

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

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

Committee Members in Attendance

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

OHPR Staff in Attendance

Jeanene Smith  
Rob Stenger  
Lisa Angus

Committee Members Not in Attendance

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

Public Comment

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

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

*Meeting convened at 2pm by Dr. McMullan.*

**Committee approved the Meeting #5 Summary**

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

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

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

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

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

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

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

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

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

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

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

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

The Final scheduled Committee meeting is:

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

**1:00 – 2:30 pm**

**PSOB, Room 918** (9<sup>th</sup> floor)

800 NE Oregon Street

Portland, OR