

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

800 NE Oregon Street Portland, Room 1C
Friday, January 22nd
2:00 – 5:00 pm

Agenda

- 2:00 Welcome and Introductions - (Bart)
- 2:05 Approval of Meeting #5 Summary - (Bart)
- 2:10 Overview of Federal Meaningful Use Rules and Integration of Public Health and Community Organizations (Rob)
- 2:20 Discussion of Draft Coordination and Integration Measures (Bart)
- 3:15 *Break*
- 3:30 Public Comment (Bart)
- 3:40 Discussion of Draft Person and Family Centered Care Measures (Bart)
- 4:15 Overview of Guiding Principles for Implementation (Rob)
- 4:20 Discussion of Guiding Principles for Implementation (Bart)
- 4:50 Next Steps – Discuss Process for Meeting #7
- 5:00 Adjourn

Exhibit Materials:

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

**Patient Centered Primary Care Home Program - Standards Advisory Committee
Meeting #5 Summary**

Thursday, January 7, 2010
3:00-5:00pm

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
David Labby, MD
Robert Law, MD
Mary Minniti, CPHQ
Melinda Muller, MD, FACP
Carole Romm, MPA, RN
Glenn Rodriguez, MD
Tom Syltebo, MD
David Pollack, MD (ex officio)

OHPR Staff in Attendance

Jeanene Smith
Rob Stenger
Lisa Angus

Committee Members Not in Attendance

David Dorr, MD, MS (ex officio)
Chuck Kilo, MD, MPH (ex officio)
John Saultz, MD (ex officio)
Barney Speight (ex officio)
Jane-Ellen Weidanz (ex officio)

Public Comment

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

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

Meeting convened at 3pm by Dr. McMullan.

Committee approved the Meeting #4 Summary.

The Committee discussed proposed measures 1-4 under the Comprehensive Whole Person Care Core Attribute. Key discussion points included:

- Scope of Services Measures
 - o Comprehensive scope of services is important and must be inclusive of acute care, management of chronic illness and comprehensive attention to an individual’s health needs across organ systems.
 - o While a broad scope is important, most primary care clinics are currently under-resourced and under-staffed to actually deliver comprehensive care to all patients.
 - o Maintain the four measures that reflect unique but overlapping domains of comprehensive care (prevention, medical services, mental health and substance abuse, and health risk behaviors).
 - o Checklists of specific services are overly prescriptive and not necessary to ensure a broad scope; general categories (acute, chronic, preventive) are sufficient.
 - o Use of claims data to verify delivery of comprehensive services is not necessary as a higher-level measure; attestation of scope by clinics is sufficient.
 - o Consider the addition of developmental screening for children to the existing measures.
 - o Consider the addition of language on diagnosis and management to the mental health and substance abuse measure. Listing of specific screening tools is not necessary. Also, consider the addition of intermediate and advanced measures that reflect direct collaboration and co-location (actual or virtual) with mental and behavioral health professionals.
 - o Measures on mental health should not penalize primary care clinics in areas with an inadequate mental health care workforce and/or limited access to services.
 - o Attention to health risk behaviors and social determinants of health are important to the primary care home model. Consider the addition of advanced measures that reflect outcomes such as referrals, delivery of services, linkage to community resources or reduction in risk factors within the clinics’ patient population.

Dr. McMullan called for public comment at 4:00pm, no individuals offered public comment.

The Committee discussed proposed measures 1-5 under the Continuity Core Attribute. Key discussion points included:

- Provider Continuity Measures
 - o Add primary care teams to language about continuity, but teams must be small groups of clinicians and clinic staff, not an entire clinic.
 - o Evidence suggests that continuity with an individual clinician (not just a clinic or group of providers) improves patient satisfaction and health outcomes.
 - o Continuity “benchmarks” should not penalize clinics that might have difficulty achieving high provider continuity by virtue of their patient population or provider mix (e.g. teaching clinics, homeless and migrant health worker clinics).
 - o Documentation of a follow-up plan is an important element of continuity that should be reflected in the primary care home measures.

- Information Continuity Measures
 - o Primary Care Home measures should contain parameters about the structured organization of clinical information (e.g. med list, problem list, allergies, etc.) either within this standard or elsewhere.
 - o It would be difficult to accurately measure transmission of structured clinical summaries at key points without full electronic information exchange.
 - o The long-term goal for information continuity is real-time electronic exchange of clinical information. Keep this as an advanced measure and consider elimination of the “basic” measures.
 - o Information exchange can happen in multiple forms. Direct verbal contact with a member of the primary care team should be included as an appropriate means of information exchange.
 - o Information continuity standards must be applied to other providers, not just the primary care home (e.g. hospitals, emergency departments and specialty providers should be required to ask about a patient’s primary care home and communicate with the primary care team).
 - o Eliminate continuity measure 4, this will be added to measures under the access to care core attribute.

- Geographic Continuity Measures
 - o Hospitals should be required to coordinate/communicate with primary care homes.
 - o Consider limiting the “basic” measure to an agreement with usual hospital providers (if the primary care home does not provide hospital care).
 - o Measuring follow-up visits is a reasonable proxy measure, but the goal of geographic continuity measures should be to ensure continuity and coordination during key care transitions.

The committee had general discussion about its next meeting and requested OHPR staff complete the following tasks:

- Revise Coordination and Integration measures to include language on coordination with local public health entities and other community services that support self-management or provide other critical services that influence health.
- Extend the scheduled Meeting #6 on 1/22/10 by 1 hour to 5:00pm. The first half of this meeting will focus on the final two core attributes (Coordination and Integration, Person and Family Centered Care) and the second half of the meeting will focus on principles for application of the primary care home standards.
- Schedule an additional wrap-up meeting or conference call in late January. This meeting will focus on review of revised standards and the DRAFT final report of the committee. It will also be an opportunity for public comment on these documents.

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

The next scheduled Committee meetings are:

Friday, January 22, 2010 (#6)

2:00 - 4:00 pm

PSOB, Room 1C

800 NE Oregon Street

Portland, OR

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 based.</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 its screening strategy for mental health and substance use conditions AND documents on-site and local referral resources.</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>Institutional Continuity</u>: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care.</p>
Coordination and Integration	<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 Tracking</u>: PCH demonstrates tracking referral status and whether consultation results are communicated to patients and clinicians.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates that it provides patients with written care plans or care summaries.</p> <p><u>End of Life Planning</u>: PCH documents offering patients age 65 or older the opportunity to complete a POLST form or advanced directive AND attests to submitting completed POLST forms to the Oregon POLST registry.</p>
Person and Family Centered Care	<p><u>Primary Care Home Agreement</u>: PCH has a written agreement that contains at least the following elements: patient options for accessing care, names of primary care team members, information on care planning and information on patient responsibilities.</p> <p><u>Interpreter Services</u>: PCH documents the use of real time face-to-face or telephonic interpreter services.</p> <p><u>Education and Self Management Support</u>: PCH documents patient education and self-management training</p>

Overview of Draft PCPCH Measures by Tier

	efforts, including available community resources.
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REQUIRED Tier 2 Primary Care Home (PCH) Measures

Access to Care	<u>Appointment Access</u> : PCH sets a specific goal for improving an appointment access measure and demonstrates improvement.
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	<u>Mental Health and Substance Abuse Services</u> : PCH documents direct collaboration or co-management of patients with a specialty mental health provider.
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>Institutional Continuity</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 Coordinator</u>: PCH demonstrates employment or contract with a care coordinator who has responsibility for performing the following functions: population management/tracking, self management support, some "behaviorist" functions and care coordination for hospitalized patients.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates improvement in the percentage of patients with a particular chronic condition (e.g. diabetes) who have a care plan or summary.</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 or advanced directive.</p>
Person and Family Centered Care	<p><u>Primary Care Home Agreement</u>: PCH meets benchmark of the percentage of active patients who have signed a PCH agreement.</p> <p><u>Patient Experience Survey</u>: PCH surveys a sample of its patients at least quarterly. The patient survey must include questions on access to care, comprehensiveness of care, coordination of care and patient satisfaction.</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 providers.
Continuity	<i>No measures required for tier 3.</i>
Coordination and Integration	<p><u>Clinical Information Exchange</u>: PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange).</p> <p><u>Electronic Medical Record</u>: PCH has an electronic medical record and demonstrates “meaningful use” of the electronic record, according to CMS rules.</p> <p><u>Comprehensive Care Planning</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients with a particular chronic condition (e.g. diabetes) who have a care plan containing all four elements above.</p>
Person and Family Centered Care	<i>No measures required for tier 3.</i>

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>Institutional Continuity</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>Patient Registries</u>: PCH tracks at least three conditions or prevention measures using a patient registry.</p> <p><u>Patient Registries</u>: PCH uses registries to generate reminders for clinicians or patients.</p> <p><u>Care Coordinator</u>: PCH demonstrates measurement and improvement in each of the care coordinator 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 Tracking</u>: PCH demonstrates collaborative care planning with specialists for patients receiving ongoing specialty care.</p>
Person and Family Centered Care	<p><u>Education and Self Management Support</u>: PCH tracks the percentage of patients with a particular chronic condition (e.g. diabetes) who have been referred to or participated in education or self management training, including community programs outside the PCH.</p> <p><u>Education and Self Management Support</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients with a specific condition (e.g. diabetes) who have received education about their condition or participated in self management training.</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 based.</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
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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 a specialty mental health provider.</p> <p>Tier 3 (REQUIRED)**: PCH documents actual or virtual co-location with specialty mental health 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: 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 4: Institutional Continuity</p> <p>PCH tracks when its patients are cared for in institutional settings (hospital, nursing facility, inpatient treatment) and is actively involved during and after institutional care.</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	Key Questions
<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: Registries and 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: Patient Registries</p> <p>PCH uses registries to track and improve clinical prevention and/or chronic disease care.</p> <p>Additional Measure: PCH tracks at least three conditions or prevention measures using a searchable patient registry.</p> <p>Additional Measure: PCH uses registries to generate reminders for clinicians or patients.</p>	<p>Are registries needed as an independent measure?</p> <p>Should electronic registries be required, given that a registry measure is contained within federal meaningful use rules?</p>
<p>Coordination Measure 2: Electronic Medical Record</p> <p>PCH has an electronic medical record (EMR) and uses this tool to improve care.</p> <p>Tier 3 (REQUIRED): PCH has an electronic medical record and demonstrates “meaningful use” of the electronic record, according to CMS rules.</p>	<p>Should small clinics be able to waive the EMR measure if this is the only thing preventing Tier 3 recognition?</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. 	

Measure and Description – Coordination and Integration	Key Questions
<p>Coordination Measure 3: Care Coordinator</p> <p>PCH employs or contracts with an individual or individuals with primary responsibility for care coordination for complex patients.</p> <p>Tier 2 (REQUIRED): PCH demonstrates (contract and/or job description) employment or contract with a care coordinator who has responsibility for performing the following functions:</p> <ul style="list-style-type: none"> - population management/tracking, including registry management - patient self management support and education - some “behaviorist” functions - care coordination and follow up of hospitalized patients <p>Additional Measure: PCH demonstrates measurement and improvement in delivery of each of the care coordinator functions.</p>	<p>Should this measure specify training of the care coordinator or just functions?</p> <p>Should employment of a specific individual responsible for care planning be a requirement?</p> <p>Should the additional measure be a required Tier 3 measure?</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>Is a quantitative measure and/or reporting desirable?</p>
<p>Coordination Measure 5: Referral and Specialty Care Tracking</p> <p>PCH tracks clinically important ambulatory care its patients receive outside the PCH.</p> <p>Tier 1 (REQUIRED): PCH demonstrates tracking referral status and whether consultation results are communicated to patients and clinicians.</p> <p>Additional Measure: PCH demonstrates collaborative care planning with specialists for patients receiving ongoing specialty care.</p>	<p>Is a quantitative measure and/or reporting desirable?</p> <p>Would some measure of existing collaborative/referral relationships between the primary care home and specialists be a useful addition?</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. 	

Measure and Description – Coordination and Integration	Key Questions
<p>Coordination Measure 6: Comprehensive Care Planning</p> <p>PCH plans and coordinates care for patients with one or more chronic conditions.* Care planning involves at least the following elements:</p> <ul style="list-style-type: none"> • self-management goals • goals of preventive and chronic illness care • action plan for exacerbations of chronic conditions (when appropriate) • end of life planning (when appropriate) <p>Tier 1 (REQUIRED): PCH demonstrates that it provides patients with written care plans or care summaries.</p> <p>Tier 2 (REQUIRED): PCH demonstrates improvement in the percentage of patients with a particular chronic condition (e.g. diabetes) who have a care plan or summary.</p> <p>Tier 3 (REQUIRED): PCH meets a benchmark or demonstrates improvement in the percentage of patients with a particular chronic condition (e.g. diabetes) who have a care plan containing all four elements above.</p> <p>* PCH practices should have some flexibility to target care planning activities to patients in their population most likely to benefit.</p>	<p>Should PCHs be able to define which patients in their panel need a care plan or should this measure contain some uniform criteria beyond “one or more chronic conditions”?</p> <p>Should there be some requirement that care plans are up to date (e.g. reviewed within the past 1 year).</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 age 65 or older the opportunity to complete a POLST form or advanced directive 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 or advanced directive.</p>	<p>Should the Tier 2 measure contain a metric of % patients who complete a POLST, not just offers?</p>

Measure and Description – Person and Family Centered Care	Key Questions
<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: Primary Care Home Agreement</p> <p>PCH has a written agreement with its patients that outlines the roles and responsibilities of the PCH and patients.</p> <p>Tier 1 (REQUIRED): PCH has a written agreement that contains at least the following elements: patient options for accessing care, names of primary care team members, information on care planning and information on patient responsibilities.</p> <p>Tier 2 (REQUIRED): PCH meets benchmark of the percentage of active patients who have signed a PCH agreement.</p>	<p>Would tracking of such an agreement be sufficient or is a benchmark needed?</p>
<p>Person Measure 2: Interpreter Services</p> <p>Interpreter services are available to patients who request them.</p> <p>Tier 1 (REQUIRED): PCH documents the use of real time face-to-face or telephonic interpreter services.</p>	<p>Would a benchmark metric (% non English speakers who get an interpreter) be useful as an advanced measure?</p> <p>Would an additional communication measure (e.g. health literacy assessment) be useful as an advanced measure?</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. 	

Measure and Description – Person and Family Centered Care	Key Questions
<p>Person Measure 3: Education and Self-Management Support</p> <p>PCH offers education and self management training to patients with one or more chronic conditions who would benefit from such services. Education and self management training 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 education and self-management training efforts, including available community resources.</p> <p>Additional Measure: PCH tracks the percentage of patients with a particular chronic condition (e.g. diabetes) who have been referred to or participated in education or self management training, including community programs outside the PCH.</p> <p>Additional Measure: PCH meets a benchmark or demonstrates improvement in the percentage of patients with a specific condition (e.g. diabetes) who have received education about their condition or participated in self management training.</p>	<p>Should higher tier measures of self management and patient education be required?</p> <p>Should any of the following measures be added as a higher tier measure:</p> <ul style="list-style-type: none"> • Measurement/improvement of patient activation or readiness to change • Measurement of linkages (information sharing, coordination) with evidence-based community or public health education and self management programs such as the state’s “Living Well” program. • Specific training or staffing requirements for PCH staff to participate in education and self management. • Detailed tracking of self management goals and progress.
<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 2 (REQUIRED): PCH surveys a sample of its patients at least quarterly. The patient survey must include questions on access to care, comprehensiveness of care, coordination of care and patient satisfaction.</p>	<p>Should a Tier 3 measure be added demonstrating improvement in pt survey results?</p> <p>Should a standardized set of questions be required?</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 – 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

- Eliminated language listing specific conditions/populations appropriate for registries.
- Revised measures. One measure on use of registries for information tracking and one measure on use of registries to generate clinical reminders.

Measure 2 – Electronic Medical Record

- Revised this measure to require that a PCH have an EMR and demonstrates meaningful use.
- This measure would be REQUIRED for Tier 3.

Measure 3 – Care coordinator

- Eliminated list of examples of types of staff doing care coordination.
- Added a REQUIRED Tier 2 measure requiring demonstration of a care coordinator and roles through a contract and job description.
- Added an additional measure for tracking of all four care coordinator roles.

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.
- Collaboration and care planning with specialists for patients receiving ongoing care was added as an additional 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 – Primary Care Home Agreement

- Changed measure name from “Medical home” to “primary care home”
- Tier 1 and Tier 2 measures would be REQUIRED.

Measure 2 – Interpreter Services

- Interpreter services REQUIRED as a tier 1 measure.

Measure 3 – Education and Self Management Support

- The lack of a measure in this area was identified as a deficiency by several committee members.
- Added this measure, including a REQUIRED tier 1 measure for reporting on existing efforts and two additional measures on tracking and meeting a benchmark on the percentage of patients receiving education or self management training.
- See the additional questions in the measures document on options for improving this measure.

Measure 4 – Patient Experience Survey

- Conducting a patient survey at least quarterly would be a REQUIRED tier 2 measure.

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. Requiring primary care clinics to meet proposed Primary Care Home measures without significant additional investments to improve both the delivery system and primary care workforce could exacerbate existing workforce shortages and health disparities in underserved populations. The intent of the Health Fund Board and Oregon Legislature in recommending the development of Primary Care Homes is not achievable without these additional investments.
2. Basic Primary Care Home functions (tier 1) should be achievable by most primary care clinics in Oregon (regardless of size, patient mix or geographic location) that make reasonable efforts to improve their practices. Additional resources will be required for clinics to achieve advanced (tier 2 and tier 3) functioning as Primary Care Homes.
3. Primary Care Home measures could be applied initially to a subset of a clinic population, but are intended to eventually be applied to an entire clinic or all patients served by a clinic. Care coordination and other services provided by a Primary Care Home could be of potential benefit to all patients, not just those with specific chronic diseases.
4. Payment for Primary Care Homes should be risk-adjusted based on the underlying characteristics of the patient population served.
5. The process of Primary Care Home measurement should seek to minimize the administrative burden on individual clinics.
6. 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).
7. Separate incentives and payment mechanisms are needed to support Primary Care Home infrastructure (systems, staffing) versus achievement of specific population health or cost outcomes.
8. Primary Care Home performance should be measured using internal clinical data, whenever possible.
9. 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.
10. Measurement of Primary Care Homes should be transparent to all parties, including consumers, clinics, health plans and purchasers.

11. Primary Care Home measures should allow community- and practice-level flexibility, especially in the context of demonstration projects.
12. Primary Care Home measures and incentives should be applied consistently across health plans, to provide clinics with a uniform set of expectations.
13. 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.
14. A robust "medical neighborhood" is required to support the Primary Care Home. If Primary Care Homes are required to partner with local public health agencies and community organizations to educate patients and improve health, such agencies and organizations must have sufficient and stable funding to carry out these roles.
15. Learning collaboratives and other mechanisms to spread learning and speed delivery system change should be developed and financed in conjunction with efforts to measure Primary Care Homes.
16. 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.

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.
- Primary Care Homes should have flexibility to select the cost of care and utilization measures most appropriate for their patient population.