Report Title: Patient-Centered Primary Care Homes Commons Standards and Best Practices: Results from a Narrative Evaluation.

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OREGON'S PATIENT-CENTERED PRIMARY CARE HOMES COMMON STANDARDS AND BEST PRACTICES

RESULTS FROM A NARRATIVE EVALUATION

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INTRODUCTION

In a transforming healthcare delivery system, Patient-Centered Primary Care Homes (PCPCH) are considered a key initiative to meeting the tenets of the Triple Aim. Currently, there are a variety of accreditation programs and standards available for clinics that have adopted a medical home model across the United States. At the policy level, Oregon has paid particular attention to promoting the PCPCH program, with the goal that 100% of Oregon Health Plan (OHP) members have access to a PCPCH by 2015 and 100% of all Oregonians.

Instead of relying solely on national standards, such as those used by NCQA, Oregon has adopted its own set of accreditation metrics by which to designate clinics that wish to become PCPCHs. In addition to scoring the clinics using this system, evaluators conducting PCPCH site visits provided detailed summaries of clinic practices that can be leveraged to further refine state expectations around PCPCH standards.

METHODS

Data Source: We relied on site visit reports from 57[1] PCPCH clinics located around the state of Oregon. These site visits were conducted in 2013 and 2014.

Analysis: These site visit reports were entered into ATLAS.ti, qualitative analysis software, and coded by multiple members of a trained qualitative research team. The coded data underwent content analysis[1]; researchers looked for thematic commonalities across clinics around each reported measure that was not captured in the current standards.

The Report and Tool: The following document provides a summary of performance and activities across clinics for each measure. A verification summary is included for each measure to depict any discrepancies in measure attestation. For example, if a site attested to meeting a measure, but failed to meet the measure during the site visit, this site would be counted as "unverified" in the verification summary. Additional relevant activities being undertaken by clinics in relation to specific measures were included in the tool as additional constructs by which to evaluate and track PCPCH performance over time. When applicable, we included an example that was highlighted by the research team as a "best practice" to identify any case in which a clinic was performing in an exceptional manner.

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[1]*n=57, but not all sites addressed all measures

[2]Hsieh, Hsiu-Fang, and Sarah E. Shannon. "Three approaches to qualitative content analysis." Qualitative health research 15.9 (2005): 1277-1288.

CORE ATTRIBUTE 1: ACCESS TO CARE

COMMON THEMES ACROSS SITES

- **Patient Communication:** Less than a quarter of sites were recognized for high-quality communication with patients
- **Data Tracking:** Sites struggled with data tracking, including use of survey results and inputting information from phone calls
- **Internal Communication:** Overall, sites were likely to have solid communication plans in place with staff
- **Care Access:** There were some inconsistencies in the evaluation of this measure across report sections

VERIFICATION SUMMARY

- **Measure 1.A:** 1 unverified site
- **Measure 1.B:** 5 unverified sites
- **Measure 1.C:** 2 unverified sites

SUMMARY

- Few sites (16%) were recognized for their use of patient communication processes and strategies. Communication strategies included using online platforms and mailers, as well as implementing group visits. It should be noted that only 30% of sites communicated effectively with patients about office hours and other important information. It appears that many sites could benefit from evaluating and improving patient communication strategies.

- It was mentioned that many sites could improve their data tracking and analysis processes. It was suggested to over half the sites to better track calls to advice lines and outcomes from those calls (61%), as well as to improve tracking and analysis of patient survey data (71%).

- It appears that many sites have some type of internal communication processes, as only 20% sites were recommended to improve communication and/or information sharing with their staff. However, measure 1.A reports the opposite finding that only a few sites were engaging all staff in communication.

- In regards to care access, it was recommended to a few sites that staff and provider recruitment (21%), as well as utilizing providers and other staff in patient education roles (27%) would increase patient access. There were some inconsistencies from what was summarized and what was reported in the above measures individually. First, 48% sites were recommended in this summary to extend office hours, however in measure 1.B a majority of sites verified that they offered extended hours. Additionally, it was only recommended in the summary section to 9 sites (16%) that same day appointments should be more available; however, in measure 1.B only 18 sites (44%) mentioned offering same day appointments, leading to the assumption that more sites should have received this recommendation in the summary section.

- When preparing this recommendation section, reviewers should contextualize all measures, as it seems that some recommendations were not pertinent to all sites and even contradicted the findings stated above.

Based on the 2014 TA guide, the following measures were not included in any sites visits:

- *1.D – Same Day Access* ***(not in analysis)***
- *1.E – Electronic Access* ***(not in analysis)***
- *1.F – Prescription Refills* ***(not in analysis)***

1.A - In-Person Access

COMMON PRACTICES ACROSS SITES

- **Patient Survey (non-CAHPS & CAHPS):** Most sites were using a survey to collect information about access
- **Internal Communication:** Few sites communicated and shared results of surveys with staff and other providers

VERIFICATION SUMMARY

Only one site's (2%) attestation could not be verified for this measure due to incomplete and insufficient CAPHS surveys. This site was a privately-owned clinic.

NARRATIVE SUMMARY

Most PCPCH sites (98%) surveyed a sample of their patient population; over half of sites (63%) meeting this measure used a CAHPS survey. Of those not using a CAHPS survey, five sites described plans for switching to CAHPS surveys in the future. However, very few sites (8%) met the benchmarks set by the PCPCH guidelines to obtain Tier 3 status for this measure. The three sites that were able to meet Tier 3 were privately-owned practices and one hospital-affiliated, rural health clinic. The reason for few sites meeting Tier 3 status could be investigated further.

Finally, only nine sites (18%) mentioned sharing the results of the survey with staff and other providers. This could be an area for improvement for many sites.

1.B - After Hours Access

COMMON PRACTICES ACROSS SITES

- **Extended Hours:** Most sites offered office hours outside of the traditional hours
- **Same Day Appointment Availability:** Only a few sites described availability of same day appointments

VERIFICATION SUMMARY

Five sites' (13%) attestation could not be verified because the sites were not open for the minimum of four extra hours weekly. Two of the sites mentioned expanding staff size and office hours in the future. Most sites were affiliated with hospitals.

BEST PRACTICE EXAMPLE FROM THE FIELD

"At the time of attestation, clinic hours were Monday 8 am to 8 pm and Tuesday through Friday 8 am to 5 pm. Starting in March 2013, clinic hours were expanded to Monday 8 am to 7 pm; Tuesday, Wednesday and Friday, 8 am to 6 pm; Thursday 8 am to 5 pm; and 10 am to 2 pm every other Saturday. Same-day open-access appointments are available for routine and urgent visits."

NARRATIVE SUMMARY

This measure focused on providing access during nontraditional hours as well as for urgencies. A majority of sites (94%) offered extended hours, outside of the traditional 8:00 AM - 5:00 PM, Monday - Friday time frame. Many were open before or after those hours and offer weekend hours. Additionally, half (50%) the sites described the availability of same day appointments for urgent or unexpected appointments.

1.C.0 – Telephone & Electronic Access

COMMON PRACTICES ACROSS SITES

- **Active Advice Telephone Line:** Most sites have a working advice telephone line, allowing patients 24-hour access to care
- **Data Tracking:** Over half the sites track phone calls made to the office, and often track outcomes of these calls

VERIFICATION SUMMARY

Two sites (4%) could not verify this measure because the sites did not offer access to an advice line 24-hours a day. One site has a voicemail for patients to leave messages on and the other site refers patients to a nearby emergency room; neither is sufficient to meet this measure. Both of these sites are privately-owned clinics.

NARRATIVE SUMMARY

Almost all PCPCH sites (96%) met this "must-pass" measure, depicting that most sites have a working advice telephone line. Interestingly, more than half (58%) of the sites reported they are engaged in logging and tracking phone calls to the office and outcomes of the calls. The two sites that could not verify this measure did not employ an answering service where patients can get medical advice at all times.

BEST PRACTICE EXAMPLE FROM THE FIELD

"Utilizing the co-location structure, teams try to address patient issues with clinicians in a "one-touch" manner when possible, but when necessary the EHR is used to route call documents to the clinicians for action. After-hours calls are received through a shared call phone by the on-call clinician. All phone interactions are recorded in the EHR - the clinicians have remote access capability – and the EHR is used to route notes to appropriate team members for follow-up action when indicated."

CORE ATTRIBUTE 2: ACCOUNTABILITY

COMMON THEMES ACROSS SITES

- **Quality Improvement:** Half the sites were engaging in a quality improvement effort to directly help increase the clinic's ability to be responsive to patient's needs
- **Internal Communication:** Many sites need to improve on internal communication with staff and other providers

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic met benchmarks on the CHIPRA measures chosen to submit for their PCPCH attestation. In addition, the clinic participates in Children's Health Alliance quality improvement projects that focus on optimal care of patients with asthma as well as two immunization improvement initiatives. Success in initiatives is supported by the involvement that includes the whole treatment team and support staff."

VERIFICATION SUMMARY

- **Measure 2.A.0:** 1 unverified site
- **Measure 2.A:** 1 unverified site

SUMMARY

- Half of the sites currently have QI strategies, however it was recommended to most sites (93%) in the summary section that sites either need to create or improve their current QI plan or culture. The summary of findings for this attribute was found to be inconsistent with findings from the above measure; it was reported that many sites (91%) used PSDA, LEAN, or similar QI methodologies, which is vastly different than 28% as stated in measure 2.A.

- Another theme was a lack of internal communication and engagement. A majority of sites (82%) received recommendations around investing in staff training and identifying a staff quality champion. This echoes recommendations from the first core attribute.

- Only a handful of sites were advised to improve data tracking in regards to EHR tracking and charting (4%), increase partnerships with outside providers and organizations (7%), and improve communication and data sharing with patients (5%).

Based on the 2014 TA guide, the following measures were not included in any sites visits:

- *2.B – Public Reporting* ***(not in analysis)***
- *2.C – Patient & Family Involvement in Quality Improvement* ***(not in analysis)***
- *2.D – Quality Improvement* ***(not in analysis)***
- *2.E – Ambulatory Sensitive Utilization* ***(not in analysis)***

2.A.0 & 2.A - Performance & Clinical Quality

COMMON PRACTICES ACROSS SITES

- **Data Tracking:** Almost all sites are tracking PCPCH Quality Measures; however few sites are meeting the defined benchmarks
- **Quality Improvement:** Half of the sites were engaging in some quality improvement effort; however only a quarter of sites are using PSDA or similar QI processes
- **Internal Communication:** Many sites need to improve on internal communication with staff and other providers, such as sharing data

VERIFICATION SUMMARY

Reporting and calculating quality metrics data appeared to be a problem for the two sites that were unable to verify these measures. One privately-owned site (10%) failed to verify measure 2.A.0 and a different site, a hospital affiliated clinic, (2%) did not verify meeting measure 2.A.

NARRATIVE SUMMARY

Almost all sites (98%) are tracking PCPCH Quality Measures, however fewer than half (42%) are meeting any PCPCH-defined benchmarks required to meet Tier 3 status for this measure. Sites meeting Tier 3 status are mostly privately-owned clinics, with a handful of hospital-affiliated clinics and FQHCs. Sites are using EHR to chart and report metrics, along with using dashboards.

BEST PRACTICE EXAMPLE FROM THE FIELD

"NWPC-MFP measured and tracked clinical data for diabetes, hypertension, end of life, continuity of care, and preventive care services on their 2012 performance improvement work plan. The clinic has begun to design process improvement activities to enhance outcomes. For example, the clinic used PDSA cycles for implementation of an online portal. Additionally the medical director and quality manager are members of the NWPC Quality Management Executive Task Force, and the clinical staff (physicians and nurses) participates in work groups related to preventive services, women's health, chronic diseases and PCPCH to facilitate quality patient care."

Over half the sites (58%) are engaging in QI strategies, plan, initiatives, and committees. However, only a quarter of sites (28%) specifically stated using PSDA, LEAN, POLST, or similar QI methodologies or processes, depicting there may be room for sites to develop more thorough QI plans and strategies. For those without QI plans, 4 sites mentioned future QI implementation plans.

Fewer than half the sites (34%) reported high internal communication, such as sharing information from EHR tracking with other staff members and staff engagement. This could be identified as an area for improvement at many sites.

It is unclear why this measure is separated into two measures: 2.A.0 (must-pass) and 2.A. It appears they could be consolidated for ease, as only 10 sites attested to 2.A.0.

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE

COMMON THEMES ACROSS SITES

- **Quality Improvement:** Most sites were recommended to improve QI processes and initiatives
- **Overall Communication:** Communication with internal staff and external providers need improvement
- **Data Tracking:** Over half the sites were recommended to track screenings, referrals, and outcomes more accurately

BEST PRACTICE EXAMPLE FROM THE FIELD

"OTC offers unique whole-person care to all adults in coordination with integrated mental and behavioral health, and a focus on screening and intervention to minimize risk and promote health. Comprehensive efforts in substance abuse, opiate treatment, and non-allopathic care are especially innovative. Sharing best practices and implementation insight with others in the local and state provider community is recommended."

VERIFICATION SUMMARY

- **Measure 3.A:** 5 unverified sites
- **Measure 3.B.0:** 1 unverified site
- **Measure 3.C.0:** 5 unverified sites
- **Measure 3.C:** 8 unverified sites
- **Measure 3.D:** 1 unverified site

SUMMARY

- Summary themes are consistent with Core Attributes 1 & 2 themes.

- Quality improvement efforts were frequently mentioned in this summary section. Only five sites were recommended to generally improve or continue QI efforts. For other sites, there were more specific QI recommendations. Many sites (56%) were recommended to establish or better standardize pre-visit planning. This recommendation mirrors findings in measure 3.A. Additionally, screening procedures were a focus of many reports. It was suggested that most sites (85%) should develop a universal screening strategy (using Bright Futures and USPSTF guidelines) and furthermore, most sites (55%) should screen all patients, not just a subset of the population.

- Another common theme in this section was internal and external communication. It was suggested to about half the sites (51%) to better share information with staff and other providers on site. External communication could also be improved. A majority of sites (75%) were recommended to better establish formal relationships with outside providers and referral sites, with 6 sites (11%) needing to improve information and data sharing with other providers as well as with community organizations.

- Data tracking, in reference to screenings, referrals, and outcomes, also need improvement. Over half the sites (55%) were recommended to more accurately track and analyze data.

Based on the 2014 TA guide, the following measures were not included in any sites visits:

- *3.E – Preventive Service Reminders* ***(not in analysis)***

3.A – Preventive Services

COMMON PRACTICES ACROSS SITES

- **Appropriate Services for Age & Gender:** A majority of sites followed Bright Futures and/or USPSTF guidelines
- **Data Tracking:** Three-quarters of sites used EHR for tracking of patient services, including EHR alerts and reminders
- **Pre-Visit Plan & Process:** Half of sites used a pre-visit plan that included "scrubbing" and "huddling"

VERIFICATION SUMMARY

Five sites (9%) were not able to verify this measure. Two sites were FQHCs and three were privately-owned clinics. Verification was not met because sites could not prove consistent use of Bright Futures or USPSTF guidelines. Some sites mentioned that services were "provider-dependent."

NARRATIVE SUMMARY

Of the sites that were verified as meeting this measure, 36 sites (73%) followed either or both (depending on their patient population) the Bright Futures for pediatrics and USPSTF for adults guidelines. A majority of sites (76%) used EHR for tracking when services are needed, for example EHR alert and reminders are used to prompt providers about upcoming screenings and services.

Over half the sites (53%) also reported using a pre-visit planning process that often included "scrubbing" and "huddling", where providers and staff would meet to discuss the needs of patients prior to scheduled appointment times.

For all sites that attested to this measure, those that met this measure only met the requirements for Tier 1. This may suggest that Tier 2 and Tier 3 are not needed or measurement reassessment is needed.

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinicians offer preventive services recommended by the USPSTF and Bright Futures by using standardized forms, templates, smart phrases and alerts in the EHR. The clinic also has a pre-visit planning process to capture recommended preventive screenings. In preparation for patients' visits, the MAs "scrub" the records, review the health maintenance alerts, and notify the clinician of any preventive needs during the huddle. The clinic also provided "Standards of care/ preventive services" for diabetic patients, men's healthcare maintenance and women's healthcare maintenance. Additionally the clinic designed a standardized outreach process for the MA/front office staff to ensure that patients receive the recommended health maintenance services."

3.B.0 - Medical Services

COMMON PRACTICES ACROSS SITES

- **Comprehensive Medical Care:** Most sites offered all the categories defined within comprehensive medical care

VERIFICATION SUMMARY

Only one site (2%) could not verify this measure. However, the reasoning is unknown because there was no narrative for this site. This site is a FQHC.

NARRATIVE SUMMARY

As defined by the TA guide, comprehensive care includes four categories. Most sites mentioned provisions of these categories of care: acute care/minor illnesses and injuries (96%), chronic disease management (95%), office-based procedures and diagnostic tests (96%), and patient education and self-management (82%).

BEST PRACTICE EXAMPLE FROM THE FIELD

In addition to providing acute care, chronic disease management, office-based procedures and diagnostic tests, and patient education and self-management, "[…] OCM also provides ancillary therapies (chiropractic care, massage, physical therapy, and acupuncture), homeopathic/naturopathic medicine, and behavioral health management."

3.C.0 & 3.C – Mental Health, Substance Abuse, & Developmental Services

COMMON PRACTICES ACROSS SITES

- **Active Screening Strategy:** Most sites have a screening strategy in place
- **Referral Processes:** Most sites provided a list of referral services; Over half of sites had a co-located provider and another quarter of sites reported a cooperative relationships with an outside care provider
- **External Communication:** Only half the sites were able to show two-way communication documentation

VERIFICATION SUMMARY

Five sites (9%) could not verify measure 3.C.0 due to the absence or inconsistent use of a screening strategy. Eight sites (17%) could not verify measure 3.C. Lack of two-way communication and co-management with outside providers as well as lack of documentation were reasons for the inability to verify these measures. Organizational type of clinic varied across these 13 sites; there were hospital affiliated, FQHCs, and privately-owned clinics.

NARRATIVE SUMMARY

Most sites (91%) attested to having a screening strategy in place for mental health, substance abuse, and developmental conditions. However, several sites (11%) mentioned that their screening strategies were not consistently used. Along with a screening strategy, most sites (88%) provided a list of on-site and/or local providers for patients needing specialty care.

BEST PRACTICE EXAMPLE FROM THE FIELD

"Adolescent and adult patients are screened for mental health and substance use during annual exams and routine visits via a review of systems, which is conducted by the clinician. Senior patients are screened for depression via a PHQ-2 during their Medicare wellness visit […] Patients are also referred to a psychiatric nurse practitioner in Lincoln City, as well as a psychiatric nurse practitioner and psychiatrist in Newport […] Adolescent patients requiring mental health services are referred to the Taft School-based Health Center […] For pediatric patients developmental milestones are reviewed with parents and the clinician conducts a review of systems at well child exams. Age-appropriate developmental screening tools are built into the WCC forms. Patients may be referred to Early Intervention, Head Start, OHSU Child Development Rehabilitation Center, and Shriners Hospital for Children."

Once referred to a specialist, about a quarter of sites (29%) attested to having a cooperative referral process and co-management with the outside care provider. Additionally, over half (55%) of the sites had a co-located referral provider either located physically on-site or virtually. This makes it easier for the patient to receive the specialty care they need. Five sites, both verified and non-verified sites, mentioned future plans for creating or improving co-location of referral services and care.

About half (49%) also documented clear two-way communication between the PCPCH providers and the referral provider. However, external communication appears to be a struggle for some sites, as 24% of sites mentioned problems in this area. Some reported not documenting communication with outside providers, others only documented one-way communication, while a few mentioned inconsistent communication processes.

3.D – Comprehensive Health Assessment & Intervention

COMMON PRACTICES ACROSS SITES

- **Identified Health Risks and/or Developmental Promotion Behaviors:** Most sites documented health risks
- **Specified Assessments and/or Interventions:** Most sites documented assessments or interventions associated with identified health risks

VERIFICATION SUMMARY

Only one privately-owned clinic site (2%) could not verify this measure. The site was unable to provide clear assessment and strategies for comprehensive care and there were no health promotion or risk intervention patient materials available.

NARRATIVE SUMMARY

Many sites (98%) met this measure. Regardless, there was not consistent reporting of detailed and specific risks/behaviors and the assessments/interventions within site visit reports. Many site visits reports (89%) documented health risks and/or developmental promotion behaviors, only 87% mentioned the assessments and 91% identified the types of interventions.

Although this measure has three tiers, only Tier 1 was met by sites. The separation of Tiers could be reviewed to assess if all three tiers are needed for this measure.

CORE ATTRIBUTE 4: CONTINUITY

COMMON THEMES ACROSS SITES

- **Formal External Relationships:** A majority of sites were recommended to expand relationships with outside providers
- **CCO Structure:** Over a third of sites were encouraged to continue to focus and build on their CCO structure
- **Internal Communication:** Over a quarter of sites were recommended to better engage staff and other providers on-site
- **Data Tracking:** Some sites need improvement in tracking, reporting, and analysis of data and workflows related to continuity

VERIFICATION SUMMARY

- **Measure 4.A.0:** 1 unverified site
- **Measure 4.A:** 2 unverified sites
- **Measure 4.B.0:** 3 unverified sites
- **Measure 4.B:** 8 unverified sites
- **Measure 4.C.0:** 0 unverified sites
- **Measure 4.D:** 4 unverified sites
- **Measure 4.E.0:** 2 unverified sites

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic's structure of full-time providers arranged in a treatment team encourages high continuity. With the team structure there is also strong continuity with nursing. A family calling in and scheduling a same-day appointment will often talk to the same nurse each time they call. The patient interviews confirmed the experience of accessibility and high continuity with their primary care provider. In addition, the clinic has a history of high employee retention adding to the familiar faces patients see when they come to the clinic."

SUMMARY

- It was recommended to most sites (71%) to expand their formal relationships with outside providers, and 17 sites (31%) were encouraged to build a real-time health information exchange with outside providers. Additionally, 22 sites (40%) were recommended to continue their development of the CCO structure.

- Internally, it was suggested to a quarter of sites (29%) to better engage onsite providers and staff in continuity of care. For example, staff could be encouraged to double check assigned physicians before making appointments.

- Finally, data tracking was again mentioned as an area for improvement for some sites (29%). It was recommended for these sites to improve tracking, reporting, and analysis of data and workflows.

Based on the 2014 TA guide, the following measures were not included in any sites visits:

- *4.F – Planning for Continuity (not in analysis)*
- *4.G – Medication Reconciliation (not in analysis)*

4.A.0 & 4.A – Personal Clinician Assigned

COMMON PRACTICES ACROSS SITES

- **Reported Assignment Percent:** Nearly all sites reported the personal clinician assignment percentage and met the 90% benchmark
- **Reported Assignment Strategy:** Only a third of sites stated the process used assigning an individual patient to a clinician

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic reported 100% (3571/3571) of active patients are assigned to a personal clinician, which is above the PCPCH benchmark of 90%. Assignment is based on a patient's personal preference (provider gender, area of focus [e.g., nutrition, naturopathy]) and provider availability. Medicare patients generally see the osteopathic physician."

VERTIFICATION SUMMARY

One site (8%) could not verify measure 4.A.0 due to an inability to demonstrate data calculation methods. Two sites (4%) could not verify measure 4.A. One site could not provide data calculation methods and the other site was found to have 3 patients without an assigned PCP. All three sites were privately-owned clinics.

NARRATIVE SUMMARY

Overall, only 12 reports (21%) had specific 4.A.0 sections, which is a Must-Pass measure. It appears that many reports combined this Must-Pass measure with 4.A, which is only offered as a Tier 3 measure. Of the sites that reported this Must-Pass measure, 11 (92%) reported a percentage of patients that are assigned a personal clinician or team. Of the sites that reported the 4.A.3 measure, 96% of sites reported the personal clinician assignment percentage and met the 90% benchmark.

It was interesting that only some sites reported patient-clinician assignment strategies, which describes the process for assigning an individual patient to a clinician. For 4.A.0, a third of sites (33%) reported how patients are assigned and 38% for measure 4.A.3 reported a strategy. It could be beneficial for all sites to report exactly how patients are assigned for sharing of best practices and lessons learned.

It is unclear why this measure has been separated into two parts: Must-Pass and Tier 3. This is depicted in the lack of site visit reports to actually identify 4.A.0. It appears that these two could be easily combined into one measure.

4.B.0 & 4.B – Personal Clinician Continuity

COMMON PRACTICES ACROSS SITES

- **Reported Percent of Patient Visits (with patient-assigned clinician or team):** A majority of sites reported the percentage of visits that occurred with the patient-assigned clinician or team

VERIFICATION SUMMARY

Three sites (13%) were unable to verify measure 4.B.0. Multiple sites could not provide sufficient data and struggled to perform the correct calculations. These sites were privately-owned. Eight sites (19%) were unable to verify measure 4.B. Sites could not provide sufficient data, incorrectly grouped all clinicians as a "team," or fell below the benchmark. These sites were hospital affiliated, FQHC, and privately-owned clinics.

NARRATIVE SUMMARY

This measure had an issue similar to 4.A.0 & 4.A regarding splitting it into a Must-Pass measure and a Tiered measure. Only 24 sites (42%) actually detailed the 4.B.0 measure and 43 sites (75%) mentioned the 4.B Tiered measure (while 10 sites documented both measures). Of the Must-Pass measure reports, almost all (92%) reported the percentage of patient visits with patient-assigned clinician or team. Of the Tiered measure, a majority of sites (81%) met the 80% benchmarks.

BEST PRACTICE EXAMPLE FROM THE FIELD

Along with achieving 93% of patients visits with patient-assigned clinician or team, Rockwood Health Center "staff and providers demonstrated attention to continuity improvement through protocols to try and get patients in with their PCP and via tracked monthly continuity reports showing the frequency of providers seeing their patients AND patients seeing their identified providers. […] Clinical teams have tried to improve continuity through chronic disease tracking/outreach that includes scheduling with the PCP for needed services. Front-desk protocols for continuity scheduling were observed in action. The clinic provided the "Open Access Management Team Implementation Toolkit," which helped Rockwood achieve their continuity goals."

It is unclear why this measure has been separated into two parts: Must-Pass and Tiered. This is depicted in the small number of site visit reports to report on 4.B.0. It appears that these two could be easily combined into one measure.

4.C.0 – Organization of Clinical Information

COMMON PRACTICES ACROSS SITES

- **Health Record for All Patients:** All sites reported using a health record for all patients
- **Meaningful Use Guidelines:** A majority of health records followed Meaningful Use guidelines
- **Update-To-Date Health Record:** Most sites reported updating all health records regularly, often at every visit

VERIFICATION SUMMARY

There were no unverified sites for this measure.

NARRATIVE SUMMARY

All sites (100%) met this Must-Pass measure by maintaining a health record for each patient. Many (91%) follow Meaningful Use guidelines (either included in an EHR or non-EHR), which includes information on problems and medications, allergies, basic demographics, preferred language, BMI/growth chart, and immunizations. Additionally, most sites (86%) reported updating each health record regularly, often at every visit.

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic uses EPIC OCHIN, an EHR that meets Meaningful Use guidelines. This requires that the EHR contain the elements listed above. The clinicians, MAs and office staff review and update the clinical record at each office visit […] Additionally the clinicians' documentation is monitored and feedback was provided according to standardized guidelines."

4.D – Clinical Information Exchange

COMMON PRACTICES ACROSS SITES

- **External Electronic Communication:** Many sites are able to share information in real time with outside providers
- **Two-Way Communication:** Nearly half the sites reported successful two-way communication with outside providers

VERIFICATION SUMMARY

Four sites (11%) were unable to verify this measure. Three sites did not use electronic communication methods and the other site had access to an electronic portal, but did not use it effectively. All of these sites are privately-owned clinics.

NARRATIVE SUMMARY

Of the 38 sites that attested to this measure, 34 sites (89%) documented their ability to share information electronically in real time with providers outside of the immediate clinic staff. It was encouraging to see that nearly half the sites (47%) reported that two-way communication with outside providers and hospitals was successful. This includes outside providers sharing reports back with the PCPCH sites.

BEST PRACTICE EXAMPLE FROM THE FIELD

"MCMC-IMG shares clinical information electronically through NextGen. MCMC specialists have electronic access to patient information in the EHR. The hospitalists and ER physicians at MCMC have electronic access to patient information in NextGen for MCMC-IMG patients. Conversely, the MCMC-IMG clinicians have electronic access to hospital-based patient information through Meditech. Additionally, the clinicians are electronically notified of an ED visit and/or hospital admission. The clinicians also have electronic access to clinical information from OHSU and Providence."

4.E.0 – Specialized Care Setting Transitions

COMMON PRACTICES ACROSS SITES

- **Collaborative Care:** A majority of sites reported collaborative patient care with outside specialty care clinics
- **Written Agreements with Specialty Care Clinics:** Many sites had written agreements in place with these clinics
- **External Communication:** Sites also were able to demonstrate effective direct communication with clinics

VERIFICATION SUMMARY

Only two sites (4%) could not verify a formal relationship with a neighboring specialty care clinic(s). These sites were both privately-owned clinics.

NARRATIVE SUMMARY

Of sites that verified this measure, most sites (73%) acknowledged collaborative care between outside specialty care clinics and the PCPCH clinic. Additionally, many sites (77%) had written agreements with specialty care clinics facilitating easy transition of care. Furthermore, many sites (74%) were able to demonstrate direct communication with specialty care clinics regarding care and status of PCPCH patients.

CORE ATTRIBUTE 5: COORDINATION & INTEGRATION

COMMON THEMES ACROSS SITES

- **Care Management:** Many sites need to improve care management, especially in the areas of proactive care and care plans for patients with complex needs
- **Data Tracking:** About half the sites need to better track referrals, tests, and results
- **Identification Process:** Some sites need to implement a process for identifying high-risk and complex needs patients

VERIFICATION SUMMARY

- **Measure 5.A.1a & Measure 5.A.1b:** 0 unverified sites for both measures
- **Measure 5.B:** 2 unverified sites
- **Measure 5.C:** 2 unverified sites
- **Measure 5.D:** 1 unverified site
- **Measure 5.E:** 0 unverified sites
- **Measure 5.E.1a & Measure 5.E.1b:** 5 unverified sites & 1 unverified site
- **Measure 5.F:** 12 unverified sites
- **Measure 5.G.0:** 1 unverified site

SUMMARY

- A majority of sites (65%) were recommended to improve care management to include proactive care and care plans for high-risk and complex needs patients.

- Data tracking was also recommended to about half the sites (46%) for referrals, tests, and results in hopes of improving patient care and coordination. This is inconsistent with the results in Measure 5.D and Measure 5.E which showed nearly all sites had a tracking system in place.

- Finally, it was recommended for over a third of the sites (39%) to implement an identification process for high-risk and complex needs patients. An example of such a process would be using a risk stratification tool to accurately identify patients in need.

5.A.1a & 5.A.1b – Population Data Management

COMMON PRACTICES ACROSS SITES

- **Up-To-Date Patient Data:** A majority of sites keep current data information, but few use customizable reports and templates to assist in maintaining this information
- **Proactive Care Management:** Many sites have proactive care management techniques in place
- **Follow-Up Care:** Over half the sites reported that a staff member was assigned to follow-up with patients after visits

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic staff also use an Excel spreadsheet to track patients with special health care needs who were identified using the Children with Special Health Care Needs (CSHCN) Screener© tool. The spreadsheet includes patient names, assessment dates, care plans, diagnoses, etc. The staff uses this registry to proactively reach out to patients for recommended care such as immunizations, WCCs, appropriate screenings, recall visits, and care coordination activities."

VERIFICATION SUMMARY

There were no unverified sites for these measures.

NARRATIVE SUMMARY

Most sites keep up-to-date patient data information in the following areas: clinical and diagnostics (81%) and demographics (75%). Less than a third of sites (31%) used customizable reports and templates to assist in maintaining current information. Most sites (81%) reported using proactive care management techniques, including internal registries for patients with chronic illnesses and care alerts for preventative services. Additionally, over half the sites (52%) reported that a staff member was assigned to follow-up if it was necessary.

Separation of these two measures into 5.A.1a and 5.A.1b is slightly confusing and not consistent with other measures.

5.B—Electronic Health Record

COMMON PRACTICES ACROSS SITES

- **EHR with Meaningful Use Guidelines:** Nearly all sites use a EHR that follows Meaningful Use guidelines

VERIFICATION SUMMARY

Only two sites (4%) were unable to verify this measure. Both sites were not able to prove that their clinicians were certified in the Meaningful Use Guidelines. These sites were both privately-owned clinics.

NARRATIVE SUMMARY

Of sites that attested to meeting this measure, 96% documented use of EHR that is equipped with Meaningful Use Guidelines.

5.C – Complex Care Coordination

COMMON PRACTICES ACROSS SITES

- **Care Coordinator:** Nearly all sites have a dedicated care coordinator and a few sites were able to provide job descriptions
- **Process for Identifying Complex Patients:** Three-quarters of sites described how they identify patients with complex needs

VERIFICATION SUMMARY

Two sites (5%) were not able to verify this measure. One site was not able to prove that they inform patients as to who their specific care coordinator is. The other site has a designated RN Care Coordinator, however, patients are not informed of this role and oftentimes the CC only conducts a one-time follow up.

NARRATIVE SUMMARY

Of sites that attested to this measure, most (95%) had a dedicated care coordinator (CCs). CCs, if not a job-specific position, were nurses, managers, social workers, medical assistants, and even clinicians. Nine sites (21%) provided job descriptions that described care coordination roles within certain job titles.

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinic has recently begun implementing a risk stratification strategy to help target resources and more successful interventions based upon identified health risks and needs. Patients are risk stratified into five tiers based on a model created by CHA that takes into consideration physical/mental health and psychosocial needs. A care manager is assigned to work proactively with the tier-1 (complex medical or psychological care needs) patients. Patients & families are introduced to the care manager at the time of the patient's visit to their clinician. Tier 2 to 5 patients have their care coordinated by the medical assistant under the direction of the clinician."

Many sites (79%) described using some process for identifying complex patients. Sites used patient screening and/or risk stratification tools to make this identification.

In most site visit reports, 5.C.1 & 5.C.2 were separated. This separation based on tiers was unique only to this measure. These measures are closely related and should be combined, as the other measures are presented. Furthermore, only 29 sites attested to 5.C.2 exemplifying the combination of these two measures could be seamless.

5.D - Test & Result Tracking

COMMON PRACTICES ACROSS SITES

- **Tracking System:** Nearly all sites have a system in place for tracking tests and results
- **Electronic Integration:** Three-quarters of sites used an EHR system to assist in tracking, easing communication with patients and initiation of follow-up care

VERIFICATION SUMMARY

Only one site (2%) did not verify this measure. This site, a county health department clinic, does not review lab results in a timely fashion nor could the site demonstrate that they notify patients of the results.

NARRATIVE SUMMARY

Almost all sites (98%) had a system in place for tracking tests and results. Often sites (75%) used an EHR system for this tracking process, making it easy to communicate with other staff and outside providers. Using an electronic system also makes it easier to communicate with patients about results. These systems also initiated any follow-up planning or care that was needed for 25 sites (57%).

5.E, 5.E.1a, & 5.E.1b– Referral & Specialty Care Coordination

COMMON PRACTICES ACROSS SITES

- **Coordinated Referrals:** Many sites are effectively coordinating referrals and tracking visits when necessary
- **Care Coordinator:** A majority of sites either have a staff member provide direct management or a dedicated CC
- **External Communication:** Communication with outside referrals, specialty clinics, and community-based organizations is conducted at many sites
- **Data Tracking:** Many sites have a system to track referrals, however, only a few use an EHR system to facilitate this process

VERIFICATION SUMMARY

Five sites (11%) could not verify measure 5.E.1a. Sites were either not able to provide consistent or reliable tracking of referrals for all patients or stated that understaffing reduced ability to communicate with patients and specialty clinics. These sites were hospital affiliated, privately-owned, and FQHC. One site (2%) could not verify measure 5.E.1b due to poor coordinator and communication with neighboring hospitals; this site was a rural health clinic.

NARRATIVE SUMMARY

Most sites (87%) reported that referrals made by the clinic are coordinated and referral visits are tracked internally (78%). Many sites (86%) had a staff member who would provide direct management for all referrals and about half (55%) had a recognized, dedicated CC. It was encouraging to see that 20 sites (69%) attesting to measure 5.E described all staff as dedicated.

External communication with referral and specialty care clinics appears high. Many sites reported that they communicate well with outside providers (76%) and community-based organizations (69%) about the needs of their patients. Many sites (86%) also mentioned having a data tracking system in place to better coordinate referrals and other services. Additionally, just under half (44%) mentioned specifically using an EHR system to facilitate this.

For 5.E.1a, there were 45 attested sites; for 5.E.1b, there were 42; and finally for 5.E, there were 29. These measures were separated, similar to measure 5.C. This does not appear necessary and in fact, based on the 2014 TA guide, these measures have been combined.

5.F – Comprehensive Care Planning

COMMON PRACTICES ACROSS SITES

- **Written Care Plan:** Only half of sites provide a written care plan for high-risk patients and less than half were able to describe their process for identifying patients in need of care plans
- **Clear Goals:** Only half of sites stated clear goals within the care plan
- **Developed Collaboratively with Patient & Clinician:** A few sites acknowledged the inclusion of patients when developing the care plan

VERIFICATION SUMMARY

There were 12 sites (36%) unable to verify this measure. Most either did not have a comprehensive care plan in place with all required components or had not yet implemented care plans into visits. Of these 12 sites, most sites were privately-owned clinics; only a few were hospital affiliated or a FQHC.

NARRATIVE SUMMARY

Of sites that attested to this measure, over half (64%) were able to provide a written care plan for patients. Less than half the sites (45%) described the specific process used to identify high-risk patients that would benefit from a care plan. Many sites included clear goals regarding preventive and chronic illness care (52%) as well as self-management goals (52%).

A few sites (21%) mentioned that the care plan was co-developed between the patient and the clinician. This was a unique component of only a few site reports.

This measure appears to no longer exist according to the 2014 TA guide.

BEST PRACTICE EXAMPLE FROM THE FIELD

KPNW-NLR "provides focused high intensity support to patients with complex chronic conditions that are high utilizers of ED and hospital services. Chronic pain therapeutic management plans are used, which include patient pain inventories. The cases and plans for patients with chronic pain/taking chronic narcotics are reviewed in care conferences, and difficult cases are reviewed by a Chronic Pain Team. [T]he diabetic case manager stated that she conducts an initial assessment and based on findings, develops an individualized care plan with goals based on patient input and evidence-based guidelines. A schedule for follow-up is established to assess the patient's progress toward meeting their goals. The patient also receives a letter summarizing the care plan, which includes self-management activities and goals."

5.G.0 – End-of-Life Planning

COMMON PRACTICES ACROSS SITES

- **Palliative Care/Hospice Referrals:** Most sites provide referrals for palliative care and/or hospice for patients
- **POLST Planning Process:** Over three-quarters of sites use POLST to guide the end-of-life planning process
- **Advanced Directive Documents:** Less than half use Advanced Directive legal documents

VERIFICATION SUMMARY

One site (2%) was not able to verify this measure. This site did not have a routine strategy to address end-of-life issues and was not familiar with POLST. This is a privately-owned primary care clinic.

NARRATIVE SUMMARY

This measure focused on end-of-life planning processes at each site. Many sites (91%) provide referrals for palliative care and hospice to their patients. In addition to referrals, many sites (86%) used POLST to aid in the end-of-life planning process. However, under half (44%) used Advanced Directive documents.

Few sites mentioned: providing or referring patients to counseling services (9%), and partnering with community organizations or coalitions (5%). These could be areas for improvement for sites wanting to provide more comprehensive end-of-life services.

This measure 5.G.0 is now measure 5.F in the 2014 TA guide.

BEST PRACTICE EXAMPLE FROM THE FIELD

"It was reported that the clinic also uses "Choosing Options, Honoring Options," a coalition of individuals and organizations whose purpose is to facilitate end of life conversations in the community. This program provides end of life education and resources to individuals, family members, caregivers and professional staff. Additionally, in support of this philosophy, all clinic staff completed their own POLSTs and advance directives."

CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE

COMMON THEMES ACROSS SITES

- **Patient Engagement:** Sites were lacking on patient engagement activities
- **Quality Improvement:** About a quarter of sites need to improve patient-centered QI projects
- **Data Tracking:** Half the sites need to improve tracking of survey data
- **Staff Engagement:** About a third of sites need to better engage staff and other providers

VERIFICATION SUMMARY

- **Measure 6.A:** 4 unverified sites
- **Measure 6.B:** 0 unverified sites
- **Measure 6.C:** 1 unverified site

SUMMARY

- For a majority of sites (86%), patient engagement activities were recommended. This includes shared decision making, group visits, patient advisory council, and encouraging patients to be more proactive in their health. Additionally, 13 sites (23%) were encouraged to implement quality improvement projects that are specifically focused around patient experience, care, and coordination.

- Data tracking and analysis was also recommended to about half the sites (46%), especially for CAHPS survey results. For the sites not using a CAHPS survey, it was suggested to those 19 sites (34%) to use a CAHPS-specific survey in the future.

- Staff engagement and empowerment was also mentioned as an area for improvement for 20 sites (36%). This includes sharing data with staff to assist in identifying areas for improvement.

Based on the 2014 TA guide, the following measures were not included in any sites visits:

- *6.D – Communication of Rights, Roles, and Responsibilities* ***(not in analysis)***

6.A – Language/Cultural Interpretation

COMMON PRACTICES ACROSS SITES

- **Interpreter Service:** Many sites use an interpreter service for patients that speak other languages
- **Bilingual Staff:** Nearly three-quarters of sites have bilingual staff on-site

VERFIFICATION SUMMARY

The 4 sites (7%) unable to verify meeting this measure could not provide interpreter services throughout all operating hours. All of these sites are privately-owned clinics.

NARRATIVE SUMMARY

Almost all sites were able to verify meeting this measure for language/cultural interpretation. Fifty-one sites (89%) confirmed use of an interpreter service, while 41 sites (72%) had bilingual staff. Many sites have access to both interpreter service and bilingual staff. It was surprising, however, that only 9 sites (16%) mentioned use of bilingual materials. Additionally, 10 sites (18%) relied on family members for interpretation and translation services. These sites should be encouraged to hire an interpreter service in the future.

6.B – Education & Self-Management Support

COMMON PRACTICES ACROSS SITES

- **Educational Materials:** Every site reported sharing written materials with patients, with about half focused on prevention
- **Referral to Community Programs:** Over half the sites include referrals to community programs as part of education and self-management support
- **On-Site Counseling:** Only a quarter of sites offered counseling on-site

VERIFICATION SUMMARY

No sites were unable to meet this measure.

NARRATIVE SUMMARY

Every site (100%) was verified that attested to this measure by providing written materials and educational resources to patients; less than half the sites (40%) mentioned these materials and resources had a focus on prevention. Over half the sites (56%) also made referrals for patients to community programs and services. Only a few (25%) offered on-site counseling for education and self-management issues.

BEST PRACTICE EXAMPLE FROM THE FIELD

"The clinician provides much of the patient education and may use materials from the education module in NexGen or access other written materials [..] for topics such as sleep hygiene, depression, relaxation exercises, smoking cessation, medications, and dry mouth. MCMC also offers diabetes health and education services to help people understand what a diagnosis of diabetes means and how to live a healthy life with diabetes. In addition to one-on-one care and counseling, training on the proper use of self-management tools, including blood sugar monitoring and insulin administration devices, is offered."

All sites met the Tier 1 level for this measure. It appears that sites are not tracking when resources and materials are distributed. Use and qualifications of Tier 2 and 3 for this measure could be reconsidered.

6.C – Experience of Care

COMMON PRACTICES ACROSS SITES

- **Patient Survey (non-CAHPS & CAHPS):** All sites administered a patient care survey
- **PCPCH benchmarks:** Very few sites met the defined benchmarks for this measure on care experience
- **Outside Contractor:** Only a quarter of sites used an outside contractor to administer the survey
- **Survey Components:** There is inconsistent reporting of survey components

VERIFICATION SUMMARY

One site (2%) could not verify this measure because the site did not collect the minimum 30 completed surveys. Additionally clinic staff did not review survey results. This site is a privately-owned clinic.

NARRATIVE SUMMARY

All sites (100%) administered a patient care survey. Of the attested sites, almost two-thirds (62%) administered a CAHPS survey, however only 3 sites (6%) met the defined benchmarks. These sites were all privately-owned clinics. The structuring of this measure may be to be reassessed with the low number of sites meeting Tier 3 requirements.

Most sites administered the survey themselves, while 13 sites (26%) contracted with an outside company to administer them. Of the sites not using a CAHPS survey, 8 sites (44%) planned on using CAHPS surveys in the future.

Reports were inconsistent in stating the components of the surveys, non-CAHPs or CAHPS. Components included: provider communication (76%), staff helpfulness (76%), care coordination (66%), access to care (58%), provider rating (20%), and willingness to recommend (8%).

It was surprising that only 10 sites (20%) mentioned that they share survey data with staff members. This could be identified as an area for improvement in the future.