



Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
Meeting Minutes
August 21 2015 1:00 P.M. – 4:00 P.M.
Barbara Roberts Health Services Building
Salem, Oregon

Present

Mitchell Anderson (co-chair)
Doug Lincoln, MD (co-chair)
Carolyn Anderson
Carrie Baldwin-Sayre, ND
Maggie Bennington Davis, MD
Seth Bernstein, PhD
Patty Black
Chris Bouneff
Kevin Campbell
Scott Fields, MD
Robin Henderson, PsyD
Joe Hromco, PhD
Barbara Martin, PA
Charlotte Navarre
Jorge Ramirez Garcia, PhD
Dan Reece
Kathy Savicki
Christine Seals, MD
Barb Seatter
Davina Jones (for Colleen Smith)
Larlene Dunsmuir (for Susan King)

Staff

Nicole Merrithew
Deepti Shinde
Megan Bowen
Chris Carrera
Amy Harris

Joining by phone

Colleen Reuland
Helen Kurre, MBA
David Dorr, MD
Lynnea Lindsey-Pengelly, PhD

Absent

Tammy Alexander, MED
Kristin Dillon, MD
Meg Portwood, FNP
Evan Saulino, MD
Megan Viehmann, PharmD
Bruin Rugge, MD
Kris Keith

Introductions and Overview of Committee Meetings

Co-chair Mitch Anderson convened the meeting at 1:05 P.M. Members introduced themselves by name and organization affiliation. Following introductions, Mitch reviewed the meeting agenda (see meeting materials).

Staff Summary from Last Meeting

PCPCH Program staff drafted a summary of committee recommendations from work session #2 for Meaningful Use Measures 1.E – Electronic Access, 3.E – Preventive Services Reminders and 4.G – Medication Reconciliation, and 6.C Patient Experience of Care (see meeting materials). Megan Bowen presented the summary to the committee to ensure it accurately reflected their recommendations. Overall, committee groups reported the Meaningful Use measures should be de-emphasized in the PCPCH model, but agreed the concepts were important to retain. Based on committee recommendations, PCPCH Staff drafted proposed revisions to the measures (see meeting materials):

- 1.E - Keep current standard language but reduce point value from 15 points to 5 points
- 3.E - Reorder the measures so that MU is less valued in this standard. Addition of a new 15 point measure that is more transformative than MU measure.
- 4.G - Change standard name to Medication Reconciliation and Management. Reorder the measures so that MU is less valued in this standard.

Based on committee recommendations, PCPCH Staff drafted proposed revisions to Measure 6.C:

- Change 6.C.1 so that it is a must pass measure, no change to language of measure.
- 6.C.2 – PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process. (10 pts.)
- 6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process and meets benchmarks on the majority of domains regarding provider communication, coordination of care, and practice staff helpfulness. (15 pts.)

Following Megan’s presentation, some committee members voiced concerns regarding the recommendation to change the measure from an annual survey to every two years. Other committee members supported this recommendation citing the challenge for smaller clinics to survey patients annually. Nicole Merrithew clarified the rationale behind the recommended change to provide clinics more time to implement Quality Improvement initiatives using the survey data.

Measure Work Session

At 1:40 P.M. Mitch introduced Standard 3.C – Mental Health, Substance Abuse and Developmental Services to the committee. (See meeting materials) He explained the intent of this standard is to ensure that primary care homes are routinely assessing their patients for these issues, and providing appropriate treatment, referral and care coordination for these conditions. However, there is tremendous variability in how PCPCHs use behavioral health services in practice. Megan provided examples of integration and co-location from PCPCH site visits. PCPCH staff drafted and presented proposed changes to Standard 3.C for committee consideration (see meeting materials).

The committee discussed general challenges posed in Standard 3.C. such as defining integration, the differentiation between behavioral health services and specialty mental health, and health system administrative processes that do not support physical and behavioral health care integration.

Following this discussion, Mitch asked the committee members to meet in small groups to consider the services in 3.C. from the individual's perspective. The goal of this discussion was to think of the patient's perspective in how, when and where the behavioral health services are provided. The committee reconvened as a group and the following points were noted:

- The provider and/or care team should be responsible for following up with the patient when a referral for behavioral health services is given. It should not be just the patient's responsibility.
- When a practice is truly integrated, care should appear seamless to the patient.

Public Comment

Following a brief break, the committee reconvened at 2:45 P.M. Mitch recommended the committee take public comment at this time, since it was noted several members of the public were in attendance. Jill Boyd from Greater Oregon Behavioral Health, Inc. (GOHBI) and Eastern Oregon Coordinated Care Organization (EOCCO) described how she works as a practice transformation coach in rural Oregon and sees firsthand the stigma associated with people receiving behavioral health services in a small community. She supports behavioral health integration. Jill also asked how the discussion of 3.C may impact the Behavioral Health Home standards.

Measure Work Session

At 3:55 P.M. the committee members met in small groups to continue their discussion of 3.C, using worksheet questions as a guide (see meeting materials). The committee reconvened as a group and reported their discussions. The following points were noted:

- Behavioral Health Services and Specialty Mental Health Services should be clearly defined in the measure or technical specifications.
- There should be a signed Collaborative Agreement between the PCPCH and community mental health clinics. (Similar to hospital agreement). However, concern was expressed that some community mental health clinics do not have capacity to manage a formalized referral process.
- Co-location and Integration are not the same. At an integrated PCPCH, both physical and behavioral health providers would have access to care plans, share medical records, can attend in-person meetings, attends huddles (team meetings), and is viewed as a member of the care team.
- SB 832 addresses licensure requirements of who can provide behavioral health services, but does not address specific training in primary care. Behavioral Health Providers who work in primary care should have some kind of special training.
- Developmental screenings should not be included in 3.C.0 and should be its own measure.

- Psychosocial screenings should be added to the measure or captured in some way to assess social determinants of health. (3.C.2)
- Measure should still be “check all that apply” since co-location and integration are not the same and co-location does not necessarily lead to integration.

Conclusion

Nicole stated the next meeting will be held in Portland on September 1. Since there are only 7 business days between meetings, PCPCH staff will focus their efforts on finalizing the materials for the September 1 meeting and will draft recommendations for 3.C. based on the committee’s discussion to be presented at a future meeting.

Public Comment

Mitch opened the meeting to public testimony at 3:55 P.M. There were no additional public comments.

Adjourned at 4:00 P.M.

DRAFT