

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

**Meeting #3 Summary  
Friday, September 27, 3-5 p.m.  
Wilsonville Learning Center**

Committee members in attendance

Susan King (co-chair)  
Arthur Jaffe, MD  
Craig Hostetler, MHA  
Kara Williams  
Kelly Volkmann  
Liz McElhinny  
Weston Heringer, DMD

Committee members in attendance by phone

Bonnie Reagan, MD  
Frances Biagioli, MD  
Kathy Savicki  
Kelli Kennedy  
Marilyn Hartzell  
Regan Gray  
Robert Dannenhoffer, MD  
Tom Sincic, FNP  
Colleen Reuland (ex officio)

OHA/DHS liaisons in attendance

Walter Shaffer, MD

OHA/DHS liaisons in attendance by phone

Molly Emmons  
Katherine Bradley

OHPR staff in attendance

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

Members of the public

Jody Noon  
Resa Bradeen, MD

The meeting was convened by Susan King at 3 p.m. Welcome and introductions were completed. The minutes of meeting #2 were approved.

The committee moved to discussing revisions to Attributes 1-4 from the prior meeting. Dr. Jaffe brought up that BMI percentile should be included in the list of information within the medical record. The committee agreed and language will be changed to reflect this.

The committee discussed many of the measures having language around improving a certain percentage of a measure. The discussion concluded that where possible an external benchmark might be used however in general the improvement will be measured against historical data within the primary care home. OHPR also discussed how some of these operational details will be fleshed out during measurement phases.

Members of the committee requested further clarification on where these standards and measures will be used. OHPR clarified ultimately they will make up part of required information presented to the Health Policy Board. These standards will be the base, although may not be used verbatim, to guide payment reform to incentivize excellent care as specified in the Triple Aim. They will also be used to guide defining core functions of a patient centered home for various medical home demonstration projects around the state. In addition OHPR stressed that these are not a final product, but a step within a process of reforming care in the state, and as such will be refined and changed over time.

Colleen Reuland clarified that within the Accountability standard, preventive service indicator should be at least one of the clinical improvement indicators, and in addition patient input in some capacity should shape the quality improvement processes.

Dr. Hartzell stressed that, within the access standard, children with special health care needs have unique needs and accordingly need longer appointments, or more coordinated appointments, to provide optimal care. The committee decided existing language on improving in-person access is broad enough to capture this need however it will be called out within the guiding principles section of the document.

The committee felt strongly immunizations need to be part of a pediatric primary care home. OHPR discussed how the prior committee went down the road of spelling out certain preventive measures and eventually moved away from a laundry list approach to the existing language. The committee concluded that the existing language of preventive services captures immunizations, and the importance of providing or coordinating immunizations should be specified in the document.

#### Attribute #5 - Coordination and Integration

The committee felt broadening the language around identifying subpopulations was needed. The committee felt some mechanism that allows a primary care how to identify and group data within the practice is important and a first step prior to defining subpopulations with special care needs. This may be feasible with an EHR, but is not required in any Tier 1 measures to allow practices to become primary care homes without the substantial upfront investment in an EHR.

#### Care Coordination

The committee discussed whether care coordination should apply to all children, or just some children with increased care needs. There was an additional concern with how this would be measured. The committee decided that coordination of care should occur regardless of level of need of coordination. This may be more in-depth coordination for children with special health care needs, or may be as simple as ensuring parents know when the next immunizations are due. The document purposefully does not specify who must provide the care coordination in order to facilitate innovative ways of providing care. The committee also discussed whether responsibility should be spelled out in the document; some felt a team member should not be held accountable for noncompliance, and others felt one person should be considered responsible in order to provide better care and prevent amorphous care coordination with

families falling through the cracks. In addition the committee felt care and coordination should take place within the scope of practice of the care provider.

The committee felt primary care homes should have in place a system to make test results available, in a secure way, and interpret those results where possible.

The committee felt referral and specialty care coordination should also be broadened to community settings such as Head Start and schools in order to facilitate communication. A discussion was held on the balance between provider and specialty care settings' responsibility for communication.

The committee wanted to clarify measures around care summaries. The committee felt the care summary should be developed in concert with families, and should be geared to the level of care needed by the patient.

The committee felt end of life planning and care should involve counseling, or the process of referring for counseling, regarding options as well as filing out POLST forms where appropriate.

#### Attribute 6 – Person and Family Centered Care

The committee felt the communication standard should be revised to reflect measures denoting a one-time information exchange on patient responsibilities and how the primary care home functions. Where feasible the committee felt patients should receive written materials in the language of their choice.

#### Public Comment:

Dr. Resa Bradeen, medical director the Children's Health Alliance, presented public comment. Dr. Bradeen applauded the committee's work to develop a pediatric primary care home and recognition of the different facilities compared to adult needs. Dr. Bradeen mentioned concern that the key drivers of the Health Policy Boards' Triple Aim are different for children, and that the committee must strive to avoid increasing provider burden with increased costs without demonstrating improvement in outcomes. Dr. Bradeen also voiced concern that the committee's process and timeline seemed truncated if it was part of the state CHIPRA grant recently awarded to Oregon in cooperation with other states.

OHPR discussed that the CHIPRA grant is separate from this process, and has different goals in addition to implementing pediatric primary care home pilot projects on a small scale. The eventual goal of the state is that every patient will have a primary care home. The next steps will be defining the technical detail of how to measure, implement, and evaluate a primary care home.

The meeting was adjourned at 5 p.m.