Report Title: Report on the Results of the 2012-2013 Qualitative Patient Centered Primary Care Home (PCPCH) Evaluation

Author/Organization: Jill Jamison Rissi, PhD and Robin Baker, MPH, Mark O. Hatfield School of Government, Portland State University

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For more information contact:

Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301
pcpch@state.or.us

Report on the Results of the 2012-2013

Qualitative Patient Centered Primary Care Home (PCPCH) Evaluation

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Jill Jamison Rissi, PhD and Robin Baker, MPH, Portland State University

This report describes the results of qualitative document reviews and interviews with key stakeholders regarding the development and implementation of Oregon's Patient Centered Primary Care Home (PCPCH) Program. This is part of the Oregon Health Authority's overall evaluation of the implementation of PCPCH, a multi-organizational collaborative evaluation contracted to Portland State University.

Introduction

The Patient-Centered Medical Home (PCMH) is a model of enhanced primary care that shows promise for reforming health care by changing the way care is organized and delivered. The model typically includes core features such as an emphasis on patient/physician relationship, patient-centeredness, enhanced access, payment reform in alignment with PCMH values, comprehensive care/whole-person orientation, care coordination, quality and safety, and team-based care. This model of care has been implemented in several states and agencies, both within the public and private sectors. By the end of 2012, more than 26 states had adopted the PCMH model in their Medicaid programs, including Oregon.

Fueled by evidence suggesting that the PCMH is a viable model for achieving the "Triple Aim" of better population health, better experience of care, and reduced costs, Oregon passed HB 2009 (2009) creating the Oregon Health Authority (OHA) and Oregon's version of the PCMH, the patient-centered primary care home (PCPCH) Program. In 2011, HB 3650 was passed, emphasizing the PCPCH as foundational to Coordinated Care Organizations (CCO). OHA began accepting applications from primary care sites for PCPCH recognition in October of 2011 and, as of May 2013, 385 PCPCH clinics have been recognized.

The decision to include the PCPCH Program in the 2009 legislation was influenced by many factors. Subsequent evaluation research on the efficacy of the model has been somewhat equivocal, but largely perceived as positive. Evidence supporting the medical home model includes reductions in hospitalizations, hospital readmissions, and emergency department (ED) visits;[1] improvements in

[1] Nielson, M; Langner, B; Zema, C; Hacker, T; and Grundy, P. (2012). *The benefits of implementing the primary care patient-centered medical home: A review of cost and quality results.* Patient-Centered Primary Care Collaborative.

quality and annual savings ranging from $71 to $640 per patient;[2, 3] increased patient satisfaction and access to care; and, better disease management, patient engagement, and preventative care.[4]

Development of the PCPCH Program was facilitated by several committees appointed by the OHA Director to assist OHPR in developing strategies to identify and measure patient centered primary care homes. The first Patient Centered Primary Care Home Standards Advisory Committee was made up of a diverse group of Oregon stakeholders including patients, clinicians, health plans and payers. In addition to developing the six core attributes, the committee articulated standards and detailed patient centered primary care home measures. The core attributes, standards and measures were intended as a tool for the Oregon Health Authority, policymakers and other Oregon stakeholders seeking to assess the degree to which primary care clinics are functioning as patient centered primary care homes and promote widespread adoption of the model. According to the PCPCH Standards Advisory Committee's 2010 final report, goals for the Program included developing strategies to identify and measure PCPCH outputs and outcomes; promoting the adoption of the PCPCH model by clinic sites; and, ensuring that populations covered by OHA would receive care in the PCPCH model.[5]

Evaluation of the PCPCH Program

Most PCMH evaluations focus on utility, cost, and outcomes. Fewer examine how PCMH programs are developed and implemented and the impact those processes have on engagement and successful implementation. Beyond preliminary research into specific outcomes of care under a primary care home model, early evaluations of PCMH implementation demonstrate that practice redesign is complex and that most interventions fail to meet expectations. For these reasons, comprehensive evaluations are necessary to identify and analyze factors that may facilitate and/or hinder successful transition to a medical home model of care.[6]

Similarly, a comprehensive evaluation can help to identify and explore the factors that facilitate or impede the successful development and implementation of the PCPCH model as public policy. To explore the factors that have facilitated, or impeded implementation of the PCPCH Program, the Oregon Health Authority contracted with a multi-disciplinary team of researchers at Portland State University working in collaboration with the Oregon Health Research and Education Consortium (OHREC). Beginning with the statutes and administrative rules which established the PCPCH Program, the scope of the evaluation includes an assessment of the six core attributes of the model that provide defining criteria for PCPCH clinics. The six dimensions include: 1) implementation; 2) fidelity to the model; 3) clinical quality; 4) cost and efficiency of care; 5) patient experience of care; and, 6) provider and staff experience.

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[2] Fields D, Leshen E, and Patel K. (2010) Analysis & commentary. Driving quality gains and cost savings through adoption of medical homes. *Health Affairs*; 29(5): 819-826.

[3] DeVries, A. et al. (2012). Impact of medical home on quality, healthcare utilization, and costs*. American Journal of Managed Care*; 18(9):534-44.

[4] Nielson, M. et al. (2012)

[5] Oregon Health Authority, Office for Oregon Health Policy and Research. (2010, February) *Final Report of the Patient Centered Primary Care Home Standards Advisory Committee: Standards and Measures for Patient Centered Primary Care Homes.*

[6] Crabtree, B. et al. (2011). Evaluation of patient centered medical home practice transformation initiatives. *Medical Care*; 49(1): 10-16.

Evaluation goals include those related to the Triple Aim; modifications to improve the PCPCH model; OHA's implementation efforts; and, evidence for continued support of the Program. To address these goals, the research team developed a four-part evaluation framework:

A. Quantitative analysis of risk-adjusted service utilization, costs of care, and efficiency.
B. Comprehensive baseline and 12-month post-implementation surveys to assess fidelity to the model.
C. Document review and qualitative interviews with key informants regarding development and implementation processes.
D. Site Visits for verification of compliance with recognition standards and performance metrics, and identification of opportunities for enhanced clinic support and technical assistance.

The overall goal for the qualitative component (Part III) of the comprehensive evaluation was to identify factors that facilitated, or impeded the implementation of the PCPCH Program, and provide policymakers and other stakeholders with key insights regarding successful engagement and implementation strategies.

Methods

A mixed-method approach included document analysis, and in-depth, qualitative interviews. The overall research design is based on the Consolidated Framework for Implementation Research (CFIR), which was adapted and utilized for analysis of policy, legislative, and seminal administrative documents (N=8), and for in-depth qualitative interviews (N=23). CFIR was developed by Damschroder et al to unify multiple, overlapping implementation theories and promote theory development around intervention effectiveness, as well as the context and factors that facilitate or impede effectiveness.[7] The framework includes five domains (intervention, inner setting, outer setting, individuals, and process), which interact with each other in complex ways that may impact the efficacy of implementation efforts. In addition, each domain contains a set of constructs that also interact with each other within and across domains to influence the implementation process.

CFIR domains and constructs were adapted to create specific instrumentation for the PCPCH evaluation project, resulting in an evaluation matrix that was utilized for comparative analysis of both the documents and the interviews. The evaluation matrix was designed to assess five key domains, including: 1) characteristics of the PCPCH model; 2) external setting; 3) internal setting; 4) characteristics and roles of key individuals; and, 5) process. The framework was designed to answer questions in five key domains (The analytic domain and key indicator matrix is provided in Appendix A.):

- **Characteristics of the PCPCH Model:** attributes of the PCPCH including perceived source of the program (internal or external), quality of evidence to support the PCPCH model, relative

[7] Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. a, & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation science : IS, 4, 50

advantage over alternatives, degree of adaptability and complexity, and cost associated with the PCPCH.

- **External Environment:** qualities of the external environment including the extent to which the need for change as well as the resources to support change are known and identified, degree to which organization and agencies are connected, and the extent to which stakeholders feel pressure or incentivized to adopt the PCPCH model.
- **Internal Environment:** organizational attributes of OHA including decision-making structure, culture, values, and size as well as the perceived tension for change, shared perception of importance of the PCPCH program and its compatibility with organizational goals and values, degree to which goals and information about the PCPCH program are communicated to stakeholders, and the extent to which stakeholders feel that leadership is engaged and resources are dedicated for implementation.
- **Characteristics and Roles of Individuals:** individual traits including knowledge and beliefs about the PCPCH program as well as identification with particular perspectives or interests.
- **Process:** the degree to which appropriate stakeholders are identified and engaged during development and implementation, strategic plans are thought out in advance and the quality of those plans, and operational structures are developed and in place implementation.

Analysis focused on determining how the implementation process itself (Domain "A") may influence observed outcomes in each of the other domains. An extensive literature review was conducted on two key areas, the medical home model and implementation science. The literature review identified and assessed potential challenges related to the PCPCH model and implementation process, and suggested relevant domains and indicators, as well as document analysis and interview protocols.

Document Review: We reviewed the enabling legislation HB 2009 (2009) and ORS 442.210 which established the PCPCH program; HB 3418 (2009) and ORS 413.260 which charged OHA with researching and evaluating reimbursement systems for the promotion of the PCPCH model for Medicaid members; and, the original and final statutes as signed into law (ORS 442.210 and ORS 413.260). In addition, we reviewed subsequent legislation, HB 3650 (2011) and ORS 414.655, which formally identifies the PCPCH program as a foundational and critical component of Coordinated Care Organizations (CCO) for providing comprehensive and coordinated care to Oregon Health Plan (OHP) members. Finally, we reviewed several OHA reports that were central to the development and implementation of the PCPCH Program.

Key Informant Interviews: In May/June 2013, following preliminary document analysis, in-depth qualitative interviews were conducted. KIs were recruited via email and phone, and were identified and selected based on the principle of maximum variation. Specific criteria included: 1) professional background and role; 2) length, nature and degree of engagement with implementation of the PCPCH Program; and 3) geographic and disciplinary affiliations. Key informants included persons who had been, and/or were currently involved in the development and implementation of the PCPCH Program. These individuals were representative of policymakers, service providers, community health advocates, health system leaders, and health service providers. One individual refused to participate, three were unresponsive to our requests for an interview, and two were willing, but ultimately unable to schedule an interview within the project timeline. Semi-structured interviews explored respondents' experience with the PCPCH program. In addition, several interview questions acknowledged the

complexity of the Program, and asked interviewees to identify potential program improvements, both retrospective and prospective.

Interviews were conducted by two-member teams, and most were completed in-person. Two KIs were interviewed by just one member of the research team, and ten interviews were conducted by phone. All interviews lasted over an hour, and several were considerably longer. After each interview, the interviewers completed post-interview reviews in order to capture key points and identify emerging themes in the narrative. The study team created a coding dictionary, transcribed the interviews and analyzed the transcripts to validate the themes previously identified through document analysis.

Analysis: Finally, the results of the document and interview analyses were synthesized. Working independently, members of the research team reviewed the emerging themes in the context of the five domains of the analytic framework, then compared and synthesized interview findings with the document analysis results to develop a summary of key findings. Key findings from Part III of the PCPCH Evaluation are summarized below. A detailed discussion, along with quotes from respondents and further analysis, follows.

Summary of Key Findings

1. Support for the program among policymakers and health system leaders was influenced by exposure to a successful PCHM program in a neighboring state, while health service providers' support was based largely on perception of the model as the "right thing to do." Both groups expressed belief in the benefits attributed to the PCMH model of care.
2. The PCPCH Program has received broad support, but its complexity and uncertainty regarding future modifications may present challenges to maintaining commitment to the shared vision of the PCPCH model and ongoing support for the Program.
3. Implementation of CCOs and other health system transformation efforts were seen as being integrally related to, and supportive of, the PCPCH model. However, in some respects they were also viewed as competition for resources and attention, suggesting the need for greater alignment of PCPCH with other transformation initiatives.
4. Strong leadership within OHA and the commitment of Program staff were complemented by external leadership among key community-based organizations.
5. Many individuals noted positive experiences serving on committees, task forces, and work groups, and several respondents indicated that including more participants would provide additional perspectives that could be useful for future Program improvements.
6. Communication with community stakeholders was critical to the successful development and implementation of the PCPCH Program, and will be equally important for its sustainability.
7. The range of concerns expressed by interviewees suggests the need for ongoing strategic planning to ensure the sustainability of the PCPCH Program and model of care.

KEY POINT: Evidence, Values, and Beliefs Contributed to Support for the PCPCH Model

1. Support for the Program among health service providers was based largely on perception of the model as the "right thing to do," while support among policymakers and health system leaders was influenced by exposure to a successful PCMH program in a neighboring state. Both groups expressed belief in the benefits attributed to the medical home model of care.

Health service community and provider support for the program was based largely on the perception of the model as the "right thing to do" and belief in the benefits attributed to it. The value placed on the PCPCH model and its efficacy were frequently associated with the elements of the Triple Aim, suggesting that consistent references to those three goals have been foundational to the recognition of common interests, creation of shared goals, and commitment to a unitary vision among Program stakeholders.

Although perceptions about the strength and quality of empirical evidence to support the efficacy of the PCPCH Program vacillated between full acceptance and cautious optimism, faith in the efficiency and effectiveness of the PCPCH model was strong. Many of the respondents unquestioningly believed that the model is capable of generating cost savings and improving the quality of care. However, when asked to explain the primary advantages of the PCPCH program many re-counted benefits related to broader policy narratives of the Triple Aim and larger healthcare transformation initiatives. Specific benefits for identifiable groups of people such as patients, providers, or staff were rarely mentioned in the interviews, even when prompted. Occasionally, there were vague references to the needs of patients and how the PCPCH program might benefit them, but even when specifically asked how or why, most respondents did not stray far from the Triple Aim narrative.

I would say the Triple Aim is just that, that is the guiding star …and that is the hope for the medical home, which I think is also why it resonated so well…

It is an effective and efficient model to improve health and improve health care and save cost - but really to improve health care.

Clearly, there was a desire to improve outcomes, quality, and patient focus. That definitely was out there. I think also…how can we manage cost of Medicaid? …And the level of cost containment. Those are the main drivers…cost and quality, engagement, improvement with the healthcare...

A possible explanation for the strong belief in the perceived benefits of the PCPCH model is that the interviews were conducted relatively soon after efforts to promote participation in the program and other highly publicized healthcare transformation initiatives. Notably, even among those who were more cautious, or stated that the evidence for the model was somewhat equivocal, support for the program was almost universal based upon the belief that it was the "right thing to do."

I think patient centered primary care homes are something…there certainly is some research but it's one of those things that has the 'Stephen Colbert truthiness' to it. It just seems like it's right… I don't remember any specific research that people used to say 'oh this proves it's

better or worse or whatever,' I think it's just an overall sense that this would be a good thing to do.

…[T]he lack of double-blind, randomized studies shouldn't stop us from what seems right.

I think a part of its going to be people just feeling that they want to take this step in the right direction and they may not have all the data at their fingertips, but they truly believe that this is the best approach in comparison to the status quo.

This notion of the "rightness" of the model appears to complement the conceptualization of the PCPCH Program as an evidence-based effort, and the requirement for research and pilot studies that demonstrated tangible and measurable advantages. This finding highlights the strength of situated, experiential knowledge, underlying values, and beliefs in generating broad-based support for the implementation of health system reform initiatives, even when research designed to provide definitive evidence of the efficacy of the proposed intervention is nascent. This finding also highlights the critical importance of individuals' past experiences, values, and beliefs in creating a shared vision and establishing common goals. Each of these elements played a role in the development of HB 2009 as well as implementation of the PCPCH Program.

The shared experience of a small group of key stakeholders who visited the Alaska Native Medical Center in Anchorage[8] was central to policymakers' and stakeholders' narratives about the defining characteristics of the primary care home model and evidence of its efficacy.

[It was] a pretty large group of people having a shared experience and coming back with… a shared vision of it… all saw the same thing; [it] took a awhile for us internally, to clearly articulate what was most meaningful about it to us, but at least they were all looking at the same thing.

… [M]any of those who went to the South Central Foundation were really bitten by the bug and were convinced that this is really a major transformation...

At the same time you had other forces working, CareOregon was really involved with SouthCentral Foundation; they took teams of people up to visit… to get exposed to the model…So you had buy-in being created, and the Northwest Health Foundation paid for people to go up and visit… and see what they were doing. There was really this movement afoot - not driven by anything except a recognition that something was going on up there that was really working with a very difficult population.

While clearly inspirational, the context of the SouthCentral story and the situation in Oregon were very different. Despite these differences, site visits to the Alaska Native Medical Center appear to have served as a catalyst in the development of Oregon's PCPCH program. It is likely that the centrality of this experience in shaping Oregon's PCPCH Program was premised not upon the environment and

[8] Once federally owned, most primary care at the Alaska Native Medical Center was delivered in urgent care or emergency departments. In 1999, SouthCentral Foundation, an Alaska Native-owned non-profit healthcare corporation, and the Alaska Native Tribal Health Consortium assumed ownership and management and embarked on a journey to transform how care was organized and delivered. In 2010, the Center received the highest level of PCMH recognition from the National Committee on Quality Assurance (NCQA) and in 2011 received a Malcolm Baldrige National Quality Award.

program in Alaska *per se*, but on the common vision and commitment that was created among key individuals who shared this experience, many of whom were instrumental in the development of the PCPCH Program.

KEY POINT: Broad Support for the PCPCH Program, Tempered by Several Concerns

2. Support for the PCPCH model is strong and widespread, but the Program's complexity and uncertainty regarding future modifications may present challenges to maintaining commitment and ongoing support.

Citing initial confusion during the certification process, administrative burdens such as documentation and reporting, and concern about payment mechanisms, some respondents were concerned that the model itself was complex and costly. Almost all respondents mentioned that because the program is embedded within a larger healthcare transformation environment, PCPCH documentation and reporting requirements have a cumulative burden on clinics, which are often overwhelmed by documentation and reporting requirements of multiple initiatives and programs. While part of the appeal of the PCPCH program was that it was home grown, there were some drawbacks to this approach. Respondents acknowledged that opting to develop unique standards, rather than adopting a set of standards that are already in existence, such those that were developed (and subsequently revised) by the National Committee on Quality Assurance, added additional layers of complexity.

I hear nationally…why didn't you adopt it [NCQA standards] again? The consternation is that you're creating a second set of standards and for people locally who are trying to get NCQA accredited - it creates an issue for them.

I think [about] the amount of administration to keep a separate certification system that is accepted nationally by everybody else. You wonder, is there enough to add value to PCPCH to maintaining their own system?

The administrative burden of the program was most often tied to concerns about cost. Respondents often pointed out that successful implementation of the model requires upfront investment. While most respondents regarded cost savings as a long-term benefit that would eventually provide return on investment on short term costs, there were concerns that resources needed for implementation are significantly underestimated. In particular, several raised questions about the capacity of small practices and rural clinics to successfully adopt the model, and suggesting that the model is more feasible for larger, more urban practices.

One of my big concerns is that these new standards tremendously disadvantage small and rural practices, and give significant advantage to large and urban practices.

In a rural community with one or two doc practices, one or two nurse practices, or one or two physician assistant practices, the [PCPCH]…may or may not compute…. This is a conversation that makes sense for medium and large practices, and make less and less sense as you get towards the single doc practice.

Unpacking these concerns leads to two different but related issues. The first is primarily about the perceived cost of administration. Several respondents noted that smaller, rural practices may not have the necessary staff or infrastructure to keep up on documentation and reporting requirements. Unlike their urban counterparts, rural practices are more likely to be small and less likely to have staff whose responsibility can be shifted to managing participation in such programs like the PCPCH. As a consequence, some respondents suggested that the additional administrative burden may make the PCPCH program less accessible to many rural and small practices.

It's just not as cost-effective for some of these [small] practices to make this huge investment, whereas a lot of this kind of stuff is already embedded in some of the bigger systems. If you look across the state, this is what we're really seeing now, you know whether it's in Bend, Medford, Corvallis…it's much tougher… for a lot of these smaller primary care clinics to do all of this stuff on their own.

I think it is a huge challenge for small practices to address this…we have CCO, then PCPCH, then we have [EHR] meaningful use. To deal with all of that when you don't have the management infrastructure that a big organization would have…I don't think we have the infrastructure to document and demonstrate what we do.

It's still a fair amount of administrative work and so for us that's exactly out of our pocket upfront… to try to accomplish this whereas in a big system they can absorb that and they can have dedicated time and employees to do this we…we're having to bootstrap it. I think it would be helpful if there were some assistance provided to small practices to do this.

The second issue concerns the standards and the capacity of small, rural clinics. Some respondents raised questions about the feasibility of implementing the model in certain contexts. While the points system was lauded by many as a creative approach to maintain flexibility within the program, several respondents with rural and small practice perspectives were still concerned that some of the must-pass standards did not take into consideration the unique context of rural Oregon. Although participation in the PCPCH Program is not mandatory, sites that choose to participate must comply with the must-pass standards. In addition to their concerns about such compliance, the KIs we spoke with noted the importance of engaging in broader health system transformation initiatives and for that reason often saw PCPCH recognition as requisite.

A review of relevant PCPCH documents, reports, and interviews with key informants suggests that flexibility was a priority in designing the program in order to promote broader engagement as well as increase the applicability of the program in multiple settings.

A key theme which emerged from both Committees' deliberations was that of flexibility in application and refinement of the model over time. Based on stakeholder feedback, an implementation plan has been developed that does not incorporate all of the standards articulated by the Committees, but rather a subset of standards that may be more feasible for immediate implementation. – Implementation Reference Guide

A conversation that had gone on in the advisory committee was that we didn't want to have five different models. We didn't want to have one for kids, one for adults, one for older adults, one for… you know. This was supposed to be something that you could implement statewide

for all populations and practices, and they wanted to leave it flexible enough that it would work for all populations.

It was really meant to help people take their first, second and third step toward transformation. It is not meant to say 'you can't do this so don't bother to apply.' Everybody needs to apply and everyone needs to do it.

While many do believe that the point-based, tiered recognition system increases the flexibility of the PCPCH Program, those with a more rural perspective tended to argue that despite this flexibility the program favors larger practices in urban settings. This sentiment may be partially attributable to the timing of the interviews. While the interviews were initially structured to focus on the first set of standards, because they coincided with the release of the second set of proposed standards for public review and comment, respondents who were interviewed later in the study were aware of the revised standards, and immediately raised concerns about the proposed new standards during the interview.

Confusion regarding the standards was particularly notable. For example, several respondents erroneously believed that co-location of behavioral and primary care was a new "must-pass" standard and questioned the feasibility of such a standard in rural settings. Most were unaware that behavioral health integration is *not* a must-pass standard and, in fact, any standards pertaining to the coordination of behavioral health and primary care remain unchanged from the original standards.

One [standard] now requires colocation of a behavioral health person in your office. <u>Really</u> now, the ratio of physical health to mental health providers is at least five to one. So in a practice of less than five, it makes <u>absolutely</u> no sense - there's no logic of having someone from behavioral health in an office of less than one or two docs. And small offices are <u>predominantly</u> in the rural parts of the state and large practices are predominantly in the urban parts of the state… there's no way in the world the rural practices are going to be able to do that.

There are some things that, even having gone through the process, I think that it's hard for a practice like ours to qualify. Maybe the point system makes up for it, but there are some things that are designated as a must have… the behavioral health part…. is also important but practically speaking… difficult to achieve. So more flexibility and maybe the ability to tweak the standards so that they don't present big barriers. I'm thinking about a… small independent practice…I don't think they're patient centered and I'm not sure if they feel like they can because of all the obstacles like the cost of it, how to figure it out, dedicated staff time…all those things I think make it really difficult. So if they were approached they would say "well that sounds all very nice but that's not feasible for us." It shouldn't be like that, everybody should be able to do it…

While some of these concerns arose from misinformation, some of these concerns reflect "situated knowledge," or information about the policy problem, impacts, contributory causes, and possible solutions that is known to certain respondents because of their experience working within particular contexts and embedded with the complex healthcare system. These accounts of complexity reveal many of the contradictions, tensions, and disagreements within what may appear to be a unitary policy. Even when perceptions are erroneous, knowledge of such beliefs is relevant information that could help OHA understand more fully the impact, as well as the reception that programs like the PCPCH are likely to have among health service providers and community health advocates. In this

particular case, while the PCPCH program enjoys broad support, concerns about cost, complexity, and rural disadvantage point to areas that require more attention, outreach, communication, and possibly, financial support, to relieve some of these concerns and to ensure that participants have accurate information regarding the Program.

KEY POINT: Implementation Processes for the PCPCH Program and CCOs are Interdependent.

3. Concurrent implementation of Coordinated Care Organizations may compete with the PCPCH Program for high-level administrative attention and financial resources, but the initiatives are widely seen as inextricably interdependent.

Implementation of the PCPCH Program was frequently conflated with implementation of Coordinated Care Organizations, sometimes to the detriment, but also to the benefit of both. Because integration of primary care and other health-related services are foundational to CCOs, tying the PCPCH Program to other transformation initiatives has facilitated adoption of the model. However, the larger CCO initiative has also overshadowed and drawn attention away from the PCPCH Program. Balancing the urgency and scope of CCO implementation with the more focused trajectory of the PCPCH Program will be critical to the success of both initiatives. The external environment can have a significant impact on how and why certain initiatives and programs are received in particular ways. As noted previously, many of the respondents supported the PCPCH program, not necessarily because of definitive, research-based evidence, but because of their belief in the "rightness" of the model as foundational to broader health system transformation goals embodied in CCO implementation. In particular, respondents' often vague references to the perceived health care delivery benefits of the PCPCH Program were juxtaposed with very clear financial motivations for seeking certification.

> *[There was a] group who sort of led [the adoption of the PCPCH model], even before significant financial incentives became available, and then a big middle group who [participated] when the ACA dollars came up… there's no question that additional group…, if not for that financial incentive, would probably not have jumped through the hoop for becoming certified.*

> *We had some great primary care practices that were <u>really</u> interested in doing things differently, they just had their hands tied in terms of the reimbursement model. They just couldn't really make anything pencil out and you had this initiative [PCPCH] being put on the table and there was a lot of support to say, 'well, gosh if I could actually get reimbursed better for some of this, you know we're more than happy to spend time, we're more than happy to add to the staff.'*

Recognition as a PCPCH was also seen as a necessary precursor to participation in a CCO and other reform initiatives, all of which carried financial implications. While some respondents mentioned that the promise of enhanced ACA payments or external grant money served as an impetus for participation, most often motivation was tied to CCO implementation.

> *…and then we had the potential CCO legislation, which made health reform front and center for everyone. With the veiled, semi-veiled, but semi-overt message that the primary care home*

was going to be a key piece of this legislation and, wow, there might even be further investment by the CCOs into the primary care system.

Here you have larger clinics, larger systems driven by their own internal incentives - I think they have all gotten to Level 3 in order to meet the CCO criteria and primarily to get the incentive payments. So the CCO is basically one of the purchasers that is pushing this.

We were able to make [the primary care home model] part of the CCO contract and… so it allowed us to frame the CCOs as an agent of change, and as our agent to help establish, and then help spread this model.

It's embedded in the CCO contract; it's in the incentive pool - if you want to do well, you need a PCPCH.

With PCPCHs formally recognized by law as foundational to CCOs, practices may see adoption of the model as requisite for participation in the larger healthcare system. In many ways CCOs and other healthcare transformation initiatives motivated participation in the PCPCH Program; however, respondents also cited the difficulty in balancing the long term goals of the PCPCH Program with the short term needs of CCO and broader healthcare transformation.

The primary care home is perfectly nested within the CCO…it is one of the cornerstones of an effective organization. But in some ways they are really at odds with one another, because in the mandate from CCO, we have to reduce the cost quickly. So that work is going to be really centralized and that's going to be really focusing on high need and high cost… PCPCH care is: a) important, but it is looking more at long term; and, b) it is indexed for more of the medium population, sort of the middle of the bell curve. I find that PCPCH at best incompletely represents the work that we do, and at worst it detracts from the work that we are trying to do.

As more practices seek PCPCH recognition, it will become increasingly important for OHA to consider how best to balance the short-term urgency of larger health system transformation initiatives with the long-term goals of the PCPCH Program—which are widely recognized as foundational to that transformation. In addition, as CCOs gain momentum and become more established, OHA may need to clarify the locus of the PCPCH initiative with regard to the allocation of global capitation payments and other CCO decisions that could affect the viability of the PCPCH model of care. Many respondents commented on the potential imbalance of power within CCO governance structures, and suggested that OHA may need to consider how to support the interests of primary care to effectively negotiate reimbursement rates with CCOs under the global capitation mechanism.

KEY POINT: Organizational and Community-Based Leadership are Closely Linked

4. Strong leadership within OHA and the commitment of Program staff were complemented by external leadership among key community-based organizations.

The Oregon Health Authority was created through HB 2009 (2009), which also established the PCPCH program and housed it within the OHA Office of Health Policy Research (OHPR). The

development and implementation of the PCPCH Program followed shortly after the transfer of most health related functions of the Department of Human Services to the newly created OHA. Since that time, the OHA has become a much larger and more complex organization, responsible for multiple reform initiatives. Relative to those initiatives, the PCPCH Program is very small, with just three full-time staff members and, occasionally, a student intern. Transitions among OHA staff, including the PCPCH Program, as well as personnel changes within external supporting agencies and organizations, sometimes led to miscommunications and uncertainty regarding the program. Collectively, these changes led many respondents to note a degree of frustration, stating that it was difficult at times to find the locus of control for decision-making. This may have been partly due to staff turnover and transitions, the contracting out of some implementation activities, and the fact that much of the supporting infrastructure was still being developed. Despite these limitations, respondents overwhelmingly reported having positive experiences when seeking assistance from PCPCH Program staff.

They're really trying to do PCPCH…they're trying to build the plane while it's flying.

The purpose of creating the Health Authority was to break down some of the silos and the barriers and the walls between the different offices, so we would all work together to do programs across the authority. But I think this is another example where those things can be said, but the extent to which that same sentiment trickles down to the worker and the staff; it doesn't always happen.

In addition to OHPR, other offices and divisions are also involved in OHA's efforts to transition to a coordinated and integrated organization. The historical working relationships and physical proximity among key personnel helped to mitigate the challenges of implementing the PCPCH Program, particularly when critical activities crossed operational lines of authority. Strong leadership support and political exigencies, such as the emphasis placed by the Governor and legislative leader on the concept of the medical home as a foundational element of health system transformation, may have helped to overcome some of the coordination and integration barriers. Several respondents noted that OHA has been able to leverage this support in order to keep the Program moving along towards full implementation even when coordination proved challenging.

[PCPCH] was a priority and everyone in the organization knew it. That doesn't mean that everyone behaved like it was priority, but most people did… that was of value at times.

I think the Governor has really helped moved these innovations forward.

Anything that's related to transformation… that's been a facilitator because this was seen as linked, that's been the thing that [said], "No, really, we have to focus on this because it's a priority of the director and of other folks, because it's related to transformation."

Respondents were also positive in their review of leadership engagement within OHA and the state. Noting that the work of healthcare transformation is extremely complex, many were impressed by the relatively short timeline from development of standards to recognition of practices.

A lot of the leadership in the agency has been very focused on the larger health system transformation efforts, and… they're all the while continuing to say… that primary care homes are a very important component of that transformation. So the leadership has been very

good to make those high-level policy statements…, and say, "Yeah. This is [important]; we need to transform primary care.

I actually think that it's been <u>really</u> pretty amazing that the state, and Bruce Goldberg, and the Governor, and the people who work for OHA have been able to get this thing up and running so fast. You know they always talk about how government is so inefficient and takes a long time to do anything, but people worked really hard to do this and it's actually going forward. It's pretty amazing - we've done this in less than 3 years. It really speaks to the quality of the people that are working for the state.

A number of other factors also converged to create a sense of urgency, which both facilitated and challenged the implementation of the Program within very short period of time. Such factors included ongoing and highly publicized budgetary constraints, and political pressure from the Governor, community stakeholders, a large Medicaid managed care organization, and a small group of politically active and vocal primary care providers/advocates. Coupled with the larger policy narrative of the Triple Aim (and, arguably national health system reform) these factors framed inaction as an unpalatable alternative, and heightened PCPCH acceptance and support. While most respondents were reluctant to prioritize motivations for supporting the PCPCH Program, or select one from among the elements of the Triple Aim that they felt was the primary driver, many did indicate that budgetary constraints and a growing conviction that the health care system is unsustainable were huge incentives for the development and implementation of the PCPCH program.

I would say the Triple Aim is the guiding star. That is the hope for the medical home, which I think is also why it resonated so well at a time that it did.

We can't keep on the path we are on, we know it is unsustainable. It is going to break us; it is going to break our education system because healthcare sucks more and more money away from essential services. So we know we have to do something. Why would we fiddle around the edges, when we have really good evidence that that these are the elements that will make a difference?

KEY POINT: Engagement with Community Stakeholders Generated Insights and Support

5. Many individuals noted positive experiences serving on committees, task forces, and work groups, and several respondents suggested that including more participants would provide additional perspectives that could be useful for future Program improvements.

Overall respondents overwhelmingly felt that their experiences on committees, task forces, and other related development and implementation groups were extremely positive. They felt that the process was well organized, meetings were effectively facilitated, everyone was able to respectfully share their perspectives, and no one single person dominated the conversation. In addition, they appreciated the work of staff members who compiled straw proposals for consideration noting that it saved time and provided something substantial for committee work. One respondent did note the potential downside of staff work; that it filters information received by the committee, and thus potentially limits conversation, placing boundaries around the work and consequently the recommendations proposed by the committee.

On both committees, I was incredibly impressed with the level of expertise across the system. I was just astonished by how smart the people were and how committed they were to the change process… those [were] some of the most impressive public policy processes that I have ever been involved with. It helps that none of them were driven by political issues, but by clinical experts hashing out issues…There were a lot of people who were actively engaged in the discussion and brought different perspectives. I don't feel that any one person or perspective dominated.

While Oregon is renowned for community engagement, some respondents indicated that they would have liked to have seen more involvement from people with perspectives not normally "at the table". A clear and resonating theme that arose from the interviews is the small, close-knit nature of Oregon's health policy community. Many of the key players are well known to each other and have extensive historical relationships that are based on other health policy initiatives and/or programs. These pre-existing relationships were vital throughout many stages of development, including the early conceptualization and the model, passage of the legislation, and implementation of the program.

I would say most of the people on the standards committee were what I would call the usual suspects. <u>Really</u> great people who very much care about healthcare changes and who are often selected because they're very visible, either because of their professional associations or the work that they do… you can tell they'd been on other committees for Oregon Health Authority before.

While the relatively close-knit nature of the health policy community appears foundational to the structure of and support for the program, it also potentially limited broader engagement and active outreach of less involved stakeholders. Respondents referred to people serving as committee members and/or working in administrative roles with OHA, managed care organizations, and other healthcare organizations as the "usual suspects."

Sometimes there are the usual suspects that you know they know their stuff; you're familiar with them, they know you, you don't have to explain yourself. They really can provide some of that detailed feedback you're looking for if you really want to get to the heart of the matter because you don't have to start at the beginning. But at the same time, sometimes you lose maybe the broader perspective you might get because you're also going to that group of usual suspects.

When discussing the needs of a broad range of Oregonians, respondents who were relatively more sensitive to behavioral health, rural, and patient advocacy perspectives felt that the "voice" of these constituencies in health policy conversations was very limited. Although Oregon is known for substantial stakeholder engagement, respondents suggested that in reality there is a relatively small cadre of clinical providers who are actively engaged in health policy. Several key informants noted the need to reach out to a broader range of perspectives, including those of other disciplines, as well as providers who were less proactively engaged in health policy activities.

If you were doing it again, I'd think you'd want to try to recruit… more balance on the committee… It would have been nice to have more people who have [an alternative] perspective.

The roster of the group… there's one, two people from Eugene and one from Coos Bay. The good news is that everybody else could get there in just a few minutes. One from Lincoln City, everybody else, in Portland, Portland, Portland, Portland, Portland…so what a shock that you're going to have this urban… tilt.

The question of engagement – who, how, and to what end – was generally associated with development of the initial standards, as well as their subsequent revision. Several respondents voiced concerns about the content, rigor, consistency with other criteria, and the timing of implementation for the new standards, and related these concerns to who was, or was not, 'at the table' and how their participation in the process influenced the content and rigor of the standards. It is important that OHA consider how best to engage less involved stakeholders to ensure that diverse perspectives are included during development and implementation.

KEY POINT: Communication is, and will be Critical for Integration and Sustainability.

6. Communication with community stakeholders was critical to the successful development and implementation of the PCPCH Program, and will be equally important for ensuring its sustainability and alignment with other transformation initiatives.

One of the challenges of a short timeline is ensuring that stakeholders are kept informed about program development and implementation activities. According to the respondents, information about the PCPCH program came from a variety of sources, some of it official such as OHA's website or emails, and others less official, such as opinion leaders knowledgeable about the program, professional associations, and other healthcare organizations. While most felt that their access to information was adequate, they acknowledged that this was likely because they were active participants and had "insider" knowledge about PCPCH Program developments. Several respondents related the difficulty they had finding Program-related information, and the need to actively search the Program website or call Program staff or other sources.

I think communication could be better…. Communicate with the clinics and even if the answer is letting people know they are figuring it out; that answer is better than not saying anything.

There are other practices that aren't [following PCPCH criteria] because they just try to get through the day. I guess you would… want to target those practices and do outreach and recruiting - provide them with that information.

Several respondents mentioned that information about the PCPCH Program could be more effectively communicated to the larger community as a means of engaging more stakeholders, maintaining support, and enhancing participation. Some felt that the "pull" method of information dissemination, requiring providers and other stakeholders to seek out the information on the OHA website, was not the best means to communicate. They suggested that OHA should consider other communication methods to actively "push" information out into the community to ensure that relevant stakeholders are aware of the Program, understand the guidelines and metrics, and are actively informed when modifications are proposed and implemented.

The communication was shoddy…I happened to find out about it [PCPCH] in a newsletter that somebody forwarded to me. Somebody forwarded this from the state. When I asked, they were saying 'you should've gone to our website to sign up…' Why is this a push strategy, not a pull strategy? Why is it on me because I didn't sign up at your website?

In addition to suggestions for improving communication processes and targets, some respondents suggested that the content of communications be expanded and shared stories of colleagues who, despite working within a clinical site that had been recognized as a PCPCH, did not have a clear understanding of what it meant to be a PCPCH with regard to care redesign and integration, standards and metrics, or overall goals.

When asked about technical assistance efforts for PCPCH, responses were varied. Some focused on the work of their own organization and less on the efforts of OHA or the Patient Centered Primary Care Institute (PCPCI). In general, awareness of TA resources was limited, and respondents who knew of, or had accessed such assistance were unclear about the source of it, or cited community-based organizations as the source. However, most respondents either did not mention, or were not well-informed about technical assistance support.

In general we don't get information directly from OHA, but OPCA is part of the training institute, so maybe that is where the model is going with Quality Corp, they are choosing the local regional TA providers because they already have a relationship with us, but there is still not a clear message or clear plan.

The respondents' lack of clarity may simply reflect that fact that they are closer to the activities that occur within their own organizations. Another explanation is that the Patient Centered Primary Care Institute (PCPCI) was relatively new and just starting to get some traction at the time of the interviews. [9] Because assessment of TA needs was ongoing and specific TA initiatives were in the early stages of development and implementation, it is likely that some stakeholders were unaware of these resources. Among those who were aware of the PCPCI, it may have been difficult for people to assess the quality and usefulness of the nascent TA efforts.

In addition to the confusion about what it was that the PCPCI was doing in terms of technical assistance, several respondents expressed frustration with what they saw as fragmentation in the way that technical assistance was being provided.

We had a big problem with how the [TA] money was [spent]. There were people who sat on that committee that helped create the idea and instead [the OHA started] a new TA [program] instead of enhancing the TA that already assisted the state. I think that created a waste - $1.3 million to create a whole new structure…

Among those who commented on the quality of OHA's technical assistance, most complimented the efforts of the OHPR staff who provided consultation and information via phone and email. In particular, several noted that being able to reach a person and receive assistance was extremely helpful when seeking clarification on the certification process and the standards. Ongoing and expanded

[9] The Patient Centered Primary Care Institute is a public-private partnership involving OHA, Quality Corp, and Northwest Health Foundation that was created to provide technical assistance in the form of practice transformation knowledge and resources. The PCPCI contract was awarded to Quality Corp relatively shortly before the KI interviews were conducted.

community outreach may help alleviate confusion about the role of Quality Corp and the technical assistance resources available through the PCPCI.

Payment mechanisms constituted a second theme with regard to the content of communication about the PCPCH Program. A number of respondents expressed frustration and concern about the mechanism for receiving enhanced payments based on their certification and tier level. Respondents noted challenges with delayed payments and additional reporting requirements for ACA payments, as well as concerns about the sustainability of the program without significant payment reform. Many respondents stated that OHA will need to engage other payers in order to properly incentivize practices to remain engaged with the program. Several pointed out that while the ACA payments provided an initial incentive, relying on Medicaid was not a viable long term plan since the PCPCH activities were conducted for all of patients, not just those enrolled in Medicaid.

KEY POINT: Sustainability Will Depend on Active, Ongoing Strategic Management

7. The range of concerns expressed by interviewees suggests the need for ongoing strategic planning to ensure the sustainability of the PCPCH Program and model of care.

The range of concerns expressed by interviewees also speaks to a larger issue of strategic planning to ensure the sustainability of the PCPCH model of care, particularly within a CCO system of health service delivery. Respondents commented on what they perceived to be an overall lack of long term planning by OHA. However, a review of the PCPCH relevant documents and conversations with key informants does suggest that OHA is aware of many of the concerns raised by respondents. It could be that respondents are not aware of OHA's strategic plans because of communication problems that could be addressed by proactively pushing information out into the community. Such communication might also address respondents' perceptions about what they see as policy analysis and development, versus program implementation and oversight.

Of note, several respondents suggested that while OHPR has very talented and knowledgeable policy planners, and the PCPCH Program staff have been exceptional, additional support and the depth of operational resources might be enhanced by aligning the Program more closely with other programs whose primary functions are more operationally oriented.

I think part of the challenge we have is that they have policy people trying to implement [a complex program] and that is a different skill set. I don't think operational people can do clinical, and I don't think policy people can do operational or clinical... all inform each other, but you need all of those perspectives.

OHA is a policy making genius… they are very good at policy development, but not as strong on the implementation side.

I think the policy discussion… they have fabulous knowledge and expertise, including the staff. On the ground it is just different. Different skill set, different DNA, people with different knowledge.

Building on the notion of differences between policy planning skills and implementation and operational skills, respondents' may have perceived challenges stemming from internal communications and limited decision-making support resources, or from a more general need for strategic planning around the PCPCH Program.

Conclusion

The PCPCH program gained momentum rather quickly due to a number of factors including the shared experience of site visits to the Alaska Native Medical Center by a small group of influential stakeholders, the perceived "rightness" of the model, strong leadership support, and dedicated staff. Respondents expressed concerns about a range of issues from the cost and administrative burden on practices, rural disadvantage, payment mechanisms, and communication. In particular, there were concerns about the future of program and clinic participation due to implementation of more rigorous standards at the same time that ACA payments were ending and many were still uncertain whether practices would receive appropriate or any enhanced compensation through CCOs. To the degree that these issues could negatively impact ongoing participation in the program, respondents were especially concerned given that they strongly supported the model and believed that it was the "right way" to provide care.

The insights gleaned from this evaluation suggest that two factors may be particularly relevant to Program support and sustainability. First, because many individual and organizational stakeholders must consider both short-term operational planning as they implement clinical aspects of the PCPCH model, and long-term strategic planning as they grapple with the challenges of integration and care coordination, processes to ensure ongoing engagement with broader health system transformation initiatives, such as CCO implementation, should be actively addressed. Second, a comprehensive, systematic, and robust strategy for communication regarding technical assistance resources and support, as well as financial reimbursement strategies to support the PCPCH model of care under CCO's global capitation allocation, will be important for assuring sustainability and, ultimately, health system transformation.

Appendix A
CFIR: Evaluation Framework Domains
Appendix B

CFIR *sub-construct	**Explanation** Adapted from Damschroder et al (2009)
INTERVENTION	
Source	Perception of whether the PCPCH program was externally or internally developed
Evidence	Perception of the quality of evidence suggesting the PCPCH program will have intended outcomes
Relative advantage	Perception of the relative advantage of implementing the PCPCH program versus alternatives
Adaptability	Refers to the degree to which intervention is perceived as adaptable to local needs
Trialability	Ability to test the PCPCH program on a small scale & to reverse course if needed
Complexity	Perceived difficulty of implementing the PCPCH program
Design quality & packaging	Perception of how the PCPCH program is put together & "marketed" to users
Costs	Costs of the PCPCH program & costs associated with implementing the PCPCH program
EXTERNAL SETTING	
Patient needs & resources	Extent to which needs, as well as barriers and facilitators to meet those needs are known & prioritized
Network	Degree to which an organization is externally networked with other external organizations
Peer pressure	Competitive pressure to implement the PCPCH program
Incentives	Incentives to encourage implementation of the PCPCH program
INTERNAL SETTING	
Organizational structure	The size, age, maturity, degree of differentiation of an organization
Decision-making	How decisions are made in the organization
Network	The nature & quality of social networks
Culture	Norms, values, basic assumptions
Implementation climate	
*Tension for change	Degree to which a current situation needs change
*Compatibility	The degree of tangible fit between meanings & values key stakeholders attach to the PCPCH program
*Relative priority	Shared perception of the importance of implementing the PCPCH program
*Organizational incentives	Extrinsic incentives to encourage buy-in from staff
*Goals & feedback	Degree to which goals are clearly communicated, acted upon, & staff are provided feedback
*Learning climate	Climate in which leaders express fallibility & encourage feedback from team, team members feel they are essential, valued, & knowledgeable partners, time for reflective thinking & evaluation, ease of access to information about the PCPCH program & how to incorporate into work tasks
Leadership engagement	Commitment, involvement, & accountability of leaders & managers with the implementation
Available resources	The level of resources dedicated for implementation & ongoing operations
CHARACTERISTICS OF INDIVIDUALS	
Knowledge & beliefs about the PCPCH program	Individual attitudes toward & value placed on the PCPCH program as well as familiarity with facts, truths, & principles related to PCPCH
Self-efficacy	Individual belief in their own capabilities to execute the core components of the PCPCH implementation
Maturity in role	Particular stage an individual is in as he/she moves toward skilled, enthusiastic, & sustained implementation of PCPCH
Individual identification with organization	Individual perception of organization & his/her relationship & degree of commitment with that organization
PROCESS	
Structural planning	Degree to which schemes for implementing the PCPCH were developed in advance & the quality of those schemes
Technical systems planning	Degree to which operating systems for implementing the PCPCH was developed in advance
Engagement	Attracting & involving appropriate individuals in the implementation & use of the PCPCH program
Influence	Individuals with formal or informal influence on the attitudes & beliefs of others
Feedback	Formal & informal feedback, evaluations, public forums, staff surveys

PCPCH Development and Implementation Timeline Milestones

2007 – Trip to SouthCentral Foundation (Anchorage, AK)

2009

- HB 2009 passes, creates OHA as well as the PCPCH program to be housed within OHPR
- Nov 2009 – Jan 2010 – First PCPCH Standards Advisory Committee convenes
- Feb 2010 – PCPCH Standards Advisory Committee "final" report is released, OHRP is awarded CHIP-RA Grant

2010

- Aug 2010 – Pediatrics PCPCH Standards Advisory Committee convenes
- Nov 2010 –Final Version of PCPCH Standards Advisory Committee with pediatrics section report released
- Dec 2010 – Jun 2011 – OHPR seeks stakeholder input on standards (payers, providers, etc…)

2011

- HB 3650 passes, with PCPCH as foundational to CCOs
- Oct 2011 – PCPCH practice self-assessment tool released, OHPR begins accepting PCPCH applications
- Dec 2011 – PCPCH implementation task force report released

2012

- Jan 2012 – More than 80 clinics submit a PCPCH application
- Mar 2012 – Additional Medicaid funds available to clinics that receive PCPCH certification, OAR for PCPCH is released, SB 1580 passes approving OHA's proposals for CCOs
- Aug 2012 – More than 200 clinics are recognized as PCPCHs
- Aug 2012 – Oct 2012 – Second PCPCH Standards Advisory Committee convenes
- Oct 2012 – Second PCPCH Standards Advisory Committee report is released

2013

- May 2013 – 385 clinics are recognized as PCPCHs