January 2012

Oregon Health Authority's Patient-Centered Primary Care Homes (PCPCH) Attestation: Key Learnings from the Front-Line Based on Practice-Level Review and/or Completion of the PCPCH Attestation

Purpose

As a partner to the Oregon Health Authority on the Tri-State Child Health Improvement Consortium, the Oregon Pediatric Improvement Partnership (OPIP) staff and our OPIP Executive Committee are committed to providing feedback about learnings that are gathered through engagement of front-line practices on the Patient-Centered Care Primary Care Home efforts. Given our shared commitment to improve quality of care for children and adolescents, we have invested in identifying concrete improvements that can be made in the process so that it can better achieve the vision and goals outlined in the PCPCH standards. Our goal is to represent and provide feedback specific to care for **children and adolescents.**

The feedback provided in this January 2012 memo is based on the following:

- Experience of practices and practice facilitators as they reviewed and piloted a submission of PCPCH attestation via the Enhancing Child Health Outcomes (ECHO) Learning Collaborative.
- OPIP staff review of the PCPCH application and related instructions.
- OPIP Executive Committee input based on their experiences reviewing and/or submitting the PCPCH application.

Content of this Issue Brief:

The following document describes learnings gathered about the overall application and application process as well as specific learnings about the specific components of the application.

LEARNINGS AND FEEDBACK ABOUT THE OVERALL PROCESS AND APPLICATION

- ***For Practices Caring for Children, Ensure a Pediatric Focus***
  - Given that there is one attestation for the practices who serve both adults and children, many of the important concepts noted by the Pediatrics Standards Advisory Committee were either missed or made ignorable by allowing a practice to attest to doing something, even if it was just for the adult population.
  - Because of this lack of specificity, some practices can theoretically achieve Tier 3 in the PCPCH Standards, but not have any of the attested standards applied to the delivery of pediatric health services. While it may be argued that transformations that affect the adult population within a practice will be generally applied to all patients within that clinic, the current measures do not ensure that these processes permeate the entire practice. We have observed specific instances where practice-based processes are not being applied to children, despite achievement of Tier 3 on the PCPCH Standards. This observation becomes particularly important in light of the potential for enhanced payments for children who are cared for in certified PCPCH practices; the PCPCH attestation process must include assurances that enhanced payments received for children and youth are for processes/systems that actually impact this pediatric population
  - Furthermore, one could also achieve Tier 3 status and NOT identify children and youth with special health care needs. This vulnerable population is incredibly important and central to the tenants of medical home. We feel that this is an example of something that needs to be more explicitly measured in the attestation, rather than obscured within a larger measure..
  - ❖ **Suggestion for Improvement:** We recommend the addition of a front-end portal to the application that asks whether the practice cares for children. The portal could then direct the user to a customized application that presents the same attributes and general concepts, but teases out the important pediatric aspects of care. If this is not done, at a minimum, for practices that care for adults and children, it is important to understand whether they are "attesting" to a process for all their patients or for just their adult or pediatric patients. While the aforementioned solution would help tease out the pediatric aspects that exist, it is our recommendation that separate pediatric standards be developed.

- ***Office-Reported Tools Require Various Stakeholders in the Office to Provide Input, and to Attest to the Systems in Place***
  - Through our work with practices, a significant level of variation in responses to the questions in the attestation was observed among different staff members of the same organization.
    - This variation was both in the knowledge they had about aspects of their practice and also in how they interpreted the question and/or the intent of each element of the attestation.
  - ❖ **Suggestion for Improvement:** We recommend that additional wording be added that clarifies the importance of various persons with various roles in the practice completing the attestation and for a team review of the attestation before it is submitted.

- ***Wording of the Measures Need to be Improved In Order for Reliable and Valid Attestations to be Obtained***
    - Many aspects of the specific measures are anchored to the conceptual and visionary statements that are outlined by the PCPCH Standards.
        - However, the wording of the standards are not necessarily articulated in a way that maps to a "measure" or component of an attestation that would be a standardized and reliable way to verify completion by practices across the state.
    - Many of the measures lack a concrete process by which a practice can clearly attest that they have a measure in place.
        - While the related guide provides helpful descriptions and explanations, for many of the measures the words "could" or "might" is often used as a framing, therefore allowing a practice to still use subjective judgment about what could count towards those activities.
        - For many of the measures, there are "or" statements that allow for gaps where certain components of medical home care can be avoided or ignored.
            - An example is: "**3.C.0 PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources."**
            - The OPIP partners strongly feel that a fully functioning pediatric medical home would be engaged in all three, and not just one of the activities on the list.
            - This concern was verified in working with the practices to complete the attestation. We observed that there was not standardization in how the practices interpreted these multi-factorial components. Some practices only said "yes" if they had all the components in place, while others answered "yes" if they only had one or some in place. Given the intent of the advisory groups that crafted the standards was to highlight the importance of each of those components, it seems that specific information is needed about which component the practice is and is not doing.
    - ❖ **Suggestion for Improvement:** Update the wording in order to provide clarity and specifications that would enhance the reliability and validity of responses. For measures that have "or" statements, create separate measures for each component of medical home. Lastly, review the measure descriptions that include the word "could" or "should" and identify specific processes that must be in place in order for a practice to attest a positive response.

- ***Improve the Definitions and Specifications Provided to Further Enhance Reliability and Validity***
    - In places throughout the attestation there are examples of very broad and general definitions that lead to ambiguity in interpreting what would be appropriate to attest to having in place, even with the use of the technical assistance and reporting guidelines.
    - This became clear when working with practices, as there were instances where two practices would answer differently to the same question, even though they had the same or similar process in place. After consulting the technical assistance and reporting guidelines, and all other supplemental documents, we were still not able to provide guidance on which answers were correct.

- One example of this is "**5.G.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services."**
    - There were practices that answered "yes" as they have done such things as outlined in the reporting guide, know how to do it, and feel confident attesting to meeting the standard.
    - Others answered "No" as they provide these services very rarely, and don't have a formal policy or process around it; however, they have done such things as outlined in the reporting guide, and know how they would do it if the situation arises.
    - In this example, the two practices have nearly identical approaches, but answer completely differently on the attestation. Per the wording and the required subjective assessment, both are correct in choosing a different response.

❖ **Suggestion for Improvement:** Update the wording in order to provide clarity and specifications that would enhance the reliability and validity of responses. For measures that have "or" statements, create separate measures for each component of medical home. Lastly, review the measure descriptions that include the word "could" or "should" and identify specific processes that must be in place in order for a practice to attest a positive response.

- ***Consider Improvements in the Application Process to be Sensitive to Practice Burden and Needs***

o Reconsider Annual Resubmission:
Requiring practices to resubmit and re-enter all data on an annual basis would appear to be unnecessarily burdensome. **Ideally, practices could attest to whether elements of the attestation have remained the same, and re-enter only those fields that require updating.** Additionally, there are some measures that may not be meaningful or important to collect annually. An example of this is the CAHPS survey- In most states this not done annually, but rather staggered every three years in order to allow for time to collect, report, and act on the findings.

❖ Time Period for Resubmission:
From the perspective of practices who are implementing changes rapidly through quality improvement activities, limiting the ability to resubmit to only once every six months may be seen as frustrating and stifling of innovation. This may lead to a situation where practices are waiting to implement changes in order to map with resubmission dates of the attestation. In order to allow practices to innovate and improve at their own pace, while getting the appropriate recognition and reimbursement, **it is our recommendation that more frequent resubmission be allowed.**

- Practice-Site Specific Attestation:
  We would be very interested in learning more about the reasoning behind the requirement that each practice-site location with "four walls" is to submit an attestation. For our only multi-site practice (The Children's Clinic, 2 sites) this means submitting two different attestations, even though the answers for each are the same. For comparison, the NCQA has also struggled with this issue, and has opted for the following definition:

  The multi-site application process is an option for organizations or medical groups with three or more practice sites that share an electronic record system and standardized policies and procedures across all of the practice sites applying for NCQA PCMH 2011 Recognition at one time. Practice sites do not all have to submit at the same time or to be the same specialty or the same size

- Burden of documentation on practices:
  Many of the standards can be variably interpreted; this ambiguity has created a burden of documentation for the practices attesting to PCPCH certification. The remainder of the memo includes specific examples of where standards have been interpreted in different ways by the practices, and some suggestions for clarifying the standards. As the standards are currently written, practices have to provide a fair amount of documentation in case of audits; this risk is somewhat enhanced by the ambiguous nature of many of the standards, as practices are likely to be audited to understand the true nature of their clinical processes before results can be aggregated and understood at a statewide level.

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LEARNINGS AND FEEDBACK ABOUT SPECIFIC ATTRIBUTES

ATTRIBUTE: ACCESS TO CARE

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missing, which have been identified as imperative for medical home for children and for realizing the concept of patient-centered medical home in general. Examples of important PCPCH concepts not captured:

- **Prescription Refills:** This an incredibly important component of care that is not captured in the current application and that can lead to chronic disease exacerbations and increased ER and/or urgent care costs.
- **Health Record:** In the Pediatric Standards Advisory Committee, the concept of responding to requests for administrative paperwork and for providing information about how to access care was identified as essential for children, but is missing from the application.

- **Electronic Access:** Currently**,** there are no measures on this. In the standards there is language about patient portals and email. We understand that this is likely to reduce the emphasis on EMRs in the application, but it should be a future focus given the evidence of the effectiveness of these approaches.

RECOMMENDED ADDITIONAL MEASURES

- All of the current measures are anchored to surveys of the patients, which are extremely valuable and important. However, none of the measures are actually anchored to important office systems and processes around *ACCESS* that could be tracked.
    - Examples include potential items such as those in the NCQA application:
        - Practice has a written process and defined standards and demonstrates that it monitors performance against the standards for
            - Providing same-day appointments
            - Documenting clinic advice in the medical record.
        - Medical Home Responsibilities: The practice has a process and materials that it provides to patients/families on the role of the medical home that include ….
            - This was raised as an important consideration in the Pediatrics Standards Advisory Committee. This was also identified by a number of the ECHO practices as something they are interested in doing as part of their medical home improvement efforts, as they felt it was central to establishing roles and responsibilities.

Feedback about Specific PCPCH Application Components Related to ACCESS

1.A.2 - PCPCH surveys a sample of its population on in-person access to care using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools

- Consider allowing practices to use other standardized surveys that include components of the CAHPS, but that are not limited to just the CAHPS.
    - This would allow practices to use a reliable, validated survey that has items on access, but may also include additional items that are more relevant to a specific focus for quality improvement in their setting.
    - ❖ **Suggestion for Improvement:** Our recommendation is that the specifications be broadened to be anchored to tools that have been endorsed by the National Quality Forum (NQF) or are included in the National Quality Measure Clearinghouse in order to ensure reliable, valid surveys are used. This is particularly relevant as the current reporting requirements suggest annual sampling of CAHPS, whereas another surveys may be easier to implement on an annual basis. If measures remain anchored to CAHPS, consider a longer periodicity for collection of the CAHPS that may be different than the submission process.

- If the measures need to be anchored to the CAHPS, it is important to consider the periodicity by which the CAHPS would be required. Given the current submission process is annual process, this would require a practice to administer the CAHPS annually which raises a number of feasibility issues. In addition, it is unclear whether that allows for a sufficient time for a practice to actual implement and address the CAHPS findings in a meaningful way. Past experience with other practices has shown that this would not be enough turn around time in order to the data to be used meaningfully.

1. B.1 - PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.

- Seven of the eight ECHO practices were able to attest to meeting this standard, and it does not seem to be a discriminate variable of the intent of this measure.
- Given the lack of evidence behind the efficacy of "4 hours" provided outside of traditional business hours, questions about the validity of this item were raised during the Pediatrics Standards Advisory Committee.
- ❖ **Suggestion for Improvement:** Consideration of the NCQA Medical Home measure wording that describes how the practice has written a process and defined standards addressing access, and demonstrates that it monitors performance against standards.

ATTRIBUTE: ACCOUNTABILITY

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missing, which we feel are imperative for medical home for children and for realizing the concept of patient-centered medical home in general. Examples of important PCPCH concepts not captured:

- **Performance Improvement/Clinical Quality Improvement**
  - Tracking of quality improvement efforts around preventive services is not included and is centrally important to children.
  - It is also important to include in the application whether the practice has processes in place that use the data for quality improvement AND enhancing services in specific areas (prevention, utilization, chronic care, acute care).
- **Patient-Family Involvement**
  - It would be appropriate to incorporate a measure related to patient involvement in quality improvement.

Feedback about the PCPCH Application Components Related to ACCOUNTABILITY

- This component of the Application is the one that is the **most problematic**, and for which there are significant validity and reliability issues. It is important to be aware that these technical issues,

including clarification of measure definitions, **should be critically assessed** before any further enhanced reimbursements are made based on the measures reported or benchmarks achieved.

- For the majority of the measures, the **specifications provided are based on the CHIPRA or NQF specifications with adjustments that may greatly impact the validity or reliability of the approach**.
    - Many of the measures are anchored to HEDIS specifications for Medicaid Managed Care Organizations or population-based measures at the state-level. Some of the measures (not all) were tweaked to adjust for not having continuous enrollment information, yet the tweaks do not consider some of the alternate modifications that would be needed. Additionally, some of the modifications greatly impact the validity of the measure.
        - For example, the developmental screening measure has deviations that impact the reliability (how all practices would collect it) and validity (what the data means). Examples of modifications made that impact the tool are:
            1. The tool is anchored to just claims data, but the NQF measure is a hybrid measure.
            2. The continuous enrollment criterion was removed, but the age-specifications were not adjusted. If the continuous enrollment is removed, then a different age group should be considered to be anchored to the visits at which screening is recommended.
            3. The specifications for the developmental screening include a reference to criterion about screening tools that are not included in the Technical Assistance and Reporting Guide. These specifications are integral to ensuring that a practice is using a validated tool that meet specific criterion in order for it to count towards their attestation.
    - Amongst the lack of clarity, each practice then is required to interpret and translate how they would collect the measure using the data systems that they have in place.
        - We observed significant variations in how the practices interpreted the process by which a practice-level measure would be collected and reported.
        - We also observed significant variations in the data sources or methods used for querying the results. These variations are NOT standardized across practices and therefore the data reports are NOT standardized or comparable between the practices without knowledge about how the data was collected and/or based on the resources the practices had for data collection.
        - There are no elements in the application by which the practices describe how they identified the numerators and denominators for the measures; therefore there is no way to know about the variations in how practices collected data, since they are simply reporting just the numbers. From a larger data management perspective, this means that the data collected from the practices cannot be accurately aggregated on a state level.
- Of the full set of measures, only a small number are applicable for the Pediatric population.

- Given that Tier 3 is anchored to two measures from the Core Set and one measure from the Menu Set, there is a more limited choice of measures for pediatrics than for family medicine, and some of these are more difficult to measure than those for adult patients.
    - One of the measures (Follow up care for children prescribed ADHD medication) is actually two measures rolled into one – the continuation and maintenance phase are separate measures. One states that we see a child back within a month of medication initiation; the other states that we see a child back every 6 months during maintenance.
- The immunization rate measure that was selected is very restrictive and does not map to the measure usually reported by the state (the state measure reported by public health doesn't include rotavirus, hepatitis A or influenza vaccines).

ATTRIBUTE: COMPREHENSIVE WHOLE-PERSON CARE

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missed that are imperative for medical home for children and for realizing the concept of patient-centered medical home in general. Examples of important PCPCH concepts not captured:

- **There is not an explicit measure that is JUST on preventive services, which is essential and a priority for a pediatric medical home.**
    - The current measure is very vague and difficult to interpret (90% of Bright Futures or EPSDT)
    - The standard specifically says Bright Futures *OR* EPSDT which leads to ambiguity and lack of focus on what is required.
        - Again, this is why we recommend having the application questions be anchored to whether the practice cares for children or not. If so, then the practice needs to attest to providing the recommended care for children and adolescents, which is Bright Futures.
    - It is important to include in the attestation whether the practice has processes that use the data for quality improvement AND enhancing services in specific areas (prevention, utilization, chronic care, acute care)

Feedback about the PCPCH Application Components Related to COMPREHENSIVE WHOLE-PERSON CARE

3. A.1 PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPSTF Recommended Services and/or Bright Futures periodicity guideline)

- The preventive standard is anchored to a practice coordinated 90% of recommended preventive services, yet the specifications note that UPSTF and/or Bright Futures periodicity guidelines. For children and youth, it is essential that national guidelines – Bright Futures – be the anchor.
- Given the general nature of this measure, our assessment is that it is not auditable.

- There is not standardization and validity across our eight sites about what a "yes" response would mean.

❖ **Suggestion for Improvement:** Remove the "or" wording from the measure for those caring for children. Break out the measure into specific components of the Bright Futures recommendations that are "flag ships" for whether the practice has thoughtfully incorporated Bright Futures. OPIP can provide examples of what could be included if this option is explored.

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 transitions of care; Office-based procedures and diagnostic tests; Patient education and self-management.

- Given the general nature of this measure, and the flexibility to have it anchored to just some of the components, it loses the robustness originally intended in the standards.

❖ **Suggestion for Improvement:** Create a measure, or submeasures within this one, for each of the components so that they each can be defined. Improve the clarity and specifications about what "counts" for each aspect of care, as we saw a wide variation in the interpretation of the terms.

3. C.0 PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

- This measure is multi-factorial and therefore does not capture whether one or all of the measures are occurring.
- Again, for children, specific components are imperative to happen, and this allows a practice to say "yes" if they have a process for only one and not all components.

❖ **Suggestion for Improvement:** Our recommendation is that each of the components be broken out in order for them to be actionable.

3. C.2 PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers.

- Even with the Technical Assistance and Reporting Guidelines, practices are unclear about how direct collaboration would be defined in terms of being audited.
    - Of the examples given, are all required, or just some?

❖ **Suggestion for Improvement:** Enhance the definition of this measure in terms of how it would be audited.

3. C.3 PCPCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers.

- More clarity and definitions are needed about what would be considered "virtual" location.

- Again, there was consistent variation in interpretation, and therefore lack of standardization, in the definition the practices used in answering this question.

3. D.1 PCPCH documents comprehensive health assessment and intervention for at least three health risks or developmental promotion behaviors.

- This measure is multi-factorial (health risk *OR* developmental problems).
- For pediatrics, screening for developmental promotion is an essential component to care, and yet a family practice could do all or some of these for adults only and still say "yes".
- We saw wide variation and lack of standardization and interpretability among our sites in approaching this measure.
- A majority of the family medicine sites answered "yes" to this item despite the fact that many of the processes identified by the practices were NOT anchored to children.

❖ **Suggestion for Improvement:** Modify the measure to be anchored to each of the tools and create specificity for a pediatric population focus if the practice cares for children and adolescents:

  - Support healthy behaviors
  - Risk behavior screening and intervention
  - Safety and anticipatory guidance
  - Developmental screening and promotion

ATTRIBUTE: CONTINUITY

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missing which have been identified as imperative for medical home for children and for realizing the concept of patient-centered medical home in general. One important PCPCH concepts not captured is the following:

- **Clinical Information Exchange**
  - The one measure provided does not accurately capture the important intent of the standard.

Feedback about the PCPCH Application Components Related to CONTINUITY

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.

- There was confusion about this component of work among practices.
- All of our sites said "yes" to this item, but the degree to which the elements are present, standardized, and used for population-based management is extremely varied.
- Also, preferred language is listed, but not the persons race-ethnicity.

- ❖ **Suggestion for Improvement:** We strongly encourage improving the provided list to be anchored to important components reflected in the CHIPRA legislation including:
    - Race and Ethnicity
    - Special health care needs. For this, specific definitions of what would count should be provided given the issues noted earlier with various interpretations to this issue.

4. D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange)

- An improved or more detailed definition of what "real time" and "other providers and care entities" would be beneficial in providing clarity around this measure.
- Given the general nature of the measure, a practice could report on one type of provider and one type of communication and answer "yes". For children, being able to share with community based agencies is essential.

4. E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

- There was significant confusion and variation in the understanding of this measure, resulting in significant variation in how people attested to this measure.
- Specifically, practices were not sure if this needed to be a formal contract, or simply an informal document shared by the two entities.
- Additionally, there was a noticeable variation in how practices interpreted "usual hospital providers".
- **Suggestion for Improvement:** Addition of a more detailed description as it pertains to how these elements would be audited.

ATTRIBUTE: COORDINATION AND INTEGRATION

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missing, and which have been identified as imperative for medical home for children and for realizing the concept of patient-centered medical home in general. Examples of important PCPCH concepts not captured:

- **Collaborative Care Planning**
    - We feel that operationalzing "PCPCH demonstrates collaborative care planning with other health care professionals" is imperative to better capture given the importance of community-based, integrated systems of care. This is particularly important for children.
- **Pre-visit Planning**
    - Under the measures related to test and result tracking, the concept of pre-visit planning was missed and is very important for children with special health care needs.

5. A.1b 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.

- Given the general nature of this measure, and the lack of clarity about what would be an appropriate "yes" response, there was significant variation in the responses and a number of sites indicated doing this activity.
- It is unclear whether they are doing the activities that are intended by more robust medical home definitions.
- Specifically, this allows a practice to indicate "yes" if it does this for one specific population rather than requiring that the practice manage a more broadly defined group of CYSHCN, as is specified by the rule (OAR 410-141-0860) that established the PCPCH program. This plays out differently in Pediatric and Family Medicine practices, and in both cases the reality within the practices falls short of the ideal goal of non condition-specific population management. In Pediatric practices, providers can reach the highest tier by following only one condition, such as asthma, without taking a broader approach to population management. In Family Medicine practices, providers can attest to the highest tier by following adults with special health care needs (such as diabetes or congestive heart failure), again missing the vulnerable population of CYSHCN. This is particularly problematic for children where there are not a handful of chronic conditions that can identify a large portion of patients. It is imperative that practices build capacity and target efforts to children and youth with special health care needs as defined by national standards and the Maternal and Child Health Bureau.

❖ **Suggestion for Improvement:** We feel it is **imperative** to clarify and specify persons with special health care needs broadly, rather than allowing for a single condition approach to population management. Additionally, for those that care for adults and children, it is important that they do population management for children as well.

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

- Due to the indistinct nature of this item and the lack of clarity about what would "count", there was significant variation in the responses and a number of sites indicated doing this activity.
- It is unclear whether they have the explicit care coordination that is central to medical home constructs. That said, given the wording, they are not necessarily incorrect in answering yes.

❖ **Suggestion for Improvement:** We recommend providing further clarification as it pertains to what is auditable. Ensure that the enhanced language is anchored to the aspects of care coordination that have been shown to be effective in the literature.

5. D.1 PCPCH demonstrates tracking of tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.

- This is multi-factorial and therefore some practices attested “yes" if certain components were done.
- ❖ **Suggestion for Improvement:** We recommend separating timely notifications of results from feedback to patients, families, and ordering clinicians to be sure all components are addressed.

5. E.1b PCPCH either manages hospital or skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings.

- Even after reviewing the Technical Assistance and Reporting Guidelines, practices were unclear about what the expectation for documentation would be. Would it require documentation of all of the examples provided or just one?
- ❖ **Suggestion for Improvement:** We recommend further clarification of this measure as it pertains to how it would be audited.

5. E.3 PCPCH tracks referrals and coordinates care where appropriate for community settings outside the PCPCH (such as dental, educational, social service, foster care, public health, or long term care settings).

- The linkage to the community settings is lost and not specific as it is obscured in the more general description provided in this measure. A practice could coordinate with just one of the sites and get credit, which doesn’t get at the important components of care coordination that were central to the committee’s recommendations.
- ❖ **Suggestion for Improvement:** We recommend breaking out each service and/or to create sub-groups that are within each service. For children, we recommend that it require coordination with the education and public health system at a minimum.

5. F.2 PCPCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan that includes the following: self management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate).

- There are many **important, separate concepts** in this one measure.
- We had a number of sites indicate doing this item, yet none of them had standardized methods for identifying children and youth with special healthcare needs, which the literature has shown to be imperative to ensuring needs are met.

- Given the vague language used, if a provider could – by provider gestalt – identify who they thought needed services then they could say "yes". What we have observed is that this can mean selection of care coordination services for a very small group of children with complex chronic conditions.
    - However, the evidence in the literature shows that this approach missed important groups of children.

❖ **Suggestion for Improvement:** We recommend breaking out identification of patients with special health care needs and identification of high-risk and/or medical factors. Also, we recommend a separate measure that is specific to written care plans for persons with special health care needs.

5. G.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

- The general nature of this measure and the accompanying explanation in the Technical Assistance and Reporting Guide do not clarify which, and how many of the examples provided would be necessary to be in alignment with the intent of the measure.
- This is particularly important in primary care pediatrics, where this is a rare occurrence.
- There was significant variation in how practices answered this question, as practices with similar protocol interpreted how it fit with the measure differently.
- More clarity is needed about what is required.

❖ **Suggestion for Improvement:** We strongly recommend that this not be a "must-pass" measure for pediatrics. Furthermore, we recommended more clarity on what would "count" towards this effort.

ATTRIBUTE: FAMILY-CENTERED CARE

General Feedback

We are aware that the application represents a subset of the standards. That said, there are essential elements that are missing, and which have been identified as imperative for medical home for children and for realizing the concept of patient-centered medical home in general. Examples of important PCPCH concepts not captured:

- **Role of Medical Home**
    - As mentioned before, our sites indicate a strong need to have processes and system that communicate the roles and responsibilities of the provider and patient in the medical home. This component of the standards is missing in the application. There are some good models that could be adapted from in the NCQA items.
- **Language and Cultural Considerations**
    - While there are items about translators, we still feel it is too weak on language and cultural competence considerations. Again, we recommend the NCQA items be considered.
- **Education and health promotion**
    - The measures are so generic and vague, that the important concepts about meaningful and relevant patient education and health promotion materials needs to be better assessed.

Feedback about the PCPCH Application Components Related to FAMILY-CENTERED CARE

6. B.1 PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

- The general nature of the question and accompanying explanations do not specify which or how many examples would be expected of the PCPCH.

❖ **Suggestion for Improvement:** We recommend more detailed descriptions of what is required to meet the intent of the measure.

6. C.2 PCPCH surveys a sample of its population using one of the CAHPS survey tools.

6. C.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools and meets benchmarks on a majority of the survey domains.

- As previously noted, we think it is invaluable to require patient-based surveys.
- However, we do not necessarily agree that the only tools that are applicable for higher tiers are CAHPS, as there are other standardized, validated tools that a practice could use that may be more meaningful and relevant to their efforts.
- If the measures need to be anchored to the CAHPS, it is important to consider the periodicity by which the CAHPS would be required. Given the current submission process is annual process, this would require a practice to administer the CAHPS annually which raises a number of feasibility issues. In addition, it is unclear whether that allows for a sufficient time for a practice to actual implement and address the CAHPS findings in a meaningful way. Past experience with other practices has shown that this would not be enough turn around time in order to the data to be used meaningfully.

❖ **Suggestion for Improvement:** Broaden specifications to tools that have been endorsed by the NQF or are included in the National Quality Measure Clearinghouse in order to ensure reliable, valid surveys are used. If measures remain anchored to CAHPS, consider a longer periodicity for collection of the CAHPS that may be different than the submission process.