/Measures
- strengthen the explanations and technical assistance available for individual Standards/Measures specifications
- implement structures in the health care marketplace to provide financial support and sustainable funding for initial and sustained PCPCH transformation – for example through all OHA purchasing, and through other entities under OHA influence such as CoverOregon and the Insurance Division.

Most common PCPCH Standards/Measures clinics met/had verified, but site visit revealed various levels of ability, implementation, and comprehensiveness in meeting these PCPCH Standards/Measures:

- **1.A – In-Person Access Standard**
  - **1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care and reports results. (Tier 1 – 5 points)**
  - **1.A.2 PCPCH surveys a sample of its population on in-person access to care using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools. (Tier 2- 10 points)**
  - **1.A.3 PCPCH surveys a sample of its population on in-person access to care using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools and meets benchmarks. (Tier 3 - 15 points)**

  Clinics meeting this standard demonstrated significant variability regardless of what Tier/point measure they attested to. Many clinics had taken steps to improve access – for example implementing "advanced access scheduling" or other strategies to protect "same day" appointment availability. Some clinics attesting to 1.A.1 (5 points) used robust clinic-developed or industry standard surveys that mirrored significant parts of CAHPS. A few of those clinics shared patient survey responses with staff, though only a subset of those designed improvement projects around patient responses to these non-CAHPS patient surveys regarding access. One clinic used a patient experience survey given via touch-pad while patients/families were waiting to check out at the end of their appointment – ideally providing immediate feedback with higher response rates and less cost than mailed surveys.

  Approximately ½ of clinics attesting to 1.A.2 OR 1.A.3 had staff at the clinic or within the organization responsible for reviewing CAHPS data. Few clinics shared CAHPS data with front line staff or designed improvement strategies around the data. Approximately ½ of clinics who had run a CAHPS survey meeting 1.A.2 OR 1.A.3 had very limited knowledge of standard survey processes and/or biases, and clinics often had often not reviewed or did not fully understand their CAHPS survey data results.

- **2.A – Performance & Clinical Quality Improvement Standard**

  Most clinics with significant QI activities and structures (such as a QI committee, QI roles and expectations defined, data sharing with front-line staff) were able to demonstrate significant improvement in a variety of clinical process and/or outcome measures. Many clinics described specific improvement projects they'd undertaken in the last year and

shared outcomes demonstrating numerous examples of these data improvements.
Clinics meeting the "Must Pass" measure 2.A.0 only demonstrated very limited Quality Improvement (QI) or data management capability or activity - as would be expected. However, QI and data management capabilities were extremely variable in clinics often regardless of if they were meeting Measure 2.A.2 (Tier 2 – 10 points) or Measure 2.A.3 (Tier 3 – 15 points). Some clinics with extensive QI activities reported on Core or Menu NQF measures they were working to improve or those without defined benchmarks – and therefore they attested to 2.A.2 (Tier 2 – 10 points). Alternatively, some clinics with no QI activities at all downloaded Q-corp data, and reported those NQF measures where they were meeting benchmark – and they attested to 2.A.3 (Tier 3 – 15 points).

Best Practice example: "X clinic measures, tracks, and shares a variety of clinical data in the clinic, with teams, and with individual providers. Numerous data measures are on a white board in the main "nursing station" area of the clinic. Sharing of this data with front-line staff has allowed the clinic to foster a continuous quality improvement culture. Staff described that on-going review and discussion of QI data related to care, process, and outcomes helps them understand why changes in care are needed and helps them to feel good about the job they are doing when they see improvement occur. The clinic has used "Plan, Do, Study, Act" (PDSA) cycles to improve data measurements. Specific examples of QI work sited by the teams included improving diabetes foot monofilament screening and increasing the percentage of women receiving mammograms. A practice-based improvement project focused on proactive outreach and management to promote recommended chronic disease and preventive care."

- **3.A.1 PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPSTF Recommended Services and/or Bright Futures periodicity guideline). (Tier 1 – 5 points)**

  Implementation of this PCPCH Measure was one of the most variable of all the PCPCH Standards/Measures. Some clinics demonstrated very robust, evidence-based preventive care activities: preventive care data tracking and sharing with front-line staff, QI projects focused on improving preventive care, proactive outreach for USTPF/Bright Futures recommended services, and pre-visit preparation/action to ensure recommended services were provided for all patients. Other clinics where this measure was verified had EHR templates that could trigger clinician discussion or ordering of USPTF/Bright Futures recommended services only during preventive visits - appointments initiated by the patient. It was clear some of these EHR templates had not been updated – for example with most recent USPTF recommendations against routine

PSA (prostate cancer) screening and/or yearly Pap (cervical cancer) screening starting at age 21.

Best practice example: "In addition to staff outreach to patients to close "gaps" in recommended preventive care…in preparation for any scheduled patient visit, the MAs "scrub" the records, review the health maintenance alerts, and notify the clinician of any preventive needs during the "huddle." Some clinicians take this proactive visit prevention planning a step further and implemented protocols allowing recommended preventive screening tests or vaccination orders to be "teed up" by the MA. These are signed off by the clinician during the office visit after discussion with the patient."

Minimal verification example: "X clinic provides services for adults and follows USPSTF guidelines, using standardized templates by age and gender in the Health Maintenance section of the EHR Preventive Visit template note (ie Medicare Annual Wellness Visit or physical exam) to trigger clinicians to provide recommended services. Some "pre-visit planning" activities are conducted by individual clinicians and MAs. However, there is not a formal proactive "huddle" or "chart scrubbing" process in place."

- **3.C.0 PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources. (Must Pass)**

  This measure was one of the most variable in practice implementation. Some clinics demonstrating best practices had developed and implemented standard screening workflows involving the team, and were tracking and sharing data for recognized mental health (ie. PHQ-2), substance abuse, and/or developmental (ie. MCHAT) screenings. Less than ½ of the clinics were routinely using standard depression and substance abuse screening tools for all patients. Clinics meeting minimal verification standards only performing screening for mental health and substance abuse for new patients and at preventive visits (ie Medicare Annual Wellness Visits (AWVs) or patient-initiated Preventive Care visits/physical exams). These screenings were generally via paper form or direct clinician "Review of systems". For many clinics, specific education and links to TA and screening tool resources were incorporated into the site visit reports.

- **3.C.2 PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers. (Tier 2 – 10 Points)**

  A few clinics meeting this measure had developed defined relationships with area mental or behavioral health providers that facilitated patient

"hand-offs" or referrals, as well as communication and collaboration for better co-management of patient care. Others meeting this measure at a minimal verification level had "as needed" communication with mental/behavioral health practitioners.

Best Practice example: "Patients requiring mental health services are usually referred to the psychiatric nurse practitioner at The XXX Clinic, or to Y Family Counseling Center (YFCC). XXX Clinic providers have electronic access to the clinic's EHR, and documentation demonstrating this shared electronic record was provided and reviewed. YFCC providers do not have electronic access; patients sign a "Medical Records Release" form that is faxed along with the referral, to YFCC. According to staff, YFCC sends a "screening" message, indicating that "a note might be in the chart" for the PCP to review."
Minimal verification example: "the clinic does not have any formal agreements or co-management arrangements with community mental health providers. However, the clinicians reported "as needed" collaboration with mental health providers. The clinic provided chart notes for three patients…demonstrating two-way communication."

- **3.D.1 - PCPCH documents comprehensive health assessment and intervention for at least three health risk or developmental promotion behaviors. (Tier 1 – 5 points)**

Clinics routinely assessed health risks at "Preventive" visits – for example WCCs and Medicare AWVs – often using specific templates (paper or EHR). Comprehensive evaluation of health risks in age ranges between 18-65 was significantly less frequent, even at preventive visits. Resources for intervention were variable in practice – sometimes robust, involving co-located support staff or classes/group visits, sometimes limited to providing phone numbers and printed EHR template handouts.

Best Practice Example: "XXX clinic has been tracking the use of various health risk screening tools and services, and provides data summaries which drive team health assessment improvement goals…staff demonstrated integrated knowledge of multiple standard workflows for use of appropriate age-based health-risk screening which is aided by EHR-based tools. XXX staff focuses on using patient education materials that are understandable and appropriate for their populations. The team RN does specific patient-education for provider-referred patients. The clinic Community Health Worker is a resource to address community needs, and he maintains an extensive "Smartphrases" list in the EHR which helps clinicians and other team members provide patients written information to connect with community resources and support groups**"**
Minimal verification example: "New adult patients are screened for tobacco, alcohol and drug use, exercise, and sexual risk factors using an "Adult Health Questionnaire." New pediatric patients are screened for safety and injury prevention using the "Pediatric Health

Questionnaire." Age-appropriate anticipatory guidance is provided via standardized WCC templates that include safety, sleep, nutrition, behavior, falls, guns, and poisons. The clinician also provides individualized education, counseling, resources, referrals and follow-up as needed based on the identified risk and/or developmental factor(s). Examples provided include 4-month, 6-month, and 12-month WCC packets with age-appropriate information. Chart notes reviewed included (adult visits with) discussions of smoking cessation; diet and exercise; and alcohol use."

- **4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (Tier 3 – 15 points)**

  The implementation of this measure was directly impacted by the functionality of the "medical neighborhood". Some clinics share could share information with specialty providers and hospitals through EHR portals or shared EHR brand (most common was EPIC CareEverywhere), other clinics were using alternative HIT solutions effectively – for example in the Portland Metro area. However, there were examples of clinics that met this measure with "CareAccord", or other HIT strategies, but reported extremely limited functionality or value in practice because there was not a "critical mass" of other providers using the technology – they had the capability to share information but others didn't.

- **5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information. (Tier 1 – 5 points)**

  Clinics meeting this measure often did so managing limited populations – the most common example was patients with diabetes. Most clinics expressed a desire to augment their proactive patient management – with adequate staffing and reliable data – but were limited by EHR functional capability and staff/financial limitations. Clinics demonstrating the most robust implementation of this measure had staff dedicated completely or partially to activities meeting the intent of this measure.

  Best practice example: "The care coordinator tracks and proactively manages patients with diabetes and hypertension. She uses the Solutions database to run monthly reports, contacts patients for follow-up, schedules appointments and orders labs/tests per protocol. She also maintains registries of patients to generate patient reminders for indicated care such as pap smears, immunizations and WCC…Monthly data was provided from January 2012 to March 2013. Data from the diabetic foot exams was posted on a visual display board in the clinic and reflected an improvement from 46% to 67% (October to March 2013)."

- **5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (Tier 2 – 10 points)**

  Clinics meeting this Measure had specific staff dedicated to care coordination activities, but they use variable staffing and strategies. In particular, larger organizations often had care coordination staff for high risk patients, sometimes stationed remote from the clinic. Sometimes this was done effectively, but sometimes lack of co-location was reported to reduce effectiveness of coordination and communication. Comprehensiveness of addressing care coordination needs for complex patients was variable, and clinics often described difficulty defining care coordinator roles and training needs, financial barriers to sustain robust care coordination activities, and difficulty hiring care coordinators with ability to work effectively with high-risk patients.

  Best practice example: "In addition to recent augmentation of disease-specific care management, XXX clinic identifies a cohort of "more complex" patients referred directly by providers for more comprehensive RN care management such as pre-visit planning, and provider directed after-visit follow-up. Increasingly these patients are identified through a standard patient screening tool, and they are flagged in the EHR with a code that can be tracked…."more complex" patients are given a card with their RN care coordinator's name and contact information.**"**

- **5.E.1b PCPCH either manages hospital or skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings. (Tier 1 – 5 points)**

  Some clinics had clinicians managing their own patients in the hospital and/or in skilled nursing facilities (SNF). Others demonstrated active involvement in hospital and SNF care facilitated by clinic staff – for example an RN who maintains frequent communication with facility staff about patient care and status, as well as acting to coordinate discharge planning and follow up. Other clinics meeting the minimal verification standard for this measure did so by demonstrating physician responses to hospital admission/planned discharge and/or SNF communications/order requests and responses by electronic, phone, or FAX message.

- **5.G.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (Must Pass)**

Clinics generally demonstrated basic functionality in meeting patient end-of-life care needs if they arose. However, only a few clinics had structures or processes to actively address end-of-life care wishes with patients in advance of a health crisis precipitating the conversation.

Best practice example: "…clinicians reported they attempt to address the POLST and/or advance directives at every visit for adult patients, particularly over the age of 65….and refer patients to hospice/palliative care programs when needed. The clinic also uses "Choosing Options, Honoring Options," a coalition of individuals and organizations whose purpose is to facilitate end of life conversations in the community. This program provides end of life education and resources to individuals, family members, caregivers and professional staff. Additionally, in support of this philosophy, all clinic staff completed their own POLSTs and advance directives.**"**

Minimal verification example: "Although the clinicians have not had any patients requiring hospice services, they plan to refer to Legacy Health or Doernbecher Hospital for hospice or palliative care services. Also, if the need arises, they are aware of POLST and will address any end of life and/or POLST issues."

- **Measure6.B.1 PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (Tier 1 – 5 points)**

The robustness of implementing this Measure was another one of the most variable, often reflecting the focus and emphasis the clinic or organization puts on patient education/health promotion/self management support overall.

Best practice example: "staff and providers are trained to routinely provide "after visit summaries" for patients at office visits. One team described the use of a "YouTube" video to foster language-independent asthma medication teaching. RNs provide motivational interviewing, patient change-readiness assessments, and educational teaching at in-person visits, or through phone follow up recommended by the primary care provider…a Community Health Worker is on staff and can do home visits and help patients navigate the health care and social support systems. The clinic provided a variety of patient and family education and self-management materials as examples of tools they use. "

Minimal verification example: "Specific information can be downloaded through Epic templates and included in the after-visit summary. Examples of pamphlets included information on HPV infection and prevention for teens, diabetes ("What to Know Head to Toe"), osteoporosis prevention, screenings for women ("Women: Stay Healthy at Any Age"), and the Oregon Tobacco Quit Line."

- **6.C – Experience of Care Standard**

  As noted for Standard 1A., clinics meeting this standard at any Measure level demonstrated significant variability regardless of what Tier/point Measure they attested to. Some clinics attesting to 6.A.1 (5 points) used robust clinic-developed or industry standard surveys that mirrored significant parts of CAHPS. Few clinics shared CAHPS data with front line staff or designed improvement strategies around the data. A significant number of clinics had very limited knowledge of standard survey processes and/or biases, and clinics often had often not reviewed or did not fully understand their CAHPS survey data results.

E. Patient Experience of Care

Patient interviews were piloted with the initial 5 clinics, and then fully incorporated into the Site visit day structure. Modified CAHPS patient experience questions with additional open-ended questions form the backbone of the patient interviews. Patients did not identify problems accessing care quickly when they needed it during clinic hours, but delays in getting phone advice or difficulty with call flow in some clinics were identified as problems, or a focus of past improvement efforts. Some patients in clinics were aware of how to access after hours advice, but a significant number of patients were unaware of how to get after hours advice.

Occasionally patients identified areas for improvement, but frequently no areas for improvement were identified. This suggests that more robust facilitation or probing questions to better assess patient experience and prevent a tendency for patients to provide "positive" answers for a "visit from the state" should be under consideration for future site visits. Patient participation was variable – from 1-8 patients at each site visit. Pediatric clinics particularly cited the burden of mid-day timing and parental responsibility/financial barriers to patient/family participation. Some clinics provided patients a gift-card or meal as recognition of the burden and value of their participation in the site visit. Some clinics suggested the site visitors should provide such a "material recognition" of patient time and input particularly because the patient interview portion of the site visit is mandatory. Recommendations to improve assessment of patient experience in PCPCH recognized clinics include:

- The OHA/PCPCH Program should designate resources to recognize and value the time/input of patients during the PCPCH site visits – for example through a "gift-card" method (could consider "farmers market" voucher) or the provision of a meal for participants. This will encourage more reliable patient participation, and release clinics from the financial burden of providing this resource. The estimated cost of

such a program is $80 per site visit, however it would require additional administrative resources for adequate organization.

- The OHA/PCPCH Program should engage community partners such as the Patient Centered Primary Care Institute (PCPCI) and affiliated patient-representative organizations to help evaluate and more comprehensively consider how to assess patient experience in the interview portion of the PCPCH site visits. Consideration should be given to implementing a model similar to Minnesota, which contracts/trains/incorporates patients into the site visit as the "interviewers" of patients as "peers" - instead of the Program Site Visitor taking on that role.

F. **Provider & Staff Experience**

A key part of the site visits that provided evaluation of provider and staff experience, were specific questions about PCPCH implementation, successes/barriers, and future plans that were included during interviews with clinic leadership and staff. The following list provides a summary of common provider/staff reported experiences:

1. PCPCH Standards/Measures provided a "framework for improvement" that some clinics felt guided their improvement strategies – several clinics that initially were recognized as Tier 2 clinics and subsequently at Tier 3 cited similar experiences.
2. A significant number of clinics felt they had been working on "PCPCH-type" improvements for "years", but when they elaborated or were asked more probing questions by Site Visitors, most of them had been doing organized "medical home" or PCPCH-specific work for 5-6 years at the high end, and for 1-2 years or less on the low end of the timeline.
3. Numerous clinics cited visits to other sites – Alaska, Pennsylvania, PCPCHs in Oregon – where there had been some transformation success - as key to "believing" they could implement PCPCH-type care and for providing an initial roadmap.
4. Desire for mentorships ("someone like us who has done this") and other specific TA needs was high. Most clinics did not feel they had adequate access to these resources. However, organized collaborative efforts and funding – for example through CareOregon in the Portland-metro area – were cited as foundational to initial and longer-term success for Tier 3 clinics who had been working on PCPCH-type care for several years.
5. Lack of resources (financial/staff/time) under current payment/reimbursement models was unanimously identified by clinics as a primary barrier to continued transformation and sustainability.
6. Difficulty with communication between sub-specialists/hospitals and the PCPCH was also recurrently identified as a key barrier to improving patient care, coordination, and outcomes. In some of the practices – particularly in some larger health system practices - the PCPCH application attestation, data management, and other QI efforts were primarily focused at the

organizational rather than front line clinic level, and the integration and engagement of frontline clinical/non-clinical staff appeared insufficient to promote sustainability and continued progress to foster the intent of PCPCH-type care.

7. Clinics were unanimously concerned about and having difficulty understanding and implementing the required documentation/service/reporting for the Medicaid ACA-Qualified PCPCH payment program. During the site visit, Technical Assistance was provided to aid the understanding and accurate implementation of documentation and processes necessary for the ACA-qualified payment program. The clinics who had submitted ACA-qualified lists for payment expressed concern about the timeliness and accuracy of receiving the payments.
8. Clinics provided feedback that the TA provided at the site visits was valuable – particularly when the "Clinical Advisor" was included to provide a more thorough assessment and consultation/TA.
    - "the site visit findings provide a nice template to continue structuring the work being done at the clinic. We are all benefiting from the changes, patients as well as staff and providers. We derived a lot of valuable information from the discussions and look forward to continued communication, particularly with (the Clinical Advisor), who had great suggestions and information to share. We have an all staff meeting coming up…when we will be outlining and prioritizing the next steps."

<u>Additional work in this PCPCPH Part IV Evaluation project area has included:</u>

- participation and clinical advising in the PCPCH Standards Advisory Committee (SAC) (September/October 2012) that was refining the PCPCH Standards. The final PCPCH SAC Report was reviewed and edited.
- participation and clinical advising in multiple CPCI and other multi-payer stakeholder meetings as well as materials/data/clinical measures review – this work is ongoing.
- participation and clinical advising in weekly PCPCH Program Team meetings (that include OHA Leadership and DMAP staff) by phone and in-person – this work is ongoing.
- participation and clinical advising to promote CCO/PCPCH alignment within the OHA and CCO Transformation Center.
- planning and regular meetings with the Director of the Patient Centered Primary Care Institute (PCPCI), acting as the Chairperson/providing facilitation for meetings of the Expert Oversight Panel of the PCPCI – this work is ongoing.

Current status of Site Visit protocols/tools

- Pre-visit planning communications – complete, delays in site visit scheduling continue and further improvements in pre-visit communication protocols are needed
- Pre-visit documentation requirements – complete, anecdotal feedback: clinics appreciate clearer expectations, implementation has improved site visit flow.
- On-site documentation requirements and review – complete, anecdotal feedback: clinics appreciate clearer expectations, improved implementation at is needed at site visits
- Interview tool revisions to focus various interviews on verification needs – complete, official PCPCH interview tools are used variably, multiple tools in use - standardization is needed

Technical Assistance - PCPCI

Commonly identified areas of need for concrete technical assistance included:

- Mental/Behavioral Health integration
- Complex and routine care management
- Care planning
- Team-based care/team roles
- Data management and use in the clinic

There was nearly unanimous interest in participating in and accessing TA resources, but there also was confusion about where/how/when to access resources, and how any resources might fit with the myriad of efforts and resources in the industry.

The information obtained through participation in the site visits has provided the PCPCH Clinical Advisor with valuable perspective as Chair of the Expert Oversight Panel of the PCPCI, to help develop appropriate TA resources and strategies to meet identified PCPCH clinic needs.

Summary Recommendations to guide future PCPCH Site Visit/Program evaluation strategy

1. Expand site visit capacity to allow visits to each Oregon PCPCH every 3 years.
2. Take steps to complete site visit reports and send them to clinics in a more timely manner.
3. Implement strategies to use the insight gained at site visits as a springboard for improvement at those clinics.
4. Incorporate PCPCH-experienced clinicians as “consultants” at each site visit – to provide a robust assessment and “mentorship” collaboration with clinics, and foster meeting goals identified during site visits

5. Consider strategy modification for patient interview and assessment of patient experience - including materially valuing patient time and input, and incorporating a trained “peer” patient interviewer at each site visit.
6. Use all methods available to ensure sustainable financing of nascent PCPCH innovation by fostering administratively simple, sustainable levels of funding across the OHA and other payers to support provision of a robust PCPCH model of care for all Oregonians.