Transforming Primary Care: Best Practices to Improve Population Health

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Declaration of Interests

• First author contracted as evaluator of program by state health authority
• Second author employed as program director by state health authority
• No competing or proprietary interests
Objectives

• Describe a model of primary care practice organization.
• Identify effective strategies to support primary care transformation.
• Articulate facilitators of, and barriers to, transformation of primary care delivery.
• Apply lessons learned to participants’ own settings.
Oregon, USA
Theory of Change: Oregon

Improved care coordination across the system, emphasis on primary care

New payment models that reward improved outcomes

Integration of physical, behavioral, oral health with community health

Standards and accountability for care that is safe, accessible, and effective

Test, accelerate and spread across the state

Redesigned delivery system

Improved outcomes
Reduced costs
Healthier population
Key Elements

- Benefits and services are integrated and coordinated
- One global budget that grows at a fixed rate
- Local accountability for health and budget
- Local flexibility
- Metrics: Standards for safe and effective care

[Logos: Oregon Health Authority, Patient-Centered Primary Care Home Program]
Patient-Centered Primary Care Home Program

Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

Goals (2011):

• All state-covered lives receive care through a PCPCH
• 75% of all Oregonians have access to quality care through a PCPCH by 2015
• Align primary care transformation efforts by spreading the model to payers outside government
Key Program Elements

Eligibility:

- Any primary care practice

Key PCPCH program functions:

- PCPCH recognition and verification
- Refinement and evaluation of the PCPCH standards
- Technical assistance development
- Communication and provider engagement
PCPCH Core Attributes

• Access to Care
  • “Health care team, be there when we need you”

• Accountability
  • “Take responsibility for us to receive the best possible health care”

• Comprehensive Whole Person Care
  • “Provide/help us get the health care and information we need”

• Continuity
  • “Be our partner over time in caring for us”

• Coordination and Integration
  • “Help us navigate the system to get the care we need safely and in a timely manner”

• Person and Family Centered Care
  • “Recognize we are the most important part of the care team, and we are responsible for our overall health and wellness”
Oregon’s Health System Transformation

Integration and coordination of benefits and services

Local accountability for health and resource allocation

Standards for safe and effective care

Global budget indexed to sustainable growth

COORDINATED CARE ORGANIZATION

PATIENT CENTERED PRIMARY CARE HOME
Rapid Spread of PCPCH

- Program launched October 2011
- One year: 250 practices recognized
- Two years: 425 practices recognized
- Currently: 550 practices recognized
- Estimate another 400-500 practices could still be recognized
- Potential impact on health status for entire population of Oregon (3.9 million people) is substantial
PCPCH Profile

• Staffing
  • Average # providers = 5.1 (1-39 FTE)
  • Average # other clinical staff = 9.4 (0-70 FTE)
  • Average # annual visits = 14,539 (229-134,000)

• Services
  • Majority serve adult and pediatric populations
  • Majority provide obstetrics care

• Ownership
  • Nearly half owned by a larger system
  • 40% independent and unaffiliated
  • About 10% independent but in alliances
Rationale for Participation

• Better Patient Care
  • Standards are evidenced-based and aligned with regional metrics, and with state and national transformation efforts

• Business Case
  • Practices listed on state website
  • Consumer knowledge of quality care

• Payment Incentives
  • Preferred contracting status for both public and private health plans
Implementation of the Model

• 80% added 1+ new service for PCPCH recognition
  • Care management, tracking, enhanced data
• Impact of PCPCH recognition: Triple Aim
  • 85% - improve the individual experience of care
  • 82% - improve population health management
  • 48% - decrease the costs of care
• Impact of PCPCH recognition: Quality and Access
  • 85% - increase quality of care to patients
  • 75% - increase access to services
PCPCH Expenditures/Utilization

Figure 1: PCPCH Expense and Utilization % Change vs. Non-PCPCH Sites
(* = P<.05)
Effective Strategies
Keys to Success

• Leadership -- administrative and clinical
  • Vision, champions, resources

• Resource adequacy
  • Staffing, financial incentives, operational capability

• Process
  • Community engagement, balance of stability/flexibility

• Context
  • Concurrent system transformation, organizational learning

• Facilitated learning
  • Technical assistance, knowledge mobilization, experts
Examples of Best Practices

• Commitment to quality and performance improvement
• Collaboration of physical and behavioral health providers
• Health indicator tracking across patient populations
• Culturally responsive organization and staffing
• Use of care management teams and coordinated plans
• Flexible appointments and extended hours
Government Agency Perspective

• Build vision through collaborative public discussion and dialogue
• Involve diverse providers and payers
• Simple, clear, standards-based approach
• Focus on population health “beyond clinic and hospital walls”
• Draw upon expertise from other state and national experiences
Myths – Not Our Reality!

- Share best practices, then clinics will just do it.
- Make it a requirement and/or pay for it, then it will definitely happen.
- Send people to training, then they will implement new processes at their clinic.
- With clinician leadership, transformation will occur.
- Create standards, then practices will implement the necessary elements.
Our Biggest Challenges

Moving beyond early adopters requires a new approach

Learning is time intensive and costly for practices and systems

Change requires support and systems, and takes time

Need aligned measures and financial incentives to sustain change work
Technical Assistance

- Public-private partnership launched in 2012
- Offers technical assistance for practices at all stages of transformation
- Ongoing mechanism to support quality improvement
  - PCPCH Learning Collaborative
  - Training and practice facilitation services
  - Monthly webinars
  - TA expert learning network
- Website of downloadable resources
Next Steps in PCPCH Program

- Enhance communication and engagement
  - Maintain relationships with recognized clinics
  - Engage unrecognized clinics
- Expand technical assistance
  - Expand site visit process to integrate practice coach and clinical champion
  - Follow-up and assistance with ongoing implementation
- Launch 3-Star designation
  - Recognize clinics that are the “best of the best”
Resources

- health.oregon.gov
  - Local health reform resources
- www.PrimaryCareHome.oregon.gov
  - PCPCH program resources and information
- www.pcpci.org
  - Self-assessment tool
  - Topic-specific webinars
  - Learning resources
  - Online learning modules
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