Patient-Centered Primary Care Home Standards Advisory Committee

AGENDA
September 1, 2015
Lincoln Building, 7th floor Transformation Center Training Room
421 SW Oak Street, Portland
9 a.m. - Noon

#	Time	Item	Presenter
1	9:00	Welcome, introductions, and charge for the day	Mitch Anderson Doug Lincoln
2	9:15	Staff summary from last meeting	PCPCH Program Staff
3	9:30	Staff measure recommendations and discussion: • 1C: Telephone and electronic access • 3A: Preventive Services • 5A1/2: Population data management • 5C: Complex care coordination • 2A: Performance and clinic quality	Evan Saulino All
	10:00	Break	
5	10:15	PCPCH model tier structure	Nicole Merrithew All
6	11:50	Public Testimony	
	12:00	Adjourn	

Next meeting:
September 25, 2015
9 a.m. - Noon
Portland State Office Building, Room 1E
800 NE Oregon St., Portland

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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

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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).

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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.

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- 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.

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Measure Work Sessions Materials

Standard 1.C - Telephone and Electronic Access

Measure 1.C.1 (5 points) - When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient's medical record.

- 94% of clinics have attested to this measure.

Intent: "Make sure we can get the advice, or be directed to the appropriate care we need when your office is closed."

Access to clinical advice outside of in-person office visits is an important primary care home function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that PCPCH patients, caregivers, and families can obtain clinical advice via telephone from a live person at all times.

From 2014 TA guide: "Documentation required**:** Attestation only. At a verification site visit, clinics should be able to produce documented examples of advice calls during both normal business hours and after-hours."

Staff recommendation: Eliminate this measure from the PCPCH model.
This is a duplicative measure. Demonstrating this measure is a significant part of how 1.C.0 (the must pass measure) is verified at site visits – see "Documentation required" above. It is also generally a community standard especially now that EHRs are more widespread (compared to 2012).

Standard 3.A – Preventive Services

Measure 3.A.1 (5 points) - PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.

- 34% of clinics have attested to this measure.

Intent: "Help make sure we get the recommended preventive care we need"

Preventive care is a core component of primary health care. The intent of this standard is to ensure that primary care homes are routinely providing access to age and gender-appropriate preventive care for the entire patient population served at the clinic. The scope of recommended preventive care is determined by best evidence. Each practice is not required to deliver all of the services themselves, but must have a process to ensure that all patients can access needed preventive services. The clinic should also have a process to coordinate the results of any screening tests.

Staff recommendation: Add the following language to 3.A.1: "and identifies areas for improvement"

Site visits demonstrate that the scope of preventive care services offered or coordinated can be variable at different PCPCHs. In particular Measure 3.A.1 is written with such a low bar that clinics could be offering any number of recommended preventive services and still meet the measure. Adding the requirement that clinics identify areas for improvement will require them to demonstrate that even if they are not offering a broad array of preventive services, they have reviewed evidence-based recommendation guidelines, and are knowledgeable about where they need to work to close gaps.

Standard 5.A – Population Data Management

Measure 5.A.1a (5 points) PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population, including the identification of sub-populations.

Measure 5.A.1b (5 points) **-** PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.

Note: This is a check-all-measures that-apply standard and so clinics attest to 5.A.1a and 5.A.1b for a total of 10 points. There are a total of 4 such check-all-that apply standards in the current PCPCH model.

- 71% of clinics attested to both of these measures.

Intent - "Follow our care closely and make sure we know when tests, prevention services, and guidance are recommended to improve our health."

In order to coordinate and manage care, a primary care home should be able to produce and track basic information about its patient population. In addition, clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need.

Staff recommendations:

- Blend these two 5-point measures into one. Add "and utilize" to 5.A.1a language so that the measures reads "PCPCH demonstrates the ability to identify, aggregate, and display **and utilize** up-to-date data regarding its patient population, including the identification of sub-populations.

Site visits have demonstrated that now, with widespread EHR use, 5.A.1a as currently written can reflect the EHR quality and operator technical abilities rather than reflecting active or accurate data use for improved patient care or coordination/integration. Additionally, in order to be able to do 5.A.1b, the clinic MUST be able to do 5.A.1a, thus the first measure is duplicative. By adding the words "and utilize" to measure 5.A.1a, this would encourage clinics to act on data, not just be able to produce it. This may encourage those clinics trying to meet the measure to focus more on outcomes rather than process.

- Implement 2012 SAC recommendation to add a new medium value measure focused on patient risk stratification and management. Add a 10-point measure: 5.A.2 - PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior.

Site visit experience has shown that risk stratification can be a difficult process, but it reaps rewards. Published research demonstrates this strategy can help clinics more effectively target care management and intervention efforts. Addition of this measure would align with work and

outcomes data from the Comprehensive Primary Care Initiative (CPCI). Rewarding ability to do risk stratification successfully may encourage the spread of processes being developed in CPC, Pediatric, and other clinics across Oregon.

Standard 5.C - Complex Care Coordination

Measure 5.C.1 (5 points) PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.

- 73% of clinics have attested to this measure.

Intent: "Help us navigate the health care system to get the care we need, in a safe and timely way. Stay involved when we get care in other places."

Staff Recommendation: Change 5.C.1 language to recognize the roles of different members of the health care team in different PCPCHs, and focus on function rather than process. The current language of 5.C.1 as written is difficult to verify at some site visits because of variable clinic structure/teams/workforce in different PCPCHs because many clinics do not have only one person dedicated to care coordination.

Change 5.C.1 to read "PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care."

Standard 2.A – Performance & Clinical Quality

Measure 2.A.0 (Must-Pass) - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
Measure 2.A.2 (10 points) - PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures.
Measure 2.A.3 (15 points) - PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures.

Intent: "Take responsibility for making sure we receive the best possible health care."
Measuring and improving on clinical quality is a foundational element of primary care homes. The intent of these measures is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate.

Staff Recommendations: Application data submission and site visit experience have demonstrated significant variability in the ability of PCPCHs to reliably access and utilize data for quality improvement work. We recommend there be a ladder of 5/10/15 point measures in addition to the must-pass measure, to promote a focus on improvement. Proposed measures for Standard 2.A:

- 2.A.0: Must pass measure unchanged
- 2.A.3: Highest value measure (meet benchmarks on three Quality Measures) unchanged.
- Current 2.A.2 becomes new 2.A.1 and goes down in point value (ie from 10 to 5 points)
- **NEW 2.A.2:** PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (10 points)

Definition of improvement would not be in the language of the measure, but instead in the TA Guide.

Example language that could define Standard 2.A in TA Guide:

Eligible Measures – Adult and Pediatric core set and menu set measures are found in the PCPCH Quality Measures: Technical Specifications section beginning on page **X.** At least one reported measure should be inclusive of children or adolescents if the PCPCH population includes those age groups. In general, measures selected should reflect the PCPCH population and practices seeing both children and adults should report on measures representative of both groups.

Demonstrating Improvement- to meet 2.A.2, clinics should submit two measurements:

- 10% improvement is adequate for measures where there is 12 months between data collection or two consecutive 12 month reporting time frames.
- 5% improvement is adequate for measures where there is 6 months between data collection of two consecutive 6 month reporting time frames.

Proposal to Revise the Tier/Point Thresholds in the PCPCH model

Background:

The PCPCH model has 54 measures and 33 standards that revolve around 6 core attributes. In most cases in each standard, the measures are divided into three levels that reflect basic to more advanced primary care home functions. The first level of measures focus on foundational primary care home elements that the committee believes should be achievable by most primary care clinics in Oregon with significant effort, but without significant investment of new resources. Level 2 and Level 3 measures on the other hand reflect intermediate and advanced functions, with a focus on demonstrating improvements in care processes or outcomes.

Example:

CORE ATTRIBUTE 1: ACCESS TO CARE - "Health care team, be there when we need you."

Standard 1.A) In-Person Access

Level 1 (foundational)	**Measure** 1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care. (5 pts)
Level 2 (intermediate)	**Measure**1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care. (10 pts)
Level 3 (advanced)	**Measure** 1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care. (15 pts)

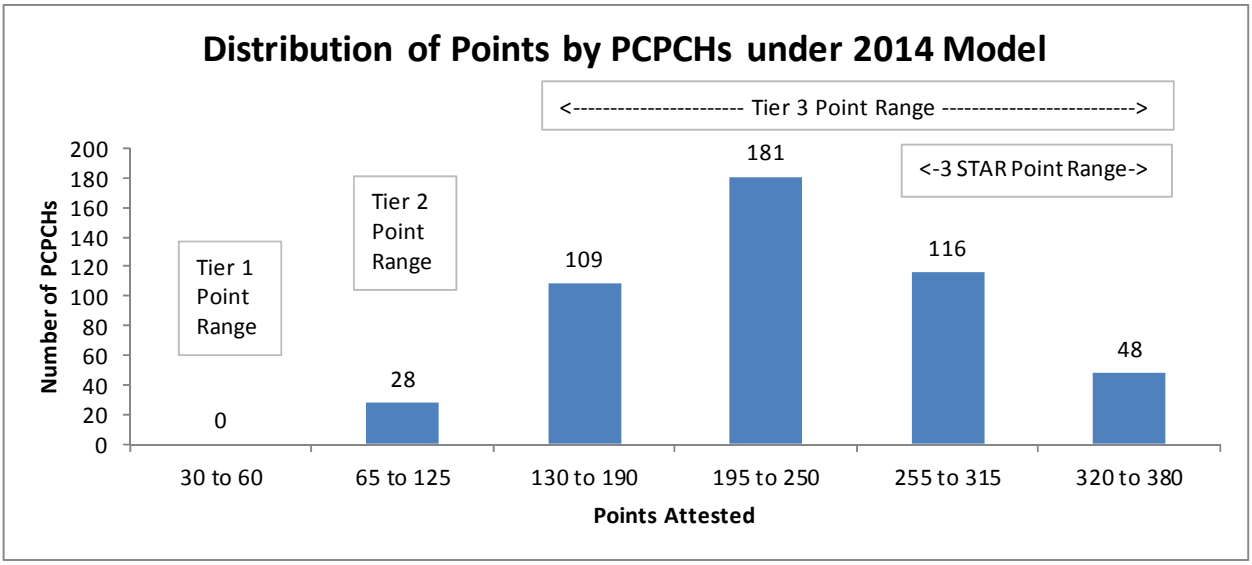
All clinics seeking PCPCH recognition must attest to doing the 10 must-pass standards in the model. Additionally clinics attest to the measures that are currently in place at their clinic and each measure has a corresponding point value attached. Depending on which measures they attest to, they accumulate points and the total accumulated points determine which tier they fall into in the model.

Current State:

- There are currently 569 clinics recognized as PCPCHs.
- Out of these clinics, 86% are recognized under the current 2014 PCPCH model, the other 14% are recognized under the 2011 model.
- All data below refer to the clinics recognized under the 2014 model.

- Descriptive statistics:
    - Range of points attested to = 65 points to 380 points
        - 380 points is the maximum possible, 30 points is the minimum possible but no clinics have attested to less than 65 points.
    - Average points attested to = 228; Median points attested to = 223
- Current Tier/Points Thresholds:

Tier	Current Thresholds	Additional Requirements	% of Clinics in Tier
Tier 1	30 - 60 points	+ 10 must-pass standards	0%
Tier 2	65-125 points	+ 10 must-pass standards	6%
Tier 3	130 – 380 points	+ 10 must-pass standards	**94%**
3 STAR Designation	255 – 380 points	+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit	NA



Intent

Achieving Tier 3 PCPCH recognition was intended for those clinics that had more advanced primary care home functions in place. Given that 94% of recognized clinics have achieved Tier 3 status and given site visit experience, this may not be what Tier 3 recognition represents currently in the

model. So that practices are incentivized to continue along in the transformation process, the rigor of the model needs to be increased for those clinics that have already achieved Tier 3 status while continuing to support practices currently achieving Tier 1 and Tier 2 status.

The current tier/point thresholds have been in effect since the launch of the PCPCH model in 2010. The 2010 Standards Advisory Committee acknowledged the need for the model to evolve over time as primary care practices become more sophisticated in coordinating and managing the care of individuals and populations. The 2012 Standards Advisory Committee recommended changing the tier/point thresholds to make it more difficult to achieve both Tier 2 and Tier 3 recognition. They proposed the following tier/point structure:

Tier 1: 60-130 points and all 10 must-pass measures

Tier 2: 135-250 points and all 10 must-pass measures

Tier 3: 255-380 points and all 10 must-pass measures

This recommendation was ultimately never adopted when the PCPCH Oregon Administrative Rules were revised in 2012.

Current Staff Recommendation:

Tier	**Proposed Threshold**	**Additional Requirements**	**% of Clinics in Tier**
Tier 1	60 - 145 points	+ 10 must-pass standards	11%
Tier 2	150 - 250 points	+ 10 must-pass standards	51%
Tier 3	255 - 380 points	+ 10 must-pass standards	34%
3 STAR Designation	255 - 380 points	+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit	NA

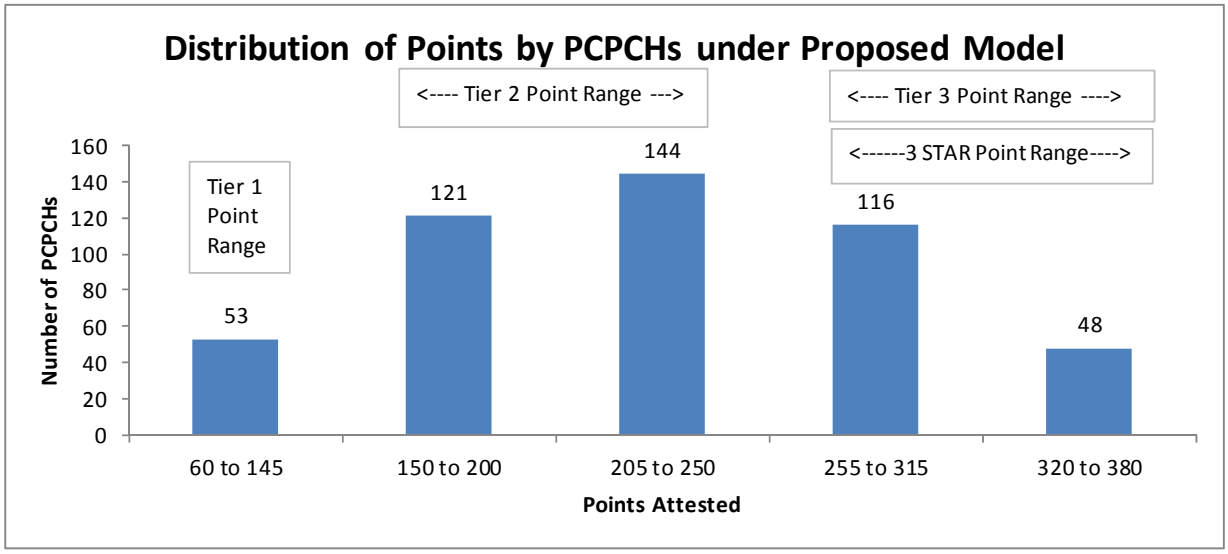
Note:

% of Clinics in Tier was calculated using attested point values for current recognized PCPCHs, or in other words, if this proposed point threshold went into effect today this is the % of clinics that would fall into each tier.

These proposed point thresholds are based on the current PCPCH model that has a maximum of 380 points possible. Based on feedback from this committee that total point value may increase or decrease and the actual point thresholds may need to be slightly adjusted from what is shown above.

The staff recommendation varies slightly from the tier/point structure suggested by the 2012 SAC based on current point values for recognized PCPCHs. For example if the Tier 1 range was 60 to 130

points, only 6% of clinics would fall into this range; Increasing it to 60-145 points makes it so that 11% of clinics fall into the Tier 1 range.



- We recommend that the proposed changes go into effect on January 1, 2016.

- The revised tier/point thresholds will not affect any clinic's current recognition status, it will **not** apply retroactively. For example if a clinic attested in March 2015 with 240 points and is recognized currently as a Tier 3, they would remain Tier 3 until the 2 year cycle of that recognition expired (in this case their recognition as Tier 3 would be valid for March 2015 to March 2017). If in March 2017 they again attested to 240 points however, this clinic would be recognized as a Tier 2.

- The proposed model would have an impact on the number of Tier 3 clinics beginning in 2016. 290 clinics could potentially move from Tier 3 into Tier 2 if they re-apply for recognition and do not attest to additional measures compared to their current application.

	% clinics under current model	% clinics under proposed model		# clinics under current model	# clinics under proposed model
Tier 1	0%	11%		0	53
Tier 2	6%	51%		28	265
Tier 3	94%	34%		454	164

Specific feedback/questions:

1. What are the positive aspects of this recommendation?

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2. What are the negative aspects of this recommendation?

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3. Do the proposed changes to the model meet the intent to move practices along in the transformation process? If not, what do you recommend?

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4. Additional comments:

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