

**Patient Centered Primary Care Home Program - Standards Advisory Committee
Meeting #7**

800 NE Oregon Street Portland, Room 918 (9th floor)

Thursday, January 28, 2010

1:00 – 2:30 pm

Agenda

- 1:00 Approval of Meeting #6 Summary - (Bart)
- 1:05 Discussion of Guiding Principles - (Bart)
- 1:30 Discussion of PCPCH Measures – (Bart)
- 2:00 Public Comment
- 2:30 *Adjourn*

Exhibit Materials:

1. Draft Agenda
2. Meeting #6 Summary
3. Overview of Draft PCPCH Measures 1.26 - Table
4. Revised Draft PCPCH Standards and Measures 1.26 - Table
5. Guidance to PCPCH Measures Revisions
6. Draft Guiding Principles for PCPCH Application

**Patient Centered Primary Care Home Program - Standards Advisory Committee
Meeting #6 Summary**

Friday, January 22, 2010
2:00-5:00pm

Committee Members in Attendance

J. Bart McMullan, Jr, MD (chair)
Mitchell Anderson (co-chair)
James Beggs, MD (phone)
Karen Erne, PHR, MA
Craig Hostetler
Arthur Jaffe, MD
Susan King, RN
Carolyn Kohn
Robert Law, MD (phone)
Mary Minniti, CPHQ
Melinda Muller, MD, FACP
Carole Romm, MPA, RN
Glenn Rodriguez, MD
David Dorr, MD, MS (ex officio)
David Pollack, MD (ex officio)
John Saultz, MD (ex officio)

OHPR Staff in Attendance

Jeanene Smith
Rob Stenger
Lisa Angus

Committee Members Not in Attendance

David Labby, MD
Tom Syltebo, MD
Chuck Kilo, MD, MPH (ex officio)
Barney Speight (ex officio)
Jane-Ellen Weidanz (ex officio)

Public Comment

6 members of the public signed in. No individuals offered public comment.

Meeting Summary (**Committee actions in bold**)

Meeting convened at 2pm by Dr. McMullan.

Committee approved the Meeting #5 Summary

Rob Stenger, OHPR provided an overview of proposed Federal rules for Meaningful Use of Electronic Health Records (EHR) and the overlap of these rules with the Primary Care Home Standards and Measures under discussion by the committee. Key points included:

- Meaningful use rules include significant per-provider financial incentives for Medicaid or Medicare providers who demonstrate meaningful EHR use before 2015, with the greatest benefit for providers who demonstrate meaningful use starting in 2011.
- Meaningful use rules are structured in three stages, with expected progression from stage 1 to stage 3 over a period of 3-5 years. Stage 1 measures focus primarily on demonstration of EHR processes and functions, Stage 2 and 3 measures focus primarily on outcomes.
- A number of measures proposed within the meaningful use rules, such as medication reconciliation, capability to produce disease-based registries and organization of clinical information have also been considered by the committee as possible measures.

The Committee discussed proposed measures 1-7 under the Coordination and Integration Core Attribute. Key discussion points included:

- Registries and Data Management Measures
 - o Consider changing the measure name of measure 1 from “registries” to “population management systems” or another name
 - o Registries are a core primary care home function that should occur even if a practice doesn’t have this function through an Electronic Health Record
 - o Tier 1 Registry Measure should specify that registries are accurate verifiable lists of sub-populations within a practice, and may be organized around demographic or disease based factors.
 - o Tier 2 Registry Measure should require demonstration of the core registry functions of tracking and proactive management or intervention.
 - o Change the name of Measure #2 to Electronic Health Records.
 - o There was general consensus on keeping the EHR measure and aligning this measure with Federal meaningful use rules.
- Care Coordination Measures
 - o There was general consensus that the goal of measure #3 should be the demonstration of a single point of responsibility/accountability for care coordination functions, but that practices could meet this goal without having a specific individual designated as a “care coordinator.”
 - o Higher level measures of the care coordinator function should specify additional steps taken to coordinate care for patients with complex care needs.
 - o “behaviorist” functions should be clarified as motivational interviewing and coaching
 - o Test and result tracking was recognized as an important measure, and the committee noted that other aspects of this area, such as eliminating repeated tests and providing patients with electronic access to results are contained in other measures.
 - o Referral and specialty care tracking was recognized as an important measure. The committee discussed the need for additional language to clarify the importance of involving the patient and family in care planning with specialists and tracking referral to community-based programs.

- The committee also noted the possible need for an additional measure to include engagement and communication of the PCH team when patients are cared for in hospital and nursing home settings. Coordination of hospital and nursing home care is not adequately addressed by measures under continuity.
- Care Planning Measures
 - There was general consensus that some level of care planning is important for all patients, but there are certain “at risk” or “unstable” patients for whom more comprehensive planning and documentation is needed.
 - Intensity of care planning does not necessarily correlate with the # of chronic conditions, clinics need to be able to determine who needs a higher intensity of services.
 - Care planning should focus on collaborative goal setting and monitoring of whether goals are met at more advanced levels of PCH functioning.
 - Committee agreed that end of life planning is an important measure and that clinics should offer these services to patients.
 - Recommend changing language to “appropriate” patients, rather than patients over 65 for the tier 1 of measure 7.
 - Recommend limiting the tier 2 measure to POLST only.

The Committee discussed proposed measures 1-4 under the Person and Family Centered Care Continuity Core Attribute. Key discussion points included:

- Communication Measures
 - There was general consensus that patients and clinicians need to understand their mutual roles and responsibilities with regards to the PCH.
 - Consider adding coordination of care to the elements contained in the primary care home agreement.
 - Most of the committee favored requiring clinics and patients to sign some document as a verification that a conversation about roles and responsibilities occurred. Most also agreed that this information needs to be recorded in some “trackable” way outside a chart note.
 - On interpreter services, committee members clarified that a provider speaking directly in the patient’s preferred language would meet this standard and also recommended that clinics should be required to document patients’ primary language.
 - Several committee members recommended a standardized assessment of either health literacy or preferred learning style as an advanced measure of communication.
- Education and Self-Management Support
 - The committee generally agreed that this is an important area for measurement.
 - Recommend broadening the measure to include any patients who may benefit (rather than just chronic conditions)... this should be a larger group than those who need intensive care coordination.
 - Recommend including family and caregivers.
 - Recommend requiring follow up of education and self management efforts at higher “tiers” of this measure.
 - Consider adding a standardized measure of patient readiness to change as an advanced measure of education and self management support.
 - Consider changing self management training to “coaching” or “support.”

- Experience of Care Measures
 - o This measure is important, make sure categories of questions broadly reflect all PCH functions.
 - o Consider revising the tiers of this measure as follows: Tier 1 – survey pts at least yearly; Tier 2 – demonstrate using data to improve care; - Tier 3 collect pt experience data in a standardized way that can be compared across clinics.

In addition to the discussion on specific measures above, the committee made the following general recommendations about proposed PCH measures.

- Cross-reference important areas of overlap, for example registries and EHR meaningful use or care coordination and self management support.
- Consider the following “parking lot” issues in further revision of the proposed PCH measures:
 - o How to measure and document cultural competency.
 - o Organization and accuracy of clinical information (problem lists, medication lists, allergies, demographic information, emergency contacts and medical decision-makers, etc.)
 - o How to interface the PCH with mental health and addiction services.
 - o Ensuring care coordination across all care settings.
 - o How to measure knowledge of patient context (social history).

The committee briefly discussed the Guiding Principles for PCH Implementation. Committee members agreed to send recommended edits and comments on this document to OHP staff and review at the next committee meeting.

Dr. McMullan adjourned the meeting at 5:00pm.

The Final scheduled Committee meeting is:

Thursday, January 28, 2010 (#7 – Final Wrap up and Public Comment)

1:00 – 2:30 pm

PSOB, Room 918 (9th floor)

800 NE Oregon Street

Portland, OR

Overview of Draft PCPCH Measures by Tier

REQUIRED Tier 1 Primary Care Home (PCH) Measures

Access to Care	<p><u>Appointment Access</u>: PCH tracks and reports a standard measure of appointment access.</p> <p><u>After Hours Appointments</u>: PCH offers appointments at least 4 hours weekly outside traditional business hours.</p> <p><u>Telephone Advice</u>: PCH provides continuous access to clinical advice by telephone.</p>
Accountability	<p><u>Performance Improvement</u>: PCH tracks at least three performance indicators* and reports goals for improvement.</p>
Comprehensive Whole Person Care	<p><u>Preventive Services</u>: PCH reports, using a checklist, that it offers a certain percentage of recommended preventive services.</p> <p><u>Medical Services</u>: PCH reports that it routinely offers all of the following categories of services: acute care, chronic care, office procedures, patient education, and end of life counseling.</p> <p><u>Mental Health and Substance Abuse Services</u>: PCH documents its screening strategy for mental health and substance use conditions AND documents on-site and local referral resources.</p> <p><u>Health Risk Behavior Assessment and Intervention</u>: PCH documents routine assessment and intervention for at least three health risk behaviors.</p>
Continuity	<p><u>Personal Clinician Assignment</u>: PCH reports the percentage of active patients assigned a personal clinician and team.</p> <p><u>Personal Clinician Continuity</u>: PCH reports how often patients see their personal clinician or a team member.</p> <p><u>Organization of Clinical Information</u>: PCH maintains a health record containing certain elements that is updated at each visit.</p> <p><u>Specialized Care Settings</u>: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care.</p>
Coordination and Integration	<p><u>Population Data Management</u>: PCH demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients.</p> <p><u>Care Coordination</u>: PCH assigns individual responsibility for care coordination for each patient to a member of the health care team.</p> <p><u>Test and Result Tracking</u>: PCH demonstrates tracking tests ordered by its clinicians and ensures timely notification of results to patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH either manages hospital and nursing facility care or demonstrates active involvement and coordination of care when its patients receive care in these specialized settings.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates that it can provide all patients with a written care summary.</p> <p><u>End of Life Planning</u>: PCH documents offering patients the opportunity to complete a POLST form or advanced directive</p>

Overview of Draft PCPCH Measures by Tier

	(when appropriate) AND attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out).
Person and Family Centered Care	<p><u>Communication of Patient and PCH Expectations</u>: PCH educates patients about PCH and patient roles and responsibilities.</p> <p><u>Interpreter Services</u>: 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><u>Education and Self Management Support</u>: PCH documents patient and family education and self-management training efforts, including available community resources.</p> <p><u>Patient Experience Survey</u>: PCH surveys a sample of its patients at least annually on their experience of care for each PCH core attribute.</p>

Overview of Draft PCPCH Measures by Tier

REQUIRED Tier 2 Primary Care Home (PCH) Measures

Access to Care	<p><u>Appointment Access</u>: PCH sets a specific goal for improving an appointment access measure and demonstrates improvement.</p>
Accountability	<p><u>Performance Improvement</u>: PCH demonstrates improvement towards its reported goals on at least three performance indicators.</p> <p><u>Public Reporting</u>: PCH publically reports practice-level clinical quality indicators to an external entity.</p>
Comprehensive Whole Person Care	<p><u>Mental Health and Substance Abuse Services</u>: PCH documents direct collaboration or co-management of patients with a specialty mental health and substance abuse provider.</p>
Continuity	<p><u>Personal Clinician Assignment</u>: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.</p> <p><u>Personal Clinician Continuity</u>: PCH meets a benchmark or demonstrates improvement in patients' usual provider continuity with their assigned personal clinician and team.</p> <p><u>Specialized Care Settings</u>: PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge.</p>
Coordination and Integration	<p><u>Care Coordination</u>: PCH describes its process for identifying and coordinating the care of patients with complex care needs.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates the ability to identify high risk individuals and that it can provide these individuals with a written care plan containing specific elements.</p> <p><u>End of Life Planning</u>: 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.</p>
Person and Family Centered Care	<p><u>Communication of Patient and PCH Expectations</u>: PCH meets benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities.</p> <p><u>Patient Experience Survey</u>: PCH demonstrates using the results of its patient experience survey to improve care.</p>

Overview of Draft PCPCH Measures by Tier

REQUIRED Tier 3 Primary Care Home (PCH) Measures

Access to Care	<u>Appointment Access</u> : PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to appointments on a patient experience survey.
Accountability	<u>Clinical Quality Improvement</u> : PCH demonstrates improvement in a certain number of clinical quality indicators. PCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement.
Comprehensive Whole Person Care	<u>Mental Health and Substance Abuse Services</u> : PCH documents actual or virtual co-location with specialty mental health and substance abuse providers.
Continuity	<u>Clinical Information Exchange</u> : PCH shares clinical information electronically in real time with other health care providers.
Coordination and Integration	<u>Electronic Health Record</u> : PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules. <u>Comprehensive Care Planning</u> : PCH measures and demonstrates improvement in the percentage of high risk individuals with a written care plan that has been updated in the past year.
Person and Family Centered Care	<u>Patient Experience Survey</u> : PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics.

Overview of Draft PCPCH Measures by Tier

Additional Primary Care Home (PCH) Measures

Access to Care	<p><u>After Hours Appointments</u>: PCH offers appointments 8 or more hours weekly outside traditional business hours.</p> <p><u>Telephone Advice</u>: Telephone encounters (including after hours) are documented in the patient’s medical record.</p> <p><u>Telephone Advice</u>: PCH tracks and improves the time required to resolve telephone requests for clinical advice.</p> <p><u>Electronic Access</u>: PCH provides at least one option for electronic access, such as e-mail or a “web portal.”</p> <p><u>Prescription Refills</u>: PCH tracks the percentage of prescription refill requests completed within 48 hours and meets a benchmark or demonstrates improvement in this percentage over time.</p>
Accountability	<p><u>Ambulatory Sensitive Utilization</u>: 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.</p>
Comprehensive Whole Person Care	<p><u>Health Risk Behavior Assessment and Intervention</u>: PCH documents improvement in its rates of intervention for a given health risk behavior (e.g. increase in referral rates for alcohol treatment among documented users).</p> <p><u>Health Risk Behavior Assessment and Intervention</u>: PCH documents reduction of the percentage of its patients with a given health risk behavior over time (e.g. decrease in the percentage of active smokers).</p>
Continuity	<p><u>Clinical Information Exchange</u>: 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.</p> <p><u>Specialized Care Settings</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.</p>
Coordination and Integration	<p><u>Population Data Management</u>: 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><u>Care Coordination</u>: 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><u>Test and Result Tracking</u>: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receiving ongoing specialty care outside the PCH.</p>
Person and Family Centered Care	<p><u>Education and Self Management Support</u>: PCH assesses patients’ activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management.</p> <p><u>Education and Self Management Support</u>: 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><u>Education and Self Management Support</u>: PCH demonstrates active follow up with patients regarding their self management goals.</p>

Patient Centered Primary Care Home Program - Standards Advisory Committee
 Proposed Standards and Measures – Detail

Required Measures – essential primary care home (PCH) element – required for recognition and payment as a PCH.

Additional Measures – important primary care home (PCH) element - not required for recognition, but PCHs could earn enhanced payment by meeting these additional measures.

Measure and Description – Access to Care
<p>ACCESS TO CARE – Be there when I need you.</p> <ul style="list-style-type: none"> • Make it easy for me to get care and advice when I need and want it for myself and my family members. • Provide flexible, responsive options for me to get care in a timely way.
<p>Standard: In-Person Access</p> <ul style="list-style-type: none"> • Make sure I can quickly and easily get an appointment with someone who knows me and my family. • Ensure that office visits are well-organized and run on time.
<p>Access Measure 1: Appointment Access</p> <p>PCH tracks and improves access to appointments in the clinic and patient satisfaction with appointment access.</p> <p>Tier 1 (REQUIRED): PCH tracks and reports a standard measure of appointment access.</p> <p>Tier 2 (REQUIRED): PCH sets a specific goal for improving an appointment access measure and demonstrates improvement.</p> <p>Tier 3 (REQUIRED): PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to appointments on a patient experience survey.</p>
<p>Access Measure 2: After Hours Appointments</p> <p>PCH offers appointments outside of traditional business hours (8:00am - 5:00pm, M-F).</p> <p>Tier 1 (REQUIRED): PCH offers appointments at least 4 hours weekly outside traditional business hours.</p> <p>Additional Measure: PCH offers appointments 8 or more hours weekly outside traditional business hours.</p>
<p>Standard: Telephone and Electronic Access</p> <ul style="list-style-type: none"> • Make sure I know what to do if I need or want help when your office is closed. • Provide multiple ways for me to easily get care or advice outside of office visits.

Measure and Description – Access to Care
<p>Access Measure 3: Telephone Advice</p> <p>PCH provides telephone access to a clinician for advice 24 hours a day and tracks and improves telephone care.</p> <p>Tier 1 (REQUIRED): PCH provides continuous access to clinical advice by telephone.</p> <p>Additional Measure: Telephone encounters (including after hours encounters) are documented in the patient’s medical record.</p> <p>Additional Measure: PCH tracks and improves the time required to resolve telephone requests for clinical advice.</p>
<p>Access Measure 4: Electronic Access</p> <p>PCH provides an option for patients to access care, clinical advice and test results in an electronic format.</p> <p>Additional Measure: PCH provides at least one option for electronic access, such as secure e-mail or a secure “web portal.”</p>
<p>Standard: Administrative Access</p> <ul style="list-style-type: none"> Respond to my requests for help with refills, paperwork, etc. in the most efficient way possible to meet my needs.
<p>Access Measure 5: Prescription Refills</p> <p>PCH responds promptly to patient requests for prescription refills.</p> <p>Additional Measure: PCH tracks the percentage of prescription refill requests completed within 48 hours and meets a benchmark or demonstrates improvement in this percentage over time.</p>

Measure and Description - Accountability
ACCOUNTABILITY – Take responsibility for making sure I receive the best possible health care.
<p>Standard: Performance Improvement</p> <ul style="list-style-type: none"> • Work to improve the care and services you provide and ask me for feedback and ideas about what to improve. • Publicly report information about the safety, quality and cost of the care you provide. • Show me what you are doing to ensure I will get the right care while avoiding unnecessary care.
<p>Accountability Measure 1: Performance Improvement</p> <p>PCH measures its own performance, sets internal goals and improves its care over time.</p> <p>Tier 1 (REQUIRED): PCH tracks at least three performance indicators* and reports goals for improvement.</p> <p>Tier 2 (REQUIRED): PCH demonstrates improvement towards its reported goals on at least three performance indicators.</p> <p>*Performance indicators could be defined by the PCH across a range of domains, such as clinical processes, clinical outcomes or patient or staff satisfaction.</p>
<p>Accountability Measure 2: Clinical Quality Improvement</p> <p>PCHs improve clinical quality indicators* in their patient population.</p> <p>Tier 3 (REQUIRED): PCH demonstrates improvement in a certain number of clinical quality indicators. PCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement.</p> <p>* PCHs should have the ability to select quality measures most relevant to their patient population from a pre-established statewide set of nationally accepted quality measures.</p>
<p>Accountability Measure 3: Public Reporting</p> <p>PCH participates in a program of voluntary public reporting of practice-level clinical quality indicators (e.g. reporting of performance indicators to a health plan, Medicare or Medicaid, the State, or the Oregon Quality Corporation).</p> <p>Tier 2 (REQUIRED): PCH publicly reports practice-level clinical quality indicators to an external entity.</p>
<p>Standard: Cost and Utilization</p> <ul style="list-style-type: none"> • Keep me informed about the relative costs, benefits and risks of the different options for my care so I can make informed decisions. • Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve my quality of life.

Measure and Description - Accountability

Accountability 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.

* PCHs should have the ability to select utilization measures most relevant to their patient population from a pre-established set of utilization measures. Examples of utilization measures could include: ER visits (total or among high users), re-admissions, admissions for ambulatory sensitive conditions, hospital bed days/1000 patients, high cost imaging, duplicated tests, generic medication prescribing.

Measure and Description – Comprehensive Whole Person Care
<p>COMPREHENSIVE WHOLE PERSON CARE – Provide or help me get the health care and services I need.</p> <ul style="list-style-type: none"> • Help me get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use. • Help me understand my health risks and/or conditions and give me tools and support to manage my own care.
<p>Standard: Scope of Services</p> <ul style="list-style-type: none"> • Provide most of the care I need for common problems at your clinic.
<p>Comprehensive Measure 1: Preventive Services</p> <p>PCH offers most age and gender appropriate preventive services, including the following: USPSTF recommended services, ACIP recommended vaccinations and developmental screening in infancy and early childhood.</p> <p>Tier 1 (REQUIRED): PCH reports, using a checklist, that it offers a certain percentage of recommended preventive services.</p>
<p>Comprehensive Measure 2: Medical Services</p> <p>PCH offers a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible.</p> <p>Tier 1 (REQUIRED): PCH reports that it routinely offers all of the following categories of services:</p> <ul style="list-style-type: none"> ▪ Acute care for minor illnesses and injuries ▪ Ongoing management of chronic diseases ▪ Office-based procedures and diagnostic tests ▪ Patient education and self-management support ▪ Advice and counseling on end of life issues (adult only)
<p>Comprehensive Measure 3: Mental Health and Substance Abuse Services</p> <p>PCH routinely offers care for mental health and substance use disorders, including all of the following: screening, diagnosis, management and appropriate referral to specialty services.</p> <p>Tier 1 (REQUIRED): PCH documents its screening strategy for mental health and substance use conditions AND documents on-site and local referral resources.</p> <p>Tier 2 (REQUIRED)**: PCH documents direct collaboration or co-management of patients with specialty mental health and substance abuse providers.</p> <p>Tier 3 (REQUIRED)**: PCH documents actual or virtual co-location with specialty mental health and substance abuse providers.</p> <p>** Practices could be exempt from Tier 2 and 3 measures if a shortage of mental health providers or services exists within their geographic area or for their patient population.</p>

Measure and Description – Comprehensive Whole Person Care

Comprehensive Measure 4: Health Risk Behavior Assessment and Intervention
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The PCH routinely assesses common health risk behaviors in its population and offers interventions to support behavior change. Examples of common health risk behaviors include, but are not limited to: alcohol or drug use, tobacco use, obesity, physical inactivity, injury or violence, nutrition and sexual risk behaviors.

Tier 1 (REQUIRED): 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 (e.g. increase in referral rates for alcohol treatment among documented users).
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Additional Measure: PCH documents reduction of the percentage of its patients with a given health risk behavior over time (e.g. decrease in the percentage of active smokers).

Measure and Description - Continuity
<p>CONTINUITY – Be my partner over time in caring for my health.</p> <ul style="list-style-type: none"> • Let me choose my personal clinician. • Know who I am and remember important information about my health history, needs and values. • Help me make well-informed decisions about my health and health care.
<p>Standard: Provider Continuity</p> <ul style="list-style-type: none"> • Make sure I can choose a personal clinician and health care team who know and understand me. • Make sure I can see or talk with my chosen personal clinician or team whenever I need to.
<p>Continuity Measure 1: Personal Clinician Assignment</p> <p>The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle.</p> <p>Tier 1 (REQUIRED): PCH reports the percentage of active patients assigned a personal clinician and team.</p> <p>Tier 2 (REQUIRED): PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.</p>
<p>Continuity Measure 2: Personal Clinician Continuity</p> <p>The PCH tracks and seeks to improve patients' continuity with their chosen personal clinician and primary care team.</p> <p>Tier 1 (REQUIRED): PCH reports how often patients see their personal clinician or a team member.</p> <p>Tier 2 (REQUIRED): PCH meets a benchmark or demonstrates improvement in patients' usual provider continuity* with their assigned personal clinician and team.</p> <p>* Usual Provider Continuity = total clinic visits/visits with personal clinician or a team member.</p>
<p>Standard: Information Continuity</p> <ul style="list-style-type: none"> • Make sure that all health professionals caring for me have access to up-to-date and accurate information about my health history and values. • Ensure that my personal health information is always protected and kept private. • Make it easy for me to access my personal health information.

Measure and Description - Continuity
<p>Continuity Measure 3: Organization of Clinical Information</p> <p>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.</p> <p>Tier 1 (REQUIRED): PCH maintains a paper or electronic health record 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.</p>
<p>Continuity Measure 4: Clinical Information Exchange</p> <p>PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information.</p> <p>Tier 3 (REQUIRED): PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange).</p> <p>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.</p>
<p>Standard: Geographic Continuity</p> <ul style="list-style-type: none"> Stay involved in my care wherever I go within the health care system, and help me to coordinate my care across places and people.
<p>Continuity Measure 5: Specialized Care Settings</p> <p>PCH tracks when its patients are cared for in specialized care settings (e.g. hospital, nursing facility or other residential treatment) and is actively involved during and after care in these settings.</p> <p>Tier 1 (REQUIRED): PCH has a written agreement with its usual hospital providers or directly provides routine hospital care.</p> <p>Tier 2 (REQUIRED): PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge.</p> <p>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.</p>

Measure and Description – Coordination and Integration
<p>COORDINATION AND INTEGRATION – Help me navigate the health care system to get the care I need in a safe and timely way.</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.</p> <p>Tier 1 (REQUIRED): 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 (REQUIRED): 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.

<p>Measure and Description – Coordination and Integration</p> <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"> - tracking of indicated care and tests - self management support and education - motivational interviewing and coaching on behavior change - coordination of care received outside the PCH and in specialized care settings <p>Tier 1 (REQUIRED): 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 (REQUIRED): PCH describes 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.</p> <p>Tier 1 (REQUIRED): 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 (REQUIRED): 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 (REQUIRED): 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.</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.

<p>Measure and Description – Coordination and Integration</p>
<p>Coordination Measure 6: Comprehensive Care Planning</p> <p>PCH plans and coordinates care for its patients at the level of intensity indicated by each individual's needs.</p> <p>Tier 1 (REQUIRED): PCH demonstrates that it can provide all patients with a written care summary that includes the following:</p> <ul style="list-style-type: none"> - indicated preventive care - goals of preventive and chronic illness care <p>Tier 2 (REQUIRED): 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 including the following:</p> <ul style="list-style-type: none"> - 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) <p>Tier 3 (REQUIRED): 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.</p> <p>* 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.</p>
<p>Coordination Measure 7: End of Life Planning</p> <p>The PCH offers end of life planning or counseling to patients who may benefit from these services.</p> <p>Tier 1 (REQUIRED): 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).</p> <p>Tier 2 (REQUIRED): 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.</p>

Measure and Description – Person and Family Centered Care
<p>PERSON AND FAMILY CENTERED CARE – Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.</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 I to understand and check to be sure we understand. • Share information with me in an unbiased way.
<p>Person Measure 1: Communication of Patient and PCH Expectations</p> <p>PCH communicates with its patients about the roles and responsibilities of the PCH and patients.</p> <p>Tier 1 (REQUIRED): 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 (REQUIRED): 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 (REQUIRED): 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>Measure and Description – 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 (REQUIRED): 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 (REQUIRED): 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 (REQUIRED): PCH demonstrates using the results of its patient experience survey to improve care.</p> <p>Tier 3 (REQUIRED): PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics.</p>

Changes to Standards/Measures

I recommend using this as a companion document as you review the revised standards and measures table.

General Measurement Approach

In prior drafts, all measures appeared as required. To respond to committee members' concerns about the flexibility of such an approach and the desire to reward incremental improvements in care at any level, the following modifications were made.

1. Specification of a smaller number of REQUIRED measures at each Tier.
2. Creation of a category of "additional" measures.

Additional measures should not be seen as "optional." This approach will allow flexibility in how the PCH measures could be applied as payment models are developed. Assuming that there will be some form of "base" payment for a PCH meeting each tier, a payer could choose to utilize the additional measures in the following ways:

- Provide incremental additional payments for PCHs meeting additional measures
- Require that a PCH meet a certain percentage of additional measures to qualify for payment at each tier.

A similar approach is used within the NCQA measurement framework and the payment models used in several state medical home demonstrations.

Access to Care

Measure 1 - Appointment Access

- Eliminated specific access measures (allows flexibility at the practice level)
- Added a tier 2 measure, requiring a practice to demonstrate improvement
- Added a tier 3 measure, requiring a practice to improve or meet a benchmark of patient satisfaction with access to care (comparable across practices)
- This would be a REQUIRED measure at all three tiers.

Measure 2 – After Hours Appointments

- Added this measure.
- This would be a REQUIRED tier 1 measure, with additional measures available.

Measure 3 – Telephone Advice

- Added additional measures for documenting telephone encounters and tracking/improving the time required to resolve requests for telephone advice. 24/7 Access to telephone advice would be a REQUIRED tier 1 measure.

Measure 4 – Electronic Access

- Added this as an additional measure of enhanced access to care.

Measure 5 – Prescription Refills

- Revised this measure to reflect refills only, as a proxy for other administrative functions.

Accountability

- Modified core attribute language for accountability and standard language for performance improvement.

Measure 1 – Performance Improvement

- Changed measure name from “performance indicator tracking” to “performance improvement”
- Increased the number of indicators required for Tier 1 and included goal setting/reporting.
- Added “demonstrates improvement towards goals” as a Tier 2 measure.
- Tier 1 and Tier 2 measures would be REQUIRED.

Measure 2 – Clinical Quality Improvement

- Changed measure title from “clinical performance reporting” to “clinical quality improvement”
- Added language specifying that clinics could select measures most relevant to their patient population from a common measure set.
- This measure would be REQUIRED for tier 3.

Measure 3 – Public Reporting

- Changed measure name from “clinical performance reporting” to “public reporting.”
- Listed examples of entities to which a practice could report clinical quality indicators.
- Specified that only practice-level clinical data would be reported (as opposed to provider level).
- This would be a REQUIRED tier 2 measure.

Measure – Point of Care Decision Support

- This measure was eliminated. Certain aspects of decision support such as required under Federal “meaningful use” rules (see coordination measure 2).

Measure 4 – Ambulatory Sensitive Utilization

- Added language on effective care management and reductions in utilization.

Measure – Cost of Care

- This measure was deleted. Language on accountability for health care costs will be added to the guiding principles for implementation. It was the general sense of the

Accountability working group that it would be easiest to start with utilization measures and phase in cost over time.

Comprehensive Whole Person Care

Measure 1 – Preventive Services

- Added childhood developmental screening to this measure and specified that a PCH should offer (not provide) comprehensive preventive services.
- This would be a REQUIRED Tier 1 measure.

Measure 2 – Medical Services

- Replaced the checklist of services with a simple list of service categories and specified that a PCH should offer (not provide) comprehensive medical services.
- This would be a REQUIRED Tier 1 measure.

Measure 3 – Mental Health and Substance Abuse Services

- Added language broadening the scope of services beyond screening and referral (diagnosis and management).
- Removed language on specific screening tools.
- Added Tier 2 and Tier 3 measures on integration of MH services (direct collaboration and actual or virtual co-location with MH specialists).
- This would be a REQUIRED measure at all tiers.

Measure 4 – Health Risk Behavior Assessment and Intervention

- Broadened the REQUIRED tier 1 measure to require routine assessment and intervention for at least three health risk behaviors.
- Added additional outcome measures for practices that demonstrate improvement in intervention rates or reduce rates of health risk behaviors in their patient population.

Continuity

Measure 1 – Personal Clinician Assignment

- Added language about assignment to a personal clinician and team
- These would be REQUIRED measures at tier 1 and tier 2.

Measure 2 – Personal Clinician Continuity

- Added language about tracking continuity with a patient's assigned personal clinician and team.
- These would be REQUIRED measures at tier 1 and tier 2.

Measure 3 – Organization of Clinical Information

- Added this REQUIRED Tier 1 measure specifying that the PCH maintain an accurate, up-to-date health record containing common data elements (e.g. problem list).

Measure 4 – Clinical Information Exchange

- Deleted tier 1 & tier 2 measures on tracking exchange of clinical summaries.
- Tier 3 measure of participation in a health information exchange would be REQUIRED (if infrastructure exists).
- Added an additional measure of whether the PCH makes personal health information electronically available to patients.

Measure – After Hours Documentation

- Deleted this measure... see additional measure under Access 3 – telephone advice.

Measure 4 – Institutional Continuity

- Revised REQUIRED tier 1 measure to reflect that the PCH has an agreement with the usual hospital provider.
- Revised REQUIRED tier 2 measure to reflect only seeing/contacting patients within 1 week of hospital discharge.
- Added an additional measure of seeing/contacting patients after ER visits.

Coordination and Integration

Measure 1 – Patient Registries

- Changed title to “population data management”
- Revised measures. REQUIRED tier 1 measure demonstrating reliable identification, tracking and proactive management of a sub-population of patients and an additional measure on demonstrating the use of such a system to improve a specific care indicator.
- Eliminated a requirement for a specific number of registries.

Measure 2 – Electronic Medical Record

- Changed to “Electronic Health Record.”

Measure 3 – Care coordinator

- Changed title to “care coordination”
- Revised care coordination functions to include motivational interviewing and coaching
- Revised measures to REQUIRE individual responsibility for care coordination (tier 1); description of the process for complex patients (tier 2) and specific training for care coordination functions (additional).
- This standard is primarily about responsibility for care coordination and training, specific care coordination functions are measured under other measures (test and referral tracking, care planning and patient education).

Measure 4 – Test and Result Tracking

- Tracking and reporting results would be a REQUIRED Tier 1 measure.

Measure 5 – Referral and Specialty Care Tracking

- Tracking referral status and results would be a REQUIRED Tier 1 measure.

- Added a REQUIRED Tier 1 measure on coordination of care in hospital and nursing home settings.
- Added collaboration and care planning with other health care professionals for patients receiving ongoing care outside the PCH, and added language about patients and families in this measure.

Measure – Medication Reconciliation

- This measure was eliminated. Federal meaningful use rules contain a measure that eligible providers must perform medication reconciliation at 80% of “relevant encounters or transitions of care” so this is covered under Coordination Measure 2.

Measure 6 – Comprehensive Care Planning

- Revised care planning elements to specify care plans should contain goals for preventive/chronic illness care and an action plan for exacerbations of chronic illness.
- Revised tier 2 and tier 3 measures to reflect improving the % of pts with a care plan and the % of care plans covering all 4 elements.
- Care planning measures would be REQUIRED for all tiers.

Measure 7 – End of Life Planning

- Added REQUIRED tier 1 and tier 2 measures requiring offering POLST to pts 65+ and meeting benchmark for % pts 65+ offered end of life counseling.

Person and Family Centered Care

Measure 1 – Communication of Patient and PCH Expectations

- Changed measure name from “primary care home agreement”
- Modified language to specify “educational materials” outlining patient and PCH roles and responsibilities and requiring documentation of communication with patients. Tier 1 and Tier 2 measures would be REQUIRED.

Measure 2 – Interpreter Services

- Clarified that bilingual providers acceptable. REQUIRED as a tier 1 measure.

Measure 3 – Education and Self Management Support

- Revised language to change “training” to “support” and added families and caregivers.
- Documentation of education and self management efforts and community resources REQUIRED for Tier 1.
- Revised additional measures as follows
 - Measure on activation/readiness to change
 - Measure on tracking/improving the % of patients offered education/support
 - Measure on active follow up with patients re SM goals

Measure 4 – Patient Experience Survey

- Revised language to require questions on all core attributes (except accountability).
- Revised measures so a measure is REQUIRED at each tier:
 - Tier 1 – annual survey covering all core attributes
 - Tier 2 – uses survey to improve care
 - Tier 3 – collects/reports survey data in a standardized format, comparable with other clinics.

Guiding Principles for Application of Primary Care Home Measures

The PCPCH Standards Advisory Committee recommends that the Oregon Health Authority and others consider the following guiding principles in the application of the proposed standards and measures contained in this report.

1. Payment reform is an essential step for developing primary care homes. Currently, primary care clinics use fee for service payments to fund essential but unpaid primary care functions such as care coordination. The current payment model fails to recognize the complexity and intensity of primary care, devalues the work of all members of the primary care team, contributes to overwork and burnout of clinicians, does not assess and reward quality care and decreases opportunities for meaningful communication between patients and their health care providers.
2. The goals of the Health Fund Board and Oregon Legislature for the development of Primary Care Homes is not achievable without significant additional payment for primary care services and an increase in the primary care workforce. Requiring primary care clinics to meet proposed Primary Care Home measures without additional resources or workforce could exacerbate existing workforce shortages and worsen health disparities in underserved populations.
3. Basic Primary Care Home functions (tier 1) require changes to the existing care delivery model, but should be achievable by most primary care clinics in Oregon (regardless of size, patient mix or geographic location) without significant additional payments. Additional resources will be required for clinics to achieve advanced (tier 2 and tier 3) functioning as Primary Care Homes.
4. Primary Care Home measures are intended to be applied to an entire clinic or all patients served by a clinic, regardless of whether patients are publically or privately insured. Care coordination and other services provided by a Primary Care Home are of potential benefit to all patients, not just those with specific chronic diseases.
5. Payment for Primary Care Homes should be risk-adjusted based on the underlying characteristics of the patient population served. Risk-adjusted payment models should include payments for all patients, including those in the lowest risk groups.
6. The process of Primary Care Home measurement should seek to minimize the administrative burden on and cost to individual clinics.
7. Primary Care Home measurement should be integrated and aligned with other efforts to improve health care quality or delivery (e.g. health information technology incentives, quality improvement programs and pay for performance incentives).
8. Payment mechanisms for Primary Care Homes should include both ongoing payments that adequately support Primary Care Home infrastructure (systems, staffing, etc.) and incentive payments based on outcomes.

9. Primary Care Home performance and improvement over time should be measured using internal clinical data, such as data directly from a clinic's Electronic Health Record, as opposed to external data such as claims data whenever possible.
10. The measures of Primary Care Home roles and functions will evolve over time. The state should establish a process to regularly review and update Primary Care Home measures.
11. Evaluation criteria for Primary Care Homes should be transparent to all parties, including consumers, clinics, health plans and purchasers.
12. Payment models based on Primary Care Home measures should reward incremental delivery system changes and allow clinics flexibility in how they implement and demonstrate meeting measures.
13. Primary Care Home measures and incentives should be applied consistently across public and private health plans, to provide clinics with a uniform set of expectations.
14. Communication within the health care system is critical to the success of Primary Care Homes. Other health care providers and facilities should be required to identify each patient's Primary Care Home, communicate with the Primary Care Home in a timely manner, and participate in care coordination.
15. A robust "medical neighborhood" is required to support the Primary Care Home. Primary Care Homes should be encouraged to partner with local public health agencies and community organizations to educate patients, identify community health priorities, and develop plans to improve the overall health of their communities. Public Health departments and other agencies and organizations that make up the "medical neighborhood" must have sufficient and stable funding to carry out these roles.
16. Learning collaboratives and other mechanisms to spread learning and speed delivery system change and integration should be developed and financed in conjunction with efforts to measure Primary Care Homes.
17. It is reasonable to expect advanced (tier 3) Primary Care Homes to be accountable, in part, for unnecessary or preventable utilization and the risk-adjusted overall cost of health care within their patient populations. Efforts to measure and reward Primary Care Homes for efficiently managing care should adhere to the following principles:
 - A common set of cost and utilization measures should be developed and applied consistently across payers. **These measures should be based on a primary care home's entire patient population and be risk adjusted based on characteristics such as patient age, prevalence of chronic medical conditions, or prevalence of mental health conditions or substance abuse.**

Examples of standardized utilization measures could include:

- ER visits (total or among high users)
- Re-admissions

- Admissions for ambulatory sensitive conditions
- Bed days/1000 patients
- High cost imaging
- Duplicated tests
- Generic medication prescribing

Examples of standardized cost of care measures could include:

- Total cost of care for pts with certain chronic diseases
 - Cost of care in last 6 months of life
 - Cost of specialty care
 - Cost of diagnostic imaging
 - Cost of medications
- Primary Care Homes must have timely access to patient-level utilization and cost data for care delivered outside the Primary Care Home.
 - Cost of care and utilization measures applied to a Primary Care Home should be appropriate for the patient population served