

**Patient Centered Primary Care Home Program
Pediatric Advisory Committee**

**Meeting #2 Summary
Friday, September 10, 3-5 p.m.**

Committee members in attendance

David Labby, MD (co-chair)
Arthur Jaffe, MD
Bonnie Reagan, MD
Craig Hostetler, MPA
Frances Biagioli, MD
Kara Williams
Kathy Savicki
Kelli Kennedy
Kelly Volkmann
RJ Gillespie, MD
Regan Gray
Tom Sinsic, FNP

Committee members in attendance by phone

Marilyn Hartzell
Robert Dannenhoffer, MD
Warren Griffin, MD
Weston Heringer, DMD
Colleen Reuland (ex officio)

OHA/DHS liaisons in attendance

Molly Emmons
Dianna Pickett
Katherine Bradley

OHA/DHS liaisons in attendance by phone

Bill Bouska

OHPR staff in attendance

Jeanene Smith, MD, MPH
Doug Lincoln, MD, MPH
Nicole Merrithew

One member of the public signed in.

The committee meeting was convened by Dr. Labby at 1 p.m. Introductions and welcomes were completed. The minutes of meeting #1 were approved.

Doug Lincoln reviewed the revised Attribute #1, Access. Dr. Gillespie noted the AAP Medical Home document calls for a medical home to take all payment methods, including CHIP and Medicaid, however this is absent from state language. Drs. Labby and Smith discussed the difficulty of mandating payer mix for statewide application of these standards, however it was agreed upon that a guiding principle should be that the medical home measures apply to all of a medical home's population regardless of payment source. It was also brought up that the measures should have reference to the literature and evidence base where it exists. This was agreed upon and will be incorporated into the committee's final report.

Attribute #2 – Accountability

Dr. Labby clarified measures 1 and 2. Thinking of the structure / process / outcome of a medical home, the performance indicators are more process and the clinical quality indicators more outcomes based. It was noted

that outcomes data are much scarcer in pediatrics, both based on the literature and on the fact dividends on pediatric prevention may not be paid for years.

It was felt that while the committee's work should be broad and not specify clinical quality indicators, the indicators that emphasize prevention should be stressed.

Dr. Jaffe brought up many professional boards are now requiring QI for maintenance of certification. It was felt that the state standard should be high and some board QI efforts may not be applicable. In contrast the committee felt becoming a primary care home should not be overly onerous to providers, and QI efforts should align with certification efforts wherever possible. In addition patient input could be tied to a QI indicator; this will be further addressed in attribute #6.

Public reporting as specified in measure 3 may need to be aggregated for very small rural practices with a low denominator.

A discussion of measure 4 centered around what is and how to define preventable utilization. Concern was put forth insurers would define preventable utilization. Dr. Labby emphasized the measure was not tiered; however it needed to be a part of overall reform in the state. In addition OHPR discussed other state's models, such as Minnesota, which risk adjust in order to not penalize providers caring for children with special health care needs, for example.

Attribute #3 – Comprehensive Whole Person Care

The committee noted there is not a great deal of evidence on long term outcomes of preventive services for children but that any evidence base, for example that detailed in the Bright Futures guidelines, should be emphasized. It was decided to add the language "coordinates" in addition to "offers" direct services, as the medical home should be rewarded for coordinating care, for example immunizations provided at a school based health center. It was decided to add language to capture developmental screening to measure 3. The final report will emphasize the unique role of safety in child health. Colleen Reuland brought up EHRs and the role of decreasing errors with electronic prescribing. The decision to not include EHR requirements in tier 1 measures was a conscious one by the state to allow the highest number of practices able to become a medical home without requiring a substantial investment in EHR upfront. In addition OHPR articulated EHRs will hopefully become a means to an end, for example by specifying coordination of care within the measures, and then allowing practices to innovate with EHRs to satisfy that requirement.

Attribute #4 - Continuity

The committee wanted to clarify that increasing percentage of patients with PCPs over time will be a relative (i.e. compared to within the practice over time) rather than an absolute comparison. Dr. Jaffe brought up the point this is a real concern in academic centers, for example, when residents graduate and there is a time period when the staff or patients potentially do not know who their new PCP is. OHPR brought up data in the adult world that demonstrated increased continuity of PCP was correlated with improved outcomes. The issue of continuity was felt particularly applicable to CSHCN.

The committee voiced concern that measure 5 was defined too narrowly in terms of hospital care to capture the range of care that occurs in child specific settings such as Head Start centers and schools. In addition, the committee felt optimal care of children would involve a means for tracking care within other community organizations where practical. It was felt tier 2 measures should include more traditional secondary places of care and tier 3 measures should include community wide settings. The committee also strongly felt coordinating with EI should be a tier 1 measure. OHPR agreed to wordsmith. Dr. Gillespie brought up the idea of a "shared care plan" which is central to these ideas and will be addressed in Attribute 5, Coordination of Care.

Public comment was solicited with no members of the public making comment. The venues for the next 2 meetings will be coordinated by OHPR and emailed to the group in short order. Dr. Labby adjourned the meeting at 5 p.m.