**Patient Centered Primary Care Home Program - Standards Advisory Committee Meeting #4**

800 NE Oregon Street Portland, Room 1B
Tuesday, December 22, 2009
Noon – 2:00 pm

***Agenda***

**11: 45** *Lunch available for Committee Members*

**12:00** Welcome and Introductions - (Bart)

**12:05** **Approval of Meeting #3 Summary -** (Bart)

**12:10** Overview of Draft PCPCH Measures and Guiding Principles - (Rob)

**12:20** Discussion of Draft PCPCH Measures (Bart)

12:20 – Access
12:40 – Accountability

1:00 *Break*

1:10 Public Comment (Bart)

1:20 Continued Discussion of Draft PCPCH Measures* (Bart)

1:20 – Comprehensive Whole Person Care

**Additional topics to be discussed as time allows.*

**2:00** *Adjourn*

**Exhibit Materials:**

1. Draft Agenda
2. Meeting #3 Summary
3. Draft PCPCH Measures by Tier – Overview Table
4. Draft PCPCH Standards and Measures - Table

# Patient Centered Primary Care Home Program - Standards Advisory Committee
# Meeting #3 Summary

Monday, November 30, 2009
3:00 – 5:00 pm

Committee Members in Attendance
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
David Dorr, MD, MS (ex officio)
Chuck Kilo, MD, MPH (ex officio, phone)
David Pollack, MD (ex officio)

OHPR Staff in Attendance
Jeanene Smith, MD
Gretchen Morley
Rob Stenger, MD
Lisa Angus

Committee Members Not in Attendance
J. Bart McMullan, Jr, MD (chair)
David Labby, MD
Glenn Rodriguez, MD
Tom Syltebo, MD
John Saultz, MD (ex officio)
Barney Speight (ex officio)
Jane-Ellen Weidanz (ex officio)

Public Attendance
Two members of the general public signed in.

Minutes (**Committee actions in bold**)

*Meeting convened at 3pm by Mr. Anderson.*

**Committee approved the Meeting #2 Summary.**

Jeanene Smith (OHPR) provided an overview of the work of the Oregon Heath Authority Health Policy Board and how this work intersects with the work of the PCPCH Standards Advisory Committee, especially with regards to primary care workforce development and payment reform. Dr. Smith Reported that:

- The Health Policy Board has appointed two legislatively mandated committees, 1 group focusing on the health care workforce and 1 group focusing on public purchasers.
- The Health Policy Board is considering the formation of additional working groups to focus on payment reform and health care costs and quality.
- Next steps for the PCPCH work by OHPR will likely include consideration by the Health authority leadership, including several of these committees.

Rob Stenger (OHPR) provided an overview of the revised standards and the goals for the meeting. General discussion on the revised standards included the following:

- Need to make sure measures are feasible/achievable for small clinics, especially those with limited resources/capacity, and do not create unnecessary administrative burden
- It may be useful to have a demonstration or "sentinel provider" approach to test standards and help address implementation strategies and challenges
- General agreement that framing the standards in patient centered language is a productive approach to making them understandable and accessible, may be useful to keep the side-by-side "provider-centered" and "patient-centered" language.

The core attribute of Access and its three standards were discussed at the last committee meeting. The Committee proceeded to discuss the proposed standards under each of the remaining five core attributes. A brief summary of these discussions is as follows:

<u>Continuity</u>

- Provider continuity is an important standard. This could be with a primary care provider or other members of the health care team, depending on patient needs/setting. Measures in this area should not discriminate by provider type.

- Information continuity is an important standard. Need to clarify in measures what constitutes appropriate/timely sharing of clinical information. An EHR should not be required to meet an "entry level" information continuity standard. Information continuity could include sharing clinical summaries with patients.

- Geographic continuity should be a broader concept and not just limited to hospital and nursing home care. The general principle is that the PCPCH team should participate in care, regardless of where the patient is located. The group was unclear about whether unique measures of continuity were needed or whether these could be incorporated into care coordination.

**There was general consensus among the group to keep three standards under the core attribute of Continuity (provider continuity, information continuity, geographic continuity) with the recognition that there may not be unique geographic continuity measures.**

Person and Family Centered Care

- Language under this core attribute needs to reflect the importance of understanding patient needs/wants but also a partnership between patients and providers. Patient wants/values should be considered but may not be the most appropriate basis for decisions in all scenarios.

- Language on patient education and goal setting should be added to the current standards.

- Use of tools to assess patient engagement/readiness to change is an important component of person and family centered care and could be measures of an advanced PCPCH.

- Language under communication and patient self-management should reflect health and wellbeing, not just medical management. Additional language is also needed to reflect the role of family members and other caregivers.

- Cultural and linguistic competence and shared decision-making should be captured in measures if possible, though this may be through the patient experience survey.

- It would be helpful if there were some standard measurement of patient centeredness, difficult for practices to determine this themselves in an objective way.

**There was general agreement among the group to keep two standards under person and family centered care (communication and self management support and experience of care).**

Coordination and Integration

- The distinction between ambulatory and facility care seems artificial. From the patient perspective care should be coordinated in all settings … institutional coordination needs to be broader than just hospital and SNF care.

- One possibility for measurement may be focusing on a mechanism/capacity for care coordination within the practice.

- May want to explicitly measure/mention coordination with mental and behavioral health providers. Despite the core attribute title including “integration” the standards to not seem to address mental health explicitly.

- Measures could perhaps focus on “critical” care coordination times/events or identification of high risk situations or individuals.

- EHRs are not a requirement for registry and tracking functions, but some electronic registry probably is needed beyond a very early tier.

**There was general agreement to collapse care coordination into a single standard with multiple measures reflecting the various mechanisms for coordinating care.**

Comprehensive Whole Person Care

- Broaden the comprehensiveness of language under this standard, specifically "health services and support" instead of "medical services" and addition of specific language on substance abuse.
- Need to add language on comprehensive health assessment (personal or population) that is shared by patients and providers and follow- up care as a component of care planning.
- Add education to the list of "comprehensive" services.
- What is a care plan: A document? A process? An assessment? Not the same for every person. Measures must be relevant for each patient and not overly prescriptive and burdensome.
- Comprehensive scope of services is important, though need to recognize the limitations of many providers (e.g. poor access to dental care) and the fact that certain unique populations might require exceptionally broad sets of comprehensive services (e.g. homeless clinic).
- Equity could be incorporated into measures of comprehensiveness… prevalence of delivered care in certain populations vs. expected rates.

**There was general agreement to keep two standards (scope of services and care planning) under comprehensive whole person care, recognizing that significant care will be needed to develop appropriate care planning measures.**

Accountability

- It is unclear how useful a "process" measure of Quality Improvement would be, especially since many specialty boards require QI experience as a requirement for maintenance of board certification. The core competency under quality improvement is the ability of clinic to conduct measurement of a performance indicator and then take action to improve performance over time.
- Population management is an important component of accountability, but the population should be limited to patients in the PCPCH panel. Sophisticated/advanced population management measures could include methods to conduct outreach efforts to patients who do not regularly come to the clinic.
- Cost and Efficiency measures are an important component of accountability. From a purchaser perspective, this would ideally be measured as the best possible medical results for the lowest cost (value). Possible measures could include admissions, unnecessary ER visits, duplicated tests, intense management of high utilization patients, but there are a number of challenges to measurement in this area including:
  - need to be aggregate measures of cost
  - utilization/cost measures require risk adjustment and are sometimes not controllable

- clinics don’t have cost/utilization data in real time or at the point of care to inform management decisions.

**There was general agreement among the committee to incorporate the above discussion points into the further development of standards and measures under the accountability core attribute.**

Mr. Anderson called for public comment at 4:55. No individuals wished to offer public comment.

*Meeting adjourned at 5:05 pm.*

## Overview of Primary Care Home Measures By Tier

| | Access to Care | Accountability | Comprehensive Whole Person Care | Continuity | Coordination and Integration | Person and Family Centered Care |
|---|---|---|---|---|---|---|
| Tier 1 | A1 – Appointment Access<br>A2 – Telephone Advice | AC1 – Performance Indicator Tracking | CM1 – Preventive Services<br>CM2 – Medical Services<br>CM4 – Health Risk Behaviors | CN1 – Personal Clinician Assignment<br>CN2 – Personal Clinician Continuity<br>CN3 – Clinical Info. Exchange<br>CN4 – After Hours Documentation<br>CN5 – Institutional Continuity | CI1 – Patient Registries<br>CI4 – Test and Result Tracking<br>CI6 – Medication Reconciliation<br>CI7 – Comprehensive Care Planning | P1 – Medical Home Agreement<br>P2 – Interpreter Services |
| Tier 2 | A3 – Administrative Access | AC1 – Performance Indicator Tracking<br>AC2 – Clinical Performance Reporting<br>AC4 – POC Decision Support | CM3 – Mental Health and Substance Abuse Services<br>CM4 – Health Risk Behaviors | CN1 – Personal Clinician Assignment<br>CN2 – Personal Clinician Continuity<br>CN3 – Clinical Info. Exchange<br>CN5 – Institutional Continuity | CI1 – Patient Registries<br>CI3 – Care Coordinator<br>CI4 – Test and Result Tracking<br>CI5 – Referral and Specialty Tracking<br>CI7 – Comprehensive Care Planning<br>CI8 – End of Life Planning | P1 – Medical Home Agreement<br>P3 – Patient Experience Survey |
| Tier 3 | A1 – Appointment Access | *AC3 – Clinical Quality Benchmarks***<br>*AC5 – Ambulatory Sensitive Utilization***<br>*AC6 – Cost of Care*** | | CN3 – Clinical Info. Exchange | CI1 – Patient Registries<br>CI2 – Electronic Medical Record<br>CI6 – Medication Reconciliation<br>CI7 – Comprehensive Care Planning | |

** Not Required for Tier 3, may not be associated with a particular tier.

# Patient Centered Primary Care Home Program - Standards Advisory Committee

Proposed Standards and Measures – Detail
*************ALPHABETICAL BY CORE ATTRIBUTE*************

<table>
<tr><td>Measure and Description – Access to Care</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">ACCESS TO CARE – Be there when I need you.<br>• Make it easy for me to get care and advice when I need and want it for myself and my family members.<br>• Provide flexible, responsive options for me to get care in a timely way.</td></tr>
<tr><td colspan="3">Standard: In-Person Access<br>• Make sure I can quickly and easily get an appointment with someone who knows me and my family.<br>• Ensure that office visits are well-organized and run on time.</td></tr>
<tr><td>Access Measure 1: Appointment Access<br><br>Practice tracks a standard measure of appointment access. Examples of a standard measure could include:<br>- 3rd next available appointment (any appt or with PCP)<br>- % Open appointments next 4 weeks<br>- % appointment slots reserved for same day/urgent<br><br>Tier 1 Measure: practice tracks and reports an access measure<br><br>Tier 3 Measure: practice meets a benchmark of appointment access</td><td>Tier 1,3<br>Systems</td><td>Is a Tier 2 or 3 benchmark needed?<br><br>Is a standard appointment access measure desirable?<br><br>Should access be measured for different appointment types (e.g. routine vs urgent)?<br><br>Is a measure of “after hours” appointments needed? (e.g. at least X hours/wk outside of 8-5 M-F)</td></tr>
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<tr><td>Measure and Description – Access to Care</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">Standard: Telephone and Electronic Access<br>• Make sure I know what to do if I need or want help when your office is closed.<br>• Provide multiple ways for me to easily get care or advice outside of office visits.</td></tr>
<tr><td>Access Measure 2: Telephone Advice<br><br>Practice provides telephone access to a member of the health care team trained in phone triage and clinical advice during business hours AND when the clinic is closed.<br><br>Tier 1 Measure: practice provides continuous access to clinical advice by telephone (self report)</td><td>Tier 1<br>Systems</td><td>Is a Tier 2 or 3 quantitative measure or benchmark of phone access desirable? (e.g. response time, phone abandonment rate)<br><br>Is a Tier 2 or 3 measure of electronic access options desirable? (e.g. e-mail, web portal)</td></tr>
<tr><td colspan="3">Standard: Administrative Access<br>• Respond to my requests for help with refills, paperwork, etc. in the most efficient way possible to meet my needs.<br>• Make it easy for me to access my personal health information.</td></tr>
<tr><td>Access Measure 3: Administrative Access<br><br>Practice tracks the timeliness of response to patient requests for administrative tasks such as paperwork and prescription refills.</td><td>Tier 2<br>Systems</td><td>Could this type of access be measured by pt experience survey or some other means?<br><br>Should a measure of access to personal health information be added? (e.g. Tier 3: real-time electronic access to personal health information?)<br><br>Should this measure focus on prescription refills only? Quantitative or qualitative?</td></tr>
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<tr><td>Measure and Description - Accountability</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">ACCOUNTABILTIY – Show me that your care is safe, of high quality and uses time and resources, both yours and mine, efficiently.</td></tr>
<tr><td colspan="3">Standard: Performance Improvement<br>• Work to improve the care and services you provide and ask me for feedback and ideas about what to improve.<br>• Publically report information about the safety, quality and cost of the care you provide.<br>• Show me what you are doing to ensure I will not get the wrong or unnecessary care.</td></tr>
<tr><td>Accountability Measure 1: Performance Indicator Tracking<br><br>Practice demonstrates tracking its own performance across a range of domains, such as:<br>- clinical outcomes (e.g. A1C under control, BP under control)<br>- clinical process (e.g. rates of immunizations or mammograms)<br>- patient experience (pt survey results, measures of access or wait time, measures of care coordination, etc.)<br><br>Tier 1 Measure: Practice tracks performance indicators in at least one domain and reports results internally.<br><br>Tier 2 Measure: Practice tracks performance indicators in all three domains and reports results internally.</td><td>Tier 1,2<br>Systems/ Clinical</td><td>Should improvement (not just reporting) of performance indicators be required under this measure or are the “benchmarks” found in other measures sufficient?<br><br>Current measures with benchmarks:<br>In-person Access (tier 3)<br>Clinical Quality Measures<br>Personal Clinician Assignment (tier 2)<br>Personal Clinician Continuity (tier 2)<br>Clinical Information Exchange (tier 2)<br>Geographic Continuity (tier 2)<br>Medication Reconciliation (tier 3)<br>Care Planning (tier 3)<br>Medical Home Agreement (tier 2)</td></tr>
<tr><td>Accountability Measure 2: Clinical Performance Reporting<br><br>Practice participates in a program of voluntary public reporting of practice-level clinical performance indicators (e.g. reporting of performance indicators to a health plan or the Oregon Quality Corporation).</td><td>Tier 2<br>Clinical</td><td>Should small practices be exempt from the requirement of public reporting?<br><br>If so, could these practices still report and receive feedback on their relative performance?</td></tr>
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| Measure and Description - Accountability | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Accountability Measure 3: Clinical Quality Benchmarks***<br><br>Practices meet specific benchmark levels of performance across a set of clinical performance indicators, to be determined.<br><br>Possible measure sets:<br>Adults – Q-corp quality measures or some subset<br>Peds: need to develop measure set - subset of HEDIS, CHIPRA or Q-corp measures<br><br>*Benchmarks would ideally be defined by an independent, external entity, such as Q-corp (not health plans or payers). | **Tier ????**<br>*Clinical* | Ideally, clinical quality measures would be determined using clinical/chart data and NOT claims data, though this may not be possible initially.<br><br>Should clinical quality performance be required for recognition as an advanced (Tier 2 or 3) primary care home or should clinics at any level be eligible for payment based on excellent performance?<br><br>Should there be some flexibility for practices to select clinical quality measures most relevant to their patient population?<br><br>Should payment for quality performance be risk-adjusted? |
| **Accountability Measure 4: Point-of-Care Decision Support**<br><br>Practice demonstrates use of at least two evidence-based decision support tools that are integrated into clinical processes at the point of care. Examples could include:<br>- safety or preferred medication alerts at the time of prescription ordering<br>- evidence based flow sheets/checklists/reminders for ordering tests/imaging or preventive services<br><br>Electronic ordering systems with built in evidence-based decision support or safety alerts would meet this standard but are not required. | **Tier 2**<br>*Systems* | Is this a useful measure? Achievement of specific clinical quality benchmarks may be sufficient to "measure" whether practices are using evidence-based clinical care processes. |

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<tr><td>Measure and Description - Accountability</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">Standard: Cost and Utilization<br>• Keep me informed about the relative costs, benefits and risks of the different options for my care so I can make informed decisions.<br>• Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve my quality of life.</td></tr>
<tr><td>Accountability Measure 5: Ambulatory Sensitive Utilization<br><br>Practice reduces risk-adjusted utilization of specific services as compared to the prior time period or some benchmark across practices. Possible measures include:<br>- ER visits<br>- Re-admissions<br>- Admissions for ambulatory sensitive conditions<br>- Bed days/1000 patients<br>- High cost imaging<br>- Duplicated tests<br>- Generic medication prescribing</td><td>Tier ???<br>Financial</td><td>Would REQUIRE frequent, timely reporting to practices on these measures with patient-level claims data.<br><br>Is it useful to define a common set of utilization measures and/or a common format or process for reporting claims data to practices?<br><br>Should utilization measures be required for recognition as an advanced primary care home or should clinics at any level be eligible for payment based on risk-adjusted performance?</td></tr>
<tr><td>Accountability Measure 6: Cost of Care<br><br>Practice reduces the total cost of care for patients in its panel or specific patient populations as compared to a prior time period or some benchmark across practices. Possible measures include:<br>- Total cost of care for pts with certain chronic diseases<br>- Cost of care in last 6 months of life<br>- Cost of specialty care<br>- Cost of diagnostic imaging<br>- Cost of medications</td><td>Tier ???<br>Financial</td><td>Would REQUIRE frequent, timely reporting to practices on these measures with patient-level claims data. It would also be helpful to report to practices on average cost/utilization by hospital and specialist.<br><br>Is it useful to define a common set of cost measures and/or a common format or process for reporting claims data to practices?<br><br>Should utilization measures be required for recognition as an advanced primary care home or should clinics at any level be eligible for payment based on risk-adjusted performance?</td></tr>
<tr><td></td><td></td><td>Are both of the above measures needed?<br><br>Would it be useful to add a measure of patient cost?</td></tr>
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<tr><td>Measure and Description – Comprehensive Whole Person Care</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">COMPREHENSIVE WHOLE PERSON CARE – Provide or help me get the health care and services I need.<br>• Help me get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use.<br>• Help me understand my health risks and/or conditions and give me tools and support to manage my own care.</td></tr>
<tr><td colspan="3">Standard: Scope of Services<br>• Provide most of the care I need for common problems at your clinic.</td></tr>
<tr><td>Comprehensive Measure 1: Preventive Services*<br><br>Practice routinely provides or arranges for most US Preventive Services Task Force (USPSTF) recommended age-appropriate preventive services and CDC Advisory Committee on Immunization Practices (ACIP) age-appropriate vaccinations.<br><br>Tier 1 Measure: Practice reports, using a checklist, that it routinely provides or arranges for a certain percentage of recommended services and immunizations.<br><br>*This measure is about whether services are available in the primary care home.  Rates of delivery of specific services will be measured under Accountability Measure #3: Clinical Quality Benchmarks.</td><td>Tier 1<br>Structure</td><td>Would a higher tier measure using claims data be appropriate to assess the breadth of routine preventive services provided by the practice?</td></tr>
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<tr><td>Measure and Description – Comprehensive Whole Person Care</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td>Comprehensive Measure 2: Medical Services<br><br>Practice routinely provides a broad range of common primary care services. For example, the following list developed by Starfield and colleagues:<br><br>• Nutrition counseling<br>• Family planning or birth control services<br>• Tests for lead poisoning<br>• Suturing for a minor laceration<br>• Counseling and testing for HIV/AIDS<br>• Vision screening<br>• Splinting for a sprained ankle<br>• Wart removal<br>• Pap smears<br>• Rectal exam or sigmoidoscopy<br>• Smoking counseling<br>• Removal of an ingrown toenail<br>• Joint taps and injections<br>• Advice on advance directives<br>• Advice on preparing for changes consequent to aging<br>• Suggestions on nursing home care<br>• Prenatal care<br>• Immunizations<br>• Substance or drug abuse assessment, counseling and treatment<br>• Assessment and counseling for behavior or mental health problems<br><br>Tier 1 Measure: Practice reports, using a checklist, that it provides a certain percentage of the above services. Will need different % cutoffs based on provider type (e.g. adult vs peds).</td><td>Tier 1<br>Structure</td><td>How important is it for a broad range of primary care services to be available “on site” at the primary care home clinic?<br><br>Would a higher tier measure using claims data be appropriate to assess the breadth of primary care services provided?<br><br>Should the bullets in italics be removed from this list given measures 1 and 3 on preventive and mental health/addiction services?</td></tr>
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<tr><td>Measure and Description – Comprehensive Whole Person Care</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td>Comprehensive Measure 3: Mental Health and Substance Abuse Services<br><br>Practice conducts formal assessment and referral for mental health conditions and substance abuse. The practice should document services offered, a detailed screening strategy (including specific screening instruments and who is screened) and on-site or local referral resources. Appropriate primary care screening tools may include:<br>• Alcohol Use Disorders Identification Test (AUDIT)<br>• Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)<br>• Drug Abuse Screening Test (DAST)<br>• CAGE Questionnaire<br>• PHQ2 or PHQ9 symptom check-list<br>• SIG E CAPS mood screen<br>• PRIME screen (early detection of schizophrenic disorders)<br><br>Tier 1 Measure – practice documents screening strategy for mental health conditions and substance abuse AND documents on-site and local referral resources.</td><td>Tier 2</td><td>Is this a useful measure in addition to Measure 1 on USPSTF interventions and Measure 2 on available primary care services?<br><br>Would a higher tier measure (either here or under accountability) be useful to document MH/Addiction screening?<br>- Could be either % screened or % diagnosed with a certain conditions compared with expected prevalence.</td></tr>
</table>

| Measure and Description – Comprehensive Whole Person Care | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Comprehensive Measure 4: Health Risk Behavior Assessment and Intervention**<br><br>The practice demonstrates documentation of common health risk behaviors and a process for tracking interventions. Common health risk behaviors would be identified by the practice, as appropriate to its patient population. Examples of common health risk behaviors include:<br>• Alcohol/Drug Use<br>• Tobacco Use<br>• Obesity<br>• Physical Activity<br>• Injury/Violence<br>• Nutrition<br>• Sexual Risk Behaviors<br><br>**Tier 1 Measure:** Documentation of risk behaviors<br><br>**Tier 2 Measure:** Documentation of interventions | **Tier 1,2**<br>Structure | Is the tier 2 measure necessary, or could health risk behavior assessment and intervention be one of the tracked data elements under the patient registry or performance improvement measures?<br><br>Is a tier 3 measure of performance desirable?<br>(e.g. % of smokers counseled, % obese pts counseled) |

| Measure and Description - Continuity | **Tier**<br>*Outcome Type* | Key Questions |
| --- | --- | --- |
| **CONTINUITY – Be my partner over time in caring for my health.**<br>• Let me choose my personal clinician.<br>• Know who I am and remember important information about my health history, needs and values.<br>• Help me make well-informed decisions about my health and health care. | | |
| **Standard: Provider Continuity**<br>• Make sure I can see or talk with my chosen personal clinician or team whenever I need to.<br>• When it is not possible for me to see a member of my primary care team, ensure that important information about my health history and values are available to those who will care for me. | | |
| **Continuity Measure 1: Personal Clinician Assignment**<br><br>The practice assigns individuals to a personal clinician using individual and family choice as the primary guiding principle AND reports the percent of patients with a personal clinician assigned.<br><br>***Tier 1 Measure*** – clinic has a process for assignment of personal clinician AND reports the % patients assigned a personal clinician.<br><br>***Tier 2 Measure*** – clinic meets benchmark for personal clinician assignment (X% of active patients have an assigned personal clinician) | **Tier 1,2**<br>*Systems* | Should the personal clinician of each patient be reported or only the overall percentage of patients assigned?<br>• Reporting the pcp for each patient would allow plans/clinics to agree on the panel cared for by each clinic/pcp.<br><br>Should there be different Tier 2 and Tier 3 benchmarks? |

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<tr><td>Measure and Description - Continuity</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td>Continuity Measure 2: Personal Clinician Continuity<br><br>The practice tracks AND reports how often patients see their personal clinician or a member of the primary care team.<br><br>Tier 1 Measure – clinic reports how often patient see their personal clinician or a team member (% of total clinic visits/% with personal clinician or team)<br><br>Tier 2 Measure – meets benchmark for usual provider continuity with personal clinician (X% total clinic visits are with patients' assigned personal clinician)</td><td>Tier 1,2<br>Systems</td><td>Should personal clinician continuity be measured by provider or by clinic?<br><br>Should there be different Tier 2 and Tier 3 benchmarks?<br><br>Should some measure of team continuity be required?</td></tr>
<tr><td colspan="3">Standard: Information Continuity<ul><li>Make sure that all health professionals caring for me have access to up-to-date and accurate information about my health history.</li><li>Ensure that my personal health information is always protected and kept private.</li></ul></td></tr>
<tr><td>Continuity Measure 3: Clinical Information Exchange<br><br>Practice has demonstrates timely and confidential exchange of structured clinical summaries with hospitals and consultants AND tracks the exchange of clinical information at key times such as consultation, hospital admission and at patient visits.<br><br>Tier 1 Measure – practice tracks the transmission of structured clinical summaries within 24 hours of hospital admission, at patient visits and at the time of consultation with a specialist.<br><br>Tier 2 Measure – practice meets a benchmark of % of clinical summaries transferred within 24 hours of a hospital admission<br><br>Tier 3 Measure – practice sends and receives clinical information electronically in real time (health information exchange).</td><td>Tier 1,2,3<br>Systems</td><td>Should Tier 2 or 3 measures include reporting and/or benchmarks of clinical information exchange at times other than hospital admission?<br><br>Should there be a common definition of the data elements in a structured clinical summary? Possible data elements include: medication list, active problem list, most recent clinic note, allergies, recent test/lab results, follow up plans.<br><br>Is participation in a health information exchange a reasonable tier 3 measure?</td></tr>
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| Measure and Description - Continuity | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Continuity Measure 4: After Hours Documentation**<br><br>Practice demonstrates that after hours telephone providers have access to patients' pertinent clinical information and document contacts in the patient chart. | **Tier 1**<br>*Systems* | Should real-time after hours access (essentially remote EMR access) be required at tier 2 or higher?<br><br>Is this an important measure? |
| **Standard: Geographic Continuity**<br>• Stay involved in my care wherever I go within the health care system, and help me to coordinate my care across places and people. | | |
| **Continuity Measure 5: Institutional Continuity**<br><br>Practice has a system for tracking patients admitted to institutions (hospital, nursing facility, inpatient treatment) and is actively involved during and after institutional care.<br><br>**Tier 1 Measure** – practice documents routine tracking and coordination of care of patients in facilities (e.g. contract with usual hospital provider(s), case manager responsible for tracking patients in institutions, participation in discharge and follow-up planning)<br><br>**Tier 2 Measure** – practice meets benchmark for hospital coordination and follow up (X% patients seen or called during hospital stay and within 1 week of discharge) | **Tier 1,2**<br>*Systems* | Should the Tier 2 measure be broadened to facilities other than hospitals? |

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<tr><td>Measure and Description – Coordination and Integration</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">COORDINATION AND INTEGRATION – Help me navigate the health care system to get the care I need in a safe and timely way.<br>• 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.<br>• Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions.</td></tr>
<tr><td colspan="3">Standard: Registries and Data Management<br>• Follow my care closely and let me know when tests or checkups are needed.<br>• Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health.</td></tr>
<tr><td>Coordination Measure 1: Patient Registries<br><br>Practice has a searchable population registry of active patients with a particular chronic condition or preventive care need. Registries may be electronic but do not require an electronic health record. The following conditions/interventions may be appropriate for patient registries:<br><br>Asthma, Depression, Diabetes, Geriatric Conditions, Heart Failure, Hyperlipidemia, Hypertension, Immunizations or screening tests, etc.<br><br>Tier 1 Measure – practice tracks at least one condition or intervention using a registry<br><br>Tier 2 Measure - practice tracks at least three conditions or interventions using a registry<br><br>Tier 3 Measure – practice tracks six or more conditions or interventions using a registry</td><td>Tier 1,2,3<br>Structure</td><td>Should electronic registries be required? At what tier?<br><br>Should only tiers 1 and 2 be required for pediatric practices due to the low prevalence of chronic conditions in this population?</td></tr>
</table>

| Measure and Description – Coordination and Integration | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Coordination Measure 2: Electronic Medical Record***<br><br>Practice has an electronic medical record with the following data management fields to support electronic management of patient information and registry/care tracking functions:<br>- Basic Demographic Information<br>- Problem Lists<br>- Medication Lists<br>- Labs/Tests<br>- Risk Factors (e.g. smoking)<br>- Immunizations and Screening<br>- Registry Functionality<br>- Care Coordination Activities<br><br>*Federal Health Information Technology (HIT) "meaningful use" rules are still in development. When these rules are finalized, standards involving the use of health information technology could be modified to align with these rules. | **Tier 3**<br>*Structure* | Should certain practices (e.g. small/rural) be able to waive the EMR measure if this is the only thing preventing Tier 3 recognition? |

<table>
<tr><td>Measure and Description – Coordination and Integration</td><td>Tier<br>Outcome Type</td><td>Key Questions</td></tr>
<tr><td colspan="3">Standard: Care Coordination<br>• 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.<br>• 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.<br>• 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.</td></tr>
<tr><td>Coordination Measure 3: Care Coordinator<br><br>Practice employs or contracts with an individual or individuals with primary responsibility for care coordination for complex patients. Care coordinators should receive specific training in and perform the following functions:<br>- population management using tools such as registries and chronic disease protocols<br>- development and monitoring of individual care plans<br>- patient coaching/motivational interviewing and education, including some “behaviorist” functions<br>- care coordination and follow up of hospitalized patients<br><br>Examples of Staff Filling the Care Coordinator Role:<br>RN cross-trained in case management<br>Social worker/case manager<br>Medical assistant cross-trained in care management<br>Health coach<br>Behavioral health specialist</td><td>Tier 2<br>Structure</td><td>Would a measure of team functioning be more appropriate than specifying a care coordinator role or a useful addition?<br><br>Could participation in a learning collaborative be one way of satisfying the care coordinator training requirement?</td></tr>
</table>

| Measure and Description – Coordination and Integration | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Coordination Measure 4: Test and Result Tracking**<br><br>Practice has a system for tracking lab and imaging tests ordered by the practice which includes notifying providers and patients of important test results, flagging abnormal results and developing follow up plans.<br><br>**Tier 1 Measure:** System tracks ordered tests and includes a mechanism for tracking when patients are notified of results.<br><br>**Tier 2 Measure:** System tracks planned tests and includes reminders for patients and clinicians. | **Tier 1,2**<br>*Systems* | Is a quantitative measure and/or reporting desirable? If so, what measure and at what tier? |
| **Coordination Measure 5**: **Referral and Specialty Care Tracking**<br><br>Practice has a system for tracking clinically important ambulatory care its patients receive outside the PCPCH. This system should include:<br>- tracking of referral status<br>- tracking whether consultation results have been received<br>- routing communication to the primary care team, and<br>- developing follow up or ongoing care plans with specialists as needed. | **Tier 2**<br>*Systems* | Is a quantitative measure and/or reporting desirable? If so, what measure and at what tier?<br><br>Would some measure of the extent and type of existing collaborative/referral relationships between the primary care home and specialists be a useful addition? |

| Measure and Description – Coordination and Integration | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Coordination Measure 6: Medication Reconciliation**<br><br>Practice routinely reviews a patient's medications and documents medication review/reconciliation. Critical times for medication review might include:<br>- after hospital/facility discharge<br>- when a new medication is prescribed<br>- after specialty consultation<br><br>**Tier 1 Measure:** practice documents routine medication review<br><br>**Tier 3 Measure:** practice reports and meets a benchmark for the % of patients with medication review during hospital follow up visits | **Tier 1, 3**<br>*Systems* | Should the Tier 3 measure require medication review at times other than after hospital discharge? |

| Measure and Description – Coordination and Integration | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Standard: Care Planning**<br>• Help me and my family set goals and plan for my care in a way that is understandable and meets my needs.<br>• Provide me with the information I need to care for my own illness and challenge me to actively care for myself. | | |
| **Coordination Measure 7: Comprehensive Care Planning**<br><br>Practice identifies patients with one or more chronic conditions for whom a comprehensive care plan or summary would be appropriate and demonstrates that care plans/summaries incorporate the following elements:<br>• self-management goals<br>• status of preventive and chronic illness care (when appropriate)<br>• exacerbations of chronic conditions (when appropriate)<br>• end of life care/advance directives (when appropriate)<br><br>**Tier 1 Measure:** Practice documents care plans or summaries<br><br>**Tier 2 Measure:** Practice tracks/reports % of patients with a particular chronic condition (e.g. diabetes) who have a care plan or summary.<br><br>**Tier 3 Measure:** Practice meets benchmark % of patients with a specific condition (e.g. diabetes) who have a care plan. | **Tier 1,2,3**<br>*Systems* | Should practices be able to define which patients in their panel need a care plan or should this measure contain some uniform criteria?<br><br>(e.g. specific chronic conditions, high users of services, vulnerable populations, etc.) |
| **Coordination Measure 8: End of Life Planning (Adult practices only)**<br><br>The practice identifies patients who may benefit from end of life planning or counseling. End of life planning must include the use of a POLST form. In addition, the practice must demonstrate submission of completed POLST forms to the Oregon POLST registry unless patients "opt out" of participation in the registry. | **Tier 2**<br>*Systems* | Is it appropriate to develop a quantitative metric/benchmark for this measure? (e.g. % pts >65 with POLST?) |

| Measure and Description – Person and Family Centered Care | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **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.**<br>• Listen to me and my family members or caregivers and promote experiences that enhance my independence and control over my health.<br>• Respect my culture and values and build a relationship with me that is responsive to my needs and preferences. | | |
| **Standard: Communication**<br>• Communicate in the language that my family members and I can understand.<br>• Explain things in ways that make it easy for my family members and I to understand and check to be sure we understand.<br>• Share information with me in an unbiased way. | | |
| **Person Measure 1: Medical Home Agreement**<br><br>Practice has a medical home agreement and reviews/signs this agreement with all patients. The agreement must contain the following:<br>- information on patient options for accessing care (including appointments, phone/electronic clinical advice and after hours/urgent care)<br>- Information on primary care team (name of personal clinician and team members)<br>- Information on care planning<br>- Information on personal/patient responsibilities<br><br>**Tier 1 Measure** – practice has agreement<br><br>**Tier 2 Measure** – practice meets benchmark (agreement signed with X% of patients) | **Tier 1,2**<br>*Systems* | Would tracking of such an agreement be sufficient or is a benchmark needed? |

| Measure and Description – Person and Family Centered Care | **Tier**<br>*Outcome Type* | Key Questions |
|---|---|---|
| **Person Measure 2: Interpreter Services**<br><br>Practice makes interpreter services available to its patients who need them. Standard could be met through documentation of an interpreter on staff or use of a telephone interpreter. | **Tier 1**<br>*Systems* | Would a benchmark metric (% non English speakers who get an interpreter) be useful as an advanced measure?<br><br>Would an additional communication measure (e.g. health literacy assessment) be useful as an advanced measure? |
| **Standard: Education and Self-Management Support**<br>• Respect my capacity to learn and engage me and my family members as partners in managing my health.<br>• Help me know what I need to do to manage and maintain my health.<br>• Invite me to set goals for improving my health and support my efforts to change my behavior to improve my health and wellness. | | |
| **No Measures Proposed Under This Standard**<br><br>While patient education and self-management support are important topics, these are covered in other areas, such as care planning and care coordinator. | | Are education and self-management support adequately reflected under the care planning standard?<br><br>If a separate patient education or self management measure is desired, how could this be quantified? |
| **Standard: Experience of Care**<br>• Regularly ask my family and me about our care experience.<br>• Value our feedback and use this information to improve the way we work together. | | |
| **Person Measure 3: Patient Experience Survey**<br><br>Practice regularly surveys its patients on their experience of care and uses this information to improve care. Survey questions should include the following areas: access to care, comprehensiveness, coordination, continuity and patient satisfaction.<br><br>**Tier 2 Measure:** Practice conducts survey. | **Tier 2**<br>*Patient Experience* | Is a Tier 3 measure on reporting or benchmarking of pt survey results desirable?<br><br>Should a standardized patient survey be required? |