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.