

Patient-Centered Primary Care Home Standards Advisory Committee

AGENDA

July 23, 2015

Portland State Office Building, Room 1E

800 NE Oregon St., Portland

9:00 a.m. to Noon

#	Time	Item	Materials	Presenter
1	9:00	Welcome, introductions, and charge for the day	1	Mitch Anderson Doug Lincoln
2	9:15	Staff summary from last meeting	2	Evan Saulino
3	9:30	Measure work sessions <ul style="list-style-type: none">• Meaningful Use measures<ul style="list-style-type: none">○ 1E: Electronic access○ 3E: Preventive services reminders○ 4G: Medication reconciliation	3	Evan Saulino All
	10:30	Break		
5	10:45	Measure work sessions <ul style="list-style-type: none">• 6C: Patient experience of care	4	Evan Saulino All
7	11:50	Public Testimony		
	12:00	Adjourn		

Materials:

1. June 25th Meeting Minutes
2. Work Session 1 Summary
3. Meaningful Use Measure Worksheet
4. 6C Measure Worksheet

Next meeting:

August 21, 2015

1 – 4pm

Human Services Building, Room 137 A&B

500 Summer St. NE, Salem

Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
Meeting Minutes
June 25, 2015 9:00 A.M. – 12:00 P.M.
Portland State Office Building, Room 1D
Portland, Oregon

Present

Mitchell Anderson (co-chair)
Tammy Alexander, MED
Carolyn Anderson
Carrie Baldwin-Sayre, ND
Seth Bernstein, PhD
Patty Black
Chris Bouneff
Kristin Dillon, MD
Scott Fields, MD
Robin Henderson, PsyD
Joe Hromco, PhD
Kris Keith
Susan King
Helen Kurre, MBA
Lynnea Lindsey-Pengelly, PhD
Barbara Martin, PA
Charlotte Navarre
Jorge Ramirez Garcia, PhD
David Ross (attending for Colleen Reuland)
Kathy Savicki
Christine Seals, MD

Barb Seatter
Megan Viehmann, PharmD

Joining by phone

Dan Reece (staff)
Maggie Bennington Davis, MD

Absent

Doug Lincoln, MD (co-chair)
Meg Portwood, FNP
Bruin Rugge, MD
Colleen Smith
David Dorr, MD

Staff

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

Introductions and Overview of Committee Meetings

Following introductions, Co-Chair Anderson thanked the committee for their participation, reviewed the Charter (see meeting documents), and described the scope of work for the committee through November 2015. 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 developing standards for integration of primary care into behavioral health care settings.

Nicole Merrithew stated that this advisory committee is comprised of more members than past committees in part because of the need for diverse and broad areas of expertise. To best facilitate these meetings, the committee will divide into small groups for work sessions around a specific topic, and then report their discussion and recommendations to the entire committee.

Overview of PCPCH Program

To ensure all committee members have the same foundational knowledge, Nicole conducted an overview presentation about the PCPCH Program (see meeting documents). Topics included:

- PCPCH model review
- Evaluation data and results
- Lessons learned from evaluations and site visits
- Legislation affecting PCPCH Program

Measure Work Sessions

Committee members divided into groups of five to discuss two specific PCPCH model measures: 1F - Prescription refills and 6C - Patient experience of care.

1F- Prescription refills

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

Should this measure be weighted more heavily given its association with having a robust PCPCH infrastructure and impact on patient care?

Overall, committee groups reported this measure should be weighted more heavily. It is important from the patient perspective to receive timely refills, and is especially important to certain patient populations (i.e.: those with chronic disease diagnosis).

In its current form, the measure does not encourage transformation. Different levels of accomplishment should be added to meet the intent of the measure.

It was suggested to develop a lesser weighted measure for tracking refill requests and having a process in place to authorize prescription meds in a planned way, and then increase the weight on the current measure of turnaround time assessment.

Should a measure also be included that either encourages improvement or sets a benchmark?

Committee groups reported that a benchmark or quality improvement process should be incorporated into the measure. There is no known national benchmark for prescription refills. Suggestions for a benchmark include:

- A percentage of reconciliations complete in certain number of hours
- A quality improvement/internal practice benchmark determined by the clinic
- Timeliness of refills by classes of medications
- “Fewer refills per patient” [as a benchmark] would be evidence of pro-active Rx management.

Other discussion points

- Apply this measure to a sub-set of a clinic’s population such as those with a chronic disease diagnosis.
- Refills are received in a variety of methods, so perhaps the measure should focus on how the majority of refills come in.

6C - Patient experience of care

The committee was unable to discuss this measure due to time constraints.

Public Comment

Co-Chair Anderson opened the meeting to public comments. There were no public comments.

Adjourned at 12:00 P.M.

DRAFT

Work Session 1 Summary

The measure discussed currently states: PCPCH tracks the time to completion for prescription refills (5 points).

➤ *34% of clinics have attested to this measure.*

Staff recommended:

Clinics actually doing 1.F.1 demonstrate relatively robust clinic quality improvement ability and PCPCH infrastructure.

- Consider weighting this measure more heavily (i.e. worth more points).
- Consider adding a benchmark (or standard of care average) refill time for clinics to aspire to.

We asked:

1. Should this measure be weighted more heavily given its association with having a robust PCPCH infrastructure and impact on patient care?

2. Should a measure also be included that either encourages improvement or sets a benchmark?

Summary of feedback:

Overall, committee groups reported this measure should be weighted more heavily. It is important from the patient perspective to receive timely refills, and is especially important to certain patient populations (i.e.: those with chronic disease diagnosis).

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. There is no known national benchmark for prescription refills. Suggestions for a benchmark include:

- A percentage of reconciliations complete in certain number of hours
- A quality improvement/internal practice benchmark determined by the clinic
- Timeliness of refills by classes of medications
- “Fewer refills per patient” [as a benchmark] would be evidence of pro-active Rx management.

It was suggested to develop a lesser weighted measure for tracking refill requests and having a process in place to authorize prescription meds in a planned way, and then increase the weight on the current measure of turnaround time assessment. The desired state is something like “Help us obtain our prescribed medications in a way that’s reliable and convenient.” The path to getting there involves first thinking about when refill requests represent “desired” versus “undesirable” care processes and trying to limit their number overall. The second stone on the path is processing the requests that do come in promptly and communicating with patients what “prompt” means.

Staff recommended course of action based on discussion and feedback:

Edit Standard 1F to include two measures:

- **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.

Rationale:

- This recommendation captures the essence of the discussion without over-specifying and therefore constraining practices and creating additional administrative burden.
- While a 5 point measure was not included, we will be adding a “best practices” section for this standard to our technical assistance guide which will describe how the first step in meeting the measure is having a process in place to track prescription refills (not necessarily inclusive of time to refill).

Measure Work Session Materials

Meaningful Use Measures:

Measure 1.E.3 Electronic Access - (15pts) Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.

➤ *80% of clinics have attested to this measure.*

A clinic that meets any of the following Meaningful Use measures will qualify for PCPCH Measure 1.E.3:

- Stage 1 Meaningful Use core measure 12
 - More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
- Stage 1 Meaningful Use menu measure 5
 - At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
- Stage 2 Meaningful Use measure 7
 - Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.
 - Measure 2: More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.

Measure 3.E.3 Preventive Services Reminders - (15pts) Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.

➤ *32% of clinics have attested to this measure.*

A clinic that meets any of the following Meaningful Use measures will qualify for PCPCH Measure 3.E.3:

- Meaningful Use Stage 1 Menu Set Measure 4
 - More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
- Meaningful Use Stage 2 Core Measure 12
 - More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

Measure 4.G.3 Medication Reconciliation - (15pts) Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of care

➤ *47% of clinics have attested to this measure.*

A clinic that meets any of the following Meaningful Use measures will qualify for PCPCH Measure 3.E.3:

- Meaningful Use Stage 1 Menu Set Measure 6
 - The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
- Meaningful Use Stage 2 Core Measure 14
 - The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Intent: “Use available electronic technology effectively to communicate with me about my health care”

The Meaningful Use (MU) measures were included in the PCPCH model in order to foster policy and practice alignment. The PCPCH standards of electronic access, preventive services reminders, and medication reconciliation (i.e. those listed above) were developed by the PCPCH Standards Advisory Committee, and identified as important areas to address within the model. In 2012, the Standards Advisory Committee chose to align the Tier 3 measures in each of these areas with MU. In the early years of the PCPCH model, MU measures were important to fostering EHR adoption and robust utilization. However, currently:

- 83% of recognized PCPCHs use EHRs that meet MU criteria,
- 68% of physicians, nurse practitioners and physician assistants in Oregon demonstrated MU and/or adopted, implemented or upgraded an EHR, and
- 90% of PCPCHs recognized under the 2014 Standards attested to at least one MU measure.

At the same time, EHR technology barriers and MU are sources of frustration in the primary care provider community. PCPCH site visit results indicate that there is significant variability in how MU measures are achieved, and often the processes in place to meet the MU measures are less than transformative. Simultaneously, MU metrics are regularly reported to CMS, and CMS is conducting MU audits.

Staff recommendation:

- Decrease emphasis on MU measures as MU measures alone are not indicators of robust PCPCHs. (For example, consider making all MU measures 5 points rather than 15 points.)
- Replace the 15-point measures with alternative measures that would better assess PCPCH robustness in the area the MU measure addresses (i.e. electronic access, etc.).

Specific feedback/questions:

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

2. If included in the PCPCH model, do you agree that emphasis on MU measures in the PCPCH model should decrease to reflect the reality of clinic practice and EHR technologies?

3. 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)?

Additional comments:

Additional information for reference:

Other measures currently included in Standards 3E and 4G:

Preventive Services Reminders

3.E.1 - PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services. (5 points)

3.E.2 - PCPCH tracks the number of unique patients who were sent appropriate reminders. (10 points)

Medication Reconciliation

4.G.1 - Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation. (5 points)

4.G.2 - PCPCH tracks the percentage of patients whose medication regimen is reconciled. (10 points)

Measure Work Session Materials

Measures 6.C.1, 6.C.2, 6.C.3 Experience of Care

- *84% of clinics have attested to one of the three measures in this standard.*

Measures 6.C.1 - (5pts) PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.

- *21% of clinics have attested to this measure.*

Measure 6.C.2 - (10pts) PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.

- *55% of clinics have attested to this measure.*

Measure 6.C.3 - (15pts) PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.

- *8% of clinics have attested to this measure.*

Intent: “Ask us about our care experience. Value our feedback and use this information to improve the way we work together. “

To be truly person and family centered, a primary care home should understand the care experiences of its patients and their family members and seek to improve the care experience where appropriate. Any patient survey assessing the described areas in the measure can meet 6.C.1 - CAHPS survey tools are recommended. CAHPS is required for measures 6.C.2 and 6.C.3.

Staff recommendation:

The 2012 Standards Advisory Committee recommended adding patient experience of care as a “Must-pass” measure.

- Consider making patient/family experience a required part of the PCPCH model of care (i.e. a Must- pass measure).

Specific feedback/questions:

1. 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?

Additional comments:
