



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

Executive Summary

The Executive Committee for the Oregon Pediatric Improvement Partnership (OPIP) is committed to partnering with the Oregon Health Authority in improving the quality of care delivered by front-line primary care practices. We believe that the Patient-Centered Primary Care Home (PCPCH) Standards can be an important first step to ensuring that the triple aim of improved outcomes, better experience of care, and lowered costs are achieved.

In the course of piloting the PCPCH Submission process, we have identified specific and significant gaps that we believe need to be addressed to ensure that the health care needs of children and adolescents are adequately addressed. The recommendations that follow are based on:

- 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.
- Input from members of the OPIP Executive Committee based on their experiences reviewing and/or submitting the PCPCH application.

The full recommendations can be found in the accompanying issue brief, which is summarized below.

Ensure Practices Serving Children & Youth are Providing Care Specific to Their Needs

The most important observation is that the PCPCH accreditation process does not include attestation as to whether the completed standards are being applied to adults, children, or both; this is an important distinction in practices that care for both these populations. 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.

Ensure Children with Special Health Care Needs Are Identified and Their Needs for Medical Home Are Targeted

The current language allows a practice to track a condition-specific subpopulation of patients for the population management standards, 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.

Ensure Key Components of a Pediatric Patient-Centered Medical Home Are Achieved

During the pediatric workgroup meeting on the PCPCH standards a number of specific elements of a pediatric medical home were identified. However, in this generalized PCPCH application, these specific components are lost in the general wording of the measures.

- For instance, the standard related to “screening strategy for mental health, substance use, or developmental conditions” is an example of where pediatric practices may differ from those practices focused on adults. In highly-functioning pediatric practices, all three of these screening protocols should be in place, but the standard allows for practices to choose only one of these important conditions to still meet the standard. Such multi-factorial measures allow for gaps in comprehensive pediatric health care; furthermore such measures cannot be aggregated across practices as each practice may be doing different components of the measure. Standards such as these should ideally be broken out in order to be meaningfully tracked and to ensure appropriate care for children is being delivered. Furthermore, it is imperative for children that a family-centered approach and social risk screening is conducted given the evidence about the impact of these factors on the child’s health and the family’s needs for care coordination.
- Similarly, the standard that relates to “comprehensive health assessment and intervention for at least three health risks or developmental promotion behaviors”

allows for gaps in care. In pediatric practices, developmental promotion is an essential component of building health capacity, as is anticipatory guidance and risk-reduction. Family Medicine practices can attest to completing this standard without including developmental promotion activities in their clinical services. Such standards leave too much room for interpretation, cannot be aggregated, and therefore should rightly be separated into the individual concepts included in the original language.

- 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.
- Additionally, a number of key elements noted by the pediatric work group are *NOT* included in this shortened version of the application. The attached Issue Brief highlights additional measures that should be considered for those practices serving children.

Clarifications Are Needed on the Intent and Goal of Specific PCPCH Measures

- Many of the standards included language that could be widely interpreted; therefore there was significant variation in how practices responded to each of the measures. This scenario leads to questionable reliability and validity of the measures across practices. While these variations are to be expected in such an early version of the PCPCH Standards, they should be adequately clarified to allow for enhanced reliability and validity of the measurement, reporting, and interpretation. The accompanying Issue Brief provides specific examples of measures most needing improvements.
- A number of the measures are anchored to – and limited to – the use of the CAHPS tools. We recommend consideration of allowing practices to use other standardized and validated surveys that include components of the CAHPS, but that are not limited to the CAHPS exclusively. This would allow practices to use a reliable, validated survey that has items on access included, but might also have additional items that are more relevant to a specific focus for quality improvement in their setting. 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 survey may be easier to implement on an annual basis.



Improve the Quality Measure Specifications for Practice-Level Data Collection, Reporting and Use

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 modified in way that significantly impacts the reliability and validity.

- For example, the developmental screening measure has adjustments and 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, yet 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 meets specific criteria in order for it to count.

We observed significant variations in how the practices interpreted methods for how 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. This is particularly important to be addresses as OHA moves to provide further enhanced reimbursements based on what is reported within specific measures.

Improve the Application Process to Enhance Practice Participation

A number of specific improvements to the application process have been identified including (*See the attached Issue Brief for a more detailed description*):

- **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.
- **Revise the 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.

- **Practice-Site Specific Attestation:** Reconsider the requirement that each practice-site location with “four walls” should submit an attestation. Consider using the criteria specified by NCQA.

Summary of recommendations:

- 1) Ensure Practices Serving Children & Youth are Providing Care Specific to Their Needs*
- 2) Ensure Children with Special Health Care Needs Are Identified and Their Needs for Medical Home Are Targeted*
- 3) Ensure Key Components of a Pediatric Patient-Centered Medical Home Are Achieved*
- 4) Clarifications Are Needed on the Intent and Goal of Specific PCPCH Measures*
- 5) Improve the Quality Measure Specifications for Practice-Level Data Collection, Reporting and Use*
- 6) Improve the Application Process to Enhance Practice Participation*

It should be recognized that the PCPCH application and implementation process is expected to change with time, and the end goal is the transformation of all primary care practices into high-functioning medical homes. To that end, practices should be alerted of any changes to the standards that may affect which tier they have previously achieved. This notification should be done with ample time for practices to explore clinical processes that need adaptation or documentation prior to required resubmissions. It should also be supported through hands-on technical assistance. The focus of the PCPCH Standards should remain on setting a high bar for primary care practices, without allowing any vulnerable population to be left behind in the transformation process. Such a focus must maintain advocacy for children, particularly those with special health care needs.