

Patient-Centered Primary Care Home Standards Advisory Committee

AGENDA

August 21, 2015

Barbara Roberts Human Services Building, Room 137 A/B

500 Summer St. NE, Salem

1 – 4 p.m.

#	Time	Item	Presenter
1	1:00	Welcome, introductions, and charge for the day	Mitch Anderson Doug Lincoln
2	1:15	Staff summary from last meeting	Megan Bowen
3	1:30	Measure work session <ul style="list-style-type: none">• 3C: Mental health, substance abuse, and developmental services	Mitch Anderson All
	2:30	Break	
5	2:45	Measure work session <ul style="list-style-type: none">• 3C: Mental health, substance abuse, and developmental services	Mitch Anderson All
7	3:50	Public Testimony	
	4:00	Adjourn	

Next meeting:

September 1, 2015

9am - Noon

Lincoln Building, Ste. 750, Training Room

421 SW Oak St., Portland

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.

Work Session 2 Summary

The committee was asked to discuss four standards in the PCPCH model in this session. The first three standards relate to Meaningful Use (MU) and were discussed in conjunction. The fourth standard relates to the patient experience.

Meaningful Use Standards:

Standard 1.E – Electronic Access

Current language:

1.E.3 - 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. (15pts)

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

Standard 3.E – Preventive Services Reminders

Current language :

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.(5pts)

- *20% of clinics have attested to this measure.*

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

- *17% of clinics have attested to this measure.*

3.E.3 - 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. (15pts)

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

Standard 4.G – Medication Reconciliation

Current language :

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. (5pts)

- *19% of clinics have attested to this measure.*

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

- *10% of clinics have attested to this measure.*

4.G.3 - 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. (15pts)

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

Staff recommended:

- 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.

The committee was asked:

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)?

Summary of feedback from committee by question:

1. Each committee group felt strongly that the concepts in the MU 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.
2. All committee groups agreed the MU measures should not have as much as 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.
3. Some specific recommendations received were:
 - to downgrade 1.E.3 to 5 points or to replace it
 - have clinics proactively send reminders that are most clinically relevant to their population
 - incorporate pharmacists more into processes (e-prescribing exchange, sharing clinical data with other pharmacies like community pharmacies).
 - Add as a best practice that a pharmacist be located in the clinic
 - add measure around process for identifying complex patients (patients with 2 more chronic conditions or 4 or more medications or patients taking high risk medications) because perhaps not all patients need high level medication reconciliation.

Staff recommendations based on discussion and feedback:**Standard 1.E – Electronic Access**

- Recommendation - Keep current standard language but reduce point value from 15 points to 5 points
- Rationale – For some MU measures, such as electronic access, clinics can meet them by just checking the box. The most valuable measures in the PCPCH model, those worth 15 points, should be those that are the most transformative and this measure is not transformative.

2. Standard 3.E – Preventive Services Reminders

- Recommendation – 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.
New order of measures:

3.E.1 - Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventive/follow-up care (5 pts.)

3.E.2 – PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders. (10 pts.)

3.E.3 – PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. The PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, **and** tracks the completion of those recommended preventive services. (15 points)

In the technical specifications for this measure it will state that clinic must track reminders and completion of preventive services for at least 3 preventive services that are relevant to that clinic's population.

- Rationale - For some MU measures clinics can meet them by just checking the box. The most valuable measures in the PCPCH model, those worth 15 points, should be those that are the most transformative and this measure is not transformative. Additionally, adding the tracking of completion of recommended preventive services improves on accountability, patient-centeredness and coordination.

3. Standard 4.G – Medication Reconciliation

- Recommendation – Change standard name to Medication Reconciliation and Management. Reorder the measures so that MU is less valued in this standard.
New order of measures:

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 using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. (5 pts.)

4.G.2 – PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter. (10 pts.)

4.G.3 – PCPCH provides Comprehensive Medication Management for appropriate patients and families. (15 pts.)

In the technical specifications for this measure Comprehensive Medication Management will be further defined as:

Comprehensive Medication Management is the provision of the following services utilizing the professional practice of pharmaceutical care by a licensed pharmacist or other health care professional for patients taking multiple (5 or more) medications for multiple (two or more) chronic health conditions:

- (1) Assessment of the patient's health status including the personal medication experience and use patterns of all prescribed and OTC medications;
- (2) Documentation of the patient's current clinical status and clinical goals of therapy;
- (3) Assessment of each medication for appropriateness, effectiveness, safety and adherence focusing on achievement of desired clinical goals;
- (4) Identification of all drug therapy problems including additions or deletions in medications or changes in dosage needed to meet desired clinical goals;
- (5) Development of a comprehensive medication therapy plan for the patient in consultation with the prescribing practitioner that is aligned with recognized standards of practice;
- (6) Documentation and follow up of the effects of recommended drug therapy changes on the patient's clinical status and savings in overall costs including ER visits and hospitalizations.

- Rationale - Adding the requirement that clinics not just track but also report the percentage of patients whose medication regimen is reconciled at the time of PCPCH application ensures that the clinic has a process in process for doing this at time of application. The addition of the 15 point measure incorporating the concepts of Comprehensive Medication Management is consistent with the theme that measures in the PCPCH model worth 15points are truly transformational and not just checking the box.

4. Standard 6.C – Experience of Care

Current language:

6.C.1 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. (5 pts.)

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

6.C.2 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. (10 pts.)

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

6.C.3 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. (15 pts.)

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

Staff recommended:

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

The committee was asked:

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?

Summary of feedback from committee by question:

1. All committee groups reported consensus that Measure 6.C.1 should be changed to a must-pass measure. The committee also recommended that the measure be revised to encourage clinics to utilize the patient survey data they receive in a meaningful way. Some ideas for utilizing patient data included:

- 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

Staff recommendations based on discussion and feedback:

- Recommendation –
 - 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.)
- Rationale – PCPCHs need to demonstrate that they are utilizing patient survey data and using it as part of a quality improvement process and not just collecting it.

Measure Work Session Materials

Measures 3.C.0, 3.C.2, 3.C.3 Mental Health, Substance Abuse, and Developmental Services

- *46% of clinics have attested to all three measures in this standard. Note: This is a check-all-measures that-apply standard and so clinics attest to 3.C.0 and can also attest to 3.C.2 and 3.C.3. There are a total of 4 such check-all-that apply standards in the current PCPCH model.*

Measure 3.C.0 - (Must Pass) PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

- 100% of clinics have attested to this measure. It is a must-pass measure.

Measure 3.C.2 - (10pts) PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.

- *77% of clinics have attested to this measure.*

Measure 3.C.3 - (15pts) PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.

- *52% of clinics have attested to this measure.*

Intent: “Ask about and effectively manage and care for mental/behavioral health, substance abuse, and developmental issues, which directly affect my overall health.”

Assessment and appropriate intervention for mental health, substance use and developmental, behavioral or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, or developmental conditions is strongly associated with improved health outcomes in these populations. 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.

Staff recommendation: Site visits have demonstrated significant differences in robustness of screening and intervention strategies. In particular the meaning of cooperative referral process and co-management has shown enormous variability. Closing the chasm between traditional medical and mental/behavioral/substance abuse/developmental services is an area of definite interest and excitement across Oregon. It is clear that co-location of these services, while potentially and actually beneficial, does not offer the same patient benefits as integration of services. Evidence demonstrating the patient *and* clinic/staff benefits of integration with behavioral health professionals is particularly strong. ⁱ We recommend the following changes to standard 3.C:

- For standard 3.C.0 replace “or” with “and”.
 - New 3.C.0 – (0 pts.) PCPCH has a screening strategy for mental health, substance use, **and** developmental conditions and documents on-site and local referral resources.
- 3.C.2 becomes a combination of the current 3.C.2 and 3.C.3
 - New 3.C.2 – (10 pts.) PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed **OR** is co-located with specialty mental health, substance abuse, or developmental providers.
- New 3.C.3 – (15 pts.) PCPCH offers *integrated* behavioral health services, including population-based, same-day consultations by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions.
 - Technical specifications will spell out the details of what “integrated” means.
- Change from being a check-all-that-apply standard to a check one. Clinics cannot be fully integrated without also having a co-referral process and co-location so they should receive points for the integration but not integration + co-referral+ co-location.

Specific feedback/questions:

1. Please describe the services in 3.C. from the individual’s perspective. For example, what happens and when.

2. Do you think the language and value changes proposed for standard 3.C. (above) capture the correct intent, reflect current evidence, and will reward the expanding scope of efforts to identify, and effectively treat mental/behavioral health, substance abuse, and developmental issues? Is 3.C.2 as proposed an appropriate “middle ground or stepping stone” between screening and integration? Does this language align with the individual’s perspective? If not, what would you recommend to accomplish this?

3. Although it will be defined in the technical specifications and not in the measure language, how would you define co-location and integration? Specifically how should integrated behavioral health services be defined?

Examples:

- Threshold of minimum number of hours available

- Training and background specifications for individuals that provide behavioral health services

3. Should 3C remain as a check-all-that apply standard where clinics can attest and receive points for co-referral/co-location + integration? Or should 3C be changed to a check one standard where clinics can attest to and receive points for co-referral/co-location **or** integration?

Additional comments:

ⁱ Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade (2010) Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

<http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>