

# Florida Pediatric Medical Home

DEMONSTRATION PROJECT EVALUATION 2011



*Report Prepared by the Institute for Child Health Policy at the University of Florida*



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# Executive Summary

On February 4, 2009, President Barack Obama signed Public Law 111-3, the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA is a reauthorization of the 1997 amendment to the Social Security Act that created Title XXI, the Children's Health Insurance Program (CHIP). The CHIPRA legislation had many components, one of which directed the Centers for Medicare and Medicaid (CMS) to establish a demonstration grant program for states. Grantee states could participate in one of five categories that were designed to improve children's health. Florida, in collaboration with Illinois, was named a grantee state in 2010. One of the categories that Florida is participating in is aimed at developing provider-based models that will improve child health outcomes. Florida chose to implement the patient-centered medical home (PCMH) model as its provider-based model.

To date the project has recruited 20 demonstration practices, embarked on monthly and bi-annual learning sessions with the practices, and collected baseline evaluation data. The Institute for Child Health Policy (the Institute) was contracted by the state to conduct a four-

year, longitudinal, independent evaluation of the project. The evaluation plan was designed to assess the experiences of multiple stakeholders including parents whose children receive care in the demonstration practices, staff working at the demonstration practices, community stakeholders who interact with the demonstration practices, and the core clinical teams. This report describes the baseline evaluation data of the project. Assessment of the overall project will be addressed at the end of the four-year evaluation period.

Key findings are described below.

- Florida has made much progress in 2011. Twenty practices were recruited, an Expert Group was convened, the American Academy of Pediatrics (AAP) was selected to facilitate the practice transformation, and practices met face-to-face in September for a Learning Session.
- Baseline data suggest that participating practices excel in some areas of the PCMH model and lag behind in others. For example, practices report high levels of data management compared with low levels of quality improvement activities.

- Staff was surveyed about their ability to adapt to change, burnout, and job satisfaction. Staff report average to low burnout, high satisfaction with working conditions, and high levels of cultural sensitivity. Core clinical team members report higher ability to adapt to change, a key factor to the implementation of the PCMH.
- Interviews with the core clinical teams reveal that the project was overwhelming at first and more time was needed to implement changes. However, practices felt that the information provided helped them to structure what needed to change within their practice. Teamwork was stressed as a key to becoming a PCMH.
- According to parents whose children received care in the practices, in general the care received is on par with care for children in publicly-funded health care programs in the rest of the state. Parents report a higher frequency of PCMH as compared to parents in Florida who participated in a recent national survey. Areas for improvement are related to provider support and anticipatory guidance.

# 1 Background

## CHIPRA Legislation

On February 4, 2009, President Barack Obama signed Public Law 111-3, the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA is a reauthorization of the 1997 amendment to the Social Security Act that created Title XXI, the State Children's Health Insurance Program (SCHIP), later shortened to Children's Health Insurance Program (CHIP). CHIP is designed to provide healthcare coverage to children whose family incomes are too high to qualify for Medicaid but are nevertheless limited in their ability to find affordable coverage elsewhere.

CHIPRA extends CHIP funding through federal fiscal year 2013 and has provisions to expand coverage to uninsured children and improve the quality of

children's health care<sup>1</sup>. Under Section 401(a) of the Act, there are seven provisions to improve child health quality activities for children enrolled in Medicaid and CHIP. Two of the CHIPRA provisions call for the development of:

- Demonstration projects for improving the quality of children's health care and the use of health information technology, and
- A core set of measures that will be used to provide a national standard for measurement, reporting, and quality improvement for children's health care.

As a result of these two provisions, CMS issued an invitation to apply for CHIPRA Quality Demonstration Grants in September of 2009. Ten grants were to be awarded and states

were encouraged to collaborate with one another. All grants have a five-year performance period and are to be used to: A) evaluate and experiment with new and existing measures of quality for children covered by CHIP and Medicaid; B) promote the use of health information technology; C) evaluate provider-based models to improve health care delivery; D) demonstrate the impact of electronic health records to improve pediatric health and pediatric health care quality while reducing health care costs; and E) provide a model of the applicant's own design that expands the activities under categories A-D<sup>2</sup>. **Table 1** shows the CHIPRA Quality Demonstration grantee states and the categories they are working on. For those states working on Category C, the table also notes the provider-

**Table 1. CHIPRA Quality Demonstration Grantee States**

STATE	CATEGORY	PROVIDER BASED MODEL FOR CATEGORY C
Colorado, New Mexico	C, E	School Based Health Centers
Florida, Illinois	A, B, C, E	PCMH
Maine, Vermont	A, B, C, E	PCMH
Maryland, Georgia, Wyoming	B, C, D	Care Management Entities
Massachusetts	A, C, E	PCMH
North Carolina	A, B, C, D	PCMH
Oregon, Alaska, West Virginia	A, B, C	PCMH
Pennsylvania	A, B, D	N/A
South Carolina	A, B, C	PCMH
Utah, Idaho	B, C, D	PCMH

*Note: Lead state listed first*

based model that is being implemented.

Florida and Illinois submitted a joint grant application for categories A, B, C, and E. Florida’s Agency for Health Care Administration (AHCA) and Illinois’ Department of Healthcare and Family Services serve as the lead State agencies.

The grant includes national stakeholders such as the AAP, Health Management Associates (HMA), and the National Committee for Quality Assurance (NCQA). Florida stakeholders include the Institute for Child Health Policy (Institute) at the University of Florida, the Florida Department of Health (DOH), Florida Healthy Kids Corporation (FHKC), and the University of South Florida (Figure 1). Florida and Illinois’ proposal was selected in early 2010.

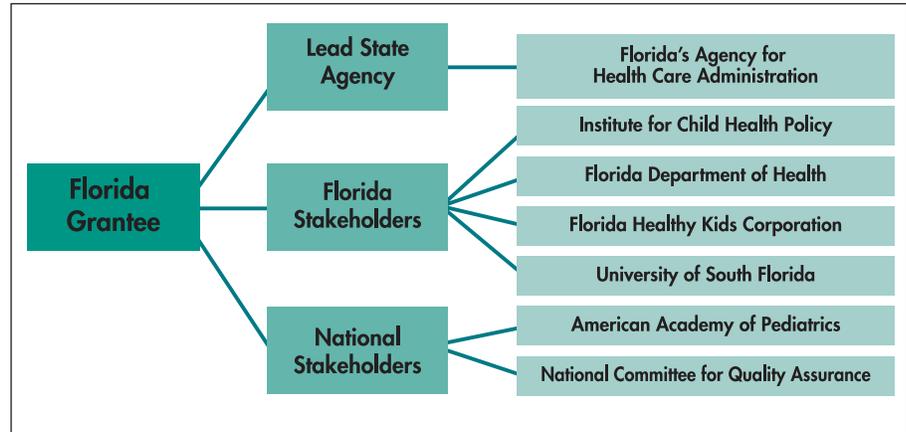
## PCMH Model

### PCMH Principles

The concept of the PCMH has existed since 1967<sup>3</sup>.

This approach to care is comprehensive and based on partnerships between multiple stakeholders such as patients, families, providers, and other organizations in the community. According to the

**Figure 1. Structure of the Florida Quality Demonstration Grant**



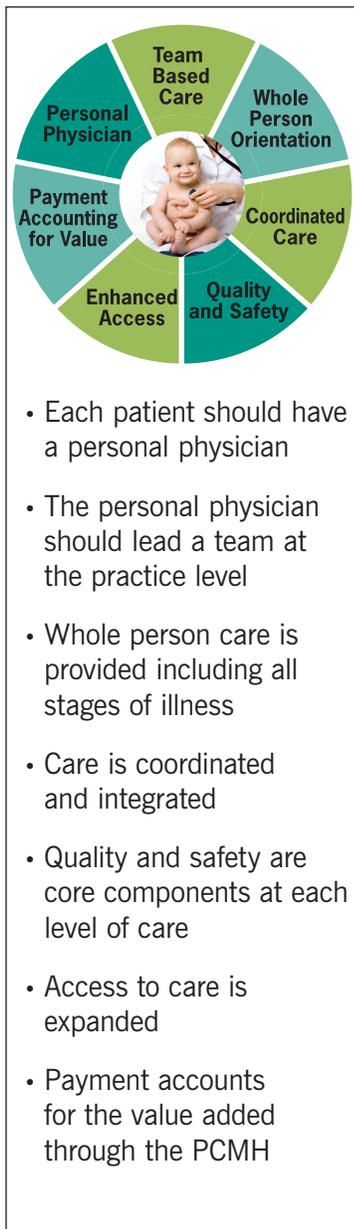
AAP’s 1992 policy statement, a PCMH provides accessible, continuous, comprehensive, family-centered, coordinated, and compassionate medical care<sup>4</sup>. The definition of a PCMH was further expanded in 2002 to include cultural effectiveness<sup>5</sup>. Most recently, a 2007 statement on the Joint Principles of the PCMH by the American Academy of Family Physicians (AAFP), AAP, American College of Physicians, and the American Osteopathic Association identified seven core principles of a PCMH<sup>6</sup> (Figure 2).

### PCMH Model

Because the AAP’s 1992 definition of a medical home left many providers uncertain as to how to apply the theoretical features of the model, a 2002 revision to the policy statement clearly

spelled out the practical implications of a PCMH. For example, accessible care should be delivered in a patient’s own community. Providers should follow their patients through infancy to young adulthood in order to foster continuity. If services are to be comprehensive, then a patient’s primary care physician should be able to “facilitate essentially all aspects of care,” and patients should have access to care for acute conditions 24/7. Coordinated care implies, among other things, that all components of a patient’s medical record are held in a centralized database, and that upon referral, the PCMH team will communicate patients’ clinical issues to outside providers. Finally, a major component of culturally effective care is clear

**Figure 2. Joint Principles of the PCMH**



communication. Therefore, a PCMH should provide patients with translators/interpreters, when needed, and written material that is in the family’s primary language<sup>5</sup>.

**Evidence for the PCMH Model**

Due to the relatively new and evolving nature of the PCMH concept, there is limited evidence on the effectiveness of the model. Similarly, the measures for PCMH effectiveness have yet to become standardized<sup>7</sup>. As Homer et al. (2008) point out in their review of the pediatric PCMH literature, “None of the studies examined the medical home in its entirety,” and the majority of studies are, “... tempered by weak designs, inconsistent definitions and extent of medical home attributes...” However, the majority of existing literature does provide evidence of improved outcomes<sup>8</sup>. For example, Grumbach and Grundy (2010) find that PCMHs are associated with higher quality of care, lower rates of hospitalization and use of emergency services, and lower costs to patients<sup>9</sup>. However, a recent review shows that many evaluations of the PCMH have some method issues and show mostly inconclusive results<sup>10</sup>.

**Payment Mechanisms for PCMH**

The Joint Principles of the Medical Home and the 2012 AAP Financing Principles both call for payment re-structuring that reflects the new types of activities necessitated by the PCMH model, such as enhanced care coordination<sup>6,11</sup>. To achieve this aim, a variety of reimbursement approaches are currently being tested. A 2010 review of 26 PCMH demonstration projects found that the majority use a payment model which combines three distinct types of reimbursement: (i) fee-for-service payments, (ii) fixed, monthly case management fees, and (iii) bonuses for clinical performance<sup>12</sup>. Early evidence is encouraging. For example, within two years, Oklahoma, which complements PCMH payments with performance-based pay, experienced a \$29 decrease in Medicaid costs per patient per year. Colorado, which uses fee-for-service payments to reward well-care, saw a 76 percentage-point increase in the number of pediatricians accepting Medicaid. In Vermont, where networks are paid to support PCMHs, inpatient costs fell by 22% per person per month, and emergency department costs fell by 36% per person per month<sup>13</sup>.

## **PCMH Recognition and Accreditation Programs**

The NCQA PCMH recognition program is perhaps the most widely known<sup>12</sup>, and uses a set of criteria and a points system to assign practices a recognition level between one and three. The NCQA's PCMH 2011 must-pass elements are: (i) access during office hours, (ii) use data for population management, (iii) care management, (iv) support self-care process, (v) track referrals and follow-up, and (vi) implement continuous quality improvement<sup>14</sup>. Of the more than 3,500 NCQA-recognized practices nationwide, approximately one-third serve children, while only 15% are specific to pediatrics<sup>15</sup>. In Florida, 91 practices have NCQA recognition, with 85 at the highest level<sup>15</sup>. Three other national recognition programs exist as well as some recognition tools designed by payers such as BlueCross Blue Shield of Michigan<sup>16</sup>. Importantly, participation in some PCMH demonstration projects and payment pilot programs are often contingent on the pursuit of PCMH recognition<sup>16</sup>.

## **PCMH Initiatives**

Between 2006 and 2008, a national demonstration project was conducted by TransforMED

in an attempt to measure the effectiveness of the PCMH. Thirty-six family practices from across the country participated in the project<sup>17</sup>. A notable lesson from the project was the magnitude of the transition to a PCMH in terms of the time and resources needed for the change initiatives<sup>18</sup>. The National Center for Medical Home Implementation, the Patient-Centered Primary Care Collaborative<sup>19</sup>, and the National Academy for State Health Policy all track PCMH initiatives across the U.S.<sup>20</sup>

## **Implementation Challenges**

Although there has been much agreement about the potential value of the PCMH, implementation can be challenging for several reasons. First, there is an extraordinary amount of information available on the PCMH. Much of this information is available online or in print form. Yet, the ability, and the scarcity of time needed, to process the volume of information tend to be formidable barriers to implementation of the PCMH. One way to combat this barrier is through facilitated education forums<sup>12</sup>. Second, PCMH can be implemented in a variety of ways. Practices may wish to make marginal changes around

a system that is otherwise functioning well, or they may wish to completely re-design care delivery. Third, physicians have competing demands. Even if they are given materials to review and set on a course of action, it may be difficult to find time to implement these changes. Studies have shown that implementation of the PCMH takes time; as long as two years<sup>21</sup>. Finally, there is little evidence on the best way to implement the PCMH model<sup>10</sup>.

## **Evaluation Challenges**

Practice level interventions are challenging to implement, and perhaps even more challenging to evaluate. Evaluation is further complicated by the fact that although a number of PCMH tools exist, few have been validated and there is no consensus across the medical or academic communities on which tools are optimal. Additionally, practice-level benchmarks are not available for all tools. Even among the 12 CHIPRA Quality Demonstration Grantee states implementing the PCMH model as their provider-based model of care for Category C, evaluation plans and tools differ considerably (**Appendix**). ■

# Florida Pediatric Medical

## 2 Home Demonstration Project

**Figure 3. 2011 QI Activities**

Jan-May	<ul style="list-style-type: none"> <li>• Convene Expert Group</li> <li>• Develop Materials</li> </ul>
June	<ul style="list-style-type: none"> <li>• AAP IRB Approval</li> <li>• Recruitment Phase</li> </ul>
July	<ul style="list-style-type: none"> <li>• Select 20 Practices</li> </ul>
August	<ul style="list-style-type: none"> <li>• Baseline Data Collection</li> </ul>
Sept	<ul style="list-style-type: none"> <li>• Learning Session #1</li> </ul>
Oct-Mar	<ul style="list-style-type: none"> <li>• Monthly Data Collection</li> <li>• Monthly Calls</li> </ul>

After being selected as a grantee state, work groups and steering committees began to convene in March 2010 to create work plans, timelines, and subcontracts to complete the work for all parts of the CHIPRA grant. Subcontracts were awarded by AHCA in 2011 to (i) the AAP to implement a PCMH quality improvement (QI) project, and (ii) the Institute to undertake an independent evaluation of the Florida Pediatric Medical Home Demonstration Project.

The Florida Pediatric Medical Home Demonstration Project is a five-year program. Year one of the program began in 2010 and was devoted to planning activities, with the following four years of the program designated as the implementation and evaluation phases. For the purposes of this report, the

baseline year of data collection in 2011 is noted as year one, 2012 as year two, 2013 as year three, and 2014 as year four.

### QI Project

The AAP was charged with the following tasks:

- Establishing and implementing a PCMH QI project that would be practice-based.
- Facilitating the education and quality improvement work of a three-person core clinical team from each practice involved in the project.
- Recruiting 20 practices to be included in the community of learners for the project.

The aim of the QI project is to move practices along the medical home continuum towards the provision of comprehensive care for all the core areas identified in the Joint Principles of the PCMH. Core clinical teams from the participating practices were asked to submit baseline data, attend a Learning Session to receive instruction on PCMH concepts and QI science, and participate in a six-month QI action period before attending a second Learning Session (see **Figure 3**).

An in-depth description of the QI project for 2011 is given below<sup>i</sup>.

### Development Phase

Several areas of the AAP have been integrally involved in managing the project, including the Division of Children with Special Needs, the Quality Improvement Innovation Networks (QuIIN), the Chapter Alliance for Quality Improvement (CAQI), and the Education in Quality Improvement for Pediatrics Practices (EQIPP) program. The AAP formed an Expert Group to provide guidance in planning the project protocol and to oversee the implementation of the project. Expert Group membership included: AAP staff, physicians, the Florida Chapter of the AAP, AHCA and Department of Health (DOH) representatives, HMA representatives, a QI advisor, and the evaluation team. The Learning Collaborative design was approved by the AAP Institutional Review Board (IRB) (#11KA01) on June 18, 2011.

### Practice Recruitment and Selection

Recruitment of practices was primarily achieved via the following physician email distribution lists: Children's Medical Services Network (CMSN); Florida Healthy

<sup>i</sup> Although not reported here, the AAP has recently been contracted by the state of Florida to extend the QI project to a total of 18 months, with the goal of sustaining changes, scaling up initiatives, and spreading best practices.

Kids Corporation; The Florida Chapters of the AAP and AAFP, respectively; and Florida QullIN members. Additionally, two informational webinars were held in June. Practices were told that they need only apply if they met three selection criteria: (i) Minimum of 100 children with special health care needs (CSHCN), (ii) Participation in Medicaid, a Medicaid health plan, or Florida KidCare, and (iii) No former participation in the Medical Home Implementation Project in Duval County. Practices could be pediatric practices, family medicine practices, hospital-based practices, or federally qualified health centers that serve children in Medicaid and CHIP. All recruitment materials were branded with the Florida Pediatric Medical Home Demonstration Project logo.

Several non-monetary incentives were available to the selected demonstration practices, as follows: (i) American Medical Association Physician's Recognition Award Category 1 Credits™, (ii) American Board of Pediatrics Part 4 Maintenance of Certification credit, (iii) access to the AAP EQIPP *Medical Home in Pediatric Primary Care* course, and (iv) a 30% discount to two other EQIPP courses—*Bright Futures* and *Give your Immunization Rates a Shot in the Arm*, respectively.

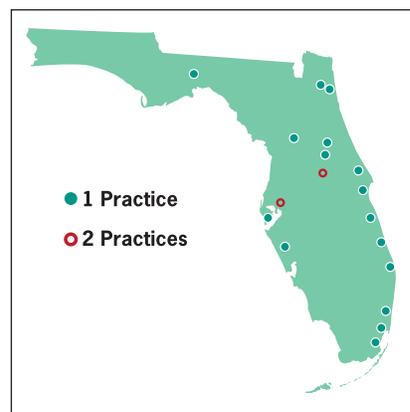
As part of the application process, practices nominated a three-member core clinical team (a lead physician, and two other team members regardless of their position) who would attend the Learning Sessions and act as medical home champions within the practice. As part of the application process, practices were informed that preference would be given to applicants who identified a parent from their practice to partner with them in the QI activities and to participate in the Learning Sessions.

Applications were accepted until July 20, 2011, practice selection took place on July 27, and selected practices were notified of their acceptance on August 1, 2011. A scoring sheet was used to grade practices based on 24 criteria (e.g., participation of a parent partner, number of publicly-insured CSHCN, other physicians in the practice support the program, etc.). Practices with the top 20 scores were selected for inclusion. Two practices did not accept the invitation and were replaced by the next two top-scoring practices. The location of the final 20 demonstration practices is shown in **Figure 4**.

#### Baseline Data Collection

Selected practices were sent a pre-work package describing the project requirements; the details

**Figure 4. Location of Demonstration Practices**



of which were reiterated during an orientation webinar. The core clinical teams were instructed how to access the EQIPP *Medical Home in Pediatric Primary Care* course for extra resources and how to submit their baseline data (survey and medical record reviews). Core clinical teams were also able to access a secure project workspace website that detailed administrative information (e.g., data collection requirements, upcoming dates, team contact information, etc.) and additional resources (e.g., practice data reports/run charts, progress reports, tools and resources, Learning Session slides, and monthly webinars).

Core clinical teams were required to complete a baseline survey, addressing areas such as: (i) know and manage your patient population, (ii) develop a cross-disciplinary PCMH improvement team, (iii)

enhance access to care, (iv) provide family-centered care, (v) provide and document planned, proactive, comprehensive care, and (vi) coordinate care across all settings. Practices were also required to complete a baseline medical record review of 20 Medicaid, Medicaid health plan, or Florida KidCare patients, specifically measuring the percentage of the selected charts that showed: (i) an identified primary care pediatrician or physician-led care team, (ii) a primary care pediatrician or physician-led care team member provided the most recent health supervision visit, (iii) patient and/or family concerns elicited at the visit, (iv) all expressed concerns addressed or with plans made to address them, (v) a medical summary or comprehensive care plan created or updated/maintained at the visit, (vi) a current copy of their medical summary or comprehensive care plan reviewed and offered to them at the visit, and (vii) a follow-up visit scheduled or recommended.

### **First Learning Session**

The first Learning Session was held September 23-24, 2011 in Orlando. All 20 practices attended for a total of 57 core clinical team members and 12 parent partners. Since the PCMH concept is truly all-encompassing, the AAP was

not prescriptive in which PCMH domains to concentrate on first; rather, practices received extensive educational content from local and national PCMH experts and feedback on their baseline data. Additionally, practices were given an 'ideas for change' packet and allotted time to work on their individualized QI strategies. Practices were encouraged to plan and implement small-scale tests of change following the Model for Improvement, using Plan-Do-Study-Act (PDSA) cycles<sup>22</sup>. Practices were also encouraged to learn from each other and their parent partners, with time dedicated to sharing information about each practice's operations, meeting the parent partners, and sharing ideas for change. This collaborative model was also carried beyond the first Learning Session with the development of a project listserv.

### **Action Period**

The QI action period began in October 2011. During this six-month phase, the core clinical teams were asked to complete the following on a monthly basis: (i) submit medical record review data from 10 Medicaid, Medicaid health plan, or Florida KidCare patients, (ii) submit a narrative progress update, and (iii) participate in a webinar. To accommodate the physicians schedules, monthly calls were

offered on two different dates and times each month. The six topics covered by the monthly webinars were: (i) *Title V and CSHCN resources in Florida*, (ii) *Pediatric care plans*, (iii) *Medical home coding*, (iv) *Health information technology*, (v) *Medical home recognition programs*, and (vi) *Engaging parent partners*. Part of each webinar was dedicated to discussions between the practices, led by the QI advisor.

During this six-month period, several additional services were offered to the practices, including: (i) a Medical home 101 webinar to explain PCMH concepts to the practice members not part of the core clinical team, (ii) mentorship offered by Expert Group members and the QI advisor to practices, where requested, (iii) development of a listserv and educational webinars and an in-person workshop for care coordinators in the practice, and (iv) a checklist broadly outlining where practices should concentrate their efforts. Practices were also regularly referred to the National Center for Medical Home Implementation website and provided other relevant resources over the course of the project.

During this phase, the AAP also provided several opportunities

for parent engagement at the project level, including: (i) eliciting parent partner needs through a survey assessment, (ii) development of a parent partner listserv to share resources, (iii) periodic conference calls for parent partners, and (iv) a special webinar for parent partners and core clinical teams to develop a parent partner position description. Moreover, the AAP has encouraged practices to embrace parent involvement by holding targeted webinars, discussing parental engagement at the Learning Sessions, and distributing resources through the project listserv. Where feasible, the AAP has encouraged practices to engage parents in their improvement efforts, through such things as developing parent advisory boards and surveying their patient population to elicit parent feedback.

## Evaluation

The PCMH model is an overarching concept that touches most aspects of a practice's operations and takes two years or more to implement<sup>17</sup>. As such, the evaluation needs to capture short and long term effects of the PCMH implementation. To this end, a four-year, longitudinal, independent evaluation was planned by the

Institute and approved by the working group. The evaluation protocol was approved by the University of Florida IRB in May 2011 (#80-2011).

### Evaluation Design

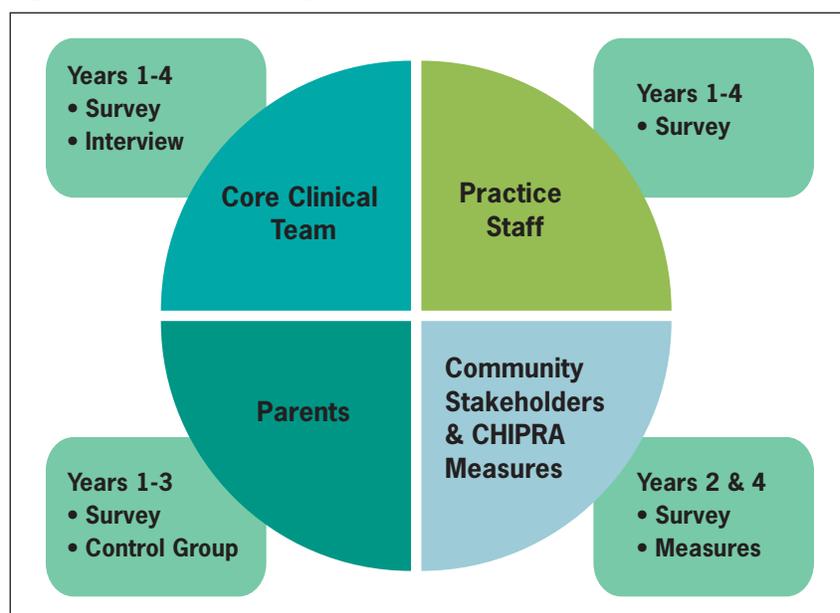
The evaluation plan was designed to assess the experiences of multiple stakeholders including parents whose children receive care in the demonstration practices, staff working at the demonstration practices, community stakeholders who interact with the demonstration practices, and the core clinical teams (**Figure 5**).

The Institute's evaluation of the core clinical team includes two components: a survey and an interview. Both qualitative

and quantitative approaches were adopted to best capture the PCMH model's complexity and to fully understand the "medical homeness" of each practice at baseline. Although the core clinical team is leading the PCMH initiative, the whole practice is going through the process of implementing practice-wide changes. It is therefore important to survey staff members' attitudes towards their practice environment to see if their attitudes align with the core clinical team.

The core clinical team, practice staff, and parents are assessed at baseline, and annually every year thereafter<sup>ii</sup>. Community stakeholders are assessed at two time points, in Years 2 and Year 4.

**Figure 5. Evaluation Design**



<sup>ii</sup> Current funding allows for annual parent telephone surveys to be conducted until 2013. A fourth year of surveys in 2014 may be considered if funding allows.

Surveys tools used in the evaluation are described in **Table 2**.

### Matched Control Group

Evaluation guidelines recommend the use of a comparison group to control for any pre-post changes in the demonstration group’s outcome measures that are not

attributable to the intervention itself<sup>iii</sup>. The initial evaluation plan involved recruiting a comparison group of 20 practices matched by patient and practice characteristics to the demonstration group. Despite attempting to recruit 20 comparison practices using four recruitment methods, this approach was abandoned

(**Table 3** and **Figure 6**). Rather than conduct a pre-post analysis without a comparison group, the Institute instead identified a group of comparable children — not comparable practices — to act as a control group for the telephone surveys measuring children’s health care experiences.

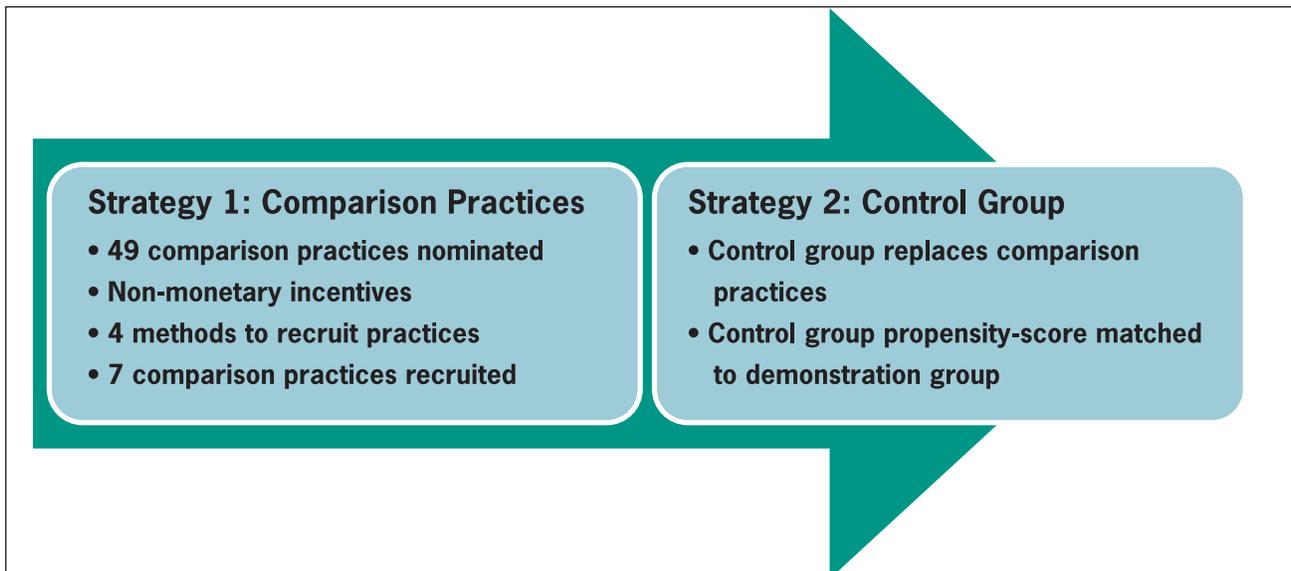
Table 2. Baseline Survey Tools		
STAKEHOLDER	SURVEY TOOL	CONCEPTS MEASURED
Core Clinical Team	Medical Home Index (MHI) <sup>23</sup>	<ul style="list-style-type: none"> <li>Chronic condition management</li> <li>Care coordination</li> <li>Community outreach</li> <li>Data management</li> <li>Organizational capacity</li> <li>Quality improvement</li> </ul>
	TransformMED Practice Environment Checklist <sup>17</sup>	<ul style="list-style-type: none"> <li>Adaptive reserve</li> <li>Community knowledge</li> <li>Cultural sensitivity</li> <li>Health information technology integration</li> <li>Patient safety culture</li> </ul>
	Qualitative Interview Guide <sup>17</sup>	<ul style="list-style-type: none"> <li>Transformation process</li> <li>Internal practice factors</li> <li>External practice factors</li> <li>Community linkages</li> </ul>
Practice Staff	TransformMED Practice Environment Checklist	<ul style="list-style-type: none"> <li>Adaptive reserve</li> <li>Community knowledge</li> <li>Cultural sensitivity</li> <li>Health information technology integration</li> <li>Patient safety culture</li> </ul>
	Maslach Burnout Inventory – General Scale (MBI-GS) <sup>24</sup>	<ul style="list-style-type: none"> <li>Exhaustion</li> <li>Cynicism</li> <li>Professional efficacy</li> </ul>
	Job Satisfaction <sup>25</sup>	<ul style="list-style-type: none"> <li>Satisfaction with work environment</li> </ul>
Parents	Consumer Assessment of Healthcare Providers and Systems — PCMH (CAHPS-PCMH) <sup>26</sup>	<ul style="list-style-type: none"> <li>Getting timely appointments, care, and information</li> <li>Provider-patient communication</li> <li>Courteous and helpful office staff</li> <li>Provider’s attention to child’s growth and development</li> <li>Provider’s advice on child’s health and safety</li> <li>Provider’s support of patient self-management</li> </ul>
	National Survey of Children with Special Health Care Needs (NS-CSHCN) <sup>27</sup>	<ul style="list-style-type: none"> <li>Family-centered care</li> <li>Getting needed referrals</li> <li>Usual sources for sick and well care</li> <li>Care coordination when needed</li> <li>Personal doctor or nurse</li> </ul>

<sup>iii</sup> A Randomized Controlled Trial, although considered the most rigorous approach, was not feasible because of the small number of applicants for the Florida Pediatric Medical Home Demonstration Project.

**Table 3. Recruitment Strategies for Comparison Practices**

APPROACH	COMPARISON PRACTICE RECRUITMENT STRATEGIES
<b>Cold-Contact Nominated Comparison Practices</b>	Nominated comparison practices were initially contacted using a three-pronged approach: (i) Cold-calling, (ii) FedExing the application package, and (iii) Reminder phone calls. Initial cold-calls were conducted in early August and secondary calls were conducted one week after the FedEx packages were sent.
<b>CMSN Regional Area Offices</b>	In Florida there are 20 CMSN area offices, located within eight regions, which regularly have contact with pediatric offices serving publicly-insured CSHCN. The CMSN Regional Nursing Directors were asked to reach out to the potential comparison practices in their region. The CMSN Nursing Directors were provided with a telephone script and asked to report the appropriate contact person, whether the practice would like additional information, how they would like to receive that information (fax, email, FedEx), and to gauge whether the practice was interested or not interested.
<b>Contact by Fax and Email</b>	Nominated comparison practices were re-contacted by the Institute using two approaches: (i) Fax flyer, and (ii) Email. After compiling fax numbers, all potentially eligible comparison practices were faxed a recruitment flyer and the application package. The Florida Chapter of the AAP was asked to provide the email addresses of their members within the potentially eligible practices. Providers were emailed the recruitment flyer and the application package.
<b>CMSN Regional Medical Directors</b>	In a final effort, the CMSN Regional Medical Directors were tasked with the same outreach tasks as the CMSN Regional Nursing Directors.

**Figure 6. Recruitment Strategies**



Recruitment strategies are described below.

### **Strategy 1: Comparison Practices**

Upon application, demonstration practices were asked to nominate three potential practices in their area with similar characteristics (e.g., patient population, geographic region, practice type, etc.). However, some demonstration practices nominated less than three practices, and several suggested the same nominees. In total, there were 49 uniquely nominated potential comparison practices.

Nominated practices were approached using four sequential recruitment strategies between August and December 2011 (**Table 3**). As a result of these four recruitment approaches, seven comparison practices applied and five practices completed the baseline practice survey by December 2011<sup>iv</sup>. Without monetary incentives, the Expert Group deemed the pace of recruitment too slow to recruit 20 comparison practices that matched the demonstration practices<sup>28</sup>. Non-monetary incentives on offer were: (i) 30% discounts to two AAP courses — *Bright Futures* and *Give your Immunization Rates a Shot in the Arm*, (ii) Discounted

membership per person to the Florida Chapter of the AAP, (iii) Complimentary one-year membership to the AAP Council on Clinical Information Technology, and (iv) Feedback of parent telephone surveys and CHIPRA core measure results conducted by the Institute.

### **Strategy 2: Control Group**

A control group for the parent telephone survey was identified by matching characteristics of the children whose families completed the telephone survey in the demonstration group. As with the demonstration group, children in the control group will be included over the course of the four years. Administrative data for Florida's Medicaid and CHIP programs was queried to obtain a matched control group based on the following child characteristics: age, race/ethnicity, gender, funding source, and special health care needs (SHCN) or not. CSHCN are enrolled in CMSN, the State's Title V Program. A statistical matching technique was used to generate a population from which to draw the control group sample, stratified by whether the child had a SHCN or not. The stratification was to ensure that the demonstration and control group had the

same stratification of CSHCN and non-CSHCN. Statistical tests reveal that the control group population does not differ significantly from the demonstration group for any of the five child characteristics ( $P > 0.05$ ). ■

### **REPORT PURPOSE**

The purpose of this report is to describe the baseline evaluation data that were collected in year one of Florida's Pediatric Medical Home Demonstration Project. Data submitted to the AAP as part of the QI project is not presented in this report as it is not part of the Institute's evaluation. Individual sections of this report will describe the approach that was taken to assess the experiences of the stakeholder group in question, tools used in the assessment, and a description of the baseline data results. The reader is cautioned that the purpose of this report is to report baseline data only; therefore, no interpretations should be made about the data as these would be premature. Likewise, recommendations are not included in this report.

<sup>iv</sup> 196 telephone surveys were completed with families attending these seven comparison practices.

# 3 Core Clinical Team — Survey

## Overview

As previously described, the 20 demonstration practices were required to nominate a three-person core clinical team to participate in the project activities. One member had to be a lead physician and the other two members could hold a clinical or non-clinical position within the practice. The first evaluation task that the core clinical teams were asked to complete was a practice survey. Core clinical teams were sent a survey via e-mail in August 2011. Survey questions included the MHI tool and items about their practice environment<sup>23,17</sup> (**Table 2**). Surveys were administered prior to the first Learning Session in September 2011 with the purpose of understanding the characteristics of the practices and their baseline level of medical homeness. Practices were requested to return the survey via e-mail within three weeks.

When interpreting the results, there are several caveats to consider:

- Results for the 20 demonstration practices are reported as a single number,
- Where available, results are compared against national benchmark data.

## Medical Home Index

A number of instruments were assessed by the Institute and the Expert Group to measure the baseline medical homeness of the 20 demonstration practices. Cost, ease of administration, available benchmarks, and the ability to have access to the raw data were all considered and, ultimately, the MHI was chosen. The MHI has 25 themes that are divided into six domains including:

1. Organizational capacity (7 themes)
2. Chronic condition management (6 themes)
3. Care coordination (6 themes)
4. Community outreach (2 themes)
5. Data management (2 themes)
6. Quality improvement (2 themes)

## Analyses and Reporting

For each of the 25 themes, practices choose a level from 1 to 4 to determine whether they partially or fully meet the criteria for that level; level 1 is basic pediatric care, level 2 is responsive care, level 3 is proactive care, and level 4 is comprehensive care. A mean score is calculated for each domain (the number of themes varies across the domains) and the scores range from 1 to 8. A raw

mean score is calculated from the 25 themes and then transformed to a 100-point scale to represent a summary MHI score. A MHI score of 100 represents the highest level of medical homeness, with a practice fully offering comprehensive care for all 25 themes. In a 2003 study by Cooley and colleagues of 43 primary care pediatric practices located in nine states, the MHI was found to have excellent psychometric properties (e.g., overall alpha coefficient was 0.96; internal consistency reliability across the domains ranged from 0.81 to 0.91; interclass correlation between the summary scores and external reviewers was 0.98<sup>23</sup>). Mean domain scores from this study are used as benchmarks in this report<sup>23</sup>.

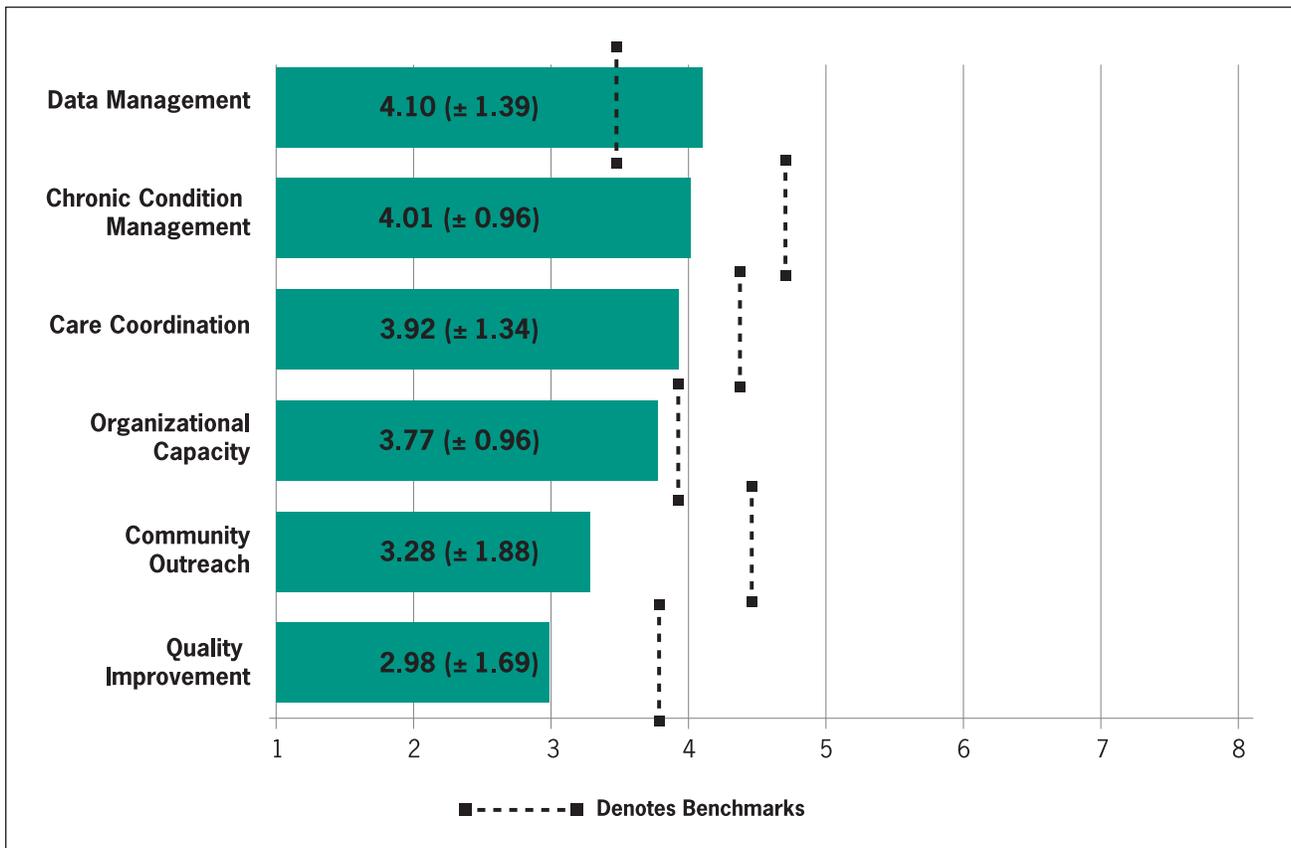
## Key Findings

- The MHI mean score of 39.8 is lower than the benchmark of 43.9 (**Table 4**).
- The highest MHI domain score is for data management and is the only domain to exceed its benchmark. The remaining five domain scores are below their respective benchmarks (**Figure 7**).
- There is a large degree of variability between the Florida practices, both in terms of their individual domain scores and their overall MHI score.

**Table 4. Overall MHI Score for the Demonstration Group Versus Benchmark**

MHI SCORE	DEMONSTRATION GROUP	BENCHMARK <sup>23</sup>
Mean ( $\pm$ Standard Deviation (SD))	39.8 ( $\pm$ 15.0)	43.9 ( $\pm$ 15.8)
Median	37.4	41.7

**Figure 7. Baseline MHI Mean Scores for Florida Demonstration Practices ( $\pm$  SD)**



## Adaptive Reserve

One of the largest, and the first national assessments of the PCMH model began in 2006<sup>29-31</sup>. The National Demonstration Project, called TransforMED, recruited 36 practices across the United States and conducted a comprehensive evaluation. Results from the National Demonstration Project were published in 2010 and describe a number of practice, provider, and patient outcomes. One of the main findings from the study was that a practice's ability to adapt and make changes was an important factor in its ability to become a PCMH. Coined 'adaptive reserve,' this concept accounts for a number of characteristics including: relationship infrastructure, facilitative

leadership, sense-making, teamwork, work environment, and culture of learning. Examples of attributes that are illustrative of the components of the adaptive reserve scale are shown in **Table 5**.

### Analyses and Reporting

The lead physician from each core clinical team was asked to respond to 23 items about their practice's adaptive reserve on a five-point Likert scale. Negatively worded questions are reverse-scored. A raw mean score is calculated and then transformed to a scale from 0 to 1, where 0 represents the lowest score and 1 the highest score. The adaptive reserve score was shown by the National Demonstration Project to have good psychometric properties (e.g., Cronbach alpha score was 0.97, denoting

excellent internal consistency)<sup>31</sup>. The mean practice adaptive reserve score from the National Demonstration Project at baseline is included in **Table 6** as a way to compare the baseline scores of the demonstration practices.

### Key Findings

- At baseline, Florida's mean practice adaptive reserve score (0.70) is similar to the national benchmark of 0.69 (**Table 6**).
- There is variability among Florida demonstration practices in terms of their self-reported abilities to adapt and make changes. At baseline, the minimum adaptive reserve score for the 20 practices was 0.52 and the maximum was 0.86.

**Table 5. Attributes of Adaptive Reserve**

ATTRIBUTE	EXAMPLES OF ATTRIBUTES
Relationship infrastructure	Mindfulness, reflection, respectful interaction, cognitive diversity, trust, communication
Facilitative leadership	Leadership supports change, ensures an enjoyable environment
Sense-making	Having information that is needed
Teamwork	Operating as a team
Work environment	Enjoyable environment
Culture of learning	Learning from mistakes

**Table 6. Core Clinical Teams' Adaptive Reserve Score Versus Benchmark**

	DEMONSTRATION GROUP				Benchmark Mean (± SD)
	Mean (± SD)	Median	Minimum	Maximum	
ADAPTIVE RESERVE	0.70 (± 0.07)	0.71	0.52	0.86	0.69 (± 0.35)

## Practice Environment

In addition to assessing adaptive reserve, researchers in the National Demonstration Project developed survey questions to assess several other components of a practice's environment. After a principal component factor analysis, the following four practice environment factors emerged:

1. Community knowledge (4 items),
2. Health information technology (HIT) integration (4 items),
3. Cultural sensitivity (3 items), and
4. Patient safety culture (3 items).

The National Demonstration Project showed that the practice environment factors have good psychometric properties. Cronbach alpha scores indicate good internal consistency for three factors (community knowledge: 0.82; patient safety culture: 0.81; HIT integration: 0.73), and acceptable internal consistency for the cultural sensitivity factor (0.68)<sup>17</sup>.

### Analyses and Reporting

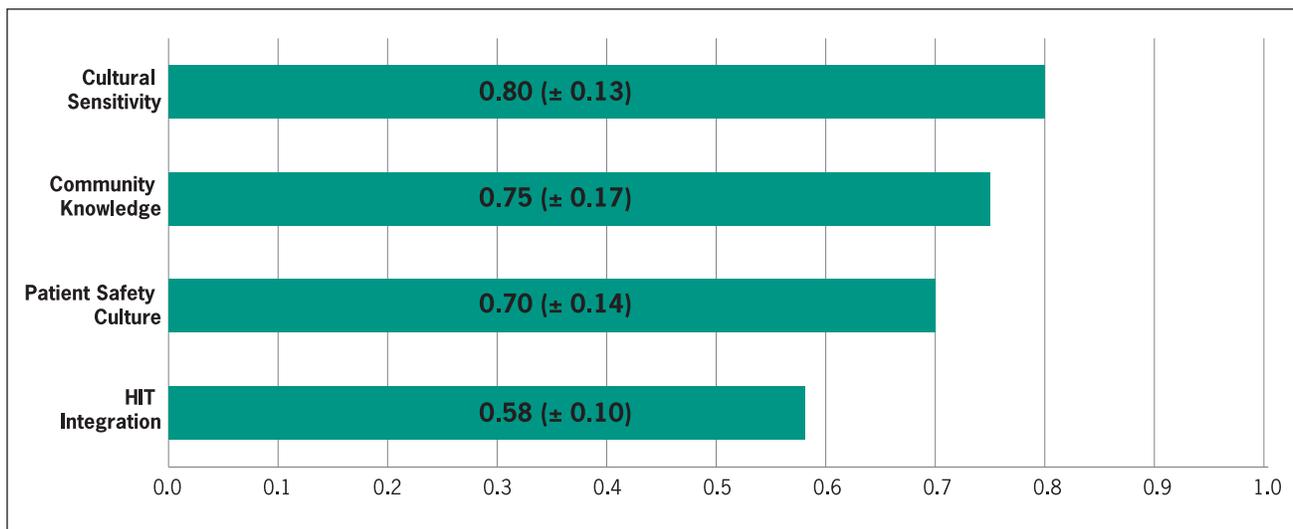
The lead physician from each core clinical team in Florida's project was asked to respond to 14 items about their practice environment on a five-point Likert scale (1=strongly disagree to 5=strongly agree). Negatively worded questions are reverse-scored. For each of

the four practice environment factors, raw mean scores are calculated and then transformed to a scale from 0 to 1, where 0 represents the lowest score and 1 the highest score. There is no benchmark data available from the National Demonstration Project for the four practice environment factors.

### Key Findings

- The Florida demonstration practices score highest on the cultural sensitivity domain, followed by the community knowledge, patient safety culture, and HIT integration domains (**Figure 8**). ■

Figure 8. Core Clinical Teams' Practice Environment Mean Scores ( $\pm$  SD)



# 4 Core Clinical Team — Interview

## Overview

The second component of the practice assessment was an in-person qualitative interview. Questions were adapted from two interview guides<sup>17</sup> used in the National Demonstration Project, approved by the Expert Group, and pilot tested prior to implementation. A structured interview guide was created which included an interviewer script, structured questions, examples, and standard prompts to elicit additional information. Twenty interviews were completed with the core clinical team from each practice. Interviews were conducted with all three members at once in a private area of their practice, with one to two trained interviewers, while two audio recorders taped the interview. Questions were directed to the core clinical team as a whole, but allowed for each member to contribute individually. Each core clinical team was given the questions in advance (ranging from 3 days to 4 weeks prior) although few stated they prepared answers ahead of time.

The following four domains of PCMH transformation were covered in the interview:

- Transformation Process,
- Factors Internal to the Practice,
- Factors External to the Practice, and
- Community Interactions.

Interviews averaged 60 minutes in length as team members typically took turns speaking, resulting in some cross talk.

## Analyses and Reporting

Audio-files were initially transcribed verbatim. In a second pass of the transcripts, personal and practice identifying information were removed and blinded. Core clinical team members' positions in their practice (e.g., physician, nurse, etc.) were left in the transcript to allow for the differentiation of experiences from each personnel based on their level of interaction with patients and staff.

A coding manual was developed by the Institute and provided to an independent assessor to determine inter-rater reliability of the four domains and to conduct a thematic analysis for the four domains. Atlas Ti®

qualitative analysis software was used by the Institute and the independent assessor. The inter-rater reliability between the Institute and the independent assessor was 0.95, denoting excellent reliability between coders.

## Key Findings

- Major themes are described below by the four domains of interest. This is not a comprehensive list of findings and does not account for emergent themes.

## PCMH Transformation Process

The majority of respondents described the experience as “overwhelming” at first. Most respondents described the situation as the need to process a lot of information in a short amount of time and move into action before they were fully prepared. Many also reported that they had been operating in a specific way for several years and the transformation was a complete upheaval of their system.

*“It’s overwhelming because it involves a lot of different facets of change...trying to get a practice that’s*

*been in its current setting for...30-some odd years and then trying to kind of slowly transform it — it's an overwhelming process."*

Some respondents reported a sense of feeling they were not up to par after attending the Learning Session and learning about the full criteria/range of activities and expectations for the project. However, upon reflection, they came to realize they were not presented with new activities or expectations but rather had been provided a structure and process for the project.

*"Now that it seems to be more structured...suddenly it's like you have to remember to do this every time...so it can be overwhelming until you realize you are already doing most of it but it was not well organized."*

*"The planful way in which this is organized, and it's not rocket science, so it has an organized, simple approach and it's continuous. So you know, if you can just get people to kind of be thinking along small changes, do it now, fix it, measure it, reassess, fix it, measure it, reassess..."*

About three-quarters of the respondents reported that the project forced them to organize

their practice and processes in ways that were time consuming but necessary and beneficial. The structure of the project improved service delivery and helped the practice to grow efficiently.

*"My experience has been very positive and it's given me a structure and the tools to use to make improvements."*

*"I think that truly what this project does is basically fine tune any medical practice and be able to put that on paper...you have a very clear statement of how it's progressing, what you have to do next, what you have to do in the future."*

*"The project was very positive...it has shown us weakness in our practices...making small changes can make a big difference."*

#### **AAP**

Most practices felt that AAP involvement was positive, particularly the Learning Session which gave participants an opportunity to speak to other practices involved in the PCMH transformation, while some respondents felt that the AAP needed to provide clearer and locally available resources, more ongoing training, a single point of contact, and better examples for change. Almost all the practices had positive comments

on the AAP's availability for questions and concerns.

*"It was outstanding...to go to a conference and get it all put together...and get a nice overview, see what others are doing and seeing what might work for us. It was exciting."*

*"All of the information that we've got from there and the paperwork and the packets and the ideas and — very helpful. I don't think we would have even known where to start with all of that — without that."*

*"I think the only other thing that I would...like to see is, like, an example of like, not the perfect, you know, medical home, but a couple different options, not...just in Florida, but throughout the country."*

*"I would have liked to have seen...clearer cases and examples of practices that have transformed to a medical home, that have achieved and seen to a Level 3."*

Most practices felt that they needed additional time to make changes, especially larger practices, and this was sometimes perceived as more of a barrier than any financial issues. Respondents felt that it was difficult to schedule frequent meetings with all the staff present. In addition, it

was a challenge to prioritize changes and some respondents expressed concern over how to document these changes for evaluation.

*“It’s a huge institution and it’s a huge practice...so when we’re trying to implement this, getting a kind of support for everything from as little as making small changes in the EMR to how we bill stuff or how we communicate...it sort of takes ten meetings.”*

*“It’s mainly time, it’s having the time to implement the changes, it’s having the time to fill out the forms on all of these patients and not have the patients waiting and...backlogging the waiting room because you’re filling out a form. So I think that’s our biggest challenge.”*

*“I think it’s unrealistic that we’re going to see big jumps in our numbers over the next four months...I don’t think in that size months we’ll ever really do well on that measurement.”*

## **Internal Factors**

The majority of respondents felt a combination of internal factors affected their practice and made it unique. Some of these distinguishing features included being open 24 hours, serving minority and underserved

populations, serving patients with chronic conditions and rare disorders, being in a rural area, having limited access to specialties for consults, having non-English speaking patients, and having a diverse staff available to assist with these unique factors.

*“Our clinic is unique because all of our patients or at least 98% of our patients have a chronic medical condition... usually two or more.”*

*“We have a diverse staff and it’s good because...we want to be trying to serve everyone and we need people who are trilingual. One of my doctors is and...several of our employees and staff are bilingual.”*

*“You’re just known as the guru for specialty syndromes and chronically ill and if anybody has anything that they remotely think is weird then they’re here in a heartbeat.”*

Most respondents described that work was successfully completed by a combination of factors that primarily resulted from a team approach, as well as providing examples for change. Some practices acknowledged that there was a specific group of individuals that took on leadership roles and guided others. A few

practices reported that internal issues, such as the staff and physicians being on different pages, negatively impacted their progress with the project. Most practices felt that any resistant staff would eventually accept the transformation once they understood the value of the project (respondents often reported that they had not yet informed the entire staff about all the details yet).

*“We have to, you know, we have to jump in and support each other to make this clinic actually run, you know? So I think, really, it’s a collaborative team, I mean, it takes all of us.”*

*“Every part of us gets things done. There’s just certain individuals that are better at it than others. I have go-to people with the front desk”*

*“I think they might be little bit on different pages. Not because they’re not interested, but because they don’t really know and understand fully. I think they understand generally the idea, very generally the idea, of Medical Home, but not really specifically.”*

*“We think it’s going to be very beneficial for the practice, not only, for delivering patient care, but also for the infrastructure of*

*the clinic. I think it's going to improve...many aspects, especially staff satisfaction."*

All practices reported wanting a care coordinator but some perceived that their financial situation or project funding did not permit this. A care coordinator was perceived as a key component of the PCMH transformation because this individual can spend the extra time with patients and more quickly identify issues that need to be addressed. Some practices reported a desire for additional care coordinators because of the increasing volume of patients.

*"I think that we would never even be able to fathom doing...patient-centered medical home and comprehensive care plans and anything like that without having a unique individual to take ownership of that and I think in the current world of our case manager, there would be no one who could take that on reasonably... you would have to divide it amongst people and then you lose some accountability."*

*"I have wanted a care coordinator for more years that I can say...there's no funding and the way that the healthcare system works is that...you basically pay for the number of patients you*

*see coming through...you have someone of that level paying that salary, but they're not actually bringing in any extra money."*

## **External Factors**

The primary external factor was insurance. Many of the practices reported that due to the economic climate they are seeing a different case-mix of patients; as families lose their commercial insurance, many of the practices are seeing more publicly-insured patients compared with privately-insured patients. Furthermore, many of the publicly-insured patients experience difficulties accessing timely specialist care as the number of specialists seeing publicly-insured children has decreased. As a result, many of the practices are spending more and more time trying to coordinate care with specialists; however these extra efforts are not compensated under the PCMH model. Practices also reported that changes in pharmacy benefits caused additional delays for patients and staff due to the need to identify alternative medications and contact the pharmacy for assistance, all of which is uncompensated time under the PCMH model. Respondents suggested that more insurance plans should recognize PCMHs.

*"You spend time, more busy work. We are constantly working just to keep the same services, at either the same or just a little below. We're fighting for everything. It's like you get tired of fighting. You're fighting on the phones with the pharmacist. You're fighting with Medicaid. You're fighting with insurance companies. You're talking to medical directors."*

*"Quality is obviously what's driving the medical home, but economics has to be part of that...I mean, we've gone from 14% to 25% Medicaid, you know, over the last few years, so that's a major shift for us."*

*"Medicaid is a moving and confusing target that would make the strongest of men and women pull out their hair and weep and lay on the ground and stamp their feet."*

Some respondents reported issues with patients visiting other cheaper clinics, such as urgent care and walk-in centers, instead of coming to them. Many respondents also cited lack of transportation and distance from the practice as reasons that patients chose to seek medical care in their own area instead. Transportation issues have prevented patients from seeing specialists.

*“For our patients, it’s really, really major to have everything in one place because...we deal with a lot of transportation problems... especially in this area. We deal with a lot of people that take the bus.”*

*“At night, when we talk to them and say, ‘why did you go to the after-hours clinic?’ because we do ask...their answer is, ‘it was on the corner. It was on the corner and I’m not driving 30 miles to come see you’.”*

Respondents reported the project helped them to prioritize what needed to change within their practice. Some practices felt that the electronic medical record (EMR)<sup>v</sup> was an internal and external factor that impacted their ability to implement the project; respondents felt that the transition to EMR was a large obstacle on its own. Although many respondents felt that the EMR would be beneficial in the long run and improve quality of care, they were concerned about slowing down staff who do not have sufficient typing or computer skills. Some respondents reported that patients were becoming frustrated with wait times caused by the new record system. Practices also noted that a current lack of EMR

was going to be a challenge, especially in terms of developing a comprehensive care plan. Other practices with functioning EMRs lamented the lack of interoperability.

*“When we go to that new electronic medical record, I mean, that’s a whole other level of just total system overload.”*

*“I’m not a computer person, but I was less unhappy with this particular electronic medical record than I had been with any of the others I looked at and to find that I don’t think it’s feasible for me is like very depressing.”*

*“Implementing an EHR is not inexpensive; ...the loss in productivity...your loss of your access to the patients while you are going live because everybody is slower.”*

*“I know I need electronic medical records. We priced several since we came back... and, of course, the one I want is the one I can’t have.”*

Other identified external issues included the lack of value-based purchasing, lack of specialists in the area, changing practice locations during the transformation process, change of personnel, poor economy, staff cut due to lack of funds, new laws related to controlled

substances for specific patients, such as ADHD patients, and other laws that require additional, “redundant” forms to be completed.

*“It’s just such a disconnect between what we really want to be doing and what we need to do and kind of how the funding happens...I think as we’re struggling whether or not to do Medical Home I think that one payer, Blue Cross/Blue Shield, really for us tipped the scales. I think if we had seen no possibility in sight that anybody was going to recognize Medical Home we might have stalled for another year or two.”*

*“There needs to be funding; there needs to be shared costs, and I’m not sure that’s occurring. I mean, it’s not occurring. I shouldn’t say I’m not sure. There is none, and you’re not sharing cost in this system.”*

## **Community**

All respondents reported both negative and positive aspects of their connection to the health care system. Several said the system provided them with access to needed specialists, like having access to the patient’s information electronically, but others reported that poor

<sup>v</sup>Depending on the software vendor of choice, some practices use the term EMR while others use the term electronic health record (EHR).

communication with hospitals and specialists would impact their ability to function as a PCMH. Some practices identified a need for promoting the value of a PCMH to other health care facilities in the area and informing them of the transformation in progress so that they would be more motivated to send reports back in a timely manner. Many practices reported insurance issues when making referrals.

*“There aren’t too many specialists around here because there are like two barriers for a lot of our patients. Not only are they Medicaid but they are also children and most of the specialists around here are adult specialists so they don’t often take care of children.”*

*“And we’re spending so much more time just on getting this. It takes two people to call all of them and still it’s not being sent and you know, you have to follow up. It’s just, you know, like you have to hire a whole ... just to get these people to react and I think the approach will be different in that we will start going, physically going to these specialists and telling them what we want to do, what we want to accomplish and how we can, if we have to go pick them up once a week, that would, that would save us a lot more time than being on hold for 30, 40 minutes for one patient.”*

Interactions with school systems were mostly positive, but some practices acknowledged

that they did not have a communication system in place and hoped to change this in the future. Many practices mentioned their positive connection was directly to the school nurse.

*“I do it on the phone a lot with our kids with special needs. And you know what needs faxed to them so the patient can get the care they need at school...most of those kids go through seeing us or they have a nurse there that helps coordinate really well.”*

*“School nurses are usually right on top of it. If there is a question they’ll call me and vice versa.” ■*

# 5 Practice Staff Survey

## Overview

Although the core clinical team is directly involved in the project, the entire staff at the practice should be engaged if the PCMH is to be fully implemented. Impact of the PCMH on staff will vary. For example, a daily huddle might be used to help organize the operations and expectations of staff. This may impact staff in a minimal way. Alternatively, practices might move away from a physician-lead approach to a team-based approach whereby traditional physician tasks are delegated to other staff. This may constitute a major change in staff expectations and tasks. Given the importance of the staff in this project, Florida chose to include a staff survey in its evaluation plan. Staff will be surveyed each year of the project and their responses tracked over time using a personal identification number. In year one staff were given a hard copy survey when the Institute conducted the on-site core clinical team interview. All staff members, including clinicians, were invited to participate in the staff survey regardless of their position.

Staff surveys were administered during the month of October 2011. Two, four, and six weeks later one member of the core clinical team was contacted via e-mail and asked to remind the

staff to complete their surveys. Reminder flyers were also posted in the workplace. Three hundred and ninety-nine surveys were distributed and 170 returned (72% non-clinician staff, 28% clinician staff). Across practices, the average response rate was 50%, with a minimum response rate of 13% and a maximum response rate of 100%.

## Adaptive Reserve

Staff was asked the same adaptive reserve items from the TransforMED Practice Environment Checklist as the core clinical team.

### Analyses and Reporting

Analyses and reporting methods for the 23-item adaptive reserve scale have been described previously in this report (see page 19). Staff was asked to respond to statements about their adaptive reserve capabilities on a five-point Likert scale (1=strongly disagree to 5=strongly agree). Negatively worded questions were reverse-scored. Mean scores were calculated for the five factors and then transformed to a scale from 0 to 1, where 0 represents the lowest score and 1 the highest score.

Adaptive reserve scores are reported for the Florida demonstration group, and are further split into two groups:

(i) Staff who are clinicians, (ii) Staff who are non-clinicians.

### Key Findings

- The mean practice adaptive reserve score (0.63) reported by all staff members in the demonstration group is below the benchmark of 0.69 (**Figure 9**).
- Non-clinician staff report a significantly lower adaptive reserve score than clinician staff ( $P=0.015$ ).

## Practice Environment

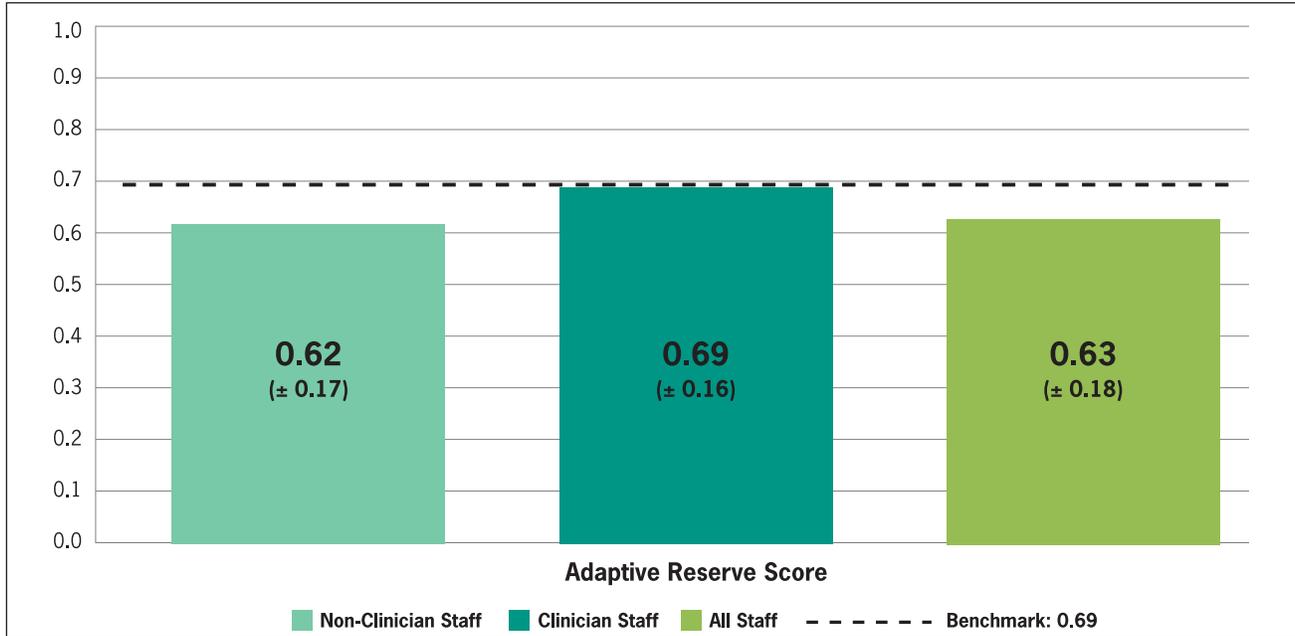
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### Analyses and Reporting

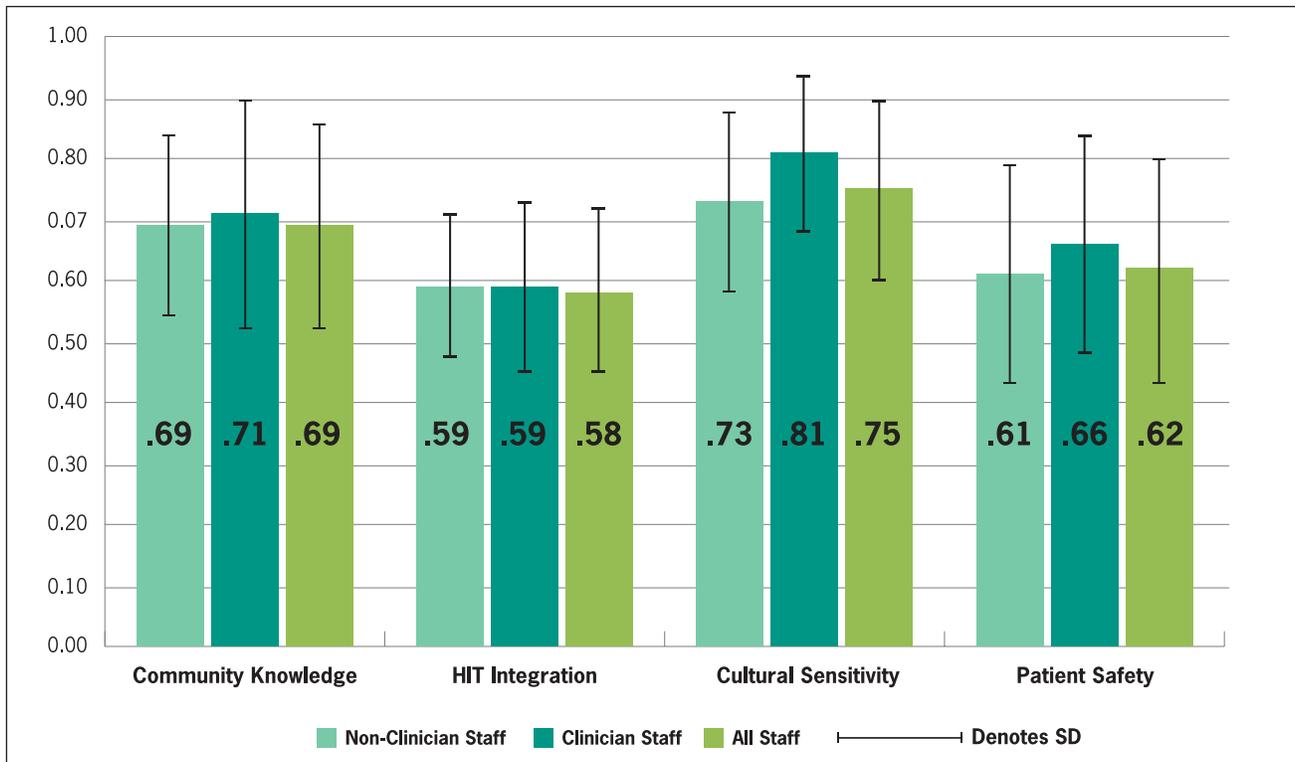
Analyses and reporting methods are identical to those described in the core clinical team section of this report (see page 20). Staff was asked to respond to 14 statements about their practice environment on a five-point Likert scale (1=strongly disagree to 5=strongly agree). Scores from 0 (lowest score) to 1 (highest score) were produced for the four practice environment factors: community knowledge, HIT integration, cultural sensitivity, and patient safety culture.

Practice environment scores are reported for the Florida

**Figure 9. Comparison of Non-Clinician Staff and Clinician Staff Adaptive Reserve Scores ( $\pm$  SD)**



**Figure 10. Staff Practice Environment Mean Scores ( $\pm$  SD)**



demonstration group, and are further split into two groups: (i) Staff who are clinicians, and (ii) Staff who are non-clinicians. There are no benchmarks for the practice environment scores.

### Key Findings

- Staff in the demonstration group rate their practices highest for the cultural sensitivity domain, followed by community knowledge, patient safety culture, and HIT integration. This order remains the same for both the clinician staff and the non-clinician staff (**Figure 10**).
- Clinician staff rate their practice's cultural sensitivity significantly higher than non-clinician staff ( $P=0.02$ ), but do not differ with respect to the other three domain scores.

## Job Satisfaction

Practice transformation to a PCMH is hard work. Transformation is not immediate. As such, burnout and decreased job satisfaction may affect the staff. This is especially critical in the area of primary care where, as compared to specialty care, compensation and work hours are often suboptimal<sup>32</sup>. A 2012 review noted that greater job satisfaction has been linked to improved patient care, greater adherence to treatment regimes,

and more quality improvement activities for physicians<sup>33</sup>. Therefore, monitoring these phenomena over time is an important evaluation component in Florida's project.

### Analyses and Reporting

Warr's 10-item job satisfaction scale was included on the staff surveys<sup>25</sup>. Items cover factors ranging from work hours to peers. All items are rated on a seven-point Likert scale (1=extreme dissatisfaction to 7=extreme satisfaction). Warr's scale was developed in 1979 and has been used in many studies to assess job satisfaction over a diverse group of industries. The last item is a global job satisfaction question that asks, "*Taking everything into consideration, how do you feel about your job?*". Global satisfaction scores range from 5.33 for blue collar males in a manufacturing industry<sup>25</sup> and from 5.0 to 5.6 for some physician studies<sup>34,35</sup>.

### Key Findings

- Of the 10 items, all staff rate remuneration the worst facet of their job and physical working conditions the best.
- Staff employed at the demonstration practices has a 10-item mean score of 5.41 ( $\pm 1.04$ ), indicating that they are moderately to very satisfied with their working

conditions (**Figure 11**). The mean global job satisfaction score is similarly high (5.54).

- For every aspect of job satisfaction, non-clinician staff rate their satisfaction lower than clinician staff (**Figure 12**). Clinician and non-clinician staff significantly differ with respect to most facets of work, except for their "hours of work," and "freedom to choose your own method of work."

Figure 11. Staff Job Satisfaction 10-Item Mean Scores ( $\pm$  SD), by Staff Type

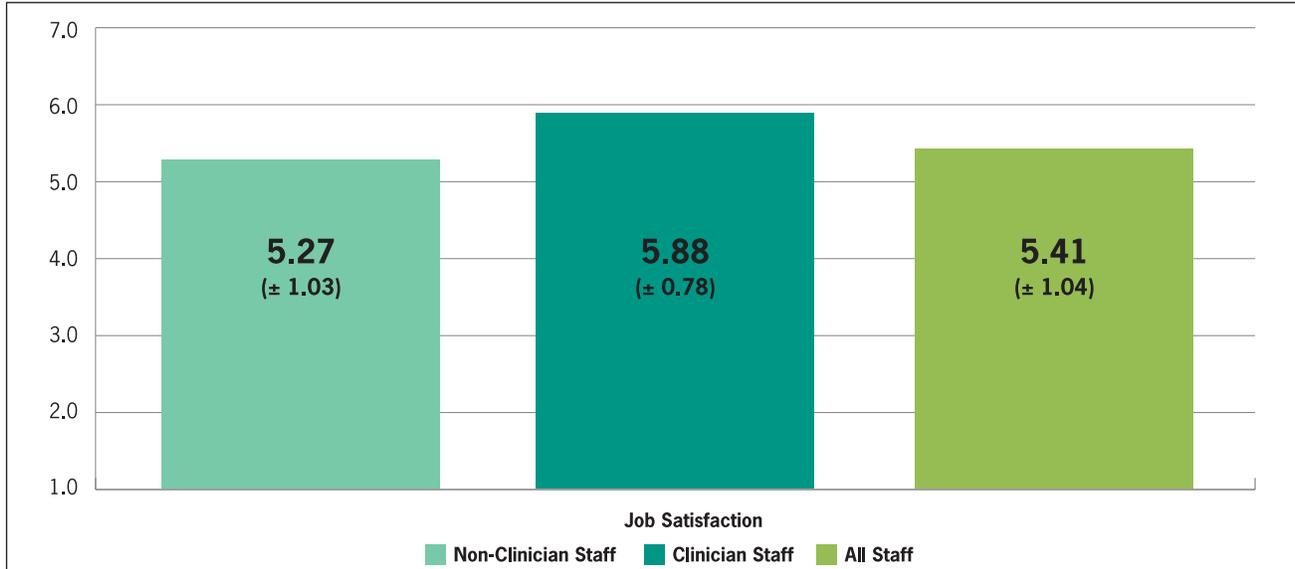
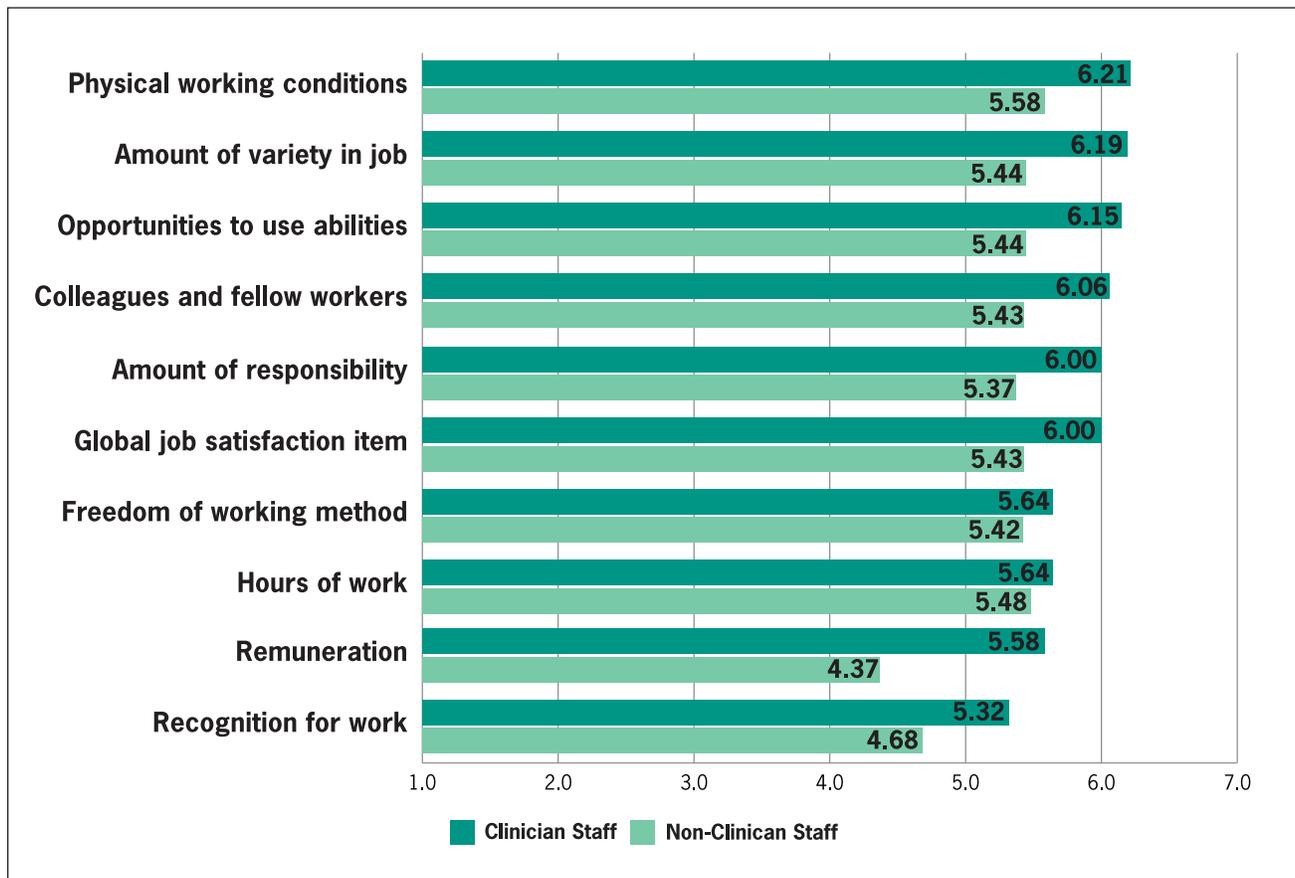


Figure 12. Comparison of Job Satisfaction Scores for Non-Clinician Staff and Clinician Staff



## Job Burnout

Job burnout was assessed on the staff survey by the Maslach Burnout Inventory — General Scale (MBI-GS). Workers experiencing burnout are characterized by exhaustion, cynicism, and are doubtful of their capacity to perform in their jobs. The MBI-GS is a 16-item instrument that produces scores for three subscales: exhaustion (five items), cynicism (five items), and professional efficacy (six items)<sup>24</sup>. The three-factor structure of job burnout has been validated in psychometric studies, and is thought to describe burnout better than a combined total score.

## Analyses and Reporting

Staff was asked to respond to 16 items on a six-point scale about how frequently they experience burnout symptoms (0=never to 6=daily). Negatively worded items were not reverse-scored per the authors’ instructions. Mean scores were calculated for each subscale on a scale of 0 to 6.

A high degree of burnout is reflected in high scores on the exhaustion and cynicism subscales and low scores on the professional efficacy subscale. Subscale scores can be interpreted using the guidelines in **Table 7**. These guidelines were established for a North American sample

of 3,727 participants, where the normative distribution was partitioned into thirds and scores were attributed as either “high,” “average,” or “low” burnout<sup>24</sup>.

## Key Findings

- Staff in the Florida practices have professional efficacy scores that indicate a low level of burnout, but have average levels of cynicism and exhaustion (**Table 8**).
- Although not shown here, there were no significant differences between clinician staff and non-clinician staff for any of the three job burnout domains ( $P > 0.05$ ). ■

**Table 7. Cut-off Thresholds for the MBI-GS Subscales**

MBI-GS SUBSCALE	LOW BURNOUT	AVERAGE BURNOUT	HIGH BURNOUT
Exhaustion	0 - 2.00	2.01 - 3.19	3.20 - 6.00
Cynicism	0 - 1.00	1.01 - 2.19	2.20 - 6.00
Professional Efficacy	6.00 - 5.00	4.99 - 4.01	4.00 - 0.00

**Table 8. Staff Job Burnout**

SUBSCALE	STAFF MEAN (± SD)	BURNOUT RATING
Exhaustion	2.31 (± 1.49)	Average Burnout
Cynicism	1.29 (± 1.30)	Average Burnout
Professional Efficacy	5.03 (± 0.91)	Low Burnout

# 6 Parent Survey

## Overview

The final section of the report describes the health care experiences of parents whose children are enrolled in Medicaid or CHIP and (i) receive care at a Florida demonstration practice, or (ii) are in the control group. Two standardized survey instruments were used to assess parental perceptions of medical homeness: the Consumer Assessment of Healthcare Providers and Systems — PCMH (CAHPS-PCMH) and the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN). Sternberg et al.'s 2011 review of quality measures endorsed the CAHPS survey tool as the most feasible for inclusion in the CHIPRA core measurement set because it has “*known reliability and performance characteristics, and most closely reflects the aims of the medical home*”<sup>36</sup>.

## Data Sources

Data sources for the demonstration and control groups are described below.

### Demonstration Group

Practices supplied the Medicaid Provider Numbers (MPNs) and

National Provider Identifiers (NPIs) for all providers employed at their practices. MPNs and NPIs were matched to claims and encounter datasets supplied by the Florida AHCA and the Florida Healthy Kids Corporation<sup>vi</sup>. Children who saw a listed provider during the time period July 1, 2010 to June 30, 2011 were eligible to participate. If siblings attended the same practice, one child per household was randomly selected. Next, the sample was stratified depending on whether children were enrolled in CMSN, the State's Title V Program for CSHCN<sup>vii</sup>. The goal was to target 50% CSHCN, but not all practices had sufficient sample sizes.

A random sample of parents whose children met the criteria were sent a letter inviting them to participate in a telephone survey. Families were contacted a maximum of 25 times and searches were conducted to update outdated contact information. Telephone surveys were conducted with families from 10 AM to 9 PM, seven days per week from October to December 2011. Surveys were conducted in both English and Spanish. The respondent was chosen by asking to speak to

the individual most familiar with the targeted child's health in the household. All parents were asked to confirm that their child had attended a Florida demonstration practice in the last 12 months. Parents completing the survey received a \$15 gift card to Starbucks or Walmart.

### Control Group

Claims and administrative data for Florida's publicly-insured pediatric population were used to obtain a matched control group based on the following child characteristics: age, race/ethnicity, gender, plan (Medicaid, Medikids, Title XXI), and SHCN or not. Nearest-neighbor propensity-score matching SAS<sup>®</sup> code was used to generate the matched control group<sup>37</sup>, stratified by whether the child had a SHCN or not. Multiple control children were matched for each child in the demonstration group and assigned as match 1, match 2, match 3, etc. based on their propensity-score (the higher the propensity score, the better the match). Recruitment was staggered to allow recruitment of the best-matched sample first, before release of second-tier matches.

<sup>vi</sup> Data supplied by AHCA include claims and encounters for children enrolled in Primary Care Case Management (Medipass), Fee-For-Service, Health Plans (Health Maintenance Organizations, Provider Service Networks), Title XIX CMSN, and Medikids.

<sup>vii</sup> Claims and encounter data are not available for children enrolled in CMSN Title XXI.

Telephone surveys were conducted with families from January to May 2012 using the same approach and incentives as for the demonstration group. Parents were asked to respond to the survey questions about the primary care provider their children saw most often in the last 12 months. A primary care provider was defined as the provider their child would see if he or she needed a checkup (e.g., for preventive care, immunizations, or well child visits) or got sick or hurt.

## Response Rates

Florida’s goal was to obtain 50 completed surveys for each demonstration practice, or 1,000 overall. In total, 990 families participated in the parent survey for the demonstration group<sup>viii</sup>. Using American Association for Public Opinion Research guidelines<sup>38</sup>, the response rate for the demonstration group is 47% and the cooperation rate is 71%. Similarly, 990 families from the control group

participated in the parent survey, for a response rate of 50% and a cooperation rate of 70%<sup>ix</sup>.

Statistical tests reveal that the control and demonstration groups do not differ for any of the five child characteristics of interest ( $P > 0.05$ ) (**Table 9**). Children’s mean ages for the demonstration and control groups are 7.90 years ( $\pm 0.18$  years) and 7.61 years ( $\pm 0.16$  years), respectively.

**Table 9. Representativeness of the Matched Control Group**

	DEMONSTRATION GROUP		CONTROL GROUP		
	N	%	N	%	
<b>CHILD’S GENDER</b>					
Male	531	53.6%	550	55.8%	NS
Female	459	46.4%	436	44.2%	
<b>CHILD’S RACE/ETHNICITY</b>					
Black non-Hispanic	212	21.4%	188	19.0%	NS
White non-Hispanic	232	23.4%	251	25.4%	
Hispanic	201	20.3%	202	20.4%	
Other or Unknown	345	34.9%	349	35.3%	
<b>CHILD’S INSURANCE</b>					
Medicaid	799	80.7%	798	80.6%	NS
CHIP	191	19.2%	192	19.4%	
<b>% SPECIAL HEALTH CARE NEEDS</b>					
	655	66.2%	646	65.3%	NS

NS=Not Significant

<sup>viii</sup> Forty surveys were collected in one practice with a small sample size of publicly-insured children.

<sup>ix</sup> For both the demonstration and control groups the response rate was higher for families of CSHCN than for families of children without SHCN.

## CAHPS

The CAHPS-PCMH is an expanded version of the existing Clinician and Group CAHPS (CG-CAHPS) Survey<sup>26</sup>. The CG-CAHPS was developed by the Agency for Healthcare Research and Quality (AHRQ) to assess respondents' experiences with health care providers and staff in doctor's offices<sup>39</sup>. Topic areas covered by the CG-CAHPS survey include doctor communication, anticipatory guidance, accessibility of services, and customer service by office staff. The CAHPS-PCMH expands the survey to include other topic areas relevant to the PCMH. The Institute was granted permission to use the pilot beta-version of the CAHPS-PCMH in 2010<sup>x</sup>.

### Analyses and Reporting

CAHPS-PCMH survey results may be analyzed at the individual item level or by composite. Composites represent the combination of two or more closely related individual survey items. There are six CAHPS-PCMH composites:

- Getting Timely Appointments, Care, and Information
- How Well Providers Communicate With

Patients (Doctor-Patient Communication)

- Helpful, Courteous, and Respectful Office Staff (Courteous and Helpful Office Staff)
- Provider's Attention to Your Child's Growth and Development (Child's Growth and Development)
- Provider's Advice on Keeping Your Child Safe and Healthy (Child's Health and Safety)
- Provider's Support You in Taking Care of Your Own Health.

The first five CAHPS composites are derived from the CG-CAHPS, with the last composite, 'Provider's Support You in Taking Care of Your Own Health', unique to the CAHPS-PCMH dataset. The first three CAHPS composites ask parents to respond how often (*always, usually, sometimes, never*) a given health care experience occurs (**Table 10**). The last three CAHPS composites ask parents to respond whether or not (*yes, no*) they receive provider support and anticipatory guidance (**Table 11**). CAHPS composites are reported using a 100-point global proportion, which represents the mean proportion of respondents

selecting a particular response (e.g., *always, usually, sometimes/never* or *yes, no*) across items of the composite.

The CAHPS-PCMH survey also includes seven single-item PCMH questions that are scored individually<sup>26</sup>; however, results are grouped within three theme areas:

- Access to Care
- Attention to Care From Other Providers
- Information About Care and Appointments

Last, the CAHPS-PCMH survey includes an overall provider rating on a scale of 0 to 10. The overall provider rating is collapsed into three categories: (i) response of 9 or 10, (ii) response of 7 or 8, and (iii) response of 0 to 6, which are reported on a 100 percentage point scale.

The 2010 national averages from the AHRQ CAHPS Benchmarking Database for the CG-CAHPS Child Primary Care Survey composites (percentage selecting Usually + Always or Yes) are provided as a benchmark<sup>40</sup>. CAHPS-PCMH benchmark data for publicly-insured children is not currently available.

<sup>x</sup> Question wording changed slightly between the CAHPS beta-version and the final version of the CAHPS-PCMH.

## CAHPS Core Composites

### Overview

Parents are asked to respond how often (*always, usually, sometimes, never*) a given health care experience occurs (Table 10).

### Key Findings

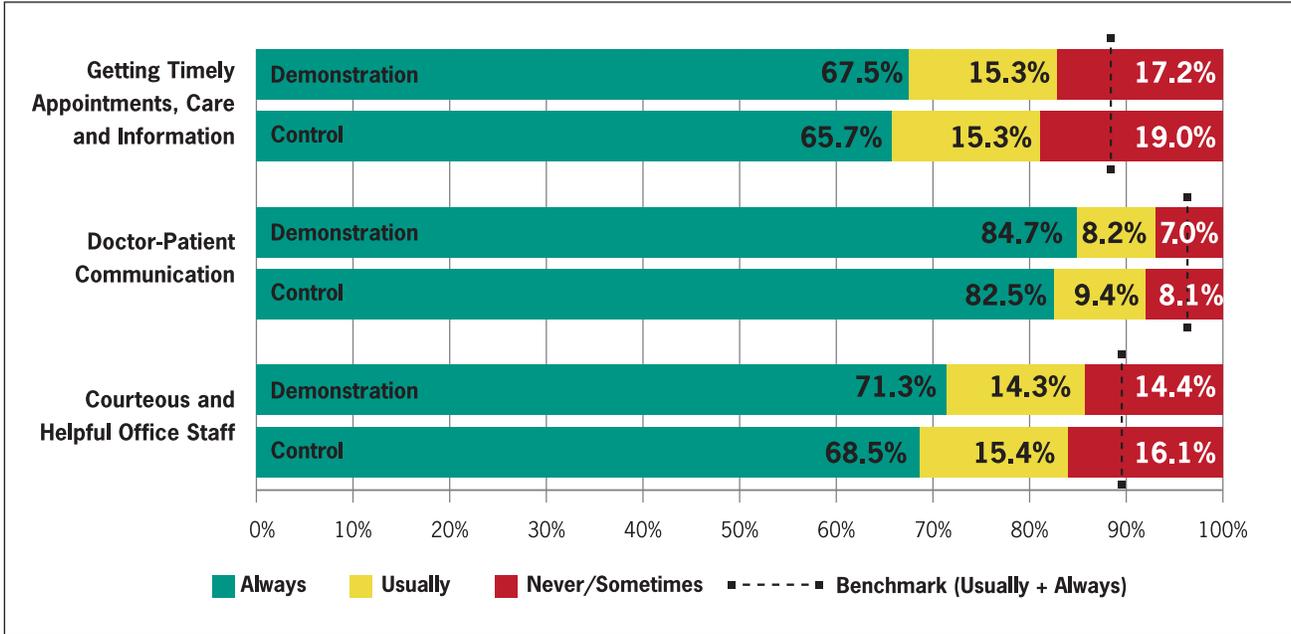
- For all three CAHPS composites, the global proportions for the ‘usually + always’ category are above 80% for both the control and demonstration groups; yet fall below the 2010 benchmarks (Figure 13).
- Around eight in ten parents report that they usually or always can get timely care, compared with the benchmark of 88.5%.
- Parents report that the best aspect of care is the doctor-patient communication. Still, both the demonstration and control groups fall short of the benchmark by 3.4 and 4.5 percentage points, respectively.
- Global proportions for the ‘usually + always’ category are comparable between the demonstration and control groups.

**Table 10. CAHPS Composite Measures**

Getting Timely Appointments, Care and Information	<p><i>In the last 12 months, how often did the following occur:</i></p> <ol style="list-style-type: none"> <li>1. When you phoned this provider’s office to get an appointment for care your child needed right away, how often did you get an appointment as soon as you thought your child needed?</li> <li>2. When you made an appointment for a check-up or routine care for your child with this provider, how often did you get an appointment as soon as you thought your child needed?</li> <li>3. When you phoned this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?</li> <li>4. When you phoned this provider’s office after regular office hours, how often did you get an answer to your medical question as soon as you needed?</li> <li>5. Wait time includes time spent in the waiting room and exam room. How often did your child see this provider within 15 minutes of his or her appointment time?</li> </ol>
Doctor-Patient Communication	<p><i>In the last 12 months, how often did this provider:</i></p> <ol style="list-style-type: none"> <li>1. Explain things about your child’s health in a way that was easy to understand?</li> <li>2. Listen carefully to you?</li> <li>3. Give you easy to understand instructions about taking care of these health questions or concerns?</li> <li>4. Seem to know the important information about your child’s medical history?</li> <li>5. Show respect for what you had to say?</li> <li>6. Spend enough time with your child?</li> </ol>
Courteous and Helpful Office Staff	<p><i>In the last 12 months, how often did clerks and receptionists at this provider’s office:</i></p> <ol style="list-style-type: none"> <li>1. Be as helpful as you thought they should be?</li> <li>2. Treat you with courtesy and respect?</li> </ol>

Note: All questions are measured with a response of “Always”, “Usually”, “Sometimes”, or “Never”

Figure 13. CAHPS Composites



## CAHPS Core Composites (Yes/No)

### Overview

Three CAHPS composites relate to provider support and anticipatory guidance as detailed in **Table 11**. Parents are asked to respond yes or no to a series of questions. Benchmark data is not currently available.

### Key Findings

- Less than two-thirds of parents in either the demonstration or control groups report that providers offer anticipatory

guidance regarding their children’s health and safety or their growth and development (**Figure 14**).

- Less than one-half of parents in either the demonstration or control groups report that providers support them in taking care of their children’s health.
- Parents from the demonstration group report that their children’s providers engage in anticipatory guidance and support more than parents in the control group.

## Single-Item Measures: Attention to Care from Other Providers

### Overview

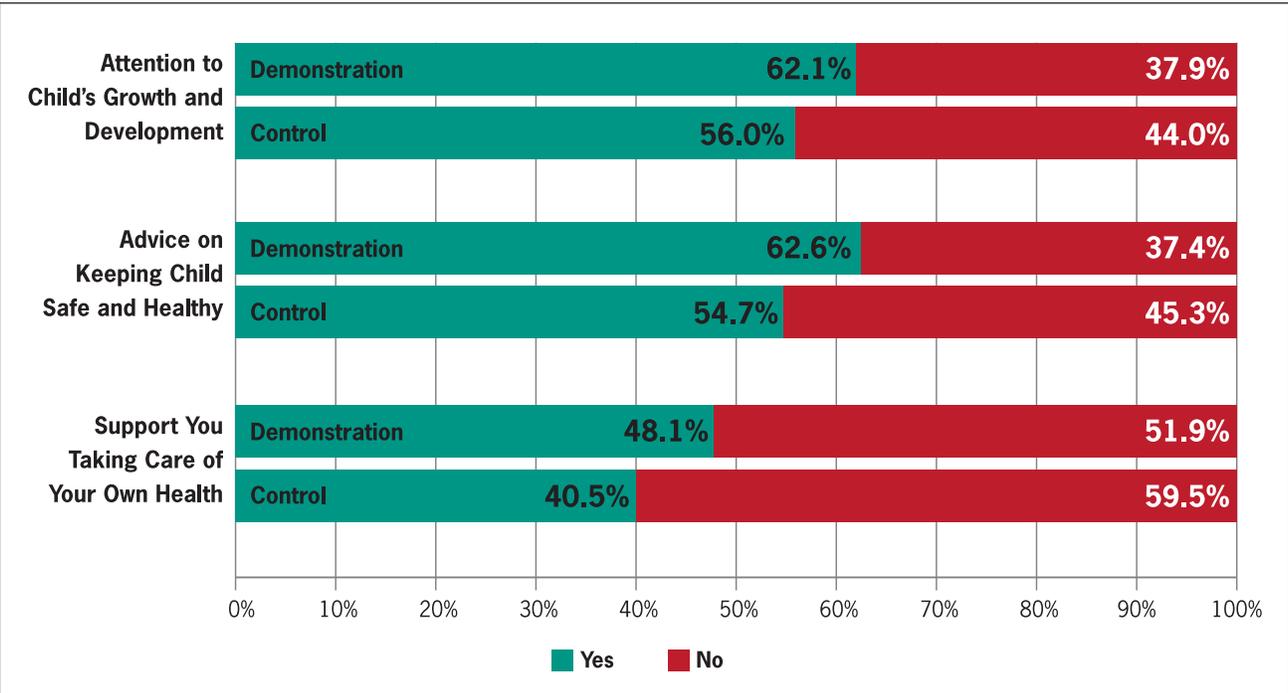
Three questions are asked that relate to provider’s attention to care from other providers.

- In the last 12 months, how often did this provider seem informed and up-to-date about the care your child got from specialists? (*Always, Usually, Sometimes, Never*)
- In the last 12 months, when this provider ordered a blood test, x-ray or other test for

**Table 11. CAHPS Composites Measures Yes/No**

Child's Growth and Development	<p><i>In the last 12 months, did you and anyone in this provider's office talk about:</i></p> <ol style="list-style-type: none"> <li>1. Your child's learning ability?</li> <li>2. The kinds of behaviors that are normal for your child at this age?</li> <li>3. How your child's body is growing?</li> <li>4. Your child's moods and emotions?</li> <li>5. How much time your child spends on a computer and in front of a TV?</li> <li>6. How your child gets along with others?</li> </ol>
Child's Health and Safety	<p><i>In the last 12 months, did you and anyone in this provider's office:</i></p> <ol style="list-style-type: none"> <li>1. Talk about things you can do to keep your child from getting injured?</li> <li>2. Give you information about how to keep your child from getting injured?</li> <li>3. Talk about how much or what kind of food your child eats?</li> <li>4. Talk about how much or what kind of exercise your child gets?</li> <li>5. Talk about whether there are any problems in your household that might affect your child?</li> </ol>
Provider's Support in Taking Care of Your Own Health	<p><i>In the last 12 months, did anyone in this provider's office:</i></p> <ol style="list-style-type: none"> <li>1. Work with you to set specific goals for managing your child's health?</li> <li>2. Talk about the things that make it hard for you to manage your child's health?</li> </ol>

**Figure 14. CAHPS Composites Yes/No**



your child, how often did someone from this provider's office follow up to give you those results? (*Always, Usually, Sometimes, Never*)

- In the last 12 months, how often did you and anyone in this provider's office talk about all the prescription medicines your child was taking? (*Always, Usually, Sometimes, Never*)

### Key Findings

- When asked about their providers' attention to care from other providers, more than three-quarters of parents in the demonstration and control groups report usually or always receiving the best care (**Figure 15**).

- Parents' perceptions are that providers pay the most attention to the care that children receive from specialists. In both the demonstration and control groups, only one in six parents report that their children's providers are only sometimes or never up-to-date about their children's specialty care.

- Parents' perceptions are that providers pay the least attention to becoming fully informed about all the prescription medicines that children take. One in four parents report that their children's providers never, or only sometimes, discuss all the prescription medicines their children are taking.

- The demonstration and control groups significantly differ with regards to follow-up of test results ( $P=0.029$ ).

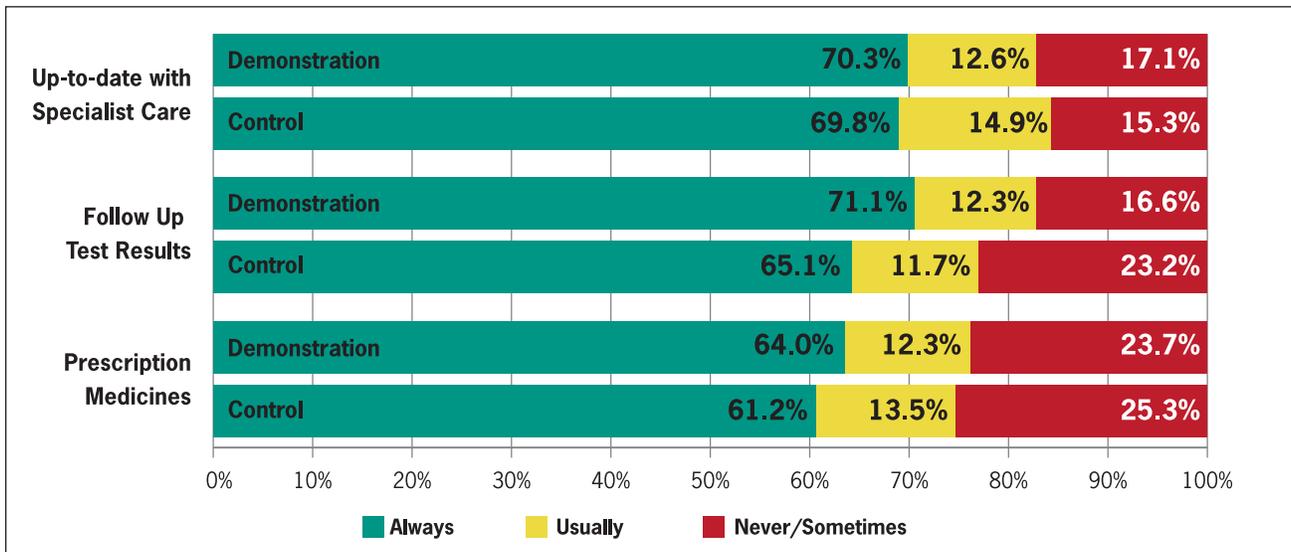
## Single-Item Measures: Information About Care and Appointments

### Overview

Two questions are asked that relate to information about care and appointments.

- Did this provider's office give you information about what to do if your child needed care during evenings, weekends or holidays? (*Yes, No*)
- Some offices send patients reminders between visits about tests, treatment or appointments. In the last

**Figure 15. Attention to Care From Other Providers**



12 months, did you get any reminders about your child's care from this provider's office between visits? (Yes, No)

### Key Findings

- Eighty-eight percent of parents in both the demonstration and control groups report that they are given information about after-hours care (Figure 16).
- Sixty-eight percent of demonstration group parents report that they receive reminders between visits. Comparatively, 63% of the control group receive reminders, which is significantly lower than the demonstration group ( $P=0.013$ ).

## Single-Item Measures: Access to Care

### Overview

Two questions are asked that relate to access to care.

- In the last 12 months, how often were you able to get the care your child needed from this provider's office during evenings, weekends or holidays? (*Always, Usually, Sometimes, Never*)
- In the last 12 months, how many days did you usually have to wait for an appointment when your child needed care right away? (*Same Day, 1 Day, 2 to 3 Days, 4 to 7 Days, More than 7 Days*)

### Key Findings

- Sixty-eight percent of demonstration group parents report that they usually or always get needed care for their children on evenings, weekends, or holidays, compared with a significantly lower 56.3% of parents in the control group ( $P < 0.001$ ) (Table 12).
- Roughly nine in ten parents in both the demonstration and control groups report that they are able to get same-day appointments or appointments within one day when their children need care right away. Parents' abilities to get same day appointments significantly differ between the demonstration and control groups ( $P=0.02$ ).

Figure 16. Information About Care and Appointments

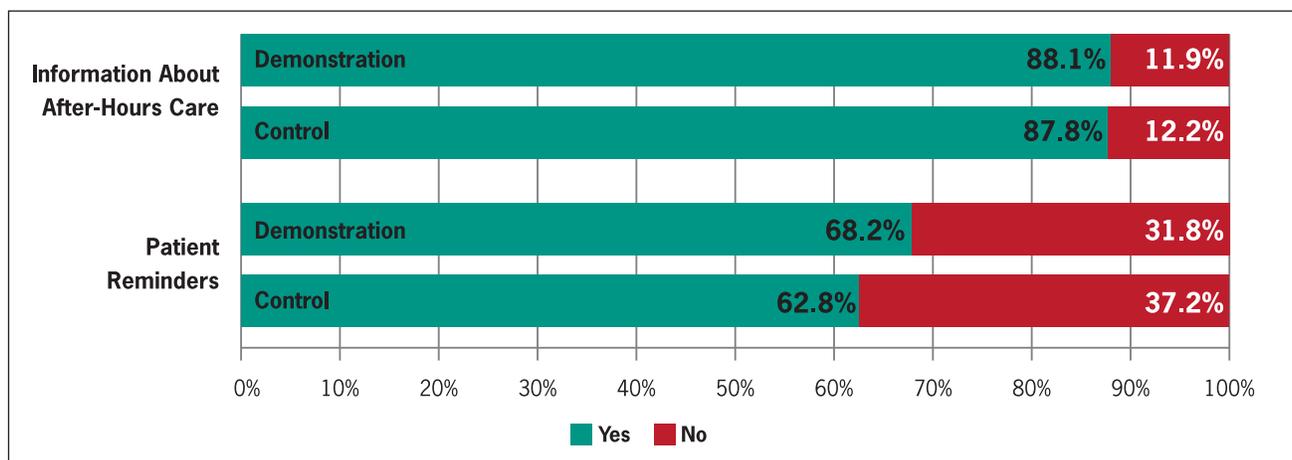


Table 12. Access to Care		
ACCESS TO CARE	DEMONSTRATION GROUP	CONTROL GROUP
<b>After-Hours Care</b>		
Always	57.0%	42.5%
Usually	11.2%	13.8%
Sometimes/Never	31.9%	43.7%
<b>Appointment Wait Time</b>		
Same Day	71.5%	65.7%
1 Day	17.3%	20.5%
2 to 3 Days	7.6%	9.0%
4 to 7 Days	1.2%	2.1%
More Than 7 Days	2.3%	2.6%

## Provider Ratings

### Overview

Parents are asked to provide an overall rating of their child’s provider on a scale of zero to 10.

- Using any number from 0 to 10, where 0 is the worst provider possible and 10 is

the best provider possible, what number would you use to rate this provider? (0-10)

### Key Findings

- Roughly seven in ten parents in the control and demonstration groups rate their children’s providers a “9” or “10” (Table 13). There are no significant differences

in provider ratings between the demonstration and control groups ( $P=0.31$ ).

- At baseline, both the control and demonstration groups have provider ratings below the national benchmark.

Table 13. Overall Provider Rating			
PROVIDER RATING	DEMONSTRATION GROUP	CONTROL GROUP	BENCHMARK
6 or under	5.8%	6.9%	3.2%
7 or 8	21.4%	23.2%	19.0%
9 or 10	72.9%	69.9%	77.9%

## NS-CSHCN

The NS-CSHCN provides national and state level data on the prevalence of special health care needs and their impact on children and families<sup>41</sup>. This nationally representative survey of CSHCN ages 0 to 17 years has been conducted every four years since 2001. The medical home module from the 2005/2006 NS-CSHCN was used in the parent telephone survey for the Florida Pediatric Medical Home Demonstration Project. This module addresses whether or not practices offer comprehensive care, coordinated care, family-centered care, and whether or not there is an established relationship with a specific provider.

### Analyses and Reporting

A standard NS-CSHCN SAS<sup>®</sup> scoring program was used to calculate the five medical home sub-component measures and the overall medical home composite score<sup>41</sup>. Children must meet the threshold criteria on all five sub-components, or legitimately have skipped one or more sub-components, to qualify as having a medical home. In other words, the overall medical home composite is the “percent of children who have a primary care provider AND usual sources for both

sick and preventive care AND consistently get family-centered care from their doctors and other health care providers AND, if needed, receive effective care coordination AND, if needed, have no problems getting referrals<sup>41</sup>.” The “if needed” statements denote where some children may legitimately have skipped a sub-component because the question did not pertain to them.

Florida data from the 2005/2006 NS-CSHCN is provided as a benchmark, where available<sup>27</sup>.

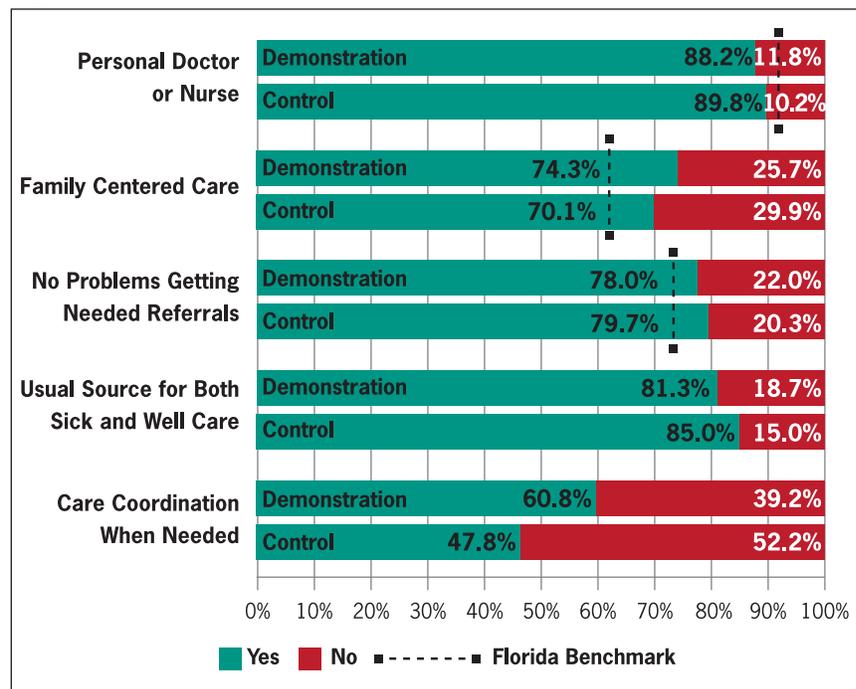
## NS-CSHCN Medical Home Sub-Components

### Overview

The NS-CSHCN includes five medical home sub-component measures as follows.

- Child has at least one personal doctor or nurse (1 item)
- Family centered care (7 items)
- No problems getting needed referrals (2 items)
- Usual sources for both sick and well care (5 items)
- Care coordination when needed (6 items)

Figure 17. NS-CSHCN Sub-Components



### Key Findings

- Both the demonstration and control groups exceed the Florida benchmarks of 61.7% for the sub-component “Family Centered Care” and 73.1% for the sub-component “No Problems Getting Needed Referrals” (Figure 17).
- The demonstration and control groups fall below the Florida benchmark of 91.6% for the sub-component “At Least One Personal Doctor or Nurse”.
- Over 80% of parents in the demonstration and control groups report a usual source of care for both sick care and well care.

- Parents in both the demonstration and control groups rate the sub-component “Getting Care Coordination When Needed” as their lowest aspect of care.

## NS-CSHCN Medical Home Composite

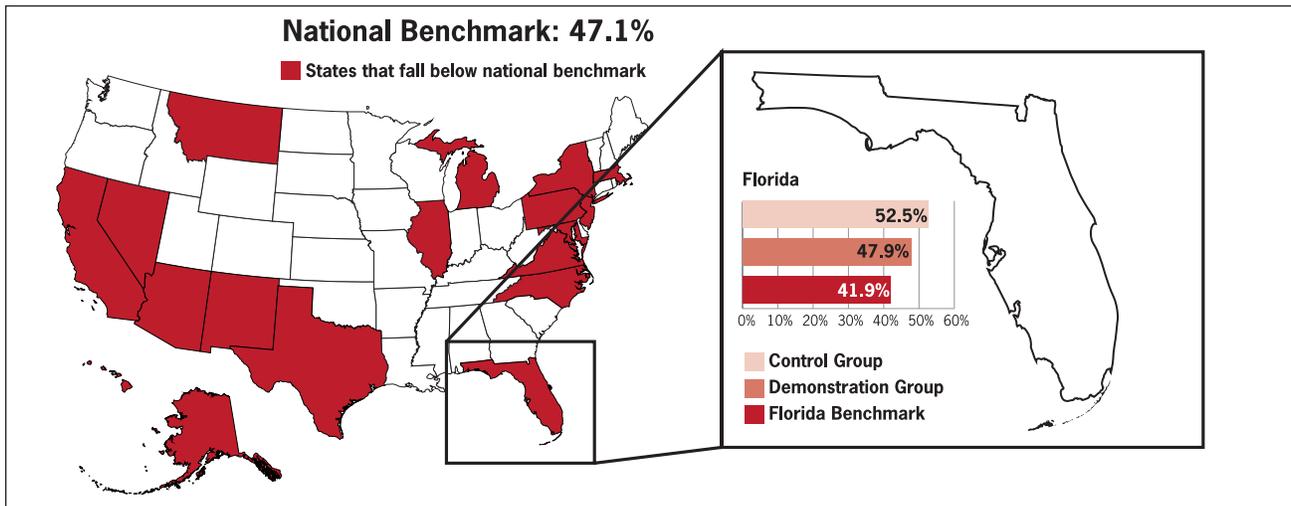
### Overview

Children qualify as having a medical home if they receive ongoing, coordinated, and comprehensive care, as determined by the five sub-component measures above. Compared with the other states, Florida ranks 45th out of 51 states for the medical home composite measure (Figure 18)<sup>42</sup>.

### Key Findings

- At baseline, parents whose children are treated in Florida’s demonstration practices report that 47.9% of children meet the overall criteria for receiving ongoing, coordinated, and comprehensive care within a medical home (Figure 18).
- The medical home composite rating for the demonstration and control groups surpasses the Florida benchmark of 41.9%. ■

Figure 18. NS-CSHCN: Child Receives Ongoing Comprehensive Care in a Medical Home



# 7 Conclusion

## Conclusion

CHIPRA Quality Demonstration Grants provide states with several opportunities to track and improve the quality of children's health care in the U.S. Florida, along with 17 other states, is participating in the grant. There are five categories of the grant, and Category C is focused on evaluating provider-based models to improve health care delivery. Florida chose to implement the PCMH model and successfully recruited 20 demonstration practices to join the Florida Pediatric Medical Home Demonstration Project in 2011. Other project milestones in 2011 were to convene the first Learning Session, submission of monthly QI data to the AAP, and completion of all baseline evaluation activities.

## Observations

- At baseline, the average self-reported "medical homeness" for the practices participating in Florida's project is below a national pediatric study. Yet, this is not particularly surprising since Florida has lagged behind other states in implementing the PCMH model. As a result this project represents a significant opportunity for participating practices and stakeholders

around the state. Practices are excited to participate and report that they are learning valuable information from the AAP and each other.

- Florida's decision to include staff in the evaluation is critical. Staff involvement in the project as well as alignment with the core clinical team's perspectives were recurring themes. For example, core clinical teams were quick to point out in their interviews how they operate as a team. When asked how they approach tasks and challenges, the majority report they use a team approach. Comparison of the staff and core clinical team surveys allowed core clinical teams to learn about the congruence of adaptive reserve. This feedback will be important as the project continues so as to minimize change fatigue and keep staff focused on the project's goal of becoming a PCMH.
- Quantitative data is not enough. Experiences, stories, and reflection can augment quantitative data and provide insight into the practice's unique circumstances. Interviews with the core clinical teams revealed information helpful to guide the project as well

as understanding what is important to the core clinical teams. For example, many practices found the project overwhelming at first. Florida responded and chose to extend the AAP's facilitation another six months. Although important, funding did not affect the practices' decision to participate as they are not receiving enhanced payment in the project. It is important to note that several practices indicated they will seek NCQA recognition.

- Two PCMH measures were used in the parent telephone surveys. Florida was fortunate to be able to use the beta version of the new CAHPS-PCMH tool. This tool includes core components as well as new items that help assess anticipatory guidance, and provider support. Parent responses can be used to help guide the practices on how to incorporate changes that will be aimed at targeted areas. Results from the CAHPS-PCMH can be compared to the NS-CSHCN.
- The demonstration group surpassed the 2005/2006 NS-CSHCN Florida benchmark of 41.9%. Although several areas for improvement were identified through the parent surveys,

the state has not embarked on a PCMH survey before. This information will not only be important for the overall project, but for Florida health agencies as they understand if, and how, PCMH can be used for the children they serve.

**Next Steps for the Florida Pediatric Medical Home Demonstration Project**

One of the key findings from the interviews with the core clinical teams was that they felt overwhelmed by the tasks at hand and requested more facilitated time to implement their desired changes. In

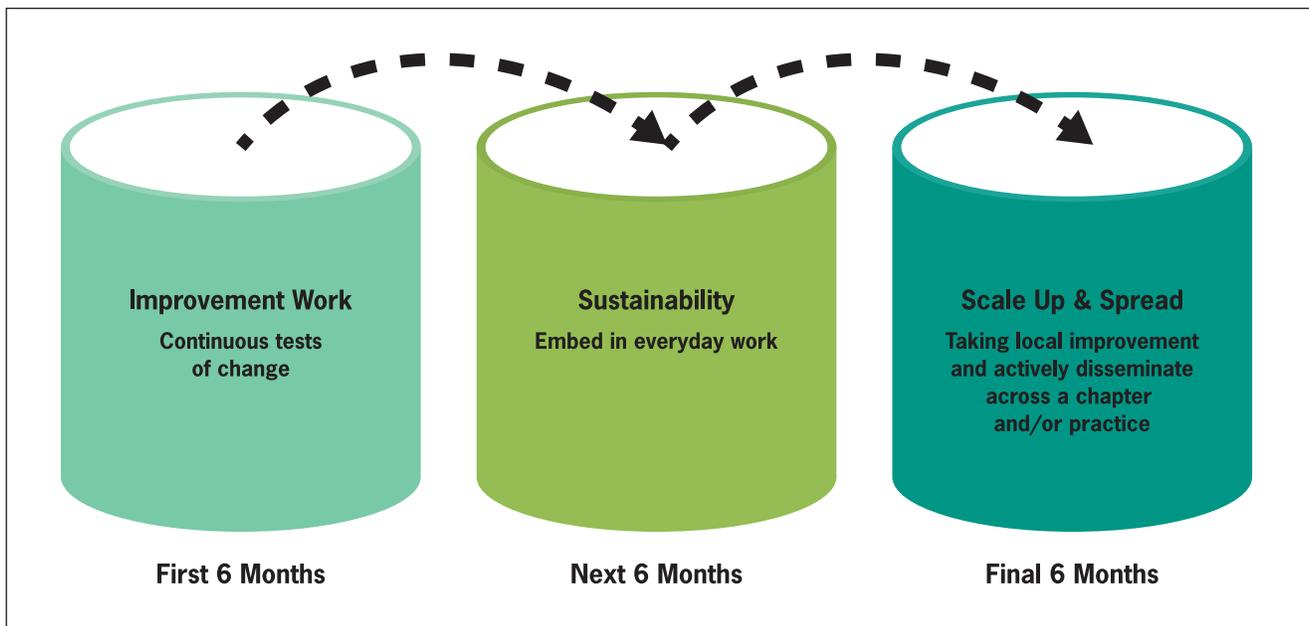
response, the AAP has extended its role in the project to an 18-month timeframe. The AAP will be working with the Chapter Quality Network, a program of the CAQI, in phase two of the project. There will be additional QI cycles following a second and third Learning Session. In the third Learning Session practices will focus on sustainability and spreading best practices to other practices within the Florida Chapter of the AAP (Figure 19).

**Next Steps for the Evaluation**

This report describes baseline results from the evaluation. The next phase of the evaluation will involve:

- Conducting a stakeholder survey with organizations that are in frequent contact with the demonstration practices.
- Reporting the CHIPRA core measure set for the demonstration and control groups over time. Due to financial constraints only measures derived from administrative data will be calculated.
- Obtaining and incorporating additional practice level data that describe the characteristics of the practices. This data will be tracked every year to note changes in caseloads,

Figure 19. Phase 2 of the Florida Pediatric Medical Home Demonstration Project



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case-mix, number of physicians practicing, or other attributes that might significantly impact the way in which the PCMH model is implemented and evaluated.

- Analyze data longitudinally. These analyses will take into account practice and patient-level attrition, adjust for any differences in baseline scores between the demonstration and control groups, and other statistical modeling considerations.
- Determine the feasibility of incorporating an analysis of cost and utilization data.
- Understand how exogenous factors, such as Medicaid and CHIP policies and economic conditions, affect the practices and the evaluation.

Despite the challenges faced in the first year of the project, Florida has been successful in launching the Florida Pediatric Medical Home Demonstration Project. The first of its kind in the state, results from this project will be important to policymakers, families, and providers as Florida moves towards spreading the PCMH model to all children. ■

# 8 Abbreviations

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<b>AAFP</b>	– American Academy of Family Physicians
<b>AAP</b>	– American Academy of Pediatrics
<b>AHCA</b>	– Agency for Health Care Administration
<b>AHRQ</b>	– Agency for Healthcare Research and Quality
<b>CAHPS</b>	– Consumer Assessment of Healthcare Providers and Systems
<b>CAQI</b>	– Chapter Alliance for Quality Improvement
<b>CHIP</b>	– Children’s Health Insurance Program
<b>CHIPRA</b>	– Children’s Health Insurance Program Reauthorization Act
<b>CMS</b>	– Centers for Medicare and Medicaid Services
<b>CMSN</b>	– Children’s Medical Service Network
<b>CSHCN</b>	– Children with Special Health Care Needs
<b>DOH</b>	– Florida Department of Health
<b>EMR</b>	– Electronic Medical Record
<b>EQIPP</b>	– Education in Quality Improvement for Pediatric Practice
<b>FHKC</b>	– Florida Healthy Kids Corporation
<b>HIT</b>	– Health Information Technology
<b>HMA</b>	– Health Management Associates
<b>Institute</b>	– Institute for Child Health Policy
<b>IRB</b>	– Institutional Review Board
<b>MBI-GS</b>	– Maslach Burnout Inventory - General Scale
<b>MHI</b>	– Medical Home Index
<b>MPN</b>	– Medical Provider Number
<b>NCQA</b>	– National Committee for Quality Assurance
<b>NPI</b>	– National Provider Identifier
<b>NS-CSHCN</b>	– National Survey of Children with Special Health Care Needs
<b>PCMH</b>	– Patient-Centered Medical Home
<b>PDSA</b>	– Plan, Do, Study, Act
<b>QI</b>	– Quality Improvement
<b>QuIIN</b>	– Quality Improvement Innovation Network
<b>SAS</b>	– Statistical Analysis System
<b>SD</b>	– Standard Deviation
<b>SHCN</b>	– Special Health Care Needs

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# 9 Appendix

## Quality Demonstration Grantee Evaluation Plans

Twelve of the 18 CHIPRA Quality Demonstration Grantee states chose to implement the PCMH model as their provider-based model of care for Category C. **Table 14** shows how Florida’s project and evaluation plan compares to the initial evaluation plans of the other Category C participating

states as of February 2011. Although some grantee states have subsequently changed their initial evaluation plans, **Table 14** illustrates that only four states initially proposed collecting information on 20 or more practices and five states intended to evaluate a comparison group of practices. A review recently commented that both the sample size and the inclusion of a comparison

group were both critical elements when designing a rigorous evaluation of the PCMH<sup>10</sup>. The selection of survey tools to evaluate the “medical homeness” of each practice, however, is not standardized. Across the 12 states, a mixture of instruments was selected to measure medical home transformation at the practice level. Some states chose to use multiple tools. ■

**Table 14. Evaluation Plan for Category C States, February 2011**

	NUMBER INTERVENTION PRACTICES	NUMBER COMPARISON PRACTICES	MEDICAL HOME TOOL
Florida	20	20 *	MHI
Illinois	20-60	N/A	NCQA
Maine	4	8-9 *	NCQA & “practice culture” instrument
Vermont	Up to 105	TBD *	NCQA
Massachusetts	22	TBD *	MHI & portion of MHIQ
North Carolina	12	12	MHI
Oregon	~15	N/A	N/A
Alaska	1-3	N/A	N/A
West Virginia	7-8	TBD	NCQA
South Carolina	18	~18	NCQA
Utah	~12	~12 *	MHI
Idaho	TBD	N/A	N/A

Notes: \*Pending decisions about comparison group, N/A- Not applicable, TBD- To be decided  
States are broken into contract groups

Evaluation Plan as of February 2011,<sup>43</sup> adapted from:

Mathematica Policy Research. Design Plan for the National Evaluation of the CHIPRA Quality Demonstration Grant Program. Washington, D.C.: Mathematica Policy Research 2011.

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