

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

Tuesday, December 22nd
Noon-2:00pm

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
Carolyn Kohn (phone)
David Labby, MD
Robert Law, MD
Mary Minniti, CPHQ
Melinda Muller, MD, FACP
Glenn Rodriguez, MD
Tom Syltebo, MD
David Dorr, MD, MS (ex officio)
David Pollack, MD (ex officio)
John Saultz, MD (ex officio)

OHPR Staff in Attendance

Gretchen Morley
Jeanene Smith, MD
Rob Stenger, MD

Committee Members Not in Attendance

Susan King, RN
Carole Romm, MPA, RN
Chuck Kilo, MD, MPH (ex officio)
Barney Speight (ex officio)
Jane-Ellen Weidanz (ex officio)

Public Comment

Two members of the general public provided public comment.

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

Meeting convened at noon by Dr. McMullan.

Committee approved the Meeting #3 Summary.

Jeanene Smith and Rob Stenger (OHP) provided an overview of the work the committee thus far and next steps after the committee's work on primary care home standards is completed. There was also general discussion on next steps. Key points included:

- The Oregon Health Policy Board is currently seeking applicants for three subcommittees: the Health Systems Performance Committee, the Medical Liability Task Force and the Oregon Health Improvement Plan Committee. The Health Systems Performance committee will include work on primary care payment reform, building on the work of the Standards Advisory Committee.
- In addition to finishing discussion on Primary Care Home measures, the committee will focus on providing policy guidance on application of the standards in its final meetings.
- The committee reached general consensus on the concept that Primary Care Home measures should have three tiers representing basic, intermediate and advanced primary care home capabilities:
 - o "Basic" or Tier 1 Primary Care Homes should have basic structures and clinical process in place, including a capacity to measure internal outcomes. These requirements should be achievable by an average clinic with significant effort, but not significant additional resources.
 - o "Intermediate" or Tier 2 Primary Care Homes should have additional structure and clinical process improvements and demonstrate an ability to track and improve performance over time.
 - o "Advanced" or Tier 3 Primary Care Homes should have mature capacity to manage the care of patients in their panel and be expected to demonstrate improvements in population health indicators for their assigned patients.
- Other points of discussion included:
 - o "Tiers" are not necessarily linear, some clinics may be very advanced in some functions and not in others, and this should be recognized and rewarded.
 - o The measurement framework needs to have some flexibility... not all measures need to necessarily be "required" for each tier, but should still be rewarded and encouraged if they are met.
 - o Pacing of moving clinics toward an "advanced" level of functioning must be coordinated with payment that supports the resource-intensive capacities (such as case management staff and health information technology) that are required for higher-level primary care homes.
 - o Primary Care Home measures will need to be continually revised and updated, and must evolve over time.

The Committee Discussed proposed measures 1-3 under the Access to Care Core Attribute. Key points included:

- Appointment Access Measures
 - o Consider adding an intermediate measure that reflects improvement in an access measure.
 - o Patient experience measures of access need to be included in the patient survey measure.
 - o Consider adding a measure of weekend and evening appointments.

- A standard measure of access (e.g. 3rd next available) is not necessarily desirable at this time, clinics should be required to track a standard measure, but have flexibility to choose which one.
- Telephone/Electronic Access Measures
 - Consider adding a higher tier measure of electronic access options (e.g. secure e-mail)
 - Consider adding a measure of whether the telephone provider knows the patient or has real-time access to the medical record (may be difficult for practices using a contracted after hours advice line)
 - Consider adding a measure on documentation of clinical telephone encounters in the medical record.
 - Tracking of the timeliness and resolution of daytime phone calls would be a reasonable intermediate or advanced measure.
- Administrative Access
 - This measure is too broad as written; consider narrowing to a measure of prescription refills only.
 - Patient access to personal medical records should be added as a measure under the “Information Continuity” standard.

The Committee discussed proposed measures 1-6 under the Accountability Core Attribute. Key points included:

- Performance Improvement
 - Measures need to recognize performance improvement, not just tracking and reaching a benchmark level of performance.
 - Tier 1 measure of tracking a single performance indicator is probably too low.
 - “Benchmark” levels of performance may be unfair to some clinics if not reasonably risk adjusted. A statewide “benchmark” is likely not appropriate in most cases, and there is weak evidence to suggest that this approach will improve care versus recognizing and rewarding performance improvements.
 - Public reporting of clinical outcomes (measure 3) is a reasonable expectation for intermediate or advanced primary care homes, but need to limit the administrative burden as much as possible.
 - Measure 4 (point of care decision support) may not be needed as a stand-alone process measure so long as clinics demonstrate improvement in outcomes.
 - Performance Improvement measures under accountability need to balance the administrative burden of reporting/tracking performance indicators with potential benefits, especially for intermediate “process” outcomes.
- Cost and Utilization
 - Primary Care Home Measures need to distinguish between attributes and expected outcomes of primary care homes. Performance improvement capacity is an attribute of an intermediate or advanced primary care home, whereas decreasing cost or unnecessary utilization are possible outcomes, but not essential definitional elements.
 - Payers and plans have an expectation of cost savings and utilization reductions. Unclear if patients/consumers share these expectations.

- Primary care providers currently lack adequate information to manage total system cost and utilization.
- Any efforts to measure cost and utilization at the clinic level need to be case mix adjusted to be meaningful.
- Tracking progress/improvement in these areas would be more appropriate than using “benchmarks.”
- Reduction in unnecessary utilization is a more reasonable short-term target for advanced primary care homes than overall cost reductions.

Given the lack of a clear consensus on Accountability measures, Dr. McMullan requested volunteers for a working group to revise these measures before the next committee meeting. Dr. Pollack, Dr. Labby, Dr. Muller and Dr. Rodriguez volunteered for this working group.

Two individuals offered public comments:

Jeff Heatherington, President, FamilyCare Inc.

- Encouraged the committee to explicitly address adequate time for clinician-patient interactions in the Primary Care Home measures.
- Encouraged the committee to consider specific recommendations on payment reform, noting that primary care providers are not adequately paid for services they currently provide and this must be addressed before the system can be improved through development of primary care homes.
- Encouraged the committee to consider the impact of primary care home measurement on the primary care workforce, noting that retention and growth in the number of primary care providers is essential for long-term sustainability.

Nancy Clarke, Executive Director, Oregon Health Care Quality Corporation

- Encouraged the committee to consider the cost and administrative burden of an extensive set of Primary Care Home measures and only require those process measures that are essential to getting clinics to an “advanced” level of function where they are capable of producing improvement in clinical outcomes.

Dr. McMullan adjourned the meeting at 2:05.

The next scheduled Committee meetings are:

Thursday, January 7, 2010 (#5)

3:00 – 5:00 pm

PSOB, Room 1D

800 NE Oregon Street

Portland, OR

Friday, January 22, 2010 (#6 Final Wrap up)

2:00 - 4:00 pm

PSOB, Room 1C

800 NE Oregon Street

Portland, OR