

**Patient Centered Primary Care Home Program - Standards Advisory Committee  
Meeting #3 Summary**

Monday, November 30, 2009  
3:00 – 5:00 pm

Committee Members in Attendance

Mitchell Anderson (co-chair)  
James Beggs, MD (phone)  
Karen Erne, PHR, MA  
Craig Hostetler  
Arthur Jaffe, MD  
Susan King, RN  
Carolyn Kohn  
Robert Law, MD (phone)  
Mary Minniti, CPHQ  
Melinda Muller, MD, FACP  
Carole Romm, MPA, RN  
David Dorr, MD, MS (ex officio)  
Chuck Kilo, MD, MPH (ex officio, phone)  
David Pollack, MD (ex officio)

OHPR Staff in Attendance

Lisa Angus  
Gretchen Morley  
Jeanene Smith, MD  
Rob Stenger, MD

Committee Members Not in Attendance

J. Bart McMullan, Jr, MD (chair)  
David Labby, MD  
Glenn Rodriguez, MD  
Tom Syltebo, MD  
John Saultz, MD (ex officio)  
Barney Speight (ex officio)  
Jane-Ellen Weidanz (ex officio)

Public Attendance

Two members of the general public signed in.

Minutes (**Committee actions in bold**)

*Meeting convened at 3pm by Mr. Anderson.*

**Committee approved the Meeting #2 Summary.**

Jeanene Smith (OHPR) provided an overview of the work of the Oregon Health Authority Health Policy Board and how this work intersects with the work of the PCPCH Standards Advisory Committee, especially with regards to primary care workforce development and payment reform. Dr. Smith Reported that:

- The Health Policy Board has appointed two legislatively mandated committees, 1 group focusing on the health care workforce and 1 group focusing on public purchasers.
- The Health Policy Board is considering the formation of additional working groups to focus on payment reform and health care costs and quality.
- Next steps for the PCPCH work by OHPR will likely include consideration by the Health authority leadership, including several of these committees.

Rob Stenger (OHPR) provided an overview of the revised standards and the goals for the meeting. General discussion on the revised standards included the following:

- Need to make sure measures are feasible/achievable for small clinics, especially those with limited resources/capacity, and do not create unnecessary administrative burden
- It may be useful to have a demonstration or “sentinel provider” approach to test standards and help address implementation strategies and challenges
- General agreement that framing the standards in patient centered language is a productive approach to making them understandable and accessible, may be useful to keep the side-by-side “provider-centered” and “patient-centered” language.

The core attribute of Access and its three standards were discussed at the last committee meeting. The Committee proceeded to discuss the proposed standards under each of the remaining five core attributes. A brief summary of these discussions is as follows:

#### Continuity

- Provider continuity is an important standard. This could be with a primary care provider or other members of the health care team, depending on patient needs/setting. Measures in this area should not discriminate by provider type.
- Information continuity is an important standard. Need to clarify in measures what constitutes appropriate/timely sharing of clinical information. An EHR should not be required to meet an “entry level” information continuity standard. Information continuity could include sharing clinical summaries with patients.
- Geographic continuity should be a broader concept and not just limited to hospital and nursing home care. The general principle is that the PCPCH team should participate in care, regardless of where the patient is located. The group was unclear about whether unique measures of continuity were needed or whether these could be incorporated into care coordination.

**There was general consensus among the group to keep three standards under the core attribute of Continuity (provider continuity, information continuity, geographic continuity) with the recognition that there may not be unique geographic continuity measures.**

### Person and Family Centered Care

- Language under this core attribute needs to reflect the importance of understanding patient needs/wants but also a partnership between patients and providers. Patient wants/values should be considered but may not be the most appropriate basis for decisions in all scenarios.
- Language on patient education and goal setting should be added to the current standards.
- Use of tools to assess patient engagement/readiness to change is an important component of person and family centered care and could be measures of an advanced PCPCH.
- Language under communication and patient self-management should reflect health and wellbeing, not just medical management. Additional language is also needed to reflect the role of family members and other caregivers.
- Cultural and linguistic competence and shared decision-making should be captured in measures if possible, though this may be through the patient experience survey.
- It would be helpful if there were some standard measurement of patient centeredness, difficult for practices to determine this themselves in an objective way.

**There was general agreement among the group to keep two standards under person and family centered care (communication and self management support and experience of care).**

### Coordination and Integration

- The distinction between ambulatory and facility care seems artificial. From the patient perspective care should be coordinated in all settings ... institutional coordination needs to be broader than just hospital and SNF care.
- One possibility for measurement may be focusing on a mechanism/capacity for care coordination within the practice.
- May want to explicitly measure/mention coordination with mental and behavioral health providers. Despite the core attribute title including “integration” the standards do not seem to address mental health explicitly.
- Measures could perhaps focus on “critical” care coordination times/events or identification of high risk situations or individuals.
- EHRs are not a requirement for registry and tracking functions, but some electronic registry probably is needed beyond a very early tier.

**There was general agreement to collapse care coordination into a single standard with multiple measures reflecting the various mechanisms for coordinating care.**

### Comprehensive Whole Person Care

- Broaden the comprehensiveness of language under this standard, specifically “health services and support” instead of “medical services” and addition of specific language on substance abuse.
- Need to add language on comprehensive health assessment (personal or population) that is shared by patients and providers and follow- up care as a component of care planning.
- Add education to the list of “comprehensive” services.
- What is a care plan: A document? A process? An assessment? Not the same for every person. Measures must be relevant for each patient and not overly prescriptive and burdensome.
- Comprehensive scope of services is important, though need to recognize the limitations of many providers (e.g. poor access to dental care) and the fact that certain unique populations might require exceptionally broad sets of comprehensive services (e.g. homeless clinic).
- Equity could be incorporated into measures of comprehensiveness... prevalence of delivered care in certain populations vs. expected rates.

**There was general agreement to keep two standards (scope of services and care planning) under comprehensive whole person care, recognizing that significant care will be needed to develop appropriate care planning measures.**

### Accountability

- It is unclear how useful a “process” measure of Quality Improvement would be, especially since many specialty boards require QI experience as a requirement for maintenance of board certification. The core competency under quality improvement is the ability of clinic to conduct measurement of a performance indicator and then take action to improve performance over time.
- Population management is an important component of accountability, but the population should be limited to patients in the PCPCH panel. Sophisticated/advanced population management measures could include methods to conduct outreach efforts to patients who do not regularly come to the clinic.
- Cost and Efficiency measures are an important component of accountability. From a purchaser perspective, this would ideally be measured as the best possible medical results for the lowest cost (value). Possible measures could include admissions, unnecessary ER visits, duplicated tests, intense management of high utilization patients, but there are a number of challenges to measurement in this area including:
  - need to be aggregate measures of cost
  - utilization/cost measures require risk adjustment and are sometimes not controllable

- clinics don't have cost/utilization data in real time or at the point of care to inform management decisions.

**There was general agreement among the committee to incorporate the above discussion points into the further development of standards and measures under the accountability core attribute.**

Mr. Anderson called for public comment at 4:55. No individuals wished to offer public comment.

*Meeting adjourned at 5:05 pm.*