OREGON PEDIATRIC IMPROVEMENT PARTNERSHIP (OPIP)

SEMI-ANNUAL CALL WITH FRONT-LINE PROVIDERS

SEPTEMBER 17, 2015
OPIP Mission

- OPIP is meant to create a meaningful, long-term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

- OPIP is dedicated to building health and improving outcomes for children and youth by:
  1) Collaborating in quality measurement and improvement activities across the state;
  2) Supporting evidence-guided quality activities in clinical practices;
  3) Incorporating the patient and family voice into quality efforts; and
  4) Informing policies that support optimal health and development for all children and youth.
Why Are We Having These Semi-Annual Calls for Front-line Practices Invested in Child Health in Oregon?

Provide Updates, Spread Innovation

• Key part of OPIP’s mission is to support practice-level quality improvement and implementation and to facilitate spread of innovations across the state.
  
  — GOAL FOR THIS CALL: Provide update on key projects so you can let us know if you want more information, share tools or methods that may be useful

Policy-Level Work

• A component of OPIP’s mission is focused on informing policies that support optimal health and development for all children and youth.

• A critical component of this work is providing actionable and meaningful information to policymakers that is informed by the front-line.

• Conversely, for the policy-level efforts that we are involved in, provide you with an update and potential implications for front-line practices
  
  — GOAL FOR THIS CALL: Provide updates on key policy-relevant activities
Agenda for Today’s Call


• Area #1: Adolescent Preventive Services (Based on your feedback, a lot here)
• Area #2: Children & Youth with Special Health Care Needs
• Area #3: Trauma Informed Care for Children and Youth

Part 2: Update on Key Policy-Level Activities

• Revisions to Patient Centered Primary Care Homes Standards
• Coordinated Care Organization Incentive Metrics
• Child Health and Well-Being Measures Workgroup

If we have time, will prioritize PCPCH but are providing slides with an update.
Asking Questions and Getting Information

• Slides are available to be downloaded, we will also post on our website along with a recording

• Muted the call line given the number of people on the call

• If you have a question, type the question in the CHAT function on the lower right of the webinar screen.
  
  – After the call, we will follow-up with you to make sure that we answer the question.

  – If you want more information or want to be kept in the loop on a project, send an email to OPIP@ohsu.edu

• When we get to policy-discussions, we will unmute call line

Do not cite or reproduce without appropriate citation.
Focus Area #1:
Adolescent Preventive Services
Focus Area #1: Adolescent Preventive Services

• Overview of project-level activities focused on adolescent preventive services

• Highlight of innovative tools related to:
  – Adolescent Transition Plans
  – Confidentiality and Privacy
  – Implementing SBIRT and Submitting Claims in Alignment with CCO Incentive Metrics
Focus Area #1: Adolescent Preventive Services

• Project #1: QI coaching on PCPCH, included adolescent preventive services & behavioral health screening (Funded by PCPCI, Contracts)

• Project #2: OPIP as a partner in the Oregon Pediatric Society’s Adolescent Health Project (Funded by Oregon Health Authority) http://oregonstart.org/modules

• Project #3: Improving Access to and Quality of Adolescent Well-Care Services Through Partnerships with School-Based Health Centers (Funded by MODA/OEBB Health Grant)
Resources You Can Access

1) OPIP Resource Page with Resources for Practices: [https://projects.oregon-pip.org/resources/adolescent-care](https://projects.oregon-pip.org/resources/adolescent-care)

2) PCPCI Webinars
   1. Implementing Bright Futures Aligned Adolescent Well-Visits

   2. Addressing the Adolescent SBIRT and Depression Screening and Follow-Up Incentive Metrics:

Issue Briefs:

• Why Adolescent Well-Visits are Important:

• Strategies Needed to Improve Well-Visits, Policy-Level Implications:

Identified a number of issues using claims data to track and evaluate efforts related to adolescent well-visits, including SBIRT and depression screening provided in the context of these visits.

• Developed a brief on the issues of using current CCO incentive metrics to track efforts:
Transitioning to the

Adolescent as the Primary Patient

• Create an office policy for transition, and explain this policy and related resources in the office. Utilize standardized processes and scripting to further normalize the activity

Examples:

– Gottransition.org

– https://projects.oregon-pip.org/resources/adolescent-care & gottransition.org

– http://www.pcpcci.org/resources/webinars/enhancing-adolescent-well-visits
### Transitioning to the Adolescent as the Primary Patient

<table>
<thead>
<tr>
<th>AGE</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Make youth and family aware of transition policy</td>
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<tr>
<td>14</td>
<td>Initiate health care transition planning</td>
</tr>
<tr>
<td>16</td>
<td>Prepare youth and parents for adult model of care and discuss transfer</td>
</tr>
<tr>
<td>18</td>
<td>Transition to adult model of care</td>
</tr>
<tr>
<td>18-22</td>
<td>Transfer care to adult medical home and/or specialists with transfer package</td>
</tr>
<tr>
<td>23-26</td>
<td>Integrate young adults into adult care</td>
</tr>
</tbody>
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**Bright Futures Recommendations** advise that these discussions begin at age 12:
- For all children; special emphasis and importance for children and youth with special health care needs (CYSHCN)

**Framing safe conversations about WHY you are transitioning the adolescent to being the primary patient - scripting for staff**
- Two key elements setting the stage:
  - **Normative statements**: “We do this for all teens”
  - **Purpose statements**: “To help take better care of your teen” or “To encourage good and open communication”

*Source: GotTransition.org*
Transitioning From Pediatric to Adult Health Care

Transitioning from pediatric to adult health care can be a challenge for teens and young adults. The Children’s Clinic is committed to helping our patients make a smooth transition during this process. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a “pediatric” model of care where parents make most decisions to an “adult” model of care where the youth take full responsibility for making decisions.

- We will work together with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occurs before age 22.
- Encourage teens and young adults to assume more responsibility and make more independent judgments for their health care needs.
- Our providers will identify and assist those patients who are at risk of having a more complicated transition due to special medical, developmental, social and/or environmental needs.
Consent and Confidentiality: What are Adolescent’s Rights


Elizabeth Thorne, Oregon Health Authority, Office of Adolescent Health elizabeth.k.thorne@state.or.us
Examples of Explaining Privacy and Confidentiality

Customizable Handouts and Posters

From the Adolescent Health Initiative

Link to Tool:
https://projects.oregon-pip.org/resources/adolescent-care

Health Rights for Teens

1. You will not be treated differently because of your race, skin color, place where you were born, religion, sex, age, sexual orientation, gender identity, disability, or health insurance.

2. You will be treated with respect by all health center staff.

3. If your parents are with you, we ask your parents to leave for part of your visit - this is your time to talk to us privately. We also encourage you to share with your parent/caregiver or another trusted adult in your life the information we discuss.

4. The private information you share with our health center staff will not be shared with other people without you saying it is okay (giving consent).

A) According to Michigan law, all teens can get the following services without the permission of his/her parent or legal guardian:
   - Pregnancy Testing, Prenatal Care and Pregnancy Services
   - Birth Control Information and Contraceptives
   - Testing and Treatment for Sexually Transmitted Infections
   - Substance Abuse Treatment

B) According to Michigan law, teens 14 or older can get the following services without the permission of his/her parent or legal guardian:
   - Outpatient Counseling (mental health) Services, up to 12 visits

C) We must share your private information (by law) when:
   a. You tell our staff or we suspect that an adult is hurting you.
   b. You tell our staff that you want to hurt yourself.
   c. You tell our staff you want to hurt someone else.
   d. You are under 12 years old and are sexually active.

5. We will work in partnership with you to determine the care you need. You will receive the best possible care and have your options for care explained to you.

6. You have the right to review your health center record.

7. If you have questions about your rights or feel you have been mistreated, please inform the health center staff.

*Some insurance plans may mail a list of tests received to your house. Talk to your provider if you are using your family’s insurance and want confidential care.

Do not cite or reproduce without appropriate citation.
Examples of Explaining Privacy and Confidentiality

Teen Patient Handout

[Clinic welcome statement]

We provide quality care for teens and young adults and your family to meet all of your health care needs. As you become more independent and take on more input from you about your health, Oregon law allows your health care services on their own. Starting at age 14 in clinic, it is our practice to ask all parents and guardians to visit. This gives you and your provider a chance to uncomfortable talking about in front of others.

Your safety is most important to us. Know that if it is hurting you, we will never be there. We will always encourage you to talk to your parents and parents can help start the conversation.

As you begin to take more responsibility for your care:

- Learn about your medical problems, and let us know what things we are discussing.
- Follow the treatment plan that we agree upon.
- Be honest. Tell us about your medical history and things you are taking.
- Let us know when other healthcare providers need to be kept in the loop to send us a report whenever you see them.
- Be on time for your appointments. If you are running late, please try to reschedule or cancel them at least 24 hours.
- Call us if you do not receive test results within a reasonable time.
- Use the "after hours" line only for issues that cannot wait.
- Come to our health center when we are sick.
- Tell us how we can improve our services.

We are always available to discuss your health problems, and we work with you to help you make the best choices for your health.

*Some insurance plans may mail information about your provider if you are using your family's insurance.

Parent or Caregiver Handout

[Clinic welcome statement]

Adolescence is a time of rapid change and development. Teens and young adults need specialized medical care and a provider with whom they can discuss issues from normal body growth and development, illnesses, preventive care, sexual concerns and emotional problems. Our practice goal is to provide comprehensive health care to our patients and their families.

As teens begin to develop into adults and take more responsibility for their health, they ask for more input from them about their health. Starting around age 14 [or clinic’s standard age], it is our practice to ask all parents or guardians to visit outside for part of the visit.

If teens feel they can speak with clinicians in confidence, this opens the door for conversations about the risks of certain behaviors that may lead to serious problems. Sometimes teenagers will hide their behavior so parents are not the first to find out. Our goal is to help prevent and identify any issues before they become serious. Data indicate that many youth are facing health challenges that we are well-positioned to help with.

Among 13th graders in Oregon:

- 35% were depressed in the past year
- 15% seriously considered suicide in the past year
- 45% have had sex
- 51% drank in the past month
- 21% used marijuana in the past month

We know that parents and guardians are an important source of health information for youth, and that they likely help in decisions around your teen’s care. We always encourage the teen to discuss important issues with their parent or guardian. Private time during the visit helps youth gain more independence in accessing health care, and helps to build trust in their care team. The best approach gives parents a role in young people’s lives while empowering our teen patients to take responsibility for their own health.

We let all teen patients know that our services are confidential. However, safety of our patients is our priority, and there are some cases but there are some cases when we are required to break confidentiality for safety reasons.

The staff is always available to discuss health problems or answer questions. Our staff wants to work with you to help your teen(s) make the best choices for a healthy future. Please let us know if you have any questions or concerns.

*2015 Oregon Healthy Teens Survey.

Customizable Handouts and Posters

From the Adolescent Health Initiative, Updated by OHA Adolescent Health

Link to Tool: https://projects.oregon-pip.org/resources/adolescent-care
CONFIDENTIALITY

Your privacy and safety are important to us. In general, adolescents may request privacy regarding some health information. If there is a safety concern, privacy cannot be maintained when you are less than 18 years of age or when we are required to report by law.

Having your parent or guardian included in your healthcare is important. We will work with you to involve them as needed while still protecting your privacy.

Oregon state law allows:

- General medical service may be provided to all clients 15 years and older without parent or guardian consent.
- Mental health (counseling) which includes drug and alcohol services may initially be provided to a person 14 years or older without parent or guardian consent.
- Family planning (birth control) and sexually transmitted disease services may be provided to a person of any age without parent or guardian consent.

There are certain situations related to your safety that must be reported, such as:

- You tell us that you plan to cause serious harm or death to yourself or someone else.
- You are doing things that could cause serious harm or death to you or someone else.
- You tell us you are being abused (physically, sexually or emotionally).
- You tell us you have been abused in the past (physically, sexually or emotionally).
- You tell us that you are having sex with someone who is three or more years older than you.
- You have a life threatening health problem.

You have the right to ask about treatment planned for you and to refuse that treatment. You have the right to a chaperone during an examination. (A chaperone is someone who watches the examiner during the examination).

Signed ___________ Reviewed with ___________ Date ________

*Oregon State law requires a parent or legal guardian’s consent to provide medical treatment to an individual under 15 years of age except for family planning and sexually transmitted disease services. ORS 109.610, ORS 109.640, ORS 109.670
Review Work Flow and Processes to Identify Potential Areas Where Breaches of Information Can Occur

Examples:

• Visit reminders
• After visit summaries and medication lists (e.g. birth control)
• Electronic medical record
  – Parental access
• Explanation of benefits that accompanies bills (more on billing later)
Setting the Stage – Tips I Have Used at The Children’s Clinic

• It’s all about the framing... Growing Independence vs. “sex, drugs, and rock & roll”

• “Conditional Confidentiality”

• Start the process at age 12... Give a road map for the next few years
  – Explain confidentiality, privacy, the “adult model of care”
  – Tell parents and patients that after age 14, part of the visit will be just between the teen and I
  – Responsibility steps for the teen to take, based on age (knowing names of medications /doses/allergies, planning questions for well-visits, calling an advice nurse, making their own appointments, obtaining refills, etc.)
  – Still offer a chaperone during private exams
  – Encourage teens to see their parents as a continued resource
  – Visual version of policy statement

• “Performing an Atraumatic Parentectomy” resource for providers.
EMR Example

Anticipatory Guidance - 14-18YR: BRADLEY X TEST

Discussed:

- Seat Belts
- Helmets
- Guns
- TV
- Substance Abuse
- Sexual Behavior
- Nutrition/Exercise
- STD's
- Condoms
- Contraception
- Handouts Given

Comments:

Adolescent Transition Planning

- Discussed Confidentiality Policy (HIPAA)
- Assess health care skills
- Set/Prioritize/review individualized transition plans.

For patients with intellectual disabilities:

- Discuss need for guardianship and alternatives.

Transition Planning Comments/Notes:

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)
1) Adolescent well-visits
   • Based on claims data ONLY, measure of access to care

2) Substance Abuse Screening & Brief Intervention
   • Based on claims data ONLY
   • Age range lowered to now include 12-17 year olds

3) Depression Screening and Follow-Up to Depression Screening
   • Specifications based on the Meaningful Use measure
   • For incentive metric, age range lowered to now include 12-17 year olds
   • Data extracted from electronic health records and submitted to CCO/OHA.
Screening Tools for Adolescent Substance Use

• Generally, for adolescents CRAFFT is recommended – assesses Car, Relax, Alone, Forget, Family & Friends, and Trouble

• CCO Guidance document counts CRAFFT as a full screener if a discussion is had with the adolescent about the results.

• If the CRAFFT is completed (either partially or entirely) and:
  – There is no discussion concerning the screening results, nor any education or brief intervention offered to the adolescents, then the tool is being used as a brief annual screen, and should not be billed / encountered. This use of the CRAFFT would not count toward the CCO incentive metric.
  – Based on clinical judgment, the screening results were discussed with the adolescent and education or brief intervention was facilitated, then the tool is being used as a full screen, and should be billed / encountered. This use of the CRAFFT would count toward the CCO incentive metric.
    o Determining factor not based on the score, but on the education or brief intervention offered and facilitated by the provider.
    o Anticipatory Guidance is recommended for both high and low risk adolescents.
      – Reinforcing good choices/behaviors of low risk adolescents
      – Motivating change in high risk adolescents

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Some Disclaimers Before We Share About HOW Practices Used Claims/Documentation to Meet Incentive Metrics

- There are some “grey” issues and we have seen variations by CCO and region
- Difference between public and privately insured
  - Remember: Billing needs to be done universally; you can’t do things for just publicly insured.
  - Payment Policies likely vary and need to be taken into account
  - Some plans may apply charge to deductible
    - Have found that use of modifiers like -25 and -33 reduce likelihood of it being applied to deductibles
    - That said, when it doubt, CHECK FIRST!!
- Purpose of this section is focused on how to bill/document for adolescents given the factors we just discussed
  - These factors and considerations may not be as important or applicable for adult patients
- Resources to help you in navigating your interpretation of the technical specifications:
  - metrics.questions@state.or.us
Overview of strategies practices have used related to the two parts:

1. Screening
2. Brief Intervention
Billing Codes Aligned with Metrics And Factors to Consider for Adolescents

• Screening:
  – Diagnosis code v79.1 or v82.9.
    - V79.1 – screening for alcohol use / abuse (For Metric- Accepted as a stand alone code)
    - v82.9 – screening for general condition (For Metric – NOT accepted as a stand alone code)
  – Strategies Used: 99420, with diagnosis code v79.1 or v82.9.

CONSIDER ADOLESCENT CONFIDENTIALITY
  - Most of our sites have used the non-specific codes for this reason
  - If you use the specific code, have a plan for how to explain to parents that may get an explanation of benefits

  – Use with modifier -25 to indicate is part of the visit; Can use modifier -33 to indicate it is a Bright Futures Recommendation
  – Used for patients who had a full screen.
  – No time limitations or requirements for this code.
  – CRAFFT counts under this *if a discussion about the results takes place with the patient.*

• Brief Intervention
Billing Codes Aligned with Metrics And Factors to Consider for Adolescents

• Screening

• Brief Intervention:
  – **99408** – Used for patients who were screened and had a brief intervention (15-30 minutes).
  – **99409** – Used for longer intervention (>30 minutes).
  – G codes exist for Medicare patients
    o **Not applicable to pediatrics** - Some practices have internal agreements with CCO
    o See guidance documents for more information
Agenda for Today’s Call


• Area #1: Adolescent Preventive Services

• Area #2: Children & Youth with Special Health Care Needs

• Area #3: Trauma Informed Care for Children and Youth

Part 2: Update on Key Policy-Level Activities

• Revisions to Patient Centered Primary Care Homes Standards

• Coordinated Care Organization Incentive Metrics

• Child Health and Well-Being
Focus Area #2: Children and Youth with Special Health Care Needs

- **Project #1**: QI coaching on PCPCH, included adolescent preventive services & behavioral health screening

- **Project #2**: Supporting practices to improve care for CYSHCN and develop community based resources lists, obtain parent feedback
  *(Funded by WVCH Transformation Grant)*

- **Project #3**: Enhancing Systems of Services for Children and Youth With Special Health Care Needs
  *(Funded by Maternal and Child Health Bureau to Oregon Center for Children and Youth with Special Health Needs - OPIP is a partner on this work)*
Supporting Practices to Create a Community-Resources List

• OPIP currently working with a number of practice on strategies to create and maintain a list of community resources.
• Fundamental planning question:

**Who will maintain this list?**
- Care Coordinator? Referral Coordinator? Medical Assistant?

**Where will this document ‘live’?**
- Printed in a binder in a central location? On a shared drive? On an interactive web-based tool?

**How will it get updated?**
- Can multiple people update the list, or just the maintainer? What will be the workflow to pass information along about a closed or new resource?

**How often will it get reviewed?**
- Continually at QI/Staff meetings? Every 6 months? Annually?
Creating the List: Proposed Workflow

- It is important to outline your key considerations **FIRST**. Once you have those elements decided upon, it is time to create the list itself.
- Creating an effective resource list requires more than just listing names and contact information. In order to **collect the necessary information** for a quality list, and also to **establish effective communication** between the resource and your practice, the following general workflow is recommended:

Visual citation:

Do not cite or reproduce without appropriate citation.
Step 2. Contact Resources to Determine What They Offer

- **Assign the task of reaching out**
  - It may help to divide the list among staff members and ask them to contact each resource.

- **Collect common information from all resources**
  - It can be best to conduct the follow up interviews in person if you are able. The ability to actually see the resource and not rely on a web site or professional photo to determine its cleanliness, professionalism, and value is helpful.

"Good Morning (afternoon), I'm (name) calling from the (name of clinic), here in (name of community). We are trying to improve our understanding of resources in our community, so we can better coordinate and communicate with them in partnership with our patients. We are building a resource directory of all the resources here in (name of the community) that help with (insert topic). We'd like to learn more about (name of resource) and perhaps build a relationship with your organization. Who should I speak to?"
Information to Collect

**Basic Organization Information** - Name, Address, Phones, Website, Primary contact etc.

**Program Description** – Purpose or mission of resource

**Description of ‘Typical User’** – Who do they see and not see

**Accessibility** – Hours of operation and physical barriers

**Affordability** – Cost, insurances accepted

**Continuity** – Funding sources, years in operation etc.

**Communication** – How will the resource communicate back to you? Do they have communication preferences from you?

**Feedback** – Any considerations known about organization from providers or families.
Step 2. Contact Resources to Determine What They Offer

In a ‘perfect world’ you could contact all resources to better understand, but in a busy primary care practice, you may need to take baby steps....

1. Contact the **top 20** resources you refer to
2. Then contact **new resources** to the area/region
3. **Partner with parents** to reach out to community resources as you go along
   – Ask parents – what are your favorite resources? Least favorite resources? What resources do you wish existed?

Start small, make it manageable, and add incrementally
Step 3. Create a Resource Directory That Suits Your Clinic

Once you have a list of all the resources, along with all the information you collected, you'll want to compile the information into a directory format that fits your office.

Next are two examples from practices that have started this work:

1. Woodburn Pediatrics
2. Childhood Health Associates of Salem
Woodburn Pediatrics

Uses an interactive tool called *FreeMind*
Childhood Health Associates of Salem

Have built out an internal WIKI that all staff can view and maintain.

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**Special Needs Community Resources**

From CHAOS Wiki

**Contents**

- 1 Challengers Little League
- 2 Camp Attitude
- 3 IMAPACT Exercise Program
- 4 Weighted Blankets
- 5 Special Blessings (support group)
- 6 Services for Children with Autism Spectrum Disorders
- 7 Toolkit for Providers for OLDER Special Needs Kids

**Challengers Little League**

- Little League for special needs children.
- Ages 5-21 (or completion of their school program).
- All about having fun!!! FREE

View Flyer

Contact info:

Jalynn Miller District 7 Challenger Little League Representative (503)428-2680
D7Challengers@yahoo.com
Step 4. Invite Promising Resources To Visit the Clinic

Invite the most likely referral organizations to visit your clinic to build relationships and credibility

- Studies indicate that this could help mitigate clinician concerns – which tend to be cost, credibility of the resource, and convenience
- Helps the community resource understand provider/practice concerns
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• Coordinated Care Organization Incentive Metrics
• Child Health and Well-Being
Clinical Innovation Fellows

• Program run out of OHA’s Transformation Center

• 15 clinic-based projects selected, sponsored by CCOs.

• Year of support for project development to prepare innovative clinic work for spread to other practices.

• TCC has been working on assessing parental ACE scores for 2 ½ years – project selected for further development.
Current Goals for the Project

1. Determine the most applicable assessment tools for parental ACEs and resilience, as measured by primary care provider uptake and qualitative feedback of the assessment tools.

2. Develop support materials for primary care providers in using ACE and resilience assessments, including workflow mapping, scripting for tool introduction, trigger questions for initial conversations about ACEs and their impact on parenting, anticipatory guidance subjects, and resources for use in well visits.

3. Measure developmental screening rates, referral rates to Early Intervention, and rates of completion of services for children whose parents experienced high ACE scores or low resilience scores.

4. Create clinical workflows for families where (a) ACE scores are high or resilience scores are low and (b) where developmental screening tools are failed, to provide additional referrals to home visitation to ensure completion of referrals to developmental services.
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If we have time, will prioritize PCPCH but are providing slides with an update.
Oregon’s Patient Centered Primary Care Homes Standards

**DISCLAIMER:**
- This is my personal report and summary based on my participation on the PCPCH Standards Advisory Committee.
- Meant to provide an overview of what I have heard, what I have shared and what I would love input on ([reulandc@ohsu.edu](mailto:reulandc@ohsu.edu))
- None of what I report is final or firm – all needs to go through vetting process and public comment

**PCPCH Standards Advisory Committee Website:**
[http://www.oregon.gov/oha/pcpch/Pages/SAC.aspx](http://www.oregon.gov/oha/pcpch/Pages/SAC.aspx)

- **Next Meeting:** The committee will discuss the development of the Behavioral Health Home standards on:
  - **Friday, September 25, 2015**
    - Public listen-in only conference line: 1-888-808-6929
    - Access code: 8391264
2015 PCPCH Standards Advisory Committee

• Meetings started in June and are slated to end by December ’15

• New members on the group, intentional and explicit focus on behavioral health integration
  – First set of meetings dedicated to advising the Oregon Health Authority (OHA) on specific standards and measures of the PCPCH model, including potential changes to Tier Structure
  – Later meetings will focus on developing standards for integration of primary care into behavioral health care settings

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Measures We Have Focused on To Date

• **1C** – Telephone and Electronic Access
• **1F** - Prescription refills
• **2A** - Performance and Clinical Quality
• **3C** - Mental Health, Substance Abuse and Developmental Services
• **3E** - Preventive Services
• **5C** - Complex Care Coordination
• **6C** - Patient Experience of Care
Measures We Have Focused on To Date


- **1F - Prescription refills**
  - 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 ≥ 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.
Measures We Have Focused on To Date


- **Meaningful Use** measures should be de-emphasized in the PCPCH model, but agreed the concepts were important to retain.
  - **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.
Measures We Have Focused on To Date


• 6C – Patient Experience of Care
  - 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 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 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.)
Measures We Have Focused on To Date

August and September Meetings:

• Standard 3.C – Mental Health, Substance Abuse and Developmental Services
  – Change the “or” statement in 3.C.1 to “AND” and require it for all populations that the practice serves
  – A number of issues remain
  – Likely more metrics within this standard given the need for a focus on behavioral health integration
Measures We Are Focusing On

• 5A1/2: Population Data Management

  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.

• PCPCH Staff recommendations: Would Love Practice-Level Input Today
  – 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.

  – 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.
## Potential Revisions to Tier Structure

<table>
<thead>
<tr>
<th>Tier</th>
<th>Current Thresholds</th>
<th>Additional Requirements</th>
<th>% of Clinics in Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>30 - 60 points</td>
<td>+ 10 must-pass standards</td>
<td>0%</td>
</tr>
<tr>
<td>Tier 2</td>
<td>65-125 points</td>
<td>+ 10 must-pass standards</td>
<td>6%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>130 – 380 points</td>
<td>+ 10 must-pass standards</td>
<td>94%</td>
</tr>
<tr>
<td>3 STAR Designation</td>
<td>255 – 380 points</td>
<td>+ 10 must-pass standards, + Meet 11 out of 13 specified measures, + All measures are verified with site visit</td>
<td>NA</td>
</tr>
</tbody>
</table>
Potential Revisions to Tier Structure


- **DISCLAIMER:** There was a robust discussion around the proposal below and there was no clarity on general consensus within the SAC on direction:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Proposed Threshold</th>
<th>Additional Requirements</th>
<th>% of Clinics in Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>60 - 145 points</td>
<td>+ 10 must-pass standards</td>
<td>11%</td>
</tr>
<tr>
<td>Tier 2</td>
<td>150 - 250 points</td>
<td>+ 10 must-pass standards</td>
<td>51%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>255 - 380 points</td>
<td>+ 10 must-pass standards</td>
<td>34%</td>
</tr>
<tr>
<td>3 STAR</td>
<td>255 - 380 points</td>
<td>+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit</td>
<td>NA</td>
</tr>
</tbody>
</table>
Agenda for Today’s Call


• Area #1: Adolescent Preventive Services
• Area #2: Children & Youth with Special Health Care Needs
• Area #3: Trauma Informed Care for Children and Youth

Part 2: Update on Key Policy-Level Activities

• Revisions to Patient Centered Primary Care Homes Standards
• Coordinated Care Organization Incentive Metrics
• Child Health and Well-Being

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Metrics & Scoring Update

• **Dropping EHR adoption** – several metrics are e-reporting measure, so clinics have to have an EHR to submit.

• **Adding tobacco prevalence** (specifications to be determined).
  – To meet the bundled measure, CCOs would have to: 1) Meet the cessation benefit floor; AND 2) Submit EHR-based data; AND 3) Meet prevalence benchmark or improvement target.

• **Adding 2 year old immunizations**
  – One of the requirements under the waiver is that quality measures are maintained (or improved) while incentive metrics are improving.
  – Well visits birth to 15 months has dropped across most CCOs (all but 3) over the last year.
  – 2 year old immunizations was previously proposed as a potential metric, serving as a proxy for well visits (political decision...CCOs knew immunizations might be coming).

• Incentive metric list therefore increasing from 17 to 18 total measures.
Metrics & Scoring Update

• Effective Contraceptive Use
  – Based on One Key Question Initiative: “Would you like to become pregnant in the next year?”
  – **Denominator:** Women age 15-50
  – **Numerator:** Women with evidence of contraception in pharmacy claims.

• September meeting:
  – Benchmarks for both metrics are to be determined for the 2016 incentive pool.
  – Also still need to decide Challenge Pool metrics – considering a combined metric (Adolescent well visit + SBIRT + depression screening) or an equity metric (one of the existing metrics where disparities are reduced).
Agenda for Today’s Call


• Area #1: Adolescent Preventive Services
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Part 2: Update on Key Policy-Level Activities

• Revisions to Patient Centered Primary Care Homes Standards
• Coordinated Care Organization Incentive Metrics
  • Child Health and Well-Being
Child and Family Well-Being Measures Workgroup

- Spotlight on September 22nd 7:30-9:00am OPIP Partner Call – You are welcome! Email Colleen if you want to join the call

- Oregon Health Policy Board and Early Learning Council formed joint body in 2012 to align health and early learning transformation efforts.

- CFWB workgroup was formed as a technical advisory committee.
  - Development of a shared measurement strategy to inform program planning, policy decisions
  - Create a recommended library of measures to support this strategy
  - Finished year-long work in September 2015, with final report created and presented to the Joint Policy Board.

- Identified six domains of well-being, compiled potential measures and classified as potential “accountability” or “monitoring” measures.
  - Relationships
  - Economic Stability
  - Community
  - Comprehensive Person-Centered Health Care
  - Early Childhood Care and Education
  - Comprehensive Person-Centered System Integration
## Dashboard – High Priority Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Relationships</strong></td>
<td></td>
</tr>
<tr>
<td>Child Abuse and Neglect per 1000 Children</td>
<td>Annual</td>
</tr>
<tr>
<td>Disproportionality in Foster Care: The percentage of children in out-of-home placement by race and ethnicity compared to overall percentage of the under-18 population by race and ethnicity</td>
<td>Annual</td>
</tr>
<tr>
<td>Children with an Incarcerated Parent per 1000 Children Ages 0-18</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>II. Economic Stability</strong></td>
<td></td>
</tr>
<tr>
<td>Child Poverty Rate: The percentage of children estimated to live in families with incomes at or below the Federal Poverty Level</td>
<td>Annual</td>
</tr>
<tr>
<td>Food Insecurity Among Children: The percentage of households with children that reported reduced quality, variety, or desirability of diet or uncertainty about having enough food for all household members</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>III. Community</strong></td>
<td></td>
</tr>
<tr>
<td>Child Lives in a Supportive Neighborhood: The percentage of survey applicants who respond in agreement to four questions regarding their neighborhood being supportive</td>
<td>Was every 4 years; now annual</td>
</tr>
<tr>
<td>Rate of Crimes Against Persons, Property and Behavioral Crimes: The Rate of Crime per 1,000 Population.</td>
<td>Annual</td>
</tr>
<tr>
<td>The percentage of Adults Who Have Had 4 or More Adverse Childhood Experiences</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>IV. Comprehensive Person-Centered Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>The Percentage of Children Who Have Received Developmental Screening by 36 Months</td>
<td>Annual</td>
</tr>
<tr>
<td>The Percentage of Children Ages 3 to 6 That Had One or More Well-Child Visits with a PCP During the Year</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>V. Early Childhood Care and Education</strong></td>
<td></td>
</tr>
<tr>
<td>Kindergarten Assessment: Average Score by Domain4</td>
<td>Annual</td>
</tr>
<tr>
<td>Early Childcare and Education Slots Available per 100 Children</td>
<td>Biannual</td>
</tr>
<tr>
<td><strong>VI. Comprehensive Person-Centered System Integration</strong></td>
<td></td>
</tr>
<tr>
<td>Percentage of Children Lifted Out of Poverty by Safety Net Programs Based on the Supplemental Poverty Measure</td>
<td>Annual, using a 3-year rolling average</td>
</tr>
<tr>
<td>Rate of Follow-up to Early Intervention after Referral</td>
<td>Annual</td>
</tr>
<tr>
<td>Kindergarten Attendance Rate</td>
<td>Annual</td>
</tr>
</tbody>
</table>
Work Still Left to Do...

• Kindergarten Readiness Bundle
  – While this is a key metric, complicated to get a bundled measure across systems, and with reliable sub-metrics.
  – Current proposal is to combine Health Care, Family, and Kindergarten Assessment components.
  – Intention is a shared metric between Hubs and CCOs – currently there is not a shared incentive pool.
  – Timeline:
    o Phase 1: Develop specifications on elements, build data tools, negotiate responsibility for elements and build cross-sector communication strategies.
    o Phase 2: Require reporting for health care and family components, set benchmarks.

• Other areas felt to be important but not easy to measure – ACEs / Toxic Stress
  – Current data source is BRFSS – how to improve on a measure that is cumulative and represents events that may be decades old?
  – No measure exists that assesses the extent to which ACEs are present in communities.
We appreciate you taking the time to join us today

Please don’t hesitate to follow up with any one of us or opip@ohsu.edu with any questions or comments.

• Next Call in March 2016