

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

Friday, September 24, 2010
3-5 p.m.

Clackamas Community College
Wilsonville Training Center, **Room 211**
29353 Town Center Loop East, Wilsonville, OR

| # | Time | Item & Related Materials | Presenter(s) | Action Item |
|---|------|---|--------------|-------------|
| 1 | 3:00 | Welcome and Introductions | Co-Chairs | |
| 2 | 3:10 | Review and approve Attributes #2 - 4 | All | X |
| 3 | 3:40 | Discussion of PCPCH Measures <ul style="list-style-type: none">• Coordination and Integration• Person and Family Centered Care | All | |
| 4 | 4:50 | Public Comment | Co-Chairs | |
| 5 | 5:00 | Adjourn | | |

Meeting Materials:

1. Agenda
2. Draft Minutes from Meeting #2
3. Revised Attributes #2 - 4 Matrix
4. Attributes #5 - 6 Matrix
5. Excerpt from Appendix D of the PCPCH Standards Advisory Committee report

**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.

| Attribute #2: Accountability | |
|--|---|
| <i>Patient Centered Language: "Take responsibility for making sure I receive the best possible health care."</i> | |
| <u>Standard: Performance Improvement</u> | |
| | Measure 1 - Performance Improvement: PCH measures its own performance, sets goals and improves its care over time. |
| | Tier 1: PCH tracks at least three performance indicators and reports goals for improvement. |
| | Tier 2: PCH demonstrates improvement towards its reported goals on at least three performance indicators. |
| | Measure 2 - Clinical Quality Improvement: PCH improves clinical quality indicators in its patient population |
| | Tier 3: PCH demonstrates improvement in a certain number of clinical quality indicators. |
| | Measure 3 - Public Reporting: PCH participates in a program of voluntary public reporting. |
| | Tier 2: PCH publically reports practice-level clinical quality indicators to an external entity. |
| <u>Standard: Cost and Utilization</u> | |
| | Measure 4 - Ambulatory Sensitive Utilization: PCH manages patient care effectively, thereby reducing unnecessary or preventable utilization of specific services that increase costs without improving health. |
| | Additional Measure: PCH demonstrates risk-adjusted reductions in utilization measures or excellent performance across its patient population according to prior performance or a risk-adjusted community standard. |

| REVISED | |
|--|---|
| <i>"Take responsibility for helping us receive the best possible health care."</i> | |
| <u>Standard: Performance Improvement</u> | |
| | Measure 1 - Performance Improvement: PCH measures its own performance, sets goals and improves its care over time. |
| | Tier 1: PCH tracks at least three performance indicators and reports goals for improvement. |
| | Tier 2: PCH demonstrates improvement towards its reported goals on at least three performance indicators. |
| | Measure 2 - Clinical Quality Improvement: PCH improves clinical quality indicators, with an emphasis on indicators of preventive services , in its patient population. |
| | Tier 3: PCH demonstrates improvement in a certain number of clinical quality indicators. |
| | Measure 3 - Public Reporting: PCH participates in a program of voluntary public reporting. |
| | Tier 2: PCH publically reports practice-level clinical quality indicators to an external entity. |
| <u>Standard: Cost and Utilization</u> | |
| | Measure 4 - Ambulatory Sensitive Utilization: PCH manages patient care effectively, thereby reducing unnecessary or preventable utilization of specific services that increase costs without improving health. |
| | |

| Attribute #3: Comprehensive Whole Person Care | |
|---|--|
| <i>Patient Centered Language: "Provide or help me get the health care and services I need."</i> | |
| <u>Standard: Scope of Services</u> | |
| | Measure 1 - Preventive Services: PCH offers most age and gender appropriate preventive services. |
| | Tier 1: PCH reports, using a checklist, that it offers a certain percentage of recommended preventive services. |
| | Measure 2 - Medical Services: PCH offers a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible. |
| | Tier 1: PCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases; Office-based procedures and diagnostic tests; Patient education and self-management |
| | Measure 3 - Mental Health and Substance Abuse Services: PCH routinely offers care for mental health and substance use disorders. |
| | Tier 1: PCH documents its screening strategy for mental health and substance use conditions and documents on-site and local referral resources. |
| | Tier 2: PCH documents direct collaboration or co-management of patients with specialty mental health and substance abuse providers. |
| | Tier 3: PCH documents actual or virtual co-location with specialty mental health and substance abuse providers. |
| | Measure 4 - Health Risk Behavior Assessment and Intervention: The PCH routinely assesses common health risk behaviors in its population and offers interventions to support behavior change. |
| | Tier 1: PCH documents routine assessment and intervention for at least three health risk behaviors. |
| | Additional Measure: PCH documents improvement in its rates of intervention for a given health risk behavior. |
| | Additional Measure: PCH documents reduction of the percentage of its patients with a given health risk behavior over time. |

| REVISED | |
|---|--|
| <i>"Provide or help me get the health care, information, and services we need."</i> | |
| <u>Standard: Scope of Services</u> | |
| | Measure 1 - Preventive Services: PCH offers most age and gender appropriate preventive services. |
| | Tier 1: PCH reports, using a checklist, that it offers or coordinates a certain percentage of recommended preventive services. |
| | Measure 2 - Medical Services: PCH offers or coordinates a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible. |
| | Tier 1: PCH reports that it routinely offers or coordinates all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including transitions of care ; Office-based procedures and diagnostic tests; Patient education and self-management |
| | Measure 3 - Mental Health, Developmental , and Substance Abuse Services: PCH routinely offers or coordinates care for mental health, developmental , and substance use disorders. |
| | Tier 1: PCH documents its screening strategy for mental health, developmental , and substance use conditions and documents on-site and local referral resources. |
| | Tier 2: PCH documents direct collaboration or co-management of patients with specialty mental health, developmental , and substance abuse providers. |
| | Tier 3: PCH documents actual or virtual co-location with specialty mental health, developmental , and substance abuse providers. |
| | Measure 4 - Health Risk Behavior Assessment and Intervention: The PCH routinely assesses common health risk behaviors within the family unit and offers interventions, including safety and anticipatory guidance , to support healthy behaviors and environments . |
| | Tier 1: PCH documents routine assessment and intervention for at least three health risk behaviors. |
| | Additional Measure: PCH documents improvement in its rates of intervention for a given health risk behavior. |
| | Additional Measure: PCH documents reduction of the percentage of its patients with a given health risk behavior over time. |

| Attribute #4: Continuity | |
|---|--|
| Patient Centered Language: “Be my partner over time in caring for my health.” | |
| <u>Standard: Provider Continuity</u> | |
| | Measure 1 - Personal Clinician Assignment: The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle. |
| | Tier 1: PCH reports the percentage of active patients assigned a personal clinician and team. |
| | Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team. |
| Measure 2 - Personal Clinician Continuity: The PCH tracks and seeks to improve patients’ continuity with their chosen personal clinician and primary care team. | |
| | Tier 1: PCH reports patients’ usual provider continuity with their assigned personal clinician or a team member. |
| | Tier 2: PCH meets a benchmark or demonstrates improvement in patients’ usual provider continuity with their assigned personal clinician and team. |
| <u>Standard: Information Continuity</u> | |
| Measure 3 - Organization of Clinical Information: PCH maintains up-to-date and accurate records and organizes clinical information in a way that is easily shared with and understandable by health care professionals inside and outside the PCH. | |
| | Tier 1: PCH maintains a health record for each patient that contains at least the following elements (problem list, medication list, allergies, basic demographic information and preferred language) and updates this record as needed at each visit. |
| Measure 4 - Clinical Information Exchange: PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information. | |
| | Tier 3: PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange). |
| | Additional Measure: PCH demonstrates that it transmits data to patients’ electronic personal health records or provides an electronic means for patients to access their personal health information in real time (See also Access Measure #4). |
| <u>Standard: Geographic Continuity</u> | |
| Measure 5 - Specialized Care Settings: PCH tracks when its patients are cared for in specialized care settings and is actively involved during and after care in these settings | |
| | Tier 1: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care. |
| | Tier 2: PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge. |
| | Additional Measure: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department. |

| REVISED | |
|---|---|
| “Be our partner over time in caring for us.” | |
| <u>Standard: Provider Continuity</u> | |
| | Measure 1 - Personal Clinician Assignment: The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle. |
| | Tier 1: PCH reports the percentage of active patients assigned a personal clinician and team. |
| | Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team. |
| Measure 2 - Personal Clinician Continuity: The PCH tracks and seeks to improve patients’ continuity with their chosen personal clinician and primary care team. | |
| | Tier 1: PCH reports patients’ usual provider continuity with their assigned personal clinician or a team member. |
| | Tier 2: PCH meets a benchmark or demonstrates improvement in patients’ usual provider continuity with their assigned personal clinician and team. |
| <u>Standard: Information Continuity</u> | |
| Measure 3 - Organization of Clinical Information: PCH maintains up-to-date and accurate records and organizes clinical information in a way that is easily shared with and understandable by health care professionals inside and outside the PCH. | |
| | Tier 1: PCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI and/or growth chart, and immunization record ; and updates this record as needed at each visit. |
| Measure 4 - Clinical Information Exchange: PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information. | |
| | Tier 3: PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange). |
| | Additional Measure: PCH demonstrates that it transmits data to patients’ electronic personal health records or provides an electronic means for patients to access their personal health information in real time (See also Access Measure #4). |
| <u>Standard: Geographic Continuity</u> | |
| Measure 5 - Specialized Care Settings: PCH tracks when its patients are cared for in specialized care settings and is actively involved during and after care in these settings. | |
| | Tier 1: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care. |
| | Tier 2: PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge. |
| | Additional Measure: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department. |

| | |
|--|--|
| Attribute #5: Coordination and Integration | |
| Patient Centered Language: “Help me navigate the health care system to get the care I need in a safe and timely way.” | |
| <u>Standard: Data Management</u> | |
| | Measure 1 - Population Data Management: PCH uses a system to organize, track and improve the care of sub-populations of its patients with specific care needs |
| | Tier 1: PCH demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients. |
| | Additional Measure: PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients. |
| | Measure 2 - Electronic Health Record: PCH has an electronic health record (EHR) and uses this tool to improve patient care. |
| | Tier 3: PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules. |
| <u>Standard: Care Coordination</u> | |
| | Measure 3 - Care Coordination: PCH assigns individual responsibility for care coordination for each patient to a member of the health care team. |
| | Tier 1: PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating his or her care. |
| | Tier 2: PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. |
| | Additional Measure: PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions. |
| | Measure 4 - Test and Result Tracking: PCH tracks laboratory and imaging tests and follows up on results. |
| | Tier 1: PCH demonstrates tracking tests ordered by its clinicians and ensures timely notification of results to patients and clinicians. |
| | Additional Measure: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians. |
| | Measure 5 - Referral and Specialty Care Coordination: PCH tracks and coordinates the care its patients receive outside the PCH. |
| | Tier 1: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians. |
| | Tier 1: PCH either manages hospital and skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings. |
| | Additional Measure: PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receive ongoing specialty care outside the PCH. |
| <u>Standard: Care Planning</u> | |
| | Measure 6 - Comprehensive Care Planning: PCH plans and coordinates care for its patients at the level of intensity indicated by each individual’s needs. |
| | Tier 1: PCH demonstrates that it can provide all patients with a written care summary that includes the following: current problem list, medication list and allergies, indicated preventive care, goals of preventive and chronic illness care. |
| | Tier 2: PCH demonstrates the ability to identify high-risk individuals who need and will benefit from additional care planning. |
| | Tier 3: PCH measures and demonstrates improvement in the percentage of high-risk individuals who have a written care plan that has been reviewed with the patient and/or caregivers in the past year. |
| | Measure 7 - End of Life Planning: The PCH offers end of life planning or counseling to patients who may benefit from these services. |
| | Tier 1: PCH documents offering patients the opportunity to complete a POLST form or advanced directive (when appropriate) and attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out). |
| | Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of patients age 65 or older who are offered the opportunity to complete a POLST. |

| AAP Medical Home Characteristics | NCQA PCMH 2011 Changes | Bright Futures Guidelines |
|--|--|--|
| <p>2.1: The medical home physician is known to the child or youth and family. 5.1: A plan of care is developed by the physician, child or youth, and family and is shared with other providers, agencies, and organizations involved with the care of the patient. 5.2: Care among multiple providers is coordinated through the medical home. 5.3: A central record or database containing all pertinent medical information, including hospitalizations and specialty care, is maintained at the practice. 5.4: The medical home physician shares info among the child and family and provides specific reason for referral to appropriate specialists. 5.6: When a child or youth is referred for a consultation or additional care, the med home physician assists the child, youth, and family in communicating clinical issues. 5.7: The med home physician evaluates and interprets the consultant's recommendations for the child and family and, in consultation with them and specialists, implements recommendations that are indicated and appropriate. 5.8: The plan of care is coordinated with educational and other community organizations to ensure that special health needs of the individual child are addressed.</p> <p>4.1: Care is delivered or directed by a well-trained physician who is able to manage and facilitate essentially all aspects of care. 4.6: The child's or youth's and family's medical, educational, developmental, psychological, and other service needs are identified and addressed. 4.8: Extra time for an office visit is scheduled for children with special health care needs, when indicated. 7.1: The child's or youth's and family's cultural background, including beliefs, rituals, and customs, are recognized, valued, respected, and incorporated into the care plan.</p> | <p>2D: Using Data for Population Management ✓ No major changes</p> <p>2A: Basic Data ✓ No major changes</p> <p>2B: Searchable Clinical Data Added: ✓ Documentation of screening results in the medical record ✓ Use of standardized codes Integration of data into patient record</p> <p>3D: Electronic Prescribing – New Element Clinicians in the practice write at least 75% of all prescriptions using electronic prescription reference information at the point of care: 1. Electronic system is integrated with the patients’ medical records 2. Electronic system connects to pharmacies, pharmacy benefit manager 3. Electronic system receives renewal requests electronically 4. Electronic system uses patient specific information to generate alerts at the point of care: drug-drug interactions, drug-disease interactions, drug-allergy alerts 5. Electronic system alerts prescriber to generic alternatives 6. Electronic system alerts prescriber to formulary status</p> <p>1G: Practice Organization Added: ✓ Regular team communication ✓ Team trained to coordinate care, in patient self-management, in population management, in communicating with vulnerable populations and in performance measurement and quality improvement</p> | <p>Theme: Promoting Family Support Theme: Promoting Community Relationships and Resources</p> |

Areas for Consideration:

- Adequate for CSHCN?
- Coordination with schools or early child development centers?
- Measure 7 Tier 2 (“percentage of patients 65 or older”) – other end of life considerations?

| | |
|--|---|
| Attribute #6: Person and Family Centered Care | |
| Patient Centered Language: "Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness." | |
| <u>Standard: Communication</u> | |
| | Measure 1 - Communication of Roles and Responsibilities: PCH communicates with its patients about the roles and responsibilities of the PCH and patients. |
| | Tier 1: PCH has a written document or other educational materials that outline PCH and patient roles and responsibilities and documents (e.g. through a patient signature) that this information has been communicated to each patient or a family member/caregiver |
| | Tier 2: PCH meets a benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities. |
| | Measure 2 - Interpreter Services: PCH communicates with patients in their language of choice. |
| | Tier 1: PCH documents the use of either providers who speak a patient's language or real time face-to-face or telephonic interpreters to communicate with patients in their language of choice. |
| <u>Standard: Education and Self-Management Support</u> | |
| | Measure 3 - Education and Self-Management Support: PCH offers education and self-management support to patients and their families and caregivers who would benefit from such services. |
| | Tier 1: PCH documents patient and family education and self-management support efforts, including available community resources. |
| | Additional Measure: PCH assesses patients' activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management. |
| | Additional Measure: PCH tracks and improves the percentage of patients with a particular chronic condition (e.g. diabetes) who have been offered education or self management support, including referral to community programs outside the PCH. |
| | Additional Measure: PCH demonstrates active follow up with patients regarding their self-management goals. |
| <u>Standard: Experience of Care</u> | |
| | Measure 4 - Patient Experience Survey: PCH regularly surveys its patients on their experience of care and uses this information to improve care. |
| | Tier 1: PCH surveys a sample of its patients at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family center |
| | Tier 2: PCH demonstrates using the results of its patient experience survey to improve care. |
| | Tier 3: PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics |

| AAP Medical Home Characteristics | NCQA PCMH 2011 Changes | Bright Futures Guidelines |
|---|--|---|
| 2.2: Mutual responsibility and trust exists between the patient and family and the medical home physician. 2.3: The family is recognized as the principal caregiver and center of strength and support for child. 2.5: Families and youth are supported to play a central role in care coordination. 2.6: Families, youth, and physicians share responsibility in decision making. 3.2: The family is recognized as the principal caregiver and center of strength and support for child. 4.5: The physician advocates for the child, youth, and family in obtaining comprehensive care and shares responsibility for the care that is provided. 5.5: Families are linked to family support groups, parent-to-parent groups, and other family resources. 6.1: Concern for the well-being of the child or youth and family is expressed and demonstrated in verbal and nonverbal interactions. 6.2: Efforts are made to empathize with the feelings and perspectives of the family as well as the child or youth. 7.2: All efforts are made to ensure that the child or youth and family understand the | 1E: Patient/Family Partnership – New Element ✓ Practice discusses with and distributes written information to patients and their families on the role of the medical home, including responsibilities of the practice and of the patient/family. 1F: Culturally and Linguistically Appropriate Services – New Element ✓ Practice engages in activities to understand and meet the cultural and linguistic needs of its patients. 4A: Self-Care Process ✓ Practice engages in activities to understand and meet the cultural and linguistic needs of its patients. 5D: Referrals to community resources – New Element ✓ The practice supports patients needing access to community resources. 2C: Comprehensive Health Assessment – New Element ✓ Practice conducts and documents a comprehensive health | Theme: Promoting Family Support Theme: Promoting Community Relationships and Resources |

| | | |
|---|--|--|
| <p>results of the medical encounter and the care plan, including provision of interpreters as needed. 7.3: Written materials are provided in the family's primary language.</p> | <p>assessment for all patients to understand their risks and needs of information. 6B: Patient/Family Feedback ✓ NCQA is working with the AHRQ CAHPS team to develop a Medical Home version of CAHPS Clinician and Group survey.</p> | |
|---|--|--|

Areas for Consideration:

- "I am ultimately responsible" wording
- Measure 3 adequately capture range of family supports?

| |
|--|
| Core Attribute: COORDINATION AND INTEGRATION |
| <p><i>Help me navigate the health care system to get the care I need in a safe and timely way.</i></p> <ul style="list-style-type: none"> • Make sure I understand what care or services I need to stay healthy and manage my medical and mental health problems and where to get them. • Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions. |
| <p>Standard: Data Management</p> <ul style="list-style-type: none"> • Follow my care closely and let me know when tests or checkups are needed. • Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health. |
| <p>Coordination Measure 1: Population Data Management</p> <p>PCH uses a system to organize, track and improve the care of sub-populations of its patients* with specific care needs (See also Coordination Measure #2).</p> <p>Tier 1: PCH demonstrates the ability to reliably identify, track and proactively manage** the care needs of a sub-population of its patients.</p> <p>Additional Measure: PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients.</p> <p>*PCHs may choose to create lists or registries of sub-populations based on a variety of conditions (e.g. diabetes or pregnancy) or demographic characteristics (e.g. children < age 1 or women).</p> <p>**Proactive management could be demonstrated through the use of a list or registry to track and improve care delivery through strategies such as care protocols and patient or clinician reminders.</p> |
| <p>Coordination Measure 2: Electronic Health Record</p> <p>PCH has an electronic health record (EHR) and uses this tool to improve patient care.</p> <p>Tier 3: PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules.</p> |
| <p>Standard: Care Coordination</p> <ul style="list-style-type: none"> • When I need to go to other providers or places for care or services, help me coordinate and plan my care without delays and confusion. • When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places. • Make sure I understand the reasons for sending me to a specialist or for a test, prepare me for what to expect and follow up with me afterwards to make sure I understand the results. |

| |
|--|
| Core Attribute: COORDINATION AND INTEGRATION |
| <p>Coordination Measure 3: Care Coordination</p> <p>PCH assigns individual responsibility for care coordination for each patient to a member of the health care team. Care coordination functions might include the following:</p> <ul style="list-style-type: none"> - coordination of care received outside the PCH and in specialized care settings - tracking of indicated care and tests - self management support and education - motivational interviewing and coaching on behavior change <p>Tier 1: PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating his or her care.</p> <p>Tier 2: PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.</p> <p>Additional Measure: PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions.</p> |
| <p>Coordination Measure 4: Test and Result Tracking</p> <p>PCH tracks laboratory and imaging tests and follows up on results.</p> <p>Tier 1: PCH demonstrates tracking tests ordered by its clinicians and ensures timely notification of results to patients and clinicians.</p> <p>Additional Measure: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians.</p> |
| <p>Coordination Measure 5: Referral and Specialty Care Coordination</p> <p>PCH tracks and coordinates the care its patients receive outside the PCH.</p> <p>Tier 1: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.</p> <p>Tier 1: PCH either manages hospital and skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings (See also Continuity Measure #5).</p> <p>Additional Measure: PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receive ongoing specialty care outside the PCH.</p> |
| <p>Standard: Care Planning</p> <ul style="list-style-type: none"> • Help me and my family set goals and plan for my care in a way that is understandable and meets my needs. • Provide me with the information I need to care for my own illness and challenge me to actively care for myself. |

Core Attribute: COORDINATION AND INTEGRATION

Coordination Measure 6: Comprehensive Care Planning

PCH plans and coordinates care for its patients at the level of intensity indicated by each individual's needs.

Tier 1: PCH demonstrates that it can provide all patients with a written care summary that includes the following:

- current problem list, medication list and allergies (See also Continuity Measure #3)
- indicated preventive care
- goals of preventive and chronic illness care

Tier 2: PCH demonstrates the ability to identify high-risk individuals* who need and will benefit from additional care planning. PCH demonstrates that it can provide these individuals with a written care plan that includes the following:

- self management goals
- goals of preventive and chronic illness care
- action plan for exacerbations of chronic illness (when appropriate)
- end of life care plans (when appropriate)

Tier 3: PCH measures and demonstrates improvement in the percentage of high-risk individuals* who have a written care plan that has been reviewed with the patient and/or caregivers in the past year.

* PCH practices should have the ability to define high-risk individuals within their patient population and target care planning activities to patients most likely to benefit, such as individuals at risk of a chronic illness exacerbation.

Coordination Measure 7: End of Life Planning

The PCH offers end of life planning or counseling to patients who may benefit from these services.

Tier 1: PCH documents offering patients the opportunity to complete a POLST form or advanced directive (when appropriate) AND attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out).

Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of patients age 65 or older who are offered the opportunity to complete a POLST.

| |
|---|
| Core Attribute: PERSON AND FAMILY CENTERED CARE |
| <p><i>Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.</i></p> <ul style="list-style-type: none"> • Listen to me and my family members or caregivers and promote experiences that enhance my independence and control over my health. • Respect my culture and values and build a relationship with me that is responsive to my needs and preferences. |
| <p>Standard: Communication</p> <ul style="list-style-type: none"> • Communicate in the language that my family members and I can understand. • Explain things in ways that make it easy for my family members and me to understand and check to be sure we understand. • Share information with me in an unbiased way. |
| <p>Person Measure 1: Communication of Roles and Responsibilities</p> <p>PCH communicates with its patients about the roles and responsibilities of the PCH and patients.</p> <p>Tier 1: PCH has a written document or other educational materials that outline PCH and patient roles and responsibilities and documents (e.g. through a patient signature) that this information has been communicated to each patient or a family member/caregiver. Educational materials should contain at least the following information: options for accessing care, names of primary care team members, information on care planning and care coordination and information on patient responsibilities.</p> <p>Tier 2: PCH meets a benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities.</p> |
| <p>Person Measure 2: Interpreter Services</p> <p>PCH communicates with patients in their language of choice.</p> <p>Tier 1: PCH documents the use of either providers who speak a patient’s language or real time face-to-face or telephonic interpreters to communicate with patients in their language of choice.</p> |
| <p>Standard: Education and Self-Management Support</p> <ul style="list-style-type: none"> • Respect my capacity to learn and engage me and my family members as partners in managing my health. • Help me know what I need to do to manage and maintain my health. • Invite me to set goals for improving my health and support my efforts to change my behavior to improve my health and wellness. |

| |
|--|
| <p>Core Attribute: PERSON AND FAMILY CENTERED CARE</p> |
| <p>Person Measure 3: Education and Self-Management Support</p> <p>PCH offers education and self-management support to patients and their families and caregivers who would benefit from such services. Education and self management support should include the following:</p> <ul style="list-style-type: none"> • information about basic diagnosis, prognosis, exacerbations and/or treatment of conditions • strategies for self-management of chronic conditions to change the course of illness and improve health • community or written resources or support group contacts (when appropriate). <p>Tier 1: PCH documents patient and family education and self-management support efforts, including available community resources.</p> <p>Additional Measure: PCH assesses patients' activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management.</p> <p>Additional Measure: PCH tracks and improves the percentage of patients with a particular chronic condition (e.g. diabetes) who have been offered education or self management support, including referral to community programs outside the PCH.</p> <p>Additional Measure: PCH demonstrates active follow up with patients regarding their self-management goals.</p> |
| <p>Standard: Experience of Care</p> <ul style="list-style-type: none"> • Regularly ask my family and me about our care experience. • Value our feedback and use this information to improve the way we work together. |
| <p>Person Measure 4: Patient Experience Survey</p> <p>PCH regularly surveys its patients on their experience of care and uses this information to improve care.</p> <p>Tier 1: PCH surveys a sample of its patients at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centeredness.</p> <p>Tier 2: PCH demonstrates using the results of its patient experience survey to improve care.</p> <p>Tier 3: PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics (See also Access Measure #1).</p> |