

Oregon Pediatric Improvement Partnership (OPIP) Semi-Annual Call with **Front-Line Providers**

October 6th, 2016 @ 7am-8:30am

Phone: **1-866-366-9319**

Webinar Site: <https://ohsu.adobeconnect.com/opip>



OPIP Mission

- OPIP supports 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 staff and projects are focusing on building health and improving outcomes for children and youth by:
 - 1) Collaborating in **quality improvement** activities across the state;
 - 2) Collaborating in **quality measurement** activities across the state;
 - 3) Supporting **evidence-guided quality activities** in clinical practices;
 - 4) Incorporating the **patient and family voice** into quality efforts; and
 - 5) 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, and 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

Fun Update!!!!

Part 1: Highlight of Projects and Innovative Tools for Practices

- **Area #1: Children with Special Health Care Needs**
- **Area #2: Developmental Screening : Community-Based Pathways Focused on From Screening to Services**
- **Area #3: Adolescent Preventive Services**

Part 2: Update on Key Policy-Level Activities

- **Revisions to Patient Centered Primary Care Home Standards for 2017**
- **Oregon Health Policy Board (OHPB) Listening Sessions and Survey**
- **Multi-payer Learning Collaborative (SB 231)**
- **Health Plan Quality Metrics Committee (SB 440) Committee**

Asking Questions and Getting Information

- Slides are available to be downloaded, we will also post on our website along with a recording.
- Call line will be **muted** due to 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** the call line so people can participate verbally.

Fun Update: OPIP's New Medical Director

- Thrilled and excited to welcome **Lydia Chiang, MD** as OPIP's New Medical Director
- Key things that stood out for us:
 - Pediatrician with lifelong passion for improving the health of children
 - Practiced in very different settings and with various types of patients
 - Currently at OHSU Westside Clinic
 - Experience leading Quality Improvement in her various clinic settings
 - Experience working on grant that involved quality metrics and partnership with family medicine partners
 - Interest and desire to learn more about health policy and impacts
 - Ability to clearly articulate context, issues and ideas

Part 1: Highlight of Projects and Innovative Tools for Practices

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Oregon Pediatric
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OPIP Efforts Focused on CYSHCN



- **OCCYSHN's Enhancing Systems of Services for CYSHCN Project**
 - OPIP Serves on the State Implementation Team
 - OPIP Subcontractor to Lead Efforts Focused on Enhanced Quality of Medical Home for CYSHCN across four sites
 - Kaiser Permanente North West
 - OHSU – General Pediatrics Clinic
 - Salem Pediatric Clinic
 - Pediatric Specialists of Pendleton
- **Patient Centered Primary Care Home**
 - Standards Advisory Committee – Informing standards related to CYSHCN and care coordination
 - Patient Centered Primary Care Institute: Webinar on CYSHCN
- **August 11th Meeting of Policymakers and Leaders in CCOs - Complex Care Management for Children and Youth with Special Health Care Needs (CYSHCN)**

Enhancing Systems and Services for CYSHCN: OPIP Support to Front-Line Practices

Continued work with primary care practices on:

- Identifying CYSHCN
- Care Coordination Methods
 - Pre-Visit Calls
 - Care coordination needs assessments
 - Care plans
 - Referral tracking
 - Coordination with community-based providers
 - Parent partners

Side Note: Elements have a sig. number of points within PCPCH

- May be important to consider given changing Tier Structure, Inclusion of these concepts in the STAR criteria

Based on this Work: Selected Tools and Resources We Are Sharing Today for You Front-Line Practices

- 1) Script to Use for **Pre-Visit Planning** – via a Phone Call with Families - for Complex Children
- 2) Overview **presentation that is a compendium of tools** and OPIP learnings related to supporting practices in **Identifying CYSHCN** and **Care Coordination**
- 3) **Recorded Webinar** for Patient Centered Primary Care Institute: “**Identifying** Children and Youth with Special Health Care Needs (CYSHCN) & **Understanding Their Health and Care Coordination Needs: Real-World Methods, Models, & Strategies**”

Tool #1: Preparing For Visits with Complex Children: Use of Pre-Visit Preparation Phone Call with Families

- Includes phone script with introduction and framing
- Template with key questions including:
 - Pt top concerns/goals
 - Barriers to making the appt.
 - Other visits to ER, Hospital, Specialists since last visit
 - Other tests received
 - Forms or letters they may need
 - Med changes or requests
 - Other resources
 - Social determinants
- Reviewed by OPIP Parent Advisor



Available for download

Pre-Visit Framing–

Hello- May I speak with (name of patient primary caregiver) My name is Nicole. Your son / daughter, (Name of child) has an appointment coming up with Dr. XX on (time, date, location, for what purpose). He / she asked me to touch base with you before your appointment. Our goal is to give your family the best care possible and make the best use of your time at our clinic and want to make sure we thoroughly cover anything that you would like to discuss in your upcoming visit. We understand that office visits can be hectic for our patients and their families, so we are reaching out to you ahead of time to see if we can make a list of some of the things that you would like to make sure to cover in your visit. Is this a good time to talk? (if so, great, if not set a different time) Would it be okay if I asked you some questions to help us prepare for (child's name) appointment?

Pre-Visit Template

*If new patient - verify they released their health records, if not start process

What are your **top concerns, goals or topics** that you want to talk about at this visit (examples: the growth, development, learning, self-care, sleeping etc.)?

Do you see any barriers to attending your appointment (i.e.: transportation, childcare)

Has your child been to the **ER** since your last visit?

Has your child been in the **hospital** since your last visit?

Have you been able to make your **subspecialist** appointments?

Have there been any changes to your child's plan of care?

Verify specialists seen and chart note in record

Has your child had any **blood work** or **imaging** done outside of OHSU (Legacy, Providence etc.) since your last visit?

When & Where?

In chart?

Are there any **forms or letters** you will need us to fill out?

Have there been any **med changes** or dosing changes since your last appt here?

Are there any **resources** that would be helpful in caring for your child?

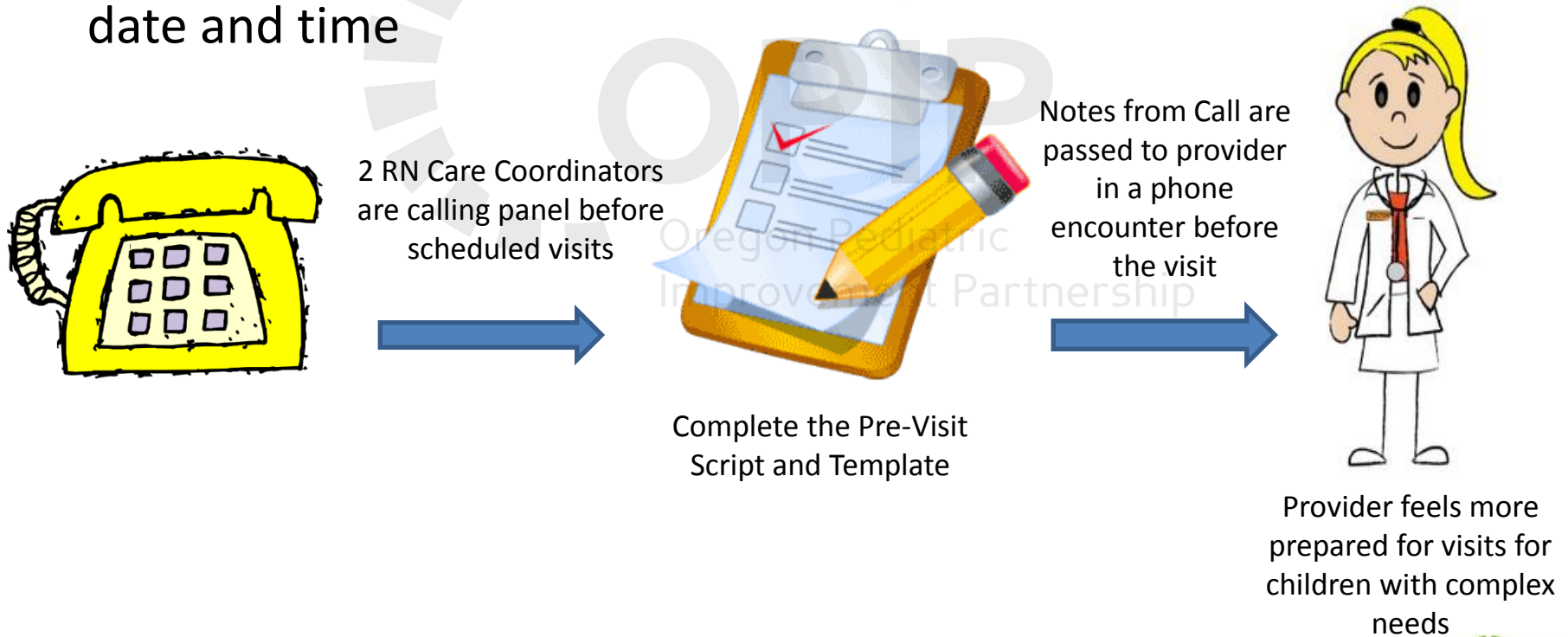
Would you like to sign up for an online account portal, this would allow you access to your (please verify): after-visit summaries, bloodwork results and a medication list.

Social Determinants –

1. Since the last time I saw your child, has anything really **scary or upsetting** happened to your child or anyone in your family?
2. What have you done since the last time I saw you that has been **fun for the family**?

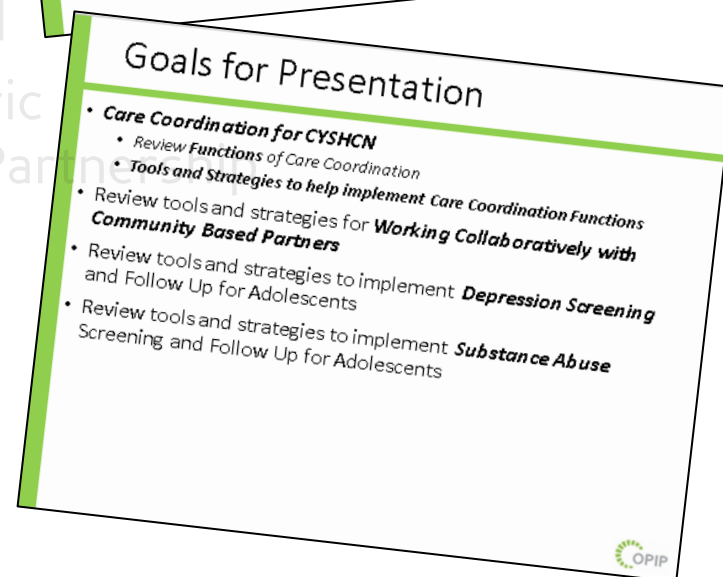
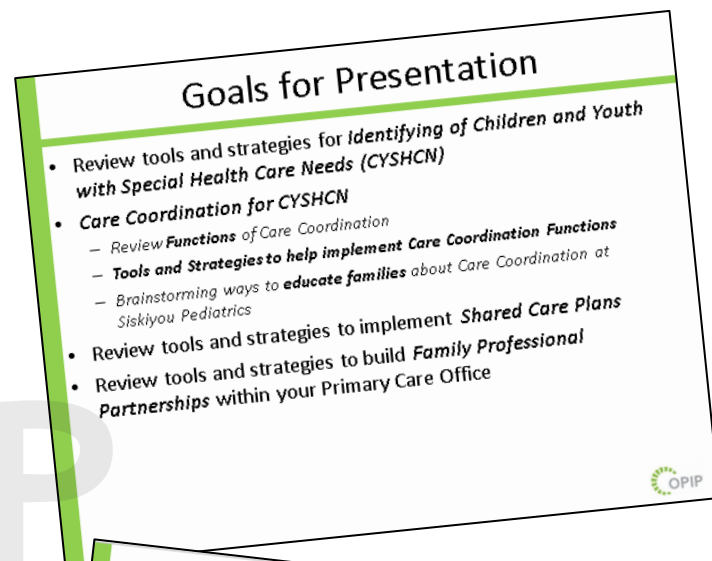
Learnings from Pre-Visit Call Implementation

- Both families and providers agree that the pre-visit calls are helpful in **prioritizing visit** and ensuring that **everyone's needs are met**
- Minor changes have been made to the script since implementation which include provider information, appointment date and time



Tool #2: Compendium of tools and OPIP learnings related to supporting practices in Identifying CYSHCN & Care Coordination

- OPIP provided **coaching calls** to practices on specific areas related to CYSHCN and care coordination.
- Created **presentations**, based on needs identified by practices, that **provide a compendium of TOOLS and METHODS** for enhanced **Care Coordination for CYSHCN**:
 - Functions of Care Coordination for CYSHCN
 - Identification of CYSHCN
 - Tools for Care Coordination
 - Shared Care Plans
 - Building Family/Professional Partnerships
 - Resource lists and community based partnerships



Available for download

#3: PCPCI Webinar on Identifying CYSHCN & Methods to Understand Care Coordination Needs

This webinar was presented on September 13th via the Patient Centered Primary Care Institute (PCPCI)

Topic Overview and Importance

- Medical Home as a concept was first introduced in 1967 by the American Academy of Pediatrics, specifically for CYSHCN, and while medical home is a hot topic, medical home specific to CYSHCN is not- **children are not little adults!**
- Given the current climate of reform, and the need to reduce spending while improving quality, it is important to understand **WHICH children** would benefit most from complex care management, and **WHAT team and services** will best meet the needs of the child and family
- Methods, models, and data sources for the topic of identifying CYSHCN **depend on the PURPOSE** of identification

Overview of Webinar for PCPCI- Identification of Children and Youth With Special Health Care Needs (CYSHCN)

Webinar Overview

- **How and why** identifying CYSHCN is **different than identifying adults** with special health care needs
- Specific **tools and methods at the systems-level** for identifying CYSHCN for complex care management
- Specific **tools and methods** at the primary care practice-level for identifying CYSHCN for complex care management
- **Methods, models, and tools** for family-centered **complex care management teams and care coordination processes**

Webinar Materials (Recording, Slides, Tools):

<http://pcpci.org/resources/webinars/identifying-children-youth-special-health-care-needs-cyshcn>

Various Reasons for Identifying CYSHCN that Impact Methodology Used

- To **track and assess** a broad population of **CYSHCN** and assess for disparities in quality
- To identify a specific population that would benefit from **care coordination**
- To identify a specific population that would benefit from **complex care management**
- To identify a specific population to allocate **care coordination resources**
- To identify a specific population to inform **payment methodologies**
 - Rate setting
 - Alternative Payment Methodology (APM) tied to care coordination
 - APM tied to reduction of costs (not all CYSHCN's costs can be reduced)

Various Data Sources Available to Practices and Systems (Target for this Webinar) Impact Methodology Used

- 1. Claims – total and cost, type of claims, type of services received**
- 2. Diagnosis**
- 3. Chart/EMR Data – Problem lists, clinical gestalt**
- 4. Provider Gestalt**
- 5. Parent report on standardized tools**
 - Within population surveys**
 - At time of enrollment**
 - Administered within clinic**

Strategies Spotlight Highlight Different Reasons and Different Data Sources

Various Reasons for Identifying:

- To track and assess a broad population of CYSHCN and **assess for disparities in quality**
- To identify a specific population that would benefit from **care coordination**
- To identify a specific population that would benefit from **complex care management**
- To identify a specific population to allocate **care coordination resources**
- To identify a specific population to inform **payment methodologies**

Various Data Sources:

1. Claims, Total number, type of claims, type of services received
2. Diagnosis
3. EMR Data – Problem lists, clinical gestalt
4. Provider Gestalt
5. Parent report on standardized tools
 - Within population surveys
 - At time of enrollment
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Complex Care Management for Children and Youth with Special Health Care Needs (CYSHCN)

August 11th, 2016

Northwest Health Foundation –
Bamboo Room



Complex Care Management for Children & Youth with Special Health Care Needs (CYSHCN)

Thursday, August 11th, 2016 from 9-11am

Northwest Health Foundation, Bamboo Room
221 NW 2nd Ave, Suite #300, Portland, OR 97209

ATTENDEES:

State

Nancy Allen – Intensive Services Coordinator, Addictions & Mental Health Department, OHA nancy.a.allen@state.or.us
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Lisa Bui – Quality Improvement Director, Health Policy & Analytics Department, OHA lisa.t.bui@state.or.us
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Karen Wheeler – Integrated Health Programs Director, Health Systems Division, OHA karen.wheeler@state.or.us
Cate Wilcox – Manager, Maternal & Child Health Section, OHA cate.s.wilcox@state.or.us

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David Wagner – Assistant Professor, Institute on Development & Disability, OHSU (Representing NICH) wagnedav@ohsu.edu
Alex Davis – Care Coordinator, CareOregon

Providers & OPIP Steering Committee Members

Gregory Blaschke – President, Oregon Pediatric Society; Pediatrician, OHSU, Department of Pediatrics blaschke@ohsu.edu
Albert Chaffin – Pediatrician, Pediatric Associates of the Northwest; Children's Health Alliance/Children's Health Foundation achaffin@panwpc.com
Doug Lincoln – Pediatrician, Metropolitan Pediatrics DLincoln@metropediatrics.com

August 11th Agenda

1. **Spotlight** of OPIP efforts with practices and health systems focused on care coordination and complex care management
2. **Keynote** from Rita Mangione-Smith, MD, MPH:
Development of Innovative Methods to Stratify Children with Complex Needs for Tiered Care: Assessing Both Medical and Social Complexity
3. **Shared discussion about opportunities** for health systems to obtain and leverage data about children in existing state-level databases to inform complex care management **for children**

Key Take-Aways

- **Summary included in materials on the right**
- **Opportunities Identified in the Group-Level Discussion**
 1. Overall, the group **confirmed the value and need for standardization in a) defining CYSHCN, and b) the value of using medical and social complexity factors in identifying CYSHCN.**
 - That said, the approaches presented have not been used in Oregon and **would be valuable for consideration across public and private payors.**
 - By the end of the conversation, all participants were clear on the unique and important factors that need to be considered in identifying CYSHCN and how they are different than for adults.
 2. **In the current resource and reform environment, it necessary to leverage the information we currently have to more effectively assign and allocate complex care management resources.**
 3. **A majority of the CCO leaders noted the value of information about social complexity that is in the state's Integrated Client Service Data Warehouse (ICS) and that they would support pilots around the use of information in this database to better design complex care programs for children and youth.**
 - An important component of this strategy would be operationalizing how this database could be used to **create a social complexity index or score**, there meeting legal data sharing requirements.
 4. **Dr. Steiner Hayward** noted her support for a focus on the opportunities identified and requested feedback relating to **legislative opportunities** that could be considered.

OPIP's Next Steps

- OHA
 - Examining Pediatric Medical Complexity Algorithm (PMCA) for Medicaid insured
 - Examining feasibility of a general social complexity score from ICS
- Within OPIP Work with Systems and Practices
 - KPNW: Use of PMCA and Social Complexity Algorithm to identify CYSHCN for complex care
 - Meetings with KPNW and Care Oregon to discuss feasibility of receiving information to run PMCA that includes behavioral health services
 - Lucile Packard Child Health Foundation Proposal
 - Methods around complex care management
 - Pilot of use of data regarding social complexity in care coordination and care management

Part 1: Highlight of Projects and Innovative Tools for Practices

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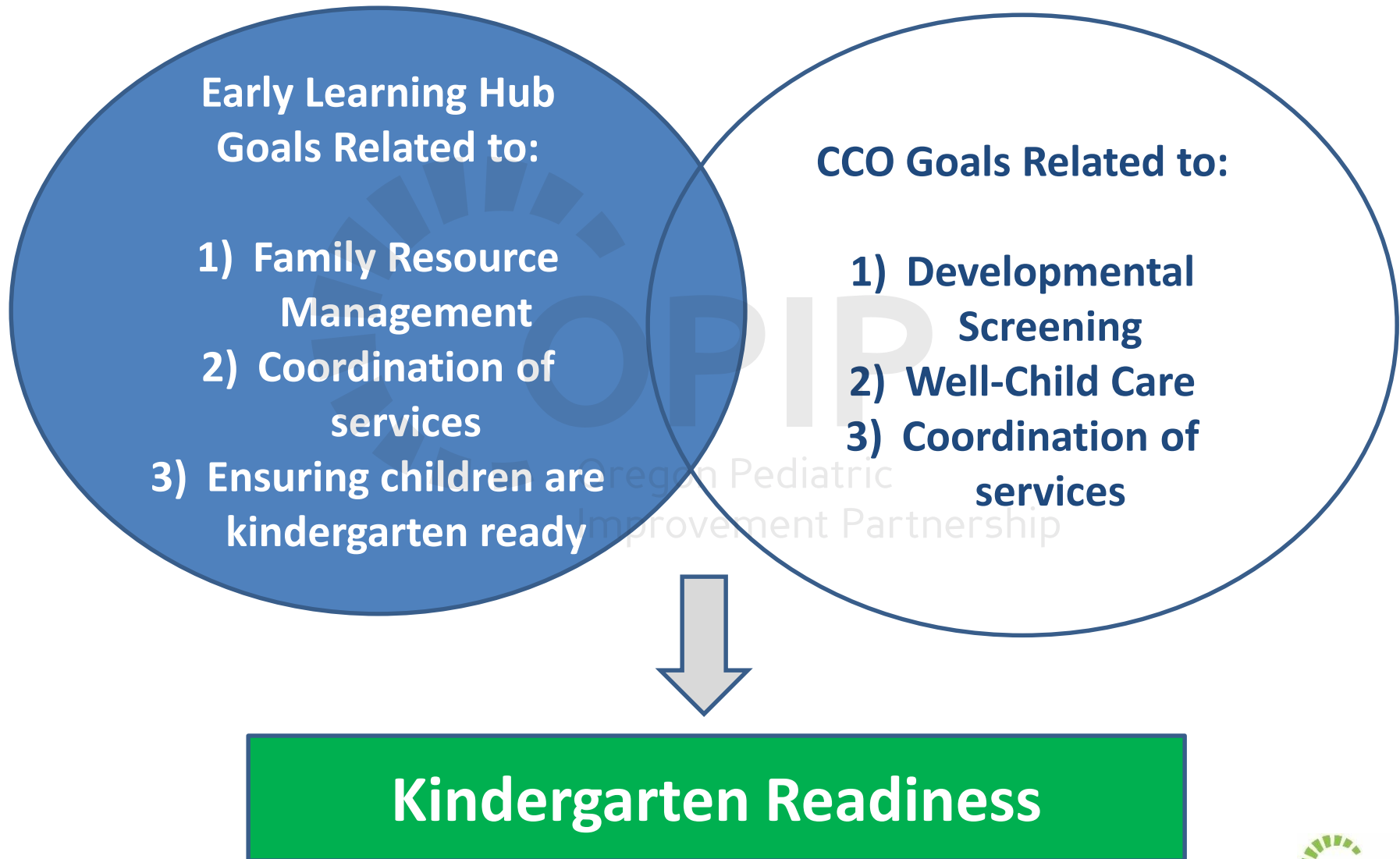
OPIP Efforts Focused Developmental Screening : Community-Based Pathways Focused on From Screening to Services



- Working in three communities on a project focused on the full pathway from a child being identified at-risk on developmental screening to receiving services.
- Two sources of funding
 1. Oregon Health Authority – Transformation Center and Overlap in CCO & Early Learning Hub goals
 2. Willamette Education Service District (WESD)
 - WESD received funds to improve **referral to EI and follow-up processes** focused on young children. Includes a specific focus on **EI Ineligible** children. (*Ends June '17*)
 - OPIP a subcontractor
- OPIP leading community-based improvement efforts in Marion, Polk and Yamhill Counties

The Need for the Project:

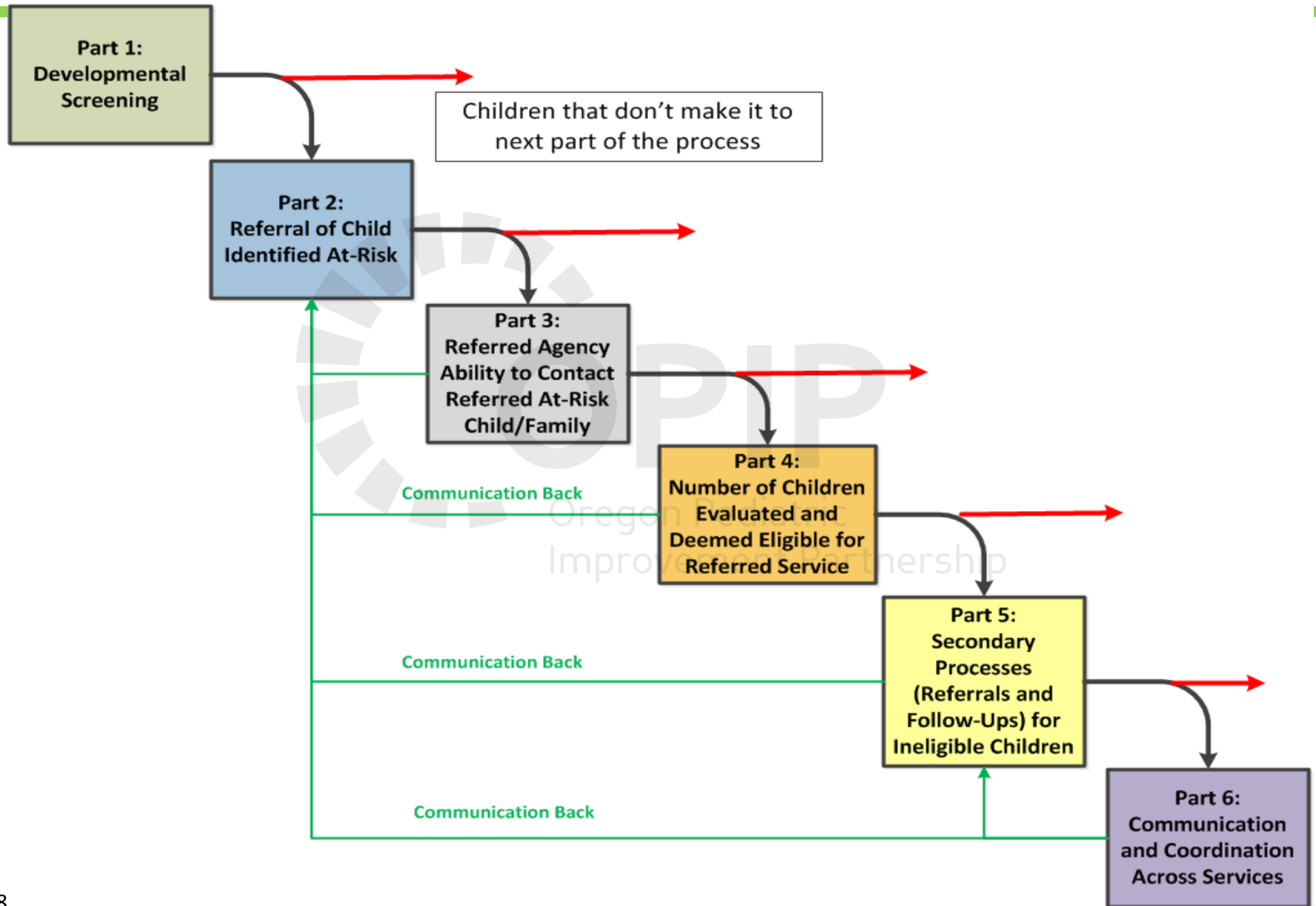
Addressing Shared Goals focus on Young Children



Four Key Activities in the Project

- **Activity 1:** **Engage stakeholders** from Yamhill, Marion, and Polk Counties who are conducting developmental screening and/or who provide follow-up services to children identified at-risk.
- **Activity 2:** **Data:** Identify and periodically track the number of children: i) at-risk using developmental screening tools; ii) of those children, how many are referred; iii) how many are evaluated by EI; iv) of those evaluated children, how many are found ineligible for EI services; and v) how many ineligible children are referred for other services to address the risk identified. **Sources: WESD, PCP Pilot Sites, CCO level data.**
- **Activity 3:** **Expand** PCP, EI and Community-Based Provider **processes** in **referring children** identified at-risk to follow-up (Pathway from screening, to referral, to follow-up)
- **Activity 4:** **Summarize** Key Learnings

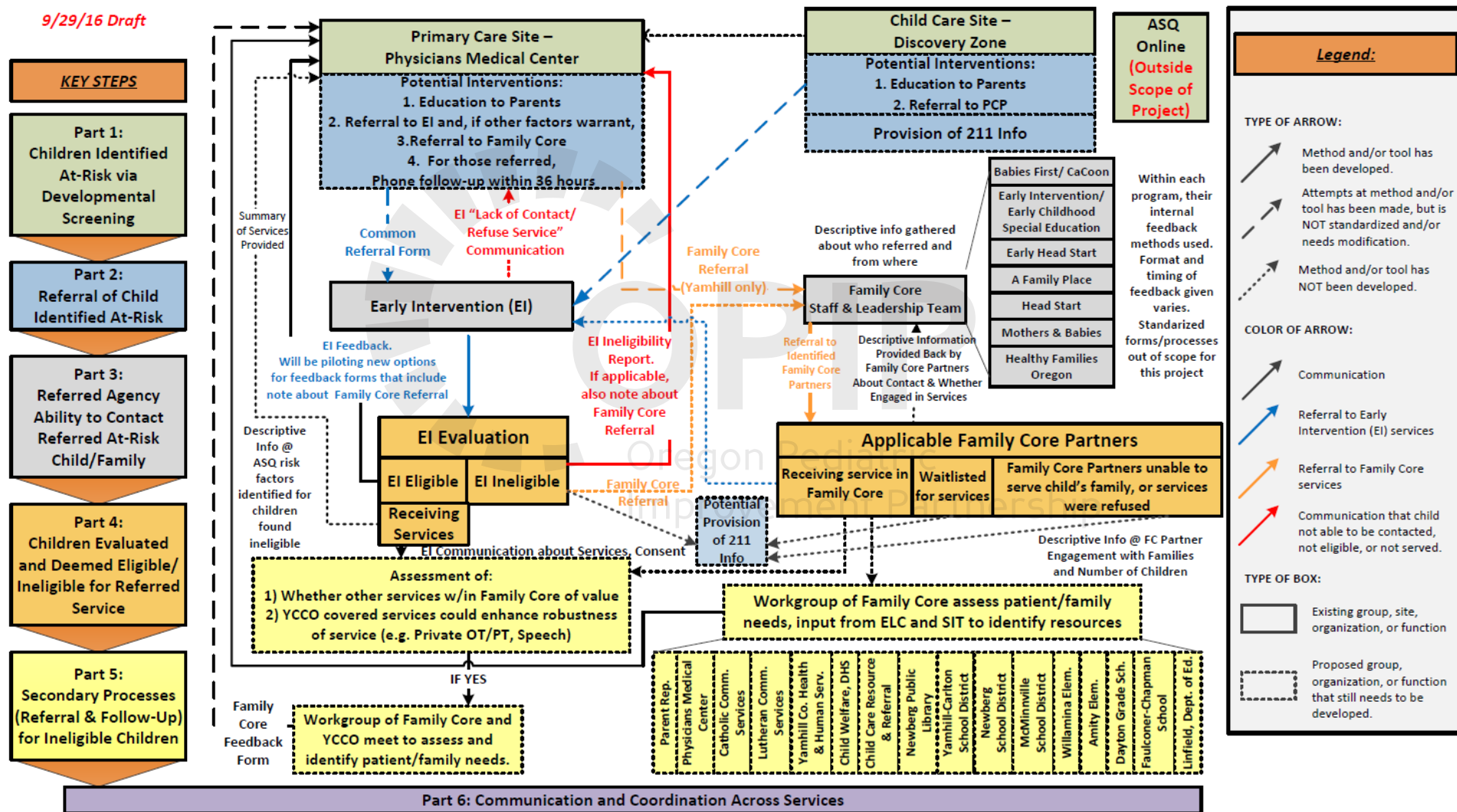
Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up



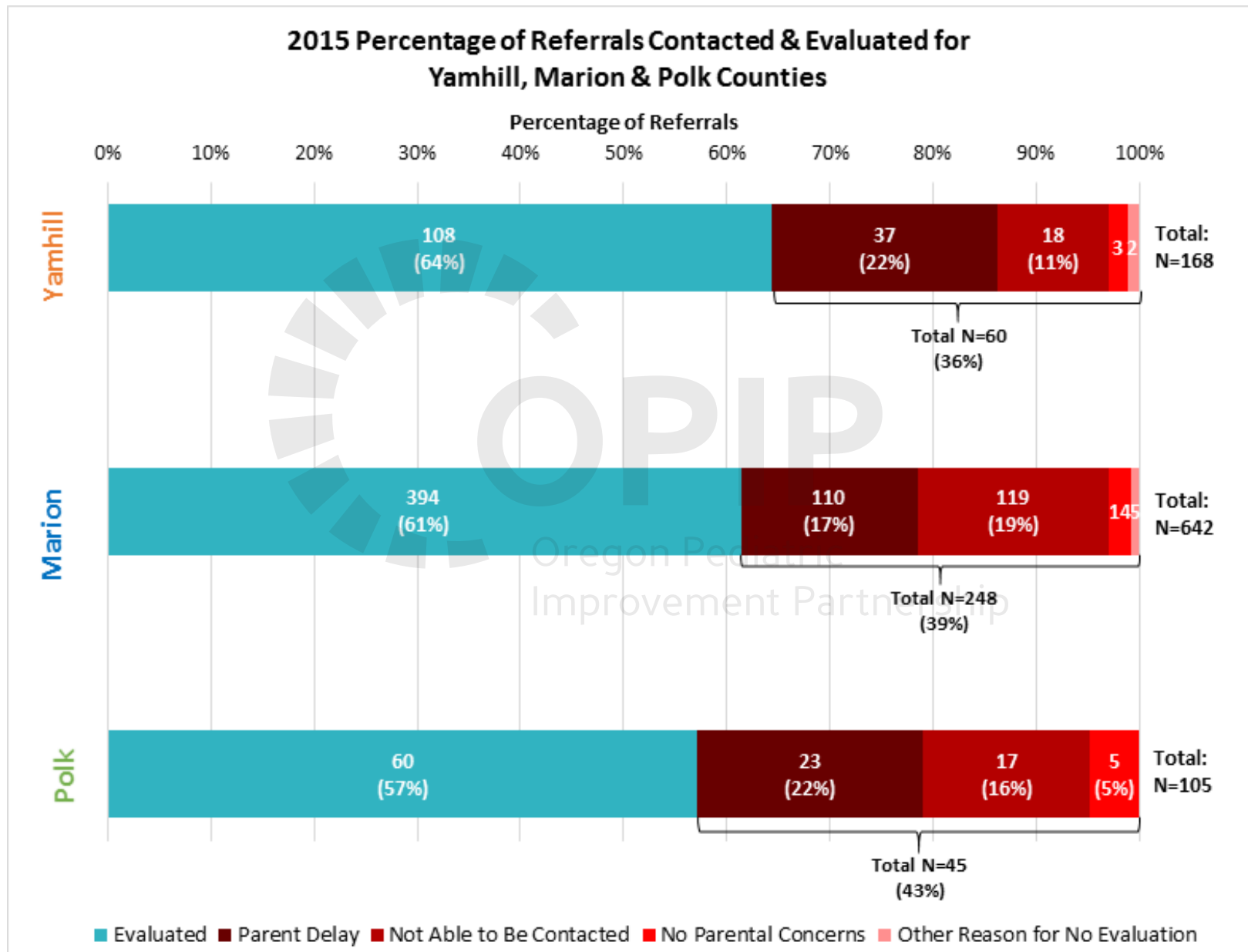
Current Developmental Screening, Referral and Follow-up Pathway for Community-Based QI Project in Yamhill

DRAFT - Yamhill Referral and Triage Map of pilot sites for Children Identified At-Risk on ASQ: Priority Partners, Pathways, & Potential Care Coordination Tools for OPIP Project

9/29/16 Draft



Referrals to EI that Are Not Able to be Evaluated



Based on this Work: Selected Tools and Resources We Are Sharing Today for You Front-Line Practices

- 1) Script to Use to **Follow-UP** (within 36 hours) with children who were referred to Early Intervention (Currently in draft form and being piloted by sites)

Tools in development, let us know if you are interested in receiving examples:

- Education sheet to parents about the developmental screening results and what to expect in terms of referral to EI, who to ask questions

Follow-Up Phone Call for Children Referred to EI to Answer Questions & Address Barriers: Conducted within 36 hours of Referral

• Goal:

- Enhance patient-centeredness of the process.
- Answer questions within the time period that people make a decision about whether to go to the referral
- Reduce the number of referred children that don't get evaluated
- Address barriers to the referral
- Provide information Who to contact for support or questions

• In draft form

- Practices will be piloting in next few months
- If you use, keep us in the loop on what you learn

Phone Follow Up within 36 Hours

Hello- May I speak with (name of patient's primary caregiver). My name is (your name) and I'm Dr. XX's (whatever your position is). Your son / daughter, (Name of child) had an appointment with Dr. XX on (time, date, location) for a well visit.

At your appointment, Dr. XX recommended that your child go to (Insert EI program Name) [and if applicable to Family Core]. We realize it can be overwhelming to get a lot of information about next steps at your appointment, so I wanted to call and answer any questions that you have may have had come up since then.

So what questions do you have about why Dr. XX wanted (insert child's name) to go to Early Intervention at Willamette Education Service District, or about what will happen next?

- Answer question.
 - If not: Great. You should be getting a call from the Early Intervention Coordinator, their names are Sandra or Gemma, to schedule an appointment.
 - When completing the referral, you were asked to sign the consent form. This gives Early Intervention permission to share information about the evaluation back to us. This helps us to provide the best care for (insert child name)
 - At the appointment Willamette Education Service District will be doing a more detailed evaluation of (insert child's name) development.
 - Then, based on their assessment they will help us understand what we can do to support (insert child's name) and whether your child may benefit from services.

If Applicable: Do you have any questions about your referral to Family Core? Family Core is a group of different agencies that support families and young children. The group will meet to determine which agency is the best fit for you and your child. Then, the specific agency identified will contact you.

- Answer questions.
- If not: Great.

Can you think of any barriers that might come up for you and your family in getting (insert child's name) to these services?

Are there any other questions that you have or anything else I can do to help you in getting to these appointments?

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).



Available for download

Part 1: Highlight of Projects and Innovative Tools for Practices

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OPIP Efforts Focused on Adolescent Preventive Services



- **Supporting practices** on implementing care processes related to:
 - Confidentiality/privacy
 - One-on-one time
 - SBIRT
 - Depression screening, follow-up to depression screening
- Project focused on improving the **provision of adolescent well-visits** at a community-level by **leveraging partnerships with School Based Health Centers (SBHCs)**
 - Providing on-site **training and support** to **pilot SBHCs (N=2)**
 - **Developing educational materials** for adolescents and their parents that **provide information about why well-care is important, what to expect, and the unique role SBHCs can play in providing well-child care.**
 - Developing and assessing models for enhancing the SBHC's **population management and care coordination** with primary care practices.
 - Identifying **policy-level improvements.**
- **Ten-part webinar series** for the Oregon Health Authority (OHA) Transformation Center and **Coordinated Care Organizations** on improving the metrics related to adolescents: 1) Well-visit, 2) Depression Screening Follow-Up; 3) Substance Abuse Screening, Brief Intervention, Referral, and Treatment

Overview of OPIP's 10 Part Webinar Series for CCOs

Part 1: What, Why, and How to **Educate** about Adolescent Well-Care Visits

- ***Three webinars***

Part 2: From **Recommendations to Implementation:** Implementing & Documenting AWW in Alignment with CCO Incentive Metrics

- ***Five webinars***

Part 3: Going to Them – Leveraging Partnerships with **School Based Health Centers (SBHCs)**

- ***Two webinars***

All are recorded and on the Transformation Center website.

(<https://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>)



OPIP Ten Part Webinar Series for CCOs

| Series 1: What, Why and How to Educate about Adolescent Well-Care Visits | |
|---|--|
| May 19 1-2 p.m. | 1. Engaging and Convincing Key Stakeholders about the Value of Adolescent Well-Care Visits Register here |
| June 16 1-2 p.m. | 2. Educating Youth about Adolescent Well-Care Visits Register here |
| September 29 1-2 p.m. | 3. Educating Parents About Adolescent Well-Care Visits Register here |
| Series 2: From Recommendations to Implementation: Implementing and Documenting Adolescent Well-Care Visits in Alignment with CCO Incentive Metrics | |
| June 2 1-2 p.m. | 1. Enhancing Adolescent Well-Care Visits: Getting Them In, Setting the Stage and Implementing Strength & Risk Screening Tools Register here |
| June 30 1-2 p.m. | 2. Privacy and Confidentiality: Rules and Regulations Related to Adolescent Preventive Services Register here |
| July 7 2-3 p.m. | 3. Depression Screening for Adolescents Register here |
| July 27 1-2 p.m. | 4. SBIRT for Adolescents Register here |
| September 8 1-2 p.m. | 5. Alignment of Private and Public Adolescent Well-Care Visit Coverage and Explanation of Benefits: Impacts on the Front Line Register here |
| Series 3: Going to Them! Leveraging Partnerships with School-Based Health Centers | |
| August 18 1-2 p.m. | 1. Leveraging School-Based Health Centers to Educate Youth about Adolescent Well-Care Visits Register here |
| September 20 1-2 p.m. | 2. Capturing Care Provided in School-Based Health Centers for CCO Incentive Metrics Register here |

Selected Tools and Resources within the Webinar for CCOs We Are Sharing for You Front-Line Practices

- 1) Educational materials **for teens** about well-visits and why they are important
 - Two different posters/flyers that could be used
- 2) Educational materials **for parents of teens** about well-visits and why they are important
 - Poster/flyer
 - Letter that you can send to empaneled teens
- 3) Models and example of fax-based communication forms with School Based Health Centers (SBHCs)

Experience Related to Educational Materials About Adolescent Well-Visits

- Prior to founding OPIP, part of the Child and Adolescent Health Measurement (cahmi.org) and led work related to Young Adult Health Care Survey
- **Projects with primary care practices** to improve the quality of care provided in their medical homes
 - Large number of practices focused on adolescent well-care
 - Developed quality improvement tools to support practices in these efforts
 - OPIP's parent advisor reviewed
- Project working with **two pilot School Based Health Center (SBHCs)**, included development of educational materials to youth
 - Total of **8 in-person** meetings held with youth to obtain feedback, with additional feedback collected via email
 - Prior/During School Year:
 - Oregon Statewide Youth Action Council (SYAC), part of Oregon School Based Health Alliance (OSBHA)
 - Oregon Health Authority (OHA) - Office of Adolescent Health, OSBHA
 - SBHC pilot sites: Tigard High SBHC/Virginia Garcia, & Pendleton High SBHC/Umatilla Co.
- Materials Today Are Informed By This Work
 - That said, this an opportunity for more focus and a need for youth and parent engagement in **primary care setting**
 - A topic OPIP would love to support in collaboration with CCOs through potential TA Bank consultation

#1) Educational Materials Directed to Teens

- Created two different documents that provide different levels of information.
 1. **Yellow SBHC poster:** Contains **general information** about your practice and services for youth.
 2. **Green AWC poster/flyer:** Contains more **specific information** about the importance of annual **Adolescent Well-Visits** and **types of services provided**
- **Ways Practices Could Disseminate These Materials**
 - Posters put up in office and bathroom
 - Flyers sent home to youth
- **Please keep citation that the materials were modified from materials developed by OPIP as we are in the process of submitting copyright**
 - However, we are happy for people to use the resources with citation.
- **Repeat of the Disclaimer: OPIP feels there would be value in stakeholder engagement and pilot testing with primary practices on these materials**
 - Value of PCP feedback and Youth feedback about PCP lens
 - Could be an option for a TA Bank Consultant contract with OPIP via CCOs

#1) Educational Materials Directed to Teens



Available for download: (PRACTICE Poster Templates and Directions_6.16.16)

- **Yellow PRACTICE poster:**

- Editable template that contains general information to enhance awareness and knowledge.
- Two Versions: **With and without** the Safe Space/Pride triangle at bottom.

(See Pages 5 & 6 in the file: “PRACTICE Poster Templates and Directions_6.16.16”)

- **Green PRACTICE poster:**

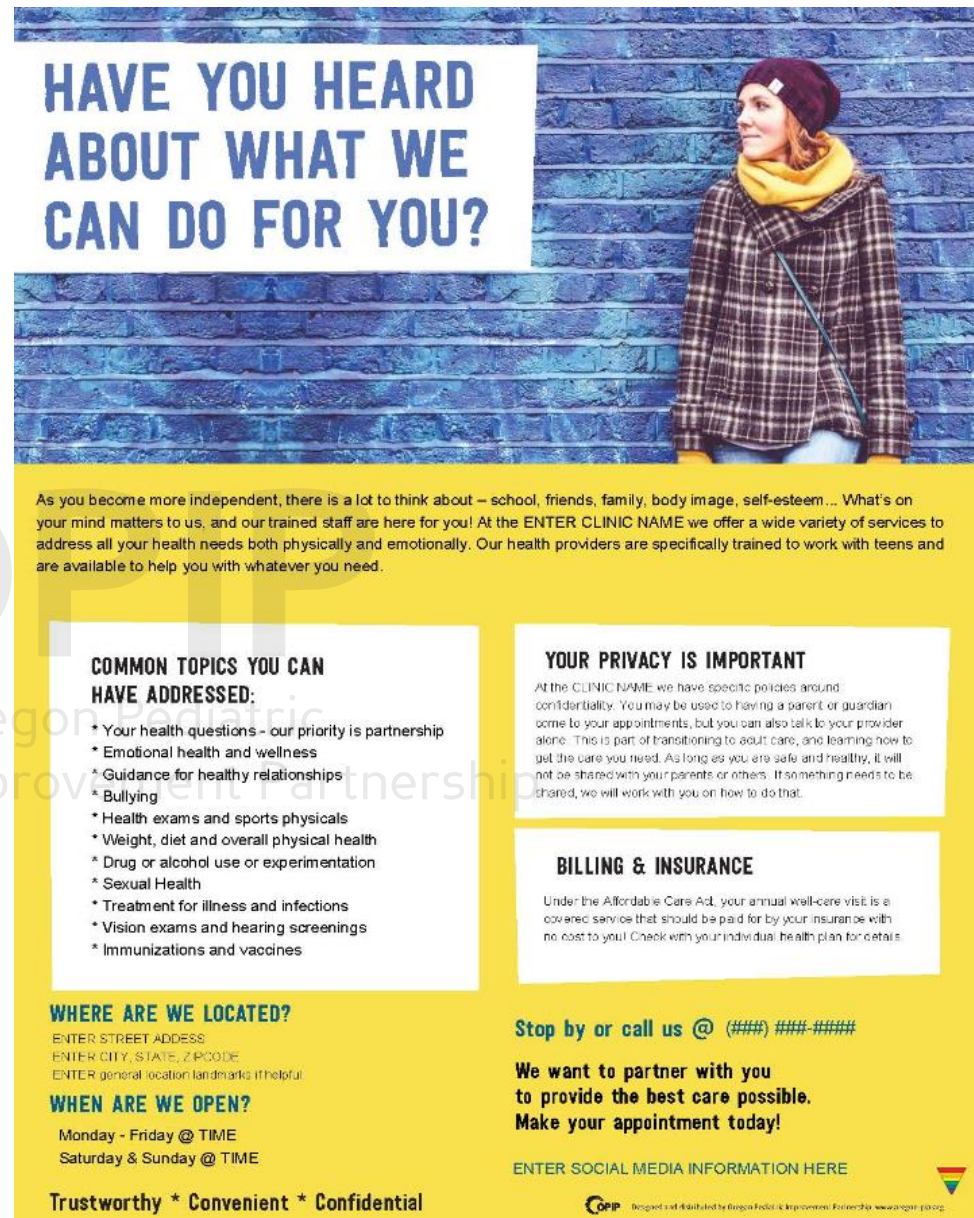
- Editable template that contains more specific information about the importance of having an annual adolescent well-care visit and the types of services offered at the practice
- You can also choose to use the version **with or without** the Safe Space/Pride triangle at the bottom.
- **Also 2 versions of TEXT for green Practice poster: MINIMAL changes; and ENHANCED changes**
 - **Version 1 (“V1”):** minimal changes to text were made to language, and is closer to **original** SBHC poster. **(See Pages 7 & 8 in the file: “PRACTICE Poster Templates and Directions_6.16.16”)**
 - **Version 2 (“V2”):** more enhanced changes to text were made to language, with additional highlight of the **ACA policies** for inclusion of well-care visits with no cost-sharing, and **transition of care**. **(See Pages 9 & 10 in the file: “PRACTICE Poster Templates and Directions_6.16.16”)**

- **If you need assistance in navigating this form or have questions, feel free to contact us as we know it can be confusing (opip@ohsu.edu)**

#1) Educational Materials to Teens: Yellow Poster

Editable text in the PDF template will include:

- Editable introduction text and general inclusion of what your practice can do for youth.
- List of services the practice provides
- Location information
- Hours of operation and walk-in availability
- Privacy statement *with added note about transition of care*
- Billing and Insurance policies with note about *ACA well-care visits with no cost-sharing*
- Phone number
- Website or social media contact info (such as Twitter or Facebook)
- You can also choose to use the version *with or without* the Safe Space/Pride Triangle at the bottom (**PAGES 5 & 6 in PRACTICE resource packet**)



HAVE YOU HEARD ABOUT WHAT WE CAN DO FOR YOU?

As you become more independent, there is a lot to think about – school, friends, family, body image, self-esteem... What's on your mind matters to us, and our trained staff are here for you! At the ENTER CLINIC NAME we offer a wide variety of services to address all your health needs both physically and emotionally. Our health providers are specifically trained to work with teens and are available to help you with whatever you need.

COMMON TOPICS YOU CAN HAVE ADDRESSED:

- * Your health questions – our priority is partnership
- * Emotional health and wellness
- * Guidance for healthy relationships
- * Bullying
- * Health exams and sports physicals
- * Weight, diet and overall physical health
- * Drug or alcohol use or experimentation
- * Sexual Health
- * Treatment for illness and infections
- * Vision exams and hearing screenings
- * Immunizations and vaccines

YOUR PRIVACY IS IMPORTANT

At the CLINIC NAME we have specific policies around confidentiality. You may be used to having a parent or guardian come to your appointments, but you can also talk to your provider alone. This is part of transitioning to adult care, and learning how to get the care you need. As long as you are safe and healthy, it will not be shared with your parents or others. If something needs to be shared, we will work with you on how to do that.

BILLING & INSURANCE

Under the Affordable Care Act, your annual well-care visit is a covered service that should be paid for by your insurance with no cost to you! Check with your individual health plan for details.

WHERE ARE WE LOCATED?

ENTER STREET ADDRESS:
ENTER CITY, STATE, & ZIP CODE
ENTER general location/landmarks if helpful

WHEN ARE WE OPEN?

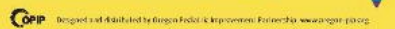
Monday - Friday @ TIME
Saturday & Sunday @ TIME

Stop by or call us @ (###) ###-####

We want to partner with you to provide the best care possible. Make your appointment today!

ENTER SOCIAL MEDIA INFORMATION HERE

Trustworthy * Convenient * Confidential

 Oregon Pediatric Improvement Partnership www.opip.org

#1) Educational Materials to Teens: Green Poster

Green SBHC poster:

Editable text in the PDF template will include:

- **Editable intro text** with practice name
- List of clinical staff
- Location information
- Hours of operation **and weekend/evening availability**
- **Editable closing text**
- Practice website or social media contact info (such as Twitter or Facebook)
- Common topics and list of services your practice currently provides
- Privacy statement **and transition of care**
- Billing and Insurance policies **about well-care visits under ACA and no cost-sharing**
- Phone number
- You can also choose to use the version **with or without** the Safe Space/Pride Triangle at the bottom (**PAGES 9 & 10 in PRACTICE resource packet**)

DID YOU KNOW?

Only 1 in 5 Oregon teens gets an annual check-up, and the odds of having **poor physical and mental health** in adulthood can be **52% higher** for people who **don't receive needed care** early in life.

1 in every 3 Oregon teens experienced depression last year, and 1 in 6 seriously considered suicide.

Each year there are 9.5 million new STD infections among young adults.

Teens who start drinking at an earlier age are 4 to 5 times more likely than others to develop alcohol abuse as adults.



COMMON TOPICS ADDRESSED AT A CHECK-UP:

- * Your health questions- our priority is to partner with you
- * Emotional health and wellness
- * Guidance for healthy relationships
- * Bullying
- * Health exams and sports physicals
- * Weight, diet and overall physical health
- * Drug or alcohol use or experimentation
- * Sexual health
- * Treatment for illness and infections
- * Vision exams and hearing screenings
- * Immunizations and vaccines
- * Dental cleanings

YOUR PRIVACY IS IMPORTANT

At the ENTER CLINIC NAME HERE we have specific policies around confidentiality. For the most part, what you talk about will stay between you and your health provider and will not be shared with your parents or others. If something needs to be shared, we will always talk with you about it first, and work with you on how to do that.

BILLING & INSURANCE

No student will be turned away due to ability to pay. We welcome ALL students, and accept most insurance including the Oregon Health Plan. If you don't have insurance, don't worry – we will still see you.

That's why it's important to have a check-up each year... even when you are NOT sick.

From sprained ankles, to feeling stressed, to relationships and even sexual health, confidential services are available to you at the ENTER CLINIC NAME HERE.

Our providers are specifically trained and interested in working with teens and they will never judge you. They will listen and help you overcome challenges to become successful and independent both in body and mind.

Our Clinical Staff Include:

- * Staff Member (i.e. NP)
- * Staff Member (i.e. RN)
- * Staff Member (i.e. MH Counselor)
- * Staff Member (i.e. Dental Hygienist)

WHERE ARE WE LOCATED?

* We are located:
ENTER LOCATION INFORMATION

* We are open:
ENTER HOURS INFORMATION

INDICATE HERE IF HAVE WALK-IN AVAILABILITY

Trustworthy * Convenient * Confidential

Our goal is to partner with you to provide the best care possible. Stop by today!

ENTER SOCIAL MEDIA OR WEBSITE INFORMATION HERE

If you have **QUESTIONS** or if you want to make an **APPOINTMENT**, stop by or call us @ ###-###-####

 Designed and distributed by Oregon Pediatric Improvement Partnership. www.opip.org

Personalizing the Statistics to Your Area:

One Option - Oregon Healthy Teens Survey

- **Background**

- Administered in odd numbered years (the most recent is 2015)
- An anonymous, voluntary, research-based survey
- Conducted among 8th and 11th graders statewide
- Results provided by county, gender, race and ethnicity

- **Survey Components**

- Topics include:
 - Tobacco, alcohol and other drug use
 - Access to tobacco and alcohol
 - Personal safety behaviors and perceptions
 - Violence and related behaviors
 - Diet and exercise
 - Extracurricular activities
 - Sexual activity and HIV/AIDS knowledge
 - Health conditions and access to care
 - Individual, peer, community and family influences on risk behaviors

- **For more information and to access survey results:**

<https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx>

- **Questions and requests:**

- Renee Boyd at 971-673-1145 or renee.k.boyd@state.or.us



Selected Tools and Resources within the Webinar for CCOs We Are Sharing for You Front-Line Practices

- 1) Educational materials **for teens** about well-visits and why they are important
 - Two different posters/flyers that could be used
- 2) Educational materials **for parents of teens** about well-visits and why they are important
 - Poster/flyer
 - Letter that you can send to empaneled teens
- 3) Models and example of fax-based communication forms with School Based Health Centers (SBHCs)

DID YOU KNOW?

Only **1 in 5** Oregon teens gets an **annual check-up**, and the chances of having **poor physical and mental health** as an adult can be **52% higher** for people who **don't receive needed care** early in life.

We want YOUR TEEN get the BEST CARE possible!

Health and health habits developed in teen years impact their health as adults. That's why national recommendations call for teens to have a well-care visit each year... even when your teen is NOT sick.

Our providers partner with teens to address health issues early and to help them build the healthcare skills they will need as adults. Our goal is to help them be healthy in both body and mind.

WELL-CARE VISITS: WHAT IS ADDRESSED

National recommendations for what should be addressed in a well-care visits have changed dramatically over the last decade. Well-care visits are now focused on early identification of health risks and promotion of health that have life-long impacts. Important health components that will be included in a well-care visit, are:

- ✓ *Teen health history and physical exam*
- ✓ *Vision and hearing screenings*
- ✓ *Immunizations and vaccines*
- ✓ *Weight, diet and overall physical health*
- ✓ *Emotional health and wellness screening and support*
- ✓ *Bullying and prevention of violence*
- ✓ *Guidance for healthy relationships*
- ✓ *Sexual health, and prevention of STIs/STDs and pregnancy*
- ✓ *Discussion of drug or alcohol use or experimentation*

How do I, or my teen, schedule an appointment?

Please call us at (###) ###-#### today!

Help your teen get the best care possible!
Trustworthy * Comprehensive * Teen-Centered



Annual Well-Care Visits Can Prevent Potential Risks:

- * **1 in every 3** Oregon teens experienced **depression** last year
- * **1 in 6** Oregon teens seriously **considered suicide**
- * Each year there are **9.5 million** newly diagnosed cases of **STIs** among young adults
- * Teens who **start drinking** at an early age are **4 to 5 times** more likely to develop **alcohol abuse** as adults

WELL-CARE VISITS vs. SPORTS PHYSICALS: WHAT'S THE DIFFERENCE?:

Sports physicals focus only on physical exams and do not include all of the nationally recommended components of well-care visit. A sports physical form can be completed at the time of well-care visit.

EMPOWERING YOUR TEEN TO TAKE CONTROL OF THEIR HEALTH:

The teen years are a critical time to transition the teen to play an active and primary role in their health and use of health care. In alignment with national recommendations, we will make sure to explain our confidentiality policies and ensure that the provider spend a part of the visit alone with the teen to build trust and to provide the best care possible.

ANNUAL WELL-CARE VISITS COVERED!

Your teen's annual well-care visit is a covered service that should be paid for by your insurance, at no cost to you, based on provisions in the Affordable Care Act that went into effect in 2010! Check with your individual health plan for details.

Poster for Educating PARENTS

Contains specific information about the importance of annual well-care visits and types of services offered and where.

Available for download



Dear parent,

Our records show that your teen is due for a check-up.

Only **1 in 5** Oregon teens gets an annual check-up, and the odds of having poor physical and mental health in adulthood can be **52%** higher for people who don't receive needed care early in life.

That's why it is important to have a check-up each year...even when you are NOT sick.

Common topics addressed at check-up:

- Health exams and sports physicals
- Weight, diet, and overall physical health
- Emotional health and wellness
- Drug or alcohol use or experimentation
- Sexual health
- Treatment for illness and infections
- Immunizations/vaccines
- Any health questions/concerns

From minor illnesses, to feeling stressed, to relationships and emotional health, confidential services are available at our office.

Our providers are trained and interested in working with teens. They will listen and help patients overcome challenges to become successful and independent both in body and mind. Our office has several outside resources for referrals if necessary.

Please contact our office today to schedule an appointment!

Sincerely,

Sara S. Rickman, M.D.
Rhonda L. Wyland, M.D.
Lynn Lieuallen, RN, FNP
Teri Rosselle, RN, FNP

Did you know:

- Car crashes are the leading cause of teen deaths. **22%** of teen drivers who died in car crashes had been drinking.
- Approximately **20%** of teens will experience depression before they reach adulthood. Depression increases a teen's risk for attempting suicide by **12 times**.
- Suicide is the **2nd leading cause of death** for ages 10-24. Over 5,400 youths attempt suicide in the U.S. every day. Approximately 75 Oregon youths die by suicide each year.
- **30%** of teens with depression also develop a substance abuse problem.
- Teen drinking raises the risk of injuries (the **third leading cause of death** among teens), sexual assault, STD's, and unplanned pregnancy.

Example Letter Template

Contains specific information about the importance of annual well-care visits and types of services offered and where.

After using this form, an increase in 65 patients compared to same time period last year → a 68% increase



Available for download

Selected Tools and Resources within the Webinar for CCOs We Are Sharing for You Front-Line Practices

- 1) Educational materials **for teens** about well-visits and why they are important
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Models for Enhancing the SBHC's Population Management & Care Coordination with Primary Care Practices

Some background first of OPIP's effort

As part of broader project working with the pilot SBHC sites to:

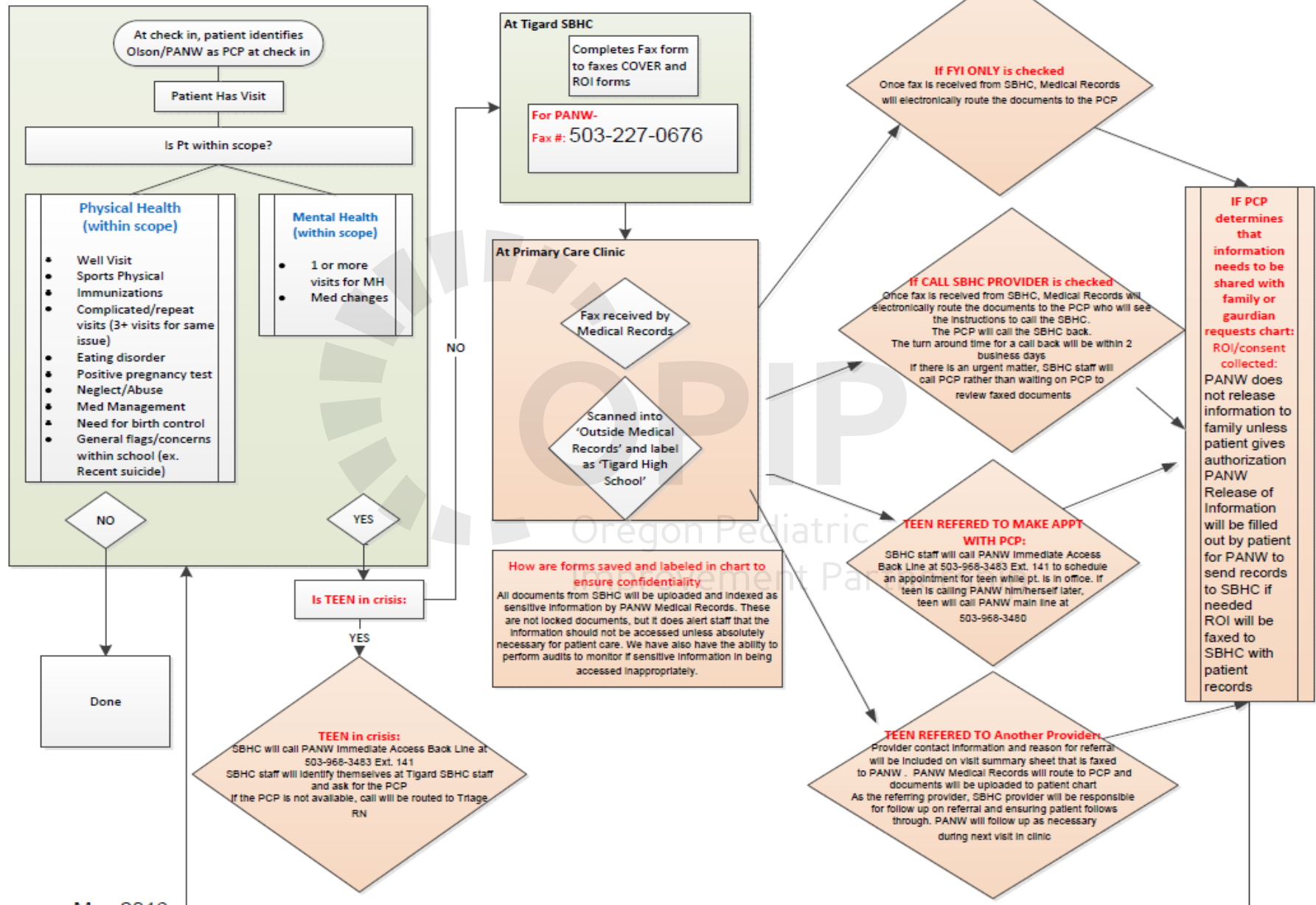
- Improve the well-care provided in their own SBHC
- Develop and assess models for enhancing SBHC population management and care coordination with primary care practices

As it relates to educating youth about well-visits two key opportunities have arisen:

- 1) **Guiding Youth Receiving Mental Health in the SBHC to Obtain General Well-Child Care**
- 2) **SBHC and Primary Care Provider Communication for the Youth to Support Access and Coordination**

Communication Process Between PCP and SBHC

Pediatric Associates of the NW





Pediatrics Associates of the Northwest

Fax Number: (503) 227-0676

CONFIDENTIAL COMMUNICATION

Virginia Garcia's Tigard High – School Based Health Center

PLEASE ATTACH ROI/CONSENT FORM

Name: _____

DOB: _____

Insurance: _____

☐ Assigned Patient - Needs to establish care ☐ New patient - Needs to establish care

Date of Visit at Tigard HS SBHC: _____

Provider Seen: _____

☐ Elizabeth Pruett, PNP

☐ Gina Batliner, MA

Contact Information for Youth: _____

Phone: _____ ☐ Did not consent to release phone #

Primary Care Provider Identified : _____

☐ Did not know provider name

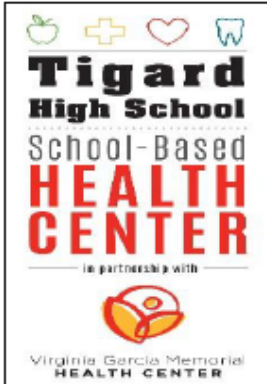
Summary of Visit

| | | |
|---|---|---|
| Type of Provider | <input type="checkbox"/> Physical health provider | <input type="checkbox"/> Mental Health Provider |
| Type of Visit | <input type="checkbox"/> Well Visit <input type="checkbox"/> Sports Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> ED Follow-Up <input type="checkbox"/> Sick-Visit <input type="checkbox"/> Follow-up to referral from PCP <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Mental health assessment <input type="checkbox"/> Follow-up to referral from PCP <input type="checkbox"/> Other: _____ |
| Reason for Visit | _____ | _____ |
| Problem List and/or Diagnosis | _____ | _____ |
| Medications Noted by Teen | <input type="checkbox"/> None <input type="checkbox"/> _____ | <input type="checkbox"/> None <input type="checkbox"/> _____ |
| Results of Labs and Positive Screens | <input type="checkbox"/> None <input type="checkbox"/> _____ | <input type="checkbox"/> None <input type="checkbox"/> _____ |
| Follow-Up Steps Needed | <input type="checkbox"/> FYI ONLY – No follow up needed <input type="checkbox"/> Call SBHC provider <input type="checkbox"/> Teen referred to make appt with PCP <input type="checkbox"/> Teen referred to another provider Who: _____ <input type="checkbox"/> Other: _____ | <input type="checkbox"/> FYI ONLY – No follow up needed <input type="checkbox"/> Call SBHC provider <input type="checkbox"/> Teen referred to make appt with PCP <input type="checkbox"/> Teen referred to another provider Who: _____ <input type="checkbox"/> Other: _____ |
| Other Information For Provider | _____ | _____ |

Communication Form: SBHC to PCP



**Available for
download:
SBHC_PCP_Communication
Templates.pdf**



Fax #: (503) 431-5776

DRAFT 5/11/16

CONFIDENTIAL COMMUNICATION

Virginia Garcia's Tigard High – School Based Health Center

PLEASE ATTACH ROI/CONSENT FORM

Name: _____

DOB: _____

Insurance: _____

Date of Visit at PANW: _____

Provider Seen: _____

Communication Form: PCP to SBHC



| Referral Form from Pediatric Associates of the Northwest to Tigard HS SBHC | | |
|---|---|--|
| <i>Provider Referring To</i> | <input type="checkbox"/> Physical Health Provider | <input type="checkbox"/> Mental Health Provider |
| <i>Relevant Problem List and/or Diagnosis</i> | | |
| <i>Relevant Medications for Referral</i> | <input type="checkbox"/> None <input type="checkbox"/> | <input type="checkbox"/> None <input type="checkbox"/> |
| <i>Reason for Referral to Tigard SBHC</i> | <input type="checkbox"/> HPV follow up First administration date: <input type="checkbox"/> Meningococcal Booster Booster needed on: <input type="checkbox"/> Weight check Recommended periodicity: <input type="checkbox"/> BP check <input type="checkbox"/> Other: | <input type="checkbox"/> MH screening follow-up |
| <i>Other Information For SBHC Staff</i> | <input type="checkbox"/> Call PANW Provider: _____ | <input type="checkbox"/> Call PANW Provider: _____ |
| <i>Information Requested Back</i> | <input type="checkbox"/> No follow up needed <input type="checkbox"/> If you are unable to get them in by: (insert date) <input type="checkbox"/> Summary of Visit | <input type="checkbox"/> No follow up needed <input type="checkbox"/> If you are unable to get them in by: (insert date) <input type="checkbox"/> Summary of Visit |

**Available for
download:
SBHC_PCP_Communication
Templates.pdf**

Part 2: Update on Key Policy-Level Activities


- **Revisions to Patient Centered Primary Care Home Standards for 2017**
- **OHPB Listening Sessions and Survey**
- **Multi-payer Learning Collaborative (SB 231)**
- **Health Plan Quality Metrics Committee (SB 440) Committee**



**KEEP
CALM
AND DON'T
SHOOT THE
MESSENGER**

PCPCH 2017 Standards: Technical Specifications

A refresher:

- Standards have been updated and go into effect in 2017
- The [2017 Technical Assistance and Reporting Guidelines](#) were released in August 2016. 
- 12 Standards were revised
- One additional “must pass” measure (**6.C.0** – Patient & Family Surveys)
- Expanded tier structure from 3 tiers to 5 tiers
- Clinics may no longer apply for recognition under the 2014 criteria.
- **2017** [Self-assessment tool](#) can help you identify standards you meet before filling out the application.
- Review the [PCPCH Electronic Application System](#) document for helpful information about the application system.

Application Timelines

- Clinics that were recognized in 2014 and due to re-apply for recognition in 2016 were granted an extension of their recognition until January 1, 2017. This applies to over 400 clinics (out of 600). The PCPCH program recently granted a 90-day grace period to these clinics so all must re-apply by March 30, 2017.
- Clinics that were recognized in 2015 are due to re-apply 2 years from their recognition date. For example, if a clinic was recognized on April 6, 2015 they are due to re-apply on April 6, 2017. This applies to about 150 clinics. There is a 30 day grace period for these clinics.
- Clinic that were recognized in 2016 are due to re-apply on January 1, 2017. This applies to about 75 clinics. The PCPCH program recently granted a 90-day grace period to these clinics so all must re-apply by March 30, 2017.

PCPCH 2017 Standards: Technical Specifications

Refresher on Tiers and NCQA:

- **Tiers of recognition**

- **Five different tiers** of recognition depending on various criteria they can demonstrate meeting.
- Tier 5 (5 STAR) being the highest a clinic can achieve → requires site visit.

- **National Committee for Quality Assurance and Oregon PCPCH Recognition**

- OHA will recognize Patient Centered Medical Home sites **at the level** that the National Committee for Quality Assurance has recognized the site, with submission of additional information.

| Tier Level | Point Range | Additional Required Criteria |
|-----------------|------------------|--|
| Tier 1 | 30 - 60 points | + All must-pass standards |
| Tier 2 | 65 - 125 points | + All must-pass standards |
| Tier 3 | 130 - 250 points | + All must-pass standards |
| Tier 4 | 255 - 380 points | + All must-pass standards |
| 5 STAR (Tier 5) | 255 - 380 points | + All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit |

5 STAR Designation

Tier 5 in the PCPCH model is a unique designation called 5 STAR. This designation distinguishes exemplary clinics that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices.

5 STAR designated practices must meet the following criteria:

- Be recognized as a PCPCH Tier 4 under the 2017 PCPCH Standards
- Attest to 255 points or more on the clinic's most recently submitted PCPCH application
- Meet 11 or more of the 13 specified measured listed in the table on page 10.
- Receive a site visit to verify they are meeting all PCPCH standards attested to. The designation will not be awarded on attestation only.

PCPCH 2017 Standards: 11 Must Pass Measures

- 1.C.0** - PCPCH provides continuous access to clinical advice by telephone.
- 2.A.0** - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
- 3.B.0** - PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support.
- 3.C.0** - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources.
- 4.A.0** - PCPCH reports the percentage of active patients assigned to a personal clinician or team.
- 4.B.0** - PCPCH reports the percent of patient visits with assigned clinician or team.
- 4.C.0** - PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.
- 4.E.0** - PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
- 5.F.0** - PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
- 6.A.0** - PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice
- 6.C.0** - PCPCH surveys a sample of its patients and families at least every two years 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.

PCPCH 2017 Standards: 5 STAR Designation Criteria Measures

- 1.B.1** - After Hours Access
- 2.D.3** Quality Improvement
- 3.C.2** - Referral Process or Co-location with Mental Health, Substance Abuse or Developmental Providers
- 3.C.3** - Integrated behavioral health services
- 4.B.3** - Personal Clinician Continuity
- 5.C.1** - Responsibility for Care Coordination
- 5.C.2** - Coordination of Care
- 5.C.3** - Individualized Care Plan
- 5.E.1** - Referral Tracking For Specialty Care
- 5.E.2** - Coordination with Specialty Care
- 5.E.3** - Cooperation with Community Service Providers
- 6.A.1** - Language/Cultural Interpretation
- 6.C.2 or 6.C.3** - Experience of Care

Source:

<http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf>



Oregon PCPCH Program and 2011 and 2014 NCQA Recognition Requirements
For practices that are recognized by the National Committee for Quality Assurance as a
Patient-Centered Medical Home

| Requirement | Oregon PCPCH Tier Recognition | | | | |
|--|---|--|---|---|---|
| | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 (5 STAR) |
| 2011 or 2014 Level 1 NCQA PCMH Recognition | Attests and provides evidence of recognition to OHA | N/A | N/A | N/A | N/A |
| 2011 or 2014 Level 2 NCQA Recognition | N/A | Attests and provides evidence of recognition to OHA | N/A | N/A | N/A |
| 2011 or 2014 Level 3 NCQA Recognition | N/A | N/A | Attests and provides evidence of recognition to OHA | N/A | N/A |
| PCPCH Performance & Clinical Quality Standard 2.A | 2.A.0 PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures | 2.A.2 PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures | 2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures | N/A | N/A |
| PCPCH Coordination and Integration Standard 5.F | Attests to meeting must pass measure 5.F.0 | Attests to meeting must pass measure 5.F.0 | Attests to meeting must pass measure 5.F.0 | Attests to meeting must pass measure 5.F.0 | Attests to meeting must pass measure 5.F.0 |
| Submission of PCPCH recognition application to Oregon Health Authority | Optional | Optional | Optional | Attests to PCPCH measures as outlined in this document. | Attests to PCPCH measures as outlined in this document. |

PCPCH 2017 Standards: Technical Specifications

Important changes to note, from OPIP's perspective, based on review of the TECHNICAL SPECIFICATIONS:

1. Measures tied to Patient Experience of Care – **1.A** and **6.C**
2. Performance and Clinical Quality - **2.A.2**
3. Behavioral Health Services - **3.C.0-3.C.3**



Things to Note in TECHNICAL SPECIFICATIONS:

1.A and 6.C - Measures tied to Patient Experience of Care –

- Per the specifications – “Clinics must obtain survey results for a minimum of **25 patients per provider**, and must include all completed survey results in the reported data”
- Patients must be included from **all providers** who have an **assigned patient** panel at the clinic

2.A.2 Performance and Clinical Quality

- Changed from requiring only the reporting of core and menu set measures to **requiring demonstrated improvement on TWO measures** from the core set and one measure from menu set

PCPCH 2017 Standards: Technical Specifications

3.C Behavioral Health Service

3.C.0

- “Clinics must utilize and be able to produce an up-to-date list of referral and community-based resources for commonly diagnosed mental, substance abuse and developmental, behavioral or social delays for patients requiring specialty care that meets the needs of their patient population.”
- ‘Screening only at provider discretion or upon diagnosis does NOT meet the intent of this measure’

3.C.2:

- **Further defines a cooperative referral process to include:**
 - Providing reason for referral and relevant clinical information
 - Tracking referral status
 - Following up to obtain specialist’s report
 - Documenting agreements with specialists for co-management
 - Providing systematic 2 way communication and exchange of patient information

12 Revised PCPCH Standards for 2017

- **1C** - Telephone and Electronic Access
- **1E** - Electronic Access
- **1F** - Prescription Refills
- **2A** - Performance & Clinical Quality
- **3A** - Preventive Services
- **3B** - Medical Services
- **3C** - Mental Health, Substance Abuse and Developmental Services
- **3E** - Preventive Services Reminders
- **4G** - Medication Reconciliation
- **5A** - Population Data Management
- **5C** - Complex Care Coordination
- **6C** - Patient Experience of Care

Standards that Points were Reduced due to Meaningful Use

- **1C** - Telephone and Electronic Access
- **1E** - Electronic Access
- **1F** - Prescription Refills
- **3E** - Preventive Services Reminders
- **4G** - Medication Reconciliation

Oregon Pediatric
Improvement Partnership

3A - Preventive Services

- **3A - Preventive Services**

- **3.A.1** - PCPCH routinely offers or coordinates recommended preventive services **appropriate for your population (i.e. age and gender)** based on best available evidence **and identifies areas for improvement**. (5 points)
- **3.A.2** - PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH population. (10 points)
- **3.A.3** - PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services. (15 points)

Improvement Partnership

| 2017 measure that changed: | The change from previous version: |
|----------------------------|--|
| 3.A.1 | Slight revision of language, and addition of “identifies of areas of improvement”. |

3C - Mental Health, Substance Abuse and Developmental Services

- **3.C – Mental Health, Substance Abuse & Developmental Services**
 - **3.C.0** – PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes. (0 points)
 - **3.C.2** – 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, and developmental providers. (10 points)
 - **3.C.3** - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers specially trained in assessing and addressing psychological aspects of health conditions. (15 points)

| 2017 measure that changed: | The change from previous version: |
|----------------------------|---|
| 3.C.0 | Slight change in language; addition of “and” & “processes” |
| 3.C.2 | Slight change in language; addition of “and” and the co-location items that were previously in the level 3 measure. |
| 3.C.3 | New measure; old measure was added to level 2 |

4G - Medication Reconciliation

• 4.G – Medication Reconciliation

- **4.G.1** – Upon receipt of a patient from another setting of care or provider of care (transition of care) the PCPCH performs medication reconciliation **using a method that satisfies either Stage 1 or Stage 2 meaningful use measures.** (5 points)
- **4.G.2** – PCPCH **develops a process**, tracks **and reports** the percentage of patients whose medication regimen is reconciles **at each relevant patient encounter.** (10 points)
- **4.G.3** – PCPCH provides Comprehensive Medication Management for appropriate patients and families. (15 points)

| 2017 measure that changed: | The change from previous version: |
|----------------------------|--|
| 4.G.1 | Addition of meaningful use requirements that were in previous level 3 measure worth 15 points. This is now a level 1 measure worth 5 points. |
| 4.G.2 | Addition of language: develops a process and reports findings for each patient encounter. |
| 4.G.3 | New measure; previous measure moved to level 1 |

5A - Population Data Management

- **5A – Population Data Management**
 - **5.A.1** - 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. (5 points)
 - **5.A.2** - PCPCH demonstrates the ability to stratify their population according to the health risk such as special health care needs or health behavior. (10 points)

| 2017 measure that changed: | The change from previous version: |
|----------------------------|---|
| 5.A.1 | Slight change in language, addition of “utilize”, also combines previous measures (5A1a and 5A1b) into one measure. |
| 5.A.2 | New measure; no previous level 2 measure option |

5C – Complex Care Coordination

- **5C – Complex Care Coordination**

- **5.C.1** - PCPCH demonstrates that members of the health care team have identified roles in care coordination for patients, and tells each patient or family the name of the team member responsible for coordinating his or her care. (5 points)
- **5.C.2** - PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (10 points)
- **5.C.3** - PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness. (15 points)

| 2017 measure that changed: | The change from previous version: |
|----------------------------|--|
| 5.C.1 | Change in language to focus on “demonstration of defined roles” in care coordination, rather than previous version that “assigns individual responsibility”. |

Part 2: Update on Key Policy-Level Activities

- Revisions to Patient Centered Primary Care Home Standards for 2017
- OHPB Listening Sessions and Survey
- Multi-payer Learning Collaborative (SB 231)
- Health Plan Quality Metrics Committee (SB 440) Committee

Oregon Health Policy Board Listening Sessions

- **OHBP Listening Sessions:**

<https://www.oregon.gov/oha/OHPB/Pages/cc-future.aspx>

| | | | |
|------------|------------|--------------------------|---|
| 10/7/2016 | 12:00-2:30 | Pendleton - Hermiston | Eastern Oregon Trade and Event Center 1705 East Airport Road Hermiston |
| 10/18/2016 | 4:30-7:00 | Portland | Ambridge Event Center Ballroom 1333 NE MLK Boulevard Portland |

- **Oregon Health Policy Board Listening Session and Survey**

- <https://www.surveymonkey.com/r/OHPB>
- Fill out by 10/18/2016

Part 2: Update on Key Policy-Level Activities

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Oregon Pediatric
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SB231 Multi-Payer Learning Collaborative

- <http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>
- Aims to ensure that sufficient resources are allocated to Oregon's primary care system - was enacted by the 2015 legislature.
- Requires commercial insurers and Coordinated Care Organizations (CCOs) to report the **percentage of their total medical expenditures that are directed to primary care.**

Learning Collaborative

- OHA is required to convene a learning collaborative with the purpose of sharing best practices on primary care alternative payment methodologies and initiative alignment.
- It is anticipated that the learning collaborative will meet monthly for 4-6 months beginning in March 2016.
 - We have meetings through November 😊
- ***Colleen Reuland on the Committee***

SB 231 Recent Activities

- September: Draft of **recommendations to the Oregon Health Policy Board**
 - You will see a heavy emphasis on alignment with CPC-PLUS
 - That said, a number of us have noted the lack of inclusion of a focus on CHILDREN or Pediatrics in CPC-PLUS
- October 17th Meeting: Developing a recommendation on **payment methodology** to also be recommended for consideration by OHPB.
- Email Colleen (reulandc@ohsu.edu) if you would like to review material and provide comments to inform my role and feedback I may provide on the committee

Health Plan Quality Metrics Committee (SB 440) Committee

- Applications open for the Health Plan and Quality Metric Committee
- Established by Senate Bill 440 (2015), will convene in early 2017.
- The purpose of this committee is to identify **health outcome and quality measures** that may be applied to services provided by **coordinated care organizations** or paid for by **health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board**.
- The committee will be the **single body to align health outcome and quality measures** used in Oregon to ensure that the measures and requirements are coordinated, evidence-based, and focused on a long term statewide vision.
 - The Metric & Scoring Committee will become a subcommittee of this new committee.
- Committee members are **appointed by the Governor** and will serve an **initial 1-year term**. The committee shall consist of:
 - Two (2) health care providers;
 - One (1) hospital representative;
 - One (1) individual representing insurers, large employers, or multiple employer welfare arrangements;
 - Two (2) health care consumer representatives;
 - Two (2) coordinated care organization (CCO) representatives;
 - One (1) individual with expertise in health care research;
 - One (1) individual with expertise in health care quality measures; and
 - One (1) individual with expertise in mental health and addiction services.

Application form is available online here: <http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx>

Applications will be accepted until **8:00 am, Wednesday, October 19th**.

Opportunity to Advise OPIP & Pilot Improvement Tools

- **Clinical Advisory Panel**

- Creating a clinical advisory panel from practices across the state to review and provide input on OPIP projects
- Quarterly calls set a time that works for the panel
- Contact **Colleen Reuland** know if interested to learn more
 - reulandc@ohsu.edu
 - 503-494-0456

We appreciate you taking the time to join us today

Next Call is April 6th, 2017 7-8:30 am

