

Florida Pediatric Medical Home  
DEMONSTRATION PROJECT EVALUATION 2013



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





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Report Prepared by the Institute for Child Health Policy at the University of Florida, May 2014

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# Executive Summary

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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 Services (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.

Twenty practices were recruited to the demonstration project in 2011 and embarked on a provider-based quality improvement (QI) program led by the American Academy of Pediatrics (AAP). The QI program included three in-person learning sessions, monthly educational webinars, and two 6-month periods of data

collection. The Institute for Child Health Policy (the Institute) at the University of Florida was contracted by the state to conduct a four-year, longitudinal, multi-stakeholder evaluation. This report describes evaluation data collected in calendar year 2013 from the demonstration practices and describes parent perspectives on the care their children receive in a PCMH. Key findings for year three are described below.

## Core Clinical Teams

- Practices significantly improved their Medical Home Index (MHI) scores in year three, with all MHI domain scores exceeding their respective benchmarks.
- Practices described successes and challenges in their continuing journey to become a medical home.
- Practices discussed unique strategies they implemented to make their medical home more efficient for staff and parents. The practices mentioned that these changes improved patient satisfaction and increased staff efficiency and for the most part they have been able to maintain them over the course of the project.
- Practices continue to make improvements in their relationships with community

stakeholders such as specialists, schools, and hospitals.

## Staff

- Practice Staff's levels of Job Burnout decreased in year three, while their levels of Job Satisfaction remained similar to levels in year two.

## Parents

- Parents in the demonstration group reported a higher level of satisfaction compared to those in a control group across all of the CAHPS core composites.
- More than 80% of parents in the demonstration group reported positive interactions with their child's provider.
- Children with special health care needs in the demonstration group surpassed the Florida and national benchmarks for receiving ongoing comprehensive care.

## Performance Measures

- In both years two and three, the demonstration group exceeded the benchmark on more measures than the control group, indicating a positive effect of intervention.

# Florida Pediatric Medical Home 1 Demonstration Project

## CHIPRA Quality Demonstration Grants

On February 4, 2009, President Barack Obama signed Public Law 111-3, the Children's Health Insurance Program Reauthorization Act (CHIPRA). 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 specifically call for the development of:

- Demonstration projects for improving the quality of children's health care and the use of health information technology (HIT).
- A core set of measures that will be used to provide a

national standard for measurement, reporting, and QI 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 to submit proposals in the following five categories: A) evaluate and experiment with new and existing measures of quality for children covered by CHIP and Medicaid; B) promote the use of HIT; C) evaluate provider-based models to improve health care delivery; D) demonstrate the impact of electronic health records (EHR) 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

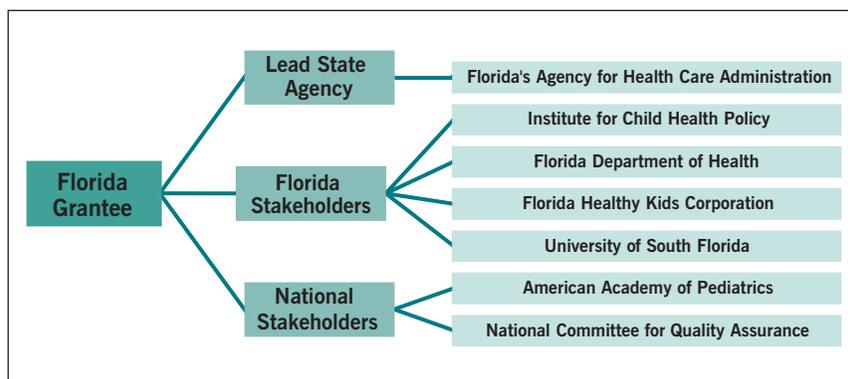
categories A-D<sup>2</sup>. Florida and Illinois submitted a joint grant application for categories A, B, C, and E.

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 at the University of Florida (UF), 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, along with sixteen other grantee states (Appendix 1).

Florida chose to implement the PCMH model as its provider-based model for Category C, henceforth referred to as the Florida Pediatric Medical Home Demonstration Project. Subcontracts were awarded by AHCA in 2011 to (i) the AAP, to implement a PCMH 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

Figure 1. Structure of the Florida Quality Demonstration Grant



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.

## 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 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**).

Because the AAP's 1992 definition of a medical home left

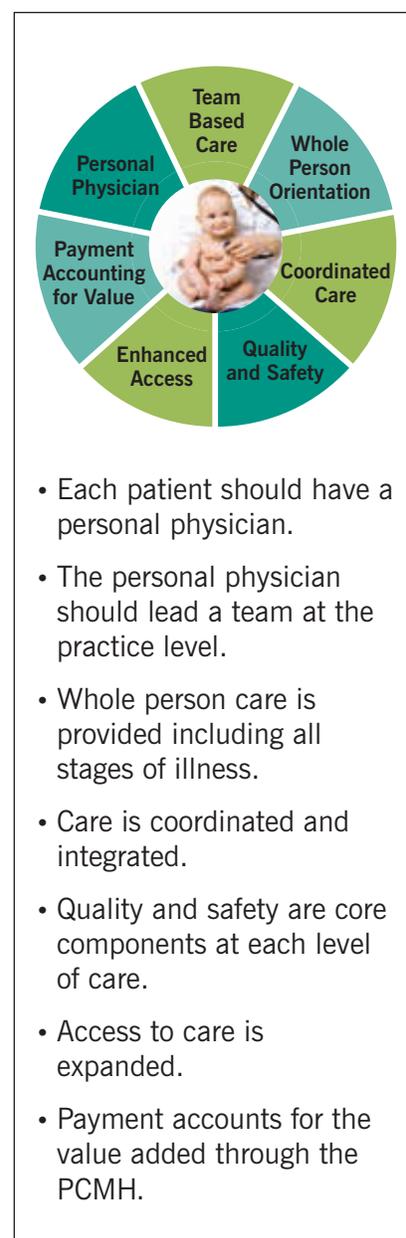
many providers uncertain as to how to apply the theoretical features of the model, a 2002 revision to the policy statement clearly spelled out the practical implications of a PCMH. The reader is referred to the Institute's 2011 evaluation report for a complete history of the PCMH model and a summary of national PCMH initiatives<sup>7</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, which can be overwhelming to practices who have limited resources and time to implement such initiatives. One way to combat this formidable barrier is through facilitated education forums<sup>8</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, clinicians 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>9</sup>. Finally, there is little evidence on the best way to implement the PCMH model<sup>10</sup>.

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



## Evaluation Challenges

Practice level interventions are challenging to implement, and perhaps even more challenging to evaluate. Due to the relatively new and evolving nature of the PCMH concept, there is limited evidence in the literature on the effectiveness of the model. Similarly, the measures for PCMH effectiveness have yet to become standardized<sup>11</sup>, and a recent review shows that many evaluations of the PCMH have some methodological issues and show mostly inconclusive results<sup>10</sup>. Evaluation is further complicated by the issues of attrition in longitudinal studies, and the fact that although a number of PCMH tools exist, few have been validated. 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.

## AAP Quality Improvement Activities

### 2011

During 2011, the AAP recruited and selected 20 practices in Florida to participate in the Florida Pediatric Medical Home Demonstration Project. To be eligible, practices had to accept Medicaid and CHIP and serve at least 100 children with special health care needs (CSHCN). The AAP was responsible for recruiting the demonstration practices, providing the practices with educational opportunities, and facilitating QI work led by a three-person core clinical team (lead physician and two other staff members) from each practice (**Figure 3**).

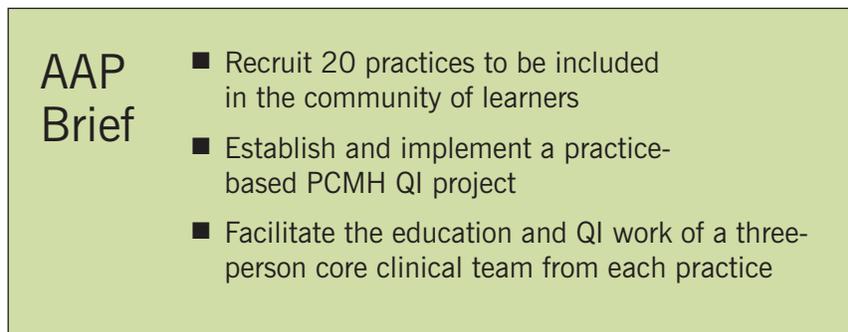
The aim of the QI project was to provide physicians and their staff

with strategies, tools, and resources necessary to strengthen their medical home capacity and to provide high quality, family-centered care for all children and youth, including those with special health care needs. The QI project was approved by the AAP's Institutional Review Board (IRB) (#11KA01) on June 18, 2011, and a revision was approved on March 26, 2012.

In the early stages of the grant, 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 AAP Florida Chapter, AHCA and DOH representatives, HMA representatives, a QI advisor, and the Institute. The primary responsibilities of the AAP included managing the project through the AAP's Division of Children with Special Needs and implementing the QI project through the AAP's Quality Improvement Innovation Network (QuIIN).

During calendar year 2011, core clinical teams from the participating practices were asked to submit baseline data prior to a Learning Session on PCMH concepts and QI science. A six-month action period followed, during which the core clinical teams audited their

**Figure 3. The Role of the AAP**



medical records and participated in monthly educational webinars (**Figure 4**). Participants also were given access to the AAP Education in Quality Improvement for Pediatric Practices (EQIPP) program. The reader is referred to the 2011 UF evaluation report for an in-depth description of all QI activities for calendar year 2011<sup>7</sup>.

## 2012

One of the key findings from the baseline interviews was that many of the core clinical teams felt overwhelmed by the scope of the project and wanted more facilitated time with the AAP to implement their desired

changes. In response, the AAP extended its role in the QI project for a longer period. As part of “Phase 2,” the AAP offered an additional QI action period following the second Learning Session and introduced a third Learning Session. Participating physicians were again eligible for continuing medical education (CME) credits for Phase 2 work. Sixteen of the 20 practices elected to participate in Phase 2 of the QI project (**Figure 4**)<sup>1</sup>.

During Phase 2 of calendar year 2012, core clinical teams participated in the second and third Learning Sessions, the second action period, and EQIPP surveys. Additional value-added

activities, including resources for Parent Partners, Care Coordinators, and Practice Facilitation, also occurred during 2012. The reader is referred to the 2012 UF evaluation report for an in-depth description of all QI activities for calendar year 2012<sup>12</sup>.

## 2013

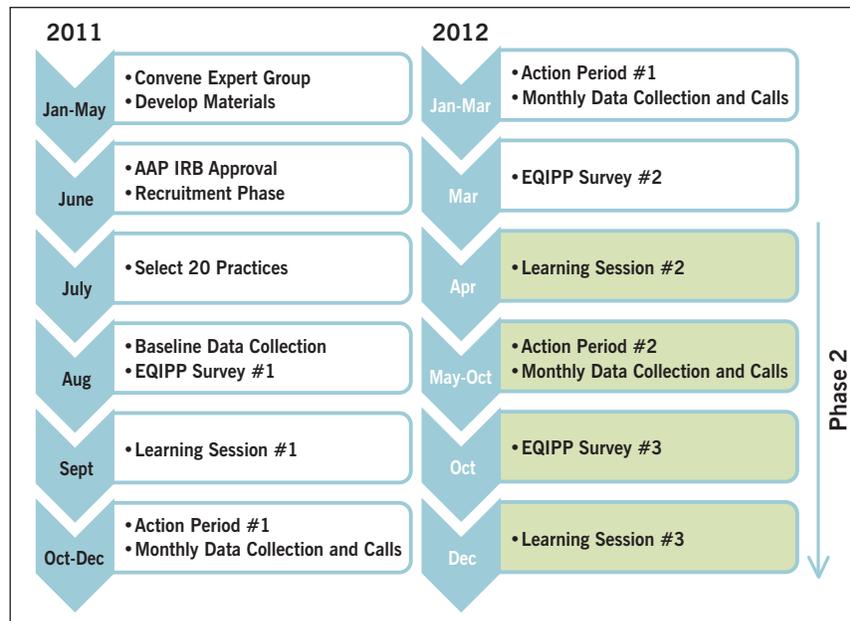
Activities for calendar year 2013 included monthly resources and updates emailed from the AAP to the practices. Emails centered on topics such as educational opportunities, research articles, and instructional webinars that might be of interest to the practices.

## Practice Demographics

### Phase One

Practice recruitment was primarily achieved through the following email distribution lists: Children’s Medical Services Network (CMSN); FHKC; the Florida Chapters of the AAP and AAFP, respectively; and Florida QIIN members. Practices had to serve publicly-insured children and meet a minimum quota of CSHCN to be eligible to participate. The reader is referred to the 2011 evaluation report for a detailed description of the recruitment and selection process<sup>7</sup>.

**Figure 4. QI Activities in Calendar Years 2011 and 2012**



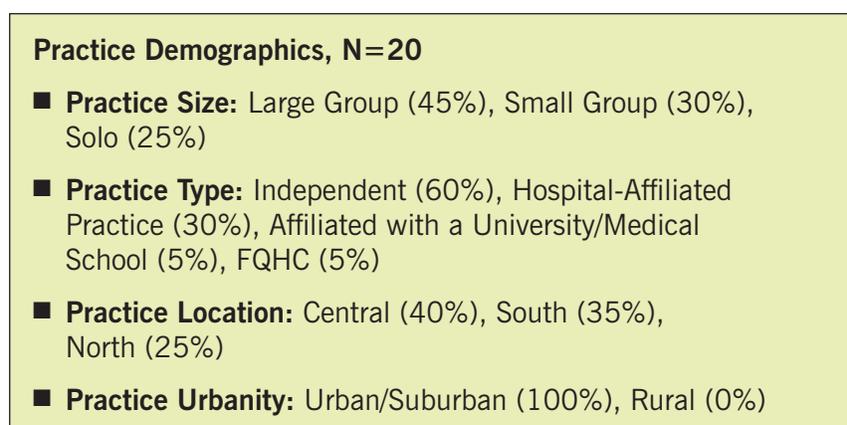
<sup>1</sup>Phases 1 and 2 comprise Round 1 of the Florida Pediatric Medical Home Demonstration Project.

The 20 demonstration practices recruited were primarily independent or hospital-affiliated practices (**Figure 5**). Nearly half of practices classify themselves as a part of a “large group”, which consists of more than three physicians. All practices classify themselves as urban or suburban, with no practices operating in rural areas. No practice had NCQA medical home recognition, the Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH), at baseline.

### Phase Two

There was attrition between Phase 1 and Phase 2 of the Florida Pediatric Medical Home Demonstration Project. Sixteen of the 20 practices continued with the second phase of the QI project. One federally qualified health-center (FQHC) and two large-group, independent practices elected not to continue and one hospital-affiliated

**Figure 5. Practice Demographics**

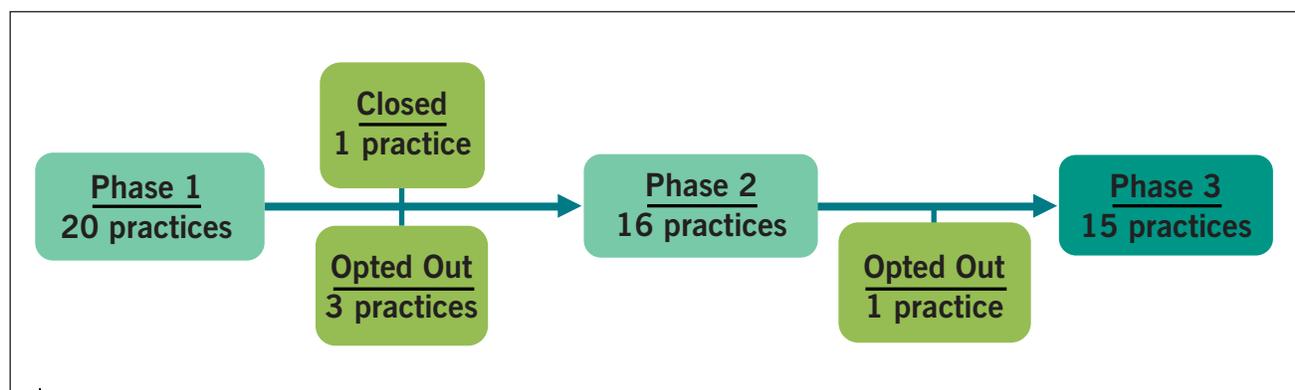


practice closed down (**Figure 6**). Additionally, one hospital-affiliated practice experienced a change of location, staffing, patient population, and became a designated FQHC.

In year three, the 16 practices were surveyed again about their practice demographics (**Table 1**). One practice opted out, and only thirteen of the fifteen demonstration practices returned the practice demographic survey. The mean number of full-time equivalent employees is 11 per

practice, and the majority of practices have a designated person on-site who coordinates care (62%). The number of pediatric patients per practice ranges from 95 to 20,000, and there is large variability in the characteristics of patients across practices. Use of EHRs is commonplace (85%). Moreover, 50% of practices use registries to track/follow-up with CSHCN, and 54% of practices have formal specialty referral tracking processes.

**Figure 6. Practice Attrition in Phase 2**



## Evaluation Design

A four-year, longitudinal, multi-stakeholder evaluation was designed by the Institute to capture both short and long term effects of PCMH implementation. The evaluation plan aims 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 themselves (**Figure 7**). Although the core clinical team is responsible for leading the PCMH initiative, practice transformation is likely to have a wide-spread effect on other parties both inside and outside the practice.

The core clinical team, practice staff, and parents are assessed at baseline and then annually

Figure 7. Multi-Stakeholder Evaluation Design



thereafter, while community stakeholders are assessed at two time points (**Figure 8**). Both qualitative and quantitative survey methods are used to

assess the experiences of the core clinical team. Survey tools used in the third year of the evaluation are described in **Appendix 2**.

Table 1. Practice Demographics, Year Three (N=13)\*

PRACTICE CHARACTERISTICS	PERCENTAGE OF PRACTICES	MEAN PER PRACTICE
<b>Processes/Use of Technology</b>		
Electronic Health Records	85%	–
Registry to Track/Follow-up with CSHCN	50%	–
Formal Specialty Referral Tracking Process	54%	–
<b>Pediatric Patients</b>		
Number of Patients per Practice		5,327
Publicly Insured CSHCN per Practice		366
<b>Practice Staff</b>		
Care-Coordinator On-Site	62%	
Number of Full Time Equivalent Employees		11

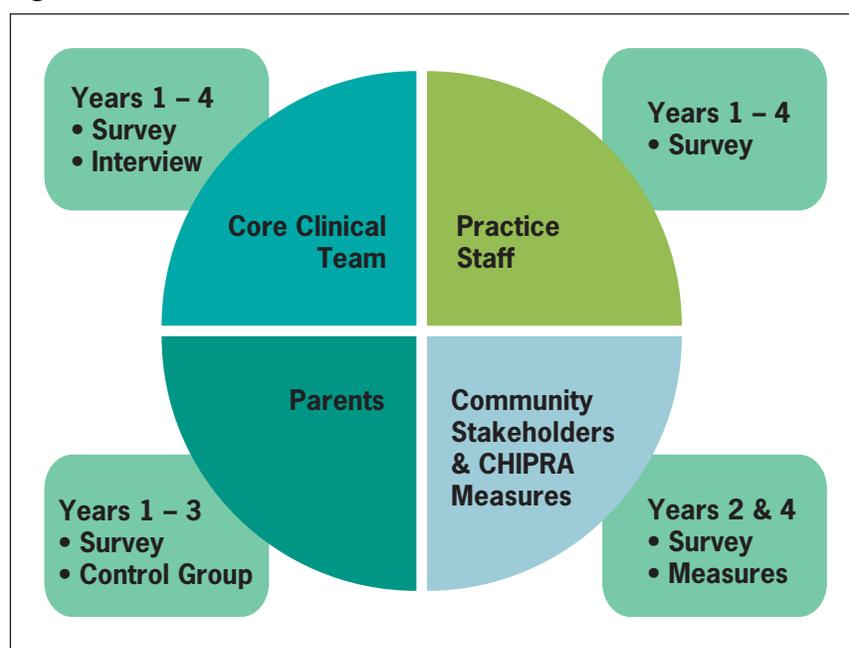
\*Note: Only thirteen of the fifteen demonstration practices returned the practice demographic survey.

## Report Purpose

The purpose of this report is to describe evaluation data collected in year three of Florida's Pediatric Medical Home Demonstration Project. Individual sections of this report will describe the approach that was taken to assess the experiences of the core clinical team practice staff and parents whose children receive care in the demonstration practices.

Assessment of the overall project will not be addressed until the end of the four-year evaluation period, as practice transformation is not yet complete. As such, recommendations are not included in the 2013 evaluation report, and the reader is cautioned against making premature interpretations of the data.

Figure 8. Evaluation Timeframe



## 2 Core Clinical Team – Survey

### Overview

As previously described, the 16 demonstration practices were required to nominate a three-person core clinical team to participate in the project. One member had to be a lead physician and the other two members could hold a clinical or non-clinical position within the practice. Core clinical teams were asked to complete a year three survey in August 2013. The survey tools administered to the core clinical team in year two remained the same in year three (**Appendix 2**). Of the 16 disseminated surveys, 15 surveys were returned and included in final analysis.

When interpreting the core clinical team survey results the reader should be aware of the following:

- Aggregate results are presented for 15 practices in year three, 16 practices in year two, and 20 practices in year one.
- Year three results are compared against baseline national benchmark data where available.
- Significant results are reported based on a two-tailed test at the  $P < .05$  level.

### Medical Home Index

The MHI has 25 themes that are divided into the

following six domains:

- 1. Organizational Capacity**  
(7 themes) *Ex. Access to Medical Records*
- 2. Chronic Condition Management**  
(6 themes) *Ex. Care Coordination*
- 3. Care coordination**  
(6 themes) *Ex. Family Involvement*
- 4. Community Outreach**  
(2 themes) *Ex. Community Assessment of Needs for CSHCN*
- 5. Data Management**  
(2 themes) *Ex. Data Retrieval Capacity*
- 6. Quality Improvement**  
(2 themes) *Ex. Structures of Quality Standards*

For each of the 25 themes, practices choose a level from 1 to 4 to determine whether they partially or fully met 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 of the six domains, each ranging from 1 to 8 depending on whether the practice partially or fully met the criteria. Based on the responses from the four levels, 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 home-ness, with a practice fully offering comprehensive care for all 25 themes.

A 2003 study by Cooley et al. of 43 primary care pediatric practices across nine states showed that the MHI has 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>13</sup>). Mean domain scores from this study are used as the benchmarks in this report<sup>13</sup>.

### Key Findings

- The MHI mean score (**Table 2**) significantly increased from 57.5 in year two to 65.5 in year three ( $P < 0.05$ ), surpassing the benchmark (43.9). All MHI domain scores in year three exceeded their respective benchmarks (**Figure 9**).
- Overall, the MHI scores have remained consistent from year two with the MHI total score and the Organizational Capacity domain showing the only significant improvements from year two ( $P < 0.05$ ).
- In part because of the implementation of electronic medical records, and the

benefit it provides to data management, the Data Management domain has been the highest MHI domain score three years in a row (**Figure 9**).

- Practices report the most improvement since baseline to year 3 for the Quality

Improvement domain (2.98 to 5.10); however, this was also the only domain to slightly decrease from year two (5.23) to year three.

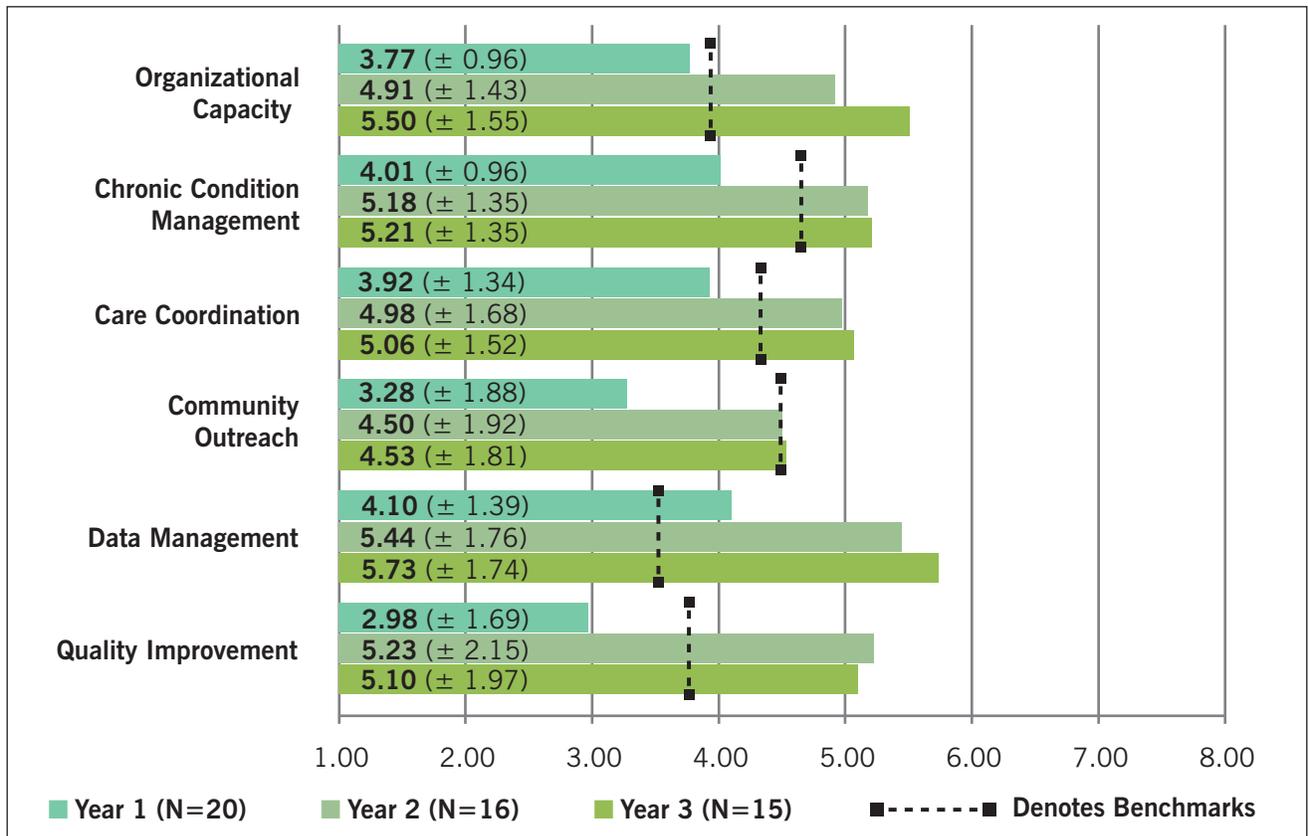
- There remains a large degree of variability among how the 15 practices perceive their

medical home implementation, which is seen in both the individual MHI domain scores and overall MHI scores. The highest overall MHI score for the 15 practices was 99 and the lowest overall MHI score was 29.5.

Table 2. Overall MHI Score for the Demonstration Group, Year Three		
MHI SCORE	YEAR THREE (N=15)	BENCHMARK <sup>13</sup>
MHI Mean [± Standard Deviation (SD)]	65.5 (± 18.1) (+8.0 ↑)	43.9 (± 15.8)
Median	64.3 (+6.3 ↑)	41.7

\*Arrows denote the movement in mean and median scores from year two to year three.

Figure 9. MHI Mean Scores for Florida Demonstration Practices (± SD)



\* SD denotes Standard Deviation.

## Adaptive Reserve

One of the largest, and the first, national assessments of the PCMH model began in 2006<sup>14-16</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.

One member from each core clinical team was asked to respond to 23 items about their practice's adaptive reserve on a five-point Likert scale (1=strongly disagree to 5=strongly agree). 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>16</sup>.

### Key Findings

- In year three, the Florida practices' mean practice Adaptive Reserve score (0.74) is higher than the national benchmark of 0.69 (Table 3).
- Practice Adaptive Reserve scores are consistent among all three years with a slight, but not statistically significant, improvement of 0.4 points since the year 1 baseline ( $P > 0.05$ ).
- There continues to be variability among Florida demonstration practices in terms of their self-reported abilities to adapt and make changes. In year three, the minimum adaptive reserve score for the 15 practices was 0.46 and the maximum was 0.87.

## Practice Environment

The Practice Environment Checklist, developed by the National Demonstration Project, measures four aspects of the practice's environment. All four factors have been shown to have acceptable psychometric properties<sup>17</sup> and are as follows:

### 1. Community Knowledge

(4 items) *Ex. This practice works effectively together as*

*a team with community organizations.*

### 2. Health Information

Technology (HIT) Integration (4 items)

*Ex. The use of electronic medical records during patient visits interferes with the doctor-patient relationship.*

### 3. Cultural Sensitivity

(3 items) *Ex. Cultural issues are important in our interactions with patients.*

### 4. Patient Safety Culture

(3 items) *Ex. It is just by chance that more serious mistakes don't happen in our practice.*

One member from each core clinical team 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

- Mean domain scores remain roughly unchanged compared

to last year (Figure 10) with slight improvements, but no significant changes, from year two to year three.

- The Florida demonstration practices continue to score highest on the Cultural Sensitivity domain followed by the Community Knowledge, Patient Safety Culture, and HIT Integration domains.

### Practice Staff Engagement

This year’s practice survey, as with year two, included a number of new questions intended to measure the success of the medical home initiative. Specifically, the intent of these questions was to gauge practices’ internal communications and staff

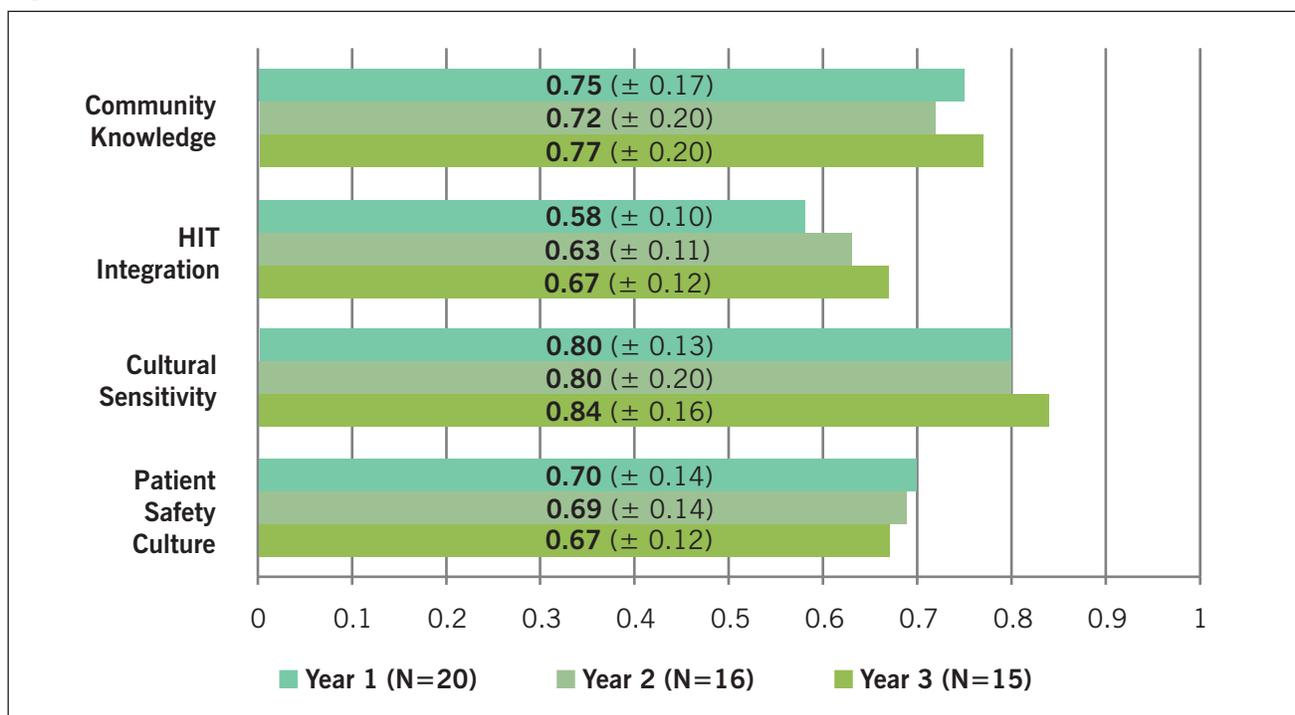
understanding of and engagement with the medical home project. One member from each core clinical team was asked to respond to items regarding staff engagement on a five-point Likert scale (1=strongly disagree to 5=strongly agree). The core clinical team member was also asked whether or not the medical home project has

**Table 3. Core Clinical Teams’ Adaptive Reserve Score versus Benchmark**

	DEMONSTRATION GROUP				BENCHMARK MEAN (± SD)
	MEAN (± SD)	MEDIAN	MINIMUM	MAXIMUM	
Adaptive Reserve	0.74 (± 0.11)*	0.67	0.46	0.87	0.69 (± 0.35)

\*No change in mean score from year two to year three.

**Figure 10. Core Clinical Teams’ Practice Environment Mean Scores (± SD)**



improved everybody else's jobs, in their opinion, on a five-point Likert scale (1=much worse to 5=much better).

### Key Findings

- Twelve of the fifteen core clinical teams (80%) agree that they have been able to 'communicate with the practice staff about the purpose of the medical home project' and 'disseminate information they have learned during the project to the practice staff' (Figure 11).
- Nearly all practices (13 out of 15) report having 'frequent and good communication'

about the different medical home change initiatives in place at their practice (Figure 11).

- Ten of the 15 practices allot 'time for staff training on the medical home', indicating there is room for improvement in this area.
- Thirty-three percent of core clinical teams report that they think the 'medical home project has made the practice staffs' jobs much better, 40% report staffs' jobs are slightly better, and 27% report no change in staffs' jobs (Figure 12); which significantly differs from Year 2, but only in a

one-tailed test at the 5% level.

- Around three-fourths of the core clinical teams in year 3 perceive that practice staff 'understand their role in the project' – an improvement from two-thirds in year two – and 57% are 'enthusiastic about the medical home initiative' (Figure 13).
- In part due to staff turnover, three core clinical teams agree that 'staff in their practice know very little about the medical home project' compared to only one practice in year 2 (Figure 13).

Figure 11. Year 3 Core Clinician Teams' Perceptions of Practice Staff Communication

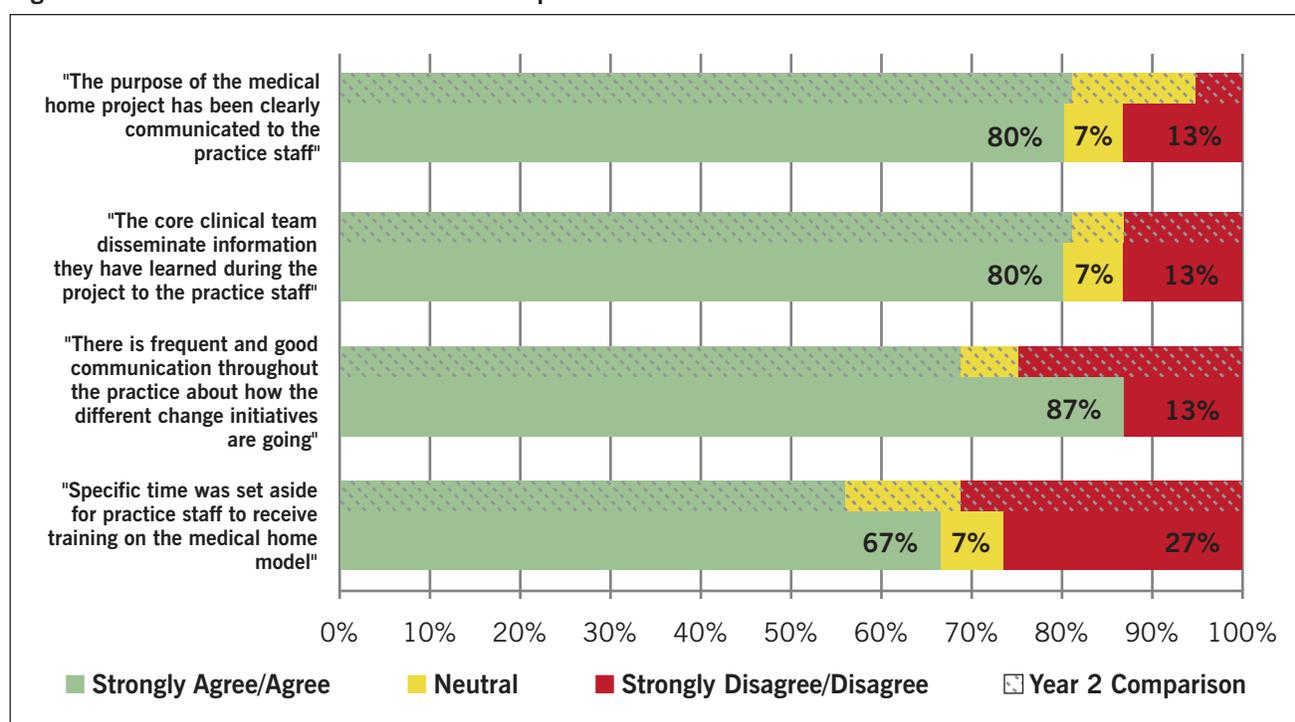
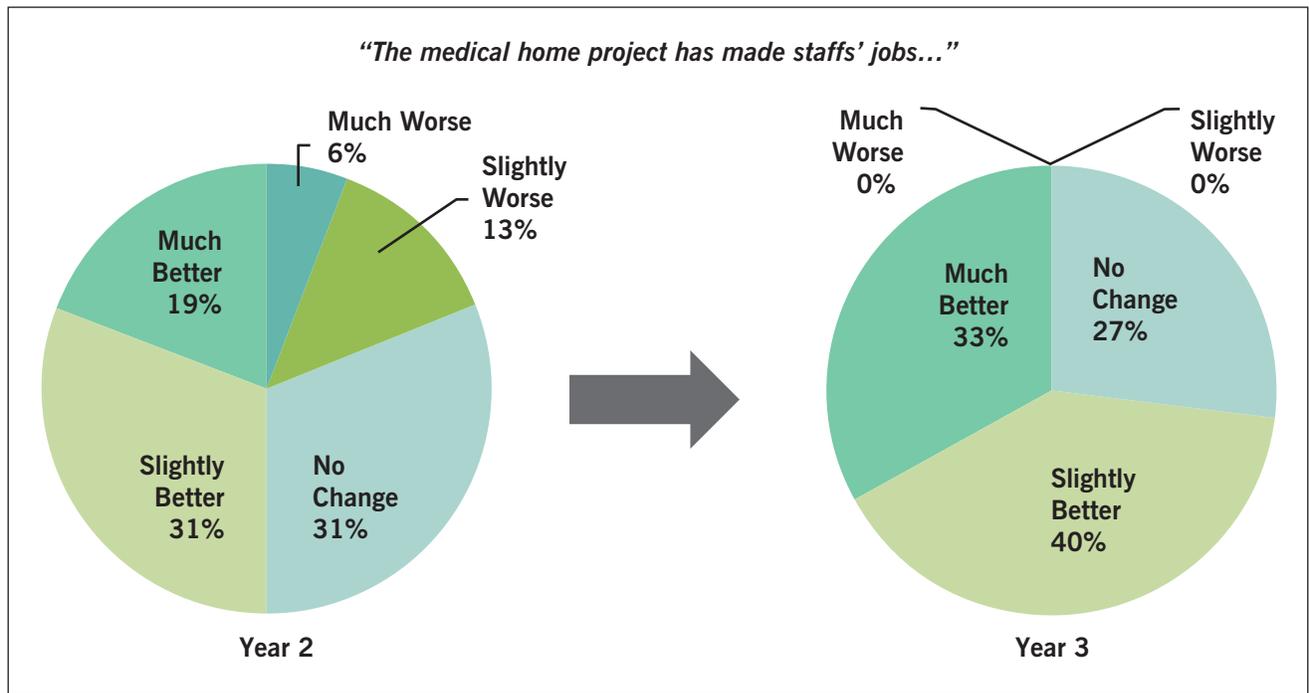
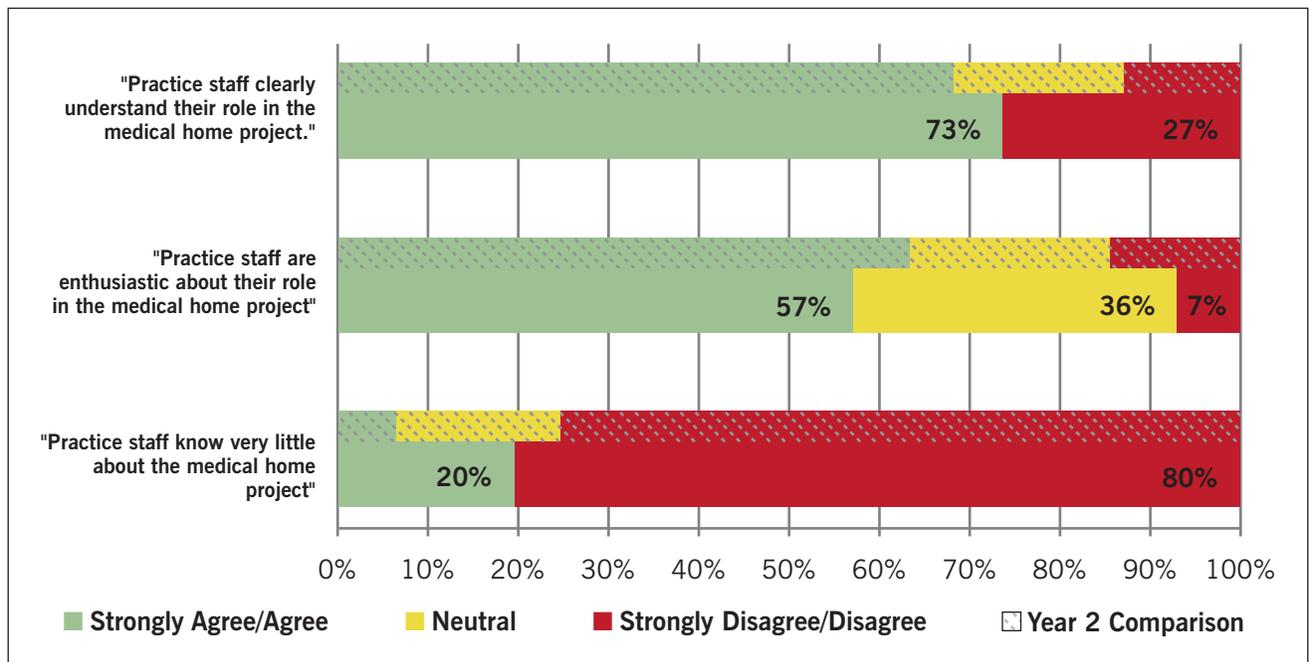


Figure 12. Year 3 Core Clinician Teams' Perceptions of Staff Job Satisfaction\*



\* Year three significantly differs from year two only in a one-tailed test at the 5% level.

Figure 13. Year 3 Core Clinician Teams' Perceptions of Practice Staff Engagement



## Communication With Community Stakeholders

This year's practice survey, as with year two, included a number of questions intended to measure the practices' interactions with community stakeholders (state-employed care coordinators and specialists). One member from each core clinical team was asked to respond to three items regarding information exchange with the community stakeholders on a five-point Likert scale (1=strongly disagree to 5=strongly agree). Additionally, the core clinical

team member was asked about the percentage of time that stakeholders provide all requested information to the practice and vice versa.

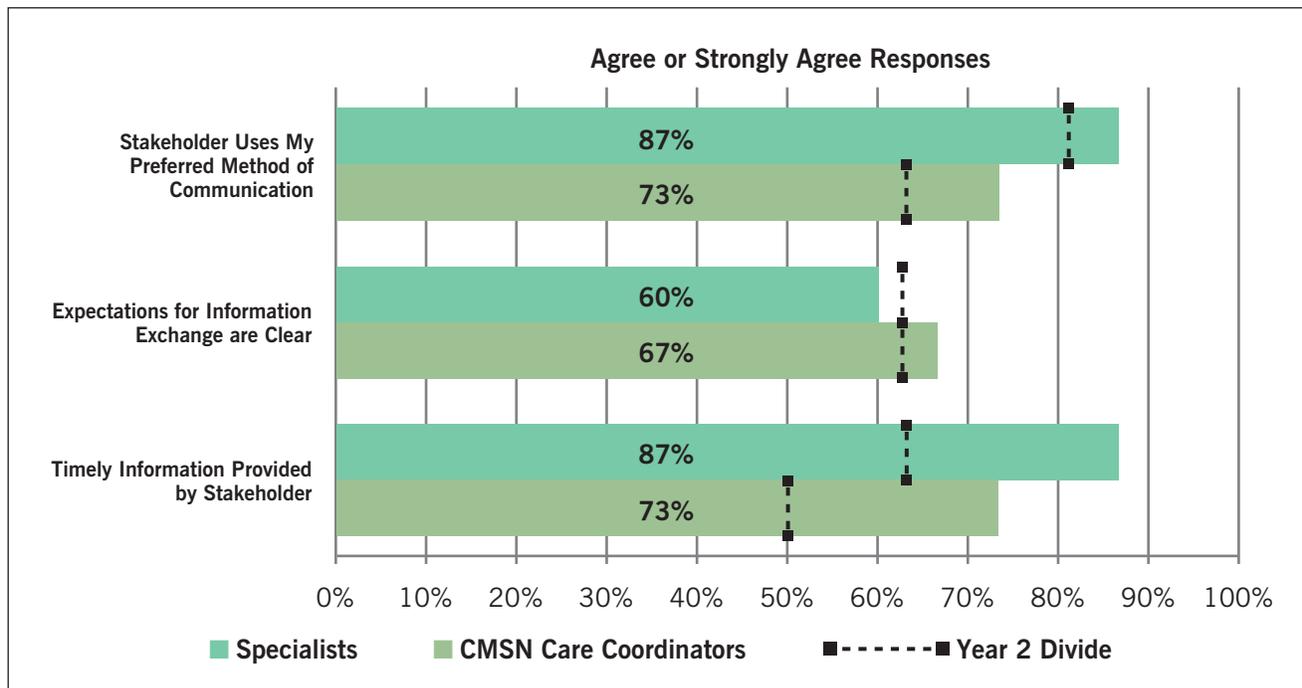
### Key Findings

- As seen in year two, more practices report that Specialists 'use their preferred method of communication' as compared to CMSN Care Coordinators.
- Similar to year two, around two-thirds of practices agree that there are 'clear expectations for information exchange' between their practice and either Specialists

(60%) or CMSN Care Coordinators (67%) (Figure 14).

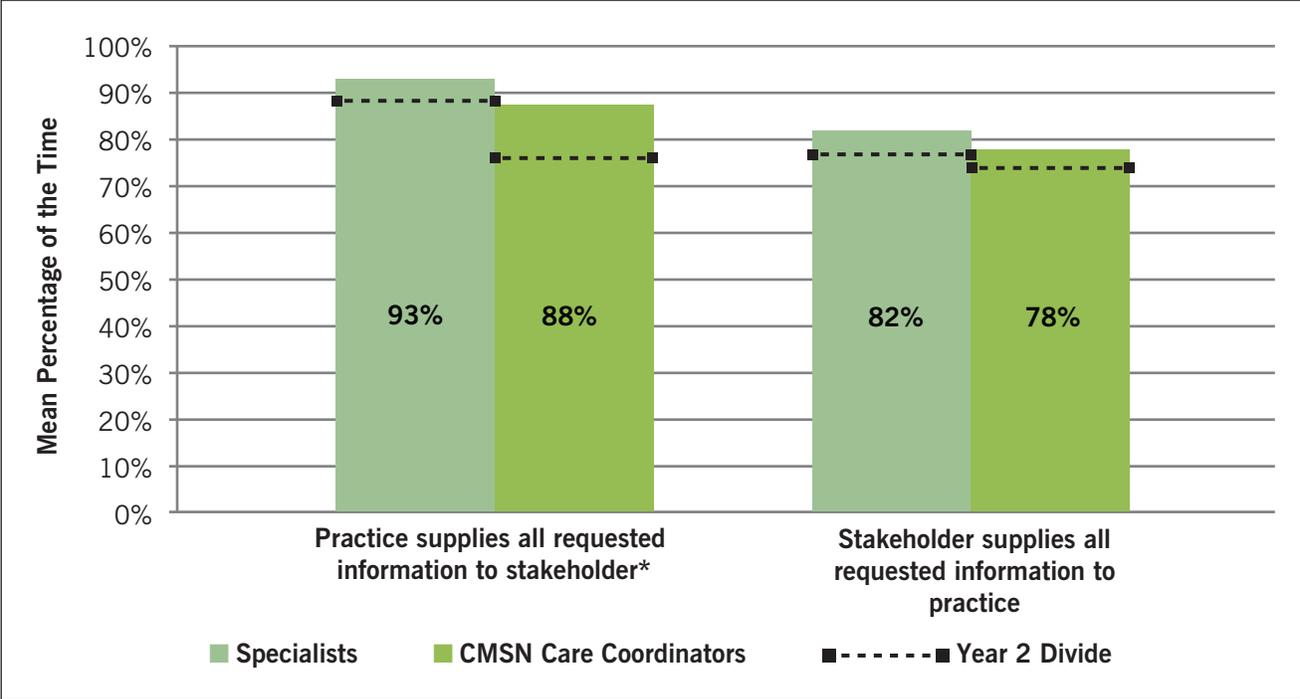
- Practices report 'supplying significantly more information to stakeholders' in year 3 than year 2 (Figure 15), however, this difference is only significant in the one-tailed test at the 5% level.
- Showing some improvement, the demonstration practices in year 3 report that both stakeholders 'supplies all requested information' about 80% of the time as compared to 75% of the time in year 2 (Figure 15), but that 'timely information is not always provided' (Figure 14).

Figure 14. Ease of Communication with Community\*



\* Year 1 data are not available.

**Figure 15. Information Exchange between Practices and Stakeholders**



\* Year three significantly differs from year two only in a one-tailed test at the 5% level.

# 3 Core Clinical Team – Interview

## Overview

The second component of the practice assessment was an in-person qualitative interview with the core clinical team. Questions for the year three core clinical team interview were modified to explore how practices had experienced the PCMH transformation process in their second year. A new structured interview guide was created which included an interviewer script, structured questions, and standard prompts to elicit additional information. Interviews were completed with all 16 core clinical teams participating in the second phase of the QI project. One practice however, experienced 100% staff turnover and was unable to answer most of the questions because their new core clinical team lacked background and context of the project. Interviews were conducted with all core clinical team 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.

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

### 1. Ability to Make Changes

- Successful Changes
  - *Characteristics for Maintaining Changes*
- Challenging Changes
  - *Characteristics of Challenging Changes*
- Future Changes
- Impact of Changes on Stakeholders
  - *Positive Effects: Patients and Staff*
  - *Negative Effects: Patients and Staff*

### 2. Innovation and Resourcefulness

- Translation of Innovation of Resourcefulness
- Impact of Innovation and Resourcefulness

### 3. Measuring Transformation Success

- Measures of Success
- Communicating with Other Practices
- Final Goals
- Plans for Future

### 4. Medical Home Neighborhoods and Community

- Medical Home Community
- Community Member Relationships
  - *Positive Relationships*
  - *Difficult Relationships*

- Impact of Community Coordination with Stakeholders

Interviews averaged 39 minutes in length as team members typically took turns speaking, resulting in some cross talk. 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 person based on their level of interaction with patients and staff.

A thematic analysis was conducted by a subcontractor for the four domains. Atlas Ti<sup>®</sup> qualitative analysis software was used for analysis.

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.

#### 1. Ability to Make Changes

For year three, we wanted to see how practices utilized the ability to make changes toward becoming a Medical Home and implementing resources and lessons given to them at the

learning sessions. Every practice reported successes and challenges in implementing these changes. Each practice had their own approach on how these resources for Medical Homes best fit into their practice.

**Successful Changes**

All practices were able to provide examples of implemented changes in the past year. However, the depth and scope of changes varied from practice to practice, with a few practices reporting much higher levels of success than

others. The most frequently discussed areas of successful improvements and continued progress included asthma care plans, care plans in general, huddles, medical record improvements, mental health services, and changes in hours/availability (**Table 4**).

Table 4. Successful Changes		
TOOLS	PRACTICE RESPONSES	REPRESENTATIVE QUOTE
Care Plans	9/16	“We actually give it [care plans] to all, to every kind of visit, if they want it. I think that’s been really well received by the parents because it’s everything that, you know, they need ... Say the weekend comes and they have to go ... to the emergency room. On there is their specialist, all their diagnoses, their medications ... everything that, that you could hand to say an ER doctor ... they’d be able to ... see all that. So I think that they really liked having that information”
Huddles	5/16	“That’s [huddles] really well received by the staff. I think it helps to have our day flow, you know, better.”
Electronic Medical Record Implementation	6/16	“As far as this program, it’s [EMR system] good because you’re able to change what you need, like the templates for the visits you’re able to input what you want. Of course it was a struggle at first because it was new and everybody was trying to get used to it, but it’s very good, it’s easy, it’s simple; it’s a good program.”
Mental Health	3/16	“I think also we incorporated the maternal depression scale into the chart from, I think it was zero all the way up to nine months of age. So that’s part, and if we identify a mother that is at-risk, then we refer them back to either their OB or to we have a couple of smaller units here under an umbrella for new moms, or over to the health department for psychiatric care. So those are two things that we were able to maintain really well.”
New Hours of Availability	4/16	“As a small practice with a solo practitioner we cannot be here all the time but we basically had instituted ... working hours ... we had increased access by a lot and it had worked for us. Since ... school finished at 3:00 and we close at 5:30 we are going to accommodate a lot of those patients.”
Surveys <sup>a</sup>	5/16	“There was a point in time when we were doing surveys, I’m not sure where it’s at today, but I remember they were doing surveys, handing them out and going by what patients say.”

<sup>a</sup>Most practices felt that they did not remember to consistently administer the surveys or only did a one-time survey in the past.

### **Characteristics for Maintaining Changes**

The majority of practices attributed the ability to maintain changes to their staff. Themes included improved communication, being “on the same page,” working as a team, strong leadership roles, presence of a champion, staff turnover, and belief in the “Medical Home.”

*“It was, you know, chaotic because we had all these people who didn’t know how to run the office ... so then we started hiring people and really gaining some stability.”*

*“I think it’s a teamwork effort. I mean I think that our employees have become vested in it, they believe in it.”*

*“The practice leadership ... we make sure that everybody understands ... what’s expected from them when they participate. If somebody does not work here anymore and we have somebody new, this is what we do. We establish protocols.”*

*“We have told them that they are models for the rest of our organization, and that, you know, I think that that gives them a sense of pride that they’re the only ones doing this and this is where healthcare is going. So we have told them ‘you are the experts.’”*

### **Challenging Changes**

The majority of practices attempted to implement huddles, but six practices felt this change was not feasible to maintain, mostly due to lack of time and early working hours. Some practices also struggled to maintain care plans, or did not feel that care plans were particularly useful for patients. Other changes that were not feasible to implement or maintain included hiring a case worker/manager, referrals to outside services, identifying a parent partner, and tracking immunizations.

*“It’s [huddles] totally impossible. You just can’t. I mean ... we get in here, most of us, 8:30 in the morning and ... there’s already patients at the door, so it’s kind of hard.”*

*“My gut tells me that for most people it [care plans] goes home and goes home on the kitchen counter never to be looked at again or in the trash is where it goes.”*

*“As you know, a case worker is really essential, especially when you have as many medically complex and underserved and special need kids as we do, so it’s just ... I mean we spend a lot of time doing a lot of stuff that would be really best done by a caseworker.”*

*“Our parent partner has not been strong at all. We haven’t*

*even been able to initiate that.”*

### **Characteristics of Challenging Changes**

The main reasons given for difficulty making or maintaining changes included lack of control in a large practice (2), lack of familiarity with new technology (e.g., EHR changes) (2), complex population of patients (2), staff turnover (2), and lack of resources, time, or funds (3).

*“We just didn’t have the funds. I mean we didn’t have the, the staff to be able to take one person to put towards that.”*

*“We’re in a very large multi-specialty practice, so kicking them is like kicking a dinosaur in the butt and waiting for it to turn around seven years later.”*

*“Our patients are just a different population.”*

### **Future Changes**

Seven practices discussed changes they hoped to implement in the future. Examples included increasing working hours, patient portals, quality audits, transition to care, registry entries, and updating records.

*“I think the one they’re really trying to focus on is the after-hours, trying to get that back. Because that’s really helpful for parents who can’t come during the day, they can come after work; that’s way easier.”*

*"I think, we never really got into patient portals. We have one on our system, but we haven't really been doing training for the patients on how to access their patient portals ... so I would see that as a project within the next year."*

*"I think the thing that we're trying to do, and it's very difficult, I thought it would be easier with EMRs but it's actually more difficult than with paper charts, and that is looking at quality, more quality audits and management from that perspective."*

### **Impact of Changes on Stakeholders**

Twelve practices described how changes have positively (10) and negatively (2) affected their patients, while four practices described how changes have specifically affected their staff. Two practices discussed positive changes for their staff, and two practices discussed challenges faced by their staff during their medical home transformation.

### **Positive Effects: Patients and Staff**

Positive effects for patients included improved or more efficient care for chronic patients and patients with asthma, greater patient satisfaction, and greater patient understanding/comprehension of care. Two practices felt that the Medical

Home process created more efficiency and more opportunities for staff training.

*"I definitely see an improvement of my chronic patients. I have a fair number of red charts that I follow and I definitely think that we've made advances in a couple patients specifically because I know their story, I know exactly what's going on with them and I can get them into the specialists that they need and work kind of on our way to a diagnosis on one child that I really didn't have a diagnosis before."*

*"Where they were going before, they were going to the community, but now they are staying because they feel like they get taken care of... especially with the ones with the special needs."*

*"We're all carrying laptops around to better access their information. We don't have to wait for a paper chart to be pulled or sent from another office ... lots of positive comments and appreciations."*

*"Everybody being on the same page is just amazing. Everybody agreeing, everybody knowing what works better for us and they see a difference because a lot of us have been here a while before the Medical Home project even started ... so we all can see a difference."*

*"Those things do make it more*

*efficient and make sure that we're keeping on course, so I do like that."*

*"The department has sent us for training, [Staff Member] and I to get more involved with the NCQA."*

### **Negative Effects: Patients and Staff**

Negative effects or challenges for patients included long wait times and acclimating the patients to new technology (texting, patient portal, etc.). Two practices described the challenges of involving all levels of staff in the Medical Home process.

*"It's up in the air. We need to get the patients to use it ... We took their email. We told them you will get a message from us so you use your ID, you create your own password and you have access to your kid's chart. They can just call us. So we just need to get them to do it."*

*"I mean I work directly with the CMS patients so the biggest complaint is if they have to wait."*

*"Some of them get it [spirit of medical home] better than others. Some of them just ... they think of it as how it impacts their workload or whatever, but some of them get it ... that we're here for the quality improvement and what that actually means, so yes, some of them get it a whole lot better than others."*

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## 2. Innovation and Resourcefulness

For year three we wanted to see how practices used the resources and lessons provided for them at the learning sessions to develop innovative changes to meet their practice needs. Given that Medical Home can be implemented various ways and is not a “one-size-fits-all” solution, we explored how practices adapted the spirit of Medical Home and enhanced their transformation process.

### Translation of Innovation and Resourcefulness

Half of the practices (8) discussed ways in which they translated Medical Home strategies to another area of their practice. Most of these practices mentioned unique strategies that included changes in availability, family plans, mental health, performance metrics, policy documentation, and involvement in research projects.

*“We have a continuity binder for the office now like so that anybody could kind of pick it up and see what the policies are, what our meetings are, what our job descriptions are; so we reference that quite often.”*

*“Some of our more difficult, complicated patients have personal phone numbers for us.”*

*“Well, like the family-centered plans. I don’t think that was something that was actually part of any of the actual workshops, but that’s something that we did work on and do. And like I said, the, the pre-visit consults I think worked better than the family-centered care plan, but we did ... we have been working on that, our own multiple versions.”*

### Impact of Innovation and Resourcefulness

Some practices discussed the impact that these strategies had on their patients and the quality of care they are able to provide. Practices mentioned improved patient satisfaction, increased staff efficiency, and being able to better accommodate their parents’ schedules.

*“ ... So it gives [Core Team Member] a little more time to do some of the reporting like we’re following up on all these specialists, who are not at [Hospital] because now [Hospital] seems to have gotten with the program to get, our referrals up to date.”*

*“Yeah I mean lots of feedback ... satisfaction with the practice or services in-general was increased, not so much by how much the primary care providers address the mental health issues of their children, but that the services are offered*

*here. So it’s not enough to recognize that there’s something going on, but to have something for them to do with it, you know, here’s an option for you. And certainly it was. The numbers were staggering how much they appreciate and value having that here in their medical home, a staff they’re already familiar with, an office they’re already comfortable in, and those things, so certainly it was beneficial.”*

## 3. Measuring Transformation Success

For year three, we wanted to see how practices defined a successful transformation. All of the 16 practices discussed how they defined a successful Medical Home transformation. Although some practices mentioned formal measures of success, many practices felt that they gauge their level of success with more informal methods.

### Measures of Success

All of the 16 practices provided examples of how they defined a successful transformation. The most common responses included being recognized as a NCQA certified medical home (6), patient and staff surveys/feedback (4), an overall sense of satisfaction and progress/happiness among patients and staff (5), and tracking outcomes

of referrals (2) as measures of success (Table 5).

### Communicating with Other Practices

Three practices were asked if they had communicated with other practices involved in the Medical Home transformation projects. Two felt that these discussions were helpful, while the third did not see any benefits.

*“In fact, we have, at CMS we have a meeting once a month that’s Medical Home meetings, and [Practice] is always on the line with us also.”*

*“Yeah we made contact with them at the meetings, but then you try to follow up with one of them ... that didn’t get their certification, but that wasn’t very helpful.”*

*“You know, you just compare ... see what they’re doing, what their edge is and just kind of compare with your peers and see how you bond yourself with what they’re doing and there is always something you learn. In any process that you get involved with, if you pay attention enough you will learn something that can be beneficial to you.”*

### Final Goals

Eleven practices discussed their final goals related to the Medical Home project. The following two goals were mentioned by 50% of the practices as being the final goal for their Medical Home transformation: NCQA certification (8) and continuing to improve and provide the best care for their patients (8).

Three practices generally discussed NCQA certification and positive hopes for the future, whereas the remaining five practices felt that time, cost,

**Table 5. Measures of Success**

MEASURES OF SUCCESS	PRACTICE RESPONSES	REPRESENTATIVE QUOTE
Meeting NCQA Measures or Gaining NCQA Medical Home Certification	6/16	“We’re going for the trophy. We’re waiting. We’re in review for our NCQA recognition.”
Feedback from Parent and Staff Surveys	4/16	“I use a CAHP survey. I like to look at the CAHP survey. I like to see what ( ... ) there were some things we did worse on, even after we had transformed.” “Staff surveys, we do have routine staff meetings, so there’s more of an informal ‘What are your concerns,’ ‘What’s working,’ ‘What’s not working,’ ‘How do we fix this?’
Parent and Staff and Satisfaction	5/16	“I would say success ... that the patients come out of our office feeling, you know, they didn’t just treat my sore throat.”
Tracking Referrals	2/16	“Well our emergency room visits for our asthma kids; small tested chains like we did our referral process, like we developed an Excel spreadsheet so we could track to make sure the process we had in place was actually in place, so that we can track that.”

and other issues might keep them from achieving NCQA certification. For some of these practices in which NCQA certification was out of reach, they viewed the project as a way to improve patient satisfaction or experience.

#### NCQA Certification

*“If the cost is going to be that much and the, and just by having the title ... We have enough titles already.”*

*“I mean NCQA not only helps to frame our work, I mean it’s really setting up the standards, even though we have to say that NCQA has a lot of requirements that maybe not applicable in a daily basis, but I think it would help us to frame the steps that we need to go towards to get it.”*

#### Patient Satisfaction

*“We’ve always wanted to provide the best care you know, we want for the standard, we want a protocol and we want patient to know that when they come here they’re going to get the best care.”*

*“The end point would be to, I guess to continue to improve the way we service our children with special healthcare needs as well as the general population.”*

#### **Plans for the Future**

Several practices discussed their plans for the future and how

they are related to the Medical Home project. Practices discussed plans for working toward recognition as a NCQA certified medical home.

*“If we work on the NCQA certification I think there is an end goal to it.”*

*“We’ve been able to add some more because we’re working ... towards the NCQA recognition.”*

*“Our goal, which we did not achieve but I’ll probably try again, because apparently it was a lot harder than I thought, was to become certified.”*

#### **4. Medical Home Neighborhoods and Community**

For year three we wanted to see how practices defined their Medical Home neighborhood or community. All of the practices gave examples of what they considered to be a part of their Medical Home community. Several practices discussed the challenges of defining their Medical Home community and how it impacted the coordination of care for their patients.

#### **Medical Home Community**

The most frequently mentioned entities were specialists (12), schools (11), and hospitals (7). A few other entities mentioned included CMS, day care

providers, foster care organizations, libraries, mental health organizations, and the YMCA (**Table 6**).

#### **Community Stakeholder Relationships**

##### **Positive Relationships**

Over two-thirds of the practices gave examples of entities in the community with whom it was easiest to interact. Ten of these practices felt they had good communication and relationships with specialists, but a few (3) clarified that this was unique to certain specialties (e.g. pulmonology (2), psychology, radiology, and cardiology) and not others. Other entities mentioned less frequently included hospitals, foster care organizations, and schools.

*“The specialists are fairly easy to communicate with ... Some definitely more than others.”*

*“Our psychologist will call, we have really good, they’ll call us and say, and tell us what we need to do.”*

*“The schools, I have a good relationship with the schools, but I’m on their advisory board.”*

##### **Difficult Relationships**

Three quarters of practices gave examples of entities in the community that were most difficult to interact with. The

most frequently mentioned entities were certain specialists (7), hospitals (3), schools (2), and CMS (2). Specific specialties with poor communication included dermatologists (2), psychologists/psychiatrists (2), endocrinologists, and urologists.

Some practices discussed insurance issues (3), lack of time, and communication limited to only doctors as being barriers to good communication with these entities.

*“School nurses ... sometimes the things they expect from my*

*patients and the things they expect from me are difficult to accommodate.”*

*“It’s not the specialists; it’s more the insurance companies ... They regularly change their formulary and it’s frustrating.”*

Table 6. Medical Home Community	
COMMUNITY MEMBERS	PRACTICE RESPONSES
Specialists	<p>12/16 Practices</p> <p><b>Positive Relationships</b>            “They make themselves available and they usually have a representative like our pulmonologist sleep medicine doc has a guy that comes around here on a regular basis and says ‘Is there anything you need.’”</p> <p><b>Challenging Relationships</b>            “Yeah, we have problems with some of our outlying specialists. It is like pulling teeth to get information. It’s a bit challenging, I have to say.”</p>
Schools	<p>11/16 Practices</p> <p><b>Positive Relationships</b>            “I mean we’ve always been very open. I’ve invited, I’ve had school meetings here. I’ve had a meeting where I had the principal and three educators from one school for one kid all met with me here; we were trying to figure out what we were going to do with her, and they were very open to that.”</p> <p><b>Challenging Relationships</b>            “And the schools are really ... We don’t have a whole great relationship cause there’s like 8 gazillion schools; they all have their different policies and procedures.”</p>
Hospitals	<p>11/16 Practices</p> <p><b>Positive Relationships</b>            “I mean I would say [*hospital], the children’s hospital is relatively easy to deal with ... things have changed pretty significantly there in the last five or ten years.”</p> <p><b>Challenging Relationships</b>            “Hospitals I think are the worst. I mean they’re really bad. Well because I mean that’s the problem. If somebody else admits our patient and no one calls us and then the mother comes and says ‘I was in the hospital for a week’ and it’s very embarrassing. Nobody called us. How did we not know? ‘You didn’t see my child.’ We weren’t aware.”</p>

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### **Impact of Community Coordination with Stakeholders**

Six practices perceived that these interactions affected stakeholders and most were able to give specific examples or stories. The most commonly discussed examples included positive effects on patients and achieving wider recognition in the community, as well as in the local government or even global attention.

#### Patients

*“The biggest success I’ve had was, it took me 15 months, but I got one of our kids who’s got Prader-Willi into the [\*Hospital]. And it was a lot of the, like the head of the*

*pediatric ICU helped me, the pulmonologist helped, Dr. [Core Team Member] helped. It took us a while but we got him there, so that was the big thing.”*

*“I’m really proud of our community resource, and here in the office, you know, we put together an Excel sheet and labeled each sheet of the Excel file you know like ‘neuropsychologists,’ ‘asthma resources,’ ‘ADHD resources,’ ‘autism resources’ and on that page is everything locally that’s there. We load it on the computer down there and then that way the MAs can just if I say ‘Hey can you print out that asthma resources sheet’ they just print it out and we give it right to the parent there. So that’s been nice.”*

#### Recognition

*“And [name] pointed that out at the last - or maybe it was six months ago or so - at the regional or the Northeast Florida Pediatric Society meeting that we were the only practice [at the meeting to participate in the Florida Medical Home demonstration project]. So I think it helped elevate the stature of our practice in the community in general.”*

*“I think there’s greater awareness of our practice in the community and a greater awareness of our investment in that as well.”*

# 4 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 and this may impact staff in a minimal way. Alternatively, practices might move away from a physician-led 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 surveys were administered between September and November 2013. All staff members, including physicians, were invited to participate in the staff survey, regardless of their position. 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. Only staff at the 16 practices participating in the second phase of the QI project were surveyed in year three.

Four hundred and sixty-two surveys were distributed, and 189 were returned. Twenty-eight percent of respondents were physicians (doctor of medicine (MD)/doctor of osteopathic medicine (DO)/ physician assistant (PA)/nurse practitioner (NP) or residents), and 71% were non-physicians (nursing staff, front office/administrative staff, social workers, medical records, etc.)<sup>ii</sup>. Across practices, the average response rate was 47%, with a minimum response rate of 0% and a maximum response rate of 100%.

When interpreting the practice staff survey; results the reader should be aware of the following:

- Year three scores are delineated by respondent type as follows: (a) staff who are physicians and (b) staff who are non-physicians.
- Year three scores are compared against baseline national benchmark data where available.

- Cross-sectional data for each survey year are reported for all respondents, regardless if they participated in the survey in only one of the three survey years<sup>iii</sup>.
- Wherever the sample size permits<sup>iv</sup>, analyses were undertaken at the individual practice level as well as at the aggregate level across practices.
- Aggregate results are presented for 15 practices in year three, 16 practices in year two, and 20 practices in year one.
- Significant results are reported based on a two-tailed test at the  $P < .05$  level.

## Adaptive Reserve

All staff members were asked the same adaptive reserve items from the TransforMED Practice Environment Checklist as the core clinical team. Analyses and reporting methods for the 23-item adaptive reserve scale have been described previously in this report (see page 17).

<sup>ii</sup>Twelve respondents did not answer the question used to classify staff into physician and non-physician staff.

<sup>iii</sup>Practice staff was surveyed in years one, two, and three. Responses were tracked over time using a personal identification number (ID). Per the UF's IRB instructions, practice staff generated their own ID (first initial of their name; last four digits of their telephone number) and retained their ID on a postcard for future reference. The number of IDs that linked across years was less than 21%, either due to staff turnover (18% of respondents report that they have worked at a demonstration practice for less than one year), issues related to remembering the ID number, or lack of interest. As a result, the Institute has compared practice-level results across years instead of individual-level results.

<sup>iv</sup>Practice size varies across demonstration practices, ranging from 4 to 125 staff members with a median of 16 staff members per practice.

## Key Findings

- The mean practice adaptive reserve score reported by all staff members in year three (0.63) is consistent with year two levels ( $P > 0.05$ , **Figure 16**); and remains below the national benchmark (0.69).
- In all three years, non-physician staff report a significantly lower adaptive reserve score than physicians ( $P < 0.05$ , all years).
- At the individual practice level, one practice showed a statistically significant

increase in their adaptive reserve scores for all staff members between years two and three ( $P < 0.05$ ).

## Practice Environment

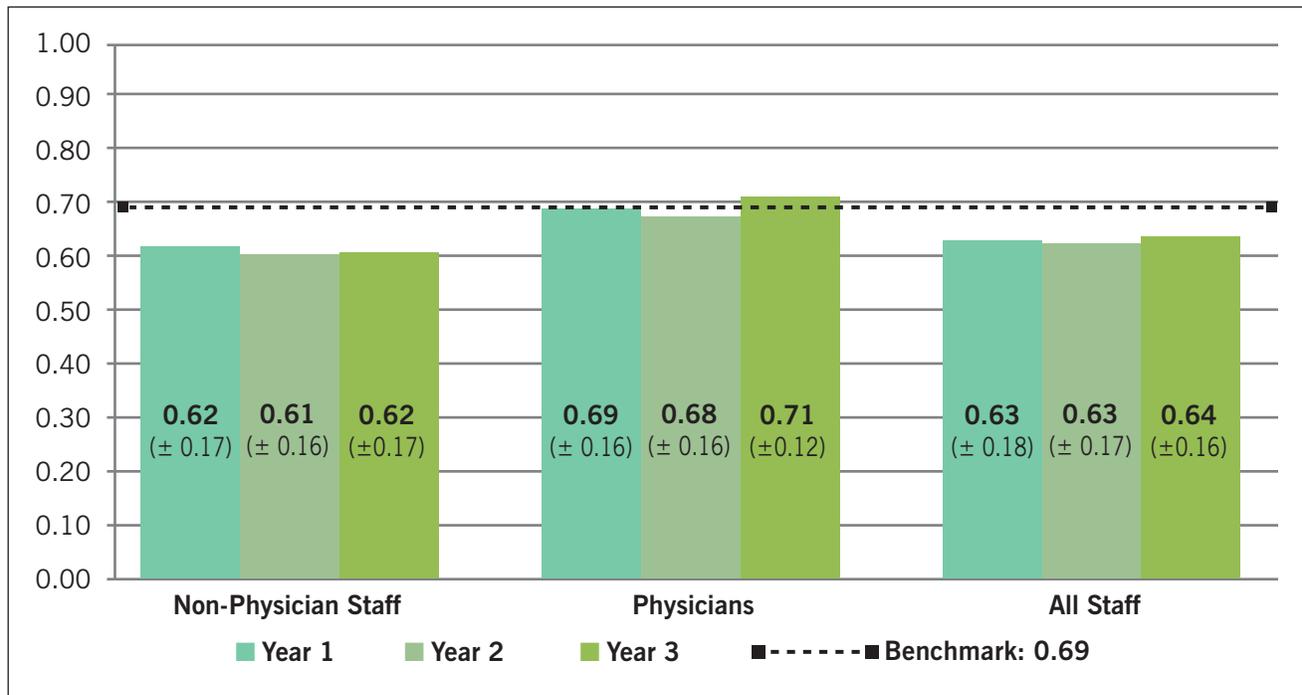
All staff members were asked to respond to the same practice environment items from the TransformMED Practice Environment Checklist as the core clinical team. Analyses and reporting methods are identical to those described in the core clinical team section of this report (see page 17). There are no benchmarks for the practice

environment scores.

## Key Findings

- As seen in year two, all staff rate their practices highest for cultural sensitivity\*\*, followed by community knowledge, patient safety culture, and HIT integration in year three (**Figure 17**).
- Of the four practice environment factors, there are no statistically significant differences in total scores between years two and three ( $P > 0.05$ )\*\*.

**Figure 16. Staff Adaptive Reserve Score ( $\pm$  SD), by Year and Staff Type**



\*\* Cultural sensitivity significantly increased from year two to year three, but only in a one-tailed test at the 5% level.

- In all three years, physicians rate their practice's cultural sensitivity significantly higher than non-physician staff ( $P < 0.05$ ), but do not significantly differ with respect to community knowledge nor HIT integration. This is the first year that physicians rate their practice's patient safety culture significantly higher than non-physician staff ( $P < 0.05$ ).
- At the individual practice level, two practices report significant changes in their practice environment scores

for all staff members for year three compared to year two ( $P < 0.05$ ). Cultural sensitivity scores increased for one practice, and the patient safety scores increased for the other practice.

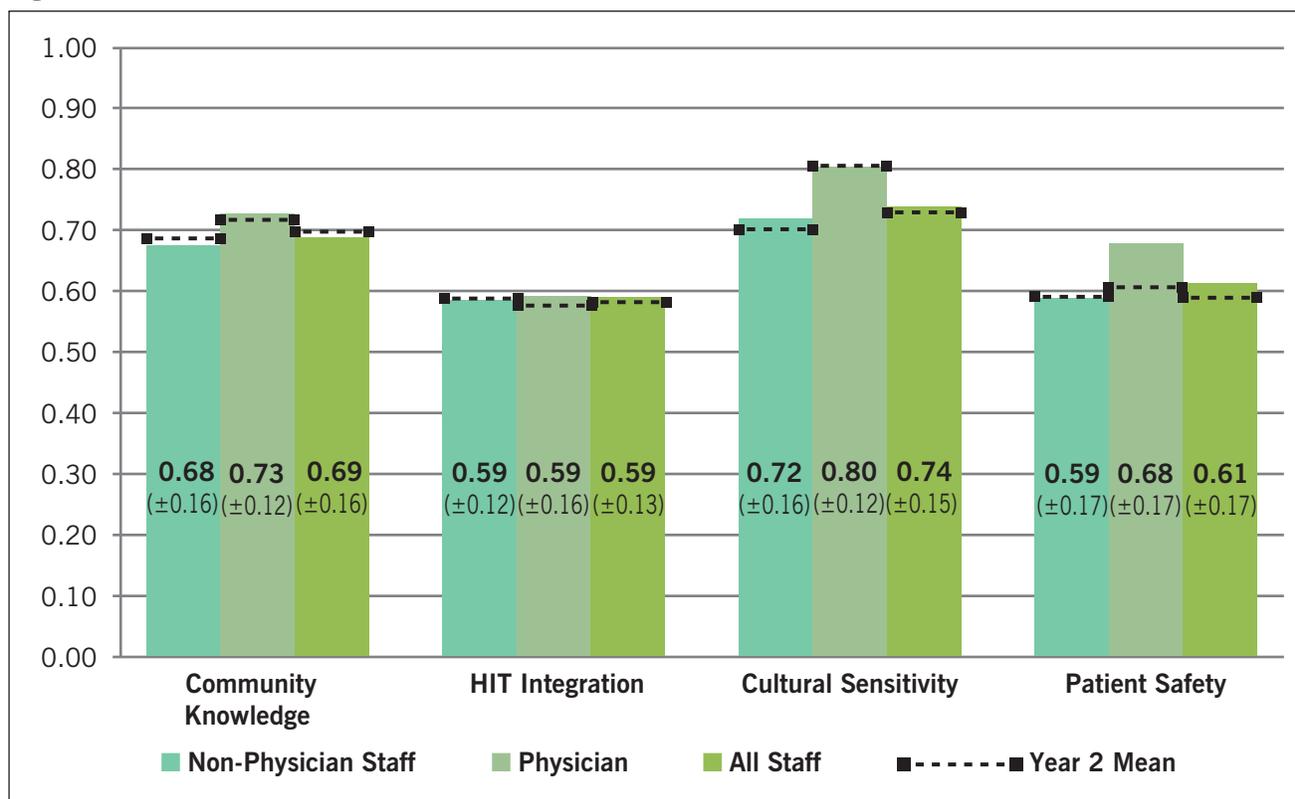
### Job Satisfaction

Practice transformation to a PCMH is hard work and 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>18</sup>. A 2012 review noted that greater job satisfaction has been linked to improved patient care, greater adherence to treatment regimes, and more QI activities for physicians<sup>19</sup>. Therefore, monitoring these phenomena over time is an important evaluation component in Florida's project.

Warr's 10-item job satisfaction scale was included on the staff surveys<sup>20</sup>. Items cover factors ranging from work hours to peers. All items are rated on a

Figure 17. Staff Practice Environment Mean Scores ( $\pm$  SD)



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>20</sup> and from 5.0 to 5.6 for some physician studies<sup>21, 22</sup>.

### Key Findings

- Of the 10 items, non-physician staff rate their physical

working conditions as the best facet of their job, while physicians are most satisfied with their colleagues/fellow workers (**Table 7**). For the last three years, both physician and non-physician staff report being least satisfied with their remuneration.

- Non-physician staff rate their satisfaction significantly lower than physicians for six of the 10 items ( $P < 0.05$ ); there are no statistically significant differences between the two groups for hours of work, their colleagues and fellow workers, physical working conditions, and freedom to choose working method ( $P > 0.05$ ).

- In year three, both physician and non-physician staff combined have a 10-item mean score of 5.33 ( $\pm 0.94$ ) indicating that they are still satisfied with their working conditions (**Figure 18**). This score has increased slightly from year two to year three, but not significantly ( $P > 0.05$ ).
- At the individual practice level, no practices reported any statistically significant changes ( $P < 0.05$ ) in their mean job satisfaction scores for all staff members between years two and three.

**Table 7. Year 3 Job Satisfaction Change Scores by Staff Type**

JOB SATISFACTION	NON-PHYSICIAN STAFF		PHYSICIANS	
	SCORE	CHANGE	SCORE	CHANGE
Physical working conditions	5.53	+0.01 ↑	5.80	-0.03 ↓
Freedom of working method	5.43	-0.01 ↓	5.48	-0.03 ↓
Colleagues and fellow workers**	5.35	-0.12 ↓	6.14	-0.05 ↓
Recognition of work**	4.70	+0.04 ↑	5.56	+0.25 ↑
Amount of responsibility**	5.27	-0.04 ↓	5.80	-0.01 ↓
Remuneration	4.64	+0.31 ↑	5.08	+0.01 ↑
Opportunities to use abilities**	5.26	-0.21 ↓	5.70	-0.23 ↓
Hours of work	5.48	-0.05 ↓	5.14	-0.10 ↓
Amount of job variety**	5.20	-0.01 ↓	5.92	-0.05 ↓
Global job satisfaction item**	5.33	+0.06 ↑	5.92	+0.09 ↑

\*Arrows denote the movement in mean scores from year two to year three.

\*\*Job satisfaction items differ significantly between staff type.

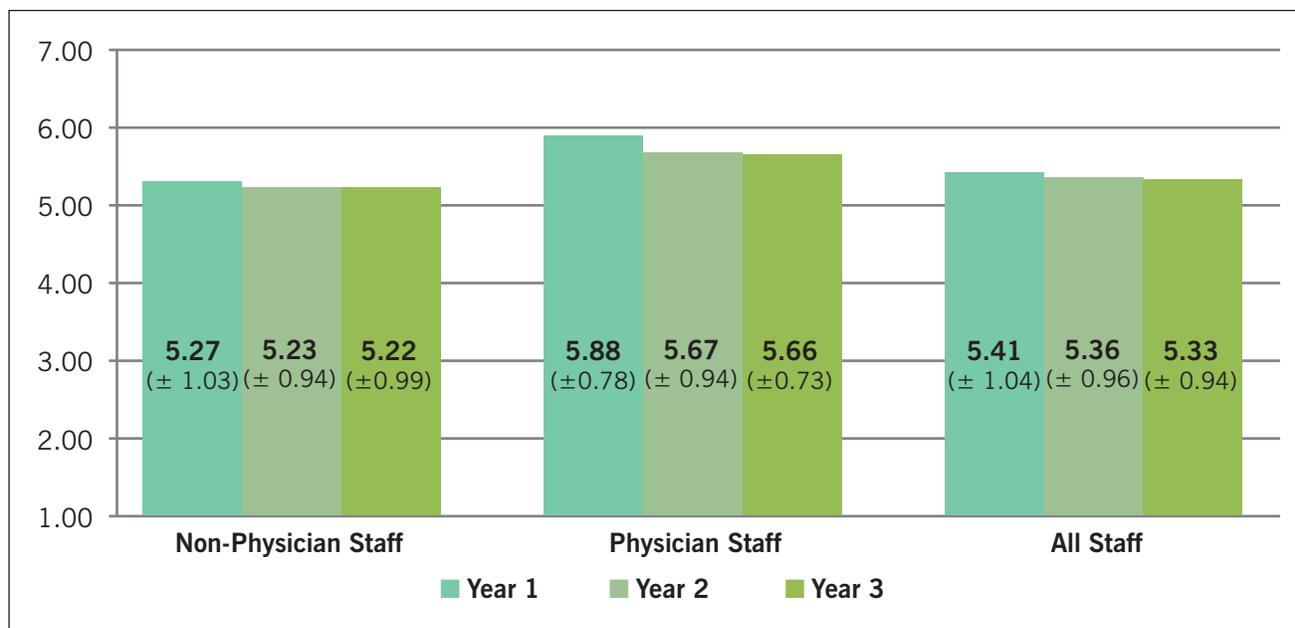
## Job Burnout

Job burnout was assessed on the staff survey by the Maslach Burnout Inventory – General Scale (MBI-GS). Workers experiencing burnout may be characterized by exhaustion or cynicism, and can be 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>23</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. Staff were 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 8**. 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>23</sup>.

**Figure 18. 10-Item Mean Job Satisfaction Scores ( $\pm$  SD), by Year and Staff Type**



**Table 8. 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

## Key Findings

- As seen in year two, physician and non-physician staff report average burnout levels of exhaustion, cynicism, and professional efficacy in year three (**Table 9**). There were no statistically significant changes for any of the three job burnout measures in year three ( $P > 0.05$ ).
- Although not shown here, physicians report statistically significant higher rates of exhaustion than non-physician staff ( $P < 0.05$ ). There are no statistically significant differences between physician and non-physicians' burnout scores in year three for cynicism or professional efficacy ( $P > 0.05$ ).
- At the individual practice level, one practice showed a statistically significant increase in their professional efficacy score from year two to year three ( $P < 0.05$ ).

## Practice Staff Engagement

Similar to the practice survey, this year's staff survey incorporated new questions intended to measure the level of practice staff engagement with the medical home initiative. These questions measure internal practice communication about the project, and understanding of the medical home concept among staff. Staff were asked to respond to items regarding staff engagement on a five-point Likert scale (1=strongly disagree to 5=strongly agree). Staff were also asked whether or not the medical home project has improved their jobs on a five-point Likert scale (1=much worse to 5=much better).

### Key Findings

- Sixty-one percent of all staff report that they know who their medical home representatives are in the practice. There are no

statistically significant differences between physicians and non-physicians for this measure ( $P > 0.05$ ).

- Frequent and good communication was the only medical home communication measure that had more than 50% agreement from all staff, showing there is room for improvement, especially for non-physician staff (**Figure 19**).
- Physicians indicate significantly higher levels of program communication and understanding than non-physician staff for two of the four measures ( $P < 0.05$ ). For instance, 54% of physicians report there was a specific time set aside for medical home training, compared with one-third (36%) of non-physician staff (**Figure 19**).
- The majority of staff (62%) report that the medical home project has resulted in no change to their job

**Table 9. Staff Job Burnout**

BURNOUT DOMAIN	STAFF MEAN ( $\pm$ SD)	BURNOUT RATING
Exhaustion**	2.29 ( $\pm$ 1.35) (-0.25 ↓)	Average Burnout
Cynicism	1.25 ( $\pm$ 1.13) (-0.03 ↓)	Average Burnout
Professional Efficacy	4.79 ( $\pm$ 0.92) (-0.11 ↓)	Average Burnout

\*Arrows denote the movement in mean scores from year two to year three.

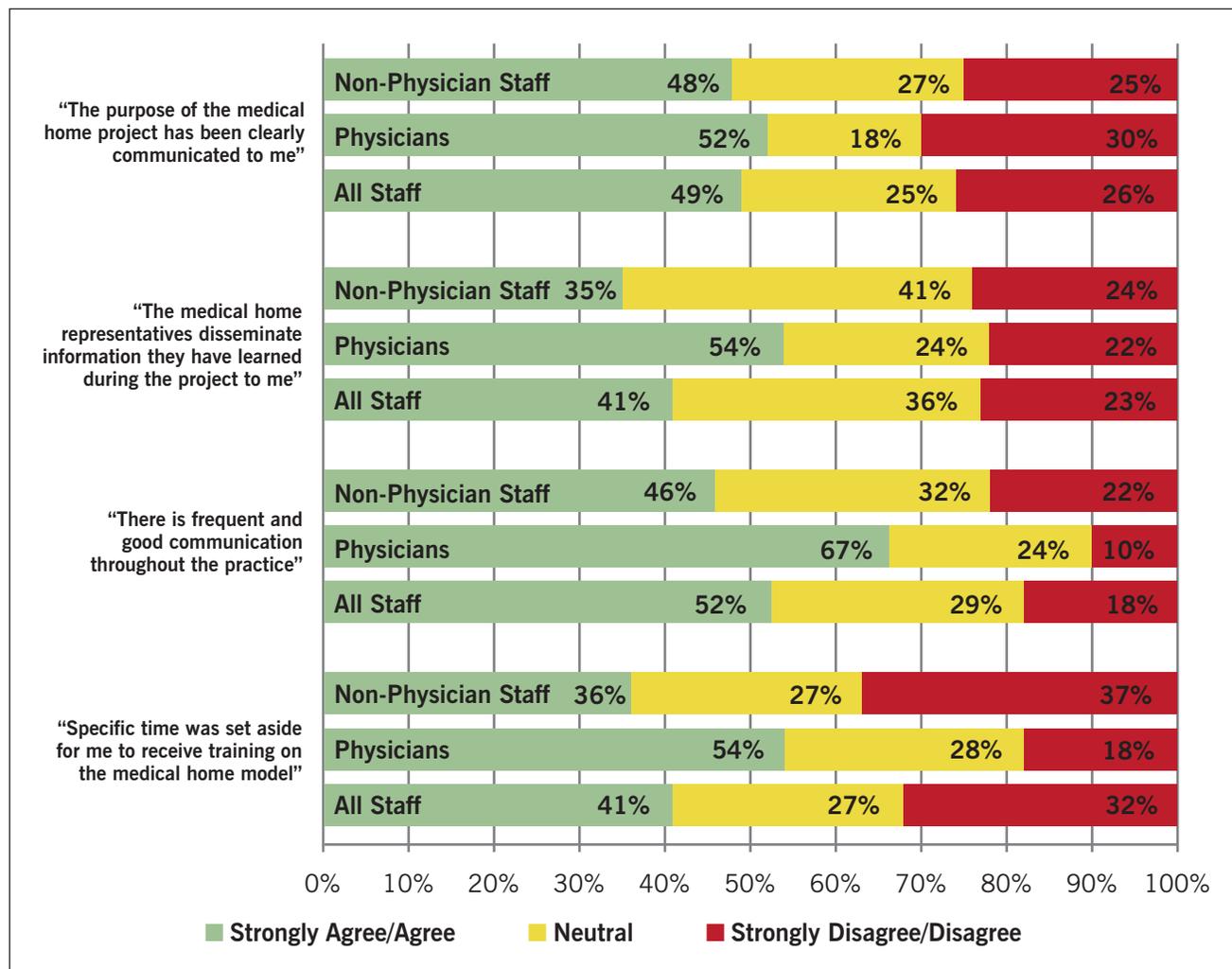
\*\* Exhaustion significantly decreased from year two to year three but only in a one-tailed test at the 5% level.

satisfaction (Figure 20); thirty-two percent report that their jobs are slightly or much better as a result of the project. There are no statistically significant differences between physicians and non-physicians for this measure ( $P > 0.05$ ).

■ Around one-half of all staff members agree that they understand their role in the project and are enthusiastic about the medical home initiative (Figure 21). Physicians report significantly higher levels of enthusiasm about the project than non-physician staff ( $P < 0.05$ ).

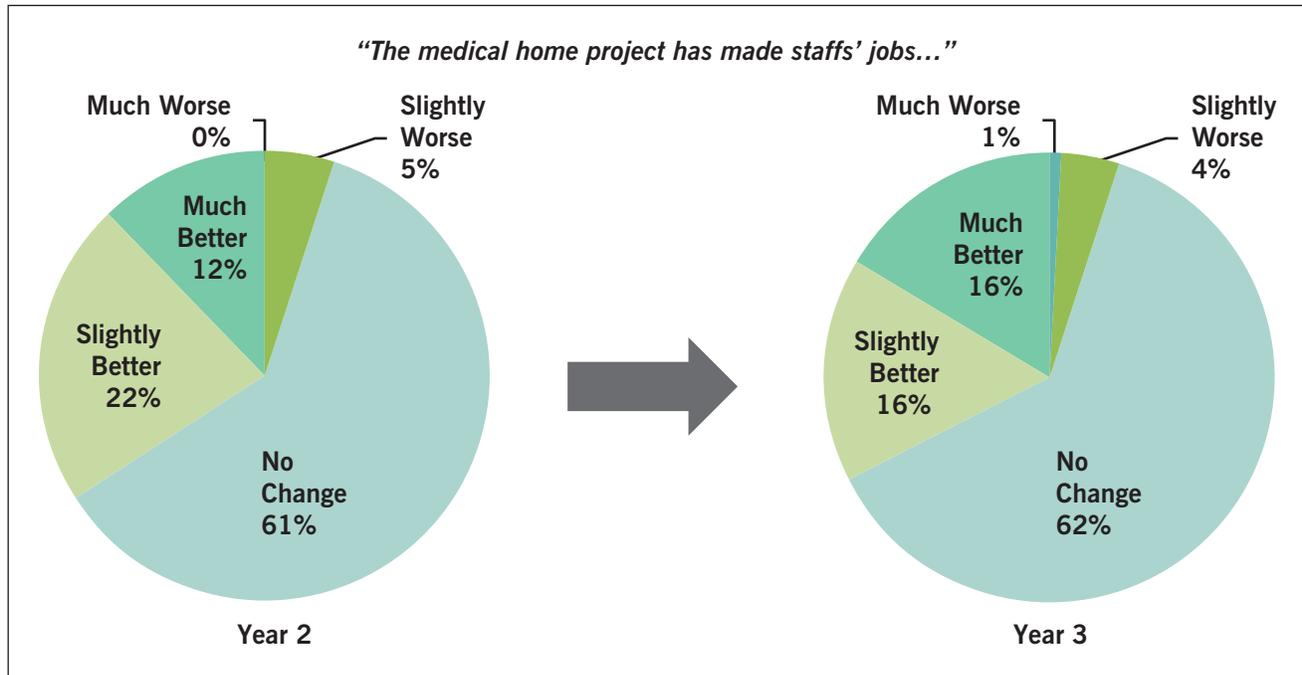
■ One-third of all staff members agree that they know very little about the medical home project (Figure 21). There are no statistically significant differences between physicians and non-physicians for this measure ( $P > 0.05$ ).

Figure 19. Staff Perceptions of Communication with Medical Home Representatives\*



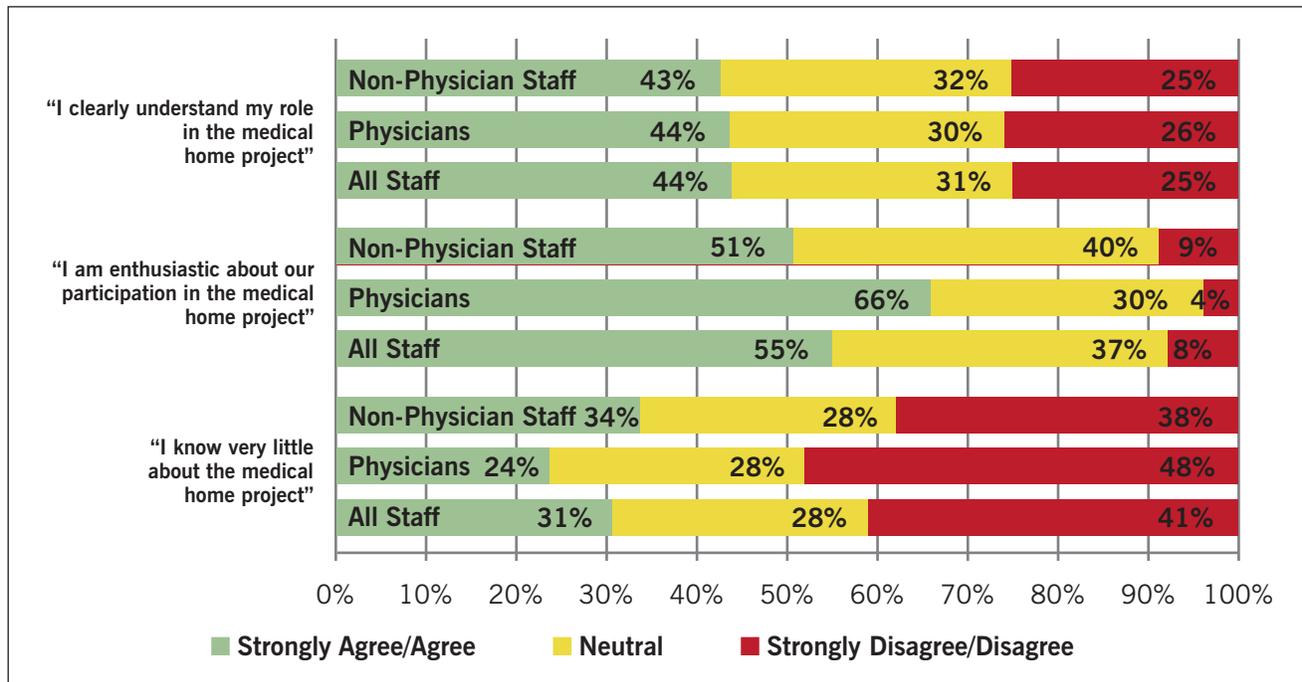
\*Totals may not equal 100% because of rounding.

Figure 20. Staff Perceptions of Job Satisfaction\*



\*Totals may not equal 100% because of rounding.

Figure 21. Staff Perceptions of Medical Home Project Engagement



# 5 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>24</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<sup>v</sup> and the Florida Healthy Kids Corporation. Children who saw a listed provider during the time period of 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>vi</sup>. The goal was to target 50% CSHCN, but not all practices had sufficient sample sizes.

Telephone surveys with families were conducted from September to November 2013. Parents completing the survey in the third year received a \$20 gift card of their choice to either Starbucks or Wal-Mart. The increase in monetary compensation (the incentive was \$15 in years one and two) was to bolster participation and cooperation.

Due to expected attrition, a demonstration replacement group was obtained using the

same process as the original demonstration group. An analysis of the demographics of the families who dropped out after year 2 showed that they did not share any specific characteristics. Therefore, children for the replacement group were again randomly selected from children who saw a listed provider during the time period of July 1, 2012 to June 30, 2013.

### 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>25</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

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

the best-matched sample first, before release of second-tier matches.

Telephone surveys were conducted with families from December 2013 to February 2014 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.

As with the demonstration group, a control replacement group was needed and surveyed from February 2014

to April 2014.

### Response Rates

Florida’s goal was to obtain 50 completed surveys for each demonstration practice, or 1,000 overall. Both the demonstration and control groups had 990 families participate in year one. In year two, the number of families participating in the demonstration group parent survey totaled 906 and 915 for the control group. In year three, the number of families participating in the demonstration group parent survey totaled 863, with 532 original participants and 331 replacement participants. For the control group, 864 participants were surveyed, with 608 returning families and an

additional 256 replacement families surveyed. Using American Association for Public Opinion Research guidelines<sup>26</sup>, response and cooperation rates were calculated for all four groups (**Table 10**).

Statistical tests reveal that the demonstration and control groups do not differ in the child’s race/ethnicity characteristic (**Table 11**). Statistically significant differences were observed in the child’s gender and insurance ( $P < 0.01$ ). Because the demonstration and control groups differ by gender and insurance, it is possible some of the observed differences between the groups presented are a result of differences in the characteristics of the sample and not necessarily actual differences between the two groups.

Table 10. Year 3 Response and Cooperation Rates			
	PARTICIPANTS	RESPONSE RATE	COOPERATION RATE
<b>Demonstration Group</b>			
Original Cohort	532	76.1%	92.8%
Replacement Cohort	331	32.2%	63.2%
<b>TOTAL</b>	<b>863</b>		
<b>Control Group</b>			
Original Cohort	608	79.4%	93.1%
Replacement Cohort	256	35.6%	58.0%
<b>TOTAL</b>	<b>864</b>		

## CAHPS

The CAHPS-PCMH is an expanded version of the existing Clinician and Group CAHPS (CG-CAHPS) Survey<sup>27</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>28</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>vii</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)

**Table 11. Representativeness of the Matched Control Group**

	DEMONSTRATION GROUP RESPONDERS (N= 863)		CONTROL GROUP RESPONDERS (N= 864)		SIGNIFICANCE
	N	%	N	%	
<b>Child's Gender</b>					
Male	413	47.9%	480	55.6%	S
Female	450	52.1%	384	44.4%	
<b>Child's Race/Ethnicity</b>					
Black non-Hispanic	181	22.0%	157	18.2%	NS
White non-Hispanic	215	26.1%	257	29.8%	
Hispanic	177	21.5%	189	21.9%	
Other or Unknown	250	30.4%	261	30.2%	
<b>Child's Insurance</b>					
Medicaid	676	78.3%	733	84.8%	S
CHIP	187	21.7%	131	15.1%	
% Special Health Care Needs	249	28.9%	319	36.9%	S

NS= Not Significant  
S= Significant

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

- 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 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 in Taking Care of Your Own Health', being 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 12**). The last three

Table 12. CAHPS Composite Measures (Always, Usually, Sometimes, Never)	
CAHPS COMPOSITE MEASURES	
<b>Getting Timely Appointments, Care and Information</b>	<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>
<b>Doctor-Patient Communication</b>	<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>
<b>Courteous and Helpful Office Staff</b>	<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," and "Never."

CAHPS composites ask parents to respond whether or not (*yes, no*) they receive provider support and anticipatory guidance (**Table 13**). 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>27</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>29</sup>. The CG-CAHPS data include children who are commercially and publicly insured. CAHPS-PCMH benchmark data for publicly-insured children are not currently available.

**Table 13. CAHPS Composites Measures (Yes/No)**

<b>CAHPS COMPOSITE MEASURES</b>	
<b>Child's Growth and Development</b>	<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>
<b>Child's Health and Safety</b>	<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>
<b>Provider's Support in Taking Care of Your Own Health</b>	<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>

## CAHPS Core Composites (Always, Usually, Sometimes, Never)

### Overview

Parents are asked to respond how often (*always, usually, sometimes, never*) a given health care experience occurs (Table 12).

### Key Findings

- Over 80% of parents report they are always or usually satisfied with both the timeliness of the care they receive, as well as the

courteousness of the office staff (Figure 22).

- Over 90% of parents report they are always or usually satisfied with doctor-patient communication.
- Higher percentages of parents in the control group reported being always or usually satisfied with timeliness of care, doctor-patient communication, and courteousness of staff.
- Parents in the control group surpass the 2010 benchmark in the “Courteous and Helpful Office Staff” composite.

## CAHPS Core Composites (Yes/No)

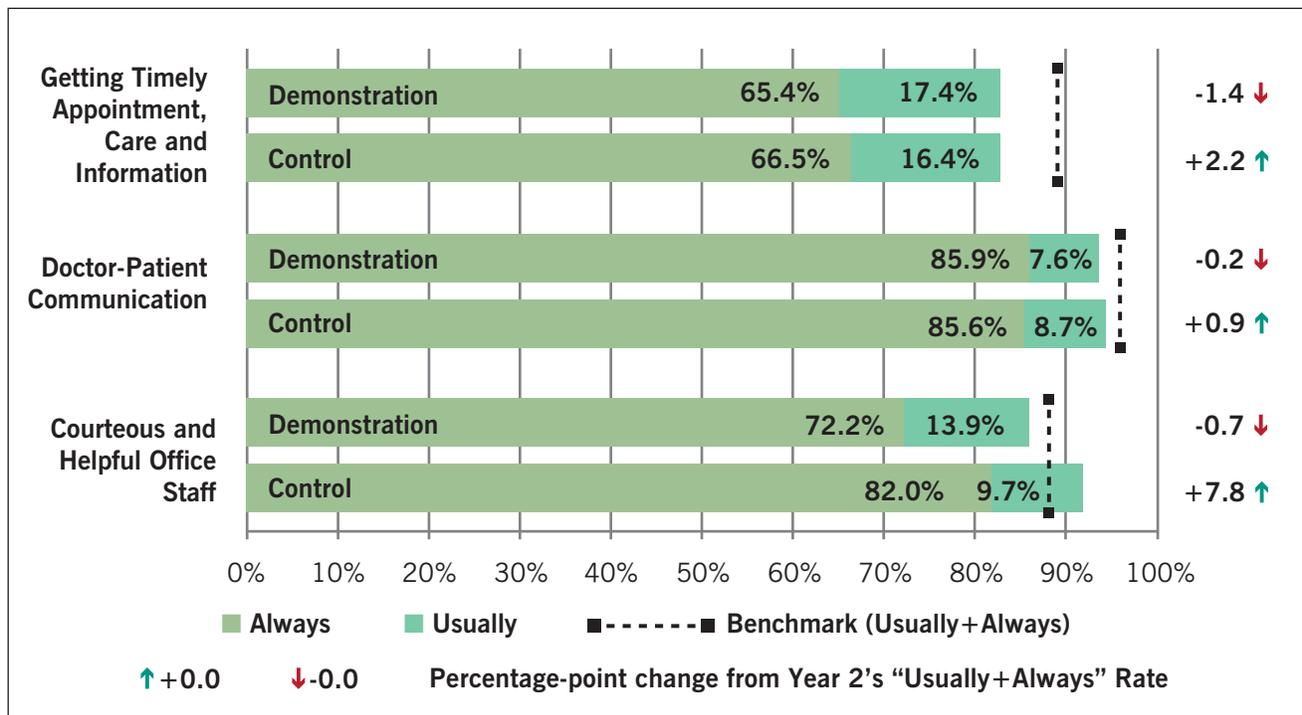
### Overview

Three CAHPS composites relate to provider support and anticipatory guidance as detailed in Table 13. Parents are asked to respond yes or no to a series of questions. Benchmark data are not currently available.

### Key Findings

- More than one half of parents, in both the demonstration and control groups, report that

Figure 22. CAHPS Composites (Always, Usually, Sometimes, Never)



providers offer anticipatory guidance on their child's growth and development, as well as their child's health and safety (Figure 23).

- Parents were more likely to answer 'no' to their child's doctor being supportive in them taking care of their own health.
- The demonstration group reports a higher level of satisfaction compared to the control group across all of the CAHPS Core Composites and among each group of parents.

### Single-Item Measures: Attention To Care From Other Providers

#### Overview

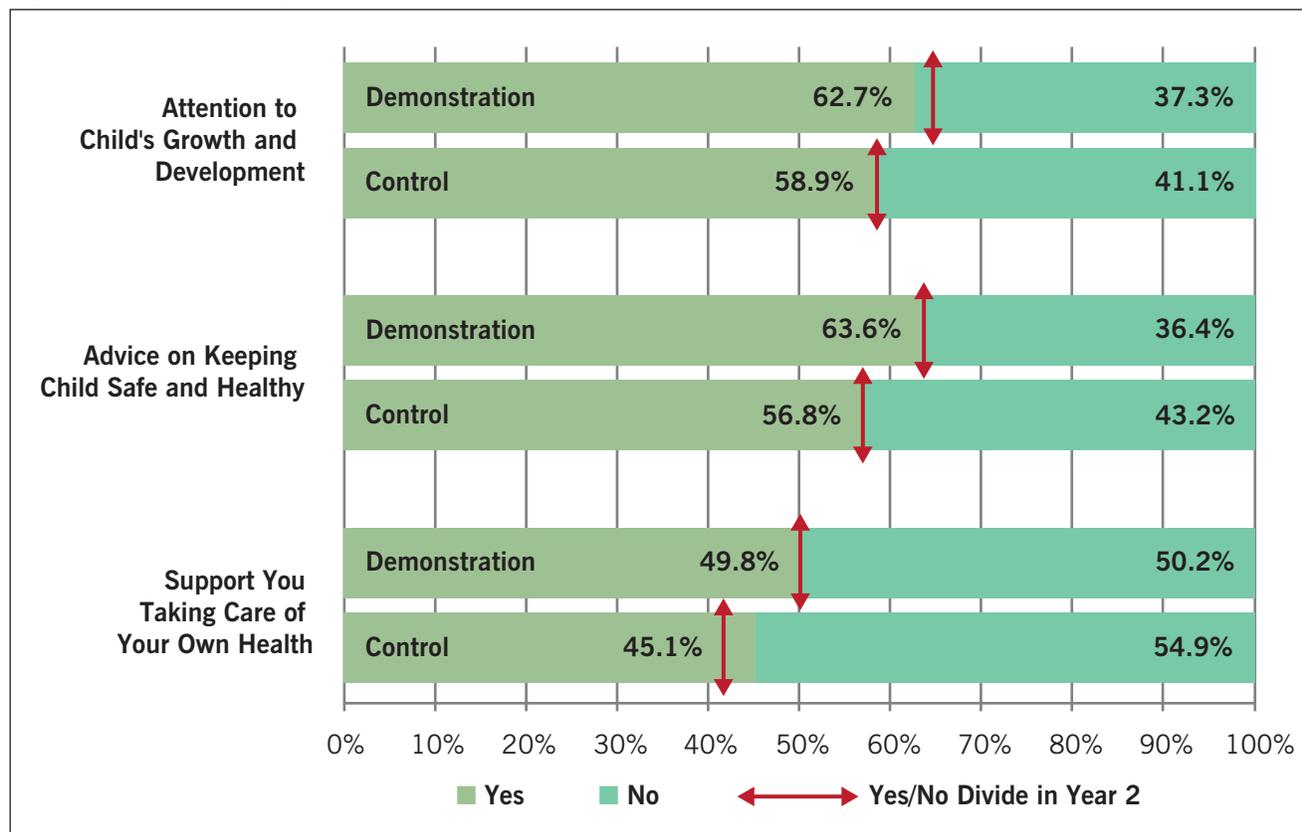
Three questions are asked that relate to provider's attention to care from other providers.

- 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 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*).

Figure 23. CAHPS Composites (Yes/No)



## Key Findings

- More than three quarters of parents in both the demonstration and control groups report their child’s provider is always or usually up-to-date with specialist care, follow-up test results and prescription medicines (Figure 24).
- The demonstration group rates all three categories more favorably than does the control group.
- Compared to year two, the demonstration group had the

highest increase in their providers being up-to-date with specialist care, while the control group had the highest increase in their providers always or usually talking about the child’s prescription medications.

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

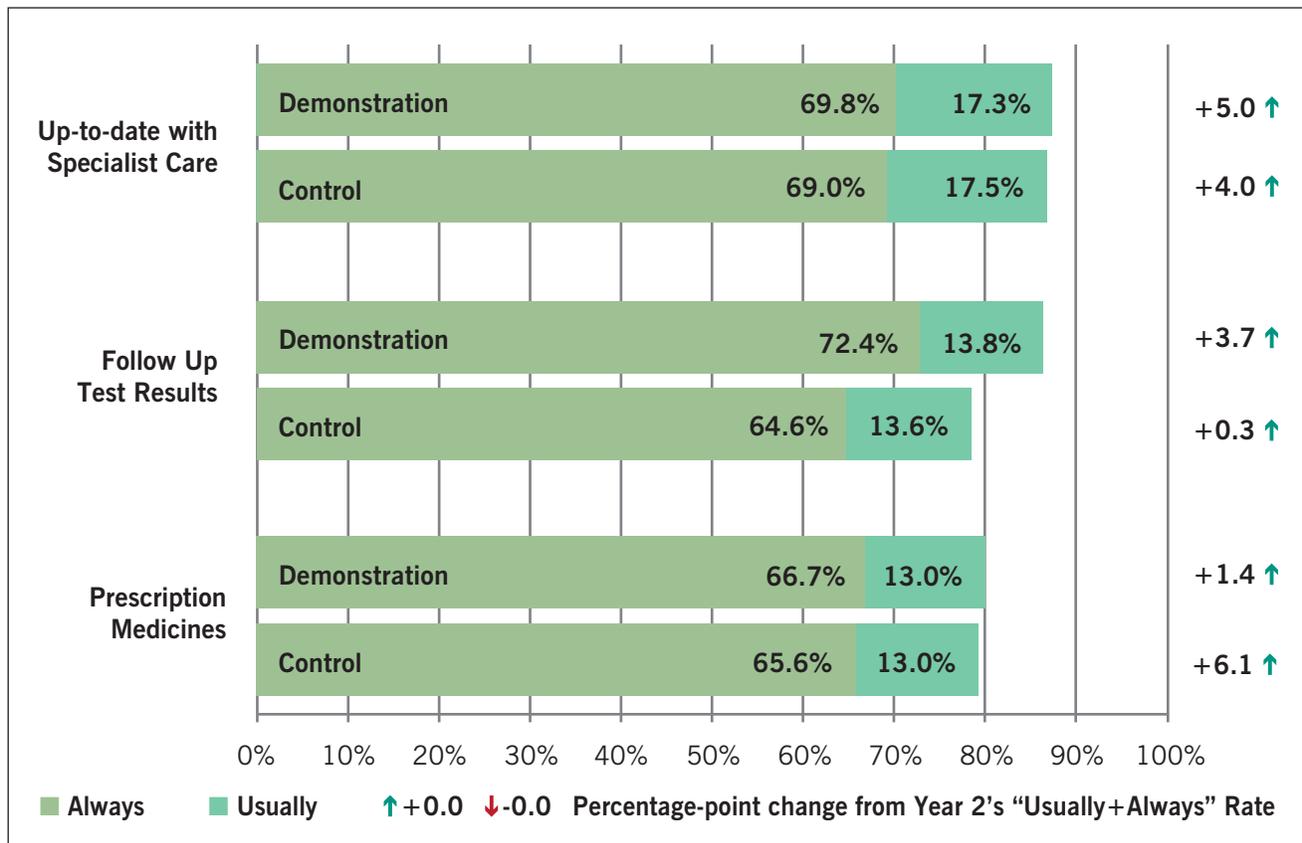
### Overview

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

Figure 24. Attention to Care From Other Providers



### Key Findings

- Over 87% of parents in the demonstration and control groups report that they are given information about after-hours care (Figure 25).
- Over 65% of parents in both the demonstration and control groups report that they receive reminders between visits.
- The demonstration group rates both information about after-hours care and patient reminders more favorably than does the control group.
- Compared to year two, both the demonstration and control groups had an increase in positive responses to receiving information about after-hours care in year three; however,

responses for receiving patient reminders were lower in year three for both the demonstration and control groups as compared to year two.

### Single-Item Measures: Access To Care

#### Overview

Two questions are asked that relate to access to care.

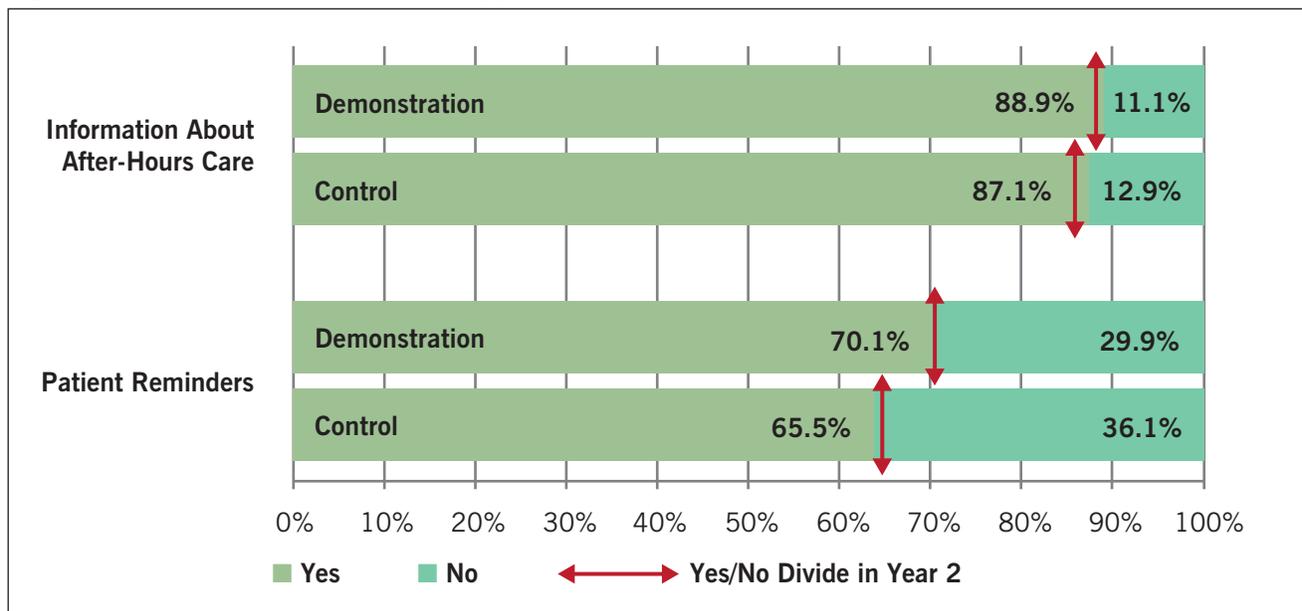
- In the last 12 months, how often were you able to get the care your child needed from this provider's office during evenings, weekends, or holidays? (*Always, Usually, Sometimes, Never*)
- In the last 12 months, how

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

- More than 65% of parents in both the demonstration and control groups report that they always or usually get care for their children on evenings, weekends, or holidays (Table 14).
- More than 60% of parents in both the demonstration and control groups indicate that they are able to get same day appointments, and at least 80% in both groups were able

Figure 25. Information About Care and Appointments



to get appointments the same day or next day.

- Access to same day appointments declined in the demonstration group, and stayed the same for the control group.
- Compared to year two, in year three, more parents in the demonstration group report having to wait more than seven days for an appointment.

## Provider Ratings

### Overview

Parents are asked to provide an overall rating of their child’s provider on a scale of 0 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

- Over 75% of parents in the demonstration group rated their child’s provider a “9” or “10,” while almost 72% of parents in the control group rated providers similarly (Table 15).
- Although both the demonstration and the control groups had increases in the “9+” category, both groups

**Table 14. Access to Care**

ACCESS TO CARE	DEMONSTRATION GROUP		CONTROL GROUP	
<b>After-Hours Care</b>				
Always	55.5%	+2.5 ↑	51.4%	+6.9 ↑
Usually	11.5%	+0.4 ↑	14.0%	-1.5 ↓
Sometimes/Never	33.0%	-2.9 ↓	34.7%	-5.3 ↓
<b>Appointment Wait Time</b>				
Same Day	63.8%	-3.8 ↓	66.0%	No Change
1 Day	21.5%	+3.1 ↑	20.0%	-0.6 ↓
2 to 3 Days	9.3%	-0.5 ↓	10.3%	-0.1 ↓
4 to 7 Days	2.4%	-0.3 ↓	2.8%	+1.0 ↑
More Than 7 Days	2.9%	+1.4 ↑	1.1%	-0.1 ↓

\*Arrows denote the percentage-point movement in scores from year two to year three.

**Table 15. Overall Provider Rating**

ACCESS TO CARE	DEMONSTRATION GROUP		CONTROL GROUP		BENCHMARK
6 or under	5.0%	+0.8 ↑	6.0%	-1.3 ↓	3.2%
7 or 8	18.9%	-1.3 ↓	22.5%	+1.0 ↑	19.0%
9 or 10	76.1%	+0.7 ↑	71.5%	+0.03 ↑	77.9%

\*Arrows denote the percentage-point movement in scores from year two to year three.

continue to fall short of the benchmark.

- The control group surpassed the benchmark by having more than 19% of parents rating their providers with a “7 or 8.”

## 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>30</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>30</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>30</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 are provided as a benchmark, where available<sup>31</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)
- Receives family centered care (7 items)
- No problems getting needed referrals (2 items)
- Usual sources for both sick and well care (5 items)

- Receives care coordination when needed (6 items)

## Key Findings

- Over 90% of parents in both the demonstration and control group report having a personal doctor or nurse; the demonstration group surpassed the Florida benchmark (Figure 26).
- Both the demonstration and control groups surpassed the Florida benchmark for having received family-centered care and no problems getting needed referrals.
- Although almost 80% of parents in the demonstration group report having a usual source for both sick and well care visits, this group declined in this component compared to year two.
- Compared to year two, both the demonstration and control group answered more favorably that they received care coordination when needed.

## 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 45<sup>th</sup> out of 51 states for the medical home composite measure (Figure 27)<sup>32</sup>.

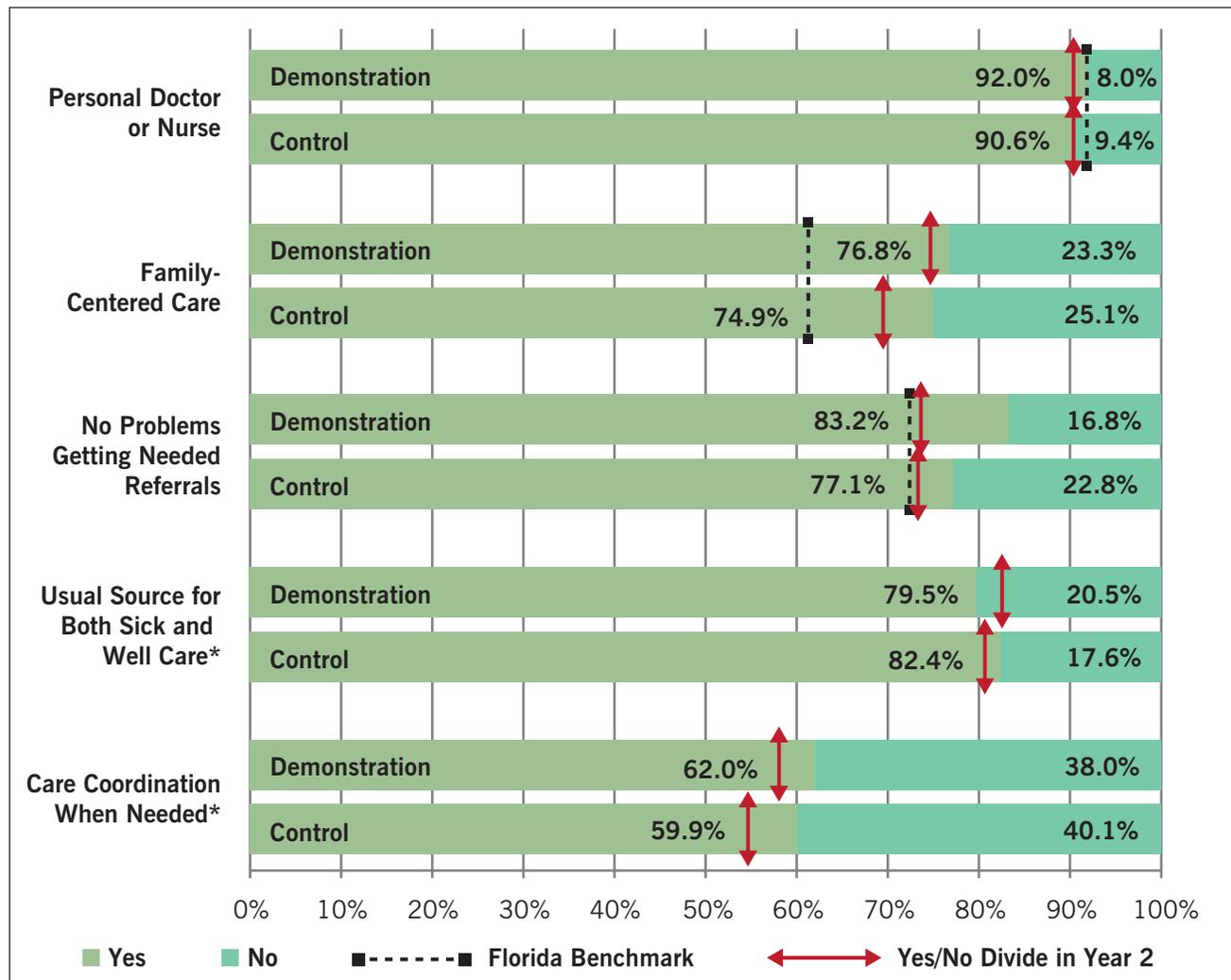
### Key Findings

- In year three, parents whose children are treated in Florida’s demonstration practices report that 56.5% of children meet the overall criteria for receiving ongoing, coordinated, and comprehensive care within a medical home (Figure 27).

Both the demonstration and control practices surpass the Florida benchmark by at least nine percentage points.

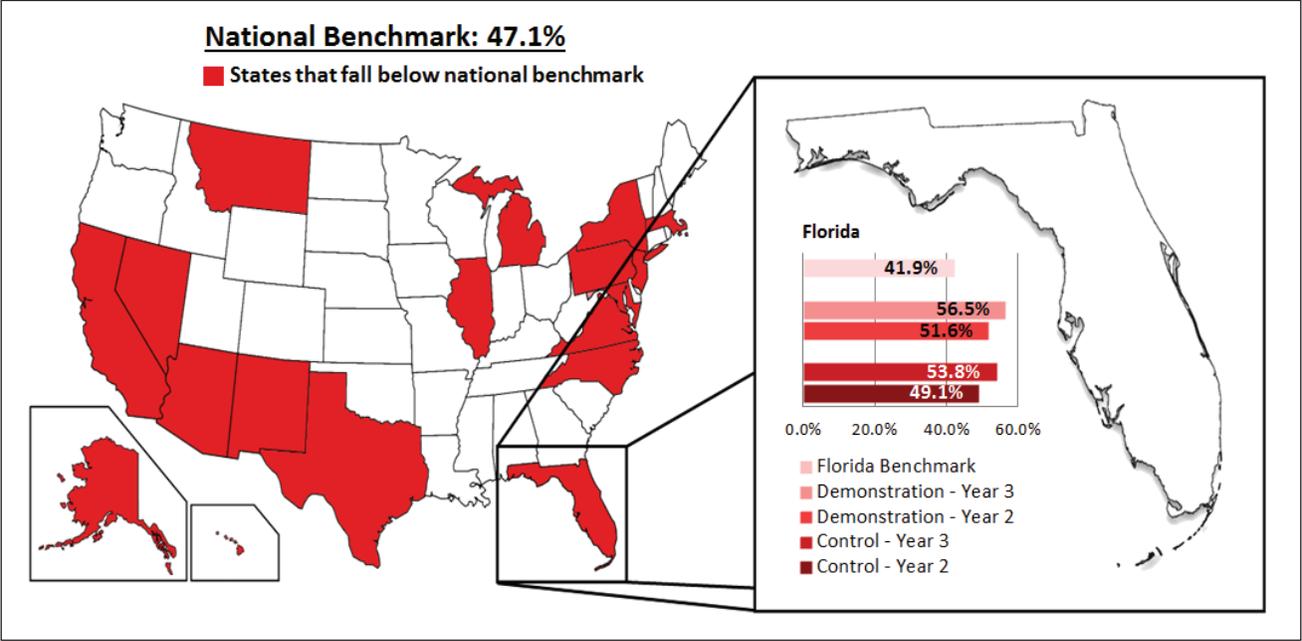
- Compared to year two, demonstration and control practices report improvements in regards to the overall medical home composite.

Figure 26. NS-CSHCN Sub-Components



\*Benchmark data are not available.

Figure 27. NS-CSHCN: Child Receives Ongoing Comprehensive Care in a Medical Home



# 6 Performance Measures

## Overview

In addition to implementing the PCMH as the provider-based model for Category C of the CHIPRA Quality Demonstration Grant, Florida was tasked with testing and refining a core set of 24 pediatric performance measures (Category A). The core set comprises measures from the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), alongside non-HEDIS measures.

In 2011, Florida reported 20 of the 24 core measures using administrative data, registry data, and medical record reviews. In 2012, and again in 2013, Florida reported 22 out of the 24 core measures using the

same data sources<sup>viii</sup>. Where the data were available, these measures were calculated for all children in KidCare, the umbrella organization for CHIP and Medicaid in Florida. The reader is referred to the CHIPRA Core Set Technical Specifications released by CMS<sup>33</sup> and the Institute’s report “Pediatric Performance Measurement in Florida’s CHIPRA Demonstration Grant”<sup>34, 35</sup> for further details.

This report describes a subset of 15 out of 22 of the CHIPRA core set – including both HEDIS and non-HEDIS measures. Seven measures are excluded in this report as data collection for these measures extended beyond the scope of this project. For excluded measures and the reason for their

exclusion, see **Table 16**.

These measures are derived from administrative data and can be used as an additional tool to gauge transformation success to a PCMH. Aggregate results are presented for the 16 demonstration practices and a matched group of control children.

## Data Sources

### Demonstration Group

Demonstration 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 AHCA<sup>ix</sup> and the Florida

Table 16. Excluded Core Set Measures	
Measure	Exclusion Reason
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC: BMI).	Mandatory hybrid measure. Hybrid data collection is beyond the scope of this project.
Developmental Screening in the First Three Years of Life	
Annual Pediatric Hemoglobin (HbA1c) Testing and Control	
Pediatric Central-Line Associates Bloodstream Infection	
Ambulatory Care: Emergency Department Visits (AMB)	The denominator (member months) is not available.
Percent of Live Births Weighing Less than 2,500 grams	Derived from birth vital statistics registry data. Linking to birth vital statistics registry data is beyond the scope of this project.
Cesarean Rate for Nulliparous Singleton Vertex	

<sup>viii</sup>The remaining two original measures were not reported either because the technical specifications are yet to be finalized or, according to the federal government, the measure is already available in a different source and therefore, states do not need to take action.

<sup>ix</sup>Data supplied by the AHCA includes claims and encounters for children enrolled in Primary Care Case Management (MediPass), Fee-For-Service, Title XIX Children’s Medical Services Network (CMSN), and MediKids. Claims and encounter data are not available for children enrolled in Title XXI CMSN. Title XIX Health Plans (Health Maintenance Organizations and Provider Service Networks) encounter data are not used.

Healthy Kids Corporation. All children who saw a listed provider during calendar year 2012 were included.

### 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 special health care need or not. Nearest-neighbor propensity-score matching SAS<sup>®</sup> code was used to generate the matched control group<sup>36</sup>. Children must have used health care services during calendar year 2012. There were no statistically significant differences between the demonstration and control groups based on the five child characteristics of interest.

### HEDIS Measures

The Institute uses Quality Spectrum Insight (QSI) to produce results for the HEDIS administrative measures that are included in the CHIPRA Core Set. QSI is NCQA-certified HEDIS reporting software that adheres to the annually updated NCQA HEDIS guidelines to derive the performance measure results. All HEDIS administrative measures are calculated based on calendar year 2012.

### Non-HEDIS Measures

The CHIPRA Core Set Technical Specifications were used to generate the additional non-HEDIS measures.

### Comparative Data

The following comparative data are presented:

- NCQA Benchmark – HEDIS Medicaid HMO 2010 50<sup>th</sup> percentile benchmark. Benchmark data are currently not available for the non-HEDIS measures.
- Florida Baseline Data – The Florida state rate for baseline year 2011 was determined by the Institute. The measurement year for these rates was 2011. The reader is referred to the Institute's report "Pediatric Performance Measurement in Florida's CHIPRA Demonstration Grant"<sup>34</sup> for specific calculations.

### Limitations

Importantly, there are several caveats for calculating these performance measures.

- As noted in the CHIPRA A 2012 report<sup>35</sup>, claims and encounter data for children enrolled in Title XXI Children's Medical Services Network (CMSN) and Title XIX Health Plans are not included.
- All measures reported use

administrative data and do not account for data that might be found in medical records.

- There are no available benchmarks for these measures at the practice-level. Benchmarks included in this report are at the health plan level, but are included as a way to interpret the data.
- There is no standardized way to assign children to a practice. Since there is no field in the administrative data to capture "practice name," children were assigned to a practice if a provider employed at that practice submitted a claim during the measurement year. However, there are several cases that may cause care to be captured outside of that scenario. This limitation was presented to the National Evaluation Team, and they are currently working on an assignment algorithm.

### Outcome Measures

The following tables (**Table 17-19**) show the administrative measure results from the CHIPRA Core Set, separated by the three legislative areas addressed. Each table lists the measure results for the current measurement year (2012), and prior year (2011), and is broken out by demonstration and control group. The reader is referred to

the “Florida Pediatric Medical Home Demonstration Project Evaluation, 2012 Report Addendum: Performance Measures” for the 2010 administrative measure results.

When available, NCQA benchmarks (HEDIS Medicaid HMO 2010 50<sup>th</sup> percentile benchmark) are listed. Benchmark data are currently not available for the non-HEDIS measures. Florida

Baseline Data are reported as well. The reader is referred to the Institute’s report “Pediatric Performance Measurement in Florida’s CHIPRA Demonstration Grant” for specific calculations.

Table 17. Prevention and Health Promotion Measures								
Performance Measure	Core Set Technical Specifications	Year 3 – 2012		Year 2 – 2011		Florida Baseline 2011	NCQA Benchmark 2010	
		Demonstration Group	Control Group	Demonstration Group	Control Group			
<b>Frequency of Ongoing Prenatal Care</b>	<i>Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:</i>							
	<= 20% of expected visits	<b>9.7%</b> (41) ↑	6.9% (637) ↑	3.4%	5.1%	6.7%	7.0%	
	21% to 40% of expected visits	0.0% (41) ↓	<b>5.4%</b> (1270) ↑	3.4%	4.6%	5.0%	4.6%	
	41% to 60% of expected visits	29.3% (41) ↑	13.3% (637) ↑	<b>19.0%</b>	<b>11.3%</b>	10.9%	7.2%	
	61% to 80% of expected visits	<b>36.6%</b> (41) ↑	<b>27.7%</b> (637) ↓	NA	<b>29.0%</b>	28.5%	13.5%	
	>= 81% of expected visits	24.3% (41) ↓	46.4% (637) ↓	44.8%	50.0%	49.5%	64.2%	
<b>Timeliness of Prenatal Care (PPC)</b>	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment	53.6% (41) ↓	71.4% (63) ↓	74.1%	75.9%	74.1%	86.0%	
<b>Chlamydia Screening (CHL)</b>	Percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	40.8% (213) ↑	51.0% (28685) ↑	38.5%	44.1%	52.6%	53.0%	
<b>Well-Child Visits in the First 15 Months of Life (W15)</b>	<i>Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a PCP during their first 15 months of life</i>							
	0 visits	<b>4.0%</b> (615) ↑	<b>56.1%</b> (11658) ↑	1.2%	1.2%	2.8%	1.4%	
	1 visit	1.1% (615) ↑	<b>1.7%</b> (2004) ↑	1.0%	0.9%	1.9%	1.6%	
	2 visits	2.9% (615) ↑	2.7% (2004) ↑	1.2%	1.8%	2.8%	2.8%	
	3 visits	3.6% (615) ↑	4.3% (2004) ↑	3.0%	2.1%	5.0%	5.4%	
	4 visits	7.9% (615) ↑	7.3% (2004) ↑	4.2%	6.0%	9.3%	10.3%	
	5 visits	9.9% (615) ↓	13.6% (2004) ↓	11.2%	11.1%	16.2%	16.5%	
6 or more visits	<b>74.7%</b> (615) ↓	<b>67.5%</b> (2004) ↓	<b>78.1%</b>	<b>76.8%</b>	62.1%	60.1%		

**Table 17. Prevention and Health Promotion Measures** *(continued)*

Performance Measure	Core Set Technical Specifications	Year 3 – 2012		Year 2 – 2011		Florida Baseline 2011	NCQA Benchmark 2010
		Demonstration Group	Control Group	Demonstration Group	Control Group		
<b>Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)</b>	Percentage of children ages 3 to 6 that had one or more well-child visits with a Primary Care Practitioner (PCP) during the measurement year	<b>82.7% (2085) ↓</b>	57.3% (12281) ↓	<b>85.0%</b>	<b>74.4%</b>	67.6%	71.8%
<b>Adolescent Well-Care Visit (AWC)</b>	Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	<b>74.1% (1031) ↑</b>	<b>60.6% (5727) ↑</b>	<b>71.8%</b>	<b>51.1%</b>	46.7%	46.8%
<b>Percentage of Eligibles That Received Preventive Dental Services</b>	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs (i.e., individuals eligible for EPSDT services) that received preventive dental services	26.1% (8360) ↓	16.7% (54176) ↓	27.8%	19.8%	9.0%	n/a
<b>Childhood Immunization Status (CIS)</b>	<i>The percentage of children 2 years of age who had four DTaP, three IPV, one MMR, three HIB, three HepB, one VZV, four PCV, two HepA, two or three RV, and two flu vaccines by their second birthday</i>						
	DTaP	80.2% (687) ↓	72.1% (2170) ↓	<b>87.5%</b>	80.1%	79.9%	81.8%
	Hep A	<b>85.4% (687) ↑</b>	<b>72.7% (2170) ↑</b>	<b>48.9%</b>	<b>37.3%</b>	88.4%	34.8%
	Hep B	78.1% (687) ↓	66.4% (2170) ↓	89.3%	80.1%	90.5%	91.8%
	HIB	91.5% (687) ↓	85.8% (2170) ↓	94.0%	90.2%	90.2%	95.4%
	Influenza	<b>50.7% (687) ↑</b>	30.3% (2170) ↑	<b>44.4%</b>	29.9%	80.0%	40.0%
	MMR	90.5% (687) ↓	88.0% (2170) ↓	<b>94.3%</b>	91.4%	91.3%	91.7%
	PCV	<b>80.0% (687) ↓</b>	70.8% (2170) ↓	<b>86.5%</b>	78.9%	77.5%	79.3%
	Polio	87.1% (687) ↓	80.8% (2170) ↓	<b>93.7%</b>	88.0%	37.1%	90.7%
	Rotavirus	<b>66.6% (687) ↑</b>	<b>58.6% (2170) ↓</b>	<b>62.3%</b>	<b>59.8%</b>	60.4%	49.9%
	VZV	<b>92.7% (687) ↓</b>	88.3% (2170) ↓	<b>94.9%</b>	<b>92.4%</b>	30.3%	91.3%
	Combo2	69.4% (687) ↓	56.8% (2170) ↓	<b>81.4%</b>	69.2%	69.5%	76.6%
	Combo3	65.7% (687) ↓	53.2% (2170) ↓	<b>77.7%</b>	65.4%	65.2%	71.0%
	Combo4	<b>62.5% (687) ↑</b>	<b>44.9% (2170) ↑</b>	<b>42.6%</b>	29.5%	30.0%	29.5%
	Combo5	<b>52.1% (687) ↓</b>	41.1% (2170) ↓	<b>55.0%</b>	<b>46.9%</b>	47.8%	42.0%
	Combo6	<b>37.5% (687) ↓</b>	19.7% (2170) ↓	<b>38.3%</b>	23.9%	23.8%	32.9%
	Combo7	<b>50.2% (687) ↑</b>	<b>36.2% (2170) ↑</b>	<b>33.4%</b>	<b>22.2%</b>	23.6%	19.7%
	Combo8	<b>36.2% (687) ↑</b>	<b>18.0% (2170) ↑</b>	<b>22.7%</b>	12.8%	13.2%	16.0%
	Combo9	<b>30.5% (687) ↑</b>	16.3% (2170) ↓	<b>28.6%</b>	18.0%	18.8%	21.1%
	Combo10	<b>29.6% (687) ↑</b>	<b>15.2% (2170) ↑</b>	<b>17.7%</b>	9.8%	10.8%	11.7%

**Table 17. Prevention and Health Promotion Measures (continued)**

Performance Measure	Core Set Technical Specifications	Year 3 – 2012		Year 2 – 2011		Florida Baseline 2011	NCQA Benchmark 2010
		Demonstration Group	Control Group	Demonstration Group	Control Group		
<b>Child and Adolescent Access to Primary Care Practitioners (CAP)</b>	Percentage of children and adolescents that had a visit with a PCP in the measurement year (12 months to 6 years) or with a PCP during the measurement year or the year prior to the measurement year (7 years to 19 years)						
	12 to 24 months	NA (0) —	NA (0) —	<b>99.5%</b>	<b>97.7%</b>	94.8%	96.8%
	25 months to 6 years	<b>97.4% (2739)</b> ↓	74.0% (14447) ↓	<b>98.3%</b>	<b>93.6%</b>	81.7%	89.8%
	7 to 11 years	<b>98.6% (1274)</b> ↓	80.7% (9833) ↓	<b>99.2%</b>	<b>93.5%</b>	85.4%	91.3%
	12 to 19 years	<b>97.7% (1365)</b> ↓	85.7% (12947) ↓	<b>98.9%</b>	<b>91.0%</b>	84.1%	88.9%
All members	98.0% (6181) ↓	80.8% (39735) ↓	98.8%	93.0%	84.2%	n/a	

Note: Numbers in parentheses indicate the number of observations.  
 ↑↓ Indicates the direction of change from Year 2 to Year 3.

**BOLD** values indicate a rate ABOVE the NCQA benchmark.  
 NA= Not applicable as denominator <30 n/a= Not available.

**Table 18. Management of Acute Conditions Measures**

Performance Measure	Core Set Technical Specifications	Year 3 – 2012		Year 2 – 2011		Florida Baseline 2011	NCQA Benchmark 2010
		Demonstration Group	Control Group	Demonstration Group	Control Group		
<b>Appropriate Testing of Children with Pharyngitis (CWP)</b>	Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode	<b>72.2% (216)</b> ↑	58.9% (2179) ↑	<b>68.4%</b>	57.0%	58.9%	65.5%
<b>Percentages of Eligibles that Received Dental Treatment Services</b>	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs (i.e., individuals eligible for EPSDT services) that received dental treatment services	14.3% (8360) ↓	7.9% (57096) ↓	14.4%	11.0%	4.9%	n/a

Note: Numbers in parentheses indicate the number of observations.  
 ↑↓ Indicates the direction of change from Year 2 to Year 3.

**BOLD** values indicate a rate ABOVE the NCQA benchmark.  
 NA= Not applicable as denominator <30 n/a= Not available.

**Table 19. Management of Chronic Conditions Measures**

Performance Measure	Core Set Technical Specifications	Year 3 – 2012		Year 2 – 2011		Florida Baseline 2011	NCQA Benchmark 2010
		Demonstration Group	Control Group	Demonstration Group	Control Group		
<b>Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits</b>	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related Emergency Room visits	13.0% (1974) ↑	12.3% (7746) ↑	10.5%	11.1%	10.8%	n/a
<b>Follow-up Care for Children Prescribed ADHD Medication (ADD)</b>	<i>Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed</i>						
	Initiation phase	<b>39.3%</b> (117) ↑	34.8% (752) ↓	30.4%	37.5%	41.9%	37.9%
	Continuation and maintenance phase	<b>46.0%</b> (37) ↑	39.1% (171) ↓	37.5%	39.6%	NA	39.6%
<b>Follow-Up After Hospitalization for Mental Illness (FUH)</b>	<i>Percentage of discharges for children ages 6 to 20 that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge</i>						
	30 days follow-up	NA (27) —	57.1% (196) ↓	<b>66.7%</b>	58.5%	53.8%	62.6%
	7 days follow-up	NA (27) —	33.1% (196) ↓	<b>45.5%</b>	39.0%	34.9%	43.5%
<b>Adolescent Immunization Status (IMA)</b>	<i>The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, &amp; acellular pertussis vaccine (Tdap) by their 13th birthday</i>						
	Tdap/Td	<b>86.8%</b> (250) ↓	<b>78.5%</b> (2366) ↓	<b>92.4%</b>	<b>81.2%</b>	54.3%	46.7%
	Meningococcal	<b>76.0%</b> (250) ↓	58.5% (2366) ↓	<b>81.4%</b>	58.6%	73.2%	60.8%
	Combo1	<b>75.6%</b> (250) ↓	<b>56.5%</b> (2366) ↑	<b>79.7%</b>	<b>56.3%</b>	52.5%	42.4%

Note: Numbers in parentheses indicate the number of observations.  
 ↑↓ Indicates the direction of change from Year 2 to Year 3.

**BOLD** values indicate a rate ABOVE the NCQA benchmark.  
 NA= Not applicable as denominator <30 n/a= Not available.

# 7 Conclusion

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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. In 2012, the practices received training and information on implementing system and process changes.

In 2013, the practices continued to make improvements in processes and outcomes as well as maintain prior changes. The action phase for round 1 has ended, and the demonstration practices have since realized success in many areas. Some of the practices have also faced unexpected challenges, such as staff turnover and other practice level initiatives, that have taken precedence over the medical home. All of these factors affect their ability to focus on sustainability and continual quality improvement. Practices will be evaluated for a final year in 2014.

In addition to the evaluation of the round 1 practices, the following additional medical-home related activities have been conducted as part of the CHIPRA C project:

- Several of the lead physicians from round 1 have been chosen to become statewide facilitators. Facilitators have been trained and are available to help other pediatric practices across the state become medical homes.
- A new group of round 2 practices were chosen to complete a similar pediatric medical home demonstration project in the fall of 2013 and will be evaluated in the final year.
- The Expert Group has endorsed the creation of a Pediatric Medical Home and Quality Improvement Leadership group. The group is currently being organized and will include key members from around the state that can help to build PCMH infrastructure and influence practices and providers to adopt the PCMH model.

## 8 Abbreviations

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AAFP – AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAP – AMERICAN ACADEMY OF PEDIATRICS

AHCA – AGENCY FOR HEALTH CARE ADMINISTRATION

CHIP – CHILDREN'S HEALTH INSURANCE PROGRAM

CHIPRA – CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

CMS – CENTERS FOR MEDICARE AND MEDICAID SERVICES

CMSN – CHILDREN'S MEDICAL SERVICES NETWORK

CSHCN – CHILDREN WITH SPECIAL HEALTH CARE NEEDS

DOH – FLORIDA DEPARTMENT OF HEALTH

EHR – ELECTRONIC HEALTH RECORD

EMR – ELECTRONIC MEDICAL RECORD

EQIPP – EDUCATION IN QUALITY IMPROVEMENT FOR PEDIATRIC PRACTICE

FHKC – FLORIDA HEALTHY KIDS CORPORATION

FQHC – FEDERALLY QUALIFIED HEALTH-CENTER

HIT – HEALTH INFORMATION TECHNOLOGY

HMA – HEALTH MANAGEMENT ASSOCIATES

INSTITUTE – INSTITUTE FOR CHILD HEALTH POLICY

IRB – INSTITUTIONAL REVIEW BOARD

MBI-GS – MASLACH BURNOUT INVENTORY – GENERAL SCALE

MHI – MEDICAL HOME INDEX

NCQA – NATIONAL COMMITTEE FOR QUALITY ASSURANCE

PCMH – PATIENT-CENTERED MEDICAL HOME

QI – QUALITY IMPROVEMENT

QUIIN – QUALITY IMPROVEMENT INNOVATION NETWORK

SD – STANDARD DEVIATION

UF – UNIVERSITY OF FLORIDA

# Appendix 1. Quality

## 9 Demonstration Grantees

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 20**). Across the 12 states, a mixture of instruments and methodologies was selected to measure medical home transformation at the practice level. Please refer to the 2011 evaluation report for further details<sup>7</sup>.

**Table 20. 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.*

# 10 Appendix 2. 2013 Survey Tools

Table 21. Year Three Survey Tools		
STAKEHOLDER	SURVEY TOOL	CONCEPTS MEASURED
Core Clinical Team	Medical Home Index (MHI) <sup>13</sup> TransformMED Practice Environment Checklist <sup>17</sup> Practice Communication – Internal and External	<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> <li>• Adaptive reserve</li> <li>• Community knowledge</li> <li>• Cultural sensitivity</li> <li>• Health Information Technology integration</li> <li>• Patient safety culture</li> <li>• Practice staff engagement</li> <li>• Communication with community stakeholders</li> </ul>
	Qualitative Interview Guide	<ul style="list-style-type: none"> <li>• Internal processes</li> <li>• Patient interactions</li> <li>• Learning collaborative model</li> <li>• Lessons learned</li> </ul>
Practice Staff	TransformMED Practice Environment Checklist Maslach Burnout Inventory – General Scale (MBI-GS) <sup>23</sup> Job Satisfaction <sup>20</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> <li>• Exhaustion</li> <li>• Cynicism</li> <li>• Professional efficacy</li> <li>• Satisfaction with work environment</li> </ul>
Parents	Consumer Assessment of Healthcare Providers and Systems – PCMH (CAHPS-PCMH) <sup>27</sup> National Survey of Children with Special Health Care Needs (NS-CSHCN) <sup>31</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> <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>

# 11 Endnotes

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