Evaluation Highlight No. 2, May 2013

How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?

Many State Medicaid and CHIP programs and private health plans are SXUVXLQJ PHGLFDO KRPH LQLWLDWLYHV LQ RI FDUH IRU FKLOGUHQ DQG DGXOWV EXW Y and measurement goals have led to the development of a number of GL•HUHQW PHGLFDO KRPH PHDVXUHV (valuation Highlight W examines the measurement of medical homeness in selected CHIPRA 4XDOLW\ 'HPRQVWUDWLRQ *UDQW 3URJUDP development of the Medical Home Index-Revised Short Form (MHI-RSF), an adaptation of the short version of the Medical Home Index 0+, IRU XVH LQ HYDOXDWLQJ WKH GHPRQV MHI-RSF data, we present preliminary statistics on medical homeness

CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

The 18 demonstration States are implementing 51 projects in ve general categories:

- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The demonstration began on February 22, 2010 and will conclude on February 21, 2015. The national evaluation of the grant program started on August 8, 2010 and will be completed by September 8, 2015.

KEY MESSAGES

Selecting a tool for assessing medical homeness is critical for implementing DQG HYDOXDWLQJ H•RUWV WR HQKDQFH PHC
The experiences of the demonstration States provide important lessons IRU RWKHU PHGLFDO KRPH LQLWLDWLYHV

- &+,3 5$ GHPRQVWUDWLRQ 6WDWHV VHOHFW based on a variety of factors, including other medical home activities in the State, the target population for the medical home intervention, DQG SURSHUWLHV RI WKH WRROV WKHPVHC
- The MHI-RSF provides a low-burden option for collecting valid and UHOLDEOH LQIRUPDWLRQ RQ PHGLFDO KRPHQ

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Background

The patient centered medical home (PCMH) model originated in the pediatric community and has seen renewed popularity in recent H•RUWV WR LPSURYH TXDOLW\ RI FDUH IRU F K L O G U H Q[1]. The Agency for Healthcare Research and Quality (AHRQ) and several professional societies agree on the general characteristics of a medical home, which include accessible, coordinated, continuous, comprehensive, and patient-centered F D U H[2]. However, each concept can be G H À Q H G GL•HUHQWO\ DFURVV GLYHUVH FOLQLFV practices, and patient populations, and as a result, many medical home assessment or recognition tools K D Y H HPHUJHG[3]. Each tool WLPH includes unique questions to capture D JLYHQ FRQFHSW DQG SODFHV GL•HUHQW HPSKDVLV RQ VSHFLÀF DWWULEXWHV 7KH XVH RI GL•HUHQW WRROV SUHYHQWV “apples-to-apples” comparisons across demonstration projects, thus making any evaluation less useful IRU SROLF\PDNHUV DQG UHVHDUFKHUV Nonetheless, measurement of medical homeness—the extent to which a practice exhibits the attributes of a medical home—is critical to:

- (YDOXDWLQJ ZKHWKHU GHPRQVWUDWLRQV and pilots actually transform clinics DQG SUDFWLFHV LQWR PHGLFDO KRPHV
- 8QGHUVWDQGLQJ ZKHWKHU VXFK WUDQVIRUPDWLRQV D•HFW NH\ KHDOWK care outcomes such as access, quality, RU FRVWV

Twelve States are using CHIPRA Quality Demonstration Grant Program funding to design and implement PCMHs for child-serving practices, including pediatric and family practices DQG)HGHUDOO\ 4XDOLÀHG +HDOWK &HQWHUV)4+&V

leveraged its prior work with commercial and Medicaid health plans to be one of the first to develop a medical home recognition tool. To date, the NCQA 2008 tool has been used most frequently in evaluations of medical home demonstrations.

- Alignment with other medical home initiatives underway in their State. Using the NCQA tool was desirable because (1) it sends a consistent message to practices about what a medical home is and how it will be measured and (2) eliminates burden on practices that might have to participate in multiple initiatives by Medicaid, CHIP, or commercial insurers, given that most practices serve children covered by multiple payers.

cross-state impact analysis would not be I H D V L E O H

Modi cations to the Medical Home Index produced a viable measure for cross-state comparisons

To enable a cross-state impact evaluation of the PCMH demonstrations, the national evaluation team asked selected States to collect supplemental data on medical homeness using a reliable and valid measurement tool that would be responsive to changes over the grant S H U L R G 3 U R M H F W V W D • L Q P D Q \ 6 W D W H V

Table 3. Distribution of Baseline MHI-RSF Scores Across 63 Intervention Practices

	Mean (SD)	Minimum	Median	Maximum
Standardized total score	56.1 (11.4)	32.1	53.6	91.1
Overall mean score	4.5 (0.9)	2.6	4.3	7.3
Domain mean scores				
Organizational capacity	4.5 (1.1)	1.0	4.3	6.7
Chronic condition management	4.5 (0.9)	3.0	4.3	7.5
Care coordination	4.5 (1.2)	1.7	4.3	7.7
Community outreach	4.0 (1.8)	1.0	4.0	8.0
Data management	5.0 (1.2)	2.5	5.0	8.0
Quality improvement	3.9 (2.0)	1.0	3.0	8.0

Note: Overall standardized total scores are standardized to a scale of 1-100. The overall and domain mean scores are on a scale of 1-8. SD is standard deviation.

States (Alaska, Massachusetts, North Carolina, Oregon, South Carolina, and West Virginia) provided baseline data to the national evaluation team for this analysis. The data presented here were collected between July 2011 and May 2012, and methods for selecting demonstration practices and collecting data varied across States. Each Sta[illegible] include practices that varied along key dimensions, such as size, ownership, and geographic location, but selected practices do not nece[illegible] mix of practices in each State as a whole. As a result, the results presented in this Highlight should not be interpreted as representative of all practices in these States or child-serving practices more generally.[11]

Twenty-five intervention practices in two States (Massachusetts, North Carolina) completed the full MHI, while 38 intervention practices in four States (Alaska, Oregon, South Carolina, and West Virginia) completed the MHI-RSF. In this analysis, we consider only the 14 questions in the MHI-RSF, even if the practice submitted the full MHI. Table 3 describes the standardized total scores for the MHI-RSF across 63 intervention practices. The standardized total score adds the scores across all questions on the MHI-RSF and assigns a value on a scale of 0-100, with 100 representing the highest degree of medical homeness.[12] [illegible] and the mean of [illegible] average score across the practices. The median score of [illegible] that half of all practices scored below the scale. Overall, [illegible] that while some practices had a high level of medical homeness before the demonstration program, many practices have [illegible] substantial room [illegible]

Table 3 also includes the overall and domain mean scores. These scores average the scores across questions on the entire survey and within each domain on a scale of [illegible][13] overall score was [illegible] domain scores ranged from a low of [illegible] for quality improvement to a high of [illegible] for data management. This indicates that there are larger opportunities for improvement in some domains, but that [illegible] progress is possible in all areas.

Conclusions

CHIPRA demonstration States selected different assessment tools based on a variety of factors, including other medical home activities in the State, the target population for the medical home intervention, and properties of the tools themselves. The [illegible] tools creates numerous challenges for policymakers and researchers, but by developing the MHI-RSF, the national evaluation team was able to generate the consistent measure of medical homeness needed for its future cross-State quantitative ev[illegible] analysis suggests that the MHI-RSF provides a valid and reliable measure of medical homeness, and baseline data indicate variation in the level of medical homeness across practi[illegible] that there is room for improvement as a result of the CHIPRA demonstration projects. Moreover, by u[illegible] RSF, the national evaluation will be able to provide policymakers and program directors with useful information about [illegible] the relative success of [illegible] to enhancing medical h[illegible] initiatives.

Implications

[illegible] suggest State program staff are [illegible] difficult decisions abou[illegible] for tracking their efforts [illegible] medical homes. Selectin[illegible] tool for assessing medical homeness is critical, but there is no consensus on the best tool for any g[illegible] experience of the demonstration States suggests the following:

- NCQA is a leader in medical home recognition, and its tool is often used for consistency with other medical home initiatives in the State and for th[illegible] provided by its docume[illegible]
- The MHI was designed sp[illegible] assess attributes of the medical home for children, particularly for children with special health care n[illegible] with the formal NCQA application process, the MHI's low cost and ease of administration could make it attractive under certain circums[illegible]