

Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
Meeting Minutes
July 23, 2015 9:00 A.M. – 12:00 P.M.
Portland State Office Building, Room 1E
Portland, Oregon

Present

Mitchell Anderson (co-chair)
Doug Lincoln, MD (co-chair)
Carolyn Anderson
Carrie Baldwin-Sayre, ND
Seth Bernstein, PhD
Patty Black
Chris Bouneff
David Dorr, MD
Scott Fields, MD
Robin Henderson, PsyD
Joe Hromco, PhD
Kris Keith
Helen Kurre, MBA
Lynnea Lindsey-Pengelly, PhD
Barbara Martin, PA
Charlotte Navarre
Jorge Ramirez Garcia, PhD
Colleen Reuland
Bruin Rugge, MD
Christine Seals, MD
Barb Seatter
Megan Viehmann, PharmD

Staff

Nicole Merrithew
Deepti Shinde
Megan Bowen
Chris Carrera
Amy Harris
Evan Saulino, MD

Joining by phone

Colleen Smith
Dan Reece

Absent

Tammy Alexander, MED
Maggie Bennington Davis, MD
Kristin Dillon, MD
Susan King
Kathy Savicki
Meg Portwood, FNP

Introductions and Overview of Committee Meetings

The meeting was convened at 9:10 A.M. Co-chair Doug Lincoln had all members introduce themselves by name and organization affiliation. Following introductions, co-chair Mitch Anderson reviewed the meeting agenda (see meeting materials) and reminded committee members that the first few meetings will be dedicated to advising the Oregon Health Authority (OHA) on specific standards and measures of the PCPCH model, while later meetings will focus on behavioral health integration.

Staff Summary from Last Meeting

PCPCH Program staff drafted a summary of committee recommendations from work session #1 for Measure 1.F- Prescription refills (see meeting materials). Evan Saulino presented the summary to the committee to ensure it accurately reflected their recommendations. Overall, committee groups reported Measure 1.F should be weighted more heavily. It is important from the patient perspective to receive timely refills, and is especially important to certain patient populations. However, in its current form, the measure does not encourage transformation. Different levels of accomplishment should be added to meet the intent of the measure. Committee groups reported that a benchmark or quality improvement process should be incorporated into the measure.

Based on committee recommendations, PCPCH Staff drafted proposed revisions to the measure:

- 1.F.2 - PCPCH tracks the time to completion for prescription refills. (10 points)
- 1.F.3 - PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription refills. (15 points)
 - To meet measure 1.F.3, there are two options:
 - 1) Clinics must demonstrate $\geq 10\%$ improvement in reported scores over a period of at least one year.
 - 2) Clinics must demonstrate that 75% or more $((\text{numerator} \div \text{denominator}) \times 100)$ of prescription refills during the last 12 months were completed within 48 hours.

Following Evan's presentation, some committee members noted that the technical specifications around the benchmark for 1.F.3 needed further clarification. Nicole Merrithew agreed and stated that technical specifications for many measures that will be discussed in the meetings will need further development. Nicole asked committee members interested in developing the specifications for 1.F.3 in a subcommittee to contact her.

Measure Work Sessions

At 9:35 A.M. committee members divided into groups of five to discuss three Meaningful Use (MU) Measures, 1.E.3 Electronic Access, 3.E.3, Preventive Services Reminders, 4.G.3, Medication Reconciliation, and Measure 6C Patient Experience of Care.

Meaningful Use Measures

Evan Saulino provided a brief overview of the intent of the Meaningful Use measures, and referred committee members to the questions on their worksheet to guide the discussion (see meeting materials). Committee members discussed the measures and these questions in their small groups for 15 minutes, and then convened as a whole to report their discussion and recommendations.

Should MU measures continue to be included in the PCPCH model in order to foster alignment with state and federal policy?

Each committee group felt strongly that the concepts in the Meaningful Use Measures (Electronic Access, Preventive Services Reminders and Medication Reconciliation) were important to the PCPCH model of care delivery, and should continue to be included in the model.

It was noted that MU may align with state and federal policy, but MU does not necessarily encourage “team based care” since many provider types (PA, NP, etc.) are not eligible for MU incentives.

If included in the PCPCH model, do you agree (with the PCPCH staff recommendation) that emphasis on MU measures in the PCPCH model should decrease to reflect the reality of clinic practice and EHR technologies?

All committee groups agreed the MU measures should not have as much of an emphasis in the PCPCH model as they currently do. For many clinics meeting MU measures is just “checking the box” and does not encourage transformation in practice. The most valuable measures in the PCPCH model should be those that are the most transformative, and the MU measures are not.

The committee did note it should be thoughtful about the money tied to MU when considering changes to the PCPCH model.

If the current MU language is replaced, do you have suggestions to replace 1.E.3 (electronic access), 3.E.3 (preventive service reminders), and 4.G.3 (medication reconciliation)?

The following recommendations were received:

1.E.3 Electronic Access

- Downgrade to 5 points or replace
 - Electric access for patients, health buddies, online programs

3.E.3 Preventive Services Reminders

- Proactive clinically relevant reminders to population of clinic

4.G.3 Medication Reconciliation

- Pharmacists/other pharmacies should be included somehow – community pharmacies, e-prescribing exchange, share clinical data with other pharmacies
- Make this standard tied to more complex patients – all patients don’t need high level med rec.
- Population based metric (i.e.: for patients with 2 or more chronic condition or 4 or more medications/high risk medic)
 - Identify this population and do med rec for them
- Measure around *clinic process* for identifying complex patients
- Gold standard: Pharmacist in the clinic

6.C - Patient experience of care

After a short break, the meeting resumed at 10:50 A.M. Evan Saulino provided a brief overview of the intent of the measure, and referred committee members to the questions on their worksheet to guide the discussion (see meeting materials). Committee members discussed the measure and these

questions in their small groups for 15 minutes, and then convened as a whole to report their discussion and recommendations.

Should Standard 6.C include a Must-pass measure that requires all recognized PCPCHs to assess patient/family experience at least annually? If so, does the measure language currently in 6.C.1 meet the intent? If not, what is needed to make it better?

All committee groups reported consensus that Measure 6.C.1 should be a Must-pass measure.

It was recommended the measure be revised to encourage clinics to utilize the patient survey data they receive in a meaningful way. Some ideas include:

- Sharing data with providers, staff and patients
- Implementing a Quality Improvement initiative using data
- Demonstrating improvement could be an alternative to meeting the benchmark
- Must pass measure should require clinic to report they actually reviewed the results

Other discussion points:

- The must-pass measure should not specify the use of CAHPS.
- Need both patient survey and patient advisory council in the PCPCH model. Survey is fundamental component, patient advisory council more advanced.

Conclusion

Nicole stated the next meeting will be held in Salem on August 21. The PCPCH model measure for discussion will be 3.C – Mental Health, Substance Abuse & Developmental Services. Nicole requested committee members email her any preliminary feedback about this measure prior to next month's meeting so it can be shared with committee member prior to the meeting.

Public Comment

The co-chairs opened the meeting to public testimony at 11:55 A.M. There were no public comments.

Adjourned at 12:00 P.M.