PATIENT-CENTERED PRIMARY CARE HOME (PCPCH)
Report on the Results of the 2012-2013 Supplemental Surveys, August 2013

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This report describes the results of the two administrations of the supplemental survey of the initial group of primary care practices recognized in 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, which has been contracted to Portland State University.

Background
The Patient-Centered Primary Care Home (PCPCH) Program is an initiative established in 2009 by the Oregon Legislature. The PCPCH model of care has figured prominently in Oregon legislation that is designed to achieve the "Triple Aim" of better population health, better individual care, and lower system costs. The PCPCH legislation placed much of the responsibility for achieving these goals within the Office for Oregon Health Policy and Research (OHPR) within the Oregon Health Authority (OHA). OPHR contracted with Portland State University (PSU) for a three-part evaluation of the implementation of PCPCH.

The OHA, which houses the PCPCH Program, administers the application, recognition, and verification process for primary care practices applying to become Patient-Centered Primary Care Homes. Practices apply for recognition as a PCPCH through a structured process. These practices adopt a patient-centered model of care, where teams of health professionals work together to form the "primary care home" for patients. They coordinate services to meet patients' needs with attention to primary care, behavioral health, prevention, and management of chronic conditions.

Evaluation at the Practice Level
This report describes the evaluation of the implementation of the PCPCH Program, based upon a survey of the first 205 recognized practices (as of August 2012) and then a follow-up survey of the 368 practices recognized as of May 2013. The survey design is based upon the six core attributes of a primary care home adopted by the OHA, which are also the basis of the recognition application. This report presents the results of both the baseline evaluation and the follow-up survey approximately one year later.

The purpose of this evaluation is to gather input on the six attributes through an anonymous online survey completed by the identified practice site contact (or their designate) of each recognized PCPCH. All information is organizational and related to operating procedures; no individual patient or staff specific data were requested.

Survey Development
The survey was developed by an advisory group, consisting of members of the PSU Evaluation Team and the OHA PCPCH leadership group (approximately ten people in total). The group worked through multiple iterations, reviewing the current application for PCPCH recognition against the six core attributes and responding to OHA's insights into areas that needed to be enhanced (based upon an OHA literature review and its current work on developing the next version of the PCPCH recognition standards). This process identified topics for additional questions. The evaluation team then developed these questions, and the advisory group reviewed them and made suggestions for revisions. The PSU evaluation team also drew heavily upon its work with the OPCA and the survey that this team had conducted for OPCA annually for the past three years that assessed the integration of a "medical home" or comparable concept.

Once the survey content was agreed upon, an introductory cover memo was developed and approved by PCPCH leadership, and an application to the PSU Human Subjects Research Review Committee (HSRRC) was prepared and submitted in September 2012 by the survey evaluation team. Approval indicating exemption from further human subjects review was received on September 28, 2012 (PSU HSRRC #122326) and the team moved forward with the next steps of survey administration.

At this point the survey was set up in Qualtrics (the online survey software used by PSU), and the advisory group was invited to pretest the survey for both content and flow. The emphasis of the pretest was to verify layout, clarity, and accuracy, and note issues with survey navigation (forced responses, skip patterns, etc.). Constructive feedback was offered and final revisions to the survey were made.

To prepare for the second administration of the survey, the PSU evaluation team met with OHA staff to refine the survey format. Most of the edits addressed clarity of questions, shortened the survey where possible and removed questions that were of lesser interest to OHA by the time of the second survey. Two additional questions were added by OHA to further assess issues of PCPCH implementation. Since the survey edits were primarily deletions and not additions of content, no additional human subjects review was required prior to survey administration.

Survey Population
The initial survey population was defined as those practices recognized as a PCPCH as of August 8th, 2012. At that time there were 208 recognized PCPCHs; three of these were designated as Tier 1 and OHA staff recommended that they not be included in the survey. Thus there were 205 potential participants in the survey. At the time of the second administration of the survey, there were 368 recognized practices. As this larger survey population included a greater number of practices recognized as Tier 1, OHA and the PSU evaluation team decided to include all practices regardless of recognition tier in the second round of analysis.

For the first survey, a master data file of identifying information (in Excel format) was provided to the PSU evaluation team by OHA. The evaluation team and OHA staff devoted considerable effort to "clean up" this file and ensure the integrity and accuracy of the data for the first survey administration, as well as the currency of practice contacts and their contact information. The OHA data file for the second survey administration was more accurate, so less work was required to clarify practice information in order to prepare for the survey administration.

OHA staff requested that all individual practices be surveyed, and that the evaluation be designed in order to minimize the survey burden on those individuals who were responsible for multiple sites. A process was established whereby each individual listed as the practice site contact for multiple sites was contacted by email in advance of the survey by the evaluation team leader, and asked if they could respond to the survey once for all practices (if the practices had similar processes in place) or if each practice was sufficiently different to merit individual responses. OHA staff (the PCPCH program office) was copied on each of these communications, and in some cases, the practices had additional questions that were directed to the PCPCH office. For the first survey the 205 recognized practices were categorized into "unique" respondents (N=82) and "duplicate" respondents (17 individuals representing 123 practices). In two cases, these "duplicate" respondents requested that they receive more than one survey, with each response representing a logical grouping of practices within a large organization. For the second survey, the population consisted of 368 practices; 128 of these were "unique" and 241 were "duplicates" that were contacted via 43 organizational contacts. Three "duplicate" respondents requested that they receive more than one survey, with each response representing a logical grouping of practices within a large organization.

Survey Administration
The web-based survey was originally administered to all 205 recognized Tier 2 and Tier 3 PCPCHs in October 2012. The survey was re-administered in June 2013 to all 368 recognized Tier 1, 2 and 3 practices. This timing reflects OHA's implementation of the PCPCH Program, as well as the funding of the contract under which this work is conducted (funding ends in August 2013 and all reporting must be completed by then).

The survey was administered from Portland State, using an OHA identified email so that the contact was recognizable to most of the survey recipients (the PCPCH program director, Nicole Merrithew, at nicole.merrithew@state.or.us). As described above, the survey population was divided into two groups: those who were responsible for a single site ("unique" respondents) and those individuals who were responsible for multiple sites ("duplicate" respondents). The "duplicate" respondents received a survey in which the language was identical to the "unique" respondents except for three questions asking descriptive information about size and clinic volume. The duplicate respondents were asked to complete the survey once, and then respond to a personalized email to provide the details of the three size-related questions for each of their practices (number of FTE primary providers, number of FTE other clinical staff, and number of total visits for past year); the evaluation team then duplicated the master responses for those groups of practices and entered these data into the master file, duplicating the responses for the rest of the questions for each of the relevant practices.

Respondents were initially given a three-week response time. At two weeks a reminder was sent; at three weeks it was determined that there were more potential respondents, so the survey response period was extended. Targeted follow-up with particular attention to the duplicate respondents was conducted, which garnered some additional responses.

Categorizations of urban/rural location were developed in conjunction with the PSU Population Center and the Oregon Office of Rural Health. Based upon population size, all PCPCH practices were categorized based upon zip codes as located in geographic regions that are urban large (urbanized areas greater than 200,000), urban medium (urbanized areas of 100,000 to 200,000), urban small (urbanized areas of 40,000 to 100,000), and rural (communities 10 or more miles

from a population center of at least 40,000). None of the recognized practices exist in frontier regions (counties with less than 6 people per square mile). This categorization was compared with population density as a basis for categorization, and little difference was found. As a result there are some regions that are adjacent to a large metropolitan area but may be categorized as urban medium or small because of location outside of defined urban boundaries. It was not feasible to do further analysis of socioeconomic or other demographic data that might lead to insights regarding access to, and utilization of, services. For the purposes of this report, this categorization by geography should suffice.

Descriptive Findings
The re-administration of the PCPCH supplemental survey was sent to the 368 practices that were recognized as PCPCHs as of May 1st, 2013. Of these 368 practices, 252 practices responded to the survey for a response rate of 68.5%. The initial PCPCH supplemental survey was distributed to the 205 practices that were recognized as PCPCHs as of August 8th, 2012. Of these 205 practices, 181 practices responded to the survey for a response rate of 88%. This report is based upon an analysis of these data, complemented by additional descriptive information. Some of the "duplicate" respondents answered the survey, but did not provide the additional information on size and volume for each of that organization's sites; other "duplicate" respondents were not able to get complete responses from all of their organization's sites; thus there are some gaps in the size and volume data.

The second survey population of 368 practices were categorized by OHA as 2.7% Tier 1 (N=10), 34% Tier 2 (N=125), and 63.3% Tier 3 (N=233). Twenty-one percent of the second set of respondents were categorized as Tier 2 (N=53), and 78% were Tier 3 (N=197). Two Tier 1 practices (0.8%) responded and are included in the reporting of the second survey. The second survey respondents are more representative of the Tier 3 group than the overall population, and less representative of both Tiers 1 and 2. The initial survey population of 205 practices consisted of 64 Tier 2 (31%), and 141 Tier 3 (69%). Thirty-two percent of the initial respondents were in Tier 2 (N=58), and 68% were in Tier 3 (N=123).

The overall distribution of the practices by geographic region suggests differences in extent of service available in large/medium/small urban and rural settings. Tables 1 and 2 show the distribution of the overall PCPCH population as well as the responses to this survey. The geographic distribution of respondents on both surveys is comparable to the geographic distribution of all practices.

Table 1. Geographic Distribution of PCPCH Practices in Survey 1

Geographic Category	PCPCH Population (N)	PCPCH Population (%)	Survey Response (N)	Survey Response (%)
Urban Large	54	26.3 %	52	28.7 %
Urban Medium	36	17.6 %	33	18.2 %
Urban Small	62	30.2 %	55	30.4 %
Rural	53	25.9 %	41	22.7 %
Total	205	100 %	181	100%

Table 2. Geographic Distribution of PCPCH Practices in Survey 2

Geographic Category	PCPCH Population (N)	PCPCH Population (%)	Survey Response (N)	Survey Response (%)
Urban Large	82	22.3 %	53	21.0 %
Urban Medium	61	16.6 %	46	18.3 %
Urban Small	96	26.1 %	66	26.2 %
Rural	131	35.6 %	87	34.5 %
Total	368	100 %	252	100 %

The size of the practices varied. Respondents were categorized into four categories by number of full-time equivalent (FTE) primary providers (MD, DO, ND, NP, or PA): 0-2, 3-5, 6-9 and 10 or more. As can be seen in Table 3 below, the average number of primary providers in survey 2 was slightly less (5.1) than in survey 1 (6.6). In the second survey, practices indicated they had one to 39 FTE providers, while in the first survey the number of FTE providers ranged from one to 35. Size as measured by number of other full-time equivalent (FTE) clinical staff ranged from zero to 70. The average number of other FTE clinical staff among the respondents was 11.94 in the first survey, and 9.4 in the second survey.

Table 3. Distribution of Primary Providers

Category	Survey 1 Response (N)	Survey 1 Response (%)	Survey 2 Response (N)	Survey 2 Response (%)
0-2	39	22.0 %	66	27.4 %
3-5	47	26.6 %	92	38.2 %
6-9	46	26.0 %	47	19.5 %
10 or more	45	25.4 %	36	14.9 %
Average	6.6		5.1	
Total	177	100 %	241	100 %

Practices were asked to estimate their total number of visits in the past year. Responses were categorized into five ranges of total annual visits: less than 5,000, 5,000-9,000, 10,000-19,999, 20,000-39,999, and more than 40,000. Of the 240 practices in the second survey that reported their total visits, 29.8% (N=75) practices saw ≤5, 000 patients, 13.1% (N=33) saw between 5,000 and 9,999, 28.6 (N=72) saw 10,000 to 19,999, 15.5% (N=39) saw 20,000 to 39,999, and 8.3% (N=21) saw ≥40, 000 patients or more. The average number of annual visits in the second survey was 14,539 with responses ranging from 229 to 134,000. In the initial survey responses ranged from approximately 200 to over 125,000, and the average number of annual visits was approximately 19,000. This change may be a reflection of the practices that responded to the second survey, and may or may not reflect the overall population of recognized PCPCH practices.

Of the practices responding, the overwhelming majority of sites serve adult and pediatric populations (71.0%, N=179 in the second survey, and 75.7%, N=181 in the first survey). Fewer respondents (17.9% in the second survey and16.6% in the first survey) serve only pediatric populations and the least number of respondents (11.1% in the second survey and 7.7% in the first survey) serve only adults. In the second survey, the majority of respondents (75.4%, N=190) provide obstetrics care, as compared to almost half (45.9%) of the initial survey respondents.

Two additional questions were added to the second survey to further describe the survey population. Of the second survey respondents, only 17.9% (N=25) provide complementary and alternative medicine (CAM) such as naturopathic care, acupuncture, massage, etc. Practices described their organization structure in terms of practice ownership and independence. Forty percent of the respondents (N=102) self-identified as independent and unaffiliated with any other practice, 12.3% (N=31) as independent governance but part of an alliance for shared group purchasing/other economies of scale (such as an IPA), and 47.2% (N=119) as owned by a larger system that governs the practice and determines operations, finance, etc.

When the data are analyzed by organizational structure, distribution by size varies within each governance structure presenting no clear patterns. More rural practices are more likely to be independent/unaffiliated and independent/allied practices; however among the respondents that are owned by a larger system, the distribution of urban and rural practices is fairly equal. Of the 214 practices responding that PCPCH implementation helped their practice make progress toward improving the individual experience of care, the distribution by organizational structure was very similar at about 80-85% (the N varies) from each group reporting positive response.

Ninety seven percent (N=99) of the 102 independent/unaffiliated practices responded that PCPCH implementation helped them to improve population health management. This is compared to a response of 75.6% (N=90) from the 119 larger system practices and 58.1% (N=18) among the 31 allied practices. For practices that felt PCPCH is helping them decrease the cost of care, response by organizational structure is fairly equally distributed. Approximately 70-80% of respondents from each organizational structure believe that the PCPCH model is helping their practice to increase quality of care. Forty to fifty five percent (N varies) from each organizational structure group indicated that PCPCH is helping them to lower costs. Among practices that believe that the PCPCH model is helping their practice increase access, a positive response is highest among independent/unaffiliated (80.4%, N=82) and larger system practices (74.8%, N=89) as compared to the 58.1% (N=18) of independent/allied practices.

No clear associations were seen between organizational structure and use of services for patients with limited English proficiency.

In analyzing whether organizational structure is related to the most important factors that influenced a practice's decision to become a PCPCH the following results were found. Sixty-four percent (N=74) of large system practices ranked 'eligibility for enhanced payment' as the most important factor influencing their decision, compared to 54.8% (N=17) of independent/ allied and 22.5% (N=23) of independent/unaffiliated practices. Sixty-nine percent (N=71) of independent/unaffiliated practices ranked 'opportunity to improve patient care' as the most important factor influencing their decision, compared to 38.7% (N=12) of independent allied and 37% (N=44) of large system practices. No clear associations were found when 'ability to improve marketability to patients' and 'encouragement from CCOs and/or other payers' were analyzed by organizational structure.

Findings for Each Core Attribute
The following discussion is organized by the six core attributes within the PCPCH model. Within each attribute, the discussion focuses on additional data collected on the measures of that attribute. Where no additional data were collected on an attribute in the supplemental survey, a notation is indicated.

Further analyses were then conducted on these results to determine if any clear associations could be observed among categorizations such as geography, practice size (as measured by FTE providers), organizational structure, and other questions including participation in collaboratives, barriers to implementation, and new services implemented. Urban practices tend to be larger and rural tend to be smaller. There is no clear differentiation in practice styles among the three urban categories. Practices categorized as Tier 2 tend to be smaller and Tier 3 tend to be larger.

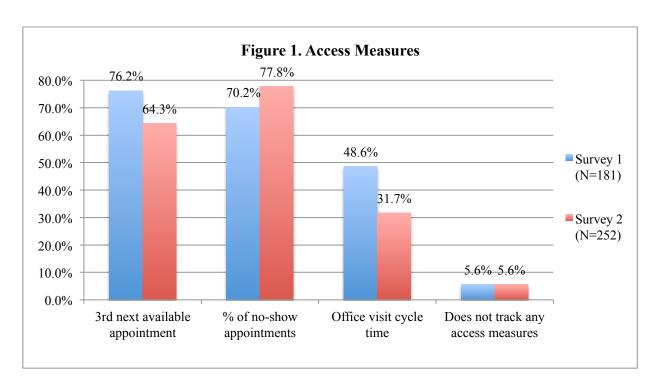**Core Attribute #1: Access to Care**
<u>In-Person Access</u>
In the second survey, 34.1% (N=86) of practices administer a patient satisfaction survey once or twice per year. The majority of respondents (60.3%, N=152) survey patients on some other, unspecified time frame, while only 5.6% (N=14) of respondents do not administer a patient satisfaction survey. In the first survey, almost half of the 181 respondents (44.8%, N=65) administer a patient satisfaction survey once per year. The least number of respondents (11.6%, N=21) conduct a survey twice per year. The remaining respondents (52.5%, N=79) survey patients through quarterly (50.6%, N=40), continuous (31.6%, N=25), or monthly (17.7%, N=14) assessments. Table 4 displays the ways in which practices make use of patient satisfaction data (respondents could indicate multiple responses). Only fourteen respondents (5.6%) in the second survey and four respondents (2.2%) in the first survey indicated they do not use the data at present. While in the first survey patient experience data was most commonly reviewed by all providers/staff and used to improve services, in the second survey managers were the most likely users of patient experience data.

Table 4. Patient Satisfaction Data

	Survey 1 (N=181)		Survey 2 (N=252)	
Use of data	**N**	**Percent**	**N**	**Percent**
Patient experience data are routinely reviewed by providers/staff and used to improve services	158	87.3%	156	61.9%
Patient experience data are routinely reviewed by managers and used to improve services	153	84.5%	203	80.6%
Data are reported to stakeholders (board, patients, staff)	112	61.9%	146	57.9%

Figure 1 below displays the access measures that practices track. In both the first and second surveys, the majority of respondents were most often tracking third next available appointment and percent of no-show appointments. In the second survey, the percent of practices tracking office visit cycle time decreased by a small percent.
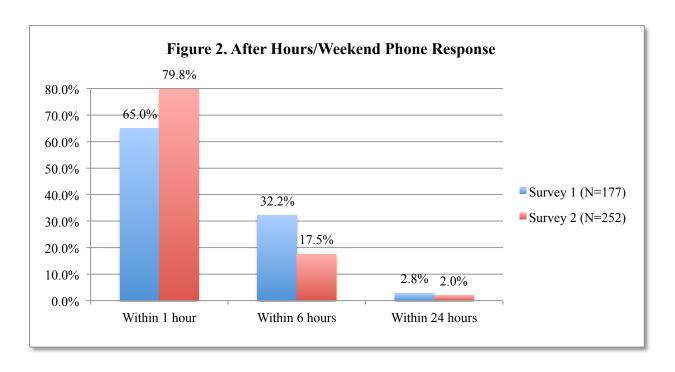
Figure 1. Access Measures

After Hours Access

Practices were asked how they determine what kinds of visits and services their patients prefer, specifically with regard to after hours or "nontraditional" visits. In both the first and second surveys, the greatest number of respondents relied on staff/provider judgments (88.5%, N=223 in the second survey, and 73.5%, N=133 in the first survey) and use informal input via individual patient comments (66.7%, N=168 in the second survey, and 64.1%, N=116 in the first survey). Some practices utilize informal input via a patient advisory council (23.4%, N= 59 in the second survey, and 32.6%, N=59 in the first survey) and conduct formal surveys of patients (45.2%, N=114 in the second survey, and 44.8%, N=81 in the first survey).

Telephone and Electronic Access

After hours or on weekends, almost all respondents (99.2%, N=250 in the second survey, and 97.8%, N=177 in the first survey) provide urgent phone response from a clinical provider within a specified time. Figure 2 below displays the time period in which these respondents ideally respond. In the second survey, practices overwhelming respond within 1 hour.

Figure 2. After Hours/Weekend Phone Response

Practices were asked who usually talks to their patients when patients seek telephone advice. Approximately two thirds of respondents (67.9%, N=171 in the second survey and 68.5%, N=124 in the first survey) reported that nurses answer patient calls. Other responses include medical assistant (28.2%, N=71 in the second survey, and 21%, N=38 in the first survey) and physician (2.0%, N=5 in the second survey, and 9.4%, N=17 in the first survey). The remaining respondents (2.0%, N=5 in the second survey, and 1.1%, N=2 in the first survey) have panel managers, NPs or some other provider who fills this role. The greatest number of respondents (70.2%, N= 177 in the second survey, and 59.1%, N=107 in the first survey) indicated contact is *usually* by a member of the patient's own care team. For some respondents this contact is *always* by a member of the patient's care team (29.0%, N= 73 in the second survey, and 23.8%, N=43 in the first survey). In the second survey, only 0.8% (N=2) responded that the first phone contact is *rarely* or *never* a member of the patient's care team, whereas in the first survey twelve percent responded *rarely* and five percent responded that the first phone contact is *not* usually a member of the patient's care team. Most respondents (61.5%, N=155 in the second survey and 72.4%, N=131 in the first survey) provide patients/families with access to an interactive website.

When the data were analyzed by size in the first survey, no clear associations were evident. In the second survey, of the 71 practices that responded that phone contact was 'always' made with a member of the patient's care team, 43.7% (N=31) are small practices of 0-2 providers. Of the 168 practices that responded that phone contact is 'usually' made with a member of the patient's care team, 43.5% (N=73) are practices of 3-5 providers. This shows that, in relation to size and telephone access, the smaller the practice the more likely it is that a patient will be able to have contact by telephone with a member of his/her care team. In both the first and second surveys, no clear associations were evident when these data are analyzed by geography.

Core Attribute #2: Accountability
Performance and Clinical Quality Improvement
The majority of respondents have a quality improvement team or committee (90.1%, N=227 in

the second survey, and 96.1%, N=174 in the first survey), and are currently participating in one or more formal quality improvement collaboratives (51.2%, N=129 in the second survey, and 69.6%, N=126 in the first survey). Table 5, below, lists the well-defined, formal quality improvement collaboratives in which respondents have participated (percentages are based upon all those who participated in collaboratives, not all those responding). In both surveys, practices had most often participated in the following collaboratives: Care Oregon PC3 and PCR, CPCI, and High Value Medical Home and HVPCC.

Table 5. Quality Improvement Collaboratives

	Survey 1 (N=126)		Survey 2 (N=129)	
Quality Improvement Collaborative	**N**	**Percent**	**N**	**Percent**
Care Oregon PC3 (Patient and Population Centered Primary Care) and PCR (Primary Care Renewal)	44	34.9%	50	38.8%
CPCI (Comprehensive Primary Care Initiative)	36	28.6%	38	29.5%
High Value Medical Home and HVPCC (High Value Patient Centered Care)	59	46.8%	35	27.1%
SNMHI (Safety Net Medical Home Initiative)	12	11.4%	14	10.9%
ECHO (Enhancing Child Health in Oregon)	6	4.8%	5	3.9%

In the first survey an analysis of the distribution of collaborative participation across geographic areas showed that around 65-70% (the number varies) of the "Urban Large" and "Urban Medium" practices participated in collaboratives. "Rural" practices were less likely to have participated in collaboratives, but over half (53.7%, N=22) had participated. Participation in a collaborative in the first survey was highest among the "Urban" respondents (83.6%, N=46). In the second survey, participation in collaboratives was fairly equally distributed across geographic categories. A more detailed analysis by collaborative grouping would be necessary to understand the relationship between geography and criteria for collaborative participation, as these responses reveal no clear pattern, but may not offer any additional explanation on PCPCH implementation.

When the data are analyzed by size of practice (number of primary providers), in the first survey collaborative participation increased as the number of FTE primary providers increased. The 45 respondents with 10 or more FTE primary providers were most positively associated with collaborative participation (88.9%, N=40). In the larger sample size of the second survey this pattern did not repeat itself. In the second survey, participation in collaboratives is fairly equal among medium sized practices and varies for very small versus very large practices. Sixty to sixty five percent of medium sized practices with 3-9 providers (the number varies) participated in one or more collaboratives. Almost 53% (N=19) of large practices with ten or more providers participated in collaboratives, compared to only 30.3% (N=20) of very small practices with zero to two providers. Of the 123 Tier 3 practices surveyed in the first round, 74.8% (N=92) participated in collaboratives. Of 58 Tier 2 respondents, 58.6% (N=34) participated in collaboratives. Although this may have suggested initially that larger and more sophisticated practices are more likely to participate in collaborative, upon re-administration of the survey no clear association was found between tier of recognition and collaborative participation. Of the 197 Tier 3 practices surveyed in the second round, 53.3% (N=105) participated in collaboratives. Of 53 Tier 2 respondents, 43.4% (N=23) participated in collaboratives.

To gather more information about the use of improvement methods in routine clinic operations, practices were asked a series of questions about the extent to which they engage in systematic practice improvement. The greatest number of respondents use clinical quality data to systematically improve practices (96.0%, N=242 in the second survey, and 90.6%, N=164 in the first survey), and a structured method for practice improvement in their organizations (80.2%, N=202 in the second survey, and 87.8%, N=159 in the first survey). Almost all respondents in both surveys (97.6%, N=246 in the second survey, and 97.8%, N=177 in the first survey) give their providers feedback in regards to clinical quality measures.

Respondents were asked the ways in which they share individual/team performance data. Table 6, below, displays their responses. The results about sharing of individual/team performance data are comparable across respondents from both surveys and across categories.

Table 6. Sharing of Individual/Team Performance Data

	Survey 1 (N=181)		Survey 2 (N=252)	
Data are Shared	**N**	**Percent**	**N**	**Percent**
All providers can see performance data	139	76.8%	200	79.4%
All staff can see performance data	119	65.8%	152	60.3%
Only with the specific provider	85	47.0%	99	39.3%
Patients can see performance data	26	14.4%	31	12.3%
Performance data are not shared	3	1.7%	5	2.0%

When collaborative participation is analyzed against the responses, the following associations are found. In the first survey collaborative participation is positively associated with every form of sharing individual/team performance data. Among the practices that share data with the specific provider only, all providers, all staff, and/or patients, between sixty-five and eighty percent of practices (N varies) for each variable participated in collaboratives. In the second survey where the sample size was larger, the effect of collaborative participation was not as strong. In the second survey, collaborative participation had relation to the practice of sharing data with all providers or the specific provider only; however participation in colllaboratives is slightly higher among the 152 practices who share data with staff (53.9%, N=82). Of the 31 practices that share these data with patients, 83.9% (N=26) participated in collaboratives. In both surveys, very few practices (2.0%, N=5 in the second survey and 1.7%, N=3 in the first survey) do not share individual/team performance data.

The majority of respondents (73.4%, N=185 in the second survey, and 77.3%, N=140 in the first survey) have a process to identify patients who are high utilizers of medical services. Of those respondents, most (82.7%, N=153 in the second survey, and 70.7%, N=99 in the first survey) have formal care management programs for these patients. In both surveys, the responses demonstrated some positive association with the practices' participation in collaboratives. In the first survey, of the 140 respondents that have a process to identify high utilizers, 76.4% (N=107) participated in collaboratives. Of the 99 respondents that have formal care management processes, 80.8% (N=80) participated in collaboratives. In the second survey, practices that have a process to identify and have formal care management for high utilizers were more likely to have participated in collaboratives. Processes to identify high utilizers of medical services will

increasingly help both PCPCHs and CCOs in managing costs and improving care, so these findings will be of continuing importance to these organizations.

Many respondents (63.9%, N=161 in the second survey, and 73.5%, N=133 in the first survey) administer a staff satisfaction survey. Of these respondents, the greatest number administer the survey annually (72.7%, N=117 in the second survey, and 81.2%, N=108 in the first survey). Few respondents offer the survey twice per year (13.0%, N=21 in the second survey, and 4.5%, N=6 in the first survey) or in some other way (14.3%, N=21 in the second survey, and 14.3%, N=19 in the first survey). Of the respondents who administer staff satisfaction surveys, the greatest number of respondents (54.0%, N= 136 in the second survey, and 86.5%, N=115 in the firs survey) indicate that staff experience data are routinely reviewed and used by managers, and staff experience data are reported to staff (52.0%, N= 131 in the second survey, and 81.2%, N=108 in the first survey). For some respondents, staff experience data are reported to stakeholders such as boards and/or patients (44.4%, N=112 in the second survey, and 30.1%, N=40 in the first survey). The remaining respondents are not currently using the data (0.8%, N=2 in the second survey, and 3.8%, N=5 in the first survey).

Core Attribute #3: Comprehensive Whole Person Care
Preventive and Medical Services
In survey 1, a series of questions were asked about preventive and medical services; most of these were deleted from survey 2 by the OHA staff in an attempt to streamline the survey and decrease response burden, in particular since the information obtained in survey 1 did not contribute substantially to the overall understanding of PCPCH implementation.

Two hundred and six responding practices (81.7%) in the second survey and 115 practices (63.5%) in the first survey send out reminders for preventive services. Collaborative participation is most positively associated with a positive response on preventive services from the first survey where 76.5% (N=88) participated in at least one collaborative, whereas no clear associations were found for this response in the second survey.

Mental Health, Substance Abuse, and Developmental Services
At least two-thirds of respondents reported that primary care and behavioral health providers generally work together within their practices (72.2%, N=182 in the second survey, and 64.6%, N=117 in the first survey). In the first survey 62.4% (N=73) of these practices participated in collaboratives, whereas collaboratives had no effect on response in the second survey. These practices were also asked if same day services are available with behavioral health providers if a patient needs mental health services during a regular medical visit. Table 7 indicates that while the majority of respondents almost always or usually offer same day behavioral health services (83.2%, N=94 in the first survey, and 73.1%, N=133 in the second survey), there is still an opportunity for enhanced behavioral health services integration in the remaining practices. In the first survey the majority of practices that answered same day health services are 'almost always' available or 'usually' available also participated in collaboratives. In the second survey, among the 28 practices (15.4%) that answered that same day health services are 'almost always' available, 78.6% (N=22) also participated in collaboratives; however this pattern was not reflected in the 'usually' response.

Table 7. Availability of Same Day Behavioral Health Services

Availability:	Survey 1 (N=113)		Survey 2 (N=182)	
	N	Percent	N	Percent
Almost always	26	23.0%	28	15.4%
Usually	68	60.2%	105	57.7%
Rarely or never	19	16.8%	49	26.9%

Among the practices where primary care and behavioral health providers work together (N=182 in the second survey and N=117 in the first survey), the majority use common care plans that are formal written documents (52.2%, N=95 in the second survey and 60.8%, N=79 in the first survey).

Comprehensive Health Assessment and Intervention
Many respondents regularly use screening methods to identify patients at risk for harmful health behaviors (84.5%, N=213 in the second survey, and 86.7%, N=157 in the first survey). In the first survey these respondents were asked to identify the three health behaviors for which they most frequently screen patients. This level of detail was not asked in the second survey in an attempt to streamline the overall survey.

Core Attribute #4: Continuity
No questions were asked on the survey about the following measures in Core Attribute #4: Personal Clinician Assigned, Personal Clinician Continuity, Organization of Clinical Information, or Clinical Information Exchange.

Specialized Care Setting
Practices were asked how often they are notified when one of their patients is admitted or discharged from their usual hospital providers. In the second survey, the 252 respondents indicated that over 57.5% (N=145) are almost always and 31.3% (N=79) are usually notified. The remaining 11.1% (N=28) reported that they are rarely or never notified. In the first survey the 181 responses indicated that over 80% (N=152) are almost always or usually notified; 26 respondents (14.4%) indicated they are rarely notified. Only 3 respondents (1.7%) indicated never. In the first survey, 70-80% of the 152 practices (N=84.0%) that answered that they are almost always or usually notified also participated in collaboratives. The results of the second survey followed a slightly different pattern and revealed that of the 79 practices that answered they are usually notified, 65.8% (N=52) participated in collaboratives. However the data also showed that in the second survey, of the 145 practices that responded that they are always notified, 44.8% (N=65) participated in collaboratives.

In the first survey, as the number of FTE providers in a practice increased, the likelihood that practices almost always are notified of admission or discharge from the hospital consistently increased; this was not shown to be true in the second survey where the sample was larger and the distribution by size was evenly distributed. In both surveys, the smaller the number of FTE providers in a practice, the more likely that the practice responded they are rarely or never notified by a hospital. In the second survey, of the 145 practices responding that they are always notified, the greatest number of respondents (34.5%, N=50) were from rural areas. In the first

survey there are no clear associations between likelihood that practices are notified and geographic location.

Most respondents have a standard process to follow-up with patients after discharge from hospital (82.5%, N=208 in the second survey, and 63.5%, N=115 in the first survey).

Core Attribute #5: Coordination and Integration
No questions were asked on the survey about two measures in Core Attribute #5: Test and Result Tracking, and End of Life Planning

Population Data Management
Respondents were asked if their practices have systems in place to identify certain diagnoses, risk factors and conditions that are clinically important to their patient populations. Table 8 below displays the responses. In the second survey more practices have systems in place to track items of clinical importance, and there was a slight increase in percent of respondents who are tracking the measures presented below.

Table 8: Tracking of Important Clinical Conditions

	Survey 1 (N=181)		Survey 2 (N=252)	
Systems in place for tracking:	**N**	**Percent**	**N**	**Percent**
The most frequently seen diagnoses (e.g. asthma, diabetes)	157	86.7%	231	91.7%
The most important risk factors in the practice's patient population (e.g., smoking, obesity)	96	53.0%	172	68.3%
Conditions clinically important in the practice's patient population (e.g. that reflect social or demographic groups)	76	42.0%	154	61.1%
None of the above	22	12.2%	11	5.2%

The majority of respondents generate regular reports about patient data at the team/panel level (69.8%, N=176 in the second survey, and 79.6%, N=144 in the first survey). Table 9 illustrates that reports are shared primarily with specific provider teams, and then with all providers, and rarely with patients. These results may or may not be generalizable to all PCPCHs, but reflect those who responded to these surveys.

Table 9: Sharing of Patient Data Reports

	Survey 1 (N=144)		Survey 2 (N=176)	
Reports are shared with:	**N**	**Percent**	**N**	**Percent**
Specific provider teams	122	84.7%	157	62.3%
All providers	102	70.8%	123	48.8%
Patients	8	5.6%	5	2.8%

In both surveys, collaborative participation is positively associated with all of the listed methods of sharing individual/team performance data.

Electronic Health Records
Almost all practices (97.2%, N=245 in the second survey, and 96.1%, N=174 in the first survey) use an electronic health/medical record (EHR). Practices were asked how long they have used an EHR for direct patient care. In both surveys, more than half (62.4%, N=153 in the second survey, and 57.8%, N=100 in the first survey) have had an EHR for 5 years or more, and another quarter (27.8%, N=68 in the second survey, and 22.5%, N=39 in the first survey) indicated 3 to 4 years, demonstrating that these practices are likely well adapted to the use of the EHR. There may be some differences in integration of EHR functions observed in the remaining respondents (9.8%, N=24 in the second survey, and 20%, N=34 in the first survey) who have 2 or less years of experience.

Care Coordination
More than half of the respondents use care management teams (74.6%, N=188 in the second survey, and 63.0%, N=114 in the first survey). For the purpose of this survey, care management teams are defined as a group of providers and other staff who meet with each other regularly to discuss the care of a defined group of patients and who share responsibility for their care. The majority of respondents (74.2%, N=187 in the second survey, and 54.7%, N=99 in the first survey) co-locate providers and other care team members in their practices (i.e. they sit together).

In the second survey, of the 188 practices that use care management teams and the 187 practices that co-locate these providers, respondents in each category were slightly more likely to have participated in collaboratives. Smaller practices (made up of 0-5 providers) were the most likely to co-locate. In the first survey, both collaborative participation and size were fairly evenly distributed across the 114 practices (63.0%) that use care management teams. In both surveys, the majority of respondents that use care management teams also participated in collaboratives (70.7%, N=133 in the second survey and 64.9%, N=74) in the first survey). Practices that co-locate providers (137 respondents in the second survey and 99 in the first survey) were slightly more likely to have participated in collaboratives (20% more positive answers in the second survey, and 10% more in the first survey).

Seventy-five percent of respondents to the second survey (N=191) and 85% of respondents to the first survey (N=154) use guideline-based reminders for services the patient should receive; providers see these when they are seeing the patient, such as a pop-up within an EHR or an appropriate reminder attached to the chart. Almost all practices responded that their providers are able to transmit prescriptions electronically directly to pharmacies (98.8%, N=249 in the second survey, and 92.8%, N=168 in the first survey).

Referral and Specialty Care Coordination
An area of interest in studying the primary care home is gaining an understanding of the networks of relationships that practices establish within and across their communities. Table 10 presents the different kinds of formal relationships that practices have in their communities. The most marked difference between the first and second survey results is found in the decrease in number of respondents indicating "Provide funding to support operations" option. This may be a result of economic conditions, may reflect changing relationships in some communities as Coordinated Care Organizations (CCOs) are being established as community-level networks, or

may be a function of bias of those who responded to survey 2 as compared to survey 1. Also of note is the increase of almost 20% by survey 2 of practices that share staff between/among sites.

Table 10. Formal Community Relationships

Systems	Survey 1 (N=181)		Survey 2 (N=252)	
	N	Percent	N	Percent
Facilitate delivery of services (e.g. hospital care, after-hours care, urgent care)	170	93.9%	220	87.3%
Link patients to community resources (e.g. referrals to social services)	146	80.7%	180	71.4%
Enhance the efficiency of operations (e.g. group purchasing)	105	58.0%	131	52.0%
Facilitate data collection and management (e.g. participate in an HIT consortium)	99	54.7%	128	50.8%
Share staff between/among sites (e.g. through shared administrative structure)	60	33.1%	127	50.4%
Provide health promotion services outside of clinic visits (e.g. with a nonprofit organization)	76	42.0%	100	39.7%
Provide funding to support operations (e.g. shared administrative structure with a "parent" organization)	121	66.9%	97	38.5%
No formal relationships exist	3	1.7%	7	2.8%

Comprehensive Care Planning
In survey 1, a series of questions were asked about comprehensive care planning; these were deleted from survey 2 by the OHA staff as part of the attempt to streamline the survey and decrease response burden, in particular since the information obtained in survey 1 did not contribute substantially to the overall understanding of PCPCH implementation.

Core Attribute #6: Person- and Family-Centered Care
Language/Cultural Interpretation
The majority of respondents offer formal training programs to staff to improve their skills in cultural competence (52.8%, N=133 in the second survey, and 58.0%, N=105 in the first survey) and patient communication (76.2%, N=192 in the second survey, and 56.9%, N=103 in the first survey). Table 11 displays the extent to which practices facilitate communication during routine visits for patients with limited English proficiency in both the first and second survey. The bolded percent in each row represents the most common response for each communication method. From these results it is evident that the standard practice is not that the provider delivers care in the patient's preferred language, but instead practices increasingly are using on-site interpreters and/or accessing a phone interpreter service or "language line." While these resources are clearly valuable, this does suggest an opportunity to build capacity of providers to speak the patient's preferred language, either through targeted recruitment of providers who are multilingual and/or through support of language training.

Table 11. Communication Practices for Patients with Limited English Proficiency

	Survey 1 (N=181)			Survey 2 (N=252)		
	Always	**Usually**	**Rarely or Never**	**Always**	**Usually**	**Rarely or Never**
Provider delivering care speaks patient's preferred language	5.0%	**58.0%**	37.0%	2.4%	40.90%	**56.7%**
On-site trained interpreter is utilized	6.6%	**67.9%**	25.4%	36.9%	**47.2%**	15.9%
Phone interpreter service or "language line" is used	17.1%	**71.2%**	11.6%	24.6%	**49.2%**	26.2%

Twenty-five practices initiated telephone and/or electronic access to a care provider in the process of becoming recognized as a PCPCH; of these, 56% (N=14) were rural practices. Of the 11 practices that initiated interpreting services as part of becoming recognized, 45.5% (N=5) were rural practices. There may be some need for attention to be paid in future to assisting rural practices to develop capacity to provide patient-relevant interpreting services.

In the first survey among the 103 practices (56.9%) that offer patient communication training and the 105 practices (58.0%) that offer cultural competency training, 73-76% participated in collaboratives. These associations with collaborative participation were mostly similar in the larger sampling of the second survey. In the re-administration of the survey, of 192 practices (76.2%) that offer training in patient communication, slightly less than half (49.5%, N=95) participated in collaboratives. Of the 133 practices (52.8%) that offer training in cultural competence; 53.4% (N=71) participated in collaboratives. This may suggest that participation in collaboratives contributes to spreading the practices that highlight the importance of patient communication and cultural competence.

Education and Self-Management Support
In the second survey, 76.6% (N=193) of practices indicated that they offer health promotion programs outside of regular patient encounters. In the first survey, 69.1% (N=125) of respondents indicated that they offer health promotion programs outside of regular patient encounters. Thirty-eight percent of respondents (N=69) to the first survey use group visits for the programs listed above, and 44.8% (N=113) of the second survey respondents do so.

Experience of Care
Nearly all (95.6%, N=241 in the second survey, and 100%, N=181 in the first survey) offer same-day appointments. Most respondents (98.4%, N=248 in the second survey, and 90.1%, N=163 in the first survey) protect a certain number of appointment slots per day for same-day appointments for existing patients.

Implementation of the PCPCH Model
Practices were asked which services and processes they initiated directly in relation to implementation of the PCPCH model. Table 12 below displays which services respondents now offer but previously did not offer. Results account for all 252 respondents to survey 2; responses to survey 1 are not included since the answers should remain stable for practices that were recognized initially and responded to the previous survey.

Forty-three respondents to survey 2 (17.1%) indicated that no new services were implemented as part of seeking PCPCH recognition; this means that 209 (82.9%) did add at least one new service. The explanation for those practices that did not implement new services may be that they already had these services in place, or that they did not feel the need (or have the ability) to implement new services. It is also feasible that some of these 43 respondents had already implemented some of these services as a result of participating in a learning collaborative, or hearing a presentation from another practice at a professional meeting.

Table 12. Survey 2: Service Implementation Related to the PCPCH Model (N=252)

Services Implemented with PCPCH	N	Percent
Formal process for tracking patients who are admitted or discharged from a hospital	126	50.0%
Care management teams that are responsible for a defined panel of patients	111	44.0%
Formal process for tracking patients who are referred to a specialist	91	36.1%
Formal care management programs for patients with chronic conditions	88	34.9%
Formal care management programs for patients who are high utilizers of medical services	81	32.1%
EHR capability for sorting patients by diagnosis, risk factors, medication, or other factors	79	31.3%
Use of clinical support staff (nurses, dieticians, health educators, etc.) for health promotion and/or chronic disease management	70	27.8%
Health promotion program(s) outside of regular patient encounters	62	24.6%
A quality improvement team or committee	55	21.8%
Formal relationships (e.g., a memorandum of understanding, letter of agreement, or contract) for specialty referrals	25	9.9%
Telephone and/or electronic access to a nurse or physician during regular and/or after hours	25	9.9%
Sending patient reminders for preventive services	24	9.5%
Contractual relationship(s) for administrative services provided by another organization or entity	15	6.0%
Interpreter services for patients with limited English proficiency	11	4.4%

These results may suggest training and technical assistance opportunities in future both for recognized practices and for those practices seeking recognition.

In the first survey, participation (or not) in collaboratives by practices showed no clear association with those that reported that they implemented no new services in relation to the PCPCH program. In the second survey, only 43 practices (17.1%) reported that they implemented no new services in relation the PCPCH program. In the first survey further analysis of implementation by collaborative participation did not reveal any additional insights because of small response numbers. Even when as many as 42 practices indicated a positive response on a specific service implementation, the proportion participating in collaboratives was small and therefore no further conclusions were possible.

Of the 99 practices in the first survey that have formal care management programs for high medical utilizers, 59.6% (N=59) reported that they did not implement any new services with their PCPCH implementation. Of the102 practices responding to survey 1 that implemented no new services, 57.8% (N=59) reported that they almost always are notified when a patient is admitted or discharged from their usual hospital provider, and 46.1% (N=47) have a system to identify the most important risk factors in their practices' patient population (e.g., smoking, obesity). In the second survey because there were very few practices that implemented no new services (17.1%, N=43), no clear associations could be found using the analyses detailed above.

Oregon implemented the PCPCH program as part of the state's strategy to achieve the Triple Aim of improving the individual experience of care, improving population health management, and decreasing the cost of care. In survey 2, respondents were asked a question about the extent to which the implementation of the PCPCH model helped them to make progress towards achieving the Triple Aim. Table 13 presents these results, and shows that more than half of the respondents answered that PCPCH implementation helped them "somewhat" to improve individual experience of care and population health management. Approximately half of the respondents answered that PCPCH implementation had "little or no" effect in helping them to decrease the cost of care (although this may be an area where practices have less specific information). The bolded percent in each row in Table 13 represents the most common response for each aspect of the Triple Aim.

Table 13. PCPCH Implementation and Achievement of the Triple Aim (N=252)

	Little or none	Some	A Lot
Improving the individual experience of care	15.1%	**57.5%**	27.4%
Improving population health management	17.9%	**47.6%**	34.5%
Decreasing the cost of care	**52.0%**	41.7%	6.3%

Table 14 displays responses addressing the extent to which implementation of the PCPCH model helped respondents to address issues of quality and accessibility for their patients. This question was only asked in the survey re-administration. The results show that around half of the respondents answered that PCPCH implementation is "somewhat" helping them to increase quality of care and access to services. The bolded percent in each row in Table 14 represents the most common response for each category.

Table 14. PCPCH Implementation and Quality/Access (N=252)

	Little or none	Some	A Lot
The PCPCH model is helping our practice to increase the quality of care for patients and their families	15.1%	**50.4%**	34.5%
The PCPCH model is helping our practice to increase access to services for patients and their families	25.0%	**49.2%**	25.8%

Practices were also asked to rank the most important factors that influenced their decision to become a recognized PCPCH. Table 15 below presents these rankings. The most important factor cited by respondents was the opportunity to improve patient care. The second most

important factor was eligibility for enhanced payment. It is of interest that both marketability and encouragement from CCOs/other payers were of much less importance.

Table 15: Factors Influencing Decision to Become Recognized PCPCH (N=252)

	Most important		2nd most important		3rd most important		Least important	
	N	%	N	%	N	%	N	%
Opportunity to improve patient care	127	50.4	81	32.1	30	11.9	14	5.6
Eligibility for enhanced payment	114	45.2	68	27.0	43	17.1	27	10.7
Ability to improve marketability to patients	2	0.8	32	12.7	85	33.7	133	52.8
Encouragement from Coordinated Care Organizations and/or other payers	9	3.6	71	28.2	94	37.3	78	31.0

Technical Assistance Feedback
A final set of questions sought input on technical assistance needs and topics; this information was collected to inform the curricular offerings of the Patient Centered Primary Care Institute (PCPCI). A brief report on these results was provided to the Oregon Quality Corporation at the completion of the first survey to assist them in planning the PCPCI. Thirty- two percent of respondents in the second survey (N=81) and 49% (N=89) of respondents in the first survey indicated that they currently participate in some formal education, training or technical assistance focused on building knowledge and skills related to implementing the primary care home.

Respondents were also asked to identify the most significant barriers that they perceive will affect their practice's transformation to PCPCH; the results from survey 2 are presented in Table 16 below. Fourteen respondents in both surveys (5.6% in the second survey, and 7.7% in the first survey) indicated that they anticipate no significant barriers to PCPCH implementation, and that all necessary programs were in place prior to PCPCH. Of 250 respondents who answered this question for survey 2 (and could provide multiple responses), the results show that sufficient financial and human resources as well as staffing and training were the most commonly identified barriers.

Table 16. Barriers to PCPCH Implementation (N=250)

Barrier	N	Percent
Cost and lack of resources	87	34.8%
Staffing and training	64	25.6%
Time	47	18.8%
Administrative burden and reporting	45	18.0%
Change management and fatigue	34	13.6%
Bureaucracy and complexity of PCPCH program	28	11.2%
Lack of payment reform	28	11.2%
Team care and service coordination	23	9.2%
Technology issues	21	8.4%
CCO coordination	7	2.8%

Finally, respondents were asked to identify topics for future training to assist them in the implementation of the PCPCH. A list of topics was provided; respondents could also identify additional topics. The results for survey 2 are presented in Table 17 below.

Table 17. Topics for Future Training on PCPCH (N=252)

Topic	N	Percent
Patient and family engagement and communication	180	71.4%
Behavioral health integration	169	67.1%
Care management/complex case management	168	66.7%
Comprehensive care planning	167	66.3%
Care coordination	146	57.9%
Team-based care and empanelment	129	51.2%
Quality improvement methods and strategies	124	49.2%
Identifying resources in the community for patients	116	46.0%
Implementing and using patient experience of care surveys	94	37.3%
Data systems	94	37.3%
Leadership	90	35.7%
Processes for organizational change	88	34.9%
Health impact assessment	82	32.5%
Increasing patient access to care	81	32.1%
Health policy and health reform	54	21.4%

Summary of Findings

These findings supplement the information collected by OHA in the initial PCPCH recognition applications, and suggest some areas for further investigation. Of particular note are the services or activities that the majority of respondents report they are doing, and those that very few are doing. Table 18, below, indicates the activities that 90% or more of the respondents to the second survey indicated they have in place. Responses that relate to a "must-pass" standard are marked with an asterisk (*).

Table 18. Most Frequently Reported Activities, Survey 2 (N=252)

90% + of all responding practices do the following:	% Response
Provide urgent phone response from a clinical provider after hours or on weekends *	99.2%
Providers are able to transmit prescriptions electronically directly to pharmacies	98.8%
Protect appointment slots per day for same-day appointments for existing patients	98.4%
Give providers feedback regarding clinical quality measures *	97.6%
Use an electronic health/medical record	97.2%
Use clinical quality data to systematically improve practices *	96.0%
Offer same day appointments *	95.6%
Administer a patient satisfaction survey	94.4%
Use patient satisfaction data in multiple ways	94.4%
Have systems to track diagnoses that are most important to their patient populations	91.7%
Have a quality improvement team or committee *	90.1%

Table 19, below, indicates those activities reported by 80-89% and 70-79% of the respondents to survey 2. As in the previous table, responses that relate to a "must-pass" standard are marked with an asterisk (*).

Table 19. Next Most Frequently Reported Activities, Survey 2 (N=252)

80-89% + of all responding practices do the following:	% Response
Practice is notified almost always or usually when a patient is discharged from a usual hospital provider *	88.8%
Staff/provider judgments determine after hours/nontraditional visit strategy	88.5%
Have formal community relationships to facilitate delivery of services (e.g. hospital care, after-hours care, urgent care)	87.3%
Regularly use screening methods to identify patients at risk for harmful health behaviors	84.5%
On-site trained interpreter is utilized always or usually for patients with limited English proficiency *	84.1%
Have a standard process to follow-up with patients after discharge from hospital *	82.5%
Send patients reminders for preventive services	81.7%
Patient experience data are routinely reviewed by managers and used to improve services	80.6%
Use a structured method for practice improvement in their organizations *	80.2%
70-79% + of all responding practices do the following:	**% Response**
All providers can see individual/team performance data *	79.4%
Track no-show appointments as a measure of access	77.8%
Use guideline-based reminders for services the patient should receive	75.0%
Use care management teams *	74.6%
Phone interpreter service or "language line" is used always or usually for patients with limited English proficiency *	73.8%
Have a process to identify patients who are high utilizers of medical services *	73.4%
Offer same day behavioral health services almost always or usually *	73.1%
Primary care and behavioral health providers generally work together within the practice *	72.2%
Have formal community relationships to link patients to community resources (e.g. referrals to social services)	71.4%

Table 20, below, indicates the activities that are reported least often by respondents to the second survey.

Table 20. Least Reported Activities, Survey 2 (N=252)

Less than 20% of all responding practices do the following:	% Response
Patients can see individual/team performance data	12.3%
Reports about patient data at the team/panel level are shared with patients	2.8%
Performance data are not shared	2.0%

Both the frequently reported activities (Tables 18 and 19) and the least reported activities (Table 20) suggest opportunities for consideration for recommended or required PCPCH activities in the future, as well as opportunities for training and technical assistance for those practices that do not have these in place. In addition, it appears that an opportunity for training rests in helping small practices, in particular, to gain more proficiency in the use of data for routine reporting.

PCPCH implementation is clearly linked to the practices' expectations of achieving the elements of the Triple Aim. Eighty-five percent report that implementation of the PCPCH model is helping them achieve the aim of improving the individual experience of care, and 82% report progress towards achieving the aim of improving population health management. Similarly, PCPCH implementation is helping practices increase the quality of care for patients and their families (78% positive response) and increase access to services (75% positive response). Slightly less than half of the respondents indicate PCPCH is helping them achieve the aim of decreasing the cost of care, but this may actually reflect a lack of detailed knowledge of costs as compared to actual evidence that costs are not decreasing. This is an area for further emphasis to help practices understand the relationship between PCPCH and costs of care.

The two most important factors influencing the decision of a practice to become recognized as a PCPCH are the opportunity to improve patient care, and the eligibility for enhanced payment. Improved marketability and encouragement from CCOs or other payers were not identified as key factors influencing the PCPCH decision. The most important barriers to PCPCH implementation were cost and lack of resources; staffing and training; time; and the administrative burden and reporting. These all have implications for ongoing technical assistance from OHA to the practices to help them implement the PCPCH model.

Participation in collaboratives to accelerate learning and spread of promising practices has become a common activity for health services organization working on improving the delivery of services. Many of the practices that are now recognized as PCPCHs have participated in collaboratives, and the results of this survey show that such practices are more likely to use mechanisms that enhance primary care delivery, such as sending out reminders for preventive services, and offering staff training in patient communication and cultural competence. Similarly, sharing of practice data is more common among those practices that have participated in collaboratives. Other definitive conclusions about further relationships among collaborative participation, size, geography and PCPCH implementation revealed no clear associations given the small numbers in the current response pool. Over time as more practices are recognized as PCPCHs in Oregon, it will be feasible to further explore such relationships.

The PCPCH program is being implemented as a single model but is serving a range of practices from small and minimally resourced (in terms of technology and administrative expertise) to practices housed within large complex health systems that are well-resourced and have extensive technological and intellectual support. While the model allows for small practices to be recognized, and the tiers to distinguish among the recognized practices, many challenges of responding and documenting PCPCH implementation were revealed through the survey process since the program applies to the spectrum of practices.

As one would expect, urban practices tend to be larger and rural tend to be smaller. There is no clear differentiation in practice styles among the three urban categories. Practices categorized as Tier 2 tend to be smaller and Tier 3 tend to be larger. Smaller practices (as measured by number

of primary providers) tend to offer more access to the patients' own care team, both in person and via telephone. However, connections to other parts of the system may be more limited for smaller practices. This may be seen in varied involvement in activities such as linkage to discharge information, ability to access technology or electronic prescribing, and opportunities to enhance service delivery through community-based collaborations. Similarly, size often appears related to the technological sophistication of the practices in terms of use of data, sharing of reports, and ability to pursue population-based strategies, yet some small practices reported expertise in these areas and are just as "sophisticated" as their larger counterparts. This is likely due to the spread of promising practices both through collaboratives and through other mechanisms for learning (conferences, web-based resources, technical assistance and training); as a result, no clear conclusions can be made about size and progress towards routine use of the various elements of the primary care home model.

Communication practices for patients with limited English proficiency are an important element in person- and family-centered care. In survey two, 84% use on-site trained interpreter (an increase from 74% in the first survey) and 74% use a phone interpreter service or "language line" (88% response in the first survey, but variations may be due to which practices responded). This raises an opportunity for technical assistance to ensure that all practices have access to some means of translation for non- or limited English speakers. The results suggest that participation in collaboratives contributes to spreading the practices that highlight the importance of patient communication and cultural competence.

Many practices implemented some new services in order to achieve PCPCH recognition, in particular with respect to formalized processes of care management and tracking of patients. The results when analyzed by collaborative participation again suggest that participation in a collaborative helps a practice to get started in implementing new activities and in learning how to do this based on the experience of others (either in the collaborative or those whose experience is the basis for training). It appears that collaborative participation has helped many practices to be ready for PCPCH recognition, and that they already have many of these activities in place when they are first recognized. This is in contrast to those who have not participated in collaboratives, and thus at time of recognition are either in the process of implementing many of the activities related to PCPCH or need additional technical assistance prior to, or soon after, recognition to assist them in advancing as a PCPCH.

Practices also commented on a variety of administrative issues related to PCPCH. The survey process itself created a work burden on practices, as someone needed to be identified to respond. Practices indicated that they perceive an administrative burden with PCPCH in terms of the recognition process, payment challenges, and other requests for information from OHA.

From a survey management perspective, the collection of information about the recognized practices is a challenge, both because new practices are regularly being recognized but others (especially some small practices) may close or be purchased, and there appears to be a lack of communication with OHA to advise of this change in status (which obviously has implications for payment). This lack of communication by the practices also results in confusion about who is the practice contact as the contacts change due to staffing changes, and are not reported to OHA. Similarly, there is often a question about who manages the application process vs. who is responsible for the payment processes.

As a result of conducting these two surveys, there have been discussions about revising the recognition application itself to include more of the information that was collected in this survey so that there are both the elements that are required for assessment for recognition and those elements that provide additional description and organizational demographics for subsequent analysis. It is clear that there is value to continuing some sort of external evaluation such as the work reported here, in order to collect information on PCPCH implementation and link that information to the recognition application, providing OHA with objective and additional analysis from an outside source. However, future work should be designed to minimize the administrative burden on the practices and to streamline OHA's requests for information from the practices to decrease the perception of excessive demands on the practices.

Conclusion
These findings demonstrate the early progress of implementation of the Patient Centered Primary Care Home program in Oregon. All findings should be interpreted in the context of those practices that chose to respond; responses were not mandatory. All data reported are based on the survey findings, supplemented by some organizational information; these data were not linked to the information in each practice's recognition application. Future evaluation of the PCPCH implementation would be enhanced by integrating information such as has been requested on this supplemental survey into the recognition application process, in order to reduce the survey burden on the practices and to augment the survey responses, thus providing OHA with a more comprehensive picture of the progress of PCPCH implementation.

We look forward to continuing to work with OHA on the evaluation of this very important element of Oregon's strategy for health system transformation.

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