Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings

Executive Summary, September 2016

Study Aims

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) **to evaluate the implementation of the Patient Centered Primary Care Home (PCPCH) program, including**: **(Aim 1)** to understand the organizational conditions and process improvement activities of "exemplary" PCPCH clinics; **(Aim 2)** to estimate the impact of the PCPCH program on the utilization and expenditure patterns of clinics' clientele; and **(Aim 3)** to assess the general consistency and usefulness of PCPCH scoring in evaluating PCPCH performance.

Findings

The study's findings indicate that Oregon's PCPCH program has been very successful in meeting the goals of cost-effective, system-wide care transformation embodied in the Triple Aim. The PCPCH program has fostered the following elements **of health systems transformation** as envisioned by OHA:

- Encouraged clinics to embrace team-based care and continuous improvement, and to adopt a "patient centered lens." This shift in organizational culture supports new clinic processes such as care coordination, shared decision-making and using data to drive actions, resulting in care teams that are more aware of patients' goals.
- Helped clinics to shift towards population-based strategies that will improve the health of groups of patients who share a diagnosis or demographic characteristics.

In terms of costs and utilization, the PCPCH program has:

- Reduced total service expenditures per person by 4.2% or approximately $41 per person per quarter (~$13.50/month). Effects increased significantly the longer clinics were designated as a PCPCH, generally doubling from the first to third year of recognition.
- Resulted in $13 in savings in other services, such as specialty care, emergency department and inpatient care, for every $1 increase in primary care expenditures related to the PCPCH program.
- Saved an estimated $240M over its first three years. This amount should increase as more clinics become recognized and then continue to develop and mature in the program.

The **relevance of PCPCH recognition in evaluating PCPCH performance** was demonstrated as follows:

- The cumulative effect of the six PCPCH attributes has more impact on cost and utilization measures than their independent effects. In addition, the 18 standards identified as core by PCPCH staff appear to better identify level of performance than the total PCPCH score.
- Interviews revealed perceptions that while some of the attributes create organizational tension or conflicting priorities when implemented simultaneously, others are complementary.

While the program is a success overall, the study revealed some issues that can be addressed at the systems level (S), the program level (P), or through technical assistance (TA). These are critical considerations to advance the program's goals and future success:

- **(S)** Payment models and other financial arrangements do not currently incentivize clinics to operate in alignment with PCPCH program aims. Clinic leaders struggle to financially support the changes necessary for both general and top-tier recognition.
- **(S)** Barriers to information exchange with other clinics and hospitals significantly impede PCPCH clinics. The lack of interoperability across EHR platforms can rarely be addressed by individual clinics.
- **(P)** Considerable differences exist between PCPCH and non-PCPCH clinics. PCPCH patients are generally younger and Medicaid-insured. PCPCH designated clinics tend to be larger than non-PCPCH clinics or practices.

- **(P)** Terms such as "patient-centered" and "comprehensive whole-person care" are sometimes understood as describing a team's or provider's philosophy, rather than specific activities. This misunderstanding of program terminology can be a barrier to a clinic's improvement.
- **(P)** Patients have trouble understanding the relative value of different tiers of recognition. Patients also sometimes resist concepts like shared decision-making.
- **(TA)** Clinics with adequate space and up-to-date technological resources flourished, while clinics with outdated EHRs and inadequate space reported obstacles to making changes.
- **(TA)** Clinic leaders found training to support organizational cultural change to be critical, including: interpersonal communications; hiring practices; reductions in organizational hierarchy; transparency in planning and decision-making processes; and normalization of accountability through evaluation, information sharing, and solicitation and provision of feedback. Significant staff turnover was a common experience in early implementation but provided opportunities for new hiring strategies.
- **(TA)** Clinics most affected by Medicaid expansion find that newly insured patients need time to learn to navigate the primary care system. These clinics need robust networks of social services as they serve patients whose housing, transportation, and economic situations complicate medical care.

Conclusions

The findings demonstrate that the PCPCH program has achieved some noteworthy indicators of progress toward accomplishment of the Triple Aim in only a few years of operation. PCPCH designated clinics have accomplished significant transformation, resulting in greater effectiveness and efficiency, both within primary care and the larger health care system. These successes are not easily obtained or sustained, and take several iterations of experimentation and adaptation in which clinic leaders must be willing to examine all aspects of clinic process and culture. Dialogue and transparency at all levels of the clinic are essential. Ultimately, the larger health systems environment must support clinic and individual changes. Expanded support for clinics, and a continuing emphasis on creating this supportive environment for implementation, should both sustain the progress made and invite further engagement from primary care clinics across Oregon. For additional recommendations from the PSU research team related to these implementation findings, see Executive Summary Supplement: Recommendations.

Methodology

The PSU research team worked with OHA program leaders to identify "exemplary" clinics at the time of evaluation based upon representativeness across participating PCPCH organizations, diversity of clinic characteristics, attestation scores, stability in ownership, and willingness to participate in the case study. Twenty clinics were selected and interviewed to assess their experience in the PCPCH program. In addition, PSU was provided access to Oregon APAC claims and eligibility data covering one year prior and three years following PCPCH program implementation (October 2010-September 2014). PCPCH program effects were identified as the "difference in difference" of pre- to post-designation changes within clinics that attained PCPCH designation to those who were never designated. All study protocols were approved by the PSU Institutional Research Board (IRB).

PCPCH Evaluation Team

Investigators: Sherril Gelmon, DrPH, Neal Wallace, PhD, and Billie Sandberg, PhD
Research Assistants: Shauna Petchel, MPH, and Nicole Bouranis, MA
OHSU-PSU School of Public Health & Mark O. Hatfield School of Government
Portland State University

Executive Summary Supplement: Recommendations Based upon Program Findings

September 2016

System Level Strategies:

S-1: Reform payment mechanisms to provide incentives and rewards for participation in the PCPCH program, advancement along program tiers that increases program benefits, and adequate and sustainable reimbursement of critical and high-impact components of the PCPCH model.

S-2: Develop and coordinate **a more systematic approach and regional coordination to achieve interoperability of electronic health records** (EHRs) across providers in Oregon.

Program-Specific Strategies:

P-1: Monitor the considerable differences in patient and provider characteristics that exist between currently participating PCPCH clinics and those that have not yet opted in.

P-2: Consider the implications of the findings that **attainment of the six program attributes works collectively** and not independently, and that the 18 standards identified as core by PCPCH staff appear to outperform total PCPCH score, in further efforts to develop the PCPCH recognition process.

P-3: Adopt value-neutral program language that more clearly points to specific operational changes and avoids terminology that implies care was negligent or mishandled prior to PCPCH recognition.

P-4: Work with other organizations and improvement-focused collaboratives to streamline and develop more universal definitions of core concepts and standards for required metrics.

P-5: Use media and other strategies **to raise public awareness** of the value of PCPCH across Oregon.

P-6: Emphasize through ongoing communications that the **transformation aims of PCPCH are dependent upon the engagement or resistance of individual people** within the clinics.

Technical Assistance Strategies with Individual Clinics:

TA-1: Support clinics to find or develop staffing to meet program documentation/reporting mandates.

TA-2: Provide financial assistance for initial structural changes, facilities expansions, and technological improvements to equip clinics with the physical and digital resources that support the cultural and process changes that will be implemented through the PCPCH developmental process.

TA-3: Provide skill-building and training resources to support organizational cultural change.

TA-4: Allow clinics a financial "grace period" to experiment with workflows, organization and team structures, and other processes for performance improvement without risking their bottom line.

TA-5: Allow time to assess the patient culture and support the shift to PCPCH.

TA-6: Meet clinics "where they are," and avoid language that clinics may perceive as critical.

TA-7: Provide examples of practices that illustrate workflow or documentation processes and reveal the intent behind each standard. Consider adding examples of practices that do not meet the standards.